Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE C	TY IN In Lieu of Form CMS-2552-10
This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to r	
payments made since the beginning of the cost reporting period being deemed c	
	EXPI RES 05-31-2019
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider	r CCN: 15-1323 Period: Worksheet S
AND SETTLEMENT SUMMARY	From 01/01/2016 Parts I-III
	To 12/31/2016 Date/Time Prepared: 5/30/2017 1:22 pm
PART I - COST REPORT STATUS	575072017 1.22 pm
Provider 1. [X] Electronically filed cost report	Date: 5/30/2017 Time: 1:22 pm
use only 2. [] Manually submitted cost report	
3. [0] If this is an amended report enter the number of times	the provider resubmitted this cost report
4. [F] Medicare Utilization. Enter "F" for full or "L" for low	
Contractor 5. [1] Cost Report Status 6. Date Received:	10. NPR Date:
use only (1) As Submitted 7. Contractor No.	11. Contractor's Vendor Code: 4
(2) Settled without Audit 8. [N] Initial Report for this Pr	
(3) Settled with Audit 9. [N] Final Report for this Prov	vider CCN number of times reopened = 0-9.
(4) Reopened	
(5) Amended	
PART LL - CERTIFICATION	
MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION CONTAINED IN THIS COST	REPORT MAY BE PLINI SHABLE BY CRIMINAL CLVLL AND
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UNDER FEDERAL LAW. FURTHERMO	
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OR INDIRECTLY OF A KICKBACK	
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.	
CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)	
I HEREBY CERTIFY that I have read the above certification statement a	and that I have examined the accompanying
electronically filed or manually submitted cost report and the Balanc	e Sheet and Statement of Revenue and
Expenses prepared by COMMUNITY HOSPT. OF LAGRANGE CTY IN (15-1323)	for the cost reporting period beginning
01/01/2016 and ending 12/31/2016 and to the best of my knowledge and	
correct, complete and prepared from the books and records of the prov	
instructions, except as noted. I further certify that I am familiar	
provision of health care services, and that the services identified i	n this cost report were provided in
compliance with such laws and regulations.	
(Si gned)	

Officer or Administrator of Provider(s)

tle XIX 5.00

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1.00 2.00

3.00

5.00

6.00

Title

		Title	XVIII		
Cost Center Description	Title V	Part A	Part B	HIT	Ti t
	1.00	2.00	3.00	4.00	
PART III - SETTLEMENT SUMMARY					
Hospi tal	0	226, 478	-340, 721	16, 740	
Subprovider - IPF	0	0	0		
Subprovider - IRF	0	0	0		
Swing bed - SNF	0	167, 405	0		

393, 883 -340, 721 200.00 Total 0 16, 740 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.

0

Date

1.00

2.00

3.00

5.00

6.00

Swing bed - NF

ITAL AND HOSPITAL HEALTH CARE COMPLE	. IDENTIFICATION DATA	Provid	ler CCN: 1	5-1323	Period: From 01/01/	2016	Workshe Part I	
					To 12/31/		Date/Ti 5/30/20	
1.00	2.00		3.00		2	4.00		
Hospital and Hospital Health Care Street: 207 NORTH TOWNLINE ROAD	PO Box:							
City: LAGRANGE	State: IN	Zip Cod	e: 46761-	1325 Count	ty: LAGRANGE			
	Component Name	CCN	CBSA	Provi der			nt Syste	
		Number	Number	Туре	Certi fi ed	1, V	0, or XVIII	XI X
	1.00	2.00	3.00	4.00	5.00	6.00		8.00
Hospital and Hospital-Based Compon				1				
Hospi tal	COMMUNITY HOSPT. OF LAGRANGE CTY IN	151323	99915	1	05/01/2005	Ν	0	Р
Subprovider - IPF	LAGRANGE CIT IN							
Subprovider - IRF								
Subprovider - (Other)		457000	00045					
Swing Beds – SNF Swing Beds – NF	SWING BEDS	15Z323	99915		05/01/2005	N	0	N
Hospital-Based SNF								
0 Hospital-Based NF								
0 Hospital-Based OLTC								
0 Hospital-Based HHA 0 Separately Certified ASC								
D Hospi tal -Based Hospi ce								
Hospital-Based Health Clinic - RHC								
) Hospital-Based Health Clinic - FQH								
) Hospital-Based (CMHC)) Hospital-Based (CORF)								
Hospi tal -Based (OPT) I								
) Hospital-Based (OOT) I								
) Hospital-Based (OSP) I) Renal Dialysis								
0 Other								
					From:		To:	
					1.00	21.0	2.0	
0 Cost Reporting Period (mm/dd/yyyy) 0 Type of Control (see instructions)					01/01/2	010	12/31/	2016
Inpatient PPS Information								
Does this facility qualify and is					N		Ν	
share hospital adjustment, in acco for yes or "N" for no. Is this fac								
amendment hospital?) In column 2,			12.100(0)		e			
1 Did this hospital receive interim					N		Ν	
period? Enter in column 1, "Y" for reporting period occurring prior t								
for no for the portion of the cost			2					
(see instructions)	· · · · · · · · · · · · · · · · · · ·							
2 Is this a newly merged hospital th					N		Ν	
determined at cost report settleme or "N" for no, for the portion of					s			
in column 2, "Y" for yes or "N" fo					n			
or after October 1.				· .				
3 Did this hospital receive a geogra of the OMB standards for delineati							N	
in column 1, "Y" for yes or "N" fo								
prior to October 1. Enter in colum					e			
cost reporting period occurring on hospital contain at least 100 but			,		h			
42 CFR 412. 105)? Enter in column 3				ance wit	"			
) Which method is used to determine	<i>N</i> edicaid days on lines 2	4 and/or 2				3	Ν	
1, enter 1 if date of admission, 2 method of identifying the days in								
used in the prior cost reporting p						_		
	In-S	itate In-S	tate 0	ut-of	Out-of M	edi cai		her
				State dicaid I	State H Wedicaid	MO day		i cai d ays
	pard				eligible		u.	uys
		da	ys		unpai d			
		00 2.		3.00	4.00	5.00		. 00
				0	0		ol	0
	al, enter the	0	0	0	٥		-	"
in-state Medicaid paid days in col	al, enter the umn 1, in-state		0	0	0			
in-state Medicaid paid days in col Medicaid eligible unpaid days in c out-of-state Medicaid paid days in	al, enter the umn 1, in-state blumn 2, column 3,		0	0				
in-state Medicaid paid days in col Medicaid eligible unpaid days in c	al, enter the umn 1, in-state blumn 2, column 3, aid days in column		0	0				

SPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DAT	TA	Provider CC	CN: 15-1323	Period: From 01/0	1/2014	Worksh Part I	eet S-2	
					31/2016	Date/T	ime Pre 017 12:	pare
	In-State Medicaid paid days	In-State Medicaid eligible unpaid	Out-of State Medicaid paid days	Out-of State Medicaid eligible	Medica HMO da	aid (ays Me)ther di cai d days	
-	1.00	days 2.00	3.00	unpai d 4. 00	5.00		6.00	+
00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	0			0		0		25.
				1.	Rural S 00	2.	r Geogr 00	1
00 Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for		at the beg	ginning of t	he	2			26.
 Cost reporting period. Enter in for abain on 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 	ge) status "2" for r	ural. If ap		t	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 n	ni ng: 00	Endi 2	ng: 00	
00 Enter applicable beginning and ending dates of SCH st		cript line	36 for numb			۷.	30	36.
of periods in excess of one and enter subsequent date 00 If this is a Medicare dependent hospital (MDH), enter		r of period	ds MDH statu	s	0			37.
 is in effect in the cost reporting period. 11 Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions) 				ſ	N			37
00 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
					/N 00		/N 00	
00 Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage req CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes 00 Is this hospital subject to the HAC program reduction)? Enter i uirements or "N" for	n column 1 in accordar no. (see i	"Y" for yes nce with 42 nstructions	me 1	V V	1	V V	39. 40.
"N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	er 1. Ente	r "Y" for y			V	XVIII	XI X	-
Prospective Payment System (PPS)-Capital					1.00) 2.00	3.00	
00 Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	·	·				N	N	45
00 Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.	. L, Pt. I	II and Wkst	t. L-1, Pt.	I through	N	N	N	46
					N N	N	N	47
00 Is the facility electing full federal capital payment	? Enter "	r tor yes						56
00 Is the facility electing full federal capital payment Teaching Hospitals 00 Is this a hospital involved in training residents in				" for yes	N			57
 00 Is the facility electing full federal capital payment Teaching Hospitals 00 Is this a hospital involved in training residents in or "N" for no. 00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y 	approved G eriod duri yes or "N h of this ", complet	ME programs ng which re ' for no ir cost report e Worksheet	s? Enter "Y esidents in n column 1. ting period?	approved If column Enter "Y	1 N			
 00 Is the facility electing full federal capital payment Teaching Hospitals 00 Is this a hospital involved in training residents in or "N" for no. 00 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 00 If line 56 is yes, did this facility elect cost reimb 	approved G eriod duri yes or "N h of this , complet , if appli ursement f	ME programs ng which re 'for no ir cost report e Worksheet cable. or physicia	s? Enter "Y esidents in n column 1. ting period? t E-4. If co	approved If column Enter "Y lumn 2 is	1 N			58.
 1s the facility electing full federal capital payment Teaching Hospitals 1s this a hospital involved in training residents in or "N" for no. 1f line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 1f line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes 	approved G eriod duri yes or "N h of this , complet ursement f complete W s, complete	ME programs ng which re 'for no ir cost report e Worksheet cable. or physicia cst. D-5. Wkst. D-2,	esidents in n column 1. ting period? t E-4. If co ans' service Pt. I.	approved If column Enter "Y lumn 2 is s as	1 N N N			59.
 1s the facility electing full federal capital payment Teaching Hospitals 1s this a hospital involved in training residents in or "N" for no. 1f line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 1f line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes 	approved G yes or "N h of this , complet , if appli ursement f complete W , complete costs for for yes or	ME programs "for no ir cost report e Worksheet cable. or physicia kst. D-5. Wkst. D-2, a program t "N" for no	Residents in n column 1. ting period? t E-4. If co ans' service Pt. I. that meets t <u>p. (see inst</u>	approved If column Enter "Y Iumn 2 is s as he ructions)	N " N N N			59
 18 the facility electing full federal capital payment Teaching Hospitals 18 this a hospital involved in training residents in or "N" for no. 19 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 10 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health 	approved G eriod duri yes or "N h of this , complet , if appli ursement f complete W , complete costs for	ME programs ng which re 'for no ir cost report e Worksheet cable. or physicia kst. D-5. Wkst. D-2, a program t	s? Enter "Y esidents in n column 1. ting period? t E-4. If co ans' service Pt. I. that meets t	approved If column Enter "Y Iumn 2 is s as he ructions)	1 N N N	Direc	t GME	
 1s the facility electing full federal capital payment Teaching Hospitals 1s 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 for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are you claiming nursing school and/or allied heal th provider-operated criteria under §413.85? Enter "Y" 	approved G yes or "N h of this , complet , if appli ursement f complete W , complete costs for for yes or	ME programs "for no ir cost report e Worksheet cable. or physicia kst. D-5. Wkst. D-2, a program t "N" for no	Residents in n column 1. ting period? t E-4. If co ans' service Pt. I. that meets t <u>p. (see inst</u>	approved If column Enter "Y Iumn 2 is s as s as he ructions) E II	1 " N N N N 00	5.	00	59 60
 18 the facility electing full federal capital payment Teaching Hospitals 18 this a hospital involved in training residents in or "N" for no. 19 If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II 10 If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes, Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health 	approved G eriod duri yes or "N h of this ", complet , if appli ursement f complete W , complete costs for for yes or Y/N 1.00	ME programs mg which re 'for no ir cost report e Worksheet cable. or physicia <st. d-5.<br="">Wkst. D-2, a program t "N" for no IME</st.>	6? Enter "Y esidents in n column 1. ting period? t E-4. If co ans' service Pt. I. that meets t Direct GM 3.00	approved If column Enter "Y Iumn 2 is s as s as he ructions) E II	1 N N N N ME	5.	00	59.

	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provider CC		eriod: rom 01/01/2016	Worksheet S-2 Part I	
				Te			
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
	Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)		0.00	0.00			61.
. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.00			61.
. 04	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.00			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		0.00	0.00			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)		0.00	0.00			61.
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	-
			1.00	2.00	3.00	4.00	1
	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 and enter in column 4, direct GME FTE unweighted count.				0.00	0.00) 61.
1	Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.				0.00	0.00) 61.
						1.00	
	ACA Provisions Affecting the Health Resources and Se					0.00	
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instru Enter the number of FTE residents that rotated from	ctions)				0.00	
	during in this cost reporting period of HRSA THC pro	gram. (s	see instruction		5		
	Teaching Hospitals that Claim Residents in Nonprovid Has your facility trained residents in nonprovider s			ost reporting p	eriod? Enter	N	63.
	"Y" for yes or "N" for no in column 1. If yes, compl	ete line	es 64-67. (see				
				Unweighted FTEs	Unweighted FTEs in	Ratio (col. 1/ (col. 1 + col.	
				Nonprovi der	Hospi tal	2))	
				Si te 1.00	2.00	3.00	-
	Section 5504 of the ACA Base Year FTE Residents in N	lonprovi	der Settings	1			
00	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facili in the base year period, the number of unweighted no resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighte	n <u>e June</u> ty trair n-primar all nor d non-pr	30, 2010. ned residents ry care nprovider rimary care	0. 00			64
	resident FTEs that trained in your hospital. Enter i of (column 1 divided by (column 1 + column 2)). (see	instruc	ctions)				
		instruc		Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	

leal th Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPL		ISPT. OF LAGRANGE CTY TA Provider (CCN: 15-1323 Pe	eriod: rom 01/01/2016	u of Form CMS-2 Worksheet S-2 Part I	
			To			pared:
	Program Name	Program Code	Unweighted	Unweighted	Ratio (col. 3/	
	3		FTEs Nonprovi der	FTEs in Hospital	(col. 3 + col. 4))	
-	1.00	2.00	Si te 3. 00	4.00	5.00	-
55.00 Enter in column 1, if line 63	1.00	2.00	0.00			65.00
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column						
4)). (see instructions)						
			Unweighted	Unweighted	Ratio (col. 1/	1
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Si te		,,,	
	·		1.00	2.00	3.00	
Section 5504 of the ACA Current Y beginning on or after July 1, 201		n Nonprovider Settin	igsEffective fo	or cost reporti	ng periods	
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 +	unweighted non-primar al. Enter in column 3	ry care resident 3 the ratio of	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
-	1.00	2.00	Si te	4.00	F 00	-
57.00 Enter in column 1, the program	1.00	2.00	3.00	4.00	5.00 0.000000	67.00
name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)						
				1.0	0 2 00 2 00	-
Inpatient Psychiatric Facility PF	ps			1.00	0 2.00 3.00	
70.00 Is this facility an Inpatient Psy	/chiatric Facility (I	PF), or does it con	tain an IPF subp	rovi der? N		70.00
Enter "Y" for yes or "N" for no. 71.00 If line 70 yes: Column 1: Did the recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFR Column 3: If column 2 is Y, indic (see instructions) Inpatient Rehabilitation Facility	e facility have an ap fore November 15, 20 umn 2: Did this faci & 412.424 (d)(1)(iii) cate which program ye	004? Enter "Y" for lity train resident (D)? Enter "Y" for	yes or "N" for n s in a new teach yes or "N" for n	io. (see ii ng io.	0	71.00
	abilitation Facility	/(IRF), or does it (contain an IRF	N		75.00
15.00 IS THIS FACILITY AN INDATIENT REP						1

HIGSPITAL_AND_HOSSPITAL_HEALTH CARE_COMPLEX_IDENTIFICATION DATA Provider_COL: 15-1323	Health Financial Systems COMMUNITY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
To 12/31/2016 Determine Program darg Term Gars Hospital (L10h)? Enter 'Y' for yes and 'W' for no. 1.00 00.00 is this a long term care hospital (L10h)? Enter 'Y' for yes and 'W' for no. N 80.00 01.0 is this a long term care hospital (L10h)? Enter 'Y' for yes and 'W' for no. N 80.00 01.0 is this a long term care hospital for any of the cost reporting period? Enter 'Y' for yes or 'W' for no. N 80.00 02.00 is this a new hospital care of the subgrowther (excluded unit) under 42 CFR Section 5413.40(f)(1)(1)? Enter 'Y' is no yes or 'W' for no. N 85.00 60.00 Did this facility excludies in the worther subgrowther (excluded unit) under 42 CFR Section 5413.40(f)(1)(0)(1)(1)(1)? Enter 'Y' is no yes or 'W' for no in the applicable colum. N 90.00 01.00 Did this facility by excludies colum. 1.00 2.00 90.00 90.00 01.00 Did this facility coreate and CF/110 Facility for purpose of title V and XIX? Enter 'N' for yes or 'W' for no in the applicable colum. N 90.00 02.00 Des this facility coreate and CF/110 Facility for purpose of 'W' for no in the applicable colum. 0.00 0.00 90.00 03.00 Des this facility coreate and CF/110 Facility for purpose of 'W' for no in the applicable colum. 0.00 0.00 90.00 03.00	HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provider C				2
Long Term Care Hospital PPS Example 1 Evaluation of the transmission of transmissing transmission of transmission of transmissing tra			epared:			
Book Description Description N B 0.0 0.0 15. This a lingtic collocated within another hospital for part or all of the cost reporting period? Inter N B 0.0 0.10.00 15. This a lingtic collocated within another hospital for part or all of the cost reporting period? Inter N B 0.0 0.10.00 15. This a new hospital under 42 CR Section \$133.40(7)(1)(1)? Enter "Y" for yes or "N" for no. N B 0.0 0.00 15. This a new hospital a "submit of classified under section 1886(d)(1)(3)(1v)(1)? Enter "Y" N B 0.0 0.10 15. This neglital "submit of the cost report elither in part? Enter" "Y" for yes or "N" for no. N B 0.0 0.10 15. This neglital "submit of the submit of the submit of the cost report elither in part? Enter" "For yes or "N" for no in the applicable colum. N N 90.00 10.00 15. This part of the submit o						
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In column 1 and termination date. if applicable, in column 2. 128.00 [fthis is a Medicare certified liver transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 128.00 [fthis is a Medicare certified lung transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 129.00 [fthis is a Medicare certified pancreas transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 [fthis is a Medicare certified intestinal transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 [fthis is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 130.00 [fthis is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, if applicable, in column 2. 131.00 [fthis is a Medicare certified other transplant center, enter the certification date in column 1 and termination date, in applicable, in column 2. 131.00 [fthis is an angen procurement organization (POP) unter in column 1 and termination date, in applicable, in column 2. 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Chapter 107 Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter the home office chain number. (see instructions) 140.00 141.00 Name: PARVIEW HEALTH SYSTEM, INC. Contractor's Name: WISCONSIN PHYSICIANSContractor's Number: 08101 141.00 142.00 City: FORT WWHE State: N 142.00
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134. 00 If this is an organ procurement organization (OPD), enter the OPD number in column 1 and termination date, if applicable, in column 2. All Providers 134. 00 140. 00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 1.00 Y 15H032 140. 00 11 this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 3.00 141. 00 142. 00 Name: PARKVIEW HEALTH SYSTEM, INC. Contractor's Name: WISCONSIN PHYSICIANS[Contractor's Number: 08101 141. 00 143. 00/er to 501 CORPORATE DRIVE P0 Box: 5600 142. 00 144. 00/Are provider based physicians' costs included in Worksheet A? Y 144. 00 144. 00/Are provider based physicians' costs included in Worksheet A? Y 144. 00 145. 00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for inpatient services only? Enter "Y" for yes or "N" for no in column 1. N N 145. 00 146. 00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in colum 2. N 146. 00 147. 00Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N
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period? Enter "Y" for yes or "N" for no in column 2. 146.00 Has the cost allocation methodology changed from the previously filed cost report? Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If N 146.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 147.00
146.00 Has the cost allocation methodology changed from the previously filed cost report? N 146.00 Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If yes, enter the approval date (mm/dd/yyyy) in column 2. 146.00 147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, §4020) If Image: Column 2. Image: Second
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no. N 147.00 148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.N147.00148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no.N148.00
148.00 Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 148.00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N 149.00
Part A Part B Title V Title XIX
1.00 2.00 3.00 4.00 Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)
155. 00 Hospi tal N N N 155. 00
156.00 Subprovi der - I PF N N N N 156.00
156.00 Subprovider - IPF N N N 156.00 157.00 Subprovider - IRF N N N N 157.00 158.00 SUBPROVIDER N N N N 158.00 159.00 SNF N N N N 159.00
156.00 Subprovider - IPF N N N 156.00 157.00 Subprovider - IRF N N N 157.00 158.00 SUBPROVIDER N N N 158.00 159.00 SNF N N N 159.00 160.00 HOME HEALTH AGENCY N N N 160.00
156.00 Subprovider - IPF N N N 156.00 157.00 Subprovider - IRF N N N 157.00 158.00 SUBPROVIDER N N N 158.00 159.00 SNF N N N N 159.00

Health Financial Systems	COMMUNITY HOSPT. C	F LAGRANGE CTY	IN		In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1323 Pe Fr To						Worksheet S- Part I Date/Time Pr 5/30/2017 12	epared:
		Part A	Part	В	Title V	Title XIX	
		1.00	2.00	C	3.00	4.00	
161.30 OUTPATIENT OCCUPATIONAL THERAPY			N		Ν	N	161. 30
161.40 OUTPATIENT SPEECH PATHOLOGY			N		N	N	161.40
						1.00	
Multicampus						1	
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.		•				N	165.00
	Name	County	State			FTE/Campus	
	0	1.00	2.00	3.0	0 4.00	5.00	
166.00 If line 165 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	0 166. 00
						1.00	
Health Information Technology (HI					ct	1	
167.00 Is this provider a meaningful user						Y	167.00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H			e 167 is '	'Y"), ei	nter the	19, 50	7168.00
168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a							168. 01
exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter th transition factor. (see instructions)						0. C	0169.00
	····· ·· /				Begi nni ng	Endi ng	
						2.00	
170.00 Enter in columns 1 and 2 the EHR k period respectively (mm/dd/yyyy)	eginning date and ending	date for the re	eporti ng		10/01/2015	09/30/2016	170.00
				_	1.00	2.00	-
171.00 If line 167 is "Y", does this prov	vider have any days for in	ndi vi dual s enrol	led in		N		0171.00
section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	eported on Wkst. S-3, Pt. mn 1. If column 1 is yes,	I, line 2, col	. 6? Ente				

In Lieu of Form CMS-2552-10 Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-1323 Period: Worksheet S-2 From 01/01/2016 Part II 12/31/2016 Date/Time Prepared: То 5/30/2017 12:53 pm Y/N Date 1.00 2.00 General Instruction: Enter Y for all YES responses. Enter N for all NO responses. Enter all dates in the mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS Provider Organization and Operation Has the provider changed ownership immediately prior to the beginning of the cost 1.00 Ν reporting period? If yes, enter the date of the change in column 2. (see instructions) V/I Y/N Date

1.00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 Ν 2.00 yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. Is the provider involved in business transactions, including management 3.00 Ν 3.00 contracts, with individuals or entities (e.g., chain home offices, drug or medical supply companies) that are related to the provider or its officers, medical staff, management personnel, or members of the board of directors through ownership, control, or family and other similar relationships? (see instructions) Y/N Date Туре 1.00 2.00 3.00 Financial Data and Reports Column 1: Were the financial statements prepared by a Certified Public Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 4.00 Y А 4.00 or "R" for Reviewed. Submit complete copy or enter date available in column 3. (see instructions) If no, see instructions. 5.00 Are the cost report total expenses and total revenues different from 5.00 Ν those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper 1.00 2.00 Approved Educational Activities Column 1: Are costs claimed for nursing school? Column 2: If yes, is the provider is Ν 6.00 6.00 the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 7.00 Ν 8.00 Were nursing school and/or allied health programs approved and/or renewed during the Ν 8.00 cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved graduate medical education 9.00 Ν 9.00 program in the current cost report? If yes, see instructions.

1.00

10.00	Was an approved Intern and Resident GME program initiated of	or renewed in t	the current	Ν		10.00
	cost reporting period? If yes, see instructions.					
11.00	Are GME cost directly assigned to cost centers other than I	& R in an App	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	
					1.00	
	Bad Debts				-1	
	Is the provider seeking reimbursement for bad debts? If yes				Y	12.00
13.00	If line 12 is yes, did the provider's bad debt collection p	oolicy change o	during this cos	t reporting	N	13.00
	period? If yes, submit copy.					
14.00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	Fyes, see insti	ructions.	N	14.00
	Bed Complement					
15.00	Did total beds available change from the prior cost reporti	ng period? If	yes, see instru	uctions.	N	15.00
		Par	rt A	Pa	rt B	
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16.00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17.00	Was the cost report prepared using the PS&R Report for	Y	04/30/2015	Y	04/30/2015	17.00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18.00	If line 16 or 17 is yes, were adjustments made to PS&R	Y		Y		18.00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19.00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

Health Financial Systems COM

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In Lieu of Form CMS-2552-10

HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CC	Provi der CCN: 15-1323 Pe Fr To		Worksheet S-2 Part II Date/Time Pre 5/30/2017 12:	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	Date 2.00	Y/N 3.00	 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 (EXCE 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 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 If yes, see instructions	d into during	this cost rep	orting period?	Ν	24.00
25.00	Have there been new capitalized leases entered into during the cost reporting period? If yes, see instructions.					25.00
26.00						26.00
27.00	Has the provider's capitalization policy changed during the copy.	Ν	27.00			
28.00	Interest Expense Were new loans, mortgage agreements or letters of credit en	N	28.00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	Ν	29.00			
30. 00	treated as a funded depreciation account? If yes, see instru- Has existing debt been replaced prior to its scheduled matu		debt? If yes,	see	Ν	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					
	Have changes or new agreements occurred in patient care ser arrangements with suppliers of services? If yes, see instru-	ctions.	0		N	32.00
33.00	If line 32 is yes, were the requirements of Sec. 2135.2 app 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 ar	rangement with	provi der-bas	ed physi ci ans?	N	34.00
35.00	If yes, see instructions.					35.00
	physicians during the cost reporting period? If yes, see in	structions.		V /N	Dete	
				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 off		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 othe		39.00			
40.00	see instructions. If line 36 is yes, did the provider render services to the	home office?	lfyes, see	Ν		40.00
	instructions.					
		1.	00	2.	00	
41.00		ERI C		NI CKESON		41.00
42.00	held by the cost report preparer in columns 1, 2, and 3, respectively.					42.00
42.00	preparer.	PARKVI EW HEALT	H SYSIEM, INC			42.00
43.00	Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	(260) 373-8406		ERI C. NI CKESON@I	YARKVI EW. CUM	43.00

Heal th F	Financial Systems CO	MMUNITY HOSPT.	OF L	AGRANGE	CTY IN	 In Lieu	u of Form CMS-	2552-10
HOSPI TAL	L AND HOSPITAL HEALTH CARE REIMBURSEMENT Q	JESTI ONNAI RE		Provi de	er CCN: 15-1323	eriod: rom 01/01/2016	Worksheet S-2 Part II	2
								epared: 53 pm
					3.00			
Co	ost Report Preparer Contact Information							
41.00 E	Enter the first name, last name and the tit	le/position	DIF	RECTOR,	REIMBURSEMENT			41.00
h	neld by the cost report preparer in columns	5 1, 2, and 3,						
r	respectively.							
42.00 E	Enter the employer/company name of the cost	report						42.00
р	preparer.							
43.00 E	Enter the telephone number and email addres	s of the cost						43.00
r	report preparer in columns 1 and 2, respect	i vel y.						

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1323	Period: From 01/01/2016 To 12/31/2016		pared
						I/P Days / O/P	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	<u>Visits / Trips</u> Title V	
		1.00	2.00	3.00	4.00	5.00	
. 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)	30. 00	25	5 9, 1	50 66, 960. 00	0	2. (
. 00	HMO I PF Subprovider						3.
. 00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	4.0
. 00	Hospital Adults & Peds. Swing Bed SNI Hospital Adults & Peds. Swing Bed NF					0	6.
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)		25	5 9, 1	50 66, 960. 00	0	7.
. 00	INTENSIVE CARE UNIT						8.
. 00	CORONARY CARE UNIT						9.
0.00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGI CAL INTENSI VE CARE UNI T						11.
2.00 3.00	OTHER SPECIAL CARE (SPECIFY) NURSERY	43.00				0	12. 13.
4.00	Total (see instructions)	43.00	25	9, 1	50 66, 960. 00	0	13.
5.00	CAH visits		20	7,1	50 00, 700.00	0	
5.00	SUBPROVIDER - IPF					0	16.
7.00	SUBPROVIDER - IRF						17
3. 00	SUBPROVI DER						18.
9.00	SKILLED NURSING FACILITY						19
0. 00	NURSING FACILITY						20
I. 00	OTHER LONG TERM CARE						21
2.00	HOME HEALTH AGENCY						22.
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.
1.00	HOSPI CE						24
1.10	HOSPICE (non-distinct part)	30.00					24
5.00	CMHC - CMHC						25
5. 10	CMHC - CORF	99.10				0	25
5. 20	CMHC - OUTPATIENT PHYSICAL THERAPY	99.20				0	
5.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	99.30				0	25
5.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	99.40				0	
5.00 5.25	RURAL HEALTH CLINIC	89.00				0	26
5.25 7.00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26)	69.00	25			0	20.
3.00	Observation Bed Days		23			0	
9.00	Ambulance Trips					0	20.
). 00). 00	Employee discount days (see instruction)						30.
1.00	Employee discount days (see first detroit)						31.
2.00	Labor & delivery days (see instructions)		(0		32.
2. 01	Total ancillary labor & delivery room						32.
	outpatient days (see instructions)						
3.00	LTCH non-covered days						33

ISPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CC		Period: From 01/01/2016 To 12/31/2016	Worksheet S-3 Part I Date/Time Pre 5/30/2017 12:	pare
		I/P Days	/ O/P Visits / Trips		Full Time E	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 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	762	25	1, 99	7		1.
00	HMO and other (see instructions)	566	215				2.
00	HMO I PF Subprovi der	0	215				3.
00	HMO I RF Subprovi der	0	0				4.
00	Hospital Adults & Peds. Swing Bed SNF	396	0	39	06		5.
00	Hospital Adults & Peds. Swing Bed NF		263	26			6.
00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 158	288	2, 65			7.
00	INTENSIVE CARE UNIT						8
00	CORONARY CARE UNIT						9
00	BURN INTENSIVE CARE UNIT						10
00	SURGI CAL INTENSI VE CARE UNI T						11
00	OTHER SPECIAL CARE (SPECIFY)		1.41		,		12
00	NURSERY	1 150	141 429	46	-	170 10	13
00 00	Total (see instructions) CAH visits	1, 158 0	429	3, 12	0.00	172.10	14
00	SUBPROVIDER - IPF	0	0		0		10
00	SUBPROVIDER - IRF						17
00	SUBPROVIDER						18
00	SKILLED NURSING FACILITY						19
00	NURSING FACILITY						20
00	OTHER LONG TERM CARE						21
00	HOME HEALTH AGENCY						22
00	AMBULATORY SURGICAL CENTER (D. P.)						23
00	HOSPI CE						24
10	HOSPICE (non-distinct part)	0	0		0		24
00	CMHC - CMHC						25
10	CMHC - CORF	0	0		0 0.00	0.00	
20	CMHC - OUTPATIENT PHYSICAL THERAPY	0	0		0 0.00	0.00	
30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0	0		0 0.00	0.00	
40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0	0		0 0.00	0.00	
00	RURAL HEALTH CLINIC	0	0		0 0 00	0.00	26
25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	
00	Total (sum of lines 14-26)		10	0.4	0.00	172.10	
00 00	Observation Bed Days	0	13	84	- /		28 29
00	Ambulance Trips Employee discount days (see instruction)	0			0		30
00	Employee discount days (see fistruction) Employee discount days - IRF				8		30
00	Labor & delivery days (see instructions)	О	5	18			32
. 00	Total ancillary labor & delivery room outpatient days (see instructions)	0	5		0		32
00	LTCH non-covered days	0					33

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provider CO	F	eriod: rom 01/01/2016 o 12/31/2016	Worksheet S-3 Part I Date/Time Pre 5/30/2017 12:	pared:
		Full Time		Di sch	arges		
	Component	Equi val ents Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions)		0	308	0	1, 009	1.00
3.00	HMO I PF Subprovi der				0		3.00
4.00	HMO I RF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)						6.00 7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL INTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	0.00	0	200	2.4	1 000	13.00
14.00	Total (see instructions)	0.00	0	308	34	1, 009	
15.00	CAH visits						15.00 16.00
16.00							17.00
17.00 18.00	SUBPROVI DER – I RF SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)						24.10
25.00	CMHC - CMHC						25.00
25.10	CMHC - CORF	0. 00					25.10
25.20	CMHC - OUTPATIENT PHYSICAL THERAPY	0.00					25.20
25.30	CMHC - OUTPATIENT OCCUPATIONAL THERAPY	0.00					25.30
25.40	CMHC - OUTPATIENT SPEECH PATHOLOGY	0.00					25.40
26.00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32.01	Total ancillary labor & delivery room						32.01
33.00	outpatient days (see instructions) LTCH non-covered days						33.00

Heal th	Financial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provider CC		Period:	Worksheet S-1	
					From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/30/2017 12:	
			1			0/00/2011 121	
						1.00	
	Uncompensated and indigent care cost co						
1.00	Cost to charge ratio (Worksheet C, Part		ivided by li	ne 202 column	8)	0. 276855	1.00
0.00	Medicaid (see instructions for each lir	ie)				F/F 400	0.00
2.00	Net revenue from Medicaid					565, 190	2.00
3.00 4.00	Did you receive DSH or supplemental pay If line 3 is "yes", does line 2 include		al navmanta	From Modicaid	2	YN	3.00 4.00
4.00 5.00	If line 4 is "no", then enter DSH or su				ſ	115, 691	5.00
6.00	Medi cai d charges	apprementar payments in				6, 256, 396	6.00
7.00	Medicaid cost (line 1 times line 6)					1, 732, 115	7.00
8.00	Difference between net revenue and cost	ts for Medicaid program	(line 7 min	us sum of lin	es 2 and 5: if	1, 051, 234	8.00
	< zero then enter zero)	1 5					
	Children's Health Insurance Program (CH	IIP) (see instructions ⁻	for each line	e)			
9.00	Net revenue from stand-alone CHIP					0	9.00
10.00	Stand-alone CHIP charges					0	10.00
	Stand-alone CHIP cost (line 1 times lin					0	11.00
12.00	Difference between net revenue and cost	ts for stand-alone CHIP	(line 11 mi	nus line 9; i	f < zero then	0	12.00
	enter zero) Other state or local government indiger	t care program (coo i p	structions f	ar each line)			
13.00	Net revenue from state or local indiger)	369, 672	13 00
14.00	Charges for patients covered under state					3, 333, 058	
14.00	10)	te of rocal margent ca				3, 333, 030	14.00
15.00	State or local indigent care program co	ost (line 1 times line	14)			922, 774	15.00
16.00	Difference between net revenue and cost	ts for state or local i	ndigent care	program (lin	e 15 minus line	553, 102	16.00
	13; if < zero then enter zero)						
47.00	Uncompensated care (see instructions for		<u> </u>				1 1 7 00
	Private grants, donations, or endowment					0	17.00
18.00 19.00	Government grants, appropriations or th				(our of lines	Ű	18.00
19.00	Total unreimbursed cost for Medicaid, 8, 12 and 16)	CHIP and State and Toc	ai indigent i	care programs	(sum of fines	1, 604, 336	19.00
				Uni nsured	Insured	Total (col. 1	
				patients	pati ents	+ col. 2)	
	1			1.00	2.00	3.00	
	Charity care charges for the entire fac			623, 65		1, 433, 578	
	Cost of patients approved for charity of		20)	172, 66		396, 893	
22.00	Partial payment by patients approved for			99		7, 739	
23.00	Cost of charity care (line 21 minus lin	ne 22)		171, 66	9 217, 485	389, 154	23.00
						1.00	
24.00	Does the amount in line 20 column 2 ind	clude charges for patie	nt days beyo	nd a length o	f stay limit	N	24.00
	imposed on patients covered by Medicaid			5	5		
	If line 24 is "yes," charges for patie			ogram's lengt	n of stay limit	0	25.00
	Total bad debt expense for the entire h					4, 434, 778	
27.00	Medicare bad debts for the entire hospi					212, 603	
	Non-Medicare and non-reimbursable Medic					4, 222, 175	
	Cost of non-Medicare and non-reimbursal		xpense (line	I TIMES II NE	28)	1, 168, 930	
	Cost of uncompensated care (line 23 col Total unreimbursed and uncompensated ca		Lino 20)			1, 558, 084 3, 162, 420	
51.00	Liorai ani chimai sen ana ancombensatea ca	are cost (inne is piùs	iiie 30)			3, 102, 420	1 31.00

				F T	rom 01/01/2016 o 12/31/2016	Date/Time Pre	nar
						5/30/2017 12:	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	<u>col. 4)</u> 5.00	+
GEN	VERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	0.00	
1	100 CAP REL COSTS-BLDG & FIXT		1, 516, 310	1, 516, 310			
	101 EMS WEST STATION		0	0			
	200 CAP REL COSTS-MVBLE EQUIP 201 EMS WEST STATION EQUIP.		0	0	541, 673 19, 794		
	300 OTHER CAP REL COSTS		0	0	0	0	
	400 EMPLOYEE BENEFITS DEPARTMENT	1, 527, 874	3, 005, 589	4, 533, 463	0	4, 533, 463	
	500 ADMINISTRATIVE & GENERAL	5, 449, 953	3, 386, 149	8, 836, 102	-384,340		5
1	600 MAINTENANCE & REPAIRS	0	0	0	0	070.452	
1	700 OPERATION OF PLANT 800 LAUNDRY & LINEN SERVICE	279, 101	717, 686 80, 800	996, 787 80, 800			
	900 HOUSEKEEPI NG	168, 460	40, 960				
00 010	DOO DI ETARY	343, 647	312, 858			227, 858	
	100 CAFETERI A	0	0	0			
	200 MAINTENANCE OF PERSONNEL	0	0	0 308, 901	0 -98		12
	300 NURSI NG ADMI NI STRATI ON 400 CENTRAL SERVI CES & SUPPLY	307, 790	1, 111 -44, 314	-44, 314			
	500 PHARMACY	471, 904	1, 326, 995				
	600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16
	700 SOCIAL SERVICE	0	0	0	0	0	
	900 NONPHYSI CI AN ANESTHETI STS 000 NURSI NG SCHOOL	0	0	0	0	0	19
	100 I&R SERVICES-SALARY & FRINGES APPRV	0	0		0	0	
	200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22
	300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	
	PATIENT ROUTINE SERVICE COST CENTERS					l .	
	000 ADULTS & PEDIATRICS	1, 602, 229	479, 963				
	300 NURSERY CI LLARY SERVI CE COST CENTERS	0	0	0	173, 178	173, 178	43
	DOO OPERATI NG ROOM	710, 824	352, 951	1, 063, 775	-5, 150	1, 058, 625	50
00 052	200 DELIVERY ROOM & LABOR ROOM	0	0	0			
	300 ANESTHESI OLOGY	0	809, 999			809, 999	
	400 RADI OLOGY-DI AGNOSTI C	647, 808	618, 281	1, 266, 089			
	000 LABORATORY 250 BLOOD CLOTTING FOR HEMOPHILIACS	0	983, 496	983, 496 0		983, 335 0	
	500 RESPI RATORY THERAPY	289, 167	11, 039	-	-	-	
	600 PHYSI CAL THERAPY	555, 759	12, 432	568, 191	-211, 195	356, 996	
	700 OCCUPATIONAL THERAPY	0	0	0			
	800 SPEECH PATHOLOGY 900 ELECTROCARDI OLOGY	0	0	0	77, 229	77, 229	68
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	536, 400	536, 400	-203, 396		
	200 I MPL. DEV. CHARGED TO PATIENTS	0	000, 100	0			
00 07:	300 DRUGS CHARGED TO PATIENTS	0	75	75			
	697 CARDI AC REHABI LI TATI ON	0	0	0	-	0	
	698 HYPERBARI C OXYGEN THERAPY 699 LI THOTRI PSY	0	0	0	-	0	
	TPATIENT SERVICE COST CENTERS	0	0	0	0	0	
00 090	DOO CLINIC	0	0	0	-	0	90
	001 LI FEBRI DGE SENI OR CARE	126, 251	104, 673				
	100 EMERGENCY	776, 130	1, 695, 095	2, 471, 225	-5, 744	2, 465, 481	
	200 OBSERVATION BEDS (NON-DISTINCT PART HER REIMBURSABLE COST CENTERS						92
	500 AMBULANCE SERVICES	966, 294	251, 432	1, 217, 726	-820	1, 216, 906	95
10 099	910 CORF	0	0	0	0	0	99
	920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	
	930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	
	940 OUTPATIENT SPEECH PATHOLOGY ECIAL PURPOSE COST CENTERS	0	0	0	0	0	99
	300 INTEREST EXPENSE		205, 595	205, 595	-205, 595	0	113
. 00	SUBTOTALS (SUM OF LINES 1-117)	14, 223, 191	16, 405, 575				
	VREI MBURSABLE COST CENTERS	1					1
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	6, 870			-,	
	200 PHYSI CI ANS' PRI VATE OFFI CES 950 OCCUPATI ONAL HEALTH	0	1, 432 -21, 105				192
	950 OCCOPATIONAL HEALTH 951 FOUNDATION	60, 554	-21, 105 7, 194			67, 748	
	952 COMMUNITY & VOLUNTEER SVCS	13, 487	127, 128			140, 615	
	954 ER PHYSICIAN	0	0	0		0	194
	953 SHI PSHEWANA RADI OLOGY AND LAB				0		194

Health Financial Systems	COMMUNITY HOSPT. OF L	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

RECLAS	SIFICATION AND ADJUSTMENTS OF IRTAL BALANCE O	F EXPENSES	Provider C	JN: 15-1323	From 01/01/2016 To 12/31/2016	Date/Time Pr	
	Cost Center Description	Adjustments (See A-8) 6.00	Net Expenses For Allocation 7.00			5/30/2017 12	:53 pm
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	16, 942					1.00
1.01	00101 EMS WEST STATION	C					1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP	C	011,070				2.00
2.01	00201 EMS WEST STATION EQUIP.	C	19, 794				2.01
3.00	00300 OTHER CAP REL COSTS	C	0 0				3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-826, 005					4.00
5.00	00500 ADMINISTRATIVE & GENERAL	-2, 333, 621	6, 118, 141				5.00
6.00	00600 MAINTENANCE & REPAIRS	C	, U				6.00
7.00	00700 OPERATION OF PLANT	-4, 683	965, 770				7.00
8.00	00800 LAUNDRY & LINEN SERVICE	C	80, 800				8.00
9.00	00900 HOUSEKEEPI NG	C	209, 395				9.00
10.00	01000 DI ETARY	C	227, 858				10.00
11.00	01100 CAFETERI A	-252, 963	172, 843				11.00
12.00	01200 MAINTENANCE OF PERSONNEL	C	0 0				12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	C	308, 803				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	C	-44, 388				14.00
15.00	01500 PHARMACY	C	526, 684				15.00
16.00	01600 MEDICAL RECORDS & LIBRARY	C	0 0				16.00
17.00	01700 SOCIAL SERVICE	C	0 0				17.00
19.00	01900 NONPHYSICIAN ANESTHETISTS	C	0				19.00
20.00	02000 NURSI NG SCHOOL	C	0				20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	C	0				21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	C	0				22.00
23.00	02300 PARAMED ED PRGM-(SPECIFY)	C	0				23.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	19, 046	1, 670, 788				30.00
43.00	04300 NURSERY	C	173, 178				43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	C	1, 058, 625				50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	C	590, 253				52.00
53.00	05300 ANESTHESI OLOGY	-788, 419	21, 580				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	-1,740	1, 182, 361				54.00
60.00	06000 LABORATORY	C	983, 335				60.00
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	C	0 0				62.30
65.00	06500 RESPI RATORY THERAPY	C	296, 342				65.00
66.00	06600 PHYSI CAL THERAPY	C	356, 996				66.00
67.00	06700 OCCUPATI ONAL THERAPY	C	131, 357				67.00
68.00	06800 SPEECH PATHOLOGY	-13,038	64, 191				68.00
69.00	06900 ELECTROCARDI OLOGY	C	0 0				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	C	333, 004				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	C	203, 359				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	-395, 853	876, 901				73.00
76.97	07697 CARDI AC REHABI LI TATI ON	C					76.97
76.98	07698 HYPERBARI C OXYGEN THERAPY	C	0 0				76.98
76.99	07699 LI THOTRI PSY	C	0 0				76.99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	C	0 0				90.00
90.01	09001 LI FEBRI DGE SENI OR CARE	C	232, 438				90. 01
91.00	09100 EMERGENCY	-660, 585	1, 804, 896				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS	1	-				
95.00	09500 AMBULANCE SERVI CES	C	1, 216, 906				95.00
99.10	09910 CORF	C	0 0				99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	C	0 0				99.20
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	C	0 0				99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	C	0 0				99.40
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE	C	0 0				113.00
118.00		-5, 240, 919	25, 367, 301				118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	6, 870				190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	C	872				192.00
194.00	07950 OCCUPATI ONAL HEALTH	C) 1				194.00
194.01	07951 FOUNDATI ON	C	67, 748				194.01
194.03	07952 COMMUNITY & VOLUNTEER SVCS	C	140, 615				194.03
	07954 ER PHYSICIAN	c c	0				194.04
194.06	07953 SHI PSHEWANA RADI OLOGY AND LAB	C	0				194.06
200.00	TOTAL (SUM OF LINES 118-199)	-5, 240, 919	25, 583, 407				200. 00
	•						

ASSI FI CATI ONS	Comme	JNITY HOSPT. OF	Provi der CCN: 15-1		<u>of Form CMS-2552</u> Vorksheet A-6
				To 12/31/2016	Date/Time Prepare 5/30/2017 12:53 p
Cost Contor	Increases	Salary	Other		
Cost Center 2.00	Li ne # 3.00	Salary 4.00	0ther 5.00		
A - REHAB THERAPY RECLASS					
OCCUPATIONAL THERAPY	67.00 68.00	128, 481 75, 538	2, 876 1, 691		1
SPEECH PATHOLOGY			<u> </u>		2
B - OB RECLASS		· · ·			
NURSERY	43.00	143, 674	29, 504		1
DELIVERY ROOM & LABOR ROOM	<u>52.00</u>	<u>489, 693</u> 633, 367	<u>100, 560</u> 130, 064		2
C - CLINIC DIETICIAN		000,007	100,001		
LIFEBRIDGE SENIOR CARE	90.01	<u> </u>	<u>0</u>		1
TOTALS F - CAFETERIA RECLASS		2, 159	0		
CAFETERIA	11.00	222, 218	203, 588		1
0		222, 218	203, 588		
G - INSURANCE RECLASS CAP REL COSTS-BLDG & FIXT	1.00	0	34, 736		1
CAP REL COSTS-BEDG & TTXT	2.00		12, 997		2
0		00	47,733		
H - DRUGS CHARGED TO PATIE			1 070 010		
DRUGS CHARGED TO PATIENTS	73.00 0.00	0	1, 273, 319 0		1
	0.00	0	0		
		•_	0		4
0 I – SALARY RECLASS		0	1, 273, 319		
ADMI NI STRATI VE & GENERAL	5.00	0	2, 699, 527		1
0		0	2, 699, 527		
J - OCCUPATIONAL HEALTH RE		0	21 10/		1
OCCUPATI ONAL HEALTH	194.00 0.00	0	21, 106 0		1
	0.00	Ő	0		3
	0.00	0	0		4
	0.00 0.00	0	0		6
	0.00	0	0		7
0		0	21, 106		
K - DEPRECIATION CAP REL COSTS-MVBLE EQUIP	2.00	0	499, 801		1
EMS WEST STATION	1.01	0	16, 040		2
EMS WEST STATION EQUIP.	2.01	о	18, 974		3
ADMI NI STRATI VE & GENERAL		0	<u>6, 892</u> 541, 707		4
L - BLDG & LEASE EXPENSE		<u> </u>	541,707		
CAP REL COSTS-BLDG & FIXT	1.00	0	88, 044		1
CAP REL COSTS-MVBLE EQUIP	2.00	0	28, 875		2
EMS WEST STATION EQUIP.	2. 01 0. 00	0	820 0		3
	0.00	Ő	0		Ę
	0.00	0	0		6
	0.00 0.00	0	0 0		3
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)	0.00	О	0		10
	0.00	0	0		11
	0.00 0.00	0	0		12
	0.00	ő	õ		14
	0.00	0	0		15
	0.00 0.00	0	0		16
	<u> </u>	0	117, 739		
M - INTEREST RECLASS	· · ·				
CAP REL COSTS-BLDG & FIXT		0	205, 595		1
U N - IMPLANTABLE MEDICAL SU	PPLI ES	U	205, 595		
IMPL. DEV. CHARGED TO	72.00	0	203, 359		1
PATI ENTS	<u>+</u> +				
0 0 - RECLASS HOSPITALIST FE	FS	0	203, 359		
	30.00	0	336,000		1
ADULTS & PEDIATRICS					

	Financial Systems SIFICATIONS		JNITY HOSPT. OF		CCN: 15-1323	Peri od:	u of Form CMS-2552 Worksheet A-6
						From 01/01/2016 To 12/31/2016	Date/Time Prepare
						10 12/01/2010	5/30/2017 12:53 p
	Cost Center	Decreases Li ne #	Salary	Other	_ Wkst. A-7 Ref	1	
	6.00	7.00	8.00	9.00	10.00	·	
	A - REHAB THERAPY RECLASS						
00	PHYSI CAL THERAPY	66.00	204, 019	4, 567		0	1.
00	L	0.00				ol	2.
			204, 019	4, 567	/		
00	B - OB RECLASS ADULTS & PEDIATRICS	30.00	633, 367	130, 064		0	1.
00 00	ADDETS & FEDTATRICS	0.00	033, 307	130,004		0	2.
			633, 367	130, 064			
	C - CLINIC DIETICIAN		· · · ·	· · · · ·		-	
00	DI ETARY	1000	<u>2, 1</u> 59	0		o	1.
	TOTALS		2, 159)		
~~	F - CAFETERIA RECLASS	10.00	000 010	000 500			
00	DI ETARY	<u>10.00</u>	<u>222, 2</u> 18 222, 218	20 <u>3, 5</u> 88 203, 588		0	1.
	G - INSURANCE RECLASS		222, 210	203, 360			
00	ADMI NI STRATI VE & GENERAL	5.00	0	47, 733	3 1	2	1.
00		0.00	Ö	() 1		2.
				47, 733		1	
	H - DRUGS CHARGED TO PATIENTS						
00	PHARMACY	15.00	0	1, 268, 050		0	1.
00	OPERATING ROOM	50.00	0	1, 442		0	2.
00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 804		0	3.
00	EMERGENCY	<u>91.00</u>	— — — -	23 1, 273, 319			4.
	I – SALARY RECLASS		U	1, 273, 315			
00	ADMI NI STRATI VE & GENERAL	5.00	2, 699, 527	()	0	1.
	0		2, 699, 527			1	
	J - OCCUPATIONAL HEALTH RECLAS	SS					
00	RADI OLOGY-DI AGNOSTI C	54.00	0	15, 340		0	1.
00	LABORATORY	60.00	0	161		0	2.
00	RESPI RATORY THERAPY	65.00	0	96		0	3.
00	PHYSICAL THERAPY	66.00	0	875		0	4.
00	MEDI CAL SUPPLI ES CHARGED TO PATI ENT	71.00	0	37		0	5.
00	DRUGS CHARGED TO PATIENTS	73.00	0	640		0	6.
00	EMERGENCY	91.00	Ö	3, 957		0	7.
			0	21, 106			
	K - DEPRECIATION				1		
00	CAP REL COSTS-BLDG & FIXT	1.00	0	541, 707	7	9	1.
00		0.00	0	C)	9	2.
00		0.00	0	0		9	3.
00		0.00	0	541, 707	<u> </u>	0	4.
	L - BLDG & LEASE EXPENSE		U	541,707	·		
00	OPERATION OF PLANT	7.00	0	25, 200) 1	0	1.
00	RADI OLOGY-DI AGNOSTI C	54.00	0	62, 844			2.
00	AMBULANCE SERVICES	95.00	0	820) 1	o	3.
00	ADMI NI STRATI VE & GENERAL	5.00	0	7,499		o	4.
00	OPERATION OF PLANT	7.00	0	1, 134		0	5
00	HOUSEKEEPING	9.00	0	25		0	6
00		10.00	0	682			7.
00 00	CENTRAL SERVICES & SUPPLY	14.00 15.00	0	74			8.
00	PHARMACY ADULTS & PEDIATRICS	15.00 30.00	U	4, 165 3, 019			9
00	OPERATING ROOM	30.00 50.00	0	3, 019		0	10
00	RESPI RATORY THERAPY	65.00	0	3, 768		ő	12
00	PHYSI CAL THERAPY	66.00	o	1, 734		0	13
00	EMERGENCY	91.00	o	1, 764		o	14
00	PHYSICIANS' PRIVATE OFFICES	192.00	0	560		o	15
00	LI FEBRI DGE SENI OR CARE	90.01	0	645	5	o	16
00	NURSING ADMINISTRATION	13.00	o	98		o	17
	0		0	117, 739			
	M - INTEREST RECLASS		1			-	
00	INTEREST EXPENSE	1 <u>13.</u> 00	0	205, 595		4	1.
	O	FS	U	205, 595	וו		
00	MEDICAL SUPPLIES CHARGED TO	71.00	0	203, 359		0	1.
	PATI ENT	, 1. 00	5	200,000		-	''
		+	+				

5.00

ō

0

3, 761, 290

203, 359

336, 000

336, 000

3,084,777

0

1.00

500.00

0 - RECLASS HOSPITALIST FEES

ADMI NI STRATI VE & GENERAL

500.00 Grand Total: Decreases

1.00

Heal th	Financial Systems COMM	UNITY HOSPT. OF	- LAGRANGE CTY	IN	In Li	eu of Form CMS-	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provider CC		Period: From 01/01/2010 To 12/31/2010	Worksheet A-7 6 Part I	pared:
				Acqui si ti on	IS		
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1,00	2.00	3,00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	BALANCES					
1.00	Land	282, 529	0		0	0 0	1.00
2.00	Land Improvements	1, 972, 720	0		0	o o	2.00
3.00	Buildings and Fixtures	13, 429, 858	0		0	o o	3.00
4.00	Building Improvements	29, 098	0		0	o o	4.00
5.00	Fixed Equipment	7, 798, 716	770, 217		0 770, 21	7 5, 888	5.00
6.00	Movable Equipment	7, 483, 570	1, 076, 759		0 1, 076, 75	9 620, 075	6.00
7.00	HIT designated Assets	1, 578, 837	19, 507		0 19, 50	7 0	7.00
8.00	Subtotal (sum of lines 1-7)	32, 575, 328	1, 866, 483		0 1, 866, 48	3 625, 963	8.00
9.00	Reconciling Items	34, 780	764, 948		0 764, 94	в о	9.00
10.00	Total (line 8 minus line 9)	32, 540, 548	1, 101, 535		0 1, 101, 53	625, 963	10.00
	· · · ·	Endi ng Bal ance	Fully				
		Ũ	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	282, 529					1.00
2.00	Land Improvements	1, 972, 720	452, 240				2.00
3.00	Buildings and Fixtures	13, 429, 858	46, 946				3.00
4.00	Building Improvements	29, 098	13, 778				4.00
5.00	Fixed Equipment	8, 563, 045	508, 867				5.00
6.00	Movable Equipment	7, 940, 254	3, 776, 236				6.00
7.00	HIT designated Assets	1, 598, 344	0				7.00
8.00	Subtotal (sum of lines 1-7)	33, 815, 848	4, 798, 067				8.00
9.00	Reconciling Items	799, 728	0				9.00
10.00	Total (line 8 minus line 9)	33, 016, 120	4, 798, 067				10.00

Heal th	Financial Systems COMM	UNITY HOSPT. OF	LAGRANGE CTY	IN	In Lieu of Form CMS-255			
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der CCN: 15-1323		Period: From 01/01/2016 To 12/31/2016		pared:	
			SU	JMMARY OF CAP	TAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)		
		9.00	10.00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	1, 516, 310	0		0 0	0	1.00	
1.01	EMS WEST STATION	0	0		0 0	0	1.01	
2.00	CAP REL COSTS-MVBLE EQUIP	0	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, 516, 310			0 0	0	3.00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum					
	·	Capi tal -Rel ate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15.00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM						
1.00	CAP REL COSTS-BLDG & FIXT	0	1, 516, 310				1.00	
1.01	EMS WEST STATION	0	0				1.01	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00	
2.01	EMS WEST STATION EQUIP.	0	0				2.01	
3.00	Total (sum of lines 1-2)	0	1, 516, 310				3.00	

		UNITY HOSPT. OF	- LAGRANGE CTY	IN	In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C		Period: From 01/01/2016 To 12/31/2016		oared:
		COMF	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col 2)	instructions)	Insurance	
		1.00	2.00	3.00	4,00	5.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		2100	0100		0100	
1.00	CAP REL COSTS-BLDG & FIXT	23, 956, 443	0	23, 956, 44	3 0. 747349	0	1.00
1.01	EMS WEST STATION	320, 808	0	320, 80	8 0. 010008	0	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	7, 707, 816	162, 280	7, 545, 53	6 0. 235392	0	2.00
2.01	EMS WEST STATION EQUIP.	232, 438	0	232, 43	8 0.007251	0	2.01
3.00	Total (sum of lines 1-2)	32, 217, 505	162, 280	32, 055, 22	5 1.000000	0	3.00
		ALLOCAT	TION OF OTHER (-		OF CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel ate				
			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	-		0 991, 545		1.00
1.01	EMS WEST STATION	0	0		0 16, 040		1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 499, 801		2.00
2.01	EMS WEST STATION EQUIP.	0	-		0 18, 974		2.01
3.00	Total (sum of lines 1-2)	0	-		0 1, 526, 360	117, 739	3.00
			Sl	JMMARY OF CAPI			
	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						
1.00	CAP REL COSTS-BLDG & FIXT	205, 595			0 0		1.00
1.01	EMS WEST STATION	0	0		0 0	10/010	1.01
2.00	CAP REL COSTS-MVBLE EQUIP	0	,	1	0 0		2.00
2.01	EMS WEST STATION EQUIP.	0	0		0 0	19, 794	2. 01
3.00	Total (sum of lines 1-2)	205, 595	47, 733		0 0	1, 897, 427	3.00

Heal th	Fi nan	ici al	Systems
AD JUST	MENTS	TO	EXPENSES

	Financial Systems MENTS TO EXPENSES	COMML	<u>INLEY HUSPT. OF</u>	LAGRANGE CTY IN Provider CCN: 15-1323	Peri od:	u of Form CMS-2 Worksheet A-8	
					From 01/01/2016 To 12/31/2016		pared
			-	Expense Classification To/From Which the Amount i			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
. 00	Investment income - CAP REL	1.00 B	2.00	3.00 CAP REL COSTS-BLDG & FIXT	4.00	5.00	1.0
. 01	COSTS-BLDG & FIXT (chapter 2) Investment income - EMS WEST		OE	EMS WEST STATION	1.01	0	1.0
00	STATION (chapter 2) Investment income - CAP REL			CAP REL COSTS-MVBLE EQUIP	2.00		
	COSTS-MVBLE EQUIP (chapter 2) Investment income - EMS WEST			EMS WEST STATION EQUIP.	2.01		
	STATION EQUIP. (chapter 2)			WIS WEST STATION EQUIT.			
. 00	Investment income - other (chapter 2)		0		0.00		
	Trade, quantity, and time discounts (chapter 8)		0		0.00		
. 00	Refunds and rebates of expenses (chapter 8)		0		0.00	0	5.0
. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.
00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.
. 00	Television and radio service	А	-4, 5500	OPERATION OF PLANT	7.00	0	8.
	(chapter 21) Parking lot (chapter 21)		0		0.00		
	Provider-based physician adjustment	A-8-2	-1, 693, 174			0	
1.00	Sale of scrap, waste, etc. (chapter 23)	A	-1330	DPERATION OF PLANT	7.00	0	11.
2.00	Related organization transactions (chapter 10)	A-8-1	-2, 204, 455			0	12.
	Laundry and linen service Cafeteria-employees and guests	В	0 -252, 963		0.00 11.00		
	Rental of quarters to employee		0		0.00		
5. 00	and others Sale of medical and surgical supplies to other than		Ο		0.00	0	16.
	patients Sale of drugs to other than		о		0.00	0	17.
	patients Sale of medical records and		0		0.00	0	18.
0.00	abstracts Nursing school (tuition, fees,		0		0.00	0	19.
	books, etc.) Vending machines		0		0.00		
	Income from imposition of interest, finance or penalty		0		0.00		
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.
	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	OF	RESPI RATORY THERAPY	65.00		23.
1.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	OF	PHYSI CAL THERAPY	66.00		24.
5.00	limitation (chapter 14) Utilization review - physicians' compensation		0 *	*** Cost Center Deleted **	* 114.00		25.
b. 00	(chapter 21) Depreciation - CAP REL COSTS-BLDG & FIXT		oc	CAP REL COSTS-BLDG & FIXT	1.00	0	26.
5. 01	Depreciation - EMS WEST		OE	EMS WEST STATION	1.01	0	26.
. 00	STATION Depreciation - CAP REL		oc	CAP REL COSTS-MVBLE EQUIP	2.00	0	27.
	COSTS-MVBLE EQUIP Depreciation - EMS WEST		OE	EMS WEST STATION EQUIP.	2.01	0	27.
	STATION EQUIP. Non-physician Anesthetist		0	NONPHYSI CI AN ANESTHETI STS	19.00		28.
9.00	Physicians' assistant Adjustment for occupational	A-8-3	О	DCCUPATI ONAL THERAPY	0.00	0	
	therapy costs in excess of limitation (chapter 14)						

ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1323	Period: From 01/01/2016		
					To 12/31/2016	Date/Time Pre 5/30/2017 12:	
				Expense Classification To/From Which the Amount i			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
81.00	Adjustment for speech pathology costs in excess of limitation (chapter 14)	A-8-3	0	SPEECH PATHOLOGY	68.00		31.0
32.00	CAH HIT Adjustment for Depreciation and Interest		0		0.00	0	32.0
33.00	HAF NET FEE EXPENSE	A	53, 362	ADMINISTRATIVE & GENERAL	5.00	0	33.0
33. 01	CAH HIT ADJ DEPR CARRYFRWD 2016	А	-3, 374	ADMI NI STRATI VE & GENERAL	5.00	0	33. 0
33. 02	CAH HIT ADJ DEPR CARRYFRWD 2015	A	-18, 320	ADMI NI STRATI VE & GENERAL	5.00	0	33. 0
33. 03	CAH HIT ADJ DEPR CARRYFRWD	А	-24, 262	ADMI NI STRATI VE & GENERAL	5.00	0	33. 0
33.04	CAH HIT ADJ DEPR CARRYFRWD	A	-57, 396	ADMINISTRATIVE & GENERAL	5.00	0	33.0

-82, 235 ADMI NI STRATI VE & GENERAL

2, 085 ADMI NI STRATI VE & GENERAL -13, 038 SPEECH PATHOLOGY

-395, 853 DRUGS CHARGED TO PATIENTS

-3, 151 ADMI NI STRATI VE & GENERAL

17, 940 CAP REL COSTS-BLDG & FIXT

4, 125 ADMI NI STRATI VE & GENERAL

-1, 740 RADI OLOGY-DI AGNOSTI C

19, 268 ADULTS & PEDIATRICS

-82, 612 ANESTHESI OLOGY

326, 782 ANESTHESI OLOGY

-5, 240, 919

-222 ADULTS & PEDIATRICS

-826, 005 EMPLOYEE BENEFITS DEPARTMENT

33.05

0 34.00

41.00

0 44.00

47.00

48.00

49.01

49.02

49.04

50.00

0 35.00

0 38.00

0 40.00

0

0

0 49.00

0

0

0 49.03

0

5.00

5.00

68.00

73.00

4.00

5.00

54.00

1.00

5 00

0.00

30.00

30.00

53.00

53.00

2013

2012

DEPREC

A/P

FOR A/R

33.05

34 00

35.00

38.00

40.00

41.00

44.00

47.00

48.00

49.00

49.01

49.02

49.03

49.04

50.00

CAH HIT ADJ DEPR CARRYFRWD

SPEECH THERAPY CONTRACTED

EKG INTERPRETATION COSTS

ADD-BACK OF DEMOLISHED ASSET

ADD-BACK OF DEMOLITION COSTS

TELEMETRY MONITORING EXPENSE

MEDICAL DIRECTOR ADDITIONAL

GROSS-UP ANESTHESIA EXPENSE

(Transfer to Worksheet A, column 6, line 200.)

TOTAL (sum of lines 1 thru 49)

(2) Basis for adjustment (see instructions).

B. Amount Received - if cost cannot be determined.

PHARMACY EMPLOYEE RX PURCHASES

MI SCELLANEOUS REVENUE

SELF INSURANCE

SUBSCRI PTI ONS

LOBBY % OF DUES &

ON-CALL PROF TIME

А

В

В

В

А

A

A

А

Α

A

A

А

A

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

(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu 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	8-1
OFFICE	COSTS			From 01/01/2016 To 12/31/2016		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost		
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED C	RGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	5.00	ADMINISTRATIVE & GENERAL	HOME OFFICE ALLOCATION	4, 721, 740	4, 820, 000	1.00
2.00	5.00	ADMINISTRATIVE & GENERAL	RELATED PARTY SUBSIDY ADJ.	0	2, 106, 195	2.00
3.00	0.00			0	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			4, 721, 740	6, 926, 195	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.

1103 1101	not been posted to worksheet A, cordining i and/or z, the amount arrowable should be marcated in cordining 4 or this part.					
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
	B INTERPRIATIONSHIP TO PELAT	TED OPCANIZATION(S) AND/OP HO				

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 LA	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 01/01/2016	Worksheet A-8-1 Date/Time Prepared: 5/30/2017 12:53 pm

					5/30/201/12:	<u>53 pili</u>
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF TRAM	NSACTIONS WITH RELATED C	RGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:				
1.00	-98, 260	0				1.00
2.00	-2, 106, 195	0				2.00
3.00	0	0				3.00
4.00	0	0				4.00
5.00	-2, 204, 455					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.

<u> </u>	103 1101	been posted to worksheet A,	cordinars i and/or 2, the amount arrowable should be rind cated in cordinar 4 of this part.	
		Rel ated Organi zati on(s)		
		and/or Home Office		
		Type of Business	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

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.

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

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

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

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

Heal th	Fi nanci al	Systems	
	ED DACED		

COMMUNI TY	HOSPT.	0F	LAGRANGE CTY IN	

In Lieu of Form CMS-2552-10 Worksheet A-8-2

Heal th	Financial Syste	ems CON	MMUNITY HOSPT. (OF LAGRANGE CTY	′ I N	In Lie	eu of Form CMS-	2552-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provider (Period:	Worksheet A-8	3-2
						From 01/01/2016		
						To 12/31/2016		
	What A Line #	Cast Contar (Dhusi si an	Total	Professi onal	Provi der	DCE Amount	5/30/2017 12:	
	Wkst. A Line #					RCE Amount	Physi ci an/Prov	
		Identifier	Remuneration	Component	Component		ider Component	
	1.00	0.00				6.00	Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		AGGREGATE-ANESTHESI OLOGY	406, 725		76, 261		3	
2.00		AGGREGATE-ANESTHESI OLOGY	702, 125			° °	3	
3.00		DR. A	30, 000		30, 000		0	3.00
4.00	91.00	AGGREGATE-EMERGENCY	1, 523, 276	660, 585	862, 691	0	0	4.00
5.00	30.00	DR. B	13, 390	0	13, 390	0 0	0	5.00
6.00	90.01	LIFEBRIDGE SENIOR CARE	14, 864	0	14, 864	l 0	0	6.00
7.00	0.00		0	0	C	o o	0	7.00
8,00	0.00		0	0	(0	0	
9.00	0.00		0	0	(0	
10.00	0.00			0			0	
200.00	0.00		2, 690, 380	1, 693, 174	997, 206		0	
200.00	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	200.00
	WKSL. A LINE #	I denti fi er	Limit	Unadjusted RCE			of Malpractice	
		rdentifier			Continuing	Share of col.		
					Education	12	Thisui ance	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1 00		AGGREGATE - ANESTHESI OLOGY	8.00				14.00 0	1.00
1.00			-				-	
2.00		AGGREGATE-ANESTHESI OLOGY	0				-	
3.00		DR. A	0	0	0	0	0	
4.00		AGGREGATE-EMERGENCY	0	0	C	0	0	
5.00		DR. B	0	0	C	0 0	0	
6.00		LIFEBRIDGE SENIOR CARE	0	0	C	0 0	0	
7.00	0.00		0	0	0	0 0	0	7.00
8.00	0.00		0	0	C	0 0	0	8.00
9.00	0.00		0	0	0	0 0	0	9.00
10.00	0.00		0	0	0	0 0	0	10.00
200.00			0	0	0	0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		Identi fi er	Component	Limit	Di sal l owance			
			Share of col.					
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		AGGREGATE - ANESTHESI OLOGY	0					1.00
2.00		AGGREGATE - ANESTHESI OLOGY	0	o o				2.00
3.00		DR. A		o o				3.00
4.00		AGGREGATE-EMERGENCY		0		-		4.00
5.00		DR. B		0				5.00
5.00 6.00		LIFEBRIDGE SENIOR CARE				°		6,00
				, o	-	°		
7.00	0.00			0		-		7.00
8.00	0.00		0	0	-	-		8.00
9.00	0.00		0					9.00
10.00	0.00		0	0		-		10.00
200.00			0	0	0	1, 693, 174		200.00

	LLOCATION - GENERAL SERVICE COSTS		Provider CC	F	eriod: rom 01/01/2016 o 12/31/2016		pared:
					LATED COSTS	5/30/2017 12:	53 pm
	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	
1 00	GENERAL SERVICE COST CENTERS	1 210 020	1 210 020				1.00
1.00 1.01 2.00 2.01	00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION 00200 CAP REL COSTS-MVBLE EQUIP 00201 EMS WEST STATION EQUIP.	1, 319, 920 16, 040 541, 673 19, 794	1, 319, 920 0	16, 040	541, 673 0	19, 794	1.00 1.01 2.00 2.01
4.00 5.00 6.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	3, 707, 458 6, 118, 141 0	238, 550 0	0 0 0	0 97, 897 0	000000000000000000000000000000000000000	4.00 5.00 6.00
7.00 8.00 9.00 10.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY	965, 770 80, 800 209, 395 227, 858	74, 970 4, 286 14, 028 56, 283	0 0 0 0	30, 767 1, 759 5, 757 23, 098	0	7.00 8.00 9.00 10.00
11. 00 12. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION	172, 843 0 308, 803	0 0	0 0 0 0	0	0 0 0	11.00 12.00 13.00
15. 00 16. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	-44, 388 526, 684 0	26, 735 23, 008 4, 541 0	0 0 0 0	10, 972 9, 442 1, 863 0	0	14.00 15.00 16.00 17.00
20. 00 21. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV		0 0 0	0 0 0	0 0 0	000000000000000000000000000000000000000	19.00 20.00 21.00
23.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY) I NPATI ENT ROUTI NE SERVICE COST CENTERS	0	0	0	0	0	22.00 23.00
	03000 ADULTS & PEDIATRICS 04300 NURSERY	1, 670, 788 173, 178	297, 070 4, 473	0			30.00 43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	1, 058, 625	169, 323	0	69, 487	0	50.00
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	590, 253 21, 580	21, 144 0	0	8, 677 0	0	52.00 53.00
	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS	1, 182, 361 983, 335 0	85, 492 33, 478 0	0 0 0	35, 084 13, 739 0		54.00 60.00 62.30
65.00 66.00 67.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	296, 342 356, 996 131, 357	17, 519 56, 113 0	0 0 0	7, 189 23, 028 0		65.00 66.00 67.00
68.00 69.00 71.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	64, 191 0 333, 004	0 0 0	0 0 0	0 0 0	0 0 0	68.00 69.00 71.00
72.00 73.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	203, 359 876, 901 0	0 0 0	0 0 0	0 0	0 0 0	72.00 73.00 76.97
76. 98	07698 HYPERBARI C 0XYGEN THERAPY 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76. 98 76. 99
90. 01	09000 CLI NI C 09001 LI FEBRI DGE SENI OR CARE	0 232, 438	0 15, 418	0	6, 327	0	90. 00 90. 01
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	1, 804, 896	117, 259	0	48, 121	0	91.00 92.00
	09500 AMBULANCE SERVI CES 09910 CORF	1, 216, 906 0	0	16, 040 0	0	19, 794 0	95.00 99.10
99.30	09920 OUTPATI ENT PHYSI CAL THERAPY 09930 OUTPATI ENT OCCUPATI ONAL THERAPY 09940 OUTPATI ENT SPEECH PATHOLOGY	0 0 0	0 0 0	0 0 0	0 0 0	0 0 0	99.20 99.30 99.40
113. 00 118. 00	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	25, 367, 301	1, 259, 690	16, 040	516, 956	19, 794	113. 00 118. 00
192.00 194.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES 07950 OCCUPATI ONAL HEALTH	6, 870 872 1	3, 778 56, 452 0	0 0 0	1, 550 23, 167 0	0	190. 00 192. 00 194. 00
194.03 194.04	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS 07954 ER PHYSICIAN	67, 748 140, 615 0	0 0 0	0 0 0	0 0 0	0	194. 01 194. 03 194. 04
194.06 200.00 201.00		0	0	0	0		194.06 200.00 201.00

Health Financial Systems	COMMUNITY HOSPT. 0	F LAGRANGE CTY	IN	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider C		eriod: rom 01/01/2016 o 12/31/2016		pared: 53 pm
			CAPITAL RE	LATED COSTS		
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)		EMS WEST STATI ON		EMS WEST STATION EQUIP.	
	0	1.00	1.01	2.00	2.01	
202.00 TOTAL (sum lines 118-201)	25, 583, 407	1, 319, 920	16, 040	541, 673	19, 794	202.00

	Financial Systems COMM LOCATION - GENERAL SERVICE COSTS	IUNI TY HOSPT. OF	LAGRANGE CTY Provider CC	CN: 15-1323 Pe	eriod: fom 01/01/2016 0 12/31/2016	of Form CMS-2 Worksheet B Part I Date/Time Pre 5/30/2017 12:	epared:
	Cost Center Description	EMPLOYEE BENEFITS DEPARTMENT		ADMI NI STRATI VE & GENERAL	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	
		4.00	4A	5.00	6.00	7.00	
	GENERAL SERVICE COST CENTERS						1.00
	DO101 EMS WEST STATION						1.00
2.00	DO200 CAP REL COSTS-MVBLE EQUIP						2.00
	DO201 EMS WEST STATION EQUIP.						2.01
	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 707, 458					4.00
1	DO500 ADMI NI STRATI VE & GENERAL DO600 MAI NTENANCE & REPAI RS	1, 012, 636	7, 467, 224	7, 467, 224 0	o		5.00
	DOTOD OPERATION OF PLANT	102, 758	1, 174, 265	483, 836	0	1, 658, 101	
	DO800 LAUNDRY & LINEN SERVICE	0	86, 845	35, 783	0	7, 062	
	DO900 HOUSEKEEPI NG	62, 023	291, 203	119, 985	0	23, 113	9.00
	D1000 DI ETARY	43, 912	351, 151	144, 686	0	92, 729	
		81, 815	254, 658	104, 927	0	0	
	D1200 MAI NTENANCE OF PERSONNEL D1300 NURSI NG ADMI NI STRATI ON	0 113, 321	0 422, 124	0 173, 929	0	0	
	01400 CENTRAL SERVICES & SUPPLY	113, 321	-6, 681	173, 424	0	44, 048	
	D1500 PHARMACY	173, 743	732, 877	301, 970	0	37, 907	
16.00	D1600 MEDICAL RECORDS & LIBRARY	0	6, 404	2, 639	0	7, 481	
	D1700 SOCIAL SERVICE	0	0	0	0	0	17.00
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	0	0	
	D2000 NURSING SCHOOL	0	0	0	0	0	
	D2100 I &R SERVICES-SALARY & FRINGES APPRV D2200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	
	D2300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	
	NPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					201.00
	D3000 ADULTS & PEDIATRICS	356, 711	2, 446, 482	1, 008, 037	0	489, 440	30.00
	04300 NURSERY	52, 897	232, 384	95, 750	0	7, 369	43.00
	ANCI LLARY SERVICE COST CENTERS	0(1 700	4 550 440	(40 . 44 0		070.0/0	1 50 00
	D5000 OPERATING ROOM D5200 DELIVERY ROOM & LABOR ROOM	261, 708 180, 293	1, 559, 143 800, 367	642, 418 329, 778	0	278, 969 34, 836	
	D5300 ANESTHESI OLOGY	180, 293	21, 580	329, 778 8, 892	0	34, 830 0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	238, 507	1, 541, 444	635, 126	0	140, 852	
	D6000 LABORATORY	0	1, 030, 552	424, 621	0	55, 157	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	62.30
	06500 RESPI RATORY THERAPY	106, 464	427, 514	176, 150	0	28, 863	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	129, 502	565, 639	233, 062	0	92, 450	
	D6800 SPEECH PATHOLOGY	47, 303 27, 811	178, 660 92, 002	73, 614 37, 908	0	0	
	06900 ELECTROCARDI OLOGY	0	,2,002	0,,,,00	o	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	333, 004	137, 209	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	203, 359	83, 791	0	0	
	07300 DRUGS CHARGED TO PATIENTS	0	876, 901	361, 312	0	0	
	07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C 0XYGEN THERAPY	0	0	0	0	0	
	07699 LI THOTRI PSY	0	0	0	0	0	
-	DUTPATIENT SERVICE COST CENTERS						, 0. , ,
	09000 CLI NI C	0	0	0	0	0	90.00
	09001 LI FEBRI DGE SENI OR CARE	47, 277	301, 460		0	25, 401	
	09100 EMERGENCY	285, 752	2, 256, 028	929, 558	0	193, 191	
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0				92.00
	09500 AMBULANCE SERVICES	355, 765	1,608,505	662, 757	0	0	95.00
	09910 CORF	0	1,000,000	002, 737	0	0	
	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	99.30
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	99.40
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	3, 680, 198	25, 255, 094	7, 331, 949	о	1, 558, 868	113.00
	IONREI MBURSABLE COST CENTERS	3,000,190	25, 255, 074	7, 331, 949	<u>Ч</u>	1, 556, 606	1110.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	12, 198	5, 026	0	6, 225	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	80, 491	33, 165	0		192.00
	07950 OCCUPATIONAL HEALTH	0	1	0	0		194.00
101 01	07951 FOUNDATION	22, 294	90, 042	37, 100	0		194.01
	07952 COMMUNITY & VOLUNTEER SVCS	4, 966	145, 581	59, 984	0		194.03
194.03			0	0	0	0	194.04
194.03 194.04	07954 ER PHYSICIAN	0	0	-			101 04
194.03 194.04 194.06	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	0	0	0	194.06
194.03 194.04		0	0 0 0	0	0	0	200. 00 201. 00

	Financial Systems COMM ALLOCATION - GENERAL SERVICE COSTS	<u>NUNITY HOSPT. OF</u>	Provider CC	N: 15-1323 P	eriod:	u of Form CMS-2 Worksheet B	2002-1
					rom 01/01/2016 o 12/31/2016	Date/Time Pre	pared:
	Cost Center Description	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY		5/30/2017 12: MAINTENANCE OF PERSONNEL	
	GENERAL SERVICE COST CENTERS	8.00	9.00	10.00	11.00	12.00	
1.00 1.01 2.00 2.01 4.00 5.00 6.00 7.00	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						1.00 1.0 2.00 2.0 4.00 5.00 6.00 7.00
8.00 9.00 10.00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY	129, 690 0 921	434, 301 24, 738	614, 225			8.0 9.0 10.0
13. 00 14. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	0 0 0	0 0 0 11, 751	0 0 0 0	359, 585 0 19, 485 0	0 0 0	
16. 00 17. 00 19. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0 0 0 0	10, 113 1, 996 0 0	0 0 0 0	0	0 0 0 0	16.00 17.00 19.00
21. 00 22. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	0 0 0	0 0 0 0	0 0 0 0	0 0 0	0 0 0 0	
30. 00 43. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	36, 377 2, 270	130, 572 1, 966	614, 225 0		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	19, 129 7, 704 0	74, 424 9, 294 0	0 0 0		0 0 0	
60. 00 62. 30	05400 RADI OLOGY-DI AGNOSTI C 06000 LABORATORY 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 06500 RESPI RATORY THERAPY	18, 481 0 0 1, 660	37, 577 14, 715 0 7, 700	0 0 0 0	0	0 0 0 0	
66. 00 67. 00 68. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	6, 381 2, 114 246	24, 664 0 0	0 0 0 0	26, 499	0 0 0	66.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION	000000000000000000000000000000000000000	0 0 0	0 0 0 0 0		0 0 0 0	71. 0 72. 0 73. 0
76. 98	07698 HYPERBAR C OXYGEN THERAPY 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76.9
90. 01 91. 00	09000 CLINIC 09001 LIFEBRIDGE SENIOR CARE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0 0 24, 797	0 6, 777 51, 540	0 0 0		0 0 0	90.0
99. 10	OTHER REI MBURSABLE COST CENTERS 09500 AMBULANCE SERVICES 09910 CORF	6, 147 0	0	0	-	0	99.1
99.30	09920 OUTPATI ENT PHYSI CAL THERAPY 09930 OUTPATI ENT OCCUPATI ONAL THERAPY 09940 OUTPATI ENT SPEECH PATHOLOGY SPECI AL PURPOSE COST CENTERS	0 0 0	0 0 0	0 0 0	-	0 0 0	99.30
118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	126, 227	407, 827	614, 225			113. 0 118. 0
192.00 194.00 194.01	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFICES 07950 OCCUPATI ONAL HEALTH 07951 FOUNDATI ON 07952 COMMUNI TY & VOLUNTEER SVCS	0 3,463 0 0 0	1, 661 24, 813 0 0 0	0 0 0 0 0	0	0 0 0	190. 0 192. 0 194. 0 194. 0 194. 0
194.04	07954 ER PHYSICIAN 07953 SHIPSHEWANA RADIOLOGY AND LAB Cross Foot Adjustments	0	0	0000		0 0	194. 0 194. 0 200. 0 201. 0
201.00		129, 690	434, 301	614, 225	359, 585		201.

		MMUNITY HOSPT. OF				u of Form CMS-	2552-10
CUST	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2016 To 12/31/2016	Worksheet B Part I Date/Time Pre 5/30/2017 12:	epared: 53 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	RECORDS & LI BRARY	SOCIAL SERVICE	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	16.00	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01	00101 EMS WEST STATION						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 EMS WEST STATION EQUIP.						2.01
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00 11.00	01000 DI ETARY 01100 CAFETERI A						10.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	615, 538					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	49, 118				14.00
15.00	01500 PHARMACY	0	2, 386	1, 106, 54			15.00
16.00 17.00	01600 MEDI CAL RECORDS & LI BRARY	0	0		0 18, 520 0 0	0	16.00 17.00
19.00	01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS	0	0			0	
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	
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	
23.00	02300 PARAMED ED PRGM-(SPECIFY)	0	0		0 0	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	215, 148	766	9	1 2,030	0	30.00
43.00	04300 NURSERY	24, 493	976	3		0	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	139, 486	8, 615	35		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	83, 481	3, 325	11		0	52.00
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 1, 329	1, 65	0 0 7 5,923	0	
60.00	06000 LABORATORY	0	1, 329	1, 81		0	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0	218		o o	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	159	11		0	66.00
67.00	06700 OCCUPATIONAL THERAPY	0	53	4		0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	6		5 94 0 0	0	68.00 69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	15, 115		0 0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	9, 229		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1, 090, 46	4 0	0	
76.97		0	0		0 0	0	
76.98 76.99		0	0			0	
70.99	OUTPATIENT SERVICE COST CENTERS	0	U		<u>0</u> 0	0	70.99
90.00		0	0		0 0	0	90.00
90. 01	09001 LI FEBRI DGE SENI OR CARE	0	36		0 0	0	
91.00		152, 930	3, 519	1, 66	7 8, 106	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
95.00	09500 AMBULANCE SERVICES	0	3, 292	10, 18	6 0	0	95.00
99.10	09910 CORF	0	-, _, _, _	,	0 0	0	
99.20	09920 OUTPATI ENT PHYSI CAL THERAPY	0	0		0 0	0	99. 20
99.30		0	0		0 0	0	
99.40	09940 OUTPATIENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS	0	0		0 0	0	99.40
113.00	D 11300 I NTEREST EXPENSE						113.00
118.00		615, 538	49, 024	1, 106, 54	3 18, 520	0	118.00
	NONREI MBURSABLE COST CENTERS						
	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES 07950 OCCUPATI ONAL HEALTH	0	13 0				192.00 194.00
	107951 FOUNDATION	0	53		0 0		194.00
	307952 COMMUNITY & VOLUNTEER SVCS	0	11		0 0		194.03
	4 07954 ER PHYSICIAN	0	0		0 0		194.04
	607953 SHI PSHEWANA RADI OLOGY AND LAB	0	0		0 0	0	194.06
200.00			~			~	200.00
201 04			()		ui ()	()	12UI U()
201.00	0	615, 538	49, 118	1, 106, 54	3 18, 520		202.00

IST A	LLOCATION - GENERAL SERVICE COSTS		Provider C		Period: From 01/01/2016	Worksheet B Part I	
					To 12/31/2016	Date/Time Pre 5/30/2017 12:	
				I NTERNS &	RESI DENTS	10/00/2017 12:	
	Cost Center Description	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOOL		RSERVICES-OTHER PRGMCOSTS	PARAMED ED PRGM	
		ANESTHETISTS		Y & FRI NGES APPRV	APPRV	PRGM	
		19.00	20.00	21.00	22.00	23.00	
	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		1				1 1.
	00101 EMS WEST STATION						1.
	00200 CAP REL COSTS-MVBLE EQUIP						2.
	00201 EMS WEST STATION EQUIP.						2.
	00400 EMPLOYEE BENEFITS DEPARTMENT						4
	00500 ADMI NI STRATI VE & GENERAL 00600 MAI NTENANCE & REPAI RS						5
	00700 OPERATION OF PLANT						7
	00800 LAUNDRY & LINEN SERVICE						8
	00900 HOUSEKEEPING						9
00	01000 DI ETARY						10
. 00	01100 CAFETERI A						11
	01200 MAINTENANCE OF PERSONNEL						12
	01300 NURSI NG ADMI NI STRATI ON						13
	01400 CENTRAL SERVICES & SUPPLY						14
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY						15
	01700 SOCIAL SERVICE						17
	01900 NONPHYSI CI AN ANESTHETI STS	(19
	02000 NURSI NG SCHOOL						20
	02100 I &R SERVICES-SALARY & FRINGES APPRV				0		21
. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV				0		22
00	02300 PARAMED ED PRGM-(SPECIFY)					0	23
	INPATIENT ROUTINE SERVICE COST CENTERS	1	T	1	1		
	03000 ADULTS & PEDIATRICS	(0 0	0	
	04300 NURSERY	() C		0 0	0	43
	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM				0 0	0	50
	05200 DELIVERY ROOM & LABOR ROOM		-		0 0	0	
	05300 ANESTHESI OLOGY				0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C				0 0	0	
00	06000 LABORATORY	(o c		0 0	0	60
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	(o c		0 0	0	62
	06500 RESPI RATORY THERAPY	() C		0 0	0	
	06600 PHYSI CAL THERAPY	() C		0 0	0	
	06700 OCCUPATIONAL THERAPY				0 0	0	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY					0	68
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT				0 0	0	
	07200 IMPL. DEV. CHARGED TO PATIENTS				0 0	0	
	07300 DRUGS CHARGED TO PATIENTS				0 0	0	
	07697 CARDI AC REHABI LI TATI ON	(o c		0 0	0	
98	07698 HYPERBARI C OXYGEN THERAPY	(o c		0 0	0	76
	07699 LI THOTRI PSY	() C)	0 0	0	76
	OUTPATIENT SERVICE COST CENTERS	1		1			1
	09000 CLINIC				0 0	0	
-	09001 LI FEBRI DGE SENI OR CARE 09100 EMERGENCY					0	
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART			1	0	0	91
	OTHER REIMBURSABLE COST CENTERS	1	1	1			1 12
	09500 AMBULANCE SERVICES	() C)	0 0	0	95
	09910 CORF	0) c		0 0	0	
	09920 OUTPATI ENT PHYSI CAL THERAPY	(o c		0 0	0	
	09930 OUTPATIENT OCCUPATIONAL THERAPY	(ol c		0 0	0	
	09940 OUTPATIENT SPEECH PATHOLOGY	(<u>и</u> С	n	0 0	0	99
	SPECIAL PURPOSE COST CENTERS 11300 INTEREST EXPENSE						1113
3.00 3.00		(o o	0	118
. 00	NONREI MBURSABLE COST CENTERS		۰ <u> </u>	1	J 0	0	
0. 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(0 0	0	190
	19200 PHYSI CI ANS' PRI VATE OFFI CES				0 0		192
	07950 OCCUPATI ONAL HEALTH				0 0		194
	07951 FOUNDATI ON	0) c		0 0		194
	07952 COMMUNITY & VOLUNTEER SVCS) C		0 0		194
	07954 ER PHYSICIAN) C		0 0		194
	07953 SHI PSHEWANA RADI OLOGY AND LAB	0			0 0		194
D. 00	5) C		0 0		200
			11 C	1	0	0	201
1.00 2.00	0			1	0 0		20

ST ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1323	Period: From 01/01/20	Worksheet B 16 Part I
				To 12/31/20	16 Date/Time Prepare
Cost Center Description	Subtotal	Intern &	Total		5/30/2017 12:53
		Residents Cost			
		& Post Stepdown			
		Adjustments			
	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS		ГГ			
00 00100 CAP REL COSTS-BLDG & FIXT					1
01 00101 EMS WEST STATION 00 00200 CAP REL COSTS-MVBLE EQUIP					1
01 00201 EMS WEST STATION EQUIP.					2
00 00400 EMPLOYEE BENEFITS DEPARTMENT					4
00 00500 ADMINI STRATI VE & GENERAL					5
00600 MAINTENANCE & REPAIRS					6
00700 OPERATION OF PLANT					7
00 00800 LAUNDRY & LINEN SERVICE					8
00 00900 HOUSEKEEPI NG 00 01000 DI ETARY					9
00 01100 CAFETERIA					11
00 01200 MAINTENANCE OF PERSONNEL					12
00 01300 NURSING ADMINI STRATI ON					13
00 01400 CENTRAL SERVICES & SUPPLY					14
00 01500 PHARMACY					15
00 01600 MEDI CAL RECORDS & LI BRARY					16
00 01700 SOCIAL SERVICE					17
00 01900 NONPHYSICIAN ANESTHETISTS 00 02000 NURSING SCHOOL					19 20
. 00 02000 NORSTING SCHOOL . 00 02100 I &R SERVICES-SALARY & FRINGES APPI	R/V				20
00 02200 I &R SERVICES-OTHER PRGM COSTS APPI					22
00 02300 PARAMED ED PRGM-(SPECIFY)					23
INPATIENT ROUTINE SERVICE COST CENTERS					
00 03000 ADULTS & PEDIATRICS	5, 012, 983		5, 012, 9		30
00 04300 NURSERY	373, 599	0	373, 5	599	43
ANCI LLARY SERVI CE COST CENTERS 00 05000 OPERATI NG ROOM	2, 768, 087	0	2, 768, 0	7.00	50
00 05200 DELIVERY ROOM & LABOR ROOM	1, 295, 971	1	2,708,0		52
00 05300 ANESTHESI OLOGY	30, 472	1	30, 4		53
00 05400 RADI OLOGY-DI AGNOSTI C	2, 427, 717		2, 427, 7		54
00 06000 LABORATORY	1, 526, 860	0	1, 526, 8	360	60
. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	-		0	62
	664, 707		664, 7		65
00 06600 PHYSI CAL THERAPY	950, 377		950, 3		66
00 06700 0CCUPATI ONAL THERAPY 00 06800 SPEECH PATHOLOGY	260, 401 133, 584		260, 4 133, 5		67
00 06900 ELECTROCARDI OLOGY	133, 304	0	155, 5	0	69
00 07100 MEDICAL SUPPLIES CHARGED TO PATIE	NT 485, 328		485, 3	-	71
00 07200 IMPL. DEV. CHARGED TO PATIENTS	296, 379	0	296, 3	379	72
. 00 07300 DRUGS CHARGED TO PATIENTS	2, 328, 677	0	2, 328, 6	577	73
. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	76
98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0	76
07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0		0	76
00 09000 CLINIC	0	o		0	90
01 09001 LI FEBRI DGE SENI OR CARE	468, 468		468, 4	-	90
00 09100 EMERGENCY	3, 670, 971		3, 670, 9		91
. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PA		0			92
OTHER REIMBURSABLE COST CENTERS	0 ()	,		207	
. 00 09500 AMBULANCE SERVICES	2, 290, 887	0	2, 290, 8	-	95
. 10 09910 CORF . 20 09920 OUTPATI ENT PHYSI CAL THERAPY	0	0		0	99
30 09930 OUTPATIENT OCCUPATIONAL THERAPY				0	99
40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0		0	99
SPECIAL PURPOSE COST CENTERS		· · · · · · · · · · · · · · · · · · ·			
3. 00 11300 I NTEREST EXPENSE					113
3. 00 SUBTOTALS (SUM OF LINES 1-117)	24, 985, 468	0	24, 985, 4	168	118
NONREI MBURSABLE COST CENTERS			05	107	
D. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTER			25, 1		190
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	234, 953	0	234, 9	103	192
4. 00 07950 OCCUPATI ONAL HEALTH 4. 01 07951 FOUNDATI ON	131, 010	0	131, (10	194 194
4. 03 07952 COMMUNITY & VOLUNTEER SVCS	206, 848		206, 8		194
4. 04 07954 ER PHYSI CI AN	200, 040	0	200, 0	0	194
4. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0		0	194
0.00 Cross Foot Adjustments	0	o o		0	200
1.00 Negative Cost Centers	0	0		0	201
2.00 TOTAL (sum lines 118-201)	25, 583, 407	0	25, 583, 4	107	202

Heal th	Fina	nci	al	Syste	ems		
		0E	CAL		DEI	ATED	C

ealth Financial Systems CO ALLOCATION OF CAPITAL RELATED COSTS	MMUNITY HOSPI. O	Provider C	CN: 15-1323 Pe	eriod: com 01/01/2016	u of Form CMS- Worksheet B Part II Date/Time Pre	
			CAPITAL REL		Date/Time Pre 5/30/2017 12:	53 pm
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	EMS WEST STATI ON	MVBLE EQUIP	EMS WEST STATION EQUIP.	
	0	1.00	1.01	2.00	2.01	
I. 00 OO100 CAP REL COSTS-BLDG & FIXT						1 1.00
I. 01 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 5. 00 00500 ADMINISTRATIVE & GENERAL	0	0 238, 550	0	0 97, 897	0	
5. 00 00600 MAI NTENANCE & REPAI RS	0	0		0	0	
00700 OPERATION OF PLANT	0	74, 970	0	30, 767	0	
. 00 00800 LAUNDRY & LINEN SERVICE	0	4, 286		1, 759	0	
0. 00 00900 HOUSEKEEPI NG 0. 00 01000 DI ETARY	0	14, 028 56, 283		5, 757 23, 098	0	
1. 00 01100 CAFETERIA	0	0		23, 098	0	
2.00 01200 MAINTENANCE OF PERSONNEL	0	0		0	0	
3. 00 01300 NURSING ADMINISTRATION	0	0	-	0	0	
4.00 01400 CENTRAL SERVICES & SUPPLY	0	26, 735		10, 972	0	
5. 00 01500 PHARMACY 6. 00 01600 MEDI CAL RECORDS & LI BRARY	0	23, 008 4, 541	0	9, 442 1, 863	0	
7. 00 01700 SOCIAL SERVICE	0	4, 541	0	1, 003	0	
9. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
0. 00 02000 NURSI NG SCHOOL	0	0	0	0	0	
1.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
2.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 3.00 02300 PARAMED ED PRGM-(SPECIFY)	0	-		0	0	
INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23.00
0. 00 03000 ADULTS & PEDI ATRI CS	0	297, 070	0	121, 913	0	30.00
3. 00 04300 NURSERY	0	4, 473	0	1, 836	0	43.00
ANCI LLARY SERVI CE COST CENTERS	0	140 222		40 497	0	
2.00 05200 DELIVERY ROOM & LABOR ROOM	0			69, 487 8, 677	0	
3. 00 05300 ANESTHESI OLOGY	0	0		0,0,7	0	
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	85, 492	0	35, 084	0	54.00
0. 00 06000 LABORATORY	0	33, 478		13, 739	0	
2. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 5. 00 06500 RESPIRATORY THERAPY	0	0 17 510		0 7, 189	0	
6. 00 06600 PHYSI CAL THERAPY	0	17, 519 56, 113		23, 028	0	
7. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	
8.00 06800 SPEECH PATHOLOGY	0	0	0	0	0	
9. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 2.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	-		0	0	
6. 97 07697 CARDI AC REHABI LI TATI ON	0	-		0	0	
6. 98 07698 HYPERBARI C OXYGEN THERAPY	0	-		0	0	
6. 99 07699 LI THOTRI PSY	0	0	0	0	0	76.99
0.00 09000 CLINIC	0	0	0	0	0	90.00
0. 01 09001 LI FEBRI DGE SENI OR CARE	0	-		6, 327	0	
1. 00 09100 EMERGENCY	0			48, 121	0	91.00
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
OTHER REI MBURSABLE COST CENTERS 5.00 09500 AMBULANCE SERVI CES	0	0	16, 040	0	19, 794	95.00
9. 10 09910 CORF	0	0	10,040	0	19, 794	
9. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	-	0	o	0	
9.30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	-		0	0	
9. 40 09940 OUTPATI ENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	99.40
13.00 11300 INTEREST EXPENSE						113.00
18.00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 259, 690	16, 040	516, 956	19, 794	118.00
NONREI MBURSABLE COST CENTERS						
20.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			1, 550		190.00
22. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			23, 167		192.00
94. 00 07950 OCCUPATI ONAL HEALTH 94. 01 07951 FOUNDATI ON	0	0	0	0		194. 00 194. 01
24. 03 07952 COMMUNITY & VOLUNTEER SVCS	0	0	0	0		194.01
94. 04 07954 ER PHYSI CI AN	0	0	0	o		194.04
94. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	0	0	0	194.06
00.00 Cross Foot Adjustments				~	~	200.00
01.00Negative Cost Centers02.00TOTAL (sum lines 118-201)	0	0 1, 319, 920	0 16, 040	0 541, 673		201.00 202.00
UZ. UU TIVIAL (SUII TITIES TIO-201)	I 0	1, 319, 920	10, 040	341,0/3	19, 794	1202.00

	Financial Systems COMN ATION OF CAPITAL RELATED COSTS COMN	<u>IUNI TY HOSPT. OF</u>	Provider C	CN: 15-1323 Pe	eriod: rom 01/01/2016	u of Form CMS- Worksheet B Part II	
				To			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					1.00
1.01	00101 EMS WEST STATION						1.01
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
2.01	00201 EMS WEST STATION EQUIP.		_				2.01
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0	226 447			4.00
5.00 6.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	336, 447	0	336, 447	0		5.00
7.00	00700 OPERATION OF PLANT	105, 737	0	21, 800	0	127, 537	
8.00	00800 LAUNDRY & LINEN SERVICE	6, 045	0	1, 612	0	543	8.00
9.00	00900 HOUSEKEEPI NG	19, 785	0	5, 406	0	1, 778	
10.00	01000 DI ETARY	79, 381	0	6, 519	0	7, 133 0	
12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0	0	4, 728	0	0	
13.00	01300 NURSI NG ADMI NI STRATI ON	0	0	7, 837	0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	37, 707	0	0	0	3, 388	14.00
15.00	01500 PHARMACY	32, 450	0	13, 606	0	2, 916	
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	6, 404	0	119	0	575	
17.00 19.00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
23.00	02300 PARAMED ED PRGM- (SPECIFY)	0	0	0	0	0	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	418, 983	0	45, 415	0	37, 644	30. 00
43.00	04300 NURSERY	6, 309	0		0	567	
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	238, 810	0		0	21, 458	
52.00	05200 DELIVERY ROOM & LABOR ROOM	29, 821	0	14, 859	0	2, 680	
53.00 54.00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	120, 576	0	401 28, 617	0	0 10, 834	
54.00 60.00	06000 LABORATORY	47, 217	0	19, 132	0	4, 243	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	
65.00	06500 RESPI RATORY THERAPY	24, 708	0	7, 937	0	2, 220	65.00
66.00	06600 PHYSI CAL THERAPY	79, 141	0	10, 501	0	7, 111	66.00
67.00 68.00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	3, 317 1, 708	0	0	
59.00 59.00	06900 ELECTROCARDI OLOGY	0	0	1,700	0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	6, 182	0	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	3, 775	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	16, 280	0	0	
	07697 CARDIAC REHABILITATION 07698 HYPERBARIC OXYGEN THERAPY	0	0	0	0	0 0	1
76.99		0	0	0	0	0	
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	0	0	0	0	0	
90.01 91.00	09001 LI FEBRI DGE SENI OR CARE 09100 EMERGENCY	21, 745 165, 380	0	5, 597	0	1, 954	
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	105, 380	0	41, 883	0	14, 860	91.00 92.00
, 2, 00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			I		/2.00
	09500 AMBULANCE SERVI CES	35, 834	0	29, 862	0	0	
	09910 CORF	0	0	0	0	0	
99.20		0	0	0	0	0	1 = -
99.30 99.40	09930 OUTPATIENT OCCUPATIONAL THERAPY 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	
77.40	SPECIAL PURPOSE COST CENTERS	<u> </u>	0			0	, , , , , , , , , , , , , , , , , , , ,
113.00	11300 INTEREST EXPENSE						113.00
118.00		1, 812, 480	0	330, 352	0	119, 904	118.00
100.00	NONREI MBURSABLE COST CENTERS	5, 328	0	224	0	470	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	5, 328	0	226 1, 494	0		190. 00 192. 00
	07950 OCCUPATI ONAL HEALTH	0	0	0	0		194. 00
	07951 FOUNDATI ON	0	0	1, 672	Ö		194.01
	07952 COMMUNI TY & VOLUNTEER SVCS	0	0	2, 703	0		194. 03
	07954 ER PHYSI CLAN	0	0	0	0		194.04
194.06 200.00	07953 SHI PSHEWANA RADI OLOGY AND LAB Cross Foot Adjustments	0	0	0	0	0	194.06 200.00
<u>ະ</u> ບບ. ປໄ		0			_		
201.00	Negative Cost Centers		Ω	n	OI.	0	201.00

	Financial Systems COMM TION OF CAPITAL RELATED COSTS	IUNI TY HOSPT. OI	F LAGRANGE CTY Provider C	CN: 15-1323 Pe	eriod: rom 01/01/2016	u of Form CMS- Worksheet B Part II Date/Time Pre	pared:
	Cost Center Description	LAUNDRY &	HOUSEKEEPING	DI ETARY		5/30/2017 12: MAINTENANCE OF	53 pm
		LINEN SERVICE 8.00	9.00	10.00	11.00	PERSONNEL 12.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	10.00	11.00	12.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
1.01 2.00	00101 EMS WEST STATION 00200 CAP REL COSTS-MVBLE EQUIP						1.01 2.00
2.00	00201 EMS WEST STATION EQUIP.						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE	8, 200					8.00
9.00	00900 HOUSEKEEPI NG	0	26, 969				9.00
10.00	01000 DI ETARY	58	1, 536				10.00
11.00 12.00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0		0	4, 728 0	0	11.00
12.00	01300 NURSI NG ADMI NI STRATI ON	0		0	256	0	12.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	730	0	0	0	14.00
15.00	01500 PHARMACY	0	628	0	280	0	15.00
16.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	124	0	0	0	16.00
17.00 19.00	01900 NONPHYSICIAN ANESTHETISTS	0		0	0	0	17.00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20.00
21.00	02100 I &R SERVI CES-SALARY & FRI NGES 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-(SPECIFY) I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0	0	0	0	23.00
30.00	03000 ADULTS & PEDI ATRI CS	2, 298	8, 108	94, 627	918	0	30.00
43.00	04300 NURSERY	144	122	0	105	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	1,210	4, 622	0	595	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	487	4, 022	0	356	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 169		0	596	0	54.00
60.00 62.30	06000 LABORATORY	0	914	0	0	0	60.00 62.30
65.00	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	105	478	0	297	0	65.00
66.00	06600 PHYSI CAL THERAPY	403	1, 532	0	348	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	134	0	0	74	0	67.00
68.00	06800 SPEECH PATHOLOGY	16	0	0	44	0	68.00
69.00 71.00	06900 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0	0	0	69.00 71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76.97
	07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY	0		0	0	0	•
/0. //	OUTPATIENT SERVICE COST CENTERS						, 0. , ,
90.00	09000 CLINIC	0	0	0	0	0	
	09001 LI FEBRI DGE SENI OR CARE	0	421	0	139	0	
91.00 92.00	09100 EMERGENCY 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	1, 568	3, 200	0	653	0	91.00 92.00
,2100	OTHER REI MBURSABLE COST CENTERS	1	1	1	I		/2.00
95.00	09500 AMBULANCE SERVICES	389	0	0	0	0	
99. 10 99. 20	09910 CORF 09920 OUTPATI ENT PHYSI CAL THERAPY	0	0	0	0	0	
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0		0	0	0	
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	
	SPECIAL PURPOSE COST CENTERS						
113.00 118.00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	7 091	25 225	04 427	1 441	0	113.00
118.00	NONREIMBURSABLE COST CENTERS	7, 981	25, 325	94, 627	4, 661	0	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	103	0	0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	219	1, 541	0	0		192.00
	07950 OCCUPATI ONAL HEALTH	0	0	0	0		194.00
	07951 FOUNDATION 07952 COMMUNITY & VOLUNTEER SVCS			0	50 17		194. 01 194. 03
	07954 ER PHYSICIAN	0	0	0	0	0	194.04
	07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	0	О	0	194.06
200.00	3					~	200. 00 201. 00
201.00 202.00		8, 200	26, 969	0 94, 627	0 4, 728		201.00
202.00		0,200	20,707	1 ,1,027	1, 720	0	

				То	12/31/2016	Date/Time Pre 5/30/2017 12:	pared: 53 pm
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	
		13.00	14.00	15.00	16.00	17.00	
	GENERAL SERVICE COST CENTERS	1					1.00
	DOTODICAP REL COSTS-BLOG & FIXT						1.00
	DO200 CAP REL COSTS-MVBLE EQUIP						2.00
	DO201 EMS WEST STATION EQUIP.						2. 01
	DO400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	DO500 ADMI NI STRATI VE & GENERAL DO600 MAI NTENANCE & REPAI RS						5.00 6.00
	DOTOD OPERATION OF PLANT						7.00
	DO800 LAUNDRY & LINEN SERVICE						8.00
	DO900 HOUSEKEEPING						9.00
	D1000 DI ETARY D1100 CAFETERI A						10.00 11.00
	D1200 MAINTENANCE OF PERSONNEL						12.00
	D1300 NURSI NG ADMI NI STRATI ON	8, 093					13.00
	01400 CENTRAL SERVICES & SUPPLY	0	21, 970				14.00
		0	1, 067	50, 947	7 000		15.00
	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE	0	0	0	7, 222	0	16.00 17.00
	D1900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
	D2000 NURSI NG SCHOOL	0	0	0	0	0	20.00
	D2100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
	D2200 I&R SERVICES-OTHER PRGM COSTS APPRV	0	0	0	0	0	22.00
-	D2300 PARAMED ED PRGM-(SPECIFY) NPATIENT ROUTINE SERVICE COST CENTERS	0	U	0	0	0	23.00
	D3000 ADULTS & PEDI ATRI CS	2, 828	343	4	792	0	30.00
-	D4300 NURSERY	322	436	2	156	0	43.00
	ANCI LLARY SERVICE COST CENTERS	1 024	2 052	1/	110	0	F0 00
	D5000 OPERATING ROOM D5200 DELIVERY ROOM & LABOR ROOM	1, 834 1, 098	3, 853 1, 487	16 5	118 0	0	50.00 52.00
	D5300 ANESTHESI OLOGY	0	0	0	0	0	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	594	76	2, 310	0	54.00
	D6000 LABORATORY	0	0	84	0	0	60.00
	D6250 BLOOD CLOTTING FOR HEMOPHILIACS D6500 RESPIRATORY THERAPY	0	0 97	0	0	0	62.30 65.00
	D6600 PHYSI CAL THERAPY	0	71	5	547	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	24	2	101	0	67.00
	D6800 SPEECH PATHOLOGY	0	3	0	37	0	68.00
		0	0	0	0	0	69.00
	D7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6, 762 4, 128	0	0	0	71.00 72.00
	D7300 DRUGS CHARGED TO PATIENTS	0	4, 120	50, 207	0	0	73.00
	D7697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	76.98
	D7699 LITHOTRIPSY DUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	76.99
	DOPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
	09001 LI FEBRI DGE SENI OR CARE	0	16	0	0	0	90. 01
	09100 EMERGENCY	2, 011	1, 574	77	3, 161	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
	09500 AMBULANCE SERVICES	0	1, 472	469	0	0	95.00
	09910 CORF	0	0	0	0	0	99.10
	09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	99. 20
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	0	0	0	
	09940 OUTPATIENT SPEECH PATHOLOGY SPECIAL PURPOSE COST CENTERS	0	U	0	U	0	99.40
	11300 I NTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	8, 093	21, 927	50, 947	7, 222	0	118.00
	NONREI MBURSABLE COST CENTERS		~	-	~		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	8	0	0		190. 00 192. 00
	07950 OCCUPATIONAL HEALTH	0	0	0	0		192.00 194.00
194.010	D7951 FOUNDATI ON	0	24	0	0	0	194. 01
	07952 COMMUNITY & VOLUNTEER SVCS	0	5	0	0		194.03
	07954 ER PHYSICIAN	0	0	0	0		194. 04 194. 06
194.06 C 200.00	07953 SHIPSHEWANA RADIOLOGY AND LAB Cross Foot Adjustments	0	0	0	0		194.06 200.00
			10.055				
200.00	Negative Cost Centers	0	19, 855	0	O		201. 00 202. 00

ALLUCA	TION OF CAPITAL RELATED COSTS		Provider (CCN: 15-1323 F	Period: From 01/01/2016	Worksheet B Part II	
					Го 12/31/2016	Date/Time Pre 5/30/2017 12:	
				INTERNS &	RESIDENTS		
	Cost Center Description	NONPHYSI CI AN ANESTHETI STS	NURSING SCHOO	L 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	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT		1				1.00
1.01	00101 EMS WEST STATION						1.01
2.00 2.01	00200 CAP REL COSTS-MVBLE EQUIP 00201 EMS WEST STATION EQUIP.						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00 3.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00
9.00	00900 HOUSEKEEPING						9.00
	01000 DI ETARY						10.00
	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL						11.00
	01300 NURSI NG ADMI NI STRATI ON						13.00
	01400 CENTRAL SERVICES & SUPPLY						14.00
	01500 PHARMACY						15.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16.00 17.00
	01900 NONPHYSICIAN ANESTHETISTS						19.00
	02000 NURSI NG SCHOOL			0			20.00
	02100 I & R SERVICES-SALARY & FRINGES APPRV			(-		21.00
	02200 I & R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECI FY)				0	0	22.00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS			1		0	23.00
30. 00	03000 ADULTS & PEDIATRICS						30. 00
43.00	04300 NURSERY						43.00
50.00	ANCILLARY SERVICE COST CENTERS						50.00
	05200 DELIVERY ROOM & LABOR ROOM						52.00
	05300 ANESTHESI OLOGY						53.00
	05400 RADI OLOGY-DI AGNOSTI C						54.00
	06000 LABORATORY 06250 BLOOD CLOTTING FOR HEMOPHILIACS						60.00
	06500 RESPI RATORY THERAPY						65.00
	06600 PHYSI CAL THERAPY						66.00
	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY						67.00 68.00
	06900 ELECTROCARDI OLOGY						69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT						71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS						72.00
	07300 DRUGS CHARGED TO PATIENTS 07697 CARDIAC REHABILITATION						73.00
	07698 HYPERBARI C OXYGEN THERAPY						76.98
76. 99	07699 LI THOTRI PSY						76.99
90.00	OUTPATIENT SERVICE COST CENTERS	1	1		1		90.00
	09001 LI FEBRI DGE SENI OR CARE						90.00
91.00	09100 EMERGENCY						91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
95 00	OTHER REIMBURSABLE COST CENTERS 09500 AMBULANCE SERVICES						95.00
	09910 CORF						99.10
	09920 OUTPATIENT PHYSICAL THERAPY						99.20
	09930 OUTPATIENT OCCUPATIONAL THERAPY 09940 OUTPATIENT SPEECH PATHOLOGY						99.30 99.40
77.40	SPECIAL PURPOSE COST CENTERS			1			99.40
	11300 INTEREST EXPENSE						113.00
118.00)	0 (0 0	0	118.00
190 00	NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190.00
	19200 PHYSI CLANS' PRI VATE OFFICES						190.00
194.00	07950 OCCUPATI ONAL HEALTH						194.00
							194.01
	07952 COMMUNI TY & VOLUNTEER SVCS 07954 ER PHYSI CI AN						194.03 194.04
	07953 SHI PSHEWANA RADI OLOGY AND LAB						194.04
200.00	Cross Foot Adjustments	0		0 0	0 0		200. 00
201.00	Negative Cost Centers	(0 0	0 0	0	201.00

LOCATION OF CAPITAL RELATED COSTS		Provider CC		Period: Worksheet From 01/01/2016 Part II To 12/31/2016 Date/Time	
				10 12/31/2016 Date/11me 5/30/2017	
Cost Center Description	Subtotal	Intern & Residents Cost	Total		
		& Post			
		Stepdown Adjustments			
	24.00	25.00	26.00		
GENERAL SERVICE COST CENTERS	1				1
00 00100 CAP REL COSTS-BLDG & FIXT 01 00101 EMS WEST STATION					1.
00 00200 CAP REL COSTS-MVBLE EQUIP					2.
01 00201 EMS WEST STATION EQUIP.					2.
00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.
00 00500 ADMINISTRATIVE & GENERAL 00 00600 MAINTENANCE & REPAIRS					5.
00 00700 OPERATION OF PLANT					7.
00 00800 LAUNDRY & LINEN SERVICE					8.
00 00900 HOUSEKEEPING 00 01000 DI ETARY					9. 10.
00 01100 CAFETERIA					10.
00 01200 MAINTENANCE OF PERSONNEL					12.
00 01300 NURSI NG ADMI NI STRATI ON					13.
00 01400 CENTRAL SERVICES & SUPPLY 00 01500 PHARMACY					14.
00 01500 PHARMACY 00 01600 MEDI CAL RECORDS & LI BRARY					15.
00 01700 SOCIAL SERVICE					17.
00 01900 NONPHYSICIAN ANESTHETISTS					19.
00 02000 NURSING SCHOOL 00 02100 I &R SERVICES-SALARY & FRINGES APPRV					20.
00 02100 I &R SERVICES-SALARY & FRINGES APPRV 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV					21.
00 02300 PARAMED ED PRGM-(SPECI FY)					23.
INPATIENT ROUTINE SERVICE COST CENTERS					
00 03000 ADULTS & PEDIATRICS 00 04300 NURSERY	611, 960 12, 477	0	611, 96 12, 47		30. 43.
ANCI LLARY SERVICE COST CENTERS	12,477	0	12,47	,	43.
00 05000 OPERATI NG ROOM	301, 461	0	301, 46	1	50.
00 05200 DELIVERY ROOM & LABOR ROOM	51, 370	0	51, 37		52.
00 05300 ANESTHESI OLOGY 00 05400 RADI OLOGY-DI AGNOSTI C	401 167, 105	0	40 167, 10		53. 54.
00 06000 LABORATORY	71, 590	0	71, 59		60.
. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0	62.
00 06500 RESPI RATORY THERAPY	35,842	0	35, 84		65.
00 06600 PHYSI CAL THERAPY 00 06700 OCCUPATI ONAL THERAPY	99, 659 3, 652	0	99, 65 3, 65		66. 67.
00 06800 SPEECH PATHOLOGY	1, 808	0	1, 80		68.
00 06900 ELECTROCARDI OLOGY	0	0		0	69.
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 00 07200 IMPL. DEV. CHARGED TO PATIENTS	12, 944 7, 903	0	12, 94 7, 90		71.
00 07300 DRUGS CHARGED TO PATIENTS	66, 487	0	66, 48		72.
97 07697 CARDI AC REHABI LI TATI ON	0	0		0	76.
98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0	76.
99 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0		0	76.
00 09000 CLINIC	0	0		0	90.
01 09001 LI FEBRI DGE SENI OR CARE	29, 872	0	29, 87		90.
00 09100 EMERGENCY 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	234, 367	0	234, 36	.7	91.
00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS		0			92.
00 09500 AMBULANCE SERVICES	68, 026	0	68, 02	6	95.
10 09910 CORF	0	0		0	99.
20 09920 OUTPATIENT PHYSICAL THERAPY 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		0	99. 99.
40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0		0	99.
SPECIAL PURPOSE COST CENTERS					
3. 00 11300 I NTEREST EXPENSE	4 77 4 66 4		4 77 (0.0		113.
3. 00 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	1, 776, 924	0	1, 776, 92	4	118.
D. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 144	0	6, 14	4	190.
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	90, 033	0	90, 03		192.
4.00 07950 OCCUPATIONAL HEALTH	0	0		0	194.
4. 01 07951 FOUNDATION 4. 03 07952 COMMUNI TY & VOLUNTEER SVCS	1, 746 2, 725	0	1, 74 2, 72		194. 194.
4. 03/07952/COMMUNITY & VOLUNTEER SVCS 4. 04/07954/ER PHYSICIAN	2,725	0	2,12	0	194.
4. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0		0	194.
0.00 Cross Foot Adjustments	0	0		o	200.
1.00 Negative Cost Centers 2.00 TOTAL (sum lines 118-201)	19,855	0	19,85		201.
/ UCL ULAL (SUM DES 8-701)	1, 897, 427	0	1, 897, 42	. /]	202.

ST ALLOCATION - STATISTICAL BASIS		Provider C	F	eriod: rom 01/01/2016	Worksheet B-1	
				0 12/31/2016	Date/Time Pre 5/30/2017 12:	
			LATED COSTS			
Cost Center Description	BLDG & FIXT (SQUARE FEET)	EMS WEST STATI ON	MVBLE EQUIP	EMS WEST STATION EQUIP.	EMPLOYEE BENEFI TS	
		(SQUARE FEET)			DEPARTMENT	
				(SQUARE FEET)	(GROSS SALARI ES)	
	1.00	1.01	2.00	2. 01	4.00	
GENERAL SERVICE COST CENTERS 00 00100 CAP REL COSTS-BLDG & FIXT	77, 906					1 1.
01 00101 EMS WEST STATION	0	9, 760				1.
00 00200 CAP REL COSTS-MVBLE EQUI P			77, 906			2.
01 00201 EMS WEST STATION EQUIP. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		9, 760 0	10, 069, 831	2.
00 00500 ADMI NI STRATI VE & GENERAL	14, 080	0	14, 080		2, 750, 426	
00 00600 MAI NTENANCE & REPAI RS	0	0	0	-	0	
00 00700 OPERATION OF PLANT 00 00800 LAUNDRY & LINEN SERVICE	4, 425	0	4, 425		279, 101 0	
00 00900 HOUSEKEEPI NG	828	0	828		168, 460	
. 00 01000 DI ETARY	3, 322	0	3, 322		119, 270	
. 00 01100 CAFETERIA . 00 01200 MAINTENANCE OF PERSONNEL	0	0	0	0	222, 218 0	
. 00 01300 NURSI NG ADMI NI STRATI ON	0	0	0	0	307, 790	
. 00 01400 CENTRAL SERVICES & SUPPLY	1, 578	0	1, 578		0	
	1, 358	0	1, 358		471, 904	
. 00 01600 MEDICAL RECORDS & LIBRARY . 00 01700 SOCIAL SERVICE	268	0	268		0	
. 00 01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	
. 00 02000 NURSI NG SCHOOL	0	0	0	0	0	
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	
INPATIENT ROUTINE SERVICE COST CENTERS		0		0		1 20
. 00 03000 ADULTS & PEDIATRICS	17, 534	0				
. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	264	0	264	0	143, 674	43
. 00 05000 OPERATING ROOM	9, 994	0	9, 994	0	710, 824	50
. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 248	0	1, 248		489, 693	52
. 00 05300 ANESTHESI OLOGY	0	0	0	-	0	
. 00 05400 RADI OLOGY-DI AGNOSTI C . 00 06000 LABORATORY	5, 046 1, 976	0	5, 046 1, 976		647, 808 0	
. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0		0	
00 06500 RESPI RATORY THERAPY	1,034	0	1, 034		289, 167	
. 00 06600 PHYSI CAL_THERAPY . 00 06700 0CCUPATI 0NAL_THERAPY	3, 312	0	3, 312 0		351, 740 128, 481	
. 00 06800 SPEECH PATHOLOGY	0	0		0	75, 538	
. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	
. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT	0	0	0	0	0	
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS . 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	
. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
. 99 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0	0	0	0	76
. 00 09000 CLINIC	0	0	0	0	0	90
. 01 09001 LI FEBRI DGE SENI OR CARE	910	0	910	0	128, 410	
. 00 09100 EMERGENCY	6, 921	0	6, 921	0	776, 130	
00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92
. 00 09500 AMBULANCE SERVICES	0	9, 760	0	9, 760	966, 294	95
. 10 09910 CORF	0	0	0	0	0	99
20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	
. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY . 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0		0	0	
SPECIAL PURPOSE COST CENTERS	0	0		0	0	1 ''
3.00 11300 INTEREST EXPENSE						113
8. 00 SUBTOTALS (SUM OF LINES 1-117)	74, 351	9, 760	74, 351	9, 760	9, 995, 790]118
NONREI MBURSABLE COST CENTERS 0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	223	0	223	0	0	190
2. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	3, 332	0	3, 332			192
4. 00 07950 OCCUPATI ONAL HEALTH	0	0	0	0	0	194
	0	0	0	0	60, 554	
4.03 07952 COMMUNITY & VOLUNTEER SVCS 4.04 07954 ER PHYSICIAN	0			0	13, 487 0	194
4. 06 07953 SHIPSHEWANA RADIOLOGY AND LAB	0	0	0	0		194
0.00 Cross Foot Adjustments						200
1.00 Negative Cost Centers			1			201

Health Financial Systems CO	MMUNITY HOSPT. O	F LAGRANGE CTY	IN	In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C		Period: From 01/01/2016	Worksheet B-1	
				To 12/31/2016		
		CAPI TAL RE	LATED COSTS			
Cost Center Description	BLDG & FIXT (SQUARE FEET)	EMS WEST STATION (SQUARE FEET)	· · · · · · · · · · · · · · · · · · ·	EMS WEST STATION EQUIP.	EMPLOYEE BENEFI TS DEPARTMENT	
				(SQUARE FEET)	(GROSS SALARI ES)	
	1.00	1.01	2.00	2.01	4.00	
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 319, 920	16, 040	541, 673	3 19, 794	3, 707, 458	202.00
203.00 Unit cost multiplier (Wkst. B, Part I 204.00 Cost to be allocated (per Wkst. B, Part II)) 16. 942469	1. 643443	6. 95290!	5 2.028074		203. 00 204. 00
205.00 Unit cost multiplier (Wkst. B, Part					0. 000000	205.00

ealth Financial Systems COM COST ALLOCATION - STATISTICAL BASIS	MUNITY HOSPT. O	F LAGRANGE CTY Provider C		In Lie eriod:	u of Form CMS- Worksheet B-1	
JUST ALLUCATION - STATISTICAL DASIS		Provider Co	F	rom 01/01/2016		
	-			o 12/31/2016	5/30/2017 12:	
Cost Center Description	Reconciliation	ADMI NI STRATI VE & GENERAL	MAINTENANCE & REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
			(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	
		5.00	(00	7.00	LAUNDRY)	
GENERAL SERVICE COST CENTERS	5A	5.00	6.00	7.00	8.00	
1. 00 00100 CAP REL COSTS-BLDG & FIXT						1.0
I. 01 00101 EMS WEST STATION						1.0
2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.01 00201 EMS WEST STATION EQUIP.						2.0
1. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5. 00 00500 ADMINI STRATI VE & GENERAL	-7, 467, 224	18, 122, 864				5.0
5. 00 00600 MAINTENANCE & REPAIRS	0		0	E0 401		6.0
7.00 00700 OPERATION OF PLANT 3.00 00800 LAUNDRY & LINEN SERVICE	0	1, 174, 265 86, 845		59, 401 253	10, 000	7.0 8.0
9. 00 00900 HOUSEKEEPI NG	0	291, 203	0	828	0	
10. 00 01000 DI ETARY	0	351, 151	0	3, 322	71	
1.00 01100 CAFETERIA 12.00 01200 MAINTENANCE OF PERSONNEL	0	254, 658	0	0	0	
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	422, 124	0	0	0	1
4.00 01400 CENTRAL SERVICES & SUPPLY	6, 681	0	0	1, 578	0	1
15.00 01500 PHARMACY	0	732, 877	0		0	
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE	0	6, 404	0	268 0	0	
19.00 01900 NONPHYSI CLAN ANESTHETI STS	0	0	0	0	0	
20. 00 02000 NURSI NG SCHOOL	0	0	0	0	0	
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	
INPATIENT ROUTINE SERVICE COST CENTERS		0	0		0	20.0
30. 00 03000 ADULTS & PEDIATRICS	0	2, 446, 482	0		2, 805	
13.00 04300 NURSERY	0	232, 384	0	264	175	43.0
ANCI LLARY SERVI CE COST CENTERS	0	1, 559, 143	0	9, 994	1, 475	50.0
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	800, 367	0		594	
53. 00 05300 ANESTHESI OLOGY	0	21, 580	0	-	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 50. 00 06000 LABORATORY	0	1, 541, 444	0	5, 046 1, 976	1, 425 0	
60.00 06000 LABORATORY 62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	1, 030, 552 0		1, 978	0	
55. 00 06500 RESPI RATORY THERAPY	0	427, 514	0	1, 034	128	
66.00 06600 PHYSI CAL THERAPY	0	565, 639	0	3, 312	492	
57. 00 06700 OCCUPATI ONAL THERAPY 58. 00 06800 SPEECH PATHOLOGY	0	178, 660	0	0	163 19	
59. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	1
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	333, 004	0		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	203, 359	0	0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS 76. 97 07697 CARDIAC REHABILITATION	0	876, 901 0	0	0	0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
76. 99 07699 LI THOTRI PSY	0	0	0	0	0	76.9
001000 001000 001000 00100000 001000000 001000000	0	0	0	0	0	90.0
20. 01 09001 LI FEBRI DGE SENI OR CARE	0	301, 460				
01.00 09100 EMERGENCY	0	2, 256, 028	0	6, 921	1, 912	
022.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.0
25. 00 09500 AMBULANCE SERVICES	0	1, 608, 505	0	0	474	95.0
29. 10 09910 CORF	0	0	0	0	0	
29. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0	0	0	
09.30 09930 OUTPATIENT OCCUPATIONAL THERAPY 09.40 09940 OUTPATIENT SPEECH PATHOLOGY	0		0 0	0	0	
SPECIAL PURPOSE COST CENTERS	0	0	0	0	0	77.4
13.00 11300 I NTEREST EXPENSE						113. 0
118.00 SUBTOTALS (SUM OF LINES 1-117)	-7, 460, 543	17, 794, 551	0	55, 846	9, 733	118. 0
NONREI MBURSABLE COST CENTERS	0	12, 198	0	223	0	190. 0
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	80, 491	0			192.0
94.00 07950 OCCUPATI ONAL HEALTH	0	1	0	0		194.0
194.01 07951 FOUNDATION	0	90, 042	0	0		194.0
194. 03 07952 COMMUNITY & VOLUNTEER SVCS 194. 04 07954 ER PHYSICIAN		145, 581 0		0		194. 0 194. 0
194. 06 07953 SHI PSHEWANA RADI OLOGY AND LAB	0	0	0	0		194.0
200.00 Cross Foot Adjustments						200. 0
201.00 Negative Cost Centers			_	1 450 101	120 400	201.0
202.00 Cost to be allocated (per Wkst. B, Part I)		7, 467, 224	0	1, 658, 101	129, 690	202.0
			1	1		1

Health Financial Systems CC	MMUNITY HOSPT. O	F LAGRANGE CTY	IN	In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-1323		eri od:	Worksheet B-1		
				rom 01/01/2016 o 12/31/2016		narod	
			1	0 12/31/2010	5/30/2017 12:		
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)		336, 447	C	127, 537	8, 200	204.00	
205.00 Unit cost multiplier (Wkst. B, Part		0. 018565	0. 000000	2. 147051	0. 820000	205.00	

COST A	Financial Systems COMM LLOCATION - STATISTICAL BASIS	MUNITY HOSPT. 0	Provider CC	N: 15-1323 F	Period:	u of Form CMS-2 Worksheet B-1	2002-10
					rom 01/01/2016 o 12/31/2016		
	Cost Center Description	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (MEALS SERVED)	CAFETERI A (FTE)	(NUMBER	ADMI NI STRATI ON (DI RECT NRSI NG	
		9.00	10.00	11.00	12.00	HRS) 13.00	
1 00	GENERAL SERVICE COST CENTERS		1				1.0
11.00 12.00 13.00 14.00 15.00 16.00 17.00 19.00 20.00 21.00 22.00	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 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I & SERVICES-SALARY & FRINGES APPRV 02200 I & SERVICES-OTHER PRGM COSTS APPRV 02200 PARAMED ED PRGM-(SPECIFY)	58, 320 3, 322 0 0 1, 578 1, 358 268 0 0 0 0 0 0 0 0 0 0 0 0 0	19, 171 0 0 0 0 0	8, 766 C 475 C 519 C C C C C C C C C C C C C C C C C C C		101, 554 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 1. \ 0\\ 2. \ 00\\ 2. \ 0\\ 4. \ 0\\ 5. \ 0\\ 6. \ 0\\ 7. \ 0\\ 8. \ 0\\ 9. \ 0\\ 10. \ 0\\ 10. \ 0\\ 11. \ 0\\ 12. \ 0\\ 13. \ 0\\ 14. \ 0\\ 15. \ 0\\ 14. \ 0\\ 15. \ 0\\ 16. \ 0\\ 17. \ 0\\ 20. \ 0\\ 21. \ 0\\ 22. \ 0\\ 23. \ 0\\ \end{array}$
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	17, 534		1, 702			30.00
43.00	04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	264	0	194	i 0	4, 041	43.00
52. 00 53. 00 54. 00 60. 00 62. 30 65. 00 66. 00 67. 00 68. 00 69. 00 71. 00 71. 00 72. 00 73. 00 76. 98 76. 98	05000 OPERATI NG ROOM 05200 DELI VERY ROOM & LABOR ROOM 05200 RAESTHESI 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 OCCUPATI ONAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07697 CARDI AC REHABI LI TATI ON 07698 HYPERBARI C OXYGEN THERAPY 07699 LI THOTRI PSY 0UTPATI ENT SERVI CE COST CENTERS 09000 CLI NI C	9,994 1,248 0 5,046 1,976 0 1,034 3,312 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1, 103 660 0 1, 105 0 551 646 138 81 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		23, 013 13, 773 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	50.00 52.00 53.00 60.00 62.30 65.00 66.00 67.00 68.00 69.00 71.00 72.00 73.00 76.92 76.98 76.98 76.99
90. 01 91. 00	09001 LIFEBRIDGE SENIOR CARE 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	910 6, 921		258 1, 210		0 25, 231	90. 0 91. 0 92. 0
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	95.00 99.10 99.20 99.30 99.40
113. 00 118. 00	11300 INTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117)	54, 765	19, 171	8, 642	2 0	101, 554	113. 00 118. 00
192.00 194.00 194.01 194.03 194.04 194.06 200.00	5	223 3, 332 0 0 0 0 0 0 0 0 0 0		0 0 93 31 0 0		0 0 0 0 0	190. 00 192. 00 194. 00 194. 00 194. 00 194. 00 200. 00
201. 00 202. 00		434, 301	614, 225	359, 585	5 O	615, 538	201. 0 202. 0

Health Financial Systems COM	IUNITY HOSPT. OF LAGRANGE CTY IN			In Lieu of Form CMS-2552-10			
COST ALLOCATION - STATISTICAL BASIS		Provider CO		Period: From 01/01/2016	Worksheet B-1		
		_		To 12/31/2016			
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF	NURSI NG		
	(SQUARE FEET)	(MEALS SERVED)	(FTE)	PERSONNEL	ADMI NI STRATI ON		
		· · · ·		(NUMBER			
				HOUSED)	(DIRECT NRSING		
					HRS)		
	9.00	10.00	11.00	12.00	13.00		
203.00 Unit cost multiplier (Wkst. B, Part I)	7. 446862	32. 039278	41.02042	0. 000000	6. 061189	203.00	
204.00 Cost to be allocated (per Wkst. B, Part II)	26, 969	94, 627	4, 72	во	8, 093	204.00	
205.00 Unit cost multiplier (Wkst. B, Part	0. 462431	4. 935945	0. 53935	7 0. 000000	0. 079692	205.00	

CUSIF	Financial Systems COMM LLOCATION - STATISTICAL BASIS		LAGRANGE CTY Provider CO	CN: 15-1323 P	eri od:	u of Form CMS- Worksheet B-1	
				F	rom 01/01/2016 o 12/31/2016	Date/Time Pre	
	Cost Center Description	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUI S.)	MEDI CAL RECORDS & LI BRARY (TI ME SPENT)	SOCIAL SERVICE (TIME SPENT)	5/30/2017 12: NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	<u>53 pm</u>
		REQUIS.) 14.00	15.00	16.00	17.00	19.00	
1 00	GENERAL SERVICE COST CENTERS	1					1.00
$\begin{array}{c} 1. \ 00\\ 1. \ 01\\ 2. \ 00\\ 2. \ 01\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 19. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\end{array}$	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 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I & SERVICES-SALARY & FRINGES APPRV 02200 I & SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	1, 082, 319 52, 580 0 0 0 0 0 0 0 0 0 0 0	438, 872 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10, 000 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0	0	$\begin{array}{c} 1. \ 00\\ 1. \ 0^{-}\\ 2. \ 00\\ 2. \ 0^{-}\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 7. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 13. \ 00\\ 15. \ 00\\ 15. \ 00\\ 15. \ 00\\ 15. \ 00\\ 16. \ 00\\ 22. \ 00\\ 22. \ 00\\ 23. \ 00\\ 23. \ 00\\ \end{array}$
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	16, 882	36	1, 096	0	0	30.00
43.00		21, 498	13	216	0	0	43.00
50.00	ANCI LLARY SERVI CE COST CENTERS	189, 833	140	164	0	0	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	73, 271	45	0	0	0	
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	29, 287	657	3, 198		0	54.00
60.00	06000 LABORATORY	0	720	0	0	0	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0	0	0	
65.00 66.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	4, 793 3, 513	0 47	758	-	0	
67.00	06700 OCCUPATIONAL THERAPY	1, 164	16	140		0	
68.00	06800 SPEECH PATHOLOGY	134	2	51	0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	333, 089	0	0	-	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	203, 359	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	432, 495	0	0	0	
76.97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0	0	0	0	
76. 99		0	0	0	0	0	76.9
90.00	OUTPATIENT SERVICE COST CENTERS	0	0	0	0	0	90.00
90.01	09001 LI FEBRI DGE SENI OR CARE	783	0	0	0	0	
91.00	09100 EMERGENCY	77, 534	661	4, 377	0	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
	OTHER REIMBURSABLE COST CENTERS						
95.00	09500 AMBULANCE SERVICES	72, 532	4, 040	0	0	0	
99.10		0	0	0	0	0	
99.20 99.30	09920 OUTPATI ENT PHYSI CAL THERAPY 09930 OUTPATI ENT OCCUPATI ONAL THERAPY	0	0	0	0	0	
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0	0	0	
77.40	SPECIAL PURPOSE COST CENTERS	<u> </u>	0	0	0	0	77.40
113.00	11300 I NTEREST EXPENSE						113.00
118.00		1, 080, 252	438, 872	10, 000	0	0	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	375	0	0	-		190. 00
	19200 PHYSI CI ANS' PRI VATE OFFI CES	278	0	0	0		192.00
	07950 OCCUPATIONAL HEALTH	0	0	0	0		194.00
	07951 FOUNDATION	1, 175 239	0	0	0		194. 01 194. 03
	07952 COMMUNI TY & VOLUNTEER SVCS 07954 ER PHYSI CI AN	239	0	0	0		194. 03
	07954 ER PHYSICIAN 07953 SHIPSHEWANA RADIOLOGY AND LAB		0	0	0		194.02
200.00			0	0	0	0	200.00
	5						200.00
201.00							
201.00 202.00		49, 118	1, 106, 543	18, 520	0	0	202.0

Health Financial Systems COMM	IUNI TY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS				Period: From 01/01/2016	Worksheet B-1	
				To 12/31/2016	Date/Time Pre 5/30/2017 12:	pared: 53 pm
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE		
	SERVICES &	(COSTED	RECORDS &		ANESTHETI STS	
	SUPPLY	REQUI S.)	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. 045382	2. 521334	1.852000	0. 000000	0.00000	203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	41, 825	50, 947	7, 222	2 0	0	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 020299	0. 116086	0. 722200	0. 000000	0.000000	205. 00

	Financial Systems COM LOCATION - STATISTICAL BASIS		E LAGRANGE CTY		Period:	u of Form CMS-255 Worksheet B-1	52-10
COST AL	LUCATION - STATISTICAL DASIS		TTOVIDEI C	F	rom 01/01/2016 o 12/31/2016	Date/Time Prepar	ared:
			INTEDNS &	RESIDENTS		5/30/2017 12:53	
	Cost Center Description	NURSING SCHOOL	SERVICES-SALAR Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM		
		(ASSI GNED	APPRV	APPRV	(ASSI GNED		
		TIME)	(ASSIGNED TIME)	(ASSI GNED TI ME)	TIME)		
		20.00	21.00	22.00	23.00		
	SENERAL SERVICE COST CENTERS			1			1 00
	00100 CAP REL COSTS-BLDG & FIXT 00101 EMS WEST STATION						1.00 1.01
2.00 0	00200 CAP REL COSTS-MVBLE EQUIP						2.00
	00201 EMS WEST STATION EQUIP. 00400 EMPLOYEE BENEFITS DEPARTMENT						2.01 4.00
	00500 ADMINISTRATIVE & GENERAL						4.00 5.00
	00600 MAINTENANCE & REPAIRS						6.00
	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.00 8.00
	00900 HOUSEKEEPING						9.00
	01000 DI ETARY						10.00
	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL						11.00 12.00
13.00 0	01300 NURSI NG ADMI NI STRATI ON					1	13.00
	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY						14.00 15.00
	01600 MEDICAL RECORDS & LIBRARY						16.00
	01700 SOCIAL SERVICE						17.00
	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	0					19.00 20.00
	02100 I & R SERVICES-SALARY & FRINGES APPRV	0	0				20.00
	02200 I & R SERVICES-OTHER PRGM COSTS APPRV			C			22.00
	D2300 PARAMED ED PRGM-(SPECIFY) NPATIENT ROUTINE SERVICE COST CENTERS				0	2	23.00
30.00 0	03000 ADULTS & PEDI ATRI CS	0	0				30. 00
	04300 NURSERY NCI LLARY SERVI CE COST CENTERS	0	0	C	0 0	4	43.00
	D5000 OPERATI NG ROOM	0	0	C	0 0	5	50.00
	D5200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0				53.00 54.00
60.00 0	06000 LABORATORY	0	0		0	6	60. 00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS 06500 RESPIRATORY THERAPY	0	0	0	0		62.30 65.00
	06600 PHYSI CAL THERAPY	0	0	c c	0		66. 00
	06700 OCCUPATIONAL THERAPY	0	0	C	0		67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0				68.00 69.00
71.00 0	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0		71.00
	07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	0	0	C C	0		72.00 73.00
	07697 CARDI AC REHABI LI TATI ON	0	0				76.97
	07698 HYPERBARI C OXYGEN THERAPY	0	0	C	0		76. 98
	07699 LITHOTRIPSY DUTPATIENT SERVICE COST CENTERS	0	0	C C	0 0		76. 99
90.00 0	09000 CLINIC	0	0	C	0 0		90.00
	09001 LI FEBRI DGE SENI OR CARE 09100 EMERGENCY	0	0	C	0		90. 01 91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		, 0		91.00 92.00
0	THER REIMBURSABLE COST CENTERS			1			~~ ~~
	09500 AMBULANCE SERVI CES 09910 CORF	0	0				95.00 99.10
	09920 OUTPATIENT PHYSICAL THERAPY	0	0	c c	0		99.20
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0	C	0		99.30
	09940 OUTPATIENT SPEECH PATHOLOGY	0	0	C	0	9	99. 40
113.001	1300 INTEREST EXPENSE						13.00
118.00	SUBTOTALS (SUM OF LINES 1-117) IONREI MBURSABLE COST CENTERS	0	0	C	0 0	11	18.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	19	90. 00
192.001	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	o		92.00
	07950 OCCUPATI ONAL HEALTH 07951 FOUNDATI ON	0					94.00 94.01
194.030	07952 COMMUNI TY & VOLUNTEER SVCS	0	0	c c	0	19	94.03
194 04 0	07954 ER PHYSICIAN	0	0	C	0 0		94.04
			^			140	
	07953 SHI PSHEWANA RADI OLOGY AND LAB Cross Foot Adjustments	0	0	C	0		94.06 00.00

Health Financial Systems C	OMMUNITY HOSPT. O	F LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider C	i	Period: From 01/01/2016	Worksheet B-1	
				To 12/31/2016	Date/Time Pre 5/30/2017 12:	epared: 53 pm
		I NTERNS &	RESI DENTS			
Cost Center Description	NURSI NG SCHOOL	SERVICES-SALAR Y & FRINGES	SERVICES-OTHE	R PARAMED ED PRGM		
	(ASSI GNED TI ME)	APPRV (ASSI GNED	APPRV (ASSI GNED	(ASSI GNED TI ME)		
	20.00	TIME) 21.00	TIME) 22.00	23.00		
202.00 Cost to be allocated (per Wkst. B, Part I)	0	0	(0 0		202.00
203.00 Unit cost multiplier (Wkst. B, Part	I) 0. 000000	0. 000000	0.00000	0. 000000		203.00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	0		0 0		204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 00000	0.000000		205.00

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-1323	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/30/2017 12:	pared 53 pm
			Title	XVIII	Hospi tal	Cost	
					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	<u> </u>
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1				4
30.00	03000 ADULTS & PEDIATRICS	5, 012, 983		5, 012, 98		0	
13.00	04300 NURSERY	373, 599		373, 59	99 0	0	43. (
	ANCI LLARY SERVICE COST CENTERS	0.7/0.007		0.740.00			1 - 0
50.00	05000 OPERATING ROOM	2, 768, 087		2, 768, 08		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 295, 971		1, 295, 97		0	
53.00	05300 ANESTHESI OLOGY	30, 472		30, 47		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 427, 717		2, 427, 71		0	
50.00	06000 LABORATORY	1, 526, 860		1, 526, 86		0	
52.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0		(() 70	0 0	0	
55.00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	664, 707	0	664, 70		0	
56.00		950, 377	0	950, 37		0	
57.00	06700 OCCUPATIONAL THERAPY	260, 401	0	260, 40		0	
58.00 59.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	133, 584	0	133, 58	0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	485, 328		485, 32	ů v	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	296, 379		296, 37		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	2,328,677		2, 328, 67		0	1
76.97	07697 CARDI AC REHABI LI TATI ON	2, 320, 077		2, 320, 01	0 0	0	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	
76.99	07699 LI THOTRI PSY	0			0 0	0	
0. 77	OUTPATIENT SERVICE COST CENTERS	0			<u> </u>	0	1 /0.
90.00	09000 CLINIC	0			0 0	0	90.
90.00	09001 LI FEBRI DGE SENI OR CARE	468, 468		468, 46	-	0	
91.00	09100 EMERGENCY	3, 670, 971		3, 670, 97		0	
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 302, 017		1, 302, 01		0	
	OTHER REIMBURSABLE COST CENTERS	,,,,		,, .	<u> </u>		1
95.00	09500 AMBULANCE SERVICES	2, 290, 887		2, 290, 88	37 0	0	95.
99.10	09910 CORF	0			0	0	99.
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0			0	0	99.
99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0			0	0	99.
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0			0	0	99.
	SPECIAL PURPOSE COST CENTERS				· · ·		1
113.00	11300 INTEREST EXPENSE						113.
200.00	Subtotal (see instructions)	26, 287, 485	0	26, 287, 48	35 0	0	200.
201.00	Less Observation Beds	1, 302, 017		1, 302, 01	17	0	201.
202.00	Total (see instructions)	24, 985, 468	0	24, 985, 46	68 0	0	202.

COMPU	I Financial Systems COMM TATION OF RATIO OF COSTS TO CHARGES	IUNI TY HOSPT. OF	Provider C		Period:	u of Form CMS-2 Worksheet C	
					From 01/01/2016	Part I	
					To 12/31/2016	Date/Time Pre 5/30/2017 12:	53 pm
			Title	XVIII	Hospi tal	Cost	00 pm
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
						Ratio	
	INDATIENT DOUTINE SEDVICE COST CENTERS	6.00	7.00	8.00	9.00	10.00	
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	6, 260, 574		6, 260, 5	7.4		30.00
43.00	04300 NURSERY	557, 111		557, 1			43.00
43.00	ANCI LLARY SERVICE COST CENTERS	557, 111		557,1			43.00
50.00	05000 OPERATING ROOM	3, 227, 696	12, 234, 462	15, 462, 15	0. 179023	0. 000000	50.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	475,034	1, 423, 262			0.000000	
53.00	05300 ANESTHESI OLOGY	341, 116	1, 423, 202	1 1		0.000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 311, 531	21, 396, 690			0.000000	
60.00	06000 LABORATORY	1, 283, 268	6, 312, 926			0.000000	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	1, 203, 200	0, 312, 720	7, 370, 1	0 0.000000	0.000000	
65.00	06500 RESPI RATORY THERAPY	531,862	1, 854, 581	2, 386, 44		0.000000	
66.00	06600 PHYSI CAL THERAPY	247, 498	1, 363, 155			0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	283, 694	305, 714			0.000000	•
68.00	06800 SPEECH PATHOLOGY	38, 590	82, 889			0.000000	
69.00	06900 ELECTROCARDI OLOGY	00,070	02,007	121, 1	0 0.000000	0. 000000	•
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	461, 187	1, 548, 347	2, 009, 53		0. 000000	•
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	510, 895	463, 523			0. 000000	•
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 317, 785	5, 686, 570			0. 000000	•
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0.000000	0. 000000	•
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0.000000	0. 000000	
76.99	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	1 90. OC
90. 01	09001 LI FEBRI DGE SENI OR CARE	0	647, 746	647, 74	46 0. 723228	0.000000	90.01
91.00	09100 EMERGENCY	451, 472	12, 006, 870	12, 458, 34	0. 294660	0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 127, 365	1, 127, 30	1. 154921	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
95.00	09500 AMBULANCE SERVI CES	0	3, 997, 757	3, 997, 7	57 0. 573043	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	D 11300 I NTEREST EXPENSE						113.00
200.00		18, 299, 313	71, 948, 116	90, 247, 42	29		200.00
201.00							201.00
202.00) Total (see instructions)	18, 299, 313	71, 948, 116	90, 247, 42	29		202.00

	MUNITY HOSPI. OF	LAGRANGE CIY IN	In Lieu	u of Form CMS-2552-
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1323	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared 5/30/2017 12:53 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient Ratio 11.00			
INPATIENT ROUTINE SERVICE COST CENTERS	11.00			
30. 00 03000 ADULTS & PEDI ATRI CS				30.0
43. 00 04300 NURSERY				43.0
ANCI LLARY SERVI CE COST CENTERS				
50. 00 05000 OPERATING ROOM	0.000000			50.0
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52.0
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.0
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.0
60. 00 06000 LABORATORY	0. 000000			60. 0
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62.3
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.0
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 0
67.00 06700 OCCUPATIONAL THERAPY	0. 000000			67.0
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.0
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.0
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000			71. (
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000			72.0
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.0
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 9
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76.9
76. 99 07699 LI THOTRI PSY	0. 000000			76.9
OUTPATIENT SERVICE COST CENTERS	•			
90. 00 09000 CLINIC	0. 000000			90. (
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 000000			90.0
91.00 09100 EMERGENCY	0. 000000			91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92.0
OTHER REIMBURSABLE COST CENTERS				
95.00 09500 AMBULANCE SERVICES	0. 000000			95.0
99. 10 09910 CORF				99. 1
99. 20 09920 OUTPATIENT PHYSICAL THERAPY				99. 2
99.30 09930 OUTPATIENT OCCUPATIONAL THERAPY				99. 3
99. 40 09940 OUTPATIENT SPEECH PATHOLOGY				99. 4
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113. (
200.00 Subtotal (see instructions)				200. (
201.00 Less Observation Beds				201. (

COMPUTA	ITION OF RATIO OF COSTS TO CHARGES		Provider CO		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/30/2017 12:	epared: 53 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	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	5 010 000		5 010 00		5 010 000	
	03000 ADULTS & PEDIATRICS	5, 012, 983		5, 012, 98		5, 012, 983	
	04300 NURSERY	373, 599		373, 59	9 0	373, 599	43.00
	ANCILLARY SERVICE COST CENTERS	0.7/0.007	1	0.7/0.00	-	0 7/0 007	
	05000 OPERATING ROOM	2, 768, 087		2, 768, 08		2, 768, 087	
	05200 DELIVERY ROOM & LABOR ROOM	1, 295, 971		1, 295, 97		1, 295, 971	
	05300 ANESTHESI OLOGY	30, 472		30, 47		30, 472	
	05400 RADI OLOGY-DI AGNOSTI C	2, 427, 717		2, 427, 71		2, 427, 717	
	06000 LABORATORY	1, 526, 860		1, 526, 86		1, 526, 860	
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0			0 0	0	
	06500 RESPI RATORY THERAPY	664, 707	0			664, 707	
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	950, 377		950, 37		950, 377	
	06800 SPEECH PATHOLOGY	260, 401	, o	260, 40		260, 401	
	06900 ELECTROCARDI OLOGY	133, 584	0	133, 58	0 0	133, 584 0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	485, 328		485, 32	-	485, 328	
	07200 IMPL. DEV. CHARGED TO PATIENTS	296, 379		296, 37		296, 379	
	07300 DRUGS CHARGED TO PATIENTS	2, 328, 677		2, 328, 67		2, 328, 677	
	07697 CARDI AC REHABI LI TATI ON	2, 320, 077		2, 320, 07	0 0	2, 320, 0, 7	
	07698 HYPERBARI C OXYGEN THERAPY	0			0 0	0	
	07699 LI THOTRI PSY	0			0 0	0	
	DUTPATIENT SERVICE COST CENTERS	0			0	0	, , 0. ,
	09000 CLINIC	0			0 0	0	90.00
	09001 LI FEBRI DGE SENI OR CARE	468, 468		468, 46	-	468, 468	
	09100 EMERGENCY	3, 670, 971		3, 670, 97		3, 670, 971	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 302, 017		1, 302, 01		1, 302, 017	
	OTHER REIMBURSABLE COST CENTERS	,,,		, ,		,,,	1
	09500 AMBULANCE SERVICES	2, 290, 887		2, 290, 88	7 0	2, 290, 887	95.00
	09910 CORF	0		,	0	0	
	09920 OUTPATIENT PHYSICAL THERAPY	0			0	0	
	09930 OUTPATIENT OCCUPATIONAL THERAPY	0			0	0	99.30
	09940 OUTPATIENT SPEECH PATHOLOGY	0			0	0	99.40
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	26, 287, 485	0	26, 287, 48	5 0	26, 287, 485	200.00
201.00	Less Observation Beds	1, 302, 017		1, 302, 01		1, 302, 017	
202.00	Total (see instructions)	24, 985, 468	0				

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CO	CN: 15-1323	Period:	Worksheet C	
					From 01/01/2016 To 12/31/2016	Part I Date/Time Pre 5/30/2017 12:	pared:
			Titl	e XIX	Hospi tal	PPS	55 pili
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Rati o	
	1	6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					
30.00	03000 ADULTS & PEDIATRICS	6, 260, 574		6, 260, 57			30.00
43.00	04300 NURSERY	557, 111		557, 11	11		43.00
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	3, 227, 696	12, 234, 462			0.00000	
52.00	05200 DELIVERY ROOM & LABOR ROOM	475, 034	1, 423, 262			0.00000	
53.00	05300 ANESTHESI OLOGY	341, 116	1, 496, 259			0.00000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 311, 531	21, 396, 690			0.00000	
60.00	06000 LABORATORY	1, 283, 268	6, 312, 926	7, 596, 19		0.00000	
62.30	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0.00000	0.000000	
65.00	06500 RESPI RATORY THERAPY	531,862	1,854,581	2, 386, 44		0.00000	
66.00	06600 PHYSI CAL THERAPY	247, 498	1, 363, 155			0.000000	
67.00	06700 OCCUPATIONAL THERAPY	283, 694	305, 714			0.00000	
68.00	06800 SPEECH PATHOLOGY	38, 590	82, 889	121, 47		0.000000	
69.00	06900 ELECTROCARDI OLOGY	0	0	0 000 5	0 0.00000	0.00000	
71.00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	461, 187	1, 548, 347	2,009,53		0.00000	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	510, 895	463, 523			0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 317, 785	5, 686, 570	8, 004, 35		0.000000	
76.97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0.000000	0.000000	
76.98	07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0.000000	0.000000	
76. 99	07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS	0	0		0 0.00000	0. 000000	76. 99
90.00	09000 CLINIC	0	0		0 0.000000	0. 000000	90.00
90.00	09001 LI FEBRI DGE SENI OR CARE	0	647, 746			0.000000	90.00
91.00	09100 EMERGENCY	451, 472	12, 006, 870			0.000000	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	451, 472	1, 127, 365			0.000000	
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>	1, 127, 303	1, 127, 30	1. 134721	0.000000	72.00
95.00	09500 AMBULANCE SERVICES	0	3, 997, 757	3, 997, 75	0, 573043	0. 000000	95.00
99.10	09910 CORF	0	3, 777, 737	5, 777, 70	0 0.373043	0.000000	99.10
99.20	09920 OUTPATIENT PHYSICAL THERAPY	0	0		0		99.20
99.20 99.30	09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0		0		99.30
99.40	09940 OUTPATIENT SPEECH PATHOLOGY	0	0		0		99.40
, ,. 40	SPECIAL PURPOSE COST CENTERS	<u> </u>	0		<u> </u>	<u> </u>	1 ,
113 00	11300 I NTEREST EXPENSE						113.00
200.00		18, 299, 313	71, 948, 116	90, 247, 42	29		200. 00
200.00 201.00		10, 277, 313	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	,0,2+7,42	- /		200.00
201.00		18, 299, 313	71, 948, 116	90, 247, 42			201.00

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1323	Peri od:	Worksheet C
			From 01/01/2016	Part I
			To 12/31/2016	Date/Time Prepare 5/30/2017 12:53
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient		nooprea	
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30
43. 00 04300 NURSERY				43
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 179023			50
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 682702			52
53. 00 05300 ANESTHESI OLOGY	0. 016585			53
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 106909			54
60. 00 06000 LABORATORY	0. 201003			60
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000			62
65. 00 06500 RESPI RATORY THERAPY	0. 278535			65
66. 00 06600 PHYSI CAL THERAPY	0. 590057			66
67.00 06700 OCCUPATI ONAL THERAPY	0. 441801			67
68.00 06800 SPEECH PATHOLOGY	1. 099647			68
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 241513			71
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 304160			72
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 290926			73
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0. 000000			76
76. 99 07699 LI THOTRI PSY	0. 000000			76
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 723228			90
91. 00 09100 EMERGENCY	0. 294660			91
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 154921			92
OTHER REIMBURSABLE COST CENTERS				
95. 00 09500 AMBULANCE SERVICES	0. 573043			95
99. 10 09910 CORF				99
99. 20 09920 OUTPATIENT PHYSICAL THERAPY				99
99. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY				99
99. 40 09940 OUTPATI ENT SPEECH PATHOLOGY				99
SPECIAL PURPOSE COST CENTERS	· · ·			
113.00 11300 INTEREST EXPENSE				113
200.00 Subtotal (see instructions)				200
201.00 Less Observation Beds				201
202.00 Total (see instructions)				202

		MUNITY HOSPT. OI			In Lie	u of Form CMS-2	2552-1
	ON OF OUTPATIENT SERVICE COST TO CHARGE RA	ATIOS NET OF	Provi der C		Period: From 01/01/2016	Worksheet C Part II	
REDUCTION	NS FOR MEDICAID ONLY				To 12/31/2016	Date/Time Pre	pared.
					10 12/01/2010	5/30/2017 12:	53 pm
				e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost			Operating Cost	
			(Wkst. B, Part			Reducti on	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col. 2)			
		1.00	2.00	3.00	4.00	5.00	
	CILLARY SERVICE COST CENTERS		l		_		
	000 OPERATING ROOM	2, 768, 087				0	00.00
	200 DELIVERY ROOM & LABOR ROOM	1, 295, 971				0	
	300 ANESTHESI OLOGY	30, 472				0	53.0
	400 RADI OLOGY-DI AGNOSTI C	2, 427, 717				0	54.0
	000 LABORATORY	1, 526, 860			0 0	0	60.00
	250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0 0	0	62.3
	500 RESPI RATORY THERAPY	664, 707				0	65.00
	600 PHYSI CAL THERAPY	950, 377				0	66.0
	700 OCCUPATI ONAL THERAPY	260, 401				0	67.0
	800 SPEECH PATHOLOGY	133, 584				0	68.0
	900 ELECTROCARDI OLOGY	0	-		0 0	0	69.0
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	485, 328				0	71.0
	200 IMPL. DEV. CHARGED TO PATIENTS	296, 379				0	
	300 DRUGS CHARGED TO PATIENTS	2, 328, 677	66, 487	2, 262, 19	0 0	0	73.0
	697 CARDI AC REHABI LI TATI ON	0	C		0 0	0	
76.98 07	698 HYPERBARI C OXYGEN THERAPY	0	C		0 0	0	76.9
	699 LI THOTRI PSY	0	C)	0 0	0	76.9
	TPATIENT SERVICE COST CENTERS	-		1			
	000 CLINIC	0	-		0 0	0	
	001 LI FEBRI DGE SENI OR CARE	468, 468				0	
	100 EMERGENCY	3, 670, 971				0	
	200 OBSERVATION BEDS (NON-DISTINCT PART	1, 302, 017	158, 944	1, 143, 07	3 0	0	92.0
	HER REIMBURSABLE COST CENTERS						
	500 AMBULANCE SERVI CES	2, 290, 887	68, 026	2, 222, 86	01 0	0	
	910 CORF	0	C		0 0	0	
	920 OUTPATIENT PHYSICAL THERAPY	0	C		0 0	0	
	930 OUTPATIENT OCCUPATIONAL THERAPY	0	C		0 0	0	99.3
	940 OUTPATIENT SPEECH PATHOLOGY	0	C)	0 0	0	99.40
	ECIAL PURPOSE COST CENTERS						
	300 INTEREST EXPENSE						113.0
200.00	Subtotal (sum of lines 50 thru 199)	20, 900, 903					200. 0
201.00	Less Observation Beds	1, 302, 017					201.00
202.00	Total (line 200 minus line 201)	19, 598, 886	1, 152, 487	18, 446, 39	9 0	0	202.00

alth Financial Systems CON LCULATION OF OUTPATIENT SERVICE COST TO CHARGE F		ELAGRANGE CTY		Peri od:	u of Form CMS Worksheet C	2002
DUCTIONS FOR MEDICALD ONLY	ATTOS NET OF	i i ovi dei c	GN. 15-1525	From 01/01/2016	Part II	
BOOTTONS FOR MEDICATE ONET				To 12/31/2016	Date/Time Pr	epare
					5/30/2017 12	:53 pi
			e XIX	Hospi tal	PPS	_
Cost Center Description		Total Charges				
		(Worksheet C,				
	Operating Cost			6		
	Reducti on	8)	/ col. 7)			
	6.00	7.00	8.00			
ANCI LLARY SERVI CE COST CENTERS						
0. 00 05000 OPERATI NG ROOM	2, 768, 087					50.
. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 295, 971					52.
. 00 05300 ANESTHESI OLOGY	30, 472	1, 837, 375	0. 0165	85		53.
. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 427, 717	22, 708, 221	0. 1069	09		54
. 00 06000 LABORATORY	1, 526, 860	7, 596, 194	0. 2010	03		60
. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.0000	00		62
00 06500 RESPIRATORY THERAPY	664, 707	2, 386, 443	0. 2785	35		65
. 00 06600 PHYSI CAL THERAPY	950, 377	1, 610, 653		57		66
. 00 06700 OCCUPATIONAL THERAPY	260, 401	589, 408				67
00 06800 SPEECH PATHOLOGY	133, 584	121, 479				68
. 00 06900 ELECTROCARDI OLOGY	0	0	1			69
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	485, 328	2,009,534				71
. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	296, 379					72
00 07200 DRUGS CHARGED TO PATIENTS	2, 328, 677	8,004,355				73
. 97 07697 CARDI AC REHABI LI TATI ON	2, 320, 077	0,004,000				76
. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	1			76
. 99 07699 LI THOTRI PSY	0					76
OUTPATIENT SERVICE COST CENTERS	0	0	0.0000	50		- /0
. 00 09000 CLINIC	0	0	0.0000	20		90
. 01 09001 LI FEBRI DGE SENI OR CARE	468, 468					90
. 00 09100 EMERGENCY	3, 670, 971					91
. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART	1, 302, 017	1, 127, 365	1. 1549	21		92
OTHER REIMBURSABLE COST CENTERS	0.000.007	0 007 757	0.5700	10		
. 00 09500 AMBULANCE SERVICES	2, 290, 887	3, 997, 757				95
	0	0				99
. 20 09920 OUTPATIENT PHYSICAL THERAPY	0	0	0.0000			99
. 30 09930 OUTPATIENT OCCUPATIONAL THERAPY	0	0				99
. 40 09940 OUTPATIENT SPEECH PATHOLOGY	0	0	0.0000	00		99
SPECIAL PURPOSE COST CENTERS						
3.00 11300 INTEREST EXPENSE						113
0.00 Subtotal (sum of lines 50 thru 199)	20, 900, 903					200
1.00 Less Observation Beds	1, 302, 017					201
2.00 Total (line 200 minus line 201)	19, 598, 886	83, 429, 744				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	IL COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016		
		Title	e 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.		. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	301, 461	15, 462, 158	0. 01949	403, 609	7, 869	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	51, 370	1, 898, 296	0. 02706	1 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	401	1, 837, 375	0. 00021	8 51, 286	11	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	167, 105	22, 708, 221	0. 00735	9 447, 693	3, 295	54.00
60. 00 06000 LABORATORY	71, 590	7, 596, 194	0. 00942	4 309, 326	2, 915	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0.00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	35, 842	2, 386, 443	0. 01501	9 160, 388	2, 409	65.00
66. 00 06600 PHYSI CAL THERAPY	99, 659	1, 610, 653	0. 06187	5 55, 732	3, 448	66.00
67.00 06700 OCCUPATI ONAL THERAPY	3, 652	589, 408	0.00619	6 64, 807	402	67.00
68.00 06800 SPEECH PATHOLOGY	1,808	121, 479	0. 01488	3 12, 174	181	68.00
69.00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 944	2,009,534	0. 00644	1 117, 339	756	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	7,903	974, 418	0. 00811	0 243, 336	1, 973	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	66, 487				4, 903	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000		0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000		0	76.98
76. 99 07699 LI THOTRI PSY	0	0	0.00000		0	76.99
OUTPATIENT SERVICE COST CENTERS		-		-		
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	29,872	647, 746			0	90.01
91. 00 09100 EMERGENCY	234, 367				342	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	158, 944				0	92.00
OTHER REIMBURSABLE COST CENTERS		,,			<u> </u>	
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	1, 243, 405	79, 431, 987		2, 474, 127	28, 504	
			•			•

Health Financial Systems COM	NUNITY HOSPT. OF	- LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS				Date/Time Pre 5/30/2017 12:	
			XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Allied Healt	n All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0	0		0 0	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0		0 0	0	76. 98
76. 99 07699 LI THOTRI PSY	0	0		0 0	0	76.99
OUTPATIENT SERVICE COST CENTERS		-	·			
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	0		0 0	0	90.01
91.00 09100 EMERGENCY	0	0		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	0		0 0	0	200.00
		•	•			•

APPORTI ONMENT OF I NPATIENT/OUTPATIENT ANCI LLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1323 Period: From 01/01/2016 To 12/31/2016 Orcksheet D Date/Time Prepared: 5/30/2017 12:53 pm 5/30/2017 12:55 pm 5/30/2017	Health Financial Systems COM	UNITY HOSPT. O	F LAGRANGE CTY	IN	In Lie	eu of Form CMS-2	2552-10
Involution optimized To 12/31/2016 Date/Time Prepared: 5.3 pm To 12/31/2017 Date/Time Prepared: 5.3 pm Cost Center Description Total Outpatient Cost (sum of 6.00 Total Outpatient Cost (sum of 8) Total Form Kit. C, Part I, col. Dospital (col. 5 + col. 7) Despital To Charges (col. 6 + col. 7) Ippatient To Char		RVICE OTHER PAS	S Provider C				
Cost Center Description Total Outpatient Cost (sum of col. 2, 3 and 4) Total (from Wkst. C, eart i, col. 8) Total of Cost to Charges (col. 5 + col. 7) Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program Charges ANCILLARY SERVICE COST CENTERS 0 300 9.00 10.00 ANCILLARY SERVICE COST CENTERS 0 1, 89, 296 0.000000 0.000000 0.000000 50.00 05300 ALBOR R00M 0 1, 89, 296 0.000000 0.000000 0.000000 52.00 52.00 05300 ALBOR R00M 0 1, 89, 296 0.000000 0.000000 52.00 54.00 05400 0.05300 ALBOR R00M 0 7, 579 0.000000 0.000000 309, 326 60.00 66.00 0.50000 LABORTORY 0 2, 366, 443 0.000000 0.000000 309, 326 60.00 66.00 0 0.60000 0.000000 0.000000 0.000000 16.838 65.00 66.00 0.60000 0.000000 0.000000 0.000000 16.0388 65.0	THROUGH COSTS						narod
Cost Center Description Total Outpatient Cost (sum of 4) Total Cost (sum of 4) Total (sum of 4) Total (sum of 4) Total (sum of 4) Total (sum of 4) Total (sum of 8) Total (sum of 8) Total (sum of 6) Total (sum of 8) Total (sum of 8) Total (sum of 8) Total (sum of 8) Total (sum of 6) Total (sum of 8) Total (sum of 8) Total (sum of 6) Total (sum of 8) Total (sum of 8) <thtotal (sum of 8) Total (sum of 8)</thtotal 					10 12/31/2010	5/30/2017 12:	53 pm
ANCI LLARY SERVICE COST CENTERS Outpatient Cost (sum 0) (4) (from Wkst, C Part I, col. 8) to Charges (col. 5 + col. 7) Ratio of Cost to Charges (col. 6 + col. 7) Ratio of Cost to Charges (col. 6 + col. 7) Program Charges ANCI LLARY SERVICE COST CENTERS			Title	e XVIII	Hospi tal		
Cost (sum of col. 2, 3 and 4) Part I, col. 8) (col. 5 + col. 7) to Charges (col. 6 + col. 7) Charges (col. 6 + col. 7) 50.00 05000 DEERATING ROOM 52.00 05000 DEERATING ROOM 6.00 0 15,462,158 0.000000 0.000000 403,609 52.00 50.00 50.00 05300 ANESTHESI OLOGY 0.5300 ANESTHESI OLOGY 54.00 0 15,462,158 0.000000 0.000000 0.000000 12,865 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 2,2708,221 0.000000 0.000000 10,932 60.00 60.00 60.00 Lobool LABORATORY 0 7,596,194 0.000000 0.000000 62.30 60.00 06500 RESPI RATORY THERAPY 0 16,063 0.000000 0.000000 62.30 60.00 06500 RESPI RATORY THERAPY 0 16,043 0.000000 0.000000 62.30 61.00 G6000 PHSI CAL THERAPY 0 16,0453 0.000000 0.000000 62.30 62.00 0 0.000000 0.000000 0.000000 0.000000 0.000000 62.30 63.00 <td>Cost Center Description</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	Cost Center Description						
Col. 2, 3 and 4) 8) 7) (col. 6 + col. 7) 7) (col. 6 + col. 7) ANCI LLARY SERVICE COST CENTERS							
4) 7) 6.00 7.00 8.00 9.00 10.00 ANCI LLARY SERVICE COST CENTERS 0 0.00000 0.000000 40.3609 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 0 15,462,158 0.000000 0.000000 65.00 53.00 05300 ANESTHESI OLOGY 1,837,375 0.000000 0.000000 447,693 54.00 64.00 0 7,596,194 0.000000 0.000000 447,693 54.00 65.00 05600 RESPI RATORY 0 7,596,194 0.000000 0.000000 309,326 60.00 66.00 06600 DHEGRATORY 0 7,596,194 0.000000 0.000000 308,326 60.00 66.00 06600 PHYSI CAL THERAPY 0 1,610,653 0.000000 0.000000 64,807 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0 589,408 0.000000 0.000000 64,807 67.00 69.00 06900 ELECTROCARDI OLOGY 0 121,479 0.000000 0						Charges	
ANCI LLARY SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 ANCI LLARY SERVICE COST CENTERS 0 0.000000 0.000000 403,609 50.00 50.00 05500 DELIVERY ROOM & LABOR ROOM 0 15,462,158 0.000000 0.000000 403,609 50.00 53.00 05300 ANESTHESI OLOGY 0 1,837,375 0.000000 0.000000 407,693 54.00 60.00 06400 LABORATORY 0 2,788,221 0.000000 0.000000 407,693 54.00 62.30 065500 REDOD CLOTTI NG FOR HEMOPHI LI ACS 0 7,596,194 0.000000 0.000000 403,886 60.00 66.00 066000 RESPI RATORY THERAPY 0 2,386,443 0.000000 0.000000 55,732 66.00 66.00 066000 SPEECH PATHOLOGY 0 121,479 0.000000 0.000000 12,174 68.00 69.00 066000 SPEECH PATHOLOGY 0 0 0.000000 0.000000			8)	7)			
ANCI LLARY SERVICE COST CENTERS 50.00 05000 OPERATI NG ROOM 0 15, 462, 158 0.000000 0.000000 403, 609 50.00 52.00 DELI VERY ROOM & LABOR ROOM 0 1, 898, 296 0.000000 0.000000 52.00 53.00 DS300 ANESTHESI OLOGY 0 1, 837, 375 0.000000 0.000000 447, 693 54.00 64.00 D6500 LABORATORY 0 7, 596, 194 0.000000 0.000000 309, 326 60.00 65.00 06500 RESPI RATORY THERAPY 0 2, 386, 443 0.000000 0.000000 160, 388 65.00 64.00 06600 PHSTI CAL THERAPY 0 1, 610, 653 0.000000 0.000000 160, 388 65.00 65.00 06600 PHSTI CAL THERAPY 0 1, 610, 653 0.000000 0.000000 12, 174 66.00 68.00 066000 PHSTI NATORY THERAPY 0 0 0.000000 0.000000 12, 174 68.00 069.00 12, 1479 <td></td> <td></td> <td></td> <td></td> <td>• /</td> <td></td> <td></td>					• /		
50.00 05000 OPERATING ROM 0 15, 462, 158 0.000000 0.000000 403, 609 50.00 52.00 05200 DELIVERY ROM & LABOR ROM 0 1, 898, 296 0.000000 0.000000 0 52.00 53.00 05200 DELIVERY ROM & LABOR ROM 0 1, 897, 375 0.000000 0.000000 51.286 53.00 54.00 05400 RADI OLGCY-DI AGNOSTI C 0 22, 708, 221 0.000000 0.000000 447, 693 54.00 60.00 LABORATORY 0 7, 596, 194 0.000000 0.000000 62.30 06250 BLOD CLOTTING FOR HEMOPHILIACS 0 0 0.000000 0.000000 62.30 06500 RESPI RATORY THERAPY 0 2, 386, 443 0.000000 0.000000 62.30 06700 OCCUPATI ONAL THERAPY 0 589, 408 0.000000 0.000000 64.807 67.00 0 06400 SPEECH PATHOLOGY 0 121, 479 0.000000 0.000000 69.00 71.00 0.000000 0.000000 0 69.00 71.00		6.00	7.00	8.00	9.00	10.00	
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 1, 898, 296 0.000000 0.000000 52.00 53.00 05300 AMESTHESI DLOGY 0 1, 837, 375 0.000000 0.000000 53.00 54.00 05400 RADI DLOGY-DI AGNOSTI C 0 22, 708, 221 0.000000 0.000000 447, 693 53.00 64.00 06000 LABORATORY 0 7, 596, 194 0.000000 0.000000 447, 693 60.00 62.30 06250 BLOD CLOTTI NG FOR HEMOPHI LI ACS 0 0 0.000000 0.000000 160, 388 65.00 65.00 06500 RESPI RATORY THERAPY 0 1, 610, 653 0.000000 0.000000 160, 388 65.00 64.00 06400 PYSI CAL THERAPY 0 1, 610, 653 0.000000 0.000000 64, 807 67.00 65.00 06500 RESPI RATORY THERAPY 0 121, 479 0.000000 0.000000 64, 807 67.00 68.00 06800 SPEECH PATHOLOGY 0 0.000000 0.000000 17.174 68.00		-					
53.00 05300 ANESTHESI OLOGY 0 1, 837, 375 0.000000 0.000000 51, 286 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 22, 708, 221 0.000000 0.000000 447, 693 64.00 62.30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0 7, 596, 194 0.000000 0.000000 62.30 65.00 06500 RESPI RATORY THERAPY 0 2, 386, 443 0.000000 0.000000 160, 388 65.00 66.00 OHYSI CAL THERAPY 0 1, 610, 653 0.000000 0.000000 55, 732 66.00 67.00 06200 LECTROCARDI OLOGY 0 121, 479 0.000000 0.000000 69.00 68.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0.000000 121, 479 0.000000 0.000000 171, 339 71.00 71.00 OTOM MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 974, 418 0.000000 0.000000 117, 339 72.00 73.00 07300 DRUAC CHARGED TO PATI ENTS 0 0.0000000 0.000000		0					1
54.00 05400 RADI OLOGY - DI AGNOSTI C 0 22, 708, 221 0.000000 0.000000 447, 693 54.00 60.00 06000 LABORATORY 0 7, 596, 194 0.000000 0.000000 309, 326 60.00 62.30 06500 RESPI RATORY THERAPY 0 2, 386, 443 0.000000 0.000000 160, 388 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 610, 653 0.000000 0.000000 64.807 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 1, 610, 653 0.000000 0.000000 64.807 67.00 67.00 06600 PEECH PATHOLOGY 0 121, 479 0.000000 0.000000 64.807 67.00 69.00 06800 SEECH PATHOLOGY 0 0 0.000000 0.000000 17.70 67.00 72.00 07200 I IMPL DVARGED TO PATI ENTS 0 974, 418 0.000000 0.000000 243, 336 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 974, 418 0.0000000 0.0000000 0<		0					
60.00 06000 LABORATORY 0 7, 596, 194 0.000000 0.000000 309, 326 60.00 62.30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0 0 0.000000 0.000000 0 62.30 65.00 066500 RESPI RATORY THERAPY 0 2,386,443 0.000000 0.000000 160,388 65.00 66.00 06600 PHYSI CAL THERAPY 0 1,610,653 0.000000 0.000000 64,807 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0 589,408 0.000000 0.000000 64,807 67.00 68.00 06800 FEECH PATHOLOGY 0 121,479 0.000000 0.000000 69.00 69.00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 2,009,534 0.000000 0.000000 117,339 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 8,004,355 0.000000 0.000000 243,336 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0.000000 0.000000 0 0.000000		0					1
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0.00000 0.000000 0 62.30 65.00 06500 RESPIRATORY THERAPY 0 2,386,443 0.000000 0.000000 160,388 65.00 66.00 06600 PHYSICAL THERAPY 0 1,610,653 0.00000 0.000000 55,732 66.00 67.00 0CCUPATIONAL THERAPY 0 589,408 0.000000 0.000000 64,807 67.00 68.00 06800 SPEECH PATHOLOGY 0 121,479 0.000000 0.000000 127,14 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0.000000 117,339 71.00 71.00 MTIO MEDI CAL SUPPLIES CHARGED TO PATIENT 0 9.043,355 0.000000 0.000000 243,336 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 8.004,355 0.000000 0.000000 243,336 72.00 76.97 76.97 CARDI AC REHABILITATION 0 0 0.000000 0.000000 0 76.97 76.98		0					
65.00 06500 RESPI RATORY THERAPY 0 2, 386, 443 0.000000 0.000000 160, 388 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 610, 653 0.000000 0.000000 55, 732 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 589, 408 0.000000 0.000000 64, 807 67.00 68.00 06800 SPECH PATHOLOGY 0 121, 479 0.000000 0.000000 12, 174 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0.000000 12, 174 68.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 2, 009, 534 0.000000 0.000000 117, 339 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 974, 418 0.000000 0.000000 29, 3336 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 8, 004, 355 0.000000 0.000000 0 76.97 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0.0000000 0 <td></td> <td>0</td> <td>7, 596, 194</td> <td></td> <td></td> <td></td> <td></td>		0	7, 596, 194				
66.00 06600 PHYSI CAL THERAPY 0 1, 610, 653 0.000000 0.000000 55, 732 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 589, 408 0.000000 0.000000 64, 807 67.00 68.00 06800 SPEECH PATHOLOGY 0 121, 479 0.000000 0.000000 12, 174 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0.000000 0 000000 17, 339 71.00 71.00 07100 MEDI CAL SUPLI ES CHARGED TO PATI ENT 0 2, 009, 534 0.000000 0.000000 243, 336 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 8, 004, 355 0.000000 0.000000 0 73.00 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0.000000 0.000000 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 0.000000 0 76.98 90.00 09000 CLI NI C 0 0 0.000000 0 90.00		0	C				
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	200.00 Total (lines 50-199)	0	79, 431, 987			2, 474, 127	200. 00

APPORIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1323 Period: From 01/01/2016 To 12/31/2016 Dirksheet D Patri U Date/Time Prepared: 5/30/2017 12:53 pt Soutpatient Cost Center Description Inpatient Program Pass-Through Costs (col. 8 x col 10) Outpatient Program Charges Voitpatient Program Charges Poss-Through Costs (col. 9 x col 12) Voitpatient Program Charges MACILLARY SERVICE COST CENTERS 0 0 0 0 50.00 50.00 05000 OPERATING ROOM 52.00 0 0 0 0 50.00 50.00 05000 OPERATING ROOM 52.00 0 0 0 0 0 0 50.00 50.00 05000 OPERATING ROOM 52.00 0 0 0 0 0 50.00 50.00 052000 DELIVERY ROOM & LABOR ROOM 52.00 0	Health Financial Systems COMM	IUNITY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10	
To 12/31/2016 Date/Time Prepared: 5.3 pm Title XVIIII Hospital Cost Cost Center Description Inpatient Program Costs (col. 8 x col. 10) Dutpatient Program Costs (col. 9 x col. 10) Through Costs (col. 9 x col. 10) Through Costs (col. 9 x col. 10) State Program Costs (col. 9 x col. 10) ANCILLARY SERVICE COST CENTERS 11.00 12.00 50.00 ANCILLARY SERVICE COST CENTERS 11.00 12.00 50.00 ANCILLARY SERVICE COST CENTERS 11.00 12.00 Sammough Costs (col. 9 x col. 10) 50.00 Sammough Costs (col. 9 x col. 10) 50.00 Sammough Costs (col. 9 x col. 10) 50.00 Sammough Costs (col. 9 x col. 12) 50.00 Sammough Costs (col. 9 x col. 12) 50.00 Sammough Costs (col. 9 x col. 12) 50.00 Sammough Costs (colspan="2" <td c<="" td=""><td></td><td>VICE OTHER PASS</td><td>5 Provider C</td><td>CN: 15-1323</td><td></td><td>Part IV</td><td></td></td>	<td></td> <td>VICE OTHER PASS</td> <td>5 Provider C</td> <td>CN: 15-1323</td> <td></td> <td>Part IV</td> <td></td>		VICE OTHER PASS	5 Provider C	CN: 15-1323		Part IV	
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62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 62.30 65.00 06500 RESPI RATORY THERAPY 0 0 0 66.00 06600 PHYSI CAL THERAPY 0 0 0 67.00 06700 0CCUPATIONAL THERAPY 0 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 0 0 67.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 76.97 CARDI AC REHABILITATION 0 0 0 76.97 76.98 07699 LI HOTRI PSY 0 0 0 76.98 90.00 09000 CLI NI C 0 0 0 90.01 90.01 19001 LI FEBRI DGE SENI OR CARE 0 0 0<	54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0			
65.00 06500 RESPI RATORY THERAPY 0 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 67.00 0 COUPATI ONAL THERAPY 0 0 0 67.00 67.00 68.00 06800 SPECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 68.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 71.00 72.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 73.00 73.00 73.00 76.97 76.97 76.98 97 76.98 97 76.98 97 76.98 99 11 HOTRI PSY 0 0 0 76.99 00.01 09000 CLI NI C 0 0 0 0 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 90.01 91.00 92.00 92.00 92.00 92.00 92.00<	60. 00 06000 LABORATORY	0	C		0			
66.00 06600 PHYSI CAL THERAPY 0 0 0 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 69.00 71.00 O7100 MEDI CAL SUPLI ES CHARGED TO PATI ENT 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 73.00 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76.98 76.98 76.99 OT400 LI INT C 0 0 0 76.99 76.99 70.00 09000 CLI NI C 0 0 0 90.00 90.01 90.01 09001 LI FEBRI DGE SENI OR CARE 0 0 90.01 </td <td></td> <td>0</td> <td>C</td> <td></td> <td>0</td> <td></td> <td></td>		0	C		0			
67.00 06700 0CCUPATIONAL THERAPY 0 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 0 0 69.00 06900 ELECTROCARDIOLOGY 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76.97 07697 CARDIA C REHABILITATION 0 0 0 76.97 76.98 MYPERBARI C OXYGEN THERAPY 0 0 0 76.97 76.98 07699 LITHOTRIPSY 0 0 76.98 0000 09000 CLINIC 0 0 90.00 0000 09000 CLINIC 0 0 90.00 90.00 09000 CLINIC 0 0 90.01 91.00 09000 CLINIC 0 0 90.01 92.00 092000 DSERVATION BEDS (NON-DI STINCT		0	C		0		65.00	
68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 76.97 07697 CARDI AC REHABILI TATI ON 0 0 0 76.97 76.98 NYPERBARI C 0XYGEN THERAPY 0 0 0 76.97 76.99 014011 FOTRI PSY 0 0 0 76.97 0000 09000 CLI NI C 0 0 90.00 0010 09000 CLI NI C 0 0 90.00 90.00 09000 CLI NI C 0 0 90.01 91.00 09000 CLI NI C 0 0 90.01 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 91.00 92.00 0SERVATI O	66. 00 06600 PHYSI CAL THERAPY	0	C		0		66.00	
69.00 06900 ELECTROCARDIOLOGY 0 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 72.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76.97 76.99 07699 LITHOTRIPSY 0 0 0 76.99 0UTPATIENT SERVICE COST CENTERS 0 0 0 90.00 90.00 90.00 09000 CLINIC 0 0 90.00 90.01 91.00 09000 CLINIC 0 0 90.01 90.01 90.01 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 <td< td=""><td>67.00 06700 OCCUPATI ONAL THERAPY</td><td>0</td><td>C</td><td></td><td>0</td><td></td><td>67.00</td></td<>	67.00 06700 OCCUPATI ONAL THERAPY	0	C		0		67.00	
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 73.00 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 76.98 76.98 07699 LI THOTRI PSY 0 0 76.99 0000 09000 CLI NI C 0 0 90.00 90.00 09000 CLI NI C 0 0 90.01 90.01 09000 CLI NI C 0 0 90.01 91.00 09100 EMERGENCY 0 0 91.00 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART 0	68.00 06800 SPEECH PATHOLOGY	0	C		0		68.00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 76.98 00 00000 CLI NI C 0 0 0 90.00 09.001 09000 LI FEBRI DGE SENI OR CARE 0 0 90.01 91.00 09000 DSERVATI ON BEDS (NON-DI STI NCT PART 0 0 90.01 92.00 092000 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 92.00 0THER REI MBURSABLE COST CENTERS 0 0 92.00 95.00 95.00 95.00	69.00 06900 ELECTROCARDI OLOGY	0	C		0		69.00	
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 76.98 70.00 07699 LI THOTRI PSY 0 0 0 76.98 70.00 09000 CLI NI C 0 0 0 90.00 90.00 09000 LI FEBRI DGE SENI OR CARE 0 0 90.01 90.01 91.00 09100 EMERGENCY 0 0 0 91.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 92.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00 95.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C		0		71.00	
76. 97 O7697 CARDI AC REHABI LI TATI ON 0 0 76. 97 76. 98 O7698 HYPERBARI C OXYGEN THERAPY 0 0 0 76. 98 76. 99 O7699 LI THOTRI PSY 0 0 0 76. 98 76. 99 OT699 LI THOTRI PSY 0 0 0 76. 99 0UTPATI ENT SERVICE COST CENTERS 0 0 0 90. 00 90. 00 O9000 CLI NI C 0 0 90. 00 90. 01 09001 LI FEBRI DGE SENI OR CARE 0 0 90. 01 91. 00 09100 EMERGENCY 0 0 91. 00 92. 00 92. 00 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 92. 00 0 0 0 0 0 92. 00 95. 00 95. 00	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0		72.00	
76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0 76.99 0UTPATI ENT SERVICE COST CENTERS 0 0 0 90.00 90.00 09001 CLI NI C 0 0 90.00 90.01 09001 LI FEBRI DGE SENI OR CARE 0 0 90.01 91.00 09100 EMERGENCY 0 0 90.01 92.00 0BSERVATI ON BEDS (NON-DI STI NCT PART 0 0 92.00 0THER REI MBURSABLE COST CENTERS 0 0 92.00 95.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00	
76.99 07699 LI THOTRI PSY 0 0 76.99 OUTPATI ENT SERVICE COST CENTERS 0 0 0 90.00 9000 CLI NI C 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.00 90.01 90.00 91.00 92.00 <td>76. 97 07697 CARDI AC REHABI LI TATI ON</td> <td>0</td> <td>C</td> <td></td> <td>0</td> <td></td> <td>76.97</td>	76. 97 07697 CARDI AC REHABI LI TATI ON	0	C		0		76.97	
OUTPATI ENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 90.00 90. 01 09000 CLINIC 0 0 90.00 90. 01 09001 LIFEBRIDGE SENIOR CARE 0 0 0 90.01 91. 00 09100 EMERGENCY 0 0 0 91.00 92. 00 095ERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 0THER REI MEURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C		0		76. 98	
90. 00 09000 CLINIC 0 0 0 90. 00 90. 00 90. 00 90. 00 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 90. 01 91. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 92. 00 95. 00 <th< td=""><td>76. 99 07699 LI THOTRI PSY</td><td>0</td><td>C</td><td></td><td>0</td><td></td><td>76.99</td></th<>	76. 99 07699 LI THOTRI PSY	0	C		0		76.99	
90.01 09001 LI FEBRI DGE SENIOR CARE 0 0 90.01 91.00 09100 EMERGENCY 0 0 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 0 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	OUTPATIENT SERVICE COST CENTERS							
91.00 09100 EMERGENCY 0 0 0 91.00 92.00 </td <td>90. 00 09000 CLI NI C</td> <td>0</td> <td>С</td> <td>)</td> <td>0</td> <td></td> <td>90.00</td>	90. 00 09000 CLI NI C	0	С)	0		90.00	
92.00 OBSERVATION BEDS (NON-DISTINCT PART 0 0 92.00 OTHER REIMBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	90. 01 09001 LI FEBRI DGE SENI OR CARE	0	C		0		90.01	
OTHER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00	91.00 09100 EMERGENCY	0	C		0		91.00	
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C		0		92.00	
	OTHER REIMBURSABLE COST CENTERS							
200.00 Total (lines 50-199) 0 0 0 200.00	95. 00 09500 AMBULANCE SERVICES						95.00	
	200.00 Total (lines 50-199)	0	C		0		200. 00	

Health Finan		NUNITY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
APPORTI ONMEN	IT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1323	Peri od:	Worksheet D	
					From 01/01/2016 To 12/31/2016		narod
					10 12/31/2010	Date/Time Pre 5/30/2017 12:	53 pm
			Title	XVIII	Hospi tal	Cost	00 pm
				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	Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LARY SERVICE COST CENTERS				-		
	OPERATING ROOM	0. 179023	0	1, 517, 14	.9 0	0	
	DELIVERY ROOM & LABOR ROOM	0. 682702	0		0 0	0	
	ANESTHESI OLOGY	0. 016585	0	189, 08	0 0	0	53.00
	RADI OLOGY-DI AGNOSTI C	0. 106909	0	5, 499, 22	2 0	0	
60.00 06000	LABORATORY	0. 201003	0	1, 901, 03	2 0	0	60.00
62.30 06250	BLOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
65.00 06500	RESPI RATORY THERAPY	0. 278535	0	125, 06	7 0	0	65.00
66.00 06600	PHYSI CAL THERAPY	0. 590057	0	412, 91	6 0	0	66.00
67.00 06700	OCCUPATIONAL THERAPY	0. 441801	0	99, 56	4 0	0	67.00
68.00 06800	SPEECH PATHOLOGY	1. 099647	0	20, 74	9 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. 241513	0	183, 28	7 0	0	71.00
72.00 07200	IMPL. DEV. CHARGED TO PATIENTS	0. 304160	0	139, 93	5 0	0	72.00
73.00 07300	DRUGS CHARGED TO PATIENTS	0. 290926	0	2, 484, 83	0 0	0	73.00
76.97 07697	CARDIAC REHABILITATION	0. 000000	0		0 0	0	76.97
76.98 07698	HYPERBARI C OXYGEN THERAPY	0. 000000	0	1	0 0	0	76.98
76.99 07699	LI THOTRI PSY	0. 000000	0	1	0 0	0	76.99
OUTPAT	TIENT 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. 723228	0	428, 10	4 0	0	90.01
91.00 09100	EMERGENCY	0. 294660	0	2, 737, 51	7 0	0	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART	1. 154921	0	999, 52	0 0	0	92.00
OTHER	REIMBURSABLE COST CENTERS						
95.00 09500	AMBULANCE SERVICES	0. 573043			0		95.00
200.00	Subtotal (see instructions)		0	16, 737, 97	2 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	16, 737, 97	2 0	0	202.00

		UNITY HOSPT. OI			In Lie	u of Form CMS	-2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pro 5/30/2017 12	
				XVIII	Hospi tal	Cost	
		Cos					
	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	271, 605	0	1			50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
	05300 ANESTHESI OLOGY	3, 136	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	587, 916					54.00
	06000 LABORATORY	382, 113	0				60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
	06500 RESPI RATORY THERAPY	34, 836	0				65.00
66.00	06600 PHYSI CAL THERAPY	243, 644	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	43, 987	0				67.00
68.00	06800 SPEECH PATHOLOGY	22, 817	0				68.00
69.00	06900 ELECTROCARDI OLOGY	0	0				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	44, 266	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	42, 563	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	722, 902	0				73.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	0				76.97
76. 98	07698 HYPERBARI C OXYGEN THERAPY	0	0				76.98
76.99	07699 LI THOTRI PSY	0	0				76.99
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0				90.00
90.01	09001 LI FEBRI DGE SENI OR CARE	309, 617	0				90.01
91.00	09100 EMERGENCY	806, 637	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1, 154, 367	0				92.00
	OTHER REIMBURSABLE COST CENTERS			1			
95.00	09500 AMBULANCE SERVICES	0					95.00
200.00		4, 670, 406	0				200.00
201.00		0	, i i i i i i i i i i i i i i i i i i i				201.00
_000	Only Charges						
202.00		4, 670, 406	0				202.00

Heal th Financi	al Systems COMM	IUNITY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-:	2552-10
APPORTI ONMENT	OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO		Period:	Worksheet D	
			Component (From 01/01/2016 To 12/31/2016		narodi
			component (JUN. 15-2525	10 12/31/2010	5/30/2017 12:	
			Title	XVIII	Swing Beds - SNF		
				Charges		Costs	
Co	ost 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	
	RY SERVICE COST CENTERS	0.470000					
	PERATING ROOM	0. 179023	0		0 0	0	
	ELIVERY ROOM & LABOR ROOM	0. 682702	0		0 0	0	02.00
	NESTHESI OLOGY	0. 016585	0		0 0	0	
	ADI OLOGY-DI AGNOSTI C	0. 106909	0		0 0	0	01100
	ABORATORY	0. 201003	0		0 0	0	
	LOOD CLOTTING FOR HEMOPHILIACS	0. 000000	0		0 0	0	62.30
	ESPI RATORY THERAPY	0. 278535	0		0 0	0	
	HYSI CAL THERAPY	0. 590057	0		0 0	0	
	CCUPATI ONAL THERAPY	0. 441801	0		0 0	0	07100
	PEECH PATHOLOGY	1. 099647	0		0 0	0	00.00
	LECTROCARDI OLOGY	0. 000000	0		0 0	0	
	EDICAL SUPPLIES CHARGED TO PATIENT	0. 241513	0		0 0	0	
	MPL. DEV. CHARGED TO PATIENTS	0. 304160	0		0 0	0	
	RUGS CHARGED TO PATIENTS	0. 290926	0		0 0	0	
	ARDIAC REHABILITATION	0. 000000	0		0 0	0	
	YPERBARIC OXYGEN THERAPY	0. 000000	0		0 0	0	1 101 10
	I THOTRI PSY	0. 000000	0		0 0	0	76.99
	ENT SERVICE COST CENTERS	1					
90.00 09000 CL		0.00000	0		0 0	0	
	I FEBRI DGE SENI OR CARE	0. 723228	0		0 0	0	1 /01/01
	MERGENCY	0. 294660	0		0 0	0	
	BSERVATION BEDS (NON-DISTINCT PART	1. 154921	0		0 0	0	92.00
	EI MBURSABLE COST CENTERS	0.5700.40					0.5.00
	MBULANCE SERVICES	0. 573043	-		0	-	95.00
	ubtotal (see instructions)		0		0 0	0	200.00
	ess PBP Clinic Lab. Services-Program				0		201.00
	nly Charges		0		0	_	202.00
202.00 Ne	et Charges (line 200 +/- line 201)		0		0 0	0	202.00

		UNITY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	u of Form CMS-	2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1323	Peri od:	Worksheet D	
			Component	CCN: 15-Z323	From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	narod
			component	CCN. 13-2323	10 12/31/2010	5/30/2017 12:	
			Title	XVIII	Swing Beds - SNF	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost]			
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCI LLARY SERVICE COST CENTERS						_
	05000 OPERATING ROOM	0	-				50.00
	05200 DELIVERY ROOM & LABOR ROOM	0	0				52.00
	05300 ANESTHESI OLOGY	0	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
	06000 LABORATORY	0	0				60.00
	06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0				62.30
	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				76.9
	07698 HYPERBARI C OXYGEN THERAPY	0	-	•			76.98
	07699 LI THOTRI PSY	0	0				76.99
	OUTPATIENT SERVICE COST CENTERS	T	1	1			
	09000 CLINIC	0	-	•			90.00
	09001 LI FEBRI DGE SENI OR CARE	0	-	•			90.01
	09100 EMERGENCY	0	-				91.00
	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	-				200.00
201.00		0					201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	0	0				202.00

Health Financial Systems COM	NUNITY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provider C		Period:	Worksheet D	
				From 01/01/2016 To 12/31/2016		pared: 53 pm
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	611, 960	74, 795	537, 16	5 2, 844	188.88	30.00
43.00 NURSERY	12, 477		12, 47	7 466	26.77	43.00
200.00 Total (lines 30-199)	624, 437		549, 64	2 3, 310		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00			-	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	25	4, 722				30.00
43.00 NURSERY	141	3, 775				43.00
200.00 Total (lines 30-199)	166	8, 497				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 01/01/2016 To 12/31/2016		pared: 53 pm
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,		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	301, 461	15, 462, 158	0. 01949	7 73, 776	1, 438	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	51, 370	1, 898, 296	0. 02706	1 74, 840	2, 025	52.00
53.00 05300 ANESTHESI OLOGY	401	1, 837, 375	0. 00021	8 16, 574	4	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	167, 105	22, 708, 221	0.00735	9 8, 083	59	54.00
60. 00 06000 LABORATORY	71, 590	7, 596, 194	0.00942	4 18, 286	172	60.00
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 00000	0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	35, 842	2, 386, 443	0. 01501	9 3, 676	55	65.00
66. 00 06600 PHYSI CAL THERAPY	99,659			5 153	9	66.00
67.00 06700 OCCUPATI ONAL THERAPY	3,652				6	67.00
68.00 06800 SPEECH PATHOLOGY	1,808				0	68,00
69.00 06900 ELECTROCARDI OLOGY	0	0			0	69,00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	12, 944	2,009,534			44	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS	7,903				0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	66, 487				172	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0,001,000	0. 00000		0	76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0.00000		0	76.98
76. 99 07699 LI THOTRI PSY	0	0	0.00000		0	76.99
OUTPATIENT SERVICE COST CENTERS			0.00000	0 0	0	10.77
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	29,872	e e e e e e e e e e e e e e e e e e e			0	90.01
91. 00 09100 EMERGENCY	234, 367				124	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	159, 979				0	92.00
OTHER REIMBURSABLE COST CENTERS	137, 717	1, 127, 303	0.14170	<u> </u>	0	/2.00
95. 00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	1, 244, 440	79, 431, 987		230, 401	4 108	200.00
	1 1,211,440	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	I	200,401	1, 100	

Health Financial Systems COMMUNITY HOSPT. OF LAGRANGE CTY IN In Lieu of Form CMS-255								
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS	Provider C	CN: 15-1323	Period: From 01/01/2016 To 12/31/2016			
				e XIX	Hospi tal	PPS		
Cost Center Description	Nursing School	AI I	ied Health	All Other	Swi ng-Bed	Total Costs		
			Cost	Medi cal	Adjustment	(sum of cols.		
				Education Cos	st Amount (see	1 through 3,		
					instructions)	minus col. 4)		
	1.00		2.00	3.00	4.00	5.00		
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 03000 ADULTS & PEDI ATRI CS	0		0		0 0	0	30.00	
43.00 04300 NURSERY	0		0		0	0	43.00	
200.00 Total (lines 30-199)	0		0		0	0	200.00	
Cost Center Description	Total Patient	Per	Diem (col.	Inpati ent	I npati ent			
	Days	5	÷ col. 6)	Program Days	s Program			
					Pass-Through			
					Cost (col. 7 x			
					col. 8)			
	6.00		7.00	8.00	9.00			
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 03000 ADULTS & PEDI ATRI CS	2,844		0.00		25 C		30.00	
43. 00 04300 NURSERY	466		0.00	14	11 C		43.00	
200.00 Total (lines 30-199)	3, 310			16	56 C		200. 00	

Health Financial Systems COM	NUNITY HOSPT. OF	- LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS	6 Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Pre 5/30/2017 12:	
		Titl	e XIX	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS	1					
50.00 O5000 OPERATI NG ROOM	0	0		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 CARDIAC REHABILITATION	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						
90. 00 09000 CLINIC	0	C)	0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	0		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	C)	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS						
95.00 09500 AMBULANCE SERVICES						95.00
200.00 Total (lines 50-199)	0	C		0 0	0	200. 00

APPORTI ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Provider CCN: 15-1323 Period: From 01/01/2016 To 12/31/2016 Period: Patr.Time Prepared: 5/30/2017 12:53 pm 5/30/2017 12:55	Health Financial Systems COMM	NUNITY HOSPT. O	F LAGRANGE CTY	IN	In Lie	u of Form CMS-:	2552-10
Andown boold To 12/31/2016 Date/Time Prepared: 5/30/2017 Date/Time Prepared: 5/30/2017 Cost Center Description Total Outpatient Cost (sum of 4) Total Outpatient Cost (sum of 4) Total Form Kst, C, Part I, col. Hospital (col. 5 + col. PPS ANCILLARY SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 52.00 05000 DPERATING ROM (col. 5 + col. 0 15,462,158 0.000000 0.000000 73,776 50.00 52.00 05000 DECATING ROM (col. ABORATORY 0 1,837,375 0.000000 0.000000 16,674 840 52.00 54.00 06000 LABORATORY 0 1,837,375 0.000000 0.000000 16,674 66.00 66.00 06000 CHORTORY 0 7,596,194 0.000000 0.000000 62.30 66.00 06000 PHYSICAL HERAPY 0 2,664,43 0.000000 0.000000 66.00 66.00 06000 SPECENPRATORY 0 1,610,653 0.000000 0.000000 66.00 67.00 06700 OCUPATIONAL THERAPY	APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PAS	S Provider C				
Cost Center Description Total Outpatient Cost (sum of col. 2, 3 and 4) Total (from Wkst. C, eart I, col. 8) Total of Cost to Charges (col. 5 + col. 7) Outpatient Ratio of Cost to Charges (col. 6 + col. 7) Inpatient Program (col. 6 + col. 7) ANCILLARY SERVICE COST CENTERS 0 1000000 10.000 10.000 ANCILLARY SERVICE COST CENTERS 0 1, 862, 960 0.000000 0.000000 7, 776 50.00 05200 DELIVERY ROM & LABOR ROM 0 0 1, 878, 296 0.000000 0.000000 74, 840 52.00 50.00 05200 DELIVERY ROM & LABOR ROM 0 0 1, 878, 296 0.000000 0.000000 74, 840 52.00 50.00 05200 LABORATORY 0 7, 594 0.000000 0.000000 16, 574 53.00 50.00 05200 RESPLENTORY THERAPY 0 2, 366, 443 0.000000 0.000000 16, 574 53.00 51.00 05200 RESPLENTORY THERAPY 0 2, 366, 443 0.000000 0.000000 16, 574 53.00 62.30 06250 BLOD CLOTTIN FOR THENPY 0 2, 366, 443 0.000000 0.	THROUGH COSTS						
Cost Center Description Total Outpatient Cost (sum of 4) Total Total Cost (sum of 4) Total (cost (sum of 4) Total (cost (sum of 8) Hospital (cost (sum of 8) Hospital (cost (sum of 8) Program (cost (sum of 8) ANCILLARY SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 ANCILLARY SERVICE COST CENTERS 6.00 7.00 8.00 9.00 10.00 50.00 05200 DELIVERY ROOM & LABOR ROOM 0 15.462,158 0.000000 0.000000 73.776 50.00 53.00 05300 ARESTHESI OLOCY 0 1.837.375 0.000000 0.000000 16.574 53.00 54.00 05500 RESDI CUTTING FOR HEMOPHI LLACS 0 7.596,194 0.000000 0.000000 8.038 54.00 65.00 06500 RESPI RATORY THERAPY 0 1.610.653 0.000000 0.000000 153.462.056 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00					0 12/31/2016	Date/lime Pre	pared:
Cost Center Description Total Outpatient Cost (sum of col. 2, 3 and 4) Total Cost (sum of col. 2, 3 and 4) Ratio of Cost Cost (sum of col. 5 + col. 7) Ratio of Cost Cost (sol. 5 + col. 7) Inpatient Ratio of Cost (sol. 6 + col. 7) ANCILLARY SERVICE COST CENTERS 0 7.00 8.00 9.00 10.00 50.00 05000 OPERATING ROOM 52.00 0 0 15.462.158 0.000000 0.000000 73.776 50.00 05300 ANESTHESI OLOGY 0 1.898,296 0.000000 0.000000 74.840 52.00 53.00 05300 ANESTHESI OLOGY 0 2.708,221 0.000000 0.000000 16.574 53.00 54.00 05400 (ABUI OLGY-DI AGNOSTI C 0 2.386,443 0.000000 0.000000 8.083 54.00 65.00 06500 RESPI RATORY THERAPY 0 1.610,653 0.000000 0.000000 3.66.00 66.00 66.00 06600 SPEECH PATHORY THERAPY 0 1.610,653 0.000000 0.000000 9.757 71.00 67.00 06600 SPEECH PATHORY THERAPY 0 1.610,653 0.000			Titl	e XIX	Hospi tal		<u>55 pili</u>
Cost (sum of col. 2, 3 and 4) Part I, col. 8) (col. 5 + col. 7) to Charges (col. 6 + col. 7) Charges (col. 6 + col. 7) 50.00 05000 DPERATING ROOM & LABOR ROOM 0 15,462,158 0.000000 0.000000 73,776 50.00 52.00 05300 DPERATING ROOM & LABOR ROOM 0 15,462,158 0.000000 0.000000 74,840 52.00 54.00 05300 ANDILLOGY – JAGNOSTIC 0 22,708,221 0.000000 0.000000 18,286 60.00 60.00 Gobool LABORATORY 0 7,596,194 0.000000 0.000000 18,286 60.00 61.00 Gobool LABORATORY 0 2,386,443 0.000000 0.000000 3,676 65.00 65.00 OBSDO RECHTRORATIORY 0 1,610,653 0.000000 0.000000 3,676 65.00 60.00 Gobool CLABORATORY 0 1,610,653 0.000000 0.000000 3,676 65.00 61.00 Gobool LABORATORY 0 1,21,479 0.0000000 0.000000	Cost Center Description	Total	Total Charges	Ratio of Cost		Inpatient	
col. 2, 3 and 4) 8) 7) (col. 6 + col. 7) ANCI LLARY SERVICE COST CENTERS		Outpati ent					
4) 7) 6.00 7.00 8.00 9.00 10.00 ANCI LLARY SERVICE COST CENTERS 0 0.000000 0.000000 7.766 50.00 50.00 05200 DELIVEY ROM & LABOR ROM 0 15,462,158 0.000000 0.000000 74,840 52.00 52.00 05300 ANESTHESI OLOGY 0 1,837,375 0.000000 0.000000 8,083 54.00 64.00 05400 RADI OLOGY-DI AGNOSTI C 0 22,708,221 0.000000 0.000000 8,083 54.00 65.00 05600 DESPI RATORY THERAPY 0 7,596,194 0.000000 0.000000 8,283 56.00 66.00 06600 PHYSI CAL THERAPY 0 1,610,653 0.000000 0.000000 3,676 65.00 67.00 06700 0.020400 121,479 0.000000 0.000000 0.000000 69.00 68.00 06800 SPECH PATHOLOGY 0 121,479 0.000000 0.000000 69.00		Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	Charges	
6.00 7.00 8.00 9.00 10.00 ANCI LLARY SERVICE COST CENTERS		col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 DPERATING ROOM 0 15, 462, 158 0.000000 73, 776 50. 00 52. 00 052000 DELI VERY ROOM & LABOR ROOM 0 1, 898, 296 0.000000 74, 870 52. 00 53. 00 05300 ANESTHESI OLOGY 0 1, 837, 375 0.000000 0.000000 8, 883 54. 00 64. 00 06400 LABORATORY 0 7, 796, 194 0.000000 0.000000 18, 286 60. 00 65. 00 06500 RESPI RATORY THERAPY 0 2, 386, 443 0.000000 0.000000 153 66. 00 66. 00 OG500 RESPI RATORY THERAPY 0 1, 610, 653 0.000000 0.000000 153 66. 00 67. 00 OG700 OCCUPATI ONAL THERAPY 0 1, 610, 653 0.000000 0.000000 931 67. 00 68. 00 0.6800 SPEECH PATHOLOGY 0 1, 214, 79 0.000000 0.000000 0.000000 0.000000 0.000000 0							
50.00 05000 OPERATI NG ROOM 0 15, 462, 158 0.000000 73, 776 50.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0 1, 898, 296 0.000000 0.000000 74, 840 52.00 53.00 05300 ANESTHESI OL CGY 0 1, 837, 375 0.000000 0.000000 16, 574 53.00 64.00 05400 RADI OLOGY-DI AGNOSTI C 0 22, 708, 221 0.000000 0.000000 8, 083 54.00 60.00 062500 LOBO CLOTTING FOR HEMOPHI LIACS 0 0 0.000000 0.000000 0 62.30 06500 RESPI RATORY THERAPY 0 2, 386, 443 0.000000 0.000000 62.30 06700 0CCUPATI ONAL THERAPY 0 1, 610, 653 0.000000 0.000000 63.00 68.00 69000 ELECTROCARDI OLOGY 0 121, 479 0.000000 0.000000 69.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENT 0 2.009, 534 0.000000 0.000000 69.00 72.00 07200 IMELCAL SUPPLIES CHARGED TO PATI ENTS		6.00	7.00	8.00	9.00	10.00	
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 1,898,296 0.000000 0.000000 74,840 52.00 53.00 05300 ANESTHESI OLOGY 0 1,837,375 0.000000 0.000000 16,574 53.00 64.00 05400 RADIOLOGY-DIAGNOSTI C 0 22,708,221 0.000000 0.000000 18,286 60.00 65.00 06500 RESPI RATORY 0 7,596,194 0.000000 0.000000 0.62.30 65.00 06500 RESPI RATORY THERAPY 0 2,386,443 0.000000 0.000000 13 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 1,610,653 0.000000 0.000000 135 66.00 67.00 06700 0CUPATI ONAL THERAPY 0 121,479 0.000000 0.000000 68.00 69.00 06800 SPEECH PATHOLOGY 0 121,479 0.000000 0.000000 67.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 974,418 0.000000 0.000000 67.97 73.00 07697							
53.00 05300 ANESTHESI OLOGY 0 1, 837, 375 0.000000 0.000000 16, 574 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 22, 708, 221 0.000000 0.000000 8, 083 54.00 60.00 LABORATORY 0 7, 596, 194 0.000000 0.000000 18, 286 60.00 62.30 06500 RESPI RATORY THERAPY 0 2, 386, 443 0.000000 0.000000 3, 676 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 610, 653 0.000000 0.000000 931 67.00 67.00 06700 0CCUPATI ONAL THERAPY 0 589, 408 0.000000 0.000000 931 67.00 68.00 06800 SPECH PATHOLOGY 0 121, 479 0.000000 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0.000000 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 2, 099, 534 0.000000 0.000000 0 72.00 73.00 07300	50.00 05000 OPERATI NG ROOM	0	15, 462, 158	0.00000	0. 000000	73, 776	50.00
54.00 05400 RADI OLOGY-DI AGNOSTI C 0 22, 708, 221 0.000000 0.000000 8, 083 54.00 60.00 06000 LABORATORY 0 7, 596, 194 0.000000 0.000000 18, 286 60.00 62.30 06500 RESPI RATORY THERAPY 0 2, 386, 443 0.000000 0.000000 3, 676 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 610, 653 0.000000 0.000000 153 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 1, 610, 653 0.000000 0.000000 0 68.00 68.00 06800 SPEECH PATHOLOGY 0 121, 479 0.000000 0.000000 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0.000000 69.00 71.00 07100 MED LEV. CHARGED TO PATI ENTS 0 974, 418 0.000000 0.000000 71.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 974, 418 0.000000 0.000000 0 72.00 74.97 07	52.00 05200 DELIVERY ROOM & LABOR ROOM	0	1, 898, 296	0.00000	0. 000000	74, 840	52.00
60.00 06000 LABORATORY 0 7, 596, 194 0.000000 0.000000 18, 286 60.00 62.30 06250 BLOOD CLOTTI NG FOR HEMOPHI LI ACS 0 0.000000 0.000000 0 62.30 65.00 06500 RESPI RATORY THERAPY 0 2, 386, 443 0.000000 0.000000 3, 676 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 610, 653 0.000000 0.000000 931 67.00 67.00 06700 OCCUPATI ONAL THERAPY 0 589, 408 0.000000 0.000000 0 68.00 68.00 06800 SPEECH PATHOLOGY 0 121, 479 0.000000 0.000000 0 68.00 69.00 OF000 ELECTROCARDI OLOGY 0 0 0.000000 0.000000 0 72.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 8,004,355 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0.000000 0.000000 0 76.97	53. 00 05300 ANESTHESI OLOGY	0	1, 837, 375	0.00000	0. 000000	16, 574	53.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS 0 0 0.00000 0.000000 0 62.30 65.00 06500 RESPI RATORY THERAPY 0 2,386,443 0.00000 0.000000 3,676 65.00 66.00 06600 PHYSI CAL THERAPY 0 1,610,653 0.00000 0.000000 931 67.00 67.00 0CCUPATI ONAL THERAPY 0 589,408 0.000000 0.000000 931 67.00 68.00 06800 SPEECH PATHOLOGY 0 121,479 0.000000 0.000000 0 68.00 69.00 O4900 ELECTROCARDI OLOGY 0 0 0.000000 0.000000 69.00 71.00 MDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 974,418 0.000000 0.000000 20,756 73.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 8,004,355 0.000000 0.000000 0 76.97 76.97 CARDI AC REHABI LI TATI ON 0 0 0.000000 0.000000 0 76.97 76.98 07698 HYPERBARI C 0XY	54.00 05400 RADI OLOGY-DI AGNOSTI C	0	22, 708, 221	0.00000	0. 000000	8, 083	54.00
65.00 06500 RESPI RATORY THERAPY 0 2, 386, 443 0.000000 0.000000 3, 676 65.00 66.00 06600 PHYSI CAL THERAPY 0 1, 610, 653 0.000000 0.000000 153 66.00 67.00 06700 OCCUPATI ONAL THERAPY 0 589, 408 0.000000 0.000000 931 67.00 68.00 06800 SPECH PATHOLOGY 0 121, 479 0.000000 0.000000 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0.000000 0.000000 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 974, 418 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 8, 004, 355 0.000000 0.000000 20, 756 73.00 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0.000000 0.000000 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 0 76.98 90.00 09000	60. 00 06000 LABORATORY	0	7, 596, 194	0. 000000	0. 000000	18, 286	60.00
66.00 06600 PHYSI CAL THERAPY 0 1, 610, 653 0.000000 0.000000 153 66.00 67.00 06700 0CCUPATI ONAL THERAPY 0 589, 408 0.000000 0.000000 931 67.00 68.00 06800 SPECH PATHOLOGY 0 121, 479 0.000000 0.000000 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0.000000 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 2,009,534 0.000000 0.000000 0 72.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 974,418 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 8,004,355 0.000000 0.000000 0 76.97 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0.000000 0 76.97 76.99 07699 LI THOTRI PSY 0 0 0.000000 0.000000 0 90.00 90.00	62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	0	0. 000000	0. 000000	0	62.30
67.00 06700 0CCUPATIONAL THERAPY 0 589,408 0.000000 0.000000 931 67.00 68.00 06800 SPEECH PATHOLOGY 0 121,479 0.000000 0.000000 0 68.00 69.00 06900 ELECTROCARDIOLOGY 0 0 0.000000 0.000000 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 2,009,534 0.000000 0.000000 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 974,418 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 8,004,355 0.000000 0.000000 0 72.00 76.97 07697 CARDIA C REHABILITATION 0 0 0.000000 0.000000 0 76.97 76.98 07698 HYPERBARI C OXYGEN THERAPY 0 0 0.000000 0 0.000000 0 76.98 90.00 07699 LI THOTRI PSY 0 0 0.000000 0.000000 0 00.000000 <td< td=""><td>65. 00 06500 RESPI RATORY THERAPY</td><td>0</td><td>2, 386, 443</td><td>0. 000000</td><td>0. 000000</td><td>3, 676</td><td>65.00</td></td<>	65. 00 06500 RESPI RATORY THERAPY	0	2, 386, 443	0. 000000	0. 000000	3, 676	65.00
68.00 06800 SPEECH PATHOLOGY 0 121,479 0.000000 0.000000 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 0.000000 0.000000 0 69.00 71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 2,009,534 0.000000 0.000000 6,757 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 974,418 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 8,004,355 0.000000 0.000000 20,756 73.00 76.97 07697 CARDI AC REHABI LI TATI ON 0 0 0.000000 0.000000 0 76.97 76.98 N7698 HYPERBARI C OXYGEN THERAPY 0 0 0.000000 0.000000 0 76.97 90.00 09000 CLI NI C 0 0 0.000000 0.000000 90.00 90.01 09000 CLI NI C 0 0 0.000000 0.000000 90.01 91.00 90.01<	66. 00 06600 PHYSI CAL THERAPY	0	1, 610, 653	0. 000000	0. 000000	153	66.00
69.00 06900 ELECTROCARDIOLOGY 0 0 0.000000 0.000000 0 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 2,009,534 0.000000 0.000000 6,757 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 974,418 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 8,004,355 0.000000 0.000000 20,756 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0.000000 0.000000 0 76.97 76.98 07699 LITHOTRIPSY 0 0 0.000000 0.000000 0 76.99 0UTPATIENT SERVICE COST CENTERS 0 0 0.000000 0.000000 0 90.00 90.00 09000 CLINIC 0 0 0.000000 0.000000 0 90.00 91.01 09010 EMERGENCY 0 0 0.000000 0.000000 0 90.01 92.00 09SERVATI ON BEDS (NON-DI STINCT PART	67.00 06700 OCCUPATI ONAL THERAPY	0	589, 408	0. 000000	0. 000000	931	67.00
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 2,009,534 0.000000 0.000000 6,757 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 974,418 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 8,004,355 0.000000 0.000000 20,756 73.00 76.97 ORADI AC REHABILI TATI ON 0 0 0.000000 0.000000 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 0 000000 0 000000 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0.000000 0 000000 0 00 0.000000 0 0 90.00 90.00 09000 CLI NI C 0 0 0.000000 0 00.000000 0 90.00 90.01 09000 CLI NI C 0 0 0.000000 0.000000 0 90.01 91.01 09001 LI FEBRI DGE SENI OR CARE 0	68.00 06800 SPEECH PATHOLOGY	0	121, 479	0. 000000	0. 000000	0	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 974,418 0.000000 0.000000 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 8,004,355 0.000000 0.000000 20,756 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0.000000 0.000000 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 0.000000 0 76.98 76.99 D1FATIENT SERVICE COST CENTERS 0 0 0.000000 0.000000 0 76.98 90.00 09000 CLINIC 0 0 0.000000 0.000000 0 90.00 90.01 09001 LI FEBRI DGE SENI OR CARE 0 647,746 0.000000 0.000000 0 90.01 91.00 09100 EMERGENCY 0 12,458,342 0.000000 0.000000 6,569 91.00 92.00 DSERVATION BEDS (NON-DI STINCT PART 0 1,27,365 0.000000 0.000000 6,569 91.00 95.00 09500<	69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 000000	0. 000000	0	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 0 8,004,355 0.000000 0.000000 20,756 73.00 76.97 07697 CARDI AC REHABILITATION 0 0 0.000000 0.000000 0 76.97 76.98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 0.000000 0 76.98 76.99 07699 LI THOTRI PSY 0 0 0.000000 0.000000 0 76.98 70.00 09000 CLI NI C 0 0 0.000000 0.000000 0 90.00 90.00 09000 CLI NI C 0 0 0.000000 0.000000 0 90.00 90.01 09001 LI FEBRI DGE SENI OR CARE 0 647,746 0.000000 0.000000 0 90.01 91.00 09100 EMERGENCY 0 12,458,342 0.000000 0.000000 6,569 91.00 92.00 OBSERVATION BEDS (NON-DI STINCT PART 0 1,127,365 0.000000 0.000000 6,569 92.00 OTHER REI MBURSABLE COST CENTER	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2,009,534	0. 000000	0. 000000	6, 757	71.00
76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0.000000 0.000000 0 76. 97 76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.000000 0.000000 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0.000000 0.000000 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0.000000 0.000000 0 76. 99 0 07699 LI THOTRI PSY 0 0 0.000000 0.000000 0 76. 99 0 09000 CLI NI C 0 0 0.000000 0.000000 0 90. 00 90. 00 09000 CLI NI C 0 0 0.000000 0.000000 90. 00 90. 01 09001 LI FEBRI DGE SENI OR CARE 0 647, 746 0.000000 0.000000 6, 569 91. 00 91. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 1, 127, 365 0.000000 0.000000 6, 569 91. 00 07HER REI MBURSABLE COST CENTERS	72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	974, 418	0. 000000	0. 000000	0	72.00
76. 98 07698 HYPERBARI C 0XYGEN THERAPY 0 0 0.00000 0.000000 0 76. 98 76. 99 07699 LI THOTRI PSY 0 0 0.000000 0.000000 0 76. 98 00 00000 CLI NI C 0 0 0.000000 0.000000 0 90. 00 90. 00 09000 CLI NI C 0 0 0.000000 0.000000 0 90. 00 90. 01 09001 CLI FBRI DGE SENI OR CARE 0 647, 746 0.000000 0.000000 0 90. 01 91. 00 09100 EMERGENCY 0 12, 458, 342 0.000000 0.000000 6, 569 91. 00 92. 00 DBSERVATI ON BEDS (NON-DI STI NCT PART 0 1, 127, 365 0.000000 0.000000 0 92. 00 0 04500 AMBULANCE SERVI CES 95. 00 95. 00 95. 00 95. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	8,004,355	0.00000	0. 000000	20, 756	73.00
76.99 07699 L1 THOTRI PSY 0 0 0.00000 0.00000 0 76.99 OUTPATI ENT SERVICE COST CENTERS 0 0 0.000000 0.000000 0 90.00 90.00 09000 CLI NI C 0 0 0.000000 0.000000 0 90.00 90.01 09001 LI FEBRI DGE SENI OR CARE 0 647,746 0.000000 0.000000 0 90.01 91.00 09100 EMERGENCY 0 12,458,342 0.000000 0.000000 6,569 91.00 92.00 095200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 1,127,365 0.000000 0.000000 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	0.00000	0. 000000	0	76.97
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 0.00000 0.000000 0 90.00 90.01 09000 CLINIC 0 0 0.000000 0.000000 0 90.00 90.01 09001 LIFEBRIDGE SENIOR CARE 0 647,746 0.000000 0.000000 0 90.01 91.00 09100 EMERGENCY 0 12,458,342 0.000000 0.000000 6,569 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 1,127,365 0.000000 0.000000 0 92.00 0THER REI MBURSABLE COST CENTERS 95.00 09500 AMBULANCE SERVICES 95.00 95.00	76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	0	0. 000000	0. 000000	0	76. 98
90. 00 09000 CLI NI C 0 0 0.00000 0.000000	76. 99 07699 LI THOTRI PSY	0	0	0. 000000	0. 000000	0	76.99
90. 01 09001 LI FEBRI DGE SENI OR CARE 0 647, 746 0.00000 0.00000 0 90. 01 91. 00 09100 EMERGENCY 0 12, 458, 342 0.000000 0.000000 6, 569 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART 0 1, 127, 365 0.000000 0.000000 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVI CES 95. 00 95. 00	OUTPATIENT SERVICE COST CENTERS	·					
91. 00 09100 EMERGENCY 0 12, 458, 342 0. 000000 0. 000000 6, 569 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART 0 1, 127, 365 0. 000000 0. 000000 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00	90. 00 09000 CLI NI C	0	0	0.00000	0. 000000	0	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 1, 127, 365 0. 000000 0. 000000 0 92. 00 0THER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00 95. 00 95. 00	90. 01 09001 LI FEBRI DGE SENI OR CARE	0	647, 746	0. 000000	0. 000000	0	90.01
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 1, 127, 365 0.000000 0.000000 0 92. 00 OTHER REI MBURSABLE COST CENTERS 95. 00 09500 AMBULANCE SERVICES 95. 00 95. 00 95. 00 95.	91.00 09100 EMERGENCY	0	12, 458, 342	0. 000000	0. 000000	6, 569	91.00
95. 00 09500 AMBULANCE SERVICES 95. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0. 000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
200.00 Total (Lines 50-199) 0 79, 431, 987 230, 401 200.00	95. 00 09500 AMBULANCE SERVICES						95.00
	200.00 Total (lines 50-199)	0	79, 431, 987			230, 401	200. 00

Health Financial Systems COMM	IUNI TY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	VICE OTHER PASS	5 Provider C	CN: 15-1323	Peri od:	Worksheet D
THROUGH COSTS				From 01/01/2016	Part IV
				To 12/31/2016	Date/Time Prepared: 5/30/2017 12:53 pm
		Ti tl	e XIX	Hospi tal	PPS
Cost Center Description	I npati ent	Outpati ent	Outpati ent		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Throug	h	
	Costs (col. 8		Costs (col.	9	
	x col. 10)		x col. 12)		
	11.00	12.00	13.00		
ANCI LLARY SERVI CE COST CENTERS	r				
50.00 05000 OPERATI NG ROOM	0	C		0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C		0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0	54.00
60. 00 06000 LABORATORY	0	C		0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS	0	C		0	62.30
65. 00 06500 RESPI RATORY THERAPY	0	C		0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	C		0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C)	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C)	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	C)	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C		0	76. 97
76. 98 07698 HYPERBARI C OXYGEN THERAPY	0	C		0	76. 98
76. 99 07699 LI THOTRI PSY	0	C)	0	76. 99
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0	C		0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0	C		0	90. 01
91.00 09100 EMERGENCY	0	C		0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	C)	0	92.00
OTHER REIMBURSABLE COST CENTERS					
95. 00 09500 AMBULANCE SERVICES					95.00
200.00 Total (lines 50-199)	0	C		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 SER	/ICES AND VACCINE COST	Provider CO		Peri od:	Worksheet D	
				From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	narod
				10 12/31/2010	5/30/2017 12:	53 pm
		Ti tl	e XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	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						-
50.00 05000 OPERATI NG ROOM	0. 179023	0		0 49, 827	0	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 682702	0		0 0	0	52.00
53.00 05300 ANESTHESI OLOGY	0. 016585	0		0 7, 999	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 106909	0		0 264, 743	0	54.00
60. 00 06000 LABORATORY	0. 201003	0		0 97, 733	0	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIAC		0		0 0	0	62.30
65. 00 06500 RESPI RATORY THERAPY	0. 278535	0		0 3, 156	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 590057	0		0 1, 867	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 441801	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1. 099647	0		0 1, 165	0	68.00
69.00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PA	TI ENT 0. 241513	0		0 4, 685	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 304160	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 290926	0		0 39, 429	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 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE	0. 723228	0		0 0	0	90.01
91.00 09100 EMERGENCY	0. 294660	0		0 257, 322	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	PART 1. 154921	0		0 35, 819	0	92.00
OTHER REIMBURSABLE COST CENTERS						1
95.00 09500 AMBULANCE SERVICES	0. 573043	0		0		95.00
200.00 Subtotal (see instructions)		0		0 763, 745	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		0 763, 745	0	202.00

Health Financial Systems	COMN OTHER HEALTH SERVICES AND	UNITY HOSPT. O	E LAGRANGE CTY		Period:	u of Form CMS Worksheet D	-2552-10
APPORTIONMENT OF MEDICAL	_, UTHER HEALTH SERVICES AND	VACCINE CUSI	Provider C	JN: 15-1323	From 01/01/2016	Part V	
					To 12/31/2016	Date/Time Pr	epared:
						5/30/2017 12	:53 pm
				e XIX	Hospi tal	PPS	_
			sts				
Cost Center	Description	Cost	Cost				
		Rei mbursed	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		-		1			
50.00 05000 OPERATING R		0	8, 920				50.00
52.00 05200 DELIVERY R0		0	0				52.00
53.00 05300 ANESTHESI OL		0	133				53.00
54.00 05400 RADI OLOGY-D	I AGNOSTI C	0	28, 303				54.00
60. 00 06000 LABORATORY		0	19, 645				60.00
	ING FOR HEMOPHILIACS	0	0				62.30
65. 00 06500 RESPI RATORY		0	879				65.00
66.00 06600 PHYSI CAL TH		0	1, 102				66.00
67.00 06700 OCCUPATI ONA		0	0				67.00
68.00 06800 SPEECH PATH		0	1, 281				68.00
69.00 06900 ELECTROCARD		0	0				69.00
	PLIES CHARGED TO PATIENT	0	1, 131				71.00
72.00 07200 IMPL. DEV.		0	0				72.00
73.00 07300 DRUGS CHARG	ED TO PATIENTS	0	11, 471				73.00
76. 97 07697 CARDI AC REH.	ABI 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 SERVIC	E COST CENTERS						
90.00 09000 CLINIC		0	0				90.00
90. 01 09001 LI FEBRI DGE	SENI OR CARE	0	0				90.01
91.00 09100 EMERGENCY		0	75, 823				91.00
92.00 09200 OBSERVATI ON	BEDS (NON-DISTINCT PART	0	41, 368				92.00
OTHER REI MBURSABL	E COST CENTERS						
95.00 09500 AMBULANCE S	ERVI CES	0					95.00
200.00 Subtotal (se	ee instructions)	0	190, 056				200.00
	inic Lab. Services-Program	0					201.00
Only Charge							
	(line 200 +/- line 201)	0	190, 056				202.00

	Financial Systems COMMUNITY HOSPT. OF L ATION OF INPATIENT OPERATING COST	AGRANGE CTY IN Provider CCN: 15-1323	In Lie Period:	u of Form CMS-2 Worksheet D-1	2552-10
			From 01/01/2016 To 12/31/2016	Date/Time Pre 5/30/2017 12:	
		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, 503	1.00
2.00 3.00	Inpatient days (including private room days, excluding swing- Private room days (excluding swing-bed and observation bed day do not complete this line.		ivate room days,	2, 844 0	2.00 3.00
4.00 5.00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo reporting period		r 31 of the cost	1, 997 396	4.00 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) Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	263	7.00
8.00	Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8.00
9.00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to newborn days)	o the Program (excluding	swing-bed and	762	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	396	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	nly (including private r	oom days) after	0	11. 00
12.00	Swing-bed NF type inpatient days applicable to titles V or XL) through December 31 of the cost reporting period	X only (including privat	e room days)	0	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	e)	0	13.00
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	
	Nursery days (title V or XIX only)			0	
17.00	SWING BED ADJUSTMENT 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	es after December 31 of	the cost		18.00
19.00	reporting period 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 Medicaid rate for swing-bed NF services applicable to services	s after December 31 of t	he cost	123. 32	20. 00
21.00	reporting period Total general inpatient routine service cost (see instructions	-)		5, 012, 983	21.00
22.00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)		ing period (line	3, 012, 983 0	21.00
23.00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportin	g period (line 6	0	23.00
24.00	Swing-bed cost applicable to NF type services through December 7 x line 19)	r 31 of the cost reporti	ng period (line	32, 433	24.00
25.00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25.00
26.00 27.00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost ((line 21 minus line 26)		641, 168 4, 371, 815	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00 29.00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	d 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 33.00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
34.00	Average per diem private room charge differential (line 32 mir	nus line 33)(see instruc	tions)	0.00	
35.00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
36.00 37.00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	fferential (line	0 4, 371, 815	36.00 37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENITS			
38.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 537. 21	38.00
39.00	Program general inpatient routine service cost (line 9 x line	38)		1, 171, 354	39.00
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 1, 171, 354	40. 00 41. 00

		UNITY HOSPT. OF					u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi	der CC		Period: From 01/01/2016	Worksheet D-1	
						To 12/31/2016		
				T: +1 o	XV/LLL	llaani tal	5/30/2017 12:	53 pm_
	Cost Center Description	Total	Tota		XVIII Average Per	Hospital Program Days	Cost Program Cost	
	bost bonter beschiptron	Inpatient Cost					(col. 3 x col.	
			·	-	col. 2)		4)	
42.00	NURSERV (title V & XIX only)	1.00	2.00	0	3.00	4.00 0 0	5.00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0		0	0.0	0 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 (Wk						582, 151	48.00
49.00	Total Program inpatient costs (sum of lines a	41 through 48)(see instr	ructio	ns)		1, 753, 505	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	servi ces	(from	Wkst D sum	of Parts L and	0	50.00
50.00	111)							50.00
51.00	Pass through costs applicable to Program inpa and IV)		y service	es (fro	om Wkst. D, s	um 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 medical education costs (line 49 minus line !		lated, no	on-phy:	sician anesth	etist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54.00	Program discharges						0	54.00
	Target amount per discharge						0.00	
	Target amount (line 54 x line 55)						0	56.00
	Difference between adjusted inpatient operati Bonus payment (see instructions)	ing cost and ta	rget amou	int (i	ine 56 minus	The 53)	0	57.00 58.00
	Lesser of lines 53/54 or 55 from the cost re	porting period	ending 19	96, u	pdated and co	mpounded by the	0.00	
	market basket	0 1	0					
	Lesser of lines 53/54 or 55 from prior year of						0.00	
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		0 (11100	01 /		the target		
	Relief payment (see instructions)						0	62.00
63.00	Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instru	ctions)				0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 d	of the	cost reporti	ng period (See	608, 735	64.00
	instructions)(title XVIII only)							
65.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decemb	er 31 of	the c	ost reporting	period (See	0	65.00
66.00	Total Medicare swing-bed SNF inpatient routin CAH (see instructions)	ne costs (line	64 plus l	ine 6	5)(title XVII	l only). For	608, 735	66. 00
67.00	Title V or XIX swing-bed NF inpatient routine	e costs through	December	· 31 o	f the cost re	porting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after D	ecember 3	1 of	the cost repo	rting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient n	routine costs (line 67 +	line	68)		0	69.00
	PART III - SKILLED NURSING FACILITY, OTHER NU		•					
	Skilled nursing facility/other nursing facili	3						70.00
71.00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine /0 ÷	iine .	2)			71.00 72.00
	Medically necessary private room cost application		(line 14	x li	ne 35)			73.00
	Total Program general inpatient routine servi							74.00
75.00		routine service	costs (f	rom W	orksheet B, P	art II, column		75.00
76 00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)						76.00
	Program capital -related costs (line 9 x line							77.00
	Inpatient routine service cost (line 74 minus							78.00
	00 0 0	· · ·			,			79.00
	Total Program routine service costs for compa Inpatient routine service cost per diem limi		OST LIMIT	ation	(TINE 78 min	us line 79)		80. 00 81. 00
	Inpatient routine service cost per drem finm Inpatient routine service cost limitation (li)					81.00
	Reasonable inpatient routine service costs (83.00
	Program inpatient ancillary services (see ins							84.00
	Utilization review - physician compensation	•						85.00
ou. UU	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		rougn 85)					86.00
87.00	Total observation bed days (see instructions)						847	87.00
88.00	Adjusted general inpatient routine cost per o	•	line 2)				1, 537. 21	
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)					1, 302, 017	89.00

Health Financial Systems COMM	IUNI TY HOSPT. OI	F LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
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	611, 960	5, 012, 983	0. 12207	5 1, 302, 017	158, 944	90.00
91.00 Nursing School cost	0	5, 012, 983	0.00000	0 1, 302, 017	0	91.00
92.00 Allied health cost	0	5, 012, 983	0.00000	0 1, 302, 017	0	92.00
93.00 All other Medical Education	0	5, 012, 983	0.00000	0 1, 302, 017	0	93.00

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST

COMMUNITY HOSPT. OF L	AGRANGE CTY IN	In Lieu	u of Form CMS-2552-10
	Provider CCN: 15-1323	Period: From 01/01/2016	Worksheet D-1

	5/30/2017 12:	pared: 53 pm
Cost Center Description	PPS	
	1.00	
PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS		
1.00 Inpatient days (including private room days and swing-bed days, excluding newborn)	3, 503	1.00
2.00 Inpatient days (including private room days, excluding swing-bed and newborn days)	2, 844	2.00
3.00 Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.	0	3.00
4.00 Semi-private room days (excluding swing-bed and observation bed days)	1, 997	4.00
5.00 Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	396	5.00
reporting period 6.00 Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
reporting period (if calendar year, enter 0 on this line)	0/2	7 00
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period	263	7.00
8.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8.00
reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and	25	9.00
newborn days)		
10.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)	0	10.00
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11.00
12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12.00
through December 31 of the cost reporting period 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	13.00
14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days)		14.00
15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only)		15.00 16.00
SWING BED ADJUSTMENT	1	
17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17.00
18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period		18.00
19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19.00
reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20.00
21.00 Total general inpatient routine service cost (see instructions)	5, 012, 983	
22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)	0	22.00
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)	0	23.00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25.00
x line 20) 26.00 Total swing-bed cost (see instructions)	612, 699	26.00
27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4, 400, 284	
PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	1	
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges)	0	
30.00 Semi-private room charges (excluding swing-bed charges)	0	
31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32.00 Average private room per diem charge (line 29 ÷ line 3)	0.00	
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35)	0.00	
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line		
27 minus Line 36)		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38.00 Adjusted general inpatient routine service cost per diem (see instructions)	1, 547. 22	38.00
39.00 Program general inpatient routine service cost (line 9 x line 38)	38, 681	
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00 Total Program general inpatient routine service cost (line 39 + line 40)	38, 681	41.00

		UNITY HOSPT. OF					u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi d	er CC		Period: From 01/01/2016	Worksheet D-1	
						0 12/31/2016		
				Title	e XIX	Hospi tal	5/30/2017 12: PPS	53 pm
	Cost Center Description	Total	Total		Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpati ent	Days			(col. 3 x col.	
		1.00	2.00		<u>col. 2)</u> 3.00	4.00	4) 5.00	
42.00	NURSERY (title V & XIX only)	373, 599		466	801.71		113, 041	42.00
40.00	Intensive Care Type Inpatient Hospital Units							40.00
	I NTENSI VE CARE UNI T CORONARY CARE UNI T							43.00 44.00
	BURN INTENSIVE CARE UNIT							45.00
	SURGICAL INTENSIVE CARE UNIT							46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description							47.00
	Cost center bescription						1.00	
	Program inpatient ancillary service cost (Wk						80, 247	48.00
49.00	Total Program inpatient costs (sum of lines	41 through 48)(see instru	ictio	ns)		231, 969	49.00
50.00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpa	atient routine	services (from	Wkst D sum	of Parts L and	8, 497	50.00
	Pass through costs applicable to Program inpl and IV)		ry services	s (fro	om Wkst. D, su	m of Parts II	4, 108	
52.00 53.00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		lated por	, phy	cician anactha	tict and	12,605	52.00 53.00
55.00	medical education costs (line 49 minus line 1		erateu, nor	i-pity:		tist, anu	219, 364	55.00
	TARGET AMOUNT AND LIMIT COMPUTATION							
	Program di scharges						0	54.00
	Target amount per discharge Target amount (line 54 x line 55)						0. 00 0	55.00 56.00
	Difference between adjusted inpatient operat	ing cost and ta	arget amour	nt (li	ine 56 minus l	ine 53)	0	57.00
58.00	Bonus payment (see instructions)						0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 199	96, uj	pdated and com	pounded by the	0.00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year	cost report, up	dated by t	he ma	arket basket		0.00	60.00
61.00	If line 53/54 is less than the lower of line						0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		s (lines 5	64 X (60), or 1% of	the target		
62.00	Relief payment (see instructions)	instructions)					0	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)				0	63.00
64.00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of	tho	cost reportir	a period (See	0	64.00
04.00	instructions) (title XVIII only)	ta through beec		the		g period (see	0	04.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 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 plus li	ne 6!	5)(title XVIII	only) For	0	66.00
	CAH (see instructions)	(- p		-,(
67.00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	n December	31 01	f the cost rep	orting 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	of [·]	the cost repor	ting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient						0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU							70.00
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	5						70. 00 71. 00
72.00	Program routine service cost (line 9 x line				,			72.00
	Medically necessary private room cost application				ne 35)			73.00
74.00 75.00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•			orksheet B Pa	rt II column		74.00 75.00
70.00	26, line 45)							70.00
	Per diem capital-related costs (line 75 ÷ lin							76.00
77.00 78.00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu:	· ·						77.00 78.00
79.00	Aggregate charges to beneficiaries for excess		orovider re	cord	s)			79.00
80.00	Total Program routine service costs for compa					is line 79)		80.00
81.00	Inpatient routine service cost per diem limi							81.00
82.00 83.00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82.00 83.00
	Program inpatient ancillary services (see ins		- /					84.00
	Utilization review - physician compensation							85.00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		nrough 85)					86.00
87.00	Total observation bed days (see instructions						847	87.00
88.00	Adjusted general inpatient routine cost per	diem (line 27 ÷					1, 547. 22	88.00
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)					1, 310, 495	89.00

Health Financial Systems COMM	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 01/01/2016 To 12/31/2016	Date/Time Pre 5/30/2017 12:	
		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	611, 960	5, 012, 983	0. 12207	5 1, 310, 495	159, 979	90.00
91.00 Nursing School cost	0	5, 012, 983	0.00000	0 1, 310, 495	0	91.00
92.00 Allied health cost	0	5, 012, 983	0.00000	1, 310, 495	0	92.00
93.00 All other Medical Education	0	5, 012, 983	0.00000	1, 310, 495	0	93.00

Health Financial Systems COMMUNITY HOSPT. OF			In Lie	eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1323	Period: From 01/01/2016	Worksheet D-3	3
			To 12/31/2016		epared.
			10 12/01/2010	5/30/2017 12:	
	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, 174, 216		30.00
43. 00 04300 NURSERY			1, 17 1, 210		43.00
ANCI LLARY SERVI CE COST CENTERS		1		1	
50.00 05000 OPERATI NG ROOM		0. 1790	403, 609	72, 255	50.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0. 6827	D2 C	0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 0165	85 51, 286	851	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1069	09 447, 693	47, 862	2 54.00
60. 00 06000 LABORATORY		0. 2010	309, 326	62, 175	60.00
62.30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000		0 0	
65. 00 06500 RESPI RATORY THERAPY		0. 2785			
66. 00 06600 PHYSI CAL THERAPY		0. 5900			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4418			
68.00 06800 SPEECH PATHOLOGY		1.0996			
69. 00 06900 ELECTROCARDI OLOGY		0.0000		-	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2415			
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3041			
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2909			
76. 97 07697 CARDI AC REHABI LI TATI ON		0.0000		0	
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0000		0	1 1 0 1 1 0
76. 99 07699 LI THOTRI PSY OUTPATI ENT SERVI CE COST CENTERS		0.0000		C	76.99
90. 00 09000 CLINIC		0.0000	20 0		90.00
90. 01 09001 LI FEBRI DGE SENI OR CARE		0. 7232			
91. 00 09100 EMERGENCY		0. 2946		-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 1549			
OTHER REI MBURSABLE COST CENTERS					1
95. 00 09500 AMBULANCE SERVI CES					95.00
200.00 Total (sum of lines 50-94 and 96-98)			2, 474, 127	582, 151	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	es (line 61)		C		201.00
202.00 Net Charges (line 200 minus line 201)		1	2, 474, 127	,	202.00

Health Financial Systems COMMUNITY HOSPT. OF LA	GRANGE CTY	IN	In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CO	CN: 15-1323	Peri od:	Worksheet D-3	3
	Component (CCN: 15-Z323	From 01/01/2016 To 12/31/2016) Date/Time Pre	narad
	component (JUN: 15-Z323	10 12/31/2010	5/30/2017 12:	53 pm
	Title		Swing Beds - SNI	F 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	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1		1	
30. 00 03000 ADULTS & PEDI ATRI CS 43. 00 04300 NURSERY			C		30.00
ANCI LLARY SERVICE COST CENTERS					43.00
50. 00 05000 OPERATI NG ROOM		0. 1790	23 1, 796	322	50.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 6827		0 0	
53. 00 105300 ANESTHESI OLOGY		0.0165			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 1069		-	
60. 00 06000 LABORATORY		0. 2010			
62. 30 06250 BLOOD CLOTTING FOR HEMOPHILIACS		0.0000			
65. 00 06500 RESPIRATORY THERAPY		0. 2785			
66. 00 06600 PHYSI CAL THERAPY		0. 5900			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4418			
68.00 06800 SPEECH PATHOLOGY		1.0996			
69. 00 06900 ELECTROCARDI OLOGY		0.0000			1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0. 2415	13 18, 500	4, 468	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 3041	60 C		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2909	26 193, 344	56, 249	73.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0.0000	00 00		76.97
76. 98 07698 HYPERBARI C OXYGEN THERAPY		0.0000	00 00	0 0	76. 98
76. 99 07699 LI THOTRI PSY		0.0000	00 00	0 0	76.99
OUTPATI ENT SERVI CE COST CENTERS					
90. 00 09000 CLINIC		0.0000		° °	
90. 01 09001 LI FEBRI DGE SENI OR CARE		0. 7232		0 0	
91. 00 09100 EMERGENCY		0. 2946		0 0	1 11 00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART		1. 1549	21 0	0 0	92.00
OTHER REI MBURSABLE COST CENTERS				1	05 63
95.00 09500 AMBULANCE SERVICES			FE0.000	107.000	95.00
200.00 Total (sum of lines 50-94 and 96-98)	(1) (1)		558, 228	3 197, 908	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(IINE 61)			2	201.00
202.00 Net Charges (line 200 minus line 201)		I	558, 228	5	202.00

Health Fina	ancial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY	IN	In Lie	eu of Form CMS-	2552-10
	ANCILLARY SERVICE COST APPORTIONMEN	Т	Provider C		Period: From 01/01/2016 To 12/31/2016		
						5/30/2017 12:	53 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description			Ratio of Cos		Inpatient	
				To Charges	Program	Program Costs (col. 1 x col.	
					Charges	(COL 1 X COL 2)	
				1.00	2.00	3.00	
I NPA	TIENT ROUTINE SERVICE COST CENTERS			1.00	2.00	3.00	
	O ADULTS & PEDIATRICS				14,010		30.00
43.00 0430	NURSERY				43, 236		43.00
ANCI	LLARY SERVICE COST CENTERS						
	O OPERATING ROOM			0. 17902	23 73, 776	13, 208	50.00
52.00 0520	O DELIVERY ROOM & LABOR ROOM			0. 68270	74, 840	51, 093	52.00
	0 ANESTHESI OLOGY			0. 01658			
	0 RADI OLOGY-DI AGNOSTI C			0. 10690			
	00 LABORATORY			0. 20100		3, 676	
	O BLOOD CLOTTING FOR HEMOPHILIACS			0.00000		-	
	0 RESPI RATORY THERAPY			0. 27853			
	0 PHYSI CAL THERAPY			0. 59005			
	O OCCUPATI ONAL THERAPY			0. 44180			
	O SPEECH PATHOLOGY			1. 09964		-	
	0 ELECTROCARDI OLOGY			0.00000		0	
	O MEDICAL SUPPLIES CHARGED TO PATIE	NT		0. 24151			
	O IMPL. DEV. CHARGED TO PATIENTS			0. 30416		Ŭ	
	O DRUGS CHARGED TO PATIENTS			0. 29092			
	07 CARDI AC REHABI LI TATI ON			0.0000		-	
	8 HYPERBARI C OXYGEN THERAPY			0.0000		e e e e e e e e e e e e e e e e e e e	
				0.00000	00 0	0	76.99
90.00 0900	ATLENT SERVICE COST CENTERS			0.00000	0 0	0	90.00
	1 LI FEBRI DGE SENI OR CARE			0. 72322		0	
	O EMERGENCY			0. 29466			
	O OBSERVATION BEDS (NON-DISTINCT PA	RT		1. 15492		0	
	R REIMBURSABLE COST CENTERS			1. 13472	- 1 0	0	/2.00
	O AMBULANCE SERVICES						95.00
200.00	Total (sum of lines 50-94 and 96-	98)			230, 401	80, 247	200.00
201.00	Less PBP Clinic Laboratory Service		(line 61)		0		201.00
202.00	Net Charges (line 200 minus line				230, 401		202.00
·							

	ATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-1323 Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/30/2017 12:	pared:
	Title XVIII Hospital	Cost	
		1.00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES	4 670 406	1.00
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)	4, 670, 406 0	2.00
3.00	PPS payments	0	3.00
4.00	Outlier payment (see instructions)	0	4.00
5.00 6.00	Enter the hospital specific payment to cost ratio (see instructions) Line 2 times line 5	0. 000 0	5.00 6.00
7.00	Sum of line 3 plus line 4 divided by line 6	0.00	
8.00	Transitional corridor payment (see instructions)	0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200	0	9.00
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)	0 4, 670, 406	10.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES	1, 070, 100	11.00
	Reasonable charges		
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)	0	
	Total reasonable charges (sum of lines 12 and 13)	0	
	Customary charges	-	
15.00	Aggregate amount actually collected from patients liable for payment for services on a charge basis	0	
16.00	Amounts that would have been realized from patients liable for payment for services on a chargebasis had such payment been made in accordance with 42 CFR §413.13(e)	0	16.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)	0. 000000	17.00
	Total customary charges (see instructions)	0	18.00
19.00	Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see instructions)	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see	0	20.00
	instructions)		
	Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)	4, 717, 110	
	Interns and residents (see instructions) Cost of physicians' services in a teaching hospital (see instructions)	0	22.00 23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT		
25.00 26.00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for CAH, see instructions)	39, 326 3, 002, 801	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23] (see	1, 674, 983	
	instructions)		
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50)	0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)	0 1, 674, 983	
	Primary payer payments	2, 077	
32.00	Subtotal (line 30 minus line 31)	1, 672, 906	32.00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)	0	33.00
	Allowable bad debts (see instructions)	253, 602	
	Adjusted reimbursable bad debts (see instructions)	164, 841	35.00
	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)	253, 602 1, 837, 747	
	MSP-LCC reconciliation amount from PS&R	1,037,747	38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	39.00
	Pioneer ACO demonstration payment adjustment (see instructions)	0	39.50
	Partial or full credits received from manufacturers for replaced devices (see instructions) RECOVERY OF ACCELERATED DEPRECIATION	0	39.98 39.99
	Subtotal (see instructions)	1, 837, 747	
40. 01	Sequestration adjustment (see instructions)	36, 755	
	Interim payments	2, 141, 713	
42.00 43.00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)	0 - 340, 721	
	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	
	\$115.2		
	TO BE COMPLETED BY CONTRACTOR		
90, 00	Original outlier amount (see instructions)		90 00
	Original outlier amount (see instructions) Outlier reconciliation adjustment amount (see instructions)	0 0	90.00 91.00
91. 00 92. 00	5	0	91.00 92.00

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider CC	:N: 15-1323	Period: From 01/01/2010 To 12/31/2010		parec
		Title		Hospi tal	Cost	
		Inpatient	t Part A	Pa	rt 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		1, 316, 80	68 0	2, 141, 713 0	1. (2. (
00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. (
01	ADJUSTMENTS TO PROVIDER			0	0	3.
02				0	0	3.
03				0	0	3.
04 05				0	0	3. 3.
05	Provider to Program			0	0	3.
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	3
52				0	0	3
53				0	0	3
54 99	Subtatal (sum of lines 2.01.2.40 minus sum of lines			0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 316, 80	68	2, 141, 713	4.
	TO BE COMPLETED BY CONTRACTOR	L I				
00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.
01	TENTATI VE TO PROVIDER			0	0	5
02				0	0	5
)3				0	0	5
	Provider to Program					-
50 51	TENTATI VE TO PROGRAM			0	0	5
51 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) SETTLEMENT TO PROVIDER		224 4	70	0	6
01 02	SETTLEMENT TO PROVIDER		226, 4	/8	340, 721	6
)2)0	Total Medicare program liability (see instructions)		1, 543, 34	0	1, 800, 992	7
				Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	0		1.00	2.00	8

ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED		Provider Component (Period: From 01/01/2016 Fo 12/31/2016		
		component	JON. 13-2323	10 12/31/2010	5/30/2017 12:	
				wing Beds - SNF		
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		631, 010	D	0	1.
00	Interim payments payable on individual bills, either		(C	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment					3.
00	amount based on subsequent revision of the interim rate					3.
	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			D	0	
02				D	0	
03				D	0	
04				D D	0	
05	Dravidor to Dragram		(0	3
50	Provider to Program ADJUSTMENTS TO PROGRAM		· · · · · ·		0	3
50 51	ADJUSTMENTS TO FROGRAM				0	
52					0	
53					0	
54			(D	0	3
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines		(C	0	3.
	3. 50-3. 98)					
00	Total interim payments (sum of lines 1, 2, and 3.99)		631, 010	0	0	4
	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)					
	TO BE COMPLETED BY CONTRACTOR		<u> </u>			
00	List separately each tentative settlement payment after					15
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
)1)2	TENTATI VE TO PROVIDER				0	
)2)3					0	
	Provider to Program		<u> </u>			Ĭ
50	TENTATI VE TO PROGRAM		(D	0	5
51			(C	0	
52				C	0	
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(D	0	5
20	5.50-5.98)					
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		167, 40!	5	0	6
)2	SETTLEMENT TO PROGRAM				0	
00	Total Medicare program liability (see instructions)		798, 41	-	0	
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		()	1.00	2.00	

Heal th	u of Form CMS-2	2552-10					
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-1323 Period:						
			From 01/01/2016 To 12/31/2016		nared		
			10 12/31/2010	5/30/2017 12:			
		Title XVIII	Hospi tal	Cost			
				1.00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION						
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.		e 14	1,009	1.00		
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12		762	2.00		
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			566	3.00		
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	1-12		1, 997	4.00		
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			90, 247, 429	5.00		
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 l			1, 433, 578	6.00		
7.00	CAH only - The reasonable cost incurred for the purchase of c	ertified HIT technology	Wkst. S-2, Pt. I	19, 507	7.00		
	line 168						
8.00	Calculation of the HIT incentive payment (see instructions)			17, 082	8.00		
9.00	Sequestration adjustment amount (see instructions)			342	9.00		
10.00	Calculation of the HIT incentive payment after sequestration		16, 740	10.00			
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH						
30.00	30.00 Initial/interim HIT payment adjustment (see instructions)						
31.00	Other Adjustment (specify)			0	31.00		
32.00	Balance due provider (line 8 (or line 10) minus line 30 and l	ine 31) (see instruction	is)	16, 740	32.00		

Heal th	Financial Systems COMMUNITY HOSPT. OF L	AGRANGE CTY IN	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1323	Peri od:	Worksheet E-2	
		Component CCN: 15-Z323	From 01/01/2016 To 12/31/2016	Date/Time Pre	narod.
		Component CCN. 13-2323	10 12/31/2010	5/30/2017 12:	
		Swing Beds - SNF			
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		614, 822	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		100.007		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		199, 887	0	3.00
4.00	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see ins Per diem cost for interns and residents not in approved teaching			0.00	4.00
4.00	instructions)	ing program (see		0.00	4.00
5.00	Program days		396	0	5.00
6.00	Interns and residents not in approved teaching program (see in	nstructions)	0,0	0	6.00
7.00	Utilization review - physician compensation - SNF optional me		0	0	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		814, 709	0	
9.00	Primary payer payments (see instructions)		0	0	9,00
10.00	Subtotal (line 8 minus line 9)		814, 709	0	10.00
11.00	Deductibles billed to program patients (exclude amounts applic	cable to physician	0	0	11.00
	professional services)	1 5			
12.00	Subtotal (line 10 minus line 11)		814, 709	0	12.00
13.00	Coinsurance billed to program patients (from provider records)) (exclude coinsurance	0	0	13.00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (enter the lesser of line 12 minus line 13, or line	14)	814, 709	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions	s)	0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
	Allowable bad debts (see instructions)		0	-	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		0	0	17.01
18.00	Allowable bad debts for dual eligible beneficiaries (see inst	ructions)	0	0	18.00
19.00	Total (see instructions)		814, 709	0	19.00
19.01	Sequestration adjustment (see instructions)		16, 294	0	19.01 20.00
20. 00 21. 00	Interim payments Tentative settlement (for contractor use only)		631, 010	0	20.00
	Balance due provider/program (line 19 minus lines 19.01, 20, a	and 21)	U U	0	21.00
22.00 23.00	Protested amounts (nonallowable cost report items) in accorda		167, 405	0	22.00
23.00	chapter 1, §115.2	THE WILLII CWIS PUD. 15-2,	0	0	23.00
	10.00 Co. 1/ 31.0.2		1 I		I

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1323	Peri od:	Worksheet E-3	2552-
			From 01/01/2016	Part V	
			To 12/31/2016	Date/Time Pre 5/30/2017 12:	
		Title XVIII	Hospi tal	Cost	<u>55 pii</u>
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDI	ICARE PART A SERVICES - COS	ST REIMBURSEMENT		
. 00	Inpatient services			1, 753, 505	
. 00	Nursing and Allied Health Managed Care payment (see inst	ructions)		0	
. 00	Organ acquisition			0	
. 00	Subtotal (sum of lines 1 through 3)			1, 753, 505	
. 00 . 00	Primary payer payments Total cost (line 4 less line 5). For CAH (see instruction	nc)		0 1 771 040	
. 00	COMPUTATION OF LESSER OF COST OR CHARGES	115)		1, 771, 040	0.0
	Reasonable charges				
. 00	Routine service charges			0	7.0
. 00	Ancillary service charges			0	
. 00	Organ acquisition charges, net of revenue			0	9.
0. 00	Total reasonable charges			0	10.
	Customary charges				
1. 00	Aggregate amount actually collected from patients liable	1 5	5	0	11.
2.00	Amounts that would have been realized from patients liab		on a charge basis	0	12.
	had such payment been made in accordance with 42 CFR 413	. 13(e)			
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.000000	
	Total customary charges (see instructions)		· · · · · · · · · · · · · · · · · · ·	0	
5.00	Excess of customary charges over reasonable cost (compleinstructions)	te only if line 14 exceeds i	The 6) (See	0	15.
6.00	Excess of reasonable cost over customary charges (comple	te only if line 6 exceeds li	ne 14) (see	0	16.
0.00	instructions)			0	10.
7.00	Cost of physicians' services in a teaching hospital (see	instructions)		0	17.
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
3. 00	Direct graduate medical education payments (from Workshe	et E-4, line 49)		0	18.
9.00	Cost of covered services (sum of lines 6, 17 and 18)			1, 771, 040	19.
	Deductibles (exclude professional component)			243, 959	
	Excess reasonable cost (from line 16)			0	
	Subtotal (line 19 minus line 20 and 21)			1, 527, 081	
	Coinsurance			0	
. 00	Subtotal (line 22 minus line 23)			1, 527, 081	
	Allowable bad debts (exclude bad debts for professional	services) (see instructions)		73, 480	
b. 00	Adjusted reimbursable bad debts (see instructions)	i potruoti opo)		47, 762	
	Allowable bad debts for dual eligible beneficiaries (see Subtotal (sum of lines 24 and 25, or line 26)	instructions)		73, 480 1, 574, 843	
9.00 9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			1, 574, 843	
. 00 . 50	Pioneer ACO demonstration payment adjustment (see instru	ctions)		0	
. 99	Recovery of Accel erated Depreciation			0	
. 00	Subtotal (see instructions)			1, 574, 843	
). 00	Sequestration adjustment (see instructions)			31, 497	
	Interim payments			1, 316, 868	
	Tentative settlement (for contractor use only)			0	
3.00	Balance due provider/program (line 30 minus lines 30.01,	31, and 32)		226, 478	33.
		-	chapter 1,	0	

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 01/01/2016 To 12/31/2016	u of Form CMS- Worksheet G Date/Time Pre	
l y)		General Fund	Speci fi c	Endowment Fund	5/30/2017 12:	
		1.00	Purpose Fund 2.00	3.00	4.00	-
	CURRENT ASSETS					
00	Cash on hand in banks	40, 118		0 0	0	
00	Temporary investments	0		0 0	0	
00	Notes receivable	0		0 0	0	
00	Accounts receivable	4, 484, 598			0	
00 00	Other receivable Allowances for uncollectible notes and accounts receivable	82, 465			0	
00 00	Inventory	331, 673			0	
00	Prepaid expenses	93, 569		0 0	0	
00	Other current assets	0		o o	0	9
. 00	Due from other funds	-2, 619, 007		o o	0	10
. 00	Total current assets (sum of lines 1-10)	2, 413, 416		0 0	0	11
	FI XED ASSETS					
. 00	Land	282, 529		0 0	0	
. 00	Land improvements	1, 972, 720		0 0	0	
. 00	Accumulated depreciation	-1, 057, 923			0	
. 00 . 00	Buildings Accumulated depreciation	13, 429, 858 -3, 325, 922			0	
. 00	Leasehold improvements	-3, 323, 922 29, 098			0	
. 00	Accumul ated depreciation	-28, 460		0 0	0	
	Fixed equipment	7, 763, 317		0 0	0	
	Accumulated depreciation	-4, 631, 472		0 0	0	
	Automobiles and trucks	154, 457		o o	0	21
. 00	Accumulated depreciation	-78, 012		o o	0	22
	Major movable equipment	8, 585, 525		0 0	0	
	Accumulated depreciation	-5, 863, 836		0 0	0	
	Minor equipment depreciable	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	HIT designated Assets Accumulated depreciation	0			0	
	Mi nor equi pment-nondepreci abl e	0		0 0	0	
	Total fixed assets (sum of lines 12-29)	17, 231, 879		0 0	0	
	OTHER ASSETS		1	· · · · ·		
. 00	Investments	0		0 0	0	31
. 00	Deposits on Leases	0		0 0	0	32
. 00	Due from owners/officers	0		0 0	0	33
	Other assets	5,011,241		0 0	0	
	Total other assets (sum of lines 31-34)	5,011,241		0 0	0	
. 00	Total assets (sum of lines 11, 30, and 35)	24, 656, 536		0 0	0	36
. 00	CURRENT LI ABI LI TI ES Accounts payable	1, 502, 739		0 0	0	37
. 00	Salaries, wages, and fees payable	522, 153		0 0	0	
	Payrol I taxes payable	022,100		0 0	0	
	Notes and Loans payable (short term)	840, 000		0 0	0	
	Deferred income	0		o o	0	
. 00	Accelerated payments	0				42
. 00	Due to other funds	0		0 0	0	
. 00	Other current liabilities	367, 325		0 0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	3, 232, 217		0 0	0	45
00	LONG TERM LIABILITIES Mortgage payable	0		0 0	0	
. 00 . 00	Notes payable	0			0	
00	Unsecured Loans	0			0	
. 00	Other long term liabilities	23, 935, 717		0 0	0	
. 00	Total long term liabilities (sum of lines 46 thru 49)	23, 935, 717		o o	0	
00	Total liabilities (sum of lines 45 and 50)	27, 167, 934		0 0	0	51
	CAPI TAL ACCOUNTS					
00	General fund balance	-2, 511, 398				52
00	Specific purpose fund			0		53
. 00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
. 00	Governing body created - endowment fund balance			0	0	56
. 00 . 00	Plant fund balance - invested in plant Plant fund balance - reserve for plant improvement,				0	
. 00	replacement, and expansion				0	1 36
	Total fund balances (sum of lines 52 thru 58)	-2, 511, 398		o o	0	59
. 00						

Heal th	Financial Systems COMM	IUNI TY HOSPT. OF	LAGRANGE CTY	IN	In Lie	u of Form CMS-2	2552-10
	IENT OF CHANGES IN FUND BALANCES	<u> </u>	Provider CC		Period: From 01/01/2016 To 12/31/2016	Worksheet G-1 Date/Time Prep 5/30/2017 12:	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2.00	3.00	4.00	5.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)		-2, 511, 398 3, 135, 762 624, 364 0 624, 364			0 0 0 0 0 0 0	1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Deductions (debit adjustments) (specify) TRANSFERS. Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 3, 135, 762 0 0 0 0	3, 135, 762 -2, 511, 398		0 0 0 0 0 0 0 0 0 0	0 0 0 0 0	12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 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) Additions (credit adjustments) (specify)	0	0 0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) TRANSFERS. Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 0 0 0 0		0 0 0 0		$\begin{array}{c} 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$

STATEN	Financial Systems COMMUNITY HOSPT. OF L	Provider CC		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
	Cost Center Description		Inpati ent	Outpati ent	5/30/2017 12: Total	
		-	1.00	2.00	3.00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services]
1.00	Hospi tal		3, 576, 0	20	3, 576, 020	1.00
2.00	SUBPROVIDER - IPF					2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVIDER					4.00
5.00	Swing bed - SNF		375, 2	60	375, 260	•
6.00	Swing bed - NF			0	0	
7.00	SKILLED NURSING FACILITY					7.00
8.00 9.00	NURSING FACILITY OTHER LONG TERM CARE					8.00 9.00
9.00 10.00	Total general inpatient care services (sum of lines 1-9)		3, 951, 2	00	3, 951, 280	1
10.00	Intensive Care Type Inpatient Hospital Services		5, 751, 2	00	5, 751, 200	10.00
11.00	INTENSIVE CARE UNIT					11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI 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	lines		0	0	16.00
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16))	3, 951, 2		3, 951, 280	•
18.00	Ancillary services		13, 202, 4		13, 202, 446	•
19.00	Outpatient services			0 72, 952, 768		•
	RURAL HEALTH CLINIC			0 0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	•
22.00	HOME HEALTH AGENCY			0 4, 018, 824	4 010 004	22.00
23.00 24.00	AMBULANCE SERVICES CMHC			0 4, 018, 824	4, 018, 824	23.00
24.00	CORF			0 0	0	
24.10	OUTPATI ENT PHYSI CAL THERAPY				0	•
24.30	OUTPATI ENT OCCUPATI ONAL THERAPY			0 0	0	
24.40	OUTPATIENT SPEECH PATHOLOGY			0 0	0	
25.00	AMBULATORY SURGICAL CENTER (D. P.)			-	-	25.00
26.00	HOSPI CE					26.00
27.00	OTHER (SPECIFY)			0 0	0	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	17, 153, 7	26 76, 971, 592	94, 125, 318	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			30, 824, 326		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00 32.00
32.00 33.00				0		32.00
33.00				0		34.00
35.00				0		35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)			0		37.00
38.00				0		38.00
39.00				0		39.00
40.00				0		40.00
41.00				0		41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	2)(transfer		30, 824, 326		43.00
	to Wkst. G-3, line 4)					

Heal th	Financial Systems	COMMUNITY HOSPT. OF L	AGRANGE CTY IN	In Lie	u of Form CMS-2	2552-10
	IENT OF REVENUES AND EXPENSES		Provider CCN: 15-1323	Peri od: From 01/01/2016 To 12/31/2016	Worksheet G-3 Date/Time Prep	pared:
					5/30/2017 12:	53 pm
					1.00	
1.00	Total patient revenues (from Wkst. G-2	, Part I, column 3, lin	e 28)		94, 125, 318	1.00
2.00	Less contractual allowances and discou	nts on patients' accoun	ts		61, 398, 131	2.00
3.00	Net patient revenues (line 1 minus lin	e 2)			32, 727, 187	3.00
4.00	Less total operating expenses (from Wk	st. G-2, Part II, line	43)		30, 824, 326	4.00
5.00	Net income from service to patients (I	ine 3 minus line 4)			1, 902, 861	5.00
	OTHER INCOME					
6.00	Contributions, donations, bequests, et	С			140, 919	6.00
7.00	Income from investments				-1, 560	7.00
8.00	Revenues from telephone and other misc	ellaneous communication	servi ces		0	8.00
9.00	Revenue from television and radio serv	'i ce			0	9.00
10.00	Purchase di scounts				0	10.00
11.00	Rebates and refunds of expenses				0	11.00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from laundry and linen service	1			0	13.00
14.00	Revenue from meals sold to employees a	nd guests			252, 963	14.00
15.00	Revenue from rental of living quarters				0	15.00
16.00	Revenue from sale of medical and surgi		han patients		0	16.00
17.00	Revenue from sale of drugs to other th				395, 853	17.00
18.00	Revenue from sale of medical records a				0	18.00
19.00	Tuition (fees, sale of textbooks, unif				0	19.00
20.00	Revenue from gifts, flowers, coffee sh	ops, and canteen			12, 688	
21.00	Rental of vending machines				0	21.00
22.00	Rental of hospital space				32, 535	22.00
23.00	Governmental appropriations				0	23.00
24.00	GAIN ON SALE OF ASSETS				14, 836	24.00
24.01	COUNTY REIMBURSEMENT AMBULANCE SRV				349, 000	24.01
24.02	MI SCELLANEOUS				35, 667	
25.00	Total other income (sum of lines 6-24)				1, 232, 901	
26.00	Total (line 5 plus line 25)				3, 135, 762	
27.00					0	27.00
	Total other expenses (sum of line 27 a				0	28.00
29.00	Net income (or loss) for the period (I	ine 26 minus line 28)			3, 135, 762	29.00