Heal th Financi	al Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY IN	In Lieu	u of Form CMS-2552-10
	s required by law (42 USC 1395g; since the beginning of the cost				FORM APPROVED OMB NO. 0938-0050 EXPIRES 05-31-2019
HOSPITAL AND AND SETTLEMEN	HOSPITAL HEALTH CARE COMPLEX COST T SUMMARY	REPORT CERTIFICATION	Provider CCN: 15-1323	 Period: From 01/01/2018 To 12/31/2018 	Worksheet S Parts I-III Date/Time Prepared: 5/29/2019 2:50 pm
	REPORT STATUS				
Provi der	1. [X] Electronically filed cos			Date: 5/29/20	19 Time: 2:50 pm
use only	2. [] Manually submitted cost	report			
	3. [0] If this is an amended re 4. [F] Medicare Utilization. En	eport enter the number nter "F" for full or "L	of times the provider " for low.	resubmitted this co	ost report
Contractor		Date Received:		O.NPR Date:	
use only	(1) As Submitted 7.	Contractor No.	1 The provider CCN 1	1. Contractor's Vendo	or Code: 4
	(2) Settled without Audit 8.	[N] Final Report for	this Provider CCN 1.		les reopened = 0-9.
	(3) Settled with Audit (4) Reopened	[in] i man insperie for			les reopened = 0-9.
	(5) Amended				
	(3) Amended				
PART II - CER	TIFICATION				
	TION OR FALSIFICATION OF ANY INFO				
	E ACTION, FINE AND/OR IMPRISONMEN		-		
	ROCURED THROUGH THE PAYMENT DI REC		KICKBACK OR WERE OTH	ERWISE ILLEGAL, CRIN	IINAL, CIVIL AND
	E ACTION, FINES AND/OR IMPRISONME				
CERTI	FICATION BY CHIEF FINANCIAL OFFIC	CER OR ADMINISTRATOR OF	PROVI DER(S)		
el ect Exper 01/01 corre i nstr provi	EBY CERTIFY that I have read the ronically filed or manually submi ses prepared by COMMUNITY HOSPT. /2018 and ending 12/31/2018 and t ct, complete and prepared from th uctions, except as noted. I furt sion of health care services, and	tted cost report and t OF LAGRANGE CTY IN (1 to the best of my knowl ne books and records of ther certify that I am d that the services ide	he Balance Sheet and 5-1323) for the cost edge and belief, this the provider in acco familiar with the law	Statement of Revenue reporting period be report and statemer rdance with applicat s and regulations re	e and eginning nt are true, ble egarding the
compl	iance with such laws and regulati	ons.			
[X]	I have read and agree with the al				
	signature on this certification s	statement to be the leg	jally binding equivale	ent of my original si	gnature.
		(Si gned)	JEANNA WICKENS		
			Officer or Admi	nistrator of Provid	er(s)
			CFO		
			Title		
			(Dated when repo	ort is electronicall	y signed.)
			Date		· · · · ·
			Title XVIII		

	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-90, 074	-358, 451	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	-2, 561	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-92, 635	-358, 451	0	0	200. 00

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

	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provic	ler CCN: 1		Period: From 01/01/ To 12/31/		Workshe Part I Date/Ti 5/29/20	me Pre	epared
	1.00	2.00		3.00		4	4.00			
	Hospital and Hospital Health Care Co									
)0)0	Street: 207 NORTH TOWNLINE ROAD City: LAGRANGE	PO Box: State: IN	Zin Cod	0. 16761	122E Count	ty: LAGRANGE				1.
0	CITY. LAGRANGE	Component Name	CCN	CBSA	Provi der	1 1	Davmo	ent Syst	om (D	<u>∠</u> .
		component Name	Number	Number	Type	Certi fi ed	5	, 0, or		
							V	XVIII		1
		1.00	2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Componer							-		
0	Hospi tal	COMMUNITY HOSPT. OF	151323	99915	1	05/01/2005	N	0	P	3.
0	Subprovidor LDE	LAGRANGE CTY IN								
0	Subprovider - IPF Subprovider - IRF									4
0	Subprovider - (Other)									6
0	Swing Beds - SNF	SWING BEDS	15Z323	99915		05/01/2005	N	0	N	7
0	Swing Beds - NF	SWING DEDS	132323	/////5		03/01/2003				8
0	Hospital-Based SNF									9
00	Hospital-Based NF								1	10
00	Hospi tal -Based OLTC									11
00	Hospital-Based HHA									12
	Separately Certified ASC									13
	Hospi tal -Based Hospi ce									14
	Hospital - Based Health Clinic - RHC									15
00	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I									17
	Hospital-Based (CORF) I									17
20	Hospital -Based (OPT) I									17
	Hospital-Based (OOT) I									17
40	Hospital-Based (OSP) I								1	17
00	Renal Dialysis									18
00	Other									19
						From:		То):	
									00	1
00	Cost Reporting Period (mm/dd/yyyy)					1.00	118	2.0		20
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					1.00 01/01/20	018			
	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)					1.00	018	2.0		
	Type of Control (see instructions)				1. 00	1.00 01/01/20	018	2.0	/2018	
00	Type of Control (see instructions)					1.00 01/01/20 2 2.00	018	2. (12/31,	/2018	21
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it				1.00 N	1.00 01/01/20 2	018	2. (12/31,	/2018	21
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju	stment, in accordance v	ith 42 CFF			1.00 01/01/20 2 2.00	018	2. (12/31,	/2018	21
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" for	stment, in accordance v r yes or "N" for no. Is	ith 42 CFF this			1.00 01/01/20 2 2.00	018	2. (12/31,	/2018	21
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section §	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an	ith 42 CFF this			1.00 01/01/20 2 2.00	018	2. (12/31,	/2018	21
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" for	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle am r yes or "N" for no.	ith 42 CFF this endment	2		1.00 01/01/20 2 2.00	018	2. (12/31,	/2018	21
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" for facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N	ith 42 CFF this endment ts for thi " for no f	s ⁷ or	N	1.00 01/01/20 2.00 N	018	2. (12/31,	/2018	21
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" for facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to	ith 42 CFF this endment ts for thi " for no f October 1	s for	N	1.00 01/01/20 2.00 N	018	2. (12/31,	/2018	21
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle am r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic	ith 42 CFF this endment ts for thi "for no f October 1 n of the c	s for	N	1.00 01/01/20 2.00 N	D18	2. (12/31,	/2018	21
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim ur cost reporting period? Enter in colu the portion of the cost reporting per Enter in column 2, "Y" for yes or "N reporting period occurring on or aft	stment, in accordance w r yes or "N" for no. Is 412.106(c)(2)(Pickle am r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst	ith 42 CFF this endment ts for thi "for no f October 1 n of the c ructions)	s For L cost	N	1.00 01/01/20 2.00 N N	D18	2. (12/31,	/2018	21 22 22 22
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting per Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle am r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst requires final uncompe	ith 42 CFF this endment ts for thi for no f October 1 n of the c ructions) nsated car	s For L cost	N	1.00 01/01/20 2.00 N	018	2. (12/31,	/2018	21 22 22 22
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "M reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost report	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to "for no for the portic er October 1. (see inst requires final uncompe port settlement? (see i	ith 42 CFF this endment ts for thi " for no f October 1 n of the c ructions) nsated car nstructior	s For L cost	N	1.00 01/01/20 2.00 N N	018	2. (12/31,	/2018	21 22 22 22
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting per Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst requires final uncompe port settlement? (see i " for no, for the porti	ith 42 CFF this endment ts for thi " for no f October 1 n of the c ructions) nsated car nstructior on of the	s For L cost re Is)	N	1.00 01/01/20 2.00 N N	018	2. (12/31,	/2018	21 22 22 22
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "M reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost report	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst requires final uncompe port settlement? (see i " for no, for the porti er 1. Enter in column 2	ith 42 CFF this endment ts for thi " for no f October 1 n of the c ructions) nsated car nstructior on of the , "Y" for	s for cost re ns) yes	N	1.00 01/01/20 2.00 N N	018	2. (12/31,	/2018	21 22 22 22
00 00 00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting per Enter in column 2, "Y" for yes or "M reporting period occurring on or aff Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "M cost reporting period prior to Octob	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst requires final uncompe port settlement? (see i " for no, for the porti er 1. Enter in column 2	ith 42 CFF this endment ts for thi " for no f October 1 n of the c ructions) nsated car nstructior on of the , "Y" for	s for cost re ns) yes	N	1.00 01/01/20 2.00 N N	018	2. (12/31,	/2018	21 22 22 22
00 00 01 02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section S hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst requires final uncompe port settlement? (see i " for no, for the porti er 1. Enter in column 2 e cost reporting period ic reclassification fro	ith 42 CFF this endment ts for thi " for no f October 1 nof the c ructions) nsated car nstructior on of the , "Y" for on or aft m urban to	s For cost re us) yes cer	N	1.00 01/01/20 2.00 N N	018	2. (12/31,	/2018	21 22 22 22 22
00 00 01 02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to "for no for the portic er October 1. (see inst requires final uncompe port settlement? (see "for no, for the porti er 1. Enter in column 2 e cost reporting period ic reclassification fro ds for delineating stat	ith 42 CFF this endment ts for thi "for no f October 1 n of the c ructions) nsated car nstructior on of the , "Y" for on or aff m urban to istical ar	s for cost cost is) yes ier peas	N N N	1.00 01/01/20 2.00 N N N	018	2. (12/31, 3. (/2018	21 22 22 22 22
00 00 01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst requires final uncompe port settlement? (see " for no, for the porti er 1. Enter in column 2 e cost reporting period ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or	ith 42 CFF this endment ts for thi " for no f October 1 n of the c ructions) nsated car nstructior on of the , "Y" for on or aff m urban to istical ar "N" for r	s For cost cost re is) yes cer peas no	N N N	1.00 01/01/20 2.00 N N N	018	2. (12/31, 3. (/2018	21 22 22 22 22
00 00 01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim ur cost reporting period? Enter in colu the portion of the cost reporting per Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst requires final uncompe port settlement? (see i " for no, for the porti er 1. Enter in column 2 e cost reporting period ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob	ith 42 CFF this endment ts for thi "for no f October 1 n of the c ructions) nsated car nstructior on of the , "Y" for on or aff m urban to istical ar "N" for r er 1. Ente	s For cost cost re is) yes cer peas no	N N N	1.00 01/01/20 2.00 N N N	018	2. (12/31, 3. (/2018	21 22 22 22 22
00 00 01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim ur cost reporting period? Enter in colu the portion of the cost reporting per Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportin in column 2, "Y" for yes or "N" for	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst requires final uncompe port settlement? (see i " for no, for the porti er 1. Enter in column 2 e cost reporting period ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1	ith 42 CFF this endment ts for thi " for no f October 1 n of the c ructions) nsated car nstructior on of the , "Y" for on or aff m urban to istical ar "N" for r er 1. Ente he cost	s For cost cost re is) yes cer peas no	N N N	1.00 01/01/20 2.00 N N N	018	2. (12/31, 3. (/2018	21 22 22 22 22
00 00 01 02	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fo facility subject to 42 CFR Section S hospital?) In column 2, enter "Y" fo Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst requires final uncompe port settlement? (see i " for no, for the porti er 1. Enter in column 2 e cost reporting period ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see inst	ith 42 CFF this endment ts for thi " for no f October 1 n of the c ructions) nsated car nstructior on of the , "Y" for on or aff m urban to istical ar "N" for r er 1. Ente he cost ructions)	s For cor cost re ns) yes cer preas no er	N N N	1.00 01/01/20 2.00 N N N	018	2. (12/31, 3. (/2018	21 22 22 22 22
00 00 01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period? Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst requires final uncompe port settlement? (see i " for no, for the porti er 1. Enter in column 2 e cost reporting period ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	ith 42 CFF this endment ts for thi " for no f October 1 n of the c ructions) nsated car nstructior on of the , "Y" for on or aff m urban to istical ar "N" for r er 1. Ente he cost ructions) 99 beds (a	s for cost cost re is) yes cer peas no er	N N N	1.00 01/01/20 2.00 N N N	018	2. (12/31, 3. (/2018	21 22 22 22 22
00 00 01	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost re Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst requires final uncompe port settlement? (see i " for no, for the porti er 1. Enter in column 2 e cost reporting period ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4	ith 42 CFF this endment ts for thi " for no f October 1 n of the c ructions) nsated car nstructior on of the , "Y" for on or aff m urban to istical ar "N" for r er 1. Ente he cost ructions) 99 beds (a	s for cost cost re is) yes cer peas no er	N N N	1.00 01/01/20 2.00 N N N	018	2. (12/31, 3. (/2018	21 22 22 22 22
00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" for Did this hospital receive interim un cost reporting period? Enter in colu the portion of the cost reporting period? Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least	stment, in accordance w r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst requires final uncompe port settlement? (see i " for no, for the porti er 1. Enter in column 2 e cost reporting period ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst cot column 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column	ith 42 CFF this endment ts for thi " for no f October 1 n of the c ructions) nsated car nstruction on of the , "Y" for on or aff m urban to istical ar "N" for r er 1. Ente he cost ructions) 99 beds (a 3, "Y" for	s for cost re is) yes .er yes .er o reas no er	N N N	1.00 01/01/20 2.00 N N N	018	2. (12/31, 3. (/2018	21 22 22 22 22 22 22
00 00 01 02 03	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju \$412.106? In column 1, enter "Y" fc facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fc Did this hospital receive interim ur cost reporting period? Enter in colu the portion of the cost reporting pe Enter in column 2, "Y" for yes or "M reporting period occurring on or aff Is this a newly merged hospital that payments to be determined at cost ref Enter in column 1, "Y" for yes or "N cost reporting period prior to Octob or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in co for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no.	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst requires final uncompé port settlement? (see i " for no, for the porti er 1. Enter in column 2 e cost reporting period ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of 1 er October 1. (see inst 100 but not more than 4 2.105)? Enter in column	i th 42 CFF this endment ts for thi " for no f October 1 n of the c ructions) nsated car nstructior on of the , "Y" for on or aff m urban tc istical ar "N" for r er 1. Ente he cost ructions) 99 beds (a 3, "Y" for and/or 25	s for cost cost re is) yes cer peas io er	N N N	1.00 01/01/20 2.00 N N N N	018	2. (12/31, 3. (/2018	20. 21. 22. 22. 22. 22. 22. 22. 22. 22.
00	Type of Control (see instructions) Inpatient PPS Information Does this facility qualify and is it disproportionate share hospital adju §412.106? In column 1, enter "Y" fof facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fof Did this hospital receive interim ur cost reporting period? Enter in colu the portion of the cost reporting period Enter in column 2, "Y" for yes or "N reporting period occurring on or aft Is this a newly merged hospital that payments to be determined at cost rec Enter in column 1, "Y" for yes or "N cost reporting period prior to Octod or "N" for no, for the portion of th October 1. Did this hospital receive a geograph rural as a result of the OMB standar adopted by CMS in FY2015? Enter in c for the portion of the cost reportir in column 2, "Y" for yes or "N" for reporting period occurring on or aft Does this hospital contain at least counted in accordance with 42 CFR 41 yes or "N" for no. Which method is used to determine Me	stment, in accordance v r yes or "N" for no. Is 412.106(c)(2)(Pickle an r yes or "N" for no. compensated care paymer mn 1, "Y" for yes or "N riod occurring prior to " for no for the portic er October 1. (see inst requires final uncompe port settlement? (see i " for no, for the porti er 1. Enter in column 2 e cost reporting period ic reclassification fro ds for delineating stat olumn 1, "Y" for yes or g period prior to Octob no for the portion of t er October 1. (see inst 100 but not more than 4 2.105)? Enter in column dicaid days on lines 24 of admission, 2 if cens of identifying the days	ith 42 CFF this endment ts for thi " for no f October 1 n of the c ructions) nsated car nstructior on of the , "Y" for on or aff m urban to istical ar "N" for r er 1. Ente he cost ructions) 99 beds (a 3, "Y" for and/or 25 us days, o in this o	s For cor cost re ns) yes cer preas no er	N N N	1.00 01/01/20 2.00 N N N N	018	2. (12/31, 3. (/2018	21 22 22 22 22 22 22

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA F	Provider CC	CN: 15-1323	Period: From 01/0 To 12/3		Workshe Part I Date/Ti		
					10 12/3	172018	5/29/20		
		In-State Medicaid paid days	ln-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medicai HMO day	ys Meo	ther di cai d days	
		1.00	2.00	3.00	4.00	5.00		5.00	
5. 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. If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0	0		0		0	(24.
					Urban/R				
00	Enter your standard geographic classification (not wa	ade) status	at the ber	inning of t	1. C	2	2.	00	26.
	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	rural. age) status r "2" for ru	at the enc ural. If ap	of the cos		2			27.
00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0			35
					Begi nr 1. C		Endi 2.		-
00	Enter applicable beginning and ending dates of SCH st		cript line	36 for numb		-			36
00	of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter		r of period	s MDH statu	5	0			37
01	is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for thaccordance with FY 2016 OPPS final rule? Enter "Y" for								37
00	instructions) If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38
					Y/		Y/ 2.		-
00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet the facility m), (ii), or the mileage	(iii)? Ent requiremer	er in colum nts in	ne N n		<u> </u>		39
	accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii or "N" for no. (see instructions)	i)? Enter i	in column 2	2 Y Tor ye					1
00		n adjustmen per 1. Enter	t? Enter "Y r "Y" for y	" for yes o	r N		Ν	1	40
00	or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob	n adjustmen per 1. Enter	t? Enter "Y r "Y" for y	" for yes o	r N	V	XVIII 2.00		40
	or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital	n adjustmen ber 1. Enter (see instr	t? Enter "Y r "Y" for y ructions)	/" for yes o ves or "N" fo	r N or	1.00	2.00	3.00	
	or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payment	n adjustmen ber 1. Enter (see instr	t? Enter "Y r "Y" for y ructions)	/" for yes o ves or "N" fo	r N or				
00	or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exco pursuant to 42 CFR §412.348(f)? If yes, complete Wkst	n adjustmen ber 1. Enter (see instr nt for dispr eption for d	t? Enter "Y r "Y" for y ructions) roportionat extraordina	(" for yes o yes or "N" fo ce share in a ary circumsta	accordance	1.00	2.00	3.00	45
00 00 00	or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment	n adjustmen per 1. Ente (see instr nt for disp eption for d t. L, Pt. I capital? Ei	t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for	/" for yes o res or "N" fo ce share in a ary circumsta L-1, Pt. - yes or "N"	accordance ances through for no.	1.00	2.00	3.00 N	45 46 47
00 00 00 00	or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in	n adjustmen ber 1. Enter (see instr t for dispr eption for d t. L, Pt. I capital? En t? Enter "	t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes	/" for yes o res or "N" fo ce share in a ary circumsta c. L-1, Pt. or "N" for n	accordance ances through for no.	1.00 N N N	2.00 N N N	3.00 N N N	45 46 47 48
00 00 00 00 00	or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is this a new hospital under 42 CFR §412.300(b) PPS of Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting pf GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "N"	n adjustmen ber 1. Enter (see instr nt for disp eption for o t. L, Pt. I capital? En capital? En eptiod durin geproved G beriod durin r yes or "N"	t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs mg which re " for no ir cost report e Worksheet	<pre>/" for yes o /es or "N" fo </pre>	accordance ances I through for no. no. ' for yes approved I f col umn 1 Enter "Y"	1.00 N N N N N N N N N	2.00 N N N	3.00 N N N	40 45 46 47 48 56 57
. 00 . 00 . 00 . 00	or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1. Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymer with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III. Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals Is this a hospital involved in training residents in or "N" for no. If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont	n adjustmen ber 1. Ente (see instr t for disp eption for t. L, Pt. II capital? En t? Enter " approved Gl beriod durin r yes or "N th of this of (", complet (, if applic) oursement for	t? Enter "Y r "Y" for y ructions) roportionat extraordina II and Wkst nter "Y for Y" for yes ME programs mg which re " for no ir cost report e Worksheet cable. or physicia	<pre>(" for yes o yes or "N" for e share in a ary circumsta c. L-1, Pt. - yes or "N" or "N" for or "N" for for seidents in a column 1. cing period? E-4. If co</pre>	accordance accordance ances 1 through for no. no. ' for yes approved 1 column 1 Enter "Y" umn 2 is	1.00 N N N N N N N N N	2.00 N N N	3.00 N N N	45 46 47 48 56

OSPI 1	Financial Systems COMMUNITY HOS TAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA		LAGRANGE CTY Provider CO	CN: 15-1323 Pe	eriod:	u of Form CMS-2 Worksheet S-2	
				T	rom 01/01/2018 p 12/31/2018	Date/Time Pre	parec
				NAHE 413.85	Worksheet A	5/29/2019 2:5 Pass-Through	0 pm
				Y/N	Li ne #	Qualification Criterion Code	
				1.00	2.00	3.00	
0. 00	Are you claiming nursing and allied health education			N			60.
	any programs that meet the criteria under §413.85? (See ins Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
1.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	N			0.00	0.00	61.
. 01	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports and and submitted before Nursh 22, 2010 (see						61.
. 02	ending and submitted before March 23, 2010. (see instructions) Enter the current year total unweighted primary care						61.
	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						
. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see						61.
. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.
. 05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line						61.
. 06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
. 10	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00	0.00	61.
. 20					0. 00	0. 00	61.
						1.00	
	ACA Provisions Affecting the Health Resources and Ser					1.00	
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a	traineo tions)	in this cost	reporting peri		0.00	
	during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ram. (s er Setti	see instruction ings	ns)	<u> </u>	0.00	
. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple					N	63.
				Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
	Section 5504 of the ACA Base Year FTE Residents in No			1.00	2.00 is your cost r	3.00 Teporting	
4. 00	period that begins on or after July 1, 2009 and befor	<u>e June</u> y trair -primar all nor non-pr columr	30, 2010. med residents ty care provider mary care n 3 the ratio	0. 00	-	-	64.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPL		SPT. OF LAGRANGE CTY TA Provider C	CCN: 15-1323 Pe	eriod: com 01/01/2018	u of Form CMS-2 Worksheet S-2 Part I	
			Te		Date/Time Pre	pared:
	Program Name	Program Code	Unweighted	Unweighted	5/29/2019 2:5 Ratio (col. 3/	
			FTËs Nonprovider Site	FTEs in Hospital	(col. 3 + col. 4))	
-	1.00	2.00	3.00	4.00	5.00	1
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column			0.00			65.00
5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			Unweighted	Unwei ghted	Ratio (col. 1/	
			FTËs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
Spotion FEOA of the ACA Owner 1	(oor ETE Dooi doot '	Nonnrouidar C-++'	1.00	2.00	3.00	
Section 5504 of the ACA Current N beginning on or after July 1, 201		i Nonprovider Setting	gsEffective fo	or cost reporti	ng periods	
66.00 Enter in column 1 the number of u FTEs attributable to rotations oc Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	ccurring in all nonpr inweighted non-primar il. Enter in column 3	rovider settings. Ty care resident 3 the ratio of	Unweighted FTEs Nonprovider Site	0.00 Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	3.00	4.00	5.00	-
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0.00	0. 000000	67.00
				1.0	0 2.00 3.00	
Inpatient Psychiatric Facility PF 70.00 Is this facility an Inpatient Psy		PF), or does it cont	tain an IPF subp	1.00	0 2.00 3.00	70.00
Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indic (see instructions) Inpatient Rehabilitation Facility	the facility have ar fore November 15, 20 umn 2: Did this faci 2 412.424 (d)(1)(iii) ate which program ye	approved GME teachi 204? Enter "Y" for y lity train residents (D)? Enter "Y" for y	, ng program in t yes or "N" for n s in a new teach yes or "N" for n	he most io. (see iing io.	0	71.00
75.00 Is this facility an Inpatient Reh	nabilitation Facility	(IRF), or does it o	contain an IRF	N		75.00
subprovider? Enter "Y" for yes a 76.00 If line 75 is yes: Column 1: Did recent cost reporting period endi no. Column 2: Did this facility t CFR 412.424 (d)(1)(iii)(D)? Enter	nd "N" for no. the facility have ar ng on or before Nove rain residents in a	approved GME teachi ember 15, 2004? Enter new teaching program	ng program in t ~ "Y" for yes or m in accordance	"N" for with 42	0	76.00

Heal th	Financial Systems COMMUNITY HOSPT. 0	F LAGRANGE CTY	IN	In Lie	u of Form CMS-	-2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C	CN: 15-1323	Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part I Date/Time Pre 5/29/2019 2:5	epared:
					1.00	
80. 00 81. 00	Long Term Care Hospital PPS Is this a long term care hospital (LTCH)? Enter "Y" for ye Is this a LTCH co-located within another hospital for part "Y" for yes and "N" for no.	es and "N" for or all of the	no. cost reportin	g period? Enter	N N	80. 00 81. 00
86.00	TEFRA Providers Is this a new hospital under 42 CFR Section §413.40(f)(1)(i Did this facility establish a new Other subprovider (exclud S412.40(f)(1)(i))				N	85.00 86.00
	\$413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. Is this hospital an extended neoplastic disease care hospit 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.	al classified	under section	I	N	87.00
				V	XI X	
				1.00	2.00	
90.00	Title V and XIX Services Does this facility have title V and/or XIX inpatient hospit	al services? E	nter "Y" for	N	Y	90.00
91.00	yes or "N" for no in the applicable column. Is this hospital reimbursed for title V and/or XIX through			Ν	N	91.00
	full or in part? Enter "Y" for yes or "N" for no in the app Are title XIX NF patients occupying title XVIII SNF beds (d	lual certificat			N	92.00
	instructions) Enter "Y" for yes or "N" for no in the applic Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column		d XIX? Enter	Ν	Ν	93.00
94.00	"Y" for yes or "N" for no in the applicable column. Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for n	o in the	Ν	N	94.00
	If line 94 is "Y", enter the reduction percentage in the ap Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.			0. 00 N	0. 00 N	95.00 96.00
98.00	If line 96 is "Y", enter the reduction percentage in the ap Does title V or XIX follow Medicare (title XVIII) for the i stepdown adjustments on Wkst. B, Pt. I, col. 25? Enter "Y"	nterns and res	idents post	0. 00 Y	0. 00 Y	97.00 98.00
98. 01	column 1 for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for the r C, Pt. I? Enter "Y" for yes or "N" for no in column 1 for t				Y	98. 01
98. 02	title XIX. Does title V or XIX follow Medicare (title XVIII) for the c bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes for title V.			Y	Y	98.02
98. 03	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a cri reimbursed 101% of inpatient services cost? Enter "Y" for y for title V, and in actume 2 for title XIX.				Ν	98.03
98.04	for title V, and in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) for a CAH outpatient services cost? Enter "Y" for yes or "N" for no i in column 2 for title XIX			N	Ν	98.04
	in column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) and add b Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in				Y	98.05
	column 2 for title XIX. Does title V or XIX follow Medicare (title XVIII) when cost Pts. I through IV? Enter "Y" for yes or "N" for no in colum column 2 for title XIX.			Y	Y	98.06
405 00	Rural Providers			N N	1	105 00
	Does this hospital qualify as a CAH? If this facility qualifies as a CAH, has it elected the all	-inclusive met	hod of paymen	t N		105.00 106.00
107.00	for outpatient services? (see instructions) If this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col	n 1. (see inst	ructions) If	N		107.00
	reimbursed. If yes complete Wkst. D-2, Pt. II. Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	dul e? See 42			108.00
		Physi cal 1.00	Occupationa 2.00		Respiratory 4.00	-
109.00	lf this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	3.00 N	N	109.00
					1.00	
	Did this hospital participate in the Rural Community Hospit Demonstration)for the current cost reporting period? Enter complete Worksheet E, Part A, lines 200 through 218, and Wo applicable.	"Y" for yes or	"N" for no.	lf yes,	N	110.00

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN		Period: From 01/01/2 To 12/31/2		Workshe Part I Date/Ti		
				5/29/20		
		1.00		2.0	00	-
11.00 If this facility qualifies as a CAH, did it participate in the Frontier Com Health Integration Project (FCHIP) demonstration for this cost reporting per "Y" for yes or "N" for no in column 1. If the response to column 1 is Y, en integration prong of the FCHIP demo in which this CAH is participating in c Enter all that apply: "A" for Ambulance services; "B" for additional beds; for tele-health services.	eriod? Enter iter the column 2.	N				111.0
			1.00) 2.00	3.00	
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 3 either "93" percent for short term hospital or "98" percent for long term psychiatric, rehabilitation and long term hospitals providers) based on the Pub. 15-1, chapter 22, §2208.1. 16.00 Is this facility classified as a referral center? Enter "Y" for yes or "N"	s "E", enter care (inclu e definition	in column µdes	N		0	115. 0
17.00 Is this facility legally-required to carry malpractice insurance? Enter "Y" no.		"N" for	Y			117.0
18.00 Is the malpractice insurance a claims-made or occurrence policy? Enter 1 if claim-made. Enter 2 if the policy is occurrence.	the policy	is	1			118. C
	Premi ums	Losses	5	Insur	ance	
-	1.00	2.00		3. 0	00	-
8.01 List amounts of malpractice premiums and paid losses:	53, 51	6 19	9, 097		33, 878	3 118. (
		1.00		2.0	00	-
 18.02 Are malpractice premiums and paid losses reported in a cost center other th Administrative and General? If yes, submit supporting schedule listing cos and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi 	st centers	N		N		118. (119. (120. (
§3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instru Enter in column 2, "Y" for yes or "N" for no. 21.00[Did this facility incur and report costs for high cost implantable devices	e Outpatient Ictions)	Y				121.0
patients? Enter "Y" for yes or "N" for no.	Ū.					
22.00 Does the cost report contain healthcare related taxes as defined in §1903(w Act?Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", enter the Worksheet A line number where these taxes are included. Transplant Center Information		N				122.
25.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" f	orno.lf	N				125.
 yes, enter certification date(s) (mm/dd/yyyy) below. 6.00 If this is a Medicare certified kidney transplant center, enter the certifiin column 1 and termination date, if applicable, in column 2. 	cation date					126.
7.00 If this is a Medicare certified heart transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.						127.
8.00 If this is a Medicare certified liver transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.						128.
(9.00 If this is a Medicare certified lung transplant center, enter the certifical column 1 and termination date, if applicable, in column 2. (0.00 If this is a Medicare certified pancreas transplant center, enter the certified pancreas transplant center, enter the certified pancreas transplant center, enter the certified pancreas transplant center.						129. 130.
date in column 1 and termination date, if applicable, in column 2. 1.00 If this is a Medicare certified intestinal transplant center, enter the cer						131.
date in column 1 and termination date, if applicable, in column 2. 2.00 If this is a Medicare certified islet transplant center, enter the certific	ation date					132.
in column 1 and termination date, if applicable, in column 2. 3.00 If this is a Medicare certified other transplant center, enter the certific in column 1 and termination date, if applicable, in column 2.	ation date					133.
4.00 If this is an organ procurement organization (OPO), enter the OPO number in and termination date, if applicable, in column 2.	ı column 1					134.
All Providers 40.00 Are there any related organization or home office costs as defined in CMS F	Pub 15 1	Y		15HC	13.2	140
	10 ID-I	I Y		1 15HC	າວ∠	140. (

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA		AGRANGE CTY Provider CC			od: 01/01/2018	u of Form CMS Worksheet S- Part I Date/Time Pr 5/29/2019 2:	-2 repared:
1.00		2.00				3.00		
If this facility is part of a chain					ne name a	and address	of the	
41.00 Name: PARKVIEW HEALTH SYSTEM, INC.	<u>contractor name a</u> Contractor's Name		NSIN PHYSICI		actor's	Number: 0810	1	141. 00
42.00 Street: 10501 CORPORATE DRIVE	PO Box:	5600	0L					142.0
43.00 City: FORT WAYNE	State:	IN		Zip C	ode:	4684	5	143.0
							1.00	_
44.00 Are provider based physicians' costs	included in Worksh	eet A?					1.00 Y	144. 0
		001 /11					•	
						1.00	2.00	
145.00 If costs for renal services are clain inpatient services only? Enter "Y" fino, does the dialysis facility incluiperiod? Enter "Y" for yes or "N" fo 146.00 Has the cost allocation methodology	or yes or "N" for no de Medicare utiliza r no in column 2.	o in co tion fo	lumn 1. lfc r this cost	olumn 1 i reporting		N		145.00
Enter "Y" for yes or "N" for no in c yes, enter the approval date (mm/dd/	olumn 1. (See CMS Pu				lf	N		140. 0
47 00Wee there a charge is the static li	hani oʻʻ Ertar IV/	for	on "N" f-	20			1.00	147.0
47.00 Was there a change in the statistica 48.00 Was there a change in the order of a							N N	147.00
49.00 Was there a change to the simplified					for no.		N	149.0
			Part A	Part		Title V	Title XIX	_
Does this facility contain a provide	r that qualifier fo		1.00	2.00		3.00	4.00	-
or charges? Enter "Y" for yes or "N"								
55. 00 Hospi tal			N	N		N	N	155. 0
56.00 Subprovider - IPF			N	N		N	N	156.0
57. 00 Subprovi der – I RF 58. 00 SUBPROVI DER			N	N		N	N	157.0
158. 00/S0BPROVI DER 159. 00/SNF			N	N		Ν	N	158.00
60. OO HOME HEALTH AGENCY			N	N		N	N	160. 0
61.00 CMHC				N		Ν	N	161. 0
				N		N	N	161.10
61. 20 OUTPATI ENT PHYSI CAL THERAPY 61. 30 OUTPATI ENT OCCUPATI ONAL THERAPY				N N		N N	N N	161.2
61. 40 OUTPATIENT SPEECH PATHOLOGY				N		N	N	161. 4
-								
Mul ti compue							1.00	_
Multicampus 65.001s this hospital part of a Multicamp Enter "Y" for yes or "N" for no.	us hospital that has	s one o	r more campu	ises in di	fferent	CBSAs?	N	165. 00
	Name	(County	State	Zip Coo		FTE/Campus	
66.00 If line 165 is yes, for each	0		1.00	2.00	3.00	4.00	5.00	00 166. 0
06.0011 The los is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							0.0	
							1.00	-
Health Information Technology (HIT)	incentive in the Am	eri can	Recovery and	d Reinvest	tment Ac	t		
67.00 Is this provider a meaningful user u 68.00 If this provider is a CAH (line 105	nder §1886(n)? Ente s "Y") and is a mea	er "Y" ani ngfu	for yes or "	N" for no).		Y 171, 92	167. 0 28168. 0
reasonable cost incurred for the HIT 68.01 If this provider is a CAH and is not			his provider	qualif∨	for a ha	ardshi p		168. 0
exception under §413.70(a)(6)(ii)? E 69.00 If this provider is a meaningful use	nter "Y" for yes or r (line 167 is "Y")	"N" fo	r no. (see i	nstructio	ns)		0. (00169.00
transition factor. (see instructions)					Begi nni ng	Endi ng	
						1.00	2.00	
70.00 Enter in columns 1 and 2 the EHR beg period respectively (mm/dd/yyyy)	nning date and endi	ing dat	e for the re	porti ng		10/01/2016	09/30/2017	170. 0

Health Financial Systems							
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDE					Worksheet S- Part I	2	
				12/31/2018			
				1.00	2.00		
171.00 If line 167 is "Y", does this provider section 1876 Medicare cost plans repor "Y" for yes and "N" for no in column 1. 1876 Medicare days in column 2. (see in	n	Ν		0 171. 00			

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

IOSPI T.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1323	Period: From 01/01/2018 To 12/31/2018		epared:
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES responses. Enter N mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation	lforall NO re	esponses. Ente	er all dates in 1	the	-
	Has the provider changed ownership immediately prior to the reporting period? If yes, enter the date of the change in c	e beginning of column 2. (see	the cost	N)		1.0
			Y/N	Date	V/I	
			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.		N			2. (
. 00	Is the provider involved in business transactions, includir contracts, with individuals or entities (e.g., chain home or or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members or of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	N			3. (
			Y/N	Туре	Date	
			1.00	2.00	3.00	
. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Cert Accountant? Column 2: If yes, enter "A" for Audited, "C" f or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled, ailable in	Y	A		4.0
. 00	Are the cost report total expenses and total revenues diffe		N			5. C
	those on the filed financial statements? If yes, submit rec	conciliation.		V /N	Logal Open	
				Y/N	Legal Oper.	_
	Approved Educational Activitian			1.00	2.00	
. 00	Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2:	If yos is th	a providor i	s N		6.0
. 00	the legal operator of the program?	TI yes, is tr	le provider is	5 11		0.0
. 00	Are costs claimed for Allied Health Programs? If "Y" see in	etructione		Ν		7.0
			during the	N		
. 00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions.		U			8.0
. 00	Are costs claimed for Interns and Residents in an approved program in the current cost report? If yes, see instruction	is.				9. (
	Was an approved Intern and Resident GME program initiated c cost reporting period? If yes, see instructions.			N		10. (
1. 00	Are GME cost directly assigned to cost centers other than I Teaching Program on Worksheet A? If yes, see instructions.	& R in an App	proved	N		11.0
					Y/N	
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes If line 12 is yes, did the provider's bad debt collection p			ost reporting	Y N	12. 13.
	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payme	ents waived? I1	fyes, see ins	structions.	N	14.
	Bed Complement				N	1 15
5.00	Did total beds available change from the prior cost reporti		yes, see ins rt A		N N	15.0
		Y/N	Date	Y/N	Date	-
		1.00	2.00	3.00	4.00	
	PS&R Data	1.00	2.00	3.00	4.00	
	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see	N		N		16. (
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date	Y	04/30/2015	Y	04/30/2015	17. (
8. 00	in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Y		Y		18. (
9. 00	cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		Ν		19. (

Health Financial Systems COM

MMUNI TY	HOSPT.	0F	LAGRANGE	CTY	ΙN	

In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC		Period: From 01/01/2018 To 12/31/2018	Worksheet S-2 Part II Date/Time Pre 5/29/2019 2:5	epared:
		Descri	ption	Y/N	Y/N	
		()	1.00	3.00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	Ν	20.00
	-	Y/N 1.00	 2.00	Y/N 3.00	Date 4.00	
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N	2.00	N	4.00	21.00
					1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEP Capital Related Cost	PT CHILDRENS H	OSPI TALS)			-
22. 00 23. 00	Have assets been relifed for Medicare purposes? If yes, see Have changes occurred in the Medicare depreciation expense of reporting period? If yes, see instructions.		als made duri	ng the cost	N N	22. 00 23. 00
24.00	Were new leases and/or amendments to existing leases entered	d into during	this cost rep	orting period?	Ν	24.00
25.00	If yes, see instructions Have there been new capitalized leases entered into during '	lfyes, see	Ν	25.00		
26.00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during the	e cost reporti	ng period? If	yes, see	Ν	26.00
27.00	instructions. Has the provider's capitalization policy changed during the copy.	cost reportin	g period?lf	yes, submit	Ν	27.00
28.00	Interest Expense Were new loans, mortgage agreements or letters of credit en	reporting	N	28.00		
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or I	serve Fund)	Ν	29.00		
30. 00	5 1 1 5					30.00
31.00	instructions. Has debt been recalled before scheduled maturity without is:	suance of new	debt? If yes,	see	Ν	31.00
	instructions. Purchased Services					
32.00	Have changes or new agreements occurred in patient care serv arrangements with suppliers of services? If yes, see instruc		d through con	tractual	Ν	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 appl no, see instructions.	lied pertainin	g to competit	ive bidding? If	Ν	33.00
34.00	Provider-Based Physicians Are services furnished at the provider facility under an arm	rangement with	provi der-bas	ed physicians?	N	34.00
35.00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exis	0				35.00
	physicians during the cost reporting period? If yes, see in		p	_	-	
				Y/N 1.00	Date 2.00	
	Home Office Costs					
	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pro	epared by the	home office?	Y Y		36.00 37.00
38.00	If yes, see instructions. If line 36 is yes , was the fiscal year end of the home offi			Ν		38.00
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other			N		39.00
40.00	see instructions. If line 36 is yes, did the provider render services to the H	home office?	lfyes, see	N		40.00
	instructions.					
		1.	00	2.	00	
41.00	Cost Report Preparer Contact Information Enter the first name, last name and the title/position	ERIC		NI CKESON		41.00
41.UU	held by the cost report preparer in columns 1, 2, and 3, respectively.			INI UKEJUN		
42.00	Enter the employer/company name of the cost report preparer.	PARKVIEW HEALT	H SYSTEM, INC			42.00
43.00		(260) 373-8406		ERI C. NI CKESON@	PARKVI EW. COM	43.00

Heal th	Financial Systems C	OMMUNI TY HOSPT.	OF LA	AGRANGE	CTY IN		In Lieu	u of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT	QUESTI ONNAI RE		Provi d	ler CCN: 15-1323		eriod: rom 01/01/2018	Worksheet S-2 Part II	
						T		Date/Time Pre 5/29/2019 2:5	pared: 0 pm
					3.00				
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the ti	tle/position	DI R	ECTOR,	REI MBURSEMENT				41.00
	held by the cost report preparer in column	ns 1, 2, and 3,							
	respecti vel y.								
42.00	Enter the employer/company name of the cos	st report							42.00
	preparer.								
43.00	Enter the telephone number and email addre	ess of the cost							43.00
	report preparer in columns 1 and 2, respec	cti vel y.							

HOSPI T	Financial Systems COMM AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC. Complex Statistic.	AL DATA	Provider CC	CN: 15-1323	Period: From 01/01/2018	Worksheet S-3 Part I	
					To 12/31/2018		
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	25	9, 12	25 81, 984. 00	0	1.00
2.00 3.00 4.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider						2.00 3.00 4.00
5.00 5.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF					0	5.00 6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	9, 12	25 81, 984. 00		7.00
3.00 9.00 10.00 11.00 12.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY)						8.00 9.00 10.00 11.00 12.00
13.00	NURSERY	43.00				0	13.00
14.00	Total (see instructions)		25	9, 12	81, 984. 00	0	14.00
15.00 16.00	CAH visits SUBPROVIDER - IPF					0	15.00 16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVIDER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
24.00	HOSPICE	30. 00					24.0 24.1
24.10	HOSPICE (non-distinct part) CMHC - CMHC	30.00					24. 1
25.10	CMHC - CORF	99.10				0	25.1
25. 20	CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	25.2
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25.3
5. 40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	25.4
6. 00	RURAL HEALTH CLINIC						26.0
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89.00				0	26.2
7.00	Total (sum of lines 14-26)		25				27.0
28.00	Observation Bed Days					0	28.00
29.00	Ambulance Trips						29.0
30.00 31.00	Employee discount days (see instruction) Employee discount days - IRF						30.0 31.0
32.00	Labor & delivery days (see instructions)		0		0		32.0
32.00	Total ancillary labor & delivery room		0		~		32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.0
33.01	LTCH site neutral days and discharges						33.0

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC	CN: 15-1323	Period: From 01/01/2018 To 12/31/2018		pared
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	895	52	2, 55	53		1.
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)	681	84				2.
. 00	HMO IPF Subprovider	0	0				3.
. 00	HMO IRF Subprovider	0	0				4.
. 00	Hospital Adults & Peds. Swing Bed SNF	205	0	20	05		5.
. 00	Hospital Adults & Peds. Swing Bed NF		0	26	59		6.
. 00	Total Adults and Peds. (exclude observation	1, 100	52	3, 02	27		7.
	beds) (see instructions)						
. 00	INTENSIVE CARE UNIT						8.
00	CORONARY CARE UNI T						9.
0. 00	BURN INTENSIVE CARE UNIT						10.
. 00	SURGI CAL I NTENSI VE CARE UNI T						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
. 00	NURSERY		159	38	39		13.
. 00	Total (see instructions)	1, 100	211	3, 41		181.50	
. 00	CAH visits	0	0	0, 1	0		15
. 00	SUBPROVIDER - IPF	U U	Ű		0		16
. 00	SUBPROVIDER - IRF						17
3.00	SUBPROVI DER						18
. 00	SKILLED NURSING FACILITY						19
. 00	NURSING FACILITY						20
. 00	OTHER LONG TERM CARE						21
2.00	HOME HEALTH AGENCY						22
. 00	AMBULATORY SURGICAL CENTER (D. P.)						23
. 00	HOSPICE						24
. 10	HOSPICE (non-distinct part)				0		24
. 00	CMHC - CMHC				0		25
. 10	CMHC - CORF	о	0		0 0.00	0.00	
. 20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0		0 0.00		
. 20	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0		0 0.00		
. 40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0		0 0.00		
. 40 . 00	RURAL HEALTH CLINIC	0	0		0.00	0.00	20
5. 00 5. 25		о	0		0 0.00	0.00	
	FEDERALLY QUALIFIED HEALTH CENTER	U	0		0.00		
. 00	Total (sum of lines 14-26)		14	7.		181.50	
. 00	Observation Bed Days	(0)	14	14	45		28.
. 00	Ambulance Trips	624					29.
. 00	Employee discount days (see instruction)			-	16		30.
. 00	Employee discount days - IRF				0		31
. 00	Labor & delivery days (see instructions)	0	9	14	40		32
. 01	Total ancillary labor & delivery room				0		32
	outpatient days (see instructions)						
3.00	LTCH non-covered days	0					33
. 01	LTCH site neutral days and discharges	0					33

SPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC/	AL DATA	Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet S-3 Part I Date/Time Pre 5/29/2019 2:5	parec
	Full Time		Di sc	harges		
Component	Equivalents Nonpaid Workers	Title V	Title XVIII	Title XIX	Total All Patients	
	11.00	12.00	13.00	14.00	15.00	
 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT OCONADY CARE UNIT 		0	20		1, 071	1. 2. 3. 4. 5. 6. 7. 8.
00 CORONARY CARE UNIT 0.00 BURN INTENSIVE CARE UNIT .00 SURGICAL INTENSIVE CARE UNIT 2.00 OTHER SPECIAL CARE (SPECIFY) 3.00 NURSERY 3.00 SUBPROVIDER - IPF 3.00 SUBPROVIDER - IPF 3.00 SUBPROVIDER - IRF 4.00 ONESING FACILITY 4.00 OTHER LONG TERM CARE 5.00 HOME HEALTH AGENCY	0. 00	0	31	3 21	1, 071	9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20. 21. 22.
 a.00 AMBULATORY SURGICAL CENTER (D.P.) b.00 HOSPICE b.10 HOSPICE (non-distinct part) c.00 CMHC - CMHC c.10 CMHC - CORF c.20 CMHC - OUTPATIENT PHYSICAL THERAPY c.30 CMHC - OUTPATIENT OCCUPATIONAL THERAPY c.40 CMHC - OUTPATIENT SPEECH PATHOLOGY c.00 RURAL HEALTH CLINIC c.25 FEDERALLY QUALIFIED HEALTH CENTER c.00 Total (sum of lines 14-26) c.00 Ambulance Trips c.00 Employee discount days (see instruction) c.00 Employee discount days - IRF c.40 Labor & delivery days (see instructions) c.01 Total anciliary labor & delivery room 	0.00 0.00 0.00 0.00 0.00 0.00					23 24 24 25 25 25 25 25 26 26 26 27 28 29 30 31 32 32
outpatient days (see instructions).00LTCH non-covered days.01LTCH site neutral days and discharges				0		33 33

Heal th	Financial Systems COMMUNITY HOSPT. OF LA	GRANGE CTY	IN	In Li€	eu of Form CMS-2	2552-10		
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-1323	Peri od:	Worksheet S-1	0		
				From 01/01/2018 To 12/31/2018				
			·					
	Uncompensated and indigent care cost computation				1.00			
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div	/ided by li	ne 202 column	8)	0. 273937	1.00		
1.00	Medicaid (see instructions for each line)	indea by in		0)	0.270707	1.00		
2.00	Net revenue from Medicaid				1, 070, 467	2.00		
3.00	Did you receive DSH or supplemental payments from Medicaid?					3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement			i d?		4.00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	rom Medicai	d		0	5.00		
6.00	Medi cai d charges				7, 735, 852	6.00		
7.00 8.00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program ((line 7 min	us sum of lin	oc 2 and E. if	2, 119, 136 1, 048, 669	7.00		
8.00	< zero then enter zero)				1, 048, 009	0.00		
	Children's Health Insurance Program (CHIP) (see instructions for	or each line	e)		-			
9.00	Net revenue from stand-al one CHIP				0	9.00		
10. 00 11. 00	Stand-alone CHIP charges Stand-alone CHIP cost (line 1 times line 10)				0	10.00		
12.00	Difference between net revenue and costs for stand-alone CHIP ((line 11 mi	nus line 0, i	f < zero then	0	12.00		
12.00	enter zero)		nus i ne 7, i		0	12.00		
	Other state or local government indigent care program (see inst	ructions fo	or each line)		1			
13.00	Net revenue from state or local indigent care program (Not incl)	1, 684, 783	13.00		
14.00	Charges for patients covered under state or local indigent care	e program (Not included	in lines 6 or	7, 572, 208	14.00		
	10)							
15.00	State or local indigent care program cost (line 1 times line 14				2,074,308			
16.00	Difference between net revenue and costs for state or local inc 13; if < zero then enter zero)	digent care	program (lir	e 15 minus line	389, 525	16.00		
	Grants, donations and total unreimbursed cost for Medicaid, CHI	P and state	e/local_indic	ent care progra	IIS (See			
	instructions for each line)				(
17.00	Private grants, donations, or endowment income restricted to fu	undi ng char	ity care		0	17.00		
18.00	Government grants, appropriations or transfers for support of h				0	18.00		
19.00	Total unreimbursed cost for Medicaid , CHIP and state and local 8, 12 and 16)	i ndi gent	care programs	(sum of lines	1, 438, 194	19.00		
			Uni nsured	Insured	Total (col. 1			
			patients	patients	+ col . 2)			
	Uncompensated Care (see instructions for each line)		1.00	2.00	3.00			
20.00	Charity care charges and uninsured discounts for the entire fac	vility	1, 073, 84	2 305, 125	1, 378, 967	20.00		
20100	(see instructions)	511125	1,0,0,0	2 000, 120	.,	20100		
21.00	Cost of patients approved for charity care and uninsured discouinstructions)	unts (see	294, 16	305, 125	599, 290	21.00		
22.00	Payments received from patients for amounts previously written charity care	off as	2, 20	2, 069	4, 271	22.00		
23.00	Cost of charity care (line 21 minus line 22)		291, 96	3 303, 056	595, 019	23.00		
					1.00			
24.00	Does the amount on line 20 column 2, include charges for patier	nt davs bev	ond a length	of stav limit	N 1.00	24.00		
25.00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th	program?			0	25.00		
	stay limit	0	our o' program	s rongen or				
26.00	Total bad debt expense for the entire hospital complex (see ins				4, 961, 587			
27. 01 28. 00	Medicare allowable bad debts for the entire hospital complex (s Non-Medicare bad debt expense (see instructions)	see instruc	u 005)		603, 491 4, 358, 096			
28.00 29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	nense (see	instructions)		4, 358, 098			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	50130 (368			2, 000, 085			
	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			3, 438, 279			
		·			•	•		

ASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CC		eriod: rom 01/01/2018 o 12/31/2018	Worksheet A Date/Time Pre	nard
					5/29/2019 2:5	
Cost Center Description	Sal ari es	Other	lotal (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
	1.00	2.00	2.00	4.00	col . 4)	
GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
00100 CAP REL COSTS-BLDG & FIXT		1, 673, 997	1, 673, 997	-349, 149	1, 324, 848	1
00101 EMS WEST STATION		0	0	17, 169		
00200 CAP REL COSTS-MVBLE EQUIP		26, 953	26, 953	706, 711	733, 664	
00201 EMS WEST STATION EQUIP. 00300 OTHER CAP REL COSTS		0	0	29, 175 0	29, 175 0	2
00400 EMPLOYEE BENEFITS DEPARTMENT	89, 777	4, 705, 868	4, 795, 645	0	4, 795, 645	
00500 ADMI NI STRATI VE & GENERAL	647, 302	11, 867, 356	12, 514, 658	-34, 272	12, 480, 386	5
00600 MAINTENANCE & REPAIRS	0	0	0	0	0	-
0 00700 OPERATION OF PLANT 0 00800 LAUNDRY & LINEN SERVICE	314, 541	813, 081	1, 127, 622	0	1, 127, 622	
00900 HOUSEKEEPING	187, 402	87, 864 78, 067	87, 864 265, 469	0	87, 864 265, 469	
00 01000 DI ETARY	404, 654	337, 048		-474, 344	267, 358	
00 01100 CAFETERI A	0	0	0	471, 439	471, 439	
00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12
00 01300 NURSI NG ADMI NI STRATI ON	341, 463	476	341, 939	0	341, 939	
00 01400 CENTRAL SERVICES & SUPPLY 00 01500 PHARMACY	10, 016 493, 867	-65, 057 72, 251	-55, 041 566, 118	0 -551	-55, 041 565, 567	
00 01600 MEDICAL RECORDS & LIBRARY	493, 807	72, 231	0	-551	0	
00 01700 SOCIAL SERVICE	Ō	0	0	0	0	
00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19
00 02000 NURSING SCHOOL	0	0	0	0	0	20
00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	22
INPATIENT ROUTINE SERVICE COST CENTERS	U	0	0	0	0	23
00 03000 ADULTS & PEDIATRICS	1, 785, 396	725, 690	2, 511, 086	-752, 434	1, 758, 652	30
00 04300 NURSERY	0	0	0	142, 943	142, 943	43
ANCI LLARY SERVI CE COST CENTERS	(70.450	705 04/	1 100 1//		1 100 1//	-
00 05000 OPERATING ROOM 00 05200 DELIVERY ROOM & LABOR ROOM	673, 450	735, 016 0	1, 408, 466 0	0 609, 491	1, 408, 466 609, 491	
00 05300 ANESTHESI OLOGY	0	931, 415	-	007,471	931, 415	
00 05400 RADI OLOGY-DI AGNOSTI C	692, 537	618, 381	1, 310, 918	0	1, 310, 918	
00 06000 LABORATORY	0	1, 152, 549	1, 152, 549	0	1, 152, 549	60
30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	
00 06500 RESPI RATORY THERAPY 00 06600 PHYSI CAL THERAPY	294,096	17, 109		0	311, 205	
00 06600 PHYSI CAL THERAPY 00 06700 OCCUPATI ONAL THERAPY	532, 678	39, 324	572, 002	-238, 905 157, 031	333, 097 157, 031	
00 06800 SPEECH PATHOLOGY	0	0	0	81, 874	81, 874	
00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	686, 020	686, 020	-287, 085	398, 935	
00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	287, 085		
00 07300 DRUGS CHARGED TO PATIENTS 07 07697 CARDIAC REHABILITATION	0 7,647	1, 686, 504 21, 806		551 0	1, 687, 055 29, 453	
07698 HYPERBARIC OXYGEN THERAPY	7,047	21,000	29,433	0	29,455	
07699 LI THOTRI PSY	0	0	0	0	0	
OUTPATIENT SERVICE COST CENTERS						4
	0	0	0	0	0	
01 09001 LI FEBRI DGE SENI OR CARE 00 09100 EMERGENCY	151, 992 851, 536	101, 531 2, 040, 145	253, 523 2, 891, 681	2, 905 0	256, 428 2, 891, 681	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART	051, 550	2,040,143	2,071,001	0	2,071,001	92
OTHER REIMBURSABLE COST CENTERS	I				<u> </u>	1 -
00 09500 AMBULANCE SERVICES	1, 011, 124	288, 614	1, 299, 738	0	1, 299, 738	95
0 09910 CORF	0	0	0	0	0	
20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	
30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY 40 09940 OUTPATI ENT SPEECH PATHOLOGY	0	0	0	0	0	
SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	- ''
00 11300 I NTEREST EXPENSE		369, 634	369, 634	-369, 634	0	113
00 SUBTOTALS (SUM OF LINES 1 through 117)	8, 489, 478	29, 011, 642		0	37, 501, 120	
NONREI MBURSABLE COST CENTERS						
00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7,411	7,411	0	7,411	
00 19200 PHYSI CLANS' PRI VATE OFFI CES 00 07950 OCCUPATI ONAL HEALTH	0	5, 209 0	5, 209 0	0	5, 209	192
01 07951 FOUNDATION	17, 505	-5, 182	-	0	12, 323	
03 07952 COMMUNITY & VOLUNTEER SVCS	14, 091	59, 990		0	74, 081	
04 07954 ER PHYSI CI AN	0	0	0	0	0	194
06 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	0	0		194
00 TOTAL (SUM OF LINES 118 through 199)	8, 521, 074	29,079,070	37, 600, 144	0	37, 600, 144	1200

Health Financial Systems	COMMUNITY HOSPT. OF LA	AGRANGE CTY IN	In Li
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL	BALANCE OF EXPENSES	Provider CCN: 15-1323	Period:

In Lieu of Form CMS-2552-10 Worksheet A

	Cost Center Description	Adjustments	Net Expenses	5/29/2019	2.30 pm
		(See A-8) 6.00	For Allocation 7.00		
G	ENERAL SERVICE COST CENTERS	0.00	7.00		
	00100 CAP REL COSTS-BLDG & FIXT	-2, 220	1, 322, 628		1.
01 0	DO101 EMS WEST STATION	0	17, 169		1.
	00200 CAP REL COSTS-MVBLE EQUIP	0			2.
	DO201 EMS WEST STATION EQUIP.	0	29, 175		2.
	00300 OTHER CAP REL COSTS	0	0		3.
	00400 EMPLOYEE BENEFITS DEPARTMENT	-866, 765			4.
00 0	00500 ADMI NI STRATI VE & GENERAL	-3, 737, 125	8, 743, 261		5.
	DO600 MAINTENANCE & REPAIRS	0	0		6.
	DO700 OPERATION OF PLANT	-5, 717	1, 121, 905		7.
	00800 LAUNDRY & LINEN SERVICE	0			8.
	00900 HOUSEKEEPI NG	0			9.
	01000 DI ETARY	0	267, 358		10.
1	01100 CAFETERI A	-258, 853	212, 586		11.
	01200 MAINTENANCE OF PERSONNEL	0	0		12.
	01300 NURSING ADMINISTRATION	-3,366			13.
1	01400 CENTRAL SERVICES & SUPPLY	0	-55, 041		14.
1	01500 PHARMACY	0			15.
1	01600 MEDI CAL RECORDS & LI BRARY	0	0 0		16.
	01700 SOCIAL SERVICE	0	0		17.
	01900 NONPHYSICIAN ANESTHETISTS	0	0 0		19.
	D2000 NURSI NG SCHOOL	0	0		20.
	02100 I &R SERVI CES-SALARY & FRI NGES APPRV	0	0		21.
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		22.
	D2300 PARAMED ED PRGM-(SPECIFY)	0	0		23.
	NPATIENT ROUTINE SERVICE COST CENTERS	400 740	1 000 004		
	03000 ADULTS & PEDIATRICS	-428, 748			30.
	04300 NURSERY	0	142, 943		43.
	NCILLARY SERVICE COST CENTERS	0	1 400 4//		
	D5000 OPERATING ROOM	0			50.
	D5200 DELIVERY ROOM & LABOR ROOM	000 750	609, 491		52.
	05300 ANESTHESI OLOGY	-829, 752			53.
	05400 RADI OLOGY-DI AGNOSTI C	-1,770			54.
		0	1, 152, 549 0		60.
	06250 BLOOD CLOTTING FOR HEMOPHILIACS		-		62. 65.
			311, 205		
	06600 PHYSI CAL_THERAPY 06700 OCCUPATI ONAL_THERAPY				66. 67.
	06800 SPEECH PATHOLOGY	-10, 263	157, 031 71, 611		68.
	06900 ELECTROCARDI OLOGY	- 10, 203	0 71,011		69.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	398, 935		71.
	07200 IMPL. DEV. CHARGED TO PATIENT	0	287, 085		71.
	07300 DRUGS CHARGED TO PATIENTS	-471, 644			72.
	07697 CARDI AC REHABI LI TATI ON	-471,044			76.
	07698 HYPERBARI C OXYGEN THERAPY	0			76.
	07699 LI THOTRI PSY	0			76.
-	DUTPATIENT SERVICE COST CENTERS		, <u> </u>		/0.
	09000 CLINIC	0	0		90.
	09001 LI FEBRI DGE SENI OR CARE	-382	256, 046		90.
	09100 EMERGENCY	-518, 114			91.
	09200 OBSERVATION BEDS (NON-DISTINCT PART	010,114	2, 0, 0, 007		92.
-	THER REIMBURSABLE COST CENTERS	I			
	09500 AMBULANCE SERVICES	0	1, 299, 738		95.
	09910 CORF	1	0		99.
	09920 OUTPATIENT PHYSICAL THERAPY	0	0		99.
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		99
	09940 OUTPATIENT SPEECH PATHOLOGY		0		99.
	SPECIAL PURPOSE COST CENTERS				
	1300 INTEREST EXPENSE	0	0		113.
8.00	SUBTOTALS (SUM OF LINES 1 through 117)	-7, 134, 719			118.
	IONREI MBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,		
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7, 411		190.
	19200 PHYSI CLANS' PRI VATE OFFICES	0	5, 209		192.
	07950 OCCUPATI ONAL HEALTH		0,207		194.
	07951 FOUNDATI ON		12, 323		194.
	07952 COMMUNITY & VOLUNTEER SVCS		74, 081		194.
	07954 ER PHYSICIAN		, , , 001		194.
	07953 SHI PSHEWANA RADI OLOGY AND LAB				194.
	A SECONDENSION IN THE OLDER AND END	-7, 134, 719	1 0		200.

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	S

COMMUNI TY	HOSPT.	0F	L	AGRANGE	CTY	IN	
			_				

	Financial Systems	COMM	UNITY HOSPT. OF				u of Form CMS-2552-
RECLASS	I FI CATI ONS			Provi der CCI	N: 15-1323	Period: From 01/01/2018 To 12/31/2018	Worksheet A-6 Date/Time Prepared 5/29/2019 2:50 pm
		Increases					
	Cost Center	Line #	Salary	Other			
	2.00	3.00	4.00	5.00			
	A - REHAB THERAPY RECLASS						
1.00	OCCUPATI ONAL THERAPY	67.00	146, 235	10, 796			1.
2.00	SPEECH PATHOLOGY	68.00	76, 245	5, 629			2.
	0		222, 480	16, 425			
	B - OB RECLASS						
1.00	NURSERY	43.00	121, 915	21, 028			1.
2.00	DELIVERY ROOM & LABOR ROOM	52.00	519, 831	89, 660			2.
	0		641, 746	110, 688			
1	C - CLINIC DIETICIAN	· ·					
1.00	LI FEBRI DGE SENI OR CARE	90.01	2, 905	0			1.
			2,905	<u>0</u>			
	F - CAFETERIA RECLASS						
1.00	CAFETERI A	11.00	256, 345	215, 094			1.
	0		256, 345	215, 094			
	G - INSURANCE RECLASS						
	CAP REL COSTS-BLDG & FIXT	1.00	0	36, 011			1.
	CAP REL COSTS-MVBLE EQUIP	2.00	0	15, 424			2.
	0			51, 435			
	H - DRUGS CHARGED TO PATIENTS	<u> </u>		01,100			
	DRUGS CHARGED TO PATIENTS	73.00	0	551			1.
				551			
f	I - SALARY RECLASS		<u> </u>				
1.00	ADMI NI STRATI VE & GENERAL	5.00	2, 582, 841	0			1.
			2, 582, 841	<u>0</u>			
L .	K - DEPRECIATION		2, 302, 041	0			
	CAP REL COSTS-MVBLE EQUIP	2.00	0	690, 860			1.
	EMS WEST STATION	1.01	0	16, 040			2.
	EMS WEST STATION EQUIP.	2.01	0	29, 075			3.
	ADMINISTRATIVE & GENERAL	5.00	0	17, 163			4.
			0	753, 138			4.1
	L - BLDG & LEASE EXPENSE		<u> </u>	755, 150			
	CAP REL COSTS-MVBLE EQUIP	2.00	0	1, 656			1.
	EMS WEST STATION EQUIP.	2.00	0	100			2.
	EMS WEST STATION LOOT	1.01	0	1, 129			3.
3.00				2, 885			5.
÷	M - INTEREST RECLASS		<u> </u>	2,005			
	CAP REL COSTS-BLDG & FIXT	1.00	0	369, 634			1.1
1.00	CAP KEL CUSTS-BLDG & FIAT		— — — ў				1.1
			U	369, 634			
	N - IMPLANTABLE MEDICAL SUPPL		0	207.005			1
	IMPL. DEV. CHARGED TO	72.00	0	287, 085			1.
H	PATI ENTS	\vdash — — $+$	— —				
F00 00	U Crand Tatal: Increases		2 704 217	287,085			500
500. 00 J	Grand Total: Increases		3, 706, 317	1, 806, 935			500.

_ASSI FI CA	cial Systems ATLONS	CONING	JNITY HOSPT. OF		CN: 15-1323	Peri od:	u of Form CMS-2552 Worksheet A-6
						From 01/01/2018 To 12/31/2018	
		Decreases					
	Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	-	
	6.00	7.00	8.00	9.00	10.00		
	EHAB THERAPY RECLASS						
	CAL THERAPY	66.00	222, 480	16, 425		0	1
		0.00	0	0		<u>o</u>	2
0			222, 480	16, 425			
	DB RECLASS						
D ADULT	S & PEDIATRICS	30.00	641, 746	110, 688		0	1
		0.00	0	0		0	2
0			641, 746	110, 688			
C - C	CLINIC DIETICIAN						
DI ETA	RY	10.00	2, 905	0		0	1
0			2, 905	0			
F – C	CAFETERIA RECLASS						
DI ETA	RY	10.00	256, 345	215, 094		0	1
0		T	256, 345	215, 094		7	
G – I	NSURANCE RECLASS					·	
D ADMIN	II STRATI VE & GENERAL	5.00	0	51, 435	1	12	1
o		0.00	0	0	1	12	2
0				51, 435		1	
H – D	RUGS CHARGED TO PATIENTS						
D PHARM		15.00	0	551		0	1
0				551		1	
I - S	ALARY RECLASS						
D ADMIN	II STRATI VE & GENERAL	5.00	0	2, 582, 841		0	1
0				2, 582, 841		1	
K – D	DEPRECIATION	I			1	- 1	
	REL COSTS-BLDG & FIXT	1.00	0	753, 138		9	1
		0.00	0	0		9	2
		0,00	0	0		9	3
		0.00	0	0		0	4
0				753, 138		-	
L – B	BLDG & LEASE EXPENSE	I			1	1	
	REL COSTS-BLDG & FIXT	1.00	0	1, 656	-	10	1
	REL COSTS-MVBLE EQUIP	2.00	0	1, 229		10	2
		0.00	0	0		10	3
-				2,885			-
M – I	NTEREST RECLASS	I		_,	<u>.</u>		
	REST EXPENSE	113.00	0	369, 634	1	11	1
0			— — —	369, 634		·	'
N - I	MPLANTABLE MEDICAL SUPPLI	ES	9	007,004			
	CAL SUPPLIES CHARGED TO	71.00	0	287, 085		0	1
PATIE		, 1. 00	Ĭ	207,000		Ĩ	'
	···· +	+	— — — "[<u>├── ──</u>	-	
	I Total: Decreases		1, 123, 476	4, 389, 776			500

RECONO	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	N: 15-1323	Period: From 01/01/2018 To 12/31/2018		pared:
				Acqui si ti on	IS		
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	320, 702	0		0 0	0	1.0
2.00	Land Improvements	1, 972, 720	6, 000		0 6,000	0	2.0
3.00	Buildings and Fixtures	13, 534, 008	0		0 0	0	3.0
4.00	Building Improvements	29, 098	0		0 0	0	4.0
5.00	Fixed Equipment	7, 763, 317	35, 943		0 35, 943	0	5.0
6.00	Movable Equipment	9, 076, 178	916, 451		0 916, 451	705, 498	6.0
7.00	HIT designated Assets	1, 764, 689	33, 208		0 33, 208	0	7.0
8.00	Subtotal (sum of lines 1-7)	34, 460, 712	991, 602		0 991, 602	705, 498	8.0
9.00	Reconciling Items	122, 482	14, 738		0 14, 738	0	9.0
10.00	Total (line 8 minus line 9)	34, 338, 230	976, 864		0 976, 864	705, 498	10.0
		Endi ng Bal ance	Fully				
		5	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	320, 702	0				1. C
2.00	Land Improvements	1, 978, 720	576, 633				2.0
3.00	Buildings and Fixtures	13, 534, 008	404, 064				3.0
4.00	Building Improvements	29, 098	29, 098				4.0
5.00	Fixed Equipment	7, 799, 260	1, 535, 105				5.0
6.00	Movable Equipment	9, 287, 131	4, 298, 503				6.0
7.00	HIT designated Assets	1, 797, 897	1, 122, 060				7.0
8.00	Subtotal (sum of lines 1-7)	34, 746, 816	7, 965, 463				8.0
9.00	Reconciling Items	137, 220	0				9.0
10.00	Total (line 8 minus line 9)	34, 609, 596	7, 965, 463				10.0

		UNITY HOSPT. OF	LAGRANGE CTY	IN		In Lieu	u of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provider CC		То	m 01/01/2018 12/31/2018	Worksheet A-7 Part II Date/Time Pre 5/29/2019 2:50	pared: 0 pm
			SL	IMMARY OF CAP	PI TAL			
	Cost Center Description	Depreciation	Lease	Interest		isurance (see hstructions)	Taxes (see instructions)	
		9.00	10.00	11.00		12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	1, 656, 834	0		0	0	17, 163	1.00
1.01	EMS WEST STATION	0	0		0	0	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	26, 953	0		0	0	0	2.00
2.01	EMS WEST STATION EQUIP.	0	0		0	0	0	2.01
3.00	Total (sum of lines 1-2)	1, 683, 787			0	0	17, 163	3.00
		SUMMARY O						
	Cost Center Description		Total (1) (sum					
		Capi tal -Rel ate						
		d Costs (see	through 14)					
		instructions)						
		14.00	15.00					
4 00	PART 11 - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM		nd 2				1 00
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 673, 997					1.00
1.01	EMS WEST STATION	0	0					1.01
2.00	CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP.	0	26, 953					2.00
2.01 3.00	Total (sum of lines 1-2)	0						2.01 3.00
3.00	Total (Sull OF THES 1-2)	I U	1, 700, 950					3.00

Heal th	Financial Systems COMM	UNITY HOSPT. OF	- LAGRANGE CTY	IN	In Lie	u of Form CMS-2	552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	1	Period: From 01/01/2018 Fo 12/31/2018		pared:) pm
		COMF	PUTATION OF RAT	FI OS	ALLOCATION OF		
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1.00	2.00	3.00	4.00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE				1		
1.00	CAP REL COSTS-BLDG & FIXT	23, 340, 980	0	23, 340, 980	0. 711905	0	1.00
1.01	EMS WEST STATION	320, 808	0				1.01
2.00	CAP REL COSTS-MVBLE EQUIP	8, 788, 066				0	2.00
2.01	EMS WEST STATION EQUIP.	499, 065		1777000		0	2.01
3.00	Total (sum of lines 1-2)	32, 948, 919					3.00
		ALLOCAT	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel ate	cols. 5			
			d Costs	through 7)			
		6.00	7.00	8.00	9.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	1			1		
1.00	CAP REL COSTS-BLDG & FIXT	0	-		920, 077		1.00
1.01	EMS WEST STATION	0	0	0	16, 040		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	0	717, 813		2.00
2.01	EMS WEST STATION EQUIP.	0	-		29, 075		2.01
3.00	Total (sum of lines 1-2)	0	°	(1, 683, 005	0	3.00
			SL	JMMARY OF CAPI	ΓAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)		
		11.00	12.00	13.00	14.00	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE			1			
1.00	CAP REL COSTS-BLDG & FIXT	351, 033	36, 011			1, 322, 628	1.00
1.01	EMS WEST STATION	0			0 0	17, 169	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	15, 424	(0 0	733, 664	2.00
2.01	EMS WEST STATION EQUIP.	0	0	(0 0	29, 175	2.01
3.00	Total (sum of lines 1-2)	351, 033	51, 435	17, 16	3 0	2, 102, 636	3.00

Heal th	Fi nanc	i al	Systems
AD JUST	MENTS 1	0 F	XPENSES

Heal th	Financial Systems	COMML	JNI TY HOSPT. OI	F LAGRANGE CTY IN	In Lie	u of Form CMS-2	2552-1
	MENTS TO EXPENSES			Provider CCN: 15-1323	Period: From 01/01/2018	Worksheet A-8	
					To 12/31/2018	Date/Time Pre 5/29/2019 2:5	
				Expense Classification of To/From Which the Amount i			
	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 COSTS-BLDG & FIXT (chapter 2)	В	-1, 559	CAP REL COSTS-BLDG & FIXT	1.00	9	1.0
1.01	Investment income - EMS WEST		0	EMS WEST STATION	1. 01	0	1.0
2.00	STATION (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
2.00	COSTS-MVBLE EQUIP (chapter 2)		0	CAL REL COSTS-MUBLE EQUIT	2.00	0	2.0
2.01	Investment income - EMS WEST STATION EQUIP. (chapter 2)		0	EMS WEST STATION EQUIP.	2.01	0	2. (
3.00	Investment income - other		0		0.00	0	3.0
4.00	(chapter 2) Trade, quantity, and time		0		0.00	0	4.0
	discounts (chapter 8)		0				
5.00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.0
6.00	Rental of provider space by		0		0.00	0	6.0
7.00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7.0
7.00	stations excluded) (chapter		0		0.00	0	/.(
8.00	21) Tel evi si on and radi o servi ce	А	-5,420	OPERATION OF PLANT	7.00	0	8. 0
9.00	(chapter 21) Parking lot (chapter 21)		0		0.00	0	9. (
10. 00	Provi der-based physi ci an	A-8-2	-1, 746, 501			0	10. (
11.00	adjustment Sale of scrap, waste, etc.	А	-297	OPERATION OF PLANT	7.00	0	11. (
12.00	(chapter 23) Related organization	A-8-1	-1, 996, 997			0	12.
13.00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13.0
14.00	Cafeteria-employees and guests	В	-258, 853	CAFETERI A	11.00		
15.00	Rental of quarters to employee and others		0		0.00	0	15. (
16.00	Sale of medical and surgical		0		0.00	0	16. (
	supplies to other than patients						
17.00	Sale of drugs to other than patients		0		0.00	0	17.
18.00	Sale of medical records and		0		0.00	0	18. (
19.00	abstracts Nursing and allied health		0		0.00	0	19. (
	education (tuition, fees,					-	
20. 00	books, etc.) Vending machines		0		0.00	0	20.
	Income from imposition of		0		0.00		
	interest, finance or penalty charges (chapter 21)						
22.00	Interest expense on Medicare		0		0.00	0	22.
	overpayments and borrowings to repay Medicare overpayments						
23.00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.
	therapy costs in excess of limitation (chapter 14)						
24.00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24. (
	limitation (chapter 14)						
25.00	Utilization review -		0	*** Cost Center Deleted **	* 114.00		25.0
	physicians' compensation (chapter 21)						
26.00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. (
26. 01	Depreciation - EMS WEST		0	EMS WEST STATION	1.01	0	26. (
27.00	STATION Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. (
27.01	COSTS-MVBLE EQUIP Depreciation - EMS WEST		Ω	EMS WEST STATION EQUIP.	2.01	n	27.(
	STATION EQUIP.						
28.00 29.00	1.5		0	NONPHYSICIAN ANESTHETISTS	19.00 0.00		28. (29. (
	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67.00		30.0
	therapy costs in excess of limitation (chapter 14)						

Heal th	Fi nanci a	I Systems
AD JUST	MENTS TO	EXPENSES

COMMUNITY HOSPT. OF LAGRANGE CTY IN

In Lieu of Form CMS-2552-10

	Financial Systems	COMMU	JNITY HUSPI. U	F LAGRANGE CTY IN		U OT FORM CMS-2	
ADJUST	MENTS TO EXPENSES				Period: From 01/01/2018	Worksheet A-8	
					To 12/31/2018	Date/Time Pre 5/29/2019 2:5	pared: 0 pm
				Expense Classification or			
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount 2.00	Cost Center	Line #	Wkst. A-7 Ref.	
20.00	Uponico (non distinct) (see	1.00		3.00 ADULTS & PEDIATRICS	4.00	5.00	30, 99
30. 99	Hospice (non-distinct) (see instructions)		U	ADULTS & PEDIATRICS	30.00		30.99
31.00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
31.00	pathology costs in excess of	A-0-3	0	SFEECH FAILOEOGI	00.00		31.00
	limitation (chapter 14)						
32.00	CAH HIT Adjustment for		0		0.00	0	32.00
02.00	Depreciation and Interest		0		0.00	0	02.00
33.00	HAF FEE EXPENSE REMOVAL	А	-1, 454, 109	ADMI NI STRATI VE & GENERAL	5.00	0	33.00
33. 02	CAH HIT ADJ DEPR CARRYFRWD	A	-288, 683	ADMI NI STRATI VE & GENERAL	5.00	0	33.02
	2012-2015						
34.00	MI SCELLANEOUS REVENUE	В	2, 574	ADMI NI STRATI VE & GENERAL	5.00	0	34.00
35.00	SPEECH THERAPY CONTRACTED	В	-10, 263	SPEECH PATHOLOGY	68.00	0	35.00
38.00	PHARMACY EMPLOYEE RX PURCHASES	В	-471, 644	DRUGS CHARGED TO PATIENTS	73.00	0	38.00
39.00	RELATED PARTY INTEREST EXPENSE	A	-18, 601	CAP REL COSTS-BLDG & FIXT	1.00	11	39.00
40.00	SELF INSURANCE	A	-866, 765	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	40.00
41.00	LOBBY % OF DUES &	A	-3, 535	ADMI NI STRATI VE & GENERAL	5.00	0	41.00
	SUBSCRI PTI ONS						
42.00	HOSPITALIST CONTRACT REMOVAL	A	-363, 167	ADULTS & PEDIATRICS	30.00	0	42.00
44.00	EKG INTERPRETATION COSTS	A	-1,770	RADI OLOGY-DI AGNOSTI C	54.00	0	44.00
44.01	MARKETING	A	-500	ADMI NI STRATI VE & GENERAL	5.00	0	44.01
44.02	MARKETING	A	0	OCCUPATI ONAL THERAPY	67.00	0	44.02
44.03	MARKETING	A	-382	LIFEBRIDGE SENIOR CARE	90.01	0	
47.00	ADD-BACK OF DEMOLISHED ASSET	A	17, 940	CAP REL COSTS-BLDG & FIXT	1.00	9	47.00
48.00	ADD-BACK OF DEMOLITION COSTS	A	4, 125	ADMINI STRATI VE & GENERAL	5.00	0	48.00
49.00	MEDICAL DIRECTOR ADDITIONAL	A	1, 970	ANESTHESI OLOGY	53.00	0	49.00
49.01	MISC REV OFFSET	А	-3.366	NURSING ADMINISTRATION	13.00	0	49.01
49.02	MEDICAL DIRECTOR ADDITIONAL	A		ADULTS & PEDIATRICS	30.00	0	•
	A/P						
49.03	ON-CALL PROF TIME	A	-84, 966	ADULTS & PEDIATRICS	30.00	0	49.03
49.04	GROSS-UP ANESTHESIA EXPENSE	A	326, 500	ANESTHESI OLOGY	53.00	0	49.04
	FOR A/R						
49.05	MEDICAL DIRECTOR ADDITIONAL	A	70, 165	ANESTHESI OLOGY	53.00	0	49.05
	A/P						
49.06	TELEMETRY MONITORING	A	19, 385	ADULTS & PEDIATRICS	30.00	0	
50.00	TOTAL (sum of lines 1 thru 49)		-7, 134, 719				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

 column 6, line 200.)

 (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

 (2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Heal th	Financial Systems	COMMUNITY HOSPT.	OF LAGRANGE CTY IN	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 15-1323	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS			From 01/01/2018 To 12/31/2018		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	7, 833, 850	5, 615, 004	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY SUBSIDY ADJ.	0	3, 782, 980	2.00
3.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE INTEREST EXP	0	432, 863	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			7, 833, 850	9, 830, 847	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

na	5 1101	been posted to worksheet A,				FOI this part.	
					Related Organization(s) and/	or Home Office	
		Symbol (1)	Nama	Democratore of	Nama	Democrateria of	<u> </u>
		Symbol (1)	Name	Percentage of	Name	Percentage of	
				Ownershi p		Ownershi p	
		1.00	2.00	3.00	4.00	5.00	
		B INTERPRIATIONSHIP TO REL	TED OPCANIZATION(S) AND/OP I	OME DEELCE			

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

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

6.00	В	0.00 PARKVIEW HEALTH SYSTEM, INC.	100.00	6.00
7.00		0.00	0.00	7.00
8.00		0.00	0.00	8.00
9.00		0.00	0.00	9.00
10.00		0.00	0.00	10.00
100.00	G. Other (financial or			100.00
	non-financial) specify:		1	1

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

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

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

C. Provider has financial interest in corporation, partnership, or other organization.

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

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

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

Health Financial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY IN	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1323	From 01/01/2018	Worksheet A-8-1 Date/Time Prepared: 5/29/2019 2:50 pm

			5/29/2019 2:3	ju pili
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUST	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	2, 218, 846	0		1.00
2.00	-3, 782, 980	0		2.00
3.00	-432, 863	0		3.00
4.00	0	0		4.00
5.00	-1, 996, 997			5.00

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

nas not	Deen posted to worksheet A,	cordinars r and/or 2, the amount arrowable should be that cated th cordinar 4 of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business	1	
	6.00	1	
	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

rerinbu								
6.00	HOME OFFICE	6.00						
7.00		7.00						
8.00		8.00						
9.00		9.00						
10. 00 100. 00		10.00						
100.00		100.00						

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

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

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

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

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

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

Heal th	Financial Syste	ems		CON	IMUNITY HOSPT. ()FL	_AGRANGE CTY	IN	In Lie	eu of Form CMS-	2552-10
PROVI DE	R BASED PHYSIC	I AN	ADJUS	STMENT			Provider C		Peri od:	Worksheet A-8	3-2
									From 01/01/2018 To 12/31/2018		
	Wkst. A Line #		Cost	Center/Physician	Total	Pr	ofessional	Provi der	RCE Amount	Physi ci an/Prov	
				Identi fier	Remunerati on	(Component	Component		ider Component	
										Hours	
	1.00			2.00	3.00		4.00	5.00	6.00	7.00	
1.00	53.00				518, 880		437, 805	81, 075			1.00
2.00	53.00				790, 582		790, 582	C		-	2.00
3.00	91.00				3, 125		0	3, 125		-	3.00
4.00	91.00				1, 772, 188		518, 114	1, 254, 074		0	4.00
5.00	30.00				13, 335		0	13, 335		0	5.00
6.00	90.00				23, 725		0	23, 725		0	6.00
7.00	53.00		G		20, 000		0	20, 000	0	0	7.00
8.00	0.00				0		0	C	0	0	8.00
9.00	0.00				0		0	C	0	0	9.00
10.00	0.00				0		0	C	0	0	10.00
200.00					3, 141, 835		1, 746, 501	1, 395, 334		0	200.00
	Wkst. A Line #		Cost	Center/Physi ci an	Unadjusted RCE		Percent of	Cost of		Physician Cost	
				ldenti fi er	Limit	Una		Memberships &		of Malpractice	
							Limit	Conti nui ng	Share of col.	Insurance	
								Educati on	12		
	1.00			2.00	8.00		9.00	12.00	13.00	14.00	
1.00	53.00				0		0	C		-	1.00
2.00	53.00				0		0	C		-	2.00
3.00	91.00				0		0	C	-	0	3.00
4.00	91.00				0		0	C	-	0	4.00
5.00	30.00				0		0	C	-	0	5.00
6.00	90.00				0		0	C	0	0	6.00
7.00	53.00		G		0		0	C	0	0	7.00
8.00	0.00				0		0	C	-	0	8.00
9.00	0.00				0		0	C	0	0	9.00
10.00	0.00				0		0	C	0	-	10.00
200.00					0		0	(0	0	200.00
	Wkst. A Line #		Cost	Center/Physician	Provi der	Ad	ljusted RCE	RCE	Adjustment		
				ldentifier	Component		Limit	Di sal I owance			
					Share of col.						
	1.00			2.00	14		1(00	17.00	10.00		
1 00	1.00		^	2.00	15.00		16.00	17.00	18.00		1 00
1.00	53.00				0		0	0			1.00
2.00	53.00				0		0	0			2.00
3.00	91.00				0			0	-		3.00
4.00	91.00				0		0	0			4.00
5.00	30.00				0		0	0			5.00
6.00	90.00				0		0	0	-		6.00
7.00	53.00		G		0		0	(7.00
8.00	0.00				0		0	(-		8.00
9.00	0.00				0		0	C			9.00
10.00	0.00				0		0	0	-		10.00
200.00					0		0	C	1, 746, 501		200.00

	ALLOCATION - GENERAL SERVICE COSTS	UNITY HUSPI. UP	Provider CC	N: 15-1323 P	eriod:	Worksheet B	2552-10
				T	rom 01/01/2018 o 12/31/2018	Part I Date/Time Pre 5/29/2019 2:50	pared:
				CAPITAL REI	LATED COSTS	372772017 2.3	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	BLDG & FIXT	EMS WEST STATI ON	MVBLE EQUIP	EMS WEST STATION EQUIP.	
		<u>col.7)</u> 0	1.00	1.01	2.00	2.01	
	GENERAL SERVICE COST CENTERS						
1.00 1.01	00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION	1, 322, 628 17, 169	1, 322, 628 0	17, 169			1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	733, 664	0	17, 109	733, 664		2.00
2.01	00201 EMS WEST STATION EQUIP.	29, 175			0	29, 175	2. 01
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	3, 928, 880 8, 743, 261	0 242, 333	0	0 134, 423	0	4.00
6.00	00600 MAINTENANCE & REPAIRS	0, 743, 201	242, 333	0	134, 423	0	6.00
7.00	00700 OPERATION OF PLANT	1, 121, 905	75, 124	0	41, 672	0	7.00
8.00 9.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	87,864	4, 295	0	2, 383 7, 798	0	8.00 9.00
9.00 10.00	01000 DI ETARY	265, 469 267, 358	14, 057 56, 398	0	7, 798 31, 284	0	10.00
11.00	01100 CAFETERI A	212, 586	0	0	0	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00 14.00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	338, 573 -55, 041	0 26, 790	0	0 14, 860	0	13.00
15.00	01500 PHARMACY	565, 567	23, 055	0	12, 789	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	4, 550	0	2, 524		16.00
17.00 19.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	17.00 19.00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECI FY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23.00
30.00	03000 ADULTS & PEDIATRICS	1, 329, 904	297, 680	0		0	
43.00	04300 NURSERY	142, 943	4, 482	0	2, 486	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	1, 408, 466	169, 670	0	94, 116	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	609, 491	21, 188	0	11, 753	0	52.00
53.00	05300 ANESTHESI OLOGY	101, 663	0	0	0	0	53.00
54.00 60.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	1, 309, 148 1, 152, 549	84, 088 33, 547	0	46, 644 18, 609	0	54.00 60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPI RATORY THERAPY	311, 205	9, 881	0	5, 481	0	65.00
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	333, 097 157, 031	56, 229 0	0	31, 190 0	0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	71, 611	0	0	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	398, 935	0	0	0	0	71.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	287, 085 1, 215, 411	0	0	0	0	•
76.97	07697 CARDI AC REHABI LI TATI ON	29, 453	5, 959	0	3, 305	0	76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
76. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	U	0	0	0	76.99
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01 91. 00	09001 LI FEBRI DGE SENI OR CARE 09100 EMERGENCY	256, 046 2, 373, 567	15, 449 117, 499	0	8, 570 65, 177	0	90.01
91.00 92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 373, 307	117,499	0	03, 177	0	91.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	1, 299, 738	0	17, 169	0	29, 175	
99. 10 99. 20	09910 CORF 09920 OUTPATI ENT PHYSI CAL THERAPY		0	0	0	0	99.10 99.20
99.20 99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
113 00	SPECIAL PURPOSE COST CENTERS						113.00
118.00		30, 366, 401	1, 262, 274	17, 169	700, 186	29, 175	•
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 411	3, 786	0	2, 100	0	190. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	5, 209	56, 568	0	31, 378	0	192.00
	07950 OCCUPATI ONAL HEALTH 07951 FOUNDATI ON	0 12, 323	0	0	0		194.00 194.01
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS	74, 081	0	0	0		194.01
194.04	07954 ER PHYSICIAN	0	0	0	0	0	194.04
	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	0	0	0	194.06
200.00			0	0	0	n	200. 00 201. 00
		1	<u> </u>	0	0	0	1-01.00

Health Financial Systems	COMMUNITY HOSPT. OF	LAGRANGE CTY	IN	In Lieu of Form CMS-2552-10		
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CO	F	eriod: rom 01/01/2018 o 12/31/2018	Worksheet B Part I Date/Time Pre 5/29/2019 2:5	pared: 0 pm
			CAPITAL RE	LATED COSTS		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	EMS WEST STATI ON	MVBLE EQUIP	EMS WEST STATION EQUIP.	
	0	1.00	1.01	2.00	2.01	
202.00 TOTAL (sum lines 118 through 201)	30, 465, 425	1, 322, 628	17, 169	733, 664	29, 175	202.00

	nancial Systems COMMI CATION - GENERAL SERVICE COSTS	JNI TY HOSPT. OF	Provi der CC	N: 15-1323 Pe	eriod: com 01/01/2018	of Form CMS-: Worksheet B Part I Date/Time Pre	epared:
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT		ADMI NI STRATI VE & GENERAL	REPAI RS	5/29/2019 2:5 OPERATION OF PLANT	0 pm
CEN		4.00	4A	5.00	6.00	7.00	
	IERAL SERVICE COST CENTERS						1.0
	01 EMS WEST STATION						1.0
2.00 002	200 CAP REL COSTS-MVBLE EQUIP						2.0
	201 EMS WEST STATION EQUIP.						2.0
	OO EMPLOYEE BENEFITS DEPARTMENT	3, 928, 880					4.0
	600 ADMINI STRATI VE & GENERAL	1, 152, 234	10, 272, 251	10, 272, 251			5.0
	000 MAINTENANCE & REPAIRS 700 OPERATION OF PLANT	112 201	1 250 002	0	0	2 027 771	6.0
	300 LAUNDRY & LINEN SERVICE	112, 201	1, 350, 902 94, 542	686, 869 48, 070	0	2, 037, 771 8, 708	
	000 HOUSEKEEPI NG	66, 849	354, 173	180, 080	0	28, 498	
	DOO DI ETARY	51, 867	406, 907	206, 893	0	114, 336	
11.00 011	00 CAFETERI A	91, 441	304, 027	154, 583	0	0	11.0
	200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	
	BOO NURSI NG ADMI NI STRATI ON	121,804	460, 377	234, 080	0	0	
	00 CENTRAL SERVI CES & SUPPLY 500 PHARMACY	3,573	-9, 818	0 205 242	0	54, 311	14.0 15.0
	000 MEDICAL RECORDS & LIBRARY	176, 168 0	777, 579 7, 074	395, 362 3, 597	0	46, 739 9, 224	
	00 SOCIAL SERVICE	0	,, 0,4	0,077	0	0,224	
	000 NONPHYSICIAN ANESTHETISTS	Ō	0	0	0	0	19.0
20.00 020	000 NURSI NG SCHOOL	О	0	0	0	0	20.0
	00 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
	200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
	300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. C
	ATIENT ROUTINE SERVICE COST CENTERS	407, 954	2, 200, 660	1, 118, 930	0	603, 481	30. 0
	BOO NURSERY	43, 489	193, 400	98, 335	0	9, 086	
	I LLARY SERVICE COST CENTERS	10, 10,	170, 100	70,000		7,000	10.0
	DOO OPERATING ROOM	240, 228	1, 912, 480	972, 404	0	343, 971	50.0
52.00 052	200 DELIVERY ROOM & LABOR ROOM	185, 430	827, 862	420, 928	0	42, 953	52.0
	300 ANESTHESI OLOGY	0	101, 663	51, 691	0	0	
	OO RADI OLOGY-DI AGNOSTI C	247, 036	1, 686, 916	857, 716	0	170, 471	
	DOO LABORATORY	0	1, 204, 705	612, 535	0	68, 009	
	250 BLOOD CLOTTING FOR HEMOPHILIACS 500 RESPIRATORY THERAPY	0 104, 908	421 475	0 219, 384	0	0	62.3 65.0
	00 PHYSICAL THERAPY	110, 651	431, 475 531, 167	270, 073	0	20, 031 113, 992	
	OO OCCUPATIONAL THERAPY	52, 164	209, 195	106, 366	0	0	67. C
	BOO SPEECH PATHOLOGY	27, 198	98, 809	50, 240	0	0	
	200 ELECTROCARDI OLOGY	O	0	0	0	0	69. C
	00 MEDICAL SUPPLIES CHARGED TO PATIENT	0	398, 935	202, 839	0	0	
	200 IMPL. DEV. CHARGED TO PATIENTS	0	287, 085	145, 969	0	0	
	300 DRUGS CHARGED TO PATIENTS 997 CARDIAC REHABILITATION	0 2, 728	1, 215, 411 41, 445	617, 978 21, 073	0	0 12, 081	
	98 HYPERBARI C OXYGEN THERAPY	2,720	41, 445	21,073	0	12,081	
	99 LI THOTRI PSY	0	0	0	0	0	
	PATIENT SERVICE COST CENTERS	-1	-				
90.00 090		0	0	0	0	0	90.0
	001 LI FEBRI DGE SENI OR CARE	55, 254	335, 319	170, 494	0	31, 320	
	00 EMERGENCY	303, 753	2, 859, 996	1, 454, 167	0	238, 205	
	200 OBSERVATI ON BEDS (NON-DI STI NCT PART		0				92.0
	OO AMBULANCE SERVICES	360, 680	1, 706, 762	867, 807	0	0	95.0
99.10 099		300, 080	1, 700, 702	007, 807	0	0	99.1
	20 OUTPATIENT PHYSICAL THERAPY	0	0	0	o	0	
	230 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	
99.40 099	040 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.4
	CIAL PURPOSE COST CENTERS						
	300 I NTEREST EXPENSE						113.0
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	3, 917, 610	30, 261, 299	10, 168, 463	0	1, 915, 416	1118. 0
	IREI MBURSABLE COST CENTERS DOO GIFT, FLOWER, COFFEE SHOP & CANTEEN		13, 297	6, 761	~	7 675	190. 0
	200 PHYSICIANS' PRIVATE OFFICES	0	93, 155	47, 365	0	114, 680	
	250 OCCUPATIONAL HEALTH	0	, 3, 133	47, 303	0		194. C
	251 FOUNDATI ON	6, 244	18, 567	9, 440	õ		194.0
194. 03 079	252 COMMUNITY & VOLUNTEER SVCS	5, 026	79, 107	40, 222	0	0	194.0
	254 ER PHYSICIAN	0	0	0	О		194. 0
	253 SHI PSHEWANA RADI OLOGY AND LAB	0	0	0	0	0	194. 0
200.00	Cross Foot Adjustments		0	_	_	-	200.0
	Negative Cost Centers	0	0	0	0		201. 0
201.00 202.00	TOTAL (sum lines 118 through 201)	3, 928, 880	30, 465, 425	10, 272, 251	0	2, 037, 771	1000

From 01/02/2018 Deriv L (1)/21/2018 Deriv L (2)/21/2018 Deriv L (2)/21/2018 <thderiv l<br="">(2)/21/2018 Deriv L (2)/21/2018</thderiv>		IUNITY HOSPT. OF				u of Form CMS-2	2552-10
Cost Contor Description Landon A Landon Landon A Landon A Landon A Landon Landon Landon A	COST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	F	rom 01/01/2018		pared [.]
LILBER SERVICE - PERSONEL 000 00001 CPU REL CODIT -SUDIT & FLIXI 1.00 11.00 12.00 00001 CPU REL CODIT -SUDIT & FLIXI 1.00 1.00 1.00 1.00 0.0000 CPU REL CODIT -SUDIT & FLIXI 1.00 1.00 1.00 1.00 0.0000 CPU REL CODIT -SUDIT & FLIXI 2.00 2.00 2.00 2.00 0.0000 CPU REL CODIT -SUDIT & FLIXI 2.00 2.00 2.00 2.00 0.0000 CPU REL CODIT -SUDIT & FLIXI 0.00 <	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DIFTARY		5/29/2019 2:5	0 pm
BRIARD SHAPLE COST CUTLENS 1.00 0.00 000000 (MEL COST CUTLENS 1.00 1.00 00000 (MEL COST CUTLENS 2.00 0.00 00000 (MELOVES ELST IST ION ELCUTP 2.00 0.00 00000 (MELOVES ELST IST ION ELCUTP 2.00 0.00 00000 (MELOVES ELST IST ION ELCUTPS 6.00 0.00 00000 (MELOVES ELST IST ION ELCUTPS 6.00 0.00 00000 (MELOVES ELST IST ION ELCUTPS 6.00 0.00 00000 (MELOVES ELST INT ION ELCUTPS 0.00 0.00 00000 (MELOVES ELST INT ION ELCUTPS 0.00 0.00 00000 (MELOVES ELST INT ION ELCUTPS 0.00 1.100 CAT ITRAY IBD2 37, 162 0.00 1.100 CAT ITRAY IBD2 37, 162 0.00 1.10 1.100 CAT ITRAY IBD2 37, 162 0.00 1.10 1.100 CAT ITRAY IBD2 37, 162 0.00 0.00 1.10 1.100 CAT ITRAY IBD2 37, 170 1.10 1.10 1.10		LINEN SERVICE				PERSONNEL	
1.101 DIOTO HER WEST STATION 1.01 2.01 DOOD EX WEST STATION E DUIP 2.01 2.01 DOOD EX WEST STATION E DUIP 2.01 0.00000 AUNTENNATE & DEPRAL 5.00 0.00000 AUNTENNATE & DEPRAL 5.00 0.00000 AUNTENNATE & DEPRAL 7.00 0.00000 AUNTENNATE & DEPRAL 0 0.00000 AUNTENNATE & DEPRENNEL 0 0.0000 AUNTENNATE & DEPRENNEL 0 </td <td>GENERAL SERVICE COST CENTERS</td> <td>0.00</td> <td>9.00</td> <td>10.00</td> <td>11.00</td> <td>12.00</td> <td></td>	GENERAL SERVICE COST CENTERS	0.00	9.00	10.00	11.00	12.00	
2.00 DOUDOI CAP PTI. DOUDOI CAP PTI. 2.00 DOUDOI CAP PTI. DOUDOI CAP PTI. 4.00 DOUDOI CAP PTI. DOUDOI CAP PTI. 4.00 DOUDOI CAP PTI. PTI. PTI. 4.00 DOUDOI CAP PTI. PTI. PTI. 6.00 DOUDOI CAP PTI. PTI. PTI. PTI. 6.00 DOUDOI CAP PTI. PTI. PTI. PTI. PTI. 6.00 DOUDOI CAP PTI. PTI.<							1.00
2.10 00070 FURS							2.00
5.00 DOSCOL ADMIN ISTRATIVE & A CENERAL 5.00 DOSCOL ADMIN ISTRATIVE & A CENERAL 5.00 7.00 DOTOD OPERATION OF PLAYT 5.02 751 700 7.00 DOTOD OPERATION OF PLAYT 5.02 751 700 7.00 DOTOD OPERATION OF PLAYT 802 522.152 761.100 1100 7.00 DOTOD OPERATION OF PLAYT 802 52.152 761.100 1100 7.00 DOTOD OPERATION OF PLAYT 6 7.00 0 458.60 1100 7.00 DOTOD OPERATION OF PLAYT 6 1.00 7.00 0 1.00							2.01
6.00 000000 (LAUREY AL THE WATE & REPAIRS 6.00 000000 (LAUREY AL THE ALTIN OF PLANT 7.00 7.00 8.00 000000 (LAUREY AL THE SERVICE 151, 220 56.2, 751 761, 100 6.00 00000 11.00 01000 (LAUREY AL THE WATE OF PERSONNEL 00 0							4.00
7.00 COND OPERATION OF FLANT 9 9.00 COND COND COND FILE 8 0 8 0 8 0 8 0 8 0							
9 000 000000 HOUSEKEEPIN INS 9 000 000000 HOUSEKEEPIN INS 9 0000000 HOUSEKEEPIN INS 9 000000 HOUSEKEEPIN INS 9 0000000 HOUSEKEEPIN INS 9 00000000 HOUSEKEEPIN INS 9 00000000 HOUSEKEEPIN INS 9 00000000000000000000000000000000000							7.00
10.00 DOTOOD DIFTARY 802 52.1.2 761.100 45.6 10 10.00 DITOOD GAPTERIA 0		-					8.00
11.00 DO TODO CAFETERIA 0 0 0 458,610 11.00 12.00 DITODO MINESING ADUM INSTRATION 0 0 0 0.00 0.00		0		761 100			
12:00 01:200 MAINTENANCE OF PERSONNELL 0 13:04 0		0			458, 610		11.00
14.00 CNUTRAL SERVICES & SUBPLY 0 15, 278 0 0 0 14, 00 15.00 D1500 (MARNACC) 0 13, 148 0 27, 699 15, 00 15.00 D1500 (MARSING SCHOLLAL RECORDS & LIBRARY 0 2, 595 0 0 0 0 0 16, 00 0		0	0	0	0	0	12.00
10 00 01500 PHARMACY 0 13, 148 0 27, 699 0 15, 00 10 01700 SGCIAL SERVICE 0 <td< td=""><td></td><td>0</td><td>0</td><td>-</td><td>25, 084</td><td></td><td>13.00</td></td<>		0	0	-	25, 084		13.00
16. 00 01600 HEDICAL RECORDS & LIBRARY 0 2.595 0		0		0	0 27 699	-	
10 00 01 00 0 <td></td> <td>0</td> <td></td> <td>-</td> <td></td> <td>-</td> <td>16.00</td>		0		-		-	16.00
20.00 02000 NURSING SCHOOL PRINGES APPRV 0		0	0	0	0	0	17.00
21.00 02100 AR SERVICES-SALARY & FRINCES APPRV 0 0 0 0 0 22.00 22.00 02200 PARAMED ED PRCM_(SPECIFY) 0 0 0 0 22.00		0	0	0	0	-	19.00
22 00 02200 AR SERVICES-OTHER PROM_COSTS APRV 0 0 0 0 0 0 23 00 IMPATIENT ROUTINE SERVICE COST CENTERS		0	0	0	0	-	•
INPATIENT AUTOLINE SERVICE COST CENTERS 1 1 1 04300 DAULTS & PEDALTRICS 47,448 169,755 761,100 97,187 0 300 43.00 03000 NURSERY 2,528 2,556 0 8,326 0 43,00 40.01 LARY SERVICE COST CENTERS 24,882 9,6758 0 54,611 0 50,00 550,00 550,00 55,00 0 53,00 053,00 0,63,00 0,83,00 0,83,438 0 52,00 0 <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>22.00</td>		0	0	0	0	0	22.00
30: 00 03000 ADULTS & PEDIATRICS 47,448 169,755 761,100 97,187 0 30.0 AND (LLARY SERVICE COST CENTERS 2,528 2,556 0 8.320 0 43.00 ANCILLARY SERVICE COST CENTERS 2,528 2,556 0 8.320 0 43.00 0.00 05000 DELUYERY ROM & LABOR ROM 10,791 12,083 0 55.00 0 55.00 0 0 0 0 0 0 53.00 0 53.00 0		0	0	0	0	0	23.00
43. 00 04300 NURSERY 2,528 2,556 0 8,326 0 43. 00 ANCLLARY SERVICE COST CENTES 50. 00 50000 DELVICEY NOOM & LABOR ROOM 10,791 12,083 0 35,438 0 52. 00 52.00 05.000 DELVICEY NOOM & LABOR ROOM 10,791 12,083 0 35,438 0 52. 00 53.00 0 0 0 0 0 53. 00 0 0 0 0 53. 00 0 0 0 63.00 0		17 119	160 755	761 100	07 107	0	20.00
50. 00 05000 DELVICRY ROOM 24.882 96,758 0 54.811 0 50.00 53. 00 05200 M & LABOR ROOM 10,791 12.083 0 35.438 0 52.00 63.00 05300 ANESTHESI OLOCY 0						-	
52:00 05200 DELIVERY ROM & LABOR ROM 10,791 12,083 0 35,438 0 52.00 54:00 05400 RADILOGY 0 <td< td=""><td>ANCI LLARY SERVI CE COST CENTERS</td><td></td><td></td><td></td><td></td><td></td><td></td></td<>	ANCI LLARY SERVI CE COST CENTERS						
53.00 05300 ANESTHESIOLOGY 0 0 0 0 0 53.00 05300 ANESTHESIOLOGY 20,826 47,953 0 66,032 0 54.00 60.00 06000 LABORATORY 0				-		-	
54. 00 654.00 ADD (LOGY-DI AGNOSTIC 20,826 47,953 0 60,362 54. 00 60. 00 GOOD (LABORATORY 0 19,131 0 0 62. 30 62.30 06250 BLODO CLOTTI NG FOR HEMOPHILI AGS 0 5. 615 32,065 0 28,713 65. 00 66.00 06500 RESPI RATORY THERAPY 5. 615 32,065 0 28,073 0 66. 00 0. 60700 OCUPATI ONAL THERAPY 2,331 0 0 9,820 67. 00 66.00 06000 SPECEL PATHOLOGY 2422 0 0 45.36 0 68.00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 70. 0 70.00		10, 791	12,083	-	35, 438	-	
62.30 662.50 RLOOD CLOTTING FOR HEMOPHILIACS 0 0 0 62.30 66.00 GROM GESPIRATORY THERAPY 0 5.635 0 28,073 0 66.00 66.00 06000 PHYSI CAL THERAPY 2,331 0 0 9,820 0 67.00 66.00 06000 SPECH PATHOLOGY 242 0 0 45.36 0 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 68.00 0 0 0 0 0 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 0 0 0 0 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 76.97 76.97 76.97 76.97 76.97 76.99 76.99 76.95		20, 826	47, 953	-	60, 362	-	54.00
65.00 06500 REST RATORY THERAPY 0 5,635 0 28,713 0 66.00 66.00 06600 PHYSI CAL THERAPY 5,615 32,065 0 28,073 0 66.00 66.00 06600 PHYSI CAL THERAPY 2,331 0 0 9,820 67.00 67.00 06700 0CCUPATI ONAL THERAPY 2,331 0 0 9,820 67.00 68.00 OBG00 ELECTROCARDIOLOGY 24.2 0		0		-	-	-	60.00
66.00 06600 PHS1 CAL THERAPY 5,615 32,065 0 28,073 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 2,331 0 0 9,820 0 67.00 68.00 06800 SPEECH PATHOLOGY 242 0 4,536 68.00 69.00 MEDICAL SUPPLIES CHARGED TO PATIENT 0		0	•	-	s	-	
67.00 06700 0CCUPATIONAL THERAPY 2,331 0 9,820 0 67.00 68.00 06800 SPEECH PATHOLOGY 242 0 0 4,536 0 68.00 00 00 0				-			66.00
69:00 00				0		0	67.00
71.00 07100 DEIC CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 72.00 72.00 72.00 72.00 0 0 0 0 0 0 0 0 0 0 72.00 72.00 72.00 72.00 72.00 0 0 0 0 0 72.00 72.00 72.00 0 0 0 0 0 72.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 73.00 0 0 0 73.00 73.00 73.00 73.00 73.00 74.00 <td< td=""><td></td><td>242</td><td>0</td><td>0</td><td></td><td>-</td><td>68.00</td></td<>		242	0	0		-	68.00
72.00 OVEL DEV. CHARGED TO PATIENTS O <tho< td=""><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td>-</td><td></td></tho<>		0	0	0	0	-	
76.97 07697 CARDI AC REHABL LITATI ON 0 3,398 0 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0<		0	0	0	0		72.00
76.98 Or599 LI THOTRI PSY O		0	0	-	0	-	73.00
76.99 076.99 076.99 0 0 0 0 0 76.95 0UTPATI ENT SERVICE COST CENTERS 0 <t< td=""><td></td><td>0</td><td>3, 398</td><td>0</td><td>0</td><td>-</td><td></td></t<>		0	3, 398	0	0	-	
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0 0 00.00 0 00.01 091.00 091.00 000.01 000.01 099.01 99.01 0992.01 0992.01 000.00 000.00 000.00 099.00 099.00 000.00 000.00 000.00 099.00 099.00 000.00 000.00 000.00 000.00 099.00 099.00 000.00 000.00 000.00 000.00 000.00 000.00 000.00 000.00 <t< td=""><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td>76.99</td></t<>		0	0	0	0		76.99
90.01 09001 LIFEBRIDGE SENIOR CARE 0 8,810 0 14,250 0 90.01 91.00 DEMERGENCY 28,378 67,006 0 64,311 0 91.00 92.00 DSERVATION BEDS (NON-DISTINCT PART 28,378 67,006 0 64,311 0 92.00 92.00 DSERVATION BEDS (NON-DISTINCT PART 28,378 0 0 0 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 99.00 0 0 0 0 99.10 0.9910 0.0 0 0 99.10 99.10 0.9920 0UTPATI ENT PHYSICAL THERAPY 0 0 0 0 99.40 0.9940 0.0 0 0 99.40 99.40 0.9940 0.0 0 0 0 99.40 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 113.00 118.00 118.00 118.00 118.00 118.00 192.00	OUTPATIENT SERVICE COST CENTERS				1		
91.00 09100 EMERGENCY 28, 378 67, 006 0 64, 311 0 91.00 92.00 085ERVATI ON BEDS (NON-DI STINCT PART 92.00 085ERVATI ON BEDS (NON-DI STINCT PART 92.00 09500 AMBULANCE SERVICES 4, 253 0 0 0 92.00 09500 AMBULANCE SERVICES 4, 253 0 0 0 0 99.10 09910 CORF 0 0 0 99.10 09920 OUTPATI ENT PHYSICAL THERAPY 0 0 0 0 99.20 99.20 09920 OUTPATI ENT OCUPATIONAL THERAPY 0 0 0 0 99.20 09940 0UTPATI ENT SPEECH PATHOLOGY 0 0 0 99.40 00940 0 0 0 99.40 00940 0 0 0 0 113.00 110.		0	0	0	0	-	
92.00 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 92.00 95.00 OMBULANCE SERVICES 4,253 0 0 0 95.00 99.10 09910 CORF 0 0 0 99.10 09910 CORF 0 0 0 99.10 09930 OUTPATI ENT PHYSICAL THERAPY 0 0 0 99.20 09930 OUTPATI ENT OCUPATIONAL THERAPY 0 0 0 99.30 99.30 09930 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 99.30 99.40 SPECI AL PURPOSE COST CENTERS 113.00 113.00 11300 INTEREST EXPENSE 113.00 113.00 113.00 113.00 113.00 1148.096 528,333 761,100 458,610 0 148.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00 190.00		28.378		-		-	
95.00 09500 AMBULANCE SERVICES 4,253 0 0 0 0 95.00 99.10 09910 CORF 0 </td <td></td> <td>20,070</td> <td>07,000</td> <td>0</td> <td>01,011</td> <td>Ű,</td> <td>92.00</td>		20,070	07,000	0	01,011	Ű,	92.00
99.10 09910 CORF 0 0 0 0 99.10 99.20 09920 OUTPATI ENT PHYSI CAL THERAPY 0 0 0 0 99.20 99.30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 99.30 99.40 09940 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.30 99.40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.30 99.40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.30 99.40 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.30 113.00 INTEREST EXPENSE 113.00 INTEREST EXPENSE 113.00 118.00 118.00 118.00 IP9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 2,159 0 0 190.00 194.00 07950 OCCUPATI ONAL HEALTH 0 0 0 0 194.01							05.00
99.20 09920 0UTPATI ENT PHYSI CAL THERAPY 0 0 0 0 99.20 99.30 09930 0UTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 99.30 99.40 09940 0UTPATI ENT SPEECH PATHOLOGY 0 0 0 0 0 99.40 SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 11300 11300 118.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 190.00 61 FT, FLOWER, COFFEE SHOP & CANTEEN 0 2, 159 0 0 190.00 192.00 192.00 192.00 192.00 192.00 194.00 0 0 0 192.00 194.00		4, 253		-	-		
99.30 09930 0UTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 99.30 99.40 09940 0UTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.40 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 1NTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 113.00 113.00 113.00 1100 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 2,159 0 0 190.00 <td< td=""><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td>-</td><td></td></td<>		0	0	0	0	-	
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117) 148,096 528,333 761,100 458,610 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 148,096 528,333 761,100 458,610 0 118.00 NONREI MBURSABLE COST CENTERS 0 0 0 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.00 0 0 190.00 0 0 190.00 0 0 190.00 0 0 190.00 0 0 190.00 0 0 0 190.00 0 0 190.00 0 0 190.00 0 0 190.00 0 0 190.00 0 0 0 0 190.00 0	99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	
113.00 11300 INTEREST EXPENSE 113.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 118.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 119.00 1192.00 1192.00 1194.00 1194.00 1194.00 1194.00 1194.00 1194.00 1194.00 1194.00 1194.00 1194.00 1194.00 1194.00 1194.00		0	0	0	0	0	99.40
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 148,096 528,333 761,100 458,610 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 2,159 0 0 190.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 0 0 0 192.00 192.00 194.01 192.00 0 0 0 192.00 194.01 194.01 0 0 0 0 194.00 194.01 194.01 0 0 0 0 0 194.02 194.04 194.04 194.04 194.04 194.04 194.04 194.04 194.04 0 0 0 0 194.04 194.04 194.04 194.04 0 0 0 194.04 194.04 194.04 194.04 0 0 0 194.04 194.04 194.04 194.04 0 0 0 194.04 194.04 0 0 0 0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>113 00</td>							113 00
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 2,159 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 3,224 32,259 0 0 192.00 194.00 07950 OCCUPATI ONAL HEALTH 0 0 0 0 194.00 194.01 07951 FOUNDATI ON 0 0 0 0 194.00 194.03 07952 COMMUNI TY & VOLUNTEER SVCS 0 0 0 0 194.00 194.04 07954 ER PHYSI CI AN 0 0 0 0 194.04 194.04 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 194.04 194.04 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 194.04 200.00 Cross Foot Adjustments - - 200.00 201.00 201.00 0 0 0 0 200.00 201.00 </td <td></td> <td>148, 096</td> <td>528, 333</td> <td>761, 100</td> <td>458, 610</td> <td></td> <td></td>		148, 096	528, 333	761, 100	458, 610		
192.00 19200 PHYSICIANS' PRIVATE OFFICES 3,224 32,259 0 0 192.00 194.00 07950 OCCUPATIONAL HEALTH 0 0 0 0 194.00 194.01 07951 FOUNDATION 0 0 0 0 194.00 194.03 07952 COMMUNITY & VOLUNTEER SVCS 0 0 0 0 194.00 194.04 07954 ER PHYSICIAN 0 0 0 0 194.00 194.04 07954 ER PHYSICIAN 0 0 0 0 194.04 194.04 07953 SHI PSHEWANA RADIOLOGY AND LAB 0 0 0 0 194.04 194.06 07953 SHI PSHEWANA RADIOLOGY AND LAB 0 0 0 194.04 200.00 Cross Foot Adjustments 200.00 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	NONREI MBURSABLE COST CENTERS						100
194.00 07950 OCCUPATIONAL HEALTH 0 0 0 0 194.00 <td< td=""><td></td><td>0</td><td></td><td>-</td><td>-</td><td></td><td></td></td<>		0		-	-		
194. 01 07951 FOUNDATION 0 0 0 194. 01 194. 03 07952 COMMUNITY & VOLUNTEER SVCS 0 0 0 0 194. 03 194. 04 07954 ER PHYSICIAN 0 0 0 0 194. 04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 0 194. 04 200. 00 Cross Foot Adj ustments 0 0 0 0 200. 00 201. 00 Negati ve Cost Centers 0 0 0 0 0 0 201. 00		3, 224	3∠, ∠59 0	0	0		
194. 04 07954 ER PHYSICIAN 0 0 0 0 194. 04 194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 0 194. 04 200. 00 Cross Foot Adjustments 0 0 0 0 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 201. 00	194. 01 07951 FOUNDATI ON	0	0	0	0	0	194.01
194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB 0 0 0 194. 06 200. 00 Cross Foot Adjustments 200. 00 <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>		0	0	0	0		
200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0		0	0	0	0		
201.00 Negative Cost Centers 0 0 0 0 0 0 201.00		0	0	0	0		200.00
202.00 101AL (sum lines 118 through 201) 151,320 562,751 761,100 458,610 0 202.00	201.00 Negative Cost Centers	0	0	0	0		
	202.00 101AL (sum lines 118 through 201)	151, 320	562, 751	761, 100	458, 610	0	202.00

GEN 00 007 01 007 00 002 00 002 00 002 00 002 00 002 00 002 00 002 00 012 00 012 00 012 00 012 00 013 00 014 00 015 00 012 00 013 00 014 00 015 00 022 00 023 00 024 00 035 00 055 00 052 00 053 00 054 00 056 00 066 00 066 00 066 00 066 00<	Cost Center Description Cost Center Description VERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT 101 EMS WEST STATION 200 CAP REL COSTS-MVBLE EQUIP 201 EMS WEST STATION EQUIP 201 EMS WEST STATION EQUIP 202 CAP REL COSTS-MVBLE EQUIP 201 EMS WEST STATION EQUIP 201 EMS WEST STATION EQUIP 200 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 600 MAINTENANCE & REPAIRS 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 900 DI ETARY 100 CAFETERIA 200 MAINTENANCE OF PERSONNEL 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE 900 NONPHYSICIAN ANESTHETISTS 900 NURSING SCHOOL 100 I &R SERVICES-SALARY & FRINGES APPRV 200 I &R SERVICES-OTHER PRGM COSTS APPRV 200 I &R SERVICE COST CENTERS 900 ADULTS & PEDIATRICS 900 ADULTS & PEDIATRICS 900 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM 300 ANESTHESIOLOGY	NURSI NG ADMI NI STRATI ON 13. 00 719, 541 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Provi der CC CENTRAL SERVI CES & SUPPLY 14.00 59,771 1,239 0 0 0 0 0 0 0 0 0 0 0 0 0	PHARMACY 15.00 1,261,766 0 0 0 0 0 0 0 0 0 0 0 0 0	MEDI CAL RECORDS & LI BRARY 16. 00 22, 490 0 0 0 0 0 0 0 0 0 0 0 391	Date/Time Pre 5/29/2019 2:5 SOCI AL SERVICE 17.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50 pm E 1. 1. 2. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 14. 15. 0 17. 0 20. 0 20. 0 20. 43. 0 43. 0 43. 0 43. 0 19. 0 19. 0 19. 0 19. 0 19. 0 19. 0 19. 0 19. 19. 19. 19. 19. 19. 19. 19.
00 00 01 00 01 00 00 002 01 002 00 002 00 002 00 002 00 002 00 002 00 002 00 012 00 012 00 013 00 014 00 013 00 014 00 013 00 014 00 015 00 016 00 017 00 017 00 017 00 017 00 017 00 017 00 017 00 017 00 033 00 052 00 052 00 052 00 052 <tr< th=""><th>NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT 101 EMS WEST STATION 200 CAP REL COSTS-MVBLE EQUIP 201 EMS WEST STATION EQUIP. 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 600 MAINTENANCE & REPAIRS 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 200 DI ETARY 100 CAFETERIA 200 MAINTENANCE OF PERSONNEL 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE 900 NONPHYSICIAN ANESTHETISTS 900 NURSING SCHOOL 100 I&R SERVICES-SALARY & FRINGES APPRV 200 I&R SERVICES-OTHER PRGM COSTS APPRV 200 ADULTS & PEDIATRICS 300 NURSING SCHOOL 100 I&R SERVICE COST CENTERS 300 NURSERY 21LLARY SERVICE COST CENTERS 300 DELIVERY ROOM & LABOR ROOM</th><th>ADMI NI STRATI ON 13. 00 719, 541 0 0 0 0 0 0 0 0 0 0 0 0 0</th><th>SERVI CES & SUPPLY 14.00 59,771 1,239 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</th><th>15.00 1,261,766 0 0 0 0 0 0 0 0 0 0 0 0 0</th><th>RECORDS & LI BRARY 16. 00 22, 490 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</th><th>SOCI AL SERVI CE 17.00 0 0 0 0 0 0 0 0 0 0 0 0</th><th>E 1. 1. 2. 2. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 14. 15. 0 17. 0 20. 0 21. 0 20. 23. 0 30. 0 43. 0 43. 0 10. 17. 18. 19. 19. 10. 10. 10. 10. 10. 10. 10. 10</th></tr<>	NERAL SERVICE COST CENTERS 100 CAP REL COSTS-BLDG & FIXT 101 EMS WEST STATION 200 CAP REL COSTS-MVBLE EQUIP 201 EMS WEST STATION EQUIP. 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 600 MAINTENANCE & REPAIRS 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 200 DI ETARY 100 CAFETERIA 200 MAINTENANCE OF PERSONNEL 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE 900 NONPHYSICIAN ANESTHETISTS 900 NURSING SCHOOL 100 I&R SERVICES-SALARY & FRINGES APPRV 200 I&R SERVICES-OTHER PRGM COSTS APPRV 200 ADULTS & PEDIATRICS 300 NURSING SCHOOL 100 I&R SERVICE COST CENTERS 300 NURSERY 21LLARY SERVICE COST CENTERS 300 DELIVERY ROOM & LABOR ROOM	ADMI NI STRATI ON 13. 00 719, 541 0 0 0 0 0 0 0 0 0 0 0 0 0	SERVI CES & SUPPLY 14.00 59,771 1,239 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	15.00 1,261,766 0 0 0 0 0 0 0 0 0 0 0 0 0	RECORDS & LI BRARY 16. 00 22, 490 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	SOCI AL SERVI CE 17.00 0 0 0 0 0 0 0 0 0 0 0 0	E 1. 1. 2. 2. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 14. 15. 0 17. 0 20. 0 21. 0 20. 23. 0 30. 0 43. 0 43. 0 10. 17. 18. 19. 19. 10. 10. 10. 10. 10. 10. 10. 10
00 00 01 00 01 00 00 002 01 002 00 002 00 002 00 002 00 002 00 002 00 002 00 012 00 012 00 013 00 014 00 013 00 014 00 013 00 014 00 015 00 016 00 017 00 017 00 017 00 017 00 017 00 017 00 017 00 017 00 033 00 052 00 052 00 052 00 052 <tr< th=""><th>100 CAP REL COSTS-BLDG & FIXT 101 EMS WEST STATION 200 CAP REL COSTS-MVBLE EQUI P 201 EMS WEST STATION EQUI P 400 EMPLOYEE BENERAL SGENERAL 500 DEATION OF PLANT 800 LAUNDRY & LINEN SERVICE SOON 900 NURSI NG ADMINISTRATION 4000 CENTRAL SERVICES & SUPPLY SOO 500 PHARMACY SOO NURSI NG SCHOOL 100 I &R SERVICES-SALARY & FRINGES APPRV 200 I &R SERVICES-SALAR</th><th>719, 541 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</th><th>59, 771 1, 239 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</th><th>1, 261, 766 0 0 0 0 0 0 0 0 19 11 4, 903</th><th>22, 490 0 0 0 0 2, 661 432 391</th><th></th><th>1. 2. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 0 17. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.</th></tr<>	100 CAP REL COSTS-BLDG & FIXT 101 EMS WEST STATION 200 CAP REL COSTS-MVBLE EQUI P 201 EMS WEST STATION EQUI P 400 EMPLOYEE BENERAL SGENERAL 500 DEATION OF PLANT 800 LAUNDRY & LINEN SERVICE SOON 900 NURSI NG ADMINISTRATION 4000 CENTRAL SERVICES & SUPPLY SOO 500 PHARMACY SOO NURSI NG SCHOOL 100 I &R SERVICES-SALARY & FRINGES APPRV 200 I &R SERVICES-SALAR	719, 541 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	59, 771 1, 239 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 261, 766 0 0 0 0 0 0 0 0 19 11 4, 903	22, 490 0 0 0 0 2, 661 432 391		1. 2. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 0 17. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.
00 00 01 00 01 00 00 002 01 002 00 002 00 002 00 002 00 002 00 002 00 002 00 012 00 012 00 013 00 014 00 013 00 014 00 013 00 014 00 015 00 016 00 017 00 017 00 017 00 017 00 017 00 017 00 017 00 017 00 033 00 052 00 052 00 052 00 052 <tr< th=""><th>100 CAP REL COSTS-BLDG & FIXT 101 EMS WEST STATION 200 CAP REL COSTS-MVBLE EQUI P 201 EMS WEST STATION EQUI P 400 EMPLOYEE BENERAL SGENERAL 500 DEATION OF PLANT 800 LAUNDRY & LINEN SERVICE SOON 900 NURSI NG ADMINISTRATION 4000 CENTRAL SERVICES & SUPPLY SOO 500 PHARMACY SOO NURSI NG SCHOOL 100 I &R SERVICES-SALARY & FRINGES APPRV 200 I &R SERVICES-SALAR</th><th>0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0</th><th>1, 239 0 0 0 0 0 0 0 0 777 909 12, 205</th><th>0 0 0 0 0 0 0 19 11 4, 903</th><th>0 0 0 0 2, 661 432 391</th><th></th><th>1. 2. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 0 17. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.</th></tr<>	100 CAP REL COSTS-BLDG & FIXT 101 EMS WEST STATION 200 CAP REL COSTS-MVBLE EQUI P 201 EMS WEST STATION EQUI P 400 EMPLOYEE BENERAL SGENERAL 500 DEATION OF PLANT 800 LAUNDRY & LINEN SERVICE SOON 900 NURSI NG ADMINISTRATION 4000 CENTRAL SERVICES & SUPPLY SOO 500 PHARMACY SOO NURSI NG SCHOOL 100 I &R SERVICES-SALARY & FRINGES APPRV 200 I &R SERVICES-SALAR	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		1. 2. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 0 17. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.
01 00 01 002 00 002 01 002 00 002 00 002 00 002 00 002 00 002 00 002 00 002 00 012 00 012 00 012 00 012 00 012 00 012 00 012 00 012 00 012 00 013 00 014 00 015 00 022 00 022 00 023 00 024 00 035 00 042 00 052 00 052 00 052 00 052 00 054 <	101 EMS WEST STATION 200 CAP REL COSTS-MVBLE EQUIP 201 EMS WEST STATION EQUIP. 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 600 MAINTENANCE & REPAIRS 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 200 MAINTENANCE OF PERSONNEL 200 MAINTENANCE OF PERSONNEL 200 MAINTENANCE OF PERSONNEL 200 MUSSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE 900 NONPHYSICIAN ANESTHETISTS 900 NONPHYSICIAN ANESTHETISTS 900 NONPHYSICIAN ANESTHETISTS 900 NONPHYSICES-SALARY & FRINGES APPRV 200 I&R SERVICES-OTHER PRGM COSTS APPRV 200 I&R SERVICES-OTHER PRGM COSTS APPRV 200 ADULTS & PEDIATRICS 300 NURSERY 21LLARY SERVICE COST CENTERS 900 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		1. 2. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 0 17. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.
D0 D02 D1 D02 D1 D02 D0 D04 D0 D05 D0 D06 D0 D07 D0 D07 D0 D07 D0 D07 D0 D07 D0 D07 D0 D11 D0 D12 D0 D13 D0 D14 D0 D14 D0 D14 D0 D22 D0 D33 D0 D43 ANC D44 D0 D52 D0 D53 D0 D54 D0 D56 D0 D64	200 CAP REL COSTS-MVBLE EQUIP 201 EMS WEST STATION EQUIP. 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 600 MAINTENANCE & REPAIRS 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING OO DIETARY 100 CAFETERIA 200 MAINTENANCE OF PERSONNEL 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICES SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICES-SALARY FRINGES APPRV 200 I&R SERVICES-SALARY <	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		2. 2. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 0 19. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.
01 002 00 004 00 005 00 006 00 007 00 006 00 007 00 007 00 007 00 017 00 012 00 014 00 014 00 014 00 014 00 014 00 014 00 014 00 012 00 014 00 022 00 022 00 022 00 022 00 030 00 046 00 052 00 054 00 054 00 054 00 056 00 056 00 056 00 056	201 EMS WEST STATION EQUIP. 400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMINISTRATIVE & GENERAL 600 MAINTENANCE & REPAIRS 700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 900 DIETARY 100 CAFETERIA 200 MAINTENANCE OF PERSONNEL 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE 900 NONPHYSICIAN ANESTHETISTS 900 NURSING SCHOOL 100 I&R SERVICES-SALARY & FRINGES APPRV 100 ADMITS & PEDIATRICS 300 PARAMED ED PRGM-(SPECIFY) 7ATIENT ROUTINE SERVICE COST CENTERS 300 NURSERY 11LARY SERVICE COST CENTERS 900 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		2. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 0 20. 21. 0 22. 0 23. 0 30. 0 43.
00 004 00 005 00 005 00 005 00 005 00 005 00 005 00 005 00 012 00 012 00 014 00 014 00 014 00 014 00 014 00 012 00 014 00 012 00 014 00 012 00 022 00 022 00 022 00 030 00 045 00 056 00 052 00 052 00 054 00 056 00 066 00 066 00 066 00 066	400 EMPLOYEE BENEFITS DEPARTMENT 500 ADMI NI STRATI VE & GENERAL 600 MAI NTENANCE & REPAI RS 700 OPERATI ON OF PLANT 800 LAUNDRY & LI NEN SERVI CE 900 HOUSEKEEPI NG 100 CAFETERI A 200 MAI NTENANCE OF PERSONNEL 300 NURSI NG ADMI NI STRATI ON 400 CENTRAL SERVI CES & SUPPLY 500 PHARMACY 600 MEDI CAL RECORDS & LI BRARY 700 SOCI AL SERVI CE 900 NONPHYSI CI AN ANESTHETI STS 1000 NURSI NG SCHOOL 101 I&R SERVI CES-SALARY & FRI NGES APPRV 200 I&R SERVI CES-SALARY & FRI NGES APPRV 200 I&R SERVI CES-COTHER PRGM COSTS APPRV 300 PARAMED ED PRGM-(SPECI FY) 7ATI ENT ROUTI NE SERVI CE COST CENTERS 300 NURSERY 211 LARY SERVI CE COST CENTERS 300 OPERATI NG ROOM 200 DELI VERY ROOM & LABOR ROOM	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 0 20. 0 21. 0 22. 0 30. 0 30.
00 000 00 000 00 000 00 000 00 001 00 011 00 012 00 013 00 014 00 013 00 014 00 013 00 014 00 015 00 022 00 023 00 024 00 033 00 044 00 033 00 042 00 033 00 044 00 035 00 045 00 055 00 056 00 056 00 056 00 056 00 066 00 066 00 066 00 066	600 MAI NTENANCE & REPAIRS 700 OPERATI ON OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 900 DI ETARY 100 CAFETERIA 200 MAI NTENANCE OF PERSONNEL 300 NURSI NG ADMI NI STRATI ON 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDI CAL RECORDS & LI BRARY 700 SOCI AL SERVICE 900 NONPHYSI CI AN ANESTHETI STS 900 NURSI NG SCHOOL 100 I &R SERVICES-SALARY & FRINGES APPRV 200 I &R SERVICES-OTHER PRGM COSTS APPRV 200 PARAMED ED PRGM- (SPECIFY) PATI ENT ROUTI NE SERVICE COST CENTERS 900 NURSERY CI LLARY SERVICE COST CENTERS 900 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 14. 15. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.
00 007 00 008 00 008 00 009 00 010 00 012 00 012 00 012 00 012 00 012 00 012 00 014 00 014 00 015 00 022 00 022 00 022 00 033 00 043 00 055 00 055 00 055 00 055 00 055 00 056 00 056 00 066 00 066 00 066 00 066 00 066 00 066 00 066 00 066	700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 900 DIETARY 100 CAFETERIA 200 MAINTENANCE OF PERSONNEL 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE 900 NONPHYSICIAN ANESTHETISTS 900 NURSING SCHOOL 100 I & SERVICES-SALARY & FRINGES APPRV 200 I & SERVICES-OTHER PRGM COSTS APPRV 200 ADURSI NG SCHOOL 100 I & SERVICES-OTHER PRGM COSTS APPRV 200 PARAMED ED PRGM- (SPECIFY) 74TIENT ROUTINE SERVICE COST CENTERS 900 ADULTS & PEDIATRICS 900 NURSERY CILLARY SERVICE COST CENTERS 900 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 0 19. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.
DO OOE DO OOE DO OOE OO OOE	800 LAUNDRY & LINEN SERVICE 900 HOUSEKEEPING 900 DIETARY 100 CAFETERIA 200 MAINTENANCE OF PERSONNEL 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE 900 NONPHYSICIAN ANESTHETISTS 900 NURSING SCHOOL 100 I & R SERVICES-SALARY & FRINGES APPRV 200 I & R SERVICES-OTHER PRGM COSTS APPRV 300 PARAMED ED PRGM- (SPECIFY) 24TIENT ROUTINE SERVICE COST CENTERS 300 NURSERY 211 <llary centers<="" cost="" service="" td=""> 300 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM</llary>	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		8. 9. 10. 11. 12. 13. 14. 15. 16. 0 17. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.
DO OOG 00 011 00 011 00 012 00 013 00 014 00 014 00 014 00 014 00 014 00 014 00 014 00 014 00 022 00 022 00 022 00 022 00 022 00 022 00 022 00 030 00 044 00 055 00 056 00 056 00 056 00 064 00 066 00 066 00 066 00 066 00 066 00 066 00 066	900 HOUSEKEEPING 900 DIETARY 100 CAFETERIA 200 MAINTENANCE OF PERSONNEL 300 NURSING ADMINISTRATION 400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE 900 NONPHYSICIAN ANESTHETISTS 900 NURSING SCHOOL 100 I &R SERVICES-SALARY & FRINGES APPRV 200 I &R SERVICES-OTHER PRGM COSTS APPRV 300 PARAMED ED PRGM- (SPECIFY) ?ATIENT ROUTINE SERVICE COST CENTERS 300 NURSERY 201 LLARY SERVICE COST CENTERS 300 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		9. 10. 11. 12. 13. 14. 15. 16. 0 20. 0 21. 0 22. 0 23. 0 30. 43.
00 010 00 011 00 012 00 013 00 014 00 014 00 014 00 014 00 014 00 014 00 016 00 017 00 016 00 017 00 022 00 022 00 022 00 022 00 022 00 022 00 022 00 022 00 022 00 022 00 032 00 032 00 043 00 052 00 052 00 052 00 052 00 052 00 052 00 052	000 DI ETARY 100 CAFETERI A 200 MAI NTENANCE OF PERSONNEL 300 NURSI NG ADMI NI STRATI ON 400 CENTRAL SERVI CES & SUPPLY 500 PHARMACY 600 MEDI CAL RECORDS & LI BRARY 700 SOCI AL SERVI CE 900 NURSI NG SCHOOL 101 I&R SERVI CES-SALARY & FRI NGES APPRV 200 I &R SERVI CES-OTHER PRGM COSTS APPRV 300 PARAMED ED PRGM- (SPECI FY) PATI ENT ROUTI NE SERVI CE COST CENTERS 300 NURSERY CI LLARY SERVI CE COST CENTERS 300 OPERATI NG ROOM 200 DELI VERY ROOM & LABOR ROOM	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		10. 11. 12. 13. 14. 15. 16. 0 20. 0 21. 0 22. 0 23. 0 30. 43.
00 01 00 012 00 012 00 013 00 014 00 014 00 014 00 014 00 014 00 015 00 012 00 022 00 022 00 022 00 022 00 022 00 022 00 022 00 022 00 022 00 022 00 022 00 032 00 032 00 043 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 <	100 CAFETERIA 200 MAINTENANCE OF PERSONNEL 300 NURSI NG ADMINI STRATI ON 400 CENTRAL SERVI CES & SUPPLY 500 PHARMACY 600 MEDI CAL RECORDS & LI BRARY 700 SOCI AL SERVI CE 900 NONPHYSI CI AN ANESTHETI STS 900 NURSI NG SCHOOL 100 I &R SERVI CES-SALARY & FRI NGES APPRV 200 I &R SERVI CES-SALARY & FRI NGES APPRV 200 I &R SERVI CES-OTHER PRGM COSTS APPRV 200 PARAMED ED PRGM- (SPECI FY) PATI ENT ROUTI NE SERVI CE COST CENTERS 300 NURSERY CI LLARY SERVI CE COST CENTERS 900 OPERATI NG ROOM 200 DELI VERY ROOM & LABOR ROOM	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		11. 12. 13. 14. 15. 16. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.
00 012 00 013 00 014 00 015 00 016 00 017 00 017 00 017 00 017 00 017 00 017 00 017 00 022 00 022 00 022 00 033 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052	200 MAI NTENANCE OF PERSONNEL 300 NURSI NG ADMI NI STRATI ON 400 CENTRAL SERVI CES & SUPPLY 500 PHARMACY 600 MEDI CAL RECORDS & LI BRARY 700 SOCI AL SERVI CE 900 NONPHYSI CI AN ANESTHETI STS 900 NURSI NG SCHOOL 100 I &R SERVI CES-SALARY & FRI NGES APPRV 200 I &R SERVI CES-OTHER PRGM COSTS APPRV 200 PARAMED ED PRGM-(SPECI FY) PATI ENT ROUTI NE SERVI CE COST CENTERS 900 ADULTS & PEDI ATRI CS 900 NURSERY 21 LLARY SERVI CE COST CENTERS 900 OPERATI NG ROOM 200 DELI VERY ROOM & LABOR ROOM	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		12. 13. 14. 15. 16. 0 17. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.
00 01: 00 01: 00 01: 00 01: 00 01: 00 01: 00 01: 00 01: 00 01: 00 01: 00 01: 00 02: 00 02: 00 02: 00 02: 00 03: 00 03: 00 04: 00 05: 00 05: 00 05: 00 05: 00 05: 00 05: 00 06: 00 06: 00 06: 00 06: 00 06: 00 06: 00 06: 00 06: 00 06: 00 06:	300 NURSI NG ADMI NI STRATI ON 400 CENTRAL SERVI CES & SUPPLY 500 PHARMACY 600 MEDI CAL RECORDS & LI BRARY 700 SOCI AL SERVI CE 900 NONPHYSI CI AN ANESTHETI STS 900 NURSI NG SCHOOL 100 I &R SERVI CES-SALARY & FRI NGES APPRV 200 I &R SERVI CES-OTHER PRGM COSTS APPRV 300 PARAMED ED PRGM- (SPECI FY) PATI ENT ROUTI NE SERVI CE COST CENTERS 900 ADULTS & PEDI ATRI CS 900 NURSERY 211 LLARY SERVI CE COST CENTERS 900 OPERATI NG ROOM 200 DELI VERY ROOM & LABOR ROOM	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		13. 14. 15. 0 17. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.
00 014 00 015 00 016 00 017 00 017 00 017 00 017 00 017 00 012 00 022 00 022 00 023 00 033 00 046 00 052 00 052 00 053 00 054 00 054 00 054 00 054 00 056 00 066 00 066 00 066 00 066 00 066 00 067 00 067 00 067 00 067 00 067	400 CENTRAL SERVICES & SUPPLY 500 PHARMACY 600 MEDICAL RECORDS & LIBRARY 700 SOCIAL SERVICE 900 NONPHYSICIAN ANESTHETISTS 900 NURSING SCHOOL 100 I&R SERVICES-SALARY & FRINGES APPRV 200 I&R SERVICES-OTHER PRGM COSTS APPRV 200 PARAMED ED PRGM-(SPECIFY) 201 ENT ROUTINE SERVICE COST CENTERS 900 ADULTS & PEDIATRICS 900 NURSERY CILLARY SERVICE COST CENTERS 900 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		14. 15. 0 0 19. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.
00 016 00 017 00 016 00 020 00 022 00 022 00 022 00 022 00 022 00 022 00 022 00 030 00 030 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 054 00 065 00 064 00 064 00 065 00 065 00 065 00 065 00 065 00 065 00 065	600 MEDI CAL RECORDS & LI BRARY 700 SOCI AL SERVI CE 900 NONPHYSI CI AN ANESTHETI STS 900 NURSI NG SCHOOL 101 I&R SERVI CES-SALARY & FRI NGES APPRV 200 I &R SERVI CES-OTHER PRGM COSTS APPRV 200 PARAMED ED PRGM-(SPECI FY) PATI ENT ROUTI NE SERVI CE COST CENTERS 900 ADULTS & PEDI ATRI CS 900 NURSERY 11 LLARY SERVI CE COST CENTERS 900 OPERATI NG ROOM 200 DELI VERY ROOM & LABOR ROOM	268, 899 22, 995 151, 632 98, 032	1, 239 0 0 0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		16. 0 17. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.
00 01.7 00 02.2 00 02.2 00 02.2 00 02.2 00 02.2 00 02.2 00 02.2 00 02.2 00 02.2 00 02.2 00 03.0 00 04.3 00 05.2 00 05.2 00 05.2 00 05.2 00 05.2 00 05.2 00 05.2 00 05.2 00 05.2 00 05.2 00 06.2 00 06.4 00 06.4 00 06.4 00 06.4 00 06.4 00 06.4 00 06.4 00 06.4 00 06.4 00	700 SOCI AL SERVICE 900 NONPHYSICI AN ANESTHETISTS 000 NURSING SCHOOL 100 I &R SERVICES-SALARY & FRINGES APPRV 200 I &R SERVICES-OTHER PRGM COSTS APPRV 300 PARAMED ED PRGM-(SPECIFY) PATI ENT ROUTINE SERVICE COST CENTERS 300 ADULTS & PEDIATRICS 300 NURSERY CILLARY SERVICE COST CENTERS 200 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	268, 899 22, 995 151, 632 98, 032	0 0 0 0 0 0 777 909 12, 205	0 0 0 0 0 0 19 11 11 4, 903	0 0 0 0 2, 661 432 391		0 17. 0 19. 0 20. 0 21. 0 22. 0 23. 0 30. 0 43.
00 014 00 020 00 022 00 022 00 022 00 022 INM 00 00 030 00 043 00 050 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 062 00 064 00 064 00 064 00 064 00 064 00 064 00 064 00 064 00 064	900 NONPHYSICIAN ANESTHETISTS 000 NURSING SCHOOL 100 I &R SERVICES-SALARY & FRINGES APPRV 200 I &R SERVICES-OTHER PRGM COSTS APPRV 300 PARAMED ED PRGM-(SPECIFY) PATI ENT ROUTINE SERVICE COST CENTERS 300 ADULTS & PEDIATRICS 300 NURSERY CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	268, 899 22, 995 151, 632 98, 032	0 0 0 0 0 777 909 12, 205	0 0 0 0 0 19 11 4, 903	0 0 0 0 2, 661 432 391		0 19. 0 20. 0 21. 0 22. 0 23. 0 30. 0 30. 0 43.
00 020 00 022 00 022 00 023 INM 00 00 030 00 043 00 050 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 066 00 066 00 066 00 066 00 066 00 066 00 066 00 066 00 066 00 066 00 067	000 NURSI NG SCHOOL 100 I &R SERVI CES-SALARY & FRI NGES APPRV 200 I &R SERVI CES-OTHER PRGM COSTS APPRV 300 PARAMED ED PRGM-(SPECI FY) PATI ENT ROUTI NE SERVI CE COST CENTERS 000 ADULTS & PEDI ATRI CS 300 NURSERY CI LLARY SERVI CE COST CENTERS 000 OPERATI NG ROOM 200 DELI VERY ROOM & LABOR ROOM	268, 899 22, 995 151, 632 98, 032	777 909 12, 205	0 19 11 4, 903	0 2, 661 432 391		0 20. 0 21. 0 22. 0 23. 0 30. 0 43.
00 02 00 022 00 022 00 036 00 044 00 045 00 055 00 055 00 055 00 056 00 066 00 066 00 066 00 066 00 066 00 066 00 066 00 066 00 066 00 066 00 066 00 066 00 067	100 I &R SERVICES-SALARY & FRINGES APPRV 200 I &R SERVICES-OTHER PRGM COSTS APPRV 300 PARAMED ED PRGM-(SPECIFY) PATIENT ROUTINE SERVICE COST CENTERS 000 ADULTS & PEDIATRICS 300 NURSERY CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	268, 899 22, 995 151, 632 98, 032	777 909 12, 205	0 19 11 4, 903	0 2, 661 432 391		0 21. 0 22. 0 23. 0 30. 0 43.
00 022 00 023 INE 00 00 033 00 043 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 062 00 062 00 064 00 064 00 065 00 064 00 064 00 064 00 064 00 064 00 064 00 064 00 064 00 067	200 I &R SERVICES-OTHER PRGM COSTS APPRV 300 PARAMED ED PRGM-(SPECIFY) PATIENT ROUTINE SERVICE COST CENTERS 000 ADULTS & PEDIATRICS 300 NURSERY CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	268, 899 22, 995 151, 632 98, 032	777 909 12, 205	0 19 11 4, 903	0 2, 661 432 391	0 0 0 0 0	0 22. 0 23. 0 30. 0 43.
O2 I IF 00 03 043 00 043 046 00 050 050 00 052 060 00 052 060 00 052 060 00 052 060 00 062 060 00 065 060 00 065 060 00 065 066 00 065 066 00 065 066 00 065 066 00 065 066 00 065 066 00 065 066 00 067 066 00 067 067	300 PARAMED ED PRGM-(SPECIFY) PATI ENT ROUTI NE SERVI CE COST CENTERS 000 ADULTS & PEDI ATRI CS 300 NURSERY CI LLARY SERVI CE COST CENTERS 000 OPERATI NG ROOM 200 DELI VERY ROOM & LABOR ROOM	268, 899 22, 995 151, 632 98, 032	777 909 12, 205	0 19 11 4, 903	0 2, 661 432 391	000000000000000000000000000000000000000	0 23. 0 30. 0 43.
INF 00 030 041 ANO 00 050 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 062 00 062 00 063 00 064 00 064 00 064 00 064 00 064 00 064 00 064 00 064 00 064 00 064 00 067 00 067	PATIENT ROUTINE SERVICE COST CENTERS 000 ADULTS & PEDIATRICS 300 NURSERY CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	268, 899 22, 995 151, 632 98, 032	777 909 12, 205	19 11 4, 903	2, 661 432 391	000000000000000000000000000000000000000	0 30. 0 43.
00 030 00 043 00 050 00 052 00 052 00 052 00 052 00 052 00 052 00 052 00 062 00 066 00 066 00 066 00 066 00 066 00 066 00 067	000 ADULTS & PEDIATRICS 300 NURSERY CILLARY SERVICE COST CENTERS 000 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	22, 995 151, 632 98, 032	909 12, 205	4, 903	432	0	0 43.
04: ANC 00 05: 00 05: 00 05: 00 05: 00 05: 00 05: 00 05: 00 06: 00 06: 00 06: 00 06: 00 06: 00 06: 00 06: 00 06: 00 06: 00 06: 00 06: 00 06: 00 06:	300 NURSERY CILLARY SERVICE COST CENTERS DOO OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	22, 995 151, 632 98, 032	909 12, 205	4, 903	432	0	0 43.
00 050 00 052 00 053 00 054 00 054 00 060 30 062 00 066 00 066 00 066 00 066 00 066 00 066 00 066 00 066 00 067	000 OPERATING ROOM 200 DELIVERY ROOM & LABOR ROOM	98, 032					2 50.
00 052 00 053 00 054 00 064 00 065 00 065 00 065 00 065 00 065 00 065 00 065 00 065 00 065 00 065 00 065 00 065 00 065 00 067 00 067	200 DELIVERY ROOM & LABOR ROOM	98, 032					0 50.
00 053 00 054 00 060 30 062 00 065 00 065 00 065 00 065 00 065 00 065 00 065 00 065 00 065 00 065 00 065 00 067			3, 875				
00 054 00 060 30 062 00 068 00 068 00 068 00 068 00 068 00 068 00 069 00 069 00 071	300 ANESTHESLOLOGY			47	0		0 52.
00 060 30 062 00 068 00 066 00 066 00 066 00 066 00 066 00 068 00 068 00 068 00 068 00 067			0	0	0	0	
30 062 00 068 00 066 00 066 00 068 00 068 00 068 00 068 00 068 00 067 00 067	400 RADI OLOGY-DI AGNOSTI C	0	1, 721	752	7, 473	0	
00 065 00 066 00 067 00 068 00 068 00 068 00 069 00 067	DOO LABORATORY	0	0	1, 523	0	0	
00 066 00 067 00 068 00 069 00 07	250 BLOOD CLOTTING FOR HEMOPHILIACS 500 RESPIRATORY THERAPY	0	0 327	0	0	0	
00 067 00 068 00 069 00 07	600 PHYSI CAL THERAPY	0	295	133	1, 725	0	
00 068 00 069 00 07	700 OCCUPATI ONAL THERAPY	0	123	55	515	0	
00 069 00 07	800 SPEECH PATHOLOGY	0	13	6	119	0	
	900 ELECTROCARDI OLOGY	0	0	0	0	0	0 69.
00 072	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	16, 958	0	0	0	0 71.
	200 IMPL. DEV. CHARGED TO PATIENTS	0	12, 195	0	0	0	0 72.
	300 DRUGS CHARGED TO PATIENTS	0	1, 720	1, 249, 428	0	0	
	697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
	698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
	699 LI THOTRI PSY TPATI ENT SERVI CE COST CENTERS	0	U	0	0	0	0 76
	DOO CLINIC	0	0	0	0	0	0 90.
	001 LI FEBRI DGE SENI OR CARE	0	427	0	0	0	
	100 EMERGENCY	177, 983	3, 727	370	9, 174	0	0 91.
00 092	200 OBSERVATION BEDS (NON-DISTINCT PART						92.
	HER REIMBURSABLE COST CENTERS						
	500 AMBULANCE SERVI CES	0	3, 138	4, 519	0	0	
		0	0	0	0	0	
	920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	
	930 OUTPATI ENT OCCUPATI ONAL THERAPY 940 OUTPATI ENT SPEECH PATHOLOGY	0	0	0	0	0	
	ECIAL PURPOSE COST CENTERS	U U	V	0	U U	0	
	300 INTEREST EXPENSE						113
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	719, 541	59, 649	1, 261, 766	22, 490	0	0 118
	NREIMBURSABLE COST CENTERS						
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	16	0	0		0 190.
	200 PHYSI CI ANS' PRI VATE OFFI CES	0	21	0	0		0 192
	950 OCCUPATIONAL HEALTH	0	0	0	0		0 194
		0	31	0	0		0 194
		0	54	0	0		0 194
	952 COMMUNITY & VOLUNTEER SVCS			~			11101
	954 ER PHYSICIAN	0	0	0	0		
D. 00 1. 00	954 ER PHYSICIAN 953 SHIPSHEWANA RADIOLOGY AND LAB	0	0 0	0 0	0 0		0 194.
2.00	954 ER PHYSICIAN	0	0 0	0	0	0	

ST AL	LOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2018	Worksheet B Part I	
					Го 12/31/2018	Date/Time Pre 5/29/2019 2:5	
				I NTERNS &	RESIDENTS		
	Cost Center Description	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	SERVI CES-SALAF Y & FRI NGES APPRV	RSERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	
		19.00	20.00	21.00	22.00	23.00	
-	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.
	00101 EMS WEST STATION						1.
	00200 CAP REL COSTS-MVBLE EQUIP						2.
	00201 EMS WEST STATION EQUIP. 00400 EMPLOYEE BENEFITS DEPARTMENT						2.
	00500 ADMINI STRATI VE & GENERAL						5.
	00600 MAI NTENANCE & REPAI RS						6.
	00700 OPERATION OF PLANT						7.
	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 9.
	01000 DI ETARY						10.
	01100 CAFETERIA						11.
	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON						12.
	01400 CENTRAL SERVICES & SUPPLY						14.
00	01500 PHARMACY						15.
	01600 MEDICAL RECORDS & LIBRARY						16.
	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	(17.
	02000 NURSI NG SCHOOL) C				20.
	02100 I&R SERVICES-SALARY & FRINGES APPRV						21.
	02200 I & R SERVI CES-OTHER PRGM COSTS APPRV				0	0	22.
	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS					0	23.
	03000 ADULTS & PEDI ATRI CS	(0	30.
		() C) (0 0	0	43.
	ANCI LLARY SERVI CE COST CENTERS	0			0 0	0	50.
00	05200 DELIVERY ROOM & LABOR ROOM	C) (0 0	0	52.
	05300 ANESTHESI OLOGY	0			0	0	
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY					0	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			-	0	
	06500 RESPI RATORY THERAPY	0	C) (0 0	0	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY					0	
	06800 SPEECH PATHOLOGY					0	68.
	06900 ELECTROCARDI OLOGY	C			0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	(0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS					0	1
	07697 CARDI AC REHABI LI TATI ON					0	
	07698 HYPERBARI C OXYGEN THERAPY	C	c c		0 0	0	
	07699 LITHOTRIPSY DUTPATIENT SERVICE COST CENTERS	() <u> </u>) (0 0	0	76
	09000 CLINIC	(0 0	0	90
	09001 LI FEBRI DGE SENI OR CARE	C	C) (0 0	0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	() C		0 0	0	91.
	OTHER REIMBURSABLE COST CENTERS						92.
00	09500 AMBULANCE SERVI CES	() C) (0 0	0	
		0				0	
	09920 OUTPATIENT PHYSICAL THERAPY 09930 OUTPATIENT OCCUPATIONAL THERAPY					0	
	09940 OUTPATI ENT SPEECH PATHOLOGY				0	0	
	SPECIAL PURPOSE COST CENTERS		1	1	1		
3.00 3.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1 through 117)	0			0 0	0	113. 118.
	VONREI MBURSABLE COST CENTERS		γ <u></u>	<u>n</u> (0	
0. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(C		-		190.
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			0		192
	07950 OCCUPATI ONAL HEALTH 07951 FOUNDATI ON						194 194
	07952 COMMUNITY & VOLUNTEER SVCS						194
1. 04	07954 ER PHYSICIAN	0) C		0 0	0	194.
	07953 SHI PSHEWANA RADI OLOGY AND LAB	0					194.
D. 00	Cross Foot Adjustments						200.
1.00	Negative Cost Centers)		1		

OST ALLOCATION - GENERAL SERVIC			Provider CC		Peri od:	u of Form CMS-2552 Worksheet B
					From 01/01/2018 To 12/31/2018	Part I Date/Time Prepare
Cost Center Descrip	tion	Subtotal	Intern &	Total		5/29/2019 2:50 pm
		I	Residents Cost			
			& Post Stepdown			
			Adjustments			
		24.00	25.00	26.00		
.00 <u>GENERAL SERVICE COST CENT</u> .00 00100 CAP REL COSTS-BLDG &						1
01 00101 EMS WEST STATION						1
00 00200 CAP REL COSTS-MVBLE						2
01 00201 EMS WEST STATION EQ						2
00 00400 EMPLOYEE BENEFITS DI 00 00500 ADMINISTRATIVE & GEI						4.
00 00600 MAI NTENANCE & REPAIL						6
00 00700 OPERATION OF PLANT						7.
00 00800 LAUNDRY & LINEN SER	/I CE					8
00 00900 HOUSEKEEPI NG						9
0. 00 01000 DI ETARY 1. 00 01100 CAFETERI A						10
2. 00 01200 MAINTENANCE OF PERS	ONNEL					12
3. 00 01300 NURSING ADMINISTRAT	ON					13
. 00 01400 CENTRAL SERVICES & S	SUPPLY					14
	DDADV					15
5.00 01600 MEDICAL RECORDS & LI 7.00 01700 SOCIAL SERVICE	DRAKI					16
0. 00 01900 NONPHYSICIAN ANESTH	ETI STS					19
0.00 02000 NURSING SCHOOL						20
. 00 02100 I &R SERVICES-SALARY						21
. 00 02200 I &R SERVICES-OTHER I						22
5.00 02300 PARAMED ED PRGM-(SPI INPATIENT ROUTINE SERVICE						23
0. 00 03000 ADULTS & PEDI ATRI CS		5, 270, 917	0	5, 270, 9	17	30.
. 00 04300 NURSERY		338, 578	0	338, 5	78	43
ANCI LLARY SERVICE COST CE 0.00 05000 OPERATING ROOM	NTERS	3, 574, 437	0	3, 574, 4	27	50
0. 00 05000 0PERATING ROOM 2. 00 05200 DELIVERY ROOM & LAB(OR ROOM	1, 452, 009	0	3, 574, 4 1, 452, 0		52
8. 00 05300 ANESTHESI OLOGY		153, 354	0	153, 3		53
I. 00 05400 RADI OLOGY-DI AGNOSTI (2	2, 854, 190	0	2, 854, 1		54
0.00 06000 LABORATORY 2.30 06250 BLOOD CLOTTING FOR I		1, 905, 903 0	0	1, 905, 9	03	60.
00 06500 RESPIRATORY THERAPY		705, 565	0	705, 5		65
0.00 06600 PHYSI CAL THERAPY		983, 138	0	983, 1		66
00 06700 OCCUPATIONAL THERAP	ſ	328, 405	0	328, 4		67
8. 00 06800 SPEECH PATHOLOGY		153, 965	0	153, 9		68
0. 00 06900 ELECTROCARDI OLOGY . 00 07100 MEDI CAL SUPPLI ES CH	ARGED TO PATIENT	0 618, 732	0	618, 7	0	69.
00 07200 I MPL. DEV. CHARGED		445, 249	0	445, 2		72
. 00 07300 DRUGS CHARGED TO PA	TI ENTS	3, 084, 537	0	3, 084, 5		73
. 97 07697 CARDI AC REHABI LI TAT		77, 997	0	77, 9		76
. 98 07698 HYPERBARI C OXYGEN TI . 99 07699 LI THOTRI PSY	1ERAPY	0	0		0	76
OUTPATIENT SERVICE COST C	ENTERS	0	0		0	70
0. 00 09000 CLINIC		0	0		0	90.
0. 01 09001 LI FEBRI DGE SENI OR C	ARE	560, 620	0	560, 6		90.
.00 09100 EMERGENCY 2.00 09200 OBSERVATION BEDS (NO	NULDISTINCT DART	4, 903, 317	0	4, 903, 3	17	91.
OTHER REIMBURSABLE COST C		I	V			72
. 00 09500 AMBULANCE SERVICES		2, 586, 479	0	2, 586, 4	79	95
0. 10 09910 CORF		0	0		0	99
20 09920 OUTPATIENT PHYSICAL 30 09930 OUTPATIENT OCCUPATI		0	0		0	99
. 40 09940 OUTPATIENT OCCUPATION		0	0		0	99.
SPECIAL PURPOSE COST CENT					3	
3.00 11300 INTEREST EXPENSE						113
8.00 SUBTOTALS (SUM OF LI		29, 997, 392	0	29, 997, 3	92	118
NONREI MBURSABLE COST CENT 0. 00 19000 GIFT, FLOWER, COFFEI		29, 908	0	29, 9	08	190
2. 00 19200 PHYSI CI ANS' PRI VATE		290, 704	0	290, 7		192
4.0007950 OCCUPATIONAL HEALTH		0	0		0	194
4. 01 07951 FOUNDATI ON		28, 038	0	28, 0		194
4.03 07952 COMMUNITY & VOLUNTEI 4.04 07954 ER PHYSICIAN	LK SVCS	119, 383	0	119, 3	83 0	194. 194.
4. 06 07953 SHI PSHEWANA RADI 0L00	GY AND LAB	0	0		0	194
0.00 Cross Foot Adjustme		0	0		0	200
1.00 Negative Cost Center		0	0		0	201
2.00 TOTAL (sum lines 118	through 201)	30, 465, 425	0	30, 465, 4	25	202

Heal th	Fina	nci	al	Syste	ems		
		OF	C A		DEL	ATED	0

Cest Center Description Directly Assigned Net Heinstein BLDE & FIXT EVALUATION ENDING EVALUATION EVALU		FINANCIAL SYSTEMS COMM	UNITE HUSPT. UP	Provider CC	N: 15-1323 P	eriod: rom 01/01/2018	Worksheet B Part II	2002-10
Cost Conter Description Directly resigned New Cost Cost Cost Cost Cost Cost Cost Cost							Date/Time Pre	pared: 0 pm
Assigned New Delated Loss STATION STATION STATION CENERAL SERVICE COST CENTERS 0 0 1.00 1.00 2.00 1.10 1.00 0000 CAP NEL COST CENTERS 0 0 1.00 1.00 1.00 1.00 1.00 0000 CAP NEL COST CENTERS 0 0 1.00 1.00 1.01 2.00 2.11 2.00 00000 CAP NEL COST CENTERS 0 0 0 0 0 0 1.11 1.10 2.00 0					CAPITAL REL	ATED COSTS	10/2//2017 210	
Deckeral_SERVICE COST_CENTERS 1.00 OCIONER REL COST_SUBLE & FLAT 1.00 CONTON LUSS WEST STATUR 1.00 CONTON LUSS STATUR 1.00 CONTON LUSS STATUR 1.00 CONTON LUSS STATUR 1.00 CONTON LUSS STATUR 1.0		Cost Center Description	Assigned New Capital	BLDG & FIXT				
1.00 DOTOC CAP REL COSTS-EUCE & FLAT 1.00 1.00 DOTOC CAP REL COSTS-EUCE & FLAT 1.10 2.00 DOZOC CAP REL COSTS-EUCE & FLAT 1.065 2.00 DOZOC CAP REL COSTS-EURLE & FLAT 1.11 2.00 DOZOC CAP REL COSTS-EURLE & FLAT 1.065 4.00 DOZOC CAP REL COSTS-EURLE & FLAT 0.00 4.00 DOZOC CAP REL COSTS-EURLE & FLAT 0.00 4.00 DOZOC CAP REL COSTS-EURLE & FLAT 0.00 6.0 DOCOC MUNEY & LINE SERVICE 0.75, 124 0.01, 134, 423 6.0 DOSOC MUNEY & LINE SERVICE 0.14, 657 0.7, 789 0.9, 0.00 0.00 DOSOC MUNEY & LINE SERVICE 0.00 <td< td=""><td></td><td></td><td>0</td><td>1.00</td><td>1.01</td><td>2.00</td><td>2.01</td><td></td></td<>			0	1.00	1.01	2.00	2.01	
1.01 00101 DASI VEST STATION 1.01 2.00 002001 DASI VEST STATION EQUIP 2.1 2.01 002001 DASI VEST STATION 0.0 0.1 5.00 002000 DAVINTE RAVEL DAVINTE RAVEL 0.1 0.4 6.00 002001 DAVINTE RAVEL 0.1 0.1 0.1 0.2 0.2 0.0								1.00
2.01 00201 LNS WE37 STATION EQUIP. 2.1 4.00 00400 RPUTYZE EBERKITS DEPARTMENT 0<	1.01	00101 EMS WEST STATION						1.01
4.00 00400 PMPOVE PERVENTS DEPARTMENT 0 0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>2.00</td></t<>								2.00
5.00 00500 [AMM NI STRATI VE & GENERAL 1,066,489 24,332 0 134,423 C 5.0 7.00 00700 [OPFRATION OF PLANT 0 75,124 0 41,672 0 7.0 8.00 00500 [AUNNY & LINEN SERVICE 0 14,657 0 7.76 0			0	0	0	0	0	2.01
6.00 00600 WI NITENNEE & REPAIRS 0			1,066,489	242, 333	0	134, 423		5.00
8.00 00800 LANINEY & LINEN SERVICE 0 4.295 0 2.383 0 8.3 10.00 01000 DISSEEFING 0 14.057 0 7.798 0 9.0 10.00 01000 DISSEEFING 0 0 0 0 11 10.00 01000 DISSEEFING 0<	6.00	00600 MAI NTENANCE & REPAI RS	0	0	0	0	0	6.00
9.00 00900 HOUSEKEEPING 0 114,057 0 7,796 0 9.1 10.00 01000 DITARY 0 56.398 0 31,224 0 10.1 11.00 0100 CAFETERIA 0 0 0 0 0 0 112. 12.00 1120 CAFETERIA 0 0 0 0 0 0 0 112. 13.00 11300 UNESING ADMINISTRATION 0 26.790 0 14,660 0 14. 15.00 01500 PHARMACY 0 23.055 0 12.789 0 15. 10.00 01500 PHARMACY 0 23.055 0 12.789 0 15. 10.00 01500 PHARMACY 0 4.550 0 2.524 0 15. 10.00 01500 UNEPSING ALBRARY 0 4.550 0 2.524 0 15. 10.00 01500 UNEPSING ALBRARY 0 4.550 0 2.524 0 15. 10.00 01500 UNEPSING SCHOOL 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		0			7.00
10.00 01000 DICTRY 0 56.398 0 31.284 0 10.01 11.00 01000 CAFETERIA 0 0 0 0 11.1 12.00 01200 MAINTENANCE OF PERSONNEL 0 0 0 0 11.1 13.00 01300 MURSING AAM INSTRATION 0 0 0 13.1 14.00 01400 CENTRANCE OF PERSONNEL 0 26.790 0 14.860 0 14.1 16.00 01600 PRAMACE VICES & SUPPLY 0 26.790 0 12.739 0 15.0 16.00 01600 PRAMACE ENVISE 0			0		0			8.00
11.00 01100 CAFETERIA 0 0 0 0 0 11.00 0 0 0 0 0 11.10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 11.2 0 0 0 0 0 0 0 0 0 11.2 0 0 0 0 0 0 0 0 0 0 0 0 11.2 0 0 0 0 0 0 0 0 11.0 0 <td></td> <td></td> <td>0</td> <td></td> <td>0</td> <td></td> <td></td> <td>10.00</td>			0		0			10.00
13.00 01300 NURSI NG ADMI NI STRATION 0 0 0 0 0 0 1 13.00 01400 CHTNAL SERVICES & SUPPLY 0 23.055 0 12.789 0 14. 15.00 01500 PHARMACY 0 4.550 0 2.524 0 16. 17.00 01700 SCIAL SERVICE 0 0 0 0 0 16. 17.00 01700 SCIAL SERVICES-ALARY & FININGES APPRV 0 <td></td> <td></td> <td>0</td> <td></td> <td>0</td> <td></td> <td></td> <td>11.00</td>			0		0			11.00
14.00 01400 (2KNTRAL SERVICES & SUPPLY 0 26,790 0 14,860 0 14. 15.00 01500 (HABMACY 0 23,055 0 2,524 0 16. 16.00 01600 (MEDI CAL, RECORDS & LIBRARY 0 4,550 0 2,524 0 16. 17.00 01700 (NNRIS NG SCHAL, SERVICES 0 0 0 0 0 17. 19.00 01900 NONPINSI CIAN ANESTHETI STS 0 0 0 0 0 0 21.0 20.00 02200 (JAR SERVICES-SALARY & FRI NGES APRV 0 0 0 0 0 22.1 23.00 0.2300 (APULTS & PEDIATRICS 0 4.482 0 2.466 0 23.0 20.00 02300 APULTS & PEDIATRICS 0 4.482 0 2.466 0 4. 3.0 30.00 03000 APULTS & PEDIATRICS 0 16.670 0 94.116 5.2 3.0 5.30 5.300 (APULTS & PEDIATRICS 2.0 2.466 43.0 5.4 5.4 5.4 5.4 5.4 5.4 5.4 5			0	0	0	0		12.00
15:00 01500 PHARMACY 0 23,055 0 12,789 0 15.10 17:00 01700 SOCIAL SERVICE 0 0 0 0 0 0 17.10 17:00 01700 SOCIAL SERVICE 0 0 0 0 0 0 17.10 10:00 01700 SOCIAL SERVICES-SALARY & FRINGES APPRV 0 0 0 0 0 0 20.0 10:00 01200 IAR SERVICES-SALARY & FRINGES APPRV 0 0 0 0 0 22.1 20:00 02200 IAR SERVICES-SALARY & FRINGES APPRV 0 0 0 0 0 0 0 22.1 10:00 02000 AUUTS & FROM.(SPECIFY) 0 0 0 0 0 22.4 0 43.0 43:00 04300 AUUTS & FROM SERVICE COST CENTERS 0 16.9,670 0 16.1,753 55.4 51.0 50:00 05000 DELVERY ROM & LABOR ROM 0 16.9,670 0 0 53.3 51.4 53.4 53.4 53.4 53.4 53.4 53.4 53.4 53.4 <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td>-</td> <td>13.00</td>			0	0	0	0	-	13.00
16.00 01600 MEDI CAL RECORDS & LIBRARY 0 4,550 0 2,524 0 16.0 17.00 01700 NONPHYSICIAN ANESTHETI STS 0 0 0 0 17.0 19.00 01900 NONPHYSICIAN ANESTHETI STS 0 0 0 0 0 0 17.0 21.00 02200 IAR SERVICES-SALARY & FRINCES APPRV 0 0 0 0 21.1 22.00 02200 IAR SERVICES-SALARY & FRINCOSTS APPRV 0 0 0 0 22.1 23.00 02300 PARAMED ED PROM-(SOFFCIFY) 0 0 0 0 22.1 30.00 03000 ADULTS & PEDI ATRICS 0 14.482 0 2.466 43.1 30.00 03000 PERATI NG ROM 0 16.670 0 04.116 52.00 30.00 05200 DELLARY SERVICE COST CENTERS 0 0 0 0 53.547 0 64.644 54.16 30.00 52.00 05200 DELLARY MERONY 0 84.088 0 64.644 54.16 54.51 30.00 54.000 6600 ADULGY THERAPY			0		0		-	14.00
19:00 001000 NUMENEN CANA AMESTHETISTS 0			0		-		-	16.00
20. 00 00 <th< td=""><td></td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>17.00</td></th<>			0	0	0	0	0	17.00
21.00 02100 #R SERVICES-SALARY & FRINCES APPRV 0 <t< td=""><td></td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td>-</td><td>19.00</td></t<>			0	0	0	0	-	19.00
22.00 02200 IAR SERVI CES.OTHER PROM COSTS APPRV 0 0 0 0 23.00 0.00 03000 PARAUE DE DRAM. CSPECIFY) 0 0 0 23.1 30.00 03000 ADULTS & PEDI ATR CS 0 297,680 0 165,122 0 30.1 30.00 03000 AUDUTS & PEDI ATR CS 0 4.482 0 2.4466 0 43.1 30.00 05200 DETATR KOOM 0 169,670 0 94,116 50.0 52.00 0			0	0	0	0		20.00
INPATI ENT ROUTI NE SERVICE COST CENTERS 00 03000 ADULTS & PEDIATRI CS 0 297, 660 0 165, 122 0 3.0 43.00 04300 NURSERY 0 4, 482 0 2, 486 0 43.0 50.00 05000 PERATING ROOM 0 169, 670 0 94, 116 0 50.0 51.00 05000 DELVERY ROOM & LABOR ROOM 0 11, 753 52.0 53.00 05300 ANESTHESI DLOGY 0 0 0 53.5 54.00 0.00 ANESTHESI DLOGY 0 0 0 54.00 0.00 LABORATORY 0 33, 547 0 18.609 66.1 60.00 06000 CLABORATORY 0 33, 547 0 881 0 64.644 65.1 61.00 06600 PESPI RATORY THERAPY 0 9.881 0 64.0 62.0 65.00 65.00 65.00 66.0 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 67.00 60.00 66.00 6			0	0	0	0	-	22.00
30: 00 00000 ADULTS & PEDIATRICS 0 297, 680 0 165, 122 0 30. 43: 00 04300 NURSERY 0 4, 482 0 2, 486 0 43. ANCI LLARY SERVICE COST CENTERS 0 4, 482 0 2, 486 0 43. 50: 00 05000 DELUICSR YROM & LABOR ROM 0 169, 670 94, 116 0 52. 51: 00 05000 RADIDLORY PROM & LABOR ROM 0 11, 753 0 52. 52: 00 05000 RADIDLORY POMA & LABOR ROM 0 11, 753 0 54. 60: 00 00 RADIDLORY POMA & LABOR ROM 0 0 0 0 54. 60: 00 00 RADIDLORY POMA & LABOR ROM 0 84.088 0 46, 644 0 54. 60: 00 00 RESPI RATORY THERAPY 0 33. 547 0 18.609 0 62. 66: 00 06600 RESPI RATORY THERAPY 0 0 0 0 64. 64. 64. 70: 00 00 0 0 0 0 0 64. 65.			0	0	0	0	0	23.00
43.00 0 0 4,482 0 2,486 0 43.1 ANCILLARY SERVICE COST CENTERS				207 (00	0	1/5 100	0	1 20 00
ANCI LLARY SERVICE COST CENTERS Image: Cost of Centers ANCI LLARY SERVICE COST CENTERS Image: Cost of Centers Solution 50:00 OSODO OPERATING ROOM 0 169,670 0 94,116 0 51:00 DESCOD DELIVERY ROOM & LABOR ROOM 0 11,753 0 52. 53:00 DESCOD CHACNORY 0 0 0 0 53. 60:00 COSODO REDIDIO CLOTTING FOR HEMOPHILLACS 0 84.088 0 46.644 0 62. 61:00 OGODO CLABORATORY 0 33.547 18.609 60. 62. 62:00 OSODO RESPI RATORY THERAPY 0 9.881 0 5.481 65. 60:00 OGODO CLUPATI ONAL THERAPY 0 0 0 66. 67.0 66.00 66.00 66.00 66.00 66.00 67.00 68.00 69.00 69.00 67.00 68.00 69.00 69.00 67.00 67.00 68.00 67.00 68.00 67.00 67.00 67.7								•
52.00 OS200 DELIVERY ROM & LABOR ROM 0 21.188 0 11.753 0 52. 53.00 OS300 ANESTHESI OLOGY 0 <td< td=""><td></td><td></td><td></td><td>17 102</td><td></td><td>27 100</td><td></td><td></td></td<>				17 102		27 100		
53.00 NESTHESI OLOGY 0 0 0 0 53.3 54.00 05400 RADIOLOGY-DI AGNOSTI C 0 84,068 0 46,644 0 54.00 60.00 06000 LABORATORY 0 33,547 18.609 0 60.00 62.30 06200 RESPI RATORY THERAPY 0 9,881 0 5,481 0 65.0 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66.0 67.00 06700 CCUPATI ONAL THERAPY 0 0 0 0 67.0 0 0 0 67.0 66.0 68.0 6800 6900 ELECTROCARDI OLOGY 0 0 0 0 67.0 <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td>50.00</td>			0					50.00
54.00 RADIOLOGY-DIAGNOSTIC 0 84,088 0 44,644 0 54.4 60.00 06000 LABORATORY 0 33,547 0 18,609 0 60.2 62.30 65250 BLODD CLOTTI NG FOR HEMOPHI LIACS 0 0 0 0 62.2 65.00 06500 RESPI RATORY THERAPY 0 9,881 0 5,481 0 65.4 66.00 6600 PMSI CAL THERAPY 0 0 0 0 67.0 67.00 0CCUPATI ONAL THERAPY 0 0 0 0 0 67.1 68.00 066000 SPEECH RATHOLOGY 0 0 0 0 68.1 71.00 07100 MEDI CAL SUPPLIES CHARGE TO PATIENT 0 0 0 0 71.1 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.1 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 74.1 76.97 07697 CARDIAC CARGED TO PATIENTS 0 0 0 75.1 76.1			0	21, 188	0	11, 753		52.00
60.00 IABORATORY 0 33, 547 0 18, 609 0 60.0 62.30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0 <			0	84.088	0	46, 644	-	53.00
65.00 06500 RESPI RATORY THERAPY 0 9,881 0 5,481 0 65. 66.00 06000 PHYSI CAL THERAPY 0 56.229 0 31,190 0 66. 67.00 06700 0000 000 0 0 0 67.00 66.0 68.00 DEECH PATHOLOGY 0 0 0 0 68.8 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.0 71.00 O7100 MPL. DEV. CHARGED TO PATI ENTS 0 0 0 73.7 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 73.7 76.97 OR597 CARDI AC REHABI LI TATI ON 0 5,959 0 3,305 0 76.7 90 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 0 76.7 90 07699 LTHORINEPSY 0 0 </td <td></td> <td></td> <td>0</td> <td></td> <td>0</td> <td></td> <td>0</td> <td>60.00</td>			0		0		0	60.00
66.00 06600 PHYSI CAL THERAPY 0 56,229 0 31,190 0 66.0 67.00 0CCUPATI ONAL THERAPY 0 0 0 0 67.00 68.00 06800 SPECIAL PATHOLOGY 0 0 0 68.0 69.00 6900 ELECTROCARDI OLOGY 0 0 0 68.0 69.00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 0 0 0 0 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 71.1 72.00 70700 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 73.1 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 74.7 76.97 7C4701 AC REHABI LI TATI ON 0 5,959 0 3,305 76.7 76.98 MYERARI C 0XYGEN THERAPY 0 0 0 0 76.7 76.99 07698 LITHOTRI PSY 0 0 0 76.7 76.7 90.00 0000 LI FEBRI DGE SENI OR C			0	Ű	0	0	-	62.30
67.00 06700 0CCUPATIONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECROCARDI OLOGY 0 0 0 69.90 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 71.10 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72.3 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.1 76.97 O7697 CARDI AC REHABILI TATION 0 5,959 0 3.305 0 76.7 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 76.7 76.97 07697 CARDI AC REHABILI TATION 0 5,959 0 3.305 0 76.7 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 0 76.7 90.00 09000 CLI NI C OSTENTERS 0 0 0			0		0		-	65.00
68.00 06800 SPEECH PATHOLOGY 0 0 0 0 68.6 69.00 06900 ELECTROCARDIOLOGY 0 0 0 0 0 69.0 72.0 0			0	50, 229	0	31, 190		67.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 72.00 73.00 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 76.97 O7697 CARDI AC REHABILITATION 0 5,959 0 3.305 0 76.7 76.97 O7699 LITHOTRIPSY 0 0 0 0 0 76.7 00.00 O9000 CLINIC 0			0	0	0	0	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 72.1 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.4 76.97 0767 CARDIA CREHABILITATION 0 5,959 0 3,305 0 76.7 76.98 07698 HYPERBARIC OXYGEN THERAPY 0 0 0 0 76.7 76.99 07699 LITHOTRIPSY 0 0 0 0 76.7 00000 CLINIC 0 0 0 0 0 76.7 90.01 09000 CLINIC 0 0 0 0 90.1 91.00 09000 EMERGENCY 0 117.499 0 8,570 90.1 92.00 09200 DESERVATION BEDS (NON-DISTINCT PART 0 117.499 0 91.0 91.0 99.10 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 99.2 99.10 09910 CORF 0 0 0 0 99.2			0	0	0	0	-	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 73.00 76.97 07697 CARDIAC REHABILLITATION 0 5,959 0 3,305 0 76.90 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76.90 01900 01101111 ENTSERVICE COST CENTERS 0 0 0 0 0 76.90 00100 0100 0 0 0 0 0 0 76.90 00100 01111 ENTSERVICE COST CENTERS 0 0 0 0 90.00 0100 0000 CLINIC 0 0 0 0 90.00 90.00 09000 CLINIC 0 0 0 90.00 90.00 91.00 09010 EMERGENCY 0 117,499 0 8,570 99.10 92.00 09520 AMBULANCE SERVICES 0 0 0 99.10 99.20 99.20 99.20 99.20 99.20 99.20 99.20 99.20 <td></td> <td></td> <td>0</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td>71.00</td>			0	0	0	0		71.00
76. 97 07697 CARDI AC REHABILLITATI ON 0 5, 959 0 3, 305 0 76. 97 76. 98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0 0 0 76. 97 90 07699 LI HOTRI PSY 0 0 0 0 0 0 76. 97 90 00 0 0 0 0 0 0 0 0 76. 97 90 00 0 0 0 0 0 0 0 76. 97 90 00 0 0 0 0 0 0 0 76. 97 90 00 0 0 0 0 0 0 0 76. 97 90.00 OPODO CLINIC 0 0 0 0 0 90. 97 90.01 LIFEBRI DGE SENI OR CARE 0 0 117, 499 0 65, 177 0 91. 95 95. 97 95. 97 95. 97 95. 97 97. 95. 97 97. 97 95. 97 97. 97 97. 9			0	0	0	0		73.00
76.99 07699 L1 HOTRI PSY 0 0 0 0 76.9 90.00 09000 CLI NI C 0 0 0 0 90.0 90.00 0 0 0 0 90.0 90.00 0 0 0 0 90.0 90.00 0 0 0 0 90.0 90.00 90.00 0 0 0 90.00 90.00 90.00 0 0 0 0 90.00 <td< td=""><td></td><td></td><td>0</td><td>5, 959</td><td>0</td><td>3, 305</td><td></td><td>•</td></td<>			0	5, 959	0	3, 305		•
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>-</td> <td>0</td> <td></td> <td>•</td>			0	0	-	0		•
90.00 09000 CLINIC 0			0	0	0	0	0	76.99
91.00 09100 EMERGENCY 0 117,499 0 65,177 0 91.0 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 117,499 0 65,177 92.0 0THER REI MBURSABLE COST CENTERS 0 0 17,169 0 29,175 95.0 99.10 O9500 AMBULANCE SERVI CES 0 0 0 0 99.10 99.20 0 0 0 0 0 99.10 99.20 009200 0UTPATI ENT PHYSI CAL THERAPY 0 0 0 0 99.20 99.20 009940 0UTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 99.20 99.30 99.30 009940 0UTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.20 99.40 009940 0 0 0 0 99.40			0	0	0	0	0	90.00
92.00 0BSERVATI ON BEDS (NON-DI STINCT PART 92.00 0THER REIMBURSABLE COST CENTERS 0 0 17,169 29,175 95.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0 99.10 99.10 00910 CORF 0 0 0 0 99.10 99.10 00920 00 0 0 0 99.10 00920 00 0 0 0 99.10 0 0 0 0 99.10 0 0 0 0 99.10 0 0 0 0 0 99.10 0 0 0 0 0 99.10 0 99.10 0 0 0 0 99.10 99.10 99.10 99.10 0 0 0 0 0 99.10			0		-			90.01
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 0 0 17, 169 0 29, 175 95.0 99.10 09910 CORF 0 0 0 0 0 99.2 99.20 00920 OUTPATI ENT PHYSI CAL THERAPY 0 0 0 0 99.2 99.30 09930 OUTPATI ENT OCUPATI ONAL THERAPY 0 0 0 0 99.2 99.40 09940 OUTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 99.2 99.40 09940 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.2 99.40 OSPECI AL PURPOSE COST CENTERS 113.00 1 NTREST EXPENSE 113.00 1 NTREST EXPENSE 113.00 1 NORE MBURSABLE COST 29.175 118.0			0	117, 499	0	65, 177	0	91.00
95.00 09500 AMBULANCE SERVICES 0 0 17, 169 0 29, 175 95.0 99.10 09910 CORF 0 0 0 0 0 99.2 99.20 00920 OUTPATI ENT PHYSICAL THERAPY 0 0 0 0 0 99.2 99.30 09930 OUTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 99.2 99.40 09940 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.2 99.40 09940 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.2 99.40 OP940 OUTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.4 99.40 SPECI AL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 113.00 1066, 489 1, 262, 274 17, 169 700, 186 29, 175 118.00 NONREI MBURSABLE COST CENTERS Interest Interest Interest Interest Interest Interest Interest Interest				<u> </u>				92.00
99.20 09920 0UTPATI ENT PHYSI CAL THERAPY 0 0 0 0 99.2 99.30 09930 0UTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 99.2 99.40 09940 0UTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.2 99.40 09940 0UTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.2 SPECIAL PURPOSE COST CENTERS 5 </td <td></td> <td></td> <td>0</td> <td>0</td> <td>17, 169</td> <td>0</td> <td>29, 175</td> <td>95.00</td>			0	0	17, 169	0	29, 175	95.00
99.30 09930 0UTPATI ENT OCCUPATI ONAL THERAPY 0 0 0 0 99.2 99.40 09940 0UTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.2 97.40 09940 0UTPATI ENT SPEECH PATHOLOGY 0 0 0 0 99.2 113.00 INTEREST EXPENSE 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 11,066,489 1,262,274 17,169 700,186 29,175 118.00 NONREL MBURSABLE COST CENTERS			0	0	0	0		99.10
99. 40 09940 OUTPATI ENT SPECH PATHOLOGY 0 0 0 0 99. 4 SPECIAL PURPOSE COST CENTERS			0	0	0	0		99.20
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,066,489 1,262,274 17,169 700,186 29,175 118.0 NONREI MBURSABLE COST CENTERS Interest expense Interest expense Interest expense 118.0			0	0	-	0		•
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1,066,489 1,262,274 17,169 700,186 29,175 118.0 NONREI MBURSABLE COST CENTERS						0]
NONREI MBURSABLE COST CENTERS								113.00
			1, 066, 489	1, 262, 274	17, 169	700, 186	29, 175	118.00
			0	3 786	0	2 100	0	190.00
					-			192.00
			0	0	0	0		194.00
			0	0	0	0		194.01 194.03
			0	0	0	0		194.03
			0	0	0	0		194.04
200.00 Cross Foot Adjustments 200.0	200.00	Cross Foot Adjustments						200.00
			1 044 400		17 140	0		201.00
202.00 TOTAL (sum Lines 118 through 201) 1,066,489 1,322,628 17,169 733,664 29,175 202.00	202.00	I TOTAL (Sum TITIES TTO LITTOUGH 201)	1,000,489	1, 322, 028	17, 109	133,004	29,1/5	1202.00

	Financial Systems COMMU TION OF CAPITAL RELATED COSTS	JNI TY HOSPT. OF	Provi der C	CN: 15-1323 Pe	eriod: rom 01/01/2018	ı of Form CMS-: Worksheet B Part II	
				To		Date/Time Pre 5/29/2019 2:5	pared:
	Cost Center Description	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	ADMI NI STRATI VE & GENERAL	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	
		2A	4.00	5.00	6.00	7.00	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
1.00	00101 EMS WEST STATION						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2. 01	00201 EMS WEST STATION EQUIP.						2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0				4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	1, 443, 245	0	1, 443, 245	_		5.00
6.00	00600 MAI NTENANCE & REPAI RS	0	0	0	0	212, 200	6.00
7.00 3.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	116, 796 6, 678	0	96, 504 6, 754	0	213, 300 911	7.00
9.00	00900 HOUSEKEEPING	21,855	0	25, 301	0	2, 983	
10.00	01000 DI ETARY	87, 682	0	29, 068	0	11, 968	
11.00	01100 CAFETERI A	0	0	21, 719	0	0	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	32, 888	0	0	13.00
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	41, 650 35, 844	0	0 55, 548	0	5, 685 4, 892	
16.00	01600 MEDICAL RECORDS & LIBRARY	7,074	0	505	0	966	1
17.00	01700 SOCI AL SERVI CE	0	0	0	Ő	0	1
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	19.00
20. 00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100 I & R SERVI CES-SALARY & FRINGES APPRV	0	0	0	0	0	1 - · · · · ·
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0 ol	0	22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	U	0	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	462, 802	0	157, 209	0	63, 167	30. 00
43.00	04300 NURSERY	6, 968	0	13, 816	0	951	43.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	263, 786	0	136, 622	0	36, 005	
52.00 53.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	32, 941	0	59, 140 7, 262	0	4, 496 0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	130, 732	0	120, 508	0	17, 844	
60.00	06000 LABORATORY	52, 156	0	86, 061	Ő	7, 119	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
65.00	06500 RESPI RATORY THERAPY	15, 362	0	30, 823	0	2, 097	
66.00	06600 PHYSI CAL THERAPY	87, 419	0	37, 945	0	11, 932	
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	14, 944 7, 059	0	0	
58.00 59.00	06900 ELECTROCARDI OLOGY	0	0	7,037	0	0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	28, 499	Ő	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	20, 508	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	86, 825	0	0	
	07697 CARDI AC REHABI LI TATI ON	9, 264	0	2, 961	0		76.9
	07698 HYPERBARI C 0XYGEN THERAPY 07699 LI THOTRI PSY	0	0	0	0	0	76.98
/0. //	OUTPATIENT SERVICE COST CENTERS		0	V	0	0	/0. /
	09000 CLI NI C	0	0	0	0	0	
	09001 LI FEBRI DGE SENI OR CARE	24, 019	0	23, 954	0	3, 278	
	09100 EMERGENCY	182, 676 0	0	204, 314	0	24, 934	
92.00	09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS	0					92.00
95.00	09500 AMBULANCE SERVICES	46, 344	0	121, 926	0	0	95.00
99.10	09910 CORF	0	0	0	0	0	
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	1
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
113 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						113.00
118. OC		3, 075, 293	0	1, 428, 663	0	200, 493	
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 886	0	950	0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	87, 946	0	6, 655	0	12,004	
	07950 OCCUPATI ONAL HEALTH 07951 FOUNDATI ON	0	0	0	0		194. 00 194. 0
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS		0	1, 326 5, 651	0		194.0
	07954 ER PHYSICIAN	0	0	0	o		194. 0
	07953 SHI PSHEWANA RADI OLOGY AND LAB	Ō	0	0	Ő		194.0
		0					200. 0
200.00 201.00 202.00	Negative Cost Centers	0 3, 169, 125	0	0 1, 443, 245	0 0	0 213, 300	201.00

ALLUC	n Financial Systems COMM ATION OF CAPITAL RELATED COSTS		LAGRANGE CTY Provider CC	N: 15-1323 F	Period: From 01/01/2018	u of Form CMS-: Worksheet B Part II	
					o 12/31/2018		pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY		MAINTENANCE OF PERSONNEL	
	GENERAL SERVICE COST CENTERS	8.00	9.00	10.00	11.00	12.00	
$\begin{array}{c} 1.\ 00\\ 1.\ 01\\ 2.\ 00\\ 2.\ 01\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00 \end{array}$	01100 CAFETERI A	14, 343 0 76 0 0	50, 139 2, 866 0 0	131, 660 C	21, 719	0	1.00 1.01 2.00 2.01 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
12.00 13.00 14.00 15.00 16.00 17.00 19.00 20.00 21.00 22.00 23.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV		0 0 1, 361 1, 171 231 0 0 0 0 0 0 0 0		1, 188 0 1, 312 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-	13.00 14.00 15.00 16.00 17.00 19.00 20.00 21.00 22.00
30. 00 43. 00	03000 ADULTS & PEDI ATRI CS	4, 497 240	15, 125 228	131, 660 (0	
 43. 00 50. 00 52. 00 53. 00 54. 00 60. 00 62. 30 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 72. 00 73. 00 76. 98 76. 98 76. 99 	ANCI LLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY	2,358 1,023 0 1,974 0 0 0 0 532 221 23 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 621 1, 077 0 4, 272 1, 704 0 502 2, 857 0 0 0 0 0 0 0 0 0 0 0 0 0		2,596 1,678 0 2,859 0 0 1,360 1,329 465 215 0	0 0 0 0 0 0 0	50.00 52.00 53.00 54.00 62.30 65.00 65.00 65.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 73.00 76.97
90. 00 90. 01 91. 00 92. 00	09000 CLINIC 09001 LIFEBRIDGE SENIOR CARE 09100 EMERGENCY	0 0 2, 690	0 785 5, 970	(((675		90.01
95.00 99.10 99.20 99.30 99.40	09500 AMBULANCE SERVICES 09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY 09930 OUTPATIENT OCCUPATIONAL THERAPY	403 0 0 0 0	0 0 0 0			0 0 0 0	99. 10 99. 20 99. 30
113. 0 118. 0	0 11300 INTEREST EXPENSE 0 SUBTOTALS (SUM OF LINES 1 through 117)	14, 037	47, 073	131, 660	21, 719	0	113. 00 118. 00
192.0 194.0 194.0 194.0 194.0	NONREI MBURSABLE COST CENTERS 0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 19200 PHYSICIANS' PRIVATE OFFICES 0 07950 OCCUPATIONAL HEALTH 1 07951 FOUNDATION 3 07952 COMMUNITY & VOLUNTEER SVCS 4 07954 ER PHYSICIAN 6 07953 SHIPSHEWANA RADIOLOGY AND LAB 0 Cross Foot Adjustments	0 306 0 0 0 0 0	192 2, 874 0 0 0 0 0 0 0			0 0 0 0 0 0	190. 00 192. 00 194. 00 194. 01 194. 03 194. 04 194. 06 200. 00 201. 00

	Financial Systems COMN TION OF CAPITAL RELATED COSTS	IUNI TY HOSPT. OF	Provider CC		Period:	u of Form CMS-: Worksheet B	2552-I
LLUUF	TION OF CAPITAL RELATED COSTS		Flow der co		From 01/01/2018 To 12/31/2018	Part II Date/Time Pre 5/29/2019 2:5	
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	RECORDS & LI BRARY	SOCI AL SERVI CE	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
. 00	00100 CAP REL COSTS-BLDG & FIXT						1 1.0
. 01	00101 EMS WEST STATION						1.0
. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.0
. 01	00201 EMS WEST STATION EQUIP.						2.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
. 00	00500 ADMI NI STRATI VE & GENERAL						5.0
. 00 . 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.0 7.0
. 00	00800 LAUNDRY & LINEN SERVICE						8.0
. 00	00900 HOUSEKEEPI NG						9.0
0. 00	01000 DI ETARY						10.0
1. 00	01100 CAFETERI A						11.0
2.00	01200 MAINTENANCE OF PERSONNEL						12.0
3.00	01300 NURSI NG ADMI NI STRATI ON	34, 076	05 051				13.0
4.00 5.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	25, 351 525	99, 29	2		14.0 15.0
6.00	01600 MEDICAL RECORDS & LIBRARY	0	0		8, 776		16.0
7.00	01700 SOCIAL SERVICE	0	0		0 0	0	
9.00	01900 NONPHYSICIAN ANESTHETISTS	0	0		0 0	0	
0. 00	02000 NURSI NG SCHOOL	0	0		0 0	0	20.0
1.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0		0 0	0	
2.00	02200 I & SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	
3.00	02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0		0 0	0	23.0
0. 00	03000 ADULTS & PEDIATRICS	12, 734	330		2 1, 038	0	30. C
3.00	04300 NURSERY	1,089	385		1 169	0	
	ANCILLARY SERVICE COST CENTERS						
0. 00	05000 OPERATING ROOM	7, 181	5, 177	38	6 153	0	50.0
2.00	05200 DELIVERY ROOM & LABOR ROOM	4, 643	1, 644		4 0	0	
3.00	05300 ANESTHESI OLOGY	0	0		0 0	0	
4.00 0.00	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY	0	730 0	5 12		0	
2.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	
5.00	06500 RESPI RATORY THERAPY	0	139		0 0	0	65.0
6. 00	06600 PHYSI CAL THERAPY	0	125	1	0 673	0	66.0
7.00	06700 OCCUPATI ONAL THERAPY	0	52		4 201	0	
8.00	06800 SPEECH PATHOLOGY	0	5		0 47	0	
9.00	06900 ELECTROCARDI OLOGY	0	0			0	
1.00 2.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	7, 192 5, 172			0	1
3.00	07300 DRUGS CHARGED TO PATIENTS	0	730	98, 32	-	0	
	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	
6. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	
6. 99	07699 LI THOTRI PSY	0	0		0 0	0	76. 9
~ ~~	OUTPATIENT SERVICE COST CENTERS						
0. 00 0. 01	09000 CLINIC 09001 LIFEBRIDGE SENIOR CARE	0	0 181		0 0 0 0	0	
1.00	09100 EMERGENCY	8, 429	1, 581	2		0	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0, 127	1,001	2	, , , ,	0	92.0
	OTHER REIMBURSABLE COST CENTERS	· · · · ·					
5.00	09500 AMBULANCE SERVI CES	0	1, 331	35	6 0	0	
9. 10	09910 CORF	0	0		0 0	0	
	09920 OUTPATIENT PHYSICAL THERAPY	0	0		0 0	0	
9.30 9.40	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0			0	99.3 99.4
9.40	09940 OUTPATIENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS	0	0			0	99.4
13.00	11300 I NTEREST EXPENSE						113. C
18.00		34,076	25, 299	99, 29	2 8, 776	0	118. C
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7		0 0		190.0
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	9		0 0		192.0
	07950 OCCUPATI ONAL HEALTH 07951 FOUNDATI ON	0	0 13				194. 0 194. 0
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS		23				194. C
	07954 ER PHYSICIAN	0	23		0 0		194.0
	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	o		0 0		194.0
00.00			_				200. 0
			23, 345		ol ol	0	201.0
01.00 02.00		34,076	48, 696	99, 29	2 8, 776		201.0

	ncial Systems COMM OF CAPITAL RELATED COSTS		Provider (Period: From 01/01/2018	Worksheet B Part II	
					To 12/31/2018	Date/Time Pre 5/29/2019 2:5	
				I NTERNS &	RESI DENTS		
	Cost Center Description	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOI	L SERVI CES-SALA Y & FRI NGES APPRV	R SERVI CES-OTHER PRGM COSTS APPRV	PARAMED ED PRGM	
		19.00	20.00	21.00	22.00	23.00	
	RAL SERVICE COST CENTERS	1	1				1.00
01 0010 ⁻ 00 00200 01 0020 ⁻ 00 00400 00 00500 00 00500 00 00600 00 00600 00 00800 00 00900 0.0 01000 1.00 01100 2.00 01200 3.00 01300 4.00 01400 5.00 01500 6.00 01600	I EMS WEST STATION CAP REL COSTS-MVBLE EQUIP EMS WEST STATION EQUIP. EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS OPERATION OF PLANT LAUNDRY & LINEN SERVICE HOUSEKEEPING D LETARY CAFETERIA MAINTENANCE OF PERSONNEL MAINTENANCE OF PERSONNEL D NURSING ADMINISTRATION O CENTRAL SERVICES & SUPPLY PHARMACY MEDICAL RECORDS & LIBRARY						1.0 2.0 2.0 4.0 5.0 6.0 7.0 8.0 9.0 10.0 11.0 12.0 11.0 13.0 14.0 15.0 16.0
	SOCIAL SERVICE						17.00
	NONPHYSICIAN ANESTHETISTS			o			19.00
1.00 02100	I&R SERVICES-SALARY & FRINGES APPRV			-	0		21.00
	I&R SERVICES-OTHER PRGM COSTS APPRV				0	(22.00
	D PARAMED ED PRGM-(SPECIFY)						23.00
	ADULTS & PEDIATRICS						30.00
	D NURSERY LLARY SERVICE COST CENTERS						43.00
	OPERATING ROOM						50.00
	DELIVERY ROOM & LABOR ROOM						52.00
) ANESTHESI OLOGY) RADI OLOGY-DI AGNOSTI C						53.0
	LABORATORY						60.0
	BLOOD CLOTTING FOR HEMOPHILIACS						62.3
	D RESPI RATORY THERAPY						65. 0 66. 0
	OCCUPATIONAL THERAPY						67.0
8. 00 06800	SPEECH PATHOLOGY						68.0
							69.0
	MEDICAL SUPPLIES CHARGED TO PATIENT						71. C
	DRUGS CHARGED TO PATIENTS						73.0
	CARDIAC REHABILITATION						76.9
	B HYPERBARI C OXYGEN THERAPY						76.9
	ATIENT SERVICE COST CENTERS						
0.00 09000							90.0
	I LIFEBRIDGE SENIOR CARE						90.0
	OBSERVATION BEDS (NON-DISTINCT PART						92.0
	REIMBURSABLE COST CENTERS	1	1				
5.00 09500 9.10 09910	AMBULANCE SERVICES						95.0 99.1
	OUTPATIENT PHYSICAL THERAPY						99.1
	OUTPATIENT OCCUPATIONAL THERAPY						99.3
	OUTPATIENT SPEECH PATHOLOGY						99.4
	AL PURPOSE COST CENTERS						113.0
18.00	SUBTOTALS (SUM OF LINES 1 through 117)	0		0	0 0	C	0 118.0
NONRE	IMBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.0
	PHYSICIANS' PRIVATE OFFICES OCCUPATIONAL HEALTH						192. 0 194. 0
	FOUNDATION						194.0
	COMMUNITY & VOLUNTEER SVCS						194.0
	ER PHYSICIAN						194. 04
	SHIPSHEWANA RADIOLOGY AND LAB	,					194.0
00.00 01.00	Cross Foot Adjustments Negative Cost Centers			-	0 0 0 0		200.00 201.00
	TOTAL (sum lines 118 through 201)				0 0		201.0

LOCATION OF CAPITAL RELATED COSTS		Provider CC	F	rom 01/01/2018 F	lorksheet B Part II Pata (Tima Dropara
					ate/Time Prepare /29/2019 2:50 pm
Cost Center Description	Subtotal	Intern & Residents Cost	Total		
		& Post			
		Stepdown Adjustments			
	24.00	25.00	26.00	-	
GENERAL SERVICE COST CENTERS 00 00100 CAP REL COSTS-BLDG & FIXT				1	1.
00100 CAP REL COSTS-BEDG & FIXT					1.
00 00200 CAP REL COSTS-MVBLE EQUIP					2.
01 00201 EMS WEST STATION EQUIP.					2.
00 00400 EMPLOYEE BENEFITS DEPARTMENT 00 00500 ADMINISTRATIVE & GENERAL					4.
00 00500 ADMINI STRATI VE & GENERAL 00 00600 MAI NTENANCE & REPAI RS					6.
00 00700 OPERATION OF PLANT					7.
00 00800 LAUNDRY & LINEN SERVICE					8.
00 00900 HOUSEKEEPI NG 00 01000 DI ETARY					9.
00 01000 DI ETARY 00 01100 CAFETERI A					10.
00 01200 MAINTENANCE OF PERSONNEL					12.
00 01300 NURSI NG ADMI NI STRATI ON					13.
00 01400 CENTRAL SERVICES & SUPPLY					14.
00 01500 PHARMACY 00 01600 MEDICAL RECORDS & LIBRARY					15.
00 01700 SOCIAL SERVICE					17.
00 01900 NONPHYSICIAN ANESTHETISTS					19.
00 02000 NURSI NG SCHOOL					20.
00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV					21.
00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 00 02300 PARAMED ED PRGM-(SPECI FY)					22.
INPATIENT ROUTINE SERVICE COST CENTERS					20.
00 03000 ADULTS & PEDI ATRI CS	853, 166	0	853, 166		30.
00 04300 NURSERY	24, 241	0	24, 241		43.
ANCI LLARY SERVI CE COST CENTERS	462, 885	0	462, 885		50.
00 05200 DELIVERY ROOM & LABOR ROOM	106, 646	0	106, 646		52.
00 05300 ANESTHESI OLOGY	7, 262	0	7, 262		53.
00 05400 RADI OLOGY-DI AGNOSTI C	281, 894	0	281, 894		54.
00 06000 LABORATORY 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	147, 160 0	0	147, 160 C		60. 62.
00 06500 RESPIRATORY THERAPY	50, 283	0	50, 283		65.
00 06600 PHYSI CAL THERAPY	142, 822	0	142, 822		66.
00 06700 OCCUPATI ONAL THERAPY	15, 887	0	15, 887		67.
00 06800 SPEECH PATHOLOGY 00 06900 ELECTROCARDI OLOGY	7,349	0	7, 349		68. 69.
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	35, 691	0	35, 691		71
00 07200 I MPL. DEV. CHARGED TO PATIENTS	25, 680	0	25, 680		72
00 07300 DRUGS CHARGED TO PATIENTS	185, 876	0	185, 876		73.
97 07697 CARDI AC REHABI LI TATI ON	13, 793	0	13, 793		76
98 07698 HYPERBARI C OXYGEN THERAPY 99 07699 LI THOTRI PSY	0	0	C		76
OUTPATIENT SERVICE COST CENTERS					
00 09000 CLINIC	0	0	C		90.
01 09001 LI FEBRI DGE SENI OR CARE	52, 892	0	52, 892		90.
00 09100 EMERGENCY 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	437, 248	0	437, 248		91. 92.
OTHER REIMBURSABLE COST CENTERS		9		l	72.
00 09500 AMBULANCE SERVICES	170, 360	0	170, 360		95.
10 09910 CORF	0	0	C		99.
20 09920 OUTPATIENT PHYSICAL THERAPY 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	C		99. 99.
40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	C		99.
SPECIAL PURPOSE COST CENTERS					
3. 00 11300 INTEREST EXPENSE	0 001 15-	_	0.001.1		113.
SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	3, 021, 135	0	3, 021, 135	·	118
0. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 838	0	7, 838		190
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	109, 794	Ö	109, 794		192
1. 00 07950 OCCUPATI ONAL HEALTH	0	О	C		194
4. 01 07951 FOUNDATION	1,339	0	1,339		194.
4. 03 07952 COMMUNI TY & VOLUNTEER SVCS 4. 04 07954 ER PHYSI CI AN	5, 674	0	5, 674		194. 194.
1. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	C		194.
D. 00 Cross Foot Adjustments	0	Ō	C)	200.
1.00 Negative Cost Centers	23, 345	0	23, 345 3, 169, 125		201.
2.00 TOTAL (sum lines 118 through 201)	3, 169, 125	0			202

_

ST ALLOCATIC	DN - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2018	Worksheet B-1	
					o 12/31/2018	Date/Time Pre 5/29/2019 2:5	
			CAPI TAL REI	LATED COSTS			
Сс	ost Center Description	BLDG & FIXT	EMS WEST	MVBLE EQUIP	EMS WEST	EMPLOYEE	
		(SQUARE FEET)	STATION (SQUARE FEET)	(SQUARE FEET)	STATION EQUIP.	BENEFI TS DEPARTMENT	
			. ,		(SQUARE FEET)	(GROSS	
		1.00	1.01	2.00	2.01	SALARI ES) 4. 00	
	SERVICE COST CENTERS	77.00(
	AP REL COSTS-BLDG & FIXT /S WEST STATION	77, 906 0	9, 760				1
	AP REL COSTS-MVBLE EQUIP	0	9,700	77, 906			2
	AS WEST STATION EQUIP.			0	9, 760		2
	MPLOYEE BENEFITS DEPARTMENT DMINISTRATIVE & GENERAL	0 14, 274	0	0 14, 274	0	11, 014, 138 3, 230, 143	
1 1	AINTENANCE & REPAIRS	0	0	0	0	3, 230, 143	
	PERATION OF PLANT	4, 425	0	4, 425	0	314, 541	
	AUNDRY & LINEN SERVICE DUSEKEEPING	253 828	0	253 828	0	0 187, 402	
. 00 01000 DI		3, 322	0	3, 322	0	145, 402	
. 00 01100 CA		0	0	0	0	256, 345	
	AINTENANCE OF PERSONNEL	0	0	0	0	0	
	JRSING ADMINISTRATION ENTRAL SERVICES & SUPPLY	0 1, 578	0	0 1, 578	0	341, 463 10, 016	
. 00 01500 PH		1,358	0	1, 358	-	493, 867	
	EDI CAL RECORDS & LI BRARY	268	0	268		0	
	DCIAL SERVICE DNPHYSICIAN ANESTHETISTS	0	0	0	0	0	
	JRSING SCHOOL	0	0	0	0	0	
	R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21
	R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
	ARAMED ED PRGM-(SPECIFY) NT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23
	DULTS & PEDI ATRI CS	17, 534	0	17, 534	0	1, 143, 650	30
. 00 04300 NL		264	0	264	0	121, 915	43
	RY SERVICE COST CENTERS	9, 994	0	9, 994	0	673, 450	50
	ELIVERY ROOM & LABOR ROOM	1, 248	0	1, 248	0	519, 831	
	NESTHESI OLOGY	0	0	0	0	0	
	ADI OLOGY-DI AGNOSTI C ABORATORY	4, 953 1, 976	0	4, 953 1, 976	0	692, 537 0	
	LOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	
. 00 06500 RE	ESPI RATORY THERAPY	582	0	582	0	294, 096	
	IYSI CAL THERAPY	3, 312	0	3, 312	0	310, 198	
	CCUPATIONAL THERAPY PEECH PATHOLOGY	0	0	0	0	146, 235 76, 245	
	LECTROCARDI OLOGY	0	0	0	0	0	
	EDI CAL SUPPLI ES CHARGED TO PATI ENT	0	0	0	0	0	
	IPL. DEV. CHARGED TO PATIENTS RUGS CHARGED TO PATIENTS	0	0	0	0	0	
	ARDI AC REHABI LI TATI ON	351	0	351	0	7, 647	
	PERBARI C OXYGEN THERAPY	0	0	0		0	
	THOTRIPSY ENT SERVICE COST CENTERS	0	0	0	0	0	76
. 00 09000 CL		0	0	0	0	0	90
. 01 09001 LI	FEBRIDGE SENIOR CARE	910	0	910		154, 897	90
. 00 09100 EN		6, 921	0	6, 921	0	851, 536	
	BSERVATION BEDS (NON-DISTINCT PART						92
. 00 09500 AN	/BULANCE SERVICES	0	9, 760	0	9, 760	1, 011, 124	
. 10 09910 CC		0	0	0	0	0	
	JTPATI ENT PHYSI CAL THERAPY JTPATI ENT OCCUPATI ONAL THERAPY		0	0	0	0	
	JTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	
	PURPOSE COST CENTERS						
8. 00 SL	NTEREST EXPENSE JBTOTALS (SUM OF LINES 1 through 117) BURSABLE COST CENTERS	74, 351	9, 760	74, 351	9, 760	10, 982, 542	113
	FT, FLOWER, COFFEE SHOP & CANTEEN	223	0	223	0	0	190
2. 00 19200 PH	HYSI CLANS' PRI VATE OFFI CES	3, 332	0	3, 332	0		192
	CCUPATIONAL HEALTH	0	0	0	0	0 17, 505	194
4. 01 07951 FC 4. 03 07952 CC	DUNDATION DMMUNITY & VOLUNTEER SVCS	0	0		0	17,505	
4. 04 07954 EF	R PHYSICIAN	0	0	0	0		194
	HIPSHEWANA RADIOLOGY AND LAB	0	0	0	0	0	194
0.00 Cr	ross Foot Adjustments						200 201

Health F	inancial Systems COMM	IUNI TY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
COST AL	LOCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2018	Worksheet B-1	
					To 12/31/2018		
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	BLDG & FIXT	EMS WEST	MVBLE EQUI P	EMS WEST	EMPLOYEE	
		(SQUARE FEET)	STATION (SQUARE FEET)	(SQUARE FEET)	STATION EQUIP.	BENEFI TS	
			(SQUARE FEET)		(SQUARE FEET)	DEPARTMENT (GROSS	
					(0000/112 1221)	SALARI ES)	
		1.00	1.01	2.00	2. 01	4.00	
202.00	Cost to be allocated (per Wkst. B,	1, 322, 628	17, 169	733, 66	4 29, 175	3, 928, 880	202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	16. 977229	1. 759119	9. 41729	8 2.989242		
204.00	Cost to be allocated (per Wkst. B, Part II)					0	204.00
205.00	Unit cost multiplier (Wkst. B, Part					0.00000	205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

	ancial Systems COMM CATION - STATISTICAL BASIS	IUNI TY HOSPT. OI	F LAGRANGE CTY Provider C		In Lie eriod:	u of Form CMS-: Worksheet B-1	
JUST ALLOC	ATTON - STATISTICAL DASIS			F	rom 01/01/2018 o 12/31/2018		
						5/29/2019 2:5	
	Cost Center Description	Reconciliation	ADMINISIRATIVE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
				(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	
		5A	5.00	6.00	7.00	LAUNDRY) 8.00	
	ERAL SERVICE COST CENTERS		0.00	0.00	7.00	0.00	
	00 CAP REL COSTS-BLDG & FIXT						1.00
	01 EMS WEST STATION 00 CAP REL COSTS-MVBLE EQUIP						1.0
	01 EMS WEST STATION EQUIP.						2.01
	OO EMPLOYEE BENEFITS DEPARTMENT	10 070 054					4.00
	00 ADMINISTRATIVE & GENERAL 00 MAINTENANCE & REPAIRS	-10, 272, 251	20, 202, 992	0			5.00
	OO OPERATION OF PLANT	0	1, 350, 902	0	59, 207		7.00
	DO LAUNDRY & LINEN SERVICE	0	94, 542	0	253	9, 998	
	00 HOUSEKEEPI NG 00 DI ETARY	0	354, 173 406, 907	0	828 3, 322	0 53	
	DO CAFETERI A	0	304, 027	0	0	0	
	DO MAINTENANCE OF PERSONNEL	0	0	0	0	0	
	00 NURSI NG ADMI NI STRATI ON 00 CENTRAL SERVI CES & SUPPLY	0 9, 818	460, 377	0	0 1, 578	0	
	DO PHARMACY	0	777, 579	0		0	
	00 MEDICAL RECORDS & LIBRARY	0	7, 074	0	268	0	
	00 SOCIAL SERVICE 00 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
	00 NURSI NG SCHOOL	0	0	0	0	0	
21.00 021	00 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.0
	00 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
	00 PARAMED_ED_PRGM-(SPECIFY) ATIENT_ROUTINE_SERVICE_COST_CENTERS	0	0	0	0	0	23.0
	00 ADULTS & PEDIATRICS	0	2, 200, 660			3, 135	30. 00
	00 NURSERY	0	193, 400	0	264	167	43.0
	I LLARY SERVI CE COST CENTERS	0	1, 912, 480	0	9, 994	1, 644	50.00
	00 DELIVERY ROOM & LABOR ROOM	0	827, 862	0		713	
	DO ANESTHESI OLOGY	0	101, 663	0	-	0	
	00 RADI OLOGY-DI AGNOSTI C 00 LABORATORY	0	1, 686, 916 1, 204, 705	0	4, 953 1, 976	1, 376 0	
	50 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	
	00 RESPI RATORY THERAPY	0	431, 475	0	582	0	
	00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY	0	531, 167 209, 195	0	3, 312 0	371 154	66.0
	00 SPEECH PATHOLOGY	0	98, 809	0	0	16	
	00 ELECTROCARDI OLOGY	0	0	0	0	0	
	00 MEDICAL SUPPLIES CHARGED TO PATIENT 00 IMPL. DEV. CHARGED TO PATIENTS	0	398, 935	0		0	
	00 DRUGS CHARGED TO PATIENTS	0	287, 085 1, 215, 411	0	0	0	
76.97 076	97 CARDI AC REHABI LI TATI ON	0	41, 445	0	351	0	76.9
	98 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
	99 LI THOTRI PSY PATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76.9
	DO CLINIC	0	0	0	0	0	90.0
	01 LI FEBRI DGE SENI OR CARE	0	335, 319			0	
	00 EMERGENCY 00 OBSERVATION BEDS (NON-DISTINCT PART	0	2, 859, 996	0	6, 921	1, 875	91.00
	ER REIMBURSABLE COST CENTERS	1		1			
	00 AMBULANCE SERVICES	0	1, 706, 762	0	0	281	95.00
99.10 099 99.20 099	10 CORF 20 OUTPATI ENT PHYSI CAL THERAPY	0	0	0	0	0	
	30 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	
	40 OUTPATI ENT SPEECH PATHOLOGY	0	0	0	0	0	99.4
	CIAL PURPOSE COST CENTERS		[1112 0
113.00113	SUBTOTALS (SUM OF LINES 1 through 117)	-10, 262, 433	19, 998, 866	0	55, 652	9, 785	113.0
NON	REIMBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,	-			
	00 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	13, 297	0	223		190.0
	00 PHYSI CLANS' PRI VATE OFFI CES 50 OCCUPATI ONAL HEALTH		93, 155 0	0	3, 332 0		192. 0 194. 0
	51 FOUNDATI ON	0	18, 567	0	0		194.0
	52 COMMUNITY & VOLUNTEER SVCS	0	79, 107	0	0		194.0
	54 ER PHYSICIAN 53 SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0		194. 0 194. 0
200.00	Cross Foot Adjustments	0		0	0	0	200. 0
201.00	Negative Cost Centers						201.00
	Coot to be all sected (see What D	1	10, 272, 251	0	2, 037, 771	151, 320	1202 00
202.00	Cost to be allocated (per Wkst. B, Part I)		10, 272, 251		2,037,771	151, 520	202.00

Heal th Fi	nancial Systems COM	NUNITY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	u of Form CMS-:	2552-10
COST ALLO	OCATION - STATISTICAL BASIS		Provider C		eriod: rom 01/01/2018	Worksheet B-1	
					o 12/31/2018		
	Cost Center Description	Reconciliation	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	
			& GENERAL	REPAI RS	PLANT	LINEN SERVICE	
			(ACCUM. COST)	(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	
						LAUNDRY)	
		5A	5.00	6.00	7.00	8.00	
204.00	Cost to be allocated (per Wkst. B, Part II)		1, 443, 245	C	213, 300	14, 343	204.00
205.00	Unit cost multiplier (Wkst. B, Part)		0. 071437	0. 000000	3. 602615	1. 434587	205. 00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)						206. 00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

0001 A	LLOCATION - STATISTICAL BASIS		Provider CC	Fi	eriod: rom 01/01/2018	Worksheet B-1	
				T		5/29/2019 2:5	pared: 0 pm
	Cost Center Description	HOUSEKEEPING (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE)	(NUMBER	NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG	
		9.00	10.00	11.00	12.00	HRS) 13.00	
	GENERAL SERVICE COST CENTERS	7.00	10.00	11.00	12.00	10.00	
$\begin{array}{c} 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00 \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION 00200 CAP REL COSTS-MVBLE EQUIP 00201 EMS WEST STATION EQUIP. 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01500 PHARMACY 01500 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV	58, 126 3, 322 0 0 1, 578 1, 358 268 0 0 0 0 0 0 0 0 0 0	16, 470 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	8, 593 0 470 0 519 0 0 0 0 0 0 0 0 0 0 0		101, 635 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1.00 1.01 2.00 2.01 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 15.00 15.00 16.00 17.00 20.00 20.00 21.00 22.00
	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23.00
	03000 ADULTS & PEDI ATRI CS 04300 NURSERY	17, 534 264		1, 821 156	0		30.00 43.00
	ANCI LLARY SERVI CE COST CENTERS						
$\begin{array}{c} 52.\ 00\\ 53.\ 00\\ 54.\ 00\\ 60.\ 00\\ 65.\ 00\\ 65.\ 00\\ 67.\ 00\\ 68.\ 00\\ 69.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 76.\ 98\\ 76.\ 99\\ \end{array}$	05000 OPERATING ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 OCCUPATIONAL THERAPY 06700 OCCUPATIONAL THERAPY 06700 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY 07699 LITHOTRIPSY 0UTPATIENT SERVICE COST CENTERS 09000 CLINIC	9, 994 1, 248 0 4, 953 1, 976 0 582 3, 312 0 0 0 0 0 0 0 0 0 0 0 0 0		1, 027 664 0 1, 131 0 0 538 526 184 85 0 0 0 0 0 0 0 0 0 0		21, 418 13, 847 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50.00 52.00 53.00 54.00 60.00 62.30 65.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 76.97 76.98 76.99 90.00
90. 01 91. 00	09001 LIFEBRIDGE SENIOR CARE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	910 6, 921	0	267 1, 205	0	0 25, 140	90. 01 91. 00 92. 00
99. 10 99. 20 99. 30	09500 AMBULANCE SERVICES 09910 CORF 09920 OUTPATIENT PHYSICAL THERAPY 09930 OUTPATIENT OCCUPATIONAL THERAPY 09940 OUTPATIENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	0 0 0 0	95.00 99.10 99.20 99.30 99.40
113. 00 118. 00	11300 INTEREST EXPENSE	54, 571	16, 470	8, 593	0		113. 00 118. 00
192.00 194.00 194.01 194.03 194.04	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES 07950 OCCUPATIONAL HEALTH 07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS 07954 ER PHYSICIAN 07953 SHIPSHEWANA RADIOLOGY AND LAB Cross Foot Adjustments	223 3, 332 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0 0 0	0 0 0 0 0	190.00 192.00 194.00 194.01 194.03 194.04 194.06 200.00 201.00
	Cost to be allocated (per Wkst. B,	562, 751	761, 100	458, 610			202.00

Heal th Fi	nancial Systems COMM	UNITY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	eu of Form CMS-2	2552-10
COST ALL	OCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2018	Worksheet B-1	
					To 12/31/2018		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF		
		(SQUARE FEET)	(MEALS SERVED)	(FTE)		ADMI NI STRATI ON	
					(NUMBER		
					HOUSED)	(DIRECT NRSING	
						HRS)	
		9.00	10.00	11.00	12.00	13.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	9. 681571	46. 211293	53. 37018	0. 000000	7.079658	203.00
204.00	Cost to be allocated (per Wkst. B,	50, 139	131, 660	21, 71	9 0	34, 076	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 862592	7. 993928	2. 52752	0.000000	0. 335278	205.00
206.00	NAHE adjustment amount to be allocated			1			206.00
	(per Wkst. B-2)						
207.00	NAHE unit cost multiplier (Wkst. D,						207.00
	Parts III and IV)						

DST AL	Financial Systems COMMU LOCATION - STATISTICAL BASIS		LAGRANGE CTY Provider CO	CN: 15-1323 P	eri od:	u of Form CMS-: Worksheet B-1	
				F T	rom 01/01/2018 o 12/31/2018	Date/Time Pre	parec
		051175.41				5/29/2019 2:5	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY (COSTED REQUI S.)	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE (TIME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED	
		(COSTED	REGOLD.)	(TIME SPENT)		TI ME)	
		REQUIS.) 14.00	15.00	16.00	17.00	19.00	
	GENERAL SERVICE COST CENTERS						
	00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION						1. 1.
	00200 CAP REL COSTS-MVBLE EQUIP						2.
	00201 EMS WEST STATION EQUIP.						2.
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
00	00500 ADMINISTRATIVE & GENERAL						5.
	00600 MAINTENANCE & REPAIRS						6.
	00700 OPERATION OF PLANT						7.
	00800 LAUNDRY & LINEN SERVICE						8.
	00900 HOUSEKEEPING						9.
	01000 DI ETARY 01100 CAFETERI A						10.
	01200 MAINTENANCE OF PERSONNEL						12.
	01300 NURSI NG ADMI NI STRATI ON						13.
	01400 CENTRAL SERVICES & SUPPLY	1, 407, 150					14.
	01500 PHARMACY	29, 167	456, 500				15.
	01600 MEDICAL RECORDS & LIBRARY	0	0	9, 998			16.
. 00	01700 SOCIAL SERVICE	0	0	0	0		17.
. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.
	02000 NURSI NG SCHOOL	0	0	0	0		20.
	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0		21.
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0		22.
	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0		23.
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDI ATRI CS	18, 301	7	1, 183	0	0	
	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	21, 396	4	192	0	0	43.
	05000 OPERATI NG ROOM	287, 343	1, 774	174	0	0	50.
. 00	05200 DELIVERY ROOM & LABOR ROOM	91, 228	17	0	0	0	52.
. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.
. 00	05400 RADI OLOGY-DI AGNOSTI C	40, 521	272	3, 322	0	0	54.
	06000 LABORATORY	0	551	0	0	0	60.
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	
	06500 RESPI RATORY THERAPY	7,690	0	0	0	0	
	06600 PHYSI CAL THERAPY	6, 949	48	767	0	0	
	06700 OCCUPATI ONAL THERAPY	2,888	20	229	0	0	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	296	2 0	53 0	0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	399, 276	0	0	0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	287, 085	0		0	0	
	07300 DRUGS CHARGED TO PATIENTS	40, 495	452, 036	0	0	0	
	07697 CARDI AC REHABI LI TATI ON	0	102,000	0	0	0	
	07698 HYPERBARI C OXYGEN THERAPY	Ő	0	0	0 0	0	
	07699 LI THOTRI PSY	0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS	_					1
. 00 [09000 CLI NI C	0	0	0	0	0	90
	09001 LI FEBRI DGE SENI OR CARE	10, 045	0	0	0	0	90.
	09100 EMERGENCY	87, 735	134	4, 078	0	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART						92
	OTHER REIMBURSABLE COST CENTERS	70.000	4 (05				
	09500 AMBULANCE SERVICES	73, 880	1, 635	0	0	0	
	09910 CORF 09920 OUTPATI ENT PHYSI CAL THERAPY	0	0	0	0	0	
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	
	SPECIAL PURPOSE COST CENTERS		-		-	-	
3. 00	11300 INTEREST EXPENSE						113
3. 00	SUBTOTALS (SUM OF LINES 1 through 117)	1, 404, 295	456, 500	9, 998	0	0	118
	NONREI MBURSABLE COST CENTERS						1.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	369	0	0	0		190
	19200 PHYSI CLANS' PRI VATE OFFI CES	488	0	0	0		192
	07950 OCCUPATIONAL HEALTH	0	0	0	0		194
		733	0	0	0		194
	07952 COMMUNITY & VOLUNTEER SVCS	1, 265	0	0	0		194 194
	07954 ER PHYSICIAN 07953 SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0		194
4.06 0.00	Cross Foot Adjustments	0	0	0	0	0	200.
1.00	Negative Cost Centers						200
	e e e e e e e e e e e e e e e e e e e	50 774	1 0/1 7//	22.400	0	0	201
2.00	Cost to be allocated (per Wkst. B,	59, 771	1, 261, 766	22, 490			1202

Heal th Fi	nancial Systems COMM	JNITY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
COST ALL	DCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2018	Worksheet B-1	
					To 12/31/2018	Date/Time Pre 5/29/2019 2:5	
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCIAL SERVICE		
		SERVICES &	(COSTED	RECORDS &		ANESTHETI STS	
		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	(ASSI GNED	
		(COSTED		(TIME SPENT)		TIME)	
		REQUIS.)					
		14.00	15.00	16.00	17.00	19.00	
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 042477	2. 764000	2. 24945	0.000000	0.00000	203.00
204.00	Cost to be allocated (per Wkst. B,	48, 696	99, 292	8, 77	6 0	0	204.00
	Part II)						
205.00	Unit cost multiplier (Wkst. B, Part	0. 018016	0. 217507	0.87777	6 0. 000000	0.00000	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)						

Health Financial Systems COM COST ALLOCATION - STATISTICAL BASIS COM	MUNITY HOSPT. OF			In Lie Period:	u of Form CMS-2552 Worksheet B-1	2-10
COST ALLOCATION - STATISTICAL DASIS			F	rom 01/01/2018 o 12/31/2018	Date/Time Prepare	ed:
		INTERNS &	RESI DENTS		5/29/2019 2:50 pm	<u>n</u>
Cost Center Description	NURSING SCHOOL	SERVICES-SALAR Y&FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM		
	(ASSI GNED	APPRV	APPRV	(ASSI GNED		
	TIME)	(ASSI GNED	(ASSI GNED	TIME)		
	20.00	TI ME) 21.00	TIME) 22.00	23.00		
GENERAL SERVICE COST CENTERS	20.00	21.00	22.00	23.00		
1.00 00100 CAP REL COSTS-BLDG & FIXT						. 00
1.01 00101 EMS WEST STATION 2.00 00200 CAP REL COSTS-MVBLE EQUIP						. 01
2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.01 00201 EMS WEST STATION EQUIP.						2.00 2.01
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						1.00
5. 00 00500 ADMI NI STRATI VE & GENERAL						5.00
6. 00 00600 MAI NTENANCE & REPAI RS 7. 00 00700 OPERATI ON OF PLANT						5.00 7.00
8.00 00800 LAUNDRY & LINEN SERVICE						3.00
9.00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY 11. 00 01100 CAFETERI A). 00 . 00
12.00 01200 MAINTENANCE OF PERSONNEL						2.00
13.00 01300 NURSING ADMINISTRATION						8.00
14. 00 01400 CENTRAL SERVICES & SUPPLY 15. 00 01500 PHARMACY						1.00 5.00
16. 00 01600 MEDICAL RECORDS & LIBRARY						5.00 5.00
17. 00 01700 SOCIAL SERVICE						. 00
19.00 01900 NONPHYSI CLAN ANESTHETI STS						9.00
20. 00 02000 NURSI NG SCHOOL 21. 00 02100 I & SERVI CES-SALARY & FRI NGES APPRV	0	0). 00 . 00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV			, C			2.00
23.00 02300 PARAMED ED PRGM-(SPECIFY)				0	23.	8.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0	C		0	30). 00
43. 00 04300 NURSERY	0					3. 00
ANCI LLARY SERVI CE COST CENTERS			-			
50.00 05000 OPERATING ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0). 00 2. 00
53. 00 05300 ANESTHESI OLOGY	0			0		3.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	c	-	0 0		1.00
60. 00 06000 LABORATORY 62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0). 00 2. 30
65. 00 06500 RESPIRATORY THERAPY	0		-			5.00
66. 00 06600 PHYSI CAL THERAPY	0	C) C	0		b. 00
67.00 06700 OCCUPATIONAL THERAPY	0	C		0		7.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0					3.00 9.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C C		0		. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		2.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 97 07697 CARDIAC REHABILITATION	0					3.00 5.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0					5. 98
76. 99 07699 LI THOTRI PSY	0	C) C	0 0	76.	5. 99
0UTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC	0	C			90). 00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0			0). 00). 01
91.00 09100 EMERGENCY	0	C	C	0 0		. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS					92.	2.00
95. 00 09500 AMBULANCE SERVICES	0	C		0	95.	5. 00
99. 10 09910 CORF	0	C) C	0		9. 10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	C		0		9.20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY 99. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0					9.30 9.40
SPECIAL PURPOSE COST CENTERS			<u>, c</u>			. 40
113.00 11300 INTEREST EXPENSE						3.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	0	C) C	0 0	118.	3. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0	190.	0. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	C C	c c	0	192.	2.00
194. 00 07950 0CCUPATI ONAL HEALTH 194. 01 07951 FOUNDATI ON	0			0	194. 194.	l. 00
194. 03 07952 COMMUNITY & VOLUNTEER SVCS	0					i. 01 I. 03
194. 04 07954 ER PHYSICIAN	0	0		o o	194.	l. 04
194.06 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	C	р с	0		1.06
200.00Cross Foot Adjustments201.00Negative Cost Centers). 00 . 00
	1	1	r	r l	12011	

Heal th	Financial Systems COMM	IUNI TY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
COST A	LOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2018		
					To 12/31/2018	Date/Time Pre 5/29/2019 2:5	
			INTERNS &	RESI DENTS			
	Cost Center Description	NURSING SCHOOL					
			Y & FRINGES	PRGM COSTS	PRGM		
		(ASSI GNED	APPRV	APPRV	(ASSI GNED		
		TIME)	(ASSI GNED	(ASSI GNED	TIME)		
			TIME)	TIME)			
		20.00	21.00	22.00	23.00		
202.00	Cost to be allocated (per Wkst. B,	0	0		0 0		202.00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0.00000	0. 000000		203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	0	0		0 0		204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 00000	0.000000		205.00
206.00	NAHE adjustment amount to be allocated (per Wkst. B-2)	0			0		206.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)	0. 000000			0. 000000		207.00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/29/2019 2:5	epared
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
	03000 ADULTS & PEDIATRICS	5, 270, 917		5, 270, 91		0	
	04300 NURSERY	338, 578		338, 57	8 0	0) 43. C
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	3, 574, 437		3, 574, 43		0	
	05200 DELIVERY ROOM & LABOR ROOM	1, 452, 009		1, 452, 00		0	
	05300 ANESTHESI OLOGY	153, 354		153, 35		0	
	05400 RADI OLOGY-DI AGNOSTI C	2, 854, 190		2, 854, 19		0	
	06000 LABORATORY	1, 905, 903		1, 905, 90		0	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	
	06500 RESPI RATORY THERAPY	705, 565	0	705, 56		0	
	06600 PHYSI CAL THERAPY	983, 138	0	983, 13		0	
	06700 OCCUPATI ONAL THERAPY	328, 405	0	328, 40		0	
	06800 SPEECH PATHOLOGY	153, 965	0	153, 96		0	
	06900 ELECTROCARDI OLOGY	0			0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	618, 732		618, 73		0	
	07200 IMPL. DEV. CHARGED TO PATIENTS	445, 249		445, 24		0	
	07300 DRUGS CHARGED TO PATIENTS	3, 084, 537		3, 084, 53		0	
	07697 CARDI AC REHABI LI TATI ON	77, 997		77, 99		0	
	07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	
-		0			0 0	0	76. 9
	OUTPATIENT SERVICE COST CENTERS	0			0 0	0	90.0
	09001 LI FEBRI DGE SENI OR CARE	560, 620		560, 62		0	
	09100 EMERGENCY	4, 903, 317		4, 903, 31		0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 113, 939		1, 113, 93		0	
	OTHER REIMBURSABLE COST CENTERS	1, 113, 939		1, 115, 93	9	0	92.0
	09500 AMBULANCE SERVICES	2, 586, 479		2, 586, 47	9 0	0	95.0
	09910 CORF	2, 300, 479		2, 300, 47	0	0	
	09920 OUTPATIENT PHYSICAL THERAPY	0			0	0	
-	09930 OUTPATIENT OCCUPATIONAL THERAPY	0			0	0	
	09940 OUTPATIENT SPEECH PATHOLOGY	0			0	0	
	SPECIAL PURPOSE COST CENTERS		I	I	<u> </u>	0	
	11300 INTEREST EXPENSE						113.
200.00		31, 111, 331	o	31, 111, 33	0	Ω	200.
200.00		1, 113, 939		1, 113, 93			200.
202.00		29, 997, 392					201.

COMPUT	Financial Systems COMM TATION OF RATIO OF COSTS TO CHARGES		Provider CC		Peri od:	u of Form CMS- Worksheet C	
					From 01/01/2018	Part I	
					To 12/31/2018	Date/Time Pre 5/29/2019 2:5	epared:
			Title	XVIII	Hospi tal	Cost	o pin
			Charges				
	Cost Center Description	I npati ent	Outpatient	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
						Ratio	
		6.00	7.00	8.00	9.00	10.00	
~ ~ ~	INPATIENT ROUTINE SERVICE COST CENTERS	4 050 705		4 050 70			1 00 00
30.00	03000 ADULTS & PEDIATRICS	4, 252, 795		4, 252, 79			30.00
43.00	04300 NURSERY	545, 362		545, 36	02		43.00
	ANCILLARY SERVICE COST CENTERS	4 225 502	10 515 401	17 041 0	0 200240	0,000000	F0 00
50.00 52.00	05200 DELIVERY ROOM & LABOR ROOM	4, 325, 592 2, 337, 734	13, 515, 481 0	17, 841, 07 2, 337, 73		0. 000000 0. 000000	
	05300 ANESTHESI OLOGY		Ű	2, 337, 73			
53.00 54.00	05300 ANESTHESTOLOGY 05400 RADI OLOGY-DI AGNOSTI C	493, 067 1, 685, 835	1, 806, 739 23, 691, 549	2, 299, 80		0. 000000 0. 000000	
60.00	06000 LABORATORY						
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 887, 107	9, 174, 824 0	11, 061, 93	0. 172294 0. 000000	0. 000000 0. 000000	
65.00	06500 RESPIRATORY THERAPY	597, 988	1, 968, 806	2, 566, 79		0. 000000	
66.00	06600 PHYSI CAL THERAPY	234, 836	1, 223, 022	2, 566, 79		0. 000000	
67.00	06700 OCCUPATI ONAL THERAPY	261,832	425, 811	687, 64		0.000000	
68.00	06800 SPEECH PATHOLOGY	37, 824	109, 343	147, 16		0. 000000	
69.00	06900 ELECTROCARDI OLOGY	57, 024	107, 343	147, 10	0 0.000000	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	722, 369	1, 827, 046	2, 549, 41		0.000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	989, 971	380, 074	1, 370, 04		0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 909, 221	7, 571, 286	10, 480, 50		0. 000000	
76.97	07697 CARDI AC REHABI LI TATI ON	2, 707, 221	93, 870	93, 87		0. 000000	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0	, 0, 0.	0 0.000000	0. 000000	
	07699 LI THOTRI PSY	0	0		0 0.000000	0. 000000	
	OUTPATIENT SERVICE COST CENTERS	-1	-				
90.00	09000 CLI NI C	0	0		0 0.000000	0.00000	90.00
90.01	09001 LI FEBRI DGE SENI OR CARE	0	713, 063	713, 06		0.000000	
91.00	09100 EMERGENCY	806, 439	15, 406, 689	16, 213, 12		0. 000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4, 284, 000	4, 284, 00	0. 260023	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0	5, 225, 127	5, 225, 12	0. 495008	0.00000	95.00
99. 10	09910 CORF	0	0		0		99.10
99. 20	09920 OUTPATIENT PHYSICAL THERAPY	0	0		0		99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		0		99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0		0		99.40
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	22, 087, 972	87, 416, 730	109, 504, 70)2		200.00
201.00	Less Observation Beds						201.00
202.00	Total (see instructions)	22, 087, 972	87, 416, 730	109, 504, 70)2		202.00

Health Financial Systems	COMMUNITY HOSPT. OF	LAGRANGE CTY IN	In Lie	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1323	Peri od:	Worksheet C
			From 01/01/2018	Part I
			To 12/31/2018	Date/Time Prepared:
		Title XVIII	llooni tol	5/29/2019 2:50 pm
Cost Center Description	PPS Inpatient	II LIE XVIII	Hospital	Cost
cost center bescription	Ratio			
	11,00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30. 00 03000 ADULTS & PEDIATRICS				30, 00
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVICE COST CENTERS				101 00
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000			54.00
60. 00 06000 LABORATORY	0. 000000			60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62.30
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76.98
76. 99 07699 LI THOTRI PSY	0. 000000			76.99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0. 000000			90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 000000			90.01
91.00 09100 EMERGENCY	0. 000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR				92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
99. 10 09910 CORF				99.10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY				99.20
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99.40 09940 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
				·

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider C		Peri od: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Pre 5/29/2019 2:5	epared: 50 pm
			Titl	e XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	-	I		- 1		
	03000 ADULTS & PEDIATRICS	5, 270, 917		5, 270, 91		5, 270, 917	
	04300 NURSERY	338, 578		338, 57	/8 0	338, 578	43.00
	ANCI LLARY SERVI CE COST CENTERS				-		
	05000 OPERATING ROOM	3, 574, 437		3, 574, 43		3, 574, 437	
	05200 DELIVERY ROOM & LABOR ROOM	1, 452, 009		1, 452, 00		1, 452, 009	
	05300 ANESTHESI OLOGY	153, 354		153, 35		153, 354	
	05400 RADI OLOGY-DI AGNOSTI C	2, 854, 190		2, 854, 19		2, 854, 190	
		1, 905, 903		1, 905, 90		1, 905, 903	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	°,		705 54	0 0	0	
	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	705, 565 983, 138	0			705, 565	
	06700 OCCUPATI ONAL THERAPY	328, 405		983, 13 328, 40		983, 138 328, 405	
	06800 SPEECH PATHOLOGY	153, 965	°	153, 96		153, 965	
	06900 ELECTROCARDI OLOGY	155, 905	0	155, 90	0 0	155, 905	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	618, 732		618, 73	-	618, 732	
	07200 I MPL. DEV. CHARGED TO PATIENTS	445, 249		445, 24		445, 249	
	07300 DRUGS CHARGED TO PATIENTS	3, 084, 537		3, 084, 53		3, 084, 537	
	07697 CARDI AC REHABI LI TATI ON	77,997		77, 99		77, 997	
	07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	
	07699 LI THOTRI PSY	0			0 0	0	
	OUTPATIENT SERVICE COST CENTERS				-, -,		-
	09000 CLI NI C	0			0 0	0	90.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	560, 620		560, 62	20 0	560, 620	90.0
91.00	09100 EMERGENCY	4, 903, 317		4, 903, 31	7 0	4, 903, 317	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 113, 939		1, 113, 93	39	1, 113, 939	92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVI CES	2, 586, 479		2, 586, 47	⁷ 9 0	2, 586, 479	95.00
99.10	09910 CORF	0			0	0	99.10
	09920 OUTPATIENT PHYSICAL THERAPY	0			0	0	
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0			0	0	
	09940 OUTPATIENT SPEECH PATHOLOGY	0			0	0	99.40
	SPECIAL PURPOSE COST CENTERS			-			
	11300 INTEREST EXPENSE						113. 0
200.00	Subtotal (see instructions)	31, 111, 331				31, 111, 331	
201.00	Less Observation Beds	1, 113, 939		1, 113, 93		1, 113, 939	
202.00	Total (see instructions)	29, 997, 392	0	29, 997, 39	92 0	29, 997, 392	202.00

	Financial Systems COMM TATION OF RATIO OF COSTS TO CHARGES	UNITY HOSPT. OF	Provi der CC		Peri od:	u of Form CMS-: Worksheet C	2002 10
					From 01/01/2018 To 12/31/2018	Part I Date/Time Pre 5/29/2019 2:5	pared:
			Titl	e XIX	Hospi tal	PPS	<u>o piii</u>
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Rati o	
		6.00	7.00	8.00	9.00	10.00	
~~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1 050 705		1 050 7			
30.00	03000 ADULTS & PEDIATRICS	4, 252, 795		4, 252, 79			30.00
43.00	04300 NURSERY	545, 362		545, 30	52		43.00
F.O. 00	ANCI LLARY SERVICE COST CENTERS	4 005 500	10 515 404	47.044.0		0.000000	50.00
50.00	05000 OPERATING ROOM	4, 325, 592	13, 515, 481	17, 841, 0			
52.00	05200 DELIVERY ROOM & LABOR ROOM	2, 337, 734	0	2, 337, 73		0.00000	
53.00	05300 ANESTHESI OLOGY	493,067	1, 806, 739	2, 299, 80		0.00000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 685, 835	23, 691, 549	25, 377, 38		0.00000	
60.00	06000 LABORATORY	1, 887, 107	9, 174, 824	11, 061, 93		0.00000	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0.000000	0.00000	
65.00	06500 RESPI RATORY THERAPY	597, 988	1, 968, 806	2, 566, 79		0.000000	
66. 00	06600 PHYSI CAL THERAPY	234, 836	1, 223, 022	1, 457, 8		0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	261, 832	425, 811	687, 64		0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	37, 824	109, 343	147, 16		0.000000	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0.000000	0.000000	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	722, 369	1, 827, 046	2, 549, 41		0.000000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	989, 971	380, 074	1, 370, 04		0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 909, 221	7, 571, 286	10, 480, 50		0.00000	
76.97	07697 CARDI AC REHABI LI TATI ON	0	93, 870	93, 8		0.00000	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0.00000	0.00000	
76. 99	07699 LI THOTRI PSY	0	0		0 0.000000	0.00000	76. 99
~~ ~~	OUTPATIENT SERVICE COST CENTERS					0.00000	
90.00	09000 CLINIC	0	0	740.0	0 0.00000		
90.01	09001 LI FEBRI DGE SENI OR CARE	0	713, 063	713, 00		0.00000	
91.00	09100 EMERGENCY	806, 439	15, 406, 689	16, 213, 12		0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4, 284, 000	4, 284, 00	0. 260023	0.00000	92.00
~~ ~~	OTHER REIMBURSABLE COST CENTERS		5 005 107	E 005 44		0.00000	1
95.00	09500 AMBULANCE SERVICES	0	5, 225, 127	5, 225, 12		0.000000	95.00
99.10	09910 CORF	0	0		0		99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0		0		99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		0		99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0		0		99.40
440.00	SPECIAL PURPOSE COST CENTERS	1					1110 00
	11300 INTEREST EXPENSE	00 007 070	07 414 700	100 504 7			113.00
200.00		22, 087, 972	87, 416, 730	109, 504, 70	J2		200.00
201.00		00 007 070	07 447 700	100 504 7			201.00
202.00	Total (see instructions)	22, 087, 972	87, 416, 730	109, 504, 70	JZ		202.00

In Lieu of Form CMS-2552-10

J			111 LIE	
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1323	Period: From 01/01/2018 To 12/31/2018	Worksheet C Part I Date/Time Prepared: 5/29/2019 2:50 pm
		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
43. 00 04300 NURSERY				43.00
ANCI LLARY SERVICE COST CENTERS	· · ·			
50.00 05000 OPERATING ROOM	0. 200349			50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 621118			52.00
53. 00 05300 ANESTHESI OLOGY	0. 066681			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 112470			54.00
60. 00 06000 LABORATORY	0. 172294			60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62.30
65. 00 06500 RESPI RATORY THERAPY	0. 274882			65.00
66. 00 06600 PHYSI CAL THERAPY	0.674372			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 477581			67.00
68.00 06800 SPEECH PATHOLOGY	1.046192			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 242696			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 324989			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 294312			73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 830904			76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76.98
76. 99 07699 LI THOTRI PSY	0. 000000			76.99
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLINIC	0. 000000			90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 786214			90.01
91.00 09100 EMERGENCY	0. 302429			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 260023			92.00
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 495008			95.00
99. 10 09910 CORF				99.10
99. 20 09920 OUTPATIENT PHYSICAL THERAPY				99.20
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY				99.30
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY				99.40
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				201.00
	i l			1202.00

ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R	ATLOS NET OF	Provider C	CN 15-1323	Peri od:	Worksheet C	
EDUCTIONS FOR MEDICALD ONLY			0111 10 1020	From 01/01/2018	Part II	
				To 12/31/2018	Date/Time Pre	pared
					5/29/2019 2:5	0 pm
			e XIX	Hospi tal	PPS	-
Cost Center Description	Total Cost	Capital Cost			Operating Cost	
		(Wkst. B, Part			Reduction	
	I, col. 26)	II col. 26)		-	Amount	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
D. 00 05000 OPERATING ROOM	3, 574, 437	462, 885	3, 111, 5	52 0	0	50.0
2. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 452, 009				0	001
3. 00 05300 ANESTHESI OLOGY	153, 354				0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 854, 190			-	0	
2. 00 05400 RADIOLOGI - DIAGNOSTI C D. 00 06000 LABORATORY	1, 905, 903				0	
2. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 905, 903			+3 0 0 0	0	62.
5. 00 06500 RESPIRATORY THERAPY	705, 565	-			0	
5. 00 06600 PHYSI CAL THERAPY	983, 138				0	66.
7. 00 06700 OCCUPATIONAL THERAPY	328, 405				0	67.
3. 00 06800 SPEECH PATHOLOGY	153, 965				0	
	153, 965				0	69.
	-	-			0	
	618, 732				0	71.
	445, 249				0	72.
	3, 084, 537				-	
5. 97 07697 CARDIAC REHABILITATION	77, 997				0	
5. 98 07698 HYPERBARI C OXYGEN THERAPY	0	-		0 0	0	76.
5. 99 07699 LI THOTRI PSY	0	C		0 0	0	76.
	0		1	0 0	0	1 00
D. 00 09000 CLINIC D. 01 09001 LIFEBRIDGE SENIOR CARE	0	-			-	
	560, 620				0	
1.00 09100 EMERGENCY	4, 903, 317				0	1
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	1, 113, 939	180, 306	933, 63	33 0	0	92.
OTHER REI MBURSABLE COST CENTERS 5. 00 09500 AMBULANCE SERVI CES	2 50/ 470	170.0/0	2 414 1	19 0	0	
	2, 586, 479					
	0	C		0 0	0	
9. 20 09920 OUTPATIENT PHYSICAL THERAPY	0			0 0	0	
9. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	C		0 0	0	1
9. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	C	1	0 0	0	99.
SPECIAL PURPOSE COST CENTERS		1	1			1110
13. 00 11300 I NTEREST EXPENSE	05 504 004		00 477 0			113.
00.00 Subtotal (sum of lines 50 thru 199)	25, 501, 836					200.
01.00 Less Observation Beds	1, 113, 939					201.
02.00 Total (line 200 minus line 201)	24, 387, 897	2, 143, 728	22, 244, 10	69 0	0	202.

ALCULATION OF OUTPATIENT SERVICE COST TO CHARGE R EDUCTIONS FOR MEDICAID ONLY	ATIOS NET OF	Provider C		Period: From 01/01/2018 To 12/31/2018		epared 50 pm
			e XIX	Hospi tal	PPS	
Cost Center Description		Total Charges				
	Capital and	(Worksheet C,	Cost to Char	ge		
	Operating Cost	Part I, column		6		
	Reduction	8)	/ col. 7)			
	6.00	7.00	8.00		-	
ANCI LLARY SERVI CE COST CENTERS						
D. 00 05000 OPERATING ROOM	3, 574, 437	17, 841, 073	0. 2003	49		50.0
2.00 05200 DELIVERY ROOM & LABOR ROOM	1, 452, 009	2, 337, 734	0. 6211	18		52.0
3. 00 05300 ANESTHESI OLOGY	153, 354	2, 299, 806	0. 0666	81		53.0
4. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 854, 190	25, 377, 384	0. 1124	70		54.0
D. 00 06000 LABORATORY	1, 905, 903	11, 061, 931	0. 1722	94		60.
2. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C	0.0000	00		62.
5. 00 06500 RESPIRATORY THERAPY	705, 565	2, 566, 794	0. 2748	82		65.
5. 00 06600 PHYSI CAL THERAPY	983, 138	1, 457, 858				66.
7. 00 06700 OCCUPATI ONAL THERAPY	328, 405	687, 643				67.
3. 00 06800 SPEECH PATHOLOGY	153, 965	147, 167				68.
2. 00 06900 ELECTROCARDI OLOGY	0	0				69.
1. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	618, 732	2, 549, 415				71.
2. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	445, 249	1, 370, 045				72.
3. 00 07200 DRUGS CHARGED TO PATIENTS	3, 084, 537					73.
5. 97 07697 CARDI AC REHABILI TATI ON	77, 997	93, 870				76.
5. 98 07698 HYPERBARIC OXYGEN THERAPY						76.
	0	0				
5. 99 07699 LI THOTRI PSY	0	0	0.0000	00		76.
OUTPATIENT SERVICE COST CENTERS		0	0.0000	00		
0. 00 09000 CLINIC	0	0				90.
D. 01 09001 LI FEBRI DGE SENI OR CARE	560, 620					90.
1. 00 09100 EMERGENCY	4, 903, 317	16, 213, 128				91.
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 113, 939	4, 284, 000	0.2600	23		92.
OTHER REIMBURSABLE COST CENTERS			1			
5. 00 09500 AMBULANCE SERVICES	2, 586, 479	5, 225, 127				95.
9. 10 09910 CORF	0	0				99.
9. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0.0000			99.
9. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0				99.
9. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0.0000	00		99.
SPECIAL PURPOSE COST CENTERS			-			
13.0011300 INTEREST EXPENSE						113.
00.00 Subtotal (sum of lines 50 thru 199)	25, 501, 836	104, 706, 545				200.
01.00 Less Observation Beds	1, 113, 939					201.
D2.00 Total (line 200 minus line 201)	24, 387, 897	104, 706, 545				202.

Health Financial Systems COMM	IUNI TY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 2:5	
			XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	462, 885	17, 841, 073	0. 02594	5 651, 121	16, 893	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	106, 646	2, 337, 734	0. 04561	9 0	0	52.00
53.00 05300 ANESTHESI OLOGY	7, 262	2, 299, 806	0.00315	8 73, 026	231	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	281, 894	25, 377, 384	0. 01110	8 488, 608	5, 427	54.00
60. 00 06000 LABORATORY	147, 160	11,061,931	0.01330	3 433, 627	5, 769	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		0. 00000			62.30
65. 00 06500 RESPI RATORY THERAPY	50, 283	2, 566, 794	0. 01959	0 202, 141	3, 960	65.00
66. 00 06600 PHYSI CAL THERAPY	142, 822					66.00
67.00 06700 OCCUPATI ONAL THERAPY	15, 887					1
68.00 06800 SPEECH PATHOLOGY	7,349					
69. 00 06900 ELECTROCARDI OLOGY	0					69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	35, 691	2, 549, 415			2, 694	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	25, 680					1
73.00 07300 DRUGS CHARGED TO PATI ENTS	185, 876					1
76. 97 07697 CARDI AC REHABI LI TATI ON	13, 793				0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0,770	,0,0,0	0. 00000		0	76.98
76. 99 07699 LI THOTRI PSY	0		0.00000		0	76.99
OUTPATIENT SERVICE COST CENTERS			0.00000	0 0	Ŭ	/0. //
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	52, 892	0			0	90.01
91. 00 09100 EMERGENCY	437, 248				°	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	180, 306					1
OTHER REIMBURSABLE COST CENTERS	100, 300	-, 204, 000	0.04200	<u> </u>	0	/2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	2, 153, 674	99, 481, 418		3, 349, 996	65 107	200.00
	2,100,074	, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	1	0,047,770	00,107	200.00

Health Financial Systems COM	MUNITY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI THROUGH COSTS	RVICE OTHER PASS	S Provider C			Worksheet D Part IV Date/Time Pre 5/29/2019 2:5	
	_		XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Nursing Schoo	Allied Health	Allied Health	
	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS	_	•				
50.00 05000 OPERATING ROOM	0	C		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
60. 00 06000 LABORATORY	0	c c		0 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	c c		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	c c		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C C)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C C)	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C)	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	c c		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	c c		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	c c		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	c c		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	c c		0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	c c		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS				-1		
90. 00 09000 CLI NI C	0	C		0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	l c		0 0	0	90.01
91. 00 09100 EMERGENCY	0			0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	c c		0 0	0	200.00
	1	1	•	1		

Health Financial Systems COM	UNITY HOSPT. OI	- LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2018		norod.
				To 12/31/2018	Date/Time Pre 5/29/2019 2:5	
		Title	xviii	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	1, 2, 3, and			(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	1	-	1	1	-	_
50. 00 05000 OPERATI NG ROOM	0	0		0 17, 841, 073		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 2, 337, 734		
53. 00 05300 ANESTHESI OLOGY	0	0		0 2, 299, 806		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 25, 377, 384		
60. 00 06000 LABORATORY	0	0		0 11, 061, 931		
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0.00000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 2, 566, 794		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 457, 858		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 687, 643	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 147, 167	0.00000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 2, 549, 415	0.00000	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 370, 045	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 10, 480, 507	0.00000	73.00
76. 97 07697 CARDIAC REHABILITATION	0	0		0 93, 870	0.00000	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0.00000	76.98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0. 000000	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	0		0 713, 063	0.00000	90.01
91.00 09100 EMERGENCY	0	0		0 16, 213, 128	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 4, 284, 000	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 99, 481, 418		200.00

Health Financial Systems COMM	NUNITY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider C		Period: From 01/01/2018	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2018	Date/Time Pre	
					5/29/2019 2:5	Opm
			XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	$(\operatorname{col} \cdot 6 \div \operatorname{col} \cdot$		Costs (col. 8	5	Costs (col. 9	
	7)	10.00	x col. 10)	10.00	x col. 12)	
ANCI LLARY SERVI CE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERATING ROOM	0. 000000	(51 101	1		0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	651, 121 0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	73, 026		0 0	0	52.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	488, 608		0 0	0	53.00
60. 00 06000 LABORATORY	0.000000	488, 608 433, 627		0 0	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	433, 027				62.30
65. 00 06500 RESPIRATORY THERAPY	0. 000000	202, 141				62.30
66. 00 06600 PHYSI CAL THERAPY	0. 000000	65, 056				66.00
67. 00 06700 0CCUPATI ONAL THERAPY	0.000000	64, 884				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	64, 884 15, 621				67.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	15, 621				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	0 192, 419				71.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	192, 419 307, 118				72.00
					e e	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 97 07697 CARDIAC REHABILITATION	0. 000000 0. 000000	798, 350			0	73.00
	0. 000000	0			-	
76. 98 07698 HYPERBARI C OXYGEN THERAPY 76. 99 07699 LI THOTRI PSY	0. 000000	0			0	76. 98 76. 99
OUTPATIENT SERVICE COST CENTERS	0.000000	0		0 0	0	70.99
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 00 109000 CETNIC 90. 01 109001 LI FEBRI DGE SENI OR CARE	0.000000	0			0	90.00
90. 01 09001 LIFEBRIDGE SENTOR CARE 91. 00 09100 EMERGENCY	0. 000000	58, 025			0	90.01
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	36, 023			0	91.00
072.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.000000	0	1	0 0	0	92.00
95. 00 09500 AMBULANCE SERVICES	1					95.00
200.00 Total (lines 50 through 199)		3, 349, 996		o o	0	200.00
	1 1	5, 547, 770	1	0 0	0	200.00

Health Financial Systems	COMMUNI TY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH	SERVICES AND VACCINE COST	Provider C		Period:	Worksheet D	
				From 01/01/2018 To 12/31/2018		narod
				10 12/31/2010	5/29/2019 2:5	
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	0.0000		0.00/.17			50.00
50.00 05000 OPERATING ROOM	0. 200349		_/,		0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 621118	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 066681	0	259, 61		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 112470		5, 563, 72		0	54.00
60. 00 06000 LABORATORY	0. 172294	0	2, 331, 19		0	60.00
62. 30 06250 BLOOD CLOTTI NG FOR HEMOPHI L		0		0 0	0	62.30
65.00 06500 RESPI RATORY THERAPY	0. 274882	0	354, 22		0	65.00
66.00 06600 PHYSI CAL THERAPY	0. 674372	0	363, 12		0	66.00
67.00 06700 OCCUPATIONAL THERAPY	0. 477581	0	84, 04		0	67.00
68.00 06800 SPEECH PATHOLOGY	1. 046192	0	21, 78		0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDI CAL SUPPLIES CHARGED TO			280, 27		0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIE		0	82, 93		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 294312	0	3, 755, 56		0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 830904	0	38, 64		0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS		-	[-	-	
90.00 09000 CLINIC	0. 000000			0 0	0	
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 786214		481, 46		0	90.01
91.00 09100 EMERGENCY	0. 302429	0	2, 856, 55		0	91.00
92.00 09200 OBSERVATI ON BEDS (NON-DI STI	NCT PART 0. 260023	0	1, 153, 21	2 0	0	92.00
OTHER REIMBURSABLE COST CENTERS				-		
95.00 09500 AMBULANCE SERVICES	0. 495008			0	-	95.00
200.00 Subtotal (see instructions)		0			0	200.00
201.00 Less PBP Clinic Lab. Servic	es-Program			0 0		201.00
Only Charges	- 201)	_	10 (52 00		_	202.00
202.00 Net Charges (line 200 - lin	e 201)	0	19, 652, 82	3 0	0	202.00

		UNITY HOSPT. OI				u of Form CMS	-2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1323	Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pr 5/29/2019 2:	epared: 50 pm
			Title	XVIII	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	406, 001	0				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
	05300 ANESTHESI OLOGY	17, 311	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	625, 752	0				54.00
60.00	06000 LABORATORY	401, 651	0				60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65.00	06500 RESPI RATORY THERAPY	97, 370	0				65.00
66.00	06600 PHYSI CAL THERAPY	244, 879	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	40, 138	0				67.00
68.00	06800 SPEECH PATHOLOGY	22, 790	0				68.00
69.00	06900 ELECTROCARDI OLOGY	0	0				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	68, 021	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	26, 953	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 105, 309	0				73.00
76.97	07697 CARDI AC REHABI LI TATI ON	32, 106	0				76.9
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0				76.98
76.99	07699 LI THOTRI PSY	0	0				76.99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0				90.00
90.01	09001 LI FEBRI DGE SENI OR CARE	378, 533	0				90.01
91.00	09100 EMERGENCY	863, 905	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	299, 862	0				92.00
	OTHER REIMBURSABLE COST CENTERS						
	09500 AMBULANCE SERVICES	0					95.00
200.00		4, 630, 581	0				200.00
201.00		0					201.00
	Only Charges						
202.00		4, 630, 581	0				202.00

Health Financial Systems CO	MUNITY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	ND VACCINE COST	Provider CO		Period:	Worksheet D	
		Component (From 01/01/2018 To 12/31/2018		naradi
		component (JUN. 15-2323	10 12/31/2010	5/29/2019 2:5	
		Title	XVIII	Swing Beds - SNF		-
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS				-	-	
50.00 05000 OPERATING ROOM	0. 200349	0		0 0	0	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 621118	0		0 0	0	02.00
53. 00 05300 ANESTHESI OLOGY	0. 066681	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 112470	0		0 0	0	01100
60. 00 06000 LABORATORY	0. 172294	0		0 0	0	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 274882	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0. 674372	0		0 0	0	
67.00 06700 OCCUPATI ONAL THERAPY	0. 477581	0		0 0	0	07100
68.00 06800 SPEECH PATHOLOGY	1. 046192	0		0 0	0	00.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 242696	0		0 0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 324989	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 294312	0		0 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 830904	0		0 0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	1 101 10
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 000000	0		0 0	0	
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 786214	0		0 0	0	1 /01/01
91. 00 09100 EMERGENCY	0. 302429	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 260023	0		0 0	0	92.00
OTHER REI MBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES	0. 495008			0		95.00
200.00 Subtotal (see instructions)		0		0 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)		0		0 0	0	202.00

Heal th	Financial Systems COMM	UNITY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1323	Peri od:	Worksheet D	
			Component	CCN: 15-Z323	From 01/01/2018 To 12/31/2018		anarod.
			component	CCN. 10-2020	10 12/31/2018	5/29/2019 2:5	
			Title	× XVIII	Swing Beds - SNF	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost	1			
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCI LLARY SERVI CE COST CENTERS						_
	05000 OPERATING ROOM	0	-				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
53.00	05300 ANESTHESI OLOGY	0	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	06000 LABORATORY	0	0				60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65.00	06500 RESPI RATORY THERAPY	0	0				65.00
	06600 PHYSI CAL THERAPY	0	0				66.00
	06700 OCCUPATI ONAL THERAPY	0	0				67.00
	06800 SPEECH PATHOLOGY	0	0				68.00
	06900 ELECTROCARDI OLOGY	0	0				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
	07697 CARDI AC REHABI LI TATI ON	0	0				76.97
	07698 HYPERBARI C OXYGEN THERAPY	0	0				76.98
76.99	07699 LI THOTRI PSY	0	0				76.99
	OUTPATIENT SERVICE COST CENTERS	1	-				
	09000 CLI NI C	0	-				90.00
	09001 LI FEBRI DGE SENI OR CARE	0	0				90.01
	09100 EMERGENCY	0	-				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0				92.00
	OTHER REIMBURSABLE COST CENTERS	1		1			
	09500 AMBULANCE SERVI CES	0					95.00
200.00		0	0				200.00
201.00	5	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	0				202.00

Health Financial Systems COM	MUNITY HOSPT. OI	F LAGRANGE CTY	IN	In Lieu of Form CMS-2552-10			
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period:	Worksheet D		
				From 01/01/2018 To 12/31/2018	Part I Date/Time Pre	narod	
				10 12/31/2010	5/29/2019 2:5	0 pm	
		Titl	e XIX	Hospi tal	PPS		
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)		
	(from Wkst. B,		Related Cost				
	Part II, col.		(col. 1 - col				
	26)		2)				
	1.00	2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS	1	r	1	1			
30. 00 ADULTS & PEDIATRICS	853, 166					•	
43.00 NURSERY	24, 241		24, 24	1 389	62.32	43.00	
_200.00 Total (lines 30 through 199)	877, 407		827, 47	9 3, 687		200.00	
Cost Center Description	I npati ent	Inpati ent					
	Program days	Program					
		Capital Cost					
		(col. 5 x col.					
		6)					
	6.00	7.00					
INPATIENT ROUTINE SERVICE COST CENTERS			1				
30. 00 ADULTS & PEDIATRICS	52					30.00	
43.00 NURSERY	159	9, 909				43.00	
200.00 Total (lines 30 through 199)	211	22, 574				200. 00	

Health Financial Systems COMM	IUNITY HOSPT. OF	- LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2018 To 12/31/2018		
	_		e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS			1	1		
50.00 OPERATING ROOM	462, 885					1
52.00 05200 DELIVERY ROOM & LABOR ROOM	106, 646	2, 337, 734	0. 04561			
53. 00 05300 ANESTHESI OLOGY	7, 262	2, 299, 806				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	281, 894	25, 377, 384			470	54.00
60. 00 06000 LABORATORY	147, 160	11, 061, 931	0. 01330	3 56, 395	750	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	50, 283	2, 566, 794	0. 01959	0 11, 824	232	65.00
66. 00 06600 PHYSI CAL THERAPY	142, 822	1, 457, 858	0. 09796	7 1, 650	162	66.00
67.00 06700 OCCUPATIONAL THERAPY	15, 887	687, 643	0. 02310	4 908	21	67.00
68.00 06800 SPEECH PATHOLOGY	7, 349	147, 167	0. 04993	6 2, 168	108	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	35, 691	2, 549, 415	0. 01400	0 9, 462	132	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	25, 680	1, 370, 045	0. 01874	4 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	185, 876	10, 480, 507	0.01773	5 61, 966	1, 099	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	13, 793	93, 870	0. 14693	7 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 00000	0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	0	0. 00000	0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	52, 892	713, 063	0. 07417	6 0	0	90.01
91.00 09100 EMERGENCY	437, 248	16, 213, 128	0. 02696	9 28, 405	766	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	181, 447	4, 284, 000	0. 04235	5 0	0	92.00
OTHER REI MBURSABLE COST CENTERS	•			·		1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	2, 154, 815	99, 481, 418		403, 136	9, 723	200. 00

Health Financial Systems	COMMUNI TY HOSPT. OF		IN	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OT	HER PASS THROUGH COST	S Provider C		Period: From 01/01/2018 To 12/31/2018		
			e XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Nursing School	Allied Health	Allied Health	All Other	
	Post-Stepdown		Post-Stepdowr	Cost	Medi cal	
	Adjustments		Adjustments		Education Cost	
	1A	1.00	2A	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			·			
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
43. 00 04300 NURSERY	0	0		o o	0	43.00
200.00 Total (lines 30 through 199)	0	0		0 0	0	200.00
Cost Center Description	Swing-Bed	Total Costs	Total Patient	Per Diem (col.	Inpati ent	
	Adjustment	(sum of cols.	Days	$5 \div col. 6)$	Program Days	
	Amount (see	1 through 3,				
		minus col. 4)				
	4,00	5.00	6,00	7.00	8,00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30, 00 03000 ADULTS & PEDIATRICS	0	0	3, 29	B 0.00	52	30.00
43. 00 04300 NURSERY		0	38	9 0.00	159	43.00
200.00 Total (lines 30 through 199)		0	3, 68	7	211	200.00
Cost Center Description	Inpati ent			· .		
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col. 8)					
	9,00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
43. 00 04300 NURSERY	0					43.00
200.00 Total (lines 30 through 199)	0					200.00
						1-00.00

Health Financial Systems	COMMUNITY HOSPT. OF	- LAGRANGE CTY	IN	In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER PASS			Period: From 01/01/2018 To 12/31/2018	Date/Time Pre 5/29/2019 2:5	pared: 0 pm
			e XIX	Hospi tal	PPS	
Cost Center Description				Allied Health	Allied Health	
		Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVICE COST CENTERS				_		
50.00 05000 OPERATING ROOM	0	C		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
60. 00 06000 LABORATORY	0	C)	0 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C)	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	C)	0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C)	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C)	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C)	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C)	0 0	0	73.00
76. 97 07697 CARDI AC REHABILI TATI ON	0	C)	0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C)	0 0	0	76.98
76. 99 07699 LI THOTRI PSY	0	C		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	C		0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	C		0 0	0	90.01
91.00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	C		0 0	0	200.00
	I I			1	1	

Health Financial Systems COM	UNITY HOSPT. OF	- LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEA	RVICE OTHER PASS	S Provider C		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2018 To 12/31/2018		narod
				10 12/31/2016	5/29/2019 2:5	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
	Education Cost	, , .,			(col. 5 ÷ col.	
		4)	cols. 2, 3,	8)	7)	
			and 4)			
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVICE COST CENTERS	1		1			
50. 00 05000 OPERATI NG ROOM	0	0		0 17, 841, 073		
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 2, 337, 734		
53. 00 05300 ANESTHESI OLOGY	0	0		0 2, 299, 806		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 25, 377, 384		
60. 00 06000 LABORATORY	0	0		0 11, 061, 931		
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	0		0 2, 566, 794		
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 457, 858		
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 687, 643	0.00000	
68.00 06800 SPEECH PATHOLOGY	0	0		0 147, 167	0.00000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0.00000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 2, 549, 415	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 1, 370, 045	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 10, 480, 507	0.00000	73.00
76. 97 07697 CARDIAC REHABILITATION	0	0		0 93, 870	0.00000	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0.00000	76.98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0.00000	76.99
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0		0 0	0. 000000	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	0		0 713, 063	0.00000	90.01
91.00 09100 EMERGENCY	0	0		0 16, 213, 128	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 4, 284, 000	0.00000	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)	0	0		0 99, 481, 418		200.00

Health Financial Systems COMM	UNITY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provider CO		Period: From 01/01/2018	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2018		pared:
					5/29/2019 2:5	
			e XIX	Hospi tal	PPS	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col. 8		Costs (col. 9	
	7)	10.00	x col. 10)	10.00	x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	0.000000	00.005			0	F0 00
50.00 05000 OPERATING ROOM	0.000000	98, 395		0 0	0	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0.000000	74, 110		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0.000000	15, 521		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0.000000	42, 332		0 0	0	54.00
60.00 06000 LABORATORY	0.000000	56, 395		0 0	0	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0.000000	0		0 0	0	62.30
65. 00 06500 RESPIRATORY THERAPY	0.000000	11, 824		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0.000000	1, 650		0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	908		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	2, 168		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000	9, 462		0 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	61, 966		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0. 000000	0		0 0	0	76. 99
OUTPATIENT SERVICE COST CENTERS				1		
90. 00 09000 CLINIC	0. 000000	0		0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 000000	0		0 0	0	90.01
91. 00 09100 EMERGENCY	0. 000000	28, 405		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1 1					
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50 through 199)		403, 136		0 0	0	200. 00

Health Financial Systems	COMM	IUNI TY HOSPT. OF	LAGRANGE CTY	IN	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEAL	TH SERVICES AND	VACCINE COST	Provider C		Period:	Worksheet D	
					From 01/01/2018 To 12/31/2018		narod
					10 12/31/2010	5/29/2019 2:5	
			Titl	e XIX	Hospi tal	PPS	•
				Charges		Costs	
Cost Center Description		Cost to Charge			Cost	PPS Services	
			Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
		1.00		(see inst.)	(see inst.)	5.00	
		1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTER	5	0.000040	0	101.07			50.00
50. 00 05000 OPERATING ROOM		0. 200349	0	131, 07		0	
52.00 05200 DELIVERY ROOM & LABOR RO 53.00 05300 ANESTHESI OLOGY	JOM	0. 621118	0		0 0	-	
		0. 066681	0	17, 96		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 112470	0	232, 60		0	
60. 00 06000 LABORATORY		0. 172294	0	122, 03		0	00.00
62. 30 06250 BLOOD CLOTTING FOR HEMOR	PHILIACS	0. 000000	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY		0. 274882	0	14, 41		0	
66.00 06600 PHYSI CAL THERAPY		0. 674372	0	38		0	00.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 477581	0	1, 28		0	07100
68.00 06800 SPEECH PATHOLOGY		1. 046192	0	3, 27		0	
69. 00 06900 ELECTROCARDI OLOGY		0. 000000			0 0	0	
71.00 07100 MEDI CAL SUPPLI ES CHARGE		0. 242696	0	12, 81		0	1 /
72.00 07200 I MPL. DEV. CHARGED TO P/		0. 324989	0	11, 15		0	1 / 2. 00
73.00 07300 DRUGS CHARGED TO PATIEN	5	0. 294312	0	43, 35	6 U	0	
76. 97 07697 CARDI AC REHABI LI TATI ON 76. 98 07698 HYPERBARI C OXYGEN THERAF	21/	0. 830904	0		0 0	0	10.77
	γ	0. 000000				0	
76. 99 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTE	nc	0. 000000	0		0 0	0	/0.99
90. 00 09000 CLINIC	3	0. 000000	0		0 0	0	90.00
90. 01 09000 CLINIC 90. 01 09001 LI FEBRI DGE SENI OR CARE		0. 786214	0		0 0		
91. 00 09100 EMERGENCY		0. 302429	0	226, 28			•
92. 00 09200 OBSERVATION BEDS (NON-DI	STINCT DADT	0. 302429	0	67,44			1
OTHER REIMBURSABLE COST CENTE		0. 200023	0	07,44	7 0	0	92.00
95. 00 09500 AMBULANCE SERVICES	13	0, 495008	0		0		95.00
200.00 Subtotal (see instruction	ne)	0.493000		884, 09	~	0	200.00
201.00 Less PBP Clinic Lab. Ser			0			U	200.00
Only Charges	vi ces-i i ogi alli					1	201.00
202.00 Net Charges (line 200 -	line 201)		0	884, 09	1 0	0	202.00
i i i i i i i i i i i i i i i i i i i		i.				. –	

Heal th	Financial Systems COMM	IUNI TY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	u of Form CMS	-2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2018 To 12/31/2018	Worksheet D Part V Date/Time Pr 5/29/2019 2:	
			Titl	e XIX	Hospi tal	PPS	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.					
		(see inst.)	(see inst.)	-			
		6.00	7.00				
	ANCI LLARY SERVI CE COST CENTERS						_
	05000 OPERATI NG ROOM	26, 260					50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	-				52.00
	05300 ANESTHESI OLOGY	1, 198					53.00
	05400 RADI OLOGY-DI AGNOSTI C	26, 161					54.00
	06000 LABORATORY	21, 026					60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
65.00	06500 RESPI RATORY THERAPY	3, 962					65.00
	06600 PHYSI CAL THERAPY	262					66.00
	06700 OCCUPATI ONAL THERAPY	614					67.00
68.00	06800 SPEECH PATHOLOGY	3, 425	0				68.00
	06900 ELECTROCARDI OLOGY	0	0				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	3, 109	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	3, 624					72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	12, 760	0				73.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0				76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0				76.98
76.99	07699 LI THOTRI PSY	0	0				76.99
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0				90.00
	09001 LI FEBRI DGE SENI OR CARE	0	0				90.01
91.00	09100 EMERGENCY	68, 435					91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	17, 538	0				92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	0					95.00
200.00	Subtotal (see instructions)	188, 374	0				200.00
201.00		0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	188, 374	0				202.00

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST

COMMUNITY HOSPT. OF LA	AGRANGE CTY IN	In Lieu	of Form CMS-2552-10
Г	Provider CCN: 15-1323		Worksheet D-1
		From 01/01/2018	

			From 01/01/2018 To 12/31/2018	Date/Time Prep 5/29/2019 2:50	
	Cost Contor Description	Title XVIII	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
1.00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	s excluding newborn)		3, 772	1.00
2.00	Inpatient days (including private room days, excluding swing-			3, 298	2.00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3.00
1 00	do not complete this line.			0 550	1 00
4.00 5.00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		r 31 of the cost	2, 553 205	4.00 5.00
5.00	reporting period	Sin days) thi bugh beceine	i Si oi the cost	203	5.00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6.00
7 00	reporting period (if calendar year, enter 0 on this line)		04 6 11 1		7 00
7.00	Total swing-bed NF type inpatient days (including private roor reporting period	n days) through December	31 of the cost	269	7.00
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)	5			
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	895	9.00
10.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	nom davs)	205	10.00
	through December 31 of the cost reporting period (see instruct	tions)	5,		
11.00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11.00
12.00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		a room dave)	0	12.00
12.00	through December 31 of the cost reporting period		e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
11.00	after December 31 of the cost reporting period (if calendar ye	ear, enter 0 on this lin	e)		4.4.00
14.00 15.00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed	days)	0	
16.00	Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT		1		
17.00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost		17.00
18.00	reporting period Medicare rate for swing-bed SNF services applicable to service	as after December 21 of	the cost		18.00
10.00	reporting period	es al tel December 51 01	the cost		10.00
19.00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	123.32	19.00
20.00	reporting period	after December 21 of t	he east	100.00	20.00
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	salter December 31 01 t	ne cost	123.32	20.00
21.00	Total general inpatient routine service cost (see instructions	s)		5, 270, 917	21.00
22.00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22.00
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a poriod (lipo 6	0	23.00
23.00	x line 18)	ST OF THE COST TEPOTETH		0	23.00
24.00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	33, 173	24.00
05 00	7 x line 19)				05 00
25.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	al of the cost reporting	period (iine 8	0	25.00
26.00	Total swing-bed cost (see instructions)			339, 693	26.00
27.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 931, 224	27.00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and abcomunition had ab	00000	0	20.00
28. 00 29. 00	Private room charges (excluding swing-bed charges)	a and observation bed ch	arges)	0	28. 00 29. 00
30.00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0. 000000	
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 \div line 4) Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0. 00 0. 00	
34.00	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 di	fferential (line	4, 931, 224	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			1, 495. 22	38.00
39.00	Program general inpatient routine service cost (line 9 x line			1, 338, 222	
40.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 1, 338, 222	
11.00	The set of		I	1, 000, 222	11.00

		UNITY HOSPT. OF			In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der	CCN: 15-1323	Period: From 01/01/2018	Worksheet D-1	
					To 12/31/2018	Date/Time Pre	
						5/29/2019 2:5	0 pm
	Cost Center Description	Total	Total	le XVIII Average Per	Hospital Program Days	Cost Program Cost	
	cost center bescription			ysDiem (col. 1		(col. 3 x col.	
				col. 2)		4)	
10.00		1.00	2.00	3.00	4.00	5.00	10.00
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						43.00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGI CAL INTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
						1.00	
	Program inpatient ancillary service cost (Wks					810, 773	48.00
	Total Program inpatient costs (sum of lines 4	41 through 48)(see instruct	ions)		2, 148, 995	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (fr	om Wkst D su	m of Parts L and	0	50.00
50.00			301 11 603 (11	om wikst. D, Su			50.00
51.00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (from Wkst. D,	sum of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines !					0	52.00
53.00	Total Program inpatient operating cost exclud		lated, non-p	hysician anest	hetist, and	0	53.00
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54.00	Program di scharges					0	54.00
55.00	Target amount per discharge					0.00	55.00
56.00	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operati	ing cost and ta	rget amount	(line 56 minus	line 53)	0	57.00 58.00
58.00 59.00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost rep	porting period	endi na 1996	updated and c	ompounded by the		59.00
07100	market basket	oor tring por rou	ondring 1990,	apaatoa ana o	ompoundoù by tho		0,1,00
60.00	Lesser of lines 53/54 or 55 from prior year of					0.00	60.00
61.00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61.00
	amount (line 56), otherwise enter zero (see i		5 (11165 54	x 00), 01 1% 0	i the target		
62.00	Relief payment (see instructions)	,				0	62.00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost	ts through Dece	mber 31 of t	he cost report	ing period (See	306, 520	64.00
04.00	instructions) (title XVIII only)	ta through beec				300, 320	04.00
65.00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	no costs (lino	64 plus lipo	65) (titlo VVI	LL only) For	306, 520	66.00
	CAH (see instructions)						
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31	of the cost r	eporting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 31 o	f the cost rep	orting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient i					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU		•		<u> </u>	1	70.00
70.00 71.00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	2		•)		70.00 71.00
72.00	Program routine service cost (line 9 x line 3			C 2)			72.00
73.00	Medically necessary private room cost applica		lline 14 x	line 35)			73.00
74.00	Total Program general inpatient routine servi	•					74.00
75.00	Capital-related cost allocated to inpatient r 26, line 45)	routine service	costs (from	Worksheet B,	Part II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.00
77.00	Program capital-related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minus						78.00
79.00 80.00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa				nus lino 70)		79.00 80.00
81.00	Inpatient routine service cost per diem limit				nus i i ne 77)		81.00
82.00	Inpatient routine service cost limitation (li)				82.00
83.00	Reasonable inpatient routine service costs (s		is)				83.00
84.00	Program inpatient ancillary services (see ins						84.00
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85.00 86.00
55.00	PART IV - COMPUTATION OF OBSERVATION BED PASS					1	55.00
	Total observation bed days (see instructions))				745	
88.00	Adjusted general inpatient routine cost per (1, 495. 22 1, 113, 939	88.00
07.00	Observation bed cost (line 87 x line 88) (see	= instructions)				1, 113, 939	07.00

Health Financial Systems COMM	IUNI TY HOSPT. OI	LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	853, 166	5, 270, 917	0. 16186	3 1, 113, 939	180, 306	90.00
91.00 Nursing School cost	0	5, 270, 917	0.00000	0 1, 113, 939	0	91.00
92.00 Allied health cost	0	5, 270, 917	0.00000	0 1, 113, 939	0	92.00
93.00 All other Medical Education	0	5, 270, 917	0.00000	0 1, 113, 939	0	93.00

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST

COMMUNITY HOSPT. OF LA	AGRANGE CTY IN	In Lieu	u of Form CMS-2552-10
	Provider CCN: 15-1323	Period:	Worksheet D-1

	TION OF INPATIENT OPERATING COST	Provider CCN: 15-1323	From 01/01/2018 To 12/31/2018	Date /Time Dra	
		Title XIX	Hospi tal	Date/Time Pre 5/29/2019 2:50 PPS	
	Cost Center Description	ii tie xix	nospi tai		
	PART I - ALL PROVIDER COMPONENTS			1.00	
[INPATIENT DAYS				1
	Inpatient days (including private room days and swing-bed day			3, 772	
	Inpatient days (including private room days, excluding swing		ivete reem deve	3, 298 0	
00	Private room days (excluding swing-bed and observation bed da do not complete this line.	ays). If you have only pr	Tvate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation I	bed days)		2, 553	4.
	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	205	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6.
00	Total swing-bed NF type inpatient days (including private roo	om days) through December	31 of the cost	269	7.
	reporting period				
00	Total swing-bed NF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)			50	
	Total inpatient days including private room days applicable newborn days)	to the Program (excluding	swing-bed and	52	9.
	Swing-bed SNF type inpatient days applicable to title XVIII (onlv (including private r	oom davs)	0	10.
	through December 31 of the cost reporting period (see instruc	5 (51			
	Swing-bed SNF type inpatient days applicable to title XVIII of		room days) after	0	11.
	December 31 of the cost reporting period (if calendar year, of Swing-bed NF type inpatient days applicable to titles V or XI		o room dave)	0	12
00	through December 31 of the cost reporting period		e room days)	0	'2
	Swing-bed NF type inpatient days applicable to titles V or X			0	13
	after December 31 of the cost reporting period (if calendar	year, enter O on this lir	ne)		
	Medically necessary private room days applicable to the Progr	ram (excluding swing-bed	days)		14
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			389 159	
	SWING BED ADJUSTMENT			137	1 10
	Medicare rate for swing-bed SNF services applicable to service	ces through December 31 c	of the cost		17
	reporting period				
00	Medicare rate for swing-bed SNF services applicable to service reporting period	ces after December 31 of	the cost		18
. 00	Medicaid rate for swing-bed NF services applicable to service	es through December 31 of	the cost	0.00	19
	reporting period	3			
00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	he cost	0.00	20
00	reporting period Total general inpatient routine service cost (see instruction	ns)		5, 270, 917	21
	Swing-bed cost applicable to SNF type services through Decemi		ing period (line	0, 270, 717	
	5 x line 17)			-	
. 00	Swing-bed cost applicable to SNF type services after December	r 31 of the cost reportin	ng period (line 6	0	23.
00	x line 18) Swing-bed cost applicable to NF type services through Decembe	or 21 of the cost reporti	ng pariod (lina	0	24.
00	7 x line 19)	er si bi the cost reporti	ng period (inne	0	24
	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(lipo 21 minus lipo 26)		308, 461 4, 962, 456	
- E	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(The 21 minus The 20)		4, 702, 430	21
	General inpatient routine service charges (excluding swing-be	ed and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 Average private room per diem charge (line 29 ÷ line 3)	÷ line 28)		0. 000000 0. 00	
	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
	Average per diem private room charge differential (line 32 mi		tions)	0.00	
00	Average per diem private room cost differential (line 34 x li	ine 31)		0.00	35.
	Private room cost differential adjustment (line 3 x line 35)		Comments of the	0	
00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	TTEPENTIAL (LINE	4, 962, 456	37
-	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
h	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD.	JUSTMENTS			1
				1, 504. 69	38
. 00	Adjusted general inpatient routine service cost per diem (see	-			
. 00 . 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Proqu	e 38)		78, 244	39.

		UNITY HOSPT. OF					u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provid	er CC		Period: From 01/01/2018	Worksheet D-1	
					-	To 12/31/2018	Date/Time Pre 5/29/2019 2:50	
				Title	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total	Dave	Average Per	Program Days	Program Cost (col. 3 x col.	
		inpatrent cost	inpatrent	Days	col. 2)	-	(cor. 3 x cor. 4)	
10.00		1.00	2.00	200	3.00	4.00	5.00	40.00
	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	338, 578		389	870.3	3 159	138, 390	42.00
43.00	INTENSIVE CARE UNIT							43.00
	CORONARY CARE UNIT							44.00
	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT							45.00 46.00
	OTHER SPECIAL CARE (SPECIFY)							40.00
	Cost Center Description	1						
48.00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200	0			<u> </u>	48.00
	Total Program inpatient costs (sum of lines				ns)		334, 079	
	PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpa III)	atient routine	services (from	Wkst. D, sum	of Parts I and	22, 574	50.00
51.00	Pass through costs applicable to Program inp and IV)	atient ancillar	y services	(fro	om Wkst. D, su	um of Parts II	9, 723	51.00
52.00	Total Program excludable cost (sum of lines	50 and 51)					32, 297	52.00
53.00	Total Program inpatient operating cost exclu		lated, nor	-phys	sician anesthe	etist, and	301, 782	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54.00	Program di scharges						0	54.00
55.00	Target amount per discharge						0.00	
	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	raot amour	+ (1)	ino 56 minus I	ino 52)	0	56.00 57.00
	Bonus payment (see instructions)		rget allour			The 55)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 199	6, u	pdated and cor	npounded by the	0.00	59.00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year o	cost report up	dated by t	ho m	arkat haskat		0.00	60.00
	If line 53/54 is less than the lower of line					the amount by	0.00	61.00
	which operating costs (line 53) are less than		s (lines 5	4 x (60), or 1% of	the target		
62 00	amount (line 56), otherwise enter zero (see Relief payment (see instructions)	instructions)					0	62.00
	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)				0	63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	mber 31 of	the	cost reportin	ng period (See	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of t	he co	ost reporting	period (See	0	65.00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 nlus li	ne 6	5)(title XVIII	only) For	0	66.00
	CAH (see instructions)					•		
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December	31 01	r the cost rep	borting period	0	67.00
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 repo	rting period	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 facil							70.00
71.00	Adjusted general inpatient routine service of	2						71.00
72.00	Program routine service cost (line 9 x line				>			72.00
73.00 74.00	Medically necessary private room cost applica Total Program general inpatient routine serv				ne 35)			73.00 74.00
75.00	Capital-related cost allocated to inpatient				orksheet B, Pa	art II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)						76.00
77.00	Program capital-related costs (line 9 x line							77.00
78.00	Inpatient routine service cost (line 74 minu:				- >			78.00
79.00 80.00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa					us line 79)		79.00 80.00
81.00	Inpatient routine service cost per diem limi				(81.00
82.00	Inpatient routine service cost limitation (I		· .					82.00
83.00 84.00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in:		s)					83.00 84.00
	Utilization review - physician compensation		ns)					84.00 85.00
	Total Program inpatient operating costs (sum							86.00
07 00	PART IV - COMPUTATION OF OBSERVATION BED PASS						775	07 00
87.00 88.00	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)				745 1, 504. 69	87.00 88.00
	Observation bed cost (line 87 x line 88) (see		,				1, 120, 994	

Health Financial Systems COM	NUNITY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period:	Worksheet D-1	
				From 01/01/2018 To 12/31/2018		
		Titl	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	853, 166	5, 270, 917	0. 161863	3 1, 120, 994	181, 447	90.00
91.00 Nursing School cost	0	5, 270, 917	0.00000	0 1, 120, 994	0	91.00
92.00 Allied health cost	0	5, 270, 917	0.00000	1, 120, 994	0	92.00
93.00 All other Medical Education	0	5, 270, 917	0.00000	1, 120, 994	0	93.00

Health Financial Systems COMMUNITY HOSPT. OF LA	GRANGE CTY	IN	In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1323	Peri od:	Worksheet D-3	3
			From 01/01/2018 To 12/31/2018		nared
			10 12/31/2010	5/29/2019 2:5	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
30. 00 03000 ADULTS & PEDIATRICS			1, 445, 792		30,00
43. 00 04300 NURSERY			1, 110, 772	-	43.00
ANCI LLARY SERVI CE COST CENTERS		1		1	
50. 00 05000 OPERATI NG ROOM		0. 20034	49 651, 121	130, 451	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 6211	18 C	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 06668	73, 026	4, 869	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1124	488, 608	54, 954	54.00
60. 00 06000 LABORATORY		0. 1722		74, 711	
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		· ·	
65. 00 06500 RESPI RATORY THERAPY		0. 27488			
66. 00 06600 PHYSI CAL THERAPY		0. 6743			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 47758			
68.00 06800 SPEECH PATHOLOGY		1. 04619			
69. 00 06900 ELECTROCARDI OLOGY		0.0000		· · · · · · · · · · · · · · · · · · ·	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT		0. 24269			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 32498			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2943			
76. 97 O7697 CARDIAC REHABILITATION		0.83090		0	
76.98 07698 HYPERBARI C OXYGEN THERAPY		0.0000		0	
76. 99 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS		0.0000		0 0	76.99
90. 00 09000 CLINIC		0.0000	00 0		90.00
90. 01 09000 LI FEBRI DGE SENI OR CARE		0. 7862			1
91. 00 09100 EMERGENCY		0. 30242		-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0. 26002		0 17, 548	
OTHER REIMBURSABLE COST CENTERS		0.20002	<u> </u>	′I U	72.00
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			3, 349, 996	810, 773	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		(201.00
202.00 Net charges (line 200 minus line 201)	()		3, 349, 996		202.00

Health Financial Systems COMMUNITY HOSPT. OF LAG		CN: 15-1323	Period:	eu of Form CMS- Worksheet D-3	
		511. 15-1525	From 01/01/2018		,
	Component (CCN: 15-Z323	To 12/31/2018	Date/Time Pre 5/29/2019 2:5	pared: 0 pm
	Title	XVIII	Swing Beds - SNI	Cost	
Cost Center Description		Ratio of Cos		I npati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			105 (7)	1	
30. 00 03000 ADULTS & PEDI ATRI CS			125, 674		30.00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVICE COST CENTERS 50.00 OPERATI NG ROOM		0. 20034	19 664	133	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 20034		0	
53. 00 05300 ANESTHESI OLOGY		0. 0211			
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 1124		-	
60. 00 06000 LABORATORY		0. 1724			
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0. 00000		0, 109	
65. 00 06500 RESPIRATORY THERAPY		0. 27488			
66. 00 06600 PHYSI CAL THERAPY		0. 6743			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 47758			
68. 00 06800 SPEECH PATHOLOGY		1. 04619			
69. 00 06900 ELECTROCARDI OLOGY		0.0000			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2426		1, 513	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 32498		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2943 ²	39, 812	11, 717	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0.83090)4 C	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0000	00 C	0	76.98
76. 99 07699 LI THOTRI PSY		0.0000	00 0	0	76.99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0.0000	00 C	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE		0. 7862		0	
91. 00 09100 EMERGENCY		0. 30242		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		0.26002	23 C	0 0	92.00
OTHER REIMBURSABLE COST CENTERS			1	•	
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)			220, 515	85, 789	
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61)		C		201.00
202.00 Net charges (line 200 minus line 201)			220, 515		202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT Provider CCN: 15-1323 Period: From 01/01/2018 To 12/31/2018 Worksheet D-3 Date/Time Propare 5/29/2019 2: 50 pm Cost Center Description Title XIX Hospital PPS INPATIENT ROUTINE SERVICE COST CENTERS Inpatient Program Charges <
To 12/31/2018 Date/Time Prepare 5/29/2019 2: 50 pm Cost Center Description Title XIX Hospital PPS To Charges Inpatient Program Charges Inpatient Program Ch
Image: Cost Center Description Title XIX Hospital PPS Cost Center Description Ratio of Cost To Charges Inpatient Program Charges
Title XIX Hospital PPS Cost Center Description Ratio of Cost To Charges Inpatient Program Charges Inpatient Program Charges <t< td=""></t<>
Cost Center Description Ratio of Cost To Charges Inpatient Program Costs (charges) In
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDI ATRI CS 72,569 30. 43. 43.00 04300 NURSERY 20,152 43. ANCILLARY SERVICE COST CENTERS 0.200349 98,395 19,713 50. 50.00 05000 OPERATI NG ROOM 0.200349 98,395 19,713 50. 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.621118 74,110 46,031 52. 53.00 05300 ANESTHESI OLOGY 0.066681 15,521 1,035 53. 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.112470 42,332 4,761 54. 60.00 06600 LABORATORY 0.172294 56,395 9,717 60. 62.30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0.000000 0 0 62. 66.00 06600 PHYSI CAL THERAPY 0.274882 11,824 3,250 65. 66.00 06600 SPEECH PATHOLOGY 0.477581 908 434 67. 68.00 <t< td=""></t<>
INPATI ENT ROUTI NE SERVI CE COST CENTERS 1.00 2.00 3.00 30.00 03000 ADULTS & PEDI ATRI CS 30.00 30.01
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 72,569 30. 43.00 04300 NURSERY 20,152 43. ANCILLARY SERVICE COST CENTERS 0.200349 98,395 19,713 50. 50.00 05200 DELIVERY ROOM & LABOR ROOM 0.621118 74,110 46,031 52. 53.00 05300 ANESTHESI OLOGY 0.112470 42,332 4,761 54. 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.112470 42,332 4,761 54. 60.00 06600 LABORATORY 0.172294 56,395 9,717 60. 62.30 06500 RESPI RATORY THERAPY 0.274882 11,824 3,250 65. 66.00 06600 PHYSI CAL THERAPY 0.674372 1,650 1,113 66. 67.00 06700 OCCUPATI ONAL THERAPY 0.477581 908 434 67. 68.00 06800 SPEECH PATHOLOGY 1.046192 2,168 2,268 68. 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0
INPATI ENT ROUTI NE SERVI CE COST CENTERS 30.00 03000 ADULTS & PEDI ATRI CS 72, 569 30. 43.00 04300 NURSERY 20, 152 43. ANCI LLARY SERVI CE COST CENTERS 0.200349 98, 395 19, 713 50. 50.00 05000 OPERATI NG ROOM 0.621118 74, 110 46, 031 52. 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.621118 74, 110 46, 031 52. 53.00 05300 ANESTHESI OLOGY 0.066681 15, 521 1, 035 53. 54.00 05400 RADI LAGNOSTI C 0.112470 42, 332 4, 761 54. 60.00 06000 LABORATORY 0.12294 56, 395 9, 717 60. 62.30 065500 BLOD CLOTTI NG FOR HEMOPHI LI ACS 0.000000 0 62. 66.00 06600 PHYSI CAL THERAPY 0.274882 11, 824 3, 250 65. 66.00 06600 PHYSI CAL THERAPY 0.674372 1, 650 1, 113 66. 67.00 06700 OCCUPATI ONAL THERAPY 0.674372 1, 650
30.00 03000 ADULTS & PEDIATRICS 72,569 30. 43.00 04300 NURSERY 20,152 43. ANCILLARY SERVICE COST CENTERS 0.200349 98,395 19,713 50. 50.00 05200 DELIVERY ROOM & LABOR ROOM 0.621118 74,110 46,031 52. 53.00 05300 ANESTHESI OLOGY 0.066681 15,521 1,035 53. 54.00 05400 RADI OLOGY -DI AGNOSTI C 0.112470 42,332 4,761 54. 60.00 06000 LABORATORY 0.172294 56,395 9,717 60. 62.30 06250 BLODD CLOTTI NG FOR HEMOPHI LI ACS 0.000000 0 62. 64.00 06600 PHYSI CAL THERAPY 0.274882 11,824 3,250 65. 66.00 06600 PHYSI CAL THERAPY 0.674372 1,650 1,113 66. 67.00 06700 OCUPATI ONAL THERAPY 0.477581 908 434 67. 68.00 06800S SPEECH PATHOLOGY 1.046192 2,168 2,268 68. <
43.00 04300 NURSERY 20, 152 43. ANCI LLARY SERVI CE COST CENTERS 50.00 05000 OPERATI NG ROOM 0.200349 98, 395 19, 713 50. 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.621118 74, 110 46, 031 52. 53.00 05300 ANESTHESI OLOGY 0.066681 15, 521 1, 035 53. 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.112470 42, 332 4, 761 54. 60.00 06400 LABORATORY 0.172294 56, 395 9, 717 60. 62.30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0.000000 0 0 62. 66.00 06600 PHYSI CAL THERAPY 0.274882 11, 824 3, 250 65. 66.00 06600 PHYSI CAL THERAPY 0.674372 1, 650 1, 113 66. 67.00 06700 OCUPATI ONAL THERAPY 0.40000 0 0 0 68.00 068000 SPEECH PATHOLOGY 0.40000 0 0 0 69.00 069000
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.200349 98,395 19,713 50. 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.621118 74,110 46,031 52. 53.00 05300 ANESTHESI OLOGY 0.66681 15,521 1,035 53. 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.112470 42,332 4,761 54. 60.00 06000 LABORATORY 0.172294 56,395 9,717 60. 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 62. 65.00 06500 RESPI RATORY THERAPY 0.274882 11,824 3,250 65. 66.00 06600 PHYSI CAL THERAPY 0.674372 1,650 1,113 66. 67.00 06700 OCUPATI ONAL THERAPY 0.477581 908 434 67. 68.00 068000 SPEECH PATHOLOGY 0.000000 0 0 0 69. 0.000000 0
50.00 05000 OPERATING ROOM 0.200349 98,395 19,713 50. 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.621118 74,110 46,031 52. 53.00 05300 ANESTHESI OLOGY 0.066681 15,521 1,035 53. 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.112470 42,332 4,761 54. 60.00 06000 LABORATORY 0.172294 56.395 9,717 60. 62.30 06500 RESPI RATORY THERAPY 0.274882 11,824 3,250 65. 64.00 06600 PHYSI CAL THERAPY 0.674372 1,650 1,113 66. 67.00 06700 OCCUPATI ONAL THERAPY 0.477581 908 434 67. 68.00 06800 SPEECH PATHOLOGY 0.000000 0 0 68. 69.00 06900 ELECTROCARDI OLOGY 0.00000 0 0 69. 71.00 07000 07000 0 0 69. 0.000000 0 69. 69.00 06900
52.00 05200 DELI VERY ROOM & LABOR ROOM 0.621118 74,110 46,031 52. 53.00 05300 ANESTHESI OLOGY 0.066681 15,521 1,035 53. 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.112470 42,332 4,761 54. 60.00 06000 LABORATORY 0.172294 56,395 9,717 60. 62.30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0.000000 0 0 62. 65.00 06600 PHYSI CAL THERAPY 0.274882 11,824 3,250 65. 66.00 06000 CCUPATI ONAL THERAPY 0.674372 1,650 1,113 66. 67.00 06700 OCCUPATI ONAL THERAPY 0.46192 2,168 2,268 68. 68.00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 69. 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69. 9,462 2,296 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENT 0.324989 0 0
53.00 05300 ANESTHESI OLOGY 0.066681 15, 521 1, 035 53. 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.112470 42, 332 4, 761 54. 60.00 06000 LABORATORY 0.172294 56, 395 9, 717 60. 62.30 06250 BLODD CLOTTI NG FOR HEMOPHI LI ACS 0.000000 0 0 62. 65.00 06500 RESPI RATORY THERAPY 0.274882 11, 824 3, 250 65. 66.00 06600 PHYSI CAL THERAPY 0.674372 1, 650 1, 113 66. 67.00 06700 OCCUPATI ONAL THERAPY 0.477581 908 434 67. 68.00 068000 SPEECH PATHOLOGY 0.000000 0 0 0 69. 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 0 69. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.242696 9, 462 2, 296 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.324989 0 0 0 72.
54.00 05400 RADI OLOGY-DI AGNOSTI C 0.112470 42,332 4,761 54. 60.00 06000 LABORATORY 0.172294 56,395 9,717 60. 62.30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0.000000 0 0 62. 65.00 06500 RESPI RATORY THERAPY 0.274882 11,824 3,250 65. 66.00 06600 PHYSI CAL THERAPY 0.674372 1,650 1,113 66. 67.00 06700 OCCUPATI ONAL THERAPY 0.477581 908 434 67. 68.00 06600 SPEECH PATHOLOGY 0.000000 0 0 0.90 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.242696 9,462 2,296 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.324989 0 0 0
60.00 06000 LABORATORY 0.172294 56,395 9,717 60. 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 62. 65.00 06500 RESPI RATORY THERAPY 0.274882 11,824 3,250 65. 66.00 06600 PHYSI CAL THERAPY 0.674372 1,650 1,113 66. 67.00 06700 OCCUPATI ONAL THERAPY 0.477581 908 434 67. 68.00 06800 SPEECH PATHOLOGY 1.046192 2,168 2,268 68. 69.00 06900 ELECTROCARDI OLOGY 0.00000 0 0. 69. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.242696 9,462 2,296 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.324989 0 0 0
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0.000000 0 62. 65. 00 06500 RESPIRATORY THERAPY 0.274882 11,824 3,250 65. 66. 00 06600 PHYSI CAL THERAPY 0.674372 1,650 1,113 66. 67. 00 06700 OCCUPATI ONAL THERAPY 0.477581 908 434 67. 68. 00 06800 SPEECH PATHOLOGY 1.046192 2,168 2,268 68. 69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69. 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0.242696 9,462 2,296 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.324989 0 0 0
65.00 06500 RESPI RATORY THERAPY 0.274882 11,824 3,250 65. 66.00 06600 PHYSI CAL THERAPY 0.674372 1,650 1,113 66. 67.00 06700 OCCUPATI ONAL THERAPY 0.477581 908 434 67. 68.00 06800 SPEECH PATHOLOGY 1.046192 2,168 2,268 68. 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.242696 9,462 2,296 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.324989 0 0 72.
66.00 06600 PHYSI CAL THERAPY 0.674372 1,650 1,113 66. 67.00 06700 OCCUPATI ONAL THERAPY 0.477581 908 434 67. 68.00 06800 SPEECH PATHOLOGY 1.046192 2,168 2,268 68. 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 0 69. 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.242696 9,462 2,296 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.324989 0 0 0
67.00 06700 OCCUPATI ONAL THERAPY 0.477581 908 434 67. 68.00 06800 SPEECH PATHOLOGY 1.046192 2,168 2,268 68. 69.00 06900 ELECTROCARDI OLOGY 0.000000 0 69. 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0.242696 9,462 2,296 71. 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.324989 0 0 72.
69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 69. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.242696 9, 462 2, 296 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.324989 0 0 72.
69. 00 06900 ELECTROCARDI OLOGY 0.000000 0 69. 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0.242696 9, 462 2, 296 71. 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0.324989 0 0 72.
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0. 242696 9, 462 2, 296 71. 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0. 324989 0 0 72.
76. 97 07697 CARDI AC REHABI LI TATI ON 0. 830904 0 0 76.
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0.000000 0 0 76.
76. 99 07699 LI THOTRI PSY 0.000000 0 0 76.
OUTPATIENT SERVICE COST CENTERS
90. 00 09000 CLINIC 0. 000000 0 0 90.
90. 01 09001 LI FEBRI DGE SENI OR CARE 0. 786214 0 0 90.
91. 00 09100 EMERGENCY 0. 302429 28, 405 8, 590 91.
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0. 260023 0 0 92.
OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95.
200.00 Total (sum of lines 50 through 94 and 96 through 98) 403,136 117,445 200.
200.00 Total (sum of thes so through 94 and 96 through 98) 403, 136 117, 443 200. 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.
201. 100 110 201. 201. 202. 00 110 202. 403, 136 202.

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1323	Period: From 01/01/2018 To 12/31/2018		
		Title XVIII	Hospi tal	Cost	o piii
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
. 00	Medical and other services (see instructions)			4, 630, 581	1.0
. 00	Medical and other services reimbursed under OPPS (see instruct	i ons)		0	2.0
. 00 . 00	OPPS payments Outlier payment (see instructions)			0	3.0
. 00	Outlier reconciliation amount (see instructions)			0	4.0
. 00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0.000	
. 00	Line 2 times line 5			0	
. 00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	
. 00 . 00	Transitional corridor payment (see instructions)	V col 12 lipo 200		0	8. 9.
. 00 D. 00	Ancillary service other pass through costs from Wkst. D, Pt. I Organ acquisitions	v, cor. 13, 111e 200		0	10.
1.00	Total cost (sum of lines 1 and 10) (see instructions)			4, 630, 581	
	COMPUTATION OF LESSER OF COST OR CHARGES				1
	Reasonable charges				
2.00 3.00	Ancillary service charges	no (0)		0	12.
4.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, li Total reasonable charges (sum of lines 12 and 13)	ne by		0	13.
1. 00	Customary charges				
5.00	Aggregate amount actually collected from patients liable for p	ayment for services on	a charge basis	0	15.
6.00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16.
7 00	had such payment been made in accordance with 42 CFR §413.13(e)		0,00000	17
7.00 8.00	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0.000000	17. 18.
9.00	Excess of customary charges over reasonable cost (complete onl)	vifline 18 exceeds li	ne 11) (see	0	19.
	instructions)				
D. 00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20.
	instructions)			4 (7(007	01
1.00 2.00	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			4, 676, 887 0	21.
3.00	Cost of physicians' services in a teaching hospital (see instr	uctions)		0	23.
4.00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)			0	24.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	-			
5.00	Deductibles and coinsurance amounts (for CAH, see instructions	-		52, 317	
6.00 7.00	Deductibles and Coinsurance amounts relating to amount on line Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p			3, 513, 650 1, 110, 920	
/.00	instructions)			1, 110, 720	27.
B. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28.
9.00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29.
0.00	Subtotal (sum of lines 27 through 29)			1, 110, 920	
1.00	Primary payer payments Subtotal (line 30 minus line 31)			1, 110, 920	31. 32.
2.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICI	ES)		1, 110, 720	02.
3.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.
4.00	Allowable bad debts (see instructions)			577, 894	
5.00 6.00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		375, 631 389, 555	
7.00	Subtotal (see instructions)			1, 486, 551	
B. 00	MSP-LCC reconciliation amount from PS&R			0	38.
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.
9.50	Pioneer ACO demonstration payment adjustment (see instructions)			39.
9.97	Demonstration payment adjustment amount before sequestration		+:>	0	39.
9.98 9.99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	ed devices (see instruc	tions)	0	39. 39.
0.00	Subtotal (see instructions)			1, 486, 551	
0. 01	Sequestration adjustment (see instructions)			29, 731	
0. 02	Demonstration payment adjustment amount after sequestration			0	40.
. 00	Interim payments			1, 815, 271	
2.00	Tentative settlement (for contractors use only)			0 259 451	
3.00 4.00	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub 15-2	chapter 1	-358, 451 0	
00	§115. 2	55 WI CH OND TUD. 13-2,	shaptor I,	0	
	TO BE COMPLETED BY CONTRACTOR				1
0. 00	Original outlier amount (see instructions)			0	
. 00	Outlier reconciliation adjustment amount (see instructions)			0	
2.00 3.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.
				0	94.

NALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	:N: 15-1323	Period: From 01/01/2018 To 12/31/2018		pared
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 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 List separately each retroactive lump sum adjustment		1, 845, 88	31 0	1, 733, 971 0	1. (2. (3. (
	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					
01	ADJUSTMENTS TO PROVIDER	09/01/2018	104, 90	00 04/11/2018	81, 300	3. (
02				0	0	3.0
03 04				0	0	3. 3.
04				0	0	3.
00	Provider to Program					0.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3.
52 53				0	0	3. 3.
53 54				0	0	3. 3.
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		104, 90	-	81, 300	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 950, 78	31	1, 815, 271	4.
00	TO BE COMPLETED BY CONTRACTOR 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.
D1	TENTATI VE TO PROVI DER			0	0	5.
02				0	Ő	5.
)3				0	0	5.
	Provider to Program				-	-
50 51	TENTATI VE TO PROGRAM			0	0	5. 5.
52				0	0	5.
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		00.00	0	0	6.
)2)0	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		90, 0 1, 860, 70		358, 451 1, 456, 820	6. 7.
.0	Total meancare program trabitity (see fistructions)		1, 000, 70	Contractor Number	NPR Date (Mo/Day/Yr)	/
		C		1.00	2.00	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider Concernent		Period: From 01/01/2018 To 12/31/2018	Date/Time Pre	pared:
				Cuitar Dada - CNI	5/29/2019 2:5	0 pm
			XVIII t Part A	Swing Beds - SNI Pai	F <u>Cost</u>	
		•			-	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1 00	Total interim normante paid te providen	1.00	2.00	3.00	4.00	1.00
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		390, 86	0	0	
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)					3. 00
3. 01	Program to Provider ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.01				0	0	
3.03				0	0	
3.04				0	0	
3.05				0	0	3.05
3.50	Provider to Program ADJUSTMENTS TO PROGRAM			0	0	3.50
3.50	ADJUSTWENTS TO FROOKAW			0	0	
3.52				0	0	
3.53				0	0	
3.54				0	0	
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3. 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)		390, 86	98	0	4.00
	TO BE COMPLETED BY CONTRACTOR					
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)					5.00
F 01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.01
5.01 5.02				0	0	
5.03				0	0	
	Provider to Program		I		I	
5.50	TENTATI VE TO PROGRAM			0	0	
5.51 5.52				0	0	
5.92 5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
-	5. 50-5. 98)					
5.00	Determined net settlement amount (balance due) based on the cost report. (1)				_	6.00
5. 01 5. 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		2, 56	0	0	
5.02 7.00	Total Medicare program liability (see instructions)		2, 50		0	
				Contractor Number	NPR Date (Mo/Day/Yr)	7.00
)	1.00	2.00	

Heal th	u of Form CMS-	2552-10					
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1323 Period:						
	From 01/01/2018 P						
To 12/31/2018 Dat							
	5/29/2019 2:5 Cost						
		Title XVIII	Hospi tal				
				1.00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION						
1.00							
2.00							
3.00							
4.00	4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12						
5.00	5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200						
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ine 20			6.00		
7.00	CAH only - The reasonable cost incurred for the purchase of co	ertified HIT technology	Wkst. S-2, Pt. I		7.00		
	line 168						
	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						
	Initial/interim HIT payment adjustment (see instructions)				30.00		
	Other Adjustment (specify)				31.00		
32.00	Balance due provider (line 8 (or line 10) minus line 30 and li	ine 31) (see instruction	is)		32.00		

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1323	Period: From 01/01/2018	Worksheet E-2	
		Component CCN: 15-Z323	To 12/31/2018	Date/Time Pre 5/29/2019 2:50	
		Title XVIII	Swing Beds - SNF		
			Part A 1.00	<u>Part B</u> 2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
	Inpatient routine services - swing bed-SNF (see instructions)		309, 585	0	1.00
	Inpatient routine services - swing bed-NF (see instructions)			_	2.00
. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins		86, 647	0	3.00
. 00	Per diem cost for interns and residents not in approved teaching			0.00	4.00
	instructions)				
	Program days	tructione)	205	0	5.00
	Interns and residents not in approved teaching program (see ins Utilization review - physician compensation - SNF optional meth		0	0	6.00 7.00
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		396, 232	0	8.00
	Primary payer payments (see instructions)		0	0	9.00
	Subtotal (line 8 minus line 9)		396, 232	0	10.00
1.00	Deductibles billed to program patients (exclude amounts applica	able to physician	0	0	11.00
2.00	professional services) Subtotal (line 10 minus line 11)		396, 232	0	12.00
	Coinsurance billed to program patients (from provider records)	(exclude coinsurance	370, 232	0	13.00
	for physician professional services)	(-	
	80% of Part B costs (line 12 x 80%)			0	14.0
	Subtotal (enter the lesser of line 12 minus line 13, or line 14 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	4)	396, 232 0	0	15.00
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16.0 16.5
	Rural community hospital demonstration project (§410A Demonstra		0		16.5
	adjustment (see instructions)				
	Demonstration payment adjustment amount before sequestration		0	0	16.9
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)		0	0	17.00 17.0
	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)	0	0	18.00
	Total (see instructions)		396, 232	0	19.00
	Sequestration adjustment (see instructions)		7, 925	0	19.0 [°]
	Demonstration payment adjustment amount after sequestration)		0	0	19.0
	Interim payments Tentative settlement (for contractor use only)		390, 868	0	20.00
	Balance due provider/program (line 19 minus lines 19.01, 20, ar	nd 21)	-2, 561	0	22.0
	Protested amounts (nonallowable cost report items) in accordance		0	0	23.00
	chapter 1, §115.2	· · · ·			
	Rural Community Hospital Demonstration Project (§410A Demonstra				
00.00	Is this the first year of the current 5-year demonstration peri Century Cures Act? Enter "Y" for yes or "N" for no.	od under the 21st			200. 00
	Cost Reimbursement				
01. 00	Medicare swing-bed SNF inpatient routine service costs (from W	kst. D-1, Pt. II, line			201.00
00 00	66 (title XVIII hospital))	What D 2 and 2 lin			202.00
02.00	Medicare swing-bed SNF inpatient ancillary service costs (from 200 (title XVIII swing-bed SNF))	WKSL. D-3, COL. 3, TIM	e		202. 0
03. 00	Total (sum of lines 201 and 202)				203. 0
04.00	Medicare swing-bed SNF discharges (see instructions)				204. 0
	Computation of Demonstration Target Amount Limitation (N/A in f	first year of the curre	nt 5-year demonst	ration	
	period) Medicare swing-bed SNF target amount				205. 0
	Medicare swing-bed SNF inpatient routine cost cap (line 205 tir	nes line 204)			205.0
	Adjustment to Medicare Part A Swing-Bed SNF Inpatient Reimburse	· ·			
	Program reimbursement under the §410A Demonstration (see instru				207. 0
08. 00	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2,	col. 1, sum of lines	1		208. 00
09 00	and 3) Adjustment to Medicare swing-bed SNF PPS payments (see instruct	tions)			209. 0
	Reserved for future use	(1013)			210.00
	Comparision of PPS versus Cost Reimbursement		· · ·		
15.00	Total adjustment to Medicare swing-bed SNF PPS payment (line 20 instructions)	09 plus line 210) (see			215. 0

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	DF LAGRANGE CTY IN Provider CCN: 15-1323	Peri od:	u of Form CMS-: Worksheet E-3	
			From 01/01/2018 To 12/31/2018	Part V Date/Time Pre 5/29/2019 2:5	
		Title XVIII	Hospi tal	Cost	
				1 00	-
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDIC			1.00	
00	Inpatient services	ARE PART A SERVICES - COST	KEIWDUKSEWENI	2, 148, 995	1 1.
00	Nursing and Allied Health Managed Care payment (see instru	(ctions)		2, 140, 775	
00	Organ acqui si ti on			0	
00	Subtotal (sum of lines 1 through 3)			2, 148, 995	
00	Primary payer payments			0	5
00	Total cost (line 4 less line 5). For CAH (see instructions			2, 170, 485	6
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
00	Routine service charges			0	
00	Ancillary service charges			0	-
00	Organ acquisition charges, net of revenue			0	
. 00	Total reasonable charges			0	10
. 00	Customary charges Aggregate amount actually collected from patients liable f	for normant for convision on	a charge bacile	0	1 11
2.00	Amounts that would have been realized from patients liable			0	
. 00	had such payment been made in accordance with 42 CFR 413.1		n a charge basis	0	1 12
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)	3(e)		0. 000000	13
. 00	Total customary charges (see instructions)			0.000000	
5.00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds li	ne 6) (see	0	
	instructions)	,			
5.00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds lin	e 14) (see	0	16
	instructions)				
7.00	Cost of physicians' services in a teaching hospital (see i	nstructions)		0	17
	COMPUTATION OF REIMBURSEMENT SETTLEMENT	5 () ()			1
		E-4, line 49)		0	
00	Cost of covered services (sum of lines 6, 17 and 18) Deductibles (exclude professional component)			2, 170, 485 288, 442	
. 00	Excess reasonable cost (from Line 16)			200, 442	
	Subtotal (line 19 minus line 20 and 21)			1, 882, 043	1 -
. 00	Coi nsurance			1,002,043	
. 00				1, 882, 043	
. 00		rvices) (see instructions)		25, 597	
. 00				16, 638	
. 00	Allowable bad debts for dual eligible beneficiaries (see i	nstructions)		9, 278	27
8. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 898, 681	28
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29
. 50	Pioneer ACO demonstration payment adjustment (see instruct			0	
. 99	Demonstration payment adjustment amount before sequestrati	on		0	1
0.00	Subtotal (see instructions)			1, 898, 681	
0.01	Sequestration adjustment (see instructions)			37, 974	
	Demonstration payment adjustment amount after sequestratio	n		0	
. 00				1, 950, 781	
2.00		0.02, 21, and 22		0	
3.00 4.00	Balance due provider/program (line 30 minus lines 30.01, 3 Protested amounts (nonallowable cost report items) in acco		chaptor 1	-90, 074 0	
r. UU	§115. 2	NUANCE WITH CWS PUD. 19-2,	unapter I,	0	34

LANC nd-t	Financial Systems COMMUNITY HOSPT. OF E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	CN: 15-1323	Period: From 01/01/2018 To 12/31/2018	u of Form CMS-: Worksheet G	
ly)		General Fund	Speci fi c	Endowment Fund	5/29/2019 2:5	opare 0 pm
		1.00	Purpose Fund 2.00		4. 00	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	
00	Cash on hand in banks	133, 365		0 0	0] 1.
00	Temporary investments	0		0 0	0	2.
00	Notes receivable	0		0 0	0	
00 00	Accounts receivable Other receivable	5, 526, 412 111, 120		0 0 0 0	0	
00 00	Allowances for uncollectible notes and accounts receivable	111, 120		0 0	0	6
00	Inventory	386, 010		0 0	0	
00	Prepaid expenses	140, 971		0 0	0	8
00	Other current assets	0		0 0	0	9
. 00	Due from other funds	-3, 738, 167		0 0	0	10
. 00	Total current assets (sum of lines 1-10)	2, 559, 711		0 0	0	11
00	FI XED ASSETS	220 702			0	1 1 2
. 00	Land Land improvements	320, 702 1, 978, 720		0 0 0 0	0	12
. 00	Accumulated depreciation	-1, 202, 612		0 0	0	14
00	Buildings	13, 534, 005		0 0	0	15
00	Accumulated depreciation	-4, 148, 900		0 0	0	16
. 00	Leasehold improvements	29, 098		0 0	0	17
. 00	Accumulated depreciation	-29, 098		0 0	0	18
. 00	Fixed equipment	7, 799, 259		0 0	0	19
. 00	Accumulated depreciation	-5, 557, 734		0 0	0	20
	Automobiles and trucks	285, 877		0 0	0	21
. 00	Accumulated depreciation	-123, 978		0 0	0	22
	Major movable equipment	9, 099, 309			0	23
. 00	Accumulated depreciation Minor equipment depreciable	-6, 468, 148			0	24
. 00	Accumulated depreciation	0			0	26
	HIT designated Assets	0		0 0	0	27
	Accumulated depreciation	0		0 0	0	
. 00	Mi nor equi pment-nondepreci abl e	0		0 0	0	29
. 00	Total fixed assets (sum of lines 12-29)	15, 516, 500		0 0	0	30
	OTHER ASSETS			_		
. 00	Investments	0		0 0	0	31
. 00	Deposits on Leases	0		0 0	0	32
. 00	Due from owners/officers	U		0 0	0	33
. 00 . 00	Other assets Total other assets (sum of lines 31-34)	5, 011, 241 5, 011, 241		0 0 0 0	0	34
. 00	Total assets (sum of lines 11, 30, and 35)	23, 087, 452		0 0	0	
. 00	CURRENT LI ABI LI TI ES	23,007,432		0	0	1 30
. 00	Accounts payable	1, 177, 417		0 0	0	37
. 00	Sal ari es, wages, and fees payabl e	537, 757		0 0	0	38
. 00	Payroll taxes payable	0		0 0	0	
	Notes and Loans payable (short term)	910, 000		0 0	0	
	Deferred income	0		0 0	0	
. 00	Accel erated payments	0				42
. 00	Due to other funds	020 502		0 0 0 0	0	
. 00 . 00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	820, 582 3, 445, 756		0 0	0	
. 00	LONG TERM LIABILITIES	5, 445, 750		0 0	0	40
. 00	Mortgage payable	0		0 0	0	46
. 00	Notes payable	0		0 0	0	47
. 00	Unsecured Loans	0		0 0	0	
. 00	Other long term liabilities	22, 091, 784		0 0	0	49
. 00	Total long term liabilities (sum of lines 46 thru 49)	22, 091, 784		0 0	0	
00	Total liabilities (sum of lines 45 and 50)	25, 537, 540		0 0	0	51
~ ~	CAPI TAL ACCOUNTS	0.450.000				
00	General fund balance	-2, 450, 088				52
00	Specific purpose fund Donor created - endowment fund balance - restricted			0		53 54
00	Donor created - endowment fund balance - restricted			0		54
. 00	Governing body created - endowment fund balance - unrestricted			0		56
. 00	Plant fund balance - invested in plant			0	0	
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	
. 00	Total fund balances (sum of lines 52 thru 58)	-2, 450, 088		0 0	0	59
	Total liabilities and fund balances (sum of lines 51 and	23, 087, 452				60

	Financial Systems COMM ENT OF CHANGES IN FUND BALANCES	UNITY HOSPT. OF	Provider CC		Peri od:		u of Form CMS- Worksheet G-1	
STATEM	ENT OF CHANGES IN FOND DALANCES		FIOVIDEI CC	N. 13-1323	From 01	1/01/2018 2/31/2018		epared:
		General	Fund	Speci al	Purpose	Fund	Endowment Fund	
1 00	Fund halances at heginning of period	1.00	2.00	3.00	2	4.00	5.00	1 00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ADJUSTMENT TO FUND BALANCE Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	-2, 466, 421 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	-2, 444, 028 2, 027, 491 -416, 537 -2, 466, 421 -2, 882, 958			0 0 0		5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)		0 -2, 882, 958			0 0		18.00 19.00
		Endowment Fund	Pl ant	Fund				
		6.00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ADJUSTMENT TO FUND BALANCE	0	000000000000000000000000000000000000000		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0	0 0 0 0 0 0		0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN:	15-1323		/01/2018 2/31/2018	Worksheet G-2 Parts I & II Date/Time Pre 5/29/2019 2:5	epared:
	Cost Center Description			Inpatient	Out	patient	Total	
				1.00		2.00	3.00	
	PART I – PATIENT REVENUES							
	General Inpatient Routine Services							
1.00	Hospi tal			4, 485, 40	08		4, 485, 408	
2.00	SUBPROVIDER - IPF							2.00
3.00	SUBPROVIDER - IRF							3.00
4.00	SUBPROVIDER			277 0	0		277 020	4.00
5.00 6.00	Swing bed - SNF Swing bed - NF			277,82	0		277, 820 0	1
7.00	SKILLED NURSING FACILITY				0		0	7.00
8.00	NURSI NG FACILITY							8.00
9.00	OTHER LONG TERM CARE							9.00
10.00	Total general inpatient care services (sum of lines 1-9)			4, 763, 22	28		4, 763, 228	
	Intensive Care Type Inpatient Hospital Services			· · ·			· · · ·	1
11.00	INTENSIVE CARE UNIT							11.00
12.00	CORONARY CARE UNI T							12.00
13.00	BURN INTENSIVE CARE UNIT							13.00
	SURGI CAL INTENSI VE CARE UNI T							14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						_	15.00
16.00	Total intensive care type inpatient hospital services (sum of l	i nes			0		0	16.00
17 00	11-15)			1 762 20	0		1 742 220	17 00
17.00 18.00	Total inpatient routine care services (sum of lines 10 and 16) Ancillary services			4, 763, 22 17, 583, 11		0	4, 763, 228 17, 583, 110	
	Outpatient services			17, 363, 1		7, 758, 863	87, 758, 863	
	RURAL HEALTH CLINIC				0	0	07, 750, 005	1
21.00	FEDERALLY QUALIFIED HEALTH CENTER				0	0	0	
22.00	HOME HEALTH AGENCY					0	0	22.00
23.00	AMBULANCE SERVI CES				0 !	5, 238, 315	5, 238, 315	
24.00	СМНС							24.00
24. 10	CORF				0	0	0	24.10
24. 20	OUTPATI ENT PHYSI CAL THERAPY				0	0	0	
	OUTPATIENT OCCUPATIONAL THERAPY				0	0	0	
	OUTPATIENT SPEECH PATHOLOGY				0	0	0	
25.00	AMBULATORY SURGICAL CENTER (D. P.)							25.00
26.00 27.00	HOSPI CE OTHER (SPECI FY)				~	0	0	26.00 27.00
27.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst		22, 346, 33	28 Q	0 2, 997, 178	115, 343, 516	
20.00	G-3, line 1)	U WKSL.		22, 340, 30	7.	2, 777, 170	115, 545, 510	20.00
	PART II - OPERATING EXPENSES							
29.00	Operating expenses (per Wkst. A, column 3, line 200)				3	7, 600, 144		29.00
30.00	BAD DEBT			4, 961, 58	37			30.00
31.00	HOME OFFICE INTEREST EXP			432, 86				31.00
32.00					0			32.00
33.00					0			33.00
34.00					0			34.00
35.00	Tatal additions (our of Lines 20.25)				U .	204 450		35.00
36.00	Total additions (sum of lines 30-35) DEDUCT (SPECIFY)					5, 394, 450		36.00
37.00 38.00					0			37.00
39.00					0			39.00
40.00					õ			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)	(transfe	er		42	2, 994, 594		43.00
								1

Heal th	Financial Systems COM	MUNITY HOSPT. OF L	AGRANGE CTY IN	In Lie	u of Form CMS-2	2552-10	
STATEM	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-1323	Peri od:	Worksheet G-3		
	From 01/01/2018 To 12/31/2018						
	10 12/31/2016						
		5/29/2019 2:50					
					1.00		
1.00	Total patient revenues (from Wkst. G-2, Part				115, 343, 516	1.00	
2.00	Less contractual allowances and discounts or	n patients' accoun	ts		71, 637, 743 43, 705, 773	2.00 3.00	
3.00							
4.00							
5.00							
	OTHER I NCOME			I			
6.00	Contributions, donations, bequests, etc				183, 961 -1, 314	6.00 7.00	
	7.00 Income from investments						
8.00							
9.00							
10.00							
11.00							
12.00	Parking lot receipts				0	12.00	
13.00	Revenue from Laundry and Linen service	ata			0	13.00	
14.00	Revenue from meals sold to employees and gue Revenue from rental of living guarters	ests			258, 731	14.00 15.00	
15. 00 16. 00	Revenue from sale of medical and surgical su	unalize to other t	ann nationta		0	15.00 16.00	
17.00	Revenue from sale of drugs to other than pat		han patrents		471, 644	17.00	
17.00	Revenue from sale of medical records and abs				471, 644	17.00	
19.00	Tuition (fees, sale of textbooks, uniforms,				0	19.00	
20.00	Revenue from gifts, flowers, coffee shops, a	,			12, 310		
20.00	Rental of vending machines				12, 310	20.00	
22.00	Rental of hospital space				36, 017		
23.00	Governmental appropriations				0,017	23.00	
24.00	GAIN ON DISPOSAL OF ASSETS				-11, 645		
24.01	COUNTY REIMBURSEMENT OF AMBULANCE SE				349,000		
24.02	MI SCELLANEOUS				17,608		
25.00	Total other income (sum of lines 6-24)				1, 316, 312		
26.00	Total (line 5 plus line 25)				2, 027, 491		
27.00					0	27.00	
28.00	Total other expenses (sum of line 27 and sub	oscripts)			0	28.00	
	Net income (or loss) for the period (line 26				2, 027, 491	29.00	