This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 09-30-2025 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0018 Worksheet S Peri od: From 01/01/2023 Parts I-III AND SETTLEMENT SUMMARY 12/31/2023 Date/Time Prepared: 5/30/2024 7:46 am PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/30/2024 7:46 am] Manually prepared cost report use only Ilf this is an amended report enter the number of times the provider resubmitted this cost report [Medicare Utilization. Enter "F" for full, "L" for low, or "N" for no. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. NPR Date:
[12] 13. NPR Date:
[13] 14. NPR Date:
[14] 15. NPR Date:
[15] 15. NPR Date:
[16] 16. NPR Date:
[17] 17. NPR Date:
[18] 17. NPR Date:
[18] 18. NPR Date:
[18] 18. NPR Date:
[18] 19. NPR Da Contractor use only (3) Settled with Audit number of times reopened = 0-9.

PART II - CERTIFICATION BY A CHIEF FINANCIAL OFFICER OR ADMINISTRATOR OR PROVIDER(S)

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by ELKHART GENERAL HOSPITAL (15-0018) for the cost reporting period beginning 01/01/2023 and ending 12/31/2023 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

	SIGNATURE OF CHIEF FINA	NCIAL OFFICER OR ADMINISTRATOR	CHECKBOX	ELECTRONI C	
		1	2	SI GNATURE STATEMENT	
1				I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification be the legally binding equivalent of my original signature.	1
2	Signatory Printed Name				2
3	Signatory Title	CHIEF FINANCIAL OFFICER			3
4	Date				4

			Title	XVIII			
		Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	661, 326	22, 153	0	38, 487	1. 00
2.00	SUBPROVI DER - I PF	0	2, 755	0		622	2. 00
3.00	SUBPROVI DER - I RF	0	0	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
7. 00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8. 00	NURSING FACILITY	0				0	8. 00
9. 00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10. 00	RURAL HEALTH CLINIC I	0		0		0	10.00
11. 00	FEDERALLY QUALIFIED HEALTH CENTER I	o		0		0	11. 00
12. 00	CMHC I	o		0		0	12.00
200.00	TOTAL	0	664, 081	22, 153	0	39, 109	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 number for this information collection is OMB 0938-0050 and the number for the Supplement to Form CMS 2552-10, Worksheet N95, is OMB 0938-1425. The time required to complete and review the information collection is estimated 675 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.

			Number	Numb	per Ty	ype	Certi fi ed		0, or	N)	
								V	XVIII	XIX	
		1.00	2. 00	3.0	00 4.	00	5. 00	6. 00	7. 00	8.00	
0 0-	Hospital and Hospital-Based Componen		4505:-		40	1	04 /04 /5 = :			-	
3. 00	Hospi tal	ELKHART GENERAL HOSPITAL	150018	211	40	1	01/01/1966	N	P	P	3. 00
4.00	Subprovi der - IPF	ELKHART PSYCH	15S018	211	40	4	01/01/2015	N	P	P	4.00
5.00	Subprovider - IRF	EERIART 1310II	133010	211		7	017 017 2013		'	i '	5.00
6. 00	Subprovider - (Other)										6. 00
7.00	Swing Beds - SNF									İ	7. 00
8.00	Swing Beds - NF			l							8. 00
9.00	Hospi tal -Based SNF										9. 00
10. 00	Hospi tal -Based NF										10. 00
11.00	Hospi tal -Based OLTC										11.00
12. 00 13. 00	Hospi tal-Based HHA Separately Certified ASC										12. 00 13. 00
14. 00	1 '										14.00
	Hospital -Based Health Clinic - RHC										15. 00
16. 00				İ							16. 00
	Hospital-Based (CMHC) I			İ						İ	17. 00
17. 10	Hospi tal -Based (CORF) I			İ							17. 10
18. 00	Renal Dialysis										18. 00
19. 00	Other										19. 00
							From:		To		
20.00	Cost Reporting Period (mm/dd/yyyy)						1.00	222	2.0		20. 00
	Type of Control (see instructions)						2	123	12/31/	2023	21.00
21.00	Type or control (see that detrolls)										21.00
				İ	1.0	0	2. 00		3. 0	00	
	Inpatient PPS Information										
22. 00	Does this facility qualify and is it				Υ		N				22. 00
	disproporti onate share hospi tal adju			₹							
	§412. 106? In column 1, enter "Y" fo										
	facility subject to 42 CFR Section § hospital?) In column 2, enter "Y" fo		enament								
22. 01	Did this hospital receive interim UC		tal UCPs	for	Υ		Y	ŀ			22. 01
22.0.	this cost reporting period? Enter in				•		· ·				
	for the portion of the cost reportin										
	1. Enter in column 2, "Y" for yes or			ne							
	cost reporting period occurring on o	r after October 1. (see									
22 02	instructions)	roquiros a final HCD +	o ho	-	N		N				22.02
22. 02	Is this a newly merged hospital that determined at cost report settlement			ump	IN		IN IN				22. 02
	1, "Y" for yes or "N" for no, for th			uiiiii							
	period prior to October 1. Enter in			no,							
	for the portion of the cost reportin										
22. 03	Did this hospital receive a geograph				N		N		Υ		22. 03
	rural as a result of the OMB standar										
	adopted by CMS in FY2015? Enter in c										
	for the portion of the cost reportin in column 2, "Y" for yes or "N" for			*1							
	reporting period occurring on or aft										
	Does this hospital contain at least			ıs							
	counted in accordance with 42 CFR 41										
	yes or "N" for no.										
22. 04	Did this hospital receive a geograph										22. 04
	rural as a result of the revised OMB										
	adopted by CMS in FY 2021? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter										
	in column 2, "Y" for yes or "N" for			71							
	reporting period occurring on or aft										
	Does this hospital contain at least			is							
	counted in accordance with 42 CFR 41	2.105)? Enter in colum	n 3, "Y" f	or							
22.25	yes or "N" for no.	anderara		.							20.00
23. 00							3 N				23. 00
	below? In column 1, enter 1 if date if date of discharge. Is the method										
	reporting period different from the			.551							
	reporting period? In column 2, ente										
		•		,			•	,			•

Health Financial Systems ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0018 Peri od: Worksheet S-2 From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 7:46 am 1. 00 2.00 3.00 59.00 Are costs claimed on line 100 of Worksheet A? If yes, complete Wkst. D-2, Pt. I Ν 59.00 NAHE 413.85 Worksheet A Pass-Through Y/N Line # Qual i fi cati on Criterion Code 1.00 2.00 3.00 60.00 Are you claiming nursing and allied health education (NAHE) costs for 60.00 any programs that meet the criteria under 42 CFR 413.85? (see instructions) Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", are you impacted by CR 11642 (or subsequent CR) NAHE MA payment adjustment? Enter "Y" for yes or "N" for no in column 2. 60.01 If line 60 is yes, complete columns 2 and 3 for each program. (see 23.00 60.01 instructions) IME Direct GME IME Direct GME 1.00 2.00 3. 00 4.00 5.00 61.00 Did your hospital receive FTE slots under ACA 0.00 61.00 0.00 section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) 61.01 Enter the average number of unweighted primary care 61.01 FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see instructions) 61.02 Enter the current year total unweighted primary care 61.02 FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions) 61.03 Enter the base line FTE count for primary care 61.03 and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions) 61 04 Enter the number of unweighted primary care/or 61 04 surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions). 61.05 Enter the difference between the baseline primary 61.05 and/or general surgery FTEs and the current year primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)
61.06 Enter the amount of ACA §5503 award that is being 61 06 used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions) Unweighted IME Unweighted Program Name Program Code FTF Count Direct GME FTE Count 1.00 2. 00 3.00 4.00 61.10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents 0. 00 0.00 61.10 for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 61. 20 Of the FTEs in line 61.05, specify each expanded 0.00 0.00 61.20 program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. 1.00 ACA Provisions Affecting the Health Resources and Services Administration (HRSA) 0.00 62.00 62.00 Enter the number of FTE residents that your hospital trained in this cost reporting period for which your hospital received HRSA PCRE funding (see instructions) 62. 01 0.00 62.01 Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital during in this cost reporting period of HRSA THC program. (see instructions)

Teaching Hospitals that Claim Residents in Nonprovider Settings

63.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter "Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)

63.00

Health Financial Systems	ELKHAR ⁻	T GENERAL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	TA Provider CO		eriod: fom 01/01/2023 o 12/31/2023	Worksheet S-2 Part I Date/Time Prep 5/30/2024 7:44	pared:
			Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2.00	3. 00	
Section 5504 of the ACA Base Yea			This base year	is your cost r	reporting	
period that begins on or after J 64.00 Enter in column 1, if line 63 is in the base year period, the num resident FTEs attributable to ro settings. Enter in column 2 the resident FTEs that trained in yo of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	0.00	0. 00	0. 000000	64. 00
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs Nonprovi der Si te	FTEs in Hospital	(col. 3 + col. 4))	
	1. 00	2.00	3. 00	4. 00	5. 00	
65.00 Enter in column 1, if line 63	1.00	2.00	0.00	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)			Unwei ghted	Unwei ghted	Ratio (col. 1/	03. 00
			FTEs Nonprovi der	FTEs in Hospital	(col. 1 + col. 2))	
			Si te		0.00	
Section 5504 of the ACA Current	Voor ETE Docidonts in	a Naparavidar Cattina	1.00	2.00	3. 00	
beginning on or after July 1, 20		nonprovider Setting	SEllective to	r cost reporti	ng perrous	
66.00 Enter in column 1 the number of		ry care resident	0.00	0.00	0. 000000	66. 00
FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of				
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2. 00	3. 00	4.00	5. 00	
67.00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0.00	0. 00	0. 000000	67. 00

116. 00

117. 00

118. 00

"N" for no.

116.00 Is this facility classified as a referral center? Enter "Y" for yes or

117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" for yes or "N" for no.

118.00|s the mal practice insurance a claims-made or occurrence policy? Enter 1

if the policy is claim-made. Enter 2 if the policy is occurrence.

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.

IOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CC	N: 15-0018		1/01/2023	Worksheet S- Part I	
				To 1:	2/31/2023	Date/Time Pr 5/30/2024 7:	
						1.00	
47.00 Was there a change in the statisti	cal basis? Enter "Y" for y	es or "N" for	no.			N	147. 0
48.00 Was there a change in the order of						N	148. 0
49.00 Was there a change to the simplifi	ed cost finding method? En					N	149. 0
		Part A	Part B	T	itle V	Title XIX	
D this facility		1.00	2.00	4:4	3.00	4.00	
Does this facility contain a prov or charges? Enter "Y" for yes or							
55. 00 Hospi tal	N TOT TO TOT EACT COMPONE	N	N	. (366 42	N 9413	N N	— 155. C
56. 00 Subprovi der – TPF		N	N		N	N N	156. 0
57.00 Subprovi der - IRF		N	N		N	N	157. 0
58. 00 SUBPROVI DER							158. 0
59. 00 SNF		N	N		N	N	159. C
60.00 HOME HEALTH AGENCY		N	N		N	N	160. C
61. 00 CMHC			N		N	N	161. C
61. 10 CORF			N		N	N	161. 1
						1.00	_
Multicampus						1.00	
65.00 s this hospital part of a Multica	amnus hosnital that has one	or more campu	ises in dif	ferent CB	RSAs2	N	H _{165. 0}
Enter "Y" for yes or "N" for no.	impus nospi tai that has one	or more campe	1303 111 011	i Ci Ciit Ob	30N3:		105.0
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5. 00	
66.00 If line 165 is yes, for each						0.0	00 166. 0
campus enter the name in column							
O, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
Gordini o (See Pristraetrons)	'						
						1.00	
Health Information Technology (HI				ent Act			
67.00 s this provider a meaningful user 68.00 of this provider is a CAH (line 10				"\ on+on	+ h a	Y	167. C
reasonable cost incurred for the I			: 107 15 1), enter	trie		100. 0
68.01 If this provider is a CAH and is i			gualify f	or a hard	lshi n		168. 0
exception under §413.70(a)(6)(ii)					.o p		1.00.0
69.00 If this provider is a meaningful of					enter the	0.	00 169. 0
transition factor. (see instruction	ons)						
					gi nni ng	Endi ng	
70 00 0 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1					1. 00	2. 00	170.0
70.00 Enter in columns 1 and 2 the EHR I period respectively (mm/dd/yyyy)	beginning date and ending d	late for the re	eporting				170. 0
					1. 00	2. 00	
71.00 If line 167 is "Y", does this prov	vider have any days for ind	li vi dual s enrol	led in		N N	2.00	0171.0
section 1876 Medicare cost plans					•		
"Y" for yes and "N" for no in colu		The second secon	_				

Health Financial Systems ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 15-0018 Peri od: Worksheet S-2 From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/30/2024 7:46 am Y/N Date 1. 00 2.00 PART II - HOSPITAL AND HOSPITAL HEATHCARE COMPLEX REIMBURSEMENT QUESTIONNAIRE 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 1 00 Has the provider changed ownership immediately prior to the beginning of the cost N 1.00 reporting period? If yes, enter the date of the change in column 2. (see instructions) Date V/I 1 00 2.00 3.00 Has the provider terminated participation in the Medicare Program? If 2.00 2.00 Ν yes, enter in column 2 the date of termination and in column 3, "V" for voluntary or "I" for involuntary. 3.00 Is the provider involved in business transactions, including management 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 Type 1.00 2.00 3.00 Financial Data and Reports
Column 1: Were the financial statements prepared by a Certified Public 4 00 4 00 Α Accountant? Column 2: If yes, enter "A" for Audited, "C" for Compiled, 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 Υ 5 00 those on the filed financial statements? If yes, submit reconciliation. Y/N Legal Oper. 1.00 Approved Educational Activities 6.00 Column 1: Are costs claimed for a nursing program? Column 2: If yes, is the provider Ν 6.00 the legal operator of the program? 7 00 Are costs claimed for Allied Health Programs? If "Y" see instructions. 7.00 Were nursing programs and/or allied health programs approved and/or renewed during the N 8.00 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. Was an approved Intern and Resident GME program initiated or renewed in the current 10.00 Ν 10.00 cost reporting period? If yes, see instructions. Are GME cost directly assigned to cost centers other than I & R in an Approved Ν 11.00 Teaching Program on Worksheet A? If yes, see instructions. Y/N 1.00 Bad Debts 12.00 Is the provider seeking reimbursement for bad debts? If yes, see instructions. 12.00 If line 12 is yes, did the provider's bad debt collection policy change during this cost reporting 13.00 Ν 13.00 period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or coinsurance amounts waived? If yes, see Ν 14.00 instructions. Bed Complement 15.00 Did total beds available change from the prior cost reporting period? If yes, see instructions Υ 15.00 Part B Y/N Y/N Date 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 Υ 04/23/2024 04/23/2024 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) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed Ν Ν 18.00 but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Ν Ν 19.00 Report data for corrections of other PS&R Report information? If yes, see instructions.

Heal th	Financial Systems ELKHART GENER	RAL HOSPITAL		In Lie	u of Form CMS-:	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der	CCN: 15-0018	Peri od: From 01/01/2023 To 12/31/2023	Worksheet S-2 Part II Date/Time Pre 5/30/2024 7:4	pared:
		Des	scription	Y/N	Y/N	
	1011 11 1000	55444 66474 6	0	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:	CTC RATIO	NS FOR CORRECT	N	N	20. 00
	report data for other: beserred the other adjustments.	Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	PT CHILDREN	S HOSPITALS)		1.00	
	Capi tal Related Cost		<u> </u>			1
22. 00	Have assets been relifed for Medicare purposes? If yes, see	e instructio	ns		N	22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to appr	aisals made dur	ing the cost	N	23. 00
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions				N	24. 00
25. 00	Have there been new capitalized leases entered into during	N	25. 00			
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost repo	rting period? I	f yes, see	N	26. 00
27. 00	Has the provider's capitalization policy changed during the copy.	N	27. 00			
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	N	28. 00			
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or	N	29. 00			
30. 00	treated as a funded depreciation account? If yes, see instr Has existing debt been replaced prior to its scheduled matu	N	30. 00			
31. 00	instructions. Has debt been recalled before scheduled maturity without is	ssuance of n	ew debt? If yes	s, see	N	31. 00
	instructions. Purchased Services					1
32.00	Have changes or new agreements occurred in patient care ser		shed through co	ontractual	N	32. 00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ning to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans					1
34.00	Were services furnished at the provider facility under an a	arrangement	with provider-b	based physicians?	Υ	34. 00
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	sting agree	ments with the	provi der-based	Υ	35. 00
	physicians during the cost reporting period? If yes, see in	nstructions.			-	
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36. 00	Were home office costs claimed on the cost report?			Υ		36. 00
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	repared by t	he home office?			37. 00
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00
39. 00	If line 36 is yes, did the provider render services to other see instructions.		39. 00			
40. 00	0.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ninstructions.					
			1. 00	2	00	-
	Cost Report Preparer Contact Information		1.00	Ζ.	00	
41. 00	<u> </u>	SALLY		BRUBAKER		41. 00
42. 00	respectively. Enter the employer/company name of the cost report	ELKHART GEN	ERAL HOSPITAL			42. 00
43. 00	· ·	574-647-384	2	SBRUBAKER@BEAC	ONHEALTHSYSTEM	43. 00
	report preparer in columns 1 and 2, respectively.	I		. ORG		II

Heal th	Financial Systems	ELKHART GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provi der C	CN: 15-0018	01/01/2023	Worksheet S-2 Part II Date/Time Pre 5/30/2024 7:4	pared:
			3.	00			
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title held by the cost report preparer in columns 1 respectively.		REIMBURSEMENT	ANALYST			41. 00
42. 00	Enter the employer/company name of the cost r preparer.	eport					42. 00
43. 00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						43. 00

Health Financial Systems ELKHART HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0018

						0 12/31/2023	5/30/2024 7:40	
							I/P Days / 0/P	Jaiii
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH/REH Hours	Title V	
		Li ne No.			Avai I abl e			
		1. 00		2. 00	3.00	4. 00	5. 00	
	PART I - STATISTICAL DATA				•			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		171	62, 415	0.00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			171	62, 415	0.00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		23			0	8. 00
8. 01	NEONATAL INTENSIVE CARE	31. 01		8				8. 01
9.00	CORONARY CARE UNIT	32. 00		0				9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00	l	0	1			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	C	0.00	0	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00						12.00
13.00	NURSERY	43. 00		000	70 700	0.00	0	13. 00
14. 00	Total (see instructions)			202	73, 730	0.00		14. 00
15. 00	CAH visits					0.00	0	15. 00
15. 10 16. 00	REH hours and visits	40. 00		10	4 200	0.00	0	15. 10 16. 00
17. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF	40. 00	1	12 0				17. 00
18. 00	SUBPROVIDER - TRE	41.00		U	·		U	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00		0	C		0	19. 00
20. 00	NURSING FACILITY	45. 00	1	0				20. 00
21. 00	OTHER LONG TERM CARE	46. 00	1	0			U	21. 00
22. 00	HOME HEALTH AGENCY	101. 00	i .	O			0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00	l .					23. 00
24. 00	HOSPI CE	116. 00	1	0	C			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00		J	۲			24. 10
25. 00	CMHC - CMHC	99. 00					o	25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00	1				l o	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)	07.00		214				27. 00
28. 00	Observation Bed Days						0	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)			0	l c			32. 00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33.00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges							33. 01
34. 00	Temporary Expansion COVID-19 PHE Acute Care	30. 00		0	0		0	34. 00

Health Financial Systems ELKHART HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 15-0018

Peri od: Worksheet S-3
From 01/01/2023 Part I
To 12/31/2023 Part I
Date/Time Prepared: 5/30/2024 7: 46 am

			L /D D / O /D \/; -; +- / T-;			5/30/2024 7: 46 am			
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents			
		T' 11 \ \0.0111	T' 11 VIV	T 1 1 All	T	F 1 0			
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll			
		6. 00	7. 00	8. 00	9. 00	10. 00			
	PART I - STATISTICAL DATA	0.00	7.00	0.00	7.00	10.00			
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	9, 279	1, 185	32, 163			1.00		
	8 exclude Swing Bed, Observation Bed and	.,	.,	,					
	Hospice days) (see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)	11, 905	8, 220				2. 00		
3.00	HMO IPF Subprovider	31	1, 553				3. 00		
4.00	HMO I RF Subprovi der	0	0	_			4. 00		
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00		
6.00	Hospital Adults & Peds. Swing Bed NF	0.070	0	0			6.00		
7. 00	Total Adults and Peds. (exclude observation	9, 279	1, 185	32, 163			7. 00		
8. 00	beds) (see instructions) INTENSIVE CARE UNIT	1, 467	96	6, 027			8. 00		
8. 01	NEONATAL INTENSIVE CARE	1, 467	98	6, 027			8. 01		
9. 00	CORONARY CARE UNIT	0	70	032			9. 00		
10.00	BURN INTENSIVE CARE UNIT	0	Ö	0			10.00		
11. 00	SURGI CAL INTENSI VE CARE UNI T	0	0	0			11.00		
12. 00	OTHER SPECIAL CARE (SPECIFY)						12. 00		
13.00	NURSERY		280	1, 988			13.00		
14.00	Total (see instructions)	10, 746	1, 659	40, 830	0.00	1, 170. 98	14. 00		
15.00	CAH visits	0	0	0			15. 00		
15. 10	REH hours and visits	0	0	0			15. 10		
16.00	SUBPROVI DER - I PF	103	100	2, 744		21. 11			
17. 00	SUBPROVIDER - IRF	0	0	0	0.00	0. 00			
18. 00	SUBPROVI DER	_	_	_			18. 00		
19. 00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00			
20.00	NURSING FACILITY		0	0		0.00			
21. 00 22. 00	OTHER LONG TERM CARE	0	0	0		0. 00 0. 00			
23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)	U	٩	Ü	0.00	0.00			
24. 00	HOSPICE	0	0	0		0.00			
24. 10	HOSPICE (non-distinct part)	o l	o _l	317		0.00	24. 10		
25. 00	CMHC - CMHC	0	0	0		0.00			
25. 10	CMHC - CORF	o	o	0		0.00			
26. 00	RURAL HEALTH CLINIC	0	o	0	0.00	0.00			
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25		
27. 00	Total (sum of lines 14-26)				0.00	1, 192. 09	27. 00		
28. 00	Observation Bed Days		0	9, 940			28. 00		
29. 00	Ambul ance Tri ps	0					29. 00		
30.00	Employee discount days (see instruction)			0			30. 00		
31. 00	Employee discount days - IRF			0			31. 00		
32. 00	Labor & delivery days (see instructions)	0	14	19			32. 00		
32. 01	Total ancillary labor & delivery room			0			32. 01		
22.00	outpatient days (see instructions)						22.00		
33. 00 33. 01	LTCH non-covered days	0					33. 00 33. 01		
	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care	0	o	0			34. 00		
34.00	Temporary Expansion Covid-17 The Acute Care	ا ا	Ч	U	1		1 34.00		

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | To 12/31/2023 | Health Financial Systems ELKHART HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CCN: 15-0018

				10	12/31/2023	Date/IIme Pre 5/30/2024 7:4	
		Full Time		Di sch	arges	0,00,202	<u> </u>
		Equi val ents			ŭ		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13.00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		C	2, 589	527	9, 378	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
2. 00	for the portion of LDP room available beds) HMO and other (see instructions)			2, 216	2, 411		2. 00
3.00	HMO I PF Subprovi der			2, 210	350		3.00
4.00	HMO IRF Subprovider				330		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF				o o		5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7.00
7.00	beds) (see instructions)						7.00
8. 00	INTENSIVE CARE UNIT						8. 00
8. 01	NEONATAL INTENSIVE CARE						8. 01
9.00	CORONARY CARE UNIT						9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	0. 00	C	2, 589	527	9, 378	
15. 00	CAH visits						15. 00
15. 10	REH hours and visits						15. 10
16. 00	SUBPROVI DER - I PF	0. 00	C	- 1	19	596	
17. 00	SUBPROVI DER - I RF	0. 00	C	0	0	0	17. 00
18.00	SUBPROVI DER						18.00
19. 00	SKILLED NURSING FACILITY	0.00					19.00
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE	0. 00 0. 00				0	20.00
	1	0.00				Ü	21.00
22. 00 23. 00	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.)	0.00					23.00
24. 00	HOSPICE	0.00					24.00
24. 10	HOSPICE (non-distinct part)	0.00					24. 10
25. 00	CMHC - CMHC	0.00					25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC	0. 00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32. 00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33. 00	LTCH non-covered days			0			33. 00
33. 01	LTCH site neutral days and discharges			0			33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care				I		34. 00

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

3. 00 Non- B 4. 00 Phys Admi 4. 01 Phys 5. 00 Phys	II - WAGE DATA RIES Il salaries (see ructions) physician anesthetist Part physician anesthetist Part iician-Part A - nistrative	Wkst. A Line Number 1.00 200.00	Amount Reported 2.00 98,153,771	Reclassificati on of Salaries (from Wkst. A-6) 3.00	Adj usted Sal ari es (col . 2 ± col . 3) 4.00	Paid Hours Related to Salaries in col. 4 5.00	5/30/2024 7: 46 Average Hourly Wage (col. 4 ÷ col. 5)	
3. 00 Non- A 3. 00 Non- B 4. 00 Phys Admi 4. 01 Phys 5. 00 Phys	RIES I salaries (see ructions) physician anesthetist Part physician anesthetist Part			A-6) 3.00	3)	col. 4	ŕ	
3.00 Non- A 3.00 Non- B 4.00 Phys Admi 4.01 Phys 5.00 Phys	RIES I salaries (see ructions) physician anesthetist Part physician anesthetist Part				4.00	5. 00	6.00	
3.00 Non- A 3.00 Non- B 4.00 Phys Admi 4.01 Phys 5.00 Phys	RIES I salaries (see ructions) physician anesthetist Part physician anesthetist Part	200. 00	98, 153, 771	0				
2.00 Non- A 3.00 Non- B 4.00 Phys Admi 4.01 Phys 5.00 Phys	ructions) physician anesthetist Part physician anesthetist Part ician-Part A -	200. 00	98, 153, 7/1	1 ()	00 450 774	0 470 500 00		
3. 00 A Non- B 4. 00 Phys Admi 4. 01 Phys 5. 00 Phys	physician anesthetist Part		0		98, 153, 771	2, 479, 538. 00	39. 59	1. 00
4.00 Phys Admi 4.01 Phys 5.00 Phys	ician-Part A -			0	0	0. 00	0. 00	2. 00
4.01 Admi Phys 5.00 Phys			0	0	0	0. 00	0.00	3. 00
5. 00 Phys	III Strati ve		228, 208	0	228, 208	1, 127. 00	202. 49	4. 00
	icians - Part A - Teaching ician and Non		0	0	0 0	0. 00 0. 00		4. 01 5. 00
6.00 Non-	ician-Part B physician-Part B for ital-based RHC and FQHC rices		0	0	0	0. 00	0. 00	6. 00
7.00 Inte	erns & residents (in an eroved program)	21. 00	0	0	0	0. 00	0. 00	7. 00
7.01 Contresi	racted interns and dents (in an approved grams)		0	0	0	0.00	0. 00	7. 01
8.00 Home	e office and/or related		0	0	0	0. 00	0. 00	8. 00
9. 00 SNF 10. 00 Excl	uded area salaries (see	44. 00	0 3, 229, 829	-33, 020	0 3, 196, 809	0. 00 76, 451. 00		9. 00 10. 00
inst	ructions) R WAGES & RELATED COSTS		5, 227, 027	-55, 020	3, 170, 607	70, 431. 00	41.02	10.00
	ract labor: Direct Patient		4, 634, 406	0	4, 634, 406	48, 190. 00	96. 17	11. 00
12.00 Continuana	ract labor: Top level gement and other gement and administrative		0	0	0	0.00	0. 00	12. 00
13. 00 Cont	rices ract Labor: Physician-Part Administrative		1, 061, 506	0	1, 061, 506	11, 036. 00	96. 19	13. 00
14.00 Home organ	e office and/or related inization salaries and		0	О	0	0.00	0. 00	14. 00
14.01 Home	office salaries		15, 059, 695	О	15, 059, 695	372, 132. 00		14. 01
	ted organization salaries office: Physician Part A		0	0	0	0. 00 0. 00		14. 02 15. 00
- Adı	lmi ni strati ve		0					
	e office and Contract sicians Part A - Teaching		0	0	0	0. 00	0.00	16. 00
16.01 Home	e office Physicians Part A eaching		0	О	0	0. 00	0.00	16. 01
Phys	office contract		0	0	0	0.00	0.00	16. 02
17.00 Wage	-RELATED COSTS e-related costs (core) (see ructions)		23, 121, 798	0	23, 121, 798			17. 00
18.00 Wage	e-related costs (other)							18. 00
19. 00 Excl	uded areas physician anesthetist Part		778, 416 0	0	778, 416 0			19. 00 20. 00
21. 00 A Non-	physician anesthetist Part		0	О	0			21. 00
	ician Part A - nistrative		0	О	0			22. 00
22. 01 Phys	ician Part A - Teaching		0	0	0			22. 01
24.00 Wage	ician Part B r-related costs (RHC/FQHC) rns & residents (in an		0	0 0	0 0			23. 00 24. 00 25. 00
appr	roved program) office wage-related		4, 521, 218	0	4, 521, 218			25. 50
25. 51 Rel a	re) Ited organization		0	0	0			25. 51
25. 52 Home - Adı	e-related (core) e office: Physician Part A ministrative - e-related (core)		0	0	0			25. 52

Provider CCN: 15-0018

					T	o 12/31/2023	Date/Time Prep 5/30/2024 7:40	
		Wkst. A Line	Amount	Reclassi fi cati	Adjusted	Pai d Hours	Average Hourly	
		Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			·	(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4		
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)							
	OVERHEAD COSTS - DIRECT SALARII							
26. 00	Employee Benefits Department	4. 00	0	0	0	0. 00		26. 00
27. 00	Administrative & General	5. 00	5, 174, 852	-986, 863	4, 187, 989	118, 444. 00	35. 36	27. 00
28. 00	Administrative & General under		1, 680, 387	0	1, 680, 387	32, 224. 00	52. 15	28. 00
	contract (see inst.)							
29. 00	Maintenance & Repairs	6. 00	0	0	0	0. 00		29. 00
30. 00	Operation of Plant	7. 00	2, 441, 085	49, 713	2, 490, 798			
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32.00	Housekeepi ng	9. 00	2, 315, 968	40, 261	2, 356, 229			
33. 00	Housekeeping under contract		0	0	0	0. 00	0. 00	33. 00
	(see instructions)							
34. 00	Di etary	10. 00	2, 320, 217	-961, 157	1, 359, 060	,		34.00
35. 00	Dietary under contract (see		0	0	0	0. 00	0. 00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	162, 536	1, 020, 020	1, 182, 556			36. 00
37. 00	Maintenance of Personnel	12. 00	0	0	0	0. 00		37. 00
38. 00	Nursing Administration	13. 00	2, 683, 735			,		38. 00
39. 00	Central Services and Supply	14. 00	863, 463	14, 479	877, 942			
40.00	Pharmacy	15. 00	4, 536, 143	-4, 295, 435	240, 708			40. 00
41. 00	Medical Records & Medical	16. 00	0	0	0	0. 00	0. 00	41. 00
	Records Library							
42. 00	Social Service	17. 00	369, 279	3, 151	372, 430			42. 00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

| Peri od: | Worksheet S-3 | From 01/01/2023 | Part III | To 12/31/2023 | Date/Time Prepared:

					'	0 12/31/2023	5/30/2024 7: 46	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		99, 834, 158	0	99, 834, 158	2, 511, 762. 00	39. 75	1.00
	instructions)							
2.00	Excluded area salaries (see		3, 229, 829	-33, 020	3, 196, 809	76, 451. 00	41. 82	2. 00
	instructions)							
3.00	Subtotal salaries (line 1		96, 604, 329	33, 020	96, 637, 349	2, 435, 311. 00	39. 68	3.00
	minus line 2)							
4.00	Subtotal other wages & related		20, 755, 607	0	20, 755, 607	431, 358. 00	48. 12	4. 00
	costs (see inst.)							
5.00	Subtotal wage-related costs		27, 643, 016	0	27, 643, 016	0.00	28. 60	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		145, 002, 952	33, 020	145, 035, 972	2, 866, 669. 00	50. 59	6. 00
7.00	Total overhead cost (see		22, 547, 665	-5, 283, 339	17, 264, 326	585, 618. 00	29. 48	7.00
	instructions)							

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lieu of Form CMS-255	52-10
HOSPITAL WAGE RELATED COSTS	Provider CCN: 15-0018		
		From 01/01/2023 Part IV	rad:

	To 12/31/2023	Date/Time Pre 5/30/2024 7:4	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	3, 050, 734	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)	•	
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST	<u> </u>	
8.00	Health Insurance (Purchased or Self Funded)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8.02	Health Insurance (Self Funded with a Third Party Administrator)	12, 633, 889	8. 02
8.03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	126, 110	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	58, 418	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	219, 884	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	717, 383	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Noncumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	7, 068, 045	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	0	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00		0	22. 00
	Tuition Reimbursement	23, 424	
24.00	Total Wage Related cost (Sum of lines 1 -23)	23, 897, 887	24. 00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0018	Period: Worksheet S-3 From 01/01/2023 Part V
		FI OIII 01/01/2023 Pai t V

		To	12/31/2023	Date/Time Pre 5/30/2024 7:4	
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1. 00	Total facility's contract labor and benefit cost		0	0	1. 00
2.00	Hospi tal		0	0	2. 00
3.00	SUBPROVI DER - I PF		0	0	3. 00
4.00	SUBPROVI DER - I RF		0	0	4. 00
5.00	Subprovi der - (0ther)		0	0	5. 00
6. 00	Swing Beds - SNF		0	0	6. 00
7. 00	Swing Beds - NF		0	0	7. 00
8. 00	SKILLED NURSING FACILITY		0	0	8. 00
9. 00	NURSING FACILITY		0	0	9. 00
	OTHER LONG TERM CARE I				10. 00
	Hospi tal -Based HHA		0	0	11. 00
	AMBULATORY SURGICAL CENTER (D. P.) I		0	0	12. 00
	Hospi tal -Based Hospi ce		0	0	13. 00
	Hospital-Based Health Clinic RHC		0	0	14. 00
	Hospital-Based Health Clinic FQHC		0	0	15. 00
16. 00	Hospi tal -Based-CMHC		0	0	16. 00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
	RENAL DIALYSIS I		0	0	17. 00
18. 00	Other		0	0	18. 00

OCDL TAI	nancial Systems ELKHART GENERAL F		10 0		Washahaat C 1	2552
JOHI IAL	UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN: 15-00		eriod: rom 01/01/2023	Worksheet S-1 Parts I & II	J
			T	o 12/31/2023	Date/Time Pre 5/30/2024 7:4	pare
PA	RT I - HOSPITAL AND HOSPITAL COMPLEX DATA				1. 00	
	compensated and Indigent Care Cost-to-Charge Ratio					
00 Co	st to charge ratio (see instructions)				0. 208363] 1
	dicaid (see instructions for each line)					1
4	t revenue from Medicaid				34, 975, 588	
	d you receive DSH or supplemental payments from Medicaid?					3
4	fline 3 is yes, does line 2 include all DSH and/or supplemen	1 2	edi cai	d?		4
	line 4 is no, then enter DSH and/or supplemental payments for	rom Medicaid			0	5
4	edicaid charges				186, 751, 040	6
4	edicaid cost (line 1 times line 6) fference between net revenue and costs for Medicaid program	(coo instructions)			38, 912, 007 3, 936, 419	
_	ildren's Health Insurance Program (CHIP) (see instructions fo				3, 930, 419	°
	t revenue from stand-alone CHIP	or each time)			0	9
-	and-alone CHIP charges				0	
	and-alone CHIP cost (line 1 times line 10)				0	11
	fference between net revenue and costs for stand-alone CHIP	(see instructions)			0	
	her state or local government indigent care program (see ins		line)	,		
	t revenue from state or local indigent care program (Not incl				9, 834	13
00 Ch	arges for patients covered under state or local indigent care	e program (Not incl	uded i	n lines 6 or	83, 648	14
10	,					l
	ate or local indigent care program cost (line 1 times line 1				17, 429	
	fference between net revenue and costs for state or local inc				7, 595	16
	ants, donations and total unreimbursed cost for Medicaid, CHI	P and state/local	i ndi gei	nt care program	is (see	
	structions for each line) ivate grants, donations, or endowment income restricted to fo	unding charity care			0	17
	overnment grants, appropriations or transfers for support of I				0	18
	otal unreimbursed cost for Medicaid , CHIP and state and Local		arams	(sum of lines	3, 944, 014	
	12 and 16)	i indigent care pro	gi dilis	(Sum of Titles	3, 744, 014	' '
		Uni ns		Insured	Total (col. 1	
		patie 1.0		pati ents 2.00	+ col . 2) 3.00	
Un	compensated care cost (see instructions for each line)	1.0	<u> </u>	2.00	3.00	
	narity care charges and uninsured discounts (see instructions)) 13, 5	27, 506	1, 173, 196	14, 700, 702	20
00 Co	st of patients approved for charity care and uninsured disco	unts (see 2,8	18, 632	1, 173, 196	3, 991, 828	21
	structions)					
	yments received from patients for amounts previously written	off as	0	0	0	22
	ari ty care					
00 Co	ost of charity care (see instructions)	2, 8	18, 632	1, 173, 196	3, 991, 828	23
					1. 00	
	ses the amount on line 20 col. 2, include charges for patient		th of	stay limit	N	24
	posed on patients covered by Medicaid or other indigent care Fline 24 is yes, enter the charges for patient days beyond th		ogram':	s length of	0	25
	ay limit		-	Ĭ		
	parges for insured patients' liability (see instructions)				0	
	d debt amount (see instructions)				16, 995, 169	
	edicare reimbursable bad debts (see instructions)				292, 957	
	edicare allowable bad debts (see instructions)				450, 702	
OO ING	on-Medicare bad debt amount (see instructions)				16, 544, 467	

16, 544, 467

3, 605, 000 7, 596, 828 11, 540, 842 31. 00

28. 00

27.01 Medicare allowable bad debts (see instructions)
28.00 Non-Medicare bad debt amount (see instructions)

29.00 Cost of non-Medicare and non-reimbursable Medicare bad debt amounts (see instructions)
30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

Heal th	Financial Systems ELKHART GENERAL HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10		
HOSPI 7	HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA Provider CCN: 15-0018 From 01/01/2023 To 12/31/2023 Example 1 Example 2							
					1. 00			
	PART II - HOSPITAL DATA				11.00			
	Uncompensated and Indigent Care Cost-to-Charge Ratio							
1.00	Cost to charge ratio (see instructions)				0. 206194	1.00		
	Medicaid (see instructions for each line)							
2.00	Net revenue from Medicaid					2. 00		
3.00	Did you receive DSH or supplemental payments from Medicaid?					3. 00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplement		ledi cai d	?		4. 00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments fr	om Medicaid				5. 00		
6.00	Medicaid charges					6. 00		
7.00	Medicaid cost (line 1 times line 6)	motruet emo)				7. 00		
8. 00	Difference between net revenue and costs for Medicaid program (Children's Health Insurance Program (CHIP) (see instructions for					8. 00		
9. 00	Net revenue from stand-alone CHIP	each fine)				9. 00		
10.00	Stand-alone CHIP charges					10. 00		
11. 00	Stand-alone CHIP cost (line 1 times line 10)					11. 00		
12. 00	Difference between net revenue and costs for stand-alone CHIP (see instructions)				12. 00		
	Other state or local government indigent care program (see inst		line)					
13.00		13. 00						
14.00	14.00 Charges for patients covered under state or local indigent care program (Not included in lines 6 or							
	10)					15. 00		
	15.00 State or local indigent care program cost (line 1 times line 14)							
16. 00	Difference between net revenue and costs for state or local ind				,	16. 00		
	Grants, donations and total unreimbursed cost for Medicaid, CHII instructions for each line)	P and state/local	i ndi gen	t care program	is (see			
17. 00		nding charity care	<u> </u>			17. 00		
18. 00	Government grants, appropriations or transfers for support of h					18. 00		
19.00	Total unreimbursed cost for Medicaid, CHIP and state and local			sum of lines		19. 00		
	8, 12 and 16)							
		Uni nsı		Insured	Total (col. 1			
		patie		pati ents	+ col . 2)			
	Uncompensated care cost (see instructions for each line)	1.0	10	2. 00	3. 00			
20. 00	Charity care charges and uninsured discounts (see instructions)	12.5	27, 506	1, 173, 196	14, 700, 702	20. 00		
21. 00	Cost of patients approved for charity care and uninsured discou		89, 291	1, 173, 196		21. 00		
21.00	instructions)	2, 7	07, 271	1, 170, 170	0, 702, 107	21.00		
22. 00	Payments received from patients for amounts previously written	off as	0	0	0	22. 00		
	chari ty care							
23. 00	Cost of charity care (see instructions)	2, 7	89, 291	1, 173, 196	3, 962, 487	23. 00		
	1				1.00			
24. 00	Does the amount on line 20 col. 2, include charges for patient		th of s	tay limit	N	24. 00		
25 00	imposed on patients covered by Medicaid or other indigent care		oanom! -	longth of		25 00		
25. 00	If line 24 is yes, enter the charges for patient days beyond the stay limit	e murgent care pr	ogram s	rength of	0	25. 00		
25. 01					0	25. 01		
	Pad dobt amount (coo instructions)				16 005 160			

16, 995, 169 290, 211 446, 478

16, 548, 691

3, 568, 508 29. 00 7, 530, 995 30. 00 7, 530, 995 31. 00

26.00

27.00

27. 01

28. 00

26.00 Bad debt amount (see instructions)

27.00 Medicare reimbursable bad debts (see instructions)

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

30.00 Cost of uncompensated care (line 23, col. 3, plus line 29)
31.00 Total unreimbursed and uncompensated care cost (line 19 plus line 30)

27.01 Medicare allowable bad debts (see instructions)
28.00 Non-Medicare bad debt amount (see instructions)

	Financial Systems	ELKHART GENERAL				u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der C	CN: 15-0018 F	Peri od:	Worksheet A	
				F T	rom 01/01/2023 o 12/31/2023	Date/Time Pre	nared.
						5/30/2024 7: 4	
	Cost Center Description	Sal ari es	Other		Recl assi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2.00	2.00	4.00	col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		0		17, 334, 592	17, 334, 592	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUI P		0				2.00
3. 00	00300 OTHER CAP REL COSTS		0		1,004,030	0 1,004,030	3.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	956	956	717, 383	718, 339	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	5, 174, 852	84, 011, 624	1	· ·		5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	0	0		0	0	6.00
7. 00	00700 OPERATION OF PLANT	2, 441, 085	6, 372, 724	8, 813, 809	49, 713	8, 863, 522	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	808, 629	1		808, 629	8. 00
9.00	00900 HOUSEKEEPI NG	2, 315, 968	2, 019, 511			4, 375, 740	9. 00
10.00	01000 DI ETARY	2, 320, 217	2, 306, 094	4, 626, 311	-2, 223, 728	2, 402, 583	10.00
11. 00	01100 CAFETERI A	162, 536	181, 975	1			
12.00	01200 MAINTENANCE OF PERSONNEL	0	0) (0	0	12. 00
13.00	01300 NURSING ADMINISTRATION	2, 683, 735	857, 001	3, 540, 736	-237, 944	3, 302, 792	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	863, 463	831, 657	1, 695, 120	14, 479	1, 709, 599	14. 00
15.00	01500 PHARMACY	4, 536, 143	20, 032, 954	24, 569, 097	-22, 663, 280	1, 905, 817	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0) (0	0	16. 00
17. 00	01700 SOCIAL SERVICE	369, 279	264, 061	633, 340	3, 151	636, 491	17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0) (0	0	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0) (0	0	19. 00
20.00	02000 NURSI NG PROGRAM	0	0) (0	0	20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0) (0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0) (0	0	22. 00
23. 00	02300 PARAMED ED PRGM	27	103, 009	103, 036	0	103, 036	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	26, 682, 777	15, 752, 784	1			
31. 00	03100 I NTENSI VE CARE UNI T	6, 168, 735	2, 478, 577	1		8, 663, 549	
31. 01	03101 NEONATAL INTENSIVE CARE	857, 966	314, 850	1, 172, 816	-460		
32. 00	03200 CORONARY CARE UNIT	0	0) (0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0) (0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0)	0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	1, 779, 363	449, 566				
41. 00	04100 SUBPROVI DER - I RF	0	-7, 880	1		-7, 880	
43. 00	04300 NURSERY	23, 002	4, 668	27, 670	3, 453, 425		
44. 00	04400 SKILLED NURSING FACILITY	0	0		0	0	44. 00
45.00	04500 NURSING FACILITY	0	0		0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0) () 0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	10, 857, 537	32, 022, 148	42, 879, 685	-16, 327, 261	26, 552, 424	50.00
51. 00	05100 RECOVERY ROOM	10, 637, 537	32, 022, 140	42, 077, 000	10, 327, 201	20, 332, 424	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0			0	52.00
53. 00	05300 ANESTHESI OLOGY		0			Ö	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	5, 815, 046	5, 639, 356	11, 454, 402	-3, 241, 419		
55. 00	05500 RADI OLOGY-THERAPEUTI C	0,010,010	0, 007, 000	11, 101, 102	0,211,117	0, 212, 700	55. 00
56. 00	05600 RADI OI SOTOPE	0	0			0	56. 00
57. 00	05700 CT SCAN	956, 705	868, 798	1, 825, 503	1, 831	1, 827, 334	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	454, 628	431, 104			888, 734	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 062, 735	9, 004, 427				1
60.00	06000 LABORATORY	2, 754, 009	6, 809, 917	1 ' '		9, 602, 709	
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0	0	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		Ö)	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	o	O		0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	1, 155, 257	760, 160	1, 915, 417	-275, 344	1, 640, 073	
65.00	06500 RESPI RATORY THERAPY	2, 091, 616	1, 572, 026	3, 663, 642	-76, 942	3, 586, 700	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 615, 380	495, 397	2, 110, 777	36, 640	2, 147, 417	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	483, 803	381, 525	865, 328	2, 971	868, 299	
68.00	06800 SPEECH PATHOLOGY	243, 800	63, 625	307, 425	2, 626	310, 051	68. 00
69.00	06900 ELECTROCARDI OLOGY	O	0) (0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0) (0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0) (222, 559	222, 559	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0) (25, 509, 369	25, 509, 369	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0) (26, 386, 252	26, 386, 252	73. 00
74.00	07400 RENAL DIALYSIS	0	0) (0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0) (0	0	75. 00
76. 00	03140 CARDI OLOGY	2, 001, 410	984, 141	2, 985, 551	-129, 274		76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0) (0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0) (0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0	04 001	0]0	0	1
90. 00	09000 CLI NI C	262, 631	81, 391	344, 022	2 525	344, 547	90. 00

Health Financial Systems	ELKHART GENERAL			In Lie	u of Form CMS-	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provi der CO		Peri od:	Worksheet A	
				From 01/01/2023 Fo 12/31/2023	Date/Time Pre 5/30/2024 7:4	
Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassifications (See A-6)		
	1. 00	2. 00	3.00	4. 00	5. 00	
90. 01 04950 SLEEP CLINIC	310, 473	166, 863	477, 336	5 2, 626	479, 962	90. 01
91. 00 09100 EMERGENCY	9, 259, 154	5, 395, 391	14, 654, 54	7, 069	14, 661, 614	91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0		0	0	
95. 00 09500 AMBULANCE SERVICES	0	0	(0	0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	1	0	0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	
99. 00 09900 CMHC 99. 10 09910 CORF	O O	0			0	
100.00 10000 1&R SERVICES-NOT APPRVD PRGM	0	0)		_	100.00
101.00 10100 HOME HEALTH AGENCY	0	0)			101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0)	0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>		`	5	0	102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	(0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0		0		106. 00
107.00 10700 LIVER ACQUISITION	o	0		0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0		0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0		0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	(0	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	0	(0	0	111. 00
113. 00 11300 I NTEREST EXPENSE		0	(0		113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	(0		115. 00
116. 00 11600 H0SPI CE	0	0	(0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	96, 703, 332	201, 459, 029	298, 162, 36	1 46, 850	298, 209, 211	J118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ol	0		0 0	0	190. 00
191. 00 19100 RESEARCH	0	0	•	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192. 00
193. 00 19300 NONPALD WORKERS	43, 652	15, 312	58, 96	4 525		193. 00
193. 01 19301 COMMUNI TY	233, 522	313, 813			548, 910	
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	1, 173, 265	5, 830, 691	1	· ·	6, 955, 006	
200.00 TOTAL (SUM OF LINES 118 through 199)	98, 153, 771	207, 618, 845			305, 772, 616	
	,					-

Provider CCN: 15-0018

Peri od: From 01/01/2023 To 12/31/2023

Worksheet A Date/Time Prepared: 5/30/2024 7:46 am

				5/30/2024 7: 4	<u>6 am</u>
	Cost Center Description	Adjustments	Net Expenses		
		(See A-8)	For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	-1, 500, 209	1	•	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	2, 028, 746	l	1	2. 00
3.00	00300 OTHER CAP REL COSTS	0	0	l control of the cont	3. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0			4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	-23, 935, 885	45, 509, 383		5. 00
6.00	00600 MAINTENANCE & REPAIRS	0	0		6. 00
7.00	00700 OPERATION OF PLANT	-552, 833	8, 310, 689		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	808, 629	•	8. 00
9.00	00900 HOUSEKEEPI NG	0	4, 375, 740	•	9. 00
10.00	01000 DI ETARY	0	2, 402, 583	•	10.00
11. 00	01100 CAFETERI A	-1, 314, 087	1, 295, 314	1	11.00
	01200 MAINTENANCE OF PERSONNEL	-1, 314, 007	1, 273, 314		1
12.00	l i	0	2 202 702		12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	3, 302, 792	•	13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-2, 803	1	•	14. 00
15. 00	01500 PHARMACY	-223, 263	1	1	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	· ·	l .	16. 00
17. 00	01700 SOCI AL SERVI CE	-23, 316	613, 175		17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0		18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0		19. 00
20.00	02000 NURSI NG PROGRAM	0	0		20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0		21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		22. 00
23. 00	02300 PARAMED ED PRGM	-37, 901	65, 135		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS			1	
30. 00	03000 ADULTS & PEDIATRICS	-4, 327, 821	34, 897, 302		30.00
31. 00	03100 NTENSI VE CARE UNIT	1,027,021	8, 663, 549	•	31.00
31. 00	03101 NEONATAL INTENSIVE CARE	-134, 500	1	•	31. 01
32. 00	l i	-134, 300	1,037,630		
	03200 CORONARY CARE UNIT	0	0		32.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		34. 00
40. 00	04000 SUBPROVI DER - I PF	0	2, 238, 843	•	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	-7, 880		41. 00
43.00	04300 NURSERY	-2, 820	3, 478, 275		43.00
44.00	04400 SKILLED NURSING FACILITY	0	0		44.00
45.00	04500 NURSING FACILITY	0	0		45.00
46.00	04600 OTHER LONG TERM CARE	0	0		46. 00
	ANCILLARY SERVICE COST CENTERS				
50.00	05000 OPERATI NG ROOM	-40, 154	26, 512, 270		50.00
51. 00	05100 RECOVERY ROOM	0	1		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	l o		52.00
53. 00	05300 ANESTHESI OLOGY		0		53.00
	05400 RADI OLOGY-DI AGNOSTI C	-215, 902	7, 997, 081		
54. 00		-215, 902		1	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
56.00	05600 RADI OI SOTOPE	0	0		56. 00
57. 00	05700 CT SCAN	0	1, 827, 334	•	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	888, 734	•	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	2, 038, 976		59. 00
60.00	06000 LABORATORY	0	9, 602, 709		60.00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63.00
64.00	06400 I NTRAVENOUS THERAPY	-630	1, 639, 443		64.00
65. 00	06500 RESPIRATORY THERAPY	0	3, 586, 700	•	65.00
66. 00	06600 PHYSI CAL THERAPY	-2, 800	1	•	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	-2,000	868, 299	•	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	310, 051	•	68. 00
		0	310,031		
69. 00	06900 ELECTROCARDI OLOGY	0	0		69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	222, 559	•	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	25, 509, 369	1	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	26, 386, 252		73. 00
74.00	07400 RENAL DIALYSIS	0	0		74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		75. 00
76.00	03140 CARDI OLOGY	-96, 054	2, 760, 223		76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	n		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		78. 00
. 5. 55	OUTPATIENT SERVICE COST CENTERS	<u>'</u>			1 . 5. 55
88. 00	08800 RURAL HEALTH CLINIC	<u> </u>	^		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				89.00
			244 547		1
90.00	09000 CLINIC	0	344, 547	•	90.00
90. 01	04950 SLEEP CLINIC	0	479, 962	•	90. 01
91. 00	09100 EMERGENCY	-3, 171, 090	11, 490, 524	·	91. 00

Provider CCN: 15-0018

			5/30/2024 7:	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8) F	or Allocation		
	6. 00	7.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 09500 AMBULANCE SERVI CES	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
99. 00 09900 CMHC	0	0		99. 00
99. 10 09910 CORF	0	0		99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0		102. 00
SPECIAL PURPOSE COST CENTERS				
105.00 10500 KIDNEY ACQUISITION	0	0		105. 00
106.00 10600 HEART ACQUISITION	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0		111. 00
113. 00 11300 I NTEREST EXPENSE	0	0		113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	-33, 553, 322	264, 655, 889		118. 00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
191. 00 19100 RESEARCH	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	o		192. 00
193. 00 19300 NONPALD WORKERS	0	59, 489		193. 00
193. 01 19301 COMMUNI TY	0	548, 910		193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	6, 955, 006		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-33, 553, 322	272, 219, 294		200. 00
				•

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0018

					То	te/Time Prepared: 30/2024 7:46 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other 5 00		
	2. 00 A - I NSURANCE	3. 00	4. 00	5. 00		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	218, 070		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP		o_	<u>26, 2</u> 08		2. 00
	0		0	244, 278		
1 00	B - INTEREST	1 00	٥	1 402 050		1.00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT INTEREST EXPENSE	1. 00 113. 00	0	1, 483, 050 1, 483, 050		1.00
2.00	0	113.00		2, 966, 100		2.00
	C - DI ETARY		<u> </u>	2,700,100		
1.00	CAFETERI A	1100	1, 016, 869	1, 244, 870		1.00
	0		1, 016, 869	1, 244, 870		
1 00	H - NURSERY	42.00	2 ((2 020	700 507		1.00
1. 00	NURSERY	4300	2, 662, 838 2, 662, 838	<u>790, 5</u> 87 790, 587		1.00
	I - ONCOLOGY		2, 002, 636	770, 367		
1.00	ADULTS & PEDIATRICS	30.00	127, 026	48, 177		1.00
2.00	RADI OLOGY-DI AGNOSTI C	54. 00	5 <u>7, 7</u> 78	21, 913		2. 00
	0		184, 804	70, 090		
1 00	M - DRUGS CHARGED	72.00		22 025 014		1.00
1. 00 2. 00	DRUGS CHARGED TO PATIENTS ADMINISTRATIVE & GENERAL	73. 00 5. 00	0	22, 025, 014 2, 119		1.00
3.00	ADMINISTRATIVE & GENERAL	0.00	o	2, 119		3.00
4. 00		0.00	o	0		4. 00
5.00		0.00	О	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	o	Ö		11. 00
12.00		0.00	o	0		12. 00
13.00		0.00	0	0		13. 00
14. 00		0.00	0	0		14.00
15. 00		0.00	0	0		15. 00
16. 00		0.00	0	<u></u> <u>0</u> 22, 027, 133		16. 00
	N - RENT		<u> </u>	22,027,133		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	75, 344		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	O	497, 435		2. 00
3.00		0.00	0	0		3.00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6.00		0.00	0	0		6.00
7. 00		0.00	o	0		7. 00
8.00		0.00	О	0		8. 00
9.00		0.00	0	0		9. 00
10. 00		0.00	•	0		10. 00
	0 - SUPPLI ES		0	572, 779		
1. 00	MEDICAL SUPPLIES CHARGED TO	71.00	0	222, 559		1. 00
	PATI ENTS			,		
2.00	I MPL. DEV. CHARGED TO	72. 00	0	25, 509, 369		2. 00
2 00	PATI ENTS	0.00				2.00
3. 00 4. 00		0. 00 0. 00	0	0		3. 00 4. 00
5. 00		0.00	0	Ö		5. 00
6. 00		0.00	ō	O		6. 00
7.00		0.00	o	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10. 00 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
12. 00		0.00	0	0		12.00
00		— — -::3	0	25, 731, 928		.2. 30
	P - DEPRECIATION	<u>'</u>				
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	15, 538, 465		 1. 00
2.00	CAP REL COSTS-MVBLE EQUIP			56 <u>0, 3</u> 93		2. 00
	O R - PHARMACY		0	16, 098, 858		
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	4, 361, 238	0		1. 00
	0	— — 	4, 361, 238	<u>o</u>		55
	'	'	'			•

					5/30/2024	
		Increases			0, 00, 202	10 (4
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
	S - AMORTIZATION					
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	19, 663		1. (
	0		0	19, 663		
	T - BENEFIT					
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	717, 383		1. (
				717, 383		İ
	V - INCENTIVE	<u> </u>		<u>.</u>		
. 00	ADMINISTRATIVE & GENERAL	5. 00	335, 965	0		1. (
. 00	PHARMACY	15. 00	65, 803	0		2. (
. 00	NEONATAL INTENSIVE CARE	31. 01	0	0		3. (
. 00	SUBPROVI DER - I PF	40.00	9, 978	0		4. (
. 00	RADI OLOGY-DI AGNOSTI C	54.00	64, 830	0		5. (
. 00	CT SCAN	57.00	6, 827	0		6. (
. 00	MAGNETIC RESONANCE I MAGING	58.00	3, 151	0		7. (
	(MRI)		-,			'''
3. 00	CARDÍ AC CATHETERI ZATI ON	59.00	14, 161	0		8. (
. 00	INTRAVENOUS THERAPY	64.00	8, 402	0		9. (
0. 00	PHYSI CAL THERAPY	66.00	36, 640	0		10.0
1. 00	CLINIC	90.00	525	0		11.
2. 00	NONPALD WORKERS	193. 00	525	0		12.
3. 00	OTHER NONREI MBURSABLE COST	194. 00	5, 251	0		13.
0.00	CENTERS	171.00	0, 201	Ö		10. (
4. 00	OPERATION OF PLANT	7. 00	49, 713	0		14. (
5. 00	HOUSEKEEPI NG	9. 00	40, 261	0		15. (
6. 00	DI ETARY	10.00	55, 712	0		16. (
7. 00	CAFETERI A	11. 00	3, 151	0		17.
8. 00	NURSING ADMINISTRATION	13. 00	17, 296	0		18.
9. 00	CENTRAL SERVICES & SUPPLY	14. 00	14, 479	0		19. (
0.00	SOCI AL SERVI CE	17. 00	3, 151	0		20. (
1. 00	ADULTS & PEDIATRICS	30.00	257, 312	0		21.
2. 00	INTENSIVE CARE UNIT	31.00	54, 453	0		22.
3. 00	OPERATING ROOM	50.00	104, 121	0		23.
4. 00	LABORATORY	60.00	41, 960	0		24.
5. 00	RESPIRATORY THERAPY	65. 00	22, 843	0		25.
6. 00	OCCUPATIONAL THERAPY	67. 00	3, 151	0		26.
7. 00	SPEECH PATHOLOGY	68.00	2, 626	0		27.
7. 00 8. 00	CARDI OLOGY	76.00	2, 626 12, 078	0		27.
9. 00	1	90. 01		0		28.
	SLEEP CLINIC	l	2, 626	-		1
0.00	EMERGENCY	91.00	84, 262	0		30.
1. 00	COMMUNITY	1 <u>93.</u> 01	1, 575	0		31.
	U LNTENCLVE		1, 322, 828	U		
00	Y - INTENSIVE	24 00	E0 240	2.050		
. 00	INTENSIVE CARE UNIT	31.00	50, 349	3,852		1.
.00 00	U Constant Table Language		50, 349	3, 852		F00
UU. UU	Grand Total: Increases		9, 598, 926	70, 487, 521		500.

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 15-0018

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 7:46 am

		Decreases				5/30/2024 7:4	46 am
	Cost Center	Li ne #	Sal ary	Other	 Wkst. A-7 Ref.		
	6.00	7.00	8.00	9. 00	10.00		
	A - INSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	244, 278			1. 00
2.00		0.00		0	12		2. 00
	0		0	244, 278			_
1 00	B - INTEREST INTEREST EXPENSE	112.00	٥	1 402 050	11		1 00
1. 00 2. 00	ADMINISTRATIVE & GENERAL	113. 00 5. 00	0	1, 483, 050 1, 483, 050			1. 00
2.00	O GENERAL			2, 966, 100			2.00
	C - DI ETARY		<u> </u>	2, 700, 100			1
1.00	DI ETARY	10.00	1, 016, 869	1, 244, 870	0		1. 00
	0		1, 016, 869	1, 244, 870]
	H - NURSERY		0.440.000	700 507			4
1. 00	ADULTS & PEDIATRICS	30.00	2, 662, 838 2, 662, 838	79 <u>0, 5</u> 87 790, 587			1. 00
	I - ONCOLOGY		2, 002, 030	790, 367			4
1.00	NURSI NG ADMI NI STRATI ON	13.00	184, 804	70, 090	0		1.00
2. 00		0.00	0	0	o		2. 00
			184, 804	70, 090			
	M - DRUGS CHARGED						
1.00	PHARMACY	15. 00	0	18, 367, 845	I I		1. 00
2.00	ADULTS & PEDIATRICS	30.00	0	161, 472	l 1		2. 00
3.00	INTENSIVE CARE UNIT	31.00	0	51, 749	I I		3. 00
4.00	NEONATAL INTENSIVE CARE	31. 01	0	460	l 1		4. 00
5. 00 6. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF	40. 00 41. 00	0	64 0	1		5. 00 6. 00
7. 00	OPERATING ROOM	50.00	0	350, 470			7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	o	1, 479, 795	1		8. 00
9. 00	CT SCAN	57. 00	o	4, 996	l 1		9. 00
10.00	CARDIAC CATHETERIZATION	59.00	O	1, 321, 190			10.00
11.00	LABORATORY	60.00	O	3, 177	0		11. 00
12.00	I NTRAVENOUS THERAPY	64. 00	0	15, 868			12. 00
13.00	RESPI RATORY THERAPY	65.00	0	99, 785			13. 00
14.00	CARDI OLOGY	76.00	0	95, 530			14.00
15.00	EMERGENCY	91.00	0	74, 386	l 1		15. 00
16. 00	NURSING ADMINISTRATION	13.00	0	<u>346</u> 22, 027, 133			16. 00
	N - RENT			22,027,100			1
1.00	ADMINISTRATIVE & GENERAL	5.00	0	193, 232	10		1. 00
2.00	OPERATION OF PLANT	7. 00	o	0	10		2. 00
3.00	NURSING ADMINISTRATION	13. 00	0	0	0		3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	271, 622	I I		4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	26, 035			5. 00
6. 00 7. 00	INTENSIVE CARE UNIT CARDIOLOGY	31.00	0	11, 500			6. 00 7. 00
7. 00 8. 00	RESPIRATORY THERAPY	76. 00 65. 00	0	45, 822 0	0		8. 00
9. 00	DI ETARY	10.00	0	17, 701	· ·		9. 00
10. 00	OPERATING ROOM	50.00	o	6, 867	10		10.00
	0			572, 779			
	0 - SUPPLIES						1
1.00	ADULTS & PEDIATRICS	30.00	0	2, 021	l 1		1. 00
2.00	INTENSIVE CARE UNIT	31.00	0	29, 168	l 1		2. 00
3.00	NEONATAL INTENSIVE CARE	31. 01	0	14 074 045			3. 00
4. 00 5. 00	OPERATING ROOM RADIOLOGY-DIAGNOSTIC	50. 00 54. 00	0	16, 074, 045 1, 634, 523			4. 00 5. 00
6. 00	OCCUPATI ONAL THERAPY	67.00	0	1, 034, 323	l 1		6. 00
7. 00	CARDI AC CATHETERI ZATI ON	59.00	O	7, 721, 157	l !		7. 00
8.00	I NTRAVENOUS THERAPY	64.00	o	267, 878			8. 00
9.00	RESPI RATORY THERAPY	65.00	O	0	O		9. 00
10.00	PHYSI CAL THERAPY	66.00	o	0	0		10.00
11.00	EMERGENCY	91.00	0	2, 807	0		11. 00
12.00	MAGNETIC RESONANCE IMAGING	58. 00	0	149	0		12. 00
	(MRI)	+					
	P - DEPRECIATION		0	25, 731, 928			-
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	16, 098, 858	9		1. 00
2. 00		0.00	o	0	l 1		2. 00
	0			16, 098, 858			_
	R - PHARMACY	-					4
1.00	PHARMACY	<u>15.</u> 00	<u>4, 361, 238</u>	0			1. 00
	C AMODILIZATION		4, 361, 238	0			-
1. 00	S - AMORTI ZATI ON ADMI NI STRATI VE & GENERAL	5.00	0	19, 663	11		1.00
50	0	<u> </u>		19, 663	 		
	1	, !	٦١	. 7, 550	·		1

RECLASSI FI CATIONS

28.00

29.00

Provider CCN: 15-0018

0

0

Peri od: Worksheet A-6 From 01/01/2023

28.00

29.00

Date/Time Prepared: 5/30/2024 7:46 am 12/31/2023 Decreases Cost Center 0ther Wkst. A-7 Ref. Li ne # Sal ary 10.00 6.00 7.00 8.00 9.00 T - BENEFIT 1.00 ADMINISTRATIVE & GENERAL 5.00 717, 383 0 1.00 717, 383 V - INCENTIVE ADMINISTRATIVE & GENERAL 1.00 5.00 1, 322, 828 0 1.00 2.00 0.00 0 2.00 0 0 0 3.00 0 3.00 0.00 0 4.00 0 0.00 0 4.00 5.00 0.00 0 0 5.00 6.00 0.00 0 0 6.00 0 7.00 0.00 7.00 0.00 8.00 8.00 0 9.00 0.00 0 9.00 10.00 0.00 0 0 10.00 0 0.00 11.00 11.00 12.00 12.00 0.00 13.00 0.00 0 0 13.00 0 14.00 0.00 0 0 0 14.00 0 0.00 15.00 15.00 16.00 0.00 16.00 17.00 0.00 0 17.00 0 0 18.00 0.00 18.00 0 19.00 0.00 19.00 20.00 0.00 20.00 21.00 0.00 21.00 0 0 0 22.00 0.00 22.00 23.00 0.00 23.00 24.00 0.00 0 24.00 0 0 25.00 0.00 25.00 26.00 0.00 26.00 0 27.00 0.00 0 27.00

0 0 0 30.00 0.00 30.00 31.00 0.00 0 31.00 1, 322, 828 - INTENSIVE 1.00 OTHER NONREIMBURSABLE COST 194.00 50, 349 3, 852 0 1.00 CENTERS 50, 349 3, 852 500.00 Grand Total: Decreases 9, 598, 926 70, 487, 521 500.00

0

0.00

0.00

RECONCILIATION OF CAPITAL COSTS CENTERS

Provider CCN: 15-0018

Peri od: Worksheet A-7 From 01/01/2023 Part I 12/31/2023

Date/Time Prepared: 5/30/2024 7:46 am Acqui si ti ons Begi nni ng Purchases Donati on Total Di sposal s and Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 4, 553, 423 420, 475 420, 475 0 1.00 0 2.00 Land Improvements 1, 143, 940 0 2.00 0 3.00 188, 059, 775 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 75, 563, 667 13, 768, 019 13, 768, 019 2, 338 4.00 5.00 Fixed Equipment 115, 608, 897 5, 038, 320 0 5, 038, 320 592, 640 5.00 0 6.00 Movable Equipment 20, 862, 168 538, 097 538, 097 6.00 0 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 405, 791, 870 19, 764, 911 19, 764, 911 594, 978 8.00 9.00 Reconciling Items 0 9.00 19, 764, 911 Total (line 8 minus line 9) 405, 791, 870 594, 978 10.00 19, 764, 911 10.00 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 4, 973, 898 1.00 2.00 Land Improvements 1, 143, 940 553, 640 2. 00 . Buildings and Fixtures 188. 059. 775 26, 463, 561 3.00 3.00 4.00 Building Improvements 89, 329, 348 40, 331, 265 4.00 5.00 Fixed Equipment 120, 054, 577 58, 911, 781 5.00 18, 994, 385 6.00 Movable Equipment 21, 400, 265 6.00 7. 00 7.00 HIT designated Assets Ω Subtotal (sum of lines 1-7) 8.00 424, 961, 803 145, 254, 632 8.00 9.00 Reconciling Items 9.00 10.00 Total (line 8 minus line 9) 424, 961, 803 145, 254, 632 10.00

Heal th	Financial Systems	ELKHART GENERA	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
RECONO	ILIATION OF CAPITAL COSTS CENTERS		Provi der CO	CN: 15-0018	Peri od:	Worksheet A-7	
					From 01/01/2023 To 12/31/2023		nared·
						5/30/2024 7: 4	6 am
			SU	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see		
		0.00	10.00	11.00	instructions)		
	DART II DECONCILLATION OF AMOUNTS FROM WORK	9.00	10.00	11.00	12.00	13. 00	
1. 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK CAP REL COSTS-BLDG & FIXT	T A, CULUMI	N Z, LINES I a	nd 2	0		1.00
2.00	CAP REL COSTS-BLDG & TTXT		0			0	2. 00
3.00	Total (sum of lines 1-2)		0		0 0	0	3. 00
		SUMMARY OF	- CAPI TAL				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1. 00	CAP REL COSTS-BLDG & FLXT	O O	n z, Lines i a	110 2			1.00
2.00	CAP REL COSTS-MVBLE EQUIP		0				2.00
3.00	Total (sum of lines 1-2)		0				3.00
		-1		1			

Heal th	n Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2023		
					To 12/31/2023	Date/Time Prep 5/30/2024 7:40	
		COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI						
1.00	CAP REL COSTS-BLDG & FLXT	403, 548, 486					1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	21, 413, 318					2.00
3.00	Total (sum of lines 1-2)	424, 961, 804					3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
		/ 00	d Costs	through 7)	0.00	40.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CI	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	CAP REL COSTS-BLDG & FIXT	INTERS			15, 538, 465	586, 437	1. 00
2.00	CAP REL COSTS-BEDG & TTXT	0			560, 393		2. 00
3.00	Total (sum of lines 1-2)	0	0		16, 098, 858		3. 00
0.00	Total (Sam of Titles 1 2)		SI	JMMARY OF CAPI		0, 107, 000	0.00
			0.0				
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		11.00	10.00	10.00	instructions)	45.00	
	DART III DECONCILIATION OF CARLTAL COSTS OF	11. 00	12.00	13. 00	14. 00	15. 00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS CI	1, 311, 882	218, 070		-1, 820, 471	15, 834, 383	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	1,311,002	26, 208		0 -1, 620, 471		2. 00
3.00	Total (sum of lines 1-2)	1, 311, 882			-1, 876, 858		
5.00	Total (sum of filles 1-2)	1, 311, 002	244, 270	1	1,070,030	10, 747, 103	5.00

Provider CCN: 15-0018

					To 12/31/2023	Date/Time Prep 5/30/2024 7:46	
				Expense Classification	on Worksheet A	373072024 7.40	J alli
				To/From Which the Amount i			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	T	1.00	2.00	3.00	4. 00	5. 00	
1. 00	Investment income - CAP REL	В	-190, 831	CAP REL COSTS-BLDG & FIXT	1.00	11	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	-	0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
2.00	COSTS-MVBLE EQUIP (chapter 2)		0	CAI REE COSTS-WIDEE EQUIT	2.00	Ĭ	2.00
3.00	Investment income - other		0		0.00	О	3.00
	(chapter 2)						
4. 00	Trade, quantity, and time	В	0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of	В	-584 423	ADMINISTRATIVE & GENERAL	5.00	0	5. 00
0.00	expenses (chapter 8)		001, 120	TOWN WE SHOULD BE A SENERAL	0.00	Ĭ	0.00
6.00	Rental of provider space by		0		0.00	o	6.00
	suppliers (chapter 8)						7 00
7. 00	Tel ephone servi ces (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service		0		0.00	0	8. 00
	(chapter 21)						
9. 00	Parking lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-7, 985, 575			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	o	11. 00
11.00	(chapter 23)		0		0.00	Ĭ	11.00
12.00	Related organization	A-8-1	120, 166			o	12.00
	transactions (chapter 10)						
13.00	Laundry and linen service		0		0.00	0	
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-1, 314, 087	CAFETERIA I	11. 00 0. 00	0	14. 00 15. 00
13.00	and others		U		0.00	٩	15.00
16. 00	Sale of medical and surgical		0		0.00	o	16.00
	supplies to other than						
47.00	patients		24. 2.2	55	45.00		47.00
17. 00	Sale of drugs to other than patients	В	-216, 263	PHARMACY	15. 00	0	17. 00
18. 00	Sale of medical records and		0		0.00	o	18. 00
10.00	abstracts		· ·		0.00	Ĭ	10.00
19. 00	Nursing and allied health		0		0.00	O	19.00
	education (tuition, fees,						
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of		0		0.00	0	21. 00
21.00	interest, finance or penalty		0		0.00	Ĭ	21.00
	charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0.00	0	22.00
	overpayments and borrowings to	1					
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
23.00	therapy costs in excess of	7 0 5	O	REST TRATORT THERAIT	03.00		23.00
	limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization (chapter 14)		0	UTILIZATION REVIEW-SNF	114.00		25. 00
_5.00	physicians' compensation		0		111.00		_3. 50
	(chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	이	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		^	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
∠1. UU	COSTS-MVBLE EQUIP		U	IONI NEL GOSTS-MVDLE EQUIP	2.00		Z1. UU
28. 00	Non-physician Anesthetist		0	NONPHYSICIAN ANESTHETISTS	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00	o	29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		Ω	ADULTS & PEDIATRICS	30.00		30. 99
, ,	instructions)		0		30.00		- 3. //
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		31. 00
	pathology costs in excess of						
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
JZ. UU	Depreciation and Interest		U		0.00		JZ. UU
33. 00	TELEVI SI ON EXPENSE	A	0	ADMINISTRATIVE & GENERAL	5.00	o	33. 00

From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

				T	o 12/31/2023	Date/Time Prep 5/30/2024 7:40	
				Expense Classification on	Worksheet A	3/30/2024 7.40	o alli
				To/From Which the Amount is			
				To, i i on the fine famount i o	to bo haj dotod		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3. 00	4. 00	5. 00	
34.00	PHYSICIAN RECRUITMENT	A	-101, 865	ADMINISTRATIVE & GENERAL	5. 00	0	34. 00
36.00	LOBBYING EXPENSE	A	0	ADMINISTRATIVE & GENERAL	5. 00	0	36. 00
39. 00	MEDICAL STAFF DUES	В	-500	ADMINISTRATIVE & GENERAL	5. 00	0	39. 00
40.00	PAYPHONE REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	40. 00
42.00	EMS REVENUE	В	-37, 901	PARAMED ED PRGM	23. 00	0	42. 00
43.00	TRUSTEE FEE	A		ADMINISTRATIVE & GENERAL	5. 00	0	43.00
44.00	ENVI RONMENTAL SERVI CES	В		HOUSEKEEPI NG	9. 00	0	44. 00
45. 00	PLANT MAINT MISC REVENUE	В	·	OPERATION OF PLANT	7. 00	0	45. 00
47.00	PHYSICAL THERAPY MISC REVENUE	В		PHYSI CAL THERAPY	66. 00	0	47. 00
49. 00	I MAGING SERVICES REVENUE	В		RADI OLOGY-DI AGNOSTI C	54. 00	0	49. 00
49. 01	CARDIOLOGY MISC REVENUE	В		CARDI OLOGY	76. 00	0	49. 01
49. 02	NURSING ADMIN MISC REVENUE	В		NURSING ADMINISTRATION	13. 00	0	49. 02
49. 03	NON-ALLOWABLE ADMIN EXPENSES	A		ADMINISTRATIVE & GENERAL	5. 00	0	49. 03
49. 04	NON-ALLOWABLE CONTRIBUTIONS	A		ADMINISTRATIVE & GENERAL	5. 00	0	49. 04
49. 05	NON-ALLOWABLE HAF EXPENSES	A		ADMINISTRATIVE & GENERAL	5. 00	0	49. 05
49. 06	LACTATION SUPPLIES SALES	В	-946	ADULTS & PEDIATRICS	30. 00	0	49. 06
	REVENUE	_	_			_	
49. 07	OTHER ADJUSTMENTS	В		ADULTS & PEDIATRICS	30.00	0	49. 07
49. 08	PHYSICIAN GUARANTEE	A		OPERATING ROOM	50.00	0	49. 08
49. 09	RENTAL REVENUE	В		CAP REL COSTS-BLDG & FIXT	1.00	14	
49. 10	COVID19 VACCINE CLINIC GRANT	В		CLINIC	90.00	0	49. 10
49. 13	OTHER REVENUE - ADMIN	В		ADMINISTRATIVE & GENERAL	5. 00	0	49. 13
49. 17	OTHER REVENUE - SURGERY	В		OPERATING ROOM	50.00	0	49. 17
49. 18	OTHER REVENUE - ED	В		EMERGENCY	91.00	0	49. 18
49. 19	OTHER REVENUE - PRENATAL PROGRAM	В	-2, 820	NURSERY	43. 00	0	49. 19
49. 21	OTHER REVENUE - CATH	В	0	CARDIAC CATHETERIZATION	59. 00	0	49. 21
49. 28	AP RECOVERIES	В	0	ADMINISTRATIVE & GENERAL	5. 00	0	49. 28
49. 29	OTHER REVENUE - OT	В	0	OCCUPATIONAL THERAPY	67. 00	0	49. 29
49. 33	OTHER REVENUE - REHAB	В	0	SUBPROVIDER - IRF	41.00	0	49. 33
49. 34	ALLOWABLE PENSION ADJUSTMENT	A	0	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	49. 34
49. 35	OTHER REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	49. 35
49. 37	OTHER REVENUE	В		SOCIAL SERVICE	17. 00	0	49. 37
49. 38	OTHER REVENUE	В		OPERATING ROOM	50.00	0	49. 38
49. 39	OTHER REVENUE	В	0	LABORATORY	60.00	0	49. 39
49. 40	OTHER REVENUE	В		INTRAVENOUS THERAPY	64. 00	0	49. 40
49. 41	TO HOME OFFICE - BUILDING	A	·	CAP REL COSTS-BLDG & FIXT	1. 00	14	49. 41
49. 42	TO HOME OFFICE - MME	A		CAP REL COSTS-MVBLE EQUIP	2. 00	14	
49. 43	TO HOME OFFICE - PLANT	A		OPERATION OF PLANT	7. 00	14	
49. 44	OTHER REVENUE	В	·	PHARMACY	15. 00	0	49. 44
49. 45	TO HOME OFFICE - WAGES	A		RADI OLOGY-DI AGNOSTI C	54.00	0	49. 45
49. 46	TO HOME OFFICE - WAGES	A		ADMINISTRATIVE & GENERAL	5. 00	0	49. 46
49. 47	TO HOME OFFICE - WAGES	A		NURSING ADMINISTRATION	13. 00	0	49. 47
49. 48	OTHER REVENUE - STERILIZATION	В	·	CENTRAL SERVICES & SUPPLY	14. 00	0	49. 48
50. 00	TOTAL (sum of lines 1 thru 49)		-33, 553, 322				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

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

⁽²⁾ Basis for adjustment (see instructions).

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

B. Amount Received - if cost cannot be determined.

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

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

* 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.

42, 676, 011

42, 555, 845

5.00

			Related Organization(s) and	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
, ,		Ownershi p		Ownershi p	
1. 00	2.00	3.00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

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

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

5.00

line 12.

TOTALS (sum of lines 1-4).

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

Heal th	Financial Syste	ems		ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
STATEME OFFICE		SERVICES FROM	RELATED	ORGANIZATIONS AND HOME	Provi der CCI	N: 15-0018	Peri od: From 01/01/2023	Worksheet A-8	3-1
OTTTOE							To 12/31/2023	Date/Time Pro 5/30/2024 7:4	
	Net	Wkst. A-7 Ref.							
	Adjustments								
	(col. 4 minus								
	col. 5)*								
	6. 00	7. 00							
	A. COSTS INCUR	RED AND ADJUSTI	MENTS RE	QUIRED AS A RESULT OF TR	ANSACTIONS WI	TH RELATED C	ORGANI ZATI ONS OR	CLAI MED	
	HOME OFFICE CO	STS:							
1.00	511, 093	10							1.00
2.00	2, 085, 133	10							2.00
3.00	40, 079, 785	0							3.00
4.00	-42, 555, 845	0							4.00
5 00	120 166								5 00

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

nas not	been posted to norksheet 11,	cordinate and or 2, the amount arrowable should be that cated the cordinate of this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	31		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	
		` ,	

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

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

6.00	6.00
7. 00	7.00
8. 00	8.00
9. 00	8. 00 9. 00
10. 00	10.00
6. 00 7. 00 8. 00 9. 00 10. 00 100. 00	10. 00 100. 00

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0018

| Period: | Worksheet A-8-2 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: 5/30/2024 7: 46 am

									5/30/2024 7:4	16 am
	Wkst. A Line #	Cost	Center/Physician	Total	Professi on	al	Provi der	RCE Amount	Physi ci an/Prov	
			Identi fi er	Remuneration	Component	t	Component		ider Component	
									Hours	
	1. 00		2.00	3.00	4. 00		5. 00	6. 00	7. 00	
1. 00	30.00	DD U	2.00	3, 866, 975	3, 866,	075		0.00		1. 00
	91. 00									
2.00				1, 054, 823						
3.00	91. 00			190, 650				0	1	
4.00	91. 00			572, 189	572,	189		0	0	
5.00	5. 00	DR. E		300		300) (0	5. 00
6.00	30.00	DR. C		459, 900	459,	900			ol o	6. 00
7.00	76. 00	DR. F		96, 054	96,	054		ol (ol o	7. 00
8.00	91. 00			1, 353, 428						
9. 00	50.00			40, 154		154				
10. 00	54. 00			65, 902						10.00
								١ ٠		
11. 00	66. 00			700		700		0 (٥ -	11. 00
12.00	54. 00			150, 000	150,			0	٧ -	12.00
13.00	31. 01	DR. N		134, 500) (C	0 0	13. 00
200.00				7, 985, 575	7, 985,	575		O	0	200.00
	Wkst. A Line #	Cost	Center/Physician	Unadjusted RCE	5 Percent	of	Cost of	Provi der	Physician Cost	
			Identi fi er	Limit			Memberships 8	Component	of Mal practice	
					Limit		Continuing	Share of col.	Insurance	
							Education	12	Trisur unice	
	1.00		2. 00	8.00	9. 00		12. 00	13. 00	14. 00	
1. 00	30.00	DD II	2.00	0.00		0		0 (1. 00
						-				
2.00	91. 00			0		0		0 (1	
3.00	91. 00			0		0		0		
4.00	91.00			0		0		0 (0 0	4. 00
5.00	5. 00	DR. E		0		0			0	5. 00
6.00	30.00	DR. C		0		0			ol o	6. 00
7.00	76, 00	DR. E		l 0		0		ol (ol o	7. 00
8. 00	91. 00			l o		0				
9. 00	50.00			0		0			-	
10. 00	54.00					0				
				-		0		-	-	
11. 00	66. 00			0		0		0 (0	11. 00
12. 00	54. 00			0		0		0	0	12. 00
13.00	31. 01	DR. N		0		0			0	13.00
200.00				0		0			0	200.00
	Wkst. A Line #	Cost	Center/Physician	Provi der	Adjusted R	CF	RCE	Adjustment		
			I denti fi er	Component	Limit		Di sal I owance	,		
			1 401121 11 01	Share of col.	2		Di Gai i Gilanos			
				14						
	1. 00		2. 00	15. 00	16. 00		17. 00	18. 00		
1 00	30.00	חם יי	2.00	15.00		0				1 00
1.00					l .	-		-, -, ,		1. 00
2.00	91. 00			0		0		1, 054, 823		2. 00
3.00	91. 00			0		0		190, 650)	3. 00
4.00	91.00	DR. B		0		0		572, 189	9	4. 00
5.00	5. 00	DR. E		0		0		300		5. 00
6.00	30.00	DR C		l o		0		459, 900		6. 00
7. 00	76. 00			0		0		96, 054		7. 00
8. 00	91.00					0		1, 353, 428		8.00
						0		-,,		9.00
9.00	50.00					-		0 40, 154		
10.00	54.00			0		0		65, 902	1	10. 00
11. 00	66. 00			0		0		700		11. 00
12.00	54.00			0		0		150, 000	0	12. 00
13.00	31. 01	DR. N		0		0		134, 500)	13. 00
200.00				0		0		7, 985, 575	1	200.00
				'	1	_	1	,,	1	

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	ELKHART GENER	AL HOSPITAL Provider CO		eriod: com 01/01/2023	worksheet B Part I Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		5/30/2024 7: 4	6 am
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
		0	1. 00	2.00	4. 00	4A	
1 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT	15 024 202	15 024 202				1.00
1. 00 2. 00 4. 00 5. 00 6. 00	00200 CAP REL COSTS-BLDG & FIAT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	15, 834, 383 3, 112, 782 718, 339 45, 509, 383	15, 834, 383 3, 139 97, 368 0	3, 112, 782 617	722, 095 30, 811 0	45, 656, 703 0	2. 00 4. 00 5. 00 6. 00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE	8, 310, 689 808, 629	3, 392, 416 96, 880	666, 896 19, 045	18, 325 0	12, 388, 326 924, 554	
9. 00	00900 HOUSEKEEPI NG	4, 375, 740	95, 950	18, 862	17, 335	4, 507, 887	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	2, 402, 583 1, 295, 314	288, 244 49, 846	56, 664 9, 799	9, 999 8, 700	2, 757, 490 1, 363, 659	
12. 00	01200 MAINTENANCE OF PERSONNEL	0	0	0	0, 700	0	12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON	3, 302, 792	43, 267	8, 506	18, 512	3, 373, 077	
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	1, 706, 796 1, 682, 554	347, 949 133, 776	68, 401 26, 298	6, 459 1, 771	2, 129, 605 1, 844, 399	
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
17. 00 18. 00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY)	613, 175	17, 158	3, 373	2, 740	636, 446 0	17. 00 18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21. 00 22. 00	02100 &R SERVI CES-SALARY & FRI NGES APPRVD 02200 &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	65, 135	4, 813	946	ō	70, 894	1
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	34, 897, 302	3, 347, 035	657, 973	179, 518	39, 081, 828	30.00
31. 00	03100 INTENSIVE CARE UNIT	8, 663, 549	3, 347, 033 257, 951	50, 709	46, 154	9, 018, 363	
31. 01	03101 NEONATAL INTENSIVE CARE	1, 037, 856	54, 171	10, 649	6, 312	1, 108, 988	1
32. 00 33. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	ő	o	0	34. 00
40.00	04000 SUBPROVI DER - I PF	2, 238, 843	253, 696	49, 873	13, 164	2, 555, 576	
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	-7, 880 3, 478, 275	238, 561	46, 897	19, 760	-7, 880 3, 783, 493	
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	45. 00 46. 00
	ANCILLARY SERVICE COST CENTERS		0	<u> </u>	٥		
50.00	O5000 OPERATI NG ROOM O5100 RECOVERY ROOM	26, 512, 270 0	1, 362, 082 0	267, 763 0	80, 645 0	28, 222, 760 0	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	1
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	1
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	7, 997, 081	1, 099, 365 0	216, 117	43, 683 0	9, 356, 246 0	54. 00 55. 00
56.00	05600 RADI OI SOTOPE	0	0	0	O	0	56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 827, 334 888, 734	165, 047 83, 395	32, 445 16, 394	7, 089 3, 368	2, 031, 915 991, 891	
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 038, 976	94, 671	18, 611	15, 280	2, 167, 538	
60.00	06000 LABORATORY	9, 602, 709	126, 220	24, 813	20, 570	9, 774, 312	1
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	U	U	U	0	60. 01 61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	1, 639, 443	0 180, 531	0 35, 489	0 8, 561	1 964 024	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	3, 586, 700	41, 942	8, 245	15, 556	1, 864, 024 3, 652, 443	
66. 00	06600 PHYSI CAL THERAPY	2, 144, 617	115, 479	22, 701	12, 154	2, 294, 951	
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	868, 299 310, 051	55, 450 33, 246	10, 900 6, 536	3, 583 1, 813	938, 232 351, 646	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0 222, 559	0	0	0	0 222, 559	70. 00 71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	25, 509, 369	0	0	o	25, 509, 369	
73.00	07300 DRUGS CHARGED TO PATIENTS	26, 386, 252	Ō	0	32, 086	26, 418, 338	73. 00
74. 00 75. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0 0	0 	0 n	0	74. 00 75. 00
76. 00	03140 CARDI OLOGY	2, 760, 223	264, 949	52, 085	14, 813	3, 092, 070	76. 00
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	77. 00 78. 00
	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	<u> </u>			70.00
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018 Peri od: Worksheet B From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 7:46 am CAPITAL RELATED COSTS **EMPLOYEE** Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP Subtotal **BENEFITS** for Cost DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89. 00 0 0 09000 CLI NI C 21, 650 1, 936 478, 265 90 00 90 00 344, 547 110, 132 90.01 04950 SLEEP CLINIC 479, 962 2, 303 482, 265 90.01 91.00 09100 EMERGENCY 11, 490, 524 387, 240 76, 125 68, 740 12, 022, 629 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92 00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94.00 09500 AMBULANCE SERVICES 0 95.00 00000000 0 0 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 96 00 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 98.00 0 99.00 09900 CMHC 0 0 99.00 0 99. 10 |09910 CORF 0 99. 10 0 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 102.00 0 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 0 0 0 106. 00 0000 0 107. 00 10700 LIVER ACQUISITION 0 107. 00 0 0 108.00 10800 LUNG ACQUISITION 0 0 108.00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 111.00 11100 I SLET ACQUISITION C 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 264, 655, 889 12, 841, 969 2, 524, 523 261, 064, 861 118. 00 118, 00 711, 740 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 191. 00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 341, 403 192. 00 0 285, 315 56,088 193. 00 19300 NONPALD WORKERS 59, 489 325 59, 814 193. 00

548.910

6, 955, 006

272, 219, 294

97.624

2, 609, 475

15, 834, 383

19 191

512, 980

3, 112, 782

1,730

8, 300

722, 095

667, 455 193. 01

0 200.00

0 201.00

10, 085, 761 194. 00

272, 219, 294 202. 00

193. 01 19301 COMMUNI TY

200.00

201.00

202.00

194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS

Cross Foot Adjustments

TOTAL (sum lines 118 through 201)

Negative Cost Centers

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0018

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Ti me Prepared:

5/30/2024 7:46 am Cost Center Description ADMINISTRATIVE MAINTENANCE & OPERATION OF LAUNDRY & HOUSEKEEPI NG & GENERAL **REPAIRS PLANT** LINEN SERVICE 9.00 5.00 6.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 45, 656, 703 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 14, 884, 722 00700 OPERATION OF PLANT 2, 496, 396 7.00 7.00 1, 227, 707 8.00 00800 LAUNDRY & LINEN SERVICE 186, 309 0 116.844 8.00 00900 HOUSEKEEPI NG 115, 723 5, 532, 003 9.00 908.393 9 00 10.00 01000 DI ETARY 555, 667 347, 644 8, 446 10.00 11.00 01100 CAFETERI A 274, 794 60, 119 0 16,846 11.00 01200 MAINTENANCE OF PERSONNEL 0 12 00 12 00 C 0 13.00 01300 NURSING ADMINISTRATION 679, 715 52, 183 0 33, 692 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 429, 141 419, 652 o 14.00 01500 PHARMACY 371, 669 0 15.00 161, 344 33, 692 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 C 0 16.00 17.00 01700 SOCIAL SERVICE 128, 252 20, 694 0 0 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 18 00 C 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 0 0 19.00 0 02000 NURSING PROGRAM 0 20 00 0 C 0 Λ 20 00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 C 22.00 02300 PARAMED ED PRGM 14, 286 16, 846 23.00 0 5,804 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 7. 875. 494 4, 036, 777 424.577 2, 216, 316 30.00 31.00 03100 INTENSIVE CARE UNIT 1, 817, 308 90, 071 311, 108 311, 810 31.00 37, 015 31.01 03101 NEONATAL INTENSIVE CARE 223, 474 0 65, 334 1, 262 31.01 32.00 03200 CORONARY CARE UNIT C 32.00 0 C 0 03300 BURN INTENSIVE CARE UNIT 33.00 0 C 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 0 34.00 04000 SUBPROVIDER - IPF 40.00 514, 979 C 305, 976 9,629 155, 397 40.00 41.00 04100 SUBPROVIDER - IRF 0 41.00 04300 NURSERY 43.00 762, 419 0 287, 722 7, 207 73, 937 43.00 44 00 04400 SKILLED NURSING FACILITY Ω 44 00 C 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04600 OTHER LONG TERM CARE 0 46.00 46.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 5, 687, 225 1, 642, 773 176, 634 0 50.00 51.00 05100 RECOVERY ROOM 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 0 0 52.00 53 00 05300 ANESTHESI OLOGY 0 53 00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 1,885,396 0 1, 325, 917 138, 630 454, 839 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 409, 455 199, 059 84 229 57 00 05700 CT SCAN 48. 264 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 199, 878 100, 581 1, 667 50, 538 58.00 59.00 05900 CARDIAC CATHETERIZATION 436, 785 114, 180 59.00 06000 LABORATORY 60.00 1, 969, 641 152, 231 67, 384 60.00 0 06001 BLOOD LABORATORY 0 60.01 C 0 0 60.01 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 63.00 0 64 00 06400 INTRAVENOUS THERAPY 375.623 217 733 0 92.675 64 00 06500 RESPIRATORY THERAPY 736,011 50, 585 67, 384 65.00 65.00 66.00 06600 PHYSI CAL THERAPY 462, 460 139, 276 3, 652 67, 384 66.00 06700 OCCUPATIONAL THERAPY 189.065 67.00 0 66, 876 0 33, 692 67.00 68.00 06800 SPEECH PATHOLOGY 70, 861 40, 098 0 16,846 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 44, 848 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 5, 140, 444 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 323, 612 0 0 0 73.00 07400 RENAL DIALYSIS 74.00 0 0 0 74.00 0 0 07500 ASC (NON-DISTINCT PART) 75 00 C Λ Λ 75.00 67, 384 03140 CARDI OLOGY 319, 548 76.00 623, 089 26, 282 76.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION C O 77.00 0 C 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 0 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 88.00 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 09000 CLINIC 8, 901 90 00 96, 376 C 132, 827 117, 921 90.00 90.01 04950 SLEEP CLINIC 97, 182 0 90.01 0 91.00 09100 EMERGENCY 2, 422, 704 467, 040 290, 931 623, 298 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92 00

| Peri od: | Worksheet B | From 01/01/2023 | Part | | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 | Date/Time Prepared: | To 12/31/2023 |

Cost Center Description				10) 12/31/2023	5/30/2024 7: 4	
OTHER RELIMBURSABLE COST CENTERS 94.00 9.00	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &		
OTHER REI MBURSABLE COST CENTERS							
94. 00 09400 IMME PROGRAM DI ALYSIS 0 0 0 0 0 0 0 94. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 97. 00 98. 00 09980 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 98. 00 99. 00 09990 CUMPC 0 0 0 0 0 0 0 0 99. 00 99. 10 09990 CUMPC 0 0 0 0 0 0 0 0 0		5.00	6. 00	7. 00	8. 00	9. 00	
95. 00 09500 MBULANCE SERVICES 0 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 98. 00 99. 00 09900 CMPC 0 0 0 0 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 99. 10 100. 00 10000 1 RS SERVI CES NOT APPRVD PRGM 0 0 0 0 0 0 0 0 101. 00 10100 1 RS SERVI CES NOT APPRVD PRGM 0 0 0 0 0 0 0 0 102. 00 10200 0910 1 TREATMENT PROGRAM 0 0 0 0 0 0 0 0 105. 00 10500 KI DNEY ACQUI SITI ON 0 0 0 0 0 0 0 106. 00 10600 HEART ACQUI SITI ON 0 0 0 0 0 0 0 0 107. 00 10700 LIVER ACQUI SITI ON 0 0 0 0 0 0 0 0 108. 00 10800 LING ACQUI SITI ON 0 0 0 0 0 0 0 0 101. 00 11000 PANCREAS ACQUI SITI ON 0 0 0 0 0 0 0 0 111. 00 11100 ISLET ACQUI SITI ON 0 0 0 0 0 0 0 0 111. 00 11100 ISLET ACQUI SITI ON 0 0 0 0 0 0 0 0 111. 00 11100 LIVER SET EXPENSE 113. 00 114. 00 11400 UTIL IZATI ON REVI EW-SNF 114. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D.P.) 0 0 0 0 0 0 0 0 111. 00 11000 GIFT. FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 190. 00 19000 GIFT. FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 191. 00 19000 19000 ROMPAIL BESEARCH 0 0 0 0 0 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 0 193. 01 19301 100MUNITY 134,500 0 314,741 0 0 193. 00 193. 01 19301 100MUNITY 134,500 0 314,741 0 0 193. 00 193. 01 19301 100MUNITY 134,500 0 314,741 0 0 193. 00 194. 00 007950 0THER MONET IMBURSABLE COST CENTERS 2,032,402 0 3,147,222 0 817,048 194.00							
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 98. 00 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 99. 10 100. 00 10000 IAR SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 101. 00 102. 00 10200 OPI 10 TREATMENT PROGRAM 0 0 0 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 0 0 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 0 0 108. 00 10800 LUING ACQUI SI TI ON 0 0 0 0 0 0 0 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 0 0 101. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 0 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 0 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 0 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 0 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 111. 00 11100 SUBTI ALS COULD SI TI ON 0 0 0 0 0 0 0 0 0		0	0	0	0	ı	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0	0	0	0	0	
98.00 09950 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 98.00 99.00 09900 CMHC 0 0 0 0 0 0 0 0 10000 IAR SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101.00 10000 IAR SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 102.00 OPI OID TREATMENT PROGRAM 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS		0	0	0	0	0	
99. 00 09900 CMHC		0	0	0	0	0	
99. 10 09910 CORF 0 0 0 0 0 0 0 0 99. 10 100. 00 10000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 102. 00 10200 OPI OI D TREATMENT PROGRAM 0 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 106. 00 108. 00 10800 LIVER ACQUI SI TI ON 0 0 0 0 0 107. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 109. 00 110. 00 11000 I NTESTI NAL ACQUI SI TI ON 0 0 0 0 0 111. 00 113. 00 11300 I NTEREST EXPENSE 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 115. 00 116. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 0 110. 00 11900 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 110. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 191. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 68, 797 0 344, 111 0 67, 384 192. 00 193. 01 19301 COMMUNITY 134, 500 0 117, 741 0 0 193. 01 194. 00 07950 OTHER NONREII MBURSABLE COST CENTERS 2, 032, 402 0 3, 147, 222 0 817, 048 194. 00		0	0	0	0	0	
100. 00 10000 1&R SERVICES-NOT APPRVD PRGM		0	0	0	0	0	
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101. 00 102.00 10200 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 0 102.00 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 0 102.00 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 0 102.00 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 0 0 102.00 OPI 0I D TREATMENT PROGRAM 0 0 0 0 0 0 0 0 0		0	0	0	0	0	
102.00 102.00 OPI OLD TREATMENT PROGRAM O O O O O O O O O O O O O O O O O O		0	0	0	0		
SPECIAL PURPOSE COST CENTERS 105. 00 105.00 KI DNEY ACQUI SI TI ON 0 0 0 0 0 0 105.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 107.00 1		0	0	0	0		
105. 00 10500 KI DNEY ACQUISITION 0 0 0 0 0 105. 00 106. 00 106. 00 106. 00 106. 00 106. 00 107. 00 10700 LI VER ACQUISITION 0 0 0 0 0 0 106. 00 107. 00 107. 00 107. 00 107. 00 107. 00 107. 00 107. 00 108. 00 LUNG ACQUISITION 0 0 0 0 0 0 108. 00 109. 00		0	0	0	0	0	102. 00
106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 0 106. 00							
107. 00 10700 LI VER ACQUI SITI ON 0 0 0 0 107. 00 108. 00 108. 00 108. 00 108. 00 108. 00 109. 00		0	0	0	0		
108. 00 10800 LUNG ACQUISITION		0	0	0	0		
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 110. 00 110. 00 111. 00 110. 00 110. 00 111. 00		0	0	0	0		
110. 00 11000 1NTESTI NAL ACQUISITION 0 0 0 0 0 0 110. 00 111. 0		0	0	0	0		
111. 00 113. 00 113. 00 113. 00 114. 00 114. 00 114. 00 114. 00 114. 00 115. 00 116. 00 116. 00 117. 00 115. 00 115. 00 116. 00 116. 00 117. 00 117. 00 115. 00 115. 00 115. 00 115. 00 116. 00 116. 00 116. 00 117. 00 115. 00 115. 00 115. 00 116. 00 116. 00 116. 00 116. 00 117. 00 117. 00 118. 00 119. 0		0	0	0	0		
113. 00 11300 11300 11300 11300 11300 11300 11400 11400 11400 11400 11400 11400 11400 11400 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 116. 00 11		0	0	0	0		
114. 00		0	0	0	0	0	
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 115. 00 116. 0							
116. 00 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS 190. 00 19100 19100 19100 19100 192. 00 19200 19300 19300 19300 19300 19301 19301 19301 194. 00 19500 197000 19700 19700 19700 19700 19700 19700 19700 1							
118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 43, 408, 951 0 11, 275, 648 1, 227, 707 4, 647, 571 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 68, 797 0 344, 111 0 67, 384 192. 00 193. 00 19300 NONPAI D WORKERS 12, 053 0 0 0 0 193. 00 193. 01 19301 COMMUNI TY 134, 500 0 117, 741 0 0 193. 01 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 2, 032, 402 0 3, 147, 222 0 817, 048 194. 00		0	0	0	0		
NONRET MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 68, 797 0 344, 111 0 67, 384 193. 00 19300 NONPAI D WORKERS 12, 053 0 0 0 0 193. 00 193. 01 19301 COMMUNI TY 134, 500 0 117, 741 0 0 193. 01 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 2, 032, 402 0 3, 147, 222 0 817, 048 194. 00		0	0	0	0		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 191. 00 191. 00 191. 00 191. 00 192. 00 192. 00 192. 00 192. 00 193. 01 193. 01 1930		43, 408, 951	0	11, 275, 648	1, 227, 707	4, 647, 571	118. 00
191. 00 19100 RESEARCH							
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 68, 797 0 344, 111 0 67, 384 192. 00 193. 00 19300 NONPAI D WORKERS 12, 053 0 0 0 0 193. 00 193. 01 19301 COMMUNI TY 134, 500 0 117, 741 0 0 193. 01 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 2, 032, 402 0 3, 147, 222 0 817, 048 194. 00		0	0	0	0		
193. 00 19300 NONPALD WORKERS 12, 053 0 0 0 193. 00 193. 01 194. 00 07950 OTHER NONRELMBURSABLE COST CENTERS 2, 032, 402 0 3, 147, 222 0 817, 048 194. 00		0	0	0	0		
193. 01 1930 COMMUNI TY			0	344, 111	0		
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 2, 032, 402 0 3, 147, 222 0 817, 048 194. 00			0	0	0		
			0	· ·	0		
200.00 Cross Foot Adjustments 200.00		2, 032, 402	0	3, 147, 222	0	817, 048	
201.00 Negative Cost Centers 0 0 0 0 201.00		0	-	-	0		
202.00 TOTAL (sum lines 118 through 201) 45,656,703 0 14,884,722 1,227,707 5,532,003 202.00	202.00 TOTAL (sum lines 118 through 201)	45, 656, 703	0	14, 884, 722	1, 227, 707	5, 532, 003	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/30/2024 7:46 am

					10 12/31/2023	5/30/2024 7: 4	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF		CENTRAL	
				PERSONNEL	ADMI NI STRATI ON	SERVI CES & SUPPLY	
		10.00	11. 00	12.00	13. 00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4.00
6.00	00600 MAINTENANCE & REPAIRS						5. 00 6. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY	3, 669, 247					10.00
11. 00	01100 CAFETERI A	0	1, 715, 418	3			11. 00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0				12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	39, 672		4, 178, 339	0 040 504	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	34, 136	1		3, 012, 534	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	0	1, 760			0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	9, 794		10, 564	0	17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	o o	,,,,,		0	0	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	o	O		o	0	19.00
20.00	02000 NURSI NG PROGRAM	0	0		o	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0		0	0	21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0		0	0	22. 00
23. 00	02300 PARAMED ED PRGM	0	35	5 (0	0	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2, 932, 616	437, 891		1, 786, 750	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	437, 708	117, 600		565, 380	0	31.00
31. 01	03101 NEONATAL INTENSIVE CARE	437, 700	11, 539		60, 748	0	31. 01
32. 00	03200 CORONARY CARE UNIT	ol	0.7,007		0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	O		o	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0		o	0	34.00
40.00	04000 SUBPROVI DER - I PF	298, 923	37, 157	' (95, 746	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0		0	0	41. 00
43. 00	04300 NURSERY	0	89, 837		197, 952	0	43.00
44. 00	04400 SKILLED NURSING FACILITY	0	0			0	44.00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0 0	0			0	45. 00 46. 00
40.00	ANCILLARY SERVICE COST CENTERS	<u> </u>		′1	9	0	40.00
50.00	05000 OPERATING ROOM	0	195, 893	3 (565, 410	0	50.00
51.00	05100 RECOVERY ROOM	o	0		o o	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0) (0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	127, 280		91, 851	0	54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0			0	55. 00 56. 00
57. 00	05700 CT SCAN	0	19, 860			0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	9, 796	1		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	o	29, 862	1	92, 912	0	59. 00
60.00	06000 LABORATORY	O	91, 309		o	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0) (o	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	22.042		111 054	0	63.00
64. 00 65. 00	06400 NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	23, 962		111, 054	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	43, 880 32, 363			0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	10, 072			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	o o	5, 910	1	ol ol	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	O	0		o	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	O	0		o	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0) (0	30, 125	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0) (0	2, 982, 409	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	81, 718	3		0	73.00
74. 00 75. 00	07400 RENAL DIALYSIS		0			0	74.00
76. 00	07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY		39, 827		39, 935	0	75. 00 76. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION		37, 02 <i>1</i>) 37, 735) 0	0	77.00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	n			Ö	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0) (0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90.00	09000 CLINIC	0	5, 551	1	163	0	90.00
90. 01 91. 00	04950 SLEEP CLINIC 09100 EMERGENCY	0	8, 397	1	0 559, 874	0	90. 01 91. 00
71.00	07100 LWLNGLINGT	<u> </u>	182, 808	<u>'</u>	009, 674	0	71.00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0018

Peri od: Worksheet B From 01/01/2023 Part I To 12/31/2023 Date/Time Prepared:

5/30/2024 7:46 am Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL PERSONNEL ADMI NI STRATI ON SERVICES & **SUPPLY** 10.00 11.00 12.00 13.00 14.00 92. 00 O9200 OBSERVATI ON BEDS (NON-DI STI NCT PART)
OTHER REI MBURSABLE COST CENTERS 92.00 94.00 09400 HOME PROGRAM DIALYSIS 94.00 95.00 09500 AMBULANCE SERVICES 000000000 0 0 0 0 0 0 0 0 0 0 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 09900 CMHC 0 99.00 99 00 0 0 99. 10 09910 CORF 0 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 101.00 0 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 105. 00 0 0 0 0 0 0 106.00 10600 HEART ACQUISITION 00000 0 0 106. 00 107.00 10700 LIVER ACQUISITION 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 0 110.00 11000 INTESTINAL ACQUISITION C 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115. 00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117)
NONREI MBURSABLE COST CENTERS 1, 687, 909 4, 178, 339 3, 012, 534 118. 00 118.00 3, 669, 247 0 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 0 0 191. 00 19100 RESEARCH 0 0 0 0 191. 00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192. 00 0 193. 00 19300 NONPALD WORKERS 1, 060 0 193. 00 0 193. 01 19301 COMMUNI TY 7, 184 0 0 193. 01 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 194.00 19, 265 200 00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 201.00 202.00 TOTAL (sum lines 118 through 201) 3, 669, 247 1, 715, 418 0 4, 178, 339 3, 012, 534 202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part I | To 12/31/2023 | Date/Time Prepared: 5/30/2024 7:46 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018

						5/30/2024 7: 4	6 am
					OTHER GENERAL		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CE (SPECI FY)	NONPHYSI CI AN	
	cost center bescription	THANWACT	RECORDS &	SOCIAL SERVICE	(SI LCITI)	ANESTHETISTS	
			LI BRARY				
		15. 00	16. 00	17. 00	18. 00	19. 00	
	GENERAL SERVI CE COST CENTERS	T				T	
1. 00 2. 00	OO100 CAP REL COSTS-BLDG & FIXT OO200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
6. 00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 12. 00	O1100 CAFETERI A O1200 MAI NTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15.00	01500 PHARMACY	2, 412, 864					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	(16. 00
17. 00	01700 SOCIAL SERVICE	0	(805, 750			17. 00
18. 00 19. 00	O1850 OTHER GENERAL SERVICE (SPECIFY) O1900 NONPHYSICIAN ANESTHETISTS	0	(0	0	18. 00 19. 00
20. 00	02000 NURSING PROGRAM		(0	0	20.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD		(ol ol	0		21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	Ö	(o	0		22. 00
23. 00	02300 PARAMED ED PRGM	0	(0	0		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					1	
30.00	03000 ADULTS & PEDI ATRI CS	2, 576		583, 257	0		30.00
31. 00 31. 01	03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE	388	(88, 346 6, 946	0	0	31. 00 31. 01
32. 00	03200 CORONARY CARE UNIT		(0, 740	0	-	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	l o	(ol ol	0	o o	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	o	(o	0	0	34.00
40. 00	04000 SUBPROVI DER - I PF	1	(43, 124	0	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	(0	0		41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	0	(84, 077	0	0	43. 00 44. 00
45. 00	04500 NURSING FACILITY		()))	0	1	45. 00
46. 00	04600 OTHER LONG TERM CARE	Ö	(1	0	-	46. 00
	ANCILLARY SERVICE COST CENTERS	,				,	
50.00	05000 OPERATI NG ROOM	11, 055	(1	0		50.00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM		(0	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY		(ol ol	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	2, 398	(ol ol	0	o o	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	o	(o	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	(0	0	0	56. 00
57. 00	05700 CT SCAN	0	(0	0	•	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	104	(0	0	58. 00 59. 00
60.00	06000 LABORATORY	104	(0	0	60.00
60. 01	06001 BLOOD LABORATORY	l o	(ol ol	0	l o	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(0	0	1	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	(0	0	0	63. 00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	277 9, 904	(0	0	0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	9, 904	(0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	l o	(ol ol	0	Ö	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	(o	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	(0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	(0	0	0	70.00
71. 00 72. 00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	(0	0	0	71.00
72.00	O7200 IMPL. DEV. CHARGED TO PATIENTS O7300 DRUGS CHARGED TO PATIENTS	2, 382, 207	(0	0	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	0	(ol ol	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	(ol ol	0	0	75. 00
76. 00	03140 CARDI OLOGY	3, 769	(0	0	0	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		0	0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY] 0	(0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS O8800 RURAL HEALTH CLINIC		(o	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER			o o	0		89. 00
90.00	09000 CLI NI C	<u> </u>		0	0	0	90. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2023 Part I
To 1/21/2022 Part/Time Propagate Provider CCN: 15-0018

			Ť	o 12/31/2023	Date/Time Pre 5/30/2024 7:4	
				OTHER GENERAL	3/30/2024 /. 4	o alli
				SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN	
		RECORDS &			ANESTHETI STS	
		LI BRARY				
	15. 00	16. 00	17. 00	18. 00	19. 00	
90. 01 04950 SLEEP CLINIC	0	C	1	١	0	
91. 00 09100 EMERGENCY	185	C	0	0	0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS			J		0	04.00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0	C			0	94. 00 95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED				0	0	96.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS				0	0	98.00
99. 00 09900 CMHC				0	0	99.00
99. 10 09910 CORF				0	0	
100.00 10000 1&R SERVICES-NOT APPRVD PRGM				0	_	100.00
101.00 10100 HOME HEALTH AGENCY				0		100.00
102.00 10200 OPI OI D TREATMENT PROGRAM				0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>		1		0	102.00
105. 00 10500 KIDNEY ACQUISITION	0		0	0	0	105. 00
106. 00 10600 HEART ACQUISITION		Č	i o			106. 00
107. 00 10700 LI VER ACQUI SI TI ON		Č		0		107. 00
108. 00 10800 LUNG ACQUISITION		C	Ö	0		108. 00
109. 00 10900 PANCREAS ACQUISITION		C	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	o	C	0	0		110.00
111.00 11100 SLET ACQUISITION	O	C	O	0		111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	C	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	C	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	2, 412, 864	C	805, 750	0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0		190. 00
191. 00 19100 RESEARCH	0	C	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	C	0	0		192. 00
193.00 19300 NONPALD WORKERS	0	C	0	0		193. 00
193. 01 19301 COMMUNI TY	0	C	0	0		193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	C	0	0		194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	C	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	2, 412, 864	C	805, 750	0	0	202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part I
To 12/31/2023 Date/Time Prepared: 5/30/2024 7:46 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018

) 12/31/2023	5/30/2024 7: 4	
			INTERNS &	RESI DENTS			
	Cook Cooks Doors at the	NUDCLNC	CEDVI CEC CALAD	CEDVI CEC OTHER	DADAMED ED	C	
	Cost Center Description	NURSI NG PROGRAM	Y & FRINGES	SERVICES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	
		20.00	21. 00	22.00	23. 00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPING						9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12. 00
13.00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)						18.00
19. 00	01900 NONPHYSI CLAN ANESTHETI STS						19.00
20. 00	02000 NURSI NG PROGRAM	0					20.00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD		0				21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD			0			22. 00
23. 00	02300 PARAMED ED PRGM				107, 865		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	0	0	-	0	59, 378, 082	30.00
31.00	03100 I NTENSI VE CARE UNI T	0	0	-	0	12, 758, 082	
31. 01	03101 NEONATAL INTENSIVE CARE	0	0	0	0	1, 515, 306	1
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	4, 016, 508	1
41. 00	04100 SUBPROVI DER - I RF	0	Ö	Ö	ol	-7, 880	1
43.00	04300 NURSERY	0	0	0	0	5, 286, 644	
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS				ما	2/ 501 750	F0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	0		0	36, 501, 750 0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	Ö	o o	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	Ö	O	o	13, 382, 557	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	2, 792, 782	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	1, 354, 351	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	2, 841, 381	1
60.00	06000 LABORATORY	0	0	0	0	12, 054, 877	1
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	U	U	0	60. 01
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	Ö	0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0	Ö	O	o	2, 685, 348	
65.00	06500 RESPI RATORY THERAPY	0	0	0	0	4, 560, 207	
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	3, 000, 086	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	1, 237, 937	
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	485, 361	
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	O O	207 522	70. 00 71. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS	0	0	0	ol Ol	297, 532 33, 632, 222	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	l 0	0		0	34, 205, 875	
74. 00	07400 RENAL DIALYSIS	l	0	ا	ő	0 0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	Ö	l ő	ol	0	75. 00
76. 00	03140 CARDI OLOGY	0	0	o	o	4, 211, 904	ı
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
05 -	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0		0	0 840, 004	89. 00 90. 00
90.00	04950 SLEEP CLINIC	0	0		0	587, 844	
70.01	1225 0222. 020	1	·	١	9	337, 044	1 ,3,31

			T-	0 12/31/2023	Date/Time Pre	pared:
		INTERNS &	RESI DENTS		5/30/2024 7: 4	o alli
		THI ENITO U	KESTBEITTS			
Cost Center Description	NURSI NG	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED	Subtotal	
	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM		
	20.00	21. 00	22. 00	23.00	24.00	
91. 00 09100 EMERGENCY	0	0	0	107, 865	16, 677, 334	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	_1		T _			
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0	0	0		109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 SLET ACQUI SI TI ON	٩	Ü	0	U	Ü	111. 00 113. 00
113. 00 11300 INTEREST EXPENSE						
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		0				114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE	U	Ü	0	0		115. 00
	U O	0		107, 865	254, 296, 094	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	U _I	0	0	107, 865	254, 296, 094	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	ام	0	0	ام	0	190. 00
191. 00 19100 RESEARCH	0	0		0		191. 00
192.0019200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	821, 695	
193. 00 19300 NONPALD WORKERS	0	0	0	0	72, 927	
193. 01 19301 COMMUNI TY	0	0	0	0	926, 880	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	0			16, 101, 698	
200.00 Cross Foot Adjustments	ol Ol	0				200. 00
201.00 Negative Cost Centers	ol Ol	0				201. 00
202.00 TOTAL (sum lines 118 through 201)	0	0	0	107, 865	272, 219, 294	
202. 00 Trothe (Sum Tries Tro thi ough 201)	٩	O		137,000	2,2,21,,27	1202.00

Health Financial Systems ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018 Period: Worksheet B

From 01/01/2023 Part I Date/Time Prepared: 12/31/2023 5/30/2024 7:46 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12. 00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15. 00 | 01500 | PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17. 00 01700 SOCIAL SERVICE 17 00 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING PROGRAM 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02300 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 59, 378, 082 30.00 31.00 03100 INTENSIVE CARE UNIT 0 12, 758, 082 31.00 03101 NEONATAL INTENSIVE CARE 0 1, 515, 306 31.01 31.01 0 03200 CORONARY CARE UNIT 32.00 0 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34.00 0 04000 SUBPROVI DER - I PF 40 00 4,016,508 40.00 41.00 04100 SUBPROVI DER - I RF -7, 880 41.00 04300 NURSERY 43 00 5, 286, 644 43 00 0 44.00 04400 SKILLED NURSING FACILITY 44.00 04500 NURSING FACILITY 0 45.00 Ω 45.00 04600 OTHER LONG TERM CARE 0 46.00 46.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 36, 501, 750 50.00 0 51.00 05100 RECOVERY ROOM 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM Λ 52.00 53.00 05300 ANESTHESI OLOGY 0000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 13, 382, 557 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 55.00 56.00 05600 RADI OI SOTOPE 56.00 57.00 05700 CT SCAN 2, 792, 782 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 1, 354, 351 58.00 05900 CARDIAC CATHETERIZATION 2.841.381 59 00 59 00 60.00 06000 LABORATORY 12, 054, 877 60.00 06001 BLOOD LABORATORY 0 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 00000000 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 06400 I NTRAVENOUS THERAPY 64.00 2, 685, 348 64.00 65 00 06500 RESPIRATORY THERAPY 4, 560, 207 65 00 06600 PHYSI CAL THERAPY 66.00 3,000,086 66.00 06700 OCCUPATIONAL THERAPY 1, 237, 937 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 485, 361 68.00 69 00 06900 FLECTROCARDLOLOGY 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0000 297, 532 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 33, 632, 222 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 34, 205, 875 73.00 74.00 07400 RENAL DIALYSIS 74.00 C 07500 ASC (NON-DISTINCT PART) 75.00 75.00 0 76.00 03140 CARDI OLOGY 4, 211, 904 76.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 88 00 0 88.00 108800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90. 00 09000 CLINIC 840,004 90.00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2023 Part I
To 1/21/2022 Part/Time Propagate Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018

			To 12/31/2023	Date/Time Prepared: 5/30/2024 7:46 am
Cost Center Description	Intern & Residents Cost & Post Stepdown Adjustments	Total		
	25. 00	26. 00		
90. 01 04950 SLEEP CLINIC	0	587, 844		90. 01
91. 00 09100 EMERGENCY	0	16, 677, 334		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			92. 00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
99. 00 09900 CMHC	0	0		99. 00
99. 10 09910 CORF	0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KIDNEY ACQUISITION	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	O _I		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	O ₁		110.00
111. 00 11100 SLET ACQUI SI TI ON	9	٥		111. 00 113. 00
113.00 11300 INTEREST EXPENSE 114.00 11400 UTILIZATION REVIEW-SNF				114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0		115.00
116. 00 11600 HOSPI CE		O _I		116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		254, 296, 094		118.00
NONREI MBURSABLE COST CENTERS	J U	254, 270, 074		118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	n	0		190. 00
191. 00 19100 RESEARCH		0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		821, 695		192. 00
193. 00 19300 NONPAI D WORKERS		72, 927		193. 00
193. 01 19301 COMMUNI TY		926, 880		193. 01
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS		16, 101, 698		194.00
200.00 Cross Foot Adjustments		0		200. 00
201.00 Negative Cost Centers		Ö		201. 00
202.00 TOTAL (sum lines 118 through 201)		272, 219, 294		202. 00
, , , , , , , , , , , , , , , , , , ,	-1	* * * * * * * * * * * * * * * * * * * *		1

| Peri od: | Worksheet B | From 01/01/2023 | Part | I | To 12/31/2023 | Date/Time Prepared: | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephon Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

					То	12/31/2023	Date/Time Prep 5/30/2024 7:40	
				CAPI TAL REI	LATED COSTS		0,00,2021 7.1	<u> </u>
		Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		oost center bescription	Assigned New	DEDO & TIXI	WVDLL EQUIT	Subtotal	BENEFITS	
			Capi tal Rel ated Costs				DEPARTMENT	
			0	1. 00	2.00	2A	4. 00	
		AL SERVICE COST CENTERS						
1. 00 2. 00		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	1	EMPLOYEE BENEFITS DEPARTMENT	0	3, 139	617	3, 756	3, 756	4. 00
5.00		ADMINISTRATIVE & GENERAL	0	97, 368		116, 509	159	5. 00
6. 00 7. 00		MAINTENANCE & REPAIRS OPERATION OF PLANT	0	0 3, 392, 416	_	0 4, 059, 312	0 95	6. 00 7. 00
8.00		LAUNDRY & LINEN SERVICE	0	96, 880		115, 925	0	8. 00
9. 00	00900	HOUSEKEEPI NG	0	95, 950		114, 812	90	9. 00
10.00	1	DIETARY	0	288, 244		344, 908	52	10.00
11. 00 12. 00	1	CAFETERIA MAINTENANCE OF PERSONNEL	0	49, 846 0		59, 645 0	45 0	11. 00 12. 00
13. 00	1	NURSING ADMINISTRATION	0	43, 267	8, 506	51, 773	96	
14.00		CENTRAL SERVICES & SUPPLY	0	347, 949		416, 350	33	
15. 00 16. 00		PHARMACY MEDICAL RECORDS & LIBRARY	0	133, 776 0		160, 074 0	9	15. 00 16. 00
17. 00	1	SOCIAL SERVICE	0	17, 158	_	20, 531	14	17. 00
18.00		OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19. 00 20. 00		NONPHYSICIAN ANESTHETISTS NURSING PROGRAM	0	0	0	0	0	19. 00 20. 00
21. 00		I &R SERVICES-SALARY & FRINGES APPRVD	0	0	o	0	0	21. 00
22. 00	02200	I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
23. 00		PARAMED ED PRGM I ENT ROUTINE SERVICE COST CENTERS	0	4, 813	946	5, 759	0	23. 00
30. 00		ADULTS & PEDIATRICS	0	3, 347, 035	657, 973	4, 005, 008	951	30. 00
31.00		INTENSIVE CARE UNIT	0	257, 951	50, 709	308, 660	238	
31. 01		NEONATAL INTENSIVE CARE	0	54, 171		64, 820	33	
32. 00 33. 00		CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00		SURGICAL INTENSIVE CARE UNIT	0	0	Ö	O	0	34. 00
40.00		SUBPROVIDER - IPF	0	253, 696	49, 873	303, 569	68	40.00
41. 00 43. 00		SUBPROVIDER - IRF NURSERY	0	238, 561	46, 897	285, 458	0 102	41. 00 43. 00
44. 00		SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45.00		NURSING FACILITY	0	0	0	0	0	45. 00
46. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0	0	0	0	0	46. 00
50.00		OPERATING ROOM	0	1, 362, 082	267, 763	1, 629, 845	417	50. 00
51.00		RECOVERY ROOM	0	0	0	0	0	
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0	0	0	0	0	52. 00 53. 00
54. 00		RADI OLOGY-DI AGNOSTI C	0	1, 099, 365	216, 117	1, 315, 482	226	
55.00		RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 57. 00		RADI OI SOTOPE CT SCAN	0	165, 047	32, 445	197, 492	0 37	
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	83, 395		99, 789	17	
59.00		CARDI AC CATHETERI ZATI ON	0	94, 671		113, 282	79	
60. 00 60. 01	1	LABORATORY BLOOD LABORATORY	0	126, 220 0		151, 033 0	106 0	
61. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY				Ö	o ,	61. 00
62.00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	0	0 180, 531		216, 020	0 44	63. 00 64. 00
65. 00	1	RESPI RATORY THERAPY	0	41, 942		50, 187	80	
66.00	1	PHYSI CAL THERAPY	0	115, 479		138, 180	63	
67. 00 68. 00	1	OCCUPATIONAL THERAPY SPEECH PATHOLOGY	0	55, 450 33, 246		66, 350 39, 782	19 9	67. 00 68. 00
69. 00	1	ELECTROCARDI OLOGY	0	0	0, 550	0	Ó	69. 00
70. 00	1	ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00 72. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	71. 00 72. 00
72.00	1	DRUGS CHARGED TO PATTENTS	0	0	0	0	166	1
74.00	07400	RENAL DIALYSIS	0	0	0	o	0	74. 00
75.00		ASC (NON-DISTINCT PART)	0	0 0 4 0 4 0	0	0	0	
76. 00 77. 00	1	CARDIOLOGY ALLOGENEIC HSCT ACQUISITION	0	264, 949 0	1	317, 034 0	77 0	
78. 00	07800	CAR T-CELL IMMUNOTHERAPY	0	Ö	-	Ő	0	1
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
		FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89. 00
					· '		<u> </u>	

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2023 Part II
To 1/21/2022 Part/Time Propagate Provider CCN: 15-0018

			To	12/31/2023	Date/Time Pre	
		CAPI TAL REI	ATED COSTS		373072024 7.4	o alli
Cost Center Description	Di rectly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
cost center bescription	Assigned New	DLDG & FIXI	MARTE ECOLA	Subtotal	BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs					
	0	1. 00	2. 00	2A	4. 00	
90. 00 09000 CLINIC	0	110, 132	·	131, 782	10	90.00
90. 01 04950 SLEEP CLINIC 91. 00 09100 EMERGENCY	0	0 387, 240		0 463, 365	12 355	90. 01 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	9	307, 240	70, 125	403, 303	300	91.00
OTHER REIMBURSABLE COST CENTERS				<u> </u>		72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0	0	0	O O		100. 00 101. 00
102.00 10200 OPLOID TREATMENT PROGRAM	0	0	0	0		101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>		<u> </u>	<u> </u>	0	102.00
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 SLET ACQUI SI TI ON	0	0	0	O		111. 00
113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	l o	12, 841, 969	2, 524, 523	15, 366, 492		118. 00
NONREI MBURSABLE COST CENTERS	-1	.=, ,	=1 == 17 ===0	,,		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	285, 315	56, 088	341, 403		192. 00
193. 00 19300 NONPAI D WORKERS	0	0	0	0		193. 00
193. 01 19301 COMMUNITY	0	97, 624		116, 815		193. 01
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	0	2, 609, 475	512, 980	3, 122, 455	43	194. 00
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers		0	0	0	0	200. 00 201. 00
202.00 TOTAL (sum lines 118 through 201)	0	15, 834, 383	_	18, 947, 165		201.00
202. 00 TOTAL (Suil TITIES TTO THE OUGH 201)	١	15, 054, 505	5, 112, 702	10, 747, 103	3, 730	1202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/30/2024 7:46 am

	Cost Contar Decement on	ADMINI CTDATI VE	MAINTENANCE O	ODEDATION OF	0 12/31/2023	5/30/2024 7: 4	
	Cost Center Description	ADMINISTRATIVE & GENERAL	REPAIRS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	
	CENEDAL CEDVICE COCT CENTEDO	5. 00	6. 00	7. 00	8. 00	9. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	116, 668	0				5.00
6. 00 7. 00	00700 OPERATION OF PLANT	6, 380	0	4, 065, 787			6. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	476	0	31, 916			8. 00
9.00	00900 HOUSEKEEPI NG	2, 322	0	31, 610		148, 834	9. 00
10.00	01000 DI ETARY	1, 420	0	94, 960	0	227	10.00
11. 00	01100 CAFETERI A	702	0	16, 421	0	453	11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	0 1, 737	0	0 14, 254	0	0 906	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 097	0	114, 629		0	14. 00
15. 00	01500 PHARMACY	950	0	44, 071	0	906	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	0	16. 00
17. 00 18. 00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY)	328	0	5, 653	0	0 0	17. 00 18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19.00
20. 00	02000 NURSI NG PROGRAM	0	0	Ö	Ö	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
23. 00	O2300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	37	0	1, 585	0	453	23. 00
30. 00	03000 ADULTS & PEDIATRICS	20, 113	0	1, 102, 652	51, 293	59, 630	30. 00
31. 00	03100 INTENSIVE CARE UNIT	4, 644	0	84, 980		8, 389	31. 00
31. 01	03101 NEONATAL INTENSIVE CARE	571	0	17, 846	152	996	31. 01
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0 0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	1, 316	0	83, 578	1, 163	4, 181	40.00
41. 00	04100 SUBPROVI DER – I RF	0	0	0	0	0	41. 00
43.00	04300 NURSERY	1, 948	0	78, 592	871	1, 989	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0 0	45. 00 46. 00
40.00	ANCILLARY SERVICE COST CENTERS	<u> </u>		0	<u> </u>		40.00
50.00	05000 OPERATING ROOM	14, 535	0	448, 726	21, 339	0	50. 00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0	0	0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 818	0	362, 176	16, 748	_	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	1, 046	0	54, 373		2, 266	57. 00
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	511 1, 116	0	27, 474 31, 189		1, 360 0	58. 00 59. 00
60.00	1 1	5, 034	0			1, 813	
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	960	0	59, 474	0	0 2, 493	63. 00 64. 00
65. 00	06500 RESPI RATORY THERAPY	1, 881	0	13, 817	0	1, 813	65. 00
66.00	06600 PHYSI CAL THERAPY	1, 182	0	38, 044	441	1, 813	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	483	0	18, 267	0	906	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	181	0	10, 953	0	453 0	68. 00 69. 00
70.00	07000 ELECTROEARDI OLOGI	0	0	0	0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	115	0	ő	0	Ö	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	13, 137	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	13, 605	0	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY	1, 592	0	87, 285	3, 175	1, 813	75. 00 76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0, 1,73	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
00.05	OUTPATIENT SERVICE COST CENTERS	1	_	-	=1	-	00.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
90.00	09000 CLINIC	246	0	36, 282	1, 075	3, 173	90.00
90. 01	04950 SLEEP CLINIC	248	0	0	0	0	90. 01
91.00	09100 EMERGENCY	6, 192	0	127, 573	35, 147	16, 769	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1		<u> </u>			92. 00

| Period: | Worksheet B | From 01/01/2023 | Part II | To | 12/31/2023 | Date/Time Prepared:

& GENERAL REPAIRS PLANT LI NEN SERVI CE 5.00 6.00 7.00 8.00 9.00
5.00 6.00 7.00 8.00 9.00
OTHER REIMBURSABLE COST CENTERS
94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 94. 0
95. 00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 95. 0
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 0
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 0
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 98. 0
99. 00 09900 CMHC 0 0 0 0 0 99. 0
99. 10 09910 CORF 0 0 0 0 99. 1
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100.0
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.0
102. 00 10200 0PI 0I D TREATMENT PROGRAM 0 0 0 0 102. 0
SPECIAL PURPOSE COST CENTERS
105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105. 0
106. 00 10600 HEART ACQUISITION 0 0 0 106. 0
107. 00 10700 LIVER ACQUISITION 0 0 0 107. 0
108. 00 10800 LUNG ACQUISITION 0 0 0 108. 0
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 0
110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.0
111.00 11100 ISLET ACQUISITION 0 0 0 111.0
113. 00 11300 I NTEREST EXPENSE
114. 00 11400 UTI LI ZATI ON REVI EW-SNF
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 0 115.0
116. 00 11600 H0SPI CE 0 0 0 0 116. 0
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 110,923 0 3,079,962 148,317 125,039 118.0
NONREI MBURSABLE COST CENTERS
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 0
191. 00 19100 RESEARCH
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 176 0 93, 995 0 1, 813 192. 0
193. 00 19300 NONPALD WORKERS 31 0 0 0 0 193. 0
193. 01 19301 COMMUNI TY 344 0 32, 161 0 0 193. 0
194. 00 07950 0THER NONREIMBURSABLE COST CENTERS 5, 194 0 859, 669 0 21, 982 194. 0
200.00 Cross Foot Adjustments 200.0
201.00 Negative Cost Centers 0 0 0 0 201.0
202.00 TOTAL (sum lines 118 through 201) 116,668 0 4,065,787 148,317 148,834 202.0

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2023 | Part II |
| To | 12/31/2023 | Date/Time | Prepared: | 5/30/2024 | 7:46 am |

					0 12/31/2023	5/30/2024 7: 4	
	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES &	
						SUPPLY	
	GENERAL SERVICE COST CENTERS	10. 00	11. 00	12. 00	13. 00	14. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAI NTENANCE & REPAI RS						6. 00
7.00	00700 OPERATION OF PLANT						7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10. 00	01000 DI ETARY	441, 567					10.00
11. 00	01100 CAFETERI A	0	77, 266				11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	, , _ , _ , _ , _ , _ , _ , _ ,	o			12.00
13.00	01300 NURSING ADMINISTRATION	0	1, 787	0	70, 553		13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1, 538	1	0	533, 647	14. 00
15. 00	01500 PHARMACY	0	79	1	0	0	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	(1	0	0	16.00
17. 00 18. 00	01700 SOCIAL SERVICE	0	441		178	0	17.00
19. 00	O1850 OTHER GENERAL SERVICE (SPECIFY) O1900 NONPHYSICIAN ANESTHETISTS	0	(0	0	18. 00 19. 00
20. 00	02000 NURSI NG PROGRAM	0			0	0	20.00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	l o	C	ol ö	ő	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	C	o o	O	Ō	22. 00
23.00	02300 PARAMED ED PRGM	O	2	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDI ATRI CS	352, 919	19, 722			0	
31.00	03100 INTENSI VE CARE UNI T	52, 675	5, 297		9, 547	0	31.00
31. 01	03101 NEONATAL INTENSIVE CARE	0	520	1	1, 026	0	31. 01
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	(0	0	32. 00 33. 00
34. 00	03400 SURGI CAL INTENSI VE CARE UNI T		(0	0	34. 00
40. 00	04000 SUBPROVI DER - I PF	35, 973	1, 674		1, 617	0	40. 00
41. 00	04100 SUBPROVI DER - I RF	0	., 5.	o o	0	0	41. 00
43.00	04300 NURSERY	0	4, 046	0	3, 343	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	C	0	0	0	44. 00
45. 00	04500 NURSING FACILITY	0	C	1	0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0		0	0	0	46. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS		0.000		0.547	0	 E0 00
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	8, 823	0	9, 547	0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			0	0	52.00
53. 00	05300 ANESTHESI OLOGY	l o	C	ol ö	ő	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	5, 733	0	1, 551	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	C	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	C	0	0	0	56. 00
57. 00	05700 CT SCAN	0	895	1	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	441	1	1 5/0	0	58.00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	1, 345 4, 113		1, 569	0	59. 00 60. 00
60. 00	06001 BLOOD LABORATORY	0	4, 113		0	0	60.00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY)		0	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C	o	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0	0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	1, 079	0	1, 875	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	1, 976		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	1, 458		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	454		0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	266	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	(0	0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	5, 336	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	l ol	Č	ol o	o	528, 311	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	3, 681	0	0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	C) o	o	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	C	0	0	0	75. 00
76. 00	03140 CARDI OLOGY	0	1, 794	0	674	0	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	C	0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0) 0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	C) 0	O	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		(0	89.00
90. 00	09000 CLINIC		250	1	3	0	90.00
90. 01	04950 SLEEP CLINIC		378		o	0	90. 01
91. 00	09100 EMERGENCY	0	8, 234	· O	9, 454	0	91. 00
				_			

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2023 Part II Provider CCN: 15-0018

COST CENTER DIETARY CAFETERIA MAINTENANCE OF PERSONNEL ADMINISTRATION SERVICES & SUPPLY					0 12/31/2023	Date/Time Pre 5/30/2024 7:4	
Personnel ADMINISTRATION SERVICES & SUPPLY	Cost Center Description	DIETARY	CAFETERI A	MAINTENANCE OF	NURSI NG		<u> </u>
92. 00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 92. 00 00 01.000 11.000 12.00 13.00 14.00 92. 00 94. 00 94. 00 95. 00 95.00 95	· ·			PERSONNEL	ADMI NI STRATI ON	SERVICES &	
92. 00 092.00 095.00 095.00 0 0 0 0 0 0 0 0 0						SUPPLY	
OTHER REI MBURSABLE COST CENTERS		10.00	11. 00	12.00	13. 00	14.00	
94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 0 0 0 95.00 995.00 995.00 995.00 O9500 AMBULANCE SERVICES 0 0 0 0 0 0 0 0 95.00 996.00 O9600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 97.00 O9700 OURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 97.00 O9700 OURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 98.00 O9850 OTHER REI IMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 99.00 O9990 CMHC 0 0 0 0 0 0 0 0 0 0 0 0 0 99.00 O9990 CMHC 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							92. 00
95. 00 09500 09500 09500 0 0 0 0 0 0 0 0 0							
96.00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 96.00 97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 97.00 98.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 98.00 99.00 09990 COMPC 0 0 0 0 0 0 0 99.00 99.10 09991 CORF 0 0 0 0 0 0 0 0 99.00 100.00 10000 LAR SERVI CES-NOT APPRVD PRCM 0 0 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101.00 101.00 10200 DPI DI TREATMENT PROGRAM 0 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS		0	0	0	0	0	
97. 00 09700 DURABLE MEDI CAL EQUI P.SOLD 0 0 0 0 0 0 77. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 99. 00 09900 CMHC 0 0 0 0 0 0 0 99. 00 09900 CMHC 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 100. 00 10000 LAR SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 102. 00 10200 DPI OLD TREATMENT PROGRAM 0 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0 0 0 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 0 105. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 0 108. 00 110. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 110. 00 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 111. 00 11000 MBURLATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 0 0 0	I I	0	0	0	0	0	1
98.00 09900 CMHC 09910 CMHC 0 0 0 0 0 0 0 0 99.00 99.00 09910 CMHC 0 0 0 0 0 0 0 0 0		0	0	0	0	0	96. 00
99. 00 09900 CMHC		0	0	0	0	0	97. 00
99. 10 09910 CORF	98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
100. 00 10000 18R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100. 00 101. 00 10100 1000 10ME HEALTH AGENCY 0 0 0 0 0 0 102. 00 102.00 OPI 10 TREATMENT PROGRAM 0 0 0 0 0 SPECI AL PURPOSE COST CENTERS		0	0	0	0	0	99. 00
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0 0 101. 00	99. 10 09910 CORF	0	0	0	0	0	99. 10
102. 00 102.00 PI OI D TREATMENT PROGRAM 0 0 0 0 102. 00	100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI I ON 0 0 0 0 0 105.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 106.00 107.00 107.00 107.00 107.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 109.0	101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
105. 00	102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 0 0 109. 00 109. 00 109. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 109. 00 1	SPECIAL PURPOSE COST CENTERS						
107. 00 10700 LI VER ACQUI SITION 0 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SITION 0 0 0 0 0 0 108. 00 109. 0	105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 109. 00 109. 00 101. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 111. 00 111. 00 11100 ISLET ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 111. 00 11100 ISLET ACQUI SI TI ON 0 0 0 0 0 0 111. 00 113. 00 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 114. 00 UTI LI ZATI ON REVI EW-SNF 114. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 0 115. 00 116. 00 HOSPI CE 0 0 0 0 0 0 0 116. 00 116. 00 SUBTOTALS (SUM OF LI NES 1 through 117) 441, 567 76, 026 0 70, 553 533, 647 118. 00 NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 191. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 193. 00 193. 01 19300 19300 NONPAI D WORKERS 0 48 0 0 0 193. 01 194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS 0 868 0 0 0 194. 00 194. 00 070950 OTHER NONREI MBURSABLE COST CENTERS 0 0 0 0 0 0 194. 00 194. 00 070950 OTHER NONREI MBURSABLE COST CENTERS 0 868 0 0 0 194. 00 0 0 0 0 0 0 0 0 0	106.00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106. 00
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 110. 00 110. 00 110. 00 110. 00 110. 00 109. 00 0 0 0 0 0 0 0 0 0	107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107. 00
110.00	108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
111. 00 11100 ISLET ACQUISITION 0 0 0 0 0 111. 00 113. 00 113. 00 113. 00 113. 00 113. 00 113. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 114. 00 115. 00 115. 00 115. 00 0 0 0 0 0 0 115. 00 115. 00 116. 00 11	109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
113. 00 11300 11300 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 114. 00 114. 00 114. 00 114. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 0 0 0 0 0 0 0 0 115. 00 115. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 118. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 441, 567 76, 026 0 70, 553 533, 647 118. 00 118. 00 119. 00 11	110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
114. 00 115. 00 115. 00 115. 00 115. 00 116. 00 118. 00 118. 00 118. 00 118. 00 118. 00 118. 00 118. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 0	111.00 11100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
115. 00 115. 00 115. 00 115. 00 116. 0	113.00 11300 I NTEREST EXPENSE						113. 00
116. 00 116. 00 116. 00 116. 00 0 0 0 0 0 0 116. 00 118. 00	114.00 11400 UTILIZATION REVIEW-SNF						114. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 441,567 76,026 0 70,553 533,647 118.00	115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00	116. 00 11600 H0SPI CE	0	0	0	0	0	116. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 191. 00 191. 00 191. 00 191. 00 192. 00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 192.00 193.00 193.00 193.00 193.01 19301	118.00 SUBTOTALS (SUM OF LINES 1 through 117)	441, 567	76, 026	0	70, 553	533, 647	118. 00
191. 00 19100 RESEARCH							
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES		0	0	0	0		
193. 00 19300 NONPAI D WORKERS	191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
193. 01 19301 COMMUNITY	192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 868 0 0 194. 00 200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0	193.00 19300 NONPALD WORKERS	0	48	0	0	0	193. 00
200. 00 Cross Foot Adjustments 200. 00 201. 00 Negative Cost Centers 0 0 0 0 0 0 0 0	193. 01 19301 COMMUNI TY	0	324	0	0	0	193. 01
201.00 Negative Cost Centers 0 0 0 0 0 201.00	194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	868	0	o	0	194. 00
	200.00 Cross Foot Adjustments						200. 00
202.00 TOTAL (sum lines 118 through 201) 441,567 77,266 0 70,553 533,647 202.00	201.00 Negative Cost Centers	0	0	0	0	0	201. 00
	202.00 TOTAL (sum lines 118 through 201)	441, 567	77, 266	0	70, 553	533, 647	202. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2023 | Part II |
| To | 12/31/2023 | Date/Time | Prepared: | 5/30/2024 | 7:46 am | Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

					0 12/31/2023	5/30/2024 7: 4	
					OTHER GENERAL		
	Cook Cooks Doors at the	DUADMACY	MEDICAL	COCLAL CEDVICE	SERVI CE	NONDUNCTOLAN	
	Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN ANESTHETI STS	
			LI BRARY			ANESTHETISTS	
		15. 00	16. 00	17. 00	18. 00	19. 00	
·	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAI NTENANCE & REPAI RS						6.00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	206, 089					14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LI BRARY	200,007	C				16. 00
17. 00	01700 SOCIAL SERVICE	l ol	C	27, 145			17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	C	0	0		18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	O	C	0	0	0	19. 00
20. 00	02000 NURSI NG PROGRAM	0	C	0	0		20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	C	0	0		21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	C			l e	22. 00
23. 00	O2300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	0	C	0	0		23. 00
30. 00	03000 ADULTS & PEDIATRICS	220	C	19, 650	0		30.00
31. 00	03100 I NTENSI VE CARE UNI T	33	C			l .	31.00
31. 01	03101 NEONATAL INTENSIVE CARE	0	C	234	0		31. 01
32.00	03200 CORONARY CARE UNIT	O	C	0	0		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	C	0	0		33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	C	0	0		34. 00
40.00	04000 SUBPROVI DER - I PF	0	C	1, 453	0		40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	C	0 2, 832	0		41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0		2, 632	0		44. 00
45. 00	04500 NURSING FACILITY	o	C	Ö	ū		45. 00
46. 00	04600 OTHER LONG TERM CARE	O	C	0	0		46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	944	C			l	50.00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	C		-		51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	0		0	0		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	205	C	Ö	0		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	C	0	0		55. 00
56.00	05600 RADI OI SOTOPE	O	C	0	0		56. 00
57. 00	05700 CT SCAN	0	C	1	0		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C	0	0		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	9	C	0	0		59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	0		0	0		60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	Ĭ			0		61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	o	C	0	0		62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	o	C	0	0		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	24	C	0	0		64. 00
65. 00	06500 RESPI RATORY THERAPY	846	C	0	0		65. 00
66.00	06600 PHYSI CAL THERAPY	0	C	0	0		66.00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY	0	C	0	0		67.00
69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0		0	0		68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	o o	C	0	0		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	C	Ö	0		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	o	C	Ō	0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	203, 470	C	0	0		73. 00
74.00	07400 RENAL DIALYSIS	0	C	0	0		74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	C	0	0		75. 00
76.00	03140 CARDI OLOGY	322	C	0	-		76.00
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	C			1	77. 00 78. 00
70.00	OUTPATIENT SERVICE COST CENTERS	ı U		. 0	0		, 73.00
88. 00		O	C	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C			l .	89. 00
90. 00	09000 CLI NI C	0	C	0	0		90.00

			-	Го 12/31/2023	Date/Time Pre 5/30/2024 7:4	
				OTHER GENERAL	07 007 202 1 7. 1	- Calii
				SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVIC	(SPECI FY)	NONPHYSI CI AN	
		RECORDS &			ANESTHETI STS	
	15.00	LI BRARY	17.00	10.00	10.00	
90. 01 04950 SLEEP CLINIC	15. 00	16. 00	17. 00	18.00	19. 00	00.01
90. 01 04950 SLEEP CLINIC 91. 00 09100 EMERGENCY	16	0	1			90. 01 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10	U	1	0		91.00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DIALYSIS	O	0	JI (0		94.00
95. 00 09500 AMBULANCE SERVICES	0	0				95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0		97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0)	0		98. 00
99. 00 09900 CMHC	0	0)	0		99. 00
99. 10 09910 CORF	0	0)	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0)	0		100.00
101.00 10100 HOME HEALTH AGENCY	0	0)	0		101. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0)	0		102. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0)	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0)	0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0)	0		107. 00
108. 00 10800 LUNG ACQUI SI TI ON	0	0)	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0)	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0)	0		110. 00
111. 00 11100 SLET ACQUI SI TI ON	0	0)	0		111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	_	_		_		114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	1	0		115. 00
116. 00 11600 HOSPI CE	0	Ü	07.44	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREIMBURSABLE COST CENTERS	206, 089		27, 14	5 0	0	118. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	٥	0	ı .	0		190. 00
190.00 19100 RESEARCH	0	0				190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0]			192.00
193. 00 19300 NONPALD WORKERS	0	0]			193. 00
193. 01 19301 COMMUNI TY	0	0				193. 01
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS		n				194. 00
200.00 Cross Foot Adjustments	9	O	1		n	200. 00
201.00 Negative Cost Centers	0	0)	ol o		201. 00
202.00 TOTAL (sum lines 118 through 201)	206, 089	0	27, 14	0		202. 00
(a d d d d d d d d d d d d d d d d d d				1		

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2023 | Part II | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 7:46 am

					3 127 317 2023	5/30/2024 7: 4	
			INTERNS &	RESI DENTS			
	0 1 0 1 5 11	NURGINO	CEDVI OEC CALAD	CEDULOEC OTHER	DADAMED ED	6 1 1 1 1	
	Cost Center Description	NURSI NG		SERVI CES-OTHER		Subtotal	
		PROGRAM 20.00	Y & FRINGES 21.00	PRGM COSTS 22.00	PRGM 23.00	24. 00	
	GENERAL SERVICE COST CENTERS	20.00	21.00	22.00	23.00	24.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
6.00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON						13.00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 16. 00	01500 PHARMACY			•			15. 00 16. 00
17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE						17. 00
	01850 OTHER GENERAL SERVICE (SPECIFY)						18. 00
	01900 NONPHYSICIAN ANESTHETISTS						19. 00
	02000 NURSI NG PROGRAM	0					20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	_	0	i			21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD			0			22. 00
23.00	02300 PARAMED ED PRGM				7, 836		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS					5, 662, 327	30. 00
31.00	03100 INTENSIVE CARE UNIT					488, 320	31. 00
31. 01	03101 NEONATAL INTENSIVE CARE					86, 198	31. 01
32. 00	03200 CORONARY CARE UNIT					0	
33. 00	03300 BURN INTENSIVE CARE UNIT					0	
34. 00	03400 SURGICAL INTENSIVE CARE UNIT					0	
40.00	04000 SUBPROVI DER - I PF					434, 592	1
41. 00	04100 SUBPROVI DER – I RF					0	
43. 00	04300 NURSERY					379, 181	1
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY					0	1
46. 00	04600 OTHER LONG TERM CARE					0	1
40.00	ANCI LLARY SERVI CE COST CENTERS						40.00
50.00	05000 OPERATING ROOM					2, 134, 176	50.00
51.00	05100 RECOVERY ROOM					0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM					0	52. 00
53.00	05300 ANESTHESI OLOGY					0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C					1, 719, 176	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C					0	
56.00	05600 RADI OI SOTOPE					0	
57. 00	05700 CT SCAN					261, 940	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)					129, 793	1
59. 00	05900 CARDI AC CATHETERI ZATI ON					148, 589	1
60. 00 60. 01	06000 LABORATORY					203, 681	60.00
61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS					0	1
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.					0	1
64. 00	06400 I NTRAVENOUS THERAPY					281, 969	1
65. 00	06500 RESPI RATORY THERAPY	1				70, 600	1
66.00	06600 PHYSI CAL THERAPY					181, 181	1
67. 00	06700 OCCUPATI ONAL THERAPY					86, 479	67. 00
68. 00	06800 SPEECH PATHOLOGY					51, 644	1
69. 00	06900 ELECTROCARDI OLOGY					0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY					0	70.00
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS					5, 451	71.00
72. 00	i i					541, 448	1
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS					220, 922 0	
74. 00 75. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)				}	0	
76. 00	03140 CARDI OLOGY					413, 766	1
77.00	07700 ALLOGENEIC HSCT ACQUISITION					413, 700	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY					0	1
. 5. 55	OUTPATIENT SERVICE COST CENTERS					0	1 . 5. 55
88. 00	08800 RURAL HEALTH CLINIC					0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER					0	1
90.00	09000 CLI NI C					172, 821	1
90. 01	04950 SLEEP CLINIC	<u> </u>	<u> </u>			638	90. 01

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2023 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

	To 12/31/2023 Date/Time Prepared: 5/30/2024 7: 46 am
INTERNS & RESIDEN	
Cost Center Description NURSING SERVICES-SALAR SERVICES	
PROGRAM Y & FRI NGES PRGM (20, 00 21, 00 22,	
91. 00 09100 EMERGENCY	667, 105 91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	92.00
OTHER REIMBURSABLE COST CENTERS	
94. 00 09400 HOME PROGRAM DI ALYSI S	0 94.00
95. 00 09500 AMBULANCE SERVI CES	0 95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0 96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0 97.00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0 98.00
99. 00 09900 CMHC	0 99.00
99. 10 09910 CORF	0 99.10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0 100. 00 0 101. 00
102.00 10200 OPLOLD TREATMENT PROGRAM	0 101.00
SPECIAL PURPOSE COST CENTERS	102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0 105.00
106. 00 10600 HEART ACQUI SI TI ON	0 106.00
107. 00 10700 LI VER ACQUI SI TI ON	0 107. 00
108.00 10800 LUNG ACQUISITION	0 108.00
109.00 10900 PANCREAS ACQUISITION	0 109.00
110.00 11000 INTESTINAL ACQUISITION	0 110.00
111.00 11100 I SLET ACQUI SITION	0 111.00
113. 00 11300 I NTEREST EXPENSE	113. 00
114.00 11400 UTILIZATION REVIEW-SNF	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0 115. 00
116. 00 11600 HOSPI CE	0 116.00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0	0 0 14, 341, 997 118. 00
NONREI MBURSABLE COST CENTERS	0 190. 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0 190.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	437, 387 192, 00
193. 00 19300 NONPALD WORKERS	81 193. 00
193. 01 19301 COMMUNI TY	149, 653 193. 01
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS	4, 010, 211 194. 00
200.00 Cross Foot Adjustments 0 0	0 7, 836 7, 836 200. 00
201.00 Negative Cost Centers 0	0 0 0 201.00
202.00 TOTAL (sum lines 118 through 201) 0 0	0 7, 836 18, 947, 165 202. 00

Health Financial Systems ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018 Period: Worksheet B

From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/30/2024 7:46 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 00700 OPERATION OF PLANT 7.00 7 00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12. 00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17 00 17 00 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 20.00 02000 NURSING PROGRAM 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21 00 21 00 22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02300 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 5, 662, 327 30.00 31.00 03100 INTENSIVE CARE UNIT 0 488, 320 31.00 03101 NEONATAL INTENSIVE CARE 00000000 31.01 86, 198 31.01 03200 CORONARY CARE UNIT 32.00 0 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 C 04000 SUBPROVI DER - I PF 40.00 434, 592 40.00 41.00 04100 SUBPROVI DER - I RF 41.00 04300 NURSERY 43 00 379, 181 43 00 44.00 04400 SKILLED NURSING FACILITY 44.00 04500 NURSING FACILITY 0 45.00 Ω 45.00 04600 OTHER LONG TERM CARE 0 46.00 46.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 2, 134, 176 50.00 51.00 05100 RECOVERY ROOM 0 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM Λ 52.00 53.00 05300 ANESTHESI OLOGY 0000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 1, 719, 176 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 56.00 05600 RADI OI SOTOPE 56.00 57.00 05700 CT SCAN 261, 940 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 129, 793 58.00 05900 CARDIAC CATHETERIZATION 148, 589 59 00 59 00 60.00 06000 LABORATORY 203, 681 60.00 06001 BLOOD LABORATORY 0 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0000000000000 63.00 06400 I NTRAVENOUS THERAPY 64.00 281, 969 64.00 65 00 06500 RESPIRATORY THERAPY 70,600 65 00 06600 PHYSI CAL THERAPY 66.00 181, 181 66.00 06700 OCCUPATIONAL THERAPY 86, 479 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 51, 644 68.00 69 00 06900 FLECTROCARDLOLOGY 69 00 Ω 70.00 07000 ELECTROENCEPHALOGRAPHY 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 5, 451 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 541, 448 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 220, 922 73.00 74.00 07400 RENAL DIALYSIS C 74.00 07500 ASC (NON-DISTINCT PART) 75.00 75.00 0 76.00 03140 CARDI OLOGY 76, 00 413, 766 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 C 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 0 78.00 OUTPATIENT SERVICE COST CENTERS 88 00 0 88.00 108800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90. 00 09000 CLINIC 172, 821 90.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018 Peri od: Worksheet B From 01/01/2023 Part II Date/Time Prepared: 12/31/2023 5/30/2024 7:46 am Cost Center Description Intern & Total Residents Cost & Post Stepdown Adjustments 25.00 26.00 90. 01 04950 SLEEP CLINIC 90.01 638 09100 EMERGENCY 0 91.00 91.00 667, 105 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 00000000 95.00 09500 AMBULANCE SERVICES 0 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 0 99. 00 09900 CMHC 99.00 99. 10 09910 CORF 99. 10 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 0 101.00 10100 HOME HEALTH AGENCY 0 101. 00 102.00 10200 OPI OI D TREATMENT PROGRAM 102. 00 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105. 00 0000000 106. 00 10600 HEART ACQUISITION 0 106. 00 107.00 10700 LIVER ACQUISITION 107. 00 0 108.00 10800 LUNG ACQUISITION 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 110.00 0 111.00 11100 I SLET ACQUISITION C 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115. 00 116. 00 11600 HOSPI CE 0 116. 00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 14, 341, 997 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190 00 0 0 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 437, 387 192. 00 193. 00 19300 NONPALD WORKERS 81 193. 00 193. 01 19301 COMMUNI TY 149, 653 193. 01 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 4, 010, 211 194. 00 200.00 Cross Foot Adjustments 200. 00 7,836

18, 947, 165

201.00

202. 00

Negative Cost Centers

TOTAL (sum lines 118 through 201)

201.00

202.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0018 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 7:46 am CAPITAL RELATED COSTS Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Reconciliation ADMINISTRATIVE (SQUARE FEET) (SQUARE FEET) BENEFITS & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 4.00 5A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 681 070 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 681,070 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 135 98, 153, 771 4.00 135 00500 ADMINISTRATIVE & GENERAL 5 00 4, 188 4, 187, 990 -45, 656, 703 226, 570, 471 4.188 5 00 6.00 00600 MAINTENANCE & REPAIRS 6.00 7.00 00700 OPERATION OF PLANT 145, 915 145, 915 2, 490, 798 12, 388, 326 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 4, 167 0 924, 554 8.00 4. 167 00900 HOUSEKEEPI NG 0 4, 507, 887 9 00 2, 356, 229 4.127 4. 127 9 00 10.00 01000 DI ETARY 12, 398 12, 398 1, 359, 060 2, 757, 490 10.00 01100 CAFETERI A 11.00 2, 144 2, 144 1, 182, 556 1, 363, 659 11.00 0 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 1, 861 1, 861 2, 516, 227 13.00 3, 373, 077 13 00 0 14.00 01400 CENTRAL SERVICES & SUPPLY 14, 966 14, 966 877, 942 2, 129, 605 14.00 01500 PHARMACY 15.00 5, 754 5, 754 240, 708 1,844,399 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16,00 C 0 16,00 17 00 01700 SOCIAL SERVICE 738 738 372, 430 636, 446 17 00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 18.00 0 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C 0 o O 19.00 02000 NURSI NG PROGRAM 0 20.00 0 0 20.00 C 0 O 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 C 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 0 0 0 22.00 02300 PARAMED ED PRGM 207 207 27 70, 894 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 143, 963 143, 963 24, 404, 277 0 39, 081, 828 30.00 03100 INTENSIVE CARE UNIT 11, 095 6, 273, 537 31.00 11, 095 9, 018, 363 31.00 03101 NEONATAL INTENSIVE CARE o 31.01 2, 330 2, 330 857, 966 1, 108, 988 31.01 03200 CORONARY CARE UNIT 0 32.00 0 C 0 32.00 C 03300 BURN INTENSIVE CARE UNIT 0 33.00 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 04000 SUBPROVIDER - IPF 10, 912 40 00 10,912 1, 789, 341 0 2, 555, 576 40 00 04100 SUBPROVI DER - I RF 41.00 7, 880 41.00 0 04300 NURSERY 43.00 10, 261 10, 261 2, 685, 840 0 3, 783, 493 43.00 04400 SKILLED NURSING FACILITY 44.00 0 44.00 0 C 04500 NURSING FACILITY 0 0 45.00 0 Λ 45.00 46.00 04600 OTHER LONG TERM CARE 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 58 586 58 586 10 961 658 0 28 222 760 50 00 51.00 05100 RECOVERY ROOM C 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 C 0 05400 RADI OLOGY-DI AGNOSTI C 47 286 5, 937, 654 54 00 47, 286 9, 356, 246 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 05600 RADI OI SOTOPE 0 56.00 56.00 57.00 05700 CT SCAN 7,099 7,099 963, 532 0 0 0 2, 031, 915 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 3.587 3, 587 58 00 457, 779 991, 891 58 00 59.00 05900 CARDIAC CATHETERIZATION 4,072 4,072 2,076,896 2, 167, 538 59.00 06000 LABORATORY 2, 795, 968 60.00 5, 429 5, 429 9, 774, 312 60.00 06001 BLOOD LABORATORY 0 60.01 0 60.01 0 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 63.00 06400 INTRAVENOUS THERAPY 7.765 7.765 1, 163, 659 1, 864, 024 64 00 64 00 65.00 06500 RESPIRATORY THERAPY 1,804 1,804 2, 114, 459 3, 652, 443 65.00 2, 294, 951 06600 PHYSI CAL THERAPY 1, 652, 020 66.00 4,967 4, 967 0 66.00 06700 OCCUPATIONAL THERAPY 2, 385 2, 385 486, 954 938, 232 67.00 67.00 06800 SPEECH PATHOLOGY 68.00 1,430 1.430 246, 426 351, 646 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 C 07000 ELECTROENCEPHALOGRAPHY 70 00 0 0 70 00 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 222, 559 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 25, 509, 369 72.00 0 C Λ 72 00 07300 DRUGS CHARGED TO PATIENTS 0 26, 418, 338 73.00 4, 361, 238 73.00 07400 RENAL DIALYSIS 74.00 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 0 0 0 75.00 03140 CARDI OLOGY 76.00 11, 396 11, 396 2, 013, 488 0 3, 092, 070 76.00 07700 ALLOGENEIC HSCT ACQUISITION C 0 0 77.00 07800 CAR T-CELL IMMUNOTHERAPY 78.00 78.00 0 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0018

				1	o 12/31/2023	Date/lime Pre 5/30/2024 7:4	
		CAPITAL REL	ATED COSTS			373072024 7.4	O alli
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation		
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS DEPARTMENT		& GENERAL (ACCUM. COST)	
				(GROSS		(ACCOM: COST)	
		1.00	2.00	SALARI ES) 4. 00	5A	5. 00	
89. 00 08900	FEDERALLY QUALIFIED HEALTH CENTER	1.00	2.00			5.00	89. 00
	CLINIC	4, 737	4, 737			478, 265	90.00
90. 01 04950	SLEEP CLINIC	0	0	l		482, 265	90. 01
	EMERGENCY	16, 656	16, 656	9, 343, 416	0	12, 022, 629	
	OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	REIMBURSABLE COST CENTERS HOME PROGRAM DI ALYSI S	0	0	0	O	0	94. 00
	AMBULANCE SERVICES	0	0			0	95.00
	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
	DURABLE MEDICAL EQUIP-SOLD	0	0	·		0	97. 00
	OTHER REIMBURSABLE COST CENTERS	0	0	·		0	98. 00
99. 00 09900 99. 10 09910		0	0			0	99. 00 99. 10
	I &R SERVICES-NOT APPRVD PRGM	0	0	· -			100.00
	HOME HEALTH AGENCY	0	0	·			101.00
	OPIOID TREATMENT PROGRAM	0	0				102. 00
	AL PURPOSE COST CENTERS						
	KIDNEY ACQUISITION	0	Ĭ				105.00
	HEART ACQUISITION	0	0				106. 00 107. 00
	LIVER ACQUISITION LUNG ACQUISITION	0	0				107.00
	PANCREAS ACQUISITION	0	0				109.00
	INTESTINAL ACQUISITION	0	0	0	0		110.00
	ISLET ACQUISITION	0	0	0	0	0	111. 00
	I NTEREST EXPENSE						113.00
	UTILIZATION REVIEW-SNF AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	114. 00 115. 00
116. 00 11600		0	0	· -	-		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	552, 360			-	215, 416, 038	1
	IMBURSABLE COST CENTERS						
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	·			190. 00
191. 00 19100	•	0	0	·			191. 00
	PHYSICIANS' PRIVATE OFFICES NONPALD WORKERS	12, 272	12, 272 0	0 44, 177		341, 403 59, 814	1
193. 01 19301	•	4, 199	4, 199			667, 455	ł
	OTHER NONREIMBURSABLE COST CENTERS	112, 239	· ·			10, 085, 761	
200. 00	Cross Foot Adjustments						200. 00
201. 00	Negative Cost Centers	45 004 000		700 005		45 454 300	201. 00
202. 00	Cost to be allocated (per Wkst. B, Part I)	15, 834, 383	3, 112, 782	722, 095		45, 656, 703	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	23. 249274	4. 570429	0. 007357		0. 201512	203. 00
204. 00	Cost to be allocated (per Wkst. B,			3, 756		116, 668	1
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part			0. 000038		0. 000515	205. 00
206. 00	NAHE adjustment amount to be allocated						206. 00
207. 00	(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D,						207. 00
207.00	Parts III and IV)						207.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0018

				Т	o 12/31/2023	Date/Time Pre 5/30/2024 7:4	
	Cost Center Description	MAINTENANCE & REPAIRS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	
		6. 00	7. 00	LAUNDRY) 8.00	9. 00	10.00	
	GENERAL SERVI CE COST CENTERS		1	1		1	
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6.00	00600 MAI NTENANCE & REPAI RS	676, 747					6. 00
7.00	00700 OPERATION OF PLANT	145, 915					7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	4, 167 4, 127	4, 167 4, 127	972, 997 0	119, 862		8. 00 9. 00
10. 00	01000 DI ETARY	12, 398	l ·		183	l .	10.00
11.00	01100 CAFETERI A	2, 144		0	365	l	11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	1, 861	0 1, 861	0	730	_	12. 00 13. 00
14. 00	01400 CENTRAL SERVI CES & SUPPLY	14, 966		Ö	0	l	14. 00
15. 00	01500 PHARMACY	5, 754	5, 754	0	730		15. 00
16. 00 17. 00	O1600 MEDICAL RECORDS & LIBRARY O1700 SOCIAL SERVICE	738	0 738	0	0	0	16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	Ö	0	o o	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG PROGRAM	0	0	0	0	0	20.00
21. 00 22. 00	02100 &R SERVI CES-SALARY & FRINGES APPRVD 02200 &R SERVI CES-OTHER PRGM COSTS APPRVD		0	0	0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	207	207	o o	365		23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					I	
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	143, 963 11, 095			48, 021 6, 756	142, 970 21, 339	30. 00 31. 00
31. 00	03101 NEONATAL INTENSIVE CARE	2, 330	,		l		31.00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	10, 912	10, 912	7, 631	3, 367	0 14, 573	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	0	0,712	0	0,307	0	41. 00
43.00	04300 NURSERY	10, 261	10, 261	5, 712	1, 602	0	43. 00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	0	0	0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE		0			0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	58, 586		139, 988 0	0	_	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	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	47, 286	47, 286	109, 869	9, 855		54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE		0	0	0	0	55. 00 56. 00
57. 00	05700 CT SCAN	7, 099	7, 099	38, 251	1, 825	_	57. 00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	3, 587		1, 321	1, 095	0	
59. 00 60. 00	O5900 CARDI AC CATHETERI ZATI ON O6000 LABORATORY	4, 072 5, 429			0 1, 460	_	59. 00 60. 00
60. 01	06001 BLOOD LABORATORY	0,427	0,427	Ö	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	7, 765	7, 765		2, 008		64. 00
65. 00	06500 RESPIRATORY THERAPY	1, 804	1		1, 460	l .	65. 00
66.00	06600 PHYSI CAL THERAPY	4, 967			1, 460	l .	66.00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	2, 385 1, 430	l ·		730 365		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	ő	0	ő	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	0	Ō	Ō	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0 000	0	0	75. 00
76. 00 77. 00	03140 CARDI OLOGY 07700 ALLOGENEI C HSCT ACQUI SI TI ON	11, 396	11, 396 0	20, 829	1, 460		76. 00 77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	Ö	ő	ő	Ö		78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	0	88. 00 89. 00
90.00	09000 CLINIC	4, 737	_	7, 054	2, 555	_	90.00
	04950 SLEEP CLINIC	0			0		

| Period: | Worksheet B-1 | From 01/01/2023 | To 12/31/2023 | Date/Time Prepared:

			To	12/31/2023	Date/Time Pre 5/30/2024 7:4	pared: 6 am
Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (HOURS OF SERVI CE)	DI ETARY (MEALS SERVED)	O diii
	(SQO/IKE TEET)	(SQS/IKE TEET)	LAUNDRY)	oekvi oe)		
	6.00	7.00	8. 00	9. 00	10.00	
91. 00 09100 EMERGENCY	16, 656	16, 656	230, 572	13, 505	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0		_	0	0	
95. 00 09500 AMBULANCE SERVI CES	0		_	0	0	
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0	0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
98. 00 09850 OTHER REI MBURSABLE COST CENTERS	0	0	0	0	0	
99. 00 09900 CMHC	0	0	0	0	0	1 , , , , , ,
99. 10 09910 CORF	0	0	0	0	0	
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0	_	1	0	•	100. 00 101. 00
102.00 10100 HOME HEALTH AGENCY	0	_	1	0		101.00
SPECIAL PURPOSE COST CENTERS		0	ıj U	0	0	102.00
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUISITION	0			0	•	106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0		_	0	•	107. 00
108. 00 10800 LUNG ACQUISITION	0	,	1	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	_	0	•	109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	Ö	0	l	110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	Ō	0		111. 00
113. 00 11300 I NTEREST EXPENSE				_	_	113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	o	0	0	115. 00
116. 00 11600 HOSPI CE	0	O	o	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	548, 037	402, 122	972, 997	100, 699	178, 882	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0		0	0	0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	12, 272	12, 272	0	1, 460		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	l	193. 00
193. 01 19301 COMMUNI TY	4, 199			0	l e	193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	112, 239	112, 239	0	17, 703	0	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		44 004 700	4 007 707			201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	0	14, 884, 722	1, 227, 707	5, 532, 003	3, 669, 247	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	28. 040363	1. 261779	46. 153101	20. 512109	203. 00
204.00 Cost to be allocated (per Wkst. B, Part II)	0	4, 065, 787	148, 317	148, 834	441, 567	204. 00
205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	7. 659273	0. 152433	1. 241711	2. 468482	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
	I	I	1		I	I

	ALLOCATION - STATISTICAL BASIS	ELKHAKI GENEK			eri od:	Worksheet B-1	
				F T	rom 01/01/2023 5 12/31/2023	Date/Time Pre	pared:
						5/30/2024 7: 4	6 am
	Cost Center Description	CAFETERIA (HOURS OF	MAINTENANCE OI PERSONNEL	F NURSING ADMINISTRATION	CENTRAL SERVI CES &	PHARMACY (COSTED	
		SERVICE)	(NUMBER	ADMINI STRATTON	SUPPLY	REQUIS.)	
			HOUSED)	(DI RECT NURS.	(COSTED		
		11.00	12. 00	HRS.) 13. 00	REQUIS.) 14.00	15. 00	
	GENERAL SERVICE COST CENTERS	11.00	12.00	13.00	14.00	13.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					 -	2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	2, 027, 015					11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	0	(0			12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	46, 878 40, 337	(822, 698	100		13. 00 14. 00
	01500 PHARMACY	2, 080	(0	23, 622, 218	
	01600 MEDICAL RECORDS & LIBRARY	0	(0	0	0	1
	01700 SOCIAL SERVICE	11, 573	(2, 080	0	0	
	O1850 OTHER GENERAL SERVICE (SPECIFY) O1900 NONPHYSICIAN ANESTHETISTS	0	(0	0	0	18. 00 19. 00
	02000 NURSING PROGRAM		(0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	o	(0	0	0	21. 00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	(0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	41	(0 0	0	0	23. 00
30. 00		517, 432	(351, 804	0	25, 217	30.00
	03100 INTENSIVE CARE UNIT	138, 962	(111, 321	0	3, 795	1
31. 01	03101 NEONATAL INTENSIVE CARE	13, 635	(11, 961	0	0	
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT		(0	0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	o	(0	0	0	34.00
	04000 SUBPROVI DER - I PF	43, 906	(18, 852	0	5	40.00
41.00	04100 SUBPROVI DER - I RF 04300 NURSERY	106, 155	(38, 976	0	0	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	,	0 30, 770	0	. 0	44. 00
45.00	04500 NURSING FACILITY	o	(0 0	0	0	
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	(0 0	0	0	46. 00
50. 00	05000 OPERATING ROOM	231, 476	(111, 327	0	108, 229	50.00
51.00	05100 RECOVERY ROOM	o	(0	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	(0	0	0	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	150, 400	(18, 085	0	0 23, 480	
	05500 RADI OLOGY-THERAPEUTI C	0	(0 0	Ö	0	l
56.00	05600 RADI OI SOTOPE	0	(0 0	0	0	
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	23, 468 11, 575	(0	0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	35, 286	(18, 294	0	1, 017	
60.00	06000 LABORATORY	107, 895	(0	0	0	1
60. 01	06001 BLOOD LABORATORY	0	(0	0	0	
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		(0	0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		·		0	0	ı
64. 00	06400 I NTRAVENOUS THERAPY	28, 315	(21, 866	0	2, 711	1
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	51, 850	(0	0	96, 965	1
67.00	1 1	38, 242 11, 902	(0	0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	6, 984	(o o	Ö	0	68. 00
	06900 ELECTROCARDI OLOGY	0	(0	0	0	69. 00
70. 00 71. 00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0	0	
72.00			Č		99	0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	96, 562	(0	0	23, 322, 098	
	07400 RENAL DIALYSIS	0	(0	0	0	
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY	47, 061	(7, 863	0	0 36, 894	75. 00 76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0		0 7,003	0	0	1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	o	(0 0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	l		0 0	O	0	88. 00
89. 00	1				0	0	
	09000 CLI NI C	6, 559		32	o	0	•

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2023 To 12/31/2023	5/30/2024 7:4	
Cost Center Description		MAINTENANCE O		CENTRAL	PHARMACY	
	(HOURS OF	PERSONNEL	ADMI NI STRATI OI		(COSTED	
	SERVI CE)	(NUMBER	(DI DECT NUDC	SUPPLY	REQUIS.)	
		HOUSED)	(DI RECT NURS.	(COSTED		
	44.00	10.00	HRS.)	REQUIS.)	45.00	
	11.00	12. 00	13. 00	14. 00	15. 00	
90. 01 04950 SLEEP CLI NI C	9, 922		-1	0		
91. 00 09100 EMERGENCY	216, 014		0 110, 23	7 0	1, 807	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS			1	1	Г	4
94.00 09400 HOME PROGRAM DIALYSIS	0			0		
95. 00 09500 AMBULANCE SERVICES	0			0	1	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0		
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0		1	0		
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0			0	0	
99. 00 09900 CMHC	0			0		
99. 10 09910 CORF	0		0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0		0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0		0	0	0	101. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0		0 (0	0	102. 00
SPECIAL PURPOSE COST CENTERS				_		
105.00 10500 KIDNEY ACQUISITION	0		0 (0	0	105. 00
106.00 10600 HEART ACQUISITION	0		0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0		0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0		o o	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0		o o	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0		o o	0	0	110.00
111.00 11100 I SLET ACQUISITION	0		o o	0	0	111.00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0		o o	0	0	115. 00
116. 00 11600 HOSPI CE	0		ol (0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 994, 510		0 822, 698	100	23, 622, 218	118.00
NONREI MBURSABLE COST CENTERS	, , , , ,					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0 (0	0	190. 00
191. 00 19100 RESEARCH	0		· I	0	•	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0		ol (0	0	192.00
193. 00 19300 NONPALD WORKERS	1, 252		ol	0		193. 00
193. 01 19301 COMMUNI TY	8, 489		-	0		193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	22, 764		ol d	0		194. 00
200.00 Cross Foot Adjustments					_	200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 715, 418		0 4, 178, 339	3, 012, 534	2, 412, 864	
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 846278	0. 00000	0 5. 07882!	30, 125. 340000	0. 102144	203 00
204. 00 Cost to be allocated (per Wkst. B,	77, 266		0 70, 55		l .	
Part II)	11,200		70, 55.	555, 047	200, 009	204.00
205.00 Unit cost multiplier (Wkst. B, Part	0. 038118	0. 00000	0. 085758	5, 336. 470000	0. 008724	205. 00
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0018 Peri od: Worksheet B-1 From 01/01/2023 12/31/2023 Date/Time Prepared: 5/30/2024 7:46 am OTHER GENERAL SERVI CE MEDI CAL SOCIAL SERVICE NONPHYSI CI AN NURSI NG Cost Center Description (SPECIFY) RECORDS & (TIME SPENT) **ANESTHETISTS PROGRAM** (TIME SPENT) (ASSI GNED LIBRARY (ASSI GNED (REVENUE) TIME) TIME) 17.00 18.00 19.00 20.00 16.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6 00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9 00 9 00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13 00 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16,00 01700 SOCIAL SERVICE 17.00 17.00 11, 136 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 0 19.00 0 02000 NURSI NG PROGRAM 0 0 20.00 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 21.00 Ω 21.00 0 22. 00 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 02300 PARAMED ED PRGM 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 0 8.061 0 0 0 03100 INTENSIVE CARE UNIT 1, 221 0 0 31.00 31.00 0000000 0 0 0 0 0 0 0 31.01 03101 NEONATAL INTENSIVE CARE 96 31.01 03200 CORONARY CARE UNIT 0 32.00 32.00 C 0 0 33.00 03300 BURN INTENSIVE CARE UNIT C 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 0 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 40.00 596 0 40.00 0 41 00 0 41 00 04300 NURSERY 0 43.00 1, 162 0 43.00 0 0 04400 SKILLED NURSING FACILITY 0 44.00 C 0 44.00 0 04500 NURSING FACILITY 45.00 45.00 C 0 46.00 04600 OTHER LONG TERM CARE 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 0 50.00 0 0 0 51.00 05100 RECOVERY ROOM C 51.00 Λ 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0000000 C 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 0 55.00 56.00 05600 RADI OI SOTOPE 0 0 56.00 0 57.00 05700 CT SCAN 0 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58 00 58 00 Ω 0 59.00 05900 CARDIAC CATHETERIZATION 0 0 0 59.00 06000 LABORATORY 0 0 0 0 60.00 60.00 0 06001 BLOOD LABORATORY 0 0 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61 00 61 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 0 0 0 0 0 0 0 0 0 0 0 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 00000 0 0 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 0 0 68.00 0 06900 ELECTROCARDI OLOGY 69.00 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 000000 70.00 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 72 00 Ω 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 07400 RENAL DIALYSIS 74.00 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 03140 CARDI OLOGY 76.00 0 0 0 76.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 77.00 77.00 78.00 07800 CAR T-CELL IMMUNOTHERAPY 0 Ω 0 0 0 78.00 OUTPATIENT SERVICE COST CENTERS 88 00 88 00 08800 RURAL HEALTH CLINIC 0 Ω 0 0 Ω 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00

Cost Center Description						To	12/31/2023	Date/Time Pre 5/30/2024 7:4	
Cost Center Description						OTHED CENEDAL		3/30/2024 /.4	o alli
Cost Center Description									
RECORDS & LIBRARY (REVENUE)		Cost Center Description	MEDI CAL	SOC	CLAL SERVICE		NONPHYSI CLAN	NURSLNG	
BIRARY CREVENUE) 17.00 18.00 19.00 20.00 0.0		Sect Seller Besser Per en			J. 7.12 OZ. 11.1 OZ.				
REVENUE				(T	TIME SPENT)	(
90. 00 09000 CLINIC 0 16.00 17.00 18.00 19.00 20.00 90. 01 04950 SLEEP CLINIC 0 0 0 0 0 0 0 0 90. 01 04950 SLEEP CLINIC 0 0 0 0 0 0 90.00 92. 00 09200 085ERVATI ON BEDS (NON-DISTINCT PART) 92.00 92. 00 09400 09400 09400 09400 0 0 0 0 0 0 0 94. 00 09400 09400 09400 09400 09400 0 0 0 0 0 0 0 0 95. 00 09500 08000 08000 08000 0 0 0				(0. 2)		`		
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95.00 095.00 AMBULANCE SERVICES 0 0 0 0 0 0 0 0 0	OTHER	REIMBURSABLE COST CENTERS							
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97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 97.00 99.00 09900 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 99.00 09900 OMHC 0 0 0 0 0 0 0 99.10 09910 OORF 0 0 0 0 0 0 0 99.10 09910 OORF 0 0 0 0 0 0 99.10 09910 OORF 0 0 0 0 0 0 99.10 09910 OORF 0 0 0 0 0 0 99.10 09910 OORF 0 0 0 0 0 0 99.10 0 0 0 0 0 0 0 99.10 0 0 0 0 0 0 0 99.10 0 0 0 0 0 0 0 99.10 0 0 0 0 0 0 0 99.10 0 0 0 0 0 0 0 99.10 0 0 0 0 0 0 0 101.00 10000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 102.00 10200 0 10 1REATHEN PROGRAM 0 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS			(0	-	-1		
99. 00 09950 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 99. 00 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 100. 00 10000 18 SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 102. 00 10200 OPI DI D TREATMENT PROGRAM 0 0 0 0 0 0 102. 00 10200 OPI DI D TREATMENT PROGRAM 0 0 0 0 0 105. 00 10500 KIDNEY ACQUISITION 0 0 0 0 0 0 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 105. 00 107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 107. 00 108. 00 10800 LUING ACQUISITION 0 0 0 0 0 109. 00 109. 00 10900 PANCERAS ACQUISITION 0 0 0 0 0 0 109. 00 109. 00 10900 PANCERAS ACQUISITION 0 0 0 0 0 0 110. 00 110. 00 11010 INTESTI NAL ACQUISITION 0 0 0 0 0 0 0 111. 00 111. 00 1110 ISLET ACQUISITION 0 0 0 0 0 0 0 111. 00 113. 00 11300 INTEREST EXPENSE 114. 00 114. 00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURRICAL CENTER (D.P.) 0 0 0 0 0 0 0 116. 00 11500 AMBULATORY SURRICAL CENTER (D.P.) 0 11. 136 0 0 0 0 0 116. 00 11500 AMBULATORY SURRICAL CENTER (D.P.) 0 11. 136 0 0 0 0 0 191. 00 19000 GIFT, ELOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 0 192. 00 192. 00 19300 NONPAID WORKERS 0 0 0 0 0 0 0 0 193. 00 193. 01 19301 COMMUNITY 0 0 0 0 0 0 0 0 0			(0		0		
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SPECIAL PURPOSE COST CENTERS			(
105. 00 10500 KI DNEY ACQUI SITION			(0	0	0	0	102. 00
106.00 10600 HEART ACQUISITION				_					
107. 00 107.00 LIVER ACQUISITION			(-			
108. 00 10800 LUNG ACQUISITION			(2	-	-			
109. 00 10900 PANCREAS ACQUISITION		•	(2	-	-	-1		
110. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 0 1110. 00 1110. 01 1110. 00 0 0 0 0 0 0 0 0		•	(2	-	-	-1		
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113. 00 11300 INTEREST EXPENSE			(0	-	٩		
114. 00			(ון	O	0	O	0	
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115. 00 116. 00 116. 00 116. 00 116. 00 116. 00 0 0 0 0 0 0 0 115. 00 116. 00 118. 00 SUBTOTALS (SUM OF LINES 1 through 117) 0 11, 136 0 0 0 0 118. 00 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 0 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 192. 00 192. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 193. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 193. 00 193. 01 19301 COMMUNI TY 0 0 0 0 0 0 0 193. 01 193. 01 COMMUNI TY 0 0 0 0 0 0 0 0 193. 01 193. 01 COMMUNI TY 0 0 0 0 0 0 0 0 0 193. 01 193. 01 COMMUNI TY 0 0 0 0 0 0 0 0 0 0 193. 01 193. 01 COMMUNI TY 0 0 0 0 0 0 0 0 0 0 193. 01 193. 01 COMMUNI TY 0 0 0 0 0 0 0 0 0 0 193. 01 193. 01 193. 01 COMMUNI TY 0 0 0 0 0 0 0 0 0 0 0 193. 01 193. 01 193. 01 COMMUNI TY 0 0 0 0 0 0 0 0 0 0 0 193. 01		•							
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190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190. 00 191. 00 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 192. 00 192. 00 193. 00 193. 00 193. 00 193. 00 193. 00 193. 01				ال	11, 136	U	U	0	118.00
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192. 00					-	-	-1		
193.00 19300 NONPAID WORKERS 193.01 19301 COMMUNITY 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 200.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 204.00 Cost to be allocated (per Wkst. B, Part II) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Cost to be allocated (per Wkst. B, Part II) 206.00 Cost to be allocated (per Wkst. B, Part II) 207.00 Cost to be allocated (per Wkst. B, Part II) 208.00 Cost to be allocated (per Wkst. B, Part II) 209.00 Cost to be allocated (per Wkst. B, Part II) 209.00 Cost to be allocated (per Wkst. B, Part II)					-	-	- 1		
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194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 194.00 200.00 201.00 Cross Foot Adjustments 0 0 0 0 0 0 194.00 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 0 201.00 201.00 Cost to be allocated (per Wkst. B, Part I) Unit cost multiplier (Wkst. B, Part I) 0.00000 72.355424 0.00000 0.00000 0.00000 203.00 204.00 Part II)					0	_	-		
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202.00									
203.00 Part I) Unit cost multiplier (Wkst. B, Part I) 0.000000 72.355424 0.000000 0.000000 0.000000 203.00 204.00 27,145 0 0 0 204.00 2			,		805 750	0	0	0	
203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 72.355424 0.000000 0.000000 0.000000 203.00 Cost to be allocated (per Wkst. B, Part II) 0.000000 27,145 0 0 0 204.00	202.00			1	003, 730	O	٥	O	202.00
204.00 Cost to be allocated (per Wkst. B, 0 27,145 0 0 204.00	203 00		0 000000		72 355424	0 000000	0 000000	0 000000	203 00
Part II)	1		0.00000						
	201100			1	277 . 10	Š	Ĭ	ŭ	2011 00
	205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000		2. 437590	0. 000000	0. 000000	0.000000	205. 00
206.00 NAHE adjustment amount to be allocated 0 206.00	206. 00	1 *						0	206. 00
(per Wkst. B-2)		(per Wkst. B-2)							
207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 207.00	207. 00							0.000000	207. 00
Parts III and IV)		Parts III and IV)							

				T	o 12/31/2023 Date/Time Pre 5/30/2024 7:4	
		INTERNS &	RESI DENTS			
	Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED		
		Y & FRINGES	PRGM COSTS	PRGM		
		(ASSI GNED TI ME)	(ASSIGNED TIME)	(ASSI GNED TI ME)		
		21.00	22.00	23.00		
1 00	GENERAL SERVI CE COST CENTERS		T	T		1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP					1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5.00	00500 ADMINISTRATIVE & GENERAL					5. 00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT					6. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00	00900 HOUSEKEEPI NG					9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A					10.00
12. 00	01200 MAINTENANCE OF PERSONNEL					12. 00
13. 00	01300 NURSING ADMINISTRATION					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY					15. 00 16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)					18.00
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM					19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0				21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD		0			22. 00
23. 00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS			100		23. 00
30. 00	03000 ADULTS & PEDIATRICS	0	0	0		30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0	O		31. 00
31. 01	03101 NEONATAL INTENSIVE CARE	0	0	0		31. 01
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0		0		32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	Ö	Ö	Ö		34. 00
40.00	04000 SUBPROVI DER - I PF	0	0	0		40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	0	0		41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	Ö	Ö		44. 00
45. 00	04500 NURSING FACILITY	0				45. 00
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0	0		46. 00
50. 00	05000 OPERATING ROOM	0	0	0		50.00
51. 00	05100 RECOVERY ROOM	0	0	0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0		52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0		0		53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	O		55. 00
56. 00	1 1	0	0	0		56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI)	0		0		57. 00 58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	Ö	Ö	Ö		59. 00
60.00	06000 LABORATORY	0	0	0		60.00
60. 01 61. 00	O6001 BLOOD LABORATORY O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0		60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	o		62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0		63. 00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0	0	0		64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0		Ö		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0		67. 00
68. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	0		68. 00
69. 00 70. 00	07000 ELECTROENCEPHALOGRAPHY			0		69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	Ö	Ö		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0		72. 00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0		0		73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	Ö	0	Ö		75. 00
76. 00	03140 CARDI OLOGY	0	0	0		76. 00
77. 00 78. 00	07700 ALLOGENEIC HSCT ACQUISITION 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0		77. 00 78. 00
10.00	OUTPATIENT SERVICE COST CENTERS	. 0		n O		70.00
	08800 RURAL HEALTH CLINIC	0	B .			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		89. 00

Peri od: From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 7: 46 am Provider CCN: 15-0018

NATERNS & RESIDENTS SERVICES					10	5 12/31/2023 Date/lime F 5/30/2024 7	
PRINCES PRINCES PRINCES PRINCES CASSIGNED THE			INTERNS &	RESI DENTS		07 007 2021 7	. 10 uiii
PRINCES PRINCES PRINCES PRINCES CASSIGNED THE							
ASSIGNED TIME)	Cost Center Description						
THE							
21.00 22.00 23.00 20.00 20.00 90.0							
0.00 0.0000 0.0000 0.0							
90. 01 04950 SLEEP CLINIC 0 0 0 0 0 0 92.00 97.0	00.00.000000000000000000000000000000000						00.00
91.00 97100 BERERENCY 9 0 100 971.00 92.00 92.00 920.00 BESTRATION BEDS (NON-DISTINCT PART) 92.00 970.00 985.00 985.00 995.00			-	-			
92.00			0				
OTHER REIMBURSABLE COST CENTERS 0 0 0 94, 00 94, 00 940 00 940 00 940 00 940 00 950 00 0		NCT DADT)		U	100		
94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 95. 00 950. 00 950. 00 960. 00 940. 00 940. 00 960. 00		INCI IAKI)					72.00
95.00 09500 AMBULANCE SERVICES 0 0 0 95.00 97.00 09700 OURABLE WEDI CAL EQUIP P-RENTED 0 0 0 97.00 97.00 09700 OURABLE WEDI CAL EQUIP P-RENTED 0 0 0 97.00 98.00 09800 OURABLE WEDI CAL EQUIP P-SOLD 0 0 0 0 97.00 99.00 09800 OURABLE WEDI CAL EQUIP P-SOLD 0 0 0 0 97.00 99.00 09900 CMMC 0 0 0 0 0 99.00 99.00 09900 CMMC 0 0 0 0 0 99.00 99.00 09900 CMMC 0 0 0 0 0 99.00 100.00 1000 1000 1000 1000 1000 1000 1000 101.00 10100 MED FRATTH AGENCY 0 0 0 0 101.00 102.00 10200 091 01 TREATMENT PROGRAM 0 0 0 0 101.00 105.00 10500 KI DNEY ACQUIS IT TON 0 0 0 105.00 106.00 10500 KI DNEY ACQUIS IT TON 0 0 0 105.00 106.00 10500 KI DNEY ACQUIS IT TON 0 0 0 105.00 107.00 10700 LART ACQUIS IT TON 0 0 0 106.00 108.00 10800 LARGA ACQUIS IT TON 0 0 0 1000 108.00 10800 LARGA ACQUIS IT TON 0 0 0 1000 109.00 10900 PARCAGEAS ACQUIS IT TON 0 0 0 110.00 101.00 11000 INTESTI NAL ACQUIS IT TON 0 0 0 111.00 110.00 11000 SLET ACQUIS IT TON 0 0 0 0 111.00 110.00 11000 SLET ACQUIS IT TON 0 0 0 0 111.00 110.00 11000 UTLE TATIO IN REVIEW-SNF 0 0 0 111.00 110.00 11000 UTLE TATIO IN REVIEW-SNF 0 0 0 115.00 110.00 11000 MSULATORY SURGICAL CENTER (D.P.) 0 0 0 0 115.00 110.00 11000 RESPECACH 0 0 0 0 119.00 110.00 11000 RESPECACH 0 0 0 0 119.00 110.00 11000 RESPECACH 0 0 0 0 119.00 110.00 11000 RESPECACH 0 0 0 0 119.00 110.00 11000 RESPECACH 0 0 0 0 119.00 110.00 11000 RESPECACH 0 0 0 0 119.00 110.00 11000 RESPECACH 0 0 0 0 0 119.00 110.00 11000 RESPECACH 0 0 0 0 0 0 119.00 110.00 11000 RESPECACH 0 0 0 0 0 0 0 0 0 110.00 11000 RESPECACH			0	0	0		94 00
96.00 09600 09680 DURABLE MEDI CAL EQUIP - PRENTED 0 0 0 0 97.00 97.00 98.00 98.00 98.00 98.00 98.00 98.00 99.00 9			0	-			
97. 00 09700 DURABLE MEDI CAL EQUI P-SQLD		ΞD	0	-	- 1		
98.00	l		0	0	0		
99. 00 09900 CMHC 99. 10 09910 CORF 0 0 0 0 0 99. 10 99. 10 09910 CORF 0 0 0 0 0 0 0 100. 00 10000 LAR SERVICES-NOT APPRVD PRCM 0 0 0 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00		NTERS	0	-	· ·		
100.00 10000 LAR SERVICES-NOT APPRVD PRGM	l		0	0	0		99. 00
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00	99. 10 09910 CORF		o	0	0		99. 10
102.00 102.00 OPI OI D TREATMENT PROGRAM 0 0 0 0 102.00	100.00 10000 I&R SERVICES-NOT APPRVD PR	GM	0	0	0		100.00
SPECIAL PURPOSE COST CENTERS	101.00 10100 HOME HEALTH AGENCY		0	0	0		101.00
105. 00 10500 IDNEY ACQUISITION	102.00 10200 OPI OID TREATMENT PROGRAM		0	0	0		102. 00
106. 00 10500 107000 107000 107000 107000 107000 107000 10700 10700 107000 107000 107000 107000	SPECIAL PURPOSE COST CENTERS						
107. 00 10700 LUVER ACQUISITION			0	0	0		
108. 00 10800 LUNG ACQUISITION 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 1000 11100 111000 11100 11100 111000 11100 111000 111000 111000 111000 111000 111000 111	1 1		0	0	0		
109.00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1 1		0	-	-		
110. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 1110. 00 1110. 01 11100 ISLET ACQUISITION 0 0 0 0 0 0 0 1111. 00 1113. 00 113.00 INTERST EXPENSE 113. 00 11400 UTIL LIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 0 116. 00 116			0	0	0		
111. 00 11300 I SLET ACQUISITION 0 0 0 0 113. 00 11300 I STEREST EXPENSE 114. 00 11400 UTILIZATION REVIEW-SNF 114. 00 11500 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 115. 00 115. 00 116. 00 11600 HOSPICE 0 0 116. 00 11600 HOSPICE 0 0 116. 00 11600 HOSPICE 0 0 116. 00 11600 HOSPICE 0 118. 00 119. 00			0	-	· ·		
113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 115.00 116.00 11600 HOSPICE 0 0 0 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 0 0 100 100 100			0	0	0		
114.00			0	0	0		
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 116.00 116.00 116.00 116.00 116.00 100 116.00							
116.00 11600 HOSPICE SUBTOTALS (SUM OF LINES 1 through 117) 0 0 100 118.00 118.00 118.00 118.00 118.00 100 100 118.00		(D. D.)					
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 0 0 100 100 100 118.00 100		(D. P.)	0	Ü	T		
NONREI MBURSABLE COST CENTERS 190.00 191000 191000 191000 191000 191000 19100 19100 19100 19100 19100 19100 19100		LL 117)		0			1
190. 00		through 117)	l O	U	100		118.00
191.00 19100 RESEARCH 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 19300 NONPAID WORKERS 0 0 0 0 0 19300 NONPAID WORKERS 0 0 0 0 0 193.00 19300 NONPAID WORKERS 0 0 0 0 0 193.00 193.00 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 193.01 194.00 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 205.00 WAHE adjustment amount to be allocated (per Wkst. B, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 0.000000 78.360000 207.00 207.00 207.00		R CANTEEN		0	0		190 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 193.00 19300 NONPAID WORKERS 0 0 0 0 0 193.00 19300 NONPAID WORKERS 0 0 0 0 0 193.00		X CANTLLIN	0				1
193.00 19300 NONPAID WORKERS 193.01 19301 COMMUNITY 0 0 0 0 193.01 19301 COMMUNITY 0 0 0 0 0 193.01 194.00 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 194.00 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part II) 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000 0.000000 0.000000 0.000000 0.000000		S	0	-			
193. 01 19301 COMMUNITY 0 0 0 0 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	-	Ö		
194. 00			0	0	0		
200.00 201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. D, NAHE unit cost multiplier (Wkst. D, 200.00 201.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		CENTERS	0	0	-		
201.00 202.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B, Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 204.00 Cost to be allocated (per Wkst. B, Part II) 205.00 Unit cost multiplier (Wkst. B, Part III) 206.00 NAHE adjustment amount to be allocated (per Wkst. B, Part III) 207.00 NAHE unit cost multiplier (Wkst. D, O.00000) NAHE unit cost multiplier (Wkst. D, O.00000) NAHE unit cost multiplier (Wkst. D, O.00000) 201.00 0.000000 1,078.650000 1,078.650000 7,836 203.00 7,836 205.00 0.000000 7,836 0.000000 0.000000 7,836 0.000000 0.000000 7,836 0.000000 205.00 206.00 207.00		02.112.10		J			
202.00 Cost to be allocated (per Wkst. B, Part I) 0.000000 1,078.65 202.00 203.00 Unit cost multiplier (Wkst. B, Part I) 0.000000 1,078.650000 203.00 204.00 Cost to be allocated (per Wkst. B, Part II) 0.000000 0.000000 7,836 204.00 205.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 0.000000 78.360000 205.00 11) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 0.000000 0.000000 207.00							
Part 1) Unit cost multiplier (Wkst. B, Part 1) 0.000000 1,078.650000 203.00 204.00 Cost to be allocated (per Wkst. B, Part 1) Unit cost multiplier (Wkst. B, Part 1) Unit cost multiplier (Wkst. B, Part 1) Unit cost multiplier (Wkst. B, Part 1) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 78.360000 205.00 11) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 207.00 207	1 1 3	Vkst. B.	0	0	107, 865		
204.00 Cost to be allocated (per Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) Unit cost multiplier (Wkst. B, Part II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, III) 0.0000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000	, , ,			_	,		
Part II) Unit cost multiplier (Wkst. B, Part 0.000000 78.360000 205.00 II) 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 207.00	203.00 Unit cost multiplier (Wkst	B, Part I)	0. 000000	0. 000000	1, 078. 650000		203. 00
205.00 Unit cost multiplier (Wkst. B, Part II) 0.000000 78.360000 206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0 0.000000 207.00 NAHE unit cost multiplier (Wkst. D, O.000000) 0.000000 0.000000	204.00 Cost to be allocated (per	Wkst. B,	0	0	7, 836		204. 00
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 207.00	Part II)						
206.00 NAHE adjustment amount to be allocated (per Wkst. B-2) 0 206.00 207.00 NAHE unit cost multiplier (Wkst. D, 0.000000) 207.00		B, Part	0. 000000	0. 000000	78. 360000		205. 00
(per Wkst. B-2) NAHE unit cost multiplier (Wkst. D, 0.000000 207.00							
207.00 NÄHE unit cost multiplier (Wkst. D, 0.000000 207.00		be allocated			0		206. 00
	1 1 1	()MI 1 5			0 0000		007 00
raitS iii dilu IV)		(WKST. D,			0.000000		207.00
	raits III and IV)		ı l	l			I

		ocial Systems OF RATIO OF COSTS TO CHARGES	ELKHART GENER	AL HOSPITAL Provi der C	CN: 15-0018	Peri od:	worksheet C	2552-10
						From 01/01/2023 To 12/31/2023	Part I Date/Time Pre 5/30/2024 7:4	pared:
				Title	XVIII	Hospi tal	5/30/2024 7: 4 PPS	6 am
				 	T	Costs		
		Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
			26) 1. 00	2.00	3.00	4. 00	5. 00	
		IENT ROUTINE SERVICE COST CENTERS	T					
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	59, 378, 082		59, 378, 08 12, 758, 08			30. 00 31. 00
31.00		NEONATAL INTENSIVE CARE	12, 758, 082 1, 515, 306		1, 515, 30			
32. 00		CORONARY CARE UNIT	1, 313, 300		1, 313, 30	o o	0	32. 00
33. 00	1	BURN INTENSIVE CARE UNIT	0		•	o o	0	33. 00
34.00		SURGICAL INTENSIVE CARE UNIT	0			0 0	0	34. 00
40. 00		SUBPROVI DER - I PF	4, 016, 508		4, 016, 50	8 0	4, 016, 508	
41. 00 43. 00		SUBPROVIDER - IRF NURSERY	5, 286, 644		5, 286, 64	4	5, 286, 644	41. 00 43. 00
44. 00	1	SKILLED NURSING FACILITY	0, 200, 044		3, 200, 04	0 0	0, 200, 044	44. 00
45.00		NURSING FACILITY	0			0 0	0	1
46. 00		OTHER LONG TERM CARE	0			0 0	0	46. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	36, 501, 750		36, 501, 75	0 0	36, 501, 750	50.00
51.00		RECOVERY ROOM	30, 301, 730		30, 301, 73	0 0	30, 301, 730	51.00
52. 00		DELIVERY ROOM & LABOR ROOM	0			o o	Ö	52. 00
53. 00		ANESTHESI OLOGY	0			0 0	0	53. 00
54. 00		RADI OLOGY - DI AGNOSTI C	13, 382, 557		13, 382, 55	7 0		
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	0			0	0	55. 00 56. 00
57. 00		CT SCAN	2, 792, 782		2, 792, 78	2 0	1	
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	1, 354, 351		1, 354, 35		1, 354, 351	1
59. 00		CARDI AC CATHETERI ZATI ON	2, 841, 381		2, 841, 38		2, 841, 381	
60.00		LABORATORY	12, 054, 877		12, 054, 87	7 0	12, 054, 877	60.00
60. 01 61. 00		BLOOD LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	60. 01 61. 00
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 0	Ö	62. 00
63.00		BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	63. 00
64. 00		I NTRAVENOUS THERAPY	2, 685, 348		2, 685, 34		2, 685, 348	1
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	4, 560, 207 3, 000, 086	0	4, 560, 20 3, 000, 08		4, 560, 207 3, 000, 086	65. 00 66. 00
67.00		OCCUPATIONAL THERAPY	1, 237, 937	0	1, 237, 93		1, 237, 937	67. 00
68. 00		SPEECH PATHOLOGY	485, 361	0	485, 36		485, 361	
69. 00	1	ELECTROCARDI OLOGY	0			0 0	0	69. 00
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	297, 532		297, 53	0	0 297, 532	70. 00 71. 00
72.00		IMPL. DEV. CHARGED TO PATIENTS	33, 632, 222		33, 632, 22			
73.00	07300	DRUGS CHARGED TO PATIENTS	34, 205, 875		34, 205, 87		34, 205, 875	
		RENAL DIALYSIS	0		1	0	-	
		ASC (NON-DISTINCT PART) CARDIOLOGY	4, 211, 904		4, 211, 90	0 0	0 4, 211, 904	
77. 00		ALLOGENEIC HSCT ACQUISITION	4,211,704		4, 211, 90	0 0		77. 00
78. 00	07800	CAR T-CELL IMMUNOTHERAPY	0			0 0	0	78. 00
		TIENT SERVICE COST CENTERS			1			
88. 00 89. 00		RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	88. 00 89. 00
90.00		CLINIC	840, 004		840, 00	-	840, 004	1
90. 01		SLEEP CLINIC	587, 844		587, 84	4 0	587, 844	
91. 00		EMERGENCY	16, 677, 334		16, 677, 33		16, 677, 334	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS	14, 018, 481		14, 018, 48	1	14, 018, 481	92. 00
94. 00		HOME PROGRAM DIALYSIS	0			0 0	0	94. 00
95.00		AMBULANCE SERVICES	0			0 0	0	95. 00
96.00		DURABLE MEDICAL EQUIP-RENTED	0			0	0	96. 00
97. 00 98. 00		DURABLE MEDICAL EQUIP-SOLD OTHER REIMBURSABLE COST CENTERS	0		•	0	0	97. 00 98. 00
	09900		0			o	0	99.00
99. 10			0			О	0	99. 10
		I &R SERVI CES-NOT APPRVD PRGM	0			0		
		HOME HEALTH AGENCY OPIOID TREATMENT PROGRAM	0			0		101. 00 102. 00
102.00		AL PURPOSE COST CENTERS	0			<u> </u>	0	102.00
	10500	KIDNEY ACQUISITION	0			0		105. 00
		HEART ACQUISITION	0			0		106. 00
		LIVER ACQUISITION	0			U O		107. 00 108. 00
		LUNG ACQUISITION PANCREAS ACQUISITION	0			o		108.00
110.00	11000	INTESTINAL ACQUISITION	0			О	0	110. 00
111.00	11100	ISLET ACQUISITION	0			o	0	111. 00

Health Financial Systems	ELKHART GENER	ELKHART GENERAL HOSPITAL			In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co	CN: 15-0018	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/30/2024 7:4			
		Ti tl e	XVIII	Hospi tal	PPS			
				Costs				
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Cost	s RCE Di sal I owance	Total Costs			

		Part I, col.					
		26)					
		1.00	2. 00	3. 00	4. 00	5. 00	
113. 00 113	00 INTEREST EXPENSE						113. 00
114. 00 114	00 UTILIZATION REVIEW-SNF						114. 00
115. 00 115	OO AMBULATORY SURGICAL CENTER (D. P.)	0		0		0	115. 00
116. 00 116	00 HOSPI CE	0		0		0	116. 00
200.00	Subtotal (see instructions)	268, 322, 455	0	268, 322, 455	0	268, 322, 455	200. 00
201.00	Less Observation Beds	14, 018, 481		14, 018, 481		14, 018, 481	201. 00
202.00	Total (see instructions)	254, 303, 974	0	254, 303, 974	0	254, 303, 974	202. 00

Health Financial Systems

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

					5/30/2024 7: 4	6 am
			XVIII	Hospi tal	PPS	
Cost Center Description	I npati ent	Charges Outpatient	Total (col. 6	Cost or Other	TEFRA	
cost center bescription	Tripati erit	outpatrent	+ col . 7)	Ratio	Inpati ent	
			' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	Na tr o	Ratio	
	6. 00	7. 00	8. 00	9. 00	10. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	122, 323, 768		122, 323, 768			30.00
31. 00 03100 INTENSIVE CARE UNIT	31, 806, 916		31, 806, 916			31.00
31. 01 03101 NEONATAL INTENSIVE CARE 32. 00 03200 CORONARY CARE UNIT	2, 412, 805		2, 412, 80			31. 01 32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0					33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0					34. 00
40. 00 04000 SUBPROVI DER - 1 PF	6, 641, 038	•	6, 641, 038	3		40.00
41. 00 04100 SUBPROVI DER - I RF	0					41. 00
43. 00 04300 NURSERY	3, 934, 551		3, 934, 55	I		43. 00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0					44. 00
45. 00 04500 NURSING FACILITY	0		9			45. 00
46.00 O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0			<u>/ </u>		46. 00
50. 00 05000 OPERATING ROOM	59, 689, 837	100, 591, 459	160, 281, 290	0. 227736	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0,,00,,00,	0	1	0.000000	0. 000000	
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0. 000000	0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	0		0. 000000	0. 000000	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	18, 344, 875	66, 556, 546	84, 901, 42		0. 000000	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0.00000	0. 000000	
56. 00 05600 RADI OI SOTOPE	0	0	(0. 000000	0. 000000	
57. 00 05700 CT SCAN	26, 498, 342	64, 831, 878			0.000000	1
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	3, 342, 588 20, 139, 278	9, 980, 971 30, 218, 972			0. 000000 0. 000000	
60. 00 06000 LABORATORY	49, 855, 034	39, 861, 728			0. 000000	1
60. 01 06001 BLOOD LABORATORY	17,000,004	07,001,720	07,710,702	0. 000000	0. 000000	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	Ö		0. 000000	0. 000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0. 000000	0.000000	1
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0. 000000	0. 000000	63.00
64.00 06400 INTRAVENOUS THERAPY	2, 027, 801	2, 988, 988			0. 000000	1
65. 00 06500 RESPI RATORY THERAPY	19, 120, 760	3, 792, 346			0. 000000	1
66. 00 06600 PHYSI CAL THERAPY	3, 347, 599	3, 273, 809			0.000000	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	2, 982, 643	1, 211, 714			0.000000	1
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	784, 409	622, 355	1, 406, 76	0. 345019 0. 000000	0. 000000 0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0.00000	0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	840, 242	1, 048, 550	1, 888, 792		0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	89, 304, 754	107, 013, 874			0.000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	73, 329, 299	136, 496, 200	209, 825, 499	0. 163021	0. 000000	73. 00
74. 00 07400 RENAL DI ALYSI S	0	0		0. 000000	0. 000000	
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	(0.000000	0.000000	
76. 00 03140 CARDI OLOGY 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON	7, 861, 678	23, 697, 856	31, 559, 534		0.000000	
77.00 07700 ALLOGENEIC HSCT ACQUISITION 78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0		0. 000000 0. 000000	0. 000000 0. 000000	1
OUTPATIENT SERVICE COST CENTERS			1	0.00000	0.00000	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	(88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89. 00
90. 00 09000 CLI NI C	1, 413	1, 134, 064	1, 135, 47	0. 739781	0. 000000	90. 00
90. 01 04950 SLEEP CLINIC	0	2, 658, 640			0. 000000	1
91. 00 09100 EMERGENCY	11, 183, 280				0.000000	1
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	6, 560, 482	28, 844, 737	35, 405, 219	0. 395944	0. 000000	92.00
94.00 OTHER REIMBURSABLE COST CENTERS 94.00 O9400 HOME PROGRAM DI ALYSI S	0	0		0. 000000	0. 000000	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	1	0.00000	0. 000000	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	Ö	1		0. 000000	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0. 000000	0.000000	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0. 000000	0. 000000	98. 00
99. 00 09900 CMHC	0	0				99. 00
99. 10 09910 CORF	0	0				99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0				100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	1			101.00
102.00 10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0	0	1)		102. 00
105. 00 10500 KIDNEY ACQUISITION	0	0				105. 00
106. 00 10600 HEART ACQUISITION	0	Ö	1	Ó		106. 00
107. 00 10700 LIVER ACQUISITION	0	0				107. 00
108.00 10800 LUNG ACQUISITION	0	0				108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	1			109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	1			110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0	"	ן		111.00
113. 00 11300 I NTEREST EXPENSE			<u> </u>	<u> </u>		113. 00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/30/2024 7:4	
		Titl∈	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o	C		0		115. 00
116. 00 11600 HOSPI CE	o	C		0		116. 00
200.00 Subtotal (see instructions)	562, 333, 392	658, 149, 521	1, 220, 482, 91	3		200. 00

562, 333, 392

658, 149, 521 1, 220, 482, 913

201. 00 202. 00

Subtotal (see instructions)
Less Observation Beds
Total (see instructions)

Title XVIII

		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient		<u> </u>	
	Rati o			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31.00 03100 I NTENSI VE CARE UNIT				31.00
31. 01 03101 NEONATAL INTENSIVE CARE				31. 01
32. 00 03200 CORONARY CARE UNIT				32. 00
33.00 03300 BURN INTENSIVE CARE UNIT				33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34. 00
40. 00 04000 SUBPROVI DER - 1 PF				40. 00
41. 00 04100 SUBPROVI DER - I RF				41. 00
43. 00 04300 NURSERY				43. 00
44.00 04400 SKILLED NURSING FACILITY				44. 00
45.00 04500 NURSING FACILITY				45. 00
46.00 O4600 OTHER LONG TERM CARE				46. 00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 227736			50.00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000			52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 157625			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI 01 SOTOPE	0. 000000			56. 00
57. 00 05700 CT SCAN	0. 030579			57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 101651			58. 00
59. 00 05900 CARDIAC CATHETERIZATION	0. 056423			59.00
60. 00 06000 LABORATORY	0. 036423			60.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0. 134366			60.00
	1			
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 535272			64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 199022			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 453089			66. 00
67. 00 06700 0CCUPATI ONAL THERAPY	0. 295143			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 345019			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 157525			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 171314			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 163021			73. 00
74.00 07400 RENAL DIALYSIS	0. 000000			74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 00 03140 CARDI OLOGY	0. 133459			76. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0. 000000			78. 00
OUTPATIENT SERVICE COST CENTERS	0.000000			70.00
88. 00 08800 RURAL HEALTH CLINIC				88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89. 00
90. 00 09000 CLINI C	0. 739781			90.00
90. 01 04950 SLEEP CLINIC	0. 221107			90.00
91. 00 09100 EMERGENCY	0. 221107			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 395944			92. 00
OTHER REIMBURSABLE COST CENTERS	0.000000			04.00
94. 00 09400 HOME PROGRAM DIALYSIS	0.000000			94.00
95. 00 09500 AMBULANCE SERVICES	0.000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98. 00
99. 00 09900 CMHC				99. 00
99. 10 09910 CORF				99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				100. 00
101.00 10100 HOME HEALTH AGENCY				101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM				102. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KIDNEY ACQUISITION				105. 00
106. 00 10600 HEART ACQUISITION				106. 00
107. 00 10700 LIVER ACQUISITION				107. 00
108. 00 10800 LUNG ACQUISITION				108. 00
109. 00 10900 PANCREAS ACQUISITION				109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON				110.00
111. 00 11100 SLET ACQUISITION	1			111.00
113. 00 11300 INTEREST EXPENSE				113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	1			114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115. 00
113. OUTTOUUTAMBULATURT SURGICAL CENTER (D. P.)				[115.00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 15-0018	Peri od: From 01/01/2023 To 12/31/2023		
		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
116. 00 11600 HOSPI CE					116. 00
200.00 Subtotal (see instructions)					200.00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

	Financial Systems	ELKHART GENER			In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der C	F	eriod: rom 01/01/2023 o 12/31/2023	Date/Time Pre	pared:
			Ti tI	e XIX	Hospi tal	5/30/2024 7: 4 PPS	<u>6 am</u>
	·				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		ı				
30.00	03000 ADULTS & PEDIATRICS	59, 378, 082	ł	59, 378, 082		59, 378, 082	30.00
31.00	03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE	12, 758, 082		12, 758, 082		12, 758, 082	31.00
31. 01 32. 00	03200 CORONARY CARE UNIT	1, 515, 306		1, 515, 306		1, 515, 306 0	31. 01 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0			0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	o o		ĺ	Ö	Ö	34.00
40.00	04000 SUBPROVI DER - I PF	4, 016, 508		4, 016, 508	0	4, 016, 508	1
41.00	04100 SUBPROVI DER - I RF	0		0	0	0	41. 00
43.00	04300 NURSERY	5, 286, 644		5, 286, 644	0	5, 286, 644	1
44. 00	04400 SKILLED NURSING FACILITY	0		0	0	0	44. 00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0			0	0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS				0	0	40.00
50.00	05000 OPERATI NG ROOM	36, 501, 750		36, 501, 750	0	36, 501, 750	50.00
51.00	05100 RECOVERY ROOM	0		0	0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0		0	0	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	13, 382, 557		13, 382, 557	0	13, 382, 557 0	54. 00 55. 00
56. 00	05600 RADI OLOGI - THERAPEUTI C	0			0	0	56. 00
57. 00	05700 CT SCAN	2, 792, 782		2, 792, 782	0	2, 792, 782	•
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 354, 351		1, 354, 351		1, 354, 351	•
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 841, 381		2, 841, 381	0	2, 841, 381	59. 00
60.00	06000 LABORATORY	12, 054, 877		12, 054, 877	0	12, 054, 877	1
60. 01	06001 BLOOD LABORATORY	0		0	0	0	60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0 0	61. 00 62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	2, 685, 348		2, 685, 348	Ö	2, 685, 348	64.00
65.00	06500 RESPI RATORY THERAPY	4, 560, 207		4, 560, 207		4, 560, 207	65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 000, 086	ł .	3, 000, 086		3, 000, 086	1
67. 00	06700 OCCUPATI ONAL THERAPY	1, 237, 937	0	1, 237, 937		1, 237, 937	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	485, 361	0	485, 361 0		485, 361 0	68. 00 69. 00
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	0			0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	297, 532		297, 532	Ö	297, 532	•
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	33, 632, 222		33, 632, 222	0	33, 632, 222	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	34, 205, 875	l	34, 205, 875	0	34, 205, 875	1
74. 00	07400 RENAL DIALYSIS	0 0	l	0	_	0	74. 00
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY	4, 211, 904		0 4, 211, 904		0 4, 211, 904	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	4,211,704		4, 211, 704		0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0		Ö		0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0		0		0	88. 00
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	840, 004		840, 004	1	0 840, 004	89. 00 90. 00
90.00	04950 SLEEP CLINIC	587, 844		587, 844		587, 844	ı
91. 00	09100 EMERGENCY	16, 677, 334	ł	16, 677, 334		16, 677, 334	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	14, 018, 481		14, 018, 481		14, 018, 481	•
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DI ALYSI S	0		0	· ·	0	94. 00
95. 00 96. 00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0		0	0	0	95. 00 96. 00
97.00	09700 DURABLE MEDICAL EQUIP-RENTED	0			0	0	97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0		ĺ	Ö	ő	98. 00
99. 00	09900 CMHC	0		0)	0	99. 00
	09910 CORF	0		0)	0	99. 10
	10000 I &R SERVICES-NOT APPRVD PRGM	0		0		0	100.00
	10100 HOME HEALTH AGENCY 10200 OPIOID TREATMENT PROGRAM	0		0			101. 00 102. 00
102.00	SPECIAL PURPOSE COST CENTERS	0			1	0	102.00
105.00	10500 KIDNEY ACQUISITION	0		0		0	105. 00
	10600 HEART ACQUISITION	0		0			106. 00
	10700 LIVER ACQUISITION	0		0			107. 00
	10800 LUNG ACQUISITION	0		0			108.00
	10900 PANCREAS ACQUISITION 11000 INTESTINAL ACQUISITION						109. 00 110. 00
	111100 SLET ACQUISITION	0					111.00
	1		ı		I	·	1

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0018	Peri od: From 01/01/2023 To 12/31/2023	Worksheet C Part I Date/Time Pre 5/30/2024 7:4	
		Ti tl	e XIX	Hospi tal	PPS	
·		·		Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

Health Financial Systems	ELKHART GENERAL	HUSPITAL	In Lie	U OT FORM CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0018	Peri od:	Worksheet C
			From 01/01/2023	Part I
			To 12/31/2023	Date/Time Prepared:
				5/30/2024 7:46 am

			Ti +I	e XIX	Hospi tal	5/30/2024 7: 4 PPS	<u>6 am</u>
			Charges	C AIA	nospi tai	110	
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col. 7)	Rati o	Inpati ent	
		6. 00	7. 00	8. 00	9. 00	Rati o 10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	9.00	10.00	
30. 00	03000 ADULTS & PEDI ATRI CS	122, 323, 768		122, 323, 768	3		30. 00
31.00	03100 INTENSIVE CARE UNIT	31, 806, 916		31, 806, 916			31. 00
31. 01	03101 NEONATAL INTENSIVE CARE	2, 412, 805		2, 412, 80	5		31. 01
32.00	03200 CORONARY CARE UNIT	0			O		32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0			D		33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0		()		34.00
40.00	04000 SUBPROVI DER - I PF	6, 641, 038		6, 641, 038	3		40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	3, 934, 551		3, 934, 55	1		41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	3, 734, 551		3, 734, 33			44. 00
45. 00	04500 NURSING FACILITY	o					45. 00
46.00	04600 OTHER LONG TERM CARE	0		(o l		46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	59, 689, 837	100, 591, 459	160, 281, 29		0. 000000	
51.00	05100 RECOVERY ROOM	0	0		0.000000	0.000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0.000000	0.000000	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	18, 344, 875	66, 556, 546	84, 901, 42 ⁻	0. 000000 1 0. 157625	0. 000000 0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	10, 344, 675	00, 550, 540	04, 701, 42	0. 137023	0.00000	
56. 00	05600 RADI OI SOTOPE	0	0		0. 000000	0. 000000	
57. 00	05700 CT SCAN	26, 498, 342	64, 831, 878	91, 330, 220		0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	3, 342, 588	9, 980, 971			0. 000000	
59.00	05900 CARDI AC CATHETERI ZATI ON	20, 139, 278	30, 218, 972	50, 358, 250	0. 056423	0. 000000	59. 00
60.00	06000 LABORATORY	49, 855, 034	39, 861, 728	89, 716, 762		0. 000000	
60. 01	06001 BLOOD LABORATORY	0	0		0. 000000	0. 000000	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0.000000	0.000000	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0.000000	0.000000	
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	2, 027, 801	2, 988, 988	5, 016, 78	0. 000000 9 0. 535272	0. 000000 0. 000000	
65. 00	06500 RESPIRATORY THERAPY	19, 120, 760	3, 792, 346			0. 000000	
66. 00	06600 PHYSI CAL THERAPY	3, 347, 599	3, 273, 809			0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	2, 982, 643	1, 211, 714			0. 000000	
68.00	06800 SPEECH PATHOLOGY	784, 409	622, 355	1, 406, 764	0. 345019	0. 000000	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0. 000000	0. 000000	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000	0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	840, 242	1, 048, 550			0.000000	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	89, 304, 754	107, 013, 874			0.000000	
73. 00 74. 00	07400 RENAL DIALYSIS	73, 329, 299	136, 496, 200	209, 825, 49	0. 163021 0. 000000	0. 000000 0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0.00000	0. 000000	
76. 00	03140 CARDI OLOGY	7, 861, 678	23, 697, 856	31, 559, 53		0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0. 000000	0. 000000	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	(0.000000	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS			1			
	08800 RURAL HEALTH CLINIC	0	0		0.000000	0.000000	
89. 00 90. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 1, 413	1, 134, 064	1	0. 000000 7 0. 739781	0. 000000 0. 000000	
90. 00	04950 SLEEP CLINIC	1, 413	2, 658, 640			0.00000	
91. 00	09100 EMERGENCY	11, 183, 280	33, 324, 834			0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 560, 482	28, 844, 737			0. 000000	
	OTHER REIMBURSABLE COST CENTERS]
94.00	09400 HOME PROGRAM DIALYSIS	0	0	(0. 000000	0. 000000	94. 00
95.00	09500 AMBULANCE SERVICES	0	0		0. 000000	0. 000000	
96. 00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		0. 000000	0. 000000	
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		0.000000	0.000000	
98. 00 99. 00	O9850 OTHER REIMBURSABLE COST CENTERS O9900 CMHC	0	0		0.000000	0. 000000	98. 00 99. 00
	09910 CORF	0	0				99. 10
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0				100.00
	10100 HOME HEALTH AGENCY	o	0	1			101. 00
	10200 OPI OI D TREATMENT PROGRAM	0	0	1			102. 00
	SPECIAL PURPOSE COST CENTERS						
	10500 KIDNEY ACQUISITION	0	0		0. 000000	0. 000000	
	10600 HEART ACQUISITION	0	0		0.000000	0.000000	
	10700 LIVER ACQUISITION	0	0		0.000000	0.000000	
	10800 LUNG ACQUISITION 10900 PANCREAS ACQUISITION	0	0		0. 000000 0. 000000	0. 000000 0. 000000	
	11000 NTESTINAL ACQUISITION	0	0		0.000000	0. 000000	
	11100 SLET ACQUISITION	o	Ö	1	0. 000000	0. 000000	
	11300 I NTEREST EXPENSE		_	[113. 00
	•				'		

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Peri od: From 01/01/2023	Worksheet C Part I	
			-	To 12/31/2023	Date/Time Pre 5/30/2024 7:4	epared: 16 am
		Ti tl	e XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·	·	+ col. 7)	Ratio	Inpati ent	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0		115. 00
116. 00 11600 HOSPI CE	0	0		0		116. 00
200.00 Subtotal (see instructions)	562, 333, 392	658, 149, 521	1, 220, 482, 91	3		200. 00
201 00 Less Observation Reds						201 00

562, 333, 392

658, 149, 521 1, 220, 482, 913

201. 00 202. 00

Subtotal (see instructions)
Less Observation Beds
Total (see instructions)

Title XIX

		Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
, and the second second second second second second second second second second second second second second se	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	11.00				
30. 00 03000 ADULTS & PEDIATRICS					30. 00
31. 00 03100 INTENSIVE CARE UNIT					31.00
31. 01 03101 NEONATAL INTENSIVE CARE					31. 01
32. 00 03200 CORONARY CARE UNIT					32.00
33.00 03300 BURN INTENSIVE CARE UNIT					33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT					34.00
40. 00 04000 SUBPROVI DER - 1 PF					40.00
41. 00 04100 SUBPROVI DER - RF					41.00
43. 00 04300 NURSERY					43. 00
					44. 00
45. 00 04500 NURSI NG FACI LI TY					45. 00
46.00 O4600 OTHER LONG TERM CARE					46. 00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 227736				50.00
51. 00 05100 RECOVERY ROOM	0. 000000				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 157625				54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
56. 00 05600 RADI 0LOGY - THERAPEUTI C	1 1				56. 00
· · · · · · · · · · · · · · · · · · ·	0.000000				
57. 00 05700 CT SCAN	0. 030579				57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 101651				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 056423				59. 00
60. 00 06000 LABORATORY	0. 134366				60.00
60. 01 06001 BL00D LABORATORY	0. 000000				60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 535272				64. 00
1 I	1				
65. 00 06500 RESPI RATORY THERAPY	0. 199022				65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 453089				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 295143				67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 345019				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 157525				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 171314				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 163021				73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000				74. 00
	1				
	0.000000				75. 00
76. 00 03140 CARDI OLOGY	0. 133459				76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000				77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0. 000000				78. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC	0.000000				88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				89.00
90. 00 09000 CLI NI C	0. 739781				90.00
90. 01 04950 SLEEP CLINIC	0. 221107			İ	90. 01
91. 00 09100 EMERGENCY	0. 374703				91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 395944				92. 00
OTHER REIMBURSABLE COST CENTERS	0. 373744				, 00
	0. 000000				04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	1				94.00
95. 00 09500 AMBULANCE SERVI CES	0. 000000				95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98.00
99. 00 09900 CMHC					99. 00
99. 10 09910 CORF				İ	99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM				,	100. 00
101. 00 10100 HOME HEALTH AGENCY				l l	101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM					102. 00
SPECIAL PURPOSE COST CENTERS	0.05===				105 55
105. 00 10500 KI DNEY ACQUI SI TI ON	0. 000000				105. 00
106. 00 10600 HEART ACQUI SI TI ON	0. 000000				106. 00
107.00 10700 LIVER ACQUISITION	0. 000000			-	107. 00
108.00 10800 LUNG ACQUISITION	0. 000000			-	108. 00
109. 00 10900 PANCREAS ACQUISITION	0. 000000				109. 00
110. 00 11000 NTESTINAL ACQUISITION	0. 000000			•	110. 00
111. 00 11100 ISLET ACQUISITION	0. 000000				111.00
113. 00 11300 INTEREST EXPENSE	0.000000				111.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)					115. 00

ELKHART GENERAL	_ HOSPI TAL	In Lieu of Form CM		2552-10
	Provider CCN: 15-0018	Peri od:	Worksheet C	
		10 12/31/2023		
			5/30/2024 7: 4	6 am
	Title XIX	Hospi tal	PPS	
PPS Inpatient				
Ratio				
11. 00				
				116. 00
				200.00
				201.00
				202. 00
	PPS Inpatient Ratio	Title XIX PPS Inpatient Ratio	Provider CCN: 15-0018	Provider CCN: 15-0018

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

Period: Worksheet C
From 01/01/2023 Part II
To 12/31/2023 Date/Time Prepared: 5/30/2024 7:46 am Provider CCN: 15-0018

			10	12/31/2023	5/30/2024 7:4	
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	,		Net of Capital	Reduction	Reduction	
	I, col. 26)	11 (01. 26)	Cost (col. 1 - col. 2)		Amount	
	1. 00	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	36, 501, 750	2, 134, 176	34, 367, 574	0	0	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY - DI AGNOSTI C	12 202 557	1 710 174	11 //2 201	0	0	53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C 55. 00 05500 RADI OLOGY - THERAPEUTI C	13, 382, 557	1, 719, 176	11, 663, 381	0	0	54. 00 55. 00
56. 00 05600 RADI OI SOTOPE	0	0		0	0	56. 00
57. 00 05700 CT SCAN	2, 792, 782	261, 940	2, 530, 842	Ö	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 354, 351	129, 793		0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 841, 381	148, 589	2, 692, 792	0	0	59. 00
60. 00 06000 LABORATORY	12, 054, 877	203, 681	11, 851, 196	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62. 00 63. 00
64. 00 06400 NTRAVENOUS THERAPY	2, 685, 348	281, 969	2, 403, 379	0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	4, 560, 207	70, 600		Ö	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 000, 086	181, 181	2, 818, 905	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 237, 937	86, 479	1, 151, 458	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	485, 361	51, 644	433, 717	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	297, 532	U F 4F1	202 001	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	33, 632, 222	5, 451 541, 448		0	0	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	34, 205, 875			0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	01,200,070	0	00, 701, 700	Ö	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 00 03140 CARDI OLOGY	4, 211, 904	413, 766	3, 798, 138	0	0	76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0	0	0	78. 00
0UTPATI ENT SERVI CE COST CENTERS 88. 00 08800 RURAL HEALTH CLINI C	0	0	0	O	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	Ö	0	0	89. 00
90. 00 09000 CLI NI C	840, 004	172, 821	667, 183	0	0	90. 00
90. 01 04950 SLEEP CLINIC	587, 844	638	587, 206	0	0	90. 01
91. 00 09100 EMERGENCY	16, 677, 334	667, 105		0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	14, 018, 481	1, 336, 816	12, 681, 665	0]	0	92. 00
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S	1 0		0	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES	0	0		0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	Ö	Ö	Ö	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0 0	0	0	0		100. 00 101. 00
102.00 10200 OPI OI D TREATMENT PROGRAM	0	0	_	0		101.00
SPECIAL PURPOSE COST CENTERS			, o _l	<u> </u>	0	102.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUISITION	0	0	0	0		106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0	0	0		108.00
109. 00 10900 PANCREAS ACQUISITION 110. 00 11000 INTESTINAL ACQUISITION	0	0	0	0		109. 00 110. 00
111. 00 11100 SLET ACQUISITION	0	0		0		111.00
113. 00 11300 NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	o		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
200.00 Subtotal (sum of lines 50 thru 199)	185, 367, 833			0		200.00
201.00 Less Observation Beds 202.00 Total (line 200 minus line 201)	14, 018, 481 171, 349, 352	1, 336, 816 7, 291, 379		0		201. 00 202. 00
202.00 Total (True 200 IIII lus True 201)	171, 347, 352	1,291,3/9	104,007,973	٩	0	202.00

Provider CCN: 15-0018

Un Lieu of Form CMS-2552-10
Worksheet C
Part II
B1/2023 Part II
Date/Time Prepared:
5/30/2024 7:46 am

		Ti tl	e XIX	Hospi tal	PPS	<u>o ani</u>
Cost Center Description	Cost Net of	Total Charges				
	Capital and	(Worksheet C,	Cost to Charge			
	Operating Cost F	Part I, column	Ratio (col. 6			
	Reduction	8)	/ col. 7)			
	6.00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	36, 501, 750	160, 281, 296	0. 227736			50.00
51.00 05100 RECOVERY ROOM	0	C	0.000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C	0.000000			52.00
53. 00 05300 ANESTHESI OLOGY	0	C	0.000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	13, 382, 557	84, 901, 421	0. 157625			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	C	0.000000			55. 00
56. 00 05600 RADI 0I SOTOPE	0	C	0.000000			56. 00
57.00 05700 CT SCAN	2, 792, 782	91, 330, 220	0. 030579			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 354, 351	13, 323, 559	0. 101651			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 841, 381	50, 358, 250	0. 056423			59. 00
60. 00 06000 LABORATORY	12, 054, 877	89, 716, 762	0. 134366			60.00
60. 01 06001 BLOOD LABORATORY	0	C	0.000000			60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C	0.000000			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C	0.000000			62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0.000000			63.00
64.00 06400 INTRAVENOUS THERAPY	2, 685, 348	5, 016, 789	0. 535272			64.00
65. 00 06500 RESPIRATORY THERAPY	4, 560, 207	22, 913, 106	0. 199022			65. 00
66. 00 06600 PHYSI CAL THERAPY	3, 000, 086	6, 621, 408	0. 453089			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 237, 937	4, 194, 357	0. 295143			67. 00
68. 00 06800 SPEECH PATHOLOGY	485, 361	1, 406, 764	0. 345019			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	C	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o	C	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	297, 532	1, 888, 792				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	33, 632, 222	196, 318, 628				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	34, 205, 875	209, 825, 499				73. 00
74. 00 07400 RENAL DI ALYSI S	0	,, C				74. 00
75.00 07500 ASC (NON-DISTINCT PART)	o	C	0. 000000			75. 00
76. 00 03140 CARDI OLOGY	4, 211, 904	31, 559, 534				76. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0.,001,001	0.000000			77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	Ċ	1			78. 00
OUTPATIENT SERVICE COST CENTERS	-1	-				
88. 00 08800 RURAL HEALTH CLINIC	0	C	0.000000			88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o	C	0. 000000			89. 00
90. 00 09000 CLI NI C	840, 004	1, 135, 477				90.00
90. 01 04950 SLEEP CLINIC	587, 844	2, 658, 640				90. 01
91. 00 09100 EMERGENCY	16, 677, 334	44, 508, 114				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	14, 018, 481	35, 405, 219				92.00
OTHER REIMBURSABLE COST CENTERS			<u>'</u>			
94. 00 09400 HOME PROGRAM DIALYSIS	0	C	0.000000			94.00
95. 00 09500 AMBULANCE SERVICES	0	C	0. 000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	C	0. 000000			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	C	0. 000000			97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	C	0.000000			98. 00
99. 00 09900 CMHC	0	C	0. 000000			99.00
99. 10 09910 CORF	0	C	0.000000			99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	C				100.00
101.00 10100 HOME HEALTH AGENCY	o	C				101.00
102.00 10200 OPIOID TREATMENT PROGRAM	O	C				102.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0	C	0.000000			105. 00
106.00 10600 HEART ACQUISITION	0	C	0. 000000			106. 00
107. 00 10700 LIVER ACQUISITION	0	C	0.000000			107. 00
108.00 10800 LUNG ACQUISITION	0	C	0.000000			108. 00
109.00 10900 PANCREAS ACQUISITION	0	C	0. 000000			109.00
110.00 11000 INTESTINAL ACQUISITION	0	C	0. 000000			110.00
111.00 11100 ISLET ACQUISITION	0	C	0. 000000			111.00
113. 00 11300 NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)		C	0. 000000			115. 00
116. 00 11600 HOSPI CE		C	0. 000000			116. 00
200.00 Subtotal (sum of lines 50 thru 199)	185, 367, 833	1, 053, 363, 835				200. 00
201.00 Less Observation Beds	14, 018, 481	C				201. 00
202.00 Total (line 200 minus line 201)		1, 053, 363, 835	5			202. 00
			'			

Health Financial Systems	ELKHART GENER	AI HOSPITAI		In lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provi der C	Provider CCN: 15-0018		Worksheet D	pared:
		Title	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost		· ·	
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	5, 662, 327	0	5, 662, 32	27 42, 103	134, 49	30.00
31. 00 INTENSIVE CARE UNIT	488, 320	_	488, 32			
31. 01 NEONATAL INTENSIVE CARE	86, 198		86, 19			1
32. 00 CORONARY CARE UNIT	00,170		00, 1	0 002	0.00	1
33. 00 BURN INTENSIVE CARE UNIT	0				0.00	
34. 00 SURGICAL INTENSIVE CARE UNIT					0.00	1
40. 00 SUBPROVI DER - I PF	434, 592	_	434, 59	2, 744	•	
41. 00 SUBPROVIDER - TPF	434, 392		434, 35	0 2,744	0.00	
	270 101	U	270 16	0		
	379, 181		379, 18		l	1
44.00 SKILLED NURSING FACILITY	0			0	0.00	
45. 00 NURSING FACILITY	0		7 050 //	0		45. 00
200.00 Total (lines 30 through 199)	7, 050, 618		7, 050, 61	8 53, 514		200. 00
Cost Center Description	Inpatient	Inpatient				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)	1			
LABORT SALT DOUTLAND OFFICE OF	6. 00	7. 00				
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.070	4 047 000	.1			00.00
30. 00 ADULTS & PEDIATRICS	9, 279					30.00
31. 00 INTENSIVE CARE UNIT	1, 467	118, 856				31. 00
31.01 NEONATAL INTENSIVE CARE	0	0)			31. 01
32. 00 CORONARY CARE UNIT	0	0)			32. 00
33.00 BURN INTENSIVE CARE UNIT	0	0)			33. 00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0)			34.00
40. 00 SUBPROVI DER - I PF	103	16, 313	\$ 			40. 00
41. 00 SUBPROVI DER - I RF	0	0)			41.00
43. 00 NURSERY	0	0)			43. 00
44.00 SKILLED NURSING FACILITY	0	0)			44. 00
45.00 NURSING FACILITY	0	0)			45. 00
200.00 Total (lines 30 through 199)	10, 849	1, 383, 102	2			200.00
•	•		•			-

	Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-	2552-10
APP0R1	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der Co		Peri od:	Worksheet D	
					From 01/01/2023 To 12/31/2023	Part II Date/Time Pre	narod:
					10 12/31/2023	5/30/2024 7: 4	6 am
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	0.00	0.00			
	ANGLILADY CEDVICE COCT CENTEDS	1.00	2. 00	3. 00	4. 00	5. 00	
EO 00	ANCI LLARY SERVI CE COST CENTERS	2 124 174	1/0 201 20/	0.01221	T 10 (01 0(0	240.072	 EO OO
50.00	05000 OPERATING ROOM	2, 134, 176	160, 281, 296			248, 872 0	ł
51.00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0	0. 00000 0. 00000		0	52.00
52. 00 53. 00	05300 ANESTHESI OLOGY	0	0			0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 719, 176	84, 901, 421	0. 00000 0. 02024		١	
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, /19, 1/6	84, 901, 421	0. 02024		93, 900	55.00
56. 00	05600 RADI OLOGY - THERAPEUTI C	0	0			0	ł
57. 00	05700 CT SCAN	2/1 0/0	01 220 220	0.00000		1	
58. 00		261, 940		0.00286			
	05800 MAGNETIC RESONANCE I MAGING (MRI)	129, 793		0.00974			
59. 00	05900 CARDI AC CATHETERI ZATI ON	148, 589					
60.00	06000 LABORATORY	203, 681	89, 716, 762	0. 00227			
60. 01	06001 BLOOD LABORATORY	0	0	0. 00000	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.00000		0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63.00
64.00	06400 I NTRAVENOUS THERAPY	281, 969					•
65. 00	06500 RESPI RATORY THERAPY	70, 600					1
66. 00	06600 PHYSI CAL THERAPY	181, 181	6, 621, 408				
67. 00	06700 OCCUPATI ONAL THERAPY	86, 479		0. 02061		20, 580	
68. 00	06800 SPEECH PATHOLOGY	51, 644	1, 406, 764			1	
69. 00	06900 ELECTROCARDI OLOGY	0	0	0. 00000		0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 451	1, 888, 792	0. 00288		l	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	541, 448				88, 726	
73. 00	07300 DRUGS CHARGED TO PATIENTS	220, 922	209, 825, 499			l	
74. 00	07400 RENAL DIALYSIS	0	0	0. 00000		0	74. 00
75. 00	07500 ASC (NON-DI STINCT PART)	0	0	0.00000		0	
76. 00	03140 CARDI OLOGY	413, 766	31, 559, 534				
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0.00000		0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	0 0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS			0.0000			00.00
88. 00	08800 RURAL HEALTH CLINIC	0	0				
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	170 001	1 105 477	0.00000			89.00
90.00	09000 CLINIC	172, 821				l	90.00
90. 01	04950 SLEEP CLINIC	638		0.00024		0	90. 01
91.00	09100 EMERGENCY	667, 105					
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 336, 816	35, 405, 219	0. 03775	1, 338, 842	50, 552	92.00
04.00	OTHER REIMBURSABLE COST CENTERS			0.0000			04.00
94.00	09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	0	0	
95. 00	09500 AMBULANCE SERVICES		_	0.0000		_	95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED			0.00000		0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0		0.00000		0	97. 00
98. 00 200. 00	09850 OTHER REIMBURSABLE COST CENTERS	0 420 105	1 052 242 025	0. 00000		0 771, 789	98. 00
∠∪∪. ∪(Total (lines 50 through 199)	ο, ο∠δ, 195	1, 053, 363, 835	I	118, 001, 587	//1,/89	∠∪∪. ∪∪

32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGI CAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY	0 0 0 0 0	000000000000000000000000000000000000000	0 0 0	000000000000000000000000000000000000000	0 0 0 0 0	33. 00 34. 00 40. 00 41. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0		44. 00
45. 00 04500 NURSING FACILITY	0	0	0	0		45. 00
200.00 Total (lines 30 through 199) Cost Center Description	Cwing Dod	Tatal Casts	Total Dotiont	Don Diam (asl	Inpati ent	200. 00
cost center bescription	Swing-Bed Adjustment Amount (see instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	Total Patient Days	5 ÷ col. 6)	Program Days	
LAIDATI FAIT DOUTLAIF CEDIU OF COCT OFAITEDO	4. 00	5. 00	6.00	7. 00	8. 00	
30.00 O3000 ADULTS & PEDIATRICS	0		42, 103	0.00	9, 279	30.00
31. 00 03100 ADDLI'S & PEDITATRICS 31. 00 03100 INTENSI VE CARE UNIT 31. 01 03101 NEONATAL INTENSI VE CARE 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSI VE CARE UNIT	U	0 0	6, 027 652 0 0	0.00 0.00 0.00 0.00 0.00	9, 279 1, 467 0 0	31. 00 31. 01 32. 00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF 43. 00 04300 NURSERY 44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0 0 0 0	0 2, 744 0 1, 988 0	0. 00 0. 00 0. 00 0. 00 0. 00	0 103 0 0 0	40. 00 41. 00 43. 00
45.00 04500 NURSING FACILITY 200.00 Total (lines 30 through 199)		0	0 53, 514	0. 00	10.840	45. 00 200. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		50, 511		10, 01,	200. 00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
31. 00	000000000000000000000000000000000000000					31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00
43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY 200. 00 Total (lines 30 through 199)	000000000000000000000000000000000000000					43. 00 44. 00 45. 00 200. 00

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2023 | Part IV |
| To 12/31/2023 | Date/Time Prepared: | 5/30/2024 7:46 am | THROUGH COSTS

						'	12,01,2020	5/30/2024 7: 4	6 am
				Title XVIII Hospital		PPS			
	Cost Center Description	Non Physician	N	ursi ng	Nursi ng		Allied Health	Allied Health	
		Anesthetist	P	rogram	Program		Post-Stepdown		
		Cost	Post	-Stepdown			Adjustments		
			Adj	ustments					
		1. 00		2A	2. 00		3A	3. 00	
	ANCILLARY SERVICE COST CENTERS								
50. 00	05000 OPERATI NG ROOM	0)	0		0	0	0	50. 00
51. 00	05100 RECOVERY ROOM	0)	0	•	0	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0)	0		0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0)	0		0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0)	0		0	0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0)	0		0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0)	0		0	0	0	56. 00
57. 00	05700 CT SCAN	0)	0		0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0)	0		0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0)	0		0	0	0	59. 00
60. 00	06000 LABORATORY	0)	0		0	0	0	60. 00
60. 01	06001 BLOOD LABORATORY	0)	0		0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY								61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0		0	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0		0	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0		0		0	0	0	64. 00
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
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		0		0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0)	0		0	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0)	0		0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0)	0		0	0	0	73. 00
74. 00	07400 RENAL DI ALYSI S	0		0		0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0		0		0	0	0	75. 00
76. 00	03140 CARDI OLOGY	0)	0		0	0	0	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0)	0		0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0)	0		0	0	0	78. 00
00.00	OUTPATIENT SERVICE COST CENTERS		J		Γ	_			00.00
88. 00	08800 RURAL HEALTH CLINIC	0	()	0	•	0	0	1	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	()	0		0	0	0	89. 00
90.00	09000 CLINIC	0	()	0		0	0	0	90.00
90. 01	04950 SLEEP CLINIC	0	()	0		0	0	107.0/5	90. 01
91.00	09100 EMERGENCY	0	()	0		0	0	107, 865	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	ار			0		0	92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0	N .	0		0	0	0	94. 00
95.00	09500 AMBULANCE SERVICES	0	Ί	U		U	Ü	0	95.00
95. 00 96. 00	09600 DURABLE MEDICAL EQUIP-RENTED		\	0		0	^	0	95. 00 96. 00
97.00	09700 DURABLE MEDICAL EQUIP-RENTED		()	0		0	0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS		()	0		0	0	0	98.00
200.00	I I		()	0		0	0		
200.00	Total (Tilles 50 till ough 199)	1	Ί	U	l	U	Ü	107,603	200.00

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared: | Tree | Prepared Provider CCN: 15-0018 THROUGH COSTS

				0 12/31/2023	5/30/2024 7:4		
			Ti tl e	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
		4.00	F 00	4.00	7.00	instructions)	
	ANCILLARY SERVICE COST CENTERS	4.00	5. 00	6. 00	7. 00	8. 00	
50. 00	05000 OPERATING ROOM	0	0		160, 281, 296	0. 000000	50.00
51. 00	05100 RECOVERY ROOM		0			0.000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	o o			0.000000	•
53. 00	05300 ANESTHESI OLOGY	0	0			0. 000000	•
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	Ö		84, 901, 421	0. 000000	•
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	Ö	l .	0	0. 000000	1
56. 00	05600 RADI OI SOTOPE	0	Ö		0	0. 000000	1
57. 00	05700 CT SCAN	0	Ö		91, 330, 220	0. 000000	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	O	1		0. 000000	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0	O		50, 358, 250	0. 000000	59. 00
60.00	06000 LABORATORY	0	0	(89, 716, 762	0.000000	60.00
60. 01	06001 BLOOD LABORATORY	0	0	(0	0.000000	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(0	0.000000	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	0.000000	1
64. 00	06400 I NTRAVENOUS THERAPY	0	0	1		0. 000000	1
65. 00	06500 RESPI RATORY THERAPY	0	0	1		0. 000000	•
66. 00	06600 PHYSI CAL THERAPY	0	0	1	-,,	0. 000000	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	.,,	0. 000000	•
68.00	06800 SPEECH PATHOLOGY	0	0	`	1, 406, 764	0. 000000	
69.00	06900 ELECTROCARDI OLOGY	0	0	1	0	0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	1	0.000000	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	1		0. 000000 0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	1		0.000000	1
74. 00	07400 RENAL DIALYSIS	0	0		209, 623, 499	0.000000	1
75. 00	07500 ASC (NON-DISTINCT PART)	0	0			0. 000000	•
76. 00	03140 CARDI OLOGY	0	0	1		0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	Ö			0. 000000	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	Ö			0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS		-				
88. 00	08800 RURAL HEALTH CLINIC	0	C	(0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	O		0	0. 000000	89. 00
90.00	09000 CLI NI C	0	0		1, 135, 477	0.000000	90.00
90. 01	04950 SLEEP CLINIC	0	0	(2, 658, 640	0.000000	90. 01
91.00	09100 EMERGENCY	0	107, 865	107, 865	44, 508, 114	0. 002423	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(35, 405, 219	0.000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	(0	0. 000000	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	(0	0. 000000	1
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0]	0	0.000000	1
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	107.045	107.04	U 1 0E2 242 025	0. 000000	
200.00	Total (lines 50 through 199)	l O	107, 865	107, 865	1, 053, 363, 835	I	200. 00

 Heal th Financial
 Systems
 ELKHART
 GENERAL

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

					5/30/2024 7: 4	6 am	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.	•	Costs (col. 8	_	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11.00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS	•					
50.00	05000 OPERATI NG ROOM	0. 000000	18, 691, 069	0	17, 168, 482	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0	_	0	Ö	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	4, 637, 276		9, 862, 425	Ö	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	4,037,270		7, 002, 425	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	0	-	0	0	56.00
57. 00	05700 CT SCAN	0. 000000	-	-	9, 351, 110	0	57. 00
		1	7, 773, 388				1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0.000000	981, 228		1, 509, 443	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	5, 645, 686		9, 510, 294	0	59. 00
60. 00	06000 LABORATORY	0. 000000	13, 195, 058		4, 183, 198	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	0	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	530, 856	0	943, 484	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0. 000000	5, 370, 410	0	593, 025	0	65.00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 136, 763	0	139, 027	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	998, 151		35, 215	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	272, 079		7, 204	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	- 1	0	Ö	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	282, 472	- 1	138, 444	Ö	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	32, 170, 301		30, 358, 685	Ö	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	19, 184, 646		31, 294, 681	Ö	73. 00
74. 00	07400 RENAL DIALYSIS	0. 000000	17, 104, 040		0 0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	١	0	0	75. 00
76. 00	03140 CARDI OLOGY	0. 000000	2, 479, 942	-	6, 111, 058	0	76.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION				6, 111, US8 N	0	77.00
	1 1	0.000000	0	-	0	_	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0	0	U	0	78. 00
00 00	OUTPATIENT SERVICE COST CENTERS	0.000000			0	0	1 00 00
88. 00	08800 RURAL HEALTH CLINIC	0.000000	0	- 1	0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	-	0	0	89. 00
90.00	09000 CLINIC	0. 000000	176		251, 742	0	90.00
90. 01	04950 SLEEP CLINIC	0. 000000	0	١	501, 443	0	90. 01
91. 00	09100 EMERGENCY	0. 002423	3, 313, 244		3, 348, 196	8, 113	l
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	1, 338, 842	0	4, 296, 128	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000	0	0	0	0	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	0	0	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0	0	0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0	0	0	0	98. 00
200.00			118, 001, 587	8, 028	129, 603, 284	8. 113	200.00
	, , , , , , , , , , , , , , , , , , , ,	1	-, ,	.,	, =	-,	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COS		VACCINE COST	Provider CO	Provi der CCN: 15-0018		Worksheet D Part V Date/Time Pre 5/30/2024 7:4	pared: 6 am
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
			Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
		1.00	2.00	(see inst.)	(see inst.)	F 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
50. 00	05000 OPERATING ROOM	0. 227736	17, 168, 482		0 0	3, 909, 881	50. 00
51.00	05100 RECOVERY ROOM	0. 000000	0		0 0	0, 707, 001	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	Ö	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	١	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 157625	9, 862, 425			1, 554, 565	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	7, 002, 429 N				55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0 0		56. 00
57. 00	05700 CT SCAN	0. 030579	9, 351, 110		0 0	1	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 030374	1, 509, 443		0 0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 056423	9, 510, 294		0 0		59.00
60.00	06000 LABORATORY	0. 030423	4, 183, 198			562, 080	60.00
60. 00	06001 BLOOD LABORATORY	0. 000000	4, 103, 170		0	0 302,080	60. 00
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	U		0 0	1	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	•	62.00
	1	1	0		0 0	1	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	042 404			-	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 535272	943, 484		0		64. 00
65. 00	06500 RESPIRATORY THERAPY	0. 199022	593, 025		0 0		65. 00
66.00	06600 PHYSI CAL THERAPY	0. 453089	139, 027		٥		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 295143	35, 215		0 0	10, 393	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 345019	7, 204		0	2, 486	68. 00
69.00	06900 ELECTROCARDI OLOGY	0.000000	0		0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	120 444		0 0	0	70.00
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0. 157525	138, 444		0		71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 171314	30, 358, 685		0 0	-,,	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 163021	31, 294, 681		0 8, 733		73.00
74. 00	07400 RENAL DIALYSIS	0.000000	0		0 0	1	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0.000000	(111 050		0	1	75. 00
76. 00	03140 CARDI OLOGY	0. 133459	6, 111, 058		0	815, 576	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0.000000	0		0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
00 00	OUTPATIENT SERVICE COST CENTERS						00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER						88. 00
	09000 CLINIC	0.720701	251 742			107 224	89. 00
90.00		0. 739781	251, 742		0 0		90.00
90. 01	04950 SLEEP CLINIC 09100 EMERGENCY	0. 221107	501, 443		0 0		90. 01
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 374703	3, 348, 196		0 0		91.00
92. 00	OTHER REIMBURSABLE COST CENTERS	0. 395944	4, 296, 128		0 0	1, 701, 026	92. 00
94 00	09400 HOME PROGRAM DIALYSIS	0. 000000			0 0		94. 00
	09500 AMBULANCE SERVICES	0. 000000			0		95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	1	97. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0		98.00
200.00		0.000000	129, 603, 284		0 8, 733	-	
200.00			127,003,204		0, 733	22, 074, 000	200.00
201.00	Only Charges				٥		201.00
202.00			129, 603, 284		0 8, 733	22, 094, 080	202 00
_52.00	1 3 333 (1 200 11 201)	1	.27,000,204	ı	-, 0,755	1 22,071,000	

| Period: | Worksheet D | From 01/01/2023 | Part V | To 12/31/2023 | Date/Time Prepared: | 5/30/2024 7:46 am Provi der CCN: 15-0018

					5/30/2024 7:46	<u> am</u>
		Title X	(VIII	Hospi tal	PPS	
	Cost	S				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces S	Services Not				
	Subject To	Subject To				
		ed. & Coins.				
		(see inst.)				
	6.00	7. 00				
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	0	0				50. 00
	0	0				51. 00
51. 00 05100 RECOVERY ROOM		-1				
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55.00
56. 00 05600 RADI 0I SOTOPE	0	0				56.00
57. 00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	o	o				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	o	0				59.00
60. 00 06000 LABORATORY	o	o				60. 00
60. 01 06001 BLOOD LABORATORY	0	Ö				60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	٩				61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	1	0				62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0				64. 00
65. 00 06500 RESPIRATORY THERAPY	0	0				65.00
66. 00 06600 PHYSI CAL THERAPY	0	0				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0				67.00
68. 00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	o	ol				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	O	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	o				71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	l ő	0				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS		1, 424				73. 00
74. 00 07400 RENAL DI ALYSI S		1, 424				74.00
	_	0				
	0	9				75. 00
76. 00 03140 CARDI OLOGY	0	0				76. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
78.00 O7800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC						88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90. 00 09000 CLI NI C	0	0				90.00
90. 01 04950 SLEEP CLINIC	O	o				90. 01
91. 00 09100 EMERGENCY	o	o				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	O	o				92.00
OTHER REIMBURSABLE COST CENTERS	9					, 2. 00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0				94. 00
95. 00 09500 AMBULANCE SERVI CES	0	٩				95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0					
	1	0				96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0				97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98. 00
200.00 Subtotal (see instructions)	0	1, 424				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	1, 424			l	202. 00

	ELIVIADT OFNED	MAL LIGGEL TAL			6.5	0550 40
Heal th Financial Systems	ELKHART GENER		ON 45 0040		u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0018	Peri od: From 01/01/2023	Worksheet D Part II	
		Component	CCN: 15-S018	To 12/31/2023		pared:
		Titl∈	· XVIII	Subprovider -	PPS	o aiii
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	2.00	4.00	F 00	
ANCILLARY SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
50. 00 O5000 OPERATING ROOM	2, 134, 176	160, 281, 296	0. 01331	5 0	0	50.00
51. 00 05100 RECOVERY ROOM	2, 134, 170	100, 201, 290	0.00000		0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM			0.00000		0	52.00
53. 00 05300 ANESTHESI OLOGY	0		0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 719, 176	84, 901, 421			24	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 717, 170	04, 701, 421	0.00000		0	55.00
56. 00 05600 RADI OI SOTOPE	0		0. 00000		0	56.00
57. 00 05700 CT SCAN	261, 940	1			16	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	129, 793				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	148, 589				0	59. 00
60. 00 06000 LABORATORY	203, 681	89, 716, 762			80	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	00	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000	0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	281, 969	5, 016, 789	0. 05620	05	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	70, 600	22, 913, 106			30	65. 00
66. 00 06600 PHYSI CAL THERAPY	181, 181	6, 621, 408			27	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	86, 479		1		25	
68. 00 06800 SPEECH PATHOLOGY	51, 644				0	1
69. 00 06900 ELECTROCARDI OLOGY	0	1			0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0.00000		0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	5, 451				0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	541, 448				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	220, 922				43	73.00
74. 00 07400 RENAL DI ALYSI S	0		0.00000		0	74.00
75. 00 07500 ASC (NON-DISTINCT PART) 76. 00 03140 CARDI OLOGY	412.766	21 550 524	0.00000		0	75. 00
76. 00 03140 CARDI OLOGY 77. 00 07700 ALLOGENEI C HSCT ACQUI STITION	413, 766		1		33	76. 00 77. 00
78. 00 07/00 ALLOGENETE HISET ACCOUNTION 78. 00 07800 CAR T-CELL IMMUNOTHERAPY			1		0	
OUTPATIENT SERVICE COST CENTERS			0.00000	0	0	70.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0. 00000		0	89.00
90. 00 09000 CLI NI C	172, 821	1	1		0	90.00
90. 01 04950 SLEEP CLINIC	638		1		0	90. 01
91. 00 09100 EMERGENCY	667, 105		1		248	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		i	00 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	·		•			1
94. 00 09400 HOME PROGRAM DIALYSIS	0	C	0.00000	0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.00000		0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.00000		0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.00000		0	98. 00
200.00 Total (lines 50 through 199)	7, 291, 379	1, 053, 363, 835	l	114, 147	526	200. 00

Health Financial Systems	ELKHART GENER				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY THROUGH COSTS	SERVICE OTHER PAS	S Provider CC Component C		Peri od: From 01/01/2023 To 12/31/2023	Worksheet D Part IV Date/Time Pre 5/30/2024 7:4	pared:
		Title	XVIII	Subprovider -	PPS	0 4
Cost Center Description	Non Physician Anesthetist Cost	Nursi ng Program Post-Stepdown Adj ustments	Nursi ng Program	Allied Health Post-Stepdown Adjustments	Allied Health	
	1.00	2A	2. 00	3A	3. 00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00	000000000000000000000000000000000000000			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0	51. 00 52. 00 53. 00 54. 00 55. 00 57. 00 58. 00 59. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00
67. 00 06700 OCCUPATIONAL THERAPY 68. 00 06800 SPECH PATHOLOGY 69. 00 06900 ELECTROCARDIOLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DIALYSIS 75. 00 07500 ASC (NON-DISTINCT PART) 76. 00 03140 CARDIOLOGY 77. 00 07700 ALLOGENEIC HSCT ACQUISITION 78. 00 07800 CAR T-CELL IMMUNOTHERAPY 0UTPATIENT SERVICE COST CENTERS				0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 00 77. 00

0

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89. 00

90.00

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91.00

94.00 0

95.00

96.00

97.00 0

0

0 92.00

0 98.00

107, 865 200. 00

107, 865

89.00

90.00

90. 01

91.00

92.00

94.00

200.00

09000 CLI NI C

04950 SLEEP CLINIC

95. 00 09500 AMBULANCE SERVICES

09400 HOME PROGRAM DIALYSIS

96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

09100 EMERGENCY

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

	Financial Systems IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ELKHART GENER RVI CE OTHER PASS			Peri od:	worksheet D	
HROUG	H COSTS		Component		From 01/01/2023 To 12/31/2023		epared:
			Title	· XVIII	Subprovi der – I PF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,		
		Education Cost		Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	4.00	5.00	0.00	7.00	0.00	
0. 00	05000 OPERATING ROOM	O	0		0 160, 281, 296	0. 000000	50. C
1. 00	05100 RECOVERY ROOM	0	0	1	0 100, 281, 290	0.000000	
2. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0.000000	
3. 00	05300 ANESTHESI OLOGY		0		0	0.000000	
4. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 84, 901, 421	0.000000	
5. 00	05500 RADI OLOGY-THERAPEUTI C		0		0 84, 901, 421	0.000000	
5. 00	05600 RADI OI SOTOPE		0		0 0	0.000000	
7. 00	05700 CT SCAN		0	i .	0 91, 330, 220	0.000000	1
. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0		0 13, 323, 559	l e	
. 00	05900 CARDI AC CATHETERI ZATI ON		0		0 50, 358, 250	l .	
. 00	06000 LABORATORY		0		0 89, 716, 762		
. 01	06001 BLOOD LABORATORY	0	0		0 69,710,702	0.000000	
. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	٩	0		0	0.00000	61.
. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0	0. 000000	1
. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0.000000	
1. 00	06400 I NTRAVENOUS THERAPY	0	0		0 5, 016, 789	l	
5. 00	06500 RESPIRATORY THERAPY	0	0		0 22, 913, 106		
5. 00	06600 PHYSI CAL THERAPY	0	0		0 6, 621, 408	l .	
7. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 4, 194, 357		
3. 00	06800 SPEECH PATHOLOGY		0		0 1, 406, 764		
9. 00	06900 ELECTROCARDI OLOGY	0	0		1,400,704	0.000000	
. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0.000000	
. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 888, 792	l e	
. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 196, 318, 628	l e	
. 00	07300 DRUGS CHARGED TO PATIENTS		0		0 209, 825, 499		1
. 00	07400 RENAL DIALYSIS	0	0	1	0 209, 823, 499	0.000000	1
. 00	07500 ASC (NON-DISTINCT PART)		0		0 0	0. 000000	
. 00	03140 CARDI OLOGY		0	1	0 31, 559, 534	l e	
. 00	07700 ALLOGENEIC HSCT ACQUISITION		0		0 01,007,001	0. 000000	
	07800 CAR T-CELL IMMUNOTHERAPY		0		0 0	0. 000000	
	OUTPATIENT SERVICE COST CENTERS				<u> </u>	0.00000	1
. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	88.
. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		0 0	l	1
. 00	09000 CLI NI C	o	0		0 1, 135, 477		
. 01	04950 SLEEP CLINIC		0		0 2, 658, 640	l .	
	09100 EMERGENCY		107, 865	107, 86			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	O			0 35, 405, 219		
	OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					
. 00	09400 HOME PROGRAM DI ALYSIS	0	0		0 0	0.000000	94.
. 00	09500 AMBULANCE SERVICES	1					95.
. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0 0	0. 000000	
. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0		0 0	0.000000	
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0.000000	
0. 00		o	107, 865	107.04	5 1, 053, 363, 835	l	200.

APP0R	Financial Systems FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	ELKHART GENERAL RVI CE OTHER PASS	Provi der Co	CN: 15-0018	Peri od: From 01/01/2023	u of Form CMS- Worksheet D Part IV	
THROUG	GH COSTS		Component	CCN: 15-S018	To 12/31/2023	Date/Time Pre 5/30/2024 7:4	
			Title	· XVIII	Subprovi der - I PF	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col . 6 ÷ col .		Costs (col.	8	Costs (col. 9	
		7)	10. 00	x col . 10) 11.00	12.00	x col . 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50. 00	05000 OPERATING ROOM	0. 000000	0		0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 000000	0		0 0	0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	•	0 0	0	
53. 00	05300 ANESTHESI OLOGY	0. 000000	0	•	0 0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	1, 184		0 0	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	
56. 00	05600 RADI OI SOTOPE	0. 000000	0	•	0 0	0	
57. 00	05700 CT SCAN	0. 000000	5, 475	•	0 0	0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0	1	0 0	0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0	•	0 0	0	
60.00	06000 LABORATORY	0. 000000	35, 124		0 0	0	1
60. 01	06001 BLOOD LABORATORY	0. 000000	0	1	0 0	0	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	9, 878		0 0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	1, 000		0 0	0	66.00
67. 00	06700 OCCUPATIONAL THERAPY	0. 000000	1, 192		0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	41, 243		0	0	73.00
74. 00	07400 RENAL DI ALYSI S	0. 000000	0		0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	
76. 00	03140 CARDI OLOGY	0. 000000	2, 508		0	0	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0	0	
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	J 78. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0	•	0 0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	
90.00	09000 CLI NI C	0. 000000	0	•	0 0	0	
90. 01	04950 SLEEP CLINIC	0. 000000	0	•	0 0	0	
91.00	09100 EMERGENCY	0. 002423	16, 543		40 0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92. 00
04.05	OTHER REIMBURSABLE COST CENTERS	0.00000=1		1	-		1 0, 0=
	09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0 0	0	94.00
95.00	09500 AMBULANCE SERVICES	0.00000	_			_	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	•	0 0		96.00
		0. 000000	0	•	0 0		97.00
98. 00 200. 00	09850 OTHER REIMBURSABLE COST CENTERS Total (lines 50 through 199)	0. 000000	0 114, 147		0 40 0		98. 00 200. 00
	I LIOTAL (LINES SU THROUGH 199)	1	11/1 1/17	1	/IIII ()		11700 OC

Health Financial Systems	ELKHART GENER	DAI HOSDITAI		Inlie	eu of Form CMS-	2552_10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provi der C		Period: From 01/01/2023 To 12/31/2023	Worksheet D Part I Date/Time Pre 5/30/2024 7:4	pared:
	_	Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,	*	Related Cost		,	
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
30. 00 ADULTS & PEDIATRICS	5, 662, 327	C	5, 662, 32	7 42, 103	134. 49	30.00
31. 00 INTENSIVE CARE UNIT	488, 320	l .	488, 32		81. 02	1
31. 01 NEONATAL INTENSIVE CARE	86, 198		86, 19			
32. 00 CORONARY CARE UNIT	00, 190		00, 17	0 032	0.00	
	0			0		
33.00 BURN INTENSIVE CARE UNIT	0			0	0.00	
34. 00 SURGICAL INTENSIVE CARE UNIT	0	_		0	0.00	
40. 00 SUBPROVI DER - I PF	434, 592	C	434, 59	2, 744	l	1
41. 00 SUBPROVI DER - I RF	0	C)	0	0.00	
43. 00 NURSERY	379, 181		379, 18	1, 988	190. 73	
44.00 SKILLED NURSING FACILITY	0			0 0	0.00	44. 00
45.00 NURSING FACILITY	0			0 0	0.00	45. 00
200.00 Total (lines 30 through 199)	7, 050, 618		7, 050, 61	8 53, 514		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 185	159, 371				30.00
31. 00 INTENSIVE CARE UNIT	96		1			31.00
31. 01 NEONATAL INTENSIVE CARE	98					31. 01
32. 00 CORONARY CARE UNIT	0		1			32.00
33. 00 BURN INTENSIVE CARE UNIT	0	_	1			33. 00
34. 00 SURGICAL INTENSIVE CARE UNIT		_				34.00
						40.00
	100		1			1
41. 00 SUBPROVI DER - I RF	0		1			41.00
43. 00 NURSERY	280		1			43. 00
44.00 SKILLED NURSING FACILITY	0	1)			44. 00
45.00 NURSING FACILITY	0	_)			45. 00
200.00 Total (lines 30 through 199)	1, 759	249, 348	3			200. 00

Heal th	Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APP0R1	FIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der Co		Period: From 01/01/2023		
				-	To 12/31/2023	Date/Time Pre 5/30/2024 7:4	pared: 6 am
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
	·	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col. 1 ÷ col.	Charges	column 4)	
		Part II, col.	8)	2)			
		26) 1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00	05000 OPERATI NG ROOM	2, 134, 176	160, 281, 296	0. 01331	9, 966, 105	132, 699	50.00
51. 00	05100 RECOVERY ROOM	0	0	0. 000000		0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	Ö	0. 00000		0	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	0.00000		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 719, 176	84, 901, 421	0. 02024	9 3, 795, 386	76, 853	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000		0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0. 00000		0	
57.00	05700 CT SCAN	261, 940	91, 330, 220			12, 799	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	129, 793	13, 323, 559				
59.00	05900 CARDI AC CATHETERI ZATI ON	148, 589	50, 358, 250	0.00295	1 2, 824, 781	8, 336	59. 00
60.00	06000 LABORATORY	203, 681	89, 716, 762	0. 002270	8, 668, 083	19, 677	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0. 00000	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.00000	0	0	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	281, 969	5, 016, 789	0. 05620	5 807, 057	45, 361	64. 00
65.00	06500 RESPI RATORY THERAPY	70, 600	22, 913, 106	0.00308	1 3, 359, 523	10, 351	65.00
66.00	06600 PHYSI CAL THERAPY	181, 181	6, 621, 408	0. 02736	366, 568	10, 030	66.00
67.00	06700 OCCUPATI ONAL THERAPY	86, 479	4, 194, 357	0. 02061	350, 169	7, 220	67.00
68.00	06800 SPEECH PATHOLOGY	51, 644	1, 406, 764	0. 03671	1 119, 024	4, 369	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0.00000	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 451	1, 888, 792	0. 00288	6 0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	541, 448	196, 318, 628			0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	220, 922	209, 825, 499			12, 077	
74.00	07400 RENAL DI ALYSI S	0	0	0.00000		0	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0.00000	0	0	75. 00
76.00	03140 CARDI OLOGY	413, 766	31, 559, 534	0. 01311	1, 012, 429	13, 274	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 000000		0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0	0. 00000	0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS	T	_	1			
88. 00	08800 RURAL HEALTH CLINIC	0	0	0. 00000		· -	00.00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89. 00
90.00	09000 CLINIC	172, 821	1, 135, 477			0	90.00
90. 01	04950 SLEEP CLINIC	638	2, 658, 640			0	90. 01
91.00	09100 EMERGENCY	667, 105				33, 239	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	1, 336, 816	35, 405, 219	0. 03775	8 0	0	92. 00
94. 00	09400 HOME PROGRAM DIALYSIS	0		0.00000	0 (0	94. 00
95.00	09500 AMBULANCE SERVICES			0.00000			95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	_	0. 00000	n n	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-RENTED		0	0. 00000		0	97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS			0. 00000		0	98.00
200.00		8, 628 195	1, 053, 363, 835		49, 988, 491		
200.00	1.5ta. (11165 55 thi bagii 177)	0,020,170	., 555, 555, 655	ı	17,700,471	071,007	1200.00

					5/30/2024 /: 40	o am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng	Allied Health	Allied Health	All Other	
cost center bescription						
	Program	Program	Post-Stepdown	Cost	Medi cal	
	Post-Stepdown		Adjustments		Education Cost	
	Adjustments					
	1A	1 00	24	2. 00	2.00	
LANDATI ENT. DOUTLINE OFFICE OF COOT, OFFITEDO	I IA	1.00	2A	2.00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1		ı		
30. 00 03000 ADULTS & PEDI ATRI CS	0	(0	0	0	30. 00
31.00 03100 INTENSIVE CARE UNIT	0	l c	ol o	0	0	31.00
l •					_	
31. 01 03101 NEONATAL INTENSIVE CARE	0					31. 01
32. 00 03200 CORONARY CARE UNIT	0	(0	0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT		(ol o	0	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0			0	Ö	34. 00
	1	_	1	_		
40. 00 04000 SUBPROVI DER - 1 PF	0	(0	0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	l c	ol o	0	0	41.00
43. 00 04300 NURSERY			م ار	0	0	43.00
]	il .		i o'	
44.00 O4400 SKILLED NURSING FACILITY	0	_	ال ال	1	i '	44. 00
45.00 04500 NURSING FACILITY	0	(C	0	0	i '	45. 00
200.00 Total (lines 30 through 199)		(ol o	0	ο'	200. 00
Cost Center Description	Swi ng-Bed	Total Costs	Total Dationt	Per Diem (col.	Inpati ent	200.00
cost center bescription						
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)					
	4. 00	5. 00	6.00	7. 00	8. 00	
I NDATI ENT DOUTINE CEDVI CE COCT CENTEDO	4.00	3.00	0.00	7.00	0.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			10.400		4 405	
30. 00 03000 ADULTS & PEDI ATRI CS	0	(42, 103	0.00	1, 185	30.00
31.00 03100 INTENSIVE CARE UNIT			6, 027	0.00	96	31.00
31. 01 03101 NEONATAL INTENSIVE CARE		1	652	0.00	98	31. 01
		_	1			
32. 00 03200 CORONARY CARE UNIT		(0			32. 00
33.00 03300 BURN INTENSIVE CARE UNIT			0	0.00	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	1	1	م ار	0.00	0	34.00
		_	1 °			40.00
	0		2, 744			
41. 00 04100 SUBPROVI DER - I RF	0	() 0	0.00	0	41.00
43. 00 04300 NURSERY			1, 988	0.00	280	43.00
44.00 04400 SKILLED NURSING FACILITY		(1			44.00
		_	1			
45. 00 04500 NURSING FACILITY		(0.00		45. 00
200.00 Total (lines 30 through 199)		(53, 514		1, 759	200. 00
Cost Center Description	Inpatient					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	0					30.00
	l e				ļ.	
31.00 03100 INTENSIVE CARE UNIT	0				ļ.	31. 00
31. 01 03101 NEONATAL INTENSIVE CARE	0				ļ.	31. 01
32. 00 03200 CORONARY CARE UNIT	0				!	32. 00
					ļ	
	_				ļ	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0				ļ	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0				ļ	40.00
41. 00 04100 SUBPROVI DER - RF					ļ	41. 00
		l .			ļ	
43. 00 04300 NURSERY	0				ļ	43.00
44.00 04400 SKILLED NURSING FACILITY	0				ļ	44.00
45. 00 04500 NURSI NG FACI LI TY	0				ļ	45. 00
l l					l	
200.00 Total (lines 30 through 199)	0	1				200. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Tel THROUGH COSTS

					10 12/31/2023	5/30/2024 7: 4	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
			Adjustments				
		1. 00	2A	2. 00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	(1	0 0		50. 00
51. 00	05100 RECOVERY ROOM	0	()	0	0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	()	0 0		52. 00
53. 00	05300 ANESTHESI OLOGY	0	()	0 0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	()	0 0	1	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	()	0 0	1	55. 00
56. 00	05600 RADI OI SOTOPE	0	()	0 0	0	56. 00
57. 00	05700 CT SCAN	0	()	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	()	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	(0 0	0	59. 00
60.00	06000 LABORATORY	0	(0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	(0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	(0 0	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	(0 0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	(0 0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	(0 0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	(0 0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0			0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0			0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	(0 0	0	73. 00
74.00	07400 RENAL DI ALYSI S	0	ĺ		0 0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	ĺ		0 0	0	75. 00
76. 00	03140 CARDI OLOGY	0	Ċ		0	o o	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	Ċ		0	o o	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	Ċ		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS			1			
88. 00	08800 RURAL HEALTH CLINIC	0	()	0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(0 0	0	89. 00
90.00	09000 CLI NI C	0	(0 0	0	90. 00
90. 01	04950 SLEEP CLINIC	0	ĺ		0 0	0	90. 01
91. 00	09100 EMERGENCY	0	Ċ		0	107, 865	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	()	0 0	0	94. 00
95.00	09500 AMBULANCE SERVI CES	1					95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	(0 0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	98. 00
200.00	Total (lines 50 through 199)	0	(0 0	107, 865	200. 00
		•	•	•	•	•	•

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2023 | Part IV | To 12/31/2023 | Date/Time Prepared: | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Telephone | Tel
 Heal th Financial
 Systems
 ELKHART
 GENERAL

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

					10 12/31/2023	5/30/2024 7: 4	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	'	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATI NG ROOM	0	0		0 160, 281, 296		
51. 00	05100 RECOVERY ROOM	0	0		0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0	0.000000	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 84, 901, 421	0.000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0. 000000	55. 00
56. 00	05600 RADI OI SOTOPE	0	0		0	0.00000	56. 00
57. 00	05700 CT SCAN	0	0	•	0 91, 330, 220		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 13, 323, 559		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	1	0 50, 358, 250		59. 00
60.00	06000 LABORATORY	0	0		0 89, 716, 762		60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0.000000	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0.000000	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0.000000	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0 5, 016, 789		
65. 00	06500 RESPI RATORY THERAPY	0	0	i .	0 22, 913, 106		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	i .	0 6, 621, 408		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	1	0 4, 194, 357	0. 000000	1
68. 00	06800 SPEECH PATHOLOGY	0	0		0 1, 406, 764		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0. 000000	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	1	0 0	0.00000	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 1, 888, 792		1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 196, 318, 628		ł
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 209, 825, 499		73. 00
74.00	07400 RENAL DIALYSIS	0	0		0		
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0.000000	1
76. 00	03140 CARDI OLOGY	0	0		0 31, 559, 534		76.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0		77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY OUTPATIENT SERVICE COST CENTERS	l O	0		0 0	0.000000	78. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0.00000	89.00
90.00	09000 CLINIC	0	0	•			90.00
90.00	04950 SLEEP CLINIC	0	0		0 1, 135, 477 0 2, 658, 640		90.00
91.00	09100 EMERGENCY	0	107, 865				91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	107, 863		0 35, 405, 219		91.00
92.00	OTHER REIMBURSABLE COST CENTERS	ı o	0		0 35, 405, 219	0.000000	92.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0 0	0.000000	94.00
95.00	09500 AMBULANCE SERVICES	1					95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	o	0		0 0	0.000000	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	o	0		0 0	0.000000	97. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	o	0		0 0	0.000000	98. 00
200.00	Total (lines 50 through 199)	o	107, 865	107, 86	5 1, 053, 363, 835		200. 00

| Peri od: | Worksheet D | From 01/01/2023 | Part IV | To | 12/31/2023 | Date/Time | Prepared: Provider CCN: 15-0018 THROUGH COSTS

					10 12/3	1/2023	5/30/2024 7:4	
			Titl	e XIX	Hospi t	al	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpat		Outpati ent	
		Ratio of Cost	Program	Program	Progr	am	Program	
		to Charges	Charges	Pass-Through	n Charc	jes	Pass-Through	
		(col. 6 ÷ col.	ŭ	Costs (col.	8		Costs (col. 9	
		7)		x col. 10)			x col. 12)	
		9. 00	10.00	11.00	12.0	00	13. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0. 000000	9, 966, 105		0 22, 4	46, 869	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0	1	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	3, 795, 386		0 11, 6	15, 186	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	0		0	0	0	56. 00
57.00	05700 CT SCAN	0. 000000	4, 462, 595		0 15, 0	21, 980	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	570, 084		0 1.5	47, 550	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	2, 824, 781			81, 064	0	59.00
60.00	06000 LABORATORY	0. 000000	8, 668, 083			01, 570	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0, 111, 111		0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_			_	_	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	807, 057		-	80, 475	Ö	64. 00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	3, 359, 523			46, 555	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	366, 568	1		40, 333 17, 982	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	350, 169	l .	-	17, 3 62 09, 368	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0.000000	119, 024	1		60, 149	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	119,024	1	0	00, 149 0	0	69.00
70.00	07000 ELECTROCARDI OLOGI	0. 000000	0	1	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		-	ں 23, 581	0	70.00
71.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000	0	1	0	23, 361	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	11, 469, 010	l .	_	0 10 220	0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	11, 469, 010	•	0 10, 5	10, 238	0	74.00
75. 00		0. 000000	0		0	0	0	75.00
	07500 ASC (NON-DISTINCT PART)	1	1 012 420		_	U E1 02E	_	
76.00	03140 CARDI OLOGY	0.000000	1, 012, 429	1		51, 835	0	76.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0	0	0	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0	0	0	78. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0. 000000	0	I	0	0	0	88. 00
			0	•	0	0	0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	-		0	U	_	89. 00
90.00	09000 CLINIC	0.000000	0			49, 182	0	90.00
90. 01	04950 SLEEP CLINIC	0.000000	0			28, 726	0	90. 01
91.00	09100 EMERGENCY	0. 002423	2, 217, 677			66, 382	33, 114	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 7, 1	01, 086	0	92. 00
04.00	OTHER REIMBURSABLE COST CENTERS	0.000000		1				04.00
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000	0		0	0	0	94. 00
95.00	09500 AMBULANCE SERVICES	0 000005	=			_	_	95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0	0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		U	0	0	97. 00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		U 00 0	0	0	98. 00
200.00	Total (lines 50 through 199)		49, 988, 491	5, 3	/3 99, 0	59, 778	33, 114	1200. OO

APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co		Peri od:	Worksheet D	
					From 01/01/2023 To 12/31/2023	Part V Date/Time Pre	nared:
					10 12/31/2023	5/30/2024 7: 4	6 am
			Ti tl	e XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9	1	Subject To	Subject To		
				Ded. & Coins.			
		1.00	0.00	(see inst.)	(see inst.)	F 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
50. 00	05000 OPERATING ROOM	0. 227736	22, 446, 869		0 0	5, 111, 960	50.00
51. 00	05100 RECOVERY ROOM	0. 000000				0, 111, 700	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	1
53. 00	05300 ANESTHESI OLOGY	0. 000000					53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 157625	1		0 0		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000			0 0		55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000			0 0	٥	56.00
57. 00	05700 CT SCAN	0. 030579				459, 357	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 101651				157, 310	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 056423	1 ' '			145, 631	59.00
60. 00	06000 LABORATORY	0. 134366					1
60. 01	06001 BLOOD LABORATORY	0. 000000			0 0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				•	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000		•		0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	1		0 0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 535272	1			631, 875	64.00
65. 00	06500 RESPIRATORY THERAPY	0. 199022			0 0	128, 679	1
66. 00	06600 PHYSI CAL THERAPY	0. 453089	1		0 0	144, 074	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 295143	1		0 0	32, 279	
68. 00	06800 SPEECH PATHOLOGY	0. 345019	1		0 0		ı
69. 00	06900 ELECTROCARDI OLOGY	0. 000000		•	0 0	20, 753	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	1	l	0 0	•	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 157525	1		0 0	3, 715	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 171314	1		0 0	3, 713	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 163021	1		0 0	1, 713, 390	1
74. 00	07400 RENAL DIALYSIS	0. 000000			0 0	1, 713, 370	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	1		0 0	1	75. 00
76. 00	03140 CARDI OLOGY	0. 133459	1		0 0	1	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000			0 0		1
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	1		0 0		1
70.00	OUTPATIENT SERVICE COST CENTERS	0.00000	,		<u> </u>		70.00
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLINIC	0. 739781	49, 182		0 0	36, 384	90.00
90. 01	04950 SLEEP CLINIC	0. 221107	1		0 0	94, 794	90. 01
91. 00	09100 EMERGENCY	0. 374703	1				
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 395944			0 0		
,2,00	OTHER REIMBURSABLE COST CENTERS	0.070711	771017000		<u> </u>	2/011/002	72.00
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000)		0 0		94.00
95.00	09500 AMBULANCE SERVI CES	0. 000000	0		0		95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			0	0	1
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			0	0	1
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			0	0	98. 00
200.00	1		99, 059, 778		0	20, 020, 727	
201.00	1 1				0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		99, 059, 778		0 0	20, 020, 727	202. 00

Peri od: Worksheet D From 01/01/2023 Part V To 12/31/2023 Date/Time Prepared: 5/30/2024 7: 46 am

					5/30/2024 7:4	6 am
		Title X	XIX	Hospi tal	PPS	
	Cos	ts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6. 00	7. 00				
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0				50.00
51.00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	o				52. 00
53. 00 05300 ANESTHESI OLOGY		Ö				53. 00
		0				54. 00
	0	٩				1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0				55. 00
56. 00 05600 RADI 0I SOTOPE	0	0				56. 00
57. 00 05700 CT SCAN	0	0				57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	o				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	O	0				59. 00
60. 00 06000 LABORATORY		0				60.00
60. 01 06001 BLOOD LABORATORY		0				60. 01
	0	U				1
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0					61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
64.00 06400 INTRAVENOUS THERAPY	0	o				64.00
65. 00 06500 RESPIRATORY THERAPY	0	o				65. 00
66. 00 06600 PHYSI CAL THERAPY		o				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0				67. 00
	0	-1				
68. 00 06800 SPEECH PATHOLOGY	0	0				68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	o				73. 00
74. 00 07400 RENAL DI ALYSI S	0	0				74. 00
		0				75. 00
	0	-1				
76. 00 03140 CARDI OLOGY	0	0				76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 00
78.00 07800 CAR T-CELL IMMUNOTHERAPY	0	0				78. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC						88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90. 00 09000 CLINIC		0				90.00
		0				90. 01
	0	٩				
91. 00 09100 EMERGENCY	0	0				91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	O				94.00
95. 00 09500 AMBULANCE SERVICES	0					95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0				96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0				97. 00
l l		-1				
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0				98. 00
200.00 Subtotal (see instructions)	0	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201. 00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	О				202. 00
		-1				•

Health Financial Systems	ELKHART GENER	PAL HOSDITAL		Inlie	u of Form CMS_	2552_10	
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS			CN: 15-0018	Peri od:	u of Form CMS-2552-10 Worksheet D		
APPORTIONMENT OF IMPATIENT ANCILLARY SERVICE CAPITAL COSTS		Trovider 0	Provider CCN: 15-0018		Part II		
		Component	Component CCN: 15-S018		Date/Time Prepared:		
		T: ±1	- VIV	Culturate de la con	5/30/2024 7:4	6 am	
		1111	e XIX	Subprovider - IPF	PPS		
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs		
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x		
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)		
	Part II, col.	8)	2)				
	26)						
ANOLILARY OFFICE COOT OFFITTED	1.00	2. 00	3. 00	4. 00	5. 00		
ANCI LLARY SERVI CE COST CENTERS	0.404.477	1/0 004 00/	0.04004	-		F0 00	
50. 00 05000 OPERATI NG ROOM	2, 134, 176	160, 281, 296	•		0	50.00	
51. 00 05100 RECOVERY ROOM	0		0.00000		0	51.00	
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0		0.00000		0	52.00	
53. 00 05300 ANESTHESI OLOGY	1 710 17/	04 001 401	0.00000		0	53.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	1, 719, 176	84, 901, 421	0. 02024 0. 00000		387 0	54. 00 55. 00	
56. 00 05500 RADI 0L0GY - THERAPEUTI C	0		0.00000		0	56.00	
57. 00 05700 CT SCAN	261, 940				186		
58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	129, 793				45		
59. 00 05900 CARDI AC CATHETERI ZATI ON	148, 589				0	59.00	
60. 00 06000 LABORATORY	203, 681	89, 716, 762			1, 073		
60. 01 06001 BLOOD LABORATORY	203,001		0.00000		0	60. 01	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.00000	.0	O	61. 00	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	0	0	62. 00	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0		0.00000		0	63.00	
64. 00 06400 I NTRAVENOUS THERAPY	281, 969	5, 016, 789	1		0	64. 00	
65. 00 06500 RESPIRATORY THERAPY	70, 600		1		73	65.00	
66. 00 06600 PHYSI CAL THERAPY	181, 181		1		150	66. 00	
67. 00 06700 OCCUPATI ONAL THERAPY	86, 479		1		11	67. 00	
68. 00 06800 SPEECH PATHOLOGY	51, 644	1, 406, 764	0. 03671	1 0	0	68. 00	
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69. 00	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000	00	0	70. 00	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 451				0	71. 00	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	541, 448				0	72. 00	
73.00 07300 DRUGS CHARGED TO PATIENTS	220, 922				472	73. 00	
74. 00 07400 RENAL DI ALYSI S	0	0	0.00000		0	74. 00	
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000		0	75. 00	
76. 00 03140 CARDI OLOGY	413, 766		1		536	76. 00	
77. 00 07700 ALLOGENEI C HSCT ACQUISITION	0				0	77. 00	
78. 00 07800 CAR T-CELL IMMUNOTHERAPY	0	0	0.00000	00 0	0	78. 00	
0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC		0	0 00000	00 0	0	00 00	
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0 0		0.00000		0	88. 00 89. 00	
90. 00 09000 CLINIC	172, 821	-	1		0	90.00	
90. 01 04950 SLEEP CLI NI C	638		1		0	90.00	
91. 00 09100 EMERGENCY	667, 105		1		3, 847		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	007, 103			· ·		1	
OTHER REIMBURSABLE COST CENTERS		00, 100, 217	0.0000		0	72.00	
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	0 0	0	94. 00	
95. 00 09500 AMBULANCE SERVICES						95. 00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0	0		
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 00000		0		
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 00000		0	98. 00	
200.00 Total (lines 50 through 199)	7, 291, 379	1, 053, 363, 835	5	1, 336, 969	6, 780	200. 00	

Heal th	Financial Systems	ELKHART GENER	AL HOSPITAL		In Li∈	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER			Provider Co	CN: 15-0018	Peri od:	Worksheet D	
THROUG	THROUGH COSTS			CON 15 CO10	From 01/01/2023		
			Component	CCN: 15-S018	To 12/31/2023	5/30/2024 7:4	6 am
		Title XIX		e XIX	Subprovi der -		
					I PF		
	Cost Center Description	Non Physician	Nursi ng	Nursi ng		Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown Adjustments		Adjustments		
		1. 00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	ZA	2.00	JA	3.00	
50.00	05000 OPERATI NG ROOM	0	0		0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55. 00
56.00	05600 RADI 0I SOTOPE	0	0		0 0	· O	56. 00
57.00	05700 CT SCAN	0	0		0 0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	00.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	1 0 / 1 0 0
60. 00	06000 LABORATORY	0	0		0 0	0	00.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	1 00.0.
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0				61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	
64. 00	106400 I NTRAVENOUS THERAPY	0	0		0	0	
65. 00	06500 RESPIRATORY THERAPY	0	0		0		
66. 00	06600 PHYSI CAL THERAPY		0			0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY		0		0 0	ا ا	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		o o	o o	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	Ö		0 0	o o	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70. 00
	I I	1		1	1	1	1

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107, 865 200. 00

107, 865

71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS

07200 I MPL. DEV. CHARGED TO PATIENTS

07300 DRUGS CHARGED TO PATIENTS

07700 ALLOGENEIC HSCT ACQUISITION

07800 CAR T-CELL IMMUNOTHERAPY

08800 RURAL HEALTH CLINIC

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

09600 DURABLE MEDICAL EQUIP-RENTED

Total (lines 50 through 199)

09700 DURABLE MEDICAL EQUIP-SOLD

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

09400 HOME PROGRAM DIALYSIS

09500 AMBULANCE SERVICES

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)

07500 ASC (NON-DISTINCT PART)

07400 RENAL DIALYSIS

03140 CARDI OLOGY

09000 CLI NI C

04950 SLEEP CLINIC

09100 EMERGENCY

72.00

74.00

75.00

76.00

77.00

78.00

88.00

89. 00

90.00

90. 01

91.00

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	_Financial_Systems TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	ELKHART GENER		CN. 1E 0010	Peri od:	u of Form CMS-2 Worksheet D	2552-10
	TONMENT OF INPATTENT/OUTPATTENT ANCILLARY SEF SH COSTS	RVICE UTHER PASS			From 01/01/2023	Part IV	
			Component	CCN: 15-S018	To 12/31/2023	Date/Time Pre 5/30/2024 7:4	
			Ti tl	e XIX	Subprovi der - I PF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	·	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum o		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS	11.00	0.00	0.00	7.00	0.00	
50.00	05000 OPERATING ROOM	0	0		0 160, 281, 296	0. 000000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 0	0. 000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0. 000000	1
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0		0 84, 901, 421	0.000000	1
55. 00	O5500 RADI OLOGY-THERAPEUTI C	0	0		0	0.000000	1
56. 00 57. 00	05600	0	0		0 0 91, 330, 220	0. 000000 0. 000000	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0 13, 323, 559	0.000000	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	•	0 50, 358, 250	0. 000000	1
60.00	06000 LABORATORY	0	ĺ	i e	0 89, 716, 762	0. 000000	
60. 01	06001 BLOOD LABORATORY	0	Ö	•	0 0	0. 000000	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0. 000000	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0. 000000	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 5, 016, 789	0. 000000	
65. 00	06500 RESPI RATORY THERAPY	0	0		0 22, 913, 106	0. 000000	
66. 00	06600 PHYSI CAL THERAPY	0	0		0 6, 621, 408	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 4, 194, 357	0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0	0	•	0 1, 406, 764	0.000000	
69. 00 70. 00	06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	·	1	0 1, 888, 792	0. 000000 0. 000000	1
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0			0 196, 318, 628	0. 000000	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 209, 825, 499	0. 000000	1
74. 00	07400 RENAL DI ALYSI S	0	Ö		0 0	0. 000000	1
75.00	07500 ASC (NON-DISTINCT PART)	0	o		0 0	0.000000	1
76.00	03140 CARDI OLOGY	0	0		0 31, 559, 534	0. 000000	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0. 000000	77. 00
78. 00	07800 CAR T-CELL IMMUNOTHERAPY	0	0		0 0	0. 000000	78. 00
	OUTPATIENT SERVICE COST CENTERS	1 -	г	T			
88. 00	08800 RURAL HEALTH CLINIC	0			0 0	0.000000	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0.000000	1
90. 00 90. 01	09000 CLI NI C 04950 SLEEP CLI NI C	0	0		0 1, 135, 477 0 2, 658, 640	0. 000000 0. 000000	1
	09100 EMERGENCY	0	107, 865	107, 8		0. 002423	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0 35, 405, 219		
00	OTHER REIMBURSABLE COST CENTERS				5, 33, 100, 217	3.000000	1 .2. 00
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0 0	0. 000000	94. 00
95.00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0			0	0. 000000	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0			0 0	0. 000000	
	09850 OTHER REIMBURSABLE COST CENTERS	0	l .		0 0	0. 000000	
200.00	Total (lines 50 through 199)	0	107, 865	ı 107. 8	65 1, 053, 363, 835		200.00

	Financial Systems	ELKHART GENERAL				u of Form CMS-	2552-10
	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	Provi der Co	CN: 15-0018	Peri od:	Worksheet D	
THROUG	H COSTS		Component	CCN: 15-S018	From 01/01/2023 To 12/31/2023	Part IV Date/Time Pre 5/30/2024 7:4	
			Ti tl	e XIX	Subprovi der - I PF	PPS	
	Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug	h Charges	Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12.00	13. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	0		0 0	0	50.00
51.00	05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	19, 130		0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	1
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	
57. 00	05700 CT SCAN	0. 000000	64, 905		o o	0	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	4, 666	1	0 0	0	1
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	4, 000	1		0	1
60.00	06000 LABORATORY	0. 000000	472, 522		0 0	0	1
60. 00	06001 BLOOD LABORATORY	1	472, 322		0 0	0	
		0. 000000	U		0	U	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	0			_	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	0. 000000	23, 555	1	0 0	0	
66. 00	06600 PHYSI CAL THERAPY	0. 000000	5, 465		0 0	0	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	521	•	0	0	1
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	1
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0		0	0	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	448, 647		0	0	73. 00
74.00	07400 RENAL DI ALYSI S	0. 000000	0		0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75. 00
76.00	03140 CARDI OLOGY	0. 000000	40, 880		0 0	0	76. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
78.00	07800 CAR T-CELL IMMUNOTHERAPY	0. 000000	0		0 0	0	78. 00
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	89. 00
90.00	09000 CLI NI C	0. 000000	0		0 0	0	1
90. 01	04950 SLEEP CLINIC	0. 000000	0		0 0	0	1
91. 00	09100 EMERGENCY	0. 002423	256, 678	6	22 0	Ö	1
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0		
	OTHER REIMBURSABLE COST CENTERS			1	-,		1
94.00	09400 HOME PROGRAM DI ALYSI S	0. 000000	n		0 0	0	94. 00
	09500 AMBULANCE SERVICES	3. 000000	O				95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	1
	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	1
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	
70. UU		0.000000	U				
200.00	Total (lines 50 through 199)	l l	1, 336, 969	1 4	22 0	Λ	200.00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-1
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0018	Period: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Prepared: 5/30/2024 7:46 am
	Title XVIII	Hospi tal	PPS

				5/30/2024 7:4	6 am
		Title XVIII	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s. excludina newborn)		42, 103	1.00
2.00	Inpatient days (including private room days, excluding swing-			42, 103	2.00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	3. 00
	do not complete this line.	· · · · · · · · · · · · · · · · · · ·			
4.00	Semi-private room days (excluding swing-bed and observation be			32, 163	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
	reporting period		04 6 11		, ,,,
6. 00	Total swing-bed SNF type inpatient days (including private roof reporting period (if calendar year, enter 0 on this line)	om days) after December	31 OF the COST	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private roor	n days) through December	31 of the cost	0	7. 00
7.00	reporting period	adys) through becomber	or or the cost	١	7.00
8.00	Total swing-bed NF type inpatient days (including private roor	n days) after December 3	1 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)	3 7			
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	9, 279	9. 00
	newborn days) (see instructions)			_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		dolli days) arter	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12. 00
	through December 31 of the cost reporting period	· ····y (······ ·······················		- [
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye				
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	14. 00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 o	f the cost	0.00	17. 00
17.00	reporting period	os trirough becomber of o	THE COST	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
20. 00	reporting period	after December 21 of t	ha acat	0. 00	20.00
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s arter becember 31 or t	ile cost	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions	5)		59, 378, 082	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	0	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
24.00	x line 18)	- 21 -6		0	24.00
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng perroa (irne	U	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
	x line 20)	9			
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		59, 378, 082	27. 00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		<u> </u>		
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 -	line 28)		0. 000000	31.00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	F 11116 20)		0.00000	32.00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruc	tions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin		,	0. 00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	59, 378, 082	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU		T	1 410 21	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		1, 410. 31 13, 086, 266	ı
40.00	Medically necessary private room cost applicable to the Progra	•		13, 000, 200	40.00
	Total Program general inpatient routine service cost (line 39	,		13, 086, 266	
		,	'		

	Financial Systems ATION OF INPATIENT OPERATING COST	ELKHART GENERA	Provider CC	N: 15-0018	Peri od: From 01/01/2023		
					To 12/31/2023		
	Cost Contar Decement on	Total	Title	XVIII Average Per	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total npatient Days[Program Cost (col. 3 x col. 4)	
. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00	42.
. 00	Intensive Care Type Inpatient Hospital Un	i ts		0.1	50 0		
. 00 . 01	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE	12, 758, 082 1, 515, 306	6, 027 652	2, 116. 8 2, 324. 0			1
	CORONARY CARE UNIT	1, 515, 306	002	2, 324. (
	BURN INTENSIVE CARE UNIT	0	0	0.0		·	
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0	0. (00 0	0	46. 47.
. 00	Cost Center Description						17.
. 00	Program inpatient ancillary service cost	(Wkst D 2 col 2	Line 200)			1. 00 20, 458, 953	48.
	Program inpatient cellular therapy acquis			II, line 10,	column 1)	20, 456, 955	
	Total Program inpatient costs (sum of lin					36, 650, 594	49.
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program	innationt routing s	arvicas (from	Wket D sur	of Parts L and	1, 366, 789] 50.
. 00	[111]	impatrent routine s	ervices (ITOIII	WKSt. D, Sui	ii Oi Pai tS i aiiu	1, 300, 769	30.
. 00	Pass through costs applicable to Program	inpatient ancillary	services (fro	om Wkst. D, s	sum of Parts II	779, 817	51.
. 00	and IV) Total Program excludable cost (sum of lin	nes 50 and 51)				2, 146, 606	52.
. 00	Total Program inpatient operating cost ex	cluding capital rel	ated, non-phys	sician anesth	netist, and	34, 503, 988	
	medical education costs (line 49 minus li TARGET AMOUNT AND LIMIT COMPUTATION	ne 52)					
. 00	Program di scharges					0	54
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge Adjustment amount per discharge (contract					0. 00 0. 00	
. 00	Target amount (line 54 x sum of lines 55,	55.01, and 55.02)				0	56
. 00 . 00	Difference between adjusted inpatient ope Bonus payment (see instructions)	erating cost and tar	get amount (li	ne 56 minus	line 53)	0	
. 00	Trended costs (lesser of line 53 ÷ line 5	64, or line 55 from	the cost repor	ting period	endi ng 1996,	0.00	1
. 00	updated and compounded by the market bask Expected costs (lesser of line 53 ÷ line		prior year co	et roport i	indated by the	0.00	60
	market basket)			•			
. 00	Continuous improvement bonus payment (if 55.01, or line 59, or line 60, enter the 53) are less than expected costs (lines 5 enter zero. (see instructions)	lesser of 50% of th	e amount by wh	nich operatir	ng costs (line	0	61
. 00	Relief payment (see instructions)					0	62
. 00	Allowable Inpatient cost plus incentive p PROGRAM INPATIENT ROUTINE SWING BED COST	payment (see instruc	tions)			0	63
. 00	Medicare swing-bed SNF inpatient routine	costs through Decem	ber 31 of the	cost reporti	ng period (See	0	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine	costs after Decembe	r 31 of the co	st reportino	g period (See	0	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient ro	outine costs (line 6	4 plus line 65	5)(title XVII	I only); for	0	66
. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient rou	·	•	, ,	3,	0	
	(line 12 x line 19)	3			. 3.		
. 00	Title V or XIX swing-bed NF inpatient rou (line 13 x line 20)	itine costs after De	cember 31 of 1	the cost repo	orting period	0	68
. 00	Total title V or XIX swing-bed NF inpatie PART III - SKILLED NURSING FACILITY, OTHE	,				0	69
. 00	Skilled nursing facility/other nursing fa)		70
	Adjusted general inpatient routine service		ne 70 ÷ line 2	2)			71
	Program routine service cost (line 9 x li Medically necessary private room cost app	-	(line 14 x lir	ne 35)			73
. 00	Total Program general inpatient routine s	service costs (line	72 + line 73)	•			74
. 00	Capital-related cost allocated to inpatie 26, line 45)	ent routine service	costs (from Wo	orksheet B, F	art II, column		75
	Per diem capital-related costs (line 75 ÷	-					76
	Program capital-related costs (line 9 x l Inpatient routine service cost (line 74 m						77
. 00	Aggregate charges to beneficiaries for ex	cess costs (from pr		*			79
	Total Program routine service costs for c	•	st limitation	(line 78 mir	nus line 79)		80
. 00 . 00	Inpatient routine service cost per diem I Inpatient routine service cost limitation						81
. 00	Reasonable inpatient routine service cost	s (see instructions)				83
	Program inpatient ancillary services (see Utilization review - physician compensati		5)				84 85
	Total Program inpatient operating costs (86
	PART IV - COMPUTATION OF OBSERVATION BED	PASS THROUGH COST					
. 00	Total observation bed days (see instructi	ons)				9, 940	87

Provider CCN: 15-0018	Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
To 12/31/2023 Date/Time Prepared: 5/30/2024 7: 46 am	COMPUTATION OF INPATIENT OPERATING COST		Provi der CC				
Cost Center Description 1.00 1.00						Date/Time Prep	
1.00			Title	XVIII	Hospi tal	PPS	
Second S	Cost Center Description						
Cost Center Description Cost Routine Cost (from line 21) Column 1 ÷ column 2 Column 2 Column 2 Column 2 Column 3 Column 2 Column 3 Column 4 Column 2 Column 5 Column 1 ÷ column 2 Column 6 Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Computation of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Computation of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Computation of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Computation of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Computation of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see instructions) Solution of Observation Bed Pass Through Cost (col. 3 x col. 4) (see						1.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST Sp. 378, 082 O.000000 14, 018, 481 O.91.00 O.00 O.0000000 O.000000 O.000000 O.0000000 O.0000000 O.00000000 O.0000000 O.000000000 O.0000000000	89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				14, 018, 481	89. 00
Bed Cost (from line 89)	Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST 1.00 2.00 3.00 4.00 5.00			(from line 21)	column 2	Observati on	Bed Pass	
A (see instructions)					Bed Cost (from	Through Cost	
1.00 2.00 3.00 4.00 5.00					line 89)	(col. 3 x col.	
1.00 2.00 3.00 4.00 5.00						4) (see	
COMPUTATION OF OBSERVATION BED PASS THROUGH COST 90.00 Capital -related cost 5,662,327 59,378,082 0.095361 14,018,481 1,336,816 90.00 91.00 Nursing Program cost 0 59,378,082 0.000000 14,018,481 0 91.00 92.00 Allied health cost 0 59,378,082 0.000000 14,018,481 0 92.00 14,018,48						instructions)	
90.00 Capital -related cost 5,662,327 59,378,082 0.095361 14,018,481 1,336,816 90.00 91.00 Nursing Program cost 0 59,378,082 0.000000 14,018,481 0 91.00 92.00 Allied health cost 0 59,378,082 0.000000 14,018,481 0 92.00		1.00	2.00	3. 00	4. 00	5. 00	
91.00 Nursing Program cost 0 59,378,082 0.000000 14,018,481 0 91.00 92.00 Allied health cost 0 59,378,082 0.000000 14,018,481 0 92.00	COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
92. 00 Allied health cost 0 59, 378, 082 0.000000 14, 018, 481 0 92. 00	90.00 Capital -related cost	5, 662, 327	59, 378, 082	0. 09536	1 14, 018, 481	1, 336, 816	90.00
	91.00 Nursing Program cost	0	59, 378, 082	0.00000	0 14, 018, 481	0	91.00
	92.00 Allied health cost	0	59, 378, 082	0.00000	0 14, 018, 481	0	92.00
93. 00 Al I other Medical Education 0 59, 378, 082 0. 000000 14, 018, 481 0 93. 00	93.00 All other Medical Education	0	59, 378, 082	0. 00000	0 14, 018, 481	0	93. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-	O018 Peri od: From 01/01/2023	Worksheet D-1
	Component CCN: 15	7-S018 To 12/31/2023	
	Title XVIII		PPS
		LDE	

		II the Aviii	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			2, 744	1. 00
2.00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day			2, 744	
3. 00	do not complete this line.	75). IT you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 744	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	11 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember e	or the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private roor	days) after December 21	of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	days) at tel becember 31	or the cost	U	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	103	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	oly (i polydina privato ro	om days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)		Joili days)	U	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		room days)	0	12. 00
12.00	through December 31 of the cost reporting period	t only (frictually private	(100 days)	U	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
14. 00	after December 31 of the cost reporting period (if calendar ye	•	, I	0	14. 00
15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	dii (excluding swing-bed c	iays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
47.00	SWING BED ADJUSTMENT			0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	tne cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
19. 00	reporting period	through December 21 of	the cost	0.00	19. 00
19.00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through becember 31 or	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		4, 016, 508	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0	22. 00
	5 x line 17)	04 6 11			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportir	ng period (line	0	24. 00
25 00	7 x line 19))1 -6 thtt!		0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	or the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		4, 016, 508	27. 00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	irges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		3 ,	0	
30.00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27	lino 20)		0. 000000	30.00
31. 00 32. 00	Average private room per diem charge (line 29 ÷ line 3)	- ITTIE 26)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00	
34. 00	Average per diem private room charge differential (line 32 mir		i ons)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	ne 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	4, 016, 508	
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see		T	1, 463. 74	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line	38)		150, 765	39. 00
40.00	Medically necessary private room cost applicable to the Program	•		150 745	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ 11116 40)	I	150, 765	41.00

MPUT	Financial Systems ATION OF INPATIENT OPERATING COST		Provider CC	N: 15-0018	Peri od:	Worksheet D-1	·2552 I
			Component C	CN: 15-S018	From 01/01/2023 To 12/31/2023		
			Title	XVIII	Subprovider -	PPS	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost Ir	ipati ent Daysl	col. 1	÷	(col. 3 x col. 4)	
. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	5. 00) 42
	Intensive Care Type Inpatient Hospital Units	-	- 1				
. 00	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE	0	0	0. 0 0. 0			
. 00	CORONARY CARE UNIT	0	0	0. 0		0	
	BURN INTENSIVE CARE UNIT	0	О	0.0		0	
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0	0.0	00 0	0	46
. 00	Cost Center Description						4/
00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 21, 101	48
. 00	Program inpatient cellular therapy acquisiti			II, line 10,	column 1)	21, 101	
. 00	Total Program inpatient costs (sum of lines				·	171, 866	49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routine so	rvices (from	Wket D sum	of Parts I and	16, 313	50
. 00	Tass through costs appricable to Frogram imp	attent routine se	ervices (IIOIII	WKSt. D, Suii	I OI FAILS I AIIU	10, 313	30
. 00	Pass through costs applicable to Program inp and IV)	atient ancillary	services (fro	om Wkst. D, s	sum of Parts II	566	51
. 00	Total Program excludable cost (sum of lines	50 and 51)				16, 879	52
. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION		ated, non-phys	sician anesth	etist, and	154, 987	53
. 00	Program di scharges					0	54
. 00	Target amount per discharge					0.00	
. 01 . 02	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	use only)				0. 00 0. 00	
. 00	Target amount (line 54 x sum of lines 55, 55					0.00	
. 00	Difference between adjusted inpatient operat		get amount (li	ne 56 minus	line 53)	0	
. 00	Bonus payment (see instructions)	I' FF # 4				0.00	
. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,		·	0.	0	0.00	
. 00	market basket) Continuous improvement bonus payment (if lin 55.01, or line 59, or line 60, enter the les	ser of 50% of the	amount by wh	nich operatin	ıg costs (İine	0	61
2. 00	53) are less than expected costs (lines 54 x enter zero. (see instructions) Relief payment (see instructions)	00), 01 1 % 01 1	ine target and	ount (Trie 50), otherwise	0	62
	Allowable Inpatient cost plus incentive paym	ent (see instruct	i ons)			0	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Decemb	ner 31 of the	cost reporti	ng period (See	0	64
	instructions) (title XVIII only)	J		·	3 1		
. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts after December	31 of the co	ost reporting	period (See	0	65
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64	l plus line 65	5)(title XVII	I only); for	0	66
. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routin	e costs through [ecember 31 of	the cost re	porting period	0	67
. 00	(line 12 x line 19)	-				_	
. 00	Title V or XIX swing-bed NF inpatient routin (line 13 \times line 20)	e costs after Dec	eiliber 31 OT 1	.ne cost repo	n tring period	0	68
. 00	Total title V or XIX swing-bed NF inpatient					0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70
	Adjusted general inpatient routine service c						71
	Program routine service cost (line 9 x line	•	lino 14 ·· !	2E)			72
. 00 . 00	Medically necessary private room cost applic Total Program general inpatient routine serv			ie 35)			73
. 00	Capital -related cost allocated to inpatient 26, line 45)	routine service o		orksheet B, F	Part II, column		75
. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76
. 00	Inpatient routine service cost (line 74 minu						78
. 00	Aggregate charges to beneficiaries for exces				11 70		79
. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		ST limitation	(line 78 min	ius Iine 79)		80
. 00	Inpatient routine service cost per diem IImi Inpatient routine service cost limitation (I						82
. 00	Reasonable inpatient routine service costs (· · · · · · · · · · · · · · · · · · ·					83
. 00	Program inpatient ancillary services (see in		. `				84
						(85
. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						86

Health Financial Systems	ELKHART GENERA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
			CCN: 15-S018	From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 7:40	
		Title	XVIII	Subprovider - IPF	PPS	
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per of	diem (line 27 ÷	line 2)			0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00
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 O	COST					
90.00 Capital -related cost	434, 592	4, 016, 508	0. 10820	1 0	0	90.00
91.00 Nursing Program cost	O	4, 016, 508	0.00000	0 0	0	91.00
92.00 Allied health cost	o	4, 016, 508	0.00000	0 0	0	92.00
93.00 All other Medical Education	o	4, 016, 508		0 0	0	93. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0018	Peri od: From 01/01/2023 To 12/31/2023	Worksheet D-1 Date/Time Pre 5/30/2024 7:4	pared:
	Title XIX	Hospi tal	PPS	
0 1 0 1 5 : 1:				

		Title XIX	Hospi tal	PPS	o aiii
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00 2. 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-b			42, 103 42, 103	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed day		vate room days.	42, 103	3.00
	do not complete this line.	,=, ,== , , , ,			
4.00	Semi-private room days (excluding swing-bed and observation be		24 6 11	32, 163	4.00
5. 00	Total swing-bed SNF type inpatient days (including private rooreporting period	om days) through December	1 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December 3	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)			_	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	n days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	n days) after December 3°	1 of the cost	0	8. 00
	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	1, 185	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII or	nlv (including private ro	nom davs)	0	10. 00
	through December 31 of the cost reporting period (see instruct	i ons)	<i>,</i>	· ·	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, er Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
12.00	through December 31 of the cost reporting period	Comy (Thereaming private	o room days)	· ·	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI>			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar ye Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	ill (excluding swing-bed to	lays)	1, 988	
16. 00	Nursery days (title V or XIX only)			280	16. 00
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	f the cost	0.00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
	reporting period				
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng poriod (line	59, 378, 082 0	21. 00 22. 00
22.00	5 x line 17)	er 31 of the cost reporti	ng perrou (Trie	U	22.00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	g period (line 6	0	23. 00
24.00	x line 18)	- 24		0	24.00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 line 19)	31 of the cost reportin	ig period (iine	U	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
0/ 00	x line 20)				0, 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (Tine 21 minus line 26)		0 59, 378, 082	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			37, 370, 002	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 =	line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	1111e 20)		0.00000	32. 00
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34. 00	Average per diem private room charge differential (line 32 mir		tions)	0.00	34.00
35. 00 36. 00	Average per diem private room cost differential (line 34 x lir Private room cost differential adjustment (line 3 x line 35)	ie 31)		0.00	35. 00 36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dit	fferential (line	59, 378, 082	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	ICTMENTS			
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU Adjusted general inpatient routine service cost per diem (see			1, 410. 31	38. 00
39. 00	Program general inpatient routine service cost per drem (see			1, 671, 217	39. 00
40.00	Medically necessary private room cost applicable to the Progra	,		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		1, 671, 217	41.00

	Financial Systems ATION OF INPATIENT OPERATING COST	ELKHART GENERAL	HOSPITAL Provider CCM		In Lie eriod: rom 01/01/2023	u of Form CMS-: Worksheet D-1	
					o 12/31/2023	Date/Time Pre 5/30/2024 7:4	
			Title		Hospi tal	PPS	o diii
	Cost Center Description	Total Inpatient CostIn		col . 2)	Program Days	Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1. 00 5, 286, 644	2. 00 1, 988	3. 00 2, 659. 28	4. 00 280	5. 00 744, 598	42. 00
	Intensive Care Type Inpatient Hospital Units						
	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE	12, 758, 082 1, 515, 306	6, 027 652	2, 116. 82 2, 324. 09	96 98	203, 215 227, 761	1
	CORONARY CARE UNIT	0	0	0.00	0	0	
	BURN INTENSIVE CARE UNIT	0	0	0.00		0	
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	0	0. 00	0	0	46. 00 47. 00
	Cost Center Description	1	'				
48. 00	Program inpatient ancillary service cost (Wk:	st. D-3, col. 3,	line 200)			1. 00 8, 633, 275	48. 00
48. 01	Program inpatient cellular therapy acquisition Total Program inpatient costs (sum of lines of PASS THROUGH COST ADJUSTMENTS	on cost (Workshee	et D-6, Part I		column 1)	0 11, 480, 066	48. 01
50. 00	Pass through costs applicable to Program inpa	atient routine se	ervices (from)	Wkst. D, sum	of Parts I and	233, 510	50.00
51. 00	III) Pass through costs applicable to Program inpa	atient ancillary	services (fro	m Wkst D su	m of Parts II	397, 212	51.00
	and IV)	,	361 11 663 (11 6	iii wkst. <i>D</i> , sui	. 01 141 (3 11		
	Total Program excludable cost (sum of lines! Total Program inpatient operating cost excluded medical education costs (line 49 minus line!	ding capital rela	ited, non-phys	ician anesthe	tist, and	630, 722 10, 849, 344	
	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
	Target amount per discharge					0.00	
	Permanent adjustment amount per discharge	ioo anliv)				0.00	
	Adjustment amount per discharge (contractor of Target amount (line 54 x sum of lines 55, 55.	0.00	1				
57. 00	Difference between adjusted inpatient operati	0					
58. 00 59. 00							58. 00 59. 00
60. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54, or line 55 from prior year cost report, updated by the						60.00
61. 00	market basket) Continuous improvement bonus payment (if line 55.01, or line 59, or line 60, enter the less					0	61. 00
	53) are less than expected costs (lines 54 \times enter zero. (see instructions)						
63.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruct	ions)			0	
	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	er 31 of the	cost reportin	g period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)</pre>	ts after December	31 of the co	st reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH, see instructions	ne costs (line 64	plus line 65)(title XVIII	only); for	0	66. 00
	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19) $$	0		·	0 .	0	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)			· ·	ting period	0	
	Total title V or XIX swing-bed NF inpatient of PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facility	JRSING FACILITY,	AND ICF/IID OF	NLY		0	70.00
71. 00	Adjusted general inpatient routine service co	ost per diem (lir		, ,			71.00
	Program routine service cost (line 9 x line Modically pocossary private room cost applied	•	lino 14 v 1:-	o 35)			72.00
	Medically necessary private room cost applications Total Program general inpatient routine servi	•		e 30 <i>)</i>			73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service o	,	rksheet B, Pa	rt II, column		75. 00
	Per diem capital-related costs (line 75 ÷ lin Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)		_			78. 00
	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa			*.	sline 70)		79. 00 80. 00
	Inpatient routine service costs for compa		, c i i i ii tati Uil	CTTIC 70 IIITIU:	5 11116 /7)		81.00
82. 00	Inpatient routine service cost limitation (li	ne 9 x line 81)					82.00
	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in						83. 00 84. 00
85. 00	Utilization review - physician compensation	(see instructions					85. 00
86. 00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ough 85)				86. 00
	Total observation bed days (see instructions))				9, 940	
88. 00	Adjusted general inpatient routine cost per o	diem (line 27 ÷ l	ine 2)			1, 410. 31	88.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Peri od:	Worksheet D-1	
				From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 7:40	
		Title	e XIX	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				14, 018, 481	89. 00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	5, 662, 327	59, 378, 082	0. 09536	1 14, 018, 481	1, 336, 816	90.00
91.00 Nursing Program cost	0	59, 378, 082	0.00000	0 14, 018, 481	0	91.00
92.00 Allied health cost	0	59, 378, 082	0.00000	0 14, 018, 481	0	92.00
93.00 All other Medical Education	0	59, 378, 082	0. 00000	0 14, 018, 481	0	93. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0018		Worksheet D-1
	Component CCN: 15-S018	From 01/01/2023 To 12/31/2023	
	Title XIX	Subprovi der -	PPS

		Title XIX	Subprovi der - I PF	PPS	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			2, 744	1. 00
2.00	Inpatient days (including private room days, excluding swing-		ivata room days	2, 744 0	2.00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). IT you have only pr	ivate room days,	U	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 744	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	om davs) after December	31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	on days) at tel becember	of the cost	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
0.00	reporting period	m daya) aftar Dagambar 3	1 of the cost	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	m days) after becember 3	or the cost	U	8. 00
9.00	Total inpatient days including private room days applicable to	o the Program (excluding	swing-bed and	100	9. 00
	newborn days) (see instructions)			_	
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on through December 31 of the cost reporting period (see instruc-		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en	nter 0 on this line)			
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	X only (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye	ear, enter O on this lin	e)		
14. 00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed	days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)				15. 00 16. 00
10.00	SWING BED ADJUSTMENT			280	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
10.00	reporting period	 D 21 - -	46	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		4, 016, 508	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ing period (line	0	22. 00
22 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	21 of the cost reportin	a ported (line 4	0	23. 00
23. 00	x line 18)	31 of the cost reportin	g perrou (Trile 6	U	23.00
24. 00	Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ng period (line	0	24. 00
25 00	7 x line 19)	21 -6			25 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (iine 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 016, 508	27. 00
28 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	d and observation had ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	a and observation bed ch	ai ges)	0	
30. 00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00 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 mi)	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x li		ŕ	0. 00	35. 00
36.00	Private room cost differential adjustment (line 3 x line 35)		ee	0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	rrerential (line	4, 016, 508	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU				
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 463. 74	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			146, 374 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	•		146, 374	
		· · · · · · · · · · · · · · · · · · ·	'		

2.00 NURSERY (title V Intensive Care T 3.00 INTENSIVE CARE U 3.01 NEONATAL INTENSI 4.00 CORONARY CARE UN 5.00 BURN INTENSIVE C 6.00 SURGICAL INTENSI 7.00 OTHER SPECIAL CA Cost Center 8.00 Program inpatien 9.00 Program inpatien 9.00 Pass through cos and IV) 1.00 Pass through cos and IV) 2.00 Total Program ex 3.00 Total Program in medical education TARGET AMOUNT AN Program discharg 5.00 Target amount per 9.00 Target amount (I Difference betwee 8.00 Bonus payment (s 9.00 Trended costs (I updated and compound for the second for t	T Description T & XIX only) ype Inpatient Hospital Uni NIT VE CARE IT ARE UNIT VE CARE UNIT RE (SPECIFY) Description It ancillary service cost of the cellular therapy acquisical patient costs (sum of line) T ADJUSTMENTS Its applicable to Program in the cellular toperating cost excensions (line 49 minus line) LIMIT COMPUTATION Description T ADJUSTMENTS T ADJUSTMENTS T S APPLICABLE TO PROGRAM T COMPUTATION	(Wkst. D-3, col. 3, ition cost (Workshee es 41 through 48.01) inpatient routine seinpatient ancillary es 50 and 51) cluding capital relane 52) or use only) 55.01, and 55.02) rating cost and targed, or line 55 from the et) 54, or line 55 from the et) 11 ine 53 ÷ line 54 is lesser of 50% of the	2.00 2.00 0 0 0 0 0 0 0 0 0 0 0 t D-6, Part II (see instructi rvices (from V services (from V ted, non-physi et amount (lin the cost report prior year cost	CN: 15-S018 E XIX Average Per Diem (col. 1 col. 2) 3.00 0.0 0.0 0.0 0.0 Wkst. D, sur Diem Wkst. D,	# 4.00 00 0 0 0 00 0 0 00 0 0 0 00 0 0 00 0 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 00 0 0 0 0 00 0 0 0 00 0 0 0 0	1.00 251,056 397,430 15,838 7,402 23,240 374,190	0 42 0 433 0 443 0 443 0 446 47 6 48 6 48 6 0 49 8 50 5 51 0 52 0 53			
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PROGRAM INPATIEN Medicare swing-b instructions)(ti Medicare swing-b instructions)(ti Total Medicare sc CAH, see instruct OO Title V or XIX s (line 12 x line Title V or XIX s (line 13 x line Total title V or PART III - SKILL	see instructions)					C	0 62			
.00 Medicare swing-binstructions)(ti .00 Medicare swing-binstructions)(ti .00 Total Medicares .00 Total Medicares .00 Title V or XIX s (line 12 x line .00 Title V or XIX s (line 13 x line .00 Total title V or PART III - SKILL	ent cost plus incentive pa	ayment (see instruct	i ons)			<u> </u>	0 63			
instructions)(ti .00 Medicare swing-b instructions)(ti .00 Total Medicare s CAH, see instruct .00 Title V or XIX s (line 12 x line Title V or XIX s (line 13 x line .00 Total title V or PART III - SKILL	T ROUTINE SWING BED COST ed SNF inpatient routine o	rosts through Decemb	er 31 of the (cost reporti	ng period (See	<u> </u>	0 64			
instructions)(ti Total Medicare s CAH, see instruct Title V or XIX s (line 12 x line Title V or XIX s (line 13 x line Total title V or PART III - SKILL	•	costs through becemb	er 51 or the t	cost reporti	ng perrou (see		7 04			
Total Medicare s CAH, see instruct OO Title V or XIX s (line 12 x line) Title V or XIX s (line 13 x line) Total title V or PART III - SKILL	ed SNF inpatient routine of	costs after December	31 of the cos	st reportino	g period (See	C	0 65			
CAH, see instruction. COUNTY TITLE V or XIX solution. COUNTY TITLE V or XIX solution. COUNTY TOTAL TITLE V or PART III - SKILL	tie XVIII only) wing-bed SNF inpatient rou	utine costs (line 64	nlus line 65	S)(title XVII	l only): for	ر ا	0 66			
(line 12 x line Title V or XIX s (line 13 x line Total title V or PART III - SKILL		attile costs (Tille of	prus rriie ee,	,, (11 11 0 7, 111	1 om y), 101					
.00 Title V or XIX s (line 13 x line .00 Total title V or PART III - SKILL	wing-bed NF inpatient rout	tine costs through D	ecember 31 of	the cost re	eporting period	C	0 67			
(line 13 x line Total title V or PART III - SKILL	wing-bed NF inpatient rout	tine costs after Dec	ember 31 of th	he cost repo	orting period	C	0 68			
PART III - SKILL	20)			•	3					
	XIX swing-bed NF inpatier					<u> </u>	0 69			
	facility/other nursing fac)		70			
, ,	inpatient routine service	e cost per diem (line					71			
"	service cost (line 9 x lir ary private room cost appl		ling 14 v liss	no 35)			72			
1	neral inpatient routine se	,		ic 33)			74			
. 00 Capi tal -rel ated	cost allocated to inpatier	,		orksheet B, F	Part II, column		75			
26, line 45) .00 Per diem capital	-related costs (line 75 ÷	line 2)					76			
	related costs (line 9 x li	. *					77			
1 -	e service cost (line 74 mi	•					78			
00 0	s to beneficiaries for exc			`						
,		•		*.	nus line 70)					
.00 Inpatient routin	utine service costs for come service cost per diem li	omparison to the cos		*.	nus line 79)		80 81			
	utine service costs for co e service cost per diem li e service cost limitation	omparison to the cosimitation (line 9 x line 81)	t limitation	*.	nus line 79)		80 81 82			
	utine service costs for co e service cost per diem li e service cost limitation ient routine service costs	omparison to the cos imitation (line 9 x line 81) s (see instructions)	t limitation	*.	nus line 79)		80 81 82 83			
.00 Total Program in	utine service costs for co e service cost per diem li e service cost limitation	omparison to the cosimitation (line 9 x line 81) s (see instructions) instructions)	t limitation	*.	nus line 79)		80 81 82			

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		Component (From 01/01/2023 To 12/31/2023		
		Titl	e XIX	Subprovi der - I PF	PPS	
Cost Center Description						
					1. 00	
88.00 Adjusted general inpatient routine cost per of	diem (line 27 ÷	line 2)			0.00	88.00
89.00 Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
				,	4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	COST					
90.00 Capital -related cost	434, 592	4, 016, 508	0. 10820	1 0	0	90.00
91.00 Nursing Program cost	0	4, 016, 508	0. 00000	0	0	91.00
92.00 Allied health cost	0	4, 016, 508	0. 00000	0	i ol	92.00
93.00 All other Medical Education	0	4, 016, 508	0. 00000	0 0	0	93.00

Health Financial Systems ELKHARI GENERAL F	HUSPITAL		In Lie	eu of form CMS	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC		Peri od:	Worksheet D-3	
			rom 01/01/2023		
		7	To 12/31/2023		
		2071.1.1		5/30/2024 7: 4	6 am
	IITIE	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cost		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1. 00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			33, 336, 068		30. 00
31.00 O3100 INTENSIVE CARE UNIT			7, 832, 784		31.00
31. 01 03101 NEONATAL INTENSIVE CARE			0		31. 01
32. 00 03200 CORONARY CARE UNIT			0		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT			0		34.00
40. 00 04000 SUBPROVI DER - 1 PF			0		40. 00
41. 00 04100 SUBPROVI DER - I RF			0		41. 00
43. 00 04300 NURSERY					43.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM		0. 227736	18, 691, 069	4, 256, 629	50.00
51. 00 05100 RECOVERY ROOM		0.000000	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0.000000	o	0	52. 00
53. 00 05300 ANESTHESI OLOGY		0.000000	o	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 157625	4, 637, 276	730, 951	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0.000000		0	55. 00
56. 00 05600 RADI 0I SOTOPE		0. 000000		0	56.00
57. 00 05700 CT SCAN		0. 030579			57. 00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI)		0. 101651			1
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 056423			
60. 00 06000 LABORATORY		0. 134366	1		1
60. 01 06001 BL00D LABORATORY		0. 000000		1, 772, 407	1
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0. 000000		0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS				0	62.00
		0. 000000		0	63.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 000000			1
64. 00 06400 I NTRAVENOUS THERAPY		0. 535272			64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 199022			
66. 00 06600 PHYSI CAL THERAPY		0. 453089			
67. 00 06700 OCCUPATI ONAL THERAPY		0. 295143		294, 597	
68. 00 06800 SPEECH PATHOLOGY		0. 345019			
69. 00 06900 ELECTROCARDI OLOGY		0. 000000		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.000000		0	70.00
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		0. 157525			
72. 00 O7200 I MPL. DEV. CHARGED TO PATIENTS		0. 171314			
73.00 O7300 DRUGS CHARGED TO PATIENTS		0. 163021			
74. 00 07400 RENAL DI ALYSI S		0. 000000		0	74. 00
75.00 O7500 ASC (NON-DISTINCT PART)		0. 000000		0	75. 00
76. 00 03140 CARDI OLOGY		0. 133459			1
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0. 000000	0	0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY		0. 000000	0	0	78. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0. 000000)	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.000000		0	89. 00
90. 00 09000 CLI NI C		0. 73978	176	130	90.00
90. 01 04950 SLEEP CLINIC		0. 221107	7 0	0	90. 01
91. 00 09100 EMERGENCY		0. 374703		1, 241, 482	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 395944			1
OTHER REIMBURSABLE COST CENTERS					
94. 00 O9400 HOME PROGRAM DI ALYSI S		0. 000000	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES		0.00000	1	Ĭ	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 000000)	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0. 000000		0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0. 000000		0	98.00
200.00 Total (sum of lines 50 through 94 and 96 through 98)		0.000000	118, 001, 587		
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		110,001,367	20, 400, 703	200.00
202.00 Net charges (line 200 minus line 201)	(TITIE OI)		118, 001, 587		
202.00 Net charges (True 200 IIII hus True 201)	l		110,001,387	I	202. 00

Health Financial Systems ELKHART INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	GENERAL HOSPITAL Provider CCN: 15	5-0018 F	eriod:	u of Form CMS-2 Worksheet D-3	∠35Z-I
THE ATTEMP AND LEARN SERVICE GOOD AND ONLY COMMENT	Component CCN: 1	F	From 01/01/2023 Fo 12/31/2023	Date/Time Pre	nared:
	·			5/30/2024 7: 4	
	Title XVII		Subprovi der - I PF	PPS	
Cost Center Description		o of Cost Charges	Program	Inpatient Program Costs (col. 1 x col. 2)	
LANDATI ENT. DOUTLAND OFFICE OF COOT OFFITTED		1.00	2. 00	3. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			T		30 0
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 03101 NEONATAL INTENSIVE CARE 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 43. 00 04300 NURSERY			250, 326		30. 0 31. 0 31. 0 32. 0 33. 0 34. 0 40. 0 41. 0 43. 0
ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM		0. 227736	ol ol	0	50. 00
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY		0. 000000 0. 000000 0. 000000 0. 157625 0. 000000 0. 030579 0. 101651 0. 056423 0. 134366 0. 000000	0 0 0 5 1, 184 0 0 0 7 5, 475 1 0 3 0 35, 124	0 0 187 0 167 0 4, 719 0	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 3. 00 06300 BLOOD STORING, PROCESSING & TRANS. 4. 00 06400 I NTRAVENOUS THERAPY 5. 00 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 07. 00 06700 OCCUPATI ONAL THERAPY 8. 00 06800 SPEECH PATHOLOGY 9. 00 07000 ELECTROCARDI OLOGY 0. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS		0. 000000 0. 000000 0. 535272 0. 199022 0. 453089 0. 295143 0. 345019 0. 000000 0. 157522	0 2 2 9,878 9 1,000 3 1,192 9 0 0 0 0	0 0 1, 966 453 352 0 0	62. 0 63. 0 64. 0 65. 0 66. 0 67. 0 68. 0 69. 0 71. 0
72. 00		0. 171314 0. 163021 0. 000000 0. 000000 0. 133459 0. 000000	1 41, 243 0 0 0 0 9 2, 508 0 0	0 6, 723 0 0 335 0	74. 00 75. 00 76. 00 77. 00
0UTPATIENT SERVICE COST CENTERS 8. 00		0. 000000 0. 000000 0. 739781 0. 221107 0. 374703 0. 395944	0 1 0 7 0 3 16, 543	0 0 0 0 6, 199	88. 0 89. 0 90. 0 90. 0 91. 0
OTHER REIMBURSABLE COST CENTERS		0.000000	J 21		
14.00 09400 HOME PROGRAM DI ALYSIS 5.00 09500 AMBULANCE SERVICES 09600 DURABLE MEDICAL EQUIP-RENTED 17.00 09700 DURABLE MEDICAL FOULP-SOLD		0. 000000 0. 000000	0	0	95. 0

0.000000

0.000000

0 97.00 0 98.00 21, 101 200.00

201. 00 202. 00

200.00

201.00 202.00

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

98.00 09850 OTHER REIMBURSABLE COST CENTERS

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

Health Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider C		Peri od:	Worksheet D-3	
				From 01/01/2023 To 12/31/2023	Date/Time Pre	narod:
				10 12/31/2023	5/30/2024 7:4	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description			Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			1			
30. 00 03000 ADULTS & PEDI ATRI CS				23, 359, 373		30.00
31. 00 03100 INTENSIVE CARE UNIT				5, 935, 427		31.00
31. 01 03101 NEONATAL INTENSIVE CARE				833, 656		31. 01
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT				0		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT				0		33. 00 34. 00
40. 00 04000 SUBPROVI DER - 1 PF				0		40.00
41. 00 04100 SUBPROVI DER - IFF				0		41.00
43. 00 04300 NURSERY				2, 440, 475		43. 00
ANCI LLARY SERVI CE COST CENTERS			1	2/ 110/ 170		10.00
50. 00 05000 OPERATI NG ROOM			0. 22773	6 9, 966, 105	2, 269, 641	50.00
51.00 05100 RECOVERY ROOM			0.00000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0.00000	0 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY			0.00000	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 15762	5 3, 795, 386	598, 248	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C			0.00000	0	0	55. 00
56. 00 05600 RADI 0I SOTOPE			0.00000	0	0	56. 00
57.00 05700 CT SCAN			0. 03057	9 4, 462, 595	136, 462	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)			0. 10165		57, 950	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON			0. 05642		159, 383	1
60. 00 06000 LABORATORY			0. 13436		1, 164, 696	1
60. 01 06001 BLOOD LABORATORY			0.00000		0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.00000		0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0.00000		0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.			0.00000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY			0. 53527 0. 19902		431, 995 668, 619	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY			0. 19902			
67. 00 06700 OCCUPATI ONAL THERAPY			0. 49500		103, 350	
68. 00 06800 SPEECH PATHOLOGY			0. 34501		41, 066	1
69. 00 06900 ELECTROCARDI OLOGY			0. 00000		0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY			0. 00000		Ö	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 15752		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 17131		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 16302	1 11, 469, 010	1, 869, 689	73. 00
74. 00 07400 RENAL DI ALYSI S			0.00000	0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)			0.00000	0 0	0	75. 00
76. 00 03140 CARDI OLOGY			0. 13345		135, 118	1
77.00 07700 ALLOGENEIC HSCT ACQUISITION			0.00000		0	77. 00
78. 00 07800 CAR T-CELL IMMUNOTHERAPY			0.00000	0 0	0	78. 00
OUTPATIENT SERVICE COST CENTERS			0 005	al =		00.00
88. 00 08800 RURAL HEALTH CLINIC			0.00000		0	1
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0.00000		0	
90. 00 09000 CLI NI C 90. 01 04950 SLEEP CLI NI C			0. 73978		0 0	90.00
90. 01 04950 SLEEP CLI NI C 91. 00 09100 EMERGENCY			0. 22110		830, 970	90. 01 91. 00
			0. 37470 0. 39594			
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS			0. 37374	- 1 0	0	92.00
94. 00 09400 HOME PROGRAM DIALYSIS			0.00000	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES			3.00000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED			0. 00000	0 0	0	
97. 00 09700 DURABLE MEDICAL EQUI P-SOLD			0. 00000		ő	
98.00 09850 OTHER REIMBURSABLE COST CENTERS			0.00000		0	98. 00
200.00 Total (sum of lines 50 through 94 and 9	96 through 98)			49, 988, 491	8, 633, 275	
201.00 Less PBP Clinic Laboratory Services-Pro	ogram only charges	(line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)				49, 988, 491		202. 00

Health Financial Systems INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	ELKHART GENERAL HOSPITAL Provider	CCN: 15-0018	Peri od:	wof Form CMS-3 Worksheet D-3	
		CCN: 15-S018	From 01/01/2023 To 12/31/2023	Date/Time Pre 5/30/2024 7:4	
	Ti t	tle XIX	Subprovi der - I PF	PPS	
Cost Center Description		Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					1 20 0
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 31. 01 03101 NEONATAL INTENSIVE CARE 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 40. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF			3, 686, 855		30. 0 31. 0 31. 0 32. 0 33. 0 34. 0 40. 0 41. 0
43. 00 O4300 NURSERY					43.0
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM		0. 2277	36 0	0	50.0
51. 00 05100 RECOVERY ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE IMAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY 60. 01 06010 BLOOD LABORATORY 61. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORI NG PROCESSI NG & TRANS 64. 00 06400 INTRAVENOUS THERAPY		0. 0000 0. 0000 0. 0000 0. 1576 0. 0000 0. 0305 0. 1016 0. 0564 0. 1343 0. 0000 0. 0000 0. 0000 0. 0000 0. 0000 0. 5352	00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 3,015 0 0 1,985 474 0 63,491 0	52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00
55. 00		0. 1990 0. 4530 0. 2951 0. 3450 0. 0000 0. 0000 0. 1575 0. 1713 0. 1630	22 23, 555 89 5, 465 43 521 19 0 00 0 00 0 25 0 14 0 21 448, 647	4, 688 2, 476 154 0 0 0 0 73, 139	65. 0 66. 0 67. 0 68. 0 69. 0 70. 0 71. 0 72. 0 73. 0
75. 00		0. 00000 0. 1334 0. 00000 0. 00000	59 40, 880 00 0	0 5, 456 0 0	76. 00 77. 00
001PATIENT SERVICE COST CENTERS 88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 90. 01 04950 SLEEP CLINIC 91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 00000 0. 00000 0. 7397; 0. 2211! 0. 3747; 0. 3959;	00 0 81 0 07 0 03 256, 678		89. 0 90. 0 90. 0 91. 0
OTHER REIMBURSABLE COST CENTERS					
94. 00 09400 HOME PROGRAM DI ALYSIS 95. 00 09500 AMBULANCE SERVICES 96. 00 09600 DURABLE MEDICAL FOLLE-RENTED		0.0000		0	95. 0

96.00

97.00 0

98. 00 0

201. 00 202. 00

251, 056 200. 00

0.000000

0.000000

0.000000

1, 336, 969

97.00

200.00

201.00 202.00

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

09700 DURABLE MEDICAL EQUIP-SOLD

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

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

98.00 09850 OTHER REIMBURSABLE COST CENTERS

	Title WILL Heari	+ 0	5/30/2024 7: 4 PPS	6 am
	Title XVIII Hospi	tai	PPS	
			1. 00	
4 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1 4 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to October 1 (see instructions)		0 23, 443, 843	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after October 1 (see instructions)		6, 927, 435	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to 0 1 (see instructions)	ctober	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or afte October 1 (see instructions)	r	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount		0	2. 00 2. 01
2.02	Outlier payment for discharges for Model 4 BPCI (see instructions)		0	2. 02
2.03	Outlier payments for discharges occurring prior to October 1 (see instructions)		629, 555	2. 03
2. 04 3. 00	Outlier payments for discharges occurring on or after October 1 (see instructions) Managed Care Simulated Payments		41, 091 0	2. 04 3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see instructions)		173. 90	4. 00
1. 00	Indirect Medical Education Adjustment		170.70	1.00
5. 00	FTE count for allopathic and osteopathic programs for the most recent cost reporting period end or before 12/31/1996. (see instructions)	ing on	0. 00	5. 00
5. 01 6. 00	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see instructions) FTE count for allopathic and osteopathic programs that meet the criteria for an add-on to the c	on for	0. 00 0. 00	5. 01 6. 00
6.00	new programs in accordance with 42 CFR 413.79(e)	ар гог	0.00	0.00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window closed under §1 the CAA 2021 (see instructions)	27 of	0. 00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B) ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) I		0. 00 0. 00	7. 00 7. 01
	cost report straddles July 1, 2011 then see instructions.			
7. 02	Adjustment (increase or decrease) to the hospital's rural track program FTE limitation(s) for r track programs with a rural track for Medicare GME affiliated programs in accordance with 413.7 and 87 FR 49075 (August 10, 2022) (see instructions)		0.00	7. 02
8. 00	Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).		0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the report straddles July 1, 2011, see instructions.	e cost	0.00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)	I	0. 00	8. 02
8. 21	The amount of increase if the hospital was awarded FTE cap slots under §126 of the CAA 2021 (se instructions)	е	0. 00	8. 21
9. 00	Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines 7 and 7.01, plu minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructions)	s or	0.00	9. 00
10.00	FTE count for allopathic and osteopathic programs in the current year from your records		0.00	
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			11. 00 12. 00
13. 00	Total allowable FTE count for the prior year.			13.00
14. 00	Total allowable FTE count for the penultimate year if that year ended on or after September 30, otherwise enter zero.	1997,		14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			15. 00
16. 00	Adjustment for residents in initial years of the program (see instructions)			16.00
17. 00 18. 00	Adjustment for residents displaced by program or hospital closure Adjusted rolling average FTE count		0.00	17. 00 18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).		0.00000	
20. 00	Prior year resident to bed ratio (see instructions)		0. 000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)		0. 000000	21. 00
22. 00	IME payment adjustment (see instructions)		0	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)		0	22. 01
23. 00	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).		0.00	23. 00
24. 00	IME FTE Resident Count Over Cap (see instructions)		0.00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)		0.00	25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)		0. 000000	26.00
27. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)		0. 000000	27. 00 28. 00
28. 00 28. 01	IME add-on adjustment amount - Managed Care (see instructions)		0	28. 00
29. 00	Total IME payment (sum of lines 22 and 28)		0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment		0	29. 01
30. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)		3. 93	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)		24. 22	•
32.00	Sum of lines 30 and 31		28. 15	1
33.00	Allowable disproportionate share percentage (see instructions)		12.44	1
34. 00	Disproportionate share adjustment (see instructions)		944, 547	34.00

CALCUI	ATION OF REIMBURSEMENT SETTLEMENT	HOSPITAL Provider CCN: 15-0018	Peri od:	u of Form CMS-2 Worksheet E	
712002	ATTOM OF RETHINGROEMENT GETTEEMENT	Trevider con. 10 core	From 01/01/2023 To 12/31/2023	Part A Date/Time Prep 5/30/2024 7:40	pared: 6 am
		Title XVIII	Hospi tal	PPS	<u> </u>
			Prior to 10/1		
	Uncompanyated Care Dayment Adjustment		1. 00	2. 00	
35. 00	Uncompensated Care Payment Adjustment Total uncompensated care amount (see instructions)		6 874 403 459	5, 938, 006, 757	35. O
35. 01	Factor 3 (see instructions)		0. 000327497	0. 000306281	35. 0
35. 02	Hospital UCP, including supplemental UCP (see instructions)		2, 251, 344	1, 818, 698	
35. 03	Pro rata share of the hospital UCP, including supplemental UCF	o (see instructions)	1, 683, 881	457, 159	35.0
36. 00	Total UCP adjustment (sum of columns 1 and 2 on line 35.03)		2, 141, 040		36.0
10 00	Additional payment for high percentage of ESRD beneficiary dis	scharges (lines 40 throu			1,00
10.00	Total Medicare discharges (see instructions) Total ESRD Medicare discharges (see instructions)		0		40. C
1. 01	Total ESRD Medicare covered and paid discharges (see instructi	ons)	0		41.0
2. 00	Divide line 41 by line 40 (if less than 10%, you do not qualit		0.00		42. C
3. 00	Total Medicare ESRD inpatient days (see instructions)		0		43.0
4. 00	Ratio of average length of stay to one week (line 43 divided by	by line 41 divided by 7	0. 000000		44. 0
5. 00	days) Average weekly cost for dialysis treatments (see instructions)		0.00		45. C
6. 00	Total additional payment (line 45 times line 44 times line 41.		0.00		46.0
7. 00	Subtotal (see instructions)		34, 127, 511		47.0
8. 00	Hospital specific payments (to be completed by SCH and MDH, sm	mall rural hospitals	0		48.0
	only. (see instructions)			•	
				Amount 1.00	
9. 00	Total payment for inpatient operating costs (see instructions))		34, 127, 511	49. (
0. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and	d Pt. II, as applicable)		2, 468, 785	50. (
1. 00	Exception payment for inpatient program capital (Wkst. L, Pt.	III, see instructions)		0	51. (
2. 00	Direct graduate medical education payment (from Wkst. E-4, lir	ne 49 see instructions).		0	52. (
3. 00	Nursing and Allied Health Managed Care payment			3, 824	53.
4. 00 4. 01	Special add-on payments for new technologies Islet isolation add-on payment			147, 082 0	54. (54. (
5. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69	9)		Ö	55. (
5. 01	Cellular therapy acquisition cost (see instructions)	,		0	55. (
6. 00	Cost of physicians' services in a teaching hospital (see intru	ucti ons)		0	56. (
7. 00	Routine service other pass through costs (from Wkst. D, Pt. II		hrough 35).	0	57.
8.00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 11 line 200)		8, 028	
9. 00 0. 00	Total (sum of amounts on lines 49 through 58) Primary payer payments			36, 755, 230 0	59. (60. (
1. 00	Total amount payable for program beneficiaries (line 59 minus	line 60)		36, 755, 230	
2. 00	Deductibles billed to program beneficiaries			3, 069, 300	•
3. 00	Coinsurance billed to program beneficiaries			17, 200	63.
4. 00	Allowable bad debts (see instructions)			161, 760	1
5. 00	Adjusted reimbursable bad debts (see instructions)			105, 144	•
	Allowable bad debts for dual eligible beneficiaries (see instr Subtotal (line 61 plus line 65 minus lines 62 and 63)	ructions)		48, 007	•
8. 00	Credits received from manufacturers for replaced devices for a	annlicable to MS_DRGs (s	ee instructions)	33, 773, 874 0	1
9. 00	Outlier payments reconciliation (sum of lines 93, 95 and 96).	11	,	0	69.
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		-,	0	70.
0. 50	Rural Community Hospital Demonstration Project (§410A Demonstr	ration) adjustment (see	instructions)	0	70. !
0. 75	N95 respirator payment adjustment amount (see instructions)			0	70.
0.87	Demonstration payment adjustment amount before sequestration			0	70.8
0.88	SCH or MDH volume decrease adjustment (contractor use only)	cuctions)		0	
0.89	Pioneer ACO demonstration payment adjustment amount (see instr HSP bonus payment HVBP adjustment amount (see instructions)	uctions)		0	70. 70.
0. 90	HSP bonus payment HRR adjustment amount (see instructions)			0	70.
0. 92	Bundled Model 1 discount amount (see instructions)			0	70.
0. 93	HVBP payment adjustment amount (see instructions)			-51, 984	70.
70. 94	HRR adjustment amount (see instructions)			-26, 081	70.
	Recovery of accelerated depreciation			Λ.	70.

Health Financial Systems ELKHAI	RT GENERAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der C	CN: 15-0018	Peri od: From 01/01/2023 To 12/31/2023	Worksheet E Part A Date/Time Pre 5/30/2024 7:4	pared: 6 am
		Title	XVIII	Hospi tal	PPS	
			FFY	(уууу)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy the corresponding federal year for the period prior		n column 0		0	0	70. 96
70.97 Low volume adjustment for federal fiscal year (yyyy the corresponding federal year for the period endin				0	0	70. 97
70.98 Low Volume Payment-3	0	ŕ		0	0	70. 98
70.99 HAC adjustment amount (see instructions)					0	70. 99

70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	0	0	70. 96
70.07	the corresponding federal year for the period prior to 10/1)	0		70.07
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)	0	0	70. 97
70. 98	Low Volume Payment-3	0	0	70. 98
70. 99	HAC adjustment amount (see instructions)	S .	0	1
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		33, 695, 809	
71. 01	Sequestration adjustment (see instructions)		673, 916	1
71. 02	Demonstration payment adjustment amount after sequestration		0	71. 02
71. 03	Sequestration adjustment-PARHM pass-throughs			71. 03
72.00	Interim payments		32, 360, 567	1
72. 01	Interim payments-PARHM			72. 01
73. 00	Tentative settlement (for contractor use only)		0	
73. 01	Tentative settlement-PARHM (for contractor use only)		//4 00/	73. 01
74. 00	Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and 73)		661, 326	74. 00
74. 01	Balance due provider/program-PARHM (see instructions)			74. 01
75. 00	Protested amounts (nonallowable cost report items) in accordance with		645, 051	1
70.00	CMS Pub. 15-2, chapter 1, §115.2		0.07001	70.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90. 00
	plus 2.04 (see instructions)			
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0	
92.00	Operating outlier reconciliation adjustment amount (see instructions)		0	
93.00	Capital outlier reconciliation adjustment amount (see instructions) The rate used to calculate the time value of money (see instructions)		0	
94. 00 95. 00	Time value of money for operating expenses (see instructions)		0.00	ı
96. 00			0	1
70.00	Trine varue of money for capital for a cod expenses (see first actions)	Prior to 10/1	On/After 10/1	70.00
		1. 00	2. 00	
	HSP Bonus Payment Amount			
				4
100.00	HSP bonus amount (see instructions)	0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment			
101. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions)	0.000000000	0. 0000000000	101. 00
101. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions)		0. 0000000000	
101. 00 102. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment	0.000000000	0. 0000000000	101. 00 102. 00
101. 00 102. 00 103. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	0.000000000	0. 0000000000 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions)	0.0000000000	0. 0000000000 0	101. 00 102. 00
101. 00 102. 00 103. 00 104. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions)	0.000000000 0 0.0000 0	0. 0000000000 0	101. 00 102. 00 103. 00
101. 00 102. 00 103. 00 104. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no.	0.000000000 0 0.0000 0	0. 0000000000 0	101. 00 102. 00 103. 00 104. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement	0.000000000 0 0.0000 0	0. 0000000000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)	0.000000000 0 0.0000 0	0. 0000000000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions)	0.000000000 0 0.0000 0	0. 0000000000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions)	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
101. 00 102. 00 103. 00 104. 00 200. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the period)	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the period) Medicare target amount	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement	0. 000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions)	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Line 59)	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 00000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR Adjustment for HSP Bonus Payment HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Derogram reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions)	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 00000 0 cration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
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101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment for HSP Bonus Payment HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) Adjustment to Medicare IPPS payments (see instructions)	0. 000000000 0 0. 0000 0	0. 0000000000 0 0. 00000 0 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00 211. 00 213. 00	HVBP Adjustment for HSP Bonus Payment HVBP adjustment factor (see instructions) HVBP adjustment amount for HSP bonus payment (see instructions) HRR Adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment factor (see instructions) HRR adjustment amount for HSP bonus payment (see instructions) Rural Community Hospital Demonstration Project (§410A Demonstration) Adjustment Is this the first year of the current 5-year demonstration period under the 21st Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49) Medicare discharges (see instructions) Case-mix adjustment factor (see instructions) Computation of Demonstration Target Amount Limitation (N/A in first year of the period) Medicare target amount Case-mix adjusted target amount (line 203 times line 204) Medicare inpatient routine cost cap (line 202 times line 205) Adjustment to Medicare Part A Inpatient Reimbursement Program reimbursement under the §410A Demonstration (see instructions) Medicare Part A inpatient service costs (from Wkst. E, Pt. A, Line 59) Adjustment to Medicare IPPS payments (see instructions) Reserved for future use Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement Total adjustment to Medicare Part A IPPS payments (from line 211)	0.0000000000 0.0000 0.0000 current 5-year demonst	0. 0000000000 0 0. 00000 0 cration	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 210. 00 211. 00
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PART 8 MEDICAL AND OTHER MEATH SERVICES 1.00 1.02		Title XVIII Hospi	i tal	PPS	o ani
Note				1.00	
Medical and other services (see Instructions)		PART B - MEDICAL AND OTHER HEALTH SERVICES		1.00	
Description 22,031,174 3.00 0	1.00			1, 424	1. 00
0.001 Continuer payment (see instructions) 70, 443 4.00 4.00 6.00		· · · · · · · · · · · · · · · · · · ·			
0.000 0.00					
Earther the hospit plat specific payment to cost ratio (see instructions)					
2.00 Sam of Fines 3 . 4, and 4.01, divided by line 6 0.00 7.00		· · · · · · · · · · · · · · · · · · ·			
Transit formal corridor payment (see instructions)					
Ancil lary service other pass through costs including REH direct graduate medical education costs from 8,113 9,00					
Wist. D. Pt. IV. col. 13. line 200 10.00			ts from		
0.00 Grgan acquisit flores 1,329 11.00 Total cost (sum of lines 1 and 10) (see Instructions) 1,329 11.00 Total cost (sum of lines 1 and 10) (see Instructions) 2.00 10.00 1.00	7. 00		13 110111	0, 113	7. 00
COMPUTATION OF IFSSER OF COST OR CHARGES Commentation of the property of t	10.00	Organ acqui si ti ons		0	10. 00
Reasonable charges	11. 00			1, 424	11. 00
12.00					
13.00 organ acquistion charges (From West, D-4, Pt. III., col. 4, line 69) 0 13.00	12. 00			8, 733	12. 00
Customary charges		Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			
15.00 Aggregate amount actually collected from patients Iable for payment for services on a charge basis 0 15.00	14. 00			8, 733	14. 00
16. 00 Amount's that would have been read ized from patients ilable for payment for services on a chargebasis 0 10. 00	15 00		basi s	1 0	15 00
had such payment been made in accordance with 42 CFR \$413.13(e)*				l e e e e e e e e e e e e e e e e e e e	
18.00 Total customary charges (see instructions) 8, 733 18.00 19.00 19.00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 18) (see 7, 309 19.00 19	10.00		CDG31 3		10.00
19. 00 Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see 7, 309 19. 00	17. 00			0.000000	17. 00
Instructions					
20.00 Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see 0 20.00	19.00		ee	7, 309	19.00
1. 424 21. 00	20. 00		ee	0	20. 00
22.00 Interns and residents (see instructions) 0.22.00		· · · · · · · · · · · · · · · · · · ·			
23.00 Cost of physicians' services in a teaching hospital (see instructions) 23.10, 302 4.00		g ,			
24. 00 Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) 23,110,302 24. 00		· · · · · · · · · · · · · · · · · · ·			
COMPUTATION OF RELIMBURSEMENT SETTLEMENT					
26.00 Deductible sand Coinsurance amounts relating to amount on line 24 (for CAH, see instructions) 18,832,900 26.00 27.00 28.50 27.00 28.50					
27.00 Subtotal (Clines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines 22 and 23 (see 19,278,826 27.00 19.278,826 27.00 19.278,826 27.00 19.278,826 27.00 19.278,826 27.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 28.00 29.00 28.00 29.00 29.00 29.00 29.00 20.00 20.00 20.00 20.00 20.00 29.00		· · · · · · · · · · · · · · · · · · ·		-	
Instructions			(500		
28.00 Direct graduate medical education payments (from Wkst. E-4, line 50) 28.00 28.50	27.00		(See	19, 278, 820	27.00
29.00 ESRD direct medical education costs (From Wkst. E-4, line 36) 29.00 30.0	28. 00			0	28. 00
30. 00 Subtotal (sum of lines 27, 28, 28. 50 and 29) 19, 278, 826 30. 00 Primary payer payments 3, 255 31. 00 32. 00 Subtotal (line 30 minus line 31) 19, 278, 826 30. 00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 19, 275, 571 32. 00 Composite rate ESRD (from West. 1-5, line 11) 0 33. 00 34. 00 Allowable bad debts (see instructions) 284, 718 34. 00 35. 00 Aljusted reimbursable bad debts (see instructions) 244, 178 36. 00 37. 00 Subtotal (see instructions) 244, 178 36. 00 37. 00 Subtotal (see instructions) 244, 178 36. 00 37. 00 Subtotal (see instructions) 244, 178 36. 00 37. 00 Subtotal (see instructions) 244, 178 36. 00 MP-LCC reconciliation amount from PS&R 29, 200 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39. 00 39. 50 39					
31.00 Primary payer payments 3, 255 31.00 Subtotal (line 30 minus line 31) 19, 275, 571 32.00 ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) 19, 275, 571 32.00 33.00 Composite rate ESRD (From Wkst. 1-5, line 11) 0 33.00 34.00 Allowable bad debts (see instructions) 284, 178 34.00 35.00 Adjusted reimbursable bad debts (see instructions) 185, 067 35.00 36.00 Allowable bad debts (see instructions) 244, 178 36.00 37.00 Subtotal (see instructions) 244, 178 36.00 38.00 MSP-LCC reconciliation amount from PSAR -87 38.00 38.00 MSP-LCC reconciliation amount from PSAR -87 38.00 39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 99.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.75 39.75 39.79 Pomonstration payment adjustment amount (see instructions) 39.75 39.99 Pomostration payment adjustment amount before sequestration 39.99 Pomostration payment adjustment amount before sequestration 39.99 Pomostration payment adjustment amount before sequestration 39.99 Pomostration payment adjustment amount before sequestration 39.99 Pomostration payment adjustment sequestration 39.99 Pomostration payment adjustment sequestration 39.99 Pomostration payment adjustment sequestration 39.99 Pomostration payment adjustment sequestration 39.99 Pomostration payment adjustment sequestration 39.99 Pomostration adjustment sequestration 39.99 Pomostration adjustment sequestration 39.90 3				-	
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33.00 Composite rate ESRD (from Wkst. 1-5, line 11) 284,718 34.00 33.00 34.00 All owable bad debts (see instructions) 284,718 34.00 35.00 All owable bad debts (see instructions) 185,067 35.00 36.00 All owable bad debts for dual eligible beneficiaries (see instructions) 244,178 36.00 37.00 30.00					
34. 00					
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36.00					
37.00 Subtotal (see instructions) 19,460,638 37.00 38.00 MSP-LCC reconciliation amount from PS&R -87 38.00 39.00 MSP-LCC reconciliation amount from PS&R -87 38.00 39.00 3					
39.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 39.00 39.00 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.50 39.97 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.97 39.99 39.99 39.90					
39.50 Pioneer ACO demonstration payment adjustment (see instructions) 39.50 39.77 N95 respirator payment adjustment amount (see instructions) 0 39.75 39.97 Demonstration payment adjustment amount before sequestration 0 39.97 39.98 Partial or full credits received from manufacturers for replaced devices (see instructions) 0 39.98 39.99 RECOVERY OF ACCELERATED DEPRECIATION 0 39.99 40.00 Subtotal (see instructions) 19,460,725 40.00 40.01 Sequestration adjustment (see instructions) 389,215 40.01 40.02 Demonstration payment adjustment amount after sequestration 40.02 40.03 Sequestration adjustment PARHM pass-throughs 40.03 41.00 Interim payments 19,049,357 41.00 42.01 Tentative settlement (for contractors use only) 41.01 42.00 Tentative settlement (for contractor use only) 42.01 43.00 Balance due provi der/program (see instructions) 42.01 43.00 Balance due provi der/program (see instructions) 42.01 44.00 Frotested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 41.01 51.52 70 51.52 70 51.52 70 51.52 70 70 70 70 70 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00 70.00					
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42.00 42.01 Tentative settlement (for contractors use only) 43.00 Bal ance due provider/program (see instructions) 43.01 Bal ance due provider/program-PARHM (see instructions) 43.01 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5115.2 TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 0 Utilier reconciliation adjustment amount (see instructions) 0 91.00 92.00 The rate used to calculate the Time Value of Money 0 42.00 42.01 43.00 43.01 44.00 91.01 91.02 90.00 91.00 92.00	41.00	Interim payments		19, 049, 357	41.00
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43.01 44.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 44.00 From the provider program PARHM (see instructions) 43.01 To be completed by contractor program outlier amount (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		, , , , , , , , , , , , , , , , , , , ,		22 153	
44.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 \$\frac{\f				22, 100	
TO BE COMPLETED BY CONTRACTOR 90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 90.00 O 91.00 92.00		Protested amounts (nonal owable cost report items) in accordance with CMS Pub. 15-2, chapter 1	i	0	
90.00 Original outlier amount (see instructions) 91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 90.00 91.00 92.00					
91.00 Outlier reconciliation adjustment amount (see instructions) 92.00 The rate used to calculate the Time Value of Money 0.00 92.00	90 00			0	90 00
92.00 The rate used to calculate the Time Value of Money 0.00 92.00		, , ,			
93.00 Time Value of Money (see instructions) 0 93.00	92.00	The rate used to calculate the Time Value of Money		0.00	92. 00
	93. 00	Time Value of Money (see instructions)		0	93. 00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0018	Peri od: From 01/01/2023	Worksheet E Part B	
			To 12/31/2023		
		Title XVIII	Hospi tal	PPS	<u> </u>
				1. 00	
94.00 Total (sum of lines 91 and 93)				0	94. 00
				1. 00	
MEDICARE PART B ANCILLARY COSTS					
200.00 Part B Combined Billed Days				0	200. 00

Health Financial Systems ELKANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED | Peri od: | Worksheet E-1 | From 01/01/2023 | Part | To 12/31/2023 | Date/Time Prepared: Provider CCN: 15-0018

			'	0 12/31/2023	5/30/2024 7: 40	
		Title	XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4.00	
1. 00	Total interim payments paid to provider		32, 360, 567		19, 049, 357	1. 00
2. 00	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,		C		0	2. 00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3. 01	ADJUSTMENTS TO PROVIDER				0	3. 01
3. 01	ADJUSTMENTS TO PROVIDER		i c			3. 01
3. 02			i c			3. 02
3. 04 3. 05					0	3. 04 3. 05
3.05	Provider to Program				U	3.05
3. 50	ADJUSTMENTS TO PROGRAM		C		0	3. 50
3. 51	ADJUSTIVILINTS TO FROGRAM				0	3. 50
3. 52					0	3. 51
3. 53					0	3. 53
3. 54						3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		32, 360, 567		19, 049, 357	4. 00
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
3.00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					3.00
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		C		0	5. 01
5.02			C		0	5. 02
5.03			C		0	5. 03
	Provider to Program					
5.50	TENTATIVE TO PROGRAM		C		0	5. 50
5. 51			0		0	5. 51
5.52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		C		0	5. 99
6. 00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER		661, 326		22, 153	6. 01
6. 01	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		001, 320		22, 153	6. 01
7. 00	Total Medicare program liability (see instructions)		33, 021, 893		19, 071, 510	
7.00	Total medicale program frability (See Histructions)		33,021,693	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2. 00	
8. 00	Name of Contractor			00	2.00	8. 00
	1			1	'	2.20

Component CCN: 15-S018

Title XVIII

			A	I PF	1.0	
		I npati en	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2. 00	3. 00	4. 00	
1.00	Total interim payments paid to provider		78, 108		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
2 00	write "NONE" or enter a zero					2 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate					3. 00
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		o	3. 02
3.03			0		0	3. 03
3.04			0		0	3.04
3.05			0		0	3. 05
	Provider to Program			<u> </u>		
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51			0		0	3. 51
3.52			0		0	3. 52
3.53			0		0 0	3. 53 3. 54
3. 54 3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0			3. 54 3. 99
3. 99	3. 50-3. 98)		0		ا	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		78, 108		0	4. 00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as		70, 100		Ĭ	1. 00
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	ı				- 04
5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
5. 02 5. 03			0		0	5. 02 5. 03
5.03	Provider to Program				U	5.03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	TENTITY E TO TROOM III		Ö		Ö	5. 51
5. 52			Ö		ol	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		Ö		o	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		2, 755		0	6. 01
6. 02	SETTLEMENT TO PROGRAM				0	6. 02
7. 00	Total Medicare program liability (see instructions)		80, 863		0	7. 00
				Contractor	NPR Date	
		,)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor)	1.00	2.00	8. 00
5. 50	Thams of softer do to	I		ļ	1	0.00

Heal th	Financial Systems ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0018 From 01/01/2023 F To 12/31/2023 E				
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	2 14		1. 00
2.00	Medicare days (see instructions)				2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3. 00
4.00	Total inpatient days (see instructions)				4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6. 00
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00
8.00	Calculation of the HIT incentive payment (see instructions)				8. 00
9.00	Sequestration adjustment amount (see instructions)				9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00
	Other Adjustment (specify)				31.00
	22.00 Palance due provider (line 9 (or line 10) minus line 20 and line 21) (see instructions)				

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

30. 00 31. 00 32. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0018	Peri od:	Worksheet E-3
	Component CCN: 15-S018	From 01/01/2023 To 12/31/2023	
	Title XVIII	Subprovi der - I PF	PPS
		IPF	

		I PF		
			1. 00	
	PART II - MEDICARE PART A SERVICES - IPF PPS		1.00	
1. 00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)		104, 127	1. 00
2.00	Net IPF PPS Outlier Payments		0	2. 00
3.00	Net IPF PPS ECT Payments		0	3. 00
4. 00	Unweighted intern and resident FTE count in the most recent cost report filed on or be-	fore November	0.00	4. 00
	15, 2004. (see instructions)			
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were	di spl aced by	0.00	4. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment			
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)			
5.00	New Teaching program adjustment. (see instructions)		0.00	5.00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth per	riod of a "new	0.00	6. 00
	teaching program" (see instuctions)			
7. 00	Current year's unweighted I&R FTE count for residents within the new program growth per	riod of a "new	0. 00	7. 00
	teaching program" (see instuctions)			
8. 00	Intern and resident count for IPF PPS medical education adjustment (see instructions)		0.00	8. 00
9.00	Average Daily Census (see instructions)		7. 517808	
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.		0. 000000	
11.00	Teaching Adjustment (line 1 multiplied by line 10).		0	11.00
12.00	Adjusted Net IPF PPS Payments (sum of lines 1, 2, 3 and 11)		104, 127	
13.00	Nursing and Allied Health Managed Care payment (see instruction)		0	13.00
14. 00			0	14. 00
15. 00	Cost of physicians' services in a teaching hospital (see instructions)		104 127	15.00
16.00	Subtotal (see instructions)		104, 127 0	16. 00 17. 00
17. 00 18. 00	Primary payer payments		104, 127	
19. 00	Subtotal (line 16 less line 17). Deductibles		24, 000	
20. 00	Subtotal (line 18 minus line 19)		24, 000 80, 127	
21. 00	Coi nsurance		400	
22. 00			79, 727	
23. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)		4, 224	
24. 00			2, 746	
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)		2, 740	25. 00
26. 00	· · · · · · · · · · · · · · · · · · ·		82, 473	
27. 00	Direct graduate medical education payments (see instructions)		02, 473	
28. 00	Other pass through costs (see instructions)		40	
29. 00	Outlier payments reconciliation		0	
30. 00			0	
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	
30. 98	Recovery of accelerated depreciation.		0	
30. 99	Demonstration payment adjustment amount before sequestration		0	
31. 00	Total amount payable to the provider (see instructions)		82, 513	
31. 01	Sequestration adjustment (see instructions)		1, 650	31. 01
31. 02	Demonstration payment adjustment amount after sequestration		0	31. 02
32.00	Interim payments		78, 108	32.00
33.00	Tentative settlement (for contractor use only)		0	33. 00
34.00	Balance due provider/program (line 31 minus lines 31.01, 31.02, 32 and 33)		2, 755	34.00
35.00	Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2, cl	hapter 1,	0	35.00
	§115. 2			
	TO BE COMPLETED BY CONTRACTOR			
	Original outlier amount from Worksheet E-3, Part II, line 2		0	
51. 00	Outlier reconciliation adjustment amount (see instructions)		0	51. 00
52. 00	The rate used to calculate the Time Value of Money		0. 00	
53. 00	Time Value of Money (see instructions)		0	53. 00
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING ON OR BEFORE MA	AY 11, 2023 (THE	END OF	
05 -	THE COVI D-19 PHE)			
99. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February	y 29, 2020.	0. 000000	
99. 01	Calculated Teaching Adjustment Factor for the current year. (see instructions)		0. 000000	99.01

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lieu	of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15	From 01/01/2023 To 12/31/2023	Worksheet E-3 Part VII Date/Time Prepared: 5/30/2024 7:46 am

			lo 12/31/2023	Date/lime Pre 5/30/2024 7:4	
		Title XIX	Hospi tal	PPS	<u> </u>
			I npati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XI)	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1.00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant programs only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8.00	Routi ne servi ce charges		32, 568, 931		8. 00
9.00	Ancillary service charges		49, 988, 491	99, 059, 778	
10.00	Organ acquisition charges, net of revenue		0		10. 00
11. 00	Incentive from target amount computation		0		11. 00
12.00	Total reasonable charges (sum of lines 8 through 11)		82, 557, 422	99, 059, 778	12. 00
	CUSTOMARY CHARGES				
13. 00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basi s				
14. 00	Amounts that would have been realized from patients liable for		0	0	14. 00
45.00	a charge basis had such payment been made in accordance with	12 CFR §413.13(e)			45.00
15. 00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	
16.00	Total customary charges (see instructions)	1611 44	82, 557, 422	99, 059, 778	
17. 00	Excess of customary charges over reasonable cost (complete onl	y IT line 16 exceeds	82, 557, 422	99, 059, 778	17. 00
18. 00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete onl	v if lime 4 avecade lime	0	0	18. 00
18.00	16) (see instructions)	y II IIIne 4 exceeds IIIne	0	U	18.00
19. 00	Interns and Residents (see instructions)		0	0	19.00
20. 00	Cost of physicians' services in a teaching hospital (see instr	suctions)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 1		0	0	
21.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be			0	21.00
22. 00	Other than outlier payments	Compreted for 113 provide	0	0	22. 00
	Outlier payments		0	0	
24. 00	Program capital payments		0	O	24.00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		5, 373	33, 114	
27. 00	Subtotal (sum of lines 22 through 26)		5, 373	33, 114	1
28. 00	Customary charges (title V or XIX PPS covered services only)		0,0,0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		5, 373	33, 114	1
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		3,575	55, 111	27.00
30. 00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	, ,)	5, 373	33, 114	
32. 00	Deducti bl es		0	0	1
33. 00	Coinsurance		0	0	
34. 00	Allowable bad debts (see instructions)		0	0	34. 00
	Utilization review		0		35. 00
36. 00		1 33)	5, 373	33, 114	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	, , ,	0	0	37. 00
	Subtotal (line 36 ± line 37)		5, 373	33, 114	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0		39. 00
	Total amount payable to the provider (sum of lines 38 and 39)		5, 373	33, 114	40.00
41. 00	Interim payments		0	0	41.00
42.00	Balance due provider/program (line 40 minus line 41)		5, 373	33, 114	42.00
43.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub 15-2,	0	0	43.00
	chapter 1, §115.2	·			

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0018 Component CCN: 15-S018	From 01/01/2023	
	Title XIX	Subprovi der -	PPS

		THE XIX	I PF	113	
			Inpati ent	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVICE	S FOR TITLES V OR XIX	SERVI CES		
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient hospital/SNF/NF services		0		1. 00
2.00	Medical and other services			0	2. 00
3.00	Organ acquisition (certified transplant programs only)		0		3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
5.00	Inpatient primary payer payments		0		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		0	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e Charges				
8. 00	Routine service charges		0	_	8. 00
9.00	Ancillary service charges		1, 336, 969	0	9. 00
10.00	Organ acquisition charges, net of revenue		0		10.00
11. 00	Incentive from target amount computation		0	_	11. 00
12. 00	Total reasonable charges (sum of lines 8 through 11)		1, 336, 969	0	12. 00
40.00	CUSTOMARY CHARGES	_ <u>.</u>		0	40.00
13. 00	Amount actually collected from patients liable for payment for ser basis	vices on a charge	0	0	13. 00
14.00	Amounts that would have been realized from patients liable for pay	ment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 42 CF	R §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1, 336, 969	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only if	line 16 exceeds	1, 336, 969	0	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete only if	Fline 4 exceeds line	0	0	18. 00
	16) (see instructions)		_	_	
19. 00	Interns and Residents (see instructions)		0	0	19. 00
20.00	Cost of physicians' services in a teaching hospital (see instructi	ons)	0	0	20.00
21. 00	Cost of covered services (enter the lesser of line 4 or line 16)		0	0	21. 00
22.00	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be comp	Teted for PPS provide	rs.	0	22.00
22. 00	Other than outlier payments			0	22. 00 23. 00
23. 00	Outlier payments			U	24. 00
24. 00 25. 00	Program capital payments Capital exception payments (see instructions)				25. 00
26. 00	Routine and Ancillary service other pass through costs		622	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		622	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		022	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		622	0	29. 00
27.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		022	0	27.00
30. 00	Excess of reasonable cost (from line 18)		O	0	30. 00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		622	0	31. 00
32. 00	Deductibles		0	0	32. 00
33. 00	Coinsurance		0	0	33. 00
34. 00	Allowable bad debts (see instructions)		o	0	34. 00
35. 00	Utilization review		0	· ·	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)		622	0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		622	0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)		0	· ·	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)		622	0	40. 00
41. 00	Interim payments		0	0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)		622	0	42. 00
43. 00	Protested amounts (nonallowable cost report items) in accordance w	ith CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2				
			•		

Health Financial Systems ELKHART GENERAL HOSPITAL In		In Lie	Lieu of Form CMS-2552-10		
OUTLIE	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0018	Peri od:	Worksheet E-5	
			From 01/01/2023 To 12/31/2023	Date/Time Prep 5/30/2024 7:46	
		Title XVIII		PPS	
				1. 00	
TO BE COMPLETED BY CONTRACTOR					
1.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03 plus 2.04 (see instructions)				0	1.00
2.00 Capital outlier from Wkst. L, Pt. I, line 2				0	2.00
3.00 Operating outlier reconciliation adjustment amount (see instructions)				0	3.00
4.00 Capital outlier reconciliation adjustment amount (see instructions)				0	4.00
5.00 The rate used to calculate the time value of money (see instructions)				0.00	5.00
6.00	Time value of money for operating expenses (see instru	uctions)		0	6.00
7.00	Time value of money for capital related expenses (see	instructions)		0	7.00

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

Provider CCN: 15-0018 Peri

Peri od: Worksheet G From 01/01/2023 To 12/31/2023 Date/Time Prepared: 5/30/2024 7:46 am

OH y)					5/30/2024 7:4	6 am
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
		1.00	2.00	3. 00	4. 00	
	CURRENT ASSETS	1 11 100 000	ı		1	
1.00	Cash on hand in banks	14, 493, 000		_	_	1.00
2.00	Temporary investments Notes receivable	0	0	_	0	2.00
3. 00 4. 00	Accounts recei vable	86, 119, 000	1	_	0	3. 00 4. 00
5.00	Other recei vable	4, 532, 000		0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	-23, 733, 000		0	0	6.00
7. 00	Inventory	11, 540, 000		0	ő	7.00
8.00	Prepaid expenses	522, 000		0	ō	8.00
9.00	Other current assets	0	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11.00	Total current assets (sum of lines 1-10)	93, 473, 000	0	0	0	11. 00
	FIXED ASSETS					
12.00	Land	4, 974, 000		_	_	12.00
13. 00	Land improvements	0	0	_		13. 00
14. 00	Accumulated depreciation	0	0	0	_	14. 00
15. 00	Bui I di ngs	278, 533, 000	1	0	0	15.00
16.00	Accumulated depreciation	-260, 715, 000	1	0	0	16.00
17. 00 18. 00	Leasehold improvements	0	0	_	0	17. 00 18. 00
19. 00	Accumulated depreciation Fixed equipment	141, 455, 000	1	_	0	19.00
20. 00	Accumulated depreciation	141, 455, 000		0	0	20.00
21. 00	Automobiles and trucks			0	ő	21.00
22. 00	Accumulated depreciation	0		0	ő	22. 00
23. 00	Maj or movable equipment	0	o o	0	Ō	23. 00
24. 00	Accumul ated depreciation	0	o	0	0	24. 00
25.00	Mi nor equi pment depreci abl e	0	0	0	0	25. 00
26.00	Accumulated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	164, 247, 000) 0	0	0	30. 00
21 00	OTHER ASSETS		0 401 000	0		21 00
31. 00 32. 00	Investments Penesits on Leases	0	8, 421, 000	0	_	31. 00 32. 00
33. 00	Deposits on leases Due from owners/officers	0		0	0	33.00
34. 00	Other assets	8, 094, 000		0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	8, 094, 000		0		35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	265, 814, 000				36.00
00.00	CURRENT LIABILITIES	20070117000	7 07 12 17 000			00.00
37.00	Accounts payable	24, 847, 000	0	0	0	37. 00
38.00	Sal ari es, wages, and fees payable	0	0	0	0	38. 00
39.00	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	4, 082, 000	0	0	0	40. 00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0)			42. 00
43. 00	Due to other funds	0	0	0	0	43. 00
44. 00	Other current liabilities	98, 000	1	_	0	44.00
45. 00	Total current liabilities (sum of lines 37 thru 44)	29, 027, 000) 0	0	0	45. 00
47 00	LONG TERM LIABILITIES	1 0	J 0	0		1 47 00
46. 00 47. 00	Mortgage payable	0	0	_	_	46. 00 47. 00
48. 00	Notes payable Unsecured Loans	0		_		48.00
49. 00	Other long term liabilities	50, 160, 000		_		49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	50, 160, 000		_		50.00
51.00	Total liabilities (sum of lines 45 and 50)	79, 187, 000		_		51.00
01100	CAPITAL ACCOUNTS	7771077000	<u> </u>			0 00
52. 00	General fund balance	186, 627, 000)			52. 00
53. 00	Specific purpose fund		8, 421, 000			53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	57. 00
58. 00	Plant fund balance - reserve for plant improvement,		1		0	58. 00
	repl acement, and expansi on	1	1			
59. 00	Total fund balances (sum of lines 52 thru 58)	186, 627, 000			0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	265, 814, 000	8, 421, 000	0	0	60. 00
	[59]	I	I	l	I	l

Provider CCN: 15-0018

				1	0 12/31/2023	5/30/2024 7:40	
		General	Fund	Special Pu	rpose Fund	Endowment Fund	J dill
					1		
		1.00	2.00	3.00	4. 00	5. 00	
1. 00	Fund balances at beginning of period	11.00	174, 391, 000		7, 814, 000	0.00	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		44, 513, 000		, ,		2. 00
3.00	Total (sum of line 1 and line 2)		218, 904, 000		7, 814, 000		3.00
4.00	ASSETS RELEASED FROM RESTRICTION	113,000		l c		0	4.00
5.00	INVESTMENT INCOME	190, 000		607, 000)	0	5.00
6.00		0		l c)	0	6.00
7.00		0		[c)	0	7.00
8.00		0		[c)	0	8.00
9.00		0		0)	0	9.00
10.00	Total additions (sum of line 4-9)		303, 000		607, 000		10.00
11. 00	Subtotal (line 3 plus line 10)		219, 207, 000		8, 421, 000		11.00
12.00	OTHER	32, 580, 000		C)	0	12.00
13.00		0		C)	0	13.00
14.00		0		C)	0	14.00
15.00		0		C)	0	15.00
16.00		0		C)	0	16.00
17.00		0		0		0	17.00
18. 00	Total deductions (sum of lines 12-17)		32, 580, 000		0		18. 00
19. 00	Fund balance at end of period per balance		186, 627, 000		8, 421, 000		19.00
	sheet (line 11 minus line 18)			L			
		Endowment Fund	PI ant	Fund			
		6.00	7. 00	8. 00	-		
1. 00	Fund balances at beginning of period	0	71.00	0.00			1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)						2. 00
3. 00	Total (sum of line 1 and line 2)	0)		3. 00
4.00	ASSETS RELEASED FROM RESTRICTION		0				4. 00
5.00	INVESTMENT INCOME		0				5.00
6.00			0				6.00
7.00			0				7.00
8.00			0				8.00
9.00			0				9. 00
10.00	Total additions (sum of line 4-9)	0		l c)		10.00
11. 00	Subtotal (line 3 plus line 10)	0)		11.00
12.00	OTHER		0				12.00
13.00			0				13.00
14.00			0				14.00
15. 00			0				15.00
16.00			0				16.00
17. 00			0				17.00
18.00	Total deductions (sum of lines 12-17)	0		C)		18. 00
19.00	Fund balance at end of period per balance	0		C			19.00
	sheet (line 11 minus line 18)						

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

			To 12/31/2023	Date/Time Pre 5/30/2024 7:4	
	Cost Center Description	Inpatient	Outpati ent	Total	o dili
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES	•			
	General Inpatient Routine Services				
1.00	Hospi tal	122, 323, 76	58	122, 323, 768	1. 00
2.00	SUBPROVI DER - I PF	6, 641, 03	38	6, 641, 038	2. 00
3.00	SUBPROVI DER - I RF		0	0	3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		0	0	5. 00
6.00	Swing bed - NF		0	0	6. 00
7.00	SKILLED NURSING FACILITY		0	0	7. 00
8.00	NURSING FACILITY		0	0	8. 00
9.00	OTHER LONG TERM CARE		0	0	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	128, 964, 80	06	128, 964, 806	10. 00
	Intensive Care Type Inpatient Hospital Services				
11. 00	INTENSIVE CARE UNIT	31, 806, 9		31, 806, 916	11. 00
11. 01	NEONATAL INTENSIVE CARE	2, 412, 80		2, 412, 805	11. 01
12. 00	CORONARY CARE UNIT		0	0	12. 00
13. 00	BURN INTENSIVE CARE UNIT		0	0	13. 00
14. 00	SURGI CAL INTENSIVE CARE UNIT		0	0	14. 00
15.00	OTHER SPECIAL CARE (SPECIFY)			0.4.04.0.70.4	15. 00
16. 00	Total intensive care type inpatient hospital services (sum of line	es 34, 219, 72	21	34, 219, 721	16. 00
17.00	11-15)	1/2 104 5	.7	1/2 104 527	17 00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	163, 184, 52		163, 184, 527	17. 00
18.00	Ancillary services	377, 469, 13			18.00
19. 00 20. 00	Outpatient services	17, 745, 17			19. 00 20. 00
	RURAL HEALTH CLINIC		0 0	0	
21. 00 22. 00	FEDERALLY QUALIFIED HEALTH CENTER HOME HEALTH AGENCY		0	0 0	21. 00 22. 00
23. 00	AMBULANCE SERVICES		0	0	23. 00
24. 00	CMHC		0	0	24. 00
24. 00	CORF		0		24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P.)	•	0	0	25. 00
26. 00	HOSPI CE			0	26. 00
27. 00	NURSERY	3, 934, 55	51	3, 934, 551	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to V			1, 220, 482, 913	28. 00
20.00	G-3. Line 1)	302, 333, 3	030, 147, 321	1, 220, 402, 713	20.00
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		305, 772, 616		29. 00
30.00	ADD (SPECIFY)		0		30. 00
31.00			0		31. 00
32.00			0		32. 00
33.00			0		33. 00
34.00			0		34. 00
35.00			0		35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37.00	DEDUCT (SPECIFY)		0		37. 00
38. 00			0		38. 00
39. 00			0		39. 00
40.00			0		40. 00
41.00			0		41. 00
42.00	Total deductions (sum of lines 37-41)		0		42. 00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(tr	ansfer	305, 772, 616		43. 00
	to Wkst. G-3, line 4)	I		l	

Health Financial Systems ELKHART GENERAL HOSPITAL			eu of Form CMS-2	2552-10		
STATEMENT OF REVENUES AND EXPENSES			Provider CCN: 15-0018	Peri od:	Worksheet G-3	
	From 01/01/2023 To 12/31/2023		Date/Time Prepared:			
				12, 01, 2020	5/30/2024 7: 46	
					1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	I, column 3, lin	e 28)		1, 220, 482, 913	1.00
2.00	Less contractual allowances and discounts on	patients' accoun	ts		881, 510, 913	2.00
3.00	Net patient revenues (line 1 minus line 2)				338, 972, 000	3. 00
4.00	Less total operating expenses (from Wkst. G-2	2, Part II, line	43)		305, 772, 616	4.00
5.00	Net income from service to patients (line 3 m	minus line 4)			33, 199, 384	5. 00
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc				0	6. 00
7.00	Income from investments				0	7. 00
8.00	Revenues from telephone and other miscellaneo	ous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service				0	9. 00
10.00	. 00 Purchase di scounts			0	10.00	
11.00	Rebates and refunds of expenses				584, 423	11. 00
12.00	Parking lot receipts				0	12.00
13.00	Revenue from Laundry and Linen service				0	13.00
14.00	Revenue from meals sold to employees and gues	sts			1, 314, 087	14.00
15.00	Revenue from rental of living quarters				0	15. 00
16.00	Revenue from sale of medical and surgical sup	oplies to other t	han patients		0	16.00
17.00	Revenue from sale of drugs to other than pati	ents			216, 263	17.00
18.00	Revenue from sale of medical records and abst	tracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, e	etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, ar	nd canteen			0	20.00
21.00	Rental of vending machines				0	21. 00
22.00	Rental of hospital space				0	22. 00
23.00	Governmental appropriations				0	23. 00
24.00	OTHER INCOME				8, 992, 886	24. 00
24. 50	COVI D-19 PHE Fundi ng				205, 341	24. 50
25.00	Total other income (sum of lines 6-24)				11, 313, 000	25. 00
26.00	Total (line 5 plus line 25)				44, 512, 384	26. 00
27. 00	OTHER EXPENSE				-616	27. 00

27.00 OTHER EXPENSE

28.00 Total other expenses (sum of line 27 and subscripts)

29.00 Net income (or loss) for the period (line 26 minus line 28)

-616 27. 00 -616 28. 00 44, 513, 000 29. 00

Heal th	Financial Systems ELKHART GENERA	J HOSPITAI	In lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0018	Peri od: From 01/01/2023 To 12/31/2023	Worksheet L Parts I-III Date/Time Pre 5/30/2024 7:4	pared:
		Title XVIII	Hospi tal	PPS	
				4 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			2, 307, 352	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier		0	1. 01	
2.00	Capital DRG outlier payments			25, 991	2. 00
2.01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3.00	Total inpatient days divided by number of days in the cost r	reporting period (see inst	ructions)	106. 47	3. 00
4.00	Number of interns & residents (see instructions)			0.00	4. 00
5. 00	Indirect medical education percentage (see instructions)			0.00	5. 00
6. 00	Indirect medical education adjustment (multiply line 5 by th 1.01) (see instructions)	ne sum of lines 1 and 1.01	, columns 1 and	0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)	patient days (Worksheet E	, part A line	3. 93	7. 00
8.00	Percentage of Medicaid patient days to total days (see instr	ructions)		24. 22	8. 00
9.00	Sum of lines 7 and 8			28. 15	9. 00
10. 00	Allowable disproportionate share percentage (see instruction	ns)		5. 87	10. 00
11.00	Disproportionate share adjustment (see instructions)			135, 442	
12. 00	Total prospective capital payments (see instructions)			2, 468, 785	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1. 00
2.00	Program inpatient ancillary capital cost (see instructions)			0	2. 00
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
4.00	Capital cost payment factor (see instructions)			0	4. 00
5.00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	1. 00
2.00	Program inpatient capital costs for extraordinary circumstar	nces (see instructions)		0	2.00
3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0 0. 00	3. 00 4. 00
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	5. 00
6. 00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	
7. 00	Adjustment to capital minimum payment level for extraordinar		: line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)		,	0	8. 00
9.00	Current year capital payments (from Part I, line 12, as appl	i cabl e)		0	9. 00
10.00	Current year comparison of capital minimum payment level to	1 1 3 1	′ ′	0	10. 00
11. 00	Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14)	capital payment (from pri	or year	0	11. 00
12.00	00 Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)				12. 00
13.00					13. 00
14. 00	Carryover of accumulated capital minimum payment level over	capital payment for the f	following period	0	14. 00
15 00	(if line 12 is negative, enter the amount on this line)				15 00
15. 00 16. 00	Current year allowable operating and capital payment (see in	ISTI UCTI ONS)		0	15. 00 16. 00
				17. 00	
	1 - 2 - 2 - 3 - 3 - 3 - 3 - 3 - 3 - 3 - 3		'	O	