Health Financia	al Systems	COMMUNITY HOSPT. OF LAG	GRANGE CTY IN	In Lie	u of Form CMS-2552-1
This report is	required by law (42 USC 1395)	g; 42 CFR 413.20(b)). Failu	ire to report can resul	t in all interim	FORM APPROVED
payments made	since the beginning of the cos	st reporting period being d	leemed overpayments (42	USC 1395g).	OMB NO. 0938-0050
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX CO	Provi der CCN: 151323	Peri od: From 01/01/2015	Worksheet S Parts I-III	
7 OETTELMENT	Sommart.			To 12/31/2015	Date/Time Prepared: 5/31/2016 11:54 am
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed	cost report		Date: 5/31/20	16 Time: 11:54 an
use only	2. [] Manually submitted co	st report			
	3. [0] If this is an amended 4. [F] Medicare Utilization.			esubmitted this co	ost report
Contractor use only	5. [1]Cost Report Status (1) As Submitted	7. Contractor No.	11. 0	IPR Date: Contractor's Vendo	or Code: 4
	(2) Settled without Audit (3) Settled with Audit	8. [N] Initial Report for 9. [N] Final Report for the second of the	this Provider CCN 12. [nis Provider CCN		nes reopened = 0-9.

PART II - CERTIFICATION

(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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPT. OF LAGRANGE CTY IN (151323) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)					
		Offi cer	or	Admi ni strator	of Provider(s)
					. ,
	T: +1 -				
	Title				
	Date				

			Title	Title XVIII			
	Cost Center Description		Part A	Part B	HIT	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-52, 769	-301, 423	100, 889	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	99, 362	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	46, 593	-301, 423	100, 889	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151323 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/31/2016 11:39 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 207 NORTH TOWNLINE ROAD 1.00 PO Box: 1.00 State: IN Zip Code: 46761-1325 County: LAGRANGE 2.00 City: LAGRANGE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY HOSPT. OF 151323 99915 05/01/2005 Ν 0 3.00 LAGRANGE CTY IN Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF SWING BEDS 157323 99915 7 00 05/01/2005 N 0 N 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 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 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Hospital-Based (CORF) I 17.10 17.10 17. 20 Hospi tal -Based (OPT) I 17.20 17.30 Hospital-Based (00T) I 17.30 Hospi tal -Based (OSP) I 17.40 17.40 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2015 12/31/2015 20.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22 00 N N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting N Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be 22.02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" for yes or "N" fo<u>r no</u> used in the prior cost reporting period? In column 2 In-State Medi cai d 0ther In-State Out-of Out-of Medi cai d Medi cai d State State HMO days Medi cai d el i gi bl e Medi cai d Medi cai d paid days days unpai d paid days el i gi bl e unpai d davs 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 24.00 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.

	Financial Systems COMMUNITY HO FAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		AGRANGE CTY Provi der	IN CCN: 151323	Peri o		In Lieu			t S-2	2552-10
					From	01/0	1/2015 1/2015	Par	t I		pared:
		In-State	e In-State	Out-of	Out-c		Medi ca	5/3	1/201 Oth	6 11:	39 am
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		para day	unpai d	pai d days	eligib	ol e			uu	ys	
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25. 00	If this provider is an IRF, enter 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.		0 0	0		0		0			25. 00
	pino para ana ori gi bio bat anpara aayo iii oo anni oi				Urb	an/R	ural S	Date	of (
26. 00	Enter your standard geographic classification (not was		us at the beg	inning of t	he	1. C	2		2.00		26. 00
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifilf this is a sole community hospital (SCH), enter the	age) statu r "2" for ication ir	rural. If ap n column 2.	pplicable,			2				27. 00 35. 00
	effect in the cost reporting period.	e Hulliber C	perrous so	JII Status III		•	_	_	·		33.00
						egi nr 1. C		E	2. 00		
36. 00	Enter applicable beginning and ending dates of SCH sof periods in excess of one and enter subsequent date		oscript line	36 for numb	er						36. 00
37. 00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	r the numb	per of period	ls MDH statu	IS		0				37. 00
38. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.										38. 00
						1. C			Y/N 2.00		
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR $\S412.101(b)(2)(iior "N" for no. Does the facility meet the mileage reconstruction of the second sec$	i)? Enter	in column 1	"Y" for yes	5	N			N		39. 00
40. 00	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	n adjustme oer 1. Ent	or no. (see i ent? Enter "Y ter "Y" for y	" for yes o	r	N			N		40. 00
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol	n adjustme oer 1. Ent	or no. (see i ent? Enter "Y ter "Y" for y	" for yes o	r	N	V		111	XI X	40. 00
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45. 00 46. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exceptursuant to 42 CFR §412.348(f)? If yes, complete WkstPt. III.	n adjustme per 1. Ent . (see ins nt for dis eption for t. L, Pt.	or no. (see in ent? Enter "Y for y structions) sproportionat extraordination and Wkst	" for yes or "N" f	accorda ances I throu	ance	V 1.00	2.	N N	N N	45. 00 46. 00
45. 00 46. 00 47. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkster. III. Is this a new hospital under 42 CFR §412.300 PPS capits the facility electing full federal capital payments.	n adjustme per 1. Ent . (see ins nt for dis eption for t. L, Pt.	or no. (see in ent? Enter "Y for yestructions) sproportionat extraordina III and Wkst ter "Y for yester "Y for yester"	re share in ary circumst: L-1, Pt.	accorda ances I throu	ance	V 1.00	2.	00 N	3. 00 N	45. 00
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45. 00 46. 00 47. 00 48. 00 56. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkster. III. Is this a new hospital under 42 CFR §412.300 PPS capits the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for	n adjustme per 1. Ent . (see ins nt for dis eption for t. L, Pt. ital? Ent t? Enter approved period dur r yes or "	or no. (see in ent? Enter "Y" for yestructions) sproportionat rextraordinat III and Wkst ter "Y for yes "Y" for yes GME programs ring which re	re share in ary circumst L-1, Pt. es or "N" for "N" fo	accorda ances I through no.	ance ugh yes ed umn 1	V 1.00 N N N N N N N N N	2.	N N	3. 00 N N	45. 00 46. 00 47. 00 48. 00
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45. 00 46. 00 47. 00 48. 00 56. 00 57. 00 58. 00 59. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkster. III. Is this a new hospital under 42 CFR §412.300 PPS capits the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting in the first month of the following state of the facility? Enter "Y" for is "Y" did residents start training in the first month of yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. III line 56 is yes, did this facility elect cost reimled fined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes, Are you claiming nursing school and/or allied health	n adjustme per 1. Ent . (see ins . (see ins . (see ins . (see ins . (see ins . (see ins . L, Pt. . ital? Ent t? Enter approved period dur r yes or " th of this Y", complet complete s, complete costs for	pr no. (see i ent? Enter "Y fer "Y" for y structions) sproportionat extraordina III and Wkst ter "Y for yes "Y" for yes "N" for no ir se cost report et et Worksheet i cable. for physicia wkst. D-5. te Wkst. D-5. te Wkst. D-2, a program t	re share in ary circumst L-1, Pt. es or "N" for "N" fo	accorda accorda ances I throu or no. no. '" for y approve If column 2 es as	ance yes ed umn 1 "Y"	V 1.00 N N N N N N N N N	2.	N N	3. 00 N N	45. 00 46. 00 47. 00 48. 00 56. 00 57. 00
45. 00 46. 00 47. 00 48. 00 56. 00 57. 00 58. 00 59. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkster. III. Is this a new hospital under 42 CFR §412.300 PPS capits the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting payments of the programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first monifor yes or "N" for no in column 2. If column 2 is "N" "N", complete Wkst. D, Parts III & IV and D-2, Pt. III line 56 is yes, did this facility elect cost reimle defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	n adjustme per 1. Ent . (see ins . (see ins . (see ins . (see ins . (see ins . (see ins . L, Pt. . ital? Ent t? Enter approved period dur r yes or " th of this Y", complet complete s, complete costs for	pr no. (see i ent? Enter "Y fer "Y" for y structions) sproportionat extraordina III and Wkst ter "Y for yes "Y" for yes "N" for no ir se cost report et et Worksheet i cable. for physicia wkst. D-5. te Wkst. D-5. te Wkst. D-2, a program t	re share in ary circumst L-1, Pt. es or "N" for "N" fo	accorda ances I through through the second through	ance yes ed umn 1 "Y"	V 1.00 N N N N N N N N N	2.	N N	3. 00 N N N	45. 00 46. 00 47. 00 48. 00 56. 00 57. 00
45. 00 46. 00 47. 00 48. 00 56. 00 57. 00 58. 00 59. 00 60. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkster. III. Is this a new hospital under 42 CFR §412.300 PPS capits the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting in the first month of the following state of the facility? Enter "Y" for is "Y" did residents start training in the first month of yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. III line 56 is yes, did this facility elect cost reimled fined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes, Are you claiming nursing school and/or allied health	n adjustme per 1. Ent . (see ins . (see ins . (see ins . (see ins . (see ins . eption for t. L, Pt. . ital? Ent t? Enter approved period dur r yes or " th of this y", complet s, complete s, complete s, complete s, costs for	cr no. (see in ent? Enter "Y for yestructions) sproportionat extraordina III and Wkst ter "Y for yes "Y" for yes GME programs ing which ref scost report tet Worksheet icable. for physicia Wkst. D-5. tet Wkst. D-5. a program tor "N" for no	res for yes or es or "N" for yes or "N" for yes or "N" for or "N" for es dents in a column 1. Fing period? E-4. If cours' service Pt. I. that meets to yes or "S" for yes instituted to the column service of the column service pt. I. that meets to yes or "N" for yes instituted to the column service of the column service pt. I. that meets to yes or "N" for yes or "N" for "N"	accorda ances I through through the second through	yes ed umn 1 "Y" is	V 1.000 N N N N N N N N N	2.	N N N N N N N N N N N N N N N N N N N	N N N N N N N N N N N N N N N N N N N	45. 00 46. 00 47. 00 48. 00 56. 00 57. 00

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		1. 00	2. 00	3. 00	4. 00	5. 00	
61.0	O Did your hospital receive FTE slots under ACA	N			0.00	0.00	61.00
	section 5503? Enter "Y" for yes or "N" for no in						
	column 1. (see instructions)						
61. C	1 Enter the average number of unweighted primary care		0.00	0.00			61. 01
	FTEs from the hospital's 3 most recent cost reports						
	ending and submitted before March 23, 2010. (see						
	i nstructi ons)						
61. C	2 Enter the current year total unweighted primary care		0.00	0.00			61. 02
	FTE count (excluding OB/GYN, general surgery FTEs,						
	and primary care FTEs added under section 5503 of						
	ACA). (see instructions)						

Health Financial Systems				LAGRANGE CTY		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HE	EALTH CARE COMPL	EX IDENTIFICATION DA	TA	Provi der		eriod: com 01/01/2015	Worksheet S-2 Part I	
					To		Date/Time Pre	
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61.03 Enter the base li		r primary care which is used for		0.00	0.00			61. 03
determining compl								
instructions)	6	. ,		0.00				
61.04 Enter the number surgery allopathi				0.00	0.00			61. 04
current cost repo								
61.05 Enter the differe				0.00	0.00)		61. 05
		the current year's ery FTE counts (line						
61.04 minus line	61.03). (see in	structions)						
61.06 Enter the amount				0.00	0.00)		61. 06
care or general s		that are nonprimary structions)						
, , , , , , , ,	<u> </u>	<u> </u>	Pr	ogram Name	Program Code	Unweighted IME		
						FTE Count	Direct GME FTE Count	
				1. 00	2. 00	3.00	4. 00	
61.10 Of the FTEs in li					2100	0.00		61. 10
specialty, if any for each new prog		of FTE residents						
		in column 2, the						
program code, ent	er in column 3,	the IME FTE						
unwei ghted count FTE unwei ghted co		umn 4, direct GME						
61. 20 Of the FTEs in li		fy each expanded				0.00	0.00	61. 20
program specialty	, if any, and t	ne number of FTE						
residents for eac		ram. (see the program name,						
		ode, enter in column						
3, the IME FTE un	weighted count	and enter in column						
4, direct GME FTE	unweighted cou	nt.						
							1.00	
ACA Provisions Af 62.00 Enter the number		th Resources and Ser				ad far which	0.00	(2.00
		s that your nospital funding (see instruc		d in this cost	reporting peri	od for which	0.00	62.00
62.01 Enter the number	of FTE resident	s that rotated from a	Teachi	ing Health Cent	ter (THC) into	your hospital	0.00	62. 01
during in this co	st reporting pe	riod of HRSA THC prog	gram. (s	see instruction	ns)			
63.00 Has your facility		sidents in Nonprovide nts in nonprovider se			ost reportina p	eri od? Enter	N	63.00
		umn 1. If yes, comple			instructions)			
					Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
					Nonprovi der	Hospi tal	2))	
					Si te	·		
Soction FEOA of +	ho ACA Paga Vaa	r ETE Docidonts in No	opprovi	dor Sottings	1.00	2.00	3. 00	
		r FTE Residents in No uly 1, 2009 and befor	•	•	illi s base year	is your cost i	epor tring	
64.00 Enter in column 1	, if line 63 is	yes, or your facilit	y traii	ned residents	0.00	0.00	0. 000000	64. 00
		oer of unweighted nor tations occurring in						
		number of unweighted						
		ur hospital. Enter ir 1 + column 2)). (see	instru	ctions)				
		Program Name	Pr	ogram Code	Unwei ghted	Unweighted FTEs in	Ratio (col. 3/	
					FTEs Nonprovi der	Hospi tal	(col. 3 + col. 4))	
					Si te	·		
		1. 00		2. 00	3. 00	4. 00	5. 00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151323 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/31/2016 11:39 am Unwei ghted Unwei ghted Program Name Program Code Ratio (col. (col. 3 + col FTEs FTEs in 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 65.00 65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Ratio (col. 3/ Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151323 Pe	eri od:	ieu of Form Worksheet		552-10					
	om 01/01/201	I5 Part I	e Prep						
		1.00							
Long Term Care Hospital PPS									
0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 1.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no. TEFRA Providers	period? Ente	r N		80. 00 81. 00					
5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes o Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		. N		85. 00 86. 00					
7.00 Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? for yes or "N" for no.		N		87. 00					
	1. 00	2. 00							
Title V and XIX Services	1.00	2.00							
0.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90. 00					
vision in the applicable column. 10.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N		91. 00						
22.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92. 00					
13.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		93. 00						
14.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N		94.00						
15.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 16.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	00 N	0. 00	95. 00 96. 00						
7.00 If line 96 is "Y", enter the reduction percentage in the applicable column.	0.	00	0. 00	97. 00					
Rural Providers 05.00 Does this hospital qualify as a critical access hospital (CAH)?	Υ			105. 00					
06.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N N			106. 00					
07.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N			107. 00					
08.00 is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108. 00					
Physical Occupational 1.00 2.00	Speech 3.00	Respi rat 4.00							
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N	N N		109. 00					
		1.00							
10.00 Did this hospital participate in the Rural Community Hospital Demonstration project (410 the current cost reporting period? Enter "Y" for yes or "N" for no.	A Demo)for	N		110. 00					
	1.	00 2.00 3	3. 00						
Miscellaneous Cost Reporting Information									
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter i	N	0	115. 00						
3 either "93" percent for short term hospital or "98" percent for long term care (includ psychiatric, rehabilitation and long term hospitals providers) based on the definition i Pub. 15-1, chapter 22, §2208.1.	116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.								
psychiatric, rehabilitation and long term hospitals providers) based on the definition i Pub.15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. 17.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "		N Y		117. 00					
psychiatric, rehabilitation and long term hospitals providers) based on the definition i Pub. 15-1, chapter 22, §2208.1. 16.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N" for			118. 00					

1. 00 70, 073

2.00

4, 614

3. 00 27, 643 118. 01

118.01 List amounts of mal practice premiums and paid losses:

lealth Financial Systems C HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	OMMUNITY HOSPT. OF LA FICATION DATA	Provider CCN:		Period: From 01/01/2015 To 12/31/2015		-2 repared:
				1.00	2.00	_
Are malpractice premiums and paid losses r Administrative and General? If yes, submi and amounts contained therein.				1.00 N	2.00	118. (
19.00 DO NOT USE THIS LINE 20.00 s this a SCH or EACH that qualifies for t \$3121 and applicable amendments? (see inst "N" for no. Is this a rural hospital with Hold Harmless provision in ACA §3121 and a Enter in column 2, "Y" for yes or "N" for	ructions) Enter in co < 100 beds that quali applicable amendments	olumn 1, "Y" foo fies for the Oo	yes or utpatient		N	119. (120. (
121.00 Did this facility incur and report costs f patients? Enter "Y" for yes or "N" for no. Transplant Center Information		able devices cha	arged to	Y		121. (
125.00 Does this facility operate a transplant ce		es and "N" for	no. If	N		125. (
yes, enter certification date(s) (mm/dd/yy 126.00 If this is a Medicare certified kidney tra in column 1 and termination date, if appli	insplant center, ente	the certifica	tion date			126. 0
127.00 If this is a Medicare certified heart tran in column 1 and termination date, if appli	splant center, enter cable, in column 2.					127. (
128.00 If this is a Medicare certified liver trans in column 1 and termination date, if appliance in this is a Medicare certified lung trans	cable, in column 2.			n		128. (
column 1 and termination date, if applicat 30.00 If this is a Medicare certified pancreas t	Die, in column 2. Fransplant center, en	ter the certific				130. (
date in column 1 and termination date, if I31.00 If this is a Medicare certified intestinal date in column 1 and termination date, if	transplant center,	enter the certi	fi cati on			131. (
132.00 f this is a Medicare certified islet trar in column 1 and termination date, if appli	splant center, enter cable, in column 2.	the certificati				132. (
133.00 If this is a Medicare certified other trar in column 1 and termination date, if appli 134.00 If this is an organ procurement organizati and termination date, if applicable, in co All Providers	cable, in column 2. on (OPO), enter the (133. (
140.00 Are there any related organization or home chapter 10? Enter "Y" for yes or "N" for rare claimed, enter in column 2 the home of	no in column 1. If yes	s, and home offi	ce costs	Y	15H032	140. (
1.00	2. 00			3.00		
If this facility is part of a chain organi home office and enter the home office cont 141.00 Name: PARKVIEW HEALTH SYSTEM, INC. Cor		ractor number.				141. (
142.00 Street: 10501 CORPORATE DRIVE PO	SERVI Box: 5600					142.
143.00 City: FORT WAYNE Sta	ite: IN		Zip Code:	: 4684	15	143. (
144 00 Are provider based abusicional costs instru	idad in Warkshast A2				1.00	144
144.00 Are provider based physicians' costs inclu	iueu in worksheet A?				Y	144. (
145 COLE costo for moral accordance and a	Wko+ A 1:== 74		-	1.00	2.00	145
145.00 f costs for renal services are claimed or inpatient services only? Enter "Y" for yes no, does the dialysis facility include Mecperiod? Enter "Y" for yes or "N" for no i	or "N" for no in col licare utilization fo	umn 1. If colur	nn 1 is	N		145.
146.00 Has the cost allocation methodology change Enter "Y" for yes or "N" for no in column yes, enter the approval date (mm/dd/yyyy)	1. (See CMS Pub. 15-			N		146.
4	0.5.1				1.00	
147.00 Was there a change in the statistical basi	s? Enter "Y" for yes	or "N" for no.			N	147. (
148.00Was there a change in the order of allocat 149.00Was there a change to the simplified cost				no.	N N	148. (149. (

149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no.						
	Part A	Part B	Title V	Title XIX		
	1.00	2.00	3.00	4.00		
Does this facility contain a provider that qualifies for an	exemption from	n the applicati	on of the lowe	r of costs		
or charges? Enter "Y" for yes or "N" for no for each compon	ent for Part A	and Part B. (S	ee 42 CFR §413	. 13)		
155. 00 Hospi tal	N	N	N	N	155. 00	
156.00 Subprovider - IPF	N	N	N	N	156. 00	
157.00 Subprovider - IRF	N	N	N	N	157. 00	
158. 00 SUBPROVI DER					158. 00	
159. 00 SNF	N	N	N	N	159. 00	
160.00 HOME HEALTH AGENCY	N	N	N	N	160. 00	
161. 00 CMHC		N	N	N	161. 00	
161. 10 CORF		N	N	N	161. 10	
161. 20 OUTPATIENT PHYSICAL THERAPY		N	N	N	161. 20	
161. 30 OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161. 30	
161. 40 OUTPATIENT SPEECH PATHOLOGY		N	N	N	161. 40	
·			•	•		

Health Financial Systems	COMMUNITY HOSE	PT. OF LAGRANGE CTY I	N		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der (CCN: 15132	From O	: 1/01/2015 2/31/2015		epared:
						1.00	
Multicampus						1. 00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one or more campu	ses in di	fferent CE	BSAs?	N	165. 00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5. 00	
166.00 If line 165 is yes, for each 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	0 166. 00
	-					1. 00	
Health Information Technology (HIT							4.7.00
167.00 s this provider a meaningful user 168.00 f this provider is a CAH (line 10					a +ba	Y 112 F/	167. 00 7168. 00
reasonable cost incurred for the H			10/ 15	Y), enter	the	113, 50	/168.00
168. 01 If this provider is a CAH and is reception under §413. 70(a)(6)(ii)?	not a meaningful user,	does this provider			dshi p		168. 01
169.00 If this provider is a meaningful utransition factor. (see instruction	ıser (line 167 is "Y")				enter the	0.0	0169. 00
	-			Ве	gi 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 end	ding date for the re	porti ng	10,	/01/2014	09/30/2015	170. 00
						1 00	-
171.00 If line 167 is "Y", does this prov	ildan hava any dava fi	ar individuale erral	lad in a	oction 107		1. 00 N	171. 00
Medicare cost plans reported on Wk (see instructions)						IV.	171.00

		UNITY HOSPT. OF LAGRANG				u of Form CMS-	
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE Pro	ovi der		Peri od: From 01/01/2015	Worksheet S-: Part II	
					To 12/31/2015	Date/Time Pro 5/31/2016 11	epared: :39 am
					Y/N	Date	. 07 4111
					1. 00	2. 00	
	General Instruction: Enter Y for all YES resp	onses. Enter N for all	NO res	sponses. Ente	er all dates in t	:he	
	mm/dd/yyyy format.						
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation						
1. 00	Has the provider changed ownership immediatel	y prior to the heginni	na of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of t	the change in column 2.	(see i	instructions)			1.00
	,	<u> </u>		Y/N	Date	V/I	
				1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in yes, enter in column 2 the date of termination			N			2. 00
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g.	, chain home offices,	drug	N			3. 00
	or medical supply companies) that are related officers, medical staff, management personnel	d to the provider or it: I, or members of the boa	s ard				
	of directors through ownership, control, or f	amily and other simila	ır				
	relationships? (see instructions)			Y/N	Type	Date	
			-	1.00	2. 00	3. 00	
	Financial Data and Reports			1.00	2.00	0.00	
4. 00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Compilenter date available in	I ed,	Y	A		4. 00
5. 00	column 3. (see instructions) If no, see instr Are the cost report total expenses and total those on the filed financial statements? If y	revenues different from		N			5. 00
	those on the fired financial statements. If	res, sabilit receiver rat	1 011.		Y/N	Legal Oper.	
					1. 00	2.00	
	Approved Educational Activities						
6. 00	Column 1: Are costs claimed for nursing schothe legal operator of the program? Are costs claimed for Allied Health Programs?	-		e provider is			6.00
7. 00 8. 00	Were nursing school and/or allied health programs?			during the	N N		7. 00 8. 00
9. 00	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents i	ons.		· ·	N N		9.00
10. 00	program in the current cost report? If yes, s Was an approved Intern and Resident GME progr	see instructions.			N N		10.00
	cost reporting period? If yes, see instruction	ons.					
11. 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		an Appi	rovea	N		11. 00
						Y/N	
	Pad Dobts					1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bac	1 dehts? If was see in	structi	ons		Y	12.00
13. 00	If line 12 is yes, did the provider's bad deb period? If yes, submit copy.	3 ·			ost reporting	N	13. 00
13.00	1, ,	ed? If	yes, see ins	structions.	N	14. 00	
14. 00	Bed Complement Did total beds available change from the price	or cost reporting period	d? If v	ves, see inst	ructions.	N	15. 00
14. 00	Bed Complement	or cost reporting period	d? If		ructions. art A	N Part B	15. 00
14. 00	Bed Complement	or cost reporting period Description	d? If				15. 00
14. 00	Bed Complement Did total beds available change from the pric		d? If	Pa	art A	Part B	15. 00
14. 00 15. 00	Bed Complement Did total beds available change from the price PS&R Data	Description	d? If	Y/N 1.00	art A Date	Part B Y/N 3.00	
14. 00	Bed Complement Did total beds available change from the pric	Description	d? If	Pa Y/N	art A Date	Part B Y/N	16. 00

·	PS&R Data					
16. 00	Was the cost report prepared using the PS&R		N		N	16. 00
	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					
	instructions)					
17. 00	Was the cost report prepared using the PS&R		Υ	04/30/2015	Υ	17. 00
	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					
40.00	2 and 4. (see instructions)		.,		.,	40.00
18. 00	If line 16 or 17 is yes, were adjustments		Y		Υ	18. 00
	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					
19. 00	this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments	-	N		N	19. 00
19.00	made to PS&R Report data for corrections of		IN		IN IN	19.00
	other PS&R Report information? If yes, see					
	instructions.					
20. 00	If line 16 or 17 is yes, were adjustments		N		N	20.00
20.00	made to PS&R Report data for Other? Describe		IN		IN	20.00
	the other adjustments:					
	The other adjustments.	'		I	I	ı

Health Financial Systems	COMMUNITY HOSPT. OF LAC	GRANGE CTY IN		In Lieu	ı of Form CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE	RELMBURSEMENT OUESTLONNALRE	Provi der CCN: 151323	Peri od:		Worksheet S-2

Provider CCN: 151323 From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 5/31/2016 11:39 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provi der-Based Physi ci ans Are services furnished at the provider facility under an arrangement with provider-based physicians? Ν 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position FRIC NI CKESON 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel v. PARKVIEW HEALTH SYSTEM, INC. 42.00 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost (260) 373-8406 ERIC. NI CKESON@PARKVI EW. COM 43.00 report preparer in columns 1 and 2, respectively.

report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 151323 Peri od: Worksheet S-2 From 01/01/2015 To 12/31/2015 Part II Date/Time Prepared: 5/31/2016 11:39 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 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 instructions) 17.00 Was the cost report prepared using the PS&R 04/30/2015 17.00 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) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 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.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. 20.00 If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position DIRECTOR, REIMBURSEMENT 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 12/2014 | 12/2015 | Part | Prepared: | 12/2014 | 12/2015 | Part | Prepared: | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/201
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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 COMMUNITY HOSPT. OF LAGRANGE CTY IN Provi der CCN: 151323

Component Worksheet A No. of Beds Bed Days CAH Hours Titles							10	12/31/2015	5/31/2016 11:	
Component							1			
Component										
Line Number		Component	Worksheet A	No.	of Beds	Bed Days				
1.00 Hospit al Adult sa Peds. (col umns 5, 6, 7 and 8		r Production	Line Number			,				
B exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			1.00		2.00	3.00		4. 00	5. 00	
Hospice days) (see instructions for col. 2 Cor the portion of LDP room available beds) Core	1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 1	25	66, 960. 00	0	1. 00
For the portion of LDP room available beds) 3.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00										
2.00 MMO and other (see instructions) 2.00 A.00 MIO IPF Subprovider 3.00 A.00 MIO IPF Subprovider 4.00 4.00 4.00 6.00 MIO IPF Subprovider 5.00 6.00 MIO IPF Subprovider 6.00										
3.00 HMO IPF Subprovi der 3.00 4.00 HMO IPF Subprovi der 4.00 HMO IPF Subprovi der 4.00 HMO IPF Subprovi der 5.00 6.00 Hospi tal Adult s & Peds. Swing Bed NF 0 6.0										
4. 00										
5.00										
Color										
Total Adults and Peds (exclude observation beds) See instructions) B. 00 N. 00										
beds) (see instructions) 8. 00 9. 00 10. 00		, ,			25	0.1	25	// 0/0 00		
8. 00 INTENSIVE CARE UNIT 9, 00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 11.00 12.00 11.00 12.00 11.00 12.00 11.00 12.	7.00				25	9, 1	25	00, 900. 00	0	7.00
9.00 CORONARY CARE UNIT 9.00 BURN INTENSIVE CARE UNIT 10.00 11.00	8 00									8 00
10.00 SURRI INTENSIVE CARE UNIT 10.00 11.00 12.00 13.00 14.00 16.01 16.00										l
11. 00 SURGICAL INTENSIVE CARE UNIT										•
12.00 OTHER SPECIAL CARE (SPECIFY)										1
13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CORF 25. 20 CMHC - OUTPATIENT PHYSICAL THERAPY 25. 20 CMHC - OUTPATIENT SPEECH PATHOLOGY 25. 30 CMHC - OUTPATIENT SPEECH PATHOLOGY 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)										1
14. 00			43. 00						0	l .
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CMRC 25. 10 CMHC - CORF 25. 20 CMHC - OUTPATIENT PHYSICAL THERAPY 25. 30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 25. 30 CMHC - OUTPATIENT SPEECH PATHOLOGY 25. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days - IRF 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)					25	9. 1	25	66, 960, 00		
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18. 00 SUBPROVI DER 18. 00 19. 00 SKILLED NURSI NG FACILITY 20. 00 NURSI NG FACILITY 21. 00 21. 00 OTHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 23. 00 HOSPI CE 24. 10 HOSPI CE 24. 10 HOSPI CE 25. 10 CMHC - CMHC 25. 10 CMHC - CORF 25. 10 CMHC - OUTPATIENT PHYSI CAL THERAPY 99. 10 25. 20 25. 30 CMHC - OUTPATIENT PHYSI CAL THERAPY 99. 30 25. 30 CMHC - OUTPATIENT SPEECH PATHOLOGY 99. 40 25. 30 26. 20 27. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 2	16.00	SUBPROVI DER - I PF								16. 00
19. 00 SKILLED NURSING FACILITY 19. 00 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 21. 00 20. 00 22. 00 HOME HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 22. 00 4MBULATORY SURGICAL CENTER (D. P.) 23. 00 24. 00 HOSPICE (non-distinct part) 30. 00 24. 10 HOSPICE (non-distinct part) 30. 00 24. 10 25. 00 24. 10 25. 00 25. 10 25. 00 26. 00 27. 00 28. 00 28. 00 29	17. 00	SUBPROVI DER - I RF								17. 00
20. 00	18.00	SUBPROVI DER								18. 00
21.00 OTHER LONG TERM CARE 22.00 22.00 HOME HEALTH AGENCY 22.00 23.00 24.00 HOME HEALTH AGENCY 23.00 24.00 HOSPICE 24.00 24.10 HOSPICE (non-distinct part) 30.00 24.10 HOSPICE (non-distinct part) 30.00 24.10 25.00 CMHC - CMHC 25.00	19. 00	SKILLED NURSING FACILITY								19. 00
22.00 23.00	20.00	NURSING FACILITY								1
23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 25. 10 CMHC - OUTPATIENT PHYSICAL THERAPY 25. 20 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 25. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 25. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 26. 20 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)										
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24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 25. 10 CMHC - OUTPATIENT PHYSICAL THERAPY 25. 20 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 25. 30 CMHC - OUTPATIENT SPEECH PATHOLOGY 25. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Tri ps 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 30. 00 31. 00 Outpatient days (see instructions) 30. 00 Outpatient days (see instructions) 30. 00 Outpatient days (see instructions)										1
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25. 10 CMHC - CORF 25. 20 CMHC - OUTPATIENT PHYSICAL THERAPY 25. 30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 25. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 25. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Observation Bed Days 29. 00 Ambulance Trips 29. 00 28. 00 29. 00 Employee discount days (see instruction) 29. 00 Employee discount days (see instructions) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)		1	30. 00							ł
25. 20 CMHC - OUTPATIENT PHYSICAL THERAPY 99. 20 99. 30 92. 30 99. 30 99. 30 99. 30 99. 40 99			00.40							1
25. 30										
25. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 99. 40 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 27. 00 Observation Bed Days 28. 00 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)									-	
26. 00 26. 25 27. 00 26. 25 27. 00 28. 00 0bservation Bed Days 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 00 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 26. 00 26. 25 27. 00 28. 00 29. 00 28. 00 29. 00 29. 00 30. 00 31. 00 32. 01 32. 01										
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 29. 00 Employee discount days - IRF 20. 00 Labor & delivery days (see instructions) 20. 01 Total ancillary labor & delivery room outpatient days (see instructions) 20. 01 Outpatient days (see instructions) 20. 02 Outpatient days (see instructions) 20. 02 Outpatient days (see instructions) 20. 02 Outpatient days (see instructions)			99. 40						U	ı
27.00 Total (sum of lines 14-26) 25 27.00 28.00 29.00 Ambulance Trips 29.00 29										l
28.00 Observation Bed Days 0 28.00 29.00 Ambulance Trips 29.00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 32.01 32.01 33.00 33.00 33.01 33.00 33.0					25					1
29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions)		,			23				_	1
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 30.00 31.00 32.00										1
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 31.00 0 0 0 32.00		·								
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 32.00										
32.01 Total ancillary labor & delivery room outpatient days (see instructions)		1 . 3			0		0			•
outpati ent days (see instructions)										•
33.00 LTCH non-covered days										
	33. 00	LTCH non-covered days								33. 00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN

Provi der CCN: 151323

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | Date/Time Prepared: | 5/31/2016 | 11:39 am

				'		5/31/2016 11:	39 am
		I/P Days	/ O/P Visits	/ Tri ps	Full Time	Equi val ents	
				·			
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6.00	7.00	8. 00	9. 00	10. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	967	180	2, 485			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)	756	3				2. 00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO I RF Subprovi der	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	449	0				5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF		0				6. 00
7. 00	Total Adults and Peds. (exclude observation	1, 416	180	3, 248			7. 00
0.00	beds) (see instructions)						0.00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)		400	440			12.00
13.00	NURSERY	1 41/	132			174 00	13.00
14.00	Total (see instructions)	1, 416	312		0.00	174. 80	
15. 00	CAH visits	U	0	U			15. 00
16.00	SUBPROVIDER - I PF						16.00
17. 00	SUBPROVIDER - I RF						17. 00
18. 00 19. 00	SUBPROVI DER						18. 00 19. 00
20. 00	SKILLED NURSING FACILITY NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21.00
22. 00	HOME HEALTH AGENCY						22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE						24.00
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC	o o	O				25. 00
25. 10	CMHC - CORF	0	0	0	0.00	0.00	
25. 10	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0	_	0.00		
25. 30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0	_	0.00		
25. 40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0		0.00		
26. 00	RURAL HEALTH CLINIC	ŏ	O		0.00	0.00	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)				0.00	174. 80	
28. 00	Observation Bed Days		63	661	0.00	171.00	28. 00
29. 00	Ambulance Trips	581	00	001			29. 00
30. 00	Employee discount days (see instruction)	551		34			30.00
31. 00	Employee discount days (see l'histraction)			0			31.00
32. 00	Labor & delivery days (see instructions)	0	45				32. 00
32. 01	Total ancillary labor & delivery room	Ĭ	10	0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33. 00
	·	'		•	•		•

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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provi der CCN: 151323

Peri od: Worksheet S-3 From 01/01/2015 Part I To 12/31/2015 Date/Ti me Prepared: 5/31/2016 11:39 am

						5/31/2016 11:	39 am
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12. 00	13.00	14. 00	Pati ents 15.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00		296	74	937	1. 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)			270	, 4	737	1.00
2.00	HMO and other (see instructions)			168	0		2. 00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	(296	74	937	14.00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC						24. 10 25. 00
25. 00	CMHC - CMF	0.00					25. 00 25. 10
25. 10	CMHC - CORP CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25. 10
25. 20	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25. 20
25. 40	CMHC - OUTPATIENT OCCUPATIONAL MERALT	0.00					25. 40
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0.00					27. 00
28. 00	Observation Bed Days	0.00					28. 00
29. 00	Ambulance Trips						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

	Financial Systems COMMUNITY HOSPT. OF LAGR				u of Form CMS-2	
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der (CCN: 151323	Peri od:	Worksheet S-10	0
				From 01/01/2015 To 12/31/2015	Date/Time Pre	narod:
				10 12/31/2013	5/31/2016 11:	
					1. 00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by lir	ne 202 column	n 8)	0. 309828	1. 00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				565, 190	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3. 00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p		from Medicaio	l?	N	4. 00
5.00	If line 4 is "no", then enter DSH or supplemental payments from N	Medi cai d			115, 691	5. 00
6.00	Medi cai d charges				6, 256, 396	6. 00
7. 00	Medicaid cost (line 1 times line 6)				1, 938, 407	7. 00
8. 00	Difference between net revenue and costs for Medicaid program (li	ine 7 minu	us sum of lir	nes 2 and 5; if	1, 257, 526	8. 00
	<pre>< zero then enter zero) Chita Children - Harlin Laurence Programma (CCHIR) (</pre>	6	!>			
0.00	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ach iine)		0	0.00
9.00	Net revenue from stand-allone SCHLP				0	9.00
10. 00 11. 00	Stand-alone SCHIP charges				0	10. 00 11. 00
12.00	Stand-alone SCHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone SCHIP (l	lina 11 mi	nuc Line O	if a zoro thon	0	12.00
12.00	lenter zero)	iine ii mi	nus i i ne 9;	ii < zero then	U	12.00
	Other state or local government indigent care program (see instru	ictions fo	or each line			
13. 00	Net revenue from state or local indigent care program (Not included in Not inc				369, 672	13. 00
14. 00	Charges for patients covered under state or local indigent care p				3, 333, 058	
00	10)	p. 09. a (.			0,000,000	
15. 00	State or local indigent care program cost (line 1 times line 14)				1, 032, 675	15. 00
16.00	Difference between net revenue and costs for state or local indic	gent care	program (lir	ne 15 minus line	663, 003	
	13; if < zero then enter zero)					
	Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fund	9	,			17. 00
18. 00	Government grants, appropriations or transfers for support of hos				0	18. 00
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local	i ndi gent	care program	ns (sum of lines	1, 920, 529	19. 00
	8, 12 and 16)		Uni mana	1	T-+-1 (1 1	
			Uni nsured	Insured	Total (col. 1	
			patients 1,00	patients 2.00	+ col . 2) 3.00	
20. 00	Total initial obligation of patients approved for charity care (a	at full	623, 65		1, 433, 578	20.00
20.00	charges excluding non-reimbursable cost centers) for the entire f		023, 00	007, 725	1, 433, 570	20.00
21. 00	, 9		193, 22	250, 937	444, 162	21. 00
	times line 20)	(,		,	
22. 00	Partial payment by patients approved for charity care		90	6, 747	7, 739	22. 00
23.00	1 . 3 . 3		192, 23		436, 423	23. 00
		'				
					1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient of		nd a Length o	of stay limit	N	24. 00
	imposed on patients covered by Medicaid or other indigent care pr			_		
25. 00	If line 24 is "yes," charges for patient days beyond an indigent		ogram's Lengt	th of stay limit	0	
26. 00	Total bad debt expense for the entire hospital complex (see instr				4, 434, 778	
27. 00			>		250, 185	
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line	e 26 minus	s line 27)		4, 184, 593	28. 00

28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)

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

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)

1, 296, 504 29. 00 1, 732, 927 30. 00 3, 653, 456 31. 00

4, 184, 593

28.00

		MUNITY HOSPT. OF				u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE ()F EXPENSES	Provi der		Period: From 01/01/2015	Worksheet A	
						Date/Time Pre	
	Cook Cooker Doorsinting	C-1:	0+1	T-+-1 (1 1	D1: 6:+:	5/31/2016 11:	39 am
	Cost Center Description	Sal ari es	0ther	+ col . 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
				1 001. 2)	0113 (300 11 0)	(col . 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		4 504 040	1 50/ 0/	001.100		
1.00	OO100 CAP REL COSTS-BLDG & FIXT OO101 EMS WEST STATION		1, 506, 069	1, 506, 06			
1. 01 2. 00	00200 CAP REL COSTS-MVBLE EQUIP		0		0 16, 040 0 544, 314	16, 040 544, 314	
2. 01	00201 EMS WEST STATION EQUIP.		o		5, 906	5, 906	
3.00	00300 OTHER CAP REL COSTS		o		0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 512, 294	2, 741, 692	4, 253, 98	6 0	4, 253, 986	
5. 00	00500 ADMINISTRATIVE & GENERAL	5, 711, 316	2, 974, 263	8, 685, 57	9 -45, 057	8, 640, 522	5. 00
6.00	OO6OO MAINTENANCE & REPAIRS OO7OO OPERATION OF PLANT	220 (01	722 217	0/2 01	0 25 272	0	6.00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE	239, 601	723, 317 81, 779	962, 91 81, 77		937, 645 81, 779	
9. 00	00900 HOUSEKEEPING	158, 264	40, 557	198, 82		198, 800	
10.00	01000 DI ETARY	340, 485	292, 527	633, 01		232, 024	
11. 00	01100 CAFETERI A	0	o		0 400, 451	400, 451	
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0		0	0	12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	319, 530	1, 183	320, 71		320, 629	
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	452, 150	-34, 345 1, 045, 507	-34, 34 1, 497, 65		-34, 380 542, 603	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	432, 130	1, 043, 307	1, 477, 03	0 -755,054	0 342,003	
17. 00	01700 SOCIAL SERVICE	Ö	Ö		0 0	0	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	О		0 0	0	19. 00
20. 00	02000 NURSI NG SCHOOL	0	0		0	0	20. 00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	21. 00
22. 00 23. 00	O2200 1 & R SERVI CES-OTHER PRGM COSTS APPRV O2300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	22. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	0 0	0	23.00
30. 00		1, 600, 250	459, 032	2, 059, 28	2 -732, 389	1, 326, 893	30.00
43.00	04300 NURSERY	0	0		0 159, 772		1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	685, 375	337, 994	1, 023, 36			
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY		763, 016	763, 01	569, 347	569, 347 763, 016	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	602, 703	491, 603	1, 094, 30		1, 062, 125	
60.00	06000 LABORATORY	0	873, 991	873, 99		873, 736	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	o		0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	300, 692	9, 615	310, 30		'	
66.00	06600 PHYSI CAL THERAPY	539, 994	11, 368	551, 36			1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY		0		0 108, 550 0 74, 072	108, 550 74, 072	1
69. 00	06900 ELECTROCARDI OLOGY		0		0 74,072	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	512, 297	512, 29	7 -214, 708	297, 589	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	O		0 214, 405		
	07300 DRUGS CHARGED TO PATIENTS	0	0		946, 087		
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	
76. 98 76. 99	O7698 HYPERBARI C OXYGEN THERAPY O7699 LI THOTRI PSY		0			0	1
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u></u>		<u> </u>		70.77
90.00	09000 CLI NI C	0	0	-	0 0	0	90. 00
90. 01	09001 LI FEBRI DGE SENI OR CARE	117, 738	102, 376	220, 11			
		710, 382	1, 708, 895	2, 419, 27	7 -16, 711	2, 402, 566	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	923, 887	292, 920	1, 216, 80	7 - 796	1, 216, 011	95. 00
99. 10	09910 CORF	0	O		0 0	0	1
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	0		0	0	
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		0	0	
99. 40	O9940 OUTPATI ENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS	0	U		0	0	99. 40
113.00	11300 INTEREST EXPENSE		127, 903	127, 90	3 -128, 439	-536	113. 00
118.00		14, 214, 661	15, 063, 559	29, 278, 22			
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 409	9, 40			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH	0	3, 070	3, 07			192. 00 194. 00
	07951 FOUNDATION	38, 688	-57, 550 15, 101	-57, 55 53, 78			194. 00
	07952 COMMUNITY & VOLUNTEER SVCS	13, 437	146, 188	159, 62		159, 625	
194.04	07954 ER PHYSICIAN	0	0		0 0	0	194. 04
	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0		0		194. 06
200.00	TOTAL (SUM OF LINES 118-199)	14, 266, 786	15, 179, 777	29, 446, 56	3 0	29, 446, 563	J200. 00

Heal th	Financial Systems COMM	MUNITY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	u of Form CMS-:	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der	CCN: 151323	Peri od:	Worksheet A	
					From 01/01/2015 To 12/31/2015	Date/Time Pre	nared.
					10 12/31/2013	5/31/2016 11:	39 am
	Cost Center Description	Adjustments	Net Expenses				
		(See A-8)	For Allocation	1			
	GENERAL SERVICE COST CENTERS	6. 00	7. 00				
1. 00	00100 CAP REL COSTS-BLDG & FIXT	17, 940	1, 189, 521	I			1.00
1. 01	00101 EMS WEST STATION	0	16, 040	1			1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0		1			2. 00
2.01	00201 EMS WEST STATION EQUIP.	0	5, 906	,			2. 01
3.00	00300 OTHER CAP REL COSTS	0	0				3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-727, 437		1			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-2, 129, 086	6, 511, 436				5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	0	0	1			6. 00
7.00	00700 OPERATION OF PLANT	-6, 070		1			7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE	0	81, 779	1			8. 00 9. 00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	198, 800 232, 024				10.00
11. 00	01100 CAFETERI A	-233, 989					11.00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0		1			12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	320, 629	•			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	-34, 380				14. 00
15. 00	01500 PHARMACY	0	542, 603				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0)			16. 00
17. 00	01700 SOCIAL SERVICE	0	0	1			17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0				19. 00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	1				20.00
21.00	02200 I &R SERVICES-SALARY & FRINGES APPRV		1				21.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	ł .	1			23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS			1			23.00
30.00	03000 ADULTS & PEDIATRICS	18, 441	1, 345, 334				30.00
43.00	04300 NURSERY	0		1			43.00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0		1			50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		1			52. 00
53. 00	05300 ANESTHESI OLOGY	-696, 034		1			53. 00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	-1, 647 0	1, 060, 478	1			54. 00 60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS			1			62. 30
65. 00	06500 RESPIRATORY THERAPY	0	306, 049				65. 00
66. 00	06600 PHYSI CAL THERAPY	-228		1			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	108, 550				67. 00
68. 00	06800 SPEECH PATHOLOGY	-7, 872	66, 200)			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	,				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-251, 150		1			73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	•	1			76. 97
	O7698 HYPERBARI C OXYGEN THERAPY O7699 LI THOTRI PSY	0		1			76. 98 76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS			1			70. 77
90. 00	09000 CLI NI C	0	0)			90.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	-486	218, 988				90. 01
91. 00	09100 EMERGENCY	-958, 391	1, 444, 175				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS			1			
95. 00	09500 AMBULANCE SERVICES	-300					95. 00
99. 10 99. 20	09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY	0 0					99. 10 99. 20
99. 20	09930 OUTPATIENT OCCUPATIONAL THERAPY						99. 20
99. 40	09940 OUTPATIENT SCEECH PATHOLOGY	0		1			99. 40
77. 10	SPECIAL PURPOSE COST CENTERS			1			77. 10
113.00	11300 INTEREST EXPENSE	536	0				113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-4, 975, 773	24, 245, 449	1			118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 409				190. 00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	_, -,	1			192. 00
	07950 OCCUPATIONAL HEALTH	0	1				194. 00
	07951 FOUNDATION	0		1			194. 01
	07952 COMMUNITY & VOLUNTEER SVCS	-259 0		1			194. 03 194. 04
	07954 ER PHISICIAN 07953 SHIPSHEWANA RADIOLOGY AND LAB						194. 04
200.00		-4, 976, 032	24, 470, 531				200.00
				•			

COMMUNITY HOSPT. OF LAGRANGE CTY IN Provider CCN: 151323 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 5/31/2016 11: 39 am

	Increases				5/31/2016 II: 39 am	
	Cost Center	Li ne #	Salary	Other		
	2.00	3. 00	4. 00	5. 00		
	A - REHAB THERAPY RECLASS	3.00	4.00	5.00		
1 00	OCCUPATI ONAL THERAPY	(7.00	107 420	2 2/1		1 00
1.00	•	67.00	107, 420	2, 261		1.00
2.00	SPEECH PATHOLOGY		72, 545			2. 00
	U D DEGLACO		179, 965	3, 788		
	B - OB RECLASS	40.00	404 054	20.010		
1.00	NURSERY	43.00	126, 854	32, 918		1.00
2.00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	<u>452, 0</u> 43	11 <u>7, 3</u> 04		2. 00
	0		578, 897	150, 222		
	F - CAFETERIA RECLASS			F		
1.00	CAFETERI A	<u>11.</u> 00	21 <u>4, 6</u> 53	18 <u>5, 7</u> 98		1.00
	0		214, 653	185, 798		
	G - INSURANCE RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	32, 970		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11, 626		2. 00
				44, 596		
	H - DRUGS CHARGED TO PATIENTS					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	948, 461		1. 00
2. 00		0.00	o	0		2.00
3. 00		0.00	0	0		3.00
4. 00		0.00	0	Ö		4.00
5. 00		0.00	0	0		5. 00
5.00						5.00
	U DESILARI		U	948, 461		
4 25	I - SALARY RECLASS		_1	0 (61 10-		
1. 00	ADMI NI STRATI VE & GENERAL		•	<u>2, 681, 488</u>		1.00
	0		0	2, 681, 488		
	J - OCCUPATIONAL HEALTH RECLA					
1.00	OCCUPATI ONAL HEALTH	194. 00	0	57, 550		1. 00
2.00		0.00	0	О		2. 00
3.00		0.00	0	О		3. 00
4.00		0.00	o	o		4. 00
5.00		0.00	0	0		5. 00
6. 00		0.00	ol	Ō		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
9.00				57, 550		7.00
	K - DEPRECIATION		U	57, 550		
4 00		0.00	ما	100 070		1.00
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	493, 379		1. 00
2.00	EMS WEST STATION	1. 01	0	16, 040		2. 00
3.00	EMS WEST STATION EQUIP.	2. 01	0	5, 110		3. 00
4.00	ADMI NI STRATI VE & GENERAL		0_	<u>6, 8</u> 85		4. 00
	0		0	521, 414		
	L - BLDG & LEASE EXPENSE					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	25, 517		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	39, 309		2. 00
3.00	EMS WEST STATION EQUIP.	2. 01	o	796		3. 00
4.00		0.00	ol	О		4. 00
5.00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	Ö	o		7.00
8. 00		0.00	0	0		8.00
			0			
9.00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11.00		0. 00	0	0		11.00
12.00		0. 00	0	0		12.00
13.00		0. 00	0	0		13. 00
14.00		0.00	O	0		14.00
15.00		0.00	O	0		15. 00
16.00		0.00	0	О		16. 00
17.00		0.00	ol	0		17. 00
				65, 622		
	M - INTEREST RECLASS		~1	,		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	128, 439		1.00
	0	— — 1.00	升	128, 439		1.00
	N IMPLANTABLE MEDICAL CURDI	IEC	U	120, 437		
1 00	N - IMPLANTABLE MEDICAL SUPPL		<u></u>	214 405		1 00
1. 00	I MPL. DEV. CHARGED TO	72. 00	0	214, 405		1.00
1. 00			0			1.00
	I MPL. DEV. CHARGED TO		0 0 973, 515	214, 405 		1. 00

Health Financial Systems RECLASSIFICATIONS COMMUNITY HOSPT. OF LAGRANGE CTY IN
Provider CCN: 151323 In Lieu of Form CMS-2552-10

						5/31/2016 1	1: 39 am
		Decreases	0.1	0.11			
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - REHAB THERAPY RECLASS	7.00	6.00	9.00	10.00		
1.00	PHYSI CAL THERAPY	66.00	179, 965	3, 788	8 0		1.00
2.00		0.00	0		0		2. 00
	0		179, 965	3, 788	B		
	B - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	578, 897	150, 222			1.00
2.00		0.00	<u>0</u> 578, 897	00 150, 222	0 0		2. 00
	F - CAFETERIA RECLASS		5/8,89/	150, 222	4		
1.00	DI ETARY	10.00	214, 653	185, 798	8 0		1.00
1.00			214, 653	185, 798	+		1.00
	G - INSURANCE RECLASS	, ·			1		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	44, 596			1. 00
2.00		0.00	0	0	12		2. 00
	0		0	44, 596	b		
1 00	H - DRUGS CHARGED TO PATIENTS	15 00	0	045 (11			1 00
1. 00 2. 00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	945, 611 671			1. 00 2. 00
3.00	OPERATING ROOM	50.00	0	1, 401	1		3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	270			4. 00
5.00	EMERGENCY	91.00	0	508	0		5. 00
	0		0	948, 461			
	I - SALARY RECLASS						
1.00	ADMI NI STRATI VE & GENERAL			<u>2, 681, 488</u>			1. 00
	U CCUDATIONAL HEALTH DECLAR		0	2, 681, 488	3		
1. 00	J - OCCUPATIONAL HEALTH RECLATIONAL OF THE RECLATION OF T	54.00	O	31, 594	0		1.00
2.00	LABORATORY	60.00	0	255			2. 00
3.00	RESPIRATORY THERAPY	65. 00	Ö	67	1		3. 00
4.00	PHYSI CAL THERAPY	66.00	0	6, 759	0		4. 00
5.00	OCCUPATI ONAL THERAPY	67.00	0	1, 131	0		5. 00
6.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	303	0		6. 00
7.00	PATI ENT	72.00		2 274			7.00
7. 00 8. 00	DRUGS CHARGED TO PATIENTS EMERGENCY	73. 00 91. 00	0	2, 374 14, 892			7. 00 8. 00
9. 00	OPERATING ROOM	50.00	0	14, 692			9. 00
7. 00	0		 	57, 550			7.00
	K - DEPRECIATION	<u>'</u>		, , , , , , , , , , , , , , , , , , , ,	'		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	521, 414			1. 00
2.00		0. 00	0	C	9		2. 00
3.00		0.00	0	C	9		3. 00
4. 00		0.00	0	<u></u> 0	<u> </u>		4. 00
	L - BLDG & LEASE EXPENSE		<u> </u>	321, 414	i		
1.00	OPERATION OF PLANT	7.00	0	25, 200	10		1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	O	317			2. 00
3.00	AMBULANCE SERVICES	95.00	0	796			3. 00
4.00	ADMINISTRATIVE & GENERAL	5. 00	0	7, 346			4. 00
5.00	OPERATION OF PLANT	7.00	0	73			5. 00
6. 00 7. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	0	21			6. 00 7. 00
7. 00 8. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	537 35			8. 00
9. 00	PHARMACY	15. 00	0	9, 443			9. 00
10.00	ADULTS & PEDIATRICS	30.00	Ö	2, 599			10. 00
11.00	OPERATING ROOM	50.00	0	11, 034	0		11. 00
12.00	RESPIRATORY THERAPY	65.00	0	4, 191			12. 00
13.00	PHYSI CAL THERAPY	66.00	0	1, 443			13. 00
14.00	EMERGENCY	91.00	0	1, 311			14. 00
15. 00 16. 00	PHYSICIANS' PRIVATE OFFICES LIFEBRIDGE SENIOR CARE	192. 00 90. 01	0	552 640			15. 00 16. 00
17. 00	NURSING ADMINISTRATION	13. 00	o	84			17. 00
17.00	0		 	65, 622			17.00
	M - INTEREST RECLASS		31	33, 322			
1.00	INTEREST EXPENSE	113.00	0	128, 439	11		1.00
	0		0	128, 439			
_	N - IMPLANTABLE MEDICAL SUPPL		,				
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	214, 405	0		1. 00
	PATI ENT	+		214, 405	 		
500. 00	Grand Total: Decreases		973, 515	5, 001, 783			500.00
555.00	1	1	, 0.10	5, 551, 765	-1		1 555. 55

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 Provi der CCN: 151323 Peri od: Worksheet A-7 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/31/2016 11:39 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Retirements Bal ances 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 265,000 17, 529 17, 529 0 1.00 0 2.00 Land Improvements 1, 972, 720 0 2.00 0 3.00 3.00 Buildings and Fixtures 13, 245, 217 184, 641 184, 641 0 0 4.00 Building Improvements 29, 098 0 4.00 5.00 Fixed Equipment 7, 791, 840 6,876 0 6, 876 5.00 0 6.00 Movable Equipment 7, 082, 044 415, 059 415, 059 13, 533 6.00 0 7.00 HIT designated Assets 1, 429, 338 113, 567 113, 567 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 31, 815, 257 737, 672 737, 672 13, 533 8.00 9.00 Reconciling Items 28, 442 6, 338 0 6, 338 9.00 Total (line 8 minus line 9) 31, 786, 815 13, 533 10.00 731, 334 0 731, 334 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 282, 529 1.00 2.00 Land Improvements 1, 972, 720 203, 240 2.00 13, 429, 858 . Buildings and Fixtures 3.00 46, 964 3.00 13, 778 4.00 Building Improvements 29, 098 4.00 5.00 Fi xed Equipment 7, 798, 716 508, 867 5.00 6.00 Movable Equipment 7, 483, 570 3, 743, 983 6.00 1, 542, 905 7.00 HIT designated Assets 7. 00 Ω

32, 539, 396

32, 504, 616

34, 780

4, 516, 832

4, 516, 832

3.00

Total (sum of lines 1-2)

3.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 151323 Peri od: Worksheet A-7 From 01/01/2015 Part II Date/Time Prepared: То 12/31/2015 5/31/2016 11:39 am SUMMARY OF CAPITAL Depreciation Insurance (see Taxes (see Cost Center Description Lease Interest instructions) instructions) 10.00 11.00 12.00 9.00 13.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 1, 506, 069 0 1.00 0 0 1.01 EMS WEST STATION 0 0 1.01 0 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 0 0 0 2.01 EMS WEST STATION EQUIP. 0 0 0 2.01 1, 506, 069 3.00 3.00 Total (sum of lines 1-2) SUMMARY OF CAPITAL Cost Center Description 0ther Total (1) (sum Capital-Relate of cols. 9 d Costs (see through 14) instructions) 15.00 14.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 1, 506, 069 1.00 0 1.01 EMS WEST STATION 1.01 CAP REL COSTS-MVBLE EQUIP 0 2.00 0 2.00 2.01 EMS WEST STATION EQUIP. 2.01

1, 506, 069

Health Financial Systems	COMMUNITY HOSPT. OF LAGRANGE CTY IN	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 151323	Peri od: From 01/01/2015 Part III To 12/31/2015 Date/Time Prepared: 5/31/2016 11: 39 am
	COMPUTATION OF RATIOS	ALLOCATION OF OTHER CAPITAL

	TELEVITOR OF CAPITAL COSTS CENTERS		l rovider	F	rom 01/01/2015 o 12/31/2015	Part III Date/Time Prep 5/31/2016 11:3	
		COME	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		Г	T			
1.00	CAP REL COSTS-BLDG & FIXT	23, 178, 336	l e	23, 178, 336		0	1. 00
1. 01	EMS WEST STATION	334, 586		334, 586		0	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	7, 325, 417				0	2.00
2. 01	EMS WEST STATION EQUIP.	158, 153	l .	100, 100			2. 01
3.00	Total (sum of lines 1-2)	30, 996, 492					3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS		1			
1. 00	CAP REL COSTS-BLDG & FIXT	NTERS 0	0	0	1, 002, 595		1. 00
1. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION	NTERS 0	0	0	16, 040	0	1. 01
1. 01 2. 00	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP	O O	000000000000000000000000000000000000000	0 0	16, 040 493, 379	0 39, 309	1. 01 2. 00
1. 01 2. 00 2. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP.	O 0 0 0	000000000000000000000000000000000000000	0 0 0 0	16, 040 493, 379 5, 110	0 39, 309 796	1. 01 2. 00 2. 01
1. 01 2. 00	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP	O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0	16, 040 493, 379 5, 110 1, 517, 124	0 39, 309 796	1. 01 2. 00
1. 01 2. 00 2. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP.	NTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 St	0 0 0 0 0 0 0 0 0 0 0 0 0 0	16, 040 493, 379 5, 110 1, 517, 124	0 39, 309 796	1. 01 2. 00 2. 01
1. 01 2. 00 2. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP.	0 0 0 0 0	0 0 0 0 0 5t		16, 040 493, 379 5, 110 1, 517, 124	0 39, 309 796	1. 01 2. 00 2. 01
1. 01 2. 00 2. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2)	0 0 0 0 0	Insurance (see	Taxes (see	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate	0 39,309 796 65,622 Total (2) (sum of cols. 9	1. 01 2. 00 2. 01
1. 01 2. 00 2. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2)	0 0 0 0 0	Insurance (see	Taxes (see	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see	0 39,309 796 65,622 Total (2) (sum	1. 01 2. 00 2. 01
1. 01 2. 00 2. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2)	0 0 0 0 0 0	Insurance (see instructions)	Taxes (see instructions)	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see i nstructi ons)	0 39,309 796 65,622 Total (2) (sum of cols. 9 through 14)	1. 01 2. 00 2. 01
1. 01 2. 00 2. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2) Cost Center Description	0 0 0 0 0 0 1 nterest	Insurance (see	Taxes (see	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see	0 39,309 796 65,622 Total (2) (sum of cols. 9	1. 01 2. 00 2. 01
1. 01 2. 00 2. 01 3. 00	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2) Cost Center Description PART III - RECONCILIATION OF CAPITAL COSTS CE	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Insurance (see instructions)	Taxes (see instructions)	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see instructions) 14, 00	0 39,309 796 65,622 Total (2) (sum of cols. 9 through 14)	1. 01 2. 00 2. 01 3. 00
1. 01 2. 00 2. 01 3. 00	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2) Cost Center Description PART III - RECONCILIATION OF CAPITAL COSTS CE CAP REL COSTS-BLDG & FIXT	0 0 0 0 0 0 1 nterest	Insurance (see instructions) 12.00	Taxes (see instructions)	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see instructions) 14.00	0 39,309 796 65,622 Total (2) (sum of cols. 9 through 14) 15.00	1. 01 2. 00 2. 01 3. 00
1. 01 2. 00 2. 01 3. 00 1. 00 1. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2) Cost Center Description PART III - RECONCILIATION OF CAPITAL COSTS CE CAP REL COSTS-BLDG & FIXT EMS WEST STATION	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Insurance (see instructions) 12.00 32,970	Taxes (see instructions) 13.00	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see instructions) 14.00	0 39,309 796 65,622 Total (2) (sum of cols. 9 through 14) 15.00 1,189,521 16,040	1. 01 2. 00 2. 01 3. 00 1. 00 1. 01
1. 01 2. 00 2. 01 3. 00 1. 00 1. 01 2. 00	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2) Cost Center Description PART III - RECONCILIATION OF CAPITAL COSTS CE CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Insurance (see instructions) 12.00	Taxes (see instructions) 13.00 0 0 0 0	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see i nstructions) 14.00	0 39,309 796 65,622 Total (2) (sum of cols. 9 through 14) 15.00 1,189,521 16,040 544,314	1. 01 2. 00 2. 01 3. 00 1. 00 1. 01 2. 00
1. 01 2. 00 2. 01 3. 00 1. 00 1. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2) Cost Center Description PART III - RECONCILIATION OF CAPITAL COSTS CE CAP REL COSTS-BLDG & FIXT EMS WEST STATION	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Insurance (see instructions) 12.00 32,970 0 11,626	Taxes (see instructions) 13.00 0 0 0 0 0	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see instructions) 14. 00	0 39,309 796 65,622 Total (2) (sum of cols. 9 through 14) 15.00 1,189,521 16,040	1. 01 2. 00 2. 01 3. 00 1. 00 1. 01

Health Financial Systems
ADJUSTMENTS TO EXPENSES

					To 12/31/2015		
				Expense Classification or		5/31/2016 11:	39 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	<u>, </u>	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
1. 01	Investment income - EMS WEST STATION (chapter 2)		0	EMS WEST STATION	1. 01	0	1. 01
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
2. 01	COSTS-MVBLE EQUIP (chapter 2) Investment income - EMS WEST		0	EMS WEST STATION EQUIP.	2. 01	0	2. 01
3. 00	STATION EQUIP. (chapter 2) Investment income - other		0		0.00	0	3. 00
	(chapter 2)		0				
4. 00	Trade, quantity, and time discounts (chapter 8)		Ü		0.00		
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Tel ephone servi ces (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)	A	-4, 438	OPERATION OF PLANT	7. 00	0	8. 00
9.00	Parking Lot (chapter 21) Provider-based physician	1 1 2	1 975 757		0. 00		
10. 00	adjustment	A-8-2	-1, 875, 757			0	
11. 00	Sale of scrap, waste, etc. (chapter 23)	A	-1, 632	OPERATION OF PLANT	7. 00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	-1, 914, 036			0	12. 00
13. 00	Laundry and linen service	_	0		0.00		
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-233, 989 0	CAFETERI A	11. 00 0. 00		
16. 00	and others Sale of medical and surgical		0		0.00	0	16. 00
10.00	supplies to other than		0		0.00		10.00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and	1	0		0.00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0.00		
	books, etc.)		-				
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00		
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
24.00	therapy costs in excess of	A-0-3	0	ITITOTE TILICAL I	00.00		24.00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
26. 01	COSTS-BLDG & FIXT Depreciation - EMS WEST		0	EMS WEST STATION	1. 01	0	26. 01
27. 00	STATION Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
27. 01	COSTS-MVBLE EQUIP			EMS WEST STATION EQUIP.	2. 01		
	STATION EQUIP.						
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00		28. 00 29. 00
30. 00		A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	limitation (chapter 14)						

Health Financial Systems ADJUSTMENTS TO EXPENSES Provi der CCN: 151323 Peri od: Worksheet A-8 From 01/01/2015
To 12/31/2015 Date/Time Prepared:

) 12/31/2015	5/31/2016 11:	
				Expense Classification on	Worksheet A	070172010 11.	0 7 dill
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Paci c/Codo (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	Basi s/Code (2) 1.00	2.00	3. 00	4. 00	5. 00	
30. 99	Hospice (non-distinct) (see	1.00		ADULTS & PEDIATRICS	30.00	5.00	30. 99
30. 77	instructions)		O	ADDETS & FEDIATRICS	30.00		30. 77
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						
33.00	0444 444 7 484 8588 048845848		0		0.00	0	33.00
33. 01	CAH HIT ADJ DEPR CARRYFRWD	A	-28, 501	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	2015 CAH HIT ADJ DEPR CARRYFRWD	A	20 OE1	ADMINISTRATIVE & GENERAL	E 00	0	33. 02
33. 02	2014	A	-20, 931	ADMINISTRATIVE & GENERAL	5. 00	U	33.02
33. 03	CAH HIT ADJ DEPR CARRYFRWD	A	-59 039	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
00.00	2013		07,007	7.0 11.0.1.0.1.1.1.1.2. (a. 02.1.2.10.1.2	0.00	ŭ	00.00
33. 04	CAH HIT ADJ DEPR CARRYFRWD	A	-99, 794	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
	2012						
34.00	MI SCELLANEOUS REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	
35. 00	SPEECH THERAPY CONTRACTED	В		SPEECH PATHOLOGY	68. 00	0	35. 00
36. 00	NON-PATIENT EMS REVENUE	В	-300	AMBULANCE SERVICES	95. 00	0	36. 00
37. 00			0		0. 00	0	37. 00
38. 00	PHARMACY EMPLOYEE RX PURCHASES			DRUGS CHARGED TO PATIENTS	73. 00	0	38. 00
39. 00	REVERSAL OF 2014 INTEREST	A	536	INTEREST EXPENSE	113. 00	0	39. 00
40.00	ACCRUAL	Δ.	707 407	EMDLOVEE DENEELTS DEDADTMENT	4 00	0	40.00
40.00	SELF INSURANCE	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41. 00	LOBBY % OF DUES & SUBSCRIPTIONS	A	-2, 907	ADMINISTRATIVE & GENERAL	5. 00	U	41. 00
44. 00	EKG INTERPRETATION COSTS	A	-1 450	RADI OLOGY-DI AGNOSTI C	54.00	0	44. 00
44. 01	MARKETI NG	A	·	COMMUNITY & VOLUNTEER SVCS	194. 03	0	
44. 02	MARKETING	A		RADI OLOGY-DI AGNOSTI C	54. 00	0	44. 02
44. 03	MARKETING	A		PHYSI CAL THERAPY	66.00	0	
44. 04	MARKETING	A		ADMINISTRATIVE & GENERAL	5. 00	0	44. 04
44. 05	MARKETING	A		LIFEBRIDGE SENIOR CARE	90. 01	0	44. 05
47. 00	ADD-BACK OF DEMOLISHED ASSET	A		CAP REL COSTS-BLDG & FIXT	1. 00	9	47. 00
	DEPREC						
48.00	ADD-BACK OF DEMOLITION COSTS	A	4, 125	ADMINISTRATIVE & GENERAL	5. 00	0	48. 00
49.00			0		0.00	0	49. 00
49. 01	TELEMETRY MONITORING EXPENSE	A		ADULTS & PEDIATRICS	30. 00	0	49. 01
49. 02	MEDICAL DIRECTOR ADDITIONAL	A	-304	ADULTS & PEDIATRICS	30. 00	0	49. 02
	A/P			ANEGELESI OLOGIA	50.00		
49. 03	ON-CALL PROF TIME	A		ANESTHESI OLOGY	53.00	0	
49. 04	GROSS-UP ANESTHESIA EXPENSE FOR A/R	A	282, 058	ANESTHESI OLOGY	53. 00	0	49. 04
49. 05	CHARITY CONTRIBUTIONS	A	_1 036	ADMINISTRATIVE & GENERAL	5. 00	0	49. 05
49. 05	MEDICAL DIRECTOR ADDITIONAL	A		LIFEBRIDGE SENIOR CARE	90. 01	0	49. 05
77.00	A/P		-400	ELLERY DOE SENIOR ONCE	70.01		77.00
50.00	TOTAL (sum of lines 1 thru 49)		-4, 976, 032				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)			_			
(4) D	comintion all about an mafaran			0110 D L 45 4			_

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

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

B. Amount Received - if cost cannot be determined.

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

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

OFFICE COSTS

From 01/01/2015
To 12/31/2015 Date/Time Prepared:

				10 12/31/2013	5/31/2016 11:					
	Li ne No.	Cost Center	Expense Items	Amount of	Amount					
				Allowable Cost	Included in					
					Wks. A, column					
					5					
	1. 00	2. 00	3. 00	4. 00	5. 00					
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED									
	HOME OFFICE COSTS:									
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	5, 024, 133	5, 000, 000	1. 00				
2.00	5. 00	ADMINISTRATIVE & GENERAL	RELATED PARTY SUBSIDY ADJ.	0	1, 938, 169	2. 00				
3.00	0.00			0	0	3. 00				
4.00	0.00			0	0	4. 00				
5.00	TOTALS (sum of lines 1-4).			5, 024, 133	6, 938, 169	5. 00				
	Transfer column 6, line 5 to									
	Worksheet A-8, column 2,									
	line 12.									

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

 de net been peeted to not teneet if del dimine i and of 2, the amount all order a be that eated in bertain i of the parti									
			Related Organization(s) and/	or Home Office					
					1				
C	N	D	N	D					
Symbol (1)	Name	Percentage of	Name	Percentage of					
		Ownershi p		Ownershi p					
1. 00	2. 00	3. 00	4. 00	5. 00					
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:									

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

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

6. 00	В	0.00 PARKVIEW HEALTH SYSTEM, INC. 100.00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Heal th F	inancial Syste	ems			COMMUNI TY	HOSPT.	0F	LAGRANGE	CTY	ΙN			In Lie	u of Form CN	S-2552-10
STATEME OFFICE	NT OF COSTS OF	SERVI CES	FROM	RELATED	ORGANI ZATI O	NS AND HO	ME	Provi	der	CCN:	151323	Period: From 01/	01/2015	Worksheet A	N-8-1
	00010											To 12/	31/2015	Date/Time F 5/31/2016	
	Net	Wkst. A-7	Ref.												
	Adjustments														
	(col. 4 minus														
	col. 5)*														
	6. 00	7. 00													
	A. COSTS INCUR	RED AND AD	JUSTN	IENTS REC	QUIRED AS A I	RESULT OF	TR	RANSACTI ON	S W	ITH F	RELATED (ORGANI ZATI	ONS OR	CLAI MED	
	HOME OFFICE CO	STS:													
1.00	24, 133		0												1. 00
2.00	-1, 938, 169		0												2. 00
3.00	0		0												3. 00
4.00	0		0												4. 00
5.00	-1, 914, 036														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

nas not	been posted to worksheet A,	cordinins i and/or 2, the amount arrowable should be indicated in cordinin 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
		· ·	

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

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

	HOME OFFICE	6. 00
7.00		7. 00
8.00		8. 00
9.00		9. 00
10.00		10. 00
9. 00 10. 00 100. 00		100.00

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

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

Provi der CCN: 151323

Period: From 01/01/2015 To 12/31/2015 Worksheet A-8-2 Date/Time Prepared: 5/31/2016 11: 39 am

								5/31/2016 11:	39 am
	Wkst. A Line #	Cost Center/Physician	Total	Profess	i onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Compor	nent	Component		ider Component	
								Hours	
	1. 00	2.00	3.00	4.0	0	5. 00	6, 00	7. 00	
1. 00		AGGREGATE - ANESTHESI OLOGY	405, 130		38, 241		0.00		1. 00
2. 00		AGGREGATE-ANESTHESI OLOGY	579, 125	1	79, 125	· ·	0		
				1					
3.00		DR. A	30, 000		0	,			
4.00		AGGREGATE-EMERGENCY	1, 561, 382	1	58, 391	· ·	0	0	
5.00		DR. B	12, 049		0	,	0	0	0.00
6. 00	90. 01	AGGREGATE-LI FEBRI DGE SENI OR CARE	19, 480		0	19, 480	0	0	6. 00
7.00	0.00		0		0	0	0	0	7. 00
8.00	0.00		0		0	0	0	1 0	8. 00
9.00	0. 00		0		0	0	0	0	
10. 00	0. 00		1		0	0	0	0	
200.00	0.00		2, 607, 166	1 0	75, 757	731, 409		0	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Cost of	Provi der	Physician Cost	200.00
	WKSt. A LITTE #	I denti fi er							
		rdentifier	Limit			Memberships &	Component	of Malpractice	
				Li mi	τ	Conti nui ng	Share of col.	Insurance	
	4 00	0.00	0.00			Educati on	12	44.00	
	1. 00	2. 00	8.00	9. 0		12. 00	13. 00	14. 00	
1.00		AGGREGATE-ANESTHESI OLOGY	0		0		0		
2.00		AGGREGATE-ANESTHESI OLOGY	0		0	0	0	0	2. 00
3.00	91. 00	DR. A	0		0	0	0	0	3. 00
4.00	91. 00	AGGREGATE-EMERGENCY	0		0	0	0	0	4. 00
5.00	30.00	DR. B	0		0	0	0	0	5. 00
6.00	90. 01	AGGREGATE-LI FEBRI DGE SENI OR	0		0	0	0	l 0	6. 00
		CARE							
7.00	0.00		0		0	0	0	0	7. 00
8. 00	0.00		0		0	0	0	0	
9. 00	0. 00		1		0	0	0	0	
10. 00	0.00				0	0	0	0	10.00
200.00	0.00				0	0	0		200.00
200.00	WI+ A I : //	C+ C+ (Db	Done de la ca	A -1: + -	-I DCE	RCE	A -1: + +	U	200.00
	Wkst. A Line #	,	Provi der	Adjuste			Adjustment		
		I denti fi er	Component	Li mi	τ	Di sal I owance			
			Share of col.						
	4 00	0.00	14			47.00	10.00		
	1. 00	2. 00	15. 00	16. (17. 00	18. 00		
1. 00		AGGREGATE-ANESTHESI OLOGY	0		0	0	338, 241		1. 00
2.00		AGGREGATE-ANESTHESI OLOGY	0		0	0	579, 125		2. 00
3.00	91. 00	DR. A	0		0	0	0		3. 00
4.00	91. 00	AGGREGATE-EMERGENCY	0		0	0	958, 391		4. 00
5.00	30.00	DR. B	0		0	0	0		5. 00
6.00		AGGREGATE-LI FEBRI DGE SENI OR	0		0	0	0		6, 00
0.00	, , , , ,	CARE	Ĭ		·	Į .			0.00
7. 00	0. 00		0		0	0	n		7. 00
8. 00	0.00			1	0	_	١		8. 00
9. 00	0.00			1	0	_			9. 00
10. 00	0.00			1	0				10.00
	0.00			1	-		1 075 757		
200. 00		I	1 0	1	0	0	1, 875, 757	l	200. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2015 | Part I | To 12/31/2015 | Date/Time Prepared: | 5/31/2016 11: 39 am

						5/31/2016 11:	39 am
				CAPITAL REL	LATED COSTS		
	Cost Contor Description	Not Exposes	BLDG & FLXT	EMS WEST	MVBLE EQUIP	EMS WEST	
	Cost Center Description	Net Expenses for Cost	BLUG & FIXI	STATI ON	MARTE EGOLA	STATION EQUIP.	
		Allocation		STATION		STATION EQUIP.	
		(from Wkst A					
		col. 7)					
		0	1. 00	1. 01	2. 00	2. 01	
GENE	RAL SERVICE COST CENTERS	Ŭ	1.00	1.01	2.00	2.01	
	O CAP REL COSTS-BLDG & FIXT	1, 189, 521	1, 189, 521				1.00
1	1 EMS WEST STATION	16, 040	0	16, 040			1. 01
1	O CAP REL COSTS-MVBLE EQUIP	544, 314	, and the second	10,010	544, 314		2. 00
	1 EMS WEST STATION EQUIP.	5, 906			01.701.	5, 906	2. 01
1	O EMPLOYEE BENEFITS DEPARTMENT	3, 526, 549	0	0	C	0	4. 00
	O ADMINISTRATIVE & GENERAL	6, 511, 436	214, 983	0	98, 374	l .	
1	O MAINTENANCE & REPAIRS	0	0	o	,	ol o	
1	O OPERATION OF PLANT	931, 575	67, 564	o	30, 917		7. 00
	O LAUNDRY & LINEN SERVICE	81, 779	3, 863	o	1, 768		
1	O HOUSEKEEPI NG	198, 800	12, 642	0	5, 785	l .	9. 00
1	O DI ETARY	232, 024	50, 723	0	23, 210	1	10.00
1	O CAFETERI A	166, 462	0	0	C	0	11. 00
	O MAINTENANCE OF PERSONNEL	0	o	0	C	0	12. 00
	O NURSING ADMINISTRATION	320, 629	o	0	C	0	13.00
	O CENTRAL SERVICES & SUPPLY	-34, 380	24, 094	0	11, 025	0	14.00
15. 00 0150	O PHARMACY	542, 603	20, 735	0	9, 488	0	15. 00
	O MEDICAL RECORDS & LIBRARY	0	4, 092	0	1, 872		16. 00
	O SOCIAL SERVICE	0	0	0	· C	0	17. 00
19.00 0190	O NONPHYSICIAN ANESTHETISTS	0	o	0	C	0	19. 00
	O NURSI NG SCHOOL	0	o	0	C	0	20.00
21. 00 0210	O I&R SERVICES-SALARY & FRINGES APPRV	0	o	0	C	0	21.00
	O I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	C	0	22. 00
	O PARAMED ED PRGM-(SPECIFY)	0	0	0	C	ol o	23. 00
	TIENT ROUTINE SERVICE COST CENTERS			- 1			
30. 00 0300	O ADULTS & PEDIATRICS	1, 345, 334	267, 721	0	122, 507	0	30.00
	O NURSERY	159, 772	4, 031	0	1, 845	1	43.00
ANCI	LLARY SERVICE COST CENTERS					•	
	O OPERATING ROOM	1, 010, 759	152, 595	0	69, 826	0	50.00
52.00 0520	O DELIVERY ROOM & LABOR ROOM	569, 347	19, 055	0	8, 720	0	52. 00
53.00 0530	O ANESTHESI OLOGY	66, 982	0	0	C	0	53. 00
	O RADI OLOGY-DI AGNOSTI C	1, 060, 478	77, 046	0	35, 255	0	
60.00 0600	O LABORATORY	873, 736	30, 171	0	13, 806	1	60.00
62. 30 0625	O BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	· C	0	62. 30
	O RESPIRATORY THERAPY	306, 049	15, 788	0	7, 224	0	65. 00
	O PHYSI CAL THERAPY	359, 179	50, 570	0	23, 140	l .	66.00
67. 00 0670	O OCCUPATIONAL THERAPY	108, 550	0	0	C	0	67. 00
68. 00 0680	O SPEECH PATHOLOGY	66, 200	o	0	C	0	68. 00
69. 00 0690	O ELECTROCARDI OLOGY	0	O	0	C	0	69. 00
71. 00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENT	297, 589	O	0	C	0	71. 00
72.00 0720	O IMPL. DEV. CHARGED TO PATIENTS	214, 405	0	0	C	0	72. 00
73.00 0730	O DRUGS CHARGED TO PATIENTS	694, 937	0	0	C	0	73. 00
76. 97 0769	7 CARDIAC REHABILITATION	0	0	0	C	0	76. 97
76. 98 0769	8 HYPERBARI C OXYGEN THERAPY	0	0	0	C	0	76. 98
	9 LI THOTRI PSY	0	0	0	C	0	76. 99
OUTP	ATIENT SERVICE COST CENTERS						
	O CLI NI C	0	0	0	C	0	90.00
	1 LI FEBRI DGE SENI OR CARE	218, 988	13, 894	0	6, 358	0	90. 01
91.00 0910	O EMERGENCY	1, 444, 175	105, 674	0	48, 356	0	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHE	R REIMBURSABLE COST CENTERS						
95.00 0950	O AMBULANCE SERVICES	1, 215, 711	0	16, 040	C	5, 906	95. 00
99. 10 0991	O CORF	0	0	0	C	0	99. 10
99. 20 0992	O OUTPATIENT PHYSICAL THERAPY	0	0	0	C	0	99. 20
99. 30 0993	O OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	C	0	99. 30
99. 40 0994	O OUTPATIENT SPEECH PATHOLOGY	0	0	0	C	0	99. 40
SPEC	IAL PURPOSE COST CENTERS						
113. 00 1130	O INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	24, 245, 449	1, 135, 241	16, 040	519, 476	5, 906	118. 00
NONR	EIMBURSABLE COST CENTERS						
190. 00 1900	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	9, 409	3, 405	0	1, 558	0	190. 00
	O PHYSICIANS' PRIVATE OFFICES	2, 518	50, 875	0	23, 280	l .	192. 00
	O OCCUPATIONAL HEALTH	0	0	0	C		194. 00
	1 FOUNDATI ON	53, 789	0	0	C		194. 01
194. 03 0795	2 COMMUNITY & VOLUNTEER SVCS	159, 366	O	0	C		194. 03
	4 ER PHYSICIAN	0	O	0	C		194. 04
	3 SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	C	0	194. 06
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers		0	0	C	0	201. 00

Health Financial Systems	COMMUNITY HOSPT. O	F LAGRANGE CTY	IN	In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015 Fo 12/31/2015		pared: 39 am
			CAPITAL RE	ELATED COSTS		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)		EMS WEST STATION		EMS WEST STATION EQUIP.	
	0	1. 00	1. 01	2. 00	2. 01	
202.00 TOTAL (sum lines 118-201)	24, 470, 531	1, 189, 521	16, 040	544, 314	5, 906	202. 00

Provi der CCN: 151323

				1	0 12/31/2015	5/31/2016 11:	
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		4.00	4A	5. 00	6. 00	7. 00	
	GENERAL SERVICE COST CENTERS				l		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 2. 00	00101 EMS WEST STATION 00200 CAP REL COSTS-MVBLE EQUIP						1. 01 2. 00
2. 00	00201 EMS WEST STATION EQUIP.						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 526, 549					4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 579, 149	8, 403, 942	8, 403, 942			5. 00
6.00	00600 MAI NTENANCE & REPAI RS	0	C	0	0		6. 00
7.00	00700 OPERATION OF PLANT	66, 248	1, 096, 304	1	0	1, 669, 747	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	87, 410	1	0	7, 112	8. 00
9.00	00900 HOUSEKEEPI NG	43, 759	260, 986	1	0	23, 275	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	34, 792 59, 350	340, 749 225, 812	1		93, 381 0	10. 00 11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	39, 330	223, 612) 110, 113	0	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	88, 348	408, 977	1	0	0	13.00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0	739	1	0	44, 357	14. 00
15. 00	01500 PHARMACY	125, 017	697, 843	365, 020	0	38, 173	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	5, 964	3, 120	0	7, 533	16. 00
17. 00	01700 SOCIAL SERVICE	0	C	0	0	0	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	C	0	0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	C		0	0	20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV				0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)				0	0	23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	J		91 0			25.00
30.00	03000 ADULTS & PEDI ATRI CS	282, 399	2, 017, 961	1, 055, 539	0	492, 876	30.00
43.00	04300 NURSERY	35, 074	200, 722	104, 991	0	7, 421	43. 00
	ANCILLARY SERVICE COST CENTERS				_		
50.00	05000 OPERATING ROOM	189, 503	1, 422, 683		0		50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	124, 988	722, 110 66, 982	1		35, 081 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	166, 644	1, 339, 423	1	0	141, 842	54.00
60. 00	06000 LABORATORY	0	917, 713	1	0	55, 545	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	83, 140	412, 201	215, 610	0	29, 065	65. 00
66. 00	06600 PHYSI CAL THERAPY	99, 546	532, 435	278, 500	0	93, 099	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	29, 701	138, 251	1		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	20, 058	86, 258	1	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	207 500	155 440	0	0	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS		297, 589 214, 405		0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		694, 937	1		0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C 7 . 7 7 C	0	0	l o	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	C	o	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	C	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS				T		
	09000 CLINIC	0	074 704				
90. 01 91. 00	09001 LI FEBRI DGE SENI OR CARE	32, 554	271, 794			25, 580 194, 548	•
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	196, 417	1, 794, 622	938, 711	0	194, 548	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS			4		L	72.00
95. 00	09500 AMBULANCE SERVICES	255, 450	1, 493, 107	780, 998	0	0	95. 00
99. 10	09910 CORF	0	C	0	0	0	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	C	0	0	0	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	C	0	0	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	C	0	0	0	99. 40
112 00	SPECIAL PURPOSE COST CENTERS					I	112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	3, 512, 137	24, 151, 919	8, 237, 285	0	1, 569, 817	113.00
110.00	NONREI MBURSABLE COST CENTERS	3, 312, 137	24, 131, 717	0, 237, 203		1, 307, 617	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14, 372	7, 518	0	6, 268	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	76, 673	1			192.00
194.00	07950 OCCUPATIONAL HEALTH	0	C	0		0	194. 00
194. 01	07951 FOUNDATI ON	10, 697	64, 486	33, 731	0	0	194. 01
	07952 COMMUNITY & VOLUNTEER SVCS	3, 715	163, 081	85, 303	0		194. 03
	07954 ER PHYSICIAN	0	C	0	0		194. 04
	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	C	0	0	0	194. 06
200.00	1 1		C		_		200.00
201. 00 202. 00		3, 526, 549	24, 470, 531	8, 403, 942	0		201.00
202.00	1.01/1E (30m 111103 110 201)	0, 020, 047	21, 170, 331	0, 400, 742	1	1,007,747	1-02.00

Provi der CCN: 151323

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 5/31/2016 | 11:39 am

					5/31/2016 11:	39 am
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	
	LINEN SERVICE				PERSONNEL	
	8. 00	9. 00	10. 00	11. 00	12. 00	
GENERAL SERVICE COST CENTERS	1					
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
1.01 O0101 EMS WEST STATION						1. 01
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
2.01 O0201 EMS WEST STATION EQUIP.						2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE	140, 243					8. 00
9. 00 00900 HOUSEKEEPI NG	42	420, 817				9.00
10. 00 01000 DI ETARY	1, 052	23, 970	637, 387			10.00
11. 00 01100 CAFETERI A	0	,	0	343, 927		11.00
12. 00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0.07,727	0	1
13. 00 01300 NURSI NG ADMINI STRATI ON	0	Ö	0	19, 732	0	1
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	11, 386	0	17, 732	0	
15. 00 01500 PHARMACY	0	9, 799	0	20, 449	0	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0		0	20, 449	0	
	0	1, 934	0	0	-	
17. 00 01700 SOCI AL SERVI CE	0	U	0	0	0	
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	O ₁	0	0	0	
20. 00 02000 NURSI NG SCHOOL	0	0	0	0	0	1
21.00 02100 1 &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
22.00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	1
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	46, 294	126, 520	637, 387	69, 757	0	
43. 00 04300 NURSERY	2, 202	1, 905	0	6, 697	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	21, 261	72, 113	0	46, 120	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 868	9, 005	0	23, 917	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	15, 301	36, 410	0	42, 971	0	1
60. 00 06000 LABORATORY	0	14, 258	0	,	0	1
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	, 200	0	0	Ö	1
65. 00 06500 RESPI RATORY THERAPY	435	7, 461	0	22, 362	0	
66. 00 06600 PHYSI CAL THERAPY	5, 273	23, 898	0	28, 342	0	1
67. 00 06700 OCCUPATI ONAL THERAPY	1, 795	23, 070	0	4, 305	0	
68. 00 06800 SPEECH PATHOLOGY	210	0	0	2, 910	0	
69. 00 06900 SPEECH PATHOLOGY	0	U O	0	2, 910	0	
	0	U O	0	0	0	1
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	U	U	0	0		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	U	0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	O ₁	0	0	0	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	O	0	0	0	1
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS	,					
90. 00 09000 CLI NI C	0	0	0	0	0	1
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	6, 566	0	9, 846	0	90. 01
91. 00 09100 EMERGENCY	28, 343	49, 940	0	46, 519	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	6, 535	0	0	0	0	95. 00
99. 10 09910 CORF	O	o	0	0	0	99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	1
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	O	Ö	0	0	0	
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	Ö	0	0	0	1
SPECIAL PURPOSE COST CENTERS	,	٩	<u> </u>	<u> </u>		77
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	136, 611	395, 165	637, 387	343, 927	n	118. 00
NONREI MBURSABLE COST CENTERS	130, 011	373, 103	037, 307	343, 727	0	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	1, 609	0	0		190. 00
			-	_		
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 632	24, 043	0	0		192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	이	이	0	0		194. 00
194. 01 07951 FOUNDATION	0	0	0	0		194. 01
194.03 07952 COMMUNITY & VOLUNTEER SVCS	0	0	0	0		194. 03
194. 04 07954 ER PHYSICIAN	0	0	0	0		194. 04
194.06 07953 SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194. 06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	o	ol	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	140, 243	420, 817	637, 387	343, 927	0	202. 00
			•			

Provi der CCN: 151323

					12/31/2015	5/31/2016 11:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	, a
		13. 00	SUPPLY 14. 00	15. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 EMS WEST STATION						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 EMS WEST STATION EQUIP.						2. 01
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1					4. 00 5. 00
6.00	00600 MAINTENANCE & REPAIRS						6.00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	642, 632					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	56, 869	1			14.00
15. 00	01500 PHARMACY	0	1, 578	1, 132, 862	10 551		15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE		0	0	18, 551	0	16. 00 17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20. 00	02000 NURSI NG SCHOOL	o o	0	Ö	0	Ö	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	O	0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	232, 190	4, 913	37	2, 716		30.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	22, 346	432	12	685		43.00
50. 00	05000 OPERATI NG ROOM	153, 577	9, 133	914	299	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	79, 632	1, 541	42	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 626	7, 725	5, 981	0	54.00
60. 00	06000 LABORATORY	0	0	0	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	297	0	1 (00	0	65. 00
66. 00 67. 00	06700 OCCUPATI ONAL THERAPY		231 78	337 116	1, 699 354		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	10	12	158		68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	0	0	0	l o	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	16, 339	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	11, 752	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1, 113, 698	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	U	<u> </u>	0	0	76. 99
90. 00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	0	159	0	0	0	
91.00	09100 EMERGENCY	154, 887	4, 070	1, 820	6, 659	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05.00	OTHER REIMBURSABLE COST CENTERS	1				1	05.00
95. 00	09500 AMBULANCE SERVI CES 09910 CORF	0	4, 584	8, 149	0	1	
99. 10 99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99. 10 99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
	SPECIAL PURPOSE COST CENTERS				<u>-</u>		
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		642, 632	56, 743	1, 132, 862	18, 551	0	118. 00
	NONREI MBURSABLE COST CENTERS	1				1	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12		0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH	0	104	0	0		192. 00 194. 00
	07950 OCCOPATIONAL HEALTH		5	0	0		194. 00
	307952 COMMUNITY & VOLUNTEER SVCS		5 5		0		194. 01
	107954 ER PHYSICIAN		0	0	0		194. 04
	07953 SHI PSHEWANA RADI OLOGY AND LAB		0	Ö	0		194. 06
200.00		1]			200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	642, 632	56, 869	1, 132, 862	18, 551	0	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS COMMUNITY HOSPT. OF LAGRANGE CTY IN

Provi der CCN: 151323

					LATERNO	DECL DENTS	5/31/2016 11:	
					INTERNS &	RESI DENTS		
		Cost Center Description		NURSING SCHOOL		SERVI CES-OTHER	PARAMED ED	
			ANESTHETI STS		Y & FRINGES APPRV	PRGM COSTS APPRV	PRGM	
			19. 00	20.00	21.00	22.00	23. 00	
		AL SERVICE COST CENTERS			1			
1. 00 1. 01		CAP REL COSTS-BLDG & FIXT EMS WEST STATION						1. 00 1. 01
2. 00		CAP REL COSTS-MVBLE EQUIP						2.00
2. 01		EMS WEST STATION EQUIP.			•			2. 01
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	1	ADMINISTRATIVE & GENERAL						5. 00
6.00		MAINTENANCE & REPAIRS OPERATION OF PLANT						6.00
7. 00 8. 00	1	LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	1	HOUSEKEEPI NG						9. 00
10. 00	1	DI ETARY						10. 00
11. 00	1	CAFETERI A						11.00
12. 00 13. 00	1	MAI NTENANCE OF PERSONNEL NURSI NG ADMI NI STRATI ON						12. 00 13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY						14. 00
15. 00	1	PHARMACY						15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY						16. 00
17. 00	1	SOCIAL SERVICE						17. 00
19. 00 20. 00	1	NONPHYSICIAN ANESTHETISTS NURSING SCHOOL	0	0				19. 00 20. 00
21. 00		I &R SERVI CES-SALARY & FRINGES APPRV			Ö			21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV				0		22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)					0	23. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS	0	0			0	20.00
30. 00 43. 00	1	ADULTS & PEDI ATRI CS NURSERY	0	0	1		0	
10.00		LARY SERVICE COST CENTERS				<u> </u>		10.00
50. 00		OPERATING ROOM	0	0	1	1	0	1
52. 00		DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	53. 00 54. 00
60.00	1	LABORATORY	0	Ö	ő	o	0	60.00
62. 30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	0	O	0	0	0	62. 30
65. 00	1	RESPI RATORY THERAPY	0	0	1	0	0	
66.00	1	PHYSI CAL THERAPY	0	0		0	0	66. 00 67. 00
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	1	0	0	68. 00
69. 00	1	ELECTROCARDI OLOGY	Ö	Ö			0	69. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 76. 97		DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION	0	0	0	0	0	73. 00 76. 97
76. 98	1	HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	1
76. 99		LI THOTRI PSY	0	0	Ö	0	0	
		TIENT SERVICE COST CENTERS			1			
90. 00 90. 01		CLINIC LIFEBRIDGE SENIOR CARE	0	0		1	0	90. 00 90. 01
91.00		EMERGENCY	0	0		0	0	1
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART	_				_	92.00
		REIMBURSABLE COST CENTERS			I			
95. 00 99. 10	09500	AMBULANCE SERVI CES	0	0		0	0	1
99. 10		OUTPATIENT PHYSICAL THERAPY	0	0		0	0	
99. 30		OUTPATIENT OCCUPATIONAL THERAPY	o o	Ö		o	0	1
99. 40	09940	OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
110 00		AL PURPOSE COST CENTERS			I	I I		1112 00
113.00		INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	0	O	o	0	0	113. 00 118. 00
		IMBURSABLE COST CENTERS				<u> </u>		1
		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O	l .			190. 00
		PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
		OCCUPATIONAL HEALTH FOUNDATION	0	0	0	0		194. 00 194. 01
		COMMUNITY & VOLUNTEER SVCS	0	o	Ö			194. 01
		ER PHYSICIAN	0	O	0	o	0	194. 04
		SHI PSHEWANA RADI OLOGY AND LAB	0	0	0	0		194. 06
200. 00 201. 00	1	Cross Foot Adjustments Negative Cost Centers	0	0	0	0		200. 00 201. 00
201.00	1	TOTAL (sum lines 118-201)	0	0		0		201.00
	'					1	_	
-				-			-	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323 | Period: | Worksheet B | From 01/01/2015 | Part I | To | 12/31/2015 | Date/Time P

Date/Time Prepared: 5/31/2016 11:39 am Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00101 EMS WEST STATION 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 EMS WEST STATION EQUIP 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 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 02000 NURSI NG SCHOOL 20 00 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4, 686, 190 4, 686, 190 30.00 04300 NURSERY 347, 413 43.00 347, 413 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 751, 190 50.00 2, 751, 190 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 256, 909 0 1, 256, 909 52.00 05300 ANESTHESI OLOGY 53 00 102,018 102, 018 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 2, 291, 890 0 2, 291, 890 54.00 06000 LABORATORY 60 00 1, 467, 543 1, 467, 543 60 00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 65.00 06500 RESPIRATORY THERAPY 687, 431 687, 431 65.00 06600 PHYSI CAL THERAPY 66.00 963, 814 963, 814 66.00 06700 OCCUPATI ONAL THERAPY 67.00 217, 214 217, 214 67.00 68.00 06800 SPEECH PATHOLOGY 134,677 134, 677 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 469.588 469, 588 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 338, 306 338, 306 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 172, 135 2, 172, 135 73.00 07697 CARDIAC REHABILITATION 0 76.97 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 90.01 09001 LIFEBRIDGE SENIOR CARE 456, 112 C 456, 112 90.01 91.00 09100 EMERGENCY 3, 220, 119 3, 220, 119 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 2, 293, 373 0 2, 293, 373 95 00 99. 10 09910 CORF 0 99. 10 C 0 99 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 99.30 0 C 99.30 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 99.40 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 23, 855, 922 118.00 23, 855, 922 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 29, 779 29, 779 190.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 238, 219 192 00 238, 219 194. 00 07950 OCCUPATIONAL HEALTH 0 194.00 194. 01 07951 FOUNDATI ON 98, 222 98, 222 194. 01 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 248.389 0 248, 389 194. 03 194. 04 07954 ER PHYSICIAN 0 0 194.04 0 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 194. 06 0 0 200.00 Cross Foot Adjustments 0 0 0 200. 00 201.00 Negative Cost Centers 0 0 201. 00 202.00 TOTAL (sum lines 118-201) 24, 470, 531 0 24, 470, 531 202.00

COMMUNITY HOSPT. OF LAGRANGE CTY IN Provider CCN: 151323 | In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 5/31/2016 11: 39 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

					CAPITAL REL	ATED COSTS	5/31/2016 11:	39 am
	Cos	st Center Description	Directly	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST	
	003	st center bescription	Assigned New	DEDO & TIXI	STATI ON		STATION EQUIP.	
			Capital Related Costs					
			0	1.00	1. 01	2. 00	2. 01	
		SERVICE COST CENTERS			I		l	
1. 00 1. 01		P REL COSTS-BLDG & FIXT S WEST STATION						1. 00 1. 01
2.00		P REL COSTS-MVBLE EQUIP						2. 00
2.01		S WEST STATION EQUIP.						2. 01
4.00	1 1	PLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	
5. 00 6. 00		MINISTRATIVE & GENERAL NTENANCE & REPAIRS	851, 759	214, 983	0	98, 374	0	
7. 00	1 1	ERATION OF PLANT	o	67, 564	0	30, 917	0	
8.00	1 1	JNDRY & LINEN SERVICE	O	3, 863		1, 768	0	1
9.00		JSEKEEPI NG	0	12, 642		5, 785	l	1
10. 00 11. 00	01000 DI E 01100 CAF		0	50, 723	0	23, 210	0	10. 00 11. 00
12. 00		NTENANCE OF PERSONNEL	ő	0	Ö	0	o o	12. 00
13. 00		RSING ADMINISTRATION	o	0	0	0	0	13. 00
14. 00	1 1	ITRAL SERVICES & SUPPLY	0	24, 094		11, 025	0	
15. 00 16. 00	01500 PHA	DICAL RECORDS & LIBRARY	0	20, 735 4, 092		9, 488 1, 872	0	
17. 00		CIAL SERVICE	Ö	0	1	0	ő	17. 00
19. 00		IPHYSICIAN ANESTHETISTS	o	0	0	0	0	19. 00
20.00		RSING SCHOOL	0	0	0	0	0	20.00
21. 00 22. 00		R SERVICES-SALARY & FRINGES APPRV R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21. 00 22. 00
23. 00	1 1	RAMED ED PRGM-(SPECIFY)	Ö	0	1	0	Ö	
		F ROUTINE SERVICE COST CENTERS						
30. 00 43. 00	03000 ADU 04300 NUR	JLTS & PEDI ATRI CS	0	267, 721 4, 031		122, 507 1, 845	0	1
43.00		Y SERVICE COST CENTERS	<u> </u>	4, 031	<u> </u>	1, 645	0	43.00
50.00	05000 OPE	RATING ROOM	0	152, 595	0	69, 826	0	50. 00
52.00		IVERY ROOM & LABOR ROOM	0	19, 055		8, 720	0	52. 00
53. 00 54. 00	1 1	ESTHESI OLOGY DI OLOGY-DI AGNOSTI C	0	0 77, 046	-	0 35, 255	0	
60.00	06000 LAB		ő	30, 171		13, 806	o o	1
62. 30		OOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65.00		SPI RATORY THERAPY	0	15, 788		7, 224	0	65.00
66. 00 67. 00		/SI CAL THERAPY CUPATI ONAL THERAPY	0	50, 570 0	1	23, 140	0	66. 00 67. 00
68. 00		EECH PATHOLOGY	ő	0	ő	0	o o	68. 00
69. 00	1 1	ECTROCARDI OLOGY	O	0	0	0	0	69. 00
71.00		DI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
72. 00 73. 00	1 1	PL. DEV. CHARGED TO PATIENTS JGS CHARGED TO PATIENTS	0	0	0	0	0	
76. 97		RDI AC REHABI LI TATI ON	Ö	0	Ö	0	Ö	76. 97
76. 98		PERBARI C OXYGEN THERAPY	0	0	1	0	0	
76. 99	07699 LIT	HOTRIPSY NT SERVICE COST CENTERS	0	0	0	0	0	76. 99
90. 00	09000 CLI		O	0	O	0	0	90.00
90. 01	09001 LI F	FEBRI DGE SENI OR CARE	0	13, 894		6, 358	l e	
91.00	09100 EME		0	105, 674	0	48, 356	0	
92. 00		SERVATION BEDS (NON-DISTINCT PART MBURSABLE COST CENTERS						92.00
95. 00	09500 AMB	BULANCE SERVICES	0	0	16, 040	0	5, 906	95. 00
99. 10	09910 COR		0	0	0	0	0	
99. 20 99. 30		PATIENT PHYSICAL THERAPY PATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	1
99. 40		PATIENT SPEECH PATHOLOGY	o	0	-	0	0	
	SPECIAL P	PURPOSE COST CENTERS	-	-	-	-	_	
		TEREST EXPENSE						113. 00
118. 00		BTOTALS (SUM OF LINES 1-117) JRSABLE COST CENTERS	851, 759	1, 135, 241	16, 040	519, 476	5, 906	118. 00
190.00		T, FLOWER, COFFEE SHOP & CANTEEN	0	3, 405	0	1, 558	0	190. 00
192.00	19200 PHY	'SICIANS' PRIVATE OFFICES	0	50, 875		23, 280	0	192. 00
		CUPATIONAL HEALTH	0	0	0	0	l	194. 00
	07951 FOU 07952 COM	INDATION IMUNITY & VOLUNTEER SVCS	0	0		0	l	194. 01 194. 03
	07954 ER		ő	o	Ö	0	l	194. 04
194. 06	07953 SHI	PSHEWANA RADIOLOGY AND LAB	О	0	0	0		194. 06
200. 00 201. 00		oss Foot Adjustments pative Cost Centers		_		^	_	200. 00 201. 00
201.00		TAL (sum lines 118-201)	851, 759	1, 189, 521	16, 040	544, 314		201.00
	1 233		, ,					

Heal th Financial Systems

COMMUNITY HOSPT. OF LAGRANGE CTY IN

In Lieu of Form CMS-2552-10

Provider CCN: 151323

Period:
From 01/01/2015
To 12/31/2015

Cost Center Description

Subtotal

EMPLOYEE
BENEFITS
DEPARTMENT

2A

4.00

5.00

6.00

7.00

	Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	39 am
		2A	4. 00	5.00	6. 00	7. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 1. 01 2. 00 2. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION 00200 CAP REL COSTS-MVBLE EQUIP 00201 EMS WEST STATION EQUIP.						1. 00 1. 01 2. 00 2. 01
4.00 5.00 6.00 7.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 1, 165, 116 0 98, 481	() () ()) 1, 165, 116 0 79, 502	0	177, 983	4. 00 5. 00 6. 00 7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	5, 631 18, 427	(6, 339 18, 926	0	758 2, 481	8. 00 9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	73, 933 0	(24, 710 16, 375	0	9, 954 0	10. 00 11. 00
12. 00 13. 00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	o	(0	0	0	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	35, 119	(54	0	4, 728	14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	30, 223 5, 964	(50, 606 432	0	4, 069 803	16. 00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	(0	0	0	17. 00 19. 00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	(0	0	0	20. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	(0	0	0	22. 00
23. 00	O2300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	U U					23. 00
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	390, 228 5, 876	(0		30. 00 43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	222, 421	(103, 170	0	29, 945	50. 00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	27, 775 0	(52, 366 4, 857	0		52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	112, 301	(97, 132	0	15, 119	54. 00
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	43, 977 0	(0	0	0	60. 00 62. 30
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	23, 012 73, 710	(29, 892 38, 611	0		65. 00 66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	(10, 026 6, 255	0	1	67. 00 68. 00
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(0 21, 581	0	0	69. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	(15, 548	0	0	72. 00
73. 00 76. 97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0	(50, 395	0	0	73. 00 76. 97
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	(0	0	•	76. 98 76. 99
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	C	0	0	0	
90. 01	09001 LI FEBRI DGE SENI OR CARE	20, 252	C	19, 710	0	2, 727	90. 01
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	154, 030 0	C	130, 142	0	20, 737	91. 00 92. 00
	09500 AMBULANCE SERVICES 09910 CORF	21, 946	(108, 277	0		95. 00 99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	(0	0	0	99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY 09940 OUTPATIENT SPEECH PATHOLOGY	0	(0	0	0	99. 30 99. 40
113. 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	2, 528, 422	C	1, 142, 012	0	167, 331	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	4, 963	(1, 042 5, 560	0		190. 00 192. 00
194.00	07950 OCCUPATI ONAL HEALTH	74, 155	(0	0	0	194. 00
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS	0 0	(4, 676 11, 826	0	l	194. 01 194. 03
	07954 ER PHYSICIAN 07953 SHIPSHEWANA RADIOLOGY AND LAB	0	(0	0		194. 04 194. 06
200.00	Cross Foot Adjustments	0			0		200. 00 201. 00
201.00		2, 607, 540	(1, 165, 116	0		

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 5/31/2016 11: 39 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPT. OF LAGRANGE CTY IN Provider CCN: 151323

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	5/31/2016 11: MAINTENANCE OF PERSONNEL	
		8.00	9.00	10.00	11. 00	12.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT						1.00
1	00101 EMS WEST STATION 00200 CAP REL COSTS-MVBLE EQUIP						1. 01 2. 00
1	00200 CAF KEE COSTS-WVBEE EQUIP.						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00500 ADMINISTRATIVE & GENERAL						5. 00
1	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
1	00800 LAUNDRY & LINEN SERVICE	12, 728					8. 00
1	00900 HOUSEKEEPI NG	4	39, 838				9. 00
1	01000 DI ETARY	95	2, 269	110, 961	44 075		10.00
1	01100 CAFETERIA	0	0	0	16, 375	0	11.00
1	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0	0	0	939	0	
1	01400 CENTRAL SERVICES & SUPPLY	0	1, 078	0	737	0	
	01500 PHARMACY	o	928	0	974	0	1
	01600 MEDICAL RECORDS & LIBRARY	O	183	0	0	0	16.00
	01700 SOCIAL SERVICE	o	0	0	0	0	17. 00
1	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	1
1	02000 NURSI NG SCHOOL	0	0	0	0	0	
1	02100 &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
	02200 &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	
-	INPATIENT ROUTINE SERVICE COST CENTERS	١	Ο _Ι	U _I		0	23.00
	03000 ADULTS & PEDIATRICS	4, 201	11, 977	110, 961	3, 320	0	30.00
1	04300 NURSERY	200	180	0	319	0	1
	ANCILLARY SERVICE COST CENTERS	'					
	05000 OPERATING ROOM	1, 930	6, 827	0	2, 196	0	50. 00
	05200 DELIVERY ROOM & LABOR ROOM	714	853	0	1, 139	0	1
	05300 ANESTHESI OLOGY	0	0	0	0	0	
	05400 RADI OLOGY-DI AGNOSTI C	1, 389	3, 447	0	2, 046	0	
1	06000 LABORATORY	0	1, 350 0	0	0	0	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	39	706	0	1, 065	0	62. 30 65. 00
1	06600 PHYSI CAL THERAPY	479	2, 262	0	1, 349	0	66. 00
	06700 OCCUPATI ONAL THERAPY	163	0	0	205	0	
1	06800 SPEECH PATHOLOGY	19	O	Ō	139	0	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76. 97 76. 98
1	07699 LI THOTRI PSY		0	0	0	0	1
H-	OUTPATIENT SERVICE COST CENTERS	<u> </u>	9	٥١	<u> </u>		70. 77
	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 LIFEBRIDGE SENIOR CARE	O	622	0	469	0	90. 01
1	09100 EMERGENCY	2, 572	4, 728	0	2, 215	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS	Fool			ما		05.00
	09500 AMBULANCE SERVICES 09910 CORF	593 0	0	0	0	0	
	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	1
	09930 OUTPATIENT OCCUPATIONAL THERAPY		0	0	0	0	1
	09940 OUTPATIENT SPEECH PATHOLOGY	o	0	Ö	Ö	0	1
<u> </u>	SPECIAL PURPOSE COST CENTERS	, -,	· · · · · · · · · · · · · · · · · · ·	-,	-,		
113.00	11300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	12, 398	37, 410	110, 961	16, 375	0	118. 00
	NONREI MBURSABLE COST CENTERS				-1		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	152	0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	330	2, 276	0	0		192.00
1	07950 OCCUPATI ONAL HEALTH 07951 FOUNDATI ON		0	0	O		194. 00 194. 01
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS		0	0	0		194. 01
	07954 ER PHYSICIAN		o	0	o o		194. 04
1	07953 SHI PSHEWANA RADI OLOGY AND LAB	ol	o	Ö	o		194. 06
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	12, 728	39, 838	110, 961	16, 375	0	202. 00

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2016 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151323

					To	12/31/2015	Date/Time Prep 5/31/2016 11:	
		Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
			ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
			13.00	14. 00	15. 00	16.00	17. 00	
1 00		AL SERVICE COST CENTERS						1 00
1. 00 1. 01		CAP REL COSTS-BLDG & FIXT EMS WEST STATION						1. 00 1. 01
2. 00		CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01	1	EMS WEST STATION EQUIP.						2. 01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	1	ADMINISTRATIVE & GENERAL						5. 00
6.00	1	MAINTENANCE & REPAIRS						6. 00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	1	HOUSEKEEPING						9. 00
10. 00	1	DI ETARY						10. 00
11. 00	01100	CAFETERI A						11.00
12.00	1	MAINTENANCE OF PERSONNEL						12. 00
13.00	1	NURSI NG ADMI NI STRATI ON	30, 597	25 520				13.00
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY		25, 539 709	87, 509			14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY		, 0,	07,307	7, 382		16. 00
17. 00		SOCIAL SERVICE	O	o	0	0	0	17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20. 00		NURSI NG SCHOOL	0	0	0	0	0	20.00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21. 00 22. 00
23. 00	1	PARAMED ED PRGM-(SPECIFY)		0	0	ol Ol	0	23. 00
20.00		IENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	0	<u> </u>	0	20.00
30.00	1	ADULTS & PEDIATRICS	11, 056	2, 206	3	1, 081	0	30.00
43. 00		NURSERY	1, 064	194	1	272	0	43.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	7, 312	4, 101	71	119	0	50. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	3, 791	692	3	0	0	52. 00
53. 00		ANESTHESI OLOGY	0	0	0	Ö	0	53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	О	730	597	2, 380	0	54.00
60.00	1	LABORATORY	0	0	0	0	0	60.00
62. 30	1	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY		133 104	26	676	0	65. 00 66. 00
67. 00	1	OCCUPATI ONAL THERAPY	o	35	9	141	0	67. 00
68. 00	06800	SPEECH PATHOLOGY	O	4	1	63	0	68. 00
69. 00	1	ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	7, 339	0	0	0	71.00
72. 00 73. 00	1	DRUGS CHARGED TO PATIENTS		5, 278 0	86, 028	0	0	72. 00 73. 00
76. 97	1	CARDI AC REHABI LI TATI ON		ő	00,020	o	0	76. 97
76. 98		HYPERBARI C OXYGEN THERAPY	O	О	0	О	0	76. 98
76. 99		LI THOTRI PSY	0	0	0	0	0	76. 99
00 00		TIENT SERVICE COST CENTERS CLINIC		ol	0	٥	0	90. 00
90. 00		LI FEBRI DGE SENI OR CARE		72	0	ol Ol	0	90. 00
91. 00		EMERGENCY	7, 374	1, 828	141	2, 650	0	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92.00
05.00		REI MBURSABLE COST CENTERS		2 050	(20	ما	0	05.00
95. 00 99. 10	09500	AMBULANCE SERVICES	0	2, 058 0	629	0	0	95. 00 99. 10
99. 20		OUTPATIENT PHYSICAL THERAPY		0	0	0	0	99. 20
99. 30		OUTPATIENT OCCUPATIONAL THERAPY	o	0	0	ō	0	99. 30
99. 40		OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
112 00		AL PURPOSE COST CENTERS						112 00
113.00		INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	30, 597	25, 483	87, 509	7, 382		113. 00 118. 00
110.00		IMBURSABLE COST CENTERS	30, 377	25, 405	07, 307	7, 302	0	110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5	0	0	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	47	0	0		192. 00
		OCCUPATIONAL HEALTH	0	0	0	0		194. 00
		FOUNDATION COMMUNITY & VOLUNTEER SVCS		2	0	0		194. 01 194. 03
	1	ER PHYSICIAN		0	0	0		194. 03 194. 04
		SHIPSHEWANA RADIOLOGY AND LAB		o	0	Ö		194. 06
200.00		Cross Foot Adjustments						200. 00
201.00	1	Negative Cost Centers	0 507	15, 440	07 500	7 202		201. 00
202.00	1	TOTAL (sum lines 118-201)	30, 597	40, 979	87, 509	7, 382	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPT. OF LAGRANGE CTY IN Provi der CCN: 151323

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 5/31/2016 11: 39 am

							5/31/2016 11:	39 am
					INTERNS &	RESI DENTS		
					050000000000000000000000000000000000000	050,4,050,07,150	0.0.0.0.0	
		Cost Center Description		NURSTING SCHOOL		SERVI CES-OTHER	PARAMED ED	
			ANESTHETI STS		Y & FRINGES	PRGM COSTS	PRGM	
			19. 00	20.00	APPRV 21.00	APPRV 22. 00	23. 00	
	GENER	AL SERVICE COST CENTERS	17.00	20.00	21.00	22.00	23.00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
1. 01	1	EMS WEST STATION						1. 01
2.00	1	CAP REL COSTS-MVBLE EQUIP						2. 00
2.01	1	EMS WEST STATION EQUIP.						2. 01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500	ADMINISTRATIVE & GENERAL						5. 00
6.00	00600	MAINTENANCE & REPAIRS						6. 00
7.00	00700	OPERATION OF PLANT						7. 00
8.00	00800	LAUNDRY & LINEN SERVICE						8. 00
9.00	1	HOUSEKEEPING						9. 00
10. 00	1	DI ETARY						10. 00
11. 00	1	CAFETERIA						11. 00
12.00	1	MAINTENANCE OF PERSONNEL						12.00
13.00	1	NURSI NG ADMI NI STRATI ON						13.00
14.00		CENTRAL SERVICES & SUPPLY						14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY		1				15. 00 16. 00
17. 00	1	SOCIAL SERVICE						17. 00
19. 00		NONPHYSICIAN ANESTHETISTS	(1				19. 00
20. 00	1	NURSI NG SCHOOL		ĺ				20. 00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRV			ĺ			21. 00
22. 00		I &R SERVICES-OTHER PRGM COSTS APPRV				0		22. 00
23. 00	1	PARAMED ED PRGM-(SPECIFY)					0	1
		IENT ROUTINE SERVICE COST CENTERS		•	'	'		
30.00	03000	ADULTS & PEDIATRICS						30. 00
43.00	04300	NURSERY						43.00
		LARY SERVICE COST CENTERS						
50.00	1	OPERATING ROOM						50.00
52. 00	1	DELIVERY ROOM & LABOR ROOM						52. 00
53. 00	1	ANESTHESI OLOGY						53. 00
54.00		RADI OLOGY-DI AGNOSTI C						54.00
60. 00 62. 30	1	LABORATORY						60.00
65. 00		BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY						62. 30 65. 00
66. 00		PHYSI CAL THERAPY						66. 00
67. 00	1	OCCUPATIONAL THERAPY						67. 00
68. 00	1	SPEECH PATHOLOGY						68. 00
69. 00	1	ELECTROCARDI OLOGY						69. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT						71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS						72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS						73. 00
76. 97	07697	CARDIAC REHABILITATION						76. 97
76. 98	1	HYPERBARI C OXYGEN THERAPY						76. 98
76. 99		LI THOTRI PSY						76. 99
00.00		TIENT SERVICE COST CENTERS						00.00
90.00		CLINIC						90.00
90. 01 91. 00	1	LI FEBRI DGE SENI OR CARE EMERGENCY						90. 01 91. 00
91.00		OBSERVATION BEDS (NON-DISTINCT PART						92.00
7Z. UU		REIMBURSABLE COST CENTERS		1	1			72.00
95. 00		AMBULANCE SERVICES						95. 00
99. 10	09910				1			99. 10
99. 20	1	OUTPATIENT PHYSICAL THERAPY						99. 20
99. 30		OUTPATIENT OCCUPATIONAL THERAPY						99. 30
99. 40	09940	OUTPATIENT SPEECH PATHOLOGY						99. 40
		AL PURPOSE COST CENTERS			,			
		I NTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	С	0) <u> </u>	0	0	118. 00
400.00		I MBURSABLE COST CENTERS						100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
		PHYSICIANS' PRIVATE OFFICES						192. 00
		OCCUPATIONAL HEALTH FOUNDATION						194. 00 194. 01
		COMMUNITY & VOLUNTEER SVCS						194. 01
	1	ER PHYSICIAN						194. 03
		SHI PSHEWANA RADI OLOGY AND LAB						194. 04
200.00		Cross Foot Adjustments	c		0	o	0	200. 00
201.00	1	Negative Cost Centers	Ċ		1		0	201. 00
202.00		TOTAL (sum lines 118-201)	C	0				202. 00
_		<u> </u>						

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 151323 Peri od: From 01/01/20

				5/31/2016	
Cost Center Description	Subtotal	Intern &	Total		
		Residents Cost & Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26.00		
GENERAL SERVICE COST CENTERS					
1.00 O0100 CAP REL COSTS-BLDG & FLXT					1. 00
1. 01 00101 EMS WEST STATI ON					1. 01
2.00 O0200 CAP REL COSTS-MVBLE EQUIP					2.00
2.01 00201 EMS WEST STATION EQUIP. 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 01 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL					5.00
6. 00 00600 MAI NTENANCE & REPAI RS					6.00
7. 00 00700 OPERATION OF PLANT					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10. 00
11. 00 01100 CAFETERI A					11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL					12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON					13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY					14.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY					15. 00 16. 00
17. 00 01700 SOCIAL SERVICE					17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS					19.00
20. 00 02000 NURSI NG SCHOOL					20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV					21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV					22. 00
23.00 02300 PARAMED ED PRGM-(SPECIFY)					23. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS	733, 911	0	733, 911		30. 00
43. 00 04300 NURSERY	23, 453	0	23, 453		43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	378, 092	ol	279 002		50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	91, 072	0	378, 092 91, 072		52. 00
53. 00 05300 ANESTHESI OLOGY	4, 857	o	4, 857		53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	235, 141	0	235, 141		54.00
60. 00 06000 LABORATORY	117, 799	0	117, 799		60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		62. 30
65. 00 06500 RESPIRATORY THERAPY	57, 945	0	57, 945		65. 00
66. 00 06600 PHYSI CAL THERAPY	127, 141	0	127, 141		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	10, 579	0	10, 579		67. 00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	6, 481	0	6, 481		68. 00 69. 00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	28, 920	0	28, 920		71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 826	0	20, 826		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	136, 423	0	136, 423		73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	O	0		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0		76. 98
76. 99 07699 LI THOTRI PSY	0	0	0		76. 99
OUTPAȚI ENT SERVI CE COST CENTERS					
90. 00 09000 CLI NI C	0	0	0		90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	43, 852	0	43, 852		90. 01
91. 00 09100 EMERGENCY	326, 417	0	326, 417		91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		U _I			92. 00
95. 00 09500 AMBULANCE SERVICES	133, 503	0	133, 503		95. 00
99. 10 09910 CORF	0	0	0		99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	o	Ö		99. 20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0		99. 40
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE		_			113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	2, 476, 412	0	2, 476, 412		118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(020	ol	4 020		190. 00
190. 00 19000 GTFT, FLOWER, COFFEE SHOP & CANTEEN 192. 00 19200 PHYSICIANS' PRIVATE OFFICES	6, 830 92, 352	0	6, 830 92, 352		190.00
194. 00 07950 OCCUPATI ONAL HEALTH	72, 332	0	72, 332 0		194. 00
194. 01 07951 FOUNDATI ON	4, 678	0	4, 678		194. 01
194. 03 07952 COMMUNITY & VOLUNTEER SVCS	11, 828	ol	11, 828		194. 03
194. 04 07954 ER PHYSICIAN	0	ol	0		194. 04
194.06 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	o	0		194. 06
200.00 Cross Foot Adjustments	0	О	0		200. 00
201.00 Negative Cost Centers	15, 440	0	15, 440		201. 00
202.00 TOTAL (sum lines 118-201)	2, 607, 540	0	2, 607, 540		202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

					o 12/31/2015	Date/Time Pre 5/31/2016 11:	
			CAPI TAL REI	LATED COSTS		3/31/2010 11.	Jy alli
	Cost Center Description	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST	EMPLOYEE	
		(SQUARE FEET)	STATION	(SQUARE FEET)	STATION EQUIP.	BENEFITS	
			(SQUARE FEET)		(SQUARE FEET)	DEPARTMENT (GROSS	
		1. 00	1. 01	2. 00	2. 01	SALARI ES) 4. 00	
	GENERAL SERVICE COST CENTERS	1.00	1.01	2.00	2.01	4.00	
	00100 CAP REL COSTS-BLDG & FIXT	77, 906					1.00
	OO101 EMS WEST STATION OO200 CAP REL COSTS-MVBLE EQUIP	0	9, 760	77, 906			1. 01 2. 00
2.01	00201 EMS WEST STATION EQUIP.			0	9, 760		2. 01
	OO400	0 14, 080	0	0 14, 080		12, 754, 492 5, 711, 316	4. 00 5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	Ö	0	Ö	0,711,310	6. 00
	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	4, 425 253	0	4, 425 253		239, 601 0	7. 00 8. 00
	00900 HOUSEKEEPING	828	0	828		158, 264	9. 00
10.00	01000 DI ETARY	3, 322	0	3, 322		125, 832	10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	0	0	0	_	214, 653 0	11. 00 12. 00
13.00	01300 NURSING ADMINISTRATION	Ö	0	0	0	319, 530	13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	1, 578 1, 358		1, 578 1, 358		0 452, 150	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	268	0	268		452, 150	16. 00
	01700 SOCIAL SERVICE	0	0	0		0	17. 00
	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	0	_	0	19. 00 20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00 23. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0		0	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS		0		ı o	0	25.00
	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	17, 534 264	0			1, 021, 353	30.00
43.00	ANCILLARY SERVICE COST CENTERS	204	0	204	l o	126, 854	43.00
	05000 OPERATING ROOM	9, 994	0			685, 375	50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	1, 248 0	0	1, 248 0		452, 043 0	52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 046	0	5, 046	0	602, 703	54. 00
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 976 0	0	1, 976 0		0	60. 00 62. 30
	06500 RESPI RATORY THERAPY	1, 034	Ö	1, 034		300, 692	65. 00
66.00	06600 PHYSI CAL THERAPY	3, 312	0	-,		360, 029	66. 00 67. 00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0		107, 420 72, 545	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	ő	Ö	Ö	Ö	0	73. 00
	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	0	0			0	ł
76. 99	07699 LI THOTRI PSY	0	0			0	76. 99
	OUTPATIENT SERVICE COST CENTERS	0	0			0	00.00
	09000 CLINIC 09001 LIFEBRIDGE SENIOR CARE	0 910	0			0 117, 738	90. 00 90. 01
91.00	09100 EMERGENCY	6, 921	0	6, 921	0	710, 382	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
	09500 AMBULANCE SERVICES	0	9, 760	0	9, 760	923, 887	95. 00
	09910 CORF	0	0	· -	_	0	99. 10
	09920 OUTPATIENT PHYSICAL THERAPY 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	_	0	99. 20 99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE			Γ			113. 00
118.00		74, 351	9, 760	74, 351	9, 760	12, 702, 367	•
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	223	0	223	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	3, 332					190.00
194.00	07950 OCCUPATI ONAL HEALTH	0	0	0	o		194. 00
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS	0 n	0 0	0	_	38, 688 13, 437	
194.04	07954 ER PHYSICIAN	ő	Ö	Ö		0	194. 04
194. 06 200. 00	07953 SHI PSHEWANA RADIOLOGY AND LAB Cross Foot Adjustments	0	0	0	0	0	194. 06 200. 00
200.00							200. 00
	· · · · · · · · · · · · · · · · · · ·	•	-				<u> </u>

Health Financial Systems	COMM	UNI TY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS					Peri od:	Worksheet B-1	
					rom 01/01/2015 o 12/31/2015	Date/Time Pre 5/31/2016 11:	pared: 39 am
			CAPI TAL REL	LATED COSTS			
Cost Center Description		BLDG & FIXT (SQUARE FEET)	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	EMPLOYEE BENEFITS	
		(SQUARE TEET)	(SQUARE FEET)	(SCOMIC TEET)		DEPARTMENT	
					(SQUARE FEET)	(GROSS SALARI ES)	
		1. 00	1. 01	2.00	2. 01	4. 00	
202.00 Cost to be allocated (per Wkst. B Part I)	,	1, 189, 521	16, 040	544, 314	5, 906	3, 526, 549	202. 00
203.00 Unit cost multiplier (Wkst. B, Pa	,	15. 268670	1. 643443	6. 986805	0. 605123		
204.00 Cost to be allocated (per Wkst. B Part II)	,					0	204. 00
205.00 Unit cost multiplier (Wkst. B, Pa	rt					0. 000000	205. 00

Provider CCN: 151323 | Period: | Worksheet B-1 | From 01/01/2015 | To 12/31/2017 | Provider CCN: 151323 | Provider Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

				F T	rom 01/01/2015 o 12/31/2015		
	Cost Center Description	Reconciliation	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	5/31/2016 11: LAUNDRY &	39 am
			& GENERAL	REPAIRS	PLANT	LINEN SERVICE (POUNDS OF	
			(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	LAUNDRY)	
	TOTAL OFFICE COOK OFFICE	5A	5. 00	6. 00	7. 00	8. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01	00101 EMS WEST STATION					ı	1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP					1	2. 00
2. 01	00201 EMS WEST STATION EQUIP.					ı	2. 01
4. 00 5. 00	OO4OO	-8, 403, 942	16, 066, 589			ı	4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	0, 100, 712	0	0		ı	6. 00
7.00	00700 OPERATION OF PLANT	0	1, 096, 304	0	59, 401	1	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	87, 410		253	10, 000	8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	260, 986 340, 749		828 3, 322	3 75	9. 00 10. 00
11. 00	01100 CAFETERI A	Ö	225, 812	Ö	0, 322	, 0	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	O	0	12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	408, 977	0	0	0	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY		739 697, 843	0	1, 578 1, 358	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	Ö	5, 964	0	268	Ö	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	20. 00 21. 00
21.00	02200 &R SERVICES-OTHER PRGM COSTS APPRV		0	0	0	0	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	O	ő	Ö	o	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	0			•	3, 301	30.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0	200, 722	0	264	157	43.00
50.00	05000 OPERATING ROOM	0	1, 422, 683	0	9, 994	1, 516	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	722, 110		1, 248	561	52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY	0	66, 982	0	0 5, 046	0 1, 091	53. 00 54. 00
60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY		1, 339, 423 917, 713		5, 046 1, 976	1,091	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	Ö	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	412, 201	0	1, 034	31	65. 00
66.00	06600 PHYSI CAL THERAPY	0	532, 435	1	3, 312	376	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	138, 251 86, 258	0	0	128 15	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	Ö	00, 230	Ö	o	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	297, 589	0	О	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	214, 405	0	0	0	72.00
73. 00 76. 97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0	694, 937 0	0	0	0	73. 00 76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
00.00	OUTPATIENT SERVICE COST CENTERS				٥	0	00.00
90. 00 90. 01	09000 CLINIC 09001 LIFEBRIDGE SENIOR CARE	0 0	271, 794	0	910	0	90. 00 90. 01
91. 00	09100 EMERGENCY	Ö	1, 794, 622		6, 921	2, 021	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
05.00	OTHER REIMBURSABLE COST CENTERS		1 400 107		ما	4//	05.00
95. 00 99. 10	09500 AMBULANCE SERVICES 09910 CORF	0	, , , , , ,	0	0	466 0	95. 00 99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	Ö	Ö	Ö	o	Ö	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	O	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
118.00		-8, 403, 942	15, 747, 977	0	55, 846	9, 741	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0			223 3, 332		190. 00 192. 00
	07950 OCCUPATIONAL HEALTH		76, 673 0	0	3, 332		194. 00
	07951 FOUNDATION	0	64, 486	Ö	Ö		194. 01
	07952 COMMUNITY & VOLUNTEER SVCS	0	163, 081	0	0		194. 03
	07954 ER PHYSICIAN	0	0	0	0		194. 04
200.00	07953 SHIPSHEWANA RADIOLOGY AND LAB Cross Foot Adjustments				٥	U	194. 06 200. 00
201.00	, ,					ı	201. 00
202.00			8, 403, 942	0	1, 669, 747	140, 243	202. 00
203.00	Part I) Unit cost multiplier (Wkst. B, Part I)		0. 523069	0. 000000	28. 109746	14. 024300	203 00
203.00		I	0.023009	0.00000	20. 107/40	14. 024300	1200.00

Heal th Finan	cial Systems C	COMMUNITY HOSPT. OF	F LAGRANGE CTY	IN	In Lieu of Form CMS-2552-10		
COST ALLOCAT	TION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
					rom 01/01/2015 o 12/31/2015		
	Cost Center Description	Reconciliation				LAUNDRY &	
			& GENERAL	REPAI RS	PLANT	LINEN SERVICE	
			(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	
						LAUNDRY)	
		5A	5. 00	6.00	7. 00	8. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)		1, 165, 116	(177, 983	12, 728	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 072518	0. 000000	2. 996296	1. 272800	205. 00

Provi der CCN: 151323

				To	12/31/2015	Date/Time Pre 5/31/2016 11:	pared: 39 am
	Cost Center Description	HOUSEKEEPI NG	DIETARY		MAINTENANCE OF	NURSI NG	
		(SQUARE FEET)	(MEALS SERVED)	(FTE)	PERSONNEL (NUMBER	ADMI NI STRATI ON	
					HOUSED)	(DIRECT NRSING	
		0.00	10.00	11 00	12.00	HRS)	
	GENERAL SERVICE COST CENTERS	9. 00	10.00	11. 00	12. 00	13. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1.01	00101 EMS WEST STATION						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01	00201 EMS WEST STATION EQUIP.						2. 01
4. 00 E. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00
5. 00 6. 00	00600 MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG	58, 320					9. 00
10.00	01000 DI ETARY	3, 322	21, 261				10.00
11. 00	01100 CAFETERI A	C	1 1	8, 628	_		11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	C	1	0	0	101 000	12.00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 578	1 1	495 0	0	101, 029	13. 00 14. 00
15. 00	01500 PHARMACY	1, 358	1	513	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	268	1	0	0	o o	16. 00
17. 00	01700 SOCIAL SERVICE	0	1	0	0	o o	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	C	o	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	C	0	0	0	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	C	0	0	0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	C	1 1	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	C)	0	0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	17, 534	21, 261	1, 750	0	36, 503	30. 00
43. 00	04300 NURSERY	264	1	168	0		43. 00
	ANCILLARY SERVICE COST CENTERS		-1			27 2 1 2	
50.00	05000 OPERATING ROOM	9, 994	0	1, 157	0	24, 144	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 248	0	600	0	1,	52.00
53. 00	05300 ANESTHESI OLOGY	C	1 1	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 046	1	1, 078	0	0	54.00
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 976	1	0	0	0	60. 00 62. 30
65. 00	06500 RESPIRATORY THERAPY	1, 034	1	561	0		65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 312		711	0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0,010		108	0	o	67. 00
68. 00	06800 SPEECH PATHOLOGY	C	o	73	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	C	0	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0	0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	C		0	0	0	72.00
73. 00 76. 97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDI AC REHABILI TATION			0	0	0	73. 00 76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY			0	0		76. 98
76. 99		C		0	0	o o	76. 99
	OUTPATIENT SERVICE COST CENTERS		· · · · · · · · · · · · · · · · · · ·	- "			
90.00		C	1 -1	0	0	0	90. 00
90. 01	09001 LI FEBRI DGE SENI OR CARE	910	1	247	0	1	90. 01
91.00		6, 921	0	1, 167	0	24, 350	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00				0	0	0	95. 00
99. 10				0	0		99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	i c	ol ol	0	0	o o	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	C	o	0	0	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	C	0	0	0	0	99. 40
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	F.4.7/F	04.074	0 (00		404 000	113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	54, 765	21, 261	8, 628	0	101, 029	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	223		0	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	3, 332		0	0		192. 00
	07950 OCCUPATI ONAL HEALTH	C	o	0	0	1	194. 00
194.01	1 07951 FOUNDATI ON	C	o	0	0	0	194. 01
	3 07952 COMMUNITY & VOLUNTEER SVCS	C	0	0	0		194. 03
	4 07954 ER PHYSICIAN	C	0	0	0	1	194. 04
	6 07953 SHI PSHEWANA RADI OLOGY AND LAB	C		0	0	0	194. 06
200.00							200.00
201. 00 202. 00		420, 817	637, 387	343, 927	0	642, 632	201. 00
∠∪∠. ∪(Part I)	420,017	037, 307	545, 721	U	, 042, 032	202.00
	· · · · · · · · · · · · · · · · · · ·			<u>'</u>		•	

Health Financial Systems COMM	IUNI TY HOSPT. OI	F LAGRANGE CTY	IN	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1		
				From 01/01/2015 Fo 12/31/2015		nanad.	
				10 12/31/2015	Date/Time Pre 5/31/2016 11:		
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG		
	(SQUARE FEET)	(MEALS SERVED)	(FTE)	PERSONNEL	ADMI NI STRATI ON		
				(NUMBER			
				HOUSED)	(DIRECT NRSING		
					HRS)		
	9. 00	10.00	11. 00	12.00	13. 00		
203.00 Unit cost multiplier (Wkst. B, Part I)	7. 215655	29. 979164	39. 861729	0. 000000	6. 360867	203. 00	
204.00 Cost to be allocated (per Wkst. B,	39, 838	110, 961	16, 375	5 0	30, 597	204. 00	
Part II)							
205.00 Unit cost multiplier (Wkst. B, Part	0. 683093	5. 218993	1. 897891	0. 000000	0. 302854	205. 00	

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 151323 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/31/2016 11:39 am Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NONPHYSI CI AN ANESTHETI STS SERVICES & (COSTED RECORDS & SUPPLY LI BRARY (TIME SPENT) (ASSI GNED REQUIS.) (COSTED (TIME SPENT) TIME) REQUIS.) 19.00 14.00 15.00 16.00 17.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 EMS WEST STATION 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 EMS WEST STATION EQUIP 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 1,037,488 14.00 01500 PHARMACY 15 00 28 786 272, 609 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 10,000 16.00 01700 SOCIAL SERVICE 0 17.00 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 0 19.00 0 02000 NURSI NG SCHOOL 0 O 20.00 C 20.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 C 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 89, 636 1, 464 0 0 30.00 04300 NURSERY 0 43.00 7.889 369 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 166, 615 220 161 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 28, 111 10 0 0 52.00 05300 ANESTHESI OLOGY 53 00 C 0 0 0 0 0 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 859 54.00 29,670 0 3, 224 06000 LABORATORY 60.00 C 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 65.00 5, 415 O 0 65.00 06600 PHYSI CAL THERAPY 66.00 916 66.00 4, 211 81 0 06700 OCCUPATI ONAL THERAPY 1, 425 67.00 28 191 0 67.00 68.00 06800 SPEECH PATHOLOGY 181 85 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 298, 067 0 71.00 C Λ 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 214, 405 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 267, 997 0 73.00 07697 CARDIAC REHABILITATION 0 76.97 0 C 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 C 0 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 0 0 0 90.01 09001 LIFEBRIDGE SENIOR CARE 2.906 0 0 90.01 0 91.00 09100 EMERGENCY 74, 257 438 3, 590 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 83,620 1,961 0 0 0 95.00 0 99. 10 09910 CORF 0 0 99. 10 0 99 20 09920 OUTPATIENT PHYSICAL THERAPY 0 Ω 0 99. 20 0 09930 OUTPATIENT OCCUPATIONAL THERAPY 99.30 0 C 0 0 0 99.30 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 99.40 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 118.00 1,035,194 272, 609 10,000 0 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 215 0 190. 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 1,892 C 0 194. 00 07950 OCCUPATIONAL HEALTH 0 0 0 194.00 0 194. 01 194. 01 07951 FOUNDATI ON 90 0 0 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 97 0 0 0 194. 03 194. 04 07954 ER PHYSICIAN 0 C 0 0 0 194. 04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 194. 06 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201 00 1, 132, 862 202.00 Cost to be allocated (per Wkst. B, 56, 869 18, 551 0 202.00 0 Part I)

Heal th Finan	cial Systems (COMMUNITY HOSPT.	OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COST ALLOCAT	TION - STATISTICAL BASIS			Provi der		Peri od: From 01/01/2015	Worksheet B-1	
						To 12/31/2015	Date/Time Pre 5/31/2016 11:	
	Cost Center Description	CENTRAL		PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	
		SERVICES 8	ù	(COSTED	RECORDS &		ANESTHETI STS	
		SUPPLY		REQUIS.)	LI BRARY	(TIME SPENT)	(ASSI GNED	
		(COSTED			(TIME SPENT)		TIME)	
		REQUIS.)						
		14. 00		15. 00	16. 00	17. 00	19. 00	
203.00	Unit cost multiplier (Wkst. B, Part	1) 0.0548	314	4. 155629	1. 85510	0.000000	0.000000	203. 00
204.00	Cost to be allocated (per Wkst. B,	40, 9	79	87, 509	7, 38	32 0	0	204. 00
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part	0. 0246	516	0. 321006	0. 73820	0. 000000	0.000000	205. 00
	11)							

			MUNITY HOSPT. OI	F LAG				eu of Form CMS-2552-1
COST A	ALLOCA ⁻	TION - STATISTICAL BASIS			Provi der	CCN: 151323	Peri od: From 01/01/2015	Worksheet B-1
							To 12/31/2015	
					INTERNS &	RESI DENTS		5/31/2016 11:39 am
		Cook Cooker Doorsinking	MILECI NO COLICOI	CEDVI	CEC CALAE	DEEDVI OFC. OTHE	DADAMED ED	
		Cost Center Description	NURSING SCHOOL		FRI NGES	PRGM COSTS	R PARAMED ED PRGM	
			(ASSI GNED		APPRV	APPRV	(ASSI GNED	
			TI ME)		SSIGNED TIME)	(ASSI GNED TIME)	TIME)	
			20.00		21. 00	22.00	23.00	
		AL SERVICE COST CENTERS						
1. 00 1. 01	1	CAP REL COSTS-BLDG & FIXT EMS WEST STATION						1.0
2. 00		CAP REL COSTS-MVBLE EQUIP						2.0
2. 01		EMS WEST STATION EQUIP.						2.0
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						4.0
6.00		MAINTENANCE & REPAIRS						6.0
7. 00		OPERATION OF PLANT						7.0
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 0 9. 0
10.00		DI ETARY						10.0
11.00		CAFETERI A						11. 0
12. 00 13. 00		MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION						12. 0 13. 0
14. 00		CENTRAL SERVICES & SUPPLY						14. 0
15.00		PHARMACY						15.0
16. 00 17. 00	4	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE						16. 0 17. 0
19. 00		NONPHYSI CI AN ANESTHETI STS						19. 0
20.00		NURSING SCHOOL	0					20.0
21. 00 22. 00	1	I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV			C) 	0	21. 0
23. 00	02300	PARAMED ED PRGM-(SPECIFY)					0	
20.00		I ENT ROUTINE SERVICE COST CENTERS	T 0			<u> </u>		20.6
30. 00 43. 00		ADULTS & PEDI ATRI CS NURSERY	0	1	0	1	0 0	
	ANCI L	LARY SERVICE COST CENTERS						
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0 0	1	(1	0 0	
53. 00		ANESTHESI OLOGY			(0 0	53.0
54.00		RADI OLOGY-DI AGNOSTI C	0		C		0 0	l .
60. 00 62. 30		LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS	0		(0 0	60. 0
65. 00		RESPIRATORY THERAPY	0		C		0 0	65. 0
66. 00	1	PHYSI CAL THERAPY	0		C		0 0	66. 0
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0		(0 0	67. 0 68. 0
		ELECTROCARDI OLOGY	0		C	ó	0 0	
	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0		C		0 0	
72.00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0		(0 0	72. 0 73. 0
76. 97		CARDI AC REHABI LI TATI ON	0		Č		0 0	76. 9
76. 98		HYPERBARI C OXYGEN THERAPY	0		C		0 0	76. 9
76. 99		LITHOTRIPSY TIENT SERVICE COST CENTERS] 0	7		<u>/ </u>	0 0	76. 9
90. 00	09000	CLINIC	0		C		0 0	
90. 01 91. 00		LIFEBRIDGE SENIOR CARE EMERGENCY	0		(0 0	
91.00		OBSERVATION BEDS (NON-DISTINCT PART	0	1	C	1	0	91. 0
	OTHER	REIMBURSABLE COST CENTERS						
95. 00 99. 10	4	AMBULANCE SERVICES	0		(0 0	95. 0
	4	OUTPATIENT PHYSICAL THERAPY	0		C		0 0	99. 2
99. 30	4	OUTPATIENT OCCUPATIONAL THERAPY	0		C		0 0	
99. 40		OUTPATIENT SPEECH PATHOLOGY AL PURPOSE COST CENTERS	0))	0 0	99. 4
113.00		INTEREST EXPENSE						113. 0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0		C)	0 0	118. 0
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 0	ı		<u></u>	0 0	190. 0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		C		0 0	
		OCCUPATIONAL HEALTH	0		0		0 0	194. 0
		FOUNDATION COMMUNITY & VOLUNTEER SVCS	0		() 	0 0	194. 0 194. 0
194. 04	107954	ER PHYSICIAN	0		C		o o	194. 0
		SHI PSHEWANA RADI OLOGY AND LAB	0		C)	0 0	194. 0
200. 00 201. 00	4	Cross Foot Adjustments Negative Cost Centers						200. 0 201. 0
	1	, •	1	·		1	1	1

Health Financial Systems	COMMUNITY HOSPT. C	F LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/31/2016 11:	
		INTERNS &	RESI DENTS			
Cost Center Description	NURSI NG SCHOOL	SERVI CES-SALAR				
	(ASSI GNED TI ME)	Y & FRINGES APPRV (ASSI GNED	PRGM COSTS APPRV (ASSI GNED	PRGM (ASSI GNED TI ME)		
	20.00	TI ME) 21. 00	TI ME) 22. 00	23. 00		
202.00 Cost to be allocated (per Wkst. B	(0	(0		202. 00
203.00 Unit cost multiplier (Wkst. B, Pa	rt I) 0.00000	0. 000000	0. 000000	0. 000000		203. 00
204.00 Cost to be allocated (per Wkst. B Part II)	6,	0	(0		204. 00
205.00 Unit cost multiplier (Wkst. B, Pa	o. 000000	0. 000000	0. 000000	0. 000000		205. 00

Health Financial Systems

COMMUNITY HOSPT. OF LAGRANGE CTY IN

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151323

Period:
From 01/01/2015
To 12/31/2015

Title XVIII Hospital

Cost

Cost

Cost

Cost

Therapy Limit Total Costs
(From Wkst. B, Part I col.)

Provider CCN: 151323

Period:
From 01/01/2015
Disallowance

From CMS-2552-10

Worksheet C
Part I
Date/Time Prepared:
5/31/2016 11:39 am

Cost

Therapy Limit Total Costs
Disallowance

Disallowance

			T: ±1	- \(\lambda \tau \tau \tau \tau \tau \tau \tau \ta	11: +-1	07-11	37 aiii
			11 11	e XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.	,				
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	_
00.00		4 (0/ 400		1 (0(100		0	00.00
30. 00	03000 ADULTS & PEDIATRICS	4, 686, 190		4, 686, 190		0	
43. 00	04300 NURSERY	347, 413		347, 413	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	2, 751, 190		2, 751, 190	0	0	00.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 256, 909		1, 256, 909	0	0	52.00
53.00	05300 ANESTHESI OLOGY	102, 018		102, 018	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 291, 890		2, 291, 890	0	0	54.00
60.00	06000 LABORATORY	1, 467, 543		1, 467, 543	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	1,,		0	0	0	1
65. 00	06500 RESPIRATORY THERAPY	687, 431	0	687, 431	0	0	1
66. 00	06600 PHYSI CAL THERAPY	963, 814		963, 814		0	66.00
			0			_	
67.00	06700 OCCUPATI ONAL THERAPY	217, 214	0	217, 214		0	
68. 00	06800 SPEECH PATHOLOGY	134, 677	0	134, 677		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		0	_	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	469, 588		469, 588		0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	338, 306		338, 306	0	0	, 2. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 172, 135		2, 172, 135	0	0	73.00
76. 97	07697 CARDIAC REHABILITATION	0		0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		0	0	0	76. 98
76, 99	07699 LI THOTRI PSY	0		0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						1
90. 00	09000 CLINIC	0		0	0	0	90.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	456, 112		456, 112	_	0	90. 01
91. 00	09100 EMERGENCY	3, 220, 119		3, 220, 119		0	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART						
92. 00		854, 514		854, 514		0	92.00
	OTHER REIMBURSABLE COST CENTERS		1		_	_	
95. 00	09500 AMBULANCE SERVICES	2, 293, 373		2, 293, 373	0	0	
99. 10	09910 CORF	0		0		0	
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0		0		0	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0		0		0	99. 40
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 NTEREST EXPENSE						113. 00
200.00		24, 710, 436	0	24, 710, 436	0	o	200. 00
201.00	1 /	854, 514		854, 514			201. 00
202.00	I I	23, 855, 922					202. 00
202.00	1.323. (300 111311 4011 0113)	20,000,722	1	20,000,722	١	·	1-32. 00

202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 151323 Peri od: Worksheet C From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/31/2016 11:39 am Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 5, 132, 581 5, 132, 581 30.00 30.00 43.00 04300 NURSERY 464, 130 464, 130 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 712, 807 8, 818, 680 11, 531, 487 0. 238581 0.000000 50.00 0.755965 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52 00 1,662,656 1, 662, 656 52 00 53.00 05300 ANESTHESI OLOGY 291, 666 1,006,814 1, 298, 480 0.078567 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 481, 488 18, 487, 955 19, 969, 443 0.114770 0.000000 54.00 06000 LABORATORY 1, 250, 047 0.235280 0.000000 60.00 4, 987, 378 6, 237, 425 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 0.000000 62 30 65.00 06500 RESPIRATORY THERAPY 616, 234 1, 521, 148 2, 137, 382 0.321623 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 307,001 1, 394, 883 1, 701, 884 0.566322 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 292, 979 325, 582 0.351160 67.00 618, 561 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 33, 742 121, 649 155, 391 0.866698 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 492, 464 1, 087, 195 1, 579, 659 0.297272 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 790.599 304.474 1, 095, 073 0.308935 72 00 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 640, 252 4,610,900 7, 251, 152 0.299557 0.000000 73.00 07697 CARDIAC REHABILITATION 0.000000 76. 97 0 0 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 0 0 0.000000 0.000000 07699 LI THOTRI PSY 76.99 0 C 0 0.000000 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 90 01 09001 LIFEBRIDGE SENIOR CARE 488 166 488 166 0 934338 0.000000 90 01 0 429, 107 91.00 09100 EMERGENCY 10, 538, 091 10, 967, 198 0.293614 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 906, 221 906, 221 0.942942 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 0.000000 95.00 09500 AMBULANCE SERVICES 0 3, 800, 460 3, 800, 460 0.603446 99. 10 09910 CORF 0 99. 10 09920 OUTPATIENT PHYSICAL THERAPY 0 99. 20 0 0 99. 20 0 99 30 09930 OUTPATIENT OCCUPATIONAL THERAPY C O 99 30 09940 OUTPATIENT SPEECH PATHOLOGY 0 99.40 99.40 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 200 00 18, 597, 753 76, 997, 349 58, 399, 596 200. 00 Subtotal (see instructions) 201. 00

18, 597, 753

76, 997, 349

58, 399, 596

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES COMMUNITY HOSPT. OF LAGRANGE CTY IN Provi der CCN: 151323

				5/31/2016 11:39 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
99. 10 09910 CORF				99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY				99. 20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY				99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY				99. 40
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
(1			12.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES | Peri od: | Worksheet C | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 151323

					12/31/2013	5/31/2016 11:	
			Ti t	le XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2, 00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	11.00	2.00	0.00		0.00	
30.00	03000 ADULTS & PEDIATRICS	4, 686, 190		4, 686, 190	0	4, 686, 190	30.00
43. 00	04300 NURSERY	347, 413		347, 41		347, 413	
10.00	ANCILLARY SERVICE COST CENTERS	0177110		0177	<u>, </u>	3177110	10.00
50.00	05000 OPERATING ROOM	2, 751, 190		2, 751, 190	0	2, 751, 190	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 256, 909		1, 256, 90		1, 256, 909	1
53. 00	05300 ANESTHESI OLOGY	102, 018		102, 01		102, 018	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 291, 890		2, 291, 890		2, 291, 890	
60.00	06000 LABORATORY	1, 467, 543		1, 467, 54		1, 467, 543	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		1, 10,70	1	0	
65. 00	06500 RESPI RATORY THERAPY	687, 431	0	687, 43	ا ا	687, 431	65. 00
66. 00	06600 PHYSI CAL THERAPY	963, 814	-	963, 81		963, 814	1
67. 00	06700 OCCUPATI ONAL THERAPY	217, 214	l .	217, 21		217, 214	
68. 00	06800 SPEECH PATHOLOGY	134, 677		134, 67		134, 677	
69. 00	06900 ELECTROCARDI OLOGY	134,077	l	134,07		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	469, 588		469, 58		469, 588	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	338, 306		338, 30		338, 306	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 172, 135		2, 172, 13		2, 172, 135	
76. 97	07697 CARDI AC REHABI LI TATI ON	2, 172, 133		2, 172, 13		2, 172, 133	1
76. 77	07698 HYPERBARI C OXYGEN THERAPY	0				0	1
76. 99	07699 LI THOTRI PSY	0				0	1
70. 77	OUTPATIENT SERVICE COST CENTERS				<u> </u>	U	70. 77
90. 00	09000 CLINIC	0			0	0	90.00
90. 00	09001 LI FEBRI DGE SENI OR CARE	456, 112	•	456, 11:	-	456, 112	
91. 00	09100 EMERGENCY	3, 220, 119		3, 220, 11		3, 220, 119	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	854, 514		854, 51		854, 514	
72.00	OTHER REIMBURSABLE COST CENTERS	034, 314		034, 31	T .	034, 314	72.00
95. 00	09500 AMBULANCE SERVICES	2, 293, 373		2, 293, 37	3 0	2, 293, 373	95.00
99. 10	09910 CORF	2, 273, 373		2, 273, 37		2, 273, 373	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0				0	99. 20
99. 30	09930 OUTPATIENT PHISTCAL THERAPY					0	
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY					0	
77. 40	SPECIAL PURPOSE COST CENTERS				<u>′</u>	0	J 77. 4U
113 00	11300 INTEREST EXPENSE						113. 00
200.00		24, 710, 436	0	24, 710, 43	0	24, 710, 436	
200.00	,	854, 514		854, 51		854, 514	
201.00		23, 855, 922				23, 855, 922	
202.00	p potar (see mistractions)	23,033,922	1	23,033,72	-1 4	23, 033, 722	1202.00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 151323 Peri od: Worksheet C From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/31/2016 11:39 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 5, 132, 581 5, 132, 581 30.00 30.00 43.00 04300 NURSERY 464, 130 464, 130 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 712, 807 8, 818, 680 11, 531, 487 0. 238581 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0.755965 0.000000 52 00 1,662,656 1, 662, 656 52 00 53.00 05300 ANESTHESI OLOGY 291, 666 1,006,814 1, 298, 480 0.078567 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 481, 488 18, 487, 955 19, 969, 443 0.114770 0.000000 54.00 06000 LABORATORY 1, 250, 047 0.235280 0.000000 60.00 4, 987, 378 6, 237, 425 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 0.000000 62 30 65.00 06500 RESPIRATORY THERAPY 616, 234 1, 521, 148 2, 137, 382 0.321623 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 307,001 1, 394, 883 1, 701, 884 0.566322 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 292, 979 325, 582 0.351160 67.00 618, 561 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 33, 742 121, 649 155, 391 0.866698 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 492, 464 1, 087, 195 1, 579, 659 0.297272 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 790.599 304.474 1, 095, 073 0.308935 72 00 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 640, 252 4,610,900 7, 251, 152 0.299557 0.000000 73.00 07697 CARDIAC REHABILITATION 0.000000 76. 97 0 0 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 0 0 0.000000 0.000000 07699 LI THOTRI PSY 76.99 0 C 0 0.000000 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 90 01 09001 LIFEBRIDGE SENIOR CARE 488 166 488 166 0 934338 0.000000 90 01 0 429, 107 91.00 09100 EMERGENCY 10, 538, 091 10, 967, 198 0.293614 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 906, 221 906, 221 0.942942 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 0.000000 95.00 09500 AMBULANCE SERVICES 0 3, 800, 460 3, 800, 460 0.603446 99. 10 09910 CORF 0 99. 10 09920 OUTPATIENT PHYSICAL THERAPY 0 99. 20 0 0 99. 20 0 99 30 09930 OUTPATIENT OCCUPATIONAL THERAPY C O 99 30

18, 597, 753

18, 597, 753

58, 399, 596

58, 399, 596

0

76, 997, 349

76, 997, 349

99.40

113.00

200. 00

201. 00

202. 00

09940 OUTPATIENT SPEECH PATHOLOGY

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

SPECIAL PURPOSE COST CENTERS

113. 00 11300 INTEREST EXPENSE

99.40

200 00

201.00

202.00

Health Financial Systems In Lieu of Form CMS-2552-10 COMMUNITY HOSPT. OF LAGRANGE CTY IN COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 151323 Peri od: Worksheet C Part I

From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/31/2016 11:39 am Title XIX Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 43.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 238581 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 755965 53.00 05300 ANESTHESI OLOGY 0.078567 05400 RADI OLOGY-DI AGNOSTI C 0. 114770 54.00 60.00 06000 LABORATORY 0. 235280 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 06500 RESPIRATORY THERAPY 65.00 0. 321623 66.00 06600 PHYSI CAL THERAPY 0.566322 67.00 06700 OCCUPATIONAL THERAPY 0. 351160 06800 SPEECH PATHOLOGY 0.866698 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 297272 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 308935 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 299557 73.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0.000000 07699 LI THOTRI PSY 76. 99 0.000000 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.01 09001 LIFEBRIDGE SENIOR CARE 0. 934338

30.00 43.00 50.00 52.00 53.00 54.00 60.00 62.30 65 00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 76.97 76.98 76. 99 90.00 90.01 91.00 09100 EMERGENCY 0. 293614 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 0. 942942 92.00 92.00 95.00 09500 AMBULANCE SERVICES 95.00 0.603446 99. 10 09910 CORF 99. 10 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 99. 20 99. 30 |09930 OUTPATIENT OCCUPATIONAL THERAPY 99.30 09940 OUTPATIENT SPEECH PATHOLOGY 99. 40 99.40 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200. 00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 202.00

Health Financial Systems COMMUNITY HOSPT.
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2016 Provi der CCN: 151323

					10 12/31/2013	5/31/2016 11:	
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cos		Operating Cost	
	'	(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
		·		col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 751, 190	378, 092	2, 373, 09	8 0	0	50. 00
	05200 DELIVERY ROOM & LABOR ROOM	1, 256, 909			7 0	0	52. 00
	05300 ANESTHESI OLOGY	102, 018	4, 857	97, 16	1 0	0	53. 00
	D5400 RADI OLOGY-DI AGNOSTI C	2, 291, 890	235, 141	2, 056, 74	9 0	0	54.00
	06000 LABORATORY	1, 467, 543	117, 799	1, 349, 74	4 0	0	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	687, 431	57, 945	629, 48	6 0	0	65. 00
	06600 PHYSI CAL THERAPY	963, 814	127, 141	836, 67	3 0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	217, 214	10, 579	206, 63	5 0	0	67. 00
	06800 SPEECH PATHOLOGY	134, 677	6, 481	128, 19	6 0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	1	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	469, 588			8 0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	338, 306	20, 826	317, 48	0	0	72. 00
	D7300 DRUGS CHARGED TO PATIENTS	2, 172, 135	136, 423	2, 035, 71	2 0	0	73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0)	0	0	76. 97
	07698 HYPERBARIC OXYGEN THERAPY	0	0	1	0	0	76. 98
	07699 LI THOTRI PSY	0	0		0 0	0	76. 99
	DUTPATIENT SERVICE COST CENTERS	_					
	09000 CLI NI C	0	0	1	0	0	90. 00
	09001 LI FEBRI DGE SENI OR CARE	456, 112				0	90. 01
	D9100 EMERGENCY	3, 220, 119				0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	854, 514	154, 200	700, 31	4 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	2, 293, 373	133, 503	2, 159, 87	0	_	95. 00
	09910 CORF	0	0		0	0	99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	0	0		0	0	99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		0	0	99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0		0 0	0	99. 40
	SPECIAL PURPOSE COST CENTERS					1	
	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	19, 676, 833					200. 00
201.00	Less Observation Beds	854, 514					201. 00
202.00	Total (line 200 minus line 201)	18, 822, 319	1, 719, 048	17, 103, 27	1 0	0	202. 00

REDUCTIONS FOR MEDICALD ONLY

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 5/31/2016 | 11:39 am

					5/31/2016 11:	39 am
			le 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			
	Reducti on	8)	/ col. 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 751, 190	11, 531, 487	0. 238581			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 256, 909	1, 662, 656	0. 755965			52.00
53. 00 05300 ANESTHESI OLOGY	102, 018	1, 298, 480	0. 078567			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 291, 890	19, 969, 443	0. 114770			54.00
60. 00 06000 LABORATORY	1, 467, 543	6, 237, 425	0. 235280			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	687, 431	2, 137, 382	0. 321623			65. 00
66. 00 06600 PHYSI CAL THERAPY	963, 814	1, 701, 884	0. 566322			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	217, 214	618, 561	0. 351160			67.00
68.00 06800 SPEECH PATHOLOGY	134, 677	155, 391	0. 866698			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	469, 588	1, 579, 659	0. 297272			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	338, 306	1, 095, 073	0. 308935			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 172, 135	7, 251, 152	0. 299557			73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.000000			76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.000000			76. 99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	0	0.000000			90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	456, 112	488, 166	0. 934338			90. 01
91. 00 09100 EMERGENCY	3, 220, 119	10, 967, 198	0. 293614			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	854, 514	906, 221	0. 942942			92.00
OTHER REIMBURSABLE COST CENTERS			·			
95. 00 09500 AMBULANCE SERVICES	2, 293, 373	3, 800, 460	0. 603446			95. 00
99. 10 09910 CORF	0	0	0.000000			99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0.000000			99. 20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0.000000			99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0.000000			99. 40
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (sum of lines 50 thru 199)	19, 676, 833	71, 400, 638				200.00
201.00 Less Observation Beds	854, 514					201.00
202.00 Total (line 200 minus line 201)	18, 822, 319					202.00
		,	. ,			•

	IUNI TY HOSPT. O				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		CCN: 151323	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Pre 5/31/2016 11:	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATI NG ROOM	378, 092		1		10, 914	
52.00 05200 DELIVERY ROOM & LABOR ROOM	91, 072	1, 662, 656			0	52. 00
53. 00 05300 ANESTHESI OLOGY	4, 857	1, 298, 480	0. 00374	43, 887	164	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	235, 141	19, 969, 443	0. 01177	75 415, 602	4, 894	54. 00
60. 00 06000 LABORATORY	117, 799	6, 237, 425	0. 01888	355, 053	6, 706	60. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	00	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	57, 945	2, 137, 382	0. 02711	0 234, 842	6, 367	65. 00
66. 00 06600 PHYSI CAL THERAPY	127, 141	1, 701, 884	0. 07470	86, 944	6, 495	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	10, 579	618, 561	0. 01710	76, 945	1, 316	67. 00
68. 00 06800 SPEECH PATHOLOGY	6, 481	155, 391	0. 04170	9, 931	414	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 920	1, 579, 659	0. 01830	165, 835	3, 036	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 826	1, 095, 073	0. 01901	8 245, 622	4, 671	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	136, 423	7, 251, 152	0. 01881	4 715, 605	13, 463	73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	0.00000	00	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	00	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000	00	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90. 00
90. 01 09001 LI FEBRI DGE SENI OR CARE	43, 852	488, 166	0. 08983	0	0	90. 01
91. 00 09100 EMERGENCY	326, 417	10, 967, 198	0. 02976	33, 960	1, 011	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	154, 200				0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	1, 739, 745	67, 600, 178		2, 717, 082	59, 451	200. 00

| Peri od: | Worksheet D | From 01/01/2015 | Part IV | To 12/31/2015 | Date/Time Prepared: | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | THROUGH COSTS

				'	0 12/31/2013	5/31/2016 11:	39 am
			Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician N	Nursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	,					
50.00	05000 OPERATI NG ROOM	0	0	0	0	0	00.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	01	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	01	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	01	54. 00
60. 00	06000 LABORATORY	0	0	0	0	01	60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	01	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	01	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	01	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	01	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	01	68. 00
	06900 ELECTROCARDI OLOGY	0	0	0	0	01	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	01	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	C	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0	0	0	01	90.00
	09001 LI FEBRI DGE SENI OR CARE	0	0	0	0	01	90. 01
	09100 EMERGENCY	0	0	0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	0	0	0	0	200. 00

Health Financial Systems	COMMUNITY HOSPT. OF LAG	GRANGE CTY IN	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENTHROUGH COSTS	Γ ANCILLARY SERVICE OTHER PASS	Provider CCN: 151323	Peri od: From 01/01/2015	Worksheet D Part IV Date/Time Prepared

THROUGH COSTS					rom 01/01/2015 To 12/31/2015	Part IV Date/Time Pre 5/31/2016 11:	
			Ti †l	e XVIII	Hospi tal	Cost	37 alli
Cost Center Description	Total	Total		Ratio of Cost		Inpatient	
			Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of			(col. 5 ÷ col.	to Charges	Charges	
	col. 2, 3 and		8)	7)	(col. 6 ÷ col.	ŭ	
	4)				7)		
	6.00	1	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	11	1, 531, 487	0. 000000	0.000000	332, 856	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1	1, 662, 656	0. 000000	0.000000	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	-	1, 298, 480	0. 000000	0.000000	43, 887	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	19	9, 969, 443	0. 000000	0.000000	415, 602	54.00
60. 00 06000 LABORATORY	0		5, 237, 425	0. 000000	0.000000	355, 053	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0.000000	0.000000	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	1 2	2, 137, 382	0. 000000	0. 000000	234, 842	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	-	1, 701, 884	0. 000000	0. 000000	86, 944	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		618, 561	0. 000000	0. 000000	76, 945	67. 00
68. 00 06800 SPEECH PATHOLOGY	0		155, 391	0. 000000	0. 000000	9, 931	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		0	0. 000000	0. 000000	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1, 579, 659	0. 000000	0. 000000	165, 835	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		1, 095, 073	0. 000000	0. 000000	245, 622	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1 -	7, 251, 152	0. 000000	0. 000000	715, 605	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0		0	0. 000000	0. 000000	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0	0. 000000	0. 000000	0	76. 98
76. 99 07699 LI THOTRI PSY	0		0	0. 000000	0. 000000	0	76. 99
OUTPATIENT SERVICE COST CENTERS		•					
90. 00 09000 CLI NI C	0		0	0.00000	0.000000	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0		488, 166	0. 000000	0. 000000	0	90. 01
91. 00 09100 EMERGENCY	0	10	0, 967, 198	0. 000000	0. 000000	33, 960	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		906, 221	0. 000000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS	•			-	<u>'</u>		
95. 00 09500 AMBULANCE SERVI CES							95. 00
200.00 Total (lines 50-199)	0	6	7, 600, 178			2, 717, 082	200. 00

 Heal th Financial
 Systems
 COMMUNITY HOSPT.
 OF

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 COMMUNITY HOSPT. OF LAGRANGE CTY IN Provi der CCN: 151323

THROUGH COSTS

Title XVIII Hospital Cost Cost Center Description Inpatient Program Pass-Through Costs (col. 8 x. col. 10) 12.00 13.00 Forgram Pass-Through Costs (col. 9 x. col. 12)						5/31/2016 11:	:39 am
Program Pass-Through Costs (col. 8 x col. 10)			Ti tl	e XVIII	Hospi tal	Cost	
Pass-Through Costs (col. 8 x col. 10)	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
ANCILLARY SERVICE COST CENTERS 11.00 12.00 13.00		Program	Program	Program			
X COI			Charges				
11.00 12.00 13.00)		
ANCI LLARY SERVICE COST CENTERS							
50.00 05000 OPERATI NG ROOM 0 0 0 0 0 0 0 0 0		11.00	12. 00	13. 00			
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 53.00							
53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 60.00 05400 LABORATORY 0 0 0 0 62.30 05250 BLODD CLOTTI NG FOR HEMOPHI LI ACS 0 0 0 0 65.00 05500 RESPI RATORY THERAPY 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76.99 07699 LI THOTRI PSY 0 0 0 90.00 09000 CLINI C 0 0 0 90.01 09000 CLINI C 0 0 0 90.01 09000 CLIR REGENCY 0 0 0 90.01 09000 CLIR REGENCY 0 0 0 90.01 09000 CLIR REGENCY 0 0 0 90.01 OPTHER REI MBURSABLE COST CENTERS 95.00		0	C)	0		
S4.00		0	C)	0		
60. 00 06000 LABORATORY 0 0 0 0 0 62. 30 65. 00 6250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0 0 0 0 0 62. 30 65. 00 66500 RESPI RATORY THERAPY 0 0 0 0 0 65. 00 66. 00 66.00 PHYSI CAL THERAPY 0 0 0 0 0 66. 00 66.00 PHYSI CAL THERAPY 0 0 0 0 0 66. 00 66.00 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 66. 00 66.00 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 0 0 0	53. 00 05300 ANESTHESI OLOGY	0	C)	0		
62. 30		0	C		0		
65. 00		0	C		0		
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 72. 00 07200 IMPL DEV CHARGED TO PATI ENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76. 99 000 07699 LI THOTRI PSY 0 0 0 76. 99 001 09000 CLI NI C 0 0 76. 99 001 09000 CLI NI C 0 0 76. 99 001 09000 CLI NI C 0 0 76. 99 001 09000 DRUGS SENI OR CARE 0 0 0 76. 90 09000 DRUGS CHARGED TO PATI ENTS 0 0 76. 99 001 09000 DRUGS CHARGED TO PATI ENTS 76. 99 001 09000 09000 09000 09000 09000 76. 99 001 09000 09000 09000 09000 09000 76. 99 001 09000 09000 09000 09000 76. 99 001 09000 09000 09000 09000 76. 99 001 09000 09000 09000 09000 09000 76. 99 0000 09000 09000 09000 09000 76. 99 0000 09000 09000 09000 09000 76. 99 0000 09000 09000 09000 09000 76. 90 09000 09000 09000 09000 09000 76. 90 09000 09000 09000 09000 09000 76. 90 09000 09000 09000 09000 09000 76. 90 09000 09000 09000 09000 09000 76. 90 09000 09000 09000 09000 09000 76. 90 09000 09000 09000 09000 09000 76. 90 09000 09000 09000 09000 09000 09000 76. 90 09000	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C)	0		62. 30
67. 00	65. 00 06500 RESPI RATORY THERAPY	0	C		0		65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0	C		O		66. 00
69. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0	C		o		67. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 0 0 0 0 0	68. 00 06800 SPEECH PATHOLOGY	0	C		o		68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 76. 97 07697 CARDI AC REHABILITATI ON 0 0 0 0 0 0 0 76. 97 76. 98 07699 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 76. 99 0 0 0 0 0 0 0 0 0	69. 00 06900 ELECTROCARDI OLOGY	0	C		o		69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73. 00 76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 99 07699 LITHOTRI PSY 0 0 0 0 76. 99 00000 DITHATIENT SERVICE COST CENTERS 0 0 0 90. 01 09001 LIFEBRI DGE SENI OR CARE 0 0 0 91. 00 09100 EMERGENCY 0 0 0 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0000 OTHER REI MBURSABLE COST CENTERS 95. 00 95. 00 09500 AMBULANCE SERVICES 95. 00 97. 00 07697 AMBULANCE SERVICES 95. 00 98. 00 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0 0 0 99. 00 0	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		o		71. 00
76. 97 76. 98 76. 98 76. 99 07699 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 98 76. 99 001PATIENT SERVI CE COST CENTERS 90. 00 90. 01 90. 01 90. 01 90. 00 90. 01 90. 00 90. 01 90. 00 90. 01 90. 00 90. 01 90. 00 90. 01 90. 00 90. 01 90. 00 90	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		o		72. 00
76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 76. 99 00TPATI ENT SERVI CE COST CENTERS 90. 00 90. 01 90. 01 90. 01 90. 01 90. 00 90. 01 91. 00 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 07699 LI THOTRI PSY 0	73.00 07300 DRUGS CHARGED TO PATIENTS	O	C		o		73. 00
76. 99 07699 LI THOTRI PSY 0 0 0 0 76. 99 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 90. 00 90. 01 09001 LI FEBRI DGE SENI OR CARE 0 0 0 0 90. 01 91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	76. 97 07697 CARDIAC REHABILITATION	0	C		o		76. 97
OUTPATI ENT SERVI CE COST CENTERS 90. 00 00 00 00 00 00 00	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C		o		76. 98
90. 00 09000 CLI NI C 0 0 0 90. 00 90. 01	76. 99 07699 LI THOTRI PSY	0	C		o		76. 99
90. 01 09001 LI FEBRI DGE SENI OR CARE 0 0 0 0 91. 00 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	OUTPATIENT SERVICE COST CENTERS	<u>'</u>			<u>'</u>		
91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0	90. 00 09000 CLI NI C	0	C		0		90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	90. 01 09001 LI FEBRI DGE SENI OR CARE	0	C		o		90. 01
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	91. 00 09100 EMERGENCY	O	C		o		91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	O	C		o		92.00
	OTHER REIMBURSABLE COST CENTERS	'			·		
200.00 Total (lines 50-199) 0 0 200.00	95. 00 09500 AMBULANCE SERVICES						95. 00
	200.00 Total (lines 50-199)	0	C		o		200.00

Health Financial Systems COMM	<u>MUNITY HOSPI. OF</u>	- LAGRANGE CIY	IN	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
				From 01/01/2015		
				To 12/31/2015	Date/Time Pre	pared:
		Ti +1	e XVIII	Hospi tal	5/31/2016 11: Cost	39 am
		11 (1	Charges	поѕрі таі	Costs	
Cost Center Description	Cost to Charge	DDC Doimburgood		Cost	PPS Services	
cost center bescription	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
	Part I, col. 9		Subject To	Subject To		
	rait i, coi. 9		Ded. & Coins.			
			(see inst.)	(see inst.)		
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	0. 238581		1, 216, 48	n n	0	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0. 755965		1, 210, 40	0 0		52.00
53. 00 05300 ANESTHESI OLOGY	0. 733763		139, 18	0	0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 078387		4, 481, 04		0	54.00
60. 00 06000 LABORATORY	0. 235280	l .	1, 379, 32		0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 233280	l .	1, 377, 32	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 321623		104, 66	.2		65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 566322		427, 30		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 351160		72, 05		1	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 866698	l e	28, 78		0	68.00
69. 00 06900 SPEECH PATHOLOGY	0. 000000		1	0 0		69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 297272		122, 42	0		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 297272	l e	76, 41		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 299557				0	73.00
73. 00 07300 DRUGS CHARGED TO PATTENTS 76. 97 07697 CARDI AC REHABI LI TATI ON	0. 299557		1, 650, 71	9 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	l e		0		76. 97
76. 99 07699 LI THOTRI PSY	0.000000			0		76. 98
OUTPATIENT SERVICE COST CENTERS	0.000000		1	0 0	0	76.99
90. 00 09000 CLINIC	0. 000000		ı	0 0	0	90.00
90. 00 09000 CLINIC 90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 934338		374, 06	0		
91. 00 09100 EMERGENCY	0. 934336		2, 356, 93			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 942942		754, 63		0	91.00
OTHER REIMBURSABLE COST CENTERS	0. 942942		1 754, 65	3 0	0	92.00
95. 00 09500 AMBULANCE SERVI CES	0. 603446					95. 00
200.00 Subtotal (see instructions)	0.003440	0	13, 184, 03	0		200.00
		·	13, 104, 03	0	i	200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges				0	l	201.00
202.00 Net Charges (line 200 +/- line 201)		o	13, 184, 03	6		202. 00
202.00	1	1	13, 104, 03	0	, 0	1202.00

| Peri od: | Worksheet D | From 01/01/2015 | Part V | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 151323

Cost Cost Cost Cost Cost Cost Relimbursed Services Subject To Ded. & Coins. (See inst.) Cost Relimbursed Services Subject To Ded. & Coins. (See inst.) Cost Relimbursed Services Subject To Ded. & Coins. (See inst.) Cost Relimbursed Services Ser					10 12/31/2015	Date/IIMe Pre 5/31/2016 11:	
Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. Ded. & Co			Ti tl	e XVIII	Hospi tal	Cost	
Relimbursed Services Servic		Cos	sts				
Services Subject To Ded. & Coins. Subject To Ded. & Coins. Subject To Ded. & Coins. See inst. Subject To Ded. & Coins. See inst.	Cost Center Description						
Subject To Ded. & Coins Subject To Ded. & Coins See Inst.							
Ded. & Coli ns. (See inst.)							
See inst. (see inst.)							
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 0PERATI NC ROOM 290,229 0 50. 00 52. 00 520 05200 052		6. 00	7. 00				
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0			_	1			
53. 00		290, 229	0				
54. 00 05400 RADI OLOGY-DI AGNOSTI C 514, 289 0 60. 00		0	0				
60. 00 06000 LABORATORY 324,528 0 62. 30 62. 30 6250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 62. 30 62. 30 66. 0			l .				
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 65. 00 65500 RESPIRATORY THERAPY 33, 662 0 0 65. 00 6600 PHYSI CAL THERAPY 241, 991 0 66. 00 6600 PHYSI CAL THERAPY 241, 991 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 25, 303 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 24, 951 0 68. 00 6900 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 36, 395 0 71. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 23, 607 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 494, 484 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 494, 484 0 73. 00 07409 CARDI AC REHABI LI TATI ON 0 0 0 76. 98 07699 LI THOTRI PSY 0 0 0 0 76. 98 07699 LI THOTRI PSY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			l .				
65. 00		324, 528	0				
66. 00		0	0				
67. 00			0				
68. 00		241, 991	0				
69. 00 06900 ELECTROCARDI OLOGY 71. 00 771. 00 771. 00 771. 00 772. 00 0720. 01 0720. 01 0720. 01 0720. 01 0720. 01 0720. 01 0730. 00 07300 DRUGS CHARGED TO PATI ENTS 23, 607 0 73. 00 74. 97 75. 98 07697 CARDI AC REHABI LITATI ON 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 99 07699 LI THOTRI PSY 0 0 0770. 01 07000 CLI NI C 0 0 090. 01 090.			0				
71. 00		24, 951	0				
72. 00		0	0				
73. 00 76. 97 76. 97 76. 98 76. 98 76. 99 76			0				
76. 97 76. 97 76. 98 07699 HYPERBARI C OXYGEN THERAPY 0 0 07699 LI THOTRI PSY 0 0UTPATI ENT SERVI CE COST CENTERS 90. 00 90. 01 90. 01 90. 01 91. 00 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 711, 575 0) 071HER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 09500 OSSUBTORIAL (see instructions) 201. 00 01		23, 607	0				
76. 98 76. 99 76. 99 76. 99 76. 99 0000		494, 484	0				
76. 99 07699 LITHOTRI PSY 0 0 0 76. 99 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 90. 01 09001 LI FEBRI DGE SENI OR CARE 349, 506 0 90. 01 91. 00 09100 EMERGENCY 692, 028 0 91. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 711, 575 0 92. 00 0710 CHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 95. 00 200. 00 Subtotal (see instructions) 3, 773, 483 0 200. 00 Less PBP Clinic Lab. Servi ces-Program 0 0nl y Charges		0	0				
OUTPATIENT SERVICE COST CENTERS O		0	0				
90. 00 09000 CLI NI C 0 0 0 90. 00 90. 01 09001 LI FEBRI DGE SENI OR CARE 349, 506 0 90. 01 91. 00 09100 EMERGENCY 692, 028 0 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 711, 575 0 0 0 0 0 0 0 0 0		0	0				76. 99
90. 01							
91. 00 09100 EMERGENCY 692, 028 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 711, 575 0 92. 00 07THER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 0 0		_	-				
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 711,575 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 95. 00 200. 00 Subtotal (see instructions) 3,773,483 0 200. 00 201. 00 0nly Charges 0 0nly Charges			l e				
OTHER REIMBURSABLE COST CENTERS 95.00							
95. 00		711, 575	0				92. 00
200.00 Subtotal (see instructions) 3,773,483 0 200.00 201.00 Clarges Clinic Lab. Services-Program 0 0 0 0 0 0 0 0 0							
201.00 Less PBP Ĉlinic Lab. Services-Program 0 0 201.00		0					
Only Charges		3, 773, 483	0				
		0					201. 00
202.00 Net Charges (line 200 +/- line 201) 3,773,483 0 202.00							
	202.00 Net Charges (line 200 +/- line 201)	3, 773, 483	0				202. 00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN

			Componen	1 CCN: 152323 1	0 12/31/2015	5/31/2016 11:	
			Ti tl	e XVIII Si	wing Beds - SNF		
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ARY SERVICE COST CENTERS			1			
	OPERATING ROOM	0. 238581	0	0	0	0	50.00
	DELIVERY ROOM & LABOR ROOM	0. 755965	0	0	0	0	52.00
	ANESTHESI OLOGY	0. 078567	0	0	0	0	53. 00
	RADI OLOGY-DI AGNOSTI C	0. 114770	l .	0	0	0	54. 00
1 1	LABORATORY	0. 235280	l .	0	0	0	60.00
	BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000		0	0	0	62. 30
	RESPI RATORY THERAPY	0. 321623	0	0	0	0	65. 00
	PHYSI CAL THERAPY	0. 566322	0	0	0	0	66. 00
	OCCUPATI ONAL THERAPY	0. 351160		0	0	0	67. 00
68. 00 06800	SPEECH PATHOLOGY	0. 866698	0	0	0	0	68. 00
69. 00 06900	ELECTROCARDI OLOGY	0. 000000	0	0	0	0	69. 00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 297272	0	0	0	0	71. 00
72. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 308935	0	0	0	0	72. 00
73. 00 07300	DRUGS CHARGED TO PATIENTS	0. 299557	0	0	0	0	73. 00
76. 97 07697	CARDIAC REHABILITATION	0. 000000	0	0	0	0	76. 97
76. 98 07698	HYPERBARIC OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
76. 99 07699	LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
OUTPAT	TENT SERVICE COST CENTERS						
90.00 09000	CLI NI C	0. 000000	0	0	0	0	90. 00
90. 01 09001	LIFEBRIDGE SENIOR CARE	0. 934338	0	0	0	0	90. 01
91.00 09100	EMERGENCY	0. 293614	0	0	0	0	91.00
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0. 942942	0	0	0	0	92. 00
OTHER	REIMBURSABLE COST CENTERS]
95. 00 09500	AMBULANCE SERVICES	0. 603446		0			95. 00
200.00	Subtotal (see instructions)		0	0	0	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program			0	0		201. 00
	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)		0	0	0	0	202. 00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151323 Period: From 01/01/2015 Part V Date/Time Prepared:

		Com	ponent	CCN: 15Z323	То	12/31/2	2015	Date/Time Pro 5/31/2016 11:	
			Titl∈	e XVIII	Swi ng	Beds -	SNF	Cost	
	Cos	sts							
Cost Center Description	Cost	Cos	t						
	Rei mbursed	Rei mbu							
	Servi ces	Servi ce							
	Subject To	Subj ec							
	Ded. & Coins.	Ded. & C							
	(see inst.)	(see in							
ANCILLARY SERVICE COST CENTERS	6. 00	7.0	0						
50. 00 05000 OPERATING ROOM	1 0	J	0						50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0		0						52. 00
53. 00 05300 ANESTHESI OLOGY		3	0						53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		á	0						54.00
60. 00 06000 LABORATORY	0	á	0						60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0						62. 30
65. 00 06500 RESPIRATORY THERAPY	0		0						65. 00
66. 00 06600 PHYSI CAL THERAPY	0		o						66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		o						67. 00
68. 00 06800 SPEECH PATHOLOGY	0		o						68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		o						69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		o						71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0						72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0						73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0		0						76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0						76. 98
76. 99 07699 LI THOTRI PSY	0		0						76. 99
OUTPATIENT SERVICE COST CENTERS	T								
90. 00 09000 CLI NI C	0	1	0						90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	2	0						90. 01
91. 00 09100 EMERGENCY	0	2	0						91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	<u> </u>	0						92. 00
95. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES	1 0	\							95. 00
200.00 Subtotal (see instructions)	0	()	0						200. 00
201. 00 Less PBP Clinic Lab. Services-Program	0	()	U						200.00
Only Charges		΄							201.00
202.00 Net Charges (line 200 +/- line 201)	0		o						202. 00
202. 331 mot sharges (11110-201)	1	1	O						1202.00

Health Financial Systems COMM	MUNITY HOSPT. O	F LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				rom 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/31/2016 11:	pared: 39 am
		Ti t	le XIX	Hospi tal	PPS	<u> </u>
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 & PEDIATRICS	733, 911	91, 663	642, 248	3, 146	204. 15	30.00
43. 00 NURSERY	23, 453		23, 453	419	55. 97	43.00
200.00 Total (lines 30-199)	757, 364		665, 701	3, 565		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	180					30.00
43. 00 NURSERY	132					43. 00
200.00 Total (lines 30-199)	312	44, 135				200. 00

Health Financial Systems COMM	IUNI TY HOSPT. O	F LAGRANGE CTY	I N	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der		Peri od: From 01/01/2015 To 12/31/2015		
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	Inpati ent	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						
50.00 05000 OPERATING ROOM	378, 092		0. 03278			
52.00 05200 DELIVERY ROOM & LABOR ROOM	91, 072	1, 662, 656	0. 05477	5 330, 005	18, 076	52.00
53. 00 05300 ANESTHESI OLOGY	4, 857	1, 298, 480	0.00374	1 96, 603	361	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	235, 141	19, 969, 443	0. 01177	5 99, 903	1, 176	54.00
60. 00 06000 LABORATORY	117, 799	6, 237, 425	0. 01888	6 99, 299	1, 875	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	57, 945	2, 137, 382	0. 02711	0 33, 214	900	65. 00
66. 00 06600 PHYSI CAL THERAPY	127, 141	1, 701, 884	0. 07470	6 1, 035	77	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	10, 579	618, 561	0. 01710	3 841	14	67. 00
68. 00 06800 SPEECH PATHOLOGY	6, 481	155, 391	0. 04170	8 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 920	1, 579, 659	0. 01830	8 67, 225	1, 231	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 826	1, 095, 073	0. 01901	8 21, 079	401	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	136, 423	7, 251, 152	0. 01881	4 197, 582	3. 717	73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	0.00000		0	76, 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000	0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000		0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	43, 852	488, 166			0	90. 01
91. 00 09100 EMERGENCY	326, 417		•		2, 698	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	154, 200		•			92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50-199)	1, 739, 745	67, 600, 178		1, 418, 691	43, 026	
			'			•

Health Financial Systems COMM	IUNI TY HOSPT. O	F LAGRANGE CTY	IN	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Period: From 01/01/2015 To 12/31/2015		
		Ti t	le XIX	Hospi tal	PPS	37 alli
Cost Center Description	Nursing School	Cost	All Other Medical Education Cos	Swing-Bed Adjustment t Amount (see	Total Costs (sum of cols. 1 through 3,	
					minus col. 4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0	0	30. 00
43. 00 04300 NURSERY	0	0)	O	0	43. 00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00		
30. 00 03000 ADULTS & PEDIATRICS	3, 146	0.00	18	0 (30.00
43. 00 04300 NURSERY	419		1			43. 00
200.00 Total (lines 30-199)	3, 565		31			200. 00

Health Financial Systems	COMMUNITY HOSPT. OF LAG	RANGE CTY IN	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 151323 Peri od:	Worksheet D

From 01/01/2015 | Part IV To 12/31/2015 | Date/Time Prepared: THROUGH COSTS 5/31/2016 11:39 am Title XIX Hospi tal PPS Cost Center Description Non Physician Nursing School Allied Health All Other Total Cost Anestheti st Medi cal (sum of col 1 through col . Cost Education Cost 1.00 2.00 3.00 4. 00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 0 53.00 05300 ANESTHESI OLOGY 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 06000 LABORATORY 0 60.00 0 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 0 76. 98 0 0 07699 LI THOTRI PSY 76. 99 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 0 0 09001 LIFEBRIDGE SENIOR CARE 0 0 0 90. 01 90. 01 Ω Ω 09100 EMERGENCY 0 0 0 91.00 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 92.00 0 0 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

0

0

0

0

0 200.00

200.00

Total (lines 50-199)

Health Financial Systems	COMMUNITY HOSPT. OF LAG	RANGE CTY IN	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 151323	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2015	Part IV

THROUGH COSTS			-	From 01/01/2015 To 12/31/2015	5/31/2016 11:	
			le XIX	Hospi tal	PPS	
Cost Center Description	Total		Ratio of Cost		Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col.		Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	11, 531, 487	1			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 662, 656				52. 00
53. 00 05300 ANESTHESI OLOGY	0	1, 298, 480				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	19, 969, 443	0. 00000	0.000000	99, 903	54.00
60. 00 06000 LABORATORY	0	6, 237, 425	0. 00000	0. 000000	99, 299	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	(0. 00000	0. 000000	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	2, 137, 382	0. 00000	0.000000	33, 214	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	1, 701, 884	0. 00000	0.000000	1, 035	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	618, 561	0. 00000	0.000000	841	67.00
68.00 06800 SPEECH PATHOLOGY	0	155, 391	0. 00000	0.000000	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	(0. 00000	0.000000	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 579, 659	0. 00000	0.000000	67, 225	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 095, 073	0. 00000	0.000000	21, 079	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	7, 251, 152	0. 00000	0. 000000	197, 582	73. 00
76. 97 07697 CARDIAC REHABILITATION	0		0. 00000	0. 000000	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0. 00000	0. 000000	0	76. 98
76. 99 07699 LI THOTRI PSY	0		0. 00000	0. 000000	0	76. 99
OUTPATIENT SERVICE COST CENTERS		<u>'</u>	<u>'</u>			
90. 00 09000 CLI NI C	0	(0. 00000	0.000000	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	488, 166	0. 00000	0. 000000	0	90. 01
91. 00 09100 EMERGENCY	0	10, 967, 198	0. 00000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	906, 221	0. 00000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS				,		
95. 00 09500 AMBULANCE SERVI CES						95.00
200.00 Total (lines 50-199)	0	67, 600, 178	3		1, 418, 691	200. 00

 Heal th Financial
 Systems
 COMMUNITY HOSPT. OF

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 COMMUNITY HOSPT. OF LAGRANGE CTY IN Provi der CCN: 151323

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2015 | Part IV | To 12/31/2015 | Date/Time Prepared: | 5/31/2016 | 11:39 am | Possital THROUGH COSTS

			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col. 9			
		x col. 10)		x col. 12)			
		11.00	12. 00	13.00			
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	0			0.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0			2.00
	05300 ANESTHESI OLOGY	0	0	0		5	3.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0		5-	4.00
60.00	06000 LABORATORY	0	0	0		60	0.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		6:	2. 30
65.00	06500 RESPI RATORY THERAPY	0	0	0		6	5. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0		6	6. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0		6	7. 00
68.00	06800 SPEECH PATHOLOGY	o	0	0		6	8. 00
69.00	06900 ELECTROCARDI OLOGY	o	0	0		6'	9. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	0		7	1. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	0		7:	2.00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0	0		7:	3.00
76. 97	07697 CARDI AC REHABI LI TATI ON	o	0	0		7.0	6. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	o	0	0		7.0	6. 98
76. 99	07699 LI THOTRI PSY	o	0	0		7.0	6. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0		90	0.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	o	0	0		90	0. 01
91.00	09100 EMERGENCY	o	0	0		9	1. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	l ol	0	0		9:	2. 00
	OTHER REIMBURSABLE COST CENTERS	'		•			
95.00	09500 AMBULANCE SERVI CES					9!	5. 00
200.00	Total (lines 50-199)	o	0	0		200	0.00
				•		•	

Health Financial Systems COMM	MUNITY HOSPT. 0	F LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pre 5/31/2016 11:	
		Ti t	le XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
·	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	_					
50.00 05000 OPERATING ROOM	0. 238581	0		0 493, 520	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 755965	0		0	0	
53. 00 05300 ANESTHESI OLOGY	0. 078567	0		0 57, 914	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 114770			0 2, 275, 576	0	
60. 00 06000 LABORATORY	0. 235280			0 617, 116	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			0 0	0	
65. 00 06500 RESPIRATORY THERAPY	0. 321623			0 196, 110	0	
66. 00 06600 PHYSI CAL THERAPY	0. 566322			0 144, 522	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 351160			0 56, 621	0	
68.00 06800 SPEECH PATHOLOGY	0. 866698			0 49, 176	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 297272			0 67, 397	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 308935			0 4, 476	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 299557			0 378, 340	0	
76. 97 O7697 CARDIAC REHABILITATION	0. 000000			0 0	0	1
76.98 07698 HYPERBARIC OXYGEN THERAPY	0. 000000			0 0	0	1
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000			0	0	
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 934338			0 0	0	
91. 00 09100 EMERGENCY	0. 293614			0 2, 337, 430		
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 942942	0		0 74, 360	0	92. 00
OTHER REIMBURSABLE COST CENTERS	T	1	ı	1		
95. 00 09500 AMBULANCE SERVICES	0. 603446	0		0	ı	95. 00
200.00 Subtotal (see instructions)		0		0 6, 752, 558	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				이	I	201. 00
Only Charges				, 750 550		000 00
202.00 Net Charges (line 200 +/- line 201)		0	1	0 6, 752, 558	. 0	202. 00

RANGE CTY IN In Lieu of Form CMS-2552-10
Provider CCN: 151323 | Period: | Worksheet D | From 01/01/2015 | Part V | To 12/31/2015 | Date/Time Prepared:

					То	12/31/2015	Date/Time Pr 5/31/2016 11	
			Ti 1	le XIX		Hospi tal	PPS	
		Cos	sts					
	Cost Center Description	Cost	Cost					
		Rei mbursed	Rei mbursed					
		Servi ces	Services Not					
		Subject To	Subject To					
		Ded. & Coins.	Ded. & Coins.					
		(see inst.)	(see inst.)					
	T	6.00	7. 00					
	ANCILLARY SERVICE COST CENTERS	_						
		0	117, 744					50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	(52.00
53. 00	05300 ANESTHESI OLOGY	0	4, 550					53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	261, 168					54. 00
60.00	06000 LABORATORY	0	145, 195	1				60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	(1				62. 30
65. 00	06500 RESPI RATORY THERAPY	0	63, 073					65. 00
66. 00	06600 PHYSI CAL THERAPY	0	81, 846					66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	19, 883					67. 00
68. 00	06800 SPEECH PATHOLOGY	0	42, 621	1				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	(1				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	20, 035					71. 00
72. 00		0	1, 383					72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	113, 334	l				73. 00
	07697 CARDI AC REHABI LI TATI ON	0	()				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	()				76. 98
76. 99	07699 LI THOTRI PSY	0	()				76. 99
	OUTPATIENT SERVICE COST CENTERS							
	09000 CLI NI C	0	()				90. 00
90. 01	09001 LI FEBRI DGE SENI OR CARE	0	()				90. 01
91. 00	09100 EMERGENCY	0	686, 302					91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	70, 117	'				92. 00
	OTHER REIMBURSABLE COST CENTERS							
	09500 AMBULANCE SERVICES	0						95. 00
200.00	,	0	1, 627, 251					200. 00
201.00		0						201. 00
	Only Charges							
202.00	Net Charges (line 200 +/- line 201)	0	1, 627, 251					202. 00

Health Financial Systems	COMMUNITY HOSPT. OF LAG	RANGE CTY IN	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 151323	Peri od: From 01/01/2015	Worksheet D-1
			To 12/31/2015	Date/Time Prepared: 5/31/2016 11:39 am
		Ti +Lo V/////	Hospi tal	Cost

		Title XVIII	Hospi tal	5/31/2016 11: Cost	39 am
	Cost Center Description		•	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	INPATIENT DAYS	avaludi na nawbara)		2 000	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be			3, 909 3, 146	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed days	<i>3</i> ,	vate room days,	0, 140	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation bed		- 21 -6	2, 485	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through becembe	r 31 or the cost	449	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room	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 reporting period	days) through December	31 of the cost	314	7. 00
8. 00	Teporting period Total_swing-bed_NF_type_inpatient_days (including private room=	davs) 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	967	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including privato r	nom dave)	449	10. 00
10.00	through December 31 of the cost reporting period (see instruction		Joil days)	447	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	y (including private r	oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, ent				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar yea				
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14. 00 15. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	16. 00
10.00	SWING BED ADJUSTMENT				10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost		17. 00
18. 00	reporting period	often December 21 of	the cost		18. 00
16.00	Medicare rate for swing-bed SNF services applicable to services reporting period		16.00		
19. 00	Medical d rate for swing-bed NF services applicable to services reporting period	123. 32	19. 00		
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	ne cost	123. 32	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			4, 686, 190	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ng period (line	4, 000, 170	22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	1 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	38, 722	24. 00
200	7 x line 19)	or or the cost reportin	.g po ou (00, 722	2 00
25. 00	Swing-bed cost applicable to NF type services after December 31 \times line 20)	of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			619, 171	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (ine 21 minus line 26)		4, 067, 019	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		, 1		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	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	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0.00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line	31)		0.00	35. 00
36.00					36. 00
37. 00	O General inpatient routine service cost net of swing-bed cost and private room cost differential (line				37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	TMENTS			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			4 000 71	20.00
38. 00	Adjusted general inpatient routine service cost per diem (see i	•		1, 292. 76	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	-		1, 250, 099	39. 00 40. 00
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	,		0 1, 250, 099	
00	1.2.2		ı	., 200, 077	

JIVIPUTA	TION OF INPATIENT OPERATING COST		Provi der	CCN: 151323	Peri od:	Worksheet D-1	
					From 01/01/2015 To 12/31/2015	Date/Time Pre 5/31/2016 11:	
			Ti tl	e XVIII	Hospi tal	Cost	37 ai
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
00 1	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.
	ntensive Care Type Inpatient Hospital Units		,	л <u>О.</u>	00 0		42.
	NTENSIVE CARE UNIT						43.
4	CORONARY CARE UNIT						44.
	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 47.
. 00	Cost Center Description						47.
	·					1. 00	
	Program inpatient ancillary service cost (W			_		724, 007	1
-	Total Program inpatient costs (sum of lines	41 through 48)	(see instruction	ons)		1, 974, 106	49.
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	nationt routine	sarvices (from	n Wket D eu	m of Darts L and	0	50.
	II)	patront routine	301 11 003 (11 01	ii wikst. D, su	iii or rurts r unu		
	Pass through costs applicable to Program in	patient ancilla	ry services (fi	om Wkst. D,	sum of Parts II	0	51.
	and IV)	EO and E1)					
	Fotal Program excludable cost (sum of lines Fotal Program inpatient operating cost excl		elated non-phy	vsician anest	hetist and	0	
	nedical education costs (line 49 minus line		crated, non prij	ysi ci aii aiicst	netrat, and	9] 33.
	ARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges					0	
	Farget amount per discharge Farget amount (line 54 x line 55)					0.00	1
	Difference between adjusted inpatient opera	ting cost and ta	arget amount (1	ine 56 minus	line 53)	0	
- 1	Bonus payment (see instructions)	tring cost and to	arget amount (i	1110 00 1111 1103	11110 00)	0	
00 1	esser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996, u	updated and c	ompounded by the	0.00	59
	narket basket	anat manamt	ada+ad by +ba m	markat baakat		0.00	1,0
	esser of lines 53/54 or 55 from prior year fline 53/54 is less than the lower of line.					0.00	1
	which operating costs (line 53) are less that						"
	amount (line 56), otherwise enter zero (see	instructions)	•	•	o o		
	Relief payment (see instructions)		+!>			0	
	Allowable Inpatient cost plus incentive payı PROGRAM INPATIENT ROUTINE SWING BED COST	nent (see mstr	uctions)			0	63
	Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of the	e cost report	ing period (See	580, 449	64
	nstructions)(title XVIII only)	-					
	Medicare swing-bed SNF inpatient routine co	sts after Decemb	per 31 of the d	cost reportin	g period (See	0	65
	nstructions)(title XVIII only) Fotal Medicare swing-bed SNF inpatient rout	ine costs (line	64 nlus line 6	55)(title XVI	II only) For	580, 449	66
(CAH (see instructions)	·	·	, ,	3,	000, 117	
	Title V or XIX swing-bed NF inpatient routi	ne costs through	n December 31 d	of the cost r	eporting period	0	67
1	(line 12 x line 19) Fitle V or XIX swing-bed NF inpatient routio	no costs often I	Docombor 21 of	the cost ron	orting ported	0	68.
	(line 13 x line 20)	ne costs arter t	becember 31 01	the cost rep	orting period	0	00
00 [Total title V or XIX swing-bed NF inpatient					0	69
	ART III - SKILLED NURSING FACILITY, OTHER N				<u> </u>	T	١
- 1	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service o	-		•)		70
	Program routine service cost (line 9 x line		Title 70 ÷ Title	2)			72
	Medically necessary private room cost applic		m (line 14 x li	ne 35)			73
00	Total Program general inpatient routine ser	vice costs (line	e 72 + line 73))			74
	Capital-related cost allocated to inpatient	routine service	e costs (from V	Worksheet B,	Part II, column		75
	26, line 45) Per diem capital-related costs (line 75 ÷ li	ine 2)					76
- 1	Program capital-related costs (line 9 x line	*					77
- 1	npatient routine service cost (line 74 min						78
- 1	Aggregate charges to beneficiaries for exce	, ,					79
1	Total Program routine service costs for comp		cost limitation	n (line 78 mi	nus line 79)		80
	npatient routine service cost per diem liminpatient routine service cost limitation (1)				81
4	Reasonable inpatient routine service costs		•				83
	Program inpatient ancillary services (see in	•	•				84
1	Jtilization review - physician compensation	•					85
	Total Program inpatient operating costs (su		nrough 85)				86
IP.	ART IV - COMPUTATION OF OBSERVATION BED PAS						4
	Fotal observation bed days (see instructions	s)				661	8.

Health Financial Systems COMM	UNITY HOSPT.	OF LAGR	ANGE CTY	IN	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Peri od:	Worksheet D-1	
					From 01/01/2015 To 12/31/2015		
			Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routi	ne Cost	column 1 ÷	Total	Observati on	
		(from	line 27)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00	2	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST						
90.00 Capital -related cost	733, 91	1 4	4, 067, 019	0. 18045	4 854, 514	154, 200	90. 00
91.00 Nursing School cost		0 4	4, 067, 019	0.00000	0 854, 514	0	91.00
92.00 Allied health cost		0 4	4, 067, 019	0. 00000	0 854, 514	0	92. 00
93.00 All other Medical Education		0 4	4, 067, 019	0. 00000	0 854, 514	0	93. 00

Health Financial Systems	COMMUNITY HOSPT. OF LAG	RANGE CTY IN	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151323	Peri od: From 01/01/2015	Worksheet D-1
				Date/Time Prepared: 5/31/2016 11:39 am
		Title XIX	Hospi tal	PPS

		Ti +I o VI V	Hooni tal	5/31/2016 11:	39 am
	Cost Center Description	Title XIX	Hospi tal	PPS	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	oveluding newborn)		3, 909	1. 00
1. 00 2. 00	Inpatient days (including private room days, excluding swing-bed days,			3, 909	2.00
3. 00	Private room days (excluding swing-bed and observation bed days		ivate room davs.	2, 485	3.00
	do not complete this line.	, y y p.		_,	
4.00	Semi-private room days (excluding swing-bed and observation bed			0	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	449	5. 00
4 00	reporting period	daya) after December	21 of the cost	0	/ 00
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember	31 OF the Cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	314	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	+ba Dragram (avaludina	owing bod and	180	9. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	180	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instructi		,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11. 00
12.00	December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX		o zoom dovo)	0	12 00
12. 00	through December 31 of the cost reporting period	only (including privat	e room days)	0	12. 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar yea				
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			419 132	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			132	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services		17. 00		
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to services		18. 00		
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	0.00	19. 00		
	reporting period	em dagir badambar ar ar		0.00	. ,
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			4, 686, 190	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	4, 080, 190	22.00
22.00	5 x line 17)	o. o. the dest report	g porrod (o	· ·	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 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	21 of the cost report:	ng poriod (line	0	24. 00
24.00	7 x line 19)	of the cost reporti	ng perrod (Trie	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ino 21 minus lino 24)		585, 285 4, 100, 905	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	riie 21 iiii iius Triie 20)		4, 100, 903	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00 0. 00	32. 00
33. 00					33. 00
34.00					34.00
35. 00					35.00
36. 00 37. 00					36. 00 37. 00
37.00	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38. 00	Adjusted general inpatient routine service cost per diem (see i	•		1, 303. 53	
39. 00	Program general inpatient routine service cost (line 9 x line 3	-		234, 635	39. 00
40.00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +			0 234, 635	40.00
41.00	Tiotai irogram generai impatrent foutine service cost (fille 39 +	11110 40)	l	234, 035	41.00

		MUNITY HOSPT. OI					eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Prov	ıder	CCN: 151323	Peri od: From 01/01/2015		
						To 12/31/2015	Date/Time Pre 5/31/2016 11:	
				Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient	Davs	Average Pe		Program Cost (col. 3 x col.	
					col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1. 00 347, 413	2.00	419	3. 00 829	4. 00	5. 00 109, 448	42.00
42.00	Intensive Care Type Inpatient Hospital Units	347,413		417	027	. 15	107, 440	42.00
43.00	INTENSIVE CARE UNIT							43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT							44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)							47. 00
	Cost Center Description						1. 00	
48. 00	Program inpatient ancillary service cost (Wk						506, 713	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)((see instr	uctio	ns)		850, 796	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	servi ces	(from	ı Wkst. D, sı	um of Parts I and	44, 135	50.00
E4 00						6.5	40.007	F4 00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services	s (fr	om Wkst. D,	sum of Parts II	43, 026	51.00
52.00	Total Program excludable cost (sum of lines						87, 161	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, noi	n-phy	sician anest	thetist, and	763, 635	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)						i
	Program di scharges						0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)						0.00	
57. 00								57. 00
58. 00 59. 00								58. 00 59. 00
39.00	market basket	portring period	ending 19	90, u	ipuateu anu t	compounded by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year						0.00	
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha						0	61. 00
	amount (line 56), otherwise enter zero (see		(11111			ar and an gar		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instri	ictions)				0 0	
03. 00	PROGRAM INPATIENT ROUTINE SWING BED COST	cit (see mistre	10113)					03.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 o	f the	cost report	ting period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	per 31 of	the c	ost reportin	ng period (See	0	65.00
	instructions)(title XVIII only)			. ,				
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 prus ri	ine 6	5)(TITIE XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December	31 o	of the cost i	reporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [ecember 3	1 of	the cost rea	porting period	0	68. 00
	(line 13 x line 20)					and the same		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N						0	69. 00
70. 00	Skilled nursing facility/other nursing facil					7)		70. 00
71.00	Adjusted general inpatient routine service c	ost per diem (I						71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	n (line 14	x li	ne 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	ice costs (line	2 + line	e 73)				74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (fi	rom W	orksheet B,	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)						76. 00
77.00	Program capital -related costs (line 9 x line							77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		orovi den in	ecord	ls)			78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the o				nus line 79)		80.00
	Inpatient routine service cost per diem limi		1)					81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .					82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)	·					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•						85. 00 86. 00
55. 50	PART IV - COMPUTATION OF OBSERVATION BED PAS		ougii 00)]
	Total observation bed days (see instructions							87. 00

87.00

661

1, 303. 53 88. 00 861, 633 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems COMM	UNITY HOSPT. 0	F LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/31/2016 11:	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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	733, 911	4, 100, 905	0. 17896	3 861, 633	154, 200	90. 00
91.00 Nursing School cost	C	4, 100, 905	0.00000	0 861, 633	0	91.00
92.00 Allied health cost	C	4, 100, 905	0.00000	0 861, 633	0	92.00
93.00 All other Medical Education	(4, 100, 905	0. 00000	0 861, 633	0	93. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
			From 01/01/2015 To 12/31/2015	Date/Time Pre 5/31/2016 11:	
	Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			1, 388, 535		30.0
43. 00 04300 NURSERY					43. C
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 23858	332, 856	79, 413	50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 75596	5 0	0	52.0
3. 00 05300 ANESTHESI OLOGY		0. 07856	43, 887	3, 448	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11477	70 415, 602	47, 699	54.0
00. 00 06000 LABORATORY		0. 23528	355, 053	83, 537	60.0
52.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000	00	0	62.3
55. 00 06500 RESPIRATORY THERAPY		0. 32162	234, 842	75, 531	65.0
6. 00 06600 PHYSI CAL THERAPY		0. 56632	22 86, 944	49, 238	66.0
7. 00 06700 OCCUPATI ONAL THERAPY		0. 35116	76, 945	27, 020	67. (
8. 00 06800 SPEECH PATHOLOGY		0. 86669	9, 931	8, 607	68. (
9. 00 06900 ELECTROCARDI OLOGY		0.00000	00	0	69. (
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 29727	165, 835	49, 298	71. 0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 30893	35 245, 622	75, 881	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 29955	715, 605	214, 364	73.0
6. 97 07697 CARDIAC REHABILITATION		0.00000	00	0	76. 9
6. 98 07698 HYPERBARI C OXYGEN THERAPY		0.00000	00	0	76.
6. 99 07699 LI THOTRI PSY		0.00000	00	0	76. 9
OUTPATIENT SERVICE COST CENTERS		•	_		ĺ
0, 00 09000 CLI NI C		0.00000	00 0	0	1 90. c
0. 01 09001 LI FEBRI DGE SENI OR CARE		0. 93433		0	90.0
1. 00 09100 EMERGENCY		0. 29361		9, 971	91. (
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 94294	•	0	1
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES					95.
00.00 Total (sum of lines 50-94 and 96-98)			2, 717, 082	724, 007	200

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

2, 717, 082

2, 717, 082

95. 00 724, 007 200. 00 201. 00 202. 00

200.00

201.00 202.00

Health Financial Systems COMMUNITY HOSPT. OF LAGRA	NGE CTY IN	V	In Lie	eu of Form CMS-2	2552-10
-	rovi der CC		Peri od:	Worksheet D-3	
		F	rom 01/01/2015		
C	omponent (CCN: 15Z323 T	o 12/31/2015		pared:
	Title	VVIII C	wing Beds - SNF	5/31/2016 11: Cost	39 am_
Cost Center Description		atio of Cost		Inpati ent	
cost center bescription		To Charges		Program Costs	
		10 charges		(col. 1 x col.	
			Charges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		11.00	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS			"		
50. 00 05000 OPERATI NG ROOM		0. 238581	5, 675	1, 354	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 755965	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY		0. 078567	3, 681	289	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 114770	30, 174	3, 463	54.00
60. 00 06000 LABORATORY		0. 235280	76, 091	17, 903	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY		0. 321623	58, 510	18, 818	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 566322	90, 540	51, 275	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 351160	95, 859	33, 662	67. 00
68. 00 O6800 SPEECH PATHOLOGY		0. 866698	4, 003	3, 469	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0.000000	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 297272		8, 345	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 308935		0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 299557		73, 465	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0.000000		0	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY		0.000000		0	76. 98
76. 99 07699 LI THOTRI PSY		0. 000000	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 000000		-	90. 00
90. 01 09001 LI FEBRI DGE SENI OR CARE		0. 934338		_	90. 01
91 00 09100 EMERGENCY		0 29361/	253	7.4	91 00

0. 293614

0. 942942

253

638, 102

638, 102

74

0 92.00 95.00

212, 117 200. 00 201. 00

91.00

202. 00

91.00

200.00

201. 00 202. 00

09100 EMERGENCY

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

	Financial System	RVICE COST APPORTIONMENT	COMMUNITY HOSPT.				eu of Form CMS-2	
INPAII	ENT ANCILLARY SE	RVICE COST APPORTIONMENT		Provi der	CCN: 151323	Peri od: From 01/01/2015	Worksheet D-3	
						To 12/31/2015	Date/Time Pre	pared:
							5/31/2016 11:	39 am_
				Ti t	le XIX	Hospi tal	PPS	
	Cost Cente	r Description			Ratio of Cos		Inpatient	
					To Charges	Program	Program Costs	
						Charges	(col. 1 x col.	
					1.00	0.00	2)	
	INDATI ENT. DOUTI N	E CEDVI CE COCT CENTEDO			1.00	2. 00	3. 00	
20.00		E SERVICE COST CENTERS			1	175 404	1	20.00
30.00	03000 ADULTS & P	EDI ATRI CS				175, 404	•	30. 00 43. 00
43.00	04300 NURSERY ANCI LLARY SERVI C	E COST CENTERS				171, 608		43.00
50. 00	05000 OPERATING				0. 23858	381, 247	90, 958	50. 00
52. 00	05200 DELIVERY R				0. 23636	·		1
53. 00	05300 ANESTHESI O				0.75596			1
54. 00	05400 RADI OLOGY-				0.07630			
60. 00	06000 LABORATORY	DI AGNOSTI C			0. 23528	·		
62. 30		TING FOR HEMOPHILIACS			0. 00000		1	1
65. 00	06500 RESPI RATOR				0. 32162		1	
66. 00					0. 56632	·		
67. 00					0. 35116	·		
68. 00	06800 SPEECH PAT				0. 86669		1	1
69. 00	06900 ELECTROCAR				0.0000			69. 00
71. 00		PPLIES CHARGED TO PATIEN	Т		0. 29727		1	1
		CHARGED TO PATIENTS			0. 30893			
	07300 DRUGS CHAR				0. 29955			
	07697 CARDI AC RE				0. 00000		0,,10,	1
76. 98	07698 HYPERBARI C				0.00000		_	76. 98
					0.00000		1	76. 99
, 0. , ,	OUTPATIENT SERVI				0.0000	301		1
90.00	09000 CLI NI C	oe ooo! oewiene			0.00000	00 0	0	90. 00
90. 01	09001 LI FEBRI DGE	SENLOR CARE			0. 93433		0	1
91. 00	09100 EMERGENCY				0. 2936		26, 618	
92. 00		N BEDS (NON-DISTINCT PAR	Т		0. 94294			
	OTHER REI MBURSAB							1
95.00	09500 AMBULANCE							95. 00
200.00	Total (sum	of lines 50-94 and 96-98	3)			1, 418, 691	506, 713	200.00
201 00	less PRP C	Linic Laboratory Service	s-Program only cha	arges (line 61)			,	201 00

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

506, 713 200. 00 201. 00 202. 00

1, 418, 691

201.00 202.00

Health Financial Systems	COMMUNITY HOSPT. OF LAGRANGE CTY IN	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151323	Peri od: Worksheet E From 01/01/2015 Part B Date/Ti me Prepared: 5/41/2014 11:30 pm

			To 12/31/2015		
		Title XVIII	Hospi tal	5/31/2016 11: Cost	39 alli
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			3, 773, 483	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi		0		
3.00	PPS payments			0	
4. 00 5. 00	Outlier payment (see instructions)	i one)		0.000	4. 00 5. 00
6. 00	Enter the hospital specific payment to cost ratio (see instruct Line 2 times line 5	TOTIS)		0.000	6.00
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	
10.00	Organ acqui si ti ons			0 770 400	
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			3, 773, 483	11. 00
	Reasonable charges				-
12.00	Ancillary service charges			0	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	ymont for sorvices on	a chargo basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for				
	had such payment been made in accordance with 42 CFR §413.13(e)	. 3	a ona gozao. o		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18. 00	Total customary charges (see instructions)		44) (0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	if line 18 exceeds li	ne 11) (see	0	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)				
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		3, 811, 218	
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instru	ctions)		0	22. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	ctions)			
200	COMPUTATION OF REIMBURSEMENT SETTLEMENT				2 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			27, 440	1
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for		1 007 (2, 385, 571	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plinstructions)	us the sum of lines 22	and 23] (see	1, 398, 207	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	ŕ		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			1, 398, 207	30.00
31. 00	Primary payer payments			1, 298	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	6)		1, 396, 909	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	3)		0	33. 00
34.00	Allowable bad debts (see instructions)			359, 889	
35.00	Adjusted reimbursable bad debts (see instructions)			233, 928	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		305, 223	1
37. 00	Subtotal (see instructions)			1, 630, 837	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 00 39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 00 39. 50
39. 98	Partial or full credits received from manufacturers for replace		tions)	Ö	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	(,	0	39. 99
40.00	Subtotal (see instructions)			1, 630, 837	40. 00
40. 01	Sequestration adjustment (see instructions)			32, 617	1
41. 00				1, 899, 643	1
42. 00 43. 00	37			-301, 423	
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2.	chapter 1.	-301, 423	44. 00
	§115. 2	- III - III - III - III - II - II	onapro,]
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			O	
			'		•

Health Financial Systems COMMUNITY
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Period: Worksheet E-1
From 01/01/2015
To 12/31/2015 Date/Time Prepared: 5/31/2016 11: 39 am Provi der CCN: 151323

					5/31/2016 11: 3	39 am
		Ti tl	e XVIII	Hospi tal	Cost	
		Inpatien	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	1.00	1, 719, 490		1, 899, 643	1. 00
2.00	Interim payments payable on individual bills, either		C	,	0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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	08/14/2015	57, 100		0	3. 01
3.02)	0	3. 02
3.03)	l ol	3. 03
3. 04			l d		0	3. 04
3. 05					0	3. 05
3.03	Provider to Program			1	0	3.03
3. 50	ADJUSTMENTS TO PROGRAM		С		0	3. 50
	ADJUSTIVIENTS TO PROGRAW					
3.51						3. 51
3.52			C		0	3. 52
3.53			C		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		57, 100)	0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 776, 590		1, 899, 643	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	TENTATI VE TO PROVI DER				0	5. 01
5. 02	TERMINAL TO THOUSEN		l d		l ol	5. 02
5. 03						5. 03
5.05	Provider to Program			1		3.03
5. 50	TENTATI VE TO PROGRAM			1	0	5. 50
5. 50	ILIVIATIVE TO FROGRAM					5. 50
			1			
5. 52	C.		C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C	'	0	5. 99
4 00						/ 00
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)					, 61
6. 01	SETTLEMENT TO PROVIDER				0	6. 01
6.02	SETTLEMENT TO PROGRAM		52, 769		301, 423	6. 02
7.00	Total Medicare program liability (see instructions)		1, 723, 821		1, 598, 220	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

 RANGE CTY IN
 In Lieu of Form CMS-2552-10

 Provider CCN: 151323
 Period: From 01/01/2015
 Worksheet E-1 Part I Date/Time Prepared: 5/31/2016 11: 39 am
 Health Financial Systems COMMUNITY
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					5/31/2016 11:3	39 am_
				ving Beds - SNF	Cost	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4.00	
1. 00	Total interim payments paid to provider		680, 489		0	1. 00
2.00	Interim payments payable on individual bills, either		. 0		ol	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		0		0	3. 01
3.02			0		0	3. 02
3.03			0		o	3. 03
3.04			0		o	3.04
3.05			0		o	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		ol	3. 53
3.54			0		ol	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		ol	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		680, 489		0	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	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5. 03			0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 50	TENTATIVE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 52 5. 99
5. 99	5. 50-5. 98)		U		ا	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
6.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		99, 362		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		,,, 302 ^		0	6. 02
7. 00	Total Medicare program liability (see instructions)		779, 851		0	7. 00
7.00	Total mode od o program trabitity (see thistractions)		777,031	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	· '				. '	

Heal th	Financial Systems COMMUNITY HOSPT. OF LA	GRANGE CTY IN	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151323	Peri od: From 01/01/2015 To 12/31/2015		
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION			937	
1. 00	00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1. 00
2.00	.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8–12			967	2.00
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			756	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	2		2, 485	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			76, 997, 349	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lin	ne 20		1, 433, 578	6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of cerline 168	tified HIT technology	Wkst. S-2, Pt. I	113, 567	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			102, 948	8. 00
9.00	Sequestration adjustment amount (see instructions)			2, 059	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		100, 889	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,		·	
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
33 00	00 Palance due provider (Line 9 (or Line 10) minus Line 20 and Line 21) (see instructions)				

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

0 30.00 0 31.00 100,889 32.00

Health Financial Systems	COMMUNITY HOSPT. OF LA	GRANGE CTY IN	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 151323	Peri od: From 01/01/2015	Worksheet E-2
		Component CCN: 15Z323		
		T1 11 2011 1	0 1 0 1 015	0 1

		, , , , , , , , , , , , , , , , , , ,		5/31/2016 11:	39 am
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		586, 253	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A	A, and sum of Wkst. D,	214, 238	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instr				
4.00	Per diem cost for interns and residents not in approved teaching	g program (see		0.00	4. 00
	instructions)				
5.00	Program days		449	0	
6.00	Interns and residents not in approved teaching program (see inst			0	0.00
7.00	Utilization review - physician compensation - SNF optional metho	od only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		800, 491	0	
9.00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		800, 491	0	1
11.00	Deductibles billed to program patients (exclude amounts applicate	ole to physician	0	0	11. 00
	professional services)				
	Subtotal (line 10 minus line 11)		800, 491	0	
13.00	Coinsurance billed to program patients (from provider records) ((excl ude coi nsurance	4, 725	0	13. 00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	1	795, 766	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	
	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)	0	0	1
	Total (see instructions)		795, 766	0	1 . ,
	Sequestration adjustment (see instructions)		15, 915	0	1
	Interim payments		680, 489	0	20. 00
	Tentative settlement (for contractor use only)		0	0	21. 00
	Balance due provider/program (line 19 minus lines 19.01, 20, and	,	99, 362	0	00
23.00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				

Health Financial Systems	COMMUNITY HOSPT. OF LAG	RANGE CTY IN	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 151323	From 01/01/2015	Worksheet E-3 Part V Date/Time Prepared: 5/31/2016 11:39 am
		Ti +Lo V/// / /	Hospi tal	Coct

				5/31/2016 11:	39 am_		
	Title XVIII Hospital			Cost	_		
	<u> </u>						
	1.00						
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR PART V - CALCULATION OF REIMBURSEMENT FOR PART V - CALCULATION OF REIMBURSEMENT FOR V - CALCULA	ADT A SERVICES - COST	DELMBLIDSEMENT	1.00			
1.00	Inpatient services	ART A SERVICES COST	KETWIDOKSEWENT	1, 974, 106	1.00		
		->					
2.00	Nursing and Allied Health Managed Care payment (see instruction	S)		0	2.00		
3.00	Organ acquisition			0	3. 00		
4.00	Subtotal (sum of lines 1 through 3)			1, 974, 106			
5.00	Primary payer payments			0	5. 00		
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 993, 847	6. 00		
	COMPUTATION OF LESSER OF COST OR CHARGES						
	Reasonabl e charges						
7.00	Routi ne servi ce charges			0	7. 00		
8.00	Ancillary service charges			0	8.00		
9. 00				0			
	Organ acquisition charges, net of revenue						
10. 00	Total reasonable charges			0	10. 00		
	Customary charges						
11. 00	Aggregate amount actually collected from patients liable for pa			0	11. 00		
12.00	Amounts that would have been realized from patients liable for	payment for services o	n a charge basis	0	12.00		
	had such payment been made in accordance with 42 CFR 413.13(e)						
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00		
14.00	Total customary charges (see instructions)			0	14. 00		
15. 00					15. 00		
	instructions)				10.00		
16. 00				0	16. 00		
10.00	instructions)				10.00		
17 00					17. 00		
17.00	7.00 Cost of physicians' services in a teaching hospital (see instructions)				17.00		
40.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	1' 40'			40.00		
18. 00	Direct graduate medical education payments (from Worksheet E-4,	Tine 49)			18.00		
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			1, 993, 847			
20. 00	Deductibles (exclude professional component)			251, 103			
21. 00	Excess reasonable cost (from line 16)			0	21. 00		
22.00	Subtotal (line 19 minus line 20 and 21)			1, 742, 744	22. 00		
23.00	Coi nsurance			0	23. 00		
24.00	Subtotal (line 22 minus line 23)			1, 742, 744	24. 00		
25. 00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		25, 010			
26. 00	Adjusted reimbursable bad debts (see instructions)	o, (666 11.611 4 611 61.6)		16, 257			
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		11, 446			
	,	Ctions)					
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 759, 001			
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0			
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0			
29. 99	Recovery of Accelerated Depreciation			0			
30.00	0 Subtotal (see instructions)				30. 00		
30. 01				35, 180	30. 01		
31.00	Interim payments			1, 776, 590	31.00		
32.00	Tentative settlement (for contractor use only)			0	•		
33. 00	Balance due provider/program (line 30 minus lines 30.01, 31, an	d 32)		-52, 769	33. 00		
34. 00	Protested amounts (nonallowable cost report items) in accordance		chapter 1	02,707			
31.00	§115. 2	5 omo i ab. 15 2,	5.15p (6) 1,	ĺ	31.00		
	13			ı	ı		

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

Provi der CCN: 151323

Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 5/31/2016 11: 39 am

					5/31/2016 11:	39 am_
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2, 505	0	0	0	1.00
2. 00	Temporary investments	_,	o o	0		
3.00	Notes receivable			0	0	3.00
		4 220 010	1	0		
4.00	Accounts receivable	4, 320, 019		0	0	
5.00	Other recei vable	32, 365	0	0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	263, 617	' 0	0	0	7. 00
8.00	Prepai d expenses	87, 071	0	0	0	8. 00
9. 00	Other current assets	0	0	0	0	
10. 00	Due from other funds	-1, 188, 703	1	0	Ö	10.00
				0		
11. 00	Total current assets (sum of lines 1-10)	3, 516, 874	. 0	0	0	11. 00
	FIXED ASSETS					1
12. 00	Land	282, 529	0	0	0	12. 00
13.00	Land improvements	1, 972, 720	0	0	0	13.00
14.00	Accumulated depreciation	-967, 207	' 0	0	0	14.00
15. 00	Bui I di ngs	13, 429, 858	0	0	0	15. 00
16. 00	Accumulated depreciation	-2, 914, 509	1	0	l o	16. 00
17. 00	Leasehold improvements	29, 098		0	0	17. 00
			1	0		1
18. 00	Accumulated depreciation	-26, 545	1	0	0	18. 00
19. 00	Fi xed equipment	7, 763, 936		0	0	19. 00
20. 00	Accumulated depreciation	-4, 146, 847	' 0	0	0	20. 00
21.00	Automobiles and trucks	74, 622	. 0	0	0	21. 00
22. 00	Accumul ated depreciation	-50, 489	0	0	0	22. 00
23. 00	Major movable equipment	7, 443, 728	1	0	0	23. 00
24. 00	Accumulated depreciation	-5, 956, 570		0	0	24. 00
		-3, 930, 370	1	0		
25. 00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0) 0	0	0	27. 00
28.00	Accumul ated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	16, 934, 324	0	0		30.00
00.00	OTHER ASSETS	10,701,021		<u> </u>		00.00
31. 00	Investments		0	0	0	31.00
		0	1	_		
32. 00	Deposits on Leases	0	0	0	_	32. 00
33. 00	Due from owners/officers	0) 0	0	0	33. 00
34.00	Other assets	5, 011, 241	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5, 011, 241	0	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	25, 462, 439	0	0	0	36.00
	CURRENT LIABILITIES					1
37. 00	Accounts payable	629, 495	0	0	0	37. 00
			1	-		1
38. 00	Salaries, wages, and fees payable	490, 217	1	0	_	38. 00
39. 00	Payroll taxes payable	0	0	0	0	
40. 00	Notes and Loans payable (short term)	800, 000) 0	0	0	40. 00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	0	ol o	0	0	43.00
44. 00	Other current liabilities	658, 968	0	0	l o	
45. 00	Total current liabilities (sum of lines 37 thru 44)		1	0		1
40.00		2, 578, 680	0	0	0	45. 00
	LONG TERM LIABILITIES	1	Л		I	
46. 00	Mortgage payable	0	0	0	-	
47.00	Notes payable	0	0	0	-	
48.00	Unsecured Loans	0	0	0	0	48. 00
49. 00	Other long term liabilities	25, 395, 157	0	0		49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49	25, 395, 157	l	0		
51. 00	Total liabilites (sum of lines 45 and 50)	27, 973, 837	1			51.00
31.00	· · · · · · · · · · · · · · · · · · ·	21, 913, 031		U	0	31.00
	CAPI TAL ACCOUNTS	0.544.000				
52. 00	General fund balance	-2, 511, 398				52. 00
53. 00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			n		56. 00
57. 00	Plant fund balance - invested in plant			O	0	57.00
	· ·				0	
58. 00	Plant fund balance - reserve for plant improvement,				l 0	58. 00
E0 05	repl acement, and expansi on	0.544.555		_	_	F0 00
59. 00	Total fund balances (sum of lines 52 thru 58)	-2, 511, 398		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	25, 462, 439	0	0	0	60.00
	[59]		1			

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provi der CCN: 151323

					0 12/31/2015	5/31/2016 11:	
		General	Fund	Speci al Pu	irpose Fund	Endowment Fund	07 4111
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		-2, 511, 398		(1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1, 703, 574				2. 00
3.00	Total (sum of line 1 and line 2)		-807, 824)	3.00
4.00	Additions (credit adjustments) (specify)	0		C		0	4.00
5. 00 6. 00				0		0	5. 00 6. 00
7. 00						0	7.00
8.00		0				0	8.00
9. 00		0				0	9. 00
10.00	Total additions (sum of line 4-9)		0	Ĭ		ار	10.00
11. 00	Subtotal (line 3 plus line 10)		-807, 824				11.00
12. 00	Deductions (debit adjustments) (specify)	0	007,021	l c	ì	1 0	12.00
13. 00	TRANSFERS	1, 703, 574)	0	13.00
14.00		0)	0	14. 00
15.00		o)	0	15. 00
16.00		O		[c)	0	16. 00
17. 00		0		0)	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		1, 703, 574	•	(18. 00
19. 00	Fund balance at end of period per balance		-2, 511, 398		(19. 00
	sheet (line 11 minus line 18)	Fredriment Final	PI ant	F1			
		Endowment Fund	Prant	Fund	-		
		6.00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0		C			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	o)		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		C			10.00
11.00	Subtotal (line 3 plus line 10)	0					11.00
12.00	Deductions (debit adjustments) (specify)		0				12.00
13. 00 14. 00	TRANSFERS		0				13. 00 14. 00
15. 00			0				15.00
16. 00			0				16.00
17. 00			0				17. 00
18. 00	Total deductions (sum of lines 12-17)	0	U	C	,		18.00
19. 00	Fund balance at end of period per balance	0					19.00
17. 50	sheet (line 11 minus line 18)				1		' / . 55
							l

 Heal th Financial Systems
 COMMUNITY

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

		T	o 12/31/2015	Date/Time Prep 5/31/2016 11:	
	Cost Center Description	Inpatient	Outpati ent	Total	J 7 aiii
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	<u> </u>			
	General Inpatient Routine Services				
1.00	Hospi tal	4, 043, 410		4, 043, 410	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	433, 840		433, 840	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)	4, 477, 250		4, 477, 250	10. 00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT				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 16. 00	OTHER SPECIAL CARE (SPECIFY)			0	15. 00
16.00	Total intensive care type inpatient hospital services (sum of li 11-15)	nes 0		0	16. 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	4, 477, 250		4, 477, 250	17. 00
18. 00	Ancillary services	13, 449, 394		13, 449, 394	18. 00
19. 00	Outpatient services	13, 447, 374	60, 192, 213	60, 192, 213	
20. 00	RURAL HEALTH CLINIC		· · · · · · · · · · · · · · · · · · ·	00, 172, 219	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	21. 00
22. 00	HOME HEALTH AGENCY	, i		o .	22. 00
23. 00	AMBULANCE SERVICES	0	3, 821, 258	3, 821, 258	
24. 00	CMHC		0,02.,200	0,02.,200	24. 00
24. 10	CORF	l o	o	0	24. 10
24. 20	OUTPATIENT PHYSICAL THERAPY	l o	o	0	24. 20
24. 30	OUTPATIENT OCCUPATIONAL THERAPY	0	o	0	24. 30
24. 40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24. 40
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26. 00
27.00	OTHER (SPECIFY)	0	0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	o Wkst. 17, 926, 644	64, 013, 471	81, 940, 115	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)	_	29, 446, 563		29. 00
30. 00	ADD (SPECIFY)	0	l I		30.00
31. 00		0	l I		31. 00
32. 00		0			32. 00
33. 00		0			33. 00
34. 00		0			34.00
35. 00	T-+-1	0			35. 00
36. 00	Total additions (sum of lines 30-35)		0		36.00
37. 00 38. 00	DEDUCT (SPECIFY)				37. 00 38. 00
38. 00 39. 00					38.00
40. 00					40.00
41. 00					41. 00
41.00	Total deductions (sum of lines 37-41)				41.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer	29, 446, 563		43. 00
	to Wkst. G-3, line 4)		27, 1.0,000		
	·	•			•

	of Form CMS-2 orksheet G-3 ote/Time Prep /31/2016 11:3	pared:
From 01/01/2015		
	017 2010 11.	, am
0.0.		
	1. 00	
1.00 Total patient revenues (from Wkst. G-2, Part I, column 3, line 28)	81, 940, 115	1. 00
2.00 Less contractual allowances and discounts on patients' accounts 5	51, 793, 535	2.00
3.00 Net patient revenues (line 1 minus line 2)	30, 146, 580	3.00
4.00 Less total operating expenses (from Wkst. G-2, Part II, line 43)	29, 446, 563	4.00
5.00 Net income from service to patients (line 3 minus line 4)	700, 017	5.00
OTHER I NCOME		
6.00 Contributions, donations, bequests, etc	111, 850	6.00
7.00 Income from investments	-1, 228	7. 00
8.00 Revenues from telephone and other miscellaneous communication services	0	8. 00
9.00 Revenue from television and radio service	0	9. 00
10.00 Purchase discounts	0	10.00
11.00 Rebates and refunds of expenses	0	11. 00
12.00 Parking lot receipts	0	12.00
13.00 Revenue from Laundry and Linen service	0	13. 00
14.00 Revenue from meals sold to employees and guests	233, 989	
15.00 Revenue from rental of living quarters	0	15. 00
16.00 Revenue from sale of medical and surgical supplies to other than patients	0	16. 00
17.00 Revenue from sale of drugs to other than patients		
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

21.00

22.00

23.00

24. 01

24.02

25.00

26.00 27. 00 0

13, 592

32, 496

349, 000

12, 696

1, 003, 557

1, 703, 574

0

12

0 28.00

1, 703, 574 29. 00

20.00

21.00

22.00

23.00

24. 01

24. 02

Revenue from gifts, flowers, coffee shops, and canteen

Rental of vending machines Rental of hospital space

Governmental appropriations

COUNTY REIMBURSEMENT AMBULANCE SRV

28.00 Total other expenses (sum of line 27 and subscripts)

29.00 Net income (or loss) for the period (line 26 minus line 28)

25.00 Total other income (sum of lines 6-24)

24.00 GAIN ON DISPOSAL OF ASSETS

26.00 Total (line 5 plus line 25) 27.00 OTHER EXPENSES (SPECIFY)

MI SCELLANEOUS

Health Financia	al Systems	COMMUNITY HOSPT. OF LAG	GRANGE CTY IN	In Lie	u of Form CMS-2552-1
This report is	required by law (42 USC 1395)	g; 42 CFR 413.20(b)). Failu	ire to report can resu	ult in all interim	FORM APPROVED
payments made	since the beginning of the co	st reporting period being o	deemed overpayments (4	42 USC 1395g).	OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX CO SUMMARY	OST REPORT CERTIFICATION	Provi der CCN: 151323	Period: From 01/01/2015 To 12/31/2015	
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed	cost report		Date: 5/31/20	16 Time: 12:00 pm
use only	2. [] Manually submitted co	st report			
	3. [0] If this is an amended 4. [F] Medicare Utilization.			resubmitted this c	ost report
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit		this Provider CCN 12.	NPR Date: Contractor's Vendo [0]If line 5, conumber of time	

PART II - CERTIFICATION

(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 OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPT. OF LAGRANGE CTY IN (151323) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned)							
		Offi cer	or	Admi ni stra	tor o	f Provider(s)	
	Title						
ī	Date						

			Title XVIII				
Cost Center Description		Title V	Part A	Part B	HIT	Title XIX	
	·		2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-52, 769	-301, 423	100, 889	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	99, 362	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	46, 593	-301, 423	100, 889	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated. According to the Paperwork Reduction Act of 1995, no persons are required to respond to a collection of information unless it displays a valid OMB control number. The valid OMB control number for this information collection is 0938-0050. The time required to complete and review the information collection is estimated 673 hours per response, including the time to review instructions, search existing resources, gather the data needed, and complete and review the information collection. If you have any comments concerning the accuracy of the time estimate(s) or suggestions for improving the form, please write to: CMS, 7500 Security Boulevard, Attn: PRA Report Clearance Officer, Mail Stop C4-26-05, Baltimore, Maryland 21244-1850. Please do not send applications, claims, payments, medical records or any documents containing sensitive information to the PRA Reports Clearance Office. Please note that any correspondence not pertaining to the information collection burden approved under the associated OMB control number listed on this form will not be reviewed, forwarded, or retained. If you have questions or concerns regarding where to submit your documents, please contact 1-800-MEDICARE.

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151323 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/31/2016 11:39 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 207 NORTH TOWNLINE ROAD 1.00 PO Box: 1.00 State: IN Zip Code: 46761-1325 County: LAGRANGE 2.00 City: LAGRANGE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY HOSPT. OF 151323 99915 05/01/2005 Ν 0 3.00 LAGRANGE CTY IN Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF SWING BEDS 157323 99915 7 00 05/01/2005 N 0 N 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 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 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Hospital-Based (CORF) I 17.10 17.10 17. 20 Hospi tal -Based (OPT) I 17.20 17.30 Hospital-Based (00T) I 17.30 Hospi tal -Based (OSP) I 17.40 17.40 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2015 12/31/2015 20.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22 00 N N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting N Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be 22.02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" for yes or "N" fo<u>r no</u> used in the prior cost reporting period? In column 2 In-State Medi cai d 0ther In-State Out-of Out-of Medi cai d Medi cai d State State HMO days Medi cai d el i gi bl e Medi cai d Medi cai d paid days days unpai d paid days el i gi bl e unpai d davs 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 24.00 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.

	Financial Systems COMMUNITY HO FAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		AGRANGE CTY Provi der	IN CCN: 151323	Peri o		In Lieu			t S-2	2552-10
					From	01/0	1/2015 1/2015	Par	t I		pared:
		In-State	e In-State	Out-of	Out-c		Medi ca	5/3	1/201 Oth	6 11:	39 am
		Medicai o	d Medicaid	State Medicaid	Stat Medi ca	e	HMO da		Medi da	cai d	
		para day	unpai d	pai d days	eligib	ol e			uu	ys	
		1.00	2. 00	3. 00	unpai 4. 00	_	5. 00		6.	00	
25. 00	If this provider is an IRF, enter 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.		0 0	0		0		0			25. 00
	pino para dila ori gi bio bat di para dayo i i sociami o				Urb	an/R	ural S	Date	of (
26. 00	Enter your standard geographic classification (not was		us at the beg	jinning of t	he	1. C	2		2.00		26. 00
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not we reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifilf this is a sole community hospital (SCH), enter the	age) statu r "2" for ication ir	rural. If ap n column 2.	pplicable,			2				27. 00 35. 00
	effect in the cost reporting period.	e Hulliber C	perrous so	JII Status III			_	_	·		33.00
						egi nr 1. C		E	2. 00		
36. 00	Enter applicable beginning and ending dates of SCH sof periods in excess of one and enter subsequent date		oscript line	36 for numb	er						36. 00
37. 00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	r the numb	per of period	ls MDH statu	IS		0				37. 00
38. 00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.										38. 00
						1. C			Y/N 2.00		
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR $\S412.101(b)(2)(iior "N" for no. Does the facility meet the mileage reconstruction of the second sec$	i)? Enter	in column 1	"Y" for yes	5	N			N		39. 00
40. 00	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	n adjustme oer 1. Ent	or no. (see i ent? Enter "Y ter "Y" for y	" for yes o	r	N			N		40. 00
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol	n adjustme oer 1. Ent	or no. (see i ent? Enter "Y ter "Y" for y	" for yes o	r	N	V		111	XI X	40. 00
	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital	n adjustme ber 1. Ent . (see ins	or no. (see i ent? Enter "Y ter "Y" for y structions)	" for yes o es or "N" f	or For		V 1.00	2.	00	3.00	
45. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exceptions.	n adjustme ber 1. Ent . (see ins nt for dis	or no. (see i ent? Enter "Y ter "Y" for y structions) sproportionat	re share in	accorda	ance	V	2.	111		40. 00 45. 00 46. 00
45. 00 46. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exceptursuant to 42 CFR §412.348(f)? If yes, complete WkstPt. III.	n adjustme per 1. Ent . (see ins nt for dis eption for t. L, Pt.	or no. (see in ent? Enter "Y for y structions) sproportionat extraordination and Wkst	" for yes or "N" f	accorda ances I throu	ance	V 1.00	2.	N N	N N	45. 00 46. 00
45. 00 46. 00 47. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkster. III. Is this a new hospital under 42 CFR §412.300 PPS capits the facility electing full federal capital payments.	n adjustme per 1. Ent . (see ins nt for dis eption for t. L, Pt.	or no. (see in ent? Enter "Y for yestructions) sproportionat extraordina III and Wkst ter "Y for yester "Y for yester"	re share in ary circumst L-1, Pt.	accorda ances I throu	ance	V 1.00	2.	00 N	3. 00 N	45. 00
45. 00 46. 00 47. 00 48. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks: Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capits the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in	n adjustme per 1. Ent . (see ins nt for dis eption for t. L, Pt. ital? Enter	or no. (see in ent? Enter "Y for yestructions) sproportionate extraordinate and Wkster "Y for yes"	re share in ary circumst. L-1, Pt. es or "N" for	accorda ances I throu	ance	N N N	2.	N N	3. 00 N N	45. 00 46. 00 47. 00
45. 00 46. 00 47. 00 48. 00 56. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkster. III. Is this a new hospital under 42 CFR §412.300 PPS capits the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for	n adjustme per 1. Ent . (see ins nt for dis eption for t. L, Pt. ital? Ent t? Enter approved period dur r yes or "	or no. (see in ent? Enter "Y" for yestructions) sproportionat rextraordinat III and Wkst ter "Y for yes "Y" for yes GME programs ring which re	re share in ary circumst L-1, Pt. es or "N" for "N" fo	accorda ances I through no.	ance ugh yes ed umn 1	V 1.00 N N N N N N N N N	2.	N N	3. 00 N N	45. 00 46. 00 47. 00 48. 00
45. 00 46. 00 47. 00 48. 00 56. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wksret. III. Is this a new hospital under 42 CFR §412.300 PPS capits the facility electing full federal capital payment reaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y"	n adjustme per 1. Ent . (see ins nt for dis eption for t. L, Pt. ital? Ent er approved period dur r yes or " th of this Y", comple	er no. (see in ent? Enter "Y for yes structions) sproportionat extraordinat III and Wkst ter "Y for yes GME programs ing which re 'N" for no in secost report ete Worksheet	re share in ary circumst L-1, Pt. es or "N" for "N" fo	accorda ances I through or no. no. approve If columnity	ance ugh yes ed umn 1 "Y"	V 1.00 N N N N N N N N N	2.	N N	3. 00 N N	45. 00 46. 00 47. 00 48. 00 56. 00
45. 00 46. 00 47. 00 48. 00 56. 00 57. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wks: Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capits the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting in GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first montor yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reiminal processors.	n adjustme per 1. Ent . (see ins nt for dis eption for t. L, Pt. ital? Ent approved period dur r yes or " th of this y", comple l, if appl pursement	pr no. (see i ent? Enter "Y for y structions) sproportionat rextraordina III and Wkst ter "Y for yes "Y" for yes GME programs ring which resort reporte sete Worksheet i cable. for physicia	re share in ary circumst L-1, Pt. es or "N" for or "N" for es? Enter "Y esidents in a column 1. ing period? E-4. If co	accorda ances I through the form of the color of the colo	ance ugh yes ed umn 1 "Y"	V 1.00 N N N N N N N N N	2.	N N	3. 00 N N	45. 00 46. 00 47. 00 48. 00 56. 00
45. 00 46. 00 47. 00 48. 00 56. 00 57. 00 58. 00 59. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkster. III. Is this a new hospital under 42 CFR §412.300 PPS capits the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting in the first month of the programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month of yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimled fined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes, Are you claiming nursing school and/or allied health	n adjustme per 1. Ent . (see ins . (see ins . (see ins . (see ins . (see ins . (see ins . L, Pt. . ital? Ent t? Enter approved period dur r yes or " th of this Y", complet complete s, complete costs for	pr no. (see i ent? Enter "Y fer "Y" for y structions) sproportionat extraordina III and Wkst ter "Y for yes "Y" for yes "N" for no ir se cost report et et Worksheet i cable. for physicia wkst. D-5. te Wkst. D-5. te Wkst. D-2, a program t	re share in ary circumst L-1, Pt. es or "N" for "N" fo	accorda accorda ances I throu or no. no. '" for y approve If column 2 es as	ance yes ed umn 1 "Y"	V 1.00 N N N N N N N N N	2.	N N	3. 00 N N	45. 00 46. 00 47. 00 48. 00 56. 00 57. 00
45. 00 46. 00 47. 00 48. 00 56. 00 57. 00 58. 00 59. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkster. III. Is this a new hospital under 42 CFR §412.300 PPS capits the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting payments of the programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first monifor yes or "N" for no in column 2. If column 2 is "N" "N", complete Wkst. D, Parts III & IV and D-2, Pt. III line 56 is yes, did this facility elect cost reimle defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes	n adjustme per 1. Ent . (see ins . (see ins . (see ins . (see ins . (see ins . (see ins . L, Pt. . ital? Ent t? Enter approved period dur r yes or " th of this Y", complet complete s, complete costs for	pr no. (see i ent? Enter "Y fer "Y" for y structions) sproportionat extraordina III and Wkst ter "Y for yes "Y" for yes "N" for no ir se cost report et et Worksheet i cable. for physicia wkst. D-5. te Wkst. D-5. te Wkst. D-2, a program t	re share in ary circumst L-1, Pt. es or "N" for "N" fo	accorda ances I through through the second through	ance yes ed umn 1 "Y"	V 1.00 N N N N N N N N N	2.	N N	3. 00 N N N	45. 00 46. 00 47. 00 48. 00 56. 00 57. 00
45. 00 46. 00 47. 00 48. 00 56. 00 57. 00 58. 00 59. 00 60. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkster. III. Is this a new hospital under 42 CFR §412.300 PPS capits the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting in the first month of the programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month of yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimled fined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes, Are you claiming nursing school and/or allied health	n adjustme per 1. Ent . (see ins . (see ins . (see ins . (see ins . (see ins . eption for t. L, Pt. . ital? Ent t? Enter approved period dur r yes or " th of this y", complet s, complete s, complete s, complete s, costs for	cr no. (see in ent? Enter "Y for yestructions) sproportionat extraordina III and Wkst ter "Y for yes "Y" for yes GME programs ing which ref scost report tet Worksheet icable. for physicia Wkst. D-5. tet Wkst. D-5. a program tor "N" for no	res for yes or es or "N" for yes or "N" for yes or "N" for or "N" for es dents in a column 1. Fing period? E-4. If cours' service Pt. I. that meets to yes or "S" for yes instituted to the column service of the column service pt. I. that meets to yes or "N" for yes instituted to the column service of the column service pt. I. that meets to yes or "N" for yes or "N" for "N"	accorda ances I through through the second through	yes ed umn 1 - "Y" is	V 1.000 N N N N N N N N N	2.	N N N N N N N N N N N N N N N N N N N	N N N N N N N N N N N N N N N N N N N	45. 00 46. 00 47. 00 48. 00 56. 00 57. 00

		1711	TIVIL	DITECT OWL	I WIL	DITECT GIVIL	
		1. 00	2. 00	3. 00	4. 00	5. 00	
61.0	O Did your hospital receive FTE slots under ACA	N			0.00	0.00	61.00
	section 5503? Enter "Y" for yes or "N" for no in						
	column 1. (see instructions)						
61. C	1 Enter the average number of unweighted primary care		0.00	0.00			61. 01
	FTEs from the hospital's 3 most recent cost reports						
	ending and submitted before March 23, 2010. (see						
	i nstructi ons)						
61. C	2 Enter the current year total unweighted primary care		0.00	0.00			61. 02
	FTE count (excluding OB/GYN, general surgery FTEs,						
	and primary care FTEs added under section 5503 of						
	ACA). (see instructions)						

Health Financial Systems				LAGRANGE CTY		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HE	EALTH CARE COMPL	EX IDENTIFICATION DA	TA	Provi der		eriod: com 01/01/2015	Worksheet S-2 Part I	
					To		Date/Time Pre	
			Y/N	IME	Direct GME	IME	5/31/2016 11: Direct GME	39 am
					511 00 t 0			
(4.00 5.1 11.1	ETE L C	·	1.00	2. 00	3. 00	4. 00	5. 00	(4.00
61.03 Enter the base li		r primary care which is used for		0.00	0.00			61. 03
determining compl								
instructions)	6	. ,		0.00				
61.04 Enter the number surgery allopathi				0.00	0.00			61. 04
current cost repo								
61.05 Enter the differe				0.00	0.00)		61. 05
		the current year's ery FTE counts (line						
61.04 minus line	61.03). (see in	structions)						
61.06 Enter the amount				0.00	0.00)		61. 06
care or general s		that are nonprimary structions)						
, , , , , , , ,		<u> </u>	Pr	ogram Name	Program Code	Unweighted IME		
						FTE Count	Direct GME FTE Count	
				1. 00	2. 00	3.00	4. 00	
61.10 Of the FTEs in li					2100	0.00		61. 10
specialty, if any for each new prog		of FTE residents						
		in column 2, the						
program code, ent	er in column 3,	the IME FTE						
unwei ghted count FTE unwei ghted co		umn 4, direct GME						
61. 20 Of the FTEs in li		fy each expanded				0.00	0.00	61. 20
program specialty	, if any, and t	ne number of FTE						
residents for eac		ram. (see the program name,						
		ode, enter in column						
3, the IME FTE un	weighted count	and enter in column						
4, direct GME FTE	unweighted cou	nt.						
							1.00	
ACA Provisions Af 62.00 Enter the number		th Resources and Ser				ad far which	0.00	(2.00
		s that your nospital funding (see instruc		d in this cost	reporting peri	od for which	0.00	62.00
62.01 Enter the number	of FTE resident	s that rotated from a	Teachi	ing Health Cent	ter (THC) into	your hospital	0.00	62. 01
during in this co	st reporting pe	riod of HRSA THC prog	gram. (s	see instruction	ns)			
63.00 Has your facility		sidents in Nonprovide nts in nonprovider se			ost reportina p	eri od? Enter	N	63.00
		umn 1. If yes, comple			instructions)			
					Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
					Nonprovi der	Hospi tal	2))	
					Si te	·		
Soction FEOA of +	ho ACA Paga Vaa	r ETE Docidonts in No	opprovi	dor Sottings	1.00	2.00	3. 00	
		r FTE Residents in No uly 1, 2009 and befor	•	•	illi s base year	is your cost i	epor tring	
64.00 Enter in column 1	, if line 63 is	yes, or your facilit	y traii	ned residents	0.00	0.00	0. 000000	64. 00
		oer of unweighted nor tations occurring in						
		number of unweighted						
		ur hospital. Enter ir 1 + column 2)). (see	instru	ctions)				
		Program Name	Pr	ogram Code	Unwei ghted	Unweighted FTEs in	Ratio (col. 3/	
					FTEs Nonprovi der	Hospi tal	(col. 3 + col. 4))	
					Si te	·		
		1. 00		2. 00	3. 00	4. 00	5. 00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151323 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/31/2016 11:39 am Unwei ghted Unwei ghted Program Name Program Code Ratio (col. (col. 3 + col FTEs FTEs in 4)) Nonprovi der Hospi tal Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 65.00 65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Program Code Unwei ghted Ratio (col. 3/ Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

IOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 151323 Pe	eri od:	ieu of Form Worksheet		552-10				
	om 01/01/201	I5 Part I	e Prep					
		1.00						
Long Term Care Hospital PPS								
0.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 1.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no. TEFRA Providers	period? Ente	r N		80. 00 81. 00				
5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes o Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		. N		85. 00 86. 00				
7.00 Is this hospital a "subclause (II)" LTCH classified under section 1886(d)(1)(B)(iv)(II)? for yes or "N" for no.	N		87. 00					
	1. 00	2. 00						
Title V and XIX Services	1.00	2.00						
0.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Y		90. 00				
vision in the applicable column. 10.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	N		91. 00				
22.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column.		N		92. 00				
13.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N		93. 00					
14.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N		94. 00				
15.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 16.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the applicable column.	O.	00 N	0. 00	95. 00 96. 00				
7.00 If line 96 is "Y", enter the reduction percentage in the applicable column.	0.	00	0. 00	97. 00				
Rural Providers 05.00 Does this hospital qualify as a critical access hospital (CAH)?	Υ			105. 00				
06.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N N			106. 00				
07.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II.	N			107. 00				
08.00 is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N			108. 00				
Physical Occupational 1.00 2.00	Speech 3.00	Respi rat 4.00						
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N N	N N		109. 00				
		1.00						
10.00 Did this hospital participate in the Rural Community Hospital Demonstration project (410 the current cost reporting period? Enter "Y" for yes or "N" for no.	A Demo)for	N		110. 00				
	1.	00 2.00 3	3. 00					
Miscellaneous Cost Reporting Information								
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in column 1. If is yes, enter the method used (A, B, or E only) in column 2. If column 2 is "E", enter i	N	0	115. 00					
3 either "93" percent for short term hospital or "98" percent for long term care (includ psychiatric, rehabilitation and long term hospitals providers) based on the definition i Pub. 15-1, chapter 22, §2208.1.	116.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no.							
psychiatric, rehabilitation and long term hospitals providers) based on the definition i Pub.15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N" for no. 17.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "		N Y		117. 00				
psychiatric, rehabilitation and long term hospitals providers) based on the definition i Pub. 15-1, chapter 22, §2208.1. 16.00 s this facility classified as a referral center? Enter "Y" for yes or "N" for no.	N" for			118. 00				

1. 00 70, 073

2.00

4, 614

3. 00 27, 643 118. 01

118.01 List amounts of mal practice premiums and paid losses:

lealth Financial Systems C HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	OMMUNITY HOSPT. OF LA FICATION DATA	Provider CCN:		Period: From 01/01/2015 To 12/31/2015		-2 repared:
				1.00	2.00	_
Are malpractice premiums and paid losses r Administrative and General? If yes, submi and amounts contained therein.				1.00 N	2.00	118. (
19.00 DO NOT USE THIS LINE 20.00 s this a SCH or EACH that qualifies for t \$3121 and applicable amendments? (see inst "N" for no. Is this a rural hospital with Hold Harmless provision in ACA §3121 and a Enter in column 2, "Y" for yes or "N" for	ructions) Enter in co < 100 beds that quali applicable amendments	olumn 1, "Y" foo fies for the Oo	yes or utpatient		N	119. (120. (
121.00 Did this facility incur and report costs f patients? Enter "Y" for yes or "N" for no. Transplant Center Information		able devices cha	arged to	Y		121. (
125.00 Does this facility operate a transplant ce		es and "N" for	no. If	N		125. (
yes, enter certification date(s) (mm/dd/yy 126.00 If this is a Medicare certified kidney tra in column 1 and termination date, if appli	insplant center, ente	the certifica	tion date			126. 0
127.00 If this is a Medicare certified heart tran in column 1 and termination date, if appli	splant center, enter cable, in column 2.					127. (
128.00 If this is a Medicare certified liver trans in column 1 and termination date, if appliance in this is a Medicare certified lung trans	cable, in column 2.			n		128. (
column 1 and termination date, if applicat 30.00 If this is a Medicare certified pancreas t	Die, in column 2. Fransplant center, en	ter the certific				130. (
date in column 1 and termination date, if I31.00 If this is a Medicare certified intestinal date in column 1 and termination date, if	transplant center,	enter the certi	fi cati on			131. (
132.00 f this is a Medicare certified islet trar in column 1 and termination date, if appli	splant center, enter cable, in column 2.	the certificati				132. (
133.00 If this is a Medicare certified other trar in column 1 and termination date, if appli 134.00 If this is an organ procurement organizati and termination date, if applicable, in co All Providers	cable, in column 2. on (OPO), enter the (133. (
140.00 Are there any related organization or home chapter 10? Enter "Y" for yes or "N" for rare claimed, enter in column 2 the home of	no in column 1. If yes	s, and home offi	ce costs	Y	15H032	140. (
1.00	2. 00			3.00		
If this facility is part of a chain organi home office and enter the home office cont 141.00 Name: PARKVIEW HEALTH SYSTEM, INC. Cor		ractor number.				141. (
142.00 Street: 10501 CORPORATE DRIVE PO	SERVI Box: 5600					142.
143.00 City: FORT WAYNE Sta	ite: IN		Zip Code:	: 4684	15	143. (
144 00 Are provider based abusicional costs instru	idad in Warkshast A2				1.00	144
144.00 Are provider based physicians' costs inclu	iueu in worksheet A?				Y	144. (
145 COLE costs for morel and a second	Wko+ A 1:== 74		-	1.00	2.00	145
145.00 f costs for renal services are claimed or inpatient services only? Enter "Y" for yes no, does the dialysis facility include Mecperiod? Enter "Y" for yes or "N" for no i	or "N" for no in col Nicare utilization fo	umn 1. If colur	nn 1 is	N		145.
146.00 Has the cost allocation methodology change Enter "Y" for yes or "N" for no in column yes, enter the approval date (mm/dd/yyyy)	1. (See CMS Pub. 15-			N		146.
4	0.5.1				1.00	
147.00 Was there a change in the statistical basi	s? Enter "Y" for yes	or "N" for no.			N	147. (
148.00Was there a change in the order of allocat 149.00Was there a change to the simplified cost				no.	N N	148. (149. (

149.00 Was there a change to the simplified cost finding method? En	nter "Y" for ye	es or "N" for n	0.	N	149. 00
	Part A	Part B	Title V	Title XIX	
	1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an	exemption from	n the applicati	on of the lowe	r of costs	
or charges? Enter "Y" for yes or "N" for no for each compon	ent for Part A	and Part B. (S	ee 42 CFR §413	. 13)	
155. 00 Hospi tal	N	N	N	N	155. 00
156.00 Subprovider - IPF	N	N	N	N	156. 00
157.00 Subprovider - IRF	N	N	N	N	157. 00
158. 00 SUBPROVI DER					158. 00
159. 00 SNF	N	N	N	N	159. 00
160.00 HOME HEALTH AGENCY	N	N	N	N	160. 00
161. 00 CMHC		N	N	N	161. 00
161. 10 CORF		N	N	N	161. 10
161. 20 OUTPATIENT PHYSICAL THERAPY		N	N	N	161. 20
161. 30 OUTPATIENT OCCUPATIONAL THERAPY		N	N	N	161. 30
161. 40 OUTPATIENT SPEECH PATHOLOGY		N	N	N	161. 40
·			•	•	

Health Financial Systems	COMMUNITY HOSE	PT. OF LAGRANGE CTY I	N		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der (CCN: 15132	From O	: 1/01/2015 2/31/2015		epared:
						1.00	
Multicampus						1. 00	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that ha	as one or more campu	ses in di	fferent CE	BSAs?	N	165. 00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5. 00	
166.00 If line 165 is yes, for each 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	0 166. 00
	-					1. 00	
Health Information Technology (HIT							4.7.00
167.00 s this provider a meaningful user 168.00 f this provider is a CAH (line 10					a +ba	Y 112 F/	167. 00 7168. 00
reasonable cost incurred for the H			10/ 15	Y), enter	the	113, 50	/168.00
168. 01 If this provider is a CAH and is reception under §413. 70(a)(6)(ii)?	not a meaningful user,	does this provider			dshi p		168. 01
169.00 If this provider is a meaningful utransition factor. (see instruction	ıser (line 167 is "Y")				enter the	0.0	0169. 00
	-			Ве	gi nni ng	Endi ng	
					1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	/01/2014	09/30/2015	170. 00				
						1.00	-
171.00 If line 167 is "Y", does this prov	ildan hava any dava fi	ar individuale erral	lad in a	oction 107	2	1. 00 N	171. 00
Medicare cost plans reported on Wk (see instructions)						IV.	171.00

		UNITY HOSPT. OF LAGRANG				u of Form CMS-	
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE Pro	ovi der		Peri od: From 01/01/2015	Worksheet S-2 Part II	
					To 12/31/2015	Date/Time Pro 5/31/2016 11:	epared: :39 am
					Y/N	Date	. 07 4111
					1. 00	2. 00	
	General Instruction: Enter Y for all YES resp	oonses. Enter N for all	NO re	sponses. Ente	er all dates in t	:he	
	mm/dd/yyyy format.						
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation						
1. 00	Has the provider changed ownership immediatel	v prior to the beginni	na of	the cost	N		1.00
1.00	reporting period? If yes, enter the date of t	the change in column 2.	(see	instructions)		l	1.00
	,		(Y/N	Date	V/I	
				1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in yes, enter in column 2 the date of termination			N			2. 00
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transact contracts, with individuals or entities (e.g.	, chain home offices,	drug	N			3. 00
	or medical supply companies) that are related officers, medical staff, management personnel	d to the provider or it , or members of the bo	ts pard				
	of directors through ownership, control, or f	family and other simila	ar			l	
	relationships? (see instructions)			Y/N	Type	Date	
				1.00	2. 00	3. 00	
	Financial Data and Reports			1.00	2.00	0.00	
4. 00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or	Audited, "C" for Compi enter date available i	I ed,	Y	A		4. 00
5. 00	column 3. (see instructions) If no, see instr Are the cost report total expenses and total those on the filed financial statements? If y	revenues different fro		N			5. 00
	those on the fired financial statements. If	yes, submit recenter rate	CT 011.		Y/N	Legal Oper.	
					1. 00	2.00	
	Approved Educational Activities						
6. 00	Column 1: Are costs claimed for nursing schothe legal operator of the program? Are costs claimed for Allied Health Programs?	•		e provider is			6.00
7. 00 8. 00	Were nursing school and/or allied health programs?			l during the	N N	l	7. 00 8. 00
9. 00	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents i	ons.		Ü	N N		9.00
10. 00	program in the current cost report? If yes, s Was an approved Intern and Resident GME progr	see instructions.			N N		
	cost reporting period? If yes, see instruction	ons.					10.00
11. 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		an App	roved	N		11. 00
						Y/N	
	Pad Dahta					1. 00	
12 00	Bad Debts Is the provider seeking reimbursement for bac	dehts? If you soo in	netruet	Lone		Y	12. 00
13. 00	If line 12 is yes, did the provider's bad deb period? If yes, submit copy.	3 ·			ost reporting	N	13. 00
	If line 12 is yes, were patient deductibles a	and/or co-payments wai	ved? If	yes, see ins	structi ons.	N	14. 00
14. 00	Bed Complement		nd? If	yes, see inst	ructions.	N	15. 00
	Bed Complement Did total beds available change from the price	or cost reportina perio		, .,			1 2.30
		or cost reporting perio		Pa	art A	Part B	
		or cost reporting perio Description		Y/N	art A Date	Part B Y/N	
	Did total beds available change from the price						
15. 00	Did total beds available change from the price	Description		Y/N 1.00	Date	Y/N 3. 00	44.05
14. 00 15. 00 16. 00	Did total beds available change from the price	Description		Y/N	Date	Y/N	16. 00

	PS&R Data				
16.00	Was the cost report prepared using the PS&R	N		N	16. 00
	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				
	instructions)				
17. 00	Was the cost report prepared using the PS&R	Υ	04/30/2015	Υ	17. 00
	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				
40.00	2 and 4. (see instructions)	.,		.,	40.00
18. 00	If line 16 or 17 is yes, were adjustments	Y		Υ	18. 00
	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				
10.00	this cost report? If yes, see instructions.	N.		N.	10.00
19. 00	, , ,	N		N	19. 00
	made to PS&R Report data for corrections of				
	other PS&R Report information? If yes, see instructions.				
20.00		N		N	20.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe	IN		14	20.00
	the other adjustments:				
	The other aujustillents.		l .	I	I

Health Financial Systems	COMMUNITY HOSPT. OF LAC	COMMUNITY HOSPT. OF LAGRANGE CTY IN			In Lieu of Form CMS-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE	RELMBURSEMENT OUESTLONNALRE	Provi der CCN: 151323	Peri od:		Worksheet S-2		

Provider CCN: 151323 From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 5/31/2016 11:39 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost 22.00 Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provi der-Based Physi ci ans Are services furnished at the provider facility under an arrangement with provider-based physicians? Ν 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position FRIC NI CKESON 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel v. PARKVIEW HEALTH SYSTEM, INC. 42.00 42.00 Enter the employer/company name of the cost report preparer. 43.00 Enter the telephone number and email address of the cost (260) 373-8406 ERIC. NI CKESON@PARKVI EW. COM 43.00 report preparer in columns 1 and 2, respectively.

report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 151323 Peri od: Worksheet S-2 From 01/01/2015 To 12/31/2015 Part II Date/Time Prepared: 5/31/2016 11:39 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 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 instructions) 17.00 Was the cost report prepared using the PS&R 04/30/2015 17.00 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) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 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.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. 20.00 If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position DIRECTOR, REIMBURSEMENT 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 12/2014 | 12/2015 | Part | Prepared: | 12/2014 | 12/2015 | Part | Prepared: | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/2014 | 12/201
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 Systems
 COMMUNITY HO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 COMMUNITY HOSPT. OF LAGRANGE CTY IN Provi der CCN: 151323

						10	12/31/2015	5/31/2016 11:	
								I/P Days / 0/P	J Z GIII
								Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V	
		Line Number			Avai I abl e				
		1. 00		2.00	3.00		4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 1	25	66, 960. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)								2. 00
3.00	HMO IPF Subprovider								3. 00
4.00	HMO I RF Subprovi der								4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF							0	5. 00
6. 00 7. 00	Hospital Adults & Peds. Swing Bed NF			25	0.1	2.5	// 0/0 00	0	6. 00 7. 00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)			25	9, 1	25	66, 960. 00	U	7.00
8.00	INTENSIVE CARE UNIT								8. 00
9. 00	CORONARY CARE UNIT								9. 00
10. 00	BURN INTENSIVE CARE UNIT								10.00
11. 00	SURGICAL INTENSIVE CARE UNIT								11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)								12. 00
13. 00	NURSERY	43. 00						0	13. 00
14. 00	Total (see instructions)			25	9, 1	25	66, 960. 00	0	14.00
15. 00	CAH visits				,		,	0	15. 00
16.00	SUBPROVIDER - IPF								16. 00
17.00	SUBPROVI DER - I RF								17. 00
18.00	SUBPROVI DER								18. 00
19. 00	SKILLED NURSING FACILITY								19. 00
20. 00	NURSING FACILITY								20. 00
21. 00	OTHER LONG TERM CARE								21. 00
22. 00	HOME HEALTH AGENCY								22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)								23. 00
24. 00	HOSPI CE	20.00							24. 00
24. 10	HOSPICE (non-distinct part)	30. 00							24. 10
25. 00 25. 10	CMHC - CMHC CMHC - CORF	99. 10						0	25. 00 25. 10
25. 10	CMHC - CORP CMHC - OUTPATIENT PHYSICAL THERAPY	99. 10 99. 20						0	25. 10
25. 20	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99. 30						0	25. 20
25. 40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99. 40						0	25. 40
26. 00	RURAL HEALTH CLINIC	77. 40						O	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER								26. 25
27. 00	Total (sum of lines 14-26)			25					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
31.00	Employee discount days - IRF								31. 00
32.00	Labor & delivery days (see instructions)			0		0			32. 00
32. 01	Total ancillary labor & delivery room								32. 01
	outpatient days (see instructions)								
33. 00	LTCH non-covered days				l				33. 00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN

Provi der CCN: 151323

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | Date/Time Prepared: | 5/31/2016 | 11:39 am

1/P Days / O/P Visits / Trips					'		5/31/2016 11:	39 am
Note			I/P Days	/ O/P Visits	/ Tri ps	Full Time		
Note					·			
No. Hospital Adults & Peds. (Columns 5, 6, 7 and 8 exclude Swing Bed. Observation Bed and Hospite days) (see instructions for col. 2 for the portion of LIDP room available beds) 1,000 2,000 1,000		Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 756 3								
B exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)			6.00	7.00	8. 00	9. 00	10. 00	
Hospice days) (see instructions for col. 2 For the portion of LDP room available beds) 1,	1.00		967	180	2, 485			1.00
For the portion of LDP room available beds) 2.00 HM0 IPF Subprovider 3.00 HM0 IPF Subprovider 4.00 HM0 IPF Subprovider 5.00 HM0 IPF Subprovider 6.00 Hospital Adults & Peds. Swing Bed SNF 7.00 Hospital Adults & Peds. Swing Bed SNF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 CORONARY CARE UNIT 10.00 SUBROVIDER CARE UNIT 11.00 OTHER SPECIAL CARE (SPECIFY) 13.00 OTHER SPECIAL CARE (SPECIFY) 15.00 CAMPOVIDER - IPF 16.00 SUBROVIDER - IPF 17.00 SUBROVIDER - IPF 18.00 SUBROVIDER - IPF 18.00 SUBROVIDER - IPF 19.00 OTHER LOWN FRACILITY 19.00 SUBROVIDER ADDRESSED SINCE CARE UNIT SINCE CARE								
2.00 HM0 and other (see instructions) 756 3 2.00 4.00 HM0 IRF Subprovider 0 0 0 0 4.00 HM0 IRF Subprovider 0 0 0 0 6.00 HSD IRF Subprovider 0 0 0 0 0 6.00 HSD IRF Subprovider 0 0 0 0 0 0 6.00 HSD IRF Subprovider 0 0 0 0 0 0 0 0 0 6.00 HSD IRF Subprovider 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								
MNO IPF Subprovider				_				
HNO IRF Subprovi der		` ,		3				
5.00 Hospi tal Adult ts & Peds. Swing Bed SNF 0		•	ĭ	-				
6.00 Hospi tall Adult s & Peds. Swing Bed NF 1, 416 180 3, 248 7, 00 7,		•	9	ū				
Total Adults and Peds. (exclude observation beds) (see instructions)			449					
beds) (see instructions) 8. 00 NTRSI VE CARE UNIT 9, 00 10, 00 20 20 20 20 20 20 20				-				
8. 00	7. 00	· ·	1, 416	180	3, 248			7. 00
9.00 CORONARY CARE UNIT 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 11.00	0.00							0.00
10.00 SURN INTENSIVE CARE UNIT 10.00 SURGICAL INTENSIVE CARE UNIT 11.00 11								
11. 00 URGICAL INTENSIVE CARE UNIT		1						
12.00 OTHER SPECIAL CARE (SPECIFY) 13.00 13.00 13.00 13.00 13.00 13.		1						
13.00 NIRSERY 13.00 NIRSERY 13.00 Total (see instructions) 1.416 312 3.667 0.00 174.80 14.00 15.00 15.00 16.00 SUBPROVI DER - I PF 16.00 SUBPROVI DER - I RF 18.00 18.00 SUBPROVI DER - I RF 18.00 19.00 18.00 19.00								
14.00 Total (see instructions) 1,416 312 3,667 0.00 174.80 14.00 15.00 CAH visits 0 0 0 0 0 0 15.00 15.00 16.00 SUBPROVIDER - IPF 0 16.00 17.00 SUBPROVIDER - IRF 0 0 0 0 0 0 17.00 17.00 SUBPROVIDER - IRF 0 0 SKILLED NURSING FACILITY 0.00 0 0 0 0 0 0 0 0				400	440			
15. 00 CAH visits		· ·	4.44				474.00	
16. 00 SUBPROVI DER - I PF 16. 00 17. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER - I RF 18. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACI LI TY 20. 00 NURSI NG FACI LI TY 20. 00 TOHER LONG TERM CARE 21. 00 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 23. 00 AMBULATORY SURGI CAL CENTER (D. P.) 24. 00 HoSPI CE (non-distinct part) 0 0 0 0 24. 10 25. 00 CMHC - CMHC 25. 00 CMHC - CMHC 25. 00 CMHC - OUTPATI ENT PHYSI CAL THERAPY 0 0 0 0 0. 00 0. 00 25. 10 25. 30 CMHC - OUTPATI ENT PEECH PATHOLOGY 0 0 0 0. 00 0. 00 25. 30 26. 20 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 26 26. 26 27. 00 27. 00 28. 00 CMbulance Trips 30. 00 28. 00 29. 00 Ambulance Trips 30. 00 29. 00 Ambulance Trips 30. 00 29. 00 29. 00 20			1, 416			0.00	174.80	
17. 00 SUBPROVI DER - IRF 17. 00 SUBPROVI DER 18. 00 19. 00 SKI LLED NURSI NG FACILITY 19. 00 20. 00 NURSI NG FACILITY 21. 00 21. 00 19. 00 22. 00 19. 00 23. 00 19. 00 24. 10 19. 00 25. 20 19. 00 19. 00 25. 20 19. 00 19. 00 25. 20 19. 00 19. 00 19. 00 25. 20 19. 00 19. 00 19. 00 25. 20 19. 00		· ·	U	0	0			
18. 00 SUBPROVIDER 18. 00 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 20.		· ·						
19. 00 SKILLED NURSING FACILITY 19. 00 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 19. 00 20. 00 2		1						
20. 00		1						
21.00 OTHER LONG TERM CARE 22.00 AUMBULATORY SURGICAL CENTER (D.P.) 22.00 23.00 AUMBULATORY SURGICAL CENTER (D.P.) 23.00 24.00 HOSPICE 24.10 25.00 CMHC - CMHC 25.00 CMHC - CMHC 25.00 CMHC - OUTPATIENT PHYSICAL THERAPY 0 0 0 0 0 0 0 0 0		1						
22.00		1						
23.00		1						
24.00 HOSPICE (non-distinct part) 0 0 0 0 24.10 25.00 CMHC - CMHC 25.00 CMHC - CMHC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		i i						
24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 25. 10 CMHC - CORF 25. 10 CMHC - OUTPATIENT PHYSICAL THERAPY 25. 20 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 25. 20 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 26. 30 CMHC - OUTPATIENT SPEECH PATHOLOGY 27. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 28. 20 CMHC - OUTPATIENT SPEECH PATHOLOGY 29. 00 Total (sum of lines 14-26) 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)		` ′						
25. 00 CMHC - CMHC 25. 10 CMHC - CORF 25. 10 CMHC - CORF 25. 20 CMHC - OUTPATIENT PHYSICAL THERAPY 25. 30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 26. 30 CMHC - OUTPATIENT SPEECH PATHOLOGY 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Observation Bed Days 28. 00 Observation Bed Days 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)		i i	0	0	_			
25. 10 CMHC - CORF 25. 20 CMHC - OUTPATIENT PHYSICAL THERAPY 25. 30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 25. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)			٩	U	0			
25. 20 CMHC - OUTPATIENT PHYSICAL THERAPY 0 0 0 0 0.00 0.00 25. 20 25. 30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 0 0.00 0.00 25. 30 25. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 0 0 0 0.00 0.00 25. 40 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY OUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 0.00 27. 00 28. 00 Observation Bed Days 6 63 661 29. 00 Ambulance Trips 581 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 0 45 193 32. 00 32. 01 outpatient days (see instructions)		· ·	0	0	_	0.00	0.00	
25. 30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 0 0.00 0.00 0.00 25. 30 25. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 0 0 0 0 0.00 0.00 25. 40 26. 00 RURAL HEALTH CLINIC 26. 26. 25 27. 00 Total (sum of lines 14-26) 27. 00 Observation Bed Days 63 661 28. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 0 12. 00 Labor & delivery days (see instructions) 0 45 193 22. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 0 32. 01			0	-	_			
25. 40 CMHC - OUTPATIENT SPEECH PATHOLOGY 0 0 0 0 0.00 0.00 25. 40 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 0.00 174. 80 27. 00 28. 00 Observation Bed Days 63 661 28. 00 29. 00 Ambulance Trips 581 29. 00 30. 00 Employee discount days (see instruction) 18. 00 Employee discount days - IRF 0 19. 00 32. 00 Labor & delivery days (see instructions) 19. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 19. 00 19. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 19. 00 19.			0	-	_			
26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Observation Bed Days 28. 00 Observation Bed Days 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 02		i e	0					
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & see instructions) 32. 01 Total ancillary labor & see instructions) 32. 01 Total ancillary labor & see instructions) 32. 01 September 25. 25. 25. 26. 25. 27. 28. 27. 28. 28. 29. 29. 29. 29. 29. 29. 29. 29. 29. 29			٩	U	0	0.00	0.00	
27.00 Total (sum of lines 14-26) 28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 27.00 28.00 29.00 29.00 30.00 31.00 32.01								
28.00 Observation Bed Days 28.00 29.00 Ambulance Trips 581 29.00 30.00 Employee discount days (see instruction) 34 30.00 29.00 31.00 29.00 31.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 45 193 32.01						0.00	17/ 80	
29.00 Ambulance Trips 581 29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 0 31.00 32.00 Labor & delivery days (see instructions) 0 45 193 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 32.01				62	661	0.00	174.00	
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 45 193 32.00 32.01			501	03	001			
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 31.00 45 193 32.00 32.01		·	301		24			
32.00 Labor & delivery days (see instructions) 0 45 193 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 45 20.01								
32.01 Total ancillary labor & delivery room outpatient days (see instructions)			0	4.5				
outpati ent days (see instructions)			٩	43				
	JZ. UI							JZ. U1
9 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	33 00	, , , , , , , , , , , , , , , , , , , ,	n					33 00
	55. 50	12.2 23.0. 00 0030	٩		ı	ı	1	

 Heal th Financial
 Systems
 COMMUNITY HO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provi der CCN: 151323

Peri od: Worksheet S-3 From 01/01/2015 Part I To 12/31/2015 Date/Ti me Prepared: 5/31/2016 11:39 am

						5/31/2016 11:	39 am
		Full Time Equivalents		Di sch	arges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers 11.00	12. 00	13.00	14. 00	Pati ents 15.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00		296	74	937	1. 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)			270	, 4	737	1.00
2.00	HMO and other (see instructions)			168	o		2.00
3.00	HMO IPF Subprovider				0		3.00
4.00	HMO IRF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	(296	74	937	14. 00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVIDER - IRF						17. 00
18.00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21. 00 22. 00	OTHER LONG TERM CARE						21. 00 22. 00
23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE						24. 00
24. 00	HOSPICE (non-distinct part)						24. 00
25. 00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	0.00					25. 10
25. 20	CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25. 20
25. 30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0. 00					25. 30
25. 40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0. 00					25. 40
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27. 00	Total (sum of lines 14-26)	0.00					27.00
28. 00	Observation Bed Days						28.00
29. 00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days						33. 00

	Financial Systems COMMUNITY HOSPT. OF LAGR				u of Form CMS-2		
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 151323	Peri od:	Worksheet S-10	0	
				From 01/01/2015 To 12/31/2015	Date/Time Pre	narod:	
				10 12/31/2013	5/31/2016 11:		
					1. 00		
	Uncompensated and indigent care cost computation						
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by lir	ne 202 column	n 8)	0. 309828	1. 00	
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid				565, 190	2. 00	
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3. 00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p	payments 1	from Medicaio	1?	N	4. 00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from N				115, 691	5. 00	
6.00	Medi cai d charges				6, 256, 396	6. 00	
7.00	Medicaid cost (line 1 times line 6)				1, 938, 407	7. 00	
8.00	Difference between net revenue and costs for Medicaid program (li	ine 7 minu	us sum of lir	nes 2 and 5; if	1, 257, 526	8. 00	
	< zero then enter zero)						
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for ea	ach line)				
9.00	Net revenue from stand-alone SCHIP				0	9. 00	
10.00	Stand-alone SCHIP charges				0	10.00	
11.00	Stand-alone SCHIP cost (line 1 times line 10)				0	11. 00	
12.00	Difference between net revenue and costs for stand-alone SCHIP (I	line 11 mi	nus line 9;	if < zero then	0	12. 00	
	enter zero)						
	Other state or local government indigent care program (see instru	uctions fo	or each line)				
13.00	Net revenue from state or local indigent care program (Not include	ded on lir	nes 2, 5 or 9	9)	369, 672	13.00	
14.00	Charges for patients covered under state or local indigent care p	orogram (N	Not included	in lines 6 or	3, 333, 058	14.00	
	10)						
15. 00	State or local indigent care program cost (line 1 times line 14)				1, 032, 675	15.00	
16. 00	Difference between net revenue and costs for state or local indig	gent care	program (lir	ne 15 minus line	663, 003	16.00	
	13; if < zero then enter zero)						
	Uncompensated care (see instructions for each line)						
17. 00	Private grants, donations, or endowment income restricted to fund	9	,			17. 00	
18. 00	Government grants, appropriations or transfers for support of hos				0	18. 00	
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local	i ndi gent	care program	ns (sum of lines	1, 920, 529	19. 00	
	8, 12 and 16)						
			Uni nsured	Insured	Total (col. 1		
			pati ents	pati ents	+ col . 2)		
20.00	T-1-1 : :: 1: -1 -1: -1:	-+ 6.11	1.00	2. 00	3. 00	20.00	
20. 00	Total initial obligation of patients approved for charity care (a charges excluding non-reimbursable cost centers) for the entire f		623, 65	809, 925	1, 433, 578	∠∪. ∪∪	
21. 00	, ,		193, 22	250, 937	444, 162	21 00	
21.00	times line 20)	(TITIE I	193, 22	250, 937	444, 102	21.00	
22. 00	Partial payment by patients approved for charity care		90	92 6, 747	7 720	22. 00	
23. 00	, , , , , , , , , , , , , , , , , , , ,		192, 23		· ·		
23.00	Cost of chartty care (fille 21 illifius fille 22)		172, 2	244, 190	430, 423	23.00	
					1. 00		
24. 00	Does the amount in line 20 column 2 include charges for patient of	days boyor	ad a Longth o	of stay limit	N N	24. 00	
24.00	imposed on patients covered by Medicaid or other indigent care pr		a a rength (or stay iimii t	IN	24.00	
25. 00	If line 24 is "yes," charges for patient days beyond an indigent		naram's Lenat	h of stav limit	0	25. 00	
26. 00	Total bad debt expense for the entire hospital complex (see instr		- j. a 5 1 01191	or oray rrinit	4, 434, 778		
27. 00					250, 185		
	10 Non-Medicare and non-reimbursable Medicare bad debt expense (Line 26 minus Line 27) 4.184.593 28.						

28.00 Non-Medicare and non-reimbursable Medicare bad debt expense (line 26 minus line 27)

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

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (line 1 times line 28)

1, 296, 504 29. 00 1, 732, 927 30. 00 3, 653, 456 31. 00

4, 184, 593

28.00

		MUNITY HOSPT. OF				u of Form CMS-	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE ()F EXPENSES	Provi der		Period: From 01/01/2015	Worksheet A	
						Date/Time Pre	
	Cook Cooker Doorsinting	C-1:	0+1	T-+-1 (1 1	D1: 6:+:	5/31/2016 11:	39 am
	Cost Center Description	Sal ari es	0ther	+ col . 2)	Reclassifications (See A-6)	Reclassified Trial Balance	
				1 001. 2)	0113 (300 11 0)	(col . 3 +-	
						col . 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS		4 504 040	1 50/ 0/	001.100		
1.00	OO100 CAP REL COSTS-BLDG & FIXT OO101 EMS WEST STATION		1, 506, 069	1, 506, 06			
1. 01 2. 00	00200 CAP REL COSTS-MVBLE EQUIP		0		0 16, 040 0 544, 314	16, 040 544, 314	
2. 01	00201 EMS WEST STATION EQUIP.		o		5, 906	5, 906	
3.00	00300 OTHER CAP REL COSTS		o		0	0	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 512, 294	2, 741, 692	4, 253, 98	6 0	4, 253, 986	
5. 00	00500 ADMI NI STRATI VE & GENERAL	5, 711, 316	2, 974, 263	8, 685, 57	9 -45, 057	8, 640, 522	5. 00
6.00	OO6OO MAINTENANCE & REPAIRS OO7OO OPERATION OF PLANT	220 (01	722 217	0/2 01	0 25 272	0	6.00
7. 00 8. 00	00800 LAUNDRY & LINEN SERVICE	239, 601	723, 317 81, 779	962, 91 81, 77		937, 645 81, 779	
9. 00	00900 HOUSEKEEPING	158, 264	40, 557	198, 82		198, 800	
10.00	01000 DI ETARY	340, 485	292, 527	633, 01		232, 024	
11. 00	01100 CAFETERI A	0	o		0 400, 451	400, 451	
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0		0	0	12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	319, 530	1, 183	320, 71		320, 629	
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	452, 150	-34, 345 1, 045, 507	-34, 34 1, 497, 65		-34, 380 542, 603	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	432, 130	1, 043, 307	1, 477, 03	0 -755,054	0 342,003	
17. 00	01700 SOCIAL SERVICE	Ö	Ö		0 0	0	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	О		0	0	19. 00
20. 00	02000 NURSI NG SCHOOL	0	0		0	0	20. 00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	21. 00
22. 00 23. 00	O2200 1 & R SERVI CES-OTHER PRGM COSTS APPRV O2300 PARAMED ED PRGM-(SPECIFY)	0	0		0	0	22. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	<u> </u>	<u> </u>	0 0	0	23.00
30. 00		1, 600, 250	459, 032	2, 059, 28	2 -732, 389	1, 326, 893	30.00
43.00	04300 NURSERY	0	0		0 159, 772		1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	685, 375	337, 994	1, 023, 36			
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY		763, 016	763, 01	569, 347	569, 347 763, 016	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	602, 703	491, 603	1, 094, 30		1, 062, 125	
60.00	06000 LABORATORY	0	873, 991	873, 99		873, 736	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	o		0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	300, 692	9, 615	310, 30		'	
66.00	06600 PHYSI CAL THERAPY	539, 994	11, 368	551, 36			1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY		0		0 108, 550 0 74, 072	108, 550 74, 072	1
69. 00	06900 ELECTROCARDI OLOGY		0		0 74,072	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	512, 297	512, 29	7 -214, 708	297, 589	
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	O		0 214, 405		
	07300 DRUGS CHARGED TO PATIENTS	0	0		946, 087		
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	
76. 98 76. 99	O7698 HYPERBARI C OXYGEN THERAPY O7699 LI THOTRI PSY		0			0	1
70. 77	OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u></u>		<u> </u>		70.77
90.00	09000 CLI NI C	0	0	-	0 0	0	90. 00
90. 01	09001 LI FEBRI DGE SENI OR CARE	117, 738	102, 376	220, 11			
		710, 382	1, 708, 895	2, 419, 27	7 -16, 711	2, 402, 566	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	923, 887	292, 920	1, 216, 80	7 - 796	1, 216, 011	95. 00
99. 10	09910 CORF	0	O		0	0	1
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	0		0	0	
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		0	0	
99. 40	O9940 OUTPATI ENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS	0	U		0	0	99. 40
113.00	11300 INTEREST EXPENSE		127, 903	127, 90	3 -128, 439	-536	113. 00
118.00		14, 214, 661	15, 063, 559	29, 278, 22			
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 409	9, 40			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH	0	3, 070	3, 07			192. 00 194. 00
	07951 FOUNDATION	38, 688	-57, 550 15, 101	-57, 55 53, 78			194. 00
	07952 COMMUNITY & VOLUNTEER SVCS	13, 437	146, 188	159, 62		159, 625	
194.04	07954 ER PHYSICIAN	0	0		0 0	0	194. 04
	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0		0		194. 06
200.00	TOTAL (SUM OF LINES 118-199)	14, 266, 786	15, 179, 777	29, 446, 56	3 0	29, 446, 563	J200. 00

Heal th	Financial Systems COMM	MUNITY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	u of Form CMS-:	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der	CCN: 151323	Peri od:	Worksheet A	
					From 01/01/2015 To 12/31/2015	Date/Time Pre	nared.
					10 12/31/2013	5/31/2016 11:	39 am
	Cost Center Description	Adjustments	Net Expenses				
		(See A-8)	For Allocation	1			
	GENERAL SERVICE COST CENTERS	6. 00	7. 00				
1. 00	00100 CAP REL COSTS-BLDG & FIXT	17, 940	1, 189, 521	I			1.00
1. 01	00101 EMS WEST STATION	0	16, 040	1			1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0		1			2. 00
2.01	00201 EMS WEST STATION EQUIP.	0	5, 906	,			2. 01
3.00	00300 OTHER CAP REL COSTS	0	0				3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-727, 437		1			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-2, 129, 086	6, 511, 436				5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	0	0	1			6. 00
7.00	00700 OPERATION OF PLANT	-6, 070		1			7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE	0	81, 779	1			8. 00 9. 00
10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	198, 800 232, 024				10.00
11. 00	01100 CAFETERI A	-233, 989					11.00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0		1			12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	320, 629	•			13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	-34, 380				14. 00
15. 00	01500 PHARMACY	0	542, 603				15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0)			16. 00
17. 00	01700 SOCIAL SERVICE	0	0	1			17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0				19. 00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	1				20.00
21.00	02200 I &R SERVICES-SALARY & FRINGES APPRV	0	1				21.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	ł .	1			23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS			1			23.00
30.00	03000 ADULTS & PEDIATRICS	18, 441	1, 345, 334				30.00
43.00	04300 NURSERY	0		1			43.00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0		1			50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		1			52. 00
53. 00	05300 ANESTHESI OLOGY	-696, 034		1			53. 00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	-1, 647 0	1, 060, 478	1			54. 00 60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS			1			62. 30
65. 00	06500 RESPIRATORY THERAPY	0	306, 049				65. 00
66. 00	06600 PHYSI CAL THERAPY	-228		1			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	108, 550				67. 00
68. 00	06800 SPEECH PATHOLOGY	-7, 872	66, 200)			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	,				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-251, 150		1			73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	•	1			76. 97
	O7698 HYPERBARI C OXYGEN THERAPY O7699 LI THOTRI PSY	0		1			76. 98 76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS			1			70. 77
90. 00	09000 CLI NI C	0	0)			90.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	-486	218, 988				90. 01
91. 00	09100 EMERGENCY	-958, 391	1, 444, 175				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS			1			
95. 00	09500 AMBULANCE SERVICES	-300					95. 00
99. 10 99. 20	09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY	0					99. 10 99. 20
99. 20	09930 OUTPATIENT OCCUPATIONAL THERAPY						99. 20
99. 40	09940 OUTPATIENT SCEECH PATHOLOGY	0		1			99. 40
77. 10	SPECIAL PURPOSE COST CENTERS			1			77. 10
113.00	11300 INTEREST EXPENSE	536	0				113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	-4, 975, 773	24, 245, 449	1			118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	9, 409				190. 00
192.00	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	_, -,	1			192. 00
	07950 OCCUPATIONAL HEALTH	0	1				194. 00
	07951 FOUNDATION	0		1			194. 01
	07952 COMMUNITY & VOLUNTEER SVCS	-259 0		1			194. 03 194. 04
	07954 ER PHISICIAN 07953 SHIPSHEWANA RADIOLOGY AND LAB						194. 04
200.00		-4, 976, 032	24, 470, 531				200.00
				•			

COMMUNITY HOSPT. OF LAGRANGE CTY IN Provider CCN: 151323 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 5/31/2016 11: 39 am

		Increases			5/31/2016 II: 39 am
	Cost Center	Increases Line #	Salary	Other	
	2.00	3. 00	4. 00	5. 00	
	A - REHAB THERAPY RECLASS	3.00	4.00	5.00	
1 00	OCCUPATI ONAL THERAPY	(7.00	107 420	2 2/1	1 00
1.00	•	67.00	107, 420	2, 261	1.00
2.00	SPEECH PATHOLOGY		72, 545		2. 00
	U D DEGLACO		179, 965	3, 788	
	B - OB RECLASS	40.00	404 054	20.010	
1.00	NURSERY	43.00	126, 854	32, 918	1.00
2.00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	<u>452, 0</u> 43	11 <u>7, 3</u> 04	2. 00
	0		578, 897	150, 222	
	F - CAFETERIA RECLASS			F	
1.00	CAFETERI A	11. 00	21 <u>4, 6</u> 53	18 <u>5, 7</u> 98	1.00
	0		214, 653	185, 798	
	G - INSURANCE RECLASS				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	32, 970	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	11, 626	2. 00
				44, 596	
	H - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	948, 461	1. 00
2. 00		0.00	o	0	2.00
3. 00		0.00	0	0	3.00
4. 00		0.00	0	Ö	4.00
5. 00		0.00	0	0	5. 00
5.00					5.00
	U DESILARI		U	948, 461	
4 25	I - SALARY RECLASS		_1	0 (61 10-	
1. 00	ADMI NI STRATI VE & GENERAL		•	<u>2, 681, 488</u>	1.00
	0		0	2, 681, 488	
	J - OCCUPATIONAL HEALTH RECLA				
1.00	OCCUPATI ONAL HEALTH	194. 00	0	57, 550	1.00
2.00		0.00	0	О	2. 00
3.00		0.00	0	О	3. 00
4.00		0.00	o	o	4. 00
5.00		0.00	0	0	5. 00
6. 00		0.00	ol	Ō	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
9.00				57, 550	7.00
	K - DEPRECIATION		U	57, 550	
4 00		0.00	ما	100 070	1.00
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	493, 379	1. 00
2.00	EMS WEST STATION	1. 01	0	16, 040	2. 00
3.00	EMS WEST STATION EQUIP.	2. 01	0	5, 110	3. 00
4.00	ADMI NI STRATI VE & GENERAL		0_	<u>6, 8</u> 85	4. 00
	0		0	521, 414	
	L - BLDG & LEASE EXPENSE				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	25, 517	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	39, 309	2. 00
3.00	EMS WEST STATION EQUIP.	2. 01	o	796	3. 00
4.00		0.00	ol	О	4. 00
5.00		0.00	0	0	5. 00
6. 00		0.00	0	0	6. 00
7. 00		0.00	o	o	7.00
8. 00		0.00	0	0	8.00
			0		
9.00		0.00	0	0	9.00
10.00		0.00	0	0	10.00
11.00		0. 00	0	0	11.00
12.00		0. 00	0	0	12.00
13.00		0. 00	0	0	13. 00
14.00		0.00	O	0	14.00
15.00		0.00	O	0	15. 00
16.00		0.00	0	О	16. 00
17.00		0.00	ol	0	17. 00
				65, 622	
	M - INTEREST RECLASS		~1	,	
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	128, 439	1.00
	0	— — 1.00	升	128, 439	1.00
	N IMPLANTABLE MEDICAL CURDI	IEC	U	120, 437	
1 00	N - IMPLANTABLE MEDICAL SUPPL		<u></u>	214 405	1 00
1. 00	I MPL. DEV. CHARGED TO	72. 00	0	214, 405	1.00
1. 00			0		1.00
	I MPL. DEV. CHARGED TO		0 0 973, 515	214, 405 	1. 00

Health Financial Systems RECLASSIFICATIONS COMMUNITY HOSPT. OF LAGRANGE CTY IN
Provider CCN: 151323 In Lieu of Form CMS-2552-10

						5/31/2016 1	1: 39 am
		Decreases	0.1	0.11			
	Cost Center 6.00	Li ne # 7.00	Sal ary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - REHAB THERAPY RECLASS	7.00	6.00	9.00	10.00		
1.00	PHYSI CAL THERAPY	66.00	179, 965	3, 788	8 0		1.00
2.00		0.00	0		0		2. 00
	0		179, 965	3, 788	B		
	B - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	578, 897	150, 222			1.00
2.00		0.00	<u>0</u> 578, 897	00 150, 222	0 0		2. 00
	F - CAFETERI A RECLASS		5/8,89/	150, 222	4		
1.00	DI ETARY	10.00	214, 653	185, 798	8 0		1.00
1.00			214, 653	185, 798	+		1.00
	G - INSURANCE RECLASS	, ·			1		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	44, 596			1. 00
2.00		0.00	0	0	12		2. 00
	0		0	44, 596	b		
1 00	H - DRUGS CHARGED TO PATIENTS	15 00	0	045 (11			1 00
1. 00 2. 00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	945, 611 671			1. 00 2. 00
3.00	OPERATING ROOM	50.00	0	1, 401	1		3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	270			4. 00
5.00	EMERGENCY	91.00	0	508	0		5. 00
	0		0	948, 461			
	I - SALARY RECLASS						
1. 00	ADMI NI STRATI VE & GENERAL			<u>2, 681, 488</u>			1. 00
	U CCUDATIONAL HEALTH DECLAR		0	2, 681, 488	3		
1. 00	J - OCCUPATIONAL HEALTH RECLATIONAL OF THE RECLATION OF T	54.00	O	31, 594	0		1.00
2.00	LABORATORY	60.00	0	255			2. 00
3.00	RESPIRATORY THERAPY	65. 00	Ö	67	-		3. 00
4.00	PHYSI CAL THERAPY	66.00	0	6, 759	0		4. 00
5.00	OCCUPATI ONAL THERAPY	67.00	0	1, 131	0		5. 00
6.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	303	0		6. 00
7.00	PATI ENT	72.00		2 274			7.00
7. 00 8. 00	DRUGS CHARGED TO PATIENTS EMERGENCY	73. 00 91. 00	0	2, 374 14, 892			7. 00 8. 00
9. 00	OPERATING ROOM	50.00	0	14, 692			9. 00
7. 00	0		 	57, 550			7.00
	K - DEPRECIATION	<u>'</u>		, , , , , , , , , , , , , , , , , , , ,	'		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	521, 414			1. 00
2.00		0. 00	0	C	9		2. 00
3.00		0.00	0	C	9		3. 00
4. 00		0.00	0	<u></u> <u></u> 521, 414	<u> </u>		4. 00
	L - BLDG & LEASE EXPENSE		<u> </u>	321, 414	i		
1.00	OPERATION OF PLANT	7.00	0	25, 200	10		1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	O	317			2. 00
3.00	AMBULANCE SERVICES	95.00	0	796			3. 00
4.00	ADMINISTRATIVE & GENERAL	5. 00	0	7, 346			4. 00
5.00	OPERATION OF PLANT	7.00	0	73			5. 00
6. 00 7. 00	HOUSEKEEPI NG DI ETARY	9. 00 10. 00	0	21			6. 00 7. 00
7. 00 8. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	537 35			8. 00
9. 00	PHARMACY	15. 00	0	9, 443			9. 00
10.00	ADULTS & PEDIATRICS	30.00	Ö	2, 599			10. 00
11.00	OPERATING ROOM	50.00	0	11, 034	0		11. 00
12.00	RESPIRATORY THERAPY	65.00	0	4, 191			12. 00
13.00	PHYSI CAL THERAPY	66.00	0	1, 443			13. 00
14.00	EMERGENCY	91.00	0	1, 311			14. 00
15. 00 16. 00	PHYSICIANS' PRIVATE OFFICES LIFEBRIDGE SENIOR CARE	192. 00 90. 01	0	552 640			15. 00 16. 00
17. 00	NURSING ADMINISTRATION	13. 00	o	84			17. 00
17.00	0		 	65, 622			17.00
	M - INTEREST RECLASS		31	33, 322			
1.00	INTEREST EXPENSE	113.00	0	128, 439	11		1.00
	0		0	128, 439			
_	N - IMPLANTABLE MEDICAL SUPPL		,				
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	214, 405	0		1. 00
	PATI ENT	+		214, 405	 		
500. 00	Grand Total: Decreases		973, 515	5, 001, 783			500.00
555.00	1	1	, 0.10	5, 551, 765	-1		1 555. 55

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 Provi der CCN: 151323 Peri od: Worksheet A-7 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/31/2016 11:39 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Retirements Bal ances 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 265,000 17, 529 17, 529 0 1.00 0 2.00 Land Improvements 1, 972, 720 0 2.00 0 3.00 3.00 Buildings and Fixtures 13, 245, 217 184, 641 184, 641 0 0 4.00 Building Improvements 29, 098 0 4.00 5.00 Fixed Equipment 7, 791, 840 6,876 0 6, 876 5.00 0 6.00 Movable Equipment 7, 082, 044 415, 059 415, 059 13, 533 6.00 0 7.00 HIT designated Assets 1, 429, 338 113, 567 113, 567 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 31, 815, 257 737, 672 737, 672 13, 533 8.00 9.00 Reconciling Items 28, 442 6, 338 0 6, 338 9.00 Total (line 8 minus line 9) 31, 786, 815 13, 533 10.00 731, 334 0 731, 334 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 282, 529 1.00 2.00 Land Improvements 1, 972, 720 203, 240 2.00 13, 429, 858 . Buildings and Fixtures 3.00 46, 964 3.00 13, 778 4.00 Building Improvements 29, 098 4.00 5.00 Fi xed Equipment 7, 798, 716 508, 867 5.00 6.00 Movable Equipment 7, 483, 570 3, 743, 983 6.00 1, 542, 905 7.00 HIT designated Assets 7. 00 Ω

32, 539, 396

32, 504, 616

34, 780

4, 516, 832

4, 516, 832

2.01

3.00

EMS WEST STATION EQUIP.

Total (sum of lines 1-2)

2.01

3.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 151323 Peri od: Worksheet A-7 From 01/01/2015 Part II Date/Time Prepared: То 12/31/2015 5/31/2016 11:39 am SUMMARY OF CAPITAL Depreciation Insurance (see Taxes (see Cost Center Description Lease Interest instructions) instructions) 10.00 11.00 12.00 9.00 13.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 1, 506, 069 0 1.00 0 0 1.01 EMS WEST STATION 0 0 1.01 0 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 0 0 0 2.01 EMS WEST STATION EQUIP. 0 0 0 2.01 1, 506, 069 3.00 3.00 Total (sum of lines 1-2) SUMMARY OF CAPITAL Cost Center Description 0ther Total (1) (sum Capital-Relate of cols. 9 d Costs (see through 14) instructions) 15.00 14.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 1, 506, 069 1.00 0 1.01 EMS WEST STATION 1.01 CAP REL COSTS-MVBLE EQUIP 0 2.00 0 2.00

1, 506, 069

Health Financial Systems	COMMUNITY HOSPT. OF LAGRANGE CTY IN	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 151323	Peri od: From 01/01/2015 Part III To 12/31/2015 Date/Time Prepared: 5/31/2016 11: 39 am
	COMPUTATION OF RATIOS	ALLOCATION OF OTHER CAPITAL

	TELEVITOR OF CAPITAL COSTS CENTERS	l rovider	F	rom 01/01/2015 o 12/31/2015	Part III Date/Time Prep 5/31/2016 11:3		
		COME	PUTATION OF RAT	TI OS	ALLOCATION OF OTHER CAPITAL		
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		Г	T			
1.00	CAP REL COSTS-BLDG & FIXT	23, 178, 336	l e	23, 178, 336		0	1. 00
1. 01	EMS WEST STATION	334, 586		334, 586		0	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	7, 325, 417				0	2.00
2. 01	EMS WEST STATION EQUIP.	158, 153	l .	100, 100			2. 01
3.00	Total (sum of lines 1-2)	30, 996, 492					3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS		1			
1. 00	CAP REL COSTS-BLDG & FIXT	NTERS 0	0	0	1, 002, 595		1. 00
1. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION	NTERS 0	0	0	16, 040	0	1. 01
1. 01 2. 00	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP	O O	000000000000000000000000000000000000000	0 0	16, 040 493, 379	0 39, 309	1. 01 2. 00
1. 01 2. 00 2. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP.	O 0 0 0	000000000000000000000000000000000000000	0 0 0 0	16, 040 493, 379 5, 110	0 39, 309 796	1. 01 2. 00 2. 01
1. 01 2. 00	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP	O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0	16, 040 493, 379 5, 110 1, 517, 124	0 39, 309 796	1. 01 2. 00
1. 01 2. 00 2. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP.	NTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 St	0 0 0 0 0 0 0 0 0 0 0 0 0 0	16, 040 493, 379 5, 110 1, 517, 124	0 39, 309 796	1. 01 2. 00 2. 01
1. 01 2. 00 2. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP.	0 0 0 0 0	0 0 0 0 0 5t		16, 040 493, 379 5, 110 1, 517, 124	0 39, 309 796	1. 01 2. 00 2. 01
1. 01 2. 00 2. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2)	0 0 0 0 0	Insurance (see	Taxes (see	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate	0 39,309 796 65,622 Total (2) (sum of cols. 9	1. 01 2. 00 2. 01
1. 01 2. 00 2. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2)	0 0 0 0 0	Insurance (see	Taxes (see	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see	0 39,309 796 65,622 Total (2) (sum	1. 01 2. 00 2. 01
1. 01 2. 00 2. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2)	0 0 0 0 0 0	Insurance (see instructions)	Taxes (see instructions)	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see i nstructi ons)	0 39,309 796 65,622 Total (2) (sum of cols. 9 through 14)	1. 01 2. 00 2. 01
1. 01 2. 00 2. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2) Cost Center Description	0 0 0 0 0 0 1 nterest	Insurance (see	Taxes (see	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see	0 39,309 796 65,622 Total (2) (sum of cols. 9	1. 01 2. 00 2. 01
1. 01 2. 00 2. 01 3. 00	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2) Cost Center Description PART III - RECONCILIATION OF CAPITAL COSTS CE	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Insurance (see instructions)	Taxes (see instructions)	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see instructions) 14, 00	0 39,309 796 65,622 Total (2) (sum of cols. 9 through 14)	1. 01 2. 00 2. 01 3. 00
1. 01 2. 00 2. 01 3. 00	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2) Cost Center Description PART III - RECONCILIATION OF CAPITAL COSTS CE CAP REL COSTS-BLDG & FIXT	0 0 0 0 0 0 1 nterest	Insurance (see instructions) 12.00	Taxes (see instructions)	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see instructions) 14.00	0 39,309 796 65,622 Total (2) (sum of cols. 9 through 14) 15.00	1. 01 2. 00 2. 01 3. 00
1. 01 2. 00 2. 01 3. 00 1. 00 1. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2) Cost Center Description PART III - RECONCILIATION OF CAPITAL COSTS CE CAP REL COSTS-BLDG & FIXT EMS WEST STATION	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Insurance (see instructions) 12.00 32,970	Taxes (see instructions) 13.00	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see instructions) 14.00	0 39,309 796 65,622 Total (2) (sum of cols. 9 through 14) 15.00 1,189,521 16,040	1. 01 2. 00 2. 01 3. 00 1. 00 1. 01
1. 01 2. 00 2. 01 3. 00 1. 00 1. 01 2. 00	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2) Cost Center Description PART III - RECONCILIATION OF CAPITAL COSTS CE CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Insurance (see instructions) 12.00	Taxes (see instructions) 13.00 0 0 0 0	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see i nstructions) 14.00	0 39,309 796 65,622 Total (2) (sum of cols. 9 through 14) 15.00 1,189,521 16,040 544,314	1. 01 2. 00 2. 01 3. 00 1. 00 1. 01 2. 00
1. 01 2. 00 2. 01 3. 00 1. 00 1. 01	CAP REL COSTS-BLDG & FIXT EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. Total (sum of lines 1-2) Cost Center Description PART III - RECONCILIATION OF CAPITAL COSTS CE CAP REL COSTS-BLDG & FIXT EMS WEST STATION	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Insurance (see instructions) 12.00 32,970 0 11,626	Taxes (see instructions) 13.00 0 0 0 0 0	16, 040 493, 379 5, 110 1, 517, 124 AL Other Capi tal -Rel ate d Costs (see instructions) 14. 00	0 39,309 796 65,622 Total (2) (sum of cols. 9 through 14) 15.00 1,189,521 16,040	1. 01 2. 00 2. 01 3. 00 1. 00 1. 01

Health Financial Systems
ADJUSTMENTS TO EXPENSES

					To 12/31/2015		
				Expense Classification or		5/31/2016 11:	39 alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	<u>, </u>	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
1. 01	Investment income - EMS WEST STATION (chapter 2)		0	EMS WEST STATION	1. 01	0	1. 01
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
2. 01	COSTS-MVBLE EQUIP (chapter 2) Investment income - EMS WEST		0	EMS WEST STATION EQUIP.	2. 01	0	2. 01
3. 00	STATION EQUIP. (chapter 2) Investment income - other		0		0.00	0	3. 00
	(chapter 2)		0				
4. 00	Trade, quantity, and time discounts (chapter 8)		Ü		0.00		
5. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5. 00
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Tel ephone servi ces (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service (chapter 21)	A	-4, 438	OPERATION OF PLANT	7. 00	0	8. 00
9.00	Parking Lot (chapter 21) Provider-based physician	1 1 2	1 975 757		0. 00		
10. 00	adjustment	A-8-2	-1, 875, 757			0	
11. 00	Sale of scrap, waste, etc. (chapter 23)	A	-1, 632	OPERATION OF PLANT	7. 00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	-1, 914, 036			0	12. 00
13. 00	Laundry and linen service	_	0		0.00		
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-233, 989 0	CAFETERI A	11. 00 0. 00		
16. 00	and others Sale of medical and surgical		0		0.00	0	16. 00
10.00	supplies to other than		0		0.00		10.00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and	1	0		0.00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0.00		
	books, etc.)		-				
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00		
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
24.00	therapy costs in excess of	A-0-3	0	ITITIONE THERAIT	00.00		24.00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
26. 01	COSTS-BLDG & FIXT Depreciation - EMS WEST		0	EMS WEST STATION	1. 01	0	26. 01
27. 00	STATION Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
27. 01	COSTS-MVBLE EQUIP			EMS WEST STATION EQUIP.	2. 01		
	STATION EQUIP.						
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00		28. 00 29. 00
30. 00		A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	limitation (chapter 14)						

Health Financial Systems ADJUSTMENTS TO EXPENSES Provi der CCN: 151323 Peri od: Worksheet A-8 From 01/01/2015
To 12/31/2015 Date/Time Prepared:

) 12/31/2015	5/31/2016 11:	
				Expense Classification on	Worksheet A	070172010 11.	0 7 dill
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Paci c/Codo (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center bescription	Basi s/Code (2) 1.00	2.00	3. 00	4. 00	5. 00	
30. 99	Hospice (non-distinct) (see	1.00		ADULTS & PEDIATRICS	30.00	5.00	30. 99
30. 77	instructions)		O	ADDETS & FEDIATRICS	30.00		30. 77
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of						
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						
33.00	0444 444 7 484 8588 048845848		0		0.00	0	33.00
33. 01	CAH HIT ADJ DEPR CARRYFRWD	A	-28, 501	ADMINISTRATIVE & GENERAL	5. 00	0	33. 01
33. 02	2015 CAH HIT ADJ DEPR CARRYFRWD	A	20 OE1	ADMINISTRATIVE & GENERAL	E 00	0	33. 02
33. 02	2014	A	-20, 931	ADMINISTRATIVE & GENERAL	5. 00	U	33.02
33. 03	CAH HIT ADJ DEPR CARRYFRWD	A	-59 039	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
00.00	2013		07,007	7.0 11.0.1.0.1.1.1.1.2. (a. 02.1.2.10.1.2	0.00	ŭ	00.00
33. 04	CAH HIT ADJ DEPR CARRYFRWD	A	-99, 794	ADMINISTRATIVE & GENERAL	5. 00	0	33. 04
	2012						
34.00	MI SCELLANEOUS REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	
35. 00	SPEECH THERAPY CONTRACTED	В		SPEECH PATHOLOGY	68. 00	0	35. 00
36. 00	NON-PATIENT EMS REVENUE	В	-300	AMBULANCE SERVICES	95. 00	0	36. 00
37. 00			0		0. 00	0	37. 00
38. 00	PHARMACY EMPLOYEE RX PURCHASES			DRUGS CHARGED TO PATIENTS	73. 00	0	38. 00
39. 00	REVERSAL OF 2014 INTEREST	A	536	INTEREST EXPENSE	113. 00	0	39. 00
40.00	ACCRUAL	Δ.	707 407	EMDLOVEE DENEELTS DEDADTMENT	4 00	0	40.00
40.00	SELF INSURANCE	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40.00
41. 00	LOBBY % OF DUES & SUBSCRIPTIONS	A	-2, 907	ADMINISTRATIVE & GENERAL	5. 00	U	41. 00
44. 00	EKG INTERPRETATION COSTS	A	-1 450	RADI OLOGY-DI AGNOSTI C	54.00	0	44. 00
44. 01	MARKETI NG	A	·	COMMUNITY & VOLUNTEER SVCS	194. 03	0	
44. 02	MARKETING	A		RADI OLOGY-DI AGNOSTI C	54. 00	0	44. 02
44. 03	MARKETING	A		PHYSI CAL THERAPY	66. 00	Ö	
44. 04	MARKETING	A		ADMINISTRATIVE & GENERAL	5. 00	0	44. 04
44. 05	MARKETING	A		LIFEBRIDGE SENIOR CARE	90. 01	0	44. 05
47. 00	ADD-BACK OF DEMOLISHED ASSET	A		CAP REL COSTS-BLDG & FIXT	1. 00	9	47. 00
	DEPREC						
48.00	ADD-BACK OF DEMOLITION COSTS	A	4, 125	ADMINISTRATIVE & GENERAL	5.00	0	48. 00
49.00			0		0.00	0	49. 00
49. 01	TELEMETRY MONITORING EXPENSE	A		ADULTS & PEDIATRICS	30. 00	0	49. 01
49. 02	MEDICAL DIRECTOR ADDITIONAL	A	-304	ADULTS & PEDIATRICS	30. 00	0	49. 02
	A/P			ANEGELESI OLOGIA	50.00		
49. 03	ON-CALL PROF TIME	A		ANESTHESI OLOGY	53.00	0	
49. 04	GROSS-UP ANESTHESIA EXPENSE FOR A/R	A	282, 058	ANESTHESI OLOGY	53. 00	0	49. 04
49. 05	CHARITY CONTRIBUTIONS	A	_1 036	ADMINISTRATIVE & GENERAL	5. 00	0	49. 05
49. 05	MEDICAL DIRECTOR ADDITIONAL	A		LIFEBRIDGE SENIOR CARE	90. 01	0	49. 05
77.00	A/P		-400	ELLERY DOE SENIOR ONCE	70.01		77.00
50.00	TOTAL (sum of lines 1 thru 49)		-4, 976, 032				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						
(4) D	comintion all about an mafaran			0110 D L 45 4			_

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

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

B. Amount Received - if cost cannot be determined.

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

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

OFFICE COSTS

From 01/01/2015
To 12/31/2015 Date/Time Prepared:

				10 12/31/2013	5/31/2016 11:				
	Li ne No.	Cost Center	Expense Items	Amount of	Amount				
				Allowable Cost	Included in				
					Wks. A, column				
					5				
	1. 00	2. 00	3. 00	4. 00	5. 00				
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED								
	HOME OFFICE COSTS:								
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	5, 024, 133	5, 000, 000	1. 00			
2.00	5. 00	ADMINISTRATIVE & GENERAL	RELATED PARTY SUBSIDY ADJ.	0	1, 938, 169	2. 00			
3.00	0.00			0	0	3. 00			
4.00	0.00			0	0	4. 00			
5.00	TOTALS (sum of lines 1-4).			5, 024, 133	6, 938, 169	5. 00			
	Transfer column 6, line 5 to								
	Worksheet A-8, column 2,								
	line 12.								

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

The first book posted to not know the first and of 27 the discount at the book as the following the first book and the first bo									
				Related Organization(s) and/	or Home Office				
						1			
	C	N	D	N	D				
	Symbol (1)	Name	Percentage of	Name	Percentage of				
			Ownershi p		Ownershi p				
	1. 00	2. 00	3. 00	4. 00	5. 00				
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:								

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

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

6. 00	В	0.00 PARKVIEW HEALTH SYSTEM, INC. 100.00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Heal th F	inancial Syste	ems		COMMUNI TY	HOSPT. OF	LAGRANGE CTY	IN	In Lieu	u of Form CMS-	-2552-10
STATEME OFFICE		SERVICES F	FROM RELAT	ED ORGANIZATIONS	S AND HOME	Provi der	CCN: 151323	Peri od: From 01/01/2015	Worksheet A-	3-1
011102	00313							To 12/31/2015	Date/Time Pro 5/31/2016 11:	epared: :39 am
	Net	Wkst. A-7	Ref.							
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6. 00	7. 00								
	A. COSTS INCUR	RED AND AD.	JUSTMENTS	REQUIRED AS A RI	ESULT OF T	RANSACTIONS W	TH RELATED (ORGANIZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:								
1.00	24, 133		0							1.00
2.00	-1, 938, 169		О							2.00
3.00	0		O							3.00
4.00	0		o							4.00
5.00	-1, 914, 036									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

nas not	been posted to worksheet A,	cordinate and the amount arrowable should be murcated in cordinate and this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	FED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

	HOME OFFICE	6. 00
7.00		7. 00
8.00		8. 00
9.00		9. 00
10.00		10. 00
9. 00 10. 00 100. 00		100.00

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

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

Provi der CCN: 151323

Period: From 01/01/2015 To 12/31/2015 Worksheet A-8-2 Date/Time Prepared: 5/31/2016 11: 39 am

								5/31/2016 11:	39 am
	Wkst. A Line #	Cost Center/Physician	Total	Profess	i onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Compor	nent	Component		ider Component	
								Hours	
	1. 00	2.00	3.00	4.0	0	5. 00	6, 00	7. 00	
1. 00		AGGREGATE - ANESTHESI OLOGY	405, 130		38, 241		0.00		1. 00
2. 00		AGGREGATE-ANESTHESI OLOGY	579, 125	1	79, 125	· ·	0		
				1					
3.00		DR. A	30, 000		0	,			
4.00		AGGREGATE-EMERGENCY	1, 561, 382	1	58, 391	· ·	0	0	
5.00		DR. B	12, 049		0	,	0	0	0.00
6. 00	90. 01	AGGREGATE-LI FEBRI DGE SENI OR CARE	19, 480		0	19, 480	0	0	6. 00
7.00	0.00		0		0	0	0	0	7. 00
8.00	0.00		0		0	0	0	1 0	8. 00
9.00	0. 00		0		0	0	0	0	
10. 00	0. 00		1		0	0	0	0	
200.00	0.00		2, 607, 166	1 0	75, 757	731, 409		0	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE			Cost of	Provi der	Physician Cost	200.00
	WKSt. A LITTE #	I denti fi er							
		rdentifier	Limit			Memberships &	Component	of Malpractice	
				Li mi	τ	Conti nui ng	Share of col.	Insurance	
	4 00	0.00	0.00			Educati on	12	44.00	
	1. 00	2. 00	8.00	9. 0		12. 00	13. 00	14. 00	
1.00		AGGREGATE-ANESTHESI OLOGY	0		0		0		
2.00		AGGREGATE-ANESTHESI OLOGY	0		0	0	0	0	2. 00
3.00	91. 00	DR. A	0		0	0	0	0	3. 00
4.00	91. 00	AGGREGATE-EMERGENCY	0		0	0	0	0	4. 00
5.00	30.00	DR. B	0		0	0	0	0	5. 00
6.00	90. 01	AGGREGATE-LI FEBRI DGE SENI OR	0		0	0	0	l 0	6. 00
		CARE							
7.00	0.00		0		0	0	0	0	7. 00
8. 00	0.00		0		0	0	0	0	
9. 00	0. 00		1		0	0	0	0	
10. 00	0.00				0	0	0	0	10.00
200.00	0.00				0	0	0		200.00
200.00	WI+ A I : //	C+ C+ (Db	Done de la co	A -1: + -	-I DCE	RCE	A -1: + +	U	200.00
	Wkst. A Line #	,	Provi der	Adjuste			Adjustment		
		I denti fi er	Component	Li mi	τ	Di sal I owance			
			Share of col.						
	4 00	0.00	14			47.00	10.00		
	1. 00	2. 00	15. 00	16. (17. 00	18. 00		
1. 00		AGGREGATE-ANESTHESI OLOGY	0		0	0	338, 241		1. 00
2.00		AGGREGATE-ANESTHESI OLOGY	0		0	0	579, 125		2. 00
3.00	91. 00	DR. A	0		0	0	0		3. 00
4.00	91. 00	AGGREGATE-EMERGENCY	0		0	0	958, 391		4. 00
5.00	30.00	DR. B	0		0	0	0		5. 00
6.00		AGGREGATE-LI FEBRI DGE SENI OR	0		0	0	0		6, 00
0.00	, , , , ,	CARE	Ĭ		·	ı .			0.00
7. 00	0. 00		0		0	0	n		7. 00
8. 00	0.00			1	0	_	١		8. 00
9. 00	0.00			1	0	_			9. 00
10. 00	0.00			1	0				10.00
	0.00			1	-		1 075 757		
200.00		I	1 0	1	0	0	1, 875, 757	l	200. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2015 | Part I | To 12/31/2015 | Date/Time Prepared: | 5/31/2016 11: 39 am

						5/31/2016 11:	39 am
				CAPITAL REL	LATED COSTS		
	Cost Contor Description	Not Exposes	BLDG & FLXT	EMS WEST	MVBLE EQUIP	EMS WEST	
	Cost Center Description	Net Expenses for Cost	BLUG & FIXI	STATI ON	MARTE EGOLA	STATION EQUIP.	
		Allocation		STATION		STATION EQUIP.	
		(from Wkst A					
		col. 7)					
		0	1. 00	1. 01	2. 00	2. 01	
GENE	RAL SERVICE COST CENTERS	Ŭ	1.00	1.01	2.00	2.01	
	O CAP REL COSTS-BLDG & FIXT	1, 189, 521	1, 189, 521				1.00
1	1 EMS WEST STATION	16, 040	0	16, 040			1. 01
1	O CAP REL COSTS-MVBLE EQUIP	544, 314	, and the second	10,010	544, 314		2. 00
	1 EMS WEST STATION EQUIP.	5, 906			01.701.	5, 906	2. 01
1	O EMPLOYEE BENEFITS DEPARTMENT	3, 526, 549	0	0	C	0	4. 00
	O ADMINISTRATIVE & GENERAL	6, 511, 436	214, 983	0	98, 374	1	
1	O MAINTENANCE & REPAIRS	0	0	o	,	ol o	
1	O OPERATION OF PLANT	931, 575	67, 564	o	30, 917		7. 00
	O LAUNDRY & LINEN SERVICE	81, 779	3, 863	o	1, 768		
1	O HOUSEKEEPI NG	198, 800	12, 642	0	5, 785	l .	9. 00
1	O DI ETARY	232, 024	50, 723	0	23, 210	1	10.00
1	O CAFETERI A	166, 462	0	0	C	0	11. 00
	O MAINTENANCE OF PERSONNEL	0	o	0	C	0	12. 00
	O NURSING ADMINISTRATION	320, 629	o	0	C	0	13.00
	O CENTRAL SERVICES & SUPPLY	-34, 380	24, 094	0	11, 025	0	14.00
15. 00 0150	O PHARMACY	542, 603	20, 735	0	9, 488	0	15. 00
	O MEDICAL RECORDS & LIBRARY	0	4, 092	0	1, 872		16. 00
	O SOCIAL SERVICE	0	0	0	· C	0	17. 00
19.00 0190	O NONPHYSICIAN ANESTHETISTS	0	o	0	C	0	19. 00
	O NURSI NG SCHOOL	0	o	0	C	0	20.00
21. 00 0210	O I&R SERVICES-SALARY & FRINGES APPRV	0	o	0	C	0	21.00
	O I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	C	0	22. 00
	O PARAMED ED PRGM-(SPECIFY)	0	0	0	C	ol o	23. 00
	TIENT ROUTINE SERVICE COST CENTERS			- 1			
30. 00 0300	O ADULTS & PEDIATRICS	1, 345, 334	267, 721	0	122, 507	0	30.00
	O NURSERY	159, 772	4, 031	0	1, 845	1	43.00
ANCI	LLARY SERVICE COST CENTERS					•	
	O OPERATING ROOM	1, 010, 759	152, 595	0	69, 826	0	50.00
52.00 0520	O DELIVERY ROOM & LABOR ROOM	569, 347	19, 055	0	8, 720	0	52. 00
53.00 0530	O ANESTHESI OLOGY	66, 982	0	0	C	0	53. 00
	O RADI OLOGY-DI AGNOSTI C	1, 060, 478	77, 046	0	35, 255	0	
60.00 0600	O LABORATORY	873, 736	30, 171	0	13, 806	1	60.00
62. 30 0625	O BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	· C	0	62. 30
	O RESPIRATORY THERAPY	306, 049	15, 788	0	7, 224	0	65. 00
	O PHYSI CAL THERAPY	359, 179	50, 570	0	23, 140	l .	66.00
67. 00 0670	O OCCUPATIONAL THERAPY	108, 550	0	0	C	0	67. 00
68. 00 0680	O SPEECH PATHOLOGY	66, 200	o	0	C	0	68. 00
69. 00 0690	O ELECTROCARDI OLOGY	0	O	0	C	0	69. 00
71. 00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENT	297, 589	O	0	C	0	71. 00
72.00 0720	O IMPL. DEV. CHARGED TO PATIENTS	214, 405	0	0	C	0	72. 00
73.00 0730	O DRUGS CHARGED TO PATIENTS	694, 937	0	0	C	0	73. 00
76. 97 0769	7 CARDIAC REHABILITATION	0	0	0	C	0	76. 97
76. 98 0769	8 HYPERBARI C OXYGEN THERAPY	0	0	0	C	0	76. 98
	9 LI THOTRI PSY	0	0	0	C	0	76. 99
OUTP	ATIENT SERVICE COST CENTERS						
	O CLI NI C	0	0	0	C	0	90.00
	1 LI FEBRI DGE SENI OR CARE	218, 988	13, 894	0	6, 358	0	90. 01
91.00 0910	O EMERGENCY	1, 444, 175	105, 674	0	48, 356	0	91.00
92.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHE	R REIMBURSABLE COST CENTERS						
95.00 0950	O AMBULANCE SERVICES	1, 215, 711	0	16, 040	C	5, 906	95. 00
99. 10 0991	O CORF	0	0	0	C	0	99. 10
99. 20 0992	O OUTPATIENT PHYSICAL THERAPY	0	0	0	C	0	99. 20
99. 30 0993	O OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	C	0	99. 30
99. 40 0994	O OUTPATIENT SPEECH PATHOLOGY	0	0	0	C	0	99. 40
SPEC	IAL PURPOSE COST CENTERS						
113. 00 1130	O INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	24, 245, 449	1, 135, 241	16, 040	519, 476	5, 906	118. 00
NONR	EIMBURSABLE COST CENTERS						
190. 00 1900	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	9, 409	3, 405	0	1, 558	0	190. 00
	O PHYSICIANS' PRIVATE OFFICES	2, 518	50, 875	0	23, 280	l .	192. 00
	O OCCUPATIONAL HEALTH	0	0	0	C		194. 00
	1 FOUNDATI ON	53, 789	0	0	C		194. 01
194. 03 0795	2 COMMUNITY & VOLUNTEER SVCS	159, 366	O	0	C		194. 03
	4 ER PHYSICIAN	0	O	0	C		194. 04
	3 SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	C	0	194. 06
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers		0	0	C	0	201. 00

Health Financial Systems	COMMUNITY HOSPT. O	F LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015 Fo 12/31/2015		pared: 39 am
			CAPITAL RE	ELATED COSTS		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)		EMS WEST STATION		EMS WEST STATION EQUIP.	
	0	1. 00	1. 01	2. 00	2. 01	
202.00 TOTAL (sum lines 118-201)	24, 470, 531	1, 189, 521	16, 040	544, 314	5, 906	202. 00

Provi der CCN: 151323

				1	0 12/31/2015	5/31/2016 11:	
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	
		4.00	4A	5. 00	6. 00	7. 00	
	GENERAL SERVICE COST CENTERS				l		
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 2. 00	00101 EMS WEST STATION 00200 CAP REL COSTS-MVBLE EQUIP						1. 01 2. 00
2. 00	00201 EMS WEST STATION EQUIP.						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 526, 549					4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 579, 149	8, 403, 942	8, 403, 942			5. 00
6.00	00600 MAI NTENANCE & REPAI RS	0	C	0	0		6. 00
7.00	00700 OPERATION OF PLANT	66, 248	1, 096, 304	1	0	1, 669, 747	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	87, 410	1	0	7, 112	8. 00
9.00	00900 HOUSEKEEPI NG	43, 759	260, 986	1	0	23, 275	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	34, 792 59, 350	340, 749 225, 812	1		93, 381 0	10. 00 11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	39, 330	223, 612) 110, 113	0	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	88, 348	408, 977	1	0	0	13.00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0	739	1	0	44, 357	14. 00
15. 00	01500 PHARMACY	125, 017	697, 843	365, 020	0	38, 173	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	5, 964	3, 120	0	7, 533	16. 00
17. 00	01700 SOCIAL SERVICE	0	C	0	0	0	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	C	0	0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	C		0	0	20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV				0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)				0	0	23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	J		91 0			25.00
30.00	03000 ADULTS & PEDI ATRI CS	282, 399	2, 017, 961	1, 055, 539	0	492, 876	30.00
43.00	04300 NURSERY	35, 074	200, 722	104, 991	0	7, 421	43. 00
	ANCILLARY SERVICE COST CENTERS				_		
50.00	05000 OPERATING ROOM	189, 503	1, 422, 683		0		50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	124, 988	722, 110 66, 982	1		35, 081 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	166, 644	1, 339, 423	1	0	141, 842	54.00
60. 00	06000 LABORATORY	0	917, 713	1	0	55, 545	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	83, 140	412, 201	215, 610	0	29, 065	65. 00
66. 00	06600 PHYSI CAL THERAPY	99, 546	532, 435	278, 500	0	93, 099	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	29, 701	138, 251	1		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	20, 058	86, 258	1	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	207 500	155 440	0	0	69.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 MPL. DEV. CHARGED TO PATIENTS		297, 589 214, 405		0	0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		694, 937	1		0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	C 7 . 7 7 C	0	0	l o	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	C	o	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	C	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS				T		
	09000 CLINIC	0	074 704				
90. 01 91. 00	09001 LI FEBRI DGE SENI OR CARE	32, 554	271, 794			25, 580 194, 548	•
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	196, 417	1, 794, 622	938, 711	0	194, 548	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS			4		L	72.00
95. 00	09500 AMBULANCE SERVICES	255, 450	1, 493, 107	780, 998	0	0	95. 00
99. 10	09910 CORF	0	C	0	0	0	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	C	0	0	0	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	C	0	0	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	C	0	0	0	99. 40
112 00	SPECIAL PURPOSE COST CENTERS					I	112 00
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	3, 512, 137	24, 151, 919	8, 237, 285	0	1, 569, 817	113.00
110.00	NONREI MBURSABLE COST CENTERS	3, 312, 137	24, 131, 717	0, 237, 203		1, 307, 617	1110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14, 372	7, 518	0	6, 268	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	76, 673	1			192.00
194.00	07950 OCCUPATIONAL HEALTH	0	C	0		0	194. 00
194. 01	07951 FOUNDATI ON	10, 697	64, 486	33, 731	0	0	194. 01
	07952 COMMUNITY & VOLUNTEER SVCS	3, 715	163, 081	85, 303	0		194. 03
	07954 ER PHYSICIAN	0	C	0	0		194. 04
	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	C	0	0	0	194. 06
200.00	1 1		C		_		200.00
201. 00 202. 00		3, 526, 549	24, 470, 531	8, 403, 942	0		201.00
202.00	1.01/1E (30m 111103 110 201)	0, 020, 047	21, 170, 331	0, 400, 742	1	1,007,747	1-02.00

Provi der CCN: 151323

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 5/31/2016 | 11:39 am

					5/31/2016 11:	39 am
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	
	LINEN SERVICE				PERSONNEL	
	8. 00	9. 00	10. 00	11. 00	12. 00	
GENERAL SERVICE COST CENTERS	1					
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
1.01 O0101 EMS WEST STATION						1. 01
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
2.01 O0201 EMS WEST STATION EQUIP.						2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE	140, 243					8. 00
9. 00 00900 HOUSEKEEPI NG	42	420, 817				9.00
10. 00 01000 DI ETARY	1, 052	23, 970	637, 387			10.00
11. 00 01100 CAFETERI A	0	,	0	343, 927		11.00
12. 00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0.07,727	0	1
13. 00 01300 NURSI NG ADMINI STRATI ON	0	Ö	0	19, 732	0	1
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	11, 386	0	17, 732	0	
15. 00 01500 PHARMACY	0	9, 799	0	20, 449	0	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0		0	20, 449	0	
	0	1, 934	0	0	-	
17. 00 01700 SOCI AL SERVI CE	0	U	0	0	0	
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	O ₁	0	0	0	
20. 00 02000 NURSI NG SCHOOL	0	0	0	0	0	1
21.00 02100 1 &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
22.00 02200 1 &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	1
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	46, 294	126, 520	637, 387	69, 757	0	
43. 00 04300 NURSERY	2, 202	1, 905	0	6, 697	0	43.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	21, 261	72, 113	0	46, 120	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 868	9, 005	0	23, 917	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	15, 301	36, 410	0	42, 971	0	1
60. 00 06000 LABORATORY	0	14, 258	0	,	0	1
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	, 200	0	0	Ö	1
65. 00 06500 RESPI RATORY THERAPY	435	7, 461	0	22, 362	0	
66. 00 06600 PHYSI CAL THERAPY	5, 273	23, 898	0	28, 342	0	1
67. 00 06700 OCCUPATI ONAL THERAPY	1, 795	23, 070	0	4, 305	0	
68. 00 06800 SPEECH PATHOLOGY	210	0	0	2, 910	0	
69. 00 06900 SPEECH PATHOLOGY	0	U O	0	2, 910	0	
	0	U O	0	0	0	1
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	U	U	0	0		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	U	0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	O ₁	0	0	0	
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	1
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS	,					
90. 00 09000 CLI NI C	0	0	0	0	0	1
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	6, 566	0	9, 846	0	90. 01
91. 00 09100 EMERGENCY	28, 343	49, 940	0	46, 519	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	6, 535	0	0	0	0	95. 00
99. 10 09910 CORF	O	o	0	0	0	99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	1
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	O	Ö	0	0	0	
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	Ö	0	0	0	1
SPECIAL PURPOSE COST CENTERS	,	٩	<u> </u>	<u> </u>		77
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	136, 611	395, 165	637, 387	343, 927	n	118. 00
NONREI MBURSABLE COST CENTERS	130, 011	373, 103	037, 307	343, 727	0	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	1, 609	0	0		190. 00
			-	_		
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	3, 632	24, 043	0	0		192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	이	이	0	0		194. 00
194. 01 07951 FOUNDATION	0	0	0	0		194. 01
194.03 07952 COMMUNITY & VOLUNTEER SVCS	0	0	0	0		194. 03
194. 04 07954 ER PHYSICIAN	0	0	0	0		194. 04
194.06 07953 SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194. 06
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	o	ol	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	140, 243	420, 817	637, 387	343, 927	0	202. 00
			•			

Provi der CCN: 151323

					12/31/2015	5/31/2016 11:	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	, a
		13. 00	SUPPLY 14. 00	15. 00	16. 00	17. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 EMS WEST STATION						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
2. 01	00201 EMS WEST STATION EQUIP.						2. 01
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	1					4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS						6.00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL						12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	642, 632					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	56, 869	1			14.00
15.00	01500 PHARMACY	0	1, 578	1, 132, 862	10 551		15.00
16. 00 17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	0	0	18, 551	0	16. 00 17. 00
17.00	01900 NONPHYSICIAN ANESTHETISTS		0	0	0	0	19.00
20. 00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	o o	0	Ö	0	Ö	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	O	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	232, 190	4, 913	37	2, 716		30.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	22, 346	432	12	685	0	43. 00
50. 00	05000 OPERATING ROOM	153, 577	9, 133	914	299	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	79, 632	1, 541	42	0	1	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	l o	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 626	7, 725	5, 981	0	54.00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	297	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	231	337	1, 699		66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	78		354		67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	10	12	158	0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	16, 339		0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	11, 752	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	0	1, 113, 698	0	l o	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
00.00	OUTPATIENT SERVICE COST CENTERS	O	0	O	0	0	00.00
90. 00 90. 01	09000 CLINIC 09001 LIFEBRIDGE SENIOR CARE	0	159		0	0	
91. 00	09100 EMERGENCY	154, 887	4, 070		6, 659		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	101,007	1,070	1,020	0,007		92.00
	OTHER REIMBURSABLE COST CENTERS	,		,			
95. 00	09500 AMBULANCE SERVI CES	0	4, 584	8, 149	0	_	
99. 10	09910 CORF	0	0	0	0	-	
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	U	0	0	0	99. 40
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						113. 00
118. 00	i i	642, 632	56, 743	1, 132, 862	18, 551	0	118.00
	NONREI MBURSABLE COST CENTERS	0.127.002	00,7.10	17 1027 002	10,001		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12	0	0	0	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	104	0	0	0	192. 00
194.00	07950 OCCUPATI ONAL HEALTH	0	0	0	0		194. 00
	07951 FOUNDATI ON	0	5	0	0		194. 01
	07952 COMMUNITY & VOLUNTEER SVCS	0	5	0	0		194. 03
	07954 ER PHYSI CI AN	0	0	0	0		194. 04
	07953 SHI PSHEWANA RADI OLOGY AND LAB		0	0	0	0	194. 06
200. 00 201. 00	1 1		0		^		200. 00 201. 00
201.00		642, 632	56, 869	1, 132, 862	18, 551		201.00
_52.50	1 1 1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	5.2,552	50, 507	., .52, 552	.0,001	, ,	,

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS COMMUNITY HOSPT. OF LAGRANGE CTY IN

Provi der CCN: 151323

					LATERNO	DECLIDENTS	5/31/2016 11:	
					I NTERNS &	RESIDENTS		
		Cost Center Description		NURSING SCHOOL	SERVI CES-SALAR		PARAMED ED	
			ANESTHETI STS		Y & FRINGES APPRV	PRGM COSTS APPRV	PRGM	
			19. 00	20.00	21.00	22. 00	23. 00	
		AL SERVICE COST CENTERS			1			
1. 00 1. 01		CAP REL COSTS-BLDG & FIXT EMS WEST STATION						1. 00 1. 01
2. 00		CAP REL COSTS-MVBLE EQUIP						2.00
2. 01		EMS WEST STATION EQUIP.			•			2. 01
4.00		EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	1	ADMINISTRATIVE & GENERAL						5. 00
6.00		MAINTENANCE & REPAIRS OPERATION OF PLANT						6.00
7. 00 8. 00	1	LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	1	HOUSEKEEPI NG						9. 00
10. 00	1	DI ETARY						10. 00
11. 00	1	CAFETERI A						11.00
12. 00 13. 00	1	MAI NTENANCE OF PERSONNEL NURSI NG ADMI NI STRATI ON						12. 00 13. 00
14. 00	1	CENTRAL SERVICES & SUPPLY						14. 00
15. 00	1	PHARMACY						15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY						16. 00
17. 00	1	SOCIAL SERVICE						17. 00
19. 00 20. 00	1	NONPHYSICIAN ANESTHETISTS NURSING SCHOOL	0	0				19. 00 20. 00
21. 00		I &R SERVI CES-SALARY & FRINGES APPRV			Ö			21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV				O		22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)					0	23. 00
20.00		I ENT ROUTI NE SERVI CE COST CENTERS				ما		20.00
30. 00 43. 00	1	ADULTS & PEDI ATRI CS NURSERY	0	0	1		0	1
10.00		LARY SERVICE COST CENTERS				<u> </u>		10.00
50.00		OPERATING ROOM	0	O	1	0	0	1
52. 00		DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	53. 00 54. 00
60.00	1	LABORATORY	0	0	0	0	0	60.00
62. 30	1	BLOOD CLOTTING FOR HEMOPHILIACS	0	O	Ō	Ö	0	1
65. 00	1	RESPI RATORY THERAPY	0	0	1	0	0	
66. 00	1	PHYSI CAL THERAPY	0	0		0	0	1
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	1	0	0	67. 00 68. 00
69. 00	1	ELECTROCARDI OLOGY	Ö	Ö		o	0	69.00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0	O	0	0	0	71. 00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00 76. 97		DRUGS CHARGED TO PATIENTS CARDIAC REHABILITATION	0	0	0	0	0	73. 00 76. 97
76. 97 76. 98	1	HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	1
76. 99		LI THOTRI PSY	Ö	Ö	Ö	Ö	0	
		TIENT SERVICE COST CENTERS						
90.00		CLINIC	0	0		0	0	1
90. 01 91. 00		LIFEBRIDGE SENIOR CARE EMERGENCY	0	0		0	0	90. 01 91. 00
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART		Č			O	92.00
	OTHER	REIMBURSABLE COST CENTERS						
95.00		AMBULANCE SERVICES	0	0		0	0	1
99. 10 99. 20	09910	OUTPATIENT PHYSICAL THERAPY	0	0		0	0	
99. 30		OUTPATIENT OCCUPATIONAL THERAPY	0	0	-	0	0	1
99. 40		OUTPATIENT SPEECH PATHOLOGY	0	O	0	0	0	1
		AL PURPOSE COST CENTERS			ı			
113.00		INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	0	O	О	0	0	113. 00 118. 00
110.00		IMBURSABLE COST CENTERS	0		<u> </u>	ΟĮ	0	1118.00
190.00	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
		OCCUPATIONAL HEALTH FOUNDATION	0	0	0	0		194. 00 194. 01
		COMMUNITY & VOLUNTEER SVCS		0	0	0		194. 01
		ER PHYSICIAN	Ö	o	Ö	o		194. 04
194. 06	07953	SHI PSHEWANA RADI OLOGY AND LAB	0	O	0	О		194. 06
200.00	1	Cross Foot Adjustments	0	0	0	0		200.00
201. 00 202. 00	1	Negative Cost Centers TOTAL (sum lines 118-201)	0	0		0		201. 00 202. 00
202.00	-1	1.5E (34m 11103 110 201)	١		. 0	이 역	0	1-02.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323 | Period: | Worksheet B | From 01/01/2015 | Part I | To | 12/31/2015 | Date/Time P

Date/Time Prepared: 5/31/2016 11:39 am Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00101 EMS WEST STATION 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 EMS WEST STATION EQUIP 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 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 02000 NURSI NG SCHOOL 20 00 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 4, 686, 190 4, 686, 190 30.00 04300 NURSERY 347, 413 43.00 347, 413 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 751, 190 50.00 2, 751, 190 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 256, 909 0 1, 256, 909 52.00 05300 ANESTHESI OLOGY 53 00 102,018 102, 018 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 2, 291, 890 0 2, 291, 890 54.00 06000 LABORATORY 60 00 1, 467, 543 1, 467, 543 60 00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 65.00 06500 RESPIRATORY THERAPY 687, 431 687, 431 65.00 06600 PHYSI CAL THERAPY 66.00 963, 814 963, 814 66.00 06700 OCCUPATI ONAL THERAPY 67.00 217, 214 217, 214 67.00 68.00 06800 SPEECH PATHOLOGY 134,677 134, 677 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 469.588 469, 588 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 338, 306 338, 306 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 172, 135 2, 172, 135 73.00 07697 CARDIAC REHABILITATION 0 76.97 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 90.01 09001 LIFEBRIDGE SENIOR CARE 456, 112 C 456, 112 90.01 91.00 09100 EMERGENCY 3, 220, 119 3, 220, 119 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 2, 293, 373 0 2, 293, 373 95 00 99. 10 09910 CORF 0 99. 10 C 0 99 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 99.30 0 C 99.30 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 99.40 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 23, 855, 922 118.00 23, 855, 922 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 29, 779 29, 779 190.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 238, 219 192 00 238, 219 194. 00 07950 OCCUPATI ONAL HEALTH 0 194.00 194. 01 07951 FOUNDATI ON 98, 222 98, 222 194. 01 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 248.389 0 248, 389 194. 03 194. 04 07954 ER PHYSICIAN 0 0 194.04 0 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 194. 06 0 0 200.00 Cross Foot Adjustments 0 0 0 200. 00 201.00 Negative Cost Centers 0 0 201. 00 202.00 TOTAL (sum lines 118-201) 24, 470, 531 0 24, 470, 531 202.00

COMMUNITY HOSPT. OF LAGRANGE CTY IN Provider CCN: 151323 | In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 5/31/2016 11: 39 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

				CAPITAL REL	ATED COSTS	5/31/2016 11:	J 7 dill
	Cost Center Description	Di rectly	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST	
	cost center bescription	Assigned New	DEDO & TIXI	STATI ON		STATION EQUIP.	
		Capi tal Rel ated Costs					
		0	1. 00	1. 01	2. 00	2. 01	
	GENERAL SERVICE COST CENTERS			T T			1 00
	00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION						1. 00 1. 01
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
	00201 EMS WEST STATION EQUIP.	_	_		_	_	2. 01
	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	0 851, 759	0 214, 983	0	0 98, 374	0	
	00600 MAI NTENANCE & REPAI RS	031,739	214, 703	0	90, 374	0	
	00700 OPERATION OF PLANT	0	67, 564	0	30, 917	0	1
	00800 LAUNDRY & LINEN SERVICE	0	3, 863		1, 768	0	
	00900 HOUSEKEEPI NG 01000 DI ETARY	0	12, 642 50, 723		5, 785 23, 210	0	9. 00 10. 00
	01100 CAFETERI A	o	0	Ö	23, 210	o o	11. 00
	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	0	0 24, 094	0	0 11, 025	0	
	01500 PHARMACY	0	20, 735		9, 488	0	1
	01600 MEDICAL RECORDS & LIBRARY	0	4, 092		1, 872	0	1
	01700 SOCI AL SERVI CE	0	0	0	0	0	
	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	0) 0	0	0	0	19. 00 20. 00
	02100 &R SERVICES-SALARY & FRINGES APPRV	Ö	0	ő	0	ő	1
	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	-	0	0	1
	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23. 00
	03000 ADULTS & PEDIATRICS	O	267, 721	0	122, 507	0	30. 00
43. 00	04300 NURSERY	0	4, 031	0	1, 845	0	43. 00
50.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM		152, 595	l ol	69, 826	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	19, 055		8, 720	0	
53. 00	05300 ANESTHESI OLOGY	O	0	-	0	0	
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	77, 046 30, 171		35, 255 13, 806	0	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	30, 171		13, 600	0	
	06500 RESPIRATORY THERAPY	o	15, 788	-	7, 224	ő	1
	06600 PHYSI CAL THERAPY	0	50, 570		23, 140	0	
	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0	0	67. 00 68. 00
	06900 ELECTROCARDI OLOGY	o	0	ő	0	ő	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	0	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
	07699 LITHOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	O	0	0	0	0	90.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	O	13, 894		6, 358	l e	1
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	105, 674	0	48, 356	0	91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS						92.00
	09500 AMBULANCE SERVICES	0	0	16, 040	0	5, 906	
	09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0 0	
	09930 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	1
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
113.00		851, 759	1, 135, 241	16, 040	519, 476	5. 906	118. 00
Ī	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	3, 405 50, 875		1, 558 23, 280	0	190. 00 192. 00
	07950 OCCUPATIONAL HEALTH	0	0 30, 873	0	23, 260		194. 00
194. 01	07951 FOUNDATI ON	o	Ö	o	0	0	194. 01
	07952 COMMUNITY & VOLUNTEER SVCS	0	0	0	0	l	194. 03
	07954 ER PHYSICIAN 07953 SHIPSHEWANA RADIOLOGY AND LAB) 0 n		0		194. 04 194. 06
200.00	Cross Foot Adjustments				0		200. 00
201.00		054 750	0	0	0		201. 00
202. 00	TOTAL (sum lines 118-201)	851, 759	1, 189, 521	16, 040	544, 314	5, 906	202. 00

Heal th Financial Systems

COMMUNITY HOSPT. OF LAGRANGE CTY IN

In Lieu of Form CMS-2552-10

Provider CCN: 151323

Period:
From 01/01/2015
To 12/31/2015

Cost Center Description

Subtotal

EMPLOYEE
BENEFITS
DEPARTMENT

2A

4.00

5.00

6.00

7.00

	Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	39 am
		2A	4. 00	5.00	6. 00	7. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 1. 01 2. 00 2. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION 00200 CAP REL COSTS-MVBLE EQUIP 00201 EMS WEST STATION EQUIP.						1. 00 1. 01 2. 00 2. 01
4.00 5.00 6.00 7.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 1, 165, 116 0 98, 481	() () ()) 1, 165, 116 0 79, 502	0	177, 983	4. 00 5. 00 6. 00 7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	5, 631 18, 427	(6, 339 18, 926	0	758 2, 481	8. 00 9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	73, 933 0	(24, 710 16, 375	0	9, 954 0	10. 00 11. 00
12. 00 13. 00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	o	(0	0	0	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	35, 119	(54	0	4, 728	14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	30, 223 5, 964	(50, 606 432	0	4, 069 803	16. 00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	(0	0	0	17. 00 19. 00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	(0	0	0	20. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	(0	0	0	22. 00
23. 00	O2300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	U U					23. 00
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	390, 228 5, 876	(0		30. 00 43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	222, 421	(103, 170	0	29, 945	50. 00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	27, 775 0	(52, 366 4, 857	0		52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	112, 301	(97, 132	0	15, 119	54. 00
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	43, 977 0	(0	0	0	60. 00 62. 30
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	23, 012 73, 710	(29, 892 38, 611	0		65. 00 66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	(10, 026 6, 255	0	-	67. 00 68. 00
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(0 21, 581	0	0	69. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	(15, 548	0	0	72. 00
73. 00 76. 97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	0	(50, 395	0	0	73. 00 76. 97
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	(0	0		76. 98 76. 99
	OUTPATIENT SERVICE COST CENTERS 09000 CLINIC	0	C	0	0	0	
90. 01	09001 LI FEBRI DGE SENI OR CARE	20, 252	C	19, 710	0	2, 727	90. 01
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	154, 030 0	C	130, 142	0	20, 737	91. 00 92. 00
	09500 AMBULANCE SERVICES 09910 CORF	21, 946	(108, 277	0		95. 00 99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	(0	0	0	99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY 09940 OUTPATIENT SPEECH PATHOLOGY	0	(0	0	0	99. 30 99. 40
113. 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	2, 528, 422	C	1, 142, 012	0	167, 331	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	4, 963	(1, 042 5, 560	0		190. 00 192. 00
194.00	07950 OCCUPATI ONAL HEALTH	74, 155	(0	0	0	194. 00
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS	0 0	(4, 676 11, 826	0		194. 01 194. 03
	07954 ER PHYSICIAN 07953 SHIPSHEWANA RADIOLOGY AND LAB	0	(0	0		194. 04 194. 06
200.00	Cross Foot Adjustments	0			0		200. 00
201.00		2, 607, 540	(1, 165, 116	0		

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 5/31/2016 11: 39 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPT. OF LAGRANGE CTY IN Provider CCN: 151323

	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	5/31/2016 11: MAINTENANCE OF PERSONNEL	
		8.00	9.00	10.00	11.00	12.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT						1.00
1	00101 EMS WEST STATION 00200 CAP REL COSTS-MVBLE EQUIP						1. 01 2. 00
1	00200 CAF KEE COSTS-WVBEE EQUIP.						2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
	00500 ADMINISTRATIVE & GENERAL						5. 00
1	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
1	00800 LAUNDRY & LINEN SERVICE	12, 728					8. 00
1	00900 HOUSEKEEPI NG	4	39, 838				9. 00
1	01000 DI ETARY	95	2, 269	110, 961	44 075		10.00
1	01100 CAFETERIA	0	0	0	16, 375	0	11.00
1	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0	0	0	939	0	
1	01400 CENTRAL SERVICES & SUPPLY	0	1, 078	0	737	0	
	01500 PHARMACY	o	928	0	974	0	1
	01600 MEDICAL RECORDS & LIBRARY	O	183	0	0	0	16.00
	01700 SOCIAL SERVICE	o	0	0	0	0	17. 00
1	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	1
1	02000 NURSI NG SCHOOL	0	0	0	0	0	
1	02100 &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
	02200 &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	
-	INPATIENT ROUTINE SERVICE COST CENTERS	١	Ο _Ι	U _I		0	23.00
	03000 ADULTS & PEDIATRICS	4, 201	11, 977	110, 961	3, 320	0	30.00
1	04300 NURSERY	200	180	0	319	0	1
	ANCILLARY SERVICE COST CENTERS	'					
	05000 OPERATING ROOM	1, 930	6, 827	0	2, 196	0	50. 00
	05200 DELIVERY ROOM & LABOR ROOM	714	853	0	1, 139	0	1
	05300 ANESTHESI OLOGY	0	0	0	0	0	
	05400 RADI OLOGY-DI AGNOSTI C	1, 389	3, 447	0	2, 046	0	
1	06000 LABORATORY	0	1, 350 0	0	0	0	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	39	706	0	1, 065	0	62. 30 65. 00
1	06600 PHYSI CAL THERAPY	479	2, 262	0	1, 349	0	66. 00
	06700 OCCUPATI ONAL THERAPY	163	0	0	205	0	
1	06800 SPEECH PATHOLOGY	19	O	Ō	139	0	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0	76. 97 76. 98
1	07699 LI THOTRI PSY		0	0	0	0	1
H-	OUTPATIENT SERVICE COST CENTERS	<u> </u>	9	٥	<u> </u>		70. 77
	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 LIFEBRIDGE SENIOR CARE	O	622	0	469	0	90. 01
1	09100 EMERGENCY	2, 572	4, 728	0	2, 215	0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS	Fool			ما		05.00
	09500 AMBULANCE SERVICES 09910 CORF	593 0	0	0	0	0	
	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	1
	09930 OUTPATIENT OCCUPATIONAL THERAPY		0	0	0	0	1
	09940 OUTPATIENT SPEECH PATHOLOGY	o	0	Ö	Ö	0	1
<u> </u>	SPECIAL PURPOSE COST CENTERS	, -,	· · · · · · · · · · · · · · · · · · ·	-,	-,		
113.00	11300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	12, 398	37, 410	110, 961	16, 375	0	118. 00
	NONREI MBURSABLE COST CENTERS				-1		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	152	0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	330	2, 276	0	0		192.00
1	07950 OCCUPATI ONAL HEALTH 07951 FOUNDATI ON		0	0	O		194. 00 194. 01
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS		0	0	0		194. 01
	07954 ER PHYSICIAN		o	0	o o		194. 04
1	07953 SHI PSHEWANA RADI OLOGY AND LAB	ol	o	Ö	o		194. 06
200.00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	12, 728	39, 838	110, 961	16, 375	0	202. 00

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2016 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151323

					To	12/31/2015	Date/Time Prep 5/31/2016 11:	
		Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
			ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
			13.00	14. 00	15. 00	16.00	17. 00	
1 00		AL SERVICE COST CENTERS						1 00
1. 00 1. 01		CAP REL COSTS-BLDG & FIXT EMS WEST STATION						1. 00 1. 01
2. 00		CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01	1	EMS WEST STATION EQUIP.						2. 01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	1	ADMINISTRATIVE & GENERAL						5. 00
6.00	1	MAINTENANCE & REPAIRS						6. 00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	1	HOUSEKEEPING						9. 00
10. 00	1	DI ETARY						10. 00
11. 00	01100	CAFETERI A						11.00
12.00	1	MAINTENANCE OF PERSONNEL						12. 00
13.00	1	NURSI NG ADMI NI STRATI ON	30, 597	25 520				13.00
14. 00 15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY		25, 539 709	87, 509			14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY		, 0,	07,307	7, 382		16. 00
17. 00		SOCIAL SERVICE	O	o	0	0	0	17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20. 00		NURSI NG SCHOOL	0	0	0	0	0	20.00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21. 00 22. 00
23. 00	1	PARAMED ED PRGM-(SPECIFY)		0	0	ol Ol	0	23. 00
20.00		IENT ROUTINE SERVICE COST CENTERS	<u> </u>	<u> </u>	0	<u> </u>	0	20.00
30.00	1	ADULTS & PEDIATRICS	11, 056	2, 206	3	1, 081	0	30.00
43. 00		NURSERY	1, 064	194	1	272	0	43.00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	7, 312	4, 101	71	119	0	50. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	3, 791	692	3	0	0	52. 00
53. 00		ANESTHESI OLOGY	0	0	0	Ö	0	53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	О	730	597	2, 380	0	54.00
60.00	1	LABORATORY	0	0	0	0	0	60.00
62. 30	1	BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY		133 104	26	676	0	65. 00 66. 00
67. 00	1	OCCUPATI ONAL THERAPY	o	35	9	141	0	67. 00
68. 00	06800	SPEECH PATHOLOGY	O	4	1	63	0	68. 00
69. 00	1	ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	7, 339	0	0	0	71.00
72. 00 73. 00	1	DRUGS CHARGED TO PATIENTS		5, 278 0	86, 028	0	0	72. 00 73. 00
76. 97	1	CARDI AC REHABI LI TATI ON		ő	00,020	o	0	76. 97
76. 98		HYPERBARI C OXYGEN THERAPY	O	О	0	o	0	76. 98
76. 99		LI THOTRI PSY	0	0	0	0	0	76. 99
00 00		TIENT SERVICE COST CENTERS CLINIC		ol	0	٥	0	90. 00
90. 00		LI FEBRI DGE SENI OR CARE		72	0	ol Ol	0	90. 00
91. 00		EMERGENCY	7, 374	1, 828	141	2, 650	0	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART						92.00
05.00		REI MBURSABLE COST CENTERS		2 050	(20	ما	0	05.00
95. 00 99. 10	09500	AMBULANCE SERVICES	0	2, 058 0	629	0	0	95. 00 99. 10
99. 20		OUTPATIENT PHYSICAL THERAPY		0	0	0	0	99. 20
99. 30		OUTPATIENT OCCUPATIONAL THERAPY	o	0	0	ō	0	99. 30
99. 40		OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
112 00		AL PURPOSE COST CENTERS						112 00
113.00		INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	30, 597	25, 483	87, 509	7, 382		113. 00 118. 00
110.00		IMBURSABLE COST CENTERS	30, 377	25, 405	07, 307	7, 302	0	110.00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5	0	0	0	190. 00
		PHYSICIANS' PRIVATE OFFICES	0	47	0	0		192. 00
		OCCUPATIONAL HEALTH	0	0	0	0		194. 00
		FOUNDATION COMMUNITY & VOLUNTEER SVCS		2	0	0		194. 01 194. 03
	1	ER PHYSICIAN		0	0	0		194. 03 194. 04
		SHIPSHEWANA RADIOLOGY AND LAB		o	0	Ö		194. 06
200.00		Cross Foot Adjustments						200. 00
201.00	1	Negative Cost Centers	0 507	15, 440	07 500	7 202		201. 00
202.00	1	TOTAL (sum lines 118-201)	30, 597	40, 979	87, 509	7, 382	0	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPT. OF LAGRANGE CTY IN Provi der CCN: 151323

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 5/31/2016 11: 39 am

							5/31/2016 11:	39 am
					INTERNS &	RESI DENTS		
					050000000000000000000000000000000000000	050,4,050,07,150	0.0.0.0.0	
		Cost Center Description		NURSTING SCHOOL		SERVI CES-OTHER	PARAMED ED	
			ANESTHETI STS		Y & FRINGES	PRGM COSTS	PRGM	
			19. 00	20.00	APPRV 21.00	APPRV 22. 00	23. 00	
	GENER	AL SERVICE COST CENTERS	17.00	20.00	21.00	22.00	23.00	
1.00		CAP REL COSTS-BLDG & FIXT						1.00
1. 01	1	EMS WEST STATION						1. 01
2.00	1	CAP REL COSTS-MVBLE EQUIP						2. 00
2.01	1	EMS WEST STATION EQUIP.						2. 01
4.00	00400	EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500	ADMINISTRATIVE & GENERAL						5. 00
6.00	00600	MAINTENANCE & REPAIRS						6. 00
7.00	00700	OPERATION OF PLANT						7. 00
8.00	00800	LAUNDRY & LINEN SERVICE						8. 00
9.00	1	HOUSEKEEPING						9. 00
10. 00	1	DI ETARY						10. 00
11. 00	1	CAFETERIA						11. 00
12.00	1	MAINTENANCE OF PERSONNEL						12.00
13.00	1	NURSI NG ADMI NI STRATI ON						13.00
14.00		CENTRAL SERVICES & SUPPLY						14.00
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY		1				15. 00 16. 00
17. 00	1	SOCIAL SERVICE						17. 00
19. 00		NONPHYSICIAN ANESTHETISTS	(1				19. 00
20. 00	1	NURSI NG SCHOOL		ĺ				20. 00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRV			ĺ			21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV				0		22. 00
23. 00	1	PARAMED ED PRGM-(SPECIFY)					0	1
		IENT ROUTINE SERVICE COST CENTERS		•	'	'		
30.00	03000	ADULTS & PEDIATRICS						30. 00
43.00	04300	NURSERY						43.00
		LARY SERVICE COST CENTERS						
50.00	1	OPERATING ROOM						50.00
52. 00	1	DELIVERY ROOM & LABOR ROOM						52. 00
53. 00	1	ANESTHESI OLOGY						53. 00
54.00		RADI OLOGY-DI AGNOSTI C						54.00
60. 00 62. 30	1	LABORATORY						60.00
65. 00		BLOOD CLOTTING FOR HEMOPHILIACS RESPIRATORY THERAPY						62. 30 65. 00
66. 00		PHYSI CAL THERAPY						66. 00
67. 00	1	OCCUPATIONAL THERAPY						67. 00
68. 00	1	SPEECH PATHOLOGY						68. 00
69. 00	1	ELECTROCARDI OLOGY						69. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENT						71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS						72. 00
73.00	07300	DRUGS CHARGED TO PATIENTS						73. 00
76. 97	07697	CARDIAC REHABILITATION						76. 97
76. 98	1	HYPERBARI C OXYGEN THERAPY						76. 98
76. 99		LI THOTRI PSY						76. 99
00.00		TIENT SERVICE COST CENTERS						00.00
90.00		CLINIC						90.00
90. 01 91. 00	1	LI FEBRI DGE SENI OR CARE EMERGENCY						90. 01 91. 00
91.00		OBSERVATION BEDS (NON-DISTINCT PART						91.00
7Z. UU		REIMBURSABLE COST CENTERS		1	1			72.00
95. 00		AMBULANCE SERVICES						95. 00
99. 10	09910				1			99. 10
99. 20	1	OUTPATIENT PHYSICAL THERAPY						99. 20
99. 30		OUTPATIENT OCCUPATIONAL THERAPY						99. 30
99. 40	09940	OUTPATIENT SPEECH PATHOLOGY						99. 40
		AL PURPOSE COST CENTERS			,			
		I NTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	С	0) <u> </u>	0	0	118. 00
400.00		I MBURSABLE COST CENTERS						100.00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
		PHYSICIANS' PRIVATE OFFICES						192. 00
		OCCUPATIONAL HEALTH FOUNDATION						194. 00 194. 01
		COMMUNITY & VOLUNTEER SVCS						194. 01
	1	ER PHYSICIAN						194. 03
		SHI PSHEWANA RADI OLOGY AND LAB						194. 04
200.00		Cross Foot Adjustments	c		0	o	0	200. 00
201.00	1	Negative Cost Centers	Ċ		1		0	201. 00
202.00		TOTAL (sum lines 118-201)	C	0				202. 00
_		<u> </u>						

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151323

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2016 | Date/Time Prepared: | To 12/31/2016

				o 12/31/2015 Date/lime Pr 5/31/2016 11	
Cost Center Description	Subtotal	Intern &	Total		
	F	Residents Cost & Post			
		Stepdown			
		Adjustments			
	24. 00	25.00	26. 00		
GENERAL SERVICE COST CENTERS				I	1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 1.01 00101 EMS WEST STATION					1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP					2. 00
2. 01 00201 EMS WEST STATION EQUIP.					2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00 00500 ADMINISTRATIVE & GENERAL					5. 00
6.00 00600 MAINTENANCE & REPAIRS					6. 00
7. 00 00700 OPERATION OF PLANT					7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY					9.00
11. 00 01100 CAFETERI A					11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL					12. 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 SOCI AL SERVI CE					17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS					19.00
20. 00 02000 NURSI NG SCHOOL 21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV					20.00
22. 00 02200 &R SERVICES-OTHER PRGM COSTS APPRV					22. 00
23. 00 02300 PARAMED ED PRGM- (SPECIFY)					23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	l.			1	1 20.00
30. 00 03000 ADULTS & PEDIATRICS	733, 911	0	733, 911		30.00
43. 00 04300 NURSERY	23, 453	0	23, 453		43. 00
ANCILLARY SERVICE COST CENTERS				T	4
50. 00 05000 OPERATI NG ROOM	378, 092	0	378, 092		50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	91, 072	0	91, 072		52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	4, 857 235, 141	0	4, 857 235, 141		53. 00 54. 00
60. 00 06000 LABORATORY	117, 799	0	117, 799		60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	ő	0		62. 30
65. 00 06500 RESPIRATORY THERAPY	57, 945	O	57, 945		65. 00
66. 00 06600 PHYSI CAL THERAPY	127, 141	0	127, 141		66. 00
67.00 06700 OCCUPATIONAL THERAPY	10, 579	0	10, 579		67. 00
68. 00 06800 SPEECH PATHOLOGY	6, 481	0	6, 481		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	00.000		69. 00
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	28, 920	0	28, 920		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	20, 826 136, 423	0	20, 826 136, 423		72. 00 73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	130, 423	0	130, 423		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	o	o	Ö		76. 98
76. 99 07699 LI THOTRI PSY	0	0	O		76. 99
OUTPAȚI ENT SERVI CE COST CENTERS					
90. 00 09000 CLI NI C	0	0	C)	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	43, 852	0	43, 852		90. 01
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	326, 417	0	326, 417		91.00
OTHER REIMBURSABLE COST CENTERS		······································			92. 00
95. 00 09500 AMBULANCE SERVICES	133, 503	0	133, 503		95. 00
99. 10 09910 CORF	0	ő	00,000		99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	O	C		99. 20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	o	C		99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	C)	99. 40
SPECIAL PURPOSE COST CENTERS	T			T	4
113. 00 11300 I NTEREST EXPENSE	2 474 412		2 477 412		113.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	2, 476, 412	0	2, 476, 412	4	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 830	O	6, 830		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	92, 352	ő	92, 352		192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	0	O	C		194. 00
194. 01 07951 FOUNDATI ON	4, 678	0	4, 678	3	194. 01
194.03 07952 COMMUNITY & VOLUNTEER SVCS	11, 828	o	11, 828	3	194. 03
194. 04 07954 ER PHYSICIAN	0	0	C	0	194. 04
194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	C		194. 06
200.00 Cross Foot Adjustments	0	0	15 440	2	200. 00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	15, 440 2, 607, 540	0	15, 440 2, 607, 540		201. 00 202. 00
202. OU TOTAL (SUIII TITIES TTO-201)	2,007,340	Ч	2,007,040	71	1202. UU

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

					o 12/31/2015	Date/Time Pre 5/31/2016 11:	
			CAPI TAL REI	LATED COSTS		3/31/2010 11.	Jy alli
	Cost Center Description	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST	EMPLOYEE	
		(SQUARE FEET)	STATION	(SQUARE FEET)	STATION EQUIP.	BENEFITS	
			(SQUARE FEET)		(SQUARE FEET)	DEPARTMENT (GROSS	
		1. 00	1. 01	2.00	2. 01	SALARI ES) 4. 00	
	GENERAL SERVICE COST CENTERS	1.00	1.01	2.00	2.01	4.00	
	00100 CAP REL COSTS-BLDG & FIXT	77, 906					1.00
	OO101 EMS WEST STATION OO200 CAP REL COSTS-MVBLE EQUIP	0	9, 760	77, 906			1. 01 2. 00
2.01	00201 EMS WEST STATION EQUIP.			0	9, 760		2. 01
	OO400	0 14, 080	0	0 14, 080		12, 754, 492 5, 711, 316	4. 00 5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	Ö	0	Ö	0,711,310	6. 00
	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	4, 425 253	0	4, 425 253		239, 601 0	7. 00 8. 00
	00900 HOUSEKEEPING	828	0	828 828		158, 264	9. 00
10.00	01000 DI ETARY	3, 322	0	3, 322		125, 832	10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	0	0	0	_	214, 653 0	11. 00 12. 00
13.00	01300 NURSING ADMINISTRATION	Ö	Ö	0	0	319, 530	13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	1, 578 1, 358		1, 578 1, 358		0 452, 150	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	268	0	268		452, 150	16. 00
	01700 SOCIAL SERVICE	0	0	0		0	17. 00
	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	0	_	0	19. 00 20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00 23. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0		0	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS		0		ı o	0	25.00
	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	17, 534 264	0			1, 021, 353	30.00
43.00	ANCILLARY SERVICE COST CENTERS	204	0	204	ı o	126, 854	43. 00
	05000 OPERATING ROOM	9, 994	0			685, 375	50.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	1, 248 0	0	1, 248 0		452, 043 0	52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 046	0	5, 046	0	602, 703	54. 00
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 976 0	0	1, 976 0		0	60. 00 62. 30
	06500 RESPI RATORY THERAPY	1, 034	Ö	1, 034		300, 692	65. 00
66.00	06600 PHYSI CAL THERAPY	3, 312	0	-,		360, 029	66. 00 67. 00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0		107, 420 72, 545	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	ő	Ö	Ö	Ö	0	73. 00
	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	0	0			0	ł
76. 99	07699 LI THOTRI PSY	0	0			0	76. 99
	OUTPATIENT SERVICE COST CENTERS	0	0			0	00.00
	09000 CLINIC 09001 LIFEBRIDGE SENIOR CARE	0 910	0			0 117, 738	90. 00 90. 01
91.00	09100 EMERGENCY	6, 921	0	6, 921	0	710, 382	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
	09500 AMBULANCE SERVICES	0	9, 760	0	9, 760	923, 887	95. 00
	09910 CORF	0	0	· -	_	0	99. 10
	09920 OUTPATIENT PHYSICAL THERAPY 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	_	0	99. 20 99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE			Γ			113. 00
118.00		74, 351	9, 760	74, 351	9, 760	12, 702, 367	•
	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	223	0	223	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	3, 332					190.00
194.00	07950 OCCUPATI ONAL HEALTH	0	0	0	o		194. 00
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS	0 n	0 0	0	_	38, 688 13, 437	
194.04	07954 ER PHYSICIAN	ő	Ö	Ö		0	194. 04
194. 06 200. 00	07953 SHI PSHEWANA RADIOLOGY AND LAB Cross Foot Adjustments	0	0	0	0	0	194. 06 200. 00
200.00							200. 00
	· · · · · · · · · · · · · · · · · · ·	•	-				<u> </u>

Health Financial Systems	COMM	UNI TY HOSPT. OF	LAGRANGE CTY	IN	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der CCN: 151323			Peri od:	Worksheet B-1		
					rom 01/01/2015 o 12/31/2015	Date/Time Pre 5/31/2016 11:	pared: 39 am	
		CAPI TAL REL	LATED COSTS					
Cost Center Description		BLDG & FIXT (SQUARE FEET)	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	EMPLOYEE BENEFITS		
		(SQUARE TEET)	(SQUARE FEET)	(SCOMIC TEET)		DEPARTMENT		
					(SQUARE FEET)	(GROSS SALARI ES)		
		1. 00	1. 01	2.00	2. 01	4. 00		
202.00 Cost to be allocated (per Wkst. B Part I)	,	1, 189, 521	16, 040	544, 314	5, 906	3, 526, 549	202. 00	
203.00 Unit cost multiplier (Wkst. B, Pa	,	15. 268670	1. 643443	6. 986805	0. 605123			
204.00 Cost to be allocated (per Wkst. B Part II)	,					0	204. 00	
205.00 Unit cost multiplier (Wkst. B, Pa	rt					0. 000000	205. 00	

Provi der CCN: 151323

						5/31/2016 11:	
	Cost Center Description	Reconciliation	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	
			& GENERAL (ACCUM. COST)	REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	
			· ´	, ,	· ·	LAUNDRY)	
	OFNEDAL CEDILOF COST OFNEDO	5A	5. 00	6. 00	7. 00	8. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01	00101 EMS WEST STATION						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01	00201 EMS WEST STATION EQUIP.						2. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0 400 040	4/ 0// 500				4.00
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS	-8, 403, 942	16, 066, 589	0			5. 00 6. 00
7. 00	00700 OPERATION OF PLANT		1, 096, 304	1	59. 401		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	87, 410	1	253	10, 000	8. 00
9.00	00900 HOUSEKEEPI NG	0	260, 986	1	828	3	9. 00
10.00	01000 DI ETARY	0	340, 749		3, 322	75	1
11.00	01100 CAFETERI A	0	225, 812		0	0	11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0	400 077	0	0	0	12.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	408, 977 739		1, 578	0	13. 00 14. 00
15. 00	01500 PHARMACY	0	697, 843	1	1, 358	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	5, 964		268	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0		0	0	20.00
21. 00 22. 00	02100 1 & R SERVI CES-SALARY & FRINGES APPRV 02200 1 & R SERVI CES-OTHER PRGM COSTS APPRV		0		0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)				0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			-			
30. 00	03000 ADULTS & PEDIATRICS	0		1		3, 301	30. 00
43. 00	04300 NURSERY	0	200, 722	. 0	264	157	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1 0	1 422 402	0	9, 994	1 E14	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		1, 422, 683 722, 110	1	1, 248	1, 516 561	52. 00
53. 00	05300 ANESTHESI OLOGY	Ö	1	•	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		1	5, 046	1, 091	54.00
60.00	06000 LABORATORY	0	917, 713	0	1, 976	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	412, 201	1	1, 034	31	65.00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	532, 435 138, 251	1	3, 312	376 128	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		86, 258		0	15	ı
69. 00	06900 ELECTROCARDI OLOGY	0	0	Ö	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	297, 589	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	214, 405		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	694, 937	1	0	0	73.00
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY		0		0	0	76. 97 76. 98
76. 99	07699 LI THOTRI PSY			1	_	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	0	0	0	
90. 01	09001 LIFEBRIDGE SENIOR CARE	0	1			0	90. 01
91.00	09100 EMERGENCY	0	1, 794, 622	2 0	6, 921	2, 021	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00	09500 AMBULANCE SERVICES	1 0	1, 493, 107	'l o	0	466	95. 00
99. 10	09910 CORF	0	0	0	_	0	99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		1		0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		<u> </u>	1] 113. 00
118.00	1	-8, 403, 942	15, 747, 977	·	55, 846	9. 741	118. 00
	NONREI MBURSABLE COST CENTERS			-	227 2 . 9	.,	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	14, 372	! 0	223	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	76, 673	1			192. 00
	07950 OCCUPATI ONAL HEALTH	0	0	0	0		194. 00
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS	0	64, 486 163, 081		0		194. 01 194. 03
	07954 ER PHYSICIAN		103,001		0		194. 03
	07953 SHI PSHEWANA RADI OLOGY AND LAB		0		0		194. 04
200.00	Cross Foot Adjustments			1			200. 00
201.00				1			201. 00
202. 00	71		8, 403, 942	2 0	1, 669, 747	140, 243	202. 00
203. 00	Part I) Unit cost multiplier (Wkst. B, Part I)		0. 523069	0. 000000	28. 109746	14. 024300	203 00
200.00	Tomic oost multiplier (what, b, fult I)	1	0. 323009	0.00000	20. 107/40	17. 024300	1-00.00

Heal th Finan	cial Systems C	COMMUNITY HOSPT. OF	F LAGRANGE CTY	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS			Provi der		Peri od:	Worksheet B-1	
					rom 01/01/2015 o 12/31/2015		
	Cost Center Description	Reconciliation				LAUNDRY &	
			& GENERAL	REPAI RS	PLANT	LINEN SERVICE	
			(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	
						LAUNDRY)	
		5A	5. 00	6.00	7. 00	8. 00	
204. 00	Cost to be allocated (per Wkst. B, Part II)		1, 165, 116	(177, 983	12, 728	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 072518	0. 000000	2. 996296	1. 272800	205. 00

Provi der CCN: 151323

				To	12/31/2015	Date/Time Pre 5/31/2016 11:	pared: 39 am
	Cost Center Description	HOUSEKEEPI NG	DIETARY		MAINTENANCE OF	NURSI NG	
		(SQUARE FEET)	(MEALS SERVED)	(FTE)	PERSONNEL (NUMBER	ADMI NI STRATI ON	
					HOUSED)	(DIRECT NRSING	
		0.00	10.00	11 00	12.00	HRS)	
	GENERAL SERVICE COST CENTERS	9. 00	10.00	11. 00	12. 00	13. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1.01	00101 EMS WEST STATION						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01	00201 EMS WEST STATION EQUIP.						2. 01
4. 00 E. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00
5. 00 6. 00	00600 MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG	58, 320					9. 00
10.00	01000 DI ETARY	3, 322	21, 261				10.00
11. 00	01100 CAFETERI A	C	1 1	8, 628	_		11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	C	1	0	0	101 000	12.00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	1, 578	1 1	495 0	0	101, 029	13. 00 14. 00
15. 00	01500 PHARMACY	1, 358	1	513	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	268	1	0	0	o o	16. 00
17. 00	01700 SOCIAL SERVICE	0	1	0	0	o o	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	C	o	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	C	0	0	0	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	C	0	0	0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	C	1 1	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	C)	0	0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	17, 534	21, 261	1, 750	0	36, 503	30. 00
43. 00	04300 NURSERY	264	1	168	0		43. 00
	ANCILLARY SERVICE COST CENTERS		-1			27 2 1 2	
50.00	05000 OPERATING ROOM	9, 994	0	1, 157	0	24, 144	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 248	0	600	0	1,	52.00
53. 00	05300 ANESTHESI OLOGY	C	1 1	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	5, 046	1	1, 078	0	0	54.00
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 976	1	0	0	0	60. 00 62. 30
65. 00	06500 RESPIRATORY THERAPY	1, 034	1	561	0		65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 312		711	0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0,010		108	0	o	67. 00
68. 00	06800 SPEECH PATHOLOGY	C	o	73	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	C	0	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	0	0	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	C		0	0	0	72.00
73. 00 76. 97	07300 DRUGS CHARGED TO PATIENTS 07697 CARDI AC REHABILITATION			0	0	0	73. 00 76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY			0	0		76. 98
76. 99		C		0	0	o o	76. 99
	OUTPATIENT SERVICE COST CENTERS		· · · · · · · · · · · · · · · · · · ·	- "			
90.00		C	1 -1	0	0	0	90. 00
90. 01	09001 LI FEBRI DGE SENI OR CARE	910	1	247	0	1	90. 01
91.00		6, 921	0	1, 167	0	24, 350	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00				0	0	0	95. 00
99. 10				0	0		99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	i c	ol ol	0	0	o o	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	C	o	0	0	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	C	0	0	0	0	99. 40
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE	F.4.7/F	04.074	0 (00		404 000	113.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	54, 765	21, 261	8, 628	0	101, 029	118.00
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	223		0	0	0	190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	3, 332		0	0		192. 00
	07950 OCCUPATI ONAL HEALTH	C	o	0	0	1	194. 00
194.01	1 07951 FOUNDATI ON	C	o	0	0	0	194. 01
	3 07952 COMMUNITY & VOLUNTEER SVCS	C	0	0	0		194. 03
	4 07954 ER PHYSICIAN	C	0	0	0	1	194. 04
	6 07953 SHI PSHEWANA RADI OLOGY AND LAB	C		0	0	0	194. 06
200.00							200. 00
201. 00 202. 00		420, 817	637, 387	343, 927	0	642, 632	201. 00
∠∪∠. ∪(Part I)	420,017	037, 307	545, 721	U	, 042, 032	202.00
	· · · · · · · · · · · · · · · · · · ·			<u>'</u>		•	

Health Financial Systems COMM	IUNI TY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2015 Fo 12/31/2015		nanad.
				10 12/31/2015	Date/Time Pre 5/31/2016 11:	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	
	(SQUARE FEET)	(MEALS SERVED)	(FTE)	PERSONNEL	ADMI NI STRATI ON	
				(NUMBER		
				HOUSED)	(DIRECT NRSING	
					HRS)	
	9. 00	10.00	11. 00	12.00	13. 00	
203.00 Unit cost multiplier (Wkst. B, Part I)	7. 215655	29. 979164	39. 861729	0. 000000	6. 360867	203. 00
204.00 Cost to be allocated (per Wkst. B,	39, 838	110, 961	16, 375	5 0	30, 597	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 683093	5. 218993	1. 897891	0. 000000	0. 302854	205. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 151323 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/31/2016 11:39 am Cost Center Description CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE NONPHYSI CI AN ANESTHETI STS SERVICES & (COSTED RECORDS & SUPPLY LI BRARY (TIME SPENT) (ASSI GNED REQUIS.) (COSTED (TIME SPENT) TIME) REQUIS.) 19.00 14.00 15.00 16.00 17.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 EMS WEST STATION 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 EMS WEST STATION EQUIP 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 1,037,488 14.00 01500 PHARMACY 15 00 28 786 272, 609 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 10,000 16.00 01700 SOCIAL SERVICE 0 17.00 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 0 19.00 0 02000 NURSI NG SCHOOL 0 O 20.00 C 20.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 C 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 89, 636 1, 464 0 0 30.00 04300 NURSERY 0 43.00 7.889 369 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 166, 615 220 161 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 28, 111 10 0 0 52.00 05300 ANESTHESI OLOGY 53 00 C 0 0 0 0 0 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 859 54.00 29.670 0 3, 224 06000 LABORATORY 60.00 C 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 65.00 5, 415 O 0 65.00 06600 PHYSI CAL THERAPY 66.00 916 66.00 4, 211 81 0 06700 OCCUPATI ONAL THERAPY 1, 425 67.00 28 191 0 67.00 68.00 06800 SPEECH PATHOLOGY 181 85 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 298, 067 0 71.00 C Λ 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 214, 405 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 267, 997 0 73.00 07697 CARDIAC REHABILITATION 0 76.97 0 C 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 C 0 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 0 0 0 90.01 09001 LIFEBRIDGE SENIOR CARE 2.906 0 0 90.01 0 91.00 09100 EMERGENCY 74, 257 438 3, 590 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 83,620 1,961 0 0 0 95.00 0 99. 10 09910 CORF 0 0 99. 10 0 99 20 09920 OUTPATIENT PHYSICAL THERAPY 0 Ω 0 99. 20 0 09930 OUTPATIENT OCCUPATIONAL THERAPY 99.30 0 C 0 0 0 99.30 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 99.40 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 118.00 1,035,194 272, 609 10,000 0 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 215 0 190. 00 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 1,892 C 0 194. 00 07950 OCCUPATIONAL HEALTH 0 0 0 194.00 0 194. 01 194. 01 07951 FOUNDATI ON 90 0 0 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 97 0 0 0 194. 03 194. 04 07954 ER PHYSICIAN 0 C 0 0 0 194. 04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 194. 06 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201 00 1, 132, 862 202.00 Cost to be allocated (per Wkst. B, 56, 869 18, 551 0 202.00 0 Part I)

Heal th Finan	cial Systems (COMMUNITY HOSPT.	OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS				Provi der		Peri od: From 01/01/2015	Worksheet B-1	
						To 12/31/2015	Date/Time Pre 5/31/2016 11:	
	Cost Center Description	CENTRAL		PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	
		SERVICES 8	ù	(COSTED	RECORDS &		ANESTHETI STS	
		SUPPLY		REQUIS.)	LI BRARY	(TIME SPENT)	(ASSI GNED	
		(COSTED			(TIME SPENT)		TIME)	
		REQUIS.)						
		14. 00		15. 00	16. 00	17. 00	19. 00	
203.00	Unit cost multiplier (Wkst. B, Part	1) 0.0548	314	4. 155629	1. 85510	0.000000	0.000000	203. 00
204.00	Cost to be allocated (per Wkst. B,	40, 9	79	87, 509	7, 38	32 0	0	204. 00
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part	0. 0246	516	0. 321006	0. 73820	0. 000000	0.000000	205. 00
	11)							

			MUNITY HOSPT. OI	F LAG				eu of Form CMS-2552-1
COST A	ALLOCA ⁻	TION - STATISTICAL BASIS			Provi der	CCN: 151323	Peri od: From 01/01/2015	Worksheet B-1
							To 12/31/2015	
					INTERNS &	RESI DENTS		5/31/2016 11:39 am
		Cook Cooker Doorsinking	MILECI NO COLICOI	CEDVI	CEC CALAE	DEEDVI OFC. OTHE	DADAMED ED	
		Cost Center Description	NURSING SCHOOL		FRI NGES	PRGM COSTS	R PARAMED ED PRGM	
			(ASSI GNED		APPRV	APPRV	(ASSI GNED	
			TI ME)		SSIGNED TIME)	(ASSI GNED TIME)	TIME)	
			20.00		21. 00	22.00	23.00	
		AL SERVICE COST CENTERS						
1. 00 1. 01	1	CAP REL COSTS-BLDG & FIXT EMS WEST STATION						1.0
2. 00		CAP REL COSTS-MVBLE EQUIP						2.0
2. 01		EMS WEST STATION EQUIP.						2.0
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						4.0
6.00		MAINTENANCE & REPAIRS						6.0
7. 00		OPERATION OF PLANT						7.0
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING						8. 0 9. 0
10.00		DI ETARY						10.0
11.00		CAFETERI A						11. 0
12. 00 13. 00		MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION						12. 0 13. 0
14. 00		CENTRAL SERVICES & SUPPLY						14. 0
15.00		PHARMACY						15.0
16. 00 17. 00	4	MEDICAL RECORDS & LIBRARY SOCIAL SERVICE						16. 0 17. 0
19. 00		NONPHYSI CI AN ANESTHETI STS						19. 0
20.00		NURSING SCHOOL	0					20.0
21. 00 22. 00	1	I&R SERVICES-SALARY & FRINGES APPRV I&R SERVICES-OTHER PRGM COSTS APPRV			C) 	0	21. 0
23. 00	02300	PARAMED ED PRGM-(SPECIFY)					0	
20.00		I ENT ROUTINE SERVICE COST CENTERS	T 0			<u> </u>		20.6
30. 00 43. 00		ADULTS & PEDI ATRI CS NURSERY	0	1	0	1	0 0	
	ANCI L	LARY SERVICE COST CENTERS						
50. 00 52. 00	1	OPERATING ROOM DELIVERY ROOM & LABOR ROOM	0 0	1	(1	0 0	
53. 00		ANESTHESI OLOGY					0 0	53.0
54.00		RADI OLOGY-DI AGNOSTI C	0		C		0 0	l
60. 00 62. 30		LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS	0		(0 0	60. 0
65. 00		RESPIRATORY THERAPY	0		C		0 0	65. 0
66. 00	1	PHYSI CAL THERAPY	0		C		0 0	66. 0
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0		(0 0	67. 0 68. 0
		ELECTROCARDI OLOGY	0		C	ó	0 0	
	1	MEDICAL SUPPLIES CHARGED TO PATIENT	0		C		0 0	
72.00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0		(0 0	72. 0 73. 0
76. 97		CARDI AC REHABI LI TATI ON	0		Č		0 0	76. 9
76. 98		HYPERBARI C OXYGEN THERAPY	0		C		0 0	76. 9
76. 99		LITHOTRIPSY TIENT SERVICE COST CENTERS] 0	7		<u>/ </u>	0 0	76. 9
90. 00	09000	CLINIC	0		C		0 0	
90. 01 91. 00		LIFEBRIDGE SENIOR CARE EMERGENCY	0		(0 0	
91.00		OBSERVATION BEDS (NON-DISTINCT PART	0	1	(1	0	91. 0
	OTHER	REIMBURSABLE COST CENTERS						
95. 00 99. 10	4	AMBULANCE SERVICES	0		(0 0	95. 0
	4	OUTPATIENT PHYSICAL THERAPY	0		C		0 0	99. 2
99. 30	4	OUTPATIENT OCCUPATIONAL THERAPY	0		C		0 0	
99. 40		OUTPATIENT SPEECH PATHOLOGY AL PURPOSE COST CENTERS	0))	0 0	99. 4
113.00		INTEREST EXPENSE						113. 0
118.00		SUBTOTALS (SUM OF LINES 1-117)	0				0 0	118. 0
190 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	1 0	ı		<u></u>	0 0	190. 0
192.00	19200	PHYSICIANS' PRIVATE OFFICES	0		C		0 0	
		OCCUPATIONAL HEALTH	0		0		0 0	194. 0
		FOUNDATION COMMUNITY & VOLUNTEER SVCS	0		() 	0 0	194. 0 194. 0
194. 04	107954	ER PHYSICIAN	0		C		o o	194. 0
		SHI PSHEWANA RADI OLOGY AND LAB	0		C)	0 0	194. 0
200. 00 201. 00	4	Cross Foot Adjustments Negative Cost Centers						200. 0 201. 0
	1		1	·		1	1	1

Health Financial Systems	COMMUNITY HOSPT. C	F LAGRANGE CTY	IN	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1		
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/31/2016 11:		
		INTERNS &	RESI DENTS				
Cost Center Description	NURSI NG SCHOOL	SERVI CES-SALAR					
	(ASSI GNED TI ME)	Y & FRINGES APPRV (ASSI GNED	PRGM COSTS APPRV (ASSI GNED	PRGM (ASSI GNED TI ME)			
	20.00	TI ME) 21. 00	TI ME) 22. 00	23. 00			
202.00 Cost to be allocated (per Wkst. B	(0	(0		202. 00	
203.00 Unit cost multiplier (Wkst. B, Pa	rt I) 0.00000	0. 000000	0. 000000	0. 000000		203. 00	
204.00 Cost to be allocated (per Wkst. B Part II)	6,	0	(0		204. 00	
205.00 Unit cost multiplier (Wkst. B, Pa	o. 000000	0. 000000	0. 000000	0. 000000		205. 00	

Health Financial Systems

COMMUNITY HOSPT. OF LAGRANGE CTY IN

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151323

Period:
From 01/01/2015
To 12/31/2015

Title XVIII Hospital

Cost

Cost

Cost

Cost

Therapy Limit Total Costs
(From Wkst. B, Part I col.)

Provider CCN: 151323

Period:
From 01/01/2015
Disallowance

From CMS-2552-10

Worksheet C
Part I
Date/Time Prepared:
5/31/2016 11:39 am

Cost

Therapy Limit Total Costs
Disallowance

Disallowance

			T: +1	- \/\/	11: 4-1	07-11	37 aiii
			11 11	e XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	4, 686, 190		4, 686, 190	0	0	30.00
43. 00	04300 NURSERY	347, 413		347, 413		0	
43.00	ANCI LLARY SERVI CE COST CENTERS	347,413	1	347, 413	<u> </u>	0	45.00
50. 00	05000 OPERATING ROOM	2, 751, 190	ı	2, 751, 190	O	0	50.00
		1	l .			·	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 256, 909		1, 256, 909		0	
53.00	05300 ANESTHESI OLOGY	102, 018		102, 018		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 291, 890	l .	2, 291, 890		0	0 00
60.00	06000 LABORATORY	1, 467, 543		1, 467, 543	0	0	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	
65.00	06500 RESPI RATORY THERAPY	687, 431	0	687, 431	0	0	00.00
66.00	06600 PHYSI CAL THERAPY	963, 814	0	963, 814	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	217, 214	0	217, 214	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	134, 677	0	134, 677	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0		0		0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	469, 588		469, 588	0	0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	338, 306		338, 306		0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 172, 135		2, 172, 135		0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	2, 172, 133		2, 172, 133	0	0	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY				0	0	1
	I I			0	0	_	1
76. 99	07699 LI THOTRI PSY			0	U	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	_		_		_	
90.00	09000 CLI NI C	0		0	-	0	
90. 01	09001 LI FEBRI DGE SENI OR CARE	456, 112	l .	456, 112		0	
91. 00	09100 EMERGENCY	3, 220, 119		3, 220, 119		0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	854, 514		854, 514		0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	2, 293, 373		2, 293, 373	0	0	95. 00
99. 10	09910 CORF	0		0		0	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0		0		0	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0		0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0		0		0	1
, ,	SPECIAL PURPOSE COST CENTERS	1		·			1
							113. 00
200.00		24, 710, 436	0	24, 710, 436	0	0	200. 00
200.00	,	854, 514	l .	854, 514			201. 00
	I I						
202.00	Total (see instructions)	23, 855, 922	0	23, 855, 922	0	U	202. 00

202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 151323 Peri od: Worksheet C From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/31/2016 11:39 am Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 5, 132, 581 5, 132, 581 30.00 30.00 43.00 04300 NURSERY 464, 130 464, 130 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 712, 807 8, 818, 680 11, 531, 487 0. 238581 0.000000 50.00 0.755965 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52 00 1,662,656 1, 662, 656 52 00 53.00 05300 ANESTHESI OLOGY 291, 666 1,006,814 1, 298, 480 0.078567 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 481, 488 18, 487, 955 19, 969, 443 0.114770 0.000000 54.00 06000 LABORATORY 1, 250, 047 0.235280 0.000000 60.00 4, 987, 378 6, 237, 425 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 0.000000 62 30 65.00 06500 RESPIRATORY THERAPY 616, 234 1, 521, 148 2, 137, 382 0.321623 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 307,001 1, 394, 883 1, 701, 884 0.566322 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 292, 979 325, 582 0.351160 67.00 618, 561 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 33, 742 121, 649 155, 391 0.866698 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 492, 464 1, 087, 195 1, 579, 659 0.297272 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 790.599 304.474 1, 095, 073 0.308935 72 00 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 640, 252 4,610,900 7, 251, 152 0.299557 0.000000 73.00 07697 CARDIAC REHABILITATION 0.000000 76. 97 0 0 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 0 0 0.000000 0.000000 07699 LI THOTRI PSY 76.99 0 C 0 0.000000 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 90 01 09001 LIFEBRIDGE SENIOR CARE 488 166 488 166 0 934338 0.000000 90 01 0 429, 107 91.00 09100 EMERGENCY 10, 538, 091 10, 967, 198 0.293614 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 906, 221 906, 221 0.942942 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 0.000000 95.00 09500 AMBULANCE SERVICES 0 3, 800, 460 3, 800, 460 0.603446 99.10 09910 CORF 0 99.10 09920 OUTPATIENT PHYSICAL THERAPY 0 99. 20 0 0 99. 20 0 99 30 09930 OUTPATIENT OCCUPATIONAL THERAPY C O 99 30 09940 OUTPATIENT SPEECH PATHOLOGY 0 99.40 99.40 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 200 00 18, 597, 753 76, 997, 349 58, 399, 596 200. 00 Subtotal (see instructions) 201. 00

18, 597, 753

76, 997, 349

58, 399, 596

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES COMMUNITY HOSPT. OF LAGRANGE CTY IN Provi der CCN: 151323

				5/31/2016 11:39 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 000000			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 000000			90. 01
91. 00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92. 00
OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
99. 10 09910 CORF				99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY				99. 20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY				99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY				99. 40
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 NTEREST EXPENSE				113. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00
(1			12.00

Health Financial Systems	COMMUNITY HOSPT. OF	LAGRANGE CTY	I N	In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151323	Peri od: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/31/2016 11:	
		Ti t	le XIX	Hospi tal	PPS	<u> </u>
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

			III	ie xix	ноѕрі таі	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	'	(from Wkst. B,			Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	4, 686, 190)	4, 686, 190	0	4, 686, 190	30.00
43.00	04300 NURSERY	347, 413		347, 413	0	347, 413	43.00
	ANCILLARY SERVICE COST CENTERS		'				
50.00	05000 OPERATING ROOM	2, 751, 190)	2, 751, 190	0	2, 751, 190	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 256, 909		1, 256, 909	0	1, 256, 909	52. 00
53.00	05300 ANESTHESI OLOGY	102, 018		102, 018	0	102, 018	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 291, 890		2, 291, 890		2, 291, 890	
60.00	06000 LABORATORY	1, 467, 543	1	1, 467, 543		1, 467, 543	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	687, 431	0	687, 431	0	687, 431	
66. 00	06600 PHYSI CAL THERAPY	963, 814		963, 814	0	963, 814	
67. 00	06700 OCCUPATI ONAL THERAPY	217, 214		217, 214	0	217, 214	
68. 00	06800 SPEECH PATHOLOGY	134, 677	1	134, 677	0	134, 677	
69. 00	06900 ELECTROCARDI OLOGY	,	,	0	0	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	469, 588		469, 588	0	469, 588	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	338, 306		338, 306		338, 306	
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 172, 135	 	2, 172, 135	0	2, 172, 135	
76. 97	07697 CARDI AC REHABI LI TATI ON	_,,		0	0	0	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY			0	0	0	1
76. 99	07699 LI THOTRI PSY			1 0	0	0	76. 99
, 0. , ,	OUTPATIENT SERVICE COST CENTERS		1			<u> </u>	70.77
90.00	09000 CLI NI C	C		0	0	0	90.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	456, 112		456, 112	0	456, 112	90. 01
91. 00	09100 EMERGENCY	3, 220, 119	1	3, 220, 119		3, 220, 119	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	854, 514		854, 514		854, 514	
	OTHER REIMBURSABLE COST CENTERS			20., 2			
95.00	09500 AMBULANCE SERVICES	2, 293, 373		2, 293, 373	0	2, 293, 373	95. 00
99. 10)	0		0	
99. 20	09920 OUTPATIENT PHYSICAL THERAPY)	0		0	1
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY)	0		0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY)	0		0	99. 40
	SPECIAL PURPOSE COST CENTERS		'		l		
113.00	11300 NTEREST EXPENSE						113. 00
200.00	Subtotal (see instructions)	24, 710, 436	0	24, 710, 436	0	24, 710, 436	200.00
201.00		854, 514		854, 514		854, 514	
202.00	Total (see instructions)	23, 855, 922	. 0	23, 855, 922	0	23, 855, 922	202. 00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 151323 Peri od: Worksheet C From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/31/2016 11:39 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 5, 132, 581 5, 132, 581 30.00 30.00 43.00 04300 NURSERY 464, 130 464, 130 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 712, 807 8, 818, 680 11, 531, 487 0. 238581 0.000000 50.00 05200 DELIVERY ROOM & LABOR ROOM 0.755965 0.000000 52 00 1,662,656 1, 662, 656 52 00 53.00 05300 ANESTHESI OLOGY 291, 666 1,006,814 1, 298, 480 0.078567 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 481, 488 18, 487, 955 19, 969, 443 0.114770 0.000000 54.00 06000 LABORATORY 1, 250, 047 0.235280 0.000000 60.00 4, 987, 378 6, 237, 425 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 0.000000 62 30 65.00 06500 RESPIRATORY THERAPY 616, 234 1, 521, 148 2, 137, 382 0.321623 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 307,001 1, 394, 883 1, 701, 884 0.566322 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 292, 979 325, 582 0.351160 67.00 618, 561 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 33, 742 121, 649 155, 391 0.866698 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 492, 464 1, 087, 195 1, 579, 659 0.297272 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 790.599 304.474 1, 095, 073 0.308935 72 00 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 640, 252 4,610,900 7, 251, 152 0.299557 0.000000 73.00 07697 CARDIAC REHABILITATION 0.000000 76. 97 0 0 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 0 0 0.000000 0.000000 07699 LI THOTRI PSY 76.99 0 C 0 0.000000 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 90 01 09001 LIFEBRIDGE SENIOR CARE 488 166 488 166 0 934338 0.000000 90 01 0 429, 107 91.00 09100 EMERGENCY 10, 538, 091 10, 967, 198 0.293614 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 906, 221 906, 221 0.942942 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 0.000000 95.00 09500 AMBULANCE SERVICES 0 3, 800, 460 3, 800, 460 0.603446 99.10 09910 CORF 0 99.10 09920 OUTPATIENT PHYSICAL THERAPY 0 99. 20 0 0 99. 20 0 99 30 09930 OUTPATIENT OCCUPATIONAL THERAPY C O 99 30

18, 597, 753

18, 597, 753

58, 399, 596

58, 399, 596

0

76, 997, 349

76, 997, 349

99.40

113.00

200. 00

201. 00

202. 00

09940 OUTPATIENT SPEECH PATHOLOGY

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

SPECIAL PURPOSE COST CENTERS

113. 00 11300 INTEREST EXPENSE

99.40

200 00

201.00

202.00

Health Financial Systems In Lieu of Form CMS-2552-10 COMMUNITY HOSPT. OF LAGRANGE CTY IN COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 151323 Peri od: Worksheet C Part I

From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/31/2016 11:39 am Title XIX Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 43.00 04300 NURSERY ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 238581 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 755965 53.00 05300 ANESTHESI OLOGY 0.078567 05400 RADI OLOGY-DI AGNOSTI C 0. 114770 54.00 60.00 06000 LABORATORY 0. 235280 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 06500 RESPIRATORY THERAPY 65.00 0. 321623 66.00 06600 PHYSI CAL THERAPY 0.566322 67.00 06700 OCCUPATIONAL THERAPY 0. 351160 06800 SPEECH PATHOLOGY 0.866698 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 297272 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 308935 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 299557 73.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0.000000 07699 LI THOTRI PSY 76. 99 0.000000 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.01 09001 LIFEBRIDGE SENIOR CARE 0. 934338

30.00 43.00 50.00 52.00 53.00 54.00 60.00 62.30 65 00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 76.97 76.98 76. 99 90.00 90.01 91.00 09100 EMERGENCY 0. 293614 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 0. 942942 92.00 92.00 95.00 09500 AMBULANCE SERVICES 95.00 0.603446 99. 10 09910 CORF 99. 10 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 99. 20 99. 30 |09930 OUTPATIENT OCCUPATIONAL THERAPY 99.30 09940 OUTPATIENT SPEECH PATHOLOGY 99. 40 99.40 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200. 00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 202.00

Health Financial Systems COMMUNITY HOSPT.
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: | To 12/31/2015 | Date/Time Prepared: | To 12/31/2016 Provi der CCN: 151323

					10 12/31/2013	5/31/2016 11:	
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Cos		Operating Cost	
	'	(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
		·		col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	2, 751, 190	378, 092	2, 373, 09	8 0	0	50. 00
	05200 DELIVERY ROOM & LABOR ROOM	1, 256, 909			7 0	0	52. 00
	05300 ANESTHESI OLOGY	102, 018	4, 857	97, 16	1 0	0	53. 00
	D5400 RADI OLOGY-DI AGNOSTI C	2, 291, 890	235, 141	2, 056, 74	9 0	0	54.00
	06000 LABORATORY	1, 467, 543	117, 799	1, 349, 74	4 0	0	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	687, 431	57, 945	629, 48	6 0	0	65. 00
	06600 PHYSI CAL THERAPY	963, 814	127, 141	836, 67	3 0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	217, 214	10, 579	206, 63	5 0	0	67. 00
	06800 SPEECH PATHOLOGY	134, 677	6, 481	128, 19	6 0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	1	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	469, 588			8 0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	338, 306	20, 826	317, 48	0	0	72. 00
	D7300 DRUGS CHARGED TO PATIENTS	2, 172, 135	136, 423	2, 035, 71	2 0	0	73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0)	0	0	76. 97
	07698 HYPERBARIC OXYGEN THERAPY	0	0	1	0	0	76. 98
	07699 LI THOTRI PSY	0	0		0 0	0	76. 99
	DUTPATIENT SERVICE COST CENTERS	_					
	09000 CLI NI C	0	0	1	0	0	90. 00
	09001 LI FEBRI DGE SENI OR CARE	456, 112				0	90. 01
	D9100 EMERGENCY	3, 220, 119				0	91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	854, 514	154, 200	700, 31	4 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	2, 293, 373	133, 503	2, 159, 87	0	_	95. 00
	09910 CORF	0	0		0	0	99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	0	0		0	0	99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		0	0	99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0		0 0	0	99. 40
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
200.00	Subtotal (sum of lines 50 thru 199)	19, 676, 833					200. 00
201.00	Less Observation Beds	854, 514					201. 00
202.00	Total (line 200 minus line 201)	18, 822, 319	1, 719, 048	17, 103, 27	1 0	0	202. 00

REDUCTIONS FOR MEDICALD ONLY

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 5/31/2016 | 11:39 am

					5/31/2016 11:	39 am
			le 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			
	Reducti on	8)	/ col. 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	2, 751, 190	11, 531, 487	0. 238581			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 256, 909	1, 662, 656	0. 755965			52.00
53. 00 05300 ANESTHESI OLOGY	102, 018	1, 298, 480	0. 078567			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 291, 890	19, 969, 443	0. 114770			54.00
60. 00 06000 LABORATORY	1, 467, 543	6, 237, 425	0. 235280			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	687, 431	2, 137, 382	0. 321623			65. 00
66. 00 06600 PHYSI CAL THERAPY	963, 814	1, 701, 884	0. 566322			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	217, 214	618, 561	0. 351160			67.00
68.00 06800 SPEECH PATHOLOGY	134, 677	155, 391	0. 866698			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	469, 588	1, 579, 659	0. 297272			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	338, 306	1, 095, 073	0. 308935			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 172, 135	7, 251, 152	0. 299557			73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.000000			76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.000000			76. 99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0	0	0.000000			90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	456, 112	488, 166	0. 934338			90. 01
91. 00 09100 EMERGENCY	3, 220, 119	10, 967, 198	0. 293614			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	854, 514	906, 221	0. 942942			92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	2, 293, 373	3, 800, 460	0. 603446			95. 00
99. 10 09910 CORF	0	0	0.000000			99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0.000000			99. 20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0.000000			99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0.000000			99. 40
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (sum of lines 50 thru 199)	19, 676, 833	71, 400, 638				200.00
201.00 Less Observation Beds	854, 514					201.00
202.00 Total (line 200 minus line 201)	18, 822, 319					202.00
		,	. ,			•

Provider CN: 151323	Heal th	Financial Systems COMM	IUNI TY HOSPT. O	F LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
Cost Center Description	APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der				
Cost Center Description								nanad.
Cost Center Description						10 12/31/2013		
Related Cost (From Wkst. B, Part II, col.				Ti tl	e XVIII	Hospi tal		
Column 4) Column 4		Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent		
Part II, col. 26 260 1,00 2,00 3,00 4,00 5,00			Related Cost				(column 3 x	
ANCI LLARY SERVI CE COST CENTERS 1.00 2.00 3.00 4.00 5.00						Charges	column 4)	
1.00 2.00 3.00 4.00 5.00 5.00				8)	2)			
ANCI LLARY SERVICE COST CENTERS								
50. 00 05000 OPERATING ROOM 050000 OPERATING ROOM 05000 OPERATING ROOM 050000 OPERATING ROOM 050000 OPERATING ROOM 050000 OPERATING ROOM 050000 OPERATING ROOM 05000000 OPERATING ROOM 050000 OPERATING ROOM 050000 OPERATING ROOM 0500000 OPERATING ROOM 0500000 OPERATING ROOM 0500000 OPERATING ROOM 05000000 OPERATING ROOM 05000000 OPERATING ROOM 05000000 OPERATING ROOM 05000000 OPERATING ROOM 050000000 OPERATING ROOM 0500000000 OPERATING ROOM 050000000 OPERATING ROOM 0500000000 OPERATING ROOM 0500000000 OPERATING ROOM 05000000000 OPERATING ROOM 05000000000 OPERATING ROOM 0500000000000 OPERATING ROOM 050000000000000000000000000000000000			1.00	2. 00	3. 00	4. 00	5. 00	
52. 00 05200 DELIVERY ROOM & LABOR ROOM 91, 072 1, 662, 656 0.054775 0 0 52.00 53.00 05300 ANESTHESI OLOGY 4, 857 1, 298, 480 0.003741 43, 887 164 53.00 05400 RADIOLOGY-DIAGNOSTIC 235, 141 19, 969, 443 0.011775 415, 602 4, 894 54.00 06000 LABORATORY 117, 799 6, 237, 425 0.018886 355, 053 6, 706 60.00 06000 LABORATORY 117, 799 6, 237, 425 0.018886 355, 053 6, 706 60.00 06000 LABORATORY 57, 945 2, 137, 382 0.027110 234, 842 6, 367 65.00 06000 PHYSI CAL THERAPY 57, 945 2, 137, 382 0.027110 234, 842 6, 367 65.00 06000 PHYSI CAL THERAPY 127, 141 1, 701, 884 0.074706 86, 944 6, 495 66.00 06000 PHYSI CAL THERAPY 10, 579 618, 561 0.017103 76, 945 1, 316 67.00 06000 PHYSI CAL THERAPY 10, 579 618, 561 0.017103 76, 945 1, 316 67.00 06000 PHYSI CAL SUPPLIES CHARGED TO PATI ENT 28, 920 1, 579, 659 0.018308 165, 835 3, 036 71.00 07300 DRIGG CHARGED TO PATI ENT 28, 920 1, 579, 659 0.018308 165, 835 3, 036 71.00 07300 DRIGG CHARGED TO PATI ENTS 20, 826 1, 095, 073 0.019018 245, 622 4, 671 72.00 17300 DRIGG CHARGED TO PATI ENTS 20, 826 1, 095, 073 0.019018 245, 622 4, 671 72.00 07300 DRIGG CHARGED TO PATI ENTS 20, 826 1, 095, 073 0.019018 245, 622 4, 671 72.00 07300 DRIGG CHARGED TO PATI ENTS 20, 826 1, 095, 073 0.019018 245, 622 4, 671 72.00 07300 DRIGG CHARGED TO PATI ENTS 20, 826 1, 095, 073 0.019018 245, 622 4, 671 72.00 07300 DRIGG CHARGED TO PATI ENTS 20, 826 1, 095, 073 0.019018 245, 622 4, 671 72.00 07300 DRIGG CHARGED TO PATI ENTS 20, 826 1, 095, 073 0.019018 245, 622 4, 671 72.00 07300 DRIGG CHARGED TO PATI ENTS 20, 826 1, 095, 073 0.019018 245, 622 4, 671 72.00 07300 DRIGG CHARGED TO PATI ENTS 20, 826 1, 095, 073 0.019018 245, 622 4, 671 72.00 07300 DRIGG CHARGED TO PATI ENTS 20, 826 1, 095, 073 0.019018 245, 622 4, 671 72.00 07300 DRIGG CHARGED TO PATI ENTS 20, 826 1, 095, 073 0.019018 245, 622 4, 671 72.00 07300 DRIGG CHARGED TO PATI ENTS 200, 000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000								
53. 00 05300 ANESTHESI OLOGY							10, 914	
54. 00							_	
60.00 06000 LABORATORY 117,799 6,237,425 0.018886 355,053 6,706 60.00 62.30 65.00 06500 RESPIRATORY THERAPY 57,945 2,137,382 0.027110 234,842 6,367 65.00 66.00 06600 PHYSI CAL THERAPY 127,141 1,701,884 0.074706 86,944 6,495 66.00 66.00 06600 PHYSI CAL THERAPY 10,579 618,561 0.017103 76,945 1,316 67.00 68.00 06800 SPEECH PATHOLOGY 6,481 155,391 0.041708 9,931 414 68.00 69.00 69.00 ELECTROCARDI OLOGY 0 0 0.000000 0 0 0.000000 0								
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0.0000000 0 0 62. 30 65. 00 06500 RESPIRATORY THERAPY 57,945 2,137,382 0.027110 234,842 6,367 65. 00 66. 00 06600 PHYSI CAL THERAPY 127,141 1,701,884 0.074706 86,944 6,495 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 10,579 618,561 0.017103 76,945 1,316 67. 00 68. 00 06800 SPEECH PATHOLOGY 6,481 155,391 0.041708 9,931 414 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 28,920 1,579,659 0.018308 165,835 3,036 71. 00 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 20,826 1,095,073 0.019018 245,622 4,671 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 136,423 7,251,152 0.018814 715,605 13,463 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0.000000 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0.000000 0 0 76. 98 76. 99 00 09900 LI THOTRI PSY 0 0 0.000000 0 0 76. 99 000 00000 CLI NI C 0 0 0.000000 0 0 90. 01 90. 01 09001 LI FEBRI DGE SENI OR CARE 43,852 488,166 0.089830 0 0 90. 01 91. 00 09100 EMERGENCY 326,417 10,967,198 0.029763 33,960 1,011 91. 00 92. 00 07000 OTHER REI MBURSSABLE COST CENTERS 95. 00 95. 00 09500 AMBULANCE SERVI CES 95. 00								
65. 00 06500 RESPI RATORY THERAPY 57, 945 2, 137, 382 0. 0. 027110 234, 842 6, 367 65. 00 66. 00 06500 PHYSI CAL THERAPY 127, 141 1, 701, 884 0. 074706 86, 944 6, 495 66. 00 67. 00 0CCUPATI ONAL THERAPY 10, 579 618, 561 0. 017103 76, 945 1, 316 67. 00 06800 SPEECH PATHOLOGY 6, 481 155, 391 0. 041708 9, 931 414 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0. 000000 0 0 0 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 28, 920 1, 579, 659 0. 018308 165, 835 3, 036 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 20, 826 1, 095, 073 0. 019018 245, 622 4, 671 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 136, 423 7, 251, 152 0. 018814 715, 605 13, 463 73. 00 07697 CARDI AC REHABI LI TATI ON 0 0 0. 000000 0 0 76. 97 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 0. 000000 0 0 76. 98 07699 LI THOTRI PSY 0 0 0. 0. 000000 0 0 0 76. 99 07699 LI THOTRI PSY 0 0 0. 0. 000000 0 0 0 0 0 0 00000 0 0 0 0 000000			117, 799	6, 237, 425			6, 706	
66. 00 06600 PHYSI CAL THERAPY 127, 141 1, 701, 884 0. 074706 86, 944 6, 495 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 10, 579 618, 561 0. 017103 76, 945 1, 316 67. 00 68. 00 06800 SPECH PATHOLOGY 6, 481 155, 391 0. 041708 9, 931 414 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0. 000000 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 28, 920 1, 579, 659 0. 018308 165, 835 3, 366 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 20, 826 1, 095, 073 0. 019018 245, 622 4, 671 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 136, 423 7, 251, 152 0. 018814 715, 605 13, 463 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0. 000000 0 0 76. 97 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0. 0000000 0 0 0 76. 98 76. 99 000 07699 LI THOTRI PSY 0 0 0. 0000000 0 0 0 0 0 0 0 0 0 0	62. 30		0	0			0	62. 30
67. 00 06700 0CCUPATI ONAL THERAPY 10, 579 618, 561 0. 017103 76, 945 1, 316 67. 00 68. 00 06800 SPEECH PATHOLOGY 6, 481 155, 391 0. 041708 9, 931 414 68. 00 0. 000000 0 0. 0000000 0			57, 945	2, 137, 382			6, 367	65. 00
68. 00 06800 SPEECH PATHOLOGY 6, 481 155, 391 0. 041708 9, 931 414 68. 00 69. 00 06900 ELECTROCARDIOLOGY 0 0 0. 0000000 0 0 69. 00 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 28, 920 1, 579, 659 0. 018308 165, 835 3, 036 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 20, 826 1, 095, 073 0. 019018 245, 622 4, 671 72. 00 7300 DRUGS CHARGED TO PATIENTS 136, 423 7, 251, 152 0. 018814 715, 605 13, 463 73. 00 07300 DRUGS CHARGED TO PATIENTS 136, 423 7, 251, 152 0. 018814 715, 605 13, 463 73. 00 07697 CARDI AC REHABILI TATI ON 0 0 0. 0000000 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0. 0000000 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0. 0000000 0 0 0 76. 99 0000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0			127, 141	1, 701, 884	0. 07470	6 86, 944	6, 495	66. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0.000000 0 0.000000 0 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 28, 920 1, 579, 659 0.018308 165, 835 3, 036 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 20, 826 1, 095, 073 0.019018 245, 622 4, 671 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 136, 423 7, 251, 152 0.018814 715, 605 13, 463 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0.000000 0 0 76. 98 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0.000000 0 0 0 76. 98 76. 99 000 09000 CLI NI C 0 0 0.000000 0 0 0 76. 99 000 09000 CLI NI C 0 0 0.000000 0 0 0 0 0 0 0 0 0 0 0 0	67.00	06700 OCCUPATI ONAL THERAPY	10, 579	618, 561	0. 01710	76, 945	1, 316	67. 00
71. 00	68. 00	06800 SPEECH PATHOLOGY	6, 481	155, 391	0. 04170	9, 931	414	68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 20, 826 1, 095, 073 0. 019018 245, 622 4, 671 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 136, 423 7, 251, 152 0. 018814 715, 605 13, 463 73. 00 76. 97 07697 CARDI AC REHABILITATI ON 0 0 0. 000000 0 0 76. 97 076. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0. 0000000 0 0 0 76. 98 076. 99 07699 LI THOTRI PSY 0 0 0. 0000000 0 0 0 76. 99 0000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0	69.00	06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 136, 423 7, 251, 152 0. 018814 715, 605 13, 463 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0. 000000 0 0 76. 97 0. 000000 0 0 0. 000000 0 0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 920	1, 579, 659	0. 01830	165, 835	3, 036	71. 00
76. 97 76. 97 76. 98 76. 98 76. 99 07699 HYPERBARI C OXYGEN THERAPY 0 0 0 0.000000 0 0 76. 98 76. 99 00TPATIENT SERVICE COST CENTERS 90. 00 90.01 90.01 90.01 90.01 90.00 09100 EMERGENCY 92. 00 09200 OSSERVATION BEDS (NON-DISTINCT PART 154, 200 906, 221 0.170157 0 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	20, 826	1, 095, 073	0. 01901	8 245, 622	4, 671	72. 00
76. 98 76. 99 76	73.00	07300 DRUGS CHARGED TO PATIENTS	136, 423	7, 251, 152	0. 01881	4 715, 605	13, 463	73. 00
76. 99 07699 LI THOTRI PSY 0 0 0.000000 0 0 76. 99 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0.000000 0 0 0 90. 00 90. 01 09001 LI FEBRI DGE SENI OR CARE 43, 852 488, 166 0.089830 0 0 90. 01 91. 00 09100 EMERGENCY 326, 417 10, 967, 198 0.029763 33, 960 1, 011 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 154, 200 906, 221 0.170157 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	76. 97	07697 CARDIAC REHABILITATION	0	0	0.00000	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS 90.00 00.000000 0 0 0 0 0 0	76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0	0	76. 98
90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0	76. 99	07699 LI THOTRI PSY	0	0	0.00000	0	0	76. 99
90. 01 09001 LI FEBRI DGE SENI OR CARE		OUTPATIENT SERVICE COST CENTERS	•		•			
91. 00 09100 EMERGENCY 326, 417 10, 967, 198 0. 029763 33, 960 1, 011 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 154, 200 906, 221 0. 170157 0 0 92. 00 071HER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00 95.	90.00	09000 CLI NI C	0	0	0.00000	0 0	0	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 154, 200 906, 221 0.170157 0 0 92. 00	90. 01	09001 LI FEBRI DGE SENI OR CARE	43, 852	488, 166	0. 08983	0	0	90. 01
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 154, 200 906, 221 0.170157 0 0 92. 00	91. 00	09100 EMERGENCY	326, 417	10, 967, 198	0. 02976	33, 960	1, 011	91.00
95. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	154, 200	906, 221	0. 17015			92.00
200. 00 Total (Lines 50-199) 1, 739, 745 67, 600, 178 2, 717, 082 59, 451 200. 00	95.00	09500 AMBULANCE SERVI CES						95. 00
	200.00	Total (lines 50-199)	1, 739, 745	67, 600, 178		2, 717, 082	59, 451	200. 00

| Peri od: | Worksheet D | From 01/01/2015 | Part IV | To 12/31/2015 | Date/Time Prepared: | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | 11/202 | THROUGH COSTS

				'	0 12/31/2013	5/31/2016 11:	39 am
			Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	,					
50.00	05000 OPERATI NG ROOM	0	0	0	0	0	00.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	01	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	01	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	01	54. 00
60. 00	06000 LABORATORY	0	0	0	0	01	60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	01	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	01	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	01	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	01	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	01	68. 00
	06900 ELECTROCARDI OLOGY	0	0	0	0	01	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	01	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	C	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0	0	0	01	90.00
	09001 LI FEBRI DGE SENI OR CARE	0	0	0	0	01	90. 01
	09100 EMERGENCY	0	0	0	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	C	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	0	0	0	0	200. 00

Health Financial Systems	COMMUNITY HOSPT. OF LAG	GRANGE CTY IN	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENTHROUGH COSTS	Γ ANCILLARY SERVICE OTHER PASS	Provider CCN: 151323	Peri od: From 01/01/2015	Worksheet D Part IV Date/Time Prepared

THROUGH COSTS					rom 01/01/2015 To 12/31/2015	Part IV Date/Time Pre 5/31/2016 11:	
			Ti †l	e XVIII	Hospi tal	Cost	37 alli
Cost Center Description	Total	Total		Ratio of Cost		Inpatient	
			Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of			(col. 5 ÷ col.	to Charges	Charges	
	col . 2, 3 and		8)	7)	(col. 6 ÷ col.	ŭ	
	4)				7)		
	6.00	1	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	0	11	1, 531, 487	0. 000000	0.000000	332, 856	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1	1, 662, 656	0. 000000	0.000000	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	-	1, 298, 480	0. 000000	0.000000	43, 887	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	19	9, 969, 443	0. 000000	0.000000	415, 602	54.00
60. 00 06000 LABORATORY	0		5, 237, 425	0. 000000	0.000000	355, 053	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0.000000	0.000000	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	1 2	2, 137, 382	0. 000000	0. 000000	234, 842	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	-	1, 701, 884	0. 000000	0. 000000	86, 944	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		618, 561	0. 000000	0. 000000	76, 945	67. 00
68. 00 06800 SPEECH PATHOLOGY	0		155, 391	0. 000000	0. 000000	9, 931	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		0	0. 000000	0. 000000	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		1, 579, 659	0. 000000	0. 000000	165, 835	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		1, 095, 073	0. 000000	0. 000000	245, 622	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	1 -	7, 251, 152	0. 000000	0. 000000	715, 605	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0		0	0. 000000	0. 000000	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0	0. 000000	0. 000000	0	76. 98
76. 99 07699 LI THOTRI PSY	0		0	0. 000000	0. 000000	0	76. 99
OUTPATIENT SERVICE COST CENTERS		•					
90. 00 09000 CLI NI C	0		0	0.00000	0.000000	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0		488, 166	0. 000000	0. 000000	0	90. 01
91. 00 09100 EMERGENCY	0	10	0, 967, 198	0. 000000	0. 000000	33, 960	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0		906, 221	0. 000000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS	•			-	<u>'</u>		
95. 00 09500 AMBULANCE SERVI CES							95. 00
200.00 Total (lines 50-199)	0	6	7, 600, 178			2, 717, 082	200. 00

 Heal th Financial
 Systems
 COMMUNITY HOSPT.
 OF

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 COMMUNITY HOSPT. OF LAGRANGE CTY IN Provi der CCN: 151323

THROUGH COSTS

Title XVIII Hospital Cost Cost Center Description Inpatient Program Pass-Through Costs (col. 8 x. col. 10) 12.00 13.00 Forgram Pass-Through Costs (col. 9 x. col. 12)						5/31/2016 11:	:39 am
Program Pass-Through Costs (col. 8 x col. 10)			Ti tl	e XVIII	Hospi tal	Cost	
Pass-Through Costs (col. 8 x col. 10)	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
ANCILLARY SERVICE COST CENTERS 11.00 12.00 13.00		Program	Program	Program			
X COI			Charges				
11.00 12.00 13.00)		
ANCI LLARY SERVICE COST CENTERS							
50.00 05000 OPERATI NG ROOM 0 0 0 0 0 0 0 0 0		11.00	12. 00	13. 00			
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 53.00							
53.00 05300 ANESTHESI OLOGY 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 60.00 05400 LABORATORY 0 0 0 0 62.30 05250 BLODD CLOTTI NG FOR HEMOPHI LI ACS 0 0 0 0 65.00 05500 RESPI RATORY THERAPY 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76.99 07699 LI THOTRI PSY 0 0 0 90.00 09000 CLINI C 0 0 0 90.01 09000 CLINI C 0 0 0 90.01 09000 CLIR REGENCY 0 0 0 90.01 09000 CLIR REGENCY 0 0 0 90.01 09000 CLIR REGENCY 0 0 0 90.00 09100 EMERGENCY 0 0 0 90.00 09100 EMERGENCY 0 0 0 90.00 OTHER REI MBURSABLE COST CENTERS 95.00		0	C)	0		
S4.00		0	C)	0		
60. 00 06000 LABORATORY 0 0 0 0 0 62. 30 65. 00 6250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0 0 0 0 0 62. 30 65. 00 66500 RESPI RATORY THERAPY 0 0 0 0 0 65. 00 66. 00 66.00 PHYSI CAL THERAPY 0 0 0 0 0 66. 00 66.00 PHYSI CAL THERAPY 0 0 0 0 0 66. 00 66.00 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 66. 00 66.00 PHYSI CAL THERAPY 0 0 0 0 0 0 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 0 0 0	53. 00 05300 ANESTHESI OLOGY	0	C)	0		
62. 30		0	C		0		
65. 00		0	C		0		
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 72. 00 07200 IMPL DEV CHARGED TO PATI ENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76. 99 000 07699 LI THOTRI PSY 0 0 0 76. 99 001 09000 CLI NI C 0 0 76. 99 001 09000 CLI NI C 0 0 76. 99 001 09000 CLI NI C 0 0 76. 99 001 09000 DRUGS SENI OR CARE 0 0 0 76. 90 09000 DRUGS CHARGED TO PATI ENTS 0 0 76. 99 001 09000 DRUGS CHARGED TO PATI ENTS 76. 99 001 09000 09000 09000 09000 09000 76. 99 001 09000 09000 09000 09000 09000 76. 99 001 09000 09000 09000 09000 76. 99 001 09000 09000 09000 09000 76. 99 001 09000 09000 09000 09000 09000 76. 99 0000 09000 09000 09000 09000 76. 99 0000 09000 09000 09000 09000 76. 99 0000 09000 09000 09000 09000 76. 90 09000 09000 09000 09000 09000 76. 90 09000 09000 09000 09000 09000 76. 90 09000 09000 09000 09000 09000 76. 90 09000 09000 09000 09000 09000 76. 90 09000 09000 09000 09000 09000 76. 90 09000 09000 09000 09000 09000 76. 90 09000 09000 09000 09000 09000 09000 76. 90 09000	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0		62. 30
67. 00	65. 00 06500 RESPI RATORY THERAPY	0	C		0		65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	0	C		O		66. 00
69. 00	67. 00 06700 OCCUPATI ONAL THERAPY	0	C		o		67. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 0 0 0 0 0	68. 00 06800 SPEECH PATHOLOGY	0	C		o		68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 76. 97 07697 CARDI AC REHABILITATI ON 0 0 0 0 0 0 0 76. 97 76. 98 07699 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 76. 99 0 0 0 0 0 0 0 0 0	69. 00 06900 ELECTROCARDI OLOGY	0	C		o		69. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73. 00 76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 99 07699 LITHOTRI PSY 0 0 0 0 76. 99 00000 CLI NI C 0 0 0 76. 99 09000 CLI NI C 0 0 76. 99 09000 CLI NI C 0 0 76. 99 09000 CLI NI C 0 0 76. 99 09000 O9000 CLI NI C 0 0 76. 99 O9000 O9000 CLI NI C 0 0 76. 99 O0000 O9000 CLI NI C O O 76. 99 O0000 O9000 CLI NI C O O 76. 98 O0000 O9000 CLI NI C 76. 98 O0000 O0000 O0000 76. 97 O0000 O0000 76. 98 O0000 O0000 O0000 76. 98 O0000 O0000 76. 99 O0000 O0000 76. 99 O0000 O0000 76. 99 O0000 O0000 76. 97 O0000 O0000 76. 98 O0000 O0000 76. 98 O0000 O0000 76. 98 O0000 76. 99 O0000 76. 90 O0000	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		o		71. 00
76. 97 76. 98 76. 98 76. 99 07699 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 98 76. 99 001PATIENT SERVI CE COST CENTERS 90. 00 90. 01 90. 01 90. 01 90. 00 90. 01 90. 00 90. 01 90. 00 90. 01 90. 00 90. 01 90. 00 90. 01 90. 00 90. 01 90. 00 90	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		o		72. 00
76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 0 76. 99 00TPATI ENT SERVI CE COST CENTERS 90. 00 90. 01 90. 01 90. 01 90. 01 90. 00 90. 01 91. 00 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 07699 LI THOTRI PSY 0	73.00 07300 DRUGS CHARGED TO PATIENTS	O	C		o		73. 00
76. 99 07699 LI THOTRI PSY 0 0 0 0 76. 99 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 0 0 90. 00 90. 01 09001 LI FEBRI DGE SENI OR CARE 0 0 0 0 90. 01 91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES	76. 97 07697 CARDIAC REHABILITATION	0	C		o		76. 97
OUTPATI ENT SERVI CE COST CENTERS 90. 00 00 00 00 00 00 00	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C		o		76. 98
90. 00 09000 CLI NI C 0 0 0 90. 00 90. 01	76. 99 07699 LI THOTRI PSY	0	C		o		76. 99
90. 01 09001 LI FEBRI DGE SENI OR CARE 0 0 0 0 91. 00 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	OUTPATIENT SERVICE COST CENTERS	<u>'</u>			<u>'</u>		
91. 00 09100 EMERGENCY 0 0 0 0 91. 00 92. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 0 0 0 0 0	90. 00 09000 CLI NI C	0	C		0		90.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00	90. 01 09001 LI FEBRI DGE SENI OR CARE	O	C		o		90. 01
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	91. 00 09100 EMERGENCY	O	C		o		91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	O	C		o		92.00
	OTHER REIMBURSABLE COST CENTERS	'			·		
200.00 Total (lines 50-199) 0 0 200.00	95. 00 09500 AMBULANCE SERVICES						95. 00
	200.00 Total (lines 50-199)	0	C		o		200.00

Heal th	Financial Systems COMM	MUNITY HOSPT. 0	F LAGRANGE CTY	IN	In Lie	eu of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 01/01/2015 To 12/31/2015		pared: 39 am
			Ti tl	e XVIII	Hospi tal Cost		
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	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	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0. 238581		1, 216, 48	0	0	
	05200 DELIVERY ROOM & LABOR ROOM	0. 755965)	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 078567		139, 18		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 114770	1	4, 481, 04		0	54. 00
60.00	06000 LABORATORY	0. 235280	0	1, 379, 32	8 0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0)	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0. 321623	0	104, 66	3 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 566322	. 0	427, 30	3 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 351160	0	72, 05	5 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 866698	0	28, 78	8 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0)	0	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 297272	2	122, 42	9 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 308935	0	76, 41	3 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 299557	0	1, 650, 71	9 0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0)	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0)	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0. 000000	0)	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90. 00
90. 01	09001 LI FEBRI DGE SENI OR CARE	0. 934338	0	374, 06	8 0	0	90. 01
91.00	09100 EMERGENCY	0. 293614	. 0	2, 356, 93	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 942942	. 0	754, 63	3 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	0. 603446	,		0		95. 00
200.00	Subtotal (see instructions)		0	13, 184, 03	6 0	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges	1					1

13, 184, 036

0 202. 00

202.00

Only Charges Net Charges (line 200 +/- line 201)

| Peri od: | Worksheet D | From 01/01/2015 | Part V | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 151323

Cost Cost Cost Cost Cost Cost Relimbursed Services Subject To Ded. & Coins. (See inst.) Cost Relimbursed Services Subject To Ded. & Coins. (See inst.) Cost Relimbursed Services Subject To Ded. & Coins. (See inst.) Cost Relimbursed Services Ser					10 12/31/2015	Date/IIMe Pre 5/31/2016 11:	
Cost Reimbursed Services Subject To Ded. & Coins. (see inst.) Subject To Ded. & Coins. Ded. & Co			Ti tl	e XVIII	Hospi tal	Cost	
Relimbursed Services Servic		Cos	sts				
Services Subject To Ded. & Coins. Subject To Ded. & Coins. Subject To Ded. & Coins. See inst. Subject To Ded. & Coins. See inst.	Cost Center Description						
Subject To Ded. & Coins Subject To Ded. & Coins See Inst.							
Ded. & Coli ns. (See inst.)							
See inst. (see inst.)							
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 0PERATI NC ROOM 290,229 0 50. 00 52. 00 520 05200 052		6. 00	7. 00				
52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0			_	1			
53. 00		290, 229	0				
54. 00 05400 RADI OLOGY-DI AGNOSTI C 514, 289 0 60. 00		0	0				
60. 00 06000 LABORATORY 324,528 0 62. 30 62. 30 6250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 62. 30 62. 30 66. 0			l .				
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 65. 00 65500 RESPIRATORY THERAPY 33, 662 0 0 65. 00 6600 PHYSI CAL THERAPY 241, 991 0 66. 00 6600 PHYSI CAL THERAPY 241, 991 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 25, 303 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 24, 951 0 68. 00 6900 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 36, 395 0 71. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 23, 607 0 72. 00 07300 DRUGS CHARGED TO PATI ENTS 494, 484 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 494, 484 0 73. 00 07409 CARDI AC REHABI LI TATI ON 0 0 0 76. 98 07699 LI THOTRI PSY 0 0 0 0 76. 98 07699 LI THOTRI PSY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			l .				
65. 00		324, 528	0				
66. 00		0	0				
67. 00			0				
68. 00		241, 991	0				
69. 00 06900 ELECTROCARDI OLOGY 71. 00 771. 00 771. 00 771. 00 772. 00 0720. 01 0720. 01 0720. 01 0720. 01 0720. 01 0720. 01 0720. 01 0720. 01 0720. 01 0720. 01 0720. 01 0720. 01 0720. 01 0730. 00 07300 DRUGS CHARGED TO PATI ENTS 23, 607 0 0 07300 DRUGS CHARGED TO PATI ENTS 494, 484 0 73. 00 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76. 98 07699 LI THOTRI PSY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0				
71. 00		24, 951	0				
72. 00		0	0				
73. 00 76. 97 76. 97 76. 98 76. 98 76. 99 76			0				
76. 97 76. 97 76. 98 07699 HYPERBARI C OXYGEN THERAPY 0 0 07699 LI THOTRI PSY 0 0UTPATI ENT SERVI CE COST CENTERS 90. 00 90. 01 90. 01 90. 01 91. 00 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 711, 575 0) 071HER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 09500 OSSUBTORIAL (see instructions) 201. 00 01		23, 607	0				
76. 98 76. 99 76. 99 76. 99 76. 99 0000		494, 484	0				
76. 99 07699 LITHOTRI PSY 0 0 0 76. 99 0UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 0 0 90. 01 09001 LI FEBRI DGE SENI OR CARE 349, 506 0 90. 01 91. 00 09100 EMERGENCY 692, 028 0 91. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 711, 575 0 714 FE I MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 0 95. 00 200. 00 Subtotal (see instructions) 3, 773, 483 0 200. 00 Coll of the control of t		0	0				
OUTPATIENT SERVICE COST CENTERS O		0	0				
90. 00 09000 CLI NI C 0 0 0 90. 00 90. 01 09001 LI FEBRI DGE SENI OR CARE 349, 506 0 90. 01 91. 00 09100 EMERGENCY 692, 028 0 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 711, 575 0 0 0 0 0 0 0 0 0		0	0				76. 99
90. 01							
91. 00 09100 EMERGENCY 692, 028 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 711, 575 0 92. 00 07THER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 0 0		_	-				
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 711,575 0 92. 00 0THER REIMBURSABLE COST CENTERS 95. 00 95. 00 200. 00 Subtotal (see instructions) 3,773,483 0 200. 00 201. 00 0nly Charges 0 0nly Charges			l e				
OTHER REIMBURSABLE COST CENTERS 95.00							
95. 00		711, 575	0				92. 00
200.00 Subtotal (see instructions) 3,773,483 0 200.00 201.00 Clarges Clinic Lab. Services-Program 0 0 0 0 0 0 0 0 0							
201.00 Less PBP Ĉlinic Lab. Services-Program 0 0 201.00		0					
Only Charges		3, 773, 483	0				
		0					201. 00
202.00 Net Charges (line 200 +/- line 201) 3,773,483 0 202.00							
	202.00 Net Charges (line 200 +/- line 201)	3, 773, 483	0				202. 00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN

			Componen	1 CCN: 152323 1	0 12/31/2015	5/31/2016 11:	
			Ti tl	e XVIII Sv	ving Beds - SNF		
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ARY SERVICE COST CENTERS						
	OPERATING ROOM	0. 238581	0	0	0	0	50.00
	DELIVERY ROOM & LABOR ROOM	0. 755965	0	0	0	0	52. 00
	ANESTHESI OLOGY	0. 078567	0	0	0	0	53. 00
	RADI OLOGY-DI AGNOSTI C	0. 114770	0	0	0	0	54.00
60.00 06000	LABORATORY	0. 235280	0	0	0	0	60.00
62. 30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0	0	0	0	62. 30
65. 00 06500	RESPI RATORY THERAPY	0. 321623	0	0	0	0	65. 00
66. 00 06600	PHYSI CAL THERAPY	0. 566322	0	0	0	0	66. 00
67. 00 06700	OCCUPATI ONAL THERAPY	0. 351160	0	0	0	0	67. 00
68. 00 06800	SPEECH PATHOLOGY	0. 866698	0	0	0	0	68. 00
69. 00 06900	ELECTROCARDI OLOGY	0. 000000	0	0	0	0	69. 00
71. 00 07100	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 297272	0	0	0	0	71. 00
72. 00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 308935	0	0	0	0	72. 00
73. 00 07300	DRUGS CHARGED TO PATIENTS	0. 299557	0	0	0	0	73. 00
76. 97 07697	CARDIAC REHABILITATION	0. 000000	0	0	0	0	76. 97
76. 98 07698	HYPERBARIC OXYGEN THERAPY	0. 000000	0	0	0	0	76. 98
76. 99 07699	LI THOTRI PSY	0. 000000	0	0	0	0	76. 99
OUTPAT	TENT SERVICE COST CENTERS						1
90. 00 09000	CLI NI C	0. 000000	0	0	0	0	90. 00
90. 01 09001	LIFEBRIDGE SENIOR CARE	0. 934338	0	0	0	0	90. 01
91.00 09100	EMERGENCY	0. 293614	0	0	0	0	91.00
92. 00 09200	OBSERVATION BEDS (NON-DISTINCT PART	0. 942942	0	0	0	0	92. 00
OTHER	REIMBURSABLE COST CENTERS						1
95. 00 09500	AMBULANCE SERVICES	0. 603446		0			95. 00
200.00	Subtotal (see instructions)		0	0	0	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program			0	0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0	0	0	0	202. 00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151323 Period: From 01/01/2015 Part V Date/Time Prepared:

		Com	ponent	CCN: 15Z323	То	12/31/2	2015	Date/Time Pro 5/31/2016 11:	
			Titl∈	e XVIII	Swi ng	Beds -	SNF	Cost	
	Cos	sts							
Cost Center Description	Cost	Cos	t						
	Rei mbursed	Rei mbu							
	Servi ces	Servi ce							
	Subject To	Subj ec							
	Ded. & Coins.	Ded. & C							
	(see inst.)	(see in							
ANCILLARY SERVICE COST CENTERS	6. 00	7.0	0						
50. 00 05000 OPERATING ROOM	1 0	J	0						50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0		0						52. 00
53. 00 05300 ANESTHESI OLOGY		3	0						53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		ál	0						54. 00
60. 00 06000 LABORATORY	0	á	0						60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0						62. 30
65. 00 06500 RESPIRATORY THERAPY	0		0						65. 00
66. 00 06600 PHYSI CAL THERAPY	0		o						66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		o						67.00
68. 00 06800 SPEECH PATHOLOGY	0		o						68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		o						69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		o						71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0						72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0						73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0		0						76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0						76. 98
76. 99 07699 LI THOTRI PSY	0		0						76. 99
OUTPATIENT SERVICE COST CENTERS	T								
90. 00 09000 CLI NI C	0	1	0						90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	2	0						90. 01
91. 00 09100 EMERGENCY	0	2	0						91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	<u> </u>	0						92. 00
95. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES	1 0	\							95. 00
200.00 Subtotal (see instructions)	0	()	0						200. 00
201. 00 Less PBP Clinic Lab. Services-Program	0	()	U						200.00
Only Charges		΄							201.00
202.00 Net Charges (line 200 +/- line 201)	0		o						202. 00
202. 331 100 011d1 g03 (11110 200 17 11110 201)	1	1	O						1202.00

Health Financial Systems COMM	COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-					
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				rom 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/31/2016 11:	pared: 39 am
		Ti t	le XIX	Hospi tal	PPS	07 diii
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 & PEDIATRICS	733, 911	91, 663	642, 248	3, 146	204. 15	30.00
43. 00 NURSERY	23, 453		23, 453	419	55. 97	43.00
200.00 Total (lines 30-199)	757, 364		665, 701	3, 565		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	180					30.00
43. 00 NURSERY	132					43. 00
200.00 Total (lines 30-199)	312	44, 135				200. 00

Health Financial Systems COMM	IUNI TY HOSPT. O	F LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der		Peri od: From 01/01/2015 To 12/31/2015		
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	Inpati ent	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	378, 092					
52.00 05200 DELIVERY ROOM & LABOR ROOM	91, 072	1, 662, 656	0. 05477	5 330, 005	18, 076	52.00
53. 00 05300 ANESTHESI OLOGY	4, 857	1, 298, 480	0.00374	1 96, 603	361	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	235, 141	19, 969, 443	0. 01177	5 99, 903	1, 176	54.00
60. 00 06000 LABORATORY	117, 799	6, 237, 425	0. 01888	6 99, 299	1, 875	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	57, 945	2, 137, 382	0. 02711	0 33, 214	900	65. 00
66. 00 06600 PHYSI CAL THERAPY	127, 141	1, 701, 884	0.07470	6 1, 035	77	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	10, 579	618, 561	0. 01710	3 841	14	67. 00
68. 00 06800 SPEECH PATHOLOGY	6, 481	155, 391	0. 04170	8 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 920	1, 579, 659	0. 01830	8 67, 225	1, 231	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	20, 826	1, 095, 073	0. 01901	8 21, 079	401	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	136, 423	7, 251, 152	0. 01881	4 197, 582	3. 717	73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	0.00000		0	76, 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000	0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0.00000		0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	43, 852	488, 166			0	90. 01
91. 00 09100 EMERGENCY	326, 417		1		2, 698	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	154, 200		1			
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50-199)	1, 739, 745	67, 600, 178		1, 418, 691	43, 026	
			•			•

Health Financial Systems COMM	MUNITY HOSPT. O	F LAGRANGE CTY	IN	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provi der		Period: From 01/01/2015 To 12/31/2015		
		Ti t	le XIX	Hospi tal	PPS	37 diii
Cost Center Description	Nursing School	Cost	All Other Medical Education Cos	Swing-Bed Adjustment t Amount (see	Total Costs (sum of cols. 1 through 3,	
					minus col. 4)	
LANDATI FAIT POLITIAIS CERVILOS COCT OFFITERO	1.00	2. 00	3.00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1			00.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1	0	0	30.00
43. 00 04300 NURSERY 200. 00 Total (Lines 30-199)	0	0		0	0	43. 00 200. 00
Cost Center Description	Total Patient Days 6.00	Per Di em (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		200.00
INPATIENT ROUTINE SERVICE COST CENTERS		T	1		T	
30. 00 03000 ADULTS & PEDI ATRI CS	3, 146		1			30. 00
43. 00 04300 NURSERY	419		1			43. 00
200.00 Total (lines 30-199)	3, 565	l	31	2 0	1	200. 00

Health Financial Systems	COMMUNITY HOSPT. OF LAG	RANGE CTY IN	In Lieu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 151323 Peri d	d: Worksheet D

From 01/01/2015 | Part IV To 12/31/2015 | Date/Time Prepared: THROUGH COSTS 5/31/2016 11:39 am Title XIX Hospi tal PPS Cost Center Description Non Physician Nursing School Allied Health All Other Total Cost Anestheti st Medi cal (sum of col 1 through col . Cost Education Cost 1.00 2.00 3.00 4. 00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 0 53.00 05300 ANESTHESI OLOGY 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 06000 LABORATORY 0 60.00 0 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 0 76. 98 0 0 07699 LI THOTRI PSY 76. 99 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 0 0 09001 LIFEBRIDGE SENIOR CARE 0 0 0 90. 01 90. 01 Ω Ω 09100 EMERGENCY 0 0 0 91.00 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 92.00 0 0 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

0

0

0

0

0 200.00

200.00

Total (lines 50-199)

Health Financial Systems	COMMUNITY HOSPT. OF LAG	RANGE CTY IN	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 151323	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2015	Part IV

THROUGH COSTS			-	From 01/01/2015 To 12/31/2015	5/31/2016 11:	
			tle XIX	Hospi tal	PPS	
Cost Center Description	Total		Ratio of Cost		Inpati ent	
	Outpati ent	(from Wkst. C		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col.		Charges	
	col . 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	11, 531, 48	•			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 662, 65				52. 00
53. 00 05300 ANESTHESI OLOGY	0	1, 298, 480				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	19, 969, 44	0. 000000	0.000000	99, 903	54.00
60. 00 06000 LABORATORY	0	6, 237, 42	0. 000000	0.000000	99, 299	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	(0. 000000	0.000000	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0	2, 137, 382	0. 000000	0.000000	33, 214	65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 701, 88	0. 000000	0.000000	1, 035	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	618, 56°	0. 000000	0.000000	841	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	155, 39 ⁻	0. 000000	0.000000	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		0. 000000	0.000000	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	1, 579, 659	0. 000000	0.000000	67, 225	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 095, 07		0. 000000	21, 079	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	7, 251, 15	•		197, 582	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	, , , ,	0. 000000			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0. 000000			76. 98
76. 99 07699 LI THOTRI PSY	0		0. 000000	0. 000000	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0		0.00000	0.000000	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	488, 166	•		0	90. 01
91. 00 09100 EMERGENCY	0					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	906, 22	•			92.00
OTHER REIMBURSABLE COST CENTERS				.,		1
95. 00 09500 AMBULANCE SERVI CES						95. 00
200.00 Total (lines 50-199)	0	67, 600, 178	3		1, 418, 691	

 Heal th Financial
 Systems
 COMMUNITY HOSPT. OF

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 COMMUNITY HOSPT. OF LAGRANGE CTY IN Provi der CCN: 151323

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2015 | Part IV | To 12/31/2015 | Date/Time Prepared: | 5/31/2016 | 11:39 am | PROPRIED THROUGH COSTS

			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col. 9			
		x col. 10)		x col. 12)			
		11.00	12. 00	13.00			
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0	0			0.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0			2. 00
	05300 ANESTHESI OLOGY	0	0	0		5	3. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0		5	4. 00
60.00	06000 LABORATORY	0	0	0		6	0.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		6	2. 30
65.00	06500 RESPI RATORY THERAPY	0	0	0		6	5. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0		6	6. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0		6	7. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0		6	8. 00
69.00	06900 ELECTROCARDI OLOGY	O	0	0		6	9. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	0		7	1.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	0		7	2.00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0	0		7	3. 00
76. 97	07697 CARDIAC REHABILITATION	o	0	0		7	6. 97
76. 98	07698 HYPERBARIC OXYGEN THERAPY	o	0	0		7	6. 98
76. 99	07699 LI THOTRI PSY	o	0	0		7	6. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0		9	0.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	o	0	0		9	0. 01
91.00	09100 EMERGENCY	o	0	0		9	1. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0	0		9	2. 00
	OTHER REIMBURSABLE COST CENTERS	'		•			
95.00	09500 AMBULANCE SERVICES					9	5. 00
200.00	Total (lines 50-199)	0	0	0		20	00.00
	•			•		•	

Health Financial Systems COM	MUNITY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pre 5/31/2016 11:	epared: 39 am
		Ti t	le XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subj ect To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 238581	0)	0 493, 520	0	, 00.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 755965	0)	0	0	
53. 00 05300 ANESTHESI OLOGY	0. 078567	0)	0 57, 914	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 114770	0)	0 2, 275, 576	0	
60. 00 06000 LABORATORY	0. 235280	0)	0 617, 116	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0)	0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 321623	0)	0 196, 110	0	, 00.00
66. 00 06600 PHYSI CAL THERAPY	0. 566322	0)	0 144, 522	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 351160	0		0 56, 621	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 866698	0		0 49, 176	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0)	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 297272	0)	0 67, 397	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 308935	0		0 4, 476	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 299557	0		0 378, 340	0	73.00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0		0 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0. 000000	0)	0	0	
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 934338	0)	0	0	90. 01
91. 00 09100 EMERGENCY	0. 293614	0)	0 2, 337, 430	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 942942	0)	0 74, 360	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 603446	O		0		95. 00
200.00 Subtotal (see instructions)		0)	0 6, 752, 558	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0		201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0)	0 6, 752, 558	0	202.00

RANGE CTY IN In Lieu of Form CMS-2552-10
Provider CCN: 151323 | Period: | Worksheet D | From 01/01/2015 | Part V | To 12/31/2015 | Date/Time Prepared:

					То	12/31/2015	Date/Time Pr 5/31/2016 11	
			Ti 1	le XIX		Hospi tal	PPS	
		Cos	sts					
	Cost Center Description	Cost	Cost					
		Rei mbursed	Rei mbursed					
		Servi ces	Services Not					
		Subject To	Subject To					
		Ded. & Coins.	Ded. & Coins.					
		(see inst.)	(see inst.)					
	T	6.00	7. 00					
	ANCILLARY SERVICE COST CENTERS	_						
		0	117, 744					50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	(52.00
53. 00	05300 ANESTHESI OLOGY	0	4, 550					53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	261, 168					54. 00
60.00	06000 LABORATORY	0	145, 195	1				60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	(1				62. 30
65. 00	06500 RESPI RATORY THERAPY	0	63, 073					65. 00
66. 00	06600 PHYSI CAL THERAPY	0	81, 846					66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	19, 883					67. 00
68. 00	06800 SPEECH PATHOLOGY	0	42, 621	1				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	(1				69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	20, 035					71. 00
72. 00		0	1, 383					72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	113, 334	l				73. 00
	07697 CARDI AC REHABI LI TATI ON	0	()				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	()				76. 98
76. 99	07699 LI THOTRI PSY	0	()				76. 99
	OUTPATIENT SERVICE COST CENTERS							
	09000 CLI NI C	0	()				90. 00
90. 01	09001 LI FEBRI DGE SENI OR CARE	0	()				90. 01
91. 00	09100 EMERGENCY	0	686, 302					91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	70, 117	'				92. 00
	OTHER REIMBURSABLE COST CENTERS							
	09500 AMBULANCE SERVICES	0						95. 00
200.00	,	0	1, 627, 251					200. 00
201.00		0						201. 00
	Only Charges							
202.00	Net Charges (line 200 +/- line 201)	0	1, 627, 251					202. 00

Health Financial Systems	COMMUNITY HOSPT. OF LAG	RANGE CTY IN	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 151323	Peri od: From 01/01/2015	Worksheet D-1
			To 12/31/2015	Date/Time Prepared: 5/31/2016 11:39 am
		Ti +Lo V/////	Hospi tal	Cost

		Title XVIII	Hospi tal	5/31/2016 11: Cost	39 am
	Cost Center Description		•	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	INPATIENT DAYS	avaludi na nawbara)		2 000	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be			3, 909 3, 146	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed days	vate room days,	0, 140	3. 00	
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation bed		- 21 -6	2, 485	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through becembe	r 31 of the cost	449	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room	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 reporting period	days) through December	31 of the cost	314	7. 00
8. 00	Teporting period Total_swing-bed_NF_type_inpatient_days (including private room=	davs) 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	967	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including privato r	nom dave)	449	10. 00
10.00	through December 31 of the cost reporting period (see instruction		Joil days)	447	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only	y (including private r	oom days) after	0	11. 00
40.00	December 31 of the cost reporting period (if calendar year, ent				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar yea				
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14. 00 15. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	16. 00
10.00	SWING BED ADJUSTMENT				10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost		17. 00
18. 00	reporting period	often December 21 of	the cost		18. 00
16.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period				16.00
19. 00	, 9,				19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	ne cost	123. 32	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			4, 686, 190	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ng period (line	4, 000, 170	22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	1 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	38, 722	24. 00
200	7 x line 19)	or or the cost reportin	.g po ou (00, 722	2 00
25. 00	Swing-bed cost applicable to NF type services after December 31 \times line 20)	of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			619, 171	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (ine 21 minus line 26)		4, 067, 019	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		, 1		
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	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	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0.00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line	31)		0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	4, 067, 019	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	TMENTS			
20.20	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS			4 000 71	20.00
38. 00	Adjusted general inpatient routine service cost per diem (see i	•		1, 292. 76	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	-		1, 250, 099	39. 00 40. 00
40. 00 41. 00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +	,		0 1, 250, 099	
00	1.2.2		ı	., 200, 077	

JIVIPUTA	TION OF INPATIENT OPERATING COST		Provi der	CCN: 151323	Peri od:	Worksheet D-1	
					From 01/01/2015 To 12/31/2015	Date/Time Pre 5/31/2016 11:	
			Ti tl	e XVIII	Hospi tal	Cost	37 ai
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
00 1	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42.
	ntensive Care Type Inpatient Hospital Units		,	л <u>О.</u>	00 0		42.
	NTENSIVE CARE UNIT						43.
4	CORONARY CARE UNIT						44.
	BURN INTENSIVE CARE UNIT						45.
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 47.
. 00	Cost Center Description						47.
	·					1. 00	
	Program inpatient ancillary service cost (W			_		724, 007	1
-	Total Program inpatient costs (sum of lines	41 through 48)	(see instruction	ons)		1, 974, 106	49.
	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program in	nationt routine	sarvices (from	n Wket D eu	m of Parts I and	0	50.
	II)	patront routine	301 11 003 (11 01	ii wikst. D, su	iii or rurts r unu		
	Pass through costs applicable to Program in	patient ancilla	ry services (fi	om Wkst. D,	sum of Parts II	0	51.
	and IV)	EO and E1)					
	Fotal Program excludable cost (sum of lines Fotal Program inpatient operating cost excl		elated non-phy	vsician anest	hetist and	0	
	nedical education costs (line 49 minus line		crated, non prij	ysi ci aii aiicst	netrat, and	9] 33.
	ARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges					0	
	Farget amount per discharge Farget amount (line 54 x line 55)					0.00	1
	Difference between adjusted inpatient opera	ting cost and ta	arget amount (1	ine 56 minus	line 53)	0	
- 1	Bonus payment (see instructions)	tring cost and to	arget amount (i	1110 00 1111 1103	11110 00)	0	
00 1	esser of lines 53/54 or 55 from the cost re	eporting period	endi ng 1996, ι	updated and c	ompounded by the	0.00	59
	narket basket	anat manamt	ada+ad by +ba m	markat baakat		0.00	1,0
	esser of lines 53/54 or 55 from prior year fline 53/54 is less than the lower of line.					0.00	1
	which operating costs (line 53) are less that						"
	amount (line 56), otherwise enter zero (see	instructions)	•	•	· ·		
	Relief payment (see instructions)		+!>			0	
	Allowable Inpatient cost plus incentive payı PROGRAM INPATIENT ROUTINE SWING BED COST	nent (see mstr	uctions)			0	63
	Medicare swing-bed SNF inpatient routine co	sts through Dece	ember 31 of the	e cost report	ing period (See	580, 449	64
	nstructions)(title XVIII only)	-					
	Medicare swing-bed SNF inpatient routine co	sts after Decemb	per 31 of the d	cost reportin	g period (See	0	65
	nstructions)(title XVIII only) Fotal Medicare swing-bed SNF inpatient rout	ine costs (line	64 nlus line 6	55)(title XVI	II only) For	580, 449	66
(CAH (see instructions)	·	·	, ,	3,	000, 117	
	Title V or XIX swing-bed NF inpatient routi	ne costs through	n December 31 d	of the cost r	eporting period	0	67
1	(line 12 x line 19) Fitle V or XIX swing-bed NF inpatient routio	no costs often I	Docombon 21 of	the cost ron	orting ported	0	68.
	(line 13 x line 20)	ne costs arter t	becember 31 01	the cost rep	orting period	0	00
00 [Total title V or XIX swing-bed NF inpatient					0	69
	ART III - SKILLED NURSING FACILITY, OTHER N				<u> </u>	T	۱
- 1	Skilled nursing facility/other nursing faci Adjusted general inpatient routine service o	-		•)		70
	Program routine service cost (line 9 x line		Title 70 ÷ Title	2)			72
	Medically necessary private room cost applic		m (line 14 x li	ne 35)			73
00	Total Program general inpatient routine ser	vice costs (line	e 72 + line 73))			74
	Capital-related cost allocated to inpatient	routine service	e costs (from V	Worksheet B,	Part II, column		75
	26, line 45) Per diem capital-related costs (line 75 ÷ li	ine 2)					76
- 1	Program capital-related costs (line 9 x line	*					77
- 1	npatient routine service cost (line 74 min						78
- 1	Aggregate charges to beneficiaries for exce	, ,					79
1	Total Program routine service costs for comp		cost limitation	n (line 78 mi	nus line 79)		80
	npatient routine service cost per diem liminpatient routine service cost limitation (1)				81
4	Reasonable inpatient routine service costs		•				83
	Program inpatient ancillary services (see in	•	-				84
1	Jtilization review - physician compensation	•					85
	Total Program inpatient operating costs (su		nrough 85)				86
IP.	ART IV - COMPUTATION OF OBSERVATION BED PAS						4
	Fotal observation bed days (see instructions	s)				661	8.

Health Financial Systems COMM	UNITY HOSPT.	OF LAGR	ANGE CTY	IN	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Peri od:	Worksheet D-1	
					From 01/01/2015 To 12/31/2015		
			Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routi	ne Cost	column 1 ÷	Total	Observati on	
		(from	line 27)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00	2	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST						
90.00 Capital -related cost	733, 91	1 4	4, 067, 019	0. 18045	4 854, 514	154, 200	90. 00
91.00 Nursing School cost		0 4	4, 067, 019	0.00000	0 854, 514	0	91.00
92.00 Allied health cost		0 4	4, 067, 019	0. 00000	0 854, 514	0	92. 00
93.00 All other Medical Education		0 4	4, 067, 019	0. 00000	0 854, 514	0	93. 00

Health Financial Systems	COMMUNITY HOSPT. OF LAG	RANGE CTY IN	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 151323	Period: From 01/01/2015	Worksheet D-1
			To 12/31/2015	Date/Time Prepared: 5/31/2016 11:39 am
		Title XIX	Hospi tal	PPS

		Ti +I o VI V	Hooni tal	5/31/2016 11:	39 am
	Cost Center Description	Title XIX	Hospi tal	PPS	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	oveluding newborn)		3, 909	1. 00
1. 00 2. 00	Inpatient days (including private room days, excluding swing-bed days,			3, 909	2.00
3. 00	Private room days (excluding swing-bed and observation bed days		ivate room davs.	2, 485	3.00
	do not complete this line.	, y y p.		_,	
4.00	Semi-private room days (excluding swing-bed and observation bed			0	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	449	5. 00
4 00	reporting period	21 of the cost	0	/ 00	
6. 00	Total swing-bed SNF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after becember	31 OF the Cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	314	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	the Dreamen (evaluding	owing bod and	180	9. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	180	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	oom days)	0	10.00
	through December 31 of the cost reporting period (see instructi		,		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11. 00
12.00	December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX		o zoom dovo)	0	12 00
12. 00	through December 31 of the cost reporting period	only (including privat	e room days)	0	12. 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar yea				
14.00	Medically necessary private room days applicable to the Program	(excluding swing-bed	days)	0	14.00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			419 132	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			132	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost		17. 00
	reporting period				
18. 00					18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost				19. 00
	reporting period	em dagir badambar ar ar		0.00	. ,
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			4, 686, 190	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	4, 080, 190	22.00
22.00	5 x line 17)	or or the door report	g porrod (o	· ·	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 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	21 of the cost report:	ng poriod (line	0	24. 00
24.00	7 x line 19)	of the cost reporti	ng perrod (Trie	0	24.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
	x line 20)				
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ino 21 minus lino 24)		585, 285 4, 100, 905	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	riie 21 iiii iius Triie 20)		4, 100, 903	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 minu	, ,	tions)	0. 00 0. 00	34. 00
35. 00					35.00
36. 00 37. 00	· · · · · · · · · · · · · · · · · · ·				36. 00 37. 00
37.00	7.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)				37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS				
38. 00	Adjusted general inpatient routine service cost per diem (see i	•		1, 303. 53	
39. 00	Program general inpatient routine service cost (line 9 x line 3	-		234, 635	39. 00
40.00	Medically necessary private room cost applicable to the Program Total Program general inpatient routine service cost (line 39 +			0 234, 635	40.00
41.00	Tiotai irogram generai impatrent foutine service cost (fille 39 +	11110 40)	l	234, 035	41.00

		MUNITY HOSPT. OI					eu of Form CMS-	
COMPUT	ATION OF INPATIENT OPERATING COST		Prov	ıder	CCN: 151323	Peri od: From 01/01/2015		
						To 12/31/2015	Date/Time Pre 5/31/2016 11:	
				Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient	Davs	Average Pe		Program Cost (col. 3 x col.	
					col . 2)		4)	
42.00	NURSERY (title V & XIX only)	1. 00 347, 413	2.00	419	3. 00 829	4. 00	5. 00 109, 448	42.00
42.00	Intensive Care Type Inpatient Hospital Units	347,413		417	027	. 15	107, 440	42.00
43.00	INTENSIVE CARE UNIT							43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT							44. 00 45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT							46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)							47. 00
	Cost Center Description						1. 00	
48. 00	Program inpatient ancillary service cost (Wk						506, 713	1
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)((see instr	uctio	ns)		850, 796	49. 00
50.00	Pass through costs applicable to Program inp	atient routine	servi ces	(from	ı Wkst. D, sı	um of Parts I and	44, 135	50.00
E4 00						6.5	40.007	F4 00
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	ry services	s (fr	om Wkst. D,	sum of Parts II	43, 026	51.00
52.00	Total Program excludable cost (sum of lines						87, 161	1
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		elated, noi	n-phy	sician anest	thetist, and	763, 635	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)						i
	Program di scharges						0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)						0.00	
57. 00								57. 00
58. 00 59. 00								58. 00 59. 00
39.00	market basket	portring period	ending 19	90, u	ipuateu anu t	compounded by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year						0.00	
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less tha						0	61. 00
	amount (line 56), otherwise enter zero (see		(11111			g		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instri	ictions)				0 0	
03. 00	PROGRAM INPATIENT ROUTINE SWING BED COST	cit (see mistre	10113)					03.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 o	f the	cost report	ting period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	per 31 of	the c	ost reportin	ng period (See	0	65.00
	instructions)(title XVIII only)			. ,				
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 prus ri	ine 6	5)(TITIE XVI	II only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December	31 o	of the cost i	reporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after [ecember 3	1 of	the cost rea	porting period	0	68. 00
	(line 13 x line 20)					and the same		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N						0	69. 00
70. 00	Skilled nursing facility/other nursing facil					7)		70. 00
71.00	Adjusted general inpatient routine service c	ost per diem (I						71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applic	•	n (line 14	x li	ne 35)			72. 00 73. 00
74.00	Total Program general inpatient routine serv	ice costs (line	2 + line	e 73)				74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	costs (fi	rom W	orksheet B,	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)						76. 00
77.00	Program capital -related costs (line 9 x line							77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		orovi den in	ecord	ls)			78. 00 79. 00
80.00	Total Program routine service costs for comp	arison to the o				nus line 79)		80.00
	Inpatient routine service cost per diem limitation (1)					81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .					82. 00 83. 00
84.00	Program inpatient ancillary services (see in	structions)	·					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•						85. 00 86. 00
55. 50	PART IV - COMPUTATION OF OBSERVATION BED PAS		ougii 00)]
	Total observation bed days (see instructions							87. 00

87.00

661

1, 303. 53 88. 00 861, 633 89. 00

87.00 Total observation bed days (see instructions)
88.00 Adjusted general inpatient routine cost per diem (line 27 + line 2)
89.00 Observation bed cost (line 87 x line 88) (see instructions)

Health Financial Systems COMM	IUNI TY HOSPT.	OF LAG	RANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Peri od:	Worksheet D-1	
					From 01/01/2015 To 12/31/2015	Date/Time Pre 5/31/2016 11:	
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Rou	tine Cost	column 1 ÷	Total	Observati on	
		(fro	m line 27)	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	733, 91	1	4, 100, 905	0. 17896	3 861, 633	154, 200	90.00
91.00 Nursing School cost		0	4, 100, 905	0.00000	0 861, 633	0	91.00
92.00 Allied health cost		o	4, 100, 905	0.00000	0 861, 633	0	92.00
93.00 All other Medical Education	1	o	4, 100, 905	0. 00000	0 861, 633	0	93. 00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
			From 01/01/2015 To 12/31/2015	Date/Time Pre 5/31/2016 11:	
	Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			1, 388, 535		30.0
43. 00 04300 NURSERY					43. C
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM		0. 23858	332, 856	79, 413	50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM		0. 75596	5 0	0	52.0
3. 00 05300 ANESTHESI OLOGY		0. 07856	43, 887	3, 448	53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 11477	70 415, 602	47, 699	54.0
00. 00 06000 LABORATORY		0. 23528	355, 053	83, 537	60.0
52.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000	00	0	62.3
55. 00 06500 RESPIRATORY THERAPY		0. 32162	234, 842	75, 531	65.0
6. 00 06600 PHYSI CAL THERAPY		0. 56632	22 86, 944	49, 238	66.0
7. 00 06700 OCCUPATI ONAL THERAPY		0. 35116	76, 945	27, 020	67. (
8. 00 06800 SPEECH PATHOLOGY		0. 86669	9, 931	8, 607	68. (
9. 00 06900 ELECTROCARDI OLOGY		0.00000	00	0	69. (
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 29727	165, 835	49, 298	71. 0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 30893	35 245, 622	75, 881	72.0
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 29955	715, 605	214, 364	73.0
6. 97 07697 CARDIAC REHABILITATION		0.00000	00	0	76. 9
6. 98 07698 HYPERBARI C OXYGEN THERAPY		0.00000	00	0	76.
6. 99 07699 LI THOTRI PSY		0.00000	00	0	76. 9
OUTPATIENT SERVICE COST CENTERS		•	_		ĺ
0, 00 09000 CLI NI C		0.00000	00 0	0	1 90. c
0. 01 09001 LI FEBRI DGE SENI OR CARE		0. 93433		0	90.0
1. 00 09100 EMERGENCY		0. 29361		9, 971	91. (
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 94294	•	0	1
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVI CES					95.
00.00 Total (sum of lines 50-94 and 96-98)			2, 717, 082	724, 007	200

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

2, 717, 082

2, 717, 082

95. 00 724, 007 200. 00 201. 00 202. 00

200.00

201.00 202.00

Health Financial Systems COMMUNITY HOSPT. OF LAGRA	NGE CTY IN	V	In Lie	eu of Form CMS-2	2552-10
-	rovi der CC		Peri od:	Worksheet D-3	
		F	rom 01/01/2015		
C	omponent (CCN: 15Z323 T	o 12/31/2015		pared:
	Title	VVIII C	wing Beds - SNF	5/31/2016 11: Cost	39 am_
Cost Center Description		atio of Cost		Inpati ent	
cost center bescription		To Charges		Program Costs	
		10 charges		(col. 1 x col.	
			Charges	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		11.00	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
43. 00 04300 NURSERY					43.00
ANCILLARY SERVICE COST CENTERS			"		
50. 00 05000 OPERATI NG ROOM		0. 238581	5, 675	1, 354	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 755965	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY		0. 078567	3, 681	289	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 114770	30, 174	3, 463	54.00
60. 00 06000 LABORATORY		0. 235280	76, 091	17, 903	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.000000	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY		0. 321623	58, 510	18, 818	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 566322	90, 540	51, 275	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 351160	95, 859	33, 662	67. 00
68. 00 O6800 SPEECH PATHOLOGY		0. 866698	4, 003	3, 469	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0.000000	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 297272		8, 345	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 308935		0	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 299557		73, 465	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0.000000		0	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY		0.000000		0	76. 98
76. 99 07699 LI THOTRI PSY		0. 000000	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0. 000000		-	90. 00
90. 01 09001 LI FEBRI DGE SENI OR CARE		0. 934338		_	90. 01
91 00 09100 EMERGENCY		0 29361/	253	7.4	91 00

0. 293614

0. 942942

253

638, 102

638, 102

74

0 92.00 95.00

212, 117 200. 00 201. 00

91.00

202. 00

91.00

200.00

201. 00 202. 00

09100 EMERGENCY

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

	Financial System	RVICE COST APPORTIONMENT	COMMUNITY HOSPT.				eu of Form CMS-2	
INPAII	ENT ANCILLARY SE	RVICE COST APPORTIONMENT		Provi der	CCN: 151323	Peri od: From 01/01/2015	Worksheet D-3	
						To 12/31/2015	Date/Time Pre	pared:
							5/31/2016 11:	39 am_
				Ti t	le XIX	Hospi tal	PPS	
	Cost Cente	r Description			Ratio of Cos		Inpatient	
					To Charges	Program	Program Costs	
						Charges	(col. 1 x col.	
					1.00	0.00	2)	
	INDATI ENT. DOUTI N	E CEDVI CE COCT CENTEDO			1.00	2. 00	3. 00	
20.00		E SERVICE COST CENTERS			1	175 404	1	20.00
30.00	03000 ADULTS & P	EDI ATRI CS				175, 404	•	30. 00 43. 00
43.00	04300 NURSERY ANCI LLARY SERVI C	E COST CENTERS				171, 608		43.00
50. 00	05000 OPERATING				0. 23858	381, 247	90, 958	50. 00
52. 00	05200 DELIVERY R				0. 23636	·		1
53. 00	05300 ANESTHESI O				0.75596			1
54. 00	05400 RADI OLOGY-				0.07636			
60. 00	06000 LABORATORY	DI AGNOSTI C			0. 23528	·		
62. 30		TING FOR HEMOPHILIACS			0. 00000		1	1
65. 00	06500 RESPI RATOR				0. 32162		1	
66. 00					0. 56632	·		
67. 00					0. 35116	·		
68. 00	06800 SPEECH PAT				0. 86669		1	1
69. 00	06900 ELECTROCAR				0.0000			69. 00
71. 00		PPLIES CHARGED TO PATIEN	Т		0. 29727		1	1
		CHARGED TO PATIENTS			0. 30893			
	07300 DRUGS CHAR				0. 29955			
	07697 CARDI AC RE				0. 00000		0,,10,	1
76. 98	07698 HYPERBARI C				0.00000		_	76. 98
					0.00000		1	76. 99
, 0. , ,	OUTPATIENT SERVI				0.0000	301		1
90.00	09000 CLI NI C	oe ooo! oewiene			0.00000	00 0	0	90. 00
90. 01	09001 LI FEBRI DGE	SENLOR CARE			0. 93433		0	1
91. 00	09100 EMERGENCY				0. 2936		26, 618	
92. 00		N BEDS (NON-DISTINCT PAR	Т		0. 94294			
	OTHER REI MBURSAB							1
95.00	09500 AMBULANCE							95. 00
200.00	Total (sum	of lines 50-94 and 96-98	3)			1, 418, 691	506, 713	200.00
201 00	less PRP C	Linic Laboratory Service	s-Program only cha	arges (line 61)			,	201 00

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

506, 713 200. 00 201. 00 202. 00

1, 418, 691

201.00 202.00

Health Financial Systems	COMMUNITY HOSPT. OF LAGRANGE CTY IN	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151323	Peri od: Worksheet E From 01/01/2015 Part B Date/Ti me Prepared: 5/41/2014 11:30 pm

	To 12/31/2015 Date/Ti me				
		Title XVIII	Hospi tal	5/31/2016 11: Cost	39 alli
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			3, 773, 483	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	
3.00	PPS payments		0		
4. 00 5. 00	Outlier payment (see instructions)	i one)		0.000	4. 00 5. 00
6. 00	Enter the hospital specific payment to cost ratio (see instruct Line 2 times line 5		0.000	6.00	
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	
10.00	Organ acqui si ti ons			0 770 400	
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			3, 773, 483	11. 00
	Reasonable charges				-
12.00	Ancillary service charges			0	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	ymont for sorvices on	a chargo basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for				
	had such payment been made in accordance with 42 CFR §413.13(e)	. 3	a ona gozao. o		10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18. 00	Total customary charges (see instructions)		44) (0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	if line 18 exceeds li	ne 11) (see	0	19. 00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)				
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		3, 811, 218	
22. 00 23. 00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instru	ctions)		0	22. 00 23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	ctions)			
200	COMPUTATION OF REIMBURSEMENT SETTLEMENT				2 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			27, 440	1
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for		1 007 (2, 385, 571	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plinstructions)	us the sum of lines 22	and 23] (see	1, 398, 207	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	ŕ		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			1, 398, 207	30.00
31. 00	Primary payer payments			1, 298	
32. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	6)		1, 396, 909	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	3)		0	33. 00
34.00	Allowable bad debts (see instructions)			359, 889	
35.00	Adjusted reimbursable bad debts (see instructions)			233, 928	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		305, 223	1
37. 00	Subtotal (see instructions)			1, 630, 837	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 00 39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 00 39. 50
39. 98	Partial or full credits received from manufacturers for replace		tions)	Ö	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	(,	0	39. 99
40.00	Subtotal (see instructions)			1, 630, 837	40. 00
40. 01	Sequestration adjustment (see instructions)				40. 01
41. 00					41.00
42. 00 43. 00	`				42. 00 43. 00
44. 00				-301, 423 0	44. 00
	§115. 2	- III - III - III - III - II - II	onapro,]
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)			O	
			'		•

Health Financial Systems COMMUNITY
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Period: Worksheet E-1
From 01/01/2015
To 12/31/2015 Date/Time Prepared: 5/31/2016 11: 39 am Provi der CCN: 151323

					5/31/2016 11:3	39 am
		Ti tl	e XVIII	Hospi tal	Cost	
		Inpatien	it Part A	· · · · · · · · · · · · · · · · · · ·	t B	
		1patro			, ,	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider	1.00	1, 719, 490		1, 899, 643	1. 00
2.00	Interim payments payable on individual bills, either		C		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	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		I.			
3. 01	ADJUSTMENTS TO PROVIDER	08/14/2015	57, 100		0	3. 01
3. 02	ADJUSTIMENTS TO TROVIDER	007 147 2013	37, 100			3. 02
3. 03			C		0	3. 03
3.04			0		0	3. 04
3.05			C		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51)	l ol	3. 51
3.52			1 0)	0	3. 52
3. 53					0	3. 53
3. 54			i			3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		57, 100			3. 99
3. 99			37, 100		١	3. 99
4 00	3. 50-3. 98)		4 77/ 500		4 000 (40	4 00
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 776, 590		1, 899, 643	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR		1			
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	TENTATI VE TO PROVI DER		C		0	5. 01
5.02)	l ol	5. 02
5.03			l c)	l ol	5. 03
	Provider to Program			1		
5. 50	TENTATI VE TO PROGRAM				0	5. 50
5. 51	TENTATI VE TO TROOKAWI					5. 51
5. 52						5. 52
			1			
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
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		C		0	6. 01
6.02	SETTLEMENT TO PROGRAM		52, 769	·	301, 423	6. 02
7.00	Total Medicare program liability (see instructions)		1, 723, 821		1, 598, 220	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
)	1. 00	2.00	
8. 00	Name of Contractor					8. 00
3. 00	1	1		1	1 1	0.00

 RANGE CTY IN
 In Lieu of Form CMS-2552-10

 Provider CCN: 151323
 Period: From 01/01/2015
 Worksheet E-1 Part I Date/Time Prepared: 5/31/2016 11: 39 am
 Health Financial Systems COMMUNITY
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

					5/31/2016 11:3	39 am_
				ving Beds - SNF	Cost	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4.00	
1. 00	Total interim payments paid to provider		680, 489		0	1. 00
2.00	Interim payments payable on individual bills, either		0		ol	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		0		0	3. 01
3.02			0		0	3. 02
3.03			0		o	3. 03
3.04			0		o	3.04
3.05			0		o	3.05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		0		0	3.50
3.51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		ol	3. 53
3.54			0		ol	3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		ol	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		680, 489		0	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	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5. 03			0		0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM		0		0	5. 50
5. 50	TENTATIVE TO PROGRAM		0		0	5. 50 5. 51
5. 51			0		0	5. 51
5. 52 5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 52 5. 99
5. 99	5. 50-5. 98)		٥		ا	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
6.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		99, 362		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		,,, 302 n		0	6. 02
7. 00	Total Medicare program liability (see instructions)		779, 851		0	7. 00
7.00	Total mode od o program trabitity (see thistractions)		777,031	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	· '			•	. '	

Heal th	Financial Systems COMMUNITY HOSPT. OF LA	GRANGE CTY IN	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 151323	Peri od: From 01/01/2015 To 12/31/2015		
		Title XVIII	Hospi tal	Cost	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst. S	5-3, Pt. I col. 15 line	14	937	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-1	2		967	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			756	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	2		2, 485	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			76, 997, 349	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lin	ne 20		1, 433, 578	6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cerline $\ensuremath{\text{168}}$	tified HIT technology	Wkst. S-2, Pt. I	113, 567	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			102, 948	8. 00
9.00	Sequestration adjustment amount (see instructions)			2, 059	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		100, 889	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30. 00
31.00	Other Adjustment (specify)			0	31. 00
33 00	Palance due provider (line 9 (or line 10) minus line 20 and lin	o 21) (soo instruction	6)	100 000	22 00

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

0 30.00 0 31.00 100,889 32.00

Health Financial Systems	COMMUNITY HOSPT. OF LA	GRANGE CTY IN	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 151323	Peri od: From 01/01/2015	Worksheet E-2
		Component CCN: 15Z323		
		T1 11 2011 1	0 1 0 1 015	0 1

		, , , , , , , , , , , , , , , , , , ,		5/31/2016 11:	39 am
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1.00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		586, 253	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A	A, and sum of Wkst. D,	214, 238	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instr				
4.00	Per diem cost for interns and residents not in approved teaching	, program (see		0.00	4. 00
	instructions)				
5.00	Program days		449	0	
6.00	Interns and residents not in approved teaching program (see inst			0	0.00
7.00	Utilization review - physician compensation - SNF optional metho	od only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		800, 491	0	
9.00	Primary payer payments (see instructions)		0	0	9. 00
10.00	Subtotal (line 8 minus line 9)		800, 491	0	1
11.00	Deductibles billed to program patients (exclude amounts applicab	ole to physician	0	0	11. 00
	professional services)				
	Subtotal (line 10 minus line 11)		800, 491	0	
13.00	Coinsurance billed to program patients (from provider records) ((excl ude coi nsurance	4, 725	0	13. 00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		795, 766	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	
	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)	0	0	1
	Total (see instructions)		795, 766	0	1 . ,
	Sequestration adjustment (see instructions)		15, 915	0	1
			680, 489	0	20. 00
	Tentative settlement (for contractor use only)		0	0	21. 00
	Balance due provider/program (line 19 minus lines 19.01, 20, and		99, 362	0	00
23.00		with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				

Health Financial Systems	COMMUNITY HOSPT. OF LAG	RANGE CTY IN	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 151323	From 01/01/2015	Worksheet E-3 Part V Date/Time Prepared: 5/31/2016 11:39 am
		Ti +Lo V/// / /	Hospi tal	Coct

				5/31/2016 11:	39 am
	Title XVIII Hospital		Cost		
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART V - CALCULATION OF REIMBURSEMENT FOR V - CAL	ADT A SERVICES - COST	DELMBLIDSEMENT	1.00	
1.00	Inpatient services	ART A SERVICES COST	KETWIDOKSEWENT	1, 974, 106	1. 00
		->			
2.00	Nursing and Allied Health Managed Care payment (see instruction	S)		0	2. 00
3.00	Organ acquisition			0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			1, 974, 106	
5.00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 993, 847	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routi ne servi ce charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9. 00				0	9. 00
	Organ acquisition charges, net of revenue				
10. 00	Total reasonable charges			0	10. 00
	Customary charges				
11. 00	Aggregate amount actually collected from patients liable for pa			0	11. 00
12.00	Amounts that would have been realized from patients liable for	payment for services o	n a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)				
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	13.00
14.00	Total customary charges (see instructions)			0	14.00
15. 00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15. 00
	instructions)	e execede	0) (000	· ·	
16. 00					16. 00
10.00	instructions)	TI TITLE & CACCCUS TITL	C 14) (3CC	0	10.00
17 00	00 Cost of physicians' services in a teaching hospital (see instructions)				17. 00
17.00		ctrons)		0	17.00
40.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	11 10			40.00
18. 00	Direct graduate medical education payments (from Worksheet E-4,	line 49)			18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			1, 993, 847	
20.00	Deductibles (exclude professional component)			251, 103	
21. 00	Excess reasonable cost (from line 16)			0	21. 00
22.00	Subtotal (line 19 minus line 20 and 21)			1, 742, 744	22. 00
23.00	Coinsurance			0	23. 00
24.00	Subtotal (line 22 minus line 23)			1, 742, 744	24. 00
25. 00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		25, 010	
26. 00	Adjusted reimbursable bad debts (see instructions)	3) (See Thisti detroils)		16, 257	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		11, 446	
	,	Ctrons)			
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 759, 001	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
29. 99	Recovery of Accelerated Depreciation			0	29. 99
30.00	Subtotal (see instructions)			1, 759, 001	30.00
30. 01	Sequestration adjustment (see instructions)			35, 180	30. 01
31. 00				1, 776, 590	
32. 00	Tentative settlement (for contractor use only)			0	32.00
33. 00	Balance due provider/program (line 30 minus lines 30.01, 31, an	d 32)		-52, 769	
34. 00	Protested amounts (nonallowable cost report items) in accordance		chanter 1	-32, 707	
34.00	§115. 2	e with two rub. 15-2,	спартег т,	U	34.00
	13110.2			l	

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

Provi der CCN: 151323

Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 5/31/2016 11: 39 am

					5/31/2016 11:	39 am_
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	2, 505	0	0	0	1.00
2. 00	Temporary investments	_,	o o	0		
3.00	Notes receivable			_	0	3. 00
		4 220 010	1	_		
4.00	Accounts receivable	4, 320, 019		0	0	
5.00	Other recei vabl e	32, 365	0	0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	263, 617	0	0	0	7. 00
8.00	Prepai d expenses	87, 071	0	0	0	8. 00
9. 00	Other current assets	0	0	0	0	
10. 00	Due from other funds	-1, 188, 703	1	_	Ö	10.00
11. 00	Total current assets (sum of lines 1-10)	3, 516, 874	. 0	0	0	11. 00
	FIXED ASSETS					1
12. 00	Land	282, 529		0	_	12. 00
13.00	Land improvements	1, 972, 720	0	0	0	13.00
14.00	Accumulated depreciation	-967, 207	' 0	0	0	14.00
15. 00	Bui I di ngs	13, 429, 858	0	0	0	15. 00
16. 00	Accumulated depreciation	-2, 914, 509	1	0	l o	16. 00
17. 00	Leasehold improvements	29, 098		0	0	17. 00
			1	_		1
18. 00	Accumulated depreciation	-26, 545	•	_	0	18. 00
19. 00	Fi xed equipment	7, 763, 936	1	0	0	19. 00
20. 00	Accumulated depreciation	-4, 146, 847	' 0	0	0	20. 00
21.00	Automobiles and trucks	74, 622	2 0	0	0	21. 00
22. 00	Accumulated depreciation	-50, 489	0	0	l 0	22. 00
23. 00	Major movable equipment	7, 443, 728	1	0	0	23. 00
24. 00	Accumulated depreciation	-5, 956, 570		0	l o	24. 00
		-3, 730, 370	1	_	0	
25. 00	Mi nor equi pment depreci abl e	0	0	_		25. 00
26. 00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0) 0	0	0	27. 00
28.00	Accumulated depreciation	0	0	0	0	28. 00
29.00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	16, 934, 324	. 0	0	0	30.00
	OTHER ASSETS			_		1
31. 00	Investments	1	0	0	0	31.00
			0	_		32.00
32. 00	Deposits on Leases	0	1	_		1
33. 00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	5, 011, 241	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	5, 011, 241	0	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	25, 462, 439	0	0	0	36. 00
	CURRENT LIABILITIES					1
37. 00	Accounts payable	629, 495	0	0	0	37. 00
			1	_		1
38. 00	Sal ari es, wages, and fees payable	490, 217	1	0		38. 00
39. 00	Payroll taxes payable	0	0	0	0	
40. 00	Notes and Loans payable (short term)	800, 000) 0	0	0	40. 00
41. 00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43.00	Due to other funds	1 0	ol o	0	l 0	43.00
44.00	Other current liabilities	658, 968	0	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	2, 578, 680	1	_		1
70.00	LONG TERM LIABILITIES	2,370,000	,	·		+5.00
47.00		1 ^			1 -	4, 00
46. 00	Mortgage payable	0	0	_	-	
47. 00	Notes payable	0	0	_	-	
48. 00	Unsecured Loans	0	0	0	0	48. 00
49.00	Other long term liabilities	25, 395, 157	0	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	25, 395, 157	· 0	0	0	50.00
51. 00	Total liabilites (sum of lines 45 and 50)	27, 973, 837	1			51. 00
01.00	CAPITAL ACCOUNTS	21,710,001				01.00
F2 00		2 511 200			I	F2 00
52. 00	General fund balance	-2, 511, 398				52. 00
53. 00	Specific purpose fund		0			53. 00
54.00	Donor created - endowment fund balance - restricted		1	0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			n		56. 00
57. 00	Plant fund balance - invested in plant		1		0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
50.00					l ⁰	30.00
E0 00	replacement, and expansion	0 544 000	,	_	_	E0 00
59. 00	Total fund balances (sum of lines 52 thru 58)	-2, 511, 398		0	0	
60. 00	Total liabilities and fund balances (sum of lines 51 and	25, 462, 439	0	0	0	60.00
	[59]		1			1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provi der CCN: 151323

					0 12/31/2015	5/31/2016 11:	
		General	Fund	Speci al Pu	irpose Fund	Endowment Fund	07 4111
		1.00	2. 00	3.00	4. 00	5. 00	
1.00	Fund balances at beginning of period		-2, 511, 398		(1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		1, 703, 574				2. 00
3.00	Total (sum of line 1 and line 2)		-807, 824)	3.00
4.00	Additions (credit adjustments) (specify)	0		C		0	4.00
5. 00 6. 00				0		0	5. 00 6. 00
7. 00						0	7.00
8.00		0				0	8.00
9. 00		0				0	9. 00
10.00	Total additions (sum of line 4-9)		0	Ĭ		ار	10.00
11. 00	Subtotal (line 3 plus line 10)		-807, 824				11.00
12. 00	Deductions (debit adjustments) (specify)	0	007,021	l c	ì	1 0	12.00
13. 00	TRANSFERS	1, 703, 574)	0	13.00
14.00		0)	0	14. 00
15.00		o)	0	15. 00
16.00		O		[c)	0	16. 00
17.00		0		0)	0	17. 00
18. 00	Total deductions (sum of lines 12-17)		1, 703, 574	•	(18. 00
19. 00	Fund balance at end of period per balance		-2, 511, 398		(19. 00
	sheet (line 11 minus line 18)	Fredriment Final	PI ant	F1			
		Endowment Fund	Prant	Fund	-		
		6.00	7. 00	8. 00			
1. 00	Fund balances at beginning of period	0		C			1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	o)		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		C			10.00
11.00	Subtotal (line 3 plus line 10)	0					11.00
12.00	Deductions (debit adjustments) (specify) TRANSFERS		0				12. 00 13. 00
13. 00 14. 00	TRANSFERS		0				14.00
15. 00			0				15.00
16. 00			0				16.00
17. 00			0				17.00
18. 00	Total deductions (sum of lines 12-17)	0	U	C	,		18.00
19. 00	Fund balance at end of period per balance	0					19.00
17. 50	sheet (line 11 minus line 18)				1		' / . 55
							l

 Heal th Financial Systems
 COMMUNITY

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

		T	o 12/31/2015	Date/Time Prep 5/31/2016 11:	
	Cost Center Description	Inpatient	Outpati ent	Total	J 7 aiii
	oddt denten beschiptron	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES			2. 22	
	General Inpatient Routine Services				
1.00	Hospi tal	4, 043, 410		4, 043, 410	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF				3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	433, 840		433, 840	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)	4, 477, 250		4, 477, 250	10.00
	Intensive Care Type Inpatient Hospital Services	, , , , , ,	I		
11.00	INTENSIVE CARE UNIT				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	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of li	nes 0		0	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	4, 477, 250		4, 477, 250	17.00
18.00	Ancillary services	13, 449, 394	O	13, 449, 394	18. 00
19.00	Outpati ent servi ces	0	60, 192, 213	60, 192, 213	19. 00
20.00	RURAL HEALTH CLINIC	o	0	0	20. 00
21.00	FEDERALLY QUALIFIED HEALTH CENTER	o	O	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23.00	AMBULANCE SERVICES	o	3, 821, 258	3, 821, 258	23. 00
24.00	CMHC				24. 00
24. 10	CORF	0	O	0	24. 10
24. 20	OUTPATIENT PHYSICAL THERAPY	0	0	0	24. 20
24. 30	OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	24. 30
24. 40	OUTPATIENT SPEECH PATHOLOGY	0	0	0	24. 40
25.00	AMBULATORY SURGICAL CENTER (D. P.)				25. 00
26.00	HOSPI CE				26.00
27. 00	OTHER (SPECIFY)	0	0	0	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	0 Wkst. 17, 926, 644	64, 013, 471	81, 940, 115	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		29, 446, 563		29. 00
30. 00	ADD (SPECIFY)	0	l I		30.00
31. 00		0	l I		31. 00
32. 00		0			32.00
33. 00		0			33. 00
34. 00		0			34.00
35. 00		0			35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)	0			37. 00
38. 00		0			38. 00
39. 00		0			39. 00
40. 00		0			40. 00
41.00		0			41.00
42.00	Total deductions (sum of lines 37-41)		0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer	29, 446, 563		43.00
	to Wkst. G-3, line 4)	I			

Heal th	Financial Systems COMMUNITY HOSPT. OF LAG	GRANGE CTY IN	In Lie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provi der CC	Peri od:	Worksheet G-3	
			From 01/01/2015		
			To 12/31/2015	Date/Time Prep 5/31/2016 11:3	
				0,01,2010 111	, diii
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		81, 940, 115	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			51, 793, 535	2. 00
3.00	Net patient revenues (line 1 minus line 2)			30, 146, 580	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)		29, 446, 563	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			700, 017	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			111, 850	1
7. 00	Income from investments			-1, 228	1
8.00	Revenues from telephone and other miscellaneous communication \boldsymbol{s}	ervi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			0	11. 00
	Parking Lot receipts			0	12. 00
	Revenue from Laundry and Linen service			0	13. 00
	Revenue from meals sold to employees and guests			233, 989	•
	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical supplies to other tha	n patients		0	16. 00
	Revenue from sale of drugs to other than patients			251, 150	•
	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00

20.00

21.00

22.00

23.00

24. 01

24.02

25.00

26.00 27. 00 0

13, 592

32, 496

349, 000

12, 696

1, 003, 557

1, 703, 574

0

12

0 28.00

1, 703, 574 29. 00

20.00

21.00

22.00

23.00

24. 01

24. 02

Revenue from gifts, flowers, coffee shops, and canteen

Rental of vending machines Rental of hospital space

Governmental appropriations

COUNTY REIMBURSEMENT AMBULANCE SRV

28.00 Total other expenses (sum of line 27 and subscripts)

29.00 Net income (or loss) for the period (line 26 minus line 28)

25.00 Total other income (sum of lines 6-24)

24.00 GAIN ON DISPOSAL OF ASSETS

26.00 Total (line 5 plus line 25) 27.00 OTHER EXPENSES (SPECIFY)

MI SCELLANEOUS