modi en i i manor	ar ejeteme	3101011102 011 111	111 21 0	3 01 1 01 III 0 III 0 E 0 0 E 1 0
This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fai	Ture to report can re-	sult in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	deemed overpayments	(42 USC 1395g).	OMB NO. 0938-0050
				EXPI RES 05-31-2019
HOSPITAL AND F AND SETTLEMENT	HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provider CCN: 15-1323	Peri od: From 01/01/2017 To 12/31/2017	
PART I - COST	REPORT STATUS			
Provi der	1. [ X ] Electronically filed cost report		Date: 5/30/20	18 Time: 8:09 am
use only	2. [ ] Manually submitted cost report			
	3.[0] If this is an amended report enter the number 4.[F] Medicare Utilization. Enter "F" for full or "	of times the provider _" for low.	resubmitted this co	ost report
Contractor use only	5. [ 1 ]Cost Report Status (1) As Submitted 7. Contractor No. (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 6. Date Received: 7. Contractor No. 8. [ N ] Initial Report for 9. [ N ] Final Report for 1. Settled with Audit 1. Settled with	1 or this Provider CCN 1		or Code: 4 Olumn 1 is 4: Enter nes reopened = 0-9.
DART II AFRI	I FLOATION			

## PART II - CERTIFICATION

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by COMMUNITY HOSPT. OF LAGRANGE CTY IN (15-1323) for the cost reporting period beginning 01/01/2017 and ending 12/31/2017 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.

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

(Si gned	
	Officer or Administrator of Provider(s)
	Title
	Date

			Title XVIII				
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	158, 356	-544, 165	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	-89, 373	0		0	5. 00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	68, 983	-544, 165	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. Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1323 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/29/2018 12:24 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 207 NORTH TOWNLINE ROAD 1.00 PO Box: 1.00 State: IN Zip Code: 46761-1325 County: LAGRANGE 2.00 City: LAGRANGE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 COMMUNITY HOSPT. OF 151323 99915 05/01/2005 Ν 0 3.00 LAGRANGE CTY IN Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF SWING BEDS 157323 99915 7 00 05/01/2005 N 0 N 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospital -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 Hospital-Based (CORF) I 17.10 17.10 17. 20 Hospi tal -Based (OPT) I 17.20 17.30 Hospital-Based (00T) I 17.30 Hospi tal -Based (OSP) I 17.40 17.40 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 2.00 1.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2017 12/31/2017 20.00 Type of Control (see instructions) 2 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22 00 N N 22.00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting N Ν 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be 22.02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" for yes or used in the prior cost reporting period? In column 2 "N" fo<u>r no</u> In-State Out-of Medi cai d 0ther In-State Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e unpai d davs 1.00 2.00 3.00 4.00 5.00 6.00 24.00 If this provider is an IPPS hospital, enter the 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in

column 5, and other Medicaid days in column 6.

Heal th	Financial Systems COMMUNITY HO	NSPT OF LA	GRANGE CTV	I N			Inlie	ı of Fo	orm CMS_	2552-10
	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		Provider CC		Perion From To	01/0	01/2017 81/2017	Works Part Date/	heet S-2 I Time Pre	2 epared:
		In-State Medicaid paid days	In-State Medi cai d el i gi bl e unpai d days	Out-of State Medicaid paid days	Out- Sta- Medic eligi unpa	te ai d bl e	Medica HMO da	i d	2018 12: Other edi cai d days	24 pm
		1.00	2. 00	3. 00	4. 0		5. 00		6. 00	
	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	C	0	0		0		0		25. 00
					ur	ban/k 1. (			of Geogr .00	-
26. 00	Enter your standard geographic classification (not wa		at the beg	ginning of t	he		2		. 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 enter the effective date of the geographic reclassifi	age) status ^ "2" for r cation in	ural. If ap column 2.	pl i cabl e,			2			27. 00
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	CH status ir	1		0			35. 00
	errect in the cost reporting perrou.				Е	Begi nr	ni ng:	Enc	di ng:	
24 00	Enter annuicable heginning and ending dates of SCH et	tatus Subs	orint line	24 for numb	or	1. (	00	2	. 00	36, 00
	86.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates.  87.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status								37. 00	
37. 01	accordance with FY 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see								37. 01	
38. 00	instructions) 38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates.							38. 00		
						Y/			//N	
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) for yes or "N" for no. Does the facility meet the mil with 42 CFR 412.101(b)(2)(i) or (ii)? Enter in column instructions)	or (ii)? eage requi	Enter in corements in	olumn 1 "Y" accordance		1. ( N		2	. 00 N	39. 00
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octobno in column 2, for discharges on or after October 1.	oer 1. Ente	r "Y" for y			N			N	40. 00
							1. 00	XVI I 2. 00		4
	Prospective Payment System (PPS)-Capital								, 0.00	
	Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst	eption for	extraordi na	ary circumst	ances		N N	N N	N N	45. 00 46. 00
47. 00	Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of					Ü	N	N	N	47. 00
	Is the facility electing full federal capital payment Teaching Hospitals		-				N	N	N	48. 00
56. 00	Is this a hospital involved in training residents in or "N" for no.	approved G	ME programs	S? Enter "Y	" for	yes	N			56. 00
57. 00	If line 56 is yes, is this the first cost reporting pgME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first montfor yes or "N" for no in column 2. If column 2 is "\"N", complete Wkst. D, Parts III & IV and D-2, Pt. II	r yes or "N th of this Y", complet	" for no ir cost report e Worksheet	n column 1. ing period?	If col Ente	umn 1 r "Y"				57. 00
	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	oursement f complete W	for physicia /kst. D-5.		es as		N			58. 00
59. 00	Are costs claimed on line 100 of Worksheet A? If yes	s, complete	⊕ Wkst. D-2,	Pt. I. NAHE 413. Y/N	85 W	orksh Li ne		Qual i f	Through ication	

1. 00

N

2.00

3.00

60. 00

60.00 Are you claiming nursing and allied health education (NAHE) costs for any programs that meet the criteria under §413.85? (see instructions)

Health Financial Systems COMMUNITY HO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		F LAGRANGE CTY Provider C	CN: 15-1323 P	eriod: rom 01/01/2017	w of Form CMS-: Worksheet S-2 Part I Date/Time Pre 5/29/2018 12:	pared:
	Y/N	IME	Direct GME	I ME	Direct GME	Z4 piii
61.00 Did your hospital receive FTE slots under ACA	1. 00 N	2. 00	3. 00	4.00	5. 00	61.00
section 5503? Enter "Y" for yes or "N" for no in	IN IN			0.00	0.00	01.00
column 1. (see instructions) 61.01 Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see						61. 01
instructions) 61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)	:					61. 02
61.03 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						61. 03
instructions) 61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61. 04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)	,					61. 05
61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61. 06
	Pr	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. 00	2. 00	3.00	4. 00	
<ul> <li>61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> <li>61.20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.</li> </ul>				0. 00		61. 10
					1.00	1
ACA Provisions Affecting the Health Resources and Se 62.00 Enter the number of FTE residents that your hospital				od for which	0.00	62.00
your hospital received HRSA PCRE funding (see instru 62.01 Enter the number of FTE residents that rotated from during in this cost reporting period of HRSA THC pro	ctions) a Teach gram. (	ing Health Cen see instructio	ter (THC) into			62.0
63.00 Has your facility trained residents in nonprovider s "Y" for yes or "N" for no in column 1. If yes, complete	ettings	during this c	1 9 1		N	63.00
T TOT YES OF IN TOT HE TH COLUMN 1. TT YES, COMPT	010 1111	es er till eugh	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
			1.00	2.00	3. 00	
Section 5504 of the ACA Base Year FTE Residents in N period that begins on or after July 1, 2009 and befo 64.00 Enter in column 1, if line 63 is yes, or your facili in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted	ore June ty trai on-prima all noo d non-p	a 30, 2010.  ned residents ry care nprovider rimary care	This base year  0.00			64. 00
resident FTEs that trained in your hospital. Enter i of (column 1 divided by (column 1 + column 2)). (see						

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1323 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/29/2018 12:24 pm Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0. 00 0. 00 0.000000 65.00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

alth Financial Systems COMMUNITY HOSP		AGRANGE CTY IN	In Lie	In Lieu of Form CMS-2552-10	
SPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provider CCN: 15-1323	Peri od:	Worksheet S-2	

HOSI From 01/01/2017 | Part I 12/31/2017 Date/Time Prepared: 5/29/2018 12:24 pm 1.00 Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 80.00 N 81.00 | Is this a LTCH co-located within another hospital for part or all of the cost reporting period? Enter N 81.00 for yes and "N" for no. TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or "N" for no. N 85 00 86.00 Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section 86.00 §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospital classified under section N 87.00 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no. V XIX 1.00 2.00 Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for N Υ 90 00 yes or "N" for no in the applicable column.  $\ensuremath{\mathsf{IS}}$  this hospital reimbursed for title V and/or XIX through the cost report either in 91 00 N Ν 91 00 full or in part? Enter "Y" for yes or "N" for no in the applicable column. Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see instructions) Enter "Y" for yes or "N" for no in the applicable column. Ν 92.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column. 93.00 Ν N 93.00 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the N N 94 00 applicable column. 95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 0 00 0.00 95.00 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the Ν Ν 96.00 applicable column. 97.00 | If line 96 is "Y", enter the reduction percentage in the applicable column. 97 00 0 00 0.00 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post 98.00 Υ stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. 98.01 98.01 C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation 98.02 bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) Ν 98.03 Ν reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V. and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of Ν 98.04 Ν outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in 98.05 column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Υ 98.06 Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. Rural Providers 105.00 Does this hospital qualify as a CAH? Υ 105 00 106.00|If this facility qualifies as a CAH, has it elected the all-inclusive method of payment 106.00 Ν for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R Ν 107.00 training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00|s this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 Ν 108.00 CFR Section §412.113(c). Enter "Y" for yes or "N" for no. Occupati onal Respi ratory Physi cal Speech 1 00 2 00 4 00 3 00 109. 00 109.00|If this hospital qualifies as a CAH or a cost provider, are Ν Ν Ν Ν therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy. 1.00 110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, 110.00 N complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as appl i cabl e.

Heal

15H032

140. 00

All Providers

140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1,

chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1323 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: To 12/31/2017 5/29/2018 12:24 pm 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number 141 00 Name: PARKVIEW HEALTH SYSTEM, INC. Contractor's Name: WISCONSIN PHYSICIANS Contractor's Number: 08101 141 00 SERVI CE 142.00 Street: 10501 CORPORATE DRIVE PO Box: 5600 142.00 143.00 City: FORT WAYNE State: ΙN Zip Code: 46845 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 2.00 1.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for 145.00 inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? 146, 00 Ν Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 1.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. 147. 00 N 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00 149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no Ν 149.00 Part A Part B Title V Title XIX 1 00 2 00 3.00 4 00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13) 155.00 Hospi tal Ν Ν Ν N 155 00 156.00 Subprovi der - IPF 156. 00 Ν Ν Ν Ν 157. 00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν N 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν Ν 161.00 161. 10 CORF Ν Ν 161. 10 161. 20 OUTPATIENT PHYSICAL THERAPY Ν Ν 161. 20 Ν 161. 30 OUTPATIENT OCCUPATIONAL THERAPY 161. 30 N Ν N 161. 40 OUTPATIENT SPEECH PATHOLOGY N Ν Ν 161. 40 1.00 Multicampus 165.00|Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N 165.00 Enter "Y" for yes or "N" for no. Name County State Zip Code CBSA FTE/Campus 0 1.00 2 00 3.00 4 00 5.00 166.00 If line 165 is yes, for each 0. 00 166. 00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) 1.00 Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167 00 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the 171, 928 168. 00 reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 168.01 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the 0.00169.00 transition factor. (see instructions) Endi ng Begi nni ng 1. 00 2.00 170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting 10/01/2016 09/30/2017 170. 00 period respectively (mm/dd/yyyy)

Health Financial Systems C	COMMUNITY HOSPT.	0F	LAGRANGE CTY IN	In Li∈	eu of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTI	FICATION DATA		Provi der CCN: 15-1323	Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part I Date/Time Pre 5/29/2018 12:	pared:
				1. 00	2. 00	
171.00 If line 167 is "Y", does this provider have section 1876 Medicare cost plans reported "Y" for yes and "N" for no in column 1. If 1876 Medicare days in column 2. (see instr	on Wkst. S-3, Pt f column 1 is yes	i. I	, line 2, col. 6? Enter	N n	C	171. 00

HOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (	CCN: 15-1323	Peri od: From 01/01/2017 To 12/31/2017		epared:
				Y/N	Date	
	C	l 6II NO		1.00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	i for all NU re	esponses. Ente	er all dates in t	rne	
4 00	Provider Organization and Operation					4 .00
1.00	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in a	e beginning of	the cost	N		1.00
	reporting period? IT yes, enter the date of the change in t	Joi ullii 2. (See	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2.00	Has the provider terminated participation in the Medicare F	Program? If	N	2100	0.00	2.00
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	nn 3, "V" for				
3.00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the providencers, medical staff, management personnel, or members of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3.00
			Y/N	Туре	Date	
	5' '   D		1.00	2. 00	3. 00	
4.00	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.	for Compiled, ailable in	Y	A		4. 00
5. 00	Are the cost report total expenses and total revenues differentiations on the filed financial statements? If yes, submit reconstructions are total expenses and total revenues differentiations.		N			5. 00
	, , , , , , , , , , , , , , , , , , , ,			Y/N 1. 00	Legal Oper. 2.00	
	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	S N		6. 00		
7. 00	the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see in	etructions		N		7. 00
		Are costs claimed for Allied Health Programs? If "Y" see instructions.  Were nursing school and/or allied health programs approved and/or renewed during the				
	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		cal education	N		9. 00
	was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10.00
11. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an Ap	proved	N		11. 00
					Y/N 1. 00	
	Bad Debts	and Instance	ti ono		Y	12. 00
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.			ost reporting	N N	13. 00
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement	ents waived? I	fyes, see ins	structi ons.	N	14. 00
15. 00	Did total beds available change from the prior cost reporti		yes, see inst rt A		N t B	15. 00
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data		•			
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 (see instructions)	N		N		16. 00
17. 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	04/30/2015	Υ	04/30/2015	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	Y		Y		18. 00
	cost report? If yes, see instructions.  If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		N		19. 00

Heal th	Financial Systems COMMUNITY HOSPT. 01	F LAGRANGE CTY	IN	In Lie	u of Form CMS-	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der C		Period: From 01/01/2017 To 12/31/2017	Worksheet S-2 Part II Date/Time Pro 5/29/2018 12:	epared:
			ipti on	Y/N	Y/N	
20. 00		(	0	1. 00 N	3. 00 N	20. 00
	Report data for Other? Describe the other adjustments:	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDRENS H	OSPI TALS)			
	Capital Related Cost					
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	ng the cost	N N	22. 00 23. 00		
24. 00	Were new leases and/or amendments to existing leases entered lifyes, see instructions	ed into during	this cost rep	orting period?	N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	·	0 .		N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	•	0 .		N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.  Interest Expense	e cost reportin	g period? IT	yes, submit	N	27. 00
28. 00	Were new loans, mortgage agreements or letters of credit er period? If yes, see instructions.	reporti ng	N	28. 00		
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr	,	N	29. 00		
30. 00	Has existing debt been replaced prior to its scheduled maturinstructions.	urity with new	debt? If yes,	see	N	30.00
31. 00	Has debt been recalled before scheduled maturity without is instructions.	ssuance of new	debt? If yes,	see	N	31. 00
	Purchased Services					
32. 00 33. 00	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app	uctions.	Ü		N N	32. 00
33.00	no, see instructions.  Provider-Based Physicians	Trea per tariiri		rve brudring: 11	14	33.00
34. 00		rrangement with	provi der-bas	ed physicians?	N	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		its with the p		_	35. 00
				Y/N 1. 00	2. 00	
	Home Office Costs			1.00	2.00	
36. 00	Were home office costs claimed on the cost report?			Y		36. 00
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.			Y		37. 00
38. 00 39. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other	d of the home o	ffi ce.	N N		38. 00
40. 00	see instructions.	·		N		40.00
15. 66	.00   If line 36 is yes, did the provider render services to the home office? If yes, see N instructions.					
	T	1.	00	2.	00	
41. 00	Cost Report Preparer Contact Information  Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	ERI C		NI CKESON		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	PARKVIEW HEALT	H SYSTEM, INC			42. 00
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(260) 373-8406		ERI C. NI CKESON@F	PARKVI EW. COM	43. 00
	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	1		1		

Health Financial Systems CC	OMMUNITY HOSPT.	OF L	AGRANGE CTY IN		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT (	QUESTI ONNAI RE		Provider CCN: 15-1323		ri od:	Worksheet S-2	
				Fr	om 01/01/2017 12/31/2017		nonod.
				10	12/31/201/	5/29/2018 12:	
			3. 00				
Cost Report Preparer Contact Information							
41.00 Enter the first name, last name and the ti		DIF	RECTOR, REIMBURSEMENT				41. 00
held by the cost report preparer in column	is 1, 2, and 3,						
respecti vel y.							
42.00 Enter the employer/company name of the cos	st report						42. 00
preparer.							
43.00 Enter the telephone number and email addre							43. 00
report preparer in columns 1 and 2, respec	cti vel y.						

 Heal th Financial
 Systems
 COMMUNITY HO

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA

Provider CCN: 15-1323

						5/29/2018 12:	24 pm
	·					I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1. 00	2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	2	9, 12	5 85, 584. 00	0	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)						0.00
2.00	HMO and other (see instructions)						2.00
3.00	HMO IPF Subprovider						3.00
4. 00 5. 00	HMO IRF Subprovider					0	4.00
6.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00 6. 00
7. 00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation		_	9, 12	5 85, 584. 00	0	
7.00	beds) (see instructions)			.5 9, 12	03, 304. 00	U	7.00
8.00	INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY	43. 00				0	
14. 00	Total (see instructions)	10.00	2	9, 12	5 85, 584. 00	0	14. 00
15. 00	CAH visits		-	7, 12	00,001.00	0	15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20. 00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)	30. 00					24. 10
25.00	CMHC - CMHC						25. 00
25. 10	CMHC - CORF	99. 10				0	25. 10
25. 20	CMHC - OUTPATIENT PHYSICAL THERAPY	99. 20				0	25. 20
25. 30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99. 30				0	25. 30
25. 40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99. 40				0	25. 40
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27. 00	Total (sum of lines 14-26)		2	25			27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30. 00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)			0	0		32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33. 00	LTCH non-covered days						33.00
33.01	LTCH site neutral days and discharges						33. 01

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

Provider CCN: 15-1323

In Lieu of Form CMS-2552-10

| Period: | Worksheet S-3 |
| From 01/01/2017 | Part |
| To 12/31/2017 | Date/Time Prepared: | 5/29/2018 12: 24 pm

						5/29/2018 12:	24 pm
		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	832	38			10.00	1. 00
	8 exclude Swing Bed, Observation Bed and			,			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	790	150				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO I RF Subprovi der	0	0				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	337	0				5.00
6.00	Hospital Adults & Peds. Swing Bed NF	1 1/0	0				6.00
7. 00	Total Adults and Peds. (exclude observation	1, 169	38	3, 197			7. 00
8. 00	beds) (see instructions) INTENSIVE CARE UNIT						8. 00
9. 00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY		129	369			13. 00
14. 00	Total (see instructions)	1, 169	167	•	0.00	178. 95	14.00
15. 00	CAH visits	0	0	0			15. 00
16.00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPICE (non distinct nont)	0	0				24. 00 24. 10
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC	٥	Ü	0			25. 00
25. 10	CMHC - CORF	0	0	0	0.00	0.00	
25. 10	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0				
25. 30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0				25. 30
25. 40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0	-			
26. 00	RURAL HEALTH CLINIC	-		Ī			26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	178. 95	27. 00
28. 00	Observation Bed Days		13	840			28. 00
29. 00	Ambul ance Tri ps	570					29. 00
30.00	Employee discount days (see instruction)			28			30. 00
31. 00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	3				32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH site poutral days	0					33. 00 33. 01
33. UI	LTCH site neutral days and discharges	υĮ		I	l	I	33.01

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-1323

Peri od: Worksheet S-3 From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

5/29/2018 12:24 pm Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 12.00 13.00 14.00 11.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 292 14 1,000 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 212 2 00 0 3.00 HMO IPF Subprovider 0 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 9.00 BURN INTENSIVE CARE UNIT 10.00 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 1,000 14.00 Total (see instructions) 0.00 0 292 14 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 24. 10 25. 00 CMHC - CMHC 25.00 25. 10 CMHC - CORF 0.00 25. 10 CMHC - OUTPATIENT PHYSICAL THERAPY 0.00 25 20 25. 20 CMHC - OUTPATIENT OCCUPATIONAL THERAPY 25.30 0.00 25.30 CMHC - OUTPATIENT SPEECH PATHOLOGY 0.00 25.40 RURAL HEALTH CLINIC 26.00 26, 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 00 26 25 27.00 Total (sum of lines 14-26) 0.00 27.00 28.00 Observation Bed Days 28.00 29 00 Ambulance Trips 29 00 30.00 Employee discount days (see instruction) 30.00 Employee discount days - IRF 31.00 31.00 Labor & delivery days (see instructions) 32.00 32.00 32.01 Total ancillary labor & delivery room 32.01 outpatient days (see instructions) 33.00 LTCH non-covered days 33.00 33.01 LTCH site neutral days and discharges 33.01

Hool th	Financial Systems COMMUNITY HOSDT OF LAC	DANCE CTV	LN	In Lio	u of Form CMS 1	DEE2 10		
	Financial Systems COMMUNITY HOSPT. OF LAG AL UNCOMPENSATED AND INDIGENT CARE DATA F		CN: 15-1323	nn Period: From 01/01/2017	u of Form CMS-2 Worksheet S-10			
				To 12/31/2017	Date/Time Pre 5/29/2018 12:			
					1. 00			
	Uncompensated and indigent care cost computation							
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div Medicaid (see instructions for each line)	ided by li	ne 202 column	8)	0. 277506	1. 00		
2.00	Net revenue from Medicaid				1, 048, 253	2.00		
3. 00	Did you receive DSH or supplemental payments from Medicaid?				Y	3. 00		
4. 00	If line 3 is yes, does line 2 include all DSH and/or supplemental payments from Medicaid?							
5. 00	If line 4 is no, then enter DSH and/or supplemental payments fr				0	4. 00 5. 00		
6. 00	Medicaid charges				8, 267, 868			
7.00	Medicaid cost (line 1 times line 6)				2, 294, 383			
8.00	Difference between net revenue and costs for Medicaid program (	line 7 min	us sum of lin	es 2 and 5; if	1, 246, 130	1		
	< zero then enter zero)							
	Children's Health Insurance Program (CHIP) (see instructions for	r each lin	e)					
9. 00	Net revenue from stand-alone CHIP				0			
10.00	Stand-alone CHIP charges				0			
11.00	Stand-alone CHIP cost (line 1 times line 10)				0			
12. 00	Difference between net revenue and costs for stand-alone CHIP (line 11 minus line 9; if < zero then 0 12.0							
	enter zero) Other state or local government indigent care program (see insti	rustions f	or each line)					
13. 00	Net revenue from state or local indigent care program (Not incl			1	1, 202, 673	13 00		
14. 00								
14.00	10)							
15. 00								
16. 00								
	13; if < zero then enter zero)	3	1 3 1					
	Grants, donations and total unreimbursed cost for Medicaid, CHII instructions for each line)	P and state	e/local indig	ent care program	is (see			
17.00	Private grants, donations, or endowment income restricted to fu	ndi ng char	ity care		0	17. 00		
18.00	Government grants, appropriations or transfers for support of h	ospital op	erati ons		0	18. 00		
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	i ndi gent	care programs	(sum of lines	2, 052, 740	19. 00		
	10, 12 did 10)		Uni nsured	Insured	Total (col. 1			
			patients	pati ents	+ col . 2)			
			1.00	2. 00	3. 00			
	Uncompensated Care (see instructions for each line)							
20. 00	Charity care charges and uninsured discounts for the entire fac (see instructions)	ility	697, 83	7 482, 710	1, 180, 547	20. 00		
21. 00	Cost of patients approved for charity care and uninsured discou	nts (see	193, 65	482, 710	676, 364	21. 00		
22. 00	instructions) Payments received from patients for amounts previously written	off as		0 3, 543	3, 543	22. 00		
	charity care							
23. 00	Cost of charity care (line 21 minus line 22)		193, 65	4 479, 167	672, 821	23. 00		
					1. 00			
24. 00	Does the amount on line 20 column 2, include charges for patien	t days bey	ond a Length	of stay limit		24. 00		
	imposed on patients covered by Medicaid or other indigent care program?							
25. 00		e indigent	care program	's length of	0	25. 00		
0, 0-	stay limit							
26. 00	Total bad debt expense for the entire hospital complex (see ins				5, 075, 862			
27. 00	Medicare reimbursable bad debts for the entire hospital complex				333, 442 512, 988			
// []		PP 1 115 11711/	LLOUIS I		71/ YXX	1 // 111		

27.01 Medicare allowable bad debts for the entire hospital complex (see instructions)

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt expense (see instructions)

28.00 Non-Medicare bad debt expense (see instructions)

30.00 Cost of uncompensated care (line 23 column 3 plus line 29)

31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

512, 988 4, 562, 874 1, 445, 771

2, 118, 592 30. 00 4, 171, 332 31. 00

27. 01

28.00

29.00

	Financial Systems — — COMMU SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	JNITY HOSPI. OF F FXPENSES	Provider CO		eri od:	Worksheet A	2552-10
	STITISHT AND ABSOSTMENTS OF THEME BAEANSE ST	EXI ENGES	Trovider of	F	rom 01/01/2017 o 12/31/2017	Date/Time Pre 5/29/2018 12:	
	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	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS			4 700 005			
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION		1, 722, 325	1, 722, 325	-428, 214 16, 140	1, 294, 111 16, 140	1. 00 1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP		27, 043	27, 043		729, 366	•
2.01	00201 EMS WEST STATION EQUIP.		0	· C	30, 014	30, 014	2. 01
3.00	00300 OTHER CAP REL COSTS	114 (07	0	4 744 043	0	0	3.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	114, 687 669, 256	4, 632, 260 9, 667, 341	4, 746, 947 10, 336, 597		4, 746, 947 10, 292, 832	4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6. 00
7. 00	00700 OPERATION OF PLANT	265, 121	771, 756	1, 036, 877		1, 036, 877	7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	172 220	97, 991	97, 991		97, 991	8. 00 9. 00
10.00	01000 DI ETARY	173, 328 385, 721	34, 526 344, 730	207, 854 730, 451		207, 854 269, 356	
11. 00	01100 CAFETERI A	0	0	0	459, 009	459, 009	
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13. 00 14. 00	01300 NURSI NG ADMINI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	330, 642	429 -51, 905	331, 071 -51, 905		331, 071 -51, 905	
15. 00	01500 PHARMACY	489, 210	72, 031	561, 241		560, 252	
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	C	0	0	1
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0			0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	Ö	0	O	o o	0	21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	О	0	C	o	0	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	O	0	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	1, 635, 372	817, 235	2, 452, 607	-726, 344	1, 726, 263	30.00
43. 00	04300 NURSERY	0	0 . 7 , 2 3 3	2, 102, 007 C		138, 185	
	ANCILLARY SERVICE COST CENTERS						
50. 00 52. 00	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM	728, 022	752, 960 0	1, 480, 982 0		1, 480, 982 588, 159	
53. 00	05300 ANESTHESI OLOGY	o	841, 207	841, 207		841, 207	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	683, 756	584, 735	1, 268, 491	0	1, 268, 491	54.00
60.00	06000 LABORATORY	0	1, 126, 426	1, 126, 426	0	1, 126, 426	
62. 30 65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0 285, 440	0 13, 885	299, 325		0 299, 325	62. 30 65. 00
66. 00	06600 PHYSI CAL THERAPY	570, 851	50, 768	621, 619		371, 492	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	31	31		166, 374	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	0	83, 784	83, 784 0	ı
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	912, 694	912, 694	-352, 983	559, 711	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	О	0	C	352, 983	352, 983	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	1, 878, 844			1, 879, 833	1
76. 97 76. 98	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	0	0	C		0	
76. 99	07699 LI THOTRI PSY	Ö	0	C		0	1
	OUTPATIENT SERVICE COST CENTERS		ما		ا		
90. 00 90. 01	09000 CLINIC 09001 LI FEBRI DGE SENI OR CARE	0 144, 484	0 94, 432	238, 916	0 2,086	0 241, 002	
91. 00	09100 EMERGENCY	807, 884	1, 796, 987	2, 604, 871		2, 604, 871	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	·					92. 00
05 00	OTHER REIMBURSABLE COST CENTERS	1 000 240	207 005	1, 319, 427	, ol	1 210 427	95. 00
95. 00 99. 10	09500 AMBULANCE SERVICES 09910 CORF	1, 022, 342	297, 085 0	1, 319, 427		1, 319, 427 0	
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	Ö	Ö	C	o o	0	1
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	C	0	0	
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS	0	0	C	)  0	0	99. 40
113.00	11300 I NTEREST EXPENSE		276, 498	276, 498	-276, 498	0	113. 00
118.00		8, 306, 116	26, 762, 314	35, 068, 430	0	35, 068, 430	118. 00
100 00	NONREI MBURSABLE COST CENTERS	ol	0 215	0 215	: 0	0.215	100 00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	8, 215 4, 056	8, 215 4, 056			190. 00 192. 00
194.00	07950 OCCUPATI ONAL HEALTH	o	-1, 050	-1, 050	O	-1, 050	194. 00
	07951 FOUNDATION	53, 807	-46, 402				194. 01
	07952 COMMUNITY & VOLUNTEER SVCS	13, 919	92, 940 0	106, 859 0		106, 859 0	194. 03 194. 04
	07953 SHI PSHEWANA RADI OLOGY AND LAB	o	0	C	o o		194. 06
200.00		8, 373, 842	26, 820, 073	35, 193, 915	0	35, 193, 915	200. 00

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

Provider CCN: 15-1323

Peri od: From 01/01/2017 To 12/31/2017

Date/Time Prepared: 5/29/2018 12:24 pm

				5/29/2018 12:	24 pm
	Cost Center Description		Net Expenses or Allocation 7.00		
	CENEDAL SEDVICE COST CENTEDS	0.00	7.00		
4 00	GENERAL SERVICE COST CENTERS	47,000	4 040 504		4 00
1. 00	00100 CAP REL COSTS-BLDG & FLXT	16, 393	1, 310, 504		1. 00
1. 01	00101 EMS WEST STATION	0	16, 140		1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	l ol	729, 366		2. 00
2.01	00201 EMS WEST STATION EQUIP.	o	30, 014		2. 01
3.00	00300 OTHER CAP REL COSTS	o	0		3. 00
4. 00		-1, 069, 649	-1		4. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT		3, 677, 298		
5.00	00500 ADMINISTRATIVE & GENERAL	-2, 826, 643	7, 466, 189		5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0		6. 00
7.00	00700 OPERATION OF PLANT	-5, 392	1, 031, 485		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	l ol	97, 991		8. 00
9. 00	00900 HOUSEKEEPI NG	0	207, 854		9. 00
					1
10.00	01000 DI ETARY	0,0 50,0	269, 356		10.00
11. 00	I I	-268, 526	190, 483		11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0		12.00
13.00	01300 NURSING ADMINISTRATION	0	331, 071		13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	o	-51, 905		14. 00
15. 00			560, 252		15. 00
			1		
16.00	+ +		0		16. 00
17. 00		l ol	0		17. 00
19. 00		0	0		19. 00
20.00	02000 NURSI NG SCHOOL	0	0		20.00
21. 00	1 1	o	n		21.00
22. 00		o	O		22. 00
23. 00	+ +		0		1
23.00		U	U		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				4
30. 00	I I	-78, 420	1, 647, 843		30.00
43.00	04300 NURSERY	0	138, 185		43. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	0	1, 480, 982		50.00
52. 00	1 1	o	588, 159		52. 00
53. 00	1 1	-758, 003	83, 204		53.00
54. 00		-1, 990	1, 266, 501		54. 00
60. 00	06000 LABORATORY	0	1, 126, 426		60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		62. 30
65. 00	06500 RESPI RATORY THERAPY	0	299, 325		65. 00
66.00	06600 PHYSI CAL THERAPY	l ol	371, 492		66. 00
67.00	1 1	-31	166, 343		67.00
68. 00	1 1	-11, 425	72, 359		68.00
	I I	1	72, 339		
69. 00		0	-1		69. 00
71. 00	1	0	559, 711		71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	352, 983		72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	-614, 790	1, 265, 043		73.00
76. 97	07697 CARDIAC REHABILITATION	l ol	o		76. 97
76. 98	+ +	o	o		76, 98
76. 99	1 1	0	o		76. 99
70. 77		ı o	U <sub>I</sub>		10.99
00.00	OUTPATIENT SERVICE COST CENTERS				
	09000 CLI NI C	0	0		90.00
90. 01		-105	240, 897		90. 01
91.00	09100 EMERGENCY	-561, 930	2, 042, 941		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1			92.00
	OTHER REIMBURSABLE COST CENTERS				1
95 00	09500 AMBULANCE SERVI CES		1, 319, 427		95. 00
99. 10					1
		0	0		99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	0	0		99. 20
99. 30		0	0		99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0		99. 40
	SPECIAL PURPOSE COST CENTERS				
113 0	11300   NTEREST EXPENSE	0	0		113. 00
118. 00		-6, 180, 511	28, 887, 919		118. 00
110.00	NONREI MBURSABLE COST CENTERS	0, 100, 311	20,007,717		1110.00
400.0			0.045		
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8, 215		190. 00
	D 19200 PHYSICIANS'PRIVATE OFFICES	0	4, 056		192. 00
194.00	07950 OCCUPATIONAL HEALTH	0	-1, 050		194. 00
	1 07951 FOUNDATI ON	o	7, 405		194. 01
	3 07952 COMMUNITY & VOLUNTEER SVCS	ام	106, 859		194. 03
	4 07954 ER PHYSICIAN		100, 037		194. 04
		1	0		
	6 07953 SHI PSHEWANA RADI OLOGY AND LAB	0 ( 100 511	20 012 12:		194. 06
200.00	TOTAL (SUM OF LINES 118 through 199)	-6, 180, 511	29, 013, 404		200. 00

Health Financial Systems RECLASSIFICATIONS COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 Provider CCN: 15-1323

| Peri od: | Worksheet A-6 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared:

					10 12/31/2017	5/29/2018 12:24 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
	A - REHAB THERAPY RECLASS					
1.00	OCCUPATI ONAL THERAPY	67. 00	152, 750	13, 593		1.00
2.00	SPEECH PATHOLOGY	68. 00	76, 937	6, 847		2.00
	0		229, 687	20, 440		
	B - OB RECLASS		<u> </u>	·		
1.00	NURSERY	43.00	111, 883	26, 302		1.00
2.00	DELIVERY ROOM & LABOR ROOM	52.00	476, 209	111, 950		2.00
			588, 092	138, 252		
	C - CLINIC DIETICIAN	<u>'</u>				
1.00	LI FEBRI DGE SENI OR CARE	90, 01	2, 086	0		1.00
			2, 086	0		
	F - CAFETERIA RECLASS		, , , , , ,			
1.00	CAFETERI A	11. 00	241, 763	217, 246		1.00
00	0		241, 763	217, 246		
	G - INSURANCE RECLASS		211, 700	217, 210		
1.00	CAP REL COSTS-BLDG & FLXT	1, 00	O	35, 993		1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	2.00	o	15, 007		2.00
2.00	n NEE COSTS-WVBEE EQUIT	— — <del>2.</del> 00		<del>13,007</del> 51,000		2.00
	H - DRUGS CHARGED TO PATIENTS	<u> </u>	<u> </u>	31, 000		
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	989		1, 00
1.00	0	— — <del>/3.</del> 00		- — <del>- 9</del> 89		1.00
	I - SALARY RECLASS		<u> </u>	767		
1.00	ADMINISTRATIVE & GENERAL	5. 00	2, 609, 398	0		1. 00
1.00	ADMINISTRATIVE & GENERAL	<u> </u>	2, 609, 398	0		1.00
	K - DEPRECIATION		2, 009, 390	U		
1 00	CAP REL COSTS-MVBLE EQUIP	2 00	ما	400 355		1 00
1.00	EMS WEST STATION	2.00	U	688, 355		1.00
2.00		1. 01 2. 01	0	16, 040 29, 075		2.00
3.00	EMS WEST STATION EQUIP.		0			3.00
4. 00	ADMI NI STRATI VE & GENERAL			<u>7, 235</u>		4. 00
	U DI DO A LEAGE EVENIGE		0	740, 705		
4 00	L - BLDG & LEASE EXPENSE	0.00	ما			1.00
1.00	FMO WEST STATION FOUND	0.00	0	0		1.00
2.00	EMS WEST STATION EQUIP.	2. 01	0	939		2. 00
3.00	EMS WEST STATION	<u>1.</u> 01	0	100		3. 00
	0		0	1, 039		
	M - INTEREST RECLASS					
1.00	CAP REL COSTS-BLDG & FIXT	100	•	27 <u>6, 4</u> 98		1. 00
	0		0	276, 498		
	N - IMPLANTABLE MEDICAL SUPPL		,			
1.00	IMPL. DEV. CHARGED TO	72. 00	0	352, 983		1. 00
	PATI ENTS					
	0		0	352, 983		
500 00	Grand Total: Increases		3, 671, 026	1, 799, 152		500.00

					Т	o 12/31/2017 Date/Time 5/29/2018	
		Decreases		<u>'</u>			
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7.00	8. 00	9. 00	10. 00		
	A - REHAB THERAPY RECLASS						
1.00	PHYSI CAL THERAPY	66.00	229, 687	20, 440	0		1.00
2.00		0.00	0				2. 00
	0		229, 687	20, 440			
	B - OB RECLASS						
1.00	ADULTS & PEDIATRICS	30.00	588, 092	138, 252	0		1. 00
2.00		0.00	o	C	ol ol		2.00
			588, 092	138, 252			
	C - CLINIC DIETICIAN	-					
1.00	DI ETARY	10.00	2, 086	C	0		1.00
00			2, 086	ž	+		
	F - CAFETERIA RECLASS		2,000		1		
1.00	DI ETARY	10.00	241, 763	217, 246	0		1.00
1.00			241, 763	217, 246			1.00
	G - INSURANCE RECLASS		241, 703	217, 240	η		
1 00	ADMINISTRATIVE & GENERAL	5. 00		51, 000	12		1.00
1.00	ADMINISTRATIVE & GENERAL		0				
2.00		0.00	0				2. 00
	U DRIVER SUADOED TO DATI SUE		0	51, 000	)		
	H - DRUGS CHARGED TO PATIENTS						
1.00	PHARMACY	1500	•	989			1. 00
	0		0	989	9		
	I - SALARY RECLASS						
1.00	ADMI NI STRATI VE & GENERAL		0	2, 609, 398			1.00
	0		0	2, 609, 398	3		
	K - DEPRECIATION						
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	740, 705	9		1. 00
2.00		0.00	o	C	9		2.00
3.00		0.00	o	C	9		3.00
4.00		0.00	0	C	9		4.00
		— — <del></del> †		740, 705	<del>                                     </del>		
	L - BLDG & LEASE EXPENSE		<u> </u>	7.107.00	1		
1.00	E DEDO & EENOE EN ENOE	0.00	ol	C	10		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	o	1, 039			2. 00
3. 00	CAF KEE COSTS-WVBEE EQUIF	0.00	0	1,037	10		3.00
3.00				1, 039			3.00
	M - INTEREST RECLASS		UU	1, 039	7		
4 00		440.00		07/ 400			
1.00	INTEREST EXPENSE	113.00	0	27 <u>6, 4</u> 98			1. 00
	U INDIANTABLE MEDICAL SUITE	1.50	0	276, 498	3		
	N - IMPLANTABLE MEDICAL SUPPL				-1		
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	352, 983	8 0		1.00
	PATI ENT				<del>                                     </del>		
	0		0	352, 983			
F00 00	Grand Total: Decreases		1, 061, 628	4, 408, 550	)		500.00

| Peri od: | Worksheet A-7 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 12/31/2 Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS COMMUNITY HOSPT. OF LAGRANGE CTY IN Provider CCN: 15-1323

					10 12/31/2017	5/29/2018 12: 2	
	·			Acqui si ti ons			•
		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 ASSET						
1.00	Land	282, 529	48, 696		0 48, 696		1. 00
2.00	Land Improvements	1, 972, 720	6, 000		6, 000		2. 00
3.00	Buildings and Fixtures	13, 429, 858	104, 150		0 104, 150	0	3.00
4.00	Building Improvements	29, 098	0		0	0	4.00
5.00	Fixed Equipment	8, 563, 044	0		0	0	5.00
6.00	Movable Equipment	7, 940, 254	1, 159, 774		0 1, 159, 774		6.00
7.00	HIT designated Assets	1, 598, 343	171, 928		0 171, 928		7. 00
8.00	Subtotal (sum of lines 1-7)	33, 815, 846	1, 490, 548		0 1, 490, 548		8.00
9.00	Reconciling Items	799, 728	0		0	677, 246	9. 00
10.00	Total (line 8 minus line 9)	33, 016, 118	1, 490, 548		0 1, 490, 548	224, 153	10.00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
		6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		_				
1.00	Land	320, 703	0				1. 00
2.00	Land Improvements	1, 978, 720	452, 240				2. 00
3.00	Buildings and Fixtures	13, 534, 008	46, 964				3. 00
4.00	Building Improvements	29, 098	29, 098				4. 00
5.00	Fixed Equipment	8, 563, 044	508, 867				5.00
6.00	Movable Equipment	8, 214, 733	4, 280, 132				6.00
7.00	HIT designated Assets	1, 764, 689	0				7. 00
8.00	Subtotal (sum of lines 1-7)	34, 404, 995	5, 317, 301				8. 00
9.00	Reconciling Items	122, 482	0				9. 00
10. 00	Total (line 8 minus line 9)	34, 282, 513	5, 317, 301			l	10. 00

CAP REL COSTS-MVBLE EQUIP

EMS WEST STATION EQUIP.

Total (sum of lines 1-2)

2.00

2.01

3.00

2.00

2.01

3.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 15-1323 Peri od: Worksheet A-7 From 01/01/2017 Part II Date/Time Prepared: То 12/31/2017 5/29/2018 12:24 pm SUMMARY OF CAPITAL Depreciation Insurance (see Taxes (see Cost Center Description Lease Interest instructions) instructions) 10.00 11.00 12.00 9.00 13.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 1, 713, 399 0 8, 926 1.00 0 0 1. 01 1.01 EMS WEST STATION 0 0 0 2.00 CAP REL COSTS-MVBLE EQUIP 2.00 27.043 0 0 0 2.01 EMS WEST STATION EQUIP. 0 0 2.01 1, 740, 442 0 8, 926 3.00 3.00 Total (sum of lines 1-2) SUMMARY OF CAPITAL Cost Center Description 0ther Total (1) (sum Capital-Relate of cols. 9 d Costs (see through 14) instructions) 15.00 14.00 PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2 1.00 CAP REL COSTS-BLDG & FIXT 1, 722, 325 1.00 0 1.01 EMS WEST STATION 1.01

0

0

27,043

1, 749, 368

Health Financial Systems		COMMUNITY HOSPT. OF LAGRANGE CTY IN			In Lieu of Form CMS-2552-10		
	DECONCLULATION OF CADITAL COSTS CENTERS		Drovi don CCN, 1E 1222	Dori od:	Workshoot A 7		

Heal th	Financial Systems COMM	IUNI TY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider Co	F	eriod: rom 01/01/2017 o 12/31/2017	Date/Time Prep 5/29/2018 12:	pared:
		СОМІ	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see instructions)	Insurance	
			Leases	for Ratio (col. 1 - col.	Thistructions)		
		1. 00	2.00	2) 3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		2.00	3.00	4.00	3.00	
1.00	CAP REL COSTS-BLDG & FIXT	24, 104, 767	0	24, 104, 767	0. 742187	0	1. 00
1.01	EMS WEST STATION	320, 808		320, 808		0	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	7, 933, 898				0	2. 00
2.01	EMS WEST STATION EQUIP.	280, 835	l .	200,000		0	2. 01
3.00	Total (sum of lines 1-2)	32, 640, 308				0	3. 00
		ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
	DART III DECONOLILIATION OF CARLTAL COCTO OF	6. 00	7. 00	8. 00	9. 00	10. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS 0			989. 087	0	1. 00
1.00	EMS WEST STATION	0	1		16, 040	100	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1		715, 398		2.00
2. 01	EMS WEST STATION EQUIP.		1	Ö	29. 075	939	2. 01
3.00	Total (sum of lines 1-2)	0			1, 749, 600	0	3.00
			Sl	JMMARY OF CAPIT			
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	oost center bescription	Titterest	instructions)		Capi tal -Rel ate		
			,		d Costs (see	through 14)	
					instructions)	3 ,	
		11.00	12. 00	13. 00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	CAP REL COSTS-BLDG & FIXT	276, 498	l .			1, 310, 504	1. 00
1.01	EMS WEST STATION	0	-	C	0	16, 140	1. 01
2.00	CAP REL COSTS-MVBLE EQUIP	0	15, 007	0	0	729, 366	2.00
2.01	EMS WEST STATION EQUIP.	0 27/ 400	[ U	0.004	0	30, 014	2. 01 3. 00
3. 00	Total (sum of lines 1-2)	276, 498	51, 000	8, 926	0	2, 086, 024	3.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES COMMUNITY HOSPT. OF LAGRANGE CTY IN

Provider CCN: 15-1323

					To 12/31/2017	Date/Time Prep 5/29/2018 12:	
				Expense Classification on To/From Which the Amount is		3/29/2016 12	24 piii
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1. 00 B	2. 00 -1. 547	3.00 CAP REL COSTS-BLDG & FIXT	4. 00	5. 00	1. 00
1. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - EMS WEST	_		EMS WEST STATION		0	
	STATION (chapter 2)				1. 01		
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2.00
2. 01	Investment income - EMS WEST STATION EQUIP. (chapter 2)		o	EMS WEST STATION EQUIP.	2. 01	0	2.0
3.00	Investment income - other		О		0.00	0	3.00
4. 00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.00
	expenses (chapter 8)						
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7. 00	Tel ephone servi ces (pay stati ons excluded) (chapter 21)		0		0.00	0	7. 00
8. 00	Television and radio service (chapter 21)	А	-5, 036	OPERATION OF PLANT	7. 00	0	8. 00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician adjustment	A-8-2	0 -1, 656, 266		0.00	O O	
11. 00	Sale of scrap, waste, etc.	А	-356	OPERATION OF PLANT	7. 00	0	11. 00
12. 00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	-2, 644, 452			0	12. 00
13.00	Laundry and linen service	D	0	CAFFTEDIA	0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee	В	-268, 526 0	CAFETERI A	11. 00 0. 00	0	
16. 00	and others Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
	patients						
18. 00	Sale of medical records and abstracts		0		0.00	0	
19. 00	Nursing and allied health education (tuition, fees, books, etc.)		0		0.00	0	19. 00
20. 00 21. 00	Vending machines Income from imposition of interest, finance or penalty		0		0. 00 0. 00	0 0	l
22. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22. 00
23. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		O	*** Cost Center Deleted ***	114. 00		25. 00
26. 00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
26. 01	Depreciation - EMS WEST		O	EMS WEST STATION	1. 01	0	26. 0°
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
27. 01	COSTS-MVBLE EQUIP Depreciation - EMS WEST		0	EMS WEST STATION EQUIP.	2. 01	0	27. 0°
28. 00	STATION EQUIP. Non-physician Anesthetist			NONPHYSICIAN ANESTHETISTS	19.00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of limitation (chapter 14)	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	0	

Health Financial Systems ADJUSTMENTS TO EXPENSES COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 Provi der CCN: 15-1323 Peri od: Worksheet A-8 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/29/2018 12:24 pm Expense Classification on Worksheet A

				Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted				
				10/From which the amount is t	o be Adjusted			
	Cost Center Description	Dani o (Cada (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.		
	cost center bescription	Basi s/Code (2) 1.00	Amount 2.00	3. 00	4. 00	5. 00		
30. 99	Hospice (non-distinct) (see	1.00		ADULTS & PEDIATRICS	30.00		30. 9	
30. 77	instructions)			ADDETS & LEDIATRICS	30.00		30. 7	,,
31. 00	,	A-8-3	(	SPEECH PATHOLOGY	68. 00		31. 0	20
01.00	pathology costs in excess of		•	0. 220. 17	00.00		0 0	, ,
	limitation (chapter 14)							
32.00	,		(		0.00	0	32.0	00
	Depreciation and Interest							
33.00	HAF NET FEE EXPENSE	A	(	ADMINISTRATIVE & GENERAL	5. 00	0	33.0	)()
33. 02	CAH HIT ADJ DEPR CARRYFRWD	A	-185, 509	ADMINISTRATIVE & GENERAL	5. 00	0	33.0	)2
	2012-2015							
34.00	MI SCELLANEOUS REVENUE	В	2, 508	ADMINISTRATIVE & GENERAL	5. 00	0	34.0	)()
35.00	SPEECH THERAPY CONTRACTED	В	-11, 425	SPEECH PATHOLOGY	68.00	0	35. C	)()
38. 00	PHARMACY EMPLOYEE RX PURCHASES	В	-614, 790	DRUGS CHARGED TO PATIENTS	73.00	0	38.0	)()
39. 00	RELATED PARTY INTEREST EXPENSE		(		0.00	0	39. C	)()
40.00	SELF INSURANCE	Α	-1, 069, 649	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	40. C	)()
41.00	LOBBY % OF DUES &	A	-3, 315	ADMINISTRATIVE & GENERAL	5.00	0	41. C	)()
	SUBSCRI PTI ONS							
42.00	` ` '		(		0.00	0	42. C	)()
	(3)							
44. 00	EKG INTERPRETATION COSTS	A	·	RADI OLOGY-DI AGNOSTI C	54. 00		44. C	
44. 01	MARKETI NG	A		RADI OLOGY-DI AGNOSTI C	54. 00		44. C	
44. 02		A		OCCUPATI ONAL THERAPY	67. 00		44. C	
44. 03		A		LIFEBRIDGE SENIOR CARE	90. 01	0	44. C	
47. 00	ADD-BACK OF DEMOLISHED ASSET DEPREC	A	17, 940	CAP REL COSTS-BLDG & FIXT	1. 00	9	47. C	)0
48.00	ADD-BACK OF DEMOLITION COSTS	Α	4, 125	ADMINISTRATIVE & GENERAL	5. 00	0	48. C	00
49.00	OTHER ADJUSTMENTS (SPECIFY)		(		0.00	0	49. C	00
	(3)							
49. 01		A		ADULTS & PEDIATRICS	30.00	-	49. C	
49. 02	MEDICAL DIRECTOR ADDITIONAL	А	1, 334	ADULTS & PEDIATRICS	30. 00	0	49. 0	)2
49. 03	ON-CALL PROF TIME	A	-99, 314	ADULTS & PEDIATRICS	30.00	0	49. C	)3
49. 04		A		ANESTHESI OLOGY	53.00		49. C	)4
	FOR A/R							
49. 05	MEDICAL DIRECTOR ADDITIONAL	A	6, 148	ANESTHESI OLOGY	53.00	0	49. C	)5
	A/P							
49. 06		A	19, 560	ADULTS & PEDIATRICS	30.00	0	49. C	)6
50.00			-6, 180, 511				50. C	)()
	(Transfer to Worksheet A,							
	column 6, line 200.)							_
(1) De	escription - all chapter referen	ices in this col	umn pertain t	o CMS Pub. 15-1.				

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

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

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

OFFICE COSTS

12/31/2017 Date/Time Prepared: 5/29/2018 12:24 pm Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in Wks. A, column 5 1. 00 4.00 5.00 2.00 3.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 5.00 ADMINISTRATIVE & GENERAL HOME OFFICE ALLOCATION 1.00 6, 036, 893 5, 016, 000 1.00 5. OO ADMINISTRATIVE & GENERAL RELATED PARTY SUBSIDY ADJ. 2.00 3, 665, 345 2.00 3.00 C 0.00 0 3.00 4.00 0.00 0 4.00 5.00 TOTALS (sum of lines 1-4). 6,036,893 8, 681, 345 5.00 Transfer column 6, line 5 to Worksheet A-8, column 2, line 12.

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

 as not been posted to not hence in our announce of the condition of the condition of the condition of the parti							
			Related Organization(s) and/	or Home Office			
Symbol (1)	Name	Percentage of	Name	Percentage of			
		Ownershi p		Ownershi p			
1. 00	2. 00	3. 00	4. 00	5. 00			
B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

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

6. 00	В	0.00 PARKVIEW HEALTH SYSTEM, INC. 100.00	6.00
7.00		0.00	7. 00
8.00		0.00	8. 00
9.00		0.00	9.00
10.00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- Corporation, partnership, or other organization has financial interest in provider.
- Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Health Financial Systems			COMMUNITY HOSPT. OF LAGRANGE CTY IN				In Lieu of Form CMS-2552-1		
STAT	EMENT OF COSTS OF	SERVICES FROM	RELATED ORGANI	ZATIONS AND HOME	Provi der	CCN: 15-1323	Peri od:	Worksheet A-	-8-1
OFFI	CE COSTS						From 01/01/2017		
							To 12/31/2017	Date/Time Pr	
								5/29/2018 12	2:24 pm
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED	AS A RESULT OF TR	ANSACTI ONS	WITH RELATED O	RGANIZATIONS OR (	CLAIMED	
	HOME OFFICE CO	STS:							
1 00	1 020 893	0							1 1 00

5.00 -2,644,452 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.

2.00

3.00

4.00

nas no	t been posted to worksheet A,	cordinis i and/or 2, the aniount arrowable should be indicated in cordini 4 or this part.	
	Rel ated Organi zati on(s)		
	and/or Home Office		
	Type of Business		
	1 1962 21 2221 11222		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

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

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

2.00

3.00

4.00

-3, 665, 345

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| Period: | Worksheet A-8-2 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-1323

							1	To 12/31/2017	Date/Time Pre 5/29/2018 12:	
	Wkst. A Line #	Cost Center/Physi	ci an	Total	Professi on	al	Provi der	RCE Amount	Physi ci an/Prov	2 1 2
		I denti fi er		Remuneration	Component		Component		ider Component	
					·		·		Hours	
	1. 00	2. 00		3. 00	4. 00		5. 00	6. 00	7. 00	
1.00	53. 00 DR			424, 223	347,		77, 111	0		1. 00
2.00	53. 00 DR			747, 225	747,	225	0	0	0	2.00
3.00	91. 00 DR			30, 000		0	30, 000	0	0	3.00
4.00	91. 00 DR			1, 572, 814	561,	930	1, 010, 884	0	0	4. 00
5.00	30. 00 DR			14, 891		0	14, 891	0	0	5. 00
6.00	90. 01 DR			17, 235		0	17, 235	0	0	6.00
7.00	53. 00 DR	. G		6, 000		0	6,000	0	0	7. 00
8.00	0. 00			0		0	0	0	0	8. 00
9.00	0. 00			0		0	0	0	0	9. 00
10.00	0.00			0		0	0	0	0	10.00
200.00				2, 812, 388			1, 156, 121		0	200.00
	Wkst. A Line #	Cost Center/Physi	ci an	Unadjusted RCE			Cost of	Provi der	Physician Cost	
		I denti fi er		Li mi t		RCE	Memberships &	Component	of Malpractice	
					Limit		Conti nui ng	Share of col.	Insurance	
	4 00						Educati on	12	44.00	
1 00	1. 00 53. 00 DR	2.00		8.00	9. 00	0	12. 00	13. 00	14.00	1 00
1.00	53. 00 DR 53. 00 DR			0			-	0		1.00
2. 00 3. 00	91. 00 DR			0		0	0	0		2. 00 3. 00
4. 00	91. 00 DR			0		0	0	0		
	30. 00 DR			0		0	0	0	0	4. 00
5. 00 6. 00	90. 01 DR			0		0	0	0	0	5. 00 6. 00
7. 00	53. 00 DR			0		0	0	0	0	7. 00
8. 00	0. 00	. в		0		0	0	0	0	8. 00
9. 00	0.00			0		0	0	0	0	9. 00
10. 00	0.00			0		0	0	0	· ·	10. 00
200.00	0.00			0		0	0	0		
200.00	Wkst. A Line #	Cost Center/Physi	cian	Provi der	Adjusted R	_	RCE	Adjustment	0	200.00
	micst. A Erric "	I denti fi er	OI dii	Component	Limit	.OL	Di sal I owance	naj ustilient		
				Share of col.						
				14						
	1. 00	2. 00		15. 00	16. 00		17. 00	18. 00		
1.00	53. 00 DR			0		0	0	347, 111		1.00
2.00	53. 00 DR			0		0	0	747, 225		2. 00
3.00	91. 00 DR			0		0	0	0		3. 00
4.00	91. 00 DR			0		0	0	561, 930		4. 00
5.00	30. 00 DR			0		0	0	0		5. 00
6.00	90. 01 DR			0		0	0	0		6. 00
7.00	53. 00 DR	. G		0		0	0	0		7. 00
8.00	0. 00			0		0	0	0		8. 00
9.00	0. 00			0		0	0	0		9. 00
10.00	0. 00			0		0	0	0		10. 00
200.00	I I			0	I	0	0	1, 656, 266	]	200. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1323

Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

5/29/2018 12:24 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT EMS WEST MVBLE EQUIP EMS WEST STATION EQUIP. for Cost STATI ON Allocation (from Wkst A col. 7) 1.00 1. 01 2. 00 2. 01 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1, 310, 504 1, 310, 504 1 00 1.01 00101 EMS WEST STATION 16, 140 16, 140 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 729, 366 729, 366 2.00 00201 EMS WEST STATION EQUIP. 2 01 30, 014 30, 014 2 01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 3, 677, 298 0 0 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 7, 466, 189 240, 667 133, 944 0 5.00 6.00 00600 MAINTENANCE & REPAIRS 0 6.00 0 00700 OPERATION OF PLANT 1, 031, 485 7 00 74, 436 41, 427 0 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 97, 991 4, 256 2, 369 0 8.00 00900 HOUSEKEEPI NG 207, 854 13, 928 7, 752 9.00 9.00 01000 DI ETARY 269, 356 10.00 10.00 55, 881 0 31, 101 0 01100 CAFETERI A 0 11.00 190, 483 C 0 0 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 0 0 12.00 C 01300 NURSING ADMINISTRATION 331,071 13.00 0 13.00 01400 CENTRAL SERVICES & SUPPLY -51, 905 26, 544 14, 773 0 14.00 14.00 0 15 00 01500 PHARMACY 560, 252 22.844 12.714 0 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 4, 508 2, 509 16.00 17.00 01700 SOCIAL SERVICE 0 C 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 19.00 C 0 02000 NURSING SCHOOL 0 0 20.00 Ω 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 0 21.00 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 1, 647, 843 30.00 294, 952 164, 154 0 30.00 0 43.00 04300 NURSERY 138, 185 4, 441 2.472 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 1, 480, 982 50.00 168, 115 93.565 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 588, 159 20, 993 0 11.684 0 52.00 05300 ANESTHESI OLOGY 83.204 0 53.00 Λ 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 266, 501 83, 317 46, 371 0 54.00 06000 LABORATORY 0 60.00 1, 126, 426 33, 239 18, 500 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 62.30 06500 RESPIRATORY THERAPY 299, 325 15, 139 0 65.00 8, 426 0 65.00 66.00 06600 PHYSI CAL THERAPY 371, 492 55, 713 0 31,007 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 166, 343 67.00 06800 SPEECH PATHOLOGY 72, 359 0 0 68 00 Ω 0 68 00 0 0 69.00 06900 ELECTROCARDI OLOGY 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 559, 711 o 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 352, 983 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 1, 265, 043 73 00 0 76.97 07697 CARDIAC REHABILITATION 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 76.98 0 0 76.99 07699 LI THOTRI PSY 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 09001 LIFEBRIDGE SENIOR CARE 240, 897 15, 308 8, 520 90.01 90.01 09100 EMERGENCY 0 64, 795 91.00 91.00 2,042,941 116, 422 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 1, 319, 427 16, 140 0 30, 014 95.00 99 10 09910 CORE 0 99 10 0 C C 0 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 0 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 99.30 0 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 0 99.40 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 30, 014 118. 00 28, 887, 919 1, 250, 703 16, 140 696, 083 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190 00 8.215 3, 751 0 2.088 31, 195 192.00 19200 PHYSICIANS' PRIVATE OFFICES 4,056 0 192.00 56,050 194. 00 07950 OCCUPATIONAL HEALTH -1,050 C 0 0 0 194.00 194. 01 07951 FOUNDATION 0 0 194, 01 7,405 C 0 0 194. 03 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 106, 859 C 0 194. 04 07954 ER PHYSICIAN 0 0 0 0 0 194. 04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 0 194.06 200.00 Cross Foot Adjustments 200.00 0 201.00 Negative Cost Centers 0 201.00

Health Financial Systems	COMMUNITY HOSPT. OF	UNITY HOSPT. OF LAGRANGE CTY IN			In Lieu of Form CMS-2552-10			
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der Co		Peri od:	Worksheet B			
				From 01/01/2017 To 12/31/2017	Part     Date/Time Pre	narod:		
				12/31/2017	5/29/2018 12:			
			CAPITAL RE	LATED COSTS				
		BUBB & FLVT		1 10 (D) E EQUUE				
Cost Center Description	Net Expenses	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST			
	for Cost		STATI ON		STATION EQUIP.			
	Allocation							
	(from Wkst A							
	col . 7)							
	0	1. 00	1. 01	2. 00	2. 01			
202.00 TOTAL (sum lines 118 through 201)	29, 013, 404	1, 310, 504	16, 140	729, 366	30, 014	202. 00		

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-1323

Peri od: Worksheet B From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

5/29/2018 12:24 pm Cost Center Description **EMPLOYEE** ADMINISTRATIVE MAINTENANCE & OPERATION OF Subtotal **BENEFITS** & GENERAL REPAI RS PLANT DEPARTMENT 4A 5.00 6. 00 7. 00 4.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00101 EMS WEST STATION 1.01 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.01 00201 EMS WEST STATION EQUIP. 2.01 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 3, 677, 298 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 1, 109, 310 8, 950, 110 8, 950, 110 5.00 00600 MAINTENANCE & REPAIRS 6.00 6 00 7.00 00700 OPERATION OF PLANT 89, 702 1, 237, 050 551, 520 1, 788, 570 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 104, 616 46, 641 0 7,647 8.00 00900 HOUSEKEEPI NG 9.00 288, 178 128, 480 25, 027 58.644 9.00 01000 DI ETARY 10.00 48,001 404, 339 180, 268 100, 409 10.00 11.00 01100 CAFETERI A 81, 799 272, 282 121, 393 0 0 0 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 01300 NURSING ADMINISTRATION 111, 870 13.00 442.941 197, 479 13.00 0 01400 CENTRAL SERVICES & SUPPLY 14.00 -10, 588 C 47, 696 14.00 15.00 01500 PHARMACY 761, 331 339, 428 0 0 0 41, 046 165, 521 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 7, 017 8, 100 16.00 3.128 01700 SOCIAL SERVICE 17 00 0 0 Ω 17 00 19.00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 0 19.00 02000 NURSING SCHOOL 0 0 20.00 0 0 0 20.00 0 02100 I &R SERVICES-SALARY & FRINGES APPRV 21.00 C 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 0 0 Λ 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 354 340 2, 461, 289 1, 097, 329 O 529, 977 30 00 04300 NURSERY 43.00 37,855 182, 953 81, 567 0 7, 980 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 246, 321 1, 988, 983 886, 758 0 302, 075 50.00 05200 DELIVERY ROOM & LABOR ROOM 781.958 348, 624 0 52.00 161, 122 37, 722 52.00 53.00 05300 ANESTHESI OLOGY 83, 204 37, 095 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 231, 344 1, 627, 533 725, 611 0 149, 707 54.00 60 00 06000 LABORATORY 1, 178, 165 525, 267 59, 726 60 00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 62.30 06500 RESPIRATORY THERAPY 96, 577 419, 467 187, 013 0 27, 203 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 115, 430 573, 642 255, 750 0 0 0 0 0 0 100, 107 66.00 06700 OCCUPATIONAL THERAPY 218, 025 97, 203 67 00 51,682 67 00 0 26, 031 43, 866 68.00 06800 SPEECH PATHOLOGY 98, 390 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 559, 711 249, 539 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72 00 352, 983 157, 372 0 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 1, 265, 043 564,000 0 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 0 76. 98 76. 98 0 0 07699 LI THOTRI PSY 76.99 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLI NI C 90.00 09001 LIFEBRIDGE SENIOR CARE 314, 316 27, 505 90.01 49.591 140.133 0 90.01 91.00 09100 EMERGENCY 273.342 2, 497, 500 1, 113, 477 0 209, 191 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 763, 039 95.00 345.902 1, 711, 483 0 0 95.00 99. 10 09910 CORF C 0 0 99. 10 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 C 0 0 0 99.20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 99.30 99.30 C 0 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 O  $\cap$ 99.40 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 654, 384 28, 771, 921 8, 841, 980 0 1, 681, 118 118. 00 NONREIMBURSABLE COST CENTERS 6, 740 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 14, 054 6. 266 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 91, 301 40, 705 100, 712 192. 00 194. 00 07950 OCCUPATI ONAL HEALTH 0 0 194.00 -1.0500 194. 01 07951 FOUNDATION 18, 205 25, 610 11, 418 0 194. 01 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 0 194. 03 4,709 111, 568 49, 741 0 194. 04 07954 ER PHYSICIAN 0 0 194.04 0 194.06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 194, 06 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00 1, 788, 570 202. 00 202.00 TOTAL (sum lines 118 through 201) 3.677.298 29, 013, 404 8, 950, 110

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-1323 Peri od: Worksheet B From 01/01/2017 Part I

Date/Time Prepared:

12/31/2017

5/29/2018 12:24 pm Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A MAINTENANCE OF LINEN SERVICE PERSONNEL 9.00 10.00 11.00 12.00 8.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION 1.01 1.01 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00201 EMS WEST STATION EQUIP. 2 01 2 01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 158, 904 8.00 9.00 00900 HOUSEKEEPI NG 32 441, 717 9 00 01000 DI ETARY 10.00 810 25, 259 711, 085 10 00 11.00 01100 CAFETERI A 393, 675 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 0 0 12.00 01300 NURSING ADMINISTRATION 0 13.00 0 21, 177 0 13.00 01400 CENTRAL SERVICES & SUPPLY 11, 999 0 14.00 0 14.00 0 15.00 01500 PHARMACY 10, 326 24, 242 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2,038 16.00 0 01700 SOCIAL SERVICE 17.00 0 17.00 C 0 0 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 C 0 0 19.00 02000 NURSING SCHOOL 0 20.00 20.00 0 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 C 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 0 22.00 22.00 0 0 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 57, 287 133, 321 711, 085 81, 733 0 30.00 04300 NURSERY 43.00 2,574 2,007 0 7,044 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 75, 991 28, 889 48. 072 50.00 05200 DELIVERY ROOM & LABOR ROOM 9, 489 0 52.00 10, 265 29.913 0 52.00 05300 ANESTHESI OLOGY 0 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 15, 445 37, 661 0 52, 463 0 54.00 06000 LABORATORY 0 60.00 0 15, 025 0 0 60.00 62 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 62 30 0 06500 RESPIRATORY THERAPY 0 65.00 0 6,843 23,007 0 65.00 06600 PHYSI CAL THERAPY 6,610 25, 183 0 25, 660 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 2.542 0 9.102 0 67.00 06800 SPEECH PATHOLOGY 68.00 254 C 4,071 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 C 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.00 72 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72 00 0 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 C 0 0 73.00 07697 CARDIAC REHABILITATION 0 0 76. 97 76.97 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 C 0 o 0 76.98 07699 LI THOTRI PSY 76.99 0 76.99 0 0 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 0 0 0 0 90.00 90. 01 09001 LIFEBRIDGE SENIOR CARE 6, 919 12, 670 90. 01 0 0 0 91.00 09100 EMERGENCY 0 25.790 52, 625 91.00 54, 521 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 95.00 4. 767 0 0 0 99 10 09910 CORE 0 C 0 0 0 99 10 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 99. 20 0 99 30 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 O 99 30 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 0 0 0 0 99.40 SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE 113.00 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 155, 265 414, 686 711, 085 393, 675 0 118.00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1, 696 0 0 0 190, 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 3,639 25, 335 0 0 0 192.00 0 194. 00 07950 OCCUPATIONAL HEALTH 0 194.00 0 C 194. 01 07951 FOUNDATI ON 0 0 194. 01 0 C 0 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 0 0 194. 03 194. 04 07954 ER PHYSICIAN 0 C 0 0 0 194. 04 194.06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 194.06 0 0 0 200.00 Cross Foot Adjustments 200.00 0 201.00 201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118 through 201) 158, 904 441.717 711, 085 393, 675 0 202, 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10 Provider CCN: 15-1323 

					10	12/31/2017	Date/lime Pre 5/29/2018 12:	
		Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	24 ()111
			13. 00	14. 00	15. 00	16.00	17. 00	
		AL SERVICE COST CENTERS						
1.00	1	CAP REL COSTS-BLDG & FIXT						1. 00
1. 01	1	EMS WEST STATION						1. 01
2.00	1	CAP REL COSTS-MVBLE EQUIP						2.00
2. 01	1	EMS WEST STATION EQUIP.						2. 01
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	1	MAINTENANCE & REPAIRS						6.00
7. 00	1	OPERATION OF PLANT						7. 00
8. 00	1	LAUNDRY & LINEN SERVICE						8.00
9.00	1	HOUSEKEEPI NG						9. 00
10.00	01000	DI ETARY						10.00
11. 00	1	CAFETERI A						11. 00
12. 00	1	MAINTENANCE OF PERSONNEL						12. 00
13. 00	1	NURSI NG ADMI NI STRATI ON	661, 597	40.407				13.00
14.00	1	CENTRAL SERVICES & SUPPLY	0	49, 107	1 177 070			14. 00
15. 00 16. 00	1	PHARMACY MEDICAL RECORDS & LIBRARY	0	705	1, 177, 078	20, 202		15. 00 16. 00
17. 00	1	SOCIAL SERVICE	0	0		20, 283	0	17. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20. 00	1	NURSI NG SCHOOL	0	0		Ö	0	20.00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRV	l ol	0	Ö	ol	0	21.00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV	O	0	0	o	0	22. 00
23.00	02300	PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDI ATRI CS	244, 379	658		2, 438	0	30. 00
43. 00		NURSERY	21, 014	821	63	361	0	43. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	143, 741	12, 640	2, 380	393	0	50. 00
52. 00	1	DELIVERY ROOM & LABOR ROOM	89, 432	3, 287	2, 360	0	0	52.00
53. 00	1	ANESTHESI OLOGY	07, 432	3, 207	0	0	0	53.00
54. 00	1	RADI OLOGY-DI AGNOSTI C	o	776	169	6, 671	0	54.00
60.00	1	LABORATORY	O	0		0	0	60.00
62. 30	06250	BLOOD CLOTTING FOR HEMOPHILIACS	O	0	О	o	0	62. 30
65. 00	06500	RESPI RATORY THERAPY	0	176	0	0	0	65. 00
66. 00	1	PHYSI CAL THERAPY	0	88	212	1, 659	0	66. 00
67. 00	1	OCCUPATIONAL THERAPY	0	34	82	398	0	67. 00
68. 00	1	SPEECH PATHOLOGY	0	3	82	91	0	68.00
69. 00 71. 00	1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	0	0 14, 929	0	0	0	69.00
71.00	1	IMPL. DEV. CHARGED TO PATIENTS	0	9, 409		0	0	71. 00 72. 00
73. 00		DRUGS CHARGED TO PATIENTS		1, 355		0	0	73.00
76. 97		CARDI AC REHABI LI TATI ON	o	0	0	o	0	76. 97
76. 98	1	HYPERBARI C OXYGEN THERAPY	0	0	0	o	0	76. 98
76. 99	07699	LI THOTRI PSY	0	0	0	0	0	76. 99
		TIENT SERVICE COST CENTERS						
		CLINIC	0	0	_	0	_	90.00
		LI FEBRI DGE SENI OR CARE	1/2 021	18		0 272	0	1
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART	163, 031	2, 078	47	8, 272	0	91. 00 92. 00
92.00		REIMBURSABLE COST CENTERS						92.00
95. 00		AMBULANCE SERVICES	O	2, 042	6, 306	ol	0	95. 00
99. 10	09910		0	0	0	o	0	99. 10
99. 20	09920	OUTPATIENT PHYSICAL THERAPY	0	0	0	o	0	99. 20
99. 30		OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	
99. 40		OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
112 00		AL PURPOSE COST CENTERS						112 00
113.00		INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	661, 597	49, 019	1, 177, 078	20, 283	0	113. 00 118. 00
110.00		IMBURSABLE COST CENTERS	001, 377	47,017	1, 177, 070	20, 203	0	1110.00
	19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	2	0	O	0	190. 00
192.00	19200	PHYSICIANS' PRIVATE OFFICES	O	82	0	o		192. 00
		OCCUPATIONAL HEALTH	0	0	0	0		194. 00
		FOUNDATION	이	3	0	0		194. 01
		COMMUNITY & VOLUNTEER SVCS	0	1	0	0		194. 03
		ER PHYSICIAN		0		0		194. 04
194. 06 200. 00		SHIPSHEWANA RADIOLOGY AND LAB Cross Foot Adjustments		O		O	0	194. 06 200. 00
200.00	1	Negative Cost Centers	٨	0	۸	٥	n	200.00
202.00	1	TOTAL (sum lines 118 through 201)	661, 597	49, 107	1, 177, 078	20, 283		202. 00
, ,	'					.,	,	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Peri od: From 01/01/2017 To 12/31/2017

In Lieu of Form CMS-2552-10
Worksheet B
01/2017 Part I
01/2017 Date/Time Prepared: 5/29/2018 12: 24 pm

				I NITEDNE 0	DECLIDENTS	5/29/2018 12:	24 pm
				INTERNS &	RESI DENTS		
	Cost Center Description	NONPHYSI CI AN	NURSING SCHOOL	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
	·	ANESTHETI STS		Y & FRINGES	PRGM COSTS	PRGM	
		10.00	22.22	APPRV	APPRV	00.00	
	CENEDAL SEDVICE COST CENTEDS	19. 00	20.00	21. 00	22.00	23. 00	
1.00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT			T			1.00
1. 01	00101 EMS WEST STATION						1. 01
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01	00201 EMS WEST STATION EQUIP.						2. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON						12. 00 13. 00
	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00	01500 PHARMACY						15. 00
	01600 MEDI CAL RECORDS & LI BRARY						16. 00
17. 00	01700 SOCIAL SERVICE						17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	C					19.00
20. 00	02000 NURSI NG SCHOOL	_					20.00
21. 00	02100   &R SERVICES-SALARY & FRINGES APPRV			0			21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV				0		22. 00
23.00	02300 PARAMED ED PRGM-(SPECIFY)					0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	C		1		<b>l</b>	
43.00	04300 NURSERY	C	C	0	0	0	43. 00
	ANCILLARY SERVICE COST CENTERS				T. T.		
50. 00	05000 OPERATING ROOM	C	l .			1	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	C	) C		0	1	1
53.00	05300 ANESTHESI OLOGY	(		0	0	0	
54.00	05400 RADI OLOGY - DI AGNOSTI C	C			0	0	1
60. 00 62. 30	06000 LABORATORY			0	0	0	1
65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY				0	0	1
66. 00	06600 PHYSI CAL THERAPY				0	0	1
67. 00	06700 OCCUPATI ONAL THERAPY				0	0	
68. 00	06800 SPEECH PATHOLOGY				0	Ö	1
69. 00	06900 ELECTROCARDI OLOGY	C			Ö	Ö	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	) c	o	0	0	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	o c	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	C	) c	0	0	0	73. 00
76. 97	07697 CARDIAC REHABILITATION	C	) C	0	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	C	) C	0	0	0	
76. 99	07699 LI THOTRI PSY	C	) C	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS				1		
90.00	09000 CLI NI C	C	) C	0	0	0	
90. 01	09001 LI FEBRI DGE SENI OR CARE	(		0	0	0	
91.00	09100 EMERGENCY	C	,	١	U	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		1				92.00
95. 00	09500 AMBULANCE SERVICES				٥	0	95. 00
99. 10	09910 CORF	C	1		0	i	
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	C	1	ol o	0	Ö	
	09930 OUTPATIENT OCCUPATIONAL THERAPY	C	_		0	Ö	
	09940 OUTPATIENT SPEECH PATHOLOGY	C		ol o	0	Ō	
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 I NTEREST EXPENSE						113. 00
118.00		C	) C	0	0	0	118. 00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	1	ή			190. 00
	19200 PHYSICIANS' PRIVATE OFFICES	C	) C	0	0		192. 00
	07950 OCCUPATI ONAL HEALTH	C	) C	0	0		194. 00
	07951 FOUNDATION	C	el C	0	0	l .	194. 01
	3 07952 COMMUNITY & VOLUNTEER SVCS	C -	<u>C</u>	) O	0	l .	194. 03
	107954 ER PHYSICIAN	0		<u>0</u>	0	l	194. 04
	5 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	y C	0	0		194. 06
200.00							200. 00
201. 00 202. 00		C				<b>l</b>	201.00
202.00			1	′1 0	ı V	, 0	1202.00

Provider CCN: 15-1323

| Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | To 12/31/201

			T	o 12/31/2017 Date/Time Pre 5/29/2018 12:	
Cost Center Description	Subtotal	Intern &	Total	1 0, 2, 7, 20 10 12.	
		Residents Cost & Post			
		Stepdown			
		Adjustments			
GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1. 00 00100 CAP REL COSTS-BLDG & FIXT					1.00
1.01   00101 EMS WEST STATION					1. 01
2. 00   00200   CAP   REL   COSTS-MVBLE   EQUI   P					2. 00
2. 01   00201   EMS   WEST   STATION   EQUIP.					2. 01
4.00   O0400   EMPLOYEE BENEFITS DEPARTMENT 5.00   O0500   ADMINISTRATIVE & GENERAL					4. 00 5. 00
6. 00 00600 MAI NTENANCE & REPAI RS					6. 00
7.00 00700 OPERATION OF PLANT					7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY					9. 00 10. 00
11. 00   01100   CAFETERI A					11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL					12. 00
13. 00 01300 NURSING ADMINISTRATION					13. 00
14. 00 01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00   01500   PHARMACY 16. 00   01600   MEDI CAL   RECORDS & LI BRARY					15. 00 16. 00
17. 00   01700   SOCIAL SERVICE					17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS					19.00
20. 00   02000   NURSI NG SCHOOL					20. 00
21. 00   02100   1&R SERVI CES-SALARY & FRINGES APPRV					21. 00
22. 00   02200   I &R SERVI CES-OTHER PRGM COSTS APPRV 23. 00   02300   PARAMED ED PRGM-(SPECI FY)					22. 00 23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					23.00
30. 00 03000 ADULTS & PEDI ATRI CS	5, 319, 612	0	5, 319, 612		30.00
43. 00 04300 NURSERY	306, 384	0	306, 384		43. 00
ANCILLARY SERVICE COST CENTERS	2 400 022	ما	2 400 022		F0 00
50.00   05000   OPERATING ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	3, 489, 922 1, 310, 942	0	3, 489, 922 1, 310, 942		50. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	120, 299	o	120, 299		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 616, 036	0	2, 616, 036		54.00
60. 00   06000   LABORATORY	1, 780, 058	0	1, 780, 058		60.00
62. 30   06250   BLOOD   CLOTTING FOR HEMOPHILIACS 65. 00   06500   RESPIRATORY   THERAPY	0 663, 709	0	0 663, 709		62. 30 65. 00
66. 00   06600   PHYSI CAL THERAPY	988, 911		988, 911		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	327, 386	Ö	327, 386		67. 00
68. 00 06800 SPEECH PATHOLOGY	146, 757	0	146, 757		68. 00
69. 00   06900   ELECTROCARDI OLOGY 71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0		69.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENT 72.00   07200   MPL. DEV. CHARGED TO PATIENTS	824, 179 519, 764		824, 179 519, 764		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 995, 892		2, 995, 892		73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0		76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0		76. 98
76. 99 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0	0		76. 99
90. 00 09000 CLINIC	0	ol	0		90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	501, 561	0	501, 561		90. 01
91. 00   09100   EMERGENCY	4, 126, 532	0	4, 126, 532		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0			92. 00
95. 00 O9500 AMBULANCE SERVICES	2, 487, 637	0	2, 487, 637		95. 00
99. 10 09910 CORF	0	Ö	0		99. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0		99. 20
99. 30   09930   OUTPATIENT OCCUPATIONAL THERAPY	0	0	0		99. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS	0	0	0		99. 40
113. 00 11300   INTEREST EXPENSE					113. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	28, 525, 581	0	28, 525, 581		118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	28, 758	0	28, 758		190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 194. 00 07950 OCCUPATI ONAL HEALTH	261, 774 -1, 050		261, 774 -1, 050		192. 00 194. 00
194. 01 07951 FOUNDATI ON	37, 031		37, 031		194. 00
194. 03 07952 COMMUNITY & VOLUNTEER SVCS	161, 310		161, 310		194. 03
194. 04 07954 ER PHYSICIAN	0	0	0		194. 04
194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	0		194. 06
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	0		0		200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	29, 013, 404	0	29, 013, 404		202.00
		<u> </u>			

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1323

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | 5/29/2018 12: 24 pm

					72/31/2017	5/29/2018 12:	
				CAPITAL REL	LATED COSTS		
	Cost Center Description	Di rectly Assigned New Capital Related Costs	BLDG & FIXT	EMS WEST STATION	MVBLE EQUIP	EMS WEST STATION EQUIP.	
		0	1. 00	1. 01	2. 00	2. 01	
1 00	GENERAL SERVICE COST CENTERS					I	1 00
1. 00 1. 01	00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION						1. 00 1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 EMS WEST STATION EQUIP.						2. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	0	0	0	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	814, 808	240, 667	0	133, 944		
6. 00 7. 00	00600 MAI NTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	74, 436	0	41, 427	0	6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	4, 256	Ö	2, 369		
9.00	00900 HOUSEKEEPI NG	0	13, 928	0	7, 752	0	9. 00
10.00	01000 DI ETARY	0	55, 881	0	31, 101	0	10.00
11. 00 12. 00	01100   CAFETERI A   01200   MAI NTENANCE OF PERSONNEL	0	0	0	0	0	11. 00 12. 00
13. 00	01300 NURSI NG ADMINI STRATI ON	0	0	0	0	0	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	26, 544	0	14, 773	-	14. 00
15. 00	01500 PHARMACY	0	22, 844	0	12, 714		15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	4, 508	0	2, 509	l .	16.00
17. 00 19. 00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	17. 00 19. 00
20. 00	02000 NURSI NG SCHOOL	O	Ö	0	0	Ö	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23. 00	02300   PARAMED ED PRGM-(SPECIFY)   I NPATIENT ROUTINE SERVICE COST CENTERS	0	U	0	0	0	23.00
30. 00	03000 ADULTS & PEDIATRICS	0	294, 952	0	164, 154	0	30. 00
43.00	04300 NURSERY	0	4, 441	0	2, 472	0	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	0	168, 115	O	93, 565	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	20, 993	0	11, 684		52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	83, 317	0	46, 371	0	54. 00
60.00	06000 LABORATORY	0	33, 239	0	18, 500		60.00
62. 30 65. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0	15, 139	0	8, 426	0	62. 30 65. 00
66. 00	06600 PHYSI CAL THERAPY	o o	55, 713	Ö	31, 007		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 71. 00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	69. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	Ö	Ö	0	ő	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 76. 99	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0		0	0	0	1
70. 77	OUTPATIENT SERVICE COST CENTERS		<u> </u>	<u> </u>			70.77
90. 00	09000 CLI NI C	0	0	0	0	0	90. 00
90. 01 91. 00	09001 LI FEBRI DGE SENI OR CARE 09100 EMERGENCY	0	15, 308	0	8, 520 64, 795	l .	90. 01 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		116, 422	O	04, 775		92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0	0	16, 140	0	00,011	
99. 10 99. 20	O9910   CORF   O9920   OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99. 10 99. 20
99. 30		0	0	0	0	Ö	1
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
	SPECIAL PURPOSE COST CENTERS					T	
113. 00 118. 00	) 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	814, 808	1, 250, 703	16, 140	696, 083	20 014	113. 00 118. 00
110.00	NONREI MBURSABLE COST CENTERS	014,000	1, 230, 703	10, 140	070, 003	30,014	1118.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 751	0	2, 088		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	0	56, 050	0	31, 195		192. 00
	0/07950 OCCUPATIONAL HEALTH 1/07951 FOUNDATION	0	0	0	0		194. 00 194. 01
	3 07952 COMMUNITY & VOLUNTEER SVCS		0	0	0		194. 01
194. 04	4 07954 ER PHYSICIAN	0	o	o	0	0	194. 04
	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	0	0	0	194. 06
200. 00 201. 00					0	_	200. 00 201. 00
201.00		814, 808	1, 310, 504	16, 140	729, 366		201.00
							·

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | From 01/2017 | Part II | Prepared: | Pr Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1323

						o 12/31/2017	Date/lime Pre 5/29/2018 12:	
		Cost Center Description	Subtotal	EMPLOYEE BENEFITS	ADMINISTRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	21 0111
			2A	DEPARTMENT 4. 00	5. 00	6. 00	7. 00	
	GENER	AL SERVICE COST CENTERS			2.22			
1.00	00100	CAP REL COSTS-BLDG & FIXT						1.00
1. 01		EMS WEST STATION						1. 01
2.00	1	CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01	1	EMS WEST STATION EQUIP.						2. 01
4. 00 5. 00	1	EMPLOYEE BENEFITS DEPARTMENT	0 1, 189, 419	C	1 100 410			4. 00 5. 00
6. 00	1	ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	1, 169, 419	C	1, 189, 419	0		6.00
7. 00		OPERATION OF PLANT	115, 863	C	73, 294	o	189, 157	7. 00
8.00		LAUNDRY & LINEN SERVICE	6, 625	C			809	8. 00
9.00		HOUSEKEEPI NG	21, 680	C	17, 074	0	2, 647	9. 00
10.00	1	DI ETARY	86, 982	C			10, 619	1
11.00	1	CAFETERI A	0	C	1		0	11.00
12.00	1	MAINTENANCE OF PERSONNEL	0	C	1	-	0	
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	41, 317	C			0 5, 044	13. 00 14. 00
15. 00		PHARMACY	35, 558		1	-	4, 341	15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY	7, 017	C	416		857	16. 00
17. 00	1	SOCIAL SERVICE	0	C		0	0	17. 00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0	C	) c	0	0	19. 00
20. 00		NURSI NG SCHOOL	0	C	0	0	0	20. 00
21. 00		I &R SERVICES-SALARY & FRINGES APPRV	0	C	0	0	0	21. 00
22. 00		I&R SERVICES-OTHER PRGM COSTS APPRV   PARAMED ED PRGM-(SPECIFY)	0	C		0	0	22. 00
23. 00		PARAMED ED PRGM-(SPECIFY)   ENT ROUTINE SERVICE COST CENTERS	U <sub>I</sub>		)  C	U	0	23. 00
30. 00		ADULTS & PEDIATRICS	459, 106	C	145, 829	0	56, 049	30.00
43. 00	1	NURSERY	6, 913	C	1		844	•
		LARY SERVICE COST CENTERS						
50. 00		OPERATING ROOM	261, 680	C	,		31, 947	50. 00
52.00		DELIVERY ROOM & LABOR ROOM	32, 677	C			3, 989	•
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0 129, 688	C			0 15, 833	53. 00 54. 00
60.00		LABORATORY	51, 739	C			6, 317	60.00
62. 30	1	BLOOD CLOTTING FOR HEMOPHILIACS	0	C			0, 317	62. 30
65. 00		RESPI RATORY THERAPY	23, 565	C	24, 853	0	2, 877	65. 00
66.00	06600	PHYSI CAL THERAPY	86, 720	C	33, 988	0	10, 587	66. 00
67. 00		OCCUPATI ONAL THERAPY	0	C	1,		0	67. 00
68. 00		SPEECH PATHOLOGY	0	C	1 -,		0	68. 00
69. 00 71. 00	1	ELECTROCARDIOLOGY MEDICAL SUPPLIES CHARGED TO PATIENT	0	C	0 33, 162	-	0	69. 00 71. 00
71.00		IMPL. DEV. CHARGED TO PATIENTS	0	C	1		0	72.00
73. 00		DRUGS CHARGED TO PATIENTS	o	C	74, 953		0	73. 00
76. 97		CARDI AC REHABI LI TATI ON	Ō	C	0	0	0	76. 97
76. 98	07698	HYPERBARI C OXYGEN THERAPY	0	C	) c	0	0	76. 98
76. 99		LI THOTRI PSY	0	C	) <u> </u>	0	0	76. 99
00.00		TIENT SERVICE COST CENTERS						00.00
		CLINIC LIFEBRIDGE SENIOR CARE	0 23, 828	C	1	-	_	90. 00 90. 01
90. 01 91. 00		EMERGENCY	23, 626 181, 217	C	1		2, 909 22, 124	1
92. 00		OBSERVATION BEDS (NON-DISTINCT PART	0		147, 773		22, 124	92. 00
		REIMBURSABLE COST CENTERS				'		
95.00	09500	AMBULANCE SERVICES	46, 154	C	101, 404	0	0	95. 00
99. 10	09910		0	C	1	0	0	99. 10
99. 20	4	OUTPATIENT PHYSICAL THERAPY	0	C	1	0	0	= -
99. 30		OUTPATIENT OCCUPATIONAL THERAPY	0	C	1	0	0	
99. 40		OUTPATIENT SPEECH PATHOLOGY AL PURPOSE COST CENTERS	U	C	) <u> </u>	0	0	99. 40
113 00		INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	2, 807, 748	C	1, 175, 050	0	177, 793	1
	NONRE	IMBURSABLE COST CENTERS					·	
	1	GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 839	C				190. 00
		PHYSICIANS' PRIVATE OFFICES	87, 245	C				192. 00
		OCCUPATIONAL HEALTH	0	C	0	-		194. 00
		FOUNDATION COMMUNITY & VOLUNTEER SVCS	0	(	1, 517 6, 610			194. 01 194. 03
		ER PHYSICIAN	0		0,010			194. 03
		SHI PSHEWANA RADI OLOGY AND LAB	0	C		n		194. 04
200.00		Cross Foot Adjustments	o	_				200. 00
201.00	1	Negative Cost Centers	О	C	) C	o		201. 00
202.00	)	TOTAL (sum lines 118 through 201)	2, 900, 832	C	1, 189, 419	0	189, 157	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-1323

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | 5/29/2018 12: 24 pm

					5/29/2018 12:2	24 pm_
Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	
	LINEN SERVICE				PERSONNEL	
	8. 00	9. 00	10.00	11. 00	12.00	
GENERAL SERVICE COST CENTERS						
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
1.01 O0101 EMS WEST STATION						1. 01
2. 00 00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01   00201 EMS WEST STATION EQUIP.						2. 00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00 00500 ADMINISTRATIVE & GENERAL						5. 00
6.00  00600 MAINTENANCE & REPAIRS						6. 00
7.00 00700 OPERATION OF PLANT						7. 00
8.00   00800 LAUNDRY & LINEN SERVICE	13, 632					8. 00
9. 00 00900 HOUSEKEEPI NG	3	41, 404				9. 00
10. 00   01000   DI ETARY	70	2, 368	123, 996			10. 00
11. 00   01100   CAFETERI A	0	2, 300	123, 770	16, 132		11. 00
	0	0	0	10, 132	0	
12. 00 01200 MAI NTENANCE OF PERSONNEL	0	0	0	- 0	0	12. 00
13.00 O1300 NURSING ADMINISTRATION	0	0	0	868	0	13. 00
14.00 O1400 CENTRAL SERVICES & SUPPLY	0	1, 125	0	0	0	14. 00
15. 00   01500   PHARMACY	0	968	0	993	0	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	191	0	0	0	16. 00
17. 00 01700 SOCIAL SERVICE	0	0	0	ol	0	17. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	o o	0	19. 00
20. 00   02000   NURSI NG SCHOOL	0	0	0	0	0	20. 00
	0	U o	0	0		
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRV	0	Q	0	o	0	21. 00
22.00   02200   1 &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22. 00
23.00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	4, 914	12, 496	123, 996	3, 349	0	30. 00
43. 00 04300 NURSERY	221	188	0	289	0	43.00
ANCI LLARY SERVI CE COST CENTERS		.00	<u> </u>	207	Ĭ	10.00
50. 00 05000 OPERATI NG ROOM	2, 478	7, 123	0	1, 970	0	50.00
			-			
52. 00   05200   DELI VERY ROOM & LABOR ROOM	881	889	0	1, 226	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0	O	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 325	3, 530	0	2, 150	0	54. 00
60. 00  06000 LAB0RAT0RY	0	1, 408	0	0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62. 30
65. 00 06500 RESPIRATORY THERAPY						
	()	6411	Ο	943	0	65.00
	0 567	641 2 361	0	943	0	65. 00 66. 00
66. 00 06600 PHYSI CAL THERAPY	567	2, 361	Ō	1, 051	0	66. 00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   0CCUPATI ONAL THERAPY	567 218		0	1, 051 373	0	66. 00 67. 00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	567	2, 361	Ō	1, 051	0 0 0	66. 00 67. 00 68. 00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	567 218	2, 361	0	1, 051 373	0 0 0	66. 00 67. 00 68. 00 69. 00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	567 218	2, 361	0	1, 051 373	0 0 0	66. 00 67. 00 68. 00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	567 218	2, 361	0	1, 051 373	0 0 0	66. 00 67. 00 68. 00 69. 00
66. 00   06600   PHYSI CAL THERAPY   67. 00   06700   0CCUPATI ONAL THERAPY   68. 00   06800   SPEECH PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENT   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS	567 218	2, 361	0	1, 051 373	0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00
66. 00   06600   PHYSI CAL THERAPY   67. 00   06700   OCCUPATI ONAL THERAPY   68. 00   06800   SPEECH PATHOLOGY   69. 00   06900   CTROCARDI OLOGY   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   73. 00   07300   DRUGS CHARGED TO PATIENTS	567 218	2, 361	0	1, 051 373	0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00
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   IMPL. DEV. CHARGED TO PATI ENTS   73. 00   07300   DRUGS CHARGED TO PATI ENTS   76. 97   07697   CARDI AC REHABI LI TATI ON	567 218 22 0 0 0 0 0	2, 361	0 0 0 0 0 0	1, 051 373	0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97
66. 00   06600   PHYSI CAL THERAPY   67. 00   06700   0CCUPATI 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   IMPL. DEV. CHARGED TO PATI ENTS   73. 00   07300   DRUGS CHARGED TO PATI ENTS   76. 97   07697   CARDI AC REHABI LI TATI ON   76. 98   07698   HYPERBARI C OXYGEN THERAPY	567 218 22 0 0 0 0 0	2, 361 0 0 0 0 0 0 0	0 0 0 0 0 0 0	1, 051 373	0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98
66. 00   06600   PHYSI CAL THERAPY   67. 00   06700   0CCUPATI 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   IMPL. DEV. CHARGED TO PATI ENTS   73. 00   07300   DRUGS CHARGED TO PATI ENTS   76. 97   07697   CARDI AC REHABI LI TATI ON   76. 98   07698   HYPERBARI C OXYGEN THERAPY   07699   LI THOTRI PSY	567 218 22 0 0 0 0 0	2, 361	0 0 0 0 0 0	1, 051 373	0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97
66. 00	567 218 22 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	1, 051 373	0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99
66. 00   06600   PHYSI CAL THERAPY   67. 00   06700   0CCUPATI 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   IMPL. DEV. CHARGED TO PATI ENTS   73. 00   07300   DRUGS CHARGED TO PATI ENTS   76. 97   07697   CARDI AC REHABI LI TATI ON   76. 98   07698   HYPERBARI C OXYGEN THERAPY   76. 99   07699   LI THOTRI PSY   0UTPATI ENT SERVI CE COST CENTERS   90. 00   09000   CLI NI C	567 218 22 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0	0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99
66. 00	567 218 22 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99
66. 00   06600   PHYSI CAL THERAPY   67. 00   06700   0CCUPATI 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   IMPL. DEV. CHARGED TO PATI ENTS   73. 00   07300   DRUGS CHARGED TO PATI ENTS   76. 97   07697   CARDI AC REHABI LI TATI ON   76. 98   07698   HYPERBARI C OXYGEN THERAPY   76. 99   07699   LI THOTRI PSY   0UTPATI ENT SERVI CE COST CENTERS   90. 00   09000   CLI NI C	567 218 22 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0	0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99
66. 00	567 218 222 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99
66. 00	567 218 222 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 01 91. 00 92. 00 95. 00 99. 10
66. 00	567 218 222 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00 95. 00 99. 10 99. 20
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 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 97 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 99 07699 LI THOTRI PSY 00UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 90. 01 09001 LI FEBRI DGE SENI OR CARE 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 99. 10 09910 OUTPATI ENT PHYSI CAL THERAPY 99. 30 09930 OUTPATI ENT PHYSI CAL THERAPY	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	000000000000000000000000000000000000000	1, 051 373 167 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00 95. 00 99. 10 99. 20 99. 30
66. 00	567 218 222 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00 95. 00 99. 10 99. 20
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 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 76. 97 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 99 07699 LI THOTRI PSY 00UTPATI ENT SERVI CE COST CENTERS 90. 00 09000 CLI NI C 90. 01 09001 LI FEBRI DGE SENI OR CARE 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 99. 10 09910 OUTPATI ENT PHYSI CAL THERAPY 99. 30 09930 OUTPATI ENT PHYSI CAL THERAPY	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	000000000000000000000000000000000000000	1, 051 373 167 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00 95. 00 99. 10 99. 20 99. 30
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	000000000000000000000000000000000000000	1, 051 373 167 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00 95. 00 99. 10 99. 20 99. 30
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 0 0 4, 933	0 0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00 95. 00 99. 10 99. 20 99. 30 99. 40
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	000000000000000000000000000000000000000	1, 051 373 167 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 76. 97 76. 98 76. 99 90. 00 99. 00 99. 00 99. 10 99. 20 99. 30 99. 40
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00 95. 00 99. 10 99. 20 99. 30 99. 40
66. 00   06600   PHYSI CAL THERAPY   67. 00   06700   0CCUPATI ONAL THERAPY   68. 00   06800   SPEECH PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENT   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   73. 00   07300   DRUGS CHARGED TO PATIENTS   76. 97   07697   CARDI AC REHABILITATI ON   76. 98   07698   HYPERBARI C OXYGEN THERAPY   76. 99   07699   LITHOTRI PSY   0UTPATIENT SERVI CE COST CENTERS   90. 00   09000   CLI NI C   90. 01   09001   LI FEBRI DGE SENI OR CARE   91. 00   09100   EMERGENCY   92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART   0THER REI MBURSABLE COST CENTERS   95. 00   09910   CORF   99. 10   09910   OUTPATIENT PHYSI CAL THERAPY   99. 30   09930   OUTPATIENT PHYSI CAL THERAPY   99. 40   09940   OUTPATIENT SPEECH PATHOLOGY   SPECI AL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   115. 00   NONREI MBURSABLE COST CENTERS   116. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00 95. 00 99. 10 99. 20 99. 30 99. 40 113. 00 118. 00
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 76. 97 76. 98 76. 99 90. 00 92. 00 95. 00 99. 10 99. 20 99. 30 99. 40 113. 00 118. 00 190. 00 192. 00
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 76. 97 76. 98 76. 99 90. 00 92. 00 95. 00 99. 10 99. 20 99. 30 99. 40 113. 00 118. 00 190. 00 191. 00 192. 00
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00 99. 10 99. 20 99. 30 99. 40 113. 00 118. 00 190. 00 191. 00 192. 00 194. 01
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00 99. 10 99. 20 99. 30 99. 40 113. 00 118. 00 192. 00 194. 01 194. 01 194. 01
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 519 2, 234	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00 99. 10 99. 20 99. 30 99. 40 113. 00 118. 00 190. 00 191. 00 192. 00 194. 01
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 519 2, 234		66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00 99. 10 99. 20 99. 30 99. 40 113. 00 118. 00 192. 00 194. 01 194. 01 194. 01
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 519 2, 234		66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 90. 01 91. 00 92. 00 95. 00 99. 10 99. 20 99. 30 99. 40 113. 00 118. 00 192. 00 194. 01 194. 01 194. 03 194. 04 194. 04
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 519 2, 234		66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 92. 00 95. 00 99. 10 99. 20 99. 30 99. 40 113. 00 118. 00 190. 00 192. 00 194. 01 194. 03 194. 03 194. 04 194. 04 194. 06 200. 00
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 2, 212 409 0 0 0 0 0 0 312 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 4, 933 0 0 0 0 0 0 0 0 38, 870 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	1, 051 373 167 0 0 0 0 0 0 0 519 2, 234		66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 92. 00 99. 10 99. 20 99. 30 99. 40 113. 00 118. 00 190. 00 194. 00 194. 00 194. 00 194. 01 194. 03 194. 04 194. 04 194. 06 200. 00 201. 00
66. 00	567 218 22 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 361 0 0 0 0 0 0 0 0 0 0 649 4, 933	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 051 373 167 0 0 0 0 0 0 519 2, 234		66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 97 76. 98 76. 99 90. 00 92. 00 95. 00 99. 10 99. 20 99. 30 99. 40 113. 00 118. 00 190. 00 192. 00 194. 01 194. 03 194. 03 194. 04 194. 04 194. 06 200. 00

Health Financial Systems In Lieu of Form CMS-2552-10 COMMUNITY HOSPT. OF LAGRANGE CTY IN ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-1323 Peri od: Worksheet B From 01/01/2017 Part II 12/31/2017 Date/Time Prepared: 5/29/2018 12:24 pm Cost Center Description NURSI NG CENTRAL **PHARMACY** MEDI CAL SOCIAL SERVICE ADMI NI STRATI ON SERVICES & RECORDS & **SUPPLY** LI BRARY 13.00 15.00 17.00 14.00 16,00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 00101 EMS WEST STATION 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.01 00201 EMS WEST STATION EQUIP. 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 12.00 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 13.00 27, 112 01400 CENTRAL SERVICES & SUPPLY 14.00 0 23.085 15.00 01500 PHARMACY 87, 299 0 331 01600 MEDICAL RECORDS & LIBRARY 0 16.00 8, 481 C C 0 01700 SOCIAL SERVICE 17 00 C 0 0 19.00 01900 NONPHYSICIAN ANESTHETISTS C 0 0 0 02000 NURSING SCHOOL 0 0 20.00 0 0 0 02100 I &R SERVICES-SALARY & FRINGES APPRV 0 0 21.00 0 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 C 0 0 0 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 0 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30 00 10, 015 309 9 1 019 n 04300 NURSERY 5 43.00 861 386 151 0

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS COMMUNITY HOSPT. OF LAGRANGE CTY IN

Provider CCN: 15-1323

In Lieu of Form CMS-2552-10
Worksheet B
01/2017 Part II
81/2017 Date/Time Prepared:
5/29/2018 12: 24 pm Peri od: From 01/01/2017 To 12/31/2017

				LAITEDNIC	DECI DENTO	5/29/2018 12:	24 pm
				INTERNS &	RESI DENTS		
	Cost Center Description	NONPHYSI CI AN	NURSING SCHOOL	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	-
	·	ANESTHETI STS		Y & FRINGES	PRGM COSTS	PRGM	
				APPRV	APPRV		
	CENEDAL CEDALCE COCT CENTEDS	19. 00	20.00	21.00	22.00	23. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1.00
1. 01	00101 EMS WEST STATION						1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
2. 01	00201 EMS WEST STATION EQUIP.						2. 01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY		•				9.00
11. 00							11.00
12. 00							12.00
13.00							13.00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00							16. 00
17. 00	1						17. 00
19. 00	1	C					19.00
20.00	1 I		C	) .			20.00
21. 00 22. 00	1				0		21. 00
23. 00	1					0	1
20.00	I NPATIENT ROUTINE SERVICE COST CENTERS		1				20.00
30.00							30.00
43.00	04300 NURSERY						43.00
	ANCILLARY SERVICE COST CENTERS	1			1		
50. 00	1						50.00
52. 00							52.00
53.00	· · · · · · · · · · · · · · · · · · ·						53.00
54. 00 60. 00	· · · · · · · · · · · · · · · · · · ·		}				54. 00 60. 00
62. 30	1 I						62. 30
65. 00	1 I						65. 00
66. 00	l l						66. 00
67.00	06700 OCCUPATI ONAL THERAPY						67. 00
68. 00							68. 00
69. 00							69. 00
71. 00							71.00
72.00	1 1						72.00
73. 00 76. 97	1						73. 00 76. 97
76. 97 76. 98	1						76. 97
76. 79	1						76. 99
	OUTPATIENT SERVICE COST CENTERS	l .	1				1
90.00							90.00
90. 01	1						90. 01
91. 00	1						91.00
92. 00	` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` ` `						92. 00
05.00	OTHER REIMBURSABLE COST CENTERS O9500 AMBULANCE SERVICES	<u> </u>	I	T			05.00
95. 00 99. 10							95. 00 99. 10
99. 20	1						99. 20
99. 30							99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY						99. 40
	SPECIAL PURPOSE COST CENTERS	<u>'</u>	•	•			
113.00	0 11300 I NTEREST EXPENSE						113. 00
118.00		C	) C	0	0	0	118. 00
400.00	NONREI MBURSABLE COST CENTERS	I	1				
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
	D 19200 PHYSI CI ANS' PRI VATE OFFI CES D 07950 OCCUPATI ONAL HEALTH						192. 00 194. 00
	107951 FOUNDATION						194. 00
	3 07952 COMMUNITY & VOLUNTEER SVCS						194. 01
	4 07954 ER PHYSICIAN						194. 04
	6 07953 SHI PSHEWANA RADI OLOGY AND LAB		1				194. 06
200.00		C	o c	0	0	0	200.00
201.00	Negative Cost Centers	С	1				201. 00
202.00	TOTAL (sum lines 118 through 201)	C	) c	) c	0	0	202. 00

Provider CCN: 15-1323

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 |

				To	o 12/31/2017 Date/Time Pr 5/29/2018 12	
	Cost Center Description	Subtotal	Intern &	Total	, 0, 2, 7, 20.0	
			Residents Cost & Post			
			Stepdown			
		04.00	Adjustments	07.00		
	GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
1. 01	00101 EMS WEST STATION					1. 01
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
2. 01 4. 00	00201 EMS WEST STATION EQUIP. 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 01 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					5. 00
6.00	00600 MAINTENANCE & REPAIRS					6. 00
7.00	00700 OPERATION OF PLANT					7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING					8. 00 9. 00
10. 00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
12.00	01200 MAINTENANCE OF PERSONNEL					12. 00
	01300 NURSI NG ADMI NI STRATI ON					13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
	01900 NONPHYSICIAN ANESTHETISTS					19. 00
20.00	02000 NURSI NG SCHOOL					20.00
21. 00 22. 00	02100   1 & R SERVICES-SALARY & FRINGES APPRV   02200   1 & R SERVICES-OTHER PRGM COSTS APPRV					21. 00 22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)					23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	817, 091	0	817, 091		30.00
43. 00	04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	20, 698	0	20, 698		43. 00
50. 00	05000 OPERATING ROOM	435, 216	O	435, 216		50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	91, 221	0	91, 221		52. 00
53. 00	05300 ANESTHESI OLOGY	4, 930	1 1	4, 930		53. 00
54. 00 60. 00	05400   RADI OLOGY-DI AGNOSTI C   06000   LABORATORY	252, 123		252, 123		54. 00 60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	129, 408 0		129, 408 0		62. 30
65. 00	06500 RESPI RATORY THERAPY	52, 962	0	52, 962		65. 00
66. 00	06600 PHYSI CAL THERAPY	136, 026	1 1	136, 026		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	13, 697	0	13, 697		67. 00 68. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	6, 065 0	0	6, 065 0		69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	40, 181	i o	40, 181		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	25, 337	O	25, 337		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	162, 028	1 1	162, 028		73. 00
76. 97 76. 98	07697 CARDI AC REHABILITATION 07698 HYPERBARI C OXYGEN THERAPY	0	1	0		76. 97 76. 98
76. 99	07699 LI THOTRI PSY	o	1	Ö		76. 99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLINIC	0	0	0		90.00
90. 01 91. 00	09001 LI FEBRI DGE SENI OR CARE 09100 EMERGENCY	46, 536 371, 814		46, 536 371, 814		90. 01
	09200 OBSERVATION BEDS (NON-DISTINCT PART	371,014	0	371,014		92. 00
	OTHER REIMBURSABLE COST CENTERS					
95. 00	09500 AMBULANCE SERVICES	149, 395	0	149, 395		95. 00
	09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0		99. 10 99. 20
	09930 OUTPATIENT PHISICAL THERAPY	0	0	0		99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	0	1	Ō		99. 40
	SPECIAL PURPOSE COST CENTERS					
113. 00 118. 00	11300 INTEREST EXPENSE	2 754 720		2 754 720		113. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	2, 754, 728	0	2, 754, 728		118. 00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 545	O	7, 545		190. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	106, 030	1 1	106, 030		192. 00
	07950 OCCUPATIONAL HEALTH	1 510		1 510		194. 00
	07951   FOUNDATION   07952   COMMUNITY & VOLUNTEER SVCS	1, 518 6, 610		1, 518 6, 610		194. 01 194. 03
	07954 ER PHYSICIAN	0,010	1 1	0, 010		194. 03
194.06	07953 SHIPSHEWANA RADIOLOGY AND LAB	Ō	O	0		194. 06
200.00		0	0	0		200. 00
201. 00 202. 00		24, 401 2, 900, 832		24, 401 2, 900, 832		201. 00 202. 00
202.00	TOTAL (Suill Filles 110 till bugil 201)	2, 900, 632	ı U	2, 700, 032		J202. UU

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1323

					Ť	o 12/31/2017	Date/Time Pre 5/29/2018 12:	
				CAPI TAL REI	LATED COSTS		0,2,,2010 121	_ , p
		Cost Center Description	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST	EMPLOYEE	
		·	(SQUARE FEET)	STATION (COULDE FEET)	(SQUARE FEET)	STATION EQUIP.	BENEFITS	
				(SQUARE FEET)		(SQUARE FEET)	DEPARTMENT (GROSS	
			1.00	1. 01	2.00	2. 01	SALARI ES) 4. 00	
	GENER	AL SERVICE COST CENTERS	1.00	1.01	2.00	2.01	4.00	
1.00	1	CAP REL COSTS-BLDG & FIXT	77, 906					1.00
1. 01 2. 00		EMS WEST STATION CAP REL COSTS-MVBLE EQUIP	0	9, 760	77, 906			1. 01 2. 00
2. 01	00201	EMS WEST STATION EQUIP.			0	9, 760		2. 01
4. 00 5. 00		EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	0 14, 307	0	0 14, 307	0	10, 868, 553 3, 278, 654	4. 00 5. 00
6.00	1	MAINTENANCE & REPAIRS	0	ő	0	0	0 0	6. 00
7.00	1	OPERATION OF PLANT	4, 425	l .	4, 425		265, 121	7. 00
8. 00 9. 00		LAUNDRY & LINEN SERVICE HOUSEKEEPING	253 828				0 173, 328	8. 00 9. 00
10.00	1	DIETARY	3, 322	l .	3, 322	0	141, 872	10.00
11. 00 12. 00		CAFETERIA MAINTENANCE OF PERSONNEL	0	0	0	0	241, 763 0	11. 00 12. 00
13. 00	01300	NURSING ADMINISTRATION	Ö	Ö	Ö	Ö	330, 642	13. 00
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	1, 578 1, 358	l .			0 489, 210	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	268	l .			469, 210	16. 00
17. 00		SOCI AL SERVI CE	0	0	0	0	0	17. 00
19. 00 20. 00	1	NONPHYSICIAN ANESTHETISTS NURSING SCHOOL	0	0	0	0	0	19. 00 20. 00
21. 00	02100	I&R SERVICES-SALARY & FRINGES APPRV	0	Ö	Ö	0	0	21. 00
22. 00 23. 00		I &R SERVICES-OTHER PRGM COSTS APPRV PARAMED ED PRGM-(SPECIFY)	0	0		0	0	22. 00 23. 00
23.00		IENT ROUTINE SERVICE COST CENTERS		0	0	U U	0	23.00
30. 00		ADULTS & PEDIATRICS	17, 534				1, 047, 280	30.00
43. 00		NURSERY LARY SERVICE COST CENTERS	264	0	264	0	111, 883	43. 00
50. 00	05000	OPERATING ROOM	9, 994				728, 022	50. 00
52. 00 53. 00	1	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	1, 248	0	1, 248 0		476, 209 0	52. 00 53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	4, 953	ő			683, 756	
60. 00 62. 30	1	LABORATORY BLOOD CLOTTING FOR HEMOPHILIACS	1, 976 0		.,		0	60. 00 62. 30
65. 00		RESPIRATORY THERAPY	900	_	· -		285, 440	
66.00		PHYSI CAL THERAPY	3, 312	0	-,	0	341, 164	
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	0	0	0	152, 750 76, 937	67. 00 68. 00
69. 00	06900	ELECTROCARDI OLOGY	0	Ō	0	0	0	69. 00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENT IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
73. 00	07300	DRUGS CHARGED TO PATIENTS	0	o	0	0	0	73. 00
76. 97		CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
76. 98 76. 99	1	HYPERBARI C OXYGEN THERAPY LI THOTRI PSY	0	0			0	76. 98 76. 99
	OUTPA	TIENT SERVICE COST CENTERS	_	_	_			
90. 00 90. 01	1	CLINIC LIFEBRIDGE SENIOR CARE	910	0		-	0 146, 570	90. 00 90. 01
91. 00	09100	EMERGENCY	6, 921	l .			807, 884	91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS						92. 00
95. 00		AMBULANCE SERVICES	0	9, 760	0	9, 760	1, 022, 342	95. 00
99. 10	09910		0	0	0	0	0	99. 10
99. 20 99. 30		OUTPATIENT PHYSICAL THERAPY OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99. 20 99. 30
99. 40	09940	OUTPATIENT SPEECH PATHOLOGY	Ö	Ö		Ö	0	99. 40
112 00		AL PURPOSE COST CENTERS INTEREST EXPENSE						113. 00
118.00		SUBTOTALS (SUM OF LINES 1 through 117)	74, 351	9, 760	74, 351	9, 760	10, 800, 827	
400.00		IMBURSABLE COST CENTERS	000					400 00
		GIFT, FLOWER, COFFEE SHOP & CANTEEN PHYSICIANS' PRIVATE OFFICES	223 3, 332		223 3, 332			190. 00 192. 00
194.00	07950	OCCUPATIONAL HEALTH	0	Ö	0	o	0	194. 00
		FOUNDATION   COMMUNITY & VOLUNTEER SVCS	0	0	0	0	53, 807 13, 919	
194.04	07954	ER PHYSICIAN	0	Ö	0	0	0	194. 04
194. 06 200. 00		SHIPSHEWANA RADIOLOGY AND LAB Cross Foot Adjustments	0	0	0	0	0	194. 06 200. 00
200.00		Negative Cost Centers						200. 00 201. 00

Health Financial Systems C	OMMUNITY HOSPT. OF	MUNITY HOSPT. OF LAGRANGE CTY IN			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provi der C		Period: From 01/01/2017	Worksheet B-1			
				To 12/31/2017	Date/Time Pre 5/29/2018 12:			
		CAPITAL RE	LATED COSTS					
Cost Center Description	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST	EMPLOYEE			

						0, 2,, 20.0 .2.	
			CAPI TAL REI	_ATED COSTS			
	Cost Center Description	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST	EMPLOYEE	
	·	(SQUARE FEET)	STATI ON	(SQUARE FEET)	STATION EQUIP.	BENEFI TS	
			(SQUARE FEET)			DEPARTMENT	
					(SQUARE FEET)	(GROSS	
						SALARI ES)	
		1.00	1. 01	2.00	2. 01	4. 00	
202.00	Cost to be allocated (per Wkst. B,	1, 310, 504	16, 140	729, 366	30, 014	3, 677, 298	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	16. 821606	1. 653689	9. 362129	3. 075205	0. 338343	203. 00
204.00	Cost to be allocated (per Wkst. B,					0	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part					0. 000000	205. 00
	[11]						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

Provider CCN: 15-1323

| Period: | Worksheet B-1 | | From 01/01/2017 | | Date/Time Prepared: | 5/29/2018 | 12: 24 pm | |

	Cost Center Description	Reconciliation	ADMI NI STRATI VE & GENERAL	REPAI RS	OPERATION OF PLANT	5/29/2018 12: LAUNDRY & LINEN SERVICE	24 pm
			(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	
	CENIEDAL CEDIULCE COCT CENTEDO	5A	5. 00	6. 00	7. 00	8. 00	
1. 00 1. 01 2. 00	GENERAL SERVICE COST CENTERS  00100 CAP REL COSTS-BLDG & FIXT  00101 EMS WEST STATION  00200 CAP REL COSTS-MVBLE EQUIP						1. 00 1. 01 2. 00
2. 01 4. 00 5. 00 6. 00	00201 EMS WEST STATION EQUIP. 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	-8, 950, 110	20, 074, 932				2. 01 4. 00 5. 00 6. 00
7. 00 8. 00 9. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	0	1, 237, 050 104, 616 288, 178		59, 174 253 828	10, 000 2	7. 00 8. 00 9. 00
10. 00 11. 00 12. 00 13. 00	01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMINI STRATI ON	0 0	404, 339 272, 282 0 442, 941	C C	3, 322 0 0	51 0 0	10. 00 11. 00 12. 00 13. 00
14. 00 15. 00 16. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	10, 588 0	761, 331 7, 017	)	1, 578 1, 358 268	0	14. 00 15. 00 16. 00
	01700   SOCIAL SERVICE   01900   NONPHYSICIAN ANESTHETISTS   02000   NURSING SCHOOL   02100   I&R SERVICES-SALARY & FRINGES APPRV	0 0			0 0	0 0 0 0	17. 00 19. 00 20. 00 21. 00
22. 00 23. 00	02200   &R SERVICES-OTHER PRGM COSTS APPRV 02300   PARAMED ED PRGM-(SPECIFY)   NPATIENT ROUTINE SERVICE COST CENTERS	0 0	C	d	0	0	22. 00 23. 00
30. 00 43. 00	03000 ADULTS & PEDIATRICS 04300 NURSERY	0				3, 605 162	30. 00 43. 00
50. 00 52. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM  05200 DELIVERY ROOM & LABOR ROOM	0	,	1		1, 818 646	ı
53. 00 54. 00 60. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0000	,	C	0 4, 953 1, 976	0 972 0	53. 00 54. 00 60. 00
62. 30 65. 00 66. 00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY	0000	0 419, 467 573, 642	1	0 900 3, 312	0 0 416	62. 30 65. 00 66. 00
67. 00 68. 00 69. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0000	218, 025 98, 390 0	) C	0 0	160 16 0	ı
71. 00 72. 00 73. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	559, 711 352, 983 1, 265, 043	C	0 0	0 0 0	71. 00 72. 00 73. 00
76. 97 76. 98 76. 99	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY	0000	_		0 0	0 0 0	76. 97 76. 98 76. 99
90.00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC				0	0	
90. 01 91. 00	09001 LIFEBRIDGE SENIOR CARE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	314, 316	o	910	0 1, 623	90. 01
95. 00 99. 10	OTHER REIMBURSABLE COST CENTERS  09500 AMBULANCE SERVICES  09910 CORF	0	O	) C	_	300 0	99. 10
99. 30	09920 OUTPATIENT PHYSICAL THERAPY 09930 OUTPATIENT OCCUPATIONAL THERAPY 09940 OUTPATIENT SPEECH PATHOLOGY	0 0	O	C		0 0 0	99. 20 99. 30 99. 40
113. 00 118. 00	SPECIAL PURPOSE COST CENTERS  11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	-8, 939, 522	19, 832, 399	C	55, 619	9, 771	113. 00 118. 00
192.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH	0 0 1,050	91, 301	1	3, 332	229	190. 00 192. 00 194. 00
194. 01 194. 03	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS 07954 ER PHYSICIAN	0	25, 610 111, 568 0		0 0	0	194. 01 194. 03 194. 04
	07953 SHI PSHEWANA RADI OLOGY AND LAB Cross Foot Adjustments	0	d	ol c	O		194. 06 200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)		8, 950, 110 0. 445835		,	158, 904 15. 890400	202. 00
203.00	Tomic cost multiplier (WKSL. B, Fall I)	1	0. 440000	0.00000	30. 223000	13. 070400	1200.00

Heal th Fi	nancial Systems COMM	MUNITY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS			Provi der Co		Peri od:	Worksheet B-1	
					From 01/01/2017 Fo 12/31/2017	Date/Time Pre 5/29/2018 12:	
	Cost Center Description	Reconciliation				LAUNDRY &	
			& GENERAL	REPAI RS	PLANT	LINEN SERVICE	
			(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	
						LAUNDRY)	
		5A	5. 00	6. 00	7. 00	8. 00	
204.00	Cost to be allocated (per Wkst. B, Part II)		1, 189, 419	(	189, 157	13, 632	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part		0. 059249	0. 000000	3. 196624	1. 363200	205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

Provider CCN: 15-1323

				T	o 12/31/2017	Date/Time Pre 5/29/2018 12:	
	Cost Center Description	HOUSEKEEPI NG	DIETARY		MAINTENANCE OF	NURSI NG	, p
		(SQUARE FEET)	(MEALS SERVED)	(FTE)	PERSONNEL (NUMBER	ADMI NI STRATI ON	
					HOUSED)	(DIRECT NRSING	
		9.00	10.00	11. 00	12. 00	HRS) 13. 00	
	GENERAL SERVICE COST CENTERS	7.00	10.00	11.00	12.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
1. 01 2. 00	OO101   EMS WEST STATION   OO200   CAP REL COSTS-MVBLE EQUIP						1. 01 2. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00 8. 00	OO7OO   OPERATION OF PLANT   OO8OO   LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING	58, 093					9. 00
10.00	01000 DI ETARY	3, 322	1				10.00
11. 00	01100 CAFETERI A	0	_	8, 607			11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0		0	0		12.00
13. 00 14. 00	O1300   NURSI NG ADMI NI STRATI ON   O1400   CENTRAL SERVI CES & SUPPLY	1, 578		463 0	0	100, 905 0	13. 00 14. 00
15. 00	01500 PHARMACY	1, 358	1	530	0	ő	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	268	1	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	- 1	0	0	0	17. 00
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	0		0	0	0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRV			0	0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	o o	0	0	Ö	22. 00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	o	0	0	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	17 504	10 001	1 707	0	27 272	20.00
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	17, 534 264	1	1, 787 154	0		30. 00 43. 00
10.00	ANCI LLARY SERVI CE COST CENTERS	201	<u> </u>	101		0,200	10.00
50.00	05000 OPERATING ROOM	9, 994	1	1, 051	0		50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 248	1	654	0		52.00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY-DI AGNOSTI C	0 4, 953	0	0 1, 147	0	0	53. 00 54. 00
60. 00	06000 LABORATORY	1, 976	1	0	0	ő	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	o	0	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	900	1	503	0	0	65. 00
66. 00 67. 00	O6600   PHYSI CAL THERAPY   O6700   OCCUPATI ONAL THERAPY	3, 312	1	561 199	0	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY			89	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	o	0	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	71. 00
72.00	07200 NPL. DEV. CHARGED TO PATIENTS	0		0	0	0	72.00
73. 00 76. 97	O7300   DRUGS CHARGED TO PATIENTS   O7697   CARDI AC REHABI LITATION			0	0	0	73. 00 76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY		o o	0	0	ő	76. 98
76. 99	07699 LI THOTRI PSY	0	o	0	0	0	76. 99
00.00	OUTPATIENT SERVICE COST CENTERS		ا	0	0		00.00
90. 00 90. 01	09000   CLI NI C   09001   LI FEBRI DGE   SENI OR   CARE	910		0 277	0	0	90. 00 90. 01
91. 00	09100 EMERGENCY	6, 921		1, 192	-	_	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
05.00	OTHER REIMBURSABLE COST CENTERS		ا	0	0		05.00
95. 00 99. 10	09500 AMBULANCE SERVI CES 09910 CORF	0	1	0	0	0	95. 00 99. 10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY		- 1	0	0	ő	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	o	0	0	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
113 00	SPECIAL PURPOSE COST CENTERS   11300 INTEREST EXPENSE		T			T	113. 00
118. 00		54, 538	18, 881	8, 607	0	100, 905	
	NONREI MBURSABLE COST CENTERS			,			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	223		0	0		190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	3, 332	1	0	0		192.00
	07950  OCCUPATI ONAL HEALTH  07951  FOUNDATI ON	0		0	0		194. 00 194. 01
	07952 COMMUNITY & VOLUNTEER SVCS		ol ol	0	Ö		194. 03
	07954 ER PHYSICIAN	0	o	0	0		194. 04
	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	이	0	0	0	194. 06
200. 00 201. 00	1 1						200. 00 201. 00
201.00		441, 717	711, 085	393, 675	0	661, 597	
	Part I)	<u> </u>	<u>                                     </u>		<u> </u>	<u> </u>	

Health Financial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY IN	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS			Peri od: From 01/01/2017	Worksheet B-1
			To 12/31/2017	Date/Time Prepared: 5/29/2018 12:24 pm
Cost Center Description	HOUSEKEEPING	DIFTARY CAFFTERIA	MAINTENANCE OF	NURSLNG

						5/29/2018 12:	
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	
		(SQUARE FEET)	(MEALS SERVED)	(FTE)		ADMI NI STRATI ON	
					(NUMBER		
					HOUSED)	(DIRECT NRSING	
						HRS)	
		9. 00	10.00	11. 00	12.00	13. 00	
203.00	Unit cost multiplier (Wkst. B, Part I)	7. 603618	37. 661406	45. 738933	0.000000	6. 556632	203. 00
204.00	Cost to be allocated (per Wkst. B,	41, 404	123, 996	16, 132	0	27, 112	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 712719	6. 567237	1. 874288	0.000000	0. 268688	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	UNITY HUSPI. UF		ON 4E 4000 D		U OF FORM CMS	
ATION - STATISTICAL BASIS		Provider CC	F	rom 01/01/2017	Date/Time Pre	pared:
Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED REOULS.)	PHARMACY (COSTED REQUIS.)	MEDICAL RECORDS & LIBRARY (TIME SPENT)	SOCIAL SERVICE (TIME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	24 pm
	14. 00	15. 00	16.00	17. 00	19. 00	
			Ī			1 1 00
OT EMS WEST STATION OF CAP REL COSTS-MVBLE EQUIP OF CAP REL COSTS-MVBLE OF CAP REL C	1, 842, 158 26, 430 0 0 0 0 0	620, 803 0 0 0 0 0 0	10, 000 0 0 0 0 0	0 0 0 0	0	1. 00 1. 01 2. 00 2. 01 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00
00 ADULTS & PEDI ATRI CS 00 NURSERY	24, 679 30, 808	61 33			0	
LLARY SERVICE COST CENTERS OO OPERATING ROOM OO DELIVERY ROOM & LABOR ROOM	474, 165 123, 309	1, 255 133	194	0	0	50. 00 52. 00
100 ARDI OLOGY - DI AGNOSTI C 100 RABORATORY 100 LABORATORY 100 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 100 RESPI RATORY THERAPY 100 PHYSI CAL THERAPY 100 OCCUPATI ONAL THERAPY 100 SPEECH PATHOLOGY	29, 115 0 0 6, 614 3, 315 1, 275 125	989 989 0 0 112 43	3, 289 0 0 0 0 818 196	000000000000000000000000000000000000000	0 0 0 0 0 0	54. 00 60. 00 62. 30 65. 00 66. 00 67. 00
MEDICAL SUPPLIES CHARGED TO PATIENT ON IMPL. DEV. CHARGED TO PATIENTS ON DRUGS CHARGED TO PATIENTS OF CARDIAC REHABILITATION OF HYPERBARIC OXYGEN THERAPY OF LITHOTRIPSY	0 559, 993 352, 983 50, 849 0 0	0 0 0 614, 694 0 0	0 0 0 0	0 0 0 0	0 0 0 0 0 0	71. 00 72. 00 73. 00 76. 97 76. 98
OO CLINIC 01 LIFEBRIDGE SENIOR CARE 00 EMERGENCY 00 OBSERVATION BEDS (NON-DISTINCT PART	0 657 77, 953	0 0 25	0	0	0 0 0	90. 01
OO AMBULANCE SERVICES 10 CORF 20 OUTPATIENT PHYSICAL THERAPY 80 OUTPATIENT OCCUPATIONAL THERAPY 10 OUTPATIENT SPEECH PATHOLOGY	76, 596 0 0 0 0	3, 326 0 0 0 0	0 0	0	0 0 0 0	99. 10 99. 20 99. 30
OO INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	1, 838, 866	620, 803	10, 000	0	0	113. 00 118. 00
REIMBURSABLE COST CENTERS  OF GIFT, FLOWER, COFFEE SHOP & CANTEEN OF PHYSICIANS' PRIVATE OFFICES OF OCCUPATIONAL HEALTH OF FOUNDATION COMMUNITY & VOLUNTEER SVCS OF ER PHYSICIAN SIN SHIPSHEWANA RADIOLOGY AND LAB Cross Foot Adjustments Negative Cost Centers Cost to be allocated (per Wkst. B, Part I)	91 3, 065 0 115 21 0 0	0 0 0 0 0 0 0	000000000000000000000000000000000000000	0 0 0 0 0	0 0 0 0 0	190. 00 192. 00 194. 00 194. 01 194. 03 194. 04 194. 06 200. 00 201. 00 202. 00
	RAL SERVICE COST CENTERS  100 CAP REL COSTS-BLDG & FIXT  11 EMS WEST STATION  101 CAP REL COSTS-MVBLE EQUIP  101 EMS WEST STATION EQUIP.  102 EMPLOYEE BENEFITS DEPARTMENT  103 ADMINISTRATIVE & GENERAL  104 MAINTENANCE & REPAIRS  105 OPERATION OF PLANT  106 LAUNDRY & LINEN SERVICE  107 HOUSEKEEPING  108 ID LETARY  109 CAFFERIA  109 MAINTENANCE OF PERSONNEL  100 MAINTENANCE OF PERSONNEL  100 OURSING ADMINISTRATION  100 CENTRAL SERVICES & SUPPLY  100 PHARMACY  100 MEDICAL RECORDS & LIBRARY  101 LAUNDRYSICIAN ANESTHETISTS  101 NURSING SCHOOL  101 I&R SERVICES-SALARY & FRINGES APPRV  102 I&R SERVICES-OTHER PROM COSTS APPRV  103 PARAMED ED PROM-(SPECIFY)  104 IANTENANCE OST CENTERS  105 OPERATING ROOM  106 DELIVERY ROOM & LABOR ROOM  107 ADULTS & PEDIATRICS  107 OPERATING ROOM  108 DASTHESIOLOGY  108 CAPPER AT HERAPY  109 OPERATING ROOM  109 OPERATING ROOM  100 DELIVERY ROOM & LABOR ROOM  101 ANESTHESIOLOGY  100 RADIOLOGY-DIAGNOSTIC  101 LABORATORY  101 CAPPER ATTORY THERAPY  102 OPERATIONAL THERAPY  103 PHYSICAL THERAPY  104 OPHYSICAL THERAPY  105 OPERATIONAL THERAPY  106 OPERATIONAL THERAPY  107 CARDIAC SHARGED TO PATIENTS  107 CARDIAC REHABILITATION  108 HYPERBARIC OXYGEN THERAPY  109 LELCTROCARDIOLOGY  100 IMPL. DEV. CHARGED TO PATIENTS  101 LIFEBRIDGE SENIOR CARE  102 OUTPATIENT OCCUPATIONAL THERAPY  103 PHYSICAL THERAPY  104 CHARGED TO PATIENTS  105 OUTPATIENT OCCUPATIONAL THERAPY  106 CLINIC  107 LIFEBRIDGE SENIOR CARE  108 HYPERBARIC OXYGEN THERAPY  109 OUTPATIENT OCCUPATIONAL THERAPY  100 OUTPATIENT PHYSICAL THERAPY  101 LIFEBRIDGE SENIOR CARE  102 OUTPATIENT OCCUPATIONAL THERAPY  103 OUTPATIENT OCCUPATIONAL THERAPY  104 CHARGED  106 OUTPATIENT PHYSICAL THERAPY  107 CARDIAC REHABILITATION  107 CARDIAC REHABILITATION  108 HYPERBARIC OST CENTERS  109 OUTPATIENT PHYSICAL THERAPY  100 OUTPATIENT PHYSICAL THERAPY  101 OUTPATIENT OCCUPATIONAL THERAPY  101 LIFEBRIDGE SENIOR CARE  106 OUTPATIENT OCCUPATIONAL THERAPY  107 CARDIAC REHABILITATIONAL THERAPY  108 OUTPATIENT OCCUPATIONAL THERAPY  109 OUTPATIENT SPECH PATH	Cost Center Description	COST Center Description	COST CENTER DESCRIPTION    COSTED   PHANNACY   MEDICAL RECORDS & SUPPLY (COSTED REQUIS.)   1.1 BRARY (TIME SPENT)   14.00   15.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16.00   16	CENTRAL   SERVICES & SUPPLY   COSTED   REQUIS.   COSTED   RECORDS & LIBRARY   COSTED   REQUIS.   COSTED   RECORDS & LIBRARY   COSTED   REQUIS.   COSTED   RECORDS & LIBRARY   COSTED   RECOR	COST Center Description

COST ALLOCATION - STATISTICAL BASIS  Provider CCN: 15-1323 Period: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/29/2018 12: 24 pm  Cost Center Description  CENTRAL SERVICES & (COSTED RECORDS & LIBRARY (TIME SPENT) SUPPLY REQUIS.) LIBRARY (TIME SPENT) (ASSIGNED	Health Fin	ancial Systems COMM	MUNITY HOSPT. OF LAGRANGE CTY IN			In Lieu of Form CMS-2552-10			
Cost Center Description  CENTRAL SERVICES & (COSTED RECORDS & ANESTHETISTS SUPPLY REQUIS.)  Date/Time Prepared: 5/29/2018 12: 24 pm  MEDICAL SOCIAL SERVICE NONPHYSICIAN ANESTHETISTS (ASSIGNED)	COST ALLOC	ATION - STATISTICAL BASIS					Worksheet B-1		
SERVI CES & (COSTED RECORDS & ANESTHETI STS SUPPLY REQUIS.) LI BRARY (TI ME SPENT) (ASSI GNED									
SUPPLY   REQUIS.)   LIBRARY   (TIME SPENT)   (ASSIGNED		Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN		
			SERVICES &	(COSTED	RECORDS &		ANESTHETI STS		
(OCCTED (TIME ODENT) TIME)			SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	(ASSI GNED		
(COSTED   (TIME SPENT)   TIME)			(COSTED		(TIME SPENT)		TIME)		
REQUIS.)			REQUIS.)						
14.00   15.00   16.00   17.00   19.00			14.00	15.00	16.00	17. 00	19. 00		
203.00 Unit cost multiplier (Wkst. B, Part I) 0.026657 1.896057 2.028300 0.000000 0.000000 203.00	203.00	Unit cost multiplier (Wkst. B, Part I)	0. 026657	1. 896057	2. 02830	0.000000	0. 000000	203. 00	
204.00 Cost to be allocated (per Wkst. B, 47,486 87,299 8,481 0 0 204.00	204.00	Cost to be allocated (per Wkst. B,	47, 486	87, 299	8, 48	1 0	0	204. 00	
Part II)		Part II)							
205.00 Unit cost multiplier (Wkst. B, Part   0.012531 0.140623 0.848100 0.000000 0.000000 205.00	205.00	Unit cost multiplier (Wkst. B, Part	0. 012531	0. 140623	0. 84810	0.000000	0.000000	205. 00	
		11)							
206.00 NAHE adjustment amount to be allocated 206.00	206. 00	NAHE adjustment amount to be allocated						206. 00	
(per Wkst. B-2)		(per Wkst. B-2)							
207.00 NAHE unit cost multiplier (Wkst. D,	207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00	
Parts III and IV)		Parts III and IV)							

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-1323 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/29/2018 12:24 pm INTERNS & RESIDENTS NURSING SCHOOL SERVICES-SALAR SERVICES-OTHER Cost Center Description PARAMED ED Y & FRINGES PRGM COSTS PRGM (ASSI GNED (ASSI GNED **APPRV APPRV** TIME) (ASSI GNED (ASSI GNED TIME) TIME) TIME) 20.00 23.00 21. 00 22. 00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 1.01 00101 EMS WEST STATION 1.01 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00201 EMS WEST STATION EQUIP. 2 01 2 01 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 7 00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10.00 10.00 01100 CAFETERI A 11.00 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15 00 01500 PHARMACY 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 17.00 01700 SOCIAL SERVICE 17.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING SCHOOL 20.00 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 22.00 23.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 30.00 0 43.00 04300 NURSERY 0 0 0 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 50.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 000000000000000 0 0 52.00 0 05300 ANESTHESI OLOGY 0 53.00 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 06000 LABORATORY 0 60.00 0 0 0 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0 62.30 06500 RESPIRATORY THERAPY 0 0 65.00 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0 67.00 06800 SPEECH PATHOLOGY 0 68 00 Ω 68 00 0 69.00 06900 ELECTROCARDI OLOGY C 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 Ω 73 00 76.97 07697 CARDIAC REHABILITATION 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76. 98 76.98 76.99 07699 LI THOTRI PSY 0 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 09001 LIFEBRIDGE SENIOR CARE 0 90.01 0 0 90.01 09100 EMERGENCY 0 0 0 ol 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 95.00 0 n С 0 95 00 0 99 10 09910 CORE 0 0 99 10 C 99. 20 09920 OUTPATIENT PHYSICAL THERAPY 0 0 0 0 99. 20 09930 OUTPATIENT OCCUPATIONAL THERAPY 0 0 0 99.30 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 0 0 0 99.40 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 118.00 0 0 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN C 0 0 190 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 0 0 0 0 194. 00 07950 OCCUPATIONAL HEALTH 0 0 194.00 194. 01 07951 FOUNDATION 0 0 194. 01 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 0 0 C 194.03 0 194.04 07954 ER PHYSICIAN 0 0 0 194.04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 194. 06 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00

Heal th Fi	nancial Systems COMM	UNITY HOSPT. OF	- LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
COST ALLC	OCATION - STATISTICAL BASIS		Provider CO		Peri od:	Worksheet B-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 12:	
			INTERNS &	RESI DENTS			
	Cost Center Description	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	SERVICES-OTHE	R PARAMED ED PRGM		
		(ASSIGNED TIME)	APPRV (ASSI GNED TIME)	APPRV (ASSI GNED TIME)	(ASSI GNED TI ME)		
		20.00	21. 00	22. 00	23. 00		
202. 00	Cost to be allocated (per Wkst. B, Part I)	0	0		0		202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0. 00000	0. 000000		203. 00
204. 00	Cost to be allocated (per Wkst. B, Part II)	0	0		0		204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 00000	0. 000000		205. 00
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0			0		206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0. 000000			0.000000		207. 00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1323 Peri od: Worksheet C From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/29/2018 12:24 pm Title XVIII Hospi tal Cost Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs Di sal I owance from Wkst. B, Adj Part I, col. 26) 4. 00 5. 00 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDI ATRI CS 30 00 5, 319, 612 5, 319, 612 Ω 306, 384 43.00 04300 NURSERY 306, 384 43.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 50.00 3, 489, 922 3, 489, 922 0 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 1, 310, 942 1, 310, 942 0 52.00 53.00 05300 ANESTHESI OLOGY 120, 299 120, 299 0 0 0 0 0 0 0 0 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2, 616, 036 2, 616, 036 54.00 06000 LABORATORY 60.00 1, 780, 058 1, 780, 058 60.00 Λ 06250 BLOOD CLOTTING FOR HEMOPHILIACS 62.30 0 62.30 65.00 06500 RESPIRATORY THERAPY 663, 709 663, 709 65.00 06600 PHYSI CAL THERAPY 988, 911 988, 911 66.00 66.00 0 06700 OCCUPATIONAL THERAPY 327, 386 327, 386 67.00 0 67.00 68.00 06800 SPEECH PATHOLOGY 146, 757 146, 757 0 68.00 06900 ELECTROCARDI OLOGY 69.00 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 824.179 824. 179 71 00 0 71 00 519, 764 519, 764 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 2, 995, 892 2, 995, 892 0 73.00 07697 CARDIAC REHABILITATION 76. 97 0 76.97 07698 HYPERBARI C OXYGEN THERAPY 0 76. 98 76 98 0 Ω 07699 LI THOTRI PSY 76.99 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 09001 LIFEBRIDGE SENIOR CARE 0 90.01 90.01 501, 561 501, 561 0 91.00 09100 EMERGENCY 4, 126, 532 4, 126, 532 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 1, 197, 370 1, 197, 370 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 2, 487, 637 2, 487, 637 0 0 95.00 99. 10 09910 CORF 0 99. 10 0 0 09920 OUTPATIENT PHYSICAL THERAPY 99. 20 0 0 0 99. 20

0

29, 722, 951

1, 197, 370

28, 525, 581

0

0

29, 722, 951

1, 197, 370

28, 525, 581

0

99 30

113.00

0 200. 00

0 201. 00

0 202. 00

0

0 99.40

0

09930 OUTPATIENT OCCUPATIONAL THERAPY

Subtotal (see instructions)

09940 OUTPATIENT SPEECH PATHOLOGY

Less Observation Beds

Total (see instructions)

SPECIAL PURPOSE COST CENTERS

113. 00 11300 | INTEREST EXPENSE

99 30

99.40

200.00

201.00

201.00

202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1323 Peri od: Worksheet C From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/29/2018 12:24 pm Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 4, 474, 930 4, 474, 930 30.00 30.00 43.00 04300 NURSERY 494, 543 494, 543 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 985, 828 13, 929, 350 17, 915, 178 0.194803 0.000000 50.00 1, 995, 823 0.000000 05200 DELIVERY ROOM & LABOR ROOM 1, 995, 823 0.656843 52 00 52 00 53.00 05300 ANESTHESI OLOGY 437, 183 1, 801, 642 2, 238, 825 0.053733 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 766, 212 24, 081, 499 25, 847, 711 0.101210 0.000000 54.00 0. 194587 06000 LABORATORY 0.000000 60.00 1, 576, 739 7, 571, 122 9, 147, 861 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 62 30 65.00 06500 RESPIRATORY THERAPY 469, 327 1, 947, 182 2, 416, 509 0.274656 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 320, 315 1, 353, 392 1, 673, 707 0. 590851 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 338, 770 383, 240 722, 010 0.453437 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 58, 258 86, 905 145, 163 1.010981 0.000000 68.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 69.00 1, 991, 907 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 694, 896 2, 686, 803 0.306751 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 229, 410 454. 436 0.308677 72 00 1, 683, 846 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 758, 952 7, 952, 147 9, 711, 099 0. 308502 0.000000 73.00 07697 CARDIAC REHABILITATION 0.000000 76. 97 0 0 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 0 0 0.000000 0.000000 07699 LI THOTRI PSY 76.99 0 C 0 0.000000 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 90 01 09001 LIFEBRIDGE SENIOR CARE 0 643.098 643.098 0.779914 0.000000 90 01 91.00 09100 EMERGENCY 753, 538 13, 368, 558 14, 122, 096 0.292204 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 431, 639 2, 431, 639 0.492413 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 0 4, 441, 662 4, 441, 662 0.560069 99. 10 09910 CORF 0 99. 10 09920 OUTPATIENT PHYSICAL THERAPY 0 99. 20 0 0 99. 20 0 99 30 09930 OUTPATIENT OCCUPATIONAL THERAPY Ω 0 99 30 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 0 99.40 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 200 00 102, 792, 503 20. 354. 724 82, 437, 779 200. 00 Subtotal (see instructions)

20, 354, 724

82, 437, 779

102, 792, 503

201.00

202.00

Less Observation Beds

Total (see instructions)

Peri od: Worksheet C From 01/01/2017 Part I To 12/31/2017 Date/Time Prepared:

			10 12/31/201/	5/29/2018 12: 24 pi	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS				30.	
43. 00 04300 NURSERY				43.	. 00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000 OPERATI NG ROOM	0. 000000			50.	. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 000000			52.	
53. 00   05300   ANESTHESI OLOGY	0. 000000			53.	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 000000			54.	. 00
60. 00   06000   LABORATORY	0. 000000			60.	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62.	. 30
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65.	. 00
66. 00   06600 PHYSI CAL THERAPY	0. 000000			66.	. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.	. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.	. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.	. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71.	. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			72.	. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.	. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76.	. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76.	. 98
76. 99 07699 LI THOTRI PSY	0. 000000			76.	. 99
OUTPATIENT SERVICE COST CENTERS					
90. 00   09000   CLI NI C	0. 000000			90.	
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 000000			90.	
91. 00   09100   EMERGENCY	0. 000000			91.	. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.	. 00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.	
99. 10  09910 CORF				99.	
99. 20 09920 OUTPATIENT PHYSICAL THERAPY				99.	
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY					. 30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY				99.	. 40
SPECIAL PURPOSE COST CENTERS					
113. 00 11300 I NTEREST EXPENSE				113.	
200.00 Subtotal (see instructions)				200.	
201.00 Less Observation Beds				201.	
202.00 Total (see instructions)				202.	. 00

Heal th	Financial Systems COM	MUNITY HOSPT. OI	F LAGRANG	E CTY	IN	In Lieu of Form CMS-2552-10		
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provi	der Co	CN: 15-1323	Peri od:	Worksheet C	
						From 01/01/2017	Part I	
						To 12/31/2017	Date/Time Pre	pared:
				T: ±1	- VIV	11! +-1	5/29/2018 12:	24 pm
				11 11	e XIX	Hospi tal	PPS	
	Cook Cooker Doorsinti on	T-+-1 C+	Th		T-+-1 C+-	Costs RCE	T-+-1 C+-	
	Cost Center Description	Total Cost	Therapy		Total Costs		Total Costs	
		(from Wkst. B,	Adj .			Di sal I owance		
		Part I, col.						
		26)	0.00		0.00	4.00	F 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	)	3. 00	4. 00	5. 00	
30. 00	03000 ADULTS & PEDIATRICS	5, 319, 612			5, 319, 6	12 0	5, 319, 612	30.00
	04300 NURSERY	1			306, 38			1
43.00	ANCI LLARY SERVI CE COST CENTERS	306, 384			300, 30	04  0	306, 384	43.00
EO 00	05000 OPERATING ROOM	3, 489, 922	1		2 400 0	22 0	2 400 022	FO 00
50.00	1 1	1			3, 489, 92		3, 489, 922	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 310, 942			1, 310, 94		1, 310, 942	1
53.00	05300 ANESTHESI OLOGY	120, 299	l .		120, 29		120, 299	
54.00	05400 RADI OLOGY - DI AGNOSTI C	2, 616, 036			2, 616, 03		2, 616, 036	1
60.00	06000 LABORATORY	1, 780, 058	l .		1, 780, 05	58 0	1, 780, 058	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0				0	0	
65. 00	06500 RESPI RATORY THERAPY	663, 709		0			663, 709	
66. 00	06600 PHYSI CAL THERAPY	988, 911		0	988, 91		988, 911	
67. 00	06700 OCCUPATI ONAL THERAPY	327, 386		0	327, 38		327, 386	
68. 00	06800 SPEECH PATHOLOGY	146, 757	1	0	146, 75	57 0	146, 757	
69. 00	06900 ELECTROCARDI OLOGY	0				0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	824, 179			824, 17	79 0	824, 179	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	519, 764			519, 76		519, 764	
73. 00	07300 DRUGS CHARGED TO PATIENTS	2, 995, 892			2, 995, 89	92 0	2, 995, 892	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0				0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0				0 0	0	76. 98
76. 99	07699 LI THOTRI PSY	0				0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS							
90.00	09000 CLI NI C	0				0 0	0	90.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	501, 561			501, 56	51 0	501, 561	90. 01
91.00	09100 EMERGENCY	4, 126, 532			4, 126, 53	32 0	4, 126, 532	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 197, 370			1, 197, 37	70	1, 197, 370	92.00
	OTHER REIMBURSABLE COST CENTERS							
95.00	09500 AMBULANCE SERVICES	2, 487, 637			2, 487, 63	37 0	2, 487, 637	95. 00
99. 10	09910 CORF	0				0	0	
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0				0	0	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0				0	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0				0	0	99. 40
	SPECIAL PURPOSE COST CENTERS	•				•		1
113.00	11300 INTEREST EXPENSE							113. 00
200.00	Subtotal (see instructions)	29, 722, 951		0	29, 722, 95	51 0	29, 722, 951	200.00
201.00	Less Observation Beds	1, 197, 370			1, 197, 37	70	1, 197, 370	201.00
202.00	Total (see instructions)	28, 525, 581		0	28, 525, 58	31 0	28, 525, 581	202.00
		•	•		•	•	•	•

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1323 Peri od: Worksheet C From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/29/2018 12:24 pm Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 4, 474, 930 4, 474, 930 30.00 30.00 43.00 04300 NURSERY 494, 543 494, 543 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 3, 985, 828 13, 929, 350 17, 915, 178 0.194803 0.000000 50.00 1, 995, 823 0.000000 05200 DELIVERY ROOM & LABOR ROOM 1, 995, 823 0.656843 52 00 52 00 53.00 05300 ANESTHESI OLOGY 437, 183 1, 801, 642 2, 238, 825 0.053733 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 766, 212 24, 081, 499 25, 847, 711 0.101210 0.000000 54.00 0. 194587 06000 LABORATORY 0.000000 60.00 1, 576, 739 7, 571, 122 9, 147, 861 60.00 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0.000000 62.30 62 30 65.00 06500 RESPIRATORY THERAPY 469, 327 1, 947, 182 2, 416, 509 0.274656 0.000000 65.00 66.00 06600 PHYSI CAL THERAPY 320, 315 1, 353, 392 1, 673, 707 0. 590851 0.000000 66.00 06700 OCCUPATI ONAL THERAPY 338, 770 383, 240 722, 010 0.453437 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 58, 258 86, 905 145, 163 1.010981 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 0.000000 69.00 1, 991, 907 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 694, 896 2, 686, 803 0.306751 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 229, 410 454. 436 0.308677 72 00 1, 683, 846 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 1, 758, 952 7, 952, 147 9, 711, 099 0. 308502 0.000000 73.00 07697 CARDIAC REHABILITATION 0.000000 76. 97 0 0 0.000000 76.97 07698 HYPERBARI C OXYGEN THERAPY 76. 98 76.98 0 0 0.000000 0.000000 07699 LI THOTRI PSY 76.99 0 C 0 0.000000 0.000000 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0.000000 0.000000 90.00 90 01 09001 LIFEBRIDGE SENIOR CARE 0 643.098 643.098 0.779914 0.000000 90 01 91.00 09100 EMERGENCY 753, 538 13, 368, 558 14, 122, 096 0.292204 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 2, 431, 639 2, 431, 639 0.492413 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 0 4, 441, 662 4, 441, 662 0.560069 99. 10 09910 CORF 0 99. 10 09920 OUTPATIENT PHYSICAL THERAPY 0 99. 20 0 0 99. 20 0 99 30 09930 OUTPATIENT OCCUPATIONAL THERAPY Ω 0 99 30 09940 OUTPATIENT SPEECH PATHOLOGY 99.40 0 99.40

20. 354. 724

20, 354, 724

102, 792, 503

102, 792, 503

82, 437, 779

82, 437, 779

113.00

200. 00

201.00

202. 00

SPECIAL PURPOSE COST CENTERS

Subtotal (see instructions)

Less Observation Beds

Total (see instructions)

113. 00 11300 INTEREST EXPENSE

200 00

201.00

Cost Center Description						5/29/2018 12:24 pm
INPATI ENT ROUTH NE SERVICE COST CENTERS   11.00   11.00				Title XIX	Hospi tal	PPS
INPATI ENT ROUTI NE SERVICE COST CENTERS   30.00	Cost Center Desc	cription	PPS Inpatient			
IMPATIENT ROUTINE SERVICE COST CENTERS   30.00			Ratio			
30. 00   03000  ADUITS & PEDIATRICS			11. 00			
A3. 00   04300   NURSERY	INPATIENT ROUTINE SERV	VICE COST CENTERS				
ANCILLARY SERVICE COST CENTERS   50.00   50.00   OPERATING ROOM   50.00   50.00   OPERATING ROOM   50.00   50.00   OPERATING ROOM   50.00   50.00   DELIVERY ROOM & LABOR ROOM   50.656843   52.00   53.00   05.000   ANESTHESI OLLOGY   53.00   53.00   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.000   60.0000   60.0000   60.0000   60.0000   60.0000   60.0000   60.0000   60.0000   60.0000   60.0000   60.0000   60.0000   60.0000   60.0000   60.0000   60.0000   60.0000   60.0000   60.00000   60.00000   60.00000   60.00000   60.00000   60.00000   60.00000   60.00000   60.00000   60.00000   60.00000   60.00000   60.00000   60.00000   60.000000   60.000000   60.000000   60.000000   60.000000   60.000000   60.000000   60.000000   60.000000   60.000000   60.000000   60.000000   60.000000   60.000000   60.0000000   60.000000   60.0000000   60.0000000   60.0000000   60.00000000   60.00000000   60.0000000   60.00000000   60.0000000000	30. 00 03000 ADULTS & PEDI ATF	RLCS				30. 00
50.00						43. 00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0. 656843   52.00   05300   ANESTHESI OLOGY   0. 053733   53.00   05300   ANESTHESI OLOGY   0. 053733   53.00   05400   RADI OLOGY-DI AGNOSTI C   0. 101210   54.00   60.00   06600   LABORATORY   0. 194587   60.00   62.30   62.50   BLODD CLOTTI NG FOR HEMOPHI LI ACS   0. 000000   62.30   65.00   06500   RESPI RATORY THERAPY   0. 274656   65.00   66.00   06600   PHYSI CAL THERAPY   0. 453437   67.00   67.00   06700   0CCUPATI ONAL THERAPY   0. 453437   67.00   68.00   06800   SPEECH PATHOLOGY   1. 010981   68.00   68.00   6800   SPEECH PATHOLOGY   0. 000000   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.00   69.	ANCILLARY SERVICE COST	T CENTERS				
53.00   05300   AMESTHESI OLOGY   0.053733   53.00			0. 194803			
54.00   05400   RADI OLGGY-DI AGNOSTI C   0.101210   0.104587   0.00600   0.0000   LABORATORY   0.194587   0.00600   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.00000000	52.00   05200   DELIVERY ROOM &	LABOR ROOM	0. 656843			52. 00
60.00   06000   LABORATORY   0.194587   0.00000   062.30   06250   BLOOD CLOTTING FOR HEMOPHILIACS   0.000000   06500   RESPIRATORY THERAPY   0.274656   0.65.00   06500   RESPIRATORY THERAPY   0.590851   0.6000   06500   RESPIRATORY THERAPY   0.590851   0.6000   06600   PHYSI CAL THERAPY   0.453437   0.7000   0CCUPATI ONAL THERAPY   0.453437   0.7000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	53. 00   05300   ANESTHESI OLOGY		0. 053733			53.00
62. 30   06250   BLOOD CLOTTI NG FOR HEMOPHILIACS   0. 0000000   65. 00   06500   RESPI RATORY THERAPY   0. 274656   0. 06600   06600   PHYSI CAL THERAPY   0. 590851   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	54. 00   05400   RADI OLOGY-DI AGNO	OSTI C	0. 101210			54.00
65. 00   06500   RESPIRATORY THERAPY   0. 274656   66. 00   06600   PHYSI CAL THERAPY   0. 590851   66. 00   66. 00   06600   PHYSI CAL THERAPY   0. 453437   67. 00   06700   OCCUPATI ONAL THERAPY   0. 453437   67. 00   06700   OCCUPATI ONAL THERAPY   0. 453437   67. 00   06700   OCCUPATI ONAL THERAPY   0. 453437   67. 00   06800   SPECCH PATHOLOGY   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 0000000   0. 00000000	60. 00   06000   LABORATORY		0. 194587			60.00
66. 00   06600   PHYSI CAL THERAPY   0.590851   66. 00   67. 00   06700   0CUPATI ONAL THERAPY   0.453437   67. 00   06800   SPEECH PATHOLOGY   1.010981   68. 00   69. 00   06800   SPEECH PATHOLOGY   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.00000000	62. 30   06250   BLOOD CLOTTING F	FOR HEMOPHILIACS	0. 000000			62. 30
67. 00	65. 00 06500 RESPIRATORY THEF	RAPY	0. 274656			65. 00
68. 00	66. 00 06600 PHYSI CAL THERAPY	(	0. 590851			66. 00
69. 00   06900   ELECTROCARDI OLOGY   0. 000000   171. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENT   0. 306751   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0. 308677   72. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 308502   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0. 308502   73. 00   76. 97   07697 CARDI AC REHABI LI TATI ON   0. 000000   76. 97   07698   HYPERBARI C OXYGEN THERAPY   0. 000000   76. 99   07699 LI THOTRI PSY   0. 000000   76. 99   0017PATI ENT SERVI CE COST CENTERS   0. 000000   09000   CLI NI C   0. 000000   09000   CLI NI C   0. 000000   09000   CLI NI C   0. 000000   09000   09000   CLI NI C   0. 000000   09000   09000   CLI NI C   0. 000000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   090000   09000   09000   09000   090000   090000   09000   090000   090000   090000   090000   090000   090000   090000   090000   0900	67. 00 06700 OCCUPATI ONAL THE	RAPY	0. 453437			67. 00
71. 00	68.00 06800 SPEECH PATHOLOGY	<i>(</i>	1. 010981			68. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0. 308677 73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 308502 76. 97 07697 CARDI AC REHABILITATION 0. 000000 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0. 000000 76. 99 07699 LI THOTRI PSY 0. 000000 0000 DUTPATI ENT SERVI CE COST CENTERS  90. 00 09000 CLI NI C 0. 000000 90. 01 09001 LI FEBRI DGE SENI OR CARE 0. 779914 90. 01 91. 00 09100 EMERGENCY 0. 292204 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 492413 92. 00 95. 00 09500 AMBULANCE SERVI CES 0. 560069 95. 00 99. 10 09910 CORF 99. 30 09920 OUTPATI ENT PHYSI CAL THERAPY 99. 30 99930 OUTPATI ENT SPEECH PATHOLOGY 99. 40 09940 OUTPATI ENT SPEECH PATHOLOGY 99. 40 09940 OUTPATI ENT SPEECH PATHOLOGY 99. 40 09940 OUTPATI ENT SPEECH PATHOLOGY 99. 40 09000 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) Less Observation Beds 201. 00	69. 00 06900 ELECTROCARDI OLOG	SY	0. 000000			69. 00
73. 00	71. 00 07100 MEDICAL SUPPLIES	CHARGED TO PATIENT	0. 306751			71. 00
76. 97   07697   CARDI AC REHABI LI TATI ON   0.000000   76. 97   76. 98   776. 98   HYPERBARI C OXYGEN THERAPY   0.000000   76. 98   776. 99   07699   LI THOTRI PSY   0.000000   76. 99   07699   LI THOTRI PSY   0.000000   76. 99   0000000   000000   0000000   000000   000000	72.00 07200 IMPL. DEV. CHARG	GED TO PATIENTS	0. 308677			72. 00
76. 98   07698   HYPERBARI C OXYGEN THERAPY   0.000000   76. 98   07699   LI THOTRI PSY   0.000000   76. 99   000000   0000000   000000   000000   000000	73. 00 07300 DRUGS CHARGED TO	) PATIENTS	0. 308502			73.00
76. 99	76. 97 07697 CARDI AC REHABI LI	TATI ON	0. 000000			76. 97
76. 99   07699   LI THOTRI PSY   0.000000   76. 99   0UTPATI ENT SERVI CE COST CENTERS   90. 00   09000   CLI NI C   0.000000   0.000000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.00000000	76. 98 07698 HYPERBARI C OXYGE	N THERAPY	0. 000000			76. 98
90. 00	76. 99 07699 LI THOTRI PSY		0. 000000			76. 99
90. 01	OUTPATIENT SERVICE COS	ST CENTERS				
91. 00			0. 000000			90. 00
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART   0. 492413   92. 00   07HER REI MBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVI CES   0. 560069   95. 00   99. 10   09910   CORF   99. 10   99. 20   09920   0UTPATI ENT PHYSI CAL THERAPY   99. 30   09930   0UTPATI ENT OCCUPATI ONAL THERAPY   99. 30   09930   0UTPATI ENT SPEECH PATHOLOGY   99. 40   99. 40   011300   INTEREST EXPENSE   113. 00   11300   INTEREST EXPENSE   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00	90. 01 09001 LI FEBRI DGE SENI C	OR CARE	0. 779914			90. 01
OTHER REIMBURSABLE COST CENTERS   95. 00   09500   AMBULANCE SERVICES   0. 560069   99. 10   09910   CORF   99. 10   99. 20   09920   OUTPATIENT PHYSICAL THERAPY   99. 20   09930   OUTPATIENT OCCUPATIONAL THERAPY   99. 30   09930   OUTPATIENT SPEECH PATHOLOGY   99. 40   09940   OUTPATIENT SPEECH PATHOLOGY   99. 40   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00	91.00 09100 EMERGENCY		0. 292204			91. 00
95. 00	92. 00 09200 OBSERVATION BEDS	S (NON-DISTINCT PART	0. 492413			92. 00
99. 10 09910 CORF 99. 20 09920 OUTPATI ENT PHYSI CAL THERAPY 99. 20 09930 OUTPATI ENT OCCUPATI ONAL THERAPY 99. 30 09930 OUTPATI ENT DEECH PATHOLOGY 99. 40 09940 OUTPATI ENT SPECH PATHOLOGY 99. 40 SPECIAL PURPOSE COST CENTERS  113. 00 11300 INTEREST EXPENSE 113. 00 200. 00 Subtotal (see instructions) 200. 00 Less Observation Beds 201. 00						
99. 20 99. 30 99. 30 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 20 99. 40 99. 20 99. 40 99. 40 99. 20 99. 40 99. 20 99. 40 99. 20 99. 30 99. 40 99. 20 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 30 99. 40 99. 20 99. 30 99. 40 99. 20 99. 30 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 99. 40 90. 40 90. 40 90. 40 90. 40 90. 40 90. 40 90. 40 90. 40 90. 40 90. 40 90. 40 90. 40 90		CES	0. 560069			95. 00
99. 30	99. 10  09910 CORF					99. 10
99. 40   09940   0UTPATIENT SPEECH PATHOLOGY   99. 40   SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   200. 00   Subtotal (see instructions)   200. 00   201. 00   Less Observation Beds   201. 00	99. 20 09920 OUTPATIENT PHYSI	CAL THERAPY				99. 20
SPECIAL PURPOSE COST CENTERS   113.00   11300   INTEREST EXPENSE   200.00   Subtotal (see instructions)   200.00   Less Observation Beds   201.00	99. 30   09930   OUTPATI ENT OCCUP	PATIONAL THERAPY				99. 30
113. 00   200. 00   201. 00   Less Observation Beds   113. 00   202. 00   203. 00   204. 00   205. 00   206. 00   207. 00   208. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   209. 00   20						99. 40
200. 00         Subtotal (see instructions)         200. 00           201. 00         Less Observation Beds         201. 00						
201.00 Less Observation Beds 201.00						
202.00   Total (see instructions)	201.00 Less Observation	n Beds				
	202.00   Total (see instr	ructions)				202. 00

 
 Heal th Financial
 Systems
 COMMUNITY HOSPT.

 CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
 REDUCTIONS FOR MEDICALD ONLY

| Peri od: | Worksheet C | From 01/01/2017 | Part I I | To 12/31/2017 | Date/Time Prepared:

				'	J 12/31/2017	5/29/2018 12:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost		Operating Cost	Capi tal	Operating Cost	
		(Wkst. B, Part			Reduction	Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1. 00	2. 00	3.00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS			1		_	
	05000 OPERATI NG ROOM	3, 489, 922	435, 216		0	0	00.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 310, 942	91, 221		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	120, 299	4, 930		0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 616, 036	252, 123		0	0	54.00
60.00	06000 LABORATORY	1, 780, 058	129, 408	1	0	0	60. 00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	1	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	663, 709	52, 962		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	988, 911	136, 026		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	327, 386	13, 697		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	146, 757	6, 065	140, 692	0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	824, 179	40, 181		0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	519, 764	25, 337		0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	2, 995, 892	162, 028	2, 833, 864	0	0	73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	0	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	1	0	0	
	09001 LI FEBRI DGE SENI OR CARE	501, 561	46, 536		0	0	, , , , , ,
	09100 EMERGENCY	4, 126, 532	371, 814		0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 197, 370	183, 916	1, 013, 454	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
95. 00	09500 AMBULANCE SERVICES	2, 487, 637	149, 395	2, 338, 242	0	0	,
	09910 CORF	0	0	0	0	0	99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99. 20
99. 30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99. 30
99. 40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99. 40
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE					1	113. 00
200.00		24, 096, 955	2, 100, 855		0		200. 00
201.00		1, 197, 370	183, 916		0		201. 00
202.00	Total (line 200 minus line 201)	22, 899, 585	1, 916, 939	20, 982, 646	0	0	202. 00

Heal th Financial Systems COMMUNITY HOSPT.
CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY | Peri od: | Worksheet C | From 01/01/2017 | Part II | Date/Time Prepared: | 5/29/2018 | 12: 24 pm Provi der CCN: 15-1323

						5/29/2018 12:24 pm
				e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges			
		Capital and	(Worksheet C,			
		Operating Cost	Part I, column	Ratio (col.	6	
		Reducti on	8)	/ col. 7)		
		6.00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	3, 489, 922	17, 915, 178	0. 19480	)3	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 310, 942	1, 995, 823	0. 65684	13	52.00
53.00	05300 ANESTHESI OLOGY	120, 299	2, 238, 825	0. 05373	33	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 616, 036	25, 847, 711	0. 1012 <sup>2</sup>	10	54.00
60.00	06000 LABORATORY	1, 780, 058	9, 147, 861	0. 19458	37	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	00	62. 30
65.00	06500 RESPI RATORY THERAPY	663, 709	2, 416, 509	0. 2746	56	65. 00
66.00	06600 PHYSI CAL THERAPY	988, 911	1, 673, 707		51	66.00
67.00	06700 OCCUPATI ONAL THERAPY	327, 386			37	67. 00
68. 00	06800 SPEECH PATHOLOGY	146, 757	145, 163	1. 01098	31	68. 00
	06900 ELECTROCARDI OLOGY	0		•		69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	824, 179	2, 686, 803	l .		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	519, 764				72.00
	07300 DRUGS CHARGED TO PATIENTS	2, 995, 892		l .		73. 00
	07697 CARDI AC REHABI LI TATI ON	0	0	0.00000		76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000		76. 98
	07699 LI THOTRI PSY	0	0	0. 00000		76. 99
, 0, , ,	OUTPATIENT SERVICE COST CENTERS	<u> </u>		0.0000	, ,	75177
90.00		0	0	0.00000	00	90.00
	09001 LI FEBRI DGE SENI OR CARE	501, 561	643, 098	l .		90. 01
	09100 EMERGENCY	4, 126, 532				91.00
		1, 197, 370		l .		92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	1,177,370	2, 431, 037	0. 4724	13	72.00
95. 00	09500 AMBULANCE SERVICES	2, 487, 637	4, 441, 662	0. 5600	50	95. 00
	09910 CORF	2,407,037	1 4, 441, 002	0. 00000		99. 10
	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0. 00000		99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0.00000		99. 30
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0. 00000		99. 40
77. 40	SPECIAL PURPOSE COST CENTERS			0.0000	JO <sub>1</sub>	99. 40
113 00	11300   NTEREST EXPENSE					113. 00
200.00		24, 096, 955	97, 823, 030			200. 00
200.00		1, 197, 370				200.00
201.00	1 1	22, 899, 585				201. 00
202.00	p   Total (Title 200 IIII lus Title 201)	22, 099, 303	71,023,030	I	I	1202.00

1, 951, 460

93, 381, 368

95.00

62, 077 200. 00

3, 292, 621

95. 00 09500 AMBULANCE SERVICES

Total (lines 50 through 199)

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | THROUGH COSTS

				'	0 12/31/201/	5/29/2018 12:	24 pm
			Title	e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		0	0	50. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	) (	0	0	53. 00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0	) (	0	0	54. 00
60.00	06000 LABORATORY	0	0	) (	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	) (	0	0	62. 30
65. 00	06500 RESPI RATORY THERAPY	0	0	) (	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	) (	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	) (	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	) (	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	) (	0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	) (	0	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	)  (	0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0	) (	0	0	73. 00
76. 97	07697   CARDI AC   REHABI LI TATI ON	0	0	) (	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	) (	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	) (	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000  CLI NI C	0	0	) (	0	0	90. 00
90. 01	09001 LI FEBRI DGE SENI OR CARE	0	0	) (	0	0	90. 01
91.00	09100 EMERGENCY	0	0	) (	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0		(	)	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	)  (	0	0	200. 00

 
 Heal th Financial
 Systems
 COMMUNITY
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 OF L

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE
 OTHER PASS
 In Lieu of Form CMS-2552-10
Period: Worksheet D
From 01/01/2017 Part IV Provider CCN: 15-1323 THROUGH COSTS

TTIKOOC	THROUGH COSTS			7	o 12/31/2017	Date/Time Pre 5/29/2018 12:	
			Title	: XVIII	Hospi tal	Cost	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	1 -		1			
	05000 OPERATING ROOM	0	0	(	17, 915, 178	•	
	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	1, 995, 823	l e	
	05300 ANESTHESI OLOGY	0	0	(	2, 238, 825	•	
	05400 RADI OLOGY-DI AGNOSTI C	0	0	(	25, 847, 711		
60.00	06000 LABORATORY	0	0	(	9, 147, 861	0. 000000	
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(	0	0. 000000	
65.00	06500 RESPI RATORY THERAPY	0	0	(	2, 416, 509	l .	
	06600 PHYSI CAL THERAPY	0	0	(	1, 673, 707	l	
	06700 OCCUPATI ONAL THERAPY	0	0	(	722, 010	•	
	06800 SPEECH PATHOLOGY	0	0	(	145, 163		
	06900 ELECTROCARDI OLOGY	0	0	(	0	0. 000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	2, 686, 803	l .	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	1, 683, 846	l .	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	(	9, 711, 099		
	07697   CARDI AC   REHABI LI TATI ON	0	0	(	0	0. 000000	
	07698 HYPERBARI C OXYGEN THERAPY	0	0	(	0	0. 000000	
76. 99	07699 LI THOTRI PSY	0	0	(	0	0. 000000	76. 99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	(	0	0. 000000	
	09001 LI FEBRI DGE SENI OR CARE	0	0	(	643, 098	<b>l</b>	
	09100 EMERGENCY	0	0	(	14, 122, 096	<b>l</b>	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	(	2, 431, 639	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	(	93, 381, 368		200. 00

Health Financial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY IN		In Lieu of Form CMS-2552-10
ADDODELONMENT OF LNDATLENT/OUTDATLE	IT ANCLLLADY CEDVICE OTHER DACC	Drovi don CCN, 1E 1222	Donied.	Weskeheet D

Heal th Fi	inancial Systems COMN	LAGRANGE CIY	IN	In Lie	eu of Form CMS-2	2552-10	
APPORTI O	NMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	Provi der CO		Peri od:		
THROUGH	COSTS				From 01/01/2017	Part IV	
					To 12/31/2017		
			<b>-</b>	201111		5/29/2018 12:	24 pm
				XVIII	Hospi tal	Cost	
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col . 6 ÷ col .		Costs (col.	3	Costs (col. 9	
		7)	10.00	x col. 10)	10.00	x col . 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	NCILLARY SERVICE COST CENTERS	T		Т			
	5000 OPERATING ROOM	0. 000000	772, 162	i	0	0	
	5200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	
	5300 ANESTHESI OLOGY	0. 000000	95, 145		0	0	53.00
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	0. 000000	494, 654		0	0	54.00
60.00 06	6000 LABORATORY	0. 000000	408, 086		0 0	0	60.00
62. 30 06	6250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62. 30
65. 00 06	6500 RESPIRATORY THERAPY	0. 000000	162, 496		0 0	0	65. 00
66. 00   06	6600 PHYSI CAL THERAPY	0. 000000	97, 071		0 0	0	66. 00
67. 00   06	6700 OCCUPATI ONAL THERAPY	0. 000000	101, 461		0 0	0	67. 00
68. 00 06	6800 SPEECH PATHOLOGY	0. 000000	19, 712		0 0	0	68. 00
69.00 06	6900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69. 00
71. 00 07	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	197, 874		0 0	o	71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	448, 955		0 0	o	72.00
	7300 DRUGS CHARGED TO PATIENTS	0. 000000	459, 820		0	0	73. 00
	7697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76. 97
	7698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	l 0	76. 98
	7699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
	UTPATIENT SERVICE COST CENTERS	0.00000			<u> </u>		70.77
	9000 CLINIC	0.000000	0		0 0	0	90.00
	9001 LI FEBRI DGE SENI OR CARE	0. 000000	0		0 0	0	90. 01
	9100 EMERGENCY	0. 000000	35, 185		0	0	91. 00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	35, 165		0 0	0	92.00
	THER REIMBURSABLE COST CENTERS	0.000000	0	l	0		72.00
	9500 AMBULANCE SERVICES			<u> </u>			95. 00
	· ·		2 202 (21				
200. 00	Total (lines 50 through 199)		3, 292, 621	l	0	, 01	200. 00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1323 Peri od: Worksheet D From 01/01/2017 Part V 12/31/2017 Date/Time Prepared: 5/29/2018 12:24 pm Title XVIII Hospi tal Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 1. 00 2.00 5. 00 3.00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 194803 1, 970, 134 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.656843 0 0 0 0 0 0 0 0 0 0 0 0 52.00 53. 00 05300 ANESTHESI OLOGY 0.053733 0 245, 892 53 00 0 |05400| RADI OLOGY-DI AGNOSTI C 54.00 0.101210 0 5, 547, 706 0 54.00 60. 00 | 06000 | LABORATORY 0. 194587 2, 016, 827 0 60.00 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 0 62.30 06500 RESPIRATORY THERAPY 314, 778 65.00 0.274656 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.590851 441, 931 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.453437 94, 565 0 67.00 06800 SPEECH PATHOLOGY 1 010981 20, 838 68 00 68 00 0 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.306751 288, 688 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.308677 152, 420 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73 00 0.308502 2, 758, 189 Ω 73.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 76. 98 0 76. 99 07699 LI THOTRI PSY 0.000000 0 76. 99 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 0 90.00 09001 LIFEBRIDGE SENIOR CARE 0.779914 0 366, 839 0 0 90.01 90.01 09100 EMERGENCY 0. 292204 0 91.00 91.00 0 2, 515, 820 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 484, 686 0 92.00 92.00 0.492413 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 560069 95.00 200.00 Subtotal (see instructions) 0 18, 219, 313 0 0 200. 00 Less PBP Clinic Lab. Services-Program 201.00 201.00 Only Charges 202.00 Net Charges (line 200 - line 201) 18, 219, 313 0 202.00

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

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1323 Period: From 01/01/2017 To 12/31/2017 Part V Date/Time Prepared: 5/29/2018 12: 24 pm

Cost Center Description Cost Cost Cost

					5/29/2018 12: .	24 pm_
		Title	XVIII	Hospi tal	Cost	
	Costs					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCI LLARY SERVI CE COST CENTERS	<u>'</u>					
50. 00 05000 OPERATING ROOM	383, 788	0				50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53. 00 05300 ANESTHESI OLOGY	13, 213	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	561, 483	0				54. 00
60. 00   06000   LABORATORY	392, 448	0				60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	372, 440	0				62. 30
65. 00 06500 RESPIRATORY THERAPY	86, 456	0				65. 00
66. 00   06600   PHYSI CAL THERAPY	261, 115	0				66.00
67. 00   06700   OCCUPATI ONAL THERAPY	42, 879	0				67. 00
		0				68.00
	21, 067	0				
69. 00 06900 ELECTROCARDI OLOGY	00 555	0				69. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	88, 555	0				71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	47, 049	0				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	850, 907	0				73. 00
76. 97 07697 CARDIAC REHABILITATION	0	0				76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
76. 99 07699 LI THOTRI PSY	0	0				76. 99
OUTPATIENT SERVICE COST CENTERS						
90. 00   09000   CLI NI C	0	0				90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	286, 103	0				90. 01
91. 00   09100   EMERGENCY	735, 133	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	731, 079	0				92. 00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0					95. 00
200.00 Subtotal (see instructions)	4, 501, 275	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	o					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	4, 501, 275	0				202. 00
	, , , , , ,	- 1				•

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-1323 Peri od: Worksheet D From 01/01/2017 To 12/31/2017 Part V Component CCN: 15-Z323 Date/Time Prepared: 5/29/2018 12:24 pm Title XVIII Swing Beds - SNF Cost Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Services (see Rei mbursed Ratio From Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 9 Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) 3.00 (see inst.) 1. 00 2.00 5. 00 4.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 194803 0 50.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.656843 0 0 0 0 0 0 0 0 0 0 0 0 0 0 52.00 53. 00 05300 ANESTHESI OLOGY 0.053733 0 0 53 00 0 |05400| RADI OLOGY-DI AGNOSTI C 0 54.00 0.101210 0 0 54.00 60. 00 | 06000 | LABORATORY 0. 194587 0 60.00 0 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 0 62.30 |06500| RESPIRATORY THERAPY 0 0 65.00 0.274656 0 65.00 66.00 06600 PHYSI CAL THERAPY 0.590851 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0.453437 0 67.00 0 06800 SPEECH PATHOLOGY 1 010981 68 00 68 00 0 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.306751 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0.308677 0 0 72.00 0 07300 DRUGS CHARGED TO PATIENTS 0 73.00 0 0.308502 Ω 73.00 76. 97 07697 CARDIAC REHABILITATION 0.000000 0 0 0 76.97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 0 0 76. 98 76. 99 07699 LI THOTRI PSY 0.000000 0 0 0 76. 99 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0.000000 0 0 0 0 90.00 09001 LIFEBRIDGE SENIOR CARE 0.779914 0 0 0 0 90.01 90.01 09100 EMERGENCY 0. 292204 0 0 91.00 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 92.00 0.492413 0 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0. 560069 95.00 200.00 Subtotal (see instructions) 0 0 0 200. 00 0 0 Less PBP Clinic Lab. Services-Program 201.00 201.00

0 202.00

Only Charges

Net Charges (line 200 - line 201)

			Component	CCN: 15-Z323	To 12/31/2017	Date/Time Pro 5/29/2018 12:	
			Ti tl e	XVIII	Swing Beds - SNF		
		Cos	sts		<u> </u>	<u> </u>	
	Cost Center Description	Cost	Cost	1			
	'	Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATI NG ROOM	0	0	)			50. 00
	05200 DELIVERY ROOM & LABOR ROOM	0	0	)			52.00
	05300 ANESTHESI OLOGY	0	0	)			53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0	)			54.00
60.00	06000 LABORATORY	0	0	)			60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62. 30
65.00	06500 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
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0				69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0				76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0				76. 98
76. 99	07699 LI THOTRI PSY	0	0				76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	)			90. 00
90. 01	09001 LI FEBRI DGE SENI OR CARE	0	0				90. 01
91.00	09100 EMERGENCY	0	0				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92. 00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	0					95. 00
200.00	Subtotal (see instructions)	0	0				200. 00
201.00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	0	)			202. 00

Health Financial Systems COMM	IUNI TY HOSPT. OF	F LAGRANGE CTY	IN	In Lieu of Form CMS-25		
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	CAPI TAL COSTS			Peri od:	Worksheet D	
				From 01/01/2017		nanad.
				Го 12/31/2017	Date/Time Pre 5/29/2018 12:	pareu: 24 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00 ADULTS & PEDIATRICS	817, 091	74, 361	742, 730	3, 366	220. 66	30.00
43. 00 NURSERY	20, 698		20, 698	369	56. 09	43.00
200.00 Total (lines 30 through 199)	837, 789		763, 428	3, 735		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	38	8, 385				30.00
43. 00 NURSERY	129					43.00
200.00 Total (lines 30 through 199)	167	15, 621				200. 00

1, 952, 896

93, 381, 368

408, 228

8, 643 200. 00

200.00

Total (lines 50 through 199)

Health Financial Systems Co	OMMUNITY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COST	S Provider CO		Period: From 01/01/2017 To 12/31/2017		pared: 24 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Post-Stepdown	Nursing School	Post-Stepdowr		Medi cal	
	Adj ustments		Adjustments		Education Cost	
	1A	1. 00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	,	0	0	
43. 00   04300   NURSERY	0	0	,	0	0	1 .0.00
200.00   Total (lines 30 through 199)	0	0		0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0	3, 36			
43. 00   04300   NURSERY		0	36			
200.00   Total (lines 30 through 199)		0	3, 73	5	167	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0					30.00
43. 00 04300 NURSERY	0					43. 00
200.00   Total (lines 30 through 199)	0					200. 00

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN

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

						5/29/2018 12:	24 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0	(	0	0	50.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	) c	0	0	53.00
54.00	05400  RADI OLOGY-DI AGNOSTI C	0	0	(	0	0	54. 00
60.00	06000 LABORATORY	0	0	) c	0	0	60.00
62. 30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	(	0	0	62. 30
65.00	06500 RESPI RATORY THERAPY	0	0	(	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	(	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	(	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	(	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(	0	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	(	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	(	0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	(	0	0	76. 97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	(	0	0	76. 98
76. 99	07699 LI THOTRI PSY	0	0	(	0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	(	0	0	90.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	0	0	(	0	0	90. 01
91.00	09100 EMERGENCY	0	0	(	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				0	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES						95. 00
200.00	Total (lines 50 through 199)	0	0	(	0	0	200. 00
		•		•	*	'	

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-1323 | Peri od: | Worksheet D | From 01/01/2017 | Part IV | To | 12/31/2017 | Date/Time | Prepared: THROUGH COSTS

					To 12/31/2017	Date/Time Pre 5/29/2018 12:	
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	through col.	Cost (sum of	Part I, col.	(col. 5 + col.	
			4)	col. 2, 3 and	8)	7)	
				4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS				1		4
	05000 OPERATI NG ROOM	0	0		17, 915, 178		
52. 00		0	0		1, 995, 823		
53. 00	05300 ANESTHESI OLOGY	0	0		2, 238, 825		
54.00	1	0	0	1	25, 847, 711	•	
60.00		0	0	1	9, 147, 861		
62. 30		0	0	1	0	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0	1	2, 416, 509	•	
66. 00	06600 PHYSI CAL THERAPY	0	0	1	1, 673, 707	•	
67. 00		0	0	1	722, 010	•	
68. 00		0	0	1	145, 163		1
69. 00	06900 ELECTROCARDI OLOGY	0	0	1	0	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	2, 686, 803	l .	
72. 00		0	0	1	1, 683, 846	1	
73. 00		0	0		9, 711, 099	l	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	0. 000000	1
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0	0. 000000	1
76. 99	07699 LI THOTRI PSY	0	0		0	0. 000000	76. 99
	OUTPATIENT SERVICE COST CENTERS			1			1
90.00	09000 CLI NI C	0	0	1	0	0. 000000	1
90. 01	09001 LI FEBRI DGE SENI OR CARE	0	0	1	643, 098	<b>l</b>	1
91. 00		0	0	1	14, 122, 096	<b>l</b>	1
92. 00		0	0		2, 431, 639	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS			ı	1		ļ
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	1	93, 381, 368	ı	200. 00

Health Financial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY IN		In Lieu of Form CMS-2552-10
ADDODELONMENT OF LABATIENT/OUTDATIES	IT ANCLLLADY CEDVICE OTHER DACC	Drovi don CCN, 1E 1222	Donied.	Weskeheet D

Worksheet D Part IV APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Peri od: From 01/01/2017 To 12/31/2017 | Provider CCN: 15-1323 THROUGH COSTS Date/Time Prepared: 5/29/2018 12:24 pm Title XIX Hospi tal PPS Cost Center Description I npati ent Outpati ent Outpati ent Inpatient Outpati ent Ratio of Cost Program Program Program Program Pass-Through Pass-Through to Charges Charges Charges 8 Costs (col. (col. 6 ÷ col Costs (col. x col . 12) 13.00 7) x col. 10) 11.00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 73, 066 0 0 50.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 56, 901 0 52.00 05300 ANESTHESI OLOGY 0.000000 24, 887 0 53.00 53.00 0 0 0 0 0 0 0 0 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 55, 625 0 54.00 0 06000 LABORATORY 0 0.000000 60.00 59, 592 60.00 0 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 62.30 0.000000 0 62.30 65.00 06500 RESPIRATORY THERAPY 0.000000 18, 526 0 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 0.000000 66.00 2, 119 0 0 06700 OCCUPATIONAL THERAPY 0.000000 67.00 1, 245 0 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 0 69.00 0 69.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0.000000 71 00 71 00 13, 621 0 72.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0.000000 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 0 73.00 73.00 70,818 0 0 07697 CARDIAC REHABILITATION 0 76. 97 76. 97 0.000000 0 0 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0.000000 C 0 76. 98 76. 99 07699 LI THOTRI PSY 0.000000 0 0 0 76.99 OUTPATIENT SERVICE COST CENTERS 90.00 0 90.00 0.000000 n 0 n 09000 CLI NI C 09001 LIFEBRIDGE SENIOR CARE 0 0 90.01 0.000000 C 0 90.01 09100 EMERGENCY 0.000000 31, 828 0 0 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0.000000 0 o 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 200.00 Total (lines 50 through 199) 408, 228 0 0 0 200. 00

Health Financial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY IN	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1323	Period: From 01/01/2017	Worksheet D-1
			To 12/31/2017	Date/Time Prepared: 5/29/2018 12:24 pm
		Ti +Lo VVIII	Hospi tal	Cost

		Title XVIII	Hospi tal	5/29/2018 12: Cost	24 pm
	Cost Center Description	THE WITTE	nospi tui	'	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			4, 037	1. 00
2.00	Inpatient days (including private room days, excluding swing-k			3, 366	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(S). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 526	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	337	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om davs) after December (	21 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) arter becember .	or or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	334	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 2	l of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	i days) after beceiiber 3	i oi the cost	O	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	832	9. 00
10. 00	newborn days)	alv. (i polydina privoto r	nam daya)	337	10.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	337	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
10.00	December 31 of the cost reporting period (if calendar year, er			0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	confy (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
44.00	after December 31 of the cost reporting period (if calendar ye				44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	aays)	0	
16. 00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	123. 32	19.00
20. 00	Medicald rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	123. 32	20. 00
04.00	reporting period	`		E 040 (40	04 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	5, 319, 612 0	1
22.00	5 x line 17)	or or the dost reports	ng perrou (rine	Ü	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reportion	na period (line	41, 189	24. 00
	7 x line 19)	·		,	
25. 00	Swing-bed cost applicable to NF type services after December $(x,y)$	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			521, 566	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		4, 798, 046	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	d and abases settion had abo	, race)	0	28. 00
29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	a and observation bed ch	ii ges)	0	1
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	+ line 28)		0. 000000	1
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	1
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x line)	ne зі)		0.00	•
36.00	Private room cost differential adjustment (line 3 x line 35)		56 11 1 (11	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	Terential (line	4, 798, 046	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			1
38. 00	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 425. 45	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		1, 185, 974	
40.00	Medically necessary private room cost applicable to the Progra	,		0	
41.00	Total Program general inpatient routine service cost (line 39	+ IINE 4U)	l	1, 185, 974	41.00

	ATION OF INPATIENT OPERATING COST		Provider Co		Peri od: From 01/01/2017 To 12/31/2017	Date/Time Pre	pared:
			T' 11	\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\		5/29/2018 12:	24 pm
	Cost Center Description	Total		XVIII Average Pei	Hospital r Program Days	Program Cost	
	cost center bescription	Inpatient Costli		9	3	(col. 3 x col.	
			.,,	col . 2)		4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only)	0	0	0.	00 0	0	42.00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43.00
44. 00	CORONARY CARE UNIT						44.00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46.00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description						
40.00	Danier : and the control of the cont	-+ D 21 2	1: 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			nc)		804, 338 1, 990, 312	1
49.00	PASS THROUGH COST ADJUSTMENTS	+1 (111 Ough 40) (Si	e mstructio	115)		1, 990, 312	49.00
50. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	Wkst. D, su	m of Parts I and	0	50.00
			•				
51.00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D,	sum of Parts II	0	51.00
F2 00	and IV)	50 and 51)					F2 00
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		ated non-phy	sician anost	hetist and	0	
33. 00	medical education costs (line 49 minus line	52)	ateu, non pny	31 Crair ancst	netrat, and		33.00
	TARGET AMOUNT AND LIMIT COMPUTATION						1
54.00	Program di scharges					0	54.00
55. 00	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)			! F/!	1: 52)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (i	ine 56 minus	11 ne 53)	0 0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ndina 1996 u	ndated and c	ompounded by the		59.00
07.00	market basket	oor tring porrou of	.ag,,,,	paaroa ana o	ompounded by the	0.00	07.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	
61. 00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		(lines 54 x	60), or 1% o	f the target		
62. 00	Relief payment (see instructions)	ilisti ucti olis)				0	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						]
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Deceml	oer 31 of the	cost report	ing period (See	480, 377	64.00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December	c 21 of the c	ost roportin	a pariod (Saa	0	65.00
03.00	instructions)(title XVIII only)	ts at tel Decellibe	31 Of the C	ost reportin	g perrou (see		05.00
66.00	Total Medicare swing-bed SNF inpatient routing	ne costs (line 6	4 plus line 6	5)(title XVI	II only). For	480, 377	66.00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through I	December 31 o	f the cost r	eporting period	0	67.00
68. 00	(line 12 x line 19)  Title V or XIX swing-bed NF inpatient routing	e costs after De	remher 31 of	the cost ren	orting period	0	68.00
55. 50	(line 13 x line 20)	. Sosta di tei Dei	JOINDOI 31 01	3031 Tep	o. tring periou		30.00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (I	ne 67 + line	68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NU				,		1
70.00	Skilled nursing facility/other nursing facili	•		•	)		70.00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ne /U ÷ line	۷)			71. 00 72. 00
73.00	Medically necessary private room cost applications		(line 14 x li	ne 35)			73.00
74. 00	Total Program general inpatient routine servi						74.00
75. 00	Capital-related cost allocated to inpatient	•			Part II, column		75. 00
<b>-</b> ,	26, line 45)	0)					
76.00	Per diem capital related costs (line 75 ÷ line	. *					76.00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	,	•	ovi der record	s)			79.00
80.00	Total Program routine service costs for compa				nus line 79)		80.00
81. 00	Inpatient routine service cost per diem limi	tati on			•		81.00
82. 00	Inpatient routine service cost limitation (I	· .					82.00
83.00	Reasonable inpatient routine service costs (		)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		=)				84.00
86. 00							86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						]

840 87.00 1,425.44 88.00 1,197,370 89.00

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

Health Financial Systems COMM	COMMUNITY HOSPT. OF LAG			In Lieu of Form CMS-25		2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 To 12/31/2017	Date/Time Prep 5/29/2018 12:	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	817, 091	5, 319, 612	0. 15360	1, 197, 370	183, 916	90.00
91.00 Nursing School cost	0	5, 319, 612	0.00000	1, 197, 370	0	91.00
92.00 Allied health cost	0	5, 319, 612	0.00000	1, 197, 370	0	92.00
93.00 All other Medical Education	0	5, 319, 612	0. 000000	1, 197, 370	0	93. 00

Health Financial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY IN	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-1323	Period: From 01/01/2017	Worksheet D-1
			To 12/31/2017	Date/Time Prepared: 5/29/2018 12:24 pm
		Title XIX	Hospi tal	PPS

		T: +1 - VIV	11	5/29/2018 12:	24 pm
	Cost Center Description	Title XIX	Hospi tal	PPS	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	avaluding nauharn)		4, 037	1. 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days) Inpatient days (including private room days, excluding swing-b			3, 366	2.00
3. 00	Private room days (excluding swing-bed and observation bed day		ivate room davs.	0, 555	3. 00
	do not complete this line.	3			
4.00	Semi-private room days (excluding swing-bed and observation be			2, 526	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room	om days) through Decembe	r 31 of the cost	337	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	o	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	days) arter becomber	or the cost		0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	334	7. 00
0.00	reporting period		1 -6 +1		0.00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	n days) after December 3	or the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	38	9. 00
	newborn days)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom dave) after	o	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er		dom days) arter	١	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
	through December 31 of the cost reporting period			_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI) after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)			369	15. 00
16. 00	Nursery days (title V or XIX only)			129	16. 00
17. 00	SWING BED ADJUSTMENT	as through December 21 a	f the cost		17 00
17.00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through becember 31 o	i the cost		17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0. 00	20. 00
20.00	reporting period			1	20.00
21. 00	Total general inpatient routine service cost (see instructions			5, 319, 612	
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	a period (line 6	o	23. 00
	x line 18)		9	-	
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	21 of the cost reporting	ported (line 9	o	25. 00
25.00	x line 20)	or the cost reporting	perrou (Trile 8	١	25.00
26.00	Total swing-bed cost (see instructions)			484, 124	
27. 00	General inpatient routine service cost net of swing-bed cost (	(line 21 minus line 26)		4, 835, 488	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	l and observation had ab	orgos)	0	20 00
29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	a and observation bed ch	ai yes)	0	28. 00 29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 000000	31. 00
32.00	Average private room per diem charge (line 29 ÷ line 3)	,		0.00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	34.00
35.00					35. 00
36.00	, , , , , , , , , , , , , , , , , , ,				36. 00
37. 00					37. 00
	27 minus line 36)	·	·	4, 835, 488	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU			1 407 57	20.00
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 436. 57	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		54, 590	39.00
40.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39)	•		0 54, 590	40.00
41.00	Trotal Trogram general impatrent routine service cost (IIIIe 39	11116 40)	l	54, 590	1 41.00

COMPUT	Financial Systems COMM ATION OF INPATIENT OPERATING COST		Provi der (	CCN: 15-1323	Peri od:	Worksheet D-1	
					From 01/01/2017 To 12/31/2017	Date/Time Pre 5/29/2018 12:	pared: 24 pm
	Cook Cooking Decoration	T-+-1		le XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Day:	Average Per sDiem (col. 1		Program Cost (col. 3 x col.	
		,	,	col . 2)		4)	
		1.00	2. 00	3.00	4. 00	5. 00	
2. 00	NURSERY (title V & XIX only)	306, 384	36'	9 830.	31 129	107, 110	42.0
3. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT			1		I	43.0
4. 00	CORONARY CARE UNIT						44. 0
5. 00	BURN INTENSIVE CARE UNIT						45. C
5. 00	SURGICAL INTENSIVE CARE UNIT						46.0
7. 00	OTHER SPECIAL CARE (SPECIFY)						47. C
	Cost Center Description					1.00	
8. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3. line 200)			112, 401	48. 0
9. 00	Total Program inpatient costs (sum of lines			ons)		274, 101	
	PASS THROUGH COST ADJUSTMENTS					1	
0. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, su	m of Parts I and	15, 621	50.0
1. 00	Pass through costs applicable to Program inp	atient ancillar	v services (f	rom Wkst. D. :	sum of Parts II	8, 643	51.0
	and IV)		J (.	/			
2. 00	Total Program excludable cost (sum of lines					24, 264	1
3. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line !		elated, non-ph	ysician anesti	hetist, and	249, 837	53.0
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
1. 00	Program di scharges					0	54. (
6. 00	Target amount per discharge					0.00	1
. 00	Target amount (line 54 x line 55)				1. 50)	0	
. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (	line 56 minus	Tine 53)	0	
. 00	Lesser of lines 53/54 or 55 from the cost re	portina period	endi na 1996.	updated and c	ompounded by the		1
	market basket						
. 00	Lesser of lines 53/54 or 55 from prior year					0.00	1
. 00	If line 53/54 is less than the lower of line: which operating costs (line 53) are less than					0	61.0
	amount (line 56), otherwise enter zero (see		.5 (111165 54 X	00), 01 1% 0	i the target		
	Relief payment (see instructions)					0	
. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63.0
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of th	e cost report	ing period (See	T 0	64. (
. 00	instructions)(title XVIII only)	to thi odgir book	SINDER OF OF EFF	c cost report	ing period (occ		01.0
. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	oer 31 of the	cost reportin	g period (See	0	65.0
00	instructions) (title XVIII only)	as sests (line	(4 plug ling	(E) (+: +1 o V)/I	II anlu) Fan		,,,
. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (Time	64 prus rine	os)(title xvi	ii oniy). For	0	66.0
7. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31	of the cost r	eporting period	0	67.0
	(line 12 x line 19)						,,,
8. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs arter L	December 31 of	the cost rep	orting period	0	68.0
9. 00	Total title V or XIX swing-bed NF inpatient	routine costs (	(line 67 + lin	e 68)		0	69.0
	PART III - SKILLED NURSING FACILITY, OTHER NU						
0.00	Skilled nursing facility/other nursing facili	,			)		70.0
. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. (
. 00	Medically necessary private room cost applications		n (line 14 x l	ine 35)			73. (
. 00	Total Program general inpatient routine serv						74. (
. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Worksheet B, I	Part II, column		75. 0
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. (
. 00	Program capital-related costs (line 75 ÷ 11)	,					77. (
. 00	Inpatient routine service cost (line 74 minus						78.
. 00	Aggregate charges to beneficiaries for excess	s costs (from p		*			79.
. 00	Total Program routine service costs for comp		cost limitatio	n (line 78 mi	nus line 79)		80.
. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81. (
. 00	Reasonable inpatient routine service cost it militation (i		· * .				83.
. 00	Program inpatient ancillary services (see in		•				84.
	Utilization review - physician compensation					1	85 (

85. 00

86.00

840 87.00 1,436.57 88.00 1,206,719 89.00

85.00

86.00

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

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

Health Financial Systems COMM	MUNITY HOSPT. O	F LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2017 Fo 12/31/2017	Date/Time Prep 5/29/2018 12:	pared: 24 pm_
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	817, 091	5, 319, 612	0. 15360	1, 206, 719	185, 352	90.00
91.00 Nursing School cost	0	5, 319, 612	0.00000	1, 206, 719	0	91.00
92.00 Allied health cost	0	5, 319, 612	0.00000	1, 206, 719	0	92.00
93.00 All other Medical Education	0	5, 319, 612	0.00000	1, 206, 719	0	93. 00

				6.5	
Heal th Financial Systems COMMUNITY HOSPT. OF	_			eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Peri od: From 01/01/2017	Worksheet D-3	
			To 12/31/2017		pared:
				5/29/2018 12:	24 pm
	Titl∈	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
AND AT LENT POUTLING OFFINIOS COOT OFFITEDO		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			1 00/ 507		
30. 00   03000   ADULTS & PEDI ATRI CS			1, 896, 587		30.00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS		0.10400	272.4/2	150 410	 
50. 00   05000   0PERATI NG ROOM		0. 19480		l	50.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM 53. 00   05300   ANESTHESI OLOGY		0. 65684		0	52.00
		0.05373		5, 112	53. 00 54. 00
		0. 10121		50, 064	
		0. 19458			60. 00 62. 30
		0.00000		0	
		0. 27465			
66. 00   06600   PHYSI CAL THERAPY		0. 59085		57, 354	
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH   PATHOLOGY		0. 45343 1. 01098		46, 006	
69. 00   06900  ELECTROCARDI OLOGY		1		19, 928 0	69.00
71. 00   07100  MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 00000 0. 30675		1	71.00
72. 00 07100 MPL. DEV. CHARGED TO PATIENTS		0. 30867			71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 30850			
76. 97   07697   CARDI AC   REHABI LI TATI ON		0. 00000		141, 655	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.00000		0	76. 97
76. 99   07699   LI THOTRI PSY		0.00000		0	76. 99
OUTPATIENT SERVICE COST CENTERS		0.00000	0	0	70.99
90. 00   09000   CLINI C		0.00000	0 0	0	90.00
90. 01   09001   LI FEBRI DGE   SENI OR   CARE		0. 77991		0	90.00
91. 00   09100  EMERGENCY		0. 29220			
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART		0. 49241		0, 281	92.00
OTHER DELMRIDSARIE COST CENTERS		0.47241	<u> </u>		, ,2, 00

804, 338 200. 00 201. 00 202. 00

92.00 95.00

3, 292, 621

3, 292, 621

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

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

	Financial Systems COMMUNITY HOSPT. OF LA ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	eu of Form CMS-2 Worksheet D-3	
INPAII	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provider Co		Period: From 01/01/2017	worksneet D-3	1
		Component		To 12/31/2017	Date/Time Pre 5/29/2018 12:	
		Title	XVIII	Swing Beds - SNF		
	Cost Center Description		Ratio of Cost		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS			134, 347		30.00
	04300 NURSERY					43.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM		0. 19480	3 497	97	50.00
	05200 DELIVERY ROOM & LABOR ROOM		0. 65684		0	
53.00	05300 ANESTHESI OLOGY		0. 05373	3 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 10121	0 21, 326	2, 158	54. 00
60.00	06000 LABORATORY		0. 19458	7 27, 753	5, 400	60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.00000		0	
	06500 RESPI RATORY THERAPY		0. 27465			
	06600 PHYSI CAL THERAPY		0. 59085	1 58, 248	34, 416	66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0. 45343	7 65, 787	29, 830	67.00
	06800 SPEECH PATHOLOGY		1. 01098	1 6, 981	7, 058	
	06900 ELECTROCARDI OLOGY		0.00000	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 30675		3, 019	
	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 30867	7 0	0	
	07300 DRUGS CHARGED TO PATIENTS		0. 30850		23, 052	
	07697 CARDIAC REHABILITATION		0.00000	0	0	
	07698 HYPERBARI C OXYGEN THERAPY		0.00000		0	
76. 99	07699 LI THOTRI PSY		0.00000	0 0	0	76. 99
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C		0. 00000	0	0	90.00
90. 01	09001 LI FEBRI DGE SENI OR CARE		0. 77991	4 0	0	90. 01
	09100 EMERGENCY		0. 29220		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 49241	3 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS					
	09500 AMBULANCE SERVICES					95. 00
200.00				283, 698	110, 122	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		0		201.00

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

95. 00 110, 122 200. 00 201. 00 202. 00

283, 698

201.00 202.00

Health Financial Systems COMMUNITY HOSPT. OF			In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 1		Peri od:	Worksheet D-3	
			rom 01/01/2017 o 12/31/2017	Date/Time Prep 5/29/2018 12:	pared: 24 pm
	Title XI	Χ	Hospi tal	PPS	
Cost Center Description		io of Cost Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
		1. 00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS			98, 636		30.00
43. 00 04300 NURSERY			14, 525		43.00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATI NG ROOM		0. 194803		·	50. 00
52.00 O5200 DELIVERY ROOM & LABOR ROOM		0. 656843		37, 375	52.00
53. 00   05300   ANESTHESI OLOGY		0. 053733		1, 337	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 101210		5, 630	
60. 00   06000   LABORATORY		0. 194587		11, 596	
62.30   06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.000000		0	62. 30
65. 00 06500 RESPI RATORY THERAPY		0. 274656		5, 088	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 590851	2, 119	1, 252	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 453437	1, 245	565	67.00
68. 00   06800   SPEECH PATHOLOGY		1. 010981	0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY		0.000000		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 306751	13, 621	4, 178	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 308677	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 308502	70, 818	21, 847	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0.000000	0	0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.000000	0	0	76. 98
76. 99 07699 LI THOTRI PSY		0.000000	0	0	76. 99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C		0.000000	0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE		0. 779914	0	0	90. 01
91. 00 09100 EMERGENCY		0. 292204	31, 828	9, 300	91. 00

112, 401 200. 00

91.00

92.00 0

95.00

201. 00

202. 00

9, 300

0. 292204

0. 492413

31, 828

408, 228

408, 228

91.00

200.00

201.00 202.00

09100 EMERGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

OTHER REIMBURSABLE COST CENTERS
95.00 09500 AMBULANCE SERVICES

5/29/2018 12:24 pm Title XVIII Hospi tal Cost 1.00 PART B - MEDICAL AND OTHER HEALTH SERVICES Medical and other services (see instructions) 4, 501, 275 Medical and other services reimbursed under OPPS (see instructions) 2.00 2.00 OPPS payments 3.00 0 3 00 4.00 Outlier payment (see instructions) 0 4.00 4.01 Outlier reconciliation amount (see instructions) 0 4.01 Enter the hospital specific payment to cost ratio (see instructions) 5.00 0.000 5.00 6.00 Line 2 times line 5 Ω 6.00 7.00 Sum of lines 3, 4, and 4.01, divided by line 6 0.00 7.00 Transitional corridor payment (see instructions) 8.00 8.00 9 00 Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200 9 00 0 10.00 Organ acquisitions Λ 10.00 Total cost (sum of lines 1 and 10) (see instructions) 4, 501, 275 11.00 11.00 COMPUTATION OF LESSER OF COST OR CHARGES Reasonable charges 0 12.00 Ancillary service charges 12.00 13.00 Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69) 0 13.00 14.00 Total reasonable charges (sum of lines 12 and 13) 0 14.00 Customary charges 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 for payment for services on a chargebasis 16.00 had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000) 17.00 0.000000 17.00 18.00 Total customary charges (see instructions) 0 18.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 0 19.00 instructions) 20 00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 20 00 0 instructions) 21 00 Lesser of cost or charges (see instructions) 4, 546, 288 21 00 Interns and residents (see instructions) 22.00 22.00 0 23.00 Cost of physicians' services in a teaching hospital (see instructions) 23.00 0 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 24.00 0 24.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 49, 608 Deductibles and coinsurance (for CAH, see instructions) 25, 00 25, 00 26.00 Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions) 3, 286, 346 26.00 Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see 27.00 1, 210, 334 27.00 instructions) 28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28.00 0 29.00 ESRD direct medical education costs (from Wkst. E-4, line 36) 0 29.00 30 00 1, 210, 334 30 00 Subtotal (sum of lines 27 through 29) 31.00 Primary payer payments Ω 31.00 32.00 Subtotal (line 30 minus line 31) 1, 210, 334 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11) 33 00 33 00 0 34.00 Allowable bad debts (see instructions) 321, 609 34.00 Adjusted reimbursable bad debts (see instructions) 209, 046 35.00 36, 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 321, 609 36, 00 37.00 Subtotal (see instructions) 1, 419, 380 37.00 38.00 MSP-LCC reconciliation amount from PS&R 38.00 0 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 39.00 39.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 Partial or full credits received from manufacturers for replaced devices (see instructions) 39.98 39.98 RECOVERY OF ACCELERATED DEPRECIATION 39.99 39.99 0 Subtotal (see instructions) 1, 419, 380 40.00 40 00 40.01 Sequestration adjustment (see instructions) 28, 388 40.01 40.02 Demonstration payment adjustment amount after sequestration 40.02 1, 935, 157 41.00 Interim payments 41.00 42.00 Tentative settlement (for contractors use only) Λ 42.00 Balance due provider/program (see instructions) -544, 165 43.00 43.00 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 44.00 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 90.00 91.00 Outlier reconciliation adjustment amount (see instructions) 0 91.00 The rate used to calculate the Time Value of Money 92 00 0 00 92 00 Time Value of Money (see instructions) 93.00 0 93.00 94.00 Total (sum of lines 91 and 93) 0 94.00

8.00

Part I

From 01/01/2017 Date/Time Prepared: 12/31/2017 5/29/2018 12:24 pm Title XVIII Hospi tal Cost Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 1, 514, 684 1, 935, 157 1. 00 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 08/29/2017 148, 700 0 3.01 3.02 0 3.02 3.03 3.03 0 0 3.04 0 0 3.04 3.05 0 0 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 0 3.51 0 3.51 0 0 3.52 3.52 3.53 0 3.53 0 3.54  $\cap$ 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 148, 700 Ω 3.99 3.50-3.98) 1, 935, 157 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 1, 663, 384 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 0 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 158, 356 0 6.01 6 02 SETTLEMENT TO PROGRAM 544, 165 6.02 7.00 Total Medicare program liability (see instructions) 1, 821, 740 1, 390, 992 7.00 Contractor NPR Date (Mo/Day/Yr) Number 0 1 00 2 00

Provider CCN: 15-1323

Peri od:

8.00 Name of Contractor

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-1323 Peri od: Worksheet E-1 From 01/01/2017 To 12/31/2017 Part I Component CCN: 15-Z323 Date/Time Prepared: 5/29/2018 12:24 pm Title XVIII Swing Beds - SNF Cost Part B Inpatient Part A mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 615, 749 1. 00 0 2.00 Interim payments payable on individual bills, either 2.00 submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00 List separately each retroactive lump sum adjustment 3.00 amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 ADJUSTMENTS TO PROVIDER 08/29/2017 58, 100 0 3.02 C 0 3.03 0 0 3.04 0 0 3.05 0 0 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 0 3.51 0 0 0 3.52 0 3.53 0 3.54  $\cap$ 0 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 58, 100 0 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 673, 849 0

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of					2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1323	Peri od:	Worksheet E-1	
			From 01/01/2017		
			To 12/31/2017		
				5/29/2018 12: Cost	24 pm
	Title XVIII Hospital				
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				4
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1
1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14				1.00
2.00	·			1	2.00
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. Line 2				1	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12		1	4.00
5. 00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1	5.00
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 l	ine 20		1	6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of c		Wkc+ \$ 2 D+ I	1	7. 00
7.00	Tine 168	er till ed ill i tecillorogy	WKSt. 3-2, Ft. I	1	7.00
8. 00	Calculation of the HIT incentive payment (see instructions)			1	8. 00
	. , , , , , , , , , , , , , , , , , , ,			1	
9. 00	Sequestration adjustment amount (see instructions)			1	9. 00
10. 00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				4
30.00	Initial/interim HIT payment adjustment (see instructions)			1	30.00
31.00	Other Adjustment (specify)			ı	31. 00
32 00	2.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)				

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

32.00

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

Provider CCN: 15-1323 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/29/2018 12: 24 pm

		Title XVIII	Swing Beds - SNF	Cost	24 piii
		II LIE XVIII	Part A	1'	
				Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES		1. 00	2. 00	
1. 00	Inpatient routine services - swing bed-SNF (see instructions)		485, 181	0	1. 00
	, .		400, 101	U	2. 00
2. 00 3. 00	Inpatient routine services - swing bed-NF (see instructions) Ancillary services (from Wkst. D-3, col. 3, line 200, for Part	A and sum of Wkst D	111 222	o	
3.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins		111, 223	١	3. 00
4.00	Per diem cost for interns and residents not in approved teachi			0.00	4. 00
4.00	instructions)	ng program (see		0.00	4.00
5.00	Program days		337	ol	5. 00
6. 00	Interns and residents not in approved teaching program (see in	etructions)	337		6. 00
7. 00	Utilization review - physician compensation - SNF optional met		0	Ĭ	7. 00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)	ined only	596, 404	o	8. 00
9. 00	Primary payer payments (see instructions)		0,0,101	0	9. 00
10. 00	Subtotal (line 8 minus line 9)		596, 404		10. 00
11. 00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0,0,101	1	11. 00
11.00	professional services)	able to physician		Ĭ	11.00
12. 00	Subtotal (line 10 minus line 11)		596, 404	o	12.00
13. 00	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	0,0,101	l ol	13. 00
.0.00	for physician professional services)	(ener due eer neur dinee		ا	
14.00	80% of Part B costs (line 12 x 80%)			l ol	14.00
15. 00	Subtotal (enter the lesser of line 12 minus line 13, or line 1	4)	596, 404	l ol	15. 00
16. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	1	16. 00
16. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)			16. 50
16. 55	Rural community hospital demonstration project (§410A Demonstr		0		16. 55
	adjustment (see instructions)	, []			
16. 99	Demonstration payment adjustment amount before sequestration		0	0	16. 99
17.00	Allowable bad debts (see instructions)		0	0	17.00
17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)	0	0	18.00
19.00	Total (see instructions)	,	596, 404	l ol	19.00
19. 01	Sequestration adjustment (see instructions)		11, 928		19. 01
19. 02	Demonstration payment adjustment amount after sequestration)		0		19. 02
20.00	Interim payments		673, 849	l ol	20.00
21.00	Tentative settlement (for contractor use only)		0	0	21.00
22. 00	Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	-89, 373	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	0		23.00
	chapter 1, §115.2				
	Rural Community Hospital Demonstration Project (§410A Demonstr	ation) Adjustment	-		
200.00	Is this the first year of the current 5-year demonstration per				200. 00
	Century Cures Act? Enter "Y" for yes or "N" for no.				
	Cost Reimbursement				
201.00	Medicare swing-bed SNF inpatient routine service costs (from W	/kst. D-1, Pt. II, line			201. 00
	66 (title XVIII hospital))				
202.00	Medicare swing-bed SNF inpatient ancillary service costs (from	n Wkst. D-3, col. 3, line	9		202. 00
	200 (title XVIII swing-bed SNF))				
	Total (sum of lines 201 and 202)				203. 00
204.00	Medicare swing-bed SNF discharges (see instructions)				204. 00
	Computation of Demonstration Target Amount Limitation (N/A in	first year of the currer	nt 5-year demonst	trati on	
	peri od)				
	Medicare swing-bed SNF target amount			1	205. 00
206.00	Medicare swing-bed SNF inpatient routine cost cap (line 205 ti				206. 00
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburs				
	Program reimbursement under the §410A Demonstration (see instr				207. 00
208.00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2	2, col. 1, sum of lines 1			208. 00
	and 3)				
	Adjustment to Medicare swing-bed SNF PPS payments (see instruc	ctions)			209. 00
210.00	Reserved for future use				210. 00
	Comparision of PPS versus Cost Reimbursement	200 1 11 2:23			
215. 00	Total adjustment to Medicare swing-bed SNF PPS payment (line 2	209 plus line 210) (see			215. 00
	instructions)				

Health Financial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY IN	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 15-1323	From 01/01/2017	Worksheet E-3 Part V Date/Time Prepared: 5/29/2018 12:24 pm
		T' 11 \0.0111	11	

				5/29/2018 12:	24 pm
	Title XVIII Hospital		Cost		
	· · · · · · · · · · · · · · · · · · ·				
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE	PART A SERVICES - COST	REI MBURSEMENT		
1.00	Inpati ent servi ces			1, 990, 312	1. 00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ons)		0	2. 00
3. 00	Organ acquisition	,		0	3. 00
4. 00				1, 990, 312	4. 00
5. 00				0	5. 00
6. 00	Total cost (line 4 less line 5). For CAH (see instructions)			2, 010, 215	6. 00
0.00	COMPUTATION OF LESSER OF COST OR CHARGES			2,010,210	0.00
	Reasonable charges				
7. 00	Routine service charges			0	7. 00
8. 00	Ancillary service charges			o o	8. 00
9. 00	Organ acquisition charges, net of revenue			0	9. 00
10. 00	Total reasonable charges			0	
10.00	Customary charges			U	10.00
11. 00	Aggregate amount actually collected from patients liable for patie	navment for convices on	a chargo basis	0	11. 00
12. 00	Amounts that would have been realized from patients liable for			0	12.00
12.00	had such payment been made in accordance with 42 CFR 413.13(e)		ili a Cilai ye basi s	U	12.00
12 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	)		0. 000000	12 00
13. 00 14. 00	1			0.000000	14. 00
15. 00				0	
15.00	0 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions)			U	15.00
16. 00					16. 00
10.00	instructions)	Ty IT TITLE 0 exceeds ITT	14) (366	0	10.00
17. 00	Cost of physicians' services in a teaching hospital (see insti	cuctions)		0	17. 00
17.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	de trons)		U	17.00
18. 00	Direct graduate medical education payments (from Worksheet E-4	1 Line 40)		0	18. 00
19. 00	Cost of covered services (sum of lines 6, 17 and 18)	+, Time 47)		2, 010, 215	
20. 00	Deductibles (exclude professional component)			2, 010, 213	
21. 00	Excess reasonable cost (from line 16)			273,019	
22. 00	Subtotal (line 19 minus line 20 and 21)			1, 735, 196	
23. 00	Coi nsurance			1, 735, 196	
24. 00	Subtotal (line 22 minus line 23)			1, 734, 522	
25. 00		noo) (ooo imatmustisma)		1, 734, 322	
26. 00	Allowable bad debts (exclude bad debts for professional service	Les) (see Histructions)			
	Adjusted reimbursable bad debts (see instructions)	aught and		124, 396	
27. 00	Allowable bad debts for dual eligible beneficiaries (see insti	uctions)		191, 379	
28. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 858, 918 0	
29. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`			
29. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)		0	
29. 99	Demonstration payment adjustment amount before sequestration			0	
30.00	Subtotal (see instructions)			1, 858, 918	
30. 01				37, 178	
30. 02				0	
31. 00				1, 663, 384	
32. 00	Tentative settlement (for contractor use only)			0	32. 00
33. 00	Balance due provider/program (line 30 minus lines 30.01, 30.02			158, 356	
34. 00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	0	34. 00
	§115. 2				

Health Financial Systems

COMMUNITY HOSPT.

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

Provider CCN: 15-1323

Peri od: Worksheet G From 01/01/2017 To 12/31/2017 Date/Time Prepared:

onl y)				0 12/31/201/	5/29/2018 12:	
		General Fund	Speci fi c	Endowment Fund		<u> </u>
		1. 00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	11.00	2.00	0.00	11.00	
1.00	Cash on hand in banks	73, 035		, i	0	
2.00	Temporary investments	0			0	
3.00	Notes receivable	4 414 490		0	0	
4. 00 5. 00	Accounts recei vabl e Other recei vabl e	4, 616, 689 12, 933	1		0	
6. 00	Allowances for uncollectible notes and accounts receivable	12, 733		-	Ö	
7. 00	Inventory	291, 508	3	0	0	
8.00	Prepai d expenses	116, 032	2 (	0	0	
9. 00	Other current assets	0		0	0	
10.00	Due from other funds	-2, 443, 816			0	
11. 00	Total current assets (sum of lines 1-10) FIXED ASSETS	2, 666, 381		0	0	11. 00
12. 00	Land	320, 702		0	0	12. 00
13. 00	Land improvements	1, 972, 720	1	-		
14.00	Accumulated depreciation	-1, 133, 078	1	0	0	14. 00
15. 00	Bui I di ngs	13, 534, 005	1	0	0	1
16. 00	Accumulated depreciation	-3, 744, 926	1	-	0	
17.00	Leasehold improvements	29, 098 -29, 098	1	-	0	
18. 00 19. 00	Accumulated depreciation Fixed equipment	7, 763, 317		, i	0 0	
20. 00	Accumulated depreciation	-5, 119, 261		٥	0	
21. 00	Automobiles and trucks	154, 457		o o	Ö	
22. 00	Accumulated depreciation	-104, 627	1	0	0	22. 00
23. 00	Major movable equipment	8, 921, 721	1	0	0	
24. 00	Accumulated depreciation	-6, 426, 580	) (	0	0	
25. 00 26. 00	Minor equipment depreciable	0		0	0 0	
27. 00	Accumulated depreciation HIT designated Assets	0			0	
28. 00	Accumulated depreciation	Ö			Ö	
29. 00	Mi nor equi pment-nondepreci abl e	O		0	Ō	
30.00	Total fixed assets (sum of lines 12-29)	16, 138, 450	) (	0	0	30.00
	OTHER ASSETS	_		_		
31. 00 32. 00	Investments  Deposits on Leases	0		-	0 0	
33. 00	Deposits on leases Due from owners/officers	0				
34. 00	Other assets	5, 011, 241	1	o o	0	
35. 00	Total other assets (sum of lines 31-34)	5, 011, 241	1	0	Ō	
36.00	Total assets (sum of lines 11, 30, and 35)	23, 816, 072	2 (	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	1, 100, 778	1	-		
38. 00 39. 00	Salaries, wages, and fees payable Payroll taxes payable	580, 082		0	0 0	
40. 00	Notes and Loans payable (short term)	875, 000				
41. 00	Deferred income	0,0,000		o o	Ö	
42. 00	Accel erated payments	O			_	42. 00
43.00	Due to other funds	O	) (	0	0	43.00
44. 00		672, 316		0	0	
45. 00		3, 228, 176	) (	0	0	45. 00
46. 00	LONG TERM LIABILITIES  Mortgage payable				0	46. 00
47. 00	Notes payable	0				
48. 00	Unsecured Loans	Ö		-	Ö	
49. 00	Other long term liabilities	23, 031, 924		0	0	1
50.00	Total long term liabilities (sum of lines 46 thru 49)	23, 031, 924	. (	0	0	
51. 00	Total liabilities (sum of lines 45 and 50)	26, 260, 100	) (	0	0	51. 00
F2 00	CAPITAL ACCOUNTS	2 444 020				F2 00
52. 00 53. 00	General fund balance Specific purpose fund	-2, 444, 028	3			52. 00 53. 00
54. 00	Donor created - endowment fund balance - restricted			<u></u>		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57.00	Plant fund balance - invested in plant				0	1
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion	2 444 020	3		0	59. 00
60.00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	-2, 444, 028 23, 816, 072	1		0	
23.00	59)	20,010,012	]			55.00
			•			-

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-1323

					10	12/31/201/	5/29/2018 12:	
	·	General	Fund	Speci al	Pur	pose Fund	Endowment Fund	E 1   DIII
		1.00	2. 00	3. 00		4. 00	5. 00	
1.00	Fund balances at beginning of period		-2, 511, 398			0		1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)		2, 510, 513					2. 00
3.00	Total (sum of line 1 and line 2)		-885			0		3. 00
4.00	TRANSFERS	-2, 443, 144			0		0	4.00
5.00		O			0		0	5. 00
6.00		O			0		0	6. 00
7.00		0			0		0	7. 00
8.00		0			0		0	8. 00
9.00		0			0		0	9. 00
10.00	Total additions (sum of line 4-9)		-2, 443, 144			0		10. 00
11. 00	Subtotal (line 3 plus line 10)		-2, 444, 029			0		11. 00
12.00	Deductions (debit adjustments) (specify)	0	,		0		0	12. 00
13. 00	( ()	0			0		Ö	13. 00
14. 00		0			0		Ö	14. 00
15. 00		0			0		Ö	
16. 00		0			0		0	16. 00
17. 00					0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		0		Ĭ	0		18. 00
19. 00	Fund balance at end of period per balance		-2, 444, 029			0		19. 00
. ,	sheet (line 11 minus line 18)		2,, 02,			ŭ		. , , , ,
		Endowment Fund	PI ant	Fund				
		6. 00	7. 00	8. 00				
1.00	Fund balances at beginning of period	0			0			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)							2. 00
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4.00	TRANSFERS		0					4.00
5.00			0					5.00
6.00			0					6.00
7.00			0					7. 00
8.00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11.00	Subtotal (line 3 plus line 10)	0			0			11. 00
12.00	Deductions (debit adjustments) (specify)		0					12.00
13.00			0					13.00
14.00			O					14.00
15.00			0					15. 00
16.00			o					16. 00
17.00			o					17. 00
18.00	Total deductions (sum of lines 12-17)	o			0			18. 00
19.00	Fund balance at end of period per balance	o			0			19. 00
	sheet (line 11 minus line 18)							
		·						

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

			10 12/31/2017	5/29/2018 12:	
	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	4, 514, 254	1	4, 514, 254	1. 00
2.00	SUBPROVI DER - I PF				2.00
3.00	SUBPROVI DER - I RF				3.00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF	383, 380		383, 380	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00
8.00	NURSING FACILITY				8. 00
9.00	OTHER LONG TERM CARE				9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	4, 897, 634	1	4, 897, 634	10. 00
	Intensive Care Type Inpatient Hospital Services		T		
11. 00	INTENSIVE CARE UNIT				11. 00
12. 00	CORONARY CARE UNIT				12.00
13. 00	BURN INTENSIVE CARE UNIT				13.00
14. 00	SURGI CAL INTENSIVE CARE UNIT				14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	i nes (		0	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	4, 897, 634		4, 897, 634	17. 00
18. 00	Ancillary services	16, 761, 612		16, 761, 612	18. 00
19. 00	Outpati ent servi ces		83, 681, 627	83, 681, 627	19. 00
20. 00	RURAL HEALTH CLINIC		0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY				22. 00
23. 00	AMBULANCE SERVICES		4, 459, 086	4, 459, 086	23. 00
24. 00	CMHC				24.00
24. 10	CORF		7	0	24. 10
24. 20	OUTPATIENT PHYSICAL THERAPY		0	0	24. 20
24. 30	OUTPATIENT OCCUPATIONAL THERAPY		7	0	24. 30
24. 40	OUTPATIENT SPEECH PATHOLOGY		이	0	24. 40
25. 00	AMBULATORY SURGICAL CENTER (D. P. )				25.00
26. 00	HOSPI CE				26. 00
27. 00	OTHER (SPECIFY)		0	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst. 21, 659, 24	88, 140, 713	109, 799, 959	28. 00
	G-3, line 1)				
29. 00	PART II - OPERATING EXPENSES  Operating expenses (per Wkst. A, column 3, line 200)		35, 193, 915		29. 00
30. 00	ADD (SPECIFY)				29. 00 30. 00
31. 00	ADD (SPECIFF)				31. 00
32. 00					32. 00
33. 00					33. 00
34. 00					34. 00
35. 00					35. 00
36. 00	Total additions (sum of lines 30-35)				36. 00
37. 00	DEDUCT (SPECIFY)	,			37. 00
38. 00	DEDUCT (SPECITY)				38. 00
39. 00					39. 00
40. 00		•			40. 00
41. 00			()		41. 00
41.00	Total deductions (sum of lines 37-41)		1		41.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer	35, 193, 915		43. 00
43.00	to Wkst. G-3, line 4)	(Ci dilsi ei	33, 173, 713		45.00
	100 11.000. 0 0, 11110 1)	ı	1	l	

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

near tri	Financial Systems Community Hosel. Of L	AGRANGE CIT IN	III LI E	u or Form CM3-2	2002-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-1323	Peri od:	Worksheet G-3	
			From 01/01/2017 To 12/31/2017	Date/Time Pre	narod:
			10 12/31/2017	5/29/2018 12:	
					, ,
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	e 28)		109, 799, 959	1. 00
2.00	Less contractual allowances and discounts on patients' accoun-	ts		73, 510, 923	2.00
3.00	Net patient revenues (line 1 minus line 2)			36, 289, 036	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		35, 193, 915	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			1, 095, 121	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			123, 138	
7.00	Income from investments			-1, 317	7. 00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	
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	Revenue from meals sold to employees and guests			267, 480	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
	Revenue from sale of medical and surgical supplies to other the	han patients		0	16. 00
	Revenue from sale of drugs to other than patients			614, 790	17. 00
18. 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			13, 828	
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			30, 428	22. 00
23. 00	Governmental appropriations			0	23. 00
24. 00	MI SCELLANEOUS			18, 045	24. 00
24. 01	COUNTY REIMBURSEMENT OF AMBULANCE SE			349, 000	24. 01
	Total other income (sum of lines 6-24)			1, 415, 392	25. 00
26. 00	Total (line 5 plus line 25)			2, 510, 513	26. 00
27. 00	OTHER EXPENSES (SPECIFY)			0	27. 00
	Total other expenses (sum of line 27 and subscripts)			0	28. 00
29. 00	Net income (or loss) for the period (line 26 minus line 28)			2, 510, 513	29. 00