This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0018 Worksheet S Peri od: From 01/01/2018 Parts I-III AND SETTLEMENT SUMMARY 12/31/2018 Date/Time Prepared: 5/29/2019 7:11 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically filed cost report Date: 5/29/2019 7:11 am use only Manually submitted cost report] If this is an amended report enter the number of times the provider resubmitted this cost report] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[12] [9] If line 5, column 1 is 4: Enter
[13] NPR Date:
[14] 12. Contractor's Vendor Code:
[15] 13. NPR Date:
[16] 13. NPR Date:
[17] 14. Contractor's Vendor Code:
[18] 15. Contractor's Vendor Code:
[18] 16. NPR Date:
[19] 17. Contractor's Vendor Code:
[19] 18. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[19] Contractor use only (3) Settled with Audit number of times reopened = 0-9.

PART II - CERTIFICATION

(4) Reopened (5) Amended

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

CERTIFICATION BY 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 01/01/2018 and ending 12/31/2018 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 aned) Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	246, 997	-12, 952	0	5, 769	1. 00
2.00	Subprovi der – I PF	0	16, 840	0		459	2. 00
3.00	Subprovider - IRF	0	-13, 840	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	249, 997	-12, 952	0	6, 228	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. 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. 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.

poes this hospital contain at least 100 but not more counted in accordance with 42 CFR 412.105)? Enter in yes or "N" for no. 23.00 Which method is used to determine Medicaid days on I below? In column 1, enter 1 if date of admission, 2 if date of discharge. Is the method of identifying reporting period? In column 2, enter "Y" for yes on the state of the second se	e than 499 be n column 3, ' ines 24 and, if census da the days in the prior cos	eds (as "Y" for /or 25 ays, or 3 this cost		3 1	N		23. 00
	In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medicaid HMO days	Other Medi cai d days	
	1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
24.00 If this provider is an IPPS hospital, enter the 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.		2, 535	0	328	4, 791	0	24.00

Health Financial Systems ELKHAR	T GENERAL I	HOSPI TAL		_	In Lie	u of Fo	rm CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC	CN: 15-0018	Period: From 01/	01/2018	Worksh Part I	eet S-2	
					31/2018	Date/T	ime Pre	
	In-State	In-State	Out-of	Out-of	Medi ca		<u>019 7:1</u>)ther	i aiii
	Medi cai d	Medi cai d	State	State	HMO da	J .	di cai d	
	paid days	el i gi bl e unpai d	Medicaid paid days	Medicaid eligible		'	days	
		days		unpai d				
25 00 L6 this grant day is an LD5 sector that is state	1.00	2.00	3. 00	4. 00	5.00		6. 00	25.00
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state	(119	0	C	'	89		25. 00
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.								
					Rural S 00	Date of	Geogr 00	
26.00 Enter your standard geographic classification (not wa	age) status	s at the bed	ginning of t		1	Ζ.	00	26. 00
cost reporting period. Enter "1" for urban or "2" for	r rural.				_			
27.00 Enter your standard geographic classification (not wareporting period. Enter in column 1, "1" for urban on				t	1			27. 00
enter the effective date of the geographic reclassifi			opi i cabi c,					
35.00 If this is a sole community hospital (SCH), enter the	e number of	f periods SC	CH status in		C			35. 00
effect in the cost reporting period.				Begi r	nni ng:	Endi	ng:	
0/ 00 5 1			24.6	1.	00	2.	00	0
36.00 Enter applicable beginning and ending dates of SCH since of periods in excess of one and enter subsequent date		script line	36 for numb	er				36.00
37.00 If this is a Medicare dependent hospital (MDH), enter		er of period	ds MDH statu	s	C			37. 00
is in effect in the cost reporting period.	ao MDU +	acitional ==	wmont : n					27 01
37.01 Is this hospital a former MDH that is eligible for the accordance with FY 2016 OPPS final rule? Enter "Y" for								37. 01
instructions)	,		•					
38.00 If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of								38.00
enter subsequent dates.	i perrous i	ii excess oi	one and					
					/N	Y,		
39.00 Does this facility qualify for the inpatient hospital	l payment a	adiustment f	for low volu		00 N		00 N	39. 00
hospitals in accordance with 42 CFR §412.101(b)(2)(i)), (ii), or	´(iii)? Ent	ter in colum					
1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii)								
or "N" for no. (see instructions)	ii): Liitei	TH COLUMN 2	z i ioi ye	3				
40.00 Is this hospital subject to the HAC program reduction					N	1	١	40.00
"N" for no in column 1, for discharges prior to Octol no in column 2, for discharges on or after October 1.		,	es or "N" r	or				
		,		<u>'</u>	V	XVIII		
Prospective Payment System (PPS)-Capital					1.00	0 2.00	3.00	
45.00 Does this facility qualify and receive Capital payment	nt for disp	proporti onat	te share in	accordance	· N	Y	N	45. 00
with 42 CFR Section §412.320? (see instructions)	ontion for	ovtroond:	.m., ol ========	ancoc		, NI	l NI	14 00
46.00 Is this facility eligible for additional payment exception pursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46. 00
Pt. III.				_				
47.00 Is this a new hospital under 42 CFR §412.300(b) PPS (48.00 Is the facility electing full federal capital paymen					N N	l N N	N N	47. 00 48. 00
Teaching Hospitals	t. Enter	1 101 yes	01 11 101	110.	1 11		1 1	10.00
56.00 Is this a hospital involved in training residents in	approved (GME programs	s? Enter "Y	" for yes	N			56. 00
or "N" for no. 57.00 If line 56 is yes, is this the first cost reporting process.	period duri	na which re	esidents in	approved				57.00
GME programs trained at this facility? Enter "Y" for	r yes or "N	√l for no ir	n column 1.	If column				
is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is "'					·"			
"N", complete Wkst. D, Parts III & IV and D-2, Pt. II			4. 11 60	1 4 1 5				
58.00 If line 56 is yes, did this facility elect cost reim			ans' service	s as				58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 59.00 Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		l N			59.00
<i>y</i> .			NAHE 413.8		heet A		hrough	
			Y/N	Lir	ne #		cation	
						Cirteri	on Code	
			1. 00	2.	00	3.	00	
60.00 Are you claiming nursing and allied health education any programs that meet the criteria under §413.85?			Y					60.00
60.01 If line 60 is yes, complete columns 2 and 3 for each					23. 00		l	60. 01
i nstructi ons)	- ·							

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 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 7:11 am Y/N IME Direct GME IME Direct GME 3. 00 1.00 2.00 4.00 5.00 0.00 61.00 61.00 Did your hospital receive FTE slots under ACA 0 00 Ν section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61 04 Enter the number of unweighted primary care/or 61.04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions) 61.06 Enter the amount of ACA \$5503 award that is being 61.06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Program Code Unweighted IME Unweighted Program Name FTE Count Direct GME FTE Count 1.00 2.00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program 0. 00 0.00 61.10 specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61.20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) Enter the number of FTE residents that your hospital trained in this cost reporting period for which 0.00 62.00 62.00 your hospital received HRSA PCRE funding (see instructions) Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital 62.01 0.00 62.01 during in this cost reporting period of HRSA THC program. (see instructions) Teaching Hospitals that Claim Residents in Nonprovider Settings 63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions) 63.00 Ν Unwei ghted Unwei ghted Ratio (col. (col. 1 + col FTEs in FTEs Nonprovi der Hospi tal 2)) Si te 1. 00 2.00 3.00

Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings--This base year is your cost reporting

0.00

0.00

0.000000 64.00

period that begins on or after July 1, 2009 and before June 30, 2010.

64.00 Enter in column 1, if line 63 is yes, or your facility trained residents

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)

in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider

From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 7:11 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. 3/ (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most 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)

	eriod: fom 01/01/2018 o 12/31/2018	Worksheet S- Part I Date/Time Pr 5/29/2019 7:	repared
		1. 00	
Long Term Care Hospital PPS 1.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 1.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting "Y" for yes and "N" for no.	period? Enter	N N	80. C 81. C
TEFRA Providers 1.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes on Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.		N	85. C
5413.40()(1)(1): Eitter Fill yes and North Hollows. 1.00 Is this hospital an extended neoplastic disease care hospital classified under section [1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		N	87. 0
11000(d) (1) (01) . Enter 1 101 yes of 11 101 110.	V 1. 00	XI X 2. 00	
Title V and XIX Services	1.00	2.00	
Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for yes or "N" for no in the applicable column.	N	Υ	90. 0
.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in full or in part? Enter "Y" for yes or "N" for no in the applicable column.	N	Υ	91. (
.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		N	92. (
instructions) Enter "Y" for yes or "N" for no in the applicable column. Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter "Y" for yes or "N" for no in the applicable column.	N	N	93. 0
Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the applicable column.	N	N	94. (
5.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 5.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0. 00 N	0. 00 N	95. (96. (
applicable column.	0. 00		
1.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 1.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y" for yes or "N" for no in	0. 00 N	97. 98.	
column 1 for title V, and in column 2 for title XIX. 1.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for	N	Y	98.
title XIX. 1. 02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1	Y	98.	
for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	98.	
Does title V, and III Coldmil 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	N	98.
8.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.
B. 06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.	N	Y	98.
Rural Providers 5.00 Does this hospital qualify as a CAH?	N		105.
6.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)			106.
7.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement for I&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) If yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the program is cost			107.
reimbursed. If yes complete Wkst. D-2, Pt. II. 8.00 s this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	N		108.
Physical Occupational	Speech	Respi ratory	
1.00 2.00 19.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	3.00	4.00	109.
p.o. years. In for no for each thorapy.			
0.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§41 Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If		1. 00 N	110.

ealth Financial Systems ELKHART GENERAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	- HOSPITAL Provider CCN: 15-0018	Period: From 01/01, To 12/31,	/2018	Worksheet Part I Date/Time 5/29/2019	Prepared:
		1.00		2.00	-
11.00 If this facility qualifies as a CAH, did it participate in the Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to colintegration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	st reporting period? Ente umn 1 is Y, enter the icipating in column 2.	r		2.00	111.00
			1. 00	2.00 3.	00
Miscellaneous Cost Reporting Information 15.00 s 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" percent psychiatric, rehabilitation and long term hospitals providers Pub. 15-1, chapter 22, §2208.1. 16.00 s this facility classified as a referral center? Enter "Y" for yes or is yes.	If column 2 is "E", enter for long term care (inc s) based on the definition	r in column Iudes	N N		115. 00
17.00 s this facility legally-required to carry malpractice insura		r "N" for	Y		117. 00
18.00 s the mal practice insurance a claims-made or occurrence policlaim-made. Enter 2 if the policy is occurrence.	cy? Enter 1 if the polic	y is	1		118.00
	Premi ums	Losse	S	Insuranc	е
	1.00	2.00		3.00	
18.01 List amounts of malpractice premiums and paid losses:	546,	108 1	8, 577		0 118. 0
		1.00		2.00	
18.02 Are mal practice premiums and paid losses reported in a cost of Administrative and General? If yes, submit supporting scheduland amounts contained therein. 19.00 DO NOT USE THIS LINE	le listing cost centers	N			118. 02
20.00 s 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 qua Hold Harmless provision in ACA §3121 and applicable amendment 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 implan 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 defi 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. 0
Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N" for no. If	N			125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 of this is a Medicare certified kidney transplant center, ent		е			126. 0
in column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, ente in column 1 and termination date, if applicable, in column 2.	er the certification date				127. 0
28.00 If this is a Medicare certified liver transplant center, ente in column 1 and termination date, if applicable, in column 2.	er the certification date				128. 0
29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2.		in			129. 0
30.00 If this is a Medicare certified pancreas transplant center, e date in column 1 and termination date, if applicable, in colu					130. 0
31.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu	ımn 2.				131. 0
32.00 If this is a Medicare certified islet transplant center, ente in column 1 and termination date, if applicable, in column 2.					132. 0
33.00 f this is a Medicare certified other transplant center, ente in column 1 and termination date, if applicable, in column 2.					133. 0
34.00 f this is an organ procurement organization (0PO), enter the and termination date, if applicable, in column 2.	e uru number in column 1				134. 0
40.00 Are there any related organization or home office costs as de chapter 10? Enter "Y" for yes or "N" for no in column 1. If y		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 01/01/2018 Part I 12/31/2018 Date/Time Prepared: To 5/29/2019 7:11 am 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: 142.00 143.00 City: SOUTH BEND State: Zip Code: 46601 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 Hospi tal Ν Ν Ν N 155 00 156.00 Subprovi der - IPF Ν 156. 00 Ν Ν Ν 157.00 Subprovi der - IRF 157 00 Ν Ν Ν N 158. 00 SUBPROVI DER 158.00 159.00 SNF N Ν Ν N 159. 00 160.00 HOME HEALTH AGENCY 160.00 Ν Ν Ν Ν 161.00 CMHC Ν Ν N 161.00 161. 10 CORF N Ν 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. County CBSA FTE/Campus State Zip Code Name 0 1.00 2.00 3.00 4.00 5.00 166.00 If line 165 is yes, for each 0.00166.00 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 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 167. 00 168.00|If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the d168. 00 reasonable cost incurred for the HIT assets (see instructions)

a hardshi p		168. 01
N"), enter the	9. 9	9169.00
Begi nni ng	Endi ng	
1. 00	2.00	
01/01/2018	12/31/2018	170. 00
1. 00	2.00	
N	(0 171. 00
	Beginning 1.00 01/01/2018	Beginning Ending 1.00 2.00 01/01/2018 12/31/2018 1.00 2.00 N

OSPI 7	n Financial Systems ELKHART GENER TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-0018	Peri od:	u of Form CMS- Worksheet S-2	
				From 01/01/2018 To 12/31/2018	Date/Time Pre	epared
				V (1)	5/29/2019 7:1	11 am
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N	l for all NO ro	cnoncoc Ente	1.00	2. 00	
	mm/dd/yyyy format.	riorari no re	sponses. Ente	all dates ill t	.rie	
	COMPLETED BY ALL HOSPITALS					
00	Provider Organization and Operation Has the provider changed ownership immediately prior to the	hoginning of	the cost	N		1.0
00	reporting period? If yes, enter the date of the change in c	column 2. (see	instructions)			'.'
	1 - 1 - 2 - 3 - 1		Y/N	Date	V/I	
			1. 00	2. 00	3. 00	
00	Has the provider terminated participation in the Medicare F		N			2.
	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.	III 3, V 101				
00	Is the provider involved in business transactions, includir	ng management	N			3.
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provide					
	officers, medical staff, management personnel, or members of directors through ownership, control, or family and other					
	relationships? (see instructions)	or or mirror				
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2. 00	3. 00	+
00	Column 1: Were the financial statements prepared by a Cert	ified Public	Υ	А		4.0
	Accountant? Column 2: If yes, enter "A" for Audited, "C" f					
	or "R" for Reviewed. Submit complete copy or enter date ava	ailable in				
00	column 3. (see instructions) If no, see instructions. Are the cost report total expenses and total revenues difference.	ront from	Y			5.0
00	those on the filed financial statements? If yes, submit rec		'] 5. \
	, , , , , , , , , , , , ,		!	Y/N	Legal Oper.	
				1. 00	2. 00	
00	Approved Educational Activities	lf voo in th	a providor is	. NI		١,,
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program?	ir yes, is th	ie provider is	N N		6.0
00	Are costs claimed for Allied Health Programs? If "Y" see in	nstructions.		Υ		7. 0
00	Were nursing school and/or allied health programs approved	and/or renewed	I during the	N		8.0
00	cost reporting period? If yes, see instructions.			.,		
00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction		ar education	N		9. 0
0. 00	Was an approved Intern and Resident GME program initiated of		he current	N		10.0
	cost reporting period? If yes, see instructions.					
1. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11. (
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1. 00	
	Bad Debts					
2. 00					Υ	12. (
3. 00		oolicy change d	luring this co	st reporting	N	13. (
1 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments.	ents waived? If	ves see ins	tructions	N	14. (
1. 00	Bed Complement	ones war ved: 11	yes, see 1112	tti de ti ons.	IV	' - ' \
5. 00	Did total beds available change from the prior cost reporti	ng period? If	yes, see inst		N	15. (
			t A		t B	
		Y/N 1.00	2. 00	Y/N	Date 4. 00	
	PS&R Data	1.00	2.00	3. 00	4.00	
5. 00		N		N		16. (
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 (see					
7. 00	instructions) Was the cost report prepared using the PS&R Report for	Y	04/03/2019	Υ	04/03/2019	17. (
. 00	totals and the provider's records for allocation? If	'	0470372017	'	047 037 2017	''.
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
3. 00		N		N		18. (
	Report data for additional claims that have been billed but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
9. 00		N		N		19. (
	Report data for corrections of other PS&R Report		1			
	information? If yes, see instructions.					

Heal th	Financial Systems ELKHART GENER	RAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der (CCN: 15-0018	Peri od: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Pre 5/29/2019 7:1	pared:
		Descr	i pti on	Y/N	Y/N	
00.00	1611 47 47	DEAL LOCATIONS	0	1.00	3. 00	00.00
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:	REALLOCATIONS CTC RATIO	FOR CORRECT	N	N	20. 00
	neport data for other: beserbe the other day definents.	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	FPT CHILDRENS	HOSPI TALS)		1.00	
	Capital Related Cost		,			1
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.				N	23. 00
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	<u> </u>			N	24. 00
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period?	If yes, see	N	25. 00
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during the instructions.	ne cost report	ing period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? If	yes, submit	N	27. 00
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	N	28. 00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29. 00			
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	N	30. 00			
31. 00	instructions. Has debt been recalled before scheduled maturity without is	, see	N	31. 00		
	Instructions. Purchased Services					1
32. 00	Have changes or new agreements occurred in patient care ser	rvi ces furni sh	ed through co	ntractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans					1
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement wit	h provi der-ba	sed physicians?	Υ	34. 00
35. 00	If line 34 is yes, were there new agreements or amended exiphysicians during the cost reporting period? If yes, see in		nts with the	provi der-based	Υ	35. 00
				Y/N	Date	
	lu occi			1. 00	2. 00	
36. 00	Home Office Costs Were home office costs claimed on the cost report?			Y		36. 00
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by the	home office?			37. 00
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00
39. 00	If line 36 is yes, did the provider render services to other see instructions.			, N		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see	N		40. 00
		1	. 00	2.	00	
41. 00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	SALLY		BRUBAKER		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	ELKHART GENER	AL HOSPITAL			42. 00
	preparer.					
43. 00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	574-647-3842		SBRUBAKER@BEACO . ORG	ONHEALTHSYSTEM	43. 00

Health Financial Systems ELKHART	T GENERAL HOSPITAL In Lieu of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIR	From 01/01/2018 Part II To 12/31/2018 Date/Time Pres	pared:
	5/29/2019 7: 1	1 am
	3.00	
Cost Report Preparer Contact Information		
41.00 Enter the first name, last name and the title/position		41. 00
held by the cost report preparer in columns 1, 2, and	d 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 c	cost	43.00
report preparer in columns 1 and 2, respectively.		

Health Financial Systems ELKHART HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0018

				To	12/31/2018	Date/Time Prep 5/29/2019 7:1	
						I/P Days / 0/P	ı allı
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
	55ponont	Line Number		Avai I abl e	07.11 11041 0		
		1. 00	2. 00	3.00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00	169		0.00		1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)						2. 00
3.00	HMO IPF Subprovider						3. 00
4.00	HMO IRF Subprovider						4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF					0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF					0	6. 00
7. 00	Total Adults and Peds. (exclude observation		169	61, 685	0. 00	0	7. 00
0.00	beds) (see instructions)	04.00	0.0	0.005	0.00		0.00
8.00	INTENSIVE CARE UNIT	31. 00			0.00		8. 00
8. 01	NEONATAL INTENSIVE CARE	31. 01	8	· ·	0.00		8. 01
9.00	CORONARY CARE UNIT	32. 00			0.00		9.00
10.00	BURN INTENSIVE CARE UNIT	33. 00			0.00		10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34. 00	0	U U	0. 00	ا	11. 00
12. 00 13. 00	OTHER SPECIAL CARE (SPECIFY) NURSERY	42.00					12. 00 13. 00
14. 00	4	43. 00	200	73, 000	0.00	0	14. 00
15. 00	Total (see instructions) CAH visits		200	73,000	0.00		15. 00
16. 00	SUBPROVIDER - IPF	40. 00	10	3, 650		0	16. 00
17. 00	SUBPROVIDER - I RF	41. 00					17. 00
18. 00	SUBPROVI DER	41.00	20	7,300		١	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00	0	0		ol	19. 00
20. 00	NURSING FACILITY	45. 00	0			l ől	20. 00
21. 00	OTHER LONG TERM CARE	46. 00	-				21. 00
22. 00	HOME HEALTH AGENCY	101. 00				0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00				ا	23. 00
24. 00	HOSPI CE	116. 00	0	o			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00	· -				24. 10
25.00	CMHC - CMHC	99. 00				o	25. 00
25. 10	CMHC - CORF	99. 10				0	25. 10
26.00	RURAL HEALTH CLINIC	88. 00				l ol	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		230				27. 00
28. 00	Observation Bed Days					0	28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges		1			i l	33. 01

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/29/2019 7:11 am

				'		5/29/2019 7:1	1 am
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6. 00	7. 00	8. 00	9. 00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	12, 915	734	32, 700		10.00	1.00
	8 exclude Swing Bed, Observation Bed and	12, 7.10	, , ,	02,700			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	6, 846	7, 497				2.00
3.00	HMO IPF Subprovider	159	1, 071				3.00
4.00	HMO IRF Subprovider	195	119				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	o	o	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	12, 915	734	32, 700			7. 00
8.00	INTENSIVE CARE UNIT	1, 928	0	4, 928			8.00
8. 01	NEONATAL INTENSIVE CARE	0	o	744			8. 01
9.00	CORONARY CARE UNIT	ol	o	0			9. 00
10.00	BURN INTENSIVE CARE UNIT	ol	o	0			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	ol	o	0			11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		115	2, 256			13.00
14.00	Total (see instructions)	14, 843	849	40, 628		1, 240. 95	14.00
15.00	CAH visits	0	o	0			15. 00
16.00	SUBPROVI DER - I PF	602	105	3, 040	0.00	20. 59	16. 00
17.00	SUBPROVI DER - I RF	583	89	1, 514	0.00	14. 21	17. 00
18.00	SUBPROVI DER						18. 00
19. 00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	
20.00	NURSING FACILITY		0	0	0.00	0.00	20. 00
21. 00	OTHER LONG TERM CARE			0	0.00		21. 00
22. 00	HOME HEALTH AGENCY	0	0	0		l	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)				0.00		23. 00
24. 00	HOSPI CE	0	0	0		0.00	24. 00
24. 10	HOSPICE (non-distinct part)	_	_	54			24. 10
25. 00	CMHC - CMHC	0	0	0		•	
25. 10	CMHC - CORF	0	0	0	0.00	l	25. 10
26. 00	RURAL HEALTH CLINIC	0	0	0		l	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	O	0	0.00	l .	26. 25
27. 00	Total (sum of lines 14-26)			7 704	0.00	1, 275. 75	
28. 00	Observation Bed Days		0	7, 701			28. 00
29. 00	Ambul ance Tri ps	0		205			29. 00
30.00	Employee discount days (see instruction)			395			30.00
31.00	Employee discount days - IRF		10/	0			31.00
32. 00	Labor & delivery days (see instructions)	0	186	316			32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)			U			32. 01
33. 00	LTCH non-covered days	o					33. 00
	LTCH site neutral days and discharges	o					33. 01
55. 51	and an adjoint discontinged	١	'		I .	ı	, 55. 51

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part | To 12/31/2018 | Date/Time Prepared: | Date/Time Prepared: | Date/Time Prepared: | Date/Time

				10) 12/31/2018	5/29/2019 7:1	
	·	Full Time		Di sch	arges		
		Equi val ents			ů .		
	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, 489	249	9, 920	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)			4 450	4 (04		0.00
2.00	HMO and other (see instructions)			1, 458	1, 631		2.00
3.00	HMO I PF Subprovi der				211		3.00
4.00	HMO I RF Subprovi der				10		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, 489	249	9, 920	14. 00
15. 00	CAH visits	0.00		3, 407	27/	7, 720	15.00
16. 00	SUBPROVIDER - I PF	0. 00	C	70	12	535	16. 00
17. 00	SUBPROVI DER - I RF	0. 00	C	1	8	133	
18. 00	SUBPROVI DER		_		آ		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	l		33. 01

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0018

Number Reported						To	12/31/2018	Date/Time Prep 5/29/2019 7:1	
MARTILL - MACE DATA					on of Salaries (from Wkst.	Sal ari es (col. 2 ± col.	Related to Salaries in	Average Hourly Wage (col. 4 ÷	
Martin September Septemb			1 00	2 00				6.00	
Total salaries (see 200.00 79,029.409 0 79,029.409 2.653.651.00 29.78 1.00			1.00	2. 00	0.00		0.00	0.00	
2.00 Nan-physic clan anestherist Part 0 0 0 0 0 0 0 0 0	1 00		200.00	79 029 409	0	79 029 409	2 653 551 00	29 78	1. 00
3.00 Non-physician anesthetist Part 4.00 Non-physician Part A - 4.00 Non-physician Part A - 4.00 Non-physician Part A - 4.01 Physician Part A - 4.01 Physician S - 4.01 Physician Part A - 4.01 Physician Part A - 4.01 Non-physician Part A - 4.01 Physician Part A - 4.02 Non-physician Part A - 4.02 Non-physician Part A - 4.03 Non-physician Part A - 4.04 Non-physician Part A - 4.05 Non-physician Part A - 4.05 Non-physician Part A - 4.06 Non-physician Part A - 4.06 Non-physician Part A - 4.07 Non-physician Part A - 4.08 Non-physician Part A - 4.08 Non-physician Part A - 4.00 Non-physician Part A - 5.00 Non-physic		instructions)							
4. 00 Physici dan-Part A	2.00	A anesthetist Part		U		U	0.00	0.00	2.00
4. Admin is trattive 4. Admin is trattive 5. 100 Physician - Part A - Teaching 7. 101 Physician - Part A - Teaching 8. 102 Physician - Part A - Teaching 9. 102 Physician - Part B for 103 Physician - Part B for 104 Physician - Part B for 105 Physician - Part B for 106 Physician - Part B for 107 Physician - Part B for 108 Physician - Part B for 109 Physi	3. 00	Non-physician anesthetist Part B		0	C	0	0.00	0. 00	3. 00
4.01 Physicians - Part A - Teaching 0 0 0 0 0 0 0 0 0	4.00	3		82, 791	C	82, 791	593.00	139. 61	4. 00
Physician-Part B	4. 01			0	C	0	0.00	0. 00	4. 01
6.00 Non-physic clan Part B For 0 0 0 0 0 0 0 0 0	5.00			0	C	0	0.00	0. 00	5. 00
Interms & residents (in am 21.00 0 0 0 0.00 0.00 0.00 7.00	6. 00	Non-physician-Part B for hospital-based RHC and FQHC		0	C	0	0.00	0. 00	6. 00
Contracted interins and residents (in an approved programs) 8.00 Holes office and/or related programs) 8.00 Holes office and/or related programs) 8.00 Holes office and/or related programs) 9.00 Local Contract Loca	7. 00	Interns & residents (in an	21. 00	0	C	0	0.00	0. 00	7. 00
B. 00	7. 01	Contracted interns and		0	C	0	0.00	0. 00	7. 01
9.00 September 100 personnel of 2xcl uded area salaries (see 44.00 3,413,905 128,720 3,542,625 102,409.00 34.59 10.00	0.00	programs)		0			0.00	0.00	0.00
10.00 Excluded area salaries (see 3,413,905 128,720 3,542,625 102,409.00 34.59 10.00		organization personnel		O					
Instructions		4	44. 00	0 3. 413. 905	0 128, 720	0 3, 542, 625			9. 00 10. 00
11.00 Contract labor: Direct Patient Care Care Care Care Contract labor: Direct Patient Care Management and other management and other management and other management and other management and administrative services Contract labor: Physician Part A - Manier Care Care Care Care Care Care Care Ca		instructions)		-,,	,	3, 3, 2, 2, 323			
12.00 Contract labor: Top level management and other management and administrative services 13.00 Contract labor: Physician-Part 410,271 0 410,271 2,562.00 160,14 13.00 14.00 16.00	11. 00			4, 096, 212	0	4, 096, 212	65, 578. 00	62. 46	11. 00
management and other management	12. 00	•		0	O	0	0.00	0.00	12. 00
13.00 Contract Labor: Physician-Part		management and other management and administrative							
14.00	13. 00	Contract Labor: Physician-Part		410, 271	О	410, 271	2, 562. 00	160. 14	13. 00
14. 01 Home office salaries 9, 266, 617 0 9, 266, 617 261, 305. 00 35, 46 14, 01 14. 02 14. 02 14. 02 14. 02 15. 00 Home office : Physician Part A 0 0 0 0 0 0. 00 0. 00 15. 00 15. 00 16. 00 Home office and Contract 0 0 0 0 0 0. 00 0. 00 15. 00 16. 00 Home office and Contract 0 0 0 0 0. 00 0. 00 16. 00 16. 00 Home office and Contract 0 0 0 0 0. 00 0. 00 16. 00 16. 00 Home office and Contract 0 0 0 0 0. 00 0. 00 16. 00 Home office and Contract 0 0 0 0 0. 00 0. 00 16. 00 Home office and Contract 0 0 0 0 0. 00 0. 00 16. 00 Home office and Contract 0 0 0 0 0. 00 0. 00 16. 00 Home office and Contract 0 0 0 0 0. 00	14. 00	Home office and/or related		0	O	0	0.00	0. 00	14. 00
14. 02 Related organization salaries 0 0 0 0 0 0 0 0 0	14 01			9 266 617		9 266 617	261 305 00	35 46	14 01
- Administrative	14. 02	Related organization salaries		7, 200, 017	o o	0	0.00	0. 00	14. 02
Physicians Part A - Teaching	15. 00			0	C	0	0.00	0.00	15. 00
17. 00 Wage-rel ated costs (core) (see instructions) 18. 00 Wage-rel ated costs (other) 38, 813 0 38, 813 18. 00 Wage-rel ated costs (other) 38, 813 0 38, 813 18. 00 Wage-rel ated costs (other) 38, 813 0 0 1, 882, 380 19, 00 20. 00	16. 00	Physicians Part A - Teaching		0	О	0	0.00	0. 00	16. 00
18. 00 Wage-related costs (other) (see instructions) 18. 00 38, 813 (see instructions) 19. 00 20. 00 10. 882, 380 19. 00 20. 00	17. 00	Wage-related costs (core) (see		40, 110, 045	С	40, 110, 045			17. 00
19. 00	18. 00			38, 813	C	38, 813			18. 00
20. 00 Non-physician anesthetist Part A Non-physician anesthetist Part B 21. 00 Non-physician Part A A Administrative Physician Part A - Teaching D 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	19 00			1 882 380		1 882 380			19 00
B		4		1, 002, 300	0	1, 552, 550			20. 00
Administrative Physician Part A - Teaching 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	21. 00	Non-physician anesthetist Part		0	C	0			21. 00
22. 01 Physician Part A - Teaching	22. 00			0	C	О			22. 00
24. 00 Wage-related costs (RHC/FQHC) 0 0 0 0 24. 00 25. 00 Interns & residents (in an approved program) 0 0 0 0 0 0 25. 00 25. 50 Home office wage-related (core) 4, 139, 947 0 4, 139, 947 25. 50 25. 51 Related organization wage-related (core) 0 0 0 0 0 25. 51 25. 52 Home office: Physician Part A - Administrative - wage-related (core) 0 0 0 0 0 25. 52 25. 53 Home office & Contract Physicians Part A - Teaching - wage-related (core) 0 0 0 0 0 0 25. 53 26. 00 Employee Benefits Department 4. 00 658, 766 -658, 766 0 0 0.00 0.00 0				0	0	0			22. 01
approved program A, 139, 947 D		Wage-related costs (RHC/FQHC)		0	0	0			24. 00
25. 50 Home office wage-related (core) 25. 51 Related organization wage-related (core) 4, 139, 947 0 4, 139, 947 25. 52 Home office: Physician Part A 0 0 0 0 0 25. 52 26. 53 Home office & Contract Physician Part A - Teaching wage-related (core) 27. 53 Home office & Contract Physician Part A - Teaching wage-related (core) 28. 50 Home office & Contract Physicians Part A - Teaching wage-related (core) 29. 50 DVERHEAD COSTS - DIRECT SALARIES 29. 00 Employee Benefits Department 4. 00 658, 766 -658, 766 0 0 0. 00 0. 00 26. 00	25. 00	`		0	O	0			25. 00
25. 51 Related organization wage-related (core) 25. 52 Home office: Physician Part A - Administrative - wage-related (core) 25. 53 Home office & Contract Physicians Part A - Teaching - wage-related (core) OVERHEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefits Department	25. 50	Home office wage-related		4, 139, 947	0	4, 139, 947			25. 50
25. 52 Home office: Physician Part A	25. 51	Related organization		0	o	О			25. 51
wage-related (core) Home office & Contract O O O O O D D D D D D	25. 52	Home office: Physician Part A		0	C	О			25. 52
Physicians Part A - Teaching -	25 52	wage-related (core)		•					25 52
OVERHEAD COSTS - DIRECT SALARIES 26. 00 Employee Benefits Department 4. 00 658, 766 -658, 766 0 0. 00 0. 00 26. 00	25. 53	Physicians Part A - Teaching -				0			∠5. 53
	26 00	OVERHEAD COSTS - DIRECT SALARIE		659 766	_650 766		0.00	0.00	26 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | To 12/31/2018 | Date/

							5/29/2019 7:1	1 am
		Wkst. A Line	Amount	Recl assi 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		117, 282	0	117, 282	299. 00	392. 25	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, 585, 212	70, 872	2, 656, 084	108, 281. 00	24. 53	30.00
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00	0. 00	31.00
32.00	Housekeepi ng	9. 00	2, 129, 318	54, 335	2, 183, 653	140, 529. 00	15. 54	32.00
33.00	Housekeeping under contract		0	0	0	0.00	0. 00	33.00
	(see instructions)							
34.00	Di etary	10. 00	1, 991, 163	-880, 259	1, 110, 904	53, 535. 00	20. 75	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	0	925, 027	925, 027	58, 837. 00	15. 72	36.00
37.00	Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37.00
38.00	Nursing Administration	13. 00	1, 241, 293	-175, 241	1, 066, 052	28, 832. 00	36. 97	38. 00
39.00	Central Services and Supply	14. 00	688, 794	18, 939	707, 733	34, 906. 00	20. 28	39. 00
40.00	Pharmacy	15. 00	4, 210, 883	-4, 024, 877	186, 006	2, 080. 00	89. 43	40.00
41.00	Medical Records & Medical	16. 00	344, 692	0	344, 692	9, 339. 00	36. 91	41.00
	Records Library							
42.00	Social Service	17. 00	1, 143, 437	-33, 539	1, 109, 898	33, 576. 00	33. 06	42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0. 00	43.00

| Peri od: | Worksheet S-3 | From 01/01/2018 | Part III | To 12/31/2018 | Date/Time Prepared: | Table 2010 |

					'	0 12/31/2010	5/29/2019 7: 1	
		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	$(col.2 \pm col.$	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		79, 146, 691	0	79, 146, 691	2, 653, 850. 00	29. 82	1. 00
	instructions)							
2.00	Excluded area salaries (see		3, 413, 905	128, 720	3, 542, 625	102, 409. 00	34. 59	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		75, 732, 786	-128, 720	75, 604, 066	2, 551, 441. 00	29. 63	3. 00
	minus line 2)							
4.00	Subtotal other wages & related		13, 773, 100	0	13, 773, 100	329, 445. 00	41. 81	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		44, 288, 805	0	44, 288, 805	0.00	58. 58	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		133, 794, 691	-128, 720	133, 665, 971	2, 880, 886. 00	46. 40	6. 00
7.00	Total overhead cost (see		20, 102, 027	-5, 524, 722	14, 577, 305	614, 761. 00	23. 71	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 01/01/2018 Part IV
		T- 10/01/0010 D-+-/T: D

	To 12/31/2018	Date/Time Prep 5/29/2019 7:1	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		1
1.00	401K Employer Contributions	2, 392, 375	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	o	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	20, 058, 895	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	o	6. 00
7.00	Employee Managed Care Program Administration Fees	o	7. 00
	HEALTH AND INSURANCE COST		1
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	o	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	13, 006, 007	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	o	9. 00
10.00	Dental, Hearing and Vision Plan	164, 412	10.00
11. 00	Life Insurance (If employee is owner or beneficiary)	52, 150	11. 00
	Accident Insurance (If employee is owner or beneficiary)	0	12. 00
	Disability Insurance (If employee is owner or beneficiary)	354, 236	13. 00
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15. 00		305, 158	15. 00
16. 00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		1
	TAXES		1
17. 00	FICA-Employers Portion Only	5, 641, 099	17. 00
18. 00	Medicare Taxes - Employers Portion Only	o	18. 00
19. 00	Unemployment Insurance	18, 093	19. 00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		1
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		1
22. 00	Day Care Cost and Allowances	ol	22. 00
23.00	Tuition Reimbursement	ol	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	41, 992, 425	24. 00
	Part B - Other than Core Related Cost		
25. 00	WELLNESS, REWARDS/RECOGN	38, 813	25. 00
	· '	·	

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0018	Peri od: Worksheet S-3 From 01/01/2018 Part V
		To 12/31/2018 Date/Time Prepared

		1011 01/01/2010		
		Γο 12/31/2018		
			5/29/2019 7:1	1 am
	Cost Center Description	Contract Labor		
		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 - I PF	0	0	3. 00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6. 00
7.00	Swing Beds - NF	0	0	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		0	0	18. 00

ד ום פר	Financial Systems ELKHART GENERAL HOSE TAL UNCOMPENSATED AND INDIGENT CARE DATA Pro	ovider CCN:	15 0010	Period:	u of Form CMS-2 Worksheet S-10	
JSPI I	AL UNCOMPENSATED AND INDIGENT CARE DATA	ovider con:		From 01/01/2018	worksneet 5-10	J
				To 12/31/2018	Date/Time Prep 5/29/2019 7:1	oare 1 am
					1. 00	
	Uncompensated and indigent care cost computation					
00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divide	led by line	202 column	8)	0. 291975	1.
	Medicaid (see instructions for each line)					
00	Net revenue from Medicaid				20, 244, 904	2.
00	Did you receive DSH or supplemental payments from Medicaid?		6 N II	. 10	N	3.
00 00	If line 3 is yes, does line 2 include all DSH and/or supplemental If line 4 is no, then enter DSH and/or supplemental payments from		rrom Medica	I a?	0	4. 5.
00	Medicaid charges	i wedi cai u			119, 967, 636	6.
00	Medicaid cost (line 1 times line 6)				35, 027, 551	7.
00	Difference between net revenue and costs for Medicaid program (lin	ne 7 minus	sum of lin	es 2 and 5: if	14, 782, 647	8.
	< zero then enter zero)				., . ,	
	Children's Health Insurance Program (CHIP) (see instructions for e	each line)				
00	Net revenue from stand-alone CHIP				0	9.
. 00	Stand-alone CHIP charges				0	10.
. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP (line)	no 11 minu	clino Oci	f . zoro thon	0	11. 12.
. 00	enter zero)	ne ii iii iii	STITLE 9, T	i < zero tileli	U	12
	Other state or local government indigent care program (see instruc	ctions for	each line)			
. 00	Net revenue from state or local indigent care program (Not include)	86, 376	13
. 00	Charges for patients covered under state or local indigent care pr	rogram (No	t included	in lines 6 or	795, 089	14
	10)					
. 00	State or local indigent care program cost (line 1 times line 14)				232, 146	
. 00	Difference between net revenue and costs for state or local indigently if < zero then enter zero)	jent care p	rogram (lin	e 15 minus line	145, 770	16
	Grants, donations and total unreimbursed cost for Medicaid, CHIP a	and state/	local indig	ent care program	ns (see	
. 00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to fund</pre>	ling charit	v care		0	17.
3. 00					0	18
0. 00	Total unreimbursed cost for Medicaid, CHIP and state and local in 8, 12 and 16)	ndi gent ca	re programs	(sum of lines	14, 928, 417	19
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire facili	ity	8, 284, 76	4 2, 651, 488	10, 936, 252	20.
. 00	(see instructions) Cost of patients approved for charity care and uninsured discounts	·	2 410 04	4 2, 651, 488	5, 070, 432	21
. 00	instructions)	.3 (300	2, 418, 94	2,001,400	5, 070, 432	Z I.
	1	f as	118, 98	7 199, 934	318, 921	22.
2. 00	charity care					
2. 00	Chair by Care		2, 299, 95	7 2, 451, 554	4, 751, 511	23
						20.
					1 00	20
. 00	Cost of charity care (line 21 minus line 22)	days havon	d a Length	of stay limit	1. 00	
. 00	Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care pro	ogram?			N	24
. 00	Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care prolifine 24 is yes, enter the charges for patient days beyond the stay limit	rogram? indigent c			N O	24 25
. 00	Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care proof of line 24 is yes, enter the charges for patient days beyond the stay limit. Total bad debt expense for the entire hospital complex (see instru	rogram? indigent c ructions)	are program		N 0 28, 107, 456	24 25 26
. 00	Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care proof of the control of the charges for patient days beyond the stay limit. Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see	rogram? indigent c ructions) (see instru	are program		N 0 28, 107, 456 751, 671	24. 25. 26. 27.
6. 00 6. 00 6. 00 7. 00 7. 01	Does the amount on line 20 column 2, include charges for patient imposed on patients covered by Medicaid or other indigent care proof of the line 24 is yes, enter the charges for patient days beyond the stay limit. Total bad debt expense for the entire hospital complex (see instrumedicare reimbursable bad debts for the entire hospital complex (see Medicare allowable bad debts for the entire hospital complex (see	rogram? indigent c ructions) (see instru	are program		N 0 28, 107, 456 751, 671 1, 156, 417	24. 25. 26. 27. 27.
3. 00 4. 00 5. 00 7. 00 7. 01 8. 00	Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care proof of the stay limit. Total bad debt expense for the entire hospital complex (see instructions) Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	rogram? indigent c ructions) (see instru instructi	are program ctions) ons)		N 0 28, 107, 456 751, 671 1, 156, 417 26, 951, 039	24. 25. 26. 27. 27. 28.
2. 00 3. 00 4. 00 5. 00 7. 00 7. 01 3. 00 9. 00 9. 00	Does the amount on line 20 column 2, include charges for patient of imposed on patients covered by Medicaid or other indigent care proof of the stay limit. Total bad debt expense for the entire hospital complex (see instructions) Medicare allowable bad debts for the entire hospital complex (see Non-Medicare bad debt expense (see instructions)	rogram? indigent c ructions) (see instru instructi	are program ctions) ons)		N 0 28, 107, 456 751, 671 1, 156, 417	24. 25. 26. 27.

Heal th	Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	OF EXPENSES	Provi der CC	1	Period: From 01/01/2018 Fo 12/31/2018	Worksheet A Date/Time Pre 5/29/2019 7:1	
	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 & FLXT		0		17, 738, 374		
2.00	00200 CAP REL COSTS-MVBLE EQUI P		0	(2, 505, 785		
3.00	00300 OTHER CAP REL COSTS	/50 7//	0		0	0	
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	658, 766	347, 931			671, 182	
5. 00 6. 00	OO5OO ADMINISTRATIVE & GENERAL OO6OO MAINTENANCE & REPAIRS	4, 991, 187	63, 657, 550	68, 648, 73	-21, 214, 604	47, 434, 133 0	
7. 00	00700 OPERATION OF PLANT	2, 585, 212	8, 804, 979	11, 390, 19	1 -2, 835, 642	8, 554, 549	
8. 00	00800 LAUNDRY & LINEN SERVICE	2, 303, 212	760, 665			760, 665	
9. 00	00900 HOUSEKEEPI NG	2, 129, 318	1, 649, 131				1
10.00	01000 DI ETARY	1, 991, 163	2, 257, 239				
11.00	01100 CAFETERI A	O	0		2, 490, 423	2, 490, 423	11.00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0		0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 241, 293	598, 451				
14. 00	01400 CENTRAL SERVICES & SUPPLY	688, 794	529, 962			1, 277, 847	
15.00	01500 PHARMACY	4, 210, 883	12, 271, 422			1, 492, 114	
16.00	01600 MEDICAL RECORDS & LIBRARY	344, 692	77, 165			421, 857	
17. 00 18. 00	O1700 SOCIAL SERVICE O1850 OTHER GENERAL SERVICE (SPECIFY)	1, 143, 437	858, 658	2, 002, 09	-33, 539	1, 968, 556 0	
19. 00	01900 NONPHYSICIAN ANESTHETISTS		0			0	
20. 00	02000 NURSI NG SCHOOL		0		0	0	
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD		0		0	Ö	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	o	0		0	0	1
23. 00	02300 PARAMED ED PRGM	44, 587	104, 337	148, 92	4, 510	153, 434	1
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	18, 954, 394	14, 513, 729	33, 468, 123	-1, 725, 296	31, 742, 827	30.00
31. 00	03100 I NTENSI VE CARE UNI T	3, 573, 168	1, 945, 277				
31. 01	03101 NEONATAL INTENSIVE CARE	971, 889	310, 085	1, 281, 97	22, 296		
32.00	03200 CORONARY CARE UNIT	0	0	1	0	0	
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	1, 263, 498	461, 648	1, 725, 14	5 28, 434	1, 753, 580	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	996, 178	402, 547			1, 478, 072	
43. 00	04300 NURSERY	51, 219	16, 204				
44. 00	04400 SKILLED NURSING FACILITY	0	0	0.7,	0	0	1
45.00	04500 NURSING FACILITY	o	0		0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	(0	0	46. 00
	ANCILLARY SERVICE COST CENTERS			I			
50.00	05000 OPERATI NG ROOM	8, 590, 591	36, 030, 399	44, 620, 99	-23, 525, 697	21, 095, 293	
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	0	0			0	
	05400 RADI OLOGY-DI AGNOSTI C	4, 576, 142	3, 545, 088	8, 121, 23	364, 806		
55. 00	05500 RADI OLOGY-THERAPEUTI C	4, 370, 142	3, 343, 000	0, 121, 23	0 -304, 000	7, 730, 424	
56. 00	05600 RADI OI SOTOPE	o o	0		0	Ö	1
57.00	05700 CT SCAN	747, 454	533, 497	1, 280, 95	1 255, 081	1, 536, 032	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	363, 540	230, 374	593, 91	4 313, 773	907, 687	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 538, 018	6, 648, 361	8, 186, 37	-5, 805, 347	2, 381, 032	59.00
60.00	06000 LABORATORY	2, 146, 042	8, 261, 031	10, 407, 07	42, 580	10, 449, 653	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0	1		0	1
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	1		0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	045 214	E12 04E	1, 378, 06	U 104 274	0 1 101 707	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	865, 216 2, 109, 004	512, 845 1, 330, 854		· ·		
66. 00	06600 PHYSI CAL THERAPY	1, 482, 100	451, 583		· ·	1, 976, 097	1
67. 00	06700 OCCUPATI ONAL THERAPY	560, 535	158, 862				
68. 00	06800 SPEECH PATHOLOGY	196, 526	57, 834			257, 627	1
69. 00	06900 ELECTROCARDI OLOGY	0	0	_5.,50	0	0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(17, 488, 522	17, 488, 522	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		12, 454, 550		
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	'	18, 330, 112	18, 330, 112	
74.00	07400 RENAL DIALYSIS	0	0	1	<u> </u>	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	1 200 253	0.400.50	0	0	
	03140 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS	1, 923, 540	1, 209, 050	3, 132, 59	-226, 951	2, 905, 639	76. 00
76. 00	UNITER LENI SERVICE COST CENTERS					0	88. 00
		ام	^				i uo. uu
88. 00	08800 RURAL HEALTH CLINIC	0	0) 0		
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0 545, 594	0 0 156 642	702 23	0 0	0	89. 00
88. 00	08800 RURAL HEALTH CLINIC	0 0 545, 594 377, 844	0 0 156, 642 122, 721			0 707, 137	89. 00 90. 00
88. 00 89. 00 90. 00 90. 01	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	545, 594		500, 56	18, 903	0 707, 137 519, 468	89. 00 90. 00 90. 01

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der C	CN: 15-0018	Peri od: From 01/01/2018	Worksheet A
				To 12/31/2018	Date/Time Prepared: 5/29/2019 7:11 am
Cost Center Description	Sal ari es	Other	,	1 Reclassificati	
			1 + col. 2)	ons (See A-6)	Trial Balance

Cost Center Description Salaries Other Total (col. 1 Recl assifications (See A-6) Col. 4 Col. 2 Col. 4 Col. 2 Col. 4
Salaries Other Total (col. 1 Reclassificati Reclassified Trial Balance (col. 3 + col. 4)
1.00 2.00 3.00 4.00 5.00 92.00 9
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 1.00 2.00 3.00 4.00 5.00 92.00 0THER REI MBURSABLE COST CENTERS 94.00 95.00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 1.00 2.00 3.00 4.00 5.00 92.00 95
92. 00
92. 00 OP200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REI MBURSABLE COST CENTERS 94. 00 95. 00 95. 00 95. 00 95. 00 96. 00 96. 00 96. 00 96. 00 96. 00 97. 00 98. 00 99. 00
OP4. 00
94. 00
95. 00
96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 97. 00 98.00 99850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 98.00 99.00 999.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 99. 00 99. 00 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 00 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 0
99. 00 09900 CMHC 09910 CORF 0 0 0 0 0 0 99. 00 99. 10 100. 00 100.
99. 10 09910 CORF 0 0 0 0 0 0 0 99. 10 100. 00 100.
100. 00 10000 1&R SERVI CES-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 KI DNEY ACQUI SI TI ON 0 0 0 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 ACQUI SI TI ON 0 0 0 0 107. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 109. 00 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 111. 00 113. 00 113. 00 INTEREST EXPENSE 0 0 0 0 0 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 0 0 0 0 0 114. 00 116. 00 11600 HOSPI CE 0 0 0 0 0 0 115. 00 NONREI MBURSABLE COST CENTERS
101. 00
SPECIAL PURPOSE COST CENTERS
105. 00
106. 00 10600 HEART ACQUISITION 0 0 0 0 0 106. 00 107. 00 107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUISITION 0 0 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 109. 00 110. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 0 109. 00 111. 00 111. 00 11100 ISLET ACQUISITION 0 0 0 0 0 0 111. 00 113. 00 11300 INTEREST EXPENSE 0 0 0 0 0 113. 00 114. 00 11400 UTILIZATION REVIEW-SNF 0 0 0 0 0 0 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 77, 919, 767 174, 918, 778 252, 838, 545 -21, 289 252, 817, 256 118. 00 NONREI MBURSABLE COST CENTERS
107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 107. 00 108. 00 109. 00 10900 LUNG ACQUISITION 0 0 0 0 0 0 109. 00 109. 00 109. 00 10900 INTESTINAL ACQUISITION 0 0 0 0 0 0 109. 00 110. 00 111. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 0 111. 00 111. 00 11100 ISLET ACQUISITION 0 0 0 0 0 0 111. 00 111. 00 114. 00 11400 INTESTE EXPENSE 0 0 0 0 0 113. 00 115. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 77, 919, 767 174, 918, 778 252, 838, 545 -21, 289 252, 817, 256 118. 00 NONREI MBURSABLE COST CENTERS
108. 00 10800 LUNG ACQUISITION 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 110. 00 110.00 INTESTINAL ACQUISITION 0 0 0 0 0 110. 00 113. 00 11300 INTEREST EXPENSE 0 0 0 0 111. 00 114. 00 11400 UTILIZATION REVIEW-SNF 0 0 0 0 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 77, 919, 767 174, 918, 778 252, 838, 545 -21, 289 252, 817, 256 118. 00
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 109. 00 110. 00 111. 00 11100 INTESTINAL ACQUISITION 0 0 0 0 0 0 111. 00 111. 00 111. 00 11100 ISLET ACQUISITION 0 0 0 0 0 0 111. 00 111. 00 111. 00 113. 00 1NTEREST EXPENSE 0 0 0 0 0 0 113. 00 114. 00 11400 UTI LI ZATION REVIEW-SNF 0 0 0 0 0 0 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 0 116. 00 116. 00 11600 HOSPI CE 0 0 0 0 0 0 0 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 77, 919, 767 174, 918, 778 252, 838, 545 -21, 289 252, 817, 256 118. 00 NONREI MBURSABLE COST CENTERS
110. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 110. 00 111. 00 111. 00 INTESTINAL ACQUISITION 0 0 0 0 0 113. 00 113. 00 INTEREST EXPENSE 0 0 0 0 114. 00 11400 UTILIZATION REVIEW-SNF 0 0 0 0 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 116. 00 11600 HOSPICE 0 0 0 0 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 77, 919, 767 174, 918, 778 252, 838, 545 -21, 289 252, 817, 256 118. 00 NONREI MBURSABLE COST CENTERS
111. 00
113. 00
114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115. 00 116
116. 00 11600 HOSPI CE
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 77, 919, 767 174, 918, 778 252, 838, 545 -21, 289 252, 817, 256 118. 00 NONREI MBURSABLE COST CENTERS
NONREI MBURSABLE COST CENTERS
400 00 40000 OLET FLOWER OFFEE OURS & CANTEEN
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00
191. 00 19100 RESEARCH 0 0 0 0 0 191. 00
192. 00 1920 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 192. 00
400 00 40000 40000 400
193. 00 19300 NONPAI D WORKERS 177, 308 63, 549 240, 857 2, 450 243, 307 193. 00
193. 00 19300 NONPALD WORKERS 177, 308 63, 549 240, 857 2, 450 243, 307 193. 00 193. 01 19301 COMMUNI TY 221, 507 204, 223 425, 730 15, 027 440, 757 193. 01

2.00 00000 CAP SEL COSTS-MANEL EDUIP 1.405, 371 3.971 156 3.971 3.97	Heal th	Financial Systems	ELKHART GENER	AL HOSPITAL		In Lieu	ı of Form CMS-2	2552-10
Cast Content Dissert pit time					15-0018	Peri od:		
September Sept							Date/Time Dre	nared:
Company Comp						10 12/31/2016	5/29/2019 7:1	pareu. 1 am
SELECT SETURE COST PATENCES 6.00 7.0		Cost Center Description						
SPERSENT SPRINGE COST CHYTERS								
1.00 100		CENEDAL CEDVICE COCT CENTEDS	6.00	7.00				
2.00 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 3, 797, 156 3.00 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 3, 797, 156 3.00 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 3, 797, 156 3.00 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 3, 797, 156 3.00 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 3, 797, 156 3.00 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 3, 797, 156 3.00 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 3, 797, 156 3.00 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 3, 797, 156 3.00 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 3, 797, 156 3.00 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 3, 797, 156 3.00 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 3, 797, 156 3.00 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 4. 4-10 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 4. 4-10 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 4. 4-10 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 4. 4-10 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 4. 4-10 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 4. 4-10 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 4. 4-10 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 4. 4-10 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-85, 377 4. 4-10 DOZDOCAP REL COSTS-MYBLE EDUIP 1 . 4-10 DO	1 00		_021_084	16 917 200				1.00
3.00 0.0000 OTHER CAP REL COSTS 0.00 0.00 0.0000 AVAILED TO CORRECT TO DEPARTMENT 0.00 0.0000 AVAILED TO CORRECT TO DEPARTMENT 0.00 0.0000 AVAILED TO CORRECT TO CORR								2.00
4.00 DISCHOOL SHELDYNEE HEINET IS DEPARTMENT -12,647,445 34,777,679 5.5. 5.00 DISCHOOL AND INSTRUCTOR & REPORT ISS -17,177,76,799 5.5. 6.00 DISCHOOL AND INSTRUCTOR & REPORT ISS -177,776,489 8.8. 6.00 DISCHOOL AND INSTRUCTOR -177,776,489 8.8. 6.00 DISCHOOL AND INSTRUCTOR -177,776,489 8.8. 6.00 DISCHOOL OF THE PRINCE -177,776,489 9.7. 7.00 DISCHOOL OF THE PRINCE -177,776,489 9.7. 7.00 DISCHOOL OF THE PRINCE -177,776,489 9.7. 7.00 DISCHOOL OF THE PRINCE -178,484 1.00,777,000 1.00,777,100 1.0		1	1	1				3. 00
0.000 DOSOD MAINTENANCE & REPAIRS 0 0 0 0 0 0 0 0 0			28, 201, 502	28, 872, 684				4. 00
2.00 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000000	5.00		-12, 694, 454	34, 739, 679				5. 00
B. 00 00800 AJMORY & LINEN SERVICE 1-177 760, 488 9.9 1.00 00900 AJMORY & LINEN SERVICE 1-176 1.00			_	1 -1				6. 00
9.00 009000 00900 00900 00900 00900 00900 00900 00900 00900 009000 00900 00900 00900 00900 00900 00900 00900 00900 009000 00900 00900 00900 00900 00900 00900 00900 00900 009000 00900 00900 00900 00900 00900 00900 00900 00900 009000 00900 00900 00900 00900 00900 00900 00900 00900 009000 009000 009000 009000 009000 009000 009000 009000 0090000 0090000 0090000 0090000 0090000 0090000 0090000 0090000 00900000 009000000 00900000000			1					7. 00
10.00 01000 DETARY -88,899 1,707,030 10.0 10.0 1100 CAFEERIA -848,628 11.1 10.0 01100 CAFEERIA -848,628 11.1 10.0 CAFEERIA -748,628 28.		1	1					8.00
11-10 0 1100 CAFETERIA848,828			4					ı
12.00 01200 MAINTENNAME OF PERSONNEL 0 1.27, 847 13.4 13.0 01300 01400 CENTRAL SERVICES & SUPPLY 0 1.277, 847 14.5 13.5		l						11. 00
13.00 01300 MURSI NO ADMINI STRATION 0 1, 685,074 13.1 1.61 1.00 1.0		1		1				12.00
14.00 0 1400 CENTRAL SERVICES & SUPPLY			-	-1				13.00
16.0 0 1660 MEDICAL RECORDS & LIBRARY			0					14. 00
17.00 17.0	15. 00		-184, 543	1, 307, 571				15. 00
18.0 0 01850 OTHER CENTRAL SERVICE (SPECIFY) 0 0 0 19.0 01900 010000 010000 010000 010000 010000 010000 0100000 010000000 0100000000		l I	0					16. 00
19. 00 01900 NON-HYSI CLAN AMESTHETISTS 0 0 0 20. 0 20. 00 20.00 MISSIN SIG SCIOLO 0 0 0 0 0 0 0 20. 0 20. 00 20.00 BAS ESPRU CES-SALARY & FRINGES APPRUD 0 0 0 0 22. 1 20. 00 20.00 BAS ESPRU CES-SALARY & FRINGES APPRUD 0 0 0 22. 1 20. 00 20.00 BAS ESPRU CES-SALARY & FRINGES APPRUD 0 79. 79. 79. 90 22. 3 20. 00 20.00 BAS ESPRU CES-SALARY & FRINGES APPRUD 0 79. 79. 79. 90 22. 3 20. 00 20.00			-12, 252	1, 956, 304				17. 00
20. 00			0	0				
21.00			0	0			ŗ	1
22.00 02200 RAN SERVICES-OTHER PROM OSTS APPRVD 0 22.0		1	0					21.00
23.0 02300 PARAMED ED PROM -73, 636 79, 798 23.1			0	l o				22. 00
30.00			-73, 636	79, 798				23. 00
31.00 03100 INTENSIVE CARE UNIT 0 5.417.397 31.0 331.0								
31.0		l I						30.00
32.00 0320			0					31.00
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 3.4. 40.00 04000 SURGICAL INTENSIVE CARE UNIT 0 0 3.4. 40.00 04000 SURGICAL INTENSIVE CARE UNIT 0 0 3.4. 41.00 04100 SURGICAL INTENSIVE CARE UNIT 0 0 4.0. 43.00 04300 SURGICAL INTENSIVE CARE UNIT 0 0 0 4.4. 43.00 04300 SURGICAL INTENSIVE CARE UNIT 0 0 0 4.4. 43.00 04300 FURIT SURGICAL INTENSIVE CARE UNIT 0 0 0 4.4. 45.00 04500 SURGICAL SURGICAL INTY 0 0 0 0 4.4. 45.00 04500 OSTERLONG STEM CARE 0 0 0 0 4.5. 46.00 04500 OSTERLONG TERM CARE 0 0 0 0 4.5. 46.00 04500 OTHER LONG TERM CARE 0 0 0 0 4.5. 47. 48. 48. 48. 48. 48. 48. 48. 48. 48. 48		1	0	1, 304, 270				ł
34.00 03400 SUBROVIDER - I PF		1	0					33.00
40.00 04000 SUBBROVI DER - I PF		1	0					34.00
43.00 04300 NURSERY 44.00 04500 SKILLED NURSING FACILITY 40 0 04500 NURSING FACILITY 40 0 05000 NURSING FACILITY 40 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-1, 276	1, 752, 304				40.00
44.00 04400 SKILLED NURSING FACILITY	41.00	04100 SUBPROVI DER - I RF	-1, 250	1, 476, 822				41. 00
45.00 04500 NURSI NO FACILITY 0 0 0 0 45.0 ANCILLARY SERVICE COST CENTERS			-400	2, 325, 397				43. 00
46.00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 0				0				44.00
ANCILLARY SERVICE COST CENTERS 5.0.0		l		1				45. 00
50.00 05000 05000 05000 05000 05000 051.00	46.00		1 0	<u> </u>				46.00
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 53.00	50.00		-4, 349, 008	16, 746, 285				50.00
53.00 05300 ADBURSTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	51.00	05100 RECOVERY ROOM	0	O				51.00
54. 00 05400 RADI OLOGY-DI AGNOSTIC -47, 186 7, 709, 238 55. 00 05500 RADI OLOGY-THERAPEUTIC 0 0 0 0 55. 00 05600 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 55. 00 05600 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0 0 0			0	0				52. 00
55.00 05500 RADI OLOGY-THERAPEUTI C			0	0				53. 00
56. 00 05600 RADIOI SOTOPE 0 0 0 5700 CT SCAN 0 57700 CT SCAN 0 1,536,032 57. 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 907,687 58.6 59. 00 05900 CARDI AC CATHETERI ZATI ON -2,091 2,378,941 59. 60. 01 06000 LABORATORY -2,056 10,447,597 60.0 60. 01 06001 BLOOD LABORATORY 0 0 0 60.0 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 61.0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 62.0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 63.0 64. 00 06400 I NTRAVENOUS THERAPY -1,287 1,180,500 64.0 65. 00 06500 RESPI RATORY THERAPY -3,054 3,284,225 65.0 66. 00 06600 PHYSI CAL THERAPY -10,844 1,965,253 65.0 67. 00 06700 CCUPATI ONAL THERAPY 0 725,622 67. 68. 00 06600 SPECH PATHOLOGY 0 257,627 68.0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 70.0 71. 00 07000 ELECTROCARDI OLOGY 0 0 0 70.0 71. 00 07000 ELECTROCARDI OLOGY 0 0 72,488,522 71. 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 17,488,522 71. 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 12,454,550 72. 74. 00 07400 RENAL DI ALLYSIS 0 18,330,112 73. 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 74.0 76. 00 09000 CLI NIC -9,029 2,896,610 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	1				54.00
57.00 05700 CT SCAN 0 1,536,032 57.0		1		1			ŀ	1
58 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 0 997, 687 58.0 59 00 05900 CARDIA C CATHETERI ZATION -2, 056 10, 447, 597 60.0 60 01 06000 LABORATORY -2, 056 10, 447, 597 60.0 60 01 06010 BLOOD LABORATORY 0 0 60.0 61 00 06100 DBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 60.0 62 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 62.0 63 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 62.0 64 00 06400 INTRAVENOUS THERAPY -1,287 1,180,500 63.0 65 00 06500 RESPI RATORY THERAPY -3,054 3,284,225 65.0 66 00 06600 PHYSI CAL THERAPY -10,844 1,965,253 66.0 67 00 06700 DCUPATI ONAL THERAPY -10,844 1,965,253 66.0 69 00 06900 ELECTROCARDIO LOGY 0 255,627 68.0 69 00 069				1				57.00
59. 00 05900 CARDI AC CATHETERI ZATION			1					58.00
60. 01 06001 BL00D LABORATORY 0 0 0 0 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 0 0 62.00 WOLLE BL00D & PACKED RED BL00D CELLS 0 0 0 0 06200 WOLLE BL00D & PACKED RED BL00D CELLS 0 0 0 0 6200 WOLLE BL00D & PACKED RED BL00D CELLS 0 0 0 0 62.00 WOLLE BL00D & PACKED RED BL00D CELLS 0 0 0 0 63.00 BL00D STORING, PROCESSING & TRANS. 0 0 0 64.00 INTRAVENOUS THERAPY -1.287 1, 180, 500 64.00 1NTRAVENOUS THERAPY -3,054 3, 284, 225 65.00 06500 RESPI RATORY THERAPY -10,844 1,965,253 66.00 06600 PHYSI CAL THERAPY -10,844 1,965,253 66.00 06700 OCCUPATI ONAL THERAPY 0 725,022 67.00 06700 OCCUPATI ONAL THERAPY 0 0 725,022 67.00 06900 ELECTROCARDI OLOGY 0 0 257,627 68.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			-2, 091					59.00
61. 00	60.00	06000 LABORATORY	-2, 056	10, 447, 597				60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0			_	1 -1				60. 01
63. 00			0	0				61.00
64. 00		1	0	0				62.00
65. 00		1	1 207	1 100 500				ł
66. 00		1						65.00
67. 00		1	1					66.00
69. 00								67.00
70. 00	68.00	06800 SPEECH PATHOLOGY	0	257, 627				68. 00
71. 00	69. 00	06900 ELECTROCARDI OLOGY	0	0				69. 00
72. 00		l	0	0				70. 00
73. 00			0					71. 00
74. 00			0					•
75. 00			-	1			ŀ	1
76. 00 03140 CARDI OLOGY -9, 029 2, 896, 610 76. 0 00TPATI ENT SERVICE COST CENTERS 88. 00 08900 FURAL HEALTH CLINIC 0 0 0 99. 00 09900 CLINIC -490 706, 647 99. 01 99. 01 04950 SLEEP CLINIC -7, 307 512, 161 91. 00 09100 EMERGENCY -356, 828 11, 696, 418				1 -1				75.00
SERVICE COST CENTERS SERVICE COST CENTERS				1 "				76. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 90. 00 09000 CLINIC -490 706, 647 90. 01 04950 SLEEP CLINIC -7, 307 512, 161 91. 00 09100 EMERGENCY -356, 828 11, 696, 418								
90. 00 09000 CLI NI C -490 706, 647 90. 01 04950 SLEEP CLI NI C -7, 307 512, 161 91. 00 09100 EMERGENCY -356, 828 11, 696, 418 91. 00 09100 CLI NI C 90. 00 0910			1	1				88. 00
90. 01 04950 SLEEP CLINI C				1				89. 00
91. 00 09100 EMERGENCY -356, 828 11, 696, 418 91. 0		1	1					90.00
		1	1	1				90.01
			-330, 020	11, 070, 410				92.00
			•	. '			'	

 Health Financial
 Systems
 ELKHART GRADIUSTMENTS OF TRIAL BALANCE OF EXPENSES
 ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10

Peri od: Worksheet A From 01/01/2018 Provider CCN: 15-0018

			To 12/31/2018 Date/Time P	
Cost Center Description	Adjustments	Net Expenses	5/29/2019 7	:11 am
cost center bescription		For Allocation		
	6.00	7.00		
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		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 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	6, 454, 522	259, 271, 778		118. 00
NONREI MBURSABLE COST CENTERS	·			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
191. 00 19100 RESEARCH	0	0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192. 00
193. 00 19300 NONPAI D WORKERS	0	243, 307		193. 00
193. 01 19301 COMMUNI TY	0	440, 757		193. 01
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	4, 605, 956		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	6, 454, 522	264, 561, 798		200. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0018

					/Time Prepared: /2019 7:11 am
		Increases			
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00	
	A - I NSURANCE	3.00	4.00	3.00	
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	241, 325	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP			<u>4, 5</u> 75	2. 00
	0		0	245, 900	
1. 00	B - INTEREST CAP REL COSTS-BLDG & FIXT	1.00	ol	1, 908, 431	1.00
2. 00	INTEREST EXPENSE	113. 00	Ö	1, 908, 431	2.00
2.00	0		0	3, 816, 862	2.00
	C - DIETARY	<u> </u>			
1.00	CAFETERI A	<u> </u>	<u>925, 0</u> 27	<u>1, 565, 3</u> 96	1. 00
	0		925, 027	1, 565, 396	
1. 00	D - CASE MGMT SUBPROVIDER - IRF	41. 00	49, 057		1.00
1.00	0	41.00	49, 057	<u>0</u>	1.00
	E - SERVICE CONTRACTS	· '			
1.00	NURSING ADMINISTRATION	13. 00	0	105, 618	1. 00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	44, 795	2. 00
3.00	PHARMACY	15. 00	0	137, 843	3.00
4. 00 5. 00	ADULTS & PEDIATRICS SUBPROVIDER - IRF	30. 00 41. 00	0	6, 165 5, 627	4. 00 5. 00
6. 00	OPERATING ROOM	50.00	0	320, 797	6. 00
7. 00	RADI OLOGY-DI AGNOSTI C	54. 00	Ö	1, 226, 438	7. 00
8.00	CT SCAN	57.00	0	253, 800	8. 00
9.00	MAGNETIC RESONANCE IMAGING	58. 00	0	312, 253	9. 00
10.00	(MRI)	50.00		207.005	40.00
10. 00 11. 00	CARDI AC CATHETERI ZATI ON	59.00	0	387, 095	10.00
12. 00	RESPI RATORY THERAPY CARDI OLOGY	65. 00 76. 00	0	13, 561 81, 770	12.00
13. 00	SLEEP CLINIC	90. 01	0	5, 650	13. 00
14. 00	EMERGENCY	91.00	o	538	14. 00
	0			2, 901, 950	
	H - NURSERY				
1. 00	NURSERY	43.00	1, 573, 278	68 <u>4, 5</u> 51	1.00
	I - ONCOLOGY		1, 573, 278	684, 551	
1.00	ADULTS & PEDIATRICS	30.00	172, 127	64, 628	1. 00
2.00	RADI OLOGY-DI AGNOSTI C	5400	5 <u>4, 3</u> 84	2 <u>0, 4</u> 19	2. 00
	0		226, 511	85, 047	
1. 00	M - DRUGS CHARGED DRUGS CHARGED TO PATIENTS	73. 00	o	14, 179, 304	1. 00
2. 00	DRUGS CHARGED TO FATTENTS	0.00	o	14, 179, 304	2.00
3.00		0.00	Ö	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 8. 00		0. 00 0. 00	0	0	7. 00 8. 00
9. 00		0.00		0	9. 00
10.00		0.00	o	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. 00	0	0	14. 00 15. 00
15. 00 16. 00		0.00	ol Ol	0	16. 00
17. 00		0.00	0	0	17. 00
18. 00		0.00	Ö	Ö	18. 00
	0			14, 179, 304	
4 00	N - RENT	4 00		47. 70/	4.00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00	0	47, 726 231, 658	1. 00 2. 00
2. 00 3. 00	CAL REL COSTS-WINDLE EQUIP	0.00	0	231, 658 0	3. 00
4.00		0.00	0	0	4. 00
5. 00		0.00	ő	Ö	5. 00
6.00		0.00	О	0	6. 00
7.00		0.00	О	0	7. 00
8.00		0.00	0	0	8. 00
9. 00		0.00	0	00 279, 384	9. 00
	O - SUPPLIES AND IMPLANTS		J	217, 504	
1.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	17, 488, 522	1.00
2.00	PATI ENTS	70 00			2.2-
2. 00	IMPL. DEV. CHARGED TO PATIENTS	72. 00	0	12, 454, 550	2. 00
	ILVITENTA				

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

					5/29/2019 7:	
		Increases			, , , , , , , , , , , , , , , , , , , ,	
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
3. 00		0. 00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 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	o	0		14. 00
				29, 943, 072		
	P - DEPRECIATION					1
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	15, 515, 415		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0_	2, 269, 552		2. 00
	0		0	17, 784, 967		
	R - PHARMACY					
1. 00	DRUGS CHARGED TO PATIENTS	73.00	4, 150, 808	$\frac{0}{0}$		1. 00
	0		4, 150, 808	0		
4 00	S - AMORTI ZATI ON	4 00		05 477		1 00
1. 00	CAP REL COSTS-BLDG & FIXT			25, 477		1. 00
	DENIELT ALLOCATION		0	25, 477		
1 00	T - BENEFIT ALLOCATION EMPLOYEE BENEFITS DEPARTMENT	4 00	٥	222 251		1 00
1. 00	DEPARTMENT			32 <u>3, 2</u> 5 <u>1</u> 323, 251		1. 00
	U - PHYS FEE		<u> </u>	323, 231		
1.00	ADULTS & PEDIATRICS	30.00	O	138, 462		1.00
1.00	0		— — j	138, 462		1.00
	V - INCENTIVE		-1	,		
1.00	ADMINISTRATIVE & GENERAL	5. 00	345, 353	0		1. 00
2.00	OPERATION OF PLANT	7. 00	70, 872	0		2. 00
3.00	HOUSEKEEPI NG	9. 00	54, 335	0		3. 00
4.00	DI ETARY	10.00	44, 768	0		4. 00
5.00	NURSING ADMINISTRATION	13. 00	51, 270	0		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14. 00	18, 939	0		6. 00
7. 00	PHARMACY	15. 00	125, 931	0		7. 00
8. 00	SOCI AL SERVI CE	17. 00	15, 518	0		8. 00
9.00	PARAMED ED PRGM	23.00	4, 510	0		9. 00
10.00	ADULTS & PEDIATRICS	30.00	351, 089	0		10.00
11.00	INTENSIVE CARE UNIT	31.00	72, 072	0		11.00
12.00	NEONATAL INTENSIVE CARE	31. 01 40. 00	24, 609	0		12.00
13. 00 14. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF	41. 00	28, 770 25, 094	0		13. 00 14. 00
15. 00	NURSERY	43.00	545	0		15. 00
16. 00	OPERATING ROOM	50. 00	149, 257	0		16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	54.00	93, 015	Ö		17. 00
	CT SCAN	57. 00	10, 073	0		18. 00
19. 00	MAGNETIC RESONANCE IMAGING	58. 00	4, 628	0		19. 00
	(MRI)		., 525			
20.00	CARDIAC CATHETERIZATION	59. 00	22, 597	0		20. 00
21.00	LABORATORY	60.00	43, 586	0		21. 00
22.00	I NTRAVENOUS THERAPY	64. 00	10, 346	0		22. 00
23.00	RESPIRATORY THERAPY	65. 00	46, 530	0		23. 00
24.00	PHYSI CAL THERAPY	66. 00	42, 509	0		24. 00
25. 00	OCCUPATI ONAL THERAPY	67. 00	6, 262	0		25. 00
26. 00	SPEECH PATHOLOGY	68. 00	3, 267	0		26. 00
27. 00	CARDI OLOGY	76.00	23, 958	0		27. 00
28. 00	CLINIC	90.00	4, 901	0		28. 00
29. 00	SLEEP CLINIC	90. 01	13, 386	0		29. 00
30.00	EMERGENCY	91.00	96, 053	0		30.00
31.00	NONPALD WORKERS	193. 00	2, 450	0		31.00
32.00	COMMUNITY	193. 01	15, 027	0		32.00
33. 00	OTHER NONREI MBURSABLE COST CENTERS	194. 00	3, 812	0		33. 00
	TOTALS	 	1, 825, 332	— — _n		
500. 00	Grand Total: Increases		8, 750, 013	71, 973, 623		500.00
		'				

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: Provider CCN: 15-0018

						5/29/2019	7: <u>11 am</u>
		Decreases					
	Cost Center	Li ne #	Salary	Other Other	Wkst. A-7 Ref.		
	6. 00 A - I NSURANCE	7. 00	8. 00	9. 00	10. 00		
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	O	245, 900	12		1. 00
2.00	L	0.00	o_	0	12		2. 00
	0		0	245, 900			
1 00	B - INTEREST	112.00	ما	1 000 421	11		1 00
1. 00 2. 00	I NTEREST EXPENSE ADMI NI STRATI VE & GENERAL	113. 00 5. 00	0	1, 908, 431 1, 908, 431			1. 00 2. 00
2.00	O GENERAL			3, 816, 862			2.00
	C - DI ETARY		<u> </u>	3, 010, 002			
1.00	DI ETARY	10.00	925, 027	1, 565, 396	0		1. 00
	0 — — — —		925, 027	1, 565, 396			
	D - CASE MGMT						
1. 00	SOCI AL SERVI CE	17. 00	49, 057	$ \frac{0}{0}$	0		1. 00
	E - SERVICE CONTRACTS		49, 057	0			
1.00	OPERATION OF PLANT	7. 00	ol	2, 901, 950	0		1.00
2.00		0.00	Ö	0			2. 00
3.00		0. 00	0	0	0		3. 00
4.00		0.00	0	0	0		4. 00
5.00		0.00	0	0			5. 00
6.00		0.00	0	0	0		6. 00
7. 00 8. 00		0. 00 0. 00	0	0	0		7. 00 8. 00
9. 00		0.00	0	0	0		9. 00
10. 00		0.00	o	0	o		10.00
11. 00		0.00	O	0	0		11. 00
12.00		0. 00	0	0	0		12. 00
13.00		0.00	0	0	0		13. 00
14. 00		0.00	•	0	0		14. 00
	H - NURSERY		0	2, 901, 950			
1.00	ADULTS & PEDIATRICS	30.00	1, 573, 278	684, 551	0		1.00
	0		1, 573, 278	684, 551			
	I - ONCOLOGY						
1.00	NURSING ADMINISTRATION	13.00	226, 511	85, 047			1.00
2. 00			<u>0</u> 226, 511	<u>0</u> 85, 047	9		2. 00
	M - DRUGS CHARGED		220, 311	65, 047			
1.00	ADMI NI STRATI VE & GENERAL	5. 00	O	173	0		1.00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	O	4, 643			2. 00
3.00	PHARMACY	15. 00	0	11, 103, 157	0		3. 00
4.00	ADULTS & PEDIATRICS	30. 00	0	75, 496			4. 00
5.00	INTENSIVE CARE UNIT	31.00	0	41, 030			5. 00
6. 00 7. 00	NEONATAL INTENSIVE CARE SUBPROVIDER - IPF	31. 01 40. 00	0	424 305			6. 00 7. 00
8. 00	SUBPROVIDER - I RF	41. 00	0	327			8. 00
9. 00	OPERATING ROOM	50. 00	o	180, 913			9. 00
10.00	RADI OLOGY-DI AGNOSTI C	54.00	0	671, 868			10. 00
11. 00	CT SCAN	57. 00	0	1, 106	0		11. 00
12.00	MAGNETIC RESONANCE I MAGING	58. 00	0	2, 950	0		12. 00
12 00	(MRI)	E0 00		1 570 701			12.00
13. 00 14. 00	CARDI AC CATHETERI ZATI ON LABORATORY	59. 00 60. 00	0	1, 573, 701 1, 006			13. 00 14. 00
15. 00	INTRAVENOUS THERAPY	64.00	0	3, 930			15. 00
16. 00	RESPIRATORY THERAPY	65. 00	Ö	197, 034			16. 00
17. 00	CARDI OLOGY	76. 00	0	284, 953	0		17. 00
18. 00	EMERGENCY	91.00		3 <u>6, 2</u> 88			18. 00
	O DENT		0	14, 179, 304			
1. 00	N - RENT ADMINISTRATIVE & GENERAL	5. 00	0	105, 192	10		1.00
2. 00	OPERATION OF PLANT	7. 00	0	4, 564			2.00
3. 00	DI ETARY	10. 00	0	6, 818			3. 00
4. 00	OPERATING ROOM	50.00	Ö	3, 228			4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	o	101, 939	10		5. 00
6.00	CT SCAN	57. 00	O	7, 686			6. 00
7.00	CARDI AC CATHETERI ZATI ON	59. 00	0	2, 098			7. 00
8.00	CARDI OLOGY	76.00	0	47, 726	10		8. 00
9. 00	SLEEP CLINIC	90.01	0	<u>133</u> 279, 384			9. 00
	O - SUPPLIES AND IMPLANTS		U	217, 304			
1.00	ADULTS & PEDIATRICS	30.00	0	124, 442			1. 00
2.00	INTENSIVE CARE UNIT	31.00	0	132, 090			2. 00
3.00	NEONATAL INTENSIVE CARE	31.01	0	1, 889			3. 00
4. 00	SUBPROVI DER - I PF	40. 00	0	31	0		4. 00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0018

						o 12/31/2018 Date/Time F 5/29/2019 7	Prepared: 7:11 am
		Decreases		<u>'</u>		, , , , , , , , , , , , , , , , , , , ,	
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
F 00	6.00	7. 00	8.00	9.00	10.00		5.00
5.00	SUBPROVI DER - I RF	41.00	0	104			5. 00
6. 00 7. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0	23, 811, 610 985, 255			6. 00 7. 00
8. 00	MAGNETIC RESONANCE I MAGING	58.00	0	158			8. 00
0.00	(MRI)	30.00	٩	150			0.00
9.00	CARDIAC CATHETERIZATION	59.00	O	4, 639, 240	0		9. 00
10.00	I NTRAVENOUS THERAPY	64.00	0	202, 690			10. 00
11.00	RESPI RATORY THERAPY	65.00	0	15, 636	0		11. 00
12.00	PHYSI CAL THERAPY	66.00	0	95	0		12. 00
13.00	OCCUPATI ONAL THERAPY	67.00	0	637	0		13. 00
14.00	EMERGENCY	<u>91.</u> 00	0_	2 <u>9, 1</u> 95			14. 00
	0		0	29, 943, 072			
	P - DEPRECIATION				_		
1.00	ADMINISTRATIVE & GENERAL	5.00	0	17, 784, 967			1.00
2.00			0	0	9		2. 00
	D DHADMACY		UU	17, 784, 967			
1. 00	R - PHARMACY PHARMACY	15. 00	4, 150, 808	0	0		1.00
1.00	n — —		4, 150, 808	$\frac{0}{0}$			1.00
	S - AMORTIZATION		4, 130, 000				
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0	25, 477	11		1.00
				25, 477			
	T - BENEFIT ALLOCATION	<u>'</u>		·			
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	323, 251	0		1. 00
	0		0	323, 251			
	U - PHYS FEE						
1.00	EMERGENCY	<u>91.</u> 00	•	13 <u>8, 4</u> 62			1. 00
	0		0	138, 462			
1 00	V - INCENTIVE	4 00	(50.7//				1 00
1.00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	658, 766	0			1.00
2. 00 3. 00	ADWINISTRATIVE & GENERAL	0.00	1, 166, 566	0			2. 00 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	o	0			7. 00
8.00		0.00	0	0	0		8. 00
9.00		0.00	0	0			9. 00
10.00		0.00	0	0	0		10. 00
11. 00		0.00	0	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
16. 00 17. 00		0. 00 0. 00	0	0			16. 00 17. 00
18. 00		0.00	0	0			18. 00
19. 00		0.00	0	0			19. 00
20. 00		0.00	0	0	_		20.00
21. 00		0.00	0	0			21. 00
22. 00		0.00	o	0			22. 00
23.00		0.00	0	0			23. 00
24.00		0.00	0	0	0		24. 00
25.00		0.00	О	0	0		25. 00
26. 00		0.00	0	0	0		26. 00
27. 00		0.00	0	0	0		27. 00
28. 00		0.00	0	0	0		28. 00
29. 00		0.00	0	0	0		29. 00
30.00		0.00	0	0	0		30.00
31.00		0.00	0	0			31.00
32. 00		0.00	0	0	0		32.00
33. 00			1 025 222	$\frac{0}{0}$	 		33. 00
500.00			1, 825, 332				500.00
500.00	Grand Total: Decreases		8, 750, 013	71, 973, 623			500. 00

				To	12/31/2018	Date/Time Prep 5/29/2019 7:1	pared:
				Acqui si ti ons		372772017 7.1	ı allı
		Begi nni ng	Purchases	Donati on	Total	Di sposal s and	
		Bal ances				Retirements	
		1.00	2. 00	3.00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	4, 146, 907	99, 463	0	99, 463	400, 000	1. 00
2.00	Land Improvements	948, 043	81, 071	0	81, 071	17, 532	2. 00
3.00	Buildings and Fixtures	193, 685, 835	0	0	0	0	3. 00
4.00	Building Improvements	56, 185, 135	3, 499, 075	0	3, 499, 075	313, 075	4. 00
5.00	Fi xed Equipment	94, 067, 360	2, 944, 252	0	2, 944, 252	81, 572	5. 00
6.00	Movable Equipment	19, 783, 912	549, 273	0	549, 273	0	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	368, 817, 192	7, 173, 134	0	7, 173, 134	812, 179	8. 00
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	368, 817, 192	7, 173, 134	0	7, 173, 134	812, 179	10.00
		Endi ng Bal ance	Ful I y				
			Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		_				
1.00	Land	3, 846, 370	0				1. 00
2.00	Land Improvements	1, 011, 582	487, 138				2. 00
3. 00	Buildings and Fixtures	193, 685, 835	6, 379, 429				3. 00
4.00	Building Improvements	59, 371, 135	33, 156, 880				4. 00
5.00	Fi xed Equipment	96, 930, 040	37, 485, 265				5. 00
6.00	Movable Equipment	20, 333, 185	7, 845, 780				6. 00
7. 00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	375, 178, 147	85, 354, 492				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	375, 178, 147	85, 354, 492				10. 00

Heal th	Financial Systems	ELKHART GENER	AL HOSPITAL		In Lieu of Form CMS-2552-10			
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0018	Peri od: From 01/01/2018	Worksheet A-7 Part II		
					To 12/31/2018	Date/Time Pre	pared:	
						5/29/2019 7:1	1 am	
			SL	JMMARY OF CAP	PI TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see			
						instructions)		
		9. 00	10.00	11.00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			1	
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00	
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	0ther	Total (1) (sum					
		Capi tal -Relate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		·		1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00	
3.00	Total (sum of lines 1-2)	o	0				3. 00	

Heal th	n Financial Systems	ELKHART GENER	RAL HOSPITAL		In Lieu of Form CMS-2552-			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Peri od: From 01/01/2018 To 12/31/2018	Worksheet A-7 Part III Date/Time Prep 5/29/2019 7:1		
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF			
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance		
			Leases	for Ratio	instructions)			
				(col . 1 - col 2)				
		1. 00	2.00	3.00	4. 00	5. 00		
	PART III - RECONCILIATION OF CAPITAL COSTS CI					9.00		
1.00	CAP REL COSTS-BLDG & FIXT	354, 844, 964	409, 176	354, 435, 78	0. 945745	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	20, 333, 185					2.00	
3.00	Total (sum of lines 1-2)	375, 178, 149					3. 00	
		TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL			
	Cost Center Description	Taxes	Other	Total (sum o	f Depreciation	Lease		
			Capi tal -Relate					
			d Costs	through 7)				
	DART LLL DESCRIPTION OF CARLEY COOTS OF	6.00	7. 00	8. 00	9. 00	10.00		
1 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	ENTERS	1 0	1	0 15, 515, 415	1 074 007	1 00	
1. 00 2. 00	CAP REL COSTS-BLDG & FIXI	0	ľ		0 15, 515, 415 0 2, 269, 552		1. 00 2. 00	
3.00	Total (sum of lines 1-2)	0			0 2, 269, 332		3. 00	
3.00	Total (Sull of Titles 1-2)	U	<u> </u>	I JMMARY OF CAPI		2, 004, 741	3.00	
			50	JUNIARY OF CALL	IAL			
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum		
			instructions)	instructions) Capi tal -Relate			
					d Costs (see	through 14)		
		11.00	10.00	40.00	instructions)	45.00		
	DART III DECONOLIIATION OF CARLTAL COCTO OF	11. 00	12. 00	13. 00	14.00	15. 00		
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	1, 933, 908	241, 325		0 -1, 947, 395	16, 817, 290	1. 00	
2.00	CAP REL COSTS-BLDG & FIXT	1, 933, 906	1		0 -1, 947, 393		2.00	
3.00	Total (sum of lines 1-2)	1, 933, 908			0 -2, 061, 070			
5.00	1.010. (00 01.1.1.00 1.2)	1 ., 700, 700	210,700	ı	2,001,070	25,700,110	0.00	

Health Financial Systems ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10 ADJUSTMENTS TO EXPENSES Provider CCN: 15-0018 Peri od: Worksheet A-8 From 01/01/2018 12/31/2018 Date/Time Prepared: 5/29/2019 7:11 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 1.00 Investment income - CAP REL OCAP REL COSTS-BLDG & FIXT 1. 00 1.00 COSTS-BLDG & FIXT (chapter 2) 2.00 Investment income - CAP REL OCAP REL COSTS-MVBLE EQUIP 2.00 2.00 COSTS-MVBLE EQUIP (chapter 2) 3.00 Investment income - other 0.00 3.00 (chapter 2) Trade, quantity, and time 4 00 В -92, 551 ADMINISTRATIVE & GENERAL 4 00 5 00 discounts (chapter 8) 5.00 Refunds and rebates of В -961, 107 ADMI NI STRATI VE & GENERAL 5.00 5.00 expenses (chapter 8) Rental of provider space by 6.00 0.00 6.00 suppliers (chapter 8) Tel ephone servi ces (pay 7.00 0 0.00 7.00 stations excluded) (chapter 21) 8.00 Tel evi si on and radio servi ce 0.00 8.00 (chapter 21) Parking lot (chapter 21) 9.00 0.00 9.00 Provider-based physician -3. 034. 820 10.00 10.00 A-8-2 adj ustment 11.00 Sale of scrap, waste, etc. 0.00 11.00 (chapter 23) Related organization 12.00 A-8-1 5, 311, 587 12.00 transactions (chapter 10) 13 00 Laundry and linen service 0 00 13 00 14.00 Cafeteria-employees and guests В -848, 828 CAFETERI A 11.00 14.00 Rental of quarters to employee 15.00 15.00 0.00 and others 16.00 Sale of medical and surgical 0.00 16.00 0 supplies to other than pati ents 17.00 Sale of drugs to other than В -184, 543 PHARMACY 15.00 17.00 pati ents 18.00 Sale of medical records and 0 0.00 18.00 abstracts Nursing and allied health 19 00 19 00 0 0 00 education (tuition, fees, books, etc.) 20.00 Vending machines 0.00 20.00 Income from imposition of 21.00 0.00 interest, finance or penalty charges (chapter 21) 22.00 Interest expense on Medicare 0.00 overpayments and borrowings to repay Medicare overpayments 23.00 Adjustment for respiratory A-8-3 ORESPIRATORY THERAPY 65.00 therapy costs in excess of limitation (chapter 14) 24.00 Adjustment for physical A-8-3 OPHYSICAL THERAPY 66.00 therapy costs in excess of limitation (chapter 14) 25.00 Utilization review OUTILIZATION REVIEW-SNF 114.00 physicians' compensation (chapter 21) Depreciation - CAP REL OCAP REL COSTS-BLDG & FIXT 26.00 1.00 COSTS-BLDG & FLXT Depreciation - CAP REL 27.00 OCAP REL COSTS-MVBLE EQUIP 2.00 COSTS-MVBLE EQUIP 28.00 ONONPHYSICIAN ANESTHETISTS 19.00 Non-physician Anesthetist

Provider CCN: 15-0018 Peri od: Worksheet A-8 From 01/01/2018 | Worksheet A-8
From 01/01/2018 | Date/Time Prepared:

				To	12/31/2018		
				Expense Classification on	Worksheet A	5/29/2019 7:17	ı am
				To/From Which the Amount is			
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
24 00	DUVELCI AN DECDULTMENT	1.00	2.00	3.00	4. 00	5. 00	24.00
34. 00 35. 00	PHYSICIAN RECRUITMENT MEALS ON WHEELS EXPENSE	A A		ADMINISTRATIVE & GENERAL DIETARY	5. 00 10. 00	0	34. 00 35. 00
36. 00	LOBBYING EXPENSES	A		ADMINISTRATIVE & GENERAL	5. 00	Ö	36. 00
38. 00	DELI	В		CAFETERI A	11.00	0	38. 00
39. 00	MEDICAL STAFF DUES	В		ADMINISTRATIVE & GENERAL	5. 00	0	39. 00
40.00	PAYPHONE REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	40.00
41. 00 42. 00	OTHER REVENUE-ADMIN EMS REVENUE	B B		ADMINISTRATIVE & GENERAL PARAMED ED PRGM	5. 00 23. 00	0	41. 00 42. 00
43. 00	TRUSTEE FEE	A	·	ADMINISTRATIVE & GENERAL	5. 00	0	43. 00
44. 00	ENVIRONMENTAL SERVICES	В		HOUSEKEEPI NG	9. 00	o	44.00
45. 00	PLANT MAINT. MISC. REVENUE	В		OPERATION OF PLANT	7. 00	0	45.00
46. 00	OTHER REVENUE-EMS	В		PARAMED ED PRGM	23. 00	0	46. 00
47. 00 48. 00	PHYSICAL THERAPY MISC. REVENUE OTHER REVENUE-FOUNDATION ADMIN			PHYSICAL THERAPY ADMINISTRATIVE & GENERAL	66. 00 5. 00	0	47. 00 48. 00
49. 00	I MAGING SERVICES REVENUE	В		RADI OLOGY-DI AGNOSTI C	54.00	o	49. 00
49. 01	CARDIOLOGY MISC. REVENUE	В		CARDI OLOGY	76.00	o	49. 01
49. 02	NURSING ADMIN. MISC. REVENUE	В		NURSING ADMINISTRATION	13. 00	0	49. 02
49. 03	NON-ALLOWABLE ADMIN EXPENSES	A		ADMINISTRATIVE & GENERAL	5. 00	0	49. 03
49. 04 49. 05	NON-ALLOWABLE CONTRIBUTIONS NON-ALLOWABLE HAF EXPENSE	A A	·	ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0 0	49. 04 49. 05
49. 06	LACTATION SUPPLIES SALES	B		ADULTS & PEDIATRICS	30.00		49. 06
	REVENUE						
49. 07	WOMENS' SERVICES MISC. REVENUE			CLINIC	90.00	0	49. 07
49. 08	PHYSICIAN GUARANTEE	A		OPERATING ROOM	50.00	0	49. 08
49. 09 49. 10	RENTAL REVENUE SEMI NAR REVENUE	B B		CAP REL COSTS-BLDG & FIXT ADMINISTRATIVE & GENERAL	1. 00 5. 00	14	49. 09 49. 10
49. 11	SEMI NAR REVENUE	В		OPERATING ROOM	50. 00	Ö	49. 11
49. 12	SEMI NAR REVENUE	В		EMERGENCY	91.00	0	49. 12
49. 13	OTHER REVENUE - ADMIN	В		ADMINISTRATIVE & GENERAL	5. 00	0	49. 13
49. 14	OTHER REVENUE - PAT ACCTG	В		ADMINISTRATIVE & GENERAL	5.00	0	49. 14
49. 15 49. 16	OTHER REVENUE - CT SCAN OTHER REVENUE - BREAST CENTER	B B		CT SCAN RADI OLOGY-DI AGNOSTI C	57. 00 54. 00	0 0	49. 15 49. 16
49. 17	OTHER REVENUE - BARI ATRI C	В		OPERATING ROOM	50.00	Ö	49. 17
49. 18	OTHER REVENUE - ED	В	-304, 797	EMERGENCY	91.00	0	49. 18
49. 19	OTHER REVENUE - PRENATAL	В	-400	NURSERY	43.00	0	49. 19
49. 20	PROGRAM	В	0	ADMINISTRATIVE & CENEDAL	5. 00	0	49. 20
49. 20 49. 21	SEMI NAR REVENUE OTHER REVENUE - CATH	В		ADMINISTRATIVE & GENERAL CARDIAC CATHETERIZATION	5.00 59.00	0	49. 20 49. 21
49. 22	SEMI NAR REVENUE	В		EMERGENCY	91.00	o	49. 22
49. 23	OTHER REVENUE - ONCOL ADMIN	В	0	NURSING ADMINISTRATION	13.00	0	49. 23
49. 24	OTHER REVENUE - CBM	В		SUBPROVI DER - I PF	40.00	0	49. 24
49. 25 49. 26	OTHER REVENUE - NEONATAL OTHER REVENUE	B B		INTENSIVE CARE UNIT ADULTS & PEDIATRICS	31. 00 30. 00	0 0	49. 25 49. 26
49. 20	JOINT VENTURE ACTIVITY	В		ADMINISTRATIVE & GENERAL	5. 00		
49. 28	OTHER REVENUE-AP RECOVERIES	В		ADMINISTRATIVE & GENERAL	5. 00	Ö	49. 28
49. 29	OTHER REVENUE-OT	В		OCCUPATI ONAL THERAPY	67.00	O	49. 29
49. 30	OTHER REVENUE-RT	В		RESPIRATORY THERAPY	65.00	0	49. 30
49. 31 49. 32	OTHER REVENUE-MEDICAL ONCOLOGY OTHER REVENUE-NICU	B B		ADULTS & PEDIATRICS NEONATAL INTENSIVE CARE	30. 00 31. 01	0	49. 31 49. 32
49. 33	OTHER REVENUE-REHAB	В		SUBPROVI DER - I RF	41. 00	o	49. 33
49. 34	ALLOWABLE PENSION ADJUSTMENT	Α		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49. 34
49. 35	OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	49. 35
49. 36 49. 37	OTHER REVENUE	B B		LAUNDRY & LINEN SERVICE SOCIAL SERVICE	8. 00 17. 00	0	49. 36 49. 37
49. 37 49. 38	OTHER REVENUE OTHER REVENUE	B B		OPERATING ROOM	50. 00	0	49. 37 49. 38
49. 39	OTHER REVENUE	В		LABORATORY	60.00	0	49. 39
49. 40	OTHER REVENUE	В	-1, 287	INTRAVENOUS THERAPY	64.00	0	49. 40
49. 41	TO HOME OFFICE BUILDING	В		CAP REL COSTS-BLDG & FIXT	1. 00	14	
49. 42	TO HOME OFFICE MME	B B		CAP REL COSTS-MVBLE EQUIP	2.00	14	
49. 43 50. 00	TO HOME OFFICE PLANT TOTAL (sum of lines 1 thru 49)	1	- 700, 966 6, 454, 522	OPERATION OF PLANT	7. 00	14	49. 43 50. 00
55. 55	(Transfer to Worksheet A,		3, 101, 022				55. 66
	column 6, line 200.)						
(1) Do	scription - all chapter referen	res in this rol	umn nertain to	CMS Dub 15_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.

·			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	ED 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:

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

line 12.

- 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.

Heal th	Financial Syste	ems		ELKHARI GEN	ERAL	HOSPITAL				In Lie	u of Form CMS.	-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANIZATIONS AND H	OME	Provi der	CCN:	15-0018	Peri od		Worksheet A-	8-1
OFFI CE	COSTS									01/01/2018		
									lo '	12/31/2018	Date/Time Pr 5/29/2019 7:	
	Net	Wkst. A-7 Ref.							L .		3/29/2019 /.	I I alli
	Adjustments	WKSt. A-7 Kel.										
	(col. 4 minus											
	col . 5)*											
		7.00	+									
	6. 00	7. 00										
	A. COSTS INCUR	red and adjusti	MENTS RE	QUIRED AS A RESULT O	f trai	NSACTI ONS	WI TH	I RELATED C	RGANI Z	ATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:										
1.00	1, 026, 311	10										1.00
2.00	1, 579, 046	10										2.00
3.00	25, 737, 355	0										3.00
4.00	-23, 031, 125	0										4.00
E 00	E 211 E07	1										F 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.

nas not	been posted to worksheet A,	cordinals i and/or 2, the amount arrowable should be indicated in cordinal 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	6. 00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00		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		100.00

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0018

Peri od: From 01/01/2018 To 12/31/2018 Date/Ti me Prepared: 5/29/2019 7:11 am

							5/29/2019 7:1	<u>1 am</u>
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
	1 00	0.00	0.00				Hours	
1.00	1.00	2.00	3.00	4.00	5. 00	6. 00	7. 00	4 00
1.00		ADMINISTRATIVE & GENERAL	29, 875	0	,	211, 500		1.00
2.00		SOCIAL SERVICE	1, 248	0	,	197, 500		2. 00
3.00		PARAMED ED PRGM	91, 516	2 052 074	91, 516	211, 500		3. 00
4.00		ADULTS & PEDLATRICS	2, 852, 064	2, 852, 064		227 100	1	4. 00
5.00		ADULTS & PEDIATRICS	14, 210	0	14, 210	237, 100		5. 00
6.00		OPERATING ROOM	28, 700	0	28, 700	246, 400	1	6. 00
7.00		OPERATING ROOM	6, 800	0	6, 800	246, 400	1	7. 00
8.00		RADI OLOGY DI AGNOSTI C	30, 000	0	30, 000	271, 900	1	8. 00
9.00		RADI OLOGY-DI AGNOSTI C	90, 000	0	90,000	271, 900		
10.00		CARDI AC CATHETERI ZATI ON	1, 560	0	1, 560	211, 500		10.00
11. 00		PHYSI CAL THERAPY	24, 500	0	24, 500	211, 500		11.00
12. 00 13. 00		RESPI RATORY THERAPY	7, 020	0	7, 020	211, 500		12. 00 13. 00
14. 00		CARDI OLOGY CARDI OLOGY	2, 716	0	2, 716 12, 150	211, 500 211, 500		14. 00
15. 00		CARDI OLOGY	12, 150	0			1	15. 00
		1	1, 188	0	1, 188	211, 500	1	
16. 00		CARDI OLOGY	2, 800	0	2, 800	211, 500		16.00
17. 00 18. 00		CARDI OLOGY CLI NI C	600	0	600 1, 100	211, 500	1	17. 00 18. 00
19. 00		EMERGENCY	1, 100	0		211, 500 211, 500		19.00
20. 00		SLEEP CLINIC	54, 000	0	54, 000 25, 000	211, 500		20. 00
20. 00		OPERATING ROOM	25, 000	0	25, 000 850	246, 400		21. 00
21.00		EMERGENCY	850 139, 995	0	139, 995	211, 500		21.00
23. 00		RADI OLOGY-DI AGNOSTI C	18, 750	0	18, 750	271, 900		23. 00
24. 00		SUBPROVIDER - IPF	11, 300	0	11, 300	181, 300		
25. 00		SUBPROVIDER - IRF	60, 000	0	60, 000	211, 500		
200.00	41.00	SUBFROVIDER - IKI	3, 507, 942	2, 852, 064		211,500	4, 841	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physi ci an Cost	200.00
	WKSt. A LITTE #	I denti fi er	,	Unadjusted RCE		Component	of Malpractice	
		ruentiffei	Limit	Li mi t	Continuing	Share of col.	Insurance	
				Li iiii t	Educati on	12	Trisur unce	
	1. 00	2.00	8. 00	9. 00	12. 00	13.00	14.00	
1. 00	5. 00	ADMINISTRATIVE & GENERAL	26, 844	1, 342	0	C	0	1. 00
2. 00		SOCIAL SERVICE	1, 044	52		C	o	2. 00
3.00	23. 00	PARAMED ED PRGM	57, 552	2, 878	0	C	o	3. 00
4.00	30.00	ADULTS & PEDIATRICS	0	0	0	C	o	4. 00
5. 00	30. 00	ADULTS & PEDIATRICS	11, 171	559	0	C	o	5. 00
6. 00	50. 00	OPERATING ROOM	16, 585	829	0	C	o	6.00
7. 00	50.00	OPERATING ROOM	4, 739	237	0	C	0	7.00
8.00	54.00	RADI OLOGY-DI AGNOSTI C	19, 216	961	0	C	0	8. 00
9. 00	54. 00	RADI OLOGY-DI AGNOSTI C	60, 524	3, 026	0	C	0	9. 00
10.00	59. 00	CARDIAC CATHETERIZATION	610	31	0	C	0	10.00
11. 00		PHYSI CAL THERAPY	15, 659	783	0	C	0	11.00
12. 00		RESPI RATORY THERAPY	3, 966	198		C	0	12.00
13. 00		CARDI OLOGY	1, 322	66		C	0	13.00
14. 00		CARDI OLOGY	6, 914	346		C	0	14. 00
15. 00		CARDI OLOGY	712	36		C	1	15. 00
16. 00	76. 00	CARDI OLOGY	1, 424	71	0	C	0	16. 00
17. 00		CARDI OLOGY	508			C	0	17. 00
18. 00		CLI NI C	610		0	C		18. 00
19. 00		EMERGENCY	28, 166			C	0	19. 00
20.00		SLEEP CLINIC	17, 693	885		C	0	20.00
21. 00		OPERATING ROOM	592	30		C	0	21. 00
22. 00		EMERGENCY	114, 698	5, 735	0	C	0	22. 00
23. 00		RADI OLOGY-DI AGNOSTI C	12, 549	627	0		0	23. 00
24. 00		SUBPROVIDER - IPF	10, 024	501	0	C	0	24. 00
25. 00	41.00	SUBPROVIDER - IRF	102, 191	5, 110		C	0	25. 00
200.00	Wko+ Alino#	Cost Conton (Dhyroi ei en	515, 313	25,767 Adjusted RCE	0	Adi ustmant	0	200. 00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component	Limit	RCE Di sal I owance	Adjustment		
		rdentifier	Share of col.	LIIIII	DI Sai i Owalice			
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMINISTRATIVE & GENERAL	0	26, 844		3, 031		1. 00
2. 00		SOCIAL SERVICE	Ö	1, 044		204		2. 00
3. 00		PARAMED ED PRGM	0	57, 552		33, 964	1	3. 00
4. 00		ADULTS & PEDIATRICS	0	07,332	00, 704	2, 852, 064		4. 00
5. 00		ADULTS & PEDIATRICS	0	11, 171	3, 039	3, 039	1	5. 00
6. 00		OPERATING ROOM		16, 585		12, 115	1	6. 00
7. 00		OPERATING ROOM	0	4, 739		2, 061	1	7. 00
8. 00		RADI OLOGY-DI AGNOSTI C	0	19, 216		10, 784		8. 00
9. 00		RADI OLOGY-DI AGNOSTI C	0	60, 524		29, 476	1	9. 00
10. 00		CARDI AC CATHETERI ZATI ON	0	610		950	1	10. 00
	ווו פר:							
11. 00		PHYSICAL THERAPY					1	11.00
11. 00			0			8, 841	1	

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0018 Worksheet A-8-2

Peri od: From 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 7:11 am Wkst. A Line # Cost Center/Physician Provider 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	
12.00	65. 00	RESPI RATORY THERAPY	0	3, 966	3, 054	3, 054	12.00
13. 00	76. 00	CARDI OLOGY	0	1, 322	1, 394	1, 394	13.00
14. 00	76. 00	CARDI OLOGY	0	6, 914	5, 236	5, 236	14.00
15. 00	76. 00	CARDI OLOGY	0	712	476	476	15. 00
16. 00	76. 00	CARDI OLOGY	0	1, 424	1, 376	1, 376	16.00
17. 00	76. 00	CARDI OLOGY	0	508	92	92	17. 00
18. 00	90. 00	CLI NI C	0	610	490	490	18. 00
19. 00	91. 00	EMERGENCY	0	28, 166	25, 834	25, 834	19.00
20. 00	90. 01	SLEEP CLINIC	0	17, 693	7, 307	7, 307	20.00
21. 00	50. 00	OPERATING ROOM	0	592	258	258	21. 00
22. 00	91. 00	EMERGENCY	0	114, 698	25, 297	25, 297	22. 00
23. 00	54. 00	RADI OLOGY-DI AGNOSTI C	0	12, 549	6, 201	6, 201	23. 00
24. 00	40. 00	SUBPROVIDER - IPF	0	10, 024	1, 276	1, 276	24. 00
25. 00	41. 00	SUBPROVIDER - IRF	0	102, 191	0	0	25. 00
200. 00			0	515, 313	182, 756	3, 034, 820	200. 00

	Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der C	CN: 15-0018	Peri od: Worksheet B		
					From 01/01/2018 To 12/31/2018	Part Date/Time Pre	pared.
					12,01,2010	5/29/2019 7:1	1 am
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	cost center bescription	for Cost	DLUG & FIAI	WVBLE EQUIP	BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col . 7)			1.00		
	GENERAL SERVICE COST CENTERS	0	1. 00	2.00	4. 00	4A	
1. 00	00100 CAP REL COSTS-BLDG & FIXT	16, 817, 290	16, 817, 290	1			1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP	3, 971, 156	10,017,270	3, 971, 15	6		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	28, 872, 684	3, 310				4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	34, 739, 679	228, 285	53, 90	6 1, 523, 679	36, 545, 549	
6. 00	00600 MAI NTENANCE & REPAI RS	0	0	055 //	0 0	0	6. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	7, 814, 105	3, 623, 600 106, 884			13, 263, 882	
9. 00	00900 HOUSEKEEPING	760, 488 3, 832, 184	96, 488			892, 611 4, 749, 348	
10. 00	01000 DI ETARY	1, 707, 030	247, 730			2, 419, 175	
11. 00	01100 CAFETERI A	1, 641, 595	94, 869				
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0		0	0	12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 685, 074	45, 632				
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 277, 847	366, 972			1, 990, 075	
16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	1, 307, 571 421, 857	138, 344 10, 593				
	01700 SOCIAL SERVICE	1, 956, 304	2, 746				
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0		0 0	0	1
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0	0	19. 00
20. 00		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 02300 PARAMED ED PRGM	79, 798	6, 130	1, 44	0 8 17, 940	105, 316	22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	17, 170	0, 130	1, 44	0 17, 740	103, 310	23.00
30.00	03000 ADULTS & PEDIATRICS	28, 887, 499	3, 176, 617	750, 11	2 6, 542, 099	39, 356, 327	30.00
31. 00	03100 INTENSIVE CARE UNIT	5, 417, 397	274, 310	64, 77	4 1, 331, 945	7, 088, 426	31. 00
31. 01	03101 NEONATAL INTENSIVE CARE	1, 304, 270	57, 133	13, 49	1 364, 113		
32.00	03200 CORONARY CARE UNIT	0	0	1	0	0	02.00
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	1, 752, 304	267, 567	63, 18	2 472, 186	2, 555, 239	
41. 00	04100 SUBPROVI DER – I RF	1, 476, 822	232, 944			2, 155, 863	
43.00	04300 NURSERY	2, 325, 397	364, 422	86, 05	3 593, 779	3, 369, 651	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		0	0	
45. 00	04500 NURSING FACILITY	0	0		0	0	
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0			0 0	0	46. 00
50. 00	05000 OPERATING ROOM	16, 746, 285	1, 430, 912	337, 88	9 3, 193, 479	21, 708, 565	50.00
51.00	05100 RECOVERY ROOM	0	0	,	0 0	0	1
	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	32.00
	05300 ANESTHESI OLOGY	0	0		0 0	0	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	7, 709, 238	945, 629	223, 29	6 1, 725, 949	10, 604, 112 0	1
56. 00	05600 RADI OLOGY-THERAPEUTI C		0		0 0	0	1
57. 00	05700 CT SCAN	1, 536, 032	174, 070	41, 10	4 276, 795	-	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	907, 687	87, 955			1, 150, 937	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 378, 941	99, 847				1
60.00	06000 LABORATORY	10, 447, 597	133, 121	31, 43	5 800, 075	11, 412, 228	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0) 	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	1, 180, 500	47, 888	11, 30	8 319, 924	1, 559, 620	
65.00	06500 RESPI RATORY THERAPY	3, 284, 225	44, 235	10, 44	5 787, 617	4, 126, 522	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 965, 253	121, 793			2, 672, 887	
67. 00	06700 OCCUPATI ONAL THERAPY	725, 022	58, 481			1, 004, 416	
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	257, 627	35, 064	8, 28	0 73,003	373, 974 0	1
70.00	07000 ELECTROENCEPHALOGRAPHY		0		0 0	0	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 488, 522	0		o o	17, 488, 522	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	12, 454, 550	0		0 0	12, 454, 550	
73. 00	07300 DRUGS CHARGED TO PATIENTS	18, 330, 112	0		0 1, 516, 676	19, 846, 788	
74.00	07400 RENAL DI ALYSI S	0	0		0	0	
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY	2, 896, 610	0 235, 960	55, 71	0 8 711, 602	0 3, 899, 890	75. 00 76. 00
70.00	OUTPATIENT SERVICE COST CENTERS	2,070,010	230, 900	J 55, 71	711,002	3, 077, 090	, , 0. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	
90. 00	09000 CLI NI C	706, 647	131, 062	30, 94	8 201, 147	1, 069, 804	90.00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018 Peri od: Worksheet B From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/29/2019 7:11 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A 90. 01 04950 SLEEP CLINIC 512, 161 142, 953 655, 114 90. 01 09100 EMERGENCY 408, 412 14, 449, 897 96, 440 91 00 91.00 11, 696, 418 2, 248, 627 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 O n 000000 09500 AMBULANCE SERVICES 0 95.00 0 0 0 0 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 0 97.00 0 09850 OTHER REIMBURSABLE COST CENTERS 98 00 98 00 0 0 99.00 09900 CMHC 0 Ω 99.00 99. 10 09910 CORF 0 0 0 0 99. 10 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00 0 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 Ω SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 105. 00 106.00 10600 HEART ACQUISITION 00000 0 0 0 0 106. 00 0 107. 00 10700 LIVER ACQUISITION Ω 0 107 00 108.00 10800 LUNG ACQUISITION 0 0 108. 00 0 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 0 0 111.00 11100 I SLET ACQUISITION 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.) 0 115.00 0 0 0 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREIMBURSABLE COST CENTERS 259, 271, 778 13, 299, 005 3, 140, 364 28, 463, 541 254, 509, 466 118. 00 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 0 191. 00 19100 RESEARCH 0 0 0 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 259, 475 61, 271 0 320, 746 192. 00 193. 00 19300 NONPALD WORKERS 308, 989 193. 00 243.307 65, 682

440, 757

4, 605, 956

264, 561, 798

139, 668

3, 119, 142

16, 817, 290

32, 981

736, 540

3, 971, 156

86, 428

261, 125

28, 876, 776

699, 834 193. 01

0 200. 00 0 201.00

8, 722, 763 194. 00

264, 561, 798 202. 00

193. 01 19301 COMMUNI TY

200.00

201.00

202.00

194.00 07950 OTHER NONREIMBURSABLE COST CENTERS

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/29/2019 7:11 am

STATEMENT STAT							5/29/2019 7:1	
SHEARM - SAMPLE - CONT DRITTES 1.00 CROSS PART CORT SAMPLE DUTP		Cost Center Description			OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
Company Service Contretates							9. 00	
2.00 OCCODE CAP NEL COSTS-AMPRILE DOUR PARTY TO A DOUBLE COUNTY OF THE PROPERTY OF THE PROPERT					1			
4.00 0.000 PURP OFFER FREFET IS DEPARTMENT 36, 545, 549 50 0.000 DURIN MISTRATIFUE A CENTENT 36, 545, 549 50 0.000 DURIN MISTRATIFUE A CENTENT 2, 120, 862 0.000 116, 993 1, 162, 578 5, 0.000 0.000 DURIN STRETTER STREET 2, 120, 862 0.000 114, 599 0.000 0.000 DURIN STREET 1, 100, 100 0.000 DURIN STREET 1, 100 0.000								
5.00 COCCOD AZMIN INSTRATIVE A CREEPAN 30, 545, 549 12, 975 12, 97								•
0.000 0.0000 IMITEMENT 2 125 882 0 15 389 764 1 7 7 7 8 8 7 8 8 7 8 8		1	36 545 549					•
2.70 0.07010			0	O				•
0.000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.0000000 0.0000000 0.00000000			2, 125, 882	0	15, 389, 764			
0.000 DICTARY 937,736 0 294,127 0 12,651 10,00 10,000 12,000 1				0				•
11-00 0 10100 CAFETERIA 336,077 0 112,637 0 55,613 11,00 12,00 120,00 1300 NIRSH NA ALPIANE OF PERSONNEL 34,00 0 0 0 12,00 12,00 1300 NIRSH NA ALPIANE SIRVEY 341,00 0 0 0 12,00 12,00 1300 NIRSH NA ALPIANE SIRVEY 341,00 0 0 0 0 12,00 12,00 1300 NIRSH NA ALPIANE SIRVEY 341,00 0 0 0 0 12,00 130,00				0	l			•
12.00 12.00 IMA INTERNACE OF PERSONNEL 0 0 0 0 12.00 13.00		1		0	1	0		•
13.00 01300 NURSIN KO ADMINISTRATION 341,500 0 54,179 0 22,700 13,001 15.00 01500 PHARMACY 247,875 0 104,255 0 17,815 15.00 15.00 01500 PHARMACY 247,875 0 104,255 0 47,815 15.00				0		0		•
14 00 01400 CENTRAL SERVICES & SUPPLY 318, 961 0 435, 702 0 105, 173 14, 00			-	Ö	1	0	_	•
16.00 01600 MFDICAL RECORDS & LIBRARY 39, 899 0 12,577 0 26, 997 16, 00 170. 0	14.00	01400 CENTRAL SERVICES & SUPPLY		0	435, 702	0	105, 193	14. 00
17.00 01700 SOCIAL SERVICE (SPECIFY)		1		0		0		1
18. 00 O O O O O O O O O				0	l	0		•
19. DO 01900 MORPHYSI CI AM ANESTHEID IS 0 0 0 0 0 0 0 0 22.00		1 1	379, 092	0	3, 261	0		•
20. 00			0	0	0	0		1
21.00 02100 BAT SERVICES-SALARY & FRINCES APPRVD 0 0 0 0 0 0 0 0 0			o o	Ö	Ö	0		•
23.00 02300 PARAMED ED PROM 16, 880 0 7, 778 0 3,000 22,00			0	0	0	0	0	1
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30 00 030000 ADULTS & PEDI ATRICS 6, 307, 887 0 3, 771, 568 555, 090 2, 477, 116 30.00 31.00 31.00 1 NTENSIVE CARE WINT 1, 136, 105 0 325, 665 549, 274 305, 869 31.00 31.00 31.00 1 NTENSIVE CARE WINT 0 0 0 0 0 0 0 32.00 32.00 33.00 03300 BURN INTENSIVE CARE WINT 0 0 0 0 0 0 33.00 33.00 03300 SURGICAL INTENSIVE CARE WINT 0 0 0 0 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE WINT 0 0 0 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE WINT 0 0 0 0 0 34.00 03400 SURGICAL INTENSIVE CARE WINT 0 0 0 0 0 34.00 03400 SURGICAL INTENSIVE CARE WINT 0 0 0 0 0 34.00 03400 SURGICAL INTENSIVE CARE WINT 0 0 0 0 0 34.00 03400 SURGICAL INTENSIVE CARE WINT 540.074 0 432.675 21.960 33.33 41.00 03400 SURGICAL INTENSIVE CARE WINT 540.074 0 432.675 45,515 104.456 43.00 44.00 0 0 0 0 0 0 0 0 0	23. 00		16, 880	0	7, 278	0	3, 090	23. 00
33 1.00 031100 INTENSIVE CARE UNIT	20.00		4 207 007	0	2 771 545	EEE 000	2 477 114	20.00
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40,00 04000 SUBPROVI DER - I PF 409, 543 0 317, 679 631 100, 338 40, 00 410, 00 04100 SUBPROVI DER - I RF 345, 533 0 276, 572 21, 960 33, 323 41, 00 440, 00	33.00		0	O	0	0	0	33. 00
41.00 04100 SUBPROVI DER - IRF 345, 533 0 276, 572 21, 960 33, 323 41.00 43.00 04400 ON O 0 0 0 0 0 0 0 0 44.00 04400 SKI LLED NURSI NG FACI LITY 0 0 0 0 0 0 0 0 45.00 04500 NURSIN R FACI LITY 0 0 0 0 0 0 0 0 46.00 04500 NURSI NG FACI LITY 0 0 0 0 0 0 0 0 46.00 04500 NURSI NG FACI LITY 0 0 0 0 0 0 0 0 46.00 04500 NURSI NG FACI LITY 0 0 0 0 0 0 0 0 46.00 04500 NURSI NG FACI LITY 0 0 0 0 0 0 0 0 46.00 04500 ONLY TEND (CARE 0 0 0 0 0 0 0 0 0 46.00 04500 ONLY TEND (CARE 0 0 0 0 0 0 0 0 0			0	0		0		•
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ANCILLARY SERVICE COST CENTERS S. 0.			0	O	Ō	0		•
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51.00				_				
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 53.00 53.00 05300 ANESTHESIOLOGY 0 0 0 0 0 53.00 54.00 05400 RADIOLOGY-DI ACMOSTIC 1,699,585 0 1,122,736 129,580 263,424 54.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 55.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 0 55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 0 55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 0 56.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 0 57.00 05700 CT SCAN 325,040 0 206,672 456 50,758 57.00 59.00 05900 AGRIDIA C CATHETERI ZATION 492,465 0 118,547 0 100,853 59.00 60.01 06000 LABORATORY 1,829,106 0 158,053 0 57,378 60.00 60.01 06000 LABORATORY 1,829,106 0 158,053 0 57,378 60.00 60.01 06000 LABORATORY 1,829,106 0 0 0 0 0 0 0 61.00 06100 PBP CLI IN ICAL LAB SERVICES-PREM ONLY 0 0 0 0 0 0 0 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 64.00 06600 INTRAVENOUS THERAPY 661,382 0 52,520 0 14,345 65.00 65.00 06600 PHYSICAL THERAPY 661,382 0 52,520 0 14,345 65.00 66.00 06600 PHYSICAL THERAPY 160,984 0 69,434 0 3,090 67.00 67.00 07000 0700 0700 0700 0700 0		1	1 1	0	1, 698, 908	178, 472		1
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54.00 05400 RADI OLOGY-DI AGNOSTI C 1,699,585 0 1,122,736 129,580 263,424 54,00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0			0	o o	0	0		
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58.00 05800 MACNETIC RESONANCE IMAGING (MRI) 184, 448 0 104, 428 15, 819 18, 979 58. 00 05900 CARDIAC CATHETERIZATION 492, 465 0 118, 547 0 100, 853 59. 00 00 00 00 00 00 00 00			0	0		0		•
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62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 62. 00 63. 00 06300 BLOOD STORIN RG, PROCESSING & TRANS. 0 0 0 0 0 0 0 63. 00 64. 00 06400 INTRAVENOUS THERAPY 249, 970 0 56, 857 0 06500 65. 00 65. 00 06500 RESPIRATORY THERAPY 428, 400 0 144, 603 11, 002 38, 252 66. 00 66. 00 06600 PHYSI CAL THERAPY 428, 400 0 144, 603 11, 002 38, 252 66. 00 67. 00 06700 0CUPATI ONAL THERAPY 160, 984 0 69, 434 0 3, 090 68. 00 06800 SPEECH PATHOLOGY 59, 939 0 41, 631 0 19, 126 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 2, 802, 990 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 1, 996, 165 0 0 0 0 0 73. 00 07400 REMAL DI ALYSI S 0 0 0 0 0 0 74. 00 07400 REMAL DI ALYSI S 0 0 0 0 0 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 76. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 79. 00 09000 CLIN C COST CENTERS 0 0 0 0 79. 00 09000 EMERGENCY 2, 315, 972 0 484, 903 96, 689 697, 438 91. 00 79. 00 07500 BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 0 0 70 00 00			0	O	0	0		ı
63. 00	61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
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90. 01		1 1	171 464	0	155 602	834		1
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92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 OTHER REIMBURSABLE COST CENTERS				Ö	484, 903			1
		09200 OBSERVATION BEDS (NON-DISTINCT PART)						1
94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 94. 00	0.4 =				I			
	94.00	UY4UU HUME PKUGKAM DI ALYSI S	0		0	0	0	94.00

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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 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	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		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 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	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	34, 934, 400	0	11, 212, 540	1, 162, 578	5, 327, 042	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	51, 408	0	308, 072	0	123, 878	
193. 00 19300 NONPALD WORKERS	49, 524	0	0	0		193. 00
193. 01 19301 COMMUNI TY	112, 167	0	165, 827			193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	1, 398, 050	0	3, 703, 325	0	174, 194	
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)	36, 545, 549	0	15, 389, 764	1, 162, 578	5, 625, 114	202. 00

				'	0 12/31/2018	Date/lime Prep 5/29/2019 7:1	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	
		10.00	11 00	12.00	12.00	SUPPLY	
	GENERAL SERVICE COST CENTERS	10.00	11. 00	12. 00	13. 00	14. 00	
19. 00 20. 00 21. 00 22. 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	3, 113, 691 0 0 0 0 0 0 0 0	2, 601, 191 0 34, 918 42, 274 2, 519 11, 310 40, 663 0		2, 585, 416 77 0 0 5, 460 0 0	2, 892, 282 0 0 0 0 0	15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	0	1, 421	C	0	0	23. 00
30. 00 31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 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 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	2, 429, 242 287, 251 0 0 0 0 265, 144 132, 054 0 0	717, 965 142, 219 28, 164 0 0 51, 863 35, 785 60, 378 0 0		, , ,	0 0 0 0 0 0 0 0	41. 00 43. 00 44. 00 45. 00
	ANCILLARY SERVICE COST CENTERS		225 222	J	0.7.004		
60. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 67. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 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 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03140 CARDI OLOGY 0UTPATI ENT SERVI CE COST CENTERS		305, 803 0 0 183, 914 0 29, 546 12, 896 49, 975 129, 582 0 0 28, 280 86, 824 54, 416 20, 686 7, 717 0 0 0 121, 223 0 0 76, 820		0 0 0 47, 937 0 0 0 62 50, 182 0 0 0 68, 631 0 0 0 0	0 0 0 0 0 0 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 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00
90. 00 90. 01 91. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 04950 SLEEP CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0 0 0	0 0 17, 331 13, 442 258, 300	. C	0 0 4, 340 0 323, 686	0 0 0 0	88. 00 89. 00 90. 00 90. 01 91. 00 92. 00

S729/2019 7; 11 am				Т	o 12/31/2018	Date/Time Pre	
OTHER REI MBURSABLE COST CENTERS	Cost Center Description	DIFTARV	CVEELEDIV	MAINTENANCE OF	NUDSLNG		I dili
OTHER REIMBURSABLE COST CENTERS	cost center bescriptron	DILIANI	CALLILITA				
OTHER REIMBURSABLE COST CENTERS 10.00 11.00 12.00 13.00 14.00				TERSONNEL	ADMINI STRATTON		
OTHER REI MBURSABLE COST CENTERS		10. 00	11. 00	12.00	13. 00		
95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 98. 00 09950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 99. 00 09900 CMRC 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 100. 00 10000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 101000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 101000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 101000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 101000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 101000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 101000 101	OTHER REIMBURSABLE COST CENTERS						
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 99. 10 100. 00 16000 18x SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 105. 00 10500 KI DINEY ACQUI SITI ON 0 0 0 0 0 0 105. 00 105. 00 105. 00 105. 00 106. 00 10600 HEART ACQUI SITI ON 0 0 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SITI ON 0 0 0 0 0 106. 00 109. 00 10900 PANCREAS ACQUI SITI ON 0 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SITI ON 0 0 0 0 0 109. 00 111. 00 111.00 INTEREST EXPENSE 113. 00 114. 00 11400 ITI LI ZATI ON REVIEW-SNF 113. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 0 116. 00 11600 BUSTALES (SUM OF LINES 1 through 117) 3, 113, 691 2, 566, 234 0 2, 585, 416 2, 892, 282 118. 00 119. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 191. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 0 0 0 193. 00 193. 00 19300 NONPAI D WORKERS 0 8, 848 0 0 0 0 0 193. 00 193. 00 19300 NONPAI D WORKERS 0 8, 848 0 0 0 0 0 193. 01 19300 CMMUNITY 0 8, 530 0 0 0 0 0 195. 00 193. 00 193. 00 193. 00 194. 00 193. 00 19300 1	94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 97. 00 98. 00 09800 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 99. 00 09900 CMF 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 100. 00 10000 LAR SERVI CES-NOT APPRVD PRCM 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 106. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 109. 00 10900 PAUREAS ACQUI SI TI ON 0 0 0 0 0 110. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 111. 00 11000 ISLET ACQUI SI TI ON 0 0 0 0 0 111. 00 11100 ISLET ACQUI SI TI ON 0 0 0 0 0 111. 00 11100 LSLET ACQUI SI TI ON 0 0 0 0 0 111. 00 11100 LSLET ACQUI SI TI ON 0 0 0 0 0 111. 00 11100 LSLET ACQUI SI TI ON 0 0 0 0 0 111. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 118. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 3, 113, 691 2, 566, 234 0 2, 585, 416 2, 892, 282 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 8, 848 0 0 0 0 193. 00 193.00 19300 NONPAI D WORKERS 0 8, 848 0 0 0 0 193. 00 193.00 193.00 193.00 193.00 0 0 0 0 193. 00 193.00 193.00 000MUNTY 0 8, 530 0 0 0 194. 00 193. 01	95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
98. 00	96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
99. 00 09900 CMHC	97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	O	0	0	0	0	97. 00
99. 10	98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
100. 00 10000 18R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00	99. 00 09900 CMHC	0	0	0	0	0	99. 00
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS	99. 10 09910 CORF	0	0	0	0	0	99. 10
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 0 105. 00 106. 00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 107.00 10	100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107. 00	101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
106. 00 10600 HEART ACQUISITION 0 0 0 0 106. 00 107. 00 107. 00 107. 00 107. 00 108. 00 108. 00 108. 00 108. 00 108. 00 109. 00							
107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 0 108. 00 109. 00 10900		0	0	0	0		
108.00 10800 LUNG ACQUISITION 0 0 0 0 108.00 109	1 1	0	0	0	0		
109.00 10900 PANCREAS ACQUISITION 0 0 0 0 109.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 110.00 111.00		0	0	0	0		
110. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 1110. 00		0	0	0	0		
111. 00 11100 ISLET ACQUISITION		0	0	0	0		
113.00		0	0	0	0		
114. 00 115. 00 115. 00 115. 00 115. 00 115. 00 116. 00 116. 00 116. 00 116. 00 116. 00 117. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 113, 691 2, 566, 234 0 2, 585, 416 2, 892, 282 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 191. 00 191. 00 192. 00 193. 00 19300 19300 19300 NONPAI D WORKERS 0 8, 848 0 0 0 193. 00 193. 01 19301 COMMUNI TY 0 8, 530 0 0 0 193. 01	1 1	0	0	0	0	0	
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.)	1 1						
116. 00 11600 HOSPI CE	1 1		_	_	_	_	
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 3, 113, 691 2, 566, 234 0 2, 585, 416 2, 892, 282 118. 00		0	0	0	0		
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 191. 00 191. 00 191. 00 192. 00 192. 00 192. 00 192. 00 192. 00 193. 00 193. 00 193. 01 19301 COMMUNI TY 0 8,530 0 0 0 193. 01 193.		0	0	0	0		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 8, 848 0 0 0 193. 00 193. 01 19301 COMMUNI TY 0 8, 530 0 0 0 193. 01		3, 113, 691	2, 566, 234	0	2, 585, 416	2, 892, 282	1118.00
191. 00 19100 RESEARCH 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 8, 848 0 0 0 193. 00 193. 01 19301 COMMUNI TY 0 8, 530 0 0 0 193. 01		٥		1		^	100 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 8,848 0 0 0 193. 00 193. 01 19301 COMMUNI TY 0 8,530 0 0 0 193. 01		0	0		0		
193. 00 19300 NONPAI D WORKERS 0 8, 848 0 0 0 193. 00 193. 01 19301 COMMUNI TY 0 8, 530 0 0 0 193. 01		0	0		0		
193. 01 19301 COMMUNI TY 0 8, 530 0 0 0 193. 01		0	8 848		0		
		0			0		
171. 00 07700 0111EN NORMET INDOMONDEE 0001 0ENTENO 0 17,077 0 0 0 0 174. 00		o			0		
200.00 Cross Foot Adjustments 200.00	1 1	٩	17, 377			O	
201.00 Negative Cost Centers 0 0 0 0 0 201.00	1 1	o	0	0	n	Ω	
202.00 TOTAL (sum Lines 118 through 201) 3, 113, 691 2, 601, 191 0 2, 585, 416 2, 892, 282 202.00		3, 113, 691	2, 601, 191	l ő	2, 585, 416		

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2018	Part
To 12/31/2018	Date/Time Prepared:
5/29/2019 7:11 am	Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018

					0 12/31/2018	5/29/2019 7:1	
					OTHER GENERAL		
	Cost Conton Decemintion	DUADMACY	MEDLCAL	COCLAL SERVICE	SERVI CE	NONDLIVEL CLAN	
	Cost Center Description	PHARMACY	MEDICAL RECORDS &	SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN ANESTHETI STS	
			LI BRARY			ANESTHETISTS	
		15. 00	16. 00	17. 00	18. 00	19. 00	
·	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERIA						11.00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY	2, 009, 012					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	701, 682				16. 00
17. 00	01700 SOCIAL SERVICE	o	0	l			17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	O	0	0	0		18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	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	0		22. 00 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		<u> </u>	0		23.00
30. 00	03000 ADULTS & PEDI ATRI CS	2, 115	115, 886	2, 219, 439	0	0	30. 00
31. 00	03100 INTENSIVE CARE UNIT	382	26, 738		0	0	31. 00
31. 01	03101 NEONATAL INTENSIVE CARE	0	3, 166	34, 690	0	0	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	-	33. 00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	20	7, 582	127 117	0	0	34. 00 40. 00
41. 00	04100 SUBPROVI DER – TFI	34	3, 387		0	0	41.00
43. 00	04300 NURSERY	0	4, 374		0	Ö	43. 00
44. 00	04400 SKILLED NURSING FACILITY	o	0		0	0	44.00
45.00	04500 NURSING FACILITY	o	0	0	0	0	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	10, 615	104, 657	0	0	0	50. 00
51. 00	05100 RECOVERY ROOM	10, 613	104, 037			-	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	Ö	0	Ō	-	0	52. 00
53. 00	05300 ANESTHESI OLOGY	o	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	446	75, 771	0	0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 57. 00	05600	0	70 414	0		0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		78, 416 11, 820		0	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	284	42, 969		0	ő	59. 00
60.00	06000 LABORATORY	o	87, 263	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	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	0	0	0	0	62. 00 63. 00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	234	1, 714	_	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	26, 968	26, 934	1	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	6, 945	1	0	Ö	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	o	4, 002	1	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	1, 272	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	1, 941, 315	0		0	0	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	1, 741, 313	0	0	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)		Ö	ő	O	0	75. 00
76. 00	03140 CARDI OLOGY	26, 087	35, 269	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	4 725	_	0	0	89.00
90. 00 90. 01	09000 CLI NI C 04950 SLEEP CLI NI C		4, 735 3, 752	1	0	0	90. 00 90. 01
	09100 EMERGENCY	512	55, 030	1	-		1
	· · · ·					•	·

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018

			Ť	0 12/31/2018	Date/Time Pre 5/29/2019 7:1	pared: 1 am
Cost Center Description	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	OTHER GENERAL SERVI CE (SPECI FY)	NONPHYSI CI AN ANESTHETI STS	
	15. 00	16. 00	17. 00	18. 00	19. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	7,0,00					92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	О	0	0	o	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	О	0	0	o	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	О	0	0	o	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	О	0	0	o	0	98. 00
99. 00 09900 CMHC	О	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	0	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		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	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 ACQUI SI TI ON	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) NONREIMBURSABLE COST CENTERS	2, 009, 012	701, 682	2, 793, 723	0	0	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191, 00 19100 RESEARCH	o	0	0	ol	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	0	0	ol	0	192. 00
193. 00 19300 NONPALD WORKERS	O	0	0	o		193. 00
193. 01 19301 COMMUNI TY	o	0	0	o	0	193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	o	0	0	o		194. 00
200.00 Cross Foot Adjustments					0	200.00
201.00 Negative Cost Centers	o	0	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 009, 012	701, 682	2, 793, 723	o	0	202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2018	Part
To 12/31/2018	Date/Time Prepared:
5/29/2019 7:11 am	Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018

				, ,) 12/31/2018	5/29/2019 7:1	
			INTERNS &	RESI DENTS			
	Cost Center Description	MITDST NC SCHOOL	SEDVICES SALAD	SERVI CES-OTHER	PARAMED ED	Subtotal	
	Cost Center Description	NURSTING SCHOOL	Y & FRINGES	PRGM COSTS	PRGM	Subtotal	
		20. 00	21. 00	22.00	23. 00	24. 00	
	GENERAL SERVI CE COST CENTERS						
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 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
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 MEDI CAL RECORDS & LI BRARY						16.00
17. 00 18. 00	01700 SOCIAL SERVICE						17. 00 18. 00
19. 00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS						19.00
20. 00	02000 NURSI NG SCHOOL	0					20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD		0				21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD			0			22. 00
23. 00	02300 PARAMED ED PRGM				133, 985		23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				ما	E0 0EE 240	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	0	-	0	59, 055, 349 9, 804, 366	
31. 01	03101 NEONATAL INTENSIVE CARE				0	2, 273, 217	1
32. 00	03200 CORONARY CARE UNIT	0	O	0	0	0	1
33.00	03300 BURN INTENSIVE CARE UNIT	0	O	0	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40.00	04000 SUBPROVIDER - I PF	0	0	0	0	3, 889, 678	1
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0		0	0	3, 085, 498 4, 944, 638	
44. 00	04400 SKILLED NURSING FACILITY			0	0	4, 744, 038	1
45. 00	04500 NURSING FACILITY	0	o o	1	Ö	0	1
46.00	04600 OTHER LONG TERM CARE	0	O	0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS	T -	T -	T	_1		
50.00	05000 OPERATI NG ROOM	0	_		0	28, 406, 638	1
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM		0	0	0	0	1
53. 00	05300 ANESTHESI OLOGY			Ö	Ö	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	O	0	0	14, 127, 505	1
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	
57. 00	05700 CT SCAN	0		0	0	2, 718, 889	
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION			0	0	1, 499, 409 3, 927, 878	
60.00	06000 LABORATORY			o	0	13, 673, 610	
60. 01	06001 BLOOD LABORATORY		Ö	Ö	Ö	0	1
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	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	2 020 409	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY			0	O O	2, 030, 408 4, 995, 495	
66. 00	06600 PHYSI CAL THERAPY	1 0	n	0	o n	3, 356, 505	1
67. 00	06700 OCCUPATI ONAL THERAPY			o	o	1, 262, 612	
68. 00	06800 SPEECH PATHOLOGY	0	0	0	o	503, 659	
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	0	21 040 024	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS			0	O O	21, 969, 036 15, 665, 473	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1	n	0	n	25, 090, 290	
74. 00	07400 RENAL DIALYSIS		ď	l ő	ő	23, 070, 270	
75. 00	07500 ASC (NON-DISTINCT PART)	0	O	-	0	0	1
76. 00	03140 CARDI OLOGY	0	О	0	0	5, 042, 975	76. 00
00 00	OUTPATIENT SERVICE COST CENTERS				٥١	^	00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	0	
90.00	09000 CLINIC	0	l o		0	1, 471, 195	1
	04950 SLEEP CLINIC		ď	Ö	Ö	777, 329	1
91.00	09100 EMERGENCY	0	0	0	133, 985	18, 816, 412	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	<u> </u>					92. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part I Provider CCN: 15-0018

			F	o 12/31/2018		nared:
			'	0 12/31/2010	5/29/2019 7: 1	
		INTERNS &	RESI DENTS			
Cost Center Description	NURSING SCHOOL	SERVI CES-SALAR	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						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	
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 I NTEREST 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			0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	0	0	133, 985	248, 388, 064	118. 00
NONREI MBURSABLE COST CENTERS	<u> </u>					1
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	804, 104	192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	o	367, 361	193. 00
193. 01 19301 COMMUNI TY	0	0	0	o	986, 358	193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0	0	o	14, 015, 911	194.00
200.00 Cross Foot Adjustments	0	0	0	o		200.00
201.00 Negative Cost Centers	0	0	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	0	0	0	133, 985	264, 561, 798	202. 00

In Lieu of Form CMS-2552-10 Health Financial Systems ELKHART GENERAL HOSPITAL

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018 Peri od: Worksheet B From 01/01/2018 Part I Date/Time Prepared: 12/31/2018 5/29/2019 7:11 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 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 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12. 00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15. 00 | 01500 | PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17. 00 01700 SOCIAL SERVICE 17 00 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSI NG SCHOOL 20.00 02100 | &R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02300 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 59, 055, 349 30.00 31.00 03100 INTENSIVE CARE UNIT 0 9, 804, 366 31.00 0 03101 NEONATAL INTENSIVE CARE 2, 273, 217 31.01 31.01 03200 CORONARY CARE UNIT 0000000 32.00 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 3, 889, 678 40.00 40.00 3, 085, 498 41.00 04100 SUBPROVI DER - I RF 41.00 04300 NURSERY 43 00 4, 944, 638 43 00 44.00 04400 SKILLED NURSING FACILITY 44.00 04500 NURSING FACILITY 0 45.00 Ω 45.00 04600 OTHER LONG TERM CARE 0 46.00 46.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 28, 406, 638 50.00 0 51.00 05100 RECOVERY ROOM 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 Λ 53.00 05300 ANESTHESI OLOGY 0000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 14, 127, 505 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 56.00 05600 RADI OI SOTOPE 56.00 57.00 05700 CT SCAN 2, 718, 889 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 1, 499, 409 58.00 05900 CARDIAC CATHETERIZATION 3, 927, 878 59 00 59 00 60.00 06000 LABORATORY 13, 673, 610 60.00 06001 BLOOD LABORATORY 0 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0000000000000 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 06400 INTRAVENOUS THERAPY 64.00 2,030,408 64.00 4, 995, 495 65 00 06500 RESPIRATORY THERAPY 65 00 06600 PHYSI CAL THERAPY 66.00 3, 356, 505 66.00 06700 OCCUPATIONAL THERAPY 1, 262, 612 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 503, 659 68.00 69 00 06900 FLECTROCARDLOLOGY 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 21, 969, 036 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 15, 665, 473 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 25, 090, 290 73.00 74.00 07400 RENAL DIALYSIS 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 76.00 03140 CARDI OLOGY 0 5, 042, 975 76, 00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER Λ 89.00

1, 471, 195

18, 816, 412

777, 329

90.00

90.01

91.00

90 00 90.01 09000 CLI NI C

91. 00 09100 EMERGENCY

04950 SLEEP CLINIC

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018 Peri od: Worksheet B From 01/01/2018 Part I 12/31/2018 Date/Time Prepared: 5/29/2019 7:11 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 26.00 25.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 0 0 0 0 0 0 95. 00 09500 AMBULANCE SERVICES 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 99. 00 09900 CMHC 0 99.00 99. 10 09910 CORF 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101. 00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 105. 00 0 0 0 0 0 0 0 106. 00 10600 HEART ACQUISITION 106. 00 0 107. 00 10700 LIVER ACQUISITION 0 107.00 108.00 10800 LUNG ACQUISITION 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 I SLET ACQUISITION 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 0 115.00 116. 00 11600 HOSPI CE 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 0 248, 388, 064 118.00 NONREI MBURSABLE COST CENTERS 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 0 191. 00 19100 RESEARCH 191. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 804, 104 192. 00 193. 00 19300 NONPALD WORKERS 193. 00 367, 361

986, 358

0

14, 015, 911

264, 561, 798

193. 01

194. 00

200. 00

201. 00

202.00

193. 01 19301 COMMUNI TY

200.00

201.00

202.00

194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | Table 2010 | Ta Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

					То	12/31/2018	Date/Time Prep 5/29/2019 7:1	
				CAPI TAL REI	LATED COSTS		0,27,201, 711	- Cili
		Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		oost center bescription	Assigned New	DEDO & TIXI	WVDLL EQUIT	Subtotal	BENEFITS	
			Capital				DEPARTMENT	
			Related Costs 0	1. 00	2.00	2A	4. 00	
		AL SERVICE COST CENTERS						
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT	0	3, 310	782	4, 092	4, 092	4. 00
5.00		ADMINISTRATIVE & GENERAL	0	228, 285		282, 191	217	5. 00
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	0	0 3, 623, 600	_	0 4, 479, 262	0 138	6. 00 7. 00
8. 00		LAUNDRY & LINEN SERVICE	0	106, 884		132, 123	0	8. 00
9.00	1	HOUSEKEEPI NG	0	96, 488		119, 272	114	9. 00
10. 00 11. 00		DI ETARY CAFETERI A	0	247, 730 94, 869		306, 228 117, 271	58 48	10. 00 11. 00
12. 00	1	MAINTENANCE OF PERSONNEL	0	0		0	0	12. 00
13. 00		NURSING ADMINISTRATION	0	45, 632		56, 407	55	
14. 00 15. 00		CENTRAL SERVICES & SUPPLY PHARMACY	0	366, 972 138, 344		453, 627 171, 012	37 10	14. 00 15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	10, 593		13, 094	18	16. 00
17. 00	1	SOCIAL SERVICE	0	2, 746	648	3, 394	58	17. 00
18. 00 19. 00		OTHER GENERAL SERVICE (SPECIFY) NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18. 00 19. 00
20. 00		NURSI NG SCHOOL	0	Ö	ő	Ö	0	20. 00
21.00	1	I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0	0	21. 00
22. 00 23. 00		I&R SERVICES-OTHER PRGM COSTS APPRVD PARAMED ED PRGM	0	6, 130	1, 448	7, 578	0	22. 00 23. 00
20.00	-	IENT ROUTINE SERVICE COST CENTERS		0, 100	1, 110	7, 070	3	20.00
30.00		ADULTS & PEDIATRICS	0	3, 176, 617		3, 926, 729	913	30.00
31. 00 31. 01		INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE	0	274, 310 57, 133		339, 084 70, 624	190 52	
32. 00	1	CORONARY CARE UNIT	0	0		0	0	32. 00
33.00		BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 40. 00		SURGICAL INTENSIVE CARE UNIT SUBPROVIDER - IPF	0	267, 567	63, 182	330, 749	0 67	34. 00 40. 00
41. 00	04100	SUBPROVI DER - I RF	0	232, 944		287, 950	56	
43.00		NURSERY	0	364, 422		450, 475	85	43.00
44. 00 45. 00		SKILLED NURSING FACILITY NURSING FACILITY	0	0	0	0	0	44. 00 45. 00
46. 00	04600	OTHER LONG TERM CARE	0	0	Ö	0	0	46. 00
E0 00		LARY SERVICE COST CENTERS OPERATING ROOM	0	1 420 012	227 000	1 7/0 001	454	FO 00
50. 00 51. 00		RECOVERY ROOM	0	1, 430, 912 0		1, 768, 801 0	454 0	
52. 00	05200	DELIVERY ROOM & LABOR ROOM	0	0	O	O	0	
53. 00 54. 00		ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	945, 629	0 223, 296	1 149 025	0	53. 00 54. 00
55. 00		RADI OLOGY-THERAPEUTI C	0	945, 629	223, 290	1, 168, 925 0	246	55. 00
56.00	05600	RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	1	CT SCAN	0	174, 070		215, 174	39	
58. 00 59. 00		MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	0	87, 955 99, 847		108, 724 123, 424	19 81	•
60.00	06000	LABORATORY	0	133, 121		164, 556	114	60. 00
60. 01 61. 00	1	BLOOD LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	60. 01 61. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0	О	О	0	0	
63. 00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
64. 00 65. 00	1	I NTRAVENOUS THERAPY RESPI RATORY THERAPY	0	47, 888 44, 235		59, 196 54, 680	46 112	
66. 00	1	PHYSI CAL THERAPY	0	121, 793		150, 553	79	
67. 00	06700	OCCUPATI ONAL THERAPY	0	58, 481	13, 809	72, 290	29	67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	35, 064	8, 280	43, 344	10	68. 00 69. 00
70.00		ELECTROCARDI OLOGI ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70.00
71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	o	0	71. 00
72. 00 73. 00	1	IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0	0	0	0 216	72. 00 73. 00
74.00	1	RENAL DIALYSIS		0		ol	216 0	1
75.00	07500	ASC (NON-DISTINCT PART)	0	0	O	o	0	75. 00
76. 00		CARDIOLOGY TIENT SERVICE COST CENTERS	0	235, 960	55, 718	291, 678	101	76. 00
88. 00		RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90. 00 90. 01		CLINIC SLEEP CLINIC	0	131, 062 0		162, 010 0	29 20	90. 00 90. 01
70.01	10.700	1	1 0	·	1 0	<u> </u>	20	70.01

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part II Provider CCN: 15-0018

			To	12/31/2018	Date/Time Pre 5/29/2019 7:1	pared: 1 am
		CAPI TAL REI	LATED COSTS			
Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	Related Costs	1 00	2.00	2.4	1.00	
91. 00 09100 EMERGENCY	0	1. 00 408, 412	2. 00 96, 440	2A 504, 852	4. 00	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	U	400, 412	90, 440	0	320	91.00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	O	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	Ö	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	o	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	Ö	ol	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	Ö	ol	0	98. 00
99. 00 09900 CMHC	0	0	o	o	0	99. 00
99. 10 09910 CORF	o	0	o	ol	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	О	o	0	100. 00
101.00 10100 HOME HEALTH AGENCY	O	0	О	o	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		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 I SLET ACQUI SI TI ON	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	12 200 005	2 140 274	17 420 270		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	l 0	13, 299, 005	3, 140, 364	16, 439, 369	4, 034	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	O	O	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	259, 475	61, 271	320, 746		192. 00
193. 00 19300 NONPALD WORKERS	0	237, 473	01, 2, 1	320, 740 0		193. 00
193. 01 19301 COMMUNI TY	0	139, 668	32, 981	172, 649		193. 01
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	l o	3, 119, 142		3, 855, 682		194. 00
200.00 Cross Foot Adjustments		-, ,		0		200. 00
201.00 Negative Cost Centers		0	o	ol		201. 00
202.00 TOTAL (sum lines 118 through 201)	O	16, 817, 290	3, 971, 156	20, 788, 446		202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 7:11 am

	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	5/29/2019 7: 1 HOUSEKEEPI NG	
	cost center bescription	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	GENERAL SERVICE COST CENTERS	5. 00	6. 00	7. 00	8. 00	9. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	000 400					4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	282, 408	0				5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	16, 434	0	4, 495, 834			7.00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 106	0	37, 072			8. 00
9.00	00900 HOUSEKEEPI NG	5, 884	0	33, 466	0	158, 736	9. 00
10.00	01000 DI ETARY	2, 997	0	85, 924	0	357	10.00
11.00	01100 CAFETERI A	2, 598	0	32, 905	0	1, 569	11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0 2, 640	0	15, 827	0	0 670	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 466	0	127, 282	0	2, 968	14. 00
15. 00	01500 PHARMACY	1, 916	0	47, 984	0	1, 349	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	695	0	3, 674	0	762	16. 00
17. 00	01700 SOCIAL SERVICE	2, 931	0	953 0	0	0	17. 00
18. 00 19. 00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18. 00 19. 00
20. 00	02000 NURSI NG SCHOOL		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	O2300 PARAMED ED PRGM	130	0	2, 126	0	87	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	48, 660	0	1, 101, 796	81, 312	69, 903	30.00
31. 00	03100 NTENSI VE CARE UNI T	8, 783	0			8, 631	31.00
31. 01	03101 NEONATAL INTENSIVE CARE	2, 155	0	19, 816	•	1, 424	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 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	3, 166	0	92, 804	92	0 2, 831	34. 00 40. 00
41. 00	04100 SUBPROVI DER – TFF	2, 671	0	80, 795		940	41.00
43. 00	04300 NURSERY	4, 175	0	126, 398		2, 948	43. 00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	0	U	0	46. 00
50. 00	05000 OPERATING ROOM	26, 897	0	496, 304	26, 144	15, 588	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	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	13, 138	0	327, 986	18, 982	7, 434 0	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE		0	0	0	0	56.00
57. 00	05700 CT SCAN	2, 513	0	60, 375	67	1, 432	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 426	0	30, 507	2, 317	536	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 807	0	34, 631	0	2, 846	1
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	14, 140	0	46, 172	0	1,619	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		O	J o	O	O	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	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, 932	0	16, 610	0	1, 837	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	5, 113 3, 312	0	15, 343 42, 243	0 1, 612	405 1, 079	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 244	0	20, 284		87	67.00
68. 00	06800 SPEECH PATHOLOGY	463	0	12, 162	0	540	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 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	21, 668	0	0	0	0	71. 00 72. 00
72.00	07300 DRUGS CHARGED TO PATIENTS	15, 431 24, 590	0	1	0	0	73.00
74. 00	07400 RENAL DIALYSIS	0	0	ő	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 00	03140 CARDI OLOGY	4, 832	0	81, 841	506	1, 472	76. 00
00 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0	_	0	^	00 00
88. 00 89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90. 00	09000 CLINIC	1, 325	0	45, 458	122	1, 329	90.00
90. 01	04950 SLEEP CLINIC	812	0	0	3	0	90. 01
91.00	09100 EMERGENCY	17, 903	0	141, 655	14, 164	19, 681	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94. 00
7 00	122515m2	<u> </u>		1 0	<u> </u>		, , 55

| Peri od: | Worksheet B | From 01/01/2018 | Part | I | To 12/31/2018 | Date/Time Prepared: | Table 2010 | Ta

			'	12/01/2010	5/29/2019 7:1	
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 I SLET ACQUI SI TI ON	0	0	0	0	0	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.)	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)	269, 953	0	3, 275, 536	170, 301	150, 324	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	397	0	89, 997	0		192. 00
193. 00 19300 NONPALD WORKERS	383	0	0	0		193. 00
193. 01 19301 COMMUNI TY	867	0	48, 443	0		193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	10, 808	0	1, 081, 858	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)	282, 408	0	4, 495, 834	170, 301	158, 736	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2018 | Part II |
| To | 12/31/2018 | Date/Time Prepared: | 5/29/2019 7:11 am |

				12/31/2018	5/29/2019 7:1	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	
			PERSONNEL	ADMI NI STRATI ON	SERVI CES & SUPPLY	
	10.00	11. 00	12.00	13.00	14. 00	
GENERAL SERVICE COST CENTERS			,			
1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5. 00
6. 00 00600 MAINTENANCE & REPAIRS						6. 00
7.00 OO700 OPERATION OF PLANT						7. 00
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG	205 5/4					9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A	395, 564 0	154, 391				10. 00 11. 00
12. 00 O1100 CALETERYA 12. 00 O1200 MAI NTENANCE OF PERSONNEL	0	154, 571				12.00
13. 00 01300 NURSI NG ADMINI STRATI ON	l o	2, 073		77, 672		13.00
14.00 01400 CENTRAL SERVICES & SUPPLY	O	2, 509) (2	588, 891	14. 00
15. 00 01500 PHARMACY	0	150	1	0	0	15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	671	1	0	0	16.00
17. 00 01700 SOCIAL SERVICE 18. 00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	2, 414		164	0	17. 00 18. 00
19. 00 O1900 NONPHYSICIAN ANESTHETISTS	0	0			0	19.00
20. 00 02000 NURSI NG SCHOOL		0		ol öl	0	20.00
21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	O	0		o	0	21.00
22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0) (o	0	22. 00
23. 00 02300 PARAMED ED PRGM	0	84	(0	0	23. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	200 (12	42 (12		22 120	0	20.00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 NTENSIVE CARE UNIT	308, 612 36, 492	42, 613 8, 441	1		0	30. 00 31. 00
31. 01 03101 NEONATAL INTENSIVE CARE	0	1, 672			0	31. 00
32. 00 03200 CORONARY CARE UNIT	O	0			0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0) (o	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34. 00
40. 00 04000 SUBPROVI DER - I PF	33, 684	3, 078		1, 638	0	40.00
41. 00 04100 SUBPROVI DER - RF 43. 00 04300 NURSERY	16, 776	2, 124 3, 584	1	1, 484 3, 290	0	41. 00 43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	3, 364		3, 240	0	44. 00
45. 00 04500 NURSI NG FACILITY	O	0		ol ol	0	45. 00
46.00 04600 OTHER LONG TERM CARE	0	0) (o	0	46. 00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	18, 151		11, 052	0	50.00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0			0	51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0	0			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	l o	10, 916		1, 440	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	o	0) (o	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	56. 00
57. 00 05700 CT SCAN	0	1, 754		0	0	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0	765		1 500	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	2, 966 7, 691		1, 508	0	59. 00 60. 00
60. 01 06001 BLOOD LABORATORY		7,071		ol ol	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) (o	0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	1, 679		2, 062	0	64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	0	5, 153 3, 230			0	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 228			0	67.00
68. 00 06800 SPEECH PATHOLOGY	O	458		ol ol	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	O	0		o	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0	341, 557	71.00
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	0	7 105)		247, 334	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS	0	7, 195			0	73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)		0			0	75. 00
76. 00 03140 CARDI OLOGY	l o	4, 560		1, 324	0	76. 00
OUTPATIENT SERVICE COST CENTERS	-1					
88. 00 08800 RURAL HEALTH CLINIC	0	0		O	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1 000		0	0	89.00
90. 00 09000 CLINIC 90. 01 04950 SLEEP CLINIC		1, 029 798		130	0	90. 00 90. 01
91. 00 09100 EMERGENCY		15, 331		9, 724	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		. 5, 551		', ', ', ', ', ', ', ', ', ', ', ', ',	Ü	92.00
	· '		•			-

			1	0 12/31/2018	Date/IIme Pre 5/29/2019 7:1	
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	71.00
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 SERVI CES-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 ACQUISITION	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 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)	395, 564	152, 317	0	77, 672	588, 891	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	525		0		193. 00
193. 01 19301 COMMUNI TY	0	506		0		193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	1, 043	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)	395, 564	154, 391	0	77, 672	588, 891	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2018 | Part II | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 7:11 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

					12/31/2010	5/29/2019 7:1	
					OTHER GENERAL SERVI CE		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE		NONPHYSI CI AN	
	·		RECORDS &			ANESTHETI STS	
		15. 00	16. 00	17. 00	18. 00	19. 00	
	GENERAL SERVICE COST CENTERS	13.00	10.00	17.00	10.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8.00
10.00	01000 DI ETARY			•			9. 00 10. 00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY	222, 421					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	18, 914				16. 00
17. 00	01700 SOCIAL SERVICE	0	0	.,	0		17.00
18. 00 19. 00	01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	18. 00 19. 00
20. 00	02000 NURSI NG SCHOOL	0	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	0		22. 00
23. 00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	j Oj	0	0	0		23. 00
30. 00	03000 ADULTS & PEDIATRICS	234	3, 234	7, 876	0		30. 00
31. 00	03100 INTENSIVE CARE UNIT	42	716				31. 00
31. 01	03101 NEONATAL INTENSIVE CARE	0	85				31. 01
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0				32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		0		34. 00
40. 00	04000 SUBPROVI DER - I PF	2	203		0		40. 00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	4	91 117		0		41. 00 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	0	0		46. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS O5000 OPERATI NG ROOM	1, 175	2, 801	1 0	0		50.00
51. 00	05100 RECOVERY ROOM	0	0			l	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0		52. 00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 49	0 2, 028	0	0		53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	2, 028		0		55.00
56. 00	05600 RADI OI SOTOPE	0	0	0	0		56. 00
	05700 CT SCAN	0	2, 099			l	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0 31	316 1, 150	1		1	58. 00 59. 00
60. 00	06000 LABORATORY	0	2, 336	1	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		62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	26	46		0		64. 00
65. 00	06500 RESPI RATORY THERAPY	2, 986	721		0		65. 00
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	0	186 107		0		66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		34		0		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 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	214, 927	0	ő	Ö		73. 00
74. 00	07400 RENAL DIALYSIS	0	0	0	0		74. 00
75. 00 76. 00	07500 ASC (NON-DISTINCT PART)	0	944	0			75. 00 76. 00
70.00	O3140 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS	2, 888	944	0	0		76.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	_			89. 00
90. 00 90. 01	09000 CLI NI C 04950 SLEEP CLI NI C		127 100		0		90. 00 90. 01
	09100 EMERGENCY	57	1, 473			l	91.00
							·

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

			Ť	0 12/31/2018	Date/Time Pre 5/29/2019 7:1	pared: 1 am
				OTHER GENERAL SERVI CE	3/2//2017 1.1	
Cost Center Description	PHARMACY	RECORDS &	SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN ANESTHETI STS	
	15. 00	LI BRARY 16. 00	17. 00	18. 00	19. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10.00	10.00	17.00	10.00	17.00	92. 00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0		94.00
95. 00 09500 AMBULANCE SERVICES	o	0	0	0		95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0	0	0		96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0	0	0		97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	o	0	0	0		98. 00
99. 00 09900 CMHC	o	0	0	0		99. 00
99. 10 09910 CORF	o	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		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 I SLET ACQUI SI TI ON	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		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	222, 421	18, 914	9, 914	0	0	118. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	٥	0	0	0		190. 00
191. 00 19100 RESEARCH		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	١			193. 01
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	ام	0	١	n		194. 00
200.00 Cross Foot Adjustments		O	I		0	200. 00
201.00 Negative Cost Centers	o	0	0	n		201. 00
202.00 TOTAL (sum lines 118 through 201)	222, 421	18, 914	9, 914	Ö		202. 00
			•			•

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2018 | Part II |
| To | 12/31/2018 | Date/Time Prepared: | 5/29/2019 7:11 am | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

				10) 12/31/2018	5/29/2019 7:1	
			INTERNS &	RESI DENTS			
	Coot Conton Decemintion	MINDEL MC CCHOOL	CEDVICES SALAD	CEDVI CEC OTHER	PARAMED ED	Cubtatal	
	Cost Center Description	NURSTING SCHOOL	Y & FRINGES	SERVICES-OTHER PRGM COSTS	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 EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
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						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 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14. 00 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 NONPHYSICIAN ANESTHETISTS						19. 00
20.00	02000 NURSI NG SCHOOL	0					20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRVD		0				21. 00
22. 00 23. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM			0	10, 008		22. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS				10, 006		23.00
30. 00	03000 ADULTS & PEDIATRICS					5, 625, 010	30.00
31.00	03100 INTENSIVE CARE UNIT					520, 546	1
31. 01	03101 NEONATAL INTENSIVE CARE					99, 112	31. 01
32. 00	03200 CORONARY CARE UNIT					0	
33.00	03300 BURN INTENSIVE CARE UNIT					0	
34. 00	03400 SURGICAL INTENSIVE CARE UNIT					440.745	
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF					468, 765 396, 220	1
43. 00	04300 NURSERY					598, 726	1
44. 00	04400 SKILLED NURSING FACILITY					0	1
45.00	04500 NURSING FACILITY					0	45. 00
46.00	04600 OTHER LONG TERM CARE					0	46. 00
F0 00	ANCILLARY SERVICE COST CENTERS	I	T	I	1	0.047.047	50.00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM					2, 367, 367 0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM					0	1
53. 00	05300 ANESTHESI OLOGY					0	
54.00	05400 RADI OLOGY-DI AGNOSTI C					1, 551, 144	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C					0	55. 00
56. 00	05600 RADI OI SOTOPE					0	
57. 00	05700 CT SCAN					283, 453	
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION					144, 612 170, 444	
60.00	06000 LABORATORY					236, 628	1
60. 01	06001 BL00D LABORATORY					230, 020	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	1				_	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS					0	1
63.00	06300 BLOOD STORING, PROCESSING & TRANS.					0	
64.00	06400 I NTRAVENOUS THERAPY					83, 434	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	-				84, 513 202, 294	
67.00	06700 OCCUPATI ONAL THERAPY	1				202, 294 95, 269	
68. 00	06800 SPEECH PATHOLOGY					57, 011	1
69. 00	06900 ELECTROCARDI OLOGY					0	1
70.00	07000 ELECTROENCEPHALOGRAPHY					0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					363, 225	1
72.00	07200 DRUCS CHARGED TO PATIENTS					262, 765	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS					246, 928 0	1
75. 00	07500 ASC (NON-DISTINCT PART)	1				0	1
76. 00	03140 CARDI OLOGY					390, 146	1
. 0. 00	OUTPATIENT SERVICE COST CENTERS	1				3,3,140	1
88. 00	08800 RURAL HEALTH CLINIC					0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER					0	
90.00	09000 CLINIC					211, 559	1
90. 01 91. 00	04950 SLEEP CLINIC 09100 EMERGENCY					1, 733 725, 160	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					723, 100	91.00
	12 221 222 (1011 21011101 171(1)	l .	l .	<u> </u>	l		1 . 2. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2018 Part II Provider CCN: 15-0018

INTERNS & RESIDENTS SUBSTITUTION NURSING SCHOOL SERVICES - SALAR SERVICES - OTHER PARAMED ED PROM PROM PROGRAM DI ALYSI PARAMED ED PROM PROGRAM DI ALYSI PROM PR					To 12/31/2018		epared:
Cost Center Description						5/29/2019 7:	1 <u>1 am</u>
V & FRI NGES PRGM COSTS PRGM			INTERNS &	RESI DENTS			
V & FRI NGES PRGM COSTS PRGM							
OTHER REIMBURSABLE COST CENTERS	Cost Center Description	NURSING SCHOOL				Subtotal	
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 I MME PROGRAM DI ALYSIS 0 94. 00 95. 00 95. 00 95. 00 95. 00 95. 00 95. 00 96. 00 96. 00 96. 00 96. 00 97. 00 97. 00 97. 00 97. 00 97. 00 97. 00 97. 00 97. 00 97. 00 97. 00 97. 00 97. 00 98. 00 985. 00 98. 00 98. 00 98. 00 98. 00 98. 00 98. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 00 99. 10 09910 CORF 0 100. 00 10000 RAS SERVI CES-NOT APPRVD PRGM 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 101. 00 105. 00 105. 00 10500 KI DIVEY ACQUI SI TI ON 0 105. 00 105. 00 10500 KI DIVEY ACQUI SI TI ON 0 106. 00 106. 00 10600 HEART ACQUI SI TI ON 0 106. 00 107.							
94. 00		20.00	21. 00	22. 00	23. 00	24. 00	
95. 00 09500 AMBULANCE SERVICES 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 98. 00 99. 00 09900 CMHC 0 99. 00 99. 10 09910 CORF 0 99. 10 100. 00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 1010. 00 105. 00 10500 KI DNEY ACQUI SI TI ON 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 106. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 107. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 109. 00 110. 00 11000 INTESTI NAL ACQUI SI TI ON 0 109. 00 111. 00 11000 INTESTI NAL ACQUI SI TI ON 0 111. 00 1113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 115. 00 11500 AMBULANCE SERVICES 0 109. 00 109. 00 MONREI MBURSABLE COST CENTERS 0 116. 00 109. 00 10900 GIFT, FLOWER COFFEE SHOP & CANTEEN 0 190. 00 109. 00 10900				1	1		
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 98. 00 99. 00 09900 CMHC 0 99. 00 99. 10 09910 CORF 0 99. 10 100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 101. 00							
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 9. 00 09900 CMHC 99. 10 09910 CORF 100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM 101. 00 10100 HOME HEALTH AGENCY 105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON 107. 00 10700 L LVER ACQUI SI TI ON 108. 00 10800 LUNG ACQUI SI TI ON 109. 00 10900 PANCREAS ACQUI SI TI ON 101. 00 11000 I NTESTI NAL ACQUI SI TI ON 101. 00 11100 I SLET ACQUI SI TI ON 101. 00 11100 I SLET ACQUI SI TI ON 101. 00 11100 I SLET ACQUI SI TI ON 101. 00 1100 O I TI SESTI EXPENSE 105. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116. 00 11600 HOSPI CE 117. 00 1000 I SUBTOTALS (SUM OF LINES 1 through 117) 118. 00 NONREI MBURSABLE COST CENTERS 109. 00 10900 I FF, FLOWER, COFFEE SHOP & CANTEEN	· · · · · · · · · · · · · · · · · · ·						
98. 00						`	
99. 00 09900 CMHC 09910 CORF 0 99. 00 99. 10 O9910 CORF 0 99. 10 O9910 CORF 0 99. 10 O9910 CORF 0 99. 10 O9910 O9910						`	
99. 10 100. 00 10000 &R SERVICES-NOT APPRVD PRGM 0 100. 00 101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS 105. 00 106. 00 106. 00 107. 00 107. 00 108. 00 108. 00 109. 00 109. 00 109. 00 109. 00 109. 00 109. 00 110. 00 111. 00						(
100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 100. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 101. 00 105. 00						(
101.00 10100 HOME HEALTH AGENCY							
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105. 00 106. 00 106. 00 106. 00 106. 00 106. 00 106. 00 107. 00 107. 00 107. 00 107. 00 107. 00 108. 00 10800 LIVER ACQUI SI TI ON 0 107. 00 108. 00 10800 LIVER ACQUI SI TI ON 0 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 109. 00	100.00 10000 I&R SERVICES-NOT APPRVD PRGM					(100.00
105. 00 106. 00 106. 00 106. 00 106. 00 106. 00 107. 00 107. 00 107. 00 107. 00 108. 00 108. 00 108. 00 108. 00 109. 0	101.00 10100 HOME HEALTH AGENCY					(101. 00
106. 00							
107. 00 10700 LI VER ACQUI SI TI ON							
108. 00	106. 00 10600 HEART ACQUI SI TI ON					(106. 00
109. 00 10900 PANCREAS ACQUISITION 0 109. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 111. 00 1	107.00 10700 LIVER ACQUISITION					(107. 00
110. 00	108.00 10800 LUNG ACQUISITION					(108. 00
111. 00	109.00 10900 PANCREAS ACQUISITION					(109. 00
113. 00 11300 1 NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116. 00 11600 HOSPI CE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 0 0 15, 186, 064 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 19	110.00 11000 INTESTINAL ACQUISITION					(110. 00
114. 00 11400 11400 11400 11400 11400 11400 11400 11400 11500 11500 11500 11500 11500 11500 11500 11500 11600	111.00 11100 ISLET ACQUISITION					(111. 00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.)	113.00 11300 INTEREST EXPENSE						113.00
116. 00 116. 00 116. 00 116. 00 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 0 0 15, 186, 064 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 190. 00 116. 00 11	114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 0 15, 186, 064 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00	115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)					(115. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00	116. 00 11600 HOSPI CE					(116. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	o	0		ol ol	15, 186, 064	1 118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00		-,				.,,	
						(190. 00
191, 00/19100/RESEARCH U1191, 00	191, 00 19100 RESEARCH					(191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 414, 636 192. 00	192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES					414, 636	192.00
193. 00 19300 NONPALD WORKERS 917 193. 00	193. 00 19300 NONPALD WORKERS						
193. 01 19301 COMMUNI TY 222, 477 193. 01							
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 4, 954, 344 194. 00	· · · · · · · · · · · · · · · · · · ·			İ		•	
200.00 Cross Foot Adjustments	· · · · · · · · · · · · · · · · · · ·	0	0	1	10,008		
201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	1 1	ام	0) .s, ooo	•	
202.00 TOTAL (sum Lines 118 through 201) 0 0 10,008 20,788,446 202.00		ام	0		10,008		

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/29/2019 7:11 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 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 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12. 00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17. 00 01700 SOCIAL SERVICE 17 00 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSI NG SCHOOL 20.00 20.00 02100 | &R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02300 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 625, 010 30.00 31.00 03100 INTENSIVE CARE UNIT 520, 546 31.00 000000000 03101 NEONATAL INTENSIVE CARE 31.01 99, 112 31.01 03200 CORONARY CARE UNIT 32.00 0 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 04000 SUBPROVI DER - I PF 40.00 468, 765 40.00 41.00 04100 SUBPROVI DER - I RF 396, 220 41.00 04300 NURSERY 43 00 598, 726 43 00 44.00 04400 SKILLED NURSING FACILITY 44.00 04500 NURSING FACILITY 0 45.00 Ω 45.00 04600 OTHER LONG TERM CARE 0 46.00 46.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 2, 367, 367 50.00 51.00 05100 RECOVERY ROOM 0 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 Λ 53.00 05300 ANESTHESI OLOGY 0000000 C 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 551, 144 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 56.00 05600 RADI OI SOTOPE 56.00 57.00 05700 CT SCAN 283, 453 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 144, 612 58.00 05900 CARDIAC CATHETERIZATION 59 00 59 00 170, 444 60.00 06000 LABORATORY 236, 628 60.00 06001 BLOOD LABORATORY 0 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 000000000000000 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 06400 I NTRAVENOUS THERAPY 64.00 83, 434 64.00 65 00 06500 RESPIRATORY THERAPY 84 513 65 00 06600 PHYSI CAL THERAPY 66.00 202, 294 66.00 06700 OCCUPATIONAL THERAPY 95, 269 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 57, 011 68.00 06900 ELECTROCARDI OLOGY 69 00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 363, 225 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 262, 765 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 246, 928 73.00 74.00 07400 RENAL DIALYSIS 74.00 C 07500 ASC (NON-DISTINCT PART) 75.00 75.00 76.00 03140 CARDI OLOGY 0 390, 146 76, 00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 09000 CLI NI C 211, 559 90.00 90 00 04950 SLEEP CLINIC 90.01 0 1, 733 90.01 91. 00 09100 EMERGENCY 725, 160 91.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018 Peri od: Worksheet B From 01/01/2018 Part II Date/Time Prepared: 12/31/2018 5/29/2019 7:11 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 26.00 25.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 0 0 0 0 0 0 09500 AMBULANCE SERVICES 95.00 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 99. 00 09900 CMHC 0 99.00 99. 10 09910 CORF 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101. 00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 105. 00 0 0 0 0 0 0 0 106. 00 10600 HEART ACQUISITION 106. 00 0 107.00 10700 LIVER ACQUISITION 0 107.00 108.00 10800 LUNG ACQUISITION 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 I SLET ACQUISITION 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 0 115.00 116. 00 11600 HOSPI CE 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 118.00 0 15, 186, 064 118.00 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 0 0 191. 00 19100 RESEARCH 0 191. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 00 414, 636 193. 00 19300 NONPALD WORKERS 193. 00 917 193. 01 19301 COMMUNI TY 222, 477 193. 01 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 4, 954, 344 194. 00 200.00 Cross Foot Adjustments 10, 008 200. 00 201.00 Negative Cost Centers 201. 00 202.00 TOTAL (sum lines 118 through 201) 20, 788, 446 202.00

		iciai systems	ELKHART GENER		2011 45 2042		U OF FORM CMS	
COST A	LLOCA	TION - STATISTICAL BASIS		Provider (Peri od:	Worksheet B-1	
						From 01/01/2018 To 12/31/2018	Date/Time Pre	nared.
						10 12/31/2010	5/29/2019 7:1	1 am
			CAPITAL REI	LATED COSTS				
		Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		, , , , , , , , , , , , , , , , , , ,	(SQUARE FEET)	(SQUARE FEET)			& GENERAL	
			((/	DEPARTMENT		(ACCUM. COST)	
					(GROSS		(11000m: 0001)	
					SALARI ES)			
			1.00	2.00	4. 00	5A	5. 00	
	GENER	AL SERVICE COST CENTERS	1.00	2.00	1 4.00	J/A	3.00	
1.00		CAP REL COSTS-BLDG & FLXT	685, 849					1.00
2. 00		CAP REL COSTS-MVBLE EQUIP	000,017	685, 84				2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	135		1	1		4. 00
5.00		ADMINISTRATIVE & GENERAL	9, 310		1		228, 016, 249	1
6.00	1	MAINTENANCE & REPAIRS	7, 310	7, 31	4, 107, 77	0 -30, 343, 349	228, 010, 249	1
		OPERATION OF PLANT	147 770	147 77	0 2 454 00	4 0		
7.00			147, 779			0	13, 263, 882	
8.00		LAUNDRY & LINEN SERVICE	4, 359			0	892, 611	
9.00		HOUSEKEEPI NG	3, 935	l			4, 749, 348	
10.00	1	DIETARY	10, 103				2, 419, 175	
11.00	1	CAFETERIA	3, 869	3, 86	1		2, 096, 864	
12. 00		MAINTENANCE OF PERSONNEL	0		-1	0	0	
13. 00		NURSING ADMINISTRATION	1, 861				2, 131, 009	
14. 00		CENTRAL SERVICES & SUPPLY	14, 966	l			1, 990, 075	
15. 00		PHARMACY	5, 642	l			1, 546, 548	
16. 00	1	MEDICAL RECORDS & LIBRARY	432		2 344, 69	2 0	560, 899	16. 00
17. 00	01700	SOCIAL SERVICE	112	11.	2 1, 109, 89	8 0	2, 365, 247	17. 00
18.00	01850	OTHER GENERAL SERVICE (SPECIFY)	0		0	0 0	0	18. 00
19.00	01900	NONPHYSICIAN ANESTHETISTS	0		0	0 0	0	19. 00
20.00	02000	NURSI NG SCHOOL	0		o	0	0	20.00
21.00	02100	I&R SERVICES-SALARY & FRINGES APPRVD	0		ol	0 0	0	21. 00
22.00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0		ol	0 0	0	22. 00
23.00		PARAMED ED PRGM	250	25	0 49, 09	7 0	105, 316	23. 00
		TENT ROUTINE SERVICE COST CENTERS			<u> </u>			1
30.00	03000	ADULTS & PEDIATRICS	129, 550	129, 55	0 17, 904, 33	2 0	39, 356, 327	30.00
31.00	03100	INTENSIVE CARE UNIT	11, 187	11, 18	7 3, 645, 24	0 0	7, 088, 426	31.00
31. 01	03101	NEONATAL INTENSIVE CARE	2, 330	2, 33	0 996, 49	8 0	1, 739, 007	
32.00	1	CORONARY CARE UNIT	0		1	0	0	1
33. 00	1	BURN INTENSIVE CARE UNIT	0		ol .	0	0	1
34. 00		SURGICAL INTENSIVE CARE UNIT	0			0 0	0	1
40. 00		SUBPROVIDER - IPF	10, 912	10, 91	2 1, 292, 26	8 0	2, 555, 239	
41. 00		SUBPROVIDER - IRF	9, 500		1		2, 155, 863	1
43. 00		NURSERY	14, 862				3, 369, 651	
44. 00		SKILLED NURSING FACILITY	14,002	14,00		0 0	0, 307, 031	1
45. 00	1	NURSING FACILITY	0			0 0	0	
46. 00		OTHER LONG TERM CARE	0			o o	0	
40.00		LARY SERVICE COST CENTERS		1	<u> </u>	0	0	40.00
50. 00		OPERATI NG ROOM	58, 356	58, 35	6 8, 739, 84	8 0	21, 708, 565	50.00
51. 00		RECOVERY ROOM	00,000	00,00	0	0 0	0	l
		DELIVERY ROOM & LABOR ROOM	o o			o o	0	
	1	ANESTHESI OLOGY	0			0 0		53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	38, 565	38, 56	5 4, 723, 54	1 0	10, 604, 112	1
55. 00		RADI OLOGY-THERAPEUTI C	00,000	00,00	0 1, 720, 01	o o	0,001,112	1
56. 00		RADI OI SOTOPE	0			0 0	0	1
57. 00	1	CT SCAN	7, 099	7, 09	9 757, 52	٥	2, 028, 001	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	3, 587				1, 150, 937	
	1							
59.00		CARDI AC CATHETERI ZATI ON	4, 072				3, 072, 603	1
60.00		LABORATORY	5, 429	5, 42	9 2, 189, 62	0	11, 412, 228	
60. 01	1	BLOOD LABORATORY	0	1	٩	0	0	
61.00		PBP CLINICAL LAB SERVICES-PRGM ONLY				0		61.00
62.00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	
63. 00		BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	
64. 00		I NTRAVENOUS THERAPY	1, 953				1, 559, 620	1
65. 00		RESPI RATORY THERAPY	1, 804		1		4, 126, 522	
66. 00		PHYSI CAL THERAPY	4, 967				2, 672, 887	
67. 00		OCCUPATI ONAL THERAPY	2, 385				1, 004, 416	
68. 00		SPEECH PATHOLOGY	1, 430				373, 974	
69. 00	1	ELECTROCARDI OLOGY	0		1	0	0	
70. 00	1	ELECTROENCEPHALOGRAPHY	0		O	0	0	
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0	0 0	17, 488, 522	
72. 00		IMPL. DEV. CHARGED TO PATIENTS	0		0	0 0	12, 454, 550	72. 00
73. 00		DRUGS CHARGED TO PATIENTS	0		0 4, 150, 80	0	19, 846, 788	
74.00		RENAL DIALYSIS	0		0	0 0	0	
75. 00		ASC (NON-DISTINCT PART)	0		0	0 0	0	
76. 00		CARDI OLOGY	9, 623	9, 62	3 1, 947, 49	8 0	3, 899, 890	76. 00
		TIENT SERVICE COST CENTERS						1
88. 00		RURAL HEALTH CLINIC	0	•	1	0 0	0	
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
90.00	09000	CLINIC	5, 345	5, 34	550, 49	5 0	1, 069, 804	90.00
								

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Provider CCN: 15-0018

						E /20 /2010 7.1	1 am
		CAPITAL REL	ATED COSTS			5/29/2019 7:1	ı anı
		ON TIME REE	31125 00010				
Cos	st Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
		1.00	2. 00	SALARI ES) 4. 00	5A	5. 00	
90. 01 04950 SLF	EEP CLINIC	1.00	2.00				90, 01
91. 00 09100 EME		16, 656		07.7200		,	91.00
	SERVATION BEDS (NON-DISTINCT PART)	10,030	10, 030	0, 155, 770		14, 447, 077	92.00
	IMBURSABLE COST CENTERS						72.00
	ME PROGRAM DIALYSIS	O	0	C	0	0	94. 00
	BULANCE SERVICES	O	0		-		95. 00
96. 00 09600 DUF	RABLE MEDICAL EQUIP-RENTED	0	0	C	0	0	96. 00
	RABLE MEDICAL EQUIP-SOLD	0	0	C	0	0	97. 00
98. 00 09850 OTH	HER REIMBURSABLE COST CENTERS	0	0	C	0	0	98. 00
99. 00 09900 CMF	HC	0	0	C	0	0	99. 00
99. 10 09910 COF		0	0	C	0	0	
	R SERVICES-NOT APPRVD PRGM	0	0	l ~	_		100. 00
	ME HEALTH AGENCY	0	0	C	0	0	101. 00
	PURPOSE COST CENTERS	Г		ı			
	DNEY ACQUISITION	0	0		-		105. 00
106. 00 10600 HEA		0	0		-		106. 00
107. 00 10700 LI\		0	0	l ~	_		107. 00
108. 00 10800 LUN		0	0		-		108. 00 109. 00
	NCREAS ACQUISITION TESTINAL ACQUISITION	0	0		0		1109.00
111. 00 11100 I SI		0	0		0		111.00
113. 00 11300 I N		U	0		U	U	113.00
	ILIZATION REVIEW-SNF						114. 00
	BULATORY SURGICAL CENTER (D. P.)	0	0		0	0	115. 00
116. 00 11600 HOS	` ,	0	0				116. 00
1 1	BTOTALS (SUM OF LINES 1 through 117)	542, 365	542, 365	77, 898, 478	-36, 545, 549	217, 963, 917	118. 00
NONREI MBI	URSABLE COST CENTERS						
190. 00 19000 GI F	FT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
191. 00 19100 RES	SEARCH	0	0	C	0	0	191. 00
192. 00 19200 PH	YSICIANS' PRIVATE OFFICES	10, 582	10, 582	C	0	320, 746	192. 00
193. 00 19300 NON		0	0	179, 758	0	308, 989	193. 00
193. 01 19301 COM		5, 696	5, 696	236, 534	0	699, 834	
	HER NONREIMBURSABLE COST CENTERS	127, 206	127, 206	714, 641	0	8, 722, 763	
	oss Foot Adjustments						200. 00
	gative Cost Centers						201. 00
Par	st to be allocated (per Wkst. B, rt I)	16, 817, 290				36, 545, 549	
	it cost multiplier (Wkst. B, Part I)	24. 520397	5. 790132			0. 160276	
	st to be allocated (per Wkst. B, rt II)			4, 092		282, 408	204. 00
205. 00 Uni	it cost multiplier (Wkst. B, Part)			0. 000052		0. 001239	205. 00
206. 00 NAF	HE adjustment amount to be allocated er Wkst. B-2)						206. 00
207. 00 NAF	HE unit cost multiplier (Wkst. D, rts III and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0018

Peri od: Worksheet B-1 From 01/01/2018 To 12/31/2018 Date/Ti me Prepared:

5/29/2019 7:11 am Cost Center Description MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY (HOURS OF REPAI RS PLANT LINEN SERVICE (MEALS SERVED) (SQUARE FEET) (SQUARE FEET) (POUNDS OF SERVICE) LAUNDRY) 7.00 6.00 9.00 10.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 676, 404 6.00 00700 OPERATION OF PLANT 147.779 7.00 528, 625 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 4, 359 4, 359 2, 352, 392 8.00 3, 935 9.00 00900 HOUSEKEEPI NG 3, 935 76, 468 9.00 01000 DI ETARY 10, 103 10, 103 172 132, 254 10.00 10.00 0 01100 CAFETERI A 3,869 0 11.00 3, 869 756 Λ 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 0 0 0 12.00 13.00 01300 NURSING ADMINISTRATION 1,861 1,861 323 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14, 966 0 14.00 14, 966 1,430 14.00 0 01500 PHARMACY 0 15.00 5,642 5, 642 650 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 432 432 367 0 16.00 01700 SOCIAL SERVICE 17.00 112 112 0 0 17.00 0 01850 OTHER GENERAL SERVICE (SPECIFY) 0 18 00 0 0 0 18 00 C 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 C 0 0 0 19.00 02000 NURSING SCHOOL 0 0 0 0 20.00 20.00 C 21.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 0 21.00 0 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 0 22 00 22 00 r 0 23.00 02300 PARAMED ED PRGM 250 250 42 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 129, 550 129, 550 1 123 185 33 674 103 182 30 00 31.00 03100 INTENSIVE CARE UNIT 11, 187 11, 187 190, 757 4, 158 12, 201 31.00 03101 NEONATAL INTENSIVE CARE 2, 330 2, 330 17, 759 686 31.01 31.01 32.00 03200 CORONARY CARE UNIT 0 C 32.00 0 0 0 03300 BURN INTENSIVE CARE UNIT 33 00 0 0 33 00 C 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34.00 04000 SUBPROVIDER - IPF 10, 912 10, 912 1, 276 11, 262 40.00 1, 364 40.00 5, 609 41.00 04100 SUBPROVIDER - IRF 9,500 9,500 44, 435 453 41.00 04300 NURSERY 14, 862 43.00 92.097 43.00 14, 862 1, 420 0 44.00 04400 SKILLED NURSING FACILITY 0 44.00 0 C 0 04500 NURSING FACILITY 45.00 0 0 0 0 45.00 46.00 04600 OTHER LONG TERM CARE 0 0 0 0 46, 00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 58, 356 58, 356 0 50.00 361, 126 7,509 51.00 05100 RECOVERY ROOM 0 C 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 52.00 0 0 0 0 05300 ANESTHESI OLOGY 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 38, 565 38, 565 262, 196 3, 581 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 C 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 57.00 05700 CT SCAN 7.099 7, 099 922 690 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 3.587 3, 587 32,008 258 0 58.00 05900 CARDIAC CATHETERIZATION 4,072 4, 072 1, 371 0 59.00 59.00 0 60.00 06000 LABORATORY 5.429 5, 429 0 780 0 60.00 06001 BLOOD LABORATORY 60.01 0 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 1.953 1, 953 0 885 0 64.00 06500 RESPIRATORY THERAPY 1,804 1, 804 195 65.00 0 65.00 0 4, 967 06600 PHYSI CAL THERAPY 4, 967 66.00 22, 261 520 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 2,385 2, 385 42 0 67.00 C 06800 SPEECH PATHOLOGY 68.00 1,430 1, 430 0 260 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 0 C 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 0 C 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 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 73 00 0 O 0 73 00 Ω 07400 RENAL DIALYSIS 0 74.00 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 75.00 0 03140 CARDI OLOGY 76.00 9,623 9,623 6, 994 709 0 76.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 0 C 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0 90.00 09000 CLI NI C 5.345 5, 345 1, 687 640 0 90.00 04950 SLEEP CLINIC 90.01 90 01 45 0 91.00 09100 EMERGENCY 16,656 195, 644 9, 481 0 91.00 16,656 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00

Peri od: Worksheet B-1 From 01/01/2018 | Worksneet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared:

				T	o 12/31/2018	Date/Time Pre 5/29/2019 7:1	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	i aiii
	555 Conton Bood (pt. 6)	REPAI RS	PLANT	LI NEN SERVI CE	(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						
	09400 HOME PROGRAM DIALYSIS	0		0	0	0	
	09500 AMBULANCE SERVICES	0	0	0	0	0	
	D9600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	
	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
5	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	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 SLET 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	0	115. 00
116.00	11600 H0SPI CE	0	0	0	0	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	532, 920	385, 141	2, 352, 392	72, 416	132, 254	118. 00
[NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
	19100 RESEARCH	0	0	0	0	0	191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	10, 582	10, 582	2 0	1, 684	0	192. 00
193.00	19300 NONPALD WORKERS	0	0	0	0	0	193. 00
193. 01	19301 COMMUNI TY	5, 696	5, 696	0	0	0	193. 01
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	127, 206	127, 206	0	2, 368	0	194. 00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	0	15, 389, 764	1, 162, 578	5, 625, 114	3, 113, 691	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	29. 112819	0. 494211	73. 561673	23. 543265	203. 00
204.00	Cost to be allocated (per Wkst. B,	0	4, 495, 834	170, 301	158, 736	395, 564	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	8. 504770	0. 072395	2. 075849	2. 990942	205. 00
	11)						
206.00	NAHE adjustment amount to be allocated						206. 00
	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						1

	ALLOCATION - STATISTICAL BASIS	ELKHAKI GLIVEKI			eri od:	Worksheet B-1	
					rom 01/01/2018 o 12/31/2018	Date/Time Pre	pared:
						5/29/2019 7:1	1 am
	Cost Center Description	CAFETERIA I	WAINTENANCE OF PERSONNEL	F NURSING ADMINISTRATION	CENTRAL SERVICES &	PHARMACY (COSTED	
		SERVICE)	(NUMBER	ADMINI STRATION	SUPPLY	REQUIS.)	
			HOUSED)	(DI RECT NURS.	(COSTED		
		11.00	12.00	HRS.) 13. 00	REQUIS.) 14. 00	15. 00	
	GENERAL SERVICE COST CENTERS	11.00	12.00	13.00	14.00	15.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS						6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	2, 147, 824					11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	(077 401			12.00
14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	28, 832 34, 906	(0 877, 401 0 26			13. 00 14. 00
	01500 PHARMACY	2, 080	(0 0		14, 673, 777	
	01600 MEDI CAL RECORDS & LI BRARY	9, 339	(0 0	0	0	
	O1700 SOCIAL SERVICE O1850 OTHER GENERAL SERVICE (SPECIFY)	33, 576 0	(0 1, 853 0 0		0	
	01900 NONPHYSI CI AN ANESTHETI STS		(0	0	19.00
	02000 NURSI NG SCHOOL	0	(0 0	0	0	20.00
21. 00		0	(0 0	0	0	21.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM	1, 173	(0	0	
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	1, 1, 0		<u> </u>			20.00
30.00	l l	592, 830	(0 374, 224			
31. 00 31. 01	03100 NTENSI VE CARE UNIT 03101 NEONATAL NTENSI VE CARE	117, 431 23, 255	(0 99, 955 0 21, 175			
32. 00	1 1	23, 233	(0 21, 175		0	
33. 00	03300 BURN INTENSIVE CARE UNIT	0	(0 0	0	0	
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	(0 10 503	0	0	
40.00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	42, 824 29, 548	(0 18, 503 0 16, 760		149 248	
	04300 NURSERY	49, 855	(37, 167		0	
44. 00	04400 SKILLED NURSING FACILITY	0	(o	_	0	
45.00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0 0	(O		0	
40.00	ANCI LLARY SERVI CE COST CENTERS	<u> </u>		<u> </u>	0		40.00
	05000 OPERATING ROOM	252, 504	(0 124, 846			50.00
	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	(0	0	0	
53. 00	05300 ANESTHESI OLOGY		(0	0	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	151, 859	(16, 268	0	3, 261	54. 00
	05500 RADI OLOGY-THERAPEUTI C	0	(0	0	0	55.00
56. 00 57. 00	05600	0 24, 396	(0	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	10, 648	(0 21	0	Ö	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	41, 265	(0 17, 030	0	2, 076	
60. 00 60. 01	O6000 LABORATORY O6001 BLOOD LABORATORY	106, 997	(0 0	0	0	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		(0	U	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(О	0	0	62. 00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	(0 22 201	0	0	
65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	23, 351 71, 691	(0 23, 291 0 0	0	1, 712 196, 976	
66. 00	06600 PHYSI CAL THERAPY	44, 932	(0 0	0	0	1
67.00		17, 081	(0 0	0	0	
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	6, 372	(0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY		(0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(О	58	0	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	100,005	(0	42	0	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	100, 095	(0	14, 179, 304 0	1
75. 00	07500 ASC (NON-DISTINCT PART)	o o	(0 0	0	Ō	1
76. 00	03140 CARDI OLOGY	63, 431	(0 14, 961	0	190, 538	76. 00
88 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	O		ol c	0	0	88. 00
89. 00	l l	0	(0	1
90.00	09000 CLI NI C	14, 310	(1, 473	0	0	
90. 01	04950 SLEEP CLINIC 09100 EMERGENCY	11, 099 213, 280	(0	0	0 3 742	90. 01 91. 00
71.00	O / 100 LWLNOLING	213, 200		U7, 040	1 0	3, 142	71.00

Health Finan	cial Systems	ELKHART GENER	AL HOSPITAL			In Lie	u of Form CMS-2	2552-10
COST ALLOCAT	TION - STATISTICAL BASIS		Provi der	CCI	N: 15-0018 P	eri od:	Worksheet B-1	
						rom 01/01/2018	D-+- /T: D	
					1	o 12/31/2018	Date/Time Pre 5/29/2019 7:1	
	Cost Center Description	CAFETERI A	MAI NTENANCE	OF	NURSI NG	CENTRAL	PHARMACY	ı dili
	oost center bescription	(HOURS OF	PERSONNEL		ADMI NI STRATI ON		(COSTED	
		SERVI CE)	(NUMBER	ſ		SUPPLY	REQUIS.)	
		,	HOUSED)		(DIRECT NURS.	(COSTED	,	
			Ź		HRS.)	REQUIS.)		
		11. 00	12.00		13. 00	14. 00	15. 00	
	OBSERVATION BEDS (NON-DISTINCT PART)							92. 00
	REIMBURSABLE COST CENTERS							
	HOME PROGRAM DIALYSIS	0		0	C	0	0	94.00
	AMBULANCE SERVICES	0		0	C	0	0	95. 00
	DURABLE MEDICAL EQUIP-RENTED	0		0	C	0	0	96. 00
97. 00 09700	DURABLE MEDICAL EQUIP-SOLD	0		0	C	0	0	97. 00
	OTHER REIMBURSABLE COST CENTERS	0		0	C	0	0	98. 00
99. 00 09900	CMHC	0		0	C	0	0	99. 00
99. 10 09910		0		0	C	0	0	99. 10
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	0		0	C	0	0	100.00
	HOME HEALTH AGENCY	o		0	C	0	0	101. 00
SPECI.	AL PURPOSE COST CENTERS							
	KIDNEY ACQUISITION	0		0	C	0	0	105. 00
106.00 10600	HEART ACQUISITION	0		0	C	0	0	106. 00
107. 00 10700	LIVER ACQUISITION	0		0	C	0	0	107. 00
108. 00 10800	LUNG ACQUISITION	o		0	C	0	0	108. 00
109. 00 10900	PANCREAS ACQUISITION	o		0	C	0	0	109. 00
110.00 11000	INTESTINAL ACQUISITION	o		o	C	0	0	110. 00
111. 00 11100	ISLET ACQUISITION	o		o	C	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.)	o		o	C	0	0	115. 00
116.00 11600		ol		o	C	0	0	116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	2, 118, 960		O	877, 401	100	14, 673, 777	118. 00
NONRE	MBURSABLE COST CENTERS				·		<u> </u>	
190. 00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0	C	0	0	190. 00
191. 00 19100	RESEARCH	o		0	C	0	0	191. 00
192. 00 19200	PHYSICIANS' PRIVATE OFFICES	o		0	C	0	0	192. 00
193. 00 19300	NONPALD WORKERS	7, 306		o	C	0	0	193. 00
193. 01 19301	COMMUNI TY	7, 043		0	C	0	0	193. 01
194. 00 07950	OTHER NONREIMBURSABLE COST CENTERS	14, 515		o	C	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,	2, 601, 191		o	2, 585, 416	2, 892, 282	2, 009, 012	202. 00
	Part I)							
203. 00	Unit cost multiplier (Wkst. B, Part I)	1. 211082	0.0000	000	2. 946675	28, 922. 820000	0. 136912	203. 00
204. 00	Cost to be allocated (per Wkst. B,	154, 391		o	77, 672	588, 891	222, 421	204. 00
	Part II)							
205.00	Unit cost multiplier (Wkst. B, Part	0. 071883	0. 0000	000	0. 088525	5, 888. 910000	0. 015158	205. 00
	11)							
206. 00	NAHE adjustment amount to be allocated							206. 00
	(per Wkst. B-2)							
207. 00	NAHE unit cost multiplier (Wkst. D,							207. 00
	Parts III and IV)			- 1				

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 01/01/2018 To 12/31/2018 Date/Time Prepared: 5/29/2019 7:11 am OTHER GENERAL

Cheropal Service COST CENTERS		Cost Center Description	MEDI CAL RECORDS & LI BRARY (REVENUE) 16.00	SOCIAL SERVICE (TIME SPENT) 17.00	SERVI CE (SPECI FY) (TI ME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME) 19. 00	NURSING SCHOOL (ASSIGNED TIME) 20.00	
2.00 DOZDO CAP REL COSTS - WHILE EDUIT		GENERAL SERVICE COST CENTERS	10.00	17.00	10.00	17.00	20.00	
0.00 0.00		1 1						
0.0000 0.0000 MAN INTERNATE & CENERAL		1						
6.00 DOSCODIAN INTERMENT & SERVICE		1						
0.0000 0.00000 0.0000 0.0000 0.0000 0.0000 0.0000 0.0000 0.00000 0.0000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000000		1						
9.00 0990 MUSERCEPINS		1						
10.00 01000 DETARY								
11.0 0 0 1100 CAFETERIA								1
12.00 1020 MAINTENANCE OF PERSONNEL 13.00 13								•
13.00 13.00 MIJEST NAS ADMINISTRATION 14.00		1						
15.00		1						
16.00 1000 MEDICAL RECORDS & LIBRARY 521,800,207 11,758 17.00 170.00		1 1						•
17.00 01700 SOCIAL SERVICE 0			E21 040 207					
18.00 01850 OTHER CEMERAL SERVICE (SPECIFY) 0 0 0 19.00 0 0 0 0 0 0 0 0 0			521,860,207	11 758				•
20.00 02000 NURSING SCHOOL 0 0 0 0 0 22.00		1 1	0	1 _	0			•
21.00 02100 BAS SERVICES-SALARY & FRINCES APPRVD 0 0 0 0 0 22.00 02200 BAS SERVICES-SOTHER PREMIORS OF 0 0 0 0 0 0 0 0 0 0			0	0	0	C	1	
22 00 02200 RAY SERVICES-OTHER PROM COSTS APPRYD 0 0 0 0 22.00		1 1	0	0	0		0	
23.00 02300 PARAMED ED PROM 0 0 0 0 0 0 0 0 0			0	0				
INPATI ENT ROUTH NE SERVICE COST CENTERS 86, 324, 332 9, 341 0 0 0 0 0 0 0 0 0		1						
31.00 03100 INTERSIVE CARE UNIT 19, 879, 876 433 0 0 0 31.00 32.00 03200 COROMARY CARE UNIT 0 0 0 0 0 0 32.00 33.00 03200 COROMARY CARE UNIT 0 0 0 0 0 0 32.00 34.00 03400 SUBRIO TIMENSIVE CARE UNIT 0 0 0 0 0 0 0 33.00 33.00 03300 SUBRIO TIMENSIVE CARE UNIT 0 0 0 0 0 0 0 0 34.00 03400 SUBRIO GAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 40.00 04000 SUBPROVIDER - IPF 5, 636, 982 535 0 0 0 0 0 0 41.00 04100 SUBPROVIDER - IPF 2, 518, 154 133 0 0 0 0 0 0 0 41.00 04100 SUBPROVIDER - IPF 2, 518, 154 133 0 0 0 0 0 0 0 43.00 04300 NURSERY 3, 252, 257 1,170 0 0 0 0 0 0 0 44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0			-	_	_			
31.01 03101 NEONATAL INTENSIVE CARE 2, 353, 683								
32.00 03200 COROMARY CARE UNIT			The state of the s			C	_	
33.00 03300 BURN INTENSIVE CARE UNIT		1 1	2, 333, 063	•		C		
40. 00 04000 04000 04000 05 05		1	0	1		C	-	
11.00 04100 SUBPROVIDER - I IRF 2, 518, 154 133 0 0 0 0 41.00 43.00 043.00 04400 SKI LLED NURSI NG FACILITY 0 0 0 0 0 0 0 0 0			0	1	1	C	_	
43.00 04300 NURSERY 3, 252, 257 1, 170 0 0 0 43.00 44.00 04400 SKILLED NURSI NG FACILITY 0 0 0 0 0 0 44.00 45.00 04500 04500 SML FACILITY 0 0 0 0 0 0 0 0 46.00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 0 46.00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 0 ANCILLARY SERVICE COST CENTERS						C	-	
44. 00 04400 SKI LLED NURSING FACILITY 0 0 0 0 0 0 0 44. 00 45. 00 04500 NURSING FACILITY 0 0 0 0 0 0 0 45. 00 46. 00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 0 45. 00 46. 00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 45. 00 MICHARY SERVICE COST CENTERS 50. 00 05000 OPERATIN ROMM 77. 811, 545 0 0 0 0 0 0 51. 00 51. 00 05100 RECOVERY ROOM 0 0 0 0 0 0 51. 00 52. 00 05200 DELIVERY ROOM 8 LABOR ROOM 0 0 0 0 0 0 52. 00 53. 00 05300 DELIVERY ROOM 8 LABOR ROOM 0 0 0 0 0 0 52. 00 53. 00 05300 DELIVERY ROOM 8 LABOR ROOM 0 0 0 0 0 0 53. 00 54. 00 05400 ROOM ROOM ROOM ROOM ROOM ROOM ROOM RO		1					-	
46.00 04600 014ER LONG TERM CARE		1	0, 202, 207	1		C	_	
ANCILLARY SERVICE COST CENTERS	45. 00		0	0				45. 00
50.00	46. 00		0	0	0	C	0	46. 00
51.00 05100 RECOVERY ROOM 6.1400 0 0 0 0 0 0 0 0 0	50 00		77 811 545	1	0		0	50.00
53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 56, 335, 184 0 0 0 0 0 0 0 550.0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 55.00 56.00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0 0 55.00 57.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	0					
54. 00 05400 RADI OLOGY_DI AGNOSTIC 56, 335, 184 0 0 0 0 54. 00 0 0 0 0 0 55. 00 0 0 0 0 0 0 0 0 0		1 1	0	0	0	C	0	
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 55. 00 656. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0 55. 00 557. 00 05700 CT SCAN 50. 00 05700 CT SCAN 58. 302, 216 0 0 0 0 0 57. 00 58. 00 05800 MAGNETI C RESONANCE IMAGING (MRI) 8, 788, 282 0 0 0 0 0 0 58. 00 659. 00 05900 CARDI AC CATHETERI ZATI ON 31, 946, 950 0 0 0 0 0 58. 00 60. 01 06000 LABORATORY 64, 879, 885 0 0 0 0 0 0 59. 00 60. 01 06001 BLOOD LABORATORY 64, 879, 885 0 0 0 0 0 0 0 60. 01 61. 00 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 64. 00 64. 00 06400 INTRAVENOUS THERAPY 1, 274, 615 0 0 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 20, 025, 364 0 0 0 0 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 5, 163, 352 0 0 0 0 0 0 0 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 2, 975, 197 0 0 0 0 0 0 65. 00 68. 00 06600 PHYSI CAL THERAPY 7, 18, 355 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		-	-	
56. 00 05600 RADIOI SOTOPE 0 0 0 0 0 0 0 0 57. 00		1	56, 335, 184	0	1		1	
57.00 05700 CT SCAN 58.302, 216 0 0 0 0 0 0 57.00			0		0	C	-	
59, 00 05900 CARDI AC CATHETERI ZATI ON 31, 946, 950 0 0 0 0 0 0 0 0 0	57.00	05700 CT SCAN			0	C	0	
60. 00 06000 LABORATORY 64,879,885 0 0 0 0 0 0 0 0 0				ł .	·	-	-	
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 60. 01 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 1, 274, 615 0 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 20, 025, 364 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 5, 163, 352 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 2, 975, 197 0 0 0 0 0 68. 00 06800 SPECH PATHOLOGY 945, 856 0 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 945, 856 0 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 76. 00 03140 CARDI OLOGY 26, 221, 985 0 0 0 0 89. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 90. 00 09000 CLINI C 0 0 0 0 90. 00 09000 CLINI C 0 0 0 0 90. 00 09000 CLINI C 0 0 0 90. 00 09000 CLINI C 0 0 0 90. 00 09000 CLINI C 0 0 0 90. 00 09000 0000 0000 0000 0000 90. 00 09000 0000 0000 0000 0000 0000 0000 90. 00 09000 0000 0000 0000 0000 0000 00000 00000 90. 00 09000 00000 00000 000000 00000000		1 1						
62. 00			04, 077, 003	Ö		C	1	
63. 00	61. 00							
64. 00			0	0	0	C	-	
65. 00			1 274 615	0	0			
66. 00		1			0	C	-	
68. 00					0	C	0	
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1		0	0	C		
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 75. 00 76. 00 03140 CARDI OLOGY 26, 221, 985 0 0 0 0 0 75. 00 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 88. 00 89. 00 09000 <td></td> <td>1</td> <td>945, 856</td> <td>0</td> <td>0</td> <td></td> <td>1</td> <td></td>		1	945, 856	0	0		1	
71. 00		1		0	0	C	_	
73. 00		1	0	0	0	C		
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 75. 00 76. 00 03140 CARDIO LOGY 26, 221, 985 0 0 0 0 0 0UTPATI ENT SERVI CE COST CENTERS 0 0 0 0 0 88. 00 88. 00 08900 RURAL HEALTH CLINI C 0 0 0 0 0 89. 00 99. 00 09900 CLINI C 3, 520, 459 0 0 0 0 0 99. 00			0	0	0	C		
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 00 03140 CARDI OLOGY 26, 221, 985 0 0 0 0 76. 00 OUTPATIENT SERVICE COST CENTERS 88. 00 08900 RURAL HEALTH CLINIC 0 0 0 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89. 00 90. 00 09000 CLINIC 3, 520, 459 0 0 0 0 90. 00		07400 DRUGS CHARGED TO PATIENTS	0	0	0	C	-	
76. 00 03140 CARDI OLOGY 26, 221, 985 0 0 0 0 76. 00 0 76. 00 0 0 76. 00 0 0 0 0 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		0 n		-	
OUTPATIENT SERVICE COST CENTERS 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 0 89.00 90.00 09000 CLINIC 3,520,459 0 0 0 0 90.00			26, 221, 985	o				•
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 90. 00 0 90. 00 0 90. 00		OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C 3, 520, 459 0 0 0 90. 00			0	0			1	
			3, 520, 459	0		C	•	
			1			C	•	

| Period: | Worksheet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0018

					To	12/31/2018	Date/Time Pre 5/29/2019 7:1	
					OTHER GENERAL		3/29/2019 7.1	ı allı
					SERVI CE			
	Cost Center Description	MEDI CAL	SOCIAL SERV	VI CE		NONPHYSI CI AN	NURSING SCHOOL	
	·	RECORDS &			(TIME SPENT)	ANESTHETI STS		
		LI BRARY	(TIME SPEN	NT)		(ASSI GNED	(ASSI GNED	
		(REVENUE)				TIME)	TIME)	
		16. 00	17. 00		18. 00	19. 00	20. 00	
	EMERGENCY	40, 914, 255		0	0	0	0	
	OBSERVATION BEDS (NON-DISTINCT PART)							92. 00
	REIMBURSABLE COST CENTERS HOME PROGRAM DIALYSIS	0		ol	0	0	0	94. 00
	AMBULANCE SERVICES	0		0	0	0		95.00
	DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	_	96.00
	DURABLE MEDICAL EQUIP-SOLD	0		0	0	0	Ö	97. 00
	OTHER REIMBURSABLE COST CENTERS	o o		0	0	0	0	98. 00
99. 00 09900		0		0	0	0	0	99.00
99. 10 09910		0		o	0	0	0	99. 10
	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
SPECI.	AL PURPOSE COST CENTERS							
	KIDNEY ACQUISITION	0		0	0	0		105. 00
	HEART ACQUISITION	0		0	0	0		106. 00
	LIVER ACQUISITION	0		0	0	0	_	107. 00
	LUNG ACQUISITION	0		0	0	0		108. 00
•	PANCREAS ACQUISITION	0		0	0	0		109. 00
•	INTESTINAL ACQUISITION	0		0	0	0		110.00
	I SLET ACQUI SI TI ON	U		O	0	Ü	0	111. 00
	INTEREST EXPENSE UTILIZATION REVIEW-SNF							113. 00 114. 00
•	AMBULATORY SURGICAL CENTER (D. P.)	0			0	0		115. 00
116. 00 11600		0		0	0	O		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	521, 860, 207	11	, 758	0	0		118. 00
	IMBURSABLE COST CENTERS	021/000/207	,		J	<u> </u>		
	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		0	0	0	0	193. 00
193. 01 19301		0		0	0	0		193. 01
	OTHER NONREIMBURSABLE COST CENTERS	0		0	0	0		194. 00
200. 00	Cross Foot Adjustments							200. 00
201. 00	Negative Cost Centers							201. 00
202.00	Cost to be allocated (per Wkst. B, Part I)	701, 682	2, 793,		0	0		202. 00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 001345	237. 601		0. 000000	0. 000000		
204. 00	Cost to be allocated (per Wkst. B, Part II)	18, 914	9,	, 914	0	0	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part II)	0. 000036	0. 843	3171	0. 000000	0. 000000		
206. 00	NAHE adjustment amount to be allocated (per Wkst. B-2)						0	206. 00
207. 00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						0.000000	207. 00

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

					'	5/29/2019 7:	
			INTERNS &	RESI DENTS			
		Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED		
		Sect Server Besser person	Y & FRI NGES	PRGM COSTS	PRGM		
			(ASSI GNED	(ASSI GNED	(ASSI GNED		
			TI ME) 21.00	TIME) 22.00	TI ME) 23. 00		
	GENER	AL SERVICE COST CENTERS	200		20.00		
1.00		CAP REL COSTS-BLDG & FIXT					1. 00
2. 00 4. 00		CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
5. 00		ADMINISTRATIVE & GENERAL					5. 00
6.00		MAINTENANCE & REPAIRS					6. 00
7. 00		OPERATION OF PLANT					7. 00
8.00	1	LAUNDRY & LINEN SERVICE					8.00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY					9. 00 10. 00
11. 00	1	CAFETERI A					11. 00
12. 00	1	MAINTENANCE OF PERSONNEL					12. 00
13. 00 14. 00	1	NURSI NG ADMI NI STRATI ON					13.00
15. 00	1	CENTRAL SERVICES & SUPPLY PHARMACY					14. 00 15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY					16. 00
17. 00		SOCIAL SERVICE					17. 00
18. 00 19. 00	1	OTHER GENERAL SERVICE (SPECIFY)					18.00
20. 00	1	NONPHYSICIAN ANESTHETISTS NURSING SCHOOL					19. 00 20. 00
21. 00	1	I&R SERVICES-SALARY & FRINGES APPRVD	0				21. 00
22. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRVD		0	1		22. 00
23. 00	_	PARAMED ED PRGM			100)	23. 00
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	0	0			30.00
31. 00		INTENSIVE CARE UNIT	0	Ö			31. 00
31. 01		NEONATAL INTENSIVE CARE	0	0			31. 01
32. 00 33. 00		CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0			32. 00 33. 00
34. 00		SURGICAL INTENSIVE CARE UNIT	0				34.00
40.00		SUBPROVIDER - IPF	0	0	C		40. 00
41.00		SUBPROVIDER - IRF	0	0			41.00
43. 00 44. 00		NURSERY SKILLED NURSING FACILITY	0	0	`		43. 00 44. 00
45.00		NURSING FACILITY					45. 00
46.00	1	OTHER LONG TERM CARE	0	0			46. 00
F0 00		LARY SERVICE COST CENTERS	1 0				
50. 00 51. 00	1	OPERATING ROOM RECOVERY ROOM	0	0			50. 00 51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	0	Ö			52. 00
53.00		ANESTHESI OLOGY	0	0	C	D	53. 00
54. 00		RADI OLOGY -DI AGNOSTI C	0	0	(54.00
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	0	0	1		55. 00 56. 00
57. 00	1	CT SCAN	0	0			57.00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0	О	C		58. 00
59. 00		CARDI AC CATHETERI ZATI ON	0	0	(59. 00
60. 00 60. 01	1	LABORATORY BLOOD LABORATORY	0	0			60. 00 60. 01
61. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY					61. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	D	62. 00
63. 00	1	BLOOD STORING, PROCESSING & TRANS.	0	0	(63. 00
64. 00 65. 00		INTRAVENOUS THERAPY RESPIRATORY THERAPY	0	0			64. 00 65. 00
66. 00		PHYSI CAL THERAPY	0	Ö			66. 00
67. 00		OCCUPATI ONAL THERAPY	0	0	C	D	67. 00
68.00		SPEECH PATHOLOGY	0	0			68. 00
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	0			69. 00 70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			71.00
72. 00	1	IMPL. DEV. CHARGED TO PATIENTS	0	0	C		72. 00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	0	0			73. 00 74. 00
75.00		ASC (NON-DISTINCT PART)	0				75.00
76. 00	03140	CARDI OLOGY	0	Ö	•		76. 00
00.05		TIENT SERVICE COST CENTERS	-	-			
88. 00 89. 00	1	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0			88. 00 89. 00
90.00		CLINIC		0			90.00
		SLEEP CLINIC	0	0			90. 01
			_		_		

| Period: | Worksheet B-1 | From 01/01/2018 | To 12/31/2018 | Date/Time Prepared: Provider CCN: 15-0018

				To	/Time Prepared: /2019 7:11 am
		INTERNS &	RESI DENTS		 72019 7.11 alli
	Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	
		Y & FRINGES	PRGM COSTS	PRGM	
		(ASSI GNED	(ASSI GNED	(ASSI GNED	
		TIME)	TIME)	TIME)	
04 00 00404	EMEDOENOV/	21.00	22. 00	23. 00	04.00
	EMERGENCY	0	0	100	91.00
	O OBSERVATION BEDS (NON-DISTINCT PART) R REIMBURSABLE COST CENTERS				92. 00
	HOME PROGRAM DIALYSIS	O	0	0	94. 00
	AMBULANCE SERVICES	0	0		95.00
	D DURABLE MEDICAL EQUIP-RENTED		0		96.00
	D DURABLE MEDICAL EQUIP-SOLD		0	Ö	97. 00
	OTHER REIMBURSABLE COST CENTERS		0	Ö	98. 00
	CMHC		0	0	99. 00
99. 10 09910			0	Ö	99. 10
	I&R SERVICES-NOT APPRVD PRGM		0	Ö	100.00
	HOME HEALTH AGENCY	l ol	0		101. 00
	AL PURPOSE COST CENTERS				
105. 00 10500	KIDNEY ACQUISITION	0	0	0	105. 00
106. 00 10600	HEART ACQUISITION	0	0	0	106. 00
107. 00 10700	LIVER ACQUISITION	0	0	0	107. 00
108. 00 10800	LUNG ACQUISITION	0	0	0	108. 00
	PANCREAS ACQUISITION	0	0	ŭ	109. 00
	INTESTINAL ACQUISITION	0	0	0	110. 00
	I SLET ACQUISITION	0	0	0	111. 00
	INTEREST EXPENSE				113. 00
	UTILIZATION REVIEW-SNF				114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0		115. 00
116.00 11600				0	116.00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	100	118. 00
	IMBURSABLE COST CENTERS OGIFT, FLOWER, COFFEE SHOP & CANTEEN	O	0	0	190, 00
191. 00 19100		0	0		191. 00
	PHYSICIANS' PRIVATE OFFICES		0	0	191.00
	NONPAID WORKERS		0	0	193. 00
193. 00 1930			0	0	193.00
	OTHER NONREIMBURSABLE COST CENTERS		0	0	194. 00
200.00	Cross Foot Adjustments	l	J	J	200. 00
201.00	Negative Cost Centers				201. 00
202. 00	Cost to be allocated (per Wkst. B,	0	0	133, 985	202. 00
202.00	Part I)	Ĭ	J	100, 700	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	1, 339. 850000	203. 00
204.00	Cost to be allocated (per Wkst. B,	o	0		204. 00
	Part II)			,	
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	100. 080000	205. 00
	11)				
206. 00	NAHE adjustment amount to be allocated			0	206. 00
	(per Wkst. B-2)				
207. 00	NAHE unit cost multiplier (Wkst. D,			0. 000000	207. 00
1	Parts III and IV)				

In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2018 Part I
To 12/31/2018 Date/Time Prepared: 5/29/2019 7:11 am Health Financial Systems

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

			'	0 12/31/2016	5/29/2019 7:1	
		Title	XVIII	Hospi tal	PPS	
Coot Conton Dogonintian	Total Coot	Thomany Limit	Total Coata	Costs	Total Costs	
Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	Part I, col.	Auj .		Di Sai i Owanice		
	26)					
	1.00	2. 00	3.00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		г				
30. 00 03000 ADULTS & PEDI ATRI CS	59, 055, 349	ł c	59, 055, 349		59, 058, 388	30.00
31. 00 03100 INTENSI VE CARE UNI T 31. 01 03101 NEONATAL INTENSI VE CARE	9, 804, 366 2, 273, 217		9, 804, 366 2, 273, 217	0	9, 804, 366 2, 273, 217	31. 00 31. 01
32. 00 03200 CORONARY CARE UNIT	2,273,217		2, 2/3, 2//	0	2, 273, 217	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0		ĺ	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, 889, 678		3, 889, 678	1, 276	3, 890, 954	40. 00
41. 00 04100 SUBPROVI DER - I RF	3, 085, 498		3, 085, 498		3, 085, 498	41. 00
43. 00 04300 NURSERY	4, 944, 638		4, 944, 638	0	4, 944, 638	43.00
44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY	0		0	0	0	44. 00 45. 00
46. 00 04600 OTHER LONG TERM CARE	0		0	0	0	46. 00
ANCI LLARY SERVICE COST CENTERS				J	U	40.00
50. 00 05000 OPERATI NG ROOM	28, 406, 638		28, 406, 638	14, 434	28, 421, 072	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	14, 127, 505		14, 127, 505	46, 461	14, 173, 966	54.00
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, 718, 889		2, 718, 889	0	2, 718, 889	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 499, 409		1, 499, 409		1, 499, 409	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 927, 878		3, 927, 878		3, 928, 828	59. 00
60. 00 06000 LABORATORY	13, 673, 610		13, 673, 610	0	13, 673, 610	60.00
60. 01 06001 BL00D 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	0		0	0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	2, 030, 408		2, 030, 408	0	0 2, 030, 408	63. 00 64. 00
65. 00 06500 RESPIRATORY THERAPY	4, 995, 495		4, 995, 495		4, 998, 549	65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 356, 505		3, 356, 505		3, 365, 346	66. 00
67. 00 06700 OCCUPATIONAL THERAPY	1, 262, 612	0	1, 262, 612	0	1, 262, 612	67. 00
68.00 06800 SPEECH PATHOLOGY	503, 659	0	503, 659	0	503, 659	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	21, 969, 036		21, 969, 036	0	0 21, 969, 036	70. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	15, 665, 473		15, 665, 473		15, 665, 473	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	25, 090, 290		25, 090, 290		25, 090, 290	73. 00
74. 00 07400 RENAL DI ALYSI S	0		0	0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0		0	0	0	75. 00
76. 00 03140 CARDI OLOGY	5, 042, 975		5, 042, 975	8, 574	5, 051, 549	76. 00
OUTPATIENT SERVICE COST CENTERS				0	0	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 CLI NI C	1, 471, 195		1, 471, 195	490	1, 471, 685	90.00
90. 01 04950 SLEEP CLINIC	777, 329		777, 329		784, 636	90. 01
91. 00 09100 EMERGENCY	18, 816, 412		18, 816, 412		18, 867, 543	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 257, 399		11, 257, 399		11, 257, 399	92. 00
OTHER REIMBURSABLE COST CENTERS	_					
94. 00 09400 HOME PROGRAM DI ALYSI S	0	•	0	0	0	94.00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	•	0	0	0	95. 00 96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0			0	0	97. 00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0		ĺ	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			100. 00
101. 00 10100 HOME HEALTH AGENCY	0		0		0	101. 00
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON	0	I	T 0		0	105. 00
106. 00 10600 HEART ACQUISITION		ł				105.00
107. 00 10700 LI VER ACQUI SI TI ON	0					107. 00
108. 00 10800 LUNG ACQUISITION	0	ŀ	0			107. 00
109.00 10900 PANCREAS ACQUISITION	0		0		0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0		0			110. 00
111. 00 11100 SLET ACQUISITION	0		0		0	111.00
113. 00 11300 INTEREST_EXPENSE 114. 00 11400 UTI LI ZATI ON_REVI EW-SNF	1					113. 00 114. 00
114. 00 11400 011 LIZATION REVIEW-SNF 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		0		n	114.00
- A-IIIIII SOURI SOURI SILE SENTEN (SITT)		1		<u> </u>		

Heal th Fina	ncial Systems	ELKHART GENER	RAL H	IOSPI TAL	PITAL In Lie			2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES			Provi der CC		Period: From 01/01/2018 To 12/31/2018		
				Title	XVIII	Hospi tal	PPS	
						Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Thei	rapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00		2. 00	3. 00	4. 00	5. 00	
116. 00 11600	HOSPI CE	0				0	0	116. 00
200. 00 201. 00 202. 00	Subtotal (see instructions) Less Observation Beds Total (see instructions)	259, 645, 463 11, 257, 399 248, 388, 064		0	259, 645, 46 11, 257, 39 248, 388, 06	9	11, 257, 399	201. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 7:11 am Health Financial Systems

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

					5/29/2019 7:1	1 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Inpati ent	Charges Outpatient	Total (col 6	Cost or Other	TEFRA	
cost center bescription	Пранен	outpatrent	+ col . 7)	Ratio	Inpatient	
			' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	nati o	Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	82, 803, 887		82, 803, 887			30. 00
31. 00 03100 INTENSI VE CARE UNI T	19, 879, 876		19, 879, 876			31.00
31. 01 03101 NEONATAL INTENSIVE CARE	2, 353, 683		2, 353, 683	3		31. 01
32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT	0					32. 00 33. 00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT						34.00
40. 00 04000 SUBPROVI DER - PF	5, 636, 982		5, 636, 982			40.00
41. 00 04100 SUBPROVI DER - I RF	2, 518, 154		2, 518, 154			41.00
43. 00 04300 NURSERY	3, 252, 257		3, 252, 257			43. 00
44.00 04400 SKILLED NURSING FACILITY	0					44. 00
45. 00 04500 NURSING FACILITY	0		(45. 00
46. 00 O4600 OTHER LONG TERM CARE	0		()		46. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM	31, 299, 189	46, 512, 356	77, 811, 545	0. 365070	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	31, 244, 104	40, 512, 350	77,011,543	0. 000000	0. 000000	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0		0. 000000	0. 000000	52.00
53. 00 05300 ANESTHESI OLOGY	o o	0		0. 000000	0. 000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	10, 672, 123	45, 663, 061	56, 335, 184		0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	o	0		0. 000000	0. 000000	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	(0.000000	0. 000000	56. 00
57. 00 05700 CT SCAN	15, 820, 173	42, 482, 043			0. 000000	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 416, 133	6, 372, 149			0.000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	9, 968, 824	21, 978, 126			0. 000000 0. 000000	59. 00 60. 00
60. 01 06000 LABORATORY 60. 01 06001 BL00D LABORATORY	35, 252, 654	29, 627, 231	64, 879, 885	0. 210753 0. 000000	0. 000000	60.00
61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY		0		0. 000000	0. 000000	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0. 000000	0. 000000	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	o	0		0. 000000	0. 000000	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	591, 181	683, 434	1, 274, 615		0. 000000	64. 00
65. 00 06500 RESPI RATORY THERAPY	17, 038, 717	2, 986, 647	20, 025, 364	0. 249458	0. 000000	65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 923, 903	2, 239, 449			0. 000000	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	2, 246, 911	728, 286			0. 000000	67. 00
68. 00 06800 SPEECH PATHOLOGY	551, 300	394, 556	945, 856		0.000000	68. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000 0. 000000	0. 000000 0. 000000	69. 00 70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	67, 020, 714	49, 809, 217	116, 829, 931		0. 000000	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	43, 157, 199	32, 963, 607			0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	63, 860, 891	55, 955, 939			0.000000	73. 00
74. 00 07400 RENAL DI ALYSI S	o	0		0. 000000	0. 000000	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	(0. 000000	0. 000000	75. 00
76. 00 03140 CARDI OLOGY	5, 664, 473	20, 557, 512	26, 221, 985	0. 192319	0. 000000	76. 00
OUTPATIENT SERVICE COST CENTERS			ı	N .		00.00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				88. 00 89. 00
90. 00 09000 CLI NI C	1, 840, 648	1, 679, 811			0. 000000	•
90. 01 04950 SLEEP CLINIC	6, 606	2, 783, 172			0. 000000	
91. 00 09100 EMERGENCY	9, 255, 352	31, 658, 903			0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 520, 445	16, 088, 404	19, 608, 849	0. 574098	0. 000000	92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	1		0. 000000	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0			0. 000000	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0. 000000 0. 000000	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0.00000	0. 000000	97. 00 98. 00
99. 00 09900 CMHC		0		0.00000	0.00000	99.00
99. 10 09910 CORF		0		ó		99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	Ö	0				100.00
101.00 10100 HOME HEALTH AGENCY	O	0	(101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	1			105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	1			106. 00
107.00 10700 LIVER ACQUISITION	0	0		1		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		á		1109.00
111. 00 11100 SLET ACQUI SI TI ON		0				111.00
113. 00 11300 NTEREST EXPENSE		Ö	1			113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	l .			115. 00
116. 00 11600 HOSPI CE	0	0	()		116. 00

Health Financial Systems		ELKHART GENERAL HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATI O	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CO	Provider CCN: 15-0018 Pe		Worksheet C	
					From 01/01/2018		nanad.
					To 12/31/2018	Date/Time Pre 5/29/2019 7:1	1 am
			Title	XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Ratio	I npati ent	
						Ratio	
		6.00	7. 00	8. 00	9. 00	10.00	
200.00	Subtotal (see instructions)	439, 552, 275	411, 163, 903	850, 716, 17	8		200.00
201.00	Less Observation Beds						201.00
202. 00	Total (see instructions)	439, 552, 275	411, 163, 903	850, 716, 17	8		202. 00

Title XVIII

		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
31. 01 03101 NEONATAL INTENSIVE CARE					31. 01
32. 00 03200 CORONARY CARE UNIT					32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT					33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T					34. 00
40. 00 04000 SUBPROVI DER - 1 PF					40.00
					41.00
					•
43. 00 04300 NURSERY					43. 00
44.00 04400 SKILLED NURSING FACILITY					44. 00
45.00 O4500 NURSING FACILITY					45. 00
46.00 O4600 OTHER LONG TERM CARE					46. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 365255				50.00
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. 251601				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
56. 00 05600 RADI OI SOTOPE	0. 000000				56. 00
57. 00 05700 CT SCAN	0. 046634				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 170615				58.00
	0. 170813				
					59.00
60. 00 06000 LABORATORY	0. 210753				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. 000000				62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
64. 00 06400 I NTRAVENOUS THERAPY	1. 592958				64.00
65. 00 06500 RESPIRATORY THERAPY	0. 249611				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 651775				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 424379				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 532490				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. 188043				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 205798				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 209405				73. 00
74.00 07400 RENAL DIALYSIS	0. 000000				74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
76. 00 03140 CARDI OLOGY	0. 192646				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 CLINIC	0. 418038				90.00
90. 01 04950 SLEEP CLINIC	0. 281254				90. 01
91. 00 09100 EMERGENCY	0. 461148				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 574098				92.00
	0. 374090				72.00
OTHER REIMBURSABLE COST CENTERS	0.000000				04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0.000000				94.00
95. 00 09500 AMBULANCE SERVICES	0.000000				95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-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
99. 00 09900 CMHC					99. 00
99. 10 09910 CORF					99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM					100.00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					
105. 00 10500 KI DNEY ACQUI SI TI ON					105. 00
106.00 10600 HEART ACQUISITION					106.00
106. 00 10600 HEART ACQUISTITON 107. 00 10700 LIVER ACQUISTION					108.00
108. 00 10800 LUNG ACQUISITION					108.00
109. 00 10900 PANCREAS ACQUISITION					109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON					110.00
111.00 11100 I SLET ACQUI SI TI ON					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.)					115. 00
116. 00 11600 HOSPI CE]				116.00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201. 00
	<u> </u>				

Health Financial Systems	ELKHART GENERA	L HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0018	Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/29/2019 7:1	
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient Ratio 11.00				
202.00 Total (see instructions)					202. 00

СОМРИТ	ATION OF RATIO OF COSTS TO CHARGES	-	Provi der Co		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I	paradi
						5/29/2019 7:1	pareu: 1 am
			litl	e XIX	Hospi tal Costs	PPS	
	Cost Center Description	Total Cost (from Wkst. B,	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		Part I, col.	riaj .		Di Sai i Gwanee		
		26) 1. 00	2.00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	50.055.040		50.055.04		50.050.000	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	59, 055, 349 9, 804, 366		59, 055, 34 ^o 9, 804, 36 ^o		59, 058, 388 9, 804, 366	
31. 01	03101 NEONATAL INTENSIVE CARE	2, 273, 217		2, 273, 21		2, 273, 217	
32. 00	03200 CORONARY CARE UNIT	0			0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0		1	0	0	
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	3, 889, 678		3, 889, 67	3 1, 276	3, 890, 954	34. 00 40. 00
41. 00	04100 SUBPROVI DER – I RF	3, 085, 498		3, 085, 49	· ·	3, 085, 498	
43. 00	04300 NURSERY	4, 944, 638		4, 944, 63		4, 944, 638	
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0			0 0	0	
	04600 OTHER LONG TERM CARE	0				0	1
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	28, 406, 638		28, 406, 63	14, 434	28, 421, 072 0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0				0	
53. 00	05300 ANESTHESI OLOGY	0			0	0	1
54.00	05400 RADI OLOGY - DI AGNOSTI C	14, 127, 505		14, 127, 50	46, 461	14, 173, 966	
55. 00 56. 00	O5500 RADI OLOGY-THERAPEUTI C O5600 RADI OI SOTOPE	0		1		0	
57. 00	05700 CT SCAN	2, 718, 889		2, 718, 88	9 0	2, 718, 889	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 499, 409		1, 499, 40	9 0	1, 499, 409	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 927, 878		3, 927, 87		3, 928, 828	
60. 00 60. 01	O6000 LABORATORY O6001 BLOOD LABORATORY	13, 673, 610		13, 673, 610		13, 673, 610 0	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	2, 030, 408		2, 030, 40	3 0	0 2, 030, 408	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	4, 995, 495	0	1		4, 998, 549	
66. 00	06600 PHYSI CAL THERAPY	3, 356, 505	0	3, 356, 50		3, 365, 346	
67.00	06700 OCCUPATIONAL THERAPY	1, 262, 612	0	1, 262, 613		1, 262, 612	
68. 00 69. 00	O6800 SPEECH PATHOLOGY O6900 ELECTROCARDI OLOGY	503, 659	0	503, 65	0	503, 659 0	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 969, 036		21, 969, 03		21, 969, 036	1
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	15, 665, 473 25, 090, 290		15, 665, 47; 25, 090, 290		15, 665, 473 25, 090, 290	
74.00	07400 RENAL DIALYSIS	0		20,070,27	o o	0	1
75. 00	07500 ASC (NON-DISTINCT PART)	0			0	0	
76.00	03140 CARDIOLOGY OUTPATIENT SERVICE COST CENTERS	5, 042, 975		5, 042, 97	5 8, 574	5, 051, 549	76.00
88. 00		0			0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0	
90. 00 90. 01	09000	1, 471, 195 777, 329		1, 471, 199 777, 329		1, 471, 685 784, 636	
91.00	09100 EMERGENCY	18, 816, 412		18, 816, 41		18, 867, 543	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 257, 399		11, 257, 39		11, 257, 399	
04.00	OTHER REIMBURSABLE COST CENTERS O9400 HOME PROGRAM DI ALYSI S	1 0		1		0	04.00
95.00	1 1	0		1	0 0	0	
	09600 DURABLE MEDICAL EQUIP-RENTED	0		1	0	0	1
	09700 DURABLE MEDICAL EQUIP-SOLD	0			0	0	
98.00	09850 OTHER REIMBURSABLE COST CENTERS 09900 CMHC	0			0	0	
	09910 CORF	0				0	1
	10000 I&R SERVICES-NOT APPRVD PRGM	0		1	o l		100. 00
101.00	10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	0			0	0	101. 00
105.00	10500 KIDNEY ACQUISITION	0		1 (0	105. 00
	10600 HEART ACQUISITION	0		1	o l		106. 00
	10700 LIVER ACQUISITION 10800 LUNG ACQUISITION	0		l .			107. 00 108. 00
	10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION	0			ő		108.00
110.00	11000 INTESTINAL ACQUISITION	0				0	110. 00
	11100 I SLET ACQUI SI TI ON	0			0	0	111.00
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0		(0	115. 00

Heal th Fina	ncial Systems	ELKHART GENER	RAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATI ON	I OF RATIO OF COSTS TO CHARGES			Provider CC		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/29/2019 7:1	
				Titl	e XIX	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	DHOSPICE Subtotal (see instructions) Less Observation Beds Total (see instructions)	0 259, 645, 463 11, 257, 399 248, 388, 064		0	11, 257, 39	9	259, 791, 020 11, 257, 399	201. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2018 | Part | | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 7:11 am Health Financial Systems

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

					V/1.V/		5/29/2019 7:1	<u> 1 am </u>
				Charges	e XIX	Hospi tal	PPS	
		Cost Center Description	Inpatient	Outpatient	Total (col. 6	Cost or Other	TEFRA	
		COST CENTER DESCRIPTION	Impatrent	outputtent	+ col . 7)	Ratio	Inpati ent	
					,		Rati o	
			6.00	7. 00	8. 00	9. 00	10. 00	
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	82, 803, 887		82, 803, 887			30. 00
31. 00	1	INTENSIVE CARE UNIT	19, 879, 876		19, 879, 876			31.00
31. 00	03101	NEONATAL INTENSIVE CARE	2, 353, 683		2, 353, 683			31. 00
32. 00		CORONARY CARE UNIT	2,000,000		0			32. 00
33. 00		BURN INTENSIVE CARE UNIT	Ö		Ö			33. 00
34.00	03400	SURGICAL INTENSIVE CARE UNIT	o		0			34. 00
40.00		SUBPROVI DER - I PF	5, 636, 982		5, 636, 982			40. 00
41.00		SUBPROVI DER - I RF	2, 518, 154		2, 518, 154			41. 00
43.00		NURSERY SKILLED NURSING FACILITY	3, 252, 257		3, 252, 257			43.00
44. 00 45. 00		NURSING FACILITY	0		0			44. 00 45. 00
46. 00		OTHER LONG TERM CARE			0			46. 00
10.00		LARY SERVICE COST CENTERS	<u> </u>					10.00
50.00		OPERATING ROOM	31, 299, 189	46, 512, 356	77, 811, 545	0. 365070	0. 000000	50. 00
51. 00		RECOVERY ROOM	0	0	0	0. 000000	0. 000000	
52. 00		DELIVERY ROOM & LABOR ROOM	0	0	0	0. 000000	0. 000000	
53.00		ANESTHESI OLOGY	0	0	0	0.000000	0.000000	
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	10, 672, 123	45, 663, 061	56, 335, 184	0. 250776 0. 000000	0. 000000 0. 000000	
56. 00		RADI OLOGI - ITILKAPLOTI C		0		0. 000000	0. 000000	1
57. 00		CT SCAN	15, 820, 173	42, 482, 043	58, 302, 216	0. 046634	0. 000000	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	2, 416, 133	6, 372, 149		0. 170615	0.000000	1
59. 00		CARDI AC CATHETERI ZATI ON	9, 968, 824	21, 978, 126	31, 946, 950	0. 122950	0. 000000	
60.00		LABORATORY	35, 252, 654	29, 627, 231	64, 879, 885	0. 210753	0. 000000	
60. 01		BLOOD LABORATORY	0	0	0	0.000000	0.000000	
61.00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0.000000	0.000000	1
62. 00 63. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS BLOOD STORING, PROCESSING & TRANS.	0	0	0	0. 000000 0. 000000	0. 000000 0. 000000	
64. 00		INTRAVENOUS THERAPY	591, 181	683, 434	1, 274, 615	1. 592958	0. 000000	•
65. 00		RESPI RATORY THERAPY	17, 038, 717	2, 986, 647		0. 249458	0. 000000	
66.00		PHYSI CAL THERAPY	2, 923, 903	2, 239, 449		0. 650063	0. 000000	1
67. 00		OCCUPATI ONAL THERAPY	2, 246, 911	728, 286		0. 424379	0. 000000	ł
68. 00		SPEECH PATHOLOGY	551, 300	394, 556		0. 532490	0. 000000	
69.00		ELECTROCARDI OLOGY	0	0	0	0.000000	0.000000	
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	67, 020, 714	49, 809, 217	116, 829, 931	0. 000000 0. 188043	0. 000000 0. 000000	
71.00		IMPL. DEV. CHARGED TO PATIENTS	43, 157, 199	32, 963, 607		0. 205798	0. 000000	1
73. 00		DRUGS CHARGED TO PATIENTS	63, 860, 891	55, 955, 939		0. 209405	0. 000000	1
74.00		RENAL DIALYSIS	О	0		0. 000000	0.000000	
75. 00		ASC (NON-DISTINCT PART)	0	0	0	0. 000000	0. 000000	
76. 00		CARDI OLOGY	5, 664, 473	20, 557, 512	26, 221, 985	0. 192319	0. 000000	76. 00
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	ol	0		0. 000000	0. 000000	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0	0		0. 000000	0. 000000	
		CLINIC	1, 840, 648	1, 679, 811				1
90. 01	1	SLEEP CLINIC	6, 606	2, 783, 172			0. 000000	1
91.00	09100	EMERGENCY	9, 255, 352	31, 658, 903	40, 914, 255	0. 459899	0. 000000	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)	3, 520, 445	16, 088, 404	19, 608, 849	0. 574098	0. 000000	92. 00
04.00		REIMBURSABLE COST CENTERS	ol	0		0.000000	0.000000	04.00
94. 00 95. 00		HOME PROGRAM DIALYSIS AMBULANCE SERVICES		0		0. 000000 0. 000000	0. 000000 0. 000000	
96. 00	1	DURABLE MEDICAL EQUIP-RENTED		0		0. 000000	0. 000000	
97. 00		DURABLE MEDICAL EQUIP-SOLD	Ö	0	Ö	0. 000000	0. 000000	
98. 00	09850	OTHER REIMBURSABLE COST CENTERS	o	0	0	0. 000000	0. 000000	98. 00
99. 00	09900		0	0	0			99. 00
	09910		0	0				99. 10
	1	I &R SERVICES-NOT APPRVD PRGM	0	0				100.00
101.00		HOME HEALTH AGENCY AL PURPOSE COST CENTERS	0	0	0			101. 00
105 00		KIDNEY ACQUISITION	ol	0	0			105. 00
		HEART ACQUISITION	o	0				106. 00
107.00	10700	LIVER ACQUISITION	o	0	0			107. 00
		LUNG ACQUISITION	0	0	0			108. 00
		PANCREAS ACQUISITION	0	0	0			109. 00
		INTESTINAL ACQUISITION	0	0				110.00
	1	ISLET ACQUISITION INTEREST EXPENSE	ا	0				111. 00 113. 00
		UTILIZATION REVIEW-SNF						114. 00
		AMBULATORY SURGICAL CENTER (D. P.)	o	0	0			115. 00
		HOSPI CE	o	0				116. 00
-			,					

Health Financial Systems	ELKHART GENERAL HOSPITAL			In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od:	Worksheet C		
				From 01/01/2018 To 12/31/2018	Part I Date/Time Pre 5/29/2019 7:1	epared:	
		Ti tl	e XIX	Hospi tal	PPS		
		Charges					
Cost Center Description	I npati ent	Outpati ent	Total (col. (Cost or Other	TEFRA		
			+ col. 7)	Ratio	I npati ent		
					Ratio		
	6. 00	7.00	8. 00	9. 00	10.00		
200.00 Subtotal (see instructions)	439, 552, 275	411, 163, 903	850, 716, 17	8		200.00	
201.00 Less Observation Beds						201. 00	
202.00 Total (see instructions)	439, 552, 275	411, 163, 903	850, 716, 17	8		202. 00	

Title XIX

		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient		· · · · · · · · · · · · · · · · · · ·		
'	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS					30.00
					1
31. 00 03100 INTENSI VE CARE UNI T					31.00
31. 01 03101 NEONATAL INTENSIVE CARE					31. 01
32. 00 03200 CORONARY CARE UNIT					32. 00
33.00 03300 BURN INTENSIVE CARE UNIT					33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
40. 00 04000 SUBPROVI DER - 1 PF					40.00
41. 00 04100 SUBPROVI DER - I RF					41.00
					•
43. 00 04300 NURSERY					43. 00
44.00 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. 365255				50.00
51. 00 05100 RECOVERY ROOM	0. 000000				51.00
52. 00 05200 DELI VERY 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. 251601				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
56. 00 05600 RADI 01 SOTOPE	0. 000000				56. 00
57.00 05700 CT SCAN	0. 046634				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 170615				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 122980				59.00
	0. 122960				1
60. 00 06000 LABORATORY					60.00
60. 01 06001 BL00D LABORATORY	0. 000000				60. 01
61.00 O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63.00
64. 00 06400 I NTRAVENOUS THERAPY	1. 592958				64.00
65. 00 06500 RESPIRATORY THERAPY	0. 249611				65. 00
					•
66. 00 06600 PHYSI CAL THERAPY	0. 651775				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 424379				67. 00
68.00 06800 SPEECH PATHOLOGY	0. 532490				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. 188043				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 205798				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS					•
	0. 209405				73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000				74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
76. 00 03140 CARDI OLOGY	0. 192646				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
90. 00 09000 CLINI C	0. 418038				90.00
					1
	0. 281254				90. 01
91. 00 09100 EMERGENCY	0. 461148				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 574098				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
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
	0.000000				
99. 00 09900 CMHC					99. 00
99. 10 09910 CORF					99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM					100. 00
101.00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					
105. 00 10500 KI DNEY ACQUI SI TI ON					105. 00
106. 00 10600 HEART ACQUISITION					•
					106.00
107. 00 10700 LI VER ACQUI SI TI ON					107. 00
108.00 10800 LUNG ACQUISITION					108. 00
109.00 10900 PANCREAS ACQUISITION					109. 00
110.00 11000 INTESTINAL ACQUISITION					110. 00
111.00 11100 SLET ACQUISITION					111. 00
113. 00 11300 NTEREST EXPENSE					113. 00
1 1					114. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)					115. 00
116. 00 11600 HOSPI CE					116. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 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		Worksheet C Part I Date/Time Pre 5/29/2019 7:1	
		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 Provider CCN: 15-0018

KEBOOT	10110 1	ON WEDTONIE SINET			То	12/31/2018	Date/Time Pre 5/29/2019 7:1	pared: 1 am
				Ti tl	e XIX	Hospi tal	PPS	ı aiii
		Cost Center Description	Total Cost		Operating Cost		Operating Cost	
			(WKSt. B, Part		Net of Capital Cost (col. 1 -	Reducti on	Reduction Amount	
			1, (01. 20)	11 (01. 20)	col. 2)		Amount	
			1.00	2. 00	3.00	4. 00	5. 00	
F0 00		_ARY SERVICE COST CENTERS	00.407.400	0.047.047	0 000 074			F0 00
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	28, 406, 638	2, 367, 367 0		0	0	50. 00 51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53. 00		ANESTHESI OLOGY	0	O	Ō	0	0	53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	14, 127, 505	1, 551, 144	12, 576, 361	0	0	54. 00
55. 00	1	RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 57. 00		RADI OI SOTOPE CT SCAN	2, 718, 889	283, 453	2, 435, 436	0	0	56. 00 57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	1, 499, 409	144, 612	1	0	0	58. 00
59. 00		CARDI AC CATHETERI ZATI ON	3, 927, 878	170, 444	1	0	0	59. 00
60.00	1	LABORATORY	13, 673, 610	236, 628	13, 436, 982	0	0	60. 00
60. 01	1	BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 62. 00		PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	61. 00 62. 00
63. 00	1	BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63. 00
64. 00		I NTRAVENOUS THERAPY	2, 030, 408	83, 434	1, 946, 974	0	0	64. 00
65. 00		RESPI RATORY THERAPY	4, 995, 495	84, 513		0	0	65. 00
66. 00		PHYSI CAL THERAPY	3, 356, 505	202, 294		0	0	66. 00
67. 00 68. 00		OCCUPATIONAL THERAPY SPEECH PATHOLOGY	1, 262, 612 503, 659	95, 269 57, 011		0	0	67. 00 68. 00
69. 00	1	ELECTROCARDI OLOGY	0	37,011	440, 040	0	0	69. 00
70. 00	1	ELECTROENCEPHALOGRAPHY	0	0	Ö	0	0	70. 00
71. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 969, 036	363, 225	1	0	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	15, 665, 473	262, 765	1	0	0	72. 00
73. 00 74. 00		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	25, 090, 290	246, 928 0		0	0	73. 00 74. 00
75. 00		ASC (NON-DISTINCT PART)		0	1	0	0	75. 00
76. 00	03140	CARDI OLOGY	5, 042, 975	390, 146	4, 652, 829	0	0	76. 00
00.00		TIENT SERVICE COST CENTERS				0		00.00
88. 00 89. 00	1	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	88. 00 89. 00
90.00		CLINIC	1, 471, 195	211, 559	_	0	0	90.00
90. 01	1	SLEEP CLINIC	777, 329	1, 733	1	0	0	90. 01
91.00	1	EMERGENCY	18, 816, 412	725, 160	1	0	0	91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS	11, 257, 399	1, 072, 211	10, 185, 188	0	0	92. 00
94. 00		HOME PROGRAM DI ALYSIS	l	0	O	0	0	94. 00
95.00	1	AMBULANCE SERVICES	o	0	O	0	0	95. 00
96. 00		DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 98. 00		DURABLE MEDICAL EQUIP-SOLD OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	97. 00 98. 00
99. 00	09900		0	0		0	0	99. 00
	09910		O	0	Ö	0	0	99. 10
		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	O	0	o	0	0	105. 00
		HEART ACQUISITION	o o	Ö	Ö	Ö		106. 00
		LIVER ACQUISITION	O	0	0	0		107. 00
		LUNG ACQUISITION	0	0	0	0		108.00
		PANCREAS ACQUISITION INTESTINAL ACQUISITION	0	0		0		109. 00 110. 00
		ISLET ACQUISITION	l o	Ö		0		111. 00
		INTEREST EXPENSE		· ·				113. 00
		UTI LI ZATI ON REVI EW-SNF						114. 00
	1	AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115. 00
200.00	1	HOSPICE Subtotal (sum of lines 50 thru 199)	176, 592, 717	8, 549, 896	168, 042, 821	0		116. 00 200. 00
201.00		Less Observation Beds	11, 257, 399	1, 072, 211		0		201. 00
202.00		Total (line 200 minus line 201)	165, 335, 318			0	0	202. 00

Peri od: Worksheet C From 01/01/2018 Part II To 12/31/2018 Date/Time Prepared: 5/29/2019 7:11 am Provider CCN: 15-0018 REDUCTIONS FOR MEDICALD ONLY

					5/29/2019 7:1	<u>1 am</u>
			e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges				
	Capital and		Cost to Charge			
			Ratio (col. 6			
	Reduction	8)	/ col . 7)			
ANCILLARY SERVICE COST CENTERS	6.00	7. 00	8. 00			
50. 00 05000 OPERATING ROOM	28, 406, 638	77, 811, 545	0. 365070			50.00
51. 00 05100 RECOVERY ROOM	20, 400, 030		0.000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			1			52. 00
53. 00 05300 ANESTHESI OLOGY			0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	14, 127, 505	56, 335, 184	1			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	14, 127, 303	30, 333, 104	0.000000			55. 00
56. 00 05600 RADI OI SOTOPE			0. 000000			56.00
57. 00 05700 CT SCAN	2, 718, 889	1	1			57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 499, 409		1			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 927, 878		1			59. 00
60. 00 06000 LABORATORY	13, 673, 610		1			60.00
60. 01 06001 BLOOD LABORATORY	10,070,010	1	0. 000000			60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_	1			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0. 000000			62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.			0. 000000			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	2, 030, 408	1				64. 00
65. 00 06500 RESPIRATORY THERAPY	4, 995, 495					65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 356, 505		1			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 262, 612					67. 00
68. 00 06800 SPEECH PATHOLOGY	503, 659					68. 00
69. 00 06900 ELECTROCARDI OLOGY	303, 037	II.	1			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		-	0.000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	21, 969, 036	1				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	15, 665, 473					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	25, 090, 290					73. 00
74. 00 07400 RENAL DIALYSIS	23, 070, 270	1	1			74.00
75. 00 07500 ASC (NON-DISTINCT PART)			0. 000000			75. 00
76. 00 03140 CARDI OLOGY	5, 042, 975	26, 221, 985	1			76. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0) C	0.000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0) c	0. 000000			89. 00
90. 00 09000 CLI NI C	1, 471, 195	3, 520, 459	0. 417899			90.00
90. 01 04950 SLEEP CLINIC	777, 329	2, 789, 778	0. 278635			90. 01
91. 00 09100 EMERGENCY	18, 816, 412	40, 914, 255	0. 459899			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	11, 257, 399	19, 608, 849	0. 574098			92. 00
OTHER REIMBURSABLE COST CENTERS	1 -	_				4
94. 00 09400 HOME PROGRAM DI ALYSI S	0		0.000000			94.00
95. 00 09500 AMBULANCE SERVI CES	0	l .				95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	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			98. 00
99. 00 09900 CMHC			0.000000			99. 00
99. 10 09910 CORF	0		0.000000			99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0		0.000000			100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS) <u> </u>	0.000000]101. 00
105. 00 10500 KIDNEY ACQUISITION	0)	0. 000000			105. 00
106. 00 10600 HEART ACQUISITION		ł .	0.000000			106.00
107. 00 10700 LI VER ACQUI SI TI ON		ł .	0. 000000			107. 00
108. 00 10800 LUNG ACQUISITION			0. 000000			108. 00
109. 00 10900 PANCREAS ACQUISITION			0. 000000			109.00
110. 00 11000 I NTESTINAL ACQUISITION			0. 000000			110.00
111. 00 11100 SLET ACQUISITION			0. 000000			111.00
113. 00 11300 NTEREST EXPENSE			3.000000			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. 000000			115.00
116. 00 11600 HOSPI CE			0. 000000			116.00
200.00 Subtotal (sum of lines 50 thru 199)	176, 592, 717	734, 271, 339				200.00
201.00 Less Observation Beds	11, 257, 399					201. 00
202.00 Total (line 200 minus line 201)	165, 335, 318	734, 271, 339)			202. 00

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	ELKHART GENER COSTS	AL HOSPITAL Provi der C		Peri od:	worksheet D	2552-10
				From 01/01/2018 To 12/31/2018		pared: 1 am
		Title	: XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			T			
30. 00 ADULTS & PEDIATRICS	5, 625, 010		-,,		139. 23	
31. 00 INTENSIVE CARE UNIT	520, 546		520, 54			
31. 01 NEONATAL INTENSIVE CARE	99, 112		99, 11			
32. 00 CORONARY CARE UNIT	0			0		
33.00 BURN INTENSIVE CARE UNIT	0			0	0.00	
34.00 SURGICAL INTENSIVE CARE UNIT	0			0	0.00	1
40. 00 SUBPROVI DER - I PF	468, 765	0	,		l .	1
41. 00 SUBPROVI DER - I RF	396, 220	0	396, 22		l	
43. 00 NURSERY	598, 726		598, 72	6 2, 256		
44.00 SKILLED NURSING FACILITY	0			0		
45.00 NURSING FACILITY	0			0	0.00	
200.00 Total (lines 30 through 199)	7, 708, 379		7, 708, 37	9 52, 883		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	4 00	6)				
INDATIENT POUTLNE CEDVICE COCT CENTERS	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	10.015	1 700 155	1			20.00
30. 00 ADULTS & PEDIATRICS	12, 915					30.00
31. 00 INTENSIVE CARE UNIT	1, 928		1			31.00
31. 01 NEONATAL INTENSIVE CARE 32. 00 CORONARY CARE UNIT	0	0				31. 01
33. 00 BURN INTENSIVE CARE UNIT	0	0				33. 00
	0	0				
34. 00 SURGICAL INTENSIVE CARE UNIT	(00	ľ	1			34.00
40. 00 SUBPROVI DER - PF 41. 00 SUBPROVI DER - RF	602 583	92, 828				40. 00 41. 00
	583	152, 571	1			
43.00 NURSERY 44.00 SKILLED NURSING FACILITY		0	1			43. 00 44. 00
44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY						45. 00
200.00 Total (lines 30 through 199)	16, 028	2, 247, 209				200. 00
200. 00 Total (Titles 30 till bugil 177)	10,020	2,241,209	I			1200.00

APPORTI OMMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS
Cost Center Description
Title XVIII
Title XVIII
Related Cost (From Wisst. C, and a service cost center) Part II, col. 26) Part II, col. 27) Part II, col. 26) Part II, col. 27) Part
ANCILLARY SERVICE COST CENTERS
Part II, col. 26
ANCI LLARY SERVI CE COST CENTERS
No
ANCILLARY SERVICE COST CENTERS So. 00 Compose Service Cost Centers So. 00 Cost Cost Cost Centers So. 00 Cost Cost Centers So. 00 Cost Cost Centers So. 00 Cost Centers
50.00
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0
54. 00 05400 RADI OLOGY-DI AGNOSTI C 1,551,144 56,335,184 0.027534 4,284,678 117,974 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0.000000 0 0.55.00 05600 RADI OLOGY-THERAPEUTI C 0 0 0.000000 0 0.55.00 05700 CT SCAN 283,453 58,302,216 0.004862 6,145,843 29,881 57.00 59.00 0.5900 MAGNETI C RESONANCE I MAGI NG (MRI) 144,612 8,788,282 0.016455 872,021 14,349 58.00 0.00000 0.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0.000000 0 0.000000 0 0 0.56. 00 55. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0.000000 0 0.000000 0 0.000000 0 0.000000
56. 00 05600 RADI OI SOTOPE 0 0 0.000000 0 0 0.56. 00
57. 00 05700 CT SCAN 283, 453 58, 302, 216 0.004862 6, 145, 843 29, 881 57. 00 5800 MAGNETIC RESONANCE I MAGI NG (MRI)
58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 170, 444 31, 946, 950 0.005335 3, 726, 057 19, 879 59. 00 60. 00 06000 LABORATORY 236, 628 64, 879, 885 0.003647 13, 782, 189 50, 264 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0.000000 0 0 60. 01 61. 00 6100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0.000000 0 0 0 62. 00 63. 00 6300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0.000000 0 0 0 63. 00 64. 00 06400 I NTRAVENOUS THERAPY 83, 434 1, 274, 615 0.065458 195, 212 12, 778 64. 00 66. 00 06400 PHYSI CAL THERAPY 84, 513 20, 025, 364 0.004220 7, 147, 112 30, 161 65. 00 66. 00 06600 PHYSI CAL THERAPY 95, 269 2, 975, 197 0.032021 764, 085 24, 467 67. 00 67. 00 06900 ELECTROCARDI OLOGY 57, 011 945, 856 0.060275 151, 370 9, 124 68. 00 69. 00 07000 ELECTROCARDI OLOGY 0 0.000000 0 0.000000 0 0 0.000000 0 0.000000
60. 00
60. 01
61. 00
62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 07300 DRUGS CHARGED TO PATI ENTS 73. 00 07400 RENAL DI ALYSI S 74. 00 07400 DRUGS CHARGED TO PATI ENTS 74. 00 07400 DRUGS CHARGED TO PATI ENTS 75. 00 07400 DRUGS CHARGED TO PATI ENTS 76. 00 07400 DRUGS CHARGED TO PATI ENTS 76. 00 07400 DRUGS CHARGED TO PATI ENTS 76. 100 07400 DO00000 D DRUGS CHARGED TO PATI ENTS 76. 100 07400 DO00000 D DRUGS CHARGED TO PATI ENTS 76. 100 07400 DO00000 D DRUGS CHARGED TO PATI ENTS 76. 100 07400 DO00000 D DRUGS CHARGED TO PATI ENTS 76. 100 07400 DO00000 D DRUGS CHARGED TO PATI ENTS 76. 100 07400 DO00000 D DRUGS CHARGED TO PATI ENTS 76. 100 07400 DO00000 D DRUGS CHARGED TO PATI ENTS 76. 100 07400 DO00000 D DRUGS CHARGED TO PATI ENTS 76. 100 07400 DRUGS CHARGED TO PATI ENTS 76. 100 07400 DO00000 D DRUGS CHARGED TO PATI ENTS 76. 100 DO00000 D DRUGS CHARGED TO PATI ENTS 77. 00 07400 DRUGS CHARGED TO PATI ENTS 78. 00 07400 DRUGS CHARGED TO PATI ENTS 79. 00 07400
64. 00 06400 INTRAVENOUS THERAPY 83, 434 1, 274, 615 0. 065458 195, 212 12, 778 64. 00 65. 00 06500 RESPI RATORY THERAPY 84, 513 20, 025, 364 0. 004220 7, 147, 112 30, 161 65. 00 66. 00 06600 PHYSI CAL THERAPY 202, 294 5, 163, 352 0. 039179 1, 055, 507 41, 354 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 95, 269 2, 975, 197 0. 032021 764, 085 24, 467 67. 00 69. 00 06800 SPEECH PATHOLOGY 57, 011 945, 856 0. 060275 151, 370 9, 124 68. 00 69. 00 0.000000 0 0 0.000000 0
65. 00 06500 RESPIRATORY THERAPY 84, 513 20, 025, 364 0. 004220 7, 147, 112 30, 161 65. 00 66. 00 06600 PHYSI CAL THERAPY 202, 294 5, 163, 352 0. 039179 1, 055, 507 41, 354 66. 00 06700 OCCUPATI ONAL THERAPY 95, 269 2, 975, 197 0. 032021 764, 085 24, 467 67. 00 68. 00 06800 SPEECH PATHOLOGY 57, 011 945, 856 0. 060275 151, 370 9, 124 68. 00 06900 ELECTROCARDI OLOGY 0 0 0. 000000 0 0 0 0 0 70. 00 000000 0 0 0
66. 00 06600 PHYSI CAL THERAPY 202, 294 5, 163, 352 0. 039179 1, 055, 507 41, 354 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 95, 269 2, 975, 197 0. 032021 764, 085 24, 467 67. 00 68. 00 06800 SPECH PATHOLOGY 57, 011 945, 856 0. 060275 151, 370 9, 124 68. 00 69. 00 07000 ELECTROCARDI OLOGY 0 0 0. 000000 0 0 0 0. 000000 0
67. 00 06700 0CCUPATI ONAL THERAPY 95, 269 2, 975, 197 0. 032021 764, 085 24, 467 67. 00 68. 00 06800 SPECH PATHOLOGY 57, 011 945, 856 0. 060275 151, 370 9, 124 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 363, 225 116, 829, 931 0. 003109 27, 208, 140 84, 590 71. 00 72. 00 07200 IMPL DEV CHARGED TO PATI ENTS 262, 765 76, 120, 806 0. 003452 17, 767, 812 61, 334 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 246, 928 119, 816, 830 0. 002061 22, 418, 227 46, 204 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0. 000000 0 0 74. 00
68. 00 06800 SPEECH PATHOLOGY 57, 011 945, 856 0.060275 151, 370 9, 124 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0.000000 0 0 0 0 0 0.000000 0 0 0 0
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69. 00 0 0 0 0 0 0 0 0 0
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 262, 765 76, 120, 806 0.003452 17, 767, 812 61, 334 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 246, 928 119, 816, 830 0.002061 22, 418, 227 46, 204 73. 00 74. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 246, 928 119, 816, 830 0.002061 22, 418, 227 46, 204 73. 00 74. 00 07400 RENAL DIALYSIS 0 0.000000 0 0 74. 00
74. 00 07400 RENAL DIALYSIS 0 0 0.000000 0 0 74. 00
75 OO 07500 ASC (NON_DISTINCT PART)
76. 00 03140 CARDI OLOGY 390, 146 26, 221, 985 0. 014879 2, 345, 276 34, 895 76. 00
0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C 0 0 0.000000 0 0 88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.000000 0 89. 00
90. 00 09000 CLINIC 211, 559 3, 520, 459 0. 060094 886, 749 53, 288 90. 00
90. 01 04950 SLEEP CLINIC 1,733 2,789,778 0.000621 0 0 90. 01
91. 00 09100 EMERGENCY 725, 160 40, 914, 255 0. 017724 3, 534, 221 62, 641 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 1,072,211 19,608,849 0.054680 0 92.00
OTHER REIMBURSABLE COST CENTERS
94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0.000000 0 94. 00
95. 00 09500 AMBULANCE SERVI CES 95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0.000000 0 0 96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0.000000 0 97. 00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0.000000 0 98. 00
200.00 Total (lines 50 through 199) 8,549,896 734,271,339 125,131,344 1,084,035 200.00

Health Financial Systems	ELKHART GENER	RAL HOSPITAL		In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER P	ASS THROUGH COS	TS Provider C		Peri od:	Worksheet D	
				From 01/01/2018 To 12/31/2018		nared:
				10 12/31/2010	5/29/2019 7: 1	1 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School			All Other	
	Post-Stepdown		Post-Stepdowr	Cost	Medi cal	
	Adjustments	1.00	Adjustments	2.00	Education Cost	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1A	1.00	2A	2. 00	3. 00	
30. 00 O3000 ADULTS & PEDIATRICS	1 0	0		0 (0	30.00
31. 00 03100 NTENSI VE CARE UNI T		_	1			
31. 01 03101 NEONATAL INTENSIVE CARE					_	
32. 00 03200 CORONARY CARE UNIT	0				_	
33.00 03300 BURN INTENSIVE CARE UNIT	0	Ō	,	0	Ō	1
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	,	0	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	0)	0	0	40. 00
41. 00 04100 SUBPROVI DER - 1 RF	0	0)	0	0	41.00
43. 00 04300 NURSERY	0	0)	0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	1	0		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	,	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col . 6)	Program Days	
	Amount (see instructions)	1 through 3, minus col. 4)				
	4. 00	5.00	6.00	7. 00	8.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	0.00	0.00	7.00	0.00	
30. 00 03000 ADULTS & PEDI ATRI CS	0	0	40, 40	1 0.00	12, 915	30.00
31.00 03100 INTENSIVE CARE UNIT		0	4, 92	0.00		
31.01 03101 NEONATAL INTENSIVE CARE		0	74	0.00	0	31. 01
32. 00 03200 CORONARY CARE UNIT		0		0.00	0	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		0	1	0.00		
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0		0.00		
40. 00 04000 SUBPROVI DER - I PF	0	_	-,			1
41. 00 04100 SUBPROVI DER - RF	0	,	1, 0.			1
43. 00 04300 NURSERY		0	1			
44.00 O4400 SKILLED NURSING FACILITY 45.00 O4500 NURSING FACILITY		0	1	0.00		
200.00 Total (lines 30 through 199)			1			200.00
Cost Center Description	Inpati ent	0	52,00	3	10,028	200.00
oost center bescription	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS	1	T				
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31.00 03100 INTENSIVE CARE UNIT 31.01 03101 NEONATAL INTENSIVE CARE	0					31.00
31.01 03101 NEONATAL INTENSIVE CARE 32.00 03200 CORONARY CARE UNIT						31. 01 32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT						33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T		l .				34.00
40. 00 04000 SUBPROVI DER - I PF						40.00
41. 00 04100 SUBPROVI DER - RF	o o					41. 00
43. 00 04300 NURSERY	o o					43. 00
44.00 04400 SKILLED NURSING FACILITY	Ö					44. 00
45.00 04500 NURSING FACILITY	0					45. 00
200.00 Total (lines 30 through 199)	0					200. 00
	•					-

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 7:11 am | THROUGH COSTS

						5/29/2019 7:1	1 am
			Title	xVIII	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 OPERATING ROOM		0	0	0	0	50.00
						0	
51. 00	05100 RECOVERY ROOM			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	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	C	0	0	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON) 0	1 0	0	0	59. 00
60.00	06000 LABORATORY				0	o o	60.00
60. 01	06001 BLOOD LABORATORY				0	o o	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		,	١	U	l o	61. 00
	1 1				0	_	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0	0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY) 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	C	0	0	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	C	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY		0	0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY		0	l 0	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	Ö	73. 00
74. 00	07400 RENAL DIALYSIS				0	0	74.00
					0		
75. 00	07500 ASC (NON-DISTINCT PART)		1	-		0	75. 00
76. 00	03140 CARDI OLOGY		0	0	0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS	_	_	_	_	_	
88. 00	08800 RURAL HEALTH CLINIC		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	C	0	0	0	0	90. 01
91.00	09100 EMERGENCY	C	0	0	0	133, 985	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART))	l 0		0	92.00
	OTHER REIMBURSABLE COST CENTERS	•	•			<u>'</u>	
94.00	09400 HOME PROGRAM DIALYSIS		0	0	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES			Ĭ	J	Ĭ	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED				0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-RENTED					0	97.00
	1					1	
98.00	09850 OTHER REIMBURSABLE COST CENTERS				0	122 005	98. 00
200.00	Total (lines 50 through 199)		0	0	0	133, 985	J200. 00

| Peri od: | Worksheet D | From 01/01/2018 | Part IV | To | 12/31/2018 | Date/Time | Prepared: | THROUGH COSTS

				'	0 12/31/2010	5/29/2019 7:1	
			Ti tl e	e XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4.00	5.00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	() C	77, 811, 545	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	C	0	0	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C	0	0	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	C	0	0	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C	0	56, 335, 184	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C	0	0	0.000000	55.00
56.00	05600 RADI OI SOTOPE	0	C	0	0	0.000000	56.00
57.00	05700 CT SCAN	0	C	0	58, 302, 216	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C) c	8, 788, 282	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	l c) c	31, 946, 950	0.000000	59. 00
60.00	06000 LABORATORY	0	l c	0	64, 879, 885	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	C) 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	ľ		0	0. 000000	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	Ċ		0	0. 000000	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0			1, 274, 615		64. 00
65. 00	06500 RESPIRATORY THERAPY	0	Ċ			0. 000000	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	Č		5, 163, 352	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	Ċ			0. 000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	Č	1	945, 856	0. 000000	
69. 00	06900 ELECTROCARDI OLOGY	0	Č		0	0. 000000	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	Č		0	0. 000000	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	Č		116, 829, 931	0. 000000	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0				0. 000000	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0				0. 000000	
74. 00	07400 RENAL DIALYSIS	0				0. 000000	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0		1	_	0. 000000	75. 00
76. 00	03140 CARDI OLOGY	0		1		0. 000000	76. 00
70.00	OUTPATIENT SERVICE COST CENTERS			,	20, 221, 703	0.000000	70.00
88. 00	08800 RURAL HEALTH CLINIC	0	C) C	0	0. 000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0. 000000	89. 00
90.00	09000 CLINIC	0		1	3, 520, 459		90. 00
90. 01	04950 SLEEP CLINIC	0		1	2, 789, 778	0. 000000	90. 01
91. 00	09100 EMERGENCY	0	133, 985	ή			91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	133, 703			0.000000	92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	0		<u>'</u>	17,000,047	0.000000	72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	C		0	0.000000	94. 00
95. 00	09500 AMBULANCE SERVICES			1		0.000000	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	,		_	0. 000000	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-RENTED				0	0.000000	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS				0	0.000000	
200.00			133, 985	133, 985	734, 271, 339		200. 00
200.00	Trotal (Titles 50 till bugli 177)	ı V	133, 900	y 133, 900	134, 211, 339	l l	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	Provi der CCN: 15-0018	Peri od:	Worksheet D

From 01/01/2018 | Part IV To 12/31/2018 | Date/Time Prepared: THROUGH COSTS 5/29/2019 7:11 am Title XVIII Hospi tal PPS Outpati ent I npati ent Outpati ent Cost Center Description Inpatient Outpati ent Ratio of Cost Program Program Program Program to Charges Pass-Through Pass-Through Charges Charges Costs (col. $(col. 6 \div col$ Costs (col. x col. 12) 13.00 7) x col. 10) 11. 00 9.00 10.00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 12, 846, 845 21, 077, 412 50.00 0 05100 RECOVERY ROOM 51.00 0.000000 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 0 52.00 52.00 0 05300 ANESTHESI OLOGY 0.000000 0 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0.000000 54.00 4, 284, 678 12, 639, 787 54.00 0 05500 RADI OLOGY-THERAPEUTI C 55.00 0.000000 0 0 55.00 56.00 05600 RADI OI SOTOPE 0.000000 56.00 57.00 05700 CT SCAN 0.000000 0 9, 750, 071 57.00 6, 145, 843 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 1, 591, 486 0 58.00 0.000000 872, 021 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 3, 726, 057 10, 645, 516 0 59.00 06000 LABORATORY 60.00 0.000000 13, 782, 189 0 4, 836, 802 0 60.00 06001 BLOOD LABORATORY 0.000000 60 01 60 01 |06100| PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0.000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63 00 0 63 00 64.00 06400 I NTRAVENOUS THERAPY 0.000000 195, 212 153, 497 0 64.00 65.00 06500 RESPIRATORY THERAPY 0.000000 7, 147, 112 578, 633 0 65.00 06600 PHYSI CAL THERAPY 66.00 0.000000 1,055,507 87, 329 0 66.00 06700 OCCUPATIONAL THERAPY 0.000000 0 59, 944 67 00 764, 085 Ω 67 00 06800 SPEECH PATHOLOGY 68.00 0.000000 151, 370 9,097 0 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 27, 208, 140 0 0.000000 2, 690, 228 71 00 71 00 0 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0.000000 17, 767, 812 0 11, 316, 043 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0.000000 22, 418, 227 0 15, 369, 716 0 73.00 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 74.00 0 0 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 75.00 0 03140 CARDI OLOGY 76.00 0.000000 2, 345, 276 7, 332, 744 0 76.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0.000000 0 88. 00 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89 00 89 00 0 0 90.00 09000 CLI NI C 0.000000 886, 749 524, 895 90.00 0 04950 SLEEP CLINIC 90. 01 0.000000 0 O 90.01 09100 EMERGENCY 6, 327, 461 91.00 0.003275 3, 534, 221 11, 575 20, 722 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 4, 332, 561 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 94.00 09500 AMBULANCE SERVICES 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 97 00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 0 97.00 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 98.00 0 0

125, 131, 344

11, 575

109, 323, 222

20, 722 200. 00

200.00

Total (lines 50 through 199)

Heal th	Financial Systems	ELKHARI GENER	RAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0018	Peri od: From 01/01/2018 To 12/31/2018		pared:
						5/29/2019 7:1	1 am
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Servi ces (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00	05000 OPERATING ROOM	0. 365070	21, 077, 412		0 0	7, 694, 731	50.00
51. 00	05100 RECOVERY ROOM	0. 000000		1	0 0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000			0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 250776			0 0	3, 169, 755	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			0 0	0	55. 00
56.00	05600 RADI 0I SOTOPE	0. 000000			0 0	0	56.00
57. 00	05700 CT SCAN	0. 046634			0 0	454, 685	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 170615	1, 591, 486		0 0	271, 531	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 122950	10, 645, 516		0 0	1, 308, 866	59. 00
60.00	06000 LABORATORY	0. 210753	4, 836, 802		0 0	1, 019, 371	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0 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. 000000	0		0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	1. 592958	153, 497		0 0	244, 514	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 249458	578, 633		0 0	144, 345	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 650063	87, 329		0 0	56, 769	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 424379		l .	0	25, 439	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 532490			0	4, 844	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. 188043			0 0	505, 879	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 205798		1	0 0	2, 328, 819	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 209405			0 98, 346	3, 218, 495	73. 00
74. 00	07400 RENAL DIALYSIS	0. 000000			0 0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000			0 0	0	75. 00
76. 00	03140 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS	0. 192319	7, 332, 744		0 0	1, 410, 226	76. 00
88. 00	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90. 00	09000 CLINIC	0. 417899			0 0	219, 353	
90. 01	04950 SLEEP CLINIC	0. 278635			0 0	217, 333	90. 01
91. 00	09100 EMERGENCY	0. 459899			0 0	2, 909, 993	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 574098			0 0	2, 487, 315	92.00
, 00	OTHER REIMBURSABLE COST CENTERS	2. 07 1070	., 002, 001		-, 0	2, 107, 010	1 00
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000			0		94. 00
95.00	09500 AMBULANCE SERVICES	0. 000000			0		95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			0 0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			0 0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	98. 00
200.00			109, 323, 222		0 98, 346	27, 474, 930	
201.00					0 0		201. 00
	Only Charges	I	I	1			ı

109, 323, 222

27, 474, 930 202. 00

202.00

Subtotal (see instructions)
Less PBP Clinic Lab. Services-Program
Only Charges
Net Charges (line 200 - line 201)

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2018	Part V
To 12/31/2018	Date/Time Prepared:
5/29/2019 7:11 am	Provider CCN: 15-0018

				10 12/01/2010	5/29/2019 7:1	1 am
		Title X	(VIII	Hospi tal	PPS	
	Costs		'	· · · · · · · · · · · · · · · · · · ·		
Cost Center Description	Cost	Cost				
real control of the c		Rei mbursed				
		ervi ces Not				
		Subject To				
		ed. & Coins.				
		(see inst.)				
	6.00	7.00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM		0				51.00
		-1				
52. 00 05200 DELI VERY ROOM & LABOR ROOM	_	0				52. 00
53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54. 00
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 MAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	o				59.00
60. 00 06000 LABORATORY	o	ol				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		o				62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0				63.00
64. 00 06400 I NTRAVENOUS THERAPY		0				64.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
	0	0				1
66. 00 06600 PHYSI CAL THERAPY		۳				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
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	20, 594				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 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	-	-1				1
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				96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0				97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98.00
200.00 Subtotal (see instructions)	0	20, 594				200.00
201.00 Less PBP Clinic Lab. Services-Program	0	20, 374				200.00
Only Charges	١					201.00
	o	20 504				202 00
202.00 Net Charges (line 200 - line 201)	ا	20, 594				202. 00

APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider Company		Period: From 01/01/2018		norod.
		Component	CCN: 15-S018	To 12/31/2018	Date/Time Pre 5/29/2019 7:1	pared: 1 am
		Title	XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	Inpati ent	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col.	Charges	column 4)	
	Part II, col.	8)	2)			
	26) 1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	2, 367, 367	77, 811, 545	0. 03042	4 42, 746	1, 301	50.00
51. 00 05100 RECOVERY ROOM	2, 307, 307	0	1		0	1
52.00 05200 DELIVERY ROOM & LABOR ROOM						1
53. 00 05300 ANESTHESI OLOGY	0	0	0. 000000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 551, 144	56, 335, 184			319	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	1		0	55.00
56. 00 05600 RADI 0I SOTOPE	0	0	0. 00000	0 0	0	56.00
57. 00 05700 CT SCAN	283, 453	58, 302, 216	0. 00486	2 30, 087	146	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	144, 612	8, 788, 282	0. 01645	5 3, 443	57	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	170, 444	31, 946, 950	0. 00533	5 0	0	59.00
50. 00 06000 LABORATORY	236, 628	64, 879, 885			426	60.00
50. 01 06001 BLOOD LABORATORY	0	0	0. 000000	0 0	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			0	
53.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	
54. 00 06400 NTRAVENOUS THERAPY	83, 434				0	
55. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	84, 513 202, 294				161 308	1
57. 00 06700 OCCUPATI ONAL THERAPY	95, 269				149	
58. 00 06800 SPEECH PATHOLOGY	57, 011				29	
69. 00 06900 ELECTROCARDI OLOGY	37,011				0	1
70. 00 07000 ELECTROENCEPHALOGRAPHY	Ö	1			Ö	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	363, 225	1	0. 00310		8	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	262, 765				0	
73.00 07300 DRUGS CHARGED TO PATIENTS	246, 928	119, 816, 830	0. 00206 ⁻	1 279, 271	576	73.00
74. 00 07400 RENAL DIALYSIS	0	0	0. 000000	0 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	390, 146	26, 221, 985	0. 01487	9 8, 822	131	76. 00
OUTPATIENT SERVICE COST CENTERS		1				
38.00 08800 RURAL HEALTH CLINIC	0					
39. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-			0	
90. 00 09000 CLINI C	211, 559				286	
PO. 01 04950 SLEEP CLINIC P1. 00 09100 EMERGENCY	1, 733 725, 160				0 707	
22.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	725, 160				, , , , , , , , , , , , , , , , , , ,	1
OTHER REIMBURSABLE COST CENTERS		17,000,049	0.00000	0, 190	<u> </u>	72.00
94. 00 09400 HOME PROGRAM DIALYSIS	T 0	0	0. 00000	0 (0	94.00
95. 00 09500 AMBULANCE SERVICES		I	3. 55000			95.00
P6. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0 0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		Ö	0. 000000		Ö	1
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 000000	0 0	0	98.00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0018	Peri od: From 01/01/2018	
		Component CCN: 15-S018	10 12/31/2018	Date/Time Prepared: 5/29/2019 7:11 am
		Title XVIII	Subprovi der -	PPS

			Titl∈	e XVIII	Subprovi der -	PPS	
	Cost Center Description	Non Physician Anesthetist	Nursing School Post-Stepdown		Allied Health Post-Stepdown	Allied Health	
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	0) (0	0	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	0	0		0	0	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	o o		o	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0		o o	0	56. 00
57.00	05700 CT SCAN	0	0		o o	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			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
60. 01	06001 BLOOD LABORATORY	0				0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			1)		61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.						63. 00
64. 00	06400 I NTRAVENOUS THERAPY						64.00
						0	
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	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0)	0	0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	0) (0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0) (0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0) (0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0) (0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0) (0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
76.00	03140 CARDI OLOGY	0	0		0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0) (0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		o	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	133, 985	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				0	1
,2.00	OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
94. 00	09400 HOME PROGRAM DI ALYSI S	1 0	0		0	0	94. 00
95. 00	09500 AMBULANCE SERVICES			1	1		95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED					0	1
97. 00				(0	1
	09700 DURABLE MEDICAL EQUIP-SOLD			(_	1 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS			(d o	122 005	98. 00
200.00	Total (lines 50 through 199)	0) C	η (0	133, 985	J200. 00

ealth Financial Systems PPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	ELKHART GENER SERVICE OTHER PAS		CN: 15-0018	Peri od:	eu of Form CMS-: Worksheet D	2552-10
HROUGH COSTS		Component	CCN: 15-S018	From 01/01/2018 To 12/31/2018	Part IV	pared:
		Ti tl e	e XVIII	Subprovi der - I PF	PPS	-
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	9	
	Education Cost		Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3, and 4)	8)	7)	
	4.00	5.00	6.00	7. 00	8. 00	
ANCILLARY SERVICE COST CENTERS						
0.00 05000 OPERATING ROOM	0			0 77, 811, 545		
1.00 05100 RECOVERY ROOM	0			0	0. 000000	51.00
2.00 05200 DELIVERY ROOM & LABOR ROOM	0	_	•	0		
3. 00 05300 ANESTHESI OLOGY	0	_	1	0	0. 000000	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	_	1	0 56, 335, 184		
5. 00 05500 RADI OLOGY-THERAPEUTI C	0	_		0	0. 000000	
6. 00 05600 RADI 0I SOTOPE	0	_	1	0	0. 000000	
7. 00 05700 CT SCAN	0		1	0 58, 302, 216		
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	_	1	0 8, 788, 282		
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	_	1	0 31, 946, 950		1
0. 00 06000 LABORATORY	0	1	1	0 64, 879, 885		
0. 01 06001 BLOOD LABORATORY	0	O)	0 0	0. 000000	
1. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0 000000	61.00
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	5 0			0 0		
3. 00 06300 BLOOD STORING, PROCESSING & TRANS.		ļ		0 1 274 (15	0.000000	
4. 00 06400 I NTRAVENOUS THERAPY				0 1, 274, 615 0 20, 025, 364		
5. 00 06500 RESPI RATORY THERAPY 6. 00 06600 PHYSI CAL THERAPY		_		0 20, 025, 364 0 5, 163, 352	0. 000000 0. 000000	
7. 00 06000 PHYSI CAL THERAPY 7. 00 06700 OCCUPATI ONAL THERAPY				0 2, 975, 197	0.00000	1
8. 00 06800 SPEECH PATHOLOGY				0 2, 975, 197		
9. 00 06900 SPEECH PATHOLOGY		ļ	1	0 945, 650	0.00000	
0. 00 07000 ELECTROENCEPHALOGRAPHY			1	0 0	0.000000	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-		1	0 116, 829, 931	0.000000	
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	,	ļ	1	0 76, 120, 806		
3. 00 07300 DRUGS CHARGED TO PATIENTS		ļ	1	0 119, 816, 830		
4. 00 07400 RENAL DIALYSIS		_		0 0	0. 000000	
5. 00 07500 ASC (NON-DISTINCT PART)		i o		0 0	0. 000000	
6. 00 03140 CARDI OLOGY	0			0 26, 221, 985		
OUTPATIENT SERVICE COST CENTERS	<u> </u>				•	
8. 00 08800 RURAL HEALTH CLINIC	0	O)	0 0	0.000000	88. 00
9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	89.00
0. 00 09000 CLI NI C	0	0		0 3, 520, 459	0.000000	90.00
0. 01 04950 SLEEP CLINIC	0	0	1	0 2, 789, 778	0.000000	90. 01
1. 00 09100 EMERGENCY	0		133, 98			
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 19, 608, 849	0. 000000	92.00
OTHER REIMBURSABLE COST CENTERS		1	J			
4. 00 09400 HOME PROGRAM DIALYSIS	0	O	ין	0 0	0. 000000	
5. 00 09500 AMBULANCE SERVI CES					0.000000	95.00
6. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	_	1	0 0	0.000000	
7. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		1	0 0	0.000000	1
8. 00 09850 OTHER REIMBURSABLE COST CENTERS	0		1	0 0	0.000000	
00.00 Total (lines 50 through 199)	0	133, 985	133, 98	85 734, 271, 339	I	200. 0

Hool +b	Financial Systems	ELKHART GENERAI	ПОСВІТАІ		In Lia	u of Form CMS	2552 10
APP0R1	Financial Systems TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS		Provi der C	CN: 15-0018 CCN: 15-S018	Peri od: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
			Title	· XVIII	Subprovi der -	5/29/2019 7:1 PPS	1 am
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	I PF Outpati ent	Outpati ent	
	oost center bescription	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col . 6 ÷ col .	onal goo	Costs (col.		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	42, 746		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	11, 589		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	30, 087		0 0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	3, 443		0 0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	
60.00	06000 LABORATORY	0. 000000	116, 674		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	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	0		0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	1
65.00	06500 RESPI RATORY THERAPY	0. 000000	38, 248		0 0	0	1
66. 00	06600 PHYSI CAL THERAPY	0. 000000	7, 861		0 0	0	1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	4, 641		0	0	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	482	•	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	2, 472		0 0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	279, 271		0 0	0	1
74. 00	07400 RENAL DI ALYSI S	0. 000000	0		0 0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	
76. 00	03140 CARDI OLOGY	0. 000000	8, 822		0 0	0	76. 00
00 00	OUTPATIENT SERVICE COST CENTERS	0.000000		ı	0		00.00
88. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000 0. 000000	0	•	0 0	l	1
89. 00 90. 00	09000 CLINIC	1	-		0 0	0	89. 00 90. 00
90.00	04950 SLEEP CLINIC	0. 000000 0. 000000	4, 757		0 0		
90.01	09100 EMERGENCY	0. 003275	39, 873	1.	31 0	0	
91.00	1 1	1	39, 873 8, 190		0 0		1
92.00	O9200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 000000	8, 190		U U	0	92.00
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0 0	0	94. 00
95.00	09500 AMBULANCE SERVICES	0.000000	U			l	95.00
95. 00 96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	
96.00	09700 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	1	0 0	0	
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0		
200.00	1 1	0.000000	599, 156		31 0	•	200.00
200.00	1.5ta. (1.1.55 55 till odgir 177)	1	3,7,100	''	1		,_00.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	<u>2552-10</u>
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0018	Peri od:	Worksheet D	
		Component	CCN: 15-T018	From 01/01/2018 To 12/31/2018	Part II Date/Time Pre	narod:
		Component	CCN. 15-1016	10 12/31/2010	5/29/2019 7:1	1 am
		Title	: XVIII	Subprovider - IRF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26) 1. 00	2.00	2.00	4. 00	F 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3. 00	4.00	5. 00	
50. 00 05000 OPERATING ROOM	2, 367, 367	77, 811, 545	0. 03042	24 9, 709	295	50.00
51. 00 05100 RECOVERY ROOM	2, 307, 307	l			0	1
52. 00 05200 DELIVERY ROOM & LABOR ROOM		1			0	
53. 00 05300 ANESTHESI OLOGY	0		0. 00000		Ö	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 551, 144	56, 335, 184			679	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1,001,111	00,000,101	1		0	
56. 00 05600 RADI 0I SOTOPE	0	·			Ö	1
57. 00 05700 CT SCAN	283, 453	58, 302, 216			100	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	144, 612				31	
59. 00 05900 CARDI AC CATHETERI ZATI ON	170, 444				0	
60. 00 06000 LABORATORY	236, 628				354	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000		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	0.00000	00	0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000		0	
64. 00 06400 I NTRAVENOUS THERAPY	83, 434				0	
65. 00 06500 RESPIRATORY THERAPY	84, 513				556	
66. 00 06600 PHYSI CAL THERAPY	202, 294				9, 538	
67. 00 06700 OCCUPATI ONAL THERAPY	95, 269				6, 852	
68. 00 06800 SPEECH PATHOLOGY	57, 011	l			4, 659	
69. 00 06900 ELECTROCARDI OLOGY	0				0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	1			0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	363, 225		0.00310		96	1
72.00 O7200 IMPL. DEV. CHARGED TO PATIENTS 73.00 O7300 DRUGS CHARGED TO PATIENTS	262, 765 246, 928				55 581	1
74. 00 07400 RENAL DI ALYSI S	240, 920				0	1
75. 00 07500 ASC (NON-DISTINCT PART)	0		0.00000		0	1
76. 00 03140 CARDI OLOGY	390, 146	26, 221, 985			26	1
OUTPATIENT SERVICE COST CENTERS	370, 140	20, 221, 703	0.01407	1,730	20	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		l .		Ö	
90. 00 09000 CLI NI C	211, 559				1, 841	
90. 01 04950 SLEEP CLINIC	1, 733				0	1
91. 00 09100 EMERGENCY	725, 160				0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	19, 608, 849	0.00000	00	0	92.00
OTHER REIMBURSABLE COST CENTERS	•					1
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	00	0	94. 00
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	0	0.00000		0	
			0 00000	\alpha		
98.00 09850 OTHER REIMBURSABLE COST CENTERS 200.00 Total (lines 50 through 199)	7, 477, 685	0 734, 271, 339	0. 00000	00 0 1, 181, 284	0 25, 663	

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT A	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 15-0018	Peri od: From 01/01/2018	
		Component CCN: 15-T018	10 12/31/2018	Date/Time Prepared: 5/29/2019 7:11 am
		Title XVIII	Subprovi der -	PPS

				Title	e XVIII	Subprovi der -	PPS	
	Cost Center Description	Non Physician	Nurs	sing School	Nursing School	IRF Allied Health	Allied Health	
	cost center bescription	Anesthetist		st-Stepdown	Indi Si ng School	Post-Stepdown	Airreu nearth	
		Cost		diustments		Adjustments		
		1.00	Au	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	1	2,1	2.00	0/1	0.00	
50.00	05000 OPERATI NG ROOM	0)	0	(0	0	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	0		0		0	0	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
57. 00	05700 CT SCAN	0		0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0		0		0	0	59. 00
60.00	06000 LABORATORY	0		0		0	0	60.00
60. 01	06001 BLOOD 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	0		0		0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0		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			0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY			0			0	67. 00
68. 00	06800 SPEECH PATHOLOGY			0			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY			0			Ö	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0		0	•		0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		0			0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0		0			0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0		0			0	73. 00
	07400 RENAL DI ALYSI S	0		0			0	74. 00
	07500 ASC (NON-DISTINCT PART)	0		0			0	75. 00
76. 00	03140 CARDI OLOGY	0	1	0		0	1	76. 00
	OUTPATIENT SERVICE COST CENTERS	-	1			-		
88. 00	08800 RURAL HEALTH CLINIC	0		0		0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0		0	0	89. 00
	09000 CLI NI C	0		0		0	0	90.00
90. 01	04950 SLEEP CLINIC	0		0		0	0	90. 01
91. 00	09100 EMERGENCY	0		0		0	133, 985	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		0		0	0	94.00
95. 00	09500 AMBULANCE SERVICES							95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0		0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0		0		ol o	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0		0		o o	Ō	98. 00
200.00		0		0		o o	133, 985	
		1			•	1		

	Financial Systems ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ELKHART GENER RVICE OTHER PAS		CN: 15-0018	Peri od:	eu of Form CMS-: Worksheet D	2332-10
THROUGH	COSTS		Component	CCN: 15-T018	From 01/01/2018 To 12/31/2018	Part IV	epared:
			Title	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent		9	
		Education Cost		Cost (sum o		(col. 5 ÷ col.	
			4)	cols. 2, 3, and 4)	8)	7)	
		4.00	5.00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0		1	0 77, 811, 545		•
	05100 RECOVERY ROOM	0			0	0. 000000	51.00
	D5200 DELIVERY ROOM & LABOR ROOM	0	0)	0		
	D5300 ANESTHESI OLOGY	0	0)	0	0. 000000	
	D5400 RADI OLOGY-DI AGNOSTI C	0	0		0 56, 335, 184		
- 1	D5500 RADI OLOGY-THERAPEUTI C	0	0	1	0	0. 000000	
1	D5600 RADI OI SOTOPE	0	0		0	0. 000000	1
	D5700 CT SCAN	0	0		0 58, 302, 216		
	D5800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 8, 788, 282		
1	D5900 CARDI AC CATHETERI ZATI ON	0	0		0 31, 946, 950		•
	06000 LABORATORY	0	0		0 64, 879, 885		
	06001 BLOOD LABORATORY	0	0	1	0	0. 000000	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0 000000	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		1	0		
	06300 BLOOD STORING, PROCESSING & TRANS.		0	1	0 0 1 274 (15	0.000000	
	06400 I NTRAVENOUS THERAPY			1	0 1, 274, 615 0 20, 025, 364		
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY			1	0 20, 025, 364 0 5, 163, 352	0. 000000 0. 000000	
	06700 OCCUPATIONAL THERAPY			1	0 2, 975, 197	0.00000	•
	06800 SPEECH PATHOLOGY			1	0 2, 975, 197		
	06900 ELECTROCARDI OLOGY			1	0 945, 850	0.00000	
	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY				0 0	0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0 116, 829, 931	0.000000	
	07200 IMPL. DEV. CHARGED TO PATIENTS			1	0 76, 120, 806		
	07300 DRUGS CHARGED TO PATIENTS		1		0 119, 816, 830		
	07400 RENAL DIALYSIS		0		0 117, 515, 555	0. 000000	
	07500 ASC (NON-DISTINCT PART)	0	0	,	0	0. 000000	
	03140 CARDI OLOGY	0		,	0 26, 221, 985		
	OUTPATIENT SERVICE COST CENTERS	<u>'</u>	<u> </u>			•	
	08800 RURAL HEALTH CLINIC	0	0	1	0 0	0.000000	88. 00
39. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0)	0	0.000000	89.00
	09000 CLI NI C	0	0)	0 3, 520, 459		90.00
	04950 SLEEP CLINIC	0	-	1	0 2, 789, 778		
	09100 EMERGENCY	0		1			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 19, 608, 849	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS					0.0000	1
	09400 HOME PROGRAM DIALYSIS	0	0	1	0	0. 000000	
	09500 AMBULANCE SERVI CES			l		0.00000	95.00
	D9600 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0.000000	
	D9700 DURABLE MEDICAL EQUIP-SOLD	0		1	0	0.000000	1
98. 00 0 200. 00	09850 OTHER REIMBURSABLE COST CENTERS	0		1	0 0	0.000000	98. 00 200. 00
200. UUI	Total (lines 50 through 199)	1	I ISS, 983	լ 155, 90	85 734, 271, 339	I	1200. U

llool +b	Financial Cystoms	ELVUADT CENEDA	I HOSDI TAI		le li o	u of Form CMC	2552 10
APP0R1	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	ELKHART GENERAL RVICE OTHER PASS	Provi der Co	CN: 15-0018	Period: From 01/01/2018 To 12/31/2018		
			· ·	XVIII	Subprovi der -	5/29/2019 7: 1 PPS	
					IRF		
	Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program Pass-Through	Program	Program Pass-Through	
		to Charges (col. 6 ÷ col.	Charges	Costs (col.		Costs (col. 9	
		7)		x col. 10)		x col . 12)	
		9.00	10. 00	11.00	12. 00	13.00	
	ANCILLARY SERVICE COST CENTERS	7,00	10.00	11100	12.00	10.00	
50.00	05000 OPERATI NG ROOM	0. 000000	9, 709		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		1
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	24, 677		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	20, 466		0 0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1, 913		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60.00	06000 LABORATORY	0. 000000	97, 076		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	0		0 0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	131, 726		0	0	1
66. 00	06600 PHYSI CAL THERAPY	0. 000000	243, 444		0	0	1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	213, 988		0 0	0	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	77, 294		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	30, 826		0 0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	15, 988		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	281, 805		0 0	0	1
74.00	07400 RENAL DIALYSIS	0. 000000	0		0 0	0	
75. 00 76. 00	07500 ASC (NON-DISTINCT PART)	0.000000	1 720		0 0	0	
76.00	03140 CARDI OLOGY OUTPATI ENT SERVI CE COST CENTERS	0. 000000	1, 730		0 0	0	76. 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	30, 642		0 0	0	
90. 00	04950 SLEEP CLINIC	0. 000000	0 30, 042		0 0	0	
91. 00	09100 EMERGENCY	0. 003275	0		0 0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	0		0 0	0	1
72.00	OTHER REIMBURSABLE COST CENTERS	0. 000000			0 0		72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0 0	0	94. 00
95. 00	09500 AMBULANCE SERVICES	0.000000	0			Ĭ	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	o o	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	Ō	
200.00	1 1		1, 181, 284		0 0	•	200.00
	· · · · · · · · · · · · · · · · · · ·	. '		•	•		

Health Financial Systems APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	ELKHART GENER COSTS	Provi der C		In Lie Period: From 01/01/2018 To 12/31/2018		pared:
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B, Part II, col. 26)	Swing Bed Adjustment	Reduced Capital Related Cost (col. 1 - col 2)	Days	Per Diem (col. 3 / col. 4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT 31.01 NEONATAL INTENSIVE CARE 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199) Cost Center Description	5, 625, 010 520, 546 99, 112 0 0 468, 765 396, 220 598, 726 0 7, 708, 379 I npati ent Program days	Inpatient Program Capital Cost (col. 5 x col. 6)	520, 54 99, 11 468, 76 396, 22 598, 72	6 4, 928 744 0 0 0 0 0 0 5 3, 040 0 1, 514 6 2, 256 0 0 0	133. 22 0. 00 0. 00 0. 00 154. 20 261. 70 265. 39 0. 00 0. 00	31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00
INDATIENT DOUTING CEDAL OF COCT CENTERS	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 ADULTS & PEDIATRICS INTENSIVE CARE UNIT 31.01 NEONATAL INTENSIVE CARE 32.00 CORONARY CARE UNIT 33.00 BURN INTENSIVE CARE UNIT 34.00 SURGICAL INTENSIVE CARE UNIT 40.00 SUBPROVIDER - IPF 41.00 SUBPROVIDER - IRF 43.00 NURSERY 44.00 SKILLED NURSING FACILITY NURSING FACILITY 200.00 Total (lines 30 through 199)	734 0 0 0 0 0 105 89 115 0 0	0 0 0 0 0 16, 191 23, 291 30, 520 0				30. 00 31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 200. 00

Health Financial Systems	ELKHART GENER				eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0018	Peri od: From 01/01/2018 To 12/31/2018		pared: 1 am
		Ti tI	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
ANOULL ABY CERVI OF COCT OFNITERS	1.00	2. 00	3. 00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM	2 247 247	77 011 E/E	0. 03042	9, 318, 693	283, 512	50.00
51. 00 05100 RECOVERY ROOM	2, 367, 367	77, 811, 545	0.00000		203, 312	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM			0.00000			52.00
53. 00 05300 ANESTHESI OLOGY			0.00000		0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1, 551, 144	56, 335, 184	1		51, 749	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 551, 144	30, 333, 104	0.00000		31, 747	55. 00
56. 00 05600 RADI 01 SOTOPE			0.00000		0	56.00
57. 00 05700 CT SCAN	283, 453	58, 302, 216	1		10, 757	57.00
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	144, 612					
59. 00 05900 CARDI AC CATHETERI ZATI ON	170, 444		1		1	1
60. 00 06000 LABORATORY	236, 628					
60. 01 06001 BLOOD LABORATORY	200,020	0.707.77000	0.00000		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.0000	3		61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	0	0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.			0.00000		o o	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	83, 434	1, 274, 615			19, 847	
65. 00 06500 RESPIRATORY THERAPY	84, 513				10, 354	
66. 00 06600 PHYSI CAL THERAPY	202, 294				6, 935	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	95, 269					
68. 00 06800 SPEECH PATHOLOGY	57, 011	945, 856	0. 06027	75 45, 136	2, 721	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000	0 0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	363, 225	116, 829, 931	0.00310	9 21, 896	68	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	262, 765	76, 120, 806	0.00345	52 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	246, 928	119, 816, 830	0. 00206	9, 100, 538	18, 756	73. 00
74.00 07400 RENAL DIALYSIS	0	0	0.00000		0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000		0	75. 00
76. 00 03140 CARDI OLOGY	390, 146	26, 221, 985	0. 01487	9 615, 905	9, 164	76. 00
OUTPATIENT SERVICE COST CENTERS		1			Г	
88.00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89. 00
90. 00 09000 CLI NI C	211, 559				18, 289	
90. 01 04950 SLEEP CLINIC	1, 733				0	90. 01
91. 00 09100 EMERGENCY	725, 160		1		31, 219	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	1, 072, 211	19, 608, 849	0. 05468	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			0 00000	00	0	04.00
94.00 09400 HOME PROGRAM DIALYSIS 95.00 09500 AMBULANCE SERVICES	0	1	0.00000	0	0	94. 00 95. 00
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED			0.00000	00	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED			0.00000		0	96.00
98. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 98. 00 09850 OTHER REI MBURSABLE COST CENTERS			0.00000		0	98.00
200.00 Total (lines 50 through 199)	8, 549, 896	734, 271, 339		35, 326, 894	-	
200.00 10tal (111103 00 till ough 177)	0, 547, 670	104, 211, 337	I	33, 320, 074	300,040	1200.00

Health Financial Systems	ELKHART GENER	RAL HOSPITAL		In Li€	eu of Form CMS	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER F	PASS THROUGH COS	TS Provider C	F	Period: From 01/01/2018 Fo 12/31/2018	Worksheet D Part III	pared:
		Ti tl	e XIX	Hospi tal	PPS	_
Cost Center Description	Nursi na School	Nursing School		Allied Health	All Other	
, , , , , , , , , , , , , , , , , , ,	Post-Stepdown	3	Post-Stepdown		Medi cal	
	Adjustments		Adjustments	0001	Education Cost	
	1A	1.00	2A	2. 00	3. 00	
INDATI ENT DOUTINE CEDVICE COCT CENTEDO	IA.	1.00	_ ZA	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS	_	_	.1			
30. 00 03000 ADULTS & PEDIATRICS	0		1		1	
31.00 03100 INTENSIVE CARE UNIT	0	0) (0	0	31.00
31. 01 03101 NEONATAL INTENSIVE CARE	0	ol o			o l	31. 01
32. 00 03200 CORONARY CARE UNIT	0				ol o	32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	Ö		1		1	
			1	-		
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0		1	0	ή	
40. 00 04000 SUBPROVI DER - I PF	0	0)	0	0	40. 00
41. 00 04100 SUBPROVI DER - RF	0	0) (0	0	41.00
43. 00 04300 NURSERY	0	ol o) (ol o	43.00
44. 00 04400 SKILLED NURSING FACILITY						44. 00
	,					45. 00
45. 00 04500 NURSI NG FACI LI TY	0		ή	0	1	
200.00 Total (lines 30 through 199)	0) (0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	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	
			10 10	0.00	724	20.00
30. 00 03000 ADULTS & PEDI ATRI CS	0		1,		1	
31.00 03100 INTENSIVE CARE UNIT		0	1 .,		1	
31. 01 03101 NEONATAL INTENSIVE CARE		0	744	0.00	0	31. 01
32. 00 03200 CORONARY CARE UNIT		0		0.00	ol o	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT		1			1	33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	1			0.00	1	1
		~	1		1	1
40. 00 04000 SUBPROVI DER - I PF	0	_	7 0,010			
41. 00 04100 SUBPROVI DER - I RF	0	0	1, 514	0.00	89	41.00
43. 00 04300 NURSERY		0	2, 256	0.00	115	43.00
44.00 04400 SKILLED NURSING FACILITY		l o		0.00	ol o	44.00
45.00 04500 NURSING FACILITY	1				1	1
	1				l .	
			52, 883	3	1, 043	200. 00
Cost Center Description	I npati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0)				30.00
31. 00 03100 I NTENSI VE CARE UNI T		1				31.00
	_	1				
31. 01 03101 NEONATAL INTENSIVE CARE	0	1				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 - PF	0	1				40.00
		•				1
41. 00 04100 SUBPROVI DER - RF	0	1				41.00
43. 00 04300 NURSERY	0					43. 00
44.00 04400 SKILLED NURSING FACILITY	0)				44.00
45.00 04500 NURSING FACILITY	0					45. 00
200.00 Total (lines 30 through 199)	Ö					200.00
200.00 10tal (11103 30 till bugil 177)	1	T				1200.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: | 5/29/2019 7:11 am | Provider CCN: 15-0018 THROUGH COSTS

						5/29/2019 7: 1	1 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	oust content beschiptron	Anesthetist	Post-Stepdown	liai si ng seneoi	Post-Stepdown	74111 Ca Tical til	
		Cost	Adjustments	0.00	Adjustments	0.00	
	·	1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	C	0	(0	0	50.00
51.00	05100 RECOVERY ROOM		ol a		0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM				0	0	52.00
53. 00	05300 ANESTHESI OLOGY					0	53. 00
						_	
54. 00	05400 RADI OLOGY-DI AGNOSTI C			1	0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C) 0	() 0	0	55. 00
56. 00	05600 RADI 0I SOTOPE	C	0	(0	0	56. 00
57.00	05700 CT SCAN	C	0	(0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		ol a		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON				0	0	59.00
60.00	06000 LABORATORY				,	o o	60.00
	1				-		
60. 01	06001 BLOOD LABORATORY		'	1	٥	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C	0	(0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	C	0	(0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY		ol o		0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY				0	Ö	65. 00
66. 00	06600 PHYSI CAL THERAPY					0	66. 00
	1					"	
67. 00	06700 OCCUPATI ONAL THERAPY				0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY			1) 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	C	0	(0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	C	0	(0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0	(0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		ol o	(0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS					0	73. 00
74. 00	07400 RENAL DIALYSIS					l o	74.00
	l l				1		
75. 00	07500 ASC (NON-DISTINCT PART)			(0	75. 00
76. 00	03140 CARDI OLOGY		0	(0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	C	0	(0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C	0	(0	0	89. 00
90.00	09000 CLI NI C		ol o		0	0	90.00
90. 01	04950 SLEEP CLINIC				0	o	90. 01
91. 00	09100 EMERGENCY					133, 985	91.00
			,	1	,		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		1	()	0	92. 00
	OTHER REIMBURSABLE COST CENTERS		1	T			
94. 00	09400 HOME PROGRAM DIALYSIS	[C	0	(0	0	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0) (0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD				0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS			1	م ا	o o	98. 00
200.00							
200.00	Tiotai (Titles 50 tillough 199)	1	'I	l ,	η	133, 985	200.00

| Peri od: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: | Table 2016 | Tab THROUGH COSTS

					10 12/31/2018	5/29/2019 7:1	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)			
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	0		0 77, 811, 545		1
51. 00	05100 RECOVERY ROOM	0	0		0	0.00000	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0.00000	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0	0.000000	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 56, 335, 184	l .	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0.000000	55. 00
56. 00	05600 RADI 0I SOTOPE	0	0		0	0.000000	ł
57. 00	05700 CT SCAN	0	0		0 58, 302, 216		57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 8, 788, 282		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 31, 946, 950		59. 00
60.00	06000 LABORATORY	0	0		0 64, 879, 885		60. 00
60. 01	06001 BLOOD LABORATORY	0	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		0	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		0 1, 274, 615	0.000000	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0		0 20, 025, 364	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0		0 5, 163, 352	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 2, 975, 197	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0		945, 856	0.000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0.000000	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 116, 829, 931	0.000000	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 76, 120, 806	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 119, 816, 830	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0	0.000000	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0.000000	75. 00
76.00	03140 CARDI OLOGY	0	0		0 26, 221, 985	0.000000	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	0.000000	89. 00
90.00	09000 CLI NI C	0	0		0 3, 520, 459	0.000000	90. 00
90. 01	04950 SLEEP CLINIC	0	0		0 2, 789, 778	0.000000	90. 01
91.00	09100 EMERGENCY	0	133, 985	133, 98	5 40, 914, 255	0. 003275	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 19, 608, 849	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	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	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0.000000	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0.000000	•
200.00	Total (lines 50 through 199)	0	133, 985	133, 98	5 734, 271, 339		200. 00

| Peri od: | Worksheet D | From 01/01/2018 | Part IV | To 12/31/2018 | Date/Time Prepared: | Table 2016 | Tab
 Heal th Financial
 Systems
 ELKHART
 GENERAL

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

					10 12/31/2018	5/29/2019 7:1	
			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-Throug	h Charges	Pass-Through	
		(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	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0. 000000	9, 318, 693	1	0	٥,	
51. 00	05100 RECOVERY ROOM	0. 000000	0		0	-1	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	1	0	٥,	1
53. 00	05300 ANESTHESI OLOGY	0. 000000	0	1	0	٥,	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 879, 445	1	0	0	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	٥,	
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0	0 0	
57. 00	05700 CT SCAN	0. 000000	2, 212, 549	•	0	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	333, 520		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	1, 514, 055		0	0	
60. 00	06000 LABORATORY	0. 000000	5, 150, 596		0	٥,	
60. 01	06001 BLOOD LABORATORY	0. 000000	0		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	303, 207		0	0 0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	2, 453, 662		0	0 0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	177, 019		0	0 0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	134, 924		0	0 0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	45, 136		0	0 0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0	0 0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	l .	0	٥,	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	21, 896		0	0 (0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0 (0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	9, 100, 538		0	0 0	1
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	615, 905		0 (0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	•		0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0	-1	1
90. 00	09000 CLI NI C	0. 000000	304, 341		0	0 0	90. 00
90. 01	04950 SLEEP CLINIC	0. 000000	0		0	٥,	
91.00	09100 EMERGENCY	0. 003275	1, 761, 408	5, 7		- 1	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0	0	1
95. 00	09500 AMBULANCE SERVI CES						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	٥ ا	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0	0	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0	- 1	1
200.00	Total (lines 50 through 199)		35, 326, 894	5, 7	69	0 0	200. 00

Health Financial Systems	ELKHART GENER				u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	Provi der Co	Provider CCN: 15-0018		Peri od: Worksheet D		
		Component	CCN: 15-S018	From 01/01/2018 To 12/31/2018	Part II Date/Time Pre	pared:
		T; +1	e XIX	Subprovi der -	5/29/2019 7: 1 PPS	<u>1 am </u>
		1111	e vi v	I PF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	Part I, col.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26) 1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATI NG ROOM	2, 367, 367	77, 811, 545	0. 03042	12, 962	394	50.00
51. 00 05100 RECOVERY ROOM	0	l			0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 551, 144	56, 335, 184			561	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0			0	
56. 00 05600 RADI 0I SOTOPE	0	-			0	
57. 00 05700 CT SCAN	283, 453				101	1
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON	144, 612				143 0	
60. 00 06000 LABORATORY	170, 444 236, 628	1			1, 148	
60. 01 06001 BLOOD LABORATORY	230, 020	04, 679, 883	0.00000		1, 148	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		l	0.00000		O	61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	Ö	0.00000		0	1
64. 00 06400 I NTRAVENOUS THERAPY	83, 434	1, 274, 615	0. 06545	8 0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	84, 513	20, 025, 364	0. 00422	0 37, 978	160	65. 00
66. 00 06600 PHYSI CAL THERAPY	202, 294				175	
67. 00 06700 OCCUPATI ONAL THERAPY	95, 269				65	
68. 00 06800 SPEECH PATHOLOGY	57, 011	l			14	
69. 00 06900 ELECTROCARDI OLOGY	0				0	
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0				0 2	
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	363, 225 262, 765		0. 00310 0. 00345		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	246, 928				640	
74. 00 07400 RENAL DIALYSIS	240, 720				0	1
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0. 00000		0	1
76. 00 03140 CARDI OLOGY	390, 146	26, 221, 985			372	1
OUTPATIENT SERVICE COST CENTERS						1
88. 00 08800 RURAL HEALTH CLINIC	0				0	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	
90. 00 09000 CLINIC	211, 559				196	
90. 01 04950 SLEEP CLINIC	1, 733				0	
91. 00 09100 EMERGENCY	725, 160				2, 486	
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	19, 608, 849	0.00000	0	0	92.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES			3.00000		O	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	О	0. 00000	0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	1	0	0.00000		0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD			0.00000			
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	Ö	ő	0. 00000		0	

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	Peri od: From 01/01/2018 To 12/31/2018	Date/Time Prepared:
				5/29/2019 7:11 am
		Title XIX	Subprovi der -	PPS

			Titl	e XIX	Subprovi der -	PPS	
	Cost Center Description				Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
	ANCILLADY CEDVICE COST CENTERS	1. 00	2A	2.00	3A	3. 00	
50. 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	1		\		0	50.00
51. 00	05100 RECOVERY ROOM					· -	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM					0	52.00
53. 00	05300 ANESTHESI OLOGY					0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C					0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C					0	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
59. 00	05900 CARDI AC CATHETERI ZATI ON					0	59. 00
60. 00	06000 LABORATORY					0	60.00
60. 01	06001 BLOOD LABORATORY					l o	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		1	1	1	Ĭ	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.					0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY					l o	64.00
65. 00	06500 RESPI RATORY THERAPY					o o	65. 00
66. 00	06600 PHYSI CAL THERAPY					0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY					0	67. 00
68. 00	06800 SPEECH PATHOLOGY					0	68. 00
69. 00	06900 ELECTROCARDI OLOGY					0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	i c			0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS				0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS				0	0	73. 00
74.00	07400 RENAL DI ALYSI S	C			0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	C	ol c		o	0	75. 00
76.00	03140 CARDI OLOGY	C	ol c		o	0	76. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	C) C) (0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	C) c) (0	0	89. 00
90.00	09000 CLI NI C	C) c) (0	0	90.00
90. 01	04950 SLEEP CLINIC	C) c) (0	0	90. 01
91.00	09100 EMERGENCY	C) c) (0	133, 985	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	C				0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	C) C) (0	0	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	C) c) (0	0	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	C) C) (0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	C) C) (0	0	98. 00
200.00	Total (lines 50 through 199)	C) c) (0	133, 985	200. 00

Heal th	Financial Systems	ELKHART GENER	RAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE			CN: 15-0018	Peri od:	Worksheet D	
THROUG	GH COSTS		Component	CCN: 15-S018	From 01/01/2018 To 12/31/2018	Part IV Date/Time Pre 5/29/2019 7:1	pared:
			Ti tl	e XIX	Subprovi der -	PPS	ı alıı
					IPF		
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medical	(sum of cols.	Outpatient	(from Wkst. C, Part I, col.	to Charges	
		Education Cost	1, 2, 3, and 4)	Cost (sum of cols. 2, 3,	8)	(col. 5 ÷ col. 7)	
			4)	and 4)	8)	''	
		4.00	5. 00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	C	C		0 77, 811, 545	0.000000	50.00
51.00	05100 RECOVERY ROOM	C	1		0	0.000000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	C) C		0	0.000000	
53.00	05300 ANESTHESI OLOGY	C) C		0	0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	C) C		0 56, 335, 184		
55. 00	05500 RADI OLOGY-THERAPEUTI C	C) C		0	0. 000000	
56. 00	05600 RADI OI SOTOPE	C			0 0	0.000000	
57. 00	05700 CT SCAN	C		2	0 58, 302, 216		
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	C			0 8, 788, 282		
59.00	05900 CARDI AC CATHETERI ZATI ON	C	1		0 31, 946, 950		
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	C			0 64, 879, 885	0. 000000 0. 000000	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			1	9	0.000000	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C			0	0. 000000	
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.					0.000000	
64. 00	06400 I NTRAVENOUS THERAPY		1		0 1, 274, 615		
65. 00	06500 RESPIRATORY THERAPY		1		0 20, 025, 364		
66. 00	06600 PHYSI CAL THERAPY	C			0 5, 163, 352		
67.00	06700 OCCUPATI ONAL THERAPY	C	ol c		0 2, 975, 197	0.000000	
68.00	06800 SPEECH PATHOLOGY	C	o c		0 945, 856	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	C) c		0 0	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	C) C		0 0	0.000000	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C) C		0 116, 829, 931	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C) C		0 76, 120, 806		
73.00	07300 DRUGS CHARGED TO PATIENTS	C	1		0 119, 816, 830		
74. 00	07400 RENAL DIALYSIS	C	1		0	0.000000	
75. 00	07500 ASC (NON-DISTINCT PART)	C			0	0.000000	75. 00
76. 00	03140 CARDI OLOGY	C) <u> </u>)	0 26, 221, 985	0. 000000	76. 00
00.00	OUTPATIENT SERVICE COST CENTERS			J		0.00000	00.00
88. 00	08800 RURAL HEALTH CLINIC	C		(0 0	0.00000	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	C	1		0 0 3, 520, 459	0. 000000 0. 000000	
90.00	04950 SLEEP CLINIC		1	(0 3, 520, 459		
90.01	09100 EMERGENCY		1	7 5 133, 98			
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)			133, 90	0 19, 608, 849		
72.00	OTHER DELMBURGARIE COST CENTERS		1	1	0 17,000,047	0.00000	1 72.00

0

0

0

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133, 985

734, 271, 339

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133, 985

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0.000000

0.000000

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

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ELKHART GENERA	Provider C	^N: 15_0018	Peri od:	u of Form CMS-2 Worksheet D	2552-10
	H COSTS	AVIOL UTILK PASS		CCN: 15-0018	From 01/01/2018 To 12/31/2018	Part IV Date/Time Pre	pared:
			'			5/29/2019 7:1	1 am
			liti	e XIX	Subprovi der - I PF	PPS	
	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) 11.00	12.00	x col . 12)	
	ANCILLARY SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13. 00	
50. 00	05000 OPERATING ROOM	0. 000000	12, 962		0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 000000	12, 902		0 0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	
53. 00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	20, 378		0 0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	20, 370	1	0 0	0	
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	
57. 00	05700 CT SCAN	0. 000000	20, 825		o o	0	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	8, 668	1	o o	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0, 000		o o	0	
60.00	06000 LABORATORY	0. 000000	314, 788		o o	0	
60. 01	06001 BLOOD LABORATORY	0. 000000	0.1,700	1	o o	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	
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65.00	06500 RESPIRATORY THERAPY	0. 000000	37, 978		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	4, 470		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	2, 033		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	237		0 0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	602		0 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	310, 660		0	0	
74. 00	07400 RENAL DI ALYSI S	0. 000000	0		0	0	
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	
76. 00	03140 CARDI OLOGY	0. 000000	25, 024		0 0	0	76. 00
	OUTPATIENT SERVICE COST CENTERS	2 222222		1			
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	l .	0 0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	1	0 0	0	
90.00	09000 CLINIC	0. 000000	3, 264		0 0	0	
90. 01	04950 SLEEP CLINIC	0. 000000	140.070	1	0 0	0	
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 003275 0. 000000	140, 273	1	59 O	0	
92.00	OTHER REIMBURSABLE COST CENTERS	0.000000	0		U U	0	92.00
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0 0	0	94. 00
95.00	09500 AMBULANCE SERVICES	0.000000	0			U	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	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0			0	

Health Financial Systems	ELKHART GENER				eu 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-T018	From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
		Ti tl	e XIX	Subprovi der -	5/29/2019 7:1 PPS	1 am
				I RF		
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,	·		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	3.00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 O5000 OPERATING ROOM	2, 367, 367	77, 811, 545	0. 03042	24 0	0	50.00
51. 00 05100 RECOVERY ROOM	2, 307, 307		1		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		_	1			
53. 00 05300 ANESTHESI OLOGY			0.0000		0	1
54. 00 05400 RADI OLOGY - DI AGNOSTI C	1, 551, 144	56, 335, 184			1	
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 331, 144	30, 333, 164	1		117	1
56. 00 05600 RADI 01 SOTOPE			1			1
57. 00 05700 CT SCAN	283, 453	_			17	
58.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	144, 612				0	1
59. 00 05900 CARDIAC CATHETERIZATION	170, 444		•			
60. 00 06000 LABORATORY	236, 628				84	60.00
60. 00 06000 LABORATORY	230, 020		1		04	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.0000	0	l o	61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.0000	00	0	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.			1		0	
64. 00 06400 I NTRAVENOUS THERAPY	83, 434				0	
65. 00 06500 RESPI RATORY THERAPY	84, 513				90	1
66. 00 06600 PHYSI CAL THERAPY	202, 294		•		3, 137	1
67. 00 06700 OCCUPATI ONAL THERAPY	95, 269		1			1
68. 00 06800 SPEECH PATHOLOGY	57, 011				1, 886	1
69. 00 06900 ELECTROCARDI OLOGY	37,011	l .	1			1
70. 00 07000 ELECTROENCEPHALOGRAPHY		_				
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	363, 225	_			1	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	262, 765				0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	246, 928					1
74. 00 07400 RENAL DIALYSIS	240, 720		•		0	
75. 00 07500 ASC (NON-DISTINCT PART)			0.0000		0	1
76. 00 03140 CARDI OLOGY	390, 146	26, 221, 985	1		15	
OUTPATIENT SERVICE COST CENTERS	370, 140	20, 221, 703	0.0140	1,030	13	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.0000	00 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		_			0	
90. 00 09000 CLINI C	211, 559	_			340	1
90. 01 04950 SLEEP CLINIC	1, 733				0	1
91. 00 09100 EMERGENCY	725, 160		•			1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	720, 100					
OTHER REIMBURSABLE COST CENTERS		17,000,017	0.0000	50 0		72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0.0000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	o	0. 0000	00 0	0	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		o o	1		Ō	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	O	1		Ö	
200.00 Total (lines 50 through 199)	7, 477, 685	734, 271, 339	•	326, 763	8, 073	200.00
	•	•		•	-	-

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT / THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0018 Component CCN: 15-T018	Peri od: From 01/01/2018 To 12/31/2018	Date/Time Prepared:
				5/29/2019 7:11 am
		Title XIX	Subprovi der -	PPS

Cost Center Description				Titl	e XIX	Subprovi der -	PPS	
Ancit Lary 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 050			1.00	2A	2. 00	3A	3. 00	
51-00 05100 RECOVERY ROOM ALBOR ROOM 0 0 0 0 0 0 0 0 0								
S2. 00 05.200 DELIVERY ROOM & LABOR ROOM 0		l I	0) C) (0	0	
S3. 00 05300 AMESTHESI DLOGY 0 0 0 0 0 0 53. 00		1	0) C) (0	0	1
54. 00 05400 RADIOLOGY-DIAGNOSTIC 0 0 0 0 0 0 0 0 55. 00	52. 00		0) C) (0	0	52. 00
55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 0 0 0 55.00	53.00	05300 ANESTHESI OLOGY	0) C) (0	0	53. 00
56. 00 05700 05700 CT SCAN 0 0 0 0 0 0 0 0 0		05400 RADI OLOGY-DI AGNOSTI C	0) C) (0	0	54.00
57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 57.00 8.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 0 0 0 9.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 9.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 9.00 05000 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 9.00 05000 BLODO L ABGORATORY 0 0 0 0 0 0 9.10 05000 BLODO L ABGORATORY 0 0 0 0 0 9.10 05000 BLODO L ABGORATORY 0 0 0 0 0 9.10 05000 BLODO L ABGORATORY 0 0 0 0 0 9.10 05000 BLODO LABORATORY 0 0 0 0 0 9.10 05000 BLODO LABORATORY 0 0 0 0 0 9.11 05000 05000 BLODO LABORATORY 0 0 0 0 0 9.11 05000 05000 BLODO LABORATORY 0 0 0 0 0 9.11 05000 05000 BLODO LABORATORY 0 0 0 0 0 9.12 05000 05000 0 0 0 0 0 9.13 05000 05000 05000 0 0 0 0	55.00	05500 RADI OLOGY-THERAPEUTI C	0) C) (0	0	55. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 0 0 0 0 58.00 59.00 05900 CARDIA C CATHETERI ZATION 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 PBY CLI IN CAL 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 RO, 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 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 68.00 06600 SPECH PATHOLOGY 0 0 0 0 0 69.00 06600 SPECH PATHOLOGY 0 0 0 0 0 69.00 06600 SPECH PATHOLOGRAPHY 0 0 0 0 0 71.00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 72.00 07200 LECTROCARDI OLOGY 0 0 0 0 0 73.00 07300 DRUGS CHARRGED TO PATI ENTS 0 0 0 0 0 74.00 07300 DRUGS CHARRGED TO PATI ENTS 0 0 0 0 0 75.00 07300 DRUGS CHARRGED TO PATI ENTS 0 0 0 0 0 76.00 07400 ELECTROCARDI OLOGY 0 0 0 0 0 77.00 07400 ELECTROCARDI OLOGY 0 0 0 0 0 78.00 07300 DRUGS CHARRGED TO PATI ENTS 0 0 0 0 0 78.00 07300 DRUGS CHARRGED TO PATI ENTS 0 0 0 0 0 78.00 07300 DRUGS CHARRGED TO PATI ENTS 0 0 0 0 0 78.00 07300 DRUGS CHARRGED TO PATI ENTS 0 0 0 0 0 78.00 07300 DRUGS CHARRGED TO PATI ENTS 0 0 0 0 0 78.00 07300 DRUGS CHARRGED TO PATI ENTS 0 0 0 0 0 79.00 07400 EMERGENCY 0 0 0 0 0 79.00 07400 DRUGS CHARRGED TO PATI ENTS 0 0 0 0 79.00 07400 DRUGS CHARRGED TO PATI ENTS 0 0 0 0 79.00 07400 DRUGS CHARRGED TO PATI ENTS 0 0 0 0 79.00 07400 DRUGS CH	56.00	05600 RADI 0I SOTOPE	0) C) (0	0	56. 00
59, 00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 0 0	57.00	05700 CT SCAN	0) C) (0	0	57. 00
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 0	58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0) C) (0	0	58. 00
60.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0	59.00	05900 CARDI AC CATHETERI ZATI ON	0) C) (0	0	59. 00
61.00 06100 BBP 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 0 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 68.00 06800 SPECH PATHOLOGY 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 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 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
62.00 06200 MHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 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 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68.00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 0 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 72.00 07200 IMPL DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 74.00 07400 RENAL DIALYSIS 0 0 0 0 0 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 76.00 03140 CARDIOLOGY 0 0 0 0 0 0 0 77.00 03800 RURAL HEALTH CLINIC 0 0 0 0 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 90.01 04950 SLEEP CLINIC 0 0 0 0 0 0 91.00 09000 CLINIC CENTERS 0 0 0 0 0 92.00 09000 CLINIC CENTERS 0 0 0 0 0 93.00 09000 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 94.00 09000 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 95.00 09500 MBRULANCE SERVICES 0 0 0 0 0 0 96.00 09050 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 97.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 97.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 97.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 97.00 09950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 97.00 09950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 97.00 09950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 97.00 09950	60. 01	06001 BLOOD LABORATORY	0) C) (0	0	60. 01
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 63. 00 64. 00 06400 0 1 NTRAVENOUS THERAPY 0 0 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 0 65. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 68. 00 06900 DELECTROCARDIO LOGY 0 0 0 0 0 0 69. 00 06900 ELECTROCARDIO LOGY 0 0 0 0 0 0 71. 00 07000 ELECTROCARDIO LOGY 0 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 76. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 76. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 76. 00 07400 CARDIOLOGY 0 0 0 0 0 76. 00 07400 CARDIOLOGY 0 0 0 0 76. 00 07400 CARDIOLOGY 0 0 0 0 77. 00 07900 DURALL HEALTH CLINIC 0 0 0 0 0 89. 00 08900 RERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 90. 01 04950 SLEEP CLINIC 0 0 0 0 0 91. 00 09100 ERRGENCY 0 0 0 0 0 92. 00 09000 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 97. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 99. 00 09850 OTH	61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
64.00 06400 INTRAVENOUS THERAPY 0 0 0 0 0 0 64.00 65.00 05500 RESPI RATORY THERAPY 0 0 0 0 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 67.00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 70.00 07000 ELECTROENCEPHALLOGRAPHY 0 0 0 0 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72.00 07200 IMPL. 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 DI ALYSI S 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 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 77.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 78.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 79.00 09000 CLIDITATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 79.00 09000 CLINIC 0 0 0 0 79.00 09000 CLINIC 0 0 0 0 79.00 09000 DEMERGENCY 0 0 0 0 79.00 09000 DEMERGENCY 0 0 0 0 79.00 09000 OURABLE MEDI CAL EQUI P-RENTED 0 0 0 79.00 09500 OURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 79.00 09500 OURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 79.00 09500 OURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 79.00 09500 OURABLE MEDI CAL EQUI P-SOLD 0 0 0 79.00 09500 OURABLE MEDI CAL EQUI P-SOLD 0 0 0 79.00 09500 OURABLE MEDI CAL EQUI P-SOLD 0 0 0 79.00 09500 OURABLE MEDI CAL EQUI P-SOLD 0 0 0 79.00 09500 OURABLE MEDI CAL EQUI P-SOLD 0 0 0 79.00 09500 OURABLE MEDI CAL EQUI P-SOLD 0 0 0 79.00 09500 OURABLE MEDI CAL EQUI P-SOLD 0 0 0 79.00 09500 OURABLE M	62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0	0	62.00
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67. 00 06700 0CCUPATIONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 71. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 75. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 76. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 76. 00 03140 CARDI OLOGY 0 0 0 0 0 76. 00 03140 CARDI OLOGY 0 0 0 0 0 76. 00 03140 CARDI OLOGY 0 0 0 0 0 76. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 76. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0 0 0 76. 00 09000 CLI NI C 0 0 0 0 0 77. 00 09100 EMERGENCY 0 0 0 0 0 78. 00 09200 DSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 79. 00 09400 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 79. 00 09400 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 79. 00 09500 AMBULANCE SERVI CES 0 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 79. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 79. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 79. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 79. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 79. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 79. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 79. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 79. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 79. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 79.	65.00	06500 RESPIRATORY THERAPY	0			0	0	65. 00
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69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69. 00 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 70. 00 70. 00 70000 ELECTROCHOCEPHALOGRAPHY 0 0 0 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0 0 0 75. 00 76. 00 03140 CARDI OLOGY 0 0 0 0 0 0 0 75. 00 76. 00 03140 CARDI OLOGY 0 0 0 0 0 0 0 0 76. 00 88. 00 08800 RURAL HEALTH CLINI C 0 0 0 0 0 0 89. 00 90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 89. 00 90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	67.00	06700 OCCUPATI ONAL THERAPY	0			0	0	67. 00
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0	68. 00	06800 SPEECH PATHOLOGY	0			0	0	68. 00
71. 00 07100	69. 00	1	0			0	0	
72.00	70.00	07000 ELECTROENCEPHALOGRAPHY	0			0	0	70. 00
72.00	71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	71. 00
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 74. 00 75. 00 75.00 75.00 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 0 75. 00 76. 00 03140 CARDIOLOGY 0 0 0 0 0 0 0 0 0 75. 00 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0	0	72. 00
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75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 00 03140 CARDIOLOGY 0 0 0 0 0 0 0 75. 00 76. 00 03140 CARDIOLOGY 0 0 0 0 0 0 0 0 0 75. 00 0UTPATIENT SERVICE COST CENTERS 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. 01 04950 SLEEP CLINIC 0 0 0 0 0 0 0 0 90. 00 91. 00 09100 EMERGENCY 0 0 0 0 0 0 0 90. 01 91. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 133, 985 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 0 92. 00 OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 0 95. 00 95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 0 0 97. 00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 0 98. 00		1 I	0			0	0	1
76. 00 03140 CARDI OLOGY 0 0 0 0 0 0 0 0 0 0 76. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	0			0	0	1
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88. 00			<u>'</u>	•	1	<u>'</u>		1
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 90. 00 90. 01 04950 SLEEP CLINIC 0 0 0 0 0 0 0 0 90. 01 91. 00 09100 EMERGENCY 0 0 0 0 0 0 133, 985 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 0 0 0 133, 985 91. 00 07HER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 0 94. 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 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 97. 00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 98. 00	88. 00		0) C) (0	0	88. 00
90. 00 09000 CLINIC 0 0 0 0 0 0 0 0 0	89. 00		0	ol c		0	0	89. 00
90. 01	90.00	1	0			0	0	90.00
91. 00 09100 EMERGENCY 0 0 0 0 133, 985 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. 01	l	0			0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART) 0 0 0 92. 00		1	0			0	133. 985	
OTHER REIMBURSABLE COST CENTERS 94.00 94.00 94.00 95.00 95.00 96.00 96.00 96.00 97.00 97.00 97.00 97.00 98.00 9850 OTHER REIMBURSABLE COST CENTERS 96.00 98.00 9			0					
94. 00				1		-1		
95. 00 95. 00 96. 00 96. 00 96. 00 97. 00 97. 00 98. 00 985. 0 0 985. 0 9	94.00		0) (0	0	94.00
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 0 98. 00 0 0 0 0 0 0 0 0 0]]	
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			0	ol c	ol d	ol o	0	1
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 00				م ا	ol d	0		1
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	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER						<u> 2552-10</u>
THROUG		RVICE OTHER PASS	S Provi der C	CN: 15-0018	Peri od:	Worksheet D	
	H COSTS		Component		From 01/01/2018 To 12/31/2018		nared.
			Component	0014. 15 1010	10 12/31/2010	5/29/2019 7:1	1 am
			Ti tl	e XIX	Subprovi der -	PPS	
					I RF		
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
		Education Cost	1, 2, 3, and 4)	Cost (sum of cols. 2, 3,	8)	(col. 5 ÷ col. 7)	
			4)	and 4)	0)	/)	
		4.00	5.00	6.00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	0.00	0.00	7.00	0.00	
50.00	05000 OPERATING ROOM	0	0		0 77, 811, 545	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0		1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 56, 335, 184	0. 000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0. 000000	55. 00
56.00	05600 RADI 0I SOTOPE	0	0		0	0. 000000	56. 00
57.00	05700 CT SCAN	0	0		0 58, 302, 216		
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 8, 788, 282	0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 31, 946, 950	0. 000000	
60.00	06000 LABORATORY	0	0		0 64, 879, 885	0. 000000	
60. 01	06001 BLOOD LABORATORY	0	0		0	0. 000000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0	0.000000	61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0. 000000 0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0 1, 274, 615	0.000000	
65. 00	06500 RESPIRATORY THERAPY	0			0 20, 025, 364	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0		1	0 5, 163, 352	0. 000000	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 2, 975, 197	0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0	l o		0 945, 856		
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 116, 829, 931	0. 000000	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 76, 120, 806	0. 000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 119, 816, 830	0. 000000	
74.00	07400 RENAL DI ALYSI S	0	0		0	0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0	0. 000000	
76. 00	03140 CARDI OLOGY	0	0		0 26, 221, 985	0. 000000	76. 00
	OUTPATIENT SERVICE COST CENTERS	1	1	1			
88.00	08800 RURAL HEALTH CLINIC	0	0		0 0		
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	
90.00	09000 CLINIC		0		0 3, 520, 459		
90. 01	04950 SLEEP CLINIC		122 005		0 2, 789, 778		
91. 00 92. 00	O9100 EMERGENCY O9200 OBSERVATION BEDS (NON-DISTINCT PART)	0 0	133, 985 0		40, 914, 255 0 19, 608, 849		
7Z. UU	OTHER REIMBURSABLE COST CENTERS		1 0	1	0 17,000,649	0.000000	72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0		0 0	0.000000	94 00

0 0 0

133, 985

0

0

0

133, 985

0.000000

0.000000

0.000000

0

734, 271, 339

94.00 95.00

96.00

97.00

98.00

200. 00

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

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

	Financial Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	ELKHART GENERA	Provider C	°N- 15_0∩10	Peri od:	u of Form CMS-2 Worksheet D	2552-10
	H COSTS	VALUE OTHER PASS		CCN: 15-0018	From 01/01/2018 To 12/31/2018	Part IV Date/Time Pre	pared:
			Ti tl	e XIX	Subprovi der -	5/29/2019 7:1 PPS	<u>1 am</u>
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	I RF Outpati ent	Outpati ent	
	cost center bescription	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col . 6 ÷ col .	onal goo	Costs (col.		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	0		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	4, 236		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	3, 467		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60.00	06000 LABORATORY	0. 000000	22, 977		o o	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	0		o o	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		o o	0	64.00
65.00	06500 RESPI RATORY THERAPY	0. 000000	21, 247		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	80, 062	l .	0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	68, 863	1	0 0	0	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	31, 284		0 0	0	
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	246		0 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	87, 679		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		o o	0	75.00
76. 00	03140 CARDI OLOGY	0. 000000	1, 038		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	l .	0 0	0	1
90.00	09000 CLI NI C	0. 000000	5, 664		0 0	0	1
90. 01	04950 SLEEP CLINIC	0. 000000	0		0 0	0	
91. 00	09100 EMERGENCY	0. 003275	0	•	0 0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
	OTHER REIMBURSABLE COST CENTERS		-				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	1
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	
					0 0		

COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0018	Peri od:	WI	_
COMPUTATION OF INPATTENT OPERATING COST		From 01/01/2018	Worksheet D-1	
		To 12/31/2018	Date/Time Prepared 5/29/2019 7:11 am	:
	Title XVIII	Hospi tal	PPS	

Deat I all PROVIDER COMPONENTS PART All PROVIDER COMPONENTS 1.00	-		Title XVIII	Hospi tal	5/29/2019 7:1 PPS	1 am	
		Cost Center Description	THE AVIII	1103pi tai	113		
		·			1. 00		
1,000 Impatient days (including private room days and swing-bed days, excluding newborn)							
1.00 Private room days (excluding private room days)	1 00		excluding newborn)		40 401	1 00	
Private room days (excluding swing-bed and observation bed days). If you have only private room days. do not complete this is foculding sain-gued and observation bed days? Semi-private room days (soculding sain-gued and observation bed days). Semi-private room days (soculding sain-gued and observation bed days). 100 Semi-private room days (soculding sain-gued and observation bed days). 101 Total sain-gued SNF type inpatient days (including private room days) after becember 31 of the cost reporting period (ir calendar year, enter 0 on this line). 102 Total sain-gued NF type inpatient days (including private room days) after becember 31 of the cost reporting period (ir calendar year, enter 0 on this line). 103 Total sain-gued NF type inpatient days (including private room days) after becember 31 of the cost reporting period (ir calendar year, enter 0 on this line). 104 Total inpatient days including private room days palicable to the Program (excluding swing-bed and passorm-days). 105 Total sain-gued NF type inpatient days applicable to 11 to XVII only (including private room days) after becember 31 of the cost reporting period (is cele instruction). 105 Aligned SNF type inpatient days applicable to 11 to XVII only (including private room days). 106 Total sain-gued NF type inpatient days applicable to 11 to XVII only (including private room days). 107 Total sain-gued NF type inpatient days applicable to 11 to XVII only (including private room days). 108 Total sain-gued NF type inpatient days applicable to 11 to XVII only (including private room days). 109 Total sain-gued NF type inpatient days applicable to 11 to XVII only (including private room days). 110 SN ing-bod NF type inpatient days applicable to 11 to XVII only (including private room days). 110 SN ing-bod NF type inpatient days applicable to 11 to XVII only (including private room days). 110 Total gued December 31 of the cost reporting period (if calendar year, enter 0 on this line). 110 SN ing-bod NF type inpatient days applicable to							
Semi-private room days (excluding sating-bed and observation bed days) Semi-private room days (excluding sating-bed and observation bed days) Tool Total saing-bed SF type inpatient days (including private room days) after December 31 of the cost Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost Populating period (if calledar year, enter 0 on this line) Total saing-bed NF type inpatient days (including private room days) after December 31 of the cost Populating period (if calledar year, enter 0 on this line) Dos Saing-bed NF type inpatient days applicable to the Program (excluding saing-bed and Total inpatient days including private room days) after December 31 of the cost reporting period (if calledar year, enter 0 on this line) December 31 of the cost reporting period (if calledar year, enter 0 on this line) Saing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after Dos Saing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) After December 31 of the cost reporting period (if calledar year, enter 0 on this line) Weld call ly necessary private room days applicable to the Program (excluding swing-bed days) United Vision (including private room days) After December 31 of the cost reporting period (if calledar year, enter 0 on this line) Weld call ly necessary private room days applicable to services after December 31 of the cost reporting period (including private room days) Well call ly necessary private room days applicable to services through December 31 of the cost reporting period (including private room days) Well call ly necessary private room days applicable to services after December 31 of the cost reporting period (line S x line 17) Saing-bed cost applicab				ivate room days,			
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost operating period in the cost operating period (if calendar year, enter 0 on this line) on the cost operating period in the cost operating period in the cost operating period in the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operating period (if calendar year, enter 0 on this line) on the cost operati				-			
reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after 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 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 December 31 of the cost reporting period (see instructions) 13.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (see instructions) 14.00 Medically necessary private room days applicable to title XVIII only (including private room days) 15.00 Intell nursery days (title V or XXX only) 16.00 November 31 of the cost reporting period (see instructions) 17.00 Intell nursery days (title V or XXX only) 18.00 November 31 of the cost reporting period (see instructions) 18.00 Medical rate for saing-bed SNF services applicable to services through December 31 of the cost reporting period (see instructions) 18.00 Medical rate for saing-bed SNF services applicable to services through December 31 of the cost reporting period (line S X iline 17) 18.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line S X iline 17) 18.00 Swing-bed c				- 21 -6			
10tal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 7	5.00		on days) through becember	31 OF the Cost	0	5.00	
reporting period (if calendar year, either 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost 10.00 Total inpatient days including private room days) after December 31 of the cost 10.00 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) after December 31 of the cost reporting period (ise instructions) 11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (ise instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (ise instructions) 12.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 12.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 12.00 Swing-bed ost swing-bed SNF services applicable to services through December 31 of the cost reporting period (including total total total total total total tot	6.00		om days) after December :	31 of the cost	0	6. 00	
reporting period 8. 00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10. 00 Swing-bed Smiter 3 of the cost inporting period (see instructions) 11. 00 Swing-bed Smiter 3 of the cost reporting period (see instructions) 12. 00 Swing-bed Smiter 3 of the cost reporting period (see instructions) 13. 00 Swing-bed Smiter 3 of the cost reporting period (see instructions) 13. 00 Swing-bed Smiter 3 of the cost reporting period (see instructions) 13. 00 Swing-bed Smiter 3 of the cost reporting period (see instructions) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) of 12. 00 through December 31 of the cost reporting period (see instructions) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) of 13. 00 after December 31 of the cost reporting period (see instructions) 14. 00 Medically necessary private room days applicable to titles V or XIX only (including private room days) of 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) of 15. 00 Total nursery days (title V or XIX only) of 15. 00 Medical care rate for XIX only) of 15. 00 Medical care rate for swing-bed SNF services applicable to services through December 31 of the cost of 16. 00 Medical care rate for swing-bed SNF services applicable to services after December 31 of the cost of 17. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost of 17. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (line 6 x 11. 00 Medical drate for swing-bed NF services after December 31 of the cost reporting period (line 6 x 11. 00 Medical drate for swing-bed SNF services after De		reporting period (if calendar year, enter 0 on this line)	3 ,				
10 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10 10 10 10 10 10 10 1	7. 00		m 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 SMF type inpatient days applicable to title XVIII only (including private room days) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only 0 continued to through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SMF type inpatient days applicable to title XVIII only 0 continued to this line) 12.00 Swing-bed SMF type inpatient days applicable to title XVIII only 0 continued to the cost of through December 31 of the cost reporting period 13.00 Swing-bed SMF type inpatient days applicable to title XVIII only 0 continued to the cost of through December 31 of the cost reporting period 13.00 Swing-bed SMF type inpatient days applicable to title XVII only (including private room days) 13.00 Swing-bed SMF type inpatient days applicable to title XVIII only 0 continued to the Cost of the Cost of Total contents of the Cost of Total cost of Total contents of Total Cost of Tot	8 00		m days) after December 3	1 of the cost	0	8 00	
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28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.01 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 27 + line 28) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average semi-private room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 59,058,388) 30.00 Adjusted general inpatient routine service cost per diem (see instructions) 30.00 Program general inpatient routine service cost (line 9 x line 38) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Average per diem private room cost applicable to the Program (line 14 x line 35) 30.00 Average per diem private room cost applicable to the Program (line 14 x line 35)	27. 00		(line 21 minus line 26)		59, 058, 388	27. 00	
29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 31.00 Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 33.00 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 59, 058, 388) 37.00 PART II - HOSPITAL AND SUBPROVI DERS 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 30.00 30.00 30.00 30.00 0.00 31.00 0.00 32.0	20.00		dd		0	20.00	
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 59,058,388) 37.00 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 0.00 000 000 000 000 000 000 000 000			d and observation bed ch	arges)			
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 cost 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 59, 058, 388) 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) 9 Program general inpatient routine service cost (line 9 x line 38) 11, 461.81 38.00 12, 461.81 38.00 13, 879, 276 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)							
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 59,058,388) 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 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			÷ line 28)				
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 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 34.00 35.00 36.00 37.00 16.00 17.00 18.00 19							
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 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 .00 35.00 36.00 37.00 36.00 37.00 3			1: 22) (:+	+!>			
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 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 59,058,388 59,058,388 17.00 18.879,058,388 18.870 00 18.879,276 18.879,276 18.879,276		, , ,		tions)			
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37. 00 19, 058, 388 37. 00 18, 879, 276 39. 00 40. 00		,	0 01)				
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, 461.81 38.00 Program general inpatient routine service cost (line 9 x line 38) 18, 879, 276 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		,	and private room cost di	fferential (line			
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 461.81 38.00 Program general inpatient routine service cost (line 9 x line 38) 18, 879, 276 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00				· ·			
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,461.81 38.00 Program general inpatient routine service cost (line 9 x line 38) 18,879,276 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			ICTMENTS				
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) 18,879,276 39.00 40.00	38 00				1 461 91	38 00	
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00			*				
41.00 Total Program general inpatient routine service cost (line 39 + line 40) 18,879,276 41.00		,	•				
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		18, 879, 276	41. 00	

Heal th	Financial Systems	ELKHART GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	F	eriod: rom 01/01/2018	Worksheet D-1	
			T: ±1		0 12/31/2018	5/29/2019 7:1	
	Cost Center Description	Total	Total	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
		Inpatient Cost	Inpatient Days	sDiem (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
	Intensive Care Type Inpatient Hospital Units						
43. 00 43. 01	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE	9, 804, 366 2, 273, 217	4, 928 74			3, 835, 795 0	43. 00 43. 01
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0		0. 00 0. 00		0	44. 00 45. 00
46.00	SURGICAL INTENSIVE CARE UNIT	o		0.00		0	46. 00
47.00	OST Center Description						47. 00
48. 00	Program inpatient ancillary service cost (Wk:	st D-3 col 3	Line 200)			1. 00 28, 676, 108	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		51, 391, 179	•
50. 00	Pass through costs applicable to Program inp.	atient routine	servi ces (fro	m Wkst. D, sum	of Parts I and	2, 001, 810	50. 00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancillar	y services (f	rom Wkst. D, su	m of Parts II	1, 095, 610	51. 00
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclu		lated non-ph	vsician anesthe	tist and	3, 097, 420 48, 293, 759	
33. 00	medical education costs (line 49 minus line		ratea, non pri	ysi ci aii anestne	trat, and	40, 273, 737	33.00
54. 00	, 3					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	rget amount (line 56 minus l	ine 53)	0	57. 00
58. 00 59. 00	Lesser of lines 53/54 or 55 from the cost re	0.00	58. 00 59. 00				
60. 00	market basket Lesser of lines 53/54 or 55 from prior year		0.00	60. 00			
61. 00	· · · · · · · · · · · · · · · · · · ·						
	amount (line 56), otherwise enter zero (see						
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	0					
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	e cost reportin	a period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	· ·		•		0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi				•	0	
	CAH (see instructions)		•				
	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)					0	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost repor	ting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service (cost (line 37)			70.00
71. 00 72. 00	Adjusted general inpatient routine service co Program routine service cost (line 9 x line	71)		•			71. 00 72. 00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine services.						73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient (26, line 45)				rt II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	. *					76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			· ·	s line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limit	tati on		, , , , , , , , , , , , , , , , , , , ,	,		81. 00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .				82. 00 83. 00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ns)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					7, 701	87. 00
88. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	diem (line 27 ÷	line 2)			1, 461. 81 11, 257, 399	88. 00
57.00	(See	o moti doti ons)				1 11, 201, 317	1 57.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		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 O	COST					
90.00 Capital -related cost	5, 625, 010	59, 058, 388	0. 09524	5 11, 257, 399	1, 072, 211	90.00
91.00 Nursing School cost	0	59, 058, 388	0.00000	0 11, 257, 399	0	91.00
92.00 Allied health cost	0	59, 058, 388	0.00000	0 11, 257, 399	0	92.00
93.00 All other Medical Education	0	59, 058, 388	0. 00000	0 11, 257, 399	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 01/01/2018	Worksheet D-1
	Component CCN: 15-S018		
	Title XVIII	Subprovi der -	PPS
		LDE	

		II the Aviii	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 040	1. 00
2.00	Inpatient days (including private room days, excluding swing-			3, 040	
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 040	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
, 00	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 or the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
	reporting period				
8. 00	Total swing-bed NF type inpatient days (including private roor	n days) after December 31	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-hed and	602	9. 00
7. 00	newborn days)	o the riogram (exercaring	Swifing bed dild	002	7. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		om dove) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)	Joili days) arter	U	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12.00
40.00	through December 31 of the cost reporting period				40.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra		,	0	14. 00
15. 00	Total nursery days (title V or XIX only)	(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 of	the cost	0.00	17. 00
17.00	reporting period	es till odgir becelliber 31 of	the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0.00	18. 00
40.00	reporting period			0.00	40.00
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 th	ne cost	0. 00	20. 00
	reporting period	-			
21. 00	Total general inpatient routine service cost (see instructions		ng poriod (line	3, 890, 954	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporti	ng period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	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)	131 of the cost reporting	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	, in the second			
26. 00	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	(Tine 21 minus Tine 26)		3, 890, 954	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi -private room charges (excluding swing-bed charges)			0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	Fine 28)		0. 000000 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 min	nus line 33)(see instruct	i ons)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x li	ne 31)		0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	anu private room cost dif	recential (IINe	3, 890, 954	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, 279. 92	
39.00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program	•		770, 512 0	
40. 00 41. 00	Total Program general inpatient routine service cost (line 39	,		770, 512	
	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -	,	ı	, 512	

	Financial Systems	ELKHART GENERAL				u of Form CMS-2	2552-10
COMPUTA	ATION OF INPATIENT OPERATING COST		Provider CCN	F	eriod: rom 01/01/2018	Worksheet D-1	
-			Component CC			5/29/2019 7:1	
			Title X	VIII	Subprovider - IPF	PPS	
	Cost Center Description	Total Inpatient Costlr		Average Per em (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0. 00	0	0	42.00
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43. 00
	NEONATAL INTENSIVE CARE	0	0	0.00			
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0 0	0	0. 00 0. 00	0	0 0	44. 00 45. 00
1	SURGICAL INTENSIVE CARE UNIT	o	Ö	0.00		0	46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
	Program inpatient ancillary service cost (Wks					147, 730	
	Total Program inpatient costs (sum of lines A PASS THROUGH COST ADJUSTMENTS	41 through 48)(se	ee instructions	5)		918, 242	49. 00
	Pass through costs applicable to Program inpa	atient routine s	ervices (from W	kst. D, sum	of Parts I and	92, 828	50.00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (from	ı Wkst. D, sui	m of Parts II	4, 735	51.00
52. 00	Total Program excludable cost (sum of lines!	50 and 51)				97, 563	52. 00
	Total Program inpatient operating cost exclud	9 1	ated, non-physi	cian anesthe	tist, and	820, 679	53. 00
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program di scharges					0	
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and targ	net amount (lin	e 56 minus L	ine 53)	0	
	Bonus payment (see instructions)	ng ooot and tan	got amount (iii			0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period e	nding 1996, upd	ated 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, upda	ated by the mar	ket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines	s 55, 59 or 60 er	nter the Lesser	of 50% of t		0	61. 00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see it		(lines 54 x 60), or 1% of	the target		
	Relief payment (see instructions)					0	62. 00
	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
, F. 00	instructions)(title XVIII only)		04 6 11				45.00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after December	r 31 of the cos	t reporting	period (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
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through (December 31 of	the cost ren	orting period	0	67. 00
	(line 12 x line 19)	· ·		·	0 .	Ü	07.00
68. 00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after Dec	cember 31 of th	e cost repor	ting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient	outine costs (li	ine 67 + line 6	8)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU						70.00
	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of			ι (iine 3/)			70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)					72. 00
1	Medically necessary private room cost applica			35)			73.00
	Total Program general inpatient routine servi Capital-related cost allocated to inpatient			ksheet B. Pa	rt II. column		74. 00 75. 00
	26, line 45)		•				
1	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line						76. 00 77. 00
1	Inpatient routine service cost (line 74 minus						78. 00
1	Aggregate charges to beneficiaries for excess				703		79.00
1	Total Program routine service costs for comparing the routine service cost per diem limit		st limitation (iine /8 minu	s line /9)		80. 00 81. 00
1	Inpatient routine service cost per drem from						82. 00
83. 00	Reasonable inpatient routine service costs (see instructions)				83. 00
	Program inpatient ancillary services (see insutilization review - physician compensation		5)				84. 00 85. 00
1	Total Program inpatient operating costs (sum						86.00
ļ	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST	- '				
	Total observation bed days (see instructions))				0	87.00
	Adjusted general inpatient routine cost per of		line 2)			_	88.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 7:1	
		Title	XVIII	Subprovi der - I PF	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 O		2.00	0.00		0.00	
90.00 Capital -related cost	468, 765	3, 890, 954	0. 12047	6 0	0	90. 00
91.00 Nursing School cost	0	3, 890, 954			0	91. 00
92.00 Allied health cost	0	3, 890, 954			0	92. 00
93.00 All other Medical Education	0	3, 890, 954	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	Provider CCN: 15-0018	Peri od: From 01/01/2018	Worksheet D-1
	Component CCN: 15-T018	To 12/31/2018	Date/Time Prepared: 5/29/2019 7:11 am
	Title XVIII	Subprovi der -	PPS

		II the Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			1, 514	1.00
2.00	Inpatient days (including private room days, excluding swing-b			1, 514	
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed davs)		1, 514	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
	reporting period				
6. 00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after becember 3	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	n 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)	n days) after December 31	I of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	583	9. 00
	newborn days)		3		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom days) after	o	11. 00
11.00	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	Join days) arter	ĭ	11.00
12.00	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)	/ only (including private	room days)	o	13. 00
13.00	after December 31 of the cost reporting period (if calendar ve			٥	13.00
14. 00	Medically necessary private room days applicable to the Progra		, I	0	14.00
15. 00	Total nursery days (title V or XIX only)			0	15. 00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
17.00	reporting period	o tili dagii becember oi di	1110 0031	0.00	17.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		3, 085, 498	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reportir	na period (line	0	24. 00
	7 x line 19)		.9		
25. 00	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)			o	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		3, 085, 498	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 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	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	1: 22) (:	.:>	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mir Average per diem private room cost differential (line 34 x line	, ,	LI OIIS)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	10 01)		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	3, 085, 498	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			2, 037. 98	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	•		1, 188, 142	
40.00	Medically necessary private room cost applicable to the Program general inpatient routine service cost (Line 30)	,		0 1, 188, 142	40.00
41. 00	Total Program general inpatient routine service cost (line 39	T IIIIC 40)	I	1, 100, 142	41.00

	Financial Systems	ELKHART GENERAI				eu of Form CMS-2	2552-10
COMPUTA	ATION OF INPATIENT OPERATING COST		Provi der CCN	F	eriod: rom 01/01/2018	Worksheet D-1	
			Component CC	CN: 15-T018 T	o 12/31/2018	Date/Time Pre 5/29/2019 7:1	
			Title	XVIII	Subprovider - IRF	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Costli		col . 2)		(col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4. 00 0	5.00	42.00
	Intensive Care Type Inpatient Hospital Units						
	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE	0	0	0. 00 0. 00			
	CORONARY CARE UNIT	Ö	Ö	0.00	0	l e	44. 00
	BURN INTENSIVE CARE UNIT	O	0	0.00		0	
	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. 00 436, 256	48. 00
	Total Program inpatient costs (sum of lines			s)		1, 624, 398	
	PASS THROUGH COST ADJUSTMENTS				-£ Dt	150 571	F0 00
50. 00	Pass through costs applicable to Program inpa	atient routine s	ervices (from)	WKSt. D, SUM	or Parts I and	152, 571	50.00
51. 00	Pass through costs applicable to Program inpa	atient ancillary	services (from	m Wkst. D, su	m of Parts II	25, 663	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)				178, 234	52. 00
53. 00	Total Program inpatient operating cost excluding		ated, non-physi	ician anesthe	tist, and	1, 446, 164	
	medical education costs (line 49 minus line !	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	 54.00
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)					0	
	Difference between adjusted inpatient operati Bonus payment (see instructions)	ng cost and tar	get amount (li	ne 56 minus I	ine 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost rep	oorting period e	ndi ng 1996, up	dated and com	oounded by the	1	
	market basket						(0.00
	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines				ne amount by	0.00	1
011.00	which operating costs (line 53) are less than	n expected costs					01.00
42.00	amount (line 56), otherwise enter zero (see i	nstructions)				_	42.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paymo	ent (see instruc	tions)			0 0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	•	,				
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decem	ber 31 of the (cost reportin	g period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the co	st reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	na costs (lina 6	1 nlus line 65	\((+ i + l \to \(\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \	only) For	0	66. 00
00.00	CAH (see instructions)	ie costs (Title o	4 prus rine os	(title xviii	only). To		00.00
67. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	December 31 of	the cost rep	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of t	he cost repor	ting period	0	68. 00
	(line 13 x line 20)				0.		
69. 00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU	•				0	69. 00
	Skilled nursing facility/other nursing facili	ty/ICF/IID rout	ine service co	st (line 37)			70. 00
	Adjusted general inpatient routine service of		ne 70 ÷ line 2)			71.00
	Program routine service cost (line 9 x line 1) Medically necessary private room cost applications.	•	(line 14 x line	e 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 Wo	rksheet 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	76)					77. 00
	Inpatient routine service cost (line 74 minus		aut dan naaanda	`			78. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				s line 79)		79. 00 80. 00
81. 00	Inpatient routine service cost per diem limi	tati on					81. 00
82.00	Inpatient routine service cost limitation (li						82.00
83. 00 84. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		J				83. 00 84. 00
85. 00	Utilization review - physician compensation		s)				85. 00
86. 00	Total Program inpatient operating costs (sum		ough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)					0	87. 00
88. 00	Adjusted general inpatient routine cost per of		line 2)				88. 00
	Observation bed cost (line 87 x line 88) (see	: no+muo+1 ono)					89.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 7:1	
		Title	XVIII	Subprovi der -	PPS	
	-			I RF		
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	396, 220	3, 085, 498	0. 12841	4 0	0	90.00
91.00 Nursing School cost	0	3, 085, 498	0.00000	0	0	91.00
92.00 Allied health cost	0	3, 085, 498	0.00000	0	0	92.00
93.00 All other Medical Education	0	3, 085, 498	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	From 01/01/2018	Worksheet D-1 Date/Time Prepared: 5/29/2019 7:11 am
	Title XIX	Hospi tal	PPS
C+ C+			

		Title XIX	Hospi tal	5/29/2019 7: 1 PPS	ı am
	Cost Center Description	THE XIX	nospi tui	113	
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1 00	INPATIENT DAYS	avaluding nawbarn)		40, 401	1. 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			40, 401	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		vate room days.	40, 401	3. 00
0.00	do not complete this line.	,e, yeuare ey p	vato room dayo,	· ·	0.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		32, 700	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private rooreporting period (if calendar year, enter 0 on this line)	om days) after December 3	31 OF the COST	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 31	of the cost	0	8. 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	734	9. 00
10. 00	<pre>newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or</pre>	alv (including private ro	nom days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instruct		Join days)		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, er				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	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)	(only (including private	room days)	0	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			0	13.00
14.00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)				15. 00
16. 00	Nursery days (title V or XIX only)			115	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 of	f the cost	0.00	17 00
17.00	reporting period	es thi ough becember 31 of	the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0. 00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
20.00	reporting period	arter becember 31 of the	10 0031	0.00	20.00
21.00	Total general inpatient routine service cost (see instructions	s)		59, 058, 388	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reporting	noried (line 6	0	23. 00
23.00	x line 18)	31 of the cost reporting	g perrou (Trile o	0	23.00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line	0	24. 00
	7 x line 19)	·			
25. 00	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 ((line 21 minus line 26)		59, 058, 388	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(11119 21 111110 11119 23)		07/000/000	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi -private room charges (excluding swing-bed charges)	1: 00)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 -	FIIne 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruct	ions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	, ,	,	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	59, 058, 388	37. 00
	27 minus line 36)				
	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, 461. 81	38. 00
39. 00	Program general inpatient routine service cost per drem (see	,		1, 401. 81	
40. 00	Medically necessary private room cost applicable to the Progra	,		0	
41.00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 072, 969	41. 00

near t n	Financial Systems	ELKHART GENERAL	HOSPITAL		In_Lie	eu of Form CMS-2	<u> 2552-</u> 10
	TATION OF INPATIENT OPERATING COST		Provider CCN:	15-0018	Peri od:	Worksheet D-1	
					From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
			T: +1 - \	VI V		5/29/2019 7: 1 ³	1 am
	Cost Center Description	Total	Title 2	verage Per	Hospital Program Days	PPS Program Cost	
	oost conten bescriptron	Inpatient Cost In				(col. 3 x col.	
		1.00	0.00	col . 2)	4.00	4)	
42 00	NURSERY (title V & XIX only)	1. 00 4, 944, 638	2. 00	3. 00 2, 191. 7	4. 00 77 115	5. 00 252, 054	42 00
12.00	Intensive Care Type Inpatient Hospital Units		2, 200	2, 171. 7	7	202,001	12.00
43. 00	INTENSIVE CARE UNIT	9, 804, 366	4, 928	1, 989. 5			
43. 01	NEONATAL INTENSIVE CARE CORONARY CARE UNIT	2, 273, 217	744	3, 055. 4			
44. 00 45. 00	BURN INTENSIVE CARE UNIT	0	0	0. C 0. C		0	
46. 00	SURGICAL INTENSIVE CARE UNIT	0	Ö	0. 0		Ö	46.00
47. 00							47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (W	st. D-3, col. 3,	line 200)			9, 568, 445	48. 00
	Total Program inpatient costs (sum of lines)		10, 893, 468	49.00
FO 00	PASS THROUGH COST ADJUSTMENTS		(6 WI	D	-£ D 1	122 715	
50. 00	Pass through costs applicable to Program inp	patrent routine se	ervices (from W	κsι. D, SUM	i di Parts I and	132, 715	50.00
51. 00	Pass through costs applicable to Program inp	oatient ancillary	services (from	Wkst. D, s	sum of Parts II	505, 809	51.00
E2 00	and IV)	EO and E1)				420 504	E2 00
52. 00 53. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ited. non-nhysi	cian anesth	etist, and	638, 524 10, 254, 944	
55.00	medical education costs (line 49 minus line					.5, 254, 744] 55.00
F4	TARGET AMOUNT AND LIMIT COMPUTATION						
54. 00 55. 00	Program discharges Target amount per discharge					0.00	
56. 00						0.00	
57. 00	Difference between adjusted inpatient operat	ting cost and targ	get amount (line	e 56 minus	line 53)	0	57.00
58. 00	Bonus payment (see instructions)		l' 4007 L			0	58.00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	eporting period er	idi ng 1996, upda	ated and co	ompounded by the	0.00	59.00
60. 00	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
61. 00						0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		(lines 54 x 60)), or 1% of	the target		
62. 00	1	riisti deti olisj				0	62.00
63. 00	Allowable Inpatient cost plus incentive paym	ment (see instruct	i ons)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Docomb	or 21 of the co	ost roporti	ng poriod (Soo	0	 64. 00
04.00	instructions) (title XVIII only)	sts through becenik	del 31 di the co	JST TEPOLTI	ing period (see		04.00
65. 00	Medicare swing-bed SNF inpatient routine cos	sts after December	31 of the cos	t reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line 6/	nlus line 65)	(+i+la YVII	Lonly) For	0	66. 00
	CAH (see instructions)	·			•		00.00
67. 00	Title V or XIX swing-bed NF inpatient routin	ne costs through [ecember 31 of	the cost re	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	o costs after Doc	combor 21 of the	o cost ropo	urting ported	0	68. 00
00.00	(line 13 x line 20)	ie costs arter bec	elliber 31 of the	e cost repo	itting period		00.00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70.00
71. 00	Adjusted general inpatient routine service of	•		t (Title 37)			71.00
72. 00	Program routine service cost (line 9 x line	71)	ŕ				72.00
73.00	3 31			35)			73.00
74. 00 75. 00	Total Program general inpatient routine services capital-related cost allocated to inpatient	•		ksheet R P	Part II column		74. 00 75. 00
. 5. 60	26, line 45)	. Jacimo Joi vi de C		CHOOL D, I	a. c ii, coi umili		, 5. 00
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	1 .		ovi der records)				79.00
80. 00	Total Program routine service costs for comp		st limitation (I	line 78 min	us line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82. 00 83. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82. 00 83. 00
84. 00	Program inpatient ancillary services (see in	•					84.00
85. 00	Utilization review - physician compensation						85.00
86. 00	Total Program inpatient operating costs (sun		ough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					7, 701	 87. 00
	,	*	: 2)				1
88. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	rne 2)			1, 461. 81 11, 257, 399	

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Period: From 01/01/2018	Worksheet D-1	
				To 12/31/2018	Date/Time Pre 5/29/2019 7:1	
		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	5, 625, 010	59, 058, 388	0. 09524	5 11, 257, 399	1, 072, 211	90.00
91.00 Nursing School cost	0	59, 058, 388	0. 00000	0 11, 257, 399	0	91.00
92.00 Allied health cost	0	59, 058, 388	0. 00000	0 11, 257, 399	0	92.00
93.00 All other Medical Education	0	59, 058, 388	0. 00000	0 11, 257, 399	l 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 01/01/2018	Worksheet D-1
	Component CCN: 15-S018	To 12/31/2018	Date/Time Prepared: 5/29/2019 7:11 am
	Title XIX	Subprovi der -	PPS
		IPF	

Pate 1				I PF		
PART 1 - ALL PROVIDER COMPONENTS		Cost Center Description			1 00	
Impart Int Int No. Impart and days (including private room days, excluding newborn) 3,040 2.00 Impart and days (including private room days, excluding sing-bed and newborn days) 3,040 2.00 Impart and days (including private room days, excluding sing-bed and observation bed days) 1 you have only private room days 3,040 3,0		PART I - ALL PROVIDER COMPONENTS			1.00	
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Private room days (excluding swing-bed and observation bed days) 1						
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41.00 Total Program general inpatient routine service cost (line 39 + line 40) 134,392 41.00			•			
	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		134, 392	41. 00

	Financial Systems	ELKHART GENERAL				u of Form CMS-2	2552-10
COMPUTA	ATION OF INPATIENT OPERATING COST		Provider CCN: Component CCI	F	eriod: rom 01/01/2018 o 12/31/2018		
			Title	XIX	Subprovi der -	5/29/2019 7:1 PPS	<u>1 am</u>
	Cost Center Description	Total Inpatient Costlr		Average Per em (col. 1 ÷	IPF 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		42. 00
	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	ol	0.00	0	0	43. 00
	NEONATAL INTENSIVE CARE		0	0.00		_	
	CORONARY CARE UNIT	Ö	Ö	0. 00	0	Ö	44. 00
	BURN INTENSIVE CARE UNIT	0	0	0. 00		0	
	SURGICAL INTENSIVE CARE UNIT	0	0	0. 00	0	0	46.00
47. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
48. 00	Program inpatient ancillary service cost (Wks	st D-3 col 3	line 200)			1. 00 228, 075	48. 00
	Total Program inpatient costs (sum of lines			5)		362, 467	
İ	PASS THROUGH COST ADJUSTMENTS	g , i					_
	Pass through costs applicable to Program inpa	atient routine se	ervices (from W	/kst. D, sum	of Parts I and	16, 191	50.00
1	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillary	services (from	ı Wkst. D, su	m of Parts II	6, 916	51.00
F0 00	and IV)	-O				22 107	F2 00
	Total Program excludable cost (sum of lines! Total Program inpatient operating cost exclud		atod non nhyei	cian anostho	tict and	23, 107 339, 360	1
	medical education costs (line 49 minus line !	9 1	ateu, non-physi	crair allestile	tist, and	337, 300	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	·]
	Program di scharges					0	
	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
	Difference between adjusted inpatient operati	ng cost and targ	get amount (lin	e 56 minus l	ine 53)	0	1
	Bonus payment (see instructions)					0	58. 00
	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period e	nding 1996, upd	lated and com	pounded by the	0.00	59.00
1	Lesser of lines 53/54 or 55 from prior year	cost report, upda	ated by the mar	ket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines	s 55, 59 or 60 er	nter the Lesser	of 50% of t		0	61.00
	which operating costs (line 53) are less that		(lines 54 x 60), or 1% of	the target		
	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	listi ucti olis)				0	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instruc	tions)			0	
	PROGRAM INPATIENT ROUTINE SWING BED COST		04 6 11				
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions) (title XVIII only)	ts through Decemi	per 31 of the c	ost reportin	g period (See	0	64. 00
	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	31 of the cos	t reporting	period (See	0	65. 00
	instructions)(title XVIII only)	+- (1: (4 -1 1: (5)	(+: +l - \\\ /\	1\		
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line 64	4 plus line 65)	(title XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine	e costs through [December 31 of	the cost rep	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	anata aftar Da	21 of th		ting popied		40.00
00.00	(line 13 x line 20)	e costs arter bed	zelliber 31 of th	ie cost repor	tring perrou	0	68. 00
	Total title V or XIX swing-bed NF inpatient					0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili						70. 00
	Adjusted general inpatient routine service of						71.00
72. 00	Program routine service cost (line 9 x line	71)					72. 00
1	Medically necessary private room cost applica			35)			73.00
1	Total Program general inpatient routine servi Capital-related cost allocated to inpatient			rkshoot R Da	rt II column		74. 00 75. 00
, 5. 50	26, line 45)	Satino Solvice (JUST CITOII WOT		, Corumi		, 5. 00
1	Per diem capital-related costs (line 75 ÷ lin						76. 00
1	Program capital -related costs (line 9 x line						77. 00 78. 00
1	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		ovider records)				79.00
1	Total Program routine service costs for compa	,			s line 79)		80.00
1	Inpatient routine service cost per diem limi						81.00
4	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	HROUGH COST					07.00
	Total observation had days (see instructions)	١				^	
87. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of		ine 2)			0 0.00	87. 00 88. 00

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 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 7:1	
		Titl	e XIX	Subprovi der – I PF	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 O		2.00	0.00	1 11 00	0.00	
90.00 Capital -related cost	468, 765	3, 890, 954	0. 12047	6 0	0	90. 00
91.00 Nursing School cost	0	3, 890, 954			0	91. 00
92.00 Allied health cost	0	3, 890, 954			0	92. 00
93.00 All other Medical Education	0	3, 890, 954	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 01/01/2018	Worksheet D-1
	Component CCN: 15-T018		
	Title XIX	Subprovi der -	PPS

		litie XIX	I RF	PPS	
	Cost Center Description		TIM		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			1, 514	1. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day		ivata room days	1, 514 0	2. 00 3. 00
3.00	do not complete this line.	ys). IT you have only pr	I vate 100m days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		1, 514	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room)	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 reporting period	m days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 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	o the Program (excluding	swing-bed and	89	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 instructions). Swing-bed SNF type inpatient days applicable to title XVIII of	nly (including private r	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en 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 XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	(2, 256	15. 00
16. 00	Nursery days (title V or XIX only)			115	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 c	f the cost	0. 00	17. 00
18. 00	reporting period 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	0.00	19. 00		
20. 00	Medical d rate for swing-bed NF services applicable to services reporting period	0. 00	20. 00		
21. 00 22. 00	Total general inpatient routine service cost (see instruction: Swing-bed cost applicable to SNF type services through December		ing period (line	3, 085, 498 0	21. 00 22. 00
22.00	5 x line 17)	or or the cost report	ring perrod (rrine	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December \mathbf{x} line 18)	31 of the cost reportin	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 line 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December (x,y) line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)	(line 21 minus line 24)		2 005 400	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(TITIE 21 IIITIUS TITIE 20)		3, 085, 498	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	General inpatient routine service cost/charge ratio (line 27	: line 28)		0.000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus lino 22) (soo instruc	tions)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line		0113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			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, 085, 498	
	27 minus line 36)				
	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			2, 037. 98	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	· ·		181, 380	
40. 00	Medically necessary private room cost applicable to the Progra			0	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		181, 380	41. 00

Heal th	Financial Systems	ELKHART GENERA	L HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der C		Period: From 01/01/2018	Worksheet D-1	
			Component		o 12/31/2018	Date/Time Pre	
			Ti tl	e XIX	Subprovi der -	5/29/2019 7: 1° PPS	<u>1 am</u>
					. I RF		
	Cost Center Description	Total Inpatient Costl	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		Impatrent costi		col . 2)		4)	
12.00	NUDCEDY (+:+1 - V 0 VIV1.)	1.00	2.00	3.00	4. 00	5. 00	42.00
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.00) 0	0	42. 00
43.00	INTENSIVE CARE UNIT	0	C	•		0	43. 00
	NEONATAL INTENSIVE CARE	0	0				43. 01
	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0				44. 00 45. 00
	SURGI CAL INTENSI VE CARE UNIT	o	0	•			46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3,	line 200)			130, 411	48. 00
49. 00	Total Program inpatient costs (sum of lines	41 through 48)(s	see instructio	ns)		311, 791	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine s	services (from	.Wkst D sum	of Parts L and	23, 291	50. 00
	III)						
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillary	services (fr	om Wkst. D, su	m of Parts II	8, 073	51. 00
52. 00	Total Program excludable cost (sum of lines!	50 and 51)				31, 364	52. 00
53. 00	Total Program inpatient operating cost exclud	ding capital rel	ated, non-phy	sician anesthe	tist, and	280, 427	
	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	
	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and tar	cast amount (1	ino E4 minus I	ino E2)	0	56. 00 57. 00
58. 00	Bonus payment (see instructions)	ing cost and tar	get amount (i	THE SO IIITHUS I	THE 53)		58.00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	ending 1996, ι	pdated and com	pounded by the	0.00	
60. 00	market basket Lesser of lines 53/54 or 55 from prior year (cost roport upo	lated by the m	arkot baskot		0.00	60. 00
	If line 53/54 is less than the lower of lines				he amount by	0.00	61.00
	which operating costs (line 53) are less than	n expected costs					
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	instructions)				o	62. 00
	Allowable Inpatient cost plus incentive payme	ent (see instruc	ctions)				
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decem	ber 31 of the	cost reportir	g period (See	0	64. 00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	er 31 of the c	ost reporting	period (See	0	65. 00
	instructions)(title XVIII only)			E) (11111)0/111			
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line 6	o4 plus line 6	5)(TITIE XVIII	only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	of the cost rep	orting period	o	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	o costs after Do	combor 21 of	the cost repor	ting ported	0	68. 00
08.00	(line 13 x line 20)	e costs after be	celliber 31 01	the cost repor	triig perrou		00.00
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						71. 00
	Program routine service cost (line 9 x line	*	(lima 14 v li	no 3E)			72.00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine servi						73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient (•			rt II, column		75. 00
74 00	26, line 45)	20. 2)					76. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ line Program capital-related costs (line 9 x line	. *					77.00
	Inpatient routine service cost (line 74 minus						78. 00
79. 00	Aggregate charges to beneficiaries for excess				- 1: 70)		79.00
80. 00 81. 00	Total Program routine service costs for compa Inpatient routine service cost per diem limi		ost iimitation	i (iine 78 minu	is i i iie 79)		80. 00 81. 00
	Inpatient routine service cost limitation (li						82. 00
83.00	Reasonable inpatient routine service costs (5)				83.00
84. 00 85. 00	Program inpatient ancillary services (see ing Utilization review - physician compensation		ıs)				84. 00 85. 00
	Total Program inpatient operating costs (sum						86. 00
07.00	PART IV - COMPUTATION OF OBSERVATION BED PASS						07.00
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		line 2)			0.00	87. 00 88. 00
	Observation bed cost (line 87 x line 88) (see	•	,			1	89. 00

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 (CCN: 15-T018	From 01/01/2018 To 12/31/2018		
		Titl	e XIX	Subprovi der -	PPS	
	0 1	D 11 0 1		I RF		
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	396, 220	3, 085, 498	0. 12841	4 0	0	90.00
91.00 Nursing School cost	0	3, 085, 498	0. 00000	0 0	ol	91.00
92.00 Allied health cost	0	3, 085, 498	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 085, 498	0. 00000	0 0	ol	93.00

Health Financial Systems ELKHART (GENERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CC		Peri od:	Worksheet D-3	
			From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
	T' 11	V0/111		5/29/2019 7:1	<u>1 am</u>
Cost Center Description	litie	XVIII Ratio of Cost	Hospital Inpatient	PPS Inpatient	
cost center bescription		To Charges	Program	Program Costs	
		Ĭ	Charges	(col. 1 x col.	
		1.00	0.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00 O3000 ADULTS & PEDI ATRI CS			32, 464, 893		30.00
31.00 03100 INTENSIVE CARE UNIT			7, 809, 843		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 34.00 03400 SURGICAL INTENSIVE CARE UNIT			0		33. 00 34. 00
40. 00 04000 SUBPROVI DER - PF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS	I	0.2/525	12 04/ 045	4 402 274	 E0 00
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM		0. 36525 0. 00000		4, 692, 374 0	50. 00 51. 00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0. 00000		Ö	52.00
53. 00 05300 ANESTHESI OLOGY		0. 00000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 25160			54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.00000		0	55.00
56. 00 05600 RADI 0I SOTOPE 57. 00 05700 CT SCAN		0. 00000 0. 04663		0 286, 605	56. 00 57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 17061		148, 780	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 12298		458, 230	59. 00
60. 00 06000 LABORATORY		0. 21075	3 13, 782, 189	2, 904, 638	60.00
60. 01 06001 BLOOD LABORATORY		0.00000		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	•	0. 00000 0. 00000		0	61. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63.00
64. 00 06400 NTRAVENOUS THERAPY		1. 59295		310, 965	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 24961	7, 147, 112	1, 783, 998	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 65177		687, 953	66. 00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY		0. 42437 0. 53249		324, 262 80, 603	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 00000		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 00000		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 18804		5, 116, 300	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 20579		3, 656, 580	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS		0. 20940 0. 00000		4, 694, 489 0	73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)		0.00000		0	75.00
76. 00 03140 CARDI OLOGY		0. 19264			76. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC		0. 00000 0. 41803		0 370, 695	
90. 01 04950 SLEEP CLINIC		0. 41003		370, 073	90. 01
91. 00 09100 EMERGENCY		0. 46114		1, 629, 799	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 57409	8 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS			-l		
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	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0. 00000		0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS		0. 00000	0 0	0	98. 00
Total (sum of lines 50 through 94 and 96 through			125, 131, 344	28, 676, 108	
201.00 Less PBP Clinic Laboratory Services-Program only 202.00 Net charges (line 200 minus line 201)	cnarges (line 61)		125, 131, 344		201. 00 202. 00
202. 00 Net Glarges (True 200 IIII lius True 201)	I	I	120, 131, 344	ı	₁ 202.00

Heal th	Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C		Peri od:	Worksheet D-3	
			Component		From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 7:1	
			Title	e XVIII	Subprovi der – I PF	PPS	
	Cost Center Description			Ratio of Cost		I npati ent	
				To Charges	Program	Program Costs	
					Charges	(col. 1 x col. 2)	
				1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS				0		30. 00
	03100 I NTENSI VE CARE UNI T				0		31. 00
	03101 NEONATAL INTENSIVE CARE				0		31. 01
	03200 CORONARY CARE UNIT				0		32. 00
	03300 BURN INTENSIVE CARE UNIT				0		33. 00
	03400 SURGICAL INTENSIVE CARE UNIT				0		34.00
	04000 SUBPROVI DER - I PF				1, 087, 614		40.00
41. 00	04100 SUBPROVI DER - I RF				0		41.00
43. 00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS						43. 00
50.00	05000 OPERATING ROOM			0. 36525	5 42, 746	15, 613	50.00
51. 00	05100 RECOVERY ROOM			0.00000		0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM			0.00000	0	0	52. 00
53.00	05300 ANESTHESI OLOGY			0.00000	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C			0. 25160	1 11, 589	2, 916	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C			0.00000	o	0	55. 00
56.00	05600 RADI 0I SOTOPE			0.00000	0 0	0	56. 00
57.00	05700 CT SCAN			0. 04663	4 30, 087	1, 403	57. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)			0. 17061		587	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON			0. 12298	0 0	0	59. 00

0.210753

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1.592958

0.249611

0.651775

0.424379

0.532490

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0. 188043

0.205798

0.209405

0.000000

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0. 192646

0.000000

0.000000

0.418038

0.281254

0.461148

0. 574098

0.000000

0.000000

0.000000

116, 674

38, 248

7,861

4,641

2, 472

8, 822

4, 757

39, 873

8, 190

0

279, 271

482

60.00

61.00 0

64.00

65.00

66.00

67.00

68.00

69.00

71.00

72.00 0

73.00

75.00 0

76.00

88.00

89.00 0

90.00

91.00

92.00

95.00

96.00 0

24, 589

9,547

5, 124

1,970

257

465

58, 481

1, 700

1, 989

18, 387

4, 702

0 90.01

0 94.00

0 97.00

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0 70.00

0 74.00

0 60.01

0 62.00

0 63.00

60.00

60.01

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71.00

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74.00

75.00

76.00

88.00

89.00

90.00

90.01

91.00

92 00

94.00

95.00

96.00

97.00

06000 LABORATORY

06001 BLOOD LABORATORY

06400 I NTRAVENOUS THERAPY

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

09400 HOME PROGRAM DIALYSIS

09500 AMBULANCE SERVICES

07500 ASC (NON-DISTINCT PART)

08800 RURAL HEALTH CLINIC

06600 PHYSI CAL THERAPY

06800 SPEECH PATHOLOGY

06900 FLECTROCARDI OLOGY

07400 RENAL DIALYSIS

03140 CARDI OLOGY

04950 SLEEP CLINIC

09100 EMERGENCY

09000 CLI NI C

06100 PBP CLINICAL LAB SERVICES-PRGM ONLY

06300 BLOOD STORING, PROCESSING & TRANS.

06200 WHOLE BLOOD & PACKED RED BLOOD CELLS

07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

07200 IMPL. DEV. CHARGED TO PATIENTS

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Heal th	Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C	CN: 15-0018	Peri od:	Worksheet D-3	
			Component	CCN: 15-T018	From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 7:1	pared: 1 am
			Ti tl e	e XVIII	Subprovi der - I RF	PPS	
	Cost Center Description			Ratio of Cos	t Inpatient	I npati ent	
				To Charges	Program	Program Costs	
					Charges	(col. 1 x col.	
						2)	
	T			1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			T	_		
	03000 ADULTS & PEDI ATRI CS				0		30.00
	03100 NTENSI VE CARE UNI T				0		31.00
	03101 NEONATAL INTENSIVE CARE				0		31. 01
	03200 CORONARY CARE UNIT				0		32.00
	03300 BURN INTENSIVE CARE UNIT				0		33. 00 34. 00
	03400 SURGI CAL I NTENSI VE CARE UNI T				0		40.00
	04000 SUBPROVI DER - I PF				070 (50		
	04100 SUBPROVI DER - I RF				978, 659		41. 00 43. 00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS						43.00
50 00	05000 OPERATING ROOM			0. 36525	9, 709	3, 546	50.00
	05100 RECOVERY ROOM			0.00000		0, 340	
	05200 DELIVERY ROOM & LABOR ROOM			0.00000		0	
	05300 ANESTHESI OLOGY			0.00000		0	53.00
	05400 RADI OLOGY-DI AGNOSTI C			0. 25160		6, 209	
55. 00	05500 RADI OLOGY-THERAPEUTI C			0.00000		0,20,	55. 00
	05600 RADI OI SOTOPE			0.00000		0	
	05700 CT SCAN			0. 04663		954	
	05800 MAGNETIC RESONANCE I MAGING (MRI)			0. 17061		326	
	05900 CARDI AC CATHETERI ZATI ON			0. 12298		0	
	06000 LABORATORY			0. 21075		20, 459	60.00
60. 01	06001 BLOOD LABORATORY			0.00000	0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.00000	0 0	0	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0.00000	0 0	0	62.00

0.000000

1.592958

0.249611

0.651775

0.424379

0.532490

0.000000

0.000000

0. 188043

0.205798

0.209405

0.000000

0.000000

0. 192646

0.000000

0.000000

0.418038

0. 281254

0.461148

0. 574098

0.000000

0.000000

0.000000

0.000000

0

131, 726

243, 444

213, 988

77, 294

30, 826

15, 988

281, 805

1, 730

30, 642

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1, 181, 284

1, 181, 284

0 63.00

0 70.00

0 74.00

333

0 89.00

0 90.01

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0

0 94.00

0 97.00

0 98.00 436, 256 200.00

12, 810

32,880

90, 812

41, 158

5, 797

3, 290

59, 011

158, 671

64.00

65.00

66.00

67.00

68.00

69.00

71.00

72.00

73.00

0 75.00

76.00

88.00

90.00

91.00

92.00

95.00

0 96.00

201. 00

202.00

63.00

64.00

65.00

66.00

67.00

68.00

69. 00 70. 00

71.00

72.00

73.00

74.00

75.00

76.00

88.00

89.00

90.00

90.01

91.00

92 00

94.00

95.00

97.00

200.00

201. 00 202. 00

06300 BLOOD STORING, PROCESSING & TRANS.

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)

06400 I NTRAVENOUS THERAPY

06500 RESPIRATORY THERAPY

06700 OCCUPATIONAL THERAPY

07000 ELECTROENCEPHALOGRAPHY

07300 DRUGS CHARGED TO PATIENTS

OUTPATIENT SERVICE COST CENTERS

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

07500 ASC (NON-DISTINCT PART)

08800 RURAL HEALTH CLINIC

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

Health Financial Systems	ELKHART GENERAL HOSPITAL		In Li€	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 15-0018	Peri od:	Worksheet D-3	
			From 01/01/2018 To 12/31/2018		
	Ti ·	tle XIX	Hospi tal	5/29/2019 7:1 PPS	ı am
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LNDATI FAIT DOUTLAGE CEDVI CE COCT CENTEDO		1.00	2. 00	3. 00	
30. 00 O3000 ADULTS & PEDIATRICS			16, 865, 311		30.00
31. 00 03100 NTENSI VE CARE UNI T			2, 871, 762		31.00
31. 01 03101 NEONATAL INTENSIVE CARE			1, 421, 264		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 - 1 PF			0		40. 00
41. 00 04100 SUBPROVI DER - RF			0		41. 00
43. 00 04300 NURSERY			620, 747		43. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM		0. 36525	9, 318, 693	3, 403, 699	50.00
51. 00 05100 RECOVERY ROOM		0. 00000		0, 403, 077	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 00000		o o	52. 00
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 25160		472, 870	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 00000	00	0	55. 00
56. 00 05600 RADI 0I SOTOPE		0.00000	00	0	56. 00
57. 00 05700 CT SCAN		0. 04663			57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI)		0. 1706			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 12298			59.00
60. 00 06000 LABORATORY		0. 21075			60.00
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	60. 01 61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		Ö	63. 00
64.00 06400 I NTRAVENOUS THERAPY		1. 59295		482, 996	64.00
65. 00 06500 RESPI RATORY THERAPY		0. 2496	2, 453, 662	612, 461	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 65177	75 177, 019	115, 377	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 42437		l	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 53249			1
69. 00 06900 ELECTROCARDI OLOGY		0.00000		0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 00000 0. 18804		0 4, 117	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 20579		1 4,117	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 20940			73. 00
74.00 07400 RENAL DIALYSIS		0.00000		0	74.00
75.00 07500 ASC (NON-DISTINCT PART)		0. 00000	00	0	75. 00
76. 00 03140 CARDI OLOGY		0. 19264	615, 905	118, 652	76. 00
OUTPATIENT SERVICE COST CENTERS		0.0000	20		
88. 00 08800 RURAL HEALTH CLINIC		0.00000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC		0. 00000 0. 41803		0 127, 226	89. 00 90. 00
90. 00 04950 SLEEP CLINIC		0. 41803		127, 220	90.00
91. 00 09100 EMERGENCY		0. 46114			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 57409		0.2,270	92.00
OTHER REIMBURSABLE COST CENTERS		•	•	•	
94.00 09400 HOME PROGRAM DIALYSIS		0.00000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES					95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.00000		0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0.00000		0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	6 through 00)	0.00000	0 35, 326, 894	0 569 445	98.00
200.00 Total (sum of lines 50 through 94 and 9 201.00 Less PBP Clinic Laboratory Services-Pro		1	აა, ა∠ი, გ94	9, 568, 445	200.00
202.00 Net charges (line 200 minus line 201)	gram only charges (title of)		35, 326, 894		202.00
1 1 1 2 2 3 3 4 (1 1 1 2 2 3 3 1 1 1 1 1 1 1 1 1 1 1 1 1		'	, ,	1	

Health Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der (Peri od: From 01/01/2018	Worksheet D-3	
		Component	CCN: 15-S018	To 12/31/2018		pared: 1 am
		Tit	le XIX	Subprovi der – I PF	PPS	
Cost Center Description			Ratio of Cos To Charges	t Inpatient Program	Inpatient Program Costs (col. 1 x col.	
			1.00	2. 00	2) 3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 NTENSIVE CARE LINIT				0		30. 00 31. 00

Cost Center Description	Ratio of Cost	I npati ent	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	3.00	
30. 00 03000 ADULTS & PEDIATRICS		0)	30. 00
31. 00 03100 NTENSI VE CARE UNI T		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 - 1 PF		1, 951, 537	,	40.00
41. 00 04100 SUBPROVI DER - 1 RF		0)	41. 00
43. 00 04300 NURSERY		0		43.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATING ROOM	0. 365255	12, 962	4, 734	50.00
51. 00 05100 RECOVERY ROOM	0.000000	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0.000000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 251601	20, 378	5, 127	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0.000000	0	0	56.00
57.00 05700 CT SCAN	0. 046634	20, 825	971	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 170615	8, 668	1, 479	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 122980	0	0	59.00
60. 00 06000 LABORATORY	0. 210753	314, 788	66, 343	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	0.000000	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	1. 592958	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 249611	37, 978	9, 480	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 651775	4, 470	2, 913	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 424379	2, 033	863	67. 00
68.00 06800 SPEECH PATHOLOGY	0. 532490	237	126	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. 188043	602	113	71.00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0. 205798	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 209405	310, 660	65, 054	73. 00
74.00 07400 RENAL DI ALYSI S	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. 192646	25, 024	4, 821	76. 00
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0. 000000	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	0	89. 00
90. 00 09000 CLI NI C	0. 418038	3, 264		90. 00
90. 01 04950 SLEEP CLINIC	0. 281254	0	0	90. 01
91. 00 09100 EMERGENCY	0. 461148	140, 273		91. 00
92. 00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 574098	0	0	92. 00
OTHER REIMBURSABLE COST CENTERS	0.000000		J	04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0.000000	Ü	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0.000000	^	,	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0.000000	0	0	96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000 0. 000000	0	0	97. 00 98. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0.000000	000 140	0 228, 075	
200.00 Total (sum of lines 50 through 94 and 96 through 98) 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		902, 162	. 228, 0/5	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 202.00 Net charges (line 200 minus line 201)		902, 162		201. 00 202. 00
202.00 INEL CHAIGES (TITIE 200 IIITIUS TITIE 201)	1	902, 102	:1	202.00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C		Peri od:	Worksheet D-3	
		Component	CCN: 15-T018	From 01/01/2018 To 12/31/2018		pared: 1 am
		Ti tl	e XIX	Subprovi der – I RF	PPS	
Cost Center Description			Ratio of Cos		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 & PEDIATRICS				0		30.00

	Cost Center Description	Ratio of Cost	Inpati ent	Inpatient	
		To Charges	Program Charges	Program Costs (col. 1 x col.	
			charges	2)	
		1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			1	
30.00	03000 ADULTS & PEDI ATRI CS		C		30.00
31. 00 31. 01	03100 NTENSI VE CARE UNIT		C		31.00
32. 00	03101 NEONATAL INTENSIVE CARE 03200 CORONARY CARE UNIT				31. 01 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT		0		33. 00
34. 00	03400 SURGI CAL INTENSI VE CARE UNI T		C		34. 00
40. 00	04000 SUBPROVI DER - I PF		C		40. 00
41.00	04100 SUBPROVI DER - I RF		321, 663	:	41.00
43.00	04300 NURSERY		C)	43. 00
	ANCILLARY SERVICE COST CENTERS				
50. 00	05000 OPERATI NG ROOM	0. 365255	C		50. 00
51. 00	05100 RECOVERY ROOM	0.000000	C	-	51.00
52.00	O5200 DELIVERY ROOM & LABOR ROOM O5200 ANESTURE OF OCC	0.000000	C	0	52.00
53. 00 54. 00	O5300 ANESTHESI OLOGY OF A CHOST I C	0.000000	4 224	1 044	53. 00 54. 00
55. 00	O5400 RADI OLOGY-DI AGNOSTI C O5500 RADI OLOGY-THERAPEUTI C	0. 251601 0. 000000	4, 236	1, 066	55. 00
56. 00	05600 RADI OI SOTOPE	0.000000	C		56. 00
57. 00	05700 CT SCAN	0. 046634	3, 467	1	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 170615	G, 167	l .	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 122980	C	0	59. 00
60.00	06000 LABORATORY	0. 210753	22, 977	4, 842	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	C	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	C	0	61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	C	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0.000000	C	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	1. 592958	01.047	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 249611	21, 247	•	65. 00
66. 00 67. 00	O6600 PHYSI CAL THERAPY O6700 OCCUPATI ONAL THERAPY	0. 651775	80, 062 68, 863	•	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 424379 0. 532490	31, 284	•	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0.000000	31, 204	1	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	ő	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 188043	246		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 205798		0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0. 209405	87, 679	18, 360	1
74.00	07400 RENAL DIALYSIS	0.000000	C	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0.000000	C	0	75. 00
76. 00	03140 CARDI OLOGY	0. 192646	1, 038	200	76. 00
	OUTPATIENT SERVICE COST CENTERS				
88. 00	08800 RURAL HEALTH CLINIC	0.000000	C	1	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	E ///	0	89. 00
90. 00 90. 01	09000	0. 418038 0. 281254	5, 664	2, 368	90. 00 90. 01
91. 00	09100 EMERGENCY	0. 461148	C		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 574098	C		92. 00
72.00	OTHER REIMBURSABLE COST CENTERS	0.07.1070		<u> </u>	72.00
94.00	09400 HOME PROGRAM DI ALYSI S	0.000000	C	0	94. 00
95.00	09500 AMBULANCE SERVI CES				95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0.000000	C	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	C	_	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	C	0	98. 00
200.00			326, 763	130, 411	
201.00			224 742]	201. 00
202.00	Net charges (line 200 minus line 201)	1	326, 763	1	202. 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 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prepared: 5/29/2019 7:11 am

		T: +1 o V/////	Hooni tal	5/29/2019 7:1	1 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
1 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			0	1 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurrin instructions)	g prior to October 1 (s	see	0 25, 088, 184	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurrin instructions)	g on or after October	l (see	7, 687, 462	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for 1 (see instructions)	discharges occurring p	orior to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for October 1 (see instructions)	discharges occurring	on or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			1, 367, 331 0	2. 00 2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructio	ns)		0	2. 02
3. 00 4. 00	Managed Care Simulated Payments Bed days available divided by number of days in the cost report	ing period (see instru	ctions)	0 178. 75	3. 00 4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent cost reporting	period ending on	0.00	5. 00
6. 00	or before 12/31/1996. (see instructions) FTE count for allopathic and osteopathic programs that meet the	criteria for an add-o	n to the cap for	0.00	6. 00
7. 00	new programs in accordance with 42 CFR 413.79(e) MMA Section 422 reduction amount to the IME cap as specified un	der 42 CFR §412.105(f)	(1) (i v) (B) (1)	0. 00	7. 00
7. 01	ACA § 5503 reduction amount to the IME cap as specified under 4 cost report straddles July 1, 2011 then see instructions.	2 CFR §412.105(f)(1)(i	/)(B)(2) If the	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopath affiliated programs in accordance with 42 CFR 413.75(b), 413.79 1998), and 67 FR 50069 (August 1, 2002).			0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slot report straddles July 1, 2011, see instructions.	s under § 5503 of the A	ACA. If the cost	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)				8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines instructions)	(8, 8,01 and 8,02) (s	see	0. 00	9. 00
10. 00 11. 00	FTE count for allopathic and osteopathic programs in the curren FTE count for residents in dental and podiatric programs.	t year from your record	ds	0. 00 0. 00	10. 00 11. 00
12.00	Current year allowable FTE (see instructions)			0.00	12.00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year	ended on or after Sep	tember 30. 1997.	0. 00 0. 00	13. 00 14. 00
15. 00	otherwise enter zero. Sum of lines 12 through 14 divided by 3.				15. 00
16. 00	Adjustment for residents in initial years of the program			0.00	
17. 00	Adjustment for residents displaced by program or hospital closu	re			17. 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	
22. 00	IME payment adjustment (see instructions)			0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422	of the MMA		0	22. 01
23. 00	Number of additional allopathic and osteopathic IME FTE residen $(f)(1)(iv)(C)$.		FR 412. 105	0. 00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lo instructions)	wer of line 23 or line	24 (see	0.00	
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
28.00	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) Disproportionate Share Adjustment			0	29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A pat	ient days (see instruc	tions)	2. 93	30. 00
31.00	Percentage of Medicaid patient days (see instructions)			20. 64	31.00
32.00	Sum of lines 30 and 31			23. 57	32. 00
	Allowable disproportionate share percentage (see instructions)			8. 66	
34.00	Disproportionate share adjustment (see instructions)		ļ	709, 593	34.00

	Financial Systems ELKHART GENER ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0018	Peri od: From 01/01/2018 To 12/31/2018	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/29/2019 7:1	pare
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncompensated Care Adjustment		1. 00	2. 00	
00	Total uncompensated care amount (see instructions)		6 766 695 164	8, 272, 872, 447	35.
01	Factor 3 (see instructions)		0. 000342198	0. 000375517	
02	Hospital uncompensated care payment (If line 34 is zero, en instructions)	nter zero on this line) (se		3, 106, 608	
03 00	Pro rata share of the hospital uncompensated care payment a Total uncompensated care (sum of columns 1 and 2 on line 35	5. 03)	1, 731, 902 2, 514, 938		35. 36.
00	Additional payment for high percentage of ESRD beneficiary Total Medicare discharges on Worksheet S-3, Part I excludin		gh 46) 0		40.
00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, instructions)	683, 684 an 685. (see	0		41.
01	Total ESRD Medicare covered and paid discharges excluding M an 685. (see instructions)	MS-DRGs 652, 682, 683, 684	0		41.
00 00	Divide line 41 by line 40 (if less than 10%, you do not qua Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0. 00 0		42 43
00	<pre>instructions) Ratio of average length of stay to one week (line 43 divide days)</pre>	ed by line 41 divided by 7	0. 000000		44
00	Average weekly cost for dialysis treatments (see instruction	ons)	0.00		45
00	Total additional payment (line 45 times line 44 times line	41.01)	0		46
00	Subtotal (see instructions)		37, 367, 508		47
00	Hospital specific payments (to be completed by SCH and MDH,	small rural hospitals	0		48
	only. (see instructions)			Amount	
				1. 00	
00	Total payment for inpatient operating costs (see instruction	ons)		37, 367, 508	49
00	Payment for inpatient program capital (from Wkst. L, Pt. I	and Pt. II, as applicable)		2, 873, 468	50
00	Exception payment for inpatient program capital (Wkst. L, P			0	51
00	Direct graduate medical education payment (from Wkst. E-4,	line 49 see instructions).		0	52
00	Nursing and Allied Health Managed Care payment			18, 407	
00	Special add-on payments for new technologies			0	
01 00	Islet isolation add-on payment Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line	. 40)		0	54
00	Cost of physicians' services in a teaching hospital (see in	*		0	56
00	Routine service other pass through costs (from Wkst. D, Pt.		hrough 35)	0	57
00	Ancillary service other pass through costs from Wkst. D, Pt		3 3 3	11, 575	58
00	Total (sum of amounts on lines 49 through 58)			40, 270, 958	59
00] 3 1 3 1 3			0	
00	Total amount payable for program beneficiaries (line 59 min	nus line 60)		40, 270, 958	
00	Deductibles billed to program beneficiaries			3, 570, 188	
00				30, 485 358, 195	
00				358, 195 232, 827	
00	Allowable bad debts for dual eligible beneficiaries (see in	nstructions)		63, 826	1
00	Subtotal (line 61 plus line 65 minus lines 62 and 63)	· - · - · - · · · · · · · · · · · ·		36, 903, 112	
00	Credits received from manufacturers for replaced devices for	or applicable to MS-DRGs (s	ee instructions)	0	
00	Outlier payments reconciliation (sum of lines 93, 95 and 96	b).(For SCH see instruction	s)	0	
00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	1
50	Rural Community Hospital Demonstration Project (§410A Demon		instructions)	0	70
87	Demonstration payment adjustment amount before sequestration			0	1
88	SCH or MDH volume decrease adjustment (contractor use only)			0	70
89 90	Pioneer ACO demonstration payment adjustment amount (see in HSP bonus payment HVBP adjustment amount (see instructions)			0	
91	HSP bonus payment HRR adjustment amount (see instructions)			0	
92	Bundled Model 1 discount amount (see instructions)			0	1
	HVBP payment adjustment amount (see instructions)			90, 504	1
93	Tivor payment aujustment amount (see mistructions)				
93 94	HRR adjustment amount (see instructions)			-57, 297	

Health Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der C	CN: 15-0018	Peri od: From 01/01/2018 To 12/31/2018	Worksheet E Part A Date/Time Prep 5/29/2019 7:1	pared: 1 am
		Ti tl e	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	

			To 12/31/2018	Date/Time Pre 5/29/2019 7:1	
	Title	e XVIII	Hospi tal	PPS	
		FFY	(уууу)	Amount	
			0	1.00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter i	n column O		0	0	70. 96
the corresponding federal year for the period prior to 10/1)	n oolmn 0		0	0	70.07
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or af			0	0	70. 97
70. 98 Low Volume Payment-3	ter 10/1)			0	70. 98
70. 99 HAC adjustment amount (see instructions)				0	1
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			36, 936, 319	1
71.01 Sequestration adjustment (see instructions)				738, 726	1
71.02 Demonstration payment adjustment amount after sequestration				0	71. 02
72.00 Interim payments				35, 950, 596	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, 71.0)	2, 72, and			246, 997	74. 00
73)					
75.00 Protested amounts (nonallowable cost report items) in accordance	nce with			478, 866	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, or sum of	of 2 02	T		0	90.00
plus 2.04 (see instructions)	01 2.03			U	90.00
91.00 Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92.00 Operating outlier reconciliation adjustment amount (see instru	uctions)			0	92.00
93.00 Capital outlier reconciliation adjustment amount (see instruction)				0	93. 00
94.00 The rate used to calculate the time value of money (see instru				0.00	1
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 instruc	tions)			0	96. 00
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
HSP Bonus Payment Amount				0	100.00
100.00 HSP bonus amount (see instructions)			0	0	100. 00
HVBP Adjustment for HSP Bonus Payment 101.00 HVBP adjustment factor (see instructions)			1. 0030031864	1. 0019720986	101 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions	e)		1.0030031804		101.00
HRR Adjustment for HSP Bonus Payment	3)		0	0	102.00
103.00 HRR adjustment factor (see instructions)			0. 9979	0. 9994	103 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions))		0. ,,,,		104. 00
Rural Community Hospital Demonstration Project (§410A Demonstr		ustment			
200.00 Is this the first year of the current 5-year demonstration per					200. 00
Century Cures Act? Enter "Y" for yes or "N" for no.					
Cost Reimbursement					
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line	e 49)				201. 00
202.00 Medicare discharges (see instructions)					202. 00
203.00 Case-mix adjustment factor (see instructions)	61 .	6 11			203. 00
Computation of Demonstration Target Amount Limitation (N/A in	first year	of the curren	t 5-year demonst	ration	
peri od) 204.00 Medi care target amount					204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)					204.00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)					206. 00
Adjustment to Medicare Part A Inpatient Reimbursement					200.00
207. 00 Program reimbursement under the §410A Demonstration (see inst	ructions)				207. 00
208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A,					208. 00
209.00 Adjustment to Medicare IPPS payments (see instructions)	,				209. 00
210.00 Reserved for future use					210. 00
210. 00 Neser ved 101 Tature use					
211. 00 Total adjustment to Medicare IPPS payments (see instructions)					211. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement					
211.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 1	211)				212. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 213.00 Low-volume adjustment (see instructions)					212. 00 213. 00
211.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 1		nbursement)			212. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lieu of Form CMS-2552-1	10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0	0018	: :

			10 12/01/2010	5/29/2019 7: 1	1 am
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			20, 594	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		27, 454, 208	2.00
3.00	OPPS payments			21, 248, 767	3.00
4.00	Outlier payment (see instructions)			262, 826	4.00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		20, 722	9. 00
10.00	Organ acquisitions			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			20, 594	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
12.00	Ancillary service charges			98, 346	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)	•		98, 346	14.00
	Customary charges				
15.00	Aggregate amount actually collected from patients liable for p	payment for services on a	a charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e		3		
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	,		0.000000	17. 00
18.00	Total customary charges (see instructions)			98, 346	18. 00
19.00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds lin	ne 11) (see	77, 752	
	instructions)		, ,		
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds lin	ne 18) (see	0	20. 00
	instructions)				
21.00	Lesser of cost or charges (see instructions)			20, 594	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, 532, 315	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions	5)		0	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line	e 24 (for CAH, see instru	uctions)	3, 827, 469	26.00
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, 725, 440	27. 00
	instructions)				
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			17, 725, 440	30.00
31. 00	Primary payer payments			4, 501	31.00
32.00	Subtotal (line 30 minus line 31)			17, 720, 939	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)			770, 723	
35. 00	Adjusted reimbursable bad debts (see instructions)			500, 970	35. 00
36. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		555, 174	36. 00
37. 00	Subtotal (see instructions)			18, 221, 909	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			80	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			18, 221, 829	40.00
40. 01	Sequestration adjustment (see instructions)			364, 437	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
41.00	Interim payments			17, 870, 344	41.00
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			-12, 952	43.00
44.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2, o	chapter 1,	0	44. 00
	§115. 2		·		
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92.00	The rate used to calculate the Time Value of Money			0.00	
93. 00	Time Value of Money (see instructions)			0	
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems ELKANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0018

					5/29/2019 7: 11	1 am
		Title	XVIII	Hospi tal	PPS	
		Inpatient Part A		Part 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		35, 950, 59	6	17, 820, 044	1. 00
2.00	Interim payments payable on individual bills, either			o	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)					
0.04	Program to Provider			05 (04 (0040	F0.000	0.04
3. 01	ADJUSTMENTS TO PROVIDER			0 05/24/2018	50, 300	3. 01
3. 02 3. 03				0	0 0	3. 02 3. 03
3. 03				0		3. 03
3.04				0		3. 04
3.03	Provider to Program			<u> </u>	0	3. 03
3. 50	ADJUSTMENTS TO PROGRAM			ol	0	3. 50
3. 51	ADSOSTMENTS TO TROOK IIII			0	0	3. 51
3. 52				Ö	l ol	3. 52
3. 53				Ö	l ol	3. 53
3.54				Ö	0	3. 54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			o	50, 300	3. 99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		35, 950, 59	6	17, 870, 344	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER			ol	0	5. 01
5. 02	TENTITY E TO TROVIDER			o	0	5. 02
5. 03				Ö	l ol	5. 03
	Provider to Program			-1		
5.50	TENTATI VE TO PROGRAM			0	0	5. 50
5.51				o	0	5. 51
5.52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6. 00
. 01	the cost report. (1)		04/ 00	_		/ 01
6. 01	SETTLEMENT TO PROVIDER		246, 99		0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	12, 952	6. 02
7. 00	Total Medicare program liability (see instructions)		36, 197, 59	Contractor	17, 857, 392 NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	
8. 00	Name of Contractor				2.00	8. 00
				1		

Component CCN: 15-S018

Title XVIII

		Title	XVIII	Subprovi der - I PF	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero		454, 945 0		0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
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			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		0		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		454, 945		0	4. 00
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5. 00
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02	IENTATIVE TO TROVIDER		0		0	5. 02
5. 03			Ö		Ö	5. 02
	Provider to Program			I.		
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		16, 840		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		471, 785		0	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
	In the second second	()	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

Component CCN: 15-T018

Title XVIII

		Title	e XVIII	Subprovi der - I RF	PPS	
		Inpatien	it 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		1, 159, 528		0	
2.00	Interim payments payable on individual bills, either		()	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
0.00	amount based on subsequent revision of the interim rate					0.00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)]
0.04	Program to Provider		ı ,	\ \	1 0	
3. 01 3. 02	ADJUSTMENTS TO PROVIDER		(0	
3. 02					0	
3. 04					0	
3. 05					Ö	
	Provider to Program			1		
3.50	ADJUSTMENTS TO PROGRAM		()	0	
3. 51			(0	
3. 52			(0	
3. 53 3. 54					0 0	
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	
3. 77	3. 50-3. 98)					3. 77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		1, 159, 528	3	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					1
Г 00	TO BE COMPLETED BY CONTRACTOR		ı		ı	F 00
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none,					5. 00
	write "NONE" or enter a zero. (1)					
	Program to Provider			1	·	1
5.01	TENTATI VE TO PROVI DER		()	0	5. 01
5.02			(0	
5. 03			()	0	5. 03
5. 50	Provider to Program TENTATIVE TO PROGRAM			1	0	5. 50
5. 50	TENTATIVE TO PROGRAW				0	
5. 52					Ö	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines				Ō	
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6. 00
<i>(</i> 01	the cost report. (1)				0	/ 01
6. 01 6. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		13, 840		0	
7. 00	Total Medicare program liability (see instructions)		1, 145, 688		0	
	, , , , , , , , , , , , , , , , , , , ,		.,	Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
0.00		(<u></u>	1. 00	2. 00	
8.00	Name of Contractor				l	8. 00

Heal th	Financial Systems ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0018	Peri od:	Worksheet E-1	
			From 01/01/2018 To 12/31/2018		
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				_
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	2 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				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				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	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
	line 168				
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)			9. 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	.00 Other Adjustment (specify)				
22 00	Delenes due provider (line 0 (en line 10) minus line 20 and l	ing 21) (and instruction)		22 00

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

30. 00 31. 00 32. 00

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
	Component CCN: 15-S018	From 01/01/2018	
	Component Con. 15-3016	10 12/31/2016	5/29/2019 7:11 am
	Title XVIII	Subprovi der -	PPS
		IPF	

	IPF		
	DATE HE MEDICADE DATE A CEDIMORG. LDE DOC	1.00	
1 00	PART II - MEDICARE PART A SERVICES - IPF PPS Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	475 105	1 00
1. 00 2. 00		475, 135	1. 00 2. 00
3. 00	Net IPF PPS Outlier Payments Net IPF PPS ECT Payments	76, 898 0	3. 00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0.00	4. 00
4.00	15, 2004. (see instructions)	0.00	4.00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	4. 01
	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)		
5.00	New Teaching program adjustment. (see instructions)	0.00	5.00
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 instuctions)		
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
	teaching program" (see instuctions)		
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	
9. 00	Average Daily Census (see instructions)	8. 328767	
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0. 000000	
11.00	Teaching Adjustment (line 1 multiplied by line 10).	0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)	552, 033	
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13.00
14.00	Organ acquisition (DO NOT USE THIS LINE)	0	14.00
15. 00 16. 00	Cost of physicians' services in a teaching hospital (see instructions)	552, 033	
17. 00	Subtotal (see instructions) Primary payer payments	552, 033	17. 00
18. 00	Subtotal (line 16 less line 17).	552, 033	
19. 00	Deductibles	61, 640	
20. 00	Subtotal (line 18 minus line 19)	490, 393	
21. 00	Coi nsurance	26, 130	
22. 00	Subtotal (line 20 minus line 21)	464, 263	
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	26, 183	
24. 00	Adjusted reimbursable bad debts (see instructions)	17, 019	
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	3, 931	
26. 00	Subtotal (sum of lines 22 and 24)	481, 282	
27. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	27. 00
28. 00	Other pass through costs (see instructions)	131	
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)	481, 413	31.00
31. 01	Sequestration adjustment (see instructions)	9, 628	
31. 02	Demonstration payment adjustment amount after sequestration	0	31. 02
32. 00	Interim payments	454, 945	
33. 00	Tentative settlement (for contractor use only)	0	
34. 00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)	16, 840	
35. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	35. 00
	§115. 2		
FO 00	TO BE COMPLETED BY CONTRACTOR	77, 000	FO 00
50.00		76, 898	
51.00	Outlier reconciliation adjustment amount (see instructions)	0 00	51.00
52.00	The rate used to calculate the Time Value of Money	0.00	
55.00	Time Value of Money (see instructions)	١	53. 00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL			In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CO		Peri o		Worksheet E-3
				From	01/01/2018	Part III
		Component (CCN: 15-T018	To	12/31/2018	Date/Time Prepared:
						5/29/2019 7:11 am
		Title	e XVIII	Subp	rovi der -	PPS
				•	LDE	

	IRF	113	
	DADT LLL MEDICADE DADT A SERVICES LDE DDS	1. 00	
1. 00	PART III - MEDICARE PART A SERVICES - IRF PPS Net Federal PPS Payment (see instructions)	974, 191	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0070	2. 00
3. 00	Inpatient Rehabilitation LIP Payments (see instructions)	42, 670	3. 00
4. 00	Outlier Payments	158, 053	4. 00
5. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5. 00
	to November 15, 2004 (see instructions)		
5.01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
	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)		
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 period of a "new	0. 00	7. 00
	teaching program" (see instructions)		
8.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0. 00	8. 00
9. 00	teaching program" (see instructions)	0.00	9. 00
10.00	Intern and resident count for IRF PPS medical education adjustment (see instructions) Average Daily Census (see instructions)	4. 147945	
11. 00	Teaching Adjustment Factor (see instructions)	0. 000000	11. 00
12. 00	Teaching Adjustment (see instructions)	0.000000	12. 00
13. 00	Total PPS Payment (see instructions)	1, 174, 914	13. 00
14. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14. 00
15. 00	Organ acquisition (DO NOT USE THIS LINE)	-	15. 00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17. 00	Subtotal (see instructions)	1, 174, 914	17.00
18.00	Primary payer payments	0	18.00
19. 00	Subtotal (line 17 less line 18).	1, 174, 914	19.00
20.00	Deducti bl es	6, 700	20.00
21. 00	Subtotal (line 19 minus line 20)	1, 168, 214	21. 00
22. 00	Coi nsurance	0	22. 00
23. 00	Subtotal (line 21 minus line 22)	1, 168, 214	23. 00
24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	1, 316	24. 00
25. 00	Adjusted reimbursable bad debts (see instructions)	855	25. 00
26. 00 27. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	1, 316	26. 00
28. 00	Subtotal (sum of lines 23 and 25) Direct graduate medical education payments (from Wkst. E-4, line 49)	1, 169, 069 0	27. 00 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)	ő	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	ő	31. 50
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32.00	Total amount payable to the provider (see instructions)	1, 169, 069	32.00
32. 01	Sequestration adjustment (see instructions)	23, 381	32. 01
32. 02	Demonstration payment adjustment amount after sequestration	0	32.02
33.00	Interim payments	1, 159, 528	33.00
34.00	Tentative settlement (for contractor use only)	0	34.00
35. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	-13, 840	35.00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	36. 00
	§115. 2		
EO 00	TO BE COMPLETED BY CONTRACTOR	150 053	EO 00
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4 Outlier reconciliation adjustment amount (see instructions)	158, 053 0	50. 00 51. 00
52. 00	The rate used to calculate the Time Value of Money	-	52. 00
	Time Value of Money (see instructions)	0.00	53. 00
55.50	1	۲	-0.00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCI	From 01/01/2018 To 12/31/2018	Worksheet E-3 Part VII Date/Time Prepared: 5/29/2019 7:11 am

PART_VIIOLICIDATION_OF_RET_NUMBER_SERVICES				10 12/31/2018	5/29/2019 7:1	
PART VII - CALCULATION OF REIMBURSEURNT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES			Title XIX	Hospi tal		
PART VIT - CARCULATION OF RET INSUSSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 1.0						
COMPUTATION OF NET COST OF COVERED SERVICES 1.00 1.0		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XIX	X SERVICES		
Inpatient hospital/SNF/NF services		COMPUTATION OF NET COST OF COVERED SERVICES				1
Medical and other services	1.00			0		1.00
Subtotal (sum of lines 1, 2 and 3)	2.00	Medical and other services			0	2. 00
Inpati ent primary payer payments	3.00	Organ acquisition (certified transplant centers only)		0		3. 00
0	4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
Subtotal (Line 4 less sum of lines 5 and 6)	5.00	Inpatient primary payer payments		0		5. 00
COMPUTATION OF LESSER OF COST OR CHARGES	6.00	Outpatient primary payer payments			0	6. 00
Reasonable Charges	7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
Routine service charges 0 8.00 0.00 Routine service charges 0 0.00 0.00 Routine service charges 0 0.00 0		COMPUTATION OF LESSER OF COST OR CHARGES				
9.00 Ancil Ilary service charges 35, 326,894 0 9.00		Reasonabl e Charges				
10.00 Organ acquisition charges, net of revenue 0 10.0		Routine service charges		0		
11.00 Incentive from target amount computation 35, 326, 894 012.00 CUSTOMARY CHARGES 0 35, 326, 894 012.00 CUSTOMARY CHARGES 0 0 0 0 0 0 0 0 0	9.00			35, 326, 894	0	9. 00
12. 00 Total reasonable charges (sum of lines 8 through 11) 12. 00 25. 00 25. 00 25. 00 25. 00 25. 00 27. 00	10.00			0		10.00
CUSTOMARY CHARGES 0 0 13.00				0		
13. 00 Amount actually collected from patients liable for payment for services on a charge 0 0 13. 00	12. 00			35, 326, 894	0	12. 00
basis						
14.00 Amounts that would have been realized from patients Liable for payment for services on a large basis had such payment been made in accordance with 42 CFR §413.13(e) 0.0000000 0.0000000 0.00000000	13. 00		r services on a charge	0	0	13. 00
a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 16.00 Rio of Tine 13 to Tine 14 (not to exceed 1.000000) 17.00 Total customary charges (see instructions) 18.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 35, 326, 894 0 17.00 line 4) (see instructions) 18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 Interns and Residents (see instructions) 19.00 Interns and Residents (see instructions) 19.00 Cost of physic ians' services in a teaching hospital (see instructions) 10.00 Cost of physic ians' services in a teaching hospital (see instructions) 10.00 Cost of covered services (enter the lesser of line 4 or line 16) 10.00 ReOSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22.00 Other than outlier payments 23.00 Outlier payments 24.00 Program capital payments 25.00 Capital exception payments (see instructions) 26.00 Routlier payments 27.00 Capital exception payments (see instructions) 28.00 Customary charges (tilte V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 22 through 26) 20.00 Excess of reasonable cost (from line 18) 20.00 Excess of reaso						
15.00	14. 00			0	0	14.00
16.00 Total customary charges (see instructions) 35, 326, 894 0 16.00	15 00		12 CFR §413.13(e)	0.000000	0.000000	15 00
17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 15, 326,894 0 17.00		,				
18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 0 0 18.00			wifling 1/ avacada			
18.00 Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 16) (see instructions) 19.00 19.00 10.0	17.00		y II II ne 16 exceeds	35, 326, 894	Ü	17.00
16) (see instructions)	10 00		vifling 4 exceeds line	0	0	10 00
19. 00	10.00		y II IIIle 4 exceeds IIIle	U	Ü	10.00
20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 20.00	19 00			0	0	19 00
21.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 21.00			cuctions)	_	-	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers. 22.00 10				_	-	
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 5,769 0 26.00 27.00 Subtotal (sum of lines 22 through 26) 5,769 0 26.00 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) 5,769 0 29.00 29.00 Titles V or XIX (sum of lines 21 and 27) 5,769 0 29.00 30.00 Excess of reasonable cost (from line 18) 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 5,769 0 31.00 32.00 Deductibles 0 0 32.00 33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00	21.00					21.00
23.00 Outlier payments	22 00		Compressed for 110 provide		0	22 00
24.00 Program capital payments 0 24.00		1 3		0		
25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT COMPUTATION OF REIMBURSEMENT SETTLEMENT 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 30.00 Coinsurance 31.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Uniterim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 5,769 5,769 7,769				0		
26. 00 Routine and Ancillary service other pass through costs 7. 769 7. 700 8. 00 Lottotal (sum of lines 22 through 26) 8. 00 Customary charges (title V or XIX PPS covered services only) 7. 1 tles V or XIX (sum of lines 21 and 27) 8. 00 CoMPUTATION OF REIMBURSEMENT SETTLEMENT 8. 0		9 1 3		0		25. 00
27. 00 Subtotal (sum of lines 22 through 26) 5,769 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) 5,769 0 29. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 5,769 0 31. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 5,769 0 31. 00 32. 00 Deductibles 0 0 0 32. 00 34. 00 Allowable bad debts (see instructions) 0 0 34. 00 35. 00 Utilization review 0 0 35. 00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 5,769 0 36. 00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 5,769 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) 5,769 0 40. 00 41. 00 Interim payments 0 0 41. 00 42. 00 Bal ance due provider/program (line 40 minus line 41) 5,769 0 743. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00				5, 769	0	26. 00
29.00 Titles V or XIX (sum of lines 21 and 27) 5,769 0 29.00				5, 769	0	27. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 5,769 0 31.00 32.00 Deductibles 0 0 0 32.00 33.00 Coinsurance 0 0 0 34.00 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) 5,769 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 5,769 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) 5,769 0 40.00 41.00 Interim payments 0 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 5,769 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
30.00 Excess of reasonable cost (from line 18) 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles 33.00 Coinsurance 34.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 30.00 30.00 0 0 32.00 0 0 32.00 0 0 33.00 0 0 0 343.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29.00	Titles V or XIX (sum of lines 21 and 27)		5, 769	0	29. 00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32.00 Deductibles Coinsurance Allowable bad debts (see instructions) Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) Total amount payable to the provider (sum of lines 38 and 39) 41.00 Total amount payable to the provider (sum of lines 38 and 39) 42.00 Balance due provider/program (line 40 minus line 41) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 5, 769 0 31.00 0 32.00 0 33.00 0 34.00 0 35.00 35.00 35.00 35.00 36.00 37.00 37.00 38.00 39.00 10 protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 31.00 0 32.00 0 32.00 0 32.00 0 33.00 0 33.00 0 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 35.00 36.00 37.		COMPUTATION OF REIMBURSEMENT SETTLEMENT				
32.00 Deductibles 0 0 32.00 33.00 Coinsurance 0 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 5,769 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 5,769 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) 5,769 0 40.00 41.00 Interim payments 0 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 5,769 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	30.00	Excess of reasonable cost (from line 18)		0	0	30. 00
33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 0 35.00 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 5,769 0 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38.00 Subtotal (line 36 ± line 37) 5,769 0 38.00 Subtotal (line 36 ± line 37) 5,769 0 39.00 Direct graduate medical education payments (from Wkst. E-4) 0 39.00 Total amount payable to the provider (sum of lines 38 and 39) 5,769 0 40.00 Interim payments 0 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 5,769 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00	31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6))	5, 769	0	31. 00
34. 00 Allowable bad debts (see instructions)	32.00	Deducti bl es		0	0	32. 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) 5, 769 0 36. 00 0THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37. 00 38. 00 Subtotal (line 36 ± line 37) 5, 769 0 38. 00 Direct graduate medical education payments (from Wkst. E-4) 0 39. 00 Total amount payable to the provider (sum of lines 38 and 39) 5, 769 0 40. 00 Interim payments 0 41. 00 Interim payments 0 41. 00 Balance due provider/program (line 40 minus line 41) 5, 769 0 42. 00 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43. 00				0		
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 36.00 0 37.00 0 36.00 0 37.00 37.00 5,769 0 38.00 39.00 5,769 0 41.00 41.00 42.00 43.00				0	0	
37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 39. 00 39. 00 40. 00 41. 00 41. 00 42. 00 43. 00				0		
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 5,769 0 38.00 39.00 5,769 0 40.00 41.00 42.00 43.00			d 33)	5, 769		
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 5,769 0 40.00 41.00 Interim payments 0 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 7,769 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				0		
40.00 Total amount payable to the provider (sum of lines 38 and 39) 5,769 0 40.00 41.00 Interim payments 0 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 5,769 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				5, 769	0	
41.00 Interim payments 0 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 5,769 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				0		
42.00 Balance due provider/program (line 40 minus line 41) 5,769 0 42.00 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				·		
43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00		1 3		- C		
Cnapter 1, 9115.2	43. 00		nce with CMS Pub 15-2,	0	0	43.00
		[Chapter 1, 9115.2				I

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0018	Peri od: From 01/01/2018	Worksheet E-3
	Component CCN: 15-S018		
	Title XIX	Subprovi der -	PPS
		IPF	

		' IPF		
		I npati 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	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	4.00
5.00	Inpatient primary payer payments	o		5.00
6.00	Outpatient primary payer payments		0	6.00
7.00	Subtotal (line 4 less sum of lines 5 and 6)	o	0	7.0
	COMPUTATION OF LESSER OF COST OR CHARGES			1
	Reasonable Charges			
8.00	Routine service charges	0		8.0
9.00	Ancillary service charges	902, 162	0	9.00
10.00	Organ acquisition charges, net of revenue	o		10.0
11. 00	Incentive from target amount computation	o		11.0
12. 00	Total reasonable charges (sum of lines 8 through 11)	902, 162	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	o	0	14.00
	a charge basis had such payment been made in accordance with 42 CFR §413.13(e)			
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)	902, 162	0	16.0
17.00	Excess of customary charges over reasonable cost (complete only if line 16 exceeds	902, 162	0	17.0
	line 4) (see instructions)			
18.00	Excess of reasonable cost over customary charges (complete only if line 4 exceeds line	o	0	18.0
	16) (see instructions)			
19. 00	Interns and Residents (see instructions)	0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instructions)	0	0	20.0
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)	0	0	21.0
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS provide	rs.		
22. 00	Other than outlier payments	0	0	22. 0
23. 00	Outlier payments	0	0	23. 0
24.00	Program capital payments	0		24.0
25. 00	Capital exception payments (see instructions)	0		25. 0
26. 00	Routine and Ancillary service other pass through costs	459	0	26. 0
27. 00	Subtotal (sum of lines 22 through 26)	459	0	27. 0
28. 00	Customary charges (title V or XIX PPS covered services only)	0	0	28. 0
29. 00	Titles V or XIX (sum of lines 21 and 27)	459	0	29. 0
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			
30.00	Excess of reasonable cost (from line 18)	0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)	459	0	31.0
32.00	Deducti bl es	o	0	32.0
33.00	Coinsurance	o	0	33.0
34.00	Allowable bad debts (see instructions)	o	0	34.0
35.00	Utilization review	o		35.0
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	459	0	36.0
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	o	0	37.0
	Subtotal (line 36 ± line 37)	459	0	38. 0
	Direct graduate medical education payments (from Wkst. E-4)	o		39.0
40.00	Total amount payable to the provider (sum of lines 38 and 39)	459	0	
41.00	Interim payments	0	0	
42. 00	Balance due provider/program (line 40 minus line 41)	459	0	
43. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	0	0	1
	chapter 1, §115.2	1	-	1

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0018 Component CCN: 15-T018	From 01/01/2018	
	Title XIX	Subprovi der -	PPS

		litle XIX	Subprovi der -	PPS		
			I RF	0+no+: on+		
			Inpatient 1.00	Outpati ent 2. 00		
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI	CES EOD TITLES V OD VIV		2.00		
	COMPUTATION OF NET COST OF COVERED SERVICES					
1. 00	Inpati ent hospi tal /SNF/NF servi ces		0		1.00	
2. 00	Medical and other services			0		
3.00	Organ acquisition (certified transplant centers only)		0	ŭ	3. 00	
4. 00	Subtotal (sum of lines 1, 2 and 3)		o	0	1	
5.00	Inpatient primary payer payments		0		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		326, 763	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)		326, 763	0	12. 00	
	CUSTOMARY CHARGES					
13. 00	Amount actually collected from patients liable for payment for s	services on a charge	0	0	13. 00	
	basis					
14. 00	Amounts that would have been realized from patients liable for p	3	0	0	14. 00	
15 00	a charge basis had such payment been made in accordance with 42	CFR §413. 13(e)	0. 000000	0.000000	15. 00	
15. 00 16. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		326, 763	0. 000000	1	
17. 00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	if line 14 exceeds		0	1	
17.00	line 4) (see instructions)	II IIIe 16 exceeds	326, 763	U	17.00	
18. 00	Excess of reasonable cost over customary charges (complete only	if line 4 exceeds line	o	0	18. 00	
10.00	16) (see instructions)	TT TTHE 4 CACCEGS TTHE		O	10.00	
19. 00	Interns and Residents (see instructions)		o	0	19. 00	
	Cost of physicians' services in a teaching hospital (see instruc	ctions)	o	0	1	
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 co	ompleted for PPS provide	rs.		1	
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	26. 00	
	Subtotal (sum of lines 22 through 26)		0	0		
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0		
29. 00	,		0	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)		0	0		
32. 00	Deducti bl es		0	0		
	Coinsurance		0	0		
34. 00	Allowable bad debts (see instructions)		0	0		
	Utilization review		0	_	35. 00	
	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	0	0		
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0		
38. 00	Subtotal (line 36 ± line 37)		0	0		
	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00	
40.00	1		0	0		
41. 00	Interim payments		0	0		
42. 00	Balance due provider/program (line 40 minus line 41)	a with CMC Dub 1E 2	0	0		
43. 00	Protested amounts (nonallowable cost report items) in accordance	e with two Pub 15-2,	0	0	43. 00	
	chapter 1, §115.2		1		I	

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 01/01/2018
To 12/31/2018 Date/Ti me Prepared: 5/29/2019 7:11 am

OH y)					5/29/2019 7:1	1 am
	·	General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund			
		1.00	2. 00	3. 00	4. 00	
	CURRENT ASSETS					
1.00	Cash on hand in banks	13, 337, 000	0	0	0	1. 00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes receivable	0	0	o	0	3. 00
4.00	Accounts receivable	67, 013, 000	0	o	0	4. 00
5.00	Other recei vable	1, 909, 000		ol	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-19, 065, 000		ol	0	6. 00
7. 00	Inventory	6, 970, 000		ol	0	7. 00
8. 00	Prepaid expenses	1, 348, 000		ő	0	8. 00
9. 00	Other current assets	1, 540, 000	0	0	Ö	9. 00
10.00	Due from other funds		0	0	0	10.00
		71 510 000		-		
11. 00	Total current assets (sum of lines 1-10)	71, 512, 000	0	0	0	11. 00
40.00	FI XED ASSETS	0.044.000		اء		40.00
12. 00	Land	3, 846, 000		0	0	12.00
13. 00	Land improvements	0	0	0	0	13. 00
14. 00	Accumulated depreciation	0	0	0	0	14. 00
15. 00	Bui I di ngs	254, 069, 000		이	0	15. 00
16. 00	Accumul ated depreciation	-195, 121, 000	0	0	0	16. 00
17.00	Leasehold improvements	0	0	0	0	17. 00
18.00	Accumul ated depreciation	0	0	0	0	18. 00
19.00	Fi xed equipment	117, 263, 000	0	0	0	19. 00
20.00	Accumulated depreciation	0	0	ol	0	20. 00
21.00	Automobiles and trucks	l o	0	ol	ol	21. 00
22. 00	Accumul ated depreciation	0	0	o	0	22. 00
23. 00	Major movable equipment	0	0	ol	0	23. 00
24. 00	Accumul ated depreciation	1	Ö	٥	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0		0	Ö	25. 00
26. 00	Accumulated depreciation			o	0	26. 00
	•			0	0	27. 00
27. 00	HIT designated Assets		0	o o		
28. 00	Accumulated depreciation	0	0	U O	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	180, 057, 000	0	0	0	30. 00
	OTHER ASSETS	_		_1	_	
31. 00	Investments	0		0	0	31. 00
32. 00	Deposits on Leases	0	0	0	0	32. 00
33. 00	Due from owners/officers	0	0	0	0	33. 00
34.00	Other assets	6, 365, 000	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	6, 365, 000	6, 580, 000	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	257, 934, 000	6, 580, 000	0	0	36. 00
	CURRENT LI ABI LI TI ES					
37.00	Accounts payable	23, 426, 000	0	0	0	37. 00
38.00	Salaries, wages, and fees payable	0		ol	0	38. 00
39. 00	Payroll taxes payable	0	0	o	0	39. 00
40. 00	Notes and Loans payable (short term)	2, 844, 000	0	ol	0	40. 00
41. 00	Deferred income	2,011,000	Ŏ	ő	0	41. 00
42. 00	Accel erated payments	0		ď	١	42. 00
43. 00	Due to other funds		0		0	43. 00
44. 00	Other current liabilities	473, 000		0	0	
				-		
45. 00	Total current liabilities (sum of lines 37 thru 44)	26, 743, 000	0	0	0	45. 00
47 00	LONG TERM LIABILITIES	1 0		ما		47 00
46. 00	Mortgage payable	0		0	0	
47. 00	Notes payable	0		0	0	
48. 00	Unsecured Loans	0		0	0	48. 00
49. 00	Other long term liabilities	70, 023, 000		0	0	49. 00
50. 00	Total long term liabilities (sum of lines 46 thru 49)	70, 023, 000		0	0	50. 00
51.00	Total liabilities (sum of lines 45 and 50)	96, 766, 000	0	0	0	51. 00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	161, 168, 000				52.00
53.00	Specific purpose fund		6, 580, 000			53. 00
54.00	Donor created - endowment fund balance - restricted			o		54.00
55. 00	Donor created - endowment fund balance - unrestricted			o		55. 00
56. 00	Governing body created - endowment fund balance			ol		56. 00
57. 00	Plant fund balance - invested in plant			Ĭ	0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
50.00	replacement, and expansion				١	30.00
59. 00	Total fund balances (sum of lines 52 thru 58)	161, 168, 000	6, 580, 000	o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	257, 934, 000		o	0	
00.00	[59]	237, 734, 000	0, 360, 000	٩	ا	00.00
	1/	1	1	'	!	1

Provider CCN: 15-0018

					10 12/31/2018	5/29/2019 7:1	
	·	General	Fund	Speci al	Purpose Fund	Endowment Fund	ı diii
	<u></u>	1.00	2. 00	3. 00	4. 00	5. 00	
1. 00	Fund balances at beginning of period		158, 402, 000		7, 168, 000		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		31, 415, 724				2. 00
3.00	Total (sum of line 1 and line 2)		189, 817, 724		7, 168, 000		3. 00
4.00	ASSETS RELEASED FROM RESTRICTION	27, 000			0	0	4. 00
5.00	POSTRETI REMENT BENEFIT ADJS	57, 896, 000			0	0	5. 00
6.00	INVESTMENT INCOME	22, 000			0	0	6. 00
7.00	NET ASSETS RELEASED FROM RESTRICTION	15, 000			0	0	7. 00
8.00		0			0	0	8. 00
9.00		0			0	0	9. 00
10. 00	Total additions (sum of line 4-9)		57, 960, 000		0		10.00
11. 00	Subtotal (line 3 plus line 10)		247, 777, 724		7, 168, 000	1	11. 00
12. 00	PENSI ON SETTLEMENT	65, 233, 000			0	0	12.00
13. 00	INVESTMENT LOSS	0		588, 00	00	0	13. 00
14. 00	OTHER	21, 376, 724			0	0	14. 00
15. 00		0			0	0	15. 00
16. 00		0			0	0	16. 00
17. 00	T	0	0, ,00 70,		0	0	17. 00
18.00	Total deductions (sum of lines 12-17)		86, 609, 724		588, 000		18.00
19. 00	Fund balance at end of period per balance		161, 168, 000		6, 580, 000		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund			
		Endownerre Turia	TTUTTE	T GITG			
		6.00	7. 00	8. 00			
1.00	Fund balances at beginning of period	0			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2.00
3.00	Total (sum of line 1 and line 2)	0			0		3.00
4.00	ASSETS RELEASED FROM RESTRICTION		0				4.00
5.00	POSTRETI REMENT BENEFIT ADJS		0				5.00
6.00	INVESTMENT INCOME		0				6.00
7.00	NET ASSETS RELEASED FROM RESTRICTION		0				7.00
8.00			0				8.00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	0			0		10.00
11. 00	Subtotal (line 3 plus line 10)	0			0		11. 00
12.00	PENSI ON SETTLEMENT		0				12.00
13.00	INVESTMENT LOSS		0				13.00
14. 00	OTHER		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)	0			0		18.00
19. 00	Fund balance at end of period per balance	0			0		19. 00
	sheet (line 11 minus line 18)	1		I	1		

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

			То	12/31/2018	Date/Time Prep 5/29/2019 7:1	pared:
	Cost Center Description	Inpati ent	-	Outpati ent	Total	ı aiii
	oust defited beschiption	1.00		2. 00	3. 00	
	PART I - PATIENT REVENUES	1.00		2.00	3. 00	
	General Inpatient Routine Services					
1.00	Hospi tal	82, 803,	887		82, 803, 887	1. 00
2.00	SUBPROVI DER - I PF	5, 636,			5, 636, 982	2. 00
3.00	SUBPROVI DER - I RF	2, 518,			2, 518, 154	3. 00
4. 00	SUBPROVI DER	2,0.0,			2,0.0,.01	4. 00
5. 00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY		0		0	7. 00
8.00	NURSING FACILITY		0		0	8. 00
9.00	OTHER LONG TERM CARE		0		0	9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	90, 959,	023		90, 959, 023	10.00
	Intensive Care Type Inpatient Hospital Services	<u>.</u>	•			
11.00	INTENSIVE CARE UNIT	19, 879,	876		19, 879, 876	11. 00
11. 01	NEONATAL INTENSIVE CARE	2, 353,	683		2, 353, 683	11. 01
12.00	CORONARY CARE UNIT		0		0	12.00
13.00	BURN INTENSIVE CARE UNIT		0		0	13.00
14.00	SURGI CAL INTENSIVE CARE UNIT		0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of lines	22, 233,	559		22, 233, 559	16. 00
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	113, 192,			113, 192, 582	17. 00
18. 00	Ancillary services	312, 566,		370, 598, 343	683, 165, 214	18. 00
19. 00	Outpati ent servi ces	14, 623,		52, 210, 290	66, 833, 341	
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21. 00
22. 00	HOME HEALTH AGENCY		0	U O	0	22. 00
23. 00 24. 00	AMBULANCE SERVICES CMHC		U	U	0	23. 00 24. 00
24. 00	CORF		0	O O	0	
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		0	0	0	25. 00
26. 00	HOSPICE		0	0	0	26. 00
27. 00	NURSERY	3, 252,	257	o	3, 252, 257	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst			422, 808, 633	866, 443, 394	
20.00	G-3, line 1)	110,001,	,	122, 000, 000	000, 110, 071	20.00
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			258, 107, 276		29. 00
30.00	ADD (SPECIFY)		0			30. 00
31.00			0			31. 00
32.00			0			32.00
33.00			0			33. 00
34.00			0			34.00
35. 00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)		0			37. 00
38. 00			0			38. 00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			0			41.00
42. 00	Total deductions (sum of lines 37-41)			0		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(trans	ster		258, 107, 276		43. 00
	to Wkst. G-3, line 4)	I	ı	I		

	Financial Systems	ELKHART GENERAL			u of Form CMS-2	
STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-0018	Peri od: From 01/01/2018	Worksheet G-3	
				To 12/31/2018	Date/Time Pre 5/29/2019 7:1	
					1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part		,		866, 443, 394	1
2.00	Less contractual allowances and discounts on	patients' accoun	ts		586, 312, 394	
3.00	Net patient revenues (line 1 minus line 2)				280, 131, 000	
4.00	Less total operating expenses (from Wkst. G-2		43)		258, 107, 276	
5.00	Net income from service to patients (line 3 m	inus line 4)			22, 023, 724	5. 00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	0.00
7.00	Income from investments				0	1
8.00	Revenues from telephone and other miscellaneo	ous communication	servi ces		0	
9.00	Revenue from television and radio service				0	
10.00	Purchase di scounts				92, 551	
11. 00	Rebates and refunds of expenses				961, 107	
12.00	Parking lot receipts				0	12. 00
13.00	Revenue from Laundry and Linen service				0	13. 00
14.00	Revenue from meals sold to employees and gues	its			848, 828	14. 00
15. 00	Revenue from rental of living quarters				0	15. 00
16.00	Revenue from sale of medical and surgical sup	plies to other t	han patients		0	16. 00
17. 00	Revenue from sale of drugs to other than pati	ents			184, 543	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	etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, an	d canteen			0	20. 00
21.00	Rental of vending machines				0	21. 00
22.00	Rental of hospital space				0	22. 00
23.00	Governmental appropriations				0	23. 00
24.00	OTHER				7, 304, 971	24. 00
25.00	Total other income (sum of lines 6-24)				9, 392, 000	25. 00
26.00	Total (line 5 plus line 25)				31, 415, 724	26. 00
	OTHED EVDENCES (SDECLEV)					27 00

28. 00

0 27. 00

31, 415, 724 29. 00

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)

27. 00 OTHER EXPENSES (SPECIFY)

Heal th	Financial Systems ELKHART GE	NERAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0018	Peri od: From 01/01/2018 To 12/31/2018	Worksheet L Parts I-III Date/Time Pre 5/29/2019 7:1	pared:
		Title XVIII	Hospi tal	PPS	
				4 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			2, 647, 507	1.00
1.01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2.00	Capital DRG outlier payments			96, 498	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments			0	
3.00	Total inpatient days divided by number of days in the co	ost reporting period (see inst	ructions)	107. 08	
4.00	Number of interns & residents (see instructions)			0.00	
5.00	Indirect medical education percentage (see instructions)		1 11	0.00	1
6. 00	Indirect medical education adjustment (multiply line 5 b 1.01) (see instructions)	by the sum of lines I and 1.01	, corumns r and	0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Par 30) (see instructions)	rt A patient days (Worksheet E	, part A line	2. 93	7. 00
8.00	Percentage of Medicaid patient days to total days (see i	nstructions)		20. 64	8. 00
9.00	Sum of lines 7 and 8	,		23. 57	9. 00
10.00	Allowable disproportionate share percentage (see instruc	ctions)		4. 89	10.00
11. 00	Disproportionate share adjustment (see instructions)	129, 463			
12. 00	Total prospective capital payments (see instructions)			2, 873, 468	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1. 00	Program inpatient routine capital cost (see instructions	5)		0	1.00
2.00	Program inpatient ancillary capital cost (see instruction	•		0	
3.00	Total inpatient program capital cost (line 1 plus line 2	0	3. 00		
4.00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circum	,		0	
3.00	Net program inpatient capital costs (line 1 minus line 2)				
4.00	Applicable exception percentage (see instructions)				4.00
5. 00 6. 00	Capital cost for comparison to payments (line 3 x line 4 Percentage adjustment for extraordinary circumstances (s			0.00	
7. 00	Adjustment to capital minimum payment level for extraord	,	· line 6)	0.00	
8. 00	Capital minimum payment level (line 5 plus line 7)	arriary cricamstances (rine 2 x	. True o)	0	
9. 00	Current year capital payments (from Part I, line 12, as	applicable)		0	
10.00	Current year comparison of capital minimum payment level	11 /	less line 9)	0	ı
11. 00	Carryover of accumulated capital minimum payment level of Worksheet L, Part III, line 14)	over capital payment (from pri	or year	0	11. 00
12. 00	Net comparison of capital minimum payment level to capit	al payments (line 10 plus lin	ie 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive,			0	
14.00	Carryover of accumulated capital minimum payment level c (if line 12 is negative, enter the amount on this line)			0	14. 00
	THE TIME IZ IS NEGATIVE, ENTER THE AMOUNT ON THIS IT NO.				ı
15 00		e instructions)	İ	Λ	15 00
15. 00 16. 00	Current year allowable operating and capital payment (se			0	