This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai	lure to report can resu	ult in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	deemed overpayments (4	12 USC 1395g).	OMB NO. 0938-0050
				EXPIRES 03-31-2022
HOSPITAL AND H AND SETTLEMENT	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provider CCN: 15-1323	Period: From 01/01/2019 To 12/31/2019	
PART I - COST	REPORT STATUS			
Provi der	1. [X] Electronically prepared cost report		Date: 8/21/20	20 Time: 10:08 am
use only	2. [] Manually prepared cost report			
	3.[0] If this is an amended report enter the number 4.[F] Medicare Utilization. Enter "F" for full or "L	of times the provider _" for low.	resubmitted this co	ost report
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N]Initial Report for (3) Settled with Audit 9. [N]Final Report for (4) Reopened (5) Amended	11. or this Provider CCN 12.		

PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPT. OF LAGRANGE CTY IN (15-1323) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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.

[X]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

(Si gned) JEANNÉ WI CKENS
Officer or Administrator of Provider(s)

CFO/SVP

Title

(Dated when report is electronically signed.)

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	156, 727	-410, 952	0	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing Bed - SNF	0	44, 700	0		0	5. 00
6.00	Swing Bed - NF	0				0	6. 00
200.00	Total	0	201, 427	-410, 952	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1323 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 8/21/2020 10:08 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, T, 0, or N)

/ XVIII XIX Туре Certi fi ed Number Number 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal COMMUNITY HOSPT. OF 151323 99915 05/01/2005 Ν 0 3.00 LAGRANGE CTY IN Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF SWING BEDS 157323 99915 N 7 00 7 00 05/01/2005 N 0 Swing Beds - NF 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 17. 20 Hospi tal -Based (OPT) I 17.20 17.30 Hospital-Based (00T) I 17.30 17. 40 Hospi tal -Based (OSP) I 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) 01/01/2019 12/31/2019 20.00 21.00 Type of Control (see instructions) 2 21.00 1. 00 2. 00 3.00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for N N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22. 01 Did this hospital receive interim uncompensated care payments for this Ν Ν 22.01 cost reporting 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)
Is this a newly merged hospital that requires final uncompensated care 22.02 Ν Ν 22.02 payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to N Ν Ν 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1323 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 8/21/2020 10:08 am In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days paid days unpai d el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 0 24.00 \cap n in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 0 25.00 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5. Urban/Rural S Date of Geogr 1. 00 2.00 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. 26.00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in column 1, "1" for urban or "2" for rural. If applicable, 27.00 enter the effective date of the geographic reclassification in column 2. If this is a sole community hospital (SCH), enter the number of periods SCH status in 35.00 effect in the cost reporting period. Endi ng: Begi nni ng: 1.00 2.00 36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number 36, 00 of periods in excess of one and enter subsequent dates. If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 37.00 0 is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 37.01 37.01 instructions) If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is 38.00 greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N 1.00 2.00 39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume 39. 00 hospitals in accordance with 42 CFR §412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or Ν Ν 40.00 'N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (see instructions) XVIII XIX 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance Ν 45.00 with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances Ν N Ν 46,00 pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through 47.00 | Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 47.00 Ν 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Ν Ν Ν 48.00 Teaching Hospitals Is this a hospital involved in training residents in approved GME programs? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR), MA Ν 56.00 GME payment reduction? Enter "Y" for yes or "N" for no in column 2. If line 56 is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 57.00 57.00 Ν is "Y" did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15-1, chapter 21, §2148? If yes, complete Wkst. D-5. Ν 58.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I. 59 00 N

	Financial Systems		Provi der CO		<u> </u>	u of Form CMS-2 Worksheet S-2	
nusri i	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	IA	Provider Co		rom 01/01/2019	Part I	pared:
				NAHE 413.85 Y/N	Worksheet A Line #	Pass-Through Qualification Criterion Code	
				1. 00	2. 00	3.00	
60. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in colis "Y", are you impacted by CR 11642 (or subsequent C adjustement? Enter "Y" for yes or "N" for no in colu	85? (s umn 1. R) NAHE	see If column 1	N			60.00
		Y/N	I ME	Direct GME	I ME	Direct GME	
61 00	Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4. 00	5.00	61. 00
	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see	14			0.00	0.00	61. 0
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61. 02
	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61. 03
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). Enter the difference between the baseline primary						61. 04
	and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						
51. 06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		N				61. 0
		Pro	ogram Name	Program Code	Unwei ghted IME FTE Count	Unweighted Direct GME FTE Count	
1. 10	Of the FTEs in line 61.05, specify each new program		1. 00	2. 00	3. 00	4.00	61. 1
	specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0. 00		61. 20
				(11004)		1.00	
2. 00	ACA Provisions Affecting the Health Resources and Ser Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc	trai nec			od for which	0.00	62. 00
2. 01	Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	Teachi ram. (s	see instructio		your hospital	0.00	62. 0
3. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple					N Ratio (col. 1/ (col. 1 + col.	63.0
				Nonprovi der Si te	Hospi tal	2))	
	Section 5504 of the ACA Base Year FTE Residents in No			1.00 This base year	2.00 is your cost r	3.00 reporting	
94. 00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted	y trair -primar all nor non-pr	ned residents ry care nprovider rimary care	0.00	0.00	0. 000000	64. 0
	resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see						

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1323 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 8/21/2020 10:08 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 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 Unwei ghted Ratio (col. 3/ Program Code 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 is 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 is 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)

Heal th	Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY	IN	In Lie	u of Form CMS	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider C		Peri od:	Worksheet S-	2
			rom 01/01/2019	Part I	
			o 12/31/2019	Date/Time Pr 8/21/2020 10	
				0/21/2020 10	. 06 alli
				1. 00	
	Long Term Care Hospital PPS			1.00	
80 OO	Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for	no		N	80.00
	Is this a LTCH co-located within another hospital for part or all of the		neriod? Enter	N	81. 00
01.00	"Y" for yes and "N" for no.	cost reporting	perrou: Litter	14	01.00
	TEFRA Providers				
85 00	Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter	er "V" for ves	or "N" for no	N	85.00
	Did this facility establish a new Other subprovider (excluded unit) under			14	86. 00
	§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	42 OIN SCOTIO			00.00
	Is this hospital an extended neoplastic disease care hospital classified	under section		N	87. 00
07.00	1886(d) (1) (B) (vi)? Enter "Y" for yes or "N" for no.	ander Section			07.00
	1 100 years 1 101 years 1 101 101		V	XI X	
			1. 00	2. 00	
	Title V and XIX Services				
90.00	Does this facility have title V and/or XLX inpatient hospital services? E	nter "Y" for	N	Υ	90.00
	yes or "N" for no in the applicable column.				
91.00	Is this hospital reimbursed for title V and/or XIX through the cost repor	rt either in	N	N	91.00
	full or in part? Enter "Y" for yes or "N" for no in the applicable column	٦.			
	Are title XIX NF patients occupying title XVIII SNF beds (dual certificat			N	92. 00
	instructions) Enter "Y" for yes or "N" for no in the applicable column.	, ,			
93.00	Does this facility operate an ICF/IID facility for purposes of title V ar	nd XIX? Enter	N	N	93. 00
	"Y" for yes or "N" for no in the applicable column.				
94.00	Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for r	no in the	N	N	94. 00
	applicable column.				
	If line 94 is "Y", enter the reduction percentage in the applicable colum		0. 00	0.00	95.00
96.00	Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for r	no in the	N	N	96. 00
	applicable column.				
97. 00	If line 96 is "Y", enter the reduction percentage in the applicable colum	nn.	0. 00	0.00	97. 00
	Does title V or XIX follow Medicare (title XVIII) for the interns and res		Υ	Υ	98. 00
	stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N"	'for no in			
	column 1 for title V, and in column 2 for title XIX.				
	Does title V or XIX follow Medicare (title XVIII) for the reporting of ch		Υ	Υ	98. 01
	C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and ir	n column 2 for			
	title XIX.				
98. 02	Does title V or XIX follow Medicare (title XVIII) for the calculation of		Υ	Υ	98. 02
	bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no	in column 1			
	for title V, and in column 2 for title XIX.				
98. 03	Does title V or XIX follow Medicare (title XVIII) for a critical access h		N	N	98. 03
	reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for	no in column 1			
	for title V, and in column 2 for title XIX.	24%			
	Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 10		N	N	98. 04
	outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for	title V, and			
00 05	in column 2 for title XIX.	callowers -		V	00.05
	Does title V or XIX follow Medicare (title XVIII) and add back the RCE di		Υ	Y	98. 05
	Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for t	urue v, and In			

I or outpatrent services: (see ristructions)	for outpatient services: (see instructions)						
107.00 Column 1: If line 105 is Y, is this facility eligible for co	107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for I&R N						
training programs? Enter "Y" for yes or "N" for no in column	training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions)						
Column 2: If column 1 is Y and line 70 or line 75 is Y, do	you train I&Rs	s in an					
approved medical education program in the CAH's excluded IF	PF and/or LRF ι	uni t(s)?					
Enter "Y" for yes or "N" for no in column 2. (see instructi	ons)						
108.00 Is this a rural hospital qualifying for an exception to the	CRNA fee sched	dul e? See 42	N		108. 00		
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							
	Physi cal	Occupati onal	Speech	Respi ratory			
	1.00	2.00	3.00	4. 00			
109.00 If this hospital qualifies as a CAH or a cost provider, are	N	N	N	N	109. 00		
therapy services provided by outside supplier? Enter "Y"							
for yes or "N" for no for each therapy.							
				1.00			
110.00 Did this hospital participate in the Rural Community Hospita	al Demonstratio	on project (§41	OA	N	110.00		
Demonstration) for the current cost reporting period? Enter '	'Y" for yes or	"N" for no. If	yes,				
, , , , , , , , , , , , , , , , , , , ,	-		-	1	1		

complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as

98.06

105.00

106.00

Υ

Ν

98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D,

Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in

106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment

MCRI F32 - 16. 2. 168. 1

appi i cabl e.

column 2 for title XIX.

column 2 for title XIX. Rural Providers

105.00 Does this hospital qualify as a CAH?

for outpatient services? (see instructions)

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der Co	CN: 15-1323	Peri od: From 01/01/2019	Worksheet S- Part I	
			To 12/31/2019	Date/Time Pr 8/21/2020 10	epared: :08 am
			1. 00	2.00	+
111.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cost "Y" for yes or "N" for no in column 1. If the response to colum integration prong of the FCHIP demo in which this CAH is partic Enter all that apply: "A" for Ambulance services; "B" for addit for tele-health services.	reporting p mn 1 is Y, o cipating in	period? Enter enter the column 2.	N		111.00
		1.00	2. 00	3.00	+
112.00 Did this hospital participate in the Pennsylvania Rural Health demonstration for any portion of the current cost reporting per Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceased participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	ri od? Y", enter	N			112. 00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "No in column 1. If column 1 is yes, enter the method used (A, B, or in column 2. If column 2 is "E", enter in column 3 either "93" for short term hospital or "98" percent for long term care (incompsychiatric, rehabilitation and long term hospitals providers) the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) percent cludes based on	N			0 115. 00
116.00 s this facility classified as a referral center? Enter "Y" for "N" for no.	,	N			116. 00
117.00 Is this facility legally-required to carry malpractice insurance "Y" for yes or "N" for no.		Y	1		117. 00
118.00 s the malpractice insurance a claims-made or occurrence policy if the policy is claim-made. Enter 2 if the policy is occurrence			1		118.00
		Premiums	Losses	Insurance	
		1.00	2.00	3.00	+
118.01 List amounts of malpractice premiums and paid losses:		53, 5	16 19, 097	33, 87	8 118. 01
			1. 00	2.00	
118.02 Are mal practice premiums and paid losses reported in a cost cer Administrative and General? If yes, submit supporting schedule and amounts contained therein. 119.00 Do NOT USE THIS LINE	e listing co	ost centers	N	N	118. 02
120.00 s this a SCH or EACH that qualifies for the Outpatient Hold Ha §3121 and applicable amendments? (see instructions) Enter in co "N" for no. Is this a rural hospital with < 100 beds that quali Hold Harmless provision in ACA §3121 and applicable amendments? Enter in column 2, "Y" for yes or "N" for no.	olumn 1, "Y' ifies for tl	" for yes or he Outpatient		N	120.00
121.00 Did this facility incur and report costs for high cost implanta patients? Enter "Y" for yes or "N" for no.	able devices	s charged to	Y		121. 00
122.00 Does the cost report contain healthcare related taxes as define Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is the Worksheet A line number where these taxes are included.			N		122. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for y	ves and "N"	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, enter					126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter	the certifi	ication date			127. 00
in column 1 and termination date, if applicable, in column 2. 128.00 f this is a Medicare certified liver transplant center, enter	the certifi	ication date			128. 00
in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter to column 1 and termination date, if applicable, in column 2.	the certific	cation date i	n		129. 00
130.00 If this is a Medicare certified pancreas transplant center, endidate in column 1 and termination date, if applicable, in column		tification			130. 00
131.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in column	enter the c	erti fi cati on			131. 00
132.00 If this is a Medicare certified islet transplant center, enter in column 1 and termination date, if applicable, in column 2.		ication date			132. 00
133.00 Removed and reserved 134.00 If this is an organ procurement organization (OPO), enter the (and termination date, if applicable, in column 2.	OPO number i	in column 1			133. 00 134. 00
All Providers 140.00 Are there any related organization or home office costs as deficient chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes are claimed, enter in column 2 the home office chain number. (s	s, and home	office costs	Y	15H032	140. 00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1323 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: To 12/31/2019 8/21/2020 10:08 am 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: PARKVIEW HEALTH SYSTEM, INC. Contractor's Name: WISCONSIN PHYSICIANS Contractor's Number: 08101 141 00 SERVI CE 142.00 Street: 10501 CORPORATE DRIVE PO Box: 5600 142.00 143.00 City: FORT WAYNE State: ΙN Zip Code: 46845 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 2.00 1.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146, 00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 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 the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155 00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157. 00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν N N 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν Ν 161.00 161. 10 CORF Ν Ν 161. 10 161. 20 OUTPATIENT PHYSICAL THERAPY Ν Ν 161. 20 Ν 161. 30 OUTPATIENT OCCUPATIONAL THERAPY 161. 30 N Ν N 161. 40 OUTPATIENT SPEECH PATHOLOGY N N Ν 161. 40 1.00 Multicampus 165.00|Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. County State Zip Code CBSA FTE/Campus Name 0 1.00 2 00 3.00 4 00 5.00 166.00 If line 165 is yes, for each 0. 00 166. 00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. Υ 167 00 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 168.00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Begi nni ng Endi ng 1. 00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 170. 00 period respectively (mm/dd/yyyy)

Health Financial Systems	COMMUNITY HOSPT. OF	F LAGRANGE CTY IN	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	Peri od:	Worksheet S-2	2		
			From 01/01/2019		
			To 12/31/2019	Date/Time Pre	pared:
				8/21/2020 10:	08 am
	1. 00	2.00			
171.00 If line 167 is "Y", does this provide	N	(171. 00		
section 1876 Medicare cost plans repo					
"Y" for yes and "N" for no in column	n				
1876 Medicare days in column 2. (see	instructions)				

General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions) 1.00 P/N Date V/I 2.00 Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3. "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) 4.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation. Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program? If "Y" see instructions. N Hegal Oper. Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is N Hegal Oper. Are costs claimed for Allied Health programs approved and/or renewed during the cost reporting period? If yes, see instructions.	HOSPI T	Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY I AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CC	N: 15-1323	Peri od: From 01/01/2019 To 12/31/2019	Date/Time Pr 8/21/2020 10	-2 repared:
General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation 1.00 Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions) 1.00 2.00 3.00 2.00 Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management contracts, with individuals or entitles (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Financial Data and Reports 4.00 Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation. 4.00 Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program? Approved Educational Activities 6.00 Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 8.00 Were nursing school and/or allied heal th programs approved and/or renewed during the cost reporting period? If yes, see instructions.				Y/N	Date	
Has the provider changed ownership immediately prior to the beginning of the cost reporting period? If yes, enter the date of the change in column 2. (see instructions) N		mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	ponses. Ente			
reporting period? If yes, enter the date of the change in column 2. (see instructions) Y/N	1 00	Has the provider changed ownership immediately prior to the beginning of t	he cost	N I		1.0
2.00 Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) 4.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation. Approved Educational Activities 6.00 Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program? 7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions. N Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. N Were costs claimed for Interns and Residents in an approved graduate medical education	00	reporting period? If yes, enter the date of the change in column 2. (see i	nstructions)			
Has the provider terminated participation in the Medicare Program? If yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Type Date 1.00 2.00 3.00					V/I	
yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N			1.00	2. 00	3. 00	
contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Type Date 1.00 2.00 3.00	2. 00	yes, enter in column 2 the date of termination and in column 3, "V" for	N			2.00
Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation. Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program? Column 1: Are costs claimed for Allied Health Programs? If "Y" see instructions. Nowere nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education Note that the program is the provider is the provider is the legal operator of the program? Note that the provider is the provider is the provider is the legal operator of the program? Note that the provider is the provider is the provider is the legal operator of the program? Note that the provider is the provider is the provider is the provider is the legal operator of the program? Note that the provider is the provider	3. 00	contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar	N			3.00
Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public						
Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation. Approved Educational Activities Y/N Legal Oper.			1. 00	2. 00	3. 00	
Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues different from those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper.		Financial Data and Reports				
Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education N Legal Oper. 1.00 2.00 N N N N Approved Educational Activities N N N Approved Educational Activities N N Approved Educational Activities N The legal operator of the program? N N Are costs claimed for Allied Health Programs? If "Y" see instructions. N Are costs claimed for Interns and Residents in an approved graduate medical education N	4. 00	Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, or "R" for Reviewed. Submit complete copy or enter date available in	Y	A		4. 00
Approved Educational Activities 5.00 Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program? 7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions. 8.00 Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. 9.00 Are costs claimed for Interns and Residents in an approved graduate medical education N	5. 00	Are the cost report total expenses and total revenues different from	N			5. 0
Approved Educational Activities 6.00 Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program? 7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions. 8.00 Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. 9.00 Are costs claimed for Interns and Residents in an approved graduate medical education N				Y/N	Legal Oper.	
Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is the legal operator of the program? 7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions. 8.00 Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. 9.00 Are costs claimed for Interns and Residents in an approved graduate medical education				1. 00	2. 00	
the legal operator of the program? 7.00 Are costs claimed for Allied Health Programs? If "Y" see instructions. 8.00 Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. 8.00 Are costs claimed for Interns and Residents in an approved graduate medical education N		Approved Educational Activities				
8.00 Were nursing school and/or allied health programs approved and/or renewed during the cost reporting period? If yes, see instructions. 9.00 Are costs claimed for Interns and Residents in an approved graduate medical education N		the legal operator of the program?				6. 0
cost reporting period? If yes, see instructions. 2.00 Are costs claimed for Interns and Residents in an approved graduate medical education N						7. 0
		cost reporting period? If yes, see instructions.				8. 0
	0.00	program in the current cost report? If yes, see instructions.				9.00
cost reporting period? If yes, see instructions.) Was an approved Intern and Resident GME program initiated or renewed in the current		N N		10.00
	0. 00					
Y/N		cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Appr Teaching Program on Worksheet A? If yes, see instructions.	roved	N		11.

15.00	Did total beds available change from the prior cost reporti	ng period? If	yes, see instr	uctions.	N	15. 00
		Par	t A	Par	t B	
		Y/N	Date	Y/N	Date	
		1. 00	2. 00	3. 00	4. 00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	Υ	04/30/2015	Υ	04/30/2015	17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	Y		Υ		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

12.00

13.00

14.00

Ν

Ν

Is the provider seeking reimbursement for bad debts? If yes, see instructions.

If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting period? If yes, submit copy.

If line 12 is yes, were patient deductibles and/or co-payments waived? If yes, see instructions.

12.00

13.00

14.00

Bed Complement

Heal th	Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of								
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Period: From 01/01/2019 To 12/31/2019	Worksheet S-2 Part II Date/Time Pro 8/21/2020 103	epared:			
			pti on	Y/N	Y/N	. 66 4			
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R	()	1. 00 N	3. 00 N	20.00			
20.00	Report data for Other? Describe the other adjustments:			IN	IN	20.00			
	Y/N Date Y/N								
21. 00	Was the cost report prepared only using the provider's	1. 00 N	2.00	3. 00 N	4. 00	21. 00			
	records? If yes, see instructions.					21.00			
					1. 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)						
22. 00	Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see	instructions			N	22. 00			
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		als made duri	ng the cost	N	23. 00			
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost rep	orting period?	N	24. 00			
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repor	ting period?	If yes, see	N	25. 00			
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost reporti	ng period? If	yes, see	N	26. 00			
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reportin	g period? If	yes, submit	N	27. 00			
28. 00	Interest Expense Were new loans, mortgage agreements or letters of credit er	ntered into dur	ing the cost	reporti ng	N	28. 00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		bt Service Re	serve Fund)	N	29. 00			
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	N	30. 00						
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	N	31. 00						
	Purchased Services								
32. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru		d through con	tractual	N	32. 00			
33. 00	If line 32 is yes, were the requirements of Sec. 2135.2 applino, see instructions.	olied pertainin	g to competit	ive bidding? If	N	33. 00			
	Provi der-Based Physi ci ans								
34. 00	If yes, see instructions.	· ·	•	. ,	N	34. 00			
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		ts with the p		_	35. 00			
				Y/N 1. 00	2. 00				
	Home Office Costs			1.00	2.00				
36. 00	Were home office costs claimed on the cost report?		36. 00						
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.		37. 00						
38. 00	the provider? If yes, enter in column 2 the fiscal year end		38. 00						
39. 00	If line 36 is yes, did the provider render services to othe see instructions.		39. 00						
40. 00	If line 36 is yes, did the provider render services to the instructions.		40. 00						
		1.00 2.			00				
	Cost Report Preparer Contact Information	1.00							
41. 00	held by the cost report preparer in columns 1, 2, and 3,	ERI C		NI CKESON		41. 00			
42. 00	respectively. Enter the employer/company name of the cost report preparer.	PARKVIEW HEALT	H SYSTEM, INC			42. 00			
43. 00	1' '	(260) 373-8406		ERI C. NI CKESON@F	PARKVI EW. COM	43. 00			

Heal th	Financial Systems COMMUNITY HOSPT.	0F	LAGRANGE CTY IN		In Lieu	u of Form CMS-2	2552-10
HOSPI 7	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provider CCN: 15-1323	Peri oc		Worksheet S-2	
					01/01/2019 12/31/2019	Part II Date/Time Pre 8/21/2020 10:	pared: 08 am
		L					
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	D	I RECTOR, REIMBURSEMENT				41. 00
	held by the cost report preparer in columns 1, 2, and 3,						
	respectively.						
42.00	Enter the employer/company name of the cost report						42. 00
	preparer.						
43.00	Enter the telephone number and email address of the cost						43.00
	report preparer in columns 1 and 2, respectively.						

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3
From 01/01/2019	Part
To 12/31/2019	Date/Time Prepared:
8/21/2020 10:08 am Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: Provider CCN: 15-1323	

						8/21/2020 10:0	08 am
	·					I/P Days / O/P	
						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, 125	69, 408. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7.00	Total Adults and Peds. (exclude observation		25	9, 125	69, 408. 00	0	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)						12.00
13.00	NURSERY	43. 00	0.5	0.405	(0.400.00	0	13. 00
14. 00	Total (see instructions)		25	9, 125	69, 408. 00		14. 00
15. 00	CAH visits					0	15. 00
16.00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVIDER - 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
21. 00 22. 00	OTHER LONG TERM CARE						21.00
23. 00	HOME HEALTH AGENCY						23. 00
24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE						24.00
24. 00	HOSPICE (non-distinct part)	30. 00					24. 00
25. 00	CMHC - CMHC	30.00					25. 00
25. 10	CMHC - CORF	99. 10				o	25. 10
25. 10	CMHC - OUTPATIENT PHYSICAL THERAPY	99. 20					25. 10
25. 30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99. 30					25. 20
25. 40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99. 40					25. 40
26. 00	RURAL HEALTH CLINIC	77. 10				Ĭ	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				o	
27. 00	Total (sum of lines 14-26)	07.00	25	5		Ĭ	27. 00
28. 00	Observation Bed Days					o	
29. 00	Ambulance Trips					١	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)		C	o l			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges						33. 01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1323

Peri od: Worksheet S-3 From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

8/21/2020 10:08 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Title XIX Total All Total Interns Employees On Component 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 684 38 2, 115 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 75 2 00 HMO and other (see instructions) 649 3.00 HMO IPF Subprovider C 3.00 4.00 HMO IRF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 0 5.00 5.00 158 158 Hospital Adults & Peds. Swing Bed NF 6.00 C 230 6.00 7.00 Total Adults and Peds. (exclude observation 842 38 2,503 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 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 146 389 13.00 14.00 Total (see instructions) 842 184 2,892 0.00 175. 10 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 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 HOSPI CE 24 00 24 00 24. 10 HOSPICE (non-distinct part) 0 24.10 CMHC - CMHC 25.00 25.00 25. 10 CMHC - CORF 0.00 0.00 25. 10 0 0 0 CMHC - OUTPATIENT PHYSICAL THERAPY 0 0.00 0 0.00 25. 20 25 20 25. 30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 0 0 0.00 0.00 25.30 CMHC - OUTPATIENT SPEECH PATHOLOGY 0 0.00 0.00 25.40 RURAL HEALTH CLINIC 26, 00 26, 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0 0.00 0.00 26.25 Total (sum of lines 14-26) 0.00 175. 10 27.00 28.00 Observation Bed Days 28 980 28.00 Ambulance Trips 29 00 29 00 569 30.00 Employee discount days (see instruction) 16 30.00 Employee discount days - IRF 31.00 C 31.00 Labor & delivery days (see instructions) 32.00 32.00 0 141 Total ancillary labor & delivery room 32.01 C 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 0 33.00 0 33.01 LTCH site neutral days and discharges 33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1323

Peri od: Worksheet S-3 From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

8/21/2020 10:08 am Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 12.00 13.00 11.00 14.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 256 19 971 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) 182 2 00 3.00 HMO IPF Subprovider 0 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 971 14.00 Total (see instructions) 0.00 0 256 19 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 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 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 24. 10 25. 00 CMHC - CMHC 25.00 25. 10 CMHC - CORF 0.00 25. 10 CMHC - OUTPATIENT PHYSICAL THERAPY 0.00 25 20 25. 20 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 25. 30 0.00 25.30 CMHC - OUTPATIENT SPEECH PATHOLOGY 0.00 25.40 RURAL HEALTH CLINIC 26.00 26, 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 00 26 25 27.00 Total (sum of lines 14-26) 0.00 27.00 28.00 Observation Bed Days 28.00 Ambulance Trips 29 00 29 00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 31.00 Labor & delivery days (see instructions) 32.00 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

Heal th	Financial Systems COMMUNITY HOSPT. OF LAGR	RANGE CTY IN		In Lie	u of Form CMS-2	2552-10			
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA Pr	rovider CCN:		Peri od:	Worksheet S-10	0			
				From 01/01/2019 To 12/31/2019	Date/Time Pre 8/21/2020 10:				
					1. 00				
	Uncompensated and indigent care cost computation		000	0)	0.044700				
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 dividedicald (see instructions for each line)	ded by line	202 column	8)	0. 264728	1. 00			
2.00	Net revenue from Medicaid				833, 278	2. 00			
3.00	Did you receive DSH or supplemental payments from Medicaid?			. 10		3.00			
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or supplementa If line 4 is no, then enter DSH and/or supplemental payments from	1 2	rrom wedica	10?	0	4. 00 5. 00			
6.00	Medicaid charges	iii wcar car a			8, 116, 189				
7.00	Medicaid cost (line 1 times line 6)				2, 148, 582				
8. 00	Difference between net revenue and costs for Medicaid program (I < zero then enter zero)	ine 7 minus	sum of lin	es 2 and 5; if	1, 315, 304	8. 00			
	Children's Health Insurance Program (CHIP) (see instructions for each line)								
9.00	Net revenue from stand-alone CHIP				0				
10.00	Stand-allone CHIP charges				0				
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (I	ine 11 minus	sline O·i	f / zero then	0				
12.00	enter zero)								
	Other state or local government indigent care program (see instru			`					
13. 00 14. 00	Net revenue from state or local indigent care program (Not inclu Charges for patients covered under state or local indigent care				1, 139, 267 8, 079, 301				
14.00	10)	program (No	t Theraueu	III IIIles 0 01	8, 07 7, 30 1	14.00			
15.00	State or local indigent care program cost (line 1 times line 14)				2, 138, 817	15. 00			
16. 00	Difference between net revenue and costs for state or local indi- 13; if < zero then enter zero)	gent care p	rogram (lin	e 15 minus line	999, 550	16. 00			
	Grants, donations and total unreimbursed cost for Medicaid, CHIP instructions for each line)	and state/I	ocal indig	ent care progran	ıs (see				
17. 00	Private grants, donations, or endowment income restricted to fun	ding charity	y care		0	17. 00			
18. 00	Government grants, appropriations or transfers for support of ho				0	18. 00			
19. 00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	indigent ca	re programs	(sum of lines	2, 314, 854	19.00			
			Uni nsured	Insured	Total (col. 1				
		_	patients	pati ents	+ col . 2)				
	Uncompensated Care (see instructions for each line)		1. 00	2. 00	3. 00				
20. 00	Charity care charges and uninsured discounts for the entire faci (see instructions)	lity	71, 36	3 25, 108	96, 471	20. 00			
21. 00	Cost of patients approved for charity care and uninsured discoun	ts (see	18, 89	2 25, 108	44, 000	21. 00			
22. 00	instructions) Payments received from patients for amounts previously written o	off as	14, 65	8 1, 309	15, 967	22. 00			
23. 00	charity care Cost of charity care (line 21 minus line 22)		4, 23	4 23, 799	28, 033	23. 00			
		· ·	·		·				
0.4.00				6 1 11 11	1.00	0.4.00			
	Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care p	rogram?		•	N	24. 00			
25. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit	indigent c	are program	's length of	0	25. 00			
	Total bad debt expense for the entire hospital complex (see inst				5, 543, 511	ı			
27. 00	Medicare reimbursable bad debts for the entire hospital complex				294, 284				
27. 01 28. 00	Medicare allowable bad debts for the entire hospital complex (ser Non-Medicare bad debt expense (see instructions)	e instructio	JI15 <i>)</i>		452, 744 5, 090, 767				
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense	nse (see in	structions)		1, 506, 129				
20 00	Cost of uncompensated care (line 23 column 3 plus line 29)	-	ĺ		1, 534, 162	30.00			
	Total unreimbursed and uncompensated care cost (line 19 plus line				3, 849, 016				

		JNI TY HOSPT. OF				u of Form CMS-	<u> 2552-10</u>
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der CC		Period: From 01/01/2019 To 12/31/2019	Worksheet A Date/Time Pre 8/21/2020 10:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		1, 693, 159	1, 693, 15			1.00
1. 01 2. 00	OO101 EMS WEST STATION OO200 CAP REL COSTS-MVBLE EQUIP		38, 641	38, 64	0 16, 140 1 717, 494	16, 140 756, 135	1. 01 2. 00
2. 01	00201 EMS WEST STATION EQUIP.		30, 041	30, 04	0 104, 271	104, 271	2. 01
3. 00	00300 OTHER CAP REL COSTS		0		0 0	0	1
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	59, 819	4, 808, 396			4, 868, 215	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	585, 098	11, 777, 668	12, 362, 76	6 -57, 357	12, 305, 409	5. 00
6. 00 7. 00	OO600 MAI NTENANCE & REPAI RS OO700 OPERATI ON OF PLANT	323, 511	0 782, 017	1, 105, 52	0 8 -5	1, 105, 523	6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	323, 311	72, 986			72, 986	
9. 00	00900 HOUSEKEEPI NG	187, 223	68, 792			256, 015	
10.00	01000 DI ETARY	432, 574	306, 521	739, 09		253, 279	1
11. 00	01100 CAFETERI A	0	0		0 481, 975	481, 975	1
12. 00 13. 00	O1200 MAINTENANCE OF PERSONNEL O1300 NURSING ADMINISTRATION	363, 558	0 580	364, 13	0 8 0	0 364, 138	
14. 00	01400 CENTRAL SERVICES & SUPPLY	303, 338	-73, 201			-73, 201	
15. 00	01500 PHARMACY	494, 558	80, 912	575, 47		575, 067	1
16. 00	01600 MEDICAL RECORDS & LIBRARY	O	0		0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0		0	0	17. 00
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	O O	0		0	0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0		0 0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	Ö	Ö		0 0	Ö	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 700 20/	0.42, 0.12	2 (42 11	001 507	1 040 (12	20.00
30. 00 43. 00	03000 ADULTS & PEDIATRICS 04300 NURSERY	1, 799, 206 0	842, 913 0		9 -801, 506 0 142, 430		
43.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>			0 142, 430	142, 430	1 43.00
50.00	05000 OPERATING ROOM	643, 166	532, 961	1, 176, 12			
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 659, 076		
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	709 414	935, 992 586, 939			935, 992	
60.00	06000 LABORATORY	708, 416 0	1, 210, 816			1, 295, 355 1, 210, 816	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	Ö	0	1,2.0,0.	0 0	0	
65. 00	06500 RESPI RATORY THERAPY	305, 852	23, 833			329, 685	1
66. 00	06600 PHYSI CAL THERAPY	501, 975	14, 305	516, 28			
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	U O	0		0 133, 497 0 76, 573	133, 497 76, 573	
69. 00	06900 ELECTROCARDI OLOGY	Ö	0		0 70,373	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	О	550, 043	550, 04	-128, 326	421, 717	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 128, 326		
	07300 DRUGS CHARGED TO PATIENTS 07697 CARDI AC REHABILITATION	5, 515	948, 832 39, 774				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	5, 515	37, 774	45, 26	0 0	45, 269	
76. 99	07699 LI THOTRI PSY	ō	0		0 0	0	
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLINIC 09001 LI FEBRI DGE SENI OR CARE	150 051	01 354	240.40	0 0	0	90.00
90. 01 91. 00	09100 EMERGENCY	158, 051 885, 040	91, 354 2, 254, 090			253, 246 3, 139, 092	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	003, 040	2,254,070	3, 137, 13	30	3, 137, 072	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	1, 123, 981	281, 386	1, 405, 36	7 0	1, 405, 367	
	09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY	0	0		0 0	0 0	
99. 20	09930 OUTPATIENT PHYSICAL THERAPY	0	0	•	0 0	0	
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	Ö	Ö		0 0	Ö	
	SPECIAL PURPOSE COST CENTERS						
113. 00 118. 00	11300 INTEREST EXPENSE	0 577 542	359, 779				113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	8, 577, 543	28, 229, 488	36, 807, 03	1 0	36, 807, 031] 118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18, 302	18, 30	2 0	18, 302	190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	o	2, 060	2, 06	0	2, 060	192. 00
	07950 OCCUPATIONAL HEALTH	0	0		0		194.00
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS	38, 683 43	25, 713 54, 704				194. 01 194. 03
	07954 ER PHYSICIAN	0	0,704	1	0 0		194. 03
194. 06	07953 SHI PSHEWANA RADI OLOGY AND LAB	o	0		0	0	194. 06
200.00	TOTAL (SUM OF LINES 118 through 199)	8, 616, 269	28, 330, 267	36, 946, 53	6 0	36, 946, 536	200. 00

Health Financial Systems COMMUNITY HOSPT RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provider CCN: 15-1323

Peri od: From 01/01/2019 To 12/31/2019

Worksheet A Date/Time Prepared: 8/21/2020 10:08 am

				8/21/2020 10:	08 am
	Cost Center Description	(See A-8) F	Net Expenses For Allocation		
	OFNEDAL CEDIU OF COCT OFNEDO	6. 00	7. 00		
	GENERAL SERVICE COST CENTERS		4 0// 0/0		4
1.00	00100 CAP REL COSTS-BLDG & FIXT	-5, 528	1, 266, 862		1. 00
1. 01	00101 EMS WEST STATION	0	16, 140		1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	756, 135		2. 00
2.01	00201 EMS WEST STATION EQUIP.	0	104, 271		2. 01
3.00	00300 OTHER CAP REL COSTS	ol	ol		3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-1, 006, 208	3, 862, 007		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	-3, 271, 520	9, 033, 889		5. 00
6.00	00600 MAI NTENANCE & REPAI RS	3, 271, 320	7, 033, 007		6. 00
		(212	1 000 211		
7.00	00700 OPERATION OF PLANT	-6, 212	1, 099, 311		7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	72, 986		8. 00
9.00	00900 HOUSEKEEPI NG	0	256, 015		9. 00
10. 00	01000 DI ETARY	0	253, 279		10.00
11. 00	01100 CAFETERI A	-265, 621	216, 354		11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	ol	o		12.00
13.00	01300 NURSING ADMINISTRATION	-7, 640	356, 498		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	-73, 201		14. 00
15. 00	01500 PHARMACY		575, 067		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		16.00
17. 00	01700 SOCIAL SERVICE	0	0		17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0		19. 00
20.00	02000 NURSI NG SCHOOL	0	0		20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0		22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	ol	ol		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	-1	-1		1
30. 00	03000 ADULTS & PEDIATRICS	-500, 430	1, 340, 183		30.00
		1			1
43. 00	04300 NURSERY	0	142, 430		43. 00
	ANCILLARY SERVICE COST CENTERS				4
50. 00	05000 OPERATI NG ROOM	0	1, 176, 127		50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	659, 076		52. 00
53.00	05300 ANESTHESI OLOGY	-935, 900	92		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-1, 680	1, 293, 675		54.00
60.00	06000 LABORATORY	ol	1, 210, 816		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	0		62. 30
65. 00	06500 RESPIRATORY THERAPY		329, 685		65. 00
		0			1
66.00	06600 PHYSI CAL THERAPY	0	306, 210		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	133, 497		67. 00
68. 00	06800 SPEECH PATHOLOGY	-13, 936	62, 637		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	421, 717		71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	ol	128, 326		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	-38, 733	910, 545		73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	45, 289		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY		43, 287		76. 98
	1	0			
76. 99	07699 LI THOTRI PSY	l U	0		76. 99
	OUTPATIENT SERVICE COST CENTERS				4
	09000 CLI NI C	0	0		90. 00
	09001 LI FEBRI DGE SENI OR CARE	0	253, 246		90. 01
91.00		-633, 242	2, 505, 850		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
	OTHER REIMBURSABLE COST CENTERS				1
95.00		0	1, 405, 367		95. 00
99. 10	09910 CORF	o	0		99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	o o	o		99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		99. 30
		1			
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0		99. 40
	SPECIAL PURPOSE COST CENTERS				4
113.00	11300 INTEREST EXPENSE	0	0		113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	-6, 686, 650	30, 120, 381		118. 00
	NONREI MBURSABLE COST CENTERS				1
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	18, 302		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	o o	2, 060		192.00
	07950 OCCUPATI ONAL HEALTH		0		194. 00
	07951 FOUNDATION	0	64, 396		194. 01
	3 07952 COMMUNITY & VOLUNTEER SVCS	0	54, 747		194. 03
194. 04	107954 ER PHYSICIAN	0	0		194. 04
194.06	07953 SHIPSHEWANA RADIOLOGY AND LAB	0	o		194. 06
200.00	TOTAL (SUM OF LINES 118 through 199)	-6, 686, 650	30, 259, 886		200. 00
					•

Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

					'	12/31/	2020 10:08 am
		Increases					
	Cost Center	Li ne #	Sal ary	Other			
	2. 00	3.00	4. 00	5. 00			
	A - REHAB THERAPY RECLASS		<u>. </u>	<u> </u>			
1.00	OCCUPATI ONAL THERAPY	67. 00	129, 798	3, 699			1. 00
2.00	SPEECH PATHOLOGY	68. 00	74, 451	2, 122			2. 00
	0 = = = = =		204, 249	5, 821			
	B - OB RECLASS						
1.00	NURSERY	43.00	121, 918	20, 512			1. 00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	564, 159	94, 917			2.00
	0 = = = = =		686, 077	115, 429			
	C - CLINIC DIETICIAN						
1.00	LIFEBRIDGE SENIOR CARE	90. 01	3, 841	0			1. 00
	0 = = = = =		3, 841				
	F - CAFETERIA RECLASS						
1.00	CAFETERI A	11. 00	281, 044	200, 931			1. 00
	0 — — — — — —		281, 044	200, 931			
	G - INSURANCE RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	47, 112			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	19, 861			2. 00
	0 — — — — —			66, 973			
	H - DRUGS CHARGED TO PATIENTS						
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	446			1. 00
2.00		0.00	0	0			2. 00
3.00		0.00	0	0			3. 00
	0 — — — — — —	- $ +$		446			
	I - SALARY RECLASS			<u> </u>			
1.00	ADMINISTRATIVE & GENERAL	5. 00	3, 247, 823	0			1. 00
	0 — — — — —		3, 247, 823	0			
	K - DEPRECIATION			<u> </u>			
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	702, 673			1. 00
2.00	EMS WEST STATION	1. 01	o	16, 040			2. 00
3.00	EMS WEST STATION EQUIP.	2. 01	o	104, 371			3. 00
4.00	ADMINISTRATIVE & GENERAL	5. 00	o	9, 616			4.00
	0 — — — — —	- $ +$		832, 700			
	L - BLDG & LEASE EXPENSE						
1.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	1, 632			1. 00
2.00	EMS WEST STATION EQUIP.	2. 01	O	1, 115			2.00
3.00	EMS WEST STATION	1. 01	o	100			3. 00
4.00	CAP REL COSTS-BLDG & FIXT	1.00	o	6, 672			4. 00
	0 — — — — —	- $ +$		9, 519			
	M - INTEREST RECLASS						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	359, 779			1. 00
				359, 779			
	N - IMPLANTABLE MEDICAL SUPPL	.I ES	<u> </u>				
1.00	IMPL. DEV. CHARGED TO	72.00	O	128, 326			1.00
	PATI ENTS						
		+		128, 326			
500.00	Grand Total: Increases		4, 423, 034	1, 719, 924			500.00
			.,				1

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 15-1323

| Peri od: | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: | 8/21/2020 10:08 am

						8/21/2020 10:08	am_
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - REHAB THERAPY RECLASS						
1.00	PHYSI CAL THERAPY	66.00	204, 249	5, 821	0		1.00
2.00		0.00	0	C	ol ol		2.00
			204, 249	5, 821			
	B - OB RECLASS				1		
1.00	ADULTS & PEDIATRICS	30.00	686, 077	115, 429	0		1. 00
2.00	7.502.10 a 1.25777771 00	0.00	000, 077		ol ol		2. 00
2.00			686, 077	115, 429			2.00
	C - CLINIC DIETICIAN		000,011	110, 127			
1.00	DI ETARY	10.00	3, 841	C	0		1. 00
1.00	0		3, 841	}			1.00
	F - CAFETERIA RECLASS		3, 041		,		
1.00	DI ETARY	10.00	281, 044	200, 931	0		1. 00
1.00	DIETARY — — — —	10.00		20 <u>0, 9</u> 3 <u>1</u> 200, 93 1			1.00
	G - INSURANCE RECLASS		281, 044	200, 931			
4 00		F 00		// 070	10		4 00
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	66, 973			1.00
2.00		0.00			12		2. 00
	0		0	66, 973	3		
	H - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	15. 00	0	403			1. 00
2.00	OPERATION OF PLANT	7. 00	0	5			2.00
3.00	EMERGENCY	91.00		38			3.00
	0		0	446			
	I - SALARY RECLASS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 247, 823	B O		1.00
	0		0	3, 247, 823	3		
	K - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	832, 700	9		1.00
2.00		0.00	o	C	9		2.00
3.00		0.00	o	C	9		3.00
4.00		0.00	o	C	ol ol		4.00
		+		832, 700			
	L - BLDG & LEASE EXPENSE		- 1		1		
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	1, 632	2 10		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	6, 672			2. 00
3.00	EMS WEST STATION EQUIP.	2. 01	o	1, 215			3. 00
4. 00	EMS WEST STATION EQUIT.	0.00	0	1, 210	10		4. 00
4.00			 _	9, 519			4.00
	M - INTEREST RECLASS			7, 517	'L		
1 00	INTEREST EXPENSE	113.00	0	359, 779	11		1. 00
1. 00	INTEREST EXPENSE	113.00		35 <u>9, 7</u> 79			1.00
	N IMPLANTABLE MEDICAL CURRELE		U	359, 779	<u> </u>		
1 00	N - IMPLANTABLE MEDICAL SUPPLIE		اء	100.00			1 00
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	O	128, 326	0		1. 00
	PATI ENT	+			 		
F00 5-	U		0	128, 326			00.00
500.00	Grand Total: Decreases		1, 175, 211	4, 967, 747	'	50	00.00

COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 Health Financial Systems RECONCILIATION OF CAPITAL COSTS CENTERS Worksheet A-7 Provider CCN: 15-1323 Peri od: From 01/01/2019 Part I Date/Time Prepared: 8/21/2020 10:08 am 12/31/2019 Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Retirements Bal ances 5.00 2.00 3.00 4. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 320, 702 0 1.00 2.00 Land Improvements 1, 978, 720 2.00 0 0 0 0 0 32, 849 3.00 13, 534, 008 Buildings and Fixtures 32, 849 3.00 0 Building Improvements 29, 098 4.00 0 4.00 5.00 Fixed Equipment 7, 799, 259 841, 273 0 841, 273 0 5.00 Movable Equipment 9, 385, 186 475, 411 401, 109 6.00 475, 411 0 0 0 6.00 HIT designated Assets 1, 797, 897 7.00 76, 847 76, 847 13, 155 7.00 8.00 Subtotal (sum of lines 1-7) 34, 844, 870 1, 426, 380 1, 426, 380 414, 264 8.00 9.00 Reconciling Items 235, 276 0 149, 764 9.00 Total (line 8 minus line 9) 34, 609, 594 264, 500 10.00 10.00 1, 426, 380 0 1, 426, 380 Endi ng Bal ance Fully

Depreciated Assets

7.00

	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		1
1.00	Land	320, 702	0	1. 00
2.00	Land Improvements	1, 978, 720	578, 977	2. 00
3.00	Buildings and Fixtures	13, 566, 857	483, 308	3. 00
4.00	Building Improvements	29, 098	29, 098	4. 00
5.00	Fixed Equipment	8, 640, 532	1, 535, 105	5. 00
6.00	Movable Equipment	9, 459, 488	4, 142, 743	6. 00
7.00	HIT designated Assets	1, 861, 589	583, 703	7. 00
8.00	Subtotal (sum of lines 1-7)	35, 856, 986	7, 352, 934	8. 00
9.00	Reconciling Items	85, 512	0	9. 00
10.00	Total (line 8 minus line 9)	35, 771, 474	7, 352, 934	10. 00

6.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-1323 Peri od: Worksheet A-7 From 01/01/2019 Part II Date/Time Prepared: То 12/31/2019 8/21/2020 10:08 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, 693, 159 0 0 1.00 0 0 1.01 EMS WEST STATION 0 0 1.01 0 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 38, 641 0 0 0 2.01 EMS WEST STATION EQUIP. 0 0 2.01 1, 731, 800 0 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, 693, 159 1.00 0 1.01 EMS WEST STATION 1.01 0 CAP REL COSTS-MVBLE EQUIP 2.00 38, 641 2.00 2.01 EMS WEST STATION EQUIP. 2.01 3.00 Total (sum of lines 1-2) 0 1, 731, 800 3.00

sheet A-7
[]]

RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	F	Period: From 01/01/2019 To 12/31/2019		
		COMF	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
			Leases	(col . 1 - col . 2)	· ·		
		1.00	2. 00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00	CAP REL COSTS-BLDG & FIXT	24, 215, 102	0	24, 215, 102	0. 715722	0	1.00
1. 01	EMS WEST STATION	320, 808		320, 808			1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	8, 784, 606					2.00
2.01	EMS WEST STATION EQUIP.	674, 882		0, 1, 002			2. 01
3.00	Total (sum of lines 1-2)	33, 995, 398					3. 00
		ALLOCAT	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	col s. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0	0	878, 399		1.00
1. 01	EMS WEST STATION	0	0		16, 040		1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		741, 314		2.00
2. 01	EMS WEST STATION EQUIP.	0	0		104, 371	-100	2. 01
3. 00	Total (sum of lines 1-2)	Ü	0	IMMADY OF CADIA	1, 740, 124	0	3. 00
				JMMARY OF CAPIT			
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11.00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	336, 311	47, 112	С		1, 266, 862	1. 00
1. 01	EMS WEST STATION	330, 311	47,112	i e		16, 140	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP		19, 861		1	756, 135	2. 00
2. 00	EMS WEST STATION EQUIP.		17,001		1	104, 271	2. 00
3.00	Total (sum of lines 1-2)	336, 311	66, 973		-		3. 00
					-		

| Period: | Worksheet A-8 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES COMMUNITY HOSPT. OF LAGRANGE CTY IN

Provider CCN: 15-1323

				To	12/31/2019	Date/Time Prep 8/21/2020 10:0	pared:
				Expense Classification on		8/21/2020 10.0	Jo alli
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	В		CAP REL COSTS-BLDG & FLXT	1.00	11	1. 00
1. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - EMS WEST		0	EMS WEST STATION	1. 01	0	1. 01
2. 00	STATION (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
	COSTS-MVBLE EQUIP (chapter 2)						
2. 01	Investment income - EMS WEST STATION EQUIP. (chapter 2)		0	EMS WEST STATION EQUIP.	2. 01	0	2. 01
3.00	Investment income - other		0		0. 00	0	3. 00
4. 00	(chapter 2) Trade, quantity, and time		0		0. 00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0. 00	0	6. 00
	suppliers (chapter 8)		0			U	
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
8. 00	21)	^	E 024	ODEDATION OF DIANT	7 00	0	8. 00
	Television and radio service (chapter 21)	A	-5, 634	OPERATION OF PLANT	7. 00	U	
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	-1, 569, 142		0. 00	0	9. 00 10. 00
	adj ustment				7.00		
11. 00	Sale of scrap, waste, etc. (chapter 23)	A	-3/8	OPERATION OF PLANT	7. 00	0	11. 00
12. 00	Related organization transactions (chapter 10)	A-8-1	-1, 445, 994			0	12. 00
13.00	Laundry and linen service		0	CAFETERIA	0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-265, 621 0	CAFETERI A	11. 00 0. 00	0 0	14. 00 15. 00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
10.00	supplies to other than				0.00		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		0		0. 00	0	18. 00
	abstracts						
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
20. 00	books, etc.) Vending machines		0		0. 00	0	20. 00
21. 00	Income from imposition of		0		0. 00	0	
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	0	22. 00
22.00	repay Medicare overpayments		0	RESPI RATORY THERAPY	45.00		22.00
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	PHYSI CAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	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
	COSTS-MVBLE EQUIP					0	
27. 01	Depreciation - EMS WEST STATION EQUIP.			EMS WEST STATION EQUIP.	2. 01		
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00	- 1	30. 00
	therapy costs in excess of limitation (chapter 14)						

Provider CCN: 15-1323

Peri od: Worksheet A-8

From 01/01/2019

Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted					To	rom 01/01/2019 o 12/31/2019	Date/Time Prep 8/21/2020 10:0	
Cost Center Description					Expense Classification on	Worksheet A	0/21/2020 10.	JO alli
Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref.								
1.00 2.00 3.00 4.00 5.00 30.99 1.00 3.00 3.00 3.00 30.99 1.00 3.00 30.99 1.00 3.00 30.99 31.00 30.99 31.00 30.90 31.00 30.90 31.00 30.90 31.00 30.90 31.00 30.90 31.00 3								
1.00 2.00 3.00 4.00 5.00 30.99 1.00 3.00 3.00 3.00 30.99 1.00 3.00 30.99 1.00 3.00 30.99 31.00 30.99 31.00 30.90 31.00 30.90 31.00 30.90 31.00 30.90 31.00 30.90 31.00 3								
1.00 2.00 3.00 4.00 5.00 30.99 1.00 3.00 3.00 3.00 30.99 1.00 3.00 30.99 1.00 3.00 30.99 31.00 30.99 31.00 30.90 31.00 30.90 31.00 30.90 31.00 30.90 31.00 30.90 31.00 3								
1.00 2.00 3.00 4.00 5.00 30.99 1.00 3.00 3.00 3.00 30.99 1.00 3.00 30.99 1.00 3.00 30.99 31.00 30.99 31.00 30.90 31.00 30.90 31.00 30.90 31.00 30.90 31.00 30.90 31.00 3								
30.99 Hospice (non-distinct) (see 0 ADULTS & PEDIATRICS 30.00 30.99 Instructions) 31.00 31.00 31.00 32.00 31.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 33.00 33.00 32.00 33		Cost Center Description						
Instructions			1.00				5. 00	
31.00 Adjustment for speech A-8-3 OSPECH PATHOLOGY 68.00 31.00 20.00 2	30. 99			0	ADULTS & PEDIATRICS	30. 00		30. 99
pathology costs in excess of								
1 imitation (chapter 14)	31. 00		A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
32 OO CAH HIT Adjustment for O O O O O O O O O								
Depreciation and Interest 3.0								
33. 00 HÁF FEE EXPENSE REMOVAL A -1,737,843/ADMINISTRATIVE & GENERAL 5. 00 0 33. 00 33. 02 2012-2015 A -91,446/ADMINISTRATIVE & GENERAL 5. 00 0 33. 00 34. 00 MISCELLANEOUS REVENUE B 3,230/ADMINISTRATIVE & GENERAL 5. 00 0 34. 00 35. 00 SPECH THERAPY CONTRACTED B -13,936/SPECH PATHOLOGY 68. 00 0 35. 00 38. 00 PHARMACY EMPLOYEE RX PURCHASES B -38,733/DRIGS CHARGED TO PATIENTS 73. 00 0 38. 00 40. 00 SELF INSURANCE A -22,776/CAP REL COSTS-BLDG & FIXT 1. 00 11 39. 00 40. 00 SELF INSURANCE A -1,006,208/EMPLOYEE BENEFITS DEPARTMENT 4. 00 0 40. 00 40. 00 SUBSCRIPTIONS A -3,592/ADMINISTRATIVE & GENERAL 5. 00 0 41. 00 40. 00 SUBSCRIPTION A -445,667/ADULTS & PEDIATRICS 30. 00 0 42. 00 44. 00 KG INTERPRETATION COSTS A -1,680/RADIOLTS & PEDIATRICS 30. 00 0 44. 01 44. 01 MARKETING A 0 0 0 0 0 0 44. 02 MARKETING A 0 0 0 0 0 0 0 44. 03 MARKETING A 0 0 0 0 0 0 0 44. 03 MARKETING A 0 0 0 0 0 0 0 44. 03 MARKETING A 0 0 0 0 0 0 0 45. 00 ADMINISTRATIVE & GENERAL 5. 00 0 0 0 0 46. 00 ADMINISTRATIVE & GENERAL 5. 00 0 0 0 0 47. 00 0 0 0 0 0 0 0 0 0	32. 00			0		0.00	0	32.00
33.02 CAH HIT ADJ DEPR CARRYFRWD 2012-2015 201	22.00			1 707 040	ADMINISTRATIVE & CENEDAL	Г 00	0	22.00
2012-2015 34.00 MI SCELLANEOUS REVENUE B 3,230 ADMI NI STRATI VE & GENERAL 5.00 0.34.00 35.00 35.00 9HARIMACY EMPLOYEE RX PURCHASES B -38,733 DRUGS CHARGED TO PATIENTS 73.00 0.38.00 9HARIMACY EMPLOYEE RX PURCHASES B -38,733 DRUGS CHARGED TO PATIENTS 73.00 0.38.00 40.0			1					
34. 00 MI SCELLANEOUS REVENUE B 3, 230 ADMIN IN STRATIVE & GENERAL 5. 00 0 34. 00	33. 02		Α	-91, 446	ADMINISTRATIVE & GENERAL	5.00	Ü	33. 02
35.00 SPEECH THERAPY CONTRACTED B -13,936 SPEECH PATHOLOGY 68.00 0 35.00	24.00	1		2 220	ADMINISTRATIVE & CENEDAL	Г 00	0	24.00
38.00 PHARMACY EMPLOYEE RX PURCHASES 39.00 RELATED PARTY INTEREST EXPENSE A		II		·	1			
39.00 RELATED PARTY INTEREST EXPENSE A -22,776 CAP REL COSTS-BLDG & FIXT 1.00 11 39.00 40.00 SELF INSURANCE A -1,006,208 EMPLOYER BENEFITS DEPARTMENT 4.00 40.00				·	1			
40.00 SELF INSURANCE A -1,006,208 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 40.00 41.00 LOBBY % OF DUES & SUBSCRIPTIONS								
41.00 LOBBY % OF DUES & SUBSCRIPTIONS 42.00 HOSPITALIST CONTRACT REMOVAL A -445, 667 ADULTS & PEDIATRICS 30.00 0 42.00 44.00 EKG INTERPRETATION COSTS A -1, 680 RADIOLOGY-DIAGNOSTIC 54.00 0 44.00 44.01 MARKETING A OAMINISTRATIVE & GENERAL 5.00 0 44.01 44.02 MARKETING A OOCCUPATIONAL THERAPY 67.00 0 44.02 44.03 MARKETING A OLIFEBRIDGE SENIOR CARE 90.01 0 44.03 47.00 ADD-BACK OF DEMOLISHED ASSET DEPREC 48.00 ADD-BACK OF DEMOLITION COSTS A 4.125 ADMINISTRATIVE & GENERAL 5.00 0 48.00 49.00 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.00 AP.01 MISC REV OFFSET A 7.7, 640 NURSING ADMINISTRATION 13.00 0 49.01 49.01 MISC REV OFFSET A 7.7, 640 NURSING ADMINISTRATION 13.00 0 49.02 AP.00 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.02 AP.00 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.02 AP.00 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.02 AP.00 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.02 AP.00 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.03 OA.CALL PROFITIME A -73,755 ADULTS & PEDIATRICS 30.00 0 49.03 AP.04 GROSS-UP ANESTHESIA EXPENSE A OANESTHESIOLOGY 53.00 0 49.05 AP.05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.05 AP.05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.05 AP.05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.05 AP.05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.05 AP.05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.05 AP.05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.05 AP.05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.05 AP.05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.05 AP.05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.05 AP.05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.05 AP.05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.05 AP.05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.05 AP.05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53.00 0 49.05 AP.05 MEDICAL DIRECTOR ADDITIONAL A OANE			1					
SUBSCRIPTIONS A		II	1					
44. 00 EKG INTERPRETATION COSTS A -1,680 RADI OLOGY-DI AGNOSTI C 54. 00 0 44. 00 44. 01 MARKETI NG A OADMIN ISTRATI VE & GENERAL 5. 00 0 44. 01 44. 02 MARKETI NG A OCCUPATI ONAL THERAPY 67. 00 0 44. 02 44. 03 MARKETI NG A OLI FEBRI DGE SENI OR CARE 90. 01 0 44. 02 44. 03 ADD-BACK OF DEMOLI SHED ASSET DEPREC A 17, 940 CAP REL COSTS-BLDG & FIXT 1. 00 9 47. 00 48. 00 ADD-BACK OF DEMOLITION COSTS A 4, 125 ADMIN ISTRATI VE & GENERAL 5. 00 0 48. 00 49. 00 MEDI CAL DI RECTOR ADDITIONAL A/P A -7, 640 NURSI NG ADMINI STRATI ON 13. 00 0 49. 01 49. 02 MEDI CAL DI RECTOR ADDITIONAL A/P A -73, 755 ADULTS & PEDI ATRICS 30. 00 0 49. 03 49. 04 GROSS-UP ANESTHESI A EXPENSE FOR A/P A OANESTHESI OLOGY 53. 00 0 49. 04 49. 05 MEDI CAL DI RECTOR ADDITIONAL A/P A 18, 992 ADULTS & PEDI ATRICS 30. 00 0 49. 05 <td>41.00</td> <td></td> <td>A</td> <td>-3, 592</td> <td>ADMINISTRATIVE & GENERAL</td> <td>5.00</td> <td>0</td> <td>41.00</td>	41.00		A	-3, 592	ADMINISTRATIVE & GENERAL	5.00	0	41.00
44. 01 MARKETING A OADMINISTRATIVE & GENERAL 5. 00 0 44. 01 44. 02 MARKETING A OOCCUPATIONAL THERAPY 67. 00 0 44. 02 44. 03 MARKETING A OLIFEBRIDGE SENIOR CARE 90. 01 0 44. 03 47. 00 ADD-BACK OF DEMOLISHED ASSET A 17, 940 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 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53. 00 0 49. 00 AVP. 01 MISC REV OFFSET A 7, 640 NURSING ADMINISTRATION 13. 00 0 49. 01 49. 02 AVP. 01 MEDICAL DIRECTOR ADDITIONAL A OADULTS & PEDIATRICS 30. 00 0 49. 02 AVP. 01 ON-CALL PROF TIME A 73, 755 ADULTS & PEDIATRICS 30. 00 0 49. 03 49. 04 FOR A/R 49. 05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53. 00 0 49. 04 OANESTHESIOLOGY 53. 00 0 49. 05 AVP. 05 TELEMETRY MONITORING A 18, 992 ADULTS & PEDIATRICS 30. 00 0 49. 05 AVP. 06 TELEMETRY MONITORING A 18, 992 ADULTS & PEDIATRICS 30. 00 0 49. 05 OANESTHESIOLOGY 50. 00 OAN	42.00	HOSPITALIST CONTRACT REMOVAL	A	-445, 667	ADULTS & PEDIATRICS	30.00	0	42.00
44. 02 MARKETING A 00CCUPATIONAL THERAPY 67. 00 0 44. 02 44. 03 MARKETING A 0LIFEBRIDGE SENIOR CARE 90. 01 0 44. 03 47. 00 ADD-BACK OF DEMOLISHED ASSET A 17, 940 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 MEDICAL DIRECTOR ADDITIONAL A 0 ANESTHESIOLOGY 53. 00 0 49. 00 A/P 49. 01 MISC REV OFFSET A 7-7, 640 NURSING ADMINISTRATION 13. 00 0 49. 01 49. 02 MEDICAL DIRECTOR ADDITIONAL A 0 ADULTS & PEDIATRICS 30. 00 0 49. 02 A/P 49. 03 ON-CALL PROF TIME A -73, 755 ADULTS & PEDIATRICS 30. 00 0 49. 03 49. 04 GROSS-UP ANESTHESIA EXPENSE FOR A/R 49. 05 MEDICAL DIRECTOR ADDITIONAL A 0 ANESTHESIOLOGY 53. 00 0 49. 04 49. 05 TELEMETRY MONITORING A 18, 992 ADULTS & PEDIATRICS 30. 00 0 49. 05 OTOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	44.00	EKG INTERPRETATION COSTS	A	-1, 680	RADI OLOGY-DI AGNOSTI C	54.00	0	44.00
44. 03 MARKETING A OLIFEBRIDGE SENIOR CARE 90.01 0 44.03 47. 00 ADD-BACK OF DEMOLISHED ASSET DEPREC A 17,940 CAP REL COSTS-BLDG & FIXT 1.00 9 47.00 48. 00 ADD-BACK OF DEMOLITION COSTS A 4,125 ADMINISTRATIVE & GENERAL 5.00 0 48.00 49. 00 MEDICAL DIRECTOR ADDITIONAL A/P A OANESTHESI OLOGY 53.00 0 49.00 49. 01 MI SC REV OFFSET A -7,640 NURSING ADMINISTRATION 13.00 0 49.01 49. 02 MEDICAL DIRECTOR ADDITIONAL A/P A OADULTS & PEDIATRICS 30.00 0 49.02 49. 03 ON-CALL PROF TIME A -73,755 ADULTS & PEDIATRICS 30.00 0 49.03 49. 04 GROSS-UP ANESTHESIA EXPENSE FOR A/R OANESTHESIOLOGY 53.00 0 49.04 49. 05 A/P 49. 06 TELLEMETRY MONITORING A OANESTHESIOLOGY 53.00 0 49.06 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.) -6,686,650 -6,686,650 50.00	44.01	MARKETI NG	Α	0	ADMINISTRATIVE & GENERAL	5. 00	0	44. 01
47. 00 ADD-BACK OF DEMOLISHED ASSET DEPREC 48. 00 ADD-BACK OF DEMOLITION COSTS A A 1,125 ADMINISTRATIVE & GENERAL 5. 00 0 48. 00 0 ANESTHESI OLOGY 53. 00 0 49. 00 ANESTHESI OLOGY 53. 00 0 49. 00 ADD-BACK OF DEMOLITIONAL A 0 ANESTHESI OLOGY 53. 00 0 49. 00 ANESTHESI OLOGY 53. 00 0 49. 00 ANESTHESI OLOGY 53. 00 0 49. 00 ADDLTS & PEDIATRICS 30. 00 0 49. 01 49. 02 APDLTS & PEDIATRICS 30. 00 0 49. 02 APDLTS & PEDIATRICS 30. 00 0 49. 03 APDLTS & PEDIATRICS 30. 00 0 49. 04 GROSS-UP ANESTHESI A EXPENSE A 0 ANESTHESI OLOGY 53. 00 0 49. 04 FOR A/R 49. 05 MEDICAL DIRECTOR ADDITIONAL A 0 ANESTHESI OLOGY 53. 00 0 49. 04 APDLTS & PEDIATRICS 53. 00 0 49. 05 APDLTS & PEDIATRICS 54. APDLTS & PEDIATRICS 55. 00 0 49. 06 APDLTS & PEDIATRICS 55. 00 00 49. 06 APDLTS & PEDIATRICS 55. 00 0 49. 06	44.02	MARKETI NG	Α	0	OCCUPATIONAL THERAPY	67. 00	0	44. 02
DEPREC ADD-BACK OF DEMOLITION COSTS A 4,125 ADMINISTRATIVE & GENERAL 5.00 0 48.00	44.03	MARKETI NG	A	0	LIFEBRIDGE SENIOR CARE	90. 01	0	44. 03
48.00 ADD-BACK OF DEMOLITION COSTS A 4, 125 ADMINISTRATIVE & GENERAL 5.00 0 48.00 49.00 MEDICAL DIRECTOR ADDITIONAL A 0 ANESTHESIOLOGY 53.00 0 49.00 49.01 MISC REV OFFSET A 7-7,640 NURSING ADMINISTRATION 13.00 0 49.01 49.02 MEDICAL DIRECTOR ADDITIONAL A 0 ADULTS & PEDIATRICS 30.00 0 49.02 49.03 ON-CALL PROF TIME A -73,755 ADULTS & PEDIATRICS 30.00 0 49.03 49.04 GROSS-UP ANESTHESIA EXPENSE A 0 ANESTHESIOLOGY 53.00 0 49.04 49.05 MEDICAL DIRECTOR ADDITIONAL A 0 ANESTHESIOLOGY 53.00 0 49.05 49.06 TELEMETRY MONITORING A 18,992 ADULTS & PEDIATRICS 30.00 0 49.06 50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	47.00	ADD-BACK OF DEMOLISHED ASSET	A	17, 940	CAP REL COSTS-BLDG & FIXT	1.00	9	47.00
49. 00 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53. 00 0 49. 00 49. 01 MISC REV OFFSET A -7, 640 NURSING ADMINISTRATION 13. 00 0 49. 01 49. 02 MEDICAL DIRECTOR ADDITIONAL A OADULTS & PEDIATRICS 30. 00 0 49. 02 49. 03 ON-CALL PROF TIME A -73, 755 ADULTS & PEDIATRICS 30. 00 0 49. 03 49. 04 GROSS-UP ANESTHESIA EXPENSE A OANESTHESIOLOGY 53. 00 0 49. 04 49. 05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53. 00 0 49. 05 49. 06 TELEMETRY MONITORING A 18, 992 ADULTS & PEDIATRICS 30. 00 0 49. 06 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		DEPREC						
49. 01 A/P 49. 01 MI SC REV OFFSET A -7, 640 NURSING ADMINISTRATION 13. 00 0 49. 01 49. 02 MEDI CAL DI RECTOR ADDITIONAL AP A OADULTS & PEDI ATRICS 30. 00 0 49. 02 49. 03 ON-CALL PROF TIME A -73, 755 ADULTS & PEDI ATRICS 30. 00 0 49. 03 49. 04 GROSS-UP ANESTHESIA EXPENSE FOR A/R A OANESTHESI OLOGY 53. 00 0 49. 04 49. 05 MEDI CAL DI RECTOR ADDITIONAL A/P A OANESTHESI OLOGY 53. 00 0 49. 05 49. 06 TELEMETRY MONITORING TELEMETRY MONITORING TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.) A 18, 992 ADULTS & PEDI ATRICS 30. 00 0 49. 06	48.00	ADD-BACK OF DEMOLITION COSTS	A			5. 00	0	48. 00
49. 01 MISC REV OFFSET A -7, 640 NURSING ADMINISTRATION 13. 00 0 49. 01 49. 02 MEDICAL DIRECTOR ADDITIONAL A 0 ADULTS & PEDIATRICS 30. 00 0 49. 02 49. 03 ON-CALL PROF TIME A -73, 755 ADULTS & PEDIATRICS 30. 00 0 49. 04 49. 04 GROSS-UP ANESTHESIA EXPENSE A 0 ANESTHESIOLOGY 53. 00 0 49. 04 49. 05 MEDICAL DIRECTOR ADDITIONAL A 0 ANESTHESIOLOGY 53. 00 0 49. 05 49. 06 TELEMETRY MONITORING A 18, 992 ADULTS & PEDIATRICS 30. 00 0 49. 06 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	49.00		A	0	ANESTHESI OLOGY	53.00	0	49.00
49. 02 MEDICAL DIRECTOR ADDITIONAL A OADULTS & PEDIATRICS 30.00 0 49.02 A/P 49. 03 ON-CALL PROF TIME A -73,755 ADULTS & PEDIATRICS 30.00 0 49.03 49.04 GROSS-UP ANESTHESIA EXPENSE A OANESTHESIOLOGY 53.00 0 49.04 FOR A/R 49. 05 MEDICAL DIRECTOR ADDITIONAL A/P 49. 06 TELEMETRY MONITORING A 18,992 ADULTS & PEDIATRICS 30.00 0 49.06 50.00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1 7 7						
49. 03 A/P 49. 04 ON-CALL PROF TIME A -73,755 ADULTS & PEDIATRICS 30. 00 0 49. 03 49. 04 GROSS-UP ANESTHESIA EXPENSE FOR A/R A OANESTHESIOLOGY 53. 00 0 49. 04 49. 05 MEDI CAL DI RECTOR ADDITIONAL A/P A OANESTHESIOLOGY 53. 00 0 49. 05 49. 06 TELEMETRY MONITORING A 18, 992 ADULTS & PEDIATRICS 30. 00 0 49. 06 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.) -6, 686, 650 50. 00		II		·	1		0	
49. 03 ON-CALL PROF TIME A -73,755 ADULTS & PEDIATRICS 30. 00 0 49. 03 49. 04 GROSS-UP ANESTHESIA EXPENSE FOR A/R 49. 05 MEDICAL DIRECTOR ADDITIONAL A/P 49. 06 TELEMETRY MONITORING A 18,992 ADULTS & PEDIATRICS 30. 00 0 49. 05 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)	49. 02		A	0	ADULTS & PEDIATRICS	30.00	0	49. 02
49. 04 GROSS-UP ANESTHESIA EXPENSE A OANESTHESIOLOGY 53. 00 0 49. 04 49. 05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53. 00 0 49. 05 A/P 49. 06 TELEMETRY MONITORING A 18, 992 ADULTS & PEDIATRICS 30. 00 0 49. 06 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		1 7 7						
FOR A/R 49. 05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53. 00 0 49. 05 49. 06 TELEMETRY MONITORING A 18, 992 ADULTS & PEDIATRICS 30. 00 0 49. 06 50. 00 TOTAL (sum of lines 1 thru 49) (Transfer to Worksheet A, column 6, line 200.)		d .			1		0	
49. 05 MEDICAL DIRECTOR ADDITIONAL A OANESTHESIOLOGY 53. 00 0 49. 05 49. 06 TELEMETRY MONITORING A 18, 992 ADULTS & PEDIATRICS 30. 00 0 49. 06 50. 00 (Transfer to Worksheet A, column 6, line 200.)	49. 04		Α	0	ANESTHESI OLOGY	53. 00	0	49. 04
49.06 TELEMETRY MONITORING A 18,992 ADULTS & PEDIATRICS 30.00 0 49.06 50.00 (Transfer to Worksheet A, column 6, line 200.)		I Total Control of the Control of th						
49. 06 TELEMETRY MONITORING A 18, 992 ADULTS & PEDIATRICS 30. 00 0 49. 06 50. 00 TOTAL (sum of lines 1 thru 49) -6, 686, 650 50. 00 (Transfer to Worksheet A, column 6, line 200.)	49. 05		A	0	ANESTHESTOLOGY	53. 00	0	49. 05
50.00 TOTAL (sum of lines 1 thru 49)	40.01	1 7 7		40.000	ABULL TO A DEDUATELOG	00.00		40.07
(Transfer to Worksheet A, column 6, line 200.)				·	1	30.00	0	
column 6, line 200.)	50. 00			-6, 686, 650				50.00
		7						
	(4) 5				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.

DEFICE COSTS

From 01/01/2019

UFFICE	0313			To 12/31/2019	Date/Time Pre 8/21/2020 10:	
	Li ne No.	Cost Center	Expense I tems	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	7, 677, 814	5, 615, 736	1.00
2.00	5. 00	ADMINISTRATIVE & GENERAL	RELATED PARTY SUBSIDY ADJ.	0	3, 508, 072	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).			7, 677, 814	9, 123, 808	5. 00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12					

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

			Related Organization(s) and	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
, , ,		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	В	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	Financial Syste	ems		COMMUNI TY	HOSPT. OF	LAGRANGE C	TY IN		In Lie	u of Form CMS-	2552-10
STATEM	ENT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ONS	AND HOME	Provi der	CCN:	15-1323	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS								From 01/01/2019		
									To 12/31/2019		epared:
										8/21/2020 10:	08 am
	Net	Wkst. A-7 Ref.									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJUSTM	MENTS REC	QUIRED AS A RE	SULT OF T	RANSACTI ONS	WI TH	RELATED (ORGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE CO	STS:									
1.00	2, 062, 078	0									1.00
2.00	-3, 508, 072	0									2.00

5.00 -1, 445, 994 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

3.00

4.00

5.00

nas no	t been posted to worksneet 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:

O 0

0

0

3.00

4.00

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1323

							10 12/31/2019	8/21/2020 10:	
	Wkst. A Line #	Cost	Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
			I denti fi er	Remuneration	Component	Component		ider Component	
					·			Hours	
	1. 00		2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	53. 00 D			935, 900	935, 900	0	0	0	1
2.00	53. 00 D			0	(0	0	0	2. 00
3.00	91. 00 D	R. C		0	(0	0	0	3. 00
4.00	91. 00 D	R. D		1, 971, 000	633, 242	1, 337, 758	0	0	4. 00
5.00	30. 00 D	R. E		10, 335	(10, 335	0	0	5. 00
6.00	90. 00 D	R. F		20, 294	(20, 294	0	0	6. 00
7.00	53. 00 D	R. G		0	(0	0	0	7. 00
8.00	0.00			0	(0	0	0	8. 00
9.00	0.00			0	(0	0	0	9. 00
10.00	0.00			0	(0	0	0	10.00
200.00				2, 937, 529	1, 569, 142	1, 368, 387		0	200.00
	Wkst. A Line #	Cost	Center/Physi ci an	Unadjusted RCE		Cost of	Provi der	Physician Cost	
			ldentifier	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
					Limit	Conti nui ng	Share of col.	Insurance	
						Educati on	12		
	1. 00		2.00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00	53. 00 D			0		٦		_	
2.00	53. 00 D			0	(0	0	0	
3.00	91. 00 D			0	(0	0	0	3. 00
4.00	91. 00 D			0	(0	0	0	
5.00	30. 00 D			0	(0	0	0	5. 00
6.00	90. 00 D			0	(0	0	0	6. 00
7. 00	53. 00 D	R. G		0	(0	0	0	7. 00
8. 00	0.00			0	(0	0	0	8. 00
9.00	0.00			0	(0	0	7.00
10. 00	0.00			0	(0	0	0	1
200.00				0	(0	0	0	200. 00
	Wkst. A Line #	Cost	Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
			Identifier	Component	Limit	Di sal I owance			
				Share of col. 14					
	1, 00		2. 00	15. 00	16. 00	17. 00	18.00		
1. 00	53. 00 D	R A	2. 00	0					1. 00
2. 00	53. 00 D			0	ì	-	700, 700		2. 00
3. 00	91. 00 D			0					3. 00
4. 00	91. 00 D			0			633, 242		4. 00
5.00	30. 00 D			l ő	ĺ		000,212		5. 00
6.00	90. 00 D			l ő	ĺ				6. 00
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200.00				0		0	1, 569, 142		200.00
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COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1323

Worksheet B Part I

Peri od: From 01/01/2019 Date/Time Prepared: To 12/31/2019 8/21/2020 10:08 am CAPITAL RELATED COSTS EMS WEST Cost Center Description Net Expenses BLDG & FIXT EMS WEST MVBLE EQUIP STATION EQUIP. for Cost STATI ON Allocation (from Wkst A col. 7) 1.00 1. 01 2. 00 2. 01 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1, 266, 862 1 00 1, 266, 862 1.01 00101 EMS WEST STATION 16, 140 16, 140 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 756, 135 756, 135 2.00 00201 EMS WEST STATION EQUIP. 2 01 104 271 104, 271 2 01 0 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3,862,007 C 0 0 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 9, 033, 889 232, 115 138, 540 0 5.00 6.00 00600 MAINTENANCE & REPAIRS 0 6.00 0 00700 OPERATION OF PLANT 71, 957 1, 099, 311 7 00 42.948 0 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 72, 986 4, 114 2, 456 0 8.00 00900 HOUSEKEEPI NG 256, 015 8, 036 9.00 13, 464 9.00 01000 DI ETARY 253, 279 10.00 10.00 54,020 0 32, 242 0 01100 CAFETERI A 0 11.00 216, 354 0 0 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 0 0 12.00 C 01300 NURSING ADMINISTRATION 13.00 356, 498 0 13.00 01400 CENTRAL SERVICES & SUPPLY -73, 201 14.00 14.00 25, 661 15, 316 0 15 00 01500 PHARMACY 575,067 22, 083 13, 180 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 4, 358 2, 601 16.00 17.00 01700 SOCIAL SERVICE 0 C 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 19.00 C 0 0 02000 NURSING SCHOOL 0 0 20.00 C 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 1, 340, 183 30.00 285, 128 170, 180 0 30.00 0 43.00 04300 NURSERY 142, 430 4, 293 2,562 0 43.00 ANCILLARY SERVICE COST CENTERS 162, 517 05000 OPERATING ROOM 1, 176, 127 96, 999 50.00 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 659,076 20, 294 0 12.113 0 52.00 05300 ANESTHESI OLOGY 0 53.00 92 Λ 53.00 1, 293, 675 54.00 05400 RADI OLOGY-DI AGNOSTI C 80, 543 0 48.073 0 54.00 06000 LABORATORY 60.00 1, 210, 816 32, 133 0 19, 179 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 62.30 06500 RESPIRATORY THERAPY 329, 685 9, 464 0 5.649 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 306, 210 53, 858 0 32, 145 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 133, 497 67.00 06800 SPEECH PATHOLOGY 62, 637 0 68 00 C 0 0 68 00 0 69.00 06900 ELECTROCARDI OLOGY C 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 421, 717 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 128, 326 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 910 545 0 73 00 0 76.97 07697 CARDIAC REHABILITATION 45, 289 5, 708 0 3, 407 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76.98 0 76.99 07699 LI THOTRI PSY 0 0 76.99 0 0

99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 0 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 99.30 0 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 0 99.40 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 104, 271 118. 00 30, 120, 381 1, 209, 053 16, 140 721, 631 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 18.302 3.626 0 2.164 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 2,060 54, 183 32, 340 194. 00 07950 OCCUPATIONAL HEALTH C 0 0 0 194.00 194. 01 07951 FOUNDATION 0 0 194, 01 64, 396 C 0 0 194. 03 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 54,747 C 0 194. 04 07954 ER PHYSICIAN 0 0 0 0 0 194. 04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 0 194. 06 200.00 Cross Foot Adjustments 200.00 0 201.00 Negative Cost Centers 0 201.00

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09910 CORE

09100 EMERGENCY

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART

09001 LIFEBRIDGE SENIOR CARE

Health Financial Systems (COMMUNITY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B	
				From 01/01/2019 Fo 12/31/2019		pared:
					8/21/2020 10:	08 am
			CAPITAL RE	ELATED COSTS		
			I		I	
Cost Center Description	Net Expenses	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST	
	for Cost		STATI ON		STATION EQUIP.	
	Allocation					
	(from Wkst A					
	col. 7)					
	0	1. 00	1. 01	2. 00	2. 01	
202.00 TOTAL (sum lines 118 through 201)	30, 259, 886	1, 266, 862	16, 140	756, 135	104, 271	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1323

	Cost Center Description	EMPLOYEE BENEFITS	Subtotal	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	8/21/2020 10: OPERATION OF PLANT	08 am
		DEPARTMENT 4.00	4A	5. 00	6. 00	7. 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.	0.040.007					2. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 862, 007	10 (50 5/4	10 (50 5(4			4.00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	1, 254, 020	10, 658, 564	10, 658, 564			5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	105, 843	1, 320, 059	716, 627	,	2, 036, 686	7.00
8. 00	00800 LAUNDRY & LINEN SERVICE	103, 043	79, 556			8, 703	1
9. 00	00900 HOUSEKEEPING	61, 254	338, 769	1		28, 483	1
10. 00	01000 DI ETARY	48, 319	387, 860			114, 275	
11. 00	01100 CAFETERI A	91, 949	308, 303	167, 370	0	0	11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0) c	0	0	12. 00
13.00	01300 NURSING ADMINISTRATION	118, 945	475, 443		0	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	-32, 224	1	0	54, 282	14. 00
15.00	01500 PHARMACY	161, 805	772, 135			46, 714	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	6, 959	3, 778	0	9, 219	
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0			0	17. 00 19. 00
20. 00	02000 NURSI NG SCHOOL		0			0	20.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0		0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	l ol	0		o o	l ő	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	O		0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	364, 182	2, 159, 673				
43. 00	04300 NURSERY	39, 888	189, 173	102, 697	0	9, 081	43. 00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	210 425	1 444 049	893, 609	0	242 700	50.00
50. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	210, 425 184, 576	1, 646, 068 876, 059			343, 788 42, 930	
53. 00	05300 ANESTHESI OLOGY	184, 370	92				53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	231, 772	1, 654, 063			170, 380	1
60.00	06000 LABORATORY	0	1, 262, 128			67, 973	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0) c	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	100, 066	444, 864	241, 506	0	20, 020	65. 00
66. 00	06600 PHYSI CAL THERAPY	97, 407	489, 620			113, 931	
67. 00	06700 OCCUPATI ONAL THERAPY	42, 466	175, 963			0	1
68. 00	06800 SPEECH PATHOLOGY	24, 358	86, 995			0	68. 00
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0 421, 717	ή	_	0	69. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATTENTS	0	128, 326			0	71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	910, 545			0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 804	56, 208			12, 074	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	1		0	76. 98
76. 99	07699 LI THOTRI PSY	0	0) c	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	1					
	09000 CLINIC	0	0	1			1
90. 01 91. 00	09001 LI FEBRI DGE SENI OR CARE 09100 EMERGENCY	52, 966	329, 842				
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	289, 559	2, 975, 127	1,015,120	0	238, 078	91.00
72.00	OTHER REIMBURSABLE COST CENTERS			4			72.00
95.00	09500 AMBULANCE SERVICES	367, 733	1, 893, 511	1, 027, 940	0	0	95. 00
99. 10	09910 CORF	0	0) c	0	0	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	0) C	0	0	
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0) C	0	0	
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0) <u> </u>) 0	0	99. 40
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113. 00
118. 00		3, 849, 337	30, 015, 398	10, 525, 838	0	1, 914, 396	
	NONREI MBURSABLE COST CENTERS	0/01//00/	00,010,070	10/020/000	,	1, 7, 1, 0, 0	1.10.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24, 092	13, 079	0	7, 671	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	88, 583			114, 619	
	07950 OCCUPATI ONAL HEALTH	0	0	0	1		194. 00
	07951 FOUNDATION	12, 656	77, 052				194. 01
	3 O7952 COMMUNITY & VOLUNTEER SVCS	14	54, 761	29, 728	0		194. 03 194. 04
	07954 ER PHYSICIAN 07953 SHIPSHEWANA RADIOLOGY AND LAB		0		0		194. 04
200.00			0		,		200.00
201.00	1 1	n	n	(0	n	201.00
202.00		3, 862, 007	30, 259, 886	10, 658, 564	0		
					•		•

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1323 Peri

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: | 8/21/2020 10:08 am

					8/21/2020 10:	08 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						4
1.00 O0100 CAP REL COSTS-BLDG & FLXT					1	1. 00
1.01 O0101 EMS WEST STATION					1	1. 01
2.00 O0200 CAP REL COSTS-MVBLE EQUIP					1	2. 00
2.01 O0201 EMS WEST STATION EQUIP.						2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					1	4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL					ı	5. 00
6.00 00600 MAINTENANCE & REPAIRS					1	6.00
7.00 OO700 OPERATION OF PLANT					1	7.00
8.00 00800 LAUNDRY & LINEN SERVICE	131, 448				1	8. 00
9. 00 00900 HOUSEKEEPI NG	0	551, 161			1	9.00
10. 00 01000 DI ETARY	789	31, 500	744, 983		1	10.00
11. 00 01100 CAFETERI A	0	0	0	475, 673	1	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	o	0	0	0	
13. 00 01300 NURSI NG ADMINI STRATI ON	0	0	0	26, 718	0	1
14. 00 01400 CENTRAL SERVICES & SUPPLY	0	14, 963	0	20, 710	0	
15. 00 01500 PHARMACY	0	12, 877	0	28, 578	0	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0		0	20, 370	0	
	0	2, 541	0	U O	0	
17. 00 01700 SOCIAL SERVICE	0	0	0	U		
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	O _I	0	
20. 00 02000 NURSI NG SCHOOL	0	0	0	O _I	0	1
21.00 02100 1 &R SERVI CES-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 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	39, 133	166, 259	744, 983	98, 133	0	
43. 00 04300 NURSERY	1, 801	2, 503	0	8, 680	0	43. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	18, 363	94, 765	0	52, 477	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	8, 386	11, 834	0	40, 133	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	o	0	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	17, 903	46, 965	0	63, 299	0	1
60. 00 06000 LABORATORY	0	18, 737	0	0	0	1
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	.0, .0,	0	0	0	1
65. 00 06500 RESPI RATORY THERAPY	o o	5, 519	0	33, 763	0	
66. 00 06600 PHYSI CAL THERAPY	4, 101	31, 405	0	28, 014	0	1
67. 00 06700 OCCUPATI ONAL THERAPY	1, 709	31, 403	0	8, 680	0	
		0	0		0	
68. 00 06800 SPEECH PATHOLOGY	171	0	0	4, 509	_	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	U	0	1
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	O ₁	0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0	3, 328	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	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	8, 629	0	14, 542	0	90. 01
91. 00 09100 EMERGENCY	28, 629	65, 626	0	68, 147	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					1	92.00
OTHER REIMBURSABLE COST CENTERS		•	·	•		
95. 00 09500 AMBULANCE SERVICES	7, 545	0	0	O	0	95.00
99. 10 09910 CORF	0	o	0	ol	0	1
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	Ö	0	0	ol	0	1
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	Ö	0	1
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	1
SPECIAL PURPOSE COST CENTERS	<u> </u>	9	O _I	<u> </u>		77.40
113. 00 11300 NTEREST EXPENSE						113. 00
	128, 530	517, 451	744, 983	475, 673	0	118. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	120, 330	317, 431	744, 903	473, 073	0	1110.00
	0	2 11	0	ام	0	190. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	2, 115	0	0	_	
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	2, 918	31, 595	0	0		192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0	0	0		194. 00
194. 01 07951 FOUNDATI ON	0	0	0	0		194. 01
194.03 07952 COMMUNITY & VOLUNTEER SVCS	0	0	0	0		194. 03
194. 04 07954 ER PHYSI CI AN	0	0	0	0	0	194. 04
194.06 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	o	0	ol	0	194. 06
200.00 Cross Foot Adjustments					-	200.00
201.00 Negative Cost Centers	0	ol	0	ol	0	201.00
202.00 TOTAL (sum lines 118 through 201)	131, 448	551, 161	744, 983	475, 673		202. 00
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Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1323
Period:
From 01/01/2019
To 12/31/2019 Date/Time Prepared:

			To	12/31/2019	Date/Time Prep 8/21/2020 10:0	
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	
GENERAL SERVI CE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 EMS WEST STATION 2. 00 00200 CAP REL COSTS-MVBLE EQUIP	-					1. 01 2. 00
2.01 OO200 CAL KEE COSTS-WVBEE EGOTT						2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY	-					9. 00 10. 00
11. 00 01100 CAFETERI A						11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL						12.00
13.00 01300 NURSING ADMINISTRATION	760, 267				ļ	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	37, 021				14. 00
15. 00 01500 PHARMACY	0	968	1, 280, 445			15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0	0	22, 497		16.00
17. 00 01700 SOCI AL SERVI CE 19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	17. 00 19. 00
20. 00 02000 NURSI NG SCHOOL		0	0	0	0	20.00
21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	o	Ö	ol	0	21. 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	o	0	22. 00
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	278, 843	494	2, 809	2, 562	0	
43. 00 04300 NURSERY	24, 640	579	69	414	0	43. 00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	149, 139	6, 810	11, 061	585	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	114, 033	2, 680	312	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	o	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	986	555	12, 329	0	54.00
60. 00 06000 LABORATORY	0	0	13, 973	o	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	0	493	0	0 744	0	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	152	347 139	2, 711 677	0	66.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	63	0	164	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	13, 104	0	o	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	3, 985	0	o	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	894	1, 077, 849	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 76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76. 98 76. 99
OUTPATIENT SERVICE COST CENTERS	J O	U _I	U _I	<u> </u>	U	70. 77
90. 00 09000 CLINIC	0	0	0	0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	42	0	О	0	90. 01
91. 00 09100 EMERGENCY	193, 612	3, 146	22, 815	3, 055	0	91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART						92. 00
95. 00 OTHER REIMBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES	l ol	2 470	150, 516	ol	0	95. 00
95. 00 09500 AMBULANCE SERVICES 99. 10 09910 CORF	0	2, 479	150, 516	0	0	95.00
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99. 20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	o	0	99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	o	O	Ō	ō	0	•
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE						113. 00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	760, 267	36, 881	1, 280, 445	22, 497	0	118. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	22	O	ما	0	190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	49	0	0		192. 00
194. 00 07950 OCCUPATI ONAL HEALTH		Ó	o	ol		194. 00
194. 01 07951 FOUNDATI ON	0	22	0	o		194. 01
194.03 07952 COMMUNITY & VOLUNTEER SVCS	0	47	0	o		194. 03
194. 04 07954 ER PHYSI CI AN	0	0	0	0		194. 04
194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	0	0	0	194. 06
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers			0		0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	760, 267	37, 021	1, 280, 445	22, 497		202.00
1 1 2 (22 200)	1 227 207	,,	,,	, ,]	٥١	

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1323

Peri od: Worksheet B From 01/01/2019 Part I To 12/31/2019 Date/Time Prepared:

In Lieu of Form CMS-2552-10

8/21/2020 10:08 am INTERNS & RESIDENTS NONPHYSI CI AN NURSI NG SCHOOL SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Cost Center Description ANESTHETI STS Y & FRINGES PRGM COSTS **PRGM APPRV APPRV** 23.00 19.00 20.00 21.00 22.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 EMS WEST STATION 1.01 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 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 9.00 00900 HOUSEKEEPI NG 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 0 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 0 0 0 0 0 30.00 04300 NURSERY 0 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00 05300 ANESTHESI OLOGY 0 53 00 0 0 0 0 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 000000000 0 0 0 54.00 0 60 00 06000 LABORATORY Ω 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 0 0 06700 OCCUPATIONAL THERAPY 0 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 Λ 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 07697 CARDIAC REHABILITATION 0 76.97 76.97 0 0 0 0 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY C 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90 00 0 90.00 09000 CLI NI C C 0 0 0 90.01 09001 LIFEBRIDGE SENIOR CARE 0 C 0 0 0 90.01 0 0 0 91.00 09100 EMERGENCY C 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 0 99. 10 09910 CORF 0 0 0 0 99. 10 0 0 99 20 09920 OUTPATIENT PHYSICAL THERAPY 0 99. 20 0 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 99.30 C 0 0 99.30 09940 OUTPATIENT SPEECH PATHOLOGY o 99.40 99.40 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 0 0 0 0 118.00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN C 0 190. 00 0 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.00 Ω 0 194. 00 07950 OCCUPATIONAL HEALTH 0 0 0 194.00 0 0 0 0 0 0 194. 01 194. 01 07951 FOUNDATI ON 0 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 0 0 0 0 0 194. 03 194. 04 07954 ER PHYSICIAN 0 0 0 194, 04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 194. 06 0 200.00 Cross Foot Adjustments 0 0 0 200. 00 0 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 0 0 0 202. 00

Provider CCN: 15-1323

| Peri od: | Worksheet B | From 01/01/2019 | Part | To 12/31/2019 | Date/Time Prepared: | Part | Part | Prepared: | Part | P

			To	Date/Time Pre 8/21/2020 10:	
Cost Center Description	Subtotal	Intern &	Total	7 07 2 17 2020 10.	
		Residents Cost & Post			
		Stepdown			
		Adjustments			
GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1. 00 00100 CAP REL COSTS-BLDG & FLXT					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. 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 01 4. 00
5. 00 00500 ADMINISTRATIVE & GENERAL					5. 00
6. 00 00600 MAINTENANCE & REPAIRS					6. 00
7.00 00700 OPERATION OF PLANT					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A					10.00
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 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE					16. 00 17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS					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
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	5, 268, 483	O	5, 268, 483		30.00
43. 00 04300 NURSERY	339, 637		339, 637		43. 00
ANCILLARY SERVICE COST CENTERS	007,007	91	007,007		10.00
50. 00 05000 OPERATING ROOM	3, 216, 665	0	3, 216, 665		50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	1, 571, 958	0	1, 571, 958		52. 00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	142	0	142		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY	2, 864, 429 2, 047, 989	0	2, 864, 429 2, 047, 989		54. 00 60. 00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	2,047,707		2, 047, 707		62. 30
65. 00 06500 RESPIRATORY THERAPY	746, 165	0	746, 165		65. 00
66. 00 06600 PHYSI CAL THERAPY	936, 083	0	936, 083		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	282, 757	0	282, 757		67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	139, 072 0	0	139, 072 0		68. 00 69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	663, 761		663, 761		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	201, 976	o	201, 976		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 483, 600	0	2, 483, 600		73. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	102, 124	0	102, 124		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 99 07699 LI THOTRI PSY	0	0	0		76. 98 76. 99
OUTPATIENT SERVICE COST CENTERS	0	0	U		70. 99
90. 00 09000 CLI NI C	0	0	0		90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	563, 421	O	563, 421		90. 01
91. 00 09100 EMERGENCY	5, 213, 361	0	5, 213, 361		91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0			92. 00
95. 00 09500 AMBULANCE SERVICES	3, 081, 991	O	3, 081, 991		95. 00
99. 10 09910 CORF	0,001,771	o	0,001,771		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 O9940 OUTPATIENT SPEECH PATHOLOGY	0	0	0		99. 40
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	29, 723, 614	o	29, 723, 614		118.00
NONREI MBURSABLE COST CENTERS	, , , , , ,	- '	, , , ,		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	46, 979	0	46, 979		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	285, 853	0	285, 853		192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	119 004	0	110 004		194. 00
194. 01 07951 FOUNDATION 194. 03 07952 COMMUNITY & VOLUNTEER SVCS	118, 904 84, 536		118, 904 84, 536		194. 01 194. 03
194. 04 07954 ER PHYSI CI AN	04, 330		04, 550		194. 03
194.06 07953 SHI PSHEWANA RADIOLOGY AND LAB	0	o	0		194. 06
200.00 Cross Foot Adjustments	0	0	0		200. 00
201.00 Negative Cost Centers	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	30, 259, 886	0	30, 259, 886		202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1323

Peri od: Worksheet B From 01/01/2019 Part II Date/Time Prepared:

12/31/2019

To

8/21/2020 10:08 am CAPITAL RELATED COSTS Cost Center Description Directly BLDG & FIXT EMS WEST MVBLE EQUIP EMS WEST STATION EQUIP. Assigned New STATI ON Capi tal Related Costs 1.00 1.01 2.00 2.01 0 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00101 EMS WEST STATION 1.01 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.01 00201 EMS WEST STATION EQUIP. 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 4 00 0 5.00 00500 ADMINISTRATIVE & GENERAL 892, 756 232, 115 0 138, 540 0 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 0 0 7 00 71 957 42 948 0 7 00 00800 LAUNDRY & LINEN SERVICE 0 0 8.00 4, 114 2, 456 0 8.00 9.00 00900 HOUSEKEEPI NG 0 13, 464 8,036 0 9.00 10.00 01000 DI ETARY 0 0 54,020 0 32, 242 0 10.00 01100 CAFETERIA 0 11 00 0 11 00 0 01200 MAINTENANCE OF PERSONNEL 12.00 C 0 0 0 12.00 01300 NURSING ADMINISTRATION 0 13.00 13.00 0000 0 01400 CENTRAL SERVICES & SUPPLY 15, 316 14.00 14.00 25, 661 0 01500 PHARMACY 22, 083 0 15 00 13.180 0 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 4, 358 0 2,601 0 16.00 01700 SOCIAL SERVICE 17.00 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 0 0 19.00 02000 NURSING SCHOOL 0 20.00 20 00 C 0 0 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 0 30.00 285, 128 170, 180 04300 NURSERY 43.00 0 4, 293 0 2, 562 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 162, 517 0 96, 999 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 20, 294 0 12, 113 52.00 0 53.00 05300 ANESTHESI OLOGY 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 80.543 0 48.073 54 00 0 54 00 0 60.00 06000 LABORATORY 32, 133 19, 179 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 0 0 O 62.30 06500 RESPIRATORY THERAPY 9.464 65.00 0 5.649 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 53, 858 32, 145 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 000000 0 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 06900 ELECTROCARDI OLOGY 0 0 69.00 69.00 C Λ 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT C 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0 73.00 07697 CARDIAC REHABILITATION 0 76.97 5, 708 3, 407 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76.98 07699 LI THOTRI PSY 76. 99 0 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 90.01 09001 LIFEBRIDGE SENIOR CARE 0 14, 798 0 8,832 0 90.01 09100 EMERGENCY 0 0 91.00 91.00 112, 545 67, 173 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 104, 271 95.00 16, 140 0 0 99.10 09910 CORF 0 0 99.10 C 0 09920 OUTPATIENT PHYSICAL THERAPY 99 20 0 0 99 20 Ω 0 99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 0 99.30 09940 OUTPATIENT SPEECH PATHOLOGY 0 0 99.40 SPECIAL PURPOSE COST CENTERS 113.00 11300 I NTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1 through 117) 892, 756 1, 209, 053 16, 140 721, 631 104, 271 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 3 626 0 2 164 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 54, 183 0 32, 340 0 192.00 194. 00 07950 OCCUPATIONAL HEALTH 0 0 194.00 0 0 194. 01 07951 FOUNDATI ON 0 0 0 0 194. 01 194. 03 07952 COMMUNITY & VOLUNTEER SVCS C 0 0 0 194.03 194. 04 07954 ER PHYSICIAN 0 0 0 194.04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 0 194.06 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118 through 201) 892, 756 1, 266, 862 16, 140 756, 135 104, 271 202. 00 ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1323

Period: Worksheet B From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared:

8/21/2020 10:08 am Cost Center Description Subtotal **EMPLOYEE** ADMINISTRATIVE MAINTENANCE & OPERATION OF **BENEFITS** & GENERAL REPAIRS PLANT DEPARTMENT 2A 5.00 6. 00 7. 00 4.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 EMS WEST STATION 1.01 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00201 EMS WEST STATION EQUIP. 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 1. 263. 411 1, 263, 411 5.00 00600 MAINTENANCE & REPAIRS 6.00 6 00 7.00 00700 OPERATION OF PLANT 114, 905 84, 946 199, 851 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 6,570 5, 119 0 854 8.00 00900 HOUSEKEEPI NG 2, 795 9.00 21.500 21, 800 9.00 01000 DI ETARY 24, 959 10.00 86, 262 11, 213 10.00 11.00 01100 CAFETERI A 0 19,839 0 0 0 0 0 0 0 0 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 0 01300 NURSING ADMINISTRATION 13.00 30, 595 13.00 0 0 01400 CENTRAL SERVICES & SUPPLY 5, 326 14.00 40, 977 14.00 15.00 01500 PHARMACY 35, 263 49, 687 4.584 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 6, 959 905 16.00 448 01700 SOCIAL SERVICE 17 00 0 C 0 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 02000 NURSING SCHOOL 0 0 20.00 0 0 0 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 0 C 0 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 455, 308 n 138, 975 O 59 183 30 00 04300 NURSERY 0 43.00 6,855 12, 173 0 891 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 259, 516 0 105, 924 0 33, 734 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 32, 407 0 56, 374 4, 213 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 128, 616 0 106, 439 0 16, 719 54.00 60 00 06000 LABORATORY 51, 312 Ω 81, 218 6, 670 60 00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 06500 RESPIRATORY THERAPY 15, 113 0 28, 627 1, 965 65.00 65.00 0 0 0 0 0 0 11, 180 66.00 06600 PHYSI CAL THERAPY 86,003 31, 507 66.00 06700 OCCUPATIONAL THERAPY 11, 323 67 00 0 Ω 67 00 0 68.00 06800 SPEECH PATHOLOGY 0 C 5, 598 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 27, 137 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 Ω 8 258 0 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 58, 594 0 73.00 76.97 07697 CARDIAC REHABILITATION 9, 115 3, 617 0 1, 185 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76. 98 0 0 0 C 07699 LI THOTRI PSY 76. 99 76.99 0 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 90.00 09001 LIFEBRIDGE SENIOR CARE 3,072 90.01 23.630 0 21, 225 0 90.01 91.00 09100 EMERGENCY 179, 718 191, 444 0 23, 362 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 121, 847 120.411 0 0 95.00 99. 10 09910 CORF C C 0 0 99.10 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 0 0 99.20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 99.30 99.30 0 0 0 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 O 0 99.40 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 2, 943, 851 0 1, 247, 679 0 187, 851 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 5. 790 1. 550 753 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 86, 523 0 5, 700 11, 247 192. 00 0 194. 00 07950 OCCUPATI ONAL HEALTH 0 194.00 0 \cap 194. 01 07951 FOUNDATION 0 4, 958 0 194. 01 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 0 0 194. 03 0 3, 524 0 194. 04 07954 ER PHYSICIAN 0 0 0 194.04 C 194.06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 194, 06 0 0 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 201.00 199, 851 202. 00 202.00 TOTAL (sum lines 118 through 201) 3, 036, 164 1, 263, 411

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1323
Period: From 01/01/2019 Part II
To 12/31/2019 Date/Time Prepared:

				10	12/31/2019	Date/lime Pre 8/21/2020 10:	
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	MAINTENANCE OF	00 4
		LINEN SERVICE 8.00	9. 00	10.00	11. 00	PERSONNEL 12.00	
	GENERAL SERVICE COST CENTERS	8.00	9.00	10.00	11.00	12.00	
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	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAIRS						6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	12, 543					7. 00 8. 00
9.00	00900 HOUSEKEEPI NG	12, 343	46, 095				9.00
10. 00	01000 DI ETARY	75	2, 634	125, 143			10.00
11. 00	01100 CAFETERI A	, 0	2, 034	125, 149	19, 839		11.00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	Ö	0	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	o	0	Ö	1, 114	Ō	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1, 251	0	0	0	14. 00
15.00	01500 PHARMACY	0	1, 077	0	1, 192	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	213	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV		0	0	0	0	22. 00 23. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	U U	U	<u> </u>	0		23.00
30. 00	03000 ADULTS & PEDIATRICS	3, 736	13, 906	125, 143	4, 093	0	30.00
43. 00	04300 NURSERY	172	209		362	Ö	43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 752	7, 925	0	2, 189	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	800	990	0	1, 674	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 708	3, 928	0	2, 640	0	54. 00
60.00	06000 LABORATORY	0	1, 567	0	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	0	462	0	1, 408	l	65.00
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	391 163	2, 626	0	1, 168	0	66.00
67. 00 68. 00	06800 SPEECH PATHOLOGY	163	0	0	362 188		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	100	0	69.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0	Ö	0	Ō	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	O	0	0	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	278	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
	OUTPATIENT SERVICE COST CENTERS					г -	
90.00	09000 CLINIC	0	0		0		90.00
	09001 LI FEBRI DGE SENI OR CARE	0	722		607		
91.00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	2, 732	5, 488	0	2, 842	0	91. 00 92. 00
92.00	OTHER REIMBURSABLE COST CENTERS						92.00
95. 00	09500 AMBULANCE SERVICES	720	0	0	0	0	95. 00
	09910 CORF	0	0	Ö	0	Ö	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	o	0	Ö	0	Ō	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	O	0	0	0	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE					_	113. 00
118.00		12, 265	43, 276	125, 143	19, 839	0	118. 00
100.00	NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		177		0		100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	278	177 2, 642	0	0		190. 00 192. 00
	07950 OCCUPATIONAL HEALTH	2/0	2, 042	0	0	l	194. 00
	07951 FOUNDATION		0	0	0		194. 01
	07952 COMMUNITY & VOLUNTEER SVCS		n	ا	n	l	194. 03
	07954 ER PHYSICIAN		ő		0		194. 04
	07953 SHI PSHEWANA RADI OLOGY AND LAB		o	Ö	0		194. 06
200.00	Cross Foot Adjustments						200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	12, 543	46, 095	125, 143	19, 839	0	202. 00

Health Financial Systems

In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1323 Peri od: Worksheet B From 01/01/2019 Part II 12/31/2019 Date/Time Prepared: 8/21/2020 10:08 am Cost Center Description NURSI NG CENTRAL PHARMACY MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & RECORDS & **SUPPLY** LI BRARY 13.00 15.00 17.00 14.00 16,00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 EMS WEST STATION 1.01 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.01 00201 EMS WEST STATION EQUIP. 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8 00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 31, 709 13.00 01400 CENTRAL SERVICES & SUPPLY 15, 972 14.00 14.00 15.00 01500 PHARMACY 0 418 92, 221 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 8, 525 C 16.00 C 0 01700 SOCIAL SERVICE 17 00 C 0 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS C 0 0 0 19.00 02000 NURSING SCHOOL 0 0 20.00 0 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 C 0 0 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 11 630 213 202 971 n 30.00 04300 NURSERY 43.00 1,028 250 5 157 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 6, 220 2, 938 797 0 50.00 222 05200 DELIVERY ROOM & LABOR ROOM 52.00 4, 756 1, 156 22 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 4, 671 54.00 425 40 0 54.00 0 60 00 06000 LABORATORY 1 006 0 60 00 C 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 0 0 62.30 06500 RESPIRATORY THERAPY 0 212 0 0 0 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 25 1,027 0 66.00 66 06700 OCCUPATIONAL THERAPY 67 00 27 10 257 67 00 0 68.00 06800 SPEECH PATHOLOGY 0 62 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 5, 654 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 1, 719 0 0 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 386 77,630 0 0 73.00 76.97 07697 CARDIAC REHABILITATION 0 C 0 0 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 76. 98 0 0 C 07699 LI THOTRI PSY 76.99 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 90.00 09001 LIFEBRIDGE SENIOR CARE 90.01 18 0 90.01 0 8,075 91.00 09100 EMERGENCY 1, 357 1,643 1.158 Ω 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 1, 070 95.00 0 10.841 0 0 95.00 99. 10 09910 CORF 0 C 0 0 99.10 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 C 0 0 0 99.20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 99.30 99.30 C 0 0 0 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 O 0 99.40 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 31, 709 15, 912 92, 221 8,525 0 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 192.00 21 0 194. 00 07950 OCCUPATI ONAL HEALTH 0 0 0 194, 00 C 194. 01 07951 FOUNDATION 0 0 0 194. 01 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 0 0 0 0 194. 03 20 0 o 194. 04 07954 ER PHYSICIAN 0 0 194.04 C 194.06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 194, 06 C 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 31, 582 0 201.00

31 709

47, 554

92 221

8 525

0 202. 00

TOTAL (sum lines 118 through 201)

202.00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 15-1323

Peri od: Worksheet B From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared:

8/21/2020 10:08 am INTERNS & RESIDENTS PARAMED ED NONPHYSI CI AN NURSI NG SCHOOL SERVI CES-SALAR SERVI CES-OTHER Cost Center Description ANESTHETI STS Y & FRINGES PRGM COSTS **PRGM APPRV APPRV** 23.00 19.00 20.00 21.00 22.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 EMS WEST STATION 1.01 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 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 9.00 00900 HOUSEKEEPI NG 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 0 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 30.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 05300 ANESTHESI OLOGY 53 00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 60 00 06000 LABORATORY 60 00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 66.00 66,00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 73.00 07697 CARDIAC REHABILITATION 76.97 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 76. 99 07699 LI THOTRI PSY 76.99 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 90.01 09001 LIFEBRIDGE SENIOR CARE 90.01 91.00 09100 EMERGENCY 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 99. 10 09910 CORF 99. 10 99 20 09920 OUTPATIENT PHYSICAL THERAPY 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 99.30 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 through 117) 118.00 0 0 0 0 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192 00 194. 00 07950 OCCUPATIONAL HEALTH 194.00 194. 01 07951 FOUNDATI ON 194. 01 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 194. 03 194. 04 07954 ER PHYSICIAN 194.04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 194. 06 200.00 Cross Foot Adjustments 0 200. 00 0 0 201.00 Negative Cost Centers 0 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 0 0 202.00

| Peri od: | Worksheet B | From 01/01/2019 | Part | I | To | 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1323

						e Prepared: 0 10:08 am
	Cost Center Description	Subtotal	Intern &	Total	07217202	0 10.08 am
			Residents Cost			
			& Post Stepdown			
			Adjustments			
		24. 00	25.00	26. 00		
1 00	GENERAL SERVI CE COST CENTERS		T			1.00
1. 00 1. 01	OO100 CAP REL COSTS-BLDG & FIXT OO101 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 ADMI NI STRATI VE & GENERAL					5. 00
6. 00 7. 00	OO6OO MAI NTENANCE & REPAI RS OO7OO OPERATI ON OF PLANT					6. 00 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 13. 00	O1200 MAINTENANCE OF PERSONNEL O1300 NURSING ADMINISTRATION					12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY					16. 00
	01700 SOCIAL SERVICE					17. 00
	01900 NONPHYSI CI AN ANESTHETI STS					19. 00
21. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV					20. 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	813, 360		1		30.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	22, 102	0) 22, 10	02	43. 00
50. 00	05000 OPERATI NG ROOM	421, 217	0	421, 21	17	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	102, 392		1		52.00
53.00	05300 ANESTHESI OLOGY	6	0	1	6	53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	265, 186				54.00
60. 00 62. 30	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS	141, 773	0		/ 3 O	60. 00 62. 30
65. 00	06500 RESPIRATORY THERAPY	47, 787	ا	•	37	65. 00
66.00	06600 PHYSI CAL THERAPY	133, 993	0	I .		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	12, 142				67. 00
68. 00	06800 SPEECH PATHOLOGY	5, 867	0			68. 00
69. 00 71. 00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0 32, 791	0		0	69. 00 71. 00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	9, 977				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	136, 610	Ō			73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	14, 195			95	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0		1	0	76. 98
76. 99	07699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0)	0	76. 99
90. 00	09000 CLINIC	0	0		0	90.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	49, 274		1	7.4	90. 01
91. 00	09100 EMERGENCY	417, 819			19	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0)		92. 00
95. 00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	254, 889	0	254, 88	30	95. 00
	09910 CORF	254, 007			0	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	0		0	99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		•	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0)	0	99. 40
112 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE		I	T		112 00
118.00	1	2, 881, 380	0	2, 881, 38	30	113. 00 118. 00
	NONREI MBURSABLE COST CENTERS				-1	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	8, 280		1		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	106, 411	0	1,	11	192. 00
	07950 OCCUPATI ONAL HEALTH 07951 FOUNDATI ON	0 4 067	0		U 57	194. 00 194. 01
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS	4, 967 3, 544		4, 96 3, 54		194. 01
	07954 ER PHYSICIAN	3, 344	0	5, 5-	o	194. 04
194.06	07953 SHIPSHEWANA RADIOLOGY AND LAB	0	0		O	194. 06
200.00	1 1	0	0		0	200. 00
201.00		31, 582		1,		201. 00
202.00	TOTAL (sum lines 118 through 201)	3, 036, 164	0	3, 036, 16	94	202. 00

| Period: | Worksheet B-1 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS COMMUNITY HOSPT. OF LAGRANGE CTY IN

Provider CCN: 15-1323

					0 12/31/2019	Date/Time Pre 8/21/2020 10:	
			CAPI TAL REI	LATED COSTS		0/21/2020 10.	OG alli
	Cost Center Description	BLDG & FLXT	EMS WEST	MVBLE EQUIP	EMS WEST	EMPLOYEE	
	555 55115.	(SQUARE FEET)	STATI ON		STATION EQUIP.	BENEFI TS	
			(SQUARE FEET)		(SQUARE FEET)	DEPARTMENT (GROSS	
					·	SALARI ES)	
	GENERAL SERVICE COST CENTERS	1.00	1. 01	2.00	2. 01	4. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	77, 906					1. 00
1. 01	00101 EMS WEST STATION	0	9, 760				1. 01
2. 00 2. 01	OO200 CAP REL COSTS-MVBLE EQUIP OO201 EMS WEST STATION EQUIP.			77, 906			2. 00 2. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	Ö		11, 804, 273	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	14, 274	0	14, 274	0	3, 832, 921	5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	4, 425		4, 425	0	0 323, 511	6. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	253	Ō	253	O	0	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	828	0	828		187, 223	9.00
11. 00	01100 CAFETERI A	3, 322		3, 322 0		147, 689 281, 044	10. 00 11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	0	_	0	12. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0 1, 578	0	0 1, 578	-	363, 558 0	13. 00 14. 00
15. 00	01500 PHARMACY	1, 358	l e	1, 358		494, 558	
16. 00	01600 MEDICAL RECORDS & LIBRARY	268	0	268		0	16. 00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	_	0	17. 00 19. 00
20. 00	02000 NURSI NG SCHOOL	0	0	0	-	0	20.00
21. 00	02100 I &R SERVI CES-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	INPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>	0	<u> </u>	0	23.00
30.00	03000 ADULTS & PEDIATRICS	17, 534				1, 113, 129	1
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	264	0	264	0	121, 918	43.00
50.00	05000 OPERATING ROOM	9, 994	l			643, 166	50. 00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	1, 248	0	1, 248 0		564, 159 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 953		4, 953		708, 416	1
60.00	06000 LABORATORY	1, 976	0	1, 976		0	60.00
62. 30 65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0 582	0	0 582		0 305, 852	62. 30 65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 312	Ö	3, 312		297, 726	1
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	_	129, 798	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	0	_	74, 451 0	68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	Ö	ő	Ö	o	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73. 00 76. 97	O7300 DRUGS CHARGED TO PATIENTS O7697 CARDIAC REHABILITATION	351		0 351	_	0 5, 515	73. 00 76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	O7699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76. 99
90. 00	09000 CLINIC	0	0	0	0	0	90. 00
90. 01	09001 LI FEBRI DGE SENI OR CARE	910				161, 892	90. 01
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART	6, 921	0	6, 921	0	885, 040	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	09500 AMBULANCE SERVICES	0	9, 760			1, 123, 981	95. 00
99. 10 99. 20	09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	-	0	99. 10 99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	Ö			0	99. 30
99. 40		0	0	0	0	0	99. 40
113 00	SPECIAL PURPOSE COST CENTERS			Ι			113. 00
118.00		74, 351	9, 760	74, 351	9, 760	11, 765, 547	1
100.00	NONREI MBURSABLE COST CENTERS	222		1 222		0	190. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	223 3, 332		•			190.00
194.00	07950 OCCUPATI ONAL HEALTH	0	0	0	O	0	194. 00
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS	0	0	0	_		194. 01 194. 03
	107952 COMMUNITY & VOLUNTEER SVCS	0		0			194. 03
194. 06	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	0	o		194. 06
200. 00 201. 00							200. 00 201. 00
	negative cost centers	l	l	l .	l l		1201.00

Health Financial Systems	COMMUNITY HOSPT. OF	LAGRANGE CTY	IN	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2019	Worksheet B-1		
					Date/Time Pre 8/21/2020 10:		
		CAPITAL RELATED COSTS					
Cost Center Description	BLDG & FLXT	FMS_WEST	MVBLE FOULP	FMS_WEST	FMPI OYFF		

						0/21/2020 10.	00 aiii
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST	EMPLOYEE	
		(SQUARE FEET)	STATI ON	(SQUARE FEET)	STATION EQUIP.	BENEFITS	
			(SQUARE FEET)			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,	1, 266, 862	16, 140	756, 135	104, 271	3, 862, 007	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	16. 261418	1. 653689	9. 705735	10. 683504	0. 327170	203. 00
204.00	Cost to be allocated (per Wkst. B,					0	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part					0.000000	205. 00
	[11]						
206. 00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

| Peri od: | Worksheet B-1 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1323

				Ť	o 12/31/2019	Date/Time Prep 8/21/2020 10:0	
	Cost Center Description	Reconciliation	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	
			& GENERAL (ACCUM. COST)	REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	
		ΕΛ	F 00	(00	7.00	LAUNDRY)	
	GENERAL SERVICE COST CENTERS	5A	5. 00	6. 00	7. 00	8. 00	
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						4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	-10, 658, 564	19, 633, 546	0			5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	0	1, 320, 059	1			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	79, 556			10, 000	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	338, 769 387, 860			0 60	9. 00 10. 00
11. 00	01100 CAFETERI A	0	308, 303		l '	0	11.00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	0	· ·	0	12. 00
13.00	01300 NURSING ADMINISTRATION	0	475, 443		_	0	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	32, 224 0	0 772, 135	1	,	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	6, 959		l	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	1	· ·	0	17. 00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0		0	-	0	19. 00 20. 00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	0	Ö	Ö	· ·	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	· ·	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	0	2, 159, 673	0	17, 534	2, 977	30. 00
43.00	04300 NURSERY	0	189, 173	0	264	137	43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	1, 646, 068	0	9, 994	1, 397	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	876, 059	•		638	52.00
53.00	05300 ANESTHESI OLOGY	0	92		0	0	53. 00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	1, 654, 063	1		1, 362 0	54.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		1, 262, 128 0		.,	0	60. 00 62. 30
65. 00	06500 RESPIRATORY THERAPY	0	444, 864	0	· ·	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	489, 620		-, -	312	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	175, 963 86, 995		1	130 13	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	Ö	0	1	1	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	421, 717	0	-	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	128, 326 910, 545		_	0	72. 00 73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	56, 208		351	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0			0	76. 98
76. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76. 99
90.00	09000 CLINIC	0	0	0	0	0	90. 00
90. 01	09001 LI FEBRI DGE SENI OR CARE	0					90. 01
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 975, 127	0	6, 921	2, 178	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	· ·	0	1, 893, 511			574	95. 00
99. 10 99. 20	09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY	0	0			0	99. 10 99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0			· · · · · · · · · · · · · · · · · · ·	0	99. 30
99. 40		0	0	0	0	0	99. 40
112 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE		I	I			113. 00
118. 00		-10, 626, 340	19, 389, 058	0	55, 652	9, 778	118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	24, 092	0	223	0	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	88, 583				192. 00
	0 07950 0CCUPATIONAL HEALTH 07951 FOUNDATION	0	0 77, 052		1		194. 00 194. 01
	07951 FOUNDATION 3 07952 COMMUNITY & VOLUNTEER SVCS	0	54, 761		1		194. 01
194. 04	1 07954 ER PHYSICIAN	0	0	Ō	0	0	194. 04
194. 06 200. 00	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	0	이		194. 06
200.00							200. 00 201. 00
202. 00	Cost to be allocated (per Wkst. B,		10, 658, 564	0	2, 036, 686		1
203. 00	Part		0. 542875	0. 000000	34. 399412	13. 144800	203. 00

Health Financial Systems		COMMUNITY HOSPT. OF LAGRANGE CTY IN			In Lieu of Form CMS-2552-10		
COST ALLOC	ATION - STATISTICAL BASIS		Provi der Co		Peri od:	Worksheet B-1	
		,			From 01/01/2019 Fo 12/31/2019	Date/Time Pre 8/21/2020 10:	
	Cost Center Description	Reconciliation		MAINTENANCE 8	OPERATION OF	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, 263, 411		199, 851	12, 543	204. 00
205.00	Unit cost multiplier (Wkst. B, Part		0. 064350	0.00000	3. 375462	1. 254300	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Provider CCN: 15-1323

Peri od: Worksheet B-1 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

				'	0 12/31/2019	8/21/2020 10:	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY		MAINTENANCE OF		
		(SQUARE FEET)	(MEALS SERVED)	(FTE)	PERSONNEL	ADMI NI STRATI ON	
					(NUMBER HOUSED)	(DIRECT NRSING	
					1100022)	HRS)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	GENERAL SERVICE COST CENTERS	T	Г			T	
1. 00 1. 01	OO100 CAP REL COSTS-BLDG & FIXT OO101 EMS WEST STATION						1. 00 1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2. 00	00201 EMS WEST STATION EQUIP.						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	FO 40/					8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	58, 126 3, 322					9.00
11. 00	01100 CAFETERI A	3, 322	12, 560	8, 439			10. 00 11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	l o	0, 107	0		12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	0	474	0	99, 013	•
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 578	0	0	0	0	14. 00
15.00	01500 PHARMACY	1, 358	1	507	0	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	268	1	0	0	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 21. 00	02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0		0	0	0	20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0		22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	o	0	0	1	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					'	
30.00	03000 ADULTS & PEDI ATRI CS	17, 534	12, 560	1, 741	0	36, 315	30. 00
43. 00	04300 NURSERY	264	0	154	0	3, 209	43. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	0.004		021	0	10 422	
50. 00 52. 00	O5000 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM	9, 994 1, 248	0	931 712	0		50. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	1, 240	0	712	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 953	o	1, 123	0	Ö	54.00
60.00	06000 LABORATORY	1, 976	o	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	582	0	599	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	3, 312	0	497	0	0	66.00
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	0	0	154 80	0	0	67.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	00	0		68. 00 69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	ا	0	0	Ö	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	o	0	0	Ō	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	351	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	0	76. 99
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	O	0	0		90.00
	09001 LI FEBRI DGE SENI OR CARE	910	1	258	0		90. 01
91. 00	09100 EMERGENCY	6, 921	Ö	1, 209		1	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	0	0	0	0	0	
99. 10	09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	_	99. 10
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	99. 20 99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	1	99. 40
,,, ,	SPECIAL PURPOSE COST CENTERS		91			· · · · · · · · ·	771.10
113.00	11300 NTEREST EXPENSE						113. 00
118.00		54, 571	12, 560	8, 439	0	99, 013	118. 00
	NONREI MBURSABLE COST CENTERS					_	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	223		0	0		190.00
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH	3, 332	0	0	0		192. 00 194. 00
	07951 FOUNDATION	0	0	0	0		194. 00
	07952 COMMUNITY & VOLUNTEER SVCS	0	l o	0	0	1	194. 03
	07954 ER PHYSICIAN	0		0	0	1	194. 04
194. 06	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	o	0	0	•	194. 06
200.00	1 1						200. 00
201.00							201. 00
202.00		551, 161	744, 983	475, 673	0	760, 267	202. 00
	Part I)	I	l l		Ĭ	1	<u> </u>

Health Financial Systems	COMMUNITY HOSPT. OF LAGRANGE CTY	/ IN In Lieu of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BAS	S Provi der (CCN: 15-1323

						8/21/2020 10:	08 am
	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)	9. 482177	59. 313933	56. 366039	0.000000	7. 678456	203. 00
204.00	Cost to be allocated (per Wkst. B,	46, 095	125, 143	19, 839	0	31, 709	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 793019	9. 963615	2. 350871	0.000000	0. 320251	205. 00
	[11]						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	UNITY HUSPI. UF				U OF FORM CMS	
CATION - STATISTICAL BASIS		Provi der CC	F	rom 01/01/2019	Date/Time Pre	pared:
Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	08 am
		15. 00	16. 00	17. 00	19.00	
IERAL SERVICE COST CENTERS						
OOO CAP REL COSTS-BLDG & FIXT OOI EMS WEST STATION OOO CAP REL COSTS-MVBLE EQUIP OOO CAP REL COSTS-MVBLE EQUIP OOO EMPLOYEE BENEFITS DEPARTMENT OOO ADMINISTRATIVE & GENERAL OOO MAINTENANCE & REPAIRS OOO OPERATION OF PLANT OOO LAUNDRY & LINEN SERVICE OOO HOUSEKEEPING OO CAFETERIA OOO CAFETERIA OOO MAINTENANCE OF PERSONNEL OOO NURSING ADMINISTRATION OOO CENTRAL SERVICES & SUPPLY OOO CENTRAL SERVICES & SUPPLY OOO OPENAMACY OOO MEDICAL RECORDS & LIBRARY OOO SOCIAL SERVICE OOO NONPHYSICIAN ANESTHETISTS OOO NURSING SCHOOL OOO I&R SERVICES-OTHER PROM COSTS APPRV OOO I&R SERVICES-OTHER PROM COSTS APPRV OOO OPARAMED ED PRGM-(SPECIFY)	1, 192, 108 31, 186 0 0 0 0	36, 929 0 0 0 0 0	10, 000 0 0 0 0 0	0 0 0 0	0	1. 00 1. 01 2. 00 2. 01 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00
PATIENT ROUTINE SERVICE COST CENTERS	J	0		-1		23.00
000 ADULTS & PEDIATRICS 000 NURSERY	15, 923 18, 652	81 2			0	
000 OPERATING ROOM 000 DELIVERY ROOM & LABOR ROOM 000 ANESTHESIOLOGY 000 RADIOLOGY-DIAGNOSTIC 000 LABORATORY 050 BLOOD CLOTTING FOR HEMOPHILIACS 000 RESPIRATORY THERAPY	219, 284 86, 309 0 31, 742 0 0 15, 860	319 9 0 16 403 0	5, 480 0 0 0 0	0 0 0 0	0 0 0 0 0 0	52. 00 53. 00 54. 00 60. 00 62. 30
PHYSICAL THERAPY COO OCCUPATIONAL THERAPY COO OCCUPATIONAL THERAPY COO SPEECH PATHOLOGY COO MEDICAL SUPPLIES CHARGED TO PATIENT COO IMPL. DEV. CHARGED TO PATIENTS COO DRUGS CHARGED TO PATIENTS COO DRUGS CHARGED TO PATIENTS COO CARDIAC REHABILITATION COO CARDIAC RE	4, 893 2, 035 201 0 421, 906 128, 326 28, 776 0 0	10 4 0 0 0 0 31,086 0 0	301 73 C C C C C C	0 0 0 0 0 0	0 0 0 0 0 0 0 0	67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98
000 CLINIC 001 LIFEBRIDGE SENIOR CARE 000 EMERGENCY 200 OBSERVATION BEDS (NON-DISTINCT PART	0 1, 355 101, 306	0 0 658	C	0	0 0 0	90. 01
500 AMBULANCE SERVICES 010 CORF 020 OUTPATIENT PHYSICAL THERAPY 030 OUTPATIENT OCCUPATIONAL THERAPY 040 OUTPATIENT SPEECH PATHOLOGY	79, 835 0 0 0 0	4, 341 0 0 0 0	0	0	0 0 0 0	99. 10 99. 20 99. 30
OOO INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	1, 187, 589	36, 929	10, 000	0	0	113. 00 118. 00
IREIMBURSABLE COST CENTERS 1000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1000 PHYSICIANS' PRIVATE OFFICES 1000 OCCUPATIONAL HEALTH 1051 FOUNDATION 1052 COMMUNITY & VOLUNTEER SVCS 1054 ER PHYSICIAN 1053 SHIPSHEWANA RADIOLOGY AND LAB 1055 Cross Foot Adjustments 1056 Negative Cost Centers 1057 Cost to be allocated (per Wkst. B, Part I)	723 1,576 0 696 1,524 0 0	0 0 0 0 0 0 0		0 0 0 0 0	0 0 0 0 0	190. 00 192. 00 194. 00 194. 01 194. 03 194. 04 194. 06 200. 00 201. 00 202. 00
	ERAL SERVICE COST CENTERS OO CAP REL COSTS-BLDG & FIXT OI EMS WEST STATION OO CAP REL COSTS-MVBLE EQUIP OI EMS WEST STATION EQUIP. OI EMS WEST STATION EQUIP. OI EMPLOYEE BENEFITS DEPARTMENT OO ADMINISTRATIVE & GENERAL. OO MAINTENANCE & REPAIRS OO OPERATION OF PLANT OO LAUNDRY & LINEN SERVICE OO HOUSEKEEPING OO LETARY OO CAFETERIA OO MAINTENANCE OF PERSONNEL. ONURSING ADMINISTRATION OO CENTRAL SERVICES & SUPPLY OO MEDICAL RECORDS & LIBRARY OO SOCIAL SERVICE OO NONPHYSICIAN ANESTHETISTS ONURSING SCHOOL OI &R SERVICES-OTHER PRGM COSTS APPRV OO I &R SERVICES-OTHER PRGM COSTS APPRV OO I &R SERVICES-OTHER PRGM COST SENTERS OO ADULTS & PEDIATRICS OO ADULTS & PEDIATRICS OO ADULTS & PEDIATRICS OO OPERATING ROOM OO ANESTHESIOLOGY OR ADIOLOGY-DIAGNOSTIC OO LABORATORY 50 BLOOD CLOTTING FOR HEMOPHILIACS OO RESPIRATORY THERAPY OO SCHARGED TO PATIENTS OO CLOPATIONAL THERAPY OO SELECTROCARDIOLOGY OMEDICAL SUPPLIES CHARGED TO PATIENTS OO MEDICAL SUPPLIES CHARGED TO PATIENTS OO DELICETROCARDIOLOGY OMEDICAL SUPPLIES CHARGED TO PATIENTS OO DRUGS COMMUNITY & VOLUNTERS SUPPLYSICAL THERAPY AND SUPPLYSICAL THERAPY OO UTPATIENT SPEECH PATHOLOGY OO HEDICAL PUPPLYSICAL THERAPY OO UTPATIENT SPEECH PATHOLOGY	COST CENTER DESCRIPTION CENTRAL SERVICES SUPPLY (COSTED REQUIS.) ERAL SERVICE COST CENTERS OO CAP REL COSTS-BLDG & FIXT OI EMS WEST STATION OC AP REL COSTS-MYBLE EQUIP OI EMS WEST STATION OO CAP REL COSTS-MYBLE EQUIP OI EMS WEST STATION EQUIP. OO IMPLOYEE BENEFITS DEPARTMENT OO ADMIN ISTRATIVE & GENERAL OO MAIN INFANCE & REPAIRS OO OPERATION OF PLANT OO LAURINGY & LINEN SERVICE OO HOUSEKEEPING OO LAFETERIA OOM AND THANNOE OF PERSONNEL OO NURSIN GAMM INISTRATION OO CERTERIA OOM MEDICAL SERVICES & SUPPLY OO SOCIAL SERVICES & SUPPLY OO SOCIAL SERVICE OON ON NOMPHYSICIAN AND STATION OO I LAR SERVICES-SALARY & FRINGES APPRV OO I LAR SERVICES-SOTHER PROM COSTS APPRV OO I LAR SERVICES-SOTHER PROM COSTS APPRV OO I LAR SERVICES-SOTHER PROM COSTS APPRV OO OO PARAMIDE DE PREM-(SPECIFY) OO INTERSETY ATTEM ROUTH NE SERVICE COST CENTERS OO OPERATIN FOR ROOM OO PERATING OWN OO PERATING OWN AND ANSTHESIOLOGY OO PROMO ANESTHESIOLOGY OO PROMO ON ALABOR ROOM OO PERATING ROOM OO PERATING ROOM OO PERATING ROOM OO PERATING OWN OO PERATING ROOM OO PERATING OWN OO PERATING OWN OO PERATING OWN OO PERATION OWN OO PERATING OWN OO OWN	COST Center Description CENTRAL SERVICE S SUPPLY (COSTED REQUIS.) REQUIS.) 14. 00 15. 00 ERAL SERVICE COST CENTERS OI CAP REL COSTS-BLDG & FIXT OI LEMS WEST STATION OI CAP REL COSTS-MUBLE EQUI P OI EMS WEST STATION GOIL OI MAINTENANCE & REPAIRS OO PERALT ON OF PLANT OI CAPITERI A OO MAINTENANCE & REPAIRS OO HOUSEKEEN ING OOI DI HOUSEKEEN ING OOI LAIL RECORDS & LI BRARY OO OI CAFETERI A OO MAINTENANCE OF PERSONNEL OON NORSIN AS CHOOL OON ONDRING SCHOOL OON CONTRAL SERVICES & SUPPLY OO NORDING SCHOOL OON LAIL RECORDS & LI BRARY OO ON ON LAIL RECORDS & LI BRARY OO ON LAIL REC	COST Center Description COST Central SERVICES & SUPPLY (COSTED REQUIS.) ERAL SERVICE COST CENTERS OF CAP REL COSTS-BLDG & FIXT OF CAP REL COSTS-BLDG & F	COST Center Description	Cost Center Description

Health Fin	ancial Systems COMM	NUNITY HOSPT. OF LAGRANGE CTY IN			In Lieu of Form CMS-2552-10		
COST ALLO	CATION - STATISTICAL BASIS		Provi der CO		Peri od: From 01/01/2019	Worksheet B-1	
					Γο 12/31/2019	Date/Time Pre 8/21/2020 10:	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		SERVICES &	(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 I)	0. 031055	34. 673157	2. 24970	0.000000	0.000000	203. 00
204.00	Cost to be allocated (per Wkst. B,	47, 554	92, 221	8, 52	5 0	0	204. 00
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 013398	2. 497251	0. 85250	0.000000	0.000000	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						
	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1323 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 8/21/2020 10:08 am INTERNS & RESIDENTS NURSING SCHOOL SERVICES-SALAR SERVICES-OTHER Cost Center Description PARAMED ED Y & FRINGES PRGM COSTS PRGM (ASSI GNED (ASSI GNED **APPRV APPRV** TIME) (ASSI GNED (ASSI GNED TIME) TIME) TIME) 20.00 23.00 21. 00 22. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 1.01 00101 EMS WEST STATION 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00201 EMS WEST STATION EQUIP. 2 01 2 01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15 00 01500 PHARMACY 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING SCHOOL 20.00 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 30.00 0 43.00 04300 NURSERY 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 50.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 000000000000000 0 0 52.00 0 05300 ANESTHESI OLOGY 0 53.00 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 06000 LABORATORY 0 60.00 0 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 62.30 06500 RESPIRATORY THERAPY 0 0 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 67.00 06800 SPEECH PATHOLOGY 0 68 00 Ω 68 00 0 69.00 06900 ELECTROCARDI OLOGY C 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 Ω 73 00 76.97 07697 CARDIAC REHABILITATION 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76. 98 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 09001 LIFEBRIDGE SENIOR CARE 0 90.01 0 0 90.01 09100 EMERGENCY 0 0 0 ol 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0 n С 0 95 00 0 99 10 09910 CORE 0 0 99 10 C 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 0 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 99.30 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 0 0 0 99.40 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 0 0 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN C 0 0 190 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 0 0 0 0 194. 00 07950 OCCUPATIONAL HEALTH 0 0 194.00 194. 01 07951 FOUNDATION 0 0 194. 01 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 0 0 C 194.03 0 194. 04 07954 ER PHYSICIAN 0 0 0 194.04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 194. 06 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00

Heal th Fina	ncial Systems COMM	IUNI TY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-:	2552-10
COST ALLOCA	TION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					From 01/01/2019 To 12/31/2019		
			INTERNS &	RESI DENTS			
	Cost Center Description	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	SERVICES-OTHE PRGM COSTS	R PARAMED ED PRGM		
		(ASSIGNED TIME)	APPRV (ASSI GNED	APPRV (ASSI GNED	(ASSI GNED TIME)		
			TIME)	TIME)			
		20.00	21. 00	22. 00	23. 00		
202. 00	Cost to be allocated (per Wkst. B, Part I)	0	0		0		202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 00000	0. 000000		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	0	0		0		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 00000	0.000000		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0			0		206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0. 000000			0. 000000		207. 00

Health Financial Systems COM	MUNITY HOSPT. O	F LAGRANGE CTY	IN	In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co	CN: 15-1323	Peri od:	Worksheet C	
				From 01/01/2019 To 12/31/2019	Part Date/Time Pre	narod:
				10 12/31/2019	8/21/2020 10:	08 am
		Title	: XVIII	Hospi tal	Cost	
·		<u> </u>		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)					
LUDATI FUT DOUTLING OFFICE COOT OFFITEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F 0/0 400		F 0/0 4/	20		
30. 00 03000 ADULTS & PEDI ATRI CS	5, 268, 483		5, 268, 48		0	
43. 00 04300 NURSERY	339, 637		339, 63	37 0	0	43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	3, 216, 665		2 21/ /	55 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 571, 958	l e	3, 216, 60 1, 571, 9		0	1
53. 00 05300 ANESTHESI OLOGY	1, 571, 958	ł	1	42 0	0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	2, 864, 429		2, 864, 42		0	
60. 00 06000 LABORATORY	2, 047, 989		2, 047, 9		0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	2,047,707		2,047,90	0	0	
65. 00 06500 RESPIRATORY THERAPY	746, 165	0	746, 10	55 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	936, 083		936, 0		0	1
67. 00 06700 OCCUPATI ONAL THERAPY	282, 757		282, 7		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	139, 072		139, 0		0	
69. 00 06900 ELECTROCARDI OLOGY	107,072	Ĭ	107,0	0	0	1
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	663, 761		663, 70	51 0	0	1
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	201, 976		201, 9		0	1
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 483, 600		2, 483, 60		0	
76. 97 07697 CARDI AC REHABI LI TATI ON	102, 124	l e	102, 1:		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	l		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0			0	0	76, 99
OUTPATIENT SERVICE COST CENTERS		•	•			
90. 00 09000 CLI NI C	0			0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	563, 421		563, 42	21 0	0	90. 01
91. 00 09100 EMERGENCY	5, 213, 361		5, 213, 3	61 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 578, 643		1, 578, 6	43	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	3, 081, 991		3, 081, 9	91 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	99. 40
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE						113. 00
200.00 Subtotal (see instructions)	31, 302, 257	ŀ				200. 00
201.00 Less Observation Beds	1, 578, 643	l e	1, 578, 6			201. 00
202.00 Total (see instructions)	29, 723, 614	0	29, 723, 6	14 0	0	202. 00

			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
				Í		Rati o	
		6.00	7. 00	8. 00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	3, 804, 085		3, 804, 085			30. 00
43.00	04300 NURSERY	609, 820		609, 820			43. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	4, 178, 541	12, 838, 406	17, 016, 947	0. 189027	0.000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 821, 871	0	2, 821, 871	0. 557062	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	438, 907	1, 824, 561	2, 263, 468	0.000063	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 484, 547	22, 625, 713	24, 110, 260	0. 118805	0.000000	54.00
60.00	06000 LABORATORY	1, 988, 139	10, 548, 492	12, 536, 631	0. 163360	0.000000	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0.000000	0.000000	62. 30
65.00	06500 RESPI RATORY THERAPY	556, 008	2, 554, 567	3, 110, 575	0. 239880	0.000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	195, 609	1, 315, 648	1, 511, 257	0. 619407	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	252, 378	414, 680	667, 058	0. 423887	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	53, 454	100, 720	154, 174	0. 902046	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	O	0	0	0.000000	0.000000	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	519, 760	1, 571, 545	2, 091, 305	0. 317391	0.000000	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	350, 185	471, 683	821, 868	0. 245752	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 428, 385	7, 338, 942	9, 767, 327	0. 254276	0.000000	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	264, 076		0. 386722	0.000000	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0			0.000000	76. 98
76. 99		0	0	0	0. 000000	0.000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0	0	0	0.000000	0.000000	90. 00
90. 01	09001 LI FEBRI DGE SENI OR CARE	0	750, 447	750, 447	0. 750781	0.000000	90. 01
91.00	09100 EMERGENCY	796, 097	17, 963, 521	18, 759, 618	0. 277903	0.000000	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	5, 220, 399	5, 220, 399	0. 302399	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVICES	0	5, 998, 839	5, 998, 839	0. 513765	0.000000	95. 00
99. 10	09910 CORF	0	0	0			99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	o	0	0			99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	o	0	0			99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0			99. 40
	SPECIAL PURPOSE COST CENTERS	'		<u>'</u>	· · · · · · · · · · · · · · · · · · ·		1
113.00	11300 I NTEREST EXPENSE						113. 00
200.00		20, 477, 786	91, 802, 239	112, 280, 025			200.00
201.00							201.00
202.00		20, 477, 786	91, 802, 239	112, 280, 025			202.00
				•			•

			To 12/31/2019	Part Date/Time Prepared: 8/21/2020 10:08 am
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient		110001 tu	3331
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	·			
30. 00 03000 ADULTS & PEDIATRICS				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 CARDIAC REHABILITATION	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 I 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

Heal th Fi	nancial Systems COMM	COMMUNITY HOSPT. OF LAGRANGE CTY IN				In Lieu of Form CMS-2552-10		
	ON OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-1323	Peri od:	Worksheet C		
					From 01/01/2019	Part I		
					To 12/31/2019	Date/Time Pre 8/21/2020 10:	pared:	
-			Ti +I	e XIX	Hospi tal	PPS	oo aiii	
			11 61	C ALA	Costs	110		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs		
	oost conton boodin per on	(from Wkst. B,	Adj.	1014. 00010	Di sal I owance	70141 00010		
		Part I, col.	,					
		26)						
		1.00	2.00	3.00	4. 00	5. 00		
I N	PATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03	000 ADULTS & PEDIATRICS	5, 268, 483		5, 268, 48	33 0	5, 268, 483	30. 00	
	300 NURSERY	339, 637		339, 6	37 0	339, 637	43. 00	
	CILLARY SERVICE COST CENTERS							
	OOO OPERATING ROOM	3, 216, 665		3, 216, 6		3, 216, 665		
	200 DELIVERY ROOM & LABOR ROOM	1, 571, 958		1, 571, 9	58 0	1, 571, 958	52. 00	
	300 ANESTHESI OLOGY	142			12 0	142		
	400 RADI OLOGY-DI AGNOSTI C	2, 864, 429		2, 864, 42		2, 864, 429		
	000 LABORATORY	2, 047, 989		2, 047, 98	39 0	2, 047, 989		
	250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	62. 30	
	500 RESPI RATORY THERAPY	746, 165		1,		746, 165	65. 00	
	600 PHYSI CAL THERAPY	936, 083	0	936, 0		936, 083		
	700 OCCUPATIONAL THERAPY	282, 757	0	282, 7		282, 757	67. 00	
	800 SPEECH PATHOLOGY	139, 072	0	139, 0°	72 0	139, 072	1	
	900 ELECTROCARDI OLOGY	0			0	0	69. 00	
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	663, 761		663, 70		663, 761		
	200 IMPL. DEV. CHARGED TO PATIENTS	201, 976		201, 9		201, 976		
	300 DRUGS CHARGED TO PATIENTS	2, 483, 600	l e	2, 483, 60		2, 483, 600		
	697 CARDI AC REHABI LI TATI ON	102, 124		102, 13	24 0	102, 124	1	
	698 HYPERBARIC OXYGEN THERAPY	0			0 0	0		
	699 LI THOTRI PSY	0			0 0	0	76. 99	
	TPATIENT SERVICE COST CENTERS							
	000 CLI NI C	0			0 0	0		
	001 LIFEBRIDGE SENIOR CARE	563, 421		563, 42		563, 421		
	100 EMERGENCY	5, 213, 361		5, 213, 3		5, 213, 361	1	
	200 OBSERVATION BEDS (NON-DISTINCT PART	1, 578, 643		1, 578, 6	13	1, 578, 643	92. 00	
	HER REIMBURSABLE COST CENTERS	0.004.004	l			0.004.004		
	500 AMBULANCE SERVICES	3, 081, 991		3, 081, 9	91 0	3, 081, 991		
	910 CORF	0			0	0		
	920 OUTPATIENT PHYSICAL THERAPY	0			0	0		
	930 OUTPATIENT OCCUPATIONAL THERAPY	0			0	0		
	940 OUTPATIENT SPEECH PATHOLOGY	0			0	0	99. 40	
	ECIAL PURPOSE COST CENTERS	1	Γ				440.00	
	300 INTEREST EXPENSE	21 202 257	,	21 202 2	- 7	21 202 257	113. 00	
200.00	Subtotal (see instructions)	31, 302, 257	l e			31, 302, 257		
201.00	Less Observation Beds	1, 578, 643		1, 578, 6		1, 578, 643		
202. 00	Total (see instructions)	29, 723, 614	0	29, 723, 6	14 0	29, 723, 614	₁ 202.00	

201. 00

202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1323 Peri od: Worksheet C From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 8/21/2020 10:08 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 3, 804, 085 3, 804, 085 30.00 30.00 43.00 04300 NURSERY 609,820 609, 820 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 4, 178, 541 12, 838, 406 17, 016, 947 0.189027 0.000000 50.00 0.557062 0.000000 05200 DELIVERY ROOM & LABOR ROOM 2,821,871 2, 821, 871 52.00 52 00 53.00 05300 ANESTHESI OLOGY 438, 907 1, 824, 561 2, 263, 468 0.000063 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 484, 547 22, 625, 713 24, 110, 260 0.118805 0.000000 54.00 06000 LABORATORY 1, 988, 139 0.163360 0.000000 60.00 10, 548, 492 12, 536, 631 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 0.000000 62 30 65.00 06500 RESPIRATORY THERAPY 556,008 2, 554, 567 3, 110, 575 0.239880 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 195, 609 1, 315, 648 1, 511, 257 0.619407 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 252, 378 414, 680 667, 058 0. 423887 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 53, 454 100, 720 154, 174 0.902046 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 519, 760 1, 571, 545 2, 091, 305 0.317391 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 350, 185 0.245752 72 00 471.683 821, 868 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 428, 385 7, 338, 942 9, 767, 327 0. 254276 0.000000 73.00 07697 CARDIAC REHABILITATION 76. 97 0 264, 076 264, 076 0.386722 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 0 0.000000 0.000000 07699 LI THOTRI PSY 76.99 0 0 0.000000 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0.000000 90.00 90 01 09001 LIFEBRIDGE SENIOR CARE 0 750 447 750 447 0.750781 0.000000 90 01 796, 097 91.00 09100 EMERGENCY 17, 963, 521 18, 759, 618 0.277903 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 5, 220, 399 5, 220, 399 0. 302399 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 0 5, 998, 839 5, 998, 839 0.513765 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 0 99 30 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 0 99.40 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 200 00 20, 477, 786 91, 802, 239 112, 280, 025 200. 00

20, 477, 786

91, 802, 239

112, 280, 025

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

201.00

202.00

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2019	Part
To 12/31/2019	Date/Time Prepared:
8/21/2020 10:08 am	

				8/21/2020 10:08 am
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30. 00
43. 00 04300 NURSERY				43. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 189027			50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 557062			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000063			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 118805			54.00
60. 00 06000 LABORATORY	0. 163360			60. 00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 239880			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 619407			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 423887			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 902046			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 317391			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 245752			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 254276			73. 00
76. 97 07697 CARDIAC REHABILITATION	0. 386722			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. 750781			90. 01
91. 00 09100 EMERGENCY	0. 277903			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 302399			92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 513765			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 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 | Peri od: | Worksheet C | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-1323 REDUCTIONS FOR MEDICALD ONLY

					Γο 12/31/2019	Date/Time Pre 8/21/2020 10:	pared:
			Ti +I	e XIX	Hospi tal	PPS	UO alli
	Cost Center Description	Total Cost		Operating Cos		Operating Cost	
	cost center bescription	(Wkst. B, Part				Reduction	
		I, col. 26)		Cost (col. 1		Amount	
		1, 601. 20)	11 001. 20)	col . 2)		7 tillodi i C	
		1. 00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS					5.55	
	05000 OPERATING ROOM	3, 216, 665	421, 217	2, 795, 44	3 0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 571, 958	102, 392			0	52.00
53.00	05300 ANESTHESI OLOGY	142	6			0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 864, 429	265, 186	2, 599, 24	3 0	0	54.00
60. 00	06000 LABORATORY	2, 047, 989	141, 773	1, 906, 21	6 0	0	60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	O	0		0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	746, 165	47, 787	698, 37	3 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	936, 083	133, 993	802, 090	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	282, 757	12, 142	270, 61	5 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	139, 072	5, 867	133, 20	5 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	663, 761	32, 791	630, 970	0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	201, 976	9, 977	191, 99	9 0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 483, 600	136, 610	2, 346, 99	0	0	73. 00
	07697 CARDI AC REHABI LI TATI ON	102, 124	14, 195	87, 92	9 0	0	76. 97
	07698 HYPERBARIC OXYGEN THERAPY	0	0		0	0	76. 98
	07699 LI THOTRI PSY	0	0		0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0		0	0	
	09001 LI FEBRI DGE SENI OR CARE	563, 421	49, 274			0	
	09100 EMERGENCY	5, 213, 361	417, 819			0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 578, 643	243, 714	1, 334, 92	9 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	3, 081, 991	254, 889	2, 827, 10:	2 0	-	
	09910 CORF	0	0		0	0	
	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	99. 40
	SPECIAL PURPOSE COST CENTERS	1		1		I	
	11300 INTEREST EXPENSE	05 (04 403	0 000 100		-	l .	113.00
200.00		25, 694, 137	2, 289, 632				200.00
201.00	Less Observation Beds	1, 578, 643	243, 714				201. 00
202. 00	Total (line 200 minus line 201)	24, 115, 494	2, 045, 918	22, 069, 57	6 0	0	202. 00

REDUCTIONS FOR MEDICALD ONLY

Peri od: Worksheet C From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared: 8/21/2020 10:08 am

						8/21/2020 10	:08 am_
				e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
		Capital and		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	3, 216, 665	17, 016, 947	0. 189027			50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 571, 958	2, 821, 871	0. 557062			52. 00
53.00	05300 ANESTHESI OLOGY	142	2, 263, 468	0.000063			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 864, 429	24, 110, 260	0. 118805			54. 00
60.00	06000 LABORATORY	2, 047, 989	12, 536, 631	0. 163360			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.000000			62. 30
65.00	06500 RESPI RATORY THERAPY	746, 165	3, 110, 575	0. 239880			65. 00
66. 00	06600 PHYSI CAL THERAPY	936, 083	1, 511, 257	0. 619407			66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	282, 757	667, 058	0. 423887			67. 00
68. 00	06800 SPEECH PATHOLOGY	139, 072	154, 174	0. 902046			68. 00
69. 00	06900 ELECTROCARDI OLOGY	0		0. 000000			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	663, 761	2, 091, 305	0. 317391			71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	201, 976					72. 00
	07300 DRUGS CHARGED TO PATIENTS	2, 483, 600		0. 254276			73. 00
	07697 CARDI AC REHABI LI TATI ON	102, 124					76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0		0. 000000			76. 98
	07699 LI THOTRI PSY	0	0	0. 000000			76. 99
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	1 0	0	0.000000			90.00
	09001 LI FEBRI DGE SENI OR CARE	563, 421	750, 447	0. 750781			90. 01
	09100 EMERGENCY	5, 213, 361					91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 578, 643					92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	1,070,010	0,220,077	0.002077			72.00
95. 00	09500 AMBULANCE SERVICES	3, 081, 991	5, 998, 839	0. 513765			95. 00
	09910 CORF	3,001,771	0, 770, 037	0. 000000			99. 10
	09920 OUTPATIENT PHYSICAL THERAPY		0	0. 000000			99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY		0	0. 000000			99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0. 000000			99. 40
77. 40	SPECIAL PURPOSE COST CENTERS	0		0.00000			79.40
112 00	11300 INTEREST EXPENSE		I				113. 00
200.00	I I	25, 694, 137	107, 866, 120				200. 00
200.00		1, 578, 643					200.00
201.00		1					201.00
202. UC	p Total (Time 200 minus Time 201)	24, 115, 494	107,800,120				1202. UU

2, 034, 743

101, 867, 281

3, 404, 260

56, 664 200. 00

200.00

Total (lines 50 through 199)

 Heal th Financial
 Systems
 COMMUNITY HOSPT. OF LAGRANGE CTY IN

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-1323
 | Peri od: | Worksheet D | From 01/01/2019 | Part IV | To 12/31/2019 | Date/Time Prepared: THROUGH COSTS

				'	0 12/31/2019	8/21/2020 10:	
			Ti tl e	e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	0	0) C	0	0	00.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0) C	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0) C	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0) C	0	0	54.00
60.00	06000 LABORATORY	0	0) C	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0) C	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0) C	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0) C	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0) C	0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0) C	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0) C	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0) C	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0) C	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0) C	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0) C	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0) C	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	C) C	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0) C	0	0	90.00
	09001 LI FEBRI DGE SENI OR CARE	0	0) C	0	0	90. 01
	09100 EMERGENCY	0	0) C	0	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		C		0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0) C) 0	0	200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1323 Peri od: Worksheet D From 01/01/2019 To 12/31/2019 THROUGH COSTS Part IV Date/Time Prepared: 8/21/2020 10:08 am Title XVIII Hospi tal Cost All Other Total Cost Total Charges Ratio of Cost Cost Center Description Total to Charges Medi cal (sum of cols. (from Wkst. C, Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 016, 947 0.00000050.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 2, 821, 871 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0 0 2, 263, 468 0.000000 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 24, 110, 260 0.000000 54 00 0 60.00 06000 LABORATORY 0 12, 536, 631 0.000000 60.00 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 65.00 06500 RESPIRATORY THERAPY 0 0 3, 110, 575 0.000000 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 1, 511, 257 0.000000 66.00 67. 00 06700 OCCUPATIONAL THERAPY 667, 058 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 0 154, 174 68.00 06900 ELECTROCARDI OLOGY 0 0.000000 69 00 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 2, 091, 305 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 821, 868 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 9, 767, 327 0.000000 73.00 07697 CARDIAC REHABILITATION 0 76.97 0 264, 076 0.000000 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 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 0 0.000000 90.00 0 0

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750, 447

18, 759, 618

5, 220, 399

101, 867, 281

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0.000000

0.000000

90.01

91.00

92.00

95.00

200.00

90.01

91.00

92.00

95.00

200.00

09001 LIFEBRIDGE SENIOR CARE

09500 AMBULANCE SERVICES

OTHER REIMBURSABLE COST CENTERS

09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (lines 50 through 199)

09100 EMERGENCY

Health Financial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY IN		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LADATIENT (OUTDATIES	NT ANGLELADY CEDVICE OTHER DACC	D: -I CON 1E 1222	D!I	Wasalsalaa - D

Period: From 01/01/2019 To 12/31/2019 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1323 Part IV THROUGH COSTS Date/Time Prepared: 8/21/2020 10:08 am Title XVIII Hospi tal Cost Outpati ent Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through Pass-Through to Charges Charges Charges Costs (col. (col. 6 ÷ col Costs (col. 8 x col . 12) 13.00 7) x col. 10) 11.00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 682, 543 0 0 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 0 52.00 05300 ANESTHESI OLOGY 0.000000 89, 991 0 53.00 53.00 0 0 0 0 0 0 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 592, 751 0 54.00 0 0 06000 LABORATORY 0.000000 60.00 560, 702 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0.000000 0 62.30 65.00 06500 RESPIRATORY THERAPY 0.000000 216, 370 0 0 65.00 66, 094 0 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 0 0 06700 OCCUPATIONAL THERAPY 67.00 0.000000 73, 429 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 15, 842 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 177, 450 0.000000 71 00 71 00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0.000000 158, 135 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 73.00 73.00 734, 762 0 0 07697 CARDIAC REHABILITATION 0 76. 97 76 97 0.000000 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 C 0 76. 98 76. 99 07699 LI THOTRI PSY 0.000000 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 0 90.00 0.000000 n 0 n 09000 CLI NI C 09001 LIFEBRIDGE SENIOR CARE 0 90.01 0.000000 C 0 0 90.01 09100 EMERGENCY 0.000000 36, 191 0 0 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.000000 0 o 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 200.00 Total (lines 50 through 199) 3, 404, 260 0 0 0 200. 00

	MUNITY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der C		Peri od:	Worksheet D	
				From 01/01/2019 To 12/31/2019		narod:
				10 12/31/2019	8/21/2020 10:	:pareu. O8 am
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		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	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 189027	0	1, 963, 13	5 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 557062	0		0	0	
53. 00 05300 ANESTHESI OLOGY	0. 000063	0	298, 02		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 118805	0	5, 219, 34		0	
60. 00 06000 LABORATORY	0. 163360	0	2, 685, 15	9 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. 239880	0	427, 56	8 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 619407	0	372, 33	0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 423887	0	93, 14	5 0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 902046	0	21, 33	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. 317391	0	242, 88	4 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 245752	0	125, 63	2 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 254276	0	3, 481, 31	1 0	0	73. 00
76. 97 07697 CARDIAC REHABILITATION	0. 386722	0	158, 57	4 0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		o o	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		o o	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. 750781	0	469, 99	6 0	0	90. 01
91. 00 09100 EMERGENCY	0. 277903	0	3, 270, 96	6 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 302399	0	1, 250, 80	6 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 513765			0		95. 00
200.00 Subtotal (see instructions)		0	20, 080, 21	2 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	20, 080, 21	2 0	0	202. 00

 Heal th Financial
 Systems
 COMMUNITY HOSPT.
 O

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provider CCN: 15-1323

					8/21/2020 10:	08 am
			XVIII	Hospi tal	Cost	
	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.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	371, 086	0				50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o	0				52.00
53. 00 05300 ANESTHESI OLOGY	19	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	620, 084	0				54.00
60. 00 06000 LABORATORY	438, 648	0				60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0				62. 30
65. 00 06500 RESPIRATORY THERAPY	102, 565	0				65. 00
66. 00 06600 PHYSI CAL THERAPY	230, 624	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	39, 483	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	19, 248	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	77, 089	0				71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	30, 874	0				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	885, 214	0				73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	61, 324	0				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	01,021	0				76. 98
76. 99 07699 LI THOTRI PSY		0				76. 99
OUTPATIENT SERVICE COST CENTERS	<u> </u>					1 70: 77
90. 00 09000 CLI NI C		0				90. 00
90. 01 09001 LI FEBRI DGE SENI OR CARE	352, 864	0				90. 01
91. 00 09100 EMERGENCY	909, 011	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	378, 242	0				92. 00
OTHER REIMBURSABLE COST CENTERS	370, 242					72.00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Subtotal (see instructions)	4, 516, 375	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	7, 510, 575	0				201. 00
Only Charges						251.00
202.00 Net Charges (line 200 - line 201)	4, 516, 375	0				202. 00
202.00	1, 310, 375	0	I			1202.00

Health Financial Systems	COMMUNITY HOSPT. OF LA	AGRANGE CTY IN	In Lieu	u of Form CMS-2552-10
ADDODEL ONMENT OF MEDICAL	OTHER HEALTH CERVILORS AND MAGGINE COST	D ' 1 OON 4E 4000	D 1 1	

Health Financial Systems COM	MMUNITY HOSPT. O	F LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ND VACCINE COST	Provi der C		Period: From 01/01/2019	Worksheet D Part V	
		Component		To 12/31/2019	Date/Time Pre	
			20011	2 2 21	8/21/2020 10:	08 am
		litle		Swing Beds - SNF		
Cost Center Description	Coot to Charge	PPS Reimbursed	Charges Cost	Cost	Costs PPS Services	
cost center bescription	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
	Part I, col. 9		Subject To	Subject To		
	1 41 1 7 , 601 . 7		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. 189027	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 557062	2		0 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000063	0		0 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 118805	0		0 0	0	54.00
60. 00 06000 LABORATORY	0. 163360	0		0 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 239880	0		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 619407			0 0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 423887			0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0. 902046	1		0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	1		0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 317391	1		0	0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 245752	1		0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 254276			0	0	
76. 97 07697 CARDIAC REHABILITATION	0. 386722			0	0	1
76. 98 07698 HYPERBARIC OXYGEN THERAPY	0. 000000			0	0	1
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS			ı	ما		
90. 00 09000 CLINIC	0. 000000			0	0	
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 750781			0	0	
91. 00 09100 EMERGENCY	0. 277903			0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0. 302399	0		0 0	0	92. 00
95. 00 09500 AMBULANCE SERVICES	0. 513765			o		95. 00
200.00 Subtotal (see instructions)	3.3.5766	ĺ 0	1	0	n	200.00
201.00 Less PBP Clinic Lab. Services-Program				ol ol		201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202. 00

		Component	CCN: 15-Z323	From 01/01/2019 To 12/31/2019	
		Title	XVIII	Swing Beds - SN	
	Cost	ts		<u> </u>	
Cost Center Description	Cost	Cost			
	Rei mbursed	Reimbursed			
	Servi ces	Services Not			
	Subj ect To	Subject To			
		Ded. & Coins.			
	(see inst.)	(see inst.)			
	6. 00	7. 00			
ANCILLARY SERVICE COST CENTERS			1		4
50. 00 05000 OPERATI NG ROOM	0	0			50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0			52.00
53. 00 05300 ANESTHESI OLOGY	0	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0			54.00
60. 00 06000 LABORATORY	0	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	0			66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0	0			67.00
68. 00 06800 SPEECH PATHOLOGY	0	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0			69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0			76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0	1		76. 98
76. 99 O7699 LITHOTRI PSY OUTPATIENT SERVI CE COST CENTERS	U U	0			76. 99
90. 00 09000 CLINIC	O	0			90.00
90. 01 09000 LI FEBRI DGE SENI OR CARE		0	ł		90.00
91. 00 09100 EMERGENCY		0	ł		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0	1		92.00
OTHER REIMBURSABLE COST CENTERS	J U	0			72.00
95. 00 09500 AMBULANCE SERVICES	0				95.00
200.00 Subtotal (see instructions)		0			200. 00
201.00 Less PBP Clinic Lab. Services-Program		0			201. 00
Only Charges	·				201.00
202.00 Net Charges (line 200 - line 201)	o	0			202. 00
1110 201)	1 9	ū	1		1

Health Financial Systems COMM	MMUNITY HOSPT. OF LAGRANGE CTY IN			In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Peri od:	Worksheet D		
				From 01/01/2019 To 12/31/2019		nanad.	
				To 12/31/2019	Date/Time Pre 8/21/2020 10:		
		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	813, 360	39, 500	773, 85	4 3, 095	250. 03	30.00	
43. 00 NURSERY	22, 102		22, 10	2 389	56. 82	43.00	
200.00 Total (lines 30 through 199)	835, 462		795, 95	6 3, 484		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	38	9, 50°	1			30.00	
43. 00 NURSERY	146	8, 296	6			43. 00	
200.00 Total (lines 30 through 199)	184	17, 79	7			200. 00	

Health Financial Systems COMM	MUNITY HOSPT. 0	F LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS		Provi der CCN: 15-1323		Worksheet D Part II Date/Time Pre 8/21/2020 10:	pared: 08 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	· ·	1,	. 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 OPERATI NG ROOM	421, 217				-	
52.00 05200 DELI VERY ROOM & LABOR ROOM	102, 392		0. 03628			
53. 00 05300 ANESTHESI OLOGY	6	2, 263, 468				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	265, 186					
60. 00 06000 LABORATORY	141, 773					
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0.00000		0	62. 30
65. 00 06500 RESPI RATORY THERAPY	47, 787				191	
66. 00 06600 PHYSI CAL THERAPY	133, 993			•		
67. 00 06700 OCCUPATI ONAL THERAPY	12, 142				14	
68. 00 06800 SPEECH PATHOLOGY	5, 867				0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	32, 791				174	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 977				0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	136, 610				824	
76. 97 07697 CARDI AC REHABI LI TATI ON	14, 195	264, 076			0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000		0	76. 98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000	0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	1	0. 00000		0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	49, 274				0	90. 01
91. 00 09100 EMERGENCY	417, 819		•	•	582	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	245, 033	5, 220, 399	0. 04693	8 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS	_					
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)	2, 036, 062	101, 867, 281	l	521, 090	11, 296	200. 00

Health Financial Systems COMM	MUNITY HOSPT. OF	LAGRANGE CTY	I N	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST	rs Provider Co		Period: From 01/01/2019 To 12/31/2019		
			e XIX	Hospi tal	PPS	
Cost Center Description		Nursing School		Allied Health		
	Post-Stepdown		Post-Stepdow		Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	1	0	0	
43. 00 04300 NURSERY	0	0	1	0	0	10.00
200.00 Total (lines 30 through 199)	0	0		0 0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		t Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)		7.00	0.00	
LAIDATI FAIT DOUTLAIF CERVILOE COCT OFATERS	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1	0	1 0 00	- 0.00		00.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	3, 09			
43. 00 04300 NURSERY		0	38			
200.00 Total (lines 30 through 199)	1 +: +	U	3, 48	4	184	200. 00
Cost Center Description	Inpati ent					
	Program Pass-Through					
	Cost (col. 7 x					
	cost (cor. / x					
	9.00					
INPATIENT ROUTINE SERVICE COST CENTERS	7.00					
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
43. 00 04300 NURSERY						43. 00
200.00 Total (lines 30 through 199)	0					200. 00
Total (Times of thi dagit 177)	1					1200.00

| Peri od: | Worksheet D | From 01/01/2019 | Part IV | To 12/31/2019 | Date/Time Prepared: | Part IV | Par
 Heal th Financial
 Systems
 COMMUNITY HOSPT. OF LAGRANGE CTY IN

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-1323
 THROUGH COSTS

				'	0 12/31/2019	8/21/2020 10:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School		Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1					
	05000 OPERATING ROOM	0	0		0	0	50. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0) (0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0) (0	0	54. 00
60.00	06000 LABORATORY	0	0) (0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0) (0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0) (0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0) (0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0) (0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0) (0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0) (0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0) (0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0) (0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0) (0	0	73. 00
76. 97	O7697 CARDI AC REHABI LI TATI ON	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	C) (0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	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 OBSERVATION BEDS (NON-DISTINCT PART	0		()	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0) (0	0	200. 00

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1323 Peri od: Worksheet D From 01/01/2019 To 12/31/2019 THROUGH COSTS Part IV Date/Time Prepared: 8/21/2020 10:08 am Title XIX Hospi tal All Other Total Cost Total Charges Ratio of Cost Cost Center Description Total to Charges Medi cal (sum of cols. (from Wkst. C, Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 4) 8) col s. 2, 3, 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 17, 016, 947 0.00000050.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 2, 821, 871 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0 0 2, 263, 468 0.000000 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 24, 110, 260 0.000000 54 00 0 60.00 06000 LABORATORY 0 12, 536, 631 0.000000 60.00 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 65.00 06500 RESPIRATORY THERAPY 0 0 3, 110, 575 0.000000 65.00 06600 PHYSI CAL THERAPY 0 0 66.00 1, 511, 257 0.000000 66.00 67. 00 06700 OCCUPATIONAL THERAPY 667, 058 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 0 154, 174 68.00 06900 ELECTROCARDI OLOGY 0 0.000000 69 00 69 00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 2, 091, 305 0.000000 71.00

07200 IMPL. DEV. CHARGED TO PATIENTS 821, 868 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 0 9, 767, 327 0.000000 73.00 07697 CARDIAC REHABILITATION 0 76.97 0 264, 076 0.000000 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 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 0 0.000000 90.00 0 0 90.01 09001 LIFEBRIDGE SENIOR CARE 0 0 750, 447 0.000000 90.01 09100 EMERGENCY 0 0 18, 759, 618 0.000000 91.00 0 91.00 5, 220, 399 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 0 0 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS

0

0

101, 867, 281

95.00

200.00

MCRI F32 - 16. 2. 168. 1

95.00

200.00

09500 AMBULANCE SERVICES

Total (lines 50 through 199)

Health Financial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY IN		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LADATIENT (OUTDATIES	NT ANGLELADY CEDVICE OTHER DACC	D: -I CON 1E 1222	D!I	Wasalsalaa - D

Period: From 01/01/2019 To 12/31/2019 Worksheet D Part IV APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1323 THROUGH COSTS Date/Time Prepared: 8/21/2020 10:08 am Title XIX Hospi tal PPS Outpati ent Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Ratio of Cost Program Program Program Program Pass-Through Pass-Through to Charges Charges Charges Costs (col. (col. 6 ÷ col Costs (col. 8 x col . 12) 13.00 7) x col. 10) 11.00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 207, 839 0 0 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 88, 856 0 52.00 05300 ANESTHESI OLOGY 0.000000 21, 847 0 53.00 53.00 0 0 0 0 0 0 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 27, 190 0 54.00 0 0 06000 LABORATORY 0.000000 60.00 64, 772 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0.000000 0 62.30 65.00 06500 RESPIRATORY THERAPY 0.000000 12, 411 0 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 0.000000 1, 240 66.00 0 0 06700 OCCUPATIONAL THERAPY 67.00 0.000000 780 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 11, 113 71 00 71 00 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 73.00 73.00 58, 893 0 0 07697 CARDIAC REHABILITATION 0 76. 97 76 97 0.000000 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 C 0 76. 98 76. 99 07699 LI THOTRI PSY 0.000000 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 0 90.00 0.000000 n 0 n 09000 CLI NI C 09001 LIFEBRIDGE SENIOR CARE 0 90.01 0.000000 C 0 0 90.01 09100 EMERGENCY 0.000000 26, 149 0 0 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.000000 0 o 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00

521, 090

0

0

0 200. 00

200.00

Total (lines 50 through 199)

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: 15-1323 Peri od: Worksheet D From 01/01/2019 Part V 12/31/2019 Date/Time Prepared: 8/21/2020 10:08 am Title XIX Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 189027 38, 767 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.557062 0 0 0 0 0 0 0 0 0 0 0 0 52.00 53. 00 05300 ANESTHESI OLOGY 0.000063 7. 969 0 53 00 0 |05400| RADI OLOGY-DI AGNOSTI C 54.00 0.118805 0 298, 587 0 54.00 60. 00 | 06000 | LABORATORY 0.163360 172, 411 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 62.30 C 0 06500 RESPIRATORY THERAPY 0 65.00 0.239880 26, 222 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.619407 6, 516 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.423887 1, 110 0 67.00 06800 SPEECH PATHOLOGY 0. 902046 68 00 68 00 4, 783 0 69.00 06900 ELECTROCARDI OLOGY 0.000000 C 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0. 317391 9, 295 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0. 245752 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73 00 0.254276 59, 750 Ω 73.00 76. 97 07697 CARDIAC REHABILITATION 0. 386722 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 76. 98 0 76. 99 07699 LI THOTRI PSY 0.000000 0 76. 99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 0 0 90.00 09001 LIFEBRIDGE SENIOR CARE 0. 750781 0 0 0 90.01 90.01 0 09100 EMERGENCY 0. 277903 0 91.00 91.00 0 411, 679 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0. 302399 0 92.00 92.00 114, 487 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 513765 88, 754 95.00 200.00 Subtotal (see instructions) 0 0 0 200. 00 1, 240, 330

C

1, 240, 330

201.00

0 202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

Only Charges

| Peri od: | Worksheet D | Part V | To | 12/31/2019 | Date/Time Prepared: | Part V | Date/Tim
 Heal th Financial
 Systems
 COMMUNITY HOSPT.
 O

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provider CCN: 15-1323

					10 12/31/2019	8/21/2020 10:	
			Ti tl	e XIX	Hospi tal	PPS	
		Cos	sts				
Cost C	enter Description	Cost	Cost				
		Rei mbursed	Reimbursed				
		Servi ces	Servi ces Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
ANCLL ADV. CE	DULCE COCT CENTEDS	6. 00	7. 00				
50. 00 05000 OPERAT	RVI CE COST CENTERS	7 220		J			50.00
	RY ROOM & LABOR ROOM	7, 328	0				50.00
53. 00 05300 ANESTH		1					52.00
	ESTULUGY OGY-DI AGNOSTI C	35, 474					54.00
60. 00 06000 LABORA		28, 165					60.00
	CLOTTING FOR HEMOPHILIACS	20, 100					62. 30
	ATORY THERAPY	6, 290					65. 00
66. 00 06600 PHYSI C		4, 036					66. 00
	TIONAL THERAPY	4, 036					67. 00
68. 00 06800 SPEECH		4, 314					68. 00
69. 00 06900 SPEECTR		4, 314					69. 00
	L SUPPLIES CHARGED TO PATIENT	2, 950					71. 00
	DEV. CHARGED TO PATTENTS	2, 730					72.00
	CHARGED TO PATIENTS	15, 193					73. 00
	C REHABILITATION	13, 173					76. 97
	ARI C OXYGEN THERAPY	0					76. 98
76. 99 07699 LI THOT		0					76. 99
	ERVICE COST CENTERS			′1			70.77
90. 00 09000 CLI NI C		0	C				90.00
	IDGE SENIOR CARE	0	Ċ				90. 01
91. 00 09100 EMERGE	NCY	114, 407	C				91.00
92. 00 09200 OBSERV	ATION BEDS (NON-DISTINCT PART	34, 621	C				92. 00
OTHER REI MBL	RSABLE COST CENTERS						
95. 00 09500 AMBULA	NCE SERVICES	45, 599					95. 00
200. 00 Subtot	al (see instructions)	298, 849	C				200. 00
201.00 Less P	BP Clinic Lab. Services-Program	0					201. 00
Onl y C	harges						
202.00 Net Ch	arges (line 200 - line 201)	298, 849	C)			202. 00

Health Financial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY IN	In Lieu of Form CMS-2552		
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1323	Peri od: From 01/01/2019	Worksheet D-1	
				Date/Time Prepared: 8/21/2020 10:08 am	
		Title XVIII	Hosni tal	Cost	

		Title XVIII	Hospi tal	8/21/2020 10:	08 am
	Cost Center Description		noop. ta.	'	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 483	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			3, 095	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 115	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	158	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private room	om days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	230	7. 00
7.00	reporting period	r days) thi ough becomber	or or the cost	250	7.00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	l 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 newborn days) (see instructions)	the Program (excluding	swing-bed and	684	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (including private ro	oom davs)	158	10.00
	through December 31 of the cost reporting period (see instruct				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (Therdaing private	e room days)	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye			_	
14. 00 15. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14. 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 service	es through December 31 of	the cost		17. 00
40.00	reporting period				40.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of 1	the cost		18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services	s through December 31 of	the cost	123. 32	19. 00
	reporting period	Ü			
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	123. 32	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	-1		5, 268, 483	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		na period (line	0, 200, 403	22. 00
	5 x line 17)		3 1 2 2 (2		
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporting	na period (line	28, 364	24. 00
24.00	7 x line 19)	or the cost reporter	ig perrou (Trie	20, 304	24.00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
27.00	x line 20)			202 000	27 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (Tine 21 minus line 26)		282, 880 4, 985, 603	26.00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(Trice 21 illinius Trice 20)		4, 700, 000	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi -private room charges (excluding swing-bed charges)	1: 20)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 - line 3)	- IIne 28)		0. 000000 0. 00	31. 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 mir	nus line 33)(see instruct	tions)	0.00	34. 00
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)		Se	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost dif	recential (IIne	4, 985, 603	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 610. 86	
39. 00	Program general inpatient routine service cost (line 9 x line			1, 101, 828	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 1, 101, 828	40. 00 41. 00
00	1g. a goo. apac. o routino ooi vioo oost (11110 07		ı	., 101, 020	

COMPLIT	Financial Systems COMMUNATION OF INPATIENT OPERATING COST	NITY HOSPT. OF	Provi der CO	N· 15-1323	Peri od:	Worksheet D-1	2552-10
COMPUT	ATTON OF INPATTENT OFERATING COST		Frovider Co	SN. 10-1323	From 01/01/2019 To 12/31/2019	Date/Time Pre	
						8/21/2020 10:	
	Cost Center Description	Total	Ti tl e Total	XVIII Average Pe	Hospital r Program Days	Cost Program Cost	
	•	npatient Cost Ir		Diem (col. 1		(col. 3 x col.	
	_	1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	0		00 0		42.00
40.00	Intensive Care Type Inpatient Hospital Units						40.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT						43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	·					1. 00	
48. 00	Program inpatient ancillary service cost (Wkst			>		721, 374	
49. 00	Total Program inpatient costs (sum of lines 41 PASS THROUGH COST ADJUSTMENTS	through 48)(Se	ee instructio	ns)		1, 823, 202	49. 00
50.00	Pass through costs applicable to Program inpat	ient routine s	ervices (from	Wkst. D, su	m of Parts I and	0	50.00
51. 00	III) Pass through costs applicable to Program inpat	ient ancillary	services (fr	om Wkst D	SUM Of Parts II	0	51. 00
31.00	and IV)	Tent and Train	services (II	OIII WKST. D,	Sum of Farts II		31.00
52.00	Total Program excludable cost (sum of lines 50	,				0	
53. 00	Total Program inpatient operating cost excludi medical education costs (line 49 minus line 52		ated, non-phy	sician anest	hetist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	- /					
	Program di scharges					-	54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0. 00 0	l l
57. 00	Difference between adjusted inpatient operation	g cost and targ	get amount (I	ine 56 minus	line 53)	0	57.00
58. 00	Bonus payment (see instructions)		!: 100/			0	
59. 00	Lesser of lines 53/54 or 55 from the cost repo market basket	irting period ei	naing 1996, u	paatea ana c	compounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year co					0.00	
61. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61.00
	amount (line 56), otherwise enter zero (see in		(11100 01 %	00), 0 0	the target		
62.00	Relief payment (see instructions)	+ (000 notrue	ti ana)			0	
03.00	Allowable Inpatient cost plus incentive paymen PROGRAM INPATIENT ROUTINE SWING BED COST	it (see mstruc	ti ons)			0	03.00
64. 00	Medicare swing-bed SNF inpatient routine costs	through Decemb	oer 31 of the	cost report	ing period (See	254, 516	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs</pre>	after December	r 31 of the c	ost renortin	na neriod (See	0	65. 00
00.00	instructions) (title XVIII only)	arter becomber	01 01 110 0	ost reportin	ig period (see		
66. 00	Total Medicare swing-bed SNF inpatient routine	costs (line 6	4 plus line 6	5)(title XVI	II only). For	254, 516	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	costs through [December 31 o	f the cost r	eporting period	0	67.00
	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	costs after Dec	cember 31 or	tne cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient ro					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NUR Skilled nursing facility/other nursing facilit				')		 70. 00
71.00	Adjusted general inpatient routine service cos)		71.00
72. 00	Program routine service cost (line 9 x line 71						72. 00
73. 00 74. 00	Medically necessary private room cost applicab Total Program general inpatient routine service			ne 35)			73. 00 74. 00
74. 00 75. 00	Capital-related cost allocated to inpatient ro	•	,	orksheet B,	Part II, column		75.00
	26, line 45)		•				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line 7	,					76. 00 77. 00
	Inpatient routine service cost (line 74 minus						78. 00
79.00	Aggregate charges to beneficiaries for excess			*.			79.00
80. 00 81. 00	Total Program routine service costs for compar Inpatient routine service cost per diem limita		st limitation	(IIne 78 mi	nus line 79)		80. 00 81. 00
82.00	Inpatient routine service cost per drem film ta Inpatient routine service cost limitation (lin						82.00
83. 00	Reasonable inpatient routine service costs (se	•)				83. 00
84. 00	Program inpatient ancillary services (see inst						84.00
	Utilization review - physician compensation (s Total Program inpatient operating costs (sum o						85. 00 86. 00
55. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS] 55. 50
	Total observation bed days (see instructions)					980	87. 00

980 87.00 1,610.86 88.00 1,578,643 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 COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-25					2552-10	
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2019 Fo 12/31/2019	Date/Time Pre 8/21/2020 10:0	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	813, 360	5, 268, 483	0. 154382	1, 578, 643	243, 714	90.00
91.00 Nursing School cost	0	5, 268, 483	0.000000	1, 578, 643	0	91.00
92.00 Allied health cost	0	5, 268, 483	0. 000000	1, 578, 643	0	92.00
93.00 All other Medical Education	0	5, 268, 483	0. 000000	1, 578, 643	0	93. 00

Health Financial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY IN	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 15-1323	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Prep8/21/2020 10:0	
		Title XIX	Hospi tal	PPS	
0 1 0 1 0 1 11					

		Title XIX	Hospi tal	8/21/2020 10: PPS	08 am
	Cost Center Description	II LIE XIX	HOSPI tai	ļ FF3	
	·			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s. excluding newborn)		3, 483	1. 00
2.00	Inpatient days (including private room days, excluding swing-			3, 095	2. 00
3.00	Private room days (excluding swing-bed and observation bed day	ys). If you have only pri	vate room days,	0	3. 00
4 00	do not complete this line.	- d - dX		2 115	4 00
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	2, 115 158	4. 00 5. 00
3.00	reporting period	om days) trii ough becember	31 of the cost	130	3.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	m days) through December	31 of the cost	230	7. 00
8. 00	Teporting period Total_swing-bed_NF_type_inpatient_days (including private room	m days) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	38	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	alv. (i nalvelina najveta n	nom dovo)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		Joili days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en				
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 XI)	Conty (including private	e room days)	0	13. 00
10.00	after December 31 of the cost reporting period (if calendar ye			· ·	10.00
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed o	days)	0	14. 00
15. 00	Total nursery days (title V or XIX only)			389	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			146	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
19. 00	reporting period	through Docombon 21 of	the cost	0.00	10.00
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through becember 31 of	the cost	0.00	19. 00
20.00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0.00	20. 00
	reporting period	_			
21. 00 22. 00	Total general inpatient routine service cost (see instructions		ing ported (Line	5, 268, 483	
22.00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	er 31 of the cost reporti	ing period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	1 31 of the cost reportion	ng period (line	0	24. 00
25. 00	X Title 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)		p	_	
26. 00	Total swing-bed cost (see instructions)			255, 894	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		5, 012, 589	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation hed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed en	ar ges)	0	29. 00
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	ous line 33)(see instruct	tions)	0. 00 0. 00	1
35. 00	Average per diem private room cost differential (line 34 x line	, ,	(10113)	0.00	•
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	5, 012, 589	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 619. 58	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			61, 544	
40. 00	Medically necessary private room cost applicable to the Progra	,		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39	+ IIne 40)		61, 544	41.00

	Financial Systems COMM ATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1323	Peri od: From 01/01/2019	Worksheet D-1	
					To 12/31/2019	Date/Time Pre 8/21/2020 10:	
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days			Program Cost (col. 3 x col.	
		1.00	2. 00	3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	339, 637					42.00
	Intensive Care Type Inpatient Hospital Units						
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:	st D-3 col 3	R line 200)			1. 00 132, 442	48. 00
	Total Program inpatient costs (sum of lines			ons)		321, 459	1
	PASS THROUGH COST ADJUSTMENTS	-				I	
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sui	m of Parts I and	17, 797	50.00
51. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillar	v services (fr	om Wkst. D.	sum of Parts II	11, 296	51.00
	and IV)		,			,	
52.00	Total Program excludable cost (sum of lines!					29, 093	1
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		elated, non-phy	sıcıan anesti	netist, and	292, 366	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					1
	Program di scharges					0	
55.00	Target amount per discharge					0.00	1
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and ta	arget amount (1	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	ing cost and to	irget amourt (i	THE 50 III HGS	11116 33)	Ö	
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996, u	updated and c	ompounded by the	0.00	59.00
50. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport un	dated by the m	markot baskot		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines					0.00	1
	which operating costs (line 53) are less than	n expected cost					
(2.00	amount (line 56), otherwise enter zero (see i	nstructions)					42.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ıctions)			0	
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST	(000 1110110	.011 0110)				00.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost report	ing period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	or 21 of the c	act roportin	a pariod (Saa	0	65. 00
03.00	instructions)(title XVIII only)	ts after becenik	der 31 of the C	cost reportini	g perrou (see		05.00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus line 6	55)(title XVI	II only). For	0	66. 00
67 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	o costs through	Docombor 21 o	of the cost r	operting period	0	67. 00
07.00	(line 12 x line 19)	e costs till ougi	i becember 31 c	of the cost in	eportring perrou		07.00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	December 31 of	the cost rep	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient (couting costs (lino 47 : lino	. 40)		0	69. 00
09.00	PART III - SKILLED NURSING FACILITY, OTHER NU						1 69.00
70. 00	Skilled nursing facility/other nursing facili)		70. 00
71. 00	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line 1) Medically necessary private room cost applications.		ı (lino 14 v li	no 25)			72.00
74. 00	Total Program general inpatient routine servi						74.00
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from V	Vorksheet B, I	Part II, column		75. 00
74 00	26, line 45)	20. 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus						78.00
79. 00	Aggregate charges to beneficiaries for excess			*	=:		79. 00
30.00	Total Program routine service costs for compa		cost limitation	n (line 78 mi	nus line 79)		80.00
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (•				83.00
	Program inpatient ancillary services (see in	,					84. 00
	Utilization review - physician compensation						85 00

86.00

87.00

980

1, 619. 58 88. 00 1, 587, 188 89. 00

85.00

86.00

Utilization review - physician compensation (see instructions)
Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

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

Health Financial Systems COMM	IUNI TY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2019 Fo 12/31/2019	Date/Time Prep 8/21/2020 10:0	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	813, 360	5, 268, 483	0. 154382	1, 587, 188	245, 033	90.00
91.00 Nursing School cost	0	5, 268, 483	0.000000	1, 587, 188	0	91.00
92.00 Allied health cost	0	5, 268, 483	0. 000000	1, 587, 188	0	92.00
93.00 All other Medical Education	0	5, 268, 483	0. 000000	1, 587, 188	0	93. 00

	Financial Systems COMMUNITY HOSPT. OF ENT ANCILLARY SERVICE COST APPORTIONMENT		CN: 15-1323	Peri od:	eu of Form CMS-2 Worksheet D-3	
				From 01/01/2019		
				To 12/31/2019	Date/Time Prep 8/21/2020 10:0	
		Ti tl e	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	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					۱
30.00	03000 ADULTS & PEDI ATRI CS			1, 594, 021		30.0
43. 00	04300 NURSERY					43. 0
FO 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM		0.1000	07 (00 540	120,010	
50.00	05200 DELIVERY ROOM & LABOR ROOM		0. 1890: 0. 5570			
53.00	05300 ANESTHESI OLOGY		0.0000		6	53.0
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1188		70, 422	
60.00	06000 LABORATORY		0. 1633			
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		1	1
65. 00	06500 RESPIRATORY THERAPY		0. 2398		1	
66. 00	06600 PHYSI CAL THERAPY		0. 6194			
67. 00	06700 OCCUPATI ONAL THERAPY		0. 4238			
68. 00	06800 SPEECH PATHOLOGY		0. 9020			
59. 00	06900 ELECTROCARDI OLOGY		0.0000		0	69. 0
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3173	91 177, 450	56, 321	71.0
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2457	52 158, 135	38, 862	72. 0
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 2542	76 734, 762	186, 832	73.0
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 3867	22 0	0	76. 9
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0.0000	00	0	76. 9
76. 99	07699 LI THOTRI PSY		0.0000	00	0	76. 9
	OUTPAȚI ENT SERVI CE COST CENTERS					1
	09000 CLI NI C		0.0000			
	09001 LI FEBRI DGE SENI OR CARE		0. 7507		0	
91. 00	09100 EMERGENCY		0. 2779		10, 058	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3023	99 0	0	92.0

95.00

721, 374 200. 00 201. 00 202. 00

3, 404, 260

3, 404, 260

OTHER REIMBURSABLE COST CENTERS

95. 00 09500 AMBULANCE SERVICES

Net charges (line 200 minus line 201)

200.00

201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98) Less PBP Clinic Laboratory Services-Program only charges (line 61)

	Financial Systems COMMUNITY HOSPT. OF LENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od:	eu of Form CMS-: Worksheet D-3	
INPAII	ENT ANCILLARY SERVICE CUST APPURITUNMENT	Provider C	UN: 15-1323	Period: From 01/01/2019		
		Component	CCN: 15-Z323	To 12/31/2019		
		Titl∈	XVIII	Swing Beds - SNF		
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges		Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
	INDATION DOUTING CODY OF COST CENTERS		1.00	2. 00	3. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS		1	120, 714		30.00
	03000 ADDLIS & PEDIATRICS			120, 714		43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00	05000 OPERATING ROOM		0. 1890	27 2, 378	450	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 5570			
53. 00	05300 ANESTHESI OLOGY		0.0000		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 1188		_	
60.00	06000 LABORATORY		0. 1633			
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		1	1
65.00	06500 RESPI RATORY THERAPY		0. 2398	80 19, 858	4, 764	65.00
66.00	06600 PHYSI CAL THERAPY		0. 6194	07 34, 539	21, 394	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0. 4238	87 49, 608	21, 028	67.00
68.00	06800 SPEECH PATHOLOGY		0. 9020	46 6, 251	5, 639	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0.0000		0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 3173		2, 063	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2457		0	
	07300 DRUGS CHARGED TO PATIENTS		0. 2542			
	07697 CARDI AC REHABI LI TATI ON		0. 3867		0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY		0.0000		0	1 , 0, , 0
76. 99	07699 LI THOTRI PSY		0.0000	00 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS				_	
90.00	09000 CLI NI C		0.0000			
90. 01	09001 LI FEBRI DGE SENI OR CARE		0. 7507		0	
	09100 EMERGENCY		0. 2779		0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3023	99 0	0	92. 00

76, 251 200. 00 201. 00 202. 00

221, 231

221, 231

OTHER REIMBURSABLE COST CENTERS
95.00 09500 AMBULANCE SERVICES

Net charges (line 200 minus line 201)

200.00

201. 00 202. 00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)

					6.5	
	ancial Systems COMMUNITY HOSPT. OF	_			eu of Form CMS-2	
INPAILENT	ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od: From 01/01/2019	Worksheet D-3	
				To 12/31/2019		pared:
					8/21/2020 10:	08 am
		Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	TIENT ROUTINE SERVICE COST CENTERS					
	O ADULTS & PEDIATRICS			46, 393	l e	30.00
	0 NURSERY			46, 468		43. 00
	LLARY SERVICE COST CENTERS					
	OO OPERATING ROOM		0. 18902			
	O DELIVERY ROOM & LABOR ROOM		0. 55706			
	OO ANESTHESI OLOGY		0.00006		1	53. 00
	O RADI OLOGY-DI AGNOSTI C		0. 11880			
	DO LABORATORY		0. 16336		10, 581	
	60 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	
	O RESPI RATORY THERAPY		0. 23988		2, 977	65. 00
	O PHYSI CAL THERAPY		0. 61940		l e	
	OO OCCUPATIONAL THERAPY		0. 42388		l e	
	OO SPEECH PATHOLOGY		0. 90204		0	68. 00
	DO ELECTROCARDI OLOGY		0.00000		0	69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENT		0. 31739		3, 527	71. 00
	ON IMPL. DEV. CHARGED TO PATIENTS		0. 24575		0	72. 00
	DO DRUGS CHARGED TO PATIENTS		0. 25427		14, 975	1
	7 CARDIAC REHABILITATION		0. 38672		0	76. 97
	HYPERBARIC OXYGEN THERAPY		0.00000		0	76. 98
	9 LI THOTRI PSY		0.00000	00 0	0	76. 99
	ATIENT SERVICE COST CENTERS					
	DO CLI NI C		0.00000			
	1 LI FEBRI DGE SENI OR CARE		0. 75078		0	90. 01
	DO EMERGENCY		0. 27790			
	OO OBSERVATION BEDS (NON-DISTINCT PART		0. 30239	99 0	0	92.00
IOTHE	D DELMBLIDSARI E COST CENTEDS					I

95. 00 132, 442 200. 00 201. 00 202. 00

521, 090

521, 090

95. 00 O9500 AMBULANCE SERVICES
Total (Sum of 1)

201.00 202.00 Total (sum of lines 50 through 94 and 96 through 98)
Less PBP Clinic Laboratory Services-Program only charges (line 61)
Net charges (line 200 minus line 201)

Health Financial Systems	COMMUNITY HOSPT. OF LA	AGRANGE CTY IN	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1323	From 01/01/2019	Worksheet E Part B Date/Time Prepared: 8/21/2020 10:08 am
		T: +1 - \0./1.1.1	11	C+

			12/01/201/	8/21/2020 10:	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			4, 516, 375	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	2.00
3. 00 4. 00	OPPS payments Outlier payment (see instructions)			0	3. 00 4. 00
4. 00	Outlier reconciliation amount (see instructions)			0	4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0. 00	7. 00
8. 00 9. 00	Transitional corridor payment (see instructions)	/ aal 12 lina 200		0	8.00
10.00	Ancillary service other pass through costs from Wkst. D, Pt. IN Organ acquisitions	7, Cot. 13, Time 200		0	9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			4, 516, 375	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12.00	Ancillary service charges	(0)		0	12.00
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lir Total reasonable charges (sum of lines 12 and 13)	le 69)		0	13. 00 14. 00
14.00	Customary charges				14.00
15. 00	Aggregate amount actually collected from patients liable for pa	yment for services on a	charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for		a chargebasis	0	16. 00
17.00	had such payment been made in accordance with 42 CFR §413.13(e)			0.000000	17.00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	17. 00 18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds lin	e 11) (see	Ö	19.00
	instructions)		, (***		
20.00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds lin	e 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			4, 561, 539	21. 00
22. 00	Interns and residents (see instructions)			4, 301, 339	22.00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ıctions)		Ö	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24. 00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			40.070	
25. 00 26. 00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line		ctions)	43, 878 3, 546, 668	25. 00 26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl	•		970, 993	
27.00	instructions)	ase sam ees 22	a.ia 20] (000	7,0,7,0	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			970, 993 0	30. 00 31. 00
32. 00	Subtotal (line 30 minus line 31)			970, 993	32.00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			434, 347	34.00
35. 00 36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ıctions)		282, 326 281, 401	
37. 00	Subtotal (see instructions)	ieti olis)		1, 253, 319	
38.00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			_	39. 50
39. 97 39. 98	Demonstration payment adjustment amount before sequestration Partial or full credits received from manufacturers for replace	ad devices (see instruct	ions)	0	39. 97 39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	devices (see mistract	10113)	0	39. 99
40.00	Subtotal (see instructions)			1, 253, 319	40.00
40. 01	Sequestration adjustment (see instructions)			25, 066	
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03 41. 00	Sequestration adjustment-PARHM pass-throughs Interim payments			1, 639, 205	40. 03 41. 00
41. 01	Interim payments-PARHM			1,037,203	41. 01
42. 00	Tentative settlement (for contractors use only)			0	42. 00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			-410, 952	43.00
43. 01 44. 00	Balance due provider/program-PARHM (see instructions) Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15_2 o	hanter 1	0	43. 01 44. 00
44.00	§115. 2	,c with GWB FUD. 19-2, C	napter I,		44.00
	TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0. 00 0	92. 00 93. 00
	Total (sum of lines 91 and 93)			0	94. 00
·	·		ļ	,	

		Title	XVIII	Hospi tal	Cost	
		Inpatien	it 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		1, 431, 470		1, 639, 205	1. 00
2.00	Interim payments payable on individual bills, either		0		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		0		0	3. 01
3. 02	7.65 COLIMENTO TO TROVIDER		0		0	3. 02
3. 02						3. 02
3. 04					0	3. 04
3.04						3. 04
3.03	Dravi dan ta Dragnam				U	3.03
2 50	Provider to Program ADJUSTMENTS TO PROGRAM		l 0		0	2 50
3. 50 3. 51	ADJUSTMENTS TO PROGRAM					3. 50 3. 51
			0			
3. 52			0		0	3. 52
3.53			0		0	3. 53
3. 54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 431, 470		1, 639, 205	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		T			
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program					
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		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		156, 727		0	6. 01
6.02	SETTLEMENT TO PROGRAM		0		410, 952	6. 02
7.00	Total Medicare program liability (see instructions)		1, 588, 197		1, 228, 253	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(0	1. 00	2.00	
8. 00	Name of Contractor					8. 00
	•	•		•		,

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1323 Peri od: Worksheet E-1 From 01/01/2019 To 12/31/2019 Part I Component CCN: 15-Z323 Date/Time Prepared: 8/21/2020 10:08 am Title XVIII Swing Beds - SNF Cost Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 282, 693 1. 00 0 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 0 3.02 3.02 3.03 0 3.03 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 3.51 0 3.51 0 0 3.52 3.52 0 3.53 0 3.53 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3.50-3.98) 282, 693 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 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 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5. 99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1)

44, 700

327, 393

0

C

Contractor

Number

1 00

0

0

NPR Date (Mo/Day/Yr)

2 00

6.01

6.02

7.00

8.00

SETTLEMENT TO PROVIDER

Total Medicare program liability (see instructions)

SETTLEMENT TO PROGRAM

8.00 Name of Contractor

6.01

6 02

7.00

Hoal th	Financial Systems COMMUNITY HOSPT. OF L	ACDANGE CTV IN	Inlia	u of Form CMS-:	2552_10		
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1323 Period:						
			From 01/01/2019				
	To 12/31/2019 Date/Time 8/21/2020						
		Title XVIII	Hospi tal	Cost			
				1. 00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION						
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S 2 Dt I col 15 line	. 1/		1.00		
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8		14		2.00		
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	-12			3.00		
4. 00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	10			4.00		
		-12			5.00		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	i no. 20					
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I		WI+ C 2 D+ I		6.00		
7. 00	CAH only - The reasonable cost incurred for the purchase of ciline 168	ertified Hil technology	WKST. 5-2, Pt. I		7. 00		
9 00	111111111111111111111111111111111111111				8.00		
8.00	Calculation of the HIT incentive payment (see instructions)						
9.00	Sequestration adjustment amount (see instructions)	(!+ + !)			9.00		
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00		
20.00	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH				20.00		
	Initial/interim HIT payment adjustment (see instructions)				30.00		
	Other Adjustment (specify)	. 24) (,		31.00		

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

32.00

Health Financial Systems COMMUNITY HOSPT. OF LA		AGRANGE CTY IN	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provider CCN: 15-1323	Peri od:	Worksheet E-2

	Component Con. 13-2323	, 10		8/21/2020 10:	
	Title XVIII	Swi r	ng Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
00	COMPUTATION OF NET COST OF COVERED SERVICES		057.0/4		١.
00	Inpatient routine services - swing bed-SNF (see instructions)		257, 061	0	1
00	Inpatient routine services - swing bed-NF (see instructions)	,	77 014	0] 2
00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. I		77, 014	0	3
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-bed pass-through, selinstructions)	ee			
01	Nursing and allied health payment-PARHM (see instructions)				1
00	Per diem cost for interns and residents not in approved teaching program (see			0.00	
,0	instructions)			0.00	
00	Program days		158	0	
00	Interns and residents not in approved teaching program (see instructions)			0	
00	Utilization review – physician compensation – SNF optional method only		0		
00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		334, 075	0	
00	Primary payer payments (see instructions)		0	0	1
00	Subtotal (line 8 minus line 9)		334, 075	0	1
00	Deductibles billed to program patients (exclude amounts applicable to physician		0	0	1
	professi onal servi ces)				
00	Subtotal (line 10 minus line 11)		334, 075	0	1:
00	Coinsurance billed to program patients (from provider records) (exclude coinsurance		0	0	1
	for physician professional services)				
00	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (see instructions)		334, 075	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	1 '
50	Pioneer ACO demonstration payment adjustment (see instructions)				1
55	Rural community hospital demonstration project (§410A Demonstration) payment		U		1
99	adjustment (see instructions) Demonstration payment adjustment amount before sequestration		0	0	1
	Allowable bad debts (see instructions)		0	0	1 1
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instructions)		0	0	1 '
	Total (see instructions)		334, 075	0	1
	Sequestration adjustment (see instructions)		6, 682	0	1
	Demonstration payment adjustment amount after sequestration)		0	0	1
	Sequestration adjustment-PARHM pass-throughs				1
00	Interim payments		282, 693	0	2
01	Interim payments-PARHM				2
00	Tentative settlement (for contractor use only)		0	0	2
01	Tentative settlement-PARHM (for contractor use only)				2
00	Balance due provider/program (line 19 minus lines 19.01, 20, and 21)		44, 700	0	
01	Balance due provider/program-PARHM (see instructions)				2
00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2		0	0	2
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment				١.,
). 00	Is this the first year of the current 5-year demonstration period under the 21st				20
	Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement				1
1 00	Medicare swing-bed SNF inpatient routine service costs (from Wkst. D-1, Pt. II, line	_	1		20
1.00	66 (title XVIII hospital))	=			20
2 00	Medicare swing-bed SNF inpatient ancillary service costs (from Wkst. D-3, col. 3, li	ne			20
00	200 (title XVIII swing-bed SNF))				-
3. 00	Total (sum of lines 201 and 202)				20
	Medicare swing-bed SNF discharges (see instructions)				20
	Computation of Demonstration Target Amount Limitation (N/A in first year of the cur	ent 5	-year demonst	rati on	
	peri od)				
5. 00	Medicare swing-bed SNF target amount				20
. 00	Medicare swing-bed SNF inpatient routine cost cap (line 205 times line 204)				20
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursement				
7. 00	Program reimbursement under the §410A Demonstration (see instructions)				20
3. 00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, col. 1, sum of lines	s 1			20
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instructions)				20
	Reserved for future use				21
). 00					1
	Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare swing-bed SNF PPS payment (line 209 plus line 210) (see		1		21

Health Financial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY IN	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-1323	From 01/01/2019	Worksheet E-3 Part V Date/Time Prepared: 8/21/2020 10:08 am

		Title XVIII	Hospi tal	8/21/2020 10:0 Cost	J8 alli
		II LIE AVIII	поѕрі таі	COST	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A	SERVICES - COST	RELMBURSEMENT	1.00	
1.00	Inpatient services			1, 823, 202	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instructions)			0	2. 00
3.00	Organ acquisition			0	3. 00
4.00	Subtotal (sum of lines 1 through 3)			1, 823, 202	4. 00
5.00	Primary payer payments			0	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			1, 841, 434	6. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
7. 00	Routine service charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10. 00	Total reasonable charges			0	10. 00
11 00	Customary charges	6		0	11 00
11. 00	Aggregate amount actually collected from patients liable for payment			0	11.00
12. 00	Amounts that would have been realized from patients liable for payme	at for services of	n a charge basis	U	12. 00
13. 00	had such payment been made in accordance with 42 CFR 413.13(e) Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13. 00
14. 00	Total customary charges (see instructions)			0.000000	14. 00
15. 00	Excess of customary charges over reasonable cost (complete only if I	ine 14 exceeds lin	ne 6) (see	0	15. 00
13.00	instructions)	THE 14 CACCCUS III	(300	O	13.00
16. 00	Excess of reasonable cost over customary charges (complete only if I	ine 6 exceeds line	e 14) (see	0	16. 00
	instructions)		, (***		
17. 00	Cost of physicians' services in a teaching hospital (see instruction	s)		0	17. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
18. 00	Direct graduate medical education payments (from Worksheet E-4, line	49)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)			1, 841, 434	
20. 00	Deductibles (exclude professional component)			232, 783	
21. 00	Excess reasonable cost (from line 16)			0	21. 00
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 608, 651	
23. 00	Coinsurance			0	23. 00
24. 00	Subtotal (line 22 minus line 23)			1, 608, 651	
25. 00	Allowable bad debts (exclude bad debts for professional services) (s	ee instructions)		18, 397	25. 00
26. 00	Adjusted reimbursable bad debts (see instructions)	٥)		11, 958	
27. 00 28. 00	Allowable bad debts for dual eligible beneficiaries (see instruction Subtotal (sum of lines 24 and 25, or line 26)	5)		7, 761 1, 620, 609	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			1, 820, 809	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 99	Demonstration payment adjustment amount before sequestration			0	29. 99
30. 00	Subtotal (see instructions)			1, 620, 609	
30. 01	Sequestration adjustment (see instructions)			32, 412	
30. 02	Demonstration payment adjustment amount after sequestration			0	30. 02
30. 03				_	30. 03
31. 00	Interim payments			1, 431, 470	31. 00
31. 01	Interim payments-PARHM				31. 01
32.00	Tentative settlement (for contractor use only)			0	32.00
32. 01	Tentative settlement-PARHM (for contractor use only)				32. 01
33.00	Balance due provider/program (line 30 minus lines 30.01, 30.02, 31,	and 32)		156, 727	33. 00
33. 01	Balance due provider/program-PARHM (lines 2, 3, 18, and 26, minus li				33. 01
34. 00	Protested amounts (nonallowable cost report items) in accordance wit	n CMS Pub. 15-2, (chapter 1,	0	34.00
	§115. 2				

Health Financial Systems COMMUNITY HOSPT.

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

Provider CCN: 15-1323

Peri od: Worksheet G From 01/01/2019 To 12/31/2019 Date/Time Prepared:

onl y)			'	0 12/31/2019	8/21/2020 10:	
		General Fund	Specific	Endowment Fund		
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	-	1			
1.00	Cash on hand in banks	180, 154	0	0	0	1.00
2. 00 3. 00	Temporary investments Notes receivable	0		-	0	2. 00 3. 00
4. 00	Accounts receivable	5, 481, 994		0	0	4. 00
5. 00	Other recei vable	9, 460	l .	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	o c	0	0	6. 00
7.00	Inventory	369, 606	1	0	0	7. 00
8.00	Prepai d expenses	77, 228	C	0	0	
9.00	Other current assets Due from other funds	2 254 174		0	0	
10. 00 11. 00	Total current assets (sum of lines 1-10)	-3, 354, 174 2, 764, 268	1		0	10.00
11.00	FIXED ASSETS	2, 704, 200		<u> </u>	0	11.00
12.00	Land	320, 702	C	0	0	12. 00
13.00	Land improvements	1, 978, 720	o c	0	0	13. 00
14.00	Accumulated depreciation	-1, 265, 888	1	0	0	14. 00
15.00	Bui I di ngs	13, 566, 854	1	0	0	15. 00
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-4, 535, 887 29, 098	1	-	0	16. 00 17. 00
18. 00	Accumul ated depreciation	-29, 098	1	-	0	18.00
19. 00	Fi xed equi pment	8, 688, 875	1		0	19.00
20.00	Accumulated depreciation	-5, 960, 122	1	0	0	20.00
21.00	Automobiles and trucks	433, 516	o c	0	0	21. 00
22. 00	Accumulated depreciation	-187, 954	_	0	0	22. 00
23. 00	Major movable equipment	8, 977, 628	C	0	0	23. 00
24. 00 25. 00	Accumulated depreciation Minor equipment depreciable	-6, 960, 881		0	0	24. 00 25. 00
26. 00	Accumul ated depreciation	0		-	0	26.00
27. 00	HIT designated Assets	Ö		-	0	27. 00
28. 00	Accumul ated depreciation	Ō	o c	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	o c	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	15, 055, 563	C	0	0	30. 00
21 00	OTHER ASSETS	0	J	O	0	21 00
31. 00 32. 00	Investments Deposits on Leases	0	C		0	31. 00 32. 00
33. 00	Due from owners/officers	0		-	0	33.00
34. 00	Other assets	5, 011, 241		0	0	34. 00
35.00	Total other assets (sum of lines 31-34)	5, 011, 241	[c	0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	22, 831, 072	C	0	0	36. 00
07.00	CURRENT LIABILITIES	000 470				07.00
37. 00 38. 00	Accounts payable Salaries, wages, and fees payable	889, 172 628, 779	1	0	0	37. 00 38. 00
39. 00	Payroll taxes payable	020,779		0	0	39.00
40. 00	Notes and Loans payable (short term)	950, 000		o	0	40.00
41.00	Deferred income	0	C	0	0	41.00
42.00	Accel erated payments	0				42. 00
43.00	Due to other funds	0	O C	0	0	1
44. 00	Other current liabilities	610, 347			0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	3, 078, 298	C	0	0	45. 00
46. 00	Mortgage payable	0		0	0	46. 00
47. 00	Notes payable	0	i c	-	0	
48. 00	Unsecured Loans	0	o c	0	0	
49. 00	Other long term liabilities	15, 214, 003	l .	0	0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	15, 214, 003			0	50.00
51. 00	Total liabilities (sum of lines 45 and 50)	18, 292, 301	C	0	0	51.00
52. 00	CAPITAL ACCOUNTS General fund balance	4, 538, 771				52.00
53. 00	Specific purpose fund	4, 330, 771				53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	4, 538, 771		0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	22, 831, 072	l .		0	
	59)	, ,				
	·					

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Peri od: Worksheet G-1 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

					10 12/31/2019	8/21/2020 10:	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3. 00	4. 00	5. 00	
1.00	Fund balances at beginning of period		-2, 450, 088		(O	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		689, 558				2. 00
3.00	Total (sum of line 1 and line 2)		-1, 760, 530			0	3. 00
4.00	TRANSFER TO CORP	5, 891, 631			0	0	4. 00
5.00	NONALLOWABLE HO INTEREST EXPENSE	407, 670			0	0	5. 00
6.00		0			0	0	6. 00
7. 00		0			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10.00	Total additions (sum of line 4-9)		6, 299, 301			0	10.00
11. 00	Subtotal (line 3 plus line 10)		4, 538, 771			0	11. 00
12.00	Deductions (debit adjustments) (specify)	0			0	0	12.00
13.00		0			0	0	13.00
14. 00		0			0	0	14.00
15. 00		0			0	0	15.00
16. 00 17. 00					0	0	16. 00 17. 00
18. 00	Total deductions (sum of lines 12-17)	١			0		18.00
19. 00	Fund balance at end of period per balance		4, 538, 771				19.00
19.00	sheet (line 11 minus line 18)		4, 556, 771		,		19.00
	Janeer (Title II miritas Title 10)	Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3.00	Total (sum of line 1 and line 2)	0			0		3. 00
4.00	TRANSFER TO CORP		0				4. 00
5.00	NONALLOWABLE HO INTEREST EXPENSE		0				5. 00
6.00			0				6. 00
7.00			0				7. 00
8.00			0				8. 00
9.00	T-+-1 -		U				9.00
10. 00 11. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0			0		10. 00 11. 00
12. 00	Deductions (debit adjustments) (specify)	١	0		U		12.00
13. 00	beductions (debit adjustments) (specify)	1	0				13. 00
14. 00		1	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)	o	٩		0		18. 00
19. 00	Fund balance at end of period per balance				ō		19. 00
55	sheet (line 11 minus line 18)						
			'		•		•

Health Financial Systems COMMUNISTATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-1323

			To 12/31/2019	Date/Time Pre 8/21/2020 10:	
	Cost Center Description	Inpatient	Outpati ent	Total	
	•	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	4, 099, 31	1	4, 099, 311	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	212, 86	0	212, 860	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSI NG FACILITY				8. 00
9. 00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	4, 312, 17	1	4, 312, 171	10. 00
44.00	Intensive Care Type Inpatient Hospital Services				44 00
11.00	INTENSIVE CARE UNIT				11.00
12.00	CORONARY CARE UNIT				12.00
13. 00 14. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT				13. 00 14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines		0	0	16.00
10.00	111-15)		U	U	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	4, 312, 17	1	4, 312, 171	17. 00
18. 00	Ancillary services	16, 565, 74		16, 565, 741	
19. 00	Outpatient services	10, 303, 74	0 91, 648, 587	91, 648, 587	19.00
20. 00	RURAL HEALTH CLINIC		0 71, 040, 307	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0 0	0	21. 00
22. 00	HOME HEALTH AGENCY			Ŭ	22.00
23. 00	AMBULANCE SERVICES		0 6, 016, 136	6, 016, 136	
24. 00	CMHC		0,0.0,.00	0,0.0,100	24. 00
24. 10	CORF		0	0	24. 10
24. 20	OUTPATIENT PHYSICAL THERAPY		0	0	24. 20
24. 30	OUTPATIENT OCCUPATIONAL THERAPY		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 Wkst.	20, 877, 91	2 97, 664, 723	118, 542, 635	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		36, 946, 536		29. 00
30.00	BAD DEBT	5, 543, 51	1		30. 00
31. 00	NONALLOWABLE HO INTEREST EXPENSE	407, 67			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)		5, 951, 181		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)		10.007.77		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer	er	42, 897, 717		43. 00
	to Wkst. G-3, line 4)	I			l

Health Financial Systems	COMMUNITY HOSPT. OF LAGRANGE CTY IN		In Lieu of Form CMS-2552-10		
STATEMENT OF REVENUES AND EXPENSES	Provider C	CCN: 15-1323	Peri od: From 01/01/2019	Worksheet G-3	

STATEMENT OF REVENUES AND EXPENSES		Provi der CCN: 15-1323	Peri od: From 01/01/2019 To 12/31/2019	Worksheet G-3	
				Date/Time Prepared:	
	<u> </u>			8/21/2020 10:	08 am
				1. 00	
1.00				118, 542, 635	1.00
	2.00 Less contractual allowances and discounts on patients' accounts			75, 808, 401	2. 00
	3.00 Net patient revenues (line 1 minus line 2)			42, 734, 234	3. 00
4.00				42, 897, 717 -163, 483	4. 00 5. 00
5. 00					
	OTHER I NCOME			82, 737	/ 00
6.00					6. 00
	7.00 Income from investments				7. 00
8.00				0	8. 00
	9.00 Revenue from television and radio service				9. 00
	10. 00 Purchase di scounts				10.00
	11.00 Rebates and refunds of expenses			0	11.00
	12.00 Parking lot receipts			0	12. 00 13. 00
	13.00 Revenue from laundry and linen service			0	
	14.00 Revenue from meals sold to employees and guests			265, 167	14.00
	15.00 Revenue from rental of living quarters			0	15. 00 16. 00
	16.00 Revenue from sale of medical and surgical supplies to other than patients			0	
17.00	17.00 Revenue from sale of drugs to other than patients			38, 733	17. 00 18. 00
				0	19. 00
19. 00 20. 00				23, 535	
				23, 535	
21. 00				-	21. 00
22. 00				42, 030	
23. 00				0	23. 00
24. 00				-995	24. 00
24. 01				349, 000	
24. 02				55, 558	
25. 00				853, 041	25. 00
26. 00				689, 558	
27. 00	· · · ·			0	27. 00
28. 00				0	28. 00
29. 00	00 Net income (or loss) for the period (line 26 minus line 28)			689, 558	29.00