				1	
Heal th Financi	al systems s required by law (42 USC 1395	LAPORTE HOSP			L OF FORM CMS-2552-10
	since the beginning of the co				OMB NO. 0938-0050
payments made	Since the beginning of the co	st reporting period being	deemed over payments (42	. 050 1575g).	EXPIRES 05-31-2019
AND SETTLEMEN		COST REPORT CERTIFICATION	Provider CCN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/31/2017 9:24 am
PART I - COST					
Provi der	1. [X] Electronically filed			Date: 5/31/20	17 Time: 9:24 am
use only	2. [] Manually submitted c				
	3. [0] If this is an amende 4. [F] Medicare Utilization	d report enter the number Enter "F" for full or "L	of times the provider re " for low.	esubmitted this co	ost report
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended	7. Contractor No.	11.C or this Provider CCN 12.[
PART II - CER	LI FI CATI ON				
MI SREPRESENTAT ADMI NI STRATI VE PROVI DED OR PE	FION OR FALSIFICATION OF ANY I E ACTION, FINE AND/OR IMPRISON ROCURED THROUGH THE PAYMENT DI E ACTION, FINES AND/OR IMPRISO	IMENT UNDER FEDERAL LAW. RECTLY OR INDIRECTLY OF A	FURTHERMORE, IF SERVICES	IDENTIFIED IN TH	IIS REPORT WERE
	CERTIFICATION BY OFFICER C	R ADMINISTRATOR OF PROVIDE	ER(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 LAPORTE HOSPITAL (15-0006) for the cost reporting period beginning 03/01/2016 and ending 12/31/2016 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)

Title

			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	131, 239	86, 603	0	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	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
200.00	Total	0	131, 239	86, 603	0	0	200.00

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

Date

	AL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA	ATA	Provi d	er CCN:	15-0006	Period: From 03/0 To 12/3	1/2016 1/2016	Part I Date/T	eet S-2 ime Pre 017 9:2	epared
	1.00		. 00	•	3.00		1	4.00			
	Hospital and Hospital Health Care Co		050								
00 00	Street: STATE & MADISON STREETS City: LAPORTE	PO Box: 2 State: 1	1	7in Code	e: 46350-	- Coun	+				1.0
50	CITY. ENONE	Component Na		CCN	CBSA	Provi de		Pavm	ent Syst	tem (P.	2.0
				Number	Number		Certifie		, 0, or		
								V	XVIII]
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
00	Hospital and Hospital-Based Componen Hospital	LAPORTE HOSPITAL		150006	43780	1	07/01/196	6 N	Р	Р	3.0
00	Subprovi der – IPF	LAI OKTE HOSTITAL	-	130000	43700	1	077017130		'	'	4.0
00	Subprovider - IRF										5.0
00	Subprovider - (Other)										6.0
00	Swing Beds - SNF										7.0
00 00	Swing Beds - NF										8.0
00	Hospi tal -Based SNF Hospi tal -Based NF										10. 0
00	Hospi tal -Based OLTC										11. (
00	Hospital-Based HHA										12.0
00	1 5										13.0
00	Hospital -Based Hospice										14.0
00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15.0
00	Hospital -Based (CMHC) I										17.0
00	Renal Dialysis										18.0
00	Other										19. (
							Fro 1. (T(<u>):</u> 00	-
00	Cost Reporting Period (mm/dd/yyyy)						03/01/		12/31		20.0
00	Type of Control (see instructions)						2				21.0
	Inpatient PPS Information								-		ł
00	Does this facility qualify and is it share hospital adjustment, in accorda								ſ	N	22.0
	for yes or "N" for no. Is this facility										
	amendment hospital?) In column 2, en				2	/(_)(o					
01	Did this hospital receive interim une						Y		٢	Y	22.0
	period? Enter in column 1, "Y" for ye										
	for no for the portion of the cost re										
	(see instructions)	cporting period t	beedirring								
02	Is this a newly merged hospital that						N		1	N	22. (
	determined at cost report settlement	•	,	in col	ump 1 '	'Y" for ve	20				
	or "N" for no, for the portion of the		noriad pr			5	,5				
	in column 2 "Y" for ves or "N" for u			ior to	October	1. Enter					
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00	or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for in prior to October 1. Enter in column 3, cost reporting period occurring on of hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Mee 1, enter 1 if date of admission, 2 i method of identifying the days in thi used in the prior cost reporting period lin-state Medicaid paid days in column Medicaid eligible unpaid days in column out-of-state Medicaid paid days in column	no, for the porti c reclassificati statistical area to for the portion 2, "Y" for yes or after October of t more than 499 b dicaid days on li f census days, or s cost reporting od? In column of h 1, in-state umn 2, olumn 3, d days in column t unpaid days in	ion of the ion from u as adopted on of the r "N" for 1. (see in beds (as c N" for no. i nes 24 an r 3 if dat g period d 2. enter " In-State Medicaid paid days 1.00 44	ior to e cost r irban to by CMS cost re no for istructi ounted d/or 25 e of di lifferen Y" for i In-S i Medio s eligi unpa dag	October eporting in FY20 porting the porting the porting the porting the portions) Doc in accor below? scharge. t from t yes or ' caid ble M aid pa ys DO	1. Enter g period of as a resul of 5? Enter period tion of th es this rdance with In column Is the the methoo 'N" for no Out-of State edicaid id days 3.00	n N t N he N th th th th th th th th th th th th th	3 Medi ca HMO da 5. 00	i d C iys Mei	N Dither di cai d days 6. 00	23.
00	or after October 1. Did this hospital receive a geographi of the OMB standards for delineating in column 1, "Y" for yes or "N" for in prior to October 1. Enter in column 2 cost reporting period occurring on oi hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, " Which method is used to determine Mee 1, enter 1 if date of admission, 2 i method of identifying the days in thi used in the prior cost reporting peri lin-state Medicaid paid days in colu out-of-state Medicaid paid days in colu out-of-state Medicaid eligible unpaid 4, Medicaid HMO paid and eligible but	no, for the porti c reclassificati statistical area no for the portio 2, "Y" for yes or r after October f t more than 499 th 'icaid days on li f census days, or s cost reporting od? In column 2 enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6.	ion of the ion from u as adopted on of the r "N" for 1. (see in beds (as c N" for no. i nes 24 an r 3 if dat g period d 2. enter " In-State Medicaid paid days 1.00 44	ior to e cost r irban to by CMS cost re no for istructi ounted d/or 25 e of di lifferen Y" for i In-S i Medio s eligi unpa dag	October eporting in FY20 porting the porting the porting the porting the portions) Doc in accor below? scharge. t from t yes or ' caid ble M aid pa ys DO	1. Enter g period of as a resul of 5? Enter period tion of th es this rdance with In column Is the the methoo 'N" for no Out-of State edicaid id days 3.00	n N t N he N th th th th th th th th th th th th th	3 Medi ca HMO da 5. 00	i d C iys Mei	N Dither di cai d days 6. 00	23.
00	or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for in prior to October 1. Enter in column 3 cost reporting period occurring on of hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Mee 1, enter 1 if date of admission, 2 i method of identifying the days in thi used in the prior cost reporting period Medicaid eligible unpaid days in column 44. Medicaid paid days in column 45. Medicaid HMO paid and eligible unpaid 4, Medicaid HMO paid and eligible unpaid 4, Medicaid apid days in Column 5, and other Medicaid days in f this provider is an IRF, enter the Medicaid paid days in column 1, the in	no, for the porti c reclassificati statistical area no for the portion 2, "Y" for yes or r after October f t more than 499 th 'Y" for yes or "f dicaid days on li f census days, or s cost reporting od? In column 2 enter the n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state n-state	ion of the ion from u as adopted on of the r "N" for 1. (see in beds (as c N" for no. i nes 24 an r 3 if dat g period d 2. enter " In-State Medicaid paid days 1.00 44	ior to e cost r rrban to l by CMS cost re no for istructi counted d/or 25 e of di lifferen Y" for s e l igi unpa dag 2.0	October eporting in FY2(porting the porting the porting the porting scharge. t from t yes or ' scharge. t from t yes or ' caid below? scharge. t from t yes or ' caid below? Scharge. t for the portion below? Scharge. t for the portion below. Scharge. t for the portion for the por	1. Enter g period of as a resul 015? Enter period tion of the sthis rdance with In column Is the the methoo N" for no Out-of State edicaid aid days 3.00	n N ee N he Out-of State Medicaid el igible unpaid 4.00	3 Medi ca HMO da 5. 00	i d C iys Mei 0 098	N Dither di cai d days 6. 00	23.
00	or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column 3, cost reporting period occurring on of hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Mee 1, enter 1 if date of admission, 2 i method of identifying the days in thi used in the prior cost reporting peri Medicaid eligible unpaid days in column 4, Medicaid paid days in column 4, Medicaid HMO paid and eligible unpaid 4, Medicaid HMO paid and eligible but column 5, and other Medicaid days in lf this provider is an IRF, enter the Medicaid eligible unpaid days in column 1, the spovider is an IRF, enter the Medicaid eligible unpaid days in column 1, the Medicaid eligible unpaid days in column 1, the	no, for the porti c reclassificati statistical area to for the portion 2, "Y" for yes or r after October of t more than 499 b 'Y" for yes or "f dicaid days on li f census days, or s cost reporting od? In column 2 num 2, olumn 3, d days in column t unpaid days in column 6. e in-state n-state umn 2,	ion of the ion from u as adopted on of the r "N" for 1. (see in beds (as c N" for no. nes 24 an r 3 if dat g period d 2, enter " In-State Medicaid paid days 1.00 44	ior to e cost r rrban to l by CMS cost re no for istructi counted d/or 25 e of di lifferen Y" for s e l igi unpa dag 2.0	October eporting in FY2(porting the porting the porting the porting scharge. t from t yes or ' scharge. t from t yes or ' caid below? scharge. t from t yes or ' caid below? Scharge. t for the portion below? Scharge. t for the portion below. Scharge. t for the portion for the por	1. Enter g period of as a resul 015? Enter period tion of the sthis rdance with In column Is the the methoo N" for no Out-of State edicaid aid days 3.00	n N ee N he Out-of State Medicaid el igible unpaid 4.00	3 Medi ca HMO da 5. 00	i d C iys Mei 0 098	N Dither di cai d days 6. 00	23.0
00	or after October 1. Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for in prior to October 1. Enter in column 3 cost reporting period occurring on of hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3, Which method is used to determine Mee 1, enter 1 if date of admission, 2 i method of identifying the days in thi used in the prior cost reporting period Medicaid eligible unpaid days in column 44. Medicaid paid days in column 45. Medicaid HMO paid and eligible unpaid 4, Medicaid HMO paid and eligible unpaid 4, Medicaid apid days in Column 5, and other Medicaid days in f this provider is an IRF, enter the Medicaid paid days in column 1, the in	enter the no, for the portion statistical area to for the portion and the portion after October of the more than 499 b yr for yes or "M dicaid days on li ficensus days, or s cost reporting od? In column 2 num 2, olumn 3, d days in column thunpaid days in column 6. e in-state n-state mn 2, 3, out-of-state	ion of the ion from u as adopted on of the r "N" for 1. (see in beds (as c N" for no. nes 24 an r 3 if dat g period d 2, enter " In-State Medicaid paid days 1.00 44	ior to e cost r rrban to l by CMS cost re no for istructi counted d/or 25 e of di lifferen Y" for s e l igi unpa dag 2.0	October eporting in FY2(porting the porting the porting the porting scharge. t from t yes or ' scharge. t from t yes or ' caid below? scharge. t from t yes or ' caid below? Scharge. t for the portion below? Scharge. t for the portion below. Scharge. t for the portion for the por	1. Enter g period of as a resul 015? Enter period tion of the sthis rdance with In column Is the the methoo N" for no Out-of State edicaid aid days 3.00	n N ee N he Out-of State Medicaid el igible unpaid 4.00	3 Medi ca HMO da 5. 00	i d C iys Mei 0 098	N Dither di cai d days 6. 00	23.

iospi t	Financial Systems LAF AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		OSPITAL Provider CC		eriod: rom 03/01/20 [.]	16 Part I 16 Date/	neet S-2 Fime Pre	pared:
					Urban/Rural		2017 9:2 f Geogr	
04 00	Enter your standard geographic classification (not wa		tuc at the boa	inning of the	1.00	1	. 00	26.00
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or	rural. ige) sta	atus at the end	of the cost		1		27.00
35.00	enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	cati on	in column 2.			0		35.00
	effect in the cost reporting period.				Begi nni ng:	Enc	li ng:	
					1.00		. 00	
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	s.	•			0		36.00
	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo	e MDH †	transitional pa	yment in	N			37.0
88. 00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of	s of MDH	istatus. If li	ne 37 is				38.00
	enter subsequent dates.				Y/N 1.00		/N 00	-
39.00	Does this facility qualify for the inpatient hospital	paymer	nt adjustment f	or low volume	N 1.00		N	39.00
0.00	hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	uiremer or "N"	nts in accordan for no. (see i	nce with 42 nstructions)	N		N	40.00
.0. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. E	Enter "Y" for y		N	V XVII	N I XIX	40.00
						.00 2.00	_	
	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	nt for a	li sproporti onat	e share in acc	cordance	N Y	N	45.00
6. 00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N N	N	46.00
	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment Teaching Hospitals					N N N N	N N	47.00 48.00
6. 00	Is this a hospital involved in training residents in	approve	ed GME programs	? Enter "Y" f	for yes	N		56.00
7.00	or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y	yes or h of th'	"N" for no in his cost report plete Worksheet	column 1. If ing period? E	column 1 Inter "Y"			57.00
8. 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	ursemer	nt for physicia	ins' services a	IS	N		58.00
	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"	, compl costs 1	ete Wkst. D-2, for a program t	hat meets the		N N		59.00 60.00
		Y/N	I ME	Direct GME	IME	Dire	ct GME	
		1.00	2.00	3.00	4.00	5	.00	-
1.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N	2.00	0.00		00		61.00
o1. 01	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		0.00	0.00				61. 01
	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		0.00	0.00				61. 02
	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.00				61. 03
	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00				61. 04
1 05	current cost reporting period.(see instructions). Enter the difference between the baseline primary		0.00	0.00				61. 05

OSPITAL AND HOSPITAL H	EALTH CARE COMPLEX I		PORTE HO TA	Provider CC		eri od:	u of Form CMS-2 Worksheet S-2	
					Fr Tc	com 03/01/2016 0 12/31/2016	Part I Date/Time Pre 5/31/2017 9:2	
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
	of ACA §5503 award t ef and/or FTEs that surgery. (see instruc	are nonprimary		0.00	0.00			61.
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
				1.00	2.00	3.00	4.00	
specialty, if any for each new prog column 1, the pro program code, ent	ne 61.05, specify ear , and the number of gram. (see instruction gram name, enter in er in column 3, the and enter in column unt.	FTE residents ns) Enter in column 2, the IME FTE				0.00	0.00	61.
1.20 Of the FTEs in li program specialty residents for eac instructions) Ent enter in column 2 3, the IME FTE ur	ne 61.05, specify ea , if any, and the nu h expanded program. er in column 1, the the program code, weighted count and e unweighted count.	mber of FTE (see program name, enter in column				0.00	0.00	61.
							1.00	
	fecting the Health R							
	of FTE residents tha eived HRSA PCRE fund			d in this cost	reporting peri	od for which	0.00	62.
2.01 Enter the number during in this co	of FTE residents tha ost reporting period s that Claim Residen	t rotated from a of HRSA THC proc	a Teachi gram. (s	see instruction		your hospital	0.00	62.
3.00 Has your facility	trained residents i for no in column 1	n nonprovider se	ettings	during this co	instructions)		N	63.
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
					1.00	2.00	3.00	
	he ACA Base Year FTE Is on or after July 1				his base year	is your cost r	reporting	
4.00 Enter in column 1 in the base year resident FTEs att settings. Enter resident FTEs tha	, if line 63 is yes, period, the number o ributable to rotatio in column 2 the numb t trained in your ho ded by (column 1 + c	or your facilit f unweighted nor ns occurring in er of unweightec spital. Enter ir	ty trair n-primar all nor n non-pr n columr	ned residents ry care nprovider rimary care n 3 the ratio	0. 00			64.0
	P	rogram Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	3.00	4.00	5.00	
5.00 Enter in column 1 is yes, or your f trained residents year period, the associated with p FTEs for each pri program in which residents. Enter the program code, column 3, the nun unweighted primar residents attribu rotations occurri non-provider sett column 4, the nun unweighted primar resident FTEs tha your hospital. En 5, the ratio of	Facility Facility Fin the base program name orimary care mary care you trained in column 2, enter in ober of ry care FTE ttable to ng in all tings. Enter in ober of ry care t trained in tter in column				0. 00	0.00	0. 000000	

Health Financial Systems	LA	PORTE HOSPITAL	-		I	n Lieu	u of For	n CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	PLEX IDENTIFICATION DA	ATA Pro	vider CCN	F	eriod: rom 03/01, o 12/31,		Workshe Part I Date/Ti 5/31/20	me Prem	pared: 3 am
				Unweighted FTEs Nonprovider Site	Unwei gh FTEs i Hospi t	n	Ratio (c (col. 1 2))	+ col .	
Section 5504 of the ACA Current	Vaar ETE Pasidants i	n Nonnrovi der	Settings	1.00	2.00		3.0		
beginning on or after July 1, 2	010	•	0		-1	·,	0.		
66.00 Enter in column 1 the number of FTEs attributable to rotations Enter in column 2 the number of FTEs that trained in your hospi	occurring in all nonpl unweighted non-prima tal. Enter in column 3	rovider settir ry care reside 3 the ratio of	igs. ent	0.00		0.00	0.	000000	66.00
(column 1 divided by (column 1	Program Name	Program (Code	Unweighted	Unwei gh	ted	Ratio (c	ol. 3/	
				FTËs Nonprovider Site	FTES i Hospi t		(col. 3 4))		
(7.00 Enter in column 1, the program	1.00	2.00		3.00	4.00		5.0		(7.00
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)				0.00		0.00	0.	000000	67.00
						1.00	2.00	2.00	
Inpatient Psychiatric Facility	PPS					1.00	2.00	3.00	
70.00 Is this facility an Inpatient P	sychiatric Facility (IPF), or does	it contai	n an IPF subj	provi der?	N			70.00
Enter "Y" for yes or "N" for no 71.00 If line 70 yes: Column 1: Did th recent cost report filed on or 1 42 CFR 412.424(d)(1)(iii)(c)) C program in accordance with 42 Cl Column 3: If column 2 is Y, ind (see instructions)	he facility have an ap before November 15, 20 blumn 2: Did this fac FR 412.424 (d)(1)(iii) icate which program ye	004? Enter "\ ility train re)(D)? Enter "\	" for yes sidents i " for yes	s or "N" for 1 n a new teacl s or "N" for 1	no. (see hing no.	N	N	0	71.00
Inpatient Rehabilitation Facili 75.00 Is this facility an Inpatient Re	ty PPS ehabilitation Facility	y (IRF), or do	es it con	itain an IRF		N			75.00
subprovider? Enter "Y" for yes 76.00 If line 75 yes: Column 1: Did th recent cost reporting period en no. Column 2: Did this facility CFR 412.424 (d)(1)(ii)(D)? Entu indicate which program year beg	and "N" for no. he facility have an a ding on or before Novo train residents in a er "Y" for yes or "N"	pproved GME te ember 15, 2004 new teaching for no. Colum	aching pr ? Enter " program i n 3: If c	ogram in the Y" for yes o n accordance column 2 is Y	r "N" for with 42	N	N	0	76.00
						-	1.0	0	
Long Term Care Hospital PPS								0	
80.00 Is this a long term care hospita 81.00 Is this a LTCH co-located within "Y" for yes and "N" for no.					period? E	nter	N		80. 00 81. 00
TEFRA Providers85.00Is this a new hospital under 4286.00Did this facility establish a new \$413.40(f)(1)(ii)? Enter "Y" for	ew Other subprovider	(excluded unit				no.	N		85. 00 86. 00
87.00 Is this hospital a "subclause (1886(d)(1)(B)(iv)(II)	? Enter "Y		Ν		87.00
for yes or "N" for no.					V		XLX	<	
Title V and XIX Services					1.00		2.0	0	
90.00 Does this facility have title V	and/or XIX inpatient	hospital serv	ices? Ent	er "Y" for	N		Y		90.00
yes or "N" for no in the applica 91.00 Is this hospital reimbursed for	title V and/or XIX tl	hrough the cos	t report	either in	N		N		91.00
full or in part? Enter "Y" for 92.00 Are title XIX NF patients occup	yes or "N" for no in [.]	the applicable	column.				Y		92.00
instructions) Enter "Y" for yes	or"N" for no in the	applicable co	lumn.	, ,					
93.00 Does this facility operate an 10 "Y" for yes or "N" for no in the		urposes of til	le V and	XIX? Enter	N		N		93.00
94.00 Does title V or XIX reduce capi applicable column.	tal cost? Enter "Y" fo	or yes, and "N	" for no	in the	N		N		94.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	OSPITAL Provider C	CN: 15-0006	Peri od:		Workshe		52-1
			From 03/01/ To 12/31/		Part I Date/Tii 5/31/20		
			V		XI X		am
			1.00		2.0		
 15.00 If line 94 is "Y", enter the reduction percentage in the apple.00 Does title V or XIX reduce operating cost? Enter "Y" for yest applicable column. 			0. 00 N		0. 0 N		95. 0 96. 0
07.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	plicable colum	n	0.00		0.0	0 9	97.0
05.00 Does this hospital qualify as a critical access hospital (C/ 06.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)		hod of paymen	t				05. 0 06. 0
07.00 f this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see inst	ructions) lf	t			10	07. 0
08.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							08. 0
	Physi cal 1.00	Occupationa 2.00	I Speec 3.00		Respira 4.0		
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N		09. 0
					1.0	0	
10.00 Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (4	10A Demo)foi	r	N		10. 0
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes of is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals provider	. If column 2 nt for long te	is "E", enter rm care (incl	in column udes	N		0 1'	15. (
Pub.15-1, chapter 22, §2208.1. 16.00 s this facility classified as a referral center? Enter "Y" 17.00 s this facility legally-required to carry malpractice insu	for yes or "N	" for no.		N			16. (17. (
no. 18.00 s the malpractice insurance a claims-made or occurrence pol				1			18. 0
claim-made. Enter 2 if the policy is occurrence.							
		Premi ums	Losse	s	Insura	ince	
		Premiums	Losse	S	Insura	ince	
18.01 List amounts of malpractice premiums and paid losses		1.00	2.00		1 nsura 3.0	0	18 (
18.01 List amounts of malpractice premiums and paid losses:			2.00 48 9	7, 296	3.0	0 011	18. (
18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scher and amounts contained therein.		1.00 24,5 than the	2.00	7, 296		0 011 0 11	18. (
 18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Hold Harmless provision in ACA \$3121 and applicable amendment 	dule listing c d Harmless pro n column 1, "Y ualifies for t	1.00 24,5 than the ost centers vision in ACA " for yes or he Outpatient	2.00 48 9 1.00 N	7, 296	3.0	0 01 ⁻ 0 1 ⁻ 1 ⁻	18. (19. (
 18.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA §3121 and applicable amendments? 21.00 Did this facility incur and report costs for high cost implational cost implations and the second statements? 	dule listing c d Harmless pro n column 1, "Y ualifies for t nts? (see inst	1.00 24,5 than the ost centers vision in ACA " for yes or he Outpatient ructions)	2.00 48 9 1.00 N	7, 296	3.0	0 0 11 0 11 12	18. (19. (20. (
 18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schera and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualified Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implapatients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the second sec	dule listing c d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device Enter "Y" for	1.00 24,5 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N"	2.00 48 9 1.00 N	7, 296	3.0	0 011 0 11 12 12	18. (19. (20. (21. (
 18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments? 21.00 Did this facility incur and report costs for high cost implapatients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 there these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for 	dule listing c d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device Enter "Y" for he Worksheet A	1.00 24,5 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number	2.00 48 9 1.00 N N Y	7, 296	3.0	0 011 0 11 12 12 12	18. (19. (20. (21. (22. (
 18. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scheral and amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in 21. 00 Did this facility incur and report costs for high cost implapatients? Enter "Y" for yes or "N" for no. 21. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 25. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 	dule listing c d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device Enter "Y" for he Worksheet A pr yes and "N" nter the certi	1.00 24,5 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If	2.00 48 9 1.00 N N Y N	7, 296	3.0	0 0 11 0 1 1 12 12 12 12	18. (19. (20. (22. (22. (
 18. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schera and amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments? 21. 00 Did this facility incur and report costs for high cost implapatients? Enter "Y" for yes or "N" for no. 22. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 there these taxes are included. Transplant Center Information 25. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26. 00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 	dule listing c d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device Enter "Y" for he Worksheet A pr yes and "N" nter the certi 2.	1.00 24,5 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date	2.00 48 9 1.00 N N Y N	7, 296	3.0	0 011 0 11 12 12 12 12 12 12 12 12	18. (19. (20. (21. (22. (25. (26. (27. (
 18. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting scherand amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA \$3121 and applicable amendments? (see instructions) Enter in 21. 00 Did this facility incur and report costs for high cost implation patients? Enter "Y" for yes or "N" for no. 21. 00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 25. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26. 00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2 27. 00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 2 	dule listing c d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device Enter "Y" for he Worksheet A pr yes and "N" nter the certif 2. ter the certif 2.	1.00 24,5 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	2.00 48 9 1.00 N Y N	7, 296	3.0	0 0 11 0 11 1 1 1 1 1 1 1 1 1 1 1 1	18. 0 18. 0 19. 0 20. 0 21. 0 22. 0 25. 0 26. 0 27. 0 28. 0 29. 0
 18. 02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schedand amounts contained therein. 19. 00 D0 NOT USE THIS LINE 20. 00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that que Hold Harmless provision in ACA §3121 and applicable amendments? (see instructions) Enter in Enter in column 2, "Y" for yes or "N" for no. 21. 00 Did this facility incur and report costs for high cost implay patients? Enter "Y" for yes or "N" for no. 22. 00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 there these taxes are included. Transplant Center Information 25. 00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26. 00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2 27. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 29. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 29. 00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 30. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2 30. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2 30. 00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2 	dule listing c d Harmless pro h column 1, "Y ualifies for t hts? (see inst antable device Enter "Y" for he Worksheet A br yes and "N" hter the certif 2. ter the certif 2. er the certific enter the certific	1.00 24,5 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date cation date i	2.00 48 9 1.00 N Y N	7, 296	3.0	0 011 0 11 12 12 12 12 12 12 12 12 12 12 12 12	18. C 19. C 20. C 21. C 22. C 25. C 26. C 27. C
 and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Outpatient Hold Harmless provision in ACA \$3121 and applicable amendment Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost implations? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 th where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2 27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2 28.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2 20.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2 	dule listing c d Harmless pro n column 1, "Y ualifies for t nts? (see inst antable device Enter "Y" for he Worksheet A for yes and "N" nter the certif 2. ter the certif 2. er the certifi enter the certifi enter the certifi r, enter the certifi	1.00 24,5 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date ication date i tification	2.00 48 9 1.00 N Y N	7, 296	3.0	0 0 11 0 1 1 1 12 12 12 12 12 12 12 12	18. C 19. C 20. C 21. C 22. C 25. C 26. C 27. C 28. C 29. C

Health Financial Systems	LAPORTE HO	SPI TAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CC		eriod:	Worksheet S-2	
				rom 03/01/2016 o 12/31/2016		pared.
				12/01/2010	5/31/2017 9:2	3 am
				1.00	2.00	-
133.00 If this is a Medicare certified other	transplant center, ent	er the certifi	cation date	1.00	2.00	133.00
in column 1 and termination date, if	applicable, in column 2					
134.00 If this is an organ procurement organ		e OPO number i	n column 1			134.00
and termination date, if applicable, All Providers	TH COLUMN 2.					
140.00 Are there any related organization or				Y	449008	140.00
chapter 10? Enter "Y" for yes or "N"						
are claimed, enter in column 2 the ho	2.00		tions)	3.00		
If this facility is part of a chain of			ugh 143 the na		of the	
home office and enter the home office						
141.00 Name: COMMUNITY HEALTH SYSTEMS 142.00 Street: 4000 MERIDIAN BLVD	Contractor's Name: WPS PO Box:	b	Contractor	's Number: 1010)1	141.00
143. 00 City: FRANKLIN	State: TN		Zip Code:	3706	57	143.00
					1.00	111.00
144.00 Are provider based physicians' costs	Included in worksheet A	?			Y	144.00
				1.00	2.00	1
145.00 If costs for renal services are claim				Y		145.00
inpatient services only? Enter "Y" fo no, does the dialysis facility includ						
period? Enter "Y" for yes or "N" for		TOT THIS COST	reporting			
146.00 Has the cost allocation methodology c		sly filed cost	t report?	N		146.00
Enter "Y" for yes or "N" for no in co		5-2, chapter 4	40, §4020) If			
yes, enter the approval date (mm/dd/y	ryyy) in column 2.					
					1.00	1
147.00 Was there a change in the statistical					N	147.00
148.00 Was there a change in the order of al		5			N	148.00
149.00 Was there a change to the simplified	cost finding method? En	Part A	Part B	Title V	N Title XIX	149.00
		1.00	2.00	3.00	4.00	
Does this facility contain a provider						
or charges? Enter "Y" for yes or "N" 155.00 Hospi tal	TOT NO TOT EACH COMPONE	<u>nt tor Part A</u> N	And Part B. (3	<u>See 42 CFR §413</u> N	3. 13) N	155.00
156. 00 Subprovi der – TPF		N	N	N	N	156.00
157.00 Subprovi der – IRF		Ν	N	N	N	157.00
158. 00 SUBPROVI DER 159. 00 SNF		N		N		158.00 159.00
160.00 HOME HEALTH AGENCY		N N	N N	N N	N N	160.00
161. 00 CMHC			N	N	N	161.00
						_
Multicampus					1.00	
165.00 Is this hospital part of a Multicampu	s hospital that has one	or more campu	uses in differe	ent CBSAs?	N	165.00
Enter "Y" for yes or "N" for no.						
	Name O	County 1.00		Code CBSA 00 4.00	FTE/Campus 5.00	-
166.00 If line 165 is yes, for each	0	1.00	2.00 3.	4.00		166.00
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)						
						_
Health Information Technology (HIT) i	ncentive in the America	n Pecovery an	d Painvastmant	Act	1.00	
167.00 Is this provider a meaningful user un				ACT	Y	167.00
168.00 If this provider is a CAH (line 105 i	s "Y") and is a meaning	ful user (line		enter the		168.00
reasonable cost incurred for the HIT						1/0 01
168.01 If this provider is a CAH and is not exception under §413.70(a)(6)(ii)? Er				i narasni p	N	168. 01
169.00 If this provider is a meaningful user				W), enter the	9.90	169.00
transition factor. (see instructions)						

eal th Financial Systems LAPORTE HOSPITAL					
		Begi nni ng	Endi ng		
		1.00	2.00		
ite and ending dat	te for the reporting	07/01/2014	09/30/2014	170.00	
		1.00	2.00		
ny days for indiv	viduals enrolled in	N		0171.00	
Wkst. S-3, Pt. I,	line 2, col. 6? Enter				
	nter the number of sectio	n			
	ATION DATA ite and ending dat iny days for indiv Wkst. S-3, Pt. I,	ATION DATA Provider CCN: 15-0006 Ite and ending date for the reporting iny days for individuals enrolled in Wkst. S-3, Pt. I, line 2, col. 6? Enter flumn 1 is yes, enter the number of sectio	ATION DATA Provider CCN: 15-0006 Period: From 03/01/2016 To 12/31/2016 Beginning 1.00 07/01/2014 Inv days for individuals enrolled in Wkst. S-3, Pt. I, line 2, col. 6? Enter From 03/01/2016 To 12/31/2016 07/01/2014 Inv days for individuals enrolled in N	ATION DATA Provider CCN: 15-0006 Period: From 03/01/2016 Worksheet S- Part I To 12/31/2016 Date/Time Pris/31/2017 Date/Time Pris/31/2017 Lead ending date for the reporting 07/01/2014 09/30/2014 Inv days for individuals enrolled in Wkst. S-3, Pt. I, line 2, col. 6? Enter N	

	Financial Systems LAPORTE H		01 45 0004		u of Form CMS-	
OSPI I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet S-2 Part II Date/Time Pro 5/31/2017 9:2	eparec
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	for all NO re	esponses. Ente	er all dates in t	he	-
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c			Y	03/01/2016	1.
	reporting period? If yes, enter the date of the change in c	Jor unin 2. (See	Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare P		N			2.
. 00	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary. Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home co	ng management	Y			3.
	or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	ler or its of the board				
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	or Compiled,	Y	A		4.
. 00	Are the cost report total expenses and total revenues diffe those on the filed financial statements? If yes, submit rec		N			5.
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	lfyes, is th	ne provider is	s N		6.
. 00 . 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		during the	N N		7. 8.
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	Ν		9.
0. 00	Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.		he current	Ν		10.
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.
					Y/N 1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 13.
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				Ν	14.
5.00	Did total beds available change from the prior cost reporti		yes, see ins [.] t A	tructions. Par	Y t B	15.
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data	N	1	NI		1/
b. 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)	Ν		N		16.
7.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/28/2017	Y	04/28/2017	17.
. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Ν		Ν		18.
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONN	NAI RE	Provider (CN: 15-0006	Period: From 03/01/20	Worksheet 16 Part II	S-2
				To 12/31/20		Prepar 9:23 a
			ipti on	Y/N	Y/N	
.00 f ine 16 or 17 is yes, were adjustments made to	DS & D		0	1.00 N	3.00 N	20
Report data for Other? Describe the other adjustments				IN	IN	20
· · · · · · · · · · · · · · · ·		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
00 Was the cost report prepared only using the provide records? If yes, see instructions.	ler's	Ν		N		2
					1.00	
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS OF	NLY (EXCEPT	CHI LDRENS	HOSPI TALS)			
Capital Related Cost 00 Have assets been relifed for Medicare purposes? If	E vos coo ir				N	2
00 Have assets been relifed for Medicare purposes? If 00 Have changes occurred in the Medicare depreciation			sals made du	ring the cost	N	2
reporting period? If yes, see instructions.	r expense due			The cost		
00 Were new leases and/or amendments to existing lease	ses entered i	nto during	this cost re	eporting period	? N	2
If yes, see instructions						
00 Have there been new capitalized leases entered into instructions.	o during the	e cost repo	rτing period	rif yes, see	N	2
00 Were assets subject to Sec. 2314 of DEFRA acquired	during the c	cost reporti	na period?	f ves, see	N	2
instructions.				. ,00, 000		
00 Has the provider's capitalization policy changed de	during the co	ost reporti	ng period? I	ົyes, submit	N	2
copy. Interest Expense						
00 Were new Loans, mortgage agreements or letters of	credit enter	ed into du	cing the cost	treporting	N	2
period? If yes, see instructions.	creart enter	eu mito uu	The cos	reporting	i N	2
00 Did the provider have a funded depreciation account	nt and/or bor	nd funds (De	ebt Service I	Reserve Fund)	N	2
treated as a funded depreciation account? If yes,						
00 Has existing debt been replaced prior to its schedulinstructions.	luled maturit	ty with new	debt? If yes	s, see	N	3
00 Has debt been recalled before scheduled maturity w	without issue	ance of new	debt? If ve	s see	N	3
instructions.			J			
Purchased Services			· · · ·			
00 Have changes or new agreements occurred in patient arrangements with suppliers of services? If yes, so			ed through co	ontractual	N	3
00 If line 32 is yes, were the requirements of Sec. 2			na to competi	tive biddina?	If N	3
no, see instructions.			.g			
Provi der-Based Physi ci ans					I	
00 Are services furnished at the provider facility un	nder an arran	ngement witl	n provider-ba	ased physi ci ans	? Y	3
If yes, see instructions. 00 If line 34 is yes, were there new agreements or am	nondod ovisti	na aaroomo	ats with the	nrovi der-based	N	3
physicians during the cost reporting period? If yes			its with the	provider based		
				Y/N	Date	
				1.00	2.00	
Home Office Costs 00 Were home office costs claimed on the cost report?	>			Y		3
00 If line 36 is yes, has a home office cost statement		ared by the	home office			3
If yes, see instructions.		5				
00 If line 36 is yes, was the fiscal year end of the				- N		3
the provider? If yes, enter in column 2 the fiscal 00 If line 36 is yes, did the provider render service:				s, N		3
see instructions.			ients: Tr ye:	5, IN		
00 If line 36 is yes, did the provider render services	es to the hom	ne office?	lf yes, see	N		4
instructions.			-			
		1	00		2.00	
Cost Report Preparer Contact Information		I.	00		2.00	
00 Enter the first name, last name and the title/positi	tion TYL	ER		LEACH		4
held by the cost report preparer in columns 1, 2,						
respecti vel y.	la					
respectively. 00 Enter the employer/company name of the cost report	t COM	MUNITY HEAL	TH SYSTEMS			42
respecti vel y.		MUNI TY HEAI 5-465-3330	TH SYSTEMS	TYLER_LEACH@	CHS. NET	4

Heal th	Financial Systems LAPORTE	HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-000	Period:	Worksheet S-2	
			rom 03/01/2016 o 12/31/2016		pared: 3 am
		3.00			
	Cost Report Preparer Contact Information				
	Enter the first name, last name and the title/position	REVENUE MANAGER			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				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 03/01/2016 To 12/31/2016		
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	109	33, 35	4 0.00	0	1.00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider						2.00 3.00
4.00 5.00 6.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	4.00 5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		109	33, 35	0.00		7.00
8.00 9.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	31.00	20	6, 12	0.00	0	8.00 9.00
10. 00 11. 00 12. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						10.00 11.00 12.00
13.00 14.00	NURSERY Total (see instructions)	43.00	129	39, 47	0.00		13.00 14.00
15.00 16.00	CAH visits SUBPROVIDER - IPF	40.00	0		0	0	15.00 16.00
17.00 18.00	SUBPROVIDER - IRF SUBPROVIDER	41.00	0		0	0	17.00 18.00
19.00 20.00 21.00 22.00 23.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	44. 00	0		0	0	19.00 20.00 21.00 22.00 23.00
24. 00 24. 10 25. 00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	30. 00					24.00 24.10 25.00
26.00 26.25 27.00 28.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	89.00	129			0	26.00 26.25 27.00 28.00
29.00 30.00 31.00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF						29.00 30.00 31.00
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days		0		0		32.00 32.01 33.00

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC		Period: From 03/01/2016 To 12/31/2016		pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	6, 631	2, 097	11, 71	2		1.00
2.00	HMO and other (see instructions)	919	0				2.00
3.00	HMO I PF Subprovi der	0	0				3.00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0		0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0		0		6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)	6, 631	2, 097	11, 71	2		7.00
8.00	INTENSIVE CARE UNIT	1, 047	537	3, 44	5		8.00
9.00	CORONARY CARE UNI T						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		918	1, 37	6		13.00
14.00	Total (see instructions)	7, 678	3, 552	16, 53	3 0.00	855.32	14.00
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER - IPF	0	0		0 0.00	0.00	16.00
17.00	SUBPROVIDER - IRF	0	0		0 0.00	0.00	17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY	0	0		0 0.00	0.00	19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24. 10	HOSPICE (non-distinct part)	0	0		0		24.10
25.00	CMHC - CMHC						25.00
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
27.00	Total (sum of lines 14-26)				0.00	855.32	
28.00	Observation Bed Days		0	2, 24	0		28.00
29.00	Ambul ance Trips	0					29.00
30.00	Employee discount days (see instruction)				0		30.00
31.00	Employee discount days - IRF				0		31.00
32. 00 32. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room	0	0		0 0		32.00 32.01
33.00	outpatient days (see instructions) LTCH non-covered days	0					33.00

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	LAPORTE HOS		CN: 15-0006	Peri od:	u of Form CMS-2 Worksheet S-3	
					From 03/01/2016 To 12/31/2016	Part I	pared
		Full Time Equivalents		Di s	charges		
	Component	Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		C	1, 7!	59 689	3, 866	1. (
. 00 . 00 . 00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider			18	85 O O O		2. (3. (4. (
5.00 5.00 5.00 7.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation				0		5. 0 6. 0 7. 0
3.00 9.00	beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT						8. (9. (
0.00 1.00 2.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						10. 11. 12.
3.00 4.00 5.00	NURSERY Total (see instructions)	0.00	C	1, 7	59 689	3, 866	13. 14. 15.
5.00 6.00	CAH visits SUBPROVIDER - IPF	0.00	C		0 0	0	15.
7.00 8.00	SUBPROVI DER – I RF SUBPROVI DER	0.00	C		0 0		17. 17. 18.
9.00 0.00 1.00	SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE	0.00					19. 20. 21.
2.00 3.00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)						22. 23.
4.00 4.10 5.00	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC						24. 24. 25.
6. 00 6. 25	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 26.
7.00 3.00 9.00	Total (sum of lines 14-26) Observation Bed Days	0.00					27. 28. 29.
9.00 0.00 1.00	Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF						29. 30. 31.
2. 00 2. 01	Labor & delivery days (see instructions) Total ancillary labor & delivery room						32. 32.
3.00	outpatient days (see instructions) LTCH non-covered days						33.

SPI T.	Financial Systems AL WAGE INDEX INFORMATION		LAPORTE F	Provider CC	F	eriod: rom 03/01/2016 o 12/31/2016		pared
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adjusted Salaries (col.2 ± col. 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							1
00	Total salaries (see	200. 00	43, 086, 307	0	43, 086, 307	1, 349, 996. 00	31. 92	1. (
00	instructions) Non-physician anesthetist Part		0	0	C	0.00	0.00	2.0
00	A Non-physician anesthetist Part		0	0	C	0.00	0.00	3. (
	В		-	_				
00	Physician-Part A - Administrative		319, 013	0	319, 013	2, 280. 00	139. 92	4. (
)1)0	Physicians - Part A - Teaching Physician and Non		0	-	C			
	Physician-Part B		0	0		0.00	0.00	5.
00	Non-physician-Part B for hospital-based RHC and FQHC services		O	0	C	0.00	0. 00	6.
00	Interns & residents (in an	21.00	0	0	C	0.00	0.00	7.
)1	approved program) Contracted interns and residents (in an approved		C	0	C	0.00	0.00	7.
00	programs) Home office and/or related organization personnel		C	0	C	0.00	0.00	8.
00	SNF	44.00	0	0	C	0.00		
00	Excluded area salaries (see instructions)		102, 650	166, 912	269, 562	7, 872. 00	34.24	10.
	OTHER WAGES & RELATED COSTS		4 0/5 050		4 0/5 050	14 004 00	(5.04	
00	Contract Labor: Direct Patient Care		1,065,353	0	1, 065, 353	16, 306. 00	65.34	11.
00	Contract labor: Top level management and other management and administrative services		C	0	C	0.00	0.00	12.
00	Contract Labor: Physician-Part A - Administrative		43, 844	0	43, 844	1, 596. 00	27.47	13.
00	Home office and/or related orgainzation salaries and		C	0	C	0.00	0.00	14.
01	wage-related costs Home office salaries		0	0	C	0.00	0.00	14.
02	Related organization salaries		0	0	C	0.00		
00	Home office: Physician Part A - Administrative		U	0	Ĺ	0.00	0.00	15.
00	Home office and Contract Physicians Part A - Teaching		0	0	C	0.00	0.00	16.
	WAGE-RELATED COSTS							
00	Wage-related costs (core) (see instructions)		10, 994, 695	0	10, 994, 695			17.
00	Wage-related costs (other)		0	0	C			18.
00	(see instructions) Excluded areas		269, 562	7, 872	277, 434			19.
00	Non-physician anesthetist Part		0	0	C			20.
00	Non-physician anesthetist Part		0	0	C			21.
00	B Physician Part A -		319, 013	2, 280	321, 293			22.
01	Administrative Physician Part A - Teaching		0		, , , , , , , , , , , , , , , , , , ,			22.
00	Physician Part B		1, 118, 260	7, 051	1, 125, 311	,		22.
00 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0	C			24. 25.
	approved program)		U	0	(25.
50 51	Home office wage-related Related orgainzation		0 0	0	C			25. 25.
52	wage-related Home office: Physician Part A - Administrative -		C	О	С	6		25.
53	wage-related Home office & Contract Physicians Part A - Teaching - wage-related		0	0	C			25.
0.5	OVERHEAD COSTS - DIRECT SALARIE		E01 5	· · · · · · · · · · · · · · · · · · ·				1
	Employee Benefits Department Administrative & General	4.00 5.00	536, 293 8, 659, 089					

Heal th	Financial Systems		LAPORTE H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider CC	1	Period: From 03/01/2016 To 12/31/2016	Worksheet S-3 Part II Date/Time Pre 5/31/2017 9:2	pared:
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$		col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
28.00	Administrative & General under contract (see inst.)		0	0	(0.00	0.00	28.00
29.00	Maintenance & Repairs	6.00	0	0	(0.00	0.00	29.00
30.00	Operation of Plant	7.00	1, 316, 548	0	1, 316, 548	8 46, 536. 00	28. 29	30.00
31.00	Laundry & Linen Service	8.00	50, 688	0	50, 688	B 4, 119. 00	12. 31	31.00
32.00	Housekeepi ng	9.00	727, 547	0	727, 54	7 49, 727. 00	14.63	32.00
33.00	Housekeeping under contract (see instructions)		0	0	(0.00	0.00	33.00
34.00	Dietary	10.00	1, 227, 909	-844, 323	383, 580	6 34, 631. 00	11.08	34.00
35.00	Dietary under contract (see instructions)		0	0	(0.00	0.00	35.00
36.00	Cafeteri a	11.00	0	844, 323	844, 323	3 40, 152. 00	21.03	36.00
37.00	Maintenance of Personnel	12.00	0	0	(0.00	0.00	37.00
38.00	Nursing Administration	13.00	2, 435, 219	0	2, 435, 219	9 74, 572. 00	32.66	38.00
39.00	Central Services and Supply	14.00	498, 432	0	498, 432	2 25, 492. 00	19.55	39.00
40.00	Pharmacy	15.00	1, 525, 194	0	1, 525, 194	4 41, 933.00	36.37	40.00
41.00	Medical Records & Medical Records Library	16.00	919, 977		919, 97			
42.00	Soci al Servi ce	17.00	2, 290	0	2, 290	0.00	0.00	42.00
43.00	Other General Service	18.00	0			0.00	0.00	43.00

Heal th	Financial Systems		LAPORTE H	IOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL WAGE INDEX INFORMATION			Provider C		Period: From 03/01/2016	Worksheet S-3	
						To 12/31/2016		oared:
							5/31/2017 9:2	
		Worksheet A		Recl assi fi cati		Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
		1.00		Worksheet A-6)	<i>,</i>	<u>col.</u> 4	(00	
		1.00	2.00	3.00	4.00	5.00	6.00	
1 00	PART III - HOSPITAL WAGE INDEX	SUMMARY	42 00/ 207		42.00(.20)	7 1 240 00/ 00	21.02	1 00
1.00	Net salaries (see		43, 086, 307	0	43, 086, 30	7 1, 349, 996. 00	31. 92	1.00
2.00	instructions) Excluded area salaries (see		102, 650	166, 912	269, 56	2 7, 872.00	34. 24	2.00
2.00	instructions)		102, 030	100, 912	209, 30.	2 7,072.00	34.24	2.00
3.00	Subtotal salaries (line 1		42, 983, 657	-166, 912	42, 816, 74	5 1, 342, 124. 00	31.90	3.00
5.00	minus line 2)		42, 703, 037	-100, 712	42,010,74	1, 342, 124.00	51.70	5.00
4.00	Subtotal other wages & related		1, 109, 197	0	1, 109, 19	7 17, 902. 00	61.96	4.00
	costs (see inst.)		.,,.,		.,,		01170	
5.00	Subtotal wage-related costs		11, 313, 708	2, 280	11, 315, 98	в 0.00	26. 43	5.00
	(see inst.)			_,				
6.00	Total (sum of lines 3 thru 5)		55, 406, 562	-164, 632	55, 241, 93	0 1, 360, 026. 00	40.62	6.00
7.00	Total overhead cost (see		17, 899, 186	-166, 912	17, 732, 27	4 631, 817. 00	28.07	7.00
	instructions)							
				-				

Heal th	Financial Systems	LAPORTE HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL WAGE RELATED COSTS	Provi der	CCN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet S-3 Part IV Date/Time Pre 5/31/2017 9:23	
					Amount	
					Reported 1.00	
	PART IV - WAGE RELATED COSTS				1.00	
	Part A - Core List					
	RETIREMENT COST					
1.00	401K Employer Contributions				670, 005	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contributi	on			0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see ins				0	3.00
4.00	Qualified Defined Benefit Plan Cost (see instru				0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Org	ani zati on)				
5.00	401K/TSA Plan Administration fees				0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan				0	6.00
7.00	Employee Managed Care Program Administration Fe	es			0	7.00
	HEALTH AND INSURANCE COST					
8.00	Heal th Insurance (Purchased or Self Funded)				5, 447, 254	8.00
8.01	Health Insurance (Self Funded without a Third P				0	8.01
8.02	Health Insurance (Self Funded with a Third Part	y Administrator)			0	8.02
8.03	Heal th Insurance (Purchased)				0	8.03
9.00	Prescription Drug Plan				0	
10. 00 11. 00	Dental, Hearing and Vision Plan Life Insurance (If employee is owner or benefic	i anu)			196, 981	
12.00	Accident Insurance (If employee is owner or benefic				32, 391	12.00
12.00	Disability Insurance (If employee is owner or b				1, 257	
14.00	Long-Term Care Insurance (If employee is owner					14.00
15.00	'Workers' Compensation Insurance	or beneficially)			1, 052, 034	
16.00	Retirement Health Care Cost (Only current year,	not the extraordinary a	crual require	d by FASB 106	1, 032, 034	
	Non cumulative portion)		son aan in oquin o		0	101.00
	TAXES					
17.00	FICA-Employers Portion Only				2, 522, 994	17.00
18.00	Medicare Taxes - Employers Portion Only				590, 055	18.00
19.00	Unemployment Insurance				0	19.00
20.00	State or Federal Unemployment Taxes				354, 183	20.00
	OTHER					
21.00	Executive Deferred Compensation (Other Than Ret instructions))	irement Cost Reported on	lines 1 throu	igh 4 above. (see	0	21.00
22.00	Day Care Cost and Allowances				0	
23.00	Tuition Reimbursement				0	
24.00					11, 019, 357	24.00
	Part B - Other than Core Related Cost					
25.00	OTHER WAGE RELATED COSTS (SPECIFY)				83, 313	25.00

HOSPITAL CONTRACT LABOR AND BENEFIT COST Provider CCN: 15-0006 Period: From 03/01/2016 To 12/31/2016 Worksheet S-3 Part V Date/Time Prepared: 5/31/2017 9:23 am Cost Center Description Contract Labor and Benefit Cost I.00 2.00 PART V - Contract Labor and Benefit Cost 1.00 2.00 Hospital and Hospital - Based Component I dentification: 1.00 2.00 O Total facility's contract labor and benefit cost 1,065,353 11,019,357 1.00 0.00 Subprovider - IPF 0 0 3.00 Subprovider - IRF 0 0 3.00 0.00 Subprovider - Other) 0	Heal th	Financial Systems	LAPORTE HOSPITAL	In Lie	u of Form CMS-2	2552-10
To 12/31/2016 Date/Time Prepared: 5/31/2017 9:23 at Benefit Cost PART V - Contract Labor and Benefit Cost Hospital and Hospital-Based Component Identification: 1.00 2.00 1.00 1.00 2.00 1.00 2.00 1.00 1.065, 353 11,019,357 1.00 1.00 2.00 Hospital 1,065,353 11,019,357 1.00 3.00 Subprovider - IPF 0 0 3.00 3.00 Subprovider - IRF 0 0 4.00 5.00 Subprovider - (Other) 0 0 5.00 6.00 Swing Beds - NF 0 0 7.00 8.00 Hospital-Based SNF 0 0 7.00 9.00 Hospital-Based NF 0 0 10.00 10.00 Hospital-Based OLTC 11.00 10.00 12.00 11.00 Hospital-Based HHA 11.00 12.00 13.00 14.00 13.00 14.00 14.00 14.00 12.00 Hospital-Based Heal th Clinic RHC	HOSPI	TAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0006			
PART V - Contract Labor and Benefit Cost Contract Labor Benefit Cost Hospital and Hospital -Based Component I dentification: 1.00 2.00 1.00 Total facility's contract labor and benefit cost 1,065,353 11,019,357 2.00 Hospital 1,065,353 11,019,357 2.00 3.00 Subprovider - IPF 0 0 3.00 4.00 Subprovider - IRF 0 0 3.00 5.00 Subprovider - (Other) 0 0 0 0 6.00 Swing Beds - SNF 0 0 0 0 0 7.00 Swing Beds - NF 0						
Cost Center Description Contract Labor Benefit Cost Hospital and Hospital -Based Component I dentification: 1.00 2.00 1.00 Total facility's contract labor and benefit cost 1,065,353 11,019,357 1.00 2.00 Hospital 1,065,353 11,019,357 2.00 0 3.00 3.00 Subprovider - IPF 0 0 3.00 3.00 Subprovider - IRF 0 0 3.00 5.00 Subprovider - IRF 0 0 0 5.00 5.00 5.00 5.00 6.00 7.00 6.00 7.00 8.00 0 0 0 0 7.00 8.00 9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 10.00 11.00 11.00 12.00 11.00 12.00 11.00 12.00 11.00 12.00 10.00 10.00 10.00 10.00 10.00 11.00 12.00 12.00 13.00 13.00 13.00 13.00 <td< td=""><td></td><td></td><td></td><td>10 12/31/2016</td><td></td><td></td></td<>				10 12/31/2016		
PART V - Contract Labor and Benefit Cost 1.00 2.00 Hospital and Hospital -Based Component Identification: 1,065,353 11,019,357 1.00 2.00 Hospital 1,065,353 11,019,357 1.00 3.00 Subprovider - 1PF 0 0 3.00 4.00 Subprovider - 1RF 0 0 4.00 5.00 Subprovider - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Begital -Based SNF 0 0 8.00 9.00 Hospital -Based SNF 0 0 8.00 9.00 Hospital -Based OLTC 11.00 9.00 11.00 11.00 Hospital -Based HHA 11.00 12.00 11.00 12.00 Separatel y Certified ASC 12.00 13.00 14.00 14.00 12.00 Hospital -Based Heal th Clinic RHC 14.00 14.00 15.00 14.00		Cost Center Description		Contract Labor		
PART V - Contract Labor and Benefit Cost Hospital and Hospital -Based Component Identification: 1.00 Total facility's contract labor and benefit cost 1,065,353 11,019,357 2.00 2.00 Hospital 1,065,353 11,019,357 2.00 3.00 Subprovider - IPF 0 0 3.00 3.00 Subprovider - IRF 0 0 0 4.00 5.00 Subprovider - (Other) 0 0 5.00 6.00 5.00 6.00 5.00 6.00 7.00 8.00 0 0 7.00 8.00 0 0 7.00 8.00 0 0 8.00 9.00 10.00 8.00 0 0 8.00 9.00 10.00 10.00 11.00 9.00 10.00 11.00 10.00 11.00 12.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00 13.00						
1.00 Total facility's contract labor and benefit cost 1,065,353 11,019,357 1.00 2.00 Hospital 1,065,353 11,019,357 2.00 3.00 Subprovider - IPF 0 0 3.00 4.00 Subprovider - IRF 0 0 4.00 5.00 Subprovider - (Other) 0 0 0 5.00 6.00 Swing Beds - SNF 0 0 0 6.00 7.00 Swing Beds - NF 0 0 0 7.00 8.00 Hospital -Based SNF 0 0 0 8.00 9.00 Hospital -Based NF 0 0 8.00 9.00 10.00 Hospital -Based NF 0 0 11.00 10.00 11.00 Hospital -Based NF 0 0 12.00 11.00 12.00 Separatel y Certified ASC 12.00 12.00 13.00 13.00 12.00 13.00 Hospital -Based Heal th Clinic RHC 14.00 15.00 15.00 15.00 15.00		PART V - Contract Labor and Benefit Cost				
2.00 Hospi tal 1,065,353 11,019,357 2.00 3.00 Subprovi der - IPF 0 0 3.00 4.00 Subprovi der - IRF 0 0 4.00 5.00 Subprovi der - (Other) 0 0 4.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 6.00 8.00 Hospi tal -Based SNF 0 0 8.00 9.00 Hospi tal -Based NF 0 0 8.00 9.00 Hospi tal -Based NF 0 0 10.00 11.00 Hospi tal -Based HHA 10.00 11.00 12.00 12.00 Separatel y Certi fi ed ASC 12.00 12.00 13.00 Hospi tal -Based Heal th Clinic RHC 14.00 13.00 14.00 Hospi tal -Based Heal th Clinic FDHC 14.00 15.00		Hospital and Hospital-Based Component Identifica	ation:			
3.00 Subprovi der - IPF 0 0 3.00 4.00 Subprovi der - IRF 0 0 4.00 5.00 Subprovi der - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 6.00 8.00 Hospi tal -Based SNF 0 0 8.00 9.00 Hospi tal -Based NF 0 0 8.00 9.00 Hospi tal -Based OLTC 10.00 11.00 10.00 11.00 Hospi tal -Based HHA 11.00 12.00 12.00 12.00 Separatel y Certified ASC 12.00 12.00 13.00 Hospi tal -Based Heal th Clinic RHC 14.00 15.00 14.01	1.00	Total facility's contract labor and benefit cos	t	1, 065, 353	11, 019, 357	1.00
4.00 Subprovider - IRF 0 0 4.00 5.00 Subprovider - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 8.00 9.00 Hospital -Based NF 0 0 8.00 9.00 Hospital -Based NF 0 0 10.00 11.00 Hospital -Based HHA 10.00 11.00 11.00 11.00 12.00 Separately Certified ASC 12.00 13.00 13.00 14.00 Hospital -Based Heal th Clinic RHC 14.00 15.00 Hospital -Based Heal th Clinic FQHC 15.00 15.00 15.00 15.00	2.00	Hospi tal		1, 065, 353	11, 019, 357	2.00
5.00 Subprovider - (Other) 0 0 5.00 6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 8.00 9.00 Hospital -Based NF 0 0 8.00 9.00 Hospital -Based NF 0 0 8.00 11.00 Hospital -Based HHA 10.00 11.00 11.00 12.00 Separately Certified ASC 12.00 13.00 14.00 14.5ptital -Based Heal th Clinic RHC 13.00 14.00 15.00 15.00 15.00 15.00	3.00	Subprovider - IPF		0	0	3.00
6.00 Swing Beds - SNF 0 0 6.00 7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 8.00 9.00 Hospital -Based NF 0 0 8.00 10.00 Hospital -Based OLTC 10.00 10.00 10.00 11.00 Hospital -Based HHA 11.00 11.00 12.00 12.00 13.00 14.00 Hospital -Based Heal th Clinic RHC 14.00 15.00 15.00 15.00	4.00	Subprovider - IRF		0	0	4.00
7.00 Swing Beds - NF 0 0 7.00 8.00 Hospital -Based SNF 0 0 8.00 9.00 Hospital -Based NF 0 9.00 10.00 Hospital -Based OLTC 10.00 10.00 11.00 Hospital -Based HHA 11.00 12.00 Separately Certified ASC 12.00 13.00 Hospital -Based Heal th Clinic RHC 14.00 15.00 Hospital -Based Heal th Clinic FOHC 14.00	5.00	Subprovider - (Other)		0	0	5.00
8.00Hospital -Based SNF008.009.00Hospital -Based NF9.0010.00Hospital -Based OLTC10.0011.00Hospital -Based HHA11.0012.00Separately Certified ASC12.0013.00Hospital -Based Health Clinic RHC14.0015.00Hospital -Based Health Clinic FOHC15.00	6.00	Swing Beds - SNF		0	0	6.00
9.00Hospital -Based NF9.0010.00Hospital -Based OLTC10.0011.00Hospital -Based HHA11.0012.00Separatel y Certified ASC12.0013.00Hospital -Based Health Clinic RHC14.0015.00Hospital -Based Health Clinic FOHC15.00	7.00	Swing Beds - NF		0	0	7.00
10. 00Hospital -Based OLTC10. 0011. 00Hospital -Based HHA11. 0012. 00Separately Certified ASC12. 0013. 00Hospital -Based Hospice13. 0014. 00Hospital -Based Health Clinic RHC14. 0015. 00Hospital -Based Health Clinic FOHC15. 00	8.00	Hospital-Based SNF		0	0	8.00
11. 00Hospital -Based HHA11. 0012. 00Separately Certified ASC12. 0013. 00Hospital -Based Hospice13. 0014. 00Hospital -Based Health Clinic RHC14. 0015. 00Hospital -Based Health Clinic FOHC15. 00	9.00	Hospital-Based NF				9.00
12.00Separatel y Certified ASC12.0013.00Hospital - Based Hospice13.0014.00Hospital - Based Health Clinic RHC14.0015.00Hospital - Based Health Clinic FQHC15.00	10.00	Hospital-Based OLTC				10.00
13. 00Hospi tal -Based Hospi ce13. 0014. 00Hospi tal -Based Heal th Clinic RHC14. 0015. 00Hospi tal -Based Heal th Clinic FQHC15. 00	11.00	Hospital-Based HHA				11.00
14.00Hospital -Based Health Clinic RHC14.0015.00Hospital -Based Health Clinic FOHC15.00	12.00	Separately Certified ASC				12.00
15.00 Hospital-Based Health Clinic FOHC 15.00	13.00	Hospi tal -Based Hospi ce				13.00
	14.00	Hospital-Based Health Clinic RHC				14.00
16.00 Hospital-Based-CMHC 16.00						
17.00 Renal Dialysis 0 0 17.00		5		0	0	
18.00 Other 0 0 18.00	18.00	Other		0	0	18.00

	Financial Systems LAPORTE H					u of Form CMS-	
PROSPE	CTIVE PAYMENT FOR SNF STATISTICAL DATA	Provider C	CN: 15-0006	Fro	iod: m 03/01/2016	Worksheet S-7	
				То	12/31/2016	Date/Time Pre 5/31/2017 9:2	
					1.00	2.00	
1.00	If this facility contains a hospital-based SNF, were all pa or was there no Medicare utilization? Enter "Y" for yes in						1.00
2.00	complete the rest of this worksheet. Does this hospital have an agreement under either section 1 swing beds? Enter "Y" for yes or "N" for no in column 1. I date (mm/dd/yyyy) in column 2.	1883 or section fyes, enter t	1913 for he agreement				2.00
		Group	SNF Days	S	wing Bed SNF Days	Total (sum of col. 2 + 3)	
0.00		1.00	2.00		3.00	4.00	
3.00 4.00		RUX RUL		0 0	0 0	0 0	1
5.00 6.00		RVX RVL		0	0	0	
7.00		RHX		0	0	C	7.00
8.00 9.00		RHL RMX		0	0	0	
10.00		RML		0	0	C	10.00
11.00 12.00		RLX RUC		0 0	0	0	1
13.00		RUB		0	0	C	13.00
14.00 15.00		RUA RVC		0 0	0	0	1
16.00		RVB		0	0	C	16.00
17.00 18.00		RVA RHC		0 0	0 0	C C	
19.00		RHB		0	0	C	
20. 00 21. 00		RHA RMC		0 0	0 0	0 0	1
22.00		RMB RMA		0	0	C	
23.00 24.00		RLB		0	0	0	1
25.00 26.00		RLA ES3		0	0	C	
27.00		ES2		0	0	C	27.00
28.00 29.00		ES1 HE2		0	0	0	
30.00		HE1		0	0	C	30.00
31.00 32.00		HD2 HD1		0	0	0	1
33.00		HC2		0	0	C	33.00
34.00 35.00		HC1 HB2		0 0	0 0	C C	
36.00		HB1		0	0	0	1
37.00 38.00		LE2 LE1		0 0	0 0	0	
39.00 40.00		LD2 LD1		0 0	0	C	39.00
41.00		LC2		0	0	C	
42.00 43.00		LC1 LB2		0 0	0	0	1
44.00		LB1		0	0	0	44.00
45.00 46.00		CE2 CE1		0 0	0	C C	
47.00		CD2		0	0	C	47.00
48.00 49.00		CD1 CC2		0 0	0 0	0	1
50.00		CC1		0	0	0	
51.00 52.00		CB2 CB1		0	0 0	0	
53.00 54.00		CA2 CA1		0 0	0	C	53.00
55.00		SE3		0	0	C	55.00
56.00 57.00		SE2 SE1		0 0	0	C	1
58.00		SSC		0	0	C	58.00
59.00 60.00		SSB SSA		0 0	0	0	1
61.00		I B2		0	0	C	61.00
62.00 63.00		I B1 I A2		0	0	0	1
64.00		I A1		0	0	C	64.00
65.00 66.00		BB2 BB1		0 0	0	0	1
67.00		BA2		0	0	C	67.00
68.00		BA1	I	0	0	C	68.00

Health Financial Systems LAPORTE	ΗΟ SPI ΤΑΙ		Inlie	u of Form CMS-	2552-10
PROSPECTIVE PAYMENT FOR SNF STATISTICAL DATA		CN: 15-0006	Peri od:	Worksheet S-7	
			From 03/01/2016 To 12/31/2016	5/31/2017 9:2	
	Group	SNF Days	Swing Bed SNF Days	Total (sum of col. 2 + 3)	
	1.00	2.00	3.00	4.00	
69.00	PE2		0 0	0	69.00
70.00	PE1		0 0	0	70.00
71.00	PD2		0 0	0	71.00
72. 00	PD1		0 0	0	72.00
73.00	PC2		0 0	0	
74. 00	PC1		0 0	0	
75. 00	PB2		0 0	0	
76.00	PB1		0 0	0	
77.00	PA2		0 0	0	
78.00	PA1		0 0	0	
199.00	AAA		0 0		199.00
200. 00 TOTAL			0 0		200.00
			CBSA at	CBSA on/after	
			Begi nni ng of	October 1 of	
			Cost Reporting		
			Peri od	Reporting Period (if	
				applicable)	
			1.00	2.00	
SNF SERVICES			1.00	2.00	
201.00 Enter in column 1 the SNF CBSA code or 5 character non-CBS	A code if a rur	al facility.			201.00
in effect at the beginning of the cost reporting period. E					
in effect on or after October 1 of the cost reporting peri					
		Expenses	Percentage	Associ ated	
				with Direct	
				Patient Care	
				and Related	
				Expenses?	
		1.00	2.00	3.00	
A notice published in the Federal Register Volume 68, No.					
payments beginning 10/01/2003. Congress expected this incr					
expenses. For lines 202 through 207: Enter in column 1 the column 2 the percentage of total expenses for each categor					
line 7, column 3. In column 3, enter "Y" for yes or "N" fo					
with direct patient care and related expenses for each cat					
202. 00 Staffing	ogo, y. (000 ma		0 0.00		202.00
203. 00 Recrui tment			0 0.00		203.00
204.00 Retention of employees		1	0 0.00		204.00
205. 00 Training			0 0.00		205.00
206.00 OTHER (SPECIFY)			0 0.00		206.00
207.00 Total SNF revenue (Worksheet G-2, Part I, line 7, column 3)		0		207.00

Heal th	Financial Systems LAPC	ORTE HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider C	CN: 15-0006	Period:	Worksheet S-1	0
				From 03/01/2016		
				To 12/31/2016		
					5/31/2017 9:2	3 am
					1.00	
	L				1.00	
	Uncompensated and indigent care cost computation				l.	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 col	lumn 3 divided by li	ne 202 columr	18)	0. 238809	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				9, 687, 520	
3.00	Did you receive DSH or supplemental payments from Medi	i cai d?			N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or sup	pplemental payments	from Medicaid	1?	N	4.00
5.00	If line 4 is "no", then enter DSH or supplemental payr	ments from Medicaid			0	5.00
6.00	Medi cai d charges				85, 750, 056	6.00
7.00	Medicaid cost (line 1 times line 6)				20, 477, 885	7.00
8.00	Difference between net revenue and costs for Medicaid	program (line 7 min	nus sum of lir	nes 2 and 5; if	10, 790, 365	8.00
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instru	uctions for each lin	ie)			1
9.00	Net revenue from stand-alone CHIP				0	9.00
10.00	Stand-alone CHIP charges				0	10.00
11.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-al	one CHIP (line 11 mi	nus line 9: i	f < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program	(see instructions f	or each line)	I		
13.00	Net revenue from state or local indigent care program				0	13.00
14.00	Charges for patients covered under state or local indi				0	
	10)	g				
15.00	State or local indigent care program cost (line 1 time	es line 14)			0	15.00
16.00			nrogram (lir	ne 15 minus line	0	
	13; if < zero then enter zero)	roodi margont oaro	program (rri		, i i i i i i i i i i i i i i i i i i i	
	Uncompensated care (see instructions for each line)					
17.00		cted to funding char	rity care		0	17.00
18.00	Government grants, appropriations or transfers for su	8	2		0	
19.00	Total unreimbursed cost for Medicaid, CHIP and state			s (sum of lines	10, 790, 365	
17.00	8, 12 and 16)	and rocal rhargent	cure program		10, 170, 000	17.00
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col. 2)	
			1,00	2.00	3.00	
20.00	Charity care charges for the entire facility (see ins	tructions)	1, 599, 1			20.00
21.00			381, 89			
22.00	Partial payment by patients approved for charity care	<i>,</i>	5, 04			
23.00			376, 79			
20100			0,0,7	/ / / / / / /	100,000	20100
					1.00	
24.00	Does the amount in line 20 column 2 include charges for	or natient days beyo	ond a length o	of stay limit	N N	24.00
24.00	imposed on patients covered by Medicaid or other indic			or stay rimit	1	24.00
25.00			ogram's Lengt	h of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex			s. stay mint	4, 067, 322	
20.00	Medicare bad debts for the entire hospital complex (se				93, 533	
27.00			s line 27)		3, 973, 789	
28.00	Cost of non-Medicare and non-reimbursable Medicare bad debt e			28)	948, 977	
29.00 30.00				, 20)	1, 399, 827	
	Total unreimbursed and uncompensated care cost (line 2				12, 190, 192	
51.00	Trotal antermoursed and uncompensated care cost (TTHE	i pius iile su)			12, 170, 192	1 31.00

202/10	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C)F EXPENSES	Provider CC	N: 15-0006 F	Period: From 03/01/2016	Worksheet A	
					12/31/2016	Date/Time Pre 5/31/2017 9:2	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	
	GENERAL SERVICE COST CENTERS	1 1	0.00/.450	0.00/.45/			
. 00 . 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		3, 906, 159 5, 947, 284	3, 906, 159 5, 947, 284		4, 865, 410 6, 498, 873	
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	536, 293	285, 012	821, 305		8, 437, 373	
. 00	00500 ADMI NI STRATI VE & GENERAL	8, 659, 089	35, 568, 469	44, 227, 558		33, 919, 346	
. 00	00700 OPERATION OF PLANT	1, 316, 548	3, 304, 270	4, 620, 818		4, 499, 061	
. 00 . 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	50, 688 727, 547	330, 332 386, 406	381, 020 1, 113, 953		381, 020 1, 113, 953	
0.00	01000 DI ETARY	1, 227, 909	1, 143, 621	2, 371, 530		1, 501, 222	
1.00	01100 CAFETERI A	0	0	_,,	897, 139	897, 139	
3.00	01300 NURSI NG ADMI NI STRATI ON	2, 435, 219	663, 497	3, 098, 716		3, 098, 716	
4.00	01400 CENTRAL SERVICES & SUPPLY	498, 432	7, 142, 631	7, 641, 063		943, 749	
5.00 6.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 525, 194 919, 977	4, 119, 282 -126, 283	5, 644, 476 793, 694		1, 745, 437 791, 306	
7.00	01700 SOCIAL SERVICE	2, 290	120, 203	2, 290		2, 290	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
0.00	03000 ADULTS & PEDIATRICS	5,073,181	3,041,786	8, 114, 967		8, 538, 605	
1.00 0.00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	2, 171, 287	629, 917	2, 801, 204	4 -7,683	2, 793, 521 0	
1.00	04000 SUBPROVIDER - TPP	0	0	(0	
3.00	04300 NURSERY	0	0	(0 0	0	43.00
4.00	04400 SKILLED NURSING FACILITY	0	0	(0 0	0	44.00
0. 00	ANCILLARY SERVICE COST CENTERS	2, 680, 575	2, 525, 702	5, 206, 277	1, 477	5, 207, 754	50.00
1.00	05100 RECOVERY ROOM	384, 972	36, 748	421, 720		421, 720	
2.00	05200 DELIVERY ROOM & LABOR ROOM	1, 570, 454	246, 900	1, 817, 354		1, 356, 575	
3.00	05300 ANESTHESI OLOGY	44, 766	2, 356, 280	2, 401, 046		2, 401, 046	
4.00	05400 RADI OLOGY-DI AGNOSTI C	2,650,514	1, 548, 852	4, 199, 366		4, 117, 267	
4.02 6.00	05402 ULTRASOUND 05600 RADI OI SOTOPE	330, 265 184, 698	50, 871 273, 158	381, 136 457, 856		381, 136 457, 856	
7.00	05700 CT SCAN	378, 434	331, 264	709, 698		709, 698	
8.00	05800 MRI	213, 159	162, 677	375, 836		375, 836	
0.00	06000 LABORATORY	2, 691, 324	2, 671, 100	5, 362, 424	-369, 474	4, 992, 950	
2.00 5.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	656, 566	0 89, 646	, 746, 212	2 -5, 588	0 740, 624	
6.00	06600 PHYSI CAL THERAPY	1, 078, 006	652, 682	1, 730, 688		1, 545, 236	
7.00	06700 OCCUPATI ONAL THERAPY	70, 734	4, 969	75, 703		287, 179	
8.00	06800 SPEECH PATHOLOGY	781, 987	157, 205	939, 192		913, 168	
9.00 1.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	2,032,902	3, 175, 882	5, 208, 784 (4, 991, 374 2, 271, 713	
	07200 I MPL. DEV. CHARGED TO PATTENT	0	0	(4, 289, 344	
	07300 DRUGS CHARGED TO PATIENTS	0	Ö	(4, 328, 576	
	07400 RENAL DI ALYSI S	0	0	(0 0	0	
6.00	03950 OTHER ANCI LLARY-OTHER	105 ((0	0	210.022	0	0	
	03610 SLEEP LAB 07697 CARDI AC REHABI LI TATI ON	195, 660	24, 261	219, 921		219, 921 0	
0. , ,	OUTPATIENT SERVICE COST CENTERS				<u>, </u>		
	09000 CLI NI C	0	0	(0 0	0	
	09001 DENTAL CLINIC	0	0	(0	0	
0. 02 0. 03	09002 OTHER OUTPATIENT SERVICE COST CENTE 09003 DIABETIC TRAINING	0	0	ĺ		0	90.02 90.03
	09100 EMERGENCY	1, 894, 987	612, 105	2, 507, 092	-33	2, 507, 059	
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
5.00	09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	(-120	-120	95.00
18.00		42, 983, 657	81, 262, 685	124, 246, 342	2 -1, 703, 409	122, 542, 933	118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	(0 0		190.00
	19001 PHYSI CLAN RECRUITMENT	0	0	(190.0
	19002 MARKETING / PUBLIC RELATIONS 19003 SPORTS MEDICINE	0	0	ſ			190. 0 190. 0
	19004 FOUNDATI ON	0	0	(190.0
91.00	19100 RESEARCH	0	0	(0	0	191. 0
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	-532, 386	-532, 386	1, 376, 053	843, 667	
	19300 NONPAI D WORKERS 19301 FREESTANDI NG VNA & HOSPI CE	0	0	(193. 00 193. 0
	19301 FREESTANDING VNA & HOSPICE	0	0	ſ			193.0
	19303 RENTAL PROPERTIES	0	0	(193. 0
93 04	19304 STARKE HOSPI TAL	0	0	(0 0	0	193. 04
	19306 RETAIL PHARMACY						193. 05

Health Financial Systems	LAPORTE H	OSPI TAL		In Lie	u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provider CO		Period: From 03/01/2016	Worksheet A	
				To 12/31/2016		
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
193.07 19307 CONTINUING CARE - MILLERS	0	0	(0 0	0	193.07
194.0007951 OTHER NONREI MBURSABLE-MARKETI NG	102, 650	32, 624	135, 27	4 327, 356	462, 630	194.00
200.00 TOTAL (SUM OF LINES 118-199)	43, 086, 307	80, 762, 923	123, 849, 23	0 0	123, 849, 230	200. 00

EULAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	UF EXPENSES	Provider CCN: 15-	From 03/01/2016	
				To 12/31/2016	Date/Time Prepare 5/31/2017 9:23 am
	Cost Center Description		Net Expenses For Allocation 7.00		
	GENERAL SERVICE COST CENTERS				
00	00100 CAP REL COSTS-BLDG & FIXT	-673, 125	4, 192, 285		1.
00 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	-163, 272	6, 498, 873 8, 274, 101		2.
00	00500 ADMI NI STRATI VE & GENERAL	-7, 978, 906	25, 940, 440		5.
00	00700 OPERATION OF PLANT	0	4, 499, 061		7.
00	00800 LAUNDRY & LINEN SERVICE	0	381, 020		8.
00	00900 HOUSEKEEPI NG	0	1, 113, 953		9.
. 00 . 00	01000 DI ETARY 01100 CAFETERI A	0 -845, 630	1, 501, 222 51, 509		10.
	01300 NURSI NG ADMI NI STRATI ON	-49, 721	3, 048, 995		13.
	01400 CENTRAL SERVICES & SUPPLY	0	943, 749		14.
	01500 PHARMACY	0	1, 745, 437		15.
	01600 MEDICAL RECORDS & LIBRARY	-33, 316	757, 990		16.
. 00	01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0	2, 290		17.
. 00	03000 ADULTS & PEDIATRICS	-46,888	8, 491, 717		30.
	03100 I NTENSI VE CARE UNI T	0	2, 793, 521		31.
. 00	04000 SUBPROVI DER – I PF	0	0		40.
	04100 SUBPROVIDER - IRF	0	0		41.
	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	0		43.
. 00	ANCI LLARY SERVICE COST CENTERS	0	0		44.
. 00	05000 OPERATI NG ROOM	-198, 935	5, 008, 819		50.
	05100 RECOVERY ROOM	0	421, 720		51.
	05200 DELIVERY ROOM & LABOR ROOM	0	1, 356, 575		52.
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	-48, 887	2, 352, 159		53. 54.
	05400 RADIOLOGI - DI AGNOSTI C 05402 ULTRASOUND	-246	4, 117, 021 381, 136		54.
	05600 RADI OI SOTOPE	0	457, 856		56.
	05700 CT SCAN	0	709, 698		57.
	05800 MRI	0	375, 836		58.
		-980, 366	4, 012, 584		60.
. 00 . 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	0	0 740, 624		62. 65.
. 00	06600 PHYSI CAL THERAPY	0	1, 545, 236		66.
. 00	06700 OCCUPATI ONAL THERAPY	0	287, 179		67.
	06800 SPEECH PATHOLOGY	0	913, 168		68.
	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	40.075	4, 991, 374		69.
	07200 IMPL. DEV. CHARGED TO PATIENTS	-48, 275	2, 223, 438 4, 289, 344		71.
	07300 DRUGS CHARGED TO PATIENTS	-167	4, 328, 409		73.
	07400 RENAL DIALYSIS	0	0		74.
	03950 OTHER ANCI LLARY-OTHER	0	0		76.
	03610 SLEEP LAB 07697 CARDIAC REHABILITATION	0	219, 921		76.
97	OUTPATIENT SERVICE COST CENTERS	0	0		
. 00	09000 CLINIC	0	0		90.
	09001 DENTAL CLINIC	0	0		90.
	09002 OTHER OUTPATIENT SERVICE COST CENTE	0	0		90.
	09003 DI ABETI C TRAI NI NG 09100 EMERGENCY	-41,976	0 2, 465, 083		90. 91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART	-41, 970	2,400,000		91.
. 00	OTHER REIMBURSABLE COST CENTERS	1 1			
00	09500 AMBULANCE SERVI CES	0	-120		95.
	SPECIAL PURPOSE COST CENTERS				
3. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	-11, 109, 710	111, 433, 223		118.
0 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.
	19001 PHYSI CI AN RECRUI TMENT	0	Ő		190.
0. 04	19002 MARKETING / PUBLIC RELATIONS	0	0		190.
	19003 SPORTS MEDI CI NE	0	0		190.
	19004 FOUNDATION	0	0		190.
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0 843, 667		191. 192.
	19300 NONPALD WORKERS	0	0		192.
3. 01	19301 FREESTANDING VNA & HOSPICE	0	ō		193.
	19302 WELLNESS CENTER	0	О		193.
	19303 RENTAL PROPERTIES	0	0		193.
	19304 STARKE HOSPITAL	0	0		193. 193.
J. UD	19306 RETAIL PHARMACY 19305 VACANT	0	0		193. 193.
3.06					
	19307 CONTINUING CARE - MILLERS	0	0		193.

Health Financial Systems	LAPORTE HO	SPI TAL		In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CO	CN: 15-0006	Period: From 03/01/2016	Worksheet A
					Date/Time Prepared: 5/31/2017 9:23 am
Cost Center Description	Adjustments	Net Expenses			
	(See A-8) F	or Allocation			
	6.00	7.00			
200.00 TOTAL (SUM OF LINES 118-199)	-11, 109, 710	112, 739, 520			200.00

LASS	SI FI CATI ONS			Provider CCN: 15-0	From 03/01/2016 To 12/31/2016 Date/	sheet A-6 'Time Prepare '2017 9:23 ar
		Increases				
	Cost Center	Line #	Salary	Other		
	2.00	3.00	4.00	5.00		
	A - EMPLOYEE BENEFITS		-			
	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 616, 068		1
C	DI ETARY	<u>10.00</u>	0	239		2
			0	7, 616, 307		
2	B - OXYGEN COSTS	71.00	ol	20,002		1
C	MEDICAL SUPPLIES CHARGED TO	71.00	0	38, 892		1
	TOTALS	- — — +	— —	38, 892		
	C - RENTAL AND LEASE EXPENSES		9	30, 072		
C	CAP REL COSTS-BLDG & FIXT	1.00	0	670, 119		1
5	CAP REL COSTS-MVBLE EQUIP	2.00	0	519, 359		2
5	PHYSICIANS' PRIVATE OFFICES	192.00	0	1, 376, 053		3
5		0.00	0	0		4
5		0.00	0	0		5
5		0.00	0	0		6
5		0.00	0	0		7
5		0.00	0	0		8
5		0.00	Ő	ō		9
00		0.00	0	0		10
00		0.00	0	0		11
00		0.00	0	0		12
00		0.00	0	0		13
00		0.00	0	0		14
	TOTALS		0	2, 565, 531		
	D - OTHER CAPITAL COSTS					
C	CAP REL COSTS-BLDG & FIXT	1.00	0	289, 132		1
C	CAP REL COSTS-MVBLE EQUIP	2.00	0	3 <u>2, 2</u> 30		2
	TOTALS		0	321, 362		
	E - MARKETING DEPARTMENT					
C	OTHER	194.00	166, 912	160, 444		1
	NONREI MBURSABLE-MARKETING	+				
			166, 912	160, 444		
C	F - MEDI CAL SUPPLI ES MEDI CAL SUPPLI ES CHARGED TO	71.00	0	2 294 259		1
J	PATIENT	/1.00	0	2, 286, 358		
)	IMPL. DEV. CHARGED TO	72.00	o	4, 289, 344		2
-	PATIENTS	72.00	5	1, 207, 011		1
C	DI ETARY	10.00	О	28, 127		3
	PHARMACY	15.00	0	50, 875		4
C	OPERATING ROOM	50.00	0	47, 755		5
C	RADI OLOGY-DI AGNOSTI C	54.00	0	240		6
C	LABORATORY	60.00	0	9, 188		7
	TOTALS		0	6, 711, 887		
	G - COST OF DRUGS/IV SOLUTIONS					
C	DRUGS CHARGED TO PATIENTS	73.00	0	4, 328, 576		1
C		0.00	0	0		2
	TOTALS		0	4, 328, 576		
	H - LABOR AND DELIVERY COSTS					
C	ADULTS & PEDIATRICS		397, 849	62, 443		1
	TOTALS		397, 849	62, 443		
	I - PT, OT, SP COSTS					
	OCCUPATI ONAL THERAPY	67.00	124, 182	87, 294		1
C	SPEECH_PATHOLOGY		0	2 <u>7,3</u> 21		2
	TOTALS		124, 182	114, 615		
	J - DIETARY COSTS TO CAFETERIA			1		
)		<u>11.00</u>	844, 323	5 <u>2, 8</u> 16		1
	TOTALS		844, 323	52, 816		

Heal th	Financial Systems		LAPORTE HO	SPI TAL		In Lie	u of Form CMS-2552-10
RECLAS	SIFICATIONS			Provider CCN	l: 15-0006	Period:	Worksheet A-6
						From 03/01/2016 To 12/31/2016	Date/Time Prepared:
						10 12/31/2010	5/31/2017 9:23 am
		Decreases					
	Cost Center	Line #	Salary	Other Wk	kst. A-7 Ref		
	6.00	7.00	8.00	9.00	10.00	-	
	A - EMPLOYEE BENEFITS						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	7, 611, 028		0	1.00
2.00	OPERATION OF PLANT	7.00	o	5, 279		0	2.00
2.00				7, 616, 307		1	2.00
	B - OXYGEN COSTS		9	7,010,007			
1.00	CENTRAL SERVICES & SUPPLY	14.00	0	38, 892		0	1.00
1.00	TOTALS		0	38, 892			1.00
	C - RENTAL AND LEASE EXPENSES		U	30, 072			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	2, 048, 466	1	0	1.00
2.00	OPERATION OF PLANT	7.00	0			0	2.00
	DI ETARY	10.00	0	116, 478			
3.00			0	1, 535		0	3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	72		0	4.00
5.00	MEDI CAL RECORDS & LI BRARY	16.00	0	2, 388		0	5.00
6.00	ADULTS & PEDIATRICS	30.00	U	36, 654			6.00
7.00	INTENSIVE CARE UNIT	31.00	0	7,683		0	7.00
8.00	OPERATING ROOM	50.00	0	46, 278		0	8.00
9.00	DELIVERY ROOM & LABOR ROOM	52.00	0	487		0	9.00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	82, 339		0	10.00
11.00	RESPI RATORY THERAPY	65.00	0	5, 588		0	11.00
12.00	ELECTROCARDI OLOGY	69.00	0	217, 410		0	12.00
13.00	EMERGENCY	91.00	0	33		0	13.00
14.00	AMBULANCE_SERVICES	95.00	0	120		O	14.00
	TOTALS		0	2, 565, 531			
	D - OTHER CAPITAL COSTS						
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	321, 362	1	3	1.00
2.00		0.00	0	0	1	3	2.00
	TOTALS		0	321, 362			
	E - MARKETING DEPARTMENT						
1.00	ADMI NI STRATI VE & GENERAL	5.00	166, 912	160, 444		0	1.00
	TOTALS		166, 912	160, 444		7	
	F - MEDICAL SUPPLIES						
1.00	MEDI CAL SUPPLI ES CHARGED TO	71.00	0	53, 537		0	1.00
	PATI ENT						
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	6, 658, 350		0	2.00
3.00		0.00	0	0		0	3.00
4.00		0.00	0	0		0	4.00
5.00		0.00	0	0		0	5.00
6.00		0.00	0	0		0	6.00
7.00		0.00	0	0		0	7.00
	TOTALS — — — —			6, 711, 887		7	1
	G - COST OF DRUGS/IV SOLUTION	IS	0	5,711,007			
1.00	PHARMACY	15.00	0	3, 949, 914		0	1.00
2.00	LABORATORY	60.00	0	378, 662		0	2.00
2.00	TOTALS			4, 328, 576			2.00
	H - LABOR AND DELIVERY COSTS		Ч	4, 320, 370			
1.00	DELIVERY ROOM & LABOR ROOM	52.00	397, 849	62, 443		0	1.00
1.00	TOTALS		397,849	62, 443			1.00
	I - PT, OT, SP COSTS		371,047	02, 443			
1 00	PHYSICAL THERAPY	44.00	70 027	114 215		0	1.00
1.00	1	66.00	70, 837	114, 615		0	1.00
2.00	SPEECH PATHOLOGY		53, 345	0		o	2.00
	TOTALS		124, 182	114, 615			
4 6 6	J - DIETARY COSTS TO CAFETERI		041.000	F0.04/			
1.00	DI ETARY	A <u>10.00</u>	844, 323	52,816		0	1.00
			844, 323 844, 323 1, 533, 266	52, 816 52, 816 21, 972, 873		0	1.00

Heal th	Financial Systems	LAPORTE H	OSPI TAL			In Lie	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC		То	od: n 03/01/2016 12/31/2016	Worksheet A-7 Part I Date/Time Pre 5/31/2017 9:2	pared:
				Acquisition	IS			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE							
1.00	Land	1, 538, 278	0		0	0	328, 308	1.00
2.00	Land Improvements	1, 549, 559			0	0	288, 525	2.00
3.00	Buildings and Fixtures	37, 947, 534	4, 574, 229		0	4, 574, 229	5, 429, 997	3.00
4.00	Building Improvements	27, 936, 535	1,032,424		0	1, 032, 424	5, 601, 352	4.00
5.00	Fixed Equipment	0	0		0	0	0	5.00
6.00	Movable Equipment	0	0		0	0	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	68, 971, 906	5, 606, 653		0	5, 606, 653	11, 648, 182	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	68, 971, 906	5, 606, 653		0	5, 606, 653	11, 648, 182	10.00
		Ending Balance					i	
		5	Depreciated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES		•				
1.00	Land	1, 209, 970	0					1.00
2.00	Land Improvements	1, 261, 034	0	1				2.00
3.00	Buildings and Fixtures	37, 091, 766	0	1				3.00
4.00	Building Improvements	23, 367, 607	0					4.00
5.00	Fixed Equipment	0	0					5.00
6.00	Movable Equipment	0	0					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	62, 930, 377	0					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	62, 930, 377	0					10.00
			- 1	1				

Heal th	Financial Systems	LAPORTE H	OSPI TAL		In Lieu of Form CMS-2552-10		
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-0006	Period: From 03/01/2016 To 12/31/2016		
					10 12/31/2010	5/31/2017 9:2	3 am
			SL	JMMARY OF CAF	PI TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	3, 906, 159	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	5, 947, 284	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	9, 853, 443	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	3, 906, 159				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	5, 947, 284				2.00
3.00	Total (sum of lines 1-2)	0	9, 853, 443				3.00

Health Financial Systems	LAPORTE H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider CO		Period: From 03/01/2016 To 12/31/2016	Worksheet A-7 Part III Date/Time Prep 5/31/2017 9:23	
	COMF	PUTATION OF RAT	10S	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE 1.00 CAP REL COSTS-BLDG & FIXT 2.00 CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	35, 713, 171 27, 217, 205 62, 930, 376	0	27, 217, 20 62, 930, 37	5 0. 432497	0 0	1.00 2.00 3.00
	71220071					
Cost Center Description	Taxes	Other Capi tal -Rel ate d Costs	Total (sum of cols. 5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1			0 00/ 150	(70, 440	1 00
1.00CAP REL COSTS-BLDG & FIXT2.00CAP REL COSTS-MVBLE EQUIP3.00Total (sum of lines 1-2)	0	•		0 3, 906, 159 0 5, 947, 284 0 9, 853, 443	519, 359	1.00 2.00 3.00
	0	SL	IMMARY OF CAPI		1, 107, 470	3.00
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE		-	000.40		4 400 005	1 00
1.00 CAP REL COSTS-BLDG & FLXT 2.00 CAP REL COSTS-MVBLE EQUIP	-673, 125 0				4, 192, 285 6, 498, 873	1.00 2.00
3.00 Total (sum of lines 1-2)	-673, 125	•			10, 691, 158	3.00

ealth Financial Systems DJUSTMENTS TO EXPENSES			Provider CCN: 15-0006	Peri od:	u of Form CMS-2 Worksheet A-8	
				From 03/01/2016 To 12/31/2016	Date/Time Prep 5/31/2017 9:23	pared
			Expense Classification o		5/31/2017 9:2	
			To/From Which the Amount is	s to be Adjusted		
Cost Center Descripti	on Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
.00 Investment income - CAP REL	-		CAP REL COSTS-BLDG & FIXT	1.00		1. (
COSTS-BLDG & FIXT (chapter .00 Investment income - CAP REL	-	0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.
.00 COSTS-MVBLE EQUIP (chapter Investment income - other	2)	0		0.00	0	3.
(chapter 2) .00 Trade, quantity, and time		0		0.00	0	4.
discounts (chapter 8) 00 Refunds and rebates of		0		0.00	0	5.
expenses (chapter 8)	,	0		0.00		
suppliers (chapter 8)		0				
.00 Telephone services (pay stations excluded) (chapter 21)	- A	-97, 846	ADMI NI STRATI VE & GENERAL	5.00	0	7.
.00 Television and radio servic (chapter 21)	ce A	-63, 479	ADMI NI STRATI VE & GENERAL	5.00	0	8.
.00 Parking lot (chapter 21) D.00 Provider-based physician	A-8-2	0 -5, 986, 520		0.00	0 0	
adjustment 1.00 Sale of scrap, waste, etc.		0		0.00	0	11.
(chapter 23) 2.00 Related organization transactions (chapter 10)	A-8-1	-162, 222			0	12.
3.00 Laundry and Linen service		0		0.00		
1.00 Cafeteria-employees and gue 5.00 Rental of quarters to emplo		-845, 630 0	CAFETERI A	11.00 0.00	0	
and others 5.00 Sale of medical and surgical supplies to other than	al B		MEDI CAL SUPPLI ES CHARGED TC PATI ENT	71.00	0	16.
patients 7.00 Sale of drugs to other than	n B	-167	DRUGS CHARGED TO PATIENTS	73.00	0	17.
patients 8.00 Sale of medical records and	в	-33, 316	MEDICAL RECORDS & LIBRARY	16.00	0	18.
abstracts 0.00 Nursing school (tuition, fe	ees,	0		0.00	0	19.
books, etc.) D. 00 Vending machines		0		0.00	0	20.
.00 Income from imposition of interest, finance or penalt	.y	0		0.00	-	
2.00 charges (chapter 21) Interest expense on Medicar overpayments and borrowings	s to	0		0.00	0	22
8.00 Repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.
1.00 I imitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24.
5.00 limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25
(chapter 21) 0.00 Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26.
COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.
COSTS-MVBLE EQUIP 8.00 Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28.
 .00 Physicians' assistant .00 Adjustment for occupational therapy costs in excess of 	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00		29. 30.
.99 Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30.
instructions) .00 Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.
Limitation (chapter 14) COO CAH HIT Adjustment for		0		0.00	0	32.
Depreciation and Interest 3.00 SILVER RECOVERY	В	_ 246	RADI OLOGY-DI AGNOSTI C	54.00	0	33.
0. 00		0		0.00		40.

Heal th	Financial Systems		LAPORTE H	IOSPI TAL	In Lie	eu of Form CMS-2	2552-10
ADJUS	TMENTS TO EXPENSES				Period:	Worksheet A-8	
					From 03/01/2016		
					To 12/31/2016	Date/Time Pre 5/31/2017 9:2	
				Expense Classification or	Workshoot A	5/51/2017 9.2	
				To/From Which the Amount is			
					to be Aujusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	•	1.00	2.00	3.00	4.00	5.00	
41.00	RENTAL INCOME	В	-673, 125	CAP REL COSTS-BLDG & FIXT	1.00	11	41.00
42.00	MISC / NON PATIENT INCOME	В	-106, 126	ADMINISTRATIVE & GENERAL	5.00	0	42.00
43.00	MISC / NON PATIENT INCOME	В	-1, 431, 018	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	TRAINING REVENUE	В	-17, 694	NURSING ADMINISTRATION	13.00	0	44.00
45.00			0		0.00	0	45.00
45.01			0		0.00	0	45.01
45.02	MARKETING EXPENSE	A	-20, 366	ADMINISTRATIVE & GENERAL	5.00	0	45.02
45.03	PHYSICIAN RECRUITING	A	-57, 172	ADMINISTRATIVE & GENERAL	5.00	0	45.03
45.04	PHYSICIAN RECRUITING	A	-163, 272	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	45.04
45.05	CHARI TABLE CONTRI BUTI ONS	A	-111, 966	ADMI NI STRATI VE & GENERAL	5.00	0	45.05
45.06	MEDICAL STAFF STIPEND	A	-31, 250	ADMI NI STRATI VE & GENERAL	5.00	0	45.06
45.07	MINORITY INTEREST	A	-1, 211, 133	ADMI NI STRATI VE & GENERAL	5.00	0	45.07
45.08		A	-48,887	ANESTHESI OLOGY	53.00	0	45.08
50.00	TOTAL (sum of lines 1 thru 49)		-11, 109, 710				50.00
	(Transfer to Worksheet A,						
	column 6, line 200,)						

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

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

Heal th	Financial Systems	LAPORTE	HOSPI TAL	In Lieu of Form CMS-2552-10		
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-0006	Period:	Worksheet A-8	8-1
OFFICE	costs			From 03/01/2016 To 12/31/2016		epared: 3 am
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED (ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	MALPRACTICE EXPENSE	24, 548	186, 770	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	TOTALS (sum of lines 1-4).			24, 548	186, 770	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.

nas	ΠΟL	Deen posteu to worksneet A,	corumns ranu/or z, the a	iount arrowable sn		or this part.	
					Related Organization(s) and/	or Home Office	
		Symbol (1)	Name	Percentage of	Name	Percentage of	
		, , , , , , , , , , , , , , , , , , ,		Ownershi p		Ownershi p	
		1.00	2.00	3.00	4.00	5.00	
-				HOME OFFICE.			

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

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

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

(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 LAPORTE H	LAPORTE HOSPITAL		
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOM	Provider CCN: 15-0006		Worksheet A-8-1
OFFICE COSTS		From 03/01/2016 To 12/31/2016	Date/Time Prepared:

			5/31/2017 9:2	
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO			
1.00	-162, 222	0		1.00
2.00	0	0		2.00
3.00	0	0		3.00
4.00	0	0		4.00
5.00	-162, 222			5.00

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

110	13 1101	been posted to worksheet A,	cordinas i androi 2, the amount arrowable should be rind cated in cordinar 4 of this part.	
		Rel ated Organi zati on(s)		
		and/or Home Office		
		Type of Business		
		6.00		
		B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HEALTHCARE	6.00				
7.00		7.00				
8.00		8.00				
9.00		9.00				
10. 00 100. 00		10.00				
100.00		100.00				

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

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

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

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

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

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

Health Financial Systems			LAPORTE HOSPITAL			In Lieu of Form CMS-2552-10		
PROVIDER BASED PHYSICIAN ADJUSTMENT				Provider CCN: 15-0006		Period: Worksheet A-8-2 From 03/01/2016 To 12/31/2016 Date/Time Prepare		
						10 12/01/2010	5/31/2017 9:2	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remuneration	Component	Component		ider Component	
					•		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5.00	ADMINISTRATIVE & GENERAL	4, 686, 328	4, 686, 328	C	0	0	1.00
2.00	13.00	NURSING ADMINISTRATION	32, 027	32, 027	C		0	2.00
3.00	30.00	ADULTS & PEDIATRICS	46, 888	46, 888	C	0	0	3.00
4.00	50.00	OPERATING ROOM	198, 935	198, 935	C	0	0	4.00
5.00	60.00	LABORATORY	980, 366	980, 366	C	0 0	0	5.00
6.00	91.00	EMERGENCY	41, 976		C	0 0	0	6.00
7.00	0,00		0	0	C	0	0	7.00
8.00	0.00			0	(0	0	8.00
9.00	0.00		0	0	(0	9.00
10.00	0.00			0	(0	10.00
200.00	0.00		5, 986, 520	5, 986, 520	(, v	0	200.00
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	, Provi der	Physician Cost	200.00
	WRSt. A LINC #	I denti fi er	Limit	Unadjusted RCE			of Malpractice	
		i denti i i ei		Limit	Conti nui ng	Share of col.	Insurance	
					Education	12	rinsurance	
	1.00	2.00	8,00	9,00	12.00	13.00	14.00	
1.00		ADMI NI STRATI VE & GENERAL	0.00		(1.00
2.00		NURSI NG ADMI NI STRATI ON	0	0	(2.00
3.00		ADULTS & PEDIATRICS		0	(0	3.00
4.00		OPERATI NG ROOM		0	(0	4.00
5.00		LABORATORY		0	(-	0	5.00
6.00		EMERGENCY		0	(0	
7.00	0.00	EMERGENCI		0			0	7.00
8.00	0.00			0			0	8.00
9.00	0.00			0			0	9.00
9.00 10.00	0.00			0			0	9.00 10.00
	0.00			0	(0	
200.00	Wkst. A Line #	Cast Cantar (Dhusi si an	Provi der	U Adiusted DCE	RCE		0	200.00
	WKSL A LINE #	Cost Center/Physician Identifier	Component	Adjusted RCE Limit	Di sal l owance	Adj ustment		
		rdentifier	Share of col.		DI Sal i Owance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ADMI NI STRATI VE & GENERAL	10.00		(1.00
2.00		NURSI NG ADMI NI STRATI ON		0	(.,		2.00
3.00	30. 00 ADULTS & PEDIATRICS			0	(3.00
4.00	50. 00 OPERATING ROOM			0	(4.00
4.00 5.00	60. 00 LABORATORY			0	(4.00 5.00
6.00	91. OO EMERGENCY			0				6,00
				-	-	11, 110		
7.00	0.00			0	0			7.00
8.00	0.00			0	0	-		8.00
9.00	0.00			0	0	-		9.00
10.00	0.00			0	0			10.00
200.00	200. 00			0	C	5, 986, 520		200.00

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	LAPORTE HO	Provider CCN: 15-0006 Period: From 03/01/201			eu of Form CMS-2552-10 Worksheet B Part I	
					o 12/31/2016		
			CAPI TAL REL	ATED COSTS		575172017 7.2	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	r	0	1.00	2.00	4.00	4A	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	4, 192, 285	4, 192, 285				1.00
1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00	00200 CAP REL COSTS-MUBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	6, 498, 873 6, 498, 873 8, 274, 101 25, 940, 440 4, 499, 061 381, 020 1, 113, 953 1, 501, 222 51, 509 3, 048, 995 943, 749 1, 745, 437	4, 172, 203 25, 615 319, 791 1, 234, 773 3, 464 50, 360 50, 394 32, 939 17, 154 21, 898 22, 226	6, 498, 873 39, 708 495, 740 1, 914, 142 5, 369 78, 066 78, 121 51, 062 26, 592 33, 944 34, 455	8 8, 339, 424 1, 664, 395 258, 032 9 9, 934 142, 593 114, 856 125, 803 477, 281 9 97, 688	28, 420, 366 7, 906, 008 399, 787 1, 384, 974 1, 744, 593 261, 313 3, 570, 022 1, 097, 281 2, 101, 042	2.00 4.00 5.00 7.00 8.00 9.00 10.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	757, 990	23, 417	36, 301	180, 307	998, 015	16.00
17.00	01700 SOCIAL SERVICE	2, 290	8, 385	12, 999	9 449	24, 123	17.00
30. 00 31. 00 40. 00 41. 00 43. 00 44. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY ANCILLARY SERVICE COST CENTERS	8, 491, 717 2, 793, 521 0 0 0 0	199, 084 91, 882 0 7, 968 0	308, 620 142, 436 ((12, 352 (425, 553 0 0 0 0 2 0	10, 071, 694 3, 453, 392 0 20, 320 0	31.00 40.00 41.00 43.00
50.00	05000 OPERATI NG ROOM	5, 008, 819	226, 163	350, 598		6, 110, 949	
51.00 52.00 53.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	421, 720 1, 356, 575 2, 352, 159	0 110, 111 0	(170, 694 (229, 820 8, 774	497, 171 1, 867, 200 2, 360, 933	53.00
54.00 54.02 56.00	05400 RADI OLOGY-DI AGNOSTI C 05402 ULTRASOUND 05600 RADI OI SOTOPE	4, 117, 021 381, 136 457, 856	81, 532 13, 423 0	126, 391 20, 809 (64, 729 36, 199	4, 844, 421 480, 097 494, 055	54.00 54.02 56.00
57.00 58.00	05700 CT SCAN 05800 MRI	709, 698 375, 836	13, 471 58, 321	20, 883 90, 408		818, 222 566, 342	57.00 58.00
60.00	06000 LABORATORY	4, 012, 584	47, 909	74, 269	527, 475	4, 662, 237	60.00
62.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	0 740, 624	9, 782 8, 748	15, 164 13, 561		24, 946 891, 614	62.00 65.00
66. 00	06600 PHYSI CAL THERAPY	1, 545, 236	222, 337	344, 666		2, 309, 635	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	287, 179 913, 168	2, 355 1, 390	3, 650 2, 154		331, 386 1, 059, 519	
	06900 ELECTROCARDI OLOGY	4, 991, 374	168, 158	260, 678		5, 818, 640	
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	2, 223, 438	0	(0	2, 223, 438	
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	4, 289, 344 4, 328, 409	0	(4, 289, 344 4, 328, 409	
	07400 RENAL DI ALYSI S	0	19, 591	30, 370	0	49, 961	
	03950 OTHER ANCI LLARY-OTHER 03610 SLEEP LAB	219, 921	0	(38, 348	0 258, 269	76.00 76.01
	07697 CARDI AC REHABI LI TATI ON	0	0			0	1
90.00	OUTPATIENT SERVICE COST CENTERS	0	0	(0	90.00
90.01	09001 DENTAL CLINIC	0	0	(0	0	90. 01
	09002 OTHER OUTPATIENT SERVICE COST CENTE 09003 DIABETIC TRAINING	0	0	(0	0	90. 02 90. 03
91.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 465, 083	67, 123	104, 055	371, 400	3, 007, 661 0	91.00
95.00	OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	-120	0	(0 0	-120	95.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	111, 433, 223	3, 159, 764			108, 747, 259	1
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 PHYSICIAN RECRUITMENT	0	37, 648 0	58, 362			190. 00 190. 03
190.04	19002 MARKETING / PUBLIC RELATIONS	0	0		32, 713	32, 713	190. 04
	19003 SPORTS MEDI CI NE	0	0	(0		190.05
	19004 FOUNDATI ON 19100 RESEARCH	0	0				190.06 191.00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	843, 667	0	C	0	843, 667	192.00
	19300 NONPAI D WORKERS 19301 FREESTANDI NG VNA & HOSPI CE	0	0				193. 00 193. 01
193.02	19302 WELLNESS CENTER	0	0	0	0	0	193. 02
193.03	19303 RENTAL PROPERTIES	0	0	0	0	0	193. 03

Health Financial Systems	LAPORTE H	OSPI TAL		In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 5/31/2017 9:2	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	Subtotal	
	0	1.00	2.00	4.00	4A	
193.04 19304 STARKE HOSPITAL 193.05 19306 RETAIL PHARMACY 193.06 19305 VACANT 193.07 19307 CONTINUING CARE - MILLERS 194.00 07951 OTHER NONREIMBURSABLE-MARKETING 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0 0 0 462, 630	0		0 0	0 0 3, 019, 871 0 0	200. 00 201. 00
202.00 TOTAL (sum lines 118-201)	112, 739, 520	4, 192, 285	6, 498, 87	8, 339, 424	112, 739, 520	202.00

Health Financial Systems	LAPORTE H	IOSPI TAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 03/01/2016	Worksheet B Part I	
				o 12/31/2016		pared: 3 am
Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10,00	
GENERAL SERVICE COST CENTERS		1				
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00 2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00 00500 ADMI NI STRATI VE & GENERAL	28, 420, 366					5.00
7.00 00700 OPERATION OF PLANT	2, 664, 775					7.00
8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING	134, 751 466, 815					8.00 9.00
10. 00 01000 DI ETARY	588, 027				2, 582, 450	
11.00 01100 CAFETERIA	88,077				1, 291, 230	•
13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY	1, 203, 301 369, 846			15, 622 19, 942	0	
15. 00 01500 PHARMACY	708, 171	89, 946		20, 242	0	
16.00 01600 MEDICAL RECORDS & LIBRARY	336, 388			21, 326	0	
17. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	8, 131	33, 934	0	7, 637	0	17.00
30. 00 03000 ADULTS & PEDIATRICS	3, 394, 700	805, 662	86, 599	181, 309	1, 118, 630	30.00
31. 00 03100 I NTENSI VE CARE UNI T	1, 163, 990			83, 678	101, 932	
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	0	-	0	0	0	
43. 00 04300 NURSERY	6, 849	-	3, 638		0	
44.00 04400 SKILLED NURSING FACILITY	0		0		0	44.00
	2 050 729	015 249	26 127	205 070	200	
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	2, 059, 738 167, 575		36, 127	205, 970 0	300 0	50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	629, 353		8, 089	100, 279	58, 271	52.00
53. 00 05300 ANESTHESI OLOGY	795, 769		0	0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 02 05402 ULTRASOUND	1, 632, 846 161, 820		18, 379 0	74, 253 12, 225	0	54.00 54.02
56. 00 05600 RADI 0I SOTOPE	166, 525		0	0	0	56.00
57. 00 05700 CT SCAN	275, 787		0	12, 268	0	57.00
58. 00 05800 MRI 60. 00 06000 LABORATORY	190, 890 1, 571, 440		0	53, 113 43, 631	0	58.00 60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	8, 408				0	62.00
65. 00 06500 RESPI RATORY THERAPY	300, 525	35, 402	0	7, 967	0	65.00
66.00 06600 PHYSICAL THERAPY	778, 479				0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	111, 696 357, 118		333		0	67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 961, 213		4, 825		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	749, 425		0	0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	1, 445, 753 1, 458, 921	0	0	0	0	72.00
74.00 07400 RENAL DIALYSIS	16, 840	-	0	17, 842	0	
76. 00 03950 OTHER ANCI LLARY-OTHER	0	0	0	0	0	
76. 01 03610 SLEEP LAB 76. 97 07697 CARDI AC REHABI LI TATI ON	87,051	0	0		0	
OUTPATI ENT SERVICE COST CENTERS		· · · · · · · · · · · · · · · · · · ·	· · · · · · · · · · · · · · · · · · ·			
90. 00 09000 CLINIC	0	0	0	0	0	
90.01 09001 DENTAL CLINIC 90.02 09002 OTHER OUTPATIENT SERVICE COST CENTE	0			0	0	
90. 03 09003 DI ABETI C TRAI NI NG	0	0	0	0	0	
91.00 09100 EMERGENCY	1, 013, 753	271, 638	30, 900	61, 130	12, 087	•
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART OTHER REI MBURSABLE COST CENTERS						92.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
SPECIAL PURPOSE COST CENTERS						
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	27, 074, 746	6, 392, 330	500, 885	1, 389, 527	2, 582, 450	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	32, 361	152, 357	79	34, 287	0	190.00
190. 03 19001 PHYSI CI AN RECRUI TMENT	0	0	0	0	0	190. 03
190. 04 19002 MARKETING / PUBLIC RELATIONS	11, 026	0	0	0		190.04
190. 05 19003 SPORTS MEDICINE 190. 06 19004 FOUNDATI ON	0			0		190. 05 190. 06
191. 00 19100 RESEARCH	0	0	0	0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	284, 364	0	0	0		192.00
193. 00 19300 NONPALD WORKERS 193. 01 19301 FREESTANDING VNA & HOSPICE	0	0		0		193. 00 193. 01
193. 02 19302 WELLNESS CENTER	0	0	0	0		193.01
193. 03 19303 RENTAL PROPERTI ES	0	0	0	0	0	193. 03
193. 04 19304 STARKE HOSPI TAL 193. 05 19306 RETAL PHARMACY	0	0		0		193. 04 193. 05
193. 06 19306 RETAIL PHARMACY 193. 06 19305 VACANT	0	0	0	0		193.05
193. 07 19307 CONTINUING CARE – MILLERS	0	0	0	0	0	193. 07
194.00079510THER NONREIMBURSABLE-MARKETING	1, 017, 869	4, 026, 096	47, 591	906, 048	0	194.00

Health Fina	ancial Systems	LAPORTE H	OSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS			Provider C		Period: Worksheet B From 03/01/2016 Part I			
					To 12/31/2016	Date/Time Pr 5/31/2017 9:		
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		
		& GENERAL	PLANT	LINEN SERVICE				
		5.00	7.00	8.00	9.00	10.00		
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)	28, 420, 366	10, 570, 783	548, 55	5 2, 329, 862	2, 582, 450	202.00	

Heal th	Financial Systems	LAPORTE F	IOSPI TAL		In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	CN: 15-0006	Period: From 03/01/2016	Worksheet B Part I	
					To 12/31/2016		epared: 23 am
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
			ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	1	11.00	13.00	14.00	15.00	16.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00 7.00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 803, 916					10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	140, 254					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	51, 427		1, 633, 07			14.00
15.00 16.00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	79, 248		1, 56 99		1, 541, 621	15.00 16.00
17.00	01700 SOCI AL SERVI CE	, 101 C			0 0	0	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	270.012				74.001	1 20 00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	379, 912 138, 798		55, 95 37, 80		74, 801 27, 280	
40.00	04000 SUBPROVI DER – I PF	C		07,00	0 0	0	
41.00	04100 SUBPROVIDER - IRF	C	u u		0 0	0	
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY		-		0 0	0	
11.00	ANCI LLARY SERVICE COST CENTERS		· · · · ·				
50.00	05000 OPERATING ROOM	154, 931		118, 77		306, 479	
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	58, 056	-	48 14, 08		0 44, 320	
53.00	05300 ANESTHESI OLOGY	C	0	7, 27		55, 864	
54.00	05400 RADI OLOGY-DI AGNOSTI C	161, 599	1	44, 46		37, 840	
54. 02 56. 00	05402 ULTRASOUND 05600 RADI OI SOTOPE		-	2, 15 40		1, 445 24, 833	
57.00	05700 CT SCAN	21, 920		4, 90		96, 497	
58.00	05800 MRI	10, 423		4, 31		34, 133	1
60.00 62.00	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	152, 517 C	1	200, 40	0 0	194, 333 0	
65.00	06500 RESPIRATORY THERAPY	42, 230	-	3, 43	-	21, 644	
66.00	06600 PHYSI CAL THERAPY	70, 434		2, 95		35, 471	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	13, 144 34, 527		10 1, 02		11, 486 4, 745	
69.00	06900 ELECTROCARDI OLOGY	99, 979		270, 97		132, 472	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	C		289, 28		59, 426	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS		-	536, 43	0 3, 033, 204	63, 129 208, 750	
	07400 RENAL DI ALYSI S	C	0		0 0		74.00
76.00	03950 OTHER ANCI LLARY-OTHER	C	-	F 2	0 0	0	
76. 01 76. 97	03610 SLEEP LAB 07697 CARDI AC REHABI LI TATI ON			52	0 0	0	
	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 01	09000 CLINIC 09001 DENTAL CLINIC	C	0		0 0	0	
90.01 90.02	09002 OTHER OUTPATIENT SERVICE COST CENTE		0		0 0	0	
90.03	09003 DI ABETI C TRAI NI NG	C	0		0 0	0	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	104, 386	505, 535	34, 53	7 0	101, 602	91.00 92.00
92.00	OTHER REIMBURSABLE COST CENTERS		11				92.00
95.00	09500 AMBULANCE SERVI CES	C	0		0 0	0	95.00
110 00	SPECIAL PURPOSE COST CENTERS	1 902 014	4 009 419	1 422 04	2 407 000	1 541 401	1110 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	1, 803, 916	4, 998, 618	1, 632, 86	8 3, 407, 099	1, 541, 621	1118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	0		0 0		190. 00
	19001 PHYSI CLAN RECRUITMENT	0	0		0 0		190. 03 190. 04
	19002 MARKETING / PUBLIC RELATIONS 19003 SPORTS MEDICINE		0		0 0		190.04
190.06	19004 FOUNDATI ON	C	o o		0 0	0	190.06
	19100 RESEARCH		0	20	0 0		191.00
	19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS			20	0 0		192.00 193.00
193.01	19301 FREESTANDING VNA & HOSPICE	c	o o		0 0	0	193.01
	19302 WELLNESS CENTER	0	0		0 0		193.02
	19303 RENTAL PROPERTIES 19304 STARKE HOSPITAL				0 0		193. 03 193. 04
193.05	19306 RETAIL PHARMACY	c	o o		0 0	0	193.05
	19305 VACANT	0	0		0 0		193.06
193.07	19307 CONTINUING CARE - MILLERS	I C	y U		0 0	0	193.07

Health Financial Systems	LAPORTE H	IOSPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 03/01/2016	Worksheet B Part I		
				To 12/31/2016			
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL		
		ADMI NI STRATI ON	SERVICES &		RECORDS &		
			SUPPLY		LI BRARY		
	11.00	13.00	14.00	15.00	16.00		
194.0007951 OTHER NONREIMBURSABLE-MARKETING	0	0	(0 0	0	194.00	
200.00 Cross Foot Adjustments						200.00	
201.00 Negative Cost Centers	0	0	(0 0	0	201.00	
202.00 TOTAL (sum lines 118-201)	1, 803, 916	4, 998, 618	1, 633, 073	3, 407, 099	1, 541, 621	202.00	

	Financial Systems LLOCATION - GENERAL SERVICE COSTS	LAPORTE HC	Provi der C	F	Period: From 03/01/2016 To 12/31/2016	u of Form CMS-2552-1 Worksheet B Part I Date/Time Prepared:
	Cost Center Description	SOCI AL SERVI CE		Intern & Residents Cost & Post Stepdown Adjustments		5/31/2017 9:23 am
		17.00	24.00	25.00	26.00	
1.00 2.00 4.00 5.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL					1. 0 2. 0 4. 0 5. 0
7.00 8.00 9.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPI NG 01000 DI ETARY					7. 0 8. 0 9. 0 10. 0
11. 00 13. 00 14. 00	01100 CAFETERIA 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY					10.0 11.0 13.0 14.0 15.0
16.00	01500 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	73, 825				13. 0 16. 0 17. 0
30. 00	03000 ADULTS & PEDIATRICS	52, 298	17, 681, 087	(17, 681, 087	30.0
40. 00 41. 00	03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	15, 383 0 0	6,003,549 0 0		0 0	31.0 40.0 41.0
	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	6, 144	76, 451 0	1		43. 0 44. 0
51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	10, 604, 755 665, 232	1		50. 0 51. 0
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	3, 538, 079 3, 219, 836			52. 0 53. 0
	05400 RADI OLOGY-DI AGNOSTI C 05402 ULTRASOUND	0	7, 399, 194 712, 063	1	.,	54.0 54.0
56.00	05600 RADI OI SOTOPE	0	802, 802	0	802, 802	56.0
	05700 CT SCAN 05800 MRI	0	1, 284, 112 1, 095, 227			57. 0 58. 0
	06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	7, 018, 446 81, 847		.,,	60. 0 62. 0
65.00	06500 RESPI RATORY THERAPY	0	1, 477, 973	0	1, 477, 973	65.0
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	4, 569, 183 479, 822		.,,	66. 0 67. 0
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	1, 464, 099 9, 664, 086		.,	68. 0 69. 0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	3, 323, 043	0	3, 323, 043	71.0
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	6, 334, 662 9, 029, 284			72. 0 73. 0
	07400 RENAL DI ALYSI S	0	168, 995	C	168, 995	74.0
76. 01	03950 OTHER ANCILLARY-OTHER 03610 SLEEP LAB	0	398, 040		-	76. 0 76. 0
76. 97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	(0 0	76.9
	09000 CLINIC 09001 DENTAL CLINIC	0	0	(0 0	90. 0 90. 0
90. 02	09002 OTHER OUTPATIENT SERVICE COST CENTE	0	0			90.0
	09003 DI ABETI C TRAI NI NG 09100 EMERGENCY	0	0 5, 143, 229		0 0 5, 143, 229	90. 0 91. 0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES		-120			92.0
95.00	SPECIAL PURPOSE COST CENTERS	0	- 120	η <u></u> (- 120	95.0
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	73, 825	102, 234, 976	(0 102, 234, 976	118. 0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 PHYSICIAN RECRUITMENT	0	315, 094 0	() 315, 094) 0	190. 0 190. 0
190.04	19002 MARKETI NG / PUBLI C RELATI ONS 19003 SPORTS MEDI CI NE	0	43, 739		43, 739	190. 0 190. 0 190. 0
190.06	19004 FOUNDATI ON	0	0			190. 0
	19100 RESEARCH 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0 1, 128, 236		0 0 0 1, 128, 236	191. 0 192. 0
193.00	19300 NONPAID WORKERS	0	0		0	193. 0
	19301 FREESTANDING VNA & HOSPICE 19302 WELLNESS CENTER	0	0 0			193. 0 193. 0
193. 03	19303 RENTAL PROPERTIES	0	0	(193. 0 193. 0
	19304 STARKE HOSPITAL 19306 RETAIL PHARMACY	0	0			193. 0

Health Financial Systems	LAPORTE HO	SPI TAL		In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 03/01/2016	Worksheet B Part I		
				To 12/31/2016			
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern &	Total			
			Residents Cos	t			
			& Post				
			Stepdown				
			Adjustments				
	17.00	24.00	25.00	26.00			
193. 06 19305 VACANT	0	0		0 0	193.06		
193.07 19307 CONTINUING CARE – MILLERS	0	0		0 0	193.07		
194.00079510THER NONREIMBURSABLE-MARKETING	0	9, 017, 475		0 9, 017, 475	194.00		
200.00 Cross Foot Adjustments		0		0 0	200.00		
201.00 Negative Cost Centers	0	0		0 0	201.00		
202.00 TOTAL (sum lines 118-201)	73, 825	112, 739, 520		0 112, 739, 520	202.00		

	Financial Systems TION OF CAPITAL RELATED COSTS	LAPORTE H	OSPITAL Provider CC		<u>In Lie</u> Period: From 03/01/2016 To 12/31/2016		pared:
			CAPI TAL REL	ATED COSTS		5/31/2017 9:2	
	Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS				1		
1.00 2.00 4.00 5.00 7.00 8.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	0	25, 615 319, 791 1, 234, 773 3, 464	39, 70 495, 74 1, 914, 14 5, 36	0 815, 531 2 3, 148, 915	65, 323 13, 042 2, 021 78	1.00 2.00 4.00 5.00 7.00 8.00
9.00 10.00 11.00 13.00	00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01300 NURSI NG ADMI NI STRATI ON	0 0 0 0	50, 360 50, 394 32, 939 17, 154	78, 06 78, 12 51, 06 26, 59	8 128, 428 1 128, 515 2 84, 001	1, 117 900 985 3, 738	9.00 10.00 11.00
14. 00 15. 00 16. 00 17. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	0 0 0 0	21, 898 22, 226 23, 417 8, 385	33, 94 34, 45 36, 30 12, 99	5 56, 681 1 59, 718	765 2, 341 1, 412 4	14.00 15.00 16.00 17.00
30. 00 31. 00 40. 00 41. 00	03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF	0 0 0 0	199, 084 91, 882 0 0	308, 62 142, 43		8, 398 3, 333 0 0	30. 00 31. 00 40. 00 41. 00
43.00 44.00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	7, 968 0	12, 35	2 20, 320 0 0	0	43.00 44.00
50.00 51.00 52.00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	226, 163 0 110, 111	350, 59 170, 69	0 0	4, 115 591 1, 800	50.00 51.00 52.00
53.00 54.00 54.02 56.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 ULTRASOUND 05600 RADI OI SOTOPE	0 0 0	0 81, 532 13, 423 0		9 34, 232 0 0	69 4, 069 507 284	53.00 54.00 54.02 56.00
57.00 58.00 60.00 62.00	05700 CT SCAN 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	13, 471 58, 321 47, 909 9, 782	20, 88 90, 40 74, 26 15, 16	8 148, 729 9 122, 178	581 327 4, 131 0	57.00 58.00 60.00 62.00
65.00 66.00 67.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	8, 748 222, 337 2, 355	13, 56 344, 66 3, 65	1 22, 309 6 567, 003 0 6, 005	1, 008 1, 546 299	65.00 66.00 67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	1, 390 168, 158 0 0	2, 15 260, 67		1, 118 3, 121 0 0	69.00 71.00
76.00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 03950 OTHER ANCILLARY-OTHER 03610 SLEEP LAB	0 0 0	0 19, 591 0 0	30, 37	0 0 0 49, 961 0 0 0 0	0 0 0 300	
76. 97 90. 00	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS 09000 CLINIC		0			0	76.97 90.00
90. 01 90. 02 90. 03 91. 00	09001 DENTAL CLINIC 09002 OTHER OUTPATIENT SERVICE COST CENTE 09003 DIABETIC TRAINING 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 0 0	0 0 0 67, 123	104, 05	D 0 D 0 D 0 5 171, 178	0 0 0 2, 909	90. 01 90. 02 90. 03
	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0			0	1
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	0	3, 159, 764	4, 898, 26	1 8, 058, 025	64, 909	118.00
190. 03 190. 04 190. 05	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 PHYSICIAN RECRUITMENT 19002 MARKETING / PUBLIC RELATIONS 19003 SPORTS MEDICINE		37, 648 0 0 0	58, 36	2 96,010 0 0 0 0 0 0 0 0	0 256 0	190.00 190.03 190.04 190.05
191.00 192.00 193.00	19004 FOUNDATION 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS 19301 FREESTANDING VNA & HOSPICE		000000000000000000000000000000000000000			0 0 0	190. 06 191. 00 192. 00 193. 00 193. 01
193. 02 193. 03	19301 PREESTANDING VNA & HOSPICE 19302 WELLNESS CENTER 19303 RENTAL PROPERTIES 19304 STARKE HOSPITAL		0 0 0		5 0 5 0 5 0 5 0 5 0	0 0	193. 01 193. 02 193. 03 193. 04

Health Financial Systems	LAPORTE HOSPI TAL			In Lieu of Form CMS-2552-10		
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 03/01/2016 To 12/31/2016		
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
193. 05 19306 RETAIL PHARMACY	0	0		0 0	0	193.05
193. 06 19305 VACANT	0	0		0 0	0	193.06
193. 07 19307 CONTINUING CARE - MILLERS	0	0		0 0		193. 07
194.0007951 OTHER NONREIMBURSABLE-MARKETING	0	994, 873	1, 542, 25	0 2, 537, 123	158	194.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	4, 192, 285	6, 498, 87	3 10, 691, 158	65, 323	202.00

Health Financial Systems ALLOCATION OF CAPITAL RELATED COSTS	LAPORTE H	OSPI TAL Provi der CO	CN: 15 0004 D	In Lieu eriod:	u of Form CMS-: Worksheet B	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider C		rom 03/01/2016	Part II Date/Time Pre 5/31/2017 9:2	
Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL 5.00	PLANT 7.00	LINEN SERVICE 8.00	9.00	10.00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00 00500 ADMINI STRATI VE & GENERAL	828, 573					5.00
7.00 00700 OPERATION OF PLANT	77, 692	3, 228, 628				7.00
8.00 00800 LAUNDRY & LINEN SERVICE	3, 929	4, 281	17, 121			8.00
9.00 00900 HOUSEKEEPING	13, 610	62, 246	8, 560	213, 961	010 0/0	9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	17, 144 2, 568	62, 288 40, 713	0	4, 215 2, 755	213, 062 106, 531	10.00 11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	35, 083	21, 203	0	1, 435	100, 531	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	10, 783	27,066	186	1, 831	0	
15. 00 01500 PHARMACY	20, 647	27, 472	0	1, 859	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	9,807	28, 944	0	1, 958	0	16.00
17. 00 01700 SOCIAL SERVICE INPATIENT ROUTINE SERVICE COST CENTERS	237	10, 364	0	701	0	17.00
30. 00 03000 ADULTS & PEDIATRICS	98, 943	246, 073	2, 703	16, 650	92, 291	30.00
31.00 03100 INTENSIVE CARE UNIT	33, 936	113, 569	943	7, 685	8, 410	31.00
40. 00 04000 SUBPROVI DER - I PF	0	0	0	0	0	40.00
41. 00 04100 SUBPROVI DER – I RF 43. 00 04300 NURSERY	0 200	0 9, 848	0	0 666	0	41.00 43.00
44.00 04400 SKILLED NURSING FACILITY	200	9, 646	0	000	0	43.00
ANCI LLARY SERVI CE COST CENTERS			-			
50. 00 05000 OPERATI NG ROOM	60, 052	279, 544	1, 128	18, 915	25	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	4, 886 18, 349	0 136, 100	0 252	0 9, 209	0 4, 808	51.00 52.00
53. 00 05300 ANESTHESI OLOGY	23, 201	0	232	9, 209	4, 808	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	47,606	100, 776	574	6, 819	0	54.00
54. 02 05402 ULTRASOUND	4, 718	16, 592	0	1, 123	0	54.02
56. 00 05600 RADI 0I SOTOPE	4,855	0	0	0	0	56.00
57.00 05700 CT SCAN 58.00 05800 MRI	8, 041 5, 565	16, 651 72, 086	0	1, 127 4, 878	0	57.00 58.00
60. 00 06000 LABORATORY	45, 816	59, 217	0	4,070	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	245	12, 090	0	818	0	62.00
65. 00 06500 RESPIRATORY THERAPY	8, 762	10, 813	0	732	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	22, 697 3, 257	274, 814 2, 911	40 10	18, 595 197	0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	10, 412	1, 718		116	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	57, 180	207, 847	151	14, 064	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	21,850	0	0	0	0	71.00
73.00 07300 DRUGS CHARGED TO PATIENTS	42, 151 42, 535			0	0	72.00 73.00
74. 00 07400 RENAL DI ALYSI S	491	24, 215	0	1, 638	0	
76.00 03950 OTHER ANCI LLARY-OTHER	0	0	0	0	0	
76.01 03610 SLEEP LAB	2, 538	0		0	0	
76. 97 07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76.97
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
90. 01 09001 DENTAL CLINIC	0	0	0	0	0	90. 01
90. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE 90. 03 09003 DIABETIC TRAINING	0	0	0	0	0	90. 02 90. 03
90. 03 109003 DTABETTC TRATITING 91. 00 109100 EMERGENCY	29, 556	82, 966	964	5, 614	997	90.03
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				-,		92.00
OTHER REIMBURSABLE COST CENTERS	-	-	-	-		
95. 00 09500 AMBULANCE SERVICES SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	95.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	789, 342	1, 952, 407	15, 634	127, 607	213, 062	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	943	46, 534	2	3, 149		190.00
190. 03 19001 PHYSI CLAN RECRUI TMENT 190. 04 19002 MARKETI NG / PUBLI C RELATI ONS	0 321	0	0	0		190. 03 190. 04
190. 05 19003 SPORTS MEDI CI NE	0	0	0	0		190.05
190. 06 19004 FOUNDATI ON	0	0	0	0		190. 06
191.00 19100 RESEARCH	0	0	0	0		191.00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES 193. 00 19300 NONPALD WORKERS	8, 291			0		192. 00 193. 00
193. 01 19301 FREESTANDING VNA & HOSPICE	0	0	0	0		193.00
193.02 19302 WELLNESS CENTER	0	0	0	0		193. 02
193. 03 19303 RENTAL PROPERTIES	0	0	0	0		193.03
193. 04 19304 STARKE HOSPI TAL 193. 05 19306 RETAL PHARMACY				0		193. 04 193. 05
193. 06 19305 VACANT	0	0	0	0	0	193.06
193. 07 19307 CONTINUING CARE - MILLERS	0	0	0	0		193.07
194.00 07951 OTHER NONREIMBURSABLE-MARKETING	29, 676	1, 229, 687	1, 485	83, 205	0	194.00

Health Fina	ancial Systems	LAPORTE H	IOSPI TAL		In Lieu of Form CMS-2552-10			
ALLOCATION OF CAPITAL RELATED COSTS			Provider C	Provider CCN: 15-0006		Worksheet B Part II		
						Date/Time Pre 5/31/2017 9:2		
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY		
		& GENERAL	PLANT	LINEN SERVICE				
		5.00	7.00	8.00	9.00	10.00		
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)	828, 573	3, 228, 628	17, 12	1 213, 961	213, 062	202.00	

Heal th Financial Syste		LAPORTE H		N. 45 000/ D		u of Form CMS-	2552-10
ALLOCATION OF CAPITAL	RELATED COSTS		Provider CC	IN: 15-0006 PE Fr Tc	eriod: com 03/01/2016 b 12/31/2016	Worksheet B Part II Date/Time Pre 5/31/2017 9:2	
Cost Cent	er Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	
		11.00	13.00	14.00	15.00	16.00	
GENERAL SERVICE		11					
	OSTS-BLDG & FIXT						1.00
	OSTS-MVBLE EQUIP BENEFITS DEPARTMENT						2.00 4.00
5. 00 00500 ADMI NI STR							5.00
7.00 00700 OPERATI ON							7.00
8.00 00800 LAUNDRY &	LINEN SERVICE						8.00
9.00 00900 HOUSEKEEP	I NG						9.00
10.00 01000 DI ETARY		007 550					10.00
11.00 01100 CAFETERIA 13.00 01300 NURSING A		237, 553	100 475				11.00 13.00
	ERVICES & SUPPLY	18, 470 6, 772	123, 675	103, 247			13.00
15.00 01500 PHARMACY		10, 436	10, 066	99	129, 601		15.00
16.00 01600 MEDICAL R	ECORDS & LI BRARY	11, 869	0	63	0	113, 771	16.00
17.00 01700 SOCIAL SE		0	0	0	0	0	17.00
	NE SERVICE COST CENTERS	F0.020	24 120	2 520	ol	E E20	20.00
30.00 03000 ADULTS & 31.00 03100 I NTENSI VE		50, 029 18, 278	36, 120 14, 330	3, 538 2, 390	0	5, 520 2, 013	
40. 00 04000 SUBPROVI D		0	14, 330	2, 370	0	2,019	40.00
41.00 04100 SUBPROVI D	ER – IRF	0	0	0	0	0	41.00
43.00 04300 NURSERY		0	0	0	0	0	43.00
44.00 04400 SKI LLED N		0	0	0	0	0	44.00
50. 00 05000 OPERATING	CE COST CENTERS	20, 402	17, 225	7, 509	0	22, 628	50.00
51.00 05100 RECOVERY		20, 402	17, 225	7, 509	0	22, 028	51.00
	ROOM & LABOR ROOM	7,645	7, 739	891	0	3, 271	52.00
53.00 05300 ANESTHESI		0	0	460	0	4, 122	53.00
54.00 05400 RADI OLOGY		21, 281	0	2, 811	9, 717	2, 792	54.00
54.02 05402 ULTRASOUN		0	0	136	0	107	54.02
56.00 05600 RADI 0I SOT 57.00 05700 CT SCAN	OPE	0	0	26	4, 450	1,832	56.00 57.00
58.00 05800 MRI		2, 887 1, 373	0	310 273	0	7, 121 2, 519	
60. 00 06000 LABORATOR	Y	20, 085	0	12, 671	0	14, 340	•
	OD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
65. 00 06500 RESPI RATO		5, 561	4, 333	217	0	1, 597	65.00
66.00 06600 PHYSI CAL		9, 275	6, 647	187	0	2, 618	•
67.00 06700 0CCUPATI 0		1,731	0	7	0	848	67.00
68.00 06800 SPEECH PA 69.00 06900 ELECTROCA		4, 547 13, 166	13, 417	65 17, 133	0	350 9, 775	
	UPPLIES CHARGED TO PATIENT	0	0	18, 290	56	4, 385	
	. CHARGED TO PATIENTS	0	0	33, 910	0	4, 658	72.00
	RGED TO PATIENTS	0	0	0	115, 378	15, 404	
74.00 07400 RENAL DIA		0	0	0	0	374	•
76.00 03950 OTHER ANC 76.01 03610 SLEEP LAB		0	0 1, 291	0 33	0	0	
76. 97 07697 CARDI AC R	EHABI LI TATI ON	0	0	0	0	0	•
	ICE COST CENTERS						
90.00 09000 CLINIC		0	0	0	0	0	90.00
90.01 09001 DENTAL CL		0	0	0	0	0	90.01
90. 02 09002 OTHER OUT 90. 03 09003 DI ABETI C	PATIENT SERVICE COST CENTE	0	0	0	0	0	90.02 90.03
91.00 09100 EMERGENCY		13, 746	12, 507	2, 184	0	7, 497	•
	ON BEDS (NON-DISTINCT PART						92.00
	BLE COST CENTERS						
95.00 09500 AMBULANCE		0	0	0	0	0	95.00
SPECIAL PURPOSE 118.00 SUBTOTALS	(SUM OF LINES 1-117)	237, 553	123, 675	103, 234	129, 601	113, 771	110 00
NONREI MBURSABLE		237, 353	125, 075	103, 234	129,001	113,771	1110.00
	WER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190.00
190. 03 19001 PHYSI CI AN		0	0	0	0	0	190. 03
190. 04 19002 MARKETI NG		0	0	0	0		190. 04
190. 05 19003 SPORTS ME		0	0	0	0		190.05
190.06 19004 FOUNDATI 0 191.00 19100 RESEARCH	IN	0	0	0	0		190.06 191.00
191. 00 19100 RESEARCH	S' PRIVATE OFFICES	0	0	13	0		191.00
193. 00 19300 NONPALD W		0	0	0	0		193.00
193. 01 19301 FREESTAND	ING VNA & HOSPICE	0	0	0	0	0	193. 01
193.02 19302 WELLNESS		0	0	0	0		193.02
193.03 19303 RENTAL PR		0	0	0	0		193.03
193.04 19304 STARKE HO 193.05 19306 RETAIL PH		0	0	0	0		193. 04 193. 05
193. 06 19305 VACANT		0	0	0	0		193.05
193. 07 19307 CONTI NUI N	G CARE - MILLERS	0	0	0	0		193.07

Health Financial Systems	LAPORTE H	IOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 03/01/2016	Worksheet B Part II	
				To 12/31/2016		
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11.00	13.00	14.00	15.00	16.00	
194.00 07951 OTHER NONREI MBURSABLE-MARKETING	0	0		0 0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	1	0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	237, 553	123, 675	103, 24	7 129, 601	113, 771	202.00

OCATI ON	OF CAPITAL RELATED COSTS		Provider C	CN: 15-0006	Period: From 03/01/2016	Worksheet B Part II
					To 12/31/2016	
	Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern & Residents Cos & Post Stepdown Adjustments	Total .t	
		17.00	24.00	25.00	26.00	
	ERAL SERVICE COST CENTERS 00 CAP REL COSTS-BLDG & FIXT	1				
	00 CAP REL COSTS-MUBLE EQUIP					
	00 EMPLOYEE BENEFITS DEPARTMENT					
0050	00 ADMINISTRATIVE & GENERAL					
0070	OO OPERATION OF PLANT					· ·
0080 0	00 LAUNDRY & LINEN SERVICE					
0090	00 HOUSEKEEPI NG					
0100	00 DI ETARY					10
	00 CAFETERI A					1
	00 NURSI NG ADMI NI STRATI ON					1
	00 CENTRAL SERVICES & SUPPLY					1
	00 PHARMACY					1
	00 MEDI CAL RECORDS & LI BRARY					1
	00 SOCIAL SERVICE	32, 690				1
	ATLENT ROUTINE SERVICE COST CENTERS	00.45-	4 604 47	1	0 4 004 4-1	
	00 ADULTS & PEDIATRICS	23, 157	1,091,126		0 1, 091, 126	30
		6, 812	446, 017		0 446, 017	3
	00 SUBPROVIDER - IPF	0	0		0 0	40
	00 SUBPROVIDER - IRF	0	0		0 0	4
		2, 721	33, 869		0 33, 869 0 0	4
	OO SKILLED NURSING FACILITY	0	0	1	0 0	4
	OO OPERATING ROOM	0	1,008,304	1	0 1,008,304	50
	00 RECOVERY ROOM	0	5, 508		0 5, 508	5
	00 DELIVERY ROOM & LABOR ROOM	0	470, 869		0 470, 869	5
	00 ANESTHESI OLOGY	0	27, 852		0 27,852	5
	00 RADI OLOGY-DI AGNOSTI C	0	404, 368		0 404, 368	5
	02 ULTRASOUND	0	57, 415		0 57, 415	5
	00 RADI OI SOTOPE	0	11, 447		0 11, 447	5
	00 CT SCAN	0	71, 072		0 71,072	5
	00 MRI	0	235, 750		0 235, 750	5
	00 LABORATORY	o	282, 445		0 282, 445	61
	00 WHOLE BLOOD & PACKED RED BLOOD CELL	0	38, 099		0 38,099	6
0650	00 RESPI RATORY THERAPY	0	55, 332		0 55, 332	6
0660	00 PHYSI CAL THERAPY	0	903, 422		0 903, 422	6
0670	00 OCCUPATI ONAL THERAPY	0	15, 265		0 15, 265	6
	00 SPEECH PATHOLOGY	0	21, 879		0 21, 879	6
	00 ELECTROCARDI OLOGY	0	764, 690		0 764, 690	6
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	44, 581		0 44, 581	7
	00 IMPL. DEV. CHARGED TO PATIENTS	0	80, 719		0 80, 719	7.
	00 DRUGS CHARGED TO PATIENTS	0	173, 317		0 173, 317	73
	00 RENAL DIALYSIS	0	76, 679		0 76, 679	7.
	50 OTHER ANCI LLARY-OTHER	0	0			70
	10 SLEEP LAB 97 CARDI AC REHABI LI TATI ON	0	4, 162		0 4, 162 0 0	70
	PATIENT SERVICE COST CENTERS	0	0	1		//
	00 CLINIC	0	0		0 0	90
	01 DENTAL CLINIC	0	0		0 0	90
	02 OTHER OUTPATIENT SERVICE COST CENTE	0	0		0 0	90
	03 DI ABETI C TRAI NI NG	0	0		0 0	90
	00 EMERGENCY	0	330, 118		0 330, 118	9
	00 OBSERVATION BEDS (NON-DISTINCT PART				0	9:
	ER REIMBURSABLE COST CENTERS	· 1		•		
	00 AMBULANCE SERVI CES	0	0		0 0	9!
	CIAL PURPOSE COST CENTERS					
00	SUBTOTALS (SUM OF LINES 1-117)	32, 690	6, 654, 305		0 6, 654, 305	118
	REIMBURSABLE COST CENTERS		A 4 4 4 7 7 7		0 444 46-	
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	146, 638		0 146, 638	190
	01 PHYSICIAN RECRUITMENT	0	0		0 0	190
	02 MARKETING / PUBLIC RELATIONS	0	577		0 577	190
		0	0		0	190
		0	0		0	190 19
	00 RESEARCH	0	0 204			
	00 PHYSICIANS' PRIVATE OFFICES	0	8, 304		0 8, 304	19:
	00 NONPALD WORKERS	0	0		0	19:
	01 FREESTANDING VNA & HOSPICE	0	0		0	19:
	02 WELLNESS CENTER	0	0		0	19:
03 1930	03 RENTAL PROPERTIES 04 STARKE HOSPITAL	0	0		0	19: 19:
01 1000						

Health Financial Systems	LAPORTE HO	SPI TAL		In Lie	u of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO		Peri od:	Worksheet B
				From 03/01/2016 To 12/31/2016	
					5/31/2017 9:23 am
Cost Center Description	SOCI AL SERVI CE	Subtotal	Intern &	Total	
			Residents Cos	st	
			& Post		
			Stepdown		
			Adjustments		
	17.00	24.00	25.00	26.00	
193. 06 19305 VACANT	0	0		0 0	193.06
193.07 19307 CONTINUING CARE - MILLERS	0	0		0 0	193. 07
194.0007951 OTHER NONREIMBURSABLE-MARKETING	0	3, 881, 334		0 3, 881, 334	194.00
200.00 Cross Foot Adjustments		0		0 0	200.00
201.00 Negative Cost Centers	0	0		0 0	201.00
202.00 TOTAL (sum lines 118-201)	32, 690	10, 691, 158		0 10, 691, 158	202.00

COST ALLOCATION - STATISTICAL	BASIS	EXTORTE IN	OSPITAL Provider (CCN: 15-0006 F	Period:	wof Form CMS- Worksheet B-1	
				F	From 03/01/2016 To 12/31/2016		
		CAPITAL REI	ATED COSTS			373172017 3.2	
Cost Center Descri	ption	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconci l i ati on	ADMI NI STRATI VE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5.00	
GENERAL SERVICE COST CEI		612, 447					1.00
2.00 00200 CAP REL COSTS-MVBL 4.00 00400 EMPLOYEE BENEFITS	LE EQUIP DEPARTMENT	3, 742	612, 44 3, 74	2 42, 550, 013			2.00 4.00
5.00 00500 ADMINI STRATI VE & 0 7.00 00700 OPERATI ON OF PLANT		46, 718 180, 387	46, 71 180, 38			84, 319, 274 7, 906, 008	
8.00 00800 LAUNDRY & LI NEN SE		506	50				
9.00 00900 HOUSEKEEPI NG		7,357	7,35			.,	
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A		7,362	7,36				
11.00 01100 CAFETERIA 13.00 01300 NURSING ADMINISTRA	ATLON	4,812	4, 81 2, 50				
14. 00 01400 CENTRAL SERVICES &		3, 199	3, 19			1, 097, 281	
15.00 01500 PHARMACY		3, 247	3, 24			2, 101, 042	15.00
16.00 01600 MEDICAL RECORDS &	LI BRARY	3, 421	3, 42				
17.00 01700 SOCIAL SERVICE	CE COST CENTERS	1, 225	1, 22	5 2, 290	0 0	24, 123	17.00
30. 00 03000 ADULTS & PEDI ATRI 0		29,084	29, 08	4 5, 471, 030	0 0	10, 071, 694	30.00
31.00 03100 INTENSIVE CARE UNI	Т	13, 423	13, 42	3 2, 171, 287			
40. 00 04000 SUBPROVIDER - IPF		0		0 0	-		
41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY		0	1, 16	0 0 4 0	-	-	
44. 00 04400 SKI LLED NURSI NG FA	ACI LI TY	0		0 0			
ANCILLARY SERVICE COST (CENTERS	-					
50. 00 05000 OPERATI NG ROOM		33, 040					
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LA	ABOR ROOM	0 16, 086	16, 08	0 384, 972 6 1, 172, 605			
53. 00 05300 ANESTHESI OLOGY		0	10,00	0 44, 766			
54.00 05400 RADI OLOGY-DI AGNOST	TI C	11, 911	11, 91	1 2, 650, 514	1 O	.,	
54. 02 05402 ULTRASOUND		1, 961	1, 96			480, 097	
56. 00 05600 RADI OI SOTOPE 57. 00 05700 CT SCAN		1, 968	1, 96	0 184, 698 8 378, 434		494, 055 818, 222	
58. 00 05800 MRI		8, 520	8, 52				
60.00 06000 LABORATORY		6, 999	6, 99			.,	
62.00 06200 WHOLE BLOOD & PACK		1, 429			-		
65. 00 06500 RESPI RATORY THERAF 66. 00 06600 PHYSI CAL THERAPY	γ	1, 278 32, 481	1, 27 32, 48				
67.00 06700 OCCUPATIONAL THERA	\ PY	344	34			331, 386	
68.00 06800 SPEECH PATHOLOGY		203	20				
69.00 06900 ELECTROCARDI OLOGY	NUADOED TO DATIENT	24, 566	24, 56	6 2, 032, 902	2 0		
71.00 07100 MEDICAL SUPPLIES 0 72.00 07200 IMPL. DEV. CHARGEE		0				2, 223, 438 4, 289, 344	
73. 00 07300 DRUGS CHARGED TO F		0		0 0	0 0	4, 328, 409	
74.00 07400 RENAL DIALYSIS		2, 862	2, 86	2 (0 0	49, 961	
76. 00 03950 OTHER ANCI LLARY-07 76. 01 03610 SLEEP LAB	THER	0				0	
76. 01 03610 SLEEP LAB 76. 97 07697 CARDI AC REHABI LI TA	ATLON	0		0 195,660 0 0			
OUTPATIENT SERVICE COST				· · · · · · · · · · · · · · · · · · ·			
90. 00 09000 CLINIC		0		0 0	0	0	
90. 01 09001 DENTAL CLINIC 90. 02 09002 OTHER OUTPATIENT S	SERVICE COST CENTE					0	
90. 03 09003 DI ABETI C TRAI NI NG	CANTOL OUST OLNIL	0		o o	Ó	0	
91.00 09100 EMERGENCY		9, 806	9, 80	6 1, 894, 987	7 0	3, 007, 661	
92.00 09200 OBSERVATI ON BEDS (92.00
95.00 09500 AMBULANCE SERVICES		0		0 0	120	0	95.00
SPECIAL PURPOSE COST CEI		0		<u> </u>	120	0	75.00
118.00 SUBTOTALS (SUM OF NONREI MBURSABLE COST CEI	LINES 1-117) NTERS	461, 607	461, 60		1		
190. 00 19000 GI FT, FLOWER, COFF		5, 500	5, 50		-		190.00
190. 03 19001 PHYSI CI AN RECRUI TM 190. 04 19002 MARKETI NG / PUBLI C				0 166, 912	-	32 713	190. 03 190. 04
190. 05 19003 SPORTS MEDI CI NE	, REENTIONO	0		0 (190.04
190. 06 19004 FOUNDATI ON		0		0 0	0 0	0	190.06
191.00 19100 RESEARCH		0					191.00
192.00 19200 PHYSI CI ANS' PRI VAT 193.00 19300 NONPAI D WORKERS	E UFFICES				0 וע ה (נ	843, 667	192.00 193.00
193. 01 19301 FREESTANDI NG VNA &	HOSPI CE	0		o c	0 0		193.00
193.02 19302 WELLNESS CENTER		0		0 0	-		193. 02 193. 03
193. 03 19303 RENTAL PROPERTIES				0 0	0 0		

Health Financial Systems	LAPORTE H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CC		Peri od:	Worksheet B-1	
				From 03/01/2016 To 12/31/2016		narodi
				12/31/2010	5/31/2017 9:2	
	CAPI TAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS			
	1.00		SALARI ES)			
	1.00	2.00	4.00	5A	5.00	100.01
193. 04 19304 STARKE HOSPITAL	0	0	(0		193.04
193. 05 19306 RETAIL PHARMACY	0	0	(0		193.05
193. 06 19305 VACANT	0	0	(0 0		193.06
193. 07 19307 CONTINUING CARE - MILLERS	0	0	(0 0		193. 07
194.00 07951 OTHER NONREI MBURSABLE-MARKETI NG	145, 340	145, 340	102, 650	0 0	3, 019, 871	
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	4, 192, 285	6, 498, 873	8, 339, 424	1	28, 420, 366	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	6. 845139	10. 611323			0. 337057	
204.00 Cost to be allocated (per Wkst. B,			65, 323	3	828, 573	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part			0.001535		0.009827	205.00
)	l			1		

COST A	Financial Systems ALLOCATION - STATISTICAL BASIS	LAPORTE H	Provider C		Peri od:	u of Form CMS- Worksheet B-1	
					From 03/01/2016 To 12/31/2016	Date/Time Pre 5/31/2017 9:2	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DI ETARY	CAFETERI A	
		PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(SQUARE FEET)	(MEALS SERVED)	(HOURS)	
		7.00	LAUNDRY) 8.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT	381, 600					7.00
3.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	506 7, 357			7		8.00
10.00	01000 DI ETARY	7, 362		7, 362			10.00
1.00	01100 CAFETERI A	4, 812		4, 812		47, 074	
3.00	01300 NURSI NG ADMI NI STRATI ON	2,506		2, 506		3, 660	
4.00 5.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	3, 199 3, 247		3, 199 3, 247		1, 342 2, 068	
16.00	01600 MEDICAL RECORDS & LIBRARY	3, 421		3, 421		2, 352	
7.00	01700 SOCIAL SERVICE	1, 225		1, 225		0	
	INPATIENT ROUTINE SERVICE COST CENTERS	00.004	07.050	00.00		0.014	
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 I NTENSI VE CARE UNI T	29, 084 13, 423				9, 914 3, 622	
10.00	04000 SUBPROVIDER - IPF	0		(0,022	40.00
1. 00	04100 SUBPROVI DER – I RF	0	0	0	-	0	41.00
13.00		1, 164		1, 164		0	43.00
14.00	04400 SKI LLED NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	0	0	(0 0	0	44.00
50.00	05000 OPERATING ROOM	33, 040	36, 315	33, 040	25	4,043	50.00
51.00	05100 RECOVERY ROOM	0			0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	16, 086	8, 131	16, 086		1, 515	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	11, 911	18, 475	11, 911		0 4, 217	53.00 54.00
54.02	05402 ULTRASOUND	1, 961		1, 961	-	0	54.02
56.00	05600 RADI OI SOTOPE	0				0	56.00
57.00	05700 CT SCAN	1,968		1, 968		572	
58.00 50.00	05800 MRI 06000 LABORATORY	8, 520 6, 999		8, 520 6, 999		272 3, 980	
52.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	1, 429		1, 429		0	62.00
5.00	06500 RESPI RATORY THERAPY	1, 278		1, 278		1, 102	
6.00	06600 PHYSI CAL THERAPY	32, 481				1,838	
57.00 58.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	344 203				343 901	67.00
59.00	06900 ELECTROCARDI OLOGY	24, 566				2,609	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0		0	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	0		0	0	72.00
		2,862	0	2, 862		0	
76.00	03950 OTHER ANCI LLARY-OTHER	0	0	(0 0	0	
76.01	03610 SLEEP LAB	0	0	(0	0	
6.97	07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	0	0	(0 0	0	76.97
90.00		0	0	(0 0	0	90.00
90. 01	09001 DENTAL CLINIC	0	0	C	0 0	0	90.01
90.02	09002 OTHER OUTPATIENT SERVICE COST CENTE	0	0			0	90.02
90.03 91.00	09003 DI ABETI C TRAI NI NG 09100 EMERGENCY	9, 806	0 31, 061	9, 806	5 1,006	0 2, 724	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	7,000	51,001	9,000	1,000	2,724	92.00
	OTHER REIMBURSABLE COST CENTERS		1				
95.00	09500 AMBULANCE SERVICES	0	0	(0 0	0	95.00
18.00	SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117)	230, 760	503, 496	222, 897	7 214, 943	47, 074	1118 00
110.00	NONREI MBURSABLE COST CENTERS	230,700	003,470	222,077	214, 743	47,074	
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 500	79	5, 500	0 0		190. 00
	19001 PHYSICIAN RECRUITMENT	0	0				190.03
	19002 MARKETING / PUBLIC RELATIONS 19003 SPORTS MEDICINE		0 0				190. 04 190. 05
	19004 FOUNDATI ON	0	0				190.06
191. OC	19100 RESEARCH	0	0	0	0 0	0	191.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0				192.00
) 19300 NONPALD WORKERS I 19301 FREESTANDI NG VNA & HOSPI CE		0 0				193. 00 193. 0
	19302 WELLNESS CENTER	0	0				193.02
93.03	19303 RENTAL PROPERTIES	0	0	C	0 0	0	193. 03
	19304 STARKE HOSPITAL	0	0	(193.04
	5 19306 RETAIL PHARMACY	0	y 0	(ס וי	0	193. 05

Health Financial Systems	LAPORTE H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period:	Worksheet B-1	
				From 03/01/2016 To 12/31/2016		
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPING	DIETARY	CAFETERI A	
	PLANT	LINEN SERVICE	(SQUARE FEET)	(MEALS SERVED)	(HOURS)	
	(SQUARE FEET)	(POUNDS OF	. ,			
		LAUNDRY)				
	7.00	8.00	9.00	10.00	11.00	
193. 07 19307 CONTI NUI NG CARE – MI LLERS	0	0		0 0	0	193.07
194.00079510THER NONREIMBURSABLE-MARKETING	145, 340	47, 839	145, 34	0 0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	10, 570, 783	548, 555	2, 329, 86	2 2, 582, 450	1, 803, 916	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	27. 701213	0. 994815	6. 23396	1 12.014581	38. 320857	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	3, 228, 628	17, 121	213, 96	1 213, 062	237, 553	204. 00
205.00 Unit cost multiplier (Wkst. B, Part	8. 460765	0. 031049	0. 57249	0. 991249	5.046374	205.00

	Financial Systems LLOCATION - STATISTICAL BASIS	LAPORTE HO	Provider C	CN: 15-0006 P	eri od:	u of Form CMS-2 Worksheet B-1	
					rom 03/01/2016 o 12/31/2016	Date/Time Pre 5/31/2017 9:2	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON (DI RECT	CENTRAL SERVI CES & SUPPLY (BI LLABLE	PHARMACY (100% ALLOCAT)	MEDI CAL RECORDS & LI BRARY (GROSS CHAR	(PATIENT DAYS)	
		NRSING) 13.00	SUPPLIE) 14.00	15.00	GES) 16.00	17.00	
	GENERAL SERVICE COST CENTERS	10.00	14.00	13.00	10.00	17:00	
$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-WVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINI STRATI ON 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	18, 737, 238 0 1, 525, 194 0 0	12, 895, 171 12, 368 7, 855 0	4, 862, 148 0	418, 230, 187	16, 533	1.00 2.00 4.00 5.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 16.00 17.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1			1
31.00 40.00 41.00 43.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY	5, 471, 030 2, 171, 287 0 0 0 0	441, 842 298, 535 0 0 0 0 0	1	7, 400, 916 0 0 0	11, 712 3, 445 0 0 1, 376 0	31.00 40.00 41.00 43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	2, 609, 839	937, 866	0	83, 139, 909	0	50.00
52.00 53.00 54.00 54.02	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05402 ULTRASOUND	0 1, 172, 605 0 0 0	3, 839 111, 233 57, 407 351, 102 17, 007	0 0 364, 534	12, 023, 900 15, 155, 677	0 0 0 0	
57.00 58.00 60.00 62.00	05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI 06000 LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06500 RESPI RATORY THERAPY	0 0 0 0 0 656, 566	3, 221 38, 706 34, 046 1, 582, 471 0 27, 135		26, 179, 296 9, 260, 198	0 0 0 0 0	56.00 57.00 58.00 60.00 62.00 65.00
67.00 68.00 69.00 71.00 72.00	06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	1, 007, 168 0 2, 032, 902 0 0	23, 345 825 8, 109 2, 139, 724 2, 284, 259 4, 235, 808 0	0 0 2, 099 0	17, 126, 806		
74.00 76.00 76.01 76.97	07400 RENAL DI ALYSI S 03950 OTHER ANCI LLARY-OTHER 03610 SLEEP LAB 07697 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS	0 0 195, 660 0	0 0 4, 133 0	0	1, 375, 611 0 77 0	0 0 0 0	74.00 76.00 76.01
90. 01 90. 02 90. 03 91. 00 92. 00	09000 CLINIC 09001 DENTAL CLINIC 09002 OTHER OUTPATIENT SERVICE COST CENTE 09003 DIABETIC TRAINING 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART 07HER REIMBURSABLE COST CENTERS	0 0 0 1, 894, 987	0 0 0 272, 716		0 0 0 27, 564, 237	0 0 0 0	90. 01 90. 02
	09500 AMBULANCE SERVI CES	0	0	0	0	0	95.00
	NONREI MBURSABLE COST CENTERS	18, 737, 238	12, 893, 552	1			118.00
190. 03 190. 04 190. 05 190. 06 191. 00 192. 00 193. 00 193. 01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19001 PHYSICIAN RECRUITMENT 19002 MARKETING / PUBLIC RELATIONS 19003 SPORTS MEDICINE 19004 FOUNDATION 19100 RESEARCH 19200 PHYSICIANS' PRIVATE OFFICES 19300 NONPAID WORKERS 19301 FREESTANDING VNA & HOSPICE 19302 WELLNESS CENTER		0 0 0 0 0 1, 619 0 0 0			0 0 0 0 0 0 0 0 0 0 0	190. 00 190. 03 190. 04 190. 05 190. 06 191. 00 192. 00 193. 00 193. 01 193. 02
193. 03 193. 04	19302 WELLNESS CENTER 19303 RENTAL PROPERTIES 19304 STARKE HOSPITAL 19306 RETAIL PHARMACY	0	000000000000000000000000000000000000000		0 0 0	0	193. 02 193. 03 193. 04 193. 05

Health Financial Systems	LAPORTE HO	OSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-0006	Peri od:	Worksheet B-1	
				From 03/01/2016 To 12/31/2016		
Cost Center Description	NURSI NG	CENTRAL	PHARMACY		SOCIAL SERVICE	
	ADMI NI STRATI ON		(100% ALLOCA	· .		
		SUPPLY			(PATIENT DAYS)	
	(DI RECT	(BI LLABLE		(GROSS CHAR		
	NRSING)	SUPPLIE)		GES)		
	13.00	14.00	15.00	16.00	17.00	
193. 06 19305 VACANT	0	0		0 0	0	193.06
193. 07 19307 CONTINUING CARE – MILLERS	0	0		0 0	0	193.07
194.0007951 OTHER NONREIMBURSABLE-MARKETING	0	0		0 0	0	194.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	4, 998, 618	1, 633, 073	3, 407, 09	99 1, 541, 621	73, 825	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 266775	0. 126642	0. 70073	0. 003686	4. 465312	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	123, 675	103, 247	129, 60	113, 771	32, 690	204. 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 006600	0. 008007	0. 02665	0. 000272	1. 977258	205.00

COMPUTATION	N OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 03/01/2016	Worksheet C Part I	
					To 12/31/2016	Date/Time Pre 5/31/2017 9:2	pared: 3 am
			Title	XVIII	Hospi tal	PPS	-
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS						
0.00 0300	0 ADULTS & PEDIATRICS	17, 681, 087		17, 681, 08	7 0	17, 681, 087	30. 00
	O INTENSIVE CARE UNIT	6,003,549		6, 003, 54	9 0	6, 003, 549	31.00
0.00 0400	0 SUBPROVIDER - IPF	0			0 0	0	40.00
1.00 0410	0 SUBPROVIDER - IRF	0			0 0	0	41.00
3.00 0430	0 NURSERY	76, 451		76, 45	1 0	76, 451	43.00
4.00 0440	O SKILLED NURSING FACILITY	0			0 0	0	44. OC
	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM	10, 604, 755		10, 604, 75	5 0		
	O RECOVERY ROOM	665, 232		665, 23	2 0		
	O DELIVERY ROOM & LABOR ROOM	3, 538, 079		3, 538, 07	9 0	3, 538, 079	52.00
	0 ANESTHESI OLOGY	3, 219, 836		3, 219, 83	6 0	3, 219, 836	53.00
	0 RADI OLOGY-DI AGNOSTI C	7, 399, 194		7, 399, 19		7, 399, 194	
	2 ULTRASOUND	712, 063		712, 06		712, 063	
	0 RADI OI SOTOPE	802, 802		802, 80	2 0	802, 802	56.00
	O CT SCAN	1, 284, 112		1, 284, 11			
	0 MRI	1, 095, 227		1, 095, 22		1, 095, 227	
	0 LABORATORY	7, 018, 446		7, 018, 44		7, 018, 446	
	O WHOLE BLOOD & PACKED RED BLOOD CELL	81, 847		81, 84		81, 847	
	0 RESPI RATORY THERAPY	1, 477, 973	0	.,,		1, 477, 973	
	0 PHYSI CAL THERAPY	4, 569, 183	0	.,		4, 569, 183	
	0 OCCUPATI ONAL THERAPY	479, 822	0	479, 82	2 0	479, 822	
	O SPEECH PATHOLOGY	1, 464, 099	0	1, 464, 09		1, 464, 099	
	0 ELECTROCARDI OLOGY	9, 664, 086		9, 664, 08		9, 664, 086	
	O MEDICAL SUPPLIES CHARGED TO PATIENT	3, 323, 043		3, 323, 04		3, 323, 043	
	OIMPL. DEV. CHARGED TO PATIENTS	6, 334, 662		6, 334, 66		6, 334, 662	
	O DRUGS CHARGED TO PATIENTS	9, 029, 284		9, 029, 28		9, 029, 284	
	O RENAL DIALYSIS	168, 995		168, 99		168, 995	
	O OTHER ANCI LLARY-OTHER	0			0 0	0	
	O SLEEP LAB	398, 040		398, 04			
6. 97 0769 0UTP	7 CARDIAC REHABILITATION ATIENT SERVICE COST CENTERS	0			0 0	0	76.9
		0			0 0	0	90.00
	1 DENTAL CLINIC	0			0 0		
	2 OTHER OUTPATIENT SERVICE COST CENTE	0			0 0	0	
	3 DI ABETI C TRAI NI NG	0			0 0	0	1
	0 EMERGENCY	5, 143, 229		5, 143, 22	9 0	5, 143, 229	
2.00 0920	O OBSERVATION BEDS (NON-DISTINCT PART R REIMBURSABLE COST CENTERS	2, 838, 707		2, 838, 70		2, 838, 707	
	O AMBULANCE SERVICES	0			0 0	0	95.0
	Subtotal (see instructions)	105, 073, 803	0		-	-	
		100,073,803	0				
200.00	Less Observation Beds	2, 838, 707		2, 838, 70	7	2, 838, 707	201 00

Cost Center Description Inpatient Out 6.00 6		btal (col. 6 + col. 7) 8.00 17, 159, 62! 7, 300, 166 (1, 686, 314	0 0. 134540 0 0. 151925 0 0. 294254 7 0. 212451 9 0. 720755 7 0. 133894 1 0. 119162 9 0. 061555	5/31/2017 9: 2: PPS TEFRA Inpati ent Rati o 10. 00 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000	30. 00 31. 00 40. 00 43. 00 44. 00 50. 00 51. 00 52. 00 53. 00 54. 00
Cost Center Description Inpatient Out 6.00 6	tpati ent Tot 7.00 49,565,164 3,252,099 713,354 10,412,513 8,310,552 4,555,742 5,742,017	+ col. 7) 8.00 17, 159, 629 7, 300, 166 (1, 686, 314 (1, 686, 314 (1, 686, 314 (1, 686, 314 (1, 686, 314 (1, 686, 314 (1, 025, 886 5, 318, 10 6, 737, 06	Rati o 9.00 0.134540 0.0.151925 0.294254 7.0.212451 9.0.720755 7.0.133894 1.0.119162 9.0.061555	Inpati ent Rati o 10.00 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000	31.00 40.00 41.00 43.00 44.00 50.00 51.00 52.00 53.00 54.00
INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 17, 159, 625 31.00 03100 INTENSI VE CARE UNI T 7, 300, 166 00.00 SUBPROVI DER - IPF 0 11.00 04100 SUBPROVI DER - IRF 0 13.00 04300 NURSERY 1, 686, 314 04400 SKI LLED NURSI NG FACI LI TY 0 ANCI LLARY SERVI CE COST CENTERS 0 50.00 05000 OPERATI NG ROOM 1, 126, 599 52.00 05100 RECOVERY ROOM 1, 126, 599 52.00 05200 DELI VERY ROOM & LABOR ROOM 11, 310, 546 53.00 05300 ANDI OLOGY -DI AGNOSTI C 1, 955, 337 54.00 05400 RADI OLOGY -DI AGNOSTI C 1, 955, 337 54.00 05400 RADI OLOGY -DI AGNOSTI C 1, 222, 748 50.00 05000 MRI 1, 222, 748 5459, 068 52.00 06500 RADRATORY 16, 239, 846 52 50.00 06500 RESPI RATORY THERAPY 1, 74, 491 55 <tr< th=""><th>49, 565, 164 3, 252, 099 713, 354 10, 412, 513 8, 310, 552 4, 555, 742 5, 742, 017</th><th>17, 159, 629 7, 300, 166 (1, 686, 314 78, 822, 386 4, 378, 699 12, 023, 900 15, 155, 67 10, 265, 886 5, 318, 10 6, 737, 06</th><th>5 5 6 0</th><th>0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000</th><th>31.00 40.00 41.00 43.00 44.00 50.00 51.00 52.00 53.00 54.00</th></tr<>	49, 565, 164 3, 252, 099 713, 354 10, 412, 513 8, 310, 552 4, 555, 742 5, 742, 017	17, 159, 629 7, 300, 166 (1, 686, 314 78, 822, 386 4, 378, 699 12, 023, 900 15, 155, 67 10, 265, 886 5, 318, 10 6, 737, 06	5 5 6 0	0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000	31.00 40.00 41.00 43.00 44.00 50.00 51.00 52.00 53.00 54.00
30.00 03000 ADULTS & PEDIATRICS 17, 159, 625 31.00 03100 INTENSIVE CARE UNIT 7, 300, 166 10.00 04000 SUBPROVI DER - IPF 0 11.00 04100 SUBPROVI DER - IRF 0 11.00 04400 SKI LLED NURSI NG FACILITY 0 ANCILLARY SERVICE COST CENTERS 0 0 60.00 05000 OPERATING ROOM 1, 126, 599 52.00 05200 DELIVERY ROOM 1, 126, 599 52.00 05200 DELIVERY ROOM 1, 126, 599 52.00 05400 RADI OLOGY -DI AGNOSTIC 1, 955, 337 54.00 05400 RADI OLOGY -DI AGNOSTIC 1, 955, 337 54.00 05400 RADI OLOGY -DI AGNOSTIC 1, 955, 337 54.00 05600 RADI OLOGY -DI AGNOSTIC 1, 222, 748 56.00 05600 RADI OLOGY -DI AGNOSTIC 1, 222, 748 52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 16, 102 55.00 06500 RESPI RATORY THERAPY 1, 174, 4	3, 252, 099 713, 354 10, 412, 513 8, 310, 552 4, 555, 742 5, 742, 017	7, 300, 166 (1, 686, 314) 78, 822, 386 4, 378, 696 12, 023, 900 15, 155, 67 10, 265, 886 5, 318, 10 6, 737, 06	0 0. 134540 0 0. 151925 0 0. 294254 7 0. 212451 9 0. 720755 7 0. 133894 1 0. 119162 9 0. 061555	0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000	31.00 40.00 41.00 43.00 44.00 50.00 51.00 52.00 53.00 54.00
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50.00 06000 LABORATORY 16, 239, 846 3 52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 16, 102 55.00 06500 RESPI RATORY THERAPY 4, 920, 129 56.00 06600 PHYSI CAL THERAPY 1, 174, 491 57.00 06700 OCCUPATI ONAL THERAPY 1, 516, 882 58.00 06800 SPEECH PATHOLOGY 438, 204 59.00 06900 ELECTROCARDI OLOGY 9, 419, 978 2 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 7, 550, 266 7 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 10, 092, 276 73.00 OR300 DRUGS CHARGED TO PATI ENTS 10, 375, 611 7 74.00 07400 RENAL DI ALYSI S 1, 375, 611 7 76.01 03610 SLEEP LAB 189, 104 7 76.97 CARDI AC REHABI LI TATI ON 0 0 0 0010 09000 CLI NI C 0 0 0 00.01 <td>8,037,450</td> <td>9, 260, 198</td> <td></td> <td>0.000000</td> <td>•</td>	8,037,450	9, 260, 198		0.000000	•
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 16, 102 55.00 06500 RESPI RATORY THERAPY 4, 920, 129 56.00 06600 PHYSI CAL THERAPY 1, 174, 491 57.00 06700 OCUPATI ONAL THERAPY 1, 174, 491 57.00 06700 OCUPATI ONAL THERAPY 1, 516, 882 58.00 06800 SPEECH PATHOLOGY 438, 204 59.00 06900 ELECTROCARDI OLOGY 9, 419, 978 51.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 7, 550, 266 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 10, 092, 276 73.00 07300 DRUGS CHARGED TO PATI ENTS 1, 375, 611 76 74.00 07400 RENAL DI ALYSI S 1, 375, 611 76 76.01 0350 OTHER ANCI LLARY-OTHER 0 0 76.01 03610 SLEEP LAB 189, 104 76 76.97 CARDI AC REHABI LI TATI ON 0 0 0 00100 099000 CLI NI C	36, 229, 519	52, 469, 36		0.000000	
55.00 06500 RESPI RATORY THERAPY 4, 920, 129 66.00 06600 PHYSI CAL THERAPY 1, 174, 491 57.00 06700 0CUPATI ONAL THERAPY 1, 516, 882 58.00 06800 SPECH PATHOLOGY 438, 204 59.00 06900 ELECTROCARDI OLOGY 9, 419, 978 2 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 7, 550, 266 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 10, 092, 276 73.00 07300 DRUGS CHARGED TO PATI ENTS 27, 862, 513 2 74.00 07400 RENAL DI ALYSI S 1, 375, 611 7 76.01 03610 SLEEP LAB 189, 104 0 76.01 03610 SLEEP LAB 189, 104 76.97 CARDI AC REHABI LI TATI ON 0 0 00 09000 CLI NI C 0 00.01 09001 DENTAL CLI NI C 0 00.02 09002 CHAR OUTPATI ENT SERVICE COST CENTE 0 00.03 09003 DI ABETI C TRAI NI NG 0	236, 407	252, 50		0.000000	
56.00 06600 PHYSI CAL THERAPY 1,174,491 57.00 06700 OCCUPATI ONAL THERAPY 1,516,882 58.00 06800 SPEECH PATHOLOGY 438,204 59.00 06900 ELECTROCARDI OLOGY 9,419,978 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 7,550,266 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 10,092,276 73.00 07300 DRUGS CHARGED TO PATI ENTS 27,862,513 2 74.00 07400 RENAL DI ALYSI S 1,375,611 0 76.01 03610 SLEEP LAB 189,104 0 76.07 07697 CARDI AC REHABI LI TATI ON 0 0 00 09000 CLI NI C 0 0 0 00.01 09001 DENTAL CLINI C 0 0 0 00.02 09002 OTHER OUTPATI ENT SERVICE COST CENTE 0 0 0 00.02 09003 DI ABETI C TRAI NI NG 0 0 0 <td>951, 930</td> <td>5, 872, 05</td> <td></td> <td>0.000000</td> <td></td>	951, 930	5, 872, 05		0.000000	
57.00 06700 OCCUPATI ONAL THERAPY 1,516,882 58.00 06800 SPEECH PATHOLOGY 438,204 59.00 06900 ELECTROCARDI OLOGY 9,419,978 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 7,550,266 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 10,092,276 73.00 07300 DRUGS CHARGED TO PATI ENTS 27,862,513 2 74.00 07400 RENAL DI ALYSI S 1,375,611 7 76.01 03610 SLEEP LAB 189,104 7 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0UTPATI ENT SERVICE COST CENTERS 0 0 0 0 00.01 09000 CLI NI C 0 0 0 0 00.02 09000 DI AL CLI NI C 0 0 0 0 00.02 09000 DI TAL CLI NI C 0 0 0 0 00.02 090001 DENTAL CLI NI C 0	6, 736, 873	7, 911, 36		0.000000	
58.00 06800 SPEECH PATHOLOGY 438, 204 59.00 06900 ELECTROCARDI OLOGY 9, 419, 978 22 71.00 OT100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 7, 550, 266 72.00 07200 I MPL. DEV. CHARGED TO PATI ENTS 10, 092, 276 73.00 07300 DRUGS CHARGED TO PATI ENTS 27, 862, 513 27 74.00 07400 RENAL DI ALYSI S 1, 375, 611 0 76.00 03950 OTHER ANCI LLARY-OTHER 0 0 76.01 03610 SLEEP LAB 189, 104 0 76.97 O7697 CARDI AC REHABI LI TATI ON 0 0 001700 CLINI C 0 0 0 0 00.01 OPOOL CLI NI C 0 0 0 0 0 00.02 09002 OTHER OUTPATI ENT SERVICE COST CENTE 0 0 0 00.02 09003 DI ABETI C TRAI NI NG 0 0	1, 599, 114	3, 115, 990		0.000000	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 7,550,266 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 10,092,276 73.00 07300 DRUGS CHARGED TO PATI ENTS 27,862,513 27 74.00 07400 RENAL DI ALYSI S 1,375,611 7 76.00 03950 OTHER ANCI LLARY-OTHER 0 0 76.01 03610 SLEEP LAB 189,104 0 76.97 CARDI AC REHABI LI TATI ON 0 0 0000 CLI NI C 0 0 0 90.01 09001 DENTAL CLI NI C 0 0 90.02 07HER OUTPATI ENT SERVICE COST CENTE 0 0 90.02 07HER OUTPATI ENT SERVICE COST CENTE 0 0 90.03 DI ABETI C TRAI NI NG 0 0	2, 561, 051	2, 999, 25		0.000000	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 7,550,266 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 10,092,276 73.00 07300 DRUGS CHARGED TO PATI ENTS 27,862,513 74.00 07400 RENAL DI ALYSI S 1,375,611 76.00 03950 OTHER ANCI LLARY-OTHER 0 76.01 03610 SLEEP LAB 189,104 76.97 CARDI AC REHABI LI TATI ON 0 0UTPATI ENT SERVI CE COST CENTERS 0 70.00 09000 CLI NI C 0 70.01 09001 DENTAL CLI NI C 0 70.02 09002 OTHER OUTPATI ENT SERVI CE COST CENTE 0 70.02 09003 DI ABETI C TRAI NI NG 0	23, 936, 379	33, 356, 35	0. 289722	0. 000000	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 27,862,513 2 74.00 07400 RENAL DI ALYSI S 1,375,611 1 76.00 03950 OTHER ANCI LLARY-OTHER 0 0 76.01 03610 SLEEP LAB 189,104 0 76.97 CARDI AC REHABILI TATI ON 0 0 00000 CLI NI C 0 0 90.01 09001 DENTAL CLINI C 0 90.02 09002 OTHER OUTPATI ENT SERVICE COST CENTE 0 90.02 09003 DI ABETI C TRAI NI NG 0	8, 571, 900	16, 122, 160		0.000000	71.00
74.00 07400 RENAL DI ALYSI S 1, 375, 611 76.00 03950 0THER ANCI LLARY-OTHER 0 76.01 03610 SLEEP LAB 189, 104 76.97 CARDI AC REHABI LI TATI ON 0 0UTPATI ENT SERVI CE COST CENTERS 0 00.00 09000 CLI NI C 0 00.01 DENTAL CLI NI C 0 00.02 09002 OTHER OUTPATI ENT SERVI CE COST CENTE 0 00.02 09003 DI ABETI C TRAI NI NG 0	7, 034, 530	17, 126, 800	0. 369868	0. 000000	72.00
76.00 03950 OTHER ANCI LLARY-OTHER 0 76.01 03610 SLEEP LAB 189, 104 76.97 07697 CARDI AC_REHABI LI TATI ON 0 0UTPATI ENT SERVICE COST CENTERS 0 0 00.00 09000 CLI NI C 0 00.01 09001 DENTAL CLI NI C 0 00.02 09002 OTHER OUTPATI ENT SERVICE COST CENTE 0 00.02 09003 DI ABETI C_TRAI NI NG 0	28, 770, 821	56, 633, 334	4 0. 159434	0. 000000	73.00
76. 01 03610 SLEEP LAB 189, 104 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0UTPATI ENT SERVI CE COST CENTERS 00. 00 090001 CLI NI C 0 00. 01 090001 DENTAL CLI NI C 0 00. 02 09002 OTHER 0UTPATI ENT 0 00. 02 09003 DI ABETI C TRAI NI NG 0	О	1, 375, 61	0. 122851	0. 000000	74.00
76.97 O7697 CARDI AC REHABI LI TATI ON O OUTPATI ENT SERVI CE COST CENTERS 0 0 P0.00 09000 CLI NI C 0 P0.01 09001 DENTAL CLI NI C 0 P0.02 09002 OTHER OUTPATI ENT SERVICE COST CENTE 0 P0.03 09003 DI ABETI C TRAI NI NG 0	0	(0.00000	0.00000	76.00
OUTPATI ENT SERVICE COST CENTERS 20.00 09000 CLINIC 0 20.01 09001 DENTAL CLINIC 0 20.02 09002 OTHER OUTPATI ENT SERVICE COST CENTE 0 20.03 09003 DI ABETI C TRAINING 0	2, 785, 799	2, 974, 903	0. 133799	0.00000	76.01
00.00 09000 CLINIC 0 00.01 09001 DENTAL CLINIC 0 00.02 09002 OTHER OUTPATIENT SERVICE COST CENTE 0 00.03 09003 DIABETIC TRAINING 0	0	(0.00000	0.00000	76.97
20. 01 09001 DENTAL CLINIC 0 20. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE 0 20. 03 09003 DIABETIC TRAINING 0					
00. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE 0 00. 03 09003 DI ABETIC TRAINING 0			0.00000	0. 000000	•
20. 03 09003 DI ABETI C TRAI NI NG 0	0		0.00000	0.000000	
	0		0.00000	0.000000	
71. 00 09100 EMERGENCY 4, 715, 647 2	0 0 0	(0.00000	0.00000	•
	0 0 0 0	(0.000000	•
092.00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART 1, 625, 519	0 0 0 22, 848, 590	(27, 564, 23	0. 249859	0.000000	92.00
	0 0 0 0	(0.000000	
25. 00 09500 AMBULANCE SERVICES 0	0 0 0 22, 848, 590 9, 735, 699	27, 564, 23 11, 361, 218		11 111111111111	
	0 0 22, 848, 590 9, 735, 699	27, 564, 23 11, 361, 218	0. 000000		
201.00 Less Observation Beds 202.00 Total (see instructions) 170, 114, 760 25	0 0 22, 848, 590 9, 735, 699	27, 564, 23 11, 361, 218			200. 00 201. 00

Health Financial Systems	LAPORTE HOS			u of Form CMS-2552-
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0006	Peri od: From 03/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared 5/31/2017 9:23 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient	·		
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.
31.00 03100 INTENSIVE CARE UNIT				31.0
40. 00 04000 SUBPROVIDER - IPF				40. (
41. 00 04100 SUBPROVIDER - IRF				41.0
43. 00 04300 NURSERY				43.0
44.00 04400 SKILLED NURSING FACILITY				44.0
ANCILLARY SERVICE COST CENTERS				
50.00 OPERATING ROOM	0. 134540			50.0
51.00 05100 RECOVERY ROOM	0. 151925			51.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 294254			52.0
53.00 05300 ANESTHESI OLOGY	0. 212451			53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 720755			54.0
54. 02 05402 ULTRASOUND	0. 133894			54.0
56. 00 05600 RADI OI SOTOPE	0. 119162			56.0
57.00 05700 CT SCAN	0.061555			57.
58. 00 05800 MRI	0. 118273			58.0
60. 00 06000 LABORATORY	0. 133763			60.0
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 324135			62.
65. 00 06500 RESPIRATORY THERAPY	0. 251696			65.
66. 00 06600 PHYSI CAL THERAPY	0. 577547			66.
67. 00 06700 OCCUPATI ONAL THERAPY	0. 153987			67.
68. 00 06800 SPEECH PATHOLOGY	0. 488154			68.0
69. 00 06900 ELECTROCARDI OLOGY	0. 289722			69.
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 206116			71.0
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 369868			72.
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 159434			73.0
74. 00 07400 RENAL DIALYSIS	0. 122851			74.0
76. 00 03950 OTHER ANCI LLARY-OTHER	0. 000000			74.
76. 01 03610 SLEEP LAB	0. 133799			76.0
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76.
OUTPATIENT SERVICE COST CENTERS	0.000000			70.
90. 00 09000 CLINIC	0. 000000			90.0
90. 01 09001 DENTAL CLINIC	0.000000			90.0
90. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE	0.000000			90.0
90. 02 09002 OTHER OUTPATTENT SERVICE COST CENTE 90. 03 09003 DI ABETI C TRAI NI NG				90.0
90. 03 09003 DTABETTC TRATINING 91. 00 09100 EMERGENCY	0. 000000 0. 186591			90.0
				91.
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0. 249859			92.0
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.0
	0.000000			
200.00 Subtotal (see instructions)				200.
201.00 Less Observation Beds				201. 202.
202.00 Total (see instructions)				202.0

	ancial Systems	LAPORTE HO		N 45 000/		u of Form CMS-	2552-10
COMPUTATION	N OF RATIO OF COSTS TO CHARGES		Provider C	CN: 15-0006	Period: From 03/01/2016 To 12/31/2016		pared:
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	TIENT ROUTINE SERVICE COST CENTERS						
	0 ADULTS & PEDIATRICS	17, 681, 087		17, 681, 08			
	00 INTENSIVE CARE UNIT	6, 003, 549		6, 003, 54		-,,	1
	00 SUBPROVI DER – I PF	0			0 0	0	
	00 SUBPROVIDER - IRF	0			0 0	0	1
	00 NURSERY	76, 451		76, 4		76, 451	1
	00 SKILLED NURSING FACILITY	0			0 0	0	44.00
	LLARY SERVICE COST CENTERS	10 (04 755		40 (04 7		40 (04 755	50.00
	00 OPERATI NG ROOM	10, 604, 755		10, 604, 75			
	00 RECOVERY ROOM	665, 232		665, 23			
	00 DELIVERY ROOM & LABOR ROOM 00 ANESTHESIOLOGY	3, 538, 079		3, 538, 0		3, 538, 079	
		3, 219, 836		3, 219, 83		3, 219, 836	
	00 RADI OLOGY-DI AGNOSTI C 02 ULTRASOUND	7, 399, 194 712, 063		7, 399, 19		7, 399, 194 712, 063	
	00 RADI 0I SOTOPE	802, 802		802, 80		802, 802	1
	DO CT SCAN	1, 284, 112		1, 284, 1		1, 284, 112	1
	DO MRI	1,095,227		1, 095, 22		1, 095, 227	
	DO LABORATORY	7,018,446		7, 018, 44		7, 018, 446	1
	00 WHOLE BLOOD & PACKED RED BLOOD CELL	81, 847		81, 84		81, 847	
	00 RESPIRATORY THERAPY	1, 477, 973	0			1, 477, 973	
	00 PHYSI CAL THERAPY	4, 569, 183	0	.,, .		4, 569, 183	
	00 OCCUPATI ONAL THERAPY	479, 822	0			479, 822	
	OO SPEECH PATHOLOGY	1, 464, 099	0	1, 464, 09		1, 464, 099	
	00 ELECTROCARDI OLOGY	9,664,086		9, 664, 08		9, 664, 086	
	MEDICAL SUPPLIES CHARGED TO PATIENT	3, 323, 043		3, 323, 04		3, 323, 043	
72.00 0720	OO IMPL. DEV. CHARGED TO PATIENTS	6, 334, 662		6, 334, 60	62 0	6, 334, 662	72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	9, 029, 284		9, 029, 28	34 0	9, 029, 284	73.00
	00 RENAL DIALYSIS	168, 995		168, 99	95 0	168, 995	74.00
76.00 0395	0 OTHER ANCI LLARY-OTHER	0			0 0	0	76.00
	0 SLEEP LAB	398, 040		398, 04	40 0	398, 040	76.01
	27 CARDIAC REHABILITATION PATIENT SERVICE COST CENTERS	0			0 0	0	76.97
	DO CLINIC	0			0 0	0	90.00
	D1 DENTAL CLINIC	0			0 0		
	2 OTHER OUTPATIENT SERVICE COST CENTE	0			0 0	0	
	03 DI ABETI C TRAI NI NG	0			0 0	0	
	00 EMERGENCY	5, 143, 229		5, 143, 22		5, 143, 229	
OTHE	00000000000000000000000000000000000000	2, 838, 707		2, 838, 70	07	2, 838, 707	
	00 AMBULANCE SERVI CES	0			0 0		
200.00	Subtotal (see instructions)	105, 073, 803	0				
201.00	Less Observation Beds	2, 838, 707		2, 838, 70		2, 838, 707	
202.00	Total (see instructions)	102, 235, 096	0	102, 235, 09	96 0	102, 235, 096	1202.00

COMPUTATI	nancial Systems ON OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 03/01/2016 To 12/31/2016	Date/Time Pre	epared:
			Titl	e XIX	Hospi tal	5/31/2017 9:2 PPS	3 am
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	6 Cost or Other Ratio	TEFRA Inpatient Ratio	
		6.00	7.00	8.00	9.00	10.00	
	ATLENT ROUTINE SERVICE COST CENTERS	-1					_
	000 ADULTS & PEDIATRICS	17, 159, 625		17, 159, 62			30.00
	00 INTENSIVE CARE UNIT	7, 300, 166		7, 300, 16	6		31.00
	000 SUBPROVIDER - IPF	0			0		40.00
	00 SUBPROVIDER - IRF	0			0		41.00
	OO NURSERY	1, 686, 314		1, 686, 31	4		43.00
	00 SKILLED NURSING FACILITY	0			0		44.00
	I LLARY SERVICE COST CENTERS	1					-
	OOO OPERATING ROOM	29, 257, 216	49, 565, 164				
	OO RECOVERY ROOM	1, 126, 599	3, 252, 099			0.00000	
	OO DELIVERY ROOM & LABOR ROOM	11, 310, 546	713, 354			0.00000	
	OO ANESTHESI OLOGY	4, 743, 164	10, 412, 513			0. 000000	
	00 RADI OLOGY-DI AGNOSTI C	1, 955, 337	8, 310, 552			0.00000	
	02 ULTRASOUND	762, 365	4, 555, 742			0.00000	
	00 RADI OI SOTOPE	995, 044	5, 742, 017			0.00000	
	OO CT SCAN	5, 459, 068	15, 402, 121			0.00000	
	BOO MRI	1, 222, 748	8,037,450			0.00000	
	DOO LABORATORY	16, 239, 846	36, 229, 519			0.00000	
	WHOLE BLOOD & PACKED RED BLOOD CELL	16, 102	236, 407			0.00000	
		4, 920, 129	951, 930			0.00000	
	00 PHYSI CAL THERAPY	1, 174, 491	6, 736, 873			0.00000	
		1, 516, 882	1, 599, 114			0.00000	
	000 SPEECH PATHOLOGY 000 ELECTROCARDI OLOGY	438, 204	2, 561, 051			0.00000	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	9, 419, 978 7, 550, 266	23, 936, 379 8, 571, 900			0. 000000 0. 000000	
	200 IMPL. DEV. CHARGED TO PATIENTS		7,034,530			0. 000000	
	OO DRUGS CHARGED TO PATIENTS	10, 092, 276 27, 862, 513	28, 770, 821			0. 000000	
	00 RENAL DIALYSIS	1, 375, 611	20, 770, 821			0. 000000	
	00 RENAL DIALISIS	1, 375, 011	0		0. 000000	0. 000000	
	10 SLEEP LAB	189, 104	2, 785, 799			0. 000000	
	97 CARDI AC REHABI LI TATI ON	189, 104	2, 783, 799		0. 000000	0. 000000	
	PATIENT SERVICE COST CENTERS	0	0		0 0.000000	0.00000	/0. 7/
		0	0		0 0. 000000	0. 000000	90.00
	01 DENTAL CLINIC	0	0		0 0.000000	0. 000000	
	02 OTHER OUTPATIENT SERVICE COST CENTE	0	0		0 0.000000	0.000000	
	03 DI ABETI C TRAI NI NG	0	0		0 0.000000	0. 000000	
	OO EMERGENCY	4, 715, 647	22, 848, 590	27, 564, 23		0. 000000	
	OO OBSERVATION BEDS (NON-DISTINCT PART	1, 625, 519	9, 735, 699			0. 000000	
	ER REIMBURSABLE COST CENTERS	., 020, 017	.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		3.2307	21000000	1
	OO AMBULANCE SERVICES	0	0		0 0.000000	0. 000000	95.00
200.00	Subtotal (see instructions)	170, 114, 760	257, 989, 624	428, 104, 38			200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	170, 114, 760	257, 989, 624	428, 104, 38	4		202.00

Health Financial S	TO OF COSTS TO CHARGES	LAPORTE HOS	Provider CCN: 15-0006	Peri od:	u of Form CMS-2552 Worksheet C
				From 03/01/2016 To 12/31/2016	Part I Date/Time Prepare 5/31/2017 9:23 am
			Title XIX	Hospi tal	PPS
Cost (Center Description	PPS Inpatient			
		Ratio			
		11.00			
INPATIENT R	DUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS	S & PEDIATRICS				30.
31.00 03100 INTENS	SIVE CARE UNIT				31.
40. 00 04000 SUBPR	OVIDER – IPF				40.
41. 00 04100 SUBPR	OVIDER – IRF				41.
43.00 04300 NURSEI	RY				43.
44. 00 04400 SKI LLI	ED NURSING FACILITY				44.
	ERVICE COST CENTERS				
50. 00 05000 0PERA	TING ROOM	0. 134540			50.
51. 00 05100 RECOVI		0. 151925			51.
52. 00 05200 DELI VI	ERY ROOM & LABOR ROOM	0. 294254			52.
53.00 05300 ANESTI	IESI OLOGY	0. 212451			53.
54. 00 05400 RADI 0I	LOGY-DI AGNOSTI C	0. 720755			54.
54.02 05402 ULTRAS	SOUND	0. 133894			54.
56.00 05600 RADI 0	SOTOPE	0. 119162			56.
57.00 05700 CT SC/	AN	0. 061555			57.
58.00 05800 MRI		0. 118273			58.
60. 00 06000 LABOR/	ATORY	0. 133763			60.
	BLOOD & PACKED RED BLOOD CELL	0. 324135			62.
	RATORY THERAPY	0. 251696			65.
56.00 06600 PHYSI (0. 577547			66.
	ATIONAL THERAPY	0. 153987			67.
58. 00 06800 SPEECI		0. 488154			68.
59. 00 06900 ELECTI		0. 289722			69.
	AL SUPPLIES CHARGED TO PATIENT	0. 206116			71.
	DEV. CHARGED TO PATIENTS	0. 369868			72.
	CHARGED TO PATIENTS	0. 159434			73.
4.00 07400 RENAL		0. 122851			74.
	ANCI LLARY-OTHER	0. 000000			76.
76.01 03610 SLEEP		0. 133799			76.
	AC REHABILITATION	0.000000			76.
	SERVICE COST CENTERS				
90.00 09000 CLINI (0.00000			90.
90. 01 09001 DENTAI		0.000000			90.
	OUTPATIENT SERVICE COST CENTE	0. 000000			90.
90. 03 09003 DI ABE		0. 000000			90.
91.00 09100 EMERGI		0. 186591			91.
	ATION BEDS (NON-DISTINCT PART	0. 249859			92.
	JRSABLE COST CENTERS				
	ANCE SERVICES	0. 000000			95.
	tal (see instructions)				200.
	Observation Beds				201.
202.00 Total	(see instructions)				202.

Heal th	Financial Systems	LAPORTE H	OSPI TAL		In Lie	u of Form CMS-:	2552-10
CALCUL	ATION OF OUTPATIENT SERVICE COST TO CHARGE R IONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 03/01/2016 To 12/31/2016	Worksheet C Part II Date/Time Pre 5/31/2017 9:2	pared: 3 am
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operating Co	st Capital	Operating Cost	
		(Wkst. B, Part				Reducti on	
		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						
50.00	05000 OPERATING ROOM	10, 604, 755	1, 008, 304	9, 596, 4	51 0	0	50.00
51.00	05100 RECOVERY ROOM	665, 232	5, 508	659, 7	24 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	3, 538, 079	470, 869	3, 067, 2	10 0	0	52.00
53.00	05300 ANESTHESI OLOGY	3, 219, 836	27, 852	3, 191, 9	84 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 399, 194	404, 368	6, 994, 8	26 0	0	54.00
54.02	05402 ULTRASOUND	712,063	57, 415	654,6	48 0	0	54.02
56.00	05600 RADI OI SOTOPE	802, 802	11, 447	791, 3	55 0	0	56.00
57.00	05700 CT SCAN	1, 284, 112	71, 072	1, 213, 0	40 0	0	57.00
58.00	05800 MRI	1, 095, 227	235, 750			0	58.00
60.00	06000 LABORATORY	7, 018, 446	282, 445			0	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	81, 847	38, 099			0	1
65.00	06500 RESPIRATORY THERAPY	1, 477, 973	55, 332			0	
66.00	06600 PHYSI CAL THERAPY	4, 569, 183	903, 422			0	1
67.00	06700 OCCUPATI ONAL THERAPY	479, 822	15, 265			0	
	06800 SPEECH PATHOLOGY	1, 464, 099	21, 879			0	
	06900 ELECTROCARDI OLOGY	9, 664, 086	764, 690			0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 323, 043	44, 581		, 0	0	
	07200 I MPL. DEV. CHARGED TO PATIENTS	6, 334, 662	80, 719			0	
	07300 DRUGS CHARGED TO PATIENTS	9, 029, 284	173, 317			0	
	07400 RENAL DI ALYSI S	168, 995	76, 679			0	1
	03950 OTHER ANCI LLARY-OTHER	00,775	, 0, 0, 7		0 0	0	1
	03610 SLEEP LAB	398,040	4, 162		-	0	
	07697 CARDI AC REHABI LI TATI ON	398,040	4, 102		0 0	0	
	OUTPATIENT SERVICE COST CENTERS	0	0	1	0 0	0	/0.9/
	09000 CLINIC	0	0		0 0	0	90.00
	09001 DENTAL CLINIC	0	0		0 0	0	
	09002 OTHER OUTPATIENT SERVICE COST CENTE	0	0		0 0		
		0	0		-	0	
	09003 DI ABETI C TRAI NI NG	0	0		0 0	0	
	09100 EMERGENCY	5, 143, 229	330, 118			0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 838, 707	175, 179	2, 663, 5	28 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS			1		-	05 00
	09500 AMBULANCE SERVICES	0	0		0 0		
200.00		81, 312, 716	5, 258, 472				200.00
201.00		2, 838, 707	175, 179				201.00
202.00	Total (line 200 minus line 201)	78, 474, 009	5, 083, 293	73, 390, 7	16 0	0	202.00

lealth Financial Systems	LAPORTE HO				u of Form CMS-25	552-
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE REDUCTIONS FOR MEDICAID ONLY	RATIOS NET OF	Provider C		Period: From 03/01/2016 To 12/31/2016	Worksheet C Part II Date/Time Prepa 5/31/2017 9:23	arec am
			e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges				
		(Worksheet C,				
	Operating Cost			6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	10, 604, 755	78, 822, 380	0. 1345	40		50. (
1.00 05100 RECOVERY ROOM	665, 232	4, 378, 698		25	5	51. (
2.00 05200 DELIVERY ROOM & LABOR ROOM	3, 538, 079	12, 023, 900	0. 2942	54	5	52.0
3. 00 05300 ANESTHESI OLOGY	3, 219, 836	15, 155, 677	0. 2124	51	5	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 399, 194	10, 265, 889	0. 7207	55	5	54.0
4. 02 05402 ULTRASOUND	712, 063	5, 318, 107	0. 1338	94	5	54. (
6. 00 05600 RADI 0I SOTOPE	802, 802	6, 737, 061	0. 1191	62	5	56. (
7.00 05700 CT SCAN	1, 284, 112	20, 861, 189				57.
8. 00 05800 MRI	1, 095, 227	9, 260, 198				58.
D. 00 06000 LABORATORY	7, 018, 446	52, 469, 365				60.
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	81, 847	252, 509				62.
5. 00 06500 RESPIRATORY THERAPY	1, 477, 973	5, 872, 059				65.
6. 00 06600 PHYSI CAL THERAPY	4, 569, 183	7, 911, 364				66.
7. 00 06700 OCCUPATI ONAL THERAPY	4, 307, 103	3, 115, 996				67.
B. 00 06800 SPEECH PATHOLOGY	1, 464, 099	2, 999, 255				68.
9. 00 06900 ELECTROCARDI OLOGY		2, 999, 255 33, 356, 357				69.
	9, 664, 086					
1. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	3, 323, 043	16, 122, 166				71.
2. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	6, 334, 662	17, 126, 806				72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	9, 029, 284	56, 633, 334				73.
4. 00 07400 RENAL DIALYSIS	168, 995	1, 375, 611				74.
6.00 03950 OTHER ANCI LLARY-OTHER	0	0				76.
6.01 03610 SLEEP LAB	398, 040	2, 974, 903				76.
5. 97 07697 CARDIAC REHABILITATION	0	0	0.0000	00		76.
OUTPATIENT SERVICE COST CENTERS						
0. 00 09000 CLINIC	0	0			ç	90.
0.01 09001 DENTAL CLINIC	0	0	0.0000	00		90.
0. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.0000	00	9	90.
D. 03 09003 DI ABETI C TRAI NI NG	0	0	0.0000	00	c	90.
1.00 09100 EMERGENCY	5, 143, 229	27, 564, 237			, c	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 838, 707	11, 361, 218		59	ç	92. (
OTHER REIMBURSABLE COST CENTERS				<u>.</u>		
5. 00 09500 AMBULANCE SERVICES	0	0	0.0000	00		95.
00.00 Subtotal (sum of lines 50 thru 199)	81, 312, 716	401, 958, 279				200.
01.00 Less Observation Beds	2, 838, 707	∩ 101, 700, 277				201.
02.00 Total (line 200 minus line 201)	78, 474, 009	401, 958, 279				202.0
	70,474,009	401, 700, 279	I	I	20	.02.

Health Financial Systems	LAPORTE H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CA	PITAL COSTS	Provider C		Period: From 03/01/2016 Fo 12/31/2016		pared: 3 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col		Per Diem (col. 3 / col. 4)	
	26)	2.00	2)	4, 00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30-199) Cost Center Description	1, 091, 126 446, 017 0 33, 869 0 1, 571, 012 Inpatient Program days 6, 00	Inpatient Program Capital Cost (col. 5 x col. 6) 7.00	1, 091, 12 446, 01 33, 86 1, 571, 01	7 3, 445 0 0 0 0 9 1, 376 0 0	129. 47 0. 00 0. 00 24. 61 0. 00	31.00 40.00 41.00 43.00
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00				
ADULTS & PEDIATRI CS 31.00 INTENSI VE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30-199)	6, 631 1, 047 0 0 0 0 7, 678	518, 611 135, 555 0 0 0 0 0 654, 166				30.00 31.00 40.00 41.00 43.00 44.00 200.00

lealth Financial Systems	LAPORTE H				u of Form CMS-2	2552-1
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAP	ITAL COSTS	Provider C	CN: 15-0006	Period: From 03/01/2016 To 12/31/2016		pared: 3 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS			1			
50. 00 05000 OPERATI NG ROOM	1, 008, 304				153, 342	•
51.00 05100 RECOVERY ROOM	5, 508				606	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	470, 869					52.00
53. 00 05300 ANESTHESI OLOGY	27, 852					
54. 00 05400 RADI OLOGY-DI AGNOSTI C	404, 368					54.00
54. 02 05402 ULTRASOUND	57, 415					
56. 00 05600 RADI OI SOTOPE	11, 447					56.00
57. 00 05700 CT SCAN	71, 072					57.00
58. 00 05800 MRI	235, 750				14, 591	58.00
50. 00 06000 LABORATORY	282, 445	52, 469, 365	0.00538	8, 363, 461	45, 021	60.00
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	38, 099	252, 509	0. 15088	32 7, 910	1, 193	62.00
55. 00 06500 RESPI RATORY THERAPY	55, 332				21, 248	65.00
56. 00 06600 PHYSI CAL THERAPY	903, 422	7, 911, 364	0. 11419	725, 000	82, 790	66.00
57.00 06700 OCCUPATIONAL THERAPY	15, 265	3, 115, 996	0.00489	99 935, 117	4, 581	67.00
58.00 06800 SPEECH PATHOLOGY	21, 879	2, 999, 255	0.00729	280, 631	2, 047	68.00
59. 00 06900 ELECTROCARDI OLOGY	764, 690	33, 356, 357	0. 02292	4, 509, 133	103, 372	69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	44, 581	16, 122, 166	0.00276	3, 922, 981	10, 847	71.0
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	80, 719	17, 126, 806	0.0047	4, 550, 151	21, 445	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	173, 317				42, 328	73.00
74. 00 07400 RENAL DIALYSIS	76, 679				48, 440	74.00
76.00 03950 OTHER ANCI LLARY-OTHER	0	0	0.0000	0 00	0	76.00
76. 01 03610 SLEEP LAB	4, 162	2, 974, 903	0, 00139	99 109, 635	153	76.0
76. 97 07697 CARDI AC REHABI LI TATI ON	0					76.9
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0.0000	0 00	0	90.00
PO. 01 09001 DENTAL CLINIC	0	0			0	90.01
00. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE	0	0	0.0000		0	90.02
09003 DI ABETI C TRAI NI NG	0	0	0.0000		0	90.03
91.00 09100 EMERGENCY	330, 118				31, 755	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	175, 179				6, 351	92.00
OTHER REIMBURSABLE COST CENTERS					2,001	
95. 00 09500 AMBULANCE SERVICES						95.00
	1	401, 958, 279	1	1		200.00

Health Financial Systems	LAPORTE H	IOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P.	ASS THROUGH COS	TS Provider C		Period: From 03/01/2016 To 12/31/2016	Date/Time Pre 5/31/2017 9:2	
		Title	XVIII	Hospi tal	PPS	-
Cost Center Description	Nursing School	Allied Health	All Other	Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos	t Amount (see	1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0	0)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
40. 00 04000 SUBPROVIDER - IPF	0	o c)	0 0	0	40.00
41. 00 04100 SUBPROVIDER - IRF	0	o c)	0 0	0	41.00
43. 00 04300 NURSERY	0	o c		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0				0	44.00
200.00 Total (lines 30-199)	0			0	0	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	Inpati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col. 8)		
	6.00	7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	13, 952	0.00	6,63	1 0		30.00
31.00 03100 INTENSIVE CARE UNIT	3, 445	0.00	1,04	7 0		31.00
40. 00 04000 SUBPROVIDER - IPF	0	0.00		0 0		40.00
41. 00 04100 SUBPROVIDER – IRF	0	0.00		0 0		41.00
43. 00 04300 NURSERY	1, 376			0 0		43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	1,070			0 0		44.00
200.00 Total (lines 30-199)	18, 773		7,67	8 0		200.00
	1 10,775	1	1 7,07	с _і 0	1	1200.00

Health Financial Systems	LAPORTE H	OSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	5 Provider C	CN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Pre 5/31/2017 9:2	pared: 3 am
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
54. 02 05402 ULTRASOUND	0	C		0 0	0	54.02
56. 00 05600 RADI OI SOTOPE	0	C		0 0	0	56.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
58. 00 05800 MRI	0	C		0 0	0	58.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
74.00 07400 RENAL DI ALYSI S	0	C		0 0	0	74.00
76.00 03950 OTHER ANCI LLARY-OTHER	0	C		0 0	0	76.00
76.01 03610 SLEEP LAB	0	C		0 0	0	76.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS				!		1
90. 00 09000 CLI NI C	0	C		0 0	0	90.00
90. 01 09001 DENTAL CLINIC	0	C		0 0	0	90.01
90. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE	0	C		0 0	0	90.02
90. 03 09003 DI ABETI C TRAI NI NG	0	C		0 0	0	90.03
91. 00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	C		0 0	0	200.00
			-			•

Health Financial Systems	LAPORTE H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PAS	S Provider C	CN: 15-0006	Period:	Worksheet D	
THROUGH COSTS				From 03/01/2016		
				To 12/31/2016	Date/Time Pre 5/31/2017 9:2	pared: 3 am
		Title	xviii	Hospi tal	PPS	5 411
Cost Center Description	Total	Total Charges			I npati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		$(col. 5 \div col$		Charges	
	col. 2, 3 and		7)	(col. 6 ÷ col.	g	
	4)		,	7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS				-		
50. 00 05000 OPERATI NG ROOM	0	78, 822, 380	0.00000	0.000000	11, 987, 364	50.00
51.00 05100 RECOVERY ROOM	0	4, 378, 698	0.00000	0.000000	481, 844	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	12, 023, 900	0.00000	0.000000	24, 869	52.00
53. 00 05300 ANESTHESI OLOGY	0	15, 155, 677	0.00000	0. 000000	2,093,452	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	10, 265, 889	0.00000	0. 000000	1, 095, 226	54.00
54. 02 05402 ULTRASOUND	0				413,076	
56. 00 05600 RADI 0I SOTOPE	0				536, 983	
57. 00 05700 CT SCAN	0				2, 948, 482	
58. 00 05800 MRI	0				573, 140	
60. 00 06000 LABORATORY	0				8, 363, 461	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0				7, 910	
65. 00 06500 RESPI RATORY THERAPY	0				2, 254, 956	
66. 00 06600 PHYSI CAL THERAPY	0				725,000	
67. 00 06700 OCCUPATI ONAL THERAPY	0				935, 117	67.00
68. 00 06800 SPEECH PATHOLOGY	0				280, 631	68.00
69. 00 06900 ELECTROCARDI OLOGY	0				4, 509, 133	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				3, 922, 981	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0				4, 550, 151	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0				13, 832, 793	
74. 00 07400 RENAL DIALYSIS			0.00000		868, 997	74.00
76. 00 03950 OTHER ANCI LLARY-OTHER					000,777	
76. 01 03610 SLEEP LAB					109, 635	76.01
76. 97 07697 CARDI AC REHABI LI TATI ON					0,035	
OUTPATIENT SERVICE COST CENTERS	0	0	0.00000	0 0.00000	0	/0.9/
90. 00 09000 CLINIC	0	0	0.00000	0 0. 000000	0	90.00
90. 01 09001 DENTAL CLINIC		-			0	90.00
90. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE			0.00000		0	90.01
90. 02 09002 0THER OUTPATTENT SERVICE COST CENTE 90. 03 09003 DI ABETI C TRAI NI NG					0	90.02
91. 00 09100 EMERGENCY					2, 651, 575	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						91.00
0142.00 09200 0BSERVATION BEDS (NON-DISTINCT PART		11,301,218	0.0000	0.00000	411,891	72.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	401, 958, 279			63, 578, 667	
200.00 [TOTAL (TTHES 30-177)	1 0	401, 730, 279	I	1	03, 370, 007	200.00

Health Financial Systems	LAPORTE HO	ISPI TAL		ln Li€	eu of Form CMS	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS			Period: From 03/01/2016 To 12/31/2016	Date/Time Pr 5/31/2017 9:	epared: 23 am
			XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)	10.00	x col. 12)			
ANCI LLARY SERVI CE COST CENTERS	11.00	12.00	13.00			
50. 00 05000 OPERATING ROOM	0	14, 328, 340		0		50.00
51. 00 05100 RECOVERY ROOM	0	756, 995		0		51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	/ 50, 995		0		52.00
53. 00 05300 ANESTHESI OLOGY	0	3, 118, 844		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0			0		54.00
	0	2,050,477		0		54.00
	0	692, 151		0		
56. 00 05600 RADI OI SOTOPE	0	2, 712, 026		0		56.00
57. 00 05700 CT SCAN	0	5, 069, 651		0		57.00
58. 00 05800 MRI	0	2, 450, 896		0		58.00
60. 00 06000 LABORATORY	0	4, 532, 583		0		60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	110, 112		0		62.00
65. 00 06500 RESPI RATORY THERAPY	0	278, 878		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	49, 627		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	45, 492		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	20, 423		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	10, 036, 830		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	4, 002, 801		0		71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	3, 241, 528		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	8, 088, 945		0		73.00
74.00 07400 RENAL DIALYSIS	0	0		0		74.00
76.00 03950 OTHER ANCI LLARY-OTHER	0	0		0		76.00
76.01 03610 SLEEP LAB	0	708, 686		0		76.01
76. 97 07697 CARDI AC REHABILI TATI ON	0	0		0		76.97
OUTPATIENT SERVICE COST CENTERS			1			
90. 00 09000 CLINIC	0	0		0		90.00
90. 01 09001 DENTAL CLINIC	0	0		0		90.01
90. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE	0	0		0		90.02
90. 03 09003 DI ABETI C TRAI NI NG	0	0		0		90.03
91. 00 09100 EMERGENCY	0	4, 698, 164		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 182, 783		0		92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	68, 176, 232		0		200.00

APPORTI O	INMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-0006	Period: From 03/01/2016 To 12/31/2016		
			Title	e XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)			
		1.00	2.00	3.00	4.00	5.00	
	VCILLARY SERVICE COST CENTERS						
	5000 OPERATI NG ROOM	0. 134540			0 0	1, 927, 735	
	5100 RECOVERY ROOM	0. 151925			0 0	115, 006	
	5200 DELIVERY ROOM & LABOR ROOM	0. 294254			0 0	0	
	5300 ANESTHESI OLOGY	0. 212451			0 0	662, 602	
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	0. 720755	2, 050, 477		0 0	1, 477, 892	54.00
	5402 ULTRASOUND	0. 133894			0 0	92, 675	54.02
56.00 05	5600 RADI OI SOTOPE	0. 119162	2, 712, 026	,	0 0	323, 170	56.00
57.00 05	5700 CT SCAN	0. 061555	5, 069, 651		0 0	312, 062	57.00
58.00 05	5800 MRI	0. 118273	2, 450, 896	,	0 0	289, 875	58.00
60.00 06	6000 LABORATORY	0. 133763	4, 532, 583	10	67 0	606, 292	60.00
62.00 06	6200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 324135	110, 112		0 0	35, 691	62.00
65.00 06	6500 RESPI RATORY THERAPY	0. 251696	278, 878		0 0	70, 192	65.00
66.00 06	6600 PHYSI CAL THERAPY	0. 577547	49, 627		0 0	28, 662	66.00
67.00 06	6700 OCCUPATIONAL THERAPY	0. 153987	45, 492		0 0	7, 005	67.00
68.00 06	6800 SPEECH PATHOLOGY	0. 488154	20, 423		0 0	9, 970	68.00
69.00 06	6900 ELECTROCARDI OLOGY	0. 289722	10, 036, 830)	0 0	2, 907, 890	69.00
71.00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 206116	4, 002, 801		0 0	825, 041	71.00
72.00 07	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 369868	3, 241, 528		0 0	1, 198, 937	72.00
73.00 07	7300 DRUGS CHARGED TO PATIENTS	0. 159434	8, 088, 945	99, 4	70 0	1, 289, 653	73.00
74.00 07	7400 RENAL DIALYSIS	0. 122851	0		0 0	0	74.00
76.00 03	3950 OTHER ANCI LLARY-OTHER	0. 000000	0)	0 0	0	76.00
	3610 SLEEP LAB	0. 133799	708, 686		0 0	94, 821	76.01
76.97 07	7697 CARDI AC REHABI LI TATI ON	0. 000000	0)	0 0	0	76.97
OL	JTPATIENT SERVICE COST CENTERS						1
90.00 09	9000 CLINIC	0.000000	0		0 0	0	90.00
90.01 09	9001 DENTAL CLINIC	0. 000000	0)	0 0	0	90.01
90. 02 09	9002 OTHER OUTPATIENT SERVICE COST CENTE	0. 000000	0)	0 0	0	90.02
90. 03 09	9003 DI ABETI C TRAI NI NG	0. 000000	0		0 0	0	90.03
	9100 EMERGENCY	0. 186591			0 0	876, 635	91. OC
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 249859			0 0	295, 529	
	THER REIMBURSABLE COST CENTERS						1
	9500 AMBULANCE SERVICES	0, 000000			0		95.00
200.00	Subtotal (see instructions)		68, 176, 232	99, 6	-	13, 447, 335	
201.00	Less PBP Clinic Lab. Services-Program				0 0	,, 500	201.00
	Only Charges				-		
202.00	Net Charges (line 200 +/- line 201)	1	68, 176, 232	99, 6	37 0	13, 447, 335	lana or

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pr 5/31/2017 9:	
			Title	XVIII	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				_
50.00	ANCI LLARY SERVICE COST CENTERS		0				
50.00	05000 OPERATING ROOM	0	0				50.00
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
54.02	05402 ULTRASOUND	0	0				54.02
56.00	05600 RADI OI SOTOPE	0	0				56.00
57.00	05700 CT SCAN	0	0				57.00
58.00	05800 MRI	0	0				58.00
60.00	06000 LABORATORY	22	0				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62.00
65.00	06500 RESPI RATORY THERAPY	0	0				65.00
66.00	06600 PHYSI CAL THERAPY	0	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0				67.00
	06800 SPEECH PATHOLOGY	0	0				68.00
69.00	06900 ELECTROCARDI OLOGY	0	0				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	15, 859	0				73.00
	07400 RENAL DIALYSIS	0	0				74.00
	03950 OTHER ANCI LLARY-OTHER	0	0				76.00
	03610 SLEEP LAB	0	0				76.01
76.97	07697 CARDI AC REHABI LI TATI ON	0	0				76.97
~~ ~~	OUTPATIENT SERVICE COST CENTERS						
90.00		0	0				90.00
	09001 DENTAL CLINIC	0	0				90.01
	09002 OTHER OUTPATIENT SERVICE COST CENTE	0	0				90.02
90.03	09003 DI ABETI C TRAI NI NG	0	0				90.03
91.00	09100 EMERGENCY	0	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
05 00							05 00
	09500 AMBULANCE SERVICES	0	~				95.00
200.00		15, 881	0				200.00
201.00	5	0					201.00
	Only Charges						

Health Financial Systems	LAPORTE H	IOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period: From 03/01/2016 To 12/31/2016		pared: 3 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col.	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col	Days	Per Diem (col. 3 / col. 4)	
	26)	2.00	2)	4.00	F 00	
INPATIENT ROUTINE SERVICE COST CENTERS				4.00	5.00	
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30-199) Cost Center Description		C C Program Capital Cost (col. 5 x col. 6)	1, 091, 12 446, 01 33, 86 1, 571, 01	7 3, 445 0 0 0 0 9 1, 376 0 0	129. 47 0. 00 0. 00 24. 61 0. 00	31.00 40.00 41.00 43.00
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 200.00 Total (lines 30-199)	2, 097 537 0 918 0 3, 552	69, 525 C 22, 592 C				30. 00 31. 00 40. 00 41. 00 43. 00 44. 00 200. 00

		OSPI TAL			u of Form CMS-:	2002 1
PPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C	CN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Pre 5/31/2017 9:2	pared: 3 am
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
0.00 05000 OPERATING ROOM	1,008,304				77, 407	
1.00 05100 RECOVERY ROOM	5, 508				259	
2.00 05200 DELIVERY ROOM & LABOR ROOM	470, 869	12, 023, 900	0. 03916	1, 585, 762	62, 100	52.0
3. 00 05300 ANESTHESI OLOGY	27, 852	15, 155, 677	0. 00183	38 931, 827	1, 713	53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	404, 368	10, 265, 889	0. 03938	39 252, 141	9, 932	54.0
4. 02 05402 ULTRASOUND	57, 415	5, 318, 107	0. 01079	96 117, 164	1, 265	54.0
6. 00 05600 RADI 0I SOTOPE	11, 447	6, 737, 061	0.00169	99 125, 377	213	56.0
7.00 05700 CT SCAN	71,072	20, 861, 189	0.00340	609, 632	2,077	57.0
8. 00 05800 MRI	235, 750			58 139, 905	3, 562	58.0
0. 00 06000 LABORATORY	282, 445	52, 469, 365	0. 00538	2, 700, 898	14, 539	60.0
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	38,099	252, 509	0. 15088	32 1, 437	217	62.0
5. 00 06500 RESPI RATORY THERAPY	55, 332				6, 048	
6. 00 06600 PHYSI CAL THERAPY	903, 422				12, 634	
7.00 06700 OCCUPATI ONAL THERAPY	15, 265				728	
8. 00 06800 SPEECH PATHOLOGY	21, 879				209	
9. 00 06900 ELECTROCARDI OLOGY	764, 690					
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	44, 581	16, 122, 166			3, 712	
2.00 07200 I MPL. DEV. CHARGED TO PATIENTS	80, 719				7, 241	
3. 00 07300 DRUGS CHARGED TO PATIENTS	173, 317				14, 917	
4. 00 07400 RENAL DIALYSIS	76, 679				4, 689	
6. 00 03950 OTHER ANCI LLARY-OTHER	0				0	
6. 01 03610 SLEEP LAB	4, 162				43	
6. 97 07697 CARDI AC REHABI LI TATI ON	0				0	
OUTPATIENT SERVICE COST CENTERS			0.00000		0	, 0. /
0. 00 09000 CLINIC	0	0	0.0000	0 0	0	90. c
0. 01 09001 DENTAL CLINIC	0	0	0. 00000		0	
0. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE	0	n 0	0. 00000		0	
0. 03 09003 DI ABETI C TRAI NI NG	0	0 0	0.00000		0	
1. 00 09100 EMERGENCY	330, 118	27, 564, 237			7, 388	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	175, 179				4, 328	
OTHER REIMBURSABLE COST CENTERS	175,179	11, 301, 210	0.0134	200,070	4, 320	72.0
5. 00 09500 AMBULANCE SERVICES						95.0
			1			1 /0.0

Health Financial Systems	LAPORTE H			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COS	TS Provider C		Period: From 03/01/2016 To 12/31/2016	Date/Time Pre 5/31/2017 9:2	
		Titl	e 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 & PEDI ATRI CS	C) C)	0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	C	C		0	0	31.00
40. 00 04000 SUBPROVI DER – I PF	C) c)	0 0	0	40.00
41. 00 04100 SUBPROVIDER - IRF	0) c		0 0	l o	41.00
43. 00 04300 NURSERY	0			0	0	43.00
44.00 04400 SKILLED NURSING FACILITY				-	0	
200.00 Total (lines 30-199)				0	-	200.00
Cost Center Description	Total Patient	Per Diem (col.	Inpati ent	I npati ent		200100
	Days	$5 \div col. 6$	Program Days			
				Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6,00	7.00	8,00	9,00		
INPATIENT ROUTINE SERVICE COST CENTERS					I	
30, 00 03000 ADULTS & PEDIATRICS	13, 952	0.00	2,09	7 0		1 30. 00
31. 00 03100 I NTENSI VE CARE UNI T	3, 445					31.00
40. 00 04000 SUBPROVI DER – I PF		0.00		0 0		40.00
41. 00 04100 SUBPROVIDER - IRF		0.00		0 0		41.00
43. 00 04300 NURSERY	1, 376			8 0		43.00
44. 00 04400 SKILLED NURSING FACILITY	1, 570			0 0		44.00
200.00 Total (lines 30-199)	18, 773		3, 55			200.00
	1 10,773	1	1 3, 55	<u>-</u>	I	1200.00

Health Financial Systems	LAPORTE H	OSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS			Period: From 03/01/2016 To 12/31/2016		pared: 3 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anestheti st			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS				-		
50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	C		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
54. 02 05402 ULTRASOUND	0	C		0 0	0	54.02
56. 00 05600 RADI 0I SOTOPE	0	C		0 0	0	56.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
58. 00 05800 MRI	0	C		0 0	0	58.00
60. 00 06000 LABORATORY	0	C		0 0	0	1
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C		0 0	0	
65. 00 06500 RESPIRATORY THERAPY	0	C		0 0	0	1
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	1
67. 00 06700 OCCUPATI ONAL THERAPY	0	C C		0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0	C C		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	C C		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C C			0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0				0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	C C			0	1
74. 00 07400 RENAL DIALYSIS	0	0			0	
76.00 03950 OTHER ANCI LLARY-OTHER	0				0	
76. 01 03610 SLEEP LAB	0			0 0	-	
76. 97 07697 CARDI AC REHABI LI TATI ON	0			0 0		
OUTPATIENT SERVICE COST CENTERS	0	L C		0 0	0	10. 77
90. 00 09000 CLINIC	0	C	1	0 0	0	90.00
90. 01 09001 DENTAL CLINIC	0				0	
90. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE	0				0	
90. 03 09003 DI ABETI C TRAI NI NG					0	
91. 00 09100 EMERGENCY					0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART					0	
OTHER REIMBURSABLE COST CENTERS	0	L C	1		1 0	72.00
95. 00 09500 AMBULANCE SERVICES			1		1	95.00
200.00 Total (lines 50-199)	0	C		0 0	0	200.00
200.00 [10tal (11163 00-177)	0	l C	1	U U	1 0	1200.00

DEPOST ON VENT OF UNDATIONT (OUTBAT) FUT OF STATES				=	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider CO	CN: 15-0006	Peri od:	Worksheet D	
THROUGH COSTS				From 03/01/2016 To 12/31/2016	Part IV Date/Time Pre	norod.
				To 12/31/2016	5/31/2017 9:2	pareu: 3 am
		Titl	e XIX	Hospi tal	PPS	o un
Cost Center Description	Total	Total Charges			Inpatient	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	5	
	4)	,	,	7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS			•			
50. 00 05000 OPERATI NG ROOM	0	78, 822, 380	0.00000	0. 000000	6, 051, 238	50.00
51.00 05100 RECOVERY ROOM	0	4, 378, 698	0.00000	0. 000000	206, 034	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	12, 023, 900	0.00000	0. 000000	1, 585, 762	
53. 00 05300 ANESTHESI OLOGY	0	15, 155, 677	0.00000	0. 000000	931, 827	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	10, 265, 889	0.00000	0. 000000	252, 141	54.00
54. 02 05402 ULTRASOUND	0	5, 318, 107			117, 164	54.02
56. 00 05600 RADI 0I SOTOPE	0	6, 737, 061	0. 00000	0. 000000	125, 377	56.00
57.00 05700 CT SCAN	0	20, 861, 189			609, 632	57.00
58. 00 05800 MRI	0	9, 260, 198		0. 000000	139, 905	58.00
50. 00 06000 LABORATORY	0	52, 469, 365	0.00000	0. 000000	2, 700, 898	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	252, 509	0.00000	0. 000000	1, 437	62.00
65. 00 06500 RESPI RATORY THERAPY	0	5, 872, 059	0.00000	0. 000000	641, 875	65.00
56. 00 06600 PHYSI CAL THERAPY	0	7, 911, 364	0.00000	0. 000000	110, 640	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	3, 115, 996			148, 691	67.00
58. 00 06800 SPEECH PATHOLOGY	0	2, 999, 255	0. 00000	0. 000000	28, 633	68.00
59. 00 06900 ELECTROCARDI OLOGY	0	33, 356, 357		0. 000000	904, 163	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	16, 122, 166		0. 000000	1, 342, 670	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	17, 126, 806		0. 000000	1, 536, 325	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	56, 633, 334	0. 00000	0. 000000	4, 874, 736	73.00
74. 00 07400 RENAL DI ALYSI S	0	1, 375, 611	0. 00000	0. 000000	84, 116	74.00
76.00 03950 OTHER ANCI LLARY-OTHER	0	0	0. 00000	0. 000000	0	76.00
76.01 03610 SLEEP LAB	0	2, 974, 903			30, 847	76.01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0			0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0	0.00000	0. 000000	0	90.00
90. 01 09001 DENTAL CLINIC	0	0			0	90.01
90. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE	0	0			0	90.02
90. 03 09003 DI ABETI C TRAI NI NG	0	0	0.00000		0	90.03
91. 00 09100 EMERGENCY	0	27, 564, 237			616, 917	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0				280, 676	
OTHER REIMBURSABLE COST CENTERS						1
						95.00
95. 00 09500 AMBULANCE SERVICES						75.00

Health Financial Systems	LAPORTE HO	SPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	Provider C		Period: From 03/01/2016 To 12/31/2016	Date/Time Pre 5/31/2017 9:2	epared: 23 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 <u>x col. 10</u>) 11.00	Outpatient Program Charges 12.00	Outpatient Program Pass-Throug Costs (col. <u>x col. 12)</u> 13.00	h		
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 54. 00 05402 ULTRASOUND 56. 00 05600 RADI OLOGY-DI AGNOSTI C 57. 00 05700 CT SCAN 58. 00 05600 RADI OL SOTOPE 57. 00 05700 CT SCAN 58. 00 06200 MRI 60. 00 06000 LABORATORY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 72. 00 07200 INPL. DEV. CHARGED TO PATI ENTS				0 0 0 0 0 0 0 0 0 0 0 0 0 0		$\begin{array}{c} 50.\ 00\\ 51.\ 00\\ 52.\ 00\\ 52.\ 00\\ 54.\ 00\\ 54.\ 02\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 60.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 74.\ 00\\ 76.\ 97\\ \end{array}$
90. 00 09000 CLINIC	0	C		0		90.00
90. 00 09001 DENTAL CLINIC 90. 01 09001 DENTAL CLINIC 90. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE 90. 03 09003 DIABETIC TRAINING 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REI MBURSABLE COST CENTERS OTHER SEMANDARY				0 0 0 0 0		90.00 90.01 90.02 90.03 91.00 92.00
95. 00 09500 AMBULANCE SERVICES 200. 00 Total (lines 50-199)	0	C		0		95. 00 200. 00

PPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ID VACCINE COST	Provider C	CN: 15-0006	Period: From 03/01/2016 To 12/31/2016		
		Titl	e XIX	Hospi tal	PPS	_
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To			
			Ded. & Coins			
			(see inst.)			
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
0. 00 05000 OPERATI NG ROOM	0. 134540				0	
1.00 05100 RECOVERY ROOM	0. 151925				0	
2.00 05200 DELIVERY ROOM & LABOR ROOM	0. 294254	0		0 0	0	
3. 00 05300 ANESTHESI OLOGY	0. 212451	0	2, 265, 3		0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 720755		1, 597, 0		0	
4. 02 05402 ULTRASOUND	0. 133894		1, 448, 7		0	
6. 00 05600 RADI OI SOTOPE	0. 119162		665, 3		0	56.00
7.00 05700 CT SCAN	0. 061555				0	57.0
8. 00 05800 MRI	0. 118273		1, 635, 2		0	58.00
0. 00 06000 LABORATORY	0. 133763	0	7, 983, 4	55 0	0	60.00
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 324135	0	36, 6	70 0	0	62.00
5. 00 06500 RESPI RATORY THERAPY	0. 251696		243, 0	89 0	0	65.00
6. 00 06600 PHYSI CAL THERAPY	0. 577547		1, 199, 6	49 0	0	66.00
7. 00 06700 OCCUPATI ONAL THERAPY	0. 153987		1, 209, 20	08 0	0	67.0
8.00 06800 SPEECH PATHOLOGY	0. 488154		669, 6	57 0	0	68.00
9. 00 06900 ELECTROCARDI OLOGY	0. 289722		3, 287, 04		0	69.0
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 206116	0	1, 411, 8	80 0	0	71.0
2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 369868		1, 180, 60	00 0	0	
3.00 07300 DRUGS CHARGED TO PATIENTS	0. 159434	0	5, 815, 8	14 0	0	73.0
4.00 07400 RENAL DIALYSIS	0. 122851	0		0 0	0	
6.00 03950 OTHER ANCI LLARY-OTHER	0. 000000			0 0	0	
6. 01 03610 SLEEP LAB	0. 133799				0	
6. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.9
OUTPATIENT SERVICE COST CENTERS	- 1					
0. 00 09000 CLINIC	0. 000000			0 0	0	
0.01 09001 DENTAL CLINIC	0. 000000			0 0	0	
0. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE	0. 000000			0 0	0	
0. 03 09003 DIABETIC TRAINING	0. 000000	0		0 0	0	
1.00 09100 EMERGENCY	0. 186591	0			0	
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 249859	0	1, 885, 2	17 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	_	1				
5. 00 09500 AMBULANCE SERVICES	0. 000000	0		0		95.00
00.00 Subtotal (see instructions)		0	55, 802, 3	62 0	0	200.00
01.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
02.00 Net Charges (line 200 +/- line 201)		0	55, 802, 3	62 0	0	202.00

Health Financial Systems	LAPORTE H				u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CC	CN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre 5/31/2017 9:2	
		Titl	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
·	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	1, 455, 170	0				50.00
51.00 05100 RECOVERY ROOM	130, 209	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	481, 283	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 151, 059	0				54.00
54. 02 05402 ULTRASOUND	193, 980	0				54.02
56. 00 05600 RADI OI SOTOPE	79, 288	0				56.00
57.00 05700 CT SCAN	199, 409	0				57.00
58. 00 05800 MRI	193, 403	0				58.00
60. 00 06000 LABORATORY	1,067,891	0				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	11, 886	0				62.00
65. 00 06500 RESPI RATORY THERAPY	61, 185	0				65.00
66. 00 06600 PHYSI CAL THERAPY	692, 854	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	186, 202	0				67.00
68.00 06800 SPEECH PATHOLOGY	326, 896	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	952, 328	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	291, 011	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	436, 666	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	927, 238	0				73.00
74.00 07400 RENAL DIALYSIS	0	0				74.00
76.00 03950 OTHER ANCILLARY-OTHER	0	0				76.00
76.01 03610 SLEEP LAB	75, 042	0				76.01
76. 97 07697 CARDIAC REHABILITATION	0	0				76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
90. 01 09001 DENTAL CLINIC	0	0				90.01
90. 02 09002 OTHER OUTPATIENT SERVICE COST CENTE	0	0				90.02
90. 03 09003 DI ABETI C TRAI NI NG	0	0				90.03
91.00 09100 EMERGENCY	1, 454, 472	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	471, 038	0				92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES	0					95.00
200.00 Subtotal (see instructions)	10, 838, 510	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	10, 838, 510	0				202.00

)MPUT.	Financial Systems LAPORTE HOS ATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0006	Period: From 03/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet D-1 Date/Time Pre 5/31/2017 9:23	pare
	Cost Center Description	Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS				-
00	Inpatient days (including private room days and swing-bed day	vs. excluding newborn)		13, 952	1.
00	Inpatient days (including private room days, excluding swing			13, 952	2.
00	Private room days (excluding swing-bed and observation bed da	ays). If you have only p	rivate room days,	0	3.
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	bed days)		11, 712	4
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	
00	reporting period				,
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	- 31 of the cost	0	7
	reporting period			_	
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 of the cost	0	8
00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	6, 631	9
	newborn days)			_	
0. 00	Swing-bed SNF type inpatient days applicable to title XVIII of through December 31 of the cost reporting period (see instruc		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11
	December 31 of the cost reporting period (if calendar year, e				
2.00	Swing-bed NF type inpatient days applicable to titles V or XI through December 31 of the cost reporting period	IX only (including privat	te room days)	0	12
3.00	Swing-bed NF type inpatient days applicable to titles V or XI	IX only (including privat	te room days)	0	13
	after December 31 of the cost reporting period (if calendar y	year, enter 0 on this lin	ne)	-	
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
. 00	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 o	of the cost	0.00	17
8. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost	0.00	18
	reporting period				
9.00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	f the cost	0.00	19
). 00	reporting period Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	the cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruction			17, 681, 087	
2.00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	ber 31 of the cost report	ting period (line	0	22
3.00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	ng period (line 6	0	23
	x line 18)				
1.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	er 31 of the cost reporti	ng period (line	0	24
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25
00	x line 20)			0	1
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 17, 681, 087	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			117 00 17 00 1	
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	narges)		28
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.000000	
. 00	Average private room per diem charge (line 29 ÷ line 3)	·		0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)		-+:)	0.00	
	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li			0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	36
. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	17, 681, 087	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PART IT - HOSPITAL AND SUBPROVIDERS UNLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
	Adjusted general inpatient routine service cost per diem (see	e instructions)		1, 267. 28	
. 00	Program general inpatient routine service cost (line 9 x line			8, 403, 334	
	Medically necessary private room cost applicable to the Progr			0	40

IPUTATION OF INPATIENT OPERATING COST		Provider C		Period: From 03/01/2016	Worksheet D-	1
				To 12/31/2016		
Cast Contar Description	Total		XVIII Average Per	Hospital Program Days	PPS Program Cost	
Cost Center Description	Inpatient Cost		Diem (col. 1		(col. 3 x col.	
	1.00	2.00	col. 2) 3.00	4.00	4) 5.00	+
00 NURSERY (title V & XIX only)	0	0) 42
Intensive Care Type Inpatient Hospital Units	(002 540	2 445	1 740 /	1 0 4 7	1 004 504	1 42
00 I NTENSI VE CARE UNI T 00 CORONARY CARE UNI T	6, 003, 549	3, 445	1, 742. 6	8 1,047	1, 824, 586	5 43 44
00 BURN INTENSIVE CARE UNIT						45
00 SURGI CAL I NTENSI VE CARE UNI T						46
00 OTHER SPECIAL CARE (SPECIFY)						47
Cost Center Description					1.00	
00 Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			12, 407, 04	1 48
00 Total Program inpatient costs (sum of lines 4	1 through 48)(s	ee instructio	ns)		22, 634, 96	1 49
PASS THROUGH COST ADJUSTMENTS 00 Pass through costs applicable to Program inpa	tiont routing c	anulaas (from	Wkct D cum	of Dorte L and	4E1 14	6 50
(111)	ittent foutine s		WKSL. D, SUM	UI PAILS I ANU	654, 166	5 50
00 Pass through costs applicable to Program inpa	tient ancillary	services (fr	om Wkst. D, s	um of Parts II	653, 489	9 51
and IV)					1 007 /	
00 Total Program excludable cost (sum of lines 5 00 Total Program inpatient operating cost exclud		ated non-nbw	sician anosth	atist and	1, 307, 655 21, 327, 306	
medical education costs (line 49 minus line 5		ateu, non-pny	Si ci ali allesti	etist, and	21, 327, 300	
TARGET AMOUNT AND LIMIT COMPUTATION						
00 Program di scharges						54
00 Target amount per discharge 00 Target amount (line 54 x line 55)						0 55 0 56
00 Difference between adjusted inpatient operati	ng cost and tar	aet amount (I	ine 56 minus	line 53)		5 50 5 57
00 Bonus payment (see instructions)	5	J				58
00 Lesser of lines 53/54 or 55 from the cost rep	orting period e	nding 1996, u	pdated and co	mpounded by the	0.00	D 59
market basket 00 Lesser of lines 53/54 or 55 from prior year of	ost report und	ated by the m	arket basket		0.00	0 60
00 If line 53/54 is less than the lower of lines				the amount by		0 61
which operating costs (line 53) are less than		(lines 54 x	60), or 1% of	the target		
amount (line 56), otherwise enter zero (see i	nstructions)					
00 Relief payment (see instructions)00 Allowable Inpatient cost plus incentive payment	ent (see instruc	tions)				0 62 0 63
PROGRAM I NPATI ENT ROUTI NE SWI NG BED COST						
00 Medicare swing-bed SNF inpatient routine cost	s through Decem	ber 31 of the	cost reporti	ng period (See	(0 64
<pre>instructions)(title XVIII only) 00 Medicare swing-bed SNF inpatient routine cost</pre>	s after Decembe	r 31 of the c	ost reporting	period (See		0 65
instructions) (title XVIII only)	s arter becenibe		UST TEPOTITING	period (see		
00 Total Medicare swing-bed SNF inpatient routir	ne costs (line 6	4 plus line 6	5)(title XVII	l only). For		0 66
CAH (see instructions)		D	£ +			
00 Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 0	r the cost re	porting period) 67
00 Title V or XIX swing-bed NF inpatient routine	e costs after De	cember 31 of	the cost repo	rting period		0 68
(line 13 x line 20)			()			
00 Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU			,		[(<u>)</u> 69
00 Skilled nursing facility/other nursing facili						70
00 Adjusted general inpatient routine service co		ne 70 ÷ line	2)			71
00 Program routine service cost (line 9 x line 7		(1:00 14 ''	no 25)			72
00 Medically necessary private room cost applica 00 Total Program general inpatient routine servi			ne 35)			73
00 Capital -related cost allocated to inpatient r	•	,	orksheet B, P	art II, column		75
26, line 45)						
00 Per diem capital -related costs (line 75 ÷ lin						76
00 Program capital-related costs (line 9 x line 00 Inpatient routine service cost (line 74 minus						77
00 Aggregate charges to beneficiaries for excess	,	ovi der record	s)			79
00 Total Program routine service costs for compa	• •		· · · · · · · · · · · · · · · · · · ·	us line 79)		80
00 Inpatient routine service cost per diem limit						81
00 Inpatient routine service cost limitation (li 00 Reasonable inpatient routine service costs (s	,					82
00 Program inpatient ancillary services (see ins		2				84
00 Utilization review - physician compensation (s)				85
00 Total Program inpatient operating costs (sum		ough 85)				86
PART IV - COMPUTATION OF OBSERVATION BED PASS 00 Total observation bed days (see instructions)					2, 240	0 87
00 Adjusted general inpatient routine cost per c		line 2)			1, 267. 28	
					2, 838, 707	

Health Financial Systems	LAPORTE H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 03/01/2016	Worksheet D-1	
				To 12/31/2016		
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	1, 091, 126	17, 681, 087	0. 06171	1 2, 838, 707	175, 179	90.00
91.00 Nursing School cost	0	17, 681, 087	0.00000	2, 838, 707	0	91.00
92.00 Allied health cost	0	17, 681, 087	0.00000	2, 838, 707	0	92.00
93.00 All other Medical Education	0	17, 681, 087	0.00000	2, 838, 707	0	93.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-0006	Period: From 03/01/2016	Worksheet D-1	
			To 12/31/2016	Date/Time Prep 5/31/2017 9:23	
	Cost Center Description	Title XIX	Hospi tal	PPS	
				1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
	Inpatient days (including private room days and swing-bed			13, 952	1
00 00	Inpatient days (including private room days, excluding swi Private room days (excluding swing-bed and observation be		rivate room days,	13, 952 0	
	do not complete this line.	5, 5, 5, 5,		44 740	
00 00	Semi-private room days (excluding swing-bed and observation Total swing-bed SNF type inpatient days (including private reporting period		er 31 of the cost	11, 712 0	4
00	Total swing-bed SNF type inpatient days (including privat reporting period (if calendar year, enter 0 on this line)	e room days) after December	31 of the cost	0	6
00	Total swing-bed NF type inpatient days (including private	room days) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	room days) after December 3	31 of the cost	0	8
00	Total inpatient days including private room days applicabl newborn days)	le to the Program (excluding	g swing-bed and	2, 097	9
. 00	Swing-bed SNF type inpatient days applicable to title XVI through December 31 of the cost reporting period (see ins		room days)	0	10
. 00	Swing-bed SNF type inpatient days applicable to title XVI December 31 of the cost reporting period (if calendar year	II only (including private m	room days) after	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V on through December 31 of the cost reporting period		e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or after December 31 of the cost reporting period (if calenda			0	1:
	Medically necessary private room days applicable to the Pr Total nursery days (title V or XIX only)			0 1, 376	14
	Nursery days (title V or XIX only)			918	
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to ser	rvices through December 31 d	of the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to ser	rvices after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to serv	vices through December 31 of	f the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to serv reporting period	vices after December 31 of t	the cost	0.00	20
	Total general inpatient routine service cost (see instruc: Swing-bed cost applicable to SNF type services through Dec		ing period (line	17, 681, 087 0	
. 00	5 x line 17) Swing-bed cost applicable to SNF type services after Dece	mber 31 of the cost reportin	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through Dece	ember 31 of the cost reporti	ng period (line	0	24
. 00	7 x line 19) Swing-bed cost applicable to NF type services after December	ber 31 of the cost reporting	g period (line 8	0	25
	x line 20) Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed co PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			17, 681, 087	
	General inpatient routine service charges (excluding swing Private room charges (excluding swing-bed charges)	g-bed and observation bed ch	narges)	0	
	Semi -private room charges (excluding swing-bed charges)			0	30
	General inpatient routine service cost/charge ratio (line	27 ÷ line 28)		0.000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line		stions)	0.00	
	Average per diem private room charge differential (line 32		crions)	0.00	
	Average per diem private room cost differential (line 34 : Private room cost differential adjustment (line 3 x line 3			0. 00 0	
	Private room cost differential adjustment (line 3 x line 3 General inpatient routine service cost net of swing-bed co		fferential (line	0 17, 681, 087	36
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST			1 0/7 00	
	Adjusted general inpatient routine service cost per diem Program general inpatient routine service cost (line 9 x)			1,267.28	
. 00	Medically necessary private room cost applicable to the Pi			2, 657, 486 0	
00					

UMPUI	TATION OF INPATIENT OPERATING COST		Provider CO		eri od:	Worksheet D-1	
					rom 03/01/2016 o 12/31/2016		
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		inpatrent cost	inpatrent bays	col. 2)		4)	
		1.00	2.00	3.00	4.00	5.00	
2.00	NURSERY (title V & XIX only)	76, 451	1, 376	55.56	918	51, 004	42.
00	Intensive Care Type Inpatient Hospital Units	(002 E40	2 445	1 742 40	E 27	025 010	1 42
. 00	I NTENSI VE CARE UNI T CORONARY CARE UNI T	6, 003, 549	3, 445	1, 742. 68	537	935, 819	43.
. 00	BURN INTENSIVE CARE UNIT						45
	SURGI CAL I NTENSI VE CARE UNI T						46.
. 00	OTHER SPECIAL CARE (SPECIFY)						47.
	Cost Center Description					1.00	
. 00	Program inpatient ancillary service cost (Wks	t D-3 col 3	line 200)			1.00 4,484,369	48.
. 00				ns)		8, 128, 678	
	PASS THROUGH COST ADJUSTMENTS					, ., .	
0. 00	Pass through costs applicable to Program inpa	ntient routine	services (from	Wkst. D, sum	of Parts I and	256, 123	50.
~~~	)					255 040	
. 00	Pass through costs applicable to Program inpa and IV)	atient and Har	y services (Tr	UNIWKSL. D, SU	m or Parts II	255, 949	51
2. 00	Total Program excludable cost (sum of lines 5	i0 and 51)				512, 072	52.
3.00	Total Program inpatient operating cost exclud		lated, non-phy	sician anesthe	tist, and	7, 616, 606	53.
	medical education costs (line 49 minus line 5	52)					
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program di scharges						54
. 00	Target amount per discharge					0.00	
. 00	Target amount (line 54 x line 55)					0.00	
. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus l	ine 53)	0	57
. 00	Bonus payment (see instructions)					0	
. 00	Lesser of lines 53/54 or 55 from the cost rep market basket	orting period	endi ng 1996, u	pdated and com	pounded by the	0.00	59
. 00	Lesser of lines 53/54 or 55 from prior year of	ost report up	dated by the m	arket basket		0.00	60
. 00	If line 53/54 is less than the lower of lines				he amount by	0	
	which operating costs (line 53) are less than		s (lines 54 x	60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see i	nstructions)					
2.00		nt (coo instru	ctions)			0	
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						03
. 00		s through Dece	mber 31 of the	cost reportin	g period (See	0	64
	instructions)(title XVIII only)					_	
5.00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	s after Decemb	er 31 of the c	ost reporting	period (See	0	65.
5. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66.
	CAH (see instructions)			0)((()())	0		
7.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 o	f the cost rep	orting period	0	67.
0 00	(line 12 x line 19)	anata aftar D	acombon 21 of	the east report	ting pariod		
3. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs arter D	ecemper 31 or	the cost repor	ting period	0	68.
9. 00		outine costs (	line 67 + line	68)		0	69.
	PART III - SKILLED NURSING FACILITY, OTHER NU	RSING FACILITY	, AND ICF/IID	ONLY			
0. 00	Skilled nursing facility/other nursing facili						70.
. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line 7		ıne /O ÷ line	2)			71
. 00	Medically necessary private room cost application	,	(line 14 x li	ne 35)			72
. 00	Total Program general inpatient routine servi	0					74
. 00	Capital-related cost allocated to inpatient r			orksheet B, Pa	rt II, column		75
	26, line 45)						
. 00 . 00	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76
. 00	Inpatient routine service cost (line 74 minus						78
. 00	Aggregate charges to beneficiaries for excess		rovi der record	s)			79
. 00	Total Program routine service costs for compa		ost limitation	(line 78 minu	s line 79)		80
. 00	Inpatient routine service cost per diem limit		、 、				81
. 00	Inpatient routine service cost limitation (li		* .				82
. 00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		5)				83
. 00			ns)				85
. 00	1 5 1					<u> </u>	86
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST					
7.00	Total observation bed days (see instructions)					2,240	
3.00	Adjusted general inpatient routine cost per c Observation bed cost (line 87 x line 88) (see		line 2)			1, 267. 28 2, 838, 707	
	(See A = A = A = A = A = A = A = A = A = A						1 04

Health Financial Systems	LAPORTE H	IOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 03/01/2016	Worksheet D-1	
				To 12/31/2016		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital-related cost	1, 091, 126	17, 681, 087	0. 06171	1 2, 838, 707	175, 179	90.00
91.00 Nursing School cost	0	17, 681, 087	0.00000	2, 838, 707	0	91.00
92.00 Allied health cost	0	17, 681, 087	0.00000	2, 838, 707	0	92.00
93.00 All other Medical Education	0	17, 681, 087	0.00000			93.00

ATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet D-3 Date/Time Pre 5/31/2017 9:2	epar
	Title	e XVIII	Hospi tal	PPS	<u>5 a</u>
Cost Center Description		Ratio of Cos		I npati ent	
'		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	-
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			4
00 03000 ADULTS & PEDIATRICS			13, 971, 418		30
00 03100 I NTENSI VE CARE UNI T			3, 580, 446		31
00 04000 SUBPROVIDER - IPF			0		40
00 04100 SUBPROVIDER - IRF			0		41
00 04300 NURSERY					43
ANCI LLARY SERVI CE COST CENTERS		0 1015	11 007 0/4	1 (10 700	ا
00 05000 OPERATING ROOM		0. 13454			
00 05100 RECOVERY ROOM		0. 15192			
00 05200 DELIVERY ROOM & LABOR ROOM		0. 29425			
00 05300 ANESTHESI OLOGY		0. 21245			
00 05400 RADI OLOGY-DI AGNOSTI C		0. 72075			
02 05402 ULTRASOUND		0. 13389			
00 05600 RADI OI SOTOPE		0. 11916			
00 05700 CT SCAN		0.06155		181, 494	
00 05800 MRI		0. 11827			
00 06000 LABORATORY		0. 13376		1, 118, 722	
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 32413			
00 06500 RESPI RATORY THERAPY		0. 25169			
00 06600 PHYSI CAL THERAPY		0. 57754			
00 06700 OCCUPATI ONAL THERAPY		0. 15398			
00 06800 SPEECH PATHOLOGY		0. 48815		136, 991	
00 06900 ELECTROCARDI OLOGY		0. 28972			
00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 20611		808, 589	
00 07200 I MPL. DEV. CHARGED TO PATI ENTS		0.36986		1, 682, 955	
00 07300 DRUGS CHARGED TO PATIENTS		0. 15943			
00 07400 RENAL DI ALYSI S		0. 12285		106, 757	
00 03950 OTHER ANCI LLARY-OTHER		0.00000		0	
01 03610 SLEEP LAB		0. 13379			
97 07697 CARDI AC REHABI LI TATI ON		0.00000	0 0	0	76
OUTPATIENT SERVICE COST CENTERS		0.0000		0	1 ~
		0.00000			
01 09001 DENTAL CLINIC 02 09002 OTHER OUTPATIENT SERVICE COST CENTE		0.00000		-	1
		0.00000		0	
03 09003 DI ABETI C TRAI NI NG		0.00000		-	
00 09100 EMERGENCY 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 18659			
00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS		0. 24985	59 411, 891	102, 915	1 74
00 09500 AMBULANCE SERVICES		1			9!
DOU 09500 AMBULANCE SERVICES D. 00 Total (sum of lines 50-94 and 96-98)			62 570 447	12 407 041	
	cape (line 41)		63, 578, 667	12, 407, 041	200
.00 Less PBP Clinic Laboratory Services-Program only cha	yes (inne of)		63, 578, 667		20

PATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-0006	Period: From 03/01/2016 To 12/31/2016		par
	Ti +1	e XIX	Hospi tal	5/31/2017 9:2 PPS	<u>3 a</u>
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	-		
00 03000 ADULTS & PEDI ATRI CS			3, 188, 207		30
00 03100 INTENSIVE CARE UNIT			1, 129, 386		31
00 04000 SUBPROVIDER - IPF			0		40
00 04100 SUBPROVIDER - IRF			0		41
00 04300 NURSERY			1, 117, 095		43
ANCI LLARY SERVICE COST CENTERS			·		4_
00 05000 OPERATING ROOM		0. 13454			
00 05100 RECOVERY ROOM		0. 15192			
00 05200 DELIVERY ROOM & LABOR ROOM		0. 29425			
00 05300 ANESTHESI OLOGY		0. 21245		197, 968	
00 05400 RADI OLOGY-DI AGNOSTI C		0. 72075		181, 732	
02 05402 ULTRASOUND		0. 13389			
00 05600 RADI 0I SOTOPE		0. 11916		14, 940	
00 05700 CT SCAN		0.06155		37, 526	
00 05800 MRI		0. 1182			
		0. 13376			
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 32413			
		0. 25169			
00 06600 PHYSI CAL THERAPY		0. 57754			
00 06700 OCCUPATIONAL THERAPY		0. 15398		22, 896	
00 06800 SPEECH PATHOLOGY		0. 48815			
00 06900 ELECTROCARDI OLOGY		0. 28972			
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2061			
00 07200 IMPL. DEV. CHARGED TO PATIENTS		0.36986		568, 237	
00 07300 DRUGS CHARGED TO PATIENTS 00 07400 RENAL DIALYSIS		0. 15943			
00 07400 RENAL DIALYSIS 00 03950 OTHER ANCILLARY-OTHER		0. 12285		10, 334	
01 03930 OTHER ANGI LLART-OTHER 01 03610 SLEEP LAB		0. 13379		4, 127	
97 07697 CARDI AC REHABI LI TATI ON		0. 00000		4, 127	
OUTPATIENT SERVICE COST CENTERS		0.00000	0	0	1 //
00 09000 CLINIC		0.0000	0 00	0	90
01 09001 DENTAL CLINIC		0.00000			
02 09002 OTHER OUTPATIENT SERVICE COST CENTE		0.00000		-	
03 09003 DI ABETI C TRAI NI NG		0.00000		0	
00 09100 EMERGENCY		0. 18659		115, 111	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 24985			
OTHER REIMBURSABLE COST CENTERS		0.2490	200, 070	10,127	1 ''
00 09500 AMBULANCE SERVICES					9!
D. 00 Total (sum of lines 50-94 and 96-98)			23, 321, 704	4, 484, 369	
Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0	1, 101, 307	20
2.00 Net Charges (line 200 minus line 201)			23, 321, 704		202

ALCUL	Financial Systems LAPORTE HOS ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	Period: From 03/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/31/2017 9:2	pared:
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				
. 00 . 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurr instructions)	ing prior to October 1	(see	0 11, 362, 928	1.00 1.01
. 02	DRG amounts other than outlier payments for discharges occurr instructions)	ing on or after October	1 (see	3, 787, 643	1. 02
. 03	DRG for federal specific operating payment for Model 4 BPCI f 1 (see instructions)	or discharges occurring	prior to October	0	1. 03
. 04	DRG for federal specific operating payment for Model 4 BPCl f October 1 (see instructions)	for discharges occurring	on or after	0	1. 04
. 00 . 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			925, 038 0	2.00 2.01
. 02	Outlier payment for discharges for Model 4 BPCI (see instruct	i ons)		0	2.02
. 00 . 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost repo	orting period (see instru	uctions)	0 121.68	3.00 4.00
. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the mos	t recent cost reporting	period ending on	0.00	5.00
. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs which meet			0.00	6.00
. 00	for new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified			0.00	7.00
. 01	ACA Section 5503 reduction amount to the IME cap as specified If the cost report straddles July 1, 2011 then see instructio		F) (1) (i v) (B) (2)	0.00	7. 01
. 00	Adjustment (increase or decrease) to the FTE count for allopa affiliated programs in accordance with 42 CFR 413.75(b), 413. 1998), and 67 FR 50069 (August 1, 2002).	thic and osteopathic pro		0.00	8.00
. 01	The amount of increase if the hospital was awarded FTE cap sl the cost report straddles July 1, 2011, see instructions.	ots under section 5503 of	of the ACA. If	0.00	8. 01
. 02	The amount of increase if the hospital was awarded FTE cap sl under section 5506 of ACA. (see instructions)	ots from a closed teachi	ng hospital	0.00	8. 02
. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lin instructions)	es (8, 8,01 and 8,02)	(see	0.00	9.00
0.00	FTE count for allopathic and osteopathic programs in the curr	ent year from your reco	rds		10.00
1.00 2.00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)				11.00 12.00
3.00	Total allowable FTE count for the prior year.				13.00
4.00	Total allowable FTE count for the penultimate year if that ye otherwise enter zero.	ar ended on or after Se	otember 30, 1997,	0.00	14.00
5.00	Sum of lines 12 through 14 divided by 3.				15.00
6.00 7.00	Adjustment for residents in initial years of the program Adjustment for residents displaced by program or hospital clo	SULLA			16.00 17.00
	Adjusted rolling average FTE count				18.00
9.00	Current year resident to bed ratio (line 18 divided by line 4	.).		0.000000	19.00
0.00	Prior year resident to bed ratio (see instructions)			0.000000	
	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
	IME payment adjustment (see instructions)			0	
2. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for Sect	ion 422 of the MMA		0	22.01
3. 00	Number of additional allopathic and osteopathic IME FTE resid $(f)(1)(iv)(C)$ .	lent cap slots under 42 S	Sec. 412.105	0.00	23.00
4.00	IME FTE Resident Count Over Cap (see instructions)	Lower of line 22 or line	24 (500	0.00	
5.00 6.00	If the amount on line 24 is greater than -0-, then enter the instructions) Posident to bed ratio (divide line 25 by line 4)	TOWEL OF TIME 23 OF TIME	5 24 (588	0.00	25.00 26.00
7.00	Resident to bed ratio (divide line 25 by line 4) IME payments adjustment factor. (see instructions)			0.000000	
	IME add-on adjustment amount (see instructions)			0	
8. 01	IME add-on adjustment amount - Managed Care (see instructions	.)		0	28. 01
	Total IME payment ( sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.0			0 0	
0 00	Disproportionate Share Adjustment				
	Percentage of SSI recipient patient days to Medicare Part A p	atient days (see instru	ctions)	3.72	
1.00	Percentage of Medicaid patient days (see instructions)			21.48	
2.00 3.00	Sum of lines 30 and 31 Allowable disproportionate share percentage (see instructions	.)			32.00 33.00
J. UU	Disproportionate share adjustment (see instructions)	·/			34.0

0.4.1.01.11	2	HOSPITAL		u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Period: From 03/01/2016 To 12/31/2016		pared:
				5/31/2017 9:2	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	2.00	
	Uncompensated Care Adjustment		1.00	2.00	
35.00	Total uncompensated care amount (see instructions)		6, 406, 145, 534	5, 977, 483, 147	35.00
35.01	Factor 3 (see instructions)		0.000131489	0.000124100	35.01
35.02	Hospital uncompensated care payment (If line 34 is zero,	enter zero on this line)	842, 340	741, 806	35.02
05 00	(see instructions)		100 515	10/ 07/	05 0/
35.03 36.00	Pro rata share of the hospital uncompensated care payment Total uncompensated care (sum of columns 1 and 2 on line	. ,	492, 515 679, 491	186, 976	35.03 36.00
30.00	Additional payment for high percentage of ESRD beneficiary				30.00
40.00	Total Medicare discharges on Worksheet S-3, Part I exclud		0		40.00
	652, 682, 683, 684 and 685 (see instructions)	5 5			
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 68	2, 683, 684 an 685. (see	0		41.00
	instructions)				
41.01	Total ESRD Medicare covered and paid discharges excluding	MS-DRGs 652, 682, 683, 684	0		41.01
42.00	an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not q	ualify for adjustment)	0.00		42.00
42.00	Total Medicare ESRD inpatient days excluding MS-DRGs 652	5 5 7	0.00		42.00
	instructions)	,,,	_		
44.00	Ratio of average length of stay to one week (line 43 divi	ded by line 41 divided by 7	0. 000000		44.00
	days)				
45.00	Average weekly cost for dialysis treatments (see instruct		0.00		45.00
46.00 47.00	Total additional payment (line 45 times line 44 times lin Subtotal (see instructions)	e 41.01)	17, 134, 243		46.00 47.00
47.00	Hospital specific payments (to be completed by SCH and MD	H small rural bospitals	17, 134, 243		47.00
40.00	only. (see instructions)		0		+0.00
				Amount	
				1.00	
49.00	Total payment for inpatient operating costs (see instruct			17, 134, 243	
50.00	Payment for inpatient program capital (from Wkst. L, Pt.			1, 439, 404	50.00 51.00
51.00 52.00	Exception payment for inpatient program capital (Wkst. L, Direct graduate medical education payment (from Wkst. E-4			0	51.00
53.00	Nursing and Allied Health Managed Care payment	, The 47 see matructions).		0	53.00
54.00	Special add-on payments for new technologies			1, 036	
54.01	Islet isolation add-on payment			0	
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, li	ne 69)		0	55.00
56.00	Cost of physicians' services in a teaching hospital (see			0	56.00
57.00	Routine service other pass through costs (from Wkst. D, P		rough 35).	0	57.00
58.00	Ancillary service other pass through costs from Wkst. D,	Pt. IV, col. 11 line 200)		0	58.00
	Total (sum of amounts on lines 49 through 58) Primary payer payments			18, 574, 683	
59.00				0 18, 574, 683	60.00 61.00
60.00	51515	inus line 60)		10, 374, 0031	
60. 00 61. 00	Total amount payable for program beneficiaries (line 59 m	inus line 60)			
60.00 61.00 62.00	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries	inus line 60)		1, 665, 384	62. 0
60.00 61.00 62.00 63.00	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries	inus line 60)		1, 665, 384 67, 942	62.00 63.00
60. 00 61. 00 62. 00	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries	inus line 60)		1, 665, 384	62.00 63.00 64.00
60.00 61.00 62.00 63.00 64.00	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			1, 665, 384 67, 942 22, 105	62.00 63.00 64.00 65.00
60.00 61.00 62.00 63.00 64.00 65.00	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			1, 665, 384 67, 942 22, 105 14, 368	62.00 63.00 64.00 65.00 66.00
60.00 61.00 62.00 63.00 64.00 65.00 65.00 66.00 67.00 68.00	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices	instructions) for applicable to MS-DRGs (se		1, 665, 384 67, 942 22, 105 14, 368 22, 105 16, 855, 725 0	62.00 63.00 64.00 65.00 66.00 67.00 68.00
$\begin{array}{c} 60. \ 00\\ 61. \ 00\\ 62. \ 00\\ 63. \ 00\\ 64. \ 00\\ 65. \ 00\\ 66. \ 00\\ 67. \ 00\\ 68. \ 00\\ 69. \ 00\\ \end{array}$	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices Outlier payments reconciliation (sum of lines 93, 95 and	instructions) for applicable to MS-DRGs (se		1, 665, 384 67, 942 22, 105 14, 368 22, 105 16, 855, 725 0 0	62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00
$\begin{array}{c} 60. \ 00\\ 61. \ 00\\ 62. \ 00\\ 63. \ 00\\ 64. \ 00\\ 65. \ 00\\ 66. \ 00\\ 67. \ 00\\ 68. \ 00\\ 69. \ 00\\ 70. \ 00\end{array}$	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices Outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	instructions) for applicable to MS-DRGs (se		1, 665, 384 67, 942 22, 105 14, 368 22, 105 16, 855, 725 0 0 0	62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00
60. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices Outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT	instructions) for applicable to MS-DRGs (se		1, 665, 384 67, 942 22, 105 14, 368 22, 105 16, 855, 725 0 0 0 0	62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 70.50
$\begin{array}{c} 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 70.\ 50\\ 70.\ 88\end{array}$	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices Outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment	instructions) for applicable to MS-DRGs (se 96).(For SCH see instructions		1, 665, 384 67, 942 22, 105 14, 368 22, 105 16, 855, 725 0 0 0 0 0 0	62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 70. 50 70. 88
$\begin{array}{c} 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 70.\ 50\\ 70.\ 88\\ 70.\ 89\\ \end{array}$	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices Outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see	instructions) for applicable to MS-DRGs (se 96).(For SCH see instructions instructions)		1, 665, 384 67, 942 22, 105 14, 368 22, 105 16, 855, 725 0 0 0 0 0 0 0 0	62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 70.50 70.88 70.88
$\begin{array}{c} 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 67.\ 00\\ 69.\ 00\\ 70.\ 00\\ 70.\ 50\\ 70.\ 88\\ 70.\ 89\\ 70.\ 90\\ \end{array}$	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices Outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see HSP bonus payment HVBP adjustment amount (see instruction	instructions) for applicable to MS-DRGs (se 96).(For SCH see instructions instructions) s)		1, 665, 384 67, 942 22, 105 14, 368 22, 105 16, 855, 725 0 0 0 0 0 0	62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 70.50 70.88 70.89 70.90
$\begin{array}{c} 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 70.\ 00\\ 70.\ 50\\ 70.\ 88\\ 70.\ 89\\ \end{array}$	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices Outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see	instructions) for applicable to MS-DRGs (se 96).(For SCH see instructions instructions) s)		1, 665, 384 67, 942 22, 105 14, 368 22, 105 16, 855, 725 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.00 70.50 70.88 70.89 70.90 70.90
$\begin{array}{c} 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 65.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 00\\ 70.\ 50\\ 70.\ 89\\ 70.\ 90\\ 70.\ 90\\ 70.\ 91\\ \end{array}$	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices Outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see HSP bonus payment HVBP adjustment amount (see instruction	instructions) for applicable to MS-DRGs (se 96).(For SCH see instructions instructions) s)		1, 665, 384 67, 942 22, 105 14, 368 22, 105 16, 855, 725 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	62.00 63.00 64.00 65.00 66.00 67.00 69.00 70.00 70.50 70.88 70.88 70.89 70.90 70.91 70.91
$\begin{array}{c} 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 62.\ 00\\ 63.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 68.\ 00\\ 70.\ 00\\ 70.\ 50\\ 70.\ 88\\ 70.\ 89\\ 70.\ 90\\ 70.\ 91\\ 70.\ 92\\ 70.\ 93\\ 70.\ 94\\ \end{array}$	Total amount payable for program beneficiaries (line 59 m Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices Outlier payments reconciliation (sum of lines 93, 95 and OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see HSP bonus payment HVBP adjustment amount (see instructions Bundled Model 1 discount amount (see instructions)	instructions) for applicable to MS-DRGs (se 96).(For SCH see instructions instructions) s)		1, 665, 384 67, 942 22, 105 14, 368 22, 105 16, 855, 725 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	62.00 63.00 64.00 65.00 66.00 67.00 68.00 69.00 70.50 70.50 70.88 70.99 70.90 70.91 70.92 70.93

Health Financial Systems	LAPORTE HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		CN: 15-0006	Period: From 03/01/2016 To 12/31/2016	Worksheet E Part A Date/Time Pre 5/31/2017 9:23	
	Title	<u>XVIII</u>	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1.00	
70.96 Low volume adjustment for federal f the corresponding federal year for	iscal year (yyyy) (Enter in column 0 the period prior to 10/1)		0	0	70. 96
	iscal year (yyyy) (Enter in column 0 the period ending on or after 10/1)		0	0	70. 97
70.98 Low Volume Payment-3				0	70.98
70.99 HAC adjustment amount (see instruct	i ons)			0	70.99
71.00 Amount due provider (line 67 minus	lines 68 plus/minus lines 69 & 70)			16, 706, 539	71.00
71.01 Sequestration adjustment (see instr	uctions)			334, 131	71.01
72.00 Interim payments				16, 241, 169	72.00
73.00 Tentative settlement (for contracto	r use only)			0	73.00
74.00 Balance due provider (Program) (lir	e 71 minus lines 71.01, 72, and 73)			131, 239	74.00
75.00 Protested amounts (nonallowable cos	t report items) in accordance with			1, 373, 936	75.00
CMS Pub. 15-2, chapter 1, §115.2					
TO BE COMPLETED BY CONTRACTOR (line					
90.00 Operating outlier amount from Wkst.				0	90.00
91.00 Capital outlier from Wkst. L, Pt. I				0	91.00
92.00 Operating outlier reconciliation ac				0	92.00
93.00 Capital outlier reconciliation adju				0	93.00
94.00 The rate used to calculate the time				0.00	
95.00 Time value of money for operating e	xpenses (see instructions)			0	95.00
96.00 Time value of money for capital rel	ated expenses (see instructions)			0	96.00
			Prior to 10/1		
			1.00	2.00	
HSP Bonus Payment Amount					
100.00 HSP bonus amount (see instructions)			0	0	100.00
HVBP Adjustment for HSP Bonus Payme					
101.00 HVBP adjustment factor (see instruc			0. 0000000000	0.000000000	
102.00 HVBP adjustment amount for HSP bonu			0	0	102.00
HRR Adjustment for HSP Bonus Paymen					
103.00 HRR adjustment factor (see instruct			0.0000	0.0000	
104.00 HRR adjustment amount for HSP bonus	payment (see instructions)		0	0	104.00

	Financial Systems LAPORTE HO ATLON OF RELMBURSEMENT SETTLEMENT	SPITAL Provider CCN: 15-0006	In Lie Period:	u of Form CMS-2	2552-10
CALCUL	ATTON OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0006	From 03/01/2016		
			To 12/31/2016	Date/Time Pre 5/31/2017 9:2	
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			15, 881	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instru PPS payments	ictions)		13, 447, 335 11, 291, 841	2.00 3.00
4.00	Outlier payment (see instructions)			140, 697	
5.00	Enter the hospital specific payment to cost ratio (see instr	ructions)		0.000	
6.00	Line 2 times line 5			0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)	LV and 12 Line 200		0	
9.00 10.00	Ancillary service other pass through costs from Wkst. D, Pt. Organ acquisitions	TV, COL. 13, TTHE 200		0	
11.00	Total cost (sum of lines 1 and 10) (see instructions)			15, 881	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
	Ancillary service charges			99, 637	
13.00 14.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Total reasonable charges (sum of lines 12 and 13)	line 69)		0 99, 637	
14.00	Customary charges			99,037	14.00
15.00	Aggregate amount actually collected from patients liable for	payment for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable f	for payment for services of		0	
	had such payment been made in accordance with 42 CFR §413.13	8(e)			
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete o	only if line 18 exceeds li	ne 11) (see	99, 637 83, 756	
17.00	instructions)		110 11) (300	03,730	
20.00	Excess of reasonable cost over customary charges (complete o	only if line 11 exceeds li	ne 18) (see	0	20.00
	instructions)				
21.00	Lesser of cost or charges (line 11 minus line 20) (for CAH s	see instructions)		15, 881	
22.00 23.00	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see ins	structions)		0	
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)			11, 432, 538	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance (for CAH, see instructions)			1, 172	
	Deductibles and Coinsurance relating to amount on line 24 (f			2, 126, 959	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) instructions)	prus the sum of filles 22	anu 23] (See	9, 320, 288	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4,	line 50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36			0	29.00
30.00	Subtotal (sum of lines 27 through 29)			9, 320, 288	
31.00	Primary payer payments			0 220 200	31.00
32.00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	(LCES)		9, 320, 288	32.00
33.00	Composite rate ESRD (from Wkst. 1-5, line 11)	1020)		0	33.00
	Allowable bad debts (see instructions)			121, 793	34.00
35.00	Adjusted reimbursable bad debts (see instructions)			79, 165	
36.00	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		121, 793	
37.00 38.00	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			9, 399, 453 0	
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39.50	Pioneer ACO demonstration payment adjustment (see instructio	ons)		0	
39. 98	Partial or full credits received from manufacturers for repl	aced devices (see instruc	ctions)	0	39. 98
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	39.99
40.00	Subtotal (see instructions)			9, 399, 453	
40. 01 41. 00	Sequestration adjustment (see instructions) Interim payments			187, 989 9, 124, 861	
42.00	Tentative settlement (for contractors use only)			0	
43.00	Balance due provider/program (see instructions)			86, 603	
44.00	Protested amounts (nonallowable cost report items) in accord	ance with CMS Pub. 15-2,	chapter 1,	0	44.00
	\$115.2				
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
92.00	The rate used to calculate the Time Value of Money				92.00
	Time Value of Money (see instructions)			0	
	Total (sum of lines 91 and 93)			<u>۱</u>	94.00

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	F		Date/Time Prep 5/31/2017 9:23	
			XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00	Total interim payments paid to provider		16, 241, 169		9, 124, 861	1.0
. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		0		0	2. 0
. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.0
01	Program to Provider	0	0		0	2.0
. 01 . 02	ADJUSTMENTS TO PROVIDER	0	0	-	0	3. C 3. C
. 02		0	0		0	3.0
. 04			0		0	3. (
. 05			0		0	3. (
	Provider to Program	1				
50	ADJUSTMENTS TO PROGRAM	0	0	-	0	3.
51 52			0		0	3. 3.
52 53					0	3. 3.
54			0		0	3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		0		0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		16, 241, 169		9, 124, 861	4.
~ ~	TO BE COMPLETED BY CONTRACTOR					_
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5.
	Program to Provider		-	I	-	_
01 02	TENTATI VE TO PROVIDER		0		0	5. 5.
02			0		0	5. 5.
50	Provider to Program	I		II	0	0.
50	TENTATI VE TO PROGRAM		0		0	5.
51			0		0	5.
52			0		0	5.
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5.
00	Determined net settlement amount (balance due) based on the cost report. (1)					6.
01	SETTLEMENT TO PROVIDER		131, 239		86, 603	6.
02	SETTLEMENT TO PROGRAM		0		0	6.
00	Total Medicare program liability (see instructions)		16, 372, 408		9, 211, 464	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	(	)	1.00	2.00	8.

Heal th	Financial Systems LAPORTE HOS	SPI TAL	In Lie	u of Form CMS-2	2552-10			
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0006 Period: Worksheet E From 03/01/2016 Part II								
	To 12/31/2016 Date/Time Pres							
	5/31/2017 9: 2							
	Title XVIII Hospital PPS							
	TO DE CONDUCTED DV CONTRACTOR FOR NONOTANDARD COST DEPORTS			1.00				
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS	1						
1.00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION Total hospital discharges as defined in AARA §4102 from Wkst.		14		1.00			
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8		; 14	0	2.00			
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	5-12		0	3.00			
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12		0	4.00			
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			0	5.00			
6.00	Total hospital charity care charges from Wkst. S-10, col. 3	ine 20		0	6.00			
7.00	CAH only - The reasonable cost incurred for the purchase of a	certified HIT technology	Wkst. S-2, Pt. I	0	7.00			
	line 168							
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00			
9.00	Sequestration adjustment amount (see instructions)			0	9.00			
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		0	10.00			
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH							
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00			
31.00	Other Adjustment (specify)		- )	0	31.00			
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see Instruction	is)	0	32.00			

		E HOSPITAL		u of Form CMS-2	
CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-		Provider CCN: 15-0006	Period: From 03/01/2016	Worksheet E-3 Part VII	
			To 12/31/2016		pared:
				5/31/2017 9:2	3 am
		Title XIX	Hospital	PPS	
			Inpatient 1.00	Outpatient 2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEAL	TH SERVICES FOR TITLES V OR >		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				1
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			10, 838, 510	•
3.00	Organ acquisition (certified transplant centers only)		0	10 000 510	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	10, 838, 510	
5.00 6.00	Inpatient primary payer payments Outpatient primary payer payments		0	0	5.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	10, 838, 510	
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonabl e Charges				
8.00	Routine service charges		0		8.00
9.00	Ancillary service charges		23, 321, 704	55, 802, 362	
10.00	Organ acquisition charges, net of revenue		0		10.00
11.00 12.00	Incentive from target amount computation Total reasonable charges (sum of lines 8 through 11)		23, 321, 704	55, 802, 362	
12.00	CUSTOMARY CHARGES		23, 321, 704	55,002,502	12.00
13.00	Amount actually collected from patients liable for payme	ent for services on a charge	0	0	13.00
	basi s	Ũ			
14.00	Amounts that would have been realized from patients liak		on 0	0	14.00
4 5 00	a charge basis had such payment been made in accordance	with 42 CFR §413.13(e)	0.000000	0,000000	45 00
15.00 16.00	Ratio of line 13 to line 14 (not to exceed 1.000000) Total customary charges (see instructions)		0. 000000 23, 321, 704	0.000000 55,802,362	
17.00	Excess of customary charges over reasonable cost (comple	ete only if line 16 exceeds	23, 321, 704	44, 963, 852	
17.00	line 4) (see instructions)		20,021,701	11, 700, 002	17.00
18.00	Excess of reasonable cost over customary charges (comple	ete only if line 4 exceeds lir	ne O	0	18.00
	16) (see instructions)				
19.00	Interns and Residents (see instructions)		0	0	
20.00 21.00	Cost of physicians' services in a teaching hospital (see Cost of covered services (enter the lesser of line 4 or		0	0 10, 838, 510	20.00
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must or			10, 030, 510	21.00
22.00	Other than outlier payments		0	0	22.00
	Outlier payments		0	0	23.00
24.00	Program capital payments		0		24.00
	Capital exception payments (see instructions)		0		25.00
	Routine and Ancillary service other pass through costs		0	0	
27.00 28.00	Subtotal (sum of lines 22 through 26) Customary charges (title V or XIX PPS covered services of		0	0	27.00
28.00	Titles V or XIX (sum of lines 21 and 27)	y)	0	10, 838, 510	•
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			10,000,010	27.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5	and 6)	0	10, 838, 510	31.00
32.00	Deducti bl es		0	0	
	Coinsurance		0	0	•
34.00 35.00	Allowable bad debts (see instructions) Utilization review		0	0	34.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines	32 and 33)	0	10, 838, 510	
	OTHER ADJUSTMENTS-ADJUSTMENT TO \$0	52 unu 55/	0	-10, 838, 510	•
38.00	Subtotal (line $36 \pm 1$ ine $37$ )		0	0	
	Direct graduate medical education payments (from Wkst. E	E-4)	0	-	39.00
40. 00	Total amount payable to the provider (sum of lines 38 ar	nd 39)	0	0	
41.00	Interim payments		0	0	
	Balance due provider/program (line 40 minus line 41)			0	42.00
42.00 43.00	Protested amounts (nonallowable cost report items) in ac			0	43.00

OD         Ca:           00         Ter           00         No:           00         AC:           00         Dut           00         Dut           00         Dut           00         La:           00         La:           00         AC:           00         CUF	and improvements ecumulated depreciation iildings ecumulated depreciation easehold improvements ecumulated depreciation xed equipment ecumulated depreciation itomobiles and trucks ecumulated depreciation ijor movable equipment	General Fund 1.00 -1,875,676 0 0 39,159,916 0 -9,529,290 2,545,241 1,075,780 1,427,569 0 32,803,540 -1,209,970 1,261,034 -1,201,513 32,536,179 -899,380 3,504,874 -1,969,414 988,233 0 0		Endowment Fund 3.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	)       1.         )       1.         )       2.         )       3.         )       4.         )       5.         )       6.         )       7.         )       8.         )       9.         )       10.         )       11.         )       12.         )       13.
OD         Ca:           00         Ter           00         No:           00         ACI           00         DO           00         DO           00         DO           00         Lai           00         ACI           00         ACI <tr< th=""><th>The second secon</th><th>-1, 875, 676 0 0 39, 159, 916 0 -9, 529, 290 2, 545, 241 1, 075, 780 1, 427, 569 0 32, 803, 540 1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414</th><th></th><th>0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0</th><th></th><th>2.         3.         4.         5.         6.         7.         8.         9.         10.         11.         12.         13.</th></tr<>	The second secon	-1, 875, 676 0 0 39, 159, 916 0 -9, 529, 290 2, 545, 241 1, 075, 780 1, 427, 569 0 32, 803, 540 1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414		0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0       0     0		2.         3.         4.         5.         6.         7.         8.         9.         10.         11.         12.         13.
OD         Ca:           00         Ter           00         No:           00         ACI           00         DO           00         DO           00         DO           00         Lai           00         ACI           00         ACI <tr< th=""><th>The second secon</th><th>0 39, 159, 916 0 -9, 529, 290 2, 545, 241 1, 075, 780 0 32, 803, 540 1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414</th><th></th><th>0 0 0 0 0</th><th></th><th>2.         3.         4.         5.         6.         7.         8.         9.         10.         11.         12.         13.</th></tr<>	The second secon	0 39, 159, 916 0 -9, 529, 290 2, 545, 241 1, 075, 780 0 32, 803, 540 1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414		0 0 0 0 0		2.         3.         4.         5.         6.         7.         8.         9.         10.         11.         12.         13.
D0         Term           D0         No           D0         Acc           D0         Acc           D0         Acc           D0         All           D0         Du           D0         Du           D0         Du           D0         Du           D0         Du           D0         Du           D0         Lai           D0         Lai           D0         Lai           D0         Lai           D0         Acc           D0         To           D0         To           D0         To           D0         To	emporary investments otes receivable counts receivable ther receivable lowances for uncollectible notes and accounts receivable lowances for uncollectible notes and rucks counul ated depreciation lowances and trucks counul ated depreciation lowances and trucks counul ated depreciation lowances and trucks counul ated depreciation lowances and trucks counts ated depreciation lowances at the provements lowances at the provements lowan	0 39, 159, 916 0 -9, 529, 290 2, 545, 241 1, 075, 780 0 32, 803, 540 1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414		0 0 0 0 0		2.         3.         4.         5.         6.         7.         8.         9.         10.         11.         12.         13.
DO         No           DO         No           DO         AC           DO         OT           DO         In           DO         <	otes receivable counts receivable ther receivable lowances for uncollectible notes and accounts receivable lowances for uncollectible notes and accounts receivable iventory repaid expenses ther current assets ue from other funds otal current assets (sum of lines 1-10) <u>XED ASSETS</u> ind ind improvements ccumulated depreciation iildings ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation it depreciation	0 -9, 529, 290 2, 545, 241 1, 075, 780 1, 427, 569 0 32, 803, 540 1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414		0 0 0 0 0 0 0 0 0 0 0		)       4.         )       5.         )       6.         )       7.         )       8.         )       9.         )       10.         )       11.         )       12.         )       13.
DO         Oth           DO         Du           DO         Lan           DO         Acc           DO         In"           DO         Del           DO         In"           DO         Del           DO         In"           DO         Del           DO         Acc           DO         Del           DO         Acc      <	ther receivable lowances for uncollectible notes and accounts receivable iventory repaid expenses ther current assets the from other funds total current assets (sum of lines 1-10) XED ASSETS and and improvements tocumulated depreciation tildings ccumulated depreciation easehold improvements tocumulated depreciation tocumulated depreciation	0 -9, 529, 290 2, 545, 241 1, 075, 780 1, 427, 569 0 32, 803, 540 1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414				5.         6.         7.         8.         9.         10.         11.         112.         13.
00         AI           00         In           00         Previous           00         To           00         To           00         To           00         To           00         To           00         To           00         Land           00         Land           00         Land           00         Land           00         Land           00         Buil           00         Acco           00         Moil           00         Acco           00         Moil           00         Acco           00         Moil           00         To           00         To           00         To           00         CUF           00         No	lowances for uncollectible notes and accounts receivable nventory repaid expenses ther current assets re from other funds vtal current assets (sum of lines 1-10) XED ASSETS und and improvements ccumulated depreciation tildings ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation tomobiles and trucks ccumulated depreciation of movable equipment	2, 545, 241 1, 075, 780 1, 427, 569 0 32, 803, 540 1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414				0       6.         0       7.         0       8.         0       9.         10.       11.         0       12.         0       13.
00         I m           00         Pro           00         Otto           00         Dot           00         Dot           00         Dot           00         Lai           00         Acc           00         To           00         To           00         To           00         To           00         To           00         CUF           00         No           00         No	Aventory repaid expenses ther current assets le from other funds otal current assets (sum of lines 1-10) XED ASSETS MADE ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS ASSETS	2, 545, 241 1, 075, 780 1, 427, 569 0 32, 803, 540 1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414				7.         8.         9.         10.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.
DO         Pro           DO         Ott           DO         Du           DO         La           OO         Acc           OO         Th'           OO         Du           OO         To           OO         To           OO         Acc           OO         To           OO         Acc           OO         Acc	repaid expenses ther current assets ie from other funds ital current assets (sum of lines 1-10) XED ASSETS ind ind improvements ccumul ated depreciation iildings ccumul ated depreciation easehold improvements ccumul ated depreciation xed equipment ccumul ated depreciation itomobiles and trucks ccumulated depreciation itomobiles equipment	1, 075, 780 1, 427, 569 0 32, 803, 540 1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414				0       8.         0       9.         10.       11.         0       12.         0       13.
DO         Oth           00         Duc           00         Duc           00         Lai           00         Aci           00         Mai	ther current assets ie from other funds ital current assets (sum of lines 1-10) XED ASSETS ind ind improvements iccumulated depreciation is depreciation assehold improvements iccumulated depreciation iccumulated depreciation	1, 427, 569 0 32, 803, 540 1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414			0 0 0 0 0 0	9.         10.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11.         11
00         Dur           00         To:           00         Lai           00         Acc           00         Bui           00         Acc           00         Bui           00         Acc           00         Mai           00         Acc           00         Mi           00         Acc           00         Mi           00         Acc           00         Mi           00         To:           00         To:           00         To:           00         To:           00         To:           00         CUF           00         Acc           00         To:           00         CUF           00         No:           00         CUF           00         No:           00         No: <tr< td=""><td>ue from other funds otal current assets (sum of lines 1-10) XED ASSETS and ind improvements ccumulated depreciation iildings ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation itomobiles and trucks ccumulated depreciation itomobiles equipment</td><td>0 32, 803, 540 1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414</td><td></td><td></td><td>0 0 0 0 0</td><td><ul> <li>10.</li> <li>11.</li> <li>12.</li> <li>13.</li> </ul></td></tr<>	ue from other funds otal current assets (sum of lines 1-10) XED ASSETS and ind improvements ccumulated depreciation iildings ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation itomobiles and trucks ccumulated depreciation itomobiles equipment	0 32, 803, 540 1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414			0 0 0 0 0	<ul> <li>10.</li> <li>11.</li> <li>12.</li> <li>13.</li> </ul>
To         To           00         Lar           00         Lar           00         Acr           00         Min           00         Acr           00         Acr           00         Acr           00         Acr           00         Min           00         Acr           00         Min           00         Min           00         Dir           00         Dir           00         Dir           00         Dir           00         Dir           00         CUF           00         No           00         Dir           00         CUF <t< td=""><td>tal current assets (sum of lines 1-10) XED ASSETS and ind improvements ccumulated depreciation iildings ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation itomobiles and trucks ccumulated depreciation of movable equipment</td><td>1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414</td><td></td><td>0 0 0 0 0 0 0 0 0 0</td><td>0</td><td>) 11. ) 12. ) 13.</td></t<>	tal current assets (sum of lines 1-10) XED ASSETS and ind improvements ccumulated depreciation iildings ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation itomobiles and trucks ccumulated depreciation of movable equipment	1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414		0 0 0 0 0 0 0 0 0 0	0	) 11. ) 12. ) 13.
FID           00         Lar           00         Lar           00         Acr           00         To           00         Dua           00         To           00         To           00         To           00         CUF           00         No           00         CUF           00         No           00         Do           00         Do           00	XED ASSETS ind ind improvements ccumulated depreciation ildings ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation itomobiles and trucks ccumulated depreciation itomobiles equipment	1, 209, 970 1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414		0 0 0 0 0 0 0 0	0 0 0	) 12. ) 13.
00         Lai           00         Lai           00         Ac:           00         Bui           00         Ac:           00         Bui           00         Ac:           00         Minito           00         To:           00         No:           00         No:           00         No:           00         No:	and improvements ccumulated depreciation iildings ccumulated depreciation easehold improvements ccumulated depreciation xed equipment ccumulated depreciation itomobiles and trucks ccumulated depreciation ijor movable equipment	1, 261, 034 -1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414		0 0 0 0 0 0	0	13.
00         Acc           00         Bui           00         Acc           00         Maj           00         Acc           00         Mi           00         Acc           00         Mi           00         Acc           00         Mi           00         Cor           00         In           00         Dep           00         To           00         To           00         To           00         To           00         CUF           00         No           00         No           00         CUF           00         No           00         No           00         No           00         No           00         No           00         No <td< td=""><td>ccumulated depreciation iI dings ccumulated depreciation casebold improvements ccumulated depreciation xed equipment ccumulated depreciation itomobiles and trucks ccumulated depreciation ijor movable equipment</td><td>-1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414</td><td></td><td>0 0</td><td>0</td><td></td></td<>	ccumulated depreciation iI dings ccumulated depreciation casebold improvements ccumulated depreciation xed equipment ccumulated depreciation itomobiles and trucks ccumulated depreciation ijor movable equipment	-1, 201, 513 32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414		0 0	0	
00         Bui           00         Acc           00         Mai           00         Acc           00         Mi           00         Acc           00         Mi           00         To           00         To           00         To           00         To           00         CUF           00         Acc           00         To           00         To           00         CUF           00         Acc           00         Acc           00         CUF           00         Acc           00         CUF           00         Do           00         Do           00         Do           00         Do	ildings cumulated depreciation easehold improvements cumulated depreciation xed equipment cumulated depreciation itomobiles and trucks cumulated depreciation ijor movable equipment	32, 536, 179 -899, 380 3, 504, 874 -1, 969, 414		0 0		s I - s
00         Acc           00         Lea           00         Acc           00         To           00         Do           00         Do           00         Do           00         Do           00         CUF           00         No	ecumulated depreciation easehold improvements ecumulated depreciation xed equipment ecumulated depreciation utomobiles and trucks ecumulated depreciation ujor movable equipment	-899, 380 3, 504, 874 -1, 969, 414				
00         Lea           00         Acc           00         Maj           00         Acc           00         Min           00         Acc           00         Min           00         Acc           00         Min           00         To           00         Dir           00         Dir           00         Dir           00         Dir           00         Dir           00         Dir           00         To           00         Dir           00         Dir           00         To           00         To           00         CUF           00         Pa:           00         No           00         No           00         Do           00         Do           00         No	easehold improvements cumulated depreciation xed equipment cumulated depreciation utomobiles and trucks cumulated depreciation jor movable equipment	3, 504, 874 -1, 969, 414		.) ∩i		
00         Acc           00         Fi :           00         Acc           00         Acc           00         Acc           00         Maj           00         Acc           00         Maj           00         Acc           00         Maj           00         Acc           00         Mi :           00         Acc           00         Mi :           00         Acc           00         Mi :           00         To           00         De           00         Du           00         Di           00         Di           00         To           00         To           00         CUF           00         Sai           00         No           00         No           00         CUF           00         No           00         No           00         No           00         No           00         No           00         No	ccumulated depreciation xed equipment ccumulated depreciation itomobiles and trucks ccumulated depreciation ij or movable equipment	-1, 969, 414		-	0	
00         Fi :           00         Acc           00         To           00         Do           00         Do           00         Do           00         Do           00         Do           00         Do           00         To           00         Acc           00         To           00         Sai           00         No           00         Do           00         Do           00         Do           00         Do           00         Do           00         Do           00         Do <td< td=""><td>xed equipment ccumulated depreciation itomobiles and trucks ccumulated depreciation ijor movable equipment</td><td></td><td>  (</td><td>0 0</td><td>0</td><td></td></td<>	xed equipment ccumulated depreciation itomobiles and trucks ccumulated depreciation ijor movable equipment		(	0 0	0	
00         Acc           00         Au           00         Acc           00         To           00         De           00         Do           00         Do           00         To           00         CUF           00         Acc           00         To           00         Acc           00         Acc           00         Acc           00         Acc           00         Acc           00         Acc           00         No           00         De           00         No           00         No           00         De           00         No           00         Acc           00         Acc	ccumulated depreciation ntomobiles and trucks ccumulated depreciation njor movable equipment	988, 233 0 0			0	
00         Au           00         Acc           00         Ma           00         Acc           00         Ma           00         Acc           00         Ma           00	itomobiles and trucks cumulated depreciation ijor movable equipment	0			0	
00         Acc           00         Maj           00         Acc           00         Deg           00         Duc           00         Duc           00         To           00         To           00         To           00         To           00         To           00         To           00         Acc           00         Sal           00         No           00         No           00         Deg           00         No           00         No           00         No           00         No           00         Acc	ccumulated depreciation njor movable equipment				0	
00         Maj           00         Acc           00         Mi           00         Acc           00         Mi           00         Acc           00         Mi           00         Acc           00         Acc           00         Mi           00         Acc           00         To           00         Di           00         Di           00         Di           00         Di           00         To           00         Di           00         To           00         Di           00         To           00         To           00         To           00         Acc           00         No           00         No           00         No           00         De           00         No           00         Do           00         Do           00         Do           00         Do           00         Acc           00	ijor movable equipment	0			0	
00         Acc           00         Min           00         Acc           00         Hi           00         Acc           00         Min           00         Acc           00         Hi           00         To           00         To           00         Del           00         Dua           00         To           00         To           00         To           00         To           00         To           00         To           00         Acc           00         To           00         Acc           00         No           00         Pa:           00         Del           00         No           00         Del           00         Do           00         Del           00         No           00         Del           00         Do           00         Do	5 1 1	24,060,775	(	0 0	0	
00         Acc           00         HI           00         Acc           00         To           00         To           00         In           00         Acc           00         Rac           00         Pa:           00         Date	cumulated depreciation	-5, 913, 294	(	o o	0	24
00         HI           00         Acc           00         Mi           00         To           00         Im           00         Im           00         Deu           00         Deu           00         Oth           00         Im           00         Deu           00         Oth           00         Acc           00         Acc           00         Acc           00         Na           00         Na           00         Na           00         Deu           00         Acc           00         Na           00         Acc	nor equipment depreciable	-871, 854	(	o c	0	25
00         Acc           00         Min           00         To           011         O           00         In           00         Deg           00         Out           00         Out           00         Out           00         CUF           00         Acc           00         Rac           00         Rac           00         Rac           00         No           00         No           00         No           00         No           00         Deg           00         Acc           00         No           00         Acc	cumulated depreciation	-4, 929	(	0 0	0	
00         Min           00         To:           00         To:           00         In:           00         Deg           00         Do:           00         To:           00         To:           00         To:           00         To:           00         To:           00         To:           00         Ac:           00         No:           00         Pa:           00         De:           00         No:           00         Do:	T designated Assets	0		0 C	0	
To           0Th           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00           00	ccumulated depreciation	0		0 0	0	
OTH           00         Im           00         Deg           00         Dud           00         Ott           00         To           00         To           00         CUF           00         Acc           00         Pay           00         No           00         Deg           00         No           00         Deg           00         No	nor equipment-nondepreciable	0		0 0		
00         I m           00         De           00         Du           00         Out           00         To           00         To           00         CUF           00         Acc           00         Pai           00         No           00         De           00         Acc	ntal fixed assets (sum of lines 12-29) HER ASSETS	52, 700, 681	(	0 0	0	30.
OO         Deg           OO         Duu           OO         To           OO         To           OO         To           OO         CUF           OO         According           OO         According           OO         Pass           OO         No           OO         Deg           OO         According           OO         According           OO         According           OO         According           OO         According	ivestments	0		o lo	0	31
00         Dur           00         01           00         To           00         To           00         CUF           00         According           00         Pay           00         No           00         De           00         According           00         Pay           00         No           00         De           00         According	eposits on leases	0		0 0		
00         To           00         To           00         CUF           00         According           00         Sal           00         Page           00         De           00         De           00         According	, ie from owners/officers	0	(	o o	0	) 33.
OO         To:           CUF         CUF           00         Acc           00         Sa           00         Pag           00         De           00         De           00         Acc	her assets	58, 430, 152	(	o c	0	34.
CUF 00 Acc 00 Sal 00 Pay 00 No 00 De 00 Acc	otal other assets (sum of lines 31-34)	58, 430, 152	(	o c	0	35
00         Acc           00         Sa           00         Pa           00         No           00         De           00         Acc	otal assets (sum of lines 11, 30, and 35)	143, 934, 373		0 0	0	36
00 Sa 00 Pa 00 No 00 De 00 Ac	RRENT_LIABILITIES			-1 -1		
00 Pa 00 No 00 De 00 Ac	counts payable	6, 821, 087		0 0		
00 No 00 De 00 Ac	ılaries, wages, and fees payable nyroll taxes payable	4, 466, 019 480, 927				
00 De 00 Ac	otes and loans payable (short term)	400, 927			0	
00 Ac	eferred income	0		0 0		
00 Du	ccelerated payments	0				42
	ie to other funds	96, 304, 216	(	o c	0	43
	her current liabilities	391, 636		0 0	0	) 44
	otal current liabilities (sum of lines 37 thru 44)	108, 463, 885	(	0 0	0	45
	NG TERM LIABILITIES			-1 -1		
	ortgage payable	0		0 0		
	otes payable nsecured Loans	0		0 0	0	
	her long term liabilities	26, 257, 994			0	
	net long term liabilities (sum of lines 46 thru 49)	26, 257, 994				
	otal liabilities (sum of lines 45 and 50)	134, 721, 879		0 0		
	PITAL ACCOUNTS			-		
	eneral fund balance	9, 212, 494				52
00 Sp			(	C		53
	pecific purpose fund			0		54
	pecific purpose fund pnor created - endowment fund balance - restricted			0		55
	pecific purpose fund pnor created - endowment fund balance - restricted pnor created - endowment fund balance - unrestricted			0		56
	pecific purpose fund pnor created - endowment fund balance - restricted pnor created - endowment fund balance - unrestricted pverning body created - endowment fund balance				0	
	pecific purpose fund onor created - endowment fund balance - restricted onor created - endowment fund balance - unrestricted overning body created - endowment fund balance ant fund balance - invested in plant				0	58
	pecific purpose fund onor created - endowment fund balance - restricted onor created - endowment fund balance - unrestricted overning body created - endowment fund balance ant fund balance - invested in plant ant fund balance - reserve for plant improvement,			o o	0	
00 To	pecific purpose fund onor created - endowment fund balance - restricted onor created - endowment fund balance - unrestricted overning body created - endowment fund balance ant fund balance - invested in plant	9, 212, 494			0	) 59

Heal th	Financial Systems	LAPORTE HO	SPI TAL			In Lie	eu of Form CMS	-25	552-10
STATEM	ENT OF CHANGES IN FUND BALANCES		Provider CC	CN: 15-0006		eriod: com 03/01/2016 0 12/31/2016		ер	
		General	Fund	Speci al	Pur	pose Fund	Endowment Fun	d	
1.00	Fund balances at beginning of period	1.00	2.00	3.00		4.00	5.00	-	1.00
2.00 3.00 4.00 5.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	9, 212, 494 9, 212, 494		0	0		0	2.00 3.00 4.00 5.00
6.00 7.00 8.00 9.00 10.00	Total additions (sum of line 4-9)	0 0 0 0	0		0 0 0 0	0		0 0 0	6.00 7.00 8.00 9.00 10.00
11.00 12.00 13.00 14.00 15.00 16.00	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0	9, 212, 494		0 0 0 0	0		0 0 0 0	11.00 12.00 13.00 14.00 15.00 16.00
17.00 18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0	0 9, 212, 494		0	0 0		0	17.00 18.00 19.00
		Endowment Fund	PI ant	Fund					
		6.00	7.00	8.00					
1.00 2.00 3.00 4.00 5.00 6.00 7.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0		0				1.00 2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0	0 0 0 0 0 0 0 0		0				8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
17.00 18.00 19.00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0	0		0 0				17. 00 18. 00 19. 00

Health Financial Systems LAPORT STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provider CCN: 15-0006			eu of Form CMS-	
STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provider CC	CN: 15-0006	Period: From 03/01/2016 To 12/31/2016		pared:
	Cost Center Description		I npati ent	Outpati ent	Total	
	·		1.00	2.00	3.00	
	PART I – PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		18, 845, 9	39	18, 845, 939	1.00
2.00	SUBPROVIDER - IPF			0	0	2.00
3.00	SUBPROVIDER - IRF			0	0	3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY			0	0	
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)		18, 845, 9	39	18, 845, 939	10.00
	Intensive Care Type Inpatient Hospital Services				1	
11.00	INTENSIVE CARE UNIT		7, 300, 1	66	7, 300, 166	
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum o	flines	7, 300, 1	66	7, 300, 166	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 1	6)	26, 146, 1		26, 146, 105	
18.00	Ancillary services		143, 968, 6		143, 968, 655	
19.00	Outpatient services			0 257, 989, 62		
20.00	RURAL HEALTH CLINIC				0 0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 (	0 0	
22.00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES			0	0 0	
24.00						24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00 28.00	OTHER (SPECIFY)	2 to Wkat	170 114 7			
28.00	Total patient revenues (sum of lines 17-27)(transfer column	3 LO WKSL.	170, 114, 7	60 257, 989, 624	4 428, 104, 384	28.00
	G-3, line 1) PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			123, 849, 230		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00				0		32.00
33.00				0		33.00
34.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			-		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			-	b	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line	42)(transfer		123, 849, 230	b	43.00
	to Wkst. G-3, line 4)					1

Heal th	Financial Systems LAPORT	E HOSPI TAL		In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES	Provider CCN	: 15-0006	Peri od:	Worksheet G-3	
				From 03/01/2016 To 12/31/2016	Date/Time Pre 5/31/2017 9:23	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3				428, 104, 384	1.00
2.00	Less contractual allowances and discounts on patients' a	iccounts			298, 256, 660	2.00
3.00	Net patient revenues (line 1 minus line 2)				129, 847, 724	3.00
4.00	Less total operating expenses (from Wkst. G-2, Part II,				123, 849, 230	4.00
5.00	Net income from service to patients (line 3 minus line 4	.)			5, 998, 494	5.00
	OTHER INCOME			1		
6.00	Contributions, donations, bequests, etc				0	6.00
7.00	Income from investments				0	7.00
8.00	Revenues from telephone and other miscellaneous communic	ation services			0	8.00
9.00	Revenue from television and radio service				0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00					0	14.00
15.00					0	15.00
16.00		her than patients			0	16.00
	Revenue from sale of drugs to other than patients				0	17.00
	Revenue from sale of medical records and abstracts				0	18.00
	Tuition (fees, sale of textbooks, uniforms, etc.)				0	19.00
	Revenue from gifts, flowers, coffee shops, and canteen				0	20.00
	Rental of vending machines				0	21.00
	Rental of hospital space				0	22.00 23.00
23.00	The second				0	
24.00					3, 214, 015	
	Total other income (sum of lines 6-24)				3, 214, 015	
	Total (line 5 plus line 25) OTHER EXPENSES				9, 212, 509 15	
	Total other expenses (sum of line 27 and subscripts)				15	
	Net income (or loss) for the period (line 26 minus line	28)			9, 212, 494	
∠9.00	Iner income (or ross) for the period (iffie 20 minus iffie	20)		I	7, 212, 494	27.00

ealth Financial Systems ALCULATION OF CAPITAL PAYMENT	LAPORTE		Period:	u of Form CMS-2 Worksheet L	2552
ALCULATION OF CAPITAL PAYMENT		Provider CCN: 15-0006	From 03/01/2016 To 12/31/2016	Parts I-III Date/Time Pre	
		Title XVIII	Hospi tal	5/31/2017 9:2 PPS	3 am
			nospital	115	
				1.00	
PART I - FULLY PROSPECTIVE I	METHOD				
CAPITAL FEDERAL AMOUNT				4 04/ 055	
00 Capital DRG other than outl 01 Model 4 BPCI Capital DRG ot				1, 216, 855	
01 Model 4 BPCI Capital DRG ot 00 Capital DRG outlier payment				0 158, 907	1.
00 Capital DRG Outfree payment 01 Model 4 BPCI Capital DRG ou				158, 907	
	d by number of days in the cos	t reporting pariod (see inst	ructions)	49.53	
00 Number of interns & residen	5	st reporting period (see thist	ructrons)	0.00	
	percentage (see instructions)			0.00	
	adjustment (multiply line 5 by	the sum of lines 1 and 1 01	columns 1 and	0.00	
1. 01) (see instructions)	adjustment (martiply fine 5 by			0	
	patient days to Medicare Part	A patient days (Worksheet E	, part A line	3. 72	7.
	ent days to total days (see in	istructions)		21.48	8
00 Sum of lines 7 and 8	5 5 .	-		25.20	9
.00 Allowable disproportionate	share percentage (see instruct	i ons)		5.23	10
. 00 Disproportionate share adju	stment (see instructions)			63, 642	11
.00 Total prospective capital p	ayments (see instructions)			1, 439, 404	12
				1 00	
PART II - PAYMENT UNDER REAS	SONABLE COST			1.00	
	apital cost (see instructions)			0	1 1
	capital cost (see instruction			0	
0 1	ital cost (line 1 plus line 2)	-		0	
00 Capital cost payment factor	,			0	
00 Total inpatient program cap				0	
				1.00	
PART III - COMPUTATION OF EX	XCEPTION PAYMENTS				
00 Program inpatient capital c				0	
	osts for extraordinary circums			0	
	al costs (line 1 minus line 2)			0	-
	tage (see instructions)			0.00	
1				∩	
00 Capital cost for comparison				0	
00 Capital cost for comparison 00 Percentage adjustment for e	extraordinary circumstances (se	e instructions)		0.00	
00 Capital cost for comparison 00 Percentage adjustment for e 00 Adjustment to capital minim	extraordinary circumstances (se num payment level for extraordi	e instructions)	line 6)	0. 00 0	7
00 Capital cost for comparison 00 Percentage adjustment for e 00 Adjustment to capital minim 00 Capital minimum payment lev	extraordinary circumstances (se num payment level for extraordi rel (line 5 plus line 7)	e instructions) nary circumstances (line 2 x	line 6)	0. 00 0 0	7. 8.
00 Capital cost for comparison 00 Percentage adjustment for e 00 Adjustment to capital minim 00 Capital minimum payment lev 00 Current year capital paymen	extraordinary circumstances (se num payment level for extraordi rel (line 5 plus line 7) nts (from Part I, line 12, as a	e instructions) nary circumstances (line 2 x npplicable)		0.00 0 0 0	7. 8. 9.
<ul> <li>Capital cost for comparison</li> <li>Percentage adjustment for e</li> <li>Adjustment to capital minim</li> <li>Capital minimum payment lev</li> <li>Current year capital paymen</li> <li>Current year comparison of</li> </ul>	extraordinary circumstances (se num payment level for extraordi rel (line 5 plus line 7) nts (from Part I, line 12, as a capital minimum payment level	e instructions) nary circumstances (line 2 x upplicable) to capital payments (line 8	less line 9)	0.00 0 0 0 0	7. 8. 9. 10.
<ul> <li>Capital cost for comparison</li> <li>Percentage adjustment for e</li> <li>Adjustment to capital minim</li> <li>Capital minimum payment lev</li> <li>Current year capital paymen</li> <li>Current year comparison of</li> <li>Carryover of accumulated ca</li> <li>Worksheet L, Part III, line</li> </ul>	extraordinary circumstances (se num payment level for extraordi rel (line 5 plus line 7) ts (from Part I, line 12, as a capital minimum payment level pital minimum payment level ov 14)	e instructions) nary circumstances (line 2 x upplicable) to capital payments (line 8 rer capital payment (from pri	less line 9) or year	0.00 0 0 0 0 0	7 8 9 10 11
00 Capital cost for comparison 00 Percentage adjustment for e 00 Adjustment to capital minim 00 Capital minimum payment lev 00 Current year capital paymen 00 Current year comparison of 00 Carryover of accumulated ca Worksheet L, Part III, line 1.00 Net comparison of capital m	extraordinary circumstances (se num payment level for extraordi rel (line 5 plus line 7) its (from Part I, line 12, as a capital minimum payment level pital minimum payment level ov a 14) inimum payment level to capita	e instructions) nary circumstances (line 2 x upplicable) to capital payments (line 8 rer capital payment (from pri Il payments (line 10 plus lin	less line 9) or year e 11)	0.00 0 0 0 0 0 0	7. 8. 9. 10. 11.
00Capital cost for comparison00Percentage adjustment for e00Adjustment to capital minim00Capital minimum payment lev00Current year capital paymen00Current year comparison of00Carryover of accumulated ca00Worksheet L, Part III, line00Net comparison of capital minim	extraordinary circumstances (se num payment level for extraordi rel (line 5 plus line 7) its (from Part I, line 12, as a capital minimum payment level pital minimum payment level ov a 14) inimum payment level to capita ment (if line 12 is positive, e	e instructions) nary circumstances (line 2 x pplicable) to capital payments (line 8 rer capital payment (from pri nl payments (line 10 plus lin enter the amount on this line	less line 9) or year e 11) )	0.00 0 0 0 0 0 0 0	7 8 9 10 11 12 13
<ul> <li>Capital cost for comparison</li> <li>Percentage adjustment for e</li> <li>Adjustment to capital minim</li> <li>Capital minimum payment lev</li> <li>Current year capital paymen</li> <li>Current year comparison of</li> <li>Carryover of accumulated ca</li> <li>Worksheet L, Part III, line</li> <li>Net comparison of capital m</li> <li>Current year exception paym</li> <li>Carryover of accumulated ca</li> </ul>	extraordinary circumstances (se num payment level for extraordi rel (line 5 plus line 7) its (from Part I, line 12, as a capital minimum payment level pital minimum payment level ov e 14) inimum payment level to capita ent (if line 12 is positive, e pital minimum payment level ov	e instructions) nary circumstances (line 2 x pplicable) to capital payments (line 8 rer capital payment (from pri nl payments (line 10 plus lin enter the amount on this line	less line 9) or year e 11) )	0.00 0 0 0 0 0 0	7 8 9 10 11 12 13
<ul> <li>Capital cost for comparison</li> <li>Percentage adjustment for e</li> <li>Adjustment to capital minim</li> <li>Capital minimum payment lev</li> <li>Current year capital paymen</li> <li>Current year comparison of</li> <li>Carryover of accumulated ca</li> <li>Worksheet L, Part III, line</li> <li>Not comparison of capital</li> <li>Current year exception paym</li> <li>Carryover of accumulated ca</li> <li>Comparison of capital</li> <li>Carryover of accumulated ca</li> <li>Carryover of accumulated ca</li> <li>Carryover of capital</li> <li>Carryover of accumulated ca</li> <li>Caryover of accumulated ca</li> <li>Carryover of accumu</li></ul>	extraordinary circumstances (se num payment level for extraordi rel (line 5 plus line 7) hts (from Part I, line 12, as a capital minimum payment level pital minimum payment level ov e 14) inimum payment level to capita ent (if line 12 is positive, e pital minimum payment level ov ter the amount on this line)	e instructions) nary circumstances (line 2 x pplicable) to capital payments (line 8 ver capital payment (from pri al payments (line 10 plus lin enter the amount on this line ver capital payment for the f	less line 9) or year e 11) )	0.00 0 0 0 0 0 0 0 0 0	7 8 9 10 11 12 13 14
<ul> <li>Capital cost for comparison</li> <li>Percentage adjustment for e</li> <li>Adjustment to capital minim</li> <li>Capital minimum payment lev</li> <li>Current year capital paymen</li> <li>OU Current year comparison of</li> <li>Carryover of accumulated ca</li> <li>Worksheet L, Part III, line</li> <li>Net comparison of capital m</li> <li>Current year exception paym</li> <li>Carryover of accumulated ca</li> <li>(if line 12 is negative, en</li> <li>Current year allowable oper</li> </ul>	extraordinary circumstances (se num payment level for extraordi rel (line 5 plus line 7) its (from Part I, line 12, as a capital minimum payment level pital minimum payment level ov e 14) inimum payment level to capita ent (if line 12 is positive, e pital minimum payment level ov	e instructions) nary circumstances (line 2 x upplicable) to capital payments (line 8 rer capital payment (from pri al payments (line 10 plus lin enter the amount on this line rer capital payment for the f e instructions)	less line 9) or year e 11) )	0.00 0 0 0 0 0 0 0	7. 8. 9. 10. 11. 12. 13. 14. 15.