number of times reopened = 0-9.

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

(3) Settled with Audit

(4) Reopened (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 OF INDIANA, INC. (15-0169) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 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 FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1	Holly 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 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	391, 225	131, 469	0	0	1.00
2.00	SUBPROVI DER - I PF	0	27, 181	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	418, 406	131, 469	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 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 In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0169 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 11:44 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 7150 CLEARVISTA DRIVE 1.00 PO Box: 1.00 State: IN 2.00 City: INDIANAPOLIS Zip Code: 46256 County: MARION 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal COMMUNITY HOSPITAL OF 150169 26900 02/25/2008 Ν Р Р 3.00 1 NDI ANA, INC. Subprovi der - IPF COMMUNITY MENTAL HEALTH Р 4.00 15S169 26900 4 01/01/2010 N 0 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) 01/01/2023 12/31/2023 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 N 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.

Heal th	Financial Systems COMMUNITY F	OSPITAL OF I	INDIANA, IN	C.		In Lieu	of For	m CMS-	2552-10
HOSPI T.	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION [Provider CC			1/2023 1/2023	Workshe Part I Date/Ti 5/24/20	me Pre)24 11:	pared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicai HMO day	ys Med	ther li cai d lays	
24 00	If this provider is an IPPS hospital, enter the	1. 00 3, 915	2. 00 3, 024	3.00	4. 00	5. 00 24, 1		o. 00 70	24.00
	in-state Medicaid paid days in column 1, in-state in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. If this provider is an IRF, enter the in-state	n	·		0	24,	0	19	25. 00
	Medicaid paid days in column 1, the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	e	O	J					
					Urban/Ru		Date of 2.0		-
26. 00	Enter your standard geographic classification (not	wage) status	at the beg	ginning of t		1	2. (26.00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not preporting period. Enter in column 1, "1" for urban penter the effective date of the geographic reclassion	wage) status or "2" for r	ural. If ap	d of the cos oplicable,	t	1			27. 00
35. 00	If this is a sole community hospital (SCH), enter t			CH status in		0			35. 00
	effect in the cost reporting period.				Begi nn		Endi		
36. 00	Enter applicable beginning and ending dates of SCH		cript line	36 for numb	1.0 er	00	2. (00	36.00
37. 00	of periods in excess of one and enter subsequent da If this is a Medicare dependent hospital (MDH), ent		r of period	ds MDH statu	s	0			37.00
37. 01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for accordance with FY 2016 OPPS final rule? Enter "Y"								37. 0 ²
38. 00	instructions) If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number enter subsequent dates.								38.00
	onto sussiquont dates.				Y/I		Υ/		
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (or "N" for no. (see instructions)	i), (ii), or the mileage	(iii)? Ent	er in colum nts in	n		2. (N		39. 00
40. 00	Is this hospital subject to the HAC program reduction of the hospital subject to the HAC program reduction. The form of the hospital subject to the ho	ober 1. Ente	r "Y" for y				N		40.00
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	(555 11.51	. 401. 007		'	V 1. 00	XVI I I	XI X 3. 00	
	Prospective Payment System (PPS)-Capital	:							45.00
45.00	Does this facility qualify and receive Capital paymwith 42 CFR Section §412.320? (see instructions)	ent for disp	горог стопат	e Share III	accor dance	N	Y	N	45.00
46. 00	Is this facility eligible for additional payment expursuant to 42 CFR §412.348(f)? If yes, complete Wk: Pt. III.	ception for st. L, Pt. I	extraordina II and Wkst	ary circumst L-1, Pt.	ances I through	N	N	N	46.00
47. 00 48. 00	Is this a new hospital under 42 CFR §412.300(b) PPS Is the facility electing full federal capital payme Teaching Hospitals					N N	N N	N N	47. 00 48. 00
56.00	Is this a hospital involved in training residents in periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after December the instructions. For column 2, if the response to involved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable	"Y" for yes er 27, 2020, column 1 is rams in the CRs) MA dir	or "N" for under 42 ("Y", or if prior year	no in colu CFR 413.78(b this hospit or penultim	mn 1. For)(2), see al was ate year,	Y	Y		56. 00
57. 00	"Y" for yes; otherwise, enter "N" for no in column : For cost reporting periods beginning prior to Decem is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no residents start training in the first month of this	ber 27, 2020 h residents in column 1. cost report	in approved If column ing period?	d GME progra 1 is "Y", d P Enter "Y"	ms trained id for yes or	Y			57.00
	"N" for no in column 2. If column 2 is "Y", comple complete Wkst. D, Parts III & IV and D-2, Pt. II, i beginning on or after December 27, 2020, under 42 C which month(s) of the cost report the residents wer for yes, enter "Y" for yes in column 1, do not comp	f applicable FR 413.77(e e on duty, i	. For cost)(1)(iv) ar f the respo	reporting p nd (v), rega onse to line	eriods rdless of 56 is "Y"				

	Enter in column 2, the program code. Enter in column							
	3, the IME FTE unweighted count. Enter in column 4,							
	the direct GME FTE unweighted count.							
					1.00			
	ACA Provisions Affecting the Health Resources and Services Administration (HRSA)							
62.00	2.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.0							
	your hospital received HRSA PCRE funding (see instru	ctions)						
62. 01	Enter the number of FTE residents that rotated from a	a Teaching Health Center	r (THC) into	your hospital	0.00	62. 01		
	during in this cost reporting period of HRSA THC proj	gram. (see instructions))					
	Teaching Hospitals that Claim Residents in Nonprovid	er Settings						
63.00	Has your facility trained residents in nonprovider so	ettings during this cost	t reporting p	eriod? Enter	N	63.00		
	"Y" for yes or "N" for no in column 1. If yes, comple	ete lines 64 through 67.	. (see instru	ctions)				

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)

	F	eriod: rom 01/01/202 o 12/31/202	3 Date/Ti	me Prepar 24 11:44	
			1.0	00	
Direct GME in Accordance with the FY 2023 IPPS Final Rule, 87 FR 49065-4907					
68.00 For a cost reporting period beginning prior to October 1, 2022, did you obta MAC to apply the new DGME formula in accordance with the FY 2023 IPPS Final (August 10, 2022)?				00	8. 00
		1.	00 2.00	3. 00	
Inpatient Psychiatric Facility PPS					
70.00 Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain Enter "Y" for yes or "N" for no.	n an IPF subp	orovi der? \	·	70	0. 00
71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching			N N	0 7	1. 00
recent cost report filed on or before November 15, 2004? Enter "Y" for yes 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in					
program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes	or "N" for r	no.			
Column 3: If column 2 is Y, indicate which program year began during this co (see instructions)	ost reportino	g period.			
Inpatient Rehabilitation Facility PPS			.		
75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it cont subprovider? Enter "Y" for yes and "N" for no.	tain an IRF	"	N	/5	75. 00
76.00 If line 75 is yes: Column 1: Did the facility have an approved GME teaching			N N	0 76	6. 00
recent cost reporting period ending on or before November 15, 2004? Enter "\no. Column 2: Did this facility train residents in a new teaching program in					
CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If co					
indicate which program year began during this cost reporting period. (see in	nstructions)				
Long Term Care Hospital PPS			1.0	00	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no.			N	80	30. 00
81.00 Is this a LTCH co-located within another hospital for part or all of the cos	st reporting	period? Enter	- N	8	31. 00
TEFRA Providers					
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "86.00 Did this facility establish a new Other subprovider (excluded unit) under 42			N		35. 00 36. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.					
87.00 Is this hospital an extended neoplastic disease care hospital classified und 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	der section		N	87	37. 00
		Approved for			
		Approved for Permanent Adjustment	Appro Perman	nent	
		Permanent Adjustment (Y/N)	Appro Permai Adjusti	nent ments	
88.00 Column 1: Is this hospital approved for a permanent adjustment to the TEFRA	target	Permanent Adjustment	Appro Perman	nent ments	38. 00
amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col.	target . 2 and line	Permanent Adjustment (Y/N) 1.00	Appro Permai Adjusti	nent ments	38. 00
amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 89. (see instructions) Column 2: Enter the number of approved permanent adjustments.	. 2 and line	Permanent Adjustment (Y/N) 1.00 N	Appro Permai Adj ustr 2.0	oved nent ments 00 0 88	38. 00
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amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 89. (see instructions) Column 2: Enter the number of approved permanent adjustments. 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 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 TEFRA target amount per discharge. Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report of the full or in part? Enter "Y" for yes or "N" for no in the applicable column.	. 2 and line Wkst. A Line No. 1.00 0.00 er "Y" for either in	Permanent Adjustment (Y/N) 1.00 N Effective Da 2.00 V 1.00	Approper Perman Adjustr 2.00 te Approper Perman Adjustr Amount Discharge 3.00 XII 2.00 Y	oved nent ments 00 0 88 oved nent ment Per arge 00 0 89 oved 00 0 89 oved 00 0 99 oved 00 0 89 oved 00 0 0 89 oved 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	39. 00 20. 00 21. 00
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amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 89. (see instructions) Column 2: Enter the number of approved permanent adjustments. 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 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 TEFRA target amount per discharge. Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report of the full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and >>> 0.	Wkst. A Line No. 1.00 0.00 er "Y" for either in n)? (see	Permanent Adjustment (Y/N) 1.00 N Effective Da 2.00 V 1.00	Approper Perman Adjustr 2.00 te Approper Perman Adjustr Amount Discharge 3.00 XII 2.00 Y	oved nent ments 00 0 88 oved nent ment Per arge 00 0 89 oved 00 0 89 oved nent ment Per arge 00 0 9 oved 00 0 9 oved 00 0 89 oved 00 0 0 89 oved 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	39. 00 20. 00 21. 00
amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 89. (see instructions) Column 2: Enter the number of approved permanent adjustments. 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 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 TEFRA target amount per discharge. Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report of full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and N"" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the yes or "N" for no in the applicable column.	er "Y" for either in n)? (see	Permanent Adjustment (Y/N) 1.00 N Effective Da 2.00 N N N N	Approper Permai Adjustra Adjustra Amount Discha 3.0	oved nent ments 00 88 oved nent ment ment ment ment ment ment ment	99. 00 90. 00 91. 00
amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 89. (see instructions) Column 2: Enter the number of approved permanent adjustments. 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 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 TEFRA target amount per discharge. Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report of the full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and "Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no applicable column.	er "Y" for either in n)? (see	Permanent Adjustment (Y/N) 1.00 N Effective Da 2.00 N N N N N	Approperman Adjustra Amount Discha 3.0	oved nent ments 00 0 88 oved nent ment per arge 10 0 8 oved nent ment per arge 10 0 9 oved nent per arge 10 0 9 oved nent ment per arge 10 0 9 oved nent ment per arge 10 0 9 oved nent per arge 10 0 9 oved nent per arge 10 0 0 8 oved nent per arge 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	20. 00 21. 00 22. 00 23. 00
amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 89. (see instructions) Column 2: Enter the number of approved permanent adjustments. 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 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 TEFRA target amount per discharge. Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report of full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and Y"" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the openicable column.	er "Y" for either in n)? (see XIX? Enter in the	Permanent Adjustment (Y/N) 1.00 N Effective Da 2.00 N N N N	Approperman Adjustra Adjustra Adjustra Adjustra Adjustra Adjustra Amount Discha 3.0	O O St	99. 00 90. 00 91. 00 92. 00
amount per discharge? Enter "Y" for yes or "N" for no. If yes, complete col. 89. (see instructions) Column 2: Enter the number of approved permanent adjustments. 89.00 Column 1: If line 88, column 1 is Y, enter the Worksheet A line number 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 TEFRA target amount per discharge. Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report of full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and N"" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column.	er "Y" for either in n)? (see XIX? Enter in the	Permanent Adjustment (Y/N) 1.00 N Effective Dar 2.00 N N N N N N O.00	Approperman Adjustra Adjustra Amount Discha 3.0	O O St	90. 00 91. 00 92. 00 94. 00

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HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider (eriod: fom 01/01/2023 0 12/31/2023	Worksheet S- Part Date/Time Pr	
		1270172020	5/24/2024 11	
	Premi ums	Losses	Insurance	
	1. 00	2.00	3.00	
118.01 List amounts of malpractice premiums and paid losses:	3, 159, 845	0		0 118. 0
			2.22	_
110 02 Are malaractice aremiums and said lesses reported in a cost center other	than the	1. 00 N	2. 00	118. C
Are malpractice premiums and paid losses reported in a cost center other Administrative and General? If yes, submit supporting schedule listing of and amounts contained therein.		IV		118.0
I19. 00 DO NOT USE THIS LINE				119. (
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless pro §3121 and applicable amendments? (see instructions) Enter in column 1, "\" "N" for no. Is this a rural hospital with < 100 beds that qualifies for 1 Hold Harmless provision in ACA §3121 and applicable amendments? (see inst	Y" for yes or the Outpatient	N	N	120. (
Enter in column 2, "Y" for yes or "N" for no.				
121.00 Did this facility incur and report costs for high cost implantable device patients? Enter "Y" for yes or "N" for no.	es charged to	Υ		121. (
122.00 Does the cost report contain healthcare related taxes as defined in §1903	3(w)(3) of the	N		122. 0
Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included.	er in column 2			
123.00 Did the facility and/or its subproviders (if applicable) purchase profess		Υ	N	123. 0
services, e.g., legal, accounting, tax preparation, bookkeeping, payroll, management/consulting services, from an unrelated organization? In column for the page of the page o				
for yes or "N" for no. If column 1 is "Y", were the majority of the expenses, i.e., greater than	n 50% of total			
professional services expenses, for services purchased from unrelated organizations				
located in a CBSA outside of the main hospital CBSA? In column 2, enter '"N" for no.	"Y" for yes or			
Certified Transplant Center Information				
25.00 Does this facility operate a Medicare-certified transplant center? Enter and "N" for no. If yes, enter certification date(s) (mm/dd/yyyy) below.	"Y" for yes	N		125.
26.00 If this is a Medicare-certified kidney transplant program, enter the cert	tification date			126.
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare-certified heart transplant program, enter the certi	ification date			127. (
in column 1 and termination date, if applicable, in column 2.	ification data			120 (
28.00 If this is a Medicare-certified liver transplant program, enter the certi in column 1 and termination date, if applicable, in column 2.	irrcation date			128.
129.00 If this is a Medicare-certified lung transplant program, enter the certifing in column 1 and termination date, if applicable, in column 2.	fication date			129.
130.00 If this is a Medicare-certified pancreas transplant program, enter the co	erti fi cati on			130.
date in column 1 and termination date, if applicable, in column 2.				101
31.00 If this is a Medicare-certified intestinal transplant program, enter the date in column 1 and termination date, if applicable, in column 2.	certification			131.
32.00 If this is a Medicare-certified islet transplant program, enter the certi	ification date			132.
in column 1 and termination date, if applicable, in column 2. 33.00Removed and reserved				133.
34.00 f this is a hospital-based organ procurement organization (OPO), enter t	the OPO number			134.
in column 1 and termination date, if applicable, in column 2.				
All Providers 40.00 Are there any related organization or home office costs as defined in CMS	S Pub. 15-1.	Y	HB0720	140.
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home	e office costs			
are claimed, enter in column 2 the home office chain number. (see instruction 1.00 2.00	ctions)	3. 00		
If this facility is part of a chain organization, enter on lines 141 thro	ough 143 the nam		of the	
home office and enter the home office contractor name and contractor num				
41.00 Name: COMMUNITY HEALTH NETWORK Contractor's Name: WISCONSIN PHYSI	CI ANS Contractor	s Number: 0810	11	141.
42.00 Street: 1500 NORTH RITTER AVENUE PO Box:				142.
43. 00 Ci ty: INDI ANAPOLI S State: IN	Zi p Code:	4621	9-3095	143.
			1.00	-
44.00 Are provider based physicians' costs included in Worksheet A?			Y Y	144.
		1 00	2.00	
45.00 f costs for renal services are claimed on Wkst. A, line 74, are the cost	ts for	1. 00 Y	2. 00	145.
inpatient services only? Enter "Y" for yes or "N" for no in column 1. If	column 1 is	1		140.
			i .	1
no, does the dialysis facility include Medicare utilization for this cost period? Enter "Y" for yes or "N" for no in column 2.	t reporting			
no, does the dialysis facility include Medicare utilization for this cost	st report?	N		146. (

Health Financial Systems	COMMUNITY HOS	PITAL OF	INDIANA, IN	C.		In Lie	u of Form CMS	5-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE			Provi der CC			riod: om 01/01/2023	Worksheet S-	-2 repared:
							1, 00	
147.00 Was there a change in the statisti	cal hasis? Enter "V"	for ves	or "N" for	no			1.00 N	147. 00
148.00 Was there a change in the order of							N N	148. 00
149.00 Was there a change to the simplifi					for no).	N	149. 00
			Part A	Part		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 '							. 13)	
155. 00 Hospi tal			N	N		N	N	155. 00
156.00 Subprovi der - IPF			N	N		N	N	156. 00
157.00 Subprovi der – IRF			N	N		N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF			N	N		N	N	158. 00 159. 00
160.00HOME HEALTH AGENCY			N N	N N		N N	N N	160.00
161, 00 CMHC			IV	N N		N	N N	161. 00
101. 00 SWITC				14		19	1.00	101.00
Multicampus							1.00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that h	nas one o	or more campu	ises in di	fferen	nt CBSAs?	N	165. 00
	Name		County	State	Zip C	ode CBSA	FTE/Campus	
	0		1. 00	2. 00	3.0	0 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	00 166. 00
							1.00	-
Health Information Technology (HI	() incentive in the A	Ameri can	Recovery and	Rei nvest	ment A	Act		
167.00 Is this provider a meaningful user							Υ	167. 00
168.00 If this provider is a CAH (line 10				167 is "	Y"), e	enter the		168. 00
reasonable cost incurred for the H					6			
168.01 If this provider is a CAH and is rexception under §413.70(a)(6)(ii)?						nardsni p		168. 01
169.00 If this provider is a meaningful utransition factor. (see instruction	ıser (line 167 is "Y"), enter the	9.	99169. 00
Tel and the first detric	,					Begi nni ng	Endi ng	
						1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	peginning date and en	ndi ng dat	e for the re	porti ng				170. 00
						1. 00	2. 00	
171.00 If line 167 is "Y", does this prov						N		0 171. 00
section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	ımn 1. If column 1 is							

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C	CN: 15-0169	Peri od: From 01/01/2023 To 12/31/2023	Date/Time Pro 5/24/2024 11:	epared:
				Y/N 1. 00	2. 00	
	PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSE General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			N		1.0
	Treporting period: IT yes, enter the date of the change IT c	orumin z. (see	Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare D	rogram2 lf	1.00 N	2. 00	3. 00	2.0
	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	n 3, "V" for				
00	Is the provider involved in business transactions, includin 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)	ffices, drug er or its f the board	Y			3.0
			Y/N	Type	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	
00	Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava	or Compiled,	Y	А	03/28/2024	4.0
00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5. 0
	Those on the fired fridherd Statements. If yes, submit fee	oner i i a ci on.		Y/N	Legal Oper.	
	Annual Charles Assisted			1. 00	2. 00	
00	Approved Educational Activities Column 1: Are costs claimed for a nursing program? Column	2: If ves. is	the provide	r N		6.0
00	the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	,		N		7. 0
00	Were nursing programs and/or allied health programs approve cost reporting period? If yes, see instructions.	d and/or renew	· ·	e N		8.0
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated o	S.		Y N		9. (
. 00	cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. (
	Trademing 11 eg. dim en nei helitete 11. 11 year deel 11. 11.			<u> </u>	Y/N 1. 00	
	Bad Debts					
. 00	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. (
. 00	If line 12 is yes, were patient deductibles and/or coinsura instructions.	nce amounts wa	nived? If yes,	see	N	14.
. 00	Bed Complement Did total beds available change from the prior cost reporti	ng period? If	yes, see ins	tructions.	N	15. (
			t A	Par		
		Y/N 1.00	Date	Y/N	Date	
	PS&R Data	1.00	2.00	3. 00	4. 00	
. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see	N		N		16. (
. 00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)	Y	04/11/2024	Υ	04/11/2024	17. (
. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	N		N		18. (
	cost report: ir yes, see Histructions.					19.

Heal th	Financial Systems COMMUNITY HOSPITAL	OF INDIANA, II	NC.	In Lie	u of Form CM	S-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0169	Period: From 01/01/2023 To 12/31/2023	Worksheet S Part II	repared:
			i pti on	Y/N	Y/N	
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R		0	1. 00 N	3. 00 N	20. 00
20.00	Report data for Other? Describe the other adjustments:			IN IN	IV	20.00
		Y/N	Date	Y/N	Date	
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2.00	3. 00 N	4. 00	21. 00
21.00	records? If yes, see instructions.	IV		IN		21.00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	10SPI TALS)			
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	n instructions				22, 00
23. 00	Have changes occurred in the Medicare depreciation expense		sals made dur	ina the cost		23. 00
	reporting period? If yes, see instructions.					
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	· ·				24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see		25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost reporti	ng period? I	f yes, see		26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportir	ng period? If	yes, submit		27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into dur	ing the cost	reporting		28. 00
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service R	eserve Fund)		29. 00
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu		debt? If yes	, see		30. 00
31. 00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes	, see		31. 00
	instructions. Purchased Services					
32. 00	Have changes or new agreements occurred in patient care ser		ed through co	ntractual		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	uctions. olied pertainir	ng to competi	tive bidding? If		33. 00
	no, see instructions. Provider-Based Physicians					
34.00		arrangement wit	th provider-b	ased physicians?		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		35. 00
	physicians during the cost reporting period? If yes, see in	nstructions.		Y/N	Date	
				1.00	2. 00	
	Home Office Costs					
36. 00						36. 00
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	nome office?			37. 00
38. 00		fice different	from that of			38. 00
	the provider? If yes, enter in column 2 the fiscal year end					
39. 00	If line 36 is yes, did the provider render services to other see instructions.	er chain compor	nents? If yes	,		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00
			00			
	Cost Report Preparer Contact Information	1.	00	2.	00	
41. 00		SHI RLEY		BI SHOP		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	COMMUNITY HEAL	TH NETWORK			42. 00
	preparer.	047 055 ::::		001 0110		
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	317-355-4135		SBI SHOP@ECOMMUI	NITY. COM	43. 00

Heal th	Financial Systems	COMMUNITY HOSPITAL	OF INDIANA,	I NC.	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEN	ENT QUESTIONNAIRE	Provi de		Peri od:	Worksheet S-2	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	
						5/24/2024 11:	44 am
				3.00			
	Cost Report Preparer Contact Informati	on					
41.00	Enter the first name, last name and t	he title/position	DI RECTOR RE	IMBURSEMENT			41. 00
	held by the cost report preparer in c	olumns 1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of th	e cost report					42.00
	preparer.	•					
43.00	Enter the telephone number and email	address of the cost					43.00
	report preparer in columns 1 and 2, r						
		1 3	•				

0 34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

34.00 Temporary Expansion COVID-19 PHE Acute Care

Provider CCN: 15-0169

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/24/2024 11:44 am I/P Days / O/P Visits / Trips Component Worksheet A No. of Beds Bed Days CAH/REH Hours Title V <u>Avai I abl</u> e Line No. 5.00 2.00 4.00 1.00 3.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 30. 00 97, 820 1.00 268 0.00 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 0 6.00 Total Adults and Peds. (exclude observation 97, 820 0 7.00 7.00 268 0.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 31.00 24 8.760 0.00 0 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11.00 NEONATAL INTENSIVE CARE UNIT 12.00 12.00 35.00 48 17, 520 0.00 0 13.00 NURSERY 43.00 0 13.00 Total (see instructions) 340 14.00 14.00 124, 100 0.00 0 CAH visits 15.00 15.00 15.10 REH hours and visits 0.00 0 15. 10 16.00 SUBPROVIDER - IPF 40.00 21 7,665 16.00 SUBPROVIDER - IRF 17.00 17.00 18 00 SUBPROVI DER 18.00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24. 00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 30.00 24. 10 CMHC - CMHC 25.00 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 26.25 Total (sum of lines 14-26) 27.00 361 27.00 28 00 Observation Bed Days 0 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31 00 31.00 32.00 Labor & delivery days (see instructions) 0 0 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

30.00

34.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

34.00 Temporary Expansion COVID-19 PHE Acute Care

Provider CCN: 15-0169

0

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Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/24/2024 11:44 am Full Time Equivalents I/P Days / O/P Visits / Trips Component Title XVIII Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 10.00 7.00 8.00 9.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 15,843 1,811 63, 257 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 18, 529 24, 564 2.00 3.00 HMO IPF Subprovider 2,650 3.00 4.00 HMO IRF Subprovider 4.00 0 0 Hospital Adults & Peds. Swing Bed SNF 5.00 0 C 0 5.00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 15,843 1,811 63, 257 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 1,713 585 7.063 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11.00 NEONATAL INTENSIVE CARE UNIT 12.00 0 1, 212 12,644 12.00 13.00 NURSERY 2, 964 7,614 13.00 Total (see instructions) 6, 572 1, 585. 58 14.00 17, 556 90, 578 3.16 14.00 CAH visits 15.00 0 15.00 15.10 REH hours and visits 0 15.10 16.00 SUBPROVIDER - IPF 1,829 C 4,713 3.00 23.87 16.00 SUBPROVIDER - IRF 17.00 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24. 00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 141 24. 10 CMHC - CMHC 25.00 25.00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 26.25 Total (sum of lines 14-26) 1, 609. 45 27.00 27.00 6.16 28 00 Observation Bed Days 2,095 11, 482 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 2, 521 Employee discount days - IRF 31.00 31.00 32.00 Labor & delivery days (see instructions) 79 1,806 32.00 Total ancillary labor & delivery room 32.01 C 32.01 outpatient days (see instructions) 33.00 33.00 LTCH non-covered days 33.01 LTCH site neutral days and discharges 33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0169

Peri od: Worksheet S-3 From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/24/2024 11:44 am Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 12.00 13.00 14.00 15.00 11.00 PART I - STATISTICAL DATA Hospital Adults & Peds. (columns 5, 6, 7 and 1.00 3, 297 446 17, 548 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 HMO and other (see instructions) 2, 790 3, 416 2.00 3.00 HMO IPF Subprovider 3.00 4.00 HMO IRF Subprovider 4.00 0 Hospital Adults & Peds. Swing Bed SNF 5.00 5 00 6.00 Hospital Adults & Peds. Swing Bed NF 6.00 Total Adults and Peds. (exclude observation 7.00 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 10.00 BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT 11.00 11.00 NEONATAL INTENSIVE CARE UNIT 12.00 12.00 13.00 NURSERY 13.00 Total (see instructions) 17, 548 14.00 0.00 3, 297 446 14.00 CAH visits 15.00 15.00 15.10 REH hours and visits 15.10 16.00 SUBPROVIDER - IPF 0.00 \mathcal{C} 159 0 411 16.00 SUBPROVIDER - IRF 17.00 17.00 18 00 SUBPROVI DER 18 00 SKILLED NURSING FACILITY 19.00 19.00 20.00 NURSING FACILITY 20.00 OTHER LONG TERM CARE 21.00 21.00 HOME HEALTH AGENCY 22 00 22 00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 24. 00 HOSPI CE 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 CMHC - CMHC 25.00 25 00 26.00 RURAL HEALTH CLINIC 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26.25 Total (sum of lines 14-26) 0.00 27.00 27.00 28 00 Observation Bed Days 28 00 29. 00 Ambul ance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 31.00 32.00 Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 0 33.01 LTCH site neutral days and discharges 0 33.01 34.00 Temporary Expansion COVID-19 PHE Acute Care 34.00

| Period: | Worksheet S-3 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION COMMUNITY HOSPITAL OF INDIANA, INC.

Provider CCN: 15-0169

					To	12/31/2023	Date/Time Pre	pared:
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	Adjusted Salaries (col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	44 alli
		1.00	2.00	A-6) 3.00	3) 4. 00	col . 4 5. 00	6. 00	
	PART II - WAGE DATA	1.00	2.00	3.00	4.00	5.00	0.00	
1. 00	SALARIES Total salaries (see	200. 00	141, 731, 700	-533, 126	141, 198, 574	3, 347, 646. 00	42. 18	1.00
	instructions)	200.00			141, 170, 374			
2. 00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		C	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A -		1, 051, 876	0	1, 051, 876	4, 844. 00	217. 15	4. 00
4. 01	Administrative Physicians - Part A - Teaching		C	0	0	0.00	0. 00	4. 01
5. 00	Physician and Non		1, 314, 118	o o	1, 314, 118			
6. 00	Physician-Part B Non-physician-Part B for		C	О	0	0.00	0. 00	6. 00
	hospital-based RHC and FQHC services							
7. 00	Interns & residents (in an	21. 00	C	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and		C	О	0	0.00	0. 00	7. 01
	residents (in an approved programs)							
8. 00	Home office and/or related		C	0	0	0.00	0. 00	8. 00
9. 00	organization personnel SNF	44. 00	C	o	0	0.00	0. 00	9. 00
10. 00	Excluded area salaries (see instructions)		4, 342, 489	-8, 009	4, 334, 480	105, 922. 00	40. 92	10. 00
	OTHER WAGES & RELATED COSTS							
11. 00	Contract labor: Direct Patient Care		15, 457, 353	0	15, 457, 353	131, 870. 00	117. 22	11. 00
12. 00	Contract Labor: Top Level management and other		C	0	0	0. 00	0. 00	12. 00
	management and administrative							
13. 00	services Contract Labor: Physician-Part		1, 673, 709	o	1, 673, 709	13, 902. 00	120. 39	13. 00
14. 00	A - Administrative Home office and/or related		(0	0	0.00	0.00	14. 00
14.00	organization salaries and				0	0.00	0.00	14.00
14. 01	wage-related costs Home office salaries		38, 958, 864		38, 958, 864	830, 048. 00	46. 94	14. 01
14. 02 15. 00	Related organization salaries		C	0	0	0.00		
	Home office: Physician Part A - Administrative		C		U	0.00		15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		C	0	0	0.00	0. 00	16. 00
16. 01	Home office Physicians Part A		C	0	0	0. 00	0. 00	16. 01
16. 02	- Teaching Home office contract		C	0	0	0.00	0. 00	16. 02
	Physicians Part A - Teaching WAGE-RELATED COSTS							
17. 00	Wage-related costs (core) (see		31, 865, 567	0	31, 865, 567			17. 00
18. 00	instructions) Wage-related costs (other)							18. 00
19. 00	(see instructions) Excluded areas		1, 043, 450	o	1, 043, 450			19. 00
20. 00	Non-physician anesthetist Part		C	0	0			20. 00
21. 00	Non-physician anesthetist Part		C	О	0			21. 00
22. 00	B Physician Part A -		60, 640	0	60, 640			22. 00
	Admi ni strati ve		22, 23.		0.00			
22. 01 23. 00	Physician Part A - Teaching Physician Part B		269, 208	0	269, 208			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	0			24. 00 25. 00
	approved program)				4			
25. 50	Home office wage-related (core)		10, 274, 563	0	10, 274, 563			25. 50
25. 51	Related organization wage-related (core)		C	0	0			25. 51
25. 52	Home office: Physician Part A		C	0	0			25. 52
	- Administrative - wage-related (core)							
		'			'			

| Period: | Worksheet S-3 | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 15-0169

					1	0 12/31/2023	Date/lime Prep 5/24/2024 11:4	
		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	60, 320		60, 320			
27. 00	Administrative & General	5. 00	6, 371, 300	-8, 151	6, 363, 149			
28. 00	Administrative & General under		6, 636, 976	0	6, 636, 976	47, 988. 00	138. 30	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30.00	Operation of Plant	7. 00	2, 202, 285	-2, 555	2, 199, 730			
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32.00	Housekeepi ng	9. 00	3, 105, 947					
33.00	Housekeeping under contract		480, 295	0	480, 295	8, 122. 00	59. 14	33. 00
	(see instructions)							
34.00	Di etary	10. 00	3, 105, 917	-2, 273, 277	832, 640		l .	34.00
35. 00	Di etary under contract (see		531, 303	0	531, 303	8, 020. 00	66. 25	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	0	2, 261, 975	2, 261, 975			36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0. 00		
38. 00	Nursing Administration	13. 00	2, 847, 811	-7, 881		,		
39. 00	Central Services and Supply	14. 00	1, 186, 358	-1, 625	1, 184, 733	39, 463. 00	30. 02	39. 00
40.00	Pharmacy	15. 00	6, 767, 153	-39, 277	6, 727, 876	133, 676. 00	50. 33	40. 00
41.00	Medical Records & Medical	16. 00	0	0	0	0.00	0.00	41.00
	Records Library							
42.00	Social Service	17. 00	2, 129, 574	-2, 545	2, 127, 029	45, 255. 00		42.00
43.00	Other General Service	18. 00	0	0	0	0. 00	0.00	43. 00

Total overhead cost (see

instructions)

7.00

40. 48

7.00

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 15-0169 Peri od: From 01/01/2023 To 12/31/2023 5/24/2024 11:44 am Average Hourly Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 (col . 2 ± col . (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 2.00 6.00 5.00 3.00 4.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 148, 066, 156 -533, 126 147, 533, 030 3, 386, 568. 00 1.00 43.56 instructions) 2.00 4, 342, 489 -8, 009 4, 334, 480 105, 922. 00 40. 92 2.00 Excluded area salaries (see instructions) 3.00 Subtotal salaries (line 1 143, 723, 667 -525, 117 143, 198, 550 3, 280, 646. 00 43.65 3.00 minus line 2) 4.00 Subtotal other wages & related 56, 089, 926 56, 089, 926 975, 820. 00 57. 48 4.00 costs (see inst.) Subtotal wage-related costs 5.00 42, 200, 770 Ω 42, 200, 770 0.00 29. 47 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 242, 014, 363 -525, 117 241, 489, 246 4, 256, 466. 00 56. 73

-87, 351

35, 337, 888

873, 029. 00

35, 425, 239

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE RELATED COSTS Provi der CCN: 15-0169

	To 12/31/2023	Date/Time Prep 5/24/2024 11:4	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	5, 161, 759	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)	10, 627	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	253, 420	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)	12, 445, 825	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	3, 084, 982	9. 00
10.00	Dental, Hearing and Vision Plan	105, 919	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	52, 412	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	1, 325, 915	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	406, 764	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumul ati ve portion)		
	TAXES		
17.00	FICA-Employers Portion Only	10, 384, 070	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		
22. 00		0	
23.00		7, 173	
24.00	Total Wage Related cost (Sum of lines 1 -23)	33, 238, 866	24. 00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	COMMUNITY HOSPITAL OF I	I NDI ANA, I	INC.	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	F	Provi der	CCN: 15-0169		Worksheet S-3
				From 01/01/2023	Part V Date/Time Prepared:

			o 12/31/2023	Date/lime Prep 5/24/2024 11:4	
	Cost Center Description		Contract Labor		TT dill
	<u> </u>		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		15, 457, 353	33, 238, 866	1.00
2.00	Hospi tal		15, 457, 353	32, 195, 416	2.00
3.00	SUBPROVI DER - I PF		0	489, 196	3.00
4.00	SUBPROVI DER - I RF				4.00
5.00	Subprovider - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	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	Other		0	554, 254	18.00

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA	, INC.	In Lie	u of Form CMS-2552-10
HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi de	er CCN: 15-0169	From 01/01/2023	Worksheet S-10 Parts I & II

позетт	AL UNCOMPENSATED AND THUTGENT CARE DATA	Tuer con.		From 01/01/2023 To 12/31/2023		pared:
					1. 00	
	PART I - HOSPITAL AND HOSPITAL COMPLEX DATA				11.00	
	Uncompensated and Indigent Care Cost-to-Charge Ratio					1
1.00	Cost to charge ratio (see instructions)				0. 216054	1. 00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				108, 488, 980	1
3.00	Did you receive DSH or supplemental payments from Medicaid?				Y	3. 00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental p	. ,	from Medicai	d?	N	4. 00
5. 00	If line 4 is no, then enter DSH and/or supplemental payments from N	Medi cai d			-20, 389, 942	5. 00
6.00	Medicaid charges				436, 234, 105	1
7.00	Medicaid cost (line 1 times line 6)				94, 250, 123	1
8. 00	Difference between net revenue and costs for Medicaid program (see Children's Health Insurance Program (CHIP) (see instructions for ea		ions)		6, 151, 085	8. 00
9. 00	Net revenue from stand-alone CHIP	ach iine)			0	9.00
10. 00	Stand-alone CHIP charges				0	
11. 00	Stand-alone CHIP cost (line 1 times line 10)					
12. 00	Difference between net revenue and costs for stand-alone CHIP (see	instruct	ions)		0	
.2.00	Other state or local government indigent care program (see instruct					1 .2.00
13.00	Net revenue from state or local indigent care program (Not included)	0	13. 00
14.00	Charges for patients covered under state or local indigent care pro				0	14. 00
	10)					
15. 00	State or local indigent care program cost (line 1 times line 14)				0	
16. 00	Difference between net revenue and costs for state or local indiger				0	16. 00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP ar instructions for each line)	nd state/	local indige	ent care program	ns (see	
17. 00	Private grants, donations, or endowment income restricted to fundir	ng charit	v care		0	17. 00
18. 00	Government grants, appropriations or transfers for support of hospi				0	1
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local inc			(sum of lines	6, 151, 085	1
	8, 12 and 16)			<u> </u>		
			Uni nsured	Insured	Total (col. 1	
		_	patients	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
20. 00	Uncompensated care cost (see instructions for each line) Charity care charges and uninsured discounts (see instructions)		14, 155, 01	7 5, 088, 869	19, 243, 886	20.00
21. 00	Cost of patients approved for charity care and uninsured discounts	(500	3, 058, 24			1
21.00	linstructions)	(See	3, 036, 24	3, 000, 073	0, 000, 341	21.00
22. 00	Payments received from patients for amounts previously written off	as	1	0	10	22. 00
	charity care					
23. 00	Cost of charity care (see instructions)		3, 058, 23	3, 808, 093	6, 866, 331	23. 00
0.4.00					1.00	04.00
24. 00	Does the amount on line 20 col. 2, include charges for patient days		a Tength of	stay limit	N	24. 00
25. 00	imposed on patients covered by Medicaid or other indigent care prog If line 24 is yes, enter the charges for patient days beyond the ir		aro program'	s Longth of	0	25. 00
23.00	stay limit	nurgent c	are program	S religiti of		25.00
25. 01	Charges for insured patients' liability (see instructions)				1, 633, 756	25. 01
26. 00	Bad debt amount (see instructions)				19, 937, 058	1
27. 00	Medicare reimbursable bad debts (see instructions)				591, 571	
27. 01	Medicare allowable bad debts (see instructions)				910, 109	1
28. 00	Non-Medicare bad debt amount (see instructions)				19, 026, 949	28. 00
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt amounts	s (see in	structions)		4, 429, 386	29. 00
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)				11, 295, 717	30. 00
31. 00	Total unreimbursed and uncompensated care cost (line 19 plus line 3	30)			17, 446, 802	31.00

Heal th F	inancial Systems (COMMUNITY HOSPITAL OF	I NDI ANA, I	NC.	In Lie	u of Form CMS-2	2552-10
HOSPI TAI	_ UNCOMPENSATED AND INDIGENT CARE DATA		Provi der C	CCN: 15-0169	01/01/2023	Worksheet S-1 Parts I & II Date/Time Pre 5/24/2024 11:	pared:
						1. 00	
P	ART II - HOSPITAL DATA						
U	ncompensated and Indigent Care Cost-to-C	Charge Ratio]
1.00	Cost to charge ratio (see instructions)					0. 215089	1.00
M	edicaid (see instructions for each line))					1
2.00	let revenue from Medicaid						2.00

				1.00	
	PART II - HOSPITAL DATA				
	Uncompensated and Indigent Care Cost-to-Charge Ratio				
1.00	Cost to charge ratio (see instructions)			0. 215089	1.00
	Medicaid (see instructions for each line)				
2.00	Net revenue from Medicaid				2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?				3. 00
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemental payment	s from Medicaio	l?		4. 00
5.00	If line 4 is no, then enter DSH and/or supplemental payments from Medicai	d			5. 00
6.00	Medi cai d charges				6. 00
7.00	Medicaid cost (line 1 times line 6)				7. 00
8.00	Difference between net revenue and costs for Medicaid program (see instru	ıctions)			8. 00
	Children's Health Insurance Program (CHIP) (see instructions for each line	e)			
9.00	Net revenue from stand-alone CHIP				9. 00
10.00	Stand-al one CHIP charges				10.00
11. 00	Stand-alone CHIP cost (line 1 times line 10)				11. 00
12.00	Difference between net revenue and costs for stand-alone CHIP (see instru	ıctions)			12.00
	Other state or local government indigent care program (see instructions for				
13.00					13. 00
14.00	Charges for patients covered under state or local indigent care program (Not included in	n lines 6 or		14. 00
	10)				
	State or local indigent care program cost (line 1 times line 14)				15. 00
16. 00	Difference between net revenue and costs for state or local indigent care				16. 00
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and state	e/local indiger	nt care program	ns (see	
	instructions for each line)				
	Private grants, donations, or endowment income restricted to funding char				17. 00
	Government grants, appropriations or transfers for support of hospital op				18. 00
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local indigent	care programs (sum of lines		19. 00
	8, 12 and 16)			T	
		Uni nsured	Insured	Total (col. 1	
		pati ents	pati ents	+ col . 2)	
		1.00	2. 00	3. 00	
20.00	Uncompensated care cost (see instructions for each line)	14 004 101	E 0E1 200	10 147 201	20.00
20.00	, , , , , , , , , , , , , , , , , , , ,	14, 096, 191	5, 051, 200		
21. 00	Cost of patients approved for charity care and uninsured discounts (see	3, 031, 936	3, 768, 847	6, 800, 783	21.00

	oncompensated care cost (see firstructions for each fine)					
20.00	Charity care charges and uninsured discounts (see instructions)	14, 096, 191	5, 051, 200	19, 147, 391	20.00	
21.00	1.00 Cost of patients approved for charity care and uninsured discounts (see 3,031,936 3,768,847					
	instructions)					
22. 00	Payments received from patients for amounts previously written off as	10	0	10	22.00	
	charity care					
23. 00	Cost of charity care (see instructions)	3, 031, 926	3, 768, 847	6, 800, 773	23.00	
				1. 00		
24.00	Does the amount on line 20 col. 2, include charges for patient days beyon	id a Length of s	stay limit	N	24.00	
	imposed on patients covered by Medicaid or other indigent care program?					
25.00	25.00 If line 24 is yes, enter the charges for patient days beyond the indigent care program's length of					
	stay limit					
25. 01	Charges for insured patients' liability (see instructions)			1, 633, 756	25. 01	
26.00	Bad debt amount (see instructions)			19, 873, 384	26.00	
27.00	Medicare reimbursable bad debts (see instructions)			563, 836	27.00	
27. 01	Medicare allowable bad debts (see instructions)			867, 440	27. 01	
28. 00	28.00 Non-Medicare bad debt amount (see instructions)					
29. 00	29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)				29.00	
30.00	Cost of uncompensated care (line 23, col. 3, plus line 29)			11, 192, 346	30.00	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus line 30)			11, 192, 346	31.00	

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	UNITY HOSPITAL (F EXPENSES	Provider CO		In Lie eriod:	u of Form CMS-2 Worksheet A	2552-10
REGERGENT ON THE PRESIDENCE OF THIRD BREAKED OF	I EXI ENGES	I Tovi dei o	F	rom 01/01/2023 o 12/31/2023	Date/Time Pre	nared:
					5/24/2024 11:	44 am
Cost Center Description	Sal ari es	Other	lotal (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance	
			, , , , , ,	(222 11 2)	(col. 3 +-	
	1.00	2.00	3.00	4. 00	col . 4) 5. 00	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1. 00 00100 CAP REL COSTS-BLDG & FIXT		0	0		22, 585, 212	1
2.00 00200 CAP REL COSTS-MVBLE EQUIP 3.00 00300 OTHER CAP REL COSTS		0	0	, ===,	14, 283, 154 0	1
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	60, 320	162, 528	_	-	133, 857	4. 00
5.00 00500 ADMINISTRATIVE & GENERAL	6, 371, 300	145, 008, 165	151, 379, 465		129, 697, 948	
7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE	2, 202, 285	8, 987, 376 1, 098, 373	11, 189, 661 1, 098, 373		11, 049, 524 1, 098, 373	1
9. 00 00900 HOUSEKEEPI NG	3, 105, 947	2, 378, 201	5, 484, 148		5, 465, 157	1
10. 00 01000 DI ETARY	3, 105, 917	4, 111, 467	7, 217, 384		1, 941, 788	1
11. 00 01100 CAFETERI A 13. 00 01300 NURSI NG ADMI NI STRATI ON	0 2, 847, 811	0 727, 685	0 3, 575, 496	-,,	5, 201, 436 3, 544, 188	1
14. 00 O1400 CENTRAL SERVICES & SUPPLY	1, 186, 358	5, 039, 884	6, 226, 242		3, 057, 061	1
15. 00 01500 PHARMACY	6, 767, 153	14, 155, 611	20, 922, 764		8, 988, 350	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY 17.00 01700 SOCIAL SERVICE	0 2, 129, 574	0 590, 762	2 720 224	0 -36	2 720 200	
19. 00 01900 NONPHYSICIAN ANESTHETISTS	2, 129, 574	590, 762	2, 720, 336 0	-36	2, 720, 300 0	1
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	O	0	0	0	0	21. 00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
I NPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS	49, 098, 120	37, 072, 654	86, 170, 774	-14, 493, 259	71, 677, 515	30.00
31.00 03100 INTENSIVE CARE UNIT	7, 489, 007	3, 508, 621	10, 997, 628		10, 049, 996	
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	9, 109, 291	4, 421, 655			13, 180, 245	
40. 00 04000 SUBPROVI DER - PF 43. 00 04300 NURSERY	2, 316, 320	683, 809 0	3, 000, 129 0		2, 966, 374 3, 299, 254	
ANCI LLARY SERVI CE COST CENTERS	<u> </u>	J		5, 277, 254	3, 277, 234	43.00
50. 00 05000 OPERATING ROOM	5, 475, 919	42, 442, 918			22, 672, 948	
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	3, 887, 536	1, 827, 475	5, 715, 011 0		5, 397, 379 7, 279, 165	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 366, 565	3, 138, 082	_		6, 042, 409	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	627, 543	7, 626, 647	8, 254, 190		3, 393, 219	
57. 00 05700 CT SCAN 58. 00 05800 MRI	1, 438, 289 841, 399	1, 395, 292 1, 595, 377	2, 833, 581 2, 436, 776		2, 911, 330 1, 685, 733	
59. 00 05900 CARDI AC CATHETERI ZATI ON	041, 344	792	792		-181	1
60. 00 06000 LABORATORY	O	15, 578, 104		i i	15, 578, 104	1
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	509, 378	273, 187	782, 565 8, 136, 773		660, 294 7, 143, 151	
66. 00 06600 PHYSI CAL THERAPY	4, 398, 062 7, 746, 898	3, 738, 711 3, 652, 653			7, 143, 131	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	2, 257, 214	2, 257, 214	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	(75. 1/7	722 020	425, 638	425, 638	
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	46, 862 1, 389, 676	675, 167 913, 250	722, 029 2, 302, 926		721, 889 2, 062, 287	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0		20, 401, 794	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	, ,	14, 139, 248	
73. 00 07300 DRUGS CHARGED TO PATIENTS 73. 01 07301 SPECI ALTY PHARMACY	0	0	0	14, 442, 436 0	14, 442, 436 0	1
74.00 07400 RENAL DIALYSIS	33, 382	1, 919, 881	1, 953, 263	-89, 693	1, 863, 570	
76. 00 03330 ENDOSCOPY	1, 954, 439	4, 138, 664	6, 093, 103	-2, 520, 518	3, 572, 585	1
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS 76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS		0	0		0	76. 02
76. 04 03953 WOUND CARE	652, 795	1, 153, 492	1, 806, 287		1, 575, 986	
76. 06 03954 IMAGING CENTER 76. 07 03955 BREAST DIAGNOSTIC CENTER	2, 124, 152 99, 409	2, 954, 140 12, 151, 393			3, 711, 763 11, 801, 069	1
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	77, 407	12, 131, 373	12, 230, 602	0	0	1
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	O	0	78. 00
90. 00 09000 CLI NI C		0			0	90.00
90. 01 04950 I NFUSI ON CENTER	134, 288	2, 845, 040	2, 979, 328	-2, 792, 410	186, 918	1
90. 26 04975 SPI NE CENTER	223, 516	67, 171	290, 687	i i	290, 687	1
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 966, 020	4, 819, 582	12, 785, 602	-550, 922	12, 234, 680	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	L					92.00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS		0				112 00
113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF	n	0	0	0		113. 00 114. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	139, 705, 531	340, 853, 809	480, 559, 340	286, 395	480, 845, 735	
NONREI MBURSABLE COST CENTERS						100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0	0	0	0		190. 00 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	o	99, 681	99, 681			192. 00
-	<u> </u>	'				

Health Financial Systems COM	MMUNITY HOSPITAL C	F INDIANA, IN	IC.	In Lie	u of Form CMS-25	552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CO		Period: From 01/01/2023	Worksheet A	
				o 12/31/2023	Date/Time Prepa 5/24/2024 11: 4	ared: 4 am
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col . 4)	
	1.00	2.00	3.00	4. 00	5. 00	
193. 00 19300 NONPALD WORKERS	0	0	C	0	0 1	93.00
194.00 07950 HOME OFFICE	0	0	C	0	0 1	94.00
194. 06 07956 PAVI LLI ONS	0	132, 082	132, 082	-114, 616	17, 466 1	94.06
194. 08 07958 OTHER NRCC	2, 026, 169	976, 722	3, 002, 891	-171, 779	2, 831, 112 1	94. 08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	(0	0 1	94. 10
200.00 TOTAL (SUM OF LINES 118 through 199)	141, 731, 700	342, 062, 294	483, 793, 994	0	483, 793, 994 2	200.00

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

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/24/2024 11:44 am

				5/24/2024 11:	<u>44 am</u>
Cost Center Description	Adj us	stments	Net Expenses		
	(See	e A-8) F	or Allocation		
	6	. 00	7.00		
GENERAL SERVICE COST CENTERS					
1.00 00100 CAP REL COSTS-BLDG & FI	XT -8	, 188, 029	14, 397, 183		1.00
2.00 00200 CAP REL COSTS-MVBLE EQU	IIP 2	, 948, 662	17, 231, 816		2. 00
3.00 00300 OTHER CAP REL COSTS		ol	o		3. 00
4.00 00400 EMPLOYEE BENEFITS DEPAR	TMENT 5	, 976, 096	6, 109, 953		4. 00
5. 00 00500 ADMINISTRATIVE & GENERA		, 948, 418	64, 749, 530		5. 00
7. 00 00700 OPERATION OF PLANT		, 678, 920	14, 728, 444		7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8.00
		0	1, 098, 373		
9. 00 00900 HOUSEKEEPI NG		0 404	5, 465, 157		9.00
10. 00 01000 DI ETARY	_	-22, 431	1, 919, 357		10.00
11. 00 01100 CAFETERI A	ı	, 911, 282	2, 290, 154		11. 00
13.00 O1300 NURSING ADMINISTRATION	3	, 963, 612	7, 507, 800		13. 00
14.00 01400 CENTRAL SERVICES & SUPF	PLY 1	, 015, 187	4, 072, 248		14. 00
15.00 01500 PHARMACY		-115, 935	8, 872, 415		15. 00
16.00 01600 MEDICAL RECORDS & LIBRA	RY 2	, 443, 403	2, 443, 403		16. 00
17. 00 01700 SOCIAL SERVICE		ol	2, 720, 300		17. 00
19.00 01900 NONPHYSICIAN ANESTHETIS	iTS .	ol	0		19. 00
21. 00 02100 I &R SERVI CES-SALARY & F	1	547, 104	547, 104		21. 00
22. 00 02200 1 &R SERVI CES-OTHER PRGM		, 293, 331	1, 293, 331		22. 00
I NPATI ENT ROUTI NE SERVI CE COS		, 273, 331	1, 273, 331		22.00
		007 050	(O EOO E/E		20.00
30. 00 03000 ADULTS & PEDI ATRI CS	-11	, 087, 950	60, 589, 565		30.00
31. 00 03100 INTENSIVE CARE UNIT		0	10, 049, 996		31.00
35. 00 02060 NEONATAL INTENSIVE CARE		-862, 018	12, 318, 227		35. 00
40. 00 04000 SUBPROVI DER - 1 PF		-238, 384	2, 727, 990		40. 00
43. 00 04300 NURSERY		0	3, 299, 254		43.00
ANCILLARY SERVICE COST CENTER	RS				1
50. 00 05000 OPERATING ROOM		0	22, 672, 948		50. 00
51.00 05100 RECOVERY ROOM		ol	5, 397, 379		51.00
52.00 05200 DELIVERY ROOM & LABOR F	MOOM	o	7, 279, 165		52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		149, 342	6, 191, 751		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0	3, 393, 219		55. 00
57. 00 05700 CT SCAN		0			57.00
			2, 911, 330		1
58. 00 05800 MRI		0	1, 685, 733		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		156, 411	156, 230		59. 00
60. 00 06000 LABORATORY		O	15, 578, 104		60. 00
64.00 06400 I NTRAVENOUS THERAPY		0	660, 294		64. 00
65. 00 06500 RESPI RATORY THERAPY		0	7, 143, 151		65. 00
66. 00 06600 PHYSI CAL THERAPY		-5, 710	7, 448, 978		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		o	2, 257, 214		67. 00
68.00 06800 SPEECH PATHOLOGY		ol	425, 638		68. 00
69. 00 06900 ELECTROCARDI OLOGY		237, 571	959, 460		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		312, 469	2, 374, 756		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGE	D TO PATIENT	0	20, 401, 794		71.00
72. 00 07200 MPL. DEV. CHARGED TO F		0			72.00
		-1	14, 139, 248		
73. 00 07300 DRUGS CHARGED TO PATIEN	115	260, 952	14, 703, 388		73. 00
73. 01 07301 SPECI ALTY PHARMACY		O	0		73. 01
74. 00 07400 RENAL DI ALYSI S		O	1, 863, 570		74. 00
76. 00 03330 ENDOSCOPY		-5, 379	3, 567, 206		76. 00
76.01 03950 OTHER ANCILLARY SERVICE	COST CENTERS	0	0		76. 01
76.02 03951 OTHER ANCILLARY SERVICE	COST CENTERS	0	0		76. 02
76. 03 03952 OTHER ANCILLARY SERVICE	COST CENTERS	0	0		76. 03
76. 04 03953 WOUND CARE		ol	1, 575, 986		76. 04
76.06 03954 I MAGING CENTER		ol	3, 711, 763		76.06
76. 07 03955 BREAST DIAGNOSTIC CENTE	·R	o	11, 801, 069		76. 07
77. 00 07700 ALLOGENEI C HSCT ACQUI SI	ı	ő	0		77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAF	ı	0	0		78. 00
		<u> </u>	<u> </u>		70.00
90. 00 O9000 CLINIC	-113		ما		00.00
		0	10/ 010		90.00
90. 01 04950 INFUSION CENTER		O	186, 918		90. 01
90. 26 04975 SPI NE CENTER		O	290, 687		90. 26
91. 00 09100 EMERGENCY	ı	, 074, 017	13, 308, 697		91. 00
92.00 09200 OBSERVATION BEDS (NON-D	ISTINCT PART				92.00
OTHER REIMBURSABLE COST CENTE	ERS				
102. 00 10200 OPI OI D TREATMENT PROGRA		0	0		102. 00
SPECIAL PURPOSE COST CENTERS	•				
113. 00 11300 NTEREST EXPENSE		0	0		113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		0	0		114. 00
118.00 SUBTOTALS (SUM OF LINES	: 1 through 117)	-	116 517 27/		118.00
	- 1 till ough 117) -64	, 328, 459	416, 517, 276		1110.00
NONREI MBURSABLE COST CENTERS	IOD 0 CANTEEN				100 00
190. 00 19000 GIFT, FLOWER, COFFEE SH	IUP & CANTEEN	0	0		190. 00
191. 00 19100 RESEARCH		0	0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFF	ICES	0	99, 681		192. 00
193. 00 19300 NONPALD WORKERS		0	0		193. 00
194.00 07950 HOME OFFICE		О	O		194. 00
-			'		

Health Financial Systems (OMMUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANC	E OF EXPENSES	Provi der CC	CN: 15-0169	Peri od: From 01/01/2023 To 12/31/2023	Worksheet A Date/Time Pre	pared:
					5/24/2024 11:	44 am_
C+ C+ D!!	A -1 !	N-4 F				

			372472024 11.4	7 -1 uiii
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7. 00		
194. 06 07956 PAVI LLI ONS	0	17, 466	1	194. 06
194. 08 07958 OTHER NRCC	0	2, 831, 112	1	194. 08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	1	194. 10
200.00 TOTAL (SUM OF LINES 118 through 199)	-64, 328, 459	419, 465, 535	2	200. 00

Health Financial Systems RECLASSIFICATIONS

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/24/2024 11:44 am

		Increases			5/24/2024 11:	44 am
	Cost Center	Increases Line #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	A - Chargeable Medical Suppli			0.00		
1.00	CARDI AC CATHETERI ZATI ON	59.00	0	104		1. 00
2. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0			2. 00
2.00	PATI ENT	71.00	O	20, 401, 774		2.00
3.00	FATTENT	0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
			0	0		
5.00		0.00		_		5. 00
6.00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10.00		0.00	0	0		10. 00
11.00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20. 00		0.00	0	0		20.00
				0		
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00	<u></u>	0.00	0	0		23. 00
	TOTALS		0	20, 401, 898]
	B - Implantable Device Reclas				<u></u>	
1.00	CARDIAC CATHETERIZATION	59. 00		450		1. 00
2.00	IMPL. DEV. CHARGED TO	72.00		14, 139, 248		2. 00
	PATI ENTS					
3.00						3. 00
				14, 139, 698		
	C - Drugs Charges to Pat		-			1
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	14, 442, 436		1. 00
2. 00	DROGS GIVINGED TO TATTENTS	0.00	0	0		2. 00
3. 00		0.00	0	0		3. 00
4. 00		0.00	0	0		4. 00
5. 00		0.00	0	0		1
				-		5. 00
6.00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8.00		0. 00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10. 00		0.00	0	0		10. 00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	Ö	0		18. 00
19. 00		0.00	0	0		19. 00
19.00	TOTALS — — — — —		— — — ö			19.00
			U	14, 442, 436		-
1 00	D - Depreciation Expense	2.00	ما	14 217 201		1 00
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	14, 317, 391		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
		0.00		_		
16.00			0	0		16.00
17.00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20. 00	<u> </u>	0.00	0	0	<u> </u>	20. 00

Health Financial Systems RECLASSIFICATIONS

Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

					5/24/2024 11	
		Increases				
	Cost Center	Li ne #	Salary	Other 5.00		
21. 00	2. 00	3.00	4.00	5. 00		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	o	Ö		23. 00
24.00		0.00	O	0		24. 00
25.00		0.00	O	0		25. 00
26. 00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28. 00		0.00	0	0		28. 00
29. 00 30. 00		0. 00 0. 00	0	0		29. 00 30. 00
31. 00		0.00	0	0		31. 00
32. 00		0.00	o	0		32. 00
	TOTALS		— — — ō	14, 317, 391		
	E - Interest Expense					
1.00	CAP REL COSTS-BLDG & FIXT _		0	<u>13, 747, 1</u> 82		1. 00
	TOTALS		0	13, 747, 182		_
1 00	F - Other Capital Rental	2 00	ما	0.2/2.570		1 00
1. 00 2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00 0. 00	0	8, 362, 579 0		1. 00 2. 00
3.00		0.00	0	0		3. 00
4. 00		0.00	Ö	Ö		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10. 00 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	o	Ö		13. 00
14.00		0.00	O	0		14. 00
15.00		0.00	O	0		15. 00
16.00		0.00	0	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00 20. 00		0. 00 0. 00	0	0		19. 00 20. 00
21. 00		0.00	0	0		21. 00
22. 00		0.00	o	0		22. 00
	TOTALS — — — —		— — — ō	8, 362, 579		
	G - STD BENEFIT RECLASSIFICAT			,		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	8, 151		1. 00
2.00	OPERATION OF PLANT	7. 00	0	2, 555		2. 00
3. 00 4. 00	HOUSEKEEPI NG DI ETARY	9.00	0	14, 015 11, 302		3. 00
5.00	NURSING ADMINISTRATION	10. 00 13. 00	0	7, 881		4. 00 5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	ő	1, 625		6. 00
7. 00	PHARMACY	15. 00	O	39, 277		7. 00
8.00	SOCIAL SERVICE	17. 00	О	2, 545		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	169, 853		9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	5, 467		10. 00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	52, 131		11.00
12. 00 13. 00	SUBPROVIDER - IPF OPERATING ROOM	40. 00 50. 00	0	3, 720 25, 349		12. 00 13. 00
14. 00	RECOVERY ROOM	51.00	0	37, 399		14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	ő	18, 687		15. 00
16. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	1, 328		16. 00
17.00	CT SCAN	57.00	o	4, 550		17. 00
18. 00	INTRAVENOUS THERAPY	64.00	o	869		18. 00
19. 00	RESPIRATORY THERAPY	65.00	0	17, 567		19. 00
20.00	PHYSI CAL THERAPY	66.00	0	43, 580		20.00
21. 00 22. 00	ELECTROENCEPHALOGRAPHY ENDOSCOPY	70. 00 76. 00	0	527 6, 685		21. 00 22. 00
23. 00	WOUND CARE	76. 00 76. 04	O O	13, 923		23. 00
24. 00	I MAGING CENTER	76. 06	o	13, 744		24. 00
25. 00	BREAST DIAGNOSTIC CENTER	76. 07	Ö	6, 067		25. 00
26. 00	SPINE CENTER	90. 26	O	828		26. 00
27. 00	EMERGENCY	91.00	o	19, 212		27. 00
28. 00	OTHER NRCC	194.08	0	<u>4, 289</u>		28. 00
	TOTALS		0	533, 126		-
1.00	H - Labor and Delivery NURSERY	43.00	2, 070, 323	0		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	4, 567, 768	0		2. 00
3. 00	NURSERY	43. 00	4, 307, 700	1, 228, 931		3. 00

Health Financial Systems RECLASSIFICATIONS COMMUNITY HOSPITAL OF INDIANA, INC.

Provider CCN: 15-0169 In Lieu of Form CMS-2552-10

					12, 31, 2323	5/24/2024 1	
		Increases					
	Cost Center	Li ne #	Sal ary	0ther			
	2. 00	3.00	4. 00	5. 00			
4.00	DELIVERY ROOM & LABOR ROOM	52. 00		2, 711, 397			4. 00
	TOTALS		6, 638, 091	3, 940, 328			
	I - CAFETERIA RECLASSIFICATIO	ON					
1.00	CAFETERI A	11. 00	2, 261, 975	0			1. 00
2.00	CAFETERI A	11. 00	0_	<u>2, 939, 4</u> 61			2. 00
	TOTALS		2, 261, 975	2, 939, 461			
	J - THERAPY						
1.00	OCCUPATI ONAL THERAPY	67. 00	1, 565, 469				1. 00
2.00	SPEECH PATHOLOGY	68. 00	295, 197				2. 00
3.00	OCCUPATI ONAL THERAPY	67. 00		691, 745			3. 00
4.00	SPEECH PATHOLOGY	6800		13 <u>0, 4</u> 41			4. 00
			1, 860, 666	822, 186			
	K - BUILDING DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	•	<u>8, 396, 816</u>			1. 00
	TOTALS		0	8, 396, 816			
	L - CAPITAL INSURANCE COSTS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	•	44 <u>1, 2</u> 14			1. 00
	TOTALS		0	441, 214			
	M - RADIOLOGY SUPPORT						
1.00	RADI OLOGY-THERAPEUTI C	55. 00	105, 364	0			1. 00
2.00	CT SCAN	57. 00	178, 754	0			2. 00
3.00	MRI	58. 00	50, 068	0			3. 00
4.00	RADI OLOGY-THERAPEUTI C	55. 00	0	99, 898			4. 00
5.00	CT SCAN	57. 00	0	169, 481			5. 00
6.00	MRI	<u>58.</u> 00	•	<u> </u>			6. 00
	TOTALS		334, 186	316, 850			
500.00	Grand Total: Increases		11, 094, 918	102, 801, 165			500.00

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/24/2024 11:44 am

		Decreases				5/24/2024 11:	. 44 alli
	Cost Center	Li ne #	Salary	Other	Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10.00		
	A - Chargeable Medical Suppli		0.00	71 00	10.00		
	CENTRAL SERVICES & SUPPLY	14. 00	0	130, 44	1 0		1.00
	PHARMACY	15. 00	0				2. 00
	ADULTS & PEDIATRICS	30.00	0				3. 00
	INTENSIVE CARE UNIT	31.00	0	665, 50	1		4. 00
	NEONATAL INTENSIVE CARE UNIT	35. 00	0	194, 98			5. 00
	SUBPROVIDER - IPF	40.00	0	4, 41	1		6. 00
	OPERATING ROOM	50.00	0	9, 414, 79			7. 00
8.00	RECOVERY ROOM	51.00	0	313, 23	7 0		8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	419, 32	1 0		9. 00
	RADI OLOGY-THERAPEUTI C	55. 00	0	3, 027, 08			10.00
	CT SCAN	57.00	0	59, 40	1		11. 00
12.00	MRI	58. 00	0	90, 63			12. 00
13.00	INTRAVENOUS THERAPY	64.00	0	113, 20	3 0		13. 00
14.00	RESPI RATORY THERAPY	65.00	0	693, 35	o o		14.00
15.00	PHYSI CAL THERAPY	66.00	0	2, 38	8 0		15. 00
16.00	ELECTROENCEPHALOGRAPHY	70.00	0	21, 83	3 0		16. 00
17.00	RENAL DIALYSIS	74.00	0	89, 69	3 0		17. 00
18. 00	ENDOSCOPY	76. 00	0	1, 736, 19	4 0		18. 00
19.00	WOUND CARE	76. 04	0	71, 42	8 0		19. 00
20.00	I MAGING CENTER	76. 06	0	126, 27	3 0		20. 00
21.00	BREAST DIAGNOSTIC CENTER	76. 07	0	4, 50	3 0		21. 00
22. 00	INFUSION CENTER	90. 01	0	27	0 0		22. 00
23.00	EMERGENCY	91.00	0	388, 78	90		23. 00
	TOTALS		0	20, 401, 89	8		
	B - Implantable Device Reclas	SS					
1.00	OPERATING ROOM	50.00		12, 248, 91	3		1. 00
2.00	RADI OLOGY-THERAPEUTI C	55.00		1, 506, 47	1		2. 00
3.00	ENDOSCOPY	<u>76.</u> 00		384, 31	4		3. 00
			0	14, 139, 69	8		
	C - Drugs Charges to Pat						
	PHARMACY	15. 00	0	11, 066, 98			1. 00
	ADULTS & PEDIATRICS	30.00	0				2. 00
3.00	INTENSIVE CARE UNIT	31. 00	0	94			3. 00
4. 00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	69	0 0		4. 00
	SUBPROVI DER - I PF	40. 00	0	41	1		5. 00
	OPERATING ROOM	50.00	0	86, 58			6. 00
	RECOVERY ROOM	51.00	0	25			7. 00
	RADI OLOGY-DI AGNOSTI C	54.00	0	107, 19			8. 00
	RADI OLOGY-THERAPEUTI C	55. 00	0	15, 96			9. 00
	CT SCAN	57. 00	0	208, 12			10. 00
	MRI	58. 00	0	98, 37			11. 00
	RESPI RATORY THERAPY	65. 00	0	1			12. 00
	PHYSI CAL THERAPY	66. 00	0	1, 06			13. 00
	ELECTROENCEPHALOGRAPHY	70. 00	0	98			14. 00
	ENDOSCOPY	76. 00	0	52			15. 00
	WOUND CARE	76. 04	0	2, 27			16. 00
	I MAGING CENTER	76. 06	0	140, 47			17. 00
	INFUSION CENTER	90. 01	0	2, 704, 51			18. 00
19. 00	EMERGENCY	<u>91.</u> 00	0				19. 00
	TOTALS		0	14, 442, 43	6		_
	D - Depreciation Expense			=	al =1		4
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0		0 9		1.00
	ADMINISTRATIVE & GENERAL	5. 00	0				2.00
	OPERATION OF PLANT	7. 00	0	137, 07			3.00
	HOUSEKEEPI NG	9.00	0	87			4. 00
	DI ETARY	10.00	0	74, 16			5. 00
	NURSING ADMINISTRATION	13.00	0	29, 14			6.00
	CENTRAL SERVICES & SUPPLY	14. 00	0	134, 21			7. 00
	PHARMACY	15. 00	0	40, 10			8.00
	ADULTS & PEDIATRICS	30.00	0	1, 346, 28			9.00
	INTENSIVE CARE UNIT	31.00	0	281, 03			10.00
	NEONATAL INTENSIVE CARE UNIT	35.00	0	155, 03			11.00
	SUBPROVI DER - I PF	40.00	0	28, 92			12.00
	OPERATING ROOM	50.00	0	1, 754, 14			13.00
	RECOVERY ROOM	51.00	0	4, 14			14.00
	RADI OLOGY THERADEUT C	54.00	0	284, 28 514, 71			15.00
	RADI OLOGY-THERAPEUTI C	55. 00 57. 00	0	516, 71			16.00
	CT SCAN	57.00	0	2, 95			17.00
	MRI	58.00	0	659, 57			18.00
	CARDI AC CATHETERI ZATI ON	59. 00	0	1, 52			19.00
	I NTRAVENOUS THERAPY	64.00	0	9, 06			20.00
	RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00 66. 00	0	50, 54			21.00
22. 00	ITHISTORE HIERAPT	66.00	U	249, 84	7 0		22. 00

Peri od: From 01/01/2023 To 12/31/2023

Date/Time Prepared: 5/24/2024 11:44 am

		D			L.	5/24/2024 11	: 44 am
	0 1 0 1	Decreases	6.1	0.11			
	Cost Center	Li ne #	Sal ary	Other Other	Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10.00		00.00
23. 00	ELECTROCARDI OLOGY	69. 00	0	140	0		23. 00
24. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	79, 768	0		24. 00
	ENDOSCOPY	76. 00	0	386, 976	0		25. 00
26. 00	WOUND CARE	76. 04	0	44, 250	0		26. 00
27. 00	I MAGING CENTER	76. 06	0	504, 414	0		27. 00
28. 00	BREAST DIAGNOSTIC CENTER	76. 07	0	39, 123	0		28. 00
29. 00	INFUSION CENTER	90. 01	0	23, 412	0		29. 00
30.00	EMERGENCY	91.00	0	161, 559	0		30. 00
31.00	PAVI LLI ONS	194.06	o	13, 780	o		31.00
32.00	OTHER NRCC	194. 08	o	35, 609	o		32. 00
	TOTALS			14, 317, 391			
	E - Interest Expense			, ,			
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	13, 747, 182	11		1. 00
1.00	TOTALS	— — " "	— — 	13, 747, 182			1.00
	F - Other Capital Rental		<u> </u>	13, 747, 102			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	ol	88, 971	10		1. 00
2. 00	ADMINISTRATIVE & GENERAL	5.00	0	224, 449	0		2. 00
	OPERATION OF PLANT		ol		0		1
3.00	1	7. 00	-	3, 064	0		3. 00
4.00	HOUSEKEEPI NG	9.00	0	18, 113	0		4. 00
5.00	NURSING ADMINISTRATION	13.00	0	2, 159	0		5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	2, 904, 528	0		6. 00
7. 00	PHARMACY	15. 00	0	537, 336	0		7. 00
8.00	SOCI AL SERVI CE	17. 00	0	36	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	17, 901	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	143	0		10. 00
11.00	OPERATING ROOM	50.00	0	1, 741, 453	0		11. 00
12.00	RADI OLOGY-DI AGNOSTI C	54.00	0	399	0		12. 00
13.00	RESPIRATORY THERAPY	65.00	o	249, 716	O		13.00
14.00	PHYSI CAL THERAPY	66.00	o	1, 008, 709	O		14. 00
15.00	ELECTROENCEPHALOGRAPHY	70.00	o	138, 052	O		15. 00
	ENDOSCOPY	76.00	o	12, 514	0		16. 00
	WOUND CARE	76. 04	0	112, 349	0		17. 00
	I MAGING CENTER	76.06	0	595, 364	0		18. 00
	BREAST DIAGNOSTIC CENTER	76.00	0	406, 107			19. 00
	INFUSION CENTER	90. 01	0	64, 210			20.00
	PAVI LLI ONS	194. 06	0	100, 836			21.00
	OTHER NRCC	194.00	o	136, 170	l 1		22.00
22.00	TOTALS		— — —	8, 362, 579			22.00
	G - STD BENEFIT RECLASSIFICAT	I ON		0, 302, 379			-
1.00	ADMINISTRATIVE & GENERAL	5.00	8, 151	0	O		1.00
	OPERATION OF PLANT			0	0		1
2.00	HOUSEKEEPI NG	7.00	2, 555	0	0		2.00
3.00		9.00	14, 015	-	0		3. 00
4.00	DI ETARY	10.00	11, 302	0	0		4. 00
5.00	NURSING ADMINISTRATION	13.00	7, 881	0	0		5. 00
6. 00	CENTRAL SERVICES & SUPPLY	14.00	1, 625	0	0		6. 00
7. 00	PHARMACY	15. 00	39, 277	0	0		7. 00
8.00	SOCI AL SERVI CE	17. 00	2, 545	0	0		8. 00
9. 00	ADULTS & PEDIATRICS	30. 00	169, 853	0	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	5, 467	0	0		10. 00
11.00	NEONATAL INTENSIVE CARE UNIT	35.00	52, 131	0	0		11. 00
12.00	SUBPROVIDER - IPF	40.00	3, 720	0	0		12. 00
13.00	OPERATING ROOM	50.00	25, 349	0	o		13. 00
14.00	RECOVERY ROOM	51.00	37, 399	0	o		14. 00
	RADI OLOGY-DI AGNOSTI C	54.00	18, 687	0	o		15. 00
	RADI OLOGY-THERAPEUTI C	55.00	1, 328	0	o		16. 00
	CT SCAN	57. 00	4, 550	0	o		17. 00
	INTRAVENOUS THERAPY	64.00	869	n	l o		18. 00
19. 00	RESPIRATORY THERAPY	65. 00	17, 567	0			19. 00
	PHYSI CAL THERAPY	66.00	43, 580	0			20.00
	ELECTROENCEPHALOGRAPHY	70.00	43, 580 527	0			21.00
	ENDOSCOPY	76. 00 76. 00	6, 685	0			21.00
	1	•		0			1
	WOUND CARE IMAGING CENTER	76. 04 76. 06	13, 923	0			23. 00
24. 00		76. 06	13, 744	0	0		24. 00
	BREAST DIAGNOSTIC CENTER	76. 07	6, 067	0	0		25. 00
26. 00	SPINE CENTER	90. 26	828	0	0		26. 00
27. 00	EMERGENCY	91.00	19, 212	0	0		27. 00
28. 00	OTHER NRCC	1 <u>94.</u> 08	4, 289	0	<u></u> <u></u>		28. 00
	TOTALS		533, 126	0			_
	H - Labor and Delivery						
1.00	ADULTS & PEDIATRICS	30.00	6, 638, 091	0	- 1		1. 00
2.00		0.00	0	0	0		2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	3, 940, 328	0		3. 00
4.00		0.00	0	0	o		4. 00
	TOTALS		6, 638, 091	3, 940, 328			

Health Financial Systems RECLASSIFICATIONS

Peri od: Worksheet A-6 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

						5/24/2024 11:44 am
		Decreases				
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
	I - CAFETERIA RECLASSIFICATIO	N				
1.00	DI ETARY	10.00	2, 261, 975	0	0	1. 00
2.00	DI ETARY	10.00	0	2, 939, 461	0	2. 00
	TOTALS		2, 261, 975	2, 939, 461		
	J - THERAPY					
1.00	PHYSI CAL THERAPY	66.00	1, 860, 666			1. 00
2.00						2.00
3.00	PHYSI CAL THERAPY	66.00		822, 186		3.00
4.00						4. 00
			1, 860, 666	822, 186		
	K - BUILDING DEPRECIATION				,	
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	8, 396, 816	9	1.00
	TOTALS			8, 396, 816		
	L - CAPITAL INSURANCE COSTS	<u> </u>				
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	441, 214	12	1.00
	TOTALS			441, 214		
	M - RADIOLOGY SUPPORT					
1.00	RADI OLOGY-DI AGNOSTI C	54.00	334, 186	0	0	1.00
2.00		0.00	0	0	0	2. 00
3.00		0.00	O	0	0	3.00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	316, 850	o	4.00
5.00		0.00	0	0	o	5. 00
6.00		0.00	ol	0	o	6. 00
	TOTALS		334, 186	316, 850	— — i	
500.00	Grand Total: Decreases		11, 628, 044	102, 268, 039		500.00

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0169 Peri od: Worksheet A-7 From 01/01/2023 Part I 12/31/2023 Date/Time Prepared: 5/24/2024 11:44 am Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 2, 705, 851 0 0 1.00 0 4, 358, 832 2.00 Land Improvements 0 2.00 3.00 332, 441, 667 2, 844, 289 1, 398, 136 3.00 Buildings and Fixtures 2, 844, 289 0 4.00 Building Improvements 3, 615, 740 173, 468 173, 468 7, 487 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 128, 901, 109 5, 208, 575 5, 208, 575 944 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 472, 023, 199 8, 226, 332 8, 226, 332 1, 406, 567 8.00 9.00 Reconciling Items 0 9.00 8, 226, 332 1, 406, 567 Total (line 8 minus line 9) 472, 023, 199 10.00 0 8, 226, 332 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7. 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 2, 705, 851 0 1.00 2.00 Land Improvements 4, 358, 832 0 2.00 3.00 Buildings and Fixtures 333, 887, 820 0 3.00 0 4.00 Building Improvements 3, 781, 721 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 6.00 134, 108, 740 0 6.00 7. 00 7.00 HIT designated Assets 0

478, 842, 964

478, 842, 964

0

0

			'	12/31/2023	5/24/2024 11:	
		SL	JMMARY OF CAPI	ΓAL		
Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
				instructions)	instructions)	
	9. 00	10.00	11. 00	12.00	13. 00	
PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00 CAP REL COSTS-BLDG & FLXT	0	0	(0	0	1. 00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0	(0	0	2. 00
3.00 Total (sum of lines 1-2)	0	0	(0	0	3. 00
	SUMMARY O	F CAPITAL				
	0.1	T 1 1 (1) (
Cost Center Description		Total (1) (sum				
	Capi tal -Rel ate					
	d Costs (see	through 14)				
	instructions)	15.00				
PART II - RECONCILIATION OF AMOUNTS FROM WORK	14.00	15.00	nd 0			
	SHEET A, CULUM	N 2, LINES I a	nu z			1 00
1.00 CAP REL COSTS-BLDG & FLXT	0	0				1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00 Total (sum of lines 1-2)	l 이	0	l			3. 00

Heal th	Financial Systems COMM	UNITY HOSPITAL	OF INDIANA, II	NC.	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	Period: From 01/01/2023 To 12/31/2023		pared:
		COM	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	344, 734, 223	C	344, 734, 223	0. 719932	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	134, 108, 740		134, 108, 740			
3.00	Total (sum of lines 1-2)	478, 842, 963		478, 842, 963			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
1.00	CAP REL COSTS-BLDG & FIXT	0	_)	8, 396, 816		
2.00	CAP REL COSTS-MVBLE EQUIP	0)	8, 869, 237		
3.00	Total (sum of lines 1-2)	0	~) (17, 266, 053	8, 362, 579	3. 00
			SI	JMMARY OF CAPI	ΓAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)			
					d Costs (see	through 14)	
					instructions)		
		11.00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	MILLDC					I .

5, 559, 153

0 5, 559, 153

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
CAP REL COSTS-BLDG & FIXT 5

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

441, 214

441, 214

0 0 0

0 0 0

14, 397, 183 1. 00 17, 231, 816 2. 00 31, 628, 999 3. 00

1.00

2.00

| Period: | Worksheet A-8 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES COMMUNITY HOSPITAL OF INDIANA, INC.

Provider CCN: 15-0169

Expense Classel Proaction on Nort-Schwert A To-From Which the Amount is to be Agi usted From the Chite Property From Which the Amount is to be Agi usted From the Chite Property From Which the Amount is to be Agi usted From the Chite Property From the Chite Propert						o 12/31/2023	Date/Time Prep 5/24/2024 11:4	
Cost Center Description Sest \$7.00e (2) Appoint Cost Center Line # Dists A-7 Ref.							0,21,2021 11.	TT GIII
1.00 Investment Income - CP NEL CONTS-REDG & FIXT Chapter 2) CONTS-REDG & FIXT Chapter 3) CONTS-REDG & CON					10/F10III WHICH THE AMOUNT IS	to be Adjusted		
1.00 Investment Income - CP NEL CONTS-REDG & FIXT Chapter 2) CONTS-REDG & FIXT Chapter 3) CONTS-REDG & CON								
1.00 Investment Income - CAP REL COSTS-RED & FIXT Chapter 2) COSTS-RED & FIXT Chapter 3) CoSTS-RED & FIXT Chapter 4) Chapter 4) CoSTS-RED & FIXT Chapter 5) CoSTS-RED & FIXT Chapter 6) COSTS-RED & FIXT Chapter 7) CoSTS-RED & FIXT Chapter 8) COSTS-RED & FIXT COSTS-RED		Cost Center Description	Rasis/Code (2)	Amount	Cost Center	line #	Wkst A_7 Ref	
CONSTS-MILLE CATENT (Chapter 2) CAMP RFI COSTS-AVMI F FOULP 2.00 0.00				2. 00	3.00	4. 00	5. 00	
Costs AMBI Froil P (chapter 2) 0	1. 00			0	CAP REL COSTS-BLDG & FIXI	1.00	0	1. 00
Investment income - other	2. 00			0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
1.00 Control Control	3. 00	Investment income - other		0		0. 00	0	3. 00
Refunds and rebates of Refunds and rebates	4.00	Trade, quantity, and time		0		0. 00	0	4. 00
Sental of provider space by 0 0.00 0.60 0.00 0.70 0.00 0.70 0.70 0.00 0.70 0.00 0.70 0.00 0.70 0.00 0.70 0.00 0	5. 00		В	-28, 074	ADMINISTRATIVE & GENERAL	5. 00	О	5. 00
Supplier's (chapter 8)	6. 00			0		0.00	0	6. 00
Stations excluded) (Chépter 27)		suppliers (chapter 8)		0				
1	7.00	stations excluded) (chapter		O		0.00		7.00
Parking Iot (chapter 21) A-8-2 -1,263,876 0 0.00 0.	8. 00			0		0.00	0	8. 00
adjustment	9. 00			0		0. 00	0	9. 00
11.00 Safe of scrap, waste, etc. (chapter 23) 12.00 Related organization A-8-1 1,173,259 0.00 0.00 0.12.00 13.00 Laundry and I linen service 0 0.00 0.00 0.13.00 15.00 Rental of quarters to employee and desired organization of others 0.00 0.00 0.00 0.14.00 16.00 Safe of medical and surgical supplies to other than patients 0.00 0.00 0.00 0.00 0.00 17.00 Sale of medical and surgical supplies to other than patients 0.00 0.00 0.00 0.00 0.00 17.00 Sale of medical records and abstracts 0.00 0.00 0.00 0.00 0.00 18.00 Sale of medical records and abstracts 0.00 0.00 0.00 0.00 0.00 19.00 Nursing and all lied heal th education (tultion, fees, books, etc.) 0.00 0.00 0.00 0.00 0.00 20.00 Vending machines 0.00 0.00 0.00 0.00 0.00 21.00 Income from imposition of linterest, finance or penality charges (chapter 21) 0.00 0.00 0.00 0.00 0.00 22.00 Interest expense on Medicare overpayments and borrowings to respect the respect of the physical charges (chapter 14) 1.11 tation (chapter 14) 1.11 tation (chapter 14) 1.11 tation (chapter 14) 1.11 tation chapter 14) 1.11 tatio	10. 00		A-8-2	-1, 263, 876			o	10. 00
12.00 Related organization	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 16.0	12. 00	Related organization	A-8-1	1, 173, 259			О	12. 00
15.00 Rental of quarters to employee and others 0 0 0 15.00 0 16.00 0 16.00 0 16.00 0 16.00 0 17.00 0 17.00 0 17.00 0 17.00 0 17.00 0 18.00 0 0 18.00 0 0 18.00 0 0 18.00 0 0 18.00 0 0 18.00 0 0 0 0 18.00 0 0 0 0 0 18.00 0 0 0 0 0 0 0 0 0	13. 00			0		0.00	0	13. 00
and others			1	-2, 798, 956 0	CAFETERI A		-	
Supplies to other than partients		and others		0				
17. 00 Sale of drugs to other than part ents 0 0.0	10.00	supplies to other than		, and the second		0.00		10.00
18.00 Sale of medical records and abstracts 0 0 0 0 0 0 0 0 0	17. 00	Sale of drugs to other than		0		0.00	0	17. 00
19.00 Nursing and allied health	18. 00	Sale of medical records and		0		0.00	0	18. 00
20. 00 Vending machines 0 1 1 1 1 1 1 1 1 1	19. 00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. 00
Interest, finance or penalty 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 1.00 25.00 27.00 27.00 28.00 29.0	20. 00			0		0.00	0	20. 00
22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments 0 0 0 0 0 0 0 0 0	21. 00			0		0.00	0	21. 00
Papay Medicare overpayments	22. 00	Interest expense on Medicare		0		0.00	0	22. 00
therapy costs in excess of	22.00	repay Medicare overpayments		0	DECDIDATORY THERADY	45.00		22.00
24. 00 Adjustment for physical therapy costs in excess of limitation (chapter 14) A-8-3 0 PHYSICAL THERAPY 66. 00 24. 00 25. 00 Utilization review - physicians' compensation (chapter 21) 0 Utilization REVIEW-SNF 114. 00 25. 00 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26. 00 27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 2.00 0 27. 00 28. 00 Non-physician Anesthetist 0 NONPHYSICIAN ANESTHETISTS 19. 00 28. 00 29. 00 Physicians' assistant 0 OCCUPATIONAL THERAPY 67. 00 30. 00 29. 00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 OADULTS & PEDIATRICS 30. 00 30. 99 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 OSPEECH PATHOLOGY 68. 00 31. 00 32. 00 CAH HIT Adjustment for 0 0.00 0 32. 00	23.00	therapy costs in excess of	A-0-3	U	RESPIRATORY THERAPY	65.00		23.00
25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL (COSTS-BLDG & FIXT 1.00 0.26.00 27.00 Depreciation - CAP REL (COSTS-BLDG & FIXT 1.00 0.26.00 28.00 Non-physician Anesthetist ONONPHYSICIAN ANESTHETISTS 19.00 28.00 29.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for O O O 30.00 O O O 30.00 O O 30.00 O O 30.00 O O 30.00 O 30.00 O O 30.00 O	24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
Chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 O 26.00	25. 00	Utilization review -		0	UTILIZATION REVIEW-SNF	114.00		25. 00
27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 2.00 0 27. 00 28. 00 Non-physician Anesthetist 0 Non-physicians' assistant 19. 00 28. 00 29. 00 Physicians' assistant 0 0 0 0 0 0 29. 00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 0 0 0 0 0 0 30. 00 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 SPEECH PATHOLOGY 68. 00 31. 00 32. 00 CAH HIT Adjustment for 0 0 0 0 0 0	26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
28. 00 Non-physician Anesthetist 0 Non-physician Anesthetist 19. 00 28. 00 29. 00 Physicians' assistant 0 0 00 00 0 29. 00 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) A-8-3 0 00 00 00 00 30. 00 30. 99 Hospice (non-distinct) (see instructions) 0 ADULTS & PEDIATRICS 30. 00 30. 99 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 0 SPEECH PATHOLOGY 68. 00 31. 00 32. 00 CAH HIT Adjustment for 0 0.00 0 32. 00	27. 00	Depreciation - CAP REL		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 A-8-3 OCCUPATIONAL THERAPY 67.00 30.00		Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS			
therapy costs in excess of i mit tation (chapter 14)			A-8-3	0	OCCUPATIONAL THERAPY			
30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for 30. 99 OADULTS & PEDIATRICS 30. 00 SPEECH PATHOLOGY 68. 00 31. 00 0 32. 00		therapy costs in excess of						
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for 0 SPEECH PATHOLOGY 68.00 31.00	30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
i mi tati on (chapter 14)	31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	32 00	limitation (chapter 14)		0		0.00	٥	32 00
	52.00	Depreciation and Interest		O		0.00		52. 50

36.00

36.01

36.02

50.00

11.00

59.00

69.00

ADJUSTMENTS TO EXPENSES Provider CCN: 15-0169 Peri od: Worksheet A-8 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/24/2024 11:44 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Cost Center Line # Wkst. A-7 Ref. Amount 2.00 3.00 4.00 5.00 33.00 OTHER ADJUSTMENTS (SPECIFY) 0.00 33. 00 (3) 33.01 Misc Revenue В -174, 737 EMPLOYEE BENEFITS DEPARTMENT 4.00 33.01 33. 02 Misc Revenue В -47, 022 ADMINI STRATI VE & GENERAL 5.00 33.02 33. 03 Mi sc Revenue -22, 431 DI ETARY 10.00 33. 03 В -115, 935 PHARMACY Misc Revenue 33.04 В 15.00 33.04 33. 05 Misc Revenue В -360 ADULTS & PEDIATRICS 30.00 33.05 Misc Revenue -1,960 NEONATAL INTENSIVE CARE UNIT 35.00 33.06 33.06 В -118, 204 RADI OLOGY-DI AGNOSTI C 33.07 Misc Revenue 54.00 33.07 В 33.08 Mi sc Revenue В -5, 710 PHYSI CAL THERAPY 66.00 33 08 33. 09 Space Rental Income В 22, 950 ADMINISTRATIVE & GENERAL 5.00 33.09 34.00 HAF Tax Offset -20, 536, 266 ADMI NI STRATI VE & GENERAL 5.00 34.00 Α PNC Non-Allow Interest Expense -36,558 CAP REL COSTS-BLDG & FIXT 34.01 1.00 34.01 Α 11 34.02 2012A Non-Allow Interest Α -20, 920 CAP REL COSTS-BLDG & FIXT 1.00 11 34.02 Expense 34.03 2012B Non-Allow Interest Α -354, 291 CAP REL COSTS-BLDG & FIXT 1.00 11 34.03 Expense -4, 153, 367 CAP REL COSTS-BLDG & FIXT 2018A Non-Allow Interest 34.04 Α 1.00 11 34.04 Expense 34.05 2020A Non-Allow Interest Α -2, 925, 148 CAP REL COSTS-BLDG & FIXT 1.00 11 34.05 Expense 2022A Non-Allow Interest -697, 745 CAP REL COSTS-BLDG & FIXT 34.06 34.06 1.00 11 Expense -86, 537 ADMI NI STRATI VE & GENERAL Non-Allow Debt Issuance 5.00 11 34.07 34.07 Α Expense 35. 01 Hospitalist Loss -11, 234, 841 ADULTS & PEDIATRICS 35.01 Α 30.00 0 35.02 Bad Debt -20, 416, 281 ADMI NI STRATI VE & GENERAL 5.00 35.02 35. 03 Bad Debt -2, 716 NEONATAL INTENSIVE CARE UNIT 35.00 35.03 Α -2, 906 ADULTS & PEDIATRICS 35.04 APP 30.00 Α 35 04 35.05 APP Α -714, 842 NEONATAL INTENSIVE CARE UNIT 35.00 35.05 -741 ADULTS & PEDIATRICS 30.00 35.06 35.06 APP Α

-112. 326 CAFETERI A

-64, 328, 459

156, 411 CARDI AC CATHETERI ZATI ON

237, 571 ELECTROCARDI OLOGY

Α

Α

Α

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

Meals on Wheels Cost

SHARED SERVICES

SHARED SERVICES

36.00

36. 01

36.02

50.00

⁽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.

Provider CCN: 15-0169 | Period: From 01/01

Worksheet A-8-1

OFFICE	COSTS			FI OIII 01/01/2023		
				To 12/31/2023		
				1	5/24/2024 11:	44 am
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
	1.00	0.00	2.00	4.00	5	
	1.00	2.00	3.00	4.00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAIMED	
1 00	HOME OFFICE COSTS:	LAD CEDVICES CALADY & EDINGE	DECL DENTS	F 47, 104		1 00
1.00	l control of the cont	I &R SERVICES-SALARY & FRINGE		547, 104		1.00
2.00	l control of the cont	I &R SERVI CES-OTHER PRGM COST		1, 293, 331		2. 00
3.00	l control of the cont		HOME OFFICE	2, 948, 662		3. 00
3. 01	l control of the cont		HOME OFFICE	6, 150, 833		3. 01
3. 02			HOME OFFICE	56, 728, 104		3. 02
3. 03	l control of the cont	l	HOME OFFICE	3, 678, 920		3. 03
3.04	l control of the cont	l	HOME OFFICE	3, 963, 612	0	3. 04
3.05	14. 00	CENTRAL SERVICES & SUPPLY	HOME OFFICE	1, 015, 187	0	3. 05
3.06	16. 00	MEDICAL RECORDS & LIBRARY	HOME OFFICE	2, 443, 403	0	3. 06
3.07	30.00	ADULTS & PEDIATRICS	HOME OFFICE	150, 898	0	3. 07
3.08	54. 00	RADI OLOGY-DI AGNOSTI C	HOME OFFICE	267, 546	0	3. 08
3.09	70.00	ELECTROENCEPHALOGRAPHY	HOME OFFICE	312, 469	0	3. 09
4.00	73. 00	DRUGS CHARGED TO PATIENTS	HOME OFFICE	260, 952	o	4.00
4.01	5. 00	ADMINISTRATIVE & GENERAL	CPN MEDICAL DIRECTOR	227, 021	o	4. 01
4.02	91.00	EMERGENCY	CPN CALL	1, 074, 017	ol	4. 02
5.00	TOTALS (sum of lines 1-4).			81, 062, 059	1	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	l			1		

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

nus n	ot been posted to norksheet A,	cor anno r ana/or z, the amoun	it allowable 311	oura de marcatea m coranin 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 RELA	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

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

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

							10 12/01/2020	5/24/2024 11:	44 am
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
			MENTS REQUIRED) AS A RESULT C	F TRANSACTI	ONS WITH RELATED	ORGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE CO								
1. 00	547, 104								1. 00
2.00	1, 293, 331								2. 00
3.00	2, 948, 662								3. 00
3. 01	6, 150, 833								3. 01
3.02	-23, 160, 696								3. 02
3.03	3, 678, 920								3. 03
3.04	3, 963, 612								3. 04
3.05	1, 015, 187	0							3. 05
3.06	2, 443, 403	0							3. 06
3.07	150, 898	0							3. 07
3.08	267, 546	0							3. 08
3.09	312, 469	0							3. 09
4.00	260, 952	0							4.00
4.01	227, 021	0							4. 01
4.02	1, 074, 017	0							4. 02
5.00	1, 173, 259								5. 00

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

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

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

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

reriiibur	Sement under title XVIII.	
6.00		6.00
7. 00 8. 00		7.00
8.00		8.00
9.00		9.00
9. 00 10. 00		10.00
100.00		100.00

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- 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.

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Peri od: Worksheet A-8-2 From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/24/2024 11:44 am

								5/24/2024 11:	44 am
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der		RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component			ider Component	
					· ·			Hours	
	1.00	2.00	3.00	4.00	5. 00		6. 00	7. 00	
1. 00	5. 00	ADMINISTRATIVE & GENERAL	877, 613	877, 6	13	0	0	0	1. 00
2.00		NEONATAL INTENSIVE CARE UNIT	142, 500	142, 50	00	ol	0	l 0	2. 00
3.00		SUBPROVIDER - IPF	238, 384			0	0	0	
4. 00		ENDOSCOPY	5, 379			o	0	0	4. 00
5. 00	0.00		0,0,7	0,0	n	n	0	ا م	5. 00
6. 00	0.00		1		0	n	0	1	6. 00
7. 00	0.00					۸	0		7. 00
8. 00	0.00				0	0	0	0	1
			0		0	۷	0	0	
9.00	0.00	4	0		0	U	0	0	9. 00
10. 00	0.00		0		0	0	0	0	
200.00			1, 263, 876			0		0	200. 00
	Wkst. A Line #		Unadjusted RCE				Provi der	Physician Cost	
		I denti fi er	Limit		CE Membershi ps		Component	of Malpractice	
				Limit	Conti nui ng		Share of col.	Insurance	
					Educati on		12		
	1. 00	2. 00	8. 00	9. 00	12. 00		13.00	14. 00	
1. 00		ADMINISTRATIVE & GENERAL	0		0	0	0	0	
2.00		NEONATAL INTENSIVE CARE UNIT	0		0	0	0	0	
3.00		SUBPROVIDER - IPF	0		0	0	0	0	3. 00
4.00	76. 00	ENDOSCOPY	0		0	0	0	0	4. 00
5.00	0.00		0		0	0	0	0	5. 00
6.00	0.00		0		0	0	0	0	6. 00
7.00	0.00		1 0		0	ol	0	l 0	7. 00
8.00	0.00		1 0		0	ol	0	0	8. 00
9.00	0.00		0		0	0	0	0	9. 00
10.00	0.00		0		0	o	0	0	10. 00
200.00			l o		0	n	0	ا م	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Ť	Adjustment	Ü	200.00
	INCSC. A EITHE #	I denti fi er	Component	Limit	Di sal I owanc	ا م	raj as tilion t		
		Tuchti i ci	Share of col.		Di Sai i Owaric	٦			
			14						
	1. 00	2.00	15. 00	16. 00	17. 00		18. 00		
1. 00		ADMINISTRATIVE & GENERAL	0		0	0	877, 613		1. 00
2. 00		NEONATAL INTENSIVE CARE UNIT	0		0	o	142, 500	•	2. 00
3. 00		SUBPROVIDER - IPF	1		0	n	238, 384		3. 00
4. 00		ENDOSCOPY			0	۸	5, 379		4. 00
5. 00	0.00	4			0	7	5, 3/7		5. 00
	0.00				0	0	0		
6.00					0	y	0		6. 00
7.00	0.00		0		0	V	0		7. 00
8.00	0.00		0		U	U	0		8. 00
9. 00	0.00		0		0	0	0		9. 00
10.00	0.00		0		0	0	0		10. 00
200.00			0		0	0	1, 263, 876		200. 00

Health Financial Systems COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0169 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 11:44 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 14, 397, 183 00100 CAP REL COSTS-BLDG & FLXT 14, 397, 183 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 17, 231, 816 17, 231, 816 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 6, 109, 953 6, 113 89, 056 6, 205, 122 4.00 00500 ADMINISTRATIVE & GENERAL 64, 749, 530 3, 591, 929 279, 756 69. 081. 587 5 00 460, 372 5 00 7.00 00700 OPERATION OF PLANT 14, 728, 444 1, 769, 902 103, 523 96, 711 16, 698, 580 7.00 1, 138, 410 8.00 00800 LAUNDRY & LINEN SERVICE 1, 098, 373 40, 037 8.00 9.00 00900 HOUSEKEEPI NG 5, 465, 157 168, 777 19,005 135, 937 5, 788, 876 9.00 01000 DI ETARY 10.00 1, 919, 357 13, 024 2, 074, 186 105, 198 36, 607 10 00 11.00 01100 CAFETERI A 2, 290, 154 321, 011 54,049 99, 448 2, 764, 662 11.00 01300 NURSING ADMINISTRATION 7, 507, 800 31, 330 124, 858 7, 720, 087 13.00 56, 099 13.00 01400 CENTRAL SERVICES & SUPPLY 4,072,248 344, 242 3, 040, 116 52, 087 7, 508, 693 14.00 14.00 9, 888, 754 8, 872, 415 15.00 01500 PHARMACY 151, 611 568, 937 295, 791 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2, 443, 403 5, 754 2, 449, 157 16.00 C 01700 SOCIAL SERVICE 17.00 2, 720, 300 27, 402 36 93, 515 2, 841, 253 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 C 0 19.00 0 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 547 104 C 0 0 547, 104 21 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 1, 293, 331 1, 293, 331 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 1, 859, 267 30.00 03000 ADULTS & PEDLATRICS 60, 589, 565 5, 423, 415 509, 042 68, 381, 289 30.00 31.00 03100 INTENSIVE CARE UNIT 10, 049, 996 613, 782 117, 028 329, 014 11, 109, 820 31.00 02060 NEONATAL INTENSIVE CARE UNIT 12, 318, 227 139, 987 398, 198 13, 690, 107 35.00 833, 695 35.00 04000 SUBPROVIDER - IPF 40.00 2, 727, 990 143, 005 101, 673 2, 977, 336 40.00 4.668 04300 NURSERY 43.00 3, 299, 254 <u>322,</u> 594 27, 503 91.022 3, 740, 373 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 26, 950, 358 50.00 22, 672, 948 636, 005 3, 401, 771 239, 634 50.00 51.00 05100 RECOVERY ROOM 5, 397, 379 353, 784 4.144 169, 271 5, 924, 578 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 7, 279, 165 711, 715 60.680 200.822 8, 252, 382 52 00 05400 RADI OLOGY-DI AGNOSTI C 6, 191, 751 319, 213 6, 950, 592 54.00 263, 166 176, 462 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 3, 393, 219 163, 239 342, 397 32, 164 3, 931, 019 55.00 57 00 05700 CT SCAN 2.911.330 54, 421 70.893 3, 041, 795 5. 151 57 00 58.00 05800 MRI 1, 685, 733 82, 806 550, 025 39, 193 2, 357, 757 58.00 05900 CARDIAC CATHETERIZATION 59.00 156, 230 1,528 0 157, 758 59.00 06000 LABORATORY 129, 364 15, 707, 468 60.00 15, 578, 104 60.00 0 06400 I NTRAVENOUS THERAPY 4, 315 9, 075 660, 294 22, 357 696, 041 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 7, 143, 151 137, 706 300, 481 192, 588 7, 773, 926 65.00 66.00 06600 PHYSI CAL THERAPY 7, 448, 978 22, 176 1, 198, 238 256, 872 8, 926, 264 66.00 2, 377, 567 67 00 06700 OCCUPATIONAL THERAPY 68, 826 2 257 214 C 51 527 67 00 06800 SPEECH PATHOLOGY 68.00 425, 638 9, 716 12, 978 448, 332 68.00 69.00 06900 ELECTROCARDI OLOGY 959, 460 10, 525 2,060 972, 045 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 2, 374, 756 94, 218 215, 727 61,074 2, 745, 775 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 20, 401, 794 20 401 794 71 00 71 00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 14, 139, 248 C 0 0 14, 139, 248 72.00 07300 DRUGS CHARGED TO PATIENTS 14, 703, 388 0 0 14, 703, 388 73.00 73.00 C 73.01 07301 SPECIALTY PHARMACY 0 0 73.01 0 1, 876, 402 07400 RENAL DIALYSIS 1 863 570 74 00 11, 364 0 1.468 74 00 76.00 03330 ENDOSCOPY 3, 567, 206 177, 623 372, 484 85, 633 4, 202, 946 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 76.01 76.01 03951 OTHER ANCILLARY SERVICE COST CENTERS 76.02 0 0 76.02 0 0 03952 OTHER ANCILLARY SERVICE COST CENTERS 76.03 0 C 0 0 0 76.03 76.04 03953 WOUND CARE 1, 575, 986 156, 715 28, 088 1, 760, 789 76.04 03954 I MAGING CENTER 76.06 3, 711, 763 0 1,031,526 92, 784 4, 836, 073 76.06 03955 BREAST DIAGNOSTIC CENTER 11, 801, 069 76.07 Ω 444, 233 4.104 12, 249, 406 76.07 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 0 0 0 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C 0 Ω 0 0 0 90.01 04950 INFUSION CENTER 186, 918 87,685 5, 904 280, 507 90.01 0 04975 SPINE CENTER 90 26 290, 687 9,790 300, 477 90.26 09100 EMERGENCY 13, 308, 697 590, 023 129, 709 349, 381 14, 377, 810 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 SUBTOTALS (SUM OF LINES 1 through 117) 416, 517, 276 14, 291, 506 16, 945, 211 <u>6, 116,</u> 230 416, 036, 102 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 95, 680 0 0 95, 680 190. 00 419, 465, 535

COST ALLOCATION - GENERAL SERVICE COSTS Worksheet B Provi der CCN: 15-0169 Peri od: From 01/01/2023 Part I Date/Time Prepared: 5/24/2024 11:44 am 12/31/2023 CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 191. 00 19100 RESEARCH 0 0 0 191. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFICES
193. 00 19300 NONPALD WORKERS 99, 681 0 99, 681 192. 00 0 0 0 0 193. 00 194.00 07950 HOME OFFICE 0 0 0 194.00 194. 06 07956 PAVI LLI ONS 114, 700 132, 166 194. 06 17, 466 194. 08 07958 OTHER NRCC 9, 997 88, 892 3, 101, 906 194. 08 2, 831, 112 171, 905 194. 10 07960 COMMUNITY REHAB HOSPITAL 0 194. 10 200.00 Cross Foot Adjustments 0 200. 00 Negative Cost Centers 201.00 0 201.00

14, 397, 183

17, 231, 816

6, 205, 122

419, 465, 535 202. 00

202.00

TOTAL (sum lines 118 through 201)

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Debind Service DIST General		Cost Center Description	ADMINISTRATIVE & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	5/24/2024 11: DI ETARY	44 am_
1.00 00100 CAP REL COSTS - BIRG A FIXT						9. 00	10.00	
2.00								
4.00 0.0000 PURP (OVER PRIFER TS DEPARTMENT 4.9 (0.11, 5.17) 5.00 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.0000 0.000000 0.00000000								
5.00 0.0000 AMMINISTRATIVE & CREERAL 69 CRETA 7.00 0.0000 ARMINISTRATIVE & CREERAL 7.00 0.0000 ARMINISTRATIVE 7.0000 ARMINISTRATIVE 7.00 0.0000 ARMINISTRATIVE 7.00 0.0000 ARMINISTRATIVE 7.00 0.0000 ARMINISTRATIVE 7.00 0.0000 ARMINISTRATIVE 7.0000							I	1
7.00 000000 (INDIAMEN & LIFEN SERVICE 224.49 0.65.10 1.4.28.674 0.60.00000 (INDIAMEN & LIFEN SERVICE 244.90 0.60.00000 (INDIAMEN & LIFEN SERVICE							I	1
B. OLD DOSIGNED LANDMAY & LINEN SERVICE 224, 449			69, 081, 587				I	1
9.00 0.000							I	
10.00 010000 LETARY			I I				I	
11-10 O 01100 CAFETERIA 914.001 122.002 0 33.831 0 11.00 11.								1
13.00 01300 MURSING ADMINISTRATION 1,922,092 92,220 0 33,831 0 13.00 15.00			l l					1
14 00 01400 CENTRAL SERVICES & SUPPLY 1,480,414 505,882 0 207,996 0 14.00 15.00 15.00 01600 WEILCAL RECORDS & LIBRARY 429,1876 9,488 0 3,470 0 15.00 16.00 01600 WEILCAL RECORDS & LIBRARY 429,1876 9,488 0 3,470 0 16.00 17.00 17.00 0700 2014 SERVICES STATEMENT STRINGS APPRY 264,9031 0 0 0 0 0 0 0 0 0			l l					
15.00 01500 PHABMACY 1,949,67 249,231 0 91,429 0 15.00 17.00 01700 001701 00							-	1
16.00 01-60 MEDI CAL RECORDS & LIBRARY 422,876 9,458 0 3,370 0 16.002 17.00 17.00 1700 01-900 000PHINSTICIAN AMESINETISTS 0 0 0 0 0 0 0 0 17.00 17.00 17.00 17.00 01-900 000PHINSTICIAN AMESINETISTS 25.00 18.00 0 0 0 0 0 0 0 0 0			I I				-	
17.00 1700 SOCIAL SERVICE 50.0 151 45.046 0 16.522 0 17.00			I I		_		_	
19.00 01900 000PPI 000PPI 018 SERVICES-ALARY & FRI NIESS APPRV 24, 903 0 0 0 0 0 0 21.00 0200 188 SERVICES-ALARY & FRI NIESS APPRV 24, 903 0 0 0 0 0 0 0 22.00 0200 187 SERVICES-ATHER PROW (25TS APPRV 244, 903 0 0 0 0 0 0 0 0 0			1					1
21.00 02100 LAR SERVICES-SALARY & FENNESS APPRY 107, 867 0 0 0 0 21.00 0 0 0 0 0 0 0 0 0						10, 323	_	1
22.00			-	-		0	_	
IMPATT ENT ROUTINE SERVICE COST CENTERS 13, 481, 943 6, 915, 439 693, 681 3, 270, 597 2, 271, 308 30. 00 03000 (ABUTS & PERITARICS 13, 481, 943 6, 915, 439 693, 681 3, 270, 597 2, 271, 308 31. 00 31. 00 31000 (ABUTS & PERITARICS 2, 190, 412 1, 008, 962 61, 713 370, 142 278, 680 31. 00 31.					0	0	-	1
30.00	22.00		234, 773		0	<u> </u>		22.00
31 00 03100 INTENSIVE CARE UNIT 2,190, 412 1,006, 982 61,713 370, 412 278, 680 31.00 04000 CROMATAL INTENSIVE CARE UNIT 2,699, 141 1,370, 499 86,900 502, 761 0.93, 040.00 04000 SUBPROVIDER - I.PF 587, 012 235, 082 30, 238 86,239 169,577 40.00 40.00 04000 CREATING ROOM 737, 7452 530, 309 50,252 194,541 0.43, 000 4300 04300 CREATING ROOM 737, 7452 530, 309 50,252 194,541 0.43, 000 4300 CREATING ROOM 737, 7452 530, 309 50,252 194,541 0.43, 000 4300 CREATING ROOM 7,180,000 6,191,579 6,191,	30 00		13 481 943	8 915 439	693 681	3 270 597	2 271 308	30.00
35.00 02000 NEOMATAL INTENSIVE CARE UNIT 2,699, 141 1,370, 493 86, 900 502, 761 1,95, 577 40.00 40.00 40.00 40.00 50000 SUBPROVIDE F F F 587, 712 235, 002 30, 238 86, 239 194, 581 0 43.00			1					
0.000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.00000000		1	1					1
143.00 04300 NURSERY 737, 452 530, 305 50, 252 194, 541 0 43, 00			1				_	
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM			1					
50.00			1	222,222		,		
52.00 05.200 DELIVERY ROOM & LABOR ROOM 1, 627, 040 1, 169, 973 110, 868 429, 201 52.00 55.00 05500 RADIOLOGY-THERAPEUTIC 775, 040 268, 345 17, 479 98, 441 0.55, 00 55.00 05500 CT SCAN 599, 720 89, 461 0.32, 819 0.57, 00 05500 CT SCAN 599, 720 89, 461 0.32, 819 0.57, 00 05500 CT SCAN 599, 720 89, 461 0.32, 819 0.57, 00 05500 CT SCAN 599, 720 89, 461 0.32, 819 0.57, 00 05500 0.5800	50.00		5, 313, 533	1, 045, 516	40, 567	383, 544	0	50.00
54 00 05400 RADIOLOGY-DI AGNOSTIC 1, 370, 379 524, 748 54, 110 192, 502 0 54, 00 0 5500 0 5500 RADIOLOGY-THERAPEUTIC 775, 040 268, 345 17, 479 98, 441 0 55. 00 0 5500 0 5500 0 5500 RADIOLOGY-THERAPEUTIC 775, 040 268, 345 17, 479 98, 441 0 55. 00 0 5500 0	51.00	05100 RECOVERY ROOM	1, 168, 090	581, 578	0	213, 350	0	51.00
55. 00 05500 RADIOLOGY-THERAPEUTIC 775, 040 268, 345 17, 479 98, 441 0 55. 00 57. 00 05700 CT SCAN 599, 720 89, 461 0 32, 819 057. 00 58. 00 05800 MRI 464, 855 136, 123 0 49, 936 0 58. 00 59. 00 05900 CABDIAC CATHETERI ZATION 31, 104 0 0 0 0 0 0 60. 00 06000 CABDIAC CATHETERI ZATION 31, 104 0 0 0 0 0 0 60. 00 06000 LABORATORY 137, 231 7, 094 0 2, 602 0.64 0 60. 00 06000 INTRAVENOUS THERAPY 137, 231 7, 094 0 2, 602 0.64 0 60. 00 06500 PRISTICAL THERAPY 1,759, 902 26, 373 0 83, 044 0 65, 00 65. 00 06500 PRISTICAL THERAPY 1,759, 902 26, 373 0 0 0 0 0 0 0 67. 00 06700 OCCUPATIONAL THERAPY 1,759, 902 36, 455 0 13, 373 0 66, 00 68. 00 06800 SPEECH PATHOLOGY 88, 393 0 0 0 0 0 0 68, 00 69. 00 06900 ELECTROCARDIOLOGY 191, 648 17, 301 0 0 0 0 68, 00 69. 00 06900 ELECTROCARDIOLOGY 191, 648 17, 301 0 0 0 0 0 0 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 787, 694 0 0 0 0 0 0 0 73. 00 07300 IMPL DEV. CHARGED TO PATIENTS 2, 787, 694 0 0 0 0 0 0 0 0 73. 00 07300 IMPL DEV. CHARGED TO PATIENTS 2, 787, 694 0 0 0 0 0 0 0 0 73. 00 07300 IMPL DEV. CHARGED TO PATIENTS 2, 787, 694 0 0 0 0 0 0 0 0 0 74. 00 07400 IMPL DEV. CHARGED TO PATIENTS 2, 898, 920 0 0 0 0 0 0 0 0 0	52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 627, 040	1, 169, 973	110, 868	429, 201	0	52. 00
57.00 OSTOO CT SCAN 599, 720 89, 461 0 32, 819 0 57, 00	54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 370, 379	524, 748	54, 110	192, 502	0	54.00
18. 00 05800 MR	55.00	05500 RADI OLOGY-THERAPEUTI C	775, 040	268, 345	17, 479	98, 441	0	55. 00
99.00 059000 CARDINAC CATHETERI ZATION 31.104 0 0 0 0 0 59.00 00.00 06000 LABORATORY 3.096, 884 212, 688 0 78, 013 0.60, 00 04.00 06400 NATAWENOUS THERAPY 137, 231 7, 094 0 2, 602 0.64, 00 06.00 06500 RESPIR ATTORY THERAPY 1, 759, 902 36, 455 0 13, 373 0.66, 00 06.00 06500 RESPIR ATTORN ALL THERAPY 1, 759, 902 36, 455 0 13, 373 0.66, 00 08.00 06500 RESPIR ATTORN ALL THERAPY 1, 759, 902 36, 455 0 0 0 0 0 0 0 08.00 06800 RESPIR ATTORN ALL THERAPY 448, 761 0 0 0 0 0 0 0 0 08.00 06800 RESPIR ATTORN ALL THERAPY 448, 761 0 0 0 0 0 0 0 0 08.00 06800 RESPIR ATTORN ALL THERAPY 448, 761 0 0 0 0 0 0 0 08.00 06800 RESPIR ATTORN ALL THERAPY 448, 761 0 0 0 0 0 0 0 0 0	57.00	05700 CT SCAN	599, 720	89, 461	0	32, 819	0	57. 00
0.0 0.0000 LABORATORY 3, 0.96, 884 212, 658 0 78, 0.13 0 60, 00 64, 00 0.400 INTERVENUES THERAPY 1, 72, 231 7, 094 0 2, 602 0.46, 00 66, 00 0.600 PRIST RATORY THERAPY 1, 752, 707 226, 373 0 83, 044 0.65, 00 0.66, 00 0.600 PRIST RATORY THERAPY 1, 759, 902 36, 455 0 13, 373 0 68, 00 0.0 0.0 0.67, 00 0.000			464, 855	136, 123	0	49, 936	0	
64.00 0.0400 INTRAVENOUS THERAPY			I I			-	0	1
65.00 06500 RESPIRATORY THERAPY 1,532,707 226,373 0 83,044 0 65.00			3, 096, 884		0		0	
66. 00 06600 PHYSICAL THERAPY 1,759, 902 36,455 0 13,373 0 66.00 67.00 07.00 0.00 0 0.00					_		0	1
67.00 06700 0CCUPATIONAL THERAPY 468, 761 0 0 0 0 0 0 0 0 0							0	1
68.0 0 06.00 06.00 06.00 0 0 0 0 0 0 0 0 0			I I			13, 373	0	1
69.00 06900			1	0	0	0	_	1
70.00 07000 12-CT 15-CT 15-C				0	0	0	_	1
171.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2, 787, 694 0 0 0 0 0 0 0 71.00			1				_	1
172.00 07200 IMPL DEV CHARGED TO PATIENTS 2,787,694 0 0 0 0 0 0 72.00			1			56, 818		1
73. 00 07300 DRUGS CHARGED TO PATIENTS 2,898,920 0 0 0 0 0 73. 00 73. 01 07301 SPECI ALTY PHARMACY 0 0 0 0 0 73. 00 73. 01 07301 SPECI ALTY PHARMACY 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSIS 369,951 18,680 0 6,853 0 74. 00 76. 00 03330 ENDOSCOPY 828,653 291,991 52,534 107,116 0 76. 00 76. 01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76. 04 03953 WOUND CARE 347,157 0 0 0 0 0 0 0 0 76. 06 03954 IMAGI NG CENTER 953,480 0 0 0 0 0 0 0 0 0			1	0	0	0	-	
73.01 07301 SPECIALTY PHARMACY 0 0 0 0 0 0 73.01 74.00 07400 RENAL DI ALYSIS 369, 951 18,680 0 6,853 0 74.00 76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76.02 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76.04 03953 WOUND CARE 347, 157 0 0 0 0 0 0 0 0 76.05 03954 IMAGING CENTER 953, 480 0 0 0 0 0 0 0 0 76.06 03958 BRAST DI AGNOSTIC CENTER 953, 480 0 0 0 0 0 0 0 0 77.00 07700 ALLOGENEIC HSCT ACQUISTITON 0 0 0 0 0 0 0 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 90.01 04950 INFUSION CENTER 55, 305 0 0 0 0 0 0 0 90.02 04950 INFUSION CENTER 55, 305 0 0 0 0 0 0 0 90.03 09000 CLINIC 0 0 0 0 0 0 0 0 0 90.04 04950 INFUSION CENTER 55, 305 0 0 0 0 0 0 0 90.05 09200 DISERVATION BEDS (NON-DISTINCT PART 59, 242 0 0 0 0 0 0 0 90.00 09100 EMERGENCY 2, 834, 729 969, 927 230, 332 355, 814 0 91.00 91.00 09100 DITER REIMBURSABLE COST CENTERS 113.00 NTEREST EXPENSE 113.00 11400 UTIL IZATION REVIEW-SNF 114.00 119.00 0 0 0 0 0 0 0 0 0				0	0	0	_	
74. 00 07400 RENAL DI ALYSIS 369, 951 18,680 0 6,853 0 74. 00 76. 00 03330 ENDOSCOPY 828,553 291, 991 52,534 107, 116 0 76. 00 76. 01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 76. 01 76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 76. 02 76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 76. 03 76. 04 03953 WOUND CARE 347, 157 0 0 0 0 0 0 76. 04 76. 06 03954 IMAGI NG CENTER 953, 480 0 0 0 0 0 0 0 76. 04 76. 07 03955 BREAST DI AGNOSTIC CENTER 2, 415, 093 0 0 0 0 0 0 0 76. 07 77. 00 07700 ALLOGENEIC HSCT ACQUI SITI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	2, 898, 920	0	0	0	_	
76. 00 03330 ENDOSCOPY 828, 653 291, 991 52, 534 107, 116 0 76, 00 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			240 OE1	10 400	0	4 052	_	
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 76. 01 76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 76. 02 76. 04 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 03 76. 04 03953 WOUND CARE 347, 157 0 0 0 0 0 76. 04 76. 06 03954 MAGING CENTER 953, 480 0 0 0 0 0 0 76. 07 76. 07 03955 BREAST DI AGNOSTIC CENTER 2, 415, 993 0 0 0 0 0 0 0 77. 00 07700 0ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 0 78. 00 00TPATIENT SERVICE COST CENTERS 79. 01 04950 INFUSION CENTER 55, 305 0 0 0 0 0 0 0 79. 26 04975 SPINE CENTER 59, 242 0 0 0 0 0 0 79. 20 09000 CLINIC 50 50 50 50 50 50 50 5		1					_	1
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 76. 02 76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76. 03 76. 04 03953 WOUND CARE 347, 157 0 0 0 0 0 0 76. 04 76. 06 03954 IMAGING CENTER 953, 480 0 0 0 0 0 0 76. 06 76. 07 03955 BREAST DI AGNOSTIC CENTER 2,415, 093 0 0 0 0 0 0 76. 07 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 78. 00 90. 00 09000 CLIN C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	271, 771 O	52, 534	107, 110	_	
76. 03 03952 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 76. 03 76. 04 03953 WOUND CARE 347, 157 0 0 0 0 76. 04 76. 06 03954 I MAGI NG CENTER 953, 480 0 0 0 0 0 76. 07 03955 BREAST DI AGNOSTI C CENTER 2, 415, 093 0 0 0 0 0 77. 00 0700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 77. 00 0700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 78. 00 07800 CAR T - CELL I IMMUNOTHERAPY 0 0 0 0 0 78. 00 07800 CAR T - CELL I IMMUNOTHERAPY 0 0 0 0 78. 00 07800 CLI NI C 0 0 0 0 0 78. 00 09000 CLI NI C 0 0 0 0 0 79. 01 04950 INFUSI ON CENTER 55, 305 0 0 0 0 79. 02 04975 SPI NE CENTER 55, 305 0 0 0 0 79. 04970 09100 EMERGENCY 2, 834, 729 969, 927 230, 332 355, 814 0 91. 00 79. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 70. 01 01020 09101 D TREATMENT PROGRAM 0 0 0 0 0 70. 01 01300 INTEREST EXPENSE 113. 00 7118. 00 11400 UTI LI ZATI ON REVIEW-SNF 11400 11400 UTI LI ZATI ON REVIEW-SNF 11400 719. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 18, 864 157, 286 0 57, 700 0 190. 0 719. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 18, 864 157, 286 0 57, 700 0 191. 00 7192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 19, 653 0 0 0 0 0 0 719. 00 19300 0000 0000 0000 0000 0000 0000 0000 72. 00 19300 00000 0000 0000 0000 0000 0000 73. 00 0000 0000 0000 0000 0000 0000 74. 0000 0000 0000 0000 0000 0000 0000 75. 0000 0000 0000 0000 0000 0000 75. 0000 0000 0000 0000 0000 0000 75. 0000 0000 0000 0000 0000 0000 75. 0000 0000 0000 0000 0000 0000 75. 0000 0000 0000 0000 0000 0000 75. 0000 0000 0000 0000 0000 0000 75. 0000 0000 0000 0000 0000 0000 75. 0000 0000 0000 000				0	0	0	_	l
76. 04 03953 WOUND CARE 347, 157 0 0 0 0 0 76. 04 76. 06 03954 IMAGI NG CENTER 953, 480 0 0 0 0 0 76. 06 76. 07 03955 BREAST DI AGNOSTIC CENTER 2, 415, 093 0 0 0 0 0 0 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 77. 00 07800 CAR T - CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00 07800 CAR T - CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 79. 00 07800 CAR T - CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 90. 01 04950 INFUSI ON CENTER 55, 305 0 0 0 0 0 0 0 90. 02 04950 INFUSI ON CENTER 55, 305 0 0 0 0 0 0 0 90. 26 04955 SPI NE CENTER 55, 242 0 0 0 0 0 0 0 92. 00 09100 EMERGENCY 2, 834, 729 969, 927 230, 332 355, 814 0 91.00 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 113. 00 11300 11300 117EREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVIEW-SNF SUBTOTALS (SUM OF LINES 1 through 117) 68, 405, 440 19, 817, 152 1, 428, 674 7, 143, 930 2, 719, 505 118. 00 190. 00 190. 00 191. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 18, 864 157, 286 0 57, 700 0 191. 00 191. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 19, 653 0 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 194. 00 194. 00 0750 HOME OFFICE 0 0 0 0 0 0 0 0 194. 00 0750 HOME OFFICE 0 0 0 0 0 0 0 0 76. 06 0 0 0 0 0 0 0 0 77. 00 0750 HOME OFFICE 0 0 0 0 0 0 0 78. 00 0750 HOME OFFICE 0 0 0 0 0 0 0 79. 00 0750 HOME OFFICE 0 0 0 0 0 0 0 79. 00 0750 HOME OFFICE 0 0 0 0 0 0 0 79. 00 0750 HOME OFFICE 0 0 0 0 0 0 0 79. 00 0750 HOME OFFICE 0 0 0 0 0 0 0 79. 00 0750 HOME OFFICE 0 0 0 0				0	0	0	_	
76. 06 03954 IMAGING CENTER			_	0	0	0	-	
76. 07			1	0	l ő	0		1
77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 77. 00 78. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 78. 00 0 0 0 0 0 0 0 0 0				0	0	0	0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0			0	0	0	0	0	1
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTER OUTPATIENT SERVICE COST CENTERS OUTPATIENT		1	0			0	_	1
90. 00			1	-		-1		1
90. 01		09000 CLI NI C	0	0	0	0	0	90.00
90. 26	90. 01	04950 INFUSION CENTER	55, 305	0	0	o	0	90. 01
91. 00			I I	0	0	o	0	1
102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O			2, 834, 729	969, 927	230, 332	355, 814	0	91. 00
102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART					I	92.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF 114.00 11400 SUBTOTALS (SUM OF LINES 1 through 117) 68,405,440 19,817,152 1,428,674 7,143,930 2,719,505 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 18,864 157,286 0 57,700 0 190.00 191.00 19100 RESEARCH 0 0 0 0 0 0 191.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 19,653 0 0 0 0 0 192.00 193.00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 194.00 07950 HOME OFFI CE 0 0 0 0 0 194.00 194								
113. 00 114.00 1	102.00	10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
114. 00		SPECIAL PURPOSE COST CENTERS						
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 68, 405, 440 19, 817, 152 1, 428, 674 7, 143, 930 2, 719, 505 118. 00							I	
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 18,864 157,286 0 57,700 0 190. 00 19100 RESEARCH 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 19,653 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 194. 00 07950 HOME OFFI CE 0 0 0 0 0 194. 00 194. 00 0 0 0 0 0 0 194. 00 0 0 0 0 0 0 0 0 0							I	1
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 18,864 157,286 0 57,700 0 190.00 191. 00 19100 RESEARCH 0 0 0 0 0 191.00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 19,653 0 0 0 0 0 192.00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193.00 194. 00 07950 HOME OFFICE 0 0 0 0 0 194.00	118.00		68, 405, 440	19, 817, 152	1, 428, 674	7, 143, 930	2, 719, 505	118. 00
191. 00 19100 RESEARCH			,					
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES			18, 864	157, 286	0	57, 700		
193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00 194. 00 07950 HOME OFFICE 0 0 0 0 0 194. 00		1	0	0	0	0		
194. 00 07950 HOME OFFICE 0 0 0 0 194. 00			19, 653	0	0	0		
			0	0] 0	0		
194. UO U/950 PAVI LLI UNS Z6, US8 U U U U 0 194. 06			0	0] 0	0		
	194.06	OND LAND IN A LOND	26, 058	0	1 0	이	0	1194.06

Health Financial Systems	COMMUNITY HOSPITAL OF	I NDI ANA,	I NC.		In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN:	15-0169	From 01/01/2023 To 12/31/2023	Worksheet B Part I Date/Time Prepared:

						5/24/2024 11:	44 am_
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7. 00	8. 00	9. 00	10.00	
194. 08 07	958 OTHER NRCC	611, 572	16, 434	0	6, 029	0	194. 08
194. 10 07	960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194. 10
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	0	0	201. 00
202.00	TOTAL (sum lines 118 through 201)	69, 081, 587	19, 990, 872	1, 428, 674	7, 207, 659	2, 719, 505	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 | 11: 44 am

					5/24/2024 11:	44 am_
Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
	11. 00	13.00	14. 00	15. 00	16. 00	
GENERAL SERVICE COST CENTERS	11100	10.00	11100	101.00	10.00	
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
7.00 O0700 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	4, 031, 033	1				11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	105, 491					13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	60, 737	1	9, 823, 332	10 400 074		14. 00
15. 00 01500 PHARMACY	204, 589 0	1	45, 394	12, 429, 064	2 044 041	15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	70, 327	1 1	0	0	2, 944, 961 0	16. 00 17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	70, 327	1	115	0	0	19.00
21. 00 02100 L&R SERVICES-SALARY & FRINGES APPRV	C	1 "1	0	0	0	
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV	C		0	0		22.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		ή	o _l			22.00
30. 00 03000 ADULTS & PEDI ATRI CS	1, 451, 299	4, 895, 609	610, 527	0	405, 422	30.00
31. 00 03100 NTENSI VE CARE UNI T	252, 539		116, 479	0	65, 054	
35.00 02060 NEONATAL INTENSIVE CARE UNIT	306, 883		146, 848	0	187, 785	
40. 00 04000 SUBPROVI DER - I PF	76, 721		22, 323	0		1
43. 00 04300 NURSERY	73, 524		29, 601	0		1
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	194, 998	659, 806	1, 540, 977	0	466, 631	50. 00
51.00 05100 RECOVERY ROOM	127, 868		78, 551	0		
52.00 05200 DELIVERY ROOM & LABOR ROOM	159, 835		65, 309	0	41, 629	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	124, 671	1	33, 569	0	71, 967	
55. 00 05500 RADI OLOGY-THERAPEUTI C	25, 574		79, 416	0	84, 248	
57. 00 05700 CT SCAN	51, 147		44, 903	0	173, 830	1
58. 00 05800 MRI	31, 967	1	12, 192	0	48, 397	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	1	8	0	7, 072	1
60. 00 06000 LABORATORY	15.000	0	430, 531	0	157, 957	
64. 00 06400 I NTRAVENOUS THERAPY	15, 983	1	8, 232	0	2, 489	1
65. 00 06500 RESPI RATORY THERAPY	124, 671	1	100, 702	0	59, 443	1
66. 00 06600 PHYSI CAL THERAPY	54, 344	1	24, 626	0	45, 456	
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	54, 344 9, 590		5, 925 1, 117	0	13, 115 4, 058	
69. 00 06900 SPEECH PATHOLOGY	3, 197		44	0	18, 374	1
70. 00 07000 ELECTROCARDI GEOGRAPHY	47, 950		31, 414	0	24, 849	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	47, 730	1	3, 535, 971	0	116, 034	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	C	ol ol	2, 450, 586	0	74, 480	
73.00 07300 DRUGS CHARGED TO PATIENTS	C	1	0	12, 429, 064	180, 347	
73. 01 07301 SPECIALTY PHARMACY	C	ol	0	0	0	73. 01
74.00 07400 RENAL DIALYSIS	C	o	1, 306	0	6, 964	74. 00
76. 00 03330 ENDOSCOPY	73, 524	l o	113, 620	0	60, 045	76. 00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	C	0	0	0	0	76. 01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS	C	0	0	0	0	76. 02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	C	0	0	0	0	76. 03
76. 04 03953 WOUND CARE	25, 574	O	26, 087	0	13, 468	1
76. 06 03954 I MAGI NG CENTER	C	0	31, 817	0	106, 226	1
76. 07 03955 BREAST DI AGNOSTI C CENTER	3, 197	0	1, 858	0	50, 455	
77. 00 07700 ALLOGENEI C HSCT ACQUISITION	C	0	0	0	0	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	C	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS		ار	0	0	0	00 00
90. 00 09000 CLINIC 90. 01 04950 INFUSION CENTER	(202		1 027	0	0	90.00
90. 01 04950 I NFUSI ON CENTER 90. 26 04975 SPI NE CENTER	6, 393		1, 837 804	0	918 741	1
91. 00 09100 EMERGENCY	294, 096	994, 483	227, 884	0	347, 811	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	274, 070	774, 403	227, 004	0	347,011	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	C	O	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS		·				1 55
113. 00 11300 NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	4, 031, 033	9, 473, 721	9, 820, 573	12, 429, 064	2, 944, 961	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0	0	0		190. 00
191. 00 19100 RESEARCH	C	ol ol	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	C	이	304	0		192. 00
193. 00 19300 NONPAI D WORKERS	C	0	0	0		193. 00
194. 00 07950 HOME OFFI CE	C	이	0	0	0	194. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS COMMUNITY HOSPITAL OF INDIANA, INC. Provider CCN: 15-0169

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 | 11: 44 am

	_				5/24/2024 11:	44 am_
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13.00	14.00	15. 00	16. 00	
194. 06 07956 PAVI LLI ONS	0	0	487	0	0	194. 06
194. 08 07958 OTHER NRCC	0	0	1, 968	0	0	194. 08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194. 10
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	4, 031, 033	9, 473, 721	9, 823, 332	12, 429, 064	2, 944, 961	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0169

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 | 11: 44 am

					5/24/2024 11:	44 am
			INTERNS &	RESI DENTS		
			050,4,050,041,45	050,4,050,07,450		
Cost Center Description	SOCI AL SERVI CE		SERVI CES-SALAR		Subtotal	
		ANESTHETI STS	Y & FRINGES	PRGM COSTS		
	17.00	10.00	APPRV	APPRV	24.00	
CENEDAL SEDVICE COST CENTERS	17. 00	19. 00	21.00	22. 00	24. 00	
GENERAL SERVICE COST CENTERS 1. 00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT			•			4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL			•			5.00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
13.00 01300 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	3, 533, 447					17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0				19. 00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRV	0		654, 971			21. 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0			1, 548, 324		22. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 951, 106	0	229, 936	543, 561	108, 101, 717	30. 00
31.00 03100 INTENSIVE CARE UNIT	362, 088	0	0	0	16, 667, 899	31. 00
35.00 02060 NEONATAL INTENSIVE CARE UNIT	0	0	0	0	20, 025, 177	35. 00
40. 00 04000 SUBPROVI DER - I PF	220, 253	0		308, 841	5, 121, 837	
43. 00 04300 NURSERY	0	0	0	0	5, 618, 275	43. 00
ANCILLARY SERVICE COST CENTERS	T		1			
50. 00 05000 OPERATI NG ROOM	0	0		512, 676	37, 325, 478	
51. 00 05100 RECOVERY ROOM	0	0	1	0	8, 164, 505	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0	0	0	12, 393, 161	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0	0	0	9, 322, 538	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	Ü	0	0	5, 279, 562	1
57. 00 05700 CT SCAN	0	Ü	0	0	4, 033, 675	1
58. 00 05800 MRI	0	Ü	0	0	3, 101, 227	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	Ü		0	195, 942	
60. 00 06000 LABORATORY	0	Ü	0	0	19, 683, 511	
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	869, 672	1
65. 00 06500 RESPI RATORY THERAPY	0	0	0	0	9, 900, 866	1
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	10, 860, 420 2, 919, 712	1
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	551, 490	1
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	1, 208, 956	
70. 00 07000 ELECTROCARD OLOGT	0	0	0	0	3, 603, 045	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	28, 076, 217	1
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	19, 452, 008	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	30, 211, 719	
73. 01 07301 SPECIALTY PHARMACY	Ö	Ö	0	0	0 0	1
74. 00 07400 RENAL DI ALYSI S	0	0	o o	0	2, 280, 156	1
76. 00 03330 ENDOSCOPY	0	0	o o	0	5, 730, 429	1
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	o o	0	0	76. 01
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	Ō	o	0	76. 02
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	Ó	O	0	76. 03
76. 04 03953 WOUND CARE	o	0	0	0	2, 173, 075	76. 04
76. 06 03954 I MAGI NG CENTER	o	0	0	0	5, 927, 596	
76. 07 03955 BREAST DIAGNOSTIC CENTER	o	0	0	0	14, 720, 009	
77.00 07700 ALLOGENEIC HSCT ACQUISITION	O	0	0	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	O	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS]
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 01 04950 I NFUSI ON CENTER	0	0	0	0	344, 960	90. 01
90. 26 04975 SPI NE CENTER	0	0	0	0	361, 264	
91. 00 09100 EMERGENCY	0	0	77, 517	183, 246	20, 893, 649	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	3, 533, 447	0	654, 971	1, 548, 324	415, 119, 747	118. 00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	329, 530	
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0	119, 638	192.00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2023 Part I | To 12/31/2023 Date/Time Prepared: | 5/24/2024 11: 44 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0169

						3/24/2024 11.	44 alli
				INTERNS &	RESI DENTS		
Cos	st Center Description	SOCIAL SERVICE	NONPHYSI CI AN	SERVI CES-SALAR	SERVI CES-OTHER	Subtotal	
			ANESTHETI STS	Y & FRINGES	PRGM COSTS		
				APPRV	APPRV		
		17. 00	19. 00	21.00	22. 00	24.00	
193.00 19300 NON	NPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 HOM	ME OFFICE	0	0	0	0	0	194. 00
194. 06 07956 PAV	VI LLI ONS	0	0	0	0	158, 711	194. 06
194. 08 07958 OTH	HER NRCC	o	0	0	o	3, 737, 909	194. 08
194. 10 07960 COM	MMUNITY REHAB HOSPITAL	o	0	0	o	0	194. 10
200.00 Cro	oss Foot Adjustments		0	0	o	0	200.00
201.00 Neg	gative Cost Centers	o	0	0	o	0	201. 00
202. 00 TOT	TAL (sum lines 118 through 201)	3, 533, 447	0	654, 971	1, 548, 324	419, 465, 535	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/24/2024 11:44 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0169

				5/24/2024	
	Cost Center Description	Intern &	Total	, , , , , , , , , , , , , , , , , , , ,	
	·	Residents Cost			
		& Post			
		Stepdown			
		Adjustments			
	OFNEDAL CEDIU OF COCT OFNEDO	25. 00	26. 00		
1 00	GENERAL SERVICE COST CENTERS	T T			1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP				1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINISTRATIVE & GENERAL				5. 00
7. 00	00700 OPERATION OF PLANT				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00	00900 HOUSEKEEPI NG				9. 00
10. 00	01000 DI ETARY				10. 00
11. 00	01100 CAFETERI A				11. 00
13.00	01300 NURSING ADMINISTRATION				13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00	01500 PHARMACY				15. 00
	01600 MEDICAL RECORDS & LIBRARY				16. 00
	01700 SOCIAL SERVICE				17. 00
	01900 NONPHYSICIAN ANESTHETISTS				19. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV				21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV				22. 00
20 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	772 407	107 220 220		20.00
30. 00 31. 00	03100 INTENSIVE CARE UNIT	-773, 497 0	107, 328, 220 16, 667, 899		30. 00 31. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT		20, 025, 177		35. 00
40. 00	04000 SUBPROVIDER - I PF	-439, 487	4, 682, 350		40.00
43. 00	04300 NURSERY	0	5, 618, 275		43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>	0,010,270		10.00
50.00	05000 OPERATING ROOM	-729, 548	36, 595, 930		50.00
51.00	05100 RECOVERY ROOM	0	8, 164, 505		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	12, 393, 161		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	9, 322, 538		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	5, 279, 562		55. 00
57. 00	05700 CT SCAN	0	4, 033, 675		57. 00
58. 00	05800 MRI	0	3, 101, 227		58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON	0	195, 942		59.00
64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0	19, 683, 511 869, 672		60. 00 64. 00
65. 00	06500 RESPI RATORY THERAPY		9, 900, 866		65. 00
66. 00	06600 PHYSI CAL THERAPY		10, 860, 420		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	l ol	2, 919, 712		67. 00
68.00	06800 SPEECH PATHOLOGY	O	551, 490		68. 00
69.00	06900 ELECTROCARDI OLOGY	O	1, 208, 956		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	3, 603, 045		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	28, 076, 217		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	19, 452, 008		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	30, 211, 719		73. 00
	07301 SPECIALTY PHARMACY	0	0		73. 01
74. 00 76. 00	07400 RENAL DI ALYSI S 03330 ENDOSCOPY	0 0	2, 280, 156		74.00
	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	5, 730, 429 0		76. 00 76. 01
	03951 OTHER ANCILLARY SERVICE COST CENTERS		ol O		76. 01
	03952 OTHER ANCILLARY SERVICE COST CENTERS		0		76. 03
	03953 WOUND CARE		2, 173, 075		76. 04
	03954 I MAGI NG CENTER	0	5, 927, 596		76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	0	14, 720, 009		76. 07
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
	OUTPATIENT SERVICE COST CENTERS	1			
	09000 CLINIC	0	0		90.00
	04950 I NFUSI ON CENTER	0	344, 960		90. 01
	04975 SPI NE CENTER 09100 EMERGENCY	-260, 763	361, 264 20, 632, 886		90. 26 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	-260, 763	20, 032, 000		92.00
12.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			72.00
102 00	10200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
.02.00	SPECIAL PURPOSE COST CENTERS	, 9	9		102.00
113.00	11300 I NTEREST EXPENSE				113. 00
	11400 UTILIZATION REVIEW-SNF				114. 00
118.00		-2, 203, 295	412, 916, 452		118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	329, 530		190. 00
	19100 RESEARCH	0	0		191. 00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	119, 638		192. 00

Health Financial Systems	COMMUNITY HOSPITAL OF I	NDI ANA, INC.	In Lieu	of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COST	S	Provider CCN:	Peri od: From 01/01/2023	Worksheet B Part I
			To 12/31/2023	Date/Time Prepared:

			Date/IIMe Prepared: 5/24/2024 11:44 am
Cost Center Description	Intern &	Total	3/24/2024 11: 44 alli
cost center bescription	Residents Cost	Total	
	& Post		
	Stepdown		
	Adjustments		
	25. 00	26. 00	
193. 00 19300 NONPALD WORKERS	0	0	193. 00
194. 00 07950 HOME OFFICE	o	0	194. 00
194. 06 07956 PAVI LLI ONS	o	158, 711	194. 06
194. 08 07958 OTHER NRCC	o	3, 737, 909	194. 08
194. 10 07960 COMMUNITY REHAB HOSPITAL	o	0	194. 10
200.00 Cross Foot Adjustments	o	0	200. 00
201.00 Negative Cost Centers	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	-2, 203, 295	417, 262, 240	202. 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 15-0169

				То	12/31/2023	Date/Time Pre 5/24/2024 11:	
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	oost deliter bescription	Assigned New	DEDO G TTAT	MVDEE EQUIT	Subtotal	BENEFI TS	
		Capital Related Costs				DEPARTMENT	
		0	1. 00	2.00	2A	4. 00	
	GENERAL SERVI CE COST CENTERS	1					
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	6, 113	89, 056	95, 169	95, 169	1
5.00	00500 ADMINISTRATIVE & GENERAL	0	460, 372		4, 052, 301	4, 289	1
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	1, 769, 902 40, 037		1, 873, 425 40, 037	1, 483 0	1
9. 00	00900 HOUSEKEEPING	0	168, 777		187, 782		1
10.00	01000 DI ETARY	0	105, 198		118, 222	561	10. 00
11.00	01100 CAFETERI A	0	321, 011		375, 060		1
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	56, 099 344, 242		87, 429 3, 384, 358		1
15. 00	01500 PHARMACY	0	151, 611		720, 548		1
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	5, 754		5, 754		
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	27, 402 0		27, 438 0	1, 434 0	1
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0	_	0	0	1
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	5, 423, 415	E00 043	5, 932, 457	28, 542	30.00
31.00	03100 INTENSIVE CARE UNIT		613, 782		730, 810		1
35.00	02060 NEONATAL INTENSIVE CARE UNIT	0	833, 695		973, 682		
40.00	04000 SUBPROVI DER - I PF	0	143, 005		147, 673		1
43. 00	04300 NURSERY ANCILLARY SERVICE COST CENTERS	0	322, 594	27, 503	350, 097	1, 395	43. 00
50.00	05000 OPERATING ROOM	0	636, 005	3, 401, 771	4, 037, 776	3, 674	50. 00
51.00	05100 RECOVERY ROOM	0	353, 784		357, 928		1
52. 00 54. 00	05200 DELIVERY ROOM & LABOR ROOM 05400 RADIOLOGY-DIAGNOSTIC	0	711, 715 319, 213		772, 395 582, 379		1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	163, 239		505, 636		1
57. 00	05700 CT SCAN	0	54, 421		59, 572		1
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	82, 806 0		632, 831 1, 528	601 0	58. 00 59. 00
60.00	06000 LABORATORY	0	129, 364		129, 364	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	4, 315		13, 390		1
65. 00	06500 RESPI RATORY THERAPY	0	137, 706		438, 187	2, 952	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	22, 176 0		1, 220, 414 51, 527		1
68. 00	06800 SPEECH PATHOLOGY	0	0		9, 716		
69. 00	06900 ELECTROCARDI OLOGY	0	10, 525		10, 525		1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	94, 218 0	1	309, 945 0	936 0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	-	0		1
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
73. 01 74. 00	07301 SPECI ALTY PHARMACY 07400 RENAL DI ALYSI S	0	0	0	0 11, 364	0 22	1
76. 00	03330 ENDOSCOPY		11, 364 177, 623		550, 107		1
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0		76. 01
76. 02 76. 03	03951 OTHER ANCILLARY SERVICE COST CENTERS 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	1
76. 03	03953 WOUND CARE			156, 715	156, 715	_	1
76. 06	03954 I MAGI NG CENTER	0	0	1, 031, 526	1, 031, 526	1, 422	1
76. 07	03955 BREAST DI AGNOSTI C CENTER	0	0	444, 233	444, 233		1
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	1
70.00	OUTPATIENT SERVICE COST CENTERS			<u> </u>	<u> </u>		70.00
90.00		0	0	-	07 (05		
90. 01 90. 26	04950 I NFUSION CENTER 04975 SPI NE CENTER	0	0	87, 685 0	87, 685 0	91 150	90. 01 90. 26
	09100 EMERGENCY	0	590, 023	129, 709	719, 732		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92. 00
102.00	OTHER REIMBURSABLE COST CENTERS 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
102.00	SPECIAL PURPOSE COST CENTERS			<u> </u>	0	0	102.00
	11300 INTEREST EXPENSE						113. 00
114. 00 118. 00	11400 UTILIZATION REVIEW-SNF SUBTOTALS (SUM OF LINES 1 through 117)	0	1// 201 504	16, 945, 211	31, 236, 717	02 004	114. 00 118. 00
110.00	NONREIMBURSABLE COST CENTERS	0	14, 291, 506	10, 745, 211	31, 230, 717	73, 806	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			95, 680		190. 00
191. 00	19100 RESEARCH	0	0	0	0	0	191. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | To 12/3

					5/24/2024 11:	44 am_
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New				BENEFI TS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1.00	2.00	2A	4. 00	
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 HOME OFFICE	0	0	0	0	0	194. 00
194. 06 07956 PAVI LLI ONS	0	0	114, 700	114, 700	0	194. 06
194. 08 07958 OTHER NRCC	0	9, 997	171, 905	181, 902	1, 363	194. 08
194.10 07960 COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194. 10
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	14, 397, 183	17, 231, 816	31, 628, 999	95, 169	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 | 11: 44 am

					5/24/2024 11:	44 am
Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	<u> </u>	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	10.00	
GENERAL SERVICE COST CENTERS	5.00	7.00	8.00	9.00	10.00	
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP					ļ	2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	4, 056, 590				ļ	5. 00
7. 00 00700 OPERATION OF PLANT	193, 336	l e			ļ	7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	13, 181	6, 809				8. 00
9. 00 00900 HOUSEKEEPI NG	67, 024	28, 705		285, 595		9. 00
10. 00 01000 DI ETARY	24, 015	l		2, 514	163, 203	•
11. 00 01100 CAFETERI A	32, 009	1		7, 671	0	11. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	89, 383	l		1, 340	0	13. 00
14. 00 01400 CENTRAL SERVI CES & SUPPLY	86, 936	1		8, 226	0	14. 00
15. 00 01500 PHARMACY	114, 492		1	3, 623	0	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	28, 356			137	0	16. 00
17. 00 01700 SOCI AL SERVI CE	32, 896	l .		655	0	17. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	02,070	0	Ö	0	0	19. 00
21. 00 02100 L&R SERVICES-SALARY & FRINGES /	APPRV 6, 334	0	Ö	0	0	21. 00
22. 00 02200 &R SERVICES-OTHER PRGM COSTS A		0	o	0	0	22. 00
INPATIENT ROUTINE SERVICE COST CENTE		-	-	-1	-	
30. 00 03000 ADULTS & PEDIATRICS	791, 563	922, 387	29, 148	129, 594	136, 306	30.00
31.00 03100 INTENSIVE CARE UNIT	128, 629			14, 666	16, 724	31. 00
35. 00 02060 NEONATAL NTENSIVE CARE UNIT	158, 504		1	19, 921	0	35. 00
40. 00 04000 SUBPROVI DER - I PF	34, 472	l	1	3, 417	10, 173	40. 00
43. 00 04300 NURSERY	43, 306		1	7, 708	0	43. 00
ANCILLARY SERVICE COST CENTERS	,		, ,	,	-	
50. 00 05000 OPERATI NG ROOM	312, 031	108, 168	1, 704	15, 197	0	50.00
51. 00 05100 RECOVERY ROOM	68, 595			8, 454	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	95, 546			17, 007	0	52. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	80, 474			7, 628	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	45, 513			3, 901	0	55. 00
57. 00 05700 CT SCAN	35, 218	l		1, 300	0	57. 00
58. 00 05800 MRI	27, 298	l		1, 979	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 827	14,003	1	1, 7/7	0	59.00
60. 00 06000 LABORATORY	181, 861	22, 001		3, 091	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	8, 059	1	1 4	103	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	and the second s	23, 420		3, 291	0	65.00
	90, 007	1			-	ł
66. 00 06600 PHYSI CAL THERAPY	103, 348	1		530	0	66.00
67. 00 06700 OCCUPATIONAL THERAPY	27, 527	0	-	U O	-	67.00
68. 00 06800 SPEECH PATHOLOGY	5, 191	1 700	0	251	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	11, 254	1, 790		251	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	31, 791	16, 024	0	2, 251	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT	- I	0	0	0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	163, 704	0	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	170, 236	0	0	0	0	73. 00
73. 01 07301 SPECI ALTY PHARMACY	0	0	0	0	0	73. 01
74. 00 07400 RENAL DI ALYSI S	21, 725	l	1	272	0	74. 00
76. 00 03330 ENDOSCOPY	48, 662	30, 209		4, 244	0	76. 00
76. 01 03950 OTHER ANCILLARY SERVICE COST CE		0	0	0	0	76. 01
76. 02 03951 OTHER ANCILLARY SERVICE COST CE		0	0	0	0	76. 02
76. 03 03952 OTHER ANCILLARY SERVICE COST CE	l l	0	0	0	0	76. 03
76. 04 03953 WOUND CARE	20, 386		0	0	0	76. 04
76.06 03954 I MAGI NG CENTER	55, 992	0	0	0	0	76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	141, 824	0	0	0	0	76. 07
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0		0	0	0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
90. 01 04950 I NFUSI ON CENTER	3, 248	l .	0	0	0	90. 01
90. 26 04975 SPI NE CENTER	3, 479	l e	0	0	0	90. 26
91. 00 09100 EMERGENCY	166, 466	100, 348	9, 678	14, 099	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	PART					92. 00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF					l	114. 00
118.00 SUBTOTALS (SUM OF LINES 1 throu	ıgh 117) 4, 016, 884	2, 050, 271	60, 027	283, 070	163, 203	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CAP	ITEEN 1, 108	16, 273	0	2, 286		190. 00
191. 00 19100 RESEARCH	0	0	o	o		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	1, 154	0	0	o	0	192. 00
193. 00 19300 NONPALD WORKERS	0	0	ol	o		193. 00
194.00 07950 HOME OFFICE	0	0	ol	o		194. 00
194. 06 07956 PAVI LLI ONS	1, 530	0	o	o		194. 06
			'	'	<u> </u>	

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0169 | Period: From 01/01/2023 | Part II |
To 12/31/2023 | Date/Time Prepared: 5/24/2024 11: 44 am

						5/24/2024 11:	44 am
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8. 00	9. 00	10.00	
194.08 07958	OTHER NRCC	35, 914	1, 700	0	239	C	194. 08
194. 10 07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	C	194. 10
200.00	Cross Foot Adjustments						200.00
201. 00	Negative Cost Centers	0	0	0	0	C	201.00
202. 00	TOTAL (sum lines 118 through 201)	4, 056, 590	2, 068, 244	60, 027	285, 595	163, 203	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/24/2024 11:44 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0169

) 12/31/2023	5/24/2024 11:	
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL SERVICES &	PHARMACY	MEDICAL RECORDS &	
			ADMI NI STRATI ON	SUPPLY		LI BRARY	
		11. 00	13.00	14. 00	15. 00	16.00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-BLDG & FIXT						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LI NEN SERVI CE						8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A	470, 861					11.00
13.00	01300 NURSING ADMINISTRATION	12, 322					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	7, 095	l .	.,			14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	23, 898	0	16, 386	909, 267	35, 226	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	8, 215	0	41	0	35, 226	1
19. 00	01900 NONPHYSI CLAN ANESTHETI STS	0,210	ő	O	Ö	0	1
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	1
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	169, 525	104, 348	220, 383	O	4, 736	30. 00
31. 00	03100 INTENSIVE CARE UNIT	29, 499			0	4, 730 760	1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	35, 847			Ö	2, 193	1
40.00	04000 SUBPROVI DER - I PF	8, 962	5, 484	8, 058	0	238	40. 00
43. 00	04300 NURSERY	8, 588	5, 187	10, 685	0	220	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	22, 778	14, 064	556, 250	O	6, 279	50. 00
51. 00	05100 RECOVERY ROOM	14, 936			0	823	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	18, 670			0	486	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	14, 563	0	12, 117	0	841	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 987	l .	28, 667	0	984	
57. 00 58. 00	05700 CT SCAN 05800 MRI	5, 974 3, 734		16, 209 4, 401	0	2, 030 565	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	3,734	0	4, 401	0	83	1
60. 00	06000 LABORATORY	Ö	Ö		Ö	1, 845	1
64. 00	06400 I NTRAVENOUS THERAPY	1, 867	0	2, 971	0	29	1
65. 00	06500 RESPI RATORY THERAPY	14, 563	l .	36, 351	0	694	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	6, 348 6, 348	l .	8, 889 2, 139	0	531 153	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	1, 120		403	0	47	68. 00
69. 00	06900 ELECTROCARDI OLOGY	373	l .	16	0	215	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	5, 601	0	,	0	290	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	.,,	0	1, 355	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	884, 594 0	0 909, 267	870 2, 107	
73. 00	07301 SPECIALTY PHARMACY		0	0	909, 207	2, 107	73. 00
74.00	07400 RENAL DIALYSIS	0	0	472	0	81	1
	03330 ENDOSCOPY	8, 588	0	,	0	701	
76. 01 76. 02	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	1
76. 02	03951 OTHER ANCILLARY SERVICE COST CENTERS 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	
76. 04		2, 987	o o	9, 417	Ö	157	1
76. 06	03954 I MAGI NG CENTER	0	0	11, 485	0	1, 241	
76. 07	03955 BREAST DI AGNOSTI C CENTER	373	0	671	0	589	1
77. 00 78. 00	07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	0	0	0	
78.00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	0	0	U U	U	0	78. 00
90. 00	09000 CLINIC	0	0	0	0	0	90.00
90. 01	04950 INFUSION CENTER	747	0	663	0	11	90. 01
90. 26	· ·	0		290	0	9	
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	34, 353	21, 197	82, 260	0	4, 063	91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS	-	1	- 1			
	11300 NTEREST EXPENSE						113.00
114. 00 118. 00	11400 UTILIZATION REVIEW-SNF	470, 861	201, 929	3, 544, 965	909, 267	2E 22/	114. 00 118. 00
1 10. U	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	4/0,861	201, 929	3, 344, 905	909, 207	35, 226	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191.00	19100 RESEARCH	0	0	0	О		191. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	110	0		192.00
	0 19300 NONPALD WORKERS 0 07950 HOME OFFICE	0	0	0	0		193. 00 194. 00
1 74. 00	7/07/30/HOWL OFFICE	1 0	1 0	ı	υ	0	1174.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 | 11: 44 am | Prepared | 14 am | Prepared | 15/24/2024 | 11: 44 am | Prepared | 14 am | Prepared | 15/24/2024 | 11: 44 am | Prepared | 15/24/2024 | 11 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL OF INDIANA, INC.

Provider CCN: 15-0169

	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES &		RECORDS &	
				SUPPLY		LI BRARY	
		11.00	13. 00	14.00	15. 00	16. 00	
194. 06 07956	PAVI LLI ONS	0	0	176	0	0	194. 06
194. 08 07958	OTHER NRCC	0	0	710	0	0	194. 08
194. 10 07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194. 10
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0	0	201. 00
202. 00	TOTAL (sum lines 118 through 201)	470, 861	201, 929	3, 545, 961	909, 267	35, 226	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/24/2024 11:44 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPITAL OF INDIANA, INC. Provider CCN: 15-0169

COST CORTION DISCRIPTION						0 12/31/2023	5/24/2024 11:	
PRIFE SERVICE COST CENTERS 17,00 19,00 21,00 22,00 24,00 1					INTERNS &	RESI DENTS		
SEMERAL SERVICE COST CENTERS 17.00 19.00 21.00 24.00 24.00 24.00 1.00 22.00 24.00		Cost Center Description	SOCIAL SERVICE	NONPHYSICIAN	SERVI CES-SALAR	SERVI CES-OTHER	Subtotal	
The color of the		, , , , , , , , , , , , , , , , , , ,			Y & FRINGES	PRGM COSTS		
PAREMIL SERVICE COST CENTERS 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			47.00	10.00			04.00	
1.00 00100 CAP REL COSTS-BLUE & FIX 2.00 00200 CAPURE COSTS-BURNET 2.00 00200 CAPURE CO		CENEDAL SEDVICE COST CENTEDS	17.00	19.00	21.00	22.00	24.00	
2.00	1 00		I		Ι			1 00
0.0400 DAPLOYEE BENEFITS DEPARTWENT		1						1
D. COLOR DISCRIPTION OF PRIVATION OF PRI		1						1
8.00 0.0000 DAUGNET AL LINEN SERVICE 8.00 1.000		1						ı
0.00 00000 000000 000000000000000	7.00	00700 OPERATION OF PLANT						7. 00
10.00 1000 CETARY		1						1
11.00 0 1100 CAFETERIA		1						1
13.00 01300 NIRSH ING ABIN NI STRATION 1.0 0.0								
14.00 01400 CFRITAL SERVICES & SUPPLY 11.00 15.00								1
15.00								
16. 00 10.00								1
17.00 1700 SOZIAL SERVICE								1
21.00			75, 339					
22 00	19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0				19. 00
IMPATT ENT BOUTTINE SERVICE COST CENTERS 8, 531, 912 30. 00 31. 00 30.00 AULTIS & PEDIATRICS 2, 923 8, 531, 912 30. 00 31. 00 30.00 AULTIS & PEDIATRICS 1, 101, 403 31. 00 30. 00 30.00 AULTIS & PEDIATRICS 1, 101, 403 31. 00 30. 00 30. 00 30.00 AURIS & PEDIATRICS 1, 101, 403 31. 00 40. 00 40.00	21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0		6, 334			21. 00
30.00 3000 ADULTS & PEDIATRICS 62, 923 8, 531, 912 30.00 31.00 3300 IMENSIVE CARE UNIT 7,720 1,101,040 31.00 33.00 30.00 IMENSIVE CARE UNIT 7,720 1,201,040 31.00 33.00 30.00 IMENSIVE CARE UNIT 7,720 1,416,746 33.00 30.00 30.00 IMENSIVE CARE UNIT 7,720 44.46 30.00 43.00 30.00 MISSIRY 10 484,162 43.00 43.00 43.00 43.00 43.00 44.00	22. 00		0			14, 974		22. 00
13.100 03100 INTENSIVE CARE UNIT					1	1		
13.00 0.000 0.00000 0.00000 0.00000 0.00000 0.00000000			1	ł				
A0. 00 040000 SUBPROVIDER - I PF		1						1
34. 00 0.4300 NURSERY 0 484, 162 43. 00		1	-					
ANCIL LIARY SERVICE COST CENTERS		1	1	ł				
50.00 050000 0FEATT NO. ROOM 0 5.077, 921 50.00 51.00 510.0	.0.00						10 17 102	10.00
1.067,005 1.067,005 1.067,005 1.067,005 1.067,005 1.067,005 1.067,005 1.067,005 1.067,005 1.067,005 1.067,005 1.067,005 1.067,005 1.067,005 1.067,005 1.067,005 1.067,00 1.06	50.00		0				5, 077, 921	50.00
15.00 0.5400 RADIOLOGY-DIAGNOSTIC 0 6.15, 727 5.4	51.00	05100 RECOVERY ROOM	0				541, 856	51.00
55.00 05500 RADIO LOCY-THERAPEUTI C		1					1, 067, 905	
130, 646 57, 00		1						
S8. 00 OSBOO MRI		1	_					ı
59.00 05900 CARDIAC CATHETERIZATION 0 431, 572 50.00		1		l				
60.00 0.00		1		l				
64.00 06400 INTRAVENDUS THERAPY 0 6.00 65.		1	0					
65.00 06500 RESPI RATORY THERAPY 0 0 1,347,770 66.00 66.00 06600 PHYSI CAL THERAPY 0 1,347,770 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 1,347,770 67.00 68.00 06600 SPECH PATHOLOGY 0 16,676 68.00 69.00 066000 ELECTROCARDIOLOGY 0 16,676 68.00 70.00 07000 ELECTROCARDIOLOGY 0 378,178 70.00 71.00 07100 DELICAT SUPPLIES CHARGED TO PATIENT 0 1,513,963 71.00 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 1,049,168 72.00 73.01 07301 SPECIALTY PHARMACY 0 1,049,168 72.00 74.00 07300 DRUGS CHARGED TO PATIENTS 0 1,049,168 72.00 74.00 07400 RESPANCIAL DIALYSIS 0 35,869 74.00 74.00 07400 RENAL DIALYSIS 0 35,869 74.00 76.00 03303 ENDOSCOPY 0 687,045 76.00 76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 76.01 76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 10,903 76.00 76.04 03953 WONDO CARE 0 190,093 76.00 76.05 03954 IMAGING CENTER 0 190,093 76.00 77.00 07700 ALDIGENEIC CHEST CENTERS 0 190,093 76.00 78.00 07500 ALDIGENEIC CENTER 0 10,000 78.00 07500 07500 07500 07500			0					
67.00 06700 06700 06200 116.070 88, 749 67, 00 68.00 6800 5PECH PATHOLOGY 0 16.676 68, 00 69.00 06900 ELECTROCARDI OLOGY 0 0 24, 456 69, 00 70.00 07000 ELECTROCARDI OLOGY 0 0 378, 178 70. 00 71.00 70.00 17.00 1			0					
68.00 06800 SPEECH PATHOLOGY 0 24,456 69.00 70.00 06900 ELECTROCARDI OLOGY 0 24,456 69.00 70.00 07000 O6900 ELECTROCARDI OLOGY 0 24,456 69.00 70.00 07000 O7000 ELECTROCARDI OLOGY 0 378,178 70.00 71.00 07100 MDEL CAL SUPPLIES CHARGED TO PATIENT 0 1,513,963 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 1,049,168 72.00 73.01 07301 SPECI ALTY PHARMACY 0 1,081,610 73.00 73.01 07301 SPECI ALTY PHARMACY 0 73.01 74.00 07400 RENAL DI ALYSIS 0 35,869 74.00 75.00 03330 ENDOSCOPY 0 687,045 76.00 76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 687,045 76.00 76.02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 76.01 76.03 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 76.02 76.04 03953 WOUND CARE 0 190,093 76.04 76.06 03954 IMAGING CENTER 0 1,101,666 76.06 76.07 03955 BREAST DI AGNOSTIC CENTER 0 1,101,666 76.06 77.00 07700 ALLOGENEIC ISCT ACQUISTITION 0 78.00 78.00 07800 CART T-CELL I IMMUNDHERPY 0 0 90.00 79.00 07900 CLINI C 0 90.00 79.00 07900 OFTICAL SERVICE COST CENTERS 0 0 90.00 79.00 07900 OFTICAL SERVICE COST CENTERS 0 0 90.00 79.00 07900 OFTICAL SERVICE COST CENTERS 0 0 90.00 79.00 07900 OFTICAL SERVICE COST CENTERS 0 0 90.00 77.00 07900 OFTICAL SERVICE COST CENTERS 0 0 90.00 77.00 07900 07900 07900 07900 07900 07900 77.00 07900 07900 07900 07900 07900 07900 07900 77.00 07900 07	66.00	06600 PHYSI CAL THERAPY	0				1, 347, 770	66. 00
69.00 06900 ELECTROCARDI OLOGY 0 24,456 69.00 70.00 07000 07000 ELECTROCARDI OLOGY 0 378,178 70.00 70.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 1,513,963 71.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 1,049,168 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 1,049,168 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 1,081,610 73.00 73.01 07301 SPECIALTY PHARMACY 0 0 35,869 74.00 74.00 07400 RENAL DI ALXYS S 0 0 35,869 74.00 76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 687,045 76.00 76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 67.00 76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 76.01 76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 76.03 76.04 03953 MOUND CARE 0 90.00 76.05 03954 IMAGING CENTER 0 90.00 76.06 03954 IMAGING CENTER 0 90.00 77.00 07700 ALLOGENEIC CHATCER 0 90.00 77.00 07700 CAT - CELL IMMUNOTHERAPY 0 90.00 90.00 07600 CAT - CELL IMMUNOTHERAPY 0 90.00 90.01 04950 INFUSION CENTER 0 90.00 90.02 04975 SPINE CENTER 0 90.00 90.00 09000 CAT - CELL IMMUNOTHERAPY 0 90.00							88, 749	67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 378, 178 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 1, 513, 963 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 1, 049, 168 72. 00 73. 01 07300 DRUGS CHARGED TO PATIENTS 0 1, 081, 610 73. 01 74. 00 07400 RENAL DIALYSIS 0 0 0, 73. 01 74. 00 07400 RENAL DIALYSIS 0 0 0, 73. 01 74. 00 07400 RENAL DIALYSIS 0 0 0, 73. 01 74. 00 07400				l				
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 1, 513, 963 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 1, 049, 168 72. 00 73. 00 74. 00		1		l			•	1
72.00 07200 MPL DEV. CHARGED TO PATIENTS 0 1, 049, 168 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 1, 081, 168 72.00 73.01				l				1
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 1, 081, 610 73. 00 73. 01 07301 SPECIALTY PHARMACY 0 0 73. 01 74. 00 07400 REMAL DI ALYYSIS 0 35,869 74. 00 76. 01 03330 ENDOSCOPY 0 687, 045 76. 00 76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 00 76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 00 76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 02 76. 04 03953 WOUND CARE 0 190, 093 76. 04 03953 WOUND CARE 0 190, 093 76. 06 03954 IMAGI NG CENTER 0 190, 093 76. 07 03955 BREAST DI AGNOSTIC CENTER 0 190, 093 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78. 00 90. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 90. 01 04950 INFUSI ON CENTER 0 90. 00 90. 02 04955 INFUSI ON CENTER 0 90. 00 90. 01 04950 INFUSI ON CENTER 0 90. 00 90. 02 04975 SPIN C ENTER 0 90. 00 90. 03 09100 EMERGENCY 0 90. 00 90. 04 04950 INFUSI ON BEDS (NON-DISTINCT PART 0 90. 05 09100 EMERGENCY 0 0 0 0 90. 01 01100 DISERVATI ON BEDS (NON-DISTINCT PART 0 0 90. 01 01100 TREATMENT PROGRAM 0 0 0 0 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTILL ZATI ON REVIEW-SNF 114. 00 114. 00 INTEREST EXPENSE 115. 340 118. 00 118. 00 SUBSTIVATION SCURER COFFEE SHOP & CANTEEN 0 0 0 100 019100 RESEARCH 0 0 0 0 10100 019100 RESEARCH 0 0 0 10100 019100		1						1
73. 01 07301 SPECI ALTY PHARMACY 0 73. 01 74. 00 07400 RENAL DI ALYSIS 0 35,869 74. 00 07400 RENAL DI ALYSIS 0 35,869 74. 00 076. 00 3330 ENDOSCOPY 0 687,045 76. 00 03330 ENDOSCOPY 0 687,045 76. 00 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 76. 01 076. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0								
74. 00 07400 RENAL DI ALYSIS 35, 869 74. 00 76. 00 03350 ENDOSCOPY 0 687.045 76. 00 76. 01 03950 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 76. 01 76. 02 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 76. 02 76. 03 03952 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 76. 03 76. 04 03953 WOUND CARE 0 0 190, 093 76. 04 76. 06 03954 IMAGI NG CENTER 0 0 190, 093 76. 04 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 0 0 77. 00 78. 00 03955 BREAST DI AGNOSTI C CENTER 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 79. 01 09000 CLI NI C 0 0 0 0 79. 02 09000 CLI NI C 0 0 0 79. 03 09000 CLI NI C 0 0 0 79. 04950 INFUSI ON CENTER 0 0 0 0 79. 00 09000 CLI NI C 0 0 79. 00 09000 CLI NI C 0 0 79. 00 09100 EMERGENCY 0 0 0 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 79. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 70. 00 0000 OLI NETARENT PROGRAM 0 0 0 70. 00 0000 OLI NETARENT PROGRAM 0 0 0 70. 00 0000 OLI NETARENT PROGRAM 0 0 0 70. 00 0000 OLI NETARENT PROGRAM 0 0 0 70. 00 0000 OLI TREATHENT PROGRAM 0 0 0 70. 00 0000 OLI TREATHENT PROGRAM 0 0 0 70. 00 0000 OLI TREATHENT PROGRAM 0 0 0 70. 00 0000 OLI TREATHENT PROGRAM 0 0 0 70. 00 0000 OLI TREATHENT PROGRAM 0 0 0 70. 00 0000 0				l .				
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 01 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 03 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 76. 04 03953 WOUND CARE 190, 093 76. 04 76. 06 03954 I MAGING CENTER 0 76. 07 03955 BREAST DI AGNOSTIC CENTER 0 77. 00 03955 BREAST DI AGNOSTIC CENTER 0 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 77. 00 09000 CLI NI C 0 90. 00 90. 01 04950 I NFUSI ON CENTER 0 90. 00 90. 00 90. 01 04950 I NFUSI ON CENTER 0 90. 00 90. 00 90. 01 04950 I NFUSI ON CENTER 0 90. 00 90. 00 91. 00 9			0				35, 869	
76. 02 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0 76. 03 03952 OTHER ANCI LLARY SERVI CE COST CENTERS 0 76. 04 03953 WOUND CARE 0 0 190, 093 76. 03 76. 03 76. 04 03953 WOUND CARE 0 0 190, 093 76. 04 76. 06 03954 I MAGI NG CENTER 0 190, 093 76. 06 76. 06 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 587, 753 76. 07 77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON 0 77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON 0 0 77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON 0 0 77. 00 0700 CAR T -CELL I IMMUNOTHERAPY 0 0 0 78. 00 09000 CLI NI C 0 0 9000 CLI NI C 0 0 9000 CLI NI C 0 90. 01 04950 I NFUSI ON CENTER 0 0 90. 01 04950 I NFUSI ON CENTER 0 0 92. 445 90. 01 90. 26 04975 SPI NE CENTER 0 0 92. 445 90. 01 90. 26 04975 SPI NE CENTER 0 90. 26 04975 SPI NE CENTER 90. 27 04550 INTUST ON BEDS (NON-DISTINCT PART 0 91. 00 9100 DI MERGENCY 90. 00 9200 DISSERVATI ON BEDS (NON-DISTINCT PART 0 91. 00 9100 DI TREATMENT PROGRAM 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11400 UTI LI ZATI ON REVI EW-S			1	l e			687, 045	76. 00
76. 03 03952 OTHER ANCI LLARY SERVI CE COST CENTERS 0 76. 03 03953 WOUND CARE 0 190, 093 76. 04 03953 WOUND CARE 0 190, 093 76. 04 190, 093 76. 05 190			· ·					
76. 04 03953 WOUND CARE 0 0 190, 093 76. 04 76. 06 03954 IMAGI NG CENTER 0 0 1, 101, 666 76. 06 76. 07 03955 BREAST DI AGNOSTIC CENTER 0 0 587, 753 76. 07 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 77. 00 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78. 00 OUTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 09000 CLI NI C 0 0 0 0 09000 CLI NI C 0 0 0 09100 EMERGENCY 0 0 09100 EMERGENCY 0 0 09100 EMERGENCY 0 0 09100 EMERGENCY 0 0 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0THER REI MBURSABLE COST CENTERS 102. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 07 OTHER REI MBURSABLE COST CENTERS 113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 19100 RUBERABLE COST CENTERS 190. 00 19000 GIT, FLOWER, COFFEE SHOP & CANTEEN 0 0 115, 347 190. 00 191. 00 19100 RESEARCH 0 0 0 191. 00 19100 COST CENTERS			0					
76. 06			0				-	
76. 07 03955 BREAST DI AGNOSTI C CENTER 0 587, 753 76. 07 77. 00 07700 ALLOGENEI C HSCT ACQUI SITION 0 77. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 77. 00 000 CAR T-CELL IMMUNOTHERAPY 0 0 0 000 CD CAR T-CELL IMMUNOTHERAPY 0 0 0 000 CD CD CENTERS 0 0 0 09000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0		-			1
77. 00			0					1
78. 00		1	0					
90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0			1	l e			0	
90. 01 04950 INFUSION CENTER 0 92, 445 90. 01 90. 26 04975 SPINE CENTER 0 33, 928 90. 26 91. 00 09100 EMERGENCY 0 1, 157, 552 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92. 00 OTHER REIMBURSABLE COST CENTERS 102. 00 10200 OPI 01 D TREATMENT PROGRAM 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTILIZATION REVIEW-SNF 114. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 115, 347 190. 00 191. 00 19100 RESEARCH 0 0 191. 00		OUTPATIENT SERVICE COST CENTERS			•			1
90. 26			0				0	90.00
91. 00				ŀ				
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART								
OTHER REIMBURSABLE COST CENTERS 102.00 10200 10200 101 10200 102			0				1, 157, 552	
102. 00 10200 OPI 0I D TREATMENT PROGRAM 0 102. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 75, 339 0 0 0 31, 152, 846 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 191. 00 19100 RESEARCH 0 191. 00 191. 00	92.00							92.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 115. 0	102 00		1				0	102 00
113. 00 114. 00 114. 00 114. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 190. 00 191. 00 1910 RESEARCH 113. 00 114. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	102.00						0	102.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 75, 339 0 0 0 31, 152, 846 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 115, 347 190. 00 191. 00 19100 RESEARCH 0 191. 00 191	113. 00							113. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 75, 339 0 0 0 31, 152, 846 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 115, 347 190. 00 191. 00 19100 RESEARCH 0 191. 00 1			1		1			
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 191. 00 1			75, 339	o	o o	o	<u>31, 15</u> 2, 846	1
191. 00 19100 RESEARCH 0 0 191. 00		NONREI MBURSABLE COST CENTERS						
			1	l e				
192. UU 1920U PHYSI CLANS' PRI VATE OFFICES 0 1, 264 192. 00				ł				
	192.00	119200 PHYSICIANS PRIVATE OFFICES	1 0	<u> </u>	1	<u> </u>	1, 264	1192.00

COMMUNITY HOSPITAL OF INDIANA, INC.

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2023 Part II | To 12/31/2023 Date/Time Prepared: | 5/24/2024 11: 44 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0169

						3/24/2024 11.	44 alli
				INTERNS &	RESI DENTS		
C	Cost Center Description	SOCIAL SERVICE	NONPHYSI CI AN	SERVI CES-SALAR	SERVI CES-OTHER	Subtotal	
			ANESTHETI STS	Y & FRINGES	PRGM COSTS		
				APPRV	APPRV		
		17. 00	19.00	21. 00	22. 00	24.00	
193. 00 19300 N	NONPALD WORKERS	0				0	193. 00
194. 00 07950 H	HOME OFFICE	0				0	194. 00
194.06 07956 P	PAVILLIONS	0				116, 406	194. 06
194. 08 07958 0	OTHER NRCC	O				221, 828	194. 08
194. 10 07960 C	COMMUNITY REHAB HOSPITAL	O				0	194. 10
200. 00 C	Cross Foot Adjustments		0	6, 334	14, 974	21, 308	200.00
201. 00 N	Negative Cost Centers	0	0	0	o	0	201. 00
202. 00 T	FOTAL (sum lines 118 through 201)	75, 339	0	6, 334	14, 974	31, 628, 999	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/24/2024 11:44 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0169

				10 12/31/2023	5/24/2024 11:44 am
	Cost Center Description	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments	04.00		
	CENEDAL CEDVICE COCT CENTEDS	25. 00	26. 00		
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT				1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP				2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5. 00	00500 ADMINISTRATIVE & GENERAL				5. 00
7. 00	00700 OPERATION OF PLANT				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE				8. 00
9.00	00900 HOUSEKEEPI NG				9. 00
10.00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11. 00
13.00	01300 NURSING ADMINISTRATION				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY				14. 00
15. 00	01500 PHARMACY				15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY				16.00
17. 00	01700 SOCIAL SERVICE				17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS				19.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV				21. 00 22. 00
ZZ. UU	INPATIENT ROUTINE SERVICE COST CENTERS				22. 00
30. 00	03000 ADULTS & PEDIATRICS	n	8, 531, 912		30.00
31. 00	03100 NTENSI VE CARE UNI T		1, 101, 040		31.00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT		1, 416, 746		35. 00
40.00	04000 SUBPROVI DER - I PF	O	250, 323		40.00
43.00	04300 NURSERY	O	484, 162		43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	0	5, 077, 921		50.00
51. 00	05100 RECOVERY ROOM	0	541, 856		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 067, 905		52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	757, 270		54.00
55. 00 57. 00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	0	616, 678		55. 00 57. 00
58. 00	05800 MRI		130, 646 685, 492		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		3, 441		59.00
60. 00	06000 LABORATORY		493, 572		60.00
64. 00	06400 I NTRAVENOUS THERAPY	l o	27, 496		64. 00
65.00	06500 RESPIRATORY THERAPY	O	609, 465		65. 00
66.00	06600 PHYSI CAL THERAPY	o	1, 347, 770		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	88, 749		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	16, 676		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	24, 456		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	378, 178		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 513, 963		71.00
72. 00 73. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	1, 049, 168		72.00
	07300 DRUGS CHARGED TO PATIENTS 07301 SPECIALTY PHARMACY		1, 081, 610 0		73. 00 73. 01
	07400 RENAL DIALYSIS		35, 869		74. 00
76. 00	03330 ENDOSCOPY		687, 045		76. 00
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS		007, 043		76. 01
	03951 OTHER ANCILLARY SERVICE COST CENTERS		0		76. 02
76. 03	03952 OTHER ANCILLARY SERVICE COST CENTERS		0		76. 03
76. 04		0	190, 093		76. 04
76. 06	03954 I MAGI NG CENTER	0	1, 101, 666		76. 06
76. 07		0	587, 753		76. 07
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY] 0	0		78. 00
00 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		0		90.00
90.00	04950 I NFUSI ON CENTER		92, 445		90.00
90. 26	04975 SPINE CENTER		3, 928		90. 26
	09100 EMERGENCY		1, 157, 552		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		,,,		92. 00
	OTHER REIMBURSABLE COST CENTERS				
102.00	10200 OPIOID TREATMENT PROGRAM	0	0		102. 00
440 -	SPECIAL PURPOSE COST CENTERS				
	11300 INTEREST EXPENSE				113.00
114. 00 118. 00	11400 UTI LI ZATI ON REVI EW-SNF		21 152 044		114.00
118.UC	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	0	31, 152, 846		118. 00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	115, 347		190. 00
	19100 RESEARCH		113, 347		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	O	1, 264		192. 00
	· · · · · · · · · · · · · · · · · · ·				

Health Financial Systems	COMMUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	CN: 15-0169	Peri od: From 01/01/2023 To 12/31/2023	Worksheet B Part II Date/Time Prepared: 5/24/2024 11:44 am
Coot Contar Decement on	Intonn 0	Total			

			5/24/2024 11:44 am
Cost Center Description	Intern &	Total	
	Residents Cost		
	& Post		
	Stepdown		
	Adjustments		
	25. 00	26.00	
193. 00 19300 NONPALD WORKERS	0	0	193. 00
194.00 07950 HOME OFFICE	0	0	194. 00
194. 06 07956 PAVI LLI ONS	0	116, 406	194. 06
194. 08 07958 OTHER NRCC	0	221, 828	194. 08
194. 10 07960 COMMUNITY REHAB HOSPITAL	o	o	194. 10
200.00 Cross Foot Adjustments	o	21, 308	200. 00
201.00 Negative Cost Centers	O	o	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	31, 628, 999	202. 00

| Period: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0169

					o 12/31/2023	Date/Time Pre 5/24/2024 11:	
		CAPITAL RE	LATED COSTS			5/24/2024 11:	44 аш
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMINI CTDATINE	
	cost center bescription		(DOLLAR VALUE)	BENEFITS	Reconciliation	& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1. 00	2.00	4.00	5A	5. 00	
1 00	GENERAL SERVICE COST CENTERS	(00 F24	T	Т	T		1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	600, 534	17, 219, 190				1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	255					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	19, 203				350, 383, 948	5. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	73, 826 1, 670	1				7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	7, 040			_	5, 788, 876	9. 00
10.00	01000 DI ETARY	4, 388	1			2, 074, 186	10.00
11. 00 13. 00	01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	13, 390 2, 340	1			2, 764, 662 7, 720, 087	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	14, 359	l ·			7, 508, 693	
15.00	01500 PHARMACY	6, 324	l ·			9, 888, 754	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	240 1, 143	ł	1		2, 449, 157 2, 841, 253	16. 00 17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0			0	19. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0				21. 00
22. 00	02200 1&R SERVICES-OTHER PRGM COSTS APPRV INPATIENT ROUTINE SERVICE COST CENTERS		0	C	0	1, 293, 331	22. 00
30.00	03000 ADULTS & PEDI ATRI CS	226, 221	508, 669	42, 290, 176	0	68, 381, 289	30. 00
31.00	03100 NTENSI VE CARE UNI T	25, 602					1
35. 00 40. 00	02060 NEONATAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	34, 775 5, 965					35. 00 40. 00
43. 00	04300 NURSERY	13, 456					43. 00
E0 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	2/ 520	2 200 270	F 450 570		24 050 250	 FO 00
50. 00 51. 00	05100 RECOVERY ROOM	26, 529 14, 757					50. 00 51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	29, 687					52. 00
54. 00 55. 00	05400 RADI OLOGY - DI AGNOSTI C	13, 315					54.00
55.00	05500 RADI OLOGY-THERAPEUTI C 05700 CT SCAN	6, 809 2, 270				3, 931, 019 3, 041, 795	1
58. 00	05800 MRI	3, 454	549, 622	891, 467	0	2, 357, 757	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	5, 396	1, 527 0				59. 00 60. 00
64.00	06400 I NTRAVENOUS THERAPY	180	l .				64.00
65. 00	06500 RESPI RATORY THERAPY	5, 744					•
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	925				8, 926, 264 2, 377, 567	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		9, 709			448, 332	68. 00
69. 00	06900 ELECTROCARDI OLOGY	439	l .	46, 862		972, 045	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 930				2, 745, 775 20, 401, 794	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		Ö	ď	Ö		ı
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	C		.,	ł
73. 01 74. 00	07301 SPECI ALTY PHARMACY 07400 RENAL DI ALYSI S	474	0	33, 382	0	0 1, 876, 402	73. 01 74. 00
76. 00	03330 ENDOSCOPY	7, 409				4, 202, 946	1
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C	_	0	76. 01
76. 02 76. 03	03951 OTHER ANCILLARY SERVICE COST CENTERS 03952 OTHER ANCILLARY SERVICE COST CENTERS		0	C	0	0	76. 02 76. 03
76. 04	03953 WOUND CARE	0	156, 600		0	1, 760, 789	76. 04
76.06	03954 I MAGI NG CENTER	0	1, 030, 770			4, 836, 073	•
76. 07 77. 00	03955 BREAST DIAGNOSTIC CENTER 07700 ALLOGENEIC HSCT ACQUISITION		443, 908 0			12, 249, 406 0	76. 07 77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0	0	78. 00
90. 00	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		0		0	0	90. 00
90. 00	04950 I NFUSION CENTER		87, 621				90.00
90. 26	04975 SPI NE CENTER	0	0	222, 688	0	300, 477	90. 26
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	24, 611	129, 614	7, 946, 808	0	14, 377, 810	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
102.00	10200 OPIOLD TREATMENT PROGRAM	0	0	C	0	0	102. 00
113 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
118. 00	3 /	596, 126	16, 932, 795	139, 116, 374	-69, 081, 587	346, 954, 515	118. 00
190. 00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 991	0	С	0	95, 680	190. 00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	3,771					

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 15-0169 | Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Ti me Prepared:

				1	0 12/31/2023	5/24/2024 11:	
		CAPI TAL REI	LATED COSTS				
			I				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP		Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS DEPARTMENT		& GENERAL	
				(GROSS		(ACCUM. COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5. 00	
191. 00 1910	O RESEARCH	0	0	0	0	0	191. 00
192. 00 1920	O PHYSICIANS' PRIVATE OFFICES	0	0	0	0	99, 681	192. 00
	O NONPALD WORKERS	0	0	0	0		193. 00
	O HOME OFFICE	0	0	0	0	l	194. 00
	6 PAVI LLI ONS	0	114, 616		0	132, 166	
	8 OTHER NRCC	417	171, 779	2, 021, 880	0	3, 101, 906	
	O COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194. 10
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	14, 397, 183	17, 231, 816	6, 205, 122		69, 081, 587	202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	23. 973968	1. 000733	0. 043965		0. 197160	203. 00
204. 00	Cost to be allocated (per Wkst. B,			95, 169		4, 056, 590	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000674		0. 011578	205. 00
004 00							00/ 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
207.00	Parts III and IV)						207.00
I	Tranto III and IV)	1	I	1	I .	I	I

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COMMUNITY HOSPITAL OF INDIANA, INC. In Lieu of Form CMS-2552-10 Peri od: From 01/01/2023 To 12/31/2023 Provi der CCN: 15-0169 Worksheet B-1 Date/Time Prepared: 5/24/2024 11:44 am LAUNDRY & HOUSEKEEPING DIETARY CAFETERIA
LINEN SERVICE (SQUARE FEET) (PATIENT DAYS) (ONSITE FTES) Cost Center Description OPERATION OF PLANT (SQUARE FEET) (POUNDS OF

			(SQUARE FEET)	(POUNDS OF LAUNDRY)				
			7. 00	8. 00	9.00	10.00	11. 00	
	GENER	AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS-BLDG & FIXT						1. 00
2.00		CAP REL COSTS-MVBLE EQUIP						2.00
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 7. 00		ADMINISTRATIVE & GENERAL OPERATION OF PLANT	507, 250					5. 00 7. 00
8.00		LAUNDRY & LINEN SERVICE	1, 670					8.00
9. 00	1	HOUSEKEEPING	7, 040					9. 00
10.00	1	DI ETARY	4, 388	0				10.00
11. 00	01100	CAFETERI A	13, 390	0	1		1, 261	11. 00
13.00	01300	NURSING ADMINISTRATION	2, 340	0	2, 340	0	33	13. 00
14.00		CENTRAL SERVICES & SUPPLY	14, 359	0	,	0	19	1
15. 00	1	PHARMACY	6, 324	0	6, 324	0	64	1
16.00		MEDICAL RECORDS & LIBRARY	240	0			0	16.00
17. 00	1	SOCIAL SERVICE	1, 143	0	1, 143		22	1
19. 00 21. 00		NONPHYSICIAN ANESTHETISTS I&R SERVICES-SALARY & FRINGES APPRV	0	0	_	0	0	1
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	_	0	0	
22.00		I ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>			<u> </u>		22.00
30.00		ADULTS & PEDIATRICS	226, 221	79, 649	226, 221	63, 148	454	30. 00
31.00	03100	INTENSIVE CARE UNIT	25, 602	7, 086	25, 602	7, 748	79	31. 00
35. 00	02060	NEONATAL INTENSIVE CARE UNIT	34, 775	9, 978	34, 775	0	96	35. 00
40.00		SUBPROVIDER - IPF	5, 965		l		24	40. 00
43. 00		NURSERY	13, 456	5, 770	13, 456	0	23	43. 00
F0 00		LARY SERVICE COST CENTERS	0, 500	4 /50	0, 500			F0 00
50.00		OPERATING ROOM RECOVERY ROOM	26, 529	4, 658	1		61	50.00
51. 00 52. 00	1	DELIVERY ROOM & LABOR ROOM	14, 757 29, 687	0 12, 730		0	40 50	1
54. 00		RADI OLOGY-DI AGNOSTI C	13, 315	6, 213	l		39	1
55. 00		RADI OLOGY-THERAPEUTI C	6, 809	2, 007			8	55. 00
57. 00	1	CT SCAN	2, 270		1		16	1
58. 00	05800	MRI	3, 454	0	1		10	58. 00
59. 00		CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	1	LABORATORY	5, 396	0			0	
64.00	1	I NTRAVENOUS THERAPY	180	0			5	64. 00
65. 00		RESPI RATORY THERAPY	5, 744	0			39	1
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	925 0	0	925 0		17 17	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	0	0	0	0	3	68.00
69. 00		ELECTROCARDI OLOGY	439	Ö	439	o o	1	69. 00
70. 00	1	ELECTROENCEPHALOGRAPHY	3, 930	0			15	1
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	o	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	1	DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
73. 01		SPECIALTY PHARMACY	0	0	_	0	0	
74.00		RENAL DIALYSIS	474	0 (022			0	74.00
76. 00 76. 01		ENDOSCOPY OTHER ANCILLARY SERVICE COST CENTERS	7, 409	6, 032	7, 409	0	23 0	1
76. 01	1	OTHER ANCIELARY SERVICE COST CENTERS	0	0	0	0	0	1
76. 02	1	OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	Ö	0	1
76. 04		WOUND CARE	o	Ö	ő	o	8	
76.06		I MAGING CENTER	0	0	0	О	0	
76. 07		BREAST DIAGNOSTIC CENTER	0	0	0	0	1	76. 07
77. 00	1	ALLOGENEIC HSCT ACQUISITION	0	0	· ·	0	0	
78. 00		CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
00.00		TIENT SERVICE COST CENTERS						00.00
90. 00 90. 01		CLINIC	0	0	0	0	0	
90. 01		INFUSION CENTER SPINE CENTER	0	0	0	0	2	90. 01 90. 26
		EMERGENCY	24, 611	26, 447	24, 611	0	92	
	1	OBSERVATION BEDS (NON-DISTINCT PART	21,011	20, 117	21,011	Ĭ	,,	92.00
		REIMBURSABLE COST CENTERS						
102.00	10200	OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECI.	AL PURPOSE COST CENTERS						
	1	INTEREST EXPENSE						113. 00
		UTI LI ZATI ON REVI EW-SNF						114. 00
118. 00		SUBTOTALS (SUM OF LINES 1 through 117)	502, 842	164, 042	494, 132	75, 609	1, 261	118. 00
100.00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 991	0	3, 991	O	0	190. 00
		RESEARCH	3, 991	0	· ·			190.00
192.00	19200	PHYSICIANS' PRIVATE OFFICES		n	0	0		192. 00
		NONPAI D WORKERS	0	0	Ö	o		193. 00
			'			'		

Provider CCN: 15-0169

						5/24/2024 11:	44 am
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		PLANT	LINEN SERVICE	(SQUARE FEET)	(PATIENT DAYS)	(ONSITE FTES)	
		(SQUARE FEET)	(POUNDS OF				
			LAUNDRY)				
		7. 00	8. 00	9. 00	10.00	11. 00	
194. 00 07950	HOME OFFICE	0	0	0	0	0	194. 00
194. 06 07956	PAVI LLI ONS	0	0	0	0	0	194. 06
194. 08 07958	OTHER NRCC	417	0	417	0	0	194. 08
194. 10 07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194. 10
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	19, 990, 872	1, 428, 674	7, 207, 659	2, 719, 505	4, 031, 033	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	39. 410295	8. 709196	14. 457534	35. 968006	3, 196. 695480	203. 00
204. 00	Cost to be allocated (per Wkst. B,	2, 068, 244	60, 027	285, 595	163, 203	470, 861	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	4. 077366	0. 365925	0. 572863	2. 158513	373. 402855	205. 00
	11)						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

0.0000 CAP REL COSTS-MORLE EQUIP	Heal th	Financial Systems COM	MUNITY HOSPITAL	OF INDIANA, I	NC.	In Lie	u of Form CMS-	2552-10
Control Cont	COST A	ALLOCATION - STATISTICAL BASIS		Provi der C	F	rom 01/01/2023	Date/Time Pre	pared:
DEFECUL SERVICE COST ENTERS 13.00 14.00 15.00 16.00 17.00		Cost Center Description	ADMINISTRATION (DIRECT NRSING	SERVICES & SUPPLY (COSTED	(COSTED	RECORDS & LIBRARY (GROSS CHAR	SOCIAL SERVICE	
Cheeses Service Cost Centres					15, 00		17. 00	
DOTOC CAP SEL COSTS MURIT FUND		GENERAL SERVICE COST CENTERS	10.00		10.00	10.00	17.00	
13.10 0 03100 INTENSIVE CARE UNIT	2.00 4.00 5.00 7.00 8.00 9.00 11.00 13.00 14.00 15.00 16.00 17.00 19.00 21.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0 0 0 0 0 0 0 0	261, 91 (662 (1 14, 552, 335 0 0 2 0 0 0	1, 911, 173, 724 0 0 0	0	19. 00
15.00 02060 NEOMATAL INTENSIVE CARE UNIT 199, 619 847, 275 0 121, 859, 029 0.33 4.713 44 43.00 04000 SUBPROVIDE I. IPF 49, 659 126, 797 0 12, 244, 233 4.713 44 43.00 04000 SUBPROVIDE I. IPF 49, 659 126, 797 0 12, 244, 233 4.713 44 46, 970 170, 791 0 12, 244, 233 4.713 44 46, 970 170, 791 0 12, 244, 233 4.713 44 46, 970 170, 791 0 12, 244, 233 4.713 44 46, 970 170, 791 0 12, 244, 233 4.713 44 46, 970 170, 791 0 12, 244, 233 4.713 44 46, 970 170, 791 0 12, 244, 233 4.713 44 46, 970 170, 791 0 12, 244, 233 4.713 44 46, 970 170, 791 0 12, 244, 233 4.713 44 46, 970 170, 791 0 12, 244, 233 4.713 44 46, 970 170, 791 0 170, 791 0 12, 244, 233 4.713 44 46, 970 170, 979 0 170, 979 0 180, 979 0 450, 970 0 150, 970 0 150, 970 0 150, 970 0 150, 970 0 150, 970 0 150, 970 0 17	30.00		944, 886	3, 522, 585	5 C	263, 090, 038	63, 148	30.00
40, 00 04000 SUBPROVI DER - I PF			1		•			
A3. 00 04300 NURSERY A6. 970 170, 791 0 12, 244, 233 0 47. 234 A8. 241 A8. 2			1		•			35. 00 40. 00
MINISTER LILARY SERVICE COST CENTERS			1		•			43.00
51 00 05100 DEJOUERY ROOM 1			.57		-	,,,		
52.00 05200 DELIVERY ROOM & LABOR ROOM 103, 630 376, 816 0 27, 014, 531 0 55 55 00 05500 RADI DUGY - THERAPEUTI C 0 458, 212 0 54, 670, 870 0 55 55 00 05500 RADI DUGY - THERAPEUTI C 0 458, 212 0 54, 670, 870 0 55 58, 00 05500 CT SCAN 0 0 70, 346 0 31, 406, 525 0 55 58, 00 05500 CT SCAN 0 0 70, 346 0 31, 406, 525 0 55 60, 00 05500 RADI ROCK - THERAPEUTI C 0 70, 346 0 31, 406, 525 0 55 60, 00 0500 CADDI AC CATHETERI ZATI ON 0 48 0 4, 589, 374 0 55 60, 00 06000 LABORATORY 0 2, 484, 052 0 102, 502, 658 0 64 60, 00 06400 INTRAVENUS THERAPY 0 581, 027 0 38, 574, 124 0 64 65 00 06500 PHSYLCAL THERAPY 0 581, 027 0 38, 574, 124 0 64 66 00 06400 PHSYLCAL THERAPY 0 34, 187 0 8, 510, 701 0 67 68 00 06500 PHSYLCAL THERAPY 0 34, 187 0 8, 510, 701 0 67 68 00 06500 SEPECH PATHOLOGY 0 251 0 11, 293, 261 0 64 69, 00 06500 ELECTROCARDI OLOGY 0 251 0 11, 293, 261 0 64 69, 00 06500 ELECTROCARDI OLOGY 0 251 0 11, 293, 261 0 64 69, 00 06500 ELECTROCARDI OLOGY 0 251 0 14, 552, 335 111, 293, 261 0 67 67 67 67 67 67 67			1		•			
54.00 05400 RADIOLOGY-DIAGNOSTIC 0 193, 684 0 46, 701, 603 0 55, 500 05500 RADIOLOGY-THERAPEUTIC 0 458, 212 0 54, 670, 870 0 55, 500 05500 RADIOLOGY-THERAPEUTIC 0 458, 212 0 54, 670, 870 0 55, 500 05900 CARDIOLOGY-THERAPEUTIC 0 259, 076 0 112, 803, 107 0 55, 500 05900 CARDIOLOGY 0 0 48 0 4, 589, 374 0 55, 500 05900 CARDIOLOGY 0 2, 484, 052 0 122, 502, 558 0 64, 600 0 0 0 0 0 0 0 0 0			1		•			51.00
55.00 0.5500 RADI OLOGY-THERAPEUTIC 0 458, 212 0 54, 670, 870 0 575, 70 0.570 0.			103, 630		•			52. 00 54. 00
57. 00 05700 CT SCAN			0		•			55.00
59.00 OSPOIC CARDIAC CATHETER ZATION 0 48 0 4,589,374 0 5			0		•		0	57.00
0.0 0.0000 LABORATORY 0 2,484,052 0 102,502,658 0 66			0		1			58. 00
64 00 06400 INTRAVENDUS THERAPY 0 47,495 0 1,615,394 0 66 50 00 06500 RESPIRATORY THERAPY 0 581,027 0 38,574,124 0 66 66.00 06600 PHYSI CAL THERAPY 0 142,085 0 29,497,764 0 66 67.00 06700 06000 06000 08,000 08,000 09,000 06,000			1		1			
65 00 06500 RESPI RATORY THERAPY 0 581, 027 0 38, 574, 124 0 66			1					60. 00 64. 00
66.00 06600 06700 0CUPATI ONAL THERAPY 0 0 142, 085 0 29, 497, 764 0 66 67.00 06700 0CUPATI ONAL THERAPY 0 34, 187 0 8, 510, 701 0 66 68.00 06800 SPECH PATHOLOGY 0 6, 447 0 2, 633, 541 0 66 69.00 06900 ELECTROCARDI OLOGY 0 251 0 11, 923, 261 0 67 69.00 06900 ELECTROCRED HATHOLOGY 0 251 0 11, 923, 261 0 67 69.00 06900 ELECTROCRED HATHOLOGY 0 251 0 11, 923, 261 0 67 70.00 7000 ELECTROCRED HATHOLOGRAPHY 0 181, 250 0 16, 125, 524 0 77 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 20, 401, 794 0 75, 297, 716 0 77 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 14, 139, 248 0 48, 332, 483 0 77 73.01 07301 SREPICAL PHARMACY 0 0 0 14, 552, 335 117, 032, 351 0 77 73.01 07301 SREPICAL PHARMACY 0 0 0 14, 552, 335 117, 032, 351 0 77 74.00 07400 RENAL DI ALYSIS 0 7, 538 0 4, 519, 237 0 77 76.00 03330 ENDOSCOPY 0 655, 558 0 38, 965, 241 0 77 76.01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76.02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 76.00 03953 WOUND CARE 0 183, 575 0 68, 933, 388 0 77 76.00 03953 WOUND CARE 0 183, 575 0 68, 933, 388 0 77 76.00 07000 ALIGN GENTER 0 10, 601 0 595, 996 0 90 09.01 04950 INFUSION CENTER 0 10, 601 0 595, 996 0 90 09.02 04975 SPINE CENTER 0 10, 601 0 595, 996 0 90 09.01 04950 INFUSION CENTER 0 10, 601 0 595, 996 0 90 09.02 04975 SPINE CENTER 0 10, 601 0 595, 996 0 90 09.02 04975 SPINE CENTER 0 0 0 0 0 0 0 09.01 04950 INFUSION CENTER 0 0 0 0 0 0 0 09.01 04950 INFUSION CENTER 0 0 0 0 0 0 0 0 09.00 09000 0100 0100 0100 0100 0100					•			65.00
68.00 06900 SPEECH PATHOLOGY 0 6, 447 0 2, 633, 541 0 66			Ö		•			66. 00
69.00			0		•			67. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 181, 250 0 16, 125, 524 0 77 77 77 0 0 77 77			0		•			68. 00
771.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 20, 401,794 0 75, 297,716 0 77 72.00 1MPL. DEV. CHARGED TO PATIENTS 0 14, 139, 248 0 48, 332, 483 0 77 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 14, 139, 248 0 48, 332, 483 0 77 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0			0					69. 00 70. 00
12. 00 07200 IMPL DEV. CHARGED TO PATIENTS 0 14, 139, 248 0 48, 332, 483 0 77. 30. 0 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 14, 552, 335 117, 032, 351 0 77. 33. 0 07301 SPECI ALTY PHARIMACY 0 0 0 0 0 0 0 0 77. 40. 0 07400 RENAL DI ALYSI S 0 7, 538 0 4, 519, 237 0 77. 60. 0 03330 ENDOSCOPY 0 655, 558 0 38, 965, 241 0 77. 60. 0 03330 ENDOSCOPY 0 655, 558 0 0 0 0 0 0 0 0 0			1					
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 14, 552, 335 117, 032, 351 0 77, 73. 01 07301 SPECI ALTY PHARMACY 0 0 0 0 0 0 0 77, 74. 00 07400 RENAL DI ALYSIS 0 7, 538 0 4, 519, 237 0 77, 76. 00 03330 ENDOSCOPY 0 655, 558 0 38, 965, 241 0 77, 76. 01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 7, 76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 7, 76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0			١					
74. 00 07400 RENAL DIALYSIS 0 7,538 0 4,519,237 0 7.6 00 03330 ENDOSCOPY 0 655,558 0 38,965,241 0 7.7 6.0 0 3330 ENDOSCOPY 0 655,558 0 38,965,241 0 7.7 6.0 10 3950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 7.7 6.0 10 3950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		07300 DRUGS CHARGED TO PATIENTS	0				0	73. 00
76. 00 03330 ENDOSCOPY 76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 76 76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 77 76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 77 76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0 77 76. 04 03953 WOUND CARE 0 0 150, 515 0 8, 739, 469 0 77 76. 06 03954 IMAGING CENTER 0 0 183, 575 0 68, 933, 388 0 76 76. 07 03955 BREAST DI AGNOSTIC CENTER 0 0 10, 722 0 32, 741, 868 0 77 77. 00 07700 ALLOGENEIC CHOTER 0 0 10, 722 0 32, 741, 868 0 77 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 0 0 78 0UTPATIENT SERVICE COST CENTERS 90. 00 99000 CLINIC 0 0 0 0 0 595, 996 0 96 90. 26 04975 SPINE CENTER 0 10, 601 0 595, 996 0 96 90. 26 04975 SPINE CENTER 0 4, 638 0 480, 554 0 97 92. 00 09100 EMERGENCY 191, 942 1, 314, 830 0 225, 704, 557 0 97 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 113. 00 11300 INTEREST EXPENSE 114. 00 11300 INTEREST EXPENSE 115. 00 11300 INTEREST EXPENSE 116. 00 1000 OF 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	(0		73. 01
76. 01 03950 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 76 76. 02 03951 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 77 76. 03 03952 OTHER ANCI LLARY SERVICE COST CENTERS 0 0 0 0 0 0 77 76. 04 03953 WOUND CARE 0 150, 515 0 8, 739, 469 0 76 76. 06 03954 IMAGING CENTER 0 183, 575 0 68, 933, 388 0 77 76. 07 03955 BREAST DI AGNOSTIC CENTER 0 10, 722 0 32, 741, 868 0 77 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0 0 0 77 78. 00 07800 CAR T - CELL I MMUNOTHERAPY 0 0 0 0 0 0 0 77 79. 00 07800 CAR T - CELL I MMUNOTHERAPY 0 0 0 0 0 0 0 0 78 79. 00 07800 CAR T - CELL I MUNOTHERAPY 0 0 0 0 0 0 0 0 78 79. 00 07800 CAR T - CELL I MUNOTHERAPY 0 0 0 0 0 0 0 0 0			0					74. 00 76. 00
76. 02 03951 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 76 76. 03 03952 OTHER ANCI LLARY SERVI CE COST CENTERS 0 0 0 0 0 0 0 77 76. 04 03953 WOUND CARE 0 0 150, 515 0 8, 739, 469 0 76 76. 06 03954 I MAGI NG CENTER 0 183, 575 0 68, 933, 388 0 76 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 10, 722 0 32, 741, 868 0 76 77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON 0 0 0 0 0 0 0 77 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 0 77 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				055, 556		38, 903, 241		76.00
76. 04 03953 WOUND CARE 0 150, 515 0 8, 739, 469 0 76 76. 06 03954 IMAGI NG CENTER 0 183, 575 0 68, 933, 388 0 77 76. 07 03955 BREAST DI AGNOSTI C CENTER 0 10, 722 0 32, 741, 868 0 76 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 78. 00 07800 CAR T-CELL I IMMUNOTHERAPY 0 0 0 0 0 0 0 90. 01 04950 INFUSI ON CENTER 0 10, 601 0 595, 996 0 90 90. 01 04950 INFUSI ON CENTER 0 10, 601 0 595, 996 0 90 90. 26 04975 SPI NE CENTER 0 4, 638 0 480, 554 0 90 92. 00 09200 DESERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 102. 00 10200 OPI OI TREATMENT PROGRAM 0 0 0 0 0 0 0 SPECI AL PURPOSE COST CENTERS 1113. 00 11300 11300 1 NTEREST EXPENSE 114 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 828, 493 56, 662, 331 14, 552, 335 1, 911, 173, 724 75, 609 119 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 0 0 192. 00 00 00 0 0 0 0 0 193. 00 194. 00 194. 00 0 0 0 0 0 194. 00 194. 00 194. 00 0 0 0 0 0 195. 00 194. 00 194. 00 0 0 0 0 0 194. 00 194. 00 194. 00 0 0 0 0 0 195. 00 194. 00 194. 00 0 0 0 0 0 0 196. 00 194. 00 194. 00 0 0 0 0 0 0 197. 00 194. 00 194. 00 194. 00 0 0 0 0 0 198. 00 199. 00 194. 00 194. 00 0 0 0 0 0 199. 00 194. 00 194. 00 194. 00 0 0 0 0 0 0 199. 00 194. 00 194. 00 194. 00 0 0 0 0 0 0 199. 00 194. 00 194. 00 194. 00 0 0 0 0 0 0 0 199. 00 194. 00 194. 00 194. 00 0 0 0 0 0 0 0 0 199. 00 194. 00 194. 00 194.			Ö	(0		76. 02
76. 06			0	(o	0		76. 03
76. 07 03955 BREAST DI AGNOSTI C CENTER 0 10, 722 0 32, 741, 868 0 76 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 77 78. 00 07800 CAR T-CELL I MUNOTHERAPY 0 0 0 0 0 0 0 0 78 OUTPATI ENT SERVI CE COST CENTERS 90. 01 04950 I INFUSI ON CENTER 0 10, 601 0 595, 996 0 99 90. 26 04975 SPI NE CENTER 0 10, 601 0 595, 996 0 99 91. 00 09100 EMERGENCY 191, 942 1, 314, 830 0 225, 704, 557 0 99 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 102. 00 10200 OP1 01 D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0					76. 04
77. 00			0		1			76. 06 76. 07
78. 00				10, 722		32, 741, 808		77.00
90. 00			0	(0		78. 00
90. 01								
90. 26			0	(0	0		90.00
91. 00			0		•			
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 92. 00 0 10200 0PI OI D TREATMENT PROGRAM 0 0 0 0 0 0 0 102. 00 0 0 0 0 0 0 0 0 0			191, 942		•			91.00
102.00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O			1,	., ,			_	92.00
113.00	102.00	10200 OPIOLD TREATMENT PROGRAM	0	() <u> </u>	0	0	102. 00
114.00	113 00							1 113. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190 191. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 190 190 190 190 190 190 190	114.00) 11400 UTILIZATION REVIEW-SNF SUBTOTALS (SUM OF LINES 1 through 117)	1, 828, 493	56, 662, 33	1 14, 552, 335	1, 911, 173, 724	75, 609	114. 00
191. 00 19100 RESEARCH 0 0 0 0 0 0 19	100 00		اء				_	100 00
			1 7	(0		190. 00 191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 1, 752 0 0 0 192		19200 PHYSICIANS' PRIVATE OFFICES	0	1, 752	•			192.00

Provider CCN: 15-0169

						5/24/2024 11:	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &		
			SUPPLY	REQUI S.)	LI BRARY	(PATIENT DAYS)	
		(DIRECT NRSING	(COSTED		(GROSS CHAR		
		HRS)	REQUI S.)		GES)		
		13. 00	14.00	15. 00	16. 00	17. 00	
•	NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950	HOME OFFICE	0	0	0	0	0	194. 00
194. 06 07956	PAVI LLI ONS	0	2, 807	0	0	0	194. 06
194. 08 07958	OTHER NRCC	0	11, 352	0	0	0	194. 08
194. 10 07960	COMMUNITY REHAB HOSPITAL	0	0	0	0	0	194. 10
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	9, 473, 721	9, 823, 332	12, 429, 064	2, 944, 961	3, 533, 447	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	5. 181163	0. 173318	0. 854094	0. 001541	46. 733153	203. 00
204.00	Cost to be allocated (per Wkst. B,	201, 929	3, 545, 961	909, 267	35, 226	75, 339	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 110435	0. 062563	0. 062483	0. 000018	0. 996429	205. 00
	[11]]					
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)	1					

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0169

Peri od: Worksheet B-1 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

5/24/2024 11:44 am INTERNS & RESIDENTS Cost Center Description NONPHYSI CI AN SERVI CES-SALAR SERVI CES-OTHER Y & FRINGES ANESTHETI STS PRGM COSTS (ASSI GNED **APPRV APPRV** (ASSI GNED TIME) (ASSI GNED TIME) TIME) 19.00 21. 00 22. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 75, 200 21 00 75, 200 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDLATRICS 0 26, 400 26, 400 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 0 02060 NEONATAL INTENSIVE CARE UNIT 35.00 C 35.00 04000 SUBPROVIDER - IPF 40.00 15,000 15,000 40.00 0 43.00 04300 NURSERY 43.00 C ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 0 24, 900 24, 900 50.00 51.00 05100 RECOVERY ROOM 51.00 C 05200 DELIVERY ROOM & LABOR ROOM 52.00 C 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05700 CT SCAN 0 57 00 C 57 00 58.00 05800 MRI 0 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 0 59.00 06000 LABORATORY 0 0 60.00 60.00 0 06400 INTRAVENOUS THERAPY 0 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 0 0 67 00 67 00 06800 SPEECH PATHOLOGY 0 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71 00 Ω 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73. 01 07301 SPECIALTY PHARMACY 0 0 73.01 07400 RENAL DIALYSIS 0 74 00 0 74 00 76.00 03330 ENDOSCOPY 0 0 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 76.01 76.01 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 76.02 0 76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 76.03 C 76.03 76.04 03953 WOUND CARE 76.04 03954 I MAGING CENTER 0 76.06 0 76.06 03955 BREAST DIAGNOSTIC CENTER 76.07 Ω 0 76 07 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C 0 Ω 0 90.01 04950 INFUSION CENTER 0 0 90.01 04975 SPINE CENTER 0 90 26 0 90.26 09100 EMERGENCY 0 8.900 8.900 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 SUBTOTALS (SUM OF LINES 1 through 117) 75, 200 75, 200 118.00 118.00 0 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 15-0169

				10	0 12/31/2023	5/24/2024 11: 44 am
			INTERNS &	RESI DENTS		
	Cost Center Description		SERVI CES-SALAR			
		ANESTHETI STS	Y & FRINGES	PRGM COSTS		
		(ASSI GNED	APPRV	APPRV		
		TIME)	(ASSI GNED	(ASSI GNED		
		10.00	TIME)	TIME)		
101 00 10	100 RESEARCH	19.00	21.00	22. 00		191. 00
	200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0		191.00
	300 NONPALD WORKERS	0	0	0		193. 00
4	950 HOME OFFICE	0	0	0		194. 00
	956 PAVILLIONS	0	0	0		194. 06
	958 OTHER NRCC	0	0	0		194. 08
	960 COMMUNITY REHAB HOSPITAL	0	0	0		194. 10
200.00	Cross Foot Adjustments		Ĭ	O		200.00
201.00	Negative Cost Centers					201. 00
202.00	Cost to be allocated (per Wkst. B,	0	654, 971	1, 548, 324		202. 00
202.00	Part I)		001,771	1,010,021		202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	8. 709721	20. 589415		203. 00
204.00	Cost to be allocated (per Wkst. B,	0	6, 334	14, 974		204. 00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 084229	0. 199122		205. 00
	11)					
206. 00	NAHE adjustment amount to be allocated					206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,					207. 00
	Parts III and IV)					

Provider CCN: 15-0169

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 11:44 am Title XVIII Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 107, 328, 220 107, 328, 220 107, 328, 220 03100 INTENSIVE CARE UNIT 16, 667, 899 16, 667, 899 0 31.00 31.00 16, 667, 899 02060 NEONATAL INTENSIVE CARE UNIT o 35.00 20, 025, 177 20, 025, 177 20, 025, 177 35 00 04000 SUBPROVIDER - IPF 40.00 4.682.350 4, 682, 350 0 4, 682, 350 40.00 04300 NURSERY 43.00 5, 618, 275 5, 618, 275 5, 618, 275 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 36, 595, 930 36, 595, 930 36, 595, 930 50.00 05100 RECOVERY ROOM 0 8, 164, 505 51 00 8, 164, 505 8, 164, 505 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 12, 393, 161 12, 393, 161 0 12, 393, 161 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 322, 538 9, 322, 538 0 0 0 9, 322, 538 54.00 05500 RADI OLOGY-THERAPEUTI C 5, 279, 562 5, 279, 562 55.00 5, 279, 562 55.00 05700 CT SCAN 57.00 4,033,675 4, 033, 675 4, 033, 675 57 00 58.00 05800 MRI 3, 101, 227 3, 101, 227 3, 101, 227 58.00 05900 CARDIAC CATHETERIZATION 59.00 195, 942 195, 942 0 195, 942 59.00 06000 LABORATORY 19, 683, 511 60 00 19, 683, 511 19 683 511 60 00 64.00 06400 INTRAVENOUS THERAPY 869, 672 869, 672 869, 672 64.00 06500 RESPIRATORY THERAPY 9, 900, 866 9, 900, 866 0 9, 900, 866 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 10, 860, 420 10, 860, 420 10, 860, 420 66.00 06700 OCCUPATIONAL THERAPY 2, 919, 712 2, 919, 712 0 2, 919, 712 67 00 67 00 0 68.00 06800 SPEECH PATHOLOGY 551, 490 551, 490 551, 490 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 208, 956 1, 208, 956 0 0 0 1, 208, 956 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 3 603 045 3 603 045 3 603 045 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 28, 076, 217 28, 076, 217 28, 076, 217 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 19, 452, 008 19, 452, 008 19, 452, 008 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 30, 211, 719 30, 211, 719 0 30, 211, 719 73.00 07301 SPECIALTY PHARMACY 73 01 73 01 0 74.00 07400 RENAL DIALYSIS 2, 280, 156 2, 280, 156 2, 280, 156 74.00 03330 ENDOSCOPY 5, 730, 429 5, 730, 429 0 5, 730, 429 76.00 76.00 0 76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 76.01 n 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76.02 0 76 02 0 76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76.03 0 2, 173, 075 03953 WOUND CARE 2, 173, 075 2, 173, 075 76.04 76.04 0 76.06 03954 I MAGING CENTER 5, 927, 596 5, 927, 596 5, 927, 596 76.06 03955 BREAST DIAGNOSTIC CENTER 76.07 14, 720, 009 14, 720, 009 14, 720, 009 76.07 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78 00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 Λ 90 00 90.01 04950 INFUSION CENTER 344, 960 344, 960 0 344, 960 90.01 90. 26 04975 SPINE CENTER 361, 264 361, 264 o 361, 264 90. 26 20, 632, 886 20, 632, 886 20, 632, 886 09100 EMERGENCY o 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 16, 488, 611 16, 488, 611 16, 488, 611 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 429, 405, 063 200. 00 Subtotal (see instructions) 200.00 429, 405, 063 0 429, 405, 063 0 201.00 Less Observation Beds 16, 488, 611 16, 488, 611 16, 488, 611 201. 00 202.00 Total (see instructions) 412, 916, 452 412, 916, 452 412, 916, 452 202. 00

Provider CCN: 15-0169

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

From 01/01/2023 Date/Time Prepared: 12/31/2023 5/24/2024 11:44 am Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 245, 527, 351 245, 527, 351 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 42, 215, 396 42, 215, 396 31.00 02060 NEONATAL INTENSIVE CARE UNIT 121, 859, 029 35.00 121, 859, 029 35.00 04000 SUBPROVIDER - IPF 40.00 13, 198, 032 13, 198, 032 40.00 04300 NURSERY 43.00 12, 244, 233 12, 244, 233 43.00 ANCILLARY SERVICE COST CENTERS 302, 911, 994 50 00 05000 OPERATING ROOM 165, 375, 503 137, 536, 491 0 120814 0.000000 50.00 05100 RECOVERY ROOM 20, 994, 455 24, 748, 710 45, 743, 165 0.178486 0.000000 51.00 51.00 05200 DELLVERY ROOM & LABOR ROOM 27, 014, 531 0.000000 52 00 27, 014, 531 0.458759 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 13, 820, 396 32, 881, 207 46, 701, 603 0.199619 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 23, 786, 746 30, 884, 124 54, 670, 870 0.096570 0.000000 55.00 05700 CT SCAN 77, 683, 784 112, 803, 107 0.035759 0.000000 57.00 35, 119, 323 57.00 58.00 05800 MRI 6, 951, 425 24, 455, 100 31, 406, 525 0.098745 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 4, 589, 374 4, 589, 374 0.042695 0.000000 59.00 60.00 06000 LABORATORY 60, 992, 469 41, 510, 189 102, 502, 658 0.192029 0.000000 60.00 06400 INTRAVENOUS THERAPY 0.538365 64.00 1, 522, 282 93, 112 1, 615, 394 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 35, 407, 289 3, 166, 835 38, 574, 124 0. 256671 0.000000 65.00 06600 PHYSI CAL THERAPY 4, 589, 213 24, 908, 551 29, 497, 764 0.368178 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 4, 709, 723 3, 800, 978 8, 510, 701 0.343064 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 1, 000, 748 68.00 1, 632, 793 2, 633, 541 0. 209410 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 9, 372, 408 2, 550, 853 11, 923, 261 0.101395 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 222, 703 14, 902, 821 16, 125, 524 0.223437 0.000000 70.00 29, 555, 995 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 45 741 721 75, 297, 716 0.372869 0.000000 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 25, 040, 408 23, 292, 075 48, 332, 483 0.402462 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 77, 979, 141 39, 053, 210 117, 032, 351 0. 258148 0.000000 73.00 73.00 73.01 07301 SPECIALTY PHARMACY 0.000000 0.000000 73.01 07400 RENAL DIALYSIS 4, 519, 237 4, 519, 237 0.504544 74.00 0.000000 74.00 76.00 03330 ENDOSCOPY 8, 167, 328 30, 797, 913 38, 965, 241 0.147065 0.000000 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 76. 01 0 0 C 0.000000 0.000000 76.01 03951 OTHER ANCILLARY SERVICE COST CENTERS 76 02 0 0 0.000000 0 000000 76 02 Ω 03952 OTHER ANCILLARY SERVICE COST CENTERS 76.03 0.000000 0.000000 76.03 03953 WOUND CARE 1, 237, 522 7, 501, 947 8, 739, 469 0.248651 0.000000 76.04 76.04 76.06 03954 I MAGING CENTER 427, 375 68, 506, 013 68, 933, 388 0.085990 0.000000 76.06 76.07 03955 BREAST DIAGNOSTIC CENTER 32, 720, 446 32, 741, 868 0 449578 21, 422 0.000000 76.07 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 C 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0.000000 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 0.000000 90 00 0.000000 09000 CLINIC 90.00 0 90.01 04950 INFUSION CENTER 2,031 593, 965 595, 996 0.578796 0.000000 90.01 90.26 04975 SPINE CENTER 480, 554 480, 554 0. 751766 0.000000 90.26 09100 EMERGENCY 50, 468, 156 225, 704, 557 0.091415 91.00 91.00 175, 236, 401 0.000000 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 2, 825, 364 14, 737, 323 17, 562, 687 0.938843 0.000000 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 200.00 Subtotal (see instructions) 1, 068, 574, 379 842, 599, 345 1, 911, 173, 724 200.00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 1, 068, 574, 379 842, 599, 345 1, 911, 173, 724 202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Peri od: Worksheet C From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared: 5/24/2024 11:44 am Provider CCN: 15-0169

				5/24/2024 11:	44 am_
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
· ·	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	1				
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 NTENSI VE CARE UNI T					31.00
					1
35. 00 02060 NEONATAL INTENSIVE CARE UNIT					35. 00
40. 00 04000 SUBPROVI DER - I PF					40.00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					_
50.00 05000 OPERATING ROOM	0. 120814				50. 00
51.00 05100 RECOVERY ROOM	0. 178486				51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 458759				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 199619				54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 096570				55. 00
57. 00 05700 CT SCAN	0. 035759				57. 00
58. 00 05800 MRI	0. 098745				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 042695				59. 00
60. 00 06000 LABORATORY	0. 192029				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 538365				64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 256671				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 368178				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 343064				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 209410				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 101395				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 223437				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 372869				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 402462				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 258148				73. 00
73. 01 07301 SPECIALTY PHARMACY	0. 000000				73. 01
74.00 07400 RENAL DIALYSIS	0. 504544				74. 00
76. 00 03330 ENDOSCOPY	0. 147065				76. 00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000				76. 01
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000				76. 02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000				76. 03
76. 04 03953 WOUND CARE	0. 248651				76. 04
76. 06 03954 I MAGI NG CENTER	0. 085990				76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	0. 449578				76. 07
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78. 00
OUTPATIENT SERVICE COST CENTERS	0.000000				1 78.00
90. 00 09000 CLINIC	0. 000000				90. 00
					•
90. 01 04950 I NFUSI ON CENTER	0. 578796				90. 01
90. 26 04975 SPI NE CENTER	0. 751766				90. 26
91. 00 09100 EMERGENCY	0. 091415				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 938843				92. 00
OTHER REIMBURSABLE COST CENTERS					
102.00 10200 OPI OI D TREATMENT PROGRAM					102. 00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00
	1				•

Provider CCN: 15-0169

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 11:44 am Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30 00 03000 ADULTS & PEDIATRICS 108, 101, 717 108, 101, 717 108, 101, 717 03100 INTENSIVE CARE UNIT 16, 667, 899 16, 667, 899 0 31.00 31.00 16, 667, 899 02060 NEONATAL INTENSIVE CARE UNIT o 35.00 20, 025, 177 20, 025, 177 20, 025, 177 35.00 04000 SUBPROVIDER - IPF 5, 121, 837 40.00 5, 121, 837 0 5, 121, 837 40.00 04300 NURSERY 43.00 5, 618, 275 5, 618, 275 5, 618, 275 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 37, 325, 478 37, 325, 478 37, 325, 478 50.00 8, 164, 505 05100 RECOVERY ROOM 0 51 00 8, 164, 505 8, 164, 505 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 12, 393, 161 12, 393, 161 0 12, 393, 161 52.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 9, 322, 538 9, 322, 538 0 0 0 9, 322, 538 54.00 05500 RADI OLOGY-THERAPEUTI C 5, 279, 562 5, 279, 562 55.00 5, 279, 562 55.00 05700 CT SCAN 57.00 4,033,675 4, 033, 675 4, 033, 675 57 00 58.00 05800 MRI 3, 101, 227 3, 101, 227 3, 101, 227 58.00 05900 CARDIAC CATHETERIZATION 59.00 195, 942 195, 942 0 195, 942 59.00 06000 LABORATORY 19, 683, 511 60 00 19, 683, 511 19 683 511 60 00 64.00 06400 INTRAVENOUS THERAPY 869, 672 869, 672 869, 672 64.00 06500 RESPIRATORY THERAPY 9, 900, 866 9, 900, 866 0 9, 900, 866 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 10, 860, 420 10, 860, 420 10, 860, 420 66.00 06700 OCCUPATIONAL THERAPY 2, 919, 712 2, 919, 712 0 2, 919, 712 67 00 67 00 0 68.00 06800 SPEECH PATHOLOGY 551, 490 551, 490 551, 490 68.00 69.00 06900 ELECTROCARDI OLOGY 1, 208, 956 1, 208, 956 0 0 0 1, 208, 956 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 3 603 045 3 603 045 3 603 045 70 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 28, 076, 217 28, 076, 217 28, 076, 217 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 19, 452, 008 19, 452, 008 19, 452, 008 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 30, 211, 719 30, 211, 719 0 30, 211, 719 73.00 07301 SPECIALTY PHARMACY 73 01 73 01 0 74.00 07400 RENAL DIALYSIS 2, 280, 156 2, 280, 156 2, 280, 156 74.00 03330 ENDOSCOPY 5, 730, 429 5, 730, 429 0 5, 730, 429 76.00 76.00 0 76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 76.01 n 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76.02 0 76 02 0 76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS 0 0 76.03 0 2, 173, 075 03953 WOUND CARE 2, 173, 075 2, 173, 075 76.04 76.04 0 76.06 03954 I MAGING CENTER 5, 927, 596 5, 927, 596 5, 927, 596 76.06 03955 BREAST DIAGNOSTIC CENTER 76.07 14, 720, 009 14, 720, 009 14, 720, 009 76.07 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 0 78 00 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 Λ 90 00 90.01 04950 INFUSION CENTER 344, 960 344, 960 0 344, 960 90.01 90. 26 04975 SPINE CENTER 361, 264 361, 264 o 361, 264 90. 26 20, 893, 649 09100 EMERGENCY 20, 893, 649 o 20, 893, 649 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 16, 488, 611 16, 488, 611 16, 488, 611 92.00 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102. 00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 431, 608, 358 200. 00 Subtotal (see instructions) 200.00 431, 608, 358 0 431, 608, 358 0 201.00 Less Observation Beds 16, 488, 611 16, 488, 611 16, 488, 611 201. 00 202.00 Total (see instructions) 415, 119, 747 415, 119, 747 415, 119, 747 202. 00

Provider CCN: 15-0169

Peri od:

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

From 01/01/2023 Date/Time Prepared: 12/31/2023 5/24/2024 11:44 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 245, 527, 351 245, 527, 351 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 42, 215, 396 42, 215, 396 31.00 02060 NEONATAL INTENSIVE CARE UNIT 121, 859, 029 35.00 121, 859, 029 35.00 04000 SUBPROVIDER - IPF 40.00 13, 198, 032 13, 198, 032 40.00 04300 NURSERY 43.00 12, 244, 233 12, 244, 233 43.00 ANCILLARY SERVICE COST CENTERS 302, 911, 994 50 00 05000 OPERATING ROOM 165, 375, 503 137, 536, 491 0 123222 0.000000 50.00 05100 RECOVERY ROOM 20, 994, 455 24, 748, 710 45, 743, 165 0.178486 0.000000 51.00 51.00 05200 DELLVERY ROOM & LABOR ROOM 27, 014, 531 0.000000 52 00 27, 014, 531 0.458759 52 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 13, 820, 396 32, 881, 207 46, 701, 603 0.199619 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 23, 786, 746 30, 884, 124 54, 670, 870 0.096570 0.000000 55.00 05700 CT SCAN 77, 683, 784 112, 803, 107 0.035759 0.000000 57.00 35, 119, 323 57.00 58.00 05800 MRI 6, 951, 425 24, 455, 100 31, 406, 525 0.098745 0.000000 58.00 59.00 05900 CARDIAC CATHETERIZATION 4, 589, 374 4, 589, 374 0.042695 0.000000 59.00 60.00 06000 LABORATORY 60, 992, 469 41, 510, 189 102, 502, 658 0.192029 0.000000 60.00 06400 INTRAVENOUS THERAPY 0.538365 64.00 1, 522, 282 93, 112 1, 615, 394 0.000000 64.00 65.00 06500 RESPIRATORY THERAPY 35, 407, 289 3, 166, 835 38, 574, 124 0. 256671 0.000000 65.00 06600 PHYSI CAL THERAPY 4, 589, 213 24, 908, 551 29, 497, 764 0.368178 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 4, 709, 723 3, 800, 978 8, 510, 701 0.343064 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 1, 632, 793 1,000,748 2, 633, 541 0. 209410 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 9, 372, 408 2, 550, 853 11, 923, 261 0.101395 0.000000 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1, 222, 703 14, 902, 821 16, 125, 524 0.223437 0.000000 70.00 29, 555, 995 71 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 45 741 721 75, 297, 716 0.372869 0.000000 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 25, 040, 408 23, 292, 075 48, 332, 483 0.402462 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 77, 979, 141 39, 053, 210 117, 032, 351 0. 258148 0.000000 73.00 73.00 73.01 07301 SPECIALTY PHARMACY 0.000000 0.000000 73.01 07400 RENAL DIALYSIS 4, 519, 237 4, 519, 237 0.504544 74.00 0.000000 74.00 76.00 03330 ENDOSCOPY 8, 167, 328 30, 797, 913 38, 965, 241 0.147065 0.000000 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 76. 01 0 0 C 0.000000 0.000000 76.01 03951 OTHER ANCILLARY SERVICE COST CENTERS 76 02 0 0 0.000000 0 000000 76 02 Ω 03952 OTHER ANCILLARY SERVICE COST CENTERS 76.03 0.000000 0.000000 76.03 03953 WOUND CARE 1, 237, 522 7, 501, 947 8, 739, 469 0.248651 0.000000 76.04 76.04 76.06 03954 I MAGING CENTER 427, 375 68, 506, 013 68, 933, 388 0.085990 0.000000 76.06 76.07 03955 BREAST DIAGNOSTIC CENTER 32, 720, 446 32, 741, 868 0 449578 21, 422 0.000000 76.07 07700 ALLOGENEIC HSCT ACQUISITION 77.00 0 C 0.000000 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0.000000 78.00 78.00 OUTPATIENT SERVICE COST CENTERS 0.000000 90 00 0.000000 09000 CLINIC 90.00 0 90.01 04950 INFUSION CENTER 2,031 593, 965 595, 996 0.578796 0.000000 90.01 90.26 04975 SPINE CENTER 480, 554 480, 554 0. 751766 0.000000 90.26 09100 EMERGENCY 50, 468, 156 225, 704, 557 0.092571 91.00 91.00 175, 236, 401 0.000000 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 92.00 92.00 2, 825, 364 14, 737, 323 17, 562, 687 0.938843 0.000000 OTHER REIMBURSABLE COST CENTERS 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 200.00 Subtotal (see instructions) 1, 068, 574, 379 842, 599, 345 1, 911, 173, 724 200.00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 1, 068, 574, 379 842, 599, 345 1, 911, 173, 724 202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | 5/24/2024 | 11: 44 am Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 15-0169

		Title XIX	Hospi tal	PPS	+ aiii
Cost Center Description	PPS Inpatient	THE SALA	110001 141		
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
31.00 03100 INTENSIVE CARE UNIT				3	31.00
35.00 02060 NEONATAL INTENSIVE CARE UNIT				3	35.00
40. 00 04000 SUBPROVI DER - 1 PF				1	40.00
43. 00 04300 NURSERY				1	43.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 123222			Ę	50.00
51.00 05100 RECOVERY ROOM	0. 178486			Ę	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 458759			Ę	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 199619			Ę	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 096570			Ę	55.00
57. 00 05700 CT SCAN	0. 035759			Ę	57.00
58. 00 05800 MRI	0. 098745			Ę	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 042695			Ę	59. 00
60. 00 06000 LABORATORY	0. 192029			ϵ	60.00
64.00 06400 INTRAVENOUS THERAPY	0. 538365			ϵ	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 256671			1	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 368178			1	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 343064			1	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 209410			1	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 101395			1	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 223437			7	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 372869				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 402462			•	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 258148			7	73.00
73. 01 07301 SPECI ALTY PHARMACY	0. 000000				73. 01
74. 00 07400 RENAL DI ALYSI S	0. 504544				74. 00
76. 00 03330 ENDOSCOPY	0. 147065				76. 00
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000				76. 01
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000				76. 02
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000				76. 03
76. 04 03953 WOUND CARE	0. 248651			l l	76. 04
76. 06 03954 I MAGI NG CENTER	0. 085990				76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	0. 449578				76. 07
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			1	77. 00
78. 00 O7800 CAR T-CELL IMMUNOTHERAPY	0. 000000			7	78. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0.000000				90.00
90. 01 04950 I NFUSI ON CENTER	0. 578796			•	90. 01
90. 26 04975 SPI NE CENTER	0. 751766				90. 26
91. 00 09100 EMERGENCY	0. 092571				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 938843				92. 00
OTHER REIMBURSABLE COST CENTERS					
102. 00 10200 OPI OI D TREATMENT PROGRAM				10	02. 00
SPECIAL PURPOSE COST CENTERS				1.	12 00
113. 00 11300 INTEREST EXPENSE				•	13.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				l l	14. 00
200.00 Subtotal (see instructions)					00.00
201.00 Less Observation Beds 202.00 Total (see instructions)					01.00
202.00 Total (see instructions)	1			J2C	02.00

Heal th Financial Systems COMMUNITY HOSPIT CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Tim Provider CCN: 15-0169

			1	0 12/31/2023	5/24/2024 11:	
		Ti tl	e XIX	Hospi tal	PPS	11 uiii
Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	(Wkst. B, Part			Reduction	Reduction	
	1, col. 26)		Cost (col. 1 -		Amount	
		Í	col . 2)			
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	37, 325, 478	5, 077, 921	32, 247, 557	0	0	50. 00
51. 00 05100 RECOVERY ROOM	8, 164, 505	541, 856	7, 622, 649	0	0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	12, 393, 161	1, 067, 905	11, 325, 256	0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 322, 538	757, 270	8, 565, 268	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 279, 562	616, 678	4, 662, 884	0	0	55. 00
57. 00 05700 CT SCAN	4, 033, 675	130, 646	3, 903, 029	0	0	57. 00
58. 00 05800 MRI	3, 101, 227	685, 492	2, 415, 735	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	195, 942	3, 441	192, 501	0	0	59. 00
60. 00 06000 LABORATORY	19, 683, 511	493, 572	19, 189, 939	0	0	60.00
64. 00 06400 I NTRAVENOUS THERAPY	869, 672	27, 496	842, 176	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	9, 900, 866	609, 465	9, 291, 401	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	10, 860, 420	1, 347, 770	9, 512, 650	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 919, 712	88, 749	2, 830, 963	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	551, 490	16, 676	534, 814	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 208, 956	24, 456	1, 184, 500	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 603, 045	378, 178	3, 224, 867	0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 076, 217	1, 513, 963		0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	19, 452, 008	1, 049, 168	18, 402, 840	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	30, 211, 719	1, 081, 610			0	73. 00
73. 01 07301 SPECIALTY PHARMACY	0	0		0	0	73. 01
74. 00 07400 RENAL DIALYSIS	2, 280, 156	35, 869	2, 244, 287	0	0	74. 00
76. 00 03330 ENDOSCOPY	5, 730, 429	687, 045		0	0	76. 00
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 01
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0	0	0	76. 02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS	o	0	0	0	0	76. 03
76. 04 03953 WOUND CARE	2, 173, 075	190, 093	1, 982, 982	0	0	76. 04
76. 06 03954 I MAGI NG CENTER	5, 927, 596	1, 101, 666		0	0	76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	14, 720, 009	587, 753	1		0	76. 07
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	1		0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	o	0	o	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS	-1					
90. 00 09000 CLI NI C	0	0	0	0	0	90. 00
90. 01 04950 INFUSION CENTER	344, 960	92, 445	252, 515	0	0	90. 01
90. 26 04975 SPI NE CENTER	361, 264	3, 928		0	0	90. 26
91. 00 09100 EMERGENCY	20, 893, 649	1, 157, 552		0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	16, 488, 611	1, 310, 746		0	0	92.00
OTHER REIMBURSABLE COST CENTERS	107 1007 011	.,	1 12/ 111/ 222	-		
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	-1	-	-	-		
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
200.00 Subtotal (sum of lines 50 thru 199)	276, 073, 453	20, 679, 409	255, 394, 044	0	n	200. 00
201.00 Less Observation Beds	16, 488, 611	1, 310, 746		-		201. 00
202.00 Total (line 200 minus line 201)	259, 584, 842	19, 368, 663				202. 00
1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		, , 500			'	

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

Provi der CCN: 15-0169

Peri od: Worksheet C
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/24/2024 11: 44 am

					5/24/2024 11:	44 am_
			e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	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			
ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00			
	27 225 470	202 011 004	0 12222			1 50 00
50. 00 05000 OPERATI NG ROOM	37, 325, 478					50.00
51. 00 05100 RECOVERY ROOM	8, 164, 505	1				51.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	12, 393, 161	27, 014, 531				52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	9, 322, 538	46, 701, 603	0. 199619			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 279, 562	54, 670, 870	0. 096570			55. 00
57. 00 05700 CT SCAN	4, 033, 675	112, 803, 107	0. 035759			57.00
58. 00 05800 MRI	3, 101, 227		0. 098745			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	195, 942					59. 00
60. 00 06000 LABORATORY	19, 683, 511	102, 502, 658				60.00
64. 00 06400 I NTRAVENOUS THERAPY	869, 672					64. 00
65. 00 06500 RESPIRATORY THERAPY	9, 900, 866					65. 00
66. 00 06600 PHYSI CAL THERAPY	10, 860, 420	1				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 919, 712	8, 510, 701				67. 00
68. 00 06800 SPEECH PATHOLOGY	551, 490					68. 00
69. 00 06900 ELECTROCARDI OLOGY	1, 208, 956	11, 923, 261	0. 101395			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	3, 603, 045	16, 125, 524	0. 223437			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 076, 217	75, 297, 716	0. 372869			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	19, 452, 008					72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	30, 211, 719		0. 258148			73. 00
73. 01 07301 SPECIALTY PHARMACY	00,211,717					73. 01
74. 00 07400 RENAL DI ALYSI S	2, 280, 156	1				74. 00
		1				•
76. 00 03330 ENDOSCOPY	5, 730, 429	1	0. 147065			76. 00
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0					76. 01
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0. 000000			76. 02
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0.00000			76. 03
76. 04 03953 WOUND CARE	2, 173, 075		0. 248651			76. 04
76.06 03954 I MAGI NG CENTER	5, 927, 596	68, 933, 388	0. 085990			76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER	14, 720, 009	32, 741, 868	0. 449578			76. 07
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.000000			77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	0	0. 000000			90. 00
90. 01 04950 I NFUSI ON CENTER	344, 960	1				90.00
90. 26 04975 SPI NE CENTER	361, 264					90. 26
91. 00 09100 EMERGENCY	20, 893, 649					91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	16, 488, 611	17, 562, 687	0. 938843			92. 00
OTHER REIMBURSABLE COST CENTERS						
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0.000000			102.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
200.00 Subtotal (sum of lines 50 thru 199)	276 073 453	1, 476, 129, 683				200. 00
201.00 Less Observation Beds	16, 488, 611	0 1,470,127,003				201.00
202.00 Total (line 200 minus line 201)		1, 476, 129, 683				201.00
202.00 Total (True 200 militus True 201)	237, 304, 042	1,4/0,127,003	I			1202.00

Health Financial Systems COMM	IUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2023		
				To 12/31/2023	Date/Time Pre 5/24/2024 11:	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	8, 531, 912	0	8, 531, 91	2 74, 739	114. 16	30. 00
31.00 INTENSIVE CARE UNIT	1, 101, 040		1, 101, 04	7, 063	155. 89	31. 00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 416, 746		1, 416, 74	6 12, 644	112. 05	35. 00
40. 00 SUBPROVI DER - I PF	250, 323	0	250, 32	3 4, 713	53. 11	40. 00
43. 00 NURSERY	484, 162		484, 16	2 7, 614	63. 59	43.00
200.00 Total (lines 30 through 199)	11, 784, 183		11, 784, 18	3 106, 773		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	15, 843	1, 808, 637				30. 00
31.00 INTENSIVE CARE UNIT	1, 713	267, 040				31. 00
35.00 NEONATAL INTENSIVE CARE UNIT	0	0)			35. 00
40. 00 SUBPROVI DER - I PF	1, 829	97, 138				40. 00
43. 00 NURSERY	0	0)			43.00
200.00 Total (lines 30 through 199)	19, 385	2, 172, 815				200. 00

In Lieu of Form CMS-2552-10 APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/24/2024 11:44 am Title XVIII Hospi tal PPS Capital Costs Cost Center Description Capi tal Total Charges Ratio of Cost Inpati ent to Charges (from Wkst. C. (column 3 x Related Cost Program (from Wkst. B. column 4) Part I. col. (col. 1 ÷ col Charges 2) Part II, col. 8) 26) 2.00 3.00 4.00 5.00 1.00 ANCILLARY SERVICE COST CENTERS 5, 077, 921 302, 911, 994 50.00 05000 OPERATING ROOM 0.016764 41, 544, 333 696, 449 50.00 51.00 05100 RECOVERY ROOM 541, 856 45, 743, 165 0.011846 4, 550, 191 53, 902 51.00 05200 DELIVERY ROOM & LABOR ROOM 1, 067, 905 27, 014, 531 0.039531 52.00 52.00 05400 RADI OLOGY-DI AGNOSTI C 757, 270 46, 701, 603 0.016215 3, 544, 234 57, 470 54.00 54.00 6, 473, 587 05500 RADI OLOGY-THERAPEUTI C 616, 678 54, 670, 870 0.011280 73,022 55.00 55.00 57.00 05700 CT SCAN 130,646 112, 803, 107 0.001158 10, 549, 289 12, 216 57.00 58.00 05800 MRI 685, 492 31, 406, 525 0.021826 1, 901, 389 41, 500 58.00 05900 CARDIAC CATHETERIZATION 4, 589, 374 0.000750 1, 045, 908 784 59 00 3 441 59 00 15, 175, 405 06000 LABORATORY 60.00 493, 572 102, 502, 658 0.004815 73,070 60.00 6, 593 64.00 06400 I NTRAVENOUS THERAPY 27, 496 1, 615, 394 0.017021 387, 336 64.00 06500 RESPIRATORY THERAPY 65.00 609, 465 38, 574, 124 0.015800 8, 030, 932 126, 889 65.00 06600 PHYSI CAL THERAPY 1, 347, 770 29, 497, 764 0.045691 66 00 1, 561, 471 71.345 66 00 67.00 06700 OCCUPATIONAL THERAPY 88, 749 8, 510, 701 0.010428 1, 277, 582 13, 323 67.00 06800 SPEECH PATHOLOGY 0.006332 68.00 16,676 2, 633, 541 369, 933 2, 342 68.00 2, 683, 198 06900 ELECTROCARDI OLOGY 11, 923, 261 69 00 24 456 0.002051 5 503 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 378, 178 16, 125, 524 0.023452 288, 483 6, 766 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 513, 963 75, 297, 716 0.020106 8, 266, 923 166, 215 71.00 9, 547, 984 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1,049,168 48, 332, 483 0.021707 207, 258 72.00 07300 DRUGS CHARGED TO PATIENTS 1, 081, 610 117, 032, 351 17, 080, 449 73 00 0.009242 73 00 157, 858 73.01 07301 SPECIALTY PHARMACY 0.000000 0 73.01 07400 RENAL DIALYSIS 35, 869 4, 519, 237 0.007937 1, 384, 890 10, 992 74.00 74.00 76.00 03330 ENDOSCOPY 687,045 38, 965, 241 0.017632 2, 533, 097 44,664 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 76.01 0 0 0 76.01 76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 0 0 76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 76.03 0 76.03 03953 WOUND CARE 190, 093 8, 739, 469 370, 133 8, 051 76.04 0.021751 76.04 1, 101, 666 03954 I MAGING CENTER 68, 933, 388 0.015982 76.06 73.549 1, 175 76.06 76.07 03955 BREAST DIAGNOSTIC CENTER 587, 753 32, 741, 868 0.017951 0 76.07 07700 ALLOGENEIC HSCT ACQUISITION 77 00 0.000000 0 0 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 78.00 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 0 90. 01 04950 INFUSION CENTER 92, 445 595, 996 0.155110 1, 804 280 90.01 3, 928 90. 26 04975 SPINE CENTER 480, 554 0.008174 90.26 0 0.005129 91. 00 | 09100 | EMERGENCY 1, 157, 552 225, 704, 557 15, 413, 298 79, 055 91.00 1, 310, 746 17, 562, 687 0.074632 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 017, 747 75, 956 92.00 200.00 Total (lines 50 through 199) 20, 679, 409 1, 476, 129, 683 155, 073, 145 1, 992, 678 200. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT	ROUTINE SERVICE OTHER PASS THROUGH COSTS	Provider CCN: 15-0169	Peri od:	Worksheet D

llear til Tillanci al Systems	OWNING IT TOSETTAL	OI TNDIANA, TI	NC.	III LI C	u or roriii cws-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	S Provider C		eriod: rom 01/01/2023	Worksheet D Part III	
				0 12/31/2023		
		Ti tl e	e XVIII	Hospi tal	PPS	44 (1111
Cost Center Description	Nursi ng	Nursi ng	Allied Health		All Other	
· ·	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	C	0	0	0	
31.00 03100 INTENSIVE CARE UNIT	0	C	0	0	0	
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0	C	0	0	0	
40. 00 04000 SUBPROVI DER - I PF	0	C	0	0	0	1 .0.00
43. 00 04300 NURSERY	0	C	0	0	0	
200.00 Total (lines 30 through 199)	0	C	0	0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)		7.00		
INPATIENT ROUTINE SERVICE COST CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
30. 00 03000 ADULTS & PEDIATRICS	٨		74, 739	0.00	15, 843	30.00
31. 00 03100 NTENSI VE CARE UNI T	١		7, 063			
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			12, 644			
40. 00 04000 SUBPROVI DER - PF			4, 713			
43. 00 04300 NURSERY	ď		7, 614			
200.00 Total (lines 30 through 199)			106, 773			200.00
Cost Center Description	Inpati ent		100,773		17, 303	200.00
oost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9, 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31.00 03100 INTENSIVE CARE UNIT	0					31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT	0					35. 00
40. 00 04000 SUBPROVI DER - 1 PF	0					40.00
43. 00 04300 NURSERY	o					43.00
200.00 Total (lines 30 through 199)	0					200.00

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time Prepared: Heal th Financial Systems COMMUNITY HOSPITAL OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0169 THROUGH COSTS

					10 12/31/2023	5/24/2024 11:	pared: 44 am
			Ti tl e	e XVIII	Hospi tal	PPS	11 aiii
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health		
	, , , , , , , , , , , , , , , , , , ,	Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0)	0	0	50. 00
	05100 RECOVERY ROOM	0	0)	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0)	0	0	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0)	0	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	0	0)	0	0	55. 00
57. 00	05700 CT SCAN	0	0)	0	0	57. 00
58. 00	05800 MRI	0	0)	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0)	0	0	59. 00
60.00	06000 LABORATORY	0	0)	0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0)	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0)	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0)	0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0)	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0)	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0)	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0)	0	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0)	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0)	0	0	73. 00
	07301 SPECIALTY PHARMACY	0	0		0	0	73. 01
	07400 RENAL DIALYSIS	0	0)	0	0	74. 00
	03330 ENDOSCOPY	0	0)	0	0	76. 00
	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0)	0	0	76. 01
	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	1	0	0	76. 02
	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 03
	03953 WOUND CARE	0	0)	0	0	76. 04
	03954 I MAGI NG CENTER	0	0)	0	0	76. 06
	03955 BREAST DIAGNOSTIC CENTER	0	0)	0	0	76. 07
	07700 ALLOGENEIC HSCT ACQUISITION	0	_	1	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	,	,				
90. 00	09000 CLI NI C	0	_	•	0 0	1	
	04950 I NFUSI ON CENTER	0	_	1	0	0	
	04975 SPI NE CENTER	0	0	1	0	0	90. 26
	09100 EMERGENCY	0	0	7	0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			U	0	72.00
200.00	Total (lines 50 through 199)	0	0	יו	0 0	0	200. 00

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 THROUGH COSTS Part IV Date/Time Prepared: 5/24/2024 11:44 am Title XVIII Hospi tal Ratio of Cost Cost Center Description All Other Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 302, 911, 994 0.00000050.00 05100 RECOVERY ROOM 0 0 45, 743, 165 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 27, 014, 531 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 46, 701, 603 54 00 0.000000 54 00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 54, 670, 870 0.000000 55.00 57.00 05700 CT SCAN 112, 803, 107 0.000000 57.00 31, 406, 525 58.00 05800 MRI 0 0 0.000000 58 00 05900 CARDIAC CATHETERIZATION 0 0 59.00 4, 589, 374 0.000000 59.00 60.00 06000 LABORATORY 102, 502, 658 0.000000 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 1, 615, 394 0.000000 64.00 06500 RESPIRATORY THERAPY Ω 0.000000 65 00 38, 574, 124 65 00 66.00 06600 PHYSI CAL THERAPY 0 29, 497, 764 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 8, 510, 701 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 0 2, 633, 541 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69 00 11, 923, 261 0.000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 16, 125, 524 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 75, 297, 716 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 48, 332, 483 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 117, 032, 351 0.000000 73.00 73. 01 07301 SPECIALTY PHARMACY 0.000000 73.01 07400 RENAL DIALYSIS 4, 519, 237 74.00 0.000000 74.00 03330 ENDOSCOPY 38, 965, 241 76.00 0 0.000000 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0.000000 76.01 76 01 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0.000000 76.02 76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS 76. 03 0.000000 76.03 03953 WOUND CARE 0 0 8, 739, 469 0.000000 76.04 76.04 0 76.06 03954 I MAGING CENTER 0 68, 933, 388 0.000000 76.06 03955 BREAST DIAGNOSTIC CENTER 32, 741, 868 0.000000 76.07 0 76.07 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 0 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 0 0.000000 90.00 04950 INFUSION CENTER 0 595, 996 00000 90.01 0.000000 90.01 0 0 90. 26 | 04975 | SPI NE CENTER 480, 554 0.000000 90.26

0

0

0

0

0

225, 704, 557

1, 476, 129, 683

17, 562, 687

0.000000

0.000000

91.00

92.00

200.00

91.00

200.00

09100 EMERGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2023 THROUGH COSTS Part IV 12/31/2023 Date/Time Prepared: 5/24/2024 11:44 am Title XVIII Hospi tal PPS Outpati ent Cost Center Description Outpati ent Inpatient I npati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through to Charges Pass-Through Charges Charges Costs (col. (col. 6 ÷ col Costs (col. x col . 12) 13.00 x col. 10) 7) 9.00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 41, 544, 333 50.00 05000 OPERATING ROOM 0.000000 20. 458. 131 50.00 0 0 05100 RECOVERY ROOM 51.00 0.000000 4, 550, 191 4, 317, 082 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 0 52.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 3, 544, 234 0 4, 291, 181 54.00 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 6, 473, 587 0 9, 200, 993 55.00 55.00 0 57.00 05700 CT SCAN 0.000000 10, 549, 289 0 9, 805, 992 0 57.00 58.00 05800 MRI 0.000000 1, 901, 389 7, 995, 979 0 58.00 1, 045, 908 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0 59.00 0 15, 175, 405 0 06000 LABORATORY 5, 229, 620 60.00 0.000000 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 387, 336 18, 787 0 64.00 06500 RESPIRATORY THERAPY 65.00 0.000000 8, 030, 932 0 73, 889 0 65.00 06600 PHYSI CAL THERAPY 0 0.000000 67, 817 66 00 1, 561, 471 0 66.00 0 67.00 06700 OCCUPATIONAL THERAPY 0.000000 1, 277, 582 18, 778 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 0.000000 369, 933 5, 938 0 68.00 06900 ELECTROCARDI OLOGY 2, 683, 198 229, 189 69.00 69 00 0.000000 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 288, 483 2, 377, 011 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 8, 266, 923 0 4, 750, 338 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 9, 547, 984 4, 909, 110 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 0.000000 17, 080, 449 12, 433, 516 0 73 00 07301 SPECIALTY PHARMACY 0 73.01 0.000000 0 73.01 07400 RENAL DIALYSIS 0.000000 1, 384, 890 0 74.00 74.00 03330 ENDOSCOPY 76.00 0.000000 2, 533, 097 0 6, 458, 204 0 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 76.01 76.01 0 0 0 76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 0 76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 0 76.03 76.03 03953 WOUND CARE 370, 133 0 1, 688, 129 76.04 0.000000 0 76.04 0 03954 I MAGING CENTER 15, 164, 123 76.06 76.06 0.000000 73.549 0 03955 BREAST DIAGNOSTIC CENTER 76.07 0.000000 0 3, 012, 641 0 76.07 C 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77 00 0.000000 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 90.00 04950 INFUSION CENTER 0 90. 01 90. 01 0.000000 1,804 265, 382 0 0 90. 26 04975 SPINE CENTER 90.26 0.000000

0.000000

0.000000

15, 413, 298

1, 017, 747

155, 073, 145

0

0 91.00

0 92.00

0 200.00

17, 030, 869

130, 250, 955

448, 256

0

91. 00 | 09100 | EMERGENCY

09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

92.00

200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/24/2024 11:44 am Title XVIII Hospi tal PPS 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. 120814 20, 458, 131 2, 471, 629 50.00 51.00 05100 RECOVERY ROOM 0.178486 4, 317, 082 0 0 770, 539 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 0 458759 52 00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.199619 4, 291, 181 0 856, 601 54.00 05500 RADI OLOGY-THERAPEUTI C 0.096570 9, 200, 993 888, 540 55.00 57.00 05700 CT SCAN 0.035759 9, 805, 992 0 0 350, 652 57 00 05800 MRI 0 58.00 0.098745 7, 995, 979 789, 563 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.042695 59.00 06000 LABORATORY 0 60.00 0.192029 5, 229, 620 0 1,004,239 60.00 0 06400 INTRAVENOUS THERAPY 18, 787 64 00 0.538365 10, 114 64 00 65.00 06500 RESPIRATORY THERAPY 0. 256671 73,889 18, 965 65.00 06600 PHYSI CAL THERAPY 0.368178 67, 817 0 0 24, 969 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 6, 442 0.343064 18, 778 0 67.00 67.00 0 06800 SPEECH PATHOLOGY 5, 938 68.00 0.209410 1, 243 68 00 69.00 06900 ELECTROCARDI OLOGY 0. 101395 229, 189 0 0 23, 239 69.00 07000 ELECTROENCEPHALOGRAPHY 2, 377, 011 0 70.00 0.223437 531, 112 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 372869 4, 750, 338 0 0 1, 771, 254 71.00 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 1, 975, 730 72 00 0.402462 4, 909, 110 0 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 258148 12, 433, 516 17, 808 3, 209, 687 73.00 07301 SPECIALTY PHARMACY 0.000000 0 73.01 0 0 73.01 07400 RENAL DIALYSIS 0 74.00 0.504544 0 74.00 0 03330 ENDOSCOPY 6, 458, 204 0 0 949, 776 76.00 0.147065 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 0 76.01 0 76.01 03951 OTHER ANCILLARY SERVICE COST CENTERS 76.02 0.000000 76.02 0 03952 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 76.03 76.03 0 0 0 76.04 03953 WOUND CARE 0.248651 1, 688, 129 419, 755 76.04 0 03954 I MAGING CENTER 0.085990 15, 164, 123 1, 303, 963 76.06 76.06 0 76. 07 03955 BREAST DIAGNOSTIC CENTER 0.449578 3, 012, 641 1, 354, 417 76.07 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 0 77 00 77 00 Λ 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 0.000000 0 0 0 04950 INFUSION CENTER 90. 01 0.578796 265, 382 0 153, 602 90.01 90. 26 04975 SPINE CENTER 0.751766 0 0 90.26 91.00 09100 EMERGENCY 0.091415 17, 030, 869 0 0 1, 556, 877 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 448, 256 0 420, 842 92 00 0.938843 200.00 Subtotal (see instructions) 130, 250, 955 0 17, 808 20, 863, 750 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 130, 250, 955 0 17, 808 20, 863, 750 202. 00 Heal th Financial Systems

COMMUNITY HOSPITAL OF INDIANA, INC.

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0169

Period:
From 01/01/2023
To 12/31/2023

Part V
Date/Time Prepared: 5/24/2024 11: 44 am

Title XVIII

Hospital

PPS

Cost Center Description

Cost
Reimbursed
Services
Subject To
Ded. & Coins.
(see inst.)

(see inst.)

		Rei mbursed	Rei mbursed		
		Servi ces	Services Not		
		Subject To	Subject To		
		Ded. & Coins.	Ded. & Coins.		
		(see inst.)	(see inst.)		
		6.00	7. 00		
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	C	0		50. 00
51.00	05100 RECOVERY ROOM	C	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C	0		52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C	o		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	C	0		55. 00
57. 00	05700 CT SCAN		0		57. 00
58. 00	05800 MRI		Ö		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON				59. 00
60. 00	06000 LABORATORY				60.00
64. 00	06400 I NTRAVENOUS THERAPY				64. 00
	06500 RESPIRATORY THERAPY				65. 00
65. 00					1
66.00	06600 PHYSI CAL THERAPY				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0		67. 00
68. 00	06800 SPEECH PATHOLOGY		0		68. 00
	06900 ELECTROCARDI OLOGY	C	0		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	C	0		70. 00
71. 00		C	0		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	C	0		72. 00
73. 00		C	4, 597		73. 00
73. 01	07301 SPECIALTY PHARMACY	C	0		73. 01
74.00	07400 RENAL DIALYSIS	C	0		74.00
76. 00	03330 ENDOSCOPY	C	0		76. 00
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	C	0		76. 01
76. 02	03951 OTHER ANCILLARY SERVICE COST CENTERS	C	o		76. 02
76. 03	03952 OTHER ANCILLARY SERVICE COST CENTERS	C	o		76. 03
76. 04	03953 WOUND CARE	C	o		76. 04
76. 06	03954 I MAGI NG CENTER	C	0		76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	C	0		76. 07
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	C	o		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY		1		78. 00
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	C	0		7 90. 00
90. 01	04950 INFUSION CENTER	i c			90. 01
90. 26	04975 SPI NE CENTER		o o		90. 26
91. 00	09100 EMERGENCY				91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92. 00
200.00			4, 597		200. 00
200.00	,		4, 377		201.00
201.00	Only Charges		1		201.00
202.00			4, 597		202. 00
202.00	ince ondriges (Trile 200 Trile 201)	1	η τ, 377	I	1202.00

Heal th	Financial Systems COMM	IUNITY HOSPITAL	OF INDIANA. II	NC.	In Lie	u of Form CMS-2	2552-10
	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA				Peri od:	Worksheet D	
					From 01/01/2023	Part II	
			Component	CCN: 15-S169	To 12/31/2023	Date/Time Pre 5/24/2024 11:	pared:
-			Ti tl e	e XVIII	Subprovi der -	PPS	<u>44 am</u>
					IPF		
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,		(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	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATING ROOM	5, 077, 921	302, 911, 994	0.01676	4 0	0	50.00
51. 00	05100 RECOVERY ROOM	5, 077, 921		•		0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	1		•		0	
52. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 067, 905				_	
54. 00 55. 00	05500 RADI OLOGY-THERAPEUTI C	757, 270			· ·	222 0	54. 00 55. 00
57. 00	05700 CT SCAN	616, 678 130, 646		•		92	57.00
58.00	05800 MRI	685, 492				132	
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 441				132	59.00
60.00	06000 LABORATORY	493, 572				1, 525	
64. 00	06400 I NTRAVENOUS THERAPY	27, 496		•	· ·	1, 525	64.00
65.00	06500 RESPIRATORY THERAPY	609, 465		1		130	1
66. 00	06600 PHYSI CAL THERAPY	1, 347, 770		•	· ·	2, 048	
67. 00	06700 OCCUPATI ONAL THERAPY	88, 749		•	· ·	370	
68. 00	06800 SPEECH PATHOLOGY	16, 676			· ·	6	68.00
69.00	06900 ELECTROCARDI OLOGY	24, 456				35	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	378, 178		•	· ·	58	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 513, 963					71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 049, 168				0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 081, 610				3, 591	
73. 01	07301 SPECIALTY PHARMACY	1,001,010		0.00000		0, 0, 1	1
74. 00	07400 RENAL DI ALYSI S	35, 869				0	1
76. 00	03330 ENDOSCOPY	687, 045		l .		0	
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	007,010				0	1
76. 02	03951 OTHER ANCILLARY SERVICE COST CENTERS		1			0	1
76. 03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0		0.00000		0	76. 03
76. 04	03953 WOUND CARE	190, 093	8, 739, 469	II.		0	
76. 06	03954 I MAGI NG CENTER	1, 101, 666		•		0	76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	587, 753				0	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	007,700				0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY					_	1
2. 20	OUTPATIENT SERVICE COST CENTERS			2. 23000	-1		1
90.00	09000 CLI NI C	0	О	0.00000	0 0	0	90.00
90. 01	04950 INFUSION CENTER	92, 445	595, 996			0	90. 01
90. 26	04975 SPI NE CENTER	3, 928	480, 554			0	90. 26
91.00	09100 EMERGENCY	1, 157, 552	225, 704, 557	0.00512	9 298, 158	1, 529	91.00

0.005129

0.000000

595, 996 480, 554 225, 704, 557

0 17, 562, 687 19, 368, 663 1, 476, 129, 683

1, 157, 552

298, 158

1, 217, 698

91.00

0 92.00

9, 844 200. 00

1, 529

91. 00 09100 EMERGENCY

92. 00 | 09200 | 098ERVATION BEDS (NON-DISTINCT PART 200. 00 | Total (lines 50 through 199)

Health Financial Systems	COMMUNITY HOSPITAL	OF INDIANA, INC.	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0169	Peri od: From 01/01/2023	Worksheet D Part IV
THROUGH COSTS		Component CCN: 15-S169		
		Title XVIII	Subprovi der -	PPS
			IPF	

-			Ti tl e	xVIII	Subprovi der - I PF	PPS	TT GIII
	Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program		Allied Health	
		1.00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0	0		0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
57. 00	05700 CT SCAN	0	0		0	l ő	57. 00
58. 00	05800 MRI	0	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0			0	59. 00
60. 00	06000 LABORATORY	0	0			Ö	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0				0	64. 00
65. 00	06500 RESPIRATORY THERAPY	0	0			0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0			0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0			0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0			0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			0	70.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0			0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0			0	73. 00
73.00		0	0			1	
	07301 SPECIALTY PHARMACY	0	0		0	0	73. 01
74.00	07400 RENAL DIALYSIS	0	0			0	74. 00
76.00	03330 ENDOSCOPY	0	0			0	76. 00
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 01
	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 02
76. 03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0		0	0	76. 03
	03953 WOUND CARE	0	0		0	0	76. 04
	03954 I MAGI NG CENTER	0	0		0	0	76. 06
76. 07	03955 BREAST DI AGNOSTI C CENTER	0	0		0	0	76. 07
	07700 ALLOGENEI C HSCT ACQUISITION	0	0		0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0		0		90. 00
90. 01	04950 I NFUSI ON CENTER	0	0		0	1	90. 01
90. 26	04975 SPI NE CENTER	0	0		0	0	90. 26
	09100 EMERGENCY	0	0		0	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
200.00	Total (lines 50 through 199)	0	0	1	0 0	0	200. 00

	MUNITY HOSPITAL				eu of Form CMS-2	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der Co		Peri od:	Worksheet D	
THROUGH COSTS		Component (rom 01/01/2023 o 12/31/2023		nared:
		Component	3014. 13 3107	0 12/31/2023	5/24/2024 11:	44 am
		Title	XVIII	Subprovi der - I PF	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	,	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	C	302, 911, 994	0.000000	50.00
51. 00 05100 RECOVERY ROOM	0	0	C	45, 743, 165	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	C	27, 014, 531	0.000000	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0	C	46, 701, 603	0.000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	C	54, 670, 870	0.000000	55. 00
57. 00 05700 CT SCAN	0	0	C	112, 803, 107	0.000000	57. 00
58. 00 05800 MRI	0	0	C	31, 406, 525	0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	C	.,	0.000000	59. 00
60. 00 06000 LABORATORY	0	0	C	102, 502, 658	0.000000	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	C	1, 615, 394	0. 000000	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	C	38, 574, 124	0.000000	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0	C	29, 497, 764	0.000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	C	-, ,		
68. 00 06800 SPEECH PATHOLOGY	0	0	C			
69. 00 06900 ELECTROCARDI OLOGY	0	0	C		0. 000000	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	C	,		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C			1
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C			
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	C			
73. 01 07301 SPECIALTY PHARMACY	0	0	C		0. 000000	
74. 00 07400 RENAL DI ALYSI S	0	0	C	., ,		
76. 00 03330 ENDOSCOPY	0	0	C		0. 000000	
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C		0. 000000	
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C		0. 000000	
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	C		0. 000000	
76. 04 03953 WOUND CARE	0	0	C			
76. 06 03954 I MAGI NG CENTER	0	0	C			
76. 07 03955 BREAST DI AGNOSTI C CENTER	0	0	C			1
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	C		0.000000	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	C	0	0.000000	78. 00
OUTPATIENT SERVICE COST CENTERS					0.000000	00.00
90. 00 09000 CLI NI C	· · · · · ·	0	C	1	0.000000	
90. 01 04950 I NFUSI ON CENTER	0	0	C			1
90. 26 04975 SPI NE CENTER 91. 00 09100 EMERGENCY		0	C			
		0				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Total (lines 50 through 199)		l .				200. 00
200.00 Total (Tries 30 through 199)	1	ı O	1	1,410,127,003	I	₁ 200.00

APPORT	Financial Systems COMM TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	MUNITY HOSPITAL C RVICE OTHER PASS	Provi der C	CN: 15-0169 P	eriod: rom 01/01/2023	u of Form CMS-2 Worksheet D Part IV	
	000.10		Component	CCN: 15-S169 T	o 12/31/2023	Date/Time Pre 5/24/2024 11:	pared: 44 am
			Title	· XVIII	Subprovi der - I PF	PPS	<u> </u>
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7) 9.00	10.00	x col. 10) 11.00	12.00	x col . 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50.00	05000 OPERATING ROOM	0. 000000	0	0	O	0	50.00
51. 00	05100 RECOVERY ROOM	0. 000000	0			0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0			0	52.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	13, 718			0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	10, 710	0		0	55.00
57. 00	05700 CT SCAN	0. 000000	79, 399			0	57. 00
58. 00	05800 MRI	0. 000000	6, 054	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	0	0	0	59. 00
60.00	06000 LABORATORY	0. 000000	316, 814	0	0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	4, 838	0	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	8, 212	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	44, 817	0		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	35, 527	0		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	895	0		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	17, 062	0		0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	2, 465	0		0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	1, 218			0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0.000000	000 501	0		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000	388, 521	0		0	73.00
73. 01 74. 00	07301 SPECI ALTY PHARMACY 07400 RENAL DI ALYSI S	0. 000000 0. 000000	0			0	73. 01 74. 00
76.00	03330 ENDOSCOPY	0. 000000	0			0	76.00
76. 00	03950 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0			0	76. 00
76. 01	03951 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0		-	0	76. 02
76. 03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0. 000000	0			0	76. 03
76. 04	03953 WOUND CARE	0. 000000	0	_		0	76. 04
76. 06	03954 I MAGI NG CENTER	0. 000000	0	l o		0	76.06
76. 07	03955 BREAST DIAGNOSTIC CENTER	0. 000000	0			0	76. 07
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0			0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0			0	
	OUTPATIENT SERVICE COST CENTERS				1		
90.00	09000 CLI NI C	0. 000000	0	0	0	0	90.00
90. 01	04950 INFUSION CENTER	0. 000000	0	0	0	0	90. 01
	04975 SPI NE CENTER	0. 000000	0	_		0	90. 26
91.00	09100 EMERGENCY	0. 000000	298, 158	0	O	0	91.00

0. 000000 0. 000000

298, 158 1, 217, 698 0 90.00 0 90.01 0 90.26 0 91.00 0 92.00 0 200.00

Health Financial Systems COM	MUNITY HOSPITAL	OF INDIANA, IN	NC.	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	<u> </u>	Period: From 01/01/2023 Fo 12/31/2023	Worksheet D Part I Date/Time Pre 5/24/2024 11:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	8, 531, 912	0	8, 531, 912	74, 739	114. 16	30.00
31.00 INTENSIVE CARE UNIT	1, 101, 040		1, 101, 040	7, 063	155. 89	31.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 416, 746		1, 416, 746	12, 644	112. 05	35. 00
40. 00 SUBPROVI DER - I PF	250, 323	0	250, 323	4, 713	53. 11	40. 00
43. 00 NURSERY	484, 162		484, 162	7, 614	63. 59	43.00
200.00 Total (lines 30 through 199)	11, 784, 183		11, 784, 183	106, 773		200.00
Cost Center Description	Inpati ent	Inpati ent				
·	Program days	Program				
		Capital Cost				
		(coi. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	1, 811	206, 744				30.00
31.00 INTENSIVE CARE UNIT	585	91, 196				31.00
35.00 NEONATAL INTENSIVE CARE UNIT	1, 212	135, 805				35. 00
40. 00 SUBPROVI DER - I PF	0					40.00
43. 00 NURSERY	2, 964	188, 481				43.00
200.00 Total (lines 30 through 199)	6, 572					200.00
· · · · · · · · · · · · · · · · · · ·		•	•			•

Heal th	Financial Systems COMI	MUNITY HOSPITAL	OF INDIANA, II	NC.	In Lie	u of Form CMS-	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part II Date/Time Pre 5/24/2024 11:	pared: 44 am
			Ti tI	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	5, 077, 921	302, 911, 994	0. 01676	4 3, 204, 801	53, 725	50.00
51.00	05100 RECOVERY ROOM	541, 856	45, 743, 165	0. 01184	6 317, 617	3, 762	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 067, 905	27, 014, 531	0. 03953	1 654, 936	25, 890	52. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	757, 270	46, 701, 603	0. 01621	5 608, 379	9, 865	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	616, 678	54, 670, 870	0. 01128	0 815, 338	9, 197	55. 00
57.00	05700 CT SCAN	130, 646	112, 803, 107	0. 00115	8 1, 301, 477	1, 507	57. 00
58.00	05800 MRI	685, 492	31, 406, 525	0. 02182	6 260, 092	5, 677	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 441	4, 589, 374	0.00075	0 4, 269	3	59.00
60.00	06000 LABORATORY	493, 572	102, 502, 658	0. 00481	5 2, 538, 319	12, 222	60.00
64.00	06400 I NTRAVENOUS THERAPY	27, 496	1, 615, 394	0. 01702	1 46, 276	788	64.00
65.00	06500 RESPIRATORY THERAPY	609, 465	38, 574, 124	0. 01580	0 3, 028, 044	47, 843	65.00
66.00	06600 PHYSI CAL THERAPY	1, 347, 770	29, 497, 764	0. 04569	1 125, 750	5, 746	66.00
67.00	06700 OCCUPATI ONAL THERAPY	88, 749	8, 510, 701	0. 01042	8 196, 080	2, 045	67.00
68.00	06800 SPEECH PATHOLOGY	16, 676	2, 633, 541	0.00633	2 94, 190	596	68. 00
69.00	06900 ELECTROCARDI OLOGY	24, 456	11, 923, 261	0.00205	1 318, 036	652	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	378, 178	16, 125, 524	0. 02345	2 83, 522	1, 959	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 513, 963	75, 297, 716	0. 02010		16, 340	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	1, 049, 168	48, 332, 483	0. 02170	7 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 081, 610	117, 032, 351	0.00924	2 3, 645, 719	33, 694	73. 00
73. 01	07301 SPECIALTY PHARMACY	0		0. 00000		0	73. 01
74.00	07400 RENAL DI ALYSI S	35, 869	4, 519, 237	0.00793	7 328, 609	2, 608	74.00
76.00	03330 ENDOSCOPY	687, 045					
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0. 00000		0	
76. 02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0. 00000	0 0	0	76. 02
76. 03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0	0. 00000	0 0	0	76. 03
76. 04	03953 WOUND CARE	190, 093	8, 739, 469	0. 02175	1 61, 534	1, 338	76. 04
76. 06	03954 I MAGI NG CENTER	1, 101, 666	68, 933, 388	0. 01598	2 0	0	76.06
76. 07	03955 BREAST DIAGNOSTIC CENTER	587, 753		1		0	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		1		0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		0.00000			
	OUTPATIENT SERVICE COST CENTERS				-		
90.00	09000 CLI NI C	0	C	0.00000	0 0	0	90.00
90. 01	04950 INFUSION CENTER	92, 445	595, 996			Ō	
90. 26	04975 SPI NE CENTER	3, 928				ő	1
91. 00	09100 EMERGENCY	1, 157, 552				_	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 310, 746					
200.00			1, 476, 129, 683		20, 967, 512		

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT RO	TINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0169	Peri od: Worksheet D

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0169 Period: From 01/01/2023
To 12/31/2023 Date/Time Prepared Date/Time Prepared To 12/31/2023 Date/Time Prepared Date/Time Prepared To 12/31/2023 Date/Time Prepared Date/Time
Title XIX Hospital PPS
Nursing Program Post-Stepdown Adjustments Nursing Program
Nursing Program Post-Stepdown Adjustments Nursing Program Post-Stepdown Adjustment Nursing Program Post-Stepdown Nursing Program Post-Stepdown Adjustment Nursing Program Post-Stepdown Nursing Program Progr
Program Program Program Program Adjustments Adjustments Program Adjustments Program Adjustments Program Adjustments Program Adjustments Adjustments Program Adjustments Program Adjustments Program Adjustments Program Adjustments Program Adjustments Program Program Program Program Adjustments Program Adjustments Program Program Program Program Adjustments Program Program Program Program Adjustments Program
Program Program Program Program Adjustments Adjustments Program Adjustments Program Adjustments Program Adjustments Program Adjustments Adjustments Program Adjustments Program Adjustments Program Adjustments Program Adjustments Program Adjustments Program Program Program Program Adjustments Program Adjustments Program Program Program Program Adjustments Program Program Program Program Adjustments Program
Post-Stepdown Adjustments
Adj ustments
NPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 0 0 0 0 0 0 31.00 31.00 03100 INTENSI VE CARE UNIT 0 0 0 0 0 0 31.00 35.00 02060 NEONATAL INTENSI VE CARE UNIT 0 0 0 0 0 0 31.00 40.00 04000 SUBPROVI DER - IPF 0 0 0 0 0 0 0 43.00 04300 NURSERY 0 0 0 0 0 0 0 200.00 Total (lines 30 through 199) 0 0 0 0 0 0 Cost Center Description Swing-Bed Adjustment Amount (see instructions) 1 through 3, insus col. 4) 1 through 3, insus col. 4) 1 NPATIENT ROUTINE SERVICE COST CENTERS 30.00 0 0 0 0 0 1,811 30.00 1 NPATIENT ROUTINE SERVICE COST CENTERS 0 0 0 74,739 0.00 1,811 30.00 30.00 3000 ADULTS & PEDIATRICS 0 0 74,739 0.00 1,811 30.00 30.00 3000 ADULTS & PEDIATRICS 0 0 74,739 0.00 1,811 30.00 30.00 3000 ADULTS & PEDIATRICS 0 0 74,739 0.00 1,811 30.00 30.00 3000 ADULTS & PEDIATRICS 0 0 74,739 0.00 1,811 30.00 30.00 3000 ADULTS & PEDIATRICS 0 0 0 74,739 0.00 1,811 30.00 30.00 3000 ADULTS & PEDIATRICS 0 0 0 74,739 0.00 1,811 30.00 30.00 3000 ADULTS & PEDIATRICS 0 0 0 0 0 0 0 30.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 0 0 30.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 0 0 30.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 30.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 30.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 30.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 30.00 ADULTS & PEDIATRICS 0 0 0 0 30.00 30.00 A
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000 ADULTS & PEDIATRICS 0 0 0 0 0 30.00
30. 00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 30. 0 31. 00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 0 0 0 0 40. 00 04300 O4300 NURSERY 0 0 0 0 0 43. 00 04300 NURSERY 0 0 0 0 0 43. 00 04300 Total (lines 30 through 199) 0 0 0 0 Cost Center Description Swing-Bed Adjustment Amount (see instructions) 1 through 3, minus col. 4) 1 through 3, minus
31. 00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 0 0 0 0 0 35. 00 04000 04000 SUBPROVIDER - IPF 0 0 0 0 0 0 0 0 0
40. 00 040000 040000 040000 040000 040000 040000 040000 040000 040000 040000 040000 040000 040000 040000 0400000 0400000 0400000 04000000 040000000 0400000000
A3. 00 O O O O O O O O O
Total (lines 30 through 199)
Cost Center Description
Cost Center Description
Adjustment Amount (see 1 through 3, instructions) minus col. 4) INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS Adjustment (sum of cols. 1 through 3, minus col. 4) 4.00 5.00 6.00 7.00 8.00 74,739 0.00 1,811 30.00
Amount (see 1 through 3, mi nus col 4)
instructions minus col. 4
4. 00 5. 00 6. 00 7. 00 8. 00 INPATIENT ROUTINE SERVICE COST CENTERS
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 74,739 0.00 1,811 30.00
30. 00 03000 ADULTS & PEDIATRICS 0 0 74, 739 0. 00 1, 811 30. 0
31 00 10310011NTENSIVE CARE UNIT
35. 00 02060 NEONATAL NTENSI VE CARE UNIT 0 12, 644 0. 00 1, 212 35. 0
40. 00 04000 SUBPROVI DER - I PF 0 0 4, 713 0. 00 0 40. 0
43. 00 04300 NURSERY 0 7, 614 0. 00 2, 964 43. 0
200.00 Total (Lines 30 through 199) 0 106, 773 6, 572 200.0
Cost Center Description Inpatient
Program
Pass-Through
Cost (col. 7 x
<u>col. 8)</u>
9.00
INPATIENT ROUTINE SERVICE COST CENTERS
30. 00 03000 ADULTS & PEDI ATRI CS 0 30. 0
31.00 03100 INTENSIVE CARE UNIT 0 31.0
35.00 02060 NEONATAL NTENSIVE CARE UNIT 0 35.00
40. 00 04000 SUBPROVI DER - I PF 0 40. 0
43. 00 04300 NURSERY 0 43. 0
200.00 Total (lines 30 through 199) 0 200.0

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | To 12/31/ Health Financial Systems COMMUNITY HOSPITAL OF APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0169 THROUGH COSTS

					10 12/31/2023	5/24/2024 11:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
	·	Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	C	1	0		50. 00
51. 00	05100 RECOVERY ROOM	0	C		0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C	1	0	0	52. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	C		0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	C	1	0	0	55. 00
57. 00	05700 CT SCAN	0	C		0	0	57. 00
58. 00	05800 MRI	0	C	1	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	C	1	0	0	59. 00
60.00	06000 LABORATORY	0	C	1	0	0	60. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	C		0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	C		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	C	1	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	C	1	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C	1	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	C	1	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	C	1	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	1	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C	1	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C	1	0	0	73. 00
73. 01	07301 SPECI ALTY PHARMACY	0	C	1	0	0	73. 01
74. 00	07400 RENAL DI ALYSI S	0	C	1	0	0	74. 00
76. 00	03330 ENDOSCOPY	0	C		0	0	76. 00
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	0	C		0	0	76. 01
76. 02	03951 OTHER ANCILLARY SERVICE COST CENTERS	0	C		0	0	76. 02
76. 03	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	C		0	0	76. 03
76. 04	03953 WOUND CARE	0	C	1	0	0	76. 04
76. 06	03954 I MAGI NG CENTER	0	C	1	0	0	76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	0	C	1	0	0	76. 07
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	C	1	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	C		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	T		T		I	
90.00	09000 CLINIC	0	C	1	0 0		90.00
90. 01	04950 I NFUSI ON CENTER	0	C .	1	0 0		90. 01
90. 26	04975 SPI NE CENTER	0	C .	1	0	0	90. 26
91. 00	09100 EMERGENCY	0	C	1	0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	_	[0	0	92.00
200.00	Total (lines 50 through 199)	0	C	1	0 0	1 0	200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPITAL OF INDIANA, INC. APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2023 To 12/31/2023 THROUGH COSTS Part IV Date/Time Prepared: 5/24/2024 11:44 am Title XIX Hospi tal Ratio of Cost Cost Center Description All Other Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 302, 911, 994 0.00000050.00 05100 RECOVERY ROOM 0 0 45, 743, 165 0.000000 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 27, 014, 531 0.000000 52.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 46, 701, 603 54 00 0.000000 54 00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 54, 670, 870 0.000000 55.00 57.00 05700 CT SCAN 112, 803, 107 0.000000 57.00 31, 406, 525 58.00 05800 MRI 0 0 0.000000 58 00 05900 CARDIAC CATHETERIZATION 0 0 59.00 4, 589, 374 0.000000 59.00 60.00 06000 LABORATORY 102, 502, 658 0.000000 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 1, 615, 394 0.000000 64.00 06500 RESPIRATORY THERAPY Ω 0.000000 65 00 38, 574, 124 65 00 66.00 06600 PHYSI CAL THERAPY 0 29, 497, 764 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 8, 510, 701 0.000000 67.00 67.00 06800 SPEECH PATHOLOGY 0 2, 633, 541 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69 00 11, 923, 261 0.000000 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 16, 125, 524 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 75, 297, 716 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 48, 332, 483 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 117, 032, 351 0.000000 73.00 73. 01 07301 SPECIALTY PHARMACY 0.000000 73.01 07400 RENAL DIALYSIS 4, 519, 237 74.00 0.000000 74.00 03330 ENDOSCOPY 38, 965, 241 76.00 0 0.000000 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0 0.000000 76.01 76 01 03951 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 76.02 76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS 76. 03 0.000000 76.03 03953 WOUND CARE 0 0 8, 739, 469 0.000000 76.04 76.04 0 76.06 03954 I MAGING CENTER 0 68, 933, 388 0.000000 76.06 03955 BREAST DIAGNOSTIC CENTER 32, 741, 868 0.000000 76.07 0 76.07 0 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0.000000 77.00 07800 CAR T-CELL IMMUNOTHERAPY 0 0 78.00 0 0.000000 78.00 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 0.000000 90.00 04950 INFUSION CENTER 0 595, 996

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90. 26 | 04975 | SPI NE CENTER

09100 EMERGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2023 THROUGH COSTS Part IV 12/31/2023 Date/Time Prepared: 5/24/2024 11:44 am Title XIX Hospi tal PPS Outpati ent Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Program Ratio of Cost Program Program Program Pass-Through to Charges Pass-Through Charges Charges Costs (col. (col. 6 ÷ col Costs (col. x col . 12) 13.00 7) x col. 10) 11. 00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 3, 204, 801 0 0 50.00 0 05100 RECOVERY ROOM 51.00 0.000000 317, 617 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 654, 936 0 52.00 52.00 0 05400 RADI OLOGY-DI AGNOSTI C 0.000000 608, 379 0 54.00 0 54.00 0 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 815, 338 55.00 0 0 57.00 05700 CT SCAN 0.000000 1, 301, 477 0 57.00 58.00 05800 MRI 0.000000 260, 092 0 0 58.00 0 59.00 05900 CARDIAC CATHETERIZATION 0.000000 59.00 4 269 0 0 06000 LABORATORY 60.00 0.000000 2, 538, 319 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 46, 276 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0.000000 3, 028, 044 0 65.00 0 06600 PHYSI CAL THERAPY 0.000000 125, 750 66 00 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 196, 080 0 67.00 06800 SPEECH PATHOLOGY 0.000000 94, 190 0 68.00 0 68.00 06900 ELECTROCARDI OLOGY 318.036 0 69.00 69 00 0.000000 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0.000000 83, 522 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 812, 685 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 0.000000 3, 645, 719 0 Ω 73 00 07301 SPECIALTY PHARMACY 73.01 0.000000 0 73.01 07400 RENAL DIALYSIS 0.000000 328, 609 0 74.00 74.00 03330 ENDOSCOPY 0 76.00 0.000000 207, 619 0 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0 0.000000 76.01 76.01 0 76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 C 0 76.02 03952 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 0 76.03 76.03 03953 WOUND CARE 0 76.04 0.000000 61, 534 0 76.04 0 03954 I MAGING CENTER 0.000000 76.06 76.06 C 0 03955 BREAST DIAGNOSTIC CENTER 0 76.07 0.000000 0 0 76.07 07700 ALLOGENEIC HSCT ACQUISITION 0 77.00 77.00 0.000000 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 90.00 04950 INFUSION CENTER 0 90. 01 90. 01 0.000000 Ω 0 0

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90. 26 04975 SPINE CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

91. 00 | 09100 | EMERGENCY

92.00

200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0169 Peri od: Worksheet D From 01/01/2023 Part V Date/Time Prepared: 12/31/2023 5/24/2024 11:44 am Title XIX Hospi tal PPS 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. 123222 2, 172, 663 0 50.00 51.00 05100 RECOVERY ROOM 0.178486 417, 517 51.00 05200 DELIVERY ROOM & LABOR ROOM 52 00 0 458759 0 52 00 C 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.199619 0 824, 967 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0.096570 594, 166 0 55.00 57.00 05700 CT SCAN 0.035759 0 2, 706, 744 57.00 0 05800 MRI 58.00 0.098745 228, 718 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.042695 0 59.00 06000 LABORATORY 60.00 0.192029 1, 244, 364 0 60.00 06400 I NTRAVENOUS THERAPY 64 00 0.538365 489 64 00 0 65.00 06500 RESPIRATORY THERAPY 0. 256671 152, 771 0 65.00 06600 PHYSI CAL THERAPY 0.368178 223, 944 0 66.00 66.00 06700 OCCUPATIONAL THERAPY 0.343064 45,023 67.00 67.00 0 60, 979 68.00 06800 SPEECH PATHOLOGY 0.209410 0 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0. 101395 0 44, 666 0 69.00 0. 223437 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 156, 349 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 372869 0 71.00 444, 620 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 0.402462 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0. 258148 433, 082 0 73.00 07301 SPECIALTY PHARMACY 0.000000 73.01 73.01 C 0 07400 RENAL DIALYSIS 74.00 0.504544 0 0 74.00 03330 ENDOSCOPY 0 395, 866 76.00 0.147065 0 76.00 03950 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 0 76.01 76.01 03951 OTHER ANCILLARY SERVICE COST CENTERS 76.02 0.000000 76.02 0 03952 OTHER ANCILLARY SERVICE COST CENTERS 0.000000 0 76.03 0 76.03 0 76.04 03953 WOUND CARE 0. 248651 0 233, 288 0 76.04 03954 I MAGING CENTER 0.085990 502, 558 76.06 76.06 0 0 76. 07 03955 BREAST DIAGNOSTIC CENTER 0.449578 364, 249 0 76.07 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 0 77 00 77 00 0 Λ 0 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0.000000 0 78.00 OUTPATIENT SERVICE COST CENTERS 90.00 0.000000 0 90.00 09000 CLINIC 0 04950 INFUSION CENTER 90.01 0.578796 0 539 0 90.01 90. 26 04975 SPINE CENTER 0.751766 0 0 0 0 90.26 91.00 09100 EMERGENCY 0.092571 0 8, 239, 451 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92 00 0 0.938843 Ω 200.00 Subtotal (see instructions) C 19, 487, 013 0 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 19, 487, 013 0 202.00

Heal th Financial Systems

COMMUNITY HOSPITAL OF INDIANA, INC.

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 15-0169

Period:
From 01/01/2023
To 12/31/2023

Part V
Date/Time Prepared:
5/24/2024 11: 44 am

PPS

Cost Center Description

Cost
Rei mbursed
Services
Services Not

				CAIA	1 HOSPI tai	113	
		Cos	sts				
	Cost Center Description	Cost	Cost				
	, , , , , , , , , , , , , , , , , , ,	Rei mbursed	Rei mbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6. 00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	267, 720	0				50.00
51.00	05100 RECOVERY ROOM	74, 521	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	164, 679	0				54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	57, 379		1			55. 00
	1	1		•			1
57. 00	05700 CT SCAN	96, 790		•			57.00
58. 00	05800 MRI	22, 585		1			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60.00	06000 LABORATORY	238, 954	0				60. 00
64.00	06400 I NTRAVENOUS THERAPY	263	0				64. 00
65.00	06500 RESPIRATORY THERAPY	39, 212	0				65. 00
66. 00	06600 PHYSI CAL THERAPY	82, 451	0				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	15, 446		1			67. 00
68. 00	06800 SPEECH PATHOLOGY	12, 770	l e				68. 00
	1 1	1		1			1
69. 00	06900 ELECTROCARDI OLOGY	4, 529					69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	34, 934		1			70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	165, 785	0				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	111, 799	0				73. 00
73. 01	07301 SPECIALTY PHARMACY		0				73. 01
74. 00	07400 RENAL DIALYSIS	0	0				74. 00
76. 00	03330 ENDOSCOPY	58, 218	Ö				76. 00
76. 01	03950 OTHER ANCILLARY SERVICE COST CENTERS	30, 210	0	•			76. 01
76. 01	03951 OTHER ANCILLARY SERVICE COST CENTERS		0	•			
	l l						76. 02
	03952 OTHER ANCILLARY SERVICE COST CENTERS	0	0				76. 03
	03953 WOUND CARE	58, 007					76. 04
	03954 I MAGI NG CENTER	43, 215					76. 06
76. 07	03955 BREAST DIAGNOSTIC CENTER	163, 758	0				76. 07
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
	OUTPATIENT SERVICE COST CENTERS						1
90. 00	09000 CLINIC	0	0				90.00
	04950 I NFUSION CENTER	· ·		•			1
	1 1	312					90. 01
90. 26	04975 SPI NE CENTER	0	1 0				90. 26
91. 00	09100 EMERGENCY	762, 734	0				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
200.00	Subtotal (see instructions)	2, 476, 061	0				200. 00
201.00	Less PBP Clinic Lab. Services-Program						201.00
	Only Charges						
202.00		2, 476, 061	0				202. 00
	1 3 3 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4 4			1			1

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169	Period: From 01/01/2023	Worksheet D-1
				Date/Time Prepared: 5/24/2024 11:44 am
		Title XVIII	Hospi tal	PPS

			10 12,01,2020	5/24/2024 11: 4	44 am
		Title XVIII	Hospi tal	PPS	
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		74, 739	1.00
2.00	Inpatient days (including private room days, excluding swing-b	ped and newborn days)		74, 739	2.00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	ivate room days,	0	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		63, 257	4.00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	r 31 of the cost	0	5.00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December :	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)				
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	15, 843	9. 00
	newborn days) (see instructions)				
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 instruct			_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, er				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	confy (including private	e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	/! /!!d!!+			12 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14 00	after December 31 of the cost reporting period (if calendar ye			0	14 00
	Medically necessary private room days applicable to the Progra	am (excluding Swing-bed o	uays)		14. 00 15. 00
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
16. 00					16.00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	a through Documber 21 o	E the cost	0.00	l 17. 00
17.00		es through becember 31 o	i the cost	0.00	17.00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	os after December 21 of	the cost	0.00	18. 00
10.00	reporting period	es ai tei beceilbei 31 01	the cost	0.00	10.00
19. 00					19. 00
17.00	reporting period				17.00
20. 00					20.00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions	5)		107, 328, 220	21.00
	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22. 00
	5 x line 17)	•	3 · · · ·		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	o	23.00
	x line 18)				
24.00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)				
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		107, 328, 220	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	1
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges)			0	30.00
	General inpatient routine service cost/charge ratio (line 27 ÷	- line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)				32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mir		tions)	0. 00	
	Average per diem private room cost differential (line 34 x lin	ne 31)		0. 00	
	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37.00		and private room cost di	fferential (line	107, 328, 220	37.00
	General inpatient routine service cost net of swing-bed cost a	ind private room cost di			ı
	27 minus line 36)	and private room cost di			
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY	•			
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see	ISTMENTS i nstructions)		1, 436. 04	
38. 00 39. 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	ISTMENTS instructions) 38)		22, 751, 182	39.00
38. 00 39. 00 40. 00	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	ISTMENTS instructions) 38) am (line 14 x line 35)			39. 00 40. 00

	Financial Systems COMM ATION OF INPATIENT OPERATING COST	UNITY HOSPITAL	Provider Co	CN: 15-0169 F	Peri od:	worksheet D-1	
					From 01/01/2023 To 12/31/2023	Date/Time Pre	
			Title	XVIII	Hospi tal	5/24/2024 11: PPS	44 am
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days		+	(col. 3 x col.	
		1. 00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0					42. 00
	Intensive Care Type Inpatient Hospital Units						
	INTENSIVE CARE UNIT	16, 667, 899	7, 063	2, 359. 89	1, 713	4, 042, 492	
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGI CAL INTENSI VE CARE UNI T						46. 00
7. 00	NEONATAL INTENSIVE CARE UNIT	20, 025, 177	12, 644	1, 583. 7	0	0	47. 00
	Cost Center Description					1. 00	
8. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	Line 200)			29, 254, 351	48. 00
	Program inpatient cellular therapy acquisition			III, line 10,	column 1)	0	1
9. 00	Total Program inpatient costs (sum of lines	41 through 48.0	1)(see instruc	tions)		56, 048, 025	49. 00
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	sarvicas (from	Wket D sum	of Parts I and	2, 075, 677	50.00
0.00	III)	atrent routine	services (ITOIII	WKSt. D, Suiii	or rarts r and	2,073,077	30.00
1. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, su	m of Parts II	1, 992, 678	51.00
2 00	and IV)	50 and 51)				4 040 355	E2 00
2. 00 3. 00	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclud		lated non-phy	sician anesthe	etist and	4, 068, 355 51, 979, 670	
	medical education costs (line 49 minus line !		ratou, non prij	or or arr arrostric	otrot, and	01,777,070] 00.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges Target amount per discharge					0 0. 00	
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor	use only)				0.00	55. 02
	Target amount (line 54 x sum of lines 55, 55,					0	
7. 00 8. 00	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and ta	irget amount (I	ine 56 minus I	ine 53)	0	
9. 00	Trended costs (lesser of line 53 ÷ line 54, o	or line 55 from	the cost repo	rting period e	endi ng 1996,	0.00	
	updated and compounded by the market basket)		•	0.			
0. 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	om prior year c	ost report, up	dated by the	0. 00	60.00
1. 00	market basket) Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus						61.00
	55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line						
	53) are less than expected costs (lines 54×10^{-2} enter zero. (see instructions)	60), or 1 % of	the target am	ount (line 56)	, otherwise		
2. 00	Relief payment (see instructions)					0	62. 00
3.00	Allowable Inpatient cost plus incentive payme	ent (see instru	ıctions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST		21 -6 +1-			0	(4.00
4. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	is through Dece	ember 31 of the	cost reportir	ig period (see	0	64. 00
5. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
, 00	instructions)(title XVIII only)		/	F) (+: +1 - \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	1\	0	// 00
6. 00	Total Medicare swing-bed SNF inpatient routing CAH, see instructions	ne costs (Tine	64 prus rine 6	5)(title XVIII	only); For	0	66. 00
7. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost rep	orting period	0	67. 00
	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after L	ecember 31 of	the cost repor	fing period	0	68. 00
59. 00	Total title V or XIX swing-bed NF inpatient (outine costs (line 67 + line	68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLY			
	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of						70.00
	Program routine service cost (line 9 x line	,	rne 70 ÷ rrne	2)			71.00
	Medically necessary private room cost applica	,	ı (line 14 x li	ne 35)			73. 00
	Total Program general inpatient routine servi	•					74. 00
5. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service	costs (from W	orksheet B, Pa	irt II, column		75. 00
6. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
7. 00	Program capital-related costs (line 9 \times line	76)					77. 00
	Inpatient routine service cost (line 74 minus		roviden r '	6)			78.00
	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			*.	ıs line 79)		79. 00 80. 00
	Inpatient routine service cost per diem limit			75 111110	, ,		81.00
	Inpatient routine service cost limitation (li		•				82.00
	Reasonable inpatient routine service costs (is)				83.00
	Program inpatient ancillary services (see in						

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der Co		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/24/2024 11:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	8, 531, 912	107, 328, 220	0. 079494	16, 488, 611	1, 310, 746	90.00
91.00 Nursing Program cost	0	107, 328, 220	0. 000000	16, 488, 611	0	91.00
92.00 Allied health cost	0	107, 328, 220	0. 000000	16, 488, 611	0	92.00
93.00 All other Medical Education	0	107, 328, 220	0. 000000	16, 488, 611	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lieu	of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 1	15-0169 Peri od: From 01/01/2023	Worksheet D-1
	Component CCN:	15-S169 To 12/31/2023	
	Title XVI	III Subprovider -	PPS

		Title XVIII	Subprovi der - I PF	PPS	
	Cost Center Description			4.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			4, 713	
2. 00 3. 00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed days)		ivato room days	4, 713 0	2. 00 3. 00
3.00	do not complete this line.	ys). IT you have only pr	I vate 100iii days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be			4, 713	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	er 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om davs) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days, ares becomber	0. 0. 1 0001	Ü	0.00
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ii days) arter becember s	ii oi the cost	O	0.00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	1, 829	9. 00
10.00	newborn days) (see instructions)	alv (i palveli pa privata r	soom dovo)	0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc-		ooiii days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
10.00	December 31 of the cost reporting period (if calendar year, el			0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XII through December 31 of the cost reporting period	x only (including privat	e room days)	0	12. 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XII	X only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar y				
14. 00 15. 00	Medically necessary private room days applicable to the Progratoral nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 c	of the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
04 00	reporting period	`		4 (00 050	04.00
21. 00 22. 00	Total general inpatient routine service cost (see instruction: Swing-bed cost applicable to SNF type services through December		ing period (line	4, 682, 350 0	21. 00 22. 00
22.00	5 x line 17)		ing period (ine	G	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
21.00	7 x line 19)		ing period (inite	G	21.00
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 682, 350	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		,		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d and observation bed ch	arges)	0	28. 00 29. 00
30. 00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	•
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mil	nus lino 22)(soo instruc	etions)	0. 00 0. 00	•
35. 00	Average per diem private room cost differential (line 34 x li		.(10115)	0.00	1
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	4, 682, 350	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			993. 50	
39.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			1, 817, 112 0	39. 00 40. 00
40. 00 41. 00	Total Program general inpatient routine service cost (line 39)	,		1, 817, 112	
	, J. J		ļ		

		UNITY HOSPITAL O		01/0		eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CCN: 15 Component CCN: 1		Period: From 01/01/2023 To 12/31/2023		epare
			Title XVII	ı	Subprovi der -	5/24/2024 11: PPS	44 ai
	Cost Center Description	Total Inpatient Costlin	Total Ave	rage Per (col. 1	Program Days	Program Cost (col. 3 x col.	
			C	ol . 2)		4)	
2. 00	NURSERY (title V & XIX only)	1.00	2. 00	3. 00 0. 0	4. 00 0 0	5.00) 42.
	Intensive Care Type Inpatient Hospital Units	-	-1			_	
3.00	INTENSIVE CARE UNIT	0	0	0.0	0 0	0	
4. 00 5. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 45.
6. 00	SURGI CAL INTENSIVE CARE UNIT						46.
7. 00	NEONATAL INTENSIVE CARE UNIT	0	0	0.0	0 0	0	47.
	Cost Center Description					1.00	-
8. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3,	line 200)			230, 888	48.
	Program inpatient cellular therapy acquisiti				column 1)	0	
9. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48.01)	(see instructions	5)		2, 048, 000	49.
0. 00	Pass through costs applicable to Program inpa	atient routine se	ervices (from Wkst	. D, sum	of Parts I and	97, 138	50.
	111)		•				
1. 00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (from Wk	st. D, s	um of Parts II	9, 844	51.
2. 00	Total Program excludable cost (sum of lines	50 and 51)				106, 982	52
3. 00	Total Program inpatient operating cost exclu	ding capital rela	nted, non-physicia	ın anesth	etist, and	1, 941, 018	53
	medical education costs (line 49 minus line !	52)					
1. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54
	Target amount per discharge					0.00	
5. 01	Permanent adjustment amount per discharge					0.00	
5. 02 5. 00	Adjustment amount per discharge (contractor Target amount (line 54 x sum of lines 55, 55					0.00	1
7. 00	Difference between adjusted inpatient operation		et amount (line 5	66 minus	line 53)	0	
3. 00	Bonus payment (see instructions)				,	0	
9. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or line 55 from t	the cost reporting	period (endi ng 1996,	0.00	59.
0. 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	prior year cost r	eport, u	pdated by the	0.00	60.
	market basket)		'		·		
1. 00	Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of the	amount by which	operati n	g costs (line	0	61
2. 00	Relief payment (see instructions)					0	
. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	i ons)			0	63
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the cost	reporti	ng period (See	0	64
5. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)</pre>	ts after December	31 of the cost r	eporti ng	period (See	0	65
5. 00	Total Medicare swing-bed SNF inpatient routil CAH, see instructions	ne costs (line 64	l plus line 65)(ti	tle XVII	l only); for	0	66
7. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through [December 31 of the	cost re	porting period	0	67
8. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after Dec	cember 31 of the d	ost repo	rting period	0	68.
9. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69
0. 00	Skilled nursing facility/other nursing facility			line 37)			70
1. 00	Adjusted general inpatient routine service c	ost per diem (lir		,			71
2.00	Program routine service cost (line 9 x line 1)	•	lino 14 v lino 25	:)			72
3. 00 4. 00	Medically necessary private room cost applications and program general inpatient routine services.		•	")			73
5. 00	Capital -related cost allocated to inpatient			neet B, P	art II, column		75
	26, line 45)						_,
	Don diem conital maletal acata (1:00 75 1:	20 21					
6. 00 7. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76

Heal th	Financial Systems COM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	eu of Form CMS-2	2552-10
COMPUTA	ATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
			Component (CCN: 15-S169	From 01/01/2023 To 12/31/2023		
			Title	XVIII	Subprovi der – I PF	PPS	
	Cost Center Description						
						1. 00	
89. 00	Observation bed cost (line 87 x line 88) (s	ee instructions)				0	89. 00
	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	Capi tal -rel ated cost	250, 323	4, 682, 350	0. 05346	1 0	0	90. 00
91.00	Nursing Program cost	0	4, 682, 350	0.00000	0	0	91. 00
92.00	Allied health cost	0	4, 682, 350	0. 00000	0	0	92. 00
93. 00	All other Medical Education	0	4, 682, 350	0. 00000	0	0	93. 00

Health Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0169	Peri od: From 01/01/2023	Worksheet D-1 Date/Time Prepared:
			10 12/01/2020	5/24/2024 11: 44 am
		Title XIX	Hospi tal	PPS

100 Total iswing-bed SNF Type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if period (if calendar year, enter 0 on this line) reporting period (if period (if calendar year, enter 0 on this line) reporting period (if period (if calendar year, enter 0 on this line) reporting period (if period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting period (if calendar year, enter 0 on this line) reporting pe					5/24/2024 11:	44 am
PART 1 - ALL PROVIDER COMPONENTS			Title XIX	Hospi tal	PPS	
PART - ALL PROVIDER COMPONENTS		Cost Center Description				
Name					1. 00	
1.00 Inpatient days (Including private room days, excluding swing-bed days, excluding newborn) 74,739 1.00 Inpatient days (Including private room days, excluding swing-bed and neaborn days) 74,739 1.00 Inpatient days (Including private room days) 74,739 1.00 Inpatient days (Including private room days) 74,739 1.00 Inpatient days (Including private room days) 75,00 Including period (Including private room days) 75,00 Including period (Including private room days) 75,00 Including period (Including period (Including private room days) 75,00 Including period (Including period (Including private room days) 75,00 Including period (Including period (Including private room days) 75,00 Including period (Including period (Including private room days) 75,00 Including period (Including period (Including private room days) 75,00 Including period (Including pe						1
1,000 private room days (secluding simpled and newborn days) 1,7 you have room days (seel instructions) 3,000 private room days (seel unding simpled and observation bed days) 1,7 you have only private room days (seel instructions) 3,000 1	4 00				74 700	1
7 rivate room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this. I line. Incomplete this line. Incomplete this. Incomplete this line. Incomplet						
do not complete this line. Semi-private room days (excluding swing-bed and observation bed days) Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1.81) Total inpatient days including private room days applicable at the Program (excluding swing-bed and 1.81) Total inpatient days including private room days applicable at the Program (excluding swing-bed and 1.81) Total inpatient days including private room days) Total inpatient days including private room days applicable to the Program (excluding swing-bed and 1.81) Total inpatient days including private room days) Total inpatient days including private room days) Total inpatient days applicable to title XVIII only (including private room days) Total inpatient days applicable to title XVIII only (including private room days) Total inpatient days applicable to titles V or XIX only (including private room days) Total inpatient days applicable to titles V or XIX only (including private room days) Total inpatient days applicable to titles V or XIX only (including private room days) Total inpatient days applicable to the Program (excluding swing-bed days) Total inpatient days applicable to the Program (excluding swing-bed days) Total inpatient days applicable to titles V or XIX only (including private room days) Total inpatient days (title V or XIX only) Total inpatient days (title V or XIX only)				ivato room dave		
6.2 Semi-private room days (excluding swing-bed and observation bed days) 6.0 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost perfitting period in the swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (including period to the swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) afte	3.00		(s). If you have only pr	i vate i ooni days,	J	3.00
total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calandar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calandar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calandar year, enter 0 on this line) Total sing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calandar year, enter 0 on this line) Total sing-bed NF type inpatient days applicable to the Program (excluding swing-bed and newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to the Cost reporting period (if calandar year, enter 0 on this line) December 31 of the cost reporting period (if calandar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calandar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) Total increase year, the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) Total increase year, the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to services through December 31 of the cost Total increase year, the period (if calendar year, enter 0 on this line) Medicare rate for swing-bed NF services applicable to services through December 31 of the co	4.00	· ·	ed days)		63, 257	4. 00
reporting period O Total swing-bed SNR type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total sing-bed Mr type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total sing-bed Mr type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions) Total inpatient days including private room days applicable to the Program (excluding swing-bed swing-bed SNF type inpatient days applicable to the Program (excluding private room days) Through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title SV or XIX only (including private room days) Through December 31 of the cost reporting period (see instructions) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) Through December 31 of the cost reporting period (see instructions) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) Through December 31 of the cost reporting period (see instructions) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) Total increase and NF type inpatient days applicable to services through December 31 of the cost (see instructions) Swing-bed NF type inpatient days applicable to services through December 31 of the cost (see instructions) Swing-bed Cost applicable to SNF services applicable to services after December 31 of the cost (see instructions) Medicale rate for swing-bed SNF services applicable to services after December 31 o				r 31 of the cost	00,20,	5. 00
10				- 1		
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and Total inpatient days including private room days applicable to the title XVII only (including private room days) after becember 31 of the cost reporting period (If calendar year, enter 0 on this line) 11.00 Swing-bed SNF type inpatient days applicable to title XVII only (including private room days) after becember 31 of the cost reporting period (If calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to title XVII only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 13.00 Swing-bed DAUDISTIMEN 14.00 Nursery days (title V or XIX only) 15.00 Total inversery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 Nedicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 Nedicare rate for swing-bed SNF services after December 31 of the cost reporting period (line 6 Nedicare rate for swing-bed SNF services after December 31	6.00		om days) after December :	31 of the cost	0	6.00
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41. 00 Total Troy am general impatrent routine service cost (Time 37 + Time 40) 2,019,412 41. 0		, , , , , , , , , , , , , , , , , , , ,	,			
	+ 1.00	Trotal Trogram general impatrent routine service cost (IIIIe 39	11116 40)	l	2,017,412	1 41.00

	Financial Systems COMM ATION OF INPATIENT OPERATING COST	UNITY HOSPITAL		CN: 15-0169	Peri od:	eu of Form CMS-2 Worksheet D-1	
					From 01/01/2023 To 12/31/2023		
			T: +	le XIX	Hospi tal	5/24/2024 11: PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Days	Diem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	5, 618, 275	7, 61	4 737.8	39 2, 964	2, 187, 106	42. 00
43. 00	INTENSIVE CARE UNIT	16, 667, 899	7, 063	2, 359. 8	39 585	1, 380, 536	43. 00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	NEONATAL INTENSIVE CARE UNIT	20, 025, 177	12, 64	1, 583.	77 1, 212	1, 919, 529	
	Cost Center Description		<u> </u>				
48. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	R line 200)			1. 00 4, 275, 155	48. 00
	Program inpatient cellular therapy acquisition			III, line 10,	column 1)	0	1
	Total Program inpatient costs (sum of lines				<u> </u>	12, 381, 738	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program input	ationt routine	sarvicas (fro	m Wket D sum	n of Darts I and	622, 226	50.00
0.00	III)	atrent routine	services (110	ii wkst. D, suii	TOT TALLS I AND	022, 220	30.00
1. 00	Pass through costs applicable to Program inpand IV)	atient ancillar	ry services (f	rom Wkst. D, s	sum of Parts II	259, 755	51.00
2. 00	Total Program excludable cost (sum of lines	50 and 51)				881, 981	52.00
53. 00	Total Program inpatient operating cost exclu	ding capital re	elated, non-phy	ysician anesth	netist, and	11, 499, 757	53.00
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					-
54. 00	Program discharges					0	54.00
	Target amount per discharge					0.00	55. 00
	Permanent adjustment amount per discharge						55. 0°
	Adjustment amount per discharge (contractor					0.00	1
6.00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat			line 56 minus	line 53)	0 0	
58. 00	Bonus payment (see instructions)	ng cost and te	inger amount (1110 00 11111103	11110 00)	Ö	
59. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost rep	orting period	endi ng 1996,	0.00	59.00
50. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line 55 fro	m prior vear	rost renort i	indated by the	0.00	60.00
0.00	market basket)	01 11110 00 110	m piroi year .	oost roport, t	ipaated by the	0.00	00.00
51. 00	Continuous improvement bonus payment (if line					0	61.00
	55.01, or line 59, or line 60, enter the less (53) are less than expected costs (lines (54) x						
	enter zero. (see instructions)	00), 01 1 % 01	the target a	ilouitt (Title 50	o), otherwise		
52. 00	Relief payment (see instructions)					0	
53. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ıctions)			0	63.00
54. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	na period (See	0	64.00
	instructions)(title XVIII only)	3		•			
55. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of the o	cost reportino	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line	65)(title XVII	I only); for	0	66. 00
7 00	CAH, see instructions		. D	-6 -1			17.00
57. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	n December 31 (or the cost re	eporting period	0	67. 00
58. 00	Title V or XIX swing-bed NF inpatient routing	e costs after [ecember 31 of	the cost repo	orting period	0	68. 00
(0.00	(line 13 x line 20)		11: /7 1:	- (0)			1,0,00
59. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
0.00	Skilled nursing facility/other nursing facility				ı		70.00
	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71.00
	Program routine service cost (line 9 x line	,	. (Lino 14 v Li	ino 25)			72.00
73. 00 74. 00	Medically necessary private room cost applications. Total Program general inpatient routine services.		•	,			73.00
75. 00	Capital-related cost allocated to inpatient	•			Part II. column		75.00
	26, line 45)				. , _5, a		
	Per diem capital-related costs (line 75 ÷ li						76.00
	Program capital -related costs (line 9 x line						77.00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovi der recor	ds)			78. 00 79. 00
30. 00	Total Program routine service costs for compa			*.	nus line 79)		80.0
81. 00	Inpatient routine service cost per diem limit			•	,	1	81.00

Health Financial Systems COMM	MUNITY HOSPITAL	OF INDIANA, IN	IC.	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/24/2024 11:4	pared: 44 am_
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	8, 531, 912	108, 101, 717	0. 07892	5 16, 607, 450	1, 310, 743	90. 00
91.00 Nursing Program cost	0	108, 101, 717	0.00000	16, 607, 450	0	91.00
92.00 Allied health cost	0	108, 101, 717	0.00000	16, 607, 450	0	92. 00
93.00 All other Medical Education	0	108, 101, 717	0. 00000	16, 607, 450	0	93. 00

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

Health Financial Systems COMM	UNITY HOSPITAL OF II	NDI ANA,	I NC		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	P	rovi der	CCN	I: 15-0169	Peri od:	Worksheet D-3	
					From 01/01/2023		
					To 12/31/2023		pared:
		T: 1	.1 - 1	V/V/I I I	11! +-1	5/24/2024 11:	44 am_
C+ C+		11 L		XVIII	Hospi tal	PPS	
Cost Center Description				Ratio of Cos	•	Inpatient	
				To Charges	Program	Program Costs (col. 1 x col.	
					Charges	2)	
			H	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS				1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS					38, 512, 471		30.00
31. 00 03100 NTENSI VE CARE UNI T			İ		9, 340, 822		31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT			l		0,010,022		35. 00
40. 00 04000 SUBPROVI DER - I PF			İ		0		40.00
43. 00 04300 NURSERY			İ				43. 00
ANCI LLARY SERVI CE COST CENTERS							10.00
50. 00 05000 OPERATING ROOM				0. 12081	41, 544, 333	5, 019, 137	50.00
51. 00 05100 RECOVERY ROOM			İ	0. 17848		812, 145	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			İ	0. 45875		0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C				0. 1996		707, 496	•
55. 00 05500 RADI OLOGY-THERAPEUTI C				0. 09657		625, 154	55. 00
57. 00 05700 CT SCAN				0. 03575		377, 232	57.00
58. 00 05800 MRI			İ	0. 09874		187, 753	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON			İ	0. 04269		44, 655	59.00
60. 00 06000 LABORATORY			İ	0. 19202		2, 914, 118	60.00
64. 00 06400 I NTRAVENOUS THERAPY				0. 53836		208, 528	64. 00
65. 00 06500 RESPI RATORY THERAPY			İ	0. 25667		2, 061, 307	65. 00
66. 00 06600 PHYSI CAL THERAPY			İ	0. 36817		574, 899	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY			İ	0. 34306		438, 292	67. 00
68. 00 06800 SPEECH PATHOLOGY				0. 2094		77, 468	68. 00
69. 00 06900 ELECTROCARDI OLOGY				0. 10139			•
70. 00 07000 ELECTROENCEPHALOGRAPHY				0. 22343		64, 458	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT				0. 37286		3, 082, 479	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			İ	0. 40246		3, 842, 701	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS			İ	0. 25814		4, 409, 284	73. 00
73. 01 07301 SPECI ALTY PHARMACY			İ	0. 00000		0	73. 01
74. 00 07400 RENAL DIALYSIS			İ	0. 50454		698, 738	74. 00
76. 00 03330 ENDOSCOPY			İ	0. 14706		372, 530	1
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS				0.00000		0	76. 01
76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS			İ	0.00000		0	76. 02
76.03 03952 OTHER ANCILLARY SERVICE COST CENTERS			İ	0.00000		0	76. 03
76. 04 03953 WOUND CARE			İ	0. 24865		92, 034	76. 04
76. 06 03954 I MAGI NG CENTER			İ	0. 08599		6, 324	76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER			İ	0. 44957		0	76. 07
77.00 07700 ALLOGENEIC HSCT ACQUISITION			İ	0.00000		0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY				0.00000	00 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C				0. 00000	00	0	90.00
90. 01 04950 INFUSION CENTER				0. 57879	1, 804	1, 044	90. 01
90. 26 04975 SPI NE CENTER				0. 75176		0	90. 26
91. 00 09100 EMERGENCY				0. 09141		1, 409, 007	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0. 93884	1, 017, 747	955, 505	92. 00
200.00 Total (sum of lines 50 through 94 and 9	6 through 98)				155, 073, 145	29, 254, 351	200. 00
201.00 Less PBP Clinic Laboratory Services-Pro	gram only charges (line 61))		0		201. 00
202.00 Net charges (line 200 minus line 201)					155, 073, 145		202. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od: From 01/01/2023	Worksheet D-3	
	Component		To 12/31/2023	Date/Time Pre 5/24/2024 11:	
	Ti tl e	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description		Ratio of Cost To Charges		Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30. 0
31.00 03100 INTENSIVE CARE UNIT					31.0
35. 00 02060 NEONATAL INTENSIVE CARE UNIT					35.0
40. 00 04000 SUBPROVI DER - I PF			5, 010, 069		40.0
43. 00 04300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS		0 10001	4	0	
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM		0. 12081		0	
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 17848 0. 45875		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 43873		_	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 19961		2,730	
57. 00 05700 CT SCAN		0. 03575		2, 839	1
58. 00 05800 MRI		0. 09874		598	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 04269		0	
50. 00 06000 LABORATORY		0. 19202		60, 837	
64. 00 06400 I NTRAVENOUS THERAPY		0. 53836	-		1
65. 00 06500 RESPIRATORY THERAPY		0. 25667		2, 108	1
66. 00 06600 PHYSI CAL THERAPY		0. 36817	8 44, 817	16, 501	66.0
67. 00 06700 OCCUPATI ONAL THERAPY		0. 34306	4 35, 527	12, 188	67.0
68.00 06800 SPEECH PATHOLOGY		0. 20941	0 895	187	68.0
59. 00 06900 ELECTROCARDI OLOGY		0. 10139	5 17, 062	1, 730	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 22343	-	551	70.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 37286		454	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 40246		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 25814		100, 296	
73. 01 07301 SPECI ALTY PHARMACY		0.00000		0	
74. 00 07400 RENAL DI ALYSI S		0. 50454		0	
76.00 03330 ENDOSCOPY 76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS		0. 14706		0	
76.01 03950 OTHER ANCILLARY SERVICE COST CENTERS 76.02 03951 OTHER ANCILLARY SERVICE COST CENTERS		0. 00000 0. 00000		0	
76. 03 03951 OTHER ANCILLARY SERVICE COST CENTERS		0.00000		0	
76. 04 03953 WOUND CARE		0. 00000		0	
76. 06 03954 I MAGI NG CENTER		0. 24803		0	
76. 07 03955 BREAST DIAGNOSTIC CENTER		0. 44957		0	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION		0. 00000		_	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0. 00000			
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0.00000	0 0	0	90.0
90 01 04950 INFUSION CENTER		0.57870		0	00 0

0. 000000 0. 578796

0. 751766

0. 091415

0. 938843

298, 158

1, 217, 698

90.01

90. 26

91.00

92.00

201. 00 202. 00

27, 256

0

230, 888 200. 00

90. 01

200.00

201.00 202.00

04950 INFUSION CENTER

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

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

90. 26 04975 SPI NE CENTER

91. 00 09100 EMERGENCY

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

Health Financial Systems COMMUNITY HOSPITAL OF	INDIANA, II	NC.	In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0169	Peri od:	Worksheet D-3	
			From 01/01/2023	D 1 /T' D	
			To 12/31/2023	Date/Time Pre 5/24/2024 11:	
	Ti tl	e XIX	Hospi tal	PPS	TT UIII
Cost Center Description		Ratio of Cos		Inpatient	
· ·		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1	7 700 404	1	
30. 00 03000 ADULTS & PEDI ATRI CS			7, 738, 434		30.00
31.00 03100 INTENSIVE CARE UNIT			4, 050, 401		31.00
35. 00 02060 NEONATAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF			6, 388, 379		35. 00 40. 00
43. 00 04300 NURSERY			104, 727 5, 009, 281		43.00
ANCI LLARY SERVI CE COST CENTERS			5,007,201		43.00
50. 00 05000 OPERATI NG ROOM		0. 12322	22 3, 204, 801	394, 902	50.00
51. 00 05100 RECOVERY ROOM		0. 17848		56, 690	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 45875		300, 458	52. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1996		121, 444	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 09657			55. 00
57. 00 05700 CT SCAN		0. 03575		46, 540	57. 00
58. 00 05800 MRI		0. 09874	15 260, 092	25, 683	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.04269	4, 269	182	59. 00
60. 00 06000 LABORATORY		0. 19202	2, 538, 319	487, 431	60.00
64. 00 06400 I NTRAVENOUS THERAPY		0. 53836	46, 276	24, 913	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 25667		777, 211	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 36817		46, 298	•
67. 00 06700 OCCUPATI ONAL THERAPY		0. 34306		67, 268	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 20941		19, 724	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 10139		1	1
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 22343		18, 662	70.00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS		0. 37286	·	303, 025	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 4024 <i>6</i> 0. 2581 ⁴		0 941, 135	72. 00 73. 00
73. 01 07300 DROGS CHARGED TO FATTENTS 73. 01 07301 SPECI ALTY PHARMACY		0. 00000		941, 133	73. 00
74. 00 07400 RENAL DI ALYSI S		0. 50454		165, 798	•
76. 00 03330 ENDOSCOPY		0. 14706		30, 533	1
76. 01 03950 OTHER ANCILLARY SERVICE COST CENTERS		0.00000		0	76. 01
76. 02 03951 OTHER ANCILLARY SERVICE COST CENTERS		0.00000		Ō	76. 02
76. 03 03952 OTHER ANCILLARY SERVICE COST CENTERS		0.00000		0	76. 03
76. 04 03953 WOUND CARE		0. 24865		15, 300	76. 04
76.06 03954 I MAGING CENTER		0. 08599	90 0	0	76. 06
76. 07 03955 BREAST DIAGNOSTIC CENTER		0. 44957	78 0	0	76. 07
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000		0	77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY		0.00000	00	0	78. 00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0.00000		0	90.00
90. 01 04950 INFUSION CENTER		0. 57879		0	90. 01
90. 26 04975 SPI NE CENTER		0. 75176		0	90. 26
91. 00 09100 EMERGENCY		0. 09257		l	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 93884			
200.00 Total (sum of lines 50 through 94 and 96 through 98) 201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		20, 967, 512	4, 275, 155	200. 00
202.00 Net charges (line 200 minus line 201)	s (TITIE OI)		20, 967, 512		201.00
202. 00 Not onal 900 (11110 200 IIII 110 201)		ı	20, 707, 312	I	1-02.00

NET 1. IMPAT INT DISCRIPTION SERVICES UNDER 1995 1.09		Title XVIII Hos	pi tal	5/24/2024 11: 4 PPS	44 am_
NEET A TRANTIFF INSPITAL SERVICES LABBER 19PS 1.00 DOOR Amounts (without the integrant of sixtherings occurring prior to October 1 (see 27,078, 77 1.01 1.01 1.02 DOG amounts (without the noutli or poyments for discharges occurring on or after October 1 (see 27,078, 77 1.01 1.02 DOG amounts (without the noutli or poyments for dose) 1.03			p. tu.		
1.00 1000 Amounts Other than outilier payments for discharges occurring prior to October 1 (see 9, 583, 582 1.02		PART A - INPATIENT HOSPITAL SERVICES UNDER LPPS		1.00	
Disc amounts other than outlier payments for discharges occurring on or after October 1 (see y, 883,952 1.02		DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see			
1.030 No. 1 No. 2 No.	1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see		9, 583, 552	1. 02
1.04 Rich For Federal specific operating payment for Wodel 4 BPCI for discharges occurring on or after 0 1.04	1.03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to	October	0	1. 03
2.01 Dutiler reconcilitation amount 0 2.02	1.04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or at	ter	0	1. 04
2.03 Outlier payments for discharges occurring on or after October 1 (see instructions) 378, 339 2.03 2.04 Outlier payments for discharges occurring on or after October 1 (see instructions) 381, 655 2.04 3.00 Onaged Care Simulated Payments Simulated Payments				0	
2.04 Dutil er payments for di schariges accurring on or after October* (See Instructions) 384,655 2.04 3.08 Managed Care Simulated Payments 3,540,640 3.00 4.00 100		, , ,			
Namaged Care Similated Payments 3.5,540,460 3.08 4.00 80 80 available of til vide by number of days in the cost reporting period (see instructions) 3.08 6.40 1.00 1					
Indirect Medical Education Adjustment Security Se	3.00	Managed Care Simulated Payments		35, 540, 640	
FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/311/99(cee) instructions) 0.00 5.00	4. 00			308. 16	4. 00
FIE cap adjustment for qualifying hospitals under \$131 of the CAA 2021 (see instructions) 0.00 6.00	5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period 6	ending on	0.00	5. 00
Advantage Company Co		FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the	e cap for		
MAA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(v)(8)(2) If the cost report straddles July 1, 2011 then see instructions. 0.00 7.01	6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under	§127 of	0.00	6. 26
Adjustment (Increase or decrease) to the hospital's rural track program FTE Limitation(s) for rural track for Medicare QME affiliated programs in accordance with 413.75(b) and 87 FR 49075 (August 10, 2022) (see instructions)		MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2)			
Adjustment (increase or decrease) to the FTE count for all lopathic and osteopathic programs for a filiated 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).	7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for track programs with a rural track for Medicare GME affiliated programs in accordance with 413		0.00	7. 02
8.01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddle s July 1, 2011, see instructions.	8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 1		3. 26	8. 00
R. 02	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. 01
Instructions 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 minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospi	tal	0.00	8. 02
minus Inne 7.02, plus/minus Line 8, plus Lines 8.01 through 8.27 (see instructions) 3.3 4 10.00			see	0.00	
11. 00 TE count for residents in dental and podiatric programs. 2. 81 11. 00 12. 00 13. 00 10. 00		minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	olus or		
12.00 Current year allowable FTE (see instructions) 6.07 12.00 13.00 Total allowable FTE count for the prior year. 6.56 13.00 10tal allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, otherwise enter zero. 6.50 14.00 15.00 Sum of lines 12 through 14 divided by 3. 6.52 15.00 16.00 Adjustment for residents in initial years of the program (see instructions) 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 18.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.021158 19.00 19.					
14.00					
15.00 Sum of lines 12 through 14 divided by 3. 6.52 15.00 16.00 Adj ustment for residents in initial years of the program (see instructions) 0.00 16.00 17.00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 Adj ustment for residents displaced by program or hospital closure 0.00 17.00 6.52 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.021158 19.00		Total allowable FTE count for the penultimate year if that year ended on or after September 3	30, 1997,		
17. 00	15. 00			6. 52	15. 00
18. 00 Adjusted rolling average FTE count 6. 52 18. 00 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0. 021158 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0. 020836 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.020836 21. 00 22. 00 IME payment adjustment (see instructions) 415, 035 22. 00 18. 00 IME payment adjustment - Managed Care (see instructions) 402, 391 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23. 00 (f)(1)(iv)(c). 0. 00 24. 00 IME FTE Resident Count Over Cap (see instructions) 0. 00 25. 00 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. 00 26. 00 Resident to bed ratio (divide line 25 by line 4) 0. 0000000 27. 00 28. 01 IME add-on adjustment amount (see instructions) 0. 28. 01 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0. 28. 01 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 415, 035 29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 402, 391					
19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0. 021158 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.020836 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.020836 21. 00 22. 00 IME payment adjustment (see instructions) 415,035 22. 00 22. 01 IME payment adjustment - Managed Care (see instructions) 402,391 22. 01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 50.00					
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.020836 21.00 22.00 IME payment adjustment (see instructions) 415,035 22.00 22.01 IME payment adjustment - Managed Care (see instructions) 402,391 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 0.0		, ,			
22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 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 (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 10.00 17.00 IME payments adjustment factor. (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment (sum of lines 22 and 28) 20.02 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 20.03 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 20.04 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 20.05 Sum of lines 30 and 31 30.06 Sum of lines 30 and 31 31.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions) 32.00 Interpayment (sum of lines 22.01 and 28.01) 33.00 Allowable disproportionate share percentage (see instructions) 33.00 Interpayment (sum of lines 32.00 and 31 34.68 33.00					
22. 01 IME payment adjustment - Managed Care (see instructions) 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 (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		· · · · · · · · · · · · · · · · · · ·			
23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(C). 24. 00 IME FTE Resident Count Over Cap (see instructions)		IME payment adjustment - Managed Care (see instructions)		1	
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 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 1 ME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Sum of lines 30 and 31 30.01 Allowable disproportionate share percentage (see instructions) 30.00 Allowable disproportionate share percentage (see instructions) 10.00 Condotted (see instructions) 25.00 Condotted (see instructions) 26.00 Locotted (see instructions) 26.00 Condotted (see instructions) 27.00 Locotted (see instructions) 30.00 Sum of lines 30 and 31 30.68 32.00	23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.1 $(f)(1)(iv)(C)$.	05		
26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 415, 035 29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22. 01 and 28. 01) 402, 391 29. 01 Disproportionate Share Adjustment 9.00 30. 00		If the amount on line 24 is greater than -O-, then enter the lower of line 23 or line 24 (see	:		
28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 32. 00 Allowable disproportionate share percentage (see instructions) 32. 00 IME add-on adjustment amount (see instructions) 415, 035 29. 00 402, 391 29. 01 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 32. 89 31. 00 33. 00 Allowable disproportionate share percentage (see instructions) 33. 00 Percentage of Medicaid patient days (see instructions)		Resident to bed ratio (divide line 25 by line 4)			
29.00 Total IME payment (sum of lines 22 and 28) 415,035 29.00 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 402,391 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 32.00 Sum of lines 30 and 31 36.68 32.00 33.00 Allowable disproportionate share percentage (see instructions) 19.48 33.00	28. 00	IME add-on adjustment amount (see instructions)		0	28. 00
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 89 31. 00 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 19. 48 33. 00					
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.89 31.00 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 19.48 33.00		Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			
32.00 Sum of lines 30 and 31 36.68 32.00 33.00 Allowable disproportionate share percentage (see instructions) 19.48 33.00		Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3. 79	
33.00 Allowable disproportionate share percentage (see instructions) 19.48 33.00					
1 1/100/21/10100					

Heal th	Financial Systems COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	eu of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0169	Peri od:	Worksheet E	
			From 01/01/2023 To 12/31/2023		naradi
			10 12/31/2023	Date/Time Pre 5/24/2024 11:	pareu: 44 am
		Title XVIII	Hospi tal	PPS	
				On/After 10/1	
			1. 00	2. 00	
	Uncompensated Care Payment Adjustment				
	Total uncompensated care amount (see instructions)			5, 938, 006, 757	
	Factor 3 (see instructions)		0. 000369054	l e	
	Hospital UCP, including supplemental UCP (see instructions)		2, 537, 024		
	Pro rata share of the hospital UCP, including supplemental UCF	P (see instructions)	1, 897, 554		
36. 00			2, 472, 212		36. 00
	Additional payment for high percentage of ESRD beneficiary dis	scharges (lines 40 throu			
40. 00	Total Medicare discharges (see instructions)		0		40.00
41.00	Total ESRD Medicare discharges (see instructions)	`	0		41.00
41. 01	Total ESRD Medicare covered and paid discharges (see instructi		0		41. 01
	Divide line 41 by line 40 (if less than 10%, you do not qualif	y for adjustment)	0.00		42.00
43.00	Total Medicare ESRD inpatient days (see instructions)	nulipo 41 dividad by 7	0 000000		43.00
44. 00	Ratio of average length of stay to one week (line 43 divided b	by line 41 divided by 7	0. 000000		44. 00
45. 00	days) Average weekly cost for dialysis treatments (see instructions)		0.00		45. 00
46. 00	Total additional payment (line 45 times line 44 times line 41.		0.00		46.00
47. 00	Subtotal (see instructions)	01)	42, 092, 881		47. 00
	Hospital specific payments (to be completed by SCH and MDH, sm	nall rural hospitals	0		48. 00
	only. (see instructions)				10.00
				Amount 1.00	
49. 00	Total payment for inpatient operating costs (see instructions)	<u> </u>		42, 495, 272	49. 00
	Payment for inpatient program capital (from Wkst. L, Pt. I and			3, 090, 377	
	Exception payment for inpatient program capital (Wkst. L, Pt.			0,070,077	
	Direct graduate medical education payment (from Wkst. E-4, lir			226, 657	1
	Nursing and Allied Health Managed Care payment	ie ir see matruetrons,.		0	
	Special add-on payments for new technologies			95, 916	
54. 01	Islet isolation add-on payment			0	1
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69	9)		0	
	Cellular therapy acquisition cost (see instructions)	,		0	55. 01
	Cost of physicians' services in a teaching hospital (see intru	uctions)		0	56.00
57.00	Routine service other pass through costs (from Wkst. D, Pt. II	I, column 9, lines 30 t	hrough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 11 line 200)		0	58.00
59. 00	Total (sum of amounts on lines 49 through 58)			45, 908, 222	59. 00
60.00	Primary payer payments			0	60.00
61. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		45, 908, 222	61.00
62.00	Deductibles billed to program beneficiaries			3, 571, 188	
63.00	Coinsurance billed to program beneficiaries			152, 334	
64. 00	Allowable bad debts (see instructions)			477, 662	
65. 00	Adjusted reimbursable bad debts (see instructions)			310, 480	65. 00

Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)

Rural Community Hospital Demonstration Project (§410A Demonstration) adjustment (see instructions)

Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)

35, 031

11, 837

-40, 587

0

0 70.50

42, 495, 180

66.00

67.00

68.00

69.00

70.00

70.75

70.87

70.88

70.89

70.90

70.91

70. 92

70. 93

37 70. 94 0 70. 95

66.00 Allowable bad debts for dual eligible beneficiaries (see instructions)

N95 respirator payment adjustment amount (see instructions)

SCH or MDH volume decrease adjustment (contractor use only)

HSP bonus payment HVBP adjustment amount (see instructions)

HSP bonus payment HRR adjustment amount (see instructions)

Bundled Model 1 discount amount (see instructions)

70.93 HVBP payment adjustment amount (see instructions)

HRR adjustment amount (see instructions)

70.95 Recovery of accelerated depreciation

Demonstration payment adjustment amount before sequestration

Pioneer ACO demonstration payment adjustment amount (see instructions)

Subtotal (line 61 plus line 65 minus lines 62 and 63)

OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)

67.00

68.00

70.00

70.50

70.75

70.88

70.89

70. 91

70. 92

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

CALCIII	Financial Systems COMMUNITY HOSPITAL OF ATION OF REIMBURSEMENT SETTLEMENT	INDIANA, I Provider C	CN: 15-0169	Peri od:	u of Form CMS-2 Worksheet E	2002-10
CALCOL	ATTOW OF RET INDURSEMENT SETTEEMENT	Trovider e	GN. 13 0107	From 01/01/2023 To 12/31/2023	Part A Date/Time Pre 5/24/2024 11:	
		Ti tl e	e XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	1. 00	70. 96
70. 90	the corresponding federal year for the period prior to 10/1)	i coi ullii o		U	Ü	70. 90
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in	column 0		0	0	70. 97
	the corresponding federal year for the period ending on or aft	er 10/1)				
70. 98	Low Volume Payment-3			0	0	
70. 99	HAC adjustment amount (see instructions)	0 0 70)			0	
	Amount due provider (line 67 minus lines 68 plus/minus lines 6 Sequestration adjustment (see instructions)	9 & 70)			42, 466, 430 849, 329	
	Demonstration payment adjustment amount after sequestration				047, 327	1
	Sequestration adjustment-PARHM pass-throughs					71. 03
72.00	Interim payments				41, 225, 876	72.00
	Interim payments-PARHM					72. 01
	Tentative settlement (for contractor use only)				0	
73. 01 74. 00	Tentative settlement-PARHM (for contractor use only)) 72 and			201 225	73. 01
74.00	Balance due provider/program (line 71 minus lines 71.01, 71.02 73)	z, 72, anu			391, 225	74.00
74. 01	Balance due provider/program-PARHM (see instructions)					74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordan	nce with			802, 879	
	CMS Pub. 15-2, chapter 1, §115.2					
00.00	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)	6.0.00	T			
90. 00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum oplus 2.04 (see instructions)	OT 2.03			0	90.00
91. 00	Capital outlier from Wkst. L, Pt. I, line 2				0	91.00
	Operating outlier reconciliation adjustment amount (see instru	ıcti ons)			0	
	Capital outlier reconciliation adjustment amount (see instruct				0	
94.00	The rate used to calculate the time value of money (see instru	ıcti ons)			0.00	94.00
	Time value of money for operating expenses (see instructions)				0	
96. 00	Time value of money for capital related expenses (see instruct	ions)		Prior to 10/1	0 /After 10/1	96. 00
				1.00	2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0.0000000000	0.0000000000	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions HRR Adjustment for HSP Bonus Payment	·)		U	0	1102.00
103.00	HRR adjustment factor (see instructions)			0.0000	0.0000	103. 00
	HRR adjustment amount for HSP bonus payment (see instructions)			0		104.00
	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) Adju	ustment			
200.00	Is this the first year of the current 5-year demonstration per	iod under	the 21st			200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement					
201 00	Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	49)				201. 00
	Medicare discharges (see instructions)	, 17)				202. 00
	Case-mix adjustment factor (see instructions)					203.00
	Computation of Demonstration Target Amount Limitation (N/A in	first year	of the curren	t 5-year demonst	ration	
	peri od)					
	Medicare target amount					204. 00
	Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205)					205. 00 206. 00
200.00	Adjustment to Medicare Part A Inpatient Reimbursement					1200.00
207.00	Program reimbursement under the §410A Demonstration (see instr	ructions)				207. 00
	Medicare Part A inpatient service costs (from Wkst. E, Pt. A,	line 59)				208. 00
	Adjustment to Medicare IPPS payments (see instructions)					209. 00
	Reserved for future use					210.00
211. 00	Total adjustment to Medicare IPPS payments (see instructions)					211. 00
	Comparision of PPS versus Cost Reimbursement	211)				212. 00
212 00	LIOTAL ADDUSTMENT TO MEDICARE PART A LPPS NAVMENTS (FROM LING .					
	Total adjustment to Medicare Part A IPPS payments (from line 2 Low-volume adjustment (see instructions)	.11)				213. 00
213.00	Low-volume adjustment (see instructions) Net Medicare Part A IPPS adjustment (difference between PPS ar	•	mbursement)			1
213.00	Low-volume adjustment (see instructions)	•	mbursement)			213

Health Financial Systems	COMMUNITY HOSPITAL OF	I NDI ANA,	I NC.	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der		Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part B Date/Time Prepared:

5/24/2024 11:44 am Title XVIII Hospi tal PPS 1.00 PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) 4. 597 Medical and other services reimbursed under OPPS (see instructions) 20, 863, 750 2.00 2.00 OPPS or REH payments 3.00 17, 229, 303 3 00 4.00 Outlier payment (see instructions) 232, 990 4.00 4.01 Outlier reconciliation amount (see instructions) 4.01 5.00 Enter the hospital specific payment to cost ratio (see instructions) 0.000 5.00 6.00 Line 2 times line 5 Ω 6.00 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 0.00 7.00 8.00 Transitional corridor payment (see instructions) 8.00 0 Ancillary service other pass through costs including REH direct graduate medical education costs from 9 00 9 00 0 Wkst. D, Pt. IV, col. 13, line 200 10.00 Organ acqui si ti ons 10.00 11.00 Total cost (sum of lines 1 and 10) (see instructions) 4, 597 11.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 12.00 Ancillary service charges 17, 808 12.00 13 00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 13.00 17, 808 Total reasonable charges (sum of lines 12 and 13) 14.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 15.00 Amounts that would have been realized from patients liable for payment for services on a chargebasis 16.00 0 16.00 had such payment been made in accordance with 42 CFR §413.13(e) 0.000000 17 00 Ratio of line 15 to line 16 (not to exceed 1.000000) 17 00 18.00 Total customary charges (see instructions) 17,808 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 13, 211 19.00 instructions) 20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 20.00 0 instructions) 21.00 Lesser of cost or charges (see instructions) 4.597 21.00 22.00 Interns and residents (see instructions) 22.00 23.00 Cost of physicians' services in a teaching hospital (see instructions) 0 23.00 Total prospective payment (sum of lines 3, 4, 4.01, 17, 462, 293 24.00 8 and 9) 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 25.00 Deductibles and coinsurance amounts (for CAH, see instructions) 25.00 3.140.324 26 00 Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 26 00 27.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 14, 326, 566 27.00 instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 81, 407 28.00 28.50 REH facility payment amount (see instructions) 28, 50 ESRD direct medical education costs (from Wkst. E-4, line 36) 29 00 29 00 30.00 Subtotal (sum of lines 27, 28, 28.50 and 29) 14, 407, 973 30.00 31.00 Primary payer payments 2, 273 31.00 Subtotal (line 30 minus line 31) 14, 405, 700 32.00 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 33.00 Composite rate ESRD (from Wkst. I-5, line 11) 389, 778 34.00 Allowable bad debts (see instructions) 34 00 35.00 Adjusted reimbursable bad debts (see instructions) 253, 356 35, 00 36.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 111,086 36.00 37.00 Subtotal (see instructions) 14, 659, 056 37.00 38. 00 MSP-LCC reconciliation amount from PS&R 38.00 39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39. 50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 N95 respirator payment adjustment amount (see instructions) 39.75 39. 97 Demonstration payment adjustment amount before sequestration 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) Λ 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 39.99 40.00 Subtotal (see instructions) 14, 659, 056 40.00 40 01 Sequestration adjustment (see instructions) 293, 181 40 01 40.02 Demonstration payment adjustment amount after sequestration 40.02 Sequestration adjustment-PARHM pass-throughs 40.03 40.03 41.00 Interim payments 14, 234, 406 41.00 Interim payments-PARHM 41 01 41 01 42.00 Tentative settlement (for contractors use only) 0 42.00 42.01 Tentative settlement-PARHM (for contractor use only) 42.01 43 00 Balance due provider/program (see instructions) 131, 469 43 00 43.01 Balance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 44.00 TO BE COMPLETED BY CONTRACTOR 90.00 90.00 Original outlier amount (see instructions) 0 91.00 Outlier reconciliation adjustment amount (see instructions) O 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

Health Financial Systems	COMMUNITY HOSPITAL OF	I NDI ANA,	I NC.	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 15-0169	Peri od:	Worksheet E	
				From 01/01/2023		
				To 12/31/2023	Date/Time Pre	pared:
					5/24/2024 11:	44 am_
		Ti tl	e XVIII	Hospi tal	PPS	
					1.00	
94.00 Total (sum of lines 91 and 93)					0	94. 00
					1. 00	
MEDICARE PART B ANCILLARY COSTS						
200.00 Part B Combined Billed Days	·				0	200. 00

From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/24/2024 11:44 am Title XVIII Hospi tal PPS Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 41, 186, 076 14, 234, 406 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 09/01/2023 39,800 0 3.01 3.02 C 0 3.02 3.03 3.03 0 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 3.51 0 3.51 0 0 3.52 3.52 0 3.53 3.53 0 3.54 \cap 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 39,800 Ω 3.99 3.50-3.98) 41, 225, 876 14, 234, 406 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 5.01 TENTATIVE TO PROVIDER 0 0 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 391, 225 131, 469 6.01 6 02 SETTLEMENT TO PROGRAM 6.02 7.00 Total Medicare program liability (see instructions) 41, 617, 101 14, 365, 875 7.00 Contractor NPR Date (Mo/Day/Yr) Number

Provider CCN: 15-0169

0

1 00

2 00

8.00

Peri od:

8.00 Name of Contractor

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

		Titl∈	e XVIII	Subprovi der - I PF	PPS	
		Inpatier	it Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		1, 687, 779		0	
2.00	Interim payments payable on individual bills, either		C)	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none, write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		T	T	г	
3. 01	ADJUSTMENTS TO PROVIDER		C		0	
3. 02 3. 03					0	
3. 04					0	3. 04
3. 05					Ö	3. 05
	Provider to Program			'		
3.50	ADJUSTMENTS TO PROGRAM		C		0	
3. 51			C		0	
3.52			C		0	3. 52
3. 53 3. 54			0		0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	
3. 77	3. 50-3. 98)					3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)	•	1, 687, 779		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					_
5. 00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after				l .	5.00
5.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5.01	TENTATI VE TO PROVI DER		C		0	5. 01
5. 02			C		0	
5. 03	Provider to Program		C		0	5. 03
5. 50	TENTATI VE TO PROGRAM			1	0	5. 50
5. 51	TENTATI VE TO TROGRAM				Ö	
5. 52		•	C)	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		[c)	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		27, 181		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		27, 101		0	
7. 00	Total Medicare program liability (see instructions)		1, 714, 960		Ō	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor)	1. 00	2.00	0.00
8. 00	Name of Contractor			I	l	8. 00

Heal th	Financial Systems COMMUNITY HOSPITAL OF	FINDIANA, INC.	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0169	Peri od: From 01/01/2023 To 12/31/2023		epared:
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				4
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14		1. 00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8. 00	Calculation of the HIT incentive payment (see instructions)				8. 00
9. 00	Sequestration adjustment amount (see instructions)				9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				4
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
31.00	Other Adjustment (specify)				31. 00
32 00	Balance due provider (line 8 (or line 10) minus line 30 and L	ine 31) (see instruction	(2)		32 00

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

32.00

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0169	Peri od:	Worksheet E-3
		From 01/01/2023	
	Component CCN: 15-S169	To 12/31/2023	
			5/24/2024 11:44 am
	Title XVIII	Subprovi der -	PPS

	I PF	113	
		1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		
00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	1, 919, 648	1
OC	Net IPF PPS Outlier Payments	0	2
0	Net IPF PPS ECT Payments	0	3
00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0. 00	
	15, 2004. (see instructions)		
)1	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0. 00	
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)		
00	New Teaching program adjustment. (see instructions)	0.00	
00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0. 00	
00	teaching program" (see instuctions)	0.00	١.
00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new tasking program" (see instructions)	0. 00	
00	teaching program" (see instructions)	0.00	
00 00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0. 00 12. 912329	
00	Average Daily Census (see instructions) Tooghing Adjustment Factor (((1 + (line 9/line 9)) raiced to the newer of 5150 1)		
00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000 0	1
00	Teaching Adjustment (line 1 multiplied by line 10). Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	1, 919, 648	
00	Nursing and Allied Health Managed Care payment (see instruction)	1, 919, 048	ı
	Organ acquisition (DO NOT USE THIS LINE)	U	1
00	Cost of physicians' services in a teaching hospital (see instructions)	0	1
00	Subtotal (see instructions)	1, 919, 648	
00	Primary payer payments	1, 717, 040	
00	Subtotal (line 16 less line 17).	1, 919, 648	
00	Deductibles	169, 424	
00	Subtotal (line 18 minus line 19)	1, 750, 224	
	Coinsurance	28, 000	
00	Subtotal (line 20 minus line 21)	1, 722, 224	
	Allowable bad debts (exclude bad debts for professional services) (see instructions)	42, 669	
	Adjusted reimbursable bad debts (see instructions)	27, 735	
	Allowable bad debts for dual eligible beneficiaries (see instructions)	7, 741	
00	Subtotal (sum of lines 22 and 24)	1, 749, 959	2
00	Direct graduate medical education payments (see instructions)	0	
00	Other pass through costs (see instructions)	0	
00	Outlier payments reconciliation	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	3
50	Pioneer ACO demonstration payment adjustment (see instructions)	0	3
98	Recovery of accelerated depreciation.	0	3
99	Demonstration payment adjustment amount before sequestration	0	3
00	Total amount payable to the provider (see instructions)	1, 749, 959	3
01	Sequestration adjustment (see instructions)	34, 999	3
02	Demonstration payment adjustment amount after sequestration	0	3
00	Interim payments	1, 687, 779	3
00	Tentative settlement (for contractor use only)	0	3
00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	27, 181	3
00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	3
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
00	Original outlier amount from Worksheet E-3, Part II, line 2	0	
00	Outlier reconciliation adjustment amount (see instructions)	0	5
00	The rate used to calculate the Time Value of Money	0. 00	5
00	Time Value of Money (see instructions)	0	5
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MAY 11, 2023 (THE	END OF	
	THE COVID-19 PHE)		1
00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000	
	Calculated Teaching Adjustment Factor for the current year. (see instructions)	0. 000000	I O

J U.	Financial Systems COMMUNITY HOSPITAL OF GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provi der CO		Peri od:	u of Form CMS-2 Worksheet E-4	
MEDI CA	AL EDUCATION COSTS			From 01/01/2023 To 12/31/2023	Date/Time Pre	
		Title	XVIII	Hospi tal	5/24/2024 11: 4 PPS	44 am
					1. 00	
	COMPUTATION OF TOTAL DIRECT GME AMOUNT				1.00	
1. 00	Unweighted resident FTE count for allopathic and osteopathic pending on or before December 31, 1996.	programs for	cost report	ng periods	0.00	1. 00
1. 01	FTE cap adjustment under §131 of the CAA 2021 (see instruction		1) (:+		0.00	1. 01
2. 00 2. 26	Unweighted FTE resident cap add-on for new programs per 42 CFI Rural track program FTE cap limitation adjustment after the cathe CAA 2021 (see instructions)				0. 00 0. 00	2. 00 2. 26
3. 00	Amount of reduction to Direct GME cap under section 422 of MMA	A			0. 00	3. 00
3. 01	Direct GME cap reduction amount under ACA §5503 in accordance	with 42 CFR	§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 trad	ck FTF limit	ation(s) for	rural track	0.00	3. 02
3. 02	programs with a rural track Medicare GME affiliation agreement 49075 (August 10, 2022) (see instructions)				0.00	3. 02
4. 00	Adjustment (plus or minus) to the FTE cap for allopathic and of		programs due	to a Medicare	3. 26	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 instracted in 271.7301)		cost report	ng periods	0.00	4. 01
4. 02	straddling 7/1/2011) ACA Section 5506 number of additional direct GME FTE cap slots 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 sloinstructions)	ots under §1	26 of the CA	A 2021 (see	0. 00	4. 21
5. 00	FTE adjusted cap (line 1 plus and 1.01, plus line 2, plus line 3.01, plus or minus line 3.02, plus or minus line 4, plus line			nus lines 3 and	3. 26	5. 00
5. 00	Unweighted resident FTE count for allopathic and osteopathic precords (see instructions)	programs for	the current	year from your	3. 34	6. 00
7. 00	Enter the lesser of line 5 or line 6		Primary Car	e Other	3. 26 Total	7. 00
			1. 00	2.00	3. 00	
3. 00	Weighted FTE count for physicians in an allopathic and osteopaprogram for the current year.	athi c	0.	3. 00	3. 34	8. 00
9. 00	If line 6 is less than 5 enter the amount from line 8, otherwimultiply line 8 times the result of line 5 divided by the amount 6. For cost reporting periods beginning on or after October 1,	unt on line	0.	2. 93	3. 26	9. 00
		, 2022, or				
10 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions.			2 81		10 00
		ent year		2. 81 2. 81		
10. 01 11. 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currotal weighted FTE count	ent year rrent year	0.	2. 81 33 5. 74		10. 01 11. 00
10. 01 11. 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currotal weighted FTE count Total weighted resident FTE count for the prior cost reporting	ent year rrent year	0. 1.	2. 81 5. 74		10. 01 11. 00
10. 01 11. 00 12. 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currotal weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost reporting the penultimate	ent year rrent year g year (see		2. 81 33 5. 74 24 3. 83		10. 01 11. 00 12. 00
10. 01 11. 00 12. 00 13. 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currotal weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided	ent year rrent year g year (see porting	1	2. 81 33 5. 74 24 3. 83 30 5. 76		10. 01 11. 00 12. 00 13. 00 14. 00
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currotal weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	ent year rrent year g year (see porting by 3).	1. 1. 0. 0.	2. 81 33 5. 74 24 3. 83 30 5. 76 96 5. 11 00 0. 00		10. 01 11. 00 12. 00 13. 00 14. 00 15. 00
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currunweighted dental and podiatric resident FTE count for the currotal weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs	ent year rrent year g year (see porting by 3). rograms	1. 1. 0. 0.	2. 81 33 5. 74 24 3. 83 30 5. 76 96 5. 11 00 0. 00 00 0. 00		10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the curround weighted FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program Adjustment for residents displaced by program or hospital closunweighted adjustment for residents displaced by program or hospital closunweighted adjustment for residents displaced by program or hospital closunweighted adjustment for residents displaced by program or hospital closunweighted adjustment for residents displaced by program or hospital closure.	ent year rrent year g year (see porting by 3). rograms sure	1. 1. 0. 0.	2. 81 33 5. 74 24 3. 83 30 5. 76 96 5. 11 00 0. 00 00 0. 00		10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 01	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currunweighted dental and podiatric resident FTE count for the currotal weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new padjustment for residents displaced by program or hospital close	ent year rrent year g year (see porting by 3). rograms sure	1. 1. 0. 0. 0.	2. 81 33 5. 74 24 3. 83 30 5. 76 96 5. 11 00 0. 00 00 0. 00 00 0. 00 00 0. 00		16. 00
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 16. 01 17. 00 18. 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currotal weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program of how in the penultimate cost repear (see instructions) Adjustment for residents in initial years of new programs or hospital closure adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count	ent year rrent year g year (see porting by 3). rograms sure	1. 0. 0. 0. 0. 0. 113, 901.	2. 81 33 5. 74 24 3. 83 30 5. 76 96 5. 11 00 0. 00 00 0. 00 00 0. 00 00 0. 00 96 5. 11 83 113, 901. 83		10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 01 17. 00 18. 00
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currunweighted dental and podiatric resident FTE count for the currotal weighted FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new prodiustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021	ent year rrent year g year (see porting by 3). rograms sure	1. 0. 0. 0. 0. 0. 113, 901.	2. 81 33 5. 74 24 3. 83 30 5. 76 96 5. 11 00 0. 00 00 0. 00 00 0. 00 00 0. 00 00 0. 00 96 5. 11 83 113, 901. 83 00 0. 00	601 294	10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 01 17. 00 18. 00 18. 01
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currotal weighted FTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new program of how in the penultimate cost repear (see instructions) Adjustment for residents in initial years of new programs or hospital closure adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count	ent year rrent year g year (see porting by 3). rograms sure	1. 0. 0. 0. 0. 0. 113, 901.	2. 81 33 5. 74 24 3. 83 30 5. 76 96 5. 11 00 0. 00 00 0. 00 00 0. 00 00 0. 00 00 0. 00 96 5. 11 83 113, 901. 83 00 0. 00	691, 384	10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 01 17. 00 18. 00
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currunweighted dental and podiatric resident FTE count for the currotal weighted FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new prodiustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021	ent year rrent year g year (see porting by 3). rograms sure ospital	1. 0. 0. 0. 0. 0. 113, 901. 0. 109, 3	2. 81 33 5. 74 24 3. 83 30 5. 76 96 5. 11 00 0. 00 00 0. 00 00 0. 00 00 0. 00 96 5. 11 83 113, 901. 83 0. 00 46 582, 038	1. 00	10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 16. 01 17. 00 18. 00 18. 01
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currounweighted fTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instructions)	ent year rrent year g year (see porting by 3). rograms sure ospital TE resident ctions)	1. 0. 0. 0. 0. 0. 113, 901. 0. 109, 3	2. 81 33 5. 74 24 3. 83 30 5. 76 96 5. 11 00 0. 00 00 0. 00 00 0. 00 00 0. 00 96 5. 11 83 113, 901. 83 0. 00 46 582, 038	1. 00 0. 00 0. 08	10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00
16. 01 17. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currounweighted fTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Unweighted adjustment for residents displaced by program or hospital closure Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instructions)	ent year rrent year g year (see porting by 3). rograms sure ospital TE resident ctions) uctions)	1.	2. 81 33 5. 74 24 3. 83 30 5. 76 96 5. 11 00 0. 00 00 0. 00 00 0. 00 00 0. 00 96 5. 11 83 113, 901. 83 0. 00 46 582, 038	1. 00 0. 00 0. 08 0. 00	10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 18. 00 18. 01 19. 00 20. 00 21. 00 22. 00
10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00	if Worksheet S-2, Part I, line 68, is "Y", see instructions. Weighted dental and podiatric resident FTE count for the currounweighted dental and podiatric resident FTE count for the currounweighted fTE count Total weighted resident FTE count for the prior cost reporting instructions) Total weighted resident FTE count for the penultimate cost repyear (see instructions) Rolling average FTE count (sum of lines 11 through 13 divided Adjustment for residents in initial years of new programs Unweighted adjustment for residents in initial years of new programs Unweighted adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count Per resident amount Per resident amount under §131 of the CAA 2021 Approved amount for resident costs Additional unweighted allopathic and osteopathic direct GME F Sec. 413.79(c)(4) Direct GME FTE unweighted resident count over cap (see instructions)	ent year rrent year g year (see porting by 3). rograms sure ospital TE resident ctions) uctions)	1.	2. 81 33 5. 74 24 3. 83 30 5. 76 96 5. 11 00 0. 00 00 0. 00 00 0. 00 00 0. 00 96 5. 11 83 113, 901. 83 0. 00 46 582, 038	1.00 0.00 0.08 0.00 0.00	10. 01 11. 00 12. 00 13. 00 14. 00 15. 00 15. 01 16. 00 16. 01 17. 00 18. 00 18. 01 19. 00 20. 00

	Financial Systems COMMUNITY HOSPITAL OF GRADUATE MEDICAL EDUCATION (GME) & ESRD OUTPATIENT DIRECT	Provider C		Peri od:	u of Form CMS-2 Worksheet E-4	
	L EDUCATION COSTS		0.11 10 0.07	From 01/01/2023		
				To 12/31/2023	Date/Time Prep 5/24/2024 11:4	pared: 44 am
		Titl∈	XVIII	Hospi tal	PPS	
			Inpatient Par A	t Managed Care	Total	
			1.00	2. 00	3. 00	
	COMPUTATION OF PROGRAM PATIENT LOAD					
26. 00	Inpatient Days (see instructions) (Title XIX - see S-2 Part I) 3.02, column 2)	(, line	19, 38	21, 179		26. 00
27. 00	Total Inpatient Days (see instructions)		89, 48	89, 483		27. 00
28. 00	Ratio of inpatient days to total inpatient days		0. 21663			28. 00
29.00	Program direct GME amount		149, 77	163, 638	313, 415	29. 00
29. 01	Percent reduction for MA DGME			3. 27		29. 01
30.00	Reduction for direct GME payments for Medicare Advantage			5, 351	5, 351	30.00
31.00	Net Program direct GME amount				308, 064	31.00
	DUDGOT MEDICAL EDUCATION COOTS FOR FORD COMPOSITE DATE. TITLE	- \0.011.	/ (AULDOLAIO DDG	ODAN AND DADAME	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 c	of col. 20 and	1 23, lines 74	0	32. 00
33. 00	Renal dialysis and home dialysis total charges (Wkst. C, Pt. I	. col. 8. s	sum of lines 7	'4 and 94)	4, 519, 237	33. 00
34. 00	Ratio of direct medical education costs to total charges (line				0. 000000	
35.00	Medicare outpatient ESRD charges (see instructions)		•		0	35. 00
36.00	Medicare outpatient ESRD direct medical education costs (line		35)		0	36. 00
	APPORTIONMENT BASED ON MEDICARE REASONABLE COST - TITLE XVIII	ONLY				
	Part A Reasonable Cost					
37. 00	Reasonable cost (see instructions)	`			58, 096, 025	1
38. 00	Organ acquisition and HSCT acquisition costs (see instructions				0	
39. 00 40. 00	Cost of physicians' services in a teaching hospital (see instr Primary payer payments (see instructions)	ructions)			0	
41. 00	Total Part A reasonable cost (sum of lines 37 through 39 minus	Line 40)			58, 096, 025	
41.00	Part B Reasonable Cost	S 11116 40)			30, 040, 023	41.00
42. 00	Reasonable cost (see instructions)				20, 868, 347	42. 00
43. 00	Primary payer payments (see instructions)				2, 273	1
44. 00	Total Part B reasonable cost (line 42 minus line 43)				20, 866, 074	
45. 00	Total reasonable cost (sum of lines 41 and 44)				78, 962, 099	
46. 00	Ratio of Part A reasonable cost to total reasonable cost (line	e 41 ÷ line	45)		0. 735746	1
47. 00	Ratio of Part B reasonable cost to total reasonable cost (line		45)		0. 264254	47. 00
	ALLOCATION OF MEDICARE DIRECT GME COSTS BETWEEN PART A AND PAR	RT B		,		
48. 00	Total program GME payment (line 31)				308, 064	
49. 00	Part A Medicare GME payment (line 46 x 48) (title XVIII only)				226, 657	
50.00	Part B Medicare GME payment (line 47 x 48) (title XVIII only)	(see instru	ıcti ons)		81, 407	I 50.00

Heal th	Financial Systems	COMMUNITY HOSPITAL OF	INDIANA, INC.	In Lie	u of Form CMS-2	2552-10
OUTLI E	R RECONCILIATION AT TENTATIVE SETTLEMENT		Provider CCN: 15-0169	Peri od:	Worksheet E-5	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/24/2024 11:4	
			Title XVIII		PPS	
					1. 00	
	TO BE COMPLETED BY CONTRACTOR					
1.00	Operating outlier amount from Wkst. E, F	Pt. A, line 2, or sum o	of 2.03 plus 2.04 (see i	nstructions)	0	1.00
2.00	Capital outlier from Wkst. L, Pt. I, lin	ne 2			0	2.00
3.00	Operating outlier reconciliation adjustr	ment amount (see instru	uctions)		0	3.00
4.00	Capital outlier reconciliation adjustmen	nt amount (see instruct	ti ons)		0	4.00
5.00	The rate used to calculate the time value	ue of money (see instru	uctions)		0.00	5.00
6.00	Time value of money for operating expens	ses (see instructions)			0	6.00
7.00	Time value of money for capital related	expenses (see instruct	tions)		o	7. 00

Health Financial Systems COMMUNITY HOSPITE
BALANCE SHEET (If you are nonproprietary and do not maintain fund-type accounting records, complete the General Fund column onl y)

Provider CCN: 15-0169

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared:

onl y)			'	0 12/31/2023	5/24/2024 11:	
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2. 00	3. 00	4. 00	
4 00	CURRENT ASSETS	0 (00	J			4 00
1.00	Cash on hand in banks	8, 600		0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0		-	0	2. 00 3. 00
4. 00	Accounts receivable	333, 136, 116	1	0	0	4.00
5. 00	Other recei vabl e	-245, 831, 722		0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	22, 584, 734		Ö	0	6. 00
7. 00	Inventory	6, 192, 334		0	0	7. 00
8.00	Prepai d expenses	0) c	0	0	8. 00
9.00	Other current assets	-262	<u>.</u>	0	0	9. 00
10.00	Due from other funds	0) c	0	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	116, 089, 800) C	0	0	11. 00
	FI XED ASSETS				_	
12.00	Land	2, 705, 851	1	-	0	12.00
13.00	Land improvements	4, 358, 830	1	-	0	13.00
14. 00 15. 00	Accumulated depreciation	0 222 007 020		0	0	14. 00 15. 00
16. 00	Buildings Accumulated depreciation	333, 887, 820		0	0	16. 00
17. 00	Leasehold improvements	3, 781, 720	1	0	0	17. 00
18. 00	Accumulated depreciation	3,701,720		0	0	18. 00
19. 00	Fixed equipment	133, 772, 540	1	-	Ö	19. 00
20. 00	Accumulated depreciation	0		0	0	20. 00
21.00	Automobiles and trucks	19, 930) c	0	0	21. 00
22.00	Accumulated depreciation	0) c	0	0	22. 00
23. 00	Major movable equipment	0) c	0	0	23. 00
24.00	Accumulated depreciation	-292, 022, 930) C	0	0	24. 00
25. 00	Mi nor equi pment depreci able	0		0	0	25. 00
26. 00	Accumulated depreciation	0		0	0	26. 00
27. 00	HIT designated Assets	0		0	0	27. 00
28. 00 29. 00	Accumulated depreciation	316, 270		0	0	28.00
30.00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	186, 820, 031	1		0	30.00
30.00	OTHER ASSETS	100, 020, 031		0	0	30.00
31. 00	Investments	0) C	0	0	31. 00
32.00	Deposits on Leases	O		0	0	32. 00
33.00	Due from owners/officers	0) c	0	0	33. 00
34.00	Other assets	1, 414, 412, 803	s c	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	1, 414, 412, 803	s c	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	1, 717, 322, 634	C	0	0	36. 00
	CURRENT LI ABI LI TI ES		_		_	
37. 00	Accounts payable	993, 194	1	0	0	37. 00
38. 00	Salaries, wages, and fees payable	0		0	0	38. 00
39. 00 40. 00	Payroll taxes payable	0		0	0	39. 00 40. 00
41. 00	Notes and Loans payable (short term) Deferred income	0		0	0	41. 00
42. 00	Accel erated payments			U	U	42.00
43. 00	Due to other funds	0	ol c	0	0	
44. 00	Other current liabilities	2, 799, 997		o	Ö	
45.00	Total current liabilities (sum of lines 37 thru 44)	3, 793, 191		0	0	
	LONG TERM LIABILITIES		•			
46.00	Mortgage payable	0	0	0	0	46. 00
47.00	Notes payable	0) C	0	0	
48. 00	Unsecured Loans	0) C	0	0	
49. 00	Other long term liabilities	4, 103, 998			0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	4, 103, 998			0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	7, 897, 189	y c	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	1, 709, 425, 445				52.00
53. 00	Specific purpose fund	1, 709, 423, 443	'l c			53.00
54. 00	Donor created - endowment fund balance - restricted					54.00
55. 00	Donor created - endowment fund balance - unrestricted					55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on					
59. 00	Total fund balances (sum of lines 52 thru 58)	1, 709, 425, 445	i c	o	0	
60.00	Total liabilities and fund balances (sum of lines 51 and	1, 717, 322, 634	· C	0	0	60. 00
	[59]		I			1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0169

				'	0 12/31/2023	5/24/2024 11:	
		Genera	I Fund	Speci al Pu	urpose Fund	Endowment Fund	77 (111)
		1.00	2.00	3.00	4. 00	5.00	
1.00	Fund balances at beginning of period		1, 607, 736, 253		(1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		101, 689, 192				2. 00
3.00	Total (sum of line 1 and line 2)		1, 709, 425, 445		(3. 00
4.00	Additions (credit adjustments) (specify)	0	l	C	1	0	4. 00
5.00		0				0	5. 00
6.00		0		(1	0	6. 00
7. 00 8. 00		0				0	7. 00 8. 00
9. 00		0			1	0	9. 00
10.00	Total additions (sum of line 4-9)	0	_		,	1	10.00
11. 00	Subtotal (line 3 plus line 10)		1, 709, 425, 445				11. 00
12. 00	Deductions (debit adjustments) (specify)	0	1	(1 0	12. 00
13. 00	beddetrons (debrt day astmerres) (speerry)	0			1	Ö	13. 00
14. 00		0			ó	0	14. 00
15. 00		0		ĺ		0	15. 00
16. 00		0		d		0	16. 00
17. 00		0				0	17. 00
18.00	Total deductions (sum of lines 12-17)		0		(18. 00
19.00	Fund balance at end of period per balance		1, 709, 425, 445		(19.00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0.00		8.00			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0		(3. 00
4.00	Additions (credit adjustments) (specify)		0				4. 00
5.00	,		0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	0		()		10.00
11. 00	Subtotal (line 3 plus line 10)	0		(11. 00
12. 00	Deductions (debit adjustments) (specify)		0				12.00
13. 00			0				13. 00
14. 00			0				14. 00
15. 00			0				15. 00
16.00			0				16.00
17. 00	T-t-1 d-dusting (12 47)		0	,			17. 00
18.00	Total deductions (sum of lines 12-17)	0	ŀ				18.00
19. 00	Fund balance at end of period per balance	0		C	<u>'</u>		19. 00
	sheet (line 11 minus line 18)	I	I	I	1		l

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

STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0169 From 01/01/2023 From 01/01/2023 To 12/31/2023 Date/Time Prepared:

		1	0 12/31/2023	5/24/2024 11:	
	Cost Center Description	I npati ent	Outpati ent	Total	
	'	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	220, 075, 141		220, 075, 141	1.00
2.00	SUBPROVI DER - I PF	13, 177, 986		13, 177, 986	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)	233, 253, 127		233, 253, 127	10.00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	42, 346, 746		42, 346, 746	11.00
12.00	CORONARY CARE UNIT				12.00
13.00	BURN INTENSIVE CARE UNIT				13.00
14.00	SURGI CAL INTENSIVE CARE UNIT				14.00
15. 00	NEONATAL INTENSIVE CARE UNIT	128, 645, 621		128, 645, 621	15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	170, 992, 367		170, 992, 367	16.00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	404, 245, 494		404, 245, 494	17. 00
18. 00	Ancillary services	638, 295, 943	929, 445, 171	1, 567, 741, 114	18. 00
19. 00	Outpati ent servi ces	0		0	19. 00
20. 00	RURAL HEALTH CLINIC	0	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	21.00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES				23. 00
24. 00	CMHC				24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)	0	1, 682, 674		27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wks	st. 1, 042, 541, 437	931, 127, 845	1, 973, 669, 282	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		483, 793, 994		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)(tran	nsfer	483, 793, 994		43.00
	to Wkst. G-3, line 4)				

Health Financial Systems	COMMUNITY HOSPITAL OF INDIANA, INC.	In l	ieu of Form CMS-2552-10
STATEMENT OF REVENUES AND EXPENSES	Provi der CCN: 15-016	9 Peri od:	Worksheet G-3

	Triancial Systems Common Triancial Triancial Triancial Systems			u or rorm cw3-2	2332-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0169	Peri od:	Worksheet G-3	
			From 01/01/2023 To 12/31/2023		narod:
			10 12/31/2023	5/24/2024 11:4	
				0,21,2021 111	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	e 28)		1, 973, 669, 282	1. 00
2.00	Less contractual allowances and discounts on patients' accoun-	ts		1, 391, 801, 674	2. 00
3.00	Net patient revenues (line 1 minus line 2)			581, 867, 608	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		483, 793, 994	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			98, 073, 614	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			52, 450	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10. 00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			2, 798, 956	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16. 00
17.00	Revenue from sale of drugs to other than patients			115, 935	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			22, 950	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	MISC: ALL OTHER REVENUE			625, 287	24. 00
24. 50	COVI D-19 PHE Fundi ng			0	24. 50
25.00	Total other income (sum of lines 6-24)			3, 615, 578	25. 00
26.00	Total (line 5 plus line 25)			101, 689, 192	26. 00
27. 00	ROUNDI NG			0	27. 00
28. 00	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			101, 689, 192	29. 00

	n Financial Systems COMMUI LATION OF CAPITAL PAYMENT	NITY HOSPITAL OF	INDIANA, INC. Provider CCN: 15-0169	In Lie	u of Form CMS-2 Worksheet L	2552-1
DALCOI	EATTON OF CALLIAL FAINLENT		Trovider cen. 13-0107	From 01/01/2023 To 12/31/2023		
			Title XVIII	Hospi tal	PPS	
					1. 00	
	PART I - FULLY PROSPECTIVE METHOD				1.00	
	CAPITAL FEDERAL AMOUNT					
. 00	Capital DRG other than outlier				2, 782, 551	1. (
. 01	Model 4 BPCI Capital DRG other than outlier				0	1. 0
. 00	Capital DRG outlier payments				71, 865	2.0
. 01	Model 4 BPCI Capital DRG outlier payments				0	
. 00	Total inpatient days divided by number of days		porting period (see ins	tructions)	239. 15	
. 00	Number of interns & residents (see instruction				6. 52	
. 00	Indirect medical education percentage (see ins				0. 77	1
00	Indirect medical education adjustment (multipl 1.01)(see instructions)	y line 5 by the	sum of lines 1 and 1.0	1, columns 1 and	21, 426	6. 0
. 00						7.0
	30) (see instructions)				3. 79	'''
. 00				32. 89	8.0	
. 00					36. 68	
10.00 Allowable disproportionate share percentage (see instructions)				7. 71		
1. 00					214, 535	
2. 00	Total prospective capital payments (see instru	ctions)			3, 090, 377	12.0
					1. 00	
	PART II - PAYMENT UNDER REASONABLE COST					
. 00	Program inpatient routine capital cost (see in				0	
. 00	Program inpatient ancillary capital cost (see				0	
. 00	Total inpatient program capital cost (line 1 p				0	
. 00	Capital cost payment factor (see instructions)				0	
. 00	Total inpatient program capital cost (line 3 x	line 4)		,	0	5. 0
					1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS					
. 00	Program inpatient capital costs (see instructi				0	
. 00	Program inpatient capital costs for extraordin	,	es (see instructions)		0	
00	Net program inpatient capital costs (line 1 mi				0	
	Applicable exception percentage (see instructi				0. 00	
. 00						
1. 00 5. 00	Capital cost for comparison to payments (line				0	
1. 00 5. 00 5. 00	Percentage adjustment for extraordinary circum	stances (see ins		v line ()	0.00	6.0
3. 00 4. 00 5. 00 5. 00 7. 00 3. 00		nstances (see ins or extraordinary		x line 6)	-	6. 0 7. 0

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

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

16.00 Current year operating and capital costs (see instructions)

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

17.00 | Current year exception offset amount (see instructions)

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

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

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

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

11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year Worksheet L, Part III, line 14)

9.00

10.00

11.00

14.00

17.00

0

0

0 12.00

0 13.00

0

0 15.00 16.00 0 0

9.00

10.00

12.00

13.00

14.00