lear til i i lianci a	ai Systems	LENIANT OLIVENAL	11031 I TAL	III LI C	1 01 101111 CM3-2332-10
This report is	required by law (42 USC 1395g	; 42 CFR 413.20(b)). Fai	lure to report can resu	ult in all interim	FORM APPROVED
payments made	since the beginning of the cos	t reporting period being	deemed overpayments (4	42 USC 1395g).	OMB NO. 0938-0050
					EXPIRES 05-31-2019
HOSPITAL AND H	OSPITAL HEALTH CARE COMPLEX CO	ST REPORT CERTIFICATION	Provider CCN: 15-0018	Peri od:	Worksheet S
AND SETTLEMENT	SUMMARY			From 01/01/2017	
				To 12/31/2017	Date/Time Prepared:
					5/25/2018 10:27 am
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically filed	cost report		Date: 5/25/20	18 Time: 10:27 am
use only	2. [] Manually submitted cos	st report			
	3. [0] If this is an amended	report enter the number	of times the provider i	resubmitted this co	ost report
	4. [F] Medicare Utilization.	Enter "F" for full or "L	_" for low. '		•
Contractor	5. [1]Cost Report Status	6. Date Received:	10.	NPR Date:	
use only	(1) As Submitted	7. Contractor No.	11.	Contractor's Vendo	or Code: 4
400 U.I. J	(2) Settled without Audit	8. [N]Initial Report fo	or this Provider CCN 12.	[0]If line 5, co	lumn 1 is 4: Enter
	(3) Settled with Audit	9. [N] Final Report for	this Provider CCN		es reopened = 0-9.
	(4) Reopened				·
	(5) Amended				
	() Ameriaea				

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 ELKHART GENERAL HOSPITAL (15-0018) 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)
	Ti tl e
	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	360, 048	109, 663	0	8, 099	1. 00
2.00	Subprovi der - I PF	0	6, 251	0		731	2. 00
3.00	Subprovi der - I RF	0	8, 551	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12. 00
200.00	Total	0	374, 850	109, 663	0	8, 830	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 ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0018 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/23/2018 2:39 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 600 EAST BLVD 1.00 PO Box: 1.00 State: IN 2.00 City: ELKHART Zip Code: 46514 County: ELKHART 2.00 Component Name Payment System (P, CCN CBSA Provi der Date 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 ELKHART GENERAL 150018 21140 01/01/1966 Ν Р Р 3.00 1 HOSPI TAI Subprovider - IPF ELKHART PSYCH Р 4.00 15S018 21140 01/01/2015 Р 4 00 4 Ν 5.00 Subprovider - IRF ELKHART REHAB 15T018 21140 5 01/01/1993 Ρ Ρ 5.00 Ν 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF 7.00 7 00 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 11.00 Hospi tal -Based OLTC 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 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 Hospi tal -Based (CORF) I 17.10 17. 10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2017 12/31/2017 20.00 21.00 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 Ν 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 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 N Ν 22.02 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 "Y" for yes or "N" for no, for the portion of the cost reporting period on in column 2, or after October 1. Did this hospital receive a geographic reclassification from urban to rural as a result Ν 22.03 Ν 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. Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 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 used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no enter "Y" for yes or "N" <u>for no</u> 0ther In-State In-State Out-of Out-of Medi cai d Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days eligible unpai d paid days days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 | If this provider is an IPPS hospital, enter the 3, 249 24. 00 1.174 341 4, 102 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3 out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 170 0 0 25 00 58 28 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.

instructions)

	inancial Systems . AND HOSPITAL HEALTH CARE COMPL			L HOSPITAL	CN: 15-0018	Peri od:	u of Form CMS-2 Worksheet S-2	
HOSFI TAL	AND HOSFITAL HEALTH CARE COMPL	EX TUENTITICATION DA	IA	Frovider C		From 01/01/2017 To 12/31/2017	Part I Date/Time Pre 5/23/2018 2:3	pared:
			Y/N	IME	Direct GME	IME	Direct GME	, p
			1. 00	2. 00	3. 00	4.00	5. 00	
su cu 61. 05 En an pr	nter the number of unweighted purgery allopathic and/or osteopurrent cost reporting period. (so the difference between the nd/or general surgery FTEs and rimary care and/or general surgery and surgery streams.	ethic FTEs in the end instructions). baseline primary the current year's ery FTE counts (line						61. 04
61. 06 En us	1.04 minus line 61.03). (see in: nter the amount of ACA §5503 aw sed for cap relief and/or FTEs are or general surgery. (see in:	ard that is being that are nonprimary						61. 06
			Pro	ogram Name	Program Code	_	Unweighted Direct GME FTE Count	
				1. 00	2. 00	3.00	4.00	
sp fo co pr un	f the FTEs in line 61.05, speci- becialty, if any, and the number or each new program. (see instru- olumn 1, the program name. Enter program code. Enter in column 3, nweighted count. Enter in column TE unweighted count.	of FTE residents uctions) Enter in in column 2, the the IME FTE				0.00	0.00	61. 10
61.20 Of pr re in En 3,	f the FTEs in line 61.05, specing ram specialty, if any, and the sidents for each expanded program column 1, and the rin column 2, the program column 2, the IME FTE unweighted countine direct GME FTE unweighted column 2.	ne number of FTE ram. (see the program name. ode. Enter in column Enter in column 4,				0.00	0.00	61. 20
					(1)		1. 00	
62. 00 En	CA Provisions Affecting the Heanter the number of FTE resident:	s that your hospital	trai ned			riod for which	0.00	62. 00
62. 01 En du	our hospital received HRSA PCRE nter the number of FTE resident: uring in this cost reporting pe	s that rotated from a giod of HRSA THC prog	Teachi ram. (s	<u>ee instructio</u>		o your hospital	0.00	62. 01
63.00 Ha	eaching Hospitals that Claim Re as your facility trained reside	nts in nonprovider se	ttings	during this c			N	63. 00
	Y" for yes or "N" for no in col	anni I. II yes, compre	ite iiile	s o4 tillough	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col. 2))	
					1. 00	2.00	3.00	
	ection 5504 of the ACA Base Yea eriod that begins on or after J				This base yea	r is your cost r	reporting	
64.00 En in re se re	nter in column 1, if line 63 is n the base year period, the num esident FTEs attributable to ro ettings. Enter in column 2 the esident FTEs that trained in yo	f line 63 is yes, or your facility trained residents iod, the number of unweighted non-primary care utable to rotations occurring in all nonprovider column 2 the number of unweighted non-primary care rained in your hospital. Enter in column 3 the ratio by (column 1 + column 2)). (see instructions)					0. 000000	64. 00
		Program Name	Pro	ogram Code	Unwei ghted FTEs Nonprovi der Si te	FTEs in	Ratio (col. 3/ (col. 3 + col. 4))	
				2.00	3. 00	4.00	5.00	1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0018 Peri od: Worksheet S-2 From 01/01/2017 Part I Date/Time Prepared: 12/31/2017 5/23/2018 2:39 pm Ratio (col. 3/ 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 0.000000 65.00 0. 00 0. 00 65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 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 ahted Unwei ghted Ratio (col. 3/ Program Code 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 Ν O N 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 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 Ν Ν 0 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)

lealth Financial Systems ELKHART GENERAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CO	CN: 15-0018	Peri od: From 01/01/2017 To 12/31/2017	u of Form CMS- Worksheet S- Part I Date/Time Pro 5/23/2018 2:	2 epared:
				1.00	
Long Term Care Hospital PPS 10.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 11.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			ng period? Enter	N N	80.00
TEFRA Providers 5.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 6.00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.				N	85. 0 86. 0
7.00 Is this hospital an extended neoplastic disease care hospital 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	classified (under sectio	n	N	87. 0
11000(d)(1)(b)(v1): Eliter 1 101 yes 01 N 101 110.			V 1. 00	XI X 2. 00	
Title V and XIX Services					
0.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	servi ces? Ei	nter "Y" for	N	Y	90.0
13.00 Is this hospital reimbursed for title V and/or XIX through the full or in part? Enter "Y" for yes or "N" for no in the appli			N	Y	91.0
2.00 Are title XIX NF patients occupying title XVIII SNF beds (dua	ıl certificati			N	92. 0
instructions) Enter "Y" for yes or "N" for no in the applicab 3.00 Does this facility operate an ICF/IID facility for purposes o		d XIX? Enter	N	N	93. 0
"Y" for yes or "N" for no in the applicable column. 4.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a	and "N" for no	o in the	N	N	94. 0
applicable column. 5.00 If line 94 is "Y", enter the reduction percentage in the appl	icable column	٦.	0. 00	0, 00	95. 0
6.00 Does title V or XIX reduce operating cost? Enter "Y" for yes			N	N	96.0
applicable column. 7.00 If line 96 is "Y", enter the reduction percentage in the appl	icable column	٦.	0. 00	0.00	97.0
18.00 Does title V or XIX follow Medicare (title XVIII) for the int stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" fo			N	N	98. 0
column 1 for title V, and in column 2 for title XIX.	,		, N	Y	00.0
8.01 Does title V or XIX follow Medicare (title XVIII) for the rep C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for tit				Y	98. 0
title XIX. 8.02 Does title V or XIX follow Medicare (title XVIII) for the cal	culation of	observati on	N	Υ	98. 0
bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or for title V, and in column 2 for title XIX.	"N" for no i	n column 1			
28.03 Does title V or XIX follow Medicare (title XVIII) for a critireimbursed 101% of inpatient services cost? Enter "Y" for yes				N	98. 0
for title V, and in column 2 for title XIX. 18.04 Does title V or XIX follow Medicare (title XVIII) for a CAH r			. N	N	98. 0
outpatient services cost? Enter "Y" for yes or "N" for no in in column 2 for title XIX.	column 1 for	title V, an	d		
18.05 Does title V or XIX follow Medicare (title XVIII) and add bac Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in co				Y	98. 0
column 2 for title XIX.				Y	00.0
8.06 Does title V or XIX follow Medicare (title XVIII) when cost r Pts. I through IV? Enter "Y" for yes or "N" for no in column			N	Y	98. 0
column 2 for title XIX. Rural Providers					
05.00 Does this hospital qualify as a CAH? 06.00 of this facility qualifies as a CAH, has it elected the all-i	nelusivo moti	and of paymo	N		105. 0 106. 0
for outpatient services? (see instructions)		. ,			
07.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col.	1. (see insti	ructions) If			107. 0
reimbursed. If yes complete Wkst. D-2, Pt. II.	·	3			100.0
08.00 s this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					108. 0
	Physi cal 1.00	Occupation 2.00	al Speech 3.00	Respi ratory 4.00	-
09.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y"	1.00	2.00	3. 30	7.00	109. 0
for yes or "N" for no for each therapy.					
				1.00	

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider CCN: 15-0018	Period: From 01/01/ To 12/31/		Worksheet Part I Date/Time 5/23/2018	Prepared:
	·	1.00			
11.00 If this facility qualifies as a CAH, did it participate in t Health Integration Project (FCHIP) demonstration for this co "Y" for yes or "N" for no in column 1. If the response to co integration prong of the FCHIP demo in which this CAH is par Enter all that apply: "A" for Ambulance services; "B" for ad- for tele-health services.	st reporting period? Ente lumn 1 is Y, enter the ticipating in column 2.			2.00	111.00
			1. 00	2.00 3.	00
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y"	If column 2 is "E", ente t for long term care (inc s) based on the definitio	r in column Iudes	N		115. 00
17.00 s this facility legally-required to carry malpractice insurno.		r "N" for	Y		117. 00
18.00 is the mal practice insurance a claims-made or occurrence policial m-made. Enter 2 if the policy is occurrence.	icy? Enter 1 if the polic	y is	1		118. 00
	Premi ums	Losse	S	Insurance	9
	1.00	2.00		3.00	
18.01 List amounts of malpractice premiums and paid losses:	643,	704 19	3, 608		0 118. 0
		1. 00		2. 00	
18.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 19.00 DO NOT USE THIS LINE		N			118. 02
20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu. Hold Harmless provision in ACA §3121 and applicable amendmen Enter in column 2, "Y" for yes or "N" for no.	column 1, "Y" for yes or alifies for the Outpatien			N	120. 00
21.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	ntable devices charged to	Y			121. 00
22.00 Does the cost report contain healthcare related taxes as def Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.					122. 00
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" fo yes, enter certification date(s) (mm/dd/yyyy) below.	r yes and "N" for no. If	N			125. 00
26.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2		е			126. 0
27.00 If this is a Medicare certified heart transplant center, ent- in column 1 and termination date, if applicable, in column 2	er the certification date				127. 00
28.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2					128. 00
29.00 f this is a Medicare certified lung transplant center, ente column 1 and termination date, if applicable, in column 2.		in			129. 00
30.00 If this is a Medicare certified pancreas transplant center, date in column 1 and termination date, if applicable, in column 1.00 If this is a Medicare certified intestinal transplant center	umn 2.				130. 00
date in column 1 and termination date, if applicable, in col 32.00 f this is a Medicare certified islet transplant center, ent	umn 2.				132. 0
in column 1 and termination date, if applicable, in column 2 33.00 f this is a Medicare certified other transplant center, ent	er the certification date				133. 00
in column 1 and termination date, if applicable, in column 2 34.00 If this is an organ procurement organization (0P0), enter the and termination date, if applicable, in column 2.					134. 00
All Providers					
40.00 Are there any related organization or home office costs as dichapter 10? Enter "Y" for yes or "N" for no in column 1. If		s Y		15H013	140.00

Health Financial Systems ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0018 Peri od: Worksheet S-2 From 01/01/2017 Part I 12/31/2017 Date/Time Prepared: To 5/23/2018 2:39 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.

Name: BEACON HEALTH SYSTEM | Contractor's Name: WISCONSIN PHYSICIAN | Contractor's Number: 08001 141 00 Name: BEACON HEALTH SYSTEM 141 00 SERVI CES 142.00 Street: 615 N MICHIGAN ST PO Box: 142.00 46601 143.00 City: SOUTH BEND State: Zip Code: 143.00 1.00 144.00 Are provider based physicians' costs included in Worksheet A? 144. 00 1. 00 2.00 145.00|| f costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is 145.00 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? Ν 146, 00 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 3.00 2 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. 00 155.00 Hospi tal Ν Ν Ν N 156.00 Subprovi der - IPF Ν Ν 156. 00 Ν Ν 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF Ν Ν Ν Ν 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν Ν 161.00 161. 10 CORF N 161. 10 1.00 Multicampus 165.00 s 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. CBSA FTE/Campus State Zip Code Name County 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0. 00 166. 00 campus enter the name in column O, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)

		1.00		
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment	Act			
167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no.		Υ	167. 00	
168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), reasonable cost incurred for the HIT assets (see instructions)	enter the	(168. 00	
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)				
169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N transition factor. (see instructions)	0.00	169. 00		
	Begi nni ng	Endi ng		
	1. 00	2.00		
170.00 Enter in columns 1 and 2 the EHR beginning date and ending date for the reporting period respectively (mm/dd/yyyy)	01/01/2017	12/31/2017	170. 00	
	1. 00	2.00		
171.00 If line 167 is "Y", does this provider have any days for individuals enrolled in section 1876 Medicare cost plans reported on Wkst. S-3, Pt. I, line 2, col. 6? Enter "Y" for yes and "N" for no in column 1. If column 1 is yes, enter the number of section 1876 Medicare days in column 2. (see instructions)	N	(171. 00	

	Financial Systems ELKHART GENER AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0018	Peri od: From 01/01/2017 To 12/31/2017	u of Form CMS- Worksheet S-2 Part II Date/Time Pre 5/23/2018 2:3	epared:
				Y/N	Date	
				1. 00	2. 00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format.	l for all NO re	esponses. Ente	er all dates in t	he	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
. 00	Has the provider changed ownership immediately prior to the	beginning of	the cost	N		1.0
	reporting period? If yes, enter the date of the change in c	orullin 2. (See	Y/N	Date	V/I	
			1.00	2.00	3. 00	
. 00	Has the provider terminated participation in the Medicare P yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2.0
. 00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home or medical supply companies) that are related to the provid officers, 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. 0
			Y/N	Type	Date	
	Financial Data and Danarta		1.00	2. 00	3. 00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" for "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.	for Compiled, milable in	Y	A		4.00
	those on the filed financial statements? If yes, submit rec					
				Y/N	Legal Oper.	-
	Approved Educational Activities			1. 00	2.00	_
. 00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	If yes, is th	ne provider is	S N		6.0
. 00	Are costs claimed for Allied Health Programs? If "Y" see in Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		d during the	Y N		7. 0 8. 0
. 00	Are costs claimed for Interns and Residents in an approved		cal education	N		9. 0
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated cost reporting period? If yes, see instructions.		the current	N		10. 0
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11. 0
					Y/N 1. 00	
	Bad Debts				11.00	
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	Y N	12. 0 13. 0
	If line 12 is yes, were patient deductibles and/or co-payme Bed Complement				N	14.0
5. 00	Did total beds available change from the prior cost reporti			tructions. Par	N	15. 0
		Y/N	t A Date	Y/N	Date	
		1. 00	2.00	3. 00	4. 00	
6. 00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16. 0
7. 00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/20/2017	Y	04/20/2017	17. 0
8. 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	N		N		18.0
9. 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. 0

RISPITAL AND HISPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CON: 15-018 Prior of the prior of th	Heal th	Financial Systems ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10		
Description Y/N Y/N Part	HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 15-0018	From 01/01/2017	Part II Date/Time Pre	pared:		
Trille 16 or 17 is yes, seen adjustments made to PSAR REALLOCATIONS FOR CORNECT N N 20.00			Desc	ri pti on		Y/N			
Report data for Other? Describe (the other adjustments: CTC RATIO V/N Date									
21.00 Were new Leases and/or amendments to existing leases entered into during this cost reporting period? If yes, see Instructions instructions. 22.00 Have changes occurred in the Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost in porting period? If yes, see instructions 24.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost in porting period? If yes, see instructions 25.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost in porting period? If yes, see instructions 26.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost in porting period? If yes, see instructions. 27.00 Have there been new capitalized leases entered into during this cost reporting period? If yes, see instructions. 28.00 Were new leases and/or amendments to existing leases entered into during the cost reporting period? If yes, see Instructions. 29.00 Have there been new capitalization policy changed during the cost reporting period? If yes, see Instructions. 29.00 Have the provider have a funded depreciation account and/or bond funds (bebt Service Reserve Fund) N 26.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see Instructions. 29.00 Have changes or new agreements or letters of credit entered into during the cost reporting period? If yes, see Instructions. 30.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Instructions. 31.00 Has debt been recalled before scheduled maturity within the debt period for the bond provider hased physicians? 32.00 Have changes or new agreements occurred in patient care services furnished through contractual in restrictions. 33.00 If it in a 31 is yes, were there new agreements or services furnished through contractual in restrictions. 34.00 If ye	20. 00								
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Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00	30. 00	Has existing debt been replaced prior to its scheduled matu		debt? If yes	s, see	N	30. 00		
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35.00 If ine 34 is yes, were there new agreements or amended existing agreements with the provider-based Y 35.00 physicians during the cost reporting period? If yes, see instructions. Home Office Costs	34. 00		rangement wit	h provider-ba	sed physi ci ans?	Υ	34. 00		
Home Office Costs 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	35. 00	If line 34 is yes, were there new agreements or amended exi		ents with the	provi der-based	Υ	35. 00		
Home Office Costs 36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of N 38.00 If line 36 is yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 39.00 See instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 If line 36 is yes, did the provider render services to the home office. 88.00 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 89.00 See instructions. 40.00 If line 36 is yes, did the provider render services to the home office. 89.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 89.00 See instructions. 40.00 If line 36 is yes, did the provider render services to other chain components? If yes, N 89.00 See instructions. 80.00 See		priyarerana darriig the cost reportriig perrod: 11 yes, see m	13 11 40 11 0113.		Y/N	Date			
36.00 Were home office costs claimed on the cost report? 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 38.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 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, respectively.					1. 00	2. 00			
37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. 38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see 1.00 2.00 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, respectively.	27.00						1 2/ 22		
38.00 If line 36 is yes, was the fiscal year end of the home office different from that of the provider? If yes, enter in column 2 the fiscal year end of the home office. 39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 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, respectively. BRUBAKER 41.00		If line 36 is yes, has a home office cost statement been pr	epared by the	home office?					
39.00 If line 36 is yes, did the provider render services to other chain components? If yes, see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00 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, respectively.	38. 00	If line 36 is yes , was the fiscal year end of the home off			N		38. 00		
40.00 If line 36 is yes, did the provider render services to the home office? If yes, see N 40.00 instructions. 1.00 2.00 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, respectively.	39. 00	If line 36 is yes, did the provider render services to othe			s, N		39. 00		
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. BRUBAKER 41.00	40. 00	If line 36 is yes, did the provider render services to the		40. 00					
Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. BRUBAKER 41.00		THE COLORS							
41.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. BRUBAKER 41.00			00						
held by the cost report preparer in columns 1, 2, and 3, respectively.			la						
	41. 00	held by the cost report preparer in columns 1, 2, and 3,	SALLY		BRUBAKER		41.00		
42.00 Enter the employer/company name of the cost report ELKHART GENERAL HOSPITAL 42.00 preparer.	42. 00	Enter the employer/company name of the cost report	ELKHART GENER	AL HOSPITAL			42. 00		
43.00 Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively. 574-647-3842 SBRUBAKER@BEACONHEALTHSYSTEM 43.00	43. 00	Enter the telephone number and email address of the cost	574-647-3842			ONHEALTHSYSTEM	43. 00		

Heal th	Financial Systems ELKHART GENE	RAL HOSPITAL	In Lie	u of Form CMS-2	552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0018	Period: From 01/01/2017	Worksheet S-2 Part II	
			To 12/31/2017		pared:
		3. 00			
	Cost Report Preparer Contact Information				
41.00	Enter the first name, last name and the title/position	REIMBURSEMENT ANALYST			41.00
	held by the cost report preparer in columns 1, 2, and 3,				
	respecti vel y.				
42.00	Enter the employer/company name of the cost report				42.00
	preparer.				
43.00	Enter the telephone number and email address of the cost				43.00
	report preparer in columns 1 and 2, respectively.				

Heal th	Financial Systems ELKHART GENERAL	L HOSPITAL		Non-CMS HFS Wo	rksheet	
HFS Su	upplemental Information	Provider CCN: 15-0018	Peri od: From 01/01/2017 To 12/31/2017	5/23/2018 2:3	pared:	
			Title V	Title XIX		
			1. 00	2. 00		
	TITLES V AND/OR XIX FOLLOWING MEDICARE					
1. 00	Do Title V or XIX follow Medicare (Title XVIII) for the Inte stepdown adjustments on W/S B, Part I, column 25? Enter Y/N		N	N	1. 00	
	and Y/N in column 2 for Title XIX. (see S-2, Part I, line 98					
2.00	Do Title V or XIX follow Medicare (Title XVIII) for the repo		. N	Υ	2.00	
2.00	Part I (e.g. net of Physician's component)? Enter Y/N in col			'	2.00	
	in column 2 for Title XIX. (see S-2, Part I, line 98.01)	dilli i i i i i i i i e v alid i / iv				
3.00	Do Title V or XIX follow Medicare (Title XVIII) for the calc	ulation of Observation Re	d N	Υ	3.00	
3.00	Cost on W/S D-1, Part IV, line 89? Enter Y/N in column 1 for			'	3.00	
	2 for Title XIX. (see S-2, Part I, line 98.02)	Title v and 1710 in cordin	'			
3. 01	Do Title V or XIX use W/S D-1 for reimbursement?		N	N	3. 01	
0.01	DO THE VOLVEY AND DETERMINATION OF THE PROPERTY.		Inpatient	Outpati ent	0.01	
			1. 00	2. 00		
	CRITICAL ACCESS HOSPITALS		1.00	2.00		
4.00	Does Title V follow Medicare (Title XVIII) for Critical Acce	ss Hospitals (CAH) being	N	N	4.00	
4.00	reimbursed 101% of cost? Enter Y or N in column 1 for inpati			14	4.00	
	for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	cite dila i di N ili coi dili.	=			
5.00	Does Title XIX follow Medicare (Title XVIII) for Critical Ac	cess Hospitals (CAH) bein	n N	N	5.00	
0.00	reimbursed 101% of cost? Enter Y or N in column 1 for inpati				0.00	
	for outpatient. (see S-2, Part I, lines 98.03 and 98.04)	one and i or it in our amin	_			
	Troi barbarronti (666 6 2) rai t 1) rinos voi os ana voi or)		Title V	Title XIX		
			1, 00	2. 00		
	RCE DI SALLOWANCE					
6.00	Do Title V or XIX follow Medicare and add back the RCE Disal	I owance on W/S C. Part I	N	Υ	6.00	
	column 4? Enter Y/N in column 1 for Title V and Y/N in colum					
	S-2, Part I, line 98.05)	•				
	PASS THROUGH COST				1	
7.00	Do Title V or XIX follow Medicare when cost reimbursed (paym	ent system is "0") for	N	Υ	7.00	
	worksheets D, parts I through IV? Enter Y/N in column 1 for	Title V and Y/N in column				
	2 for Title XIX. (see S-2, Part I, line 98.06)					
	RHC					
8.00	Do Title V & XIX impute 20% coinsurance (M-3 Line 16.04)? En	ter Y/N in column 1 for	N	N	8.00	
	Title V and Y/N in column 2 for Title XIX.					
	FOHC					
9.00	For fiscal year beginning on/after 10/01/2014, use M-series	for Title V and/or Title	N	N	9. 00	
	XIX? Enter Y/N in column 1 for Title V and Y/N in column 2 f	or Title XIX.				

| Period: | Worksheet S-3 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared:
 Heal th Financial
 Systems
 ELKHART

 HOSPITAL
 AND
 HOSPITAL
 HEALTH CARE COMPLEX
 STATISTICAL
 DATA
 Provider CCN: 15-0018

					-	Γο 12/31/2017		
							5/23/2018 2:3 I/P Days / 0/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		174	63, 510	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
2 00	for the portion of LDP room available beds)							2 00
2. 00 3. 00	HMO and other (see instructions) HMO IPF Subprovider							2.00
4.00	HMO IRF Subprovider							4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	
6. 00	Hospital Adults & Peds. Swing Bed NF						0	
7. 00	Total Adults and Peds. (exclude observation			174	63, 510	0.00	1	
7.00	beds) (see instructions)				55, 51.	0.00	1	,,,,,,
8.00	INTENSIVE CARE UNIT	31. 00		23	8, 39	0.00	0	8. 00
8. 01	NEONATAL INTENSIVE CARE	31. 01		8	2, 920	0.00	0	8. 01
9.00	CORONARY CARE UNIT	32. 00		0	(0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00	l .	0	(0.00	1	
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	(0.00	0	
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY	43. 00					0	
14.00	Total (see instructions)			205	74, 82	0.00	1	
15. 00 16. 00	CAH visits	40. 00		10	2.45		0 0	
17. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF	40.00	ŀ	10 20	3, 650 7, 300			
18. 00	SUBPROVI DER	41.00		20	7, 300)		18.00
19. 00	SKILLED NURSING FACILITY	44. 00		0	(0	1
20. 00	NURSING FACILITY	45. 00	l .	o		Ď	0	
21. 00	OTHER LONG TERM CARE	46. 00	i .	Ö				21. 00
22. 00	HOME HEALTH AGENCY	101. 00	1				0	
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00						23. 00
24. 00	HOSPI CE	116. 00		0	(D		24. 00
24. 10	HOSPICE (non-distinct part)	30. 00	l .					24. 10
25. 00	CMHC - CMHC	99. 00					0	
25. 10	CMHC - CORF	99. 10	l .				0	
26. 00	RURAL HEALTH CLINIC	88. 00					0	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00		005			0	20.20
27. 00	Total (sum of lines 14-26)			235				27. 00
28. 00	Observation Bed Days						0	28. 00
29. 00 30. 00	Ambulance Trips Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see Histruction)							31.00
32. 00	Labor & delivery days (see instructions)			0	,			32.00
32. 00	Total ancillary labor & delivery room			U	,			32. 00
JZ. U1	outpatient days (see instructions)							32.01
33. 00	LTCH non-covered days							33. 00
33. 01	LTCH site neutral days and discharges							33. 01
	•	. '				•	•	

In Lieu of Form CMS-2552-10

Period:	Worksheet S-3	
From 01/01/2017	Part	
To 12/31/2017	Date/Time Prepared:	5/23/2018 2:39 pm

				'		5/23/2018 2: 3	9 pm
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
			7.00	Pati ents	& Residents	Payrol I	
1 00		6.00	7. 00	8.00	9. 00	10. 00	4 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	13, 010	872	31, 652			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)	6, 292	7, 467				2. 00
3.00	HMO IPF Subprovider	71	894				3.00
4. 00	HMO IRF Subprovider	244	198				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6. 00	Hospital Adults & Peds. Swing Bed NF	Ĭ	0	0			6.00
7. 00	Total Adults and Peds. (exclude observation	13, 010	872	31, 652			7. 00
7.00	beds) (see instructions)	10,010	0,2	0.7,002			/. 00
8.00	INTENSIVE CARE UNIT	1, 927	0	4, 574			8. 00
8. 01	NEONATAL INTENSIVE CARE	0	0	780			8. 01
9.00	CORONARY CARE UNIT	0	0	0			9. 00
10.00	BURN INTENSIVE CARE UNIT	0	0	0			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY		271	2, 461			13. 00
14. 00	Total (see instructions)	14, 937	1, 143	39, 467	0.00	1, 245. 74	14. 00
15. 00	CAH visits	0	0	0			15. 00
16. 00	SUBPROVI DER - I PF	427	82	2, 641	0.00		16. 00
17. 00	SUBPROVIDER - IRF	495	58	1, 428	0.00	13. 22	17. 00
18.00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY	0	0	0	0.00		
20.00	NURSING FACILITY		0	0	0.00		20.00
21. 00	OTHER LONG TERM CARE	0	0	0	0.00		1
22. 00 23. 00	HOME HEALTH AGENCY	٩	٩	U	0. 00 0. 00		22. 00 23. 00
24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE	0	0	0		0.00	1
24. 00	HOSPICE (non-distinct part)		0	0	0.00	0.00	24. 00
25. 00	CMHC - CMHC	0	0	0	0.00	0.00	25. 00
25. 10	CMHC - CORF	0	0	0	0.00		
26. 00	RURAL HEALTH CLINIC	0	0	0			26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00		26. 25
27. 00	Total (sum of lines 14-26)	J	Š	· ·	0.00	1, 275. 91	
28. 00	Observation Bed Days		o	8, 205		., =	28. 00
29. 00	Ambul ance Trips	o		.,			29. 00
30. 00	Employee discount days (see instruction)			319			30.00
31.00	Employee discount days - IRF			8			31.00
32.00	Labor & delivery days (see instructions)	O	256	469			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days	0					33. 00
33. 01	LTCH site neutral days and discharges	0					33. 01

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

				10) 12/31/201/	5/23/2018 2:3	
		Full Time		Di sch	arges		
		Equi val ents			· ·		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	3, 625	240	9, 792	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)			4 075	4 (74		0.00
2.00	HMO and other (see instructions)			1, 375	1, 674		2.00
3.00	HMO I PF Subprovi der				209		3.00
4.00	HMO I RF Subprovi der				21		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8. 00	INTENSIVE CARE UNIT						8. 00
8. 01	NEONATAL INTENSIVE CARE						8. 01
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						13.00
14. 00	Total (see instructions)	0. 00	C	3, 625	240	9, 792	14. 00
15. 00	CAH visits	0.00		3, 023	240	7, 172	15.00
16. 00	SUBPROVIDER - I PF	0. 00	C	72	18	576	16.00
17. 00	SUBPROVIDER - I RF	0. 00	C		5	135	
18. 00	SUBPROVI DER		_]		18. 00
19. 00	SKILLED NURSING FACILITY	0.00					19.00
20.00	NURSING FACILITY	0. 00					20.00
21.00	OTHER LONG TERM CARE	0. 00				0	21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	0. 00					23. 00
24.00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC	0. 00					25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC	0. 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	Ambul ance Trips						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)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)			_			
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01

| Period: | Worksheet S-3 | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0018

					To	12/31/2017		
		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries (from Wkst.	,		5/23/2018 2:3° Average Hourly Wage (col. 4 ÷ col. 5)	9 DIII
				A-6)	3)	col. 4	ŕ	
	PART II - WAGE DATA	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	
	SALARI ES			1				
1. 00	Total salaries (see instructions)	200. 00	76, 376, 645	0	76, 376, 645	2, 653, 897. 00	28. 78	1. 00
2.00	Non-physician anesthetist Part		C	0	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		C	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		77, 455	0	77, 455	508.00	152. 47	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		C	0	_	0. 00 0. 00		4. 01 5. 00
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		C	О	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an approved program)	21. 00	C	0	0	0.00	0. 00	7. 00
7. 01	Contracted interns and residents (in an approved programs)		C	О	О	0.00	0.00	7. 01
8. 00	Home office and/or related organization personnel		C	0	0	0. 00	0. 00	8. 00
9.00	SNF	44. 00	2 0/4 525	0	0	0.00		9. 00
10. 00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		3, 064, 525	28, 246	3, 092, 771	97, 706. 00	31. 65	10. 00
11. 00	Contract Labor: Direct Patient		2, 050, 527	0	2, 050, 527	32, 438. 00	63. 21	11. 00
12. 00	Care Contract labor: Top level management and other management and administrative		C	0	0	0.00	0.00	12. 00
13. 00	services Contract Labor: Physician-Part		434, 584	0	434, 584	2, 641. 00	164. 55	13. 00
14. 00	A - Administrative Home office and/or related orgainzation salaries and		C	О	О	0.00	0. 00	14. 00
14. 01	wage-related costs Home office salaries		8, 892, 334	0	8, 892, 334	264, 879. 00	33. 57	14. 01
14. 02	Related organization salaries		C	0	0	0.00	0. 00	14. 02
15. 00	Home office: Physician Part A - Administrative		C	0	0	0. 00	0.00	15. 00
16. 00	Home office and Contract Physicians Part A - Teaching		C	0	0	0. 00	0. 00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		33, 947, 476	0	33, 947, 476			17. 00
18. 00	instructions) Wage-related costs (other)		53, 000					18. 00
19. 00	(see instructions) Excluded areas		1, 421, 262	0	1, 421, 262			19. 00
20. 00	Non-physician anesthetist Part A		C	0	0			20. 00
21. 00	Non-physician anesthetist Part B		C	0				21. 00
22. 00	Physician Part A - Administrative		С	0	0			22. 00
22. 01	Physician Part A - Teaching		C	0	0			22. 01 23. 00
23. 00 24. 00	Physician Part B Wage-related costs (RHC/FQHC)		C	0	0			24. 00
25. 00	Interns & residents (in an approved program)		C	0	0			25. 00
25. 50	Home office wage-related (core)		3, 804, 386	0	3, 804, 386			25. 50
25. 51	Related organization wage-related (core)		С	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative -		C	0	0			25. 52
25. 53	wage-related (core) Home office & Contract		C	0	0			25. 53
	Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	113, 843					
27. 00	Administrative & General	5. 00	4, 235, 157	0	4, 235, 157	170, 216. 00	24. 88	27. 00

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

					''	0 12/31/2017	5/23/2018 2: 3	
		Wkst. A Line	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
28. 00	Administrative & General under		107, 897	0	107, 897	289. 00	373. 35	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30. 00	Operation of Plant	7. 00	2, 459, 355	0	2, 459, 355			
31. 00	Laundry & Linen Service	8. 00	63, 661	0	63, 661	· ·		
32. 00	Housekeepi ng	9. 00	1, 912, 523	0	1, 912, 523			
33. 00	Housekeeping under contract		0	0	0	0.00	0. 00	33. 00
	(see instructions)							
34. 00	Di etary	10. 00	1, 722, 744	-837, 630	885, 114	· ·		34. 00
35. 00	Di etary under contract (see		0	0	0	0.00	0. 00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	18, 033	837, 630	855, 663			36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0.00		37.00
38. 00	Nursing Administration	13. 00	1, 461, 612	-305, 367	1, 156, 245	32, 146. 00	35. 97	38. 00
39. 00	Central Services and Supply	14. 00	652, 615		652, 615	i i		
40.00	Pharmacy	15. 00	4, 052, 609	-3, 883, 845	168, 764	2, 080. 00	81. 14	40.00
41.00	Medical Records & Medical	16. 00	334, 928	0	334, 928	9, 330. 00	35. 90	41.00
	Records Library							
42.00	Soci al Servi ce	17. 00	1, 225, 506	-28, 246	1, 197, 260			42.00
43. 00	Other General Service	18. 00	0	0	0	0.00	0.00	43. 00

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

					''	0 12/31/2017	5/23/2018 2: 39	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		76, 484, 542	0	76, 484, 542	2, 654, 186. 00	28. 82	1.00
	instructions)							
2.00	Excluded area salaries (see		3, 064, 525	28, 246	3, 092, 771	97, 706. 00	31. 65	2.00
	instructions)							
3.00	Subtotal salaries (line 1		73, 420, 017	-28, 246	73, 391, 771	2, 556, 480. 00	28. 71	3.00
	minus line 2)							
4.00	Subtotal other wages & related		11, 377, 445	0	11, 377, 445	299, 958. 00	37. 93	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		37, 804, 862	0	37, 804, 862	0.00	51. 51	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		122, 602, 324	-28, 246	122, 574, 078	2, 856, 438. 00	42. 91	6. 00
7.00	Total overhead cost (see		18, 360, 483	-4, 217, 458	14, 143, 025	639, 616. 00	22. 11	7.00
	instructions)							

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0018	Peri od: Worksheet S-3
		From 01/01/2017 Part IV

	To 12/31/201	7 Date/Time Prep 5/23/2018 2:39	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS	•	
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 497, 568	1. 00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	14, 166, 667	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST	•	
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	12, 306, 068	8. 02
8. 03	Health Insurance (Purchased)	0	1
9. 00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	215, 097	10.00
	Life Insurance (If employee is owner or beneficiary)	69, 222	
	Accident Insurance (If employee is owner or beneficiary)	0	1
	Disability Insurance (If employee is owner or beneficiary)	367, 906	13. 00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
	'Workers' Compensation Insurance	257, 334	15. 00
16. 00	·	0	ı
	Non cumulative portion)		
	TAXES	•	
17.00	FICA-Employers Portion Only	5, 464, 755	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19. 00	Unemployment Insurance	24, 121	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER	•	
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	9 0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	35, 368, 738	24. 00
	Part B - Other than Core Related Cost		
25. 00	WELLNESS PROGRAM, AWARDS AND RECOGN	53, 000	25. 00
			•

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provider CCN: 15-0018	Peri od: Worksheet S-3
		From 01/01/2017 Part V
		To 12/21/2017 Data/Time Propared:

		To	12/31/2017	Date/Time Pre 5/23/2018 2:3	
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1. 00	Total facility's contract labor and benefit cost		0	0	1.00
2.00	Hospi tal		0	0	2. 00
3.00	Subprovi der - IPF		0	0	3. 00
4. 00	Subprovi der - I RF		0	0	4. 00
5.00	Subprovi der - (0ther)		0	0	5. 00
6. 00	Swing Beds - SNF		0	0	6. 00
7. 00	Swing Beds - NF		0	0	7. 00
8. 00	Hospi tal -Based SNF		0	0	8. 00
9. 00	Hospi tal -Based NF		0	0	9. 00
10. 00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA		0	0	11. 00
12. 00	Separately Certified ASC		0	0	12.00
13. 00	Hospi tal -Based Hospi ce		0	0	13. 00
14. 00	Hospital-Based Health Clinic RHC		0	0	14. 00
15. 00	Hospital-Based Health Clinic FQHC		0	0	15. 00
16. 00	Hospi tal -Based-CMHC		0	0	16. 00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
17. 00	Renal Dialysis		0	0	17. 00
18. 00	Other		0	0	18. 00

	Financial Systems ELKHART GENERAL HOSPI			u of Form CMS-2	
JSPI I	TAL UNCOMPENSATED AND INDIGENT CARE DATA Prov	/ider CCN: 15-0018	Peri od: From 01/01/2017	Worksheet S-10	U
			To 12/31/2017	Date/Time Prep 5/23/2018 2:39	pared 9 pm
				1. 00	
	Uncompensated and indigent care cost computation			1.00	
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided	d by line 202 colum	n 8)	0. 272044	1. (
	Medicaid (see instructions for each line)				
00	Net revenue from Medicaid			21, 824, 906	2. (
00	Did you receive DSH or supplemental payments from Medicaid?			N	3. (
00	If line 3 is yes, does line 2 include all DSH and/or supplemental		ai d?	_	4. (
00	If line 4 is no, then enter DSH and/or supplemental payments from I	Medi cai d		122 5/4 7/4	
00	Medicaid charges Medicaid cost (line 1 times line 6)			123, 564, 766 33, 615, 053	•
00	Difference between net revenue and costs for Medicaid program (line	e 7 minus sum of Li	nes 2 and 5 if	11, 790, 147	
00	<pre>< zero then enter zero)</pre>	c / minas sam or in	nes z ana e, m	11, 7, 70, 117	0.
	Children's Health Insurance Program (CHIP) (see instructions for ea	ach line)			
00	Net revenue from stand-alone CHIP			0	
0. 00	Stand-allone CHIP charges			0	
1.00	Stand-alone CHIP cost (line 1 times line 10)	- 11! ! 0	: e +	0	
2. 00	Difference between net revenue and costs for stand-alone CHIP (line enter zero)	e II minus IIne 9;	ir < zero then	0	12.
	Other state or local government indigent care program (see instructions)	tions for each line)		
3. 00	Net revenue from state or local indigent care program (Not included			76, 327	13.
1. 00	Charges for patients covered under state or local indigent care pro	ogram (Not included	lin lines 6 or	856, 632	14.
	10)				
5. 00	State or local indigent care program cost (line 1 times line 14)	(1:	45! !!	233, 042	•
5. 00	Difference between net revenue and costs for state or local indiger 13; if < zero then enter zero)	nt care program (ii	ne is illinus iine	156, 715	10.
	Grants, donations and total unreimbursed cost for Medicaid, CHIP and instructions for each line)	nd state/Local indi	gent care program	ıs (see	
7. 00		ng charity care		0	17.
3. 00	Government grants, appropriations or transfers for support of hospi			0	
9. 00	Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)	digent care program	s (sum of lines	11, 946, 862	19.
	10, 12, 20, 20, 20, 20, 20, 20, 20, 20, 20, 2	Uni nsured	Insured	Total (col. 1	
		pati ents	pati ents	+ col . 2)	
	Uncompared Care (see instructions for each line)	1.00	2. 00	3. 00	
0. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili	ty 870, 6	73 416, 422	1, 287, 095	20.
	(see instructions)				
1. 00	Cost of patients approved for charity care and uninsured discounts	(see 236, 8	361 416, 422	653, 283	21.
	instructions)	107.0	152 101	2/1 1/4	22
2. 00	Payments received from patients for amounts previously written off charity care	as 107, 9	153, 181	261, 144	22.
3. 00		128, 8	398 263, 241	392, 139	23.
		,			
				1. 00	
1. 00	Does the amount on line 20 column 2, include charges for patient di		of stay limit	N	24.
5. 00	imposed on patients covered by Medicaid or other indigent care properties 24 is yes, enter the charges for patient days beyond the indicate the charges for patient days beyond the indicate the charges for patient days beyond the indicate the charges for patients are considered.		m's length of	0	25.
	stay limit Total bad debt expense for the entire hospital complex (see instru	ctions)		25, 734, 667	26.
00	Medicare reimbursable bad debts for the entire hospital complex (see Fistral	,		731, 010	1
				1, 124, 631	•
5. 00 7. 00 7. 01	Medicare allowable bad debts for the entire hospital complex (see				1
7. 00 7. 01	Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)			24, 610, 036	28.
7. 00	Non-Medicare bad debt expense (see instructions) Cost of non-Medicare and non-reimbursable Medicare bad debt expense	,	s)	24, 610, 036 7, 088, 634	
7. 00 7. 01 3. 00 9. 00 0. 00	Non-Medicare bad debt expense (see instructions)	e (see instructions	5)		29. 30.

Heal th	Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der CC	1	Period: From 01/01/2017 To 12/31/2017		
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +- col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT		0		0 17, 307, 217	17, 307, 217	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		0		3, 123, 090	3, 123, 090	2. 00
3.00	00300 OTHER CAP REL COSTS		0		0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	113, 843	222, 702				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	4, 235, 157	62, 083, 410	66, 318, 56	7 -20, 270, 468		5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0	(0	0	6. 00
7.00	00700 OPERATION OF PLANT	2, 459, 355	9, 064, 703				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	63, 661	941, 550				8.00
9.00	00900 HOUSEKEEPI NG	1, 912, 523	1, 834, 342			3, 746, 865	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	1, 722, 744 18, 033	1, 975, 995				10. 00 11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	10, 033	46, 333		0 1, 613, 064	1, 677, 430	12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	1, 461, 612	752, 493		٥		13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	652, 615	579, 854	1, 232, 46			14. 00
15. 00	01500 PHARMACY	4, 052, 609	12, 630, 657				
16. 00	01600 MEDICAL RECORDS & LIBRARY	334, 928	105, 917			440, 845	16. 00
17. 00	01700 SOCIAL SERVICE	1, 225, 506	765, 277			1, 962, 537	17. 00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0		0 0	o	18. 00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0		0 0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	(0	0	22. 00
23. 00	02300 PARAMED ED PRGM	77, 625	126, 189	203, 81	4 0	203, 814	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	10 251 447	12 24/ /07	21 (00 05	1 (20 740	20.050.207	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	19, 351, 447 3, 543, 039	12, 346, 607 2, 059, 064				30. 00 31. 00
31.00	03101 NEONATAL INTENSIVE CARE	1, 145, 814	350, 410				31.00
32. 00	03200 CORONARY CARE UNIT	1, 143, 014	330, 410	1, 470, 22	2, 347	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0	ا	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	o	Ö		0	l o	34.00
40.00	04000 SUBPROVI DER - I PF	1, 042, 998	377, 604	1, 420, 60	2 188, 471	1, 609, 073	40.00
41.00	04100 SUBPROVI DER - I RF	950, 857	354, 864	1, 305, 72	1 26, 571	1, 332, 292	41.00
43.00	04300 NURSERY	48, 729	20, 636	69, 36	5 2, 352, 999	2, 422, 364	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	(0	0	44.00
45.00	04500 NURSING FACILITY	0	0	(0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0		J 0	0	46. 00
50. 00	05000 OPERATING ROOM	8, 295, 427	34, 989, 791	43, 285, 21	8 -22, 364, 723	20, 920, 495	50. 00
51. 00	05100 RECOVERY ROOM	0	0	10/200/21	0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	O	O		0 0	ol	52.00
53.00		0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 803, 779	4, 042, 309	8, 846, 08	-399, 015	8, 447, 073	54.00
55.00		0	0		0	0	55.00
56. 00	05600 RADI OI SOTOPE	0	0		0	0	56. 00
57. 00	05700 CT SCAN	755, 553	506, 987				57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	342, 691	236, 670	579, 36			58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 409, 561 908, 022	5, 754, 045 10, 186, 392			2, 272, 131 10, 855, 157	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	700,022	10, 160, 372	11, 074, 41	-237, 237 O	0	60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0			0	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1, 040, 194	1, 040, 19	4 0	1, 040, 194	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	o	o		o o	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	1, 110, 153	575, 358	1, 685, 51	1 -205, 194		64. 00
65.00	06500 RESPI RATORY THERAPY	2, 251, 584	1, 364, 547	3, 616, 13	1 -233, 943	3, 382, 188	65.00
66. 00	06600 PHYSI CAL THERAPY	1, 388, 193	445, 948	1, 834, 14	1 5, 089	1, 839, 230	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	478, 466	214, 429				67. 00
68. 00	06800 SPEECH PATHOLOGY	162, 094	52, 622	214, 71	6 0	214, 716	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY	U	0		0 16, 903, 794	14 002 704	70. 00 71. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 16, 903, 794		71.00
			n		18, 655, 908		73.00
72. 00	07300 DRUGS CHARGED TO PATIENTS	1	0		0 0	0	74.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	Ol		l '	ما ما	l ol	75. 00
72. 00 73. 00		0	o		J 01	i 01	75.00
72. 00 73. 00 74. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY	0 0 2, 245, 297	0 1, 283, 385	3, 528, 68	2 -158, 242		
72. 00 73. 00 74. 00 75. 00 76. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY OUTPATIENT SERVICE COST CENTERS	0 0 2, 245, 297	0 1, 283, 385	3, 528, 68.	2 -158, 242	3, 370, 440	76. 00
72. 00 73. 00 74. 00 75. 00 76. 00 88. 00	07400 RENAL DI ALYSIS 07500 ASC (NON-DI STI NCT PART) 03140 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS 08800 RURAL HEALTH CLINIC	0	1, 283, 385 0	3, 528, 68	-158, 242 0 0	3, 370, 440	76. 00 88. 00
72. 00 73. 00 74. 00 75. 00 76. 00 88. 00 89. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0	0		0 0	3, 370, 440	76. 00 88. 00 89. 00
72. 00 73. 00 74. 00 75. 00 76. 00 88. 00 89. 00 90. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 0 0 567, 266	0 0 177, 207	744, 47	0 0 0 0 3 26, 427	3, 370, 440 0 0 770, 900	76. 00 88. 00 89. 00 90. 00
72. 00 73. 00 74. 00 75. 00 76. 00 88. 00 89. 00 90. 00 90. 01	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0	0	744, 47: 407, 21	0 0 0 0 3 26, 427 4 5, 307	3, 370, 440 0 0 770, 900 412, 521	76. 00 88. 00 89. 00 90. 00 90. 01

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der CC		Period: From 01/01/2017 To 12/31/2017		
Cost Center Description	Sal ari es	0ther	Total (col. 1	Reclassi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)		
					(col. 3 +-	
					col . 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0		0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0		0 0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	98. 00
99. 00 09900 CMHC	0	o		0	0	99. 00
99. 10 09910 CORF	o	o		o o	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	o		0 0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	o		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS	•	•				1
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	o		0 0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	o		0 0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	o		0 0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	O	o		0 0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	O	o		0 0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	o	ol		o o	0	111.00
113. 00 11300 I NTEREST EXPENSE		ol		o o	0	113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	o	o		o o	0	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o	o		o o		115. 00
116. 00 11600 HOSPI CE	0	o		0	0	116, 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	75, 383, 600	175, 034, 385	250, 417, 98	5 0	250, 417, 985	
NONREI MBURSABLE COST CENTERS		,,,		-		1
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
191. 00 19100 RESEARCH	ol	ol		0		191. 00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	ol	ol		o o		192. 00
193. 00 19300 NONPALD WORKERS	173, 749	64, 118	237, 86	7 0	237, 867	
193. 01 19301 COMMUNI TY	211, 819	196, 287			408, 106	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	607, 477	4, 234, 886			4, 842, 363	
200.00 TOTAL (SUM OF LINES 118 through 199)	76, 376, 645	179, 529, 676			255, 906, 321	
255. 55 ₁ 1.572 (55 5. ETNES 116 till 6 49 il 177)	. 5, 576, 616	, 527, 676	200, 700, 02	.1	1 200, 700, 021	1200.00

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

Worksheet A Date/Time Prepared: 5/23/2018 2:39 pm

Page				5/23/2018 2: 39) pm
RUMBAN SPRINGE PROTECT CHATT CHATTERS 9,90 7,90 1,90 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,00 1,	Cost Center Description		Net Expenses		
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9 - 00 00 0000 MUSICKETER INS					
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SOLO OSDOO OPERATING ROOM		0	0		46. 00
51.00		4 000 411	14 020 004		E0 00
S2.00 05200 05200 05200 05200 05200 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 05300 0530		1			
S3. 00 05300 ABSTHESI OLOGY 0 0 53. 00		_	0		
S4.00 05400 RADI OLGOY-DI ACNOSTIC C			0		
55.00 05500 RADI OLGCY-THERAPEUTI C 0 0 0 0 0 0 0 0 0	· ·	-45, 887	8, 401, 186		
57. 00 05700 CT SCAN 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 922, 401 55. 00 05900 CARDIJAC CATHETERIZATION -4, 108 2, 268, 023 55. 00 060. 00 06000 LABORATORY 0 10, 855, 157 06. 00 06000 LABORATORY 0 0 0 06100 DBODO LABORATORY 0 0 0 06100 DBODO LABORATORY 0 0 0 0 06100 DBODO LABORATORY 0 0 0 0 0 0 0 0 0		0	· · · · · · · · · · · · · · · · · · ·		
58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI)	56. 00 05600 RADI 0I SOTOPE	o	o		56. 00
59.00 059000 CARDI AC CATHETERIZATION -4,108 2,268,023 59.00 60.00 06000 LABORATORY 0 10,855,157 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 1,040,194 62.00 63.00 08300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 1,480,317 64.00 65.00 06500 RESPI RATORY THERAPY -5,101 3,377,087 65.00 66.00 06600 PHYSI CAL THERAPY -13,070 1,826,160 66.00 67.00 06700 OCCUPATI ONAL THERAPY -1,063 690,976 68.00 68.00 OSBOO SPEECH PATHOLOGY 0 214,716 68.00 69.00 OSPOO SELECTROCARDI OLOGY 0 0 69.00 71.00 O7100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0	57. 00 05700 CT SCAN	0	1, 247, 686		57. 00
60. 00 06000 LABORATORY 0 10, 855, 157 060. 01 06001 BLODD LABORATORY 0 0 0 0 0 0 0 0 0		0			
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0	1 1	-4, 108			59. 00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 1,040,194 062.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 06400 INTRAVENOUS THERAPY 0 1,480,317 065.00 06500 RESPIRATORY THERAPY -5,101 3,377,087 065.00 06500 RESPIRATORY THERAPY -13,070 1,826,160 067.00 06700 0CCUPATI ONAL THERAPY -1,063 690,976 067.00 06900 ELECTROCARDI OLOGY 0 214,716 068.00 06900 ELECTROCARDI OLOGY 0 0 0 07000 ELECTROCARDI OLOGY 0 0 0 07000 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 16,903,794 071.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 18,655,908 073.00 07300 DRUGS CHARGED TO PATI ENTS 0 18,655,908 074.00 07400 REMAL DI ALYSI S 0 0 0 0 0 0 0 0 0	· ·	0	10, 855, 157		
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 1, 040, 194 62. 00 63. 00 66. 00 06300 BLOOD STRING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0		1	0		
63. 00	· ·	0	1 040 104		
64. 00	· · · · · · · · · · · · · · · · · · ·	0	1, 040, 194		
65. 00	· ·	0	1 480 317		
66. 00		-5 101			
67. 00		1			
68. 00		1			
69. 00		1			
71. 00		0	0		
72. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		70. 00
73. 00		0	16, 903, 794		
74. 00		0			
75. 00		0	18, 655, 908		
76. 00 03140 CARDI OLOGY -12, 286 3, 358, 154 76. 00 OUTPATI ENT SERVI CE COST CENTERS 88. 00 08900 RURAL HEALTH CLINI C 0 0 0 89. 00 PEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 90. 00 09000 CLINI C -590 770, 310 90. 00 90. 01 04950 SLEEP CLINI C -3, 855 408, 666 90. 01 91. 00 09100 EMERGENCY -357, 839 11, 969, 773 91. 00		0	0		
SERVICE COST CENTERS	1 1 7	0	0		
88. 00		_12, 286	3, 358, 154		76. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 90. 00 09000 CLINIC -590 770, 310 90. 01 04950 SLEEP CLINIC -3,855 408,666 91. 00 09100 EMERGENCY -357,839 11,969,773					00 00
90. 00 09000 CLI NI C -590 770, 310 90. 00 90. 01 04950 SLEEP CLI NI C -38, 855 408, 666 91. 00 09100 EMERGENCY -357, 839 11, 969, 773 91. 00		1	0		
90. 01 04950 SLEEP CLINIC -3, 855 408, 666 91. 00 09100 EMERGENCY 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91. 00 91	· · · · · · · · · · · · · · · · · · ·	1 -1	770 310		
91. 00 09100 EMERGENCY -357, 839 11, 969, 773 91. 00		1			
		1			
		337,337	,,,,,,,,		
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 Health Financial
 Systems
 ELKHART GRADIUSTMENTS OF TRIAL BALANCE OF EXPENSES
 ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 15-0018

			10 12/31/2017	5/23/2018 2:39 pm
Cost Center Description	Adjustments	Net Expenses		
		For Allocation		
	6. 00	7. 00		
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 09500 AMBULANCE SERVI CES	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
99. 00 09900 CMHC	0	0		99. 00
99. 10 09910 CORF	0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	0	0		105. 00
106. 00 10600 HEART ACQUISITION	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0		111. 00
113.00 11300 INTEREST EXPENSE	0	0		113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115. 00
116. 00 11600 H0SPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-21, 968, 809	228, 449, 176		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
191. 00 19100 RESEARCH	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		192. 00
193.00 19300 NONPALD WORKERS	0	237, 867		193. 00
193. 01 19301 COMMUNI TY	o	408, 106		193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	4, 842, 363		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-21, 968, 809	233, 937, 512		200. 00

| Period: | Worksheet Non-ums w | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/23/2018 2:39 pm |

			5/23/2018 2	
	Cost Center Description	CMS Code	Standard Label For	
			Non-Standard Codes	
		1.00	2. 00	
1. 00	GENERAL SERVICE COST CENTERS	00100		1.00
2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	00100		2.00
3.00	OTHER CAP REL COSTS	00300		3. 00
4.00	EMPLOYEE BENEFITS DEPARTMENT	00400		4. 00
5.00	ADMINISTRATIVE & GENERAL	00500		5. 00
6.00	MAINTENANCE & REPAIRS	00600		6. 00
7. 00 8. 00	OPERATION OF PLANT	00700 00800		7. 00 8. 00
9. 00	LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG	00900		9.00
10. 00	DI ETARY	01000		10.00
11. 00	CAFETERI A	01100		11. 00
12.00	MAINTENANCE OF PERSONNEL	01200		12. 00
13.00	NURSI NG ADMINI STRATI ON	01300		13. 00
14.00	CENTRAL SERVI CES & SUPPLY	01400		14.00
15. 00 16. 00	PHARMACY MEDICAL DECORDS & LIBRARY	01500 01600		15. 00 16. 00
17. 00	MEDI CAL RECORDS & LI BRARY SOCI AL SERVI CE	01700		17. 00
18. 00	OTHER GENERAL SERVICE (SPECIFY)	01850		18. 00
19. 00	NONPHYSI CI AN ANESTHETI STS	01900		19. 00
20.00	NURSI NG SCHOOL	02000		20.00
21. 00	I &R SERVI CES-SALARY & FRI NGES APPRVD	02100		21. 00
22. 00	I &R SERVICES-OTHER PRGM COSTS APPRVD	02200		22. 00
23. 00	PARAMED ED PRGM	02300		23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	03000		30.00
31. 00	INTENSIVE CARE UNIT	03100		31.00
31. 01	NEONATAL INTENSIVE CARE	03101		31. 01
32.00	CORONARY CARE UNIT	03200		32. 00
33.00	BURN INTENSIVE CARE UNIT	03300		33.00
34.00	SURGI CAL INTENSIVE CARE UNIT	03400		34.00
40.00	SUBPROVI DER - I PF	04000		40.00
41. 00 43. 00	SUBPROVI DER	04100 04300		41. 00 43. 00
44. 00	SKILLED NURSING FACILITY	04400		44. 00
45. 00	NURSING FACILITY	04500		45. 00
46.00	OTHER LONG TERM CARE	04600		46. 00
	ANCILLARY SERVICE COST CENTERS	05000		
50. 00 51. 00	OPERATING ROOM RECOVERY ROOM	05000 05100		50. 00 51. 00
52. 00	DELIVERY ROOM & LABOR ROOM	05100		52.00
53. 00	ANESTHESI OLOGY	05300		53. 00
54.00	RADI OLOGY-DI AGNOSTI C	05400		54.00
55.00	RADI OLOGY-THERAPEUTI C	05500		55. 00
56. 00	RADI OI SOTOPE	05600		56. 00
	CT SCAN	05700		57.00
58. 00 59. 00	MAGNETI C RESONANCE I MAGING (MRI) CARDIAC CATHETERIZATION	05800 05900		58. 00 59. 00
60. 00	LABORATORY	06000		60.00
60. 01	BLOOD LABORATORY	06001		60. 01
61.00	PBP CLINICAL LAB SERVICES-PRGM ONLY	06100		61.00
62.00	WHOLE BLOOD & PACKED RED BLOOD CELLS	06200		62. 00
63.00	BLOOD STORING, PROCESSING & TRANS.	06300		63.00
64.00	INTRAVENOUS THERAPY	06400		64.00
65. 00 66. 00	RESPIRATORY THERAPY	06500 06600		65. 00 66. 00
67.00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	06700		67.00
68. 00	SPEECH PATHOLOGY	06800		68. 00
69. 00	ELECTROCARDI OLOGY	06900		69. 00
70.00	ELECTROENCEPHALOGRAPHY	07000		70. 00
71.00	MEDICAL SUPPLIES CHARGED TO PATIENTS	07100		71.00
72.00	IMPL. DEV. CHARGED TO PATIENTS	07200		72.00
73. 00 74. 00	DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	07300 07400		73. 00 74. 00
75. 00	ASC (NON-DISTINCT PART)	07500		75. 00
76. 00	CARDI OLOGY		CARDI OLOGY	76. 00
	OUTPATIENT SERVICE COST CENTERS			
88. 00	RURAL HEALTH CLINIC	08800		88. 00
89. 00	FEDERALLY QUALIFIED HEALTH CENTER	08900		89.00
90. 00 90. 01	CLINIC SLEEP CLINIC	09000 04950		90. 00
	EMERGENCY	09100		91.00
	I · · · · · ·	1 -7.00		

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
COST CENTERS USED IN COST REPORT	Provider CCN: 15-00	8 Period: Worksheet Non-CMS W

		rom 01/01/2017		
	7	Γo 12/31/2017		
Cost Center Description	CMS Code	Standard	5/23/2018 2	2: 39 piii
cost center bescription	CWS code	Non-Standa		
		Non Stand	ara codes	
	1.00	2. (00	
92. 00 OBSERVATION BEDS (NON-DISTINCT PART)	09200			92.00
OTHER REIMBURSABLE COST CENTERS	·			
94. OO HOME PROGRAM DIALYSIS	09400			94. 00
95. 00 AMBULANCE SERVICES	09500			95. 00
96. 00 DURABLE MEDICAL EQUIP-RENTED	09600			96. 00
97. 00 DURABLE MEDICAL EQUIP-SOLD	09700			97. 00
98.00 OTHER REIMBURSABLE COST CENTERS	09850			98. 00
99. 00 CMHC	09900			99. 00
99. 10 CORF	09910			99. 10
100.00 I&R SERVICES-NOT APPRVD PRGM	10000			100.00
101.00 HOME HEALTH AGENCY	10100			101. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 KI DNEY ACQUI SI TI ON	10500			105. 00
106.00 HEART ACQUISITION	10600			106. 00
107.00 LIVER ACQUISITION	10700			107. 00
108.00 LUNG ACQUISITION	10800			108. 00
109.00 PANCREAS ACQUISITION	10900			109. 00
110.00 INTESTINAL ACQUISITION	11000			110. 00
111.00 SLET ACQUISITION	11100			111. 00
113. 00 I NTEREST EXPENSE	11300			113. 00
114.00 UTILIZATION REVIEW-SNF	11400			114. 00
115.00 AMBULATORY SURGICAL CENTER (D. P.)	11500			115. 00
116. 00 H0SPI CE	11600			116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)				118. 00
NONREI MBURSABLE COST CENTERS				
190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	19000			190. 00
191. 00 RESEARCH	19100			191. 00
192.00 PHYSICIANS' PRIVATE OFFICES	19200			192. 00
193. 00 NONPALD WORKERS	19300			193. 00
193. 01 COMMUNI TY	19301			193. 01
194.00 OTHER NONREIMBURSABLE COST CENTERS	07950			194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)				200. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: Worksheet A-6 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/23/2018 2:39 pm Provider CCN: 15-0018

					10	12/31/201/	5/23/2018 2: 39 pm
		Increases					
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	Other 5 00			
	A - I NSURANCE	3.00	4.00	5. 00			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	315, 808			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	o	<u>35, 8</u> 92			2. 00
	0		0	351, 700			
1 00	B - INTEREST	1 00	ما	1 52/ /42			1 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 526, 642			1.00
2.00	INTEREST EXPENSE	113. 00	0	1, 52 <u>6, 6</u> 42 3, 053, 284			2. 00
	C - DI ETARY		<u> </u>	3, 033, 204			
1.00	CAFETERI A	11.00	837, 630	975, 454			1.00
	0		837, 630	975, 454			
4 00	D - CASE MGMT	44 00	22 24				4.00
1. 00	SUBPROVI DER - I RF	41.00	<u>28, 246</u> 28, 246	0			1. 00
	E - SERVICE CONTRACTS		20, 240	O _I			
1.00	OPERATION OF PLANT	7. 00	0	75, 763			1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	38, 984			2. 00
3.00	PHARMACY	15. 00	0	136, 635			3. 00
4.00	ADULTS & PEDIATRICS	30.00	0	13, 321			4.00
5. 00 6. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0	210, 410 1, 683, 692			5. 00 6. 00
7. 00	MAGNETIC RESONANCE I MAGING	58.00	0	343, 200			7. 00
,. 50	(MRI)	30. 00		3 13, 200			,.00
8.00	CARDIAC CATHETERIZATION	59.00	0	448, 699			8. 00
9.00	RESPI RATORY THERAPY	65.00	O	3, 905			9. 00
10.00	PHYSI CAL THERAPY	66.00	0	5, 421			10.00
11.00	CARDI OLOGY	76.00	0	146, 743			11.00
12.00	CLINIC	90.00	0	26, 427			12.00
13. 00 14. 00	SLEEP CLINIC EMERGENCY	90. 01 91. 00	0	5, 600 4, 000			13. 00 14. 00
14.00	0		- — — ў	3, 142, 800			14.00
	H - NURSERY						
1.00	NURSERY	43.00	1, 653, 261	699, 738			1.00
	O 		1, 653, 261	699, 738			
1. 00	ADULTS & PEDIATRICS	30.00	193, 774	70, 027			1. 00
2. 00	RADI OLOGY-DI AGNOSTI C	54.00	111, 593	40, 328			2.00
	0		305, 367	110, 355			
	M - DRUGS CHARGED						
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	14, 772, 063			1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	39			2.00
3. 00 4. 00	1	0. 00 0. 00	0	0			3. 00 4. 00
5. 00		0.00	0	ő			5. 00
6. 00		0.00	Ö	0			6. 00
7.00		0.00	O	0			7. 00
8.00		0. 00	0	0			8. 00
9.00		0.00	0	0			9.00
10.00		0.00	0	0			10.00
11. 00 12. 00	1	0. 00 0. 00	0	0			11. 00 12. 00
13. 00		0.00	0	o			13. 00
14. 00		0.00	o	0			14. 00
15.00		0.00	0	0			15. 00
16.00		0.00	•_	0			16. 00
	O L		0	14, 772, 102			
1. 00	N - RENT CAP REL COSTS-BLDG & FLXT	1.00	0	47, 263			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	Ö	386, 212			2. 00
3.00		0.00	o	0			3.00
4.00		0.00	0	0			4. 00
5.00		0.00	0	0			5. 00
6. 00		0.00	0	0			6. 00
7.00		0.00	0	0			7. 00
8.00		0.00	0	0			8.00
9. 00		0.00		000			9. 00
	O - SUPPLIES AND IMPLANTS		<u> </u>	·			
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	16, 903, 794			1. 00
0.00	PATI ENTS	70.00		11 004 (7)			0.05
2. 00	I MPL. DEV. CHARGED TO PATIENTS	72. 00	0	11, 004, 676			2. 00
3. 00	TATI ENTS	0.00	О	0			3. 00
4.00		0.00	o	0			4. 00
	· · · · · · · · · · · · · · · · · · ·	<u>'</u>					·

Health Financial Systems RECLASSIFICATIONS ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0018

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

					5/23/2	018 2:39 pm
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4.00	5. 00		
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10. 00
11.00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15.00		0.00	0	0		15. 00
	0		0	27, 908, 470		
	P - DEPRECIATION					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	15, 383, 227		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	0_	<u>2, 461, 7</u> 29		2. 00
	0		0	17, 844, 956		
	Q - LAB					
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0_	23 <u>9, 2</u> 57		1. 00
	0		0	239, 257		
	R - PHARMACY					
1.00	DRUGS CHARGED TO PATIENTS		3, 883, 845	0		1. 00
	0		3, 883, 845	0		
	S - AMORTIZATION					
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0_	3 <u>4, 2</u> 77		1. 00
	0		0	34, 277		
	T - BENEFIT ALLOCATION					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0_	37 <u>3, 9</u> 20		1. 00
	0		0	373, 920		
	U - PHYS FEE					
1.00	ADULTS & PEDIATRICS	30.00	0	667, 102		1. 00
2.00	INTENSIVE CARE UNIT	31.00	0	128, 761		2. 00
3.00	SUBPROVI DER - I PF	4000	0_	18 <u>9, 0</u> 63		3. 00
	0		0	984, 926		
500.00	Grand Total: Increases		6, 708, 349	70, 924, 714		500.00

RECLASSI FI CATIONS

Provider CCN: 15-0018

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

5/23/2018 2:39 pm Decreases Cost Center Sal ary 0ther Wkst. A-7 Ref. Line # 6.00 7.00 8.00 9.00 10.00 - INSURANCE 1.00 ADMINISTRATIVE & GENERAL 5.00 0 351, 700 12 1.00 2.00 2.00 0.00 12 351, 700 B - INTEREST 1.00 INTEREST EXPENSE 113.00 0 1, 526, 642 11 1.00 ADMINISTR<u>ATI</u>VE & G<u>ENE</u>RAL 2.00 1, 526, 642 2.00 5.00 0 3, 053, 284 DI ETARY 10. 00 1.00 DI ETARY 837, 630 975, 454 0 1.00 975, 454 837, 630 D - CASE MGMT 1.00 SOCIAL SERVICE 17.00 28, 246 0 1.00 28, 246 ō - SERVICE CONTRACTS 1.00 OPERATION OF PLANT 7.00 3, 142, 800 0 1.00 2.00 0.00 o 0 2.00 3.00 0.00 0 0 0 3.00 0 0 4 00 0 00 0 4 00 5.00 0.00 0 0 0 5.00 o 0 6.00 0.00 6.00 0 0.00 0 7.00 0 7.00 8.00 0.00 0 0 0 8.00 9.00 0.00 0 0 9.00 0.00 0 0 10.00 10.00 0 11.00 0.00 0 0 0 11 00 12.00 0.00 0 0 0 12.00 0 13.00 0.00 0 13.00 14.00 14.00 0.00 0 3, 142, 800 NURSERY 1.00 ADULTS & PEDIATRICS 30.00 1, 653, 261 699, 738 0 1.00 1, 653, 261 699, 738 ONCOLOGY 1.00 NURSING ADMINISTRATION 13.00 110, 355 0 305, 367 1.00 2.00 0 0.00 2.00 305, 367 110, 355 M - DRUGS CHARGED 1.00 ADMINISTRATIVE & GENERAL 5. 00 379 1.00 2.00 PHARMACY 15.00 0 11, 518, 855 0 2.00 3.00 ADULTS & PEDIATRICS 0 30.00 0 86, 407 3.00 4.00 INTENSIVE CARE UNIT 31.00 0 36, 214 0 4.00 NEONATAL INTENSIVE CARE 0 5.00 31.01 472 5.00 SUBPROVI DER - I PF SUBPROVI DER - I RF 40.00 o 507 0 6.00 6.00 0 7.00 41.00 0 312 7.00 8.00 OPERATING ROOM 50.00 170, 817 0 8.00 9.00 RADI OLOGY-DI AGNOSTI C 54.00 0 890, 207 0 9.00 0 57.00 10.00 10.00 CT SCAN 1, 125 0 11.00 CARDIAC CATHETERIZATION 59.00 0 1, 551, 343 11.00 12.00 INTRAVENOUS THERAPY 64.00 0 5, 271 0 12.00 RESPIRATORY THERAPY 0 0 13 00 65 00 219, 176 13 00 PHYSICAL THERAPY 0 0 14.00 66.00 14.00 15.00 CARDI OLOGY 76.00 0 257, 722 0 15.00 91.00 16.00 EMERGENCY 0 33, 286 0 16.00 14, 772, 102 1.00 ADMINISTRATIVE & GENERAL 5.00 0 138, 594 10 1.00 2.00 OPERATION OF PLANT 7.00 0 4, 592 10 2.00 LAUNDRY & LINEN SERVICE 0 97 105 3 00 8 00 10 3 00 4.00 OPERATING ROOM 50.00 0 7, 553 10 4.00 5.00 RADI OLOGY-DI AGNOSTI C 54.00 o 10 112, 346 5.00 57.00 0 13, 729 6.00 CT SCAN 10 6.00 0 7.00 CARDIAC CATHETERIZATION 59.00 12,000 10 7.00 8.00 CARDI OLOGY 76.00 0 47, 263 10 8.00 SLEEP CLINIC 9.00 90.01 293 10 9.00 ō 433, 475 - SUPPLIES AND IMPLANTS 1.00 DI ETARY 10.00 0 220 0 1.00 0 0 2.00 ADULTS & PEDIATRICS 30.00 144, 566 2.00 INTENSIVE CARE UNIT 0 3.00 31.00 105, 481 0 3.00 0 4.00 NEONATAL INTENSIVE CARE 31.01 0 1,877 4.00 SUBPROVIDER - IPF 5.00 40.00 0 85 0 5.00 SUBPROVIDER - IRF 41.00 0 1.363 0 6.00 6.00 OPERATING ROOM 22, 396, 763 7.00 50.00 7.00

Health Financial Systems RECLASSIFICATIONS ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0018

						10 12/31/2017	5/23/2018 2:39 pm
		Decreases					
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 232, 075	()	8. 00
9. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	0	160	(9. 00
10.00	CARDI AC CATHETERI ZATI ON	59.00	0	3, 776, 831	C		10.00
11. 00	INTRAVENOUS THERAPY	64.00	0	199, 923)	11.00
12.00	RESPIRATORY THERAPY	65.00	0	18, 672	C)	12.00
13.00	PHYSI CAL THERAPY	66. 00	0	323)	13. 00
14.00	OCCUPATI ONAL THERAPY	67. 00	0	856)	14. 00
15. 00	EMERGENCY	<u>91.</u> 00		2 <u>9, 2</u> 75			15. 00
	0		0	27, 908, 470			
	P - DEPRECIATION						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	17, 844, 956	ç		1. 00
2.00				0		2	2. 00
	0		0	17, 844, 956			
	Q - LAB				1	al .	
1. 00	LABORATORY	6000		239, 257		<u> </u>	1. 00
	0		0	239, 257			
4 00	R - PHARMACY	45.00	0.000.045				1.00
1. 00	PHARMACY	15.00	3, 883, 845	0		<u>) </u>	1.00
	U		3, 883, 845	0			
1 00	S - AMORTI ZATI ON	F 00	ما	24 277	1 11	T	1 00
1. 00	ADMI NI STRATI VE & GENERAL			3 <u>4, 2</u> 77 34, 277		1	1. 00
	T - BENEFIT ALLOCATION		U	34, 211			
1. 00	ADMINISTRATIVE & GENERAL	5. 00	٥	373, 920		<u></u>	1.00
1.00	ADWI NI 31 KATI VE & GENERAL		— — — }	37 <u>3, 9</u> 20 373, 920		<u>'</u>	1.00
	U - PHYS FEE		<u> </u>	373, 720			
1. 00	EMERGENCY	91.00	ا ا	984, 926			1.00
2. 00	LINEROLING	0.00	0	704, 720 O			2.00
3. 00		0.00	0	0			3.00
3.00		— — 	— — — }	984, 926	<u> </u>	Ĥ	3.00
500 00	Grand Total: Decreases		6, 708, 349	70, 924, 714		†	500.00
500.00	DOOI 04303	ı	0, 700, 047	.0, ,2 1, / 17	l .	1	1 555. 66

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

						To	o 12/31/2017	Date/Time Pre 5/23/2018 2:3	
	Coot Conton	I ncre		O+b o =	Coot Contor	Decrea		0+bas	
	Cost Center 2.00	Li ne #	Sal ary 4.00	0ther 5.00	Cost Center 6.00	Li ne #	Sal ary 8.00	0ther 9.00	
	A - I NSURANCE	3.00	4.00	3.00	0.00	7.00	0.00	7. 00	
1.00	CAP REL COSTS-BLDG &	1. 00	0	315, 808	ADMINISTRATIVE &	5. 00	0	351, 700	1. 00
2.00	FIXT CAP REL COSTS-MVBLE	2. 00	o	35, 892	GENERAL	0.00	0	0	2. 00
2.00	EQUIP	2.00	o o	33, 692		0.00	٩	U	2.00
	0			351, 700	0			351, 700	
	B - INTEREST	1 4 00	ما	1.50/./10	LUTEDEOT EVERNOE	1440 00		1 504 440	
1. 00	CAP REL COSTS-BLDG &	1. 00	0	1, 526, 642	INTEREST EXPENSE	113. 00	0	1, 526, 642	1. 00
2.00	INTEREST EXPENSE	113. 00	0	1, 526, 642	ADMINISTRATIVE &	5.00	o	1, 526, 642	2. 00
					GENERAL	\perp			
	O C - DIETARY		0	3, 053, 284	[0		0	3, 053, 284	
1. 00	CAFETERI A	11.00	837, 630	975, 454	DI ETARY	10.00	837, 630	975, 454	1. 00
	0		837, 630	975, 454			837, 630	975, 454	
1 00	D - CASE MGMT	44 00	20. 24/		COCLAL CERVICE	17.00	20. 24/	0	1 00
1. 00	SUBPROVI DER - I RF	41.00	2 <u>8, 2</u> 46 28, 246		SOCIAL SERVICE	17.00	<u>28, 246</u> 28, 246	0	1. 00
	E - SERVICE CONTRACTS	1	20, 2.10		<u> </u>		20, 2.0	Ü	
1.00	OPERATION OF PLANT	7. 00	0		OPERATION OF PLANT	7. 00	0	3, 142, 800	1. 00
2. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	38, 984		0.00	0	0	2. 00
3. 00	PHARMACY	15. 00	0	136, 635		0.00	o	О	3. 00
4.00	ADULTS & PEDIATRICS	30. 00	0	13, 321		0.00	o	О	4. 00
5.00	OPERATING ROOM	50.00	0	210, 410		0.00	0	0	5. 00
6. 00 7. 00	RADI OLOGY-DI AGNOSTI C MAGNETI C RESONANCE	54. 00 58. 00	0	1, 683, 692 343, 200		0.00	0	0	6. 00 7. 00
7.00	I MAGING (MRI)	30.00		343, 200		0.00	Y	ď	7.00
8.00	CARDI AC	59. 00	0	448, 699		0.00	o	О	8. 00
9. 00	CATHETERI ZATI ON RESPI RATORY THERAPY	65. 00		3, 905		0.00		0	9. 00
9. 00 10. 00	PHYSICAL THERAPY	66. 00	0	5, 421		0.00	0	0	10. 00
11. 00	CARDI OLOGY	76. 00	Ö	146, 743		0.00	Ö	Ö	11. 00
12.00	CLINIC	90.00	0	26, 427		0.00	O	0	12. 00
13.00	SLEEP CLINIC	90. 01	0	5, 600		0.00	0	0	13.00
14. 00	EMERGENCY	91.00	— — — o	<u>4, 000</u> 3, 142, 800		0.00		0 3, 142, 800	14. 00
	H - NURSERY		-1	37 : 127 333			-1	27 * 127 222	
1.00	NURSERY	43. 00	1, 653, 261		ADULTS & PEDI ATRI CS	30.00	1, 653, 261	699, 738	1. 00
	I - ONCOLOGY		1, 653, 261	699, 738	[0		1, 653, 261	699, 738	
1. 00	ADULTS & PEDIATRICS	30.00	193, 774	70, 027	NURSI NG	13.00	305, 367	110, 355	1. 00
					ADMINISTRATION				
2. 00	RADI OLOGY-DI AGNOSTI C	54. 00	11 <u>1, 5</u> 93 305, 367	4 <u>0, 3</u> 28 110, 355		0.00	000305, 367	00 110, 355	2. 00
	M - DRUGS CHARGED		305, 367	110, 333	ju		305, 307	110, 355	
1.00	DRUGS CHARGED TO	73. 00	0		ADMINISTRATIVE &	5.00	0	379	1. 00
2.00	PATI ENTS	14 00			GENERAL	15 00		11 510 055	2 00
2. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	39	PHARMACY	15. 00	0	11, 518, 855	2. 00
3.00	001121	0.00	0	0	ADULTS & PEDIATRICS	30.00	o	86, 407	3. 00
4.00		0. 00	0		INTENSIVE CARE UNIT	31.00	0	36, 214	4. 00
5. 00		0. 00	0	0	NEONATAL INTENSIVE	31. 01	0	472	5. 00
6. 00		0. 00	o	0	CARE SUBPROVI DER - I PF	40.00	o	507	6. 00
7. 00		0.00	O		SUBPROVIDER - IRF	41.00	ō	312	7. 00
8.00		0. 00	0		OPERATING ROOM	50.00	0	170, 817	8. 00
9. 00 10. 00		0.00	0		RADI OLOGY-DI AGNOSTI C CT SCAN	54. 00 57. 00	0	890, 207	9. 00 10. 00
11. 00		0.00	0		CARDI AC	59.00	ol ol	1, 125 1, 551, 343	11. 00
			1		CATHETERI ZATI ON			1, 551, 515	
12.00		0.00	0		INTRAVENOUS THERAPY	64.00	0	5, 271	12.00
13. 00 14. 00		0.00	0		RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00 66. 00	0	219, 176	13. 00 14. 00
15. 00		0.00	0		CARDI OLOGY	76.00	Ö	257, 722	15. 00
16.00		0. 00	0	0	EMERGENCY	91.00		3 <u>3, 2</u> 86	16. 00
	O N DENT		0	14, 772, 102	0		0	14, 772, 102	
1. 00	N - RENT CAP REL COSTS-BLDG &	1.00	ol	47 263	ADMINISTRATIVE &	5.00	O	138, 594	1. 00
50	FIXT	55	J		GENERAL	3.33	Ĭ	.00,074	00
2.00	CAP REL COSTS-MVBLE	2. 00	0	386, 212	OPERATION OF PLANT	7. 00	0	4, 592	2. 00
3. 00	EQUI P	0.00	o	0	LAUNDRY & LINEN	8.00	0	97, 105	3. 00
3.00		0.00	9	0	SERVI CE	0.00	ď	77, 103	3.00
4.00		0. 00	0	0	OPERATING ROOM	50.00	0	7, 553	4. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet A-6
From 01/01/2017	Non-CMS Worksheet
To 12/31/2017	Date/Time Prepared:
5/23/2018 2:39 pm	

							72/31/201/	5/23/2018 2: 3	
		Increa	ises			Decrea	ases		
	Cost Center	Line #	Sal ary	0ther	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3. 00	4. 00	5. 00	6. 00	7. 00	8. 00	9. 00	
5.00		0. 00	0		O RADI OLOGY-DI AGNOSTI C	54.00	0	112, 346	5. 00
6. 00		0.00	0		OCT SCAN	57.00	0	13, 729	6. 00
7.00		0. 00	0		O CARDI AC	59.00	0	12, 000	7. 00
0.00		0.00			CATHETERI ZATI ON	7, 00		47.040	0.00
8.00		0.00	0		O CARDI OLOGY	76.00	0	47, 263	8. 00
9. 00		0. 00		 -	OSLEEP CLINIC	90. 01	•		9. 00
	O CURRILLES AND LINE A	NTC	0	433, 47	'5 0		0	433, 475	
1 00	O - SUPPLIES AND IMPLA MEDICAL SUPPLIES		ما	1/ 002 70	A DI ETADY	10.00	ما	220	1 00
1. 00	CHARGED TO PATIENTS	71. 00	0	16, 903, 79	04 DI ETARY	10.00	0	220	1. 00
2. 00	IMPL. DEV. CHARGED TO	72. 00	o	11 004 47	6 ADULTS & PEDIATRICS	30.00	0	144, 566	2. 00
2.00	PATIENTS	72.00	۷	11,004,67	OADULIS & PEDIATRICS	30.00	۷	144, 300	2.00
3.00	I ATTENTS	0.00	0		OINTENSIVE CARE UNIT	31.00	0	105, 481	3. 00
4. 00		0.00	0		ONEONATAL INTENSIVE	31.00	0	1, 877	4. 00
4.00		0.00	٩		CARE	31.01	٩	1,077	4.00
5.00		0.00	0		OSUBPROVI DER - I PF	40.00	0	85	5. 00
6. 00		0.00	ol		OSUBPROVI DER - I RF	41.00	0	1, 363	6. 00
7. 00		0.00	o		O OPERATI NG ROOM	50.00	o	22, 396, 763	7. 00
8.00		0.00	o		O RADI OLOGY-DI AGNOSTI C	54.00	o	1, 232, 075	8. 00
9.00		0.00	o		OMAGNETIC RESONANCE	58. 00	o	160	9. 00
					IMAGING (MRI)				
10.00		0.00	o		O CARDI AC	59.00	О	3, 776, 831	10.00
					CATHETERI ZATI ON				
11.00		0.00	0		O I NTRAVENOUS THERAPY	64.00	0	199, 923	11.00
12.00		0.00	0		O RESPIRATORY THERAPY	65.00	0	18, 672	12.00
13.00		0. 00	0		O PHYSI CAL THERAPY	66.00	0	323	13.00
14.00		0. 00	0		O OCCUPATIONAL THERAPY	67.00	0	856	14. 00
15. 00		0. 00	0		O EMERGENCY	91.00	0_	2 <u>9, 2</u> 75	15. 00
	0		0	27, 908, 47	<u>'0 0</u>		0	27, 908, 470	
	P - DEPRECIATION								
1.00	CAP REL COSTS-BLDG &	1. 00	0	15, 383, 22	27 ADMINISTRATIVE &	5. 00	0	17, 844, 956	1. 00
2 00	FIXT	2 00		0 4/1 70	GENERAL	0.00		0	2 00
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2, 461, 72	[9]	0.00	0	0	2. 00
	0	_			560 — — — —	-			
	Q - LAB		<u> </u>	17,044,70	10 0		<u> </u>	17, 044, 730	
1.00	CAP REL COSTS-MVBLE	2. 00	0	239 25	57 LABORATORY	60.00	0	239, 257	1. 00
	EQUI P								
	0 — — — —			239, 25	570 — — — —			239, 257	
	R - PHARMACY				•		<u> </u>		
1.00	DRUGS CHARGED TO	73. 00	3, 883, 845		OPHARMACY	15. 00	3, 883, 845	0	1.00
	PATI ENTS				<u></u>				
	0		3, 883, 845		0 0		3, 883, 845	0	
	S - AMORTI ZATI ON		_1				_1		
1. 00	CAP REL COSTS-BLDG &	1. 00	0	34, 27	77 ADMINISTRATIVE &	5. 00	0	34, 277	1. 00
	FIXT				GENERAL	-			
	T - BENEFIT ALLOCATION		U]	34, 27	7/0		U]	34, 277	
1.00	EMPLOYEE BENEFITS	4. 00	0	373 03	O ADMINISTRATIVE &	5.00	0	373, 920	1. 00
1.00	DEPARTMENT	4.00	٩	373, 72	GENERAL	3.00	٩	373, 720	1.00
	0			373, 92		- $+$		373, 920	
	U - PHYS FEE	I	-1	2.27.1			-1	0.07.120	
1.00	ADULTS & PEDIATRICS	30.00	0	667, 10	2 EMERGENCY	91.00	0	984, 926	1.00
2.00	INTENSIVE CARE UNIT	31. 00	Ö	128, 76	•	0.00	ol	0	2. 00
3.00	SUBPROVI DER - I PF	40.00	O	189, 06	•	0.00	ol	0	3. 00
	0 — — — —	-		984, 92			o	984, 926	
500.00	Grand Total:		6, 708, 349		4 Grand Total:		6, 708, 349	70, 924, 714	500.00
	Increases				Decreases				
		•	· ·			•		•	

				10	12/31/201/	5/23/2018 2:39	
				Acqui si ti ons		0,20,2010 210	, <u>p</u>
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	3, 943, 259	203, 648	0	203, 648	0	1. 00
2.00	Land Improvements	818, 187	129, 856	0	129, 856	0	2. 00
3.00	Buildings and Fixtures	193, 237, 684	448, 151	0	448, 151	0	3. 00
4.00	Building Improvements	52, 805, 190	3, 379, 945	0	3, 379, 945	0	4. 00
5.00	Fi xed Equipment	83, 231, 592	12, 359, 546	0	12, 359, 546	1, 523, 776	5. 00
6.00	Movable Equipment	19, 354, 173	438, 739	0	438, 739	9, 000	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	353, 390, 085	16, 959, 885	0	16, 959, 885	1, 532, 776	
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	353, 390, 085	16, 959, 885	0	16, 959, 885	1, 532, 776	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	4, 146, 907	0				1. 00
2.00	Land Improvements	948, 043	468, 497				2. 00
3.00	Buildings and Fixtures	193, 685, 835	5, 745, 786				3. 00
4.00	Building Improvements	56, 185, 135	26, 867, 500				4. 00
5.00	Fixed Equipment	94, 067, 362	31, 282, 291				5. 00
6.00	Movable Equipment	19, 783, 912	6, 379, 857				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	368, 817, 194	70, 743, 931				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	368, 817, 194	70, 743, 931				10.00

Health Financial Systems	ELKHART GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der C		Period: From 01/01/2017 To 12/31/2017		pared:		
	SUMMARY OF CAPITAL							
Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)				
	9. 00	10.00	11. 00	12.00	13. 00			
PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2								
1.00 CAP REL COSTS-BLDG & FLXT	0	0)	0	0	1.00		
2.00 CAP REL COSTS-MVBLE EQUIP	0	0)	0	0	2. 00		
3.00 Total (sum of lines 1-2)	0	0		0 0	0	3. 00		
	SUMMARY OF	F CAPITAL						
Cost Center Description	0ther	Total (1) (sum						
	Capi tal -Rel ate	of cols. 9						
	d Costs (see	through 14)						
	instructions)							
	14.00	15. 00						
PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	nd 2					
1.00 CAP REL COSTS-BLDG & FLXT	0	0				1.00		
2.00 CAP REL COSTS-MVBLE EQUIP	0	0)			2. 00		
3.00 Total (sum of lines 1-2)	o	0)			3. 00		

Health Financial Systems		ELKHART GENERAL HOSPITAL			In Lieu of Form CMS-2552-10		
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der Co		Peri od:	Worksheet A-7	
					From 01/01/2017 To 12/31/2017	Part III Date/Time Pre	nared:
						5/23/2018 2: 3	
		COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col .			
		1.00	2.00	2) 3, 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI		2.00	3.00	4.00	5.00	
1.00	CAP REL COSTS-BLDG & FLXT	349, 033, 281	409, 176	348, 624, 10	0. 946299	0	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	19, 783, 912				l o	2. 00
3. 00	Total (sum of lines 1-2)	368, 817, 193	l .				3. 00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF				F CAPITAL		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate d Costs	cols. 5 through 7)			
		6. 00	7.00	8. 00	9. 00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FLXT	0	0	(15, 383, 227	393, 994	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		2, 461, 729	1, 731, 848	2.00
3.00	Total (sum of lines 1-2)	0	0	(17, 844, 956	2, 125, 842	3. 00
	SUMMARY OF CAPITAL						
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	·		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
	DART III DECONCILIATION OF CARLTAL COCTO OF	11.00	12.00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CENTERS .00 CAP REL COSTS-BLDG & FIXT 1, 560, 919 315, 808 0 -1, 128, 207 16, 525, 74						1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1, 300, 919	35, 892		239, 257		2.00
3.00	Total (sum of lines 1-2)	1, 560, 919			-888, 950		
	1 (1 .,, , , ,	1 22.,,700		-1		

| Peri od: | Worksheet A-8 | From 01/01/2017 | Date/Time Prepared: | Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0018

Fapers Classed Figation - 98 Wish-Sheet A Fame					j	To 12/31/2017	Date/Time Prep 5/23/2018 2:30	
Cost Center Description Basis/Code (2)							0, 20, 20, 6 2, 6	, p
1.00 Investment Income CAP RF 2)					10/From Which the Amount is	to be Adjusted		
1.00 Investment Income CAP RF 2)								
1.00 Investment Income CAP RF 2)								
1.00 Investment income - CAP REL OCAP REL COSIS-BUIG 8 FIX 1.00 0 1.00 0 2.00 0 2.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0 3.00 0		Cost Center Description						
Investment income - CAP REL OCAP REL COSTS-WBLE EQUIP 2.00 0 2.00	1. 00	Investment income - CAP REL	1.00					1. 00
CRISTS WHILE FOUR P (chapter 2) 0	2 00			0	CAD DEL COSTS_MVRIE FOLLID	2 00	0	2 00
Chapter 2) 4		COSTS-MVBLE EQUIP (chapter 2)		0	CAL REE GOSTS WINDEL EQUIT			
1.00 Control	3. 00			0		0.00	0	3. 00
Second	4.00	Trade, quantity, and time	В	-140, 965	ADMINISTRATIVE & GENERAL	5. 00	0	4. 00
Sental of provider space by 0 0.00 0.6.00 0.00 0.6.00 0.00 0.7.00 0.00 0.7.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	5.00		В	-704, 474	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
Supplier's (chapter 8)	6 00			0		0.00	0	6 00
Stations excluded) (Chépter 27)		suppliers (chapter 8)		0				
217	7. 00			0		0.00	0	7. 00
Chapter 21) 0		21)						
10.00 Provider-based physician A=B-2 -2,573,014 0 10.00 0 11.00	8.00	II.		0		0.00	U	8.00
adjustment			4.0.2	0 573 014		0.00	-	
Chapter 23)	10.00	adjustment	A-0-2	-2, 573, 014			U	10.00
12.00 Related organization 13.00 Laundry and I linen service 8 -151,637 LAUNDRY & LINEN SERVICE 8.00 0 13.00	11. 00			0		0.00	0	11. 00
13.00 Laundry and I linen service B -151,637 LAUNDRY & LINEN SERVICE 8.00 0.13.00 15.00 16.00 16.00 17.00 16.00 17.00 16.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00 17.00	12. 00	Related organization	A-8-1	2, 359, 616			0	12. 00
14.00 Caffetria-employees and guests B -442,442CAFETERIA 11.00 0 14.00	13. 00		В	-151, 637	LAUNDRY & LINEN SERVICE	8. 00	0	13. 00
and others' 16.00 Sale of medical and surgical supplies to other than patients 17.00 Sale of drugs to other than patients 18.00 Sale of drugs to other than patients 18.00 Sale of a supplies to other than patients 18.00 Sale of finding the surgicial supplies to other than patients 18.00 Sale of finding the surgicial supplies to other than patients 19.00 Nursing and all ied heal the education (full tion, fees, books, etc.) 20.00 Vending machines 20.00 Vending machines 20.00 Vending machines 20.00 Income from imposition of interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of linitation (chapter 14) 24.00 Adjustment for physical substantial	14. 00	Cafeteria-employees and guests	В			11.00	-	14. 00
Supplies to other than Datients Datien	15.00			0		0.00	U	15.00
patients patients	16. 00			0		0.00	0	16. 00
patients		patients						
18.00 Sale of medical records and abstracts 0 0 0 0 0 0 0 0 18.00 0 18.00 0 0 0 0 0 0 19.00 0 0 0 0 0 0 0 0 0	17. 00		В	-179, 950	PHARMACY	15. 00	0	17. 00
19.00 Nursing and all lied health education (tuit tion, fees, books, etc.) 20.00 Vending machines 0 0.00 0.00 0.00 0.00 0.20.00	18. 00	Sale of medical records and		0		0.00	0	18. 00
Dooks, etc.) O Vending machines O Co.00 O O O O O O O O O	19. 00	1		0		0.00	0	19. 00
20.00 Vending machines 0 0.00 0.00 0.20.00		,						
interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare overpayments and borrowings to repay Medicare overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT COSTS-BLDG & FIXT COSTS-BLDG & FIXT COSTS-MVBLE EQUIP 27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist ON Non-physicians' assistant ON COMPHYSICIAN ANESTHETISTS ON COSTS-BLDG & FIXT ON COSTS-BLDG &		Vending machines		0			-	
Charges (chapter 21) Chapter 14) Chapter 17) Chapter 18) Chapter 19) Chapter 19) Chapter 21) Chapter 22) Chapter 23) Chapter 24) Chapter 24) Chapter 25) Chapter 26) Chapter 26) Chapter 27) Chapter 27) Chapter 28.00 Chapter 28.00 Chapter 28.00 Chapter 28.00 Chapter 29.00 Chapte	21. 00			0		0.00	0	21. 00
overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	00.00	charges (chapter 21)				0.00		00.00
Page Medicare overpayments A-8-3 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 23.00	22. 00			0		0.00	O	22.00
therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	22.00	1 1 3	A Q 2	0	DECDIDATODY THEDADY	4E 00		22.00
24. 00 Adj ustment for physical therapy costs in excess of limitation (chapter 14) 25. 00 Utilization review - physicians' compensation (chapter 21) 26. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 27. 00 Depreciation - CAP REL COSTS-BLDG & FIXT 28. 00 Non-physician Anesthetist Physicians' assistant 29. 00 Physicians' assistant 29. 00 Adj ustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 HYSICAL THERAPY 66. 00 24. 00 24. 00 25. 00 0 UTILIZATION REVIEW-SNF 114. 00 25. 00 0 CAP REL COSTS-BLDG & FIXT 1. 00 0 CAP REL COSTS-BLDG & FIXT 1. 00 0 26. 00 27. 00 28. 00 0 NONPHYSICIAN ANESTHETISTS 19. 00 0 00 0 29. 00 30. 00 4dj ustment for occupational therapy costs in excess of limitation (chapter 14) 10 Adj ustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAP REL COSTS-BLDG & FIXT 0 CAP REL COSTS-MVBLE EQUIP 0 NONPHYSICIAN ANESTHETISTS 19. 00 0 00 0 29. 00 30. 00 4-8-3 0 OCCUPATIONAL THERAPY 67. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 3	23.00	therapy costs in excess of	A-0-3	Ü	RESPIRATORY THERAPY	65.00		23.00
therapy costs in excess of limitation (chapter 14) 25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-BLDG & FIXT 27.00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28.00 Non-physician Anesthetist 29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30.99 Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAP REL COSTS-BLDG & FIXT 0 CAP REL COSTS-MVBLE EQUIP 20.00 OCAP REL COSTS-MVBLE EQUIP 20.00 OCAP REL COSTS-MVBLE EQUIP 21.00 OCAP REL COSTS-MVBLE EQUIP 22.00 OCAP REL COSTS-MVBLE EQUIP 23.00 ONONPHYSICIAN ANESTHETISTS 34.00 OCCUPATIONAL THERAPY 35.00 OADULTS & PEDIATRICS 30.00 OCCUPATIONAL THERAPY 30.00 OADULTS & PEDIATRICS 30.00 OADULTS & PEDIATRICS 30.00 OADULTS & PEDIATRICS 30.00 OADULTS & PEDIATRICS 31.00 OADULTS & PEDIATRICS 32.00 OADULTS & PEDIATRICS 33.00 OADULTS & PEDIATRICS 34.00 OADULTS & PEDIATRICS 35.00 OADULTS & PEDIATRICS 36.00 OADULTS & PEDIATRICS 37.00 OADULTS & PEDIATRICS 37.00 OADULTS & PEDIATRICS 38.00 OADULTS & PEDIATRICS 39.00 OADULTS & PEDIATRICS 30.00 OADULTS & PEDIATRICS	24. 00	, , ,	A-8-3	0	PHYSI CAL THERAPY	66, 00		24. 00
25.00 Utilization review - physicians' compensation (chapter 21) 26.00 Depreciation - CAP REL COSTS-BLDG & FIXT	2 00	therapy costs in excess of		J	THIS SALE THEIR I	33.33		2 00
Chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 1.00 0 26.00	25. 00			0	UTILIZATION REVIEW-SNF	114. 00		25. 00
26.00 Depreciation - CAP REL COSTS-BLDG & FIXT 1.00 0 26.00 COSTS-BLDG & FIXT 1.00 0 26.00 COSTS-BLDG & FIXT 1.00 0 27.00 CAP REL COSTS-BLDG & FIXT 1.00 0 27.00 CAP REL COSTS-MVBLE EQUIP 2.00 0 C								
27. 00 Depreciation - CAP REL COSTS-MVBLE EQUIP 28. 00 Non-physician Anesthetist 29. 00 Physicians' assistant 30. 00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAP REL COSTS-MVBLE EQUIP 2. 00 ONONPHYSICIAN ANESTHETISTS 19. 00 28. 00 29. 00 30. 00 0 29. 00 30. 00 4-8-3 0 OCCUPATIONAL THERAPY 67. 00 30. 00 30. 99 31. 00 ADULTS & PEDIATRICS 30. 00 30. 00 30. 99 31. 00 ADULTS & PEDIATRICS 30. 00 31. 00 32. 00 32. 00 32. 00	26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	О	26. 00
28. 00 COSTS-MVBLE EQUIP Non-physician Anesthetist Physicians' assistant Adjustment for occupational therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) Adjustment for speech pathology costs in excess of limitation (chapter 14) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest ONONPHYSICIAN ANESTHETISTS 19. 00 28. 00 29. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 99 31. 00 32. 00 32. 00	27 00	1		0	CAP REL COSTS-MVBLE FOULP	2 00	0	27 00
29.00 Physicians' assistant 30.00 Adjustment for occupational therapy costs in excess of limitation (chapter 14) Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) A-8-3 32.00 CAH HIT Adjustment for Depreciation and Interest		COSTS-MVBLE EQUIP						
therapy costs in excess of limitation (chapter 14) 30. 99 Hospice (non-distinct) (see instructions) 31. 00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32. 00 CAH HIT Adjustment for Depreciation and Interest OADULTS & PEDIATRICS 30. 00 31. 00 30. 99 68. 00 31. 00 32. 00 0 0 0 0 32. 00				0	NONPHYSICIAN ANESTHETISTS		0	
limitation (chapter 14) Hospice (non-distinct) (see instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest OADULTS & PEDIATRICS 30.00 30.99 OADULTS & PEDIATRICS 30.00 31.00 31.00 32.00		Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY			
instructions) 31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest		limitation (chapter 14)						
31.00 Adjustment for speech pathology costs in excess of limitation (chapter 14) 32.00 CAH HIT Adjustment for Depreciation and Interest A-8-3 OSPEECH PATHOLOGY 68.00 31.00 O O O O O O O O O O O O O O O O O O	30. 99			0	ADULTS & PEDIATRICS	30. 00		30. 99
I i mi tation (chapter 14) 32.00 CAH HIT Adjustment for 0 0.00 0 32.00 Depreciation and Interest	31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
Depreciation and Interest								
	32. 00			0		0.00	0	32. 00
	33. 00		A	-12, 584	ADMINISTRATIVE & GENERAL	5.00	О	33. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provider CCN: 15-0018 Peri od: Worksheet A-8 From 01/01/2017
To 12/31/2017 Date/Time Prepared:

					10 12/31/2017	5/23/2018 2:3	
				Expense Classification on	Worksheet A		
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	oost outtor bescription	1.00	2. 00	3.00	4. 00	5. 00	
34. 00	PHYSICIAN RECRUITMENT	A A		ADMI NI STRATI VE & GENERAL	5. 00		34. 00
35. 00	MEALS ON WHEELS EXPENSE	A	-311, 879		10.00	1	35. 00
36. 00	LOBBYING EXPENSES	A		ADMINISTRATIVE & GENERAL	5. 00	1	36. 00
38. 00	DELI	В		CAFETERI A	11. 00	•	38. 00
	1		•				•
39. 00	MEDICAL STAFF DUES	В		ADMINISTRATIVE & GENERAL	5.00	1	39.00
40.00	PAYPHONE REVENUE	В		ADMI NI STRATI VE & GENERAL	5. 00	1	40.00
41. 00	OTHER REVENUE-ADMIN	В		ADMINISTRATIVE & GENERAL	5. 00	1	41. 00
42. 00	EMS REVENUE	В	•	PARAMED ED PRGM	23. 00	1	42. 00
43.00	TRUSTEE FEE	A		ADMINISTRATIVE & GENERAL	5. 00	1	43. 00
44. 00	ENVI RONMENTAL SERVI CES	В	-1, 200	HOUSEKEEPI NG	9. 00	0	44. 00
45.00	PLANT MAINT. MISC. REVENUE	В	-20, 888	OPERATION OF PLANT	7. 00	0	45. 00
46.00	OTHER REVENUE-EMS	В	0	PARAMED ED PRGM	23. 00	0	46. 00
47.00	PHYSICAL THERAPY MISC. REVENUE	В	-5, 010	PHYSICAL THERAPY	66.00	0	47. 00
48.00	OTHER REVENUE-FOUNDATION ADMIN	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	48. 00
49.00	I MAGING SERVICES REVENUE	В	-1, 168	RADI OLOGY-DI AGNOSTI C	54.00	0	49. 00
49. 01	CARDIOLOGY MISC. REVENUE	В	•	CARDI OLOGY	76. 00	1	49. 01
49. 02	NURSING ADMIN. MISC. REVENUE	В		NURSING ADMINISTRATION	13. 00		49. 02
49. 03	NON-ALLOWABLE ADMIN EXPENSES	A		ADMI NI STRATI VE & GENERAL	5. 00		49. 03
49. 04	NON-ALLOWABLE CONTRIBUTIONS	A		ADMINISTRATIVE & GENERAL	5. 00	1	49. 04
49. 05	NON-ALLOWABLE HAF EXPENSE	A	•	ADMINISTRATIVE & GENERAL	5. 00	•	49. 05
49. 06	LACTATION SUPPLIES SALES	B		l e e e e e e e e e e e e e e e e e e e	30.00	1	49. 06
49.00	II.	D	-31	ADULTS & PEDIATRICS	30.00	,	49.00
40.07	REVENUE		0	CLINIC	00.00		40.07
49. 07	WOMENS' SERVICES MISC. REVENUE	1		CLINIC	90.00	1	
49. 08	PHYSI CI AN GUARANTEE	A		OPERATING ROOM	50.00	1	49. 08
49. 09	RENTAL REVENUE	В		CAP REL COSTS-BLDG & FIXT	1.00		•
49. 10	SEMI NAR REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	1	
49. 11	SEMI NAR REVENUE	В		OPERATING ROOM	50.00	1	49. 11
49. 12	SEMI NAR REVENUE	В		EMERGENCY	91.00	1	49. 12
49. 13	OTHER REVENUE - ADMIN	В	-296, 229	ADMINISTRATIVE & GENERAL	5. 00	0	49. 13
49. 14	OTHER REVENUE - PAT ACCTG	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	49. 14
49. 15	OTHER REVENUE - CT SCAN	В	0	CT SCAN	57.00	0	49. 15
49. 16	OTHER REVENUE - BREAST CENTER	В	0	RADI OLOGY-DI AGNOSTI C	54.00	0	49. 16
49. 17	OTHER REVENUE - BARLATRIC	В	-3, 458	OPERATING ROOM	50.00	0	49. 17
49. 18	OTHER REVENUE - ED	В	-307, 526	EMERGENCY	91.00	0	49. 18
49. 19	OTHER REVENUE - PRENATAL	В		NURSERY	43.00	1	49. 19
	PROGRAM					1	
49. 20	SEMI NAR REVENUE	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	49. 20
49. 21	OTHER REVENUE - CATH	В		CARDIAC CATHETERIZATION	59. 00	1	49. 21
49. 22	SEMI NAR REVENUE	В		EMERGENCY	91.00	1	1
49. 23	OTHER REVENUE - ONCOL ADMIN	В		NURSING ADMINISTRATION	13. 00	l e	49. 23
49. 24	OTHER REVENUE - CBM	В		SUBPROVI DER - I PF	40.00	1	49. 24
49. 24	OTHER REVENUE - COM OTHER REVENUE - NEONATAL	В		INTENSIVE CARE UNIT	31.00	l	49. 24
	1	В		l e e e e e e e e e e e e e e e e e e e		1	
49. 26	OTHER REVENUE	•		ADULTS & PEDIATRICS	30.00	1	
49. 27	JOINT VENTURE ACTIVITY	В		ADMINISTRATIVE & GENERAL	5.00	1	1
	OTHER REVENUE-AP RECOVERIES	В		ADMINISTRATIVE & GENERAL	5.00	1	
49. 29	OTHER REVENUE-OT	В		OCCUPATI ONAL THERAPY	67. 00	1	
49. 30	OTHER REVENUE-RT	В	•	RESPIRATORY THERAPY	65. 00	1	
49. 31	OTHER REVENUE-MEDICAL ONCOLOGY			ADULTS & PEDIATRICS	30.00	1	
49. 32	OTHER REVENUE-NICU	В		NEONATAL INTENSIVE CARE	31. 01	0	49. 32
49. 33	OTHER REVENUE-REHAB	В	-125	SUBPROVIDER - IRF	41.00	0	49. 33
50.00	TOTAL (sum of lines 1 thru 49)		-21, 968, 809				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)					<u> </u>	<u> </u>
(1) Do	comintian all shanton noferon	ses in this sel		CMC Dub. 1E 1	-	-	

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

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

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

* 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.

24, 878, 217

22, 518, 601

5.00

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

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

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

6.00	В	BEACON HLTH SYS	100.00	0. 00	6. 00
7.00			0.00	0. 00	7.00
8.00			0.00	0. 00	8.00
9.00			0.00	0. 00	9.00
10.00			0.00	0. 00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

- (1) 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.

5.00

line 12.

TOTALS (sum of lines 1-4).

Transfer column 6, line 5 to Worksheet A-8, column 2,

Heal th	Financial Syste	ems		ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
STATEME	ENT OF COSTS OF	SERVICES FROM	RELATED	ORGANIZATIONS AND HOME	Provider CCN	: 15-0018	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS						From 01/01/2017 To 12/31/2017	Date/Time Pro 5/23/2018 2:3	
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REC	QUIRED AS A RESULT OF TRA	ANSACTIONS WIT	H RELATED (ORGANIZATIONS OR	CLAI MED	
	HOME OFFICE CO	STS:							
1.00	346, 731	10							1.00
2.00	1, 345, 636	10							2.00
3.00	23, 185, 850	0							3. 00
4.00	-22, 518, 601	0							4. 00
5.00	2, 359, 616								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.

	boon poored to non noned 7.1	cordinate i dilator 21 the amount directable chours to the cordinate of the partit	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	31		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
TI 0		10.00	

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

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

Period: Worksheet A-8-2 From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/23/2018 2:39 pm

							5/23/2018 2:3	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	Hours 7. 00	
1.00		DR. V	23, 250		23, 250	211, 500	186	1. 00
2. 00		DR. H	1, 248		1, 248	197, 500	10	
3.00		DR. B	90, 180		90, 180		558	3. 00
4.00	30. 00	DR. H	2, 395, 938	2, 395, 938	0	0	0	4. 00
5.00		DR. M	4, 930		4, 930	237, 100	34	5. 00
6.00		DR. K	31, 160		· ·	246, 400	152	
7. 00 8. 00		DR. K DR. G	5, 330 22, 500		5, 330 22, 500	246, 400 271, 900	26 90	
9. 00		DR. L	73, 200		73, 200	271, 900 271, 900	300	9. 00
10. 00		DR. W	6, 500		6, 500	211, 500	25	
11. 00		DR. V	16, 500	0	16, 500	211, 500	83	11. 00
12.00	65. 00	DR. A	7, 470		7, 470	211, 500	41	12. 00
13.00		DR. G	1, 384		1, 384	211, 500	7	13. 00
14. 00		DR. H	14, 310		14, 310	211, 500	79	
15. 00 16. 00		DR. A DR. W	810 6, 000		810 6, 000	211, 500 211, 500	5 30	
17. 00		DR. L	600		600	211, 500	30	i
18. 00		DR. W	1, 200	Ö	1, 200	211, 500	6	
19.00	91. 00	DR. B	43, 400	0	43, 400	211, 500	217	19. 00
20.00		DR. M	16, 667	0	16, 667	211, 500	126	
21. 00		DR. S	5, 400		5, 400	211, 500	40	
22. 00	91.00	AGGREGATE-EMERGENCY	140, 000		140, 000	211, 500	1, 132	
200. 00	Wkst. A Line #	Cost Center/Physician	2, 907, 977 Unadj usted RCE	2, 395, 938 5 Percent of	512,039 Cost of	Provi der	3, 150 Physi ci an Cost	
	mot. A Line #	I denti fi er	Li mi t	Unadjusted RCE		Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00	2.00	8. 00	9.00	Educati on	12 13. 00	14.00	
1. 00	1.00	2. 00 DR. V	8.00	9.00	12. 00		14. 00 0	1. 00
2. 00		DR. H	950		0		Ö	
3.00		DR. B	56, 739		0	0	0	
4.00	30. 00	DR. H	0	0	0	0	0	4. 00
5.00		DR. M	3, 876		0	0	0	
6.00		DR. K	18, 006		0	0	0	
7. 00 8. 00		DR. K DR. G	3, 080 11, 765		0) 0	0	
9. 00		DR. L	39, 216		0	0	0	
10. 00		DR. W	2, 542	127	0	Ö	Ö	
11.00		DR. V	8, 440	422	0	0	0	11. 00
12.00		DR. A	4, 169		0	0	0	12. 00
13.00		DR. G	712	36	0	0	0	
14. 00 15. 00		DR. H DR. A	8, 033 508		0	0	0 0	
16. 00		DR. W	3, 050		0	0	0	
17. 00		DR. L	305		0	0	0	
18.00		DR. W	610		0	0	0	
19.00		DR. B	22, 065				0	
20.00		DR. M	12, 812		0		0	
21. 00		DR. S	4, 067		0	0	0	
22. 00 200. 00	91.00	AGGREGATE-EMERGENCY	115, 105 334, 963		0		0	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	<u> </u>	200.00
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		DR. V	0	18, 913	4, 337	4, 337		1. 00
2.00	17. 00	DR. H	0		298	298		2. 00
3.00		DR. B	0		33, 441	33, 441		3. 00
4.00		DR. H	0		0	2, 395, 938		4. 00
5. 00 6. 00		DR. M DR. K	0		1, 054	1, 054 13, 154		5. 00 6. 00
7. 00		DR. K	0	.,	13, 154 2, 250	2, 250		7. 00
8. 00		DR. G	Ö		10, 735	10, 735		8. 00
9. 00	54. 00	DR. L	0	39, 216	33, 984	33, 984		9. 00
10.00		DR. W	0	2, 542	3, 958	3, 958		10. 00
11. 00		DR. V	0		8, 060	8, 060		11. 00
12.00		DR. A	0		3, 301	3, 301		12.00
13. 00 14. 00		DR. G DR. H	0	1	672 6, 277	672 6, 277		13. 00 14. 00
15. 00		DR. A	0		302	302		15. 00
16. 00		DR. W	0		2, 950			16. 00
			_					
17. 00	/6.00	DR. L	0	305	295	295		17. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
PROVI DER BASED PHYSI CI AN ADJUSTMENT	Provider CCN: 15-0018	Period: Worksheet A-8-2 From 01/01/2017
		To 12/31/2017 Date/Time Prepared:

							5/23/2018 2:3	39 pm
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
18. 00	90.00	DR. W	0	610	590	590		18. 00
19.00	91.00	DR. B	0	22, 065	21, 335	21, 335		19. 00
20.00	90. 01	DR. M	0	12, 812	3, 855	3, 855		20. 00
21.00	91.00	DR. S	0	4, 067	1, 333	1, 333		21. 00
22.00	91.00	AGGREGATE-EMERGENCY	0	115, 105	24, 895	24, 895		22. 00
200.00			0	334, 963	177, 076	2, 573, 014		200.00

| Peri od: | Worksheet B | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | Part | Part | Prepared: | Part Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018

COST Center Description	18 2:39 pm
For Cost Allocation (from Wkst A col . 7)	al
For Cost Allocation (from Wkst A col . 7)	al
Allocation (from Wkst A col . 7) CENERAL SERVICE COST CENTERS	
Col. 7)	
O 1.00 2.00 4.00 4A	
GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 16,525,741 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,105 17,10	
1. 00	
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 710, 465 17, 105 4, 625 732, 195 5. 00 00500 ADMINISTRATIVE & GENERAL 32, 460, 875 859, 793 232, 497 40, 662 33, 5 6. 00 00600 MAINTENANCE & REPAIRS 0 0 0 0 0 7. 00 00700 OPERATION OF PLANT 8, 431, 541 4, 437, 457 1, 199, 931 23, 612 14, 0 8. 00 00800 LAUNDRY & LINEN SERVICE 756, 469 347, 964 94, 093 611 1, 1 9. 00 00900 HOUSEKEEPING 3, 745, 665 89, 149 24, 107 18, 362 3, 8 10. 00 01000 DI ETARY 1, 573, 556 228, 887 61, 893 8, 498 1, 8	1.00
5. 00 00500 ADMINISTRATIVE & GENERAL 32, 460, 875 859, 793 232, 497 40, 662 33, 5 6. 00 00600 MAINTENANCE & REPAIRS 0 0 0 0 0 7. 00 00700 OPERATION OF PLANT 8, 431, 541 4, 437, 457 1, 199, 931 23, 612 14, 0 8. 00 00800 LAUNDRY & LINEN SERVICE 756, 469 347, 964 94, 093 611 1, 1 9. 00 00900 HOUSEKEEPING 3, 745, 665 89, 149 24, 107 18, 362 3, 8 10. 00 01000 DI ETARY 1, 573, 556 228, 887 61, 893 8, 498 1, 8	2. 00
6. 00	4. 00 93, 827 5. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 756, 469 347, 964 94, 093 611 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1 1, 1, 1 1, 1 1, 1 1, 1, 1 1, 1, 1 1, 1, 1 1, 1, 1, 1 1	0 6.00
9. 00 00900 HOUSEKEEPI NG 3, 745, 665 89, 149 24, 107 18, 362 3, 8 10. 00 01000 DI ETARY 1, 573, 556 228, 887 61, 893 8, 498 1, 8	92, 541 7. 00
10. 00 01000 DI ETARY 1, 573, 556 228, 887 61, 893 8, 498 1, 8	99, 137 8. 00 77, 283 9. 00
	72, 834 10. 00
11. 00 01100 CAFETERI A 1, 405, 684 87, 654 23, 702 8, 215 1, 5	25, 255 11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL 0 0 0 0	0 12.00
	32, 294 13. 00 08, 503 14. 00
	33, 826 15. 00
	25, 311 16. 00
	76, 957 17. 00
18. 00 01850 OTHER GENERAL SERVICE (SPECIFY)	0 18.00 0 19.00
20. 00 02000 NURSI NG SCH00L 0 0 0	0 20.00
21. 00 02100 1 &R SERVI CES-SALARY & FRI NGES APPRVD 0 0 0 0	0 21.00
22.00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRVD 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 22.00 39, 421 23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	9, 421 23.00
30. 00 03000 ADULTS & PEDI ATRI CS 27, 660, 983 3, 216, 063 869, 656 171, 779 31, 9	18, 481 30. 00
	15, 165 31. 00
31. 01 03101 NEONATAL NTENSI VE CARE	71, 902 31. 01 0 32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT 0 0 0	0 33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0	0 34.00
	33, 151 40. 00
	14, 992 41. 00 77, 106 43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY 0 0 0	0 44.00
45. 00 04500 NURSING FACILITY 0 0 0	0 45.00
46. 00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0	0 46.00
	90, 107 50. 00
51. 00 05100 RECOVERY ROOM 0 0 0	0 51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0	0 52.00
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 53.00 58,340 54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0	0 55.00
56. 00 05600 RADI OI SOTOPE 0 0 0	0 56.00
	59, 260 57. 00 28, 931 58. 00
	98, 755 59. 00
60. 00 06000 LABORATORY 10, 855, 157 122, 996 33, 259 8, 718 11, 0	20, 130 60. 00
60. 01 06001 BLOOD LABORATORY	0 60.0
61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 1, 040, 194 0 0 1, 0	0 61.00 10, 194 62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0 63.00
64. 00 06400 I NTRAVENOUS THERAPY 1, 480, 317 44, 246 11, 965 10, 659 1, 5	17, 187 64. 00
	50, 626 65. 00 32, 446 66. 00
	32, 446 66. 00 54, 214 67. 00
68. 00 06800 SPEECH PATHOLOGY 214, 716 32, 397 8, 761 1, 556 2	57, 430 68. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0	0 69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0 70.00 03, 794 71.00
)4, 676 72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS 18,655,908 0 0 18,6	55, 908 73. 00
74. 00 07400 RENAL DI ALYSI S 0 0 0 0	0 74.00
75. 00 07500 ASC (NON-DI STINCT PART)	0 75. 00 56, 676 76. 00
OUTPATIENT SERVICE COST CENTERS	70.00
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0	0 88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 90. 00 0 0 90. 00 0 0 0 0 0 0	0 89.00 29,594 90.00
7,70,010 121,070 02,770 0,440 7	

			To	12/31/2017	Date/Time Pre 5/23/2018 2:3	pared:
		CAPI TAL REL	ATED COSTS		5/23/2018 2:3	9 DIII
		CALLIAL KLL	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
3332 3311231 33331 1 211 311	for Cost	5250 a		BENEFI TS	oub to tu.	
	Allocation			DEPARTMENT		
	(from Wkst A					
	col. 7)					
	0	1.00	2.00	4. 00	4A	
90. 01 04950 SLEEP CLINIC	408, 666	0	0	2, 776	411, 442	90. 01
91. 00 09100 EMERGENCY	11, 969, 773	377, 348	102, 039	57, 253	12, 506, 413	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0		0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	_	_	_	_	_	114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	228, 449, 176	14, 647, 975	3, 960, 959	722, 661	226, 054, 109	1118.00
NONREI MBURSABLE COST CENTERS				ام		100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
191. 00 19100 RESEARCH	0	000 700	(4.000	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	239, 739	64, 828	0	304, 567	
193. 00 19300 NONPALD WORKERS	237, 867	120.045	24 005	1, 668	239, 535	
193. 01 19301 COMMUNITY	408, 106	129, 045	· ·	2, 034	574, 080	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	4, 842, 363	1, 508, 982	408, 044	5, 832	6, 765, 221	1
200.00 Cross Foot Adjustments		0				200.00
201.00 Negative Cost Centers	222 027 542	14 505 741	4 440 704	722 105		201. 00
202.00 TOTAL (sum lines 118 through 201)	233, 937, 512	16, 525, 741	4, 468, 726	732, 195	233, 937, 512	J2U2. UU

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0018

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

5/23/2018 2:39 pm Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL REPAI RS **PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 33, 593, 827 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 00700 OPERATION OF PLANT 2, 363, 051 16, 455, 592 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 201, 072 0 510, 726 1, 910, 935 8.00 00900 HOUSEKEEPI NG 650, 147 4, 658, 279 9.00 130, 849 9 00 10.00 01000 DI ETARY 314, 039 335, 951 7, 913 10.00 11.00 01100 CAFETERI A 255, 756 128, 654 0 41,867 11.00 01200 MAINTENANCE OF PERSONNEL 0 12 00 12 00 C 0 13.00 01300 NURSING ADMINISTRATION 315, 625 89, 782 14, 861 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 286, 483 497, 658 78 65, 976 14.00 01500 PHARMACY 0 29, 905 15.00 240, 425 182, 157 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 88.085 93.872 16,885 16.00 17.00 01700 SOCIAL SERVICE 331, 498 3, 724 0 0 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 18 00 C 0 18.00 0 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 0 0 0 19.00 02000 NURSING SCHOOL 20 00 0 C 0 Λ 20 00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 C O 22.00 1, 932 02300 PARAMED ED PRGM 23.00 23, 378 0 8, 313 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 352, 124 4, 720, 400 576, 001 2, 021, 600 30.00 31.00 03100 INTENSIVE CARE UNIT 996, 891 371, 996 159, 815 137, 104 31.00 03101 NEONATAL INTENSIVE CARE 31.01 263, 578 0 77, 478 925 26, 317 31.01 32.00 03200 CORONARY CARE UNIT C 32.00 0 C 0 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 0 0 34.00 04000 SUBPROVIDER - IPF 98, 089 40.00 324, 153 C 362, 852 1, 177 40.00 41.00 04100 SUBPROVIDER - IRF 270,803 315, 899 41, 220 98,089 41.00 04300 NURSERY 43.00 482, 436 0 506, 503 60, 749 26, 317 43.00 44 00 04400 SKILLED NURSING FACILITY Ω 44 00 C 0 04500 NURSING FACILITY 0 45.00 0 0 0 0 45.00 04600 OTHER LONG TERM CARE 0 0 46.00 46.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 983, 063 1, 940, 486 578, 690 709.492 50.00 51.00 05100 RECOVERY ROOM 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 52.00 53 00 05300 ANESTHESI OLOGY 0 53 00 C 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 1,602,752 0 1, 282, 385 170, 906 140, 555 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 56.00 05600 RADI OI SOTOPE 56.00 0 0 17, 345 57 00 05700 CT SCAN 244, 690 236,060 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 172, 532 119, 277 1,027 11,870 58.00 59.00 05900 CARDIAC CATHETERIZATION 402, 226 135, 404 63, 077 59.00 06000 LABORATORY 180, 528 60.00 1.847.866 0 35, 886 60.00 06001 BLOOD LABORATORY 0 60.01 Ω 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 174, 421 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 0 0 40, 717 64 00 06400 INTRAVENOUS THERAPY 259, 434 64 942 0 64 00 06500 RESPIRATORY THERAPY 578, 604 59, 988 8, 972 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 332, 419 165, 165 23, 522 23, 924 66.00 06700 OCCUPATIONAL THERAPY 79.307 1, 932 67.00 128.144 0 67.00 68.00 06800 SPEECH PATHOLOGY 43, 166 47, 551 0 11, 962 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 2.834.445 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 845, 275 C 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 3, 128, 241 0 0 0 73.00 07400 RENAL DIALYSIS 74.00 0 0 0 74.00 0 0 07500 ASC (NON-DISTINCT PART) 75.00 C 0 Λ 75 00 03140 CARDI OLOGY 319, 989 16, 902 76.00 613, 155 0 29, 261 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER C 0 0 0 89.00 09000 CLI NI C 90.00 155, 875 0 177, 735 0 25, 535 90.00 90. 01 04950 SLEEP CLINIC 68, 991 0 90.01 0 09100 EMERGENCY 279, 918 402, 433 91.00 2,097,088 C 553, 855 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94.00

				12/01/201/	5/23/2018 2:3	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	32, 271, 931	0	13, 699, 486	1, 910, 935	4, 109, 816	118. 00
NONRE MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	51, 070	0	351, 879	0	105, 865	
193. 00 19300 NONPALD WORKERS	40, 165	0	0	0		193. 00
193. 01 19301 COMMUNI TY	96, 262	0	189, 407	0		193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	1, 134, 399	0	2, 214, 820	0	442, 598	
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	33, 593, 827	0	16, 455, 592	1, 910, 935	4, 658, 279	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part I | To 12/31/2017 | Date/Time Prepared: | 5/23/2018 2:39 pm

					12, 01, 201,	5/23/2018 2: 3	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	F NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES &	
				TERSONNEL	ADMINI STRATION	SUPPLY	
	OFNEDAL CEDYLOF COCT OFNEDO	10.00	11. 00	12. 00	13. 00	14. 00	
1 00	GENERAL SERVICE COST CENTERS			T			1 00
1.00	00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
2. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
	1 1						•
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						•
9. 00	00900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY	2, 530, 737					10.00
11. 00	01100 CAFETERI A	2,530,737	1, 951, 532				11.00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	1, 701, 002				12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	37, 365		2, 339, 927		13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	0	32, 683	1	0 2,007,727	2, 591, 465	14. 00
15. 00	01500 PHARMACY	0	92, 778	1		0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	8, 548	1		0	16. 00
17. 00	01700 SOCIAL SERVICE	0	34, 255		5, 516	0	17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0.7200		0 0	0	18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0		ol ol	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0			0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0		o	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	O		o	0	22. 00
23.00	02300 PARAMED ED PRGM	0	2, 072	2	20	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	2, 001, 113	559, 492	2	1, 050, 540	0	30. 00
31.00	03100 INTENSIVE CARE UNIT	226, 037	104, 669		250, 536	0	31. 00
31. 01	03101 NEONATAL INTENSIVE CARE	0	25, 577	'	53, 880	0	31. 01
32.00	03200 CORONARY CARE UNIT	0	0		0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0) (0 0	0	34.00
40.00	04000 SUBPROVI DER - I PF	197, 259	32, 309		48, 433	0	40. 00
41.00	04100 SUBPROVI DER - I RF	106, 328	25, 187	'	41, 094	0	41. 00
43.00	04300 NURSERY	0	49, 428	3	101, 184	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0) (0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0		0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0) (0 0	0	46. 00
	ANCILLARY SERVICE COST CENTERS		200 504				
50.00	05000 OPERATING ROOM	0	223, 591		300, 131	0	50.00
51.00	05100 RECOVERY ROOM	0	Ü		0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	140.051		0 27 027	0	53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	142, 051		37, 037	0	54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0			0	55. 00 56. 00
57. 00	05700 CT SCAN	0	22, 864			0	57.00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	9, 813	1		0	58.00
59. 00	05900 CARDIAC CATHETERIZATION	0	36, 005		34, 614	0	59.00
60. 00	06000 LABORATORY	0	39, 328	1	0 34,014	0	•
60. 01	06001 BLOOD LABORATORY	0	37, 320	1		Ö	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	Ί		١	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	27, 555		76, 039	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	70, 100	1	0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	40, 174	1	23	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	14, 235		18	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	5, 047			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0,011		ol ol	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		o o	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		o o	1, 580, 794	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		o	1, 010, 671	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	O		o	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0) (o	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0) (o l	0	75. 00
76.00	03140 CARDI OLOGY	0	65, 959	<u> </u>	48, 547	0	76. 00
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>					l
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	o	0) (o c	0	89. 00
90.00	09000 CLI NI C	o	13, 577	' (1, 075	0	90.00
90. 01	04950 SLEEP CLINIC	0	8, 685	5 (o	0	90. 01
	09100 EMERGENCY	0	198, 237	'	291, 135	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00

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

			''	0 12/31/2017	5/23/2018 2:39 pm
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL
			PERSONNEL	ADMI NI STRATI ON	SERVI CES &
					SUPPLY
	10.00	11. 00	12. 00	13. 00	14. 00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0 94.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0 97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
99. 00 09900 CMHC	0	0	0	0	0 99.00
99. 10 09910 CORF	0	0	0	0	0 99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 101. 00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0 105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0 106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0 111.00
113.00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115.00
116. 00 11600 H0SPI CE	0	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 530, 737	1, 921, 584	0	2, 339, 914	<u>2, 591, 465</u> 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00
191. 00 19100 RESEARCH	0	0	0	0	0 191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0 192. 00
193. 00 19300 NONPALD WORKERS	0	6, 521	0	0	0 193. 00
193. 01 19301 COMMUNI TY	0	6, 508	0	13	0 193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	16, 919	0	0	0 194. 00
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 530, 737	1, 951, 532	0	2, 339, 927	2, 591, 465 202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2017	Part
To 12/31/2017	Date/Time Prepared:
5/23/2018 2:39 pm	Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018

				10	3 12/31/2017	5/23/2018 2:3	
					OTHER GENERAL		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CE (SPECI FY)	NONPHYSI CI AN	
	Cost Conter Bescription	THARWACT	RECORDS &	SOCIAL SERVICE	(SI ECITI)	ANESTHETISTS	
			LI BRARY				
	GENERAL SERVICE COST CENTERS	15. 00	16. 00	17. 00	18. 00	19. 00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY	1, 979, 091					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	732, 701	1			16.00
17. 00 18. 00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	2, 351, 950 0	0		17. 00 18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS		0	0	0	0	19.00
20.00	02000 NURSI NG SCHOOL	o	0	0	0		20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0		21.00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM	0	0	_	0	l	22. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	<u> </u>	0	l O	0		23.00
30. 00	03000 ADULTS & PEDI ATRI CS	3, 190	113, 144	1, 865, 471	0	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T	637	24, 514		0		31. 00
31. 01 32. 00	03101 NEONATAL INTENSIVE CARE	0	3, 259 0		0	0	31. 01 32. 00
32.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT		0	0	0	1	32.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	o	0	Ö	0	Ö	34.00
40. 00	04000 SUBPROVI DER - I PF	28	6, 753		0	0	40. 00
41.00	04100 SUBPROVI DER - I RF	28	3, 159		0	0	41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY		4, 833 0		0	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	o	0	Ö	0	Ö	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	12, 571	141, 796	0	0	0	50. 00
51. 00	05100 RECOVERY ROOM	0	141,770		0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	O	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	899	79, 806	0	0	0	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE	o o	0	ő	0	o o	56.00
57. 00	05700 CT SCAN	o	74, 810	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	12, 404	1	0	0	1
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	545	41, 834 81, 709	1	0	0	59. 00 60. 00
60. 00	06001 BLOOD LABORATORY		01, 709		0	0	60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	8, 342	i	0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	237	0 1, 806	0	0	0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	33, 890	28, 782	1	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0	6, 196	1	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	3, 925		0	0	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	1, 062 0	_	0	0	68. 00 69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0	Ö	0	Ö	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 900, 323	0	0	0	0	73.00
74. 00 75. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)		0	0	0	0	74. 00 75. 00
76. 00	03140 CARDI OLOGY	25, 874	35, 808		0	1	76.00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	1	0	0	88.00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC		4, 922	_	0	0	89. 00 90. 00
90. 01	04950 SLEEP CLINIC		3, 572	1	0	ő	90. 01
91. 00	09100 EMERGENCY	869	50, 265	0	0	0	91.00

			To	o 12/31/2017	Date/Time Pre 5/23/2018 2:3	
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE		NONPHYSI CI AN ANESTHETI STS	7 DIII
	15. 00	16. 00	17. 00	18. 00	19. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	/ /
100.00 10000 1 &R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	- I			ام		
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	1	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	0	Ü	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	Ü	0	0		110.00
111. 00 11100 SLET ACQUI SITI ON	O	Ü		0	0	111. 00
113. 00 11300 INTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	Ü		0	0	115. 00
116. 00 11600 HOSPI CE	1 070 001	722 701	0 251 250	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	1, 979, 091	732, 701	2, 351, 950	U	0	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0) 0	O		190. 00
191. 00 19100 RESEARCH	0	0		U		190.00
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		191.00
193. 00 19300 NONPALD WORKERS	0	0		0		193. 00
193. 01 19301 COMMUNI TY	0	0		0		193. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0		194. 00
200.00 Cross Foot Adjustments	٩	U	ή	٩		200. 00
201.00 Negative Cost Centers		Ō		0		200.00
202.00 TOTAL (sum lines 118 through 201)	1, 979, 091	732, 701	2, 351, 950	0		202.00
202.00 TOTAL (Suil Titles TTO till odgit 201)	1, 7/7, 091	732, 701	2, 331, 930	l 의	O	1202.00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2017	Part
To 12/31/2017	Date/Time Prepared:
5/23/2018 2:39 pm	

				' ') 12/31/201/	5/23/2018 2: 3	
			INTERNS &	RESI DENTS			
		NILIDOLNIO COLLOOL	CEDVI OEC CALAD	CEDULOES OTHER	DADAMED ED		
	Cost Center Description	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	
		20. 00	21.00	22.00	23.00	24. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAINTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16.00
17. 00 18. 00	01700 SOCIAL SERVICE						17.00
19. 00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS			•			18. 00 19. 00
20. 00	02000 NURSI NG SCHOOL	0					20.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD		0				21.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD			0			22. 00
23. 00	02300 PARAMED ED PRGM				175, 136		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				·		1
30.00	03000 ADULTS & PEDIATRICS	0	0	0	0	50, 181, 556	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	0	0		0	8, 284, 769	1
31. 01	03101 NEONATAL INTENSIVE CARE	0	0	0	0	2, 054, 412	1
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	2 110 755	34.00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0		0	3, 119, 755 2, 543, 881	1
43. 00	04300 NURSERY	0	0		0	4, 353, 501	1
44. 00	04400 SKILLED NURSING FACILITY		0	Ö	ol Ol	4, 333, 301	1
45. 00	04500 NURSING FACILITY	0	1	ő	ol	0	1
46.00	04600 OTHER LONG TERM CARE	0	l e	o	O	0	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	0	0	24, 679, 927	1
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0	0		0	13, 014, 731 0	1
56. 00	05600 RADI OLOGI - ITIERAF LUTT C		0		0	0	1
57. 00	05700 CT SCAN	0	0	0	Ö	2, 055, 034	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	Ö	ő	ol	1, 355, 862	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	O	0	o	3, 112, 460	
60.00	06000 LABORATORY	0	0	О	О	13, 205, 447	1
60. 01	06001 BLOOD LABORATORY	0	0	0	O	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	1, 222, 957	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	1
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	2, 017, 917	
65. 00	06500 RESPI RATORY THERAPY	0	0		0	4, 230, 962	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	0		U O	2, 573, 869 991, 775	1
68. 00	06800 SPEECH PATHOLOGY	0	0		0	366, 218	1
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0 0	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	Ö	ő	ol	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö	ō	ō	21, 319, 033	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	o	o	13, 860, 622	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	o	23, 684, 472	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	1
76. 00	03140 CARDI OLOGY	0	0	0	0	4, 812, 171	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS		_		ام		00.00
88. 00	08800 RURAL HEALTH CLINIC	0		0	0	0	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC				o o	0 1, 308, 313	1
90.00	04950 SLEEP CLINIC				0	1, 308, 313 492, 690	1
91. 00	09100 EMERGENCY	0			175, 136	16, 555, 349	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				1,3,130	.5, 555, 547	92. 00
		I .	1	1	I		

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

			10		5/23/2018 2:39 pm
		INTERNS &	RESI DENTS		
Cost Center Description	NURSING SCHOOL		SERVI CES-OTHER	PARAMED ED	Subtotal
		Y & FRINGES	PRGM COSTS	PRGM	
	20. 00	21. 00	22. 00	23. 00	24.00
OTHER REIMBURSABLE COST CENTERS				al	
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0 94.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0 96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0 97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0 98.00
99. 00 09900 CMHC	0	0	0	O	0 99.00
99. 10 09910 CORF	0	0	0	0	0 99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0 100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0 101. 00
SPECIAL PURPOSE COST CENTERS			,		
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0 105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0 106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0 110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0 111.00
113.00 11300 INTEREST EXPENSE					113. 00
114.00 11400 UTILIZATION REVIEW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0 115.00
116. 00 11600 HOSPI CE	0			o	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	175, 136	221, 397, 683 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190. 00
191. 00 19100 RESEARCH	0	0	0	o	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	o	813, 381 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	o	286, 221 193. 00
193. 01 19301 COMMUNI TY	0	0	0	o	866, 270 193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	o	o	10, 573, 957 194. 00
200.00 Cross Foot Adjustments	0	0	O	ol	0 200. 00
201.00 Negative Cost Centers	0	0	o	ol	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	0	0	o	175, 136	233, 937, 512 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS ELKHART GENERAL HOSPITAL Provider CCN: 15-0018

	0 1 0 1 1	1		3/23/2010 2.3	, piii
	Cost Center Description	Intern &	Total		1
		Residents Cost			1
		& Post			1
		Stepdown			1
					ł .
		Adjustments			l .
		25. 00	26. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
	i i				1
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	1			5. 00
6. 00	1 1	1			6. 00
	00600 MAI NTENANCE & REPAI RS				1
7.00	00700 OPERATION OF PLANT				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE				8. 00
9. 00	00900 HOUSEKEEPI NG				9. 00
	1 1	1			1
10. 00	01000 DI ETARY				10.00
11. 00	01100 CAFETERI A				11. 00
12.00	01200 MAINTENANCE OF PERSONNEL				12.00
	1 1				1
	01300 NURSI NG ADMI NI STRATI ON				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY				14. 00
15 00	01500 PHARMACY	1			15. 00
					1
16. 00	01600 MEDICAL RECORDS & LIBRARY				16. 00
17. 00	01700 SOCI AL SERVI CE				17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)				18. 00
	01900 NONPHYSICIAN ANESTHETISTS				19. 00
	1 1				1
	02000 NURSI NG SCHOOL				20. 00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD				21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD				22. 00
∠3. 00	02300 PARAMED ED PRGM				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				i
30.00	03000 ADULTS & PEDI ATRI CS	0	50, 181, 556		30.00
	03100 NTENSI VE CARE UNI T	o			1
	1 1	-	8, 284, 769		31.00
31. 01	03101 NEONATAL INTENSIVE CARE	0	2, 054, 412	2	31. 01
32.00	03200 CORONARY CARE UNIT	l ol	0		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT		0		33.00
	1 1	١	0		1
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	ol ol	0)	34. 00
40.00	04000 SUBPROVI DER - I PF	O	3, 119, 755		40.00
41.00	04100 SUBPROVI DER - I RF	l ol	2, 543, 881		41.00
	1 1			1	1
	04300 NURSERY	١	4, 353, 501		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		44.00
45.00	04500 NURSING FACILITY	ol	0		45. 00
46. 00	04600 OTHER LONG TERM CARE	o	0		46. 00
40.00		1 9	0	<i>y</i>	40.00
	ANCILLARY SERVICE COST CENTERS				
50. 00	05000 OPERATI NG ROOM	0	24, 679, 927		50.00
51.00	05100 RECOVERY ROOM	l ol	0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	o	0		52.00
	1 1	٩	U	,	
53. 00	05300 ANESTHESI OLOGY	O	0)	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	l ol	13, 014, 731		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	l l	55.00
	1 1	0	0		1
56. 00	05600 RADI OI SOTOPE	o o	Ü		56. 00
57. 00	05700 CT SCAN	0	2, 055, 034	4	57. 00
58 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	ا ما	1, 355, 862		58. 00
	05900 CARDI AC CATHETERI ZATI ON	o		i e	59. 00
	1 1	1	3, 112, 460		1
60. 00	06000 LABORATORY	0	13, 205, 447		60.00
60. 01	06001 BLOOD LABORATORY	O	0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	1	0		61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		1 222 057		1
	i i	ا	1, 222, 957		62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0)	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	2, 017, 917	7	64.00
65. 00	06500 RESPI RATORY THERAPY	ام	4, 230, 962		65. 00
				I I	
66. 00	06600 PHYSI CAL THERAPY	0	2, 573, 869		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	991, 775	5	67. 00
68. 00	06800 SPEECH PATHOLOGY		366, 218	3	68. 00
	06900 ELECTROCARDI OLOGY		000, 210	I I	69. 00
	i i	ا ا	0		1
	07000 ELECTROENCEPHALOGRAPHY	0	0)	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	21, 319, 033	3	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	o	13, 860, 622	l l	72. 00
				l l	1
	07300 DRUGS CHARGED TO PATIENTS	0	23, 684, 472		73. 00
74.00		0	0		74. 00
75.00	07500 ASC (NON-DISTINCT PART)	o	Λ		75. 00
76. 00			1 010 171		76. 00
70.00	03140 CARDI OLOGY	<u> </u>	4, 812, 171		70.00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	0		89. 00
		1 1	-	1	
	09000 CLI NI C	0	1, 308, 313	l e	90. 00
90. 01	04950 SLEEP CLINIC	0	492, 690		90. 01
	09100 EMERGENCY	o	16, 555, 349	1	91.00
71100	14 1	<u>'</u>	.,		<u> </u>

HOSPITAL In Lieu of Form CMS-2552-10
Provider CCN: 15-0018 Period: Worksheet B
From 01/01/2017 Part I

			From 01/01/2017 Part To 12/31/2017 Date/Time	Prepared:
			5/23/2018	
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown			
	Adjustments			
	25.00	26.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92. 00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
99. 00 09900 CMHC	0	0		99. 00
99. 10 09910 CORF	0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	O	o		100.00
101.00 10100 HOME HEALTH AGENCY	O	o		101.00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	0	0		105. 00
106.00 10600 HEART ACQUISITION	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0		107. 00
108.00 10800 LUNG ACQUISITION	o	o		108.00
109.00 10900 PANCREAS ACQUISITION	o	o		109.00
110.00 11000 INTESTINAL ACQUISITION	o	o		110.00
111.00 11100 I SLET ACQUISITION	o	o		111. 00
113.00 11300 I NTEREST EXPENSE				113. 00
114.00 11400 UTILIZATION REVIEW-SNF				114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	o	o		115. 00
116. 00 11600 HOSPI CE	o	o		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	o	221, 397, 683		118. 00
NONREI MBURSABLE COST CENTERS	<u> </u>			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
191. 00 19100 RESEARCH	o	o		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	813, 381		192. 00
193. 00 19300 NONPALD WORKERS	ol	286, 221		193. 00
193. 01 19301 COMMUNI TY	ol	866, 270		193. 01
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS		10, 573, 957		194. 00
200.00 Cross Foot Adjustments	ol	0		200. 00
201.00 Negative Cost Centers		0		201. 00
202.00 TOTAL (sum lines 118 through 201)	o	233, 937, 512		202. 00
, , , , , , , , , , , , , , , , , , ,	-1			1

Health Financial Systems
COST ALLOCATION STATISTICS ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0018 Worksheet Non-CMS W

Cost Center Description Statistics Statistics Description Code 1.00 GENERAL SERVICE COST CENTERS	1. 00 2. 00 4. 00
1.00 2.00	2. 00 4. 00
	2. 00 4. 00
GENERAL SERVICE COST CENTERS	2. 00 4. 00
	2. 00 4. 00
1. 00 CAP REL COSTS-BLDG & FIXT 1 SQUARE FEET	4. 00
2.00 CAP REL COSTS-MVBLE EQUIP 1 SQUARE FEET	
4.00 EMPLOYEE BENEFITS DEPARTMENT 4 GROSS SALARIES	
5.00 ADMINISTRATIVE & GENERAL -5 ACCUM. COST	5.00
6. 00 MAINTENANCE & REPAIRS 1 SQUARE FEET	6.00
7.00 OPERATION OF PLANT 1 SQUARE FEET 1	7.00
8. 00 LAUNDRY & LINEN SERVICE 8 POUNDS OF LAUNDRY	8.00
9. 00 HOUSEKEEPING 9 HOURS OF SERVICE 9	9.00
10. 00 DI ETARY 10 MEALS SERVED 1	10.00
11. 00 CAFETERIA 11 HOURS OF SERVICE 1	11. 00
12. 00 MAINTENANCE OF PERSONNEL 12 NUMBER HOUSED 1	12.00
13.00 NURSING ADMINISTRATION 13 DIRECT NURS. HRS. 1	13.00
14. 00 CENTRAL SERVICES & SUPPLY 14 COSTED REQUIS. 1	14.00
15. 00 PHARMACY 15 COSTED REQUIS. 1	15. 00
16. 00 MEDICAL RECORDS & LIBRARY 16 REVENUE 1	16. 00
17.00 SOCIAL SERVICE 17 TIME SPENT 1	17. 00
18.00 OTHER GENERAL SERVICE (SPECIFY) 18 TIME SPENT 1	18. 00
19.00 NONPHYSICIAN ANESTHETISTS 19 ASSIGNED TIME 1 19 ASSIGNED TIME	19. 00
20.00 NURSING SCHOOL 20 ASSIGNED TIME 2	20. 00
21.00 I&R SERVICES-SALARY & FRINGES APPRVD 21 ASSIGNED TIME 2	21. 00
22.00 I&R SERVICES-OTHER PRGM COSTS APPRVD 21 ASSIGNED TIME 2	22. 00
23. 00 PARAMED ED PRGM 23 ASSIGNED TIME 2	23. 00

| Peri od: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

				To	12/31/2017	Date/Time Prep 5/23/2018 2:39	
			CAPI TAL RE	LATED COSTS		3/23/2010 2.3	у ріп
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capital Related Costs				DEPARTMENT	
		0	1.00	2.00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT		I				1. 00
2.00	00200 CAP REL COSTS-MUBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	17, 105		21, 730		4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	0	859, 793		1, 092, 290 0	1, 207 0	5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	0	4, 437, 457	_	5, 637, 388		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	347, 964		442, 057	18	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	0	89, 149 228, 887	1	113, 256 290, 780		9. 00 10. 00
11. 00	01100 CAFETERI A	0	87, 654	1	111, 356		11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	O	_	0	0	12. 00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0	61, 169 339, 060		77, 710 430, 745		13. 00 14. 00
15. 00	01500 PHARMACY	0	124, 106	1	157, 666		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	63, 956	1	81, 250		16. 00
17. 00 18. 00	O1700 SOCIAL SERVICE O1850 OTHER GENERAL SERVICE (SPECIFY)	0	2, 537	1	3, 223 0	341	17. 00 18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	Ö	Ö	0	0	19. 00
20. 00	02000 NURSING SCHOOL	0	0	0	0	0	20. 00
21. 00 22. 00	02100 &R SERVI CES-SALARY & FRINGES APPRVD 02200 &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	0	5, 664	_	7, 196		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	_					
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	3, 216, 063 253, 445		4, 085, 719 321, 979		30. 00 31. 00
31. 01	03101 NEONATAL INTENSIVE CARE	0	52, 787	1	67, 061	327	31. 01
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	0	247, 215	66, 849	314, 064	297	40. 00
41.00	04100 SUBPROVI DER - I RF	0	215, 226		273, 425		41. 00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	345, 086		438, 401 0	485 0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0	Ö	1	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	1, 322, 076	357, 503	1, 679, 579	2, 364	50. 00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	873, 704	236, 258	0 1, 109, 962	0 1, 401	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0		55. 00
	05600 RADI OI SOTOPE	0	1/0 020	0	0	0	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	160, 830 81, 265	·	204, 320 103, 240		
59.00	05900 CARDI AC CATHETERI ZATI ON	0	92, 253		117, 199	402	59. 00
60.00	06000 LABORATORY	0	122, 996	33, 259	156, 255		60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	o	О	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0 11, 965	0 E/ 211	0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	44, 246 40, 870		56, 211 51, 922	316 642	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	112, 529	I	142, 958		66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	54, 033		68, 644	136	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	32, 397		41, 158 0	46 0	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	o	ō	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0		0	0	0	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	0	0	Ö	0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	010.013	0	0	0	75. 00
76. 00	03140 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS	0	218, 012	58, 953	276, 965	640	76. 00
88. 00	08800 RURAL HEALTH CLINIC	0	О	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	121 002		153 030	0	89. 00
90. 00 90. 01	09000 CLI NI C 04950 SLEEP CLI NI C	0	121, 093 0	l l	153, 838 0		90. 00 90. 01
	1	1 0	1	. 9	<u> </u>	32	

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2017 Part II Provider CCN: 15-0018

			To	12/31/2017	Date/Time Pre 5/23/2018 2:3	pared: 9 pm
		CAPI TAL REI	_ATED_COSTS		,	
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1. 00	2.00	2A	4. 00	
91. 00 09100 EMERGENCY	0	377, 348		479, 387	1, 700	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		•		o	·	92.00
OTHER REIMBURSABLE COST CENTERS			'			
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	o	0	0	o	0	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0	0	o	0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0	0	o	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	O	0	0	o	0	98. 00
99. 00 09900 CMHC	0	0	0	o	0	99. 00
99. 10 09910 CORF	0	0	0	o	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	O	0	0	o	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	14, 647, 975	3, 960, 959	18, 608, 934	21, 447	118. 00
NONREI MBURSABLE COST CENTERS	,		,			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	239, 739	64, 828	304, 567		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
193. 01 19301 COMMUNI TY	0	129, 045		163, 940		193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	1, 508, 982	408, 044	1, 917, 026		194. 00
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	16, 525, 741	4, 468, 726	20, 994, 467	21, 730	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0018

In Lieu of Form CMS-2552-10

Period:	Worksheet B	
From 01/01/2017	Part II	
To 12/31/2017	Date/Time Prepared:	5/23/2018 2:39 pm

		1		'	0 12/31/2017	5/23/2018 2:3	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS			ı			
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL	1, 093, 497					5. 00
6.00	00600 MAINTENANCE & REPAIRS	o	0				6. 00
7. 00	00700 OPERATION OF PLANT	76, 917	0	5, 715, 006			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	6, 545	0	177, 374		100 407	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	21, 162 10, 222	0	45, 444 116, 675		180, 407 306	9. 00 10. 00
11. 00	01100 CAFETERI A	8, 325	0	44, 681	0	1, 621	11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	o	0	0	0	0	12. 00
13.00	01300 NURSING ADMINISTRATION	10, 274	0	31, 181	0	576	13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	9, 325	0	172, 836		2, 555	14.00
16. 00	01600 MEDICAL RECORDS & LIBRARY	7, 826 2, 867	0	63, 263 32, 602	0	1, 158 654	15. 00 16. 00
17. 00	1 1	10, 790	0	1, 293	0	0 0	17. 00
18. 00	1 1	o	0	0	0	0	18. 00
19. 00	i i	0	0	0	0	0	19. 00
20.00		0	0	0	0	0	20.00
21. 00 22. 00	+ + +		0	0	0	0	21. 00 22. 00
23. 00	1 1	761	0	2, 887	0	75	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	174, 232	0				30.00
31. 00 31. 01	+ I	32, 449	0	129, 194		5, 310	31.00
31.01	03101 NEONATAL INTENSIVE CARE 03200 CORONARY CARE UNIT	8, 579	0	26, 908 0	303	1, 019 0	31. 01 32. 00
33. 00	1		0	Ö	0	Ö	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	o	0	0	0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	10, 551	0	126, 018			40. 00
41. 00	04100 SUBPROVI DER - I RF	8, 815	0	109, 711	13, 503	3, 799	41.00
43. 00 44. 00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	15, 703	0	175, 908	19, 900	1, 019 0	43. 00 44. 00
45. 00	1 1		0	Ö	0	o o	45. 00
46.00	1 1	0	0	0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS	07.000			100 570	07.477	
50. 00 51. 00	1 1	97, 098 0	0	673, 928 0	189, 572	27, 477 0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0	0	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	Ö	0	Ō	0	0	53. 00
54.00	I I	52, 169	0	445, 371	55, 986	5, 443	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 57. 00	05600 RADI 0I SOTOPE 05700 CT SCAN	0 7, 965	0	81, 983	0	0 672	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	5, 616	0	41, 425		460	58. 00
59.00	1 1	13, 092	0	47, 026		2, 443	
60.00		60, 148	0	62, 697	0	., 0, 0	
60. 01	I I	0	0	0	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	5, 677	0	0	0	0	61. 00 62. 00
63. 00	+ I	0	0	Ö	0	Ö	63. 00
64.00	1	8, 445	0	22, 554	0	1, 577	64. 00
65. 00		18, 834	0	20, 834		347	65. 00
66.00	06600 PHYSI CAL THERAPY	10, 820	0	57, 362		927	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	4, 171 1, 405	0	27, 543 16, 514		75 463	67. 00 68. 00
69. 00		0	0	0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0	0	0	0	70. 00
71. 00	1 1	92, 261	0	0	0	0	71. 00
72. 00 73. 00	l l	60, 064	0	0	0	0	72.00
74. 00		101, 824	0	0	0	0	73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		0	Ö	o	0	75. 00
76. 00	03140 CARDI OLOGY	19, 958	0	111, 132	5, 537	1, 133	76. 00
05 -	OUTPATIENT SERVICE COST CENTERS						
88. 00 89. 00	+ I	0	0	0	0	0	88. 00
90.00	+ I	5, 074	0	61, 727		989	89. 00 90. 00
90. 01	04950 SLEEP CLINIC	2, 246	0	0 0	Ö	0	90. 01
91. 00	09100 EMERGENCY	68, 260	0	192, 353	91, 697	15, 586	91. 00
92. 00							92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94. 00
71.00	1 Springer - Moord in Director o	<u>, </u>	0	. 0		<u> </u>	, , , , , , ,

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

			10	3 12/31/201/	5/23/2018 2: 3	
Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 050, 470	0	4, 757, 814	625, 994	159, 166	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	1, 662	0	122, 207	0		192. 00
193. 00 19300 NONPALD WORKERS	1, 307	0	0	0		193. 00
193. 01 19301 COMMUNI TY	3, 133	0	65, 781	0		193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	36, 925	0	769, 204	0	17, 141	1
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	1, 093, 497	0	5, 715, 006	625, 994	180, 407	202. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0018

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

5/23/2018 2:39 pm Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL ADMI NI STRATI ON SERVICES & **PERSONNEL** SUPPLY 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 418, 235 10 00 01100 CAFETERI A 11.00 11.00 166, 227 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 3, 183 123, 254 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 2, 784 618, 460 14.00 01500 PHARMACY 0 7, 903 15.00 0 15.00 0 0 01600 MEDICAL RECORDS & LIBRARY 0 0 16.00 728 0 0 16.00 17.00 01700 SOCIAL SERVICE 2, 918 291 0 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 0 0 18.00 C 0 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 C 0 0 19 00 20.00 02000 NURSING SCHOOL C 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 0 21.00 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 22.00 0 02300 PARAMED ED PRGM 0 23.00 177 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 330, 709 47, 657 55, 337 0 30.00 31 00 03100 INTENSIVE CARE UNIT 37 355 8 915 0 13 197 0 31 00 0 31.01 03101 NEONATAL INTENSIVE CARE 0 2, 179 2,838 0 31.01 03200 CORONARY CARE UNIT 0 0 32.00 32.00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 ol 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 0 34.00 40.00 04000 SUBPROVI DER - I PF 32, 599 2, 752 0 2,551 0 40.00 04100 SUBPROVI DER - I RF 0 41.00 17, 572 2, 145 2, 165 0 41.00 43 00 04300 NURSERY 0 4.210 0 5.330 43 00 0 0 04400 SKILLED NURSING FACILITY 44.00 0 0 0 44.00 04500 NURSING FACILITY 0 0 0 0 45.00 45.00 C 46.00 04600 OTHER LONG TERM CARE 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 19,045 0 15,809 0 50.00 05100 RECOVERY ROOM 0 0 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 00000 Λ 0 0 0 52.00 0 05300 ANESTHESI OLOGY 53.00 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 12, 100 1, 951 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 05600 RADI OI SOTOPE 0 56, 00 56, 00 0 0 0 57 00 05700 CT SCAN 1, 947 0 0 57.00 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 836 0 0 0 58.00 59 00 05900 CARDIAC CATHETERIZATION 3, 067 1,823 59.00 0 06000 LABORATORY 3, 350 0 60.00 0 60.00 0 60.01 06001 BLOOD LABORATORY 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 0 62.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 2, 347 4,005 0 64.00 65.00 06500 RESPIRATORY THERAPY 0000000000 5, 971 0 0 65.00 06600 PHYSI CAL THERAPY 3, 422 0 66.00 0 66,00 0 06700 OCCUPATI ONAL THERAPY 67.00 1, 212 0 67.00 06800 SPEECH PATHOLOGY 68.00 430 68.00 69.00 06900 ELECTROCARDI OLOGY 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS C 0 0 377, 261 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 241, 199 72.00 07300 DRUGS CHARGED TO PATIENTS o 0 0 0 73.00 73.00 07400 RENAL DIALYSIS 0 74 00 C 0 0 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 03140 CARDI OLOGY 76.00 0 5, 618 0 557 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 0 09000 CLI NI C 1, 156 90.00 0 57 0 90.00 04950 SLEEP CLINIC 0 90 01 90 01 740 0 91.00 09100 EMERGENCY 0 16,885 0 15, 335 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00

			1	0 12/31/2017	5/23/2018 2:3	pared: 9 pm
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG	CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
					SUPPLY	
	10.00	11. 00	12.00	13. 00	14. 00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	
95. 00 09500 AMBULANCE SERVI CES	0	0	0	0	0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0		105. 00
106.00 10600 HEART ACQUISITION	0	0	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 I SLET ACQUISITION	0	0	0	0	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	418, 235	163, 677	0	123, 253	618, 460	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	555		0		193. 00
193. 01 19301 COMMUNI TY	0	554	0	1	0	193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	1, 441	0	0	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	418, 235	166, 227	0	123, 254	618, 460	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B |
| From 01/01/2017 | Part II |
| To 12/31/2017 | Date/Time Prepared: | 5/23/2018 2:39 pm | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

				10	3 12/31/2017	5/23/2018 2:3	
					OTHER GENERAL		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CE (SPECI FY)	NONPHYSI CI AN	
	cost center bescription	PHARWACT	RECORDS &	SOCIAL SERVICE	(SPECIFI)	ANESTHETISTS	
			LI BRARY				
	T	15. 00	16. 00	17. 00	18. 00	19. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			I		T	1.00
2. 00	00200 CAP REL COSTS-BEDG & TTXT						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						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						12.00
14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY	238, 971					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	O	118, 196				16. 00
17. 00	01700 SOCIAL SERVICE	0	0	1 .0,000			17. 00
18. 00 19. 00	O1850 OTHER GENERAL SERVICE (SPECIFY) O1900 NONPHYSICIAN ANESTHETISTS		0	0	0	0	18. 00 19. 00
20. 00	02000 NURSI NG SCHOOL		0	ő	0		20.00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	O	0	0	0		21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	_	0	l	22. 00
23. 00	O2300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0		23. 00
30. 00	03000 ADULTS & PEDIATRICS	385	18, 225	14, 956	0		30.00
31. 00	03100 INTENSIVE CARE UNIT	77	3, 949		0	l .	31.00
31. 01	03101 NEONATAL INTENSIVE CARE	0	525	1	0		31. 01
32.00	03200 CORONARY CARE UNIT	0	0		0		32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT		0	0	0		33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	3	1, 088		0		40. 00
41. 00	04100 SUBPROVI DER - I RF	3	509	1	0		41. 00
43.00	04300 NURSERY	0	779	· ·	0		43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY		0	0	0		44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE	Ö	0		0		46. 00
	ANCILLARY SERVICE COST CENTERS			_			
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	1, 518	23, 012 0	1	0	l	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0	ő	0		52.00
53.00	05300 ANESTHESI OLOGY	O	0	0	0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	108	12, 855		0		54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	0	0		55. 00 56. 00
	05700 CT SCAN		12, 050		0		57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	O	1, 998		0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	66	6, 739	1	0		59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0	13, 162 0		0		60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	٩	O		0		61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	O	1, 344	0	0		62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0		63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	29 4, 092	291 4, 636	i	0		64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 092	998	1	0		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	o	632	1	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	171		0		68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY	0	0	0	0		69.00
71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0	0	0		70. 00 71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	Ö	0	o	0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	229, 461	0	0	0		73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0		74.00
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03140 CARDI OLOGY	3, 124	5, 768	0	0		75. 00 76. 00
. 0. 00	OUTPATIENT SERVICE COST CENTERS	5, 124	5, 700				1 3. 30
88. 00	08800 RURAL HEALTH CLINIC	0	0	1	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	702	_	0		89. 00
90. 00 90. 01	09000 CLI NI C 04950 SLEEP CLI NI C		793 575		0		90. 00 90. 01
	09100 EMERGENCY	105	8, 097	1	0	1	91.00
		·					_

			Т	o 12/31/2017	Date/Time Pre 5/23/2018 2:3	
				OTHER GENERAL	37 237 2010 2.3) piii
				SERVI CE		
Cost Center Description	PHARMACY		SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN	
		RECORDS &			ANESTHETI STS	
	45.00	LI BRARY	47.00	10.00	10.00	
an an annual apartnyary ay prop (year protestar paper)	15. 00	16. 00	17. 00	18. 00	19. 00	00.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS 94. 00 O9400 HOME PROGRAM DI ALYSI S	٥		J 0			94. 00
94. 00 09400 HOME PROGRAM DI ALYSIS 95. 00 09500 AMBULANCE SERVICES	0	0		0		95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0	0		0		97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0		98.00
99. 00 09900 CMHC	0	0		0		99. 00
99. 10 09910 CORF	0	0		0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	0		0		101. 00
SPECIAL PURPOSE COST CENTERS	-1	-	-			
105. 00 10500 KIDNEY ACQUISITION	0	C	0	0		105. 00
106. 00 10600 HEART ACQUISITION	0	0	0	0		106. 00
107. 00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0		111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 H0SPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	238, 971	118, 196	18, 856	0	0	118. 00
NONREI MBURSABLE COST CENTERS				T		ļ
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	Ü	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	Ü	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0		0		193. 00
193. 01 19301 COMMUNI TY 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0		193. 01 194. 00
200.00 Cross Foot Adjustments	۷	U	Ί	U	^	200. 00
201.00 Negative Cost Centers	0	0		0		200.00
202.00 TOTAL (sum lines 118 through 201)	238, 971	118, 196	18, 856	0		202.00
202.00 TOTAL (Suill TITIES TTO THEOUGH 201)	230, 9/1	110, 190	ار, 630	ı o	U	1202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2017 | Part II | To 12/31/2017 | Date/Time Prepared: | 5/23/2018 2:39 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

NURSI NG SCHOOL SERVI CES - SALAR SERVI CES - OTHER PARAMED ED Subtotal PRGM COSTS PRGM
Y & FRINGES PRGM COSTS PRGM
Y & FRINGES PRGM COSTS PRGM
20.00 21.00 22.00 23.00 24.00
1. 00
2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL 6. 00 00600 MAINTENANCE & REPAIRS 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 1000 DIETARY 11. 00 01100 CAFETERIA 12. 00 01200 MAINTENANCE OF PERSONNEL 13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY
5. 00 00500 ADMINISTRATIVE & GENERAL 6. 00 00600 MAINTENANCE & REPAIRS 7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPING 10. 00 01000 DIETARY 11. 00 01100 CAFETERIA 12. 00 01200 MAINTENANCE OF PERSONNEL 13. 00 01300 NURSING ADMINISTRATION 14. 00 01400 CENTRAL SERVICES & SUPPLY
6. 00
8. 00
9. 00 00900 HOUSEKEEPI NG 9.
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A 12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 01400 CENTRAL SERVI CES & SUPPLY
11. 00 01100 CAFETERI A 11.
12. 00 01200 MAI NTENANCE OF PERSONNEL 12. 13. 00 01300 NURSI NG ADMI NI STRATI ON 13. 14. 00 01400 CENTRAL SERVI CES & SUPPLY 14.
13. 00 01300 NURSI NG ADMI NI STRATI ON 13. 14. 00 01400 CENTRAL SERVI CES & SUPPLY 14.
15. 00 01500 PHARMACY 15.
16. 00 01600 MEDI CAL RECORDS & LI BRARY 16.
17. 00 01700 SOCI AL SERVI CE 17. 18. 00 01850 OTHER GENERAL SERVI CE (SPECI FY) 18.
19. 00 01900 NONPHYSI CI AN ANESTHETI STS
20. 00 02000 NURSI NG SCHOOL 0 20.
21. 00 02100 L&R SERVICES-SALARY & FRINGES APPRVD 0 21.
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRVD 0 22.
23. 00 O2300 PARAMED ED PRGM 11, 119 23.
INPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS 6, 638, 686 30.
30. 00 03000 ADULTS & PEDIATRICS 6, 638, 686 30. 31. 00 03100 INTENSIVE CARE UNIT 606, 328 31.
31. 01 03101 NEONATAL INTENSIVE CARE 109, 992 31.
32. 00 03200 CORONARY CARE UNI T 0 32.
33.00 03300 BURN INTENSIVE CARE UNIT 0 33.
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT
40. 00 04000 SUBPROVI DER - 1 PF 495, 033 40. 41. 00 04100 SUBPROVI DER - 1 RF 432, 143 41.
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY 43. 00 04300 NURSERY 43. 00 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 430 43
44. 00 04400 SKILLED NURSING FACILITY 0 44.
45. 00 04500 NURSI NG FACILITY 0 45.
46. 00 04600 OTHER LONG TERM CARE 0 46.
ANCI LLARY SERVI CE COST CENTERS
50. 00 05000 OPERATI NG ROOM 2, 729, 402 50. 51. 00 05100 RECOVERY ROOM 0 51.
51. 00 05100 RECOVERT ROOM 0 51. 1 1 1 1 1 1 1 1 1
53. 00 05300 ANESTHESI OLOGY 0 53.
54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 697, 346 54.
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 55.
56. 00 05600 RADI 0I SOTOPE 0 56.
57. 00 05700 CT SCAN 309, 154 57. 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 154, 009 58.
59. 00 05900 CARDI AC CATHETERI ZATI ON 191, 857 59.
60. 00 06000 LABORATORY 297, 261 60.
60. 01 06001 BLOOD LABORATORY 0 60.
61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 61.
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7, 021 62.
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63. 64. 00 06400 INTRAVENOUS THERAPY 95, 775 64.
65. 00 06500 RESPI RATORY THERAPY 107, 278 65.
66. 00 06600 PHYSI CAL THERAPY 224, 590 66.
67. 00 06700 OCCUPATI ONAL THERAPY 102, 414 67.
68. 00 06800 SPEECH PATHOLOGY 60, 187 68.
69. 00 06900 ELECTROCARDI OLOGY 0 69.
70. 00 07000 ELECTROENCEPHALOGRAPHY
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 409, 322 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 301, 263 72.
73. 00 07300 DRUGS CHARGED TO PATIENTS 331, 285 73.
74. 00 07400 RENAL DI ALYSI S 0 74.
75. 00 07500 ASC (NON-DISTINCT PART) 0 75.
76. 00 03140 CARDI OLOGY 432, 432 76.
OUTPATI ENT SERVI CE COST CENTERS 88.00 08800 RURAL HEALTH CLI NI C 0 88.
88. 00 08800 RURAL HEALTH CLINIC 0 88. 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.
90. 00 09000 CLI NI C 223, 796 90.
90. 01 04950 SLEEP CLINIC 3,643 90.
91. 00 09100 EMERGENCY 889, 405 91.
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 92.

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2017 Part II Provider CCN: 15-0018

					o 12/31/2017	Date/Time Pre 5/23/2018 2:3	pared:
			I NITERNS &	RESI DENTS		3/23/2010 2.3	9 piii
			I INTERNO G	RESTRENTS			
	Cost Center Description	NURSING SCHOOL	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	
	, and the second		Y & FRINGES	PRGM COSTS	PRGM		
		20.00	21.00	22.00	23.00	24. 00	
	REIMBURSABLE COST CENTERS						
94.00 09400	HOME PROGRAM DIALYSIS					0	94.00
	AMBULANCE SERVICES					0	95. 00
	DURABLE MEDICAL EQUIP-RENTED					0	96. 00
	DURABLE MEDICAL EQUIP-SOLD					0	97. 00
	OTHER REIMBURSABLE COST CENTERS					0	98. 00
99. 00 09900						0	99. 00
99. 10 09910						0	1 , , , ,
	I&R SERVICES-NOT APPRVD PRGM						100. 00
101.00 10100	HOME HEALTH AGENCY					0	101. 00
	AL PURPOSE COST CENTERS						
	KIDNEY ACQUISITION						105. 00
	HEART ACQUISITION						106. 00
	LIVER ACQUISITION						107. 00
	LUNG ACQUISITION						108. 00
	PANCREAS ACQUISITION						109. 00
	INTESTINAL ACQUISITION						110. 00
	ISLET ACQUISITION					0	111. 00
	INTEREST EXPENSE						113. 00
	UTILIZATION REVIEW-SNF						114. 00
	AMBULATORY SURGICAL CENTER (D. P.)						115. 00
116. 00 11600							116. 00
	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	(0	17, 573, 521	118. 00
	MBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190. 00
191. 00 19100							191. 00
	PHYSICIANS' PRIVATE OFFICES					432, 536	
	NONPALD WORKERS						193. 00
193. 01 19301						233, 469	
	OTHER NONREIMBURSABLE COST CENTERS					2, 741, 910	
200.00	Cross Foot Adjustments	0	0	(11, 119		200. 00
	Negative Cost Centers	0	0	(0		201. 00
202. 00	TOTAL (sum lines 118 through 201)	0	0	· (11, 119	20, 994, 467	202. 00

Heal th Financial Systems

ELKHART GENERAL HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-0018

Period:
From 01/01/2017
To 12/31/2017

Part II
Date/Time Prepared:
5/23/2018 2: 39 pm

				5/23/2018	2:39 pm
	Cost Center Description	Intern &	Total		
		Residents Cost			
		& Post			
		Stepdown			
		Adjustments	24.00		
	GENERAL SERVICE COST CENTERS	25. 00	26. 00		
1.00	00100 CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL				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	01200 MAI NTENANCE OF PERSONNEL				12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON				13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY				14.00
15. 00 16. 00	01500 PHARMACY				15. 00
17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE				16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)				18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS				19. 00
20. 00	02000 NURSI NG SCHOOL				20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD				21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD				22. 00
23. 00	02300 PARAMED ED PRGM				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS	0	6, 638, 686		30. 00
31.00	03100 NTENSI VE CARE UNI T	0	606, 328		31.00
31. 01 32. 00	03101 NEONATAL INTENSIVE CARE	0	109, 992 0		31. 01 32. 00
33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT		0		33.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT		0		34. 00
40. 00	04000 SUBPROVI DER – I PF	0	495, 033		40. 00
41.00	04100 SUBPROVI DER - I RF	0	432, 143		41. 00
43.00	04300 NURSERY	0	663, 699		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		44.00
45. 00	04500 NURSING FACILITY	0	0		45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0		46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	2, 729, 402		50.00
51. 00	05100 RECOVERY ROOM		2, 729, 402		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		Ö		52.00
53. 00	05300 ANESTHESI OLOGY	0	o		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 697, 346		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
56.00	05600 RADI 0I SOTOPE	0	0		56. 00
57. 00	05700 CT SCAN	0	309, 154		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	154, 009		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	191, 857		59. 00
60.00	06000 LABORATORY	0	297, 261		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	7, 021		61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		7, 021		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	95, 775		64. 00
65. 00	06500 RESPI RATORY THERAPY	0	107, 278		65. 00
66.00	06600 PHYSI CAL THERAPY	0	224, 590		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	102, 414		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	60, 187		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	469, 522		71.00
72.00			301, 263		72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		331, 285 0		73. 00 74. 00
75.00	07500 ASC (NON-DISTINCT PART)		0		74.00
76. 00	03140 CARDI OLOGY		432, 432		76.00
, 0. 00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	102, 402		75.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00			ō		89. 00
90.00	09000 CLI NI C	0	223, 796		90. 00
90. 01	04950 SLEEP CLINIC	0	3, 643		90. 01
91. 00	09100 EMERGENCY	0	889, 405		91.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2017 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

			To 12/31/2017 Date/Ti me Prepared: 5/23/2018 2:39 pm
Cost Center Description	Intern &	Total	5/23/2016 2.39 piii
oust contain beschiption	Residents Cost	Total	
	& Post		
	Stepdown		
	Adjustments		
	25. 00	26. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		92.00
OTHER REIMBURSABLE COST CENTERS			
94.00 09400 HOME PROGRAM DIALYSIS	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	98.00
99. 00 09900 CMHC	0	0	99.00
99. 10 09910 CORF	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	101. 00
SPECIAL PURPOSE COST CENTERS			
105.00 10500 KIDNEY ACQUISITION	0	0	1.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	106.00
107. 00 10700 LIVER ACQUISITION	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	111.00
113.00 11300 INTEREST EXPENSE			113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF			114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	17, 573, 521	118. 00
NONREI MBURSABLE COST CENTERS	T T		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190. 00
191. 00 19100 RESEARCH	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	432, 536	
193. 00 19300 NONPAI D WORKERS	0	1, 912	
193. 01 19301 COMMUNI TY	0	233, 469	
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	2, 741, 910	
200.00 Cross Foot Adjustments	0	11, 119	
201. 00 Negative Cost Centers	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	20, 994, 467	202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 ELKHART GENERAL HOSPITAL Provider CCN: 15-0018 Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/23/2018 2:39 pm CAPITAL RELATED COSTS

Filt Real SHAWLOT COIST CRITTERS 1.00 2.00 4.00 5A 5.00			Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
0.00 0.00 QAP REL COSTS-BLDG & FIXT				1.00	2.00		5A	5. 00	
2.00 0.0000 CAP REL COSTS-WISE FOULP 729, 441 720, 517 76, 262, 802 3, 97, 817 5, 00 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 0.0000 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 0.00000 0.00000 0.00000 0.00000000		1 00		720 441					1 00
0-0400 EMPLOYEE BENEFITS DEPARTWENT 755 755 75, 202, 802 20				729, 441	729 441				2.00
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				755					4. 00
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0.000 0.0800 LAUNDRY & LINEN SERVICE 15, 559 15, 559 63, 661 0 1, 199, 137 2.0			1	0	1	1		1	6. 00
9.00 0900 (HOUSEKEEN MG 3,935 3,935 1,912,523 0,387,283 9,911.00 0100 (DETARY 10,103 10,103 885,114 0,1872,834 10, 11.00 01100 (AFFTER) 3,866 3,869 85,663 0 1,556,563 1,10 1,10 01100 (AFFTER) 3,866 3,869 85,663 0 1,556,563 1,10 0100 (AFFTER) 3,866 1,10 01100 (AFFTER) 4,10 01100 (AFFTER									7. 00 8. 00
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12 00 01200 MAINTENANCE OF PERSONNEL 0 0 0 0 0 0 0 120									
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Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0018

			T	0 12/31/2017	Date/Time Pre 5/23/2018 2:3	
	CAPITAL REL	ATED COSTS				
Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
	1.00	2. 00	4. 00	5A	5. 00	
90. 01 04950 SLEEP CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 16, 656	0 16, 656	,			1
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0			-	1
95. 00 09500 AMBULANCE SERVICES	0	0	_	_	_	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0	_	· ·		
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0	0	1	0	
99. 00 09900 CMHC	0	0	Ö		Ö	
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS				ام		1.05.00
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON	0	0		· ·		105. 00 106. 00
106. 00 10600 HEART ACQUISITION		0		· ·		106.00
108. 00 10800 LUNG ACQUISITION		0	0	_		107.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	_		109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0	ő	_		110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0 500 007		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	646, 557	646, 557	75, 269, 757	-33, 593, 827	192, 460, 282	1118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0		· ·		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	10, 582	10, 582	_	1		
193. 00 19300 NONPALD WORKERS	0	0	173, 749	0	239, 535	193. 00
193. 01 19301 COMMUNI TY	5, 696	5, 696	211, 819	0	574, 080	193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	66, 606	66, 606	607, 477	0	6, 765, 221	
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	1/ 505 741	4 4/0 70/	722 405		22 502 027	201. 00
202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I)	16, 525, 741 22. 655350	4, 468, 726 6. 126234	·		33, 593, 827 0. 167681	
204.00 Cost to be allocated (per Wkst. B, Part II) Part II)	22. 000000	0. 120234	21, 730		1, 093, 497	1
205.00 Unit cost multiplier (Wkst. B, Part			0. 000285		0. 005458	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

Peri od: From 01/01/2017 To 12/31/2017 Date/Ti me Prepared: 5/23/2018 2:39 pm

						5/23/2018 2: 3	9 pm
	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (HOURS OF SERVI CE)	DIETARY (MEALS SERVED)	
				LAUNDRY)			
	CENEDAL CEDIUSE COCT CENTERS	6. 00	7. 00	8. 00	9. 00	10.00	
1 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			1		I	1. 00
1. 00 2. 00	00200 CAP REL COSTS-BLDG & FIXT						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS	690, 735					6. 00
7. 00	00700 OPERATION OF PLANT	195, 868					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	15, 359					8. 00
9. 00	00900 HOUSEKEEPI NG	3, 935			101, 249		9. 00
10. 00	01000 DI ETARY	10, 103		1	172		10. 00
11. 00	01100 CAFETERI A	3, 869		1	910		11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0,007	0,007	Ŏ	0	Ö	12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	2, 700	2, 700	o o	323	l o	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	14, 966		1	1, 434		14. 00
15. 00	01500 PHARMACY	5, 478		1	650		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	2, 823			367	0	16. 00
17. 00	01700 SOCIAL SERVICE	112			0	0	17. 00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0		o	0	0	18.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	0	l c	o	0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM	250	250	0	42	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	141, 956	141, 956	214, 903	43, 940	142, 826	30.00
31.00	03100 INTENSIVE CARE UNIT	11, 187	11, 187	59, 626	2, 980	16, 133	31.00
31. 01	03101 NEONATAL INTENSIVE CARE	2, 330	2, 330	345	572		31. 01
32.00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	10, 912		1	2, 132		40. 00
41. 00	04100 SUBPROVI DER - I RF	9, 500			2, 132		41. 00
43. 00	04300 NURSERY	15, 232		22, 665	572		43.00
44. 00	04400 SKILLED NURSING FACILITY	0	1	0	0	0	44.00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0		0	0	0	46. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	E0.254	E0 254	215 007	15 401	1 0	EO 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	58, 356	58, 356	215, 907	15, 421	0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			0	0	52.00
53. 00	05300 ANESTHESI OLOGY				0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	38, 565	38, 565	63, 764	3, 055		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	30, 303	30, 303	03, 704	3, 039 0	Ö	55. 00
56. 00	05600 RADI OI SOTOPE	0			0	Ö	56. 00
57. 00	05700 CT SCAN	7, 099	7, 099	2	377	l ő	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	3, 587			258		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 072		1	1, 371	0	59. 00
60.00	06000 LABORATORY	5, 429		1	780		60.00
60. 01	06001 BLOOD LABORATORY	0	0	o	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	l c	О	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	1, 953	1, 953	0	885	0	64.00
65.00	06500 RESPI RATORY THERAPY	1, 804	1, 804	0	195	0	65.00
66.00	06600 PHYSI CAL THERAPY	4, 967	4, 967	8, 776	520	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	2, 385	2, 385	0	42	0	67.00
68. 00	06800 SPEECH PATHOLOGY	1, 430	1, 430	0	260		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	<u> </u>	0	0	75. 00
76. 00	03140 CARDI OLOGY	9, 623	9, 623	6, 306	636	0	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS		_			_	00.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0		88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	F 345	- 345		0	0	89. 00
90.00	09000 CLINIC	5, 345	5, 345		555	0	90. 00 90. 01
90. 01 91. 00	04950 SLEEP CLINIC 09100 EMERGENCY	14 454	14 454	104, 436	8, 747		90.01
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	16, 656	16, 656	104, 430	0, /4/		91.00
72.00	101200 ODDERVATION DEDO (NON-DISTINCI PARI)	1	l	I .		l .	72.00

				T	o 12/31/2017	Date/Time Pre 5/23/2018 2:3	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY) piii
	, , , , , , , , , , , , , , , , , , ,	REPAI RS	PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	SERVICE)		
				LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
	OTHER REIMBURSABLE COST CENTERS			1		1	
	09400 HOME PROGRAM DI ALYSI S	0	0		0	1	
	09500 AMBULANCE SERVI CES	0	0	_	0	· -	
	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0	0	
	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0	0	
	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	
	09900 CMHC	0	0	0	0	0	1 / / / 00
	09910 CORF	0	0		0	0	
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0		100. 00
	10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS	_	_	1 -		-	ļ
	10500 KIDNEY ACQUISITION	0	0		0		105. 00
	10600 HEART ACQUISITION	0	0	_	0		106. 00
	10700 LI VER ACQUI SI TI ON	0	0	0	0		107. 00
	10800 LUNG ACQUISITION	0	0	0	0		108. 00
	10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
	11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110. 00
	11100 SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
	11300 I NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
	11600 HOSPI CE	0	0	0	0		116. 00
118. 00		607, 851	411, 983	712, 960	89, 328	180, 627	1118. 00
100.00	NONREI MBURSABLE COST CENTERS		0	1 0		1 0	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
	19100 RESEARCH	10 500	10 500	0	2 201		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	10, 582	10, 582	0	2, 301		192. 00
	19300 NONPALD WORKERS	5 (0)	U 5 (0)	0	0		193. 00
	19301 COMMUNITY	5, 696	5, 696		0 (00		193. 01
	07950 OTHER NONREIMBURSABLE COST CENTERS	66, 606	66, 606	1	9, 620	0	194. 00
200.00	,						200. 00
201.00	Negative Cost Centers Cost to be allocated (per Wkst. B,		1/ 455 500	1 010 025	4 (50 070	2 520 727	201. 00
202. 00	Part I)	0	16, 455, 592	1, 910, 935	4, 658, 279	2, 530, 737	202.00
203. 00		0. 000000	33. 252555	2. 680284	46. 008148	14. 010846	202 00
	Cost to be allocated (per Wkst. B,	0.000000					1
204. 00	Part II)	0	5, 715, 006	625, 994	180, 407	418, 235	204.00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	11. 548570	0. 878021	1. 781815	2. 315462	205 00
203.00	II)	0.00000	11. 540570	0.070021	1. 701013	2. 313402	203.00
206.00	NAHE adjustment amount to be allocated						206. 00
200.00	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						

	Financial Systems ALLOCATION - STATISTICAL BASIS	ELKHART GENER		CN: 15-0018 F	In Lie	u of Form CMS-2 Worksheet B-1	
0031 /	ALLOCATION - STATISTICAL DASIS		FIOVICE	F	rom 01/01/2017 o 12/31/2017	Date/Time Pre	
	Cost Center Description	CAFETERI A (HOURS OF SERVI CE)	MAI NTENANCE OF PERSONNEL (NUMBER HOUSED)	NURSING ADMINISTRATION (DIRECT NURS.	CENTRAL I SERVI CES & SUPPLY (COSTED	5/23/2018 2:3 PHARMACY (COSTED REQUIS.)	9 pm
		11.00	12.00	HRS.) 13. 00	REQUIS.) 14.00	15. 00	
	GENERAL SERVICE COST CENTERS		1				
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	2, 130, 051 0 40, 783 35, 673 101, 265 9, 330 37, 388 0 0 0		920, 508 33 0	100 0 0 0 0 0 0 0 0 0 0 0 0 0	13, 547, 736 0 0 0 0 0 0 0	16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00
30. 00 31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 46. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	610, 669 114, 244 27, 917 0 0 35, 265 27, 491 53, 949 0 0		98, 559 21, 196 0 0 0 19, 053 0 16, 166 0 39, 805		21, 839 4, 361 0 0 0 0 194 191 0 0	31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00
50 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	244 044	Ι (119 060	ا ا	86.054	50.00
54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 63. 00 64. 00 65. 00 66. 00 67. 00 69. 00 70. 00 71. 00 72. 00 74. 00 75. 00 76. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STINCT PART) 03140 CARDI OLOGY	244, 044 0 0 155, 045 0 24, 955 10, 711 39, 299 42, 926 0 30, 076 76, 513 43, 849 15, 537 5, 509 0 0 0 0 0 0 0 0 0 0 0 0 0		29, 913 29, 913 29, 913 29, 913 29, 913	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	86, 054 0 0 6, 151 0 0 0 3, 731 0 0 1, 625 231, 990 0 0 0 0 0 1, 3, 731 0 0 1, 625 231, 990 0 0 0 0 0 0 0 0 0 0 1, 625 1, 731 0 0 0 0 0 0 0 0 0 0 0 0 0	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00
90. 00 90. 01	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 04950 SLEEP CLINIC 09100 EMERGENCY	0 0 14, 819 9, 480 216, 371	() () 423) (0 0	0 0 0 0 5, 949	89. 00 90. 00

Health Financial Systems ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0018 Peri od: Worksheet B-1 From 01/01/2017 12/31/2017 Date/Time Prepared: 5/23/2018 2:39 pm Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** (HOURS OF PERSONNEL ADMI NI STRATI ON SERVICES & (COSTED SERVICE) (NUMBER **SUPPLY** REQUIS.) (DIRECT NURS (COSTED HOUSED) REQUIS.) HRS.) 11.00 12.00 15.00 13.00 14.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 94.00 00000000 0 0 09500 AMBULANCE SERVICES 95.00 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 96.00 0 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 0 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 98.00 Λ 99.00 09900 CMHC 0 0 0 99.00 0 99. 10 09910 CORF 0 0 0 99. 10 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 0 105. 00 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 0 106. 00 10600 HEART ACQUISITION 0 106.00 0 Ω 107. 00 10700 LIVER ACQUISITION 0 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 108.00 0 0 0 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION C 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 111. 00 113. 00 11300 | INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 097, 363 0 920, 503 100 13, 547, 736 118. 00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192. 00 0 0 193. 00 19300 NONPALD WORKERS 0 0 193.00 7.118 Ω 193. 01 19301 COMMUNI TY 7, 103 0 5 0 0 193. 01 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 194. 00 18, 467 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201 00 202.00 Cost to be allocated (per Wkst. B, 1, 951, 532 2, 339, 927 2, 591, 465 1, 979, 091 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0. 916190 0.000000 2.541995 25, 914. 650000 0. 146083 203. 00 204.00 Cost to be allocated (per Wkst. B, 166, 227 123, 254 618, 460 238, 971 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.078039 0.000000 0. 133898 6, 184. 600000 0. 017639 205. 00 II) 206.00 NAHE adjustment amount to be allocated 206.00

207.00

(per Wkst. B-2)

Parts III and IV)

NAHE unit cost multiplier (Wkst. D,

207.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/23/2018 2:39 pm Provider CCN: 15-0018

				'	0 12/31/201/	5/23/2018 2:3	
	Cost Center Description	MEDI CAL RECORDS & LI BRARY (REVENUE)	SOCIAL SERVICE	OTHER GENERAL SERVICE (SPECIFY) (TIME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	NURSING SCHOOL (ASSIGNED TIME)	
	T	16. 00	17. 00	18. 00	19. 00	20.00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1	I	T			1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						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						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL						12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY						15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	534, 080, 120	l .				16.00
17. 00 18. 00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY)	0	11, 724 0	1			17. 00 18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS		0	0	C		19. 00
20. 00	02000 NURSI NG SCHOOL		Ö	Ö		1 0	20. 00
21. 00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0			21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0			22. 00
23. 00	02300 PARAMED ED PRGM	0	0	0			23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	82, 466, 658	9, 299	0	С	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T	17, 867, 005		•			31.00
31. 01	03101 NEONATAL INTENSIVE CARE	2, 375, 090	l .			0	31. 01
32.00	03200 CORONARY CARE UNIT	0	0		_	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		_	0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	4, 921, 954	0 576				34. 00 40. 00
41. 00	04100 SUBPROVI DER – TFI	2, 302, 634			_		41.00
43. 00	04300 NURSERY	3, 522, 841	1, 221	Ō	_	o o	43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	C	0	44. 00
45.00	04500 NURSING FACILITY	0	0		_		45. 00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	0	C	0	46. 00
50. 00	05000 OPERATI NG ROOM	103, 390, 901	0	0	C	0	50.00
51.00	05100 RECOVERY ROOM	0	0			0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	C	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	C	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	58, 167, 931	0	0		0 0	54. 00 55. 00
	05600 RADI OI SOTOPE		0		_		1
57. 00	05700 CT SCAN	54, 525, 929	0	0	C	0	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	9, 041, 141		0	C	ή	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	30, 491, 096		0	C	0	59. 00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	59, 554, 659	0	0	C	1	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY)	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	6, 080, 307	0	0	C	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	C	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	1, 316, 260		0	C	0	64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	20, 978, 425 4, 516, 103		0		0 0	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 860, 680		0	_		67. 00
68. 00	06800 SPEECH PATHOLOGY	774, 289		0	C	o o	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	C	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	C	0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS		0	0		0	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0	0			73. 00
74. 00	07400 RENAL DIALYSIS		Ö	Ö	C	o o	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0			75. 00
76. 00	03140 CARDI OLOGY	26, 099, 217] 0	0	C	0	76. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0	0		0	88. 00
88.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		_		88.00
90.00	09000 CLI NI C	3, 587, 234		ő		1	1
90. 01	04950 SLEEP CLINIC	2, 603, 339	0	0	С	0	90. 01

| Peri od: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0018

				T	o 12/31/2017	Date/Time Pre 5/23/2018 2:3	pared:
				OTHER GENERAL		3/23/2010 2.3	7 PIII
				SERVI CE			
	Cost Center Description	MEDI CAL	SOCIAL SERVICE		NONPHYSI CI AN	NURSING SCHOOL	
	,	RECORDS &		(TIME SPENT)	ANESTHETI STS		
		LI BRARY	(TIME SPENT)		(ASSI GNED	(ASSI GNED	
		(REVENUE)	,		TIME)	TIME)	
		16. 00	17. 00	18. 00	19. 00	20.00	
91.00 09100	EMERGENCY	36, 636, 427	0	0	0	0	91. 00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	REIMBURSABLE COST CENTERS						
	HOME PROGRAM DIALYSIS	0	0				94. 00
	AMBULANCE SERVICES	0	0				95. 00
	DURABLE MEDICAL EQUIP-RENTED	0	0	_ ~		· -	96. 00
	DURABLE MEDICAL EQUIP-SOLD	0	0	0	_	0	97. 00
	OTHER REIMBURSABLE COST CENTERS	0	0	0	_	0	98. 00
99.00 09900		0	0	0	_	0	99. 00
99. 10 09910		0	0	0	_	0	99. 10
	I &R SERVICES-NOT APPRVD PRGM	0	0	_			100.00
	HOME HEALTH AGENCY	0	0	0	0	0	101. 00
	AL PURPOSE COST CENTERS	0	0	0	0		105 00
4	KIDNEY ACQUISITION	0		_	_	1	105. 00 106. 00
	HEART ACQUISITION LIVER ACQUISITION	0					106.00
	LUNG ACQUISITION	0		0		l e	107.00
	PANCREAS ACQUISITION	0		0	_	l e	108.00
	INTESTINAL ACQUISITION	0		0	_		1109.00
	ISLET ACQUISITION	0			0		111.00
	INTEREST EXPENSE	0		1	0	0	113. 00
	UTILIZATION REVIEW-SNF			•			114. 00
1	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00
116. 00 11600		0		0	_		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	534, 080, 120	11, 724	_			118. 00
	I MBURSABLE COST CENTERS	001/000/120	,,2	,			
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191.00 19100		0	Ö				191. 00
	PHYSICIANS' PRIVATE OFFICES	0	O	0	0	0	192. 00
	NONPALD WORKERS	0	o	0	0	0	193. 00
193. 01 19301	COMMUNI TY	0	0	0	0	0	193. 01
194. 00 07950	OTHER NONREIMBURSABLE COST CENTERS	0	0	0	0	0	194. 00
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers						201. 00
202. 00	Cost to be allocated (per Wkst. B,	732, 701	2, 351, 950	0	0	0	202. 00
	Part I)						
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 001372			0. 000000	•	1
204. 00	Cost to be allocated (per Wkst. B,	118, 196	18, 856	0	0	0	204. 00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000221	1. 608325	0.000000	0. 000000	0. 000000	205. 00
201 20							00/ 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,					0. 000000	207.00
207.00	Parts III and IV)					0.00000	207.00
I	i ai ta i i ai ai ai v	I	I	I	I	I	ı

Provider CCN: 15-0018

| Period: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: 5/23/2018 2:39 pm

					5/23/2018 2: 3	39 pm
		INTERNS &	RESI DENTS			
	Cost Center Description	SERVI CES-SALAR	SEDVICES OTHER	PARAMED ED		
	cost center bescription	Y & FRINGES	PRGM COSTS	PRGM		
		(ASSI GNED	(ASSI GNED	(ASSI GNED		
		TIME)	TIME)	TIME)		
		21.00	22. 00	23. 00		
	GENERAL SERVICE COST CENTERS	T				
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					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					9. 00
10.00	01000 DI ETARY					10.00
11. 00 12. 00	O1100 CAFETERI A O1200 MAI NTENANCE OF PERSONNEL					11. 00 12. 00
13. 00	01300 NURSING ADMINISTRATION					13. 00
	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY					16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)					18. 00
19.00	01900 NONPHYSI CLAN ANESTHETI STS					19.00
20. 00 21. 00	02000 NURSI NG SCHOOL 02100 I&R SERVI CES-SALARY & FRI NGES APPRVD	0				20.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0			22. 00
23. 00	02300 PARAMED ED PRGM		Ŭ	100		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDIATRICS	0	0	0		30. 00
31.00	03100 I NTENSI VE CARE UNI T	0	0			31.00
31. 01 32. 00	03101 NEONATAL INTENSIVE CARE	0	0	0		31. 01
32.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0		32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0		34.00
40. 00	04000 SUBPROVIDER - I PF	0	0	Ő		40.00
41.00	04100 SUBPROVI DER - I RF	0	0	0		41.00
43.00	04300 NURSERY	0	0	0		43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0		44. 00
45. 00	04500 NURSING FACILITY	0	0	0		45. 00
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0	0		46. 00
50. 00	05000 OPERATI NG ROOM	0	0	0		50.00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0		53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0	0	0		54. 00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0	0		55. 00 56. 00
	05700 CT SCAN	0	0	0		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	ő		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0		59. 00
60.00	06000 LABORATORY	0	0	0		60.00
60. 01	06001 BLOOD LABORATORY	0	0	0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	_		61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0		64. 00
65. 00	06500 RESPIRATORY THERAPY	0	0	0		65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0		68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0		69.00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0		70.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		o			73. 00
74. 00	07400 RENAL DI ALYSI S	0	o	0		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0		75. 00
76. 00	03140 CARDI OLOGY	0	0	0		76. 00
00 00	OUTPATIENT SERVICE COST CENTERS		٥	^		00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	O O	0		88.00
90.00	09000 CLINIC	0	o.	0		90.00
90. 01	04950 SLEEP CLINIC	0	0	0		90. 01

| Peri od: | Worksheet B-1 | From 01/01/2017 | To 12/31/2017 | Date/Time Prepared: Provider CCN: 15-0018

			10	5/23/2017 Date/Time P	
	INTERNS &	RESIDENTS		37 237 2010 2	. 37 piii
		NEO I DEN I O			
Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED		
p	Y & FRINGES	PRGM COSTS	PRGM		
	(ASSI GNED	(ASSI GNED	(ASSI GNED		
	TIME)	TIME)	TIME)		
	21.00	22. 00	23. 00		
91. 00 09100 EMERGENCY	0	0	100		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
OTHER REIMBURSABLE COST CENTERS	•				
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	0	o	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0		97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0		98. 00
99. 00 09900 CMHC	0	0	0		99. 00
99. 10 09910 CORF	o o	0	0		99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	Ŏ	Ö	0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS		<u> </u>	<u> </u>		101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0		105. 00
106. 00 10600 HEART ACQUISITION	Ŏ	Ö	0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0	0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0	0		109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0	0		110.00
111. 00 11100 SLET ACQUISITION	0	0	0		111.00
113. 00 11300 NTEREST EXPENSE		U	U		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	_	0	0		115.00
116. 00 11600 HOSPI CE	U	U	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	100		118.00
NONREI MBURSABLE COST CENTERS	U	U	100		-110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0		193. 00
193. 01 19301 COMMUNI TY	0	0	0		193. 00
193. 01 19301 COMMONTTY 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194. 00
	U	U	U		
					200. 00
201.00 Negative Cost Centers			475 407		201. 00
202.00 Cost to be allocated (per Wkst. B,	0	0	175, 136		202. 00
Part I)	0.000000	0.000000	1 751 2/0000		202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000				203. 00
204.00 Cost to be allocated (per Wkst. B, Part II)		0	11, 119		204. 00
	0 000000	0.000000	111 100000		205 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	111. 190000		205. 00
206.00 NAHE adjustment amount to be allocated			0		206. 00
(per Wkst. B-2)			U		200.00
207.00 NAHE unit cost multiplier (Wkst. D,			0. 000000		207. 00
Parts III and IV)			0.00000		[
1	1	'	· ·		1

Hearth Financial Systems	ELKHART GENERAL	HUSPI IAL	In Lieu	U OT FORM CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0018	Peri od:	Worksheet C
			From 01/01/2017	Part I
			To 12/31/2017	Date/Time Prepared:
				5/23/2018 2:39 pm

					5/23/2018 2:3	9 pm
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	Part I, col. 26)					
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	50, 181, 556		50, 181, 556			30. 00
31. 00 03100 I NTENSI VE CARE UNI T	8, 284, 769		8, 284, 769	0	8, 284, 769	31.00
31. 01 03101 NEONATAL INTENSIVE CARE	2, 054, 412		2, 054, 412	0	2, 054, 412	1
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT	0		0	0	0	32. 00 33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0		0	0	0	34.00
40. 00 04000 SUBPROVI DER - PF	3, 119, 755		3, 119, 755	0	3, 119, 755	40.00
41. 00 04100 SUBPROVI DER - RF	2, 543, 881		2, 543, 881	0	2, 543, 881	41.00
43. 00 04300 NURSERY	4, 353, 501		4, 353, 501	0	4, 353, 501	
44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY			0	0	0	44. 00 45. 00
46. 00 04600 OTHER LONG TERM CARE			0	0	0	46.00
ANCI LLARY SERVICE COST CENTERS						10.00
50. 00 05000 OPERATING ROOM	24, 679, 927		24, 679, 927	15, 404	24, 695, 331	50. 00
51. 00 05100 RECOVERY ROOM	0		0	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	13, 014, 731		13, 014, 731	44, 719	0 13, 059, 450	53. 00 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	13,014,731		13,014,731	0	13, 037, 430	55.00
56. 00 05600 RADI OI SOTOPE	0		Ö	0	0	56. 00
57. 00 05700 CT SCAN	2, 055, 034		2, 055, 034	0	2, 055, 034	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 355, 862		1, 355, 862		1, 355, 862	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 112, 460		3, 112, 460	3, 958		
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	13, 205, 447		13, 205, 447	0	13, 205, 447 0	60. 00 60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY] 0	0	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 222, 957		1, 222, 957	0	1, 222, 957	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	2, 017, 917		2, 017, 917		2, 017, 917	
65. 00 06500 RESPIRATORY THERAPY	4, 230, 962		4, 230, 962		4, 234, 263	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	2, 573, 869 991, 775		2, 573, 869 991, 775		2, 581, 929 991, 775	
68. 00 06800 SPEECH PATHOLOGY	366, 218		366, 218		366, 218	
69. 00 06900 ELECTROCARDI OLOGY	0		0	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70. 00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	21, 319, 033		21, 319, 033		21, 319, 033	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	13, 860, 622 23, 684, 472		13, 860, 622 23, 684, 472		13, 860, 622 23, 684, 472	72. 00 73. 00
74. 00 07400 RENAL DI ALYSI S	23,004,472		23, 004, 472	0	23, 004, 472	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0		Ō	0	0	75. 00
76. 00 03140 CARDI OLOGY	4, 812, 171		4, 812, 171	10, 496	4, 822, 667	76. 00
OUTPATIENT SERVICE COST CENTERS		I		^		00.00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	88. 00 89. 00
90. 00 09000 CLINI C	1, 308, 313		1, 308, 313	590		1
90. 01 04950 SLEEP CLINIC	492, 690		492, 690			1
91. 00 09100 EMERGENCY	16, 555, 349		16, 555, 349			91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 330, 669		10, 330, 669		10, 330, 669	92. 00
94. 00 O9400 HOME PROGRAM DI ALYSI S	0		0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES] 0	0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		Ö	0	ő	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98. 00
99. 00 09900 CMHC	0		0		0	99. 00
99. 10 09910 CORF 100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	ł	0		0	99. 10 100. 00
101.00 10100 HOME HEALTH AGENCY			0			100.00
SPECIAL PURPOSE COST CENTERS		L			<u> </u>	
105.00 10500 KIDNEY ACQUISITION	0	l e	0			105. 00
106. 00 10600 HEART ACQUISITION	0		0			106.00
107. 00 10700 LINE ACQUISITION	0	•	0			107.00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION	0	•	0			108. 00 109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON			0			110.00
111. 00 11100 SLET ACQUI SI TI ON	0		0			111. 00
113. 00 11300 NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF			_		_	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	1	0		1 0	115. 00

Heal th Finar	ncial Systems	ELKHART GENER	AL I	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES			Provider CC	CN: 15-0018	Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/23/2018 2:3	
				Title	XVIII	Hospi tal	PPS	
						Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)		erapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	,	1.00		2. 00	3.00	4. 00	5. 00	
116. 00 11600 200. 00 201. 00 202. 00	HOSPICE Subtotal (see instructions) Less Observation Beds Total (see instructions)	0 231, 728, 352 10, 330, 669 221, 397, 683		0	231, 728, 35 10, 330, 66 221, 397, 68	9	231, 867, 352 10, 330, 669	201. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0018

				Title	e XVIII	Hospi tal	5/23/2018 2: 3 PPS	9 pm
				Charges				
		Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
					+ col . 7)	Rati o	Inpatient Ratio	
			6. 00	7. 00	8. 00	9. 00	10.00	
		IENT ROUTINE SERVICE COST CENTERS						
30.00	1	ADULTS & PEDIATRICS	82, 466, 658		82, 466, 658			30.00
31. 00 31. 01		INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE	17, 867, 005 2, 375, 090		17, 867, 005 2, 375, 090			31. 00 31. 01
32. 00		CORONARY CARE UNIT	2, 375, 090		2, 373, 090			32.00
33. 00		BURN INTENSIVE CARE UNIT	o					33. 00
34.00		SURGICAL INTENSIVE CARE UNIT	O		c			34. 00
40.00	1	SUBPROVIDER - I PF	4, 921, 954		4, 921, 954			40.00
41. 00 43. 00		SUBPROVI DER – I RF NURSERY	2, 302, 634 3, 522, 841		2, 302, 634 3, 522, 841			41. 00 43. 00
44. 00		SKILLED NURSING FACILITY	3, 322, 641		3, 322, 841	,		44. 00
45.00	04500	NURSING FACILITY	o		c)		45. 00
46. 00		OTHER LONG TERM CARE	0		C			46. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	49, 825, 263	53, 565, 638	103, 390, 901	0. 238705	0. 000000	50. 00
51. 00		RECOVERY ROOM	47, 023, 203	03, 303, 030	103, 370, 701	0. 000000	0. 000000	
52.00		DELIVERY ROOM & LABOR ROOM	O	0	C	0. 000000	0. 000000	1
53.00		ANESTHESI OLOGY	0	0	C	0. 000000	0. 000000	
54. 00 55. 00	05400	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	11, 583, 439	46, 584, 492	58, 167, 931	0. 223744 0. 000000	0. 000000 0. 000000	
56. 00		RADI OLOGI - THERAPEUTI C	0	0		0.00000	0. 000000	
57. 00		CT SCAN	13, 700, 243	40, 825, 686	54, 525, 929		0. 000000	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	2, 037, 903	7, 003, 238			0. 000000	
59. 00		CARDI AC CATHETERI ZATI ON	9, 982, 726	20, 508, 370			0.000000	
60. 00 60. 01		LABORATORY BLOOD LABORATORY	30, 508, 231	29, 046, 428 0	1		0. 000000 0. 000000	1
61. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0. 000000	0.00000	
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	4, 760, 919	1, 319, 388	6, 080, 307		0. 000000	ł
63. 00		BLOOD STORING, PROCESSING & TRANS.	0	0	C	0. 000000	0. 000000	1
64.00		I NTRAVENOUS THERAPY	559, 591	756, 669	1, 316, 260	1. 533069	0.000000	
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	17, 913, 131 2, 584, 750	3, 065, 294 1, 931, 353			0. 000000 0. 000000	
67. 00		OCCUPATIONAL THERAPY	2, 342, 392	518, 288			0. 000000	67. 00
68. 00		SPEECH PATHOLOGY	490, 526	283, 763			0. 000000	
69. 00		ELECTROCARDI OLOGY	0	0	C	0. 000000	0. 000000	1
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	0	44 057 126	114 240 045	0.000000	0. 000000 0. 000000	
71.00		IMPL. DEV. CHARGED TO PATIENTS	69, 482, 909 36, 979, 797	44, 857, 136 26, 037, 881			0. 000000	
73. 00		DRUGS CHARGED TO PATIENTS	49, 296, 895	36, 091, 532	1		0. 000000	
74.00		RENAL DIALYSIS	O	0	1		0. 000000	
75. 00		ASC (NON-DISTINCT PART)	0	0 740 155	0 000 017	0.000000	0.000000	
76. 00		CARDIOLOGY TIENT SERVICE COST CENTERS	5, 351, 062	20, 748, 155	26, 099, 217	0. 184380	0. 000000	76. 00
88. 00		RURAL HEALTH CLINIC	0	0	C)		88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0	1:			89. 00
		CLINIC SLEEP CLINIC	2, 111, 900	1, 475, 334			0.000000	1
90. 01 91. 00		EMERGENCY	3, 208 7, 351, 515	2, 600, 131 29, 284, 912			0. 000000 0. 000000	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	0	17, 003, 842			0. 000000	•
		REIMBURSABLE COST CENTERS						
94. 00 95. 00		HOME PROGRAM DIALYSIS AMBULANCE SERVICES	0	0	l .	0. 000000 0. 000000	0. 000000 0. 000000	1
96.00		DURABLE MEDICAL EQUIP-RENTED	0	0		0.00000	0. 000000	•
97. 00		DURABLE MEDICAL EQUIP-SOLD	Ö	0	Č	0. 000000	0. 000000	
98. 00	1	OTHER REIMBURSABLE COST CENTERS	O	0	C	0. 000000	0. 000000	1
99. 00	09900		0	0	1			99. 00
99. 10 100. 00		I &R SERVICES-NOT APPRVD PRGM	0	0				99. 10 100. 00
	1	HOME HEALTH AGENCY	o	0				101. 00
		AL PURPOSE COST CENTERS						
	1	KIDNEY ACQUISITION	0	0	1			105.00
	1	HEART ACQUISITION LIVER ACQUISITION	0	0	1			106. 00 107. 00
	1	LUNG ACQUISITION	Ö	Ö	1			107.00
109.00	10900	PANCREAS ACQUISITION	o	0	1			109. 00
		INTESTINAL ACQUISITION	0	0	C			110.00
		ISLET ACQUISITION INTEREST EXPENSE	0	0	l c			111. 00 113. 00
		UTILIZATION REVIEW-SNF						114. 00
115.00	11500	AMBULATORY SURGICAL CENTER (D. P.)	О	0	c			115. 00
116. 00	11600	HOSPI CE	o	0) c			116. 00

Health Financial Systems	ELKHART GENER	RAL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/23/2018 2:3	
		Title	XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpatient	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
200.00 Subtotal (see instructions)	430, 322, 582	383, 507, 530	813, 830, 112	2		200.00
201.00 Less Observation Beds						201. 00
202.00 Total (see instructions)	430, 322, 582	383, 507, 530	813, 830, 112	2		202. 00

Title XVIII

			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INDATI ENT DOUTINE CEDIU CE COCT CENTEDO	11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS					30.00
31.00	03100 INTENSIVE CARE UNIT					31.00
31. 01	03101 NEONATAL INTENSIVE CARE					31. 01
32. 00	03200 CORONARY CARE UNIT					32. 00
						1
33. 00	03300 BURN INTENSIVE CARE UNIT					33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT					34. 00
40.00	04000 SUBPROVI DER - I PF					40.00
41.00	04100 SUBPROVI DER - I RF					41.00
43.00	04300 NURSERY					43.00
44. 00	1					1
	04400 SKILLED NURSING FACILITY					44. 00
45. 00	04500 NURSING FACILITY					45. 00
46.00	04600 OTHER LONG TERM CARE					46. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 238854				50.00
		1				
51. 00	05100 RECOVERY ROOM	0. 000000				51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000				53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 224513				54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
		1				
56. 00	05600 RADI OI SOTOPE	0. 000000				56. 00
57. 00	05700 CT SCAN	0. 037689				57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 149966				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 102207				59. 00
	1					
60.00	06000 LABORATORY	0. 221737				60.00
60. 01	06001 BLOOD LABORATORY	0. 000000				60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 201134				62.00
63. 00	1	0. 000000				
	06300 BLOOD STORING, PROCESSING & TRANS.	1				63. 00
64. 00	06400 I NTRAVENOUS THERAPY	1. 533069				64. 00
65.00	06500 RESPI RATORY THERAPY	0. 201839				65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 571716				66. 00
67. 00		1				
	06700 OCCUPATI ONAL THERAPY	0. 346692				67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 472973				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 186453				71. 00
		1				
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 219948				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 277373				73. 00
74.00	07400 RENAL DIALYSIS	0. 000000				74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
		1				1
76. 00	03140 CARDI OLOGY	0. 184782				76. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC					88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
90.00	09000 CLI NI C	0. 364878				90.00
		1				
90. 01	04950 SLEEP CLINIC	0. 190734				90. 01
91. 00	09100 EMERGENCY	0. 453180				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 607549				92.00
	OTHER REIMBURSABLE COST CENTERS					
94. 00	09400 HOME PROGRAM DI ALYSI S	0.000000				94. 00
		1				1
95. 00	09500 AMBULANCE SERVI CES	0. 000000				95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98. 00
		3. 000000				
99. 00	09900 CMHC					99. 00
	09910 CORF					99. 10
100.00	10000 I &R SERVICES-NOT APPRVD PRGM					100.00
	10100 HOME HEALTH AGENCY					101.00
	SPECIAL PURPOSE COST CENTERS					1
105.00						105 00
	10500 KIDNEY ACQUISITION					105. 00
	10600 HEART ACQUI SI TI ON					106. 00
107.00	10700 LIVER ACQUISITION					107. 00
	10800 LUNG ACQUISITION					108. 00
	10900 PANCREAS ACQUISITION					109. 00
110.00	11000 INTESTINAL ACQUISITION					110. 00
111.00	11100 SLET ACQUISITION					111. 00
	11300 INTEREST EXPENSE					113. 00
	1 1					
	11400 UTI LI ZATI ON REVI EW-SNF					114. 00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)					115. 00
116.00	11600 HOSPI CE					116. 00
200.00						200. 00
	1 1					201. 00
201.00	LESS ONSELVATION DEUS					1201.00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0018	Peri od: From 01/01/2017	Worksheet C	
				Date/Time Pre 5/23/2018 2:3	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
202.00 Total (see instructions)		•			202. 00

Hearth Financial Systems	ELKHARI GENERAL	HUSPI TAL	In Lie	1 OT FORM CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0018	Peri od:	Worksheet C
			From 01/01/2017	Part I
			To 12/31/2017	Date/Time Prepared:
				5/23/2018 2:39 pm

					5/23/2018 2:3	9 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
cost center bescription	(from Wkst. B,	Adj.	Total Costs	Di sal I owance	Total Costs	
	Part I, col.	7.69		21 041 1 01141100		
	26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	FO 404 FF/	ı	F0 404 FF/	4.054	50 400 (40	00.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	50, 181, 556		50, 181, 556			30. 00 31. 00
31. 00 03100 INTENSI VE CARE UNIT 31. 01 03101 NEONATAL INTENSI VE CARE	8, 284, 769 2, 054, 412		8, 284, 769 2, 054, 412	0	8, 284, 769 2, 054, 412	
32. 00 03200 CORONARY CARE UNIT	2,034,412		2,034,412	0	2, 034, 412	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0		Ö	0	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34. 00
40. 00 04000 SUBPROVI DER - 1 PF	3, 119, 755		3, 119, 755	0	3, 119, 755	40. 00
41. 00 04100 SUBPROVI DER - RF	2, 543, 881		2, 543, 881	0	2, 543, 881	41.00
43. 00 04300 NURSERY	4, 353, 501		4, 353, 501	0	4, 353, 501	
44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY			0	0	0	44. 00 45. 00
46. 00 04600 OTHER LONG TERM CARE			0	0	0	46.00
ANCI LLARY SERVICE COST CENTERS				0		10.00
50. 00 05000 OPERATI NG ROOM	24, 679, 927		24, 679, 927	15, 404	24, 695, 331	50.00
51.00 05100 RECOVERY ROOM	0		0	0	0	51.00
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 55. 00 05500 RADI OLOGY-THERAPEUTI C	13, 014, 731		13, 014, 731	44, 719		
55. 00 05500 RADI 0LOGY-THERAPEUTI C 56. 00 05600 RADI 0I SOTOPE	0		0	0	0	55. 00 56. 00
57. 00 05700 CT SCAN	2, 055, 034		2, 055, 034	0	2, 055, 034	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 355, 862		1, 355, 862		1, 355, 862	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 112, 460		3, 112, 460			
60. 00 06000 LABORATORY	13, 205, 447		13, 205, 447	0	13, 205, 447	60.00
60. 01 06001 BLOOD LABORATORY	0		0	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 222, 957		1, 222, 957	0	1, 222, 957	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	2, 017, 917		2, 017, 917	0	0 2, 017, 917	63. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	4, 230, 962				4, 234, 263	
66. 00 06600 PHYSI CAL THERAPY	2, 573, 869		2, 573, 869			
67. 00 06700 OCCUPATI ONAL THERAPY	991, 775		991, 775		991, 775	
68. 00 06800 SPEECH PATHOLOGY	366, 218	0	366, 218	0	366, 218	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 319, 033		21, 319, 033		21, 319, 033	1
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	13, 860, 622 23, 684, 472		13, 860, 622 23, 684, 472		13, 860, 622 23, 684, 472	72. 00 73. 00
74. 00 07400 RENAL DI ALYSI S	23,004,472		23, 004, 472	0	23, 004, 472	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	Ö		Ö	0	Ö	75. 00
76. 00 03140 CARDI OLOGY	4, 812, 171		4, 812, 171	10, 496	4, 822, 667	76. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0		0	0		88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	
90. 00 09000 CLI NI C 90. 01 04950 SLEEP CLI NI C	1, 308, 313		1, 308, 313			1
91. 00 09100 EMERGENCY	492, 690 16, 555, 349		492, 690 16, 555, 349			90. 01 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 330, 669		10, 330, 669		10, 330, 669	92.00
OTHER REIMBURSABLE COST CENTERS			,,		,,	
94.00 09400 HOME PROGRAM DIALYSIS	0		0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	•	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 99. 00 09900 CMHC	0		0	0	0	98. 00 99. 00
99. 10 09910 CORF			0		0	99. 00
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	Ö	ł	l ő			100.00
101.00 10100 HOME HEALTH AGENCY	0		Ö			101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	ł .	0			105. 00
106. 00 10600 HEART ACQUISITION	0		0			106. 00
107. 00 10700 LINE ACQUISITION	0	•	0			107.00
108.00 10800 LUNG ACQUISITION 109.00 10900 PANCREAS ACQUISITION	0	ŀ				108. 00 109. 00
110.00 11000 NTESTINAL ACQUISITION	0		0			1109.00
111. 00 11100 SLET ACQUI SI TI ON	0		0			111.00
113. 00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		0		0	115. 00

Heal th Fina	ncial Systems	ELKHART GENER	RAL HOSPITAL		In Lieu of Form CMS-2552-10		
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/23/2018 2:3	
			Ti tl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4. 00	5. 00	
116. 00 11600	D HOSPI CE	0			0	0	116. 00
200. 00 201. 00 202. 00	Subtotal (see instructions) Less Observation Beds Total (see instructions)	231, 728, 352 10, 330, 669 221, 397, 683		231, 728, 35 10, 330, 66 221, 397, 68	9	10, 330, 669	201. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | 5/23/2018 2:39 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0018

Cost Center Description					5/23/2018 2: 3	9 pm	
Cost Center Description				e XIX	Hospi tal	PPS	
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100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 105. 00 105.00 KI DNEY ACQUISITION 0 0 0 105. 00 105.00 105.00 105.00 105.00 105.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 107.00 107.00 108.00 108.00 108.00 108.00 108.00 108.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.00 109.	1	0	0	(
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SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 107. 00 107. 00 107. 00 107. 00 107. 00 107. 00 108. 00 108. 00 108. 00 108. 00 108. 00 108. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109.		- 1					
105. 00		J U)]		1101.00
106. 00 10600 HEART ACQUI SITI ON			0				105 00
107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 107. 00 108. 00 108. 00 108. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 10		-					
108. 00 10800 LUNG ACQUISITION		-		•			
109. 00 10900 PANCREAS ACQUI SI TI ON	, <u> </u>	-		•)		
111. 00 11100 I SLET ACQUI SI TI ON	109.00 10900 PANCREAS ACQUISITION	0	0)		109. 00
113. 00 11300 I NTEREST EXPENSE 113. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 115. 00		0	0	()		
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 115. 00		0	0	(
115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 115.00		[
			^	,	,		
1 0 0 0 0 1 10.00				l .			1
	35 11000 11001102	<u>ı</u> 9		1	1		1. 10. 00

Heal th Financial	Systems						eu of Form CMS-2552-10	
COMPUTATION OF R	RATIO OF COSTS TO CHARGES		Provider CO	Provi der CCN: 15-0018		Worksheet C Part I Date/Time Prepared: 5/23/2018 2:39 pm		
			Titl	e XIX	Hospi tal	PPS		
			Charges					
Cost	t Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o		
		6.00	7.00	8.00	9. 00	10.00		
	total (see instructions) s Observation Beds	430, 322, 582	383, 507, 530	813, 830, 11	2		200. 00 201. 00	
202.00 Tota	al (see instructions)	430, 322, 582	383, 507, 530	813, 830, 11	2		202. 00	

Title XIX

			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	LAIDATI FAIT DOUTLAG CEDVI OF COCT CENTEDS	11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					4
30. 00	03000 ADULTS & PEDIATRICS					30. 00
31. 00	03100 INTENSIVE CARE UNIT					31.00
31. 01	03101 NEONATAL INTENSIVE CARE					31. 01
32.00	03200 CORONARY CARE UNIT					32. 00
	03300 BURN INTENSIVE CARE UNIT					33. 00
	l l					
	03400 SURGICAL INTENSIVE CARE UNIT					34. 00
	04000 SUBPROVI DER - I PF					40. 00
41.00	04100 SUBPROVI DER – I RF					41.00
43.00	04300 NURSERY					43.00
	04400 SKILLED NURSING FACILITY					44. 00
	04500 NURSING FACILITY					1
	l l					45. 00
46. 00	04600 OTHER LONG TERM CARE					46. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	0. 238854				50.00
51.00	05100 RECOVERY ROOM	0. 000000				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
	05300 ANESTHESI OLOGY	0. 000000				53. 00
	l ł	1				1
	05400 RADI OLOGY-DI AGNOSTI C	0. 224513				54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
56.00	05600 RADI 0I S0T0PE	0. 000000				56. 00
57.00	05700 CT SCAN	0. 037689				57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 149966				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 102207				59. 00
	l l					
	06000 LABORATORY	0. 221737				60. 00
60. 01	06001 BLOOD LABORATORY	0. 000000				60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000				61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 201134				62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63. 00
	06400 I NTRAVENOUS THERAPY	1				
	l l	1. 533069				64. 00
	06500 RESPI RATORY THERAPY	0. 201839				65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 571716				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 346692				67.00
68. 00	06800 SPEECH PATHOLOGY	0. 472973				68. 00
	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
	l l	1				1
	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 186453				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 219948				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 277373				73. 00
	07400 RENAL DIALYSIS	0. 000000				74.00
	07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
		1				1
76. 00	03140 CARDI OLOGY	0. 184782				76. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89. 00
	09000 CLI NI C	0. 364878				90.00
	04950 SLEEP CLINIC	0. 190734				90. 01
		1				
91. 00	09100 EMERGENCY	0. 453180				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 607549				92. 00
	OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000				94. 00
95. 00	09500 AMBULANCE SERVICES	0. 000000				95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96. 00
	l l	0.000000				97. 00
	09700 DURABLE MEDI CAL EQUI P-SOLD	1				
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98. 00
	09900 CMHC					99. 00
99. 10	09910 CORF					99. 10
100.00	10000 I&R SERVICES-NOT APPRVD PRGM					100.00
	10100 HOME HEALTH AGENCY					101.00
101.00						101.00
405 -	SPECIAL PURPOSE COST CENTERS					405 55
	10500 KIDNEY ACQUISITION					105. 00
106. 00	10600 HEART ACQUISITION					106. 00
107.00	10700 LIVER ACQUISITION					107.00
	10800 LUNG ACQUISITION					108. 00
	10900 PANCREAS ACQUISITION					109. 00
	l l					
	11000 INTESTINAL ACQUISITION					110. 00
111. 00	11100 SLET ACQUISITION					111. 00
113.00	11300 INTEREST EXPENSE					113. 00
	11400 UTILIZATION REVIEW-SNF					114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)					115. 00
	, , ,					
	11600 H0SPI CE					116. 00
200.00						200. 00
201.00	Less Observation Beds					201. 00
-						

Health Financial Systems	ELKHART GENERA	L HOSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0018	Peri od: From 01/01/2017 To 12/31/2017	Worksheet C Part I Date/Time Pre 5/23/2018 2:3	
		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio 11.00				
202.00 Total (see instructions)					202. 00

Heal th Financial Systems ELKHART GE CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2017	Part II
To 12/31/2017	Date/Time Prepared:
5/23/2018 2:39 pm	Provider CCN: 15-0018

						12/31/2017	5/23/2018 2:3	
				Ti tl	e XIX	Hospi tal	PPS	
		Cost Center Description	Total Cost		Operating Cost	Capi tal	Operating Cost	
					Net of Capital	Reduction	Reduction	
			I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
			1 00	2.00	col. 2) 3.00	4.00	5. 00	
	ANCLL	LARY SERVICE COST CENTERS	1.00	2. 00	3.00	4. 00	3.00	
50.00		OPERATING ROOM	24, 679, 927	2, 729, 402	21, 950, 525	0	0	50.00
51. 00	1	RECOVERY ROOM	0	2,727,102	0	0	o o	1
52. 00	1	DELIVERY ROOM & LABOR ROOM	0	l o	o	Ö	Ō	1
53.00		ANESTHESI OLOGY	0	l c	0	0	0	53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	13, 014, 731	1, 697, 346	11, 317, 385	0	0	54.00
55.00	05500	RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56.00		RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00		CT SCAN	2, 055, 034			0	0	57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	1, 355, 862			0	0	58. 00
59. 00		CARDI AC CATHETERI ZATI ON	3, 112, 460			0	0	59. 00
60.00	1	LABORATORY	13, 205, 447			0	0	60.00
60. 01 61. 00		BLOOD LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	60. 01 61. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 222, 957	7, 021	1, 215, 936	0	0	1
63. 00		BLOOD STORING, PROCESSING & TRANS.	1, 222, 937	7,021	1, 213, 730	0	0	63.00
64. 00		INTRAVENOUS THERAPY	2, 017, 917	95, 775	1, 922, 142	0	Ö	64. 00
65. 00		RESPI RATORY THERAPY	4, 230, 962			Ö	ő	65. 00
66.00		PHYSI CAL THERAPY	2, 573, 869			0	0	66. 00
67.00	06700	OCCUPATI ONAL THERAPY	991, 775	102, 414	889, 361	0	0	67. 00
68. 00	06800	SPEECH PATHOLOGY	366, 218	60, 187	306, 031	0	0	68. 00
69. 00		ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70. 00		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 319, 033			0	0	
72.00		IMPL. DEV. CHARGED TO PATIENTS	13, 860, 622			0	0	72.00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS	23, 684, 472			0	0	73. 00
75. 00		RENAL DIALYSIS ASC (NON-DISTINCT PART)	0	0		0	0	
76. 00	1	CARDI OLOGY	4, 812, 171	432, 432	4, 379, 739	0	0	
70.00		TIENT SERVICE COST CENTERS	1,012,171	102, 102		<u>~</u> _		70.00
88. 00		RURAL HEALTH CLINIC	0	C	0	0	0	88. 00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00		CLINIC	1, 308, 313			0	0	90.00
90. 01		SLEEP CLINIC	492, 690			0	0	90. 01
91.00	1	EMERGENCY	16, 555, 349			0	0	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS	10, 330, 669	1, 366, 655	8, 964, 014	0	0	92.00
94. 00		HOME PROGRAM DIALYSIS	1 0		0	0	0	94. 00
95. 00	1	AMBULANCE SERVICES	0			0	0	
96. 00		DURABLE MEDICAL EQUIP-RENTED	0		o o	Ö	ő	
97.00	09700	DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98.00	09850	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00	09900	l e e e e e e e e e e e e e e e e e e e	0	0	0	0	0	99. 00
99. 10	09910		0	0	0	0	0	
		I &R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00		HOME HEALTH AGENCY	0	0	0	0	0	101. 00
105 00		AL PURPOSE COST CENTERS KIDNEY ACQUISITION	0		0	0		105. 00
		HEART ACQUISITION			1	0		106. 00
		LIVER ACQUISITION	0			0		107. 00
		LUNG ACQUISITION	0		o o	Ö		108. 00
		PANCREAS ACQUISITION	0	i c	0	0		109. 00
110.00	11000	INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
		ISLET ACQUISITION	0	0	0	0	0	111. 00
		INTEREST EXPENSE						113. 00
		UTI LI ZATI ON REVI EW-SNF						114. 00
		AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
	1	HOSPICE	141 100 470	0.004.305	151 104 103	0		116. 00 200. 00
200. 00 201. 00	1	Subtotal (sum of lines 50 thru 199) Less Observation Beds	161, 190, 478 10, 330, 669			0		200.00
201.00	1	Total (line 200 minus line 201)	150, 859, 809			0		202.00
_02.00	.1	1.11. (1.110 200 1.00 11110 201)	1 .55,557,567	1 3, 327, 340		٩		,_02.00

Provider CCN: 15-0018

Peri od: Worksheet C From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/23/2018 2:39 pm

					5/23/2018 2: 3	39 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
	Capital and	(Worksheet C,	Cost to Charge			
			Ratio (col. 6			
	Reduction	8)	/ col . 7)			
	6. 00	7.00	8.00			
ANCILL ADV CEDVICE COCT CENTERS	0.00	7.00	0.00			_
ANCILLARY SERVICE COST CENTERS	04 (70 007	100 000 001	0.000705			4 50 00
50.00 05000 OPERATI NG ROOM	24, 679, 927	103, 390, 901				50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000			51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0	1	0.000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	13, 014, 731	58, 167, 931	1			54.00
1	13,014,731	30, 107, 731	1			1
1	0		0.000000			55. 00
56. 00 05600 RADI OI SOTOPE	0	0	0.000000			56. 00
57.00 05700 CT SCAN	2, 055, 034	54, 525, 929	0. 037689			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 355, 862	9, 041, 141	0. 149966			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 112, 460	30, 491, 096	0. 102078			59. 00
60. 00 06000 LABORATORY	13, 205, 447					60.00
	13, 203, 447	37, 334, 037				
60. 01 06001 BLOOD LABORATORY	0		0.000000			60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	1	0.000000			61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1, 222, 957	6, 080, 307	0. 201134			62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.000000			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	2, 017, 917	1, 316, 260	1			64. 00
65. 00 06500 RESPIRATORY THERAPY	4, 230, 962					65. 00
						•
66. 00 06600 PHYSI CAL THERAPY	2, 573, 869					66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	991, 775	2, 860, 680	0. 346692			67. 00
68. 00 06800 SPEECH PATHOLOGY	366, 218	774, 289	0. 472973			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1	0.000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1	0. 000000			70.00
	21 210 022	114 240 045	1			
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	21, 319, 033		1			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 860, 622		1			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	23, 684, 472	85, 388, 427	0. 277373			73. 00
74. 00 07400 RENAL DI ALYSI S	0	0	0.000000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	1	0. 000000			75. 00
76. 00 03140 CARDI OLOGY	4, 812, 171	1	1			76. 00
OUTPATIENT SERVICE COST CENTERS	4,012,171	20,077,217	0.104300			J 70.00
			0.000000			4 00 00
88.00 08800 RURAL HEALTH CLINIC	0	ł .				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000			89. 00
90. 00 09000 CLI NI C	1, 308, 313	3, 587, 234	0. 364714			90.00
90. 01 04950 SLEEP CLINIC	492, 690	2, 603, 339	0. 189253			90. 01
91. 00 09100 EMERGENCY	16, 555, 349					91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 330, 669		1			92. 00
OTHER REIMBURSABLE COST CENTERS	10, 330, 007	17,003,042	0.007347			72.00
	1		0.00000			94. 00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	l e	0.000000			•
95. 00 09500 AMBULANCE SERVICES	0	1	0. 000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000			96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000			97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	1	0.000000			98. 00
99. 00 09900 CMHC	0		0. 000000			99. 00
99. 10 09910 CORF			0. 000000			99. 10
	0		1			
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0		0.000000			100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0.000000			101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0.000000			105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	1	0. 000000			106.00
107. 00 10700 LI VER ACQUI SI TI ON	Ö		0. 000000			107. 00
		-				
108. 00 10800 LUNG ACQUISITION	0					108.00
109.00 10900 PANCREAS ACQUISITION	0	J 0	0. 000000			109. 00
110.00 11000 INTESTINAL ACQUISITION	0	[0	0.000000			110. 00
111.00 11100 ISLET ACQUISITION	0	0	0.000000			111. 00
113. 00 11300 NTEREST EXPENSE	1]				113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	1					114. 00
	_		0 000000			
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	-	0.000000			115.00
116. 00 11600 HOSPI CE	0		0. 000000			116. 00
200.00 Subtotal (sum of lines 50 thru 199)	161, 190, 478	700, 373, 930)			200. 00
201.00 Less Observation Beds	10, 330, 669	0				201. 00
202.00 Total (line 200 minus line 201)	150, 859, 809					202. 00
			1			

Heal th	Financial Systems	ELKHART GENER	AL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
APPORT	IONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Period: From 01/01/2017 To 12/31/2017		
			Titl∈	e XVIII	Hospi tal	PPS	<u> </u>
	Cost Center Description	Capi tal	Swing Bed	Reduced		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	1.00	2.00	3.00	4.00	3.00	
	ADULTS & PEDIATRICS	6, 638, 686		6, 638, 68	6 39, 857	166. 56	30.00
	INTENSIVE CARE UNIT	606, 328		606, 32			
31. 00	NEONATAL INTENSIVE CARE	109, 992		109, 99			1
	CORONARY CARE UNIT	109, 992		109, 99	0 0		
	BURN INTENSIVE CARE UNIT		•		0 0		1
		0	ł		0 0		
34. 00	SURGICAL INTENSIVE CARE UNIT			405.00	-		1
40. 00	SUBPROVIDER - I PF	495, 033		1,			
	SUBPROVI DER - I RF	432, 143		432, 14			
43. 00	NURSERY	663, 699		663, 69			
	SKILLED NURSING FACILITY	0			0		44.00
	NURSING FACILITY	0			0		45. 00
200.00	Total (lines 30 through 199)	8, 945, 881		8, 945, 88	1 51, 741		200. 00
	Cost Center Description	I npati ent	I npati ent				
		Program days	Program				
			Capital Cost				
			(col. 5 x col.				
			6)	1			
		6. 00	7. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS	_	1	,			
	ADULTS & PEDI ATRI CS	13, 010		1			30. 00
	INTENSIVE CARE UNIT	1, 927	255, 443	5			31. 00
31. 01	NEONATAL INTENSIVE CARE	0	0)			31. 01
32. 00	CORONARY CARE UNIT	0	0)			32. 00
33. 00	BURN INTENSIVE CARE UNIT	0	0)			33. 00
34.00	SURGICAL INTENSIVE CARE UNIT	0)			34. 00
	SUBPROVI DER - I PF	427	80, 037				40. 00
41.00	SUBPROVI DER - I RF	495	149, 797	'			41.00
	NURSERY	0	O)			43. 00
	SKILLED NURSING FACILITY	0	0)			44. 00
	NURSING FACILITY	0	0				45. 00
200.00	Total (lines 30 through 199)	15, 859	2, 652, 223	s			200. 00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C	CN: 15-0018	Peri od:	Worksheet D	
				From 01/01/2017	Part II	narad.
				To 12/31/2017	Date/Time Pre 5/23/2018 2:3	pareu: 9 nm
		Title	: XVIII	Hospi tal	PPS	, p
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	0.00		1.00	5.00	
ANOLLI ADV. CEDVI OF COCT. CENTEDO	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	2 720 402	102 200 001	0.00430	20 110 025	530, 885	50.00
51. 00 05100 RECOVERY ROOM	2, 729, 402	103, 390, 901	0. 02639 0. 00000		0 530, 885	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0		0.00000		0	52.00
53. 00 05300 ANESTHESI OLOGY	0		0. 00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 697, 346	58, 167, 931	0. 02918		136, 670	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	1,077,540	30, 107, 731	0. 00000		0	55.00
56. 00 05600 RADI OI SOTOPE	0	0	0. 00000		0	56.00
57. 00 05700 CT SCAN	309, 154	54, 525, 929			32, 458	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	154, 009	9, 041, 141	0. 01703		14, 143	
59. 00 05900 CARDI AC CATHETERI ZATI ON	191, 857	30, 491, 096			24, 086	59. 00
60. 00 06000 LABORATORY	297, 261	59, 554, 659			61, 286	60.00
60. 01 06001 BL00D LABORATORY	0	0		0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	7, 021	6, 080, 307	0. 00115	5 1, 966, 516	2, 271	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	95, 775		0. 07276	3 247, 829	18, 033	64.00
65. 00 06500 RESPI RATORY THERAPY	107, 278		0. 00511		40, 999	65. 00
66. 00 06600 PHYSI CAL THERAPY	224, 590				48, 120	66. 00
67.00 06700 OCCUPATIONAL THERAPY	102, 414	2, 860, 680			30, 124	67. 00
68. 00 06800 SPEECH PATHOLOGY	60, 187	774, 289			11, 473	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000		0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	469, 522				124, 098	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	301, 263				71, 520	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	331, 285	85, 388, 427	0.00388		72, 374 0	73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000 0. 00000		0	75.00
76. 00 03140 CARDI OLOGY	432, 432	26, 099, 217			37, 320	76.00
OUTPATIENT SERVICE COST CENTERS	432, 432	20, 077, 217	0.01030	2, 232, 420	37, 320	70.00
88. 00 08800 RURAL HEALTH CLINIC	1 0	0	0.00000	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	Ö	0.00000		0	89. 00
90. 00 09000 CLI NI C	223, 796	3, 587, 234			54, 730	90.00
90. 01 04950 SLEEP CLINIC	3, 643	2, 603, 339			0	90. 01
91. 00 09100 EMERGENCY	889, 405	36, 636, 427	0. 02427	7 3, 114, 912	75, 621	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 366, 655	17, 003, 842	0. 08037	3 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.00000	0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.00000		0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 00000		0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.00000		0	98. 00
200.00 Total (lines 50 through 199)	9, 994, 295	700, 373, 930	1	129, 724, 645	1, 386, 211	J200. 00

Health Financial Systems	ELKHART GENER	RAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider Co		Peri od:	Worksheet D	
				From 01/01/2017	Part III	
				To 12/31/2017	Date/Time Pre 5/23/2018 2:3	pared:
		Ti +Lo	xVIII	Hospi tal	9/23/2018 2: 3 PPS	9 piii
Cost Center Description	Nurcina School			Allied Health	All Other	
cost center bescription		nursing school			Medical	
	Post-Stepdown		Post-Stepdowr	COST		
	Adjustments 1A	1.00	Adjustments 2A	2. 00	Education Cost 3.00	
LAIDATI ENT DOUTLAG CEDVI CE COCT CENTEDO	I IA	1.00	ZA	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			ı		1 0	20.00
30. 00 03000 ADULTS & PEDI ATRI CS	0		1	0		
31.00 03100 INTENSIVE CARE UNIT	0		1	0		
31. 01 03101 NEONATAL INTENSIVE CARE	0		1	0		
32. 00 03200 CORONARY CARE UNIT	0	0		0	0	
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0		0 0	0	40.00
41. 00 04100 SUBPROVI DER - RF	0	0)	0 0	0	41.00
43. 00 04300 NURSERY	0	0		o o	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0)	ol o		44.00
45. 00 04500 NURSING FACILITY	0	0	,	0		45. 00
200.00 Total (lines 30 through 199)	0	0		0	0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	200.00
oost conten beschiptron	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,	bays	3 . coi . o)	11 ogram bays	
	instructions)					
	4. 00	5.00	6.00	7. 00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	4.00	3.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	1 0	0	39, 85	7 0.00	13, 010	30.00
31. 00 03100 NTENSI VE CARE UNI T	0		,			
		_	.,			
31. 01 03101 NEONATAL INTENSIVE CARE		0			l .	
32. 00 03200 CORONARY CARE UNIT		0		0.00	l .	
33. 00 03300 BURN INTENSIVE CARE UNIT		0		0.00		
34.00 03400 SURGI CAL INTENSI VE CARE UNIT	_	0		0.00		1
40. 00 04000 SUBPROVI DER - I PF	0	_	2, 64			
41. 00 04100 SUBPROVI DER - I RF	0	_	1 ', '-			
43. 00 04300 NURSERY		0	2, 46			
44.00 04400 SKILLED NURSING FACILITY		0		0.00	0	44. 00
45.00 04500 NURSING FACILITY		0		0.00	0	45. 00
200.00 Total (lines 30 through 199)		0	51, 74	1	15, 859	200. 00
Cost Center Description	I npati ent	PSA Adj. All				
	Program	Other Medical				
	Pass-Through	Education Cost				
	Cost (col. 7 x					
	col. 8)					
	9. 00	13.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0				30.00
31.00 03100 INTENSIVE CARE UNIT	0	0)			31.00
31. 01 03101 NEONATAL INTENSIVE CARE	0	0	,			31. 01
32. 00 03200 CORONARY CARE UNIT	0	0	,			32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	_				33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0	_				34.00
40. 00 04000 SUBPROVI DER - 1 PF	0		1			40.00
41. 00 04100 SUBPROVI DER - 1 FF		_				1
	1	_	1			41.00
43. 00 04300 NURSERY	0					43. 00
44. 00 04400 SKILLED NURSING FACILITY	0					44. 00
45. 00 04500 NURSI NG FACI LI TY	0					45. 00
200.00 Total (lines 30 through 199)	0	0	1			200. 00

| Period: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: | 5/23/2018 2:39 pm Provider CCN: 15-0018 THROUGH COSTS

					5/23/2018 2: 3	9 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician			Allied Health	Allied Health	
	Anestheti st	Post-Stepdown	1	Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0) (0	0	50.00
51.00 05100 RECOVERY ROOM	0			0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0			0	0	52.00
53. 00 05300 ANESTHESI OLOGY				0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C				0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C				0	0	55. 00
56. 00 05600 RADI 01 SOTOPE				0	Ö	56.00
57. 00 05700 CT SCAN				0	Ö	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)					0	58.00
59. 00 05900 CARDIAC CATHETERIZATION						59.00
						1
60. 00 06000 LABORATORY					0	60.00
60. 01 06001 BLOOD LABORATORY		')	ا ا	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0) (0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0)) (0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0)) (0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0)) (0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0)) (0	0	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY	0)) (0	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0)) (0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0)) (0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0) () (0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0) (0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0) (0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0			0	0	73.00
74.00 07400 RENAL DIALYSIS	0			0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0			0	0	75. 00
76. 00 03140 CARDI OLOGY	0			0	0	76. 00
OUTPATIENT SERVICE COST CENTERS	<u>'</u>				<u> </u>	ĺ
88. 00 08800 RURAL HEALTH CLINIC	0)		0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	89. 00
90. 00 09000 CLI NI C	0			0	0	90.00
90. 01 04950 SLEEP CLINIC	0			0	0	90. 01
91. 00 09100 EMERGENCY	0			0	175, 136	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		l	Ĭ i		0	92.00
OTHER REIMBURSABLE COST CENTERS		1	`	۷۱		72.00
94. 00 09400 HOME PROGRAM DI ALYSI S) () (0	0	94.00
95. 00 09500 AMBULANCE SERVI CES		1	1	5	Ĭ	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		,	,		0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED)	J '			97.00
i i		()			0	1
98. 00 09850 OTHER REIMBURSABLE COST CENTERS						98.00
200.00 Total (lines 50 through 199)	0	'I	0	0	175, 136	J200. 00

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To | 12/31/2017 | Date/Time | Prepared: Provi der CCN: 15-0018 THROUGH COSTS

				'	0 12/31/2017	5/23/2018 2: 3	
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of col	1 Outpatient	(from Wkst. C,	to Charges	
		Education Cost	through col.	Cost (sum of		(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						
50.00	05000 OPERATING ROOM	0		0 0	103, 390, 901	0.000000	50.00
51.00	05100 RECOVERY ROOM	0		0 0	0	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0 0	0	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0		0 0	0	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0		0 0	58, 167, 931	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0 0	0	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0		0 0	0	0.000000	56. 00
57.00	05700 CT SCAN	0		0 0	54, 525, 929	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0		o c	9, 041, 141	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		ol c	30, 491, 096	0.000000	59. 00
60.00	06000 LABORATORY	0		ol c	59, 554, 659	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0		ol c	0	0.000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		ol c	6, 080, 307	0.000000	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0.000000	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0		0	1, 316, 260		
65. 00	06500 RESPIRATORY THERAPY	0		0			1
66. 00	06600 PHYSI CAL THERAPY	0			4, 516, 103		
67. 00	06700 OCCUPATI ONAL THERAPY	0					
68. 00	06800 SPEECH PATHOLOGY	0			774, 289		
69. 00	06900 ELECTROCARDI OLOGY	0			0	0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0				0.000000	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		ol d	114, 340, 045		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		ol d			
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			85, 388, 427		
74. 00	07400 RENAL DIALYSIS	0			00,000,127	0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0		ol d	ή	0. 000000	
76. 00	03140 CARDI OLOGY	0				l .	76.00
70.00	OUTPATIENT SERVICE COST CENTERS			0	20,077,217	0.000000	70.00
88. 00	08800 RURAL HEALTH CLINIC	0		ol c	0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0. 000000	
90.00	09000 CLI NI C	0			3, 587, 234	l .	90.00
90. 01	04950 SLEEP CLINIC	0				l .	90. 01
91. 00	09100 EMERGENCY	0	175, 13	-1		l .	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	175, 10	0 173, 130			92. 00
72.00	OTHER REIMBURSABLE COST CENTERS			<u> </u>	17,000,042	0.000000	72.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0		ol c	0	0.000000	94. 00
95. 00	09500 AMBULANCE SERVICES			Ĭ	1	0.00000	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0				0. 000000	
97. 00	09700 DURABLE MEDICAL EQUIP-RENTED					0.000000	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS					0.000000	
200.00			175, 13	6 175, 136	700, 373, 930		200.00
200.00	Trotal (Titles 50 till bugli 177)	ı U	175, 13	oj 175, 130	100, 313, 930	1	₁ 200.00

 Heal th Financial APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS
 Provider CCN: 15-0018 THROUGH COSTS

-						5/23/2018 2:3	9 pm
			Title	xVIII	Hospi tal	PPS	
Cost Cent	er Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
0001 00.11	o. 5000. pt. o	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
			chai ges		charges	Pass-IIII ougii	
		(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	CE COST CENTERS						
50. 00 05000 OPERATI NG	ROOM	0. 000000	20, 110, 025	0	20, 116, 434	0	50.00
51. 00 05100 RECOVERY	ROOM	0. 000000	0	C	0	0	51.00
52. 00 05200 DELI VERY	ROOM & LABOR ROOM	0. 000000	0	C	0	0	52. 00
53. 00 05300 ANESTHESI	OLOGY	0. 000000	0		0	0	53. 00
54. 00 05400 RADI OLOGY		0. 000000	4, 683, 704		15, 596, 367	0	54.00
55. 00 05500 RADI OLOGY		0. 000000	0			-	55. 00
56. 00 05600 RADI 0I SOT		0. 000000	0	Ö	_	0	56. 00
57. 00 05700 CT SCAN	OFL	0. 000000	E 704 EE7	1			57. 00
	DECOMANGE LIMAGING (MDI.)	l l	5, 724, 557				
	RESONANCE I MAGING (MRI)	0. 000000	830, 309		.,,	0	58. 00
59. 00 05900 CARDI AC C		0. 000000	3, 827, 999				59. 00
60. 00 06000 LABORATOR		0. 000000	12, 279, 282		-, ,		60.00
60. 01 06001 BL00D LAB	ORATORY	0. 000000	0	C	0	0	60. 01
61. 00 06100 PBP CLINI	CAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLO	OD & PACKED RED BLOOD CELLS	0. 000000	1, 966, 516		455, 910	0	62. 00
63. 00 06300 BLOOD STO	RING, PROCESSING & TRANS.	0. 000000	0		. 0	ol	63. 00
64. 00 06400 NTRAVENO		0. 000000	247, 829		196, 348	o	64. 00
65. 00 06500 RESPIRATO		0. 000000	8, 017, 080				65. 00
66. 00 06600 PHYSI CAL		0. 000000	967, 607				66. 00
67. 00 06700 OCCUPATIO		0. 000000					67. 00
		1	841, 427		,		
68. 00 06800 SPEECH PA		0. 000000	147, 597	1	-,		68. 00
69. 00 06900 ELECTROCA		0. 000000	0	1		0	69. 00
70. 00 07000 ELECTROEN		0. 000000	0	0	_	0	70. 00
71. 00 07100 MEDI CAL S	UPPLIES CHARGED TO PATIENTS	0. 000000	30, 223, 623	[C	3, 109, 530	0	71. 00
	. CHARGED TO PATIENTS	0. 000000	14, 959, 309	0		0	72. 00
73. 00 07300 DRUGS CHA	RGED TO PATIENTS	0. 000000	18, 653, 183	0	8, 954, 833	0	73. 00
74.00 07400 RENAL DIA		0. 000000	0	l			74. 00
75. 00 07500 ASC (NON-	DISTINCT PART)	0. 000000	0		0	ol	75. 00
76. 00 03140 CARDI OLOG		0. 000000	2, 252, 426		8, 549, 183	0	76. 00
	'ICE COST CENTERS	0.000000	2,202, .20		0,017,100		70.00
88. 00 08800 RURAL HEA		0. 000000	0	C	0	0	88. 00
	QUALIFIED HEALTH CENTER	0. 000000	0	1		0	89. 00
90. 00 09000 CLI NI C	QUALITIED HEALTH CENTER	1	ŭ	1	_		90.00
	NI O	0. 000000	877, 260		,		
90. 01 04950 SLEEP CLI		0. 000000	0	C		0	90. 01
91. 00 09100 EMERGENCY		0. 004780	3, 114, 912				91. 00
	ON BEDS (NON-DISTINCT PART)	0. 000000	0	C	4, 885, 651	0	92. 00
	BLE COST CENTERS						
94.00 09400 HOME PROG	RAM DIALYSIS	0. 000000	0	C	0	0	94.00
95. 00 09500 AMBULANCE	SERVI CES						95. 00
	EDI CAL EQUI P-RENTED	0. 000000	0	0	0	0	96. 00
	EDI CAL EQUI P-SOLD	0. 000000	0	ĺ	_	0	97. 00
	MBURSABLE COST CENTERS	0. 000000	0			0	98.00
	nes 50 through 199)	0.000000	129, 724, 645		_		
200.00 10141 (11	nes so through 177)	1	127, 124, 040	14,009	100,073,610	20, 9/5	₁ 200.00

 Heal th Financial
 Systems
 ELKHART
 GENERAL

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE
 OTHER PASS
 ELKHART GENERAL HOSPITAL Provider CCN: 15-0018

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: | 5/23/2018 2:39 pm THROUGH COSTS

						5/23/2018 2: 3	9 pm
				XVIII	Hospi tal	PPS	
	Cost Center Description	PSA Adj. Non	PSA Adj. All				
		Physi ci an	Other Medical				
		Anestheti st	Education Cost				
		Cost					
		21.00	24.00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	C)			50. 00
51.00	05100 RECOVERY ROOM	o	C				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	C)			52.00
53.00	05300 ANESTHESI OLOGY	l ol	C)			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C	,			54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	أم	Ċ	,			55. 00
56. 00	05600 RADI OI SOTOPE		Č				56.00
57. 00	05700 CT SCAN		Č				57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)						58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON						59.00
		0	C				1
60.00	06000 LABORATORY	0	C	'			60.00
60. 01	06001 BLOOD LABORATORY	0	C	1			60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	_				61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C				62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	1			63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	C				64. 00
65.00	06500 RESPI RATORY THERAPY	0	C)			65. 00
66.00	06600 PHYSI CAL THERAPY	0	C				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	C				67. 00
68.00	06800 SPEECH PATHOLOGY	o	C)			68. 00
69. 00	06900 ELECTROCARDI OLOGY	l ol	C				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C	,			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	,			71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	أم	Ċ	,			72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS		Č				73. 00
74. 00	07400 RENAL DIALYSIS		Č				74.00
75. 00	07500 ASC (NON-DISTINCT PART)		C				75. 00
76. 00	03140 CARDI OLOGY		C				76. 00
70.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>		1			70.00
00 00		ا	C				00.00
88. 00	08800 RURAL HEALTH CLINIC	U					88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	!			89. 00
90.00	09000 CLINIC	0	C	1			90.00
90. 01	04950 SLEEP CLINIC	0	C				90. 01
91. 00	09100 EMERGENCY	0	C				91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C				92. 00
	OTHER REIMBURSABLE COST CENTERS						1
94.00		0	C				94. 00
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	o	C)			96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	o	C)			97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	o	C)			98. 00
200.00		0	C				200. 00
	1 (/	۱ ۹	,	1			1

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0018 Peri od: Worksheet D From 01/01/2017 Part V Date/Time Prepared: 12/31/2017 5/23/2018 2:39 pm Title XVIII Hospi tal PPS Charges Costs Cost to Charge PPS Reimbursed PPS Services Cost Center Description Cost Cost Ratio From Services (see Rei mbursed Rei mbursed (see inst.) Worksheet C, inst.) Servi ces Services Not Part I, col. 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. 238705 20, 116, 434 4, 801, 893 50.00 51.00 05100 RECOVERY ROOM 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52 00 52 00 Ω 0 0 0 53.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0. 223744 15, 596, 367 0 3, 489, 594 54.00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 55.00 Ω 05600 RADI OI SOTOPE 0 56.00 0.000000 Ω 56.00 57.00 05700 CT SCAN 0.037689 9, 934, 146 0 374, 408 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 0.149966 1, 639, 251 0 245, 832 58.00 0 05900 CARDIAC CATHETERIZATION 0 102078 981 332 59 00 59 00 9, 613, 548 60.00 06000 LABORATORY 0. 221737 5,049,095 1, 119, 571 60.00 06001 BLOOD LABORATORY 0.000000 0 0 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 0 0 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 91, 699 62 00 0.201134 455, 910 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63.00 196, 348 06400 I NTRAVENOUS THERAPY 1.533069 301, 015 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0. 201682 700, 108 0 141, 199 0 65.00 0 06600 PHYSI CAL THERAPY 0.569931 38, 928 66.00 68, 303 66.00 67.00 06700 OCCUPATIONAL THERAPY 0. 346692 59, 235 20, 536 67.00 06800 SPEECH PATHOLOGY 0 68.00 0.472973 8,598 0 4,067 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0.000000 69.00 0 07000 ELECTROENCEPHALOGRAPHY 0 70.00 0.000000 0 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 186453 3, 109, 530 0 0 579, 781 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0. 219948 10, 546, 023 0 0 2, 319, 577 72.00 07300 DRUGS CHARGED TO PATIENTS 8, 954, 833 0 78, 508 2, 483, 829 73.00 0.277373 73.00 0 74.00 07400 RENAL DIALYSIS 0.000000 74.00 0 07500 ASC (NON-DISTINCT PART) 0.000000 0 75.00 75.00 03140 CARDI OLOGY 76.00 0. 184380 8, 549, 183 1, 576, 298 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0.000000 O 89.00 09000 CLINIC 529, 549 90.00 0.364714 0 90.00 0 193, 134 04950 SLEEP CLINIC 0 90.01 0.189253 0 90.01 2, 739, 172 91.00 09100 EMERGENCY 0.451882 6,061,698 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.607549 4, 885, 651 0 2, 968, 272 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 94.00 95.00 09500 AMBULANCE SERVICES 0.000000 0 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 0 0 0 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 97.00 0.000000 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 0 0 98.00 0 200.00 Subtotal (see instructions) 106, 073, 810 78, 508 24, 470, 137 200.00 Less PBP Clinic Lab. Services-Program O 201 00 201 00 Only Charges

106, 073, 810

0

78, 508

24, 470, 137 202. 00

202.00

Net Charges (line 200 - line 201)

| Period: | Worksheet D | From 01/01/2017 | Part V | To 12/31/2017 | Date/Time Prepared: | 5/23/2018 2:39 pm Provider CCN: 15-0018

				5/23/2018 2:39 pm
		Title XVIII	Hospi tal	PPS
	Costs	5		
Cost Center Description	Cost	Cost		
	Rei mbursed	Rei mbursed		
	Servi ces S	Services Not		
	Subject To	Subject To		
	Ded. & Coins. De	ed. & Coins.		
	(see inst.)	(see inst.)		
	6.00	7. 00		
ANCILLARY SERVICE COST CENTERS		·		
50. 00 05000 OPERATI NG ROOM	0	0		50.00
51. 00 05100 RECOVERY ROOM	o	o		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	o		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	o	o		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	o l		55. 00
56. 00 05600 RADI OI SOTOPE	0	o O		56. 00
57. 00 05700 CT SCAN		ol ol		57. 00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)		0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		ol		59. 00
60. 00 06000 LABORATORY		ol		60.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		ol		60. 00
	1	Ч		
	0			61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		64. 00
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	O		67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	21, 776		73. 00
74.00 07400 RENAL DIALYSIS	0	0		74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0		75. 00
76. 00 03140 CARDI OLOGY	0	0		76. 00
OUTPATIENT SERVICE COST CENTERS				
88.00 08800 RURAL HEALTH CLINIC	0	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90. 00 09000 CLI NI C	0	О		90.00
90. 01 04950 SLEEP CLI NI C	0	o		90. 01
91. 00 09100 EMERGENCY	O	o		91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	o	o		92.00
OTHER REIMBURSABLE COST CENTERS	<u>'</u>	'		
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00
95. 00 09500 AMBULANCE SERVI CES	o			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	O	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		ő		97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		ő		98.00
200.00 Subtotal (see instructions)		21, 776		200.00
201.00 Less PBP Clinic Lab. Services-Program		21,770		201. 00
Only Charges				201.00
202.00 Net Charges (line 200 - line 201)	0	21, 776		202. 00
202. 30	١	21,770		1202.00

Health Financial Systems	ELKHART GENER				u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0018	Peri od:	Worksheet D	
		Component	CCN: 15-S018	From 01/01/2017 To 12/31/2017	Part II Date/Time Pre 5/23/2018 2:3	
		Title	× XVIII	Subprovi der - I PF	PPS	<i>у</i> рііі
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	3		
	26)		,			
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 729, 402	103, 390, 901	0. 02639	99 4, 197	111	50.00
51. 00 05100 RECOVERY ROOM	0				0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0		1		Ő	
53. 00 05300 ANESTHESI OLOGY			1		0	1
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1, 697, 346	ļ			232	
	1, 097, 340	30, 107, 931	1		232	1
	0	_	1			1
56. 00 05600 RADI OI SOTOPE	0		1 0.0000		0	
57. 00 05700 CT SCAN	309, 154		1		138	1
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	154, 009		1		63	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	191, 857		1		0	
60. 00 06000 LABORATORY	297, 261				432	1
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	00	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	7, 021	6, 080, 307	0. 0011	55 0	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000	00	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	95, 775	1, 316, 260	0. 07276	53 0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	107, 278	20, 978, 425	0.0051	14 48, 185	246	65.00
66. 00 06600 PHYSI CAL THERAPY	224, 590	4, 516, 103	0.04973	1, 492	74	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	102, 414	2, 860, 680	0. 03580	2, 212	79	67. 00
68.00 06800 SPEECH PATHOLOGY	60, 187				12	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		ı		0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	1		Ō	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	469, 522	114, 340, 045			6	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	301, 263				ő	
73. 00 07300 DRUGS CHARGED TO PATIENTS	331, 285				259	
74. 00 07400 RENAL DI ALYSI S	001,200		1		0	
75. 00 07500 ASC (NON-DISTINCT PART)	0		0.00000		0	1
76. 00 03140 CARDI OLOGY	432, 432	26, 099, 217			167	
OUTPATIENT SERVICE COST CENTERS	432, 432	20,099,217	0.01030	10, 103	107	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.0000	00 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		l .	1			
					0	1
	223, 796				734	1
90. 01 04950 SLEEP CLINIC	3, 643				0	
91. 00 09100 EMERGENCY	889, 405				995	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	17, 003, 842	0.0000	00 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS	_	1 -	1			
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0. 00000	00	0	
95. 00 09500 AMBULANCE SERVICES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	1			0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0			0	
200.00 Total (lines 50 through 199)	8, 627, 640	700, 373, 930	1	309, 740	3, 548	200. 00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0018	Peri od: From 01/01/2017	
		Component CCN: 15-S018		Date/Time Prepared: 5/23/2018 2:39 pm
		Title XVIII	Subprovi der -	PPS

ANCILLARY SERVICE COST CENTERS				Titl€	e XVIII	Subprovi der -	PPS	
ANCILLARY SERVICE COST CENTERS		Cost Center Description			Nursing School	Allied Health	Allied Health	
ANCILLARY SERVICE COST CENTERS								
50.00 05000 05000 05000 05000 0			1.00	2A	2. 00	3A	3. 00	
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 52.00				,	,			
S2.00 05.200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 5.3.00		l	0	0		0	0	
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 53.00		1	0	0)	0	0	1
54. 00 05400 RADIO LOGY-DI AGNOSTIC 0 0 0 0 0 0 0 55. 00			0	0)	0	0	1
55.00		1	0	0) (0	0	1
56. 00 05000 CADIO ISOTOPE 0 0 0 0 0 0 57. 00 05700 CT SCAN 0 0 0 0 0 0 0 0 0		1	0	0) (0	0	1
57.00 05700 CT SCAN 0 0 0 0 0 0 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 59.00 60.00 06600 LABORATORY 0 0 0 0 0 0 0 0 61.00 06600 LABORATORY 0 0 0 0 0 0 0 61.00 06600 LABORATORY 0 0 0 0 0 0 0 62.00 06200 LABORATORY 0 0 0 0 0 0 0 63.00 06300 BLOOD LABORATORY 0 0 0 0 0 0 0 63.00 06300 BLOOD S PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 64.00 06400 MIDEAU BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 65.00 06500 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 66.00 06600 DAYSICAL THERAPY 0 0 0 0 0 0 0 0 67.00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 68.00 06600 PAYSICAL THERAPY 0 0 0 0 0 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 70.00 07000 CLUCATIONAL THERAPY 0 0 0 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 71.00 07100 MEDICAL ANGED TO PATIENTS 0 0 0 0 0 0 71.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 72.00 07200 MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 76.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 76.00 07400 RENAL DIALYSIS 0 0 0 0 0 77.00 07400 DURBABLE MEDICAL EQUI P-RENTED 0 0 0 0 0 78.00 09500 DURBABLE MEDICAL EQUI P-RENTED 0 0 0 0 0 79.00 09500 DURBABLE MEDICAL EQUI P-RENTED 0 0 0 0 79.00		1	0	0) (0	0	1
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70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0	68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
71. 00	69.00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
72. 00	70.00	07000 ELECTROENCEPHALOGRAPHY	0	0) (0	0	70.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 75. 00 76. 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0) (0	0	71. 00
74. 00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 75. 00 76. 00 03140 CARDI OLOGY 0 0 0 0 0 0 0 0 75. 00 01000 0100 0100 0100 0100 0100 0100	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0) (0	0	72. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 00 0 0 0 0 0 0 0 0 0	73.00	07300 DRUGS CHARGED TO PATIENTS	0	0) (0	0	73. 00
76. 00 03140 CARDÎ OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	74.00	07400 RENAL DIALYSIS	0	0) (0	0	74. 00
SERVICE COST CENTERS	75.00	07500 ASC (NON-DISTINCT PART)	0	0) (0	0	75. 00
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 89. 00 90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0 0 0 90. 00 90. 01 04950 SLEEP CLINIC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	76.00	03140 CARDI OLOGY	0	0) (0	0	76. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 89. 00 90. 00 90. 00 90. 00 0 0 0 0 0 0 0		OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC 0 0 0 0 0 0 90. 00 90. 01 04950 SLEEP CLINIC 0 0 0 0 0 0 0 90. 01 91. 00 09100 EMERGENCY 0 0 0 0 0 0 175, 136 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 175, 136 91. 00 0 0 0 0 0 0 0 0 0	88. 00	08800 RURAL HEALTH CLINIC	0	C) (0	0	88. 00
90. 01 04950 SLEEP CLINIC 0 0 0 0 0 0 0 90. 01 91. 00 92. 00 09100 EMERGENCY 0 0 0 0 0 175, 136 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 92. 00 07 07 07 07 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0) (0	0	89. 00
91. 00 09100 EMERGENCY 0 0 0 0 175, 136 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 92. 00 00 00 00 00 00 00 00	90.00	09000 CLI NI C	0	0) (0	0	90.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 92. 00	90. 01	04950 SLEEP CLINIC	0	0) (0	0	90. 01
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVICES 95. 00 96. 00 0 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 97. 00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 98. 00	91.00	09100 EMERGENCY	0	o c		0	175, 136	91. 00
94. 00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
95. 00 09500 AMBULANCE SERVICES 95. 00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 0 96. 00 97. 00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 97. 00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 98. 00 098. 00 00 0 0 0 98. 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		OTHER REIMBURSABLE COST CENTERS			•			
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 96. 00 97. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 0 0 98. 00	94.00	09400 HOME PROGRAM DIALYSIS	0	C) (0	0	94. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00	95.00	09500 AMBULANCE SERVICES						95. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00	96.00		0	o c		0	0	1
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00			0	o.		0	n	1
				l o		o o	Ö	1
			0	o c		o	175, 136	1

Heal th	Financial Systems	ELKHART GENER				eu of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	VICE OTHER PASS	Provider C	CN: 15-0018	Peri od: From 01/01/2017	Worksheet D Part IV	
TTIKOOC	III 60313		Component	CCN: 15-S018	To 12/31/2017	Date/Time Pre	pared:
			Ti +l e	xVIII	Subprovi der -	5/23/2018 2:3 PPS	9 pm
			11 (1)	XVIII	I PF	113	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of col 1	Outpati ent	(from Wkst. C,		
		Education Cost	through col.	Cost (sum of col. 2, 3 and		(col. 5 ÷ col. 7)	
			4)	4)	u 0)	//	
		4.00	5.00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS			•		<u> </u>	
50.00	05000 OPERATI NG ROOM	0	C		0 103, 390, 901	0.000000	50. 00
51. 00	05100 RECOVERY ROOM	0	C)	0	0. 000000	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C)	0	0. 000000	1
53.00	05300 ANESTHESI OLOGY	0	C)	0	0. 000000	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	C	1	0 58, 167, 931		1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	C	1	0	0.000000	
56.00	05600 RADI OI SOTOPE	0			0 0	0.000000	1
57. 00 58. 00	05700 CT SCAN	0	1	l .	0 54, 525, 929 0 9, 041, 141		1
59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON			1	0 9, 041, 141 0 30, 491, 096	0. 000000 0. 000000	
60.00	06000 LABORATORY	0		1	0 59, 554, 659		1
60. 01	06001 BLOOD LABORATORY	0	Č		0 37, 334, 037	0. 000000	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0.00000	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 6, 080, 307	0. 000000	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C)	0	0.000000	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	C)	0 1, 316, 260	0.000000	64. 00
65.00	06500 RESPI RATORY THERAPY	0	C		0 20, 978, 425	0. 000000	1
66.00	06600 PHYSI CAL THERAPY	0	C)	0 4, 516, 103		1
67. 00	06700 OCCUPATI ONAL THERAPY	0	1	1	0 2, 860, 680		1
68. 00	06800 SPEECH PATHOLOGY	0	C	1	0 774, 289		1
69. 00	06900 ELECTROCARDI OLOGY	0	1	1	0	0.000000	1
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 114, 340, 045	0. 000000 0. 000000	
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0			0 114, 340, 045 0 63, 017, 678		1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			0 85, 388, 427		1
74. 00	07400 RENAL DIALYSIS	0			0 03, 300, 427	0. 000000	1
75. 00	07500 ASC (NON-DISTINCT PART)	0	ĺ		0 0	0. 000000	1
76. 00	03140 CARDI OLOGY	0	ĺ	,	0 26, 099, 217	0. 000000	1
	OUTPATIENT SERVICE COST CENTERS			•			
88. 00	08800 RURAL HEALTH CLINIC	0	C		0 0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0	0. 000000	1
90.00	09000 CLI NI C	0	[C		0 3, 587, 234		
90. 01	04950 SLEEP CLINIC	0	C		0 2, 603, 339		1
91.00	09100 EMERGENCY	0				0.004780	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	1	0 17, 003, 842	0.000000	92.00

0

0 0 0

0

175, 136

0.000000

0.000000

0.000000

0.000000

0

0

700, 373, 930

0

0

0

175, 136

94.00

95.00

96.00

97.00

98.00

200. 00

OTHER REIMBURSABLE COST CENTERS

98. 00 09850 OTHER REIMBURSABLE COST CENTERS 200. 00 Total (lines 50 through 199)

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

94. 00 | 09400 | HOME PROGRAM DI ALYSI S 95. 00 | 09500 | AMBULANCE SERVI CES

	<u>Financial Systems</u> TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	ELKHART GENERA RVI.CE OTHER PASS	Provider C	CN: 15-0018	Period:	u of Form CMS-: Worksheet D	2552-10
	H COSTS	WIGE OTHER PASS		CCN: 15-S018	From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre	epared:
			Ti tl e	e XVIII	Subprovi der - I PF	5/23/2018 2:3 PPS	9 pili
	Cost Center Description	Outpati ent	I npati 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.	8	Costs (col. 9	
		7)	10.00	x col. 10)	10.00	x col . 12)	
	ANOLI LABY CERVI OF COCT CENTERS	9. 00	10. 00	11.00	12. 00	13. 00	
EO 00	ANCI LLARY SERVI CE COST CENTERS	0.000000	4 107	1	0 0	0	F0 00
50. 00 51. 00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	0. 000000 0. 000000	4, 197	1	0 0	0	
51.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	1	0 0	0	
53.00	05300 ANESTHESI OLOGY	0. 000000	0	1	0 0	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	7, 952	1	0 0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	7, 432	1	0 0	0	
56. 00	05600 RADI OI SOTOPE	0. 000000	0	1	0 0	0	
57. 00	05700 CT SCAN	0. 000000	24, 314		0 0	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	3, 714	1	0 0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0, , , ,	1	0 0	0	
60.00	06000 LABORATORY	0. 000000	86, 627		0 0	Ö	
60. 01	06001 BLOOD LABORATORY	0. 000000	0	1	0 0	0	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0)	0 0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0)	0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0	1	0 0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	48, 185		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 492		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	2, 212		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	154		0 0	0	
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0	1	0	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	1	0 0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 378		0 0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0	1	0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	66, 652	1	0 0	0	
74. 00	07400 RENAL DIALYSIS	0. 000000	0		0 0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	10 105	1	0 0	0	
76. 00	03140 CARDI OLOGY	0. 000000	10, 105	1	0 0	0	76. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0.000000	0	J	0 0	0	00 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	1	0 0	0	
90.00	09000 CLINIC	0. 000000	11, 772	1	0 0	0	
90.00	04950 SLEEP CLINIC	0. 000000	11, //2	l	0 0	0	
91. 00	09100 EMERGENCY	0. 004780	40, 986] 10	96 0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	40, 700	1	0 0	0	
,2.00	OTHER REIMBURSABLE COST CENTERS	3. 000000		1	J 0		1 /2.00
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0 0	0	94. 00
95. 00	09500 AMBULANCE SERVICES	1 27 22 23 0	Ö				95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0)	0 0	0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	O		0 0	0	
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	
	Total (lines 50 through 199)	1	309, 740		96 0	_	200.00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0018	From 01/01/2017	
		Component CCN: 15-S018	To 12/31/2017	Date/Time Prepared: 5/23/2018 2:39 pm
		Title XVIII	Subprovi der -	PPS

			11110	XVIII	I PF	113	
	Cost Center Description	PSA Adj. Non	PSA Adj. All				
	·	Physi ci an	Other Medical				
		Anestheti st	Education Cost				
		Cost					
		21. 00	24.00				
	ANCILLARY SERVICE COST CENTERS		1	1			
50. 00	05000 OPERATING ROOM	0	0	1			50. 00
51. 00	05100 RECOVERY ROOM	0	0				51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53.00	05300 ANESTHESI OLOGY	0	0				53. 00
54.00	05400 RADI OLOGY THE PARELLE C		0				54.00
55. 00	O5500 RADI OLOGY - THERAPEUTI C		0				55.00
56. 00	05600 RADI OI SOTOPE		0				56.00
57. 00 58. 00	05700 CT SCAN		0				57. 00 58. 00
59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION		0				59.00
60.00	06000 LABORATORY						60.00
60. 00	06001 BLOOD LABORATORY						60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.						63. 00
64. 00	06400 I NTRAVENOUS THERAPY		0				64. 00
65. 00	06500 RESPI RATORY THERAPY		0				65. 00
66. 00	06600 PHYSI CAL THERAPY		0				66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	Ō				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
74.00	07400 RENAL DI ALYSI S	0	0				74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0				75. 00
76. 00	03140 CARDI OLOGY	0	0				76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	•			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00	09000 CLI NI C	0	0				90.00
90. 01	04950 SLEEP CLINIC	0	0				90. 01
91. 00	09100 EMERGENCY	0	0				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0				92.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0				94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0				98. 00
200.00	Total (lines 50 through 199)	0	0				200. 00

		51.W.157.051.50				6.5	
	Financial Systems	ELKHART GENER		ON 15 0010		eu of Form CMS-:	2552-10
APPUR	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL 00313	Provider C	CN: 15-0018	Peri od: From 01/01/2017	Worksheet D Part II	
			Component	CCN: 15-T018	To 12/31/2017	Date/Time Pre 5/23/2018 2:3	
			Ti tl e	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col . 1 + col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCI LLARY SERVI CE COST CENTERS						
50. 00	05000 OPERATING ROOM	2, 729, 402	103, 390, 901	1		147	50.00
51. 00	05100 RECOVERY ROOM	0				0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C			0	
53. 00	05300 ANESTHESI OLOGY	0	C	0. 00000		0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 697, 346	58, 167, 931			223	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	C	1 0,0000		0	
56. 00	05600 RADI OI SOTOPE	0		0. 00000		0	1
57. 00	05700 CT SCAN	309, 154		•		136	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	154, 009		•		32	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	191, 857		•		l e	
60.00	06000 LABORATORY	297, 261				363	1
60. 01	06001 BLOOD LABORATORY	0	C	0. 00000	00	0	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	7, 021				8	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0.0000		0	
64. 00	06400 I NTRAVENOUS THERAPY	95, 775				0	
65. 00	06500 RESPI RATORY THERAPY	107, 278		•		372	1
66. 00	06600 PHYSI CAL THERAPY	224, 590		1		10, 008	1
67. 00	06700 OCCUPATI ONAL THERAPY	102, 414				7, 153	1
68. 00	06800 SPEECH PATHOLOGY	60, 187		1		3, 876	1
69. 00	06900 ELECTROCARDI OLOGY	0				0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0				0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	469, 522				29	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	301, 263					1
73. 00	07300 DRUGS CHARGED TO PATIENTS	331, 285				503	
74.00	07400 RENAL DIALYSIS	0	C			0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0 000 01	0.0000		0	
76. 00	03140 CARDI OLOGY	432, 432	26, 099, 217	0. 0165	3, 632	60	76. 00
00 00	OUTPATIENT SERVICE COST CENTERS	1		0.0000	20 0		00.00
88. 00	08800 RURAL HEALTH CLINIC	0	l .				
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0				0	1
90. 00 90. 01		223, 796				1, 678	1
	04950 SLEEP CLINIC	3, 643				0	
91. 00 92. 00	09100 EMERGENCY	889, 405				0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	17, 003, 842	0.0000	0 0	0	92.00
94. 00	09400 HOME PROGRAM DIALYSIS	1 0	C	0.0000	00 0	0	94. 00
95.00	09500 AMBULANCE SERVICES			0.0000	0		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		c	0.0000	00	0	1
97.00	09700 DURABLE MEDICAL EQUIP-RENTED		1	1		0	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS		1	1		0	
200.00		8, 627, 640		•	813, 162		200.00
250.00	1.0ta. (3,327,340	, , , , , , , , , , , , , , , , , , , ,	1	310, 102	21,312	,_00.00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0018	Peri od: From 01/01/2017	
		Component CCN: 15-T018		Date/Time Prepared: 5/23/2018 2:39 pm
		Title XVIII	Subprovi der -	PPS

			Titl€	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	cost center bescription	Anesthetist	Post-Stepdown		Post-Stepdown	Airred hearth	
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS	11.00				0.00	
50.00	05000 OPERATING ROOM	0	C		0	0	50.00
51.00	05100 RECOVERY ROOM	0	l c		o	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	l c		o	0	52. 00
53.00	05300 ANESTHESI OLOGY	0			0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0			0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0	0	55. 00
56.00	05600 RADI 0I S0T0PE	0	1		0	0	56.00
57. 00	05700 CT SCAN	0			0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0	0	59. 00
60.00	06000 LABORATORY	0	(0	0	60.00
	06001 BLOOD LABORATORY	0	1		0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					_	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		1		0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.					0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY					0	64.00
65. 00	06500 RESPIRATORY THERAPY					0	65. 00
	06600 PHYSI CAL THERAPY					0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY					0	67. 00
	06800 SPEECH PATHOLOGY					0	68. 00
	06900 ELECTROCARDI OLOGY					0	69.00
	07000 ELECTROENCEPHALOGRAPHY					0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS					0	72.00
	07300 DRUGS CHARGED TO PATIENTS					0	73.00
	07400 RENAL DIALYSIS					0	74. 00
	07500 ASC (NON-DISTINCT PART)		1	1		o o	75. 00
	03140 CARDI OLOGY		_		-	1	76. 00
70.00	OUTPATIENT SERVICE COST CENTERS			<u> </u>	,		70.00
88. 00	08800 RURAL HEALTH CLINIC	0			0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER					0	89. 00
	09000 CLINIC					0	90.00
	04950 SLEEP CLINIC					0	90. 01
91. 00	09100 EMERGENCY					175, 136	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		-	1		173, 130	1
72.00	OTHER REIMBURSABLE COST CENTERS		L		71		72.00
94.00	09400 HOME PROGRAM DI ALYSI S	1 0	(0	0	94. 00
	09500 AMBULANCE SERVICES			1)	Ĭ	95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED		(0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD					0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS					0	98. 00
200.00							
200.00	Total (Tilles 30 till ough 177)	1	1	1	7	175, 150	1200.00

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ELKHART GENER RVICE OTHER PASS		CN: 15-0018	Peri od:	eu of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS				CCN: 15-T018	From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre 5/23/2018 2:3	epared:
			Title	XVIII	Subprovi der - I RF	PPS	, p
	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		Cost (sum o		(col. 5 ÷ col.	
			4)	col. 2, 3 an 4)	ad 8)	7)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS			5. 55		0.00	
50. 00	05000 OPERATING ROOM	0	0		0 103, 390, 901	0. 000000	50.00
51. 00	05100 RECOVERY ROOM	0			0 0	0.000000	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			0	0. 000000	
53. 00	05300 ANESTHESI OLOGY	0	0		0	0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 58, 167, 931	0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0. 000000	•
56.00	05600 RADI OI SOTOPE	0	0		0 0	0.000000	
57. 00	05700 CT SCAN	0	0		0 54, 525, 929 0 9, 041, 141		
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		-, -, -, -, -,	0.000000	
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0		0 30, 491, 096 0 59, 554, 659	0. 000000 0. 000000	
60. 01	06001 BL00D LABORATORY	0	1		0 39, 334, 639	0.000000	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	l o			0.00000	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 6, 080, 307	0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	0	Ö		0 1, 316, 260		
65. 00	06500 RESPIRATORY THERAPY	0	0		0 20, 978, 425	0.000000	
66. 00	06600 PHYSI CAL THERAPY	0	0		0 4, 516, 103	0.000000	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 2, 860, 680	0.000000	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		0 774, 289	0. 000000	68. 00
59. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0. 000000	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 114, 340, 045		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 63, 017, 678		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 85, 388, 427	0.000000	
74.00	07400 RENAL DIALYSIS	0	0		0 0	0.00000	
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY	0	0		0 26, 099, 217	0. 000000 0. 000000	
76.00	OUTPATIENT SERVICE COST CENTERS				0 20,099,217	0.000000	76. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0. 000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0. 000000	
90.00	09000 CLINIC	0			0 3, 587, 234		
90. 01	04950 SLEEP CLINIC	o o			0 2, 603, 339	0. 000000	
91. 00	09100 EMERGENCY	0		175, 1	1 1	0. 004780	•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 17, 003, 842	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0	0		0 0	0. 000000	94.00
95. 00	09500 AMBULANCE SERVICES						95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	-		0 0	0. 000000	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0		
98. 00 200. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	l e		0 0	0. 000000	
	Total (lines 50 through 199)	0	175, 136	175, 13	36 700, 373, 930	i .	200.00

Hool +b	Financial Systems	ELVHADT CENEDAL	ПОСВІТАІ		In Lie	u of Form CMS	2552 10
APP0R1	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER CH COSTS	ELKHART GENERAI RVICE OTHER PASS	Provi der Co		Peri od: From 01/01/2017	w of Form CMS- Worksheet D Part IV	
			Component	CCN: 15-T018	To 12/31/2017	Date/Time Pre 5/23/2018 2:3	
			Title	× XVIII	Subprovi der – I RF	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)	10.00	x col . 10) 11.00	12. 00	x col . 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50. 00	05000 OPERATI NG ROOM	0. 000000	5, 557		0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 000000	0,007		0 0	0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	1
53. 00	05300 ANESTHESI OLOGY	0. 000000	0	•	0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	7, 642		0 0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56. 00
57.00	05700 CT SCAN	0. 000000	23, 908		0 0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1, 857		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 966		0 0	0	59. 00
60.00	06000 LABORATORY	0. 000000	72, 737		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	6, 497		0 0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0	1	0 0	0	1
65. 00	06500 RESPI RATORY THERAPY	0. 000000	72, 822		0 0	0	1
66. 00	06600 PHYSI CAL THERAPY	0. 000000	201, 240		0 0	0	1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	199, 806		0 0	0	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	49, 862		0 0	0	1
69. 00	06900 ELECTROCARDI OLOGY	0.000000	0		0 0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000	6, 956		0 0	0	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0. 000000 0. 000000	1, 033 129, 747		0 0	0	
74.00	07400 RENAL DIALYSIS	0. 000000	129, 747		0 0	0	1
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	
76. 00	03140 CARDI OLOGY	0. 000000	3, 632		0 0	0	
70.00	OUTPATIENT SERVICE COST CENTERS	0.000000	3, 032		0 0	0	70.00
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	•	0 0	0	
90.00	09000 CLINIC	0. 000000	26, 900	1	0 0	0	
90. 01	04950 SLEEP CLINIC	0. 000000	20, 700		0 0	Ö	
91. 00	09100 EMERGENCY	0. 004780	0		0 0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0	•	0 0	0	1
	OTHER REIMBURSABLE COST CENTERS	<u>'</u>					1
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0 0	0	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	
200.00	Total (lines 50 through 199)		813, 162		0 0	0	200. 00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0018	Peri od: From 01/01/2017	Worksheet D Part IV
		Component CCN: 15-T018	To 12/31/2017	Date/Time Prepared: 5/23/2018 2:39 pm
		Title XVIII	Subprovi der -	PPS

			11 (1)	XVIII	IRF	113	
	Cost Center Description	PSA Adj. Non	PSA Adj. All				
	·	Physi ci an	Other Medical				
		Anestheti st	Education Cost				
		Cost					
		21. 00	24. 00				
	ANCILLARY SERVICE COST CENTERS		1	ı			
50. 00	05000 OPERATING ROOM	0	0				50. 00
51.00	05100 RECOVERY ROOM	0	0				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53.00	05300 ANESTHESI OLOGY	0	0				53. 00
54.00	05400 RADI OLOGY THE PAPELLE C						54.00
55. 00	O5500 RADI OLOGY - THERAPEUTI C		0				55.00
56. 00	05600 RADI OI SOTOPE						56.00
57. 00 58. 00	05700 CT SCAN						57. 00 58. 00
59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION						59.00
60.00	06000 LABORATORY						60.00
60. 01	06001 BL00D LABORATORY						60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		,				61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0				62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.						63. 00
64. 00	06400 I NTRAVENOUS THERAPY						64. 00
65. 00	06500 RESPI RATORY THERAPY		o o				65. 00
66. 00	06600 PHYSI CAL THERAPY	0	o				66. 00
67. 00	06700 OCCUPATIONAL THERAPY	0	0				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
74.00	07400 RENAL DI ALYSI S	0	0				74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0				75. 00
76. 00	03140 CARDI OLOGY	0	0				76. 00
	OUTPATIENT SERVICE COST CENTERS			·			
88. 00	08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90.00	09000 CLINIC	0	0				90.00
90. 01	04950 SLEEP CLINIC	0	0				90. 01
91.00	09100 EMERGENCY	0	0				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0				92.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0				94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0				98. 00
200.00	Total (lines 50 through 199)	0) O				200. 00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C		Peri od:	Worksheet D	
				From 01/01/2017		narad.
				To 12/31/2017	Date/Time Pre 5/23/2018 2:3	pared: 9 nm
		Ti tI	e XIX	Hospi tal	PPS	7 piii
Cost Center Description	Capi tal	Swi ng 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			1 444 54	
30. 00 ADULTS & PEDI ATRI CS	6, 638, 686		-,,			
31. 00 INTENSIVE CARE UNIT	606, 328		606, 32			
31. 01 NEONATAL INTENSIVE CARE	109, 992		109, 99		l .	
32. 00 CORONARY CARE UNIT	0	•	1	0		
33. 00 BURN INTENSIVE CARE UNIT	0	•		0	0.00	
34. 00 SURGICAL INTENSIVE CARE UNIT	0		405.00	0 0		
40. 00 SUBPROVI DER – I PF	495, 033		1,		l .	
41. 00 SUBPROVI DER – I RF	432, 143		432, 14			
43.00 NURSERY 44.00 SKILLED NURSING FACILITY	663, 699		663, 69			
	0			0		1
45. 00 NURSING FACILITY	0 8, 945, 881		8, 945, 88	0 1 51, 741		45. 00 200. 00
200.00 Total (lines 30 through 199) Cost Center Description	Inpati ent	Inpatient	8, 945, 88	51, 741		200.00
cost center bescription	Program days	Program				
	Program days	Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS			'			
30. 00 ADULTS & PEDI ATRI CS	872	145, 240)			30. 00
31.00 INTENSIVE CARE UNIT	0	0				31.00
31.01 NEONATAL INTENSIVE CARE	0	0				31. 01
32.00 CORONARY CARE UNIT	0	0				32. 00
33.00 BURN INTENSIVE CARE UNIT	0	0				33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34. 00
40. 00 SUBPROVI DER - I PF	82					40. 00
41. 00 SUBPROVI DER - I RF	58					41.00
43. 00 NURSERY	271	73, 086	1			43. 00
44.00 SKILLED NURSING FACILITY	0	1				44. 00
45. 00 NURSING FACILITY	0	1	1			45. 00
200.00 Total (lines 30 through 199)	1, 283	251, 248	3			200. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS	Health Financial Systems	ELKHART GENER	RAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
Cost Center Description		L COSTS	Provi der C	CN: 15-0018	Peri od:		
Cost Center Description					From 01/01/2017	Part I	narod:
Cost Center Description					10 12/31/2017	5/23/2018 2:3	pareu. 9 pm
Related Cost (from Wists, B, Part II, col. Part I, col. Part II, col. Pa						PPS	
ANCILLARY SERVICE COST CENTERS	Cost Center Description						
Part II, col. 8)							
ANCILLARY SERVICE COST CENTERS					. Charges	column 4)	
NACILLARY SERVICE COST CENTERS			8)	2)			
ANCILLARY SERVICE COST CENTERS 2,729,402 103,390,901 0.026399 10,385,170 274,158 50.00 50.00 50.000 60.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 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			2.00	3 00	4 00	5.00	
50.00 05000 05000 05000 05000 05000 05000 0500 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 05000 050000 05000 05000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000 050000	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0		2, 729, 402	103, 390, 901	0. 02639	9 10, 385, 170	274, 158	50.00
53.00 05300 ABSTHESI OLOGY 0 0 0 0 0 0 0 0 0	51.00 05100 RECOVERY ROOM		, c	0.00000		l	51.00
S4 00 05400 RADI OLOGY-DI AGNOSTIC 1,697,346 58,167,931 0.029180 2,541,185 74,152 54.00	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C	0. 00000	0 0	0	52. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	53. 00 05300 ANESTHESI OLOGY	0	C	0.00000	0 0	0	53. 00
56.00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 56.00		1, 697, 346	58, 167, 931			74, 152	
57.00 05700 CT SCAN 309, 154 54, 525, 929 0, 005670 1, 868, 018 10, 592 57.00		0	C				
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 154,009 9,041,141 0.017034 313,786 5,345 58.00		0	C				
59.00 05900 CARDI AC CATHETERI ZATI ON 191, 857 30, 491, 096 0.006292 1, 564, 470 9, 844 59.00							
60. 00 06000 LABORATORY 297, 261 59, 554, 659 0. 004991 4, 983, 436 24, 872 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0. 000000 0 0 60. 01 61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 61. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7, 021 6, 080, 307 0. 001155 522, 419 603 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0. 0000000 0 0 0. 000000 0							1
60. 01 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001 06001				1			
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7, 021 6, 080, 307 0, 001155 522, 419 603 62. 00 63. 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0, 0000000 0 0 63. 00 64. 00 06400 INTRAVENOUS THERAPY 95, 775 1, 316, 260 0, 072763 302, 115 21, 983 64. 00 65. 00 06500 RESPI RATORY THERAPY 107, 278 20, 978, 425 0, 005114 2, 632, 999 13, 465 65. 00 66. 00 06600 PHYSI CAL THERAPY 224, 590 4, 516, 103 0, 049731 164, 309 8, 171 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 102, 414 2, 860, 680 0, 035801 149, 108 5, 338 67. 00 68. 00 06800 SPEECH PATHOLOGY 60, 187 774, 289 0, 077732 37, 420 2, 909 68. 00 69. 00 69. 00 ELECTROCARDI OLOGY 0 0, 0000000 0 0 0, 0000000 0							1
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7, 021 6, 080, 307 0. 001155 522, 419 603 62. 00 63. 00 6300 BLOOD STORING, PROCESSING & TRANS. 0 0. 0000000 0. 0000000 0. 63. 00 64. 00 06400 INTRAVENOUS THERAPY 95, 775 1, 316, 260 0. 072763 302, 115 21, 983 64. 00 65. 00 06500 RESPI RATORY THERAPY 107, 278 20, 978, 425 0. 005114 2, 632, 999 13, 465 65. 00 06600 PHYSI CAL THERAPY 224, 590 4, 516, 103 0. 049731 164, 309 8, 171 66. 00 66. 00 06700 0CCUPATI ONAL THERAPY 102, 414 2, 860, 680 0. 035801 149, 108 5, 338 67. 00 68. 00 06900 ELECTROCARDI OLOGY 0 0. 000000 0 0. 000000 0 0		0		0.00000	0	0	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0.000000 0 0 63. 00 64. 00 06400 INTRAVENOUS THERAPY 95,775 1,316,260 0.072763 302,115 21,983 64. 00 65. 00 06500 RESPI RATORY THERAPY 107,278 20,978,425 0.005114 2,632,999 13,465 65. 00 66. 00 06600 PHYSI CAL THERAPY 224,590 4,516,103 0.049731 164,309 8,171 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 102,414 2,860,680 0.035801 149,108 5,338 67. 00 68. 00 06800 SPEECH PATHOLOGY 60,187 774,289 0.077732 37,420 2,909 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0.000000 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 469,522 114,340,045 0.004106 24,453 100 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 331,285 85,388,427 0.003880 7,471,495 28,989 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0.000000 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0.000000 0 0 75. 00 76. 00 03140 CARDI OLOGY 432,432 26,099,217 0.016569 618,686 10,251 76. 00 90. 00 09000 CLI NI C 223,796 3,587,234 0.062387 325,007 20,276 90. 00 90. 01 04950 SLEEP CLI NI C 3,643 2,603,339 0.001399 0 0 90. 01		7 021	4 000 207	0 00115	E E22 410	402	•
64. 00 06400 INTRAVENOUS THERAPY 95, 775 1, 316, 260 0.072763 302, 115 21, 983 64. 00 6500 RESPI RATORY THERAPY 107, 278 20, 978, 425 0.005114 2, 632, 999 13, 465 65. 00 66. 00 06600 PHYSI CAL THERAPY 24, 590 4, 516, 103 0.049731 164, 309 8, 171 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 102, 414 2, 860, 680 0.035801 149, 108 5, 338 67. 00 68. 00 06800 SPEECH PATHOLOGY 60, 187 774, 289 0.077732 37, 420 2, 909 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0 0 0 69. 00 70. 00 07000 ELECTROBROEPHALOGRAPHY 0 0 0.000000 0 0 0 0 0.000000 0 0 0 0		7,021	0,000,307	1		l	1
65. 00 06500 RESPI RATORY THERAPY 107, 278 20, 978, 425 0. 005114 2, 632, 999 13, 465 65. 00 6600 06600 PHYSI CAL THERAPY 224, 590 4, 516, 103 0. 049731 164, 309 8, 171 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 102, 414 2, 860, 680 0. 035801 149, 108 5, 338 67. 00 68. 00 06800 SPEECH PATHOLOGY 60, 187 774, 289 0. 077732 37, 420 2, 909 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0. 000000 0 0 0 69. 00 07. 00 07. 00 ELECTROENCEPHALOGRAPHY 0 0 0 0. 000000 0 0 0 0 0. 000000 0 0 0 0 0. 000000		95 775	1 316 260				
66. 00							1
67. 00 06700 0CCUPATI ONAL THERAPY 102, 414 2, 860, 680 0. 035801 149, 108 5, 338 67. 00 68. 00 06800 SPECH PATHOLOGY 60, 187 774, 289 0. 077732 37, 420 2, 909 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0. 000000 0 0 0 69. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0. 000000 0 0 0 0 0							1
68. 00 06800 SPEECH PATHOLOGY 60, 187 774, 289 0.077732 37, 420 2, 909 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0 0 69. 00 0.000000 0 0 0.000000 0							•
69. 00							
70. 00		0					69. 00
72. 00	70. 00 07000 ELECTROENCEPHALOGRAPHY	0	c			0	70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 331, 285 85, 388, 427 0.003880 7, 471, 495 28, 989 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0.000000 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0.000000 0 0 0 75. 00 76. 00 03140 CARDI OLOGY 432, 432 26, 099, 217 0.016569 618, 686 10, 251 76. 00 08800 RURAL HEALTH CLINI C 0 0 0.000000 0 0 88. 00 89. 00 08900 RURAL HEALTH CLINI C 0 0 0.000000 0 0 89. 00 90. 00 09000 CLINI C 223, 796 3, 587, 234 0.062387 325, 007 20, 276 90. 00 90. 01 04950 SLEEP CLINI C 3, 643 2, 603, 339 0.001399 0 0 90. 01	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	469, 522	114, 340, 045	0. 00410	24, 453	100	71. 00
74. 00		301, 263				0	72. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 0 0 0 75. 00 76. 00 03140 CARDIOLOGY 432, 432 26, 099, 217 0.016569 618, 686 10, 251 88. 00 08800 RURAL HEALTH CLINIC 0 0.000000 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0 0 89. 00 90. 00 09000 CLINIC 223, 796 3, 587, 234 0.062387 325, 007 20, 276 90. 00 90. 01 04950 SLEEP CLINIC 3, 643 2, 603, 339 0.001399 0 0 90. 01		331, 285	85, 388, 427	1		28, 989	1
76. 00 03140 CARDÍ OLOGY 432, 432 26, 099, 217 0. 016569 618, 686 10, 251 76. 00 0UTPATI ENT SERVI CE COST CENTERS 88. 00 0890 RURAL HEALTH CLÍNI C 0 0. 000000 0 0 88. 00 89. 00 0900 CLÍNI C 223, 796 3, 587, 234 0. 062387 325, 007 20, 276 90. 00 90. 01 04950 SLEEP CLÍNI C 3, 643 2, 603, 339 0. 001399 0 0 90. 01			C			1	1
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0000000 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0000000 0 0 89. 00 90. 00 09000 CLINIC 223,796 3,587,234 0.062387 325,007 20,276 90. 00 90. 01 04950 SLEEP CLINIC 3,643 2,603,339 0.001399 0 0 90. 01			C	1			•
88. 00 08800 RURAL HEALTH CLINIC 0 0.000000 0 0 88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0.000000 0 89. 00 09000 CLINIC 223, 796 3, 587, 234 0.062387 325, 007 20, 276 90. 00 04950 SLEEP CLINIC 3, 643 2, 603, 339 0.001399 0 0 90. 01	76. 00 03140 CARDI OLOGY	432, 432	26, 099, 217	0.01656	618, 686	10, 251	76.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0 0.000000 0 0.000000 0				0 00000	0		00 00
90. 00 09000 CLINIC 223, 796 3, 587, 234 0. 062387 325, 007 20, 276 90. 00 90. 01 04950 SLEEP CLINIC 3, 643 2, 603, 339 0. 001399 0 0 90. 01		_					
90. 01 04950 SLEEP CLINIC 3, 643 2, 603, 339 0. 001399 0 0 90. 01			3 587 234			1	
							1
711 00 07100 EMERICENCE							
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 1,366,655 17,003,842 0.080373 0 92.00							1
OTHER REIMBURSABLE COST CENTERS		.,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,,		-1		
94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0.000000 0 94. 00		0	C	0.00000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES 95. 00							95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0.000000 0 0 96. 00		0	C			0	96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0.000000 0 97. 00		0	C			0	
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0.000000 0 98. 00		0	C				1
200.00 Total (lines 50 through 199) 9,994,295 700,373,930 35,598,518 552,184 200.00	200.00 Total (lines 50 through 199)	9, 994, 295	700, 373, 930	P	35, 598, 518	552, 184	200. 00

Health Financial Systems	ELKHART GENER	RAL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COS	TS Provider C		Period: From 01/01/2017	Worksheet D Part III	
				To 12/31/2017	Date/Time Pre	pared:
		T: +1	a VIV	Hooni tol	5/23/2018 2: 3	9 pm
Cost Center Description	Nursing School		e XIX	Hospital Allied Health	All Other	
cost center bescription	Post-Stepdown	Nul 31 lig 3chool	Post-Stepdown		Medi cal	
	Adjustments		Adjustments	0001	Education Cost	
	1A	1.00	2A	2. 00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	C		1	0		
31.00 03100 INTENSIVE CARE UNIT	C		1	O C		
31. 01 03101 NEONATAL INTENSIVE CARE	C	1		0	1	
32. 00 03200 CORONARY CARE UNIT	C	Ί	1	0	1	
33. 00 03300 BURN INTENSIVE CARE UNIT	C	1			0	
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - IPF	C	Ί	1		0	
41. 00 04100 SUBPROVI DER - 1 PF					0	
43. 00 04300 NURSERY					0	
44. 00 04400 SKILLED NURSING FACILITY		1				44. 00
45. 00 04500 NURSING FACILITY		Ί				45. 00
200.00 Total (lines 30 through 199)					0	200.00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpatient	
·	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
LANDATI ENT. DOUTLANE, OFFICE OF COOT, OFFITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
I NPATIENT ROUTINE SERVICE COST CENTERS 30. 00 03000 ADULTS & PEDIATRICS			39, 85	7 0.00	872	30.00
31. 00 03100 NTENSI VE CARE UNI T		1 0			•	
31. 01 03100 INTENSIVE CARE ONLY			780		•	
32. 00 03200 CORONARY CARE UNIT			1	0.00	•	
33.00 03300 BURN INTENSIVE CARE UNIT		0		0.00	•	
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0		0.00	0	34.00
40. 00 04000 SUBPROVI DER - I PF	C	0	2, 64	0.00	82	40.00
41. 00 04100 SUBPROVI DER - I RF	C	0	1, 42	0.00	58	41. 00
43. 00 04300 NURSERY		0	2, 46		1	
44.00 04400 SKILLED NURSING FACILITY		0		0.00	1	
45. 00 04500 NURSI NG FACI LI TY		0	1	0.00	I I	
200.00 Total (lines 30 through 199)		0	51, 74	1	1, 283	200. 00
Cost Center Description	Inpatient Program	PSA Adj. All Other Medical				
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00	13.00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	C	l control of the cont	1			30.00
31. 00 03100 I NTENSI VE CARE UNI T	C	l l	1			31.00
31. 01 03101 NEONATAL INTENSIVE CARE	C	l l	1			31. 01
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT	C	1				32.00
33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT		-				33.00
40. 00 04000 SUBPROVI DER - PF		-	1			40.00
41. 00 04100 SUBPROVI DER - 1 FF		 	1			41.00
43. 00 04300 NURSERY		 	ól			43. 00
44.00 04400 SKILLED NURSING FACILITY	C	 				44. 00
45.00 04500 NURSING FACILITY	C	1				45. 00
200.00 Total (lines 30 through 199)	c	0)			200. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: | 5/23/2018 2:39 pm Provider CCN: 15-0018 THROUGH COSTS

						5/23/2018 2:3	9 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
		Anesthetist	Post-Stepdown	line or rig	Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS	1.00	211	2.00	J/A	3.00	
50. 00	05000 OPERATI NG ROOM		0	0	0	0	50.00
	I I				_		
51. 00	05100 RECOVERY ROOM			0	U	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	C	1	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	C	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	C	0	0	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	C	0	0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	C	0	0	0	0	56. 00
57.00	05700 CT SCAN		0	l 0	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)			1 0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON				0	0	59. 00
60.00	06000 LABORATORY				0	Ö	60.00
60. 01	06001 BLOOD LABORATORY				0	0	60. 01
	i i		1	٥	U	0	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C	0	0	0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	C	0	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	C	0	0	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	C	0	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	C	0	0	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY		0	l 0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY		0		0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY				o o	l o	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS				0	0	72.00
					0		
73. 00	07300 DRUGS CHARGED TO PATIENTS				0	0	73. 00
74. 00	07400 RENAL DI ALYSI S		0	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	C	0	-		0	75. 00
76. 00	03140 CARDI OLOGY	C	0	0	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS	-					
88. 00	08800 RURAL HEALTH CLINIC	C	0	0	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0	0	0	0	89. 00
90.00	09000 CLI NI C	C	0	0	0	0	90.00
90. 01	04950 SLEEP CLINIC		0	l 0	0	0	90. 01
91. 00	09100 EMERGENCY			0	0	175, 136	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				Ŭ	0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
94. 00	09400 HOME PROGRAM DIALYSIS		0	0	0	0	94. 00
	I I		1	٥	U	0	
95.00	09500 AMBULANCE SERVICES					_	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED			1	0	0	96. 00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	C	'l 0	J 0	0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	C	0	0	0	0	98. 00
200.00	Total (lines 50 through 199)	[C	0	0	0	175, 136	200. 00

| Peri od: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: | Part IV | Par Provider CCN: 15-0018 THROUGH COSTS

					10 12/31/201/	5/23/2018 2:3	
-			Tit	le XIX	Hospi tal	PPS	7 piii
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	300 CONTON 2000 F F C ON	Medi cal	(sum of col 1		(from Wkst. C,		
		Education Cost	•	Cost (sum of		(col . 5 ÷ col .	
			4)	col . 2, 3 and		7)	
			,	4)	,		
		4. 00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	()	0 103, 390, 901	0.000000	50. 00
51.00	05100 RECOVERY ROOM	0	()	0	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	()	0	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	()	0	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	()	0 58, 167, 931	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	()	0	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0	(0	0.000000	56. 00
57.00	05700 CT SCAN	0	(0 54, 525, 929	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(0 9, 041, 141	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	(0 30, 491, 096	0.000000	59. 00
60.00	06000 LABORATORY	0	(0 59, 554, 659	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	(0	0.000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(0 6, 080, 307	0. 000000	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	(0	0. 000000	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	(0 1, 316, 260		
65. 00	06500 RESPIRATORY THERAPY	0	i		0 20, 978, 425		
66. 00	06600 PHYSI CAL THERAPY	0		ก	0 4, 516, 103		
67. 00	06700 OCCUPATI ONAL THERAPY	0	ì	ol	0 2, 860, 680		
68. 00	06800 SPEECH PATHOLOGY	0		ก	0 774, 289		
69. 00	06900 ELECTROCARDI OLOGY	0	,	ก	0 771,207	0. 000000	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	ì	ก	0	0. 000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	ì	ก	0 114, 340, 045		
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	ì	ก	0 63, 017, 678		
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	ì	ก	0 85, 388, 427		
74. 00	07400 RENAL DIALYSIS	0	ì	ol .	0 03, 300, 427	0.000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0		ol .	o o	0.000000	
76. 00	03140 CARDI OLOGY	0		ol .	0 26, 099, 217		
70.00	OUTPATIENT SERVICE COST CENTERS			71	0 20,077,217	0.000000	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	(ol	ol o	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		ก	0	0. 000000	89. 00
90.00	09000 CLINIC	0	ì	ก	0 3, 587, 234		
90. 01	04950 SLEEP CLINIC	0	ì	ก	0 2, 603, 339		90. 01
91. 00	09100 EMERGENCY	0	175, 136	175, 13			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	175, 150		0 17, 003, 842		92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>		21	0 17,000,042	0.000000	72.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0	(0 0	0.000000	94. 00
95. 00	09500 AMBULANCE SERVICES		`	1		0.00000	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	,		0	0. 000000	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD					0.000000	97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS					0.000000	
200.00	1		175, 136	5 175, 13	6 700, 373, 930		200.00
200.00	Tiotal (Tines 50 till ough 177)	ı U	175, 150	۱/۵, ۱۵	0 100,313,730	I	₁ 200.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2017 | Part IV | To 12/31/2017 | Date/Time Prepared: | To 12/31/2017 | T
 Heal th Financial
 Systems
 ELKHART
 GENERAL

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE
 OTHER PASS
 Provider CCN: 15-0018 THROUGH COSTS

					10 12/31/201	5/23/2018 2:3	
			Titl	e XIX	Hospi tal	PPS	
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	'	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	h Charges	Pass-Through	
		(col. 6 ÷ col.	ŭ	Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11.00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	10, 385, 170		0	0 0	50. 00
51.00	05100 RECOVERY ROOM	0. 000000	0		0	0 0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0 0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0 0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 541, 185		0	0 0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0 0	55. 00
56.00	05600 RADI 0I SOTOPE	0. 000000	0		0	0 0	56. 00
57.00	05700 CT SCAN	0. 000000	1, 868, 018		0	0 0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	313, 786		0	0 0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 564, 470		0	0 0	59. 00
60.00	06000 LABORATORY	0. 000000	4, 983, 436		0	o o	60. 00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0	o o	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	522, 419		0	ol o	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	ol o	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	302, 115		0	ol o	64. 00
65.00	06500 RESPIRATORY THERAPY	0. 000000	2, 632, 999		0	ol o	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	164, 309	1	0	ol o	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	149, 108		0	ol o	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	37, 420		0	ol o	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0	1	0	ol o	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	ol o	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	24, 453		0	ol o	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	ol o	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	7, 471, 495		0	ol o	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0	1	0	ol o	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	ol o	75. 00
76.00	03140 CARDI OLOGY	0. 000000	618, 686		0	ol o	76. 00
	OUTPATIENT SERVICE COST CENTERS	'				•	
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0		0	0 0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	ol o	89. 00
90.00	09000 CLI NI C	0. 000000	325, 007		0	ol o	90. 00
90. 01	04950 SLEEP CLINIC	0. 000000	0		0	ol o	90. 01
91.00	09100 EMERGENCY	0. 004780	1, 694, 442	8, 0	99	ol o	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	ol o	92. 00
	OTHER REIMBURSABLE COST CENTERS	·			<u> </u>	•	1
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0	0 0	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	ol o	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0	o o	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0	o o	98. 00
200.00	1		35, 598, 518	8, 0	99	0	200. 00
	· · · · · · · · · · · · · · · · · · ·			•	•	•	•

In Lieu of Form CMS-2552-10 Health Financial Systems ELKHART GENERAL HOSPITAL APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0018 Peri od: Worksheet D From 01/01/2017 THROUGH COSTS Part IV 12/31/2017 Date/Time Prepared:

5/23/2018 2:39 pm Title XIX Hospi tal PPS PSA Adj. Non PSA Adj. All Cost Center Description Physi ci an Other Medical Education Cost Anestheti st Cost 24.00 21.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 000000000000 05100 RECOVERY ROOM 51 00 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 05300 ANESTHESI OLOGY 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 57.00 05700 CT SCAN 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 59.00 60.00 06000 LABORATORY 0 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0000000000000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 63.00 06400 INTRAVENOUS THERAPY 0 64 00 64 00 06500 RESPIRATORY THERAPY 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 67. 00 06700 OCCUPATIONAL THERAPY 0 67.00 68. 00 06800 SPEECH PATHOLOGY 0 68 00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75 00 03140 CARDI OLOGY 76.00 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 89.00 90.00 09000 CLI NI C 0 90.00 04950 SLEEP CLINIC 90.01 0 90.01 0 91.00 09100 EMERGENCY 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09500 AMBULANCE SERVICES 95.00 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00

0

0

98.00

200.00

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

200.00

Health Financial Systems	ELKHART GENER		011 45 0040		u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2017	Worksheet D Part II	
		Component		To 12/31/2017	Date/Time Pre	nared:
		Component	CCIV. 13 3010	10 12/31/2017	5/23/2018 2: 3	9 pm
		Ti tl	e XIX	Subprovi der -	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	IPF Inpatient	Capital Costs	
cost center bescription	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,				column 4)	
	Part II, col.	8)	2)	. Charges	corumir 4)	
	26)	",				
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	2, 729, 402	103, 390, 901	0. 02639	9 0	0	50.00
51. 00 05100 RECOVERY ROOM	0		0. 00000		0	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0				0	
53. 00 05300 ANESTHESI OLOGY	0		0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 697, 346	58, 167, 931	1		428	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0			0	
56. 00 05600 RADI 01 SOTOPE	0		0.00000		0	
57. 00 05700 CT SCAN	309, 154	54, 525, 929			275	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	154, 009				68	
59. 00 05900 CARDI AC CATHETERI ZATI ON	191, 857	30, 491, 096			0	
60. 00 06000 LABORATORY	297, 261	59, 554, 659	1		1, 130	
60. 01 06001 BLOOD LABORATORY	0				0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					_	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	7, 021	6, 080, 307	0. 00115	5 0	0	
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	
64. 00 06400 I NTRAVENOUS THERAPY	95, 775	1, 316, 260			0	
65. 00 06500 RESPI RATORY THERAPY	107, 278				278	
66. 00 06600 PHYSI CAL THERAPY	224, 590				113	
67. 00 06700 OCCUPATI ONAL THERAPY	102, 414				106	
68. 00 06800 SPEECH PATHOLOGY	60, 187	774, 289			25	
69. 00 06900 ELECTROCARDI OLOGY	0		1		0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0. 00000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	469, 522	114, 340, 045	0. 00410	6 554	2	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	301, 263				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	331, 285	85, 388, 427	0. 00388	0 70, 753	275	73. 00
74. 00 07400 RENAL DIALYSIS	0		1		0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0		0. 00000		0	75. 00
76. 00 03140 CARDI OLOGY	432, 432	26, 099, 217	1		417	1
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	C	0.00000	0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000	o o	0	89. 00
90. 00 09000 CLI NI C	223, 796	3, 587, 234	1		394	90.00
90. 01 04950 SLEEP CLINIC	3, 643	2, 603, 339			0	90. 01
91. 00 09100 EMERGENCY	889, 405	36, 636, 427	0. 02427	7 152, 990	3, 714	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	92.00
OTHER REIMBURSABLE COST CENTERS			1			1
94. 00 09400 HOME PROGRAM DI ALYSI S	0	C	0.00000	0 0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	i c	0. 00000	o o	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.00000		0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 00000	o ol	0	98. 00
200.00 Total (lines 50 through 199)	8, 627, 640	700, 373, 930)	609, 278	7, 225	200. 00
				·		

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0018 Component CCN: 15-S018		Date/Time Prepared:
				5/23/2018 2:39 pm
		Title XIX	Subprovi der -	PPS

			Titl	e XIX	Subprovi der -	PPS	
	Cost Center Description				Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		1.00	Adjustments 2A	2.00	Adjustments 3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00	JA	3.00	
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
51. 00	05100 RECOVERY ROOM	0			0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0			0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C				0	Ō	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0				l ő	55. 00
56. 00	05600 RADI OI SOTOPE	0				l ő	56. 00
57. 00	05700 CT SCAN				0	o o	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)				0	Ō	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0	0	1
60.00	06000 LABORATORY	0			0	0	60.00
60. 01	06001 BLOOD LABORATORY	0			0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			1	1	Ĭ	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.					l o	63. 00
64. 00	06400 NTRAVENOUS THERAPY	0				o o	64. 00
65. 00	06500 RESPIRATORY THERAPY					l ő	65. 00
66. 00	06600 PHYSI CAL THERAPY					0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0			0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0			o o	Ō	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0			0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	ol c		0	0	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	o c		o	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	o c		o	0	73. 00
74.00	07400 RENAL DIALYSIS	0	o c		o	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0) c) (0	0	75. 00
76.00	03140 CARDI OLOGY	0) C) (0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	C	(0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0) C) (0	0	89. 00
90.00	09000 CLI NI C	0) C) (0	0	90.00
90. 01	04950 SLEEP CLINIC	0) C) (0	0	90. 01
91. 00	09100 EMERGENCY	0) C) (0	175, 136	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0)			0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0	C) (0	0	
95. 00	09500 AMBULANCE SERVI CES						95. 00
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0	0	
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	0) C)	0	0	1 /// 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	<u>C</u>		0	0	
200.00	Total (lines 50 through 199)	0) C) (0	175, 136	J200. 00

Cost Center Description All Other Total Cost Total Total Charges Ratio of Medical (sum of col 1 Outpatient (from Wkst. C, to Char	Prepared: 2:39 pm S ost s ol.
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-0018 Component CCN: 15-S018 Title XIX Subprovider - IPF Cost Center Description All Other Medical (sum of col 1 Outpatient Outpatient) Morksher From 01/01/2017 To 12/31/2017 Subprovider - IPF Total Cost Total (from Wkst. C, to Chair Cost) Total Charges (from Wkst. C, to Chair Cost) Total Charges (from Wkst. C, to Chair Cost)	Prepared: 2:39 pm S ost s ol.
Cost Center Description All Other Total Cost Total Total Charges Ratio of Medical (sum of col 1 Outpatient (from Wkst. C, to Char	2: 39 pm S sst sol.
Title XIX Subprovider - IPF Cost Center Description All Other Total Cost Total Total Charges Ratio of Medical (sum of col 1 Outpatient (from Wkst. C, to Char	s st s ol .
Cost Center Description All Other Total Cost Total Total Charges Ratio of Medical (sum of col 1 Outpatient (from Wkst. C, to Char	s ol .
Medical (sum of col 1 Outpatient (from Wkst. C, to Cha	s ol .
	000 50.00
Education Cost through col. Cost (sum of Part I, col. (col. 5 -	
4) col. 2, 3 and 8) 7)	
4.00 5.00 6.00 7.00 8.00	
ANCI LLARY SERVI CE COST CENTERS	
	200 51 00
51. 00 05100 RECOVERY ROOM 0 0 0 0 0 0 0	
	000 52.00
	000 53.00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0 0 58, 167, 931 0. 0	000 54.00
55. 00 05500 RADI 0LOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0	000 55.00
56. 00 05600 RADI 01 SOTOPE 0 0 0 0 0. (000 56.00
	000 57.00
	000 58.00
	000 59.00
	000 60.00
	000 60. 01
61.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	61.00
	000 62.00
	000 63.00
	000 64.00
	000 65.00
	000 66.00 000 67.00
	000 68.00
	000 69.00
	000 70.00
	000 70.00
	000 72.00
	000 73.00
	000 74.00
	000 75.00
	000 76.00
OUTPATLENT SERVICE COST CENTERS	
	000 88.00
	000 89.00
	000 90.00
	000 90. 01
	780 91.00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 17, 003, 842 0.00 0 0 0 0 0 0 0 0	92.00

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175, 136

175, 136

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0.000000

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0.000000

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700, 373, 930

94.00

95.00

96.00

97.00

98.00

200.00

94. 00 O9400 HOME PROGRAM DI ALYSI S 95. 00 O9500 AMBULANCE SERVI CES

OTHER REIMBURSABLE COST CENTERS

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

98. 00 09850 OTHER REIMBURSABLE COST CENTERS 200. 00 Total (lines 50 through 199)

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ELKHART GENERA	Provi der CO	°N: 15_0018	Peri od:	u of Form CMS-2 Worksheet D	∠35∠-10
THROUGH COSTS	KVIOL UIILK PASS			From 01/01/2017	Part IV	
		Component (CCN: 15-S018	To 12/31/2017	Date/Time Pre 5/23/2018 2:3	
		Ti tl	e XIX	Subprovi der - I PF	PPS	<i>y</i> p
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col . 6 ÷ col .		Costs (col.	8	Costs (col. 9	
	7)	10.00	x col . 10)	12.00	x col . 12)	
ANCILLARY CERVICE COST CENTERS	9. 00	10. 00	11. 00	12.00	13. 00	
ANCILLARY SERVICE COST CENTERS 50. 00 05000 0PERATING ROOM	0. 000000	0		0 0	0	50.00
	1					1
51. 00 05100 RECOVERY ROOM	0.000000	0		0 0	0	1
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0			0	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000 0. 000000				0	
55. 00 05500 RADI OLOGY - THERAPEUTI C	0. 000000	14, 667 0			0	55. 00
56. 00 05600 RADI 0I SOTOPE	1	0			0	
57. 00 05700 CT SCAN	0. 000000 0. 000000	48, 586		0	0	
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI)	0. 000000	3, 986		0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	3, 9 60			0	
60. 00 06000 LABORATORY	0. 000000	226, 309			0	
60. 01 06000 LABORATORY	0.000000	220, 309			0	1
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	U			U	61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	
65. 00 06500 RESPIRATORY THERAPY	0. 000000	54, 449		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 000000	2, 263		0 0	0	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	2, 954		0 0	0	1
68. 00 06800 SPEECH PATHOLOGY	0. 000000	316		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	554		0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	70, 753		0 0	0	73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
76. 00 03140 CARDI OLOGY	0. 000000	25, 142		0 0	0	76. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89. 00
90. 00 09000 CLI NI C	0. 000000	6, 309		0 0	0	90.00
90. 01 04950 SLEEP CLINIC	0. 000000	0		0 0	0	90. 01
91. 00 09100 EMERGENCY	0. 004780	152, 990	7:	31 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0. 000000	0		0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		ol ol	0	98. 00
200.00 Total (lines 50 through 199)	0.00000	609, 278		31 0	-	200.00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT . THROUGH COSTS	ANCILLARY SERVICE OTHER PASS		From 01/01/2017	
		Component CCN: 15-S018	To 12/31/2017	Date/Time Prepared: 5/23/2018 2:39 pm
		Title XIX	Subprovi der -	PPS

			11.01	e xix	I PF	113	
	Cost Center Description	PSA Adj. Non	PSA Adj. All				
	·	Physi ci an	Other Medical				
		Anestheti st	Education Cost				
		Cost					
		21. 00	24. 00				
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	0	1			50. 00
51. 00		0	0				51. 00
52. 00		0	0				52. 00
53. 00		0	0				53. 00
54.00	1	0	0				54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00	05600 RADI OI SOTOPE	0	0				56. 00
57. 00	05700 CT SCAN	0	0				57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0					58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0				59. 00
60. 00 60. 01	1 1	0	0				60.00
61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0				60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62. 00
63. 00							63. 00
64. 00	06400 NTRAVENOUS THERAPY						64. 00
65. 00	+ I						65. 00
66. 00	06600 PHYSI CAL THERAPY						66. 00
67. 00	1 1	0					67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00	1 1	0	0				69. 00
70. 00	I I	0	0				70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Ö				71. 00
72. 00		0	0				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
74.00	07400 RENAL DI ALYSI S	0	0				74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0				75. 00
76.00	03140 CARDI OLOGY	0	0				76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0				88. 00
89. 00		0	0				89. 00
90.00	09000 CLI NI C	0	0				90.00
90. 01	04950 SLEEP CLINIC	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						
	09400 HOME PROGRAM DIALYSIS	0	0				94. 00
95. 00	I I						95.00
96. 00		0	0				96. 00
97. 00		0	0				97. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0				98. 00
200.00	Total (lines 50 through 199)	0	0	1			200. 00

Related Cost (from Wkst. B, Part III, col. 26) 1.00 26) 1.00 26) 1.00 26) 1.00 26) 1.00 26) 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 2729, 402 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00	· ·	Ratio of Cost to Charges (col. 1 ÷ col. 2) 3.00 0.026399 0.000000 0.000000 0.000000 0.000000 0.000000	Program Charges 4.00 9 334 0 0 0 0 0 2,843 0 0 0 0 12,914 4 3,920 0 1 20,266 0 0	Part II Date/Time Pre 5/23/2018 2:3 PPS Capital Costs (column 3 x column 4) 5.00 9 0 0 0 83 0 0 73 67 0 101 0	50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00
Related Cost (from Wkst. B, Part II, col. 26) 1.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY-THERAPEUTI C 66.00 05600 RADI OL SOTOPE 67.00 05700 CT SCAN 68.00 05800 MAGNETI C RESONANCE I MAGING (MRI) 69.00 05900 CARDI AC CATHETERI ZATI ON 61.00 06001 LABORATORY 61.00 06001 BLOOD LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63.00 06300 BLOOD STORING, PROCESSI NG & TRANS. 64.00 06400 I NTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATIONAL THERAPY 68.00 06600 PHYSI CAL THERAPY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 701.260	Total Charges from Wkst. C, Part I, col. 8) 2.00 103,390,901 0 0 58,167,931 0 0 54,525,929 9,041,141 30,491,096 59,554,659 0	Ratio of Cost to Charges (col. 1 ÷ col. 2) 3.00 0.026399 0.000000 0.000000 0.000000 0.000000 0.005670 0.017034 0.006292 0.004997 0.0000000 0.001158	IRF Inpati ent Program Charges 4.00 9 334 0 0 0 0 0 0 0 2,843 0 0 0 0 12,914 4 3,920 0 1 20,266 0 0	PPS Capital Costs (column 3 x column 4) 5.00 9 0 0 0 83 0 0 73 67 0 1011	50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 00 60. 01
Related Cost (from Wkst. B, Part II, col. 26) 1.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY 54.00 05400 RADI OLOGY-DI AGNOSTI C 55.00 05500 RADI OLOGY-THERAPEUTI C 66.00 05600 RADI OL SOTOPE 67.00 05700 CT SCAN 68.00 05800 MAGNETI C RESONANCE I MAGING (MRI) 69.00 05900 CARDI AC CATHETERI ZATI ON 61.00 06001 LABORATORY 61.00 06001 BLOOD LABORATORY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63.00 06300 BLOOD STORING, PROCESSI NG & TRANS. 64.00 06400 I NTRAVENOUS THERAPY 65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATIONAL THERAPY 68.00 06600 PHYSI CAL THERAPY 69.00 06900 ELECTROCARDI OLOGY 70.00 07000 ELECTROCARDI OLOGY 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 701.260	From Wkst. C, Part I, col. 8) 2.00 103,390,901 0 58,167,931 0 54,525,929 9,041,141 30,491,096 59,554,659	to Charges (col . 1 ÷ col . 2) 3.00 0.026399 0.000000 0.000000 0.0029180 0.000000 0.005670 0.017032 0.006292 0.004997 0.0000000 0.001158	Inpatient Program Charges 4.00 9 334 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	(col umn 3 x col umn 4) 5.00 9 0 0 0 83 0 0 73 67 0 1011	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01
ANCI LLARY SERVI CE COST CENTERS	Part I, col. 8) 2.00 103, 390, 901 0 0 58, 167, 931 0 0 54, 525, 929 9, 041, 141 30, 491, 096 59, 554, 659	(col . 1 ÷ col . 2) 3.00 0.026399 0.000000 0.000000 0.029180 0.000000 0.005670 0.017034 0.006292 0.004997 0.0000000 0.001158	Charges 4.00 9 334 0 0 0 0 0 2,843 0 0 0 0 12,914 4 3,920 2 0 1 20,266 0 0	5. 00 9 0 0 0 83 0 73 67 0 101	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01
Part II, col. 26) 1.00 26) 1.00 26) 1.00 26) 1.00 26) 1.00 2729, 402 51.00 05000 0PERATI NG ROOM 05100 RECOVERY ROOM 052.00 05200 DELI VERY ROOM & LABOR ROOM 053.00 05300 ANESTHESI OLOGY 0 054.00 05400 RADI OLOGY-DI AGNOSTI C 1,697,346 05500 RADI OLOGY-THERAPEUTI C 0 05600 RADI OLOGY-THERAPEUTI C 0 05700 CT SCAN 309,154 58.00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 154,009 59.00 05900 CARDI AC CATHETERI ZATI ON 191,857 60.00 6000 LABORATORY 297,261 60.01 06001 BLOOD LABORATORY 297,261 60.00 06400 BLOOD LABORATORY 0 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7,021 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 06400 INTRAVENOUS THERAPY 95,775 65.00 06500 RESPI RATORY THERAPY 95,775 66.00 06600 PHYSI CAL THERAPY 224,590 67.00 06700 OCCUPATI ONAL THERAPY 107,278 66.00 06900 ELECTROCARDI OLOGY 0 07000 ELECTROCARDI OLOGY 0 07000 ELECTROCARDI OLOGY 0 07000 CALOR SUPPLIES CHARGED TO PATI ENTS 469,522 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 301,263	8) 2, 00 103, 390, 901 0 0 58, 167, 931 0 0 54, 525, 929 9, 041, 141 30, 491, 096 59, 554, 659 0	2) 3. 00 0. 026399 0. 000000 0. 000000 0. 029180 0. 000000 0. 005670 0. 017034 0. 006292 0. 004997 0. 0000000 0. 001158	4.00 9 334 0 0 0 0 0 2,843 0 0 0 12,914 4 3,920 2 0 1 20,266 0 0	5. 00 9 0 0 0 83 0 0 73 67 0 101	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01
ANCI LLARY SERVI CE COST CENTERS	2. 00 103, 390, 901 0 0 58, 167, 931 0 0 54, 525, 929 9, 041, 141 30, 491, 096 59, 554, 659 0	3.00 0.026399 0.000000 0.000000 0.000000 0.029180 0.000000 0.005670 0.017034 0.006292 0.004997 0.0000000 0.001158	9 334 0 0 0 0 0 0 0 2, 843 0 0 0 0 12, 914 4 3, 920 2 0 1 20, 266	9 0 0 83 0 0 73 67 0 101	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01
ANCI LLARY SERVI CE COST CENTERS	103, 390, 901 0 0 58, 167, 931 0 0 54, 525, 929 9, 041, 141 30, 491, 096 59, 554, 659	0. 026399 0. 000000 0. 000000 0. 0029180 0. 000000 0. 005670 0. 017032 0. 006292 0. 004997 0. 0000000	9 334 0 0 0 0 0 0 0 2, 843 0 0 0 0 12, 914 4 3, 920 2 0 1 20, 266	9 0 0 83 0 0 73 67 0 101	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01
ANCI LLARY SERVI CE COST CENTERS 50.00 05000 0PERATI NG ROOM 2,729,402 51.00 05100 RECOVERY ROOM 0 05200 DELI VERY ROOM & LABOR ROOM 0 05200 DELI VERY ROOM & LABOR ROOM 0 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0	103, 390, 901 0 0 58, 167, 931 0 0 54, 525, 929 9, 041, 141 30, 491, 096 59, 554, 659	0. 026399 0. 000000 0. 000000 0. 0029180 0. 000000 0. 005670 0. 017032 0. 006292 0. 004997 0. 0000000	9 334 0 0 0 0 0 0 0 2, 843 0 0 0 0 12, 914 4 3, 920 2 0 1 20, 266	9 0 0 83 0 0 73 67 0 101	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01
50. 00 05000 OPERATI NG ROOM 2, 729, 402 51. 00 05100 RECOVERY ROOM 0 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 53. 00 05300 ANESTHESI OLOGY 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 697, 346 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 57. 00 05700 CT SCAN 309, 154 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 154, 009 59. 00 05900 CARDI AC CATHETERI ZATI ON 191, 857 60. 01 06000 LABORATORY 297, 261 60. 01 06001 BLOOD LABORATORY 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7, 021 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 64. 00 06400 I NTRAVENOUS THERAPY <	0 0 0 58, 167, 931 0 0 54, 525, 929 9, 041, 141 30, 491, 096 59, 554, 659 0	0. 000000 0. 000000 0. 000000 0. 029180 0. 000000 0. 005670 0. 017034 0. 006292 0. 004997 0. 000000	0 0 0 0 0 0 0 2,843 0 0 0 0 12,914 4 3,920 2 0 1 20,266	0 0 0 83 0 0 73 67 0 101	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01
51. 00 05100 RECOVERY ROOM 0 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 53. 00 05300 ANESTHESI OLOGY 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 697, 346 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 56. 00 05600 RADI OL GOTOPE 0 57. 00 05700 CT SCAN 309, 154 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 154, 009 59. 00 05900 CARDI AC CATHETERI ZATI ON 191, 857 60. 00 06000 LABORATORY 297, 261 60. 01 06000 LABORATORY 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7, 021 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 64. 00 06400 INTRAVENOUS THERAPY 95, 775 65. 00 06500 RESPI RATORY THERAPY 107, 278 <td>0 0 0 58, 167, 931 0 0 54, 525, 929 9, 041, 141 30, 491, 096 59, 554, 659 0</td> <td>0. 000000 0. 000000 0. 000000 0. 029180 0. 000000 0. 005670 0. 017034 0. 006292 0. 004997 0. 000000</td> <td>0 0 0 0 0 0 0 2,843 0 0 0 0 12,914 4 3,920 2 0 1 20,266</td> <td>0 0 0 83 0 0 73 67 0 101</td> <td>51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01</td>	0 0 0 58, 167, 931 0 0 54, 525, 929 9, 041, 141 30, 491, 096 59, 554, 659 0	0. 000000 0. 000000 0. 000000 0. 029180 0. 000000 0. 005670 0. 017034 0. 006292 0. 004997 0. 000000	0 0 0 0 0 0 0 2,843 0 0 0 0 12,914 4 3,920 2 0 1 20,266	0 0 0 83 0 0 73 67 0 101	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 53. 00 05300 ANESTHESI OLOGY 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 697, 346 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 56. 00 05600 RADI OI SOTOPE 0 57. 00 05700 CT SCAN 309, 154 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 154, 009 59. 00 05900 CARDI AC CATHETERI ZATI ON 191, 857 60. 00 06000 LABORATORY 297, 261 60. 01 06001 BLOOD LABORATORY 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7, 021 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 64. 00 06400 INTRAVENOUS THERAPY 95, 775 65. 00 06500 RESPI RATORY THERAPY 107, 278 66. 00 06600 PHYSI CAL THERAPY	58, 167, 931 0 0 58, 167, 931 0 0 54, 525, 929 9, 041, 141 30, 491, 096 59, 554, 659 0	0. 000000 0. 000000 0. 029180 0. 000000 0. 000000 0. 005670 0. 017034 0. 006292 0. 004997 0. 000000	0 0 0 0 2, 843 0 0 0 0 12, 914 4 3, 920 2 0 1 20, 266 0 0	0 0 83 0 0 73 67 0 101	52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01
53. 00 05300 ANESTHESI OLOGY 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 697, 346 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 56. 00 05600 RADI OI SOTOPE 0 57. 00 05700 CT SCAN 309, 154 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 154, 009 59. 00 05900 CARDI AC CATHETERI ZATI ON 191, 857 60. 00 06000 LABORATORY 297, 261 60. 01 06001 BLOOD LABORATORY 0 61. 00 O6100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 62. 00 O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7, 021 63. 00 O6300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 64. 00 O6400 I NTRAVENOUS THERAPY 95, 775 65. 00 O6500 RESPI RATORY THERAPY 107, 278 66. 00 O6600 PHYSI CAL THERAPY 224, 590 67. 00 O6700 OCCUPATI ONAL THERAPY	0 58, 167, 931 0 0 54, 525, 929 9, 041, 141 30, 491, 096 59, 554, 659 0	0. 000000 0. 029180 0. 000000 0. 000000 0. 005670 0. 017034 0. 006292 0. 004997 0. 0000000	0 0 2, 843 0 0 0 0 0 12, 914 4 3, 920 2 0 1 20, 266	0 83 0 0 73 67 0 101	53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 697, 346 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 57. 00 05700 CT SCAN 309, 154 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 154, 009 59. 00 05900 CARDI AC CATHETERI ZATI ON 191, 857 60. 00 06000 LABORATORY 297, 261 60. 01 06001 BLOOD LABORATORY 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7, 021 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 64. 00 06400 I NTRAVENOUS THERAPY 95, 775 65. 00 06500 RESPI RATORY THERAPY 107, 278 66. 00 06600 PHYSI CAL THERAPY 107, 278 68. 00 06800 SPEECH PATHOLOGY 60, 187 69. 00 06900 ELECTROCARDI OLOGY 0 70. 00 07100 MEDI CAL SUPPLIES C	0 0 54, 525, 929 9, 041, 141 30, 491, 096 59, 554, 659 0	0. 029180 0. 000000 0. 000000 0. 005670 0. 017034 0. 006292 0. 004997 0. 0000000	2, 843 0 0 0 0 0 12, 914 4 3, 920 2 0 1 20, 266 0 0	83 0 0 73 67 0 101	54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 56. 00 05600 RADI OI SOTOPE 0 57. 00 05700 CT SCAN 309, 154 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 154, 009 59. 00 05900 CARDI AC CATHETERI ZATI ON 191, 857 60. 00 06000 LABORATORY 297, 261 60. 01 06001 BLOOD LABORATORY 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7, 021 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 64. 00 06400 I NTRAVENOUS THERAPY 95, 775 65. 00 06500 RESPI RATORY THERAPY 107, 278 66. 00 06600 PHYSI CAL THERAPY 224, 590 67. 00 06700 OCCUPATI ONAL THERAPY 102, 414 68. 00 06800 SPECH PATHOLOGY 60, 187 69. 00 6990 ELECTROCARDI OLOGY	0 0 54, 525, 929 9, 041, 141 30, 491, 096 59, 554, 659 0	0. 000000 0. 000000 0. 00567 0. 017034 0. 006292 0. 004997 0. 000000	0 0 0 12, 914 4 3, 920 2 0 1 20, 266	0 0 73 67 0 101	55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 60. 01
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57. 00 05700 CT SCAN 309, 154 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 154, 009 59. 00 05900 CARDI AC CATHETERI ZATI ON 191, 857 60. 00 06000 LABORATORY 297, 261 60. 01 06001 BLOOD LABORATORY 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7, 021 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 64. 00 06400 I NTRAVENOUS THERAPY 95, 775 65. 00 06500 RESPI RATORY THERAPY 107, 278 66. 00 06600 PHYSI CAL THERAPY 224, 590 67. 00 06700 OCCUPATI ONAL THERAPY 102, 414 68. 00 0800 SPECH PATHOLOGY 60, 187 69. 00 06900 ELECTROCARDI OLOGY 0 70. 00 07000 ELECTROCARDI OLOGY 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 469, 522 72. 00 07200 I MPL. DE	9, 041, 141 30, 491, 096 59, 554, 659 0	0. 005670 0. 017034 0. 006292 0. 004997 0. 000000	12, 914 4 3, 920 2 0 1 20, 266 0 0	73 67 0 101 0	57. 00 58. 00 59. 00 60. 00 60. 01
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 154,009 59. 00 05900 CARDI AC CATHETERI ZATI ON 191,857 60. 00 06000 LABORATORY 297, 261 60. 01 06001 BLOOD LABORATORY 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7,021 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 64. 00 06400 I NTRAVENOUS THERAPY 95,775 65. 00 06500 RESPI RATORY THERAPY 107,278 66. 00 06600 PHYSI CAL THERAPY 224,590 67. 00 06700 OCCUPATI ONAL THERAPY 102,414 68. 00 06800 SPEECH PATHOLOGY 0 69. 00 06900 ELECTROCARDI OLOGY 0 70. 00 07000 ELECTROENCEPHAL OGRAPHY 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 469,522 72. 00 07200 I MPL. DEV	9, 041, 141 30, 491, 096 59, 554, 659 0	0. 017034 0. 006292 0. 004997 0. 000000	4 3, 920 2 0 1 20, 266 0 0	67 0 101 0	58. 00 59. 00 60. 00 60. 01
59. 00 05900 CARDI AC CATHETERI ZATI ON 191, 857 60. 00 06000 LABORATORY 297, 261 60. 01 06001 BLOOD LABORATORY 0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 7, 021 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 64. 00 06400 I NTRAVENOUS THERAPY 95, 775 65. 00 06500 RESPI RATORY THERAPY 107, 278 66. 00 06600 PHYSI CAL THERAPY 224, 590 67. 00 06700 OCCUPATI ONAL THERAPY 102, 414 68. 00 06800 SPEECH PATHOLOGY 60, 187 69. 00 06900 ELECTROCARDI OLOGY 0 70. 00 07000 ELECTROCEPHALOGRAPHY 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 469, 522 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 301, 263	30, 491, 096 59, 554, 659 0	0. 006292 0. 004991 0. 000000	2 0 1 20, 266 0 0	0 101 0	59. 00 60. 00 60. 01
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61. 00	6, 080, 307	0. 001155			
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64. 00		0.000000	ol ol	0	63. 00
65. 00 06500 RESPI RATORY THERAPY 107, 278 66. 00 06600 PHYSI CAL THERAPY 224, 590 67. 00 06700 OCCUPATI ONAL THERAPY 102, 414 68. 00 06800 SPEECH PATHOLOGY 60, 90 06900 ELECTROCARDI OLOGY 0 70. 00 07000 ELECTROCARDI OLOGY 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 469, 522 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 301, 263	1, 316, 260	0. 072763		0	64.00
66. 00 06600 PHYSI CAL THERAPY 224, 590 67. 00 06700 OCCUPATI ONAL THERAPY 102, 414 68. 00 06800 SPEECH PATHOLOGY 60, 90 06900 ELECTROCARDI OLOGY 0 70. 00 07000 ELECTROCARDI OLOGY 0 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 469, 522 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 301, 263	20, 978, 425	0. 005114		52	
68. 00 06800 SPEECH PATHOLOGY 60, 187 69. 00 06900 ELECTROCARDI OLOGY 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 469, 522 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 301, 263	4, 516, 103	0. 04973		3, 727	
69. 00 06900 ELECTROCARDI OLOGY	2, 860, 680	0. 03580 ²	1 76, 729	2, 747	67. 00
69. 00 06900 ELECTROCARDI OLOGY	774, 289	0. 077732	27, 957	2, 173	68. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 469, 522 72. 00 07200 MPL. DEV. CHARGED TO PATIENTS 301, 263	o	0. 000000		0	69. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 301, 263	o	0. 000000	o	0	70.00
	114, 340, 045	0. 004106	6 387	2	71.00
	63, 017, 678	0. 004781	1 0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 331, 285	85, 388, 427	0. 003880	52, 623	204	73. 00
74. 00 07400 RENAL DIALYSIS 0	0	0. 000000	0	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0	0	0. 000000	0 0	0	75. 00
76. 00 03140 CARDI OLOGY 432, 432	26, 099, 217	0. 016569	9 864	14	76. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC 0	0			0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0	0	0. 000000		0	89. 00
90. 00 09000 CLI NI C 223, 796	3, 587, 234	0. 062387		452	
90. 01 04950 SLEEP CLINIC 3, 643	2, 603, 339	0. 001399		0	90. 01
91. 00 09100 EMERGENCY 889, 405	36, 636, 427	0. 024277		0	
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) 0	17, 003, 842	0. 000000	0 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS	ام	0.00000			04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0. 000000	0	0	
95. 00 09500 AMBULANCE SERVICES		0.00000		_	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0	0	0.000000		_	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0	0	0.000000		0	97. 00 98. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 200. 00 Total (lines 50 through 199) 8,627,640	700, 373, 930	0. 000000	291, 197	_	200.00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0018	Peri od: From 01/01/2017	Worksheet D
THROUGH COSTS		Component CCN: 15-T018		
		Title XLX	Subprovi der -	PPS

Cost Center Description				Titl	e XIX	Subprovi der -	PPS	
ANCILLARY SERVICE COST CENTERS		Cost Center Description	Non Physician	Nursing School	Nursing School		Allied Health	
ANCILLARY SERVICE COST CENTERS		·						
AMCI LLARY SERVICE COST CENTERS			Cost	Adjustments		Adjustments		
50.00 050000 050000 050000 0 0			1.00	2A	2. 00	3A	3. 00	
51.00 05100 RECOVERY ROOM ALBOR ROOM 0 0 0 0 0 0 0 52 00 520 00 520 00 520 00 520 00 520 00 520 00 520 00 530 00 530 00 530 00 530 00 530 00 540 00 0 0 0 0 0 0 0 0								
S2. 00 05.200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 53. 00		1	0	0) (0	0	
S3. 00 05300 AMESTHESI DLOGY 0 0 0 0 0 0 53. 00		1	0	0) (0	0	1
S4. 00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0 0 0 0 55. 00	52. 00		0	0) (0	0	52. 00
55.00 05500 RADIO LOGY-THERAPEUTI C	53. 00	05300 ANESTHESI OLOGY	0	0) (0	0	53. 00
55.00 05500 CASCOR RADIOISOTOPE 0 0 0 0 0 0 57.00		05400 RADI OLOGY-DI AGNOSTI C	0	0) (0	0	54. 00
57.00 05700 CT SCAN 0 0 0 0 0 0 0 57.00	55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0) (0	0	55. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 0 0 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 60.01 06000 LABORATORY 0 0 0 0 0 0 0 60.01 06000 LABORATORY 0 0 0 0 0 0 60.01 06000 LABORATORY 0 0 0 0 0 0 61.00 06100 PBP CLIN ICAL LAB SERVICES-PRGM ONLY 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 63.00 06300 BLOOD STORIN IN, PROCESSING & TRANS. 0 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 67.00 06500 PHYSI CAL THERAPY 0 0 0 0 0 0 68.00 06600 SPECEH PATHOLOGY 0 0 0 0 0 69.00 06600 SPECEH PATHOLOGY 0 0 0 0 0 69.00 06600 SPECEH PATHOLOGRAPHY 0 0 0 0 0 71.00 07000 LECETOROE-PHALOGRAPHY 0 0 0 0 0 0 71.00 07000 LECETOROE-PHALOGRAPHY 0 0 0 0 0 0 72.00 07200 MPLD DEV CHARGED TO PATIENTS 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 74.00 07400 SPERAL DI ALYSIS 0 0 0 0 0 75.00 07500 OSCONON-DISTINCT PART) 0 0 0 0 0 76.00 07400 SPERAL DI ALYSIS 0 0 0 0 0 76.00 07400 CLINIC CHARGED TO PATIENTS 0 0 0 0 0 76.00 07400 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 76.00 07400 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 77.00 07400 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 77.00 07400 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 77.00 07400 07400 07400 07400 77.00 07400 07400 07400 07400 78.00 07500 07500 07500 07500 07500 07500 78.00 07500 07500 07500 07500 07500 78.00 07500 07500 07500 07500 07500 78.00 07500 07500 07500 07500 78.00 07500 07500 07500 07500 78.00 07500 07500	56. 00	05600 RADI OI SOTOPE	0	0) (0	0	56. 00
59, 00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 0 0	57.00	05700 CT SCAN	0	0) (0	0	57. 00
60. 00 06.000 LABORATORY 0 0 0 0 0 0 0 0 0	58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0) (0	0	58. 00
60.01 06001 BLOOD LABDRATORY 0 0 0 0 0 0 0 0 0	59.00	05900 CARDI AC CATHETERI ZATI ON	0	0) (0	0	59. 00
61.00 06100 BPP CLI NI CAL LAB SERVI CES-PRGM ONLY 61.00 062.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0 62.00 62.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 0 0 0 0 0 64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 0 0 0 65.00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 0 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 0 68.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 0 69.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 0 0 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0 0 0 0 0 74.00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 75.00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60.00	06000 LABORATORY	0	0) (0	0	60.00
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APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE H COSTS		S Provider C	CN: 15-0018 CCN: 15-T018	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D Part IV Date/Time Pre	pared:
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	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
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52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C		0	0.000000	52. 00
53.00	05300 ANESTHESI OLOGY	0	C		0	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1		0 58, 167, 931		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	_		0	0. 000000	
56. 00	05600 RADI OI SOTOPE	0	(0	0.000000	
57. 00	05700 CT SCAN	0			0 54, 525, 929		
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 9, 041, 141	•	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0			0 30, 491, 096	•	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0			0 59, 554, 659	0. 000000 0. 000000	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		1	ή		0.000000	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 6, 080, 307	0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.				0,000,307	0.000000	
64. 00	06400 NTRAVENOUS THERAPY			á	0 1, 316, 260	1	
65. 00	06500 RESPI RATORY THERAPY				0 20, 978, 425	•	
66.00	06600 PHYSI CAL THERAPY	0	d		0 4, 516, 103	•	
67.00	06700 OCCUPATI ONAL THERAPY	0	d		0 2, 860, 680	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	l c		0 774, 289	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	C		0 0	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C		0 0	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 114, 340, 045		
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	(0 63, 017, 678	1	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	C		0 85, 388, 427	1	
74. 00	07400 RENAL DIALYSIS	0	_		0	0.00000	
75. 00	07500 ASC (NON-DISTINCT PART)	0			0	0.000000	
76. 00	03140 CARDI OLOGY	0	()	0 26, 099, 217	0.000000	76. 00
00 00	OUTPATIENT SERVICE COST CENTERS					0.000000	00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC	0			0	0.00000	88. 00 89. 00
90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER			(0 3, 587, 234	0. 000000 0. 000000	
90.00	04950 SLEEP CLINIC			()	0 2, 603, 339	•	
91. 00	09100 EMERGENCY		175, 136	7 5 175, 13		1	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			1/3, 1	0 17, 003, 842	•	
, 00	OTHER RELIMBURSABLE COST CENTERS			1	-,,,	2. 223000	1

0

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175, 136

175, 136

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700, 373, 930

94.00

95.00

96.00

97.00

98.00

200.00

94. 00 O9400 HOME PROGRAM DI ALYSI S 95. 00 O9500 AMBULANCE SERVI CES

OTHER REIMBURSABLE COST CENTERS

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

98. 00 09850 OTHER REIMBURSABLE COST CENTERS 200. 00 Total (lines 50 through 199)

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

ealth Financial Systems PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SI	ELKHART GENERA ERVICE OTHER PASS	Provi der Co	CN: 15-0018	Peri od:	u of Form CMS-2 Worksheet D	
HROUGH COSTS		Component (CCN: 15-T018	From 01/01/2017 To 12/31/2017	Part IV Date/Time Pre 5/23/2018 2:3	
		Ti tl	e XIX	Subprovi der - I RF	PPS	, p
Cost Center Description	Outpati ent	I npati 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.	8	Costs (col. 9	
	7)	10.00	x col. 10)	10.00	x col . 12)	
ANOLLI ADV. CEDVI OF COCT. CENTERS	9. 00	10. 00	11. 00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS	0.000000	224		0 0	0	F0 00
D. 00 05000 OPERATING ROOM	0.000000	334		0 0	0	
1. 00 05100 RECOVERY ROOM	0.000000	0			0	
2.00 05200 DELIVERY ROOM & LABOR ROOM 3.00 05300 ANESTHESIOLOGY	0.000000	0		0 0	0	
	0. 000000	-		-	0	
4. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000	2, 843		0 0	0	
5. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	
5. 00 05600 RADI 01 SOTOPE	0.000000	-		0 0	0	
7. 00 05700 CT SCAN	0.000000	12, 914 3, 920		0 0		
3. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	3, 920 0		0 0	0	
P. OO 05900 CARDIAC CATHETERIZATION D. OO 06000 LABORATORY	0.000000	ŭ		0 0	0	
D. 00 06000 LABORATORY D. 01 06001 BL00D LABORATORY	0. 000000 0. 000000	20, 266 0		0 0	0	
1. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	U		٩	U	61.00
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	1
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	
4. 00 06400 I NTRAVENOUS THERAPY	0.000000	0		0 0	0	
5. 00 06500 RESPIRATORY THERAPY	0. 000000	10, 164		0 0	0	
5. 00 06600 PHYSI CAL THERAPY	0. 000000	74, 948		0 0	0	
7. 00 06700 OCCUPATIONAL THERAPY	0. 000000	76, 729		0 0	0	
3. 00 06800 SPEECH PATHOLOGY	0. 000000	27, 957		0 0	0	
9. 00 06900 ELECTROCARDI OLOGY	0. 000000	27, 737		0 0	0	
D. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	387		0 0	0	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	
3. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	52, 623		0 0	0	
4. 00 07400 RENAL DIALYSIS	0. 000000	02, 020			0	
5. 00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	
5. 00 03140 CARDI OLOGY	0. 000000	864		0 0	0	
OUTPATIENT SERVICE COST CENTERS	0. 000000			<u> </u>		70.0
B. 00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
9. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	
0. 00 09000 CLI NI C	0. 000000	7, 248		0 0	0	1
D. 01 04950 SLEEP CLINIC	0. 000000	0		o o	0	
1. 00 09100 EMERGENCY	0. 004780	0		0 0	0	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	1
OTHER REIMBURSABLE COST CENTERS		-				1
4. 00 09400 HOME PROGRAM DIALYSIS	0. 000000	0		0 0	0	94.00
5. 00 09500 AMBULANCE SERVICES		_			_	95. 0
5. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	1
7. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	
3. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	
		-		o o		

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0018	From 01/01/2017	
		Component CCN: 15-T018	To 12/31/2017	Date/Time Prepared: 5/23/2018 2:39 pm
		Title XIX	Subprovi der -	PPS

			11 (1	e xix	IRF	113	
	Cost Center Description	PSA Adj. Non	PSA Adj. All				
	·	Physi ci an	Other Medical				
		Anestheti st	Education Cost				
		Cost					
		21. 00	24. 00				
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	0				50.00
51. 00	05100 RECOVERY ROOM	0	0	1			51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1			52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	1			53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0				54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00	05600 RADI OI SOTOPE	0	0				56.00
57. 00	05700 CT SCAN	0	0				57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0					58. 00 59. 00
60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	0				60.00
60. 00	06000 LABORATORY	0	0				60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	1			61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.						63.00
64. 00	06400 I NTRAVENOUS THERAPY						64. 00
65. 00	06500 RESPI RATORY THERAPY						65. 00
66. 00	06600 PHYSI CAL THERAPY						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	Ö	,			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0)			70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)			71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0)			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0)			73. 00
74.00	07400 RENAL DIALYSIS	0	0				74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0				75. 00
76.00	03140 CARDI OLOGY	0	0				76. 00
	OUTPATIENT SERVICE COST CENTERS	,					
88. 00		0	0	1			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0)			89. 00
90. 00	09000 CLI NI C	0	0)			90. 00
90. 01	04950 SLEEP CLINIC	0	0)			90. 01
91. 00	09100 EMERGENCY	0	0	1			91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
	OTHER REIMBURSABLE COST CENTERS	1		1			
	09400 HOME PROGRAM DIALYSIS	0	0	1			94. 00
95. 00	09500 AMBULANCE SERVICES						95.00
96.00		0	0	1			96.00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	1			97. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0				98. 00
200.00	Total (lines 50 through 199)	0	0	1			200. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL		In Lieu	of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der	CCN: 15-0018 Per	i od: V vm 01/01/2017	Worksheet D-1
		То		Date/Time Prepared: 5/23/2018 2:39 pm
	Ti t	le XVIII	Hospi tal	PPS

		Title XVIII	Hospi tal	5/23/2018 2:3 PPS	9 pm
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
4 00	I NPATI ENT DAYS			22.25	
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b	,		39, 857 39, 857	1. 00 2. 00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days.	16, 334	3.00
	do not complete this line.	3.			
4. 00 5. 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		31 of the cost	15, 318 0	4. 00 5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 3	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	13, 010	9. 00
10. 00	newborn days) 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	nly (including private re	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Programme			0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT				10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medical d rate for swing-bed NF services applicable to services reporting period	after December 31 of the	ne cost	0.00	20. 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	50, 182, 610 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
24. 00	x line 18) 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	31 of the cost reporting	period (line 8	0	25. 00
26. 00	X line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		50, 182, 610	
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	82, 466, 658	28. 00
29. 00	Private room charges (excluding swing-bed charges)			53, 532, 040	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			28, 934, 618	
31. 00	General inpatient routine service cost/charge ratio (line 27	- line 28)		0. 608520	31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)			3, 277. 34	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			1, 888. 93	33. 00
34.00	Average per diem private room charge differential (line 32 mir		(i ons)	1, 388. 41	
35. 00	Average per diem private room cost differential (line 34 x line)	ne 31)		844. 88	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			13, 800, 270	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	rerential (line	36, 382, 340	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 259. 07	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			16, 380, 501	39. 00
40.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 16, 380, 501	40.00
41.00	Trotal Trogram general Impatrent routine service cost (ITHE 39	1 11116 40 <i>)</i>	I	10, 300, 301	1 41.00

∐oal ±h	Financial Systems	ELKHART GENER	INTIDODL INC		In Lie	of Form CMS	2552 10
	Financial Systems ATION OF INPATIENT OPERATING COST	ELKHART GENER		CCN: 15-0018	Peri od:	eu of Form CMS-2 Worksheet D-1	2552-10
					From 01/01/2017		
					To 12/31/2017	Date/Time Pre 5/23/2018 2:3	pared: 9 nm
			Ti tl	e XVIII	Hospi tal	PPS	7 piii
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpatient Day	sDiem (col. 1	÷	(col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5.00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units		'	0.0	0	0	42.00
43.00	INTENSIVE CARE UNIT	8, 284, 769	4, 57	4 1, 811. 2	7 1, 927	3, 490, 317	43. 00
43. 01	NEONATAL INTENSIVE CARE	2, 054, 412	•	1			43. 01
44.00	CORONARY CARE UNIT	0)	0. 0	0	0	44. 00
45. 00	BURN INTENSIVE CARE UNIT	0	l .	0.0			45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT	0)	0.0	0	0	46. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
	cost center bescription					1.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	3. line 200)			28, 864, 915	48. 00
49.00	Total Program inpatient costs (sum of lines			ons)		48, 735, 733	1
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sum	of Parts I and	2, 422, 389	50. 00
E1 00	Dass through costs applicable to Drogram in	ationt ancillar	ou convions (f	rom Wkst D s	um of Dorte II	1 401 100	E1 00
51. 00	Pass through costs applicable to Program inpland IV)	atrent anciria	y services (i	TOIII WKSt. D, S	um or Parts II	1, 401, 100	51. 00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				3, 823, 489	52. 00
53. 00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anesth	etist, and	44, 912, 244	1
	medical education costs (line 49 minus line	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION					T	
54. 00	Program di scharges					0	54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (line 56 minus	line 53)	0	57. 00
58. 00	Bonus payment (see instructions)	ing ooot and to	ar got amount (l o	58. 00
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	mpounded by the	0.00	59. 00
	market basket						
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 which operating costs (line 53) are less that					0	61. 00
	amount (line 56), otherwise enter zero (see		ts (Titles 54 X	00), 01 1% 01	the target		
62.00	Relief payment (see instructions)					0	62. 00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)			0	63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST					1	
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of th	e cost reporti	ng period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ner 31 of the	cost renorting	neriad (See	0	65. 00
03.00	instructions)(title XVIII only)	ts arter become	oci oi tiic	cost reporting	perrou (see		05.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVII	l only). For	0	66. 00
	CAH (see instructions)						
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31	of the cost re	porting period	0	67. 00
68. 00	<pre>(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin</pre>	o costs after [Docombor 21 of	the cost rope	rting poriod	0	68. 00
00.00	(line 13 x line 20)	e costs arter t	becember 31 or	the cost repo	i ting period		00.00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs ((line 67 + lin	e 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER N						
70.00	Skilled nursing facility/other nursing facil	•		, ,			70.00
71. 00 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line		ine /U ÷ line	2)			71. 00 72. 00
72.00	Medically necessary private room cost applic		m (line 14 x l	ine 35)			72.00
74. 00	Total Program general inpatient routine serv						74.00
75. 00	Capital -related cost allocated to inpatient	•		,	art II, column		75. 00
	26, line 45)						
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for exces		nrovi der recor	ds)			79.00
	Total Program routine service costs for comp			•	us line 79)		80.00
81. 00	Inpatient routine service cost per diem limi				,		81. 00
82. 00	Inpatient routine service cost limitation (I		* .				82. 00
83.00	Reasonable inpatient routine service costs (ns)				83.00
84.00	Program inpatient ancillary services (see in		one)				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
00.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		ii Jugii 00)				, 00.00
87. 00	Total observation bed days (see instructions					8, 205	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 =				1, 259. 07	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	e instructions))			10, 330, 669	89. 00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Prep 5/23/2018 2:39	
		Title	XVIII	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	6, 638, 686	50, 182, 610	0. 13229	1 10, 330, 669	1, 366, 655	90.00
91.00 Nursing School cost	0	50, 182, 610	0.00000	10, 330, 669	0	91.00
92.00 Allied health cost	0	50, 182, 610	0.00000	10, 330, 669	0	92.00
93.00 All other Medical Education	0	50, 182, 610	0.00000	10, 330, 669	0	93. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0018	Peri od: From 01/01/2017	Worksheet D-1
	Component CCN: 15-S018		
	Title XVIII	Subprovi der -	PPS
		IPF	

		Sub-	IPF		
	Cost Center Description			4.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s, excluding newborn)		2, 641	1. 00
2.00	Inpatient days (including private room days, excluding swing-b			2, 641	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day	s). If you have only private	room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation be	ad days)		2, 641	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room		of the cost	2, 041	5. 00
	reporting period	,			
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 31 of	the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	a days) through Docombor 21 of	the cost	0	7. 00
7.00	reporting period	r days) till odgir becember 31 of	the cost	O	7.00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31 of t	he cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)	5			
9. 00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding swing	j-bed and	427	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private room da	ıvs)	0	10.00
	through December 31 of the cost reporting period (see instruct	i ons)		_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		ys) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		, dove)	0	12. 00
12.00	through December 31 of the cost reporting period	t only (frictualing private room	i days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private room	days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye	ear, enter 0 on this line)			
14. 00	Medically necessary private room days applicable to the Progra	m (excluding swing-bed days)		0	14. 00
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	15. 00 16. 00
10.00	SWING BED ADJUSTMENT			0	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of the	cost	0.00	17. 00
40.00	reporting period				40.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of the co	ost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of the c	ost	0. 00	19. 00
	reporting period	-			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of the cos	st	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions			3, 119, 755	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		eriod (line	0	
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting peri	od (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporting per	iod (line	0	24. 00
	7 x line 19)	or an and accordance and particles	()		
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting perio	d (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		3, 119, 755	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			2, ,	
	General inpatient routine service charges (excluding swing-bed	l and observation bed charges)			28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 -	line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	1111C 20)		0. 00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34.00	Average per diem private room charge differential (line 32 mir	, ,		0.00	
35. 00	Average per diem private room cost differential (line 34 x line 35)	ne 31)		0.00	
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost differer	itial (line	0 3, 119, 755	36. 00 37. 00
37.00	27 minus line 36)	ma private room cost differen	itiai (iiile	5, 117, 755	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38.00	Adjusted general inpatient routine service cost per diem (see			1, 181. 28	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			504, 407 0	39. 00 40. 00
41. 00	Total Program general inpatient routine service cost (line 39	,		504, 407	
		•	'		

	Financial Systems	ELKHART GENERAL				u of Form CMS-2	2552-10
COMPUTA	ATION OF INPATIENT OPERATING COST		Provider CCN: Component CCN	F	eriod: rom 01/01/2017 o 12/31/2017	Worksheet D-1 Date/Time Pre	
			Ti tle X	VIII	Subprovi der -	5/23/2018 2: 3 PPS	9 pm
	Cost Center Description	Total Inpatient Costlr		Average Per em (col. 1 ÷	Program Days	Program Cost (col. 3 x col.	
		1.00	2.00	col. 2) 3.00	4. 00	4) 5. 00	
	NURSERY (title V & XIX only)	0	0	0.00	0	0	42.00
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	ol	0.00	0	0	43. 00
	NEONATAL INTENSIVE CARE	o	ő	0.00	0	_	
44. 00	CORONARY CARE UNIT	o	0	0. 00	0	0	
1	BURN INTENSIVE CARE UNIT	0	0	0.00	0	0	
1	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0	0. 00	0	0	46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3.	line 200)			1. 00 78, 367	48. 00
	Total Program inpatient costs (sum of lines)		582, 774	
	PASS THROUGH COST ADJUSTMENTS			1+ 5	- F D	02.25=	
50. 00	Pass through costs applicable to Program inpa	atient routine so	ervices (from W	KST. D, SUM	OT Parts I and	80, 037	50.00
51. 00	Pass through costs applicable to Program inpa	atient ancillary	services (from	Wkst. D, su	m of Parts II	3, 744	51.00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				83, 781	52. 00
53. 00	Total Program inpatient operating cost exclud	ding capital rela	ated, non-physi	cian anesthe	tist, and	498, 993	1
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					+
	Program di scharges					0	54.00
	Target amount per discharge					0.00	55. 00
	Target amount (line 54 x line 55)				50)	0	
	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and targ	get amount (iin	e 56 minus i	ne 53)	0	57. 00 58. 00
	Lesser of lines 53/54 or 55 from the cost rep	portina period e	ndi na 1996, upd	ated and com	oounded by the	0.00	
	market basket	0 .			,		
	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				ac amount by	0.00	
	which operating costs (line 53) are less than					0	61.00
	amount (line 56), otherwise enter zero (see i		•	,,	, , , , , , , , , , , , , , , , , , ,		
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63.00
	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the c	ost reportin	g period (See	0	64. 00
65. 00	instructions)(title XVIII only)	to often December	- 21 of the coo	+ roporting	nonind (Con		45.00
65.00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	is arter becember	r 31 or the cos	t reporting	berroa (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line 64	4 plus line 65)	(title XVIII	only). For	0	66.00
47.00	CAH (see instructions)	a acata through I	Dogombor 21 of	the cost cos	anting paried		47.00
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through t	December 31 01	the cost rep	orting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after Dec	cember 31 of th	e cost repor	ting period	0	68. 00
	Total title V or XIX swing-bed NF inpatient					0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU						70 00
	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of			(TITIE 3/)			70.00
	Program routine service cost (line 9 x line						72. 00
1	Medically necessary private room cost application			35)			73.00
1	Total Program general inpatient routine servi			kehoot B. Do	ct II column		74.00
73.00	Capital-related cost allocated to inpatient (26, line 45)	outine service (10M IIIOTT) ereoc	Kancet D, Pa	CTT, COTUINT		75. 00
1	Per diem capital-related costs (line 75 ÷ li						76. 00
	Program capital -related costs (line 9 x line						77.00
1	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider records)				78. 00 79. 00
1	Total Program routine service costs for compa	,	· .	line 78 minu	s line 79)		80.00
1	Inpatient routine service cost per diem limi						81.00
1	Inpatient routine service cost limitation (li	•	1				82. 00 83. 00
1	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		,				84.00
1	Utilization review - physician compensation		s)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thro					86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	 87. 00
87 AA I							1 01.00
	Adjusted general inpatient routine cost per of		ine 2)			_	88.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2017 To 12/31/2017	Date/Time Pre 5/23/2018 2:3	
		Title	XVIII	Subprovider -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	495, 033	3, 119, 755	0. 15867	7 0	0	90. 00
91.00 Nursing School cost	0	3, 119, 755	0. 00000	0 0	0	91. 00
92.00 Allied health cost	0	3, 119, 755	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 119, 755	0. 00000	0 0	0	93. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0018	Peri od: From 01/01/2017	Worksheet D-1
	Component CCN: 15-T018	To 12/31/2017	Date/Time Prepared: 5/23/2018 2:39 pm
	Title XVIII	Subprovi der -	PPS

		litle XVIII	I RF	PPS	
	Cost Center Description		1100		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			1, 428	ł
2.00	Inpatient days (including private room days, excluding swing-		ivata maam daya	1, 428	ł
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). It you have only pr	ivate room days,	40	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		1, 388	4. 00
5.00	Total swing-bed SNF type inpatient days (including private ro	om days) through Decembe	r 31 of the cost	0	5. 00
4 00	reporting period	om dava) ofter December	21 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private rourseporting period (if calendar year, enter 0 on this line)	om days) arter becember	31 OF the Cost	١	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	m days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	495	9. 00
	newborn days)		5		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII on		nom days) after	o	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		dom days) arter	ı "I	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XII		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	V (:			12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar year)			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)	, 3	<i>y</i> ,	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 o	f the cost	0.00	17. 00
17.00	reporting period	es thi ough beceiliber 31 o	i the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
40.00	reporting period			0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	0.00	20. 00
	reporting period	_			
21. 00	Total general inpatient routine service cost (see instruction:		ing paried (line	2, 543, 881	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost report	ing period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
	x line 18)			_	
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December :	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	3			
	Total swing-bed cost (see instructions)	(1: 21: 1: 2/)		0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		2, 543, 881	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	2, 302, 634	28. 00
29. 00			<i>3</i> ,	73, 435	
30. 00	Semi-private room charges (excluding swing-bed charges)			2, 229, 199	1
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		1. 104770	•
32. 00	Average private room per diem charge (line 29 ÷ line 3)			1, 835. 88	1
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	1! 22) (!+	±:>	1, 606. 05	•
34. 00	Average per diem private room charge differential (line 32 min	, ,	tions)	229. 83	1
35. 00	Average per diem private room cost differential (line 34 x line 35)	le 31)		253. 91 10, 156	35.00
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	and private room cost di	fforential (line	2, 533, 725	1
37.00	27 minus line 36)	and private room cost di	rrerentrar (rrne	2, 555, 725	37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 781. 43	1
39.00	Program general inpatient routine service cost (line 9 x line			881, 808	•
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	,		0 881, 808	1
11.00	1.02a ogram general impationt routine out vice cost (illie of			301,000	1 11.00

Component Cont. 15-003 Period Cont. 15-0	Heal th	Financial Systems	ELKHART GENERA	L HOSPITAL		In Lie	u of Form CMS-2	2552-10
Cost Center Description				Provi der Co	F	eriod: rom 01/01/2017	Worksheet D-1	
Total Norman Program Boys Program Cost				· ·			5/23/2018 2:3	
Impetient Cost Impetient Cost 1				Title		I RF	PPS	
1.00 QUISSERY (title V & XIX only) 0 0 0 0 0 0 0 0 0		Cost Center Description			Diem (col. 1 ÷		(col. 3 x col.	
Interestive Care Uppe Impartient Respirate Units 0 0 0 0 0 0 0 0 0	42.00	NUDCEDY (+: +Lo V & VIV only)			3.00		5. 00	12.00
	42.00		U	0	0.00	0	0	42.00
1.00 Coronavary Case UNIT		INTENSIVE CARE UNIT		0			0	
1.00 1.00 1.00 0 0 0 0 0 0 0 0 0			l l				-	
SUBSCIACL INTERSIVE CARE INIT 0 0 0 0 0 0 0 0 0			-	-			_	
48.00 Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200) 48.00 Program inpatient costs (sum of lines 41 through 48)(see instructions) 59.00 Total Program inpatient costs (sum of lines 41 through 48)(see instructions) 59.00 Poss through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts I and 19, 997) 59.00 Total Program inpatient costs (sum of lines 50 and 51) 59.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 174,400 Sci.			-				-	
1.00	47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
198.00 Program inpattient ancillarry service cost (Wist D-3. col. 3. Tine 200) 1992, 2662 48, 1744, 270 1978 Program inpattent costs (sum of Tines 41 through 480) 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978 1978		Cost Center Description					1 00	
1,171,372 49.	48. 00	Program inpatient ancillary service cost (Wks	st. D-3. col. 3.	Line 200)				48. 00
50.00 Pass through costs applicable to Program inpatient routine services (From Wisst. D. sum of Parts I and I147,797 So. III) 51.00 Pass through costs applicable to Program inpatient ancillary services (From Wisst. D. sum of Parts II and IV) 52.00 Total Program excludable cost (sum of lines 50 and 51) 52.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 909,061 53. 53.00 Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 909,061 53. 54.00 Program discharges 0.00 55. 55.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.56. 56.00 Target amount (line 54 x line 55) 0.56. 57.00 Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53) 0.56. 58.00 Bonus payment (see instructions) 0.58. 59.00 Lesser of Lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket 0.00 59. 60.00 Target mount (line 53/54 is less than the lower of Lines 55. 59 or do enter the Lesser of 20% of the amount by 0.00 59. 60.00 Target mount (line 56) otherwise enter zero (see instructions) 0.06. 61.00 If Line 53/54 is less than the lower of Lines 55. 59 or do enter the Lesser of 20% of the amount by 0.00 69. 62.00 Relief payment (see instructions) 0.06. 63.00 Allowable Inpatient cost plus Incentive payment (see Instructions) 0.06. 64.00 Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See Instructions) (title XVIII only) 1.60 66. 65.00 Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For 0.66. 66.00 Title Vor XIX swing-bed SNF inpatient routine costs (line 67 + line 68) 0.06 69. 67.00 Total Medicare swing-bed SNF inpatient routine costs (line 67 + line 68) 0.06 69. 68.00 Title Vor XIX swing-bed NF inpatient routine costs (line 67 + line 68) 0.06 69. 69.00 Total Line 200 1.00 From payment 1 (see instructions) 1.00 1.00 1.00 1.00					ns)			
1110 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111 1111								l
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Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2017 To 12/31/2017	Date/Time Prep 5/23/2018 2:3	
		Title	XVIII	Subprovi der – I RF	PPS	
Cost Center Description	Cost 1.00	Routine Cost (from line 21)	col umn 1 ÷ col umn 2	Total Observation Bed Cost (from Iine 89)	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (2.00	3.00	4. 00	5.00	
90.00 Capi tal -related cost	432, 143	2, 543, 881	0. 16987	5 0	0	90. 00
91.00 Nursing School cost	0	2, 543, 881	0.00000	0 0	0	91. 00
92.00 Allied health cost	0	2, 543, 881			0	92.00
93.00 All other Medical Education	0	2, 543, 881	0.00000	0 0	0	93. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0018	Period: From 01/01/2017 To 12/31/2017	Worksheet D-1 Date/Time Prepared: 5/23/2018 2:39 pm
	Title XIX	Hospi tal	PPS

DBUT 1 ALL PROPURE COMPONENTS 1.00 Inpartient days (including private room days and seting-bed days, excluding newborn) 39, 857 2.00 Inpartient days (including private room days, excluding swing-bed and newborn days) 0.30 Inpartient days (including private room days, excluding swing-bed and newborn days) 0.30 Inpartient days (including private room days, excluding swing-bed and observation bed days) 1.00 Inpartient days (including swing-bed and observation bed days) 1.00 Inpartient days (including swing-bed and observation bed days) 1.00 Interest of the swing days (including private room days) after December 31 of the cost 0.00 Interest of the swing days (including private room days) after December 31 of the cost 0.00 Interest of the swing days (including private room days) 1.00 Interest of the swing days (including private room days) 1.00 Interest of the swing days (including private room days) 1.00 Interest of the swing days (including private room days) 1.00 Interest of the swing days (including private room days) 1.00 Interest of the swing days (including private room days) 1.00 Interest of the swing days (including private room days) 1.00 Interest of the swing period (including private room days) 1.00 Interest of the swing period (including private room days) 1.00 Interest of the swing period (including private room days) 1.00 Interest of the swing period (including private room days) 1.00 Interest of the swing period (including private room days) 1.00 Interest of the swing period (including private room days) 1.00 Interest of the swing period (including private room days) 1.00 Interest of the swing period (including private room days) 1.00 Interest of the swing period (including private room days) 1.00 Interest of the swing period (including private room days) 1.00 Interest of the swing period (including private room days) 1.00 Interest of the swing period (including private room days) 1.00 Int			Title XIX	Hospi tal	5/23/2018 2:3 PPS	9 pm
INPATIENT DAYS INPA		Cost Center Description			1 00	
Impattent days (including private room days and swing-bed days, excluding newborn) 39,857 2.00		PART I - ALL PROVIDER COMPONENTS			1.00	
Inpatt ent days (including private room days, excluding sating-bed and newborn days) 30,857 2,00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days, do a solution of the cost complete this line. Semi-private room days (excluding swing-bed and observation bed days). Semi-private room days) at completed in the cost completed in the cost of the cost completed in the cost of th			,			
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30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 50, 182, 610 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 10.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00 30.00	28. 00		d and observation bed cha	arges)	0	28. 00
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34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 50, 182, 610) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
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36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 50, 182, 610 37.00 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				11 0115)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 20, 182, 610 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 50, 182, 610 5		, , , , , , , , , , , , , , , , , , , ,	le 31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 259.07 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		1	and private room cost di	Eforontial (lima		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 259.07 38.00 Program general inpatient routine service cost (line 9 x line 38) 1, 097, 909 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37.00		and private room cost di	rerentral (iine	50, 182, 610	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 38.00 1, 259.07 38.00 1, 097, 909 39.00 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,259.07 38.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,259.07 38.00 1,097,909 39.00 40.00			JSTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38. 00				1, 259. 07	38. 00
	39. 00	, , ,	-		1, 097, 909	
41.00 Iotal Program general inpatient routine service cost (line 39 + line 40) 1,097,909 41.00		, , , , , , , , , , , , , , , , , , , ,	,			
	41.00	liotai Program general inpatient routine service cost (line 39	+ IIne 40)	l	1, 097, 909	41.00

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST Cost Center Description	ELKHART GENERAL	Provider CCN	N: 15-0018	Peri od:	eu of Form CMS-2 Worksheet D-1	
Cost Center Description				E 04 (04 (004 E		
Cost Center Description				From 01/01/2017 To 12/31/2017	Date/Time Pre	
Cost Center Description		Title	XIX	Hospi tal	5/23/2018 2: 39 PPS	9 pm
	Total	Total	Average Per	Program Days	Program Cost	
	Inpatient Cost Ir	patient DaysD	iem (col. 1 col. 2)	÷	(col. 3 x col. 4)	
	1.00	2.00	3. 00	4. 00	5. 00	
42.00 NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Unit	4, 353, 501	2, 461	1, 769. (00 271	479, 399	42. 00
43. 00 INTENSIVE CARE UNIT	8, 284, 769	4, 574	1, 811. 2	27 0	0	43. 00
43. 01 NEONATAL INTENSIVE CARE	2, 054, 412	780	2, 633. 8			
44.00 CORONARY CARE UNIT 45.00 BURN INTENSIVE CARE UNIT	0	0	0. (0. (· ·	
46.00 SURGICAL INTENSIVE CARE UNIT	Ö	O	0. 0		o	46. 00
47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
·					1.00	
48.00 Program inpatient ancillary service cost (W			-)		8, 774, 201	
49.00 Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	5 41 through 48)(Se	e instruction	S)		10, 351, 509	49. 00
50.00 Pass through costs applicable to Program in	npatient routine se	ervices (from	Wkst. D, sun	of Parts I and	218, 326	50. 00
51.00 Pass through costs applicable to Program in	npatient ancillarv	services (fro	m Wkst. D. s	sum of Parts II	560, 283	51.00
and IV)						
52.00 Total Program excludable cost (sum of lines 53.00 Total Program inpatient operating cost excl		ated non-nhve	ician anesth	netist and	778, 609 9, 572, 900	
medical education costs (line 49 minus line		rtea, non phys	rerair anestr		7, 372, 700] 55.00
TARGET AMOUNT AND LIMIT COMPUTATION 54.00 Program discharges					0	 54. 00
55. 00 Target amount per discharge					0.00	
56.00 Target amount (line 54 x line 55)				50)	0	
57.00 Difference between adjusted inpatient opera 58.00 Bonus payment (see instructions)	iting cost and tare	get amount (li	ne 56 minus	line 53)	0	
59.00 Lesser of lines 53/54 or 55 from the cost r	eporting period er	nding 1996, up	dated and co	ompounded by the		
market basket 60.00 Lesser of lines 53/54 or 55 from prior year	cost report und	ated by the ma	rkat haskat		0.00	60.00
61.00 If line 53/54 is less than the lower of lin				the amount by	0.00	1
which operating costs (line 53) are less th		(lines 54 x 6	0), or 1% of	the target		
amount (line 56), otherwise enter zero (see 62.00 Relief payment (see instructions)	e instructions)				0	62.00
63.00 Allowable Inpatient cost plus incentive pay	ment (see instruct	i ons)			0	63. 00
PROGRAM INPATIENT ROUTINE SWING BED COST 64.00 Medicare swing-bed SNF inpatient routine co	osts through Decemb	per 31 of the	cost reporti	ng period (See	0	64. 00
instructions)(title XVIII only)	· ·		•			
65.00 Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	osts after December	31 of the co	st reportino	period (See	0	65. 00
66.00 Total Medicare swing-bed SNF inpatient rout	ine costs (line 64	l plus line 65)(title XVII	I only). For	0	66. 00
CAH (see instructions) 67.00 Title V or XIX swing-bed NF inpatient routi	ne costs through [ecember 31 of	the cost re	norting period	0	67. 00
(line 12 x line 19)	-					
68.00 Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after Dec	cember 31 of t	he cost repo	orting period	0	68. 00
69.00 Total title V or XIX swing-bed NF inpatient					0	69. 00
PART III - SKILLED NURSING FACILITY, OTHER 70.00 Skilled nursing facility/other nursing faci						 70. 00
71.00 Adjusted general inpatient routine service	-					71.00
72.00 Program routine service cost (line 9 x line	,	lino 14 v lin	o 3E)			72.00
73.00 Medically necessary private room cost appli 74.00 Total Program general inpatient routine ser			e 35)			73.00
75.00 Capital-related cost allocated to inpatient			rksheet B, F	art II, column		75. 00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ l	ine 2)					76. 00
77.00 Program capital-related costs (line 9 x lin	ne 76)					77. 00
78.00 Inpatient routine service cost (line 74 mir 79.00 Aggregate charges to beneficiaries for exce		wider records)			78. 00 79. 00
80.00 Total Program routine service costs for com			* .	nus line 79)		80.00
81.00 Inpatient routine service cost per diem lim						81.00
82.00 Inpatient routine service cost limitation (83.00 Reasonable inpatient routine service costs						82. 00 83. 00
84.00 Program inpatient ancillary services (see i	nstructions)					84. 00
85.00 Utilization review - physician compensation 86.00 Total Program inpatient operating costs (su						85. 00 86. 00
PART IV - COMPUTATION OF OBSERVATION BED PA		,agri 00 <i>)</i>				30.00
87.00 Total observation bed days (see instruction 88.00 Adjusted general inpatient routine cost per	*				8, 205 1, 259. 07	
88.00 Adjusted general inpatient routine cost per	see instructions)	1110 2)				89.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2017	Worksheet D-1	
				To 12/31/2017	Date/Time Pre 5/23/2018 2:3	pared: 9 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	6, 638, 686	50, 182, 610	0. 13229	1 10, 330, 669	1, 366, 655	90.00
91.00 Nursing School cost	0	50, 182, 610	0. 00000	0 10, 330, 669	0	91.00
92.00 Allied health cost	0	50, 182, 610	0. 00000	0 10, 330, 669	0	92.00
93.00 All other Medical Education	0	50, 182, 610	0. 00000	0 10, 330, 669	0	93.00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0018		Worksheet D-1
	Component CCN: 15-S018	From 01/01/2017 To 12/31/2017	Date/Time Prepared: 5/23/2018 2:39 pm
	Title XIX	Subprovi der -	PPS

		litle XIX	I PF	PPS		
	Cost Center Description		111			
	PART I - ALL PROVIDER COMPONENTS			1. 00		
	INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days			2, 641	1. 00	
2.00	Inpatient days (including private room days, excluding swing-			2, 641	2. 00	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	vate room days,	0	3. 00	
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 641	4. 00	
5.00	Total swing-bed SNF type inpatient days (including private roof		r 31 of the cost	0	5. 00	
	reporting period	om dava) after Dagambar	21 of the cost	0	4 00	
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	on days) after becember :	31 OF the Cost	U	6. 00	
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00	
0.00	reporting period		1 6 11		0.00	
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	m 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	82	9. 00	
40.00	newborn days)				40.00	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc-		oom days)	0	10. 00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00	
	December 31 of the cost reporting period (if calendar year, en					
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	X only (including private	e room days)	0	12. 00	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	X only (including private	e room days)	0	13. 00	
	after December 31 of the cost reporting period (if calendar ye					
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14.00	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			2, 461 271	15. 00 16. 00	
10.00	SWING BED ADJUSTMENT			271	10.00	
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00	
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00	
10.00	reporting period	os arter becomber or or	the cost	0.00	10.00	
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	s after December 31 of t	ne cost	0. 00	20. 00	
21 00	reporting period	- \		2 110 755	21 00	
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		na period (line	3, 119, 755 0	21. 00 22. 00	
22.00	5 x line 17)	or or the dost report	ing period (inic	o o	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	r 31 of the cost reporti	na period (line	0	24. 00	
200	7 x line 19)		.g po ou (21.00	
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00	
26. 00	Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 119, 755	27. 00	
20 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had sh	argos)	0	28. 00	
29. 00		a and observation bed ch	ai ges)	0	29. 00	
30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00	
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000		
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	nus lina 22) (saa instrus	tions)	0.00	33.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mil Average per diem private room cost differential (line 34 x li		LI OHS)	0. 00 0. 00		
36. 00	Private room cost differential adjustment (line 3 x line 35)	0 01)		0.00	36. 00	
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	3, 119, 755	37. 00	
	27 minus line 36)					
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS					
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 181. 28	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line	· · · · · · · · · · · · · · · · · · ·		96, 865		
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)		96, 865	41.00	

Heal th	Financial Systems	ELKHART GENERA	L HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	TATION OF INPATIENT OPERATING COST				eriod: rom 01/01/2017	Worksheet D-1	
			Component	CCN: 15-S018 T	o 12/31/2017	Date/Time Pre 5/23/2018 2:3	
			Ti tl	e XIX	Subprovi der - I PF	PPS	
	Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1.00	2.00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0.00	0	0	42.00
43. 00	INTENSIVE CARE UNIT	0	C	0.00	0	0	43. 00
43. 01	NEONATAL INTENSIVE CARE	o	C	l .		0	
44. 00	CORONARY CARE UNIT	0	C			· ·	
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	(0 1	45. 00 46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)	٩		0.00		· ·	47. 00
	Cost Center Description			•	-		
48. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	line 200)			1. 00 165, 368	48. 00
49. 00	Total Program inpatient costs (sum of lines			ons)		262, 233	1
	PASS THROUGH COST ADJUSTMENTS	<u> </u>		,		·	
50. 00	Pass through costs applicable to Program inpa	atient routine s	services (from	n Wkst. D, sum	of Parts I and	15, 370	50.00
51. 00		atient ancillary	, services (fr	om Wkst D su	m of Parts II	7, 956	51.00
01.00	and IV)	atront unorriary	301 11 003 (11	om with b, su	01 141 15 11	,,,,,,	01.00
52. 00	Total Program excludable cost (sum of lines!					23, 326	1
53. 00	Total Program inpatient operating cost exclud		ated, non-phy	sician anesthe	tist, and	238, 907	53.00
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	02)					1
54.00	Program di scharges					0	54.00
55. 00	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and tar	ract amount (ino 56 minus I	ino 52)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and tai	get amount (i	THE 50 IIITHUS I	THE 53)	0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period e	endi ng 1996, ເ	pdated and com	pounded by the	0.00	59. 00
	market basket						/
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				he amount by	0.00	1
01.00	which operating costs (line 53) are less than					Ĭ	01.00
	amount (line 56), otherwise enter zero (see i	nstructions)					
62. 00 63. 00	Relief payment (see instructions)	ant (coo instru	oti onc)			0 0	
03.00	Allowable Inpatient cost plus incentive paymor PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstruc	tions)			0	1 63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reportin	g period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decembe	or 21 of the a	ost roporting	noriad (Saa	0	65. 00
03.00	instructions) (title XVIII only)	ts arter becembe	i 31 of the C	ost reporting	perrou (see		05.00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line 6	4 plus line 6	5)(title XVIII	only). For	0	66.00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	o costs through	Docombor 21 o	of the cost ron	orting poriod	0	67.00
07.00	(line 12 x line 19)	e costs through	December 51 (i the cost rep	or tring period	٥	07.00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repor	ting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient i	coutino costs (1	ino 67 i lino	. 60)		0	69.00
07.00	PART III - SKILLED NURSING FACILITY, OTHER NU						07.00
70. 00	Skilled nursing facility/other nursing facili	ty/ICF/IID rout	ine service d	cost (line 37)			70. 00
71.00	Adjusted general inpatient routine service of		ne 70 ÷ line	2)			71.00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	•	(line 14 v li	ne 35)			72.00
74. 00	Total Program general inpatient routine servi						74. 00
75. 00	Capital -related cost allocated to inpatient				rt II, column		75.00
76. 00	26, line 45)	20. 2)					76. 00
77.00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						77.00
78. 00	· · · · · · · · · · · · · · · · · · ·						78. 00
79.00							79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limit		st limitation	ı (IIne 78 minu	s line /9)		80. 00 81. 00
81.00	Inpatient routine service cost per drein film						82.00
83. 00	Reasonable inpatient routine service costs (s						83.00
84. 00	Program inpatient ancillary services (see in		`				84.00
85. 00 86. 00	Utilization review - physician compensation						85. 00 86. 00
66.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 65)				30.00
87. 00	Total observation bed days (see instructions))				0	
88. 00	Adjusted general inpatient routine cost per (•	line 2)			0.00	
87. UU	Observation bed cost (line 87 x line 88) (see	= INSTRUCTIONS)				ı	89.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2017 To 12/31/2017	Date/Time Pre 5/23/2018 2:3	
		Ti tl	e XIX	Subprovi der -	PPS	
				I PF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital-related cost	495, 033	3, 119, 755	0. 15867	7 0	0	90. 00
91.00 Nursing School cost	0	3, 119, 755	0. 00000	0	0	91. 00
92.00 Allied health cost	0	3, 119, 755	0. 00000	0	0	92.00
93.00 All other Medical Education	0	3, 119, 755	0.00000	0 0	0	93. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0018	Peri od: From 01/01/2017	Worksheet D-1
	Component CCN: 15-T018	To 12/31/2017	Date/Time Prepared: 5/23/2018 2:39 pm
	Title XIX	Subprovi der -	PPS

Description 1.000			Title XIX	IRF	FF3	
BRATT ALL PROVIDER COMPONENTS BRATTINE IMPS BRATTINE I		Cost Center Description				
MPATERT DAYS		DADT I ALL DDOVIDED COMPONENTS			1. 00	
1,000 Impationt days (including private room days and swing-bed days, excluding newborn) 1,428 2,00 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000 1,000						
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	3.00	, , , , ,	(s). If you have only pri	vate room days,	0	3.00
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Total swing-bed NF type inpatient days (including private room days) after Pecember 31 of the cost reporting period (if C aclendar year, enter 0 on this line) 10.00	7.00		n days) through December	31 of the cost	0	7. 00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) and through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after through December 31 of the cost reporting period (see instructions) 13.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) after 20.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) after 20.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) after 30.00 Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) after 30.00 Swing-bed SNF services applicable to the Program (excluding swing-bed days) 13.00 Swing-Bed Bab						
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41.00 Total Program general inpatient routine service cost (line 39 + line 40) 103,323 41.00					0	40. 00
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		103, 323	41. 00

Heal th	Financial Systems	ELKHART GENERA	L HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST				eriod: rom 01/01/2017	Worksheet D-1	
			Component		o 12/31/2017	Date/Time Pre 5/23/2018 2:3	
			Ti tl	e XIX	Subprovi der - I RF	PPS	- P···
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost	npatient Days	Diem (col. 1 ÷ col. 2)		(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4. 00	5.00	42.00
42.00	Intensive Care Type Inpatient Hospital Units	١		0.00	0	0	42.00
43.00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE	0	0			1	
43. 01 44. 00	CORONARY CARE UNIT	0	0				43. 01 44. 00
45. 00	BURN INTENSIVE CARE UNIT	0	0			0	
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0	0.00	0	0	46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	line 200)			1. 00 108, 484	48. 00
49. 00	Total Program inpatient costs (sum of lines			ns)		211, 807	49. 00
FO 00	PASS THROUGH COST ADJUSTMENTS		(£	. Wheat Down	-£ D 1	17.552	 FO 00
50. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from	I WKSt. D, SUM	or Parts I and	17, 552	50.00
51. 00	Pass through costs applicable to Program inpa	atient ancillary	services (fr	om Wkst. D, su	m of Parts II	9, 704	51.00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				27, 256	52. 00
53. 00	Total Program inpatient operating cost exclude		ated, non-phy	sician anesthe	tist, and	184, 551	1
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program discharges					0	54.00
55. 00	Target amount per discharge					0.00	
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and tar	get amount (1	ine 56 minus l	ine 53)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ng cost and tar	get amount (i	The committee i	1116 00)	ő	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost representations	porting period e	ndi ng 1996, ເ	pdated and com	pounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year (cost report, upd	ated by the m	arket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines	s 55, 59 or 60 e	nter the less	er of 50% of t		0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see it		(Tines 54 x	60), or 1% or	the target		
62. 00	Relief payment (see instructions)					0	
63. 00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63.00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decem	ber 31 of the	cost reportin	g period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Necembe	r 31 of the c	ost reporting	neriod (See	0	65. 00
03.00	instructions) (title XVIII only)	ts arter becembe	1 31 Of the c	ost reporting	perrou (See		05.00
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line 6	4 plus line 6	5)(title XVIII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 c	of the cost rep	orting period	0	67. 00
	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs arter be	cember 31 or	the cost repor	ting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70. 00
71. 00	Adjusted general inpatient routine service co	ost per diem (li					71. 00
72. 00 73. 00	Program routine service cost (line 9 x line 1) Medically necessary private room cost applications.	•	(line 1/ v li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine servi						74.00
75. 00	Capital -related cost allocated to inpatient	routine service	costs (from W	lorksheet B, Pa	rt II, column		75. 00
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital-related costs (line 9 x line						77. 00
78. 00 79. 00	· · · · · · · · · · · · · · · · · · ·						78. 00 79. 00
80. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81.00	Inpatient routine service cost per diem limit						81.00
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	structions)					84. 00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00
00.00	PART IV - COMPUTATION OF OBSERVATION BED PASS		ough oo,				1 55. 50
87. 00	Total observation bed days (see instructions)		lino 2)			0 00	
88. 00 89. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see		11110 2)			0.00	88. 00 89. 00
	(30)					'	

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (From 01/01/2017 To 12/31/2017	Date/Time Prep 5/23/2018 2:3	
		Titl	e XIX	Subprovi der – I RF	PPS	
Cost Center Description	Cost	Routine Cost (from line 21)	col umn 1 ÷ col umn 2	Total Observation Bed Cost (from	Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) 5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (2.00	0.00	11.00	0.00	
90.00 Capital -related cost	432, 143	2, 543, 881	0. 16987	5 0	0	90.00
91.00 Nursing School cost	0	2, 543, 881	0.00000	0	0	91.00
92.00 Allied health cost	0	2, 543, 881			0	92.00
93.00 All other Medical Education	0	2, 543, 881	0.00000	0 0	0	93. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der 0	CCN: 15-0018	Peri od:	Worksheet D-3	
			From 01/01/2017	Data /Tima Daa	narad.
			To 12/31/2017	Date/Time Pre 5/23/2018 2:3	
	Ti tl	e XVIII	Hospi tal	PPS	<i>7</i> piii
Cost Center Description		Ratio of Cos		Inpati ent	
555t 5511td. 5555t. pt. 511		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
			3	2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS			32, 462, 442		30.00
31.00 03100 INTENSIVE CARE UNIT			7, 190, 738		31.00
31.01 03101 NEONATAL INTENSIVE CARE			0		31. 01
32. 00 03200 CORONARY CARE UNIT			0		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT			0		34. 00
40. 00 04000 SUBPROVI DER - I PF			0		40. 00
41. 00 04100 SUBPROVI DER - I RF			0		41. 00
43. 00 04300 NURSERY					43. 00
ANCILLARY SERVICE COST CENTERS		T	.1		
50. 00 05000 OPERATI NG ROOM		0. 23885		4, 803, 360	50.00
51. 00 05100 RECOVERY ROOM		0.00000		0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0.00000		0	52.00
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C		0. 22451		1, 051, 552	54. 00 55. 00
		0.00000		0	
56. 00 05600 RADI 01 SOTOPE 57. 00 05700 CT SCAN		0.00000			56. 00 57. 00
58.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 03768 0. 14996		215, 753 124, 518	58.00
59. 00 05900 CARDIAC CATHETERIZATION		0. 10220	·		59.00
60. 00 06000 LABORATORY		0. 10220		1	60.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY		0. 22173		2, 722, 771	60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 20113			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY		1. 53306			64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 20183			65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 57171		553, 196	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 34669		291, 716	67.00
68. 00 06800 SPEECH PATHOLOGY		0. 47297		69, 809	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 18645	3 30, 223, 623	5, 635, 285	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 21994	8 14, 959, 309	3, 290, 270	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 27737	3 18, 653, 183	5, 173, 889	73. 00
74. 00 07400 RENAL DI ALYSI S		0.00000	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)		0.00000		0	75. 00
76. 00 03140 CARDI OLOGY		0. 18478	2, 252, 426	416, 208	76. 00
OUTPATIENT SERVICE COST CENTERS		T	_1	_	
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 09000 CLI NI C		0. 36487			
90. 01 04950 SLEEP CLINIC		0. 19073		0	90. 01
91. 00 09100 EMERGENCY		0. 45318		1	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 60754	9 0	0	92.00
OTHER REIMBURSABLE COST CENTERS		0.00000			04.00
94.00 O9400 HOME PROGRAM DIALYSIS 95.00 O9500 AMBULANCE SERVICES		0.00000		0	94. 00 95. 00
		0.00000	0		•
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0.00000		0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 98. 00 09850 OTHER REI MBURSABLE COST CENTERS		0.00000			97. 00 98. 00
200.00 Total (sum of lines 50 through 94 and 9	06 through 98)	0.00000	129, 724, 645		•
201.00 Less PBP Clinic Laboratory Services-Pro	9 ,		127, 724, 043	20,004,710	200.00
202.00 Net charges (line 200 minus line 201)	gram only charges (Title 01)		129, 724, 645		202.00
		1	.2,,,21,040	I	,_02. 00

Heal th	Financial Systems	ELKHART GENERAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 15-0018	Peri od: From 01/01/2017 To 12/31/2017	Worksheet D-3	pared:
		Ti	tle XVIII	Subprovi der - I PF	PPS	
	Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
30. 00 31. 00 31. 01 32. 00 33. 00 34. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT			000000000000000000000000000000000000000		30. 00 31. 00 31. 01 32. 00 33. 00 34. 00
41. 00 43. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04300 NURSERY			815, 689 0		40. 00 41. 00 43. 00
50. 00 51. 00 52. 00 53. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY		0. 2388 0. 0000 0. 0000 0. 0000	00 0	0	51. 00 52. 00 53. 00
55. 00 56. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN		0. 2245 0. 00000 0. 00000 0. 03768	00 0	0	55. 00 56. 00
59. 00 60. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY		0. 14996 0. 10226 0. 22173 0. 00006	3, 714 07 0 37 86, 627	557 0 19, 208	59. 00 60. 00
61. 00 62. 00 63. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY		0. 00000 0. 20113 0. 00000 1. 53300	00 0 34 0 00 0	0 0	61. 00 62. 00 63. 00

0.201839

0.571716

0.346692

0.472973

0.000000

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0. 186453

0.219948

0. 277373

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0. 184782

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0.000000

0.364878

0.190734

0.453180

0.607549

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48, 185

1, 492

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66, 652

10, 105

11, 772

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309, 740

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9,726

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0 96.00

200.00

201. 00

202.00

06500 RESPIRATORY THERAPY

06700 OCCUPATIONAL THERAPY

07000 ELECTROENCEPHALOGRAPHY

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

09600 DURABLE MEDICAL EQUIP-RENTED

09700 DURABLE MEDICAL EQUIP-SOLD

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

09400 HOME PROGRAM DIALYSIS

09500 AMBULANCE SERVICES

07500 ASC (NON-DISTINCT PART)

08800 RURAL HEALTH CLINIC

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

07200 I MPL. DEV. CHARGED TO PATIENTS

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

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

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

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

06900 ELECTROCARDI OLOGY

07400 RENAL DIALYSIS

03140 CARDI OLOGY

04950 SLEEP CLINIC

09100 EMERGENCY

09000 CLI NI C

65.00

66.00

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70.00

71.00

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94.00

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96.00

97.00

200.00

201.00

202.00

Health Financial Systems	ELKHART GENERAL	UOSDI TAI		In Lie	eu of Form CMS-2	2552 10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	ELKHARI GENERAL		CCN: 15-0018	Peri od:	Worksheet D-3	
INFAITENT ANCIELANT SERVICE COST AFFORTIONWENT		Frovider C	CN. 15-0016	From 01/01/2017	WOLKSHEET D-3	
		Component	CCN: 15-T018	To 12/31/2017	Date/Time Pre 5/23/2018 2:3	
		Title	e XVIII	Subprovi der – I RF	PPS	•
Cost Center Description			Ratio of Cos		Inpati ent	
· ·			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			_			
30. 00 03000 ADULTS & PEDI ATRI CS				0		30. 00
31. 00 03100 I NTENSI VE CARE UNI T				0		31. 00
31. 01 03101 NEONATAL INTENSIVE CARE				0		31. 01
32. 00 03200 CORONARY CARE UNI T				0		32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT				0		33.00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT				0		34.00
40. 00 04000 SUBPROVI DER - I PF				0		40.00
41. 00 04100 SUBPROVI DER - RF				795, 686		41.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS						43.00
50. 00 05000 OPERATING ROOM			0. 2388!	5, 557	1, 327	50.00
51. 00 05100 RECOVERY ROOM			0.00000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0.00000	00 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY			0.00000	00	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 2245	13 7, 642	1, 716	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C			0.00000	00	0	55. 00
56. 00 05600 RADI OI SOTOPE			0.00000	00	0	56. 00
57. 00 05700 CT SCAN			0. 03768	39 23, 908	901	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)			0. 14996	56 1, 857	278	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON			0. 10220	2, 966	303	59. 00
60. 00 06000 LABORATORY			0. 22173		16, 128	60.00
60. 01 06001 BLOOD LABORATORY			0.00000		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.00000		0	61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0. 20113		1, 307	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.			0.00000		_	63. 00
64. 00 06400 I NTRAVENOUS THERAPY			1. 53300		0	64. 00
65. 00 06500 RESPI RATORY THERAPY			0. 20183		14, 698	1
66. 00 06600 PHYSI CAL THERAPY			0. 5717			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY			0. 34669			67. 00
68. 00 06800 SPEECH PATHOLOGY			0. 4729		23, 583	68. 00
69. 00 06900 ELECTROCARDI OLOGY			0.00000		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY			0.00000		0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS			0. 1864		1, 297	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 21994		227	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS			0. 2773		35, 988	•
74. 00 07400 RENAL DI ALYSI S			0.00000		0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)			0.00000		0	75. 00
76. 00 03140 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS			0. 18478	3, 632	671	76. 00
OUTPATIENT SERVICE COST CENTERS			0.0000	20	0	00 00

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08800 RURAL HEALTH CLINIC

09000 CLI NI C

04950 SLEEP CLINIC

09100 EMERGENCY

89.00

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92.00

94.00

95.00

97.00

200.00

201.00

202.00

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

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

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

OTHER REIMBURSABLE COST CENTERS

09700 DURABLE MEDICAL EQUIP-SOLD

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

09400 HOME PROGRAM DIALYSIS

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

09500 AMBULANCE SERVICES

Health Financial Systems	ELKHART GENERAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C		Period: From 01/01/2017	Worksheet D-3	
			To 12/31/2017	Date/Time Pre	pared:
	T: +1	e XIX	Hospi tal	5/23/2018 2: 3 PPS	9 pm
Cost Center Description		Ratio of Cost		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	0.00	
30. 00 03000 ADULTS & PEDIATRICS			17, 341, 461		30. 00
31. 00 03100 I NTENSI VE CARE UNI T			2, 620, 517		31.00
31. 01 03101 NEONATAL INTENSIVE CARE 32. 00 03200 CORONARY CARE UNIT			1, 296, 035		31. 01 32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT			0		34. 00
40. 00 04000 SUBPROVI DER - 1 PF			0		40. 00
41. 00 04100 SUBPROVI DER - RF			0		41.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS			1, 165, 034		43. 00
50. 00 05000 OPERATING ROOM		0. 23885	4 10, 385, 170	2, 480, 539	50.00
51. 00 05100 RECOVERY ROOM		0. 00000		0	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000	0	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 00000		0	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 22451		1	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE		0.00000		0	55. 00 56. 00
57. 00 05700 CT SCAN		0. 03768		l e	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 14996		l	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 10220			59. 00
60. 00 06000 LABORATORY		0. 22173			60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY		0.00000		0	60. 01 61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 20113			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		0	63. 00
64.00 06400 INTRAVENOUS THERAPY		1. 53306	9 302, 115		64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 20183			65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 57171		l	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		0. 34669 0. 47297		l	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	0	0	70. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS		0. 18645		1	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS		0. 21994		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS		0. 27737 0. 00000		2, 072, 391 0	73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)		0. 00000		Ö	75. 00
76. 00 03140 CARDI OLOGY		0. 18478		114, 322	76. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000		1	88. 00
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 90. 00 09000 CLI NI C		0. 00000 0. 36487		0 118, 588	
90. 01 04950 SLEEP CLINIC		0. 19073		0	90. 01
91. 00 09100 EMERGENCY		0. 45318		l e	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 60754	9 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS		0.00000			04.00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES		0.00000	0	0	94. 00 95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.00000	0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0. 00000		ő	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS		0.00000		0	98. 00
200.00 Total (sum of lines 50 through 94 and 96	0 ,		35, 598, 518	8, 774, 201	
201.00 Less PBP Clinic Laboratory Services-Prog 202.00 Net charges (line 200 minus line 201)	gram only charges (Tine 61)		35, 598, 518		201. 00 202. 00
202. 35 ₁		ı	35, 575, 516	I	1-02.00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-0018	Peri od: From 01/01/2017	Worksheet D-3	
		Component	CCN: 15-S018	To 12/31/2017	Date/Time Pre 5/23/2018 2:3	pared: 9 pm
		Ti tl	e XIX	Subprovi der - I PF	PPS	
Cost Center Description			Ratio of Cos To Charges	Program	Inpatient Program Costs (col. 1 x col.	
			1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS				0		30.00
31. 00 03100 I NTENSI VE CARE UNIT				0		31.00
31. 01 03101 NEONATAL INTENSIVE CARE				0		31. 01

	Cost Center Description	Ratio of Cost	I npati ent	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00	03000 ADULTS & PEDI ATRI CS		0		30. 00
31. 00	03100 INTENSIVE CARE UNIT		0		31. 00
31. 01	03101 NEONATAL INTENSIVE CARE		0		31. 01
32.00	03200 CORONARY CARE UNIT		0		32. 00
33.00	03300 BURN INTENSIVE CARE UNIT		0		33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT		0		34.00
40.00	04000 SUBPROVI DER - I PF		1, 797, 429		40.00
41.00	04100 SUBPROVI DER - I RF		0		41.00
43.00	04300 NURSERY		0		43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	0. 238854	0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 000000	0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0	Ö	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 224513	14, 667	3, 293	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0.000000	11,007	0,270	55. 00
56. 00	05600 RADI OI SOTOPE	0.000000	0	ő	56. 00
57. 00	05700 CT SCAN	0. 037689	48, 586		57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 149966	3, 986		58. 00
59. 00			3, 900		
	05900 CARDI AC CATHETERI ZATI ON	0. 102207	227 200	0	59. 00
60.00	06000 LABORATORY	0. 221737	226, 309	l	60.00
60. 01	06001 BLOOD LABORATORY	0.000000	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0	0	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 201134	0	1	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	1. 533069	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 201839	54, 449		65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 571716	2, 263		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 346692	2, 954		67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 472973	316	149	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0.000000	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 186453	554	103	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 219948	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 277373	70, 753	19, 625	73. 00
74.00	07400 RENAL DIALYSIS	0.000000	0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0.000000	0	0	75. 00
76. 00	03140 CARDI OLOGY	0. 184782	25, 142	4, 646	76. 00
	OUTPATIENT SERVICE COST CENTERS	•	·		
88. 00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	Ö	89. 00
90.00	09000 CLI NI C	0. 364878	6, 309	2, 302	90.00
90. 01	04950 SLEEP CLINIC	0. 190734	0, 007	2, 302	90. 01
91. 00	09100 EMERGENCY	0. 453180	152, 990		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 453180	132, 440	l .	92.00
92.00		0.007549		1 0	72.00
04.00	OTHER REI MBURSABLE COST CENTERS	0.000000	0	0	04.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0.000000	U	1	94. 00
95. 00	09500 AMBULANCE SERVICES	0.000000	^	_	95. 00
96.00	09600 DURABLE MEDICAL EQUI P-RENTED	0.000000	0	_	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0.000000	(00.070	0	98. 00
200.00			609, 278	165, 368	
201.00			0	1	201. 00
202.00	Net charges (line 200 minus line 201)		609, 278	1	202. 00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			CN: 15-0018	Period: From 01/01/2017	Worksheet D-3	
		Component	CCN: 15-T018	To 12/31/2017	Date/Time Pre 5/23/2018 2:3	
		Ti tl	e XIX	Subprovi der - I RF	PPS	
Cost Center Description			Ratio of Cos To Charges		Inpatient Program Costs	
				Charges	(col. 1 x col. 2)	
INPATIENT ROUTINE SERVICE COST CENTERS			1.00	2. 00	3. 00	
30. 00 03000 ADULTS & PEDIATRICS				0		30. 00
31. 00 03100 INTENSIVE CARE UNIT 31. 01 03101 NEONATAL INTENSIVE CARE				0		31. 00 31. 01

	Cost Center Description	To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS				
30.00	03000 ADULTS & PEDI ATRI CS		0	1	30.00
31.00	03100 I NTENSI VE CARE UNI T		0		31.00
31. 01 32. 00	03101 NEONATAL INTENSI VE CARE 03200 CORONARY CARE UNI T		0		31. 01 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT		0		33. 00
34. 00	03400 SURGI CAL I NTENSI VE CARE UNI T		0		34. 00
40. 00	04000 SUBPROVI DER - I PF		0		40. 00
41. 00	04100 SUBPROVI DER - I RF		332, 750		41.00
43.00	04300 NURSERY		0	1	43.00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATING ROOM	0. 238854	334	80	50. 00
51.00	05100 RECOVERY ROOM	0. 000000	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0	0	53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0. 224513	2, 843	1	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0.000000	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0.000000	12.014	0	56. 00
57. 00 58. 00	O5700 CT SCAN O5900 MACUNE MACUNE (MDL)	0. 037689	12, 914 3, 920	487 588	57. 00 58. 00
59. 00	05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON	0. 149966 0. 102207	3, 920	0	59.00
60. 00	06000 LABORATORY	0. 102207	20, 266		60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	20, 200	4, 474	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	0	1	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 201134	0	Ö	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	o	63.00
64.00	06400 I NTRAVENOUS THERAPY	1. 533069	0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 201839	10, 164	2, 051	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 571716	74, 948	42, 849	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 346692	76, 729	26, 601	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 472973	27, 957	13, 223	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70. 00
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 186453	387	1	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 219948	52 (22	0	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0. 277373	52, 623	14, 596 0	73. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000 0. 000000	0	ı "	74. 00 75. 00
76. 00	03140 CARDI OLOGY	0. 184782	864	-	•
70.00	OUTPATIENT SERVICE COST CENTERS	0. 104702	- 001	100	70.00
88. 00	08800 RURAL HEALTH CLINIC	0.000000	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	ol	89. 00
90.00	09000 CLI NI C	0. 364878	7, 248	2, 645	90.00
90. 01	04950 SLEEP CLINIC	0. 190734	0	0	90. 01
91.00	09100 EMERGENCY	0. 453180	0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 607549	0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS				
94. 00	09400 HOME PROGRAM DI ALYSI S	0.000000	0	0	94. 00
95. 00	09500 AMBULANCE SERVI CES				95. 00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0.000000	0	ı "	96. 00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	0.000000	0	0	97. 00
98. 00	O9850 OTHER REIMBURSABLE COST CENTERS	0. 000000	201 107	100 404	98. 00
200. 00 201. 00			291, 197	108, 484	200.00
201.00			291, 197		201.00
202.00	The charges (Title 200 millios Title 201)	1	2/1, 17/	1 1	1202.00

MARI A - IMPAILENT HOSPITAL SERVICES MODER IPPS 1.00			T; +1 o V/// 1	Heeni tel	5/23/2018 2: 3	9 pm
PART A - INPATIBIT MOSPITAL SERVICES UNDER IPPS 1.00 Bits meants other than outli er payments for discharges occurring prior to October 1 (see 26,161,025 1.01			Title XVIII	Hospi tal	PPS	
1.00 DRG Amounts other than outlier payments for discharges occurring prior to October 1 (see 26,161,02 1.01					1. 00	
DRG amounts other than outlier payments for discharges occurring on or after Dotober 1 (see 26,161,025 1.02 DRG amounts other than outlier payments for discharges occurring on or after Dotober 1 (see 3,127,632 1.02 DRG amounts other than outlier payment for Model 4 BPCI for discharges occurring prior to October 1 (see 1.03 DRG for Frederal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.03 DRG for Frederal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Frederal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Frederal specific operating payment for Model 4 BPCI for discharges occurring on or after 0 1.03 DRG for Frederal specific operating payment for Model 4 BPCI (see instructions) 1.551,389 2.00 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring on or after 0 1.04 DRG for Model 4 BPCI for discharges occurring o	1 00				0	1 00
DRC associates other than outlier payments for discharges occurring on or after October 1 (see 8,172,637 1.02		DRG amounts other than outlier payments for discharges occurring	prior to October 1 (s	see		
1.03 1 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.03 1.0	1. 02	DRG amounts other than outlier payments for discharges occurring	on or after October 1	l (see	8, 127, 632	1. 02
October 1 (see Instructions) 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	1. 03	DRG for federal specific operating payment for Model 4 BPCI for d	ischarges occurring p	orior to October	0	1. 03
2.01 Outlier reconcilitation amount 0 2.01	1. 04	DRG for federal specific operating payment for Model 4 BPCI for d	ischarges occurring o	on or after	0	1. 04
Managed Care Simulated Payments		Outlier payments for discharges. (see instructions)				
Red days available divided by number of days in the cost reporting period (see instructions) 182.52 4.00		, ,	1)		- 1	
Indirect Medical Education Adjustment Count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, (see Instructions) Count for all opathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413, 79(e) Count for all opathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413, 79(e) Count for all opathic and osteopathic programs which meet the criteria for an add-on to the cap of the count for all opathic and osteopathic programs for count for all opathic and osteopathic programs for count for all opathic subjuly 1, 2011 files see instructions. 8.0 Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for 1993, and 67 FR 5009 (August 1, 2002). 8.10 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddle 3 Lily 1, 2011, see instructions. 8.2 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddle 3 Lily 1, 2011, see instructions. 8.2 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5500 of ACA. (see instructions) 9.00 Sun of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 of 10.00 retrease) 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 10.00 FTE count for all opathic and osteopathic programs. 10.00 Instructions) 10.00 Current year allowable FTE (see instructions) 10.00 FTE count for residents in initial year of the program 10.00 Current year residents in initial years of the program 10.00 Current year residents of the program		, ,		-+:>		
or before 12/31/1996, (see instructions) 10		Indirect Medical Education Adjustment	 	,		
To rew programs in accordance with 42 CFR 413.79(e) No. 00 N		or before 12/31/1996. (see instructions)				
ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(0)(8)(2) if the cost report straddles July 1, 2011 then see instructions. Adjustment (Increase or decrease) to the FTE count for all lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). Adjustment (Increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. Adjustment (Increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost under § 5506 of ACA. (see instructions) Adjustment of the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions) Adjustment of the instructions Adjustm		for new programs in accordance with 42 CFR 413.79(e)		·		
Agl Justment (Increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 cfR 413. 75(b), 413. 79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		ACA § 5503 reduction amount to the IME cap as specified under 42				
8. 01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report stradies July 1, 2011, see instructions. 2. 0.00 8. 01	8. 00	Adjustment (increase or decrease) to the FTE count for allopathic affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)			0.00	8. 00
8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 ACA. (see instructions)	8. 01	The amount of increase if the hospital was awarded FTE cap slots	under § 5503 of the A	ACA. If the cost	0. 00	8. 01
Instructions 10.00 TEC count for allopathic and osteopathic programs in the current year from your records 0.00 10.00	8. 02	The amount of increase if the hospital was awarded FTE cap slots	from a closed teachir	ng hospital	0. 00	8. 02
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 12.00 13.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 15.00 1	9. 00		8, 8,01 and 8,02) (s	see	0. 00	9. 00
13.00 Total allowable FTE count for the prior year. 0.00 13.00 14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, 0.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00			year from your record	ds		
14. 00		,				
15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 17.00 17.00 17.00 18.00 18.00 18.00 18.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19.00 19		Total allowable FTE count for the penultimate year if that year e	nded on or after Sept	tember 30, 1997,		
17. 00	15. 00				0. 00	15. 00
18.00 Adjusted rolling average FTE count 0.00 18.00 19.00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19.00 20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.01 IME payment adjustment (see instructions) 0.22.00 1 ME payment adjustment - Managed Care (see instructions) 0.22.01 1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA 0.00 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 0.00 23.00 (f)(1)(iv)(c). 0.1 0.00 24.00 25.00 16 the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 28.01 IME add-on adjustment amount - Managed Care (see instructions) <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>						
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instructions	24.00				0.00	24.00
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27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 3. 92 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 22. 02 31. 00 32. 00 Sum of lines 30 and 31 25. 94 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 10. 62 33. 00	26 00				0 000000	26 00
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31.00Percentage of Medicaid patient days (see instructions)22.0231.0032.00Sum of Lines 30 and 3125.9432.0033.00Allowable disproportionate share percentage (see instructions)10.6233.00	30. 00		nt days (see instruct	tions)	3. 92	30.00
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	32.00	, , , , , , , , , , , , , , , , , , , ,				
34.00 Disproportionate share adjustment (see instructions) 910, 364 34.00		, , , , , , , , , , , , , , , , , , , ,			10. 62	33. 00
	34. 00	Disproportionate share adjustment (see instructions)			910, 364	34. 00

	Financial Systems ELKHART GENERAL ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0018	Peri od: From 01/01/2017 To 12/31/2017	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/23/2018 2:3	pared
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	0n/After 10/1 2.00	
	Uncompensated Care Adjustment		1.00	2.00	
00	Total uncompensated care amount (see instructions)		5, 977, 483, 147	6, 766, 695, 164	
01	Factor 3 (see instructions)		0. 000304863	0. 000342198	
02	Hospital uncompensated care payment (If line 34 is zero, ente	er zero on this line) (se	e 1, 822, 313	2, 315, 547	35.
03	instructions) Pro rata share of the hospital uncompensated care payment amo	ount (see instructions)	1, 362, 990	583, 645	35.
	Total uncompensated care (sum of columns 1 and 2 on line 35.0	,	1, 946, 635		36.
	Additional payment for high percentage of ESRD beneficiary di				
00	Total Medicare discharges on Worksheet S-3, Part I excluding	discharges for MS-DRGs	0		40.
00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	93 684 an 685 (see	0		41.
00	instructions)	700, 004 an 000. (See			71.
01	Total ESRD Medicare covered and paid discharges excluding MS-	DRGs 652, 682, 683, 684	0		41.
00	an 685. (see instructions)	£. £ ditt)	0.00		40
00	Divide line 41 by line 40 (if less than 10%, you do not quali Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68		0.00		42. 43.
00	instructions)	12, 003, 004 an 003. (See			45.
00	Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.
00	days)		0.00		4.5
00	Average weekly cost for dialysis treatments (see instructions Total additional payment (line 45 times line 44 times line 41		0.00		45. 46.
00	Subtotal (see instructions)	. 01)	38, 697, 045		47.
00	Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	0		48.
	only (see instructions)				
				Amount 1.00	
00	Total payment for inpatient operating costs (see instructions			38, 697, 045	49.
00	Payment for inpatient program capital (from Wkst. L, Pt. I and			3, 007, 545	50.
00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	51.
00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		0 053	52. 53.
00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			28, 853 1, 036	
01	Islet isolation add-on payment			0	54
00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	9)		0	55
00	Cost of physicians' services in a teaching hospital (see intr			0	56
00	Routine service other pass through costs (from Wkst. D, Pt. I Ancillary service other pass through costs from Wkst. D, Pt.		hrough 35).	0 14, 889	57 58
00	Total (sum of amounts on lines 49 through 58)	TV, Cor. IT Title 200)		41, 749, 368	
00	Primary payer payments			9, 267	
00	Total amount payable for program beneficiaries (line 59 minus	line 60)		41, 740, 101	61
00	Deductibles billed to program beneficiaries			3, 610, 068	
00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			71, 666	
00				354, 765 230, 597	
00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)		93, 687	66
00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	,		38, 288, 964	67
00	Credits received from manufacturers for replaced devices for	• •		0	68
00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	(For SCH see instruction	S)	0	69
00 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	instructions)	0	70 70
87	Demonstration payment adjustment amount before sequestration	at. on, adjustment (366		0	70
88	SCH or MDH volume decrease adjustment (contractor use only)			0	70
89	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)			70
90	HSP bonus payment HVBP adjustment amount (see instructions)			0	70
	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70 70
91	roonarea wooer i orscourt amount (See INSTITUCTIONS)			-	
91 92				193 573	70
91	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)			193, 573 -179, 273	

Health Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der C	CN: 15-0018	Peri od: From 01/01/2017 To 12/31/2017	Worksheet E Part A Date/Time Pre 5/23/2018 2:3	pared:
		Title	e XVIII	Hospi tal	PPS	•
			FFY	(yyyy)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fiscal the corresponding federal year for the p		n column 0		0	0	70. 96
70.97 Low volume adjustment for federal fiscal the corresponding federal year for the				0	0	70. 97

	0	1.00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	0	0	70. 96
the corresponding federal year for the period prior to 10/1) 70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	0	o	70. 97
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	ا	70.97
70. 98 Low Volume Payment-3		0	70. 98
70.99 HAC adjustment amount (see instructions)		l ol	70. 99
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		38, 303, 264	71. 00
71.01 Sequestration adjustment (see instructions)		766, 065	71. 01
71.02 Demonstration payment adjustment amount after sequestration		0	71. 02
72.00 Interim payments		37, 177, 151	72. 00
73.00 Tentative settlement (for contractor use only)		0	73. 00
74.00 Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and		360, 048	74. 00
73)			
75.00 Protested amounts (nonallowable cost report items) in accordance with		573, 250	75. 00
CMS Pub. 15-2, chapter 1, §115.2 TO BE COMPLETED BY CONTRACTOR (Lines 90 through 96)			
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0	90.00
91.00 Capital outlier from Wkst. L, Pt. I, line 2		0	91.00
92.00 Operating outlier reconciliation adjustment amount (see instructions)			92.00
93.00 Capital outlier reconciliation adjustment amount (see instructions)			93.00
94.00 The rate used to calculate the time value of money (see instructions)		0.00	94.00
95.00 Time value of money for operating expenses (see instructions)		0	95. 00
96.00 Time value of money for capital related expenses (see instructions)		0	96.00
	Prior to 10/1	On/After 10/1	
	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			
101.00 HVBP adjustment factor (see instructions)	0. 000000000		
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
HRR Adjustment for HSP Bonus Payment	0.0000	0.0000	102 00
103.00 HRR adjustment factor (see instructions) 104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0.0000		103.00
Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustn		<u> </u>	104.00
200.00 Is this the first year of the current 5-year demonstration period under the			200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.	2131		200.00
Cost Reimbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
202.00 Medicare discharges (see instructions)			202. 00
203.00 Case-mix adjustment factor (see instructions)			203. 00
Computation of Demonstration Target Amount Limitation (N/A in first year of	the current 5-year demonst	rati on	
peri od)			
204.00 Medicare target amount			204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
Adjustment to Medicare Part A Inpatient Reimbursement			007.00
207.00 Program reimbursement under the §410A Demonstration (see instructions)			207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			208. 00 209. 00
209.00 Adjustment to Medicare IPPS payments (see instructions) 210.00 Reserved for future use		1 1	1709 00
210.00 Total adjustment to Medicare IPPS payments (see instructions)			
			210. 00
Comparision of PPS versus Cost Reimbursement			210. 00 211. 00
Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			210. 00 211. 00 212. 00
Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 211) 213.00 Low-volume adjustment (see instructions)	rsement)		210. 00 211. 00 212. 00 213. 00
Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)	rsement)		210. 00 211. 00 212. 00

Title XVIII		ATION OF DSH PAYMENT PERCENTAGE		Provi der CC		Peri od:	Worksheet DSH	1002 .0
Principle Prin						From 01/01/2017 Fo 12/31/2017		
Prince P				Title	XVIII	Hospi tal		9 pm
CALCULATION OF THE DSH PAWENT PERCENTAGE				djusted .mcax				
CALCINATION OF THE DSR PAYMENT PERCENTAGE 0.00 0.00 0.00 0.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00 1.00					2 00	4.00	E 00	
1.00 Percentage of SSI patient days to Medicare 3.92 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		CALCULATION OF THE DSH PAYMENT PERCENTAGE	1.00	2.00	3.00	4.00	5.00	
30 - Revised From CNS) 22.02 2.00 22.02 2.00 22.02 2.00 22.02 2.00 2.00 2.00 2.00 2.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00	1.00	Percentage of SSI patient days to Medicare	3. 92	0.00	0.00	0.00	0.00	1.00
2.00 Percentage of Medical of patient days to total 22.02 0.00 22.02 2.00 2.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00 3.00								
3.00 Sum of lines 1 and 2, if less than 15% DSH	2.00		22. 02	0.00			22. 02	2. 00
Payment Percentage - 0	3. 00		25. 94	0.00			22. 02	3. 00
pickle - If pickle worksheet MA 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5.00 182.52 5		Payment Percentage = 0						
In the Cost reporting period (Worksheet E, Part A, Line 4) 0 0 0 0 0 0 0 0 0		pickle - If pickle worksheet NA)						
Disproportionate Share Payment Percentage (transferred from Worksheet E. Part A. Line B. 33) The state Medical dipaid days (Worksheet S-2, Line 24 and Line 24, column 1) Line 2 are viscolar black bedical dipaid days (Worksheet S-2, Line 24, column 4) Line 24, column 4) Line 3 and Line 3	5. 00	in the cost reporting period (Worksheet E,	182. 52	0. 00			182. 52	5. 00
Ctransferred from Worksheet E, Part A, line 3 3.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.0 0.	6 00		10 62	0.00			7 20	6 00
1.00	0.00	(transferred from Worksheet E, Part A, line	10. 02	0.00			7.30	0.00
Second S	7. 00	Qualify for Operating DSH Eligibility (DPP	Yes				Yes	7. 00
9.00 Quality for Capital DSH Eligibility (Urban Yes Wes 10.00 with 100 or more beds)? Yes Yes 10.00 S-2, Line 45 Yes Yes 10.00 Yes 11.00 Yes 11.00 Yes Yes 10.00 Yes 11.00 Yes Yes 12.00 Yes 12.00 Yes 12.00 Yes 12.00 Yes 12.00 Yes 13.00 State Medicare Stip and tent days to Medicare Stip and tent days (Pervious From L. Part I., Line 7 - Revised From CMS) Yes Yes 13.00 State Medicare Stip and tent days (Pervious From L. Part I., Line 7 - Revised From CMS) Yes Yes 13.00 State Medicare Stip and tent days (Morksheet S-2, Line 75, Column 1 = "Yes Yes Yes 13.00 State Medicare Stip and tent days (Morksheet S-2, Line 24, Column 2) State Medicare Stip and tent days (Morksheet S-2, Line 24, Column 2) State Medicare Stip and tent days (Morksheet S-2, Line 24, Column 2) State Medicare Stip and tent days (Morksheet S-2, Line 24, Column 3) State Medicare Stip and tent days (Morksheet S-2, Line 24, Column 3) State Medicare Stip and tent days (Morksheet S-2, Line 24, Column 4) State Medicare Stip and tent days (Morksheet S-2, Line 24, Column 4) State Medicare Stip and tent days (Morksheet S-2, Line 24, Column 4) State Medicare Stip and tent days (Morksheet S-2, Line 24, Column 4) State Medicare Stip and tent days (Morksheet S-2, Line 24, Column 4) State Medicare Stip and tent days (Morksheet S-3, Part I, Column 8, Line 32) State Marksheet S-3, Part I, Column 8, Line 32) State Marksheet S-3, Part I, Column 8, Line 32) State Marksheet S-3, Part I, Column 8, Line 32) State Marksheet S-3, Part I, Column 8, Line 30 State Marksheet S-3, Part I, Column 8, Line 5 And 6) State Medicare State Medicare State Marksheet S-3, Part I, Column 8, Line 5 And 6) State Medicare State Medicare State Medicare State Marksheet S-3, Part I, Column 8, Line 5 And 6) State Medicare State Medicare State Marksheet S-3, Part	8. 00		Yes				Yes	8.00
10.00 S-2, Line 45 Yes Yes Yes Yes 10.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00 11.00		Qualify for Capital DSH Eligibility (Urban	1					9. 00
11.00 Is the provider reimbursed under the fully prospective method? (Worksheet L, Part I, II ne 1 geater than -0-) 12.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00	10. 00	·	Yes				Yes	10.00
11 ne 1 geater than -0 -0		Is the provider reimbursed under the fully	Yes				Yes	11. 00
12.00 Percentage of SSI patient days to Medicare 3.92 0.00 0.00 0.00 0.00 12.00								
- Revised from CMS) 13.00 Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y") 14.00 Medicare SSI ratio (Previous from E-3, Part 75, column 1 = "Y") 14.00 Medicare SSI ratio (Previous from E-3, Part 75, column 1 = "Y") 15.00 In-State Medicaid paid days (Worksheet S-2, line 24, column 1) 16.00 In-State Medicaid eligible unpaid paid days (Worksheet S-2, line 24, column 2) 17.00 Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 2) 18.00 Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 3) 18.00 Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4) 18.01 M/A 19.00 Medicaid MMO days (Worksheet S-2, line 24, column 4) 19.00 Medicaid did MMO days (Worksheet S-2, line 24, d., 102 column 5) 20.00 Other Medicaid days (Worksheet S-2, line 24, column 5) 20.00 Total Medicaid patient days for the DSH 8, 866 column 6) 21.00 Total Medicaid patient days for the DSH 8, 866 column 8, Line 14) 23.00 Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32) 24.00 Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 32) 25.00 Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Line 32) 26.00 Total Medicaid patient days for the DSH and 6) 27.00 Percentage of Medicaid patient days for the DSH and 6) 28.00 Total Medicaid material patient days (Worksheet S-3, Part I, Column 8, Line 32) 29.00 Percentage of Medicaid patient days for the DSH and 6) 20.00 Total Medicaid patient days for the DSH and 6) 20.00 Total Medicaid patient days for the DSH and 6) 20.00 Total Medicaid patient days for the DSH and 6) 20.00 Percentage of Medicaid patient days total 22.02 0.00 0 20.00 Total Medicaid patient days for the DSH and 6) 20.00 Total Medicaid patient days for the DSH and 6) 20.00 Total Medicaid patient days for the DSH and 6) 20.00 Total Medicaid patient days for the DSH and 6) 20.00 Total Medicaid patient days for the DSH and 6) 20.00 Total Medicaid patient days for the DSH	12. 00		3. 92	0. 00	0.00	0.00	0.00	12. 00
13.00 Is this an IRF provider or a provider with an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y") 14.00 Medicare SSI ratio (Previous from E-3, Part 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.10 17.								
an IRF excluded unit (Worksheet S-2, line 75, column 1 = "Y") Medicare SSI ratio (Previous from E-3, Part 111, line 2 - Revised from CMS) CACULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS 15.00 In-State Medicaid paid days (Worksheet S-2, line 24, column 1) 16.00 In-State Medicaid paid days (Worksheet S-2, line 24, column 2) 17.00 Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3) 18.00 Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4) 19.00 Medicaid HMO days (Worksheet S-2, line 24, column 4) 19.00 Medicaid HMO days (Worksheet S-2, line 24, d. 102 column 5) 20.00 Other Medicaid days (Worksheet S-2, line 24, d. 102 column 5) 21.00 Total Medicaid patient days for the DSH 8, 866 calculation (sum of lines 15-20) 22.00 Total patient days (Worksheet S-3, Part I, Column 8, Line 32) 23.00 Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32) 25.00 Less total Swing-bed SNF and NF patient days (Worksheet S-3, and 6) 10.00 Total Medicaid patient days for the DSH Share Column 6, Share Column 8, Line 32) 26.00 Total Medicaid patient days (Worksheet S-3, Part I, Column 8, Line 32) 27.00 Total patient (as Worksheet S-3, Part I, Column 8, Line 32) 28.00 Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Line 32) 29.00 Total Medicaid patient days for the DSH Share Sh	13. 00		Yes				Yes	13.00
14. 00 Medicare SSI ratio (Previous from E-3, Part 0.83 0.00 0.00 0.00 0.00 14. 00		an IRF excluded unit (Worksheet S-2, line						
111, line 2 - Revised from CMS) CALCULATION OF THE PERCENTAGE OF MEDICAID DAYS TO TOTAL DAYS 15.00 In-State Medicaid paid days (Worksheet S-2, 1,174 0 1,174 1 1 15.00 1,174 1 1 1 1 1 1 1 1 1	14 00		0.83	0.00	0.00	0.00	0.00	14 00
15.00	00	III, line 2 - Revised from CMS)			0. 0.	3.00	0.00	
If ine 24, column 1	15 00			0			1 174	15 00
(Worksheet S-2, line 24, column 2) 17.00 Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3) 18.00 Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4) 18.01 N/A 19.00 Medicaid HM0 days (Worksheet S-2, line 24, days of the DSH calculation (sum of lines 15-20) 20.00 Other Medicaid patient days for the DSH such calculation (sum of lines 15-20) 21.00 Total Medicaid lays (Worksheet S-3, Part I, Column 8, Line 32) 24.00 Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30) 25.00 Less total Swing-bed SNF and NF patient days of the DSH calculation (sum of lines 22-24, less line 25) 27.00 Percentage of Medicaid patient days for the DSH days (Worksheet S-3, Part I, Column 8, Line 30) 28.00 Part I, Column 8, Line 30) 29.00 Column 8, Line 30) 20.00 Column 8, Line 30	13.00		1, 174	0			1, 174	13.00
17. 00 Out-of-State Medicaid paid days (Worksheet S-2, line 24, column 3) 0 0 0 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 18. 00 0 0 18. 00 0 0 18. 00 0 0 0 0 0 0 0 0 0	16. 00		3, 249	0			3, 249	16. 00
18.00 Out-of-State Medicaid eligible unpaid days (Worksheet S-2, line 24, column 4) 0 0 0 18.00 18.01 N/A 0 0 0 0 0 19.00 Medicaid HMO days (Worksheet S-2, line 24, column 5) 0 0 0 20.00 Other Medicaid days (Worksheet S-2, line 24, column 6) 0 0 0 21.00 Total Medicaid patient days for the DSH calculation (sum of lines 15-20) 0 0 22.00 Total patient days (Worksheet S-3, Part I, Column 8, Line 14) 0 0 0 23.00 Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 32) 0 0 0 0 25.00 Less total Swing-bed SNF and NF patient days 0 0 0 26.00 Total Medicaid patient days for the DSH column 8, Line 30) 0 0 0 26.00 Total Medicaid patient days for the DSH column 8, Line 30) 0 0 0 27.00 Percentage of Medicaid patient days to total 22.02 0.00 0 0 28.00 0 0 0 0 29.00 0 0 0 0 20.00 0 0 0 20.00 0 0 0 20.00 0 0 0 20.00 0 0 0 20.00 0 0 0 20.00 0 0 0 20.00 0 0 0 20.00 0 0 20.00 0 0 20.00 0 0 0 20.00 0 0 0 20.00 0 0 0 20.00 0 0 0 20.00 0 0 20.00 0 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0 20.00 0 0	17. 00	Out-of-State Medicaid paid days (Worksheet	341	0			341	17. 00
(Worksheet S-2, line 24, column 4) 18. 01 N/A 19. 00 Medicaid HM0 days (Worksheet S-2, line 24, column 5) 20. 00 Other Medicaid days (Worksheet S-2, line 24, column 6) 21. 00 Total Medicaid patient days for the DSH calculation (sum of lines 15-20) 22. 00 Total patient days (Worksheet S-3, Part I, column 8, Line 32) 24. 00 Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32) 25. 00 Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Line 30) 26. 00 Total Medicaid patient days for the DSH days (Worksheet S-3, Part I, Column 8, Line 30) 27. 00 Percentage of Medicaid patient days to total 28. 00 Percentage of Medicaid patient days to total 29. 00 O O O O O O O O O O O O O O O O O O	18. 00		0	0			0	18. 00
19.00 Medicaid HMO days (Worksheet S-2, line 24, column 5) 20.00 Other Medicaid days (Worksheet S-2, line 24, column 6) 21.00 Total Medicaid patient days for the DSH calculation (sum of lines 15-20) 22.00 Total patient days (Worksheet S-3, Part I, Column 8, Line 14) 23.00 Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32) 24.00 Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30) 25.00 Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6) 26.00 Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25) 27.00 Percentage of Medicaid patient days to total 22.02 0.00	40.04	(Worksheet S-2, line 24, column 4)						40.04
20.00 Column 5 Other Medicaid days (Worksheet S-2, line 24, column 6) Other Medicaid patient days for the DSH S, 866 Other Medicaid patient days for the DSH S, 866 Other Medicaid patient days for the DSH S, 866 Other Medicaid patient days (Worksheet S-3, Part I, Column 8, Line 14) Other Medicaid patient days (Worksheet S-3, Part I, Column 8, Line 14) Other Medicaid patient days (Worksheet S-3, Part I, Column 8, Line 32) Other Medicaid patient days (Worksheet S-3, Part I, Column 8, Line 30) Other Medicaid patient days (Worksheet S-3, Part I, Column 8, Lines 5 Other Medicaid patient days for the DSH Other Medicaid patient		1 .		0			_	
Column 6 Total Medicaid patient days for the DSH S, 866 Calculation (sum of lines 15-20) Column 8, Line 14 Column 8, Line 14 Column 8, Line 32 Column 8, Line 30 Column	20.00	column 5)						20.00
calculation (sum of lines 15-20) Total patient days (Worksheet S-3, Part I, Column 8, Line 14) 23.00 Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32) 24.00 Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30) 25.00 Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6) 26.00 Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25) 27.00 Percentage of Medicaid patient days to total 22.02 0.00	20.00		U U	O			0	20.00
22. 00 Total patient days (Worksheet S-3, Part I, Column 8, Line 14) 23. 00 Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32) 24. 00 Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30) 25. 00 Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6) 26. 00 Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25) 27. 00 Percentage of Medicaid patient days to total 22. 02 0. 00	21. 00		8, 866	0			8, 866	21. 00
23.00 Plus total labor room days (Worksheet S-3, Part I, Column 8, Line 32) 24.00 Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30) 25.00 Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6) 26.00 Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25) 27.00 Percentage of Medicaid patient days to total 22.02 0.00	22. 00	Total patient days (Worksheet S-3, Part I,	39, 467	0			39, 467	22. 00
24.00 Plus total employee discount days (Worksheet S-3, Part I, Column 8, Line 30) 25.00 Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6) 26.00 Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25) 27.00 Percentage of Medicaid patient days to total 28.00 Single Sum of lines 22-24, less line 25 and 6) 29.00 Percentage of Medicaid patient days to total 20.00 Single Sum of lines 22-24, less line 25 and 20.00 single Sum of lines 22.02 and 20.00 single Sum of lines 22.00 single Sum of lin	23. 00	Plus total labor room days (Worksheet S-3,	469	0			469	23. 00
25.00 Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5 and 6) 26.00 Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line 25) 27.00 Percentage of Medicaid patient days to total 22.02 0.00 0 25.00	24. 00	Plus total employee discount days (Worksheet	319	0			319	24. 00
26. 00 Total Medicaid patient days for the DSH do al culation (sum of lines 22-24, less line 25) 27. 00 Percentage of Medicaid patient days to total 22. 02 0. 00 40, 255 26. 00 22. 02 27. 00	25. 00	Less total Swing-bed SNF and NF patient days (Worksheet S-3, Part I, Column 8, Lines 5	O	0			0	25. 00
27.00 Percentage of Medicaid patient days to total 22.02 0.00 22.02 27.00	26. 00	Total Medicaid patient days for the DSH calculation (sum of lines 22-24, less line	40, 255	0			40, 255	26. 00
	27. 00	Percentage of Medicaid patient days to total	22. 02	0.00			22. 02	27. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL		In Lieu of Form CMS-2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE	Provider CCN: 15-0018	Peri od:	Worksheet DSH

	ATION OF DSH PAYMENT PERCENTAGE		Provi der Co	CN: 15-0018	Peri od: From 01/01/2017 To 12/31/2017	Worksheet DSH Date/Time Pre 5/23/2018 2:3	pared:
			Title	: XVIII	Hospi tal	PPS	
		Original .m	crx Values	Adj usted	. mcax Values	Revi sed	
		Condi ti on	Percentage	Condi ti on	Percentage	Condi ti on	
		1.00	2.00	3.00	4. 00	5. 00	
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE						
28. 00	If line 3 is greater than 20.2% - 5.88% plus 82.5% of the difference between 20.2% and line 3	True	10. 62		0.00	True	28. 00
29. 00	If line 3 is less than 20.2% - 2.5% plus 65% of the difference between 15% and line 3	Fal se	0. 00		0.00	Fal se	29. 00
30.00	Line 28 or 29 as applicable		10. 62		0.00		30.00
31. 00	If Urban and fewer than 100 beds, Rural and fewer than 500 beds, or an SCH the lower of line 30 or .1200, if RRC, MDH or otherwise enter line 30.		10. 62		0.00		31.00
		Original .mcrx/	Adiusted .mcax	HES Look Un	Overri de Val ue	Revi sed Value	
		Values	Values				
		1.00	2.00	3.00	4. 00	5. 00	
	DETERMINATION OF PROVIDER TYPE						
32. 00	Does the hospital qualify under the Pickle ammendment? (Worksheet S-2, Part I, Line 22, column 2 = "Y")	Fal se				Fal se	32. 00
33. 00	Is This a Rural Referral Center? (Worksheet S-2, Part I, line 116, column 1 = "Y")	Fal se				Fal se	33. 00
34. 00	Is this a Medicare Dependant Hospital? (Worksheet S-2, Part I, Line 37 greater than -0-)	Fal se				Fal se	34. 00
35. 00	Is this a Sole Cummunity hospital? (Worksheet S-2, Part I, Line 35 greater than -0-)	Fal se				Fal se	35. 00
36. 00	Is this an Urban or Rural hospital? (Worksheet S-2, Part I, Line 26, Column 1, Urban=1, Rural=2)	Urban				Urban	36. 00

Health Financial Systems	ELKHART GENERA	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF DSH PAYMENT PERCENTAGE		Provider CCN: 15-0018	From 01/01/2017	Worksheet DSH	
			10 12/31/201/	Date/Time Prep 5/23/2018 2:39	
		Title XVIII	Hospi tal	PPS	

			Title XVIII	Hospi tal	PPS	
		Revi sed				
		Percentage				
		6.00				
	CALCULATION OF MAXIMUM DSH PAYMENT PERCENTAGE					
28. 00	If line 3 is greater than 20.2% - 5.88% plus	7. 38				28. 00
	82.5% of the difference between 20.2% and					
	line 3					
29. 00	If line 3 is less than 20.2% - 2.5% plus 65%	0. 00				29. 00
	of the difference between 15% and line 3					
30.00	Line 28 or 29 as applicable	7. 38				30.00
31.00	If Urban and fewer than 100 beds, Rural and	7. 38				31. 00
	fewer than 500 beds, or an SCH the lower of					
	line 30 or .1200, if RRC, MDH or otherwise					
	enter line 30.					

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0018	Peri od: Worksheet E From 01/01/2017 Part B To 12/31/2017 Date/Time Prepared: 5/23/2018 2: 39 pm

			127 017 2017	5/23/2018 2: 3	9 pm
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			04 77/	
1.00	Medical and other services (see instructions)			21, 776	1
2.00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		24, 441, 162	
3.00	OPPS payments			21, 167, 588	
4. 00 4. 01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			294, 380 0	4. 00 4. 01
5. 00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	
6. 00	Line 2 times line 5	Strons)		0.000	6. 00
7. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
8.00	Transitional corridor payment (see instructions)			0.00	8. 00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV. col. 13. Line 200		28, 975	
10.00	Organ acqui si ti ons	,		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			21, 776	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			78, 508	12. 00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			78, 508	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for p			0	
16. 00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16. 00
17 00	had such payment been made in accordance with 42 CFR §413.13(6	e)		0.000000	17 00
17. 00 18. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
19. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	ly if line 19 exceeds li	no 11) (coo	78, 508 56, 732	•
19.00	instructions)	Ty IT TITLE TO EXCEEUS IT	ile II) (See	50, 732	19.00
20. 00	Excess of reasonable cost over customary charges (complete onl	vifline 11 exceeds li	ne 18) (see	0	20. 00
20.00	instructions)	Ty II IIIle II execes II	110 10) (300		20.00
21.00	Lesser of cost or charges (see instructions)			21, 776	21.00
22.00	Interns and residents (see instructions)			0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see instr	ructions)		0	23. 00
24.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			21, 490, 943	24. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for			3, 854, 245	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22	and 23] (see	17, 658, 474	27. 00
28. 00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, li</pre>	no EO)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	THE 30)		0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			17, 658, 474	
31.00	Primary payer payments			8, 721	
32.00	Subtotal (line 30 minus line 31)			17, 649, 753	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34.00	Allowable bad debts (see instructions)			757, 810	
35. 00	Adjusted reimbursable bad debts (see instructions)	quati ana)		492, 577	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	uctions)		514, 258	
38.00	Subtotal (see instructions)			18, 142, 330 -633	1
39.00	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			-033	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	3)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration	3)		0	
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	Ö	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	(,	0	39. 99
40.00	Subtotal (see instructions)			18, 142, 963	40. 00
40. 01	Sequestration adjustment (see instructions)			362, 859	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
41. 00	Interim payments	17, 670, 441	41. 00		
42.00					42. 00
43. 00	Balance due provider/program (see instructions)			109, 663	•
44. 00	Protested amounts (nonallowable cost report items) in accordar	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00				0	90. 00
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00	The rate used to calculate the Time Value of Money			0.00	1
93. 00	Time Value of Money (see instructions)			0.00	
	Total (sum of lines 91 and 93)				94. 00

Health Financial Systems	ELKHART	GENERAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT			Provi der Co		Peri od:	Worksheet E	
					From 01/01/2017	Part B	
					To 12/31/2017	Date/Time Pre	pared:
						5/23/2018 2:3	9 pm
			Ti tl e	e XVIII	Hospi tal	PPS	
						Overri des	
						1. 00	
WORKSHEET OVERRIDE VALUES							
112.00 Override of Ancillary service charges (line 1	2)					0	112. 00

| Period: | Worksheet E-1 | From 01/01/2017 | Part | To 12/31/2017 | Date/Time Prepared: | 5/23/2018 2:39 pm Health Financial Systems ELKANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0018

					5/23/2018 2:39	9 pm
			XVIII	Hospi tal	PPS	
		Inpatien	it Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		37, 177, 151		17, 670, 441	1. 00
2.00	Interim payments payable on individual bills, either		C)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3.00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER)	0	3. 01
3. 02)	o	3. 02
3.03			l c)	ol	3. 03
3.04)	o	3. 04
3.05			l c)	0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		[c)	0	3. 50
3. 51			[c		0	3. 51
3.52			[C		0	3. 52
3. 53			[C		0	3. 53
3.54			C		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		C)	0	3. 99
4 00	3. 50-3. 98)		07 177 151		17 /70 441	4 00
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		37, 177, 151		17, 670, 441	4. 00
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
0.00	desk review. Also show date of each payment. If none,					0.00
	write "NONE" or enter a zero. (1)					
	Program to Provider		•	•		
5.01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02			C)	0	5. 02
5.03			C		0	5. 03
	Provider to Program			1		
5. 50	TENTATI VE TO PROGRAM		C		0	5. 50
5. 51			C		0	5. 51
5. 52	Cultural (com of lines 5 01 5 40 minus com of lines		C		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		C)		5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
5. 55	the cost report. (1)					5. 55
6. 01	SETTLEMENT TO PROVIDER		360, 048		109, 663	6. 01
6. 02	SETTLEMENT TO PROGRAM)	0	6. 02
7. 00	Total Medicare program liability (see instructions)		37, 537, 199		17, 780, 104	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
	To the second se	()	1. 00	2. 00	
8.00	Name of Contractor					8. 00

Component CCN: 15-S018

Title XVIII

Subprovi der -

	litle	XVIII	Subprovi der -	PPS	
	I npati en	t Part A		t B	
	mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
	1.00	2.00	3. 00	4. 00	
1.00 Total interim payments paid to provider		278, 276		0	1. 00
2.00 Interim payments payable on individual bills, either		C		0	2.00
submitted or to be submitted to the contractor for					
services rendered in the cost reporting period. If none,					
write "NONE" or enter a zero					
3.00 List separately each retroactive lump sum adjustment					3. 00
amount based on subsequent revision of the interim rate					
for the cost reporting period. Also show date of each					
payment. If none, write "NONE" or enter a zero. (1) Program to Provider					1
3. 01 ADJUSTMENTS TO PROVIDER		0	1	0	3. 01
3. 02				0	
3. 03		Ö		0	3. 03
3.04		ĺ		0	3. 04
3. 05				0	
Provider to Program		·			1
3. 50 ADJUSTMENTS TO PROGRAM		C)	0	3. 50
3. 51		C)	0	3. 51
3. 52		C)	0	3. 52
3. 53		C)	0	3. 53
3. 54		C)	0	3. 54
3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines		C)	0	3. 99
3. 50-3. 98)				_	
4.00 Total interim payments (sum of lines 1, 2, and 3.99)		278, 276)	0	4. 00
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
TO BE COMPLETED BY CONTRACTOR					1
5.00 List separately each tentative settlement payment after					5.00
desk review. Also show date of each payment. If none,					3.00
write "NONE" or enter a zero. (1)					
Program to Provider				•	1
5. 01 TENTATI VE TO PROVI DER		C)	0	5. 01
5. 02		C		0	
5. 03		C		0	5. 03
Provider to Program	1		1	1	
5. 50 TENTATI VE TO PROGRAM		C		0	
5. 51		0		0	
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines				0	5. 52 5. 99
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98))	0	5. 99
6.00 Determined net settlement amount (balance due) based on					6. 00
the cost report. (1)					0.00
6. 01 SETTLEMENT TO PROVIDER		6, 251		0	6. 01
6.02 SETTLEMENT TO PROGRAM		0, 201		Ö	
7.00 Total Medicare program liability (see instructions)		284, 527		0	
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
8.00 Name of Contractor	()	Number 1.00	(Mo/Day/Yr) 2.00	8. 00

Component CCN: 15-T018

Title XVIII Subprovi der -

				I RF		
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		870, 703		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05			0		0	3. 05
	Provider to Program		_		_	
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0	3. 53
3.54	Cultural (0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99)		870, 703		0	4. 00
4.00	(transfer to Wkst. E or Wkst. E-3, line and column as		670, 703		U	4.00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5.02			0		0	5. 02
5.03			0		0	5. 03
	Provider to Program			<u> </u>		
5. 50	TENTATIVE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
/ 00	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
6. 01	the cost report. (1) SETTLEMENT TO PROVIDER		8, 551		o	6. 01
6. 01	SETTLEMENT TO PROVIDER		0, 351		0	6. 01
7. 00	Total Medicare program liability (see instructions)		879, 254		0	
7.00	Total mode out o program traditity (see this tractions)		077, 234	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00
	·					

Heal th	Financial Systems ELKHART GENERAL	HOSPI TAI	In lie	u of Form CMS-2	2552-10
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0018 Period: From 01/01/2017 To 12/31/2017			Worksheet E-1 Part II Date/Time Pre 5/23/2018 2:3	pared:
		Title XVIII	Hospi tal	PPS	
	TO DE COMPLETED DV CONTRACTOR FOR MONOTANDARD COST REPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
1. 00	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION Total hospital discharges as defined in AARA §4102 from Wkst.		. 14		1. 00
2. 00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8		14		2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2	-12			3.00
4. 00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	_12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200	1-12			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of c		Wkst. S-2. Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	9.00 Sequestration adjustment amount (see instructions)				9. 00
10.00	10.00 Calculation of the HIT incentive payment after sequestration (see instructions)				10.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
31. 00	Other Adjustment (specify)				31. 00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	s)		32. 00
				Overri des	
	PONTE ATOR OVEREINE			1. 00	

108. 00

CONTRACTOR OVERRIDES

108.00 Override of HIT payment

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0018	Peri od:	Worksheet E-3
	Companent CCN, 1E CO10	From 01/01/2017	
	Component CCN: 15-S018	10 12/31/2017	5/23/2018 2:39 pm
	Title XVIII	Subprovi der -	PPS
		IPF	

PART 11 - NEDICANE PART SERVICES - IPF PPS		I PF		
PART II - JEDICARE PART A SERVICES - IPF PPS				
1.00 Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments) 334,703 1.00 1.21 2.00 Net IPF PPS Outlier Payments 1.21 2.00 3.00 Net IPF PPS Outlier Payments 0.00 4.00 Unweighted Intern and resident FTE count in the most recent cost report filed on or before November 15, 2004. (see Instructions) 0.00 4.00 4.00 University of the unweighted Intern and resident FTE count for residents that were displaced by progrem or hospital closure, that would not be counted without a temporary cap adjustment under 42 0.00 4.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00		DADT II. MEDICADE DADT A CEDIUCEC. LDE DDC	1.00	
2.00 Net IFP PPS Duthier Payments 12,125 2.00	1 00		254 702	1 00
Net IPF PPS ECT Payments				
Unweighted intern and resident FTE count in the most recent cost report filed on or before November 15, 2004 (see instructions) 4.00				
15, 2004. (see instructions) 4, 01				
Cap Increases for the unweighted intern and resident FIE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR \$412.424(d)(1)(III)(F)(1) or (2) (see instructions)	4.00		0.00	4.00
program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR \$412.424(6) (1) (1) (1) (1) (1) (1) (2) (1) (1) (2) (2) (2) (2) (2) (2) (2) (3) (3) (3) (3) (4) (1) (1) (1) (2) (1) (1) (2) (2) (3) (3) (4) (4) (4) (4) (4) (4) (4) (4) (4) (4	4 01		0.00	4 01
CFR \$412.42(d)(1)(iii)(f)(1) or (2) (see instructions)	1.01		0.00	1.01
5.00 New Teaching program adjustment. (see instructions) 0.00 5.00				
teaching program" (see instructions) 1.00 correct year's unweighted laR FIE count for residents within the new program growth period of a "new teaching program" (see instructions) 1.00 largen and resident count for IPF PPS medical education adjustment (see instructions) 1.00 largen and resident count for IPF PPS medical education adjustment (see instructions) 1.00 largen and lar	5.00		0.00	5. 00
2.00 Current 'year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions) 7. 00	6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	6. 00
teaching program" (see instructions) 0.00 8.00 9.00 Average Dail y Census (see instructions) 7. 235616 9.00 9.00 Average Dail y Census (see instructions) 7. 235616 9.00 11.00 Teaching Adj ustment Factor ((1 + (line B/line 9)) raised to the power of .5150 -1). 0.000000 10.00 11.00 Teaching Adj ustment file 1 multiplied by line 10). 0.0010 12.00 Adjusted Met IPP PSP Payments (sum of lines 1, 2, 3 and 11) 366,828 12.00 13.00 Nursing and Allied Heal th Managed Care payment (see instruction) 0.00 13.00 14.00 Organ acquisition (0.00 NT USE THIS LINE) 1.00 15.00 15.00 Cost of physicians' services in a teaching hospital (see instructions) 366,828 16.00 16.00 Subtotal (see instructions) 366,828 16.00 17.00 Primary payer payments 0.17.00 18.00 Subtotal (line 16 less line 17). 366,828 18.00 19.00 Deductible 366,828 18.00 19.00 Deductible 366,828 18.00 19.00 Deductible 366,828 18.00 19.00 Deductible 366,828 18.00 19.00 Subtotal (line 18 minus line 19) 290,556 20.00 20.00 Subtotal (line 20 minus line 21) 6,580 21.00 21.00 Coinsurance 6,580 21.00 22.00 Subtotal (line 20 minus line 21) 6,580 21.00 23.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 9,480 23.00 24.00 Adjusted relimbursable bad debts (see instructions) 290,556 20.00 25.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 290,138 26.00 25.00 Other pass through costs (see instructions) 0.77.00 26.00 Other pass through costs (see instructions) 0.97.00 27.00 Direct graduate medical education payments (from Wkst. E-4, line 49) 0.97.00 28.00 Other pass through costs (see instructions) 0.99.00 290.00 Other pass through costs (see instructions) 0.99.00		teaching program" (see instuctions)		
S. 00	7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	7. 00
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29.00 Outlier payments reconciliation 0 29.00 30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30.00 30.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 30.50 30.99 Demonstration payment adjustment amount before sequestration 0 30.99 31.00 Total amount payable to the provider (see instructions) 290,334 31.00 31.01 Sequestration adjustment (see instructions) 5,807 31.01 31.02 Demonstration payment adjustment amount after sequestration 0 31.02 32.00 Interim payments 278,276 32.00 33.00 Tentative settlement (for contractor use only) 278,276 32.00 34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 6,251 34.00 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 12,125 50.00 51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 52.00 The rate used to calculate the Time Value of Money				
30.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 30.00 30.50 30.50 90 90 90 90 90 90 90				
30.50 Pioneer ACO demonstration payment adjustment (see instructions) 0 30.50		1		
30.99 Demonstration payment adjustment amount before sequestration 0 30.99 31.00 Total amount payable to the provider (see instructions) 290, 334 31.00 31.01 Sequestration adjustment (see instructions) 5,807 31.01 31.02 Demonstration payment adjustment amount after sequestration 0 31.02 32.00 Interim payments 278, 276 32.00 33.00 Tentative settlement (for contractor use only) 0 33.00 34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 6,251 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 To BE COMPLETED BY CONTRACTOR 12,125 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 12,125 50.00 The rate used to calculate the Time Value of Money 0.00 52.00		· · · · · · · · · · · · · · · · · · ·		
31.00 Total amount payable to the provider (see instructions) 31.01 Sequestration adjustment (see instructions) 31.02 Demonstration payment adjustment amount after sequestration 32.00 Interim payments 33.00 Tentative settlement (for contractor use only) 34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 35.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 35.00 Original outlier amount from Worksheet E-3, Part II, line 2 0 Untlier reconciliation adjustment amount (see instructions) 10.00 The rate used to calculate the Time Value of Money 290, 334 31.00 290, 334 31.00 31.02 278, 276 32.00 32.00 33.00 35.00 Contested amounts (for contractor use only) 36.200 The rate used to calculate the Time Value of Money		· · · · · · · · · · · · · · · · · · ·		
31.01 Sequestration adjustment (see instructions) 5,807 31.01 31.02 Demonstration payment adjustment amount after sequestration 0 31.02 32.00 Interim payments 278,276 32.00 33.00 Tentative settlement (for contractor use only) 0 33.00 34.00 Bal ance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 6,251 34.00 35.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 51.52 TO BE COMPLETED BY CONTRACTOR 0 0 0 0 0 51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 52.00 The rate used to calculate the Time Value of Money 0.00 52.00		1		
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32.00 Interim payments 278, 276 32.00 33.00 Tentative settlement (for contractor use only) 0 33.00 34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 6, 251 34.00 7.00 51.00 52.00 The rate used to calculate the Time Value of Money 278, 276 278, 276 32.00 33.00 33.00 33.00 33.00 33.00 35.00 52.00 33.00 35.00 52.00 52.00 52.00 52.00 52.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 53.00 5				
33.00 Tentative settlement (for contractor use only) 34.00 Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33) 35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 35.00 TO BE COMPLETED BY CONTRACTOR Original outlier amount from Worksheet E-3, Part II, line 2 0 Utlier reconciliation adjustment amount (see instructions) The rate used to calculate the Time Value of Money 0 33.00 35.00 The rate used to calculate the Time Value of Money 0 33.00 35.00 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.251 36.2				
35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 §115.2 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 12, 125 50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00				
35.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 §115.2 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 12, 125 50.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00	34.00	· · · · · · · · · · · · · · · · · · ·	6, 251	34.00
\$115.2 TO BE COMPLETED BY CONTRACTOR 50.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money \$115.2 12,125 50.00 51.00 52.00	35.00			
50.00 Original outlier amount from Worksheet E-3, Part II, line 2 51.00 Outlier reconciliation adjustment amount (see instructions) 52.00 The rate used to calculate the Time Value of Money 12, 125 50.00 51.00 52.00				
51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00		TO BE COMPLETED BY CONTRACTOR		
51.00 Outlier reconciliation adjustment amount (see instructions) 0 51.00 The rate used to calculate the Time Value of Money 0.00 52.00	50.00	Original outlier amount from Worksheet E-3, Part II, line 2	12, 125	50.00
	51.00		0	51.00
53.00 Time Value of Money (see instructions) 0 53.00	52.00	The rate used to calculate the Time Value of Money	0.00	52.00
	53. 00	Time Value of Money (see instructions)	0	53.00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0018	Peri od: From 01/01/2017	Worksheet E-3 Part III
	Component CCN: 15-T018	To 12/31/2017	Date/Time Prepared: 5/23/2018 2:39 pm
	Title XVIII	Subprovi der -	PPS

		Title XVIII	Subprovi der - I RF	PPS	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS			1.00	
1.00	Net Federal PPS Payment (see instructions)			828, 340	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0.0083	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			46, 304	3. 00
4.00	Outlier Payments			28, 748	4. 00
5.00	Unweighted intern and resident FTE count in the most recent co	ost reporting period en	ding on or prior	0.00	5. 00
	to November 15, 2004 (see instructions)		3 '		
5. 01	Cap increases for the unweighted intern and resident FTE coun-	t for residents that were	e displaced by	0.00	5. 01
	program or hospital closure, that would not be counted withou	t a temporary cap adjust	ment under 42		
	CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)				
6.00	New Teaching program adjustment. (see instructions)			0. 00	6. 00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth p	eriod of a "new	0. 00	7. 00
0.00	teaching program" (see instructions)			0.00	0.00
8.00	Current year's unweighted I&R FTE count for residents within	the new program growth p	eriod of a "new	0. 00	8. 00
9. 00	teaching program" (see instructions)	tmont (coo instructions)		0.00	9. 00
10.00	Intern and resident count for IRF PPS medical education adjust Average Daily Census (see instructions)	tillerit (see riistructions)		0. 00 3. 912329	
11. 00	Teaching Adjustment Factor (see instructions)			0. 000000	
12. 00	Teaching Adjustment (see instructions)			0.000000	12.00
13. 00	Total PPS Payment (see instructions)			903, 392	13. 00
14. 00	Nursing and Allied Health Managed Care payments (see instructi	i on)		703, 372	14. 00
15. 00	Organ acquisition (DO NOT USE THIS LINE)	1 011)		O	15. 00
16. 00	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	16. 00
17. 00	Subtotal (see instructions)	1 40 11 0113)		903, 392	
18. 00	Primary payer payments			0	18. 00
19. 00	Subtotal (line 17 less line 18).			903, 392	
20. 00	Deducti bl es			7, 868	20. 00
21. 00	Subtotal (line 19 minus line 20)			895, 524	21. 00
22. 00	Coinsurance			0	22. 00
23.00	Subtotal (line 21 minus line 22)			895, 524	23. 00
24.00	Allowable bad debts (exclude bad debts for professional service	ces) (see instructions)		2, 576	24.00
25.00	Adjusted reimbursable bad debts (see instructions)			1, 674	25.00
26.00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		2, 576	26.00
27.00	Subtotal (sum of lines 23 and 25)			897, 198	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Li	ine 49)		0	28. 00
29. 00	Other pass through costs (see instructions)			0	29. 00
30.00	Outlier payments reconciliation			0	30.00
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		0	31. 50
31. 99	Demonstration payment adjustment amount before sequestration			0	31. 99
32. 00	Total amount payable to the provider (see instructions)			897, 198	
32. 01	Sequestration adjustment (see instructions)			17, 944	32. 01
32. 02	Demonstration payment adjustment amount after sequestration			070.703	32. 02
33. 00	Interim payments			870, 703	33. 00
34. 00	Tentative settlement (for contractor use only)	2 22 and 24)		0 551	34. 00 35. 00
35. 00 36. 00	Balance due provider/program (line 32 minus lines 32.01, 32.0). Protested amounts (nonallowable cost report items) in accordance		chantar 1	8, 551 2, 520	
30.00	§115. 2	ince with this Pub. 15-2, i	chapter i,	2, 520	30.00
	TO BE COMPLETED BY CONTRACTOR				
50. 00				28, 748	50. 00
	Outlier reconciliation adjustment amount (see instructions)			20, 740	51. 00
52. 00				0.00	
	Time Value of Money (see instructions)			0.00	53. 00
-	1		'	- 1	

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0018	Peri od: From 01/01/2017 To 12/31/2017 Worksheet E-3 Part VII Date/Time Prepared: 5/23/2018 2:39 pm

			0 12/31/201/	5/23/2018 2:3	
		Title XIX	Hospi tal	PPS	<u> </u>
	· · · · · · · · · · · · · · · · · · ·		I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0	I	1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant centers only)		0	I	3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	
5. 00	Inpatient primary payer payments		0	I	5. 00
6. 00	Outpatient primary payer payments			0	6. 00
7. 00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable Charges				
8. 00	Routine service charges		0		8. 00
9.00	Ancillary service charges		35, 598, 518	0	
10.00	Organ acquisition charges, net of revenue		0	I	10.00
11. 00	Incentive from target amount computation		05 500 540		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		35, 598, 518	0	12. 00
12 00	CUSTOMARY CHARGES	. comul oco on o obongo	0		12.00
13. 00	Amount actually collected from patients liable for payment for basis	services on a charge	0	0	13. 00
14. 00	Amounts that would have been realized from patients liable for	navment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 4		J	ı	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	12 0110 3410. 10(0)	0. 000000	0. 000000	15. 00
	Total customary charges (see instructions)		35, 598, 518	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete onl	v if line 16 exceeds	35, 598, 518	Ö	17. 00
	line 4) (see instructions)	y re execue	00/0/0/010	ı	
18. 00	Excess of reasonable cost over customary charges (complete onl	v if line 4 exceeds line	0	0	18. 00
	16) (see instructions)	,		1	
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instr	ructions)	0	0	20. 00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1	6)	0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be	completed for PPS provide	rs.		
22.00	Other than outlier payments		0	0	22. 00
23.00	Outlier payments		0	0	23. 00
24.00	Program capital payments		0	I	24. 00
	Capital exception payments (see instructions)		0	I	25. 00
26. 00	Routine and Ancillary service other pass through costs		8, 099	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		8, 099	0	27. 00
	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		8, 099	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30. 00	Excess of reasonable cost (from line 18)		0	0	
	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		8, 099	0	31. 00
32. 00	Deducti bl es		0	0	32. 00
33. 00	Coi nsurance		0	0	33. 00
	Allowable bad debts (see instructions)		0	0	34. 00
	Utilization review		0	1	35. 00
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	1 33)	8, 099	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	_	
	Subtotal (line 36 ± line 37)		8, 099	0	1
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0	1	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		8, 099	0	40. 00
41. 00	Interim payments		0	0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		8, 099	0	42. 00
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				
400.55	OVERRI DES		=1	-	400.00
109.00	Override Ancillary service charges (line 9)		0	, 0	109. 00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0018	Peri od: From 01/01/2017	Worksheet E-3 Part VII	
		Component CCN: 15-S018	To 12/31/2017	Date/Time Prep 5/23/2018 2:3	
		Title XIX	Subprovi der -	PPS	
			IPF		
			I npati ent	Outpati ent	
			1. 00	2. 00	
PART VII - CALCULATION OF REIMBURSEMENT	- ALL OTHER HEALTH SE	RVICES FOR TITLES V OR X	IX SERVICES		
COMPLITATION OF NET COST OF COVERED SERV	ICES				

		Inpati ent	Outpati ent	
		1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES			
1.00	Inpatient hospital/SNF/NF services	0	_	1.00
2.00	Medical and other services	_	0	
3. 00	Organ acquisition (certified transplant centers only)	0	_	3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)	0	0	
5.00	Inpatient primary payer payments	0		5. 00
6.00	Outpatient primary payer payments		0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES			
0.00	Reasonable Charges	٥		0.00
8.00	Routi ne servi ce charges	0	0	8. 00
9.00	Ancillary service charges	609, 278	0	
10.00	Organ acquisition charges, net of revenue	0		10.00
11. 00	Incentive from target amount computation	0	0	11.00
12. 00	Total reasonable charges (sum of lines 8 through 11)	609, 278	0	12.00
13. 00	CUSTOMARY CHARGES	O	0	13.00
13.00	Amount actually collected from patients liable for payment for services on a charge basis	U	U	13.00
14. 00	Amounts that would have been realized from patients liable for payment for services on	0	0	14. 00
14.00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)	o o	U	14.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)	609, 278	0.000000	16. 00
17. 00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	609, 278	0	17.00
17.00	line 4) (see instructions)	007, 270	O	17.00
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	0	0	18. 00
10.00	16) (see instructions)	Ĭ	Ü	10.00
19.00	Interns and Residents (see instructions)	o	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.00
21.00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide	rs.		
22.00	Other than outlier payments	0	0	22. 00
23.00	Outlier payments	0	0	23. 00
24.00	Program capital payments	0		24. 00
25.00	Capital exception payments (see instructions)	0		25. 00
26.00	Routine and Ancillary service other pass through costs	731	0	26. 00
27.00	Subtotal (sum of lines 22 through 26)	731	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)	0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)	731	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	731	0	
32.00	Deducti bl es	0	0	
33.00	Coi nsurance	0	0	
34.00	Allowable bad debts (see instructions)	0	0	
35.00	Utilization review	0		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	731	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	
38. 00	Subtotal (line 36 ± line 37)	731	0	
39. 00	Direct graduate medical education payments (from Wkst. E-4)	0		39. 00
40.00	Total amount payable to the provider (sum of lines 38 and 39)	731	0	
41. 00	Interim payments	0	0	
42. 00	Balance due provider/program (line 40 minus line 41)	731	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	43. 00
	Chapter 1, §115.2			
100.00	OVERRI DES	ء		100.00
109.00	Override Ancillary service charges (line 9)	0	0	109. 00

Heal th	Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0018	Peri od: From 01/01/2017	Worksheet E-3 Part VII	
			Component CCN: 15-T018	To 12/31/2017	Date/Time Prep 5/23/2018 2:39	pared: 9 pm
			Title XIX	Subprovi der -	PPS	
				IRF		
				I npati ent	Outpati ent	
				1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - AL	L OTHER HEALTH SEI	RVICES FOR TITLES V OR XI	X SERVICES		
	COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient hospital/SNF/NF services			0		1.00
2.00	Medical and other services				0	2. 00
3 00	Organ acquisition (certified transplant cen	ters only)		ol		3 00

		1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES			1
1.00	Inpatient hospital/SNF/NF services	0		1.00
2.00	Medical and other services		0	2. 00
3.00	Organ acquisition (certified transplant centers only)	0		3. 00
4. 00	Subtotal (sum of lines 1, 2 and 3)	0	0	1
5. 00	Inpatient primary payer payments	0	O	5. 00
6. 00	Outpatient primary payer payments	U	0	
7. 00				
7.00	Subtotal (line 4 less sum of lines 5 and 6)	0	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES			1
	Reasonable Charges			
8.00	Routi ne servi ce charges	0		8. 00
9.00	Ancillary service charges	291, 197	0	9. 00
10.00	Organ acquisition charges, net of revenue	0		10.00
11. 00	Incentive from target amount computation	0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)	291, 197	0	12.00
	CUSTOMARY CHARGES			1
13.00	Amount actually collected from patients liable for payment for services on a charge	0	0	13. 00
	basis		_	
14. 00	Amounts that would have been realized from patients liable for payment for services on	0	0	14. 00
00	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)		ŭ	
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)	0. 000000	0. 000000	15. 00
16. 00	Total customary charges (see instructions)	291, 197	0.000000	1
17. 00	,		0	1
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	291, 197	Ü	17.00
40.00	line 4) (see instructions)		_	40.00
18. 00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	0	0	18. 00
40.00	16) (see instructions)			40.00
19. 00	Interns and Residents (see instructions)	0	0	
20. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21. 00
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide	rs.		
22.00	Other than outlier payments	0	0	22. 00
23.00	Outlier payments	0	0	23. 00
24.00	Program capital payments	0		24. 00
25.00	Capital exception payments (see instructions)	0		25. 00
26.00	Routine and Ancillary service other pass through costs	0	0	
27. 00	Subtotal (sum of lines 22 through 26)	0	0	
28. 00	Customary charges (title V or XIX PPS covered services only)	o	0	
29. 00	Titles V or XIX (sum of lines 21 and 27)	o	0	1
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	<u> </u>		29.00
30. 00	Excess of reasonable cost (from line 18)	O	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	0	0	31.00
32. 00	Deducti bl es	0	0	
33. 00	Coi nsurance	0	0	
34.00	Allowable bad debts (see instructions)	0	0	34. 00
35. 00	Utilization review	0		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	0	0	36. 00
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	0	37. 00
38.00	Subtotal (line 36 ± line 37)	0	0	38. 00
39.00	Direct graduate medical education payments (from Wkst. E-4)	0		39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)	ol	0	40.00
41. 00	Interim payments	o	0	1
42. 00	Balance due provider/program (line 40 minus line 41)	o	0	1
43. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	
73.00	chapter 1, §115.2	١	U	75.00
	OVERRI DES			1
100.00	Override Ancillary service charges (line 9)	0	^	109. 00
107.00	November The Michigan Service Charges (The 7)	١	Ü	1107.00

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

Provider CCN: 15-0018

Peri od: Worksheet G From 01/01/2017 To 12/31/2017 Date/Time Prepared: 5/23/2018 2:39 pm

		General Fund	Speci fi c	Endowment Fund	5/23/2018 2:3 Plant Fund	9 pm
		Gerier ar Furio	Purpose Fund	Endowniem Fund	Prant Fund	
	DUDDEUT AGOSTO	1.00	2. 00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	14 515 000		ol ol	0	1.00
2.00	Temporary investments	14, 515, 000			0	
3. 00	Notes recei vabl e	0	1		0	
4.00	Accounts receivable	63, 791, 000	į (o o	0	
5.00	Other recei vable	1, 805, 000	(o	0	
6.00	Allowances for uncollectible notes and accounts receivable	-17, 893, 000	(0	0	
7.00	Inventory	7, 076, 000	(0	0	
8. 00 9. 00	Prepaid expenses Other current assets	968, 000	(0	
10.00	Due from other funds	0			0	
11. 00	Total current assets (sum of lines 1-10)	70, 262, 000	1		0	
	FIXED ASSETS	7072027000		۷۱		1 00
12.00	Land	4, 147, 000	(0	0	12. 00
13.00	Land improvements	0	(0	0	
14. 00	Accumulated depreciation	0	(0	0	
15.00	Buildings	250, 819, 000	(0	
16. 00 17. 00	Accumulated depreciation Leasehold improvements	-177, 550, 000	(0	
18. 00	Accumulated depreciation	0			0	
19. 00	Fi xed equipment	113, 851, 000		ol ol	0	
20. 00	Accumulated depreciation	0		o o	0	
21.00	Automobiles and trucks	0	(o	0	21. 00
22. 00	Accumulated depreciation	0	(0	0	
23. 00	Major movable equipment	0	(0	0	
24. 00	Accumulated depreciation	0	(0	0	
25. 00 26. 00	Minor equipment depreciable Accumulated depreciation	0	(0	
27. 00	HIT desi gnated Assets				0	
28. 00	Accumulated depreciation	0			0	
29. 00	Mi nor equi pment-nondepreci abl e	l o		ol ol	0	
30.00	Total fixed assets (sum of lines 12-29)	191, 267, 000	(o	0	30.00
	OTHER ASSETS					
31.00	Investments	0	7, 168, 000		0	
32. 00	Deposits on Leases	0	(0	0	
33. 00 34. 00	Due from owners/officers Other assets	5, 987, 000	(0	
35. 00	Total other assets (sum of lines 31-34)	5, 987, 000			0	
36. 00	Total assets (sum of lines 11, 30, and 35)	267, 516, 000			0	
	CURRENT LIABILITIES			- '		
37.00	Accounts payable	20, 854, 000	(0	0	37. 00
38. 00	Salaries, wages, and fees payable	0	(0	0	
39. 00	Payroll taxes payable	0	(0	0	
40.00	Notes and Loans payable (short term)	2, 953, 000			0	
41. 00 42. 00	Deferred income Accel erated payments	0			0	41. 00 42. 00
43. 00	Due to other funds	0	(0	1
44. 00	Other current liabilities	1, 135, 000		ol ol	0	
45.00	Total current liabilities (sum of lines 37 thru 44)	24, 942, 000	1	0	0	45. 00
	LONG TERM LIABILITIES			_		
46. 00	Mortgage payable	0	(1 1	0	
47. 00	Notes payable	0	(0	
48. 00 49. 00	Unsecured Loans Other Long term Liabilities	84, 172, 000	l .	0	0	
50.00	Total long term liabilities (sum of lines 46 thru 49)	84, 172, 000			0	
51.00	Total liabilities (sum of lines 45 and 50)	109, 114, 000		ol ol		
	CAPI TAL ACCOUNTS			-,		
52.00	General fund balance	158, 402, 000				52. 00
53.00	Specific purpose fund		7, 168, 000			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant				0	56. 00 57. 00
J1. UU	prant rund parance - riivested rii prant				0	
58 00	Plant fund balance - reserve for plant improvement					,
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion					
58. 00 59. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion Total fund balances (sum of lines 52 thru 58)	158, 402, 000	7, 168, 000	0	0	
	replacement, and expansion Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	158, 402, 000 267, 516, 000				59. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)				0	59.0

Provider CCN: 15-0018

					10 12/31/2017	5/23/2018 2:39	
		General	Fund	Special F	Purpose Fund	Endowment Fund	
				·			
		1.00	2.00	2.00	4.00	F 00	
1 00	Fund balances at beginning of period	1.00	2. 00 141, 246, 000	3. 00	4. 00 6. 514. 000	5. 00	1. 00
1. 00 2. 00	Net income (loss) (from Wkst. G-3, line 29)		18, 421, 000		6, 514, 000		2. 00
3.00	Total (sum of line 1 and line 2)		159, 667, 000		6, 514, 000		3. 00
4.00	ASSETS RELEASED FROM RESTRICTION	138, 000	137, 007, 000		0, 514, 000	o	4. 00
5.00	INVESTMENT INCOME	138,000		654, 00	~	0	5. 00
6.00	THVESTMENT TNCOME			054, 00	0	0	6. 00
7. 00					0	0	7. 00
8. 00					0	0	8. 00
9. 00		0			0	0	9. 00
10. 00	Total additions (sum of line 4-9)		138, 000		654, 000	Ĭ	10. 00
11. 00	Subtotal (line 3 plus line 10)		159, 805, 000		7, 168, 000		11. 00
12. 00	TRANSFERRED TO BEACON HEALTH SYSTEM	4, 990, 000	.07,000,000		0	0	12. 00
13. 00	POST RETIREMENT ADJ OTHER THAN PERIO	-3, 587, 000			0	Ö	13. 00
14. 00	TOOL NETTHEMENT AND OTHER THANK FERRO	0			0	0	14. 00
15. 00		0			0	o	15. 00
16, 00		o			0	o	16, 00
17. 00		0			0	0	17. 00
18.00	Total deductions (sum of lines 12-17)		1, 403, 000		0		18.00
19.00	Fund balance at end of period per balance		158, 402, 000		7, 168, 000		19.00
	sheet (line 11 minus line 18)						
		Endowment Fund	PI ant	Fund			
		(00	7.00	0.00	_		
1 00	Fund halanasa at baginning of namind	6.00	7. 00	8. 00	0		1 00
1. 00 2. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)				U .		1. 00 2. 00
3.00	Total (sum of line 1 and line 2)				0		3. 00
4.00	ASSETS RELEASED FROM RESTRICTION	۷	0		U		4. 00
5.00	INVESTMENT INCOME		0				5. 00
6. 00	TINVESTMENT TINCOME		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	J		0		10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12. 00	TRANSFERRED TO BEACON HEALTH SYSTEM]	0				12. 00
13. 00	POST RETIREMENT ADJ OTHER THAN PERIO		0				13. 00
14.00			0				14.00
15. 00			0				15. 00
16. 00			0				16.00
17. 00			0				17. 00
18.00	Total deductions (sum of lines 12-17)	o			0		18.00
19.00	Fund balance at end of period per balance	0			0		19.00
	sheet (line 11 minus line 18)						

Health Financial Systems
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0018

			0 12/31/201/	5/23/2018 2:3	
	Cost Center Description	Inpati ent	Outpati ent	Total	
	•	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	82, 466, 658	3	82, 466, 658	1. 00
2.00	SUBPROVI DER - I PF	4, 921, 954	Į.	4, 921, 954	2. 00
3.00	SUBPROVI DER - I RF	2, 302, 634	Į.	2, 302, 634	3. 00
4.00	SUBPROVI DER				4.00
5.00	Swi ng bed - SNF			0	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY			0	7. 00
8.00	NURSING FACILITY)	0	8. 00
9.00	OTHER LONG TERM CARE)	0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	89, 691, 246	b	89, 691, 246	10. 00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	17, 984, 337	'	17, 984, 337	11. 00
11. 01	NEONATAL INTENSIVE CARE	2, 447, 454	1	2, 447, 454	
12.00	CORONARY CARE UNIT)	0	12. 00
13.00	BURN INTENSIVE CARE UNIT)	0	13. 00
14.00	SURGI CAL INTENSIVE CARE UNIT)	0	14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	20, 431, 79		20, 431, 791	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	110, 123, 037		110, 123, 037	17. 00
18. 00	Ancillary services	310, 809, 146			1
19. 00	Outpati ent servi ces	9, 528, 516	50, 613, 173		
20. 00	RURAL HEALTH CLINIC		-	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	21. 00
22. 00	HOME HEALTH AGENCY		0	0	22. 00
23. 00	AMBULANCE SERVICES		0	0	23. 00
24. 00	CMHC		0	0	24. 00
24. 10	CORF		0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		0	0	25. 00
26. 00	HOSPI CE		0	0	26. 00
27. 00	NURSERY	3, 522, 841		-, -==,	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	433, 983, 540	392, 776, 555	826, 760, 095	28. 00
	G-3, line 1)				
00.00	PART II - OPERATING EXPENSES		055 007 004		00.00
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		255, 906, 321		29. 00
30.00	ADD (SPECIFY)	(1		30.00
31.00		(31.00
32. 00		(32.00
33. 00		(1		33.00
34. 00 35. 00					34. 00 35. 00
	T-+-1)		
36. 00 37. 00	Total additions (sum of lines 30-35)		Ü		36. 00 37. 00
	DEDUCT (SPECIFY)				
38. 00 39. 00					38. 00 39. 00
39. 00 40. 00			1		40.00
40.00					40.00
41.00	Total deductions (sum of lines 37-41)		΄		41.00
42.00	,	<u>_</u>	255 004 221		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe to Wkst. G-3, line 4)	'	255, 906, 321		43.00
	10 m/st. 0 3, 1116 4/	I	I	I	I

	5	ELIVIADT OFNEDAL	UOCDI TAI		6.5. 040.4	2550 40
	Financial Systems	ELKHART GENERAL			u of Form CMS-2	2552-10
STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0018	Peri od: From 01/01/2017	Worksheet G-3	
				To 12/31/2017	Date/Time Pre	nared:
				10 12/31/2017	5/23/2018 2: 3	
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part	I, column 3, line	e 28)		826, 760, 095	1. 00
2.00	Less contractual allowances and discounts on	patients' accoun	ts		562, 657, 006	2.00
3.00	Net patient revenues (line 1 minus line 2)				264, 103, 089	3.00
4.00	Less total operating expenses (from Wkst. G-2	, Part II, line	43)		255, 906, 321	4.00
5.00	Net income from service to patients (line 3 m	inus line 4)			8, 196, 768	5.00
	OTHER I NCOME					
6.00	Contributions, donations, bequests, etc				0	6. 00
7.00	Income from investments				0	7. 00
8.00	Revenues from telephone and other miscellaneo	us communication	servi ces		0	8. 00
9.00	Revenue from television and radio service				0	9. 00
10.00	Purchase di scounts				140, 965	10.00
11.00	Rebates and refunds of expenses				704, 474	11. 00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				151, 637	13.00
14.00	Revenue from meals sold to employees and gues	ts			442, 442	14.00
15. 00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgical supp	plies to other the	han patients		0	16.00
17.00	Revenue from sale of drugs to other than pation	ents			179, 950	17. 00
18. 00	Revenue from sale of medical records and abst	racts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, e	tc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and	d canteen			0	20.00
21. 00	Rental of vending machines				0	21. 00
22. 00	Rental of hospital space				0	22. 00
23. 00	Governmental appropriations				0	23. 00
	OTHER				8, 975, 573	
05 00	T 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1				40 505 044	05 00

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

27.00 LOSS ON BOND REFUNDING & INVESTMENTS
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0018	Peri od: From 01/01/2017 To 12/31/2017	Worksheet L Parts I-III Date/Time Pre 5/23/2018 2:3	pared: 9 pm
		Title XVIII	Hospi tal	PPS	
	<u> </u>		<u> </u>		
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier				1.0
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1.0
2. 00	Capital DRG outlier payments			93, 966	2.0
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2.0
3. 00	Total inpatient days divided by number of days in the cost r	eporting period (see inst	tructions)	103. 55	3.0
4. 00	Number of interns & residents (see instructions)			0. 00	4. 0
5.00	Indirect medical education percentage (see instructions)			0. 00 0	5.0
6. 00					6. 0
7. 00	1.01) (see instructions)	nationt days (Warkshoot [- nomt Alimo	2.02	7.0
7.00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions)			3. 92	/. 0
3. 00	Percentage of Medicaid patient days to total days (see instructions)			22. 02	8.0
9. 00	Sum of lines 7 and 8			25. 94	9.0
0.00				5. 39	
11.00				149, 010	
12. 00					
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions)				1.0
2. 00	Program inpatient ancillary capital cost (see instructions)			0	2.0
3. 00	Total inpatient program capital cost (line 1 plus line 2)			0	3.0
4. 00	Capital cost payment factor (see instructions)			0	4.0
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.0
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
1.00	Program inpatient capital costs (see instructions)			0	1.0
2. 00	Program inpatient capital costs for extraordinary circumstances (see instructions)			0	2.0
3. 00	Net program inpatient capital costs (line 1 minus line 2)			0	3.0
1.00	Applicable exception percentage (see instructions)			0.00	4.0
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0	5.0
	Percentage adjustment for extraordinary circumstances (see i			0.00	6.0
	Adjustment to capital minimum payment level for extraordinar	y circumstances (line 2)	(line 6)	0	7.0
. 00				0	8.0
7. 00 3. 00	Capital minimum payment level (line 5 plus line 7)			_	
7.00 3.00 9.00	Current year capital payments (from Part I, line 12, as appl			0	
7.00 3.00 9.00 10.00	Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to	capital payments (line 8		0	10. 0
7. 00 8. 00 9. 00 10. 00	Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over	capital payments (line 8			10.0
7. 00 8. 00 9. 00 10. 00 11. 00	Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payments (line 8 capital payment (from pri	or year	0	9. 0 10. 0 11. 0
6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p	capital payments (line 8 capital payment (from pri ayments (line 10 plus lir	or year ne 11)	0	10. 0 11. 0
7. 00 8. 00 9. 00 10. 00 11. 00	Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payments (line 8 capital payment (from pri ayments (line 10 plus line the amount on this line	or year ne 11) e)	0	10. (11. (

0 15.00 0 16.00 0 17.00

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)

16.00 Current year operating and capital costs (see instructions)

17.00 Current year exception offset amount (see instructions)