Health Financia	al Systems	COMMUNITY HOSPT. OF LAG	GRANGE CTY IN	In Lie	u of Form CMS-2552-1
This report is	required by law (42 USC 1395g;	42 CFR 413.20(b)). Failu	ire to report can res	sult in all interim	FORM APPROVED
payments made	since the beginning of the cost	t reporting period being d	leemed overpayments ((42 USC 1395g).	OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COS SUMMARY	ST REPORT CERTIFICATION	Provi der CCN: 15132	Peri od: From 01/01/2014 To 12/31/2014	
PART I - COST	REPORT STATUS				·
Provi der use onl y	1. [X] Electronically filed of 2. [] Manually submitted cos 3. [0] If this is an amended 4. [F] Medicare Utilization.	t report report enter the number of		Date: 5/21/20 resubmitted this co	The state of the s
Contractor use only	5. [1]Cost Report Status 6 (1) As Submitted 7 (2) Settled without Audit 8 (3) Settled with Audit 9	. Contractor No.	this Provider CCN 12		

PART II - CERTIFICATION

(4) Reopened (5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPT. OF LAGRANGE CTY IN (151323) for the cost reporting period beginning 01/01/2014 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.

(Si gned)	
	Officer or Administrator of Provider(s)
Ti tl	<u> </u>
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	113, 803	-26, 258	156, 270	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	-79, 131	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	34, 672	-26, 258	156, 270	0	200. 00

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

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

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151323 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/21/2015 9:27 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 207 NORTH TOWNLINE ROAD 1.00 PO Box: 1.00 State: IN Zip Code: 46761-1325 County: LAGRANGE 2.00 City: LAGRANGE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY HOSPT. OF 151323 99915 05/01/2005 Ν 0 3.00 LAGRANGE CTY IN Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF SWING BEDS 157323 99915 7 00 05/01/2005 N 0 N 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Hospital-Based (CORF) I 17.10 17.10 17. 20 Hospi tal -Based (OPT) I 17.20 17.30 Hospital-Based (00T) I 17.30 Hospi tal -Based (OSP) I 17.40 17.40 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2014 12/31/2014 20.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22 00 N N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting N Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be 22.02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" for yes or "N" fo<u>r no</u> used in the prior cost reporting period? In column 2 In-State Medi cai d 0ther In-State Out-of Out-of Medi cai d Medi cai d State State HMO days Medi cai d el i gi bl e Medi cai d Medi cai d paid days days unpai d paid days el i gi bl e unpai d davs 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

		pai d da		el i gi bl e unpai d days	Medicaid paid days	Medi eli	i cai d gi bl e pai d	TIMO GE		days	
	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	1.00	0	2.00	3.00		. 00	5. 00	0	6.00	25. 00
						l	Urban/R 1. (of Geogr 2.00	
26. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for	age) sta	itus a	it the beg	inning of 1	the		2			26. 00
27. 00	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) sta ~ "2" fo	r rur	al. If ap		st		2			27. 00
	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number	ofp	eriods SC	CH status ir	n		0)		35. 00
							Begi ni			di ng: 2. 00	
	Enter applicable beginning and ending dates of SCH st		Subscr	ipt line	36 for numb	ber				00	36. 00
37. 00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter in effect in the cost reporting period.	the nu		·				0			37. 00
	Enter applicable beginning and ending dates of MDH st of periods in excess of one and enter subsequent date		ubscr	ript line	38 FOR NUME	oer					38. 00
							Y/ 1. (-	Y/N 2. 00	
	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec)? Ente uiremen	er in nts in	column 1 accordar	"Y" for yes nce with 42	S	N	I		N	39. 00
	CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	n adjust per 1. E	ment? Inter	Enter "Y "Y" for y	" for yes o	or	N	I		N	40. 00
		·		·		·		V 1. 00	XVI I		
45. 00	<u>Prospective Payment System (PPS)-Capital</u> Does this facility qualify and receive Capital paymer	nt for d	li sprc	porti onat	e share in	acco	rdance	N	N	N	45. 00
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wksi							N	N	N	46. 00
47. 00	Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capi							N	N	N	47. 00
	<u>ls the facility electing full federal capital payment</u> Teaching Hospitals							N	N	N	48. 00
	Is this a hospital involved in training residents in or "N" for no.	approve	ed GME	programs	? Enter "\	Y" fo	r yes	N			56. 00
	If line 56 is yes, is this the first cost reporting programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month for yes or "N" for no in column 2. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	yes or th of th (", comp	"N" nis co olete	for no ir st report Worksheet	n column 1. ing period?	lfc ? En	olumn ´ ter "Y'				57.00
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, § 2148? If yes, complete Wh			physicia	ıns' service	es as		N			58. 00
59. 00 60. 00	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"	s, compl costs f	ete W for a	program t	hat meets t		ions)	N N			59. 00 60. 00
		Y/N		IME	Direct GN		IN	1E	Di re	ect GME	
(1.00	Did years best in ETF 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1. 00		2. 00	3. 00		4.	00		5. 00	(1.00
61. 01	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions)	N		0. 00	(0. 00		0.00		0.00	61. 00
	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)			0.00	(0. 00					61. 02

nancial Systems	COMMUNITY HOSPT. OF LAGRANGE CTY IN	In Lieu of Form

Health Financial Systems	COMMUNITY HO	SPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	X IDENTIFICATION DA	TA	Provi der		eri od:	Worksheet S-2	
				T ₀	rom 01/01/2014 o 12/31/2014	Part Date/Time Pre	pared:
)/ (NI	Luc	D: 1 0ME	LME	5/21/2015 9: 2	7 am
		Y/N	IME	Direct GME	IME	Direct GME	
		1. 00	2. 00	3. 00	4. 00	5.00	
61.03 Enter the base line FTE count for			0.00	0.00			61. 03
and/or general surgery residents, determining compliance with the 75							
instructions)	n test. (see						
61.04 Enter the number of unweighted pri			0.00	0.00			61. 04
surgery allopathic and/or osteopat							
current cost reporting period. (see 61.05 Enter the difference between the b			0.00	0.00			61. 05
and/or general surgery FTEs and th			0.00	0.00	1		01.03
primary care and/or general surger							
61.04 minus line 61.03). (see inst 61.06 Enter the amount of ACA §5503 awar			0.00	0.00			61. 06
used for cap relief and/or FTEs th			0.00	0.00	1		01.00
care or general surgery. (see inst							
		Pr	ogram Name	Program Code	Unweighted IME		
					FTE Count	Direct GME FTE Count	
			1. 00	2. 00	3. 00	4. 00	
61.10 Of the FTEs in line 61.05, specify	each new program				0.00		61. 10
specialty, if any, and the number							
for each new program. (see instruc column 1, the program name, enter							
program code, enter in column 3, t							
unweighted count and enter in colu	mn 4, direct GME						
FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify	, anch avnandad				0. 00	0.00	61. 20
61.20 Of the FTEs in line 61.05, specify program specialty, if any, and the					0.00	0.00	01.20
residents for each expanded progra							
instructions) Enter in column 1, t							
enter in column 2, the program cod 3, the IME FTE unweighted count an							
4, direct GME FTE unweighted count							
						1.00	
ACA Provisions Affecting the Healt	h Resources and Ser	vi ces	Administration	(HRSA)		1. 00	
62.00 Enter the number of FTE residents					od for which	0.00	62.00
your hospital received HRSA PCRE f				(7110)			
62.01 Enter the number of FTE residents during in this cost reporting peri					your hospital	0.00	62. 01
Teaching Hospitals that Claim Resi				13)			
63.00 Has your facility trained resident	s in nonprovider se	ettings	during this co		eriod? Enter	N	63. 00
"Y" for yes or "N" for no in colum	ın ı. IT yes, comple	ete IIne	es 64-67. (See	Unweighted	Unwei ghted	Ratio (col. 1/	
				FTEs	FTEs in	(col. 1 + col.	
				Nonprovi der	Hospi tal	2))	
				1. 00	2.00	3.00	
Section 5504 of the ACA Base Year	FTE Residents in No	nprovi	der Settinas				
period that begins on or after Jul	y 1, 2009 and befor	e June	30, 2010.				
64.00 Enter in column 1, if line 63 is y				0.00	0. 00	0. 000000	64. 00
in the base year period, the numbe 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							
or (cordinir rarvided by (cordinir r	Program Name		ogram Code	Unweighted	Unweighted	Ratio (col. 3/	
	ý .		•	FTĔs	FTEs in	(col. 3 + col.	
				Nonprovi der	Hospi tal	4))	
	1. 00		2. 00	Si te 3. 00	4. 00	5. 00	
	1.00		2.00	3.00	4.00	5.00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151323 Peri od: Worksheet S-2 From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/21/2015 9:27 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010
Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, enter 1, 2, or 3, in column 3. (see instructions) If this cost reporting period covers the beginning of the fourth year, enter 4 in column 3, or if the fifth or subsequent academic years of the new teaching program in existence, enter 5. (see instructions) For cost reporting periods beginning on or after October 1, 2012, if this cost reporting period covers the beginning of the sixth or any subsequent academic year of the new teaching program in existence, enter 6 in column 3. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF subprovider? Enter "Y" for yes and "N" for no. N 75 00

109.00 If this hospital qualifies as a CAH or a cost provider, ar	e N	N	N		N		109.00
therapy services provided by outside supplier? Enter "Y"							
for yes or "N" for no for each therapy.							
	•						
					1. 0	00	1
110.00 Did this hospital participate in the Rural Community Hospi	tal Demonstratio	on project (410	A Demo)for	r	N		110.00
the current cost reporting period? Enter "Y" for yes or "N		1 3					
				1. 00	2. 00	3.00	1
Miscellaneous Cost Reporting Information							
115.00 s this an all-inclusive rate provider? Enter "Y" for yes	or "N" for no ir	n column 1. If	column 1	N		0	115. 00
is yes, enter the method used (A, B, or E only) in column							
3 either "93" percent for short term hospital or "98" perc							
psychiatric, rehabilitation and long term hospitals provid							
Pub. 15-1, §2208. 1.	5. 5) Dassa 5 t.						
				1			
116.00Hs this facility classified as a referral center? Enter "Y	' for ves or "N'	' for no.		l N			116.00
116.00 s this facility classified as a referral center? Enter "Y			N" for	N Y			116.00
117.00 Is this facility legally-required to carry malpractice ins			N" for	N Y			116. 00 117. 00
	urance? Enter "\	(" for yes or "		N Y			

49.00 was there a change to the simplified cost finding method? Enter 1 for yes or N for N 149.									
no.									
	Part A	Part B	Title V	Title XIX					
	1.00	2.00	3.00	4. 00					
Does this facility contain a provider that qualifies for an	exemption from	m the applicati	on of the lowe	r of costs					
or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)									
155. 00 Hospi tal	N	N	N	N	155. 00				
156.00 Subprovider - IPF	N	N	N	N	156. 00				
157.00 Subprovider - IRF	N	N	N	N	157. 00				
158. 00 SUBPROVI DER					158. 00				
159. 00 SNF	N	N	N	N	159. 00				
160.00 HOME HEALTH AGENCY	N	N	N	N	160. 00				
161. 00 CMHC		N	N	N	161. 00				
161. 10 CORF		N	N	N	161. 10				
161. 20 OUTPATI ENT PHYSI CAL THERAPY		N	N	N	161. 20				

Health Financial Systems	COMMUNITY HOSE	PT. OF	LAGRANGE CTY	ΙN			In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Ą	Provi der	CCN: 1513:			/01/2014 /31/2014	Worksheet S-2 Part I Date/Time Pro 5/21/2015 9:2	epared:
			Part A	Part	В	Ti 1	tle V	Title XIX	
			1.00	2.0)	3	3. 00	4.00	
161.30 OUTPATIENT OCCUPATIONAL THERAPY				N			N	N	161. 30
161. 40 OUTPATIENT SPEECH PATHOLOGY				N			N	N	161. 40
								1.00	
Mul ti campus									
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus hospital that h	as one	e or more campu	uses in di	ffere	nt CBS	As?	N	165. 00
	Name		County	State	Zip (Code	CBSA	FTE/Campus	
	0		1. 00	2. 00	3. (00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)								0.0	0 166. 00
								1.00	
Health Information Technology (HI									4.7.00
167.00 s this provider a meaningful user								Υ 100.07	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H				9 16/ 18	Y), (enter	tne	199, 37 	3168. 00
169.00 If this provider is a meaningful utransition factor. (see instruction	user (line 167 is "Y")			(line 105	is "N	"), en	ter the	0.0	0169. 00
(555 11151 555 1156 1156 1156 1156 1156						Begi	nni ng	Endi ng	
					Ī	1	. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR Legeriod respectively (mm/dd/yyyy)	peginning date and en	ding d	date for the re	eporti ng		10/0	1/2013	09/30/2014	170. 00
								1. 00	
171.00 ffline 167 is "Y", does this prov Medicare cost plans reported on Wh (see instructions)							r no.	N	171. 00

		UNITY HOSPT. OF LAG			In Lie	eu of Form CMS	<u>-2552</u> -10
HOSPI T	TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUES	STI ONNAI RE	Provi der		Period: From 01/01/2014 To 12/31/2014	Date/Time Pr	epared:
	·				Y/N	5/21/2015 9: Date	27 am
	General Instruction: Enter Y for all YES resp	oness Enter N for	all NO sa	nonences Ente	1.00	2.00	
	mm/dd/yyyy format.	onses. Enter N For	all NO FE	esponses. Ente	all dates in	rne	
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation						
1. 00	Has the provider changed ownership immediatel reporting period? If yes, enter the date of t				N		1.00
		<u>.</u>		Y/N	Date	V/I	
2. 00	Has the provider terminated participation in	the Medicare Progra	am? If	1. 00 N	2. 00	3. 00	2.00
	yes, enter in column 2 the date of terminatic voluntary or "I" for involuntary.						
3.00	Is the provider involved in business transact contracts, with individuals or entities (e.g. or medical supply companies) that are related officers, medical staff, management personnel of directors through ownership, control, or frelationships? (see instructions)	, chain home offic d to the provider o , or members of the	es, drug r its e board	N			3.00
				Y/N	Туре	Date	
	Financial Data and Reports			1.00	2. 00	3. 00	
4. 00	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see instr	Audited, "C" for Coenter date availab	ompiled,	Y	A		4. 00
5. 00	Are the cost report total expenses and total those on the filed financial statements? If y	revenues different		N			5. 00
				•	Y/N	Legal Oper.	
	Approved Educational Activities				1. 00	2. 00	
6. 00	Column 1: Are costs claimed for nursing school the legal operator of the program?	ool? Column 2: If	yes, is th	he provider is	N		6. 00
7. 00 8. 00	Are costs claimed for Allied Health Programs? Were nursing school and/or allied health prod			d during the	N N		7. 00 8. 00
9. 00	cost reporting period? If yes, see instruction Are costs claimed for Intern-Resident program	ons.		o o	N		9. 00
10. 00	yes, see instructions.			·	N		10.00
	period? If yes, see instructions.			, ,			
11. 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		ın an App	proved	N		11. 00
						Y/N 1.00	
12 00	Bad Debts	1 1-1-1-2 16	- !+	. :		l v	12.00
	Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad deb period? If yes, submit copy.	,			st reporting	Y N	12. 00 13. 00
14. 00	If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments	waived? If	f yes, see ins	tructions.	N	14. 00
15. 00	Did total beds available change from the price	or cost reporting p	eriod? If	yes, see inst	ructions.	N	15. 00
		Descriptio	n	Y/N	rt A Date	Part B Y/N	
		0	11	1.00	2. 00	3. 00	
		U					
16. 00	Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R	0		N		N	16. 00
16. 00 17. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)			N Y	04/30/2015	N Y	16. 00

18.00

19.00

20.00

Ν

Ν

Ν

instructions.

the other adjustments:

18.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file

this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of

20.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe

other PS&R Report information? If yes, see

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

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 151323 Peri od: Worksheet S-2 From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/21/2015 9:27 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 N provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provi der-Based Physi ci ans Are services furnished at the provider facility under an arrangement with provider-based physicians? Ν 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position FRIC NI CKESON 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. 42.00 | Enter the employer/company name of the cost report PARKVIEW HEALTH SYSTEM, INC. 42.00 preparer. 43.00 Enter the telephone number and email address of the cost (260) 373-8406 ERIC. NI CKESON@PARKVI EW. COM 43.00 report preparer in columns 1 and 2, respectively.

report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 151323 Peri od: Worksheet S-2 From 01/01/2014 To 12/31/2014 Part II Date/Time Prepared: 5/21/2015 9:27 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 04/30/2015 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

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

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 151323

						10 12/31/2014	5/21/2015 9: 2	
							I/P Days / O/P	, diii
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	35p31.0111	Line Number	1101	0. 2000	Avai I abl e	57 W. 1.10 G. 1		
		1. 00		2.00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		25	9, 12	5 66, 960. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4.00	HMO IRF Subprovider							4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6.00
7.00	Total Adults and Peds. (exclude observation			25	9, 12	5 66, 960. 00	0	7. 00
	beds) (see instructions)							
8. 00	INTENSIVE CARE UNIT							8. 00
9.00	CORONARY CARE UNIT							9. 00
10. 00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13.00	NURSERY	43. 00					0	13. 00
14. 00	Total (see instructions)			25	9, 12	5 66, 960. 00		14. 00
15. 00	CAH visits						0	15. 00
16. 00	SUBPROVIDER - IPF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20.00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)							23. 00
24. 00	HOSPI CE	00.00						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC	00.40						25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
25. 20	CMHC - OUTPATIENT PHYSICAL THERAPY	99. 20					0	25. 20
25. 30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99. 30					0	25. 30
25. 40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99. 40					0	25. 40
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER			25				26. 25
27. 00	Total (sum of lines 14-26)			25	9			27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00 30. 00	Ambul ance Trips							29. 00 30. 00
30.00	Employee discount days (see instruction) Employee discount days - IRF							30.00
31.00	Labor & delivery days (see instructions)			C		0		31.00
32. 00	Total ancillary labor & delivery room			C	Ί	٥		32. 00 32. 01
32. UI	outpatient days (see instructions)							J2. U1
33 00	LTCH non-covered days							33. 00
55. 56	2.3 55401 64 4435		ı		1	1	1	50.00

33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 151323

Peri od: Worksheet S-3 From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

5/21/2015 9:27 am Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 6.00 7.00 8.00 9.00 10.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 1,015 230 2, 528 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 474 2 00 3.00 HMO IPF Subprovider 0 0 3.00 HMO IRF Subprovider 4.00 4.00 Hospital Adults & Peds. Swing Bed SNF 401 0 401 5.00 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 C 155 6.00 7.00 Total Adults and Peds. (exclude observation 1, 416 230 3,084 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 197 593 13.00 14.00 Total (see instructions) 1,416 427 3,677 0.00 176.20 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24 00 24 00 24. 10 HOSPICE (non-distinct part) 0 0 24.10 CMHC - CMHC 25.00 25.00 0 25. 10 CMHC - CORF 0 0.00 0.00 25. 10 CMHC - OUTPATIENT PHYSICAL THERAPY 0 0.00 0 0.00 25. 20 25 20 25. 30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 0.00 0.00 25.30 CMHC - OUTPATIENT SPEECH PATHOLOGY 0.00 0.00 25.40 RURAL HEALTH CLINIC 26, 00 26, 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26.25 27.00 Total (sum of lines 14-26) 0.00 176. 20 27.00 28.00 Observation Bed Days 58 28.00 663 Ambul ance Trips 4.401 29 00 29 00 30.00 Employee discount days (see instruction) 47 30.00 Employee discount days - IRF 31.00 C 31.00 Labor & delivery days (see instructions) 32.00 32.00 53 0 227 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions)

0

33.00 LTCH non-covered days

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 151323

Peri od: Worksheet S-3 From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

5/21/2015 9:27 am Full Time Di scharges Equi val ents Title V Title XVIII Total All Component Nonpai d Title XIX Workers Pati ents 12.00 13.00 11.00 14.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 273 101 933 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 112 0 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 933 14.00 Total (see instructions) 0.00 0 273 101 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24 00 24 00 24. 10 HOSPICE (non-distinct part) 24. 10 25. 00 CMHC - CMHC 25.00 25. 10 CMHC - CORF 0.00 25. 10 CMHC - OUTPATIENT PHYSICAL THERAPY 0.00 25 20 25 20 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 25.30 0.00 25.30 CMHC - OUTPATIENT SPEECH PATHOLOGY 0.00 25.40 RURAL HEALTH CLINIC 26.00 26, 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26 25 27. 00 Total (sum of lines 14-26) 0.00 27.00 28.00 Observation Bed Days 28.00 29 00 Ambulance Trips 29 00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 31.00 Labor & delivery days (see instructions) 32.00 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00

Heal th	Financial Systems COMMUNITY HOSPT. OF LAGRANGE	CTY IN	In Lie	eu of Form CMS-2	2552-10	
		ider CCN: 151323	Peri od:	Worksheet S-1		
			From 01/01/2014			
			To 12/31/2014	Date/Time Pre 5/21/2015 9: 2		
				1. 00		
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	by line 202 colum	າ 8)	0. 324853	1.00	
	Medicaid (see instructions for each line)		,	<u>'</u>	ĺ	
2.00	Net revenue from Medicaid			560, 620	2.00	
3.00	Did you receive DSH or supplemental payments from Medicaid?			Y	3.00	
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental paymental pa	ents from Medicai	d?	N	4.00	
5.00	If line 4 is "no", then enter DSH or supplemental payments from Medic	cai d		-147, 579	5. 00	
6.00	Medi cai d charges			7, 576, 412	6. 00	
7.00	Medicaid cost (line 1 times line 6)			2, 461, 220	7. 00	
8.00	Difference between net revenue and costs for Medicaid program (line	7 minus sum of li	nes 2 and 5; if	2, 048, 179	8. 00	
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instructions	for each line)				
9. 00	Net revenue from stand-alone SCHIP			0		
10.00	Stand-alone SCHIP charges			0		
11. 00	Stand-alone SCHIP cost (line 1 times line 10)			0		
12. 00	Difference between net revenue and costs for stand-alone SCHIP (line	11 minus line 9;	if < zero then	0	12. 00	
	enter zero)	6 !				
12 00	Other state or local government indigent care program (see instruction			147, 750	12 00	
13. 00 14. 00						
14.00	10)	iani (Not inciuded	III IIIles o oi	842, 280	14.00	
15. 00	State or local indigent care program cost (line 1 times line 14)			273, 617	15. 00	
16. 00	Difference between net revenue and costs for state or local indigent	care program (Li	ne 15 minus line	125, 867	16. 00	
10.00	13; if < zero then enter zero)	care program (11	ie ie iii iids iiiie	120,007	10.00	
	Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to funding	charity care		0	17. 00	
18.00	Government grants, appropriations or transfers for support of hospital	al operations		0	18. 00	
19.00	Total unreimbursed cost for Medicaid, SCHIP and state and local ind	igent care progra	ms (sum of lines	2, 174, 046	19. 00	
	8, 12 and 16)					
		Uni nsured	Insured	Total (col. 1		
		pati ents	pati ents	+ col . 2)		
	T	1.00	2. 00	3.00	00.00	
20. 00	Total initial obligation of patients approved for charity care (at for		35 673, 367	1, 274, 802	20. 00	
21 00	charges excluding non-reimbursable cost centers) for the entire facil		70 210 745	414 100	21 00	
21. 00	Cost of initial obligation of patients approved for charity care (lilitimes line 20)	ne 1 195, 3	78 218, 745	414, 123	21.00	
22. 00	Partial payment by patients approved for charity care	2, 2	73 6, 995	0 260	22. 00	
23. 00	Cost of charity care (line 21 minus line 22)	193, 1				
23.00	1003t of Ghality care (Title 21 millius Title 22)	173, 1	211,730	404, 655	23.00	
				1. 00		
24. 00	Does the amount in line 20 column 2 include charges for patient days	beyond a Length	of stay limit	N	24. 00	
	imposed on patients covered by Medicaid or other indigent care progra		,			
25.00	If line 24 is "yes," charges for patient days beyond an indigent cal		th of stay limit	0	25. 00	
26.00	Total bad debt expense for the entire hospital complex (see instruct	ions)	-	3, 700, 000	26. 00	
27.00	Medicare bad debts for the entire hospital complex (see instructions)		269, 455	27. 00	
28 00	Non-Medicare and non-reimbursable Medicare had debt expense (Line 26	minus line 27)		3 430 545	28 00	

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

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

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

1, 519, 278 30. 00 3, 693, 324 31. 00

3, 430, 545

1, 114, 423

28.00

Const. Center Description Self are less Other Total (col.) Total (col		Financial Systems — — — — — — — — — — — — — — — — — — —	UNITY HOSPI. OF F EXPENSES			eriod:	u of Form CMS-: Worksheet A	2552-10
Cost Center Description	KLOLAS	STITICATION AND ADSOSTMENTS OF THE BALANCE O	I EXI ENGLS	11 Ovi dei	F	rom 01/01/2014		
Cost Center Description					'	0 12/31/2014	Date/IIMe Pre 5/21/2015 9:2	pared: 7 am
1.00		Cost Center Description	Sal ari es	Other			Recl assi fi ed	
BENEVAL SEPRO FE CREST CREATERS					+ col . 2)	ons (See A-6)		
1.00			1. 00	2. 00	3. 00	4. 00		
1.01	1 00			1 501 200	1 501 200	252 17/	1 240 104	1 00
2.00 002000 CAP REL DOSTS-AVENEL EDUILP 0 0 511.952 511.952 2.00				1, 501, 280	1, 501, 280			•
3.00 00000 OTHER CAR PEL COSTS				o	C			
0.00 0.00 DEMILOYEE BENEFITS DEPARTIENT 1,335,998 2,686,207 4,022,205 4,088 8,170,808 5,00 5,00 0.0				0	C	19, 818		
5.00 00000 DOSOD AMINISTRATIVE & CENERAL 5.451,811 2.764,760 8.2°0,577 -45,988 8.170,989 5.00 000000 DOSOD MISTRANCE APPRIL S 254,829 740,240 995,069 2.3777 771,722 7.00 000000 DOSOD DEPART IN CONTROL SERVICE 1.507 26.461 188,030 777,592 777,592 770,920 770,920 18.00 00000 DOSOD METARY SERVICE 1.507 26.461 188,030 777,592 777,592 770,920 18.00 00000 DOSOD METARY SERVICE 1.507 26.461 188,030 777,592 777,592 770,920 18.00 0000 DOSOD METARY SERVICE S.107 26.40 188,030 777,592 777,592 770,920 18.00 0000 DOSOD METARY SERVICES SERVICE			1 225 000	2 696 267	4 022 26E	0		
0.00 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000000						1		
8.00 0.0000 LAURDRY & 1 INFN SERVICE 0 77, 592 77, 592 0 77, 592 8.00 70, 592 11.000 10.000 DIETARY 321, 207 261, 663 582, 270 -347, 165 235, 106 10.000 10.000 DIETARY 321, 207 261, 663 582, 270 -347, 165 235, 106 10.000 10.000 DIETARY 321, 207 261, 663 582, 270 -347, 165 235, 106 10.000 10.000 DIETARY 321, 207 261, 663 582, 270 -347, 165 235, 106 10.000 10.000 130.000 DIETARY 321, 207 274, 899 -77 -72, 197 -3 -21, 921, 921 14.000 130.000 DIETARY 400, 105 130.000 DIETARY 404, 105 1, 105, 032 1, 509, 197 -1, 018, 145 491, 052 14.000 15.000 DIETARY 404, 105 1, 105, 032 1, 509, 197 -1, 018, 145 491, 052 15.000 130.000 DIETARY 404, 105 1, 105, 032 1, 509, 197 -1, 018, 145 491, 052 15.000 17.000 0.0000 0.000 0.000 0.000 0.000 0.0000 0.000 0.0000 0.000		00600 MAINTENANCE & REPAIRS	0	0	C	O		6. 00
9.00 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000000		· ·	254, 829			1		ł
10.00 01000 DETARY 321, 207 261, 063 582, 270 -347, 165 229, 108 10.00 10.			161 597			l l		
12.00 01200 MAINTENANCE OF PERSONNEL 0 0 0 2.00		l l	1					ł
13.00 01300 NURSI NG ADMINISTRATION 274, 899 676 275, 575 -45 275, 530 13.00			0	o	C	345, 029		
14.00 01400 (CENTRAL SERVICES & SUPPLY 404,165 01,105,032 1,509,197 -1.018,145 491,002 11.00 01500 (DHABMACY) 404,165 01 1,105,032 1,509,197 -1.018,145 491,002 11.00 01700 (DHABMACY) 404,165 01 1,105,032 1,509,197 -1.018,145 491,002 11.00 01700 (DHABMACY) 404,165 01 0 0 0 0 0 0 0 0 10 10.00 01 10.00 01 10.00 01 00 0 0 0			274 900	0 474	275 575	0		
15.00 0 1500 [PIARMACY 404,165 1,105,032 1,509,197 -1,108,145 491,052 15.00 17.00 0 1700 [OSCIAL SERVICE 0			274, 699	•				
17.00 01700 NONPHYSICTAN AMSSTHETISTS 0 0 0 0 0 0 0 19.00			404, 165					ı
19.00 01900 NONPHYSIC IAM AMESTHETI STS 0 0 0 0 0 0 20.00 20.00 20.00 UNISIN SIG SCHOOL 0 0 0 0 0 0 0 0 0			0	0	C	0		
20.00				0	(0	
22.00 02200 RAR SERVICES-OTHER PROM COSTS APPRY 0			o	o	C	Ö	0	
23. 00 02300 PARAMED ED PRICAL-(SPECIEV) 0 0 0 0 0 23. 00			0	o	C	o	0	
INPATI ENT JULY SERVICE COST CENTERS 1, 467, 342 229, 681 1, 697, 023 -561, 214 1, 135, 809 30. 00 30. 00 3000 NULTS & PEDI ATRIC S 1, 467, 342 229, 681 1, 697, 023 -561, 214 1, 135, 809 30. 00 04300 NURSERY 0 0 0 0 141, 774 141, 774 43. 00 0 0 0 0 0 0 0 0 0			0	0	C	0	· ·	•
10,00 03000 ADULTS & PEDI ATRICS 1,467,342 229,661 1,697,023 -561,214 1,135,809 30,00	23.00		l U	U		ıl U	0	23.00
ANCILLARY SERVICE COST CENTERS 1,029,813 50.00 50.00 00 00 00 141,989 1,029,813 50.00 50.00 00 00 00 00 0	30.00		1, 467, 342	229, 681	1, 697, 023	-561, 214	1, 135, 809	30.00
50.00	43.00		0	0	C	141, 774	141, 774	43.00
52.00	50 00		711 145	377 684	1 088 829	-58 998	1 029 831	50 00
54 00 05400 RADI DLOGY-DIAGNOSTIC 568, 241 472, 573 1, 040, 814 -88, 055 952, 755 54, 00 00 00 00 00 00 00 00			0	0				
0.0 0.0000 LABORATORY 0 843, 681 843, 681 -1, 274 842, 407 60. 00 0.2 62. 30 0.0 0.0 0.0 0.0 62. 30 0.0			0			1		1
62.30 06.250 BLOOD CLOTTI NG FOR HEMOPHILIACS 0 0 0 0 0 0 0 0 0			1					1
65.00 06500 RESPI RATORY THERAPY 284, 824 26, 762 311, 586 -4, 501 307, 085 65.00		· ·		043,081				1
67.00 06700 06700 06700 06700 06700 0685,027 85,027 87.00 68.00 06800	65.00	06500 RESPI RATORY THERAPY	1			1		65. 00
68.00 06800 0880			488, 441	11, 261	499, 702			
69-00 06900 06900 01-00 05900 071-00 071-00 071-00 071-00 071-00 071-00 071-00 071-00 071-00 071-00 071-00 071-00 071-00 072-00 072-00 072-00 1MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 208, 143 208, 143 72. 00 073-00 1MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 1, 018, 650 1, 018, 650 73. 00 073-00 070-				0	C	1		
72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 208, 143 2.08, 143 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 1,018,650 1,018,650 73.00 07697 CARDIA C REHABILITATION 0 0 0 0 0 0 0 0 76.98 76.99 07697 CARDIA C REHABILITATION 0 0 0 0 0 0 0 0 76.98 76.99 07699 LITHORIR PSY 0 0 0 0 0 0 0 0 0		06900 ELECTROCARDI OLOGY	Ö	1, 325	1, 325			
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 1,018,650 1,018,650 73.00 76.97 07697 CARDI AC REHABI LITATI ON 0 0 0 0 0 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 76.98 76.99 07699 LITHOTRI PSY 0 0 0 0 0 0 0 0 76.99 OUTPATI ENT SERVI CE COST CENTERS 90.00 09000 CLI NI C 3,685 472 4,157 1,556 5,713 90.00 90.01 1,018,650 73.00 90.00 1,019,011 FEBRI DGS SENI OR CARE 108,771 97,744 206,515 -564 205,951 90.01 91.00 09100 EMERGENCY 646,861 1,528,103 2,174,964 -41,054 2,133,910 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS 99.10 09910 CORF 0 0 0 0 0 0 0 0 0 99.10 99.20 09920 OUTPATI ENT PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 99.10 99.30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 99.20 99.30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 99.40 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 157,724 157,724 -157,724 0 113.00 113.00 11300 INTEREST EXPENSE 5 157,724 157,724 -157,724 0 113.00 113.00 11300 INTEREST EXPENSE 157,104,000 61,340 91,000 190.00			0	524, 554				
76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 76. 99 07699 LITHORI PSY 0 0 0 0 76. 99 07699 07699 07699 07699 07699 07699 76. 99 07699 07699 07699 07699 07699 07699 76. 99 07699 07699 07699 07699 07699 07699 76. 99 07699 07699 076999 07699 07699 07699 76. 99 07699 07699 07699 07699 07699 07699 76. 99 07699 07699 07699 07699 07699 07699 07699 76. 99 07699 07699 07699 07699 07699 07699 07699 07699 76. 99 07699 07699 07699 07699 07699 07699 07699 07699 07699 07699 07699 76. 99 076999 076999 07699			0	0				
76. 99 007699 LI THOTRI PSY 00 00 00 00 0 0 0 0 0 0 76. 99 00070 CLI NI C 90. 01 09001 LI FEBRI DGE SENI OR CARE 108, 771 97, 744 206, 515 -564 205, 951 90. 01 91. 00 09100 EMERGENCY 092. 00 09500 AMBULANCE SERVI CES 108, 771 97, 744 206, 515 -564 205, 951 90. 01 92. 00 09500 OBSERVATI ON BEDS (NON-DI STI NCT PART 0710 PRT REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 99. 10 09910 CORF 99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 99. 10 99. 20 09920 OUTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 99. 20 99. 30 09930 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 99. 30 99. 40 09940 OUTPATI ENT SPEECH PATHOLOGY 113. 00 11300 INTEREST EXPENSE 113. 00 11300 INTEREST EXPENSE 114. 00 1900 GI FT, FLOWER, COFFEE SHOP & CANTEEN 1190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 19			o	Ö				
OUTPATI ENT SERVICE COST CENTERS 90. 00 0000 CLI NI C 3,685 472 4,157 1,556 5,713 90. 00 90. 01 0000 CLI NI C 108,771 97,744 206,515 -564 205,951 90. 01 91. 00 0010 EMERGENCY 646,861 1,528,103 2,174,964 -41,054 2,133,910 91. 00 92. 00 0BSERVATI ON BEDS (NON-DISTINCT PART 92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 92. 00 09500 AMBULANCE SERVICES 869,454 331,681 1,201,135 -194 1,200,941 95. 00 99. 10 99. 20 09920 0UTPATI ENT PHYSI CAL THERAPY 0 0 0 0 0 0 99. 10 99. 30 09930 0UTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 99. 30 99. 40			1	o				
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90. 01 09001 LI FEBRI DGE SENI OR CARE 108,771 97,744 206,515 -564 205,951 90. 01 91. 00 09100 EMERGENCY 646,861 1,528,103 2,174,964 -41,054 2,133,910 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 07 0 07 07 07 07 07 07	90. 00		3, 685	472	4, 157	1, 556	5, 713	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REI MBURSABLE COST CENTERS S69, 454 331, 681 1, 201, 135 -194 1, 200, 941 95. 00 99. 10 O9910 CORF O O O O O O O O O O O O O O O O O O			108, 771		206, 515	-564	205, 951	90. 01
OTHER REI MBURSABLE COST CENTERS S69, 454 331, 681 1, 201, 135 -194 1, 200, 941 95. 00			646, 861	1, 528, 103	2, 174, 964	-41, 054	2, 133, 910	•
95. 00	92.00							92.00
99. 20	95.00		869, 454	331, 681	1, 201, 135	-194	1, 200, 941	95. 00
99. 30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 99. 30 99. 40 O9940 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 157, 724 157, 724 -157, 724 0 113. 00 118. 00 SUBTOTALS (SUM OF LINES 1-117) 13, 353, 270 14, 408, 499 27, 761, 769 -161, 245 27, 600, 524 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 7, 342 7, 342 0 7, 342 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 1, 884 1, 884 -519 1, 365 192. 00 194. 00 07950 OCCUPATI ONAL HEALTH 0 -161, 764 -161, 764 161, 764 0 194. 00 194. 01 07951 FOUNDATI ON 17, 086 7, 775 24, 861 0 24, 861 194. 01 194. 03 07952 COMMUNI TY & VOLUNTEER SVCS 10, 961 80, 379 91, 340 0 91, 340 194. 04 194. 04 07954 ER PHYSI CI AN 0 0 0 0 0 0 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 0 0 194. 06			0	0	C	0		
99. 40 09940 OUTPATI ENT SPEECH PATHOLOGY O O O O O O O O O		109920 OUTPATIENT OCCUPATIONAL THERAPY	0	0	C	0	-	
113.00				o		_		
181. 00 SUBTOTALS (SUM OF LINES 1-117) 13, 353, 270 14, 408, 499 27, 761, 769 -161, 245 27, 600, 524 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 7, 342 7, 342 0 7, 342 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 1, 884 1, 884 -519 1, 365 192. 00 194. 00 07950 OCCUPATI ONAL HEALTH 0 -161, 764 161, 764 161, 764 0 194. 00 194. 01 07951 FOUNDATI ON 17, 086 7, 775 24, 861 0 24, 861 194. 01 194. 03 07952 COMMUNI TY & VOLUNTEER SVCS 10, 961 80, 379 91, 340 0 91, 340 194. 04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 0 0 0 194. 06								
NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 7, 342 7, 342 0 7, 342 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 1, 884 1, 884 -519 1, 365 192. 00 194. 00 194. 00 194. 00 194. 00 194. 00 194. 00 194. 00 194. 01 194. 01 194. 01 194. 01 194. 02 194. 03 194. 03 194. 03 194. 04 194. 05 194. 04 194. 05 194. 06 1			12 252 270					1
190. 00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 0 7, 342 7, 342 0 7, 342 190. 00 192.	110.00		13, 333, 270	14, 400, 499	27, 701, 709	- 101, 245	27, 000, 324	1110.00
194. 00 07950 0CCUPATI ONAL HEALTH		19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0					
194. 01 07951 FOUNDATI ON 17, 086 7, 775 24, 861 0 24, 861 194. 01 194. 03 07952 COMMUNI TY & VOLUNTEER SVCS 10, 961 80, 379 91, 340 0 91, 340 194. 03 194. 04 07954 ER PHYSI CI AN 0 0 0 0 194. 04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 0 194. 06			0					
194. 03 07952 COMMUNITY & VOLUNTEER SVCS 10, 961 80, 379 91, 340 0 91, 340 194. 03 194. 04 07954 ER PHYSI CI AN 0 0 0 0 194. 04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 0 194. 06			17. 086					
194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 0 194. 06							91, 340	194. 03
			0	o	C			
200.00 10.			13 381 317	0 14 344 115	27 725 <i>4</i> 32	_		
	_55.00	1.2 (22 6. 2 1.0 1.7)	. 5, 55., 51.,	, 5, 110	_,,,20,102	۱	_,,,20, 102	, 0. 00

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

Provi der CCN: 151323

Peri od: From 01/01/2014 To 12/31/2014

Date/Time Prepared: 5/21/2015 9:27 am

				5/21/2015 9: 2	7 am
	Cost Center Description	(See A-8) Fo	Net Expenses or Allocation		
	OFNEDAL CERVILOE COCT OFNEDO	6.00	7. 00		
	GENERAL SERVICE COST CENTERS	47.0(5)	4 0/5 4/0		
1.00	00100 CAP REL COSTS-BLDG & FIXT	17, 365	1, 265, 469		1.00
1. 01	00101 EMS WEST STATION	0	16, 040		1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	0	511, 952		2. 00
2.01	00201 EMS WEST STATION EQUIP.	0	19, 818		2. 01
3.00	00300 OTHER CAP REL COSTS	o	o		3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-560, 683	3, 461, 582		4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-1, 753, 200	6, 417, 389		5. 00
6.00	00600 MAI NTENANCE & REPAI RS	1, 700, 200	0, 117, 007		6. 00
7. 00	00700 OPERATION OF PLANT	1 4	047 003		7. 00
		-4, 209	967, 083		1
8. 00	00800 LAUNDRY & LINEN SERVICE	0	77, 592		8. 00
9.00	00900 HOUSEKEEPI NG	-27	187, 980		9. 00
10.00	01000 DI ETARY	0	235, 105		10.00
11. 00	01100 CAFETERI A	-202, 612	142, 417		11.00
12.00	1 1	0	o		12.00
13. 00	1 1	o	275, 530		13. 00
14. 00	1	o	-21, 920		14. 00
15.00			491, 052		15.00
16. 00		0	0		16. 00
17. 00		0	0		17. 00
19. 00		0	0		19. 00
20.00	02000 NURSI NG SCHOOL	0	0		20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		21.00
22. 00		0	o		22. 00
23. 00		o	o		23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	1 9	0		25.00
20.00		12 (10	1 140 420		20.00
30.00	I I	12, 619	1, 148, 428		30.00
43. 00		0	141, 774		43. 00
	ANCILLARY SERVICE COST CENTERS				1
50.00	05000 OPERATING ROOM	0	1, 029, 831		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	414, 989		52.00
53.00	05300 ANESTHESI OLOGY	-632, 220	31, 423		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	952, 759		54.00
60.00	06000 LABORATORY	o	842, 407		60.00
62. 30			042, 407		62. 30
	1	1	- 1		
65. 00	06500 RESPI RATORY THERAPY	0	307, 085		65. 00
66. 00	I I	-79	322, 990		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	85, 027		67. 00
68.00	06800 SPEECH PATHOLOGY	-10, 976	52, 526		68. 00
69.00	06900 ELECTROCARDI OLOGY	l ol	1, 325		69. 00
71. 00	1 1	0	315, 541		71.00
72. 00		0	208, 143		72.00
73. 00	1				
	1	-277, 569	741, 081		73.00
76. 97		0	0		76. 97
76. 98	+ +	0	0		76. 98
76. 99		0	0		76. 99
	OUTPATIENT SERVICE COST CENTERS				
90.00	09000 CLI NI C	0	5, 713		90. 00
90. 01	09001 LI FEBRI DGE SENI OR CARE	-100	205, 851		90. 01
91. 00		-882, 359	1, 251, 551		91.00
92. 00		002,007	1, 201, 001		92.00
72.00	OTHER REIMBURSABLE COST CENTERS				72.00
05 00		200	1 200 (41		05.00
	09500 AMBULANCE SERVI CES	-300	1, 200, 641		95. 00
99. 10	I I	0	0		99. 10
99. 20	I I	0	0		99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0		99. 40
	SPECIAL PURPOSE COST CENTERS	<u> </u>	·		1
113 00	11300 NTEREST EXPENSE	0	0		113. 00
118. 00		-4, 294, 350	23, 306, 174		118. 00
1 10.00	NONREI MBURSABLE COST CENTERS	7, 274, 330	23, 300, 174		1.10.00
400.0			7.040		100 00
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	١	7, 342		190. 00
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 365		192. 00
	D 07950 OCCUPATIONAL HEALTH	0	0		194. 00
194.0	1 07951 FOUNDATI ON	0	24, 861		194. 01
194. 03	3 07952 COMMUNITY & VOLUNTEER SVCS	ol	91, 340		194. 03
	4 07954 ER PHYSICIAN	o	0		194. 04
	6 07953 SHI PSHEWANA RADI OLOGY AND LAB		٥		194. 06
200. 00		-4, 294, 350	23, 431, 082		200.00
200.00	O TOTAL (SUM OF LINES 110-177)	-4, 274, 330	23, 431, 002		1200.00

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2014 To 12/31/2014 Worksheet A-6 Date/Time Prepared: 5/21/2015 9: 27 am Provi der CCN: 151323

					5/21/2015 9: 27 am
	Coot Conton	Increases	Calamy	O+h o.s	
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00	
	A - REHAB THERAPY RECLASS	3.00	4.00	3.00	
1.00	OCCUPATI ONAL THERAPY	67.00	89, 278	2, 058	1.00
2.00	SPEECH PATHOLOGY	68. 00	62, 071	1, 431	2. 00
	0		151, 349	3, 489	
	B - OB RECLASS				
1.00	NURSERY	43. 00	130, 280	11, 494	1. 00
2. 00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	381, 344	33, 645	2. 00
	O CLINIC DIFTICIAN		511, 624	45, 139	
1.00	C - CLINIC DIETICIAN CLINIC	90.00	1, 556	0	1. 00
1.00	O O	90.00	1, 556	0	1.00
	F - CAFETERIA RECLASS		1, 550	U	
1. 00	CAFETERI A	11. 00	189, 783	155, 246	1.00
	0		189, 783	155, 246	
	G - INSURANCE RECLASS			, =	
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	35, 410	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	O	11, 920	2. 00
	0		0	47, 330	
	H - DRUGS CHARGED TO PATIENTS				
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	1, 025, 289	1.00
2.00		0.00	0	0	2.00
3.00		0.00	0	0	3.00
4.00		0.00	0	O	4.00
5. 00 6. 00		0. 00 0. 00	O	O	5.00
0.00				00 1,025,289	6. 00
	I - SALARY RECLASS		<u> </u>	1,025,269	
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	0	2, 453, 067	1. 00
00	0			2, 453, 067	1.00
	J - OCCUPATIONAL HEALTH RECLA	ISS	-	,,	
1.00	OCCUPATI ONAL HEALTH	194. 00	0	161, 764	1. 00
2.00		0.00	0	0	2. 00
3.00		0.00	0	0	3.00
4.00		0.00	0	0	4. 00
5.00		0.00	0	0	5. 00
6.00		0.00	0	0	6. 00
7.00		0. 00 0. 00	0	0	7. 00
8. 00 9. 00		0.00	0	0	8. 00 9. 00
10.00		0.00	0	0	10.00
10.00			- — — ŏ	161, 764	10.00
	K - DEPRECIATION		-1		
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	426, 395	1. 00
2.00	EMS WEST STATION	1. 01	О	16, 040	2. 00
3.00	EMS WEST STATION EQUIP.	2. 01	0	19, 624	3. 00
4.00	ADMI NI STRATI VE & GENERAL	5.00	0	<u>8, 0</u> 88	4. 00
	0		0	470, 147	
4 60	L - BLDG & LEASE EXPENSE	4 0.5		00.007	
1.00	CAP REL COSTS MARIE FOLLO	1.00	0	23, 837	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00 2. 01	0	73, 637	2.00
3. 00 4. 00	EMS WEST STATION EQUIP.	2. 01 0. 00	0	194 0	3. 00 4. 00
5. 00		0.00	0	0	5. 00
6. 00		0.00	o	0	6. 00
7. 00		0.00	Ö	Ö	7. 00
8. 00		0.00	ő	Ö	8. 00
9. 00		0.00	Ö	Ö	9. 00
10.00		0.00	o	0	10. 00
11.00		0.00	0	0	11. 00
12.00		0.00	o	0	12. 00
13.00		0.00	0	0	13. 00
14.00		0.00	0	0	14. 00
15.00		0.00	0	0	15. 00
16.00		0.00	0	0	16.00
17. 00			0	<u> 0</u> 97, 668	17. 00
	M - INTEREST RECLASS		U	97,008	
1. 00	CAP REL COSTS-BLDG & FIXT	1.00	O	157, 724	1. 00
1.00	0 VEE COSTS-DEDG & FIXT			15 <u>7, 7</u> 24 157, 724	1.00
	N - IMPLANTABLE MEDICAL SUPPL	.I ES	<u> </u>	101, 124	
1. 00	IMPL. DEV. CHARGED TO	72. 00	0	208, 143	1.00
1.00		, 2. 33	٦	,	100
1.00	PATI ENTS	I			
	PATIENTS		0 854, 312	208, 143 4, 825, 006	500.00

Provi der CCN: 151323

Period: Worksheet A-U From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/21/2015 9:27 am

						5/21/2015 9: 2	, uill
		Decreases					
	Cost Center	Li ne #	Sal ary		kst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10. 00		
1 00	A - REHAB THERAPY RECLASS PHYSICAL THERAPY	44 00	151, 349	2 400	0		1. 00
1. 00 2. 00	PHYSICAL THERAPY	66.00	151, 349	3, 489 0	1		2. 00
2.00		0.00		3, 489	9	1	2.00
	B - OB RECLASS		131, 349	3, 409			
1.00	ADULTS & PEDIATRICS	30.00	511, 624	45, 139	0		1. 00
2. 00	ADOLIS & FEDIATRICS	0.00	311, 024	45, 137	0		2. 00
2.00			511, 624	45, 139	~	1	2.00
	C - CLINIC DIETICIAN		311, 024	45, 139			
1.00	DI ETARY	10.00	1, 556	0	0		1. 00
1.00	DIETAKT — — — —		1, 556		— — — 4	1	1.00
	F - CAFETERIA RECLASS		1, 550	U			
1. 00	DI ETARY	10.00	189, 783	155, 246	0		1. 00
1.00	0		189, 783	155, 246	— — — Ч		1.00
	G - INSURANCE RECLASS		109, 703	133, 240			
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	0	47, 330	12		1. 00
2. 00	ADMINISTRATIVE & GENERAL	0.00	0	47, 330	12		2. 00
2.00		<u> </u>			— — ' ²		2.00
	U DDUCE CHARCED TO DATIENTS		U	47, 330			
1 00	H - DRUGS CHARGED TO PATIENTS	15 00	ما	1 017 504			1 00
1. 00 2. 00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	1, 017, 584	0		1. 00 2. 00
	OPERATING ROOM		0	2, 450			
3.00	RADI OLOGY-DI AGNOSTI C	50.00	0	2, 222			3.00
4.00		54.00	0	888	0		4. 00
5.00	EMERGENCY	91.00	0	1, 992	0		5. 00
6.00	MEDICAL SUPPLIES CHARGED TO	71. 00	O	153	0		6. 00
	PATI ENT	+		1 025 200			
	U CALABY DECLACE		0	1, 025, 289			
1 00	I - SALARY RECLASS	F 00	2 452 0/7				1 00
1. 00	ADMI NI STRATI VE & GENERAL		2, 453, 067	0	0		1. 00
	U COOLIDATIONAL HEALTH BEOLA	20	2, 453, 067	0			
4 00	J - OCCUPATIONAL HEALTH RECLAS		ما	07.000			4 00
1.00	RADI OLOGY-DI AGNOSTI C	54.00	0	87, 030	0		1.00
2.00	LABORATORY	60.00	0	1, 274	0		2.00
3.00	RESPIRATORY THERAPY	65.00	0	683	0		3. 00
4.00	PHYSI CAL THERAPY	66.00	0	20, 375	0		4. 00
5.00	OCCUPATI ONAL THERAPY	67. 00	0	6, 309	0		5. 00
6.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	717	0		6. 00
7 00	PATI ENT	70.00		, ,,,,,			7.00
7.00	DRUGS CHARGED TO PATIENTS	73. 00	0	6, 639	0		7. 00
8.00	EMERGENCY	91.00	0	37, 993	0		8. 00
9.00	OPERATING ROOM	50.00	0	574	0		9. 00
10. 00	ANESTHESI OLOGY	53.00	•	170	0		10. 00
	0 L		0	161, 764			
4 00	K - DEPRECIATION	4 00	ما	470 447			4 00
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	470, 147	9		1. 00
2.00		0.00	0	0	9		2.00
3.00		0.00	0	0	9		3. 00
4.00		0.00			0		4. 00
	0		0	470, 147			
1 00	L - BLDG & LEASE EXPENSE	7 00	ام	22 700	10		1 00
1.00	OPERATION OF PLANT	7. 00	0	23, 700	10		1.00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	137	10		2. 00
3.00	AMBULANCE SERVICES	95. 00	0	194	10		3. 00
4.00	ADMINISTRATIVE & GENERAL	5. 00	0	6, 746	0		4. 00
5.00	OPERATION OF PLANT	7. 00	0	77	0		5. 00
6.00	HOUSEKEEPI NG	9. 00	0	32	0		6. 00
7. 00	DI ETARY	10. 00	0	580	0		7. 00
8.00	CENTRAL SERVICES & SUPPLY	14. 00	0	3	0		8. 00
9.00	PHARMACY	15. 00	0	561	0		9. 00
10.00	ADULTS & PEDIATRICS	30. 00	0	2, 001	0		10. 00
11. 00	OPERATING ROOM	50. 00	0	56, 202	0		11. 00
12.00	RESPI RATORY THERAPY	65. 00	0	3, 818	0		12. 00
13.00	PHYSI CAL THERAPY	66. 00	0	1, 420	0		13.00
14.00	EMERGENCY	91.00	0	1, 069	0		14.00
15.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	519	0		15. 00
16.00	LIFEBRIDGE SENIOR CARE	90. 01	0	564	0		16. 00
17.00	NURSING ADMINISTRATION	1300	0	45	0		17. 00
	0			97, 668			
	M - INTEREST RECLASS						
1.00	INTEREST EXPENSE	113.00	0	157, 724	11		1. 00
				157, 724			
	0	l l	OI.	107, 724	l l		

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 COMMUNITY HOSPT. OF LAGRANGE CTY IN Provi der CCN: 151323 Peri od: Worksheet A-6 From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/21/2015 9:27 am Decreases Wkst. A-7 Ref. 10.00 Cost Center Li ne # Sal ary 0ther 9.00 6. 00 7.00 8.00 N - IMPLANTABLE MEDICAL SUPPLIES MEDICAL SUPPLIES CHARGED TO 71.00 208, 143 0 1.00 PATI ENT

3, 307, 379

208, 143

500.00

2, 371, 939

500.00 Grand Total: Decreases

Subtotal (sum of lines 1-7)

Reconciling Items

10.00 Total (line 8 minus line 9)

8.00

9.00

8.00

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 151323 Peri od: Worksheet A-7 From 01/01/2014 Part I 12/31/2014 Date/Time Prepared: 5/21/2015 9:27 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Retirements Bal ances 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 265,000 0 1.00 7, 110 0 2.00 Land Improvements 1, 965, 610 7, 110 0 2.00 0 3.00 3.00 Buildings and Fixtures 13, 245, 217 0 C 0 0 4.00 Building Improvements 29,098 0 0 4.00 5.00 Fixed Equipment 7, 635, 336 128, 062 0 128, 062 0 5.00 7, 162, 293 6.00 Movable Equipment 400 0 400 80, 249 6.00 0 7.00 199.373 199.373 HIT designated Assets 1, 229, 965 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 31, 532, 519 334, 945 334, 945 80, 249 8.00 9.00 Reconciling Items 400 28, 042 0 28, 042 400 9.00 31, 532, 119 <u>306, 90</u>3 306, 903 79, 849 Total (line 8 minus line 9) 10.00 0 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 265,000 1.00 2.00 Land Improvements 1, 972, 720 185, 270 2.00 13, 245, 217 3.00 Buildings and Fixtures 46, 306 3.00 29, 098 13, 778 4.00 Building Improvements 4.00 5.00 Fi xed Equipment 7, 763, 398 506, 894 5.00 7, 082, 444 6.00 Movable Equipment 3, 194, 965 6.00 7. 00 7.00 HIT designated Assets 1, 429, 338 0

31, 787, 215

31, 759, 173

28,042

3, 947, 213

3, 947, 213

Heal th	Financial Systems COMM	IUNI TY HOSPT. OF	F LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151323	Peri od: From 01/01/2014 To 12/31/2014	Worksheet A-7 Part II Date/Time Prep 5/21/2015 9:23	
			Sl	JMMARY OF CAF	PITAL	372172013 7.2	, an
	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	· · · · · · · · · · · · · · · · · · ·	·	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	1, 490, 266	0		0 0	11, 014	1. 00
1. 01	EMS WEST STATION	0	0		0 0	0	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
2.01	EMS WEST STATION EQUIP.	0	0		0 0	0	2. 01
3.00	Total (sum of lines 1-2)	1, 490, 266			0 0	11, 014	3. 00
		SUMMARY 0	- CAPITAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00	L			
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM					
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 501, 280				1.00
1. 01	EMS WEST STATION	0	0				1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
2. 01	EMS WEST STATION EQUIP.	0	1 501 200				2. 01
3. 00	Total (sum of lines 1-2)	1 0	1, 501, 280	1		I	3. 00

Health Financial Systems	COMMUNITY HOSPT. OF LAGRANGE CTY IN	In Lieu of Form CMS-2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS	Provi der CCN: 151323	Peri od: Worksheet A-7 From 01/01/2014 Part III To 12/31/2014 Date/Time Prepared: 5/21/2015 9:27 am
	COMPUTATION OF RATIOS	ALLOCATION OF OTHER CAPITAL

RECONO	RECONCILIATION OF CAPITAL COSTS CENTERS				Period: From 01/01/2014 To 12/31/2014	Date/Time Prep 5/21/2015 9:27	
		COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col	instructions)	Insurance	
				2)			
	PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4. 00	5. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	22, 954, 626	0	22, 954, 62	6 0. 763514	0	1. 00
1. 01	EMS WEST STATION	320, 808	l e	320, 80		ol	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	6, 924, 292				0	2.00
2.01	EMS WEST STATION EQUIP.	158, 153	0	158, 15	0. 005260	0	2. 01
3.00	Total (sum of lines 1-2)	30, 357, 879					3. 00
		ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
	·		Capi tal -Relate	cols. 5	•		
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CE			1	4 000 050	00.007	1 00
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 1, 038, 059		1.00
1. 01 2. 00	EMS WEST STATION CAP REL COSTS-MVBLE EQUIP	0	0		0 16, 040 0 426, 395		1. 01 2. 00
2. 00	EMS WEST STATION EQUIP.	0	0		0 426, 393		2. 00
3. 00	Total (sum of lines 1-2)	0	0		0 1, 500, 118		3. 00
3.00	Total (Suil of Titles 1-2)	0	SI SI	I JMMARY OF CAPI		97,000	3.00
	Cost Center Description	Interest	Insurance (see			Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see instructions)	through 14)	
		11.00	12.00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	13.00	14.00	13.00	
1. 00	CAP REL COSTS-BLDG & FIXT	157, 149	35, 410	11, 01	4 0	1, 265, 469	1. 00
1. 01	EMS WEST STATION	0	0	1	0	16, 040	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	11, 920		0	511, 952	2. 00
2.01	EMS WEST STATION EQUIP.	0	0		0 0	19, 818	2. 01
3.00	Total (sum of lines 1-2)	157, 149	47, 330	11, 01	4 0	1, 813, 279	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES

				F T	rom 01/01/2014 o 12/31/2014		
				Expense Classification on	Worksheet A	5/21/2015 9: 2	7 am
				To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center	Line #	Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1. 00 B	2. 00 -575	3.00 CAP REL COSTS-BLDG & FIXT	4. 00 1. 00	5. 00	1. 00
	COSTS-BLDG & FIXT (chapter 2)						
1. 01	Investment income - EMS WEST STATION (chapter 2)		0	EMS WEST STATION	1. 01	0	1. 01
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
2. 01	Investment income - EMS WEST		0	EMS WEST STATION EQUIP.	2. 01	О	2. 01
3. 00	STATION EQUIP. (chapter 2) Investment income - other		0		0. 00	0	3. 00
4 00	(chapter 2)		0		0.00	0	4 00
4. 00	Trade, quantity, and time discounts (chapter 8)		U		0. 00		4. 00
5. 00	Refunds and rebates of expenses (chapter 8)		0		0. 00	0	5. 00
6. 00	Rental of provider space by		0		0. 00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0. 00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service	А	-4, 209	OPERATION OF PLANT	7. 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	-1, 693, 835			О	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, 701, 114			0	12. 00
	transactions (chapter 10)		.,,		0.00		
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-202, 612	CAFETERI A	0. 00 11. 00		13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0. 00	0	15. 00
16. 00	Sale of medical and surgical		0		0.00	О	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		0		0. 00	О	17. 00
18. 00	Sale of medical records and		0		0. 00	0	18. 00
19. 00	abstracts Nursing school (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	limitation (chapter 14)		_				
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
25.00	physicians' compensation		O	Cost center bereted	114.00		25.00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
	COSTS-BLDG & FLXT						
26. 01	Depreciation - EMS WEST STATION		0	EMS WEST STATION	1. 01	0	26. 01
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
27. 01	Depreciation - EMS WEST		0	EMS WEST STATION EQUIP.	2. 01	0	27. 01
28. 00	STATION EQUIP. Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00		29. 00 30. 00
50.00	therapy costs in excess of	71-0-3	U	OCCUPATIONAL THEMAT	07.00		50.00
	limitation (chapter 14)	1					

ADJUSTMENTS TO EXPENSES Provi der CCN: 151323 Peri od: Worksheet A-8 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/21/2015 9:27 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 2.00 3.00 4. 00 5.00 30.99 Hospice (non-distinct) (see OADULTS & PEDIATRICS 30. 99 30.00 instructions) 31.00 Adjustment for speech A-8-3 OSPEECH PATHOLOGY 68.00 31.00 pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for 32.00 -15, 254 ADMI NI STRATI VE & GENERAL 5.00 32.00 Α Depreciation and Interest HAF NET FEE EXPENSE 33 00 147, 579 ADMINI STRATI VE & GENERAL Α 5 00 33 00 33. 01 CAH HIT ADJ DEPR CARYFRWD 2013 -76, 964 ADMINI STRATI VE & GENERAL 5.00 33.01 Α CAH HIT ADJ DEPR CARYFRWD 2012 -106, 969 ADMI NI STRATI VE & GENERAL 5.00 33.02 33.02 Α 34.00 MI SCELLANEOUS REVENUE -911 ADMINI STRATI VE & GENERAL 34.00 В 5.00 SPEECH THERAPY CONTRACTED 35.00 -10, 976 SPEECH PATHOLOGY 68.00 ol 35.00 В 36.00 NON-PATIENT EMS REVENUE В -300 AMBULANCE SERVICES 95.00 36.00 HOUSEKEEPING SUPPLIES -27 HOUSEKEEPI NG 9.00 37.00 В 37.00 PHARMACY EMPLOYEE RX PURCHASES -277, 569 DRUGS CHARGED TO PATIENTS 73.00 38.00 В 0 38.00 SELF INSURANCE -560, 683 EMPLOYEE BENEFITS DEPARTMENT 40 00 Α 4.00 40 00 41.00 LOBBY % OF DUES & -2, 870 ADMI NI STRATI VE & GENERAL 5.00 41.00 Α SUBSCRI PTI ONS 44.01 MARKETI NG Α 18 PHYSI CAL THERAPY 66.00 ol 44.01 MARKETI NG -100 LIFEBRIDGE SENIOR CARE 44.02 44.02 Α 90.01 47.00 ADD-BACK OF DEMOLISHED ASSET Α 17, 940 CAP REL COSTS-BLDG & FIXT 1.00 47.00 DEPREC 48.00 ADD-BACK OF DEMOLITION COSTS 4, 125 ADMINI STRATI VE & GENERAL 5.00 48.00 Α NOT REALTED TO PATIENT CARE -97 PHYSI CAL THERAPY 49.00 49 00 66.00 Α TELEMETRY MONITORING EXPENSE 49. 01 11,569 ADULTS & PEDIATRICS 30.00 49.01 Α 49.02 MEDICAL DIRECTOR ADDITIONAL Α 1,050 ADULTS & PEDIATRICS 30.00 49.02 A/P ON-CALL PROF TIME 49.03 -110, 867 ANESTHESI OLOGY 53.00 49.03 Α GROSS-UP ANESTHESIA EXPENSE 290, 123 ANESTHESI OLOGY 49.04 49.04 Α 53.00 FOR A/R 49. 05 CHARITY CONTRIBUTIONS -822 ADMINISTRATIVE & GENERAL 5.00 49.05 Α 50.00 TOTAL (sum of lines 1 thru 49) -4, 294, 350 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.

				. 12/31/2014	5/21/2015 9: 2		
	Li ne No.	Cost Center	Expense Items	Amount of	Amount		
				Allowable Cost	Included in		
					Wks. A, column		
					5		
	1. 00	2.00	3. 00	4. 00	5. 00		
	A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED						
	HOME OFFICE COSTS:						
1.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4, 970, 901	4, 750, 000	1.00	
2.00	5. 00	ADMINISTRATIVE & GENERAL	RELATED PARTY SUBSIDY ADJ.	0	1, 922, 015	2.00	
3.00	0.00			0	0	3.00	
4.00	0.00			0	0	4.00	
5.00	TOTALS (sum of lines 1-4).			4, 970, 901	6, 672, 015	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.

 as not been pested to not kenest in detailed I and of El the amount arronage ended a service out of any in or time parti							
			Related Organization(s) and/or Home Office				
					1		
C	N	D	N	D			
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1. 00	2. 00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6. 00	В	0.00 PARKVI EW HEALTH SYSTEM, INC. 0.00	6. 00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9. 00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- C. Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related 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				COMMUNITY HOSPT. OF LAGRANGE CTY IN				In Lieu of Form CMS-2552-			-2552-10	
		SERVICES FROM	RELATED	ORGANI ZATI ONS AND H	IOME	Provi der	CCN:	151323	Peri od:	(04 (004)	Worksheet A-	8-1
OFFICE	COSTS									/01/2014 /31/2014	Date/Time Pr 5/21/2015 9:	
	Net	Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REC	QUIRED AS A RESULT (F TRANS	ACTIONS W	/I TH R	ELATED (ORGANI ZAT	IONS OR (CLAI MED	
	HOME OFFICE CO	STS:										
1.00	220, 901	0										1.00
2.00	-1, 922, 015	0										2.00
3.00	0	0	i									3.00
4.00	0	0	i									4.00
5.00	-1, 701, 114											5. 00
* The	amounts on line	es 1-4 (and sub	scripts	as appropriate) are	transf	erred in o	detai I	to Wor	ksheet A	. col umn	6. lines as	
				and negative amounts								whi ch
											6	

has not been posted to Worksheet A, columns 1 and/or 2, the amount allowable should be indicated in column 4 of this part.

Related Organization(s)
and/or Home Office

Type of Business

6.00

B. INTERRELATIONSHIP TO 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.

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

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- 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
PROVIDER BASED PHYSICIAN ADJUSTMENT

					-	Го 12/31/2014	Date/Time Pre 5/21/2015 9:2	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
					'		Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	53. 00	AGGREGATE-ANESTHESI OLOGY	411, 453	379, 951	31, 502	0	0	1. 00
2.00	53.00	AGGREGATE-ANESTHESI OLOGY	431, 525	431, 525	0	0	O	2. 00
3.00		DR. A	30, 000	0	30, 000	0	O	3. 00
4.00	91.00	AGGREGATE-EMERGENCY	1, 394, 066	882, 359	511, 707	0	O	4. 00
5.00	30.00	DR. B	7, 789	0	7, 789	0	0	5. 00
6.00	0.00		0	0	0	0	o	6. 00
7.00	0.00		0	0	0	0	o	7. 00
8.00	0.00		0	0	0	0	o	8. 00
9.00	0.00		0	0	0	0	o	9. 00
10.00	0.00		0	0	0	0	o	10.00
200.00			2, 274, 833	1, 693, 835	580, 998		o	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		Identifier	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00	•	AGGREGATE-ANESTHESI OLOGY	0	0	_			1. 00
2.00		AGGREGATE - ANESTHESI OLOGY	0	1			0	2. 00
3.00		DR. A	0	0	_	_	0	3. 00
4.00		AGGREGATE-EMERGENCY	0	0	0	0	0	4. 00
5. 00		DR. B	0	0	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0. 00		0	0	0	0	0	8. 00
9.00	0. 00		0	0	0	0	0	9. 00
10.00	0. 00		0	0	0	0	0	10. 00
200.00		0 1 0 1 (8)	0	0	0	0	0	200. 00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		Identifier	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1.00	53.00	AGGREGATE - ANESTHESI OLOGY	0	0	0	379, 951		1. 00
2.00	53.00	AGGREGATE-ANESTHESI OLOGY	0	0	0	431, 525		2. 00
3.00	91.00	DR. A	0	0	0			3. 00
4.00	91.00	AGGREGATE-EMERGENCY	0	0	0	882, 359		4. 00
5.00	30.00	DR. B	0	0	0			5. 00
6.00	0.00		0	0	0	0		6. 00
7.00	0.00		0	0	0	0		7. 00
8.00	0.00		0	0	0	0		8. 00
9.00	0.00		0	0	0	0		9. 00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1, 693, 835		200.00

Provi der CCN: 151323 | Peri od: From 01/01/2014

| Peri od: | Worksheet B | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: | 5/21/2015 9: 27 am

						12/31/2014	5/21/2015 9: 2	
					CAPITAL REL	ATED COSTS		
		Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	
			0	1. 00	1. 01	2. 00	2. 01	
1 00		AL SERVICE COST CENTERS	1 2/5 4/0	1 2/5 4/0				1 00
1. 00 1. 01		CAP REL COSTS-BLDG & FIXT EMS WEST STATION	1, 265, 469 16, 040	1, 265, 469 0	16, 040			1. 00 1. 01
2.00		CAP REL COSTS-MVBLE EQUIP	511, 952	O	10, 040	511, 952		2. 00
2.01		EMS WEST STATION EQUIP.	19, 818			0	19, 818	2. 01
4.00		EMPLOYEE BENEFITS DEPARTMENT	3, 461, 582	0	0	0	0	
5.00		ADMINISTRATIVE & GENERAL	6, 417, 389	228, 709	0	92, 525	0	
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	967, 083	0 71, 878	0	0 29, 078	0	6. 00 7. 00
8.00		LAUNDRY & LINEN SERVICE	77, 592	4, 110	ő	1, 663	Ö	8.00
9.00		HOUSEKEEPI NG	187, 980	13, 450	0	5, 441	0	9. 00
10.00		DIETARY	235, 105	53, 961	0	21, 830	0	10.00
11.00	1	CAFETERI A	142, 417	0	0	0	0	11. 00 12. 00
12. 00 13. 00		MAINTENANCE OF PERSONNEL NURSING ADMINISTRATION	275, 530	0	0	0	0	13.00
14. 00	1	CENTRAL SERVICES & SUPPLY	-21, 920	25, 632	Ö	10, 370	1	•
15.00		PHARMACY	491, 052	22, 059		8, 924	0	15. 00
16.00		MEDICAL RECORDS & LIBRARY	0	4, 353	0	1, 761	0	16. 00
17. 00 19. 00		SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	17. 00 19. 00
20. 00		NURSI NG SCHOOL	0	0	0	0	0	20.00
21. 00		I&R SERVICES-SALARY & FRINGES APPRV	o	0	Ō	0	Ō	21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
23. 00		PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	1, 148, 428	284, 813	0	115, 224	0	30. 00
43. 00		NURSERY	141, 774	4, 288		1, 735	ő	
		LARY SERVICE COST CENTERS						
50.00		OPERATING ROOM	1, 029, 831	162, 338		65, 675	l	
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	414, 989 31, 423	20, 272 0	0	8, 201 0	0	52. 00 53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	952, 759	80, 454	o o	32, 548	0	•
60.00		LABORATORY	842, 407	32, 097	0	12, 985	0	60. 00
62. 30		BLOOD CLOTTING FOR HEMOPHILIACS	0	0	_	0	0	62. 30
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	307, 085 322, 990	16, 796 53, 799		6, 795 21, 764	0	65. 00 66. 00
67. 00		OCCUPATIONAL THERAPY	85, 027	03, 749	0	21, 704	0	67.00
68. 00		SPEECH PATHOLOGY	52, 526	0	Ō	0	0	68. 00
69. 00		ELECTROCARDI OLOGY	1, 325	1, 511	0	611	0	69. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENT	315, 541	0	0	0	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	208, 143 741, 081	0	0	0	0	72. 00 73. 00
76. 97	1	CARDI AC REHABI LI TATI ON	0	Ö	Ö	0		•
76. 98		HYPERBARI C OXYGEN THERAPY	0	0		0		1
76. 99		LI THOTRI PSY	0	0	0	0	0	76. 99
90. 00		TIENT SERVICE COST CENTERS CLINIC	5, 713	0	O	0	0	90. 00
90. 01		LIFEBRIDGE SENIOR CARE	205, 851	14, 782		5, 980		
91. 00		EMERGENCY	1, 251, 551	112, 422	0	45, 481	0	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS						92. 00
95. 00		AMBULANCE SERVICES	1, 200, 641	0	16, 040	0	19, 818	95. 00
99. 10	09910		0	0	0	0	0	99. 10
99. 20	1	OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	1
99. 30		OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99. 30
99. 40		OUTPATIENT SPEECH PATHOLOGY AL PURPOSE COST CENTERS	<u> </u>	0	0	0	0	99. 40
113. 00		INTEREST EXPENSE						113. 00
118. 00	_	SUBTOTALS (SUM OF LINES 1-117)	23, 306, 174	1, 207, 724	16, 040	488, 591	19, 818	118. 00
100 00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 342	3, 622		1, 465	<u> </u>	190. 00
		PHYSICIANS' PRIVATE OFFICES	1, 365	3, 622 54, 123	0	1, 465 21, 896	l	190.00
		OCCUPATI ONAL HEALTH	0	0 1, 120	Ö	0		194. 00
		FOUNDATION	24, 861	0	0	0	l	194. 01
		COMMUNITY & VOLUNTEER SVCS	91, 340	0	0	0	l	194. 03
		ER PHYSICIAN SHIPSHEWANA RADIOLOGY AND LAB		0	0	0		194. 04 194. 06
200.00		Cross Foot Adjustments		J	Ĭ	0		200. 00
201.00)	Negative Cost Centers	<u> </u>	0	О	0	0	201. 00

Health Financial Systems (COMMUNITY HOSPT. O	F LAGRANGE CTY	IN	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	pared:
			CADITAL DI	ELATED COSTS	5/21/2015 9: 2	7 am
			CAPITAL RI	LATED COSTS		
Cost Center Description	Net Expenses	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST	
	for Cost		STATI ON		STATION EQUIP.	
	Allocation					
	(from Wkst A					
	col . 7)					
	0	1. 00	1. 01	2. 00	2. 01	
202.00 TOTAL (sum lines 118-201)	23, 431, 082	1, 265, 469	16, 04	511, 952	19, 818	202. 00

Provi der CCN: 151323

| Period: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 5/21/2015 9:27 am

					0 12/31/2014	5/21/2015 9: 2	7 am
	Cost Center Description	EMPLOYEE	Subtotal	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	
		BENEFITS		& GENERAL	REPAI RS	PLANT	
		DEPARTMENT 4.00	4A	5. 00	6. 00	7. 00	
C	GENERAL SERVICE COST CENTERS	4.00	44	3.00	0.00	7.00	
	00100 CAP REL COSTS-BLDG & FIXT						1. 00
	00101 EMS WEST STATION						1. 01
	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2.01	00201 EMS WEST STATION EQUIP.						2. 01
	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 461, 582					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 082, 161	7, 820, 784	7, 820, 784			5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	C	0	0		6. 00
	00700 OPERATION OF PLANT	91, 961	1, 160, 000	581, 162	0	1, 741, 162	7. 00
	00800 LAUNDRY & LINEN SERVICE	0	83, 365			7, 416	8. 00
9.00	00900 HOUSEKEEPI NG	58, 316	265, 187	132, 859	0	24, 270	9. 00
1	D1000 DI ETARY	46, 866	357, 762			97, 374	10. 00
	01100 CAFETERI A	68, 488	210, 905			0	11. 00
	01200 MAINTENANCE OF PERSONNEL	0	C	1	_	0	12. 00
1	01300 NURSING ADMINISTRATION	99, 204	374, 734			0	13. 00
	01400 CENTRAL SERVICES & SUPPLY	0	14, 082			46, 254	14. 00
	D1500 PHARMACY	145, 852	667, 887			39, 806	15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	6, 114	3, 063	0	7, 856	16. 00
1	01700 SOCIAL SERVICE	0	C		0	0	17. 00
	01900 NONPHYSI CLAN ANESTHETI STS	0	C		0	0	19.00
	02000 NURSING SCHOOL	0	C		0	0	20.00
	02100 I &R SERVI CES-SALARY & FRINGES APPRV	0	C		0	0	21. 00 22. 00
	D2200 I&R SERVICES-OTHER PRGM COSTS APPRV D2300 PARAMED ED PRGM-(SPECIFY)	0			0	0	
	NPATIENT ROUTINE SERVICE COST CENTERS	U U		<u> </u>	0	0	23. 00
	03000 ADULTS & PEDIATRICS	344, 893	1, 893, 358	948, 570	0	513, 957	30. 00
	04300 NURSERY	47, 015	1, 843, 336		0		43. 00
_	NCI LLARY SERVI CE COST CENTERS	47,013	174, 012	. 77,001	0	7,730	43.00
	05000 OPERATING ROOM	256, 633	1, 514, 477	758, 756	0	292, 944	50. 00
1	05200 DELIVERY ROOM & LABOR ROOM	137, 617	581, 079			36, 581	52. 00
	05300 ANESTHESI OLOGY	0	31, 423				53. 00
1	05400 RADI OLOGY-DI AGNOSTI C	205, 063	1, 270, 824			145, 182	54. 00
	06000 LABORATORY	0	887, 489				60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	o	C		0	0	62. 30
	06500 RESPIRATORY THERAPY	102, 785	433, 461	217, 165	0	30, 309	65. 00
1	06600 PHYSI CAL THERAPY	121, 647	520, 200		0	97, 081	66. 00
	06700 OCCUPATI ONAL THERAPY	32, 218	117, 245		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	22, 400	74, 926	37, 538	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	o	3, 447	1, 727	0	2, 726	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	315, 541	158, 087	0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	208, 143	104, 280	0	0	72. 00
73.00	D7300 DRUGS CHARGED TO PATIENTS	0	741, 081	371, 283	0	0	73. 00
	07697 CARDIAC REHABILITATION	0	C) C	0	0	76. 97
1	07698 HYPERBARIC OXYGEN THERAPY	0	C) C	0	0	76. 98
	07699 LI THOTRI PSY	0	C) C	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS				_	T	
	09000 CLI NI C	1, 891	7, 604				90. 00
	09001 LI FEBRI DGE SENI OR CARE	39, 253	265, 866				
	09100 EMERGENCY	233, 435	1, 642, 889	823, 091	0	202, 868	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
	OTHER REIMBURSABLE COST CENTERS	212 7/2	1 550 2/1	77/ /04	0		05 00
	09500 AMBULANCE SERVICES 09910 CORF	313, 762	1, 550, 261	776, 684	0	0	95. 00 99. 10
	09920 OUTPATIENT PHYSICAL THERAPY				0	0	99. 20
1	09930 OUTPATIENT OCCUPATIONAL THERAPY				0	0	99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY				0		99. 40
	SPECIAL PURPOSE COST CENTERS	U		'	0	0	77.40
	11300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	3, 451, 460	23, 214, 946	7, 712, 499	0	1, 636, 957	
	IONREI MBURSABLE COST CENTERS	07 10 17 100	20/211/710	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		170007707	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12, 429	6, 227	0	6, 537	190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	O	77, 384			97, 668	
194.00	07950 OCCUPATIONAL HEALTH	o	C	0	0	0	194. 00
194. 01 0	07951 FOUNDATION	6, 166	31, 027	15, 545	0	0	194. 01
194. 03	07952 COMMUNITY & VOLUNTEER SVCS	3, 956	95, 296	47, 743	0		194. 03
	07954 ER PHYSICIAN	0	C) C	0		194. 04
	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	C) C	0	0	194. 06
200.00	Cross Foot Adjustments		C)			200. 00
201.00	Negative Cost Centers	0	C	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	3, 461, 582	23, 431, 082	7, 820, 784	0	1, 741, 162	202. 00

Provi der CCN: 151323

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2014 | Part | To 12/31/2014 | Date/Time Prepared: | 5/21/2015 9:27 am | CASETED A | MANUFACCORD

	_				5/21/2015 9: 2	<u>7 am </u>
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	
	LINEN SERVICE				PERSONNEL	
	8. 00	9.00	10.00	11.00	12.00	
GENERAL SERVICE COST CENTERS	<u>'</u>		,			
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01 00101 EMS WEST STATION						1. 01
· · · · · · · · · · · · · · · · · · ·						ł
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
2.01 O0201 EMS WEST STATION EQUIP.						2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
l l						•
6. 00 00600 MAI NTENANCE & REPAI RS						6. 00
7.00 O0700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	132, 547				1	8. 00
9. 00 00900 HOUSEKEEPI NG	0	422, 316			1	9. 00
	_		/50 170			ı
10. 00 01000 DI ETARY	742	24, 056	659, 173		1	10. 00
11. 00 01100 CAFETERI A	0	0	0	316, 569		11. 00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13. 00 01300 NURSING ADMINISTRATION	0	l ol	0	17, 149	0	13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY		11, 427	0	.,,,	Ö	14. 00
	0	l	0	44.		•
15. 00 01500 PHARMACY	0	9, 834	0	16, 514		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	1, 941	0	0	0	16. 00
17. 00 01700 SOCIAL SERVICE	0	l ol	0	0	0	17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS		ام	0	0	Ö	19. 00
			0	0		
20. 00 02000 NURSI NG SCHOOL	0	ᅵ	U	Ü	0	20. 00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	l ol	0	0	0	22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0	ام	0	0	Ö	23. 00
	0	<u> </u>	U	0		23.00
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDIATRICS	40, 825	126, 970	659, 173	67, 893	0	30.00
43. 00 04300 NURSERY	2, 227	1, 912	0	7, 956	0	43.00
ANCILLARY SERVICE COST CENTERS		, ,	-			
50. 00 05000 OPERATING ROOM	26, 059	72, 370	0	46, 466	0	50.00
			-			1
52.00 05200 DELIVERY ROOM & LABOR ROOM	6, 561	9, 037	0	23, 300		52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	12, 963	35, 866	0	36, 905	0	54.00
60. 00 06000 LABORATORY	0	14, 309	0	00, 700	Ö	60.00
	_	14, 307	0	0		ı
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	l 0	U	0	0	62. 30
65. 00 06500 RESPI RATORY THERAPY	954	7, 488	0	19, 857	0	65.00
66. 00 06600 PHYSI CAL THERAPY	5, 130	23, 983	0	22, 564	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 365		0	5, 349		67. 00
		U	-			•
68. 00 06800 SPEECH PATHOLOGY	941	0	0	2, 541	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	673	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	l ol	0	0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		ام	0	0	Ö	72. 00
	0	١	0	0		•
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	l ol	0	0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	ا	0	Ō	0	76. 99
OUTPATIENT SERVICE COST CENTERS			<u> </u>			1 70. 77
	1 0		0	404		00.00
90. 00 09000 CLI NI C	0		0	401	0	90. 00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	6, 590	0	7, 755	0	90. 01
91. 00 09100 EMERGENCY	26, 284	50, 117	0	41, 919	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			_		1	92.00
						72.00
OTHER REIMBURSABLE COST CENTERS	T					1
95. 00 09500 AMBULANCE SERVICES	5, 673	0	0	0	0	95. 00
99. 10 09910 CORF	0	l ol	0	0	0	99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	ا	0	Ō	0	99. 20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	ام	_	0	0	99. 30
l l	1	٥	0	U		1
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
SPECIAL PURPOSE COST CENTERS						ł
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	129, 724	396, 573	659, 173	316, 569	ا n'	118. 00
NONREI MBURSABLE COST CENTERS	127,727	370, 373	037, 173	310, 307		110.00
	_		_		_	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	0		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	2, 823	24, 128	0	0	1 0'	192.00
194. 00 07950 OCCUPATI ONAL HEALTH	0	ام	0	Λ	n'	194. 00
194. 01 07951 FOUNDATION		ا ا	0	0		194. 00
		ا ا	U	0		
194.03 07952 COMMUNITY & VOLUNTEER SVCS	0	0	0	0		194. 03
194. 04 07954 ER PHYSICIAN	0	l ol	0	0	0	194. 04
194.06 07953 SHI PSHEWANA RADIOLOGY AND LAB	n	اً ا	n	n		194. 06
		1	U	O		1
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)	132, 547	422, 316	659, 173	316, 569	0	202. 00
	•	. '			. '	

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151323 | Period: From 01/01/2014 | Part I Date/Time Prepared:

			То	12/31/2014	Date/Time Pre 5/21/2015 9:2	
Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	, am
	ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY		
	13. 00	14. 00	15. 00	16. 00	17. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 00101 EMS WEST STATION 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1. 01 2. 00
2. 01 OO201 EMS WEST STATION EQUIP.						2. 01
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG						8. 00 9. 00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A						11. 00
12.00 01200 MAINTENANCE OF PERSONNEL						12. 00
13. 00 01300 NURSI NG ADMI NI STRATI ON	579, 625	70.040				13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY	0	78, 818 2, 185	1, 070, 839			14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	2, 183	1, 070, 839	18, 974		16.00
17. 00 01700 SOCI AL SERVI CE	o	Ö	0	0	0	17. 00
19.00 01900 NONPHYSICIAN ANESTHETISTS	0	o	0	0	0	19. 00
20. 00 02000 NURSI NG SCHOOL	0	0	0	0	0	20. 00
21.00 02100 1&R SERVICES-SALARY & FRINGES APPRV 22.00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	21. 00 22. 00
23. 00 02300 PARAMED ED PRGM- (SPECIFY)	0 0	0	0	0		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	91	51	<u> </u>			20.00
30. 00 03000 ADULTS & PEDIATRICS	240, 082	5, 773	69	4, 049	0	30. 00
43. 00 04300 NURSERY	25, 061	628	13	877	0	43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	129, 919	15, 189	2, 355	1, 051	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	67, 618	1, 839	40	0,001	o o	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	1, 883	5, 975	3, 157	0	54. 00
60. 00 06000 LABORATORY	0	0	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 65.00 06500 RESPIRATORY THERAPY		422	0	0		62. 30 65. 00
66. 00 06600 PHYSI CAL THERAPY		324	464	3, 070		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	86	122	666	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	60	86	32	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0 22, 799	0	0	0	69. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	14, 987	0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	O	0	1, 040, 953	0	0	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99 O7699 LITHOTRIPSY OUTPATIENT SERVICE COST CENTERS	0	U	U	0	0	76. 99
90. 00 09000 CLINIC	0	0	0	0	0	90. 00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	52	0	0	0	90. 01
91. 00 09100 EMERGENCY	116, 945	4, 525	2, 315	6, 072	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92. 00
95. 00 09500 AMBULANCE SERVICES	ol	7, 957	18, 447	0	0	95. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99. 20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS	0	O	0	0	0	99. 40
113. 00 11300 NTEREST EXPENSE						113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	579, 625	78, 709	1, 070, 839	18, 974	0	118. 00
NONREI MBURSABLE COST CENTERS			_1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	28 55	0	0	l e	190. 00 192. 00
192.00 19200 PHYSICIANS PRIVATE OFFICES 194.00 07950 OCCUPATIONAL HEALTH		0 25	0	0	l e	192.00
194. 01 07951 FOUNDATI ON		8	0	0		194. 01
194.03 07952 COMMUNITY & VOLUNTEER SVCS	0	18	0	0	l e	194. 03
194. 04 07954 ER PHYSI CI AN	0	0	0	0		194. 04
194.06 07953 SHI PSHEWANA RADI OLOGY AND LAB 200.00 Cross Foot Adjustments	0	O	0	0	0	194. 06 200. 00
201.00 Negative Cost Centers	0	0	0	0	0	200.00
202.00 TOTAL (sum lines 118-201)	579, 625	78, 818	1, 070, 839	18, 974		202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 151323 | Peri od:

Peri od: Worksheet B From 01/01/2014 Part I To 12/31/2014 Date/Time Prepared:

In Lieu of Form CMS-2552-10

5/21/2015 9:27 am INTERNS & RESIDENTS NONPHYSI CI AN NURSI NG SCHOOL SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Cost Center Description ANESTHETI STS Y & FRINGES PRGM COSTS **PRGM APPRV APPRV** 23.00 19.00 20.00 21.00 22.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 FMS WEST STATION 1.01 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00201 EMS WEST STATION EQUIP 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSI NG SCHOOL 0 20.00 20 00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 30.00 04300 NURSERY 0 0 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 50.00 05000 OPERATING ROOM 0 Ω 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 52.00 05300 ANESTHESI OLOGY 0 53 00 0 0 0 0 0 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 000000000 0 0 0 54.00 0 60 00 06000 LABORATORY Ω Ω 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 0 0 06700 OCCUPATIONAL THERAPY 0 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 Λ 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 07697 CARDIAC REHABILITATION 0 76.97 76.97 0 0 0 0 0 76. 98 07698 HYPERBARIC OXYGEN THERAPY C 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90 00 0 90.00 09000 CLI NI C C 0 0 0 90.01 09001 LIFEBRIDGE SENIOR CARE 0 C 0 0 0 90.01 0 0 0 91.00 09100 EMERGENCY C 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 0 0 0 95.00 0 99. 10 09910 CORF 0 0 0 0 99. 10 0 0 99 20 09920 OUTPATIENT PHYSICAL THERAPY 0 99. 20 0 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 99.30 C 0 0 99.30 09940 OUTPATIENT SPEECH PATHOLOGY o 99.40 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 118.00 0 0 0 0 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN C 0 190. 00 0 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.00 Ω 0 194. 00 07950 OCCUPATIONAL HEALTH 0 0 0 194.00 0 0 0 0 0 0 194. 01 194. 01 07951 FOUNDATI ON 0 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 0 0 0 0 0 0 0 194. 03 194. 04 07954 ER PHYSICIAN 0 0 0 194, 04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 194. 06 200.00 Cross Foot Adjustments 0 0 0 200. 00 0 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118-201) 0 0 0 202.00

			To	Date/Time Pre 5/21/2015 9:2	
Cost Center Description	Subtotal	Intern &	Total	70,21,2010 ,12	7 (3.11)
		Residents Cost & Post			
		Stepdown			
	04.00	Adjustments	04.00		
GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1. 00 00100 CAP REL COSTS-BLDG & FIXT					1. 00
1. 01 00101 EMS WEST STATION					1. 01
2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.01 00201 EMS WEST STATION EQUIP.					2. 00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL					5. 00
6. 00 00600 MAI NTENANCE & REPAI RS					6. 00
7. 00 00700 0PERATI ON OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
12. 00 O1200 MAI NTENANCE OF PERSONNEL 13. 00 O1300 NURSI NG ADMI NI STRATI ON					12. 00 13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00 01500 PHARMACY					15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00 01700 SOCIAL SERVICE 19. 00 01900 NONPHYSICIAN ANESTHETISTS					17. 00 19. 00
20. 00 02000 NURSI NG SCHOOL					20.00
21. 00 02100 1 &R SERVI CES-SALARY & FRINGES APPRV					21. 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV					22. 00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)					23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	4, 500, 719	0	4, 500, 719		30.00
43. 00 04300 NURSERY	338, 825	1	338, 825		43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM	2, 859, 586	1	2, 859, 586		50.00
52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY	1, 017, 177 47, 166	0	1, 017, 177 47, 166		52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 149, 440	1	2, 149, 440		54. 00
60. 00 06000 LABORATORY	1, 404, 353	1	1, 404, 353		60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	700 454	-	700 454		62. 30 65. 00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	709, 656 933, 437	0	709, 656 933, 437		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	183, 573	Ö	183, 573		67. 00
68.00 06800 SPEECH PATHOLOGY	116, 124	0	116, 124		68. 00
69. 00 06900 ELECTROCARDI OLOGY	8, 573	0	8, 573		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	496, 427 327, 410		496, 427 327, 410		71. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 153, 317	o	2, 153, 317		73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0		0		76. 98
76. 99 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0	0		76. 99
90. 00 09000 CLINIC	11, 815	0	11, 815		90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	440, 136		440, 136		90. 01
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 917, 025	0	2, 917, 025		91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS		<u> </u>			92.00
95. 00 09500 AMBULANCE SERVICES	2, 359, 022	0	2, 359, 022		95. 00
99. 10 09910 CORF	0	0	0		99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY 99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99. 20
99. 30 O9930 OUTPATI ENT OCCUPATI ONAL THERAPY 99. 40 O9940 OUTPATI ENT SPEECH PATHOLOGY	0	0	0		99. 30 99. 40
SPECIAL PURPOSE COST CENTERS	J	<u> </u>	<u> </u>		77. 10
113.00 11300 I NTEREST EXPENSE					113. 00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	22, 973, 781	0	22, 973, 781		118. 00
NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	26, 836	٥	26, 836		190. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	240, 828	1	240, 828		192. 00
194. 00 07950 OCCUPATI ONAL HEALTH	0	0	0		194. 00
194. 01 07951 FOUNDATION	46, 580	0	46, 580		194. 01
194. 03 07952 COMMUNITY & VOLUNTEER SVCS 194. 04 07954 ER PHYSICIAN	143, 057 0		143, 057		194. 03 194. 04
194. 04 07954 EK PHYSTCTAN 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB			0		194. 04
200.00 Cross Foot Adjustments	0	0	0		200. 00
201.00 Negative Cost Centers	0	0	0		201. 00
202.00 TOTAL (sum lines 118-201)	23, 431, 082	0	23, 431, 082		202. 00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151323 Peri od: Worksheet B From 01/01/2014 Part II То Date/Time Prepared: 12/31/2014 5/21/2015 9:27 am CAPITAL RELATED COSTS Cost Center Description Directly BLDG & FIXT EMS WEST MVBLE EQUIP EMS WEST STATION EQUIP. Assigned New STATI ON Capi tal Related Costs 1.00 1.01 2.00 2.01 0 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 00101 EMS WEST STATION 1.01 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.01 00201 EMS WEST STATION EQUIP. 00400 EMPLOYEE BENEFITS DEPARTMENT 4 00 Ω 5.00 00500 ADMINISTRATIVE & GENERAL 228, 709 0 92, 525 0 6.00 00600 MAINTENANCE & REPAIRS 971, 920 00700 OPERATION OF PLANT 0 7 00 0 71 878 29 078 0 00800 LAUNDRY & LINEN SERVICE 0 8.00 0 4, 110 1,663 0 9.00 00900 HOUSEKEEPI NG 0 13, 450 5, 441 0 10.00 01000 DI ETARY 0 0 53, 961 0 21,830 0 01100 CAFETERIA 0 11 00 0 0 01200 MAINTENANCE OF PERSONNEL 12.00 C 0 0 0 01300 NURSING ADMINISTRATION 13.00 0000 0 0 01400 CENTRAL SERVICES & SUPPLY 10, 370 14.00 25, 632 0 01500 PHARMACY 22, 059 0 8. 924 15 00 0 16.00 01600 MEDICAL RECORDS & LIBRARY 4, 353 0 1, 761 0 01700 SOCIAL SERVICE 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 0 0 02000 NURSI NG SCHOOL 0 20 00 C 0 0 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 0 0 02300 PARAMED ED PRGM-(SPECIFY) 23.00 0 0 INPATIENT ROUTINE SERVICE COST CENTERS

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151323 Peri od: Worksheet B From 01/01/2014 Part II Date/Time Prepared: 12/31/2014 5/21/2015 9:27 am Cost Center Description Subtotal **EMPLOYEE** ADMINISTRATIVE MAINTENANCE & OPERATION OF BENEFITS & GENERAL REPAIRS PLANT **DEPARTMENT** 2A 5.00 6. 00 7. 00 4.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 EMS WEST STATION 1.01 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00201 EMS WEST STATION EQUIP. 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 321, 234 321, 234 5.00 00600 MAINTENANCE & REPAIRS 971, 920 6.00 971, 920 6.00 7.00 00700 OPERATION OF PLANT 100, 956 23,870 124, 826 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 5,773 1,715 0 532 8.00 00900 HOUSEKEEPI NG 5, 457 0 9.00 18.891 1.740 9.00 01000 DI ETARY 10.00 75, 791 7.362 6, 981 10.00 4, 340 11.00 01100 CAFETERI A 0 0 0 0 0 0 0 0 0 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 0 01300 NURSING ADMINISTRATION 13.00 13.00 0 7, 711 0 01400 CENTRAL SERVICES & SUPPLY 3, 316 14.00 36,002 290 14.00 15.00 01500 PHARMACY 30, 983 13, 744 2,854 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 6, 114 126 563 16.00 01700 SOCIAL SERVICE 17 00 0 C 0 Λ 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 0 0 19.00 02000 NURSING SCHOOL 0 0 20.00 0 0 0 20.00 0 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 0 C 0 Λ 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 400, 037 n 38, 968 O 36, 845 30 00 04300 NURSERY 0 43.00 6,023 4,009 0 555 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 228, 013 0 31, 165 0 21, 002 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 28, 473 0 11, 957 2, 623 52.00 0 53.00 05300 ANESTHESI OLOGY 0 647 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 113,002 0 26, 151 0 10, 408 54.00 60 00 06000 LABORATORY 45.082 Ω 18, 263 4, 152 60 00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 Ω 62.30 06500 RESPIRATORY THERAPY 23, 591 8, 920 0 0 0 0 0 0 0 2, 173 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 75, 563 10, 705 6,960 66.00 06700 OCCUPATIONAL THERAPY 67 00 Ω 2 413 67 00 0 0 68.00 06800 SPEECH PATHOLOGY 0 1,542 0 68.00 06900 ELECTROCARDI OLOGY 69.00 71 195 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 6, 493 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 0 4. 283 0 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 15, 250 0 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76. 98 0 0 0 0 07699 LI THOTRI PSY 76. 99 76.99 0 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 156 90.00 09001 LIFEBRIDGE SENIOR CARE 1, 912 90.01 20.762 0 0 90.01 5.471 91.00 09100 EMERGENCY 157, 903 33, 807 0 14, 544 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 31, 901 35.858 0 0 95.00 99. 10 09910 CORF C C 0 0 99. 10 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 0 0 99.20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 99.30 99.30 0 0 0 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 O 0 99.40 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 118.00 2.704.093 0 316, 787 0 117, 355 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 5. 087 256 469 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 76, 019 0 1, 592 7, 002 192. 00 0 194. 00 07950 OCCUPATI ONAL HEALTH 0 194.00 C \cap 194. 01 07951 FOUNDATION 0 638 0 194. 01 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 0 0 194. 03 0 1, 961 0 194. 04 07954 ER PHYSICIAN 0 0 0 194.04 C 194.06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 194, 06 C 0 200.00 Cross Foot Adjustments 0 200.00 201.00 Negative Cost Centers 0 0 201.00

2. 785. 199

321, 234

124, 826 202. 00

TOTAL (sum lines 118-201)

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 151323

					5/21/2015 9: 2	<u>7 am</u>
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	
, and the second se	LINEN SERVICE				PERSONNEL	
	8. 00	9. 00	10.00	11. 00	12.00	
GENERAL SERVICE COST CENTERS	0.00	7. 00	10.00	11.00	12.00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
						1
1.01 O0101 EMS WEST STATION						1. 01
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2. 00
2.01 00201 EMS WEST STATION EQUIP.						2. 01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
						1
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00 00600 MAINTENANCE & REPAIRS						6. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE	8, 020					8. 00
		27, 000				1
9. 00 00900 HOUSEKEEPI NG	0	26, 088				9. 00
10. 00 01000 DI ETARY	45	1, 486	91, 665			10.00
11. 00 01100 CAFETERI A	l ol	0	0	4, 340		11. 00
12.00 01200 MAINTENANCE OF PERSONNEL		n	0	. 0	0	12. 00
		0	0	225	Ö	1
	0	0	U	235		
14.00 O1400 CENTRAL SERVICES & SUPPLY	l ol	706	O	0	0	14. 00
15. 00 01500 PHARMACY	0	607	0	226	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	l ol	120	0	0	0	16. 00
17. 00 01700 SOCI AL SERVI CE		.20	0	0	Ö	
	١	0	0	U	l .	1
19.00 O1900 NONPHYSICIAN ANESTHETISTS	이	U	U	U	0	
20. 00 02000 NURSING SCH00L	0	0	0	0	0	20. 00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV		0	0	0	0	21.00
22.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	ا	0	0	0	Ö	
		0	0	0		1
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	U	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDI ATRI CS	2, 470	7, 842	91, 665	933	0	30. 00
43. 00 04300 NURSERY	135	118	0	109		
	155	110	O O	107		1 43.00
ANCILLARY SERVICE COST CENTERS		1	_		_	4
50.00 05000 OPERATING ROOM	1, 577	4, 471	0	637	0	50.00
52.00 O5200 DELIVERY ROOM & LABOR ROOM	397	558	0	319	0	52. 00
53. 00 05300 ANESTHESI OLOGY	ol	0	0	0	o	53.00
	· -	2 214	0	En4		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	784	2, 216	0	506	0	1
60. 00 06000 LABORATORY	0	884	0	0	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	58	463	0	272	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	310	1, 482	0	309	Ö	
			0			
67. 00 06700 OCCUPATI ONAL THERAPY	83	0	0	73	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	57	0	0	35	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		42	0	0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT			0	0	Ö	1
		0	0	0		
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	U	0	U	0	
73.00 07300 DRUGS CHARGED TO PATIENTS] 0	0	0	0	0	73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0	0	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	l ol	n	0	0	0	76. 98
		0	0	0	Ö	1
	l U	Ų	U	U		76. 99
OUTPATIENT SERVICE COST CENTERS						4
90. 00 09000 CLI NI C	0	0	0	5	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	l ol	407	0	106	0	90. 01
		•	0	575		
91. 00 09100 EMERGENCY	1, 590	3, 096	U	373	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES	343	0	0	0	0	95. 00
99. 10 09910 CORF	0	o	0	Ö		
		0	-	- 1		
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	U	0	0		
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
SPECIAL PURPOSE COST CENTERS	-1	- 1	-	-		
113. 00 11300 I NTEREST EXPENSE						112 00
					_ '	113. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7, 849	24, 498	91, 665	4, 340	0	118. 00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	100	0	0	0	190. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	171	1, 490	0	0	ا م	192. 00
	1	1, 490	-	ا ا		
194. 00 07950 OCCUPATI ONAL HEALTH	0	0	0	0		194. 00
194. 01 07951 FOUNDATI ON	0	0	0	0		194. 01
194.03 07952 COMMUNITY & VOLUNTEER SVCS	l ol	ol	0	ol	0	194. 03
194. 04 07954 ER PHYSICIAN	١	o o	Ŏ	٥		194. 04
		Š	0	o o		
194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	O	0	O		194. 06
200.00 Cross Foot Adjustments					(200.00
, ,						
201.00 Negative Cost Centers	0	o	О	o		201. 00
201.00 Negative Cost Centers	0 8 020	0 26 088	0 91 665	0 4 340	0	201. 00
, ,	0 8, 020	0 26, 088	0 91, 665	0 4, 340	0	

Health Financial Systems In Lieu of Form CMS-2552-10 COMMUNITY HOSPT. OF LAGRANGE CTY IN ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151323 Peri od: Worksheet B From 01/01/2014 Part II 12/31/2014 Date/Time Prepared: 5/21/2015 9:27 am Cost Center Description NURSI NG CENTRAL **PHARMACY** MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & RECORDS & **SUPPLY** LI BRARY 13.00 15.00 17.00 14.00 16,00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 EMS WEST STATION 1.01 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.01 00201 EMS WEST STATION EQUIP. 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8 00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 7,946 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 31, 542 14.00 14.00 15.00 01500 PHARMACY 49, 288 874 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 6, 923 16.00 C C 01700 SOCIAL SERVICE 0 17 00 C 0 0 17.00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 0 19.00 02000 NURSING SCHOOL 0 0 20.00 0 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 21.00 C 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 C 0 0 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 3, 291 2, 310 3 1 477 n 30.00 04300 NURSERY 1 43.00 344 251 320 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 781 6, 078 108 384 0 50.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 927 736 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 0 754 275 0 54.00 1, 152 60 00 06000 LABORATORY 0 60 00 C C 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 0 0 62.30 06500 RESPIRATORY THERAPY 0000 0 0 0 65.00 65.00 169 66.00 06600 PHYSI CAL THERAPY 130 21 1, 120 0 66.00 06700 OCCUPATIONAL THERAPY 67 00 67 00 34 6 243 0 68.00 06800 SPEECH PATHOLOGY 24 4 12 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 9, 125 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 5.998 0 0 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 47, 912 0 0 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 76. 98 0 0 0 07699 LI THOTRI PSY 76. 99 76.99 0 0 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 0 90.00 09001 LIFEBRIDGE SENIOR CARE 90.01 0 90.01 0 21 0 2, 215 91.00 09100 EMERGENCY 1.603 1,811 107 0 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 3, 184 95.00 0 849 0 0 95.00 99. 10 09910 CORF 0 C 0 0 99. 10 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 C 0 0 0 99.20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 99.30 99.30 C 0 0 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 O 0 99.40 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1-117) 31, 499 118.00 7,946 49, 288 6,923 0 118. 00 NONREIMBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 22 0 0 0 192.00 194. 00 07950 OCCUPATI ONAL HEALTH 0 0 0 0 194, 00 C 0 194. 01 07951 FOUNDATION 0 0 0 194. 01 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 0 0 0 0 194. 03 0 194. 04 07954 ER PHYSICIAN 0 0 0 0 194.04

0

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200.00

200.00

201.00

202.00

194.06 07953 SHI PSHEWANA RADI OLOGY AND LAB

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

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

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151323 | Period: From 01/01/2014 | From 01/01/2014 | To 12/31/2014 | Date/Time Prepared:

					o 12/31/2014	Date/Time Pre 5/21/2015 9:2	
				INTERNS &	RESI DENTS	372172013 9.2	27 alli
	Cost Center Description	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL	SERVI CES-SALAR Y & FRI NGES APPRV	SERVICES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	
		19. 00	20. 00	21. 00	22. 00	23. 00	
	BENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	T		I			1.00
	00101 EMS WEST STATION						1. 01
1	00200 CAP REL COSTS-MVBLE EQUIP						2.00
1	00201 EMS WEST STATION EQUIP. 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 01 4. 00
1	00500 ADMINISTRATIVE & GENERAL						5. 00
	00600 MAINTENANCE & REPAIRS						6. 00
	00700 OPERATION OF PLANT						7. 00
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
1	1000 DI ETARY						10.00
	1100 CAFETERIA						11. 00
	01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION						12. 00 13. 00
1	01400 CENTRAL SERVICES & SUPPLY						14. 00
	1500 PHARMACY						15. 00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16. 00 17. 00
	017000 NONPHYSI CLAN ANESTHETI STS						19.00
20.00 0	22000 NURSING SCHOOL		0				20. 00
1	22100 I &R SERVI CES-SALARY & FRI NGES APPRV			C			21. 00
	02200 1&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)				0	O	22. 00 23. 00
	NPATIENT ROUTINE SERVICE COST CENTERS						25.00
	33000 ADULTS & PEDIATRICS						30. 00
	04300 NURSERY NCILLARY SERVICE COST CENTERS						43. 00
	05000 OPERATING ROOM						50.00
1	05200 DELIVERY ROOM & LABOR ROOM						52. 00
1	95300 ANESTHESI OLOGY 95400 RADI OLOGY-DI AGNOSTI C						53. 00 54. 00
	06000 LABORATORY						60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS						62. 30
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY						65. 00 66. 00
1	06700 OCCUPATI ONAL THERAPY						67. 00
	06800 SPEECH PATHOLOGY						68. 00
1	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT						69. 00 71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS						72.00
73.00 0	07300 DRUGS CHARGED TO PATIENTS						73. 00
	07697 CARDI AC REHABI LI TATI ON						76. 97
	07698 HYPERBARI C OXYGEN THERAPY 07699 LITHOTRI PSY						76. 98 76. 99
0	UTPATIENT SERVICE COST CENTERS						
	09000 CLINIC 09001 LIFEBRIDGE SENIOR CARE						90. 00 90. 01
	1900 EI FEBRI DGE SENT OR CARE						91.00
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART						92. 00
	OTHER REIMBURSABLE COST CENTERS OP500 AMBULANCE SERVICES	I		1	T T		95. 00
	19300 AMBULANCE SERVICES						99. 10
	09920 OUTPATIENT PHYSICAL THERAPY						99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY 09940 OUTPATIENT SPEECH PATHOLOGY						99. 30 99. 40
	PECIAL PURPOSE COST CENTERS			1			77. 40
	1300 INTEREST EXPENSE						113. 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) ONREI MBURSABLE COST CENTERS	() 0) C	0	C	118. 00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190. 00
	9200 PHYSI CI ANS' PRI VATE OFFI CES						192. 00
	07950 OCCUPATI ONAL HEALTH 07951 FOUNDATI ON						194. 00 194. 01
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS						194. 01
194. 04 0	07954 ER PHYSICIAN						194. 04
	07953 SHI PSHEWANA RADI OLOGY AND LAB					-	194. 06
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers						200. 00 201. 00
202. 00	TOTAL (sum lines 118-201)		1	1			202. 00
					·		

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 151323

Peri od: Worksheet B From 01/01/2014 Part II To 12/31/2014 Date/Time Prepared:

5/21/2015 9:27 am Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adjustments 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00101 EMS WEST STATION 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 EMS WEST STATION EQUIP 2.01 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8 00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12 00 12 00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSI NG SCHOOL 20 00 20 00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 585, 841 585, 841 30.00 04300 NURSERY 43.00 11,865 11,865 43.00 ANCILLARY SERVICE COST CENTERS 295, 216 50.00 05000 OPERATING ROOM 50.00 295 216 52.00 05200 DELIVERY ROOM & LABOR ROOM 45, 992 0 45, 992 52.00 05300 ANESTHESI OLOGY 53 00 647 647 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 155, 248 0 155, 248 54.00 06000 LABORATORY 0 60.00 68, 381 68, 381 60 00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 06500 RESPIRATORY THERAPY 65.00 35, 646 0 35, 646 65.00 66.00 06600 PHYSI CAL THERAPY 0 96,600 96,600 66,00 06700 OCCUPATI ONAL THERAPY 67.00 2,852 2, 852 67.00 68.00 06800 SPEECH PATHOLOGY 1,674 1,674 68.00 06900 ELECTROCARDI OLOGY 2,430 69.00 69.00 2.430 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 15, 618 15, 618 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 10, 281 10, 281 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 63, 162 73.00 63.162 07697 CARDIAC REHABILITATION 0 76.97 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 0 0 76.98 76. 99 07699 LI THOTRI PSY 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90 00 90 00 09000 CLI NI C 161 161 90.01 09001 LIFEBRIDGE SENIOR CARE 28, 679 C 28, 679 90.01 09100 EMERGENCY 91.00 217, 251 0 217, 251 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 72, 135 0 72, 135 95 00 99. 10 09910 CORF 0 99. 10 0 C 99 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 99.30 0 C 99.30 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 99.40 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 SUBTOTALS (SUM OF LINES 1-117) 1, 709, 679 118.00 1, 709, 679 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 5, 923 5. 923 190.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES Ω 192 00 86, 296 86, 296 194. 00 07950 OCCUPATI ONAL HEALTH 0 194.00 C 194. 01 07951 FOUNDATION 194. 01 641 641 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 1, 968 0 1, 968 194. 03 194.04 07954 ER PHYSICIAN 0 0 0 194.04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 194. 06 0 200.00 Cross Foot Adjustments 0 0 0 200. 00 8.772 8.772 201.00 Negative Cost Centers 0 201. 00 202.00 TOTAL (sum lines 118-201) 1, 813, 279 1, 813, 279 202.00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151323 Peri od: Worksheet B-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/21/2015 9:27 am CAPITAL RELATED COSTS BLDG & FIXT EMS WEST MVBLE EQUIP EMS WEST **EMPLOYEE** Cost Center Description (SQUARE FEET) STATI ON (SQUARE FEET) STATION EQUIP. **BENEFITS** (SQUARE FEET) DEPARTMENT (GROSS (SQUARE FEET) SALARI ES) 1.00 1. 01 2.00 2. 01 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 77 906 1 00 1.01 00101 EMS WEST STATION 9, 760 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 77, 906 2.00 00201 EMS WEST STATION EQUIP. 9, 760 2 01 2 01 Γ 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT C 9, 592, 252 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 14,080 14,080 2, 998, 744 5.00 0 6.00 00600 MAINTENANCE & REPAIRS 0 6.00 00700 OPERATION OF PLANT 7 00 254, 829 4.425 4.425 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 253 253 0 8.00 00900 HOUSEKEEPI NG o 9.00 828 828 161, 597 9.00 0 01000 DI ETARY 129, 868 10.00 10.00 3.322 3, 322 11.00 01100 CAFETERI A 0 C 189, 783 11 00 12.00 01200 MAINTENANCE OF PERSONNEL 0 0 0 12.00 0 01300 NURSING ADMINISTRATION 13.00 0 0 274, 899 13.00 01400 CENTRAL SERVICES & SUPPLY 1.578 14.00 1.578 0 14.00 15 00 01500 PHARMACY 1.358 1.358 404, 165 15 00 01600 MEDICAL RECORDS & LIBRARY 0 16.00 268 268 16.00 17.00 01700 SOCIAL SERVICE 0 0 17.00 C 0 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 19.00 0 0 0 02000 NURSING SCHOOL 0 20.00 0 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 22.00 0 0 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 17, 534 17, 534 955, 718 30.00 43.00 04300 NURSERY 0 0 130, 280 43.00 264 264 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 9, 994 9, 994 50.00 711.145 50.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 1, 248 0 1, 248 381, 344 52.00 05300 ANESTHESI OLOGY 0 53.00 C \cap Ω 53.00 54.00 0 05400 RADI OLOGY-DI AGNOSTI C 4.953 0 4, 953 568, 241 54.00 06000 LABORATORY 60.00 1,976 1,976 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 0 06500 RESPIRATORY THERAPY 284, 824 65.00 1,034 1.034 65.00 0 66.00 66.00 06600 PHYSI CAL THERAPY 3, 312 3, 312 337, 092 67.00 06700 OCCUPATI ONAL THERAPY 0 89, 278 67.00 C 06800 SPEECH PATHOLOGY 68 00 0 O 62,071 68 00 69.00 06900 ELECTROCARDI OLOGY 93 93 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 Ω 0 73 00 0 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 76. 98 76.98 C 0 76.99 07699 LI THOTRI PSY 0 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 5, 241 90.00 0 09001 LIFEBRIDGE SENIOR CARE 910 910 108, 771 90.01 90.01 09100 EMERGENCY 646, 861 91.00 91.00 6.921 6. 921 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 95 00 09500 AMBULANCE SERVICES 0 9, 760 C 9, 760 869, 454 95 00 99 10 09910 CORE 0 99 10 0 0 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 99. 20 0 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 99.30 0 0 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 0 99.40 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 9, 760 9, 564, 205 118. 00 74, 351 9,760 74, 351 NONREIMBURSABLE COST CENTERS 0 190 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 223 223 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 3, 332 3, 332 0 194. 00 07950 OCCUPATIONAL HEALTH 0 Ω 0 0 194.00 194. 01 07951 FOUNDATION 0 0 C 0 17, 086 194. 01 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 0 0 0 10, 961 194. 03 194.04 07954 ER PHYSICIAN 0 0 0 0 194. 04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 194.06 0

200.00

201.00

Cross Foot Adjustments

Negative Cost Centers

200.00

Health Financial Systems	COMMUNITY HOSPT. 0	F LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 9:2	
		CAPITAL REI	_ATED COSTS			
Cost Center Description	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST	EMPLOYEE	
	(SQUARE FEET)	STATI ON	(SQUARE FEET)	STATION EQUIP.	BENEFI TS	
		(SQUARE FEET)			DEPARTMENT	
				(SQUARE FEET)	(GROSS	
					SALARI ES)	
	1.00	1. 01	2.00	2. 01	4. 00	
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 265, 469	16, 040	511, 952	19, 818	3, 461, 582	202. 00
203.00 Unit cost multiplier (Wkst. B, Part	I) 16. 243537	1. 643443	6. 571407	2. 030533	0. 360873	203. 00
204.00 Cost to be allocated (per Wkst. B,					0	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part					0.000000	205.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS

Provi der CCN: 151323

Peri od: Worksheet B-1 From 01/01/2014 Date/Time Prepared: 5/21/2015 9: 27 am

				Т	o 12/31/2014	Date/Time Pre 5/21/2015 9: 2	
	Cost Center Description	Reconciliation	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	, am
		5A	5. 00	6.00	7. 00	8. 00	
1 00	GENERAL SERVICE COST CENTERS						1 00
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION						1. 00 1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01	00201 EMS WEST STATION EQUIP.						2. 01
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	-7, 820, 784	15, 610, 298				4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	0	15, 010, 290	Ó			6. 00
7.00	00700 OPERATION OF PLANT	0	1, 160, 000	0	59, 401		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	83, 365	1	253	10, 000	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	265, 187 357, 762	1	828 3, 322	0 56	9. 00 10. 00
11. 00	1	Ö			0	0	11. 00
12. 00		0		٦ ~	_	0	12.00
13. 00 14. 00		0	,		J	0 0	13. 00 14. 00
15. 00	1		14, 082 667, 887		1, 578 1, 358	0	15. 00
16. 00		Ö	6, 114		268	Ö	16. 00
17. 00		0	0	0	0	0	17. 00
19. 00 20. 00		0	0		0	0 0	19. 00 20. 00
21. 00					0	0	21. 00
22. 00		0	0	0	0	0	22. 00
23. 00		0	0	0	0	0	23. 00
30. 00	I NPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0	1, 893, 358	0	17, 534	3, 080	30. 00
43. 00						168	43. 00
	ANCILLARY SERVICE COST CENTERS		., .				
50.00	1	0		1		1, 966	50.00
52. 00 53. 00	1	0		•		495 0	52. 00 53. 00
54. 00	1	Ö		1	_	978	54. 00
60.00	06000 LABORATORY	0	887, 489	1		0	60.00
62. 30	1	0	0	0	0	0	62. 30
65. 00 66. 00	1	0	433, 461 520, 200	1	1, 034 3, 312	72 387	65. 00 66. 00
67. 00	1			1	0, 312	103	67. 00
68. 00	· ·	0	74, 926		_	71	68. 00
69. 00	1	0			93	0	69. 00
71. 00 72. 00		0	315, 541 208, 143		0	0 0	71. 00 72. 00
73. 00	1	Ö	741, 081		0	0	73. 00
76. 97		0	0	0	0	0	76. 97
76. 98 76. 99		0		0	0	0	76. 98 76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS		0	,,	0	0	70. 77
90. 00	09000 CLI NI C	0			0	0	90.00
90. 01		0					90. 01
91. 00 92. 00		0	1, 642, 889	0	6, 921	1, 983	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
95. 00	1	0	,	1	0	428	95. 00
99. 10 99. 20	1	0		0	0	0	99. 10 99. 20
99. 20 99. 30	1		_	0	_	0	99. 20 99. 30
99. 40	1	Ö		1	_	0	99. 40
	SPECIAL PURPOSE COST CENTERS		ı				
113. 0 118. 0	0 11300 INTEREST EXPENSE 0 SUBTOTALS (SUM OF LINES 1-117)	-7, 820, 784	15, 394, 162	<u> </u>	55, 846	0 707	113. 00 118. 00
116.0	NONREI MBURSABLE COST CENTERS	-7,020,704	15, 394, 102	.[33, 640	9, 101	110.00
190. 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12, 429) 0	223	0	190. 00
192.0	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0	,	0	3, 332		192. 00
	0 07950 OCCUPATI ONAL HEALTH 1 07951 FOUNDATI ON	0	_) 0	0		194. 00 194. 01
	3 07952 COMMUNITY & VOLUNTEER SVCS		95, 296		0		194. 01
194. 0	4 07954 ER PHYSICIAN	0	0	ol o	o o	0	194. 04
	6 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	0	0	0	194. 06
200. 0 201. 0							200. 00 201. 00
201.0			7, 820, 784	. 0	1, 741, 162	132, 547	
	Part I)						
203. 0	O Unit cost multiplier (Wkst. B, Part I)		0. 501002	0.000000	29. 311998	13. 254700	203. 00

Health Financial Systems	COMMUNI T	Y HOSPT. (F LAGRANGI	E CTY	IN	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Prov	vi der		Peri od:	Worksheet B-1	
						From 01/01/2014 To 12/31/2014		
Cost Center Description	Reco	onciliatio			MAI NTENANCE		LAUNDRY &	
			& GENE	RAL	REPAI RS	PLANT	LINEN SERVICE	
			(ACCUM.	COST)	(SQUARE FEET	(SQUARE FEET)	(POUNDS OF	
							LAUNDRY)	
		5A	5. 00)	6.00	7. 00	8. 00	
204.00 Cost to be allocated (per Part II)	Wkst. B,		32	1, 234	971, 92	0 124, 826	8, 020	204. 00
205.00 Unit cost multiplier (Wks	t. B, Part		0.0	20578	0. 00000	0 2. 101412	0. 802000	205. 00

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

Provider CCN: 151323 Period: From 01/01/2014 To 12/31/2014 Date/Time Prepared: 5/21/2015 9: 27 am

					-rom 01/01/2014 Го 12/31/2014		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	5/21/2015 9: 2 NURSI NG	7 am
		(SQUARE FEET)	(MEALS SERVED)	(FTE)	PERSONNEL (NUMBER	ADMI NI STRATI ON	
					HOUSED)	(DIRECT NRSING	
		9. 00	10.00	11. 00	12.00	HRS) 13.00	
	GENERAL SERVICE COST CENTERS	7.00	10.00	11.00	12.00	10.00	
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2. 01	00201 EMS WEST STATION EQUIP.						2. 01
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS						6.00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	50,000					8.00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	58, 320 3, 322					9.00
11. 00	01100 CAFETERI A	3, 322	1	9, 470			11.00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0		0		12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	1 570	0	51:		114, 369	1
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	1, 578 1, 358		494	-	0	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	268	l I	(Ö	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	(0	0	17. 00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0	(0	0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV		0	(21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	ō	(0	Ö	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	(0	0	23. 00
30. 00	O3000 ADULTS & PEDIATRICS	17, 534	27, 552	2, 03	1 0	47, 372	30.00
43. 00	04300 NURSERY	264		2, 03			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	9, 994	1	1, 390			
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	1, 248	0	697	7 0	13, 342	52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 953	Ö	1, 10	4 0	Ö	54.00
60.00	06000 LABORATORY	1, 976	0		0	0	60.00
62. 30 65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	1, 034	0	59 ₄		0	62. 30 65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 312	l I	67!			66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	l I	160		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0		70		0	68.00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	93	0	(0	0	69. 00 71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ö	(0	Ö	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	(0	0	73. 00
76. 97 76. 98	O7697 CARDI AC REHABI LI TATI ON O7698 HYPERBARI C OXYGEN THERAPY	0	0	(0	0	76. 97 76. 98
	07699 LI THOTRI PSY						
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0		12		0	90.00
90. 01 91. 00	09001 LI FEBRI DGE SENI OR CARE 09100 EMERGENCY	910 6, 921		232 1, 254			90. 01 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	3,72.		., 20		20,070	92. 00
05.00	OTHER REIMBURSABLE COST CENTERS	1			J .		05.00
95. 00 99. 10	09500 AMBULANCE SERVI CES 09910 CORF		0	(0	
99. 20	09920 OUTPATIENT PHYSICAL THERAPY			(
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	ō	(0	Ö	
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	(0	0	99. 40
113 00	SPECIAL PURPOSE COST CENTERS 11300 NTEREST EXPENSE						113. 00
118.00		54, 765	27, 552	9, 470	o	114, 369	
	NONREI MBURSABLE COST CENTERS						
	1900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1920 PHYSICIANS' PRIVATE OFFICES	223 3, 332					190. 00 192. 00
	07950 OCCUPATIONAL HEALTH	3, 332	l .	(194. 00
194. 01	07951 FOUNDATI ON		l o	(o o	0	194. 01
	07952 COMMUNITY & VOLUNTEER SVCS	0	0	(0		194. 03
	07954 ER PHYSICIAN 07953 SHIPSHEWANA RADIOLOGY AND LAB	0	0	(0		194. 04 194. 06
200.00				(200. 00
201.00							201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	422, 316	659, 173	316, 569	9 0	579, 625	202. 00
							1

Health Financial Systems COMM	MUNITY HOSPT. O	F LAGRANGE CTY	IN	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2014 Fo 12/31/2014		
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	
	(SQUARE FEET)	(MEALS SERVED)	(FTE)	PERSONNEL	ADMI NI STRATI ON	
				(NUMBER		
				HOUSED)	(DIRECT NRSING	
					HRS)	
	9. 00	10.00	11. 00	12.00	13. 00	
203.00 Unit cost multiplier (Wkst. B, Part I)	7. 241358	23. 924688	33. 428617	0.000000	5. 068025	203. 00
204.00 Cost to be allocated (per Wkst. B,	26, 088	91, 665	4, 340	0	7, 946	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 447325	3. 326982	0. 458289	0.000000	0. 069477	205. 00

1-01 00101 EN SETS TATION		Financial Systems COM LLOCATION - STATISTICAL BASIS	MUNITY HOSPT. OF		CCN: 151323 P	In Lie eriod: rom 01/01/2014	worksheet B-1	
SPRINGES A COSTYDE RECORDS & TIRRUPY AMESTIFITI STS CREDITS TIRRUPY CREDITS TIRRUPY CREDITS TIRRUPY CREDITS TIRRUPY CREDITS TIRRUPY TIRR		Cost Contor Description	CENTRAL	DHADMACV			5/21/2015 9: 2	
REQUIS. 15.00 16.00 17.00 19.00		cost center bescription	SERVI CES & SUPPLY	(COSTED	RECORDS & LI BRARY		ANESTHETI STS (ASSI GNED	
Cherent Staylor (OS) (EM) (SE)			REQUIS.)	15.00	14.00	17.00	10.00	
1.01		GENERAL SERVICE COST CENTERS	14.00	15.00	10.00	17.00	17.00	
2.00		l I						1.00
0.000 0.000 FART VITE REPORT ITS DEPARTMENT								2. 00
5.00								2. 01
0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000000		1						4. 00 5. 00
8.00		00600 MAINTENANCE & REPAIRS						6. 00
9.90 0.0900 INJENSEPPING 10.00 10.00 10.00 11.00		1						7.00
11.00 01100 CAFETERIA								9. 00
12.00 01200 MAINTENANCE OF PERSONNEL 1.004,620 1.14 1.00 01300 01400 CENTRAL SERVICES & SUPPLY 1.004,620 1.14 1.00 01300 01400 01400 CENTRAL SERVICES & SUPPLY 1.004,620 1.15								10.00
13.00 0.1300 MURSIN A DMIN SINATION								12.00
15.00 01500 PHARMACY 30.339 325,130 15.1 17.0 00 10.0 10.0 10.0 17.1 17.0 17.0 17.0 17.0 17.1 17.0 17.0 17.0 17.1 17.0 17.0 17.0 17.1 17.0	13.00	01300 NURSI NG ADMI NI STRATI ON						13. 00
16.00 10-000 NEDICAL RECORDS & LIBRARY 0 0 10.000 17.7 17.00 10700 5001 LESPRIC 1.00 0 0 17.7 17.00 10700 5001 LESPRIC 1.00 0 0 0 17.7 17.00 10700 1080 SCHOLD 1.00 0 0 0 19.1 17.00 10700 1.00 1.00 1.00 0 0 0 19.1 17.00 10700 1.00 1.00 1.00 0 0 0 19.1 17.00 10700 1.00 1.00 1.00 0 0 0 0 19.1 17.00 10700 1.00 1.00 1.00 0 0 0 0 19.1 17.00 10700 1.00 1.00 1.00 0 0 0 0 0 19.1 17.00 10700 1.00 1.00 1.00 1.00 0 0 0 0 0 17.00 1.00 1.00 1.00 1.00 1.00 0 0 0 0 17.00 1.00 1.00 1.00 1.00 1.00 1.00 18.00 1.00 1.00 1.00 1.00 1.00 1.00 18.00 1.00 1.00 1.00 1.00 1.00 18.00 1.00 1.00 1.00 1.00 1.00 18.00 1.00 1.00 1.00 1.00 1.00 18.00 1.00 1.00 1.00 1.00 1.00 18.00 1.00 1.00 1.00 18.00 1.00 1.00				225 120				14.00
9.00 01900 NOMPHYSICIAN AMESTHETISTS 0 0 0 0 0 29.1			1		10, 000			16. 00
20.00			0	0				17. 00
21.00 02100 RR SERVICES-SALARY & FRINCES APPRY 0 0 0 0 0 22.1, 22.0 02200 RR SERVICES-SOTHER PREMI COSTS APPRY 0 0 0 0 0 22.2, 23.00 03200 PARAMED ED PREMI-CEPTCES 0 0 0 0 0 22.2, 23.00 03200 PARAMED ED PREMI-CEPTCES 0 0 0 0 0 0 22.2, 23.00 03000 NOUTES & PEDIATRICS 80.175 21 2, 134 0 33.0, 20.0 3300 UNISTERY 20.0 03000 UNISTERY 2.0 2.1 4 462 0 43.1 4 462 0 43.1 4 462 0 43.1 4 462 0 43.1 4 4 462 0 43.1 4 4 462 0 43.1 4 4 4 4 4 4 4 4 4			0	0	_	_	0	19.00
23.00 02300 PARAMED ED PROU-CSPECIFY) 0 0 0 0 23.1	21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	O	0	0	0		21. 00
INPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 30.00 03.00 OAUTES & PEDIATRIC S 8,724 4 4 462 0 43.			0	0				22.00
A3.00 04300 NURSERY	23.00		<u> </u>	U		U] 23.00
MOCILLARY SERVICE COST CENTERS			1					30.00
50.00 05000 0FERTING ROOM 210,940 715 554 0 0 50.0 52.0 0 520 0 6200 0 61.0 10 62.0 0 0 0 0 0 0 0 0 0	43.00		8, 724	4	462	U		43. 00
53.00 06300 ANESTHESI OLOGY 0 0 0 0 5.34		05000 OPERATING ROOM	1				_	
54.00 05400 RADIO LOCY-DI AGNOSTIC 26, 155 1, 814 1, 664 0 0 54.4		1	25, 538	12			_	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 0 0 62. 65.00 06500 RESPIRATORY THERAPY 4,496 141 1,618 0 0 66. 66.00 06600 PISIS CAL THERAPY 1,191 37 351 0 0 67. 67.00 06700 OCCUPATIONAL THERAPY 1,191 37 351 0 0 67. 68.00 06800 SPEECH PATHOLOGY 827 26 177 0 0 68. 69.00 06900 ELECTROCARDIOLOGY 827 26 177 0 0 68. 69.00 06900 SPEECH PATHOLOGY 827 26 177 0 0 68. 69.00 06900 ELECTROCARDIOLOGY 827 26 177 0 0 69. 69.00 06900 ELECTROCARDIOLOGY 827 26 177 0 0 0 0 0 0 0 0 0		1	26, 155	1, 814	_	_	_	1
65.00 0.0500 RESPIRATORY THERAPY 5,855 0 0 0 0 0 0 0 0 0		1	-	0			_	
66.00 06600 PHYSI CAL THERAPY 4,496 141 1,618 0 0 66.7 67.00 06700 OCCUPATIONAL THERAPY 1,191 37 351 0 0 67.4 68.00 06800 SPEECH PATHOLOGY 827 26 17 0 0 68.4 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 67.00 07000 MEDI CAL SUPPLIES CHARGED TO PATIENT 316,643 0 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 208,143 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 208,143 0 0 0 0 0 74.00 07400 DRUG CAL RARGED TO PATIENTS 208,143 0 0 0 0 0 75.90 07697 CARDIA CREHABILITATION 0 0 0 0 0 76.98 07698 HYPEBBARI C OXYGEN THERAPY 0 0 0 0 0 76.99 07699 LITHOTRIPSY 0 0 0 0 0 76.10 07000 CLINIC SERVICE COST CENTERS 70.00 07000 CLINIC SERVICE SERVICES 3 0 0 0 0 70.00 07000 MBULANCE SERVICES 3 0 0 0 0 70.00 07000 MBULANCE SERVICES 110,510 5,601 0 0 0 70.00 07000 OWEN CALCES 0 0 0 70.00 07000 OWEN CALCES 0 0 0 0 70.00 07000 OWEN CALCES 0 0 0 0 70.00 07000 OWEN CALCES 0 0 0 70.00 07000 OWEN CALCES 0 0 0 0 70.00 07000 OWEN CALCES 0 0 70.00 07000 OWEN CALCES 0 0 0 70.00 07000 OWEN C			-	0				1
68.00 06800 SPEECH PATHOLOGY 827 26 17 0 0 68.1	66.00	06600 PHYSI CAL THERAPY	4, 496					66. 00
69-00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 6.69.							_	
172.00 07200 IMPL DEV. CHARGED TO PATIENTS 208,143 0 0 0 0 72.4			1	0			_	1
73.00 07300 DRUGS CHARGED TO PATIENTS 0 316,056 0 0 0 73.4 76.97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 76.98 07698 HYPERBARI C DXYGEN THERAPY 0 0 0 0 0 0 76.99 07699 LITHOTRI PSY 0 0 0 0 0 0 90.00 07699 LITHOTRI PSY 0 0 0 0 0 90.01 09000 CLI NI C 33 0 0 0 0 0 90.01 09000 CLI NI C 33 0 0 0 0 0 90.01 09000 CLI NI C 33 0 0 0 0 0 90.01 09000 CLI NI C 0 0 0 0 0 90.01 09000 DEBECRENCY 62,841 703 3,200 0 0 91.4 91.00 09100 EMERGENCY 62,841 703 3,200 0 0 91.4 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 92.4 95.00 09500 AMBULANCE SERVI CES 110,510 5,601 0 0 0 95.4 99.10 09910 CORF 0 0 0 0 0 99.2 99.20 09920 OUTPATI ENT PHYSI CAL THERAPY 0 0 0 0 0 99.2 99.30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 0 0 99.2 99.40 09940 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 0 0 99.40 09940 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 0 99.40 OSPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11900 0 0 0 0 0 0 0 0 194.01 07951 FOUNDATI ON 1111 0 0 0 0 0 194.01 07951 FOUNDATI ON 1111 0 0 0 0 0 194.01 07951 FOUNDATI ON 1111 0 0 0 0 0 194.01 07951 FOUNDATI ON 1111 0 0 0 0 0 194.01 07951 FOUNDATI ON 1111 0 0 0 0 0 0 0 0			1	0	-		_	
76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 0 0 76. 976. 99 07699 LITHOTRI PSY 0 0 0 0 0 0 0 0 0			· · · · · · · · · · · · · · · · · · ·	316, 056			_	1
76. 99 07699 LTHOTRI PSY 0 0 0 0 0 0 0 0 0	76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0		
OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE COST CENTERS OUTPATIENT SERVICE SENIOR CARE 725			0	0			_	
90. 01 09001 LI FEBRI DGE SENI OR CARE 725 0 0 0 0 90. 0 91. 00 09100 EMERGENCY 62,841 703 3,200 0 0 91. 0 92. 00 09200 08SERVATI ON BEDS (NON-DI STI NCT PART 92. 0 09200 098SERVATI ON BEDS (NON-DI STI NCT PART 92. 0 099. 10 09910 CORF 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY 0 0 0 0 0 99. 30 09930 OUTPATI ENT DECUPATIONAL THERAPY 0 0 0 0 0 99. 40 09940 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99. 40 09940 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99. 40 OUTPATI ENT SPEECH P		OUTPATIENT SERVICE COST CENTERS				-	_	
91.00 09100 EMERGENCY 62,841 703 3,200 0 0 91.0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.0 95.00 09500 AMBULANCE SERVICES 110,510 5,601 0 0 0 99.10 09910 CORF 0 0 0 0 0 99.20 09920 OUTPATI ENT PHYSICAL THERAPY 0 0 0 0 0 99.30 09930 OUTPATI ENT OCCUPATIONAL THERAPY 0 0 0 0 0 99.40 09940 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.40 09940 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 5 5 5 5 118.00 NONREI MBURSABLE COST CENTERS 113.00			3	0				
OTHER REIMBURSABLE COST CENTERS 95.00 O9500 AMBULANCE SERVI CES 110,510 5,601 0 0 0 0 95.0			1	703	_	_		
95. 00	92. 00							92. 00
99. 20	95. 00		110, 510	5, 601	0	0	0	95. 00
99. 30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0			0	0	0	0	_	
99. 40			0	0		0	_	1
113.00 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) 1,093,105 325,130 10,000 0 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 770 0 0 0 0 192.00 194.00 19750 OCCUPATI ONAL HEALTH 0 0 0 0 0 194.01 194.01 194.01 194.03 19752 COMMUNI TY & VOLUNTEER SVCS 247 0 0 0 0 194.04 194.04 194.04 194.05 194.06		09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0		
118.00 SUBTOTALS (SUM OF LINES 1-117) 1,093,105 325,130 10,000 0 0 118.00	113 00		Т		<u> </u>			113 00
190.00 19000 GFT, FLOWER, COFFEE SHOP & CANTEEN 387 0 0 0 190.0 192.0 192.0 19200 PHYSICIANS' PRIVATE OFFICES 770 0 0 0 192.0 194.0			1, 093, 105	325, 130	10, 000	0	0	118. 00
192. 00	100.00		207	0			0	100.00
194. 00 07950 OCCUPATI ONAL HEALTH 0 0 0 0 0 0 0 194. 0 194. 01 07951 FOUNDATI ON 111 0 0 0 0 0 0 194. 03 07952 COMMUNI TY & VOLUNTEER SVCS 247 0 0 0 0 0 194. 04 07954 ER PHYSI CI AN 0 0 0 0 0 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 0 194. 06 07953 Cross Foot Adjustments 0 0 0 0 0 200. 00 Cross Foot Adjustments 0 0 0 0 0 201. 00 Negative Cost Centers 201. 0 202. 00 Cost to be allocated (per Wkst. B, 78, 818 1, 070, 839 18, 974 0 0 0 202. 0				0				190.00
194. 03 07952 COMMUNITY & VOLUNTEER SVCS 247 0 0 0 0 194. 04 194. 04 07954 ER PHYSI CI AN 0 0 0 0 0 194. 04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 0 0 194. 06 200. 00 Cross Foot Adjustments 201. 00 Negative Cost Centers 202. 00 Cost to be allocated (per Wkst. B, 78, 818 1, 070, 839 18, 974 0 0 202. 0			-	0	0	0		194. 00
194. 04 07954 ER PHYSICIAN 0 0 0 0 0 194. 0 194. 0 0 0 0 0 0 194. 0 0 0 0 0 0 194. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	0		
200.00 Cross Foot Adjustments 200.0 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, 78,818 1,070,839 18,974 0 0 202.0			0	0	0	o o	0	194. 04
201.00 Negative Cost Centers 201.00 Cost to be allocated (per Wkst. B, 78,818 1,070,839 18,974 0 0 202.00			0	0	0	0	0	194. 06
202.00 Cost to be allocated (per Wkst. B, 78,818 1,070,839 18,974 0 0 202.0		1 1						200.00
1 112		Cost to be allocated (per Wkst. B,	78, 818	1, 070, 839	18, 974	0	0	202. 00
		Part I)	1		I	l	<u> </u>	1

Heal th Finar	ncial Systems COMM	IUNI TY HOSPT. (OF LAC	GRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COST ALLOCA	TION - STATISTICAL BASIS			Provi der		Peri od:	Worksheet B-1	
						From 01/01/2014 Fo 12/31/2014	Date/Time Pre 5/21/2015 9:2	
	Cost Center Description	CENTRAL	P	HARMACY	MEDI CAL	SOCI AL SERVI CE	NONPHYSI CI AN	
		SERVICES &	((COSTED	RECORDS &		ANESTHETI STS	
		SUPPLY	R	EQUIS.)	LI BRARY	(TIME SPENT)	(ASSI GNED	
		(COSTED			(TIME SPENT)		TIME)	
		REQUIS.)						
		14.00		15.00	16.00	17. 00	19. 00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 07200	5	3. 293572	1. 89740	0.000000	0.000000	203. 00
204. 00	Cost to be allocated (per Wkst. B,	40, 31	4	49, 288	6, 92	3 0	0	204. 00
	Part II)							
205. 00	Unit cost multiplier (Wkst. B, Part	0. 02881	5	0. 151595	0. 69230	0.000000	0.000000	205. 00
	[11)							

	Financial Systems COMM LLOCATION - STATISTICAL BASIS	MUNITY HOSPT. O			In Lie eriod:	worksheet B-1
				Fr To	com 01/01/2014 12/31/2014	
			I NTERNS &	RESI DENTS		5/21/2015 9:27 am
	Cost Center Description	NURSING SCHOOL	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
		(ASSI GNED	Y & FRINGES APPRV	PRGM COSTS APPRV	PRGM (ASSI GNED	
		TI ME)	(ASSI GNED	(ASSI GNED	TIME)	
		20. 00	TI ME) 21. 00	TI ME) 22. 00	23. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT		I			1.00
1. 01	00101 EMS WEST STATION					1.00
2. 00 2. 01	OO200 CAP REL COSTS-MVBLE EQUIP OO201 EMS WEST STATION EQUIP.					2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO 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					10.00
11. 00 12. 00	O1100 CAFETERI A O1200 MAI NTENANCE OF PERSONNEL					11. 00
13.00	01300 NURSING ADMINISTRATION					13. 00
	O1400 CENTRAL SERVI CES & SUPPLY O1500 PHARMACY					14. 00 15. 00
	01600 MEDI CAL RECORDS & LI BRARY					16. 00
	01700 SOCI AL SERVI CE					17. 00
	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0				19.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV		0			21. 00
	O2200 1 & R SERVI CES-OTHER PRGM COSTS APPRV O2300 PARAMED ED PRGM-(SPECIFY)			0	0	22. 00 23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS					20.00
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	0 0			0	
F0 00	ANCILLARY SERVICE COST CENTERS					
50. 00 52. 00	O5000 OPERATING ROOM O5200 DELIVERY ROOM & LABOR ROOM	0 0	1		0	
53.00	05300 ANESTHESI OLOGY	0	ō	0	0	53. 00
54. 00 60. 00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	0	0	0	54.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	ō	0	0	62. 30
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0	0	0	65.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	Ö	Ö	0	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	0	0	68.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	Ö	ő	Ö	0	l .
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	72.00
76. 97	07697 CARDI AC REHABI LI TATI ON	Ö	ő	Ö	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0	0	0	0	76. 98 76. 99
70. 77	OUTPATIENT SERVICE COST CENTERS			0	U	
90.00	09000 CLI NI C 09001 LI FEBRI DGE SENI OR CARE	0	0	0	0	90.00
91.00	09100 EMERGENCY	Ö	ő	o o	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					92. 00
	09500 AMBULANCE SERVICES	0	0	0	0	95. 00
99. 10 99. 20	09910 CORF 09920 OUTPATI ENT PHYSI CAL THERAPY	0	0	0	0	99. 10 99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS	0	0	0	0	99. 40
113.00	11300 NTEREST EXPENSE					113. 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	0	0	0	0	118. 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	
	19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH	0	0	0	0	192. 00 194. 00
194. 01	07951 FOUNDATI ON		0	0	0	194. 01
	07952 COMMUNITY & VOLUNTEER SVCS 07954 ER PHYSICIAN	0	0	0	0	194. 03 194. 04
194.06	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	0	0	194. 06
200. 00 201. 00	1 1					200. 00 201. 00
201.00	negative oust contens	I	I	I I		201.00

Health Financial Systems	COMMUNITY HOSPT. OF	F LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 9:2	
		INTERNS &	RESI DENTS			
Cost Center Description	NURSI NG SCHOOL	SERVI CES-SALAR Y & FRI NGES	SERVICES-OTHE PRGM COSTS	R PARAMED ED PRGM		
	(ASSI GNED TIME)	APPRV (ASSI GNED	APPRV (ASSI GNED	(ASSIGNED TIME)		
		TIME)	TIME)			
	20. 00	21. 00	22. 00	23. 00		
202.00 Cost to be allocated (per Wkst. B, Part I)	0	0		0		202. 00
203.00 Unit cost multiplier (Wkst. B, Par	t I) 0.000000	0. 000000	0.00000	0. 000000		203. 00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	0		0		204. 00
205.00 Unit cost multiplier (Wkst. B, Par	t 0. 000000	0. 000000	0.00000	0. 000000		205. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES | Peri od: | Worksheet C | From 01/01/2014 | Part I | To 12/31/2014 | Date/Time Prepared: Provi der CCN: 151323

					10 12/31/2014	5/21/2015 9: 2	
			Ti tl	e XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	•	(from Wkst. B,	Áďj.		Di sal I owance		
		Part I, col.					
		26)					
		1, 00	2.00	3, 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			•			
30.00	03000 ADULTS & PEDIATRICS	4, 500, 719		4, 500, 71	9 0	0	30.00
43.00	04300 NURSERY	338, 825		338, 82	5 0	0	43.00
	ANCILLARY SERVICE COST CENTERS		l		-,		
50.00	05000 OPERATI NG ROOM	2, 859, 586		2, 859, 58	6 0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 017, 177		1, 017, 17		0	52.00
53. 00	05300 ANESTHESI OLOGY	47, 166		47, 16		0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 149, 440		2, 149, 44		0	54.00
60.00	06000 LABORATORY	1, 404, 353	l e	1, 404, 35		0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0	0	62. 30
65. 00	06500 RESPIRATORY THERAPY	709, 656	0	709, 65	6 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	933, 437	0	933, 43		0	1
67. 00	06700 OCCUPATI ONAL THERAPY	183, 573	0	183, 57		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	116, 124	0	116, 12		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	8, 573		8, 57		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	496, 427		496, 42		0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	327, 410		327, 41		0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 153, 317		2, 153, 31		0	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0		,	ol ol	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0			o o	0	1
76, 99	07699 LI THOTRI PSY	0			0	0	76, 99
	OUTPATIENT SERVICE COST CENTERS	_			-,		
90.00	09000 CLI NI C	11, 815		11, 81	5 0	0	90.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	440, 136	l	440, 13		0	90. 01
91. 00	09100 EMERGENCY	2, 917, 025		2, 917, 02		0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	827, 199		827, 19		0	
	OTHER REIMBURSABLE COST CENTERS				-		
95.00	09500 AMBULANCE SERVI CES	2, 359, 022		2, 359, 02	2 0	0	95. 00
99. 10	09910 CORF	0		_, _,,	0	0	
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0			0	0	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0			n i	0	
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0)	0	
	SPECIAL PURPOSE COST CENTERS	_		I.	-		
113. 00	11300 I NTEREST EXPENSE						113. 00
200.00		23, 800, 980	0	23, 800, 98	o	0	200.00
201.00		827, 199	l e	827, 19			201. 00
202.00		22, 973, 781	l .				202. 00
	(222 :::21		'	,,	١	ľ	, ,_,_,

202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 151323 Peri od: Worksheet C From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/21/2015 9:27 am Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 4, 365, 246 30.00 30.00 4, 365, 246 43.00 04300 NURSERY 622, 796 622, 796 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 387, 013 9, 623, 299 13, 010, 312 0.219794 0.000000 50.00 0.558186 0.000000 05200 DELIVERY ROOM & LABOR ROOM 52.00 1, 822, 289 1, 822, 289 52 00 53.00 05300 ANESTHESI OLOGY 332, 547 923, 211 1, 255, 758 0.037560 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 115, 018 17, 295, 254 18, 410, 272 0.116752 0.000000 54.00 06000 LABORATORY 0.276022 0.000000 60.00 1, 034, 922 4, 052, 910 5, 087, 832 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0.000000 0.000000 62 30 65.00 06500 RESPIRATORY THERAPY 441, 245 1, 235, 189 1, 676, 434 0.423313 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 278, 244 1, 210, 865 1, 489, 109 0.626843 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 234, 997 297, 281 0. 344882 67.00 532, 278 0.000000 67.00 68.00 06800 SPEECH PATHOLOGY 21, 713 61, 216 82, 929 1.400282 0.000000 68.00 06900 ELECTROCARDI OLOGY 125, 832 211, 907 337, 739 0.025384 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 558, 261 1, 264, 317 1, 822, 578 0.272376 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 807 599 1, 029, 188 72 00 221, 589 0.318125 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 242, 150 3, 679, 185 5, 921, 335 0.363654 0.000000 73.00 07697 CARDIAC REHABILITATION 0.000000 76. 97 0 0 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 0 0 0.000000 0.000000 07699 LI THOTRI PSY 76.99 0 0 0.000000 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 7, 291 7, 291 1.620491 0.000000 90.00 90 01 09001 LIFEBRIDGE SENIOR CARE 0 189, 650 189, 650 2 320780 0.000000 90 01 299, 184 91.00 09100 EMERGENCY 8, 535, 874 8, 835, 058 0.330165 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 810, 728 810, 728 1.020316 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 0 3, 411, 770 3, 411, 770 0.691436 99. 10 09910 CORF 0 99. 10 09920 OUTPATIENT PHYSICAL THERAPY 0 99. 20 0 0 99. 20 0 99 30 09930 OUTPATIENT OCCUPATIONAL THERAPY Ω O 99 30 09940 OUTPATIENT SPEECH PATHOLOGY 0 99.40 99.40 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 200 00 17, 689, 056 53.031.536 70, 720, 592 200. 00 Subtotal (see instructions) 201.00 201. 00 Less Observation Beds

17, 689, 056

53, 031, 536

70, 720, 592

202.00

Total (see instructions)

Heal th Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 151323 Period: Worksheet C From 01/01/2014 To 12/31/2014 Date/Time Prepared:

5/21/2015 9:27 am Title XVIII Hospi tal Cost PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 43.00 04300 NURSERY 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 54.00 60.00 06000 LABORATORY 0.000000 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 62.30 06500 RESPIRATORY THERAPY 0.000000 65.00 65 00 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 73.00 73.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 76.97 76. 98 07698 HYPERBARIC OXYGEN THERAPY 0.000000 76.98 07699 LI THOTRI PSY 76. 99 76. 99 0.000000 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 90.00 90.01 09001 LIFEBRIDGE SENIOR CARE 0.000000 90.01 91.00 09100 EMERGENCY 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 92.00 0.000000 92.00 95.00 09500 AMBULANCE SERVICES 0. 000000 95.00 99. 10 09910 CORF 99. 10 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 99. 20 99. 30 |09930 OUTPATIENT OCCUPATIONAL THERAPY 99.30 09940 OUTPATIENT SPEECH PATHOLOGY 99. 40 99.40 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 200. 00 201.00 Less Observation Beds 201. 00 202.00 Total (see instructions) 202.00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 151323

						5/21/2015 9: 2	7 am
			Ti t	le XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	4, 500, 719		4, 500, 719	0	4, 500, 719	30.00
43.00	04300 NURSERY	338, 825		338, 825	ol ol	338, 825	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	2, 859, 586		2, 859, 586	0	2, 859, 586	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 017, 177		1, 017, 177		1, 017, 177	
53. 00	05300 ANESTHESI OLOGY	47, 166		47, 166		47, 166	•
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 149, 440		2, 149, 440		2, 149, 440	1
60.00	06000 LABORATORY	1, 404, 353		1, 404, 353		1, 404, 353	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		1, 101, 000		0	62. 30
65. 00	06500 RESPIRATORY THERAPY	709, 656	d	709, 656		709, 656	1
66. 00	06600 PHYSI CAL THERAPY	933, 437		933, 437		933, 437	
67. 00	06700 OCCUPATI ONAL THERAPY	183, 573		183, 573		183, 573	
68. 00	06800 SPEECH PATHOLOGY	116, 124		116, 124		116, 124	
69.00	06900 ELECTROCARDI OLOGY	8, 573		8, 573		8, 573	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT						•
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	496, 427		496, 427		496, 427	l
72.00		327, 410		327, 410		327, 410	1
	07300 DRUGS CHARGED TO PATIENTS	2, 153, 317		2, 153, 317		2, 153, 317	
76. 97	07697 CARDI AC REHABI LI TATI ON	0				0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0			0	0	
76. 99	07699 LI THOTRI PSY	0		(0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS				_		
90.00	09000 CLI NI C	11, 815		11, 815		11, 815	
90. 01	09001 LIFEBRIDGE SENIOR CARE	440, 136		440, 136		440, 136	
91. 00	09100 EMERGENCY	2, 917, 025		2, 917, 025		2, 917, 025	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	827, 199		827, 199	9	827, 199	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVI CES	2, 359, 022		2, 359, 022	0	2, 359, 022	ł
99. 10	09910 CORF	0				0	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0				0	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0				0	, , ,
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0		()	0	99. 40
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
200.00		23, 800, 980				23, 800, 980	
201.00	Less Observation Beds	827, 199		827, 199)	827, 199	
202.00	Total (see instructions)	22, 973, 781	C	22, 973, 78	0	22, 973, 781	202. 00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 151323 Peri od: Worksheet C From 01/01/2014 Part I Date/Time Prepared: 12/31/2014 5/21/2015 9:27 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio I npati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 4, 365, 246 30.00 4, 365, 246 43.00 04300 NURSERY 622, 796 622, 796 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 387, 013 9, 623, 299 13, 010, 312 0.219794 0.000000 0.558186 0.000000 05200 DELIVERY ROOM & LABOR ROOM 52.00 1, 822, 289 1, 822, 289 53.00 05300 ANESTHESI OLOGY 332, 547 923, 211 1, 255, 758 0.037560 0.000000 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 115, 018 17, 295, 254 18, 410, 272 0.116752 0.000000 06000 LABORATORY 0.276022 0.000000 60.00 1, 034, 922 4, 052, 910 5, 087, 832 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0.000000 0.000000 65.00 06500 RESPIRATORY THERAPY 441, 245 1, 235, 189 1, 676, 434 0.423313 0.000000 66.00 06600 PHYSI CAL THERAPY 278, 244 1, 210, 865 1, 489, 109 0.626843 0.000000 06700 OCCUPATI ONAL THERAPY 234, 997 297, 281 0. 344882 67.00 532, 278 0.000000 68.00 06800 SPEECH PATHOLOGY 21, 713 61, 216 82, 929 1.400282 0.000000

5/21/2015 9: 2	
Title XIX Hospital PPS	
Cost Center Description PPS Inpatient	
. Ratio	
11.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS	30.00
43. 00 04300 NURSERY	43.00
ANCILLARY SERVICE COST CENTERS	
50. 00 05000 OPERATI NG ROOM 0. 219794	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0.558186	52.00
53. 00 05300 ANESTHESI OLOGY 0. 037560	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 116752	54.00
60. 00 06000 LABORATORY 0. 276022	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000	62. 30
65. 00 06500 RESPI RATORY THERAPY 0. 423313	65.00
66. 00 06600 PHYSI CAL THERAPY 0. 626843	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0. 344882	67.00
68. 00 06800 SPEECH PATHOLOGY 1. 400282	68. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 025384	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.272376	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.318125	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 363654	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0. 000000	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 000000	76. 98
76. 99 07699 LI THOTRI PSY 0. 000000	76. 99
OUTPATIENT SERVICE COST CENTERS	
90. 00 09000 CLI NI C 1. 620491	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE 2. 320780	90. 01
91. 00 09100 EMERGENCY 0. 330165	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1.020316	92.00
OTHER REIMBURSABLE COST CENTERS	
95. 00 09500 AMBULANCE SERVI CES 0. 691436	95.00
99. 10 09910 CORF	99. 10
99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY	99. 20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	99. 30
99. 40 09940 OUTPATI ENT SPEECH PATHOLOGY	99. 40
SPECIAL PURPOSE COST CENTERS	
	113. 00
	200. 00
	201. 00
202.00 Total (see instructions)	202. 00

Health Financial Systems COMMUNITY HOSPT.
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provi der CCN: 151323

				1	o 12/31/2014	Date/lime Pre 5/21/2015 9:2	
			Ti t	le XIX	Hospi tal	PPS	, <u>u</u>
	Cost Center Description	Total Cost	Capital Cost	Operating Cost	Capi tal	Operating Cost	
	·	(Wkst. B, Part	(Wkst. B, Part	Net of Capital	Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	2, 859, 586				0	50. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 017, 177	1			0	52. 00
53.00	05300 ANESTHESI OLOGY	47, 166	l e			0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 149, 440				0	54.00
60.00	06000 LABORATORY	1, 404, 353	68, 381	1, 335, 972	0	0	60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	· -	_	0	62. 30
65.00	06500 RESPI RATORY THERAPY	709, 656				0	65. 00
66. 00	06600 PHYSI CAL THERAPY	933, 437				0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	183, 573				0	67. 00
68. 00	06800 SPEECH PATHOLOGY	116, 124				0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	8, 573				0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	496, 427		1		0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	327, 410				0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	2, 153, 317	63, 162	2, 090, 155	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	11, 815	l .				
90. 01	09001 LI FEBRI DGE SENI OR CARE	440, 136		1		0	90. 01
91. 00	09100 EMERGENCY	2, 917, 025				0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	827, 199	121, 721	705, 478	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS			1	1		
	09500 AMBULANCE SERVICES	2, 359, 022	72, 135	2, 286, 887	0	_	
99. 10	09910 CORF	0	0	0	0	0	99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
	SPECIAL PURPOSE COST CENTERS		T	1	T.		
	11300 INTEREST EXPENSE						113. 00
200.00		18, 961, 436					200. 00
201.00	l l	827, 199					201. 00
202.00	Total (line 200 minus line 201)	18, 134, 237	1, 111, 973	17, 022, 264	0	0	202. 00

Provi der CCN: 151323 REDUCTIONS FOR MEDICALD ONLY

					5/21/2015 9: 2	27 am	
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges				
		Capital and	(Worksheet C,				
		Operating Cost			5		
		Reduction	8)	/ col. 7)			
		6.00	7. 00	8. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 859, 586	13, 010, 312	0. 21979	4		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 017, 177	1, 822, 289	0. 55818	6		52. 00
53.00	05300 ANESTHESI OLOGY	47, 166	1, 255, 758	0. 03756	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 149, 440	18, 410, 272	0. 11675	2		54. 00
60.00	06000 LABORATORY	1, 404, 353	5, 087, 832	0. 27602	2		60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0		62. 30
65.00	06500 RESPI RATORY THERAPY	709, 656	1, 676, 434	0. 42331	3		65. 00
66.00	06600 PHYSI CAL THERAPY	933, 437	1, 489, 109	0. 62684	.3		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	183, 573	532, 278	0. 34488	2		67. 00
68. 00	06800 SPEECH PATHOLOGY	116, 124	82, 929	1. 40028	2		68. 00
69.00	06900 ELECTROCARDI OLOGY	8, 573			4		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	496, 427					71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	327, 410					72. 00
	07300 DRUGS CHARGED TO PATIENTS	2, 153, 317					73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	0.00000			76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
	07699 LI THOTRI PSY	0	0				76. 99
	OUTPATIENT SERVICE COST CENTERS		-				1
90.00	09000 CLI NI C	11, 815	7, 291	1. 62049	1		90. 00
	09001 LI FEBRI DGE SENI OR CARE	440, 136	1				90. 01
91. 00	09100 EMERGENCY	2, 917, 025	l				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	827, 199					92. 00
, , , , , ,	OTHER REIMBURSABLE COST CENTERS	02//1//	0.07.20	1. 02001	<u> </u>		1 /2:00
95. 00	09500 AMBULANCE SERVI CES	2, 359, 022	3, 411, 770	0. 69143	6		95. 00
	09910 CORF	0	0, 111, 770	0. 00000			99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	0	١	0. 00000			99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	١	0. 00000			99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0. 00000			99. 40
//. 40	SPECIAL PURPOSE COST CENTERS			0.00000	<u> </u>		1 //: 40
113 00	11300 I NTEREST EXPENSE						113. 00
200. 00		18, 961, 436	65, 732, 550				200. 00
201.00		827, 199		1			201. 00
201.00	l	18, 134, 237	l e				202. 00
202.00		10, 134, 237	1 00, 732, 550	I	1		1202.00

Provider CCN: 151323	Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-							
Capit tall Related Cost Capit tall Related Cost Capit tall Cast Capit ta	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			From 01/01/2014 To 12/31/2014	Part II Date/Time Pre 5/21/2015 9:2	pared: 7 am	
Related Cost (From Wkst. E, Part II. col. 26) ANCILLARY SERVICE COST CENTERS 1.00								
Column 4 Part II, col. C	Cost Center Description							
Part II, col. 26 1.00 2.00 3.00 4.00 5.00								
ANCI LLARY SERVI CE COST CENTERS 1.00 2.00 3.00 4.00 5.00			· ·		. Charges	column 4)		
1.00 2.00 3.00 4.00 5.00		·	8)	2)				
ANCI LLARY SERVICE COST CENTERS 50.00 05000 DFERATI NG ROOM 295, 216 13, 010, 312 0.022691 566, 762 12, 860 50.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 45, 992 1, 822, 289 0.025239 6, 299 159 52.00 53.00 05300 ANESTHESI OLOGY 647 1, 255, 758 0.000515 71, 644 37 53.00 64.00 05400 RADI OLOGY-DI AGNOSTI C 155, 248 18, 410, 272 0.008433 347, 266 2, 928 54.00 05400 RADI OLOGY-DI AGNOSTI C 155, 248 18, 410, 272 0.008433 347, 266 2, 928 54.00 06.00 06000 LABORATIORY 68, 381 5, 087, 832 0.013440 291, 209 3, 914 60.00 62.30 62.50 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0 0.000000 0 0.000000 0 0.000000 0								
50. 00 05000 OPERATI NC ROOM 295, 216 13, 010, 312 0. 022691 566, 762 12, 860 50. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 45, 992 1, 822, 289 0. 025239 6, 299 159 52. 00 53. 00 05300 ANESTHESI OLOGY 647 1, 255, 758 0. 000515 71, 644 37 53. 00 60. 00 05400 RADI OLOGY - DI AGNOSTI C 155, 248 18, 410, 272 0. 008433 347, 266 2, 928 54. 00 0. 000000 0. 00000000		1.00	2.00	3.00	4. 00	5. 00		
52. 00 05200 DELIVERY ROOM & LABOR ROOM 45, 992 1, 822, 289 0. 025239 6, 299 159 52. 00 5300 ANESTHESI OLOGY 647 1, 255, 758 0. 000515 71, 644 37 53. 00 05400 RADIOLOGY-DIAGNOSTIC 155, 248 18, 410, 272 0. 008433 347, 266 2, 928 54. 00 06000 LABORATORY 68, 381 5, 087, 832 0. 013440 291, 209 3, 914 60. 00 0600 LABORATORY 68, 381 5, 087, 832 0. 013440 291, 209 3, 914 60. 00 0600 LABORATORY 7 HERAPY 7 00 0. 000000 0 0 0. 000000 0 0 0. 000000		T	T	T				
53. 00 05300 ANESTHESI OLOGY 647 1, 255, 758 0. 000515 71, 644 37 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 155, 248 18, 410, 272 0. 008433 347, 266 2, 928 54. 00 60. 00 06000 LABORATORY 68, 381 5, 087, 832 0. 013440 291, 209 3, 914 60. 00 62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0 0. 0000000 0 0. 0000000 65. 00 06500 RESPI RATORY THERAPY 35, 646 1, 676, 434 0. 021263 184, 482 3, 923 65. 00 66. 00 06600 PHYSI CAL THERAPY 96, 600 1, 489, 109 0. 064871 91, 583 5, 941 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 2, 852 532, 278 0. 005358 77, 096 413 67. 00 68. 00 06800 SPEECH PATHOLOGY 1, 674 82, 929 0. 020186 11, 872 240 68. 00 69. 00 06900 ELECTROCARDI OLOGY 2, 430 337, 739 0. 007195 53, 928 388 69. 00 67. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 10, 281 1, 029, 188 0. 009989 423, 727 4, 233 72. 00 67. 00 07300 DRUGS CHARGED TO PATI ENTS 10, 281 1, 029, 188 0. 009989 423, 727 4, 233 72. 00 67. 09 07697 CARDI AC REHABI LI TATI ON 0 0 0. 000000 0 0 76. 98 67. 99 07699 LI THOTRI PSY 0 0 0. 000000 0 0 76. 98 67. 90 07690 CLINIC COST CENTERS 0 000000 0 0 0 67. 90 07000 CLINIC SERVICE COST CENTERS 0 000000 0 0 000000 67. 00 09000 CLINIC CLIRC CLIRC							1	
54. 00								
60.00 06000 LABORATORY 66, 381 5, 087, 832 0.013440 291, 209 3, 914 60.00 62.30 62.30 62.50 62.00 COUTTING FOR HEMOPHILIACS 0 0 0.000000 0 0 62.30 65.00 66.00 66.00 RESPIRATORY THERAPY 35, 646 1, 676, 434 0.021263 184, 482 3, 923 65.00 66.00 06.00			,					
62. 30								
65. 00 06500 RESPIRATORY THERAPY 35, 646 1, 676, 434 0. 021263 184, 482 3, 923 65. 00 666. 00 06500 PHYSI CAL THERAPY 96, 600 1, 489, 109 0. 064871 91, 583 5, 941 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 2, 852 532, 278 0. 005358 77, 096 413 67. 00 6800 SPEECH PATHOLOGY 1, 674 82, 929 0. 020186 11, 872 240 68. 00 69. 00 06900 ELECTROCARDI OLOGY 2, 430 337, 739 0. 007195 53, 928 388 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 15, 618 1, 822, 578 0. 008569 136, 285 1, 168 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 10, 281 1, 029, 188 0. 009889 423, 727 4, 233 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 63, 162 5, 921, 335 0. 010667 684, 518 7, 302 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0. 000000 0 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0. 0. 000000 0 0 76. 98 07699 LI THOTRI PSY 0 0 0. 0. 000000 0 0 0 76. 99 07699 LI THOTRI PSY 0 0 0. 0. 000000 0 0 0 0 0 0 0 0 0 0 0		1						
66. 00		_	· · · · · · · · ·			-		
67. 00 06700 0CCUPATI ONAL THERAPY 2,852 532,278 0.005358 77,096 413 67.00 68.00 06800 SPEECH PATHOLOGY 1,674 82,929 0.020186 11,872 240 68.00 69.00 06900 ELECTROCARDI OLOGY 2,430 337,739 0.007195 53,928 388 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 15,618 1,822,578 0.008569 136,285 1,168 71.00 72.00 1MPL. DEV. CHARGED TO PATI ENTS 10,281 1,029,188 0.009989 423,727 4,233 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 63,162 5,921,335 0.010667 684,518 7,302 73.00 76.97 CARDI AC REHABI LI TATI ON 0 0 0.000000 0 0 76.97 76.98 MYPERBARI C OXYGEN THERAPY 0 0 0.000000 0 0 76.98 76.99 LI THOTRI PSY 0 0 0.000000 0 0 0 76.99 0.000000 0 0 0 0.000000 0							1	
68. 00								
69. 00 06900 ELECTROCARDI OLOGY 2, 430 337, 739 0.007195 53, 928 388 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 15, 618 1, 822, 578 0.008569 136, 285 1, 168 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 10, 281 1, 029, 188 0.009989 423, 727 4, 233 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 63, 162 5, 921, 335 0.010667 684, 518 7, 302 73. 00 76. 97 CARDI AC REHABI LI TATI ON 0 0.000000 0 0 76. 97 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0.000000 0 0 0 76. 98 76. 99 0000 000000 0 0 0 0 0								
71. 00								
72. 00								
73. 00 07300 DRUGS CHARGED TO PATIENTS 63, 162 5, 921, 335 0. 010667 684, 518 7, 302 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0. 000000 0 0 76. 97 0. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0. 000000 0 0 0 76. 98 07699 LI THOTRI PSY 0 0 0. 000000 0 0 0 76. 99 0. 000000 0 0 0 0. 000000 0						1, 168		
76. 97 76. 98 76. 98 76. 99 76	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	10, 281	1, 029, 188	0. 00998	9 423, 727	4, 233	72. 00	
76. 98	73.00 07300 DRUGS CHARGED TO PATIENTS	63, 162	5, 921, 335	0. 01066	7 684, 518	7, 302	73. 00	
76. 99 07699 LITHOTRI PSY 0 0 0.000000 0 0 76. 99 0000000 0 0 0 76. 99 0000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76. 97 07697 CARDIAC REHABILITATION	0	0	0.00000	0	0	76. 97	
OUTPATIENT SERVICE COST CENTERS 90.00 O9000 CLINIC 161 7,291 0.022082 0 0 00.00	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000	0	0	76. 98	
90. 00 09000 CLI NI C 161 7, 291 0. 022082 0 0 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 91. 00 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 121, 721 810, 728 0. 150138 0 0 92. 00 09500 AMBULANCE SERVI CES 95. 00 09500 AMBULANCE SERVI CES 95. 00 99. 00 0 0 0 0 0 0 0 0 0	76. 99 07699 LI THOTRI PSY	0	0	0.00000	0	0	76. 99	
90. 01 09001 LI FEBRI DGE SENI OR CARE 28, 679 189, 650 0. 151221 0 0 90. 01 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 121, 721 810, 728 0. 150138 0 0 92. 00 09500 AMBULANCE SERVI CES 95. 00 09500 AMBULANCE SERVI CES 95. 00 99. 01 0 90. 01 0	OUTPATIENT SERVICE COST CENTERS							
91. 00 09100 EMERGENCY 217, 251 8, 835, 058 0. 024590 30, 601 752 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 121, 721 810, 728 0. 150138 0 0 92. 00 07 07 07 07 07 07 07	90. 00 09000 CLI NI C	161	7, 291	0. 02208	2 0	0	90.00	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 121, 721 810, 728 0.150138 0 0 92. 00 0 0 0 0 0 0 0 0 0		28, 679	189, 650	0. 15122	1 0	0	90. 01	
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00	91. 00 09100 EMERGENCY	217, 251	8, 835, 058	0. 02459	0 30, 601	752	91.00	
95. 00 09500 AMBULANCE SERVI CES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	121, 721	810, 728	0. 15013	8 0	0	92.00	
200. 00 Total (lines 50-199) 1,161,559 62,320,780 2,977,272 44,258 200. 00	95. 00 09500 AMBULANCE SERVICES						95.00	
	200.00 Total (lines 50-199)	1, 161, 559	62, 320, 780	1	2, 977, 272	44, 258	200. 00	

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

From 01/01/2014 Part IV To 12/31/2014 Date/Time Prepared: THROUGH COSTS 5/21/2015 9:27 am Title XVIII Hospi tal Cost Cost Center Description Non Physician Nursing School Allied Health All Other Total Cost Anestheti st Medi cal (sum of col 1 through col . Cost Education Cost 1.00 2.00 3.00 4. 00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 0 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 06000 LABORATORY 0 60.00 0 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 0 76. 98 0 0 07699 LI THOTRI PSY 76. 99 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 0 0 09001 LIFEBRIDGE SENIOR CARE 0 0 0 o 90. 01 90. 01 Ω 09100 EMERGENCY 0 0 0 91.00 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 92.00 0 0 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

0

0

0

0

0 200.00

Total (lines 50-199)

Health Financial Systems	COMMUNITY HOSPT. OF LAG	GRANGE CTY IN	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIEN	T ANCILLARY SERVICE OTHER PASS	Provider CCN: 151323	Peri od:	Worksheet D

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER H COSTS	RVICE OTHER PAS	S		<u> </u>	Period: From 01/01/2014 Fo 12/31/2014		pared: 7 am
				Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Total			Ratio of Cost		I npati ent	
					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	
	ANCILLARY SERVICE COST CENTERS							
	05000 OPERATING ROOM	0		3, 010, 312			566, 762	
	05200 DELIVERY ROOM & LABOR ROOM	0		1, 822, 289	•		6, 299	
	05300 ANESTHESI OLOGY	0)	1, 255, 758	0.000000	0.000000	71, 644	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	18	8, 410, 272			347, 266	54.00
	06000 LABORATORY	0) !	5, 087, 832	0.000000	0.000000	291, 209	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0	0. 000000	0. 000000	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0)	1, 676, 434	0. 000000	0. 000000	184, 482	65. 00
66.00	06600 PHYSI CAL THERAPY	0)	1, 489, 109	0. 000000	0. 000000	91, 583	66. 00
67.00	06700 OCCUPATIONAL THERAPY	0		532, 278	0. 000000	0. 000000	77, 096	67.00
68.00	06800 SPEECH PATHOLOGY	0		82, 929	0. 000000	0.000000	11, 872	68. 00
69.00	06900 ELECTROCARDI OLOGY	0		337, 739	0.000000	0. 000000	53, 928	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0)	1, 822, 578	0.000000	0. 000000	136, 285	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0)	1, 029, 188	0.000000	0. 000000	423, 727	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0) !	5, 921, 335	0. 000000	0. 000000	684, 518	73. 00
	07697 CARDI AC REHABI LI TATI ON	0			0. 000000	0. 000000	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	ol	0	0. 000000	0. 000000	0	76. 98
	07699 LI THOTRI PSY	0		0	0. 000000	0. 000000	0	76. 99
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>			•			1
90.00	09000 CLI NI C	0		7, 291	0.000000	0.000000	0	90.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	0	ol	189, 650	0. 000000	0. 000000	0	90. 01
	09100 EMERGENCY	0) :	8, 835, 058	•		30, 601	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		810, 728	•			1
	OTHER REIMBURSABLE COST CENTERS	<u> </u>						1
	09500 AMBULANCE SERVICES							95. 00
200.00	Total (lines 50-199)	0	6:	2, 320, 780			2, 977, 272	200. 00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS

Provider CCN: 151323 | Period: From 01/01/2014 | To 12/31/2014 | To 12/31/2014 | To Date/Time Prepared:

Date/Time Prepared: 5/21/2015 9:27 am Title XVIII Hospi tal Cost Cost Center Description I npati ent Outpati ent Outpati ent Program Program Program Pass-Through Pass-Through Charges Costs (col. Costs (col. x col . 10) 11.00 x col. 12) 13.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 01 0 06000 LABORATORY 60.00 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 65.00 0 0 66.00 06600 PHYSI CAL THERAPY 66.00 0 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 68.00 06900 ELECTROCARDI OLOGY 0 0 69.00 69.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 73.00 07697 CARDIAC REHABILITATION 0 76. 97 0 76. 97 0 07698 HYPERBARI C OXYGEN THERAPY 76. 98 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 0 0 0 90.00 09000 CLI NI C 09001 LIFEBRIDGE SENIOR CARE 0 0 90.01 0 90.01 91.00 09100 EMERGENCY 0 0 91.00

0

0

0

0

0

0

92.00

95.00

200.00

09200 OBSERVATION BEDS (NON-DISTINCT PART

OTHER REIMBURSABLE COST CENTERS

Total (lines 50-199)

95. 00 09500 AMBULANCE SERVICES

92.00

Health Financial Systems COMMUNITY HOSPI. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-1									
APPORTI ONMEN	NT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	Provi der CCN: 151323 Peri od:					
					From 01/01/2014				
					To 12/31/2014		pared:		
-			Ti +1	e XVIII	Hospi tal	5/21/2015 9:27 am Cost			
			11 (1	Charges	поѕрі таі	Costs			
	Cost Center Description	Cost to Charge	DDC Doi mburgood		Cost	PPS Services			
	Cost Center Description	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)			
		Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)			
		Part I, col. 9		Subject To	Subject To				
		rait i, coi. 9		Ded. & Coins					
				(see inst.)	(see inst.)				
		1.00	2. 00	3.00	4. 00	5. 00			
ANCLL	LARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00			
	OPERATING ROOM	0. 219794	(1, 232, 16	.1 0	0	50.00		
	DELIVERY ROOM & LABOR ROOM	0. 558186	Č	1, 202, 10	0 0		1		
	ANESTHESI OLOGY	0. 037560		136, 85	-	0	1		
	RADI OLOGY-DI AGNOSTI C	0. 116752		3, 808, 97		1 0	54. 00		
	LABORATORY	0. 276022		1, 142, 01		1 0	60.00		
	BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000		1, 142, 01	0	١	62. 30		
	RESPIRATORY THERAPY	0. 423313		374, 24	0	0	1		
	PHYSI CAL THERAPY	0. 626843		411, 63		1 0	66. 00		
	OCCUPATIONAL THERAPY	0. 344882		80, 53		١	67. 00		
	SPEECH PATHOLOGY	1. 400282		16, 07		١	68. 00		
	ELECTROCARDI OLOGY	0. 025384	Č	81, 06		0	1		
	MEDICAL SUPPLIES CHARGED TO PATIENT	0. 272376	Č	160, 48		0	1		
	IMPL. DEV. CHARGED TO PATIENTS	0. 318125	Č	79, 99		0	72.00		
	DRUGS CHARGED TO PATIENTS	0. 363654	Č	1, 141, 75		0	73. 00		
	CARDI AC REHABI LI TATI ON	0. 000000	Č]	0	0	1		
	HYPERBARI C OXYGEN THERAPY	0. 000000	Ċ		0 0	0	76. 98		
	LI THOTRI PSY	0. 000000	Ċ		0 0				
	TIENT SERVICE COST CENTERS		<u>-</u>		<u></u>	_	1		
90.00 09000		1. 620491	C	7, 18	38 0	0	90.00		
	LIFEBRIDGE SENIOR CARE	2. 320780	Ċ	125, 74		0	1		
	EMERGENCY	0. 330165	Ċ	1, 940, 82		0	1		
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	1. 020316	Ċ	465, 13		0	92.00		
	REIMBURSABLE COST CENTERS								
	AMBULANCE SERVICES	0. 691436			0		95. 00		
200. 00	Subtotal (see instructions)		Ċ	11, 204, 68	0	l o	200.00		
201. 00	Less PBP Clinic Lab. Services-Program				0 0		201. 00		
	Only Charges								
202. 00	Net Charges (line 200 +/- line 201)		C	11, 204, 68	37 0	0	202. 00		
į.		•	'		1				

RANGE CTY IN In Lieu of Form CMS-2552-10
Provider CCN: 151323 Period: Worksheet D From 01/01/2014 Part V To 12/31/2014 Date/Time Prepared:

					To 12/31/2014	Date/Time Prepared: 5/21/2015 9:27 am
			Ti tl	e XVIII	Hospi tal	Cost
		Cos	sts			
	Cost Center Description	Cost	Cost			
		Rei mbursed	Reimbursed			
		Servi ces	Services Not			
		Subject To	Subject To			
			Ded. & Coins.			
		(see inst.)	(see inst.)			
		6.00	7. 00			
	_ARY SERVICE COST CENTERS	070.000	-			
	OPERATING ROOM	270, 822	(2		50.00
	DELIVERY ROOM & LABOR ROOM	0	(2		52. 00
	ANESTHESI OLOGY	5, 140		2		53.00
1 1	RADI OLOGY-DI AGNOSTI C	444, 705		2		54.00
	LABORATORY	315, 220	()		60. 00
	BLOOD CLOTTING FOR HEMOPHILIACS	0	()		62. 30
	RESPI RATORY THERAPY	158, 424	()		65. 00
	PHYSI CAL THERAPY	258, 032)		66. 00
	OCCUPATI ONAL THERAPY	27, 776)		67. 00
	SPEECH PATHOLOGY	22, 508				68. 00
	ELECTROCARDI OLOGY	2, 058	(69. 00
	MEDICAL SUPPLIES CHARGED TO PATIENT	43, 712	(71. 00
	IMPL. DEV. CHARGED TO PATIENTS	25, 449	(72. 00
	DRUGS CHARGED TO PATIENTS	415, 202	(73. 00
	CARDI AC REHABI LI TATI ON	0	()		76. 97
	HYPERBARI C OXYGEN THERAPY	0	(76. 98
76. 99 07699		0	()		76. 99
	TIENT SERVICE COST CENTERS					
90. 00 09000		11, 648		2		90.00
	LIFEBRIDGE SENIOR CARE	291, 833		2		90. 01
	EMERGENCY	640, 793		2		91. 00
	OBSERVATION BEDS (NON-DISTINCT PART	474, 585	()		92. 00
	REI MBURSABLE COST CENTERS			T		05.00
	AMBULANCE SERVICES	2 407 007	,			95. 00
200.00	Subtotal (see instructions)	3, 407, 907	('		200.00
201. 00	Less PBP Clinic Lab. Services-Program	0				201. 00
202 00	Only Charges (Line 200 // Line 201)	2 407 007	,			202.00
202. 00	Net Charges (line 200 +/- line 201)	3, 407, 907	(' I		202.00

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST

Provider CCN: 151323
Component CCN: 15Z323
Period: From 01/01/2014
To 12/31/2014
Vorksheet D
Part V
Date/Time Prepared: 5/21/2015 9: 27 am

					5/21/2015 9: 2	7 am
		Ti tl	e XVIII S	wing Beds - SNF	Cost	
		·	Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 219794		C	0	0	50. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 558186		C	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 037560		C	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 116752		C	0	0	54.00
60. 00 06000 LABORATORY	0. 276022	0	C	0	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHI	LI ACS 0. 000000	0	C	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY	0. 423313	0	C	0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 626843	0	C	0	0	66. 00
67. 00 06700 OCCUPATIONAL THERAPY	0. 344882	0	C	o	0	67. 00
68.00 06800 SPEECH PATHOLOGY	1. 400282	0	C	o	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 025384	0	C	o	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED T	O PATI ENT 0. 272376	0	C	o	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATI	ENTS 0. 318125	0	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 363654	0	C	0	0	73. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000	0	C	o	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0	l c	o	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0	l c	o	0	76. 99
OUTPATIENT SERVICE COST CENTERS	·					
90. 00 09000 CLI NI C	1. 620491	0	C	0	0	90. 00
90. 01 09001 LIFEBRIDGE SENIOR CARE	2. 320780	0	C	0	0	90. 01
91. 00 09100 EMERGENCY	0. 330165	0	l c	o	0	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DIST	INCT PART 1. 020316	0	l c	o	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 691436		C			95. 00
200.00 Subtotal (see instructions)	0	l c	o	0	200. 00
201.00 Less PBP Clinic Lab. Servi	ces-Program		C	o o		201. 00
Only Charges	-					
202.00 Net Charges (line 200 +/-	line 201)	0	C	o o	0	202. 00
	•	•		. '		-

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151323 Period: From 01/01/2014 Part V Component CCN: 152323 Part V Date/Time Prepared:

				CCN: 15Z323	То	12/31/2	2014	Date/Time Pro 5/21/2015 9:2	
			Ti tl e	XVIII	Swi ng	Beds -	SNF	Cost	
	Cos	sts							
Cost Center Description	Cost	Cos	t						
	Rei mbursed	Rei mbu							
	Servi ces	Servi ce							
	Subject To	Subj ec							
	Ded. & Coins.	Ded. & C							
	(see inst.)	(see in							
ANCILLARY SERVICE COST CENTERS	6. 00	7.0	0						
50. 00 05000 OPERATING ROOM	1 0	J	0						50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0		0						52. 00
53. 00 05300 ANESTHESI OLOGY		3	0						53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0	á	0						54.00
60. 00 06000 LABORATORY	0	á	0						60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0						62. 30
65. 00 06500 RESPIRATORY THERAPY	0		0						65. 00
66. 00 06600 PHYSI CAL THERAPY	0		o						66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		o						67. 00
68. 00 06800 SPEECH PATHOLOGY	0		o						68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		o						69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		o						71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0						72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0						73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0		0						76. 97
76.98 07698 HYPERBARIC OXYGEN THERAPY	0		0						76. 98
76. 99 07699 LI THOTRI PSY	0		0						76. 99
OUTPATIENT SERVICE COST CENTERS	T								
90. 00 09000 CLI NI C	0	1	0						90. 00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	2	0						90. 01
91. 00 09100 EMERGENCY	0	2	0						91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	0	<u> </u>	0						92. 00
95. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 O9500 AMBULANCE SERVI CES	1 0	\							95. 00
200.00 Subtotal (see instructions)	0	()	0						200. 00
201. 00 Less PBP Clinic Lab. Services-Program	0	()	Ч						200.00
Only Charges		΄							201.00
202.00 Net Charges (line 200 +/- line 201)	0		o						202. 00
202. 33 ₁	1	1	٥Į						1202.00

Health Financial Systems COMM	COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-				2552-10	
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2014		
				Γο 12/31/2014	Date/Time Pre 5/21/2015 9:2	
		Ti t	le XIX	Hospi tal	PPS	, <u></u>
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	585, 841	65, 402	520, 439	3, 191	163. 10	30.00
43. 00 NURSERY	11, 865		11, 865	5 593	20. 01	43.00
200.00 Total (lines 30-199)	597, 706		532, 304	3, 784		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	230	37, 513				30.00
43. 00 NURSERY	197	3, 942				43.00
200.00 Total (lines 30-199)	427	41, 455				200. 00

5, 921, 335

C

0.010667

0.000000

0.000000

238, 962

0

2, 549

0

0 76. 98

73.00

76. 97

63, 162

0

07300 DRUGS CHARGED TO PATIENTS

07698 HYPERBARI C OXYGEN THERAPY

07697 CARDIAC REHABILITATION

73.00

76 97

Health Financial Systems COMM	MUNITY HOSPT. 0	F LAGRANGE CTY	IN	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Period: From 01/01/2014	Worksheet D Part III	
				To 12/31/2014	Date/Time Pre	
					5/21/2015 9:2	7 am
		Ti t	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	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 & PEDIATRICS	0	0)	0 0	0	30.00
43. 00 04300 NURSERY	0) C		o	0	43.00
200.00 Total (lines 30-199)	0	C		o	0	200. 00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		
	Days	5 ÷ col. 6)	Program Days	Program		
				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 & PEDIATRICS	3, 191	0.00	23	0 0		30. 00
43. 00 04300 NURSERY	593	0.00	19	7 0		43.00
200.00 Total (lines 30-199)	3, 784		42	7 0		200. 00
		•	•	,		•

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

From 01/01/2014 Part IV To 12/31/2014 Date/Time Prepared: THROUGH COSTS 5/21/2015 9:27 am Title XIX Hospi tal PPS Cost Center Description Non Physician Nursing School Allied Health All Other Total Cost Anestheti st Medi cal (sum of col 1 through col . Cost Education Cost 1.00 2.00 3.00 4. 00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 0 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54.00 0 06000 LABORATORY 0 60.00 0 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 76. 97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 0 76. 98 0 0 07699 LI THOTRI PSY 76. 99 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 0 0 0 09001 LIFEBRIDGE SENIOR CARE 0 0 0 o 90. 01 90. 01 Ω 09100 EMERGENCY 0 0 0 91.00 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 92.00 0 0 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00

0

0

0

0

0 200.00

Total (lines 50-199)

Health Financial Systems	COMMUNITY HOSPT. OF LAG	RANGE CTY IN	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 151323	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2014	Part IV

THROUGH COSTS 12/31/2014 Date/Time Prepared: To 5/21/2015 9:27 am Title XIX Hospi tal PPS Total Charges Ratio of Cost I npati ent Cost Center Description Total Outpati ent to Charges (from Wkst. C, Outpati ent Ratio of Cost Program Cost (sum of Part I, col. (col. 5 ÷ col to Charges Charges 8) 7) col. 2, 3 and $(col. 6 \div col$ 4) 7) 6.00 7.00 8.00 9.00 10.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 13, 010, 312 0.000000 0.000000 546, 256 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 1,822,289 0.000000 0.000000 404, 210 52.00 05300 ANESTHESI OLOGY 1, 255, 758 0.000000 0.000000 124, 122 53.00 53.00 000000000000000 05400 RADI OLOGY-DI AGNOSTI C 18, 410, 272 0.000000 0.000000 108, 140 54.00 54.00 0.000000 60.00 06000 LABORATORY 5, 087, 832 0.000000 111, 467 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 0 62.30 65.00 06500 RESPIRATORY THERAPY 1, 676, 434 0.000000 0.000000 32, 123 65.00 06600 PHYSI CAL THERAPY 1, 489, 109 0.000000 0.000000 66 00 5, 324 66 00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 532, 278 0.000000 2, 764 67.00 68.00 06800 SPEECH PATHOLOGY 82, 929 0.000000 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 337, 739 0.000000 0.000000 69.00 0 69.00 61, 941 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1, 822, 578 0.000000 0.000000 71 00 71 00 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 1,029,188 0.000000 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 5, 921, 335 0.000000 0.000000 73.00 238, 962 73.00 07697 CARDIAC REHABILITATION 76 97 0.000000 0.000000 0 76 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY C 0.000000 0.000000 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0.000000 0.000000 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 7, 291 90.00 0 0.000000 0.000000 09000 CLI NI C 0 0 90.01 09001 LIFEBRIDGE SENIOR CARE 189, 650 0.000000 0.000000 0 90.01 09100 EMERGENCY 0 8, 835, 058 0.000000 0.000000 58, 709 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 810, 728 0.000000 0.000000 0 92.00 OTHER REIMBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95.00 200.00 Total (lines 50-199) 62, 320, 780 1, 694, 018 200. 00

| Peri od: | Worksheet D | From 01/01/2014 | Part IV | To 12/31/2014 | Date/Time Prepared: | Part IV | Par THROUGH COSTS

					10 12,01,2011	5/21/2015 9:2	27 am
			Ti t	le XIX	Hospi tal	Hospi tal PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col.	9		
		x col. 10)		x col. 12)			
	T	11. 00	12. 00	13. 00			
	ANCILLARY SERVICE COST CENTERS			ı	_1		
50. 00	05000 OPERATING ROOM	0	0		0		50.00
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
60. 00	06000 LABORATORY	0	0		0		60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0		62. 30
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
71. 00		0	0		0		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0		72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0		73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0		76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0		76. 98
76. 99	07699 LI THOTRI PSY	0	0		0		76. 99
	OUTPATIENT SERVICE COST CENTERS	1		1			
	09000 CLI NI C	0	0		0		90.00
90. 01	09001 LIFEBRIDGE SENIOR CARE	0	0		0		90. 01
91. 00	09100 EMERGENCY	0	0		0		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0		92. 00
	OTHER REIMBURSABLE COST CENTERS			1			
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	0	1	0		200. 00

Health Financial Systems COMM	MUNITY HOSPT. OF LAGRANGE CTY IN In Lieu				u of Form CMS-	2552-10
APPORTI ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 01/01/2014	Worksheet D Part V	
				To 12/31/2014	Date/Time Pre	
		Ti t	le XIX	Hospi tal	5/21/2015 9: 2 PPS	7 alli
		11.0	Charges	поэрт саг	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
·	Ratio From	Services (see		Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		1				
50. 00 05000 OPERATI NG ROOM	0. 219794		561, 65	2 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 558186)	0	0	
53. 00 05300 ANESTHESI OLOGY	0. 037560	l .	67, 48		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 116752	l .	1, 823, 13		0	
60. 00 06000 LABORATORY	0. 276022		370, 17	0	0	
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			0	0	
65. 00 06500 RESPI RATORY THERAPY	0. 423313		72, 25		0	
66. 00 06600 PHYSI CAL THERAPY	0. 626843		128, 05		0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 344882		35, 86		0	
68. 00 06800 SPEECH PATHOLOGY	1. 400282	l .	2, 39	2 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 025384)	0	0	1 0 / 1 0 0
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0. 272376	l .	81, 31	0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 318125	l .	000 70	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 363654	l .	223, 79	6 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000)	0	0	1
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000)	0	0	
76. 99 07699 LI THOTRI PSY	0. 000000	0)	0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS	1 (20401		\	0 0		1 00 00
90. 00 09000 CLI NI C 90. 01 09001 LI FEBRI DGE SENI OR CARE	1. 620491 2. 320780			0	0	
91. 00 09100 EMERGENCY	0. 330165		1, 550, 20	0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 020316		56, 02		-	
OTHER REIMBURSABLE COST CENTERS	1. 020310	0	η 30, U2	2 0	U	92.00
95. 00 09500 AMBULANCE SERVI CES	0. 691436	0	N .			95. 00
200.00 Subtotal (see instructions)	0.091430		4, 972, 35	0	_	200.00
201.00 Less PBP Clinic Lab. Services-Program			4, 7/2, 33		0	200.00
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)			4, 972, 35	0	n	202. 00
	1	1	., ., ., ., .	-1	ı	1-32. 30

Provi der CCN: 151323

				10 12/31/2014	Date/lime Prep 5/21/2015 9:2	
		Ti t	le XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS	100.440	_	ı			
50. 00 05000 OPERATING ROOM	123, 448	l				50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53. 00 05300 ANESTHESI OLOGY	2, 535	l .				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	212, 854					54. 00
60. 00 06000 LABORATORY	102, 176	0				60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62. 30
65. 00 06500 RESPIRATORY THERAPY	30, 586	l .				65. 00
66. 00 06600 PHYSI CAL THERAPY	80, 273	l .				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	12, 370	l .				67. 00
68. 00 06800 SPEECH PATHOLOGY	3, 349	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	22, 147	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	81, 384	0				73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
76. 99 07699 LI THOTRI PSY	0	0				76. 99
OUTPAȚI ENT SERVI CE COST CENTERS						
90. 00 09000 CLI NI C	0	0				90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	0				90. 01
91. 00 09100 EMERGENCY	511, 823	l e				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	57, 160	0				92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0	l				95. 00
200.00 Subtotal (see instructions)	1, 240, 105	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	1, 240, 105	0			J	202. 00

Health Financial Systems	COMMUNITY HOSPT. OF LAG	GRANGE CTY IN	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 151323	Peri od: From 01/01/2014	Worksheet D-1
			To 12/31/2014	Date/Time Prepared: 5/21/2015 9:27 am
		Title XVIII	Hospi tal	Cost

		Title XVIII	Hospi tal	5/21/2015 9: 2 Cost	7 am
	Cost Center Description		·	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be			3, 747 3, 191	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed days		vate room days.	3, 141	3.00
	do not complete this line.	3 .			
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		31 of the cost	2, 528 401	4. 00 5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	31 of the cost	0	6. 00	
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	3 ,		155	7. 00
	reporting period	<i>3</i> ,			
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	.		0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swi ng-bed and	1, 015	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		oom days)	401	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl December 31 of the cost reporting period (if calendar year, ent	y (including private r	oom days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period		e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program			0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			U	16.00
17. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	through December 31 o	f the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to services reporting period	after December 31 of	the cost		18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	123. 32	19. 00		
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	ne cost	123. 32	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			4, 500, 719	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	31 of the cost report	ng period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	1 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (line	19, 115	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			519, 427	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		3, 981, 292	
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3 /	0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	33. 00
34. 00	Average per diem private room charge differential (line 32 minu		tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line	31)		0.00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	fferential (line	3, 981, 292	37. 00	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see i			1, 247. 66	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 3	*		1, 266, 375	
40. 00	Medically necessary private room cost applicable to the Program	,		0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		1, 266, 375	41.00

OMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 151323	Peri od:	Worksheet D-1	
					From 01/01/2014 To 12/31/2014	5/21/2015 9: 2	pared: 7 am
	Coat Contan Decemintion	Total		e XVIII	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per		Program Cost (col. 3 x col.	
		Impatront oost	l lipati cirt bays	col . 2)		4)	
		1. 00	2.00	3.00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)	0		0. (00 0	0	42. 0
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT		I	1			43. 0
. 00	CORONARY CARE UNIT						44.0
5. 00	BURN INTENSIVE CARE UNIT						45. 0
. 00	SURGICAL INTENSIVE CARE UNIT						46.0
7. 00	OTHER SPECIAL CARE (SPECIFY)						47. 0
	Cost Center Description					1.00	
3. 00	Program inpatient ancillary service cost (Wk:	st D-3 col 3	R line 200)			862, 736	48.0
	Total Program inpatient costs (sum of lines			ons)		2, 129, 111	•
	PASS THROUGH COST ADJUSTMENTS	, , , , , , , , , , , , , , , , , , ,	•	•			
0. 00	Pass through costs applicable to Program inp	atient routine	services (from	m Wkst. D, sur	m of Parts I and	0	50.0
1. 00		atient ancillar	v services (fi	rom Wkst D 4	sum of Parte II	0	51.0
. 00	and IV)	ationi andiilai	y services (II	Om WKSt. D, 3	Jum OI TALLS II] 31.0
. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52.0
. 00	Total Program inpatient operating cost exclu		elated, non-phy	ysician anestl	hetist, and	0	53. C
	medical education costs (line 49 minus line !	52)					
00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. (
	Target amount per discharge		0.00				
00	Target amount (line 54 x line 55)					0	56.
	Difference between adjusted inpatient operat	0					
00	Bonus payment (see instructions)	0					
00	Lesser of lines 53/54 or 55 from the cost remarket basket	0.00	59.0				
00	Lesser of lines 53/54 or 55 from prior year	0.00	60.0				
00	If line 53/54 is less than the lower of line					0	61.0
	which operating costs (line 53) are less that		s (lines 54 x	60), or 1% of	f the target		
00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	i iisti ucti olis)				0	62. (
	Allowable Inpatient cost plus incentive payment	ent (see instru	uctions)			Ö	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	e cost reporti	ing period (See	500, 312	64. (
00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the (cost reporting	a period (See	0	65.0
50	instructions) (title XVIII only)	to dittor becellik	on or the t	Jose Topol Hill	y period (See		55. (
00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	65)(title XVI	II only). For	500, 312	66.0
00	CAH (see instructions)		D 1 04	6.11			,,,
00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs througr	n December 31 o	or the cost re	eporting period	0	67.0
00	Title V or XIX swing-bed NF inpatient routing	e costs after [December 31 of	the cost repo	orting period	0	68.0
	(line 13 x line 20)			·	3 1		
00	Total title V or XIX swing-bed NF inpatient		`			0	69. (
00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil					Γ	70. (
00 00	Adjusted general inpatient routine service o	,		` ,			71. (
00	Program routine service cost (line 9 x line						72. (
00	Medically necessary private room cost application						73. (
00	Total Program general inpatient routine serv	•					74. (
00	Capital-related cost allocated to inpatient 26. line 45)	routine service	e costs (from N	Worksheet B, I	Part II, column		75. 0
00	20, 1110 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. (
00	Program capital -related costs (line 9 x line						77. (
00	Inpatient routine service cost (line 74 minus	s line 77)					78.
00	Aggregate charges to beneficiaries for excess	, ,					79.
00	Total Program routine service costs for compa		cost limitation	n (line 78 min	nus line 79)		80.
00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. (
00	Reasonable inpatient routine service costs (* .				83.
00	Program inpatient ancillary services (see in		•				84.
	Utilization review - physician compensation					1	85 (

86.00

87.00

663 1, 247. 66 88. 00 827, 199 89. 00

85.00

86.00

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

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

Health Financial Systems COMM	MUNITY HOSPT. (OF LAGE	ANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Peri od:	Worksheet D-1	
					From 01/01/2014 To 12/31/2014	Date/Time Prep 5/21/2015 9:2	
			Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Rout	ine Cost	column 1 ÷	Total	Observation	
		(from	line 27)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00		2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital -related cost	585, 84	1	3, 981, 292	0. 14714	8 827, 199	121, 721	90.00
91.00 Nursing School cost		О	3, 981, 292	0. 00000	0 827, 199	0	91.00
92.00 Allied health cost		o	3, 981, 292	0. 00000	0 827, 199	0	92.00
93.00 All other Medical Education		o	3, 981, 292	0. 00000	0 827, 199	0	93. 00

Health Financial Systems	COMMUNITY HOSPT. OF LAG	RANGE CTY IN	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 151323	Peri od: From 01/01/2014	Worksheet D-1	
				Date/Time Prep 5/21/2015 9:2	
		Title XIX	Hospi tal	PPS	
Cost Center Description					

Cost Center Pescription A LineSWINER COMPONENTS 1.00			Title XIX	Hospi tal	5/21/2015 9: 2 PPS	/ am
NATE ALL PROWIDER COMPONENTS 1.00		Cost Center Description	THE XIX	nospi tai	113	
IMPAILENT DAYS 1.00 Impatient days (including private room days and swing-bed days, excluding newborn) 3.747 1.00 Impatient days (including private room days, axcluding swing-bed day herborn days) 3.747 3.00 2.00					1. 00	
1.00 Inpattient days (Including private room days and swing-bed days, excluding newborn) 3.747 1.00						
Impatient days (Including private room days, excluding swing-bed and neebborn days) 3,101 2,00 3,00 7 10 10 10 10 10 10 1	1 00		avaludi na nawbarn)		2 747	1 00
Private room days (excluding swing-bed and observation bed days). If you have only private room days. 4.00 do not complete this live. Luding swing-bed and observation bed days). 4.01 Semi-private room days (excluding swing-bed and observation bed days). 4.02 Semi-private room days (excluding swing-bed and observation bed days). 4.00 Semi-private room days (excluding swing-bed and observation bed days). 4.00 Total swing-bed SNI type inpatient days (including private room days) after becember 31 of the cost reporting period (ir calendar year, enter 0 on this line). 5.00 Total swing-bed KF type inpatient days (including private room days) through December 31 of the cost reporting period (ir calendar year, enter 0 on this line). 5.00 Total swing-bed KF type inpatient days (including private room days) after becember 31 of the cost reporting period (ir calendar year, enter 0 on this line). 6.01 Interest on the cost reporting period (excluding swing-bed and period (ir calendar year, enter 0 on this line). 7.00 Interest on the cost reporting period (ir calendar year, enter 0 on this line). 8.01 Swing-bed SNI type inpatient days applicable to it the XVIII only (including private room days) after becember 31 or the cost reporting period (ir calendar year, enter 0 on this line). 8.01 Swing-bed SNI type inpatient days applicable to title XVIII only (including private room days). 9.01 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days). 9.02 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days). 9.03 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days). 9.04 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days). 9.05 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days). 9.06 Interest only applicable to XVIII only (including private room days). 9.07 Interest only applicable to XVIII only (including private						
do not complete this line. 4. 05 Sell-private room days (excluding saing-bed and observation bed days) 1. Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total swing-bed NF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 11. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 12. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 13. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 14. 00 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) 15. 00 Swing-bed SNF type inpatient days applicable to title V or XIX only (including private room days) 16. 00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) 17. 00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) 18. 00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) 18. 00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) 18. 00 Swing-bed NF type inpatient days applicable to title V or XIX only (including private room days) 18. 00 Swing-bed NF type inpatient days applicab				vate room days.		
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report in giperial of 100 Total sing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if callendar year, enter 0 on this line) reporting period (if callendar ye						
1-10 1-10	5.00		days) through December	31 of the cost	401	5. 00
reporting period (if calendar year, enter 0 on this line) 7.00 Total as ing-bod NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total as ing-bod NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total as ing-bod NF type inpatient days (including private room days) applicable to the Program (excluding swing-bod and newborn days) 7.00 New Type Inpatient days applicable to title XVIII only (including private room days) 10.00 through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Swing-bod NF type Inpatient days applicable to title XVIII only (including private room days) 11.00 December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bod NF type Inpatient days applicable to titles V or XIX only (including private room days) 12.00 Angles of NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Angles of NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Angles of NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Angles of NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Angles of NF type inpatient days applicable to the Program (excluding swing-bod days) 12.00 Angles of NF type inpatient days applicable to the Program (excluding swing-bod days) 12.00 Angles of NF type inpatient days applicable to the Program (excluding swing-bod days) 12.00 Angles of NF type inpatient days applicable to the Program (excluding swing-bod days) 12.00 Angles of NF type inpatient days applicable to the Program (excluding swing-bod days) 12.00 Angles of NF type services applicable to services after December 31 of the cost reporting period (including type type 12.00 Angles of NF type type 12.00 Angles of	6. 00	1 1 3 1 1 1 1	days) after December 3	31 of the cost	0	6. 00
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Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if Calendar year, enter 0 on this line) 10.00	7.00		days) through December	31 of the cost	155	7. 00
reporting period (if calendar year, enter 0 on this line) 70.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 50 swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 50 swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) after 50 swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) after 50 swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) after 50 swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 51 so 50 swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed days) 51 so 50 swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 51 so 50 swing-bed SNF services applicable to services through December 31 of the cost reporting period (including private room days) 51 so 50 swing-bed SNF services applicable to services after December 31 of the cost reporting period (including private room days) 51 so 50 swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 6 swing-bed cost applicable to SNF type services after De	9 00	1	days) after December 21	of the cost	0	9 00
10.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 0.00 1	8.00		uays) arter becember 31	of the cost	U	0.00
10.00 Swing-bed SMF type inpatient days applicable to title XVIII only (including private room days) 10.00 through December 31 of the cost reporting period (see instructions) 1.00 Swing-bed SMF type inpatient days applicable to ittle XVIII only (including private room days) after 0.11.00 12.00 13.00 Swing-bed SMF type inpatient days applicable to ittle XVIII only (including private room days) 0.12.00 13.00 Swing-bed SMF type inpatient days applicable to ittles V or XIX only (including private room days) 0.13.00 3	9.00		the Program (excluding	swi ng-bed and	230	9. 00
through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNT type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically increasing the variety of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Total nursery days (title V or XIX only) 15.00 Total nursery days (title V or XIX only) 15.00 Total nursery days (title V or XIX only) 15.00 Swing-bed Dausswant 17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicare rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicard rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicard rate for swing-bed NF services applicable to services through December 31 of the cost 19.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Medicard rate for swing-bed NF services applicable to services after December 31 of the cost 19.00 Total nursers applicable to SNF type services through December 31 of the cost reporting period (line 6 2 2 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					_	
11.00 Swing-bed SNF type inpatrient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 12.00 Swing-bed NF type inpatrient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatrient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Intra nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 17.00 Nursery days (title V or XIX only) 18.00 Nursery days (title V or XIX only) 19.00 Nursery days (title V or XIX only) 20.00 Nursery	10. 00			oom days)	0	10. 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00	11. 00			oom davs) after	0	11. 00
through December 31 of the cost reporting period 13. 00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15. 00 Total nursery days (title V or XIX only) 15. 00 Total nursery days (title V or XIX only) 15. 00 Total nursery days (title V or XIX only) 15. 00 Total nursery days (title V or XIX only) 15. 00 Total nursery days (title V or XIX only) 15. 00 Total nursery days (title V or XIX only) 15. 00 Total nursery days (title V or XIX only) 15. 00 Total nursery days (title V or XIX only) 15. 00 Total nursery days (title V or XIX only) 15. 00 Total nursery days (title V or XIX only) 15. 00 Total nursery days (title V or XIX only) 15. 00 Total nursery days (title V or XIX only) 15. 00 Total nursery days (title V or XIX only) 16. 00 Total nursery days (title V or XIX only) 17. 00 Total nursery days (title V or XIX only) 17. 00 Total nursery days (title V or XIX only) 18. 00 Total nursery days (title V or XIX only) 18. 00 Total nursery days (title V or XIX only) 19. 00 Total nursery days (title V or XIX only) 19. 00 Total nursery days (title V or XIX only) 19. 00 Total nursery days (title V or XIX only) 19. 00 Total nursery days (title V or XIX only) 19. 00 Total nursery days (title V or XIX only) 19. 00 Total nursery days (title V or XIX only) 19. 00 Total nursery days (title V or XIX only) 19. 00 Total swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6						
3. 00 Swing-bed NF type Inpati ent days applicable to titles V or XIX only (Including private room days) after December 31 of the cost reporting period (if call endar year, enter 0 on this line) 14. 00 14. 00 15. 00	12. 00		only (including private	e room days)	0	12.00
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34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 998, 274) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 34.00 37.00 35.00 37.00 36.00 37.00 36.00 37.00 37.00 38.00 39.00 Average per diem private room cost differential (line 3 x line 31) 38.00 Average per diem private room cost differential (line 3 x line 31) 38.00 Average per diem private room cost differential (line 3 x line 31) 38.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x line 31) 39.00 Average per diem private room cost differential (line 3 x						
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 998, 274) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 252.98 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 35.00 36.00 37.00 37.00 37.00 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 252.98 288, 185 39.00 40.00			s line 33)(see instruct	ions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 28, 998, 274 37.00 28, 998, 274 37.00 28, 998, 274 37.00 28, 998, 274 37.00 27, 998, 274 37.00 28, 998, 274 37.00 27, 998, 274 37.00 28, 998, 274 37.00 28, 998, 274 37.00 27, 998, 274 37.00						
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 252.98 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 288, 185 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36.00
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 252.98 38.00 Program general inpatient routine service cost (line 9 x line 38) 288, 185 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00		d private room cost dif	ferential (line	3, 998, 274	37. 00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 252.98 38.00 Program general inpatient routine service cost (line 9 x line 38) 288, 185 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 252.98 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1, 252.98 38.00 288, 185 39.00 40.00			TMENTS			
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 288, 185 39.00 40.00	38. 00				1, 252. 98	38. 00
		, ,	•			
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 288, 185 41.00		, , , , , , , , , , , , , , , , , , , ,	•			
	41.00	Tiotal Program general impatrent routine service cost (line 39 +	1111e 40)		288, 185	41.00

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Pre	
						5/21/2015 9:2	
	Cost Center Description	Total	Total	tle XIX	Hospi tal	PPS Program Cost	
		Inpatient Cost		Average Per	Program Days	Program Cost (col. 3 x col.	
				col . 2)		4)	
		1. 00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	338, 825	59:	3 571.3	7 197	112, 560	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43. 00
14. 00	CORONARY CARE UNIT						44. 00
5. 00	BURN INTENSIVE CARE UNIT						45. 00
16.00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1. 00	
8. 00	Program inpatient ancillary service cost (Wks	st. D-3. col. 3	3. line 200)			534, 785	48. 00
9. 00	Total Program inpatient costs (sum of lines 4			ons)		935, 530	1
	PASS THROUGH COST ADJUSTMENTS						
0. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, sum	of Parts I and	41, 455	50. 00
1. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillar	rv services (f	rom Wkst D s	um of Parts II	30, 638	51.00
1.00	and IV)	atront anorria	y services (i	TOII WKSt. D, S	um or rarts ir	30, 030	31.00
2. 00	Total Program excludable cost (sum of lines 5	50 and 51)				72, 093	52.00
3. 00	Total Program inpatient operating cost exclud		elated, non-ph	ysician anesth	etist, and	863, 437	53.00
	medical education costs (line 49 minus line 5	52)					
4. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.0
5. 00	Target amount per discharge					0.00	
6. 00	Target amount (line 54 x line 55)					0	56. 0
7. 00	Difference between adjusted inpatient operati	0					
8. 00	Bonus payment (see instructions)	onting ported	anding 100/	undated and as	maguadad by the	0 0. 00	
9. 00	2.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						
0. 00	Lesser of lines 53/54 or 55 from prior year of					0. 00	60.00
1. 00	If line 53/54 is less than the lower of lines					0	61.00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		rs (lines 54 x	60), or 1% of	the target		
2. 00	Relief payment (see instructions)	nstructions)				0	62. 00
3. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST						
4. 00	Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64.00
5. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	per 31 of the	cost reporting	period (See	0	65.00
0.00	instructions) (title XVIII only)			oost ropertrig	po ou (000		00.0
6. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66. 00
7. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	costs through	Docombor 21	of the cost re	norting poriod	0	67.00
7.00	(line 12 x line 19)	. costs till odgi	Pecelinei 31	or the cost le	por tring period		67.00
8. 00	Title V or XIX swing-bed NF inpatient routine	e costs after [December 31 of	the cost repo	rting period	0	68. 00
0.00	(line 13 x line 20)		(I. ((0)			
9. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
0.00	Skilled nursing facility/other nursing facili						70.00
1. 00	Adjusted general inpatient routine service co	-					71.00
2. 00	Program routine service cost (line 9 x line 7	•		>			72.00
	Medically necessary private room cost applica						73.00
4. 00 5. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r	•			art II column		74.00
2. 00	26, line 45)		. 555.5 (110111		, Ooi uiiii		, 5. 50
6. 00	Per diem capital-related costs (line 75 ÷ lin						76.00
7. 00	Program capital-related costs (line 9 x line						77. 00
3.00	Inpatient routine service cost (line 74 minus		rovidor zasa:	de)			78.0
9. 00 0. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa	,			us line 70)		79. 0
1. 00	Inpatient routine service costs for compa		Jose Trim tation	(11110 /0 111111	GS 11110 /7)		81. 0
2. 00	Inpatient routine service cost limitation (li		1)				82. 0
3.00	Reasonable inpatient routine service costs (s		ns)				83. 0
	Program inpatient ancillary services (see ins						84.

85. 00

86.00

87.00

663

85.00

86.00

84.00 Program inpatient ancillary services (see instructions)

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

Health Financial Systems COMM	IUNI TY HOSPT. (OF LAGE	RANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST			Provi der		Peri od:	Worksheet D-1	
					From 01/01/2014 To 12/31/2014	Date/Time Pre 5/21/2015 9:2	
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Rout	ine Cost	column 1 ÷	Total	Observation	
		(from	line 27)	column 2	Observati on	Bed Pass	
					Bed Cost (from	Through Cost	
					line 89)	(col. 3 x col.	
						4) (see	
						instructions)	
	1.00		2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST						
90.00 Capital-related cost	585, 84	1	3, 998, 274	0. 14652	3 830, 726	121, 720	90.00
91.00 Nursing School cost		0	3, 998, 274	0.00000	0 830, 726	0	91.00
92.00 Allied health cost		0	3, 998, 274	0.00000	0 830, 726	0	92.00
93.00 All other Medical Education		o	3, 998, 274	0.00000	0 830, 726	0	93. 00

Health Financial Systems COMMUNITY HOSPT. OF				eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151323	Peri od:	Worksheet D-3	
			From 01/01/2014 To 12/31/2014		nared.
			10 12/31/2014	5/21/2015 9: 2	
	Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			1, 276, 602		30. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 21979			
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 55818			
53. 00 05300 ANESTHESI OLOGY		0. 0375			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1167!			
60. 00 06000 LABORATORY		0. 2760			
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		-	
65. 00 06500 RESPI RATORY THERAPY		0. 4233			
66. 00 06600 PHYSI CAL THERAPY		0. 6268			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 34488			
68. 00 06800 SPEECH PATHOLOGY		1. 40028			
69. 00 06900 ELECTROCARDI OLOGY		0. 02538			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2723			
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3181:			
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3636!			
76. 97 O7697 CARDI AC REHABI LI TATI ON		0.0000		0	
76. 98 O7698 HYPERBARI C OXYGEN THERAPY		0. 00000			
76. 99 07699 LI THOTRI PSY		0.0000	00 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS				_	
90. 00 09000 CLI NI C		1. 6204		-	
90. 01 09001 LI FEBRI DGE SENI OR CARE		2. 32078		0	
91. 00 09100 EMERGENCY		0. 3301		10, 103	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 0203	16 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS					05.00
95. 00 09500 AMBULANCE SERVI CES			2 077 070	0/0 70/	95. 00
200.00 Total (sum of lines 50-94 and 96-98)	(1: (4)		2, 977, 272		
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (Tine of)	1	0	1	201.00

862, 736 200. 00 201. 00 202. 00

2, 977, 272

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

201.00 202.00

Health Financial Systems COMMUNITY HOSPT.				eu of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
	Component		From 01/01/2014 To 12/31/2014		nared:
	·		12, 01, 2011	5/21/2015 9: 2	
	Ti tl		Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INDATIONE DOUTING CODY COST CONTEDS		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 O3000 ADULTS & PEDIATRICS		1	211, 310		30.00
43. 00 04300 NURSERY			211, 310		43.00
ANCI LLARY SERVI CE COST CENTERS					43.00
50, 00 05000 OPERATING ROOM		0. 21979	4 163	36	50.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 55818		0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 03756		0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 11675		_	
60. 00 06000 LABORATORY		0. 27602			
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	62. 30
65. 00 06500 RESPIRATORY THERAPY		0. 42331		7, 879	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 62684	3 88, 564	55, 516	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 34488	2 79, 216	27, 320	67. 00
68.00 06800 SPEECH PATHOLOGY		1. 40028	2 5, 939	8, 316	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 02538	4 0	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 27237	6 5, 131	1, 398	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 31812		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 36365			73. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON		0.00000		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.00000		0	76. 98
76. 99 07699 LI THOTRI PSY		0.00000	0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		1. 62049		1	90. 00
90. 01 09001 LI FEBRI DGE SENI OR CARE		2. 32078		0	90. 01
91. 00 09100 EMERGENCY		0. 33016			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 02031	6 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS		1		ı	0- 0-
95. 00 09500 AMBULANCE SERVICES			040 007	407 704	95.00
200.00 Total (sum of lines 50-94 and 96-98)		1	318, 327	137, 721	1200.00

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

137, 721 200. 00 201. 00 202. 00

318, 327

318, 327

200.00

201.00 202.00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY	IN	In lie	eu of Form CMS-	2552-10
	CCN: 151323	Peri od:	Worksheet D-3	
		From 01/01/2014		
		To 12/31/2014	Date/Time Pre 5/21/2015 9:2	
Ti ·	tle XIX	Hospi tal	PPS	7 (1111
Cost Center Description	Ratio of Cos		Inpatient	
	To Charges	Program	Program Costs	
		Charges	(col. 1 x col.	
			2)	
	1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1		1	
30. 00 03000 ADULTS & PEDI ATRI CS		178, 758		30.00
43. 00 04300 NURSERY		249, 706		43. 00
ANCILLARY SERVICE COST CENTERS	0.0107	D4	120.0(4	F0 00
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 21979 0. 55818			
52. 00 05200 DELI VERY ROOM & LABUR ROOM 53. 00 05300 ANESTHESI OLOGY	0. 55818	· ·		
53. 00 05300 ANESTRESTOLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 03750			
60. 00 06000 LABORATORY	0. 11673	· ·		60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 00000	· ·		1
65. 00 06500 RESPI RATORY THERAPY	0. 4233		_	
66. 00 06600 PHYSI CAL THERAPY	0. 6268	· ·		
67. 00 06700 OCCUPATI ONAL THERAPY	0. 34488			
68. 00 06800 SPEECH PATHOLOGY	1. 40028	· ·	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 02538		0	1
71.00 O7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 2723		16, 871	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 3181:		0	1
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 3636!	54 238, 962	86, 899	73. 00
76. 97 O7697 CARDIAC REHABILITATION	0.00000	00	0	76. 97
76. 98 O7698 HYPERBARI C OXYGEN THERAPY	0.00000	00	0	76. 98
76. 99 07699 LI THOTRI PSY	0.00000	00	0	76. 99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	1. 62049	91 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	2. 32078	80 0	0	90. 01
91. 00 09100 EMERGENCY	0. 3301	58, 709	19, 384	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 0203	16 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES				95. 00
200.00 Total (sum of lines 50-94 and 96-98)		1, 694, 018		
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)	1	0	1	201.00

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

95. 00 534, 785 200. 00 201. 00 202. 00

1, 694, 018

201.00 202.00

Health Financial Systems	COMMUNITY HOSPT. OF LAG	RANGE CTY IN	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 151323	Peri od: From 01/01/2014	Worksheet E
				Date/Time Prepared:

			To 12/31/2014	Date/Time Pre	
		Title XVIII	Hospi tal	5/21/2015 9: 2 Cost	<u>/ am</u>
		THE ATTENDED	, noopi tui	3331	
	DADT D. HEDLOAL AND OTHER HEALTH CERVICORS			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions)			3, 407, 907	1.00
2. 00	Medical and other services reimbursed under OPPS (see instructi	ons)		0, 107, 707	1
3.00	PPS payments	,		0	3. 00
4.00	Outlier payment (see instructions)	0			
5.00	Enter the hospital specific payment to cost ratio (see instruct	0.000	1		
6. 00 7. 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0.00	
8. 00	Transitional corridor payment (see instructions)			0.00	1
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	1
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			3, 407, 907	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges				-
12. 00	Ancillary service charges			0	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, co	I. 4)		0	1
14. 00	3 \			0	14. 00
45.00	Customary charges				45.00
15. 00 16. 00	Aggregate amount actually collected from patients liable for pa Amounts that would have been realized from patients liable for			0	
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	payment for services c	in a chargebasis	0	10.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete only</pre>	if line 11 evceeds li	no 18) (soo	0	20. 00
20.00	instructions)	II IIIle II exceeds II	110 (300		20.00
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		3, 441, 986	21. 00
	Interns and residents (see instructions)			0	
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24. 00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			26, 790	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH, see instructions)		2, 072, 695	26. 00
27. 00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) pl	us the sum of lines 22	and 23} (for	1, 342, 501	27. 00
28. 00	CAH, see instructions) Direct graduate medical education payments (from Wkst. E-4, lin	o 50)		0	28. 00
	ESRD direct medical education costs (from Wkst. E-4, line 36)	e 30)		0	1
30. 00	Subtotal (sum of lines 27 through 29)			1, 342, 501	1
	Primary payer payments			177	1
32. 00	Subtotal (line 30 minus line 31)	2)		1, 342, 324	32. 00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE Composite rate ESRD (from Wkst. I-5, line 11)	5)		0	33. 00
	Allowable bad debts (see instructions)			324, 953	
	Adjusted reimbursable bad debts (see instructions)			246, 964	1
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		213, 579	•
37. 00				1, 589, 288	
38.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	ő	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	·	,	0	1
40.00	Subtotal (see instructions)	1, 589, 288	40. 00		
40. 01	Sequestration adjustment (see instructions)	31, 786 1, 583, 760	1		
41. 00 42. 00	· ·				41. 00
43. 00	,				1
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	-26, 258 0	1
	§115. 2	<u> </u>	·]
00.05	TO BE COMPLETED BY CONTRACTOR			-	
	Original outlier amount (see instructions)			0	
91. 00 92. 00	Outlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money			0 0. 00	
	Time Value of Money (see instructions)			0.00	1
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems COMMUNITY
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 151323

					5/21/2015 9: 27	/ am
		Ti tl	e XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1. 00	Total interim payments paid to provider		1, 744, 118		1, 538, 260	1. 00
2.00	Interim payments payable on individual bills, either		0		o	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER	08/15/2014	25, 700	08/15/2014	45, 500	3. 01
3.02			0		0	3. 02
3.03			0		o	3. 03
3.04			0		o	3. 04
3.05			0		o	3. 05
	Provider to Program		-1			
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		o	3. 51
3. 52			0		o	3. 52
3. 53			0		o	3. 53
3.54			0		o	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		25, 700		45, 500	3. 99
	3. 50-3. 98)				,	
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 769, 818		1, 583, 760	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02			0		0	5. 02
5. 03			0		0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
,	the cost report. (1)		440 0		_	,
6. 01	SETTLEMENT TO PROVIDER		113, 803		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		26, 258	6. 02
7.00	Total Medicare program liability (see instructions)		1, 883, 621		1, 557, 502	7. 00
				Contractor	NPR Date	
		,		Number	(Mo/Day/Yr)	
8. 00	Name of Contractor	(J	1. 00	2. 00	8. 00
6.00	INAME OF CONTRACTOR		ļ			0.00

 Heal th
 Financial
 Systems
 COMMUNITY

 ANALYSIS
 OF
 PAYMENTS
 TO
 PROVIDERS
 FOR
 SERVICES
 RENDERED

					5/21/2015 9: 2	7 am
		Ti tl	e XVIII Sv	ving Beds - SNF	Cost	
		I npati 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	Total interim payments paid to provider		650, 930		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
2 01	Program to Provider	00/15/2014	F / 200			2 01
3. 01 3. 02	ADJUSTMENTS TO PROVIDER	08/15/2014	56, 300		0	3. 01 3. 02
3. 02			0			
3. 03			0			3. 03
3. 05						
3.00	Provider to Program				0	3.03
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	765 THENTO TO TROOM III		0		o o	
3. 52			0		o o	
3. 53			0		Ö	
3. 54			l o		Ö	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		56, 300		0	3. 99
	3. 50-3. 98)		·			
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		707, 230		0	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	Г	Г			
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	TENTATIVE TO TROVIDER		0			
5. 02			l ő		0	5. 02
0.00	Provider to Program				0	0.00
5. 50	TENTATI VE TO PROGRAM		0		0	5.50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		0		0	
6. 02	SETTLEMENT TO PROGRAM		79, 131		0	
7. 00	Total Medicare program liability (see instructions)		628, 099		0	7. 00
				Contractor	NPR Date	
		,)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		J	1.00	2.00	8. 00
0.00	Induite of contractor	l			l l	J 0.00

Heal th	Financial Systems COMMUNITY HOSPT. OF LAW	SRANGE CTY IN	In lie	u of Form CMS-2	2552_10		
	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provi der CCN: 151323	Peri od: From 01/01/2014 To 12/31/2014	Worksheet E-1 Part II	pared:		
		Title XVIII	Hospi tal	Cost			
				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. S	5-3, Pt. I col. 15 line	14	933	1.00		
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-1	2		1, 015	2.00		
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			474	3.00		
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	2		2, 528	4. 00		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			70, 720, 592	5.00		
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lir	ie 20		1, 274, 802	6.00		
7.00	CAH only - The reasonable cost incurred for the purchase of cer	tified HIT technology	Wkst. S-2, Pt. I	199, 373	7. 00		
	line 168						
8.00	Calculation of the HIT incentive payment (see instructions)			159, 459	8. 00		
9.00	Sequestration adjustment amount (see instructions)			3, 189	9. 00		
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)						
	I NPATIENT HOSPITAL SERVICES UNDER PPS & CAH						
30.00	Initial/interim HIT payment adjustment (see instructions)	·		0	30.00		
31.00	Other Adjustment (specify)			0	31.00		
32 00	2.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 156.270						

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

156, 270 32. 00

Health Financial Systems	COMMUNITY HOSPT. C	OF LAG	RANGE CTY	ΙN			In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS		Provi der	CCN:	151323	Perio	od:	Worksheet E-2
						From	01/01/2014	
			Component	CCN	: 15Z323	To	12/31/2014	Date/Time Prepared:
			•					5/21/2015 O: 27 am

	CC	omponent CCN: 15Z323	10 12/31/2014	Date/IIme Pre 5/21/2015 9:2	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		505, 315	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200 for Pt. A, an		139, 098	0	3. 00
	Part V, cols. 6 and 7, line 202 for Pt. B) (For CAH, see instructi				
4.00	Per diem cost for interns and residents not in approved teaching p	rogram (see		0.00	4. 00
	instructions)				
5.00	Program days		401	0	5. 00
6.00	Interns and residents not in approved teaching program (see instru			0	6. 00
7.00	Utilization review - physician compensation - SNF optional method	onl y	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		644, 413	0	
9.00	Primary payer payments (see instructions)		0	0	
	Subtotal (line 8 minus line 9)		644, 413	0	10. 00
11. 00	Deductibles billed to program patients (exclude amounts applicable	to physician	0	0	11. 00
	professional services)				
	Subtotal (line 10 minus line 11)		644, 413	0	
13.00	Coinsurance billed to program patients (from provider records) (ex	cl ude coi nsurance	3, 496	0	13. 00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)		640, 917	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	1
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	1
	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	
	Allowable bad debts for dual eligible beneficiaries (see instructi	ons)	0	0	
	Total (see instructions)		640, 917	0	
	Sequestration adjustment (see instructions)		12, 818	0	
	Interim payments		707, 230	0	20. 00
	Tentative settlement (for contractor use only)		0	0	= 00
	Balance due provider/program (line 19 minus lines 19.01, 20, and 2		-79, 131	0	22. 00
23. 00	Protested amounts (nonallowable cost report items) in accordance w $\$115.2$	ith CMS Pub. 15-2,	0	0	23. 00

Health Financial Systems	COMMUNITY HOSPT. OF LAG	RANGE CTY IN	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 151323	From 01/01/2014	Worksheet E-3 Part V Date/Time Prepared: 5/21/2015 9:27 am
		T' 11 \0.0111	11	-

			12,01,2011	5/21/2015 9: 2	7 am
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE P	ART A SERVICES - COST	REI MBURSEMENT		
1.00	Inpatient services			2, 129, 111	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instruction	s)			2. 00
3. 00	Organ acquisition	/		0	3. 00
4. 00	Subtotal (sum of lines 1 through 3)			2, 129, 111	4. 00
5. 00	Primary payer payments			2, 12, , 111	5. 00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 150, 402	6. 00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			2, 100, 102	0.00
	Reasonable charges				
7.00	Routine service charges			0	7. 00
8.00	Ancillary service charges			0	8. 00
9. 00	Organ acquisition charges, net of revenue			Ö	
10. 00	Total reasonable charges			0	
10.00	Customary charges			U	10.00
11. 00	Aggregate amount actually collected from patients liable for pa	yment for services on	a charge basis	0	11. 00
12. 00	Amounts that would have been realized from patients liable for			0	
12.00	had such payment been made in accordance with 42 CFR 413.13(e)	payment for services c	ili a cliai ye basi s	U	12.00
13. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	12 00
14. 00	Total customary charges (see instructions)			0.000000	14. 00
15. 00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	no 6) (coo	0	15. 00
13.00	instructions)	11 Title 14 exceeds 11	rie o) (see	U	13.00
16. 00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds lin	e 14) (see	0	16. 00
10.00	instructions)	TT TTHE G EXCECUS TT	10 11) (300	o l	10.00
17. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	17. 00
.,, 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	
18. 00	Direct graduate medical education payments (from Worksheet E-4,	line 49)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	,		2, 150, 402	
20. 00	Deductibles (exclude professional component)			250, 532	
21. 00	Excess reasonable cost (from line 16)			0	
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 899, 870	
23. 00	Coi nsurance			299	
24. 00	Subtotal (line 22 minus line 23)			1, 899, 571	
25. 00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		29, 594	
26. 00	Adjusted reimbursable bad debts (see instructions)	(See That detrons)		22, 491	
27. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		12, 489	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)	(21 0113)		1, 922, 062	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			1, 722, 662	29. 00
29. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 99	Recovery of Accelerated Depreciation			0	29. 99
	,	1, 922, 062			
30. 00 30. 01					
30. 01	Sequestration adjustment (see instructions)			38, 441	
31.00	Interim payments			1, 769, 818 0	31.00
32.00	Tentative settlement (for contractor use only)	4 33)			
	Balance due provider/program (line 30 minus lines 30.01, 31, an		chantar 1	113, 803	
34. 00	Protested amounts (nonallowable cost report items) in accordanc §115.2	e with two Pub. 15-2,	спартег т,	0	34. 00
	3113. 2				

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

Provider CCN: 151323 | Period: From 01/01/2014

					5/21/2015 9: 2	7 am
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
		1 00	Purpose Fund	2.22	4 00	
	CHIPDENT ACCETS	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	2, 217	1 (<u> </u>	0	1.00
2. 00	Temporary investments	2,217			0	2. 00
3.00	Notes recei vabl e		ól	-	0	3. 00
4. 00	Accounts recei vabl e	4, 407, 620		0	Ō	
5.00	Other recei vable	-27, 025		0	0	
6.00	Allowances for uncollectible notes and accounts receivable	0		0	0	6. 00
7.00	Inventory	239, 648	3	0	0	7. 00
8.00	Prepai d expenses	120, 270		0	0	
9. 00	Other current assets	0		0	0	9. 00
10. 00	Due from other funds	-1, 572, 216	1	-	0	10. 00
11. 00	Total current assets (sum of lines 1-10)	3, 170, 514	(0	0	11. 00
10.00	FI XED ASSETS	0/5 000				10.00
12.00	Land	265, 000	1		0	1
13. 00 14. 00	Land improvements	1, 972, 720 -860, 306	1	-		13. 00 14. 00
15. 00	Accumulated depreciation Buildings	13, 245, 217		-	0	15.00
16. 00	Accumulated depreciation	-2, 509, 832	1	-	0	16.00
17. 00	Leasehold improvements	29, 098	1	-	0	17. 00
18. 00	Accumulated depreciation	-24, 630	1	-	0	18.00
19. 00	Fi xed equipment	7, 763, 398	1	-	0	19. 00
20. 00	Accumulated depreciation	-3, 658, 953	1		0	20.00
21. 00	Automobiles and trucks	42, 445			Ö	21.00
22. 00	Accumulated depreciation	-42, 445	1	-	Ö	22. 00
23. 00	Major movable equipment	7, 068, 042	1	-	0	23. 00
24. 00	Accumulated depreciation	-5, 469, 660	1	0	Ō	24. 00
25. 00	Mi nor equi pment depreci abl e	0		o o	Ō	25. 00
26. 00	Accumul ated depreciation	l o		0	0	26. 00
27. 00	HIT designated Assets	l c		0	0	27. 00
28. 00	Accumul ated depreciation	0		o	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0		0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	17, 820, 094		0	0	30. 00
	OTHER ASSETS					
31. 00	Investments	0) (0	-	31. 00
32.00	Deposits on Leases	0) (0	0	32. 00
33. 00	Due from owners/officers	0) (0	0	33. 00
34.00	Other assets	5, 012, 312	1	0	0	34. 00
35. 00	Total other assets (sum of lines 31-34)	5, 012, 312	1	·	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	26, 002, 920) (0	0	36. 00
	CURRENT LI ABI LI TI ES	100.01/			_	
37. 00	Accounts payable	483, 916		0		37. 00
38. 00	Salaries, wages, and fees payable	543, 129	1	-	0	38. 00
39. 00	Payroll taxes payable	770.000		0	0	39. 00
40.00	Notes and Loans payable (short term)	770, 000		0	0	40.00
41. 00	Deferred income) U	U	41.00
42. 00 43. 00	Accel erated payments Due to other funds		΄,	0	0	42.00
44. 00	Other current liabilities	474. 935	5 (0		
45. 00	Total current liabilities (sum of lines 37 thru 44)	2, 271, 980				
40.00	LONG TERM LIABILITIES	2,2/1,700	′1	,	<u> </u>	, 45.00
46. 00	Mortgage payable) 0	0	46. 00
47. 00	Notes payable	86, 599	1			
48. 00	Unsecured Loans	00,077		-		48. 00
49. 00	Other long term liabilities	26, 155, 739		-	Ō	
50. 00	Total long term liabilities (sum of lines 46 thru 49	26, 242, 338	1	o o		
51. 00	Total liabilites (sum of lines 45 and 50)	28, 514, 318		0		
	CAPI TAL ACCOUNTS					
52.00	General fund balance	-2, 511, 398	3			52. 00
53.00	Specific purpose fund					53.00
54.00	Donor created - endowment fund balance - restricted			0		54. 00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57.00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansi on	_				
59. 00	Total fund balances (sum of lines 52 thru 58)	-2, 511, 398	1	0	0	59.00
60. 00	Total liabilities and fund balances (sum of lines 51 and	26, 002, 920) (0	0	60. 00
	[59]	I	I	1	I	I

STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 151323 Peri od: Worksheet G-1 From 01/01/2014 12/31/2014 Date/Time Prepared: 5/21/2015 9:27 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period -2, 511, 398 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 2, 600, 528 2.00 Total (sum of line 1 and line 2) 3.00 89, 130 0 3.00 4.00 ADDITIONS (CREDIT ADJUSTMENTS) -2, 600, 529 0 0 4.00 5.00 0 5.00 6.00 0 6.00 0 7.00 0 0 0 7.00 0 8.00 0 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) -2, 600, 529 10.00 Subtotal (line 3 plus line 10) -2, 511, 399 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 00000 13.00 13.00 14.00 0 14.00 0 15.00 15.00 0 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance -2, 511, 399 19.00 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 ADDITIONS (CREDIT ADJUSTMENTS) 4.00 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0

0

0

19.00

Fund balance at end of period per balance

sheet (line 11 minus line 18)

 Heal th Financial Systems
 COMMUNITY

 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES
 In Lieu of Form CMS-2552-10 Provider CCN: 151323 | Period: | Worksheet G-2 | From 01/01/2014 | Parts I & II | To 12/31/2014 | Date/Time Prep

				o 12/31/2014	Date/Time Pre 5/21/2015 9:2			
	Cost Center Description		Inpati ent	Outpati ent	Total	/ alli		
	3331 331131 33331 1 21 311		1.00	2. 00	3. 00			
PART I - PATIENT REVENUES								
	General Inpatient Routine Services							
1.00	Hospi tal		3, 849, 275	5	3, 849, 275	1. 00		
2.00	SUBPROVI DER - I PF					2. 00		
3.00	SUBPROVI DER - I RF					3. 00		
4.00	SUBPROVI DER					4. 00		
5.00	Swing bed - SNF		322, 480		322, 480	5. 00		
6.00	Swing bed - NF		()	0	6. 00		
7.00	SKILLED NURSING FACILITY					7. 00		
8.00	NURSING FACILITY					8. 00 9. 00		
9. 00 10. 00	OTHER LONG TERM CARE		1 171 755		A 171 7EE	10.00		
10.00	Total general inpatient care services (sum of lines 1-9) Intensive Care Type Inpatient Hospital Services		4, 171, 755		4, 171, 755	10.00		
11. 00	INTENSIVE CARE UNIT		I			11. 00		
12. 00	CORONARY CARE UNIT					12. 00		
13. 00	BURN INTENSIVE CARE UNIT					13. 00		
14. 00	SURGI CAL INTENSIVE CARE UNIT					14. 00		
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00		
16. 00	Total intensive care type inpatient hospital services (sum of I	i nes			0	16. 00		
	11-15)				_			
17.00	Total inpatient routine care services (sum of lines 10 and 16)		4, 171, 755	5	4, 171, 755	17. 00		
18.00	Ancillary services		12, 963, 811	o	12, 963, 811	18. 00		
19.00	Outpati ent servi ces		(54, 997, 975	54, 997, 975	19. 00		
20.00	RURAL HEALTH CLINIC		(0	0	20. 00		
21.00	FEDERALLY QUALIFIED HEALTH CENTER		(0	0	21. 00		
22. 00	HOME HEALTH AGENCY					22. 00		
23.00	AMBULANCE SERVICES		(3, 417, 864	3, 417, 864	23. 00		
24. 00	CMHC					24. 00		
24. 10	CORF		(ή "Ι	0	24. 10		
24. 20	OUTPATIENT PHYSICAL THERAPY		(0	0	24. 20		
24. 30	OUTPATIENT OCCUPATIONAL THERAPY		(0	0	24. 30		
24. 40	OUTPATIENT SPEECH PATHOLOGY		(0	24. 40		
25. 00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00		
26. 00 27. 00	HOSPI CE OTHER (SPECI FY)				0	26. 00 27. 00		
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst	17, 135, 566	58, 415, 839	75, 551, 405	28. 00		
20.00	G-3, line 1)	U WKSL.	17, 135, 500	30, 413, 637	75, 551, 405	20.00		
	PART II - OPERATING EXPENSES							
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			27, 725, 432		29. 00		
30. 00	BAD DEBT		3, 699, 144			30.00		
31.00						31. 00		
32.00						32. 00		
33.00			(33. 00		
34.00			(34.00		
35.00			(35. 00		
36. 00	Total additions (sum of lines 30-35)			3, 699, 144		36. 00		
37. 00	DEDUCT (SPECIFY)		(37. 00		
38. 00			(38. 00		
39. 00			(39. 00		
40.00						40.00		
41. 00	T-+-1 d-du-+i (6 li 27 41)		(ן [41.00		
42. 00 43. 00	Total deductions (sum of lines 37-41) Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		31, 424, 576		42. 00 43. 00		
43.00	to Wkst. G-3, line 4)	(11 01151 61		31, 424, 3/0		43.00		
	10		1	1 1		1		

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10								
	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 151323 Period:			Worksheet G-3				
			From 01/01/2014 To 12/31/2014					
	Date/Time Prepared: 5/21/2015 9:27 am							
				5/21/2015 9: 2	/ am			
				1. 00				
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line:	387		75, 551, 405	1. 00			
2.00	Less contractual allowances and discounts on patients' accounts				2.00			
3.00	Net patient revenues (line 1 minus line 2)				3. 00			
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)				4. 00			
5. 00	Net income from service to patients (line 3 minus line 4)							
0.00	OTHER I NCOME			1, 620, 117	0.00			
6.00	Contri buti ons, donati ons, bequests, etc				6.00			
7.00	Income from investments				7. 00			
8.00	Revenues from telephone and other miscellaneous communication services				8.00			
9.00	Revenue from television and radio service				9. 00			
10.00	0 Purchase di scounts				10.00			
11. 00	Rebates and refunds of expenses				11. 00			
12.00	Parking lot receipts				12. 00			
13.00	Revenue from laundry and linen service				13.00			
14.00	Revenue from meals sold to employees and guests				14. 00			
15.00	Revenue from rental of living quarters				15. 00			
16.00	Revenue from sale of medical and surgical supplies to other than patients				16. 00			
17. 00	Revenue from sale of drugs to other than patients				17. 00			
18. 00	00 Revenue from sale of medical records and abstracts			0	18. 00			
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00			
20.00	3			11, 608				
21. 00	3			0	21. 00			
22. 00	' '			31, 037	1			
23. 00				0	23. 00			

24. 01 24.02

25.00

26.00 27. 00 28. 00 0 0 2, 600, 528 29. 00

349, 000 66, 273

980, 411

2, 600, 528

24.00

24. 01 COUNTY GRANT FOR AMB SERVICES
24. 02 MISCELLANEOUS

24.02 MISCELLANEOUS
25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)
27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)