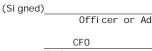
Heal th Financi	al Systems	ELKHART GENERAL H	OSPI TAL	In Lieu	u of Form CMS-2552-10
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Failu	re to report can resu	ult in all interim	FORM APPROVED
payments made	since the beginning of the cost	t reporting period being c	eemed overpayments (4	42 USC 1395g).	OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COS SUMMARY	ST REPORT CERTIFICATION	Provider CCN: 150018	Period: From 01/01/2014 To 12/31/2014	
PART I - COST	REPORT STATUS				
Provi der	1. [ X ] Electronically filed co	ost report		Date: 5/29/20	15 Time: 9:46 am
use only	2. [ ] Manually submitted cost	t report			
	3. [ O ] If this is an amended r 4. [ F ] Medicare Utilization. [			resubmitted this co	ost report
Contractor use only	(1) Ås Submitted 7 (2) Settled without Audit 8		this Provider CCN 12.		

PART II - CERTIFICATION

MISREPRESENTATION OF 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 OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ELKHART GENERAL HOSPITAL (150018) for the cost reporting period beginning 01/01/2014 and ending 12/31/2014 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.



0ffi cer	or	Admi ni strator	of	Provider(	s)
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Τi	t١	е
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Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY			_			
1.00	Hospi tal	0	-119, 741	-16, 824	-521, 736	17, 506	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	34, 704	0		0	3.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9.00
200.00	Total	0	-85, 037	-16, 824	-521, 736	17, 506	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.

PI T.	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I		<u>GENERAL H</u> A		er CCN:	150018	Period: From 01/01		u of For Workshe Part I	et S-2	
								/2014	Date/Ti 5/28/20		
	1.00	2.0	00	3.	00			4.00			
	Hospital and Hospital Health Care Co Street: 600 EAST BLVD	mplex Address: P0 Box:									1 1.
	City: ELKHART	State: IN	J Zi	p Code:	46514	Count	ty: ELKHART				2.
-		Component Nam	ne (	CCN	CBSA	Provi der	Date		ent Syst		
			Nu	umber   I	Number	Туре	Certified		, 0, or		-
		1.00	2	2.00	3.00	4.00	5.00	V 6.00	XVIII 7.00	XIX 8.00	+
	Hospital and Hospital-Based Componen		2		3.00	4.00	3.00	1 0.00	1.00	0.00	
C	Hospi tal	ELKHART GENERAL	15	50018	21140	1	01/01/196	5 N	Р	Р	3
)	Subprovider - IPF	HOSPI TAL									4
	Subprovider - IRF	ELKHART REHAB	15	5T018	21140	5	01/01/1993	3 N	P	P	5.
0	Subprovider - (Other)										6
	Swing Beds - SNF										7
)	Swing Beds - NF Hospital-Based SNF										8
	Hospi tal -Based NF										10
	Hospital-Based OLTC										11
	Hospi tal -Based HHA										12
	Separately Certified ASC Hospital-Based Hospice										13
	Hospital-Based Health Clinic - RHC										15
	Hospital-Based Health Clinic - FQHC										16
00 00	Hospital-Based (CMHC) I Renal Dialysis										17
	0ther										19
							From		То		
00	Cost Reporting Period (mm/dd/yyyy)						1.00		2.0		20
	Type of Control (see instructions)						01/01/.	2014 2	12/31/	2014	20
	Inpatient PPS Information										1
00	Does this facility qualify and is it								N		22
	share hospital adjustment, in accord for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, en				00(0)(						
D1	Did this hospital receive interim un						Y		Y		22
	period? Enter in column 1, "Y" for y reporting period occurring prior to										
	for no for the portion of the cost r										
	(see instructions)		-								
	Is this a newly merged hospital that determined at cost report settlement						e N		N		22
	or "N" for no, for the portion of th						3				
	in column 2, "Y" for yes or "N" for	no, for the portio	on of the	cost rep	orting	period o	n				
	or after October 1. Did this bespital receive a geograph	i a radiacci fi cati a	n from ur	han ta r	ural of	s a rocul	+ N		N		22
	Did this hospital receive a geograph of the OMB standards for delineating								N		22
	in column 1, "Y" for yes or "N" for	no for the portion	n of the c	ost repo	rting p	period					
	prior to October 1. Enter in column						e				
	cost reporting period occurring on o hospital contain at least 100 but no						h				
	42 CFR 412.105)? Enter in column 3,	"Y" for yes or "N"	for no.								
	Which method is used to determine Me							3	N		23.
	1, enter 1 if date of admission, 2 i method of identifying the days in th	is cost reporting	period di	fferent	from th	he method					
	used in the prior cost reporting per	<u>iod? In column 2,</u>	enter "Y	" for ye	s or "I	<u>N" for no</u>					
			In-State Medicaid	In-Sta Medica		ut-of State		Medica HMO da		ther li cai d	
			paid days	eligib			Medicaid	nino ua	-	lays	
		· · · · · · · · · · · · · · · · · · ·		unpai	d pai		eligible			-	
			1.00	days		2 00	unpai d	F 00		. 00	-
0	If this provider is an IPPS hospital	enter the	<u>1.00</u> 4,017	2.00	524	3.00	4.00	<u>5.00</u> 3.	620	<u>. 00</u> 0	24
	in-state Medicaid paid days in colum		+, UT/	''	~~ [	502		З,	520	0	24
	Medicaid eligible unpaid days in col	umn 2,									
	out-of-state Medicaid paid days in c										
	out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu										
	column 5, and other Medicaid days in	column 6.									
	If this provider is an IRF, enter th	e in-state	125		201	0	0		33		25
	Medicaid paid days in column 1, the										
	Modicaid oligible uppedd dave in!					1			1		1
	Medicaid eligible unpaid days in col out-of-state Medicaid days in column										
	Medicaid eligible unpaid days in col out-of-state Medicaid days in column Medicaid eligible unpaid days in col HMO paid and eligible but unpaid day	3, out-of-state umn 4, Medicaid									

Heal th	Financial Systems ELKH/	ART GENER	AL HOSPITAL		1	n Lieu	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION	DATA	Provi der	F	eriod: rom 01/01/ o 12/31/		Workshe Part I Date/Ti 5/28/20	me Pre	pared:
					Urban/Rur 1.00		Date of 2.0	U	
26.00	Enter your standard geographic classification (not	wage) sta	atus at the beg	ginning of the	1.00	1	2.0		26.00
27.00	cost reporting period. Enter "1" for urban or "2" f Enter your standard geographic classification (not reporting period. Enter in column 1, "1" for urban	wage) sta or "2" fo	atus at the end or rural. If ap			1			27.00
35.00	enter the effective date of the geographic reclassi If this is a sole community hospital (SCH), enter 1 effect in the cost reporting period.			CH status in		0			35.00
					Begi nni 1. 00	<u> </u>	Endi 2. (		
36.00	Enter applicable beginning and ending dates of SCH		Subscript line	36 for number	1.00		2.0		36.00
37.00	of periods in excess of one and enter subsequent da If this is a Medicare dependent hospital (MDH), ent in effect in the cost reporting period.		umber of period	ds MDH status		0			37.00
38.00	Enter applicable beginning and ending dates of MDH		Subscript line	38 for number					38.00
	of periods in excess of one and enter subsequent da	1105.			Y/N		Y/		
39.00	Does this facility qualify for the inpatient hospit	tal paymer	nt adjustment f	for low volume	1.00 N		2.0 N		39.00
	hospitals in accordance with 42 CFR §412.101(b)(2)( or "N" for no. Does the facility meet the mileage r CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for ye	(ii)? Ente requirementes or "N"	er in column 1 nts in accordar for no. (see i	"Y" for yes nce with 42 nstructions)					
40.00	Is this hospital subject to the HAC program reducti "N" for no in column 1, for discharges prior to Oct no in column 2, for discharges on or after October	tober 1. I	Enter "Y" for y		N		N		40.00
						V 1.00	XVIII ) 2.00	XI X 3.00	
	Prospective Payment System (PPS)-Capital								
	Does this facility qualify and receive Capital paym with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment ex					N N	Y N	N	45.00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wk Pt. III.	kst. L, P∙	t. III and Wkst	t. L-1, Pt. I	through				
	Is this a new hospital under 42 CFR §412.300 PPS ca Is the facility electing full federal capital payme Teaching Hospitals					N N	N N	N N	47.00 48.00
56.00	Is this a hospital involved in training residents i	n approve	ed GME programs	s? Enter "Y"	for yes	N			56.00
	or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" f is "Y" did residents start training in the first m for yes or "N" for no in column 2. If column 2 is	for yes ou onth of th "Y", comp	r "N" for no ir his cost report plete Worksheet	n column 1. If ting period?	column 1 Enter "Y"				57.00
58.00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. If line 56 is yes, did this facility elect cost rei defined in CMS Pub. 15-1, § 2148? If yes, complete	mbursemen	nt for physicia	ans' services a	as				58.00
	Are costs claimed on line 100 of Worksheet A? If y	/es, compl	lete Wkst. D-2,			N			59.00
	Are you claiming nursing school and/or allied healt provider-operated criteria under §413.85? Enter "\					Y			60.00
	· · · · · · · · · · · · · · · · · · ·	Y/N	IME	Direct GME	IME		Di rect	GME	
		1.00	2.00	3.00	4.00	)	5.0	00	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)	N				0.00		0.00	61.00
61. 01	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		0.00	0.0	þ				61.01
61. 02	instructions) Enter the current year total unweighted primary car FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of	re	0.00	0.0	þ				61. 02
61. 03	ACA). (see instructions) 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	-	0.00	0.0	D				61.03
61.04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	D				61.04
61.05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (lin	ne	0.00	0.0	D				61.05
61.06	61.04 minus line 61.03). (see instructions) 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)		0.00	0.0	C				61.06

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DA		FI To		5/28/2015 1:0	pared:
		Program Name	Program Code		Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
<ol> <li>1.10 Of the FTEs in line 61.05, specialty, if any, and the number for each new program. (see instruction column 1, the program name, enter program code, enter in column 3, tunweighted count and enter in colum FTE unweighted count.</li> <li>1.20 Of the FTEs in line 61.05, specify program specialty, if any, and the residents for each expanded program instructions) Enter in column 1, tenter in column 2, the program code 3, the IME FTE unweighted count and 4, direct GME FTE unweighted count</li> </ol>	of FTE residents tions) Enter in in column 2, the he IME FTE mn 4, direct GME reach expanded number of FTE m. (see he program name, e, enter in column d enter in column			0.00		61. 10
	h Deserves 1.0				1.00	
ACA Provisions Affecting the Healt 2.00 Enter the number of FTE residents				od for which	0.00	62.00
your hospital received HRSA PCRE f	unding (see instruc	ti ons)				
2.01 Enter the number of FTE residents during in this cost reporting peri Teaching Hospitals that Claim Resi	od of HRSA THC prog	ram. (see instruction		your hospital	0.00	62.0
8.00 Has your facility trained resident "Y" for yes or "N" for no in colum	s in nonprovider se	ettings during this c	instructions)		N	63.0
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Base Year			This base year	is your cost r	eporting	
period that begins on or after Jul 00 Enter in column 1, if line 63 is y in the base year period, the number resident FTEs attributable to rota settings. Enter in column 2 the n resident FTEs that trained in your of (column 1 divided by (column 1	es, or your facilit r of unweighted non tions occurring in umber of unweighted hospital. Enter in + column 2)). (see	y trained residents -primary care all nonprovider I non-primary care column 3 the ratio instructions)	0.00			64. 0
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te		Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	
6.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3			0.00	0.00	0. 000000	03.0

Heal th	Financial Systems	ELKHAR <sup>-</sup>	T GENERAL HO	SPI TAL		I	n Lieu	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPI	LEX IDENTIFICATION DA	TA	Provi der	1	Period: From 01/01, To 12/31,		Workshe Part I Date/Ti 5/28/20	me Pre	pared:
					Unweighted FTEs Nonprovider Site 1.00	Unwei gh FTEs i Hospi t 2.00	n al	Ratio (c (col. 1 2)) 3.0	:ol. 1/ + col. )	2 pm
	Section 5504 of the ACA Current		n Nonprovide	er Setting						
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations o Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3 column 2)). (see ins	rovider sett ry care resi 3 the ratio	i ngs. dent	O. C		0. 00			66. 00
		Program Name	Progran	n Code	Unwei ghted FTEs Nonprovi der Si te	Unwei gh FTEs i Hospi t	n	Ratio (c (col. 3 (4))	+ col.	
		1.00	2.0	00	3.00	4.00		5.0		
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0. C	10	0.00	0.	000000	67.00
							1.00	2.00	3.00	
	Inpatient Psychiatric Facility P									70.00
	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th						N N	N	0	70. 00 71. 00
	recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 3: If column 2 is Y, ente reporting period covers the begi or subsequent academic years of instructions) For cost reporting reporting period covers the begi teaching program in existence, e Inpatient Rehabilitation Facilit	lumn 2: Did this faci R 412.424 (d)(1)(iii) r 1, 2, or 3, in colu nning of the fourth y the new teaching prog periods beginning or nning of the sixth or nter 6 in column 3. ( y PPS	lity train (D)? Enter Jumn 3. (see year, enter gram in exis n or after 0 c any subseq (see instruct	residents "Y" for ye instructic 4 in colum tence, ent ctober 1, uent acade tions)	in a new teac es or "N" for ons) If this c nn 3, or if th ter 5. (see 2012, if this emic year of t	ching no. cost ne fifth s cost				
75.00	ls this facility an Inpatient Re subprovider? Enter "Y" for yes		/(IRF), or	does it co	ontain an IRF		Y			75.00
76.00	If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente 1, 2, or 3, in column 3. (see in of the fourth year, enter 4 in c teaching program in existence, e on or after October 1, 2012, if any subsequent academic year of instructions)	e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N" structions) If this c olumn 3, or if the fi nter 5. (see instruct this cost reporting	ember 15, 20 new teachin for no. Col cost reporti fth or subs tions) For c period cover	04? Enter g program umn 3: If ng period equent aca ost report s the begi	"Y" for yes of in accordance column 2 is Y covers the be ademic years of ting periods b nning of the	or "N" for e with 42 7, enter eginning of the new beginning sixth or	N	N	0	76.00
							-	1.0	0	
80.00	Long Term Care Hospital PPS Is this a long term care hospita	L (LTCH)? Enter "V"	for ves and	"N" for r	10			N		80.00
	Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers					) period? E	nter	N		80.00
	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (	excluded un				no.	N		85. 00 86. 00

Health Financial Systems ELKHART GENER	AL HOSPITAL		١n	Lieu of	Form	CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		eriod: rom 01/01/2 o 12/31/2	014 Par 014 Dat	rksheet rt I te/Time	e Prep	
			V	372	2 <u>8/2015</u> XI X	) 1.02	<u>z pili</u>
			1.00		2.00		
70.00 Does this facility have title V and/or XIX inpatient hospita	al services? E	nter "Y" for	N		Y		90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the applicable.			N		Y		91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica	ual certificat				Ν		92.00
93.00 Does this facility operate an ICF/MR facility for purposes of "Y" for yes or "N" for no in the applicable column.	of title V and	XIX? Enter	N		Ν		93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.			N		N		94.00
<ul> <li>95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.</li> </ul>			N N	0. 00	N	0.00	95. 00 96. 00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	plicable colum	n	(	0. 00		0.00	97.00
105.00 Does this hospital qualify as a Critical Access Hospital (C/ $106.00$ of this facility qualifies as a CAH, has it elected the all-		hod of payment	N				105. 00 106. 00
for outpatient services? (see instructions) 107.00 Column 1: If this facility qualifies as a CAH, is it eligib for I &R training programs? Enter "Y" for yes or "N" for no							107. 00
instructions) If yes, the GME elimination would not be on Wi the program would be cost reimbursed. If yes complete Wkst.	kst. B, Pt. I,	col. 25 and					
this facility is a CAH, do I&Rs in an approved medical educa CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or '	ation program	train in the					
instructions) 108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42	N				108. 00
CIR Section 3412. HS(C). Litter i for yes of in for ho.	Physi cal 1.00	Occupational 2.00	Speech 3.00	Re	espirat 4.00	ory	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.							109.00
for yes of in for he for each therapy.	<u> </u>	1	1		1.00		
110.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (410	)A Demo)for		N		110. 00
				1.00 2	2.00 3	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes on	r "N" for no i	n column 1. lf	column 1	N		0	115.00
is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals providen Pub. 15-1, §2208.1.	nt for long te	rm care (includ	les				
116.00[Is this facility classified as a referral center? Enter "Y" 117.00[Is this facility legally-required to carry malpractice insu			'N" for	N Y			116. 00 117. 00
no. 118.00 Is the malpractice insurance a claims-made or occurrence pol				1			118. 00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses		nsuran	се	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	035	3.00	0	118.01
		0,0,00					110101
118.02 Are malpractice premiums and paid losses reported in a cost	center other	than the	1.00 N		2.00		118. 02
Administrative and General? If yes, submit supporting scher and amounts contained therein.							110.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold	d Harmloss pro	vicion in ACA	N		N		119. 00 120. 00
\$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu	n column 1, "Y	" for yes or			IN		120.00
Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	nts? (see inst	ructions)					
121.00 Did this facility incur and report costs for high cost impla patients? Enter "V" for yes or "N" for no.	antable device	s charged to	Y				121. 00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	or yes and "N"	for no. If	N				125. 00
126.00 If this is a Medicare certified kidney transplant center, en		fication date					126. 00
in column 1 and termination date, if applicable, in column 2 127.00 If this is a Medicare certified heart transplant center, en in column 1 and termination date, if applicable, in column 2	ter the certif	ication date					127. 00

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	NERAL HOSPITAL Provider (	CCN: 150018	Peri od:		Worksheet S-	-2
				1/01/2014 2/31/2014	Part I Date/Time Pr	renared
				2/01/2011	5/28/2015 1:	
				1.00	2.00	-
8.00 If this is a Medicare certified liver transplant center,		cation date				128. 0
in column 1 and termination date, if applicable, in colum 9.00 If this is a Medicare certified lung transplant center, e		ation date	in			129.0
column 1 and termination date, if applicable, in column 2	2.					
0.00 If this is a Medicare certified pancreas transplant center date in column 1 and termination date, if applicable, in		i fi cati on				130. 0
1.00 If this is a Medicare certified intestinal transplant cer	nter, enter the ce	rtification				131.0
date in column 1 and termination date, if applicable, in 2.00 If this is a Medicare certified islet transplant center,		cation date				132.0
in column 1 and termination date, if applicable, in colum						152.0
3.00 If this is a Medicare certified other transplant center, in column 1 and termination date, if applicable, in colum		cation date				133. 0
4.00 If this is an organ procurement organization (0P0), enter		n column 1				134.0
and termination date, if applicable, in column 2. All Providers						_
0.00 Are there any related organization or home office costs a	as defined in CMS	Pub. 15-1,		Y	15H013	
chapter 10? Enter "Y" for yes or "N" for no in column 1.			s			
are claimed, enter in column 2 the home office chain numb	2.00	rons)		3.00		
If this facility is part of a chain organization, enter of			name and	d address	of the	
home office and enter the home office contractor name and 1.00 Name: BEACON HEALTH SYSTEM Contractor's Name:			tor's Nu	mber: 0800	1	141.0
	SERVI CES					
2. 00     Street: 615 N MICHIGAN ST     PO Box:       3. 00     City: SOUTH BEND     State:	IN	Zip Cod	<u>و</u> .	4660	1	142.0 143.0
		210 000	0.	1000		110.0
4 00 Are provider based physicians' costs included in Warksho	at 10				1.00	144.0
4.00 Are provider based physicians' costs included in Workshee 5.00 If costs for renal services are claimed on Worksheet A, I		osts for in	patient	servi ces	Y N	144. 0 145. 0
only? Enter "Y" for yes or "N" for no.						
				1.00	2.00	-
6.00 Has the cost allocation methodology changed from the prev	viously filed cost	report?		1.00 N	2.00	146. 0
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub			r		2.00	146. 0
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub the approval date (mm/dd/yyyy) in column 2.	p. 15−2, § 4020) I	f yes, ente	r		2.00	
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub the approval date (mm/dd/yyyy) in column 2. 7.00Was there a change in the statistical basis? Enter "Y" fo 8.00Was there a change in the order of allocation? Enter "Y"	o. 15-2, § 4020)   or yes or "N" for for yes or "N" fo	fyes, ente no. rno.		N N N	2.00	147. 0 148. 0
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Health Financial Systems	ELKHART GENERAL HO	OSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	ICATION DATA	Provider CCN: 150018	Period: From 01/01/2014	Worksheet S-2	2
				Date/Time Pre	pared:
				5/28/2015 1:0	<u>2 pm</u>
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	date and ending date	for the reporting	01/01/2014	12/31/2014	170.00
				1.00	
171.00 If line 167 is "Y", does this provider have				N	171.00
Medicare cost plans reported on Wkst. S-3, (see instructions)	Pt. I, line 2, col. 6	5? Enter "Y" for yes ar	nd "N" for no.		

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE		F	eriod: rom 01/01/2014		
			1	o 12/31/2014	Date/Time Pro 5/28/2015 1:0	
				Y/N	Date	
	General Instruction: Enter Y for all YES resp	oonses Enter N for all NO re	snonses Enter	1.00	2.00	-
	mm/dd/yyyy format.	bolises. Enter in for all no re	sponses. Enter	an dates m	the	
	COMPLETED BY ALL HOSPITALS					_
00	Provider Organization and Operation Has the provider changed ownership immediatel	Ly prior to the beginning of	the cost	N		1.
50	reporting period? If yes, enter the date of			iv.		1.
			Y/N	Date	V/I	
00	Has the provider terminated participation in	the Medicare Program? If	1.00 N	2.00	3.00	2.
0	yes, enter in column 2 the date of terminated		IN IN			2.
	voluntary or "I" for involuntary.					
00	Is the provider involved in business transact contracts, with individuals or entities (e.g.		N			3.
	or medical supply companies) that are related					
	officers, medical staff, management personnel	I, or members of the board				
	of directors through ownership, control, or t	family and other similar				
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for		Y	A		4.
	or "R" for Reviewed. Submit complete copy or					
	column 3. (see instructions) If no, see instr	ructions.				
00	Are the cost report total expenses and total		Y			5.
	those on the filed financial statements? If y	yes, submit reconciliation.		Y/N	Legal Oper.	
				1.00	2.00	
	Approved Educational Activities				1	
0	Column 1: Are costs claimed for nursing schoot the legal operator of the program?	ool?Column 2: If yes, is th	ne provider is	N		6
0	Are costs claimed for Allied Health Programs	? If "Y" see instructions.		Y		7
00	Were nursing school and/or allied health prog		during the	N		8
	cost reporting period? If yes, see instruction					
	Are costs claimed for Intern-Resident program	ms claimed on the current cos	ST REDORT? IT	N		9
0	ves see instructions					
00	yes, see instructions. Was an Intern-Resident program been initiated		·	N		
00	Was an Intern-Resident program been initiated period? If yes, see instructions.	d or renewed in the current c	cost reporting			10.
00	Was an Intern-Resident program been initiated period? If yes, see instructions. Are GME cost directly assigned to cost center	d or renewed in the current c rs other than I & R in an App	cost reporting	N N		10.
00	Was an Intern-Resident program been initiated period? If yes, see instructions.	d or renewed in the current c rs other than I & R in an App	cost reporting		Y/N	10.
00	Was an Intern-Resident program been initiated period? If yes, see instructions. Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see	d or renewed in the current c rs other than I & R in an App	cost reporting		Y/N 1.00	10.
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00 00	Was an Intern-Resident program been initiated period? If yes, see instructions. Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see	d or renewed in the current c rs other than I & R in an App instructions. d debts? If yes, see instruct	cost reporting proved	N		10.
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	Was an Intern-Resident program been initiated period? If yes, see instructions. Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments	d or renewed in the current or rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	cost reporting proved ions. during this cos yes, see instr yes, see instr Par Y/N 1.00	N t reporting ructions. t A Date 2.00	1.00 Y N N Part B Y/N 3.00	10. 11. 12. 13. 14. 15. 16. 17.
	Was an Intern-Resident program been initiated period? If yes, see instructions.         Are GME cost directly assigned to cost center         Teaching Program on Worksheet A? If yes, see         Bad Debts         Is the provider seeking reimbursement for bad         If line 12 is yes, did the provider's bad del         period? If yes, submit copy.         If line 12 is yes, were patient deductibles a         Bed Complement         Did total beds available change from the priod         PS&R Data         Was the cost report prepared using the PS&R         Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R         Report used in columns 2 and 4 . (see instructions)         Was the cost report prepared using the PS&R         Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4 . (see instructions)         If a the paid of the paid through date in columns 2 and 4 . (see instructions)         If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional	d or renewed in the current or rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	cost reporting proved ions. during this cos yes, see instr yes, see instr Par Y/N 1.00 N	N t reporting ructions. t A Date 2.00	1.00 Y N N Part B Y/N 3.00 N	10. 11. 12. 13. 14. 15. 16. 17.
	Was an Intern-Resident program been initiated period? If yes, see instructions. Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad def period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not	d or renewed in the current or rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	cost reporting proved ions. during this cos yes, see instr yes, see instr Par Y/N 1.00 N	N t reporting ructions. t A Date 2.00	1.00 Y N N Part B Y/N 3.00 N	10. 11. 12. 13. 14. 15. 16. 17.
00 00 00 00	Was an Intern-Resident program been initiated period? If yes, see instructions. Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad def period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file	d or renewed in the current or rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	cost reporting proved ions. during this cos yes, see instr yes, see instr Par Y/N 1.00 N	N t reporting ructions. t A Date 2.00	1.00 Y N N Part B Y/N 3.00 N	10. 11. 12. 13. 14. 15. 16. 17.
	Was an Intern-Resident program been initiated period? If yes, see instructions. Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report 2 here adjustments	d or renewed in the current or rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	cost reporting proved ions. during this cos yes, see instr yes, see instr Par Y/N 1.00 N	N t reporting ructions. t A Date 2.00	1.00 Y N N Part B Y/N 3.00 N	10. 11. 12. 13. 14. 15. 16. 17. 18.
	Was an Intern-Resident program been initiated period? If yes, see instructions. Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of	d or renewed in the current or rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	cost reporting proved ions. during this cos yes, see instr yes, see instr yes, see instr Par Y/N 1.00 N	N t reporting ructions. t A Date 2.00	1.00 Y N N Part B Y/N 3.00 N Y N	10. 11. 12. 13. 14. 15. 16. 17. 18.
	Was an Intern-Resident program been initiated period? If yes, see instructions. Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad def period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the priod PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4. (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report data for corrections of other PS&R Report information? If yes, see	d or renewed in the current or rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	cost reporting proved ions. during this cos yes, see instr yes, see instr yes, see instr Par Y/N 1.00 N	N t reporting ructions. t A Date 2.00	1.00 Y N N Part B Y/N 3.00 N Y N	10. 11. 12. 13. 14. 15. 16. 17. 18.
	Was an Intern-Resident program been initiated period? If yes, see instructions. Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of	d or renewed in the current or rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	cost reporting proved ions. during this cos yes, see instr yes, see instr yes, see instr Par Y/N 1.00 N	N t reporting ructions. t A Date 2.00	1.00 Y N N Part B Y/N 3.00 N Y N	10. 11. 12. 13. 14. 15. 16. 17. 18. 19.

Heal th	Financial Systems	ELKHART GENERA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der		Period: From 01/01/2014	Worksheet S-2 Part II	
					To 12/31/2014	Date/Time Pre	
				Day	rt A	5/28/2015 1:0 Part B	2 pm
		Descrip	otion	Y/N	Date	Y/N	
		0		1.00	2.00	3.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		Ν	21.00
				•			
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT Capital Related Cost	ALS ONLY (EXCEP	PI CHILDRENS H	IOSPITALS)			
22.00	Have assets been relifed for Medicare purpose	es? If yes, see	instructions			N	22.00
	Have changes occurred in the Medicare depreci			als made durir	ng the cost	Ν	23.00
24.00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing	Lossos optoros	d into during	this cost room	rting pariod?	Ν	24.00
24.00	If yes, see instructions	g reases entered		this cost rept	in thing period?	IN	24.00
25.00	Have there been new capitalized leases entere instructions.	ed into during t	the cost repor	ting period? I	f yes, see	Ν	25.00
26.00	Were assets subject to Sec.2314 of DEFRA acqu instructions.	uired during the	e cost reporti	ng period? If	yes, see	Ν	26.00
27.00	Has the provider's capitalization policy char copy.	nged during the	cost reportir	ng period?lfy	ves, submit	Ν	27.00
	Interest Expense						
28.00	Were new loans, mortgage agreements or letter period? If yes, see instructions.	rs of credit ent	tered into dur	ing the cost r	eporting	Ν	28.00
29.00	Did the provider have a funded depreciation a			ebt Service Res	erve Fund)	Ν	29.00
30.00	treated as a funded depreciation account? If Has existing debt been replaced prior to its			debt? If yes,	see	Ν	30.00
	instructions.		, ,				
31.00	Has debt been recalled before scheduled matur instructions.	rity without iss	suance of new	debt? If yes,	see	Ν	31.00
	Purchased Services				· .		
32.00	Have changes or new agreements occurred in pa arrangements with suppliers of services? If y			ed through cont	ractual	Ν	32.00
33.00	If line 32 is yes, were the requirements of S no, see instructions.			ng to competiti	ve bidding? If		33.00
	Provi der-Based Physi ci ans				1		
34.00	Are services furnished at the provider facili If yes, see instructions.	ty under an arr	rangement with	n provi der-base	ed physi ci ans?	Y	34.00
35.00	If line 34 is yes, were there new agreements	or amended exis	sting agreemer	nts with the pr	ovi der-based	Y	35.00
	physicians during the cost reporting period?						
					Y/N 1.00	Date	
	Home Office Costs				1.00	2.00	
36.00	Were home office costs claimed on the cost re	eport?			Y		36.00
37.00	If line 36 is yes, has a home office cost sta If yes, see instructions.	atement been pre	epared by the	home office?	Y		37.00
38.00	If line 36 is yes, was the fiscal year end of the provider? If yes, enter in column 2 the f				Ν		38.00
39.00	If line 36 is yes, did the provider render se see instructions.				Ν		39.00
40.00	If line 36 is yes, did the provider render se instructions.	ervices to the h	nome office?	lf yes, see	Ν		40.00
	Γ		1.	00	2.	00	
41 00	Cost Report Preparer Contact Information	(nacition C					41 00
41.00	Enter the first name, last name and the title held by the cost report preparer in columns ?		SALLY		BRUBAKER		41.00
42.00	respectively. Enter the employer/company name of the cost r	report E	ELKHART GENERA	L HOSPI TAL			42.00
43.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv		574-647-3842		SBRUBAKER@BEACO . ORG	ONHEALTHSYSTEM	43.00
					r	I	

	Financial Systems	ELKHART GENERA				u of Form CMS	
HOSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STIONNALRE	Provi dei	r CCN: 150018	Period: From 01/01/2014 To 12/31/2014	Worksheet S- Part II Date/Time Pr 5/28/2015 1:	repared
		Part B					
		Date					
		4.00					
	PS&R Data						
16. 00	Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see						16.0
17.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is	04/07/2015					17.0
18.00	yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not						18.
9. 00	included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see						19.
20. 00	instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20.
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.						21.
		_	2	3. 00			
	Cost Report Preparer Contact Information		3				-
	Enter the first name, last name and the title held by the cost report preparer in columns ? respectively.		EI MBURSEMENT	ANALYST			41.
42.00	Enter the employer/company name of the cost r	report					42.
43.00	preparer. Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						43.

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Pi	rovi der	CCN: 150018	Pe	eri od:	Worksheet S-3	
1100111	ALL AND HOST THE HEALTH GARE COMPLEX STATISTIC			ovruci	0011. 100010		om 01/01/2014	Part I	
						То	12/31/2014	Date/Time Prep 5/28/2015 1:02	
						<u> </u>		I/P Days / 0/P	2 0111
								Visits / Trips	
	Component	Worksheet A	No. o <sup>.</sup>	f Beds	Bed Days		CAH Hours	Title V	
		Line Number			Avai I abl e				
		1.00		00	3.00		4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		218	76, 84	40	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and								
	Hospice days) (see instructions for col. 2								
2.00	for the portion of LDP room available beds)								2.00
2.00	HMO and other (see instructions) HMO IPF Subprovider								3.00
3.00 4.00	HMO IRF Subprovider								4.00
4.00 5.00	Hospital Adults & Peds. Swing Bed SNF							0	5.00
6.00	Hospital Adults & Peds. Swing Bed SM Hospital Adults & Peds. Swing Bed NF							0	6.00
7.00	Total Adults and Peds. (exclude observation			218	76, 8	10	0.00	0	7.00
7.00	beds) (see instructions)			210	70, 8	40	0.00	0	7.00
8.00	INTENSI VE CARE UNI T	31.00		23	8, 3	95	0.00	0	8.00
8.01	NEONATAL INTENSIVE CARE	31.01			2, 9		0,00	0	8.01
9.00	CORONARY CARE UNIT	01.01		0	2, 7.	20	0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT								10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T								11.00
12.00	OTHER SPECIAL CARE (SPECIFY)								12.00
13.00	NURSERY	43.00						0	13.00
14.00	Total (see instructions)			249	88, 1	55	0.00	0	14.00
15.00	CAH visits							0	15.00
16.00	SUBPROVIDER - IPF	40.00		0		0		0	16.00
17.00	SUBPROVIDER - IRF	41.00		20	7,30	00		0	17.00
18.00	SUBPROVI DER								18.00
19.00	SKILLED NURSING FACILITY	44.00		0		0		0	19.00
20.00	NURSING FACILITY	45.00		0		0		0	20.00
21.00	OTHER LONG TERM CARE	46.00		0		0			21.00
22.00	HOME HEALTH AGENCY	101.00						0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115.00							23.00
24.00	HOSPI CE	116.00		0		0			24.00
24.10	HOSPICE (non-distinct part)	30. 00							24.10
25.00	CMHC - CMHC								25.00
26.00	RURAL HEALTH CLINIC								26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER								26.25
27.00	Total (sum of lines 14-26)			269					27.00
28.00	Observation Bed Days							0	28.00
29.00	Ambul ance Trips								29.00
30.00 31.00	Employee discount days (see instruction) Employee discount days - IRF								30.00 31.00
				0		~			
32.00	Labor & delivery days (see instructions) Total ancillary labor & delivery room			0		0			32.00
32. 01	outpatient days (see instructions)								32.01
33.00	LTCH non-covered days								33.00

IOSPI 1	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der	F	Period: From 01/01/2014 Fo 12/31/2014		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)	18, 400	3, 955	40, 423	3		1.00
2.00	HMO and other (see instructions)	6, 326	5, 275				2.00
. 00	HMO IPF Subprovider	0	0				3.00
. 00	HMO IRF Subprovider	0	234				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	o	0	C	)		5.00
. 00	Hospital Adults & Peds. Swing Bed NF	-	0	0	)		6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	18, 400	3, 955	40, 423	3		7.00
8.00	INTENSIVE CARE UNIT	2, 107	0	4, 894	ļ		8.00
8. 01	NEONATAL INTENSIVE CARE	0	0	867	7		8.01
0. 00	CORONARY CARE UNIT						9.00
0.00	BURN INTENSIVE CARE UNIT						10.00
1.00	SURGICAL INTENSIVE CARE UNIT						11.00
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY		0	3, 040	)		13.00
4.00	Total (see instructions)	20, 507	3, 955	49, 224	0.00	1, 397. 40	14.00
5.00	CAH visits	0	0	C	)		15.00
6.00	SUBPROVIDER - IPF	0	0	C	0.00	0.00	16.00
7.00	SUBPROVIDER - IRF	1,006	125	2, 449	0.00	15.50	17.0
8.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY	0	0	C	0.00	0.00	19.0
0.00	NURSING FACILITY		0	C	0.00	0.00	20.00
1.00	OTHER LONG TERM CARE			C	0.00	0.00	21.00
2.00	HOME HEALTH AGENCY	0	0	C	0.00	0.00	22.00
3.00	AMBULATORY SURGICAL CENTER (D. P. )				0.00	0.00	23.0
4.00	HOSPI CE	0	0	C	0.00	0.00	24.0
4. 10	HOSPICE (non-distinct part)	0	0	C	)		24.1
5.00	CMHC - CMHC						25. C
6. 00	RURAL HEALTH CLINIC						26. C
6. 25	FEDERALLY QUALIFIED HEALTH CENTER						26.2
7.00	Total (sum of lines 14-26)				0.00	1, 412. 90	27.0
8.00	Observation Bed Days		0	6, 606	5		28.0
9.00	Ambul ance Trips	0					29.0
0. 00	Employee discount days (see instruction)			475	5		30.0
1.00	Employee discount days - IRF			28			31.0
2.00	Labor & delivery days (see instructions)	0	233	428	3		32.0
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)			C			32. 0
3.00	LTCH non-covered days	0					33. C

					From 01/01/2014	Part I	
					To 12/31/2014	Date/Time Pre 5/28/2015 1:0	
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2		0		25 850	11, 495	1.00
2.00	for the portion of LDP room available beds) HMO and other (see instructions)			1, 3	23 1, 207		2.00
3.00 4.00	HMO I PF Subprovi der HMO I RF Subprovi der						3.00 4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
5.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						6. 00 7. 00
3.00	INTENSIVE CARE UNIT						8.00
3. 01	NEONATAL INTENSIVE CARE						8. Oʻ
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						10.0
12.00	OTHER SPECIAL CARE (SPECIFY)						11.00 12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	0, 00	0	4, 5	25 850	11, 495	14.00
15.00	CAH visits						15.00
16.00	SUBPROVIDER - IPF	0.00	0		0 0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0		85 11	204	17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0. 00 0. 00				0	20.00
21.00 22.00	OTHER LONG TERM CARE HOME HEALTH AGENCY	0.00				0	21.00
23.00	AMBULATORY SURGICAL CENTER (D. P. )	0.00					22.0
24.00	HOSPICE	0,00					24.0
24.10	HOSPICE (non-distinct part)						24.1
25.00	CMHC - CMHC						25.0
26.00	RURAL HEALTH CLINIC						26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26.2
27.00	Total (sum of lines 14-26)	0.00					27.0
28.00	Observation Bed Days						28.0
29.00	Ambul ance Trips						29.0
30.00	Employee discount days (see instruction)						30.0
31.00	Employee discount days - IRF						31.0
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days						32. 0 <sup>2</sup> 33. 00

)SPI T	AL WAGE INDEX INFORMATION			Provi der	F	Period: From 01/01/2014 Fo 12/31/2014	Worksheet S-3 Part II Date/Time Prep 5/28/2015 1:02	pared:
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	(col.2 ± col.		Average Hourly Wage (col. 4 ÷ col. 5)	2 piii
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							
00	Total salaries (see	200.00	77, 265, 794	0	77, 265, 794	2, 938, 867.00	26. 29	1.00
00	instructions) Non-physician anesthetist Part		C	0	C	0.00	0.00	2.00
00	A Non-physician anesthetist Part		C	0	C	0.00	0.00	3.00
00	B Physician-Part A -		C	0	C	0.00	0.00	4.00
01	Administrative Physicians - Part A - Teaching		C	0	0	0.00	0.00	4.01
00	Physician-Part B		C	Ő	C C	0.00		•
00	Non-physician-Part B		C	0	C	0.00		6.00
00	Interns & residents (in an	21.00	C	0	C	0.00	0.00	7.00
01	approved program) Contracted interns and		C	0	C	0.00	0.00	7.01
	residents (in an approved programs)							
00 00	Home office personnel SNF	44.00	8, 622, 967	0	8, 622, 967	163, 515. 00 0. 00		
00	Excluded area salaries (see	44.00	2, 365, 318	44, 446	2, 409, 764			
	instructions) OTHER WAGES & RELATED COSTS		2,000,010		2, 107, 101	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	20.02	10.00
. 00	Contract Labor: Direct Patient		514, 864	0	514, 864	8, 680. 00	59. 32	11.00
2. 00	Care Contract Labor: Top Level		C	0	С	0.00	0.00	12.00
	management and other management and administrative							
8. 00	services Contract Labor: Physician-Part A - Administrative		560, 617	0	560, 617	5, 769. 00	97.18	13.00
I. 00	Home office salaries &		C	0	C	0.00	0.00	14.00
5. 00	wage-related costs Home office: Physician Part A		C	0	C	0.00	0.00	15.00
b. 00	- Administrative Home office and Contract		C	0	C	0.00	0.00	16.00
	Physicians Part A - Teaching WAGE-RELATED COSTS							
. 00	Wage-related costs (core) (see		21, 970, 024	0	21, 970, 024	Į.		17.00
3. 00	instructions) Wage-related costs (other)		C	0	C	)		18.00
9. 00	(see instructions) Excluded areas		693, 802	0	693, 802			19.00
0. 00	Non-physician anesthetist Part A		C	0	C			20.00
. 00	Non-physician anesthetist Part B		C	0	C			21.00
2.00	Physician Part A - Administrative		C	0	C			22.00
2. 01	Physician Part A - Teaching		C	0	C	)		22.01
	Physician Part B		C	0	0	)		23.00
1.00 5.00	Wage-related costs (RHC/FQHC)			0				24.00
5. 00	Interns & residents (in an approved program) OVERHEAD COSTS - DIRECT SALARIE	· c						25.00
5. 00	Employee Benefits Department	4.00	476, 632	0	476, 632	4, 203. 00	113. 40	26.00
7.00 3.00	Administrative & General Administrative & General under	5.00	5, 835, 199 273, 543	0	5, 835, 199	253, 051. 00	23.06	27.00
9. 00	contract (see inst.) Maintenance & Repairs	6.00	-, - io					
). 00	Operation of Plant	7.00	1, 549, 109		1, 549, 109			30.00
. 00	Laundry & Linen Service	8.00	860, 895		860, 895			
2.00	Housekeeping Housekeeping under contract	9.00	1, 731, 509 C		1, 731, 509 C		12. 15	32.00
	(see instructions)							
I. 00 5. 00	Dietary Dietary under contract (see	10. 00	1, 819, 088 C	-1, 081, 991 0	737, 097 C	50, 136. 00 0. 00		
00	instructions)		00	4 004 0		75 667		
	Cafeteria Maintenance of Derconnel	11.00	33, 790	1, 081, 991	1, 115, 781			
7.00 3.00	Maintenance of Personnel Nursing Administration	12.00 13.00	1, 964, 597	-443, 155	1, 521, 442	0.00 57,222.00		37.00 38.00
9.00	Central Services and Supply	14.00	575, 712		575, 712			39.00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	15.00	3, 985, 333					

Health Financial Systems		ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					rom 01/01/2014		
				-	Го 12/31/2014		
						5/28/2015 1:0	
	Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00 Medical Records & Medical Records Library	16.00	1, 786, 130	0	1, 786, 130	85, 564. 00	20. 87	41.00
42.00 Social Service	17.00	1, 384, 694	-44, 446	1, 340, 248	43, 459. 00	30. 84	42.00
43.00 Other General Service	18.00	0	0	(	0.00	0.00	43.00

Heal th	Financial Systems		ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2014	Worksheet S-3 Part III	
						To 12/31/2014	Date/Time Pre 5/28/2015 1:02	
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		68, 916, 370	0	68, 916, 37	0 2, 776, 044. 89	24.83	1.00
	instructions)							
2.00	Excluded area salaries (see		2, 365, 318	44, 446	2, 409, 76	4 96, 303.00	25.02	2.00
	instructions)							
3.00	Subtotal salaries (line 1		66, 551, 052	-44, 446	66, 506, 60	6 2, 679, 741. 89	24.82	3.00
	minus line 2)							
4.00	Subtotal other wages & related		1, 075, 481	0	1, 075, 48	1 14, 449. 00	74.43	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		21, 970, 024	0	21, 970, 02	4 0.00	33. 03	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		89, 596, 557	-44, 446	89, 552, 11	1 2, 694, 190. 89	33. 24	6.00
7.00	Total overhead cost (see		22, 276, 231	-487, 601	21, 788, 63	0 970, 095. 89	22.46	7.00
	instructions)							

Heal th	Financial Systems	ELKHART GENERAL H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI	FAL WAGE RELATED COSTS		Provider CCN:	150018	Period: From 01/01/2014 To 12/31/2014		pared:
						Amount	
						Reported	
						1.00	
	PART IV - WAGE RELATED COSTS Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					2, 027, 548	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contril	uti on				2,027,548	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see					0	3.00
4.00	Qualified Defined Benefit Plan Cost (see ins					762, 341	4.00
4.00	PLAN ADMINISTRATIVE COSTS (Paid to External					702, 341	4.00
5.00	401K/TSA Plan Administration fees	or gam zatrony				0	5.00
6.00	Legal /Accounting/Management Fees-Pension Pla	an				0	6.00
7.00	Employee Managed Care Program Administration					0	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)					11, 633, 387	8.00
9.00	Prescription Drug Plan					0	9.00
10.00	Dental, Hearing and Vision Plan					180, 847	10.00
11.00	Life Insurance (If employee is owner or bene	efi ci ary)				94, 697	11.00
12.00	Accident Insurance (If employee is owner or	benefi ci ary)				0	12.00
13.00	Disability Insurance (If employee is owner of	or beneficiary)				189, 641	13.00
14.00	Long-Term Care Insurance (If employee is own	ner or beneficiary)				0	14.00
15.00						0	15.00
16.00	Retirement Health Care Cost (Only current ye	ear, not the extraor	di nary accrual	requi re	d by FASB 106.	0	16.00
	Non cumulative portion)						
47 00	TAXES					( 150 0/1	47 00
	FICA-Employers Portion Only					6, 159, 044	
18.00	Medicare Taxes - Employers Portion Only					0	18.00
19.00	Unemployment Insurance					84, 995	
20.00	State or Federal Unemployment Taxes OTHER					0	20.00
21.00	Executive Deferred Compensation (Other Than	Retirement Cost Rep	ported on lines	1 throu	gh 4 above. (see	0	21.00
22.00	instructions)) Day Care Cost and Allowances					0	22.00
22.00	5					202, 099	
23.00		1				202,099 21,334,599	
24.00	Part B - Other than Core Related Cost					21, 334, 399	∠4.00
25 00	H. S. A. , WELLNESS, SHT TM DI S, EE BON					1, 329, 228	25 00
25.00	In S.A., WELENESS, SHI IN DIS, EL DON					1, 527, 220	20.00

Heal th	Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provi der	CCN: 150018	Peri od:	Worksheet S-3	
					From 01/01/2014		
					To 12/31/2014		
	Cont Conton Decemination				Contract Labor	5/28/2015 1:0	2 pm
	Cost Center Description				Contract Labor		
	DADT V Contract Labor and Danafit Cost				1.00	2.00	
	PART V - Contract Labor and Benefit Cost	~					-
	Hospital and Hospital-Based Component Identif						1
1.00	Total facility's contract labor and benefit of	cost			0	0	1.00
2.00	Hospi tal				0	0	2.00
3.00	Subprovider - IPF				0	0	3.00
4.00	Subprovider - IRF				0	0	4.00
5.00	Subprovider - (Other)				0	0	5.00
6.00	Swing Beds - SNF				0	0	
7.00	Swing Beds - NF				0	0	7.00
8.00	Hospital-Based SNF				0	0	8.00
9.00	Hospital-Based NF				0	0	9.00
10.00	Hospital-Based OLTC						10.00
11.00	Hospital-Based HHA				0	0	11.00
12.00	Separately Certified ASC				0	0	12.00
13.00	Hospi tal -Based Hospi ce				0	0	13.00
14.00	Hospital-Based Health Clinic RHC						14.00
15.00	Hospital-Based Health Clinic FQHC						15.00
16.00	Hospital-Based-CMHC						16.00
17.00	Renal Dialysis				0	0	17.00
18.00	Other				0	0	18.00

Heal th	Financial Systems E	LKHART GENERAL HO	OSPI TAL		In Li€	eu of Form CMS	-2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provi der	CCN: 150018	Peri od:	Worksheet S-	10
					From 01/01/2014		
					To 12/31/2014		
						5/28/2015 1:	<u>02 pm</u>
						1.00	
	Uncompensated and indigent care cost computation	n				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line	202 column 3 div	ided by li	ne 202 colum	1.8)	0. 26668	3 1.00
1.00	Medicaid (see instructions for each line)		rucu by rri	10 202 001 0	1 0)	0.20000	1.00
2.00	Net revenue from Medicaid					31, 273, 84	3 2.00
3.00	Did you receive DSH or supplemental payments fr	rom Medicaid?				N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH	for supplemental	payments	from Medicaid	17		4.00
5.00	If line 4 is "no", then enter DSH or supplement						0 5.00
6.00	Medi cai d charges	tai pagmonto riom	mour our a			103, 490, 40	
7.00	Medicaid cost (line 1 times line 6)					27, 599, 13	
8.00	Difference between net revenue and costs for Me	edicaid program (	line 7 minu	us sum of lir	nes 2 and 5 <sup>.</sup> if		0 8.00
	< zero then enter zero)	· · · · · · · · · · · · · · · · · · ·					-
	State Children's Health Insurance Program (SCHI	P) (see instructi	ions for ea	ach line)			
9.00	Net revenue from stand-alone SCHIP			,			0 9.00
10.00							0 10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)						0 11.00
12.00	Difference between net revenue and costs for st	tand-al one SCHI P	(line 11 mi	inus line 9;	if < zero then		0 12.00
	enter zero)						
	Other state or local government indigent care p	orogram (see insti	ructions fo	or each line)			
13.00	Net revenue from state or local indigent care p						0 13.00
14.00	Charges for patients covered under state or loc	cal indigent care	program (I	Not included	in lines 6 or		0 14.00
	10)						
15.00	State or local indigent care program cost (line		,				0 15.00
16.00	Difference between net revenue and costs for st	tate or local ind	igent care	program (lin	ne 15 minus line		0 16.00
	13; if < zero then enter zero)						_
17 00	Uncompensated care (see instructions for each I			· .			
17.00	Private grants, donations, or endowment income						0 17.00
18.00	Government grants, appropriations or transfers				( 6.1)		0 18.00
19.00	Total unreimbursed cost for Medicaid, SCHIP ar 8, 12 and 16)	nd state and loca	i indigent	care program	ns (sum of lines		0 19.00
				Uni nsured	Insured	Total (col. '	1
				patients	patients	+ col. 2)	
				1.00	2.00	3.00	
20.00	Total initial obligation of patients approved f	For charity care	(at full	12, 862, 8	6 2, 756, 937	15, 619, 80	3 20.00
	charges excluding non-reimbursable cost centers						
21.00	Cost of initial obligation of patients approved	for charity car	e (line 1	3, 430, 30	08 735, 228	4, 165, 53	6 21.00
	times line 20)						
22.00	Partial payment by patients approved for charit	ty care		86, 0	52 112, 064	198, 11	6 22.00
23.00	Cost of charity care (line 21 minus line 22)			3, 344, 2	56 623, 164	3, 967, 42	0 23.00
						1.00	
24.00	Does the amount in line 20 column 2 include cha			nd a length o	of stay limit	N	24.00
	imposed on patients covered by Medicaid or othe						
	If line 24 is "yes," charges for patient days			ogram's leng	th of stay limit		0 25.00
26.00						26, 463, 93	
27.00	Medicare bad debts for the entire hospital comp					390, 83	
28.00					>	26, 073, 10	
29.00	Cost of non-Medicare and non-reimbursable Medic		ense (line	1 times line	e 28)	6, 953, 25	
30.00	Cost of uncompensated care (line 23 column 3 pl					10, 920, 67	
31.00	Total unreimbursed and uncompensated care cost	(line 19 plus li	ne 30)			10, 920, 67	4  31.00

				Т	rom 01/01/2014 5 12/31/2014	Date/Time Pre 5/28/2015 1:0	
	Cost Center Description	Sal ari es	Other		Reclassificati ons (See A-6)		
				+ (01. 2)	UIIS (See A-U)	(col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	$\vdash$
	GENERAL SERVICE COST CENTERS				4.4. 005 400	44.005.400	
00 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		0	-	14, 885, 422 2, 975, 020		
00	00300 OTHER CAP REL COSTS		0	0	2, 773, 020	0	
00	00400 EMPLOYEE BENEFITS DEPARTMENT	476, 632	243, 170		0	719, 802	
00	00500 ADMINI STRATI VE & GENERAL	5, 835, 199	63, 104, 721	68, 939, 920	-17, 381, 810		
00 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0 1, 549, 109	0 8, 244, 449	0 9, 793, 558	0 -2, 303, 819	0 7, 489, 739	
00	00800 LAUNDRY & LINEN SERVICE	860, 895	2, 165, 718		-85, 373		
00	00900 HOUSEKEEPI NG	1, 731, 509	1, 482, 541		0	3, 214, 050	
. 00	01000 DI ETARY	1, 819, 088	2, 545, 506		-2, 191, 685		
. 00 . 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	33, 790	21, 038	54, 828 0	2, 191, 206 0	2, 246, 034	
. 00	01300 NURSI NG ADMI NI STRATI ON	1, 964, 597	778, 814	-	-482, 958		
. 00	01400 CENTRAL SERVICES & SUPPLY	575, 712	573, 350		-22, 345		
. 00	01500 PHARMACY	3, 985, 333	11, 259, 561		-10, 349, 634		
. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	1, 786, 130	938, 603		0	2, 724, 733	
. 00 . 00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE	1, 384, 694	927, 883	2, 312, 577 0	-44, 446	2, 268, 131 0	
. 00	02300 PARAMED ED PRGM	158, 237	277, 339	-	-1, 382	-	
	INPATIENT ROUTINE SERVICE COST CENTERS						
. 00	03000 ADULTS & PEDI ATRI CS	21, 084, 923	11, 347, 880		-3, 106, 814		
. 00 . 01	03100 I NTENSI VE CARE UNI T 03101 NEONATAL I NTENSI VE CARE	3, 738, 295 1, 025, 076	1, 655, 818		-458, 393		
. 00	04000 SUBPROVIDER - IPF	1,025,078	313, 921 0	1, 338, 997	-71, 401	1, 267, 596 0	
. 00	04100 SUBPROVIDER - IRF	934, 559	388, 813	-	33, 904	-	
. 00	04300 NURSERY	15, 424	7, 317	22, 741	2, 447, 703	2, 470, 444	4
. 00	04400 SKILLED NURSING FACILITY	0	0	-	0	0	
. 00 . 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	
. 00	ANCI LLARY SERVICE COST CENTERS	<u> </u>	0	0	0	0	- 4
. 00	05000 OPERATI NG ROOM	7, 409, 019	32, 804, 772	40, 213, 791	-21, 843, 049	18, 370, 742	5
. 00	05100 RECOVERY ROOM	0	0	0	0	0	
. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
. 00 . 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	4, 852, 832	3, 350, 496	8, 203, 328	496, 099	-	
. 01	05401 I NTERVENTI ONAL RADI OLOGY	0	0,000,170	0, 200, 020	0	0,077,127	
. 02	05402 BREAST CENTER	0	0	0	0	0	-
. 03	05403 RADI ATI ON ONCOLOGY	0	0	0	0	0	
. 00 . 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	0	0	0	5 5
. 00		0	0	0	0	-	
. 00		806, 653	425, 314	1, 231, 967	338, 304	-	
. 00	05800 MRI	373, 850	248, 997		285, 071	907, 918	
. 00	05900 CARDI AC CATHETERI ZATI ON	1, 233, 169	7,097,305		-3, 918, 193		
. 00 . 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	10, 524, 282 0		- 289, 235	10, 235, 047 0	
. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	0	0	0	
. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	1, 551, 093	1, 551, 093	0	1, 551, 093	
. 00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0	0	0	0	
. 00	06400 I NTRAVENOUS THERAPY	1,035,667	613, 654	1, 649, 321	-341, 929		
. 01 . 00	06401 HOME I NFUSI ON 06500 RESPI RATORY THERAPY	2, 085, 817	0 1, 036, 041	0 3, 121, 858	0 -18, 604	0 3, 103, 254	
. 00	06600 PHYSI CAL THERAPY	1, 471, 000	409, 745		-172		
. 00	06700 OCCUPATI ONAL THERAPY	498, 232	124, 807		-475		
. 00	06800 SPEECH PATHOLOGY	192, 112	52, 925	245, 037	0	245, 037	
. 00		0	0	0	0	0	
. 00 . 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 25, 041, 849	0 25, 041, 849	
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	3, 976, 152		
. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	10, 457, 592		
00	07400 RENAL DI ALYSI S	0	0	0	0	0	
. 00	07500 ASC (NON-DI STINCT PART)	0	0	0	0	0	
. 00	03140 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS	1, 397, 573	786, 021	2, 183, 594	106, 657	2, 290, 251	7
. 00		481, 334	208, 869	690, 203	7,040	697, 243	9
. 01	04951 SLEEP CLINIC	388, 583	125, 496		-420		
. 00	09100 EMERGENCY	4, 808, 229	3, 603, 383		-373, 808		9
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						9
. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S				0	0	9
	09500 AMBULANCE SERVICES	0	0 0		0		9

Health Financial Systems	ELKHART GENERA	L HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der	CCN: 150018	Period:	Worksheet A	
				From 01/01/2014		nored.
				To 12/31/2014	5/28/2015 1:0	
Cost Center Description	Sal ari es	Other	Total (col.	1 Recl assi fi cati		
'			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	1 1 1 0 0
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	1 10.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS		-		-	-	
113.00 11300 INTEREST EXPENSE	_	0		0 0		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0 0		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	75, 993, 272	169, 239, 642	245, 232, 91	4 -43, 926	245, 188, 988	118.00
NONREI MBURSABLE COST CENTERS			[			100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	0	U 5 005	F 00			191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	5, 995	5, 99	43, 926		192.00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0	24	0 0		
192. 02 19202 OUTPATIENT PSYCH 193. 00 19300 NONPALD WORKERS	1(( (0)	263	26			192.02
193. 00 19300 NONPALD WORKERS 193. 01 19301 COMMUNI TY	166, 683	72, 252			238, 935	
193. 01119301 COMMUNITY 194. 001079501 OTHER NONREI MBURSABLE COST CENTERS	640, 479	546, 748			1, 187, 227	1
	465, 360 77, 265, 794	2, 152, 189 172, 017, 089			2, 617, 549 249, 282, 883	
200.00   TOTAL (SUM OF LINES 118-199)	11, 205, 194	172,017,089	249, 282, 88	0	249, 282, 883	1200.00

CLASS	Financial Systems SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CCN: 1	I50018 Period: Wor From 01/01/2014	rksheet A
				To 12/31/2014 Dat	te/Time Prepared
	Cost Center Description	Adjustments	Net Expenses		28/2015 1:02 pm
		(See A-8) 6.00	For Allocation 7.00		
	GENERAL SERVICE COST CENTERS	0.00	1 7.00		
	00100 CAP REL COSTS-BLDG & FIXT	-1, 090, 317			1.
	00200 CAP REL COSTS-MVBLE EQUIP	897, 297			2.
	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT	0 -7, 977			3.
	00500 ADMINI STRATI VE & GENERAL	-18, 195, 827			5.
	00600 MAI NTENANCE & REPAI RS	0			6.
	00700 OPERATION OF PLANT	-1, 363			7.
	00800 LAUNDRY & LINEN SERVICE	-1, 951, 467			8.
	00900 HOUSEKEEPI NG 01000 DI ETARY	-1, 200 -165, 338			9. 10.
	01100 CAFETERI A	-1,000,273			11.
	01200 MAINTENANCE OF PERSONNEL	0	0		12.
	01300 NURSI NG ADMI NI STRATI ON	-22,080			13.
	01400 CENTRAL SERVICES & SUPPLY	0	1,120,717		14.
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	-170, 023			15.
	01700 SOCIAL SERVICE	-99, 283 -35, 304			17.
	01850 OTHER GENERAL SERVICE	00,001			18.
	02300 PARAMED ED PRGM	-85, 913	348, 281		23.
	INPATIENT ROUTINE SERVICE COST CENTERS	1	1		
	03000 ADULTS & PEDIATRICS	-2,007,964			30.
	03100 I NTENSI VE CARE UNI T 03101 NEONATAL I NTENSI VE CARE	-2, 783			31.
	04000 SUBPROVI DER – I PF	0			40.
	04100 SUBPROVI DER – I RF	0	1, 357, 276		41.
	04300 NURSERY	0			43.
	04400 SKILLED NURSING FACILITY	0	, united and a second sec		44.
	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0			45. 46.
	ANCI LLARY SERVICE COST CENTERS		<u>/</u>		40.
	05000 OPERATI NG ROOM	-4, 398, 625	13, 972, 117		50.
	05100 RECOVERY ROOM	0			51.
	05200 DELIVERY ROOM & LABOR ROOM	0			52.
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	-41, 229	-		53. 54.
	05400 RADI OLOGY - DI AGNOSTI C 05401 I NTERVENTI ONAL RADI OLOGY	-41, 229			54.
	05402 BREAST CENTER	0	Ő		54.
03	05403 RADIATION ONCOLOGY	0	o		54.
	05500 RADI OLOGY-THERAPEUTI C	0	0		55.
	05600 RADI OI SOTOPE 05601 ULTRASOUND	0			56. 56.
	05700 CT SCAN	-2, 850			57.
	05800 MRI	2,000			58.
00	05900 CARDI AC CATHETERI ZATI ON	-9, 176	4, 403, 105		59.
	06000 LABORATORY	0			60.
	06001 BLOOD LABORATORY	0	-		60.
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	1, 551, 093		61. 62.
	06300 BLOOD STORING, PROCESSING & TRANS.		0		63.
	06400 INTRAVENOUS THERAPY	0	1, 307, 392		64.
	06401 HOME INFUSION	0	, s		64.
	06500 RESPI RATORY THERAPY	-2, 374			65.
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	-2,043			66. 67.
	06800 SPEECH PATHOLOGY				68.
	06900 ELECTROCARDI OLOGY	0	0		69.
00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0			71.
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0,,,0,,02		72.
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		10, 457, 592		73.
	07400 RENAL DIALYSIS 07500 ASC (NON-DI STINCT PART)				74.
	03140 CARDI OLOGY	-6, 464	-		76.
	OUTPATIENT SERVICE COST CENTERS				
	09000 CLINIC	-2, 821			90.
	04951 SLEEP CLINIC	412.050			90.
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	-412, 959	7, 624, 845		91. 92.
	OPED OF THE OF T				92.
	09400 HOME PROGRAM DI ALYSI S	0	0		94.
	09500 AMBULANCE SERVICES	0			95.
	09600 DURABLE MEDICAL EQUIP-RENTED	0	ol		96.

Health Financial Systems	ELKHART GENER	AL HOSPITAL	In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 15		Worksheet A
			From 01/01/2014 To 12/31/2014	Date/Time Prepared:
			10 12/31/2014	5/28/2015 1:02 pm
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6.00	7.00		
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		98.00
101.00 10100 HOME HEALTH AGENCY	0	0		101.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE	0	0		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115.00
116. 00 11600 HOSPI CE	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-28, 818, 356	216, 370, 632		118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
191. 00 19100 RESEARCH	0	0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	49, 921		192.00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0		192.01
192. 02 19202 OUTPATI ENT PSYCH	0	263		192.02
193. 00 19300 NONPALD WORKERS	0	238, 935		193.00
193. 01 19301 COMMUNI TY	0	1, 187, 227		193.01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	2, 617, 549		194.00
200.00 TOTAL (SUM OF LINES 118-199)	-28, 818, 356			200.00
				ļ.

	Financial Systems		ELKHART GENERA		CON 150010		eu of Form CMS-25	52-10
REULAS:	SI FI CATI ONS			Provider	CCN: 150018	Period: From 01/01/2014 To 12/31/2014	Worksheet A-6 Date/Time Prepa 5/28/2015 1:02	
		Increases					10/20/2010 1102	pin
	Cost Center	Line #	Salary	Other				
	2.00 A - INSURANCE	3.00	4.00	5.00				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	308, 969				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00		26, 049				2.00
	0		0	335, 018				
	B - INTEREST							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1,086,014				1.00
2.00	INTEREST EXPENSE	<u> </u>	<u>0</u>	<u>1, 086, 014</u> 2, 172, 028				2.00
	C – DIETARY		0	2, 172, 020				
1.00	CAFETERI A	11.00	1, 081, 991	1, 109, 215				1.00
	0		1, 081, 991	1, 109, 215				
4 00	D - CASE MANAGEMENT	44.00						4 00
1.00	SUBPROVI DER - IRF	<u>41.00</u>		0 0				1.00
	E - SERVICE CONTRACTS		44, 440	0				
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	11, 250				1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	40, 238				2.00
3.00	PHARMACY	15.00	0	114, 813				3.00
4.00 5.00	ADULTS & PEDIATRICS OPERATING ROOM	30.00 50.00	0	14, 986				4.00 5.00
5.00 6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	85, 681 806, 858				5.00 6.00
7.00	CT SCAN	57.00	0	351, 327				7.00
8.00	MRI	58.00	0	293, 146				8.00
9.00	CARDIAC CATHETERIZATION	59.00	0	416, 592				9.00
10.00	PHYSI CAL THERAPY	66.00	0	3, 118				10.00
11. 00 12. 00	CARDI OLOGY CLI NI C	76.00 90.00	0	110, 092 7, 040				11. 00 12. 00
12.00	EMERGENCY	90.00	0	3, 416				13.00
14.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	43, 926				14.00
	0		0	2, 302, 483				
	H - NURSERY							
1.00	NURSERY	43.00	<u>1, 740, 030</u> <u>1, 740, 030</u>	<u>708, 183</u> 708, 183				1.00
	I - ONCOLOGY		1, 740, 030	706, 163				
1.00	ADULTS & PEDIATRICS	30.00	344, 125	30, 863				1.00
2.00	RADI OLOGY-DI AGNOSTIC	54.00	<u>99, 0</u> 30	8, 881				2.00
	0		443, 155	39, 744				
1.00	M - DRUGS CHARGED DRUGS CHARGED TO PATIENTS	73.00	0	10, 457, 592				1.00
1.00		73.00	<u>0</u>	10, 457, 592				1.00
	N - RENT	<u> </u>		10/10//0/2				
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	338, 100				1.00
2.00		0.00	0	0				2.00
3.00 4.00		0.00 0.00	0	0				3.00 4.00
5.00		0.00	0	0				5.00
6.00		0.00	0	0				6.00
	0		0	338, 100				
1 00	0 - SUPPLIES	74.00		05 044 040				4 00
1.00	MEDICAL SUPPLIES CHARGED TO PATIENT	71.00	0	25, 041, 849				1.00
2.00	IMPL. DEV. CHARGED TO	72.00	0	3, 976, 152				2.00
	PATIENTS							
3.00		0.00	0	0				3.00
4.00 5.00		0.00 0.00	0	0 0				4.00
5.00 6.00		0.00	0	0				5.00 6.00
7.00		0.00	0	0				7.00
8.00		0.00	0	0				8.00
9.00		0.00	0	0				9.00
10.00		0.00	0	0				10.00
11. 00 12. 00		0.00 0.00	0	0 0				11. 00 12. 00
12.00		0.00	0	0				12.00
15.00		0.00	0	0				15.00
16.00		0.00	0	0			1	16.00
17.00		0.00	0	0				17.00
18.00 19.00		0.00	0	0				18.00
19.00 20.00		0.00 0.00	0	0 0				19. 00 20. 00
20.00		0.00	0	0				21.00
22.00		0.00	0	0			2	22.00
23.00		0.00	0	0				23.00
25.00		0.00	0	0				25.00

Heal th	Financial Systems		ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 150018	Peri od:	Worksheet A-	6
						From 01/01/2014 To 12/31/2014	Date/Time Pr 5/28/2015 1:	epared: 02 pm
		Increases						
	Cost Center	Line #	Sal ary	Other				
	2.00	3.00	4.00	5.00				
26.00		0.00	0	0				26.00
27.00		0.00	0	0				27.00
	0 — — — — — — —		0	29, 018, 001				
	P - DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13, 451, 434				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	2, 329, 157				2.00
	0 — — — — — — —		0	15, 780, 591				
	Q - LAB							
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	281, 714				1.00
	0 — — — — — — —		0	281, 714				
	S - AMORTIZATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	39, 005				1.00
	TOTALS			39,005	]			
500.00	Grand Total: Increases		3, 309, 622	62, 581, 674	1			500.00

	inancial Systems FICATIONS		ELKHART GENERA	L HOSPITAL Provider CC	CN: 150018   Period: From 01/01/2	Lieu of Form CMS-2552- Worksheet A-6
					To 12/31/2	014 Date/Time Prepared 5/28/2015 1:02 pm
	Cost Contor	Decreases	Salary	Othor Wkg	at A 7 Dof	
	<u> </u>	Li ne # 7.00	Salary 8.00	0ther Wks 9.00	st. A-7 Ref. 10.00	
	A – I NSURANCE					
	ADMINISTRATIVE & GENERAL	5.00	0	335, 018	12	1.
0			0	335, 018	12	2.
В	3 - INTEREST		V	333, 010		
	NTEREST EXPENSE	113.00	0	1, 086, 014	11	1.
A	ADMI NI STRATI VE & GENERAL		0	1,086,014	<u>0</u>	2.
C	C - DIETARY		0	2, 172, 028		
	DI ETARY	10.00	1, 081, 991	1, 109, 215	0	1.
0			1, 081, 991	1, 109, 215		
	O - CASE MANAGEMENT	17.00	44 444			1
0	SOCIAL SERVICE	<u>17.</u> 00	$ \frac{44, 446}{44, 446}$	<u>0</u>	0	1.
E	E - SERVICE CONTRACTS		44, 440	0	<u> </u>	
0	PERATION OF PLANT	7.00	0	2, 302, 483	0	1.
		0.00	0	0	0	2.
		0.00 0.00	0	0	0	3.
		0.00	0	0	0	4. 5.
		0.00	0	Ő	o	6.
		0.00	О	0	0	7.
		0.00	O	0	0	8.
		0. 00 0. 00	0	0	0	9. 10.
		0.00	0	0	0 0	10.
		0.00	0	0	o	12.
		0.00	0	0	0	13.
		0.00	0	0	0	14.
0	) I – NURSERY		0	2, 302, 483		
	ADULTS & PEDIATRICS	30.00	1, 740, 030	708, 183	0	1.
0	<u></u>		1, 740, 030	708, 183	=	
	- ONCOLOGY				-	
N	IURSING ADMINISTRATION	13. 00 0. 00	443, 155	39, 744	0	1.
0		0.00	443, 155	39, 744	0	Ζ.
	1 - DRUGS CHARGED					
P	PHARMACY	<u>15.00</u>	o	10, 457, 592	O	1.
0 N	J – RENT		0	10, 457, 592		
	ADMINISTRATIVE & GENERAL	5.00	0	137, 752	10	1.
L	AUNDRY & LINEN SERVICE	8.00	0	85, 373	10	2.
	PHARMACY	15.00	0	6, 850	0	3.
	PERATING ROOM	50.00	0	12, 359	0	4.
	RADI OLOGY-DI AGNOSTI C EMERGENCY	54.00 91.00	0	95, 025 741	0	5.
0	)			338, 100		
	) – SUPPLIES					
	ADMINISTRATIVE & GENERAL	5.00	0	14,680	0	1.
	DPERATION OF PLANT DIETARY	7.00 10.00	0	1, 336 479	0	2. 3.
	IURSING ADMINISTRATION	13.00	0	59	o	4.
	CENTRAL SERVICES & SUPPLY	14.00	0	62, 583	o	5.
	PHARMACY	15.00	0	5	0	6.
	PARAMED ED PRGM	23.00	0	1, 382	0	7.
	ADULTS & PEDIATRICS	30.00	0	1,048,575	0	8.
	NTENSIVE CARE UNIT IEONATAL INTENSIVE CARE	31.00 31.01	0	458, 393 71, 401		9. 10.
	SUBPROVIDER - IRF	41.00	0	10, 542	o	11.
) N	IURSERY	43.00	0	510	0	12.
	PERATING ROOM	50.00	О	21, 916, 371	0	13.
	RADI OLOGY-DI AGNOSTI C	54.00	0	323, 645	0	15.
	CT SCAN IRI	57.00 58.00	0	13, 023 8, 075	0	16. 17.
	CARDIAC CATHETERIZATION	58.00 59.00	0 0	8, 075 4, 334, 785		17.
	ABORATORY	60.00	0	4, 334, 785	0	19.
	NTRAVENOUS THERAPY	64.00	Ő	341, 929	0	20.
) R	RESPI RATORY THERAPY	65.00	о	18, 604	0	21.
	PHYSI CAL THERAPY	66.00	0	3, 290	0	22.
	CCUPATIONAL THERAPY	67.00	0	475	0	23.
	CARDI OLOGY GLEEP CLINIC	76. 00 90. 01	0	3, 435 420	0	25.
0  S		90.01	0	420	U	26.

Heal th	Financial Systems		ELKHART GENE	RAL HO	SPI TAL			In Lie	u of Form CMS-	-2552-10
RECLAS	SIFICATIONS				Provi der	· CCN: 15		Period:	Worksheet A-	6
						-		From 01/01/2014 To 12/31/2014	Date/Time Pro 5/28/2015 1:0	epared: 02 pm
		Decreases								
	Cost Center	Line #	Sal ary	C	ther	Wkst. A	A-7 Ref.			
	6.00	7.00	8.00		9.00	10	. 00			
	0		0	2	9, 018, 001					
	P - DEPRECIATION									
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	1	5, 780, 591		(	9		1.00
2.00		0.00	0		0			9		2.00
	0		0	1	5, 780, 591					
	Q - LAB									
1.00	LABORATORY	60.00	0		281, 714		14	4		1.00
	0		0		281, 714					
	S - AMORTIZATION									
1.00	ADMI NI STRATI VE & GENERAL	5.00	0		39, 005		1	1		1.00
	TOTALS		0		39,005					
500.00	Grand Total: Decreases		3, 309, 622	6	2, 581, 674			7		500.00

Heal th	Financial Systems	ELKHART GENER	AL HOSPITAL			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150018		riod: om 01/01/2014 12/31/2014		pared:
				Acqui si ti on	IS			
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		_				
1.00	Land	3, 507, 036	86, 094		0	86, 094	0	1.00
2.00	Land Improvements	597, 914	115, 273		0	115, 273	0	2.00
3.00	Buildings and Fixtures	123, 124, 927	0		0	0	0	3.00
4.00	Building Improvements	48, 556, 707	1, 377, 885		0	1, 377, 885	0	4.00
5.00	Fixed Equipment	61, 246, 027	4, 326, 652		0	4, 326, 652	4, 189, 300	5.00
6.00	Movable Equipment	14, 512, 721	2, 702, 588		0	2, 702, 588	312, 844	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	251, 545, 332	8, 608, 492		0	8, 608, 492	4, 502, 144	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	251, 545, 332	8, 608, 492		0	8, 608, 492	4, 502, 144	10.00
		Endi ng Bal ance						
		5	Depreciated					
			Assets					
		6.00	7.00	1				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		•				
1.00	Land	3, 593, 130	0					1.00
2.00	Land Improvements	713, 187	337, 805					2.00
3.00	Buildings and Fixtures	123, 124, 927	361, 629					3.00
4.00	Building Improvements	49, 934, 592	10, 612, 345					4.00
5.00	Fixed Equipment	61, 383, 379	15, 026, 142					5.00
6.00	Movable Equipment	16, 902, 465	4, 998, 710					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	255, 651, 680	31, 336, 631					8.00
9.00	Reconciling Items	0000	0					9,00
10.00	Total (line 8 minus line 9)	255, 651, 680	31, 336, 631					10.00
			2.,000,001	1				

Heal th	n Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150018	Peri od:	Worksheet A-7	
					From 01/01/2014 To 12/31/2014		pared:
						5/28/2015 1:0	
			SL	JMMARY OF CAP	21 TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
					instructions)		
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	•	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00	1			
	PART II - RECONCILIATION OF AMOUNTS FROM WORH	SHEET A, COLUM	N 2, LINES 1 a	ind 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	0				3.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 To 12/31/2014		
	COM	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
		Leases	for Ratio (col. 1 - col 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FIXT	238, 340, 039					1.00
2.00 CAP REL COSTS-MVBLE EQUIP	17, 311, 641	0	17, 311, 64			2.00
3.00 Total (sum of lines 1-2)	255, 651, 680		255, 651, 68			3.00
	ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	-	1	1	1		
1.00 CAP REL COSTS-BLDG & FIXT	0	-		0 13, 451, 434		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	-		0 2, 329, 157		2.00
3.00 Total (sum of lines 1-2)	0	°		0 15, 780, 591	1, 342, 654	3.00
		Sl	JMMARY OF CAPI			
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate		
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE			1	0 1 107 574	10 705 105	
1.00 CAP REL COSTS-BLDG & FIXT	1, 125, 019			0 -1, 197, 574		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0			0 281, 714		2.00
3.00  Total (sum of lines 1-2)	1, 125, 019	335, 018		0 -915, 860	17, 667, 422	3.00

	Financial Systems MENTS TO EXPENSES		ELKHART GENER	Provider CCN: 150018	In Lie Period: From 01/01/2014	u of Form CMS-2 Worksheet A-8	
					To 12/31/2014	Date/Time Prep 5/28/2015 1:02	
				Expense Classification or To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1.00		1.00	2.00	3.00	4.00	5.00	1.00
1.00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)			CAP REL COSTS-BLDG & FIXT	1.00	0	1.00
2.00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	Investment income - other (chapter 2)		0		0.00	0	3.00
4.00	Trade, quantity, and time	В	-92, 028	ADMI NI STRATI VE & GENERAL	5.00	0	4.00
5.00	discounts (chapter 8) Refunds and rebates of	В	-521, 159	ADMI NI STRATI VE & GENERAL	5.00	0	5.00
6.00	expenses (chapter 8) Rental of provider space by		O		0.00	0	6.00
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	
7.00	stations excluded) (chapter		U		0.00	0	7.00
8.00	21) Television and radio service		0		0.00	0	8.00
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9.00
10.00	Provider-based physician adjustment	A-8-2	-2, 161, 457			0	10.00
11.00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization	A-8-1	1, 150, 222			0	12.00
13.00	transactions (chapter 10) Laundry and linen service	В	-1, 951, 467	LAUNDRY & LINEN SERVICE	8.00	0	13.00
14.00	Cafeteria-employees and guests	В		CAFETERI A	11.00	0	14.00
15.00	Rental of quarters to employee and others		U		0.00	0	
16.00	Sale of medical and surgical supplies to other than		0		0.00	0	16.00
17.00	patients Sale of drugs to other than	В	-170, 023	PHARMACY	15.00	0	17.00
18.00	patients Sale of medical records and	В	-99, 283	MEDICAL RECORDS & LIBRARY	16.00	0	18.00
	abstracts Nursing school (tuition, fees,	5	0		0.00		19.00
	books, etc.)		0				
20. 00 21. 00	Vending machines Income from imposition of		0 0		0.00 0.00	0	
	interest, finance or penalty charges (chapter 21)						
22.00	Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24.00
21.00	therapy costs in excess of		Ū		00.00		21.00
25.00	limitation (chapter 14) Utilization review -		0	UTILIZATION REVIEW-SNF	114.00		25.00
	physicians' compensation (chapter 21)						
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00	0	29.00 30.00
	therapy costs in excess of limitation (chapter 14)		-				
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
	pathology costs in excess of limitation (chapter 14)						
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.00
	TELEVI SI ON EXPENSE	А	-26, 290	ADMI NI STRATI VE & GENERAL	5.00	0	33.00

Heal th	Financial Systems		ELKHART GENERA	L HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
	MENTS TO EXPENSES			Provider CCN: 150018	Peri od:	Worksheet A-8	
					From 01/01/2014		
					To 12/31/2014		
				Expense Classification of	n Workshoot A	5/28/2015 1:0	2 pm
			Т	To/From Which the Amount i			
	Cost Center Description		Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
35.00	MEALS ON WHEELS EXPENSE	A	-165, 338D		10.00		
36.00	LOBBYING EXPENSES	A		ADMINISTRATIVE & GENERAL	5.00		
37.00	NFS CHARGES	A		ADMI NI STRATI VE & GENERAL	5.00		
38.00	DELI	A		CAFETERIA	11.00		
39.00	MEDICAL STAFF DUES	В		ADMINISTRATIVE & GENERAL	5.00		
40.00	PAYPHONE REVENUE	В		ADMINISTRATIVE & GENERAL	5.00		
41.00	OTHER REVENUE-ADMIN	В		ADMINISTRATIVE & GENERAL	5.00		•
42.00	EMS REVENUE	В		PARAMED ED PRGM	23.00		
43.00	TRUSTEE FEE	A		ADMINISTRATIVE & GENERAL	5.00		
44.00	ENVI RONMENTAL SERVI CES	В		IOUSEKEEPI NG	9.00		
45.00	PLANT MAINT MISC REVENUE	В		PERATION OF PLANT	7.00		
46.00	OTHER REVENUE - ADMIN HIP	В		ADMINISTRATIVE & GENERAL	5.00		
47.00	PHYSICAL THERAPY MISC REVENUE	В		PHYSICAL THERAPY	66.00		
48.00	OTHER REVENUE-FOUNDATION ADMIN			ADMINISTRATIVE & GENERAL	5.00		
49.00	I MAGI NG SERVI CES MI SC REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00		
	NURSING ADMIN MISC REVENUE	В		IURSI NG ADMI NI STRATI ON	13.00		
49.03	NON-ALLOWABLE ADMIN EXPENSES	A		SOCIAL SERVICE	17.00		
49.04	NON-ALLOWABLE CONTRIBUTIONS	A		ADMINISTRATIVE & GENERAL	5.00		
49.05	NON-ALLOWABLE HAF EXPENSE	A		ADMINISTRATIVE & GENERAL	5.00		
49.06	LACTATION SUPPLIES SALES	В	-208 A	ADULTS & PEDIATRICS	30.00	0	49.06
49.07	REVENUE WOMENS' SERVICES MISC REVENUE	В	-1, 275 C		90.00	0	49.07
49.07	PHYSICIAN GUARANTEE	A		PERATING ROOM	90.00 50.00		
49.08	RENTAL REVENUE	В		CAP REL COSTS-BLDG & FIXT	1.00		
49.09	JOINT VENTURE ACTIVITY	В		ADMINISTRATIVE & GENERAL	5.00		
49.10	SEMI NAR REVENUE	B		ADMINISTRATIVE & GENERAL	5.00		
49.12	SEMI NAR REVENUE	B		PERATING ROOM	50.00		
49.12	SEMI NAR REVENUE	B		MERGENCY	91.00		
49.14	OTHER REVENUE - ADMIN	B		ADMINISTRATIVE & GENERAL	5.00		
49.15	OTHER REVENUE - HR	В		EMPLOYEE BENEFITS DEPARTMENT		0	
	OTHER REVENUE - CT SCAN	В	-2, 850C		57.00		
49.17	OTHER REVENUE - SURGERY	B		PERATING ROOM	50.00		1
49.18	OTHER REVENUE - BARLATRIC	В		PERATING ROOM	50.00		
49.19	OTHER REVENUE - ED	В	-347, 464 E		91.00		1
49.20	OTHER REVENUE - PRENATAL	В		ADULTS & PEDIATRICS	30.00		
	PROGRAM					-	
49.21	OTHER REVENUE - BONE	В	-400 C	CLINIC	90.00	0	49. 21
50.00	TOTAL (sum of lines 1 thru 49)		-28, 818, 356				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
 (2) Basis for adjustment (see instructions).
 A. Costs - if cost, including applicable overhead, can be determined.
 B. Amount Received - if cost cannot be determined.
 (3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Heal th	Financial Systems	ELKHART GENE	RAL HOSPITAL	In Lie	eu of Form CMS-	2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND			ME Provider CCN: 150018	Period: From 01/01/2014	Worksheet A-8	3-1
OFFICE				To 12/31/2014		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED					
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE NEW CAPITAL - BL	J 107, 257	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE NEW CAPITAL- EQU	897, 297	0	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE NON-CAPITAL COST	16, 547, 249	0	3.00
4.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE NON-ALLOWABLE	0	16, 401, 581	4.00
5.00	TOTALS (sum of lines 1-4).			17, 551, 803	16, 401, 581	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.

110.5 11	Ji been posteu to worksheet A,	corumns r anu/or z, the amount	it allowable sh		or this part.		
				Related Organization(s) and/	or Home Office		
	Symbol (1)	Name	Percentage of	Name	Percentage of		
			Ownershi p		Ownershi p		
	1.00	2.00	3.00	4.00	5.00		
-	B INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE						

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

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

6.00	В	BEACON HLTH SYS	100.00		0.00	6.00
7.00			0.00	1	0.00	7.00
8.00			0.00	1	0.00	8.00
9.00			0.00	1	0.00	9.00
10.00			0.00	1	0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

C. Provider has financial interest in corporation, partnership, or other organization.

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

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

Health Financial Systems ELKHART G	ENERAL HOSPITAL	In Lieu of Form CMS-2552-10		
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND	HOME Provider CCN: 150018	Period: From 01/01/2014	Worksheet A-8-1	
OFFICE COSTS			Date/Time Prepared:	

			5/28/2015 1:0	
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	107, 257	10		1.00
2.00	897, 297	10		2.00
3.00	16, 547, 249	0		3.00
4.00	-16, 401, 581	0		4.00
5.00	1, 150, 222			5.00

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

1143	not been posted to worksheet A,		the amount	arrowable should	be mulcated m	tin s part.	
	Related Organization(s)						
	and/or Home Office						
	Type of Business						
	6.00	]					
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S)	AND/OR HOME	OFFICE:			

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

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

6.00 7.00	6.00
7.00	7.00
8.00	8.00
9.00	9.00
10.00	10.00
8. 00 9. 00 10. 00 <u>100. 00</u>	100.00

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

 D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.

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

	Financial Syst ER BASED PHYSIC		ELKHART GENE			Period:	eu of Form CMS- Worksheet A-8	
						From 01/01/2014 To 12/31/2014	Date/Time Pre	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	5/28/2015 1:0 Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
	1.00	2.00	3.00	4.00	5.00	6.00	Hours 7.00	
1.00	5.00	ADMI NI STRATI VE & GENERAL	18, 000	0	18, 000	171, 400	144	1.00
2.00		ADMINISTRATIVE & GENERAL	8, 188	0				2.00
3.00 4.00		EMPLOYEE BENEFITS DEPARTMENT	15, 750 2, 300	0			105 14	3.00 4.00
4.00 5.00		PHYSICAL THERAPY	6, 500	0			388	4.00 5.00
6.00		CARDI OLOGY	923	0			5	6.00
7.00		CARDI OLOGY	580	0	580			7.00
8.00		CARDI OLOGY	945	0	945		6	8.00
9. 00 10. 00		CARDI OLOGY CARDI OLOGY	6, 866 1, 600	0	6, 866 1, 600		31 8	9. 00 10. 00
11.00		RESPI RATORY THERAPY	540	0			3	11.00
12.00		RESPI RATORY THERAPY	3, 383	0	3, 383		21	12.00
13.00		RADI OLOGY-DI AGNOSTI C	22, 917	0			162	13.00
14.00		RESPIRATORY THERAPY	675	0	675			14.00
15. 00 16. 00		CARDI AC CATHETERI ZATI ON RADI OLOGY-DI AGNOSTI C	11, 895 54, 200	0	11, 895 54, 200		33 250	15. 00 16. 00
17.00		OPERATING ROOM	41,000	0	41,000		200	17.00
18.00		EMERGENCY	9,000	0	9,000		45	18.00
19.00		EMERGENCY	100, 000	0				19.00
20.00			1, 620	0	1, 620		12	20.00
21. 00 22. 00		EMERGENCY	118, 688 5, 338	0	118, 688 5, 338		768 31	21.00 22.00
22.00		ADULTS & PEDIATRICS	15, 370	0	15, 370		106	22.00
24.00		ADULTS & PEDIATRICS	29, 341	0	29, 341		243	24.00
25.00		SUBPROVIDER – IRF	85, 000	0	85, 000		1, 956	
26.00 200.00	30.00	ADULTS & PEDIATRICS	1, 982, 147 2, 542, 766		0 560, 619		0 5, 773	26. 00 200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	200.00
		Identifier		Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	8.00	9.00	Education 12.00	12 13.00	14.00	
1.00		ADMI NI STRATI VE & GENERAL	11, 866	593				1.00
2.00		ADMI NI STRATI VE & GENERAL	5, 439	272	0			2.00
3.00 4.00		EMPLOYEE BENEFITS DEPARTMENT	7, 779 1, 154	389 58		0	0	3.00 4.00
4.00 5.00		PHYSICAL THERAPY	31, 973	1, 599		0	0	4.00 5.00
6.00		CARDI OLOGY	412	21	0	0	0	6.00
7.00		CARDI OLOGY	330	17	0	0	0	7.00
8.00		CARDI OLOGY	494	25	0	0	0	8.00
9.00 10.00		CARDI OLOGY	2, 555 659	128	0	0	0	9.00 10.00
11.00		RESPI RATORY THERAPY	247				-	
12.00	65.00	RESPI RATORY THERAPY	1, 730	87	0	0	0	12.00
13.00		RADI OLOGY-DI AGNOSTI C	13, 349			-		13.00
14. 00 15. 00		RESPI RATORY THERAPY	247 2, 719	12		0	0	14.00 15.00
16.00		RADI OLOGY-DI AGNOSTI C	27,776	136 1, 389			0	16.00
17.00		OPERATING ROOM	19, 625	981	0	0	0	17.00
18.00		EMERGENCY	3, 708	185	0	0	0	18.00
19.00		EMERGENCY	96, 330	4, 817	0	0	0	19.00
20. 00 21. 00		EMERGENCY EMERGENCY	989 63, 286	49 3, 164		0	0	20. 00 21. 00
21.00		INTENSIVE CARE UNIT	2, 555	128		0	0	22.00
23.00		ADULTS & PEDIATRICS	9, 912	496	0	0	0	23.00
				832	0	0	0	24.00
24.00		ADULTS & PEDIATRICS	16, 648				-	
25.00	41.00	SUBPROVIDER – IRF	161, 182	8, 059	0	0	0	25.00
25. 00 26. 00	41.00		161, 182 0	8, 059 0	0	0	0	25. 00 26. 00
25.00	41.00	SUBPROVI DER – I RF ADULTS & PEDI ATRI CS	161, 182	8, 059 0	0	0 0 0 Adjustment	0	25. 00 26. 00
25. 00 26. 00	41.00 30.00	SUBPROVI DER – I RF ADULTS & PEDI ATRI CS	161, 182 0 482, 964 Provi der Component	8, 059 0 24, 149	0 0 0	0 0 Adjustment	0	25. 00 26. 00
25. 00 26. 00	41.00 30.00	SUBPROVIDER - IRF ADULTS & PEDIATRICS Cost Center/Physician	161,182 0 482,964 Provider Component Share of col.	8, 059 0 24, 149 Adjusted RCE	0 0 0 RCE	0 0 Adjustment	0	25. 00 26. 00
25. 00 26. 00	41.00 30.00 Wkst. A Line #	SUBPROVIDER - IRF ADULTS & PEDIATRICS Cost Center/Physician Identifier 2.00	161, 182 0 482, 964 Provi der Component	8, 059 0 24, 149 Adjusted RCE	0 0 0 RCE	0 0 Adjustment 18.00	0	25. 00 26. 00
25.00 26.00 200.00	41.00 30.00 Wkst. A Line # 1.00 5.00	SUBPROVIDER - IRF ADULTS & PEDIATRICS Cost Center/Physician Identifier 2.00 ADMINISTRATIVE & GENERAL	161, 182 0 482, 964 Provi der Component Share of col . 14 15. 00 0	8, 059 0 24, 149 Adj usted RCE Li mi t 16. 00 11, 866	0 0 RCE Di sal I owance 17. 00 6, 134	18. 00 6, 134	0	25. 00 26. 00 200. 00
25. 00 26. 00 200. 00 1. 00 2. 00	41.00 30.00 Wkst. A Line # 1.00 5.00 5.00	SUBPROVIDER - IRF ADULTS & PEDIATRICS Cost Center/Physician Identifier 2.00 ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	161, 182 0 482, 964 Provi der Component Share of col . 14 15.00 0 0	8, 059 0 24, 149 Adj usted RCE Li mi t 16. 00 11, 866 5, 439	0 0 RCE Di sal I owance 17. 00 6, 134 2, 749	18. 00 6, 134 2, 749	0	25.00 26.00 200.00 1.00 2.00
25.00 26.00 200.00 1.00 2.00 3.00	41.00 30.00 Wkst. A Line # 1.00 5.00 5.00 4.00	SUBPROVIDER - IRF ADULTS & PEDIATRICS Cost Center/Physician Identifier 2.00 ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTMENT	161, 182 0 482, 964 Provi der Component Share of col . 14 15. 00 0	8, 059 0 24, 149 Adj usted RCE Li mi t 16. 00 11, 866 5, 439 7, 779	0 0 0 RCE Di sal I owance 17. 00 6, 134 2, 749 7, 971	18. 00 6, 134 2, 749 7, 971	0	25.00 26.00 200.00 1.00 2.00 3.00
25. 00 26. 00 200. 00 1. 00 2. 00	41.00 30.00 WKst. A Line # 1.00 5.00 4.00 90.00	SUBPROVIDER - IRF ADULTS & PEDIATRICS Cost Center/Physician Identifier 2.00 ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	161, 182 0 482, 964 Provi der Component Share of col . 14 15.00 0 0 0	8, 059 0 24, 149 Adj usted RCE Li mi t 16. 00 11, 866 5, 439	0 0 0 0 0 0 0 0 0 0 17.00 6,134 2,749 7,971 1,146	18. 00 6, 134 2, 749 7, 971	0	25.00 26.00 200.00 1.00 2.00
25.00 26.00 200.00 1.00 2.00 3.00 4.00 5.00 6.00	41.00 30.00 Wkst. A Line # 1.00 5.00 4.00 90.00 66.00 76.00	SUBPROVIDER - IRF ADULTS & PEDIATRICS Cost Center/Physician Identifier 2.00 ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTMENT CLINIC PHYSICAL THERAPY CARDIOLOGY	161, 182 0 482, 964 Provi der Component Share of col. 14 15.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 059 0 24, 149 Adj usted RCE Li mi t 16. 00 11, 866 5, 439 7, 779 1, 154 31, 973 412	0 0 0 0 0 0 0 0 0 17.00 6,134 2,749 7,971 1,146 0 0 511	18.00 6,134 2,749 7,971 1,146 0 511	00000	25.00 26.00 200.00 1.00 2.00 3.00 4.00 5.00 6.00
25.00 26.00 200.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00	41.00 30.00 Wkst. A Line # 1.00 5.00 4.00 90.00 66.00 76.00 76.00	SUBPROVI DER - I RF ADULTS & PEDI ATRI CS Cost Center/Physi ci an I denti fi er 2.00 ADMI NI STRATI VE & GENERAL ADMI NI STRATI VE & GENERAL EMPLOYEE BENEFI TS DEPARTMENT CLI NI C PHYSI CAL THERAPY CARDI OLOGY	161, 182 0 482, 964 Provi der Component Share of col . 14 15. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 059 0 24, 149 Adj usted RCE Li mi t 16. 00 11, 866 5, 439 7, 779 1, 154 31, 973 412 330	0 0 0 RCE Di sal I owance 17. 00 6, 134 2, 749 7, 971 1, 146 0 511 250	18.00 6,134 2,749 7,971 1,146 0 511 250	000000000000000000000000000000000000000	25.00 26.00 200.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00
25.00 26.00 200.00 1.00 2.00 3.00 4.00 5.00 6.00	41.00 30.00 Wkst. A Line # 1.00 5.00 5.00 4.00 90.00 66.00 76.00 76.00 76.00	SUBPROVIDER - IRF ADULTS & PEDIATRICS Cost Center/Physician Identifier 2.00 ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTMENT CLINIC PHYSICAL THERAPY CARDIOLOGY	161, 182 0 482, 964 Provi der Component Share of col. 14 15.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 059 0 24, 149 Adj usted RCE Li mi t 16. 00 11, 866 5, 439 7, 779 1, 154 31, 973 412 330 494	0 0 0 RCE Di sal I owance 17. 00 6, 134 2, 749 7, 971 1, 146 0 511 250 451	18.00 6,134 2,749 7,971 1,146 0 511 250 451	0	25.00 26.00 200.00 1.00 2.00 3.00 4.00 5.00 6.00

Heal th	Financial Syste	ems	ELKHART GENE	RAL HOSPITAL		In Li€	eu of Form CMS-	2552-10
PROVI D	ER BASED PHYSIC	I AN ADJUSTMENT		Provi der	CCN: 150018	Period: From 01/01/2014	Worksheet A-8	3-2
						To 12/31/2014	Date/Time Pre 5/28/2015 1:0	
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1.00	2.00	14	1/ 00	17.00	10.00		
10.00	1.00	2.00	15.00	16.00	17.00	18.00		10.00
10.00		CARDI OLOGY	0	659	94			10.00
11.00		RESPI RATORY THERAPY	0	247	29			11.00
12.00		RESPI RATORY THERAPY	0	1, 730	1,65			12.00
13.00		RADI OLOGY-DI AGNOSTI C	0	13, 349	9, 56			13.00
14.00		RESPI RATORY THERAPY	0	247	42			14.00
15.00		CARDIAC CATHETERIZATION	0	2, 719				15.00
16.00		RADI OLOGY-DI AGNOSTI C	0	27, 776				16.00
17.00		OPERATING ROOM	0	19, 625				17.00
18.00		EMERGENCY	0	3, 708	5, 29			18.00
19.00		EMERGENCY	0	96, 330				19.00
20.00	91.00	EMERGENCY	0	989	63	1 631		20.00
21.00	91.00	EMERGENCY	0	63, 286	55,40	2 55, 402		21.00
22.00	31.00	INTENSIVE CARE UNIT	0	2, 555	2, 78	3 2, 783		22.00
23.00	30.00	ADULTS & PEDIATRICS	0	9, 912	5,45	8 5, 458		23.00
24.00	30.00	ADULTS & PEDIATRICS	0	16, 648	12, 69	3 12, 693		24.00
25.00	41.00	SUBPROVIDER - IRF	0	161, 182		0 0		25.00
26.00	30.00	ADULTS & PEDIATRICS	0	0	1	0 1, 982, 147		26.00
200.00			0	482, 964	179, 31	0 2, 161, 457		200. 00

	inancial Systems LOCATION - GENERAL SERVICE COSTS	ELKHART GENER		1	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Pre	pared:
			CAPI TAL REI	ATED COSTS		5/28/2015 1:0	2 pm
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUI P	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1.00	2.00	4.00	4A	
	ENERAL SERVICE COST CENTERS	12 705 105	12 705 105				1 1 00
2.00 0 4.00 0 5.00 0	0100 CAP REL COSTS-BLDG & FIXT 0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0600 MAINTENANCE & REPAIRS	13, 795, 105 3, 872, 317 711, 825 33, 362, 283 0	13, 795, 105 46, 187 820, 923 0	3, 872, 31 12, 96 230, 43	5 770, 977	34, 472, 226 0	1.00 2.00 4.00 5.00 6.00
8.00 0 9.00 0 10.00 0 11.00 0	0700 OPERATION OF PLANT 0800 LAUNDRY & LINEN SERVICE 0900 HOUSEKEEPING 1000 DIETARY 1100 CAFETERIA 1200 MAINTENANCE OF PERSONNEL	7, 488, 376 989, 773 3, 212, 850 2, 007, 571 1, 245, 761 0	2, 770, 114 295, 883 88, 614 227, 514 87, 128 0	83, 05 24, 87 63, 86 24, 45	5 8, 643 4 17, 384 4 7, 400	11, 051, 620 1, 377, 354 3, 343, 722 2, 306, 349 1, 368, 548 0	8.00 9.00 10.00 11.00
14.00015.00016.00017.00018.000	<ul> <li>1300 NURSI NG ADMI NI STRATI ON</li> <li>1400 CENTRAL SERVI CES &amp; SUPPLY</li> <li>1500 PHARMACY</li> <li>1600 MEDI CAL RECORDS &amp; LI BRARY</li> <li>1700 SOCI AL SERVI CE</li> <li>1850 OTHER GENERAL SERVI CE</li> <li>2300 PARAMED ED PRGM</li> </ul>	2, 238, 373 1, 126, 717 4, 725, 237 2, 625, 450 2, 232, 827 0 348, 281	60, 510 243, 930 86, 114 81, 791 2, 522 0 5, 630	68, 472 24, 172 22, 959 708	2 5, 780 2 40, 013 9 17, 933 8 13, 456 0 0	2, 249, 513 0	14.00 15.00 16.00 17.00 18.00
1	NPATIENT ROUTINE SERVICE COST CENTERS		-,				
31.00 0 31.01 0	3000 ADULTS & PEDIATRICS 3100 INTENSIVE CARE UNIT 3101 NEONATAL INTENSIVE CARE 4000 SUBPROVIDER - IPF	27, 318, 025 4, 932, 937 1, 267, 596	2, 951, 011 251, 925 52, 470	14, 729	6 37, 532		31.00 31.01
41.00 0 43.00 0 44.00 0	4100 SUBPROVIDER - IRF 4300 NURSERY 4400 SKILLED NURSING FACILITY	1, 357, 276 2, 470, 444 0	213, 935 312, 299 0	60, 052 87, 663	2 9, 829 3 17, 625 0 0	1, 641, 092 2, 888, 031 0	41.00 43.00 44.00
	4500 NURSING FACILITY 4600 OTHER LONG TERM CARE	0	0		0 0 0 0	0	
	NCI LLARY SERVICE COST CENTERS						
	5000 OPERATING ROOM 5100 RECOVERY ROOM	13, 972, 117	1, 172, 046		6 74,387 0 0	15, 547, 546 0	50.00 51.00
52.00 0 53.00 0	5200 DELI VERY ROOM & LABOR ROOM 5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C	0 0 8, 658, 198	0 0 843, 690			0 0 9, 788, 431	52.00 53.00
54.02 0 54.03 0 55.00 0	5401   INTERVENTIONAL RADIOLOGY 5402 BREAST CENTER 5403 RADIATION ONCOLOGY 5500 RADIOLOGY-THERAPEUTIC 5600 RADIOLOGY-THERAPEUTIC						54.02 54.03 55.00
56. 01057. 00058. 000	5601 ULTRASOUND 5700 CT SCAN 5800 MRI	0 1, 567, 421 907, 918	0 159, 865 80, 777	22, 67	4 3, 753	1, 015, 122	57.00 58.00
60.00 0 60.01 0	5900 CARDI AC CATHETERI ZATI ON 6000 LABORATORY 6001 BLOOD LABORATORY 6100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY	4, 403, 105 10, 235, 047 0 0	91, 699 122, 258 0			4, 532, 925 10, 391, 623 0 0	60. 00 60. 01
	6200 WHOLE BLOOD & PACKED RED BLOOD CELL 6300 BLOOD STORING, PROCESSING & TRANS.	1, 551, 093 0	0		0 0 0 0	1, 551, 093 0	
64.01 0	6400 I NTRAVENOUS THERAPY 6401 HOME I NFUSI ON 6400 DESDI DATODY, THEDADY	1, 307, 392 0	43, 980 0		0 0	1, 374, 115 0 2, 172, 051	64.01
66. 00 0 67. 00 0 68. 00 0	6500 RESPI RATORY THERAPY 6600 PHYSI CAL THERAPY 6700 OCCUPATI ONAL THERAPY 6800 SPEECH PATHOLOGY	3, 100, 880 1, 878, 530 622, 564 245, 037	40, 625 111, 854 53, 709 32, 203	31, 398 15, 070	8 14, 769 6 5, 002 9 1, 929	3, 173, 851 2, 036, 551 696, 351 288, 208	66.00 67.00 68.00
70.00071.00072.000	6900 ELECTROCARDI OLOGY 7000 ELECTROENCEPHALOGRAPHY 7100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 7200 I MPL. DEV. CHARGED TO PATI ENTS 7300 DRUGS CHARGED TO PATI ENTS	0 0 25, 041, 849 3, 976, 152 10, 457, 592	0 0 0 0			0 0 25, 041, 849 3, 976, 152 10, 457, 592	70.00 71.00 72.00
74.00075.00076.000	7400 RENAL DIALYSI S 7500 ASC (NON-DI STINCT PART) 3140 CARDI OLOGY UTPATI ENT SERVICE COST CENTERS	0 0 2, 283, 787	0 0 170, 022	47, 72	0 0 0 0 5 14,032	2, 515, 566	74.00 75.00
90.00 0	9000 CLINIC 4951 SLEEP CLINIC 9100 EMERGENCY	694, 422 513, 659 7, 624, 845	120, 366 0 308, 426	(	3, 901	853, 408 517, 560	

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS				Period: From 01/01/2014 To 12/31/2014	Worksheet B Part I Date/Time Pre 5/28/2015 1:0	
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
OTHER REIMBURSABLE COST CENTERS		-		-	-	
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0	
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	-	101.00
SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.00
113. 00 11300 I NTEREST EXPENSE						1113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		o o	C	115.00
116. 00 11600 HOSPI CE	0	0		0 0	C	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	216, 370, 632	11, 950, 020	3, 354, 39	8 758, 202	213, 994, 853	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	49, 921	242, 377	68, 03	6 0	360, 334	1
192. 01 19201 HOSPI TAL BASED CLINIC	0	0		0 0		192.01
192. 02 19202 OUTPATI ENT PSYCH	263	0		0 0		192.02
193. 00 19300 NONPAI D WORKERS	238, 935	0		0 1, 673	240, 608	
193. 01 19301 COMMUNI TY	1, 187, 227	102, 779			1, 325, 286	1
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	2, 617, 549	1, 499, 929	421, 03	3 4, 672	4, 543, 183	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	220 464 527	12 705 105	2 070 01			201.00
202.00   TOTAL (sum lines 118-201)	220, 464, 527	13, 795, 105	3, 872, 31	7 770, 977	220, 464, 527	202.00

COST A	I Financial Systems ALLOCATION - GENERAL SERVICE COSTS	ELKHARI GENER	AL HOSPITAL Provider	F	In Lie Period: From 01/01/2014 Fo 12/31/2014	u of Form CMS-: Worksheet B Part I Date/Time Pre 5/28/2015 1:0	pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	REPAI RS	PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	34, 472, 226					5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0				6.00
7.00	00700 OPERATION OF PLANT	2,048,329					7.00
8.00	00800 LAUNDRY & LINEN SERVICE	255, 282					8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	619, 732 427, 463		114, 280 293, 409		4, 077, 734 8, 149	
11.00	01100 CAFETERIA	253, 649				43, 117	
12.00	01200 MAINTENANCE OF PERSONNEL	0		(		0	1
13.00	01300 NURSI NG ADMI NI STRATI ON	432,059	0	78, 035	-	15, 304	
14.00	01400 CENTRAL SERVICES & SUPPLY	267, 800		314, 581		67, 755	
15.00	01500 PHARMACY	903, 642	0	111, 056	6 0	30, 798	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	509, 344		105, 480		17, 389	
17.00	01700 SOCI AL SERVI CE	416, 929		3, 253		0	
18.00	01850 OTHER GENERAL SERVICE	0	-		-	0	
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	66, 182	0	7, 260	0 0	1, 990	23.00
30.00	03000 ADULTS & PEDIATRICS	5, 800, 337	0	3, 805, 726	783, 627	1, 759, 249	30.00
30.00	03100 I NTENSI VE CARE UNI T	981,036				1, 739, 249	1
31.01	03101 NEONATAL INTENSIVE CARE	249, 301	0	67, 667		27, 102	
40.00	04000 SUBPROVIDER - IPF	0	0	(		0	1
41.00	04100 SUBPROVI DER – I RF	304, 163	0	275, 897	14, 690	101, 016	41.00
43.00	04300 NURSERY	535, 273	0	402, 752	2 57, 281	27, 102	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	(	0 0	0	44.00
45.00	04500 NURSING FACILITY	0	0	0	-	0	
46.00	04600 OTHER LONG TERM CARE	0	0	(	0 0	0	46.00
F0 00	ANCI LLARY SERVI CE COST CENTERS	2 001 (12	0	1 511 510	10/ 052	435, 003	50.00
50.00 51.00	05100 RECOVERY ROOM	2, 881, 613				435,003	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0				0	1
53.00	05300 ANESTHESI OLOGY	0	0			0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 814, 207	0	1, 088, 052	152, 420	144, 748	1
54.01	05401 INTERVENTIONAL RADIOLOGY	0	0	(	0 0	0	1
54.02	05402 BREAST CENTER	0	0	(	0 0	0	54.02
54.03	05403 RADIATION ONCOLOGY	0	0	(	0 0	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0 0	0	
56.00	05600 RADI OI SOTOPE	0	0	(	0 0	0	
56.01	05601 ULTRASOUND	0	0			0	
57.00 58.00	05700 CT SCAN 05800 MRI	329, 957		206, 168		17,863	
	05900 CARDI AC CATHETERI ZATI ON	188, 145 840, 141		104, 173 118, 258		12, 224	59.00
	06000 LABORATORY	1, 926, 004		157, 668		36, 957	
60.01	06001 BLOOD LABORATORY	0	0	(	0 0	0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	287, 483	0	( ) (	0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(	0 0	0	1
64.00	06400 I NTRAVENOUS THERAPY	254, 681	0	56, 719		41, 932	
64.01	06401 HOME INFUSION	0	0	(	0	0	
65.00	06500 RESPIRATORY THERAPY	588, 248		52, 391 144, 251		9, 239	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	377, 458 129, 063		144, 251 69, 265		24, 638 1, 990	
		53, 417		41, 530		1, 990	
69.00	06900 ELECTROCARDI OLOGY	03,417	n	(		0	1
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 641, 306	0	0	0 0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	736, 948	0	0	0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 938, 231	0	(	0 0	0	73.00
74.00	07400 RENAL DI ALYSI S	0	0	0	0 0	0	
	07500 ASC (NON-DI STINCT PART)	0	0	(	0 0	0	1
76.00		466, 240	0	219, 266	5 12, 591	30, 134	76.00
00.00		150 170		155,000		24 204	00.00
90. 00 90. 01	09000 CLINIC 04951 SLEEP CLINIC	158, 172 95, 926		155, 228		26, 296 0	
	09100 EMERGENCY	1, 495, 362		397, 757	-	414, 440	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 475, 502		577,757	303,770	717, 740	92.00
	OTHER REIMBURSABLE COST CENTERS		•		<u> </u>		1
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	(	0 0	0	94.00
	09500 AMBULANCE SERVICES	0	0	0	0 0	0	
				1 (		0	96.00
96.00		0	0		0	0	
96. 00 97. 00		0	0			0	

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre	
Cast Castas Description					5/28/2015 1:0	2 pm
Cost Center Description	ADMI NI STRATI VE				HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE	0.00	
	5.00	6.00	7.00	8.00	9.00	101.00
101.00 10100 HOME HEALTH AGENCY	0	0	1	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS			1			110.00
113.00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	33, 273, 123	0	10, 720, 46	6 2, 014, 216	3, 512, 908	118.00
NONREI MBURSABLE COST CENTERS			1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190. 00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	66, 785	0	312, 57	7 0	109, 023	
192. 01 19201 HOSPI TAL BASED CLINIC	0	0		0 0	0	192.01
192. 02 19202 OUTPATI ENT PSYCH	49	0		0 0	0	192.02
193. 00 19300 NONPALD WORKERS	44, 595	0		0 0	0	193.00
193. 01 19301 COMMUNI TY	245, 631	0	132, 54	7 0	0	193.01
194.00079500THER NONREIMBURSABLE COST CENTERS	842, 043	0	1, 934, 35	9 0	455, 803	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	)	0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	34, 472, 226	0	13, 099, 94	9 2, 014, 216	4, 077, 734	202.00
					• ·	

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	ELKHART GENERA		CCN: 150018	Period: From 01/01/2014	u of Form CMS-: Worksheet B Part I	
					To 12/31/2014		
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE PERSONNEL		CENTRAL SERVICES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00							4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8.00 9.00
10.00	01000 DI ETARY	3, 035, 370					10.00
11.00		0	1, 777, 677				11.00
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0	44, 398		0 0 2, 900, 939		12.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	28, 591		0 0	2, 445, 821	
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	76, 500 66, 388		0 0	0	
17.00	01700 SOCIAL SERVICE	0	33, 719		0 2,698	0	1
	01850 OTHER GENERAL SERVICE	0	C		0 0	0	
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	4, 462		0 32	117	23.00
30.00	03000 ADULTS & PEDI ATRI CS	2, 601, 244	567, 025		0 1, 411, 681	88, 622	
	03100 I NTENSI VE CARE UNI T 03101 NEONATAL I NTENSI VE CARE	247, 386 0	99, 916 20, 379		0 309, 551 0 50, 955	38, 742 6, 035	
	04000 SUBPROVIDER - IPF	0	20, 379		0 50, 955	0,035	
41.00	04100 SUBPROVI DER – I RF	186, 740	24, 941		0 60, 425	891	41.00
43.00 44.00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	46, 301		0 134, 784	43 0	
45.00	04500 NURSI NG FACI LI TY	0	C		0 0	0	
46.00	04600 OTHER LONG TERM CARE	0	C		0 0	0	46.00
50.00	ANCI LLARY SERVICE COST CENTERS	0	196, 454		0 378, 765	1, 852, 302	50.00
51.00	05100 RECOVERY ROOM	0	C		0 0	0	
	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	123, 626		0 38, 695	0 27, 354	
54.01	05401 I NTERVENTI ONAL RADI OLOGY	0	C		0 0	0	54.01
54.02	05402 BREAST CENTER	0	C		0 0	0	
54.03 55.00	05403 RADI ATI ON ONCOLOGY 05500 RADI OLOGY-THERAPEUTI C	0	C		0 0	0	
56.00	05600 RADI OI SOTOPE	0	C		0 0	0	56.00
56. 01 57. 00	05601 ULTRASOUND 05700 CT SCAN	0	C 21, 370		0 0	0	
	05800 MRI	0	9, 708		0 204	1, 101 682	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	30, 645		0 45, 757	366, 363	59.00
	06000 LABORATORY 06001 BLOOD LABORATORY	0	C		0 0	636 0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C		0	0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0	0	
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	C 23, 385		0 0 0 85, 978	0 28, 899	
	06401 HOME INFUSION	0	20, 503 C		0 0	20,077	
	06500 RESPIRATORY THERAPY	0	56, 187		0 0	1, 572	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	36, 997 12, 363		0 20	278 40	
	06800 SPEECH PATHOLOGY	0	4, 763		0 0	40	1
	06900 ELECTROCARDI OLOGY	0	C		0 0	0	
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	C			0	
	03140 CARDI OLOGY	0	37, 566		0 43, 485	290	
90.00	OUTPATIENT SERVICE COST CENTERS	0	10, 937	1	0 9,872	0	90.00
	04951 SLEEP CLINIC	0	10, 937 11, 146		0 9,8/2	0 35	
91.00	09100 EMERGENCY	0	157, 318		0 327, 330	31, 819	91.00
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	C		0 0	0	94.00
	09500 AMBULANCE SERVI CES	0	C		0 0	0	1
	09600 DURABLE MEDICAL EQUIP-RENTED	1			_	0	96.00

Health Financial Systems	ELKHART GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS				Period: From 01/01/2014 To 12/31/2014		
Cost Center Description	DI ETARY		MAINTENANCE ( PERSONNEL	ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
	10.00	11.00	12.00	13.00	14.00	
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3, 035, 370	1, 745, 085		0 2, 900, 232	2, 445, 821	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
191. 00 19100 RESEARCH	0	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0		0 0	0	192.01
192. 02 19202 OUTPATI ENT PSYCH	0	0		0 0	0	192.02
193.00 19300 NONPALD WORKERS	0	5, 567		0 0	0	193.00
193. 01 19301 COMMUNI TY	0	12, 344		0 707	0	193.01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	14, 681		0 0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	1	0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	3, 035, 370	1, 777, 677		0 2, 900, 939	2, 445, 821	202.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	ELKHART GENER			eri od:	u of Form CMS- Worksheet B	2002-10
					rom 01/01/2014 o 12/31/2014	Part I Date/Time Pre	pared:
					OTHER GENERAL	5/28/2015 1:0	02 pm
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CE	PARAMED ED	
			RECORDS &			PRGM	
		15.00	LI BRARY 16. 00	17.00	18.00	23.00	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1 00
1.00 2.00	00200 CAP REL COSTS-BLDG & FIXT						1.00
4.00	00400 EMPLOYEE BENEFI TS DEPARTMENT						4.00
5.00 6.00	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS						5.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
9.00 10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA						11.00
12.00 13.00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON						12.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
15.00	01500 PHARMACY	5, 997, 532	2 444 724				15.00
16.00 17.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	3, 446, 734 0	2, 706, 112			16.00 17.00
18.00	01850 OTHER GENERAL SERVICE	0	0	0	0		18.00
23.00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	437, 123	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	45, 372	615, 998	2, 079, 157	0	0	30.00
31.00	03100 I NTENSI VE CARE UNI T	7, 981	117, 627			0	
31. 01 40. 00	03101 NEONATAL INTENSIVE CARE 04000 SUBPROVIDER - IPF	76	17, 006 0			0	
41.00	04100 SUBPROVI DER – I RF	396	27, 666	-	-	0	
43.00	04300 NURSERY	0	21	315, 740		0	
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0		0	
46.00	04600 OTHER LONG TERM CARE	0	0	0		0	
F0.00	ANCI LLARY SERVICE COST CENTERS	170 705	()( ()7			0	
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	179, 795 0	626, 687 0	0		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 544, 365	0 329, 094	0	0	0	
54.00 54.01	05400 RADI OLOGY - DI AGNOSTI C	544, 305	329, 094 0	0	-	0	
54.02	05402 BREAST CENTER	0	0	0	0	0	
54.03 55.00	05403 RADI ATI ON ONCOLOGY 05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	
56.00	05600 RADI OLOGI - MERALEONI C	0	0	0	-	0	
	05601 ULTRASOUND	0	0	0	0	0	
57.00 58.00	05700 CT SCAN 05800 MRI	64	298, 797 71, 483			0	
59.00	05900 CARDI AC CATHETERI ZATI ON	2, 312, 699	360, 299		-	0	
60.00		182	349, 031		-	0	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	74, 615	0	0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
64.00 64.01	06400 I NTRAVENOUS THERAPY 06401 HOME I NFUSI ON	1,632	8, 272 0		0	0	
65.00		227, 736	86, 033	0	0	0	
66.00	06600 PHYSI CAL THERAPY	0	30, 518		0	0	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	16, 356 5, 380		0	0	
69.00	06900 ELECTROCARDI OLOGY	0	0	0	-	0	69.00
70.00 71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0 0	
75.00 76.00		324, 145	151, 413			0	
	OUTPATIENT SERVICE COST CENTERS	1					
90. 00 90. 01	09000 CLINIC 04951 SLEEP CLINIC	0	23, 649 17, 937			0	
90. 01 91. 00	09100 EMERGENCY	8, 326	218, 852			437, 123	
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
94 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
74.UU	UTALISIS	0	0				94.00

Health Financial Systems	ELKHART GENERA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2014	Worksheet B	
				To 12/31/2014		nared
				10 12/31/2014	5/28/2015 1:0	
		·		OTHER GENERAL		
				SERVI CE		
Cost Center Description	PHARMACY		SOCIAL SERVIC	E	PARAMED ED	
		RECORDS &			PRGM	
	15.00	LI BRARY 16. 00	17.00	18.00	23.00	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	15.00	10.00	17.00	0 0	23.00	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
98. 00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS			•			1
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3, 652, 769	3, 446, 734	2, 706, 11	2 0	437, 123	118.00
NONREI MBURSABLE COST CENTERS		0			0	100.00
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH	0	0		0 0		190.00 191.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		191.00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0				192.00
192. 02 19202 OUTPATI ENT PSYCH	0	0		0 0		192.02
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
193. 01 19301 COMMUNI TY	387	0		0 0		193.01
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	2, 344, 376	0		0 0	0	194.00
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00   TOTAL (sum lines 118-201)	5, 997, 532	3, 446, 734	2, 706, 11	2 0	437, 123	202.00

	Financial Systems LOCATION - GENERAL SERVICE COSTS	ELKHART GENER		CCN: 150018	Period: From 01/01/2014	eu of Form CMS-2552 Worksheet B Part I
					To 12/31/2014	Date/Time Prepare
	Cost Center Description	Subtotal	Intern &	Total		5/28/2015 1:02 pm
			Residents Cost			
			& Post Stepdown			
			Adjustments			
		24.00	25.00	26.00		
	GENERAL SERVICE COST CENTERS					1
	00200 CAP REL COSTS-BEDG & TTXT					2
	00400 EMPLOYEE BENEFITS DEPARTMENT					4
	00500 ADMINI STRATI VE & GENERAL					5.
	00600 MAINTENANCE & REPAIRS					6
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7.
	00900 HOUSEKEEPI NG					9
	01000 DI ETARY					10
	01100 CAFETERI A					11.
	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION					12
	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY					13
	01500 PHARMACY					15
5.00	01600 MEDICAL RECORDS & LIBRARY					16
	01700 SOCIAL SERVICE					17.
1	01850 OTHER GENERAL SERVICE 02300 PARAMED ED PRGM					18
5.00	INPATIENT ROUTINE SERVICE COST CENTERS		II			23
0. 00	03000 ADULTS & PEDI ATRI CS	50, 853, 123	3 0	50, 853, 1	23	30
	03100 I NTENSI VE CARE UNI T	7, 933, 989	1	7, 933, 9		31
	03101 NEONATAL INTENSIVE CARE	1, 815, 370	1	1, 815, 3		31
-	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	2, 678, 233		2, 678, 2	0	40
	04300 NURSERY	4, 407, 328		4, 407, 3		43
	04400 SKILLED NURSING FACILITY	0	1		0	44
	04500 NURSI NG FACI LI TY	0			0	45
	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS		0 0		0	46
	05000 OPERATI NG ROOM	23, 806, 627	7 0	23, 806, 6	27	50
	05100 RECOVERY ROOM	0			0	51
	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY		0		0	52
	05300 ANEST HEST OLOGY 05400 RADI OLOGY-DI AGNOSTI C	14, 050, 992		14, 050, 9	0	53
	05401 I NTERVENTI ONAL RADI OLOGY	(	1	11,000, 2	0	54
	05402 BREAST CENTER	0	0 0		0	54
	05403 RADI ATI ON ONCOLOGY	0	0		0	54
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE				0	55
	05601 ULTRASOUND				0	56
1	05700 CT SCAN	2, 655, 580	0 0	2, 655, 5	80	57
	05800 MRI	1, 422, 601		1, 422, 6		58
	05900 CARDI AC CATHETERI ZATI ON	8, 672, 046	1	8,672,0		59
	06000 LABORATORY 06001 BLOOD LABORATORY	12, 862, 101	1	12, 862, 1	0	60. 60.
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	61
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 913, 191	0	1, 913, 1	91	62
	06300 BLOOD STORING, PROCESSING & TRANS.	(		4 675	0	63
	06400 I NTRAVENOUS THERAPY 06401 HOME I NFUSI ON	1, 875, 613		1, 875, 6	0	64
	06500 RESPI RATORY THERAPY	4, 195, 257		4, 195, 2	257	65
. 00	06600 PHYSI CAL THERAPY	2, 666, 898		2, 666, 8		66
	06700 OCCUPATI ONAL THERAPY	925, 428		925, 4		67
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	405, 617	1	405, 6		68
	06900  ELECTROCARDI OLOGY 07000  ELECTROENCEPHALOGRAPHY				0	69. 70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	29, 683, 155	5 0	29, 683, 1	55	71
. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	4, 713, 100	0 0	4, 713, 1	00	72
	07300 DRUGS CHARGED TO PATIENTS	12, 395, 823	1	12, 395, 8		73
	07400 RENAL DIALYSIS	0			0	74
	07500 ASC (NON-DI STI NCT PART) 03140 CARDI OLOGY	3, 800, 696	-	3, 800, 6	96	75.
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLINIC	1, 237, 562	1	1, 237, 5		90
	04951 SLEEP CLINIC	642,604		642,6		90
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	11, 860, 445	5 0	11, 860, 4	140	91.
	OTHER REIMBURSABLE COST CENTERS					
			0 0		0	94

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der CC		Period: From 01/01/2014 To 12/31/2014	
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments 25.00	Total 26.00	_	
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	24.00	23.00	20.00	0	96.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0	97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0	98.00
101.0010100 HOME HEALTH AGENCY	0	0		0	101.00
SPECIAL PURPOSE COST CENTERS	1	I I		1	
113.00 11300 INTEREST EXPENSE					113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				0	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P. ) 116.00 11600 HOSPICE	0	0		0	115.00 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	207, 473, 379	0	207, 473, 37	0	118.00
NONREI MBURSABLE COST CENTERS	207,473,377	<u> </u>	207, 473, 37	7	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190.00
191. 00 19100 RESEARCH	0	0		0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	848, 719	0	848, 71	9	192.00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0		0	192.01
192. 02 19202 OUTPATI ENT PSYCH	312	0	31	2	192.02
193. 00 19300 NONPALD WORKERS	290, 770		290, 77		193.00
193. 01 19301 COMMUNI TY	1, 716, 902		1, 716, 90		193.01
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	10, 134, 445	0	10, 134, 44	5	194.00
200.00 Cross Foot Adjustments	0	0		0	200.00
201.00 Negative Cost Centers	0	0	000 4/4 50	0	201.00
202.00  TOTAL (sum lines 118-201)	220, 464, 527		220, 464, 52	/	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	ELKHART GENER		F	eriod: rom 01/01/2014 o 12/31/2014	u of Form CMS-: Worksheet B Part II Date/Time Pre	epared:
			CAPI TAL REI	ATED COSTS		5/28/2015 1:0	2 pm
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	46, 187	12, 965	59, 152	59, 152	
5.00	00500 ADMI NI STRATI VE & GENERAL	0	820, 923	230, 435	1, 051, 358	4, 493	
6.00	00600 MAINTENANCE & REPAIRS	0	0		-	0	
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	2, 770, 114 295, 883			1, 193 663	1
9.00	00900 HOUSEKEEPI NG	0	88, 614			1, 333	
10. 00	01000 DI ETARY	0	227, 514			568	1
11.00	01100 CAFETERIA	0	87, 128			859	
12.00 13.00	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	0	0 60, 510	0 16, 985	-	0 1, 172	
14.00	01400 CENTRAL SERVICES & SUPPLY	0	243, 930			443	
15.00	01500 PHARMACY	0	86, 114			3, 069	
16.00	01600 MEDICAL RECORDS & LIBRARY	0	81, 791			1, 375	
17.00	01700 SOCIAL SERVICE	0	2, 522			1, 032	
18.00 23.00	01850 OTHER GENERAL SERVICE 02300 PARAMED ED PRGM	0	0 5, 630	0 1, 580	-	0 122	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		5,030	1, 300	7,210	122	20.00
30. 00	03000 ADULTS & PEDIATRICS	0	2, 951, 011	828, 356	3, 779, 367	15, 185	30.00
31.00	03100 INTENSIVE CARE UNIT	0	251, 925			2, 878	
31.01	03101 NEONATAL INTENSIVE CARE	0	52, 470	14, 729		789	
40.00 41.00	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0	213, 935	-	-	0 754	
43.00	04300 NURSERY	0	312, 299			1, 352	
44.00	04400 SKILLED NURSING FACILITY	0	0	0		0	1
45.00	04500 NURSING FACILITY	0	0			0	
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	46.00
50.00	05000 OPERATI NG ROOM	0	1, 172, 046	328, 996	1, 501, 042	5, 705	50.00
51.00	05100 RECOVERY ROOM	0	0	0	_	0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0 236, 826	1 000 51(	0	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 I NTERVENTI ONAL RADI OLOGY	0	843, 690	230, 820	1, 080, 516 0	3, 813 0	1
54.02	05402 BREAST CENTER	0	0	0	0	0	
54.03	05403 RADI ATI ON ONCOLOGY	0	0	0	0	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	
56.00 56.01	05600 RADI OI SOTOPE 05601 ULTRASOUND	0	0	0	0	0	
57.00	05700 CT SCAN	0	159, 865	s s	204, 740	621	57.00
58.00	05800 MRI	0	80, 777			288	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	91, 699			950	1
60.00		0	122, 258			0	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	1
64.00	06400 I NTRAVENOUS THERAPY	0	43, 980	12, 345	56, 325	797	
64.01	06401 HOME INFUSION	0	0		E2 020	0	64.01
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	40, 625 111, 854			1, 606 1, 133	1
67.00	06700 OCCUPATIONAL THERAPY	0	53, 709			384	
68.00	06800 SPEECH PATHOLOGY	0	32, 203			148	
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00	07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	
76.00	O3140 CARDI OLOGY	0	170, 022	47, 725	217, 747	1, 076	76.00
90.00	OUTPATIENT SERVICE COST CENTERS	0	120, 366	33, 787	154, 153	371	90.00
90.00 90.01	04951 SLEEP CLINIC	0	120, 300	0	134, 133	299	
91.00	09100 EMERGENCY	0	308, 426	86, 576	395, 002	3, 702	
	AND A REPLATION PERC (NON DICTINCT PART				0		92.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS			1			1 12.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Pre 5/28/2015 1:0	pared:
		CAPI TAL REI	ATED COSTS		372072013 1.0	2 011
Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
	Assigned New Capital				BENEFI TS DEPARTMENT	
	Related Costs				DEFARIMENT	
	0	1.00	2.00	2A	4.00	
95.00 09500 AMBULANCE SERVICES	0	0		0 0	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	0	97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101. 00
SPECIAL PURPOSE COST CENTERS						110.00
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF		0				114.00
115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116.00 11600 HOSPI CE	0	0		0 0		115. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	11, 950, 020	3, 354, 39	15, 304, 418		
NONREI MBURSABLE COST CENTERS	0	11, 750, 020	3, 334, 35	15, 504, 410	30, 173	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	242, 377	68, 03	36 310, 413	0	192.00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0		0 0	0	192. 01
192. 02 19202 OUTPATI ENT PSYCH	0	0	1	0 0	0	192. 02
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
193. 01 19301 COMMUNI TY	0	102, 779				193. 01
194.00079500THER NONREIMBURSABLE COST CENTERS	0	1, 499, 929	421, 03	1, 920, 962		194.00
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers	_	0		0 0		201.00
202.00   TOTAL (sum lines 118-201)	0	13, 795, 105	3, 872, 31	7 17, 667, 422	59, 152	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	ELKHART GENER		F	In Lie eriod: rom 01/01/2014 o 12/31/2014		pared:
	Cost Center Description	ADMI NI STRATI VE & GENERAL	REPAI RS	PLANT	LAUNDRY & LI NEN SERVI CE	HOUSEKEEPI NG	
	GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1 055 054					4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	1, 055, 851					5.00 6.00
7.00	00700 OPERATION OF PLANT	62, 740	-	3, 611, 624			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	7, 819					8.00
9.00	00900 HOUSEKEEPI NG	18, 982				165, 310	•
10.00		13,093		80, 892		330	
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	7,769		30, 978 0		1, 748 0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	13, 234	-	21, 514	-	620	
14.00	01400 CENTRAL SERVICES & SUPPLY	8, 203		86, 729			
15.00	01500 PHARMACY	27, 678	C	30, 618		1, 249	•
16.00	01600 MEDI CAL RECORDS & LI BRARY	15, 601	0	29, 081		705	
17.00 18.00	01700 SOCI AL SERVI CE 01850 OTHER GENERAL SERVI CE	12, 770				0	17.00 18.00
	02300 PARAMED ED PRGM	2,027			-	81	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	2,02,		2,002			20100
30.00	03000 ADULTS & PEDIATRICS	177, 635					30.00
31.00	03100 I NTENSI VE CARE UNI T	30, 049					
31. 01 40. 00	03101 NEONATAL INTENSIVE CARE 04000 SUBPROVIDER - IPF	7,636		18, 656		1, 099 0	
40.00	04000 SUBPROVIDER - TPP	9, 316	-	76, 064	-		•
43.00	04300 NURSERY	16, 395					•
44.00	04400 SKILLED NURSING FACILITY	0	0	C	0	0	44.00
45.00	04500 NURSING FACILITY	0	0		-	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	C	0	0	46.00
50.00	05000 OPERATING ROOM	88, 263	C	416, 720	48, 169	17, 635	50.00
51.00	05100 RECOVERY ROOM	0					51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C	C	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 I NTERVENTI ONAL RADI OLOGY	55, 569		299, 973	37, 278 0	5, 868 0	54.00 54.01
54.01	05402 BREAST CENTER	0			0	0	54.01
54.03	05403 RADI ATI ON ONCOLOGY	0		C C	0	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C	C	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	C	0	0	56.00
56.01	05601 ULTRASOUND 05700 CT SCAN	10 107	0	C	0	0	56.01
57.00 58.00	05800 MRI	10, 107 5, 763		56, 840 28, 720		724 496	57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON	25, 733		32, 604		2, 633	
	06000 LABORATORY	58, 993		43, 469		1, 498	
60.01	06001 BLOOD LABORATORY	0	0	C	0	0	60.01
61.00 62.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	8, 806				0	61.00 62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0, 800			0	0	
64.00	06400 I NTRAVENOUS THERAPY	7, 801	0	15, 637	0	1, 700	•
64.01	06401 HOME INFUSION	0	0	C	0	0	64.01
65.00	06500 RESPI RATORY THERAPY	18, 018		14, 444		375	•
66.00	06600 PHYSI CAL THERAPY	11, 562		39, 770			•
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	3, 953		19, 096 11, 450		81 499	
69.00	06900 ELECTROCARDI OLOGY	0		C	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	0	C	C	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	142, 163		C	0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	22, 573			0	0	72.00 73.00
73.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	59, 368			0	0	73.00
	07500 ASC (NON-DI STINCT PART)	0			0	0	75.00
	03140 CARDI OLOGY	14, 281	C	60, 451	3, 079		76.00
0.7	OUTPATIENT SERVICE COST CENTERS			1	1		
90. 00 90. 01	09000 CLINIC 04951 SLEEP CLINIC	4, 845 2, 938		42, 796	0	1, 066 0	90.00 90.01
	09100 EMERGENCY	45, 803		109, 661	-		
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	+3,003		107,001	, 4, 347	10,001	92.00
	OTHER REIMBURSABLE COST CENTERS	• 			·	-	
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	C	0	0	94.00
	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0			0	0	
	09700 DURABLE MEDICAL EQUIP-RENTED	0			0	0	•
	09851 OTHER REIMBURSABLE COST CENTERS	0	0	C C	0		•

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Peri od:	Worksheet B	
				From 01/01/2014		
				To 12/31/2014	Date/Time Pre 5/28/2015 1:0	pared:
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPING	
Cost Center Description	& GENERAL	REPAI RS	PLANT	LI NEN SERVI CE	HOUSEREEFING	
	5.00	6.00	7.00	8.00	9.00	
101.00 10100 HOME HEALTH AGENCY	0	0		0 0		101.00
SPECIAL PURPOSE COST CENTERS		•				
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 019, 122	0	2, 955, 60	6 492, 621	142, 412	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	2,046	0	86, 17	7 0	4, 420	192.00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0		0 0	0	192. 01
192. 02 19202 OUTPATI ENT PSYCH	1	0		0 0	0	192. 02
193.00 19300 NONPALD WORKERS	1, 366	0		0 0	0	193.00
193. 01 19301 COMMUNI TY	7, 524	0	36, 54		0	193. 01
194.00079500THER NONREIMBURSABLE COST CENTERS	25, 792	0	533, 29	8 0	18, 478	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00   TOTAL (sum lines 118-201)	1, 055, 851	0	3, 611, 62	4 492, 621	165, 310	202.00

Health Financial Systems	ELKHART GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014	Worksheet B Part II	
				To 12/31/2014	Date/Time Pre 5/28/2015 1:02	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE O		CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVI CES & SUPPLY	
	10.00	11.00	12.00	13.00	14.00	
GENERAL         SERVICE         COST         CENTERS           1.00         00100         CAP         REL         COSTS-BLDG         & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMI NI STRATI VE & GENERAL						4.00 5.00
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
7.00 00700 OPERATION OF PLANT						7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8.00 9.00
10. 00 01000 DI ETARY	386, 261	450.000				10.00
11. 00 01100 CAFETERIA 12. 00 01200 MAINTENANCE OF PERSONNEL	0	152, 939 0	1	0		11. 00 12. 00
13.00 01300 NURSI NG ADMI NI STRATI ON	0	3, 820		0 117, 855		13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY	0	2, 460 6, 582			491, 784 0	14.00 15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	5, 712		0 0	0	16. 00
17.00 01700 SOCIAL SERVICE	0	2, 901		0 110	0	17.00
18.00 01850 OTHER GENERAL SERVICE 23.00 02300 PARAMED ED PRGM	0	0 384		0 0 0 1	0 23	18. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	-					
30. 00 03000 ADULTS & PEDI ATRI CS 31. 00 03100 I NTENSI VE CARE UNI T	331, 017 31, 481	48, 779 8, 596	1	0 57, 351 0 12, 576	17, 819 7, 790	
31. 01 03101 NEONATAL INTENSIVE CARE	0	1, 753		0 2,070	1, 213	
40. 00 04000 SUBPROVIDER - IPF	0	0		0 0	0	40.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	23, 763 0	2, 146 3, 983		0 2, 455 0 5, 476	179 9	41.00 43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0	0	44.00
45. 00 04500 NURSING FACILITY 46. 00 04600 OTHER LONG TERM CARE	0	0		0 0	0	45.00 46.00
ANCI LLARY SERVICE COST CENTERS	0	0		<u> </u>	0	40.00
50. 00 05000 OPERATING ROOM	0	16, 902		0 15, 388	372, 446	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	51.00 52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00  05400  RADI OLOGY-DI AGNOSTI C 54. 01  05401  I NTERVENTI ONAL RADI OLOGY	0	10, 636 0	1	0 1, 572 0 0	5, 500 0	54.00 54.01
54. 02 05402 BREAST CENTER	0	0		0 0	0	54. 01 54. 02
54. 03 05403 RADI ATI ON ONCOLOGY	0	0		0 0	0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	55.00 56.00
56. 01 05601 ULTRASOUND	0	0		0 0	0	56. 01
57. 00 05700 CT SCAN 58. 00 05800 MRI	0	1, 839 835		0 0	221 137	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	2, 637		0 1,859	73, 665	
60. 00 06000 LABORATORY	0	0		0 0	128	60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0 0	0	60. 01 61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		о о	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	0	0 2, 012		0 0 0 3,493	0 5, 811	63.00 64.00
64.01 06401 HOME INFUSION	0	2,012		0 0	0	64.01
65. 00 06500 RESPI RATORY THERAPY	0	4,834		0 0	316	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	3, 183 1, 064		0 0	56 8	66.00 67.00
68.00 06800 SPEECH PATHOLOGY	0	410	1	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	69. 00 70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	73.00 74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
76. 00 03140 CARDI OLOGY OUTPATI ENT SERVICE COST CENTERS	0	3, 232		0 1, 767	58	76.00
90. 00 09000 CLI NI C	0	941		0 401	0	90.00
90. 01 04951 SLEEP CLINIC	0	959		0 0	7	90.01
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	13, 535		0 13, 298	6, 398	91.00 92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0	0		0 0 0 0	0	94.00 95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0 0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	1	0 0	0	97.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014	Worksheet B Part II	
				To 12/31/2014		pared <sup>.</sup>
					5/28/2015 1:0	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE O		CENTRAL	
			PERSONNEL	ADMI NI STRATI ON		
	10.00		10.00	10.00	SUPPLY	
	10.00	11.00	12.00	13.00	14.00	00.00
98.00 09851 OTHER REI MBURSABLE COST CENTERS	0	0		0		98.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE			1			113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						113.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0			0	114.00
116. 00 11600 HOSPI CE	0	0				116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	386, 261	150, 135		117,826		
NONREI MBURSABLE COST CENTERS	300, 201	150, 155		5 117,020	471,704	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	0	190.00
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0		0 0	0	192.01
192. 02 19202 OUTPATI ENT PSYCH	0	0		0 0	0	192.02
193. 00 19300 NONPALD WORKERS	0	479		0 0	0	193.00
193. 01 19301 COMMUNI TY	0	1, 062		29	0	193.01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	1, 263		0 0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00   TOTAL (sum lines 118-201)	386, 261	152, 939		0 117, 855	491, 784	202.00

	inancial Systems ON OF CAPITAL RELATED COSTS		Provi der		eriod: rom 01/01/2014	Worksheet B Part II	
					o 12/31/2014	Date/Time Pre 5/28/2015 1:0	pare
					OTHER GENERAL	572072013 1.0	
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL SERVI CE	SERVI CE	PARAMED ED	
			RECORDS &			PRGM	
		15.00	LI BRARY 16.00	17.00	18.00	23.00	<u> </u>
	ENERAL SERVICE COST CENTERS		10100		10100	20100	
	0100 CAP REL COSTS-BLDG & FIXT						1
	0200 CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT						2
	0500 ADMI NI STRATI VE & GENERAL						5
	0600 MAINTENANCE & REPAIRS						6
	0700 OPERATION OF PLANT						7
	0800 LAUNDRY & LINEN SERVICE						8
	0900 HOUSEKEEPI NG						9
	1000 DI ETARY						10
							11
	1200 MAI NTENANCE OF PERSONNEL 1300 NURSI NG ADMI NI STRATI ON						12
	1400 CENTRAL SERVICES & SUPPLY						14
	1500 PHARMACY	179, 482					15
	1600 MEDICAL RECORDS & LIBRARY	0	157, 224				16
. 00  0'	1700 SOCIAL SERVICE	0	0	20, 940			17
. 00  0'	1850 OTHER GENERAL SERVICE	0	C	0	0		18
	2300 PARAMED ED PRGM	0	0	0	0	11, 850	23
	NPATIENT ROUTINE SERVICE COST CENTERS	1 050		1			1
	3000 ADULTS & PEDIATRICS	1, 358	28, 083				30
	3100 I NTENSI VE CARE UNI T 3101 NEONATAL I NTENSI VE CARE	239	5, 362 775				31
	4000 SUBPROVIDER - IPF	2	775	142			40
	4100 SUBPROVIDER - IRF	12	1, 261	-	-		41
	4300 NURSERY	0	1,201	2, 443	0		43
00 04	4400 SKILLED NURSING FACILITY	0	C	0	0		44
00 04	4500 NURSING FACILITY	0	C	0	0		45
	4600 OTHER LONG TERM CARE	0	C	0	0		46
	NCI LLARY SERVICE COST CENTERS	5 001					1
	5000 OPERATING ROOM 5100 RECOVERY ROOM	5, 381 0	28, 661 0	0			50
	5200 DELIVERY ROOM & LABOR ROOM	0	0	0	0		51
	5300 ANESTHESI OLOGY	0	0	0	0		53
	5400 RADI OLOGY-DI AGNOSTI C	16, 291	15, 003	0	0		54
. 01  05	5401 I NTERVENTI ONAL RADI OLOGY	0	C	0	0		54
	5402 BREAST CENTER	0	0	0	0		54
	5403 RADIATION ONCOLOGY	0	C	0	0		54
	5500 RADI OLOGY-THERAPEUTI C	0	0	0	0		55
	5600 RADI OI SOTOPE	0	U	0	0		56
	5601 ULTRASOUND 5700 CT SCAN	0	12 422	0	0		56
	5700 CT SCAN 5800 MRI	2	13, 622 3, 259		0		58
	5900 CARDI AC CATHETERI ZATI ON	69, 210	16, 426		0		59
	6000 LABORATORY	57,210	15, 912		0		60
	6001 BLOOD LABORATORY	0	C	0	0		60
1	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61
1	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	3, 402	0	0		62
	6300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63
	6400 I NTRAVENOUS THERAPY 6401 HOME I NFUSI ON	49	377	0	0		64
	6500 RESPIRATORY THERAPY	6, 815	3, 922		0		64
	6600 PHYSI CAL THERAPY	0,015	1, 391		0		66
	6700 OCCUPATI ONAL THERAPY	0	746		0		67
	6800 SPEECH PATHOLOGY	0	245		0		68
	6900 ELECTROCARDI OLOGY	0	0	0	0		69
	7000 ELECTROENCEPHALOGRAPHY	0	C	0	0		70
	7100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0		71
	7200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0		72
	7300 DRUGS CHARGED TO PATIENTS 7400 RENAL DIALYSIS	0	0		0		73
	7400 RENAL DIALYSIS 7500 ASC (NON-DISTINCT PART)	0			0		75
	3140 CARDI OLOGY	9,700	6, 903	0	0		76
	UTPATIENT SERVICE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	3, 703				1
	9000 CLINIC	0	1, 078	0	0		90
01 04	4951 SLEEP CLINIC	0	818	0	0		90
	9100 EMERGENCY	249	9, 977	0	0		91
	9200 OBSERVATION BEDS (NON-DISTINCT PART						92
	THER REIMBURSABLE COST CENTERS		~				1
	9400 HOME PROGRAM DIALYSIS	0	0	0	0		94

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-255	52-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2014 To 12/31/2014		
Cost Center Description	PHARMACY	RECORDS & LI BRARY	SOCIAL SERVIC		PARAMED ED PRGM	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	15.00	16.00	17.00	18.00	23.00	6.00
97. 00 09700 DURABLE MEDICAL EQUIT-RENTED	0	0		0 0		7.00
98. 00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0		8.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	10	1.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						3.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						4.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		5.00
116.00 11600 HOSPI CE	0	0		0 0		6.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	109, 313	157, 224	20, 94	0 0	0 11	8.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	10	0.00
191. 00 19100 RESEARCH	0	0				1.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		2.00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0		0 0		2.01
192. 02 19202 OUTPATIENT PSYCH	0	0		0 0		2.02
193. 00 19300 NONPALD WORKERS	0	0		0 0	19	3.00
193. 01 19301 COMMUNI TY	12	0		0 0	19	3. 01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	70, 157	0		0 0	19	4.00
200.00 Cross Foot Adjustments					11, 850 20	0. 00
201.00 Negative Cost Centers	0	0		0 0		01.00
202.00  TOTAL (sum lines 118-201)	179, 482	157, 224	20, 94	0 0	11, 850 20	2.00

ealth Financia LLOCATION OF	CAPITAL RELATED COSTS	ELKHART GENER		CCN: 150018	Peri od:	eu of Form CMS-255 Worksheet B
					From 01/01/2014 To 12/31/2014	1 Date/Time Prepar
Cc	st Center Description	Subtotal	Intern &	Total		5/28/2015 1:02 p
			Residents Cost			
			& Post Stepdown			
			Adjustments			
		24.00	25.00	26.00		
	SERVICE COST CENTERS			1		
	₽ REL COSTS-BLDG & FIXT ₽ REL COSTS-MVBLE EQUIP					1
	IPLOYEE BENEFITS DEPARTMENT					2
	MINISTRATIVE & GENERAL					5
AM 00000 00	INTENANCE & REPAIRS					6
	PERATION OF PLANT					7
	UNDRY & LINEN SERVICE					8
00 00900 HC 00 01000 DI	USEKEEPI NG FTARY					10
00 01100 CA						11
	INTENANCE OF PERSONNEL					12
	IRSI NG ADMI NI STRATI ON					13
	NTRAL SERVICES & SUPPLY					14
00 01500 PH 00 01600 ME						15
	DICAL RECORDS & LIBRARY CIAL SERVICE					17
	HER GENERAL SERVICE					18
00 02300 PA	RAMED ED PRGM					23
	IT ROUTINE SERVICE COST CENTERS	-	1	1		
	ULTS & PEDIATRICS	5, 784, 879				30
	ITENSIVE CARE UNIT ONATAL INTENSIVE CARE	548, 202 104, 625				31
	IBPROVI DER – I PF	104, 823		104,	025	40
	IBPROVI DER – I RF	397, 937		397,	-	41
00 04300 NU		555, 767				43
	ILLED NURSING FACILITY	C	-		0	44
	IRSI NG FACI LI TY	C		•	0	45
	HER LONG TERM CARE RY SERVICE COST CENTERS	C	0 0	)	0	46
	PERATING ROOM	2, 516, 312	2 C	2, 516,	312	50
	COVERY ROOM	_, ,			0	51
	LIVERY ROOM & LABOR ROOM	C	0 0		0	52
		1 500 010	0		0	53
	DI OLOGY-DI AGNOSTI C ITERVENTI ONAL RADI OLOGY	1, 532, 019		1, 532,	019	54
	EAST CENTER				0	54
	DIATION ONCOLOGY	C			0	54
	DI OLOGY-THERAPEUTI C	C	0 0		0	55
	DI OI SOTOPE	C	0		0	56
	TRASOUND	200 71/		200	0	56
00 05700 CT 00 05800 MR		288, 716				57
	RDI AC CATHETERI ZATI ON	343, 156				59
00 06000 LA		276, 581				60
	OOD LABORATORY	C	0 0		0	60
	P CLINICAL LAB SERVICES-PRGM ONLY	10.000	-		200	61
1 1	IOLE BLOOD & PACKED RED BLOOD CELL .00D STORI NG, PROCESSI NG & TRANS.	12, 208		12,	208	62
	ITRAVENOUS THERAPY	94, 002	-	94	002	64
	ME INFUSION	C			0	64
00 06500 RE	SPI RATORY THERAPY	102, 359		102,		65
	IYSI CAL THERAPY	205, 306		205,	306	66
		94, 117		1	117	67
	EECH PATHOLOGY ECTROCARDI OLOGY	55, 630		55,	630	68
	ECTROEARDFOLOGT		-		o	70
	DICAL SUPPLIES CHARGED TO PATIENT	142, 163	۳ ۱	142,	163	71
	IPL. DEV. CHARGED TO PATIENTS	22, 573			573	72
	RUGS CHARGED TO PATIENTS	59, 368		59,	368	73
	NAL DIALYSIS		-		0	74
00 07500 AS 00 03140 CA	C (NON-DISTINCT PART)	319, 516			516	75
	ENT SERVICE COST CENTERS	519, 510	<u>'</u>	1 319,	510	//
00 09000 CL		205, 651	0	205,	651	90
01 04951 SL	EEP CLINIC	5, 021			021	90
00 09100 EN		688, 775			775	91
	SERVATION BEDS (NON-DISTINCT PART		0	9		92
	I MBURSABLE COST CENTERS ME PROGRAM DI ALYSI S	C			0	94
00 JU7400 HU	IBULANCE SERVICES				0	92

Health Financial Systems	ELKHART GENER	RAL HOSPITAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C	CN: 150018	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Prepared: 5/28/2015 1:02 pm
Cost Center Description		Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00		
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0	97.00
98. 00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0	98.00
101.00 10100 HOME HEALTH AGENCY	0	0		0	101. 00
SPECIAL PURPOSE COST CENTERS 113.00 I 1300 I NTEREST EXPENSE					113.00
114. 00 11400 UTI LI ZATI ON REVIEW-SNF					113.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0		0	115.00
116. 00 11600 HOSPI CE	0	0		0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	14, 502, 942	0	14, 502, 94	12	118.00
NONREI MBURSABLE COST CENTERS	14, 302, 742	<u> </u>	14, 302, 7	72	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190.00
191. 00 19100 RESEARCH	0	0		0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	403,056	0	403, 0	56	192.00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0		0	192.01
192. 02 19202 OUTPATI ENT PSYCH	1	0		1	192.02
193. 00 19300 NONPALD WORKERS	1,973	0	1, 9	73	193.00
193. 01 19301 COMMUNI TY	177, 292	0	177, 29	92	193.01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	2, 570, 308	0	2, 570, 30	08	194.00
200.00 Cross Foot Adjustments	11, 850	0	11, 8	50	200.00
201.00 Negative Cost Centers	0	0		0	201.00
202.00 TOTAL (sum lines 118-201)	17, 667, 422	0	17, 667, 42	22	202.00

	Financial Systems	ELKHART GENER		CON 150010 5		eu of Form CMS-2	
COST A	LLOCATION - STATISTICAL BASIS		Provi der	F	Period: rom 01/01/2014	Worksheet B-1	
				T	o 12/31/2014	Date/Time Pre 5/28/2015 1:0	
		CAPI TAL RE	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconci I i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
				SALARI ES)			
	GENERAL SERVI CE COST CENTERS	1.00	2.00	4.00	5A	5.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT	612, 587					1.00
2.00 4.00 5.00 6.00	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS	2, 051 36, 454	612, 587 2, 051	76, 789, 162 5, 835, 199	-34, 472, 226	185, 992, 301 0	2.00 4.00 5.00
7.00 8.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	123, 010 13, 139	123, 010 13, 139	1, 549, 109 860, 895	0 5 0	11, 051, 620 1, 377, 354	7.00 8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 935 10, 103				3, 343, 722 2, 306, 349	
11.00	01100 CAFETERI A	3, 869				1, 368, 548	11.00
12.00 13.00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	2, 687	0 2,687	1, 521, 442		0 2, 331, 143	
14.00	01400 CENTRAL SERVICES & SUPPLY	10, 832	10, 832	575, 712	2 0	1, 444, 899	14.00
	01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	3, 824 3, 632				4, 875, 536 2, 748, 133	1
17.00	01700 SOCIAL SERVICE	112	112	1, 340, 248	3 0	2, 249, 513	17.00
	01850 OTHER GENERAL SERVICE 02300 PARAMED ED PRGM	250	0 250		-	-	
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	131, 043					
31.01	03101 NEONATAL INTENSIVE CARE	2, 330	2, 330	1, 025, 076	0	1, 345, 087	31.01
	04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	9, 500	0 9, 500		-	0 1, 641, 092	
43.00	04300 NURSERY	13, 868				2, 888, 031	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		-	0	
46.00	04600 OTHER LONG TERM CARE	0	C				1
50.00	ANCI LLARY SERVI CE COST CENTERS	52,046	52,046	7, 409, 019	0	15, 547, 546	50.00
51.00	05100 RECOVERY ROOM	0	0,040	C			1
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0		-	-	
	05400 RADI OLOGY-DI AGNOSTI C	37, 465	37, 465		-	-	1
54. 01 54. 02	05401 I NTERVENTI ONAL RADI OLOGY 05402 BREAST CENTER	0	0			0	
54.03	05403 RADIATION ONCOLOGY	0			0	0	54.03
	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	C	0	0	
56.01	05601 ULTRASOUND	0		0	0	0	
	05700 CT SCAN 05800 MRI	7, 099 3, 587				1, 780, 260 1, 015, 122	1
	05900 CARDI AC CATHETERI ZATI ON	4, 072				4, 532, 925	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	5, 429	5, 429	C	0	10, 391, 623 0	60. 00 60. 01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	1, 551, 093 0	
64.00	06400 I NTRAVENOUS THERAPY	1, 953	1, 953	1, 035, 667	0	1, 374, 115	
64. 01 65. 00	06401 HOME I NFUSI ON 06500 RESPI RATORY THERAPY	0 1, 804	0 1, 804	C 2, 085, 817		0 3, 173, 851	
66. 00	06600 PHYSI CAL THERAPY	4, 967	4, 967			2, 036, 551	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	2, 385 1, 430				696, 351 288, 208	
	06900 ELECTROCARDI OLOGY	0	1, 430 0	172, 112 C	0 0	200, 200	1
	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		0			25, 041, 849 3, 976, 152	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	C	0	10, 457, 592	73.00
	07500 ASC (NON-DI STI NCT PART)		0		, 0 0 0	0	74.00 75.00
	03140 CARDI OLOGY	7, 550	7, 550	1, 397, 573	B 0	2, 515, 566	76.00
90.00	OUTPATI ENT SERVICE COST CENTERS	5, 345	5, 345	481, 334	l 0	853, 408	90.00
	04951 SLEEP CLINIC 09100 EMERGENCY	12 404	13 696	000,000		,	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	13, 696	13, 696	4,000,229		0,000,122	91.00 92.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre	nared
					5/28/2015 1:0	
	CAPI TAL REI	LATED COSTS				
Cast Castas Description						
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS	Reconci l i ati on	& GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS		(100001111 00001)	
			SALARI ES)			
	1.00	2.00	4.00	5A	5.00	
OTHER REIMBURSABLE COST CENTERS	-	-	1	-1 -	-	
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0 0	0	
98. 00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
101.00 10100 HOME HEALTH AGENCY	0	0			-	101.00
SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	101.00
113. 00 11300 I NTEREST EXPENSE						1113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	0		0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	530, 654	530, 654	75, 516, 64	0 -34, 472, 226	179, 522, 627	118.00
NONREI MBURSABLE COST CENTERS	-	-			-	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	10, 763	10, 763		0 0	360, 334	191.00
192. 00 19200 PHYSICIANS PRIVATE OFFICES 192. 01 19201 HOSPI TAL BASED CLINIC	10, 763	10, 763		0 0		192.00
192. 02/19202 OUTPATIENT PSYCH	0					192.02
193. 00 19300 NONPALD WORKERS	0	0	166, 68	3 0	240, 608	
193. 01 19301 COMMUNI TY	4, 564	4, 564			1, 325, 286	
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	66, 606	66, 606			4, 543, 183	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	13, 795, 105	3, 872, 317	770, 97	7	34, 472, 226	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	22. 519422	6. 321252			0. 185342	
204.00 Cost to be allocated (per Wkst. B, Part II)			59, 15	2	1, 055, 851	204.00
205.00 Unit cost multiplier (Wkst. B, Part			0. 00077	0	0. 005677	205 00
			0.00077		0.003077	200.00
1 ()	1	I	I	I	1	1

	Financial Systems ALLOCATION - STATISTICAL BASIS	ELKHART GENER			eriod:	u of Form CMS-2 Worksheet B-1	2552-10
					rom 01/01/2014 o 12/31/2014	Date/Time Pre	pared:
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	PLANT	LAUNDRY & LI NEN SERVICE (POUNDS OF	HOUSEKEEPI NG (HOURS OF SERVI CE)	5/28/2015 1:0 DI ETARY (MEALS SERVED)	2 pm
		6.00	7.00	LAUNDRY) 8.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS		1	1			
1.00 2.00 4.00 5.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						1.00 2.00 4.00 5.00
6.00 7.00 8.00 9.00	00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	574, 082 123, 010 13, 139 3, 935	451, 072 13, 139	1, 302, 842	86, 063		6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00	01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	10, 103 3, 869 0	3, 869 0	0	172 910 0	164, 918 0 0	10. 00 11. 00 12. 00
13.00 14.00 15.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	2, 687 10, 832 3, 824	10, 832 3, 824	208, 403 0	323 1, 430 650	000000000000000000000000000000000000000	13.00 14.00 15.00
16.00 17.00 18.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE 02300 PARAMED ED PRGM	3, 632 112 0 250	112 0	0	367 0 0	0 0 0 0	16.00 17.00 18.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	250	250	<u>ı</u> 0	42	0	23.00
30.00	03000 ADULTS & PEDIATRICS	131, 043				141, 331	30.00
31. 00 31. 01	03100 I NTENSI VE CARE UNI T 03101 NEONATAL I NTENSI VE CARE	11, 187 2, 330			2, 980 572	13, 441 0	31.00 31.01
40.00	04000 SUBPROVI DER – I PF	0	0	0	0	0	40.00
41.00	04100 SUBPROVIDER - IRF	9, 500			2, 132	10, 146	41.00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	13, 868	13, 868 0		572 0	0	43.00 44.00
45.00	04500 NURSI NG FACI LI TY	0	C C	0	0	0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	C	0	0	0	46.00
50.00	05000 OPERATI NG ROOM	52,046	52, 046	127, 393	9, 181	0	50.00
51.00	05100 RECOVERY ROOM	0	C	0	0	0	51.00
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	0	0	0	52.00 53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	37, 465	37, 465	98, 589	3, 055	0	54.00
54.01	05401 I NTERVENTI ONAL RADI OLOGY	0	0	0	0	0	54.01
54.02	05402 BREAST CENTER 05403 RADI ATI ON ONCOLOGY	0	0	0	0	0	54.02
54.03 55.00	05500 RADI OLOGY - THERAPEUTI C	0			0	0	54.03 55.00
56.00	05600 RADI OI SOTOPE	0	C	0	0	0	56.00
56.01	05601 ULTRASOUND	0	0	0	0	0	56.01
57.00 58.00	05700 CT SCAN 05800 MRI	7, 099 3, 587			377 258	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 072			1, 371	0	59.00
60.00	06000 LABORATORY	5, 429	5, 429	0	780	0	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0	0	0	63.00
64.00 64.01	06400 I NTRAVENOUS THERAPY 06401 HOME I NFUSI ON	1, 953	1, 953	0	885 0	0	64.00 64.01
65.00	06500 RESPIRATORY THERAPY	1,804	1, 804	0	195	0	65.00
66.00	06600 PHYSI CAL THERAPY	4, 967	4, 967	10, 470	520	0	66.00
67.00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	2, 385			42	0	67.00
68.00 69.00	06900 ELECTROCARDI OLOGY	1,430	1,430		260	0	68.00 69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C	0	0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0			0	0	72.00 73.00
74.00	07400 RENAL DI ALYSI S	0	0	0	0	0	
75.00	07500 ASC (NON-DI STI NCT PART)	0	0	0	0	0	75.00
76.00	03140 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS	7, 550	7, 550	8, 144	636	0	76.00
90.00	09000 CLINIC	5, 345	5, 345	0	555	0	90.00
90. 01	04951 SLEEP CLINIC	0	C	0	0	0	90.01
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	13, 696	13, 696	196, 632	8, 747	0	91.00 92.00
72.00	OTHER REIMBURSABLE COST CENTERS			1			72.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	C	-	0	0	
95.00 96.00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED	0		-	0	0	95.00 96.00
70.00	107000 DURADLE MEDICAL LUUTI-RENTED	0		<sup>'I</sup> 0	0	0	1 /0.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				rom 01/01/2014 0 12/31/2014	Date/Time Pre	nared
					5/28/2015 1:0	
Cost Center Description	MAINTENANCE &	OPERATI ON OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	REPAI RS	PLANT	LINEN SERVICE	· · · · ·	(MEALS SERVED)	
	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	SERVI CE)		
	6,00	7.00	LAUNDRY) 8.00	9,00	10.00	
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	0.00	7.00	0.00		0	97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
101.00 10100 HOME HEALTH AGENCY	0	0	(	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	(	0 0		115.00
116. 00 11600 HOSPI CE	0	0	(	0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	492, 149	369, 139	1, 302, 842	2 74, 142	164, 918	118.00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(		0	190.00
190:00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	10, 763	10, 763		2,301		191.00
192. 01 19201 HOSPI TAL BASED CLINIC	10,703	10, 703		2,301		192.00
192. 02 19202 OUTPATIENT PSYCH	0	0				192.02
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
193. 01 19301 COMMUNI TY	4, 564	4, 564		0 0		193.01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	66, 606	66, 606	(	9, 620	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	0	13, 099, 949	2, 014, 216	4, 077, 734	3, 035, 370	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000				18. 405329	•
204.00 Cost to be allocated (per Wkst. B,	0	3, 611, 624	492, 621	165, 310	386, 261	204.00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	8. 006757	0. 378113	1. 920802	2. 342140	205 00
205.00 Unit cost multiplier (wkst. B, Part	0.00000	0.000/5/	0.3/8113	1. 920802	2. 342140	205.00
	1		I	1	I	I

	Financial Systems LOCATION – STATISTICAL BASIS	ELKHART GENER				Period: From 01/01/2014	worksheet B-1	
						To 12/31/2014	Date/Time Pre 5/28/2015 1:0	
	Cost Center Description	CAFETERIA (HOURS)	PER (N	ENANCE OF SONNEL UMBER USED)	NURSI NG ADMI NI STRATI O (DI RECT NRSI N HRS)	SUPPLY	PHARMACY (COSTED REQUIS.)	
		11.00	1	2.00	13.00	14.00	15.00	
1.00       0         2.00       0         4.00       0         5.00       0         5.00       0         7.00       0         3.00       0         10.00       0         11.00       0         12.00       0         13.00       0         14.00       0         15.00       0         17.00       0         18.00       0         23.00       2	GENERAL         SERVICE         COST         CENTERS           00100         CAP         REL         COSTS-BLDG & FIXT           00200         CAP         REL         COSTS-BLDG & FIXT           00400         EMPLOYEE         BENEFITS         DEPARTMENT           00500         ADMINISTRATIVE & GENERAL         00600           00500         ADMINISTRATIVE & GENERAL           00600         MAINTENANCE & REPAIRS           00700         OPERATION OF PLANT           00800         LAUNDRY & LINEN SERVICE           00900         HOUSEKEEPING           01100         CAFETERIA           01200         MAINTENANCE OF PERSONNEL           01300         NURSI NG ADMINISTRATION           014000         CENTRAL SERVICES & SUPPLY           01500         PHARMACY           01600         MEDICAL RECORDS & LIBRARY           01700         SOCIAL SERVICE           01850         OTHER GENERAL SERVICE           02300         PARAMED ED PRGM	2, 291, 155 0 57, 222 36, 849 98, 597 85, 564 43, 459 0 5, 751	D 2 2 7 4 9	2, 291, 155 57, 222 36, 849 98, 597 85, 564 43, 459 0 5, 751	1, 009, 67 93	28, 938, 864       5       0	4, 965, 505 0 0 0 0 0	1. ( 2. ( 4. ( 5. ( 6. ( 7. ( 8. ( 9. ( 10. ( 11. ( 12. ( 13. ( 13. ( 14. ( 15. ( 15. ( 15. ( 15. ( 17. ( 18. ( 23. ( 23. (
30.00     0       31.00     0       31.01     0       40.00     0       41.00     0       43.00     0       44.00     0       45.00     0	I NPATI ENT ROUTI NE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 I NTENSIVE CARE UNIT 03101 NEONATAL I NTENSIVE CARE 04000 SUBPROVIDER - I PF 04100 SUBPROVIDER - I RF 04300 NURSERY 04400 SKI LLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	730, 810 128, 776 26, 265 0 32, 145 59, 675 0 0 0 0	5 5 5 5 0	730, 810 128, 776 26, 265 0 32, 145 59, 675 0 0 0 0	107, 74 17, 73 21, 03 46, 91	0         458, 393           5         71, 401           0         0           1         10, 542	37, 565 6, 608 63 0 328 0 0 0 0 0 0 0 0	31.0 31.0 40.0
0.00	OSOOO DELIVERY ROOM & LABOR ROOM 05200 DELIVERY ROOM & LABOR ROOM 05200 DELIVERY ROOM & LABOR ROOM	253, 199 0 0 0		253, 199 0 0 0		21, 916, 371 0 0 0 0 0 0	148, 857 0 0 0	50. 51. 52. 53.
4.01         4.02         4.03         5.00         6.00         6.01	05400 RADI OLOGY-DI AGNOSTI C 05401 I NTERVENTI ONAL RADI OLOGY 05402 BREAST CENTER 05403 RADI ATI ON ONCOLOGY 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05601 ULTRASOUND	159, 335 0 0 0 0 0 0 0 0 0 0 0 0		159, 335 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0	450, 693 0 0 0 0 0 0 0 0	54. 54. 55. 56. 56.
8.00 9.00 0.00 0.01 1.00 2.00	05700 CT SCAN 05800 MRI 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	27, 543 12, 512 39, 497 0 0 0	2	27, 543 12, 512 39, 497 0 0 0	7		53 0 1, 914, 741 151 0 0 0 0	58. 59. 60. 60. 61. 62.
4. 01 5. 00 6. 00 7. 00 8. 00 9. 00	06400 I NTRAVENOUS THERAPY 06401 HOME I NFUSI ON 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY	30, 140 0 72, 417 47, 684 15, 934 6, 139 0	D 7 1	30, 140 0 72, 417 47, 684 15, 934 6, 139 0		5 341, 929 0 0 18, 604 7 3, 290 0 475 0 0 0 0 0 0	1, 351 0 188, 548 0 0 0 0 0 0	64.
1.00         2.00         3.00         4.00         5.00         6.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STINCT PART) 03140 CARDI OLOGY 0UTPATI ENT SERVI CE COST CENTERS	0 0 0 0 0 48, 417	) ) ) ) 7	0 0 0 0 0 48, 417	15, 13	0 0 0 0 0 0 0 0 0 0 5 3, 435	0 0 0 0 268, 368	71. 72. 73. 74. 75.
0.00 0.01 1.00 2.00	09000 CLINIC 04951 SLEEP CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	14, 096 14, 365 202, 759	5	14, 096 14, 365 202, 759		0 420	0 0 6, 893	90. 90. 91. 92.
	09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0		0			0	94. 95.

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		eriod:	Worksheet B-1	
				rom 01/01/2014		
			T	0 12/31/2014		
Cost Center Description	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	5/28/2015 1:0 PHARMACY	2 pm
cost center bescription	(HOURS)		ADMI NI STRATI ON		(COSTED	
	(11001(3)	(NUMBER		SUPPLY	REQUIS.)	
			(DIRECT NRSING		RECOID. )	
			HRS)	REQUIS.)		
	11.00	12.00	13.00	14.00	15.00	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	0	0	97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	98.00
101.00 10100 HOME HEALTH AGENCY	0	0	C	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	0	C	0		115.00
116. 00 11600 HOSPI CE	0	0	C	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	2, 249, 150	2, 249, 150	1, 009, 433	28, 938, 864	3, 024, 219	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0		190. 00
191. 00 19100 RESEARCH	0	0	C	0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0		192.00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0	C	0		192.01
192. 02 19202 OUTPATI ENT PSYCH	0	0	C	0		192.02
193.00 19300 NONPAI D WORKERS	7, 175			0		193.00
193. 01 19301 COMMUNI TY	15, 909		246	0		193.01
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	18, 921	18, 921	C	0	1, 940, 966	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	4 777 477		0 000 000	0.445.004	F 007 F00	201.00
202.00 Cost to be allocated (per Wkst. B,	1, 777, 677	0	2, 900, 939	2, 445, 821	5, 997, 532	202.00
Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	0. 775887	0. 000000	2.873130	0. 084517	1. 207839	202 00
203.00 Cost to be allocated (per Wkst. B,	0. 775887	0.000000	2.873130			
Part II)	102, 939	0	117,855	471, 784	179, 482	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 066752	0. 000000	0, 116725	0. 016994	0. 036146	205 00
	0.000752	0.000000	0.110/20	0.010994	0. 030140	200.00
	I I	· ·	1	1 1		I

	Financial Systems NLLOCATION - STATISTICAL BASIS	ELKHART GENER		CCN: 150018	In Lie Period:	u of Form CMS-2552- Worksheet B-1
					From 01/01/2014 To 12/31/2014	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY (TI ME SPENT) 16.00	SOCIAL SERVICE (TIME SPENT) 17.00	OTHER GENERAL SERVICE (TIME SPENT) 18.00	PARAMED ED PRGM (ASSI GNED TIME) 23.00	5/28/2015 1:02 pm
	GENERAL SERVICE COST CENTERS			1		
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 23.\ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT         00200 CAP REL COSTS-MVBLE EQUIP         00400 EMPLOYEE BENEFITS DEPARTMENT         00500 ADMINISTRATIVE & GENERAL         00600 MAINTENANCE & REPAIRS         00700 OPERATION OF PLANT         00800 LAUNDRY & LINEN SERVICE         00900 HOUSEKEEPING         01000 DI ETARY         01200 MAINTENANCE OF PERSONNEL         01300 NURSING ADMINISTRATION         01400 CENTRAL SERVICES & SUPPLY         01500 PHARMACY         01600 MEDICAL RECORDS & LIBRARY         01700 SOCIAL SERVICE         01850 OTHER GENERAL SERVICE         02300 PARAMED ED PRGM	536, 283, 204 0 0 0	13, 156 0 0		0 0 100	1. 0 2. 0 4. 0 5. 0 6. 0 7. 0 8. 0 9. 0 10. 0 11. 0 12. 0 13. 0 14. 0 15. 0 16. 0 17. 0 18. 0 23. 0
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	05 045 040	40.400			
30.00 31.00 31.01 40.00 41.00 43.00 44.00 45.00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNIT 03101 NEONATAL I NTENSI VE CARE 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY	95, 845, 312 18, 302, 026 2, 646, 060 4, 304, 684 3, 321 0 0	10, 108 1, 228 0 196 1, 535 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.0 31.0 40.0 41.0 43.0 44.0 45.0
46.00	04600 OTHER LONG TERM CARE	0	C		0 0	46.0
50.00 51.00 52.00 53.00 54.01 54.03 55.00 56.00 56.00 56.00 57.00 58.00 60.01 61.00 62.00 63.00 64.00 64.01 65.00 64.00 64.00 64.00 67.00 68.00 67.00 71.00 72.00 73.00 73.00 74.00 75.00 74.00 75.00 74.00 75.00 74.00 75.00 74.00 75.00 74.00 75.00 74.00 75.00 74.00 75.00 74.00 75.00 74.00 75.00 74.00 75.00 74.00 75.00 75.00 76.00 76.00 90.000	05601 ULTRASOUND 05700 CT SCAN 05800 MRI 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 06400 INTRAVENOUS THERAPY 06600 PHYSICAL THERAPY 06600 PHYSICAL THERAPY 06600 PHYSICAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 CLECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY 0UTPATIENT SERVICE COST CENTERS	97, 501, 646 0 0 51, 204, 920 0 0 0 0 46, 490, 894 11, 122, 361 56, 060, 179 54, 306, 994 0 11, 609, 631 0 1, 287, 012 0 13, 386, 211 4, 748, 427 2, 544, 953 837, 06 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				51.0         52.0         53.0         54.0         54.0         54.0         55.0         56.0         57.0         56.0         57.0         58.0         59.0         60.0         61.0         62.0         63.0         64.0         65.0         66.0         67.0         68.0         69.0         70.0         71.0         72.0         73.0         74.0         75.0
90.00 90.01 91.00 92.00	09000 CLINIC 04951 SLEEP CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	3, 679, 646 2, 790, 927 34, 052, 033	C C C		0 0 0 0 0 100	90. 0 90. 0 91. 0 92. 0
	OTHER REIMBURSABLE COST CENTERS	ا - ا	-	1		
94.00	09400 HOME PROGRAM DI ALYSI S	0	C	1	0 0	94.0

					u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1
				From 01/01/2014 To 12/31/2014	Date/Time Prepared:
					5/28/2015 1:02 pm
			OTHER GENERA	-	
			SERVI CE		
Cost Center Description	MEDICAL RECORDS &	SOCIAL SERVICE	(TIME SPENT)	PARAMED ED PRGM	
	LIBRARY	(TIME SPENT)		(ASSI GNED	
	(TIME SPENT)			TIME)	
	16.00	17.00	18.00	23.00	
95. 00 09500 AMBULANCE SERVI CES	0	0		0 0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	98.00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	101.00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE					113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
115. 0011500 AMBULATORY SURGICAL CENTER (D. P. )	0	0		0	114.00
116. 00 11600 HOSPI CE	0	0		0 0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	536, 283, 204	13, 156		0 100	118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	190.00
191. 00 19100 RESEARCH	0	0		0 0	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	192.00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0		0 0	192.01
192. 02 19202 OUTPATIENT PSYCH	0	0		0 0	192.02
193. 00 19300 NONPALD WORKERS	0	0		0 0	193.00 193.01
193.01 19301 COMMUNI TY 194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 0	193.01
200.00 Cross Foot Adjustments	0	0		0 0	200.00
201.00 Negative Cost Centers					200.00
202.00 Cost to be allocated (per Wkst. B,	3, 446, 734	2, 706, 112		0 437, 123	201.00
Part I)	0, 10, 701	277007112			202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 006427	205. 694132	0. 00000	0 4, 371. 230000	203.00
204.00 Cost to be allocated (per Wkst. B,	157, 224	20, 940		0 11, 850	204.00
Part II)					
205.00 Unit cost multiplier (Wkst. B, Part	0. 000293	1. 591669	0.00000	0 118.500000	205.00
11)					

Health Financial Systems		ELKHART GENER				u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS	TO CHARGES		Provi der	1	Period: From 01/01/2014	Worksheet C Part I	
					To 12/31/2014	Date/Time Pre 5/28/2015 1:0	
			Titl	e XVIII	Hospi tal Costs	PPS	
Cost Center Descri	ption	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col. 26)					
		1.00	2.00	3.00	4.00	5.00	
30. 00 03000 ADULTS & PEDIATRI		50, 853, 123		50, 853, 12	3 18, 151	50, 871, 274	30.00
31. 00 03100 I NTENSI VE CARE UN		7, 933, 989		7, 933, 98			
31.01 03101 NEONATAL INTENSIV	E CARE	1, 815, 370		1, 815, 37			
40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF		2, 678, 233		2, 678, 23		0 2, 678, 233	
43. 00 04300 NURSERY		4, 407, 328		4, 407, 32		4, 407, 328	
44.00 04400 SKILLED NURSING F	ACI LI TY	0		1	0 0	0	44.00
45.00 04500 NURSING FACILITY 46.00 04600 OTHER LONG TERM C/	\DF	0				0	45.00 46.00
ANCI LLARY SERVICE COST		0	I	· · · · · · · · · · · · · · · · · · ·	0	0	40.00
50.00 05000 OPERATING ROOM		23, 806, 627		23, 806, 62	7 21, 375	23, 828, 002	
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & L/		0				0	51.00 52.00
53. 00 05300 DELIVERT ROOM & L/	ADUK KUUM	0			0 0	0	52.00
54.00 05400 RADI OLOGY-DI AGNOS		14, 050, 992		14, 050, 99	2 35, 992	14, 086, 984	54.00
54. 01 05401 INTERVENTIONAL RAI	DI OLOGY	0			0 0	0	54.01
54. 02 05402 BREAST CENTER 54. 03 05403 RADI ATI ON ONCOLOG	(	0			0 0	0	54.02 54.03
55.00 05500 RADI OLOGY-THERAPE		0			0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE		0			0 0	0	56.00
56.01 05601 ULTRASOUND 57.00 05700 CT SCAN		2, 655, 580		2, 655, 58		0 2, 655, 580	56.01 57.00
58. 00 05800 MRI		1, 422, 601		1, 422, 60		1, 422, 601	
59.00 05900 CARDI AC CATHETERI 2	ZATION	8, 672, 046		8, 672, 04			
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		12, 862, 101		12, 862, 10	1 0	12, 862, 101 0	60.00 60.01
61. 00 06100 PBP CLINICAL LAB	SERVICES-PRGMONLY	0			0 0	0	61.00
62.00 06200 WHOLE BLOOD & PACH		1, 913, 191		1, 913, 19	1 0	1, 913, 191	
63.00 06300 BLOOD STORING, PR		0		1 075 (1	0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAU 64. 01 06401 HOME I NFUSI ON	γ	1, 875, 613		1, 875, 61		1, 875, 613 0	
65.00 06500 RESPI RATORY THERAI	рү	4, 195, 257	c	4, 195, 25	7 2, 374		
66.00 06600 PHYSI CAL THERAPY		2, 666, 898		2, 666, 89		2, 666, 898	
67.00 06700 0CCUPATI ONAL THER/ 68.00 06800 SPEECH PATHOLOGY	APY	925, 428 405, 617		925, 42 405, 61		925, 428 405, 617	
69. 00 06900 ELECTROCARDI OLOGY		0			0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGI		0			0 0	0	
71.00 07100 MEDICAL SUPPLIES ( 72.00 07200 IMPL. DEV. CHARGEI		29, 683, 155 4, 713, 100		29, 683, 15 4, 713, 10		29, 683, 155 4, 713, 100	
73. 00 07300 DRUGS CHARGED TO F		12, 395, 823		12, 395, 82			
74.00 07400 RENAL DIALYSIS		0			0 C	-	
75. 00 07500 ASC (NON-DI STI NCT 76. 00 03140 CARDI OLOGY	PART)	0 3, 800, 696		3, 800, 69	0 0 6 6,464	0 3, 807, 160	
OUTPATIENT SERVICE COST	CENTERS	3,000,070	<u> </u>	3, 000, 07	0,404	3, 007, 100	70.00
90. 00 09000 CLI NI C		1, 237, 562		1, 237, 56			
90. 01 04951 SLEEP CLINIC 91. 00 09100 EMERGENCY		642,604		642,60			
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS	NON-DISTINCT PART	11, 860, 445 7, 145, 710		11, 860, 44 7, 145, 71		11, 925, 440 7, 145, 710	
OTHER REIMBURSABLE COST	CENTERS				-		
94.00 09400 HOME PROGRAM DI AL		0			0 0	0	
95.00 09500 AMBULANCE SERVICES 96.00 09600 DURABLE MEDICAL E0		0			0 0	0	
97.00 09700 DURABLE MEDICAL E		0			0 0	0	
98.00 09851 OTHER REI MBURSABLI		0			0 0	0	
101.00 10100 HOME HEALTH AGENC		0	<u> </u>		J	0	101.00
113.00 11300 INTEREST EXPENSE							113.00
114.00 11400 UTI LI ZATI ON REVIEN		_				-	114.00
115. 00 11500 AMBULATORY SURGIC/ 116. 00 11600 H0SPICE	al center (D. P. )						115.00 116.00
200.00 Subtotal (see ins	tructions)	214, 619, 089	C	214, 619, 08	9 162, 456		
201.00 Less Observation I		7, 145, 710		7, 145, 71		7, 145, 710	
202.00  Total (see instruc	.u 005)	207, 473, 379	C	207, 473, 37	9 162, 456	207, 635, 835	202.00

COMPUT	Financial Systems ATION OF RATIO OF COSTS TO CHARGES	ELKHART GENER		CCN: 150018	Peri od:	u of Form CMS- Worksheet C	
					From 01/01/2014 To 12/31/2014	Part I Date/Time Pre	epared:
			Ti +1	e XVIII	Hospi tal	5/28/2015 1:0 PPS	)2 pm
			Charges			113	
	Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
0.00	INPATIENT ROUTINE SERVICE COST CENTERS	07 751 070		07 751 0	70		1 20 0
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	87, 751, 873 18, 305, 031		87, 751, 8			30.0
	03101 NEONATAL INTENSIVE CARE	2, 646, 060		18, 305, 0 2, 646, 0			31.0
	04000 SUBPROVI DER – I PF	2, 040, 000		2,040,0	0		40.0
41.00	04100 SUBPROVI DER – I RF	3, 730, 512		3, 730, 5	12		41.0
43.00	04300 NURSERY	4, 461, 092		4, 461, 0	92		43.0
14.00	04400 SKI LLED NURSI NG FACI LI TY	0			0		44.0
45.00	04500 NURSING FACILITY	0			0		45.0
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0			0		46.0
50.00	05000 OPERATI NG ROOM	50, 107, 999	47, 393, 647	97, 501, 6	46 0. 244166	0.00000	50. 0
51.00	05100 RECOVERY ROOM	0	C		0 0. 000000	0.00000	51.0
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0. 000000	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	C	F4 004 -	0 0.00000	0.00000	
54.00 54.01	05400 RADI OLOGY-DI AGNOSTI C 05401 I NTERVENTI ONAL RADI OLOGY	9, 401, 748	41, 803, 172	51, 204, 9	20 0. 274407 0 0. 000000	0. 000000 0. 000000	
54. 01 54. 02	05402 BREAST CENTER	0			0 0.000000	0. 000000	
54.03	05403 RADI ATI ON ONCOLOGY	0	C		0 0.000000	0.000000	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C	)	0 0. 000000	0.00000	
56.00	05600 RADI OI SOTOPE	0	C		0 0.000000	0.00000	56.0
56. 01	05601 ULTRASOUND	0	C		0 0. 000000	0.00000	
57.00	05700 CT SCAN	5, 677, 476	40, 813, 417			0.00000	
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	2, 414, 674	8, 707, 687			0. 000000 0. 000000	
59.00 50.00	06000 LABORATORY	16, 351, 307 21, 620, 553	39, 708, 872 32, 686, 441			0. 000000	
50. 00 50. 01	06001 BLOOD LABORATORY	21, 020, 333	52, 000, 441 C	34, 300, 7	0 0.000000	0. 000000	
51.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C		0 0. 000000	0.00000	
52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	9, 112, 088	2, 497, 543	11, 609, 6	0. 164793	0.00000	
53.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0. 000000	0.00000	
54.00	06400 I NTRAVENOUS THERAPY	632, 603	654, 409	1, 287, 0		0.00000	
54.01 55.00	06401 HOME I NFUSI ON 06500 RESPI RATORY THERAPY	10, 970, 927	2, 415, 284	13, 386, 2	0 0.000000 11 0.313401	0. 000000 0. 000000	
55.00 56.00	06600 PHYSI CAL THERAPY	2, 711, 982	2, 415, 284			0. 000000	
57.00	06700 OCCUPATI ONAL THERAPY	2,003,928	541, 025			0.000000	
58.00	06800 SPEECH PATHOLOGY	509, 211	327, 856	837, 0	67 0. 484569	0.00000	68.0
	06900 ELECTROCARDI OLOGY	0	C		0 0. 000000	0.00000	
	07000 ELECTROENCEPHALOGRAPHY	0	0	11( 100 1	0 0.00000	0.00000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	75, 582, 987	40, 600, 127			0.00000	
	07300 DRUGS CHARGED TO PATIENTS	19, 884, 123 47, 703, 412	2, 980, 301 42, 012, 541			0. 000000 0. 000000	
	07400 RENAL DIALYSIS	0	42,012,041	1	0 0.000000	0. 000000	
	07500 ASC (NON-DI STINCT PART)	0	C	)	0 0. 000000	0.00000	
	03140 CARDI OLOGY	5, 006, 987	18, 551, 914	23, 558, 9	0. 161327	0.00000	) 76. C
	OUTPATIENT SERVICE COST CENTERS						
		2, 094, 638	1, 585, 008			0.00000	
	04951 SLEEP CLINIC 09100 EMERGENCY	11, 814 6, 941, 927	2, 779, 114 27, 110, 106			0. 000000 0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0, 941, 927	17, 137, 597			0. 000000	
	OTHER REIMBURSABLE COST CENTERS			1 11/10//0		01000000	, , , , , , , , , , , , , , , , , , , ,
94.00	09400 HOME PROGRAM DI ALYSI S	0	C		0 0.000000	0.00000	94.0
	09500 AMBULANCE SERVICES	0	C		0 0. 000000	0.00000	
	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0.000000	0.00000	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0 0.000000	0.00000	
	09851 OTHER REIMBURSABLE COST CENTERS 10100 HOME HEALTH AGENCY	0			0 0.000000	0.00000	98. 0 101. 0
51.00	SPECIAL PURPOSE COST CENTERS	V	L. L.	1	<u> </u>		
13.00	11300 I NTEREST EXPENSE						113. 0
	11400 UTI LI ZATI ON REVIEW-SNF						114. 0
15.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C		0		115. C
	11600 HOSPI CE	0	C		0		116. 0
116.00		105 15	070 0/5 -				
	Subtotal (see instructions)	405, 634, 952	372, 342, 506	777, 977, 4	58		200. 0 201. 0

	inancial Systems TION OF RATIO OF COSTS TO CHARGES	ELKHART GENERAL	Provi der CCN: 150018	Peri od:	u of Form CMS-255 Worksheet C
				From 01/01/2014 To 12/31/2014	Part I Date/Time Prepar
			Title XVIII	Hospi tal	5/28/2015 1:02 p PPS
	Cost Center Description	PPS Inpatient			
		Ratio			
LD	NPATIENT ROUTINE SERVICE COST CENTERS	11.00			
	3000 ADULTS & PEDIATRICS				30
	3100 I NTENSI VE CARE UNI T				31
	3101 NEONATAL INTENSIVE CARE				31
0. 00 04	4000 SUBPROVIDER - IPF				40
1.00 04	4100 SUBPROVI DER – I RF				41
3.00 04	4300 NURSERY				43
	4400 SKILLED NURSING FACILITY				44
	4500 NURSING FACILITY				45
	4600 OTHER LONG TERM CARE				46
	NCILLARY SERVICE COST CENTERS				
	5000 OPERATING ROOM	0. 244386			50
	5100 RECOVERY ROOM	0.000000			51
	5200 DELI VERY ROOM & LABOR ROOM 5300 ANESTHESI OLOGY	0. 000000			52
	5400 RADI OLOGY - DI AGNOSTI C	0. 275110			54
	5400 RADI OLOGI - DI AGNOSTI C 5401 I NTERVENTI ONAL RADI OLOGY	0. 000000			54
	5402 BREAST CENTER	0. 000000			54
	5403 RADIATION ONCOLOGY	0. 000000			54
	5500 RADI OLOGY-THERAPEUTI C	0.000000			55
. 00 05	5600 RADI OI SOTOPE	0. 000000			56
. 01 05	5601 ULTRASOUND	0. 000000			56
	5700 CT SCAN	0. 057120			57
	5800 MRI	0. 127905			58
	5900 CARDI AC CATHETERI ZATI ON	0. 154855			59
	6000 LABORATORY	0. 236841			60
	6001 BLOOD LABORATORY	0. 000000			60
	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.00000			61
	6200 WHOLE BLOOD & PACKED RED BLOOD CELL 6300 BLOOD STORI NG, PROCESSI NG & TRANS.	0. 164793 0. 000000			62
	6400 I NTRAVENOUS THERAPY	1. 457339			64
	6401 HOME I NFUSI ON	0. 000000			64
	6500 RESPI RATORY THERAPY	0. 313579			65
	6600 PHYSI CAL THERAPY	0. 561638			66
	6700 OCCUPATI ONAL THERAPY	0. 363633			67
3.00 00	6800 SPEECH PATHOLOGY	0. 484569			68
0.00 00	6900 ELECTROCARDI OLOGY	0.000000			69
1	7000 ELECTROENCEPHALOGRAPHY	0. 000000			70
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 255486			71
1	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 206132			72
	7300 DRUGS CHARGED TO PATIENTS	0. 138167			73
	7400 RENAL DI ALYSI S 7500 ASC (NON-DI STI NCT PART)	0.000000			74
	3140 CARDI OLOGY	0. 161602			76
	UTPATIENT SERVICE COST CENTERS	0.101002			
	9000 CLINIC	0. 336638			90
	4951 SLEEP CLINIC	0. 230247			90
. 00 09	9100 EMERGENCY	0. 350212			91
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 416961			92
	THER REIMBURSABLE COST CENTERS				
	9400 HOME PROGRAM DI ALYSI S	0. 000000			94
	9500 AMBULANCE SERVICES	0.000000			95
		0.000000			96
	9700 DURABLE MEDICAL EQUIP-SOLD 9851 OTHER REIMBURSABLE COST CENTERS	0. 000000			97
	0100 HOME HEALTH AGENCY	0.000000			101
	PECIAL PURPOSE COST CENTERS				10
	1300 I NTEREST EXPENSE				113
	1400 UTILIZATION REVIEW-SNF				114
	1500 AMBULATORY SURGICAL CENTER (D. P.)				115
	1600 HOSPI CE				116
0. 00	Subtotal (see instructions)				200
01.00	Less Observation Beds				201
02.00	Total (see instructions)				202

	Financial Systems	ELKHART GENER		CON 150010		u of Form CMS-	2552-10
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provider		Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre 5/28/2015 1:0	pared:
			Tit	le XIX	Hospi tal	PPS	z piii 1
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		26) 1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1		1		
30.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	50, 853, 123		50, 853, 12			•
	03100 NEONATAL INTENSIVE CARE	7, 933, 989 1, 815, 370		7, 933, 98 1, 815, 37		7, 936, 772 1, 815, 370	•
	04000 SUBPROVI DER – I PF	0		.,	0 0	0	1
	04100 SUBPROVI DER – I RF	2, 678, 233		2, 678, 23		2, 678, 233	•
	04300 NURSERY	4, 407, 328		4, 407, 32		4, 407, 328	
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0			0 0	0	
	04600 OTHER LONG TERM CARE	0			0 0	0	
	ANCILLARY SERVICE COST CENTERS	-		1	-		
	05000 OPERATING ROOM	23, 806, 627		23, 806, 62	7 21, 375		•
	05100 RECOVERY ROOM	0			0 0	0	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0				0	
	05400 RADI OLOGY-DI AGNOSTI C	14, 050, 992		14, 050, 99	2 35, 992	14, 086, 984	•
	05401 I NTERVENTI ONAL RADI OLOGY	0			0 0	0	
	05402 BREAST CENTER	0			0 0	0	
	05403 RADI ATI ON ONCOLOGY 05500 RADI OLOGY-THERAPEUTI C	0				0	
	05600 RADI OLOGI - THERAPEUTI C	0			0 0	0	
	05601 ULTRASOUND	0			0 0	0	1
	05700 CT SCAN	2, 655, 580		2, 655, 58	0 0	2, 655, 580	57.00
	05800 MRI	1, 422, 601		1, 422, 60		1, 422, 601	•
	05900 CARDI AC CATHETERI ZATI ON	8, 672, 046		8, 672, 04			•
	06000 LABORATORY 06001 BLOOD LABORATORY	12, 862, 101		12, 862, 10		12, 862, 101 0	1
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	•
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 913, 191		1, 913, 19	1 0	1, 913, 191	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	
	06400 I NTRAVENOUS THERAPY 06401 HOME I NFUSI ON	1, 875, 613		1, 875, 61	3 0	1, 875, 613 0	1
	06500 RESPI RATORY THERAPY	4, 195, 257	0	4, 195, 25	7 2, 374	4, 197, 631	•
	06600 PHYSI CAL THERAPY	2, 666, 898		2, 666, 89		2, 666, 898	•
	06700 OCCUPATI ONAL THERAPY	925, 428		925, 42		925, 428	•
	06800 SPEECH PATHOLOGY	405, 617		405, 61		405, 617	•
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	29, 683, 155		29, 683, 15	5 0	29, 683, 155	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 713, 100		4, 713, 10		4, 713, 100	72.00
	07300 DRUGS CHARGED TO PATIENTS	12, 395, 823		12, 395, 82			
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0			0 0	0	
	03140 CARDI OLOGY	3, 800, 696		3, 800, 69	°		
	OUTPATIENT SERVICE COST CENTERS				-, -,		1
	09000 CLI NI C	1, 237, 562		1, 237, 56			1
	04951 SLEEP CLINIC	642, 604		642, 60			•
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	11, 860, 445 7, 145, 710		11, 860, 44 7, 145, 71		11, 925, 440 7, 145, 710	
-	OTHER REIMBURSABLE COST CENTERS	7,145,710		7,145,71	0	7, 145, 710	92.00
	09400 HOME PROGRAM DI ALYSI S	0			0 0	0	94.00
	09500 AMBULANCE SERVICES	0			0 0	0	•
	09600 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD 09851 OTHER REIMBURSABLE COST CENTERS	0				0	
	10100 HOME HEALTH AGENCY	0			ŏ		101.00
	SPECIAL PURPOSE COST CENTERS						1
	11300 INTEREST EXPENSE						113.00
	11400 UTI LI ZATI ON REVIEW-SNF				0	_	114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.) 11600 HOSPICE				0		115.00 116.00
116 000		0	1	1	~		•
200.00	Subtotal (see instructions)	214, 619, 089	0	214, 619, 08	9 162, 456	214, 781, 545	200.00
	Less Observation Beds	214, 619, 089 7, 145, 710 207, 473, 379		7, 145, 71	0	7, 145, 710	201.00

	Financial Systems TION OF RATIO OF COSTS TO CHARGES		AL HOSPITAL Provider	CCN: 150018	Peri od:	wof Form CMS- Worksheet C	
					From 01/01/2014 To 12/31/2014	Part I Date/Time Pre	epared
			Tit	le XIX	Hospi tal	5/28/2015 1:0 PPS	)2 pm
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	07 751 070		07 751 0	70		
	D3000 ADULTS & PEDIATRICS D3100 INTENSIVE CARE UNIT	87, 751, 873 18, 305, 031		87, 751, 8 18, 305, 0			30.0
	D3101 NEONATAL INTENSIVE CARE	2, 646, 060		2, 646, 0			31.0
	04000 SUBPROVI DER – I PF	2, 040, 000		2,040,0	0		40.0
	04100 SUBPROVI DER – I RF	3, 730, 512		3, 730, 5	12		41.0
	D4300 NURSERY	4, 461, 092		4, 461, 0	92		43.0
	04400 SKI LLED NURSI NG FACI LI TY	0			0		44.0
	04500 NURSI NG FACI LI TY	0			0		45.0
	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0			0		46.0
	D5000 OPERATI NG ROOM	50, 107, 999	47, 393, 647	97, 501, 6	46 0. 244166	0.00000	50. 0
	D5100 RECOVERY ROOM	0	C	)	0 0. 000000	0.00000	
	D5200 DELIVERY ROOM & LABOR ROOM	0	C		0 0. 000000	0.00000	
	05300 ANESTHESI OLOGY	0	(	F1 66 -	0 0.00000	0.00000	
	05400 RADI OLOGY-DI AGNOSTI C 05401 I NTERVENTI ONAL RADI OLOGY	9, 401, 748	41, 803, 172	51, 204, 9	20 0. 274407 0 0. 000000	0. 000000 0. 000000	
	05402 BREAST CENTER	0	(		0 0.000000	0.000000	
	D5403 RADI ATI ON ONCOLOGY	0	(		0 0.000000	0.000000	
	05500 RADI OLOGY-THERAPEUTI C	0	C		0 0.000000	0.00000	
6.00	05600 RADI OI SOTOPE	0	C		0 0.000000	0.00000	56.
	D5601 ULTRASOUND	0	C		0 0. 000000	0.00000	
	D5700 CT SCAN	5, 677, 476	40, 813, 417			0.00000	
		2, 414, 674	8, 707, 687			0.00000	
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	16, 351, 307 21, 620, 553	39, 708, 872 32, 686, 441			0. 000000 0. 000000	
	D6001 BLOOD LABORATORY	21, 020, 333	32, 000, 441	34, 300, 7	0 0.000000	0.000000	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C		0 0.000000	0.00000	
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	9, 112, 088	2, 497, 543	11, 609, 6	0. 164793	0.00000	62.0
1	D6300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0. 000000	0.00000	
	06400 I NTRAVENOUS THERAPY	632, 603	654, 409	1, 287, 0		0.00000	
	06401 HOME INFUSION 06500 RESPIRATORY THERAPY	0 10, 970, 927	2 415 204	12 204 2	0 0.000000	0. 000000 0. 000000	
	D6600 PHYSI CAL THERAPY	2, 711, 982	2, 415, 284 2, 036, 445			0.000000	
	06700 OCCUPATI ONAL THERAPY	2,003,928	541, 025			0.000000	
	D6800 SPEECH PATHOLOGY	509, 211	327, 856			0.00000	
	D6900 ELECTROCARDI OLOGY	0	C		0 0.000000	0.00000	69.
	07000 ELECTROENCEPHALOGRAPHY	0	C	)	0 0.000000	0.00000	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	75, 582, 987	40, 600, 127			0.00000	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	19, 884, 123 47, 703, 412	2, 980, 301 42, 012, 541			0. 000000 0. 000000	
	07400 RENAL DIALYSIS	47, 703, 412	42,012,341		0 0.000000		
	07500 ASC (NON-DISTINCT PART)	0	C		0 0.000000	0.000000	
6.00	D3140 CARDI OLOGY	5, 006, 987	18, 551, 914	23, 558, 9		0.00000	
	DUTPATIENT SERVICE COST CENTERS	-		1			
		2, 094, 638	1, 585, 008			0.00000	
	04951 SLEEP CLINIC	11,814	2, 779, 114			0.00000	
	D9100 EMERGENCY D9200 OBSERVATION BEDS (NON-DISTINCT PART	6, 941, 927 0	27, 110, 106 17, 137, 597			0. 000000 0. 000000	
	OTHER REIMBURSABLE COST CENTERS		17, 137, 397	1 17, 137, 3	0.410701	0.00000	, , , , , , , , , , , , , , , , , , , ,
	D9400 HOME PROGRAM DI ALYSI S	0	C		0 0.00000	0.00000	94.
5.00	09500 AMBULANCE SERVI CES	0	C		0 0.000000	0.000000	95.
	09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0.00000	0.00000	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0.000000	0.00000	
	09851 OTHER REIMBURSABLE COST CENTERS	0			0 0.000000	0.00000	) 98. 101.
-	SPECIAL PURPOSE COST CENTERS	U	(	4	U	<u> </u>	+
	11300 I NTEREST EXPENSE						113.
	11400 UTI LI ZATI ON REVIEW-SNF						114.
15 00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C		0		115.
	11600 HOSPI CE	0	(		0		116.
16.00				·			
	Subtotal (see instructions) Less Observation Beds	405, 634, 952	372, 342, 506	777, 977, 4	58		200.

leal th Financi COMPUTATION O	F RATIO OF COSTS TO CHARGES	ELKHART GENERAL	Provi der CCN: 150018	Peri od:	u of Form CMS-2552 Worksheet C
				From 01/01/2014 To 12/31/2014	Part I Date/Time Prepare
					5/28/2015 1:02 pr PPS
C	ost Center Description	PPS Inpatient	Title XIX	Hospi tal	PP3
	·	Ratio			
	NT DOUTLNE SEDVICE COST CENTERS	11.00			
	INT ROUTI NE SERVI CE COST CENTERS				30
	NTENSI VE CARE UNI T				31
	EONATAL INTENSIVE CARE				31
	UBPROVIDER – IPF				40
	UBPROVIDER - IRF				41
3.00 04300 N					43
	KILLED NURSING FACILITY URSING FACILITY				44
	THER LONG TERM CARE				46
	RY SERVICE COST CENTERS				
	PERATING ROOM	0. 244386			50
	ECOVERY ROOM	0. 000000			51
2.00 05200 D	ELIVERY ROOM & LABOR ROOM	0. 000000			52
1 1	NESTHESI OLOGY	0.000000			53
1 1	ADI OLOGY-DI AGNOSTI C	0. 275110			54
	NTERVENTI ONAL RADI OLOGY REAST CENTER	0.000000			54
	ADIATION ONCOLOGY	0.000000			54
	ADI OLOGY-THERAPEUTI C	0. 000000			55
	ADI OI SOTOPE	0. 000000			56
	LTRASOUND	0.000000			56
7.00 05700 C	T SCAN	0. 057120			57
8.00 05800 M		0. 127905			58
	ARDI AC CATHETERI ZATI ON	0. 154855			59
		0. 236841			60
	LOOD LABORATORY BP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			60
	HOLE BLOOD & PACKED RED BLOOD CELL	0. 164793			62
	LOOD STORING, PROCESSING & TRANS.	0. 000000			63
	NTRAVENOUS THERAPY	1. 457339			64
4.01 06401 H	OME INFUSION	0. 000000			64
	ESPI RATORY THERAPY	0. 313579			65
	HYSI CAL THERAPY	0. 561638			66
	CCUPATIONAL THERAPY	0. 363633			67
1 1	PEECH PATHOLOGY LECTROCARDI OLOGY	0. 484569 0. 000000			68 69
	LECTROENCEPHALOGRAPHY	0. 000000			70
	EDICAL SUPPLIES CHARGED TO PATIENT	0. 255486			71
2.00 07200 1	MPL. DEV. CHARGED TO PATIENTS	0. 206132			72
	RUGS CHARGED TO PATIENTS	0. 138167			73
	ENAL DIALYSIS	0. 000000			74
	SC (NON-DI STINCT PART)	0.000000			75
6.00 03140 C	ENT SERVICE COST CENTERS	0. 161602			
0.00 09000 C		0. 336638			90
	LEEP CLINIC	0. 230247			90
1.00 09100 E		0. 350212			91
2.00 09200 0	BSERVATION BEDS (NON-DISTINCT PART	0. 416961			92
	EIMBURSABLE COST CENTERS				
	OME PROGRAM DI ALYSI S	0.000000			94
	MBULANCE SERVICES	0.000000			95
	URABLE MEDICAL EQUIP-RENTED URABLE MEDICAL EQUIP-SOLD	0.000000			96
	THER REIMBURSABLE COST CENTERS	0.000000			97
	OME HEALTH AGENCY				101
	PURPOSE COST CENTERS				
13.00 11300 I	NTEREST EXPENSE				113
	TILIZATION REVIEW-SNF				114
	MBULATORY SURGICAL CENTER (D. P. )				115
16.0011600 H					116
	ubtotal (see instructions)				200
	ess Observation Beds				201 202
.02.00 1	otal (see instructions)				1202

Health Financial Systems	ELKHART GENER	RAL HOSPITAL		In Lie	eu of Form CMS-:	2552-10
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE F REDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provi der	F	Period: From 01/01/2014 Fo 12/31/2014	Worksheet C Part II Date/Time Pre	pared:
		ті +	le XIX	Hospi tal	5/28/2015 1:0 PPS	2 pm
Cost Center Description	Total Cost		Operating Cost	Capital	Operating Cost	
obst center bescription		(Wkst. B, Part		Reduction	Reduction	
	I, col. 26)		Cost (col. 1 -		Amount	
			col. 2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	23, 806, 627	2, 516, 312	21, 290, 315		-	
51.00 05100 RECOVERY ROOM	0			0 0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0			0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	14, 050, 992	1, 532, 019	12, 518, 973	3 U	0	54.00
54. 01 05401 I NTERVENTI ONAL RADI OLOGY 54. 02 05402 BREAST CENTER	0			0	0	54.01 54.02
54. 03 05403 RADI ATI ON ONCOLOGY	0				0	54.02
55. 00 05500 RADI OLOGY-THERAPEUTI C					0	55.00
56. 00 05600 RADI 0I SOTOPE	0				0	56.00
56. 01 05601 ULTRASOUND	0	0		0 0	0	56.01
57. 00 05700 CT SCAN	2, 655, 580	288, 716	2, 366, 864	1 0	0	57.00
58. 00 05800 MRI	1, 422, 601				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	8, 672, 046	343, 156	8, 328, 890	0 0	0	59.00
60. 00 06000 LABORATORY	12, 862, 101	276, 581	12, 585, 520	0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	C	) (	0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C		0 0	0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 913, 191	12, 208	1, 900, 983	3 0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0	0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	1, 875, 613	94, 002	1, 781, 611	0	0	64.00
64. 01 06401 HOME INFUSION	0			0	0	64.01
65. 00 06500 RESPIRATORY THERAPY	4, 195, 257				0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	2, 666, 898				0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	925, 428 405, 617				0	68.00
69. 00 06900 ELECTROCARDI OLOGY	403, 017				0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	29, 683, 155	142, 163	29, 540, 992	2 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	4, 713, 100				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 395, 823		12, 336, 455	5 0	0	73.00
74.00 07400 RENAL DIALYSIS	0	C	) (	0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C	) (	0 0		75.00
76. 00 03140 CARDI OLOGY	3, 800, 696	319, 516	3, 481, 180	0 0	0	76.00
OUTPATIENT SERVICE COST CENTERS				-	-	
90. 00 09000 CLINIC	1, 237, 562					90.00
90. 01 04951 SLEEP CLINIC 91. 00 09100 EMERGENCY	642, 604 11, 860, 445					90.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 145, 710					91.00 92.00
OTHER REIMBURSABLE COST CENTERS	7, 143, 710	812, 582	0, 333, 120		0	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0				0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0 0	0	1
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C		0 0	0	1
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	C		0 0	0	
101.00 10100 HOME HEALTH AGENCY	0	C	0 0	0 0	0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C		0		115.00
116.00 11600 HOSPI CE	0			0		116.00
200.00 Subtotal (sum of lines 50 thru 199)	146, 931, 046					200. 00 201. 00
201.00Less Observation Beds202.00Total (line 200 minus line 201)	7, 145, 710 139, 785, 336					201.00
	137, /00, 330	1, 111, 032	1 132,073,804	*I U	I 0	202.00

ALCULATION OF OUTPATIENT SERVICE COST TO CHARGI EDUCTIONS FOR MEDICAID ONLY	E RATIOS NET OF	Provi der	CCN: 150018	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part II Date/Time Prepared
		ті +	le XIX	Hospi tal	5/28/2015 1:02 pm PPS
Cost Center Description	Cost Net of	Total Charges		nospitai	ггэ
Cost center beschiption		(Worksheet C,		ar	
	Operating Cost				
	Reduction	8)	/ col . 7)	0	
	6.00	7.00	8.00		
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	0.00		
0. 00 05000 OPERATING ROOM	23, 806, 627	97, 501, 646	0. 24410	56	50.0
1. 00 05100 RECOVERY ROOM	23,000,027				51.0
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0		1		52.0
	0				
3. 00 05300 ANESTHESI OLOGY	11.050.000	F1 004 000	0.0000		53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	14, 050, 992	51, 204, 920			54.0
4. 01 05401 INTERVENTIONAL RADIOLOGY	0	0	0.0000		54.0
4. 02 05402 BREAST CENTER	0	0			54.0
4.03 05403 RADIATION ONCOLOGY	0	0	0.0000		54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000	00	55.0
5. 00 05600 RADI 0I SOTOPE	0	0	0.0000	00	56.0
5. 01 05601 ULTRASOUND	0	0	0.0000	00	56.0
7.00 05700 CT SCAN	2, 655, 580	46, 490, 893	0.05712	20	57.0
3. 00 05800 MRI	1, 422, 601			05	58.0
9. 00 05900 CARDI AC CATHETERI ZATI ON	8, 672, 046				59.0
0. 00 06000 LABORATORY	12, 862, 101				60.0
0. 01 06001 BLOOD LABORATORY	12,002,101				60.0
	-				
1. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.0000		61.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 913, 191	11, 609, 631			62.0
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.0000		63.0
4. 00 06400 INTRAVENOUS THERAPY	1, 875, 613	1, 287, 012	1. 4573	39	64.0
4.01 06401 HOME INFUSION	0	0	0.0000	00	64.0
5. 00 06500 RESPI RATORY THERAPY	4, 195, 257	13, 386, 211	0. 31340	01	65.0
5. 00 06600 PHYSI CAL THERAPY	2, 666, 898	4, 748, 427	0. 56163	38	66.0
7.00 06700 OCCUPATI ONAL THERAPY	925, 428	2, 544, 953	0. 36363	33	67.0
3. 00 06800 SPEECH PATHOLOGY	405, 617				68.0
9. 00 06900 ELECTROCARDI OLOGY	0		1		69.0
0. 00 07000 ELECTROENCEPHALOGRAPHY	0		0.0000		70.0
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	29, 683, 155	116, 183, 114	1		71.0
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	4, 713, 100				71.0
3. 00 07300 DRUGS CHARGED TO PATIENTS	12, 395, 823				73.0
4. 00 07400 RENAL DIALYSIS	0	0	1		74.0
5. 00 07500 ASC (NON-DI STI NCT PART)	0	0	0.0000		75.0
5. 00 03140 CARDI OLOGY	3, 800, 696	23, 558, 901	0. 16132	27	76.0
OUTPATIENT SERVICE COST CENTERS			1		
D. 00 09000 CLINIC	1, 237, 562				90.0
D. 01 04951 SLEEP CLINIC	642, 604	2, 790, 928	0. 23024	47	90.0
1.00 09100 EMERGENCY	11, 860, 445	34, 052, 033	0. 34830	04	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	7, 145, 710	17, 137, 597	0. 41696	51	92.0
OTHER REIMBURSABLE COST CENTERS			•		
4. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.0000	00	94.0
5. 00 09500 AMBULANCE SERVICES	0	, s			95.0
5. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0				96.0
7. 00 09700 DURABLE MEDICAL EQUIP-KENTED	0	-			90.0
	0	-	0.0000		
3. 00 09851 OTHER REIMBURSABLE COST CENTERS	0	-			98.0
D1. 00 10100 HOME HEALTH AGENCY	0	0	0.0000		101. 0
SPECIAL PURPOSE COST CENTERS		1	1		
13.00 11300 INTEREST EXPENSE					113. 0
14.00 11400 UTI LI ZATI ON REVI EW-SNF					114. (
15.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0.0000	00	115. 0
16. 00 11600 HOSPI CE	0	0	0.0000	00	116. 0
00.00 Subtotal (sum of lines 50 thru 199)	146, 931, 046	661, 082, 890			200. 0
01.00 Less Observation Beds	7, 145, 710				201.0
D2.00 Total (line 200 minus line 201)	139, 785, 336			1	201.0

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT.	AL COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	·	•				
30. 00 ADULTS & PEDIATRICS	5, 784, 879	0	5, 784, 87	9 47,029	123.01	30.00
31.00 INTENSIVE CARE UNIT	548, 202		548, 20		112.02	31.00
31.01 NEONATAL INTENSIVE CARE	104, 625		104, 62	5 867	120.67	31.01
40.00 SUBPROVIDER - IPF	0	(		0 0	0.00	
41.00 SUBPROVIDER - IRF	397, 937		397, 93	7 2,449	162.49	
43.00 NURSERY	555, 767		555, 76			
44.00 SKILLED NURSING FACILITY	0		000,70	0 0	0.00	
45. 00 NURSING FACILITY	0				0.00	
200.00 Total (lines 30-199)	7, 391, 410		7, 391, 41	0 58, 279		200.00
Cost Center Description	I npati ent	Inpati ent	7,071,11	00,277		200.00
	Program days	Program				
	rrogram days	Capital Cost				
		$(col. 5 \times col.$				
		6)				
	6,00	7.00	-			
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	18, 400	2, 263, 384	1			30.00
31. 00 I NTENSI VE CARE UNI T	2, 107					31.00
31. 01 NEONATAL INTENSIVE CARE	2,107	230, 020				31.00
40. 00 SUBPROVIDER - IPF	0					40.00
41. 00 SUBPROVIDER - IRF	1,006	163, 465				40.00
41.00   SUBPROVIDER - TRF 43.00   NURSERY	1,000	103,400				41.00
	0					
44.00 SKILLED NURSING FACILITY	0					44.00
45.00 NURSING FACILITY	01 510					45.00
200.00 Total (lines 30-199)	21, 513	2, 662, 875	9			200. 00

APPORT	IONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der	CCN: 150018	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre 5/28/2015 1:0	pared: 2 pm
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
			(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS		1	1			
50.00	05000 OPERATING ROOM	2, 516, 312	97, 501, 646			551, 249	
51.00	05100 RECOVERY ROOM	0	0	0.0000		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0			0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0.0000	0 00	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 532, 019	51, 204, 920	0. 02991	19 5, 022, 709	150, 274	54.00
54.01	05401 INTERVENTIONAL RADIOLOGY	0	0	0.0000	0 00	0	54.01
54.02	05402 BREAST CENTER	0	0	0.0000	0 00	0	54.02
54.03	05403 RADIATION ONCOLOGY	0	0	0.0000	0 00	0	54.03
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000	0 00	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0.0000	0 00	0	56.00
56. 01	05601 ULTRASOUND	0	0	0.0000		0	56.01
57.00	05700 CT SCAN	288, 716	46, 490, 893			34, 725	
58.00	05800 MRI	148,059				15, 959	
59.00	05900 CARDI AC CATHETERI ZATI ON	343, 156				24, 585	
50.00	06000 LABORATORY	276, 581				64, 790	
50.00 50.01	06001 BLOOD LABORATORY					04,790	
		0	0	0.0000	0	0	
51.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	10.000	11 (00 (01	0.0010		4 574	61.00
52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	12, 208	11, 609, 631			4, 571	
53.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.0000		0	63.00
54.00	06400 I NTRAVENOUS THERAPY	94, 002	1, 287, 012			24, 472	
54.01	06401 HOME INFUSION	0	0	0.0000		0	
55.00	06500 RESPI RATORY THERAPY	102, 359				43, 292	
56.00	06600 PHYSI CAL THERAPY	205, 306				46, 670	
57.00	06700 OCCUPATI ONAL THERAPY	94, 117				25, 299	
58.00	06800 SPEECH PATHOLOGY	55, 630				12, 244	
59.00	06900 ELECTROCARDI OLOGY	0	0	0.00000		0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0.0000		0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	142, 163				44, 547	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	22, 573				8, 856	
73.00	07300 DRUGS CHARGED TO PATIENTS	59, 368	89, 715, 953			14, 061	
74.00	07400 RENAL DIALYSIS	0	0	0.0000	0 00	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.0000	0 0	0	75.00
76.00	03140 CARDI OLOGY	319, 516	23, 558, 901	0.01356	52 2, 921, 337	39, 619	76.00
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	205, 651	3, 679, 646	0.05588	<b>992, 030</b>	55, 444	90.00
90. 01	04951 SLEEP CLINIC	5,021	2, 790, 928	0.00179	8, 575	15	90.01
91.00	09100 EMERGENCY	688, 775				92, 491	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	812, 582				0	
	OTHER REIMBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,		-	-	1
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	0.0000	0 00	0	94.00
95.00	09500 AMBULANCE SERVICES		l	0.00000		0	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0 00	0	
7.00	09700 DURABLE MEDICAL EQUIP-RENTED			0.00000		0	
	09851 OTHER REIMBURSABLE COST CENTERS			0.00000		0	
98.00							

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTH	ER PASS THROUGH COST			Period: From 01/01/2014 To 12/31/2014	5/28/2015 1:0	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
	-	Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
31.01 03101 NEONATAL INTENSIVE CARE	0	0	)	0	0	31.01
40.00 04000 SUBPROVIDER - IPF	0	0	)	0 0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0		0 0	0	41.00
43.00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0	0	44.00
45.00 04500 NURSING FACILITY	0	0		0	0	45.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	47,029	0.00	18, 40	0 0		30.00
31.00 03100 INTENSIVE CARE UNIT	4,894	0.00	2, 10	7 0		31.00
31.01 03101 NEONATAL INTENSIVE CARE	867	0.00		0 0		31.01
40. 00 04000 SUBPROVIDER - IPF	0	0.00		0 0		40.00
41.00 04100 SUBPROVIDER - IRF	2,449	0.00	1,00	6 0		41.00
43.00 04300 NURSERY	3,040	0.00		0 0		43.00
44.00 04400 SKILLED NURSING FACILITY	0	0.00		0 0		44.00
45.00 04500 NURSING FACILITY	0	0.00		0 0		45.00
200.00 Total (lines 30-199)	58, 279		21, 51	3 0		200.00
	i					•

Health Financial Systems		L HOSPITAL			u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER PASS	Provi der	F	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/28/2015 1:0	pared:
		Ti tl	e XVIII	Hospi tal	PPS	<u>z piii</u>
Cost Center Description	Non Physician N				Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost		
	1.00	2.00	3.00	4.00	4)	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0	0	C	0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0			0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	c	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	c	0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0	c	0 0	0	54.00
54. 01 05401 INTERVENTIONAL RADIOLOGY	0	0	C	0 0	0	54.01
54.02 05402 BREAST CENTER	0	0	C		0	54.02
54.03 05403 RADIATION ONCOLOGY	0	0	C		0	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	C		0	
56. 00 05600 RADI OI SOTOPE	0	0	C		0	
56. 01 05601 ULTRASOUND	0	0		-	0	
57. 00 05700 CT SCAN	0	0	C	-	0	
58. 00 05800 MRI	0	0	0	-	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	0	-		0	
60. 01 06000 LABORATORY	0	0		-	0	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	U U	0		0	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELI		0	c	0	0	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0			0	1
64. 00 06400 I NTRAVENOUS THERAPY	Ő	0		-	0	
64. 01 06401 HOME I NFUSI ON	0	0		-	0	
65. 00 06500 RESPI RATORY THERAPY	0	0	c	0 0	0	65.00
66.00 06600 PHYSI CAL THERAPY	0	0	c	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0	c d	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	C	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	C	0 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	C	-	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1 1	0	C		0	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	-	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	, s	0	
74. 00 07400 RENAL DIALYSIS	0	0	0		0	1
75. 00 07500 ASC (NON-DI STINCT PART) 76. 00 03140 CARDI OLOGY	0	0			0	
OUTPATIENT SERVICE COST CENTERS	0	0			0	70.00
90. 00 09000 CLINIC	0	0	C	0 0	0	90.00
90. 01 04951 SLEEP CLINIC	0	0		-	0	
91. 00 09100 EMERGENCY	0	0	-	-	437, 123	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR		0			0	
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	C	0 0	0	94.00
95.00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0 0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		-	0	
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0	C	0 0	0	98.00
200.00 Total (lines 50-199)	0	0	437, 123	0	437, 123	

Health Financial Systems	ELKHART GENER				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PAS	S Provider		Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/28/2015 1:0	pared: 2 pm
		Ti tl	e XVIII	Hospi tal	PPS	2 pm
Cost Center Description	Total	Total Charges			Inpatient	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.			Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	J	
	4)		ĺ í	7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS				-		
50. 00 05000 OPERATI NG ROOM	C	97, 501, 646	0.00000	0 0.000000	21, 359, 631	50.00
51.00 05100 RECOVERY ROOM	C	0	0. 00000	0.000000	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	C	0	0. 00000	0.000000	0	52.00
53. 00 05300 ANESTHESI OLOGY	C	0	0. 00000	0.000000	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	C	51, 204, 920	0. 00000	0.000000	5, 022, 709	54.00
54.01 05401 INTERVENTIONAL RADIOLOGY	C	0	0. 00000	0.000000	0	54.01
54.02 05402 BREAST CENTER	C	0			0	54.02
54.03 05403 RADIATION ONCOLOGY	C	0	0.00000	0.000000	0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	C	0	0.00000		0	55.00
56. 00 05600 RADI OI SOTOPE	0	0	0.00000		0	56.00
56. 01 05601 ULTRASOUND	C	0			0	56.01
57. 00 05700 CT SCAN	Ċ				5, 591, 757	57.00
58. 00 05800 MRI	0		0.00000		1, 198, 810	
59. 00 05900 CARDI AC CATHETERI ZATI ON	Ċ				4, 016, 499	
60. 00 06000 LABORATORY					12, 721, 430	
60. 01 06001 BLOOD LABORATORY					0	60.01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.00000	0.000000	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	11, 609, 631	0. 00000	0 0. 000000	4, 345, 110	
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.			0.00000		4, 343, 110	63.00
64. 00 06400 I NTRAVENOUS THERAPY					335, 055	
64. 01 06401 HOME I NFUSI ON			0.00000		0	64.01
65. 00 06500 RESPI RATORY THERAPY			0.00000		5, 661, 332	
66. 00 06600 PHYSI CAL THERAPY			0.00000		1, 079, 402	66.00
67. 00 06700 OCCUPATI ONAL THERAPY					684, 103	
68. 00 06800 SPEECH PATHOLOGY					184, 233	68.00
69. 00 06900 ELECTROCARDI OLOGY		001/001			0 10 1, 200	
70. 00 07000 ELECTROENCEPHALOGRAPHY	C	-			0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C				36, 394, 748	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	C				8, 972, 172	
73. 00 07300 DRUGS CHARGED TO PATIENTS	C				21, 239, 737	
74. 00 07400 RENAL DIALYSIS					0	74.00
75. 00 07500 ASC (NON-DI STINCT PART)		-	0.00000		0	75.00
76. 00 03140 CARDI OLOGY			0.00000		2, 921, 337	76.00
OUTPATIENT SERVICE COST CENTERS		23, 330, 901	0.00000	0 0.000000	2, 721, 337	70.00
90. 00 09000 CLINIC	C	3, 679, 646	0.00000	0 0. 000000	992,030	90.00
90. 01 04951 SLEEP CLINIC					8, 575	90.00
91. 00 09100 EMERGENCY	437, 123				4, 572, 655	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	437, 123				4, 372, 033	
OTHER REIMBURSABLE COST CENTERS		1 17, 137, 377	0.0000	0.00000	0	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	C	0	0.00000	0 0. 000000	0	94.00
95. 00 09500 AMBULANCE SERVICES			0.00000	0.00000	0	94.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0 0. 000000	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED			0.00000		0	97.00
98. 00 09851 OTHER REIMBURSABLE COST CENTERS		-			0	98.00
200.00 Total (lines 50-199)	437, 123	-		0.00000	137, 301, 325	
	-57,125	1 001,002,090	I	I	107,001,020	1200.00

	⊨Financial Systems FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ELKHART GENERA		CCN: 150018	Period:	u of Form CMS- Worksheet D	
THROUC	GH COSTS				From 01/01/2014 To 12/31/2014	Part IV Date/Time Pre 5/28/2015 1:0	epared:
			Ti tl	e XVIII	Hospi tal	PPS	z piii
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	·	Program	Program	Program			
		Pass-Through	Charges	Pass-Through	n		
		Costs (col. 8		Costs (col.	9		
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	13, 039, 234		0		50.00
51.00	05100 RECOVERY ROOM	0	0		0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
53.00	05300 ANESTHESI OLOGY	0	0		0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	11, 405, 102		0		54.00
54.01	05401 I NTERVENTI ONAL RADI OLOGY	0	0		0		54.01
54.02	05402 BREAST CENTER	0	0		0		54.02
54.02	05403 RADI ATI ON ONCOLOGY	0	0		0		54.02
		0	0		-		
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0		55.00
56.00	05600 RADI OI SOTOPE	0	0		0		56.00
56. 01	05601 ULTRASOUND	0	0		0		56.01
57.00	05700 CT SCAN	0	7, 732, 170		0		57.00
58.00	05800 MRI	0	2, 020, 844		0		58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	6, 492, 424		0		59.00
60.00	06000 LABORATORY	0	6, 442, 281		0		60.00
50. 01	06001 BLOOD LABORATORY	0	0		0		60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	940, 541		0		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0		63.00
54. 00	06400 I NTRAVENOUS THERAPY	0	670, 394		0		64.00
54.00 54.01	06401 HOME I NFUSI ON	0	070, 374		0		64.01
65.00	06500 RESPI RATORY THERAPY	0	455 750		0		65.00
		0	455, 752				
66.00	06600 PHYSI CAL THERAPY	0	629, 085		0		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	158, 608		0		67. OC
68.00	06800 SPEECH PATHOLOGY	0	96, 704		0		68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0		69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0		70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	19, 603, 028		0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 342, 612		0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	5, 349, 981		0		73.00
74.00	07400 RENAL DIALYSI S	0	0		0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0		75.00
76.00	03140 CARDI OLOGY	0	7, 860, 767		0		76.00
	OUTPATIENT SERVICE COST CENTERS		., 555, 767	1	-		1 . 5. 50
90.00	09000 CLINIC	0	652, 564		0		90.00
90.00	04951 SLEEP CLINIC	0	992, 322		0		90.00
90.01	09100 EMERGENCY	58, 699	4, 823, 625		-		90.01
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	4, 312, 338		0		92.00
	OTHER REIMBURSABLE COST CENTERS	-		1			1
94.00	09400 HOME PROGRAM DI ALYSI S	0	0		0		94.00
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0		96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0		97.00
98.00	09851 OTHER REIMBURSABLE COST CENTERS	0	0		0		98.00
	Total (lines 50-199)	58, 699	95, 020, 376	61, 92	21		200.00

APPORTI ONI	nancial Systems MENT OF MEDICAL, OTHER HEALTH SERVICES AND		AL HOSPITAL Provider	CCN: 150018	Period: From 01/01/2014 To 12/31/2014	u of Form CMS-: Worksheet D Part V Date/Time Pre 5/28/2015 1:0	pared:
			Titl	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)	5.00	
		1.00	2.00	3.00	4.00	5.00	
	CILLARY SERVICE COST CENTERS	0. 244166	13, 039, 234	6	79 0	3, 183, 738	50.00
	100 RECOVERY ROOM	0. 244100			0 0	3, 103, 730	51.00
	200 DELIVERY ROOM & LABOR ROOM	0.000000			0 0	0	52.00
	300 ANESTHESI OLOGY	0.000000			0 0	0	52.00
	100 RADI OLOGY-DI AGNOSTI C	0. 274407		59	-	3, 129, 640	•
				5			•
	101 I NTERVENTI ONAL RADI OLOGY 102 BREAST CENTER	0. 000000			0	0	54.01
		0. 000000					54.02
	103 RADI ATI ON ONCOLOGY 500 RADI OLOGY-THERAPEUTI C	0. 000000			0 0	0	54.03
		0. 000000			-	0	55.00
	500 RADI OI SOTOPE	0.00000			0	•	56.00
	501 ULTRASOUND	0.000000			0 0 )3 0	0	56.01
	700 CT SCAN					441, 662	•
	300 MRI	0. 127905				258, 476	1
	200 CARDI AC CATHETERI ZATI ON DOOLLABORATORY	0. 154692 0. 236841			38 0 36 0	1,004,326	
	001 BLOOD LABORATORY					1, 525, 796	
	100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0	0	60.01
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000 0. 164793			-	154 005	61.00 62.00
	BLOOD STORING, PROCESSING & TRANS.	0. 184793		-	19 0 0 0	154, 995 0	63.00
	100 I NTRAVENOUS THERAPY	1. 457339			35 O	976, 991	64.00
	101 HOME INFUSION	0. 000000			0 0		64.00
	500 RESPIRATORY THERAPY	0. 313401			24 0	0 142, 833	
	000 PHYSICAL THERAPY	0. 561638			33 0	353, 318	
	00 OCCUPATIONAL THERAPY	0. 363633			8 0	57, 675	
	BOO SPEECH PATHOLOGY	0. 484569			5 0	46, 860	
	200 ELECTROCARDI OLOGY	0. 484589			0 0	40, 800	69.00
	000 ELECTROEARDI OLOGI 000 ELECTROENCEPHALOGRAPHY	0.000000			0 0	0	70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 255486		1, 02	-	5, 008, 299	
	200 IMPL. DEV. CHARGED TO PATIENTS	0. 206132			70 0	276, 755	
	BOO DRUGS CHARGED TO PATIENTS	0. 138167		27		739, 191	
	100 RENAL DIALYSIS				0 0	0	74.00
	500 ASC (NON-DI STINCT PART)	0. 000000			0 0	0	
	40 CARDI OLOGY	0. 161327		40			
	PATIENT SERVICE COST CENTERS	0. 101327	7, 860, 767	40	0	1, 268, 154	76.00
	DOO CLINIC	0. 336326	652, 564		34 0	219, 474	90.00
	P51 SLEEP CLINIC	0. 230247			52 0	219, 474	•
90.01 049	OO EMERGENCY	0. 348304					
	200 OBSERVATION BEDS (NON-DISTINCT PART	0. 416961			27 0		91.00
	IER REIMBURSABLE COST CENTERS	0.410901	4, 312, 330		27 0	1, 790, 077	92.00
	100 HOME PROGRAM DI ALYSI S	0. 000000	1	1	0		94.00
	500 AMBULANCE SERVICES	0. 000000			0		95.00
	000 DURABLE MEDICAL EQUIP-RENTED	0. 000000			0 0	0	
	700 DURABLE MEDICAL EQUIP-RENTED	0.000000			0 0	0	•
	351 OTHER REIMBURSABLE COST CENTERS	0.000000			0 0	0	97.00
200.00	Subtotal (see instructions)	0.00000	95, 020, 376	4, 95			
200.00	Less PBP Clinic Lab. Services-Program		70,020,370	4,93		22, 474, 621	200.00
201.00	Only Charges						201.00

Health Fin	ancial Systems	ELKHART GENER	AL HOSPITAL		In L	ieu of Form CM	S-2552-10
APPORTI ONM	IENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150018	Period: From 01/01/20 To 12/31/20	14 Date/Time P	repared:
				e XVIII	Hospi tal	5/28/2015 1 PPS	
		Cos			nospitai		
	Cost Center Description	Cost	Cost	1			
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.					
		(see inst.) 6.00	(see inst.) 7.00	-			
ANCI	I LLARY SERVI CE COST CENTERS	0.00	7.00				
	DO OPERATI NG ROOM	166	C				50.00
51.00 0510	DO RECOVERY ROOM	0	c				51.00
52.00 0520	DO DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00 0530	DO ANESTHESI OLOGY	0	0				53.00
54.00 0540	00 RADI OLOGY-DI AGNOSTI C	163	C				54.00
54.01 0540	01 I NTERVENTI ONAL RADI OLOGY	0	0				54.01
54.02 0540	02 BREAST CENTER	0	C				54.02
54.03 0540	03 RADIATION ONCOLOGY	0	0				54.03
	00 RADI OLOGY-THERAPEUTI C	0	C				55.00
56.00 0560	00 RADI OI SOTOPE	0	0				56.00
	01 ULTRASOUND	0		•			56.01
	DO CT SCAN	23					57.00
	DO MRI	13					58.00
	00 CARDI AC CATHETERI ZATI ON	52					59.00
	00 LABORATORY	80					60.00
	01 BLOOD LABORATORY	0					60. 01
	00 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61.00
	00 WHOLE BLOOD & PACKED RED BLOOD CELL	8		1			62.00
	00 BLOOD STORING, PROCESSING & TRANS.	0	0	1			63.00
	00 I NTRAVENOUS THERAPY	51	0	1			64.00
	01 HOME INFUSION	0					64.01
		8					65.00
	00 PHYSI CAL THERAPY	19		1			66.00
	00 OCCUPATI ONAL THERAPY	3					67.00
	00 SPEECH PATHOLOGY	2		1			68.00
	00  ELECTROCARDI OLOGY 00  ELECTROENCEPHALOGRAPHY	0		1			69.00 70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	261		1			70.00
	00 I MPL. DEV. CHARGED TO PATIENTS	14					72.00
	00 DRUGS CHARGED TO PATIENTS	38	-				73.00
	00 RENAL DIALYSIS	0					74.00
	DO ASC (NON-DI STINCT PART)	0		1			75.00
	40 CARDI OLOGY	66		1			76.00
	PATIENT SERVICE COST CENTERS			1			/0.00
		11	C				90.00
	51 SLEEP CLINIC	12					90.01
	DO EMERGENCY	87					91.00
	00 OBSERVATION BEDS (NON-DISTINCT PART	95					92.00
	ER REIMBURSABLE COST CENTERS						
	OO HOME PROGRAM DI ALYSI S	0	C				94.00
95.00 0950	00 AMBULANCE SERVICES	0					95.00
	00 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
97.00 0970	00 DURABLE MEDICAL EQUIP-SOLD	0	0				97.00
98.00 098!	51 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
200.00	Subtotal (see instructions)	1, 172	0				200.00
200.00		1	1	1			1
200.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Less PBP Clinic Lab. Services-Program Only Charges Net Charges (line 200 +/- line 201)	0	C				201.00 202.00

PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	FAL COSTS	Provi der	CCN: 150018	Peri od:	u of Form CMS-2 Worksheet D	
				From 01/01/2014	Part II	
		Component	CCN: 15T018	To 12/31/2014	Date/Time Pre 5/28/2015 1:0	pared: 2 pm
		Ti tl	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col. 26)	8)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
0. 00 05000 OPERATI NG ROOM	2, 516, 312	97, 501, 646			224	
1.00 05100 RECOVERY ROOM	0	C	0,00000		0	51.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0 0	0	52.0
3. 00 05300 ANESTHESI OLOGY	0	C	0.00000	0 0	0	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 532, 019	51, 204, 920	0. 02991	9 25, 679	768	54.0
4. 01 05401 INTERVENTIONAL RADIOLOGY	0	C	0.00000	0 0	0	54.0
4. 02 05402 BREAST CENTER	0	C	0.00000	0 0	0	54.0
4. 03 05403 RADIATION ONCOLOGY	0	C			0	54.0
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	C	0.00000		0	55.0
6. 00 05600 RADI OI SOTOPE	0	0	0.00000		0	
6. 01 05601 ULTRASOUND	0	0	0. 00000		0	
7. 00 05700 CT SCAN	288, 716					
B. 00 05800 MRI	148,059		0. 01331		208	
9. 00 05900 CARDI AC CATHETERI ZATI ON	343, 156					
0. 00 06000 LABORATORY	276, 581				644	
D. 01 06001 BLOOD LABORATORY						
	0	C	0.00000	0 0	0	
	10.000	11 (00 (01	0.00105	11 755	10	61.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	12, 208	11, 609, 631			12	
3. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	1 007 010	0.0000		0	
4. 00 06400 I NTRAVENOUS THERAPY	94, 002	1, 287, 012				
4. 01 06401 HOME INFUSION	0		0.0000		0	
5. 00 06500 RESPI RATORY THERAPY	102, 359		0.00764			
6. 00 06600 PHYSI CAL THERAPY	205, 306					
7.00 06700 OCCUPATIONAL THERAPY	94, 117				12, 217	
B. 00 06800 SPEECH PATHOLOGY	55, 630					
9. 00 06900 ELECTROCARDI OLOGY	0		0.00000		0	
D. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	142, 163				83	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	22, 573	22, 864, 424			0	72.0
3. 00 07300 DRUGS CHARGED TO PATIENTS	59, 368	89, 715, 953	0. 00066	205, 829	136	73.0
4. 00 07400 RENAL DIALYSIS	0	0	0. 00000	0 0	0	74.0
5.00 07500 ASC (NON-DISTINCT PART)	0	C	0.00000	0 0	0	75.0
6. 00 03140 CARDI OLOGY	319, 516	23, 558, 901	0. 01356	8, 058	109	76.0
OUTPATIENT SERVICE COST CENTERS	-					
D. 00 09000 CLINIC	205, 651				2, 153	90.0
D. 01 04951 SLEEP CLINIC	5, 021	2, 790, 928	0. 00179	09 0	0	90.0
1.00 09100 EMERGENCY	688, 775	34, 052, 033	0. 02022	2, 140	43	91.0
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	17, 137, 597	0.00000	00 0	0	92.0
OTHER REIMBURSABLE COST CENTERS	1	1	1			
4.00 09400 HOME PROGRAM DI ALYSI S	0	C	0.00000	0 0	0	
5. 00 09500 AMBULANCE SERVICES						95.0
6.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0.00000	0 0	0	96.0
7.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 00000	0 0	0	
B. 00 09851 OTHER REIMBURSABLE COST CENTERS	0	C	0. 00000	0 0	0	98.0
00.00 Total (lines 50-199)	7, 111, 532	661, 082, 890	1	1, 330, 396	35, 774	1200 0

PPORTI OI	NMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider		Period:	Worksheet D	
HROUGH (				CCN: 15T018	From 01/01/2014 To 12/31/2014		pared: 2 pm
			Ti tl	e XVIII	Subprovider - IRF	PPS	
	Cost Center Description	Non Physician	Nursing School	Allied Health		Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost	through col. 4)	
		1.00	2.00	3.00	4.00	5.00	
AN	CILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
	000 OPERATING ROOM	0	C	(	0 0	0	50.00
	100 RECOVERY ROOM	0	C				
	200 DELIVERY ROOM & LABOR ROOM	0	C	0			52.00
3.00 05	300 ANESTHESI OLOGY	0	C	0	0 0	0	53.00
4.00 05	400 RADI OLOGY-DI AGNOSTI C	0	C	0	0 0	0	54.00
4.01 05	401 I NTERVENTI ONAL RADI OLOGY	0	C	(	0 0	0	54.0
	402 BREAST CENTER	0	C		0 0	0	54.0
4.03 05	403 RADIATION ONCOLOGY	0	0	(	0 0	0	54.0
5.00 05	500 RADI OLOGY-THERAPEUTI C	0	0	(	0 0	0	55.0
6.00 05	600 RADI OI SOTOPE	0	C	(	0 0	0	56.00
6.01 05	601 ULTRASOUND	0	C	(	0 0	0	56.0
7.00 05	700 CT SCAN	0	C	0	0 0	0	57.00
8.00 05	800 MRI	0	C	0	0 0	0	58.0
9.00 05	900 CARDI AC CATHETERI ZATI ON	0	C	0	0 0	0	59.0
0. 00  06	000 LABORATORY	0	C	0	0 0	0	60.0
0. 01  06	001 BLOOD LABORATORY	0	C	0	0 0	0	60.0
	100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0			-	
	300 BLOOD STORING, PROCESSING & TRANS.	0	0			-	
	400 I NTRAVENOUS THERAPY	0	0				
	401 HOME INFUSION	0	C				
	500 RESPI RATORY THERAPY	0	C			-	
	600 PHYSI CAL THERAPY	0	C			0	
	700 OCCUPATIONAL THERAPY	0	C			0	
	800 SPEECH PATHOLOGY	0	0			0	
	900 ELECTROCARDI OLOGY	0	0			0	
	000 ELECTROENCEPHALOGRAPHY	0	0			0	
	100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0			0	
	200 I MPL. DEV. CHARGED TO PATIENTS	0	0			0	
	300 DRUGS CHARGED TO PATIENTS	0	0		-	0	
	400 RENAL DI ALYSI S	0	0		-	0	
	500 ASC (NON-DI STI NCT PART)	0	0	-	-	0	
		0	0	(	0 0	0	76.0
	TPATIENT SERVICE COST CENTERS	0	C		0 0	0	90.00
	951 SLEEP CLINIC	0					
	100 EMERGENCY	0		-	-		
		0					
	200 OBSERVATION BEDS (NON-DISTINCT PART HER REIMBURSABLE COST CENTERS	0	0	(	<u> </u>	0	1 72.0
	2400 HOME PROGRAM DIALYSIS	0	C	0	0 0	0	94.00
	1400 HOME PROGRAM DIALISIS	0	U			0	94.0
	1600 DURABLE MEDICAL EQUIP-RENTED	0	C	0	0	0	
	1700 DURABLE MEDICAL EQUIP-RENTED	0		-	-	-	
	1851 OTHER REIMBURSABLE COST CENTERS	0	0				
5. 55 JU7	Total (lines 50-199)	0	0		3 0		200.00

Health Financial Systems	ELKHART GENER				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provi der		Period:	Worksheet D	
THROUGH COSTS		Componen		From 01/01/2014 To 12/31/2014		
			e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Total		Ratio of Cost		Inpati ent	
	Outpati ent	(from Wkst. C,	U U	Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col.		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00	8.00	7)	10.00	
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
50. 00 05000 OPERATI NG ROOM	C	97, 501, 646	0.00000	0. 000000	8, 692	50.00
51. 00 05100 RECOVERY ROOM					0,072	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM			1		0	
53. 00 05300 ANESTHESI OLOGY			1		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C					25, 679	
54. 01 05401 I NTERVENTI ONAL RADI OLOGY			0.00000		0	
54. 02 05402 BREAST CENTER		-			0	
54. 03 05403 RADIATION ONCOLOGY					0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C		-			0	1
56. 00 05600 RADI OI SOTOPE		-			0	56.00
56. 01 05601 ULTRASOUND	C		1		0	56.01
57. 00 05700 CT SCAN	C				35, 889	57.00
58. 00 05800 MRI	C				15, 632	
59. 00 05900 CARDI AC CATHETERI ZATI ON	C				5, 109	59.00
60. 00 06000 LABORATORY	C					
60. 01 06001 BLOOD LABORATORY	C				0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	11, 609, 631	0.00000	0. 000000	11, 755	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C	C	0.00000	0. 000000	0	63.00
64.00 06400 INTRAVENOUS THERAPY	C	1, 287, 012	0.00000	0. 000000	0	64.00
64. 01 06401 HOME INFUSION	C	C	0.00000	0. 000000	0	64.01
65. 00 06500 RESPI RATORY THERAPY	C	13, 386, 211	0.00000	0. 000000	59, 254	65.00
66. 00 06600 PHYSI CAL THERAPY	C	4, 748, 427	0.00000	0. 000000	319, 049	66.00
67.00 06700 OCCUPATI ONAL THERAPY	C	2, 544, 953			330, 341	67.00
68.00 06800 SPEECH PATHOLOGY	C	837, 067			70, 348	68.00
69. 00 06900 ELECTROCARDI OLOGY	C	) C	0.00000		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	C		0.00000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C				67, 672	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	C				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	C				205, 829	
74.00 07400 RENAL DIALYSIS	C				0	
75.00 07500 ASC (NON-DISTINCT PART)	C		0.00000		0	
76. 00 03140 CARDI OLOGY	C	23, 558, 901	0.00000	0. 000000	8, 058	76.00
OUTPATIENT SERVICE COST CENTERS	-	L				
90. 00 09000 CLINIC	C					90.00
90. 01 04951 SLEEP CLINIC	C				0	90.01
91.00 09100 EMERGENCY	437, 123				2, 140	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	C	17, 137, 597	0.00000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS	C		0.00000		0	04 00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES		C	0.00000	0. 000000	0	94.00 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED			0,00000	0 000000	0	95.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED						96.00
98. 00 09851 OTHER REIMBURSABLE COST CENTERS			0.00000			
200.00 Total (lines 50-199)	437, 123	-		0.00000	1, 330, 396	
200.00 110tal (11163 30-177)	437,123	1 001,002,090	1	1	1, 330, 390	I∠00.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	6 Provi der	CCN: 150018	Period: From 01/01/2014	Worksheet D Part IV	
THROUGH COSTS		Componen	t CCN: 15T018		Date/Time Pre 5/28/2015 1:0	epared: D2 pm
		Ti tl	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Inpati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through Costs (col. 8	Charges	Pass-Through Costs (col.			
	x col. 10)		x col. 12)	/		
	11.00	12.00	13.00	-		
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	(	)	0		50.00
51.00 05100 RECOVERY ROOM	0	(	b	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	(	D	0		52.00
53. 00 05300 ANESTHESI OLOGY	0	(	D	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	(	D	0		54.00
54. 01 05401 INTERVENTIONAL RADIOLOGY	0	0		0		54.01
54. 02 05402 BREAST CENTER	0	0		0		54.02
54.03 05403 RADIATION ONCOLOGY	0	(		0		54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	(		0		55.00
56. 00 05600 RADI OI SOTOPE	0	(	D	0		56.00
56. 01 05601 ULTRASOUND	0	(	D	0		56.01
57.00 05700 CT SCAN	0	(		0		57.00
58. 00 05800 MRI	0	0	D	0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	D	0		59.00
60. 00 06000 LABORATORY	0	0		0		60.00
60. 01 06001 BLOOD LABORATORY	0	0	D	0		60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	(	-	0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	(		0		63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	(		0		64.00
64. 01 06401 HOME I NFUSI ON	0	0		0		64.01
65. 00 06500 RESPI RATORY THERAPY	0	(		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	(		0		66.00
67. 00 06700 OCCUPATIONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	(		0		67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0	(		0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	(		0		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	(		0		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	(		0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	(	-	0		73.00
74. 00 07400 RENAL DI ALYSI S	0	(		0		74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0	(		0		75.00
76. 00 03140 CARDI OLOGY	0	(		0		76.00
OUTPATIENT SERVICE COST CENTERS			-	-		
90. 00 09000 CLINIC	0	(		0		90.00
90. 01 04951 SLEEP CLINIC	0	C		0		90.01
91.00 09100 EMERGENCY	27	C		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	(		0		94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0		96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C	D I	0		97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0		98.00
200.00   Total (lines 50-199)	27	(	p	0		200.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE	CAPI TAL COSTS	Provi der		Period: From 01/01/2014 To 12/31/2014		
			le XIX	Hospi tal	PPS	•
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTE	RS					
30.00 ADULTS & PEDIATRICS	5, 784, 879	C	5, 784, 87	9 47, 029	123.01	30.00
31.00 INTENSIVE CARE UNIT	548, 202		548, 20	2 4, 894	112.02	31.00
31.01 NEONATAL INTENSIVE CARE	104, 625		104, 62	5 867	120.67	31.01
40.00 SUBPROVIDER - IPF	0	C		0 0	0.00	40.00
41.00 SUBPROVIDER - IRF	397, 937	C	397, 93	7 2, 449	162.49	41.00
43.00 NURSERY	555, 767		555, 76		182.82	43.00
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	
45.00 NURSING FACILITY	0			0 0	0.00	45.00
200.00 Total (lines 30-199)	7, 391, 410		7, 391, 41	0 58, 279		200.00
Cost Center Description	Inpatient	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6,00	7,00	1			
INPATIENT ROUTINE SERVICE COST CENTE	RS					
30.00 ADULTS & PEDIATRICS	3, 955	486, 505	;			30.00
31.00 INTENSIVE CARE UNIT	0	0				31.00
31.01 NEONATAL INTENSIVE CARE	0	0				31.01
40.00 SUBPROVIDER - IPF	0	0				40.00
41.00 SUBPROVIDER - IRF	125	20, 311				41.00
43. 00 NURSERY		20,011				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
45. 00 NURSING FACILITY	0	0				45.00
200.00 Total (lines 30-199)	4,080	506, 816				200.00
	4,000	555, 010	1			

PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der	CCN: 150018	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part II Date/Time Pre 5/28/2015 1:0	pared: 2 pm
			le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		1	-			
0.00 05000 OPERATING ROOM	2, 516, 312	97, 501, 646			168, 669	
1.00 05100 RECOVERY ROOM	0	0	0.0000	0 00	0	51.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.0000	0 00	0	52.00
3. 00 05300 ANESTHESI OLOGY	0	0	0.0000	0 00	0	53.00
4. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 532, 019	51, 204, 920	0. 02991	19 1, 609, 748	48, 162	54.00
4. 01 05401 INTERVENTIONAL RADIOLOGY	0	0	0.0000	0 00	0	54.01
4. 02 05402 BREAST CENTER	0	0	0.0000	0 00	0	54.02
4. 03 05403 RADIATION ONCOLOGY	0	0	0.0000		0	54.03
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000	0 00	0	55.00
6. 00 05600 RADI 0I SOTOPE	0	0	0.0000	0 00	0	56.00
6. 01 05601 ULTRASOUND	0	0	0.0000		0	56.01
57. 00 05700 CT SCAN	288, 716	46, 490, 893			286	
i8. 00 05800 MRI	148, 059				4, 140	
i9. 00 05900 CARDI AC CATHETERI ZATI ON	343, 156				6, 422	
0. 00 06000 LABORATORY	276, 581				18,001	
0. 01 06001 BLOOD LABORATORY	270, 301				0	
1. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0.00000	0	0	61.00
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	12, 208	11, 609, 631	0.00105	52 900, 137	947	
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	12,200	11,009,031	0.0000		947	63.00
4. 00 06400 INTRAVENOUS THERAPY	94,002	1 207 012	1		18, 827	
4. 01 06400 INTRAVENOUS THERAPY 4. 01 06401 HOME INFUSION	94,002	1, 287, 012	0.07303			
	102.250	12 204 211	1		0	
5. 00 06500 RESPI RATORY THERAPY	102, 359		0.00764		10, 195	
6. 00 06600 PHYSI CAL THERAPY	205, 306				8, 177	
7.00 06700 OCCUPATIONAL THERAPY	94, 117				5, 671	
8.00 06800 SPEECH PATHOLOGY	55, 630				2, 808	
9.00 06900 ELECTROCARDI OLOGY	0	0	0.00000		0	
0.00 07000 ELECTROENCEPHALOGRAPHY	0		0.0000		0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	142, 163				313	
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	22, 573				0	
3.00 07300 DRUGS CHARGED TO PATIENTS	59, 368				3, 981	
4.00 07400 RENAL DIALYSIS	0		0.00000		0	
5.00 07500 ASC (NON-DI STI NCT PART)	0	0	0.0000		0	
76. 00 03140 CARDI OLOGY	319, 516	23, 558, 901	0. 01356	62 441, 420	5, 987	76.00
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLINIC	205, 651				13, 194	
0. 01 04951 SLEEP CLINIC	5, 021				0	
1. 00 09100 EMERGENCY	688, 775				27, 583	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	812, 582	17, 137, 597	0. 0474	15 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	-					
4. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.0000	0 00	0	
5. 00 09500 AMBULANCE SERVICES						95.00
6. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.0000	0 00	0	96.00
7. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.0000	0 00	0	97.00
8.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0	0.0000		0	
200.00 Total (lines 50-199)	7, 924, 114	661,082,890		24, 272, 401	343, 363	

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE (	OTHER PASS THROUGH COST			Period: From 01/01/2014 To 12/31/2014	5/28/2015 1:0	pared: 2 pm
			le XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTER	S		_			
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	)	0	0	31.00
31.01 03101 NEONATAL INTENSIVE CARE	0	0		0	0	31.01
40. 00 04000 SUBPROVI DER - I PF	0	0		0 0	0	40.00
41.00 04100 SUBPROVIDER - IRF	0	0	)	0 0	0	41.00
43.00 04300 NURSERY	0	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0		0	0	44.00
45.00 04500 NURSING FACILITY	0	0		0	0	45.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days			
	,	· · · ·		Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTER	S					
30. 00 03000 ADULTS & PEDIATRICS	47, 029	0.00	3, 95	5 0		30.00
31.00 03100 INTENSIVE CARE UNIT	4, 894	0.00		0 0		31.00
31.01 03101 NEONATAL INTENSIVE CARE	867	0.00		0 0		31.01
40. 00 04000 SUBPROVI DER - I PF	0	0.00		0 0		40.00
41. 00 04100 SUBPROVI DER – I RF	2,449	0.00		5 0		41.00
43. 00 04300 NURSERY	3,040	0.00		0 0		43.00
44.00 04400 SKILLED NURSING FACILITY	0	0.00		0 0		44.00
45.00 04500 NURSING FACILITY	o	0.00		0 0		45.00
200.00 Total (lines 30-199)	58, 279		4, 08	0 0		200.00
	1		.,	-1 -1		

Health Financial Systems		ELKHART GENERA				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OU THROUGH COSTS	IPAILENT ANCILLARY SE	RVICE OTHER PASS	Provi der	CCN: 150018	Period: From 01/01/2014 To 12/31/2014		epared:
			Tit	le XIX	Hospi tal	PPS	
Cost Center Descr	iption	Non Physician N				Total Cost	
		Anestheti st	-		Medi cal	(sum of col 1	
		Cost			Education Cost		
						4)	
ANCI LLARY SERVI CE COST	CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATING ROOM	CENTERS	0	0		0 0	0	50.00
51. 00 05100 RECOVERY ROOM		0	0		0 0		
52. 00 05200 DELIVERY ROOM & L	ABOR ROOM	0	0		0 0		
53. 00 05300 ANESTHESI OLOGY		0	0		0 0		
54. 00 05400 RADI OLOGY-DI AGNOS	STLC	0	0		0 0	-	
54.01 05401 INTERVENTIONAL RA		0	0		0 0		
54.02 05402 BREAST CENTER		0	0		0 0		
54.03 05403 RADIATION ONCOLOG	βY	0	0		0 0	0	54.03
55.00 05500 RADI OLOGY-THERAPE		0	0		0 0	0	55.00
56. 00 05600 RADI 0I SOTOPE		0	0		0 0	0	56.00
56.01 05601 ULTRASOUND		0	0		0 0	0	56.01
57.00 05700 CT SCAN		0	0		0 0	0	57.00
58.00 05800 MRI		0	0		0 0	0	58.00
59.00 05900 CARDI AC CATHETERI	ZATION	0	0		0 0	0	59.00
60.00 06000 LABORATORY		0	0		0 0		
60.01 06001 BLOOD LABORATORY		0	0		0 0	0	
61.00 06100 PBP CLINICAL LAB							61.00
62.00 06200 WHOLE BLOOD & PAC		0	0		0 0	0	
63.00 06300 BLOOD STORING, PR		0	0		0 0		
64. 00 06400 I NTRAVENOUS THERA	ŀΡΥ	0	0		0 0		
64. 01 06401 HOME INFUSION	21/	0	0		0 0		
65.00 06500 RESPIRATORY THERA	ŀΡΥ	0	0		0 0		
66. 00 06600 PHYSI CAL THERAPY		0	0		0 0	0	
67.00 06700 OCCUPATIONAL THEF 68.00 06800 SPEECH PATHOLOGY	(APY	0	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	,	0	0		0 0		
70. 00 07000 ELECTROEARDI 0E001		0	0		0 0		
71. 00 07100 MEDICAL SUPPLIES		0	0		0 0	-	
72. 00 07200 I MPL. DEV. CHARGE		0	0		0 0		
73. 00 07300 DRUGS CHARGED TO		0	0		0 0	0	
74. 00 07400 RENAL DI ALYSI S		0	0		0 0	0	
75.00 07500 ASC (NON-DISTINCT	PART)	0	0		0 0		
76.00 03140 CARDI OLOGY		0	0		0 0	0	76.00
OUTPATIENT SERVICE COS	r centers				÷	•	
90. 00 09000 CLINIC		0	0		0 0	0	90.00
90.01 04951 SLEEP CLINIC		0	0		0 0	0	90.01
91.00 09100 EMERGENCY		0	0				91.00
92.00 09200 OBSERVATI ON BEDS		0	0		0 0	0	92.00
OTHER REIMBURSABLE COS		- I		1	-1		
94.00 09400 HOME PROGRAM DI AL		0	0		0 0	0	
95.00 09500 AMBULANCE SERVICE							95.00
96.00 09600 DURABLE MEDICAL E		0	0		0 0	-	
97.00 09700 DURABLE MEDICAL E		0	0		0 0		
98.00 09851 OTHER REI MBURSABL		0	0		0 0		
200.00 Total (lines 50-1	77)	0	0	437, 12	23 0	437, 123	1200. OO

Health Financial Systems	ELKHART GENER				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVI CE OTHER PAS	S Provider		Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/28/2015 1:0	
		Tit	le XIX	Hospi tal	PPS	2 piii
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col	. to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	_	1	1			
50.00 OPERATING ROOM	C				6, 535, 519	
51.00 05100 RECOVERY ROOM	C				0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	C				0	52.00
53. 00 05300 ANESTHESI OLOGY	C		0. 00000		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	C	51, 204, 920			1, 609, 748	54.00
54.01 05401 INTERVENTIONAL RADIOLOGY	C	0	0. 00000		0	54.01
54.02 05402 BREAST CENTER	C	0			0	54.02
54.03 05403 RADIATION ONCOLOGY	C	0	0. 00000	0 0. 000000	0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	C	0	0.00000		0	55.00
56. 00 05600 RADI 0I SOTOPE	C	0	0.00000	0 0.000000	0	56.00
56. 01 05601 ULTRASOUND	C	0	0.00000	0 0.000000	0	56.01
57.00 05700 CT SCAN	C	46, 490, 893	0. 00000	0.000000	46, 085	57.00
58. 00 05800 MRI	C	11, 122, 361	0. 00000	0.000000	311, 007	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C	56, 060, 179	0. 00000	0 0. 000000	1, 049, 143	59.00
60. 00 06000 LABORATORY	C	54, 306, 994	0. 00000	0.000000	3, 534, 530	60.00
60.01 06001 BLOOD LABORATORY	C	0	0. 00000	0.000000	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C	11, 609, 631	0. 00000	0.000000	900, 137	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	C		0. 00000	0.000000	0	63.00
64.00 06400 INTRAVENOUS THERAPY	C	1, 287, 012	0. 00000	0.000000	257, 772	64.00
64.01 06401 HOME INFUSION	C	0	0. 00000	0.000000	0	64.01
65. 00 06500 RESPI RATORY THERAPY	C	13, 386, 211	0. 00000	0.000000	1, 333, 158	65.00
66. 00 06600 PHYSI CAL THERAPY	C		0. 00000	0.000000	189, 123	66.00
67.00 06700 OCCUPATI ONAL THERAPY	C	2, 544, 953	0. 00000	0.000000	153, 344	67.00
68.00 06800 SPEECH PATHOLOGY	C	837,067	0. 00000	0.000000	42, 255	68.00
69. 00 06900 ELECTROCARDI OLOGY	C	0	0. 00000	0.000000	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	C	0	0. 00000	0.000000	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	116, 183, 114	0. 00000	0.000000	255, 584	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C	22, 864, 424	0. 00000	0.000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C			0.000000	6, 013, 820	73.00
74.00 07400 RENAL DIALYSIS	C	0	0. 00000	0.000000	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	C	0	0. 00000		0	75.00
76.00 03140 CARDI OLOGY	C	23, 558, 901	0. 00000	0.000000	441, 420	76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	C	3, 679, 646	0.00000	0 0.000000	236, 067	90.00
90. 01 04951 SLEEP CLINIC	C	2, 790, 928	0. 00000	0.000000	0	90.01
91. 00 09100 EMERGENCY	437, 123				1, 363, 689	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	C				0	
OTHER REI MBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,				1
94. 00 09400 HOME PROGRAM DI ALYSI S	C	0	0.00000	0 0.00000	0	94.00
95. 00 09500 AMBULANCE SERVICES					Ű	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0 0. 000000	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD			0.00000		0	97.00
98. 00 09851 OTHER REIMBURSABLE COST CENTERS		-			0	98.00
200.00 Total (lines 50-199)	437, 123	-		3.000000	24, 272, 401	
200.00 [10tal (11103 00-177)	457,123	1 001,002,090	I	1	27,212,401	1-00.00

Health Financial Systems	ELKHART GENERA				u of Form CMS-2552-1
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	Provi der	CCN: 150018	Period: From 01/01/2014 To 12/31/2014	
		Tit	le XIX	Hospi tal	PPS
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 x col. 10)	Outpatient Program Charges	Outpatient Program Pass-Throug Costs (col. x col. 12)	h	
	11.00	12.00	13.00		
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM	0	0		0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0	54.00
54. 01 05401 INTERVENTIONAL RADIOLOGY	0	0		0	54.0
54. 02 05402 BREAST CENTER	0	0		0	54.02
54. 03 05403 RADI ATI ON ONCOLOGY	0	0		0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0	56.00
56. 01 05601 ULTRASOUND 57. 00 05700 CT SCAN	0	0		0	56.0
	0	0		0	57.00
58. 00  05800  MRI 59. 00  05900  CARDI AC CATHETERI ZATI ON	0	0		0	58.00 59.00
60. 00 06000 LABORATORY	0	0		0	
60. 01 06000 LABORATORY	0	0		0	60. 00 60. 0
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0	64.00
64. 01 06401 HOME I NFUSI ON	0	0		0	64.0
65. 00 06500 RESPI RATORY THERAPY	0	0		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	73.00
74.00 07400 RENAL DI ALYSI S	0	0		0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0	75.00
76. 00 03140 CARDI OLOGY	0	0		0	76.00
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0	0		0	90.00
90. 01 04951 SLEEP CLINIC	0	0		0	90. 01
91.00 09100 EMERGENCY	17, 506	0		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART	0	0	l	0	92.00
OTHER REIMBURSABLE COST CENTERS			1		
94.00 09400 HOME PROGRAM DI ALYSI S	0	0		0	94.00
95. 00 09500 AMBULANCE SERVICES		~		0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS 200.00 Total (lines 50-199)	17, 506	0 0		0	98.00 200.00
200.00  Total (lines 50-199)	17, 500	0	I		J200. 00

PORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provi der	CCN: 150018	Period: From 01/01/2014	Worksheet D Part II	
		Component	CCN: 15T018	To 12/31/2014	Date/Time Pre 5/28/2015 1:0	
		Ti t	le XIX	Subprovider - IRF	PPS	•
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B, Part II, col.	Part I, col. 8)	(COI. I ÷ COI 2)	. Charges	column 4)	
	26)	0)	2)			
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		1	1			
0. 00 05000 OPERATING ROOM	2, 516, 312				11	50. C
. 00 05100 RECOVERY ROOM	0		0.0000		0	51. C
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0	C			0	52. C
00 05300 ANESTHESI OLOGY	0	C	0.0000		0	53. C
. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 532, 019	51, 204, 920			117	54. C
01 05401 INTERVENTIONAL RADIOLOGY	0	0	0.0000		0	54. C
02 05402 BREAST CENTER	0	0	0.0000		0	54. C
. 03 05403 RADI ATI ON ONCOLOGY	0	0	0.0000		0	54.0
0. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.0000		0	55.0
0. 00 05600 RADI OI SOTOPE	0	0	0.0000		0	56.0
0. 01 05601 ULTRASOUND	0	, o	0.0000		0	56.0
. 00 05700 CT SCAN	288, 716				6	57.0
	148,059		0.0133		0	58.0
2. 00 05900 CARDI AC CATHETERI ZATI ON	343, 156				0	59.0
0. 00 06000 LABORATORY 0. 01 06001 BLOOD LABORATORY	276, 581				121	60.
	0		0.00000	0 00	0	60.0
. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	12 200	11, 609, 631	0.00105	52 5, 204	5	61. ( 62. (
00 06300 BLOOD STORING, PROCESSING & TRANS.	12, 208	11,009,031	0.0000		0	63. (
. 00 06400 INTRAVENOUS THERAPY	94,002	1, 287, 012			0	64.0
. 01 06401 HOME INFUSION	94,002	1,207,012	0.00000		0	64.
00 06500 RESPIRATORY THERAPY	102, 359	13, 386, 211	0.00764		191	65.0
00 06600 PHYSI CAL THERAPY	205, 306				4, 094	66.
00 06700 OCCUPATIONAL THERAPY	94, 117				3, 364	67.
8. 00 06800 SPEECH PATHOLOGY	55, 630				1, 725	68.
0. 00 06900 ELECTROCARDI OLOGY	0		0.00000		0	69.
0.00 07000 ELECTROENCEPHALOGRAPHY	0		0.00000		0	70.
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	142, 163	116, 183, 114			5	71.
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	22, 573				0	72.
00 07300 DRUGS CHARGED TO PATIENTS	59, 368				34	73.
. 00 07400 RENAL DIALYSIS	0	0	0.0000	0 00	0	74.
00 07500 ASC (NON-DISTINCT PART)	0	c	0.0000	0 00	0	75.
0. 00 03140 CARDI OLOGY	319, 516	23, 558, 901	0. 01356	52 326	4	76.
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLINIC	205, 651	3, 679, 646	0. 05588	39 7, 150	400	90.
0. 01 04951 SLEEP CLINIC	5, 021	2, 790, 928			0	90.
. 00 09100 EMERGENCY	688, 775				0	91.
00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	17, 137, 597	0.0000	0 00	0	92.0
OTHER REIMBURSABLE COST CENTERS	T	1	1			
. 00 09400 HOME PROGRAM DI ALYSI S	0	C	0.0000	0 00	0	
00 09500 AMBULANCE SERVICES						95.
00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.00000		0	96.
00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.0000		0	97.
00 09851 OTHER REIMBURSABLE COST CENTERS	0	, i i i i i i i i i i i i i i i i i i i			0	
0.00 Total (lines 50-199)	7, 111, 532	661, 082, 890		334, 395	10, 077	200.

PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI HROUGH COSTS	ERVICE OTHER PASS		CCN: 150018 t CCN: 15T018	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre 5/28/2015 1:0	pared: 2 pm
		Tit	le XIX	Subprovider - IRF	PPS	
Cost Center Description	Non Physician N Anesthetist Cost	ursing School	Allied Healt		Total Cost (sum of col 1 through col. 4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS				0	0	1 50 0
D. 00 05000 OPERATING ROOM I. 00 05100 RECOVERY ROOM	0	0		0 0 0 0	0	
2. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	
3. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	
4. 00 05400 RADI OLOGY - DI AGNOSTI C	0	0		0 0	0	•
4. 01 05400 KADI OLOGI - DI AGNOSTI C	0	0		0 0	0	•
4. 02 05402 BREAST CENTER	0	0		0 0	0	
4. 03 05403 RADI ATI ON ONCOLOGY		0		0 0	0	
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
5. 00 05600 RADI OI SOTOPE	0	C		0 0	0	
5. 01 05601 ULTRASOUND	0	0		0 0	0	
7. 00 05700 CT SCAN	0	Ő		0 0	0	
3. 00 05800 MRI	0	0		0 0	0	
9. 00 05900 CARDI AC CATHETERI ZATI ON	o	0		0 0	0	
0. 00 06000 LABORATORY	0	C	)	0 0	0	60.0
0. 01 06001 BLOOD LABORATORY	0	C	)	0 0	0	60.0
I. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	)	0 0	0	62.0
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	)	0 0	0	63.0
1. 00 06400 I NTRAVENOUS THERAPY	0	C	)	0 0	0	64.0
4.01 06401 HOME INFUSION	0	C		0 0	0	64. C
5. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65. C
5. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	
7. 00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	
3. 00 06800 SPEECH PATHOLOGY	0	C		0 0	0	
9. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	
0.00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	
I. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
4. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	
5. 00 07500 ASC (NON-DI STI NCT PART)	0			-	0	
5. 00 03140 CARDI OLOGY OUTPATI ENT SERVICE COST CENTERS	0	0	1	0 0	0	76.0
0.00 09000 CLINIC	0	0		0 0	0	90.0
0. 01 04951 SLEEP CLINIC	0	0		0 0	0	
I. 00 09100 EMERGENCY	0	C		-	437, 123	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0		
OTHER REIMBURSABLE COST CENTERS		0	1		0	, 2.0
1. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94.0
5. 00 09500 AMBULANCE SERVICES		0				95.0
5. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0 0	0	
7. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	
3. 00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	
00.00 Total (lines 50-199)	0	C		-		

ealth Financial Systems	ELKHART GENER				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provi der		Peri od:	Worksheet D	
THROUGH COSTS		Component		From 01/01/2014 To 12/31/2014	Part IV Date/Time Prep 5/28/2015 1:02	
			le XIX	Subprovider - IRF	PPS	
Cost Center Description	Total	Total Charges			Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col.		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)	7.00	0.00	7)	10.00	
ANCI LLARY SERVI CE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
50. 00 05000 OPERATING ROOM	0	97, 501, 646	0.00000	0. 000000	429	50.00
51. 00 05100 RECOVERY ROOM	0	97, 501, 646			429	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	
					0	
53. 00 05300 ANESTHESI OLOGY	0	e e e e e e e e e e e e e e e e e e e	0.00000			
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	51, 204, 920			3, 921	54.00
54. 01 05401 I NTERVENTI ONAL RADI OLOGY	0	0	0.00000		0	
54. 02 05402 BREAST CENTER	0	0			0	
54. 03 05403 RADIATION ONCOLOGY	0	0			0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0			0	
56. 00 05600 RADI OI SOTOPE	0	0			0	56.00
56. 01 05601 ULTRASOUND	0	0	0.00000	0. 000000	0	56.01
57.00 05700 CT SCAN	0	46, 490, 893	0.00000	0. 000000	933	57.00
58. 00 05800 MRI	0	11, 122, 361	0.00000	0. 000000	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	56, 060, 179	0. 000000	0. 000000	0	59.00
50. 00 06000 LABORATORY	0	54, 306, 994	0.00000	0. 000000	23, 810	60.00
50. 01 06001 BLOOD LABORATORY	0	0	0.00000		0	
51. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	11, 609, 631	0. 000000	0. 000000	5, 204	
53. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 000000		0,201	63.00
54. 00 06400 I NTRAVENOUS THERAPY	0	1, 287, 012			Ő	
54. 01 06401 HOME INFUSION	0	1,207,012	0. 000000		0	64.01
55.00 06500 RESPIRATORY THERAPY	0	13, 386, 211	0.000000		24, 940	
66.00 06600 PHYSI CAL THERAPY	0	4, 748, 427			94, 685	
57. 00 06700 OCCUPATI ONAL THERAPY	0	2, 544, 953			90, 956	67.00
58.00 06800 SPEECH PATHOLOGY	0	2, 544, 953			25, 953	
59. 00 06900 ELECTROCARDI OLOGY	0	037,007	0.000000		25, 955	
	-	0			-	
70.00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	116, 183, 114	0.00000		4, 129	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	22, 864, 424	0.00000		0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	89, 715, 953			51, 959	
74.00 07400 RENAL DIALYSIS	0	0			0	
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000		0	
76. 00 03140 CARDI OLOGY	0	23, 558, 901	0.00000	0. 000000	326	76.00
OUTPATIENT SERVICE COST CENTERS	1					
20. 00 09000 CLINIC	0	3, 679, 646			7, 150	
20. 01 04951 SLEEP CLINIC	0				0	
P1. 00 09100 EMERGENCY	437, 123	34, 052, 033			0	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	17, 137, 597	0.00000	0. 000000	0	92.00
OTHER REIMBURSABLE COST CENTERS				1		
	0	0	0.00000	0. 000000	0	94.00
94. 00 09400 HOME PROGRAM DI ALYSI S			1			95.00
25. 00 09500 AMBULANCE SERVICES					1	
	0	0	0. 000000	0. 000000	0	
25. 00 09500 AMBULANCE SERVICES	0	0			0	96.00
25. 00 09500 AMBULANCE SERVI CES 26. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	-	-		0. 000000	-	96.00 97.00

Health Financial Systems	ELKHART GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER PASS		CCN: 150018 t CCN: 15T018	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part IV Date/Time Pre	
		Ti t	le XIX	Subprovider -	5/28/2015 1:0 PPS	<u>12 pm</u>
Cost Center Description	I npati ent	Outpati ent	Outpati ent	I RF		
	Program Pass-Through	Program Charges	Program Pass-Throug	h		
	Costs (col. 8	chai ges	Costs (col.			
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCILLARY SERVICE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	0	C		0		50.00
51.00 O5100 RECOVERY ROOM	0	0		0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	(		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 01 05401 I NTERVENTI ONAL RADI OLOGY	0	(		0		54.00 54.01
54. 02 05402 BREAST CENTER	0	(		0		54.01
54. 03 05403 RADI ATI ON ONCOLOGY	0	(		0		54.02
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C		0		55.00
56. 00 05600 RADI OI SOTOPE	0	0		0		56.00
56. 01 05601 ULTRASOUND	0	C		0		56.01
57.00 05700 CT SCAN	0	C		0		57.00
58. 00 05800 MRI	0	C		0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0		59.00
60. 00 06000 LABORATORY	0	C	D	0		60.00
60. 01 06001 BLOOD LABORATORY	0	C		0		60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0		62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0		63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		0		64.00
64. 01 06401 HOME INFUSION 65. 00 06500 RESPIRATORY THERAPY	0	(		0		64.01
66. 00 06600 PHYSI CAL THERAPY	0	0		0		65.00 66.00
67. 00 06700 OCCUPATIONAL THERAPY	0	C		0		67.00
68. 00 06800 SPEECH PATHOLOGY	0	C		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C		0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	C		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
74.00 07400 RENAL DIALYSIS	0	C		0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C		0		75.00
76. 00 03140 CARDI OLOGY	0	0	)	0		76.00
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	C		0		90.00
90. 01 04951 SLEEP CLINIC	0	0		0		90.01
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0		91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS	0	Ĺ	/	0		92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0		94.00
95. 00 09500 AMBULANCE SERVICES	0	C	1	ĭ		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C		0		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0		97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	C		0		98.00

	Financial Systems ELKHART GENERAL HOSPI	ovider CCN: 150018	Period: From 01/01/2014 To 12/31/2014	5/28/2015 1:0	pare
	Cost Center Description	Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
00	Inpatient days (including private room days and swing-bed days, exc	cluding newborn)		47, 029	1
00	Inpatient days (including private room days, excluding swing-bed ar			47, 029	2
00	Private room days (excluding swing-bed and observation bed days). I do not complete this line.	lf you have only pr	ivate room days,	18, 182	3
00	Semi-private room days (excluding swing-bed and observation bed day	ys)		22, 241	4
00	Total swing-bed SNF type inpatient days (including private room day		r 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private room day	ve) after Decomber	21 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	ys) alter becember	ST OF THE COST	0	
00	Total swing-bed NF type inpatient days (including private room days	s) through December	31 of the cost	0	7
00	reporting period	a) after December 2	1 of the east	0	8
00	Total swing-bed NF type inpatient days (including private room days reporting period (if calendar year, enter 0 on this line)	s) al tel December 3	I UI LINE CUST	0	°
00	Total inpatient days including private room days applicable to the	Program (excluding	swing-bed and	18, 400	9
	newborn days)			0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (in through December 31 of the cost reporting period (see instructions)		oom days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (i		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, enter (			0	1.10
2. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only through December 31 of the cost reporting period	y (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only			0	13
~~	after December 31 of the cost reporting period (if calendar year, e				
. 00	Medically necessary private room days applicable to the Program (ex Total nursery days (title V or XIX only)	xci uai ng swi ng-bea	days)	0	14   15
. 00				-	16
	SWING BED ADJUSTMENT				1
. 00	Medicare rate for swing-bed SNF services applicable to services the	rough December 31 o	f the cost	0.00	17
3. 00	reporting period Medicare rate for swing-bed SNF services applicable to services aft	ter December 31 of	the cost	0.00	18
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to services through reporting period	ough December 31 of	the cost	0.00	19
0. 00	Medicaid rate for swing-bed NF services applicable to services after	er December 31 of t	he cost	0.00	20
	reporting period				
2.00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31	of the cost report	ing pariod (line	50, 871, 274	21
2.00	5 x line 17)	of the cost report	riig period (rine	0	
8.00	Swing-bed cost applicable to SNF type services after December 31 of	f the cost reportin	g period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December 31 of	of the cost reporti	na poriod (lino	0	24
1.00	7 x line 19)	or the cost report	ng period (inne	0	24
5.00	5 11 51	the cost reporting	period (line 8	0	25
5.00	x line 20) Total swing-bed cost (see instructions)			0	26
7.00		21 minus line 26)		50, 871, 274	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
8.00	General inpatient routine service charges (excluding swing-bed and	observation bed ch	arges)	112, 462, 109	
. 00 . 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			52, 862, 207 59, 599, 902	
. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line	e 28)		0. 452341	
. 00	Average private room per diem charge (line 29 ÷ line 3)			2,907.39	
. 00 . 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus li	ine 33)(see instruc	tions)	2, 679. 73 227. 66	
. 00			Ci 01137	102.98	
. 00	Private room cost differential adjustment (line 3 x line 35)			1, 872, 382	36
. 00	General inpatient routine service cost net of swing-bed cost and pr	rivate room cost di	fferential (line	48, 998, 892	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMEN	NTS			1
. 00	Adjusted general inpatient routine service cost per diem (see instr	ructions)		1,081.70	
0. 00 0. 00	Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (li	ine 14 v line 35)		19, 903, 280 0	39
	Incoroarry necessary private room cost appricable to the Program (II	INC 14 A ITHE 30)		0	1 40

lealth Financial Systems COMPUTATION OF INPATIENT OPERATING COST		L HOSPITAL Provider	CCN: 150018	Peri od:	worksheet D-1	
				From 01/01/2014 To 12/31/2014		
		Titl	e XVIII	Hospi tal	PPS	- <u>-</u>
Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)	Program Days ÷	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
42.00 NURSERY (title V & XIX only)	0	0	0.0	0 0	0	42.0
1 Intensive Care Type Inpatient Hospital Uni 13.00 INTENSIVE CARE UNIT		4, 894	1, 621. 7	2, 107	3, 417, 006	1 12 0
43.00   I NTENSI VE CARE UNI T 43.01   NEONATAL I NTENSI VE CARE	7, 936, 772 1, 815, 370	4, 894 867				
44. 00 CORONARY CARE UNIT	1,010,070	007	2,0,010			44.0
45.00 BURN INTENSIVE CARE UNIT						45. C
46.00 SURGICAL INTENSIVE CARE UNIT 47.00 OTHER SPECIAL CARE (SPECIFY)						46. C
Cost Center Description						47.0
	-				1.00	
48.00 Program inpatient ancillary service cost ( 49.00 Total Program inpatient costs (sum of line			nc)		31, 125, 189 54, 445, 475	
PASS THROUGH COST ADJUSTMENTS	<u>s 41 through 40)(s</u>		(15)		54, 445, 475	49.0
50.00 Pass through costs applicable to Program i	npatient routine s	ervices (from	Wkst. D, sum	of Parts I and	2, 499, 410	50. C
51.00 Pass through costs applicable to Program i	protiont ancillary	convious (fr	om Wkct D	um of Dorte II	1, 311, 862	E1 0
and IV)	npatrent andri aly	Services (II	UNI WKSt. D, S		1, 311, 002	51.0
52.00 Total Program excludable cost (sum of line					3, 811, 272	52. C
53.00 Total Program inpatient operating cost exc		ated, non-phy	sician anesth	etist, and	50, 634, 203	53. C
medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	le 52)					
54.00 Program di scharges					0	54. C
55.00 Target amount per discharge					0.00	
6.00   Target amount (line 54 x line 55) 57.00   Difference between adjusted inpatient oper	ating cost and tar	det amount (l	ing 56 minus	line 53)	0	
58.00 Bonus payment (see instructions)		get anount (i	The 50 minus	The 33)	0	
59.00 Lesser of lines 53/54 or 55 from the cost	reporting period e	ndi ng 1996, u	pdated and co	mpounded by the	0.00	59.0
market basket 50.00 Lesser of lines 53/54 or 55 from prior yea	r cost roport und	atod by the m	arkot backot		0.00	60.0
51.00 If line 53/54 is less than the lower of li				the amount by	0.00	
which operating costs (line 53) are less t	han expected costs					
amount (line 56), otherwise enter zero (se 52.00 Relief payment (see instructions)	e instructions)				0	62. C
53.00 Allowable Inpatient cost plus incentive pa	yment (see instruc	tions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST					1	
54.00 Medicare swing-bed SNF inpatient routine c instructions)(title XVIII only)	osts through Decem	ber 31 of the	cost reporti	ng period (See	0	64. C
55.00 Medicare swing-bed SNF inpatient routine c	osts after Decembe	r 31 of the c	ost reporting	period (See	0	65. C
instructions)(title XVIII only)						
56.00 Total Medicare swing-bed SNF inpatient rou CAH (see instructions)	tine costs (line 6	4 plus line 6	5)(title XVII	I ONLY). FOR	0	66. C
57.00 Title V or XIX swing-bed NF inpatient rout	ine costs through	December 31 o	f the cost re	porting period	0	67. C
(line 12 x line 19)						
58.00  Title V or XIX swing-bed NF inpatient rout (line 13 x line 20)	ine costs after De	cember 31 of	the cost repo	orting period	0	68. C
59.00 Total title V or XIX swing-bed NF inpatier	t routine costs (I	ine 67 + line	68)		0	69. C
PART III - SKILLED NURSING FACILITY, OTHER					1	
70.00 Skilled nursing facility/other nursing fac 71.00 Adjusted general inpatient routine service	· ·					70.0
72.00 Program routine service cost (line 9 x lin		ne 70 ÷ Trhe	2)			72.0
73.00 Medically necessary private room cost appl	0	•				73.0
74.00 Total Program general inpatient routine se 75.00 Capital-related cost allocated to inpatier				art II column		74.0
75.00 Capital-related cost allocated to inpatier 26, line 45)	it routine service	COSIS (ITOM W	Orksneet B, F	art II, corumn		75. C
76.00 Per diem capital-related costs (line 75 ÷	line 2)					76.0
7.00 Program capital -related costs (line 9 x li						77.0
8.00  Inpatient routine service cost (line 74 mi 9.00  Aggregate charges to beneficiaries for exc		ovider record	s)			78.0
0.00 Total Program routine service costs for co	• •		· · ·	us line 79)		80.0
1.00 Inpatient routine service cost per diem li						81.0
<ul> <li>32.00  Inpatient routine service cost limitation</li> <li>33.00  Reasonable inpatient routine service costs</li> </ul>	• • •					82.0
34.00 Program inpatient ancillary services (see	•	)				84. (
35.00 Utilization review - physician compensatio		s)				85.0
36.00 Total Program inpatient operating costs (s		ough 85)				86.0
PART IV - COMPUTATION OF OBSERVATION BED P 37.00 Total observation bed days (see instruction					6, 606	87.0
88.00 Adjusted general inpatient routine cost pe		line 2)			1, 081. 70	
	see instructions)				7, 145, 710	1 00 0

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				To 12/31/2014	Date/Time Pre 5/28/2015 1:0	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	5, 784, 879	50, 871, 274	0. 11371	6 7, 145, 710	812, 582	90.00
91.00 Nursing School cost	0	50, 871, 274	0.00000	7, 145, 710	0	91.00
92.00 Allied health cost	0	50, 871, 274	0.00000	7, 145, 710	0	92.00
93.00 All other Medical Education	0	50, 871, 274	0.00000	7, 145, 710	0	93.00

/IPU1/	TION OF INPATIENT OPERATING COST	Provider CCN: 150018 Component CCN: 15T018	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Pre 5/28/2015 1:03	pare
		Title XVIII	Subprovider - IRF	PPS	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	NPATLENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		2, 449	1 1
00	Inpatient days (including private room days, excluding swing-be			2, 449	
00	Private room days (excluding swing-bed and observation bed days	s). If you have only pr	vate room days,	82	3
0	do not complete this line. Semi private room days (evoluding swing had and ebservation be	t dave)		2 247	4
0	Semi-private room days (excluding swing-bed and observation bea Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	2, 367 0	
	reporting period			0	
00	Total swing-bed SNF type inpatient days (including private room	n days) after December 🗧	31 of the cost	0	6
0	reporting period (if calendar year, enter 0 on this line)	dava) through December	21 of the east	0	-
00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7
0	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)				
0	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 006	9
00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII on!	v (including private r	nom davs)	0	10
00	through December 31 of the cost reporting period (see instructi		Join days)	0	
00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11
~~	December 31 of the cost reporting period (if calendar year, en			0	1.
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	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13
	after December 31 of the cost reporting period (if calendar yea				
	Medically necessary private room days applicable to the Program	n (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		I	0	
	Medicare rate for swing-bed SNF services applicable to services	s through December 31 o	f the cost	0.00	17
00	reporting period Madiaara rata far awing had SNE aarviaaa applicable to corviaa	ofter December 21 of	the east	0.00	10
00	Medicare rate for swing-bed SNF services applicable to services reporting period	saiter December 31 01	the cost	0.00	110
00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19
	reporting period				
00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of th	ne cost	0.00	20
00	Total general inpatient routine service cost (see instructions)	)		2, 678, 233	21
	Swing-bed cost applicable to SNF type services through December		ng period (line	0	
	5 x line 17)			_	
00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	31 of the cost reporting	g period (line 6	0	23
00	Swing-bed cost applicable to NF type services through December	31 of the cost reportion	ng period (line	0	24
	7 x line 19)				
00	Swing-bed cost applicable to NF type services after December 3	l of the cost reporting	period (line 8	0	25
00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost (	ine 21 minus line 26)		2, 678, 233	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	4, 304, 684	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			164, 863 4, 139, 821	
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 622167	
	Average private room per diem charge (line 29 ÷ line 3)			2, 010. 52	
	Average semi-private room per diem charge (line 30 ÷ line 4)			1, 748. 97	
	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 24 x line	, ,	tions)	261.55 162.73	
	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	5 31)		162.73	
	General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	2, 664, 889	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	TMENTO			-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see i			1, 093. 60	38
	Program general inpatient routine service cost (line 9 x line 3			1, 100, 162	
	Medically necessary private room cost applicable to the Program			0	
00	Total Program general inpatient routine service cost (line 39	Line 40)		1, 100, 162	41

OMPUT.	Financial Systems ATION OF INPATIENT OPERATING COST		AL HOSPITAL Provider	CCN: 150018	Peri od:	eu of Form CMS- Worksheet D-1	
			Componen	t CCN: 15T018	From 01/01/2014 To 12/31/2014	Date/Time Pre	
			 	e XVIII	Subprovider -	5/28/2015 1:0 PPS	
		<b>T</b> 1 1			I RF	-	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.	00 0	) C	) 4:
	INTENSIVE CARE UNIT	0	C				
	NEONATAL INTENSIVE CARE	0	C	0.	00 0	C	
00 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						4
00	SURGI CAL I NTENSI VE CARE UNI T						46
. 00	OTHER SPECIAL CARE (SPECIFY)						4
	Cost Center Description					1.00	
00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	, line 200)	-		458, 639	9 48
	Total Program inpatient costs (sum of lines 4			ons)		1, 558, 801	
~~	PASS THROUGH COST ADJUSTMENTS				<u> </u>	4/0.4/5	
00	Pass through costs applicable to Program inpa	atient routine	Services (Tron	n WKST. D, SU	n of Parts I and	163, 465	5 50
00	Pass through costs applicable to Program inpa and IV)		ry services (fr	rom Wkst. D,	sum of Parts II	35, 801	1 5'
00	Total Program excludable cost (sum of lines !					199, 266	
00	Total Program inpatient operating cost exclud medical education costs (line 49 minus line 5		erated, non-phy	sıcıan anest/	netist, and	1, 359, 535	2   <sup>5</sup>
	TARGET AMOUNT AND LIMIT COMPUTATION	·-,				· · · · · · · · · · · · · · · · · · ·	
	Program di scharges					C	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	
	Difference between adjusted inpatient operati	ng cost and ta	raet amount (I	ine 56 minus	line 53)		
00	Bonus payment (see instructions)					C C	
00	Lesser of lines 53/54 or 55 from the cost rep	porting period	ending 1996, ι	updated and c	ompounded by the	0.00	) 5'
00	market basket Lesser of lines 53/54 or 55 from prior year o	cost report un	dated by the m	narkat haskat		0.00	) 61
	If line 53/54 is less than the lower of lines					0.00	
	which operating costs (line 53) are less than	n expected cost			5		
~~	amount (line 56), otherwise enter zero (see i	nstructions)					
	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST						1 .
00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 of the	e cost report	ing period (See	C	) 64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the c	rost reportin	a period (See		) 65
00	instructions) (title XVIII only)				g period (see		
. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	55)(title XVI	ll only). For	C	66
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	costs through	Docombor 21	of the cost r	oporting poriod		6
. 00	(line 12 x line 19)	e costs through	December 31 (	on the cost i	eporting period		
. 00	Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 31 of	the cost rep	orting period	C	68
00	(line 13 x line 20)	soutino costa (	line 47 i line	40)			
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					C	) 69
	Skilled nursing facility/other nursing facili	ty/ICF/MR rout	ine service co	ost (line 37)			70
	Adjusted general inpatient routine service co		ine 70 ÷ line	2)			7
	Program routine service cost (line 9 x line 7 Medically necessary private room cost applica		$(lin = 1/ \sqrt{1})$	ne 35)			7:
00	Total Program general inpatient routine servi						7
. 00	Capital-related cost allocated to inpatient i	•			Part II, column		75
00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	2)					7
	Program capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						7
	Inpatient routine service cost (line 74 minus						78
	Aggregate charges to beneficiaries for excess						79
00	Total Program routine service costs for compa		ost limitation	n (line 78 mi	nus line 79)		8
	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li		)				8
	Reasonable inpatient routine service cost frim tatron (in		· .				8
00	Program inpatient ancillary services (see ins	structions)					84
	Utilization review - physician compensation	•					8!
00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rough 85)				80
. 00	Total observation bed days (see instructions)					C	8
. 00	Adjusted general inpatient routine cost per o	diem (line 27 ÷				0.00	88  0
. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				[ C	8

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
		Componen	t CCN: 15T018			pared: 2 pm
		Ti tl	e XVIII	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	397, 937	2, 678, 233	0. 14858	82 0	0	90.00
91.00 Nursing School cost	0	2, 678, 233	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 678, 233	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 678, 233	0. 00000	0 0	0	93.00

MPUT	Financial Systems     ELKHART GENERAL HOSPITAL     In Lie       ATION OF INPATIENT OPERATING COST     Provider CCN: 150018     Period: From 01/01/2014 To 12/31/2014		par
	Title XIX Hospital	5/28/2015 1:0 PPS	2 pi
	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
~~		17.000	
00 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days)	47, 029 47, 029	
00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	47,027	
	do not complete this line.		
00	Semi-private room days (excluding swing-bed and observation bed days)	40, 423	
00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period	0	5
00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)		
00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	0	7
00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)		
00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	3, 955	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10
	through December 31 of the cost reporting period (see instructions)	Ũ	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11
. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12
. 00	through December 31 of the cost reporting period	0	
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13
00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	1
. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days) Total nursery days (title V or XIX only)	3, 040	14
	Nursery days (title V or XIX only)		16
	SWING BED ADJUSTMENT		
. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18
. 00	reporting period	0.00	
. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20
. 00	reporting period	0.00	
. 00	Total general inpatient routine service cost (see instructions)	50, 871, 274	
. 00	5 11 51 5	0	22
8. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23
	x line 18)		
. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24
5. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25
. 00	x line 20)	0	
o. 00	Total swing-bed cost (see instructions)	0	
. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	50, 871, 274	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28
. 00	Private room charges (excluding swing-bed charges)	0	
	Semi-private room charges (excluding swing-bed charges)	0	
. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0.00 0.00	
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	35
. 00	Private room cost differential adjustment (line 3 x line 35)	0	36
. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)	50, 871, 274	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		1
	Adjusted general inpatient routine service cost per diem (see instructions)	1,081.70	
	Program general inpatient routine service cost (line 9 x line 38)	4, 278, 124	39
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40

ealth Financial Systems OMPUTATION OF INPATIENT OPERATING COST	ELKHART GENER		CN: 150018	In Lie Period:	u of Form CMS- Worksheet D-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre	epared
		Titl	e XIX	Hospi tal	5/28/2015 1:0 PPS	z pili
Cost Center Description	Total Inpatient Cost	Total Inpatient DaysD	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
2.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospit	4, 407, 328	3, 040	1, 449. 7	8 0	0	42.0
3. 00 INTENSIVE CARE UNIT	7, 936, 772	4, 894	1, 621. 7	4 0	0	43.0
3. 01 NEONATAL INTENSIVE CARE	1, 815, 370	867	2,093.8		-	
4. 00 CORONARY CARE UNI T						44. (
5. 00 BURN INTENSIVE CARE UNIT						45.
5.00 SURGICAL INTENSIVE CARE UNIT 7.00 OTHER SPECIAL CARE (SPECIFY)						46. 47.
Cost Center Description						47.
					1.00	
3.00 Program inpatient ancillary service	-				5, 731, 139	
P. 00 Total Program inpatient costs (sum o PASS THROUGH COST ADJUSTMENTS	Tines 41 through 48)(	see instruction	S)		10, 009, 263	49.
0.00 Pass through costs applicable to Pro	gram inpatient routine	services (from	Wkst. D, sum	of Parts I and	486, 505	50.
.00 Pass through costs applicable to Pro	gram inpatient ancillar	y services (fro	m Wkst. D, s	um of Parts II	360, 869	51.
and IV) 2.00 Total Program excludable cost (sum o	flines 50 and 51)				847, 374	52.
3.00 Total Program inpatient operating co		lated, non-phys	ician anesth	etist, and	9, 161, 889	
medical education costs (line 49 min	us line 52)	· •				
1.00 Program di scharges					0	54.
5.00 Target amount per discharge					0.00	
. 00 Target amount (line 54 x line 55)					0	
.00 Difference between adjusted inpatien	t operating cost and ta	rget amount (li	ne 56 minus	line 53)	0	
8.00 Bonus payment (see instructions)					0	
0.00 Lesser of lines 53/54 or 55 from the market basket	cost reporting period	enaing 1996, up	dated and co	mpounded by the	0.00	59.
0.00 Lesser of lines 53/54 or 55 from pri	or year cost report, up	dated by the ma	rket basket		0.00	60.
.00 If line 53/54 is less than the lower					0	61.
which operating costs (line 53) are amount (line 56), otherwise enter ze		s (lines 54 x 6	0), or 1% of	the target		
2.00 Relief payment (see instructions)	o (see instructions)				0	62.
3.00 Allowable Inpatient cost plus incent	ve payment (see instru	ctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED					I	
I. 00 Medicare swing-bed SNF inpatient rou instructions)(title XVIII only)	tine costs through Dece	mber 31 of the	cost reporti	ng period (See	0	64.
5.00 Medicare swing-bed SNF inpatient rou	tine costs after Decemb	er 31 of the co	st reportina	period (See	0	65.
instructions)(title XVIII only)			5			
5.00 Total Medicare swing-bed SNF inpatie	nt routine costs (line	64 plus line 65	)(title XVII	l only). For	0	66.
CAH (see instructions) 7.00 Title V or XIX swing-bed NF inpatien	t routine costs through	December 31 of	the cost re	porting period	0	67.
(line 12 x line 19)	t routine costs through	December 51 01	the cost re	por tring period		07.
3.00 Title V or XIX swing-bed NF inpatien	t routine costs after D	ecember 31 of t	he cost repo	rting period	0	68.
(line 13 x line 20)			(0)			
9.00 Total title V or XIX swing-bed NF in PART III - SKILLED NURSING FACILITY,					0	69.
0.00 Skilled nursing facility/other nursi						70.
00 Adjusted general inpatient routine s	ervice cost per diem (I	ine 70 ÷ line 2	)			71.
2.00 Program routine service cost (line 9		(1) - 14 - 11 -	- 25)			72.
8.00 Medically necessary private room cos 4.00 Total Program general inpatient rout		•	e 35)			73.
5.00 Capital-related cost allocated to in	•		rksheet B, P	art II, column		75.
26, line 45)						
. 00 Per diem capital-related costs (line	-					76.
.00 Program capital-related costs (line .00 Inpatient routine service cost (line						77.
. 00 Aggregate charges to beneficiaries f		rovider records	)			79.
.00 Total Program routine service costs	for comparison to the c		· .	us line 79)		80.
.00 Inpatient routine service cost per d		、 、				81.
00 Inpatient routine service cost limit 00 Reasonable inpatient routine service		•				82.
. 00 Program inpatient ancillary services		<i></i>				84.
00 Utilization review - physician compe		ns)				85.
0.00 Total Program inpatient operating co		rough 85)				86.
PART IV - COMPUTATION OF OBSERVATION 7.00 Total observation bed days (see inst					6, 606	87.
7.00  Total observation bed days (see inst 3.00  Adjusted general inpatient routine c		line 2)			1, 081. 70	
5. 00 Maj astea general inpatrent roatine e						

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				To 12/31/2014	Date/Time Pre 5/28/2015 1:0	
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	5, 784, 879	50, 871, 274	0. 11371	6 7, 145, 710	812, 582	90.00
91.00 Nursing School cost	0	50, 871, 274	0.00000	7, 145, 710	0	91.00
92.00 Allied health cost	0	50, 871, 274	0.00000	7, 145, 710	0	92.00
93.00 All other Medical Education	0	50, 871, 274	0. 00000	7, 145, 710	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150018 Component CCN: 15T018	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Pre 5/28/2015 1:03	pare
		Title XIX	Subprovider - IRF	PPS	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	excluding newborn)		2, 449	1 1.
	Inpatient days (including private room days, excluding swing-bed days			2, 449	2
00	Private room days (excluding swing-bed and observation bed days		vate room days,	0	3
	do not complete this line.				
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		31 of the cost	2, 449 0	
00	reporting period	in days) thi dagit becember	ST OF THE COST	0	
00	Total swing-bed SNF type inpatient days (including private room	m days) after December 3	31 of the cost	0	6
~~	reporting period (if calendar year, enter 0 on this line)		21 - 6 + 6 +		
00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)	-			
00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	125	9
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	ly (including private r	nom davs)	0	10
	through December 31 of the cost reporting period (see instruct			0	
	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XIX		room dave)	0	12
. 00	through December 31 of the cost reporting period	only (including private	e room days)	0	
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13
	after December 31 of the cost reporting period (if calendar yes				
	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	m (excluding swing-bed of	days)	0 3, 040	
	Nursery days (title V or XIX only)			3, 040	
	SWING BED ADJUSTMENT		I		
. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 o	f the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to service:	s after December 31 of .	the cost	0.00	19
. 00	reporting period			0.00	
. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 21 of th	a cost	0.00	20
. 00	reporting period	alter becember 31 01 th	le cost	0.00	
. 00	Total general inpatient routine service cost (see instructions)	)		2, 678, 233	21
. 00	Swing-bed cost applicable to SNF type services through December	r 31 of the cost reporti	ng period (line	0	22
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	31 of the cost reporting	n period (line 6	0	23
. 00	x line 18)			0	20
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportion	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	pariod (line 9	0	25
. 00	x line 20)	Tor the cost reporting	period (inne o	0	23
. 00	Total swing-bed cost (see instructions)			0	
. 00	General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		2, 678, 233	27
. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		li goo)	0	
. 00	Semi-private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
	Average per diem private room charge differential (line 32 min	us line 33)(see instruc <sup>.</sup>	tions)	0.00	
. 00	Average per diem private room cost differential (line 34 x line			0.00	
	Private room cost differential adjustment (line 3 x line 35)	nd private rear+ "	Fforontial (1:-	0	
. 00	General inpatient routine service cost net of swing-bed cost an 27 minus line 36)	nu private room cost di	Terential (line	2, 678, 233	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				1
	Adjusted general inpatient routine service cost per diem (see			1,093.60	
	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program			136, 700 0	
	Total Program general inpatient routine service cost (line 39	. ,		136, 700	

OMPUT	Financial Systems ATION OF INPATIENT OPERATING COST		AL HOSPITAL Provider	CCN: 150018	Peri od:	eu of Form CMS- Worksheet D-1	
			Componen	t CCN: 15T018	From 01/01/2014 To 12/31/2014	Date/Time Pre	
			Tit	tle XIX	Subprovider -	5/28/2015 1:0 PPS	02 p
		<b></b>			IRF		_
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4.00	5.00	
00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(	0.	00 0	C	42
00	INTENSIVE CARE UNIT	0	(	0.	00 0	0	) 43
. 01	NEONATAL INTENSIVE CARE	0	(	0.	00 0	C	
00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44
. 00 . 00	SURGICAL INTENSIVE CARE UNIT						40
	OTHER SPECIAL CARE (SPECIFY)						47
	Cost Center Description						
. 00	Program inpatient ancillary service cost (Wk	st D_3 col 3	Line 200)			1.00	9 48
	Total Program inpatient costs (sum of lines			ons)		261, 779	
	PASS THROUGH COST ADJUSTMENTS	<u> </u>					
. 00	Pass through costs applicable to Program inp	atient routine	services (from	n Wkst. D, su	m of Parts I and	20, 311	50
00	III) Pass through costs applicable to Program inp	atient ancillar	v services (fi	rom Wkst D	sum of Parte 11	10, 077	51
00	and IV)		y 301 VICES (11	$D_i$		10,077	
. 00	Total Program excludable cost (sum of lines					30, 388	
. 00	Total Program inpatient operating cost exclu-		lated, non-phy	ysician anest	hetist, and	231, 391	1 53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)				I	
00	Program discharges					0	5
. 00	Target amount per discharge					0.00	
. 00 . 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	urget amount (l	line 56 minus	line 53)		
00	Bonus payment (see instructions)		inger anount (i	THE 50 III Hus	TTHE 55)		
. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, u	updated and c	ompounded by the	0.00	
	market basket						
. 00 . 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line					0.00	
. 00	which operating costs (line 53) are less that				5		1
	amount (line 56), otherwise enter zero (see	instructions)					
2.00 3.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (soo instru	uctions)				
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST					1 0	
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost report	ing period (See	C	64
00	instructions)(title XVIII only)	ta aftar Daamh	or 21 of the	ant reportin	a posted (Coo		) 65
5. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of the o	cost reportin	g period (see	C	1 00
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line d	65)(title XVI	II only). For	0	66
00	CAH (see instructions)			6 H H			
. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs througr	December 31 (	or the cost r	eporting period		67
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost rep	orting period	0	68
	(line 13 x line 20)						
. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	) 69
. 00	Skilled nursing facility/other nursing facil						70
. 00	Adjusted general inpatient routine service c						71
	Program routine service cost (line 9 x line			25)			72
. 00 . 00	Medically necessary private room cost applic. Total Program general inpatient routine serv						73
. 00	Capital -related cost allocated to inpatient	•			Part II, column		75
	26, line 45)						
. 00 . 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
	Inpatient routine service cost (line 74 minu	,					78
	Aggregate charges to beneficiaries for exces		orovi der record	ds)			79
00	Total Program routine service costs for comp		ost limitation	n (line 78 mi	nus line 79)		80
	Inpatient routine service cost per diem limi		)				8
	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (		· .				8
00	Program inpatient ancillary services (see in		,				84
	Utilization review - physician compensation	•					85
. 00	Total Program inpatient operating costs (sum		rough 85)				86
. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					C	8
. 00	Adjusted general inpatient routine cost per		line 2)			0.00	
. 00	Observation bed cost (line 87 x line 88) (se	e instructions)				0	89

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
		Componen	t CCN: 15T018			pared: 2 pm
		Ti 1	tle XIX	Subprovider - IRF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST	•				
90.00 Capital-related cost	397, 937	2, 678, 233	0. 14858	32 0	0	90.00
91.00 Nursing School cost	0	2, 678, 233	0. 00000	0 0	0	91.00
92.00 Allied health cost	0	2, 678, 233	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 678, 233	0. 00000	0 0	0	93.00

	cial Systems ELKHART GENERAL HO CILLARY SERVICE COST APPORTIONMENT		CCN: 150018	Peri od:	u of Form CMS- Worksheet D-3	
NPATTENT AN	CILLARY SERVICE CUST APPORTIONMENT	Provi der	CCN: 150018	From 01/01/2014	worksneet D-3	
				To 12/31/2014	Date/Time Pre	
		T: +1	- 20/111	11	5/28/2015 1:0	2 pm
	Cost Center Description	11 TI	e XVIII Ratio of Cos	Hospital st Inpatient	PPS Inpatient	
	cost center bescription		To Charges		Program Costs	
					(col. 1 x col.	
					2)	
			1.00	2.00	3.00	
	ENT ROUTI NE SERVI CE COST CENTERS			20 410 450		
	ADULTS & PEDIATRICS INTENSIVE CARE UNIT			39, 419, 459 7, 855, 216		30.0
	NEONATAL INTENSIVE CARE			7, 855, 210		31.0
	SUBPROVIDER - IPF			0		40.0
11.00 04100	SUBPROVIDER - IRF			0		41.0
	NURSERY					43.0
	ARY SERVICE COST CENTERS					
	OPERATING ROOM		0. 2443		5, 219, 995	
	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM		0.0000		0	
	ANESTHESI OLOGY		0.0000		0	
	RADI OLOGY-DI AGNOSTI C		0. 2751		1, 381, 797	
54.01 05401	INTERVENTIONAL RADIOLOGY		0.0000		0	
	BREAST CENTER		0.0000		0	
	RADIATION ONCOLOGY		0.0000		0	
	RADI OLOGY-THERAPEUTI C		0.0000		0	
	RADI OI SOTOPE ULTRASOUND		0.0000		0	
	CT SCAN		0.0000		319, 401	
58.00 05800			0. 1279		153, 334	
	CARDI AC CATHETERI ZATI ON		0. 1548		621, 975	
50. 00 06000	LABORATORY		0. 2368	41 12, 721, 430	3, 012, 956	60.0
1 1	BLOOD LABORATORY		0.0000		0	
	PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
	WHOLE BLOOD & PACKED RED BLOOD CELL		0. 1647		716, 044	
	BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY		0.0000		0 488, 289	
	HOME INFUSION		0. 0000		400, 209	
	RESPI RATORY THERAPY		0. 3135		1, 775, 275	
	PHYSI CAL THERAPY		0. 5616		606, 233	
	OCCUPATIONAL THERAPY		0. 3636		248, 762	
	SPEECH PATHOLOGY		0. 4845		89, 274	
	ELECTROCARDI OLOGY		0.0000		0	
1 1	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT		0.0000 0.2554		0 9, 298, 349	
	IMPL. DEV. CHARGED TO PATIENTS		0. 2061		1, 849, 452	
	DRUGS CHARGED TO PATIENTS		0. 1381		2, 934, 631	
	RENAL DI ALYSI S		0.0000		0	
75.00 07500	ASC (NON-DISTINCT PART)		0.0000	00 0	0	75.0
76.00 03140			0. 1616	02 2, 921, 337	472, 094	76.0
	CLENT SERVICE COST CENTERS		0.22//	20 002 020	222.055	
	CLINIC SLEEP CLINIC		0. 3366		333, 955	
	EMERGENCY		0. 2302		1, 974 1, 601, 399	
	OBSERVATION BEDS (NON-DISTINCT PART		0. 4169		0	
	REIMBURSABLE COST CENTERS					1
	HOME PROGRAM DI ALYSI S		0.0000	00 0	0	94.0
	AMBULANCE SERVI CES					95.0
	DURABLE MEDICAL EQUIP-RENTED		0.0000		0	
	DURABLE MEDICAL EQUIP-SOLD		0.0000		0	
	OTHER REIMBURSABLE COST CENTERS		0.0000		0	
200.00 201.00	Total (sum of lines 50-94 and 96-98) Less PBP Clinic Laboratory Services-Program only charges (	ing (1)		137, 301, 325	31, 125, 189	200. 0
201.00	Net Charges (line 200 minus line 201)		1	137, 301, 325		201.0

Health Financial Systems	ELKHART GENERAL HOSPITAL			eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150018	Peri od:	Worksheet D-3	
	Componen	t CCN: 15T018	From 01/01/2014 To 12/31/2014		pared:
				5/28/2015 1:0	
	Titl	e XVIII	Subprovider - IRF	PPS	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000         ADULTS & PEDI ATRI CS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
31.01 03101 NEONATAL INTENSIVE CARE			0		31.01
40. 00 04000 SUBPROVIDER - IPF			0		40.00
41. 00 04100 SUBPROVIDER - IRF			1, 531, 207		41.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 2443			
51.00 05100 RECOVERY ROOM		0.0000			
52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY		0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 0000			
54. 01 05401 I NTERVENTI ONAL RADI OLOGY		0.0000			
54. 02 05402 BREAST CENTER		0.0000			
54. 03 05403 RADIATION ONCOLOGY		0.0000	00 0	0	54.03
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000	00 0	0	55.00
56. 00 05600 RADI 0I SOTOPE		0.0000			
56. 01 05601 ULTRASOUND		0.0000		-	
57. 00 05700 CT SCAN		0.0571			
58. 00 05800 MRI		0. 1279			
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY		0. 1548			59.00 60.00
60. 01 06001 BLOOD LABORATORY		0. 2308			60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 1647			
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0.0000			63.00
64.00 06400 INTRAVENOUS THERAPY		1.4573	39 0	0	64.00
64. 01 06401 HOME INFUSION		0.0000			
65. 00 06500 RESPI RATORY THERAPY		0. 3135			
66. 00 06600 PHYSI CAL THERAPY		0.5616			
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		0.3636			
69. 00 06900 ELECTROCARDI OLOGY		0. 4843			
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.0000		0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2554			1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2061		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1381	67 205, 829	28, 439	73.00
74.00 07400 RENAL DIALYSIS		0.0000			
75.00 07500 ASC (NON-DI STINCT PART)		0.0000		-	
76. 00 03140 CARDI OLOGY		0. 1616	02 8, 058	1, 302	76.00
0UTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC		0. 3366	38 38, 524	12, 969	90.00
90. 01 04951 SLEEP CLINIC		0. 2302		0	
91. 00 09100 EMERGENCY		0. 3502			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4169			
OTHER REIMBURSABLE COST CENTERS				1	
94.00 09400 HOME PROGRAM DI ALYSI S		0.0000	00 0	0	
95. 00 09500 AMBULANCE SERVICES					95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.0000		0	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD		0.0000		0	
98.00 09851 OTHER REIMBURSABLE COST CENTERS 200.00 Total (sum of lines 50-94 and 96-98)		0.0000	1, 330, 396	0 458, 639	
200.00 [10tal (sull of Thes 50-94 and 96-98) 201.00 [Less PBP Clinic Laboratory Services-Pr	couram only charges (line 61)		1, 330, 390	400,039	200.00
202.00 Net Charges (line 200 minus line 201)	eg. a only charges (The OT)		1, 330, 396		201.00
		1	., 000, 070	I	

	Financial Systems ELKHART GENERAL HC		CCN: 150018	Peri od:	worksheet D-3	
	LINI ANVILLARI JERVICE CUJI AFFORIIUNMENI	riovidel	CON. 100018	From 01/01/2014		
				To 12/31/2014		parec
					5/28/2015 1:0	2 pm
		lit	le XIX	Hospital	PPS	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	0	Program Costs (col. 1 x col.	
				Charges	2)	
			1.00	2.00	3.00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
	03000 ADULTS & PEDI ATRI CS			15, 933, 753		30.0
	03100 I NTENSI VE CARE UNI T			2,099,739		31.
	03101 NEONATAL INTENSIVE CARE			1, 653, 927		31.
0.00	04000 SUBPROVIDER - IPF			0		40.
1.00	04100 SUBPROVI DER – I RF			0		41.
	04300 NURSERY			2, 741, 638		43.
	ANCI LLARY SERVICE COST CENTERS		1		1	
	05000 OPERATING ROOM		0. 2443			50.0
1	05100 RECOVERY ROOM		0.0000			51.0
	05200 DELIVERY ROOM & LABOR ROOM		0.0000			52.
	05300 ANESTHESI OLOGY		0.0000		0	53.
	05400 RADI OLOGY-DI AGNOSTI C		0. 2751			54.
	05401 I NTERVENTI ONAL RADI OLOGY 05402 BREAST CENTER		0.0000			54. 54.
	05402 BREAST CENTER 05403 RADIATION ONCOLOGY		0.0000			54. 54.
	05500 RADI OLOGY-THERAPEUTI C		0.0000			54. 55.
	05600 RADI OLOGI - THERAPEUTI C		0.0000			56.
	05601 ULTRASOUND		0.0000		-	56.
	05700 CT SCAN		0.0571			57.
	05800 MRI		0. 1279			
	05900 CARDI AC CATHETERI ZATI ON		0. 1548			
	06000 LABORATORY		0. 2368			
	06001 BLOOD LABORATORY		0.0000			60.
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000			61.
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 1647		148, 336	62.
53.00	06300 BLOOD STORING, PROCESSING & TRANS.		0.0000	00 0	0	63.
4.00	06400 I NTRAVENOUS THERAPY		1. 4573	39 257, 772	375, 661	64.
4. 01	06401 HOME INFUSION		0.0000	00 0	0	64.
	06500 RESPI RATORY THERAPY		0. 3135	79 1, 333, 158	418, 050	65.
	06600 PHYSI CAL THERAPY		0. 5616			
	06700 OCCUPATI ONAL THERAPY		0. 3636			67.
	06800 SPEECH PATHOLOGY		0. 4845			
	06900 ELECTROCARDI OLOGY		0.0000		-	69.
1	07000 ELECTROENCEPHALOGRAPHY		0.0000		0	70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2554			
1	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2061		0 830, 911	72.
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0. 1381			73. 74.
	07500 ASC (NON-DI STI NCT PART)		0.0000			
	03140 CARDI OLOGY		0. 1616			
	OUTPATIENT SERVICE COST CENTERS		0.1010		,,,,,,,,,	1
	09000 CLINIC		0. 3366	38 236, 067	79, 469	90.
	04951 SLEEP CLINIC		0. 2302		0	90.
	09100 EMERGENCY		0. 3502		477, 580	91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 4169		0	
	OTHER REIMBURSABLE COST CENTERS					
	09400 HOME PROGRAM DI ALYSI S		0.0000	00 0	0	
	09500 AMBULANCE SERVICES					95.
	09600 DURABLE MEDI CAL EQUI P-RENTED		0.0000		0	
	09700 DURABLE MEDI CAL EQUI P-SOLD		0.0000		0	
	09851 OTHER REIMBURSABLE COST CENTERS		0.0000		0	98.
00.00				24, 272, 401	5, 731, 139	
201.00	Less PBP Clinic Laboratory Services-Program only charges (	line 61)		0		201.
202.00	Net Charges (line 200 minus line 201)		1	24, 272, 401		202.

Health Financial Systems	ELKHART GENERAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi de	r CCN: 150018	Peri od:	Worksheet D-3	1
	Compone	nt CCN: 15T018	From 01/01/2014 To 12/31/2014		
	T	tle XIX	Subprovider - IRF	PPS	<u>, 2 pm</u>
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
31. 00 03100 I NTENSI VE CARE UNI T			0		31.00
31. 01 03101 NEONATAL INTENSIVE CARE			0		31.01
40. 00 04000 SUBPROVIDER - I PF			0		40.00
41. 00 04100 SUBPROVIDER - IRF			443, 858		41.00
43.00 04300 NURSERY			0		43.00
ANCI LLARY SERVICE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 2443	86 429	105	50.00
51.00 05100 RECOVERY ROOM		0.0000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.0000	00 0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0.0000		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 2751		1, 079	
54. 01 05401 INTERVENTIONAL RADIOLOGY		0.0000		-	
54. 02 05402 BREAST CENTER		0.0000		-	
54. 03 05403 RADIATION ONCOLOGY		0.0000		0	
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.0000		0	
56. 00 05600 RADI 0I SOTOPE		0.0000		-	
56. 01 05601 ULTRASOUND		0.0000		-	
57.00 05700 CT SCAN		0.0571			
58. 00 05800 MRI		0. 1279		-	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 1548		-	
60. 00 06000 LABORATORY		0. 2368			1
60.01 06001 BLOOD LABORATORY 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 1647			
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 1047			
64. 00 06400 I NTRAVENOUS THERAPY		1. 4573		-	
64. 01 06401 HOME I NFUSI ON		0. 0000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 3135		-	
66.00 06600 PHYSI CAL THERAPY		0. 5616			
67.00 06700 OCCUPATI ONAL THERAPY		0. 3636			
68.00 06800 SPEECH PATHOLOGY		0. 4845	69 25, 953	12, 576	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.0000	00 0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY		0.0000	00 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2554	86 4, 129	1, 055	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 2061		-	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 1381			
74.00 07400 RENAL DI ALYSI S		0.0000			
75.00 07500 ASC (NON-DI STINCT PART)		0.0000		, o	
76. 00 03140 CARDI OLOGY		0. 1616	02 326	53	76.00
		0.00(/	20 7 150	2 407	00.00
90. 00   09000   CLINIC 90. 01   04951   SLEEP CLINIC		0. 3366			
90. 01  04951 SLEEP CLINIC 91. 00  09100  EMERGENCY		0. 2302		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 3502			
OTHER REIMBURSABLE COST CENTERS		0.4109	0	0	1 /2.00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.0000	00 0	0	94.00
95. 00 09500 AMBULANCE SERVICES		0.0000		l	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.0000	00 N	0	
		0.0000		0	
97.00 U9700 DURABLE MEDICAL EQUIP-SULD				-	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD 98.00 09851 OTHER REIMBURSABLE COST CENTERS		0.0000	00 0	0	98.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	1		00 0 334, 395	-	
98.00 09851 OTHER REIMBURSABLE COST CENTERS		0.0000		-	

	Financial Systems ELKHART GENERAL HI ATION OF REIMBURSEMENT SETTLEMENT		CCN: 150018	Period:	u of Form CMS Worksheet E	-2552-1
_00L		11 ovr der		From 01/01/2014 To 12/31/2014	Part A Date/Time Pr 5/28/2015 1:	
		Ti tl	e XVIII	Hospi tal	PPS	- pm
			0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		,		2.00	_
)0 )1	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurrin	a prior		0 27, 758, 512		1.00
1	to October 1 (see instructions)	y pi i ui		27, 756, 512		1.0
)2	DRG amounts other than outlier payments for discharges occurrin	g on or		10, 064, 316		1.02
03	after October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1.0
	discharges occurring prior to October 1 (see instructions)					
)4	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0		1.04
00	Outlier payments for discharges. (see instructions)			3, 031, 609		2.00
)1 )2	Outlier reconciliation amount	nc)		0		2.0
)2 )0	Outlier payment for discharges for Model 4 BPCI (see instructio Managed Care Simulated Payments	15)		12, 174, 826		3.0
00	Bed days available divided by number of days in the cost report	i ng		223. 42		4.00
	period (see instructions) Indirect Medical Education Adjustment					-
00	FTE count for allopathic and osteopathic programs for the most	recent		0.00		5.00
20	cost reporting period ending on or before 12/31/1996. (see instr			0.00		( )
00	FTE count for allopathic and osteopathic programs which meet th criteria for an add-on to the cap for new programs in accordanc			0.00		6.0
	CFR 413.79(e)					
00	MMA Section 422 reduction amount to the IME cap as specified un CFR $412.105(f)(1)(iv)(B)(1)$	der 42		0.00		7.0
01	ACA Section 5503 reduction amount to the IME cap as specified u	nder 42		0.00		7.0
	CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July	1, 2011				
00	then see instructions. Adjustment (increase or decrease) to the FTE count for allopath	ic and		0.00		8.0
	osteopathic programs for affiliated programs in accordance with	42 CFR				
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 (August 1, 2002).	FR 50069				
)1	The amount of increase if the hospital was awarded FTE cap slot	s under		0.00		8.0
	section 5503 of the ACA. If the cost report straddles July 1, 2	011, see				
)2	instructions. The amount of increase if the hospital was awarded FTE cap slot	s from a		0.00		8.0
	closed teaching hospital under section 5506 of ACA. (see instru	ctions)				
0	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines and 8,02) (see instructions)	(8, 8,01		0.00		9.0
00		t year		0.00		10.0
~~	from your records			0.00		111.0
00 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0.00 0.00		11.0
00	Total allowable FTE count for the prior year.			0.00		13.0
00	Total allowable FTE count for the penultimate year if that year	ended on		0.00		14.0
00	or after September 30, 1997, otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00		15.0
	Adjustment for residents in initial years of the program			0.00		16.0
00 00	Adjusment for residents displaced by program or hospital closur	e		0.00 0.00		17.0
00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0.00000		19.0
00	Prior year resident to bed ratio (see instructions)			0. 000000		20.0
00 00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0.00000		21.0
	IME payment adjustment - Managed Care (see instructions)			0		22.0
	Indirect Medical Education Adjustment for the Add-on for Sectio		the MMA			
00	Number of additional allopathic and osteopathic IME FTE residen slots under 42 Sec. 412.105 $(f)(1)(iv)(C)$ .	t cap		0.00		23.0
00	IME FTE Resident Count Over Cap (see instructions)			0.00		24.0
00	If the amount on line 24 is greater than -O-, then enter the lo	wer of		0.00		25.0
00	line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4)			0.000000		26.0
00	IME payments adjustment factor. (see instructions)			0. 000000		27.0
00	IME add-on adjustment amount (see instructions)			0		28.0
01 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment ( sum of lines 22 and 28)			0		28. C
01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29.0
00	Disproportionate Share Adjustment	lont days				30.0
00	Percentage of SSI recipient patient days to Medicare Part A pat (see instructions)	rent days		4.16		30.0
00	Percentage of Medicaid patient days (see instructions)			18.88		31.0
00	Sum of lines 30 and 31			23.04		32.0
00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			8. 22 777, 260		33. 0 34. 0

CULA	Financial Systems ELKHART GENERAL TION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150018	Period: From 01/01/2014	Worksheet E Part A	
			To 12/31/2014	Date/Time Prep 5/28/2015 1:02	
		Title XVIII	Hospi tal	PPS	z pili
			Prior to	On/After	
		0	0ctober 1 1.00	0ctober 1 2.00	
l	Incompensated Care Adjustment	0	1.00	2.00	
	Total uncompensated care amount (see instructions)		9, 046, 380, 143	7, 647, 644, 885	35.
	Factor 3 (see instructions)		0. 000309445	0.000288422	35.
	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		2, 799, 357	2, 205, 751	35.
	Pro rata share of the hospital uncompensated care payment		2, 093, 765	555, 971	35.
	amount (see instructions)				
	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		2, 649, 736		36
	Additional payment for high percentage of ESRD beneficiary dis	scharges (lines 40 throu	gh 46)		
00	Total Medicare discharges on Worksheet S-3, Part I	<u> </u>	0		40
	excluding discharges for MS-DRGs 652, 682, 683, 684 and				
	685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41
	682, 683, 684 an 685. (see instructions)		Ŭ		
	Total ESRD Medicare covered and paid discharges excluding		0		41
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not		0.00		42
	qualify for adjustment)		0.00		72
	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43
	682, 683, 684 an 685. (see instructions) Ratio of average length of stay to one week (line 43		0. 000000		44
	divided by line 41 divided by 7 days)		0.00000		44
00	Average weekly cost for dialysis treatments (see		0.00		45
	instructions)		0		
	Total additional payment (line 45 times line 44 times line 41.01)		0		46
	Subtotal (see instructions)		44, 281, 433		47
	Hospital specific payments (to be completed by SCH and		0		48
	MDH, small rural hospitals only.(see instructions) Total payment for inpatient operating costs (see		44, 281, 433		49
	i nstructi ons)		44, 201, 400		77
	Payment for inpatient program capital (from Wkst. L, Pt. I		3, 449, 995		50
	and Pt. II, as applicable) Exception payment for inpatient program capital (Wkst. L,		0		51
	Pt. III, see instructions)		0		51
	Direct graduate medical education payment (from Wkst. E-4,		0		52
	line 49 see instructions). Nursing and Allied Health Managed Care payment		251, 916		53
	Special add-on payments for new technologies		8, 172		54
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55
	line 69)				F /
	Cost of physicians' services in a teaching hospital (see intructions)		0		56
	Routine service other pass through costs (from Wkst. D,		0		57
	Pt. III, column 9, lines 30 through 35).		F0 (00		0
	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		58, 699		58
	Total (sum of amounts on lines 49 through 58)		48, 050, 215		59
	Primary payer payments		20, 878		60
	Total amount payable for program beneficiaries (line 59 minus line 60)		48, 029, 337		61
	Deductibles billed to program beneficiaries		3, 915, 168		62
	Coinsurance billed to program beneficiaries		128, 288		63
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		79, 450 51, 643		64 65
	Allowable bad debts for dual eligible beneficiaries (see		79, 450		66
	instructions)				
	Subtotal (line 61 plus line 65 minus lines 62 and 63)		44, 037, 524		67 68
	Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)		0		08
00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69
	96). (For SCH see instructions)				70
1	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT		0		70 70
	Pioneer ACO demonstration payment adjustment amount (see		0		70
	instructions)				
	HSP bonus payment HVBP adjustment amount (see		0		70
	instructions) HSP bonus payment HRR adjustment amount (see instructions)		0		70
92	Bundled Model 1 discount amount (see instructions)		0		70
	HVBP payment adjustment amount (see instructions)		-34, 242		70
94	HRR adjustment amount (see instructions) Recovery of accelerated depreciation		-77, 360 0		70 70

	Financial Systems ELKHART GENER				eu of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150018		eriod: com 01/01/2014 o 12/31/2014		pared:
		Title XVIII		Hospi tal	PPS	<u>~ pm</u>
				Prior to	0n/After	
				October 1	October 1	
		0		1.00	2.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)		0	0		70.96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)		0	0		70.97
70. 98	Low Volume Payment-3			0		70.98
70.99	HAC adjustment amount (see instructions)			0		70.99
71.00				43, 925, 922		71.00
71.01	Sequestration adjustment (see instructions)			878, 518		71.01
72.00	Interim payments			43, 167, 145		72.00
73.00	Tentative settlement (for contractor use only)			0		73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72, and 73)			-119, 741		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			6, 733, 484		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				1	
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0		90.00
	Capital outlier from Wkst. L, Pt. I, line 2			0		91.00
	Operating outlier reconciliation adjustment amount (see instructions)			0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0		93.00
	The rate used to calculate the time value of money (see instructions)			0.00		94.00
	Time value of money for operating expenses (see instructions)			0		95.00
96.00	Time value of money for capital related expenses (see instructions)			0		96.00
			-		On/After 10/1	
				1.00	2.00	
	HSP Bonus Payment Amount					1100.00
100.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	0	100. 00
101.00	HVBP adjustment factor (see instructions)			0	0	101. 00
	HVBP adjustment amount for HSP bonus payment (see instructi HRR Adjustment for HSP Bonus Payment	ons)		0		102.00
103 00	HRR adjustment factor (see instructions)			0.0000	0,000	103.00
				0.0000	0.0000	1.00.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Title XVIII	Period: From 01/01/2014 To 12/31/2014 Hospital	Worksheet E Part B Date/Time Prep 5/28/2015 1:00 PPS	
			incopri cui		
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
00	Medical and other services (see instructions)			1, 172	1.00
00	Medical and other services reimbursed under OPPS (see instructi	ons)		22, 432, 906	
00	PPS payments			19, 626, 243	3.00
00	Outlier payment (see instructions)			644, 266	
00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0.000	
00 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0. 00	
00	Transitional corridor payment (see instructions)			0.00	8.00
00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		61, 921	
	Organ acqui si ti ons			0	10.0
1.00	Total cost (sum of lines 1 and 10) (see instructions)			1, 172	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				-
2. 00	Reasonable charges Ancillary service charges			4 951	12.00
	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, cc	1. 4)		4, 731	13.00
	Total reasonable charges (sum of lines 12 and 13)	.,		4, 951	
	Customary charges				[
	Aggregate amount actually collected from patients liable for pa			0	
6. 00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16.00
. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17 00
	Total customary charges (see instructions)			4, 951	
. 00	Excess of customary charges over reasonable cost (complete only	ifline 18 exceeds li	ne 11) (see		19.00
	instructions)				
. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20.00
. 00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		1, 172	21 0
	Interns and residents (see instructions)			0	
	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	
. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			20, 332, 430	24.00
~~	COMPUTATION OF REIMBURSEMENT SETTLEMENT				0.5 0.
. 00 . 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	(AH see instructions)		0 4, 025, 687	
	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl		and 23} (for	16, 307, 915	
	CAH, see instructions)			10,007,77	2710
. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28.0
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			16, 307, 915	
	Primary payer payments Subtotal (line 30 minus line 31)			6, 445 16, 301, 470	
. 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)		10, 301, 470	52.00
. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.0
	Allowable bad debts (see instructions)			518, 484	
	Adjusted reimbursable bad debts (see instructions)	-+:>		337, 015	
	Allowable bad debts for dual eligible beneficiaries (see instru Subtotal (see instructions)	ictions)		518, 484 16, 638, 485	
	MSP-LCC reconciliation amount from PS&R			350	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.5
98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	39.9
. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.9
	Subtotal (see instructions)			16, 638, 135	
	Sequestration adjustment (see instructions) Interim payments			332, 763 16, 322, 196	
	Tentative settlement (for contractors use only)			10, 322, 190	
. 00	Balance due provider/program (see instructions)			-16, 824	
. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	
	\$115.2				l
00	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			-	92.0
. 00	Time Value of Money (see instructions)			0	
00	Total (sum of lines 91 and 93)			0	94. C

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150018	Period: From 01/01/2014 To 12/31/2014		pared: 2 pm
			e XVIII	Hospi tal	PPS	
		Inpati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		43, 134, 5	45 0	16, 286, 296 0	1.00 2.00 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	07/02/2014	32, 6	00 07/02/2014	35, 900	3. 01
3. 02				0	0	3. 02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
5.05	Provider to Program			0	0	5.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.5
3.52				0	0	3.5
3.53 3.54				0	0	3.53 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		32, 6	-	35, 900	3.99
	3. 50-3. 98)		, -		,	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		43, 167, 1	45	16, 322, 196	4.00
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.00
5. 01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.01
5.01				0	0	5.02
5.03				0	0	5.03
	Provider to Program					
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.5
5.51				0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.9
-	5. 50-5. 98)					
5.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.0
5. 01 5. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		119, 7	0	0 16, 824	6.0 6.0
7.02	Total Medicare program liability (see instructions)		43, 047, 4		16, 305, 372	7.0
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1.00	2.00	

00		Ti tl		To 12/31/2014	Date/Time Prep 5/28/2015 1:02	pared 2 nm
00			e XVIII	Subprovider - IRF	PPS	
00		Inpatien	t Part A		t B	
00		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
$\cap \cap$		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		1, 303, 04	0	0 0	1. ( 2. (
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER			0	0	3. (
02			1	0	0	3. (
03				0	0	3.
04				0	0	3.
05				0	0	3.
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52				0	0	3.
53				0	0	3.
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E–3, line and column as appropriate)		1, 303, 09	90	0	4.
	TO BE COMPLETED BY CONTRACTOR		•			
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
	Program to Provider					
01	TENTATI VE TO PROVI DER			0	0	5.
02				0	0	5.
03				0	0	5.
	Provider to Program					
50	TENTATIVE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		34, 70	14	0	6
)1 )2	SETTLEMENT TO PROVIDER		34, 70	0	0	6
)2 )0	Total Medicare program liability (see instructions)		1, 337, 79		0	
00	Total meancale program manifity (see instructions)		1, 337, 7	Contractor	NPR Date	/.
				Number	(Mo/Day/Yr)	
			)	1.00	2.00	

Heal th	Financial Systems ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCU	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150018	Period: From 01/01/2014	Worksheet E-1 Part II	
			To 12/31/2014		
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NON STANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		14	11, 495	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12		20, 507	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			6, 326	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12		46, 184	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			777, 977, 458	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l			15, 619, 803	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c line 168	ertified HIT technology	Wkst. S-2, Pt. I	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			2, 412, 629	8.00
9.00	Sequestration adjustment amount (see instructions)			48, 253	9.00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		2, 364, 376	10.00
	INPATIENT HOSPITAL SERVICES UNDER PPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)			2, 886, 112	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)	-521, 736	32.00

	Financial Systems ELKHART GENERAL ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150018	Peri od:	u of Form CMS-2 Worksheet E-3	
ALCOL		Component CCN: 15T018	From 01/01/2014	Part III Date/Time Pre	pare
		Title XVIII	Subprovider - IRF	5/28/2015 1:02 PPS	<u>2 pm</u>
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
. 00	Net Federal PPS Payment (see instructions)			1, 223, 437	1.
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0255	2.
. 00	Inpatient Rehabilitation LIP Payments (see instructions)			62, 762	3.
. 00	Outlier Payments			90, 072	4.
. 00	Unweighted intern and resident FTE count in the most recent c	ost reporting period en	ding on or prior	0.00	5.
	to November 15, 2004 (see instructions)		0		
. 01	Cap increases for the unweighted intern and resident FTE coun	t for residents that were	e displaced by	0.00	5.
	program or hospital closure, that would not be counted withou	t a temporary cap adjust	ment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
. 00	New Teaching program adjustment. (see instructions)			0.00	6.
. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0.00	7.
	teaching program" (see instructions)				
. 00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0.00	8.
	teaching program" (see instructions)				
00	Intern and resident count for IRF PPS medical education adjus	<pre>tment (see instructions)</pre>		0.00	9
0. 00	Average Daily Census (see instructions)			6.709589	10
I. 00	Teaching Adjustment Factor (see instructions)			0.00000	11
2.00	Teaching Adjustment (see instructions)			0	12
3.00	Total PPS Payment (see instructions)			1, 376, 271	13
4.00	Nursing and Allied Health Managed Care payments (see instruct	i on)		0	14
5.00	Organ acquisition (DO NOT USE THIS LINE)				15
5.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	16
7.00	Subtotal (see instructions)			1, 376, 271	17
3.00	Primary payer payments			0	18
9.00	Subtotal (line 17 less line 18).			1, 376, 271	19
0. 00	Deducti bl es			4, 864	20
1.00	Subtotal (line 19 minus line 20)			1, 371, 407	21
2.00	Coinsurance			8, 512	22
3.00	Subtotal (line 21 minus line 22)			1, 362, 895	23
1.00	Allowable bad debts (exclude bad debts for professional servi	ces) (see instructions)		3, 345	24
5.00	Adjusted reimbursable bad debts (see instructions)			2, 174	25
6. 00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		3, 075	26
7.00	Subtotal (sum of lines 23 and 25)			1, 365, 069	27
3. 00	Direct graduate medical education payments (from Wkst. E-4, I	ine 49)		0	28
9.00	Other pass through costs (see instructions)			27	29
0. 00	Outlier payments reconciliation			0	30
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31
I. 50	Pioneer ACO demonstration payment adjustment (see instruction	s)		0	31
1.99	Recovery of Accel erated Depreciation	-		0	31
2.00	Total amount payable to the provider (see instructions)			1, 365, 096	32
2. 01	Sequestration adjustment (see instructions)			27, 302	
	Interim payments			1, 303, 090	
1.00	Tentative settlement (for contractor use only)			0	34
5.00	Balance due provider/program line 32 minus lines 32.01, 33 an	d 34		34, 704	35
5. 00	Protested amounts (nonallowable cost report items) in accorda		chapter 1,	143, 599	36.
	§115.2 TO BE COMPLETED BY CONTRACTOR				
D. 00	Original outlier amount from Wkst. E-3, Pt. III, line 4			90, 072	50
1.00	Outlier reconciliation adjustment amount (see instructions)			90, 072	50
2.00	The rate used to calculate the Time Value of Money			0.00	
	The rate used to carearate the trille value of Molley				52.

CALCUL	Financial Systems ELKHART GENERAL HO ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150018	Peri od:	Worksheet E-3	2552-10
			From 01/01/2014 To 12/31/2014	Part VII Date/Time Pre 5/28/2015 1:0	pared: 2 pm
		Title XIX	Hospi tal	PPS	
			Inpati ent	Outpatient	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES FOR TITLES V OR X		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	CES FOR THEES V OR X			1
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2.00
3.00	Organ acquisition (certified transplant centers only)		0		3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	
5.00	Inpatient primary payer payments		0	0	5.00
6.00 7.00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		0	0	
7.00	COMPUTATION OF LESSER OF COST OR CHARGES		<u>Ч</u>	0	7.00
	Reasonabl e Charges				1
8.00	Routi ne servi ce charges		0		8.00
9.00	Ancillary service charges		24, 272, 401	0	9.00
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		24, 272, 401	0	12.00
13.00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for s	arvi cos on a charge	0	0	13.00
13.00	basis	sel vices on a charge	0	0	13.00
14.00	Amounts that would have been realized from patients liable for p	avment for services o	n O	0	14.00
	a charge basis had such payment been made in accordance with 42			-	
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		24, 272, 401	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only	ifline 16 exceeds	24, 272, 401	0	17.00
10 00	line 4) (see instructions)		-	0	10.00
18.00	Excess of reasonable cost over customary charges (complete only 16) (see instructions)	IT TIME 4 exceeds TIM	e U	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruc	ctions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co		ders.		
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		17 50(	0	25.00 26.00
26.00 27.00	Routine and Ancillary service other pass through costs Subtotal (sum of lines 22 through 26)		17, 506 17, 506	0	27.00
28.00	Customary charges (title V or XIX PPS covered services only)		17, 500	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		17, 506	0	29.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		17, 506	0	
32.00	Deductibles		0	0	•
	Coinsurance		0	0	
34.00	Allowable bad debts (see instructions)		0	0	34.00 35.00
35.00 36.00	Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	17, 506	0	35.00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	17, 300	0	37.00
	Subtotal (line 36 $\pm$ line 37)		17, 506	0	•
38.00	Direct graduate medical education payments (from Wkst. E-4)		0	-	39.00
38. 00 39. 00			17 50/	0	40.00
	Total amount payable to the provider (sum of lines 38 and 39)		17, 506	0	40.00
39.00	Total amount payable to the provider (sum of lines 38 and 39) Interim payments		0	0	41.00
39. 00 40. 00	Total amount payable to the provider (sum of lines 38 and 39)		17, 506 0 17, 506	-	41.00 42.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150018 Component CCN: 15T018	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Pre	epar
		Title XIX	Subprovider -	5/28/2015 1:0 PPS	<u>2 p</u>
			I RF I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERV	/ICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
00	Inpatient hospital/SNF/NF services		0		1
00	Medical and other services			0	
00	Organ acquisition (certified transplant centers only)	0	0		
00	Subtotal (sum of lines 1, 2 and 3)		0	0	
00	Inpatient primary payer payments		0	0	
00 00	Outpatient primary payer payments		0	0	
50	Subtotal (line 4 less sum of lines 5 and 6) COMPUTATION OF LESSER OF COST OR CHARGES		U	0	1 1
	Reasonable Charges				1
00	Routi ne servi ce charges		0		1
00	Ancillary service charges		334, 395	0	
00	Organ acquisition charges, net of revenue		0	0	1
00	Incentive from target amount computation		0		1
00	Total reasonable charges (sum of lines 8 through 11)		334, 395	0	1
	CUSTOMARY CHARGES				1
00	Amount actually collected from patients liable for payment for	services on a charge	0	0	1:
	basi s				
00	Amounts that would have been realized from patients liable for		0 ו	0	14
	a charge basis had such payment been made in accordance with 42	2 CFR §413.13(e)			
00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000 334, 395	0.000000	
00	<b>3 0 1</b>	omary charges (see instructions)			
00	Excess of customary charges over reasonable cost (complete only	y IT IINE 16 exceeds	334, 395	0	1
00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only	, if line 4 exceeds line	. 0	0	1
00	16) (see instructions)		0	0	
00	Interns and Residents (see instructions)		0	0	1
00	Cost of physicians' services in a teaching hospital (see instru	uctions)	0	0	
00	Cost of covered services (enter the lesser of line 4 or line 10		0	0	
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be o		ders.		1
00	Other than outlier payments		0	0	22
00	Outlier payments		0	0	2:
00	Program capital payments		0		2
00	Capital exception payments (see instructions)		0		2
00	Routine and Ancillary service other pass through costs		0	0	
00	Subtotal (sum of lines 22 through 26)		0	0	
00	Customary charges (title V or XIX PPS covered services only)		0	0	
00	Titles V or XIX (sum of lines 21 and 27)		0	0	2
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Excess of reasonable cost (from line 18)		0	0	30
00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		0	0	
	Deductibles		0	0	
00	Coinsurance		0	0	
00	Allowable bad debts (see instructions)		0	0	
00	Utilization review	0	-	3	
00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	0	0	3	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0		
00	Subtotal (line 36 ± line 37)	0	0	3	
00	Direct graduate medical education payments (from Wkst. E-4)	0		3	
00	Total amount payable to the provider (sum of lines 38 and 39)		0	0	
00	Interim payments		0	0	
00	Balance due provider/program (line 40 minus line 41)		0	0	
00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2,	0	0	43

	Financial Systems ELKHART GENER SHEET (If you are nonproprietary and do not maintain personality and the control Fund column and			eriod: rom 01/01/2014	u of Form CMS-: Worksheet G	
ina-typ	pe accounting records, complete the General Fund column onl	y)		0 12/31/2014	Date/Time Pre	
		General Fund	Speci fi c	Endowment Fund	5/28/2015 1:0 Plant Fund	
		1.00	Purpose Fund 2.00	3.00	4.00	
С	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00 0	Cash on hand in banks	45, 988, 000			0	
	Temporary investments	1,000			0	
	Notes receivable		0	-	0	
	Accounts recei vable Dther recei vable	54, 441, 000 6, 317, 000		-	0	
	Allowances for uncollectible notes and accounts receivable	-12, 558, 000		0	0	
	Inventory	7, 392, 000		0	0	
00 F	Prepai d'expenses	1,087,000	0	0	0	8.
	Other current assets	368, 000		-	0	
	Due from other funds		0		0	
	Total current assets (sum of lines 1-10)	103, 036, 000	0	0	0	11.
	_and	3, 593, 000	0	0	0	12.
3. 00 L	_and improvements	C	0		0	
	Accumulated depreciation	C	0	0	0	
	Buildings	173, 773, 000	1	0	0	
	Accumulated depreciation _easehold improvements	-132, 317, 000	0		0	
	Accumul ated depreciation		0		0	
	Fi xed equi pment	78, 286, 000		-	0	
	Accumulated depreciation	C	0	0	0	20.
	Automobiles and trucks	C	0	-	0	
	Accumulated depreciation	C	0	-	0	
	Major movable equipment Accumulated depreciation		0	0	0	
	Minor equipment depreciable		0	0	0	
	Accumulated depreciation		0	0	0	
	HT designated Assets	c c	0	0	0	27
	Accumulated depreciation	C	0	0	0	
	Minor equipment-nondepreciable		0		0	
	Total fixed assets (sum of lines 12-29) THER ASSETS	123, 335, 000	0	0	0	30.
	Investments	C	6, 610, 000	0	0	31.
. 00 [	Deposits on Leases	C		0	0	32
	Due from owners/officers	C	0	0	0	
	Other assets	43, 760, 000	1	0	0	
	Total other assets (sum of lines 31-34)	43, 760, 000 270, 131, 000			0	
	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	270, 131, 000	6, 610, 000	0	0	30
	Accounts payable	29, 191, 000	0	0	0	37
	Salaries, wages, and fees payable	C	0	0	0	38
	Payroll taxes payable	C C	0	0	0	
	Notes and Loans payable (short term)	2, 516, 000	0	0	0	
	Deferred income Accelerated payments		0	0	0	41
	Due to other funds		0	0	0	
	Other current liabilities	3, 837, 000	0	0	0	
	Total current liabilities (sum of lines 37 thru 44)	35, 544, 000		0	0	45.
	ONG TERM LIABILITIES	L	1			
	Mortgage payable		0	0	0	
	Notes payable Jnsecured Loans	128, 121, 000		0	0	
	Other long term liabilities		0	0	0	
	Total long term liabilities (sum of lines 46 thru 49	128, 121, 000	0	0	0	
. 00 T	Total liabilites (sum of lines 45 and 50)	163, 665, 000	0	0	0	51
	CAPITAL ACCOUNTS		1			
	General fund balance	106, 466, 000				52
	Specific purpose fund Donor created - endowment fund balance - restricted		6, 610, 000	_		53 54
	Donor created - endowment fund balance - restricted			0		55
	Governing body created - endowment fund balance			0		56
. 00   F	Plant fund balance - invested in plant				0	57
	Plant fund balance - reserve for plant improvement,				0	58
	replacement, and expansion	104 444 000	6 (10 000		_	EO
	Fotal fund balances (sum of lines 52 thru 58) Fotal liabilities and fund balances (sum of lines 51 and	106, 466, 000 270, 131, 000			0	
	istar masimus and rand barances (sum of times of and		3, 010, 000	0	0	1 00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
STATEMENT OF CHANGES IN FUND BALANCES			CCN: 150018	Period: From 01/01/2014 To 12/31/2014	Worksheet G-1 Date/Time Pre	pared:
	General	l Fund	Speci al	Purpose Fund	5/28/2015 1:0 Endowment Fund	2 pm
	1.00	2.00	3.00	4.00	5.00	
1.00Fund balances at beginning of period2.00Net income (loss) (from Wkst. G-3, line 29)		302, 784, 000 49, 380, 000		6, 278, 000		1.00 2.00
3.00 Total (sum of line 1 and line 2)		352, 164, 000		6, 278, 000		3.00
4.00 INVESTMENT INCOME	0		332, 00		0	4.00
5. 00 6. 00	0			0	0	5.00 6.00
7.00	0			0	0	7.00
8.00 9.00	0			0	0	8.00 9.00
9.00 10.00 Total additions (sum of line 4-9)	0	0		332,000	0	9.00 10.00
11.00 Subtotal (line 3 plus line 10)		352, 164, 000		6, 610, 000		11.00
12.00 TRANSFERRED TO BEACON HEALTH SYSTEM 13.00 POST RETIREMENT ADJ NON- PERIODIC	224, 915, 000 20, 783, 000			0	0	12. 00 13. 00
14.00	20, 783, 000			0	0	13.00
15. 00	0			0	0	15.00
16. 00 17. 00	0			0	0	16.00 17.00
18.00 Total deductions (sum of lines 12-17)	0	245, 698, 000		0	0	18.00
19.00 Fund balance at end of period per balance		106, 466, 000		6, 610, 000		19.00
sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
1.00 Fund balances at beginning of period	6.00	7.00	8.00	0		1.00
2.00 Net income (loss) (from Wkst. G-3, line 29)	0			0		2.00
3.00 Total (sum of line 1 and line 2)	0	0		0		3.00
4.00 INVESTMENT INCOME 5.00		0				4.00 5.00
6.00		0				6.00
7.00 8.00		0				7.00 8.00
9.00		0				8.00 9.00
10.00 Total additions (sum of line 4-9)	0			0		10.00
11.00 Subtotal (line 3 plus line 10) 12.00 TRANSFERRED TO BEACON HEALTH SYSTEM	0	0		0		11. 00 12. 00
13. 00 POST RETIREMENT ADJ NON- PERIODIC		0				13.00
14.00		0				14.00
15.00 16.00		0				15. 00 16. 00
17.00		0				17.00
18.00 Total deductions (sum of lines 12-17) 19.00 Fund balance at end of period per balance	0			0		18. 00 19. 00
sheet (line 11 minus line 18)	0			U		19.00

Heal th	Financial Systems ELKHART GENERAL H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
STATEM	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150018	Period: From 01/01/2014 To 12/31/2014	Worksheet G-2 Parts I & II Date/Time Pre 5/28/2015 1:0	pared:
	Cost Center Description		Inpatient	Outpatient	Total	
	PART I - PATIENT REVENUES		1.00	2.00	3.00	
	General Inpatient Routine Services					
1.00	Hospi tal		100, 006, 0	00	100, 006, 000	1.00
2.00	SUBPROVIDER - IPF			0	0	2.00
3.00	SUBPROVIDER - IRF		3, 801, 0	00	3, 801, 000	3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00 7.00	Swing bed - NF SKILLED NURSING FACILITY			0	0	6.00 7.00
7.00 8.00	NURSING FACILITY			0	0	
9.00	OTHER LONG TERM CARE			0	0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)		103, 807, 0		103, 807, 000	
	Intensive Care Type Inpatient Hospital Services					
11.00	INTENSIVE CARE UNIT		21, 464, 0	00	21, 464, 000	11.00
11.01	NEONATAL INTENSIVE CARE		2, 780, 0	00	2, 780, 000	11.01
12.00	CORONARY CARE UNI T					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)		24 244 0	00	24 244 000	15.00
16.00	Total intensive care type inpatient hospital services (sum of I 11-15)	rnes	24, 244, 0	00	24, 244, 000	16.00
17.00	Total inpatient routine care services (sum of lines 10 and 16)		128, 051, 0	00	128, 051, 000	17.00
18.00	Ancillary services		281, 894, 0		664, 006, 000	
19.00	Outpatient services			0 0	0	19.00
20.00	RURAL HEALTH CLINIC			0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY			0	0	
23.00	AMBULANCE SERVICES			0 0	0	
24.00				0	0	24.00
25.00 26.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE			0 0	0	25.00 26.00
20.00	OTHER (SPECIFY)			0 0	0	20.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst	409, 945, 0			
	G-3, line 1)			,,	,,	
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			249, 282, 883		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00 35.00				0		34.00 35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		249, 282, 883		43.00
	to Wkst. G-3, line 4)		I	1		I

Heal th	Financial Systems	ELKHART GENERAL HO	SPI TAL		In Lie	u of Form CMS-2	2552-10
STATEN	ENT OF REVENUES AND EXPENSES		Provider CCN:	150018	Period:	Worksheet G-3	
					From 01/01/2014 To 12/31/2014	Date/Time Pre	arod.
					10 12/31/2014	5/28/2015 1:02	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part		28)			792, 057, 000	1.00
2.00	Less contractual allowances and discounts on	patients' accounts				515, 882, 000	2.00
3.00	Net patient revenues (line 1 minus line 2)					276, 175, 000	3.00
4.00	Less total operating expenses (from Wkst. G-2		)			249, 282, 883	4.00
5.00	Net income from service to patients (line 3 m	inus line 4)				26, 892, 117	5.00
	OTHER I NCOME						
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					8, 966, 000	
8.00	Revenues from telephone and other miscellaneo	us communication se	ervi ces			0	8.00
9.00	Revenue from television and radio service					0	9.00
10.00	Purchase di scounts					92, 000	
11.00	Rebates and refunds of expenses					521, 000	
12.00	Parking lot receipts					0	12.00
13.00	Revenue from Laundry and Linen service					1, 951, 000	
14.00	Revenue from meals sold to employees and gues	ts				992, 000	
15.00	Revenue from rental of living quarters					0	
16.00	Revenue from sale of medical and surgical sup		n patients			0	16.00
17.00	Revenue from sale of drugs to other than pati					0	17.00
18.00	Revenue from sale of medical records and abst					170, 000	
19.00	Tuition (fees, sale of textbooks, uniforms, e					99, 000	
20.00	Revenue from gifts, flowers, coffee shops, an	d canteen				0	20.00
21.00	Rental of vending machines					0	21.00 22.00
22.00	Rental of hospital space					0	22.00
23.00 24.00	Governmental appropriations					0	
24.00	EMR, RENTALS, EDUCATION, OTHER INCOME					9, 697, 000 22, 488, 000	
25.00	Total other income (sum of lines 6–24) Total (line 5 plus line 25)						
	MISC					49, 380, 117 117	
	Total other expenses (sum of line 27 and subs	crinte)				117	27.00
	Net income (or loss) for the period (line 26					49, 380, 000	
27.00	Inet income (or ross) for the period (TITIE 20	minus IIIE 20)			I	47, 300, 000	27.00

CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B       Provider CCN: 150018       Period: From 01/01/201 To 12/31/2014       Worksheet I -5 bite/Time Prepared: 5/28/2015 1:0 2 pm         PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B       1.00       2.00         1.00       Total expenses related to care of program beneficiaries (see instructions)       0       2.00         2.00       Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)       0       0       2.01         2.01       Total payment due (from Wkst. I-4, col. 6.02, line 11) (see instructions)       0       0       2.01         2.02       Total payment due (see instructions)       0       0       2.03       2.01         2.03       Total payment due (see instructions)       0       0       2.03       2.03         2.04       Duductibles billed to Medicare (Part B) patients (see instructions)       0       0       3.00         3.02       Deductibles billed to Medicare (Part B) patients (see instructions)       0       0       3.02         3.02       Total deductibles and coinsurance. Ditled to Medicare (Part B) patients (see instructions)       0       0       4.00         4.02       Coinsurance billed to Medicare (Part B) patients (see instructions)       0       0       4.02         4.03       Total deduct	Heal th	Financial Systems ELKHART GENERAL HOS	PI TAL		In Lie	u of Form CMS-2	2552-10
To         12/31/2014         Date/Time Prepared: 5/28/2015 1.02 µm           PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B         1.00         2.00           Dotal expenses related to care of program beneficiaries (see instructions)         0         1.00         2.00           2.00         Total payment due (from Wst. 1-4, col. 6.01, line 11) (see instructions)         0         1.00         2.00           2.01         Total payment due (from Wst. 1-4, col. 6.02, line 11) (see instructions)         0         2.00         2.00           2.02         Total payment due (from Wst. 1-4, col. 6.02, line 11) (see instructions)         0         0         2.00           2.03         Total payment due (ace (Part B) patients (see instructions)         0         0         3.00           2.04         Dotaties billed to Medicare (Part B) patients (see instructions)         0         0         3.00           3.01         Distructions         0         0         0         3.00           3.02         Deductibles billed to Medicare (Part B) patients (see instructions)         0         0         4.01           4.02         Coinsurance billed to Medicare (Part B) patients (see instructions)         0         0         4.00           4.01         Coinsurance billed to Medicare (Part B) patients (see instructions)         0	CALCUL	ATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B	Provider CCN: 1	150018		Worksheet I-5	
PART I - CALCULATION OF RELMBURSABLE BAD DEBTS - TITLE XVIII - PART B         1.00         2.00           1.00         1.00         2.00         1.00         2.00           00         Total payment due (from Wkst. 1-4, col. 6. line 11) (see instructions)         0         0         0           2.01         Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)         0         0         2.01           2.02         Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)         2.03         2.03         2.03         2.03         2.03         2.04         2.03         2.03         2.03         2.03         2.03         2.04         2.03         3.01         3.02         2.04         3.02         2.04         3.03         3.01         3.02         3.03         3.03         3.03         3.03         3							
PART 1 - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B           1.00         2.00           1.00         Total expenses related to care of program beneficiaries (see instructions)         0         1.00           2.01         Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)         0         2.00           2.01         Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)         0         2.00           2.02         Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)         0         2.01           2.03         Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)         0         2.02           2.04         Outlier payments         0         2.03         3.01           3.00         Deductibles billed to Medicare (Part B) patients (see instructions)         0         3.02           3.01         deductibles billed to Medicare (Part B) patients (see instructions)         0         4.01           4.02         coinsurance billed to Medicare (Part B) patients (see instructions)         0         4.03           4.02         coinsurance billed to Medicare (Part B) patients (see instructions)         0         4.03           5.00         Total coinsurance billed to Medicare (Part B) patients (see instructions)         0         5.00           5.00					10 12/31/2014		
PART 1 - CALCULATION OF REIMBUSSABLE BAD DEBTS - TITLE XVIII - PART B         1 00       Total expenses related to care of program beneficiaries (see instructions)       0         2 00       Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)       0       2.00         2 01       Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)       0       2.01         2 02       Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)       2.02       2.03         2 03       Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)       2.02       2.03         2 04       Outlier payments       0       3.00       3.00         3 00       Deductibles billed to Medicare (Part B) patients (see instructions)       0       3.00         3 01       Deductibles billed to Medicare (Part B) patients (see instructions)       3.02       3.03         3 02       Coinsurance billed to Medicare (Part B) patients (see instructions)       0       4.03         4 02       Coinsurance billed to Medicare (Part B) patients (see instructions)       0       4.03         4 01       Coinsurance billed to Medicare (Part B) patients (see instructions)       0       4.03         5 00       Deductibles and coinsurance, not of bad debt       0       5.00         5 01       Transition period						1 37 207 2013 1.0.	
1 00Total expenses related to care of program beneficiaries (see instructions)01.002.00Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)02.002.01Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)02.002.02Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)02.002.03Total payment due (see instructions)02.033.04Outlier payments02.033.05Deductibles billed to Medicare (Part B) patients (see instructions)03.003.01Deductibles billed to Medicare (Part B) patients (see instructions)3.023.023.03Total consurance billed to Medicare (Part B) patients (see instructions)04.004.00Coinsurance billed to Medicare (Part B) patients (see instructions)04.004.01Coinsurance billed to Medicare (Part B) patients (see instructions)04.004.02Coinsurance billed to Medicare (Part B) patients (see instructions)04.005.01Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt05.005.03Transition period 2 (55-5%) bad debts for deductibles and coinsurance net of bad debt05.035.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt05.036.04Howable exprese rendered on or after 1/1/2013 but before 1/1/201405.035.05Total coinsurance billed to Medicare (Part B) patients (see0 <t< td=""><td></td><td></td><td></td><td></td><td>1.00</td><td>2.00</td><td></td></t<>					1.00	2.00	
2.00Total payment due (from Wkst. 1-4, col. 6, line 11) (see instructions)002.002.01Total payment due (from Wkst. 1-4, col. 6, 0.2, line 11) (see instructions)2.012.022.03Total payment due (see instructions)02.032.04Outlier payments02.043.00Deductibles billed to Medicare (Part B) patients (see instructions)03.003.01Deductibles billed to Medicare (Part B) patients (see instructions)3.013.02Deductibles billed to Medicare (Part B) patients (see instructions)3.033.03Total deductiale (and the medicare (Part B) patients)04.004.01Coinsurance billed to Medicare (Part B) patients04.004.02Coinsurance billed to Medicare (Part B) patients04.004.03Total onsurance hilled to Medicare (Part B) patients005.00Ba debts for deductibles and coinsurance, net of bad debt recoveries005.01Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt05.025.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt05.035.04Howsheld (See instructions)005.035.05Total bad debts (see instructions)005.036.00Rismuscheld (See instructions)005.037.01Insurance hilled to Medicare (Part B) patients (see instructions)05.037.03Reinbursable bad debts (see instr		PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PA	RT B				
2.00Total payment due (from Wkst. 1-4, col. 6, line 11) (see instructions)002.002.01Total payment due (from Wkst. 1-4, col. 6, 0.2, line 11) (see instructions)2.012.022.03Total payment due (see instructions)02.032.04Outlier payments02.043.00Deductibles billed to Medicare (Part B) patients (see instructions)03.003.01Deductibles billed to Medicare (Part B) patients (see instructions)3.013.02Deductibles billed to Medicare (Part B) patients (see instructions)3.033.03Total deductiale (and the medicare (Part B) patients)04.004.01Coinsurance billed to Medicare (Part B) patients04.004.02Coinsurance billed to Medicare (Part B) patients04.004.03Total onsurance hilled to Medicare (Part B) patients005.00Ba debts for deductibles and coinsurance, net of bad debt recoveries005.01Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt05.025.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt05.035.04Howsheld (See instructions)005.035.05Total bad debts (see instructions)005.036.00Rismuscheld (See instructions)005.037.01Insurance hilled to Medicare (Part B) patients (see instructions)05.037.03Reinbursable bad debts (see instr	1.00	Total expenses related to care of program beneficiaries (see inst	ructions)		0		1.00
2.02       Total payment duc(from Wkst. 1-4, col. 6.02, line 11) (see instructions)       2.02         2.03       Total payment duc (see instructions)       2.03         2.04       Outlier payments       0         3.00       Deductibles billed to Medicare (Part B) patients (see instructions)       0         3.01       Deductibles billed to Medicare (Part B) patients (see instructions)       3.01         3.02       Deductibles billed to Medicare (Part B) patients (see instructions)       3.01         3.03       Total deductibles billed to Medicare (Part B) patients       (see instructions)       3.03         4.00       Coinsurance billed to Medicare (Part B) patients       (see instructions)       4.00         4.01       Coinsurance billed to Medicare (Part B) patients (see instructions)       0       4.00         4.01       Coinsurance billed to Medicare (Part B) patients (see instructions)       0       4.02         4.02       Coinsurance billed to Medicare (Part B) patients (see instructions)       0       4.02         5.00       Bad debts for deductibles and coinsurance, net of bad debt       0       5.00         5.02       Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt       0       5.02         5.03       Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt <td< td=""><td>2.00</td><td></td><td></td><td></td><td>0</td><td>0</td><td>2.00</td></td<>	2.00				0	0	2.00
2.03Total payment due (see instructions)2.032.04Outlier payments03.00Deductibles billed to Medicare (Part B) patients (see instructions)03.01Deductibles billed to Medicare (Part B) patients (see instructions)3.013.02Deductibles billed to Medicare (Part B) patients (see instructions)3.023.03Total deductibles billed to Medicare (Part B) patients004.00Coinsurance billed to Medicare (Part B) patients004.01Coinsurance billed to Medicare (Part B) patients (see instructions)04.004.02Coinsurance billed to Medicare (Part B) patients (see instructions)004.035.00Bad debts for deductibles and coinsurance, net of bad debt recoveries004.035.01Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt05.017.02Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt05.025.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt05.035.04100% PPS bad debts (see instructions)005.036.00Allowable bad debts (see instructions)005.037.00Reimbursable bad debts (see instructions)005.037.00Reimbursable bad debts (see instructions)005.056.00Allowable bad debts (see instructions)005.057.00Reimbursable bad debts (se	2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instr	ructions)				2.01
2.04Outlier payments02.043.00Deductibles billed to Medicare (Part B) patients (see instructions)003.003.01Deductibles billed to Medicare (Part B) patients (see instructions)3.013.013.02Deductibles billed to Medicare (Part B) patients (see instructions)3.033.033.03Total deductibles billed to Medicare (Part B) patients (see instructions)004.004.01Coinsurance billed to Medicare (Part B) patients (see instructions)004.004.02Coinsurance billed to Medicare (Part B) patients (see instructions)004.024.03Total coinsurance billed to Medicare (Part B) patients (see instructions)004.035.00Bad debts for deductibles and coinsurance net of bad debt005.005.01Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt05.015.02Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt05.037.03Total bad debts for deductibles and coinsurance net of bad debt05.037.04100% PPS bad debts for deductibles and coinsurance net of bad debt005.045.05Total bad debts (see instructions)005.056.00Allowable bad debts (see instructions)07.008.00Net deductibles and coinsurance net of bad debt005.057.01Bad debts for deductibles and coinsurance net of bad debt00<	2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instru	uctions)				2. 02
3.00       Deductibles billed to Medicare (Part B) patients (see instructions)       0       3.00         3.01       Deductibles billed to Medicare (Part B) patients (see instructions)       3.01         3.02       Deductibles billed to Medicare (Part B) patients (see instructions)       3.01         3.03       Total deductibles billed to Medicare (Part B) patients (see instructions)       3.03         4.00       Coinsurance billed to Medicare (Part B) patients (see instructions)       0       4.00         4.01       Coinsurance billed to Medicare (Part B) patients (see instructions)       0       4.02         4.02       Coinsurance billed to Medicare (Part B) patients (see instructions)       0       0       4.02         5.00       Bad debts for deductibles and coinsurance, net of bad debt recoveries       0       0       5.00         5.01       Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt       0       5.01         7       recoveries for services rendered on or after 1/1/2011 but before 1/1/2012       0       5.02       5.03         5.03       Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt       0       5.03       5.03         5.04       100% PPS bad debts for deductibles and coinsurance net of bad debt       0       5.04       5.05       5.04       5.05	2.03	Total payment due (see instructions)					2.03
3.01       Deductibles billed to Medicare (Part B) patients (see instructions)       3.01         3.02       Deductibles billed to Medicare (Part B) patients (see instructions)       3.02         3.03       Total deductibles billed to Medicare (Part B) patients (see instructions)       3.03         4.00       Coinsurance billed to Medicare (Part B) patients (see instructions)       0         4.01       Coinsurance billed to Medicare (Part B) patients (see instructions)       0         4.02       Coinsurance billed to Medicare (Part B) patients (see instructions)       0         4.03       Total coinsurance billed to Medicare (Part B) patients (see instructions)       0       4.02         4.03       Total coinsurance, net of bad debt recoveries       0       0       5.03         5.01       Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt       0       5.01         5.02       Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt       0       5.03         7 recoveries for services rendered on or after 1/1/2013 but before 1/1/2014       0       5.03         5.05       Total bad debts (sum of line 5 through line 5.04)       0       6.00       6.00         6.00       Allowable bad debts (cae (Part B) patients (see instructions)       0       7.00       6.00         6.00		Outlier payments			0		
3.02       Deductibles billed to Medicare (Part B) patients (see instructions)       3.02         3.03       Total deductibles billed to Medicare (Part B) patients (see instructions)       3.03         0.00       Coinsurance billed to Medicare (Part B) patients (see instructions)       0.04.00         4.01       Coinsurance billed to Medicare (Part B) patients (see instructions)       4.00         4.02       Coinsurance billed to Medicare (Part B) patients (see instructions)       0       4.03         5.00       Bad debts for deductibles and coinsurance, net of bad debt recoveries       0       0       5.00         5.01       Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt       0       5.01         recoveries for services rendered on or after 1/1/2011 but before 1/1/2012       0       5.02       5.01         5.03       Transition period 2 (250-50%) bad debts for deductibles and coinsurance net of bad debt       0       5.02         5.04       recoveries for services rendered on or after 1/1/2013 but before 1/1/2013       0       5.03       5.04         6.04       Howkin period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt       0       5.03         7       Transi tion period 2 (250-50%) bad debts for deductibles and coinsurance net of bad debt       0       5.04         9.05       Transi tion period 3 (2	3.00				0	0	
3.03Total deductibles billed to Medicare (Part B) patients (see instructions)3.034.00Coinsurance billed to Medicare (Part B) patients04.004.01Coinsurance billed to Medicare (Part B) patients (see instructions)04.014.02Coinsurance billed to Medicare (Part B) patients (see instructions)04.014.03Total coinsurance billed to Medicare (Part B) patients (see instructions)004.035.00Bad debts for deductibles and coinsurance, net of bad debt recoveries005.005.01Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt005.017.02Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt05.025.027.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt05.035.037.04Howshle bad debts for deductibles and coinsurance net of bad debt05.035.037.05Total addebts for deductibles and coinsurance net of bad debt05.045.048.04Howshle bad debts for deductibles and coinsurance net of bad debt005.056.04Howshle bad debts for deductibles and coinsurance net of bad debt005.048.05Total bad debts for deductibles and coinsurance net of bad debt005.056.00Allowable bad debts for deductibles and coinsurance net of bad debt005.056.00Allowable bad debts for deductibles and coinsurance ne							3. 01
4.00       Coinsurance billed to Medicare (Part B) patients       0       4.00         4.01       Coinsurance billed to Medicare (Part B) patients (see instructions)       4.01         4.02       Coinsurance billed to Medicare (Part B) patients (see instructions)       4.01         4.03       Total coinsurance billed to Medicare (Part B) patients (see instructions)       0       4.03         5.00       Bad debts for deductibles and coinsurance, net of bad debt recoveries       0       0       5.00         5.01       Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt       0       5.01         7.02       Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt       0       5.02         7.03       Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt       0       5.03         7.03       Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt       0       5.03         5.04       100% PPS bad debts for deductibles and coinsurance net of bad debt       0       5.04         6.00       1100% PPS bad debts (see instructions)       0       5.05         6.00       1100% PPS bad debts (see instructions)       0       5.05         6.00       1100% PPS bad debts (see instructions)       0       5.05 <tr< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td></tr<>							
4.01       Coinsurance billed to Medicare (Part B) patients (see instructions)       4.01         4.02       Coinsurance billed to Medicare (Part B) patients (see instructions)       0         4.03       Total coinsurance billed to Medicare (Part B) patients (see instructions)       0         5.00       Bad debts for deductibles and coinsurance, net of bad debt recoveries       0       0         5.01       Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt       0       0         5.02       Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt       0       0         5.03       Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt       0       0       5.03         7       Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt       0       0       5.03         7       Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt       0       0       5.03         7       Total bad debts for deductibles and coinsurance net of bad debt       0       0       5.03         8.04       Hotward for the debt for deductibles and coinsurance net of bad debt       0       0       5.03         9.04       Hotward for deductibles and coinsurance net of bad debt       0       0       5.04       5.05			ructions)				
4.02Coinsurance billed to Medicare (Part B) patients (see instructions)4.024.03Total coinsurance billed to Medicare (Part B) patients (see instructions)005.00Bad debts for deductibles and coinsurance, net of bad debt recoveries005.01Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt005.02Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt005.02Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt005.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt005.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt005.04Services rendered on or after 1/1/20121/1/2013005.05Total bad debts (sum of line 5 through line 5.04)0006.00Allowable bad debts (see instructions)07.008.007.00Reimbursable bad debts (see instructions)07.008.009.00Unrecovered from Medicare (Part B) patients (see instructions)009.0010.00Instructions)0010.0011.00Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, Line 33)011.0012.00Total allowable expenses (see instructions)012.0013.00					0	0	
4.03Total coinsurance billed to Medicare (Part B) patients (see instructions)004.035.00Bad debts for deductibles and coinsurance, net of bad debt recoveries005.005.01Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt005.01recoveries for services rendered on or after 1/1/2011 but before 1/1/2012005.025.02Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt005.02recoveries for services rendered on or after 1/1/2012 but before 1/1/2013005.035.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt005.035.04100% PPS bad debts for deductibles and coinsurance net of bad debt005.045.05Total bad debts (sum of line 5 through line 5.04)0005.056.00Allowable bad debts (see instructions)005.056.007.00Reimbursable bad debts for dual eligible beneficiaries (see instructions)07.008.009.00Program payment (see instructions)000010.00Reimbursable bad debts (see instructions)0010.0011.00Reimbursable bad debts (see instructions)010.0010.0012.00Total allowable expenses (see instructions)010.0011.0013.00Total allowable expenses (see instructions)012.0013.0010.00			· ·				
5.00Bad debts for deductibles and coinsurance, net of bad debt recoveries005.005.01Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt005.015.02Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt005.025.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt005.035.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt005.035.04recoveries for services rendered on or after 1/1/2013 but before 1/1/2014005.035.04services rendered on or after 1/1/2014005.045.05Total bad debts (see instructions)005.056.00Allowable bad debts (see instructions)005.057.00Reimbursable bad debts (see instructions)07.008.00Net deductibles and coinsurance (Part B) patients (see009.00Program payment (see instructions)009.0010.00Unrecovered from Medicare (Part B) patients (see instructions)010.0011.00Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, Line 33)011.0011.00PART 11 - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE012.0013.00Total allowable expenses (see instructions)013.0013.00			· ·				
5.01Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012005.015.02Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013005.025.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014005.035.04100% PPS bad debts for deductibles and coinsurance net of bad debt services rendered on or after 1/1/2014005.045.05Total bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014005.045.05Total bad debts (see instructions)005.056.006.006.00Allowable bad debts (see instructions)07.008.008.00Net deductibles and coinsurance (Part B) patients (see008.009.00Program payment (see instructions)009.0010.00Reimbursable bad debts (see instructions)010.0011.00Reimbursable bad debts (see instructions)010.0012.00Total allowable expenses (see instructions)012.0010.00Total allowable expenses (see instructions)012.0013.00Total allowable costs (from Wkst. 1-4, col. 2, line 11)013.00					0	-	
recoveries for services rendered on or after 1/1/2011 but before 1/1/201205.02Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt005.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt005.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt005.04100% PPS bad debts for deductibles and coinsurance net of bad debt005.05Total bad debts (see instructions)005.056.00Allowable bad debts (see instructions)005.056.00Allowable bad debts for dual eligible beneficiaries (see instructions)07.008.00Net deductibles and coinsurance (Part B) patients (see009.00Program payment (see instructions) (transfer to Worksheet E, Part B, Line 33)0010.00Total allowable expenses (see instructions)011.0011.00Total allowable expenses (see instructions)012.0013.00Total allowable expenses (see instructions)012.00					0	-	
5.02Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt005.025.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt005.035.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt005.035.04100% PPS bad debts for deductibles and coinsurance net of bad debt0005.045.04100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for0005.045.05Total bad debts (sum of line 5 through line 5.04)0005.056.00Allowable bad debts for dual eligible beneficiaries (see instructions)07.006.007.00Reimbursable bad debts for dual eligible beneficiaries (see instructions)008.009.00Program payment (see instructions)009.0010.00Unrecovered from Medicare (Part B) patients (see instructions)0011.00PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE011.0012.0013.00Total composite costs (from Wkst. I-4, col. 2, line 11)012.00	5.01			bad debt	0	0	5.01
recoveries for services rendered on or after 1/1/2012 but before 1/1/201305.035.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt005.04100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for005.04100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for005.05Total bad debts (sum of line 5 through line 5.04)0006.00Allowable bad debts (see instructions)005.056.00Allowable bad debts for dual eligible beneficiaries (see instructions)07.008.00Net deductibles and coinsurance billed to Medicare (Part B) patients (see009.00Program payment (see instructions)009.0010.00Unrecovered from Medicare (Part B) patients (see instructions)0011.0011.00PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE0012.0013.00Total composite costs (from Wkst. I-4, col. 2, line 11)013.0013.00							
5.03Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt005.035.04100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for005.045.04100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for005.045.05Total bad debts (sum of line 5 through line 5.04)0005.056.00Allowable bad debts (see instructions)006.007.00Reimbursable bad debts for dual eligible beneficiaries (see instructions)07.008.00Net deductibles and coinsurance billed to Medicare (Part B) patients (see008.009.00Program payment (see instructions)009.0010.00Unrecovered from Medicare (Part B) patients (see instructions)010.0011.00Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, Line 33)011.0012.00Total allowable expenses (see instructions)012.0013.00Total composite costs (from Wkst. 1-4, col. 2, Line 11)013.00	5.02			bad debt	0	0	5.02
100Indicating period100	E 02			had daht	0	0	E 02
5.04100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/201405.045.05Total bad debts (sum of line 5 through line 5.04)005.056.00Allowable bad debts (see instructions)06.007.00Reimbursable bad debts for dual eligible beneficiaries (see instructions)07.008.00Net deductibles and coinsurance billed to Medicare (Part B) patients (see009.00Program payment (see instructions)009.00Unrecovered from Medicare (Part B) patients (see instructions)0011.00Reimbursable bad debts (see instructions)010.0011.00Reimbursable bad debts (see instructions)11.0012.00Total allowable expenses (see instructions)012.0013.00Total composite costs (from Wkst. 1-4, col. 2, line 11)013.00	5.05			uau ueut	0	0	5.03
services rendered on or after 1/1/2014005.05Total bad debts (sum of line 5 through line 5.04)05.056.00Allowable bad debts (see instructions)06.007.00Reimbursable bad debts for dual eligible beneficiaries (see instructions)07.008.00Net deductibles and coinsurance billed to Medicare (Part B) patients (see009.00Program payment (see instructions)009.0010.00Unrecovered from Medicare (Part B) patients (see instructions)009.0011.00Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)011.00Total allowable expenses (see instructions)12.00Total allowable expenses (see instructions)012.0013.00Total composite costs (from Wkst. 1-4, col. 2, line 11)013.00	5 04			for	0	0	5.04
5.05Total bad debts (sum of line 5 through line 5.04)005.056.00Allowable bad debts (see instructions)06.007.00Reimbursable bad debts for dual eligible beneficiaries (see instructions)07.008.00Net deductibles and coinsurance billed to Medicare (Part B) patients (see008.009.00Program payment (see instructions)009.0010.00Unrecovered from Medicare (Part B) patients (see instructions)010.0011.00Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)011.00PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE012.0013.00Total composite costs (from Wkst. I-4, col. 2, line 11)013.00	5.04		l recoverres	101	0	0	5.04
6.00Allowable bad debts (see instructions)06.007.00Reimbursable bad debts for dual eligible beneficiaries (see instructions)07.008.00Net deductibles and coinsurance billed to Medicare (Part B) patients (see009.00Program payment (see instructions)009.0010.00Unrecovered from Medicare (Part B) patients (see instructions)009.0011.00Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, Line 33)011.0012.00Total allowable expenses (see instructions)12.0012.0013.00Total composite costs (from Wkst. I-4, col. 2, Line 11)013.00	5 05				0	0	5 05
7.00Reimbursable bad debts for dual eligible beneficiaries (see instructions)07.008.00Net deductibles and coinsurance billed to Medicare (Part B) patients (see008.009.00Program payment (see instructions)009.0010.00Unrecovered from Medicare (Part B) patients (see instructions)009.0011.00Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, Line 33)011.0012.00Total allowable expenses (see instructions)12.0012.0013.00Total composite costs (from Wkst. I-4, col. 2, Line 11)013.00					0	Ű	
8.00Net deductibles and coinsurance billed to Medicare (Part B) patients (see008.009.00Program payment (see instructions)009.0010.00Unrecovered from Medicare (Part B) patients (see instructions)009.0011.00Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, Line 33)011.00PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE12.0013.0012.0013.00Total composite costs (from Wkst. I-4, col. 2, Line 11)013.00			ructions)		0		
9.00Program payment (see instructions)09.0010.00Unrecovered from Medicare (Part B) patients (see instructions)010.0011.00Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, Line 33)010.0011.00PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE11.0012.00Total allowable expenses (see instructions)012.0013.00Total composite costs (from Wkst. I-4, col. 2, Line 11)013.00					0	0	8.00
9.00Program payment (see instructions)009.0010.00Unrecovered from Medicare (Part B) patients (see instructions)10.0010.0010.0011.00Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)011.00PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE12.0012.0013.00Total allowable expenses (see instructions)012.0013.00Total composite costs (from Wkst. I-4, col. 2, line 11)013.00			(		-	-	
11.00Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)011.00PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE12.0013.0012.0013.00Total allowable expenses (see instructions)013.00	9.00				0	0	9.00
PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE       12.00         12.00       Total allowable expenses (see instructions)       0       12.00         13.00       Total composite costs (from Wkst. I-4, col. 2, line 11)       0       13.00	10.00	Unrecovered from Medicare (Part B) patients (see instructions)					10.00
12.00         Total allowable expenses (see instructions)         0         12.00           13.00         Total composite costs (from Wkst. I-4, col. 2, line 11)         0         13.00	11.00	Reimbursable bad debts (see instructions) (transfer to Worksheet	E, Part B, li	ne 33)	0		11.00
13.00 Total composite costs (from Wkst. I-4, col. 2, line 11) 0 13.00		PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENT	AGE				
	12.00	Total allowable expenses (see instructions)			0		12.00
14.00Facility specific composite cost percentage (line 13 divided by line 12)0.00000014.00	13.00	Total composite costs (from Wkst. I-4, col. 2, line 11)			0		13.00
	14.00	Facility specific composite cost percentage (line 13 divided by I	ine 12)		0.000000		14.00

CALCULATION OF CAPITAL PAYMENT		Period: From 01/01/2014		
		To 12/31/2014		
	Title XVIII	Hospi tal	5/28/2015 1:02 PPS	z pili
			1.00	
PART I - FULLY PROSPECTIVE METHOD				
CAPITAL FEDERAL AMOUNT				
.00 Capital DRG other than outlier			3, 003, 778	
.01 Model 4 BPCI Capital DRG other than outlier .00 Capital DRG outlier payments			0 302, 636	1. 2.
.00 Model 4 BPCI Capital DRG outlier payments			302, 030	
00 Total inpatient days divided by number of days in	the cost reporting period (see instr	uctions)	129.01	3.
00 Number of interns & residents (see instructions)	the cost reporting period (see math		0.00	
00 Indirect medical education percentage (see instru	ctions)		0,00	
00 Indirect medical education adjustment (multiply I			0	6.
00 Percentage of SSI recipient patient days to Medic 30) (see instructions)		part A line	4. 16	7.
00 Percentage of Medicaid patient days to total days	(see instructions)		18.88	8.
00 Sum of lines 7 and 8			23.04	9.
0.00 Allowable disproportionate share percentage (see			4. 78	
.00 Disproportionate share adjustment (line 10 times			143, 581	
.00 Total prospective capital payments (sum of lines	1, 1.01, 2, 2.01, 6 and 11)		3, 449, 995	12
			1.00	
PART II - PAYMENT UNDER REASONABLE COST			0	1
00 Program inpatient routine capital cost (see instr 00 Program inpatient ancillary capital cost (see ins			0	1. 2.
00 Total inpatient program capital cost (see fils			0	3.
00 Capital cost payment factor (see instructions)			0	4
00 Total inpatient program capital cost (line 3 x li	ne 4)		Ő	
PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
00 Program inpatient capital costs (see instructions	)		0	1
00 Program inpatient capital costs (see Histidetions			0	2
00 Net program inpatient capital costs (line 1 minus	· · · · · · · · · · · · · · · · · · ·		0	3
00 Applicable exception percentage (see instructions	)		0.00	4
00 Capital cost for comparison to payments (line 3 x	line 4)		0	5
00 Percentage adjustment for extraordinary circumsta			0.00	
00 Adjustment to capital minimum payment level for e	3	line 6)	0	
00 Capital minimum payment level (line 5 plus line 7			0	
00 Current year capital payments (from Part I, line			0	9.
			0	
.00 Current year comparison of capital minimum paymen		r year	0	11.
<ul> <li>00 Current year comparison of capital minimum paymen</li> <li>00 Carryover of accumulated capital minimum payment Worksheet L, Part III, line 14)</li> </ul>		11)	~	10
<ul> <li>00 Current year comparison of capital minimum paymen</li> <li>00 Carryover of accumulated capital minimum payment</li> <li>Worksheet L, Part III, line 14)</li> <li>00 Net comparison of capital minimum payment level t</li> </ul>	o capital payments (line 10 plus line	11)	0	
<ul> <li>0.00 Current year comparison of capital minimum paymen</li> <li>00 Carryover of accumulated capital minimum payment</li> <li>00 Worksheet L, Part III, line 14)</li> <li>00 Net comparison of capital minimum payment level t</li> <li>00 Current year exception payment (if line 12 is pos</li> <li>00 Carryover of accumulated capital minimum payment</li> </ul>	o capital payments (line 10 plus line itive, enter the amount on this line) level over capital payment for the fo		0 0 0	13.
<ul> <li>0.00 Current year comparison of capital minimum payment Carryover of accumulated capital minimum payment Worksheet L, Part III, line 14)</li> <li>0.00 Net comparison of capital minimum payment level t</li> <li>0.00 Current year exception payment (if line 12 is possible)</li> <li>0.00 Carryover of accumulated capital minimum payment (if line 12 is negative, enter the amount on this</li> </ul>	o capital payments (line 10 plus line itive, enter the amount on this line) level over capital payment for the fo line)		0	13. 14.
<ul> <li>0.00 Current year comparison of capital minimum payment</li> <li>0.00 Carryover of accumulated capital minimum payment</li> <li>Worksheet L, Part III, line 14)</li> <li>0.00 Net comparison of capital minimum payment level t</li> <li>0.00 Current year exception payment (if line 12 is pos</li> <li>0.00 Carryover of accumulated capital minimum payment</li> <li>(if line 12 is negative, enter the amount on this</li> </ul>	o capital payments (line 10 plus line itive, enter the amount on this line) level over capital payment for the fo line) ent (see instructions)		0 0	13 14 15

LUCA	TION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIF	RCUMSTANCES	Provi der	F	Period: From 01/01/2014 To 12/31/2014	Worksheet L-1 Part I Date/Time Pre 5/28/2015 1:0	pared
			Capital Rel	ated Costs			
	Cost Center Description	Extraordi nary Capi tal	CAP REL COSTS-BLDG &	CAP REL COSTS-MVBLE	Subtotal	EMPLOYEE BENEFI TS	
		Related Costs 0	FI XT 1.00	EQUI P 2.00	2A	DEPARTMENT 4.00	
	GENERAL SERVICE COST CENTERS	· · ·		2.00			
00	00100 CAP REL COSTS-BLDG & FIXT	0	0	_			1.0
00 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	2.0 4.0
00	00500 ADMINISTRATIVE & GENERAL	0	0	0		0	
00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	
00	00700 OPERATION OF PLANT	0	0	0	0	0	7.0
00	00800 LAUNDRY & LINEN SERVICE	0	0	0	0	0	
00 . 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	0	0	0	0	
	01100 CAFETERI A	0	0	0	0	0	
	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	
	01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	0	
	01400 CENTRAL SERVICES & SUPPLY	0	0	0	0	0	
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	
	01700 SOCIAL SERVICE	0	0	0	0	0	
	01850 OTHER GENERAL SERVICE	0	0	0	0	0	
. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23.0
00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	0	0	ol	0	30. 0
	03100 I NTENSI VE CARE UNI T	0	0	0	-	0	
	03101 NEONATAL INTENSIVE CARE	0	0	0	0	0	
	04000 SUBPROVI DER – I PF	0	0	0	0	0	
	04100 SUBPROVIDER - IRF	0	0	0	0	0	
	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	0	0	0	0	
	04500 NURSING FACILITY	0	0	0	0	0	
	04600 OTHER LONG TERM CARE	0	0	0	0	0	
~~	ANCI LLARY SERVI CE COST CENTERS						1 - 0
	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0	0	0	0	
	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
	05300 ANESTHESI OLOGY	0	0	0	0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	
	05401 I NTERVENTI ONAL RADI OLOGY	0	0	0	0	0	
	05402 BREAST CENTER 05403 RADI ATI ON ONCOLOGY	0	0	0	0	0	
	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.
	05600 RADI OI SOTOPE	0	0	0	0	0	56.
	05601 ULTRASOUND	0	0	0	0	0	
. 00 . 00	05700 CT SCAN 05800 MRI	0	0	0	0	0	
	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
	06000 LABORATORY	0	0	0	0	0	
	06001 BLOOD LABORATORY	0	0	0	0	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0		0	61.
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	
	06401 HOME INFUSION	0	0	0	0	0	
	06500 RESPI RATORY THERAPY	0	0	0	0	0	
	06600 PHYSI CAL THERAPY	0	0	0	0	0	
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY		0			0	
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS		0			0	
	07400 RENAL DIALYSIS	0	0	0	0	0	
	07500 ASC (NON-DI STI NCT PART)	0	0	0	0 0	0	75.
. 00	03140 CARDI OLOGY	0	0	0	0	0	76.
. 00	OUTPATI ENT SERVI CE COST CENTERS		0	0		0	90.
	04951 SLEEP CLINIC	0	0	0		0	
. 00	09100 EMERGENCY	0	0	0	0	0	
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.
. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.
	U7400 HUML FRUGRAM DIALISIS	1 0	0			0	1 74.

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Li	eu of Form CMS-	2552-10
ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIR	CUMSTANCES	Provi der	CCN: 150018	Peri od:	Worksheet L-	1
				From 01/01/201 To 12/31/201		- nared
					5/28/2015 1:0	
		Capital Rel	ated Costs			
Cost Center Description	Extraordi nary	CAP REL	CAP REL	Subtotal	EMPLOYEE	
cost center bescription	Capital	COSTS-BLDG &	COSTS-MVBLE		BENEFITS	
	Rel ated Costs	FIXT	EQUI P		DEPARTMENT	
	0	1.00	2.00	2A	4.00	
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0	0 (	96.00
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0	0 0	97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0	0 0	
101.00 10100 HOME HEALTH AGENCY	0	0		0	0 0	101.00
SPECIAL PURPOSE COST CENTERS	1				-	_
113.00 11300 INTEREST EXPENSE	0	0		0		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00
116. 00 11600 HOSPI CE	0	0		0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0		0	0 (	118.00
				0		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190.00
191.00 19100 RESEARCH	0	0		0		191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		) 192.00 ) 192.01
192. 01 19201 HOSPI TAL BASED CLINIC	0	0		0		
192. 02 19202 OUTPATI ENT PSYCH	0	0		0		) 192. 02 ) 193. 00
193. 00 19300 NONPALD WORKERS 193. 01 19301 COMMUNI TY	0	0		0		193.00
194.0007950 OTHER NONRELMBURSABLE COST CENTERS	0	0		0		193.01
200.00 Cross Foot Adjustments	0	0		0		200.00
200.00 Negative Cost Centers		0		0	0	200.00
202.00 Total (sum of lines 118 and 190-201)	0	0		0		201.00
203.00 Total Statistical Basis	0	612, 587	612, 58	27	0 76, 789, 162	
204.00 Unit Cost Multiplier		0. 000000				
	1	0.00000	0.0000	0.00000	0.000000	1207.00

Image: Control of the contro		Financial Systems TION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIP		Provi der	CCN: 150018	Period: From 01/01/2014 To 12/31/2014		epared:
BNIARD SHAPT COST CONTENS           0         OTOTOLOP RELOSTS MULL FEAD VIT           2         0         COSTOLOP RELOSTS MULL FEAD VIT           0         0         0         0           0         0         0         0           0         0         0         0         0           0         0         0         0         0           0         0         0         0         0           0         0         0         0         0           0         0         0         0         0           0         0         0         0         0         0           0         0         0         0         0         0         0           0         0         0         0         0         0         0         0           0 </th <th></th> <th>Cost Center Description</th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>		Cost Center Description						
1.00         DOTOD (CAP HIL COSTS MURG A FIXT           2.00         DOTOD (CAP HIL COSTS MURG TERLET IS LEPARTMENT           4.00         DOTOD (CAP HIL COSTS MURG TERLET IS LEPARTMENT           4.00         DOTOD (CAP HIL COSTS MURG TERLET IS LEPARTMENT           6.00         DOTOD (CAP HIL COSTS MURG TERLET IS LEPARTMENT           6.00         DOTOD (CAP HIL COSTS MURG TERLET IS LEPARTMENT         D           6.00         DOTOD (CAP HIL COSTS MURG TERLET IS LEPARTMENT         D           6.00         DOTOD (CAP HIL COSTS MURG TERLET IS LEPARTMENT         D           6.00         DOTOD (CAP HIL COSTS MURG TERLET IS LEPARTMENT         D           1.00         DOTOD (CAP HIL COSTS MURG TERLET IS LEPARTMENT         D           1.00         DOTOD (CAP HILL COSTS MURG TERLET IS LEPARTMENT         D           1.00         DOTOD (CAP HILL COSTS MURG TERLET IS LEPARTMENT         D           1.00         DOTOD (CAP HILL COSTS MURG TERLET IS LEPARTMENT         D           1.00         DOTOD (CAP HILL COSTS A SUPPLY IS LEPARTMENT         D           1.00         DOTOD (CAP HILL COSTS MURG TERLET IS LEPARTMENT         D           1.00         DOTOD (CAP HILL COSTS A SUPPLY IS LEPARTMENT         D           1.00         DOTOD (CAP HILL COSTS A SUPPLY IS LEPARTMENT         D           1.00         DOTO		CENEDAL SEDVICE COST CENTEDS	5.00	6.00	7.00	8.00	9.00	
2 00 00000 CAP REL COSTS-MUEL EQUIP 4 00 00000 CAP REL COSTS-MUEL EQUIP 5 00 00000 CAPRONE DEPARTMANT 5 00 00000 CARRENT VS & CONTRALL 5 00 000000 CARRENT VS & CONTRALL 5 00 00000000 CARRENT VS & CONTRALL	1.00							1.00
5.00         OSCOD ADMIN ISTATI VE & CENERAL         0           7.00         ODTOD OPERATION OF PLAYT         0         0         0           7.00         ODTOD OPERATION OF PLAYT         0         0         0         0           7.00         ODTOD OPERATION OF PLAYT         0								2.00
0.00         00000[MINIMERANCE & REPAIRS         0         0         0           0.00         00000[LAMBORY & LINEN SERVICE         0	4.00							4.00
0.00200         DEFEATION OF PLANT         0         0         0           0.00200         DEFEATION OF PLANT         0			0	_				5.00
0.00         0.0000         LAURDRY ALLIENT SERVICE         0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0</td><td></td><td>6.00</td></t<>			0	0		0		6.00
9.00         000001 Filter Prints         0			0			0 0		7.00
10.00         01000         01700         01000         01000         0			0			0 0	0	
12.00         01200 MAINTERMANCE OF PERSONNEL         0			0	0		0 0	-	
13. 00         01300         MURSI NG ADMI NI STRATI ON         0			0	C		0 0	0	11.00
14.00         01400         CERT SERVICES & SUPPLY         0 <th< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0</td><td>-</td><td></td></th<>			0	0		0	-	
15.00         01500         HARRACY         0			0				-	
16 00         01600         MEDICAL, RECORDS & LIBRARY         0			0				-	
18.00         01850         OTHER         CENERAL         SERVICE         0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td>-</td> <td>16.00</td>			0				-	16.00
23.00         0 (2300) PARAMED ED PRG/A         0         0         0         0         0           INPART LET NOUTINE SERVICE COST CENTERS         0	17.00	01700 SOCIAL SERVICE	0	0		0 0	0	17.00
INPATI ENT ROUTI NE SERVICE COST CENTERS           0.00         0.00         0<			0			-		
00.00         03000 ADULTS & PEDIATRICS         0	23.00		0	0		0 0	0	23.00
11.00         03100         INTENSIVE CARE         NO         0	20 00		0	0	1	0 0	0	30.00
11.01       03101       WEARATAL INTENSIVE CARE       0			-		1	-		
11.00       04100       SUBPROVIDER - I RF       0       0       0       0       0         14.00       04400       SKILLED       NURSING FACILITY       0       0       0       0       0         15.00       04600       NIKSING FACILITY       0       0       0       0       0       0         16.00       04600       OHENING FACILITY       0       0       0       0       0       0         05000       ORGONO DERLATING ROM       0       0       0       0       0       0       0         10.00       OSCOOL OPERATING ROM       0 <td></td> <td></td> <td>0</td> <td>C</td> <td></td> <td></td> <td></td> <td></td>			0	C				
13. 00         04.300         NURSERY         0         0         0         0         0           14. 00         04.500         NURSING FACILITY         0			0	C		0 0	0	
44.00       Q4400       SK1LLED       NURSING FACILITY       0       0       0       0       0         45.00       Q4600       OTHER LONG TERM CARE       0       0       0       0       0         ANCILLARY SERVICE COST CENTERS			0	0		0 0	-	41.00
45.00         Q4500         UURISING FACILITY         0         0         0         0         0         0         0           ARCILLARY SERVICE COST CENTERS			0			0 0	-	
46.00         D         D         D         D         O         O           ANCLUARY SERVICE COST CENTERS           50.00         DSC000 (DPEATING ROOM         0 <t< td=""><td></td><td></td><td>0</td><td></td><td></td><td></td><td>-</td><td></td></t<>			0				-	
50.00         05000         DPERATI ING ROM         0			0	0				
51:00         OS100         RECOVERY ROM         LABOR ROM         O					T			
52:00         OS200         DELLIVERY ROM & LABOR ROM         0        <								
53.00       05300       ABESTHESI OLGGY       0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0 0</td> <td></td> <td>51.00 52.00</td>			0			0 0		51.00 52.00
54.00         05400         RADIOLOGY-DIAGNOSTIC         0         0         0         0           54.01         05402         BREAST CENTER         0			0				-	
54.01       INTERVENTIONAL RADIOLOGY       0       0       0       0         54.02       05403       RADIATION ONCOLOGY       0			0			0 0	-	
54.03         654.03         RADI ATLON ONCOLOGY         0         0         0         0           55.00         05500         RADI OLOGY - THERAPEUTI C         0	54.01		0	0		0 0	0	54.01
55:00         OS500         RADIOLOGY -THERAPEUTIC         O <th< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td>-</td><td></td></th<>			0	0		0 0	-	
66.00         05600         RAID OI SOTOPE         0			0	0		0 0	-	
56.01         05601         ULTRASOUND         0         0         0         0         0           57.00         05700         CT SCAN         0         <			0				-	
57.00         D5700         CT SCAN         0       <			0			0 0		56.01
59.00       05900       CARDI AC CATHETERI ZATI ON       0       0       0       0         60.00       06000       LABORATORY       0			0	C		0 0	0	57.00
60.00         06000         LABORATORY         0         0         0         0         0           60.01         06001         BLOOD LABORATORY         0			0	C		0 0		
60.01       06001       BLOOD LABORATORY       0       0       0       0         61.00       06100       PPP CLINICAL LAB SERVICES-PRGM ONLY       0       0       0       0         62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       0       0         63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0       0       0       0       0         64.01       06401       INTRAVENOUS THERAPY       0       0       0       0       0       0         65.00       06500       RESPI RATORY THERAPY       0<			0	0		0 0	0	07.00
61.00       06100       PBP       CLINICAL       LAB       SERVICES-PRGM       ONLY         62.00       06200       WHOLE       BLOOD & PACKED RED       BLOOD CELL       0       0       0       0         63.00       06300       BLOOD & PACKED RED       BLOOD CELL       0			0			0 0		
62.00       06200       WHOLE BLOOD & PACKED RED BLOOD CELL       0       0       0       0         63.00       06300       BLOOD STORING, PROCESSING & TRANS.       0			0		,	0		61.00
64.00       INTRAVENOUS THERAPY       0       0       0       0         64.01       O6401       HOME INFUSION       0       0       0       0       0         65.00       RESPIRATORY THERAPY       0       0       0       0       0       0         65.00       O6600       PHYSI CAL. THERAPY       0       0       0       0       0         67.00       O6700       OCUPATI ONAL THERAPY       0       0       0       0       0         68.00       O6600       SPEECH PATHOLOGY       0       0       0       0       0       0         69.00       ELECTROCARDI OLOGY       0       0       0       0       0       0       0       0       0         70.00       O7000       ELECTROENCEPHALOGRAPHY       0			0	C		0 0	0	
64.01       06401       HOME INFUSION       0       0       0       0         65.00       06500       RESPI RATORY THERAPY       0       0       0       0       0         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0       0         67.00       0CCUPATI ONAL THERAPY       0       0       0       0       0       0         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0       0         69.00       06900       ELECTROCARDI OLOGY       0       0       0       0       0       0       0       0         70.00       OTOOD       ELECTROCARDI OLOGY       0 <td< td=""><td></td><td></td><td>0</td><td>C</td><td></td><td>0 0</td><td>0</td><td></td></td<>			0	C		0 0	0	
65.00       06500       RESPI RATORY THERAPY       0       0       0       0         66.00       06600       PHYSI CAL THERAPY       0       0       0       0       0         67.00       06700       0CCUPATI ONAL THERAPY       0			0	0		0 0	-	64.00
66.00       06600       PHYSI CAL THERAPY       0       0       0       0         67.00       06700       0CCUPATI ONAL THERAPY       0       0       0       0       0         68.00       06800       SPECH PATHOLOGY       0       0       0       0       0       0       0         69.00       06900       ELECTROCARDI OLOGY       0			0			0 0	-	64.01 65.00
67.00       06700       0CCUPATIONAL THERAPY       0       0       0       0       0         68.00       06800       SPEECH PATHOLOGY       0       0       0       0       0       0         69.00       06900       ELECTROCARDIOLOGY       0 <td< td=""><td></td><td></td><td>0</td><td></td><td></td><td>0 0</td><td>-</td><td></td></td<>			0			0 0	-	
69.00       06900       ELECTROCARDIOLOGY       0       0       0       0       0         70.00       07000       ELECTROENCEPHALOGRAPHY       0       0       0       0       0         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENT       0       0       0       0       0         72.00       07200       IMPL. DEV. CHARGED TO PATIENTS       0       0       0       0       0         73.00       07300       RUGS CHARGED TO PATIENTS       0       0       0       0       0         74.00       07400       RENAL DIALYSIS       0       0       0       0       0       0         75.00       07500       ASC (NON-DISTINCT PART)       0       0       0       0       0       0         76.00       03140       CARDIOLOGY       0<			0	C		0 0	0	67.00
70.00         07000         ELECTROENCEPHALOGRAPHY         0         0         0         0         0           71.00         07100         MEDICAL SUPPLIES CHARGED TO PATIENT         0			0	0		0 0	-	68.00
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENT       0       0       0       0         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       0       0       0         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       0         74.00       07400       RENAL DI ALYSI S       0       0       0       0       0         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0       0       0         76.00       03140       CARDI OLOGY       0       0       0       0       0       0       0         70.00       09000       CLI NI C       0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td></td><td>0 0</td><td></td><td></td></t<>			0	0		0 0		
72.00         07200         IMPL.         DEV.         CHARGED TO PATIENTS         0			0				-	70.00
73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0         74.00       07400       RENAL DIALYSIS       0       0       0       0       0         75.00       07500       ASC (NON-DI STINCT PART)       0       0       0       0       0         76.00       03140       CARDI OLOGY       0       0       0       0       0       0         00       03140       CARDI OLOGY       0       0       0       0       0       0       0         00       09000       CLINIC       0			0			0 0	-	
75.00         07500         ASC (NON-DI STINCT PART)         0         0         0         0         0           76.00         03140         CARDI OLOGY         0 <t< td=""><td></td><td></td><td>0</td><td>C</td><td></td><td>0 0</td><td>0</td><td></td></t<>			0	C		0 0	0	
76.00         03140         CARDIOLOGY         0	74.00	07400 RENAL DIALYSIS	0	C		0 0	0	74.00
OUTPATI ENT SERVICE COST CENTERS           90.00         09000 CLINIC         0		,	0	0		0 0		
90. 00         09000         CLINIC         0	/6.00		0	0	И	<u>vj</u> 0	0	76.00
90.01         04951         SLEEP CLINIC         0	90.00		0	0		0 0	0	90.00
91.00         09100         EMERGENCY         0         0         0         0         0           92.00         09200         0BSERVATI ON BEDS (NON-DI STI NCT PART         0         0         0         0         0           0THER         REI MBURSABLE         COST CENTERS         0         0         0         0         0         0			0			0 0		
OTHER         REI MBURSABLE         COST         CENTERS           94. 00         09400         HOME         PROGRAM         DI ALYSI S         0	91.00	09100 EMERGENCY	0	0		0 0	0	91.00
94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0	92.00							92.00
	04.00		-	^	J	0		04.00
		09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES						
			0			0 0	-	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0	97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
98. 00 09851 OTHER REI MBURSABLE COST CENTERS 0 0 0 0	98.00	09851 OTHER REIMBURSABLE COST CENTERS	0	0	0	0 0	0	98.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-25	52-10
ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIR	CUMSTANCES	Provi der		Peri od:	Worksheet L-1	
				From 01/01/2014		
				To 12/31/2014		
Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	5/28/2015 1:02 HOUSEKEEPI NG	рш
Cost Center Description	& GENERAL	REPAIRS	PLANT	LINEN SERVICE	HOUSEKEEFING	
	5.00	6.00	7.00	8.00	9.00	
101.00 10100 HOME HEALTH AGENCY	0.00			0 0		01.00
SPECIAL PURPOSE COST CENTERS				0		011.00
113. 00 11300 I NTEREST EXPENSE	0	C		0 0	011	13.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	C	)	0 0	0 1	14.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	c		0 0	0 1	15.00
116.00 11600 HOSPI CE	0	0	)	0 0	0 1	16.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	)	0 0	0 1	18.00
NONREI MBURSABLE COST CENTERS		·				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0 0	0 19	90.00
191. 00 19100 RESEARCH	0	0		0 0	0 19	91.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0 19	92.00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0	)	0 0	0 19	92. 01
192. 02 19202 OUTPATI ENT PSYCH	0	0	)	0 0	0 19	92.02
193. 00 19300 NONPALD WORKERS	0	0	)	0 0	0 19	93.00
193. 01 19301 COMMUNI TY	0	0		0 0	0 19	93. 01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0 19	94.00
200.00 Cross Foot Adjustments					20	00.00
201.00 Negative Cost Centers	0	0		0 0	0 20	01.00
202.00 Total (sum of lines 118 and 190-201)	0	0		0 0		02.00
203.00 Total Statistical Basis	185, 992, 301	574, 082	451, 07	2 1, 302, 842	86, 063 20	03.00
204.00 Unit Cost Multiplier	0. 000000	0. 000000	0.00000	0 0.000000	0.000000	04.00

	Financial Systems TION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIR	<u>ELKHART GENER</u> CUMSTANCES		CCN: 150018			u of Form CMS- Worksheet L-1 Part I Date/Time Pre 5/28/2015 1:0	epared:
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE PERSONNEL		NURSI NG NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
		10.00	11.00	12.00		13.00	14.00	-
1.00 2.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	000000000000000000000000000000000000000			000000000000000000000000000000000000000	000000000000000000000000000000000000000	C	15.00
17.00	01700 SOCI AL SERVI CE 01850 OTHER GENERAL SERVI CE 02300 PARAMED ED PRGM	0 0 0	(		0 0 0	0 0 0	C C C	17.00 18.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	(		0	0	C	30.00
30.00 31.00 31.01 40.00 41.00 43.00 44.00	03100 ADDLIS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY					000000000000000000000000000000000000000		<ul> <li>31.00</li> <li>31.01</li> <li>40.00</li> <li>41.00</li> <li>43.00</li> </ul>
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0			0 0	0	C C	45.00
50.00	ANCI LLARY SERVI CE COST CENTERS	0	(		0	0	C	50.00
51.00 52.00 53.00 54.00 54.01 54.02	05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 I NTERVENTI ONAL RADI OLOGY 05402 BREAST CENTER	0 0 0 0 0			0 0 0 0 0	0 0 0 0 0		52.00 53.00 54.00 54.01
58.00	05403 RADI ATI ON ONCOLOGY 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05601 ULTRASOUND 05700 CT SCAN 05800 MRI				0 0 0 0 0	0 0 0 0 0		55.00 56.00 56.01 57.00 58.00
59.00 60.00 60.01 61.00 62.00 63.00 64.00	05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	000000000000000000000000000000000000000				000000000000000000000000000000000000000		60.00 60.01 61.00 62.00 63.00
64. 01 65. 00 66. 00 67. 00 68. 00 69. 00	06401 HOME I NFUSI ON 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	000000000000000000000000000000000000000				000000000000000000000000000000000000000		64.01 65.00 66.00 67.00
70.00 71.00 72.00 73.00 74.00 75.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0 0 0 0 0				0 0 0 0 0 0		70.00 71.00 72.00 73.00 74.00 75.00
	03140 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS 09000 CLI NI C 04951 SLEEP CLI NI C 0100 REEPCENCY				0	0		90.00 90.01
91.00 92.00 94.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS	0	(	) )	0	0	C	92.00
95.00 96.00	09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0 0 0			0 0 0	0 0 0		95.00 96.00

Health Financial Systems	ELKHART GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2552-10
ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CI	RCUMSTANCES		CCN: 150018	Period: From 01/01/2014 To 12/31/2014	
Cost Center Description	DI ETARY		MAI NTENANCE	ADMI NI STRATI ON	SUPPLY
	10.00	11.00	12.00	13.00	14.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0 98.00
101.0010100 HOME HEALTH AGENCY	0	0		0 0	0 101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE	0	0		0 0	0 113.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF	0	0		0 0	0 114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0 115.00
116. 00 11600 HOSPI CE	0	0		0 0	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0		0 0	0 118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	I	0 0	0 190. 00
191. 00 19100 RESEARCH	0	0		0 0	0 191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0 192.00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0		0 0	0 192. 01
192. 02 19202 OUTPATI ENT PSYCH	0	0		0 0	0 192. 02
193.00 19300 NONPALD WORKERS	0	0		0 0	0 193.00
193. 01 19301 COMMUNI TY	0	0		0 0	0 193. 01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0 194.00
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers	0	0		0 0	0 201.00
202.00 Total (sum of lines 118 and 190-201)	0	0		0 0	0 202.00
203.00 Total Statistical Basis	164, 918	2, 291, 155	2, 291, 1	1, 009, 679	28, 938, 864 203. 00
204.00 Unit Cost Multiplier	0. 000000	0. 000000			

	Financial Systems TION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIR	ELKHART GENERA CUMSTANCES		CCN: 150018	Period: From 01/01/2014 To 12/31/2014		pared:
	Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVIC	Other General Service OTHER GENERAL SERVICE	PARAMED ED PRGM	
		15.00	LI BRARY 16.00	17.00	18.00	23.00	
	GENERAL SERVICE COST CENTERS	10.00	10.00	17.00	10.00	20.00	
13.00 14.00 15.00 16.00 17.00 18.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 AMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVICE 01850 OTHER GENERAL SERVICE 02300 PARAMED ED PRGM	0 0 0 0 0 0			0 0 0 0 0 0	0	1.00 2.00 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 18.00 23.00
31.00 31.01 40.00 41.00 43.00 44.00 45.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS O3000 ADULTS & PEDI ATRI CS O3100 I NTENSI VE CARE UNI T O3101 NEONATAL I NTENSI VE CARE O4000 SUBPROVI DER - I PF O4100 SUBPROVI DER - I RF O4300 NURSERY O4400 SKI LLED NURSI NG FACI LI TY O4500 NURSI NG FACI LI TY O4500 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0 0 0 0 0 0 0 0 0 0			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		30. 00 31. 00 31. 01 40. 00 41. 00 43. 00 44. 00 45. 00 46. 00
52.00 53.00 54.01 54.02 54.03 55.00 56.01 57.00 58.00 59.00 60.01 61.00 62.00 63.00 64.01 65.00 64.01 65.00 64.01 65.00 64.01 65.00 67.00 68.00 71.00 72.00 73.00 73.00 74.00 75.00 7	05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05401 I NTERVENTI ONAL RADI OLOGY 05402 BREAST CENTER 05403 RADI ATI ON ONCOLOGY 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 I ULTRASOUND 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06401 HOME I NFUSI ON 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03140 CARDI OLOGY						50.00 51.00 52.00 52.00 54.01 54.02 54.02 54.03 55.00 56.00 56.00 57.00 58.00 59.00 60.01 61.00 62.00 63.00 64.00 64.01 65.00 64.00 64.01 65.00 64.00 64.01 65.00 67.00 68.00 71.00 72.00 73.00 74.00 75.00 74.00 75.00 74.00 75.00 74.00 75.00 75.00 74.00 75.00 75.00 75.00 70.00 71.00 75.00 75.00 70.00 70.00 71.00 72.00 75.00 75.00 75.00 75.00 75.00 75.00 70.00 70.00 70.00 71.00 75.00 7
90. 01 91. 00	09000 CLINIC 04951 SLEEP CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0	0 0 0		0 0 0 0 0 0		90.00 90.01 91.00 92.00
94.00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S 09500 AMBULANCE SERVI CES	0	0 0		0 0 0 0		94.00 95.00

Health Financial Systems	ELKHART GENERA	L HOSPITAL		In Lie	u of Form CMS-2552	-10
ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIR	CUMSTANCES	Provider C	F	Period: From 01/01/2014 Fo 12/31/2014	Worksheet L-1 Part I Date/Time Prepare 5/28/2015 1:02 pm	
Cost Center Description	PHARMACY	RECORDS & LI BRARY		Other General Servi ce OTHER GENERAL SERVI CE	PARAMED ED PRGM	
	15.00	16.00	17.00	18.00	23.00	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(	0 0	96.	
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	(	0 0	97.	
98.00 09851 OTHER REIMBURSABLE COST CENTERS	0	0	(	0 0	98.	
101.0010100 HOME HEALTH AGENCY	0	0	(	0 0	101.	00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE	0	0	(	0 0	113.	
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0	(	0 0	114.	00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	(	0 0	115.	00
116. 00 11600 H0SPI CE	0	0	(	0 0	116.	00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	(	0 0	0 118.	00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(	0 0	190.	00
191. 00 19100 RESEARCH	0	0	(	0 0	191.	00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(	0 0	192.	00
192. 01 19201 HOSPI TAL BASED CLINIC	0	0	(	0 0	192.	01
192. 02 19202 OUTPATI ENT PSYCH	0	О	(	o o	192.	02
193. 00 19300 NONPALD WORKERS	0	О	(	o c	193.	00
193. 01 19301 COMMUNI TY	0	О	(	o c	193.	01
194.0007950 OTHER NONREI MBURSABLE COST CENTERS	0	o	(	o o	194.	00
200.00 Cross Foot Adjustments					0 200.	00
201.00 Negative Cost Centers	0	o	(	o o	0 201.	
202.00 Total (sum of lines 118 and 190-201)	0	0	(	o o	0 202.	
203.00 Total Statistical Basis	4, 965, 505	536, 283, 204	13, 156	6 0	100 203.	
204.00 Unit Cost Multiplier	0. 000000	0. 000000	0. 000000		0. 000000 204.	
·····				-11		

LOCATION OF AL	LOWABLE COSTS FOR EXTRAORDINARY CI	RCUMSTANCES		Provi der	CCN: 150018		iod: m 01/01/2014 12/31/2014	Worksheet I Part I Date/Time F 5/28/2015	Prepar
Cost	Center Description	Subtotal		itern & lents Cost	Total				
				Post					
				epdown					
		24.00		<u>ustments</u> 25.00	26.00				
	RVICE COST CENTERS				1				
1 1	REL COSTS-BLDG & FIXT								1
	REL COSTS-MVBLE EQUIP DYEE BENEFITS DEPARTMENT								2
	VI STRATI VE & GENERAL								5
	TENANCE & REPAIRS								6
00 00700 OPER	ATION OF PLANT								7
	DRY & LINEN SERVICE								8
00 00900 HOUS									9
00 01000 DI ET 00 01100 CAFE									10
	TENANCE OF PERSONNEL								12
	ING ADMINISTRATION								13
	RAL SERVICES & SUPPLY								14
00 01500 PHAR									15
	CAL RECORDS & LIBRARY								16
00 01700 SOCI 00 01850 0THE	R GENERAL SERVICE								17
	MED ED PRGM								23
	ROUTINE SERVICE COST CENTERS								
. 00 03000 ADUL	TS & PEDIATRICS		0	0		0			30
	NSI VE CARE UNI T		0	0		0			31
	ATAL INTENSIVE CARE		0	0	2	0			31
	ROVIDER – IPF ROVIDER – IRF		0	0		0			40
00 04300 NURS			0	0		0			43
	LED NURSING FACILITY		0	0		0			44
	ING FACILITY		0	0		0			45
	R LONG TERM CARE		0	0		0			46
. 00 05000 OPER	SERVICE COST CENTERS		0	0	1	0			50
00 05100 RECO			0	0		0			51
	VERY ROOM & LABOR ROOM		0	0		0			52
. 00 05300 ANES			0	0		0			53
	DLOGY-DI AGNOSTI C		0	0		0			54
. 01   05401   I NTE . 02   05402   BREA	RVENTIONAL RADIOLOGY		0	0		0			54
	ATI ON ONCOLOGY		0	0		0			54
	DLOGY-THERAPEUTI C		0	0	)	0			55
00 05600 RADI			0	0		0			56
01 05601 ULTR			0	0		0			56
.00 05700 CT S .00 05800 MRI	JAN		0	0		0			57
	I AC CATHETERI ZATI ON		0	0		0			59
00 06000 LAB0			0	0		0			60
. 01  06001  BL00	D LABORATORY		0	0		0			60
	CLINICAL LAB SERVICES-PRGM ONLY								61
	E BLOOD & PACKED RED BLOOD CELL D STORING, PROCESSING & TRANS.		0	0		0			62
	AVENOUS THERAPY		0	0		0			64
01 06401 HOME			0	0		Ö			64
00 06500 RESP	RATORY THERAPY		0	0		0			65
00 06600 PHYS			0	0		0			66
			0	0		0			67
00 06800 SPEE 00 06900 ELEC			0	0		0			68
	TROENCEPHALOGRAPHY		ō	0		õ			70
00 07100 MEDI	CAL SUPPLIES CHARGED TO PATIENT		0	0		0			71
	DEV. CHARGED TO PATIENTS		0	0	)	0			72
	S CHARGED TO PATIENTS		0	0		0			73
00 07400 RENA	L DIALYSIS (NON-DISTINCT PART)		0	0		0			74
00 07500 ASC 00 03140 CARD	· ·		0	0		0			76
	SERVICE COST CENTERS		-1	0	1	<u> </u>			
. 00 09000 CLIN	IC		0	0		0			90
01 04951 SLEE			0	0	)	0			90
. 00 09100 EMER			0	0		0			91
	RVATION BEDS (NON-DISTINCT PART BURSABLE COST CENTERS								92
	PROGRAM DI ALYSI S	1	0	0		0			94
		1	0	0		0			1 14

Health Financial Systems	ELKHART GENE	RAL HOSPITAL		In Lieu	u of Form CMS-2552-10
ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY C	I RCUMSTANCES	Provi der	CCN: 150018	Period: From 01/01/2014 To 12/31/2014	Worksheet L-1 Part I Date/Time Prepared: 5/28/2015 1:02 pm
Cost Center Description	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	24.00	25.00	26.00		
96.00 09600 DURABLE MEDICAL EQUIP-RENTED		0 0		0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD		0 0		0	97.00
98.00 09851 OTHER REIMBURSABLE COST CENTERS		0 0		0	98.00
101.0010100 HOME HEALTH AGENCY		0 0		0	101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE		0 0		0	113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF		0 0		0	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)		0 0		0	115.00
116. 00 11600 HOSPI CE		0 0		0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)		0 0		0	118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0 0		0	190. 00
191. 00 19100 RESEARCH		0 0		0	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES		0 0		0	192.00
192. 01 19201 HOSPI TAL BASED CLINIC		0 0		0	192. 01
192. 02 19202 OUTPATI ENT PSYCH		0 0		0	192.02
193. 00 19300 NONPALD WORKERS		0 0		0	193.00
193. 01 19301 COMMUNI TY		0 0		0	193. 01
194.0007950 OTHER NONREIMBURSABLE COST CENTERS		0 0		0	194.00
200.00 Cross Foot Adjustments		0		0	200.00
201.00 Negative Cost Centers		0		0	201.00
202.00 Total (sum of lines 118 and 190-201)		0 0		0	202.00
203.00 Total Statistical Basis					203.00
204.00 Unit Cost Multiplier					204.00
	I	1 I		I.	1-11100