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 01/01/2022 Parts I-III AND SETTLEMENT SUMMARY 12/31/2022 Date/Time Prepared: 5/31/2023 12:14 pm PART I - COST REPORT STATUS Provi der 1. [X] Electronically prepared cost report Date: 5/31/2023 Time: 12:14 pm] 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 01/01/2022 and ending 12/31/2022 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	HI T	Title XIX	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	HOSPI TAL	0	865, 480	-225, 380	0	55, 167	1. 00
2.00	SUBPROVI DER - I PF	0	-4	0		728	2. 00
3.00	SUBPROVI DER - I RF	0	3, 018	0		0	3. 00
5.00	SWING BED - SNF	0	0	0		0	5. 00
6.00	SWING BED - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12. 00
200.00	TOTAL	0	868, 494	-225, 380	0	55, 895	200. 00
The ab	ove amounts represent "due to" or "due from"	the applicable	nrogram for th	e element of t	he above comple	ex 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.

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 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/31/2023 12:14 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 600 EAST BLVD PO Box: 1.00 State: IN Zip Code: 46514 2.00 City: ELKHART County: ELKHART 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal ELKHART GENERAL 150018 21140 01/01/1966 Ν Р Р 3.00 1 HOSPI TAI Subprovi der - IPF ELKHART PSYCH Р 4.00 15S018 21140 01/01/2015 Р 4 00 4 N 5.00 Subprovider - IRF ELKHART REHAB 15T018 21140 5 01/01/1993 Ρ Ρ 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7 00 7 00 8.00 Swing Beds - NF 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 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 Hospi tal -Based Hospi ce 14.00 14.00 Hospital-Based Health Clinic - RHC 15.00 15 00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 17. 10 Hospi tal -Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2022 12/31/2022 20.00 21.00 Type of Control (see instructions) 2 21.00 1.00 3.00 2.00 Inpatient PPS Information 22. 00 Does this facility qualify and is it currently receiving payments for N 22.00 disproportionate share hospital adjustment, in accordance with 42 CFR \$412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim UCPs, including supplemental UCPs, for 22.01 this cost reporting period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires a final UCP to be 22.02 Ν Ν determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to Ν Ν Υ 22.03 rural as a result of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 22.04 Did this hospital receive a geographic reclassification from urban to 22 04 rural as a result of the revised OMB delineations for statistical areas 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 no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 3 Ν 23.00 below? In column 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no.

1.00 2.00 3.00 4.00 5.00 6.00 0.00			In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid		ai d	0ther ledi cai d days	14 pm
24.00 First this provider is an IPPS hospital, enter the linishs the dedical pid by which in state which call of lightly ungoid days in column 2. Instate Medical of lightly ungoid days in column 2. Out-of-state Medical of lightly ungoid days in column 3. A Medical of lightly ungoid days in column 3. A Medical of lightly ungoid days in column 4. Medical of paid and elightle but ungoid days in column 5. Out-of-state Medical of lightly ungoid days in column 6. Out-of-state Medical of lightly ungoid days in column 6. Out-of-state Medical of lightly ungoid days in column 6. Out-of-state Medical of lightly ungoid days in column 7. Out-of-state Medical of lightly ungoid days in column 8. Out-of-state Medical of lightly ungoid days in column 8. Out-of-state Medical of lightly ungoid days in column 8. Out-of-state Medical of lightly ungoid days in column 8. Out-of-state Medical of lightly ungoid days in column 8. Out-of-state Medical of lightly ungoid days in column 8. Out-of-state Medical of lightly ungoid days in column 8. Out-of-state Medical of lightly ungoid days in column 8. Out-of-state Medical days in column 8. Out-of-state Medica			1.00		3.00		5. C	00	6. 00	-
25.00 If this provider is an IRF, enter the in-state Medical dipal days in column 2, the in-state Medical dipal days in column 2, the in-state Medical dipal days in column 2, the in-state Medical dipal day in column 2, the in-state Medical dipal dipal days in column 3, the in-state Medical dipal dipal days in column 4, Medical dipal days in column 5. 26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Fater 1: 1 or urban or "2" for rural. If applicable. Some interesting period district in column 1. "1: 1 for urban or "2" for rural. If applicable. Some interesting period district in column 1. "1: 1 for urban or "2" for rural. If applicable. Some interest in the east reporting period. Gast in the cost reporting period. Sold period of the east reporting period. Sold period of the east reporting period. Sold period in the cost reporting period. Sold period period in the cost reporting period. Sold period period in the cost reporting period in the cost reporting period pe	24. 00	in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in								24. 00
26.00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural.	25. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid	10	О	0					25. 00
26. 00 Enter your standard geographic classification (not wage) status at the beginning of the cost reporting period. Enter "1" for urban or "2" for rural. If applicable. 27. 00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. Enter in colum 1, "1" for urban or "2" for rural. If applicable. 28. 00 Enter your standard geographic classification (not wage) status at the end of the cost reporting period. 38. 00 Enter applicable beginning and ending dates of SCH status. Subscript Line 36 for number of periods SCH status in period. 39. 00 Enter applicable beginning and ending dates of SCH status. Subscript Line 36 for number of periods in excess of one and enter subsequent dates. 39. 00 Enter applicable beginning and enter subsequent dates. 39. 00 Enter applicable beginning and enter subsequent dates. 39. 00 Enter applicable beginning and enter subsequent dates. 39. 00 Enter applicable beginning and enter subsequent dates. 39. 00 Enter than 1, subscript this Island for the B0H transitional payment in accordance with FV 2010 GPPS final Tive? Enter "Y" for yes or "N" for no. (see instructions) 39. 00 Enter than 1, subscript this Island for the B0H transitional payment in accordance with 2 CPR 48 412 10(b)(2)(i), (ii), or (iii)? Enter in column 2. 39. 00 Boes this facility qualify for the Inpatient hospital payment adjustment for low volume N N N N N N N N N N N N N N N N N N N										-
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36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status is in erfect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligible for the MDH transitional payment in accordance with PT 2016 OPPS final rule? Enter "Y" for yes or "N" for no. (see 38.00 If I ine 37 is 1, enter the beginning and ending dates of MDH status. If I ine 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. 10.00 If I ine 37 is 1, enter the beginning and ending dates of MDH status. If I ine 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. 10.00 Description in accordance with 42 CFR \$412.101(b)(2)(1), (ii), or (III)? Enter in column N N N N N N N N N N N N N N N N N N N	35. 00	If this is a sole community hospital (SCH), enter the			CH status ir	ı		0		35. 00
36.00 Enter applicable beginning and ending dates of SCH status. Subscript line 36 for number of periods in excess of one and enter subsequent dates. 37.00 If this is a Medicare dependent hospital (MDH), enter the number of periods MDH status 0 37.00 Is in effect in the cost reporting period. 37.01 Is this hospital a former MDH that is eligibile for the MDH transitional payment in accordance with FV 2016 oPPS final rule? Enter "V" for yes or "N" for no. (see instructions) 38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and lenter subsequent dates. 47/N										
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is in effect in the cost reporting period. 37. 01 is this hospital a former MMH that is eligible for the MDH transitional payment in accordance with FY 2016 OPPS final rule? Enter "" for yes or "N" for no. (see instructions) 38. 00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N	27.00			m of norlos	do MDU otati					27.00
Instructions 38.00 If line 37 is 1, enter the beginning and ending dates of MDH status. If line 37 is greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N Y/N		is in effect in the cost reporting period. Is this hospital a former MDH that is eligible for th	ne MDH tran:	sitional pa	ayment in	us	,			37. 00
greater than 1, subscript this line for the number of periods in excess of one and enter subsequent dates. Y/N	38. 00	instructions)	,		•					38. 00
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR \$412.101(b)(2)(i), (ii), or (iii)? Enter in column 1 'Y' for yes or 'N' for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(i), (ii), or (iii)? Enter in column 2 'Y' for yes or 'N' for no. (see instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or 'N' for no in column 1, for discharges prior to October 1. Enter "Y" for yes or 'N' for no in column 2, for discharges on or after October 1. (see instructions) Prospective Payment System (PPS)-Capital 50.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR \$412.320? (see instructions) 45.00 Does this facility eligible for additional payment exception for extraordinary circumstances with 42 CFR \$412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 CFR \$412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N N N N N N N N N N N N N N N N		greater than 1, subscript this line for the number of					N/ (N)		V/ /NI	
39.00 Does this facility qualify for the inpatient hospital payment adjustment for low volume hospitals in accordance with 42 CFR \$412.101(b)(2)(1). (ii), or (iii)? Enter in column 1 "Y" for yes or "N" for no. Does the facility meet the mileage requirements in accordance with 42 CFR 412.101(b)(2)(1). (ii), or (iii)? Enter in column 2 "Y" for yes or "N" for no. (See instructions) 40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 1, for discharges on or after October 1. (see instructions) V										-
40.00 Is this hospital subject to the HAC program reduction adjustment? Enter "Y" for yes or "N" for no in column 1, for discharges prior to October 1. Enter "Y" for yes or "N" for no in column 2, for discharges on or after October 1. (See Instructions) Prospective Payment System (PPS)-Capital 1.00 2.00 3.00 Prospective Payment System (PPS)-Capital 45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412. 320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412. 348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 CFR §412. 300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N N N N N N N N N N N N N N N N	39. 00	hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii)), (ii), or the mileage	(iii)? Ent	ter in colum nts in	ume mn				39. 00
Prospective Payment System (PPS)-Capital 45.00 Does this Facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section \$412.320" (see instructions) 46.00 Is this Facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR \$412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 CFR \$412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N N N N N N N N N N N N N N N N	40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octol	ber 1. Ente	r "Y" for y			N		N	40. 00
45.00 Does this facility qualify and receive Capital payment for disproportionate share in accordance with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N N N N N N N N N N N N N N N N										
with 42 CFR Section §412.320? (see instructions) 46.00 Is this facility eligible for additional payment exception for extraordinary circumstances pursuant to 42 CFR §412.348(f)? If yes, complete Wkst. L, Pt. III and Wkst. L-1, Pt. I through Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. N N N N A 47.00 Is the facility electing full federal capital payment? Enter "V" for yes or "N" for no. N N N N N N N N N N N N N N N N N N N	45.00		at for disc	roporti orat	to chara in	accordan	- NI	V	NI	45.00
Pt. III. 47.00 Is this a new hospital under 42 CFR §412.300(b) PPS capital? Enter "Y for yes or "N" for no. 48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Feaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penul timate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e) (1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as		with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce	eption for	extraordi na	ary circumst	tances	N			46. 00
48.00 Is the facility electing full federal capital payment? Enter "Y" for yes or "N" for no. Teaching Hospitals 56.00 Is this a hospital involved in training residents in approved GME programs? For cost reporting periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b) (2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. 57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e) (1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as	47 00	Pt. III.						l N	N	47 00
periods beginning prior to December 27, 2020, enter "Y" for yes or "N" for no in column 1. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.78(b)(2), see the instructions. For column 2, if the response to column 1 is "Y", or if this hospital was involved in training residents in approved GME programs in the prior year or penultimate year, and are you are impacted by CR 11642 (or applicable CRs) MA direct GME payment reduction? Enter "Y" for yes; otherwise, enter "N" for no in column 2. For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as		Is the facility electing full federal capital paymen							1	48. 00
57.00 For cost reporting periods beginning prior to December 27, 2020, if line 56, column 1, is yes, is this the first cost reporting period during which residents in approved GME programs trained at this facility? Enter "Y" for yes or "N" for no in column 1. If column 1 is "Y", did residents start training in the first month of this cost reporting period? Enter "Y" for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable. For cost reporting periods beginning on or after December 27, 2020, under 42 CFR 413.77(e)(1)(iv) and (v), regardless of which month(s) of the cost report the residents were on duty, if the response to line 56 is "Y" for yes, enter "Y" for yes in column 1, do not complete column 2, and complete Worksheet E-4. 58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as	56. 00	periods beginning prior to December 27, 2020, enter cost reporting periods beginning on or after December the instructions. For column 2, if the response to coinvolved in training residents in approved GME progrand are you are impacted by CR 11642 (or applicable of	"Y" for yes r 27, 2020, olumn 1 is ams in the p CRs) MA dire	or "N" for under 42 ("Y", or if prior year	r no in colu CFR 413.78(b this hospit or penultin	umn'1. Foi o)(2), see tal was mate year,	9			56. 00
58.00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as 58.00	57.00	For cost reporting periods beginning prior to Decembers is this the first cost reporting period during which at this facility? Enter "Y" for yes or "N" for no in residents start training in the first month of this of "N" for no in column 2. If column 2 is "Y", complete complete Wkst. D, Parts III & IV and D-2, Pt. II, if beginning on or after December 27, 2020, under 42 CFW which month(s) of the cost report the residents were	er 27, 2020 residents n column 1. cost report e Worksheet applicable R 413.77(e) on duty, i	in approved If column ing period? E-4. If co . For cost)(1)(iv) ar f the respo	d GME progra 1 is "Y", o ? Enter "Y' olumn 2 is ' reporting p nd (v), rega onse to line	ams trainedid 'for yes 'N", periods ardless of	ed or			57.00
	58. 00	If line 56 is yes, did this facility elect cost reim	oursement f	or physicia						58. 00

Health Financial Systems ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0018 Peri od: Worksheet S-2 From 01/01/2022 Part I Date/Time Prepared: 12/31/2022 5/31/2023 12: 14 pm XVIII XIX 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

0.00 62.01

63.00

62. 01

your hospital received HRSA PCRE funding (see instructions)

Teaching Hospitals that Claim Residents in Nonprovider Settings

during in this cost reporting period of HRSA THC program. (see instructions)

Enter the number of FTE residents that rotated from a Teaching Health Center (THC) into your hospital

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)

Health Financial Systems	ELKHAR ⁻	T GENERAL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP				Period: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part I Date/Time Pre	pared:
			Unwei ghted FTEs Nonprovi der	Unweighted FTEs in Hospital	5/31/2023 12: Ratio (col. 1/ (col. 1 + col. 2))	
			1. 00	2.00	3.00	
Section 5504 of the ACA Base Yea	r FTE Residents in No	onprovider Settings-		_	•	
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 you of (column 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in	ty trained residents n-primary care all nonprovider d non-primary care n column 3 the ratio	O. C	0.00	0. 000000	64. 00
	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	
65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)			0. C	Unwei ghted	0.000000 Ratio (col. 1/	65.00
			FTEs Nonprovi der Si te	FTEs in	(col. 1 + col. 2))	
Cootion FFO4 -F the ACA C	Voor ETE D! I I I	a Nannagail de a Colli	1.00	2.00	3.00	
Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovider Setting	gsEffective 1	for cost reporti	ng periods	
66.00 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider settings. ry care resident 3 the ratio of	O. C	0. 00	0. 000000	66. 00
(cordini - di vi ded by (cordini -	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	· ·	Ratio (col. 3/ (col. 3 + col. 4))	
67.00 Enter in column 1, the program	1. 00	2.00	3. 00	4.00	5. 00 0. 000000	67.00
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)			0.0	0.00	, 3. 000000	07.00

116. 00

117. 00

118. 00

"N" for no.

the definition in CMS Pub. 15-1, chapter 22, §2208.1.

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.

146. 00

Ν

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	ELKHART GENER		N. 1E 0010		In Lie	u of Form CMS	
HUSPITAL AND HUSPITAL HEALTH CARE CUMPLE	X IDENIIFICATION DATA	Provi der CC	N: 15-0018	Period: From 01/01	/2022	Worksheet S- Part I	2
					/2022	Date/Time Pr	
						5/31/2023 12	:14 pm
						1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y" for	ves or "N" for	no			1. 00 N	147. 0
148.00 Was there a change in the order of						N N	148. 0
149.00Was there a change to the simplifi				or no.		N	149. 0
	<u> </u>	Part A	Part B		e V	Title XIX	
		1.00	2.00	3.0	0	4. 00	
Does this facility contain a provi							
or charges? Enter "Y" for yes or '	'N" for no for each compon				R §413		
55. 00 Hospi tal		N	N N	N		N	155. (
56. 00 Subprovi der - IPF 57. 00 Subprovi der - IRF		N N	N N	N N		N N	156. (157. (
58. 00 SUBPROVI DER		IN	N N	IN IN		IN IN	
58. 00 S0BPROVI DER 59. 00 SNF		N	l N	N		N	158. (159. (
60. OO HOME HEALTH AGENCY		N N	l N	N N		N N	160. (
61. OO CMHC		IN	N N	N N		N N	161. (
61. 10 CORF			N N	N		N N	161.
01. 10 00M						14	101.
						1.00	_
Multicampus							
65.00 Is this hospital part of a Multica	ampus hospital that has on	e or more campu	ses in dif	ferent CBSAs	?	N	165. C
Enter "Y" for yes or "N" for no.							
	Name	County			CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00 4	1. 00	5. 00	
166.00 If line 165 is yes, for each						0.0	00 166. C
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)							
por anni e (ese i neti asti sne)				-			
						1.00	
Health Information Technology (HI				ent Act			
67.00 s this provider a meaningful user						Y	167. 0
68.00 If this provider is a CAH (line 10			e 167 is "Y	"), enter the	е		168. 0
reasonable cost incurred for the H							
68.01 If this provider is a CAH and is r					р		168. 0
exception under §413.70(a)(6)(ii) 169.00 f this provider is a meaningful u					r the	0.0	00169. 0
transition factor. (see instruction		IS HUL A CAR (Title 105 I	s N), enter	the	0.0	0 109. 0
transition ractor. (see mistructro	013)			Begi nr	ni na	Endi ng	
				1. 0		2. 00	_
70.00 Enter in columns 1 and 2 the EHR begins period respectively (mm/dd/yyyy)	peginning date and ending	date for the re	eporti ng		-		170. (
perrou respectivery (min/du/yyyy)							
71 001.6 1: 1/7 : - "\"	dan bara an l	attent along t	11 :	1.0	U	2. 00	0174
171.00 If line 167 is "Y", does this proving section 1876 Medicare cost plans in "Y" for yes and "N" for no in column 2. (s	reported on Wkst. S-3, Pt. umn 1. If column 1 is yes,	I, line 2, col	. 6? Enter	i on			0 171. (

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 01/01/2022 Part II Date/Time Prepared: 12/31/2022 5/31/2023 12:14 pm 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 1.00 N 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 N 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 N 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 04/17/2023 04/17/2023 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-2	2552-10	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provi der 0	CCN: 15-0018	Peri od: From 01/01/2022 To 12/31/2022	Worksheet S-2 Part II Date/Time Pre 5/31/2023 12:	pared:	
	· · · · · · · · · · · · · · · · · · ·	Descr	iption	Y/N	Y/N		
	1011 11 12 12 12 12 12 12 12 12 12 12 12 1		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:	REALLOCATIONS CTC RATIO	FOR CORRECT	N	N	20. 00	
		Y/N	Date	Y/N	Date		
04.00	I	1.00	2.00	3.00	4. 00	04.00	
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 CHILDRENS I	HOSPI TALS)				
	Capital Related Cost					1	
22.00	Have assets been relifed for Medicare purposes? If yes, see	e instructions			N	22. 00	
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.	due to apprais	sals made dur	ing the cost	N	23. 00	
24. 00	Were new leases and/or amendments to existing leases entered if yes, see instructions	ed into during	this cost re	porting period?	N	24. 00	
25. 00	Have there been new capitalized leases entered into during instructions.	the cost repo	rting period?	If yes, see	N	25. 00	
26. 00	Were assets subject to Sec. 2314 of DEFRA acquired during thinstructions.	ne cost report	ing period? I	f yes, see	N	26. 00	
27. 00	Has the provider's capitalization policy changed during the copy.	e cost reporti	ng period? If	yes, submit	N	27. 00	
28. 00	Interest Expense Were new Loans, mortgage agreements or Letters of credit er	ntered into du	ring the cost	reporti ng	N	28. 00	
29. 00	period? If yes, see instructions. Did the provider have a funded depreciation account and/or		ebt Service R	eserve Fund)	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		debt? If yes	, see	N	30. 00	
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	ssuance of new	debt? If yes	, see	N	31. 00	
	Purchased Services					1	
32. 00	Have changes or new agreements occurred in patient care ser	rvices furnish	ed through co	ntractual	N	32. 00	
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If		33. 00	
	Provi der-Based Physi ci ans						
34.00	Were services furnished at the provider facility under an a	arrangement wi	th provider-b	ased physicians?	Υ	34. 00	
35. 00	If yes, see instructions. If line 34 is yes, were there new agreements or amended exi	sting agreemen	nts 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	Home Office Costs Were home office costs claimed on the cost report?			Υ		36. 00	
36.00	If line 36 is yes, has a home office cost statement been pr	renared by the	home office?			36.00	
37.00	If yes, see instructions.	epared by the	nome office?	, i		37.00	
38. 00	If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end			N		38. 00	
39. 00	If line 36 is yes, did the provider render services to other see instructions.			, N		39. 00	
40. 00							
		1.	. 00	2.	00		
	Cost Report Preparer Contact Information						
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	SALLY		41. 00			
42. 00	respectively. Enter the employer/company name of the cost report	ELKHART GENERA		42. 00			
43. 00	preparer. Enter the telephone number and email address of the cost report preparer in columns 1 and 2, respectively.	574-647-3842		SBRUBAKER@BEACO	ONHEALTHSYSTEM	43. 00	
	The state of the second	1		1 =::=	'	"	

Heal th	Financial Systems ELKHART GENE	RAL HOSPITAL	In Lie	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider CCN: 15-0018	Period: From 01/01/2022	Worksheet S-2 Part II			
				Date/Time Pre 5/31/2023 12:	pared: 14 pm		
		3. 00					
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	REIMBURSEMENT ANALYST			41.00		
	held by the cost report preparer in columns 1, 2, and 3,						
	respecti vel y.						
42.00	Enter the employer/company name of the cost report				42.00		
	preparer.						
43.00	Enter the telephone number and email address of the cost				43.00		
	report preparer in columns 1 and 2, respectively.						

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared:

				10	12/31/2022	5/31/2023 12:	
			<u> </u>			I/P Days / O/P	
						Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH 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	Hospi tal Adul ts & Peds. (columns 5, 6, 7 and	30. 00	170	63, 850	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		170	63, 850	0.00	0	7. 00
	beds) (see instructions)			,			
8.00	INTENSIVE CARE UNIT	31. 00	23	8, 395	0.00	0	8.00
8. 01	NEONATAL INTENSIVE CARE	31. 01	8	2, 920	0.00	0	8. 01
9.00	CORONARY CARE UNIT	32. 00	0	0	0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT	33. 00	0	0	0.00	0	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00	0	0	0.00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY	43. 00				0	13.00
14. 00	Total (see instructions)		201	75, 165	0. 00	0	14.00
15.00	CAH visits	40.00		0 (50		0	15. 00
16.00	SUBPROVI DER - I PF	40. 00	10			0	16.00
17. 00	SUBPROVIDER - I RF	41. 00	0	646		0	17. 00
18. 00 19. 00	SUBPROVI DER	44.00	0			0	18. 00
20. 00	SKILLED NURSING FACILITY NURSING FACILITY	44. 00 45. 00	0			0	19. 00 20. 00
21. 00	OTHER LONG TERM CARE	46. 00	0			U	21. 00
22. 00	HOME HEALTH AGENCY	101. 00	O			0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00				O	23. 00
24. 00	HOSPI CE	116. 00	0	o			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00	Ŭ				24. 10
25. 00	CMHC - CMHC	99. 00				0	25. 00
25. 10	CMHC - CORF	99. 10				0	25. 10
26.00	RURAL HEALTH CLINIC	88. 00				0	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00				0	26. 25
27.00	Total (sum of lines 14-26)		211				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	0			32. 00
32. 01	Total ancillary labor & delivery room						32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days						33. 00
33. 01	LTCH site neutral days and discharges Temporary Expansion COVID-19 PHE Acute Care	30. 00	0	0		0	33. 01 34. 00
54.00	Transportary Expansion Covid-19 File Acute Calle	30.00	0	ı o		١	54.00

Period: Worksheet S-3
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/31/2023 12:14 pm

					1	14 pm	
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8. 00	9. 00	10.00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	12, 163	1, 683	41, 739			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)	14, 212	9, 724				2. 00
3.00	HMO IPF Subprovider	0	1, 580				3. 00
4.00	HMO IRF Subprovider	0	28				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	12, 163	1, 683	41, 739			7. 00
0.00	beds) (see instructions)	4 (40					0.00
8.00	INTENSIVE CARE UNIT	1, 640	44	6, 134			8. 00
8. 01	NEONATAL INTENSIVE CARE	0	98	576			8. 01
9. 00 10. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0	0			9. 00 10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)	U	U	U			12.00
13. 00	NURSERY		281	1, 983			13. 00
14. 00	Total (see instructions)	13, 803	2, 106	50, 432		1, 150. 35	
15. 00	CAH visits	13, 803	2, 100	30, 432		1, 150. 55	15. 00
16. 00	SUBPROVI DER - I PF	208	83	2, 870		21. 16	
17. 00	SUBPROVI DER - I RF	48	10	102		l .	
18. 00	SUBPROVI DER	10	10	102	0.00	0.07	18. 00
19. 00	SKILLED NURSING FACILITY	0	0	0	0.00	0.00	1
20. 00	NURSING FACILITY		0	0		l	
21. 00	OTHER LONG TERM CARE			0		l e	
22. 00	HOME HEALTH AGENCY	o	0	0	0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	23. 00
24.00	HOSPI CE	0	0	0	0.00	0.00	24. 00
24. 10	HOSPICE (non-distinct part)			176			24. 10
25.00	CMHC - CMHC	O	0	0	0.00	0.00	25. 00
25. 10	CMHC - CORF	0	0	0	0.00	0.00	25. 10
26.00	RURAL HEALTH CLINIC	0	0	0	0.00	0.00	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00	Total (sum of lines 14-26)				0.00	1, 172. 10	27. 00
28. 00	Observation Bed Days		0	5, 811			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	, , , , , , , , , , , , , , , , , , ,	0	14	18			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
00.5-	outpatient days (see instructions)	_					
33. 00		0					33.00
33. 01	LTCH site neutral days and discharges	0					33. 01
34.00	Temporary Expansion COVID-19 PHE Acute Care	0	0	0			34.00

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

				'	J 12/31/2022	5/31/2023 12:	
		Full Time Equivalents	<u> </u>	Di sch	arges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11. 00	12.00	13. 00	14. 00	15. 00	
	PART I - STATISTICAL DATA						
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2			0 2, 589	386	9, 911	1.00
0.00	for the portion of LDP room available beds)			0.050	0.040		0.00
2.00	HMO and other (see instructions)			2, 252	2, 012		2.00
3.00	HMO IPF Subprovider				305		3.00
4.00	HMO I RF Subprovi der				2		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF						5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation beds) (see instructions)						7. 00
8.00	INTENSIVE CARE UNIT						8. 00
8. 01	NEONATAL INTENSIVE CARE						8. 01
9. 00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11. 00	SURGICAL INTENSIVE CARE UNIT						11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13. 00
14. 00	Total (see instructions)	0.00		0 2, 589	386	9, 911	
15.00	CAH visits						15. 00
16.00	SUBPROVIDER - IPF	0.00		0 29	15	524	16. 00
17.00	SUBPROVI DER - I RF	0.00		0 6	1	11	17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY	0. 00					19. 00
20.00	NURSING FACILITY	0.00					20. 00
21. 00	OTHER LONG TERM CARE	0.00				0	21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0. 00					23. 00
24.00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC	0. 00					25. 00
25. 10	CMHC - CORF	0. 00					25. 10
26. 00	RURAL HEALTH CLINIC	0.00					26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30.00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31.00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33. 00	LTCH non-covered days			0			33.00
33. 01	LTCH site neutral days and discharges			0			33. 01
34. 00	,						34. 00
				1	'	ı	

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/

					10	3 12/31/2022	Date/lime Pre 5/31/2023 12:	
		Wkst. A Line Number		Reclassificati on of Salaries (from Wkst.	(col.2 ± col.	Salaries in	Average Hourly Wage (col. 4 ÷ col. 5)	
		1. 00	2. 00	A-6) 3. 00	3) 4. 00	<u>col . 4</u> 5. 00	6. 00	
	PART II - WAGE DATA							
1. 00	SALARIES Total salaries (see	200. 00	99, 665, 040	0	99, 665, 040	2, 437, 967. 00	40. 88	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0. 00	0. 00	2.00
3. 00	A Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		140, 225	0	140, 225	636.00	220. 48	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	0	0. 00 0. 00	l .	
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0. 00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved		0	0	0	0.00	0.00	7. 01
8. 00	programs) Home office and/or related organization personnel		0	0	0	0. 00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 3, 545, 598	0 -134, 316	0 3, 411, 282	0. 00 77, 560. 00		
	instructions) OTHER WAGES & RELATED COSTS							+
11. 00	Contract Labor: Direct Patient Care		23, 888, 064	0	23, 888, 064	168, 899. 00	141. 43	11.00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0.00	12.00
13. 00	services Contract Labor: Physician-Part A - Administrative		394, 119	0	394, 119	2, 131. 00	184. 95	13. 00
14. 00	Home office and/or related organization salaries and		0	0	0	0. 00	0. 00	14. 00
14. 01 14. 02 15. 00	wage-related costs Home office salaries Related organization salaries Home office: Physician Part A		12, 409, 231 0 0	0 0 0	12, 409, 231 0 0	331, 049. 00 0. 00 0. 00	0. 00	1
16. 00	- Administrative Home office and Contract		0	0	0	0. 00	0. 00	16. 00
16. 01	Physicians Part A - Teaching Home office Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 01
16. 02	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0.00	0.00	16. 02
17. 00	Wage-related costs (core) (see instructions)		22, 459, 636	0	22, 459, 636			17. 00
18. 00	Wage-related costs (other) (see instructions)							18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		795, 981 0	0	795, 981 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	0			21. 00
22. 00	Physician Part A - Administrative		0	0	0			22. 00
22. 01 23. 00	Physician Part A - Teaching Physician Part B		0	0	0			22. 01 23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		0	0 0	0			24. 00 25. 00
25. 50	approved program) Home office wage-related (core)		3, 856, 862	0	3, 856, 862			25. 50
25. 51	Related organization wage-related (core)		0	0	0			25. 51
25. 52	Home office: Physician Part A - Administrative - wage-related (core)		0	0	0			25. 52

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared:

					10) 12/31/2022	5/31/2023 12:	
		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 SALARIE							
26. 00	Employee Benefits Department	4. 00	0	0	0	0. 00		
27. 00	Administrative & General	5. 00	4, 095, 507					
28. 00	Administrative & General under		1, 711, 400	0	1, 711, 400	16, 422. 00	104. 21	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, 455, 927	0	2, 455, 927			
31. 00	Laundry & Linen Service	8. 00	0	0	0	0. 00		
32. 00	Housekeepi ng	9. 00	2, 152, 722	-3, 758	2, 148, 964	110, 641. 00		
33. 00	Housekeeping under contract		0	0	0	0. 00	0. 00	33. 00
	(see instructions)							
34. 00	Di etary	10. 00	2, 361, 718	-1, 219, 405	1, 142, 313	·		34.00
35. 00	Dietary under contract (see		0	0	0	0. 00	0. 00	35. 00
	instructions)							
36. 00	Cafeteri a	11. 00	166, 748	1, 214, 165	1, 380, 913			
37. 00	Maintenance of Personnel	12. 00	0	0	0	0. 00		
38. 00	Nursing Administration	13. 00	2, 824, 774			·		
39. 00	Central Services and Supply	14. 00	857, 595			·		
40.00	Pharmacy	15. 00	4, 574, 819	-4, 400, 188	174, 631	2, 080. 00	83. 96	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	988, 759	-170	988, 589			42.00
43.00	Other General Service	18. 00	0	0	0	0.00	0.00	43.00

| Peri od: | Worksheet S-3 | From 01/01/2022 | Part III | To 12/31/2022 | Date/Time Prepared: | To 12/31/202

					'	0 12/31/2022	5/31/2023 12:	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	$(col.2 \pm col.$	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2.00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						l
1.00	Net salaries (see		101, 376, 440	0	101, 376, 440	2, 454, 389. 00	41. 30	1. 00
	instructions)							l
2.00	Excluded area salaries (see		3, 545, 598	-134, 316	3, 411, 282	77, 560. 00	43. 98	2. 00
	instructions)							l
3.00	Subtotal salaries (line 1		97, 830, 842	134, 316	97, 965, 158	2, 376, 829. 00	41. 22	3. 00
	minus line 2)							l
4.00	Subtotal other wages & related		36, 691, 414	0	36, 691, 414	502, 079. 00	73. 08	4. 00
	costs (see inst.)							l
5. 00	Subtotal wage-related costs		26, 316, 498	0	26, 316, 498	0.00	26. 86	5. 00
	(see inst.)							l
6.00	Total (sum of lines 3 thru 5)		160, 838, 754	134, 316	160, 973, 070	2, 878, 908. 00	55. 91	6. 00
7.00	Total overhead cost (see		22, 189, 969	-4, 558, 130	17, 631, 839	596, 495. 00	29. 56	7. 00
	instructions)							l

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0018	Peri od: Worksheet S-3
		From 01/01/2022 Part IV

	To 12/31/2023	Date/Time Prep 5/31/2023 12:	
		Amount	
		Reported	
		1.00	
	PART IV - WAGE RELATED COSTS	•	
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	2, 863, 769	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	•	
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, 173, 030	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	154, 906	10.00
	Life Insurance (If employee is owner or beneficiary)	62, 881	
	Accident Insurance (If employee is owner or beneficiary)	0	12.00
	Disability Insurance (If employee is owner or beneficiary)	205, 563	
	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
	'Workers' Compensation Insurance	588, 022	
16. 00		0	16. 00
	Noncumulative portion)		1
	TAXES		
17. 00	FICA-Employers Portion Only	7, 177, 045	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
	Unemployment Insurance	0	19. 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	e 0	21. 00
	instructions))		
22. 00	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	30, 400	23. 00
	Total Wage Related cost (Sum of lines 1 -23)	23, 255, 616	
	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 01/01/2022 Part V

		Ť	12/31/2022	Date/Time Pre 5/31/2023 12:	
	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	Subprovider - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	SKILLED NURSING FACILITY		0	0	8. 00
9.00	NURSING FACILITY		0	0	9. 00
10.00	OTHER LONG TERM CARE I				10. 00
11. 00	Hospi tal -Based HHA		0	0	11. 00
12.00	AMBULATORY SURGICAL CENTER (D. P.) I		0	0	12. 00
13.00	Hospi tal -Based Hospi ce		0	0	13. 00
14.00	Hospital-Based Health Clinic RHC		0	0	14. 00
15. 00	Hospital-Based Health Clinic FQHC		0	0	15. 00
16. 00	Hospi tal -Based-CMHC		0	0	16. 00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
17. 00	RENAL DIALYSIS I		0	0	17. 00
18. 00	Other		o	0	18. 00

Heal th	Financial Systems ELKHART GENERAL	HOSPI TAI		In lie	u of Form CMS-2	2552-10		
	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der CCN	N: 15-0018	Peri od:	Worksheet S-10			
				From 01/01/2022	D-+- /T: D			
	To 12/31/2022 Date/Time Prepr 5/31/2023 12:1-							
			'		0,01,2020 121	, ,		
					1. 00			
	Uncompensated and indigent care cost computation				0.000504			
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di Medicaid (see instructions for each line)	vided by lin	e 202 column	8)	0. 238521	1. 00		
2.00	Net revenue from Medicaid				35, 876, 700	2.00		
3. 00	Did you receive DSH or supplemental payments from Medicaid?				00,070,700	3.00		
4.00	If line 3 is yes, does line 2 include all DSH and/or supplemer	ntal payments	from Medica	i d?		4. 00		
5.00	If line 4 is no, then enter DSH and/or supplemental payments f	rom Medicaid			0			
6.00	Medicaid charges				192, 547, 897			
7. 00 8. 00	Medicaid cost (line 1 times line 6) Difference between net revenue and costs for Medicaid program	(line 7 minu	e eum of lin	os 2 and 5: if	45, 926, 717 10, 050, 017	7. 00 8. 00		
6.00	<pre> < zero then enter zero)</pre>	(TITIE / IIITIU	5 Suii Oi III	es z anu s, m	10, 030, 017	8.00		
	Children's Health Insurance Program (CHIP) (see instructions f	or each line)					
9.00	Net revenue from stand-alone CHIP				74			
10.00	Stand-alone CHIP charges				1, 084	•		
11. 00 12. 00	Stand-alone CHIP cost (line 1 times line 10) Difference between net revenue and costs for stand-alone CHIP	(lino 11 min	us lino 0: i	f < zoro thon	259 185	•		
12.00	lenter zero)	(TITIE IT IIII II	us iiile 9, i	i < Zero trieri	100	12.00		
	Other state or local government indigent care program (see ins	tructions fo	r each line)					
13.00	Net revenue from state or local indigent care program (Not inc	luded on lin	es 2, 5 or 9)	32, 584	13.00		
14. 00	Charges for patients covered under state or local indigent car	re program (N	ot included	in lines 6 or	304, 971	14. 00		
15. 00	10) State or local indigent care program cost (line 1 times line 1	14)			72 742	15. 00		
16. 00	State or local indigent care program cost (line 1 times line 1 Difference between net revenue and costs for state or local in		nrogram (lin	e 15 minus line	72, 742 40, 158			
	13; if < zero then enter zero)	iai goire oai o	program (rrm	0 10110	10, 100	10.00		
	Grants, donations and total unreimbursed cost for Medicaid, CH	IIP and state	/local indig	ent care progran	ns (see			
17. 00	<pre>instructions for each line) Private grants, donations, or endowment income restricted to f</pre>	funding chari	ty care		0	17. 00		
18. 00	Government grants, appropriations or transfers for support of				0	18.00		
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local	al indigent c	are programs	(sum of lines	10, 090, 360	19. 00		
	8, 12 and 16)				T (4			
			Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)			
			1. 00	2. 00	3. 00			
	Uncompensated Care (see instructions for each line)							
20. 00	Charity care charges and uninsured discounts for the entire fa (see instructions)	ncility	23, 308, 27	9 404, 563	23, 712, 842	20. 00		
21. 00	Cost of patients approved for charity care and uninsured disco	ounts (see	5, 559, 51	4 404, 563	5, 964, 077	21. 00		
	instructions)	,						
22. 00	Payments received from patients for amounts previously writter	n off as		0	0	22. 00		
23. 00	charity care Cost of charity care (line 21 minus line 22)		5, 559, 51	4 404, 563	5, 964, 077	23. 00		
	,			· · · · · · · · · · · · · · · · · · ·				
0.4.00					1. 00			
24. 00	Does the amount on line 20 column 2, include charges for patie		nd a Length	of stay limit	N	24. 00		
25. 00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond to the limit		care program	's length of	0	25. 00		
26. 00	stay limit On Total bad debt expense for the entire hospital complex (see instructions) 13,733,683					26. 00		
27. 00	Medicare reimbursable bad debts for the entire hospital complete	,	uctions)		129, 061	27. 00		
27. 01	Medicare allowable bad debts for the entire hospital complex (198, 554	27. 01		
28. 00	Non-Medicare bad debt expense (see instructions)	_			13, 535, 129			
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	kpense (see i	nstructions)		3, 297, 906			
30.00	Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus l	ine 30)			9, 261, 983 19, 352, 343			
31.00	Trotal ani erinbur sed and uncompensated care cost (Trile 19 prus 1	1116 30)			17, 302, 343	J 31.00		

Provider CD:: 15 0016 Prov		n Financial Systems	ELKHART GENERAL	_	CN: 15 0010 F		u of Form CMS-2 Worksheet A	2552-10
Cost Conten Description	RECLA	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	IF EXPENSES	Provider Co	F	rom 01/01/2022		
Control Cont					Т	o 12/31/2022		pared:
The Park Service Circle First Charles 1.00		Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		TT PIII
					+ col . 2)	ons (See A-6)		
BURNEY SENSITE COST CHITLES 1.00 2.00 3.00 4.00 5.00								
DEPERMENT SERVICE CONT CENTERS			1.00	2.00	3.00	4. 00		
2.00								
3.00 000000 THER CAP BELL COSTS 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0				0	C			1
4.00 GORDO PLATIVE BREFIT IS INFARRIMENT 0 9-70, 627 9-70, 627 1, 500, 649 4 5 0				0		1, 218, 660		
0.000 DOSCOOLINA TREMANCE & REPNAIRS			0	920, 627	920, 627	588, 022		1
7. 0. 00 DODO DOPERATION OF PLANT 2,455,927 5,488,381 7,944,310 -3,421 7,940,899 7,00 9. 00 DODO CHUSTREEP ING 2,152,778 2,152,777,868 3,723,671 3,758 3,778,113 7,00 10. 00 DODO CHUSTREEP ING 2,152,778 2,152,778 2,515,778 2,515,778 2,515,778 2,515,778 2,515,778 2,515,778 2,515,778 2,515,778 2,515,778 2,515,778 2,515,778 2,515,479 3,60,713 1,700,718 1,700,718 1,700,718 2,515,440 3,778,713 1,700 1,700 1,700,718 2,515,440 3,778,713 1,700 1,700 1,700 1,700 1,700,718 2,515,440 2,715,713 1,700 1,700 1,700 1,700,718 2,515,440 2,715,713 1,700 1,700 1,700 1,700,718 2,515,440 2,715,713 1,700 1,700 1,700,718 2,715,713 1,700 1,700 1,700,718 2,715,713 1,700 1,700 1,700 1,700,718 2,715,713 1,700 1,700 1,700,718			4, 095, 507	76, 981, 268	81, 076, 775	-18, 437, 716	62, 639, 059	
B.00 DOSCOL LANIBRY AL LINEN SERVICE 0 777, 486 777, 486 8.0 0 0 0 0 0 0 0 0 0			0	0	7 044 046	0	_	1
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10.00 01000 DETARY 2, 301, 718 2, 152, 659 4, 514, 377 -2, 590, 807 1, 923, 707 10. 00 1010 01200 MAINTENANCE 7, 923, 920 11. 00 1010 01200 MAINTENANCE 7, 923, 920 11. 00 1010 1			2, 152, 722					
12.00 01200 MAITEMANCE OF FERSONNET 0 0 0 0 0 0 0 0 0	10. 00		1		1			1
13.00 01300 RURSI NO. ADMINI STRATI ON 2, 824, 774 838, 338 3, 66, 131 2 -256, 979 3, 106, 133 13.00 15.00 10500 PHARMACY 4, 574, 819 19, 055, 057 24, 230, 470 -22, 136, 480 2, 093, 991 15.00 15.00 15000 PHARMACY 4, 574, 819 19, 055, 067 24, 230, 470 -22, 136, 480 2, 093, 991 15.00 16.			1	191, 030	i .			1
14.00 01400 (PRIMANCY			١	838 338	1	1		
15.00 0 1500 [PHARMACY 4.574, 819 19, 655, 657 24, 230, 476 -22, 136, 48E 2, 093, 991 17.00 17.0						•		
17. 00 01700 SOCIAL SERVICE (SPECIFY) 988.759 386.725 1,375,444 -170 1,375,314 17. 00 18. 00 188.0		01500 PHARMACY						
18.00 01850 OTHER CEMERAL SERVICE (SPECIFY) 0 0 0 0 0 0 0 0 0			1 4	0	0	0		•
19.00 01900 MORPHYSICI AM AMESTHETISTS 0 0 0 0 0 0 0 0 0			988, 759	386, 725	1, 3/5, 484	-1/0		
20.00				0		0		
22 0.0 02000 RAT SERVICES-OTHER PROM COSTS APPRVD 0 0 168, 552 0 168, 552 23. 00 22. 00 0300 PARAMED ED PRICAL 066, 546 102, 006 168, 552 0 168, 552 23. 00 0300 AURITS & PERIDI ATRICS 26,098, 233 26,945, 312 53,043, 545 -3,228, 180 49, 815, 365 31. 00 30100 AURITS & PERIDI ATRICS 26,098, 233 26,945, 312 11,477, 689 1-90, 148 11,287, 541 31. 00 31. 00 3100 INTENSIVE CARE UNIT 0 0 0 0 0 0 0 32. 00 3300 0300 AURITS & PERIDINA CARE UNIT 0 0 0 0 0 0 0 32. 00 3300 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 32. 00 3300 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 32. 00 3300 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 32. 00 3300 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 32. 00 3300 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0	20.00		0	0	C	0	0	20. 00
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IMPATI ENT ROUTI NE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRIC S 26.098, 233 26.945, 312 53,043,545 -3.228, 180 49,815, 365 31.00 31.00 31.00 31.00 31.00 NOTENSI VE CARE UNIT 6.595,395 4.882,294 11,477,689 -190,148 11,287,541 31.00 32.00 33.00 330.00 3			0	102.004	140 550	0	140 552	
30.00 03000 ADULTS & PEDIATRICS 26, 098, 233 26, 945, 312 53, 043, 545 -3, 228, 180 49, 815, 365 30, 00 31.00 03100 INTENSIVE CARE UNIT 6, 595, 395 4, 882, 224 111, 76, 689 -1190, 148 11, 287, 541 31.00 31.00 03100 COROMARY CARE UNIT 0 0 0 0 0 0 0 33.00 033.00 03300 0300	23.00		00, 340	102,006	100, 332		100, 332	23.00
13.1 0.310 NEONATAL INTENSIVE CARE 1, 582, 378 516, 754 2, 099, 132 -205 2, 098, 927 31.01 32.00 0.3200 CORONARY CARE UNIT 0 0 0 0 0 0 0 0 33.00 0.3300 SURGI CLAI INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 40.00 0.4000 SURGI CLAI INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 40.00 0.4000 SURGI CLAI INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 40.00 0.4000 SURGI CLAI INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 40.00 0.4000 SURGI CLAI INTENSIVE CARE UNIT 0 0 0 0 0 0 0 40.00 0.4000 SURGI CLAI INTENSIVE CARE UNIT 0 0 0 0 0 0 0 40.00 0.4000 SURGI CLAI INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 40.00 0.4000 SURGI CLAI INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 40.00 0.4000 SURGI CLAI INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 40.00 0.4000 SURGI CLAI INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0	30. 00		26, 098, 233	26, 945, 312	53, 043, 545	-3, 228, 180	49, 815, 365	30.00
32.00 03200 COROMARY CARE UNIT 0 0 0 0 0 32.00 34.00 03400 SUBNI TINTENIS VE CARE UNIT 0 0 0 0 0 0 0 34.00 03400 SUBNI TINTENIS VE CARE UNIT 0 0 0 0 0 0 34.00 03400 SUBPROVI DER - I PF 2.012, 941 444, 764 2, 457, 705 235 2, 457, 940 404 41.00 04400 SUBPROVI DER - I PF 2.012, 941 444, 764 2, 457, 705 235 2, 457, 940 404 41.00 04400 SUBPROVI DER - I RF 3130, 477 164, 753 295, 230 -195, 662 99, 568 41, 00 44.00 04400 SUBLELED NURSI NG FACILITY 0 0 0 0 0 0 0 0 0			1					
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43. 00 04300 NURSERY 30,765 6,225 36,990 3,319,183 3,356,173 42.00 44.00 04400 SKILLED NURSI NG FACILITY 0 0 0 0 0 0 0 0 0 0 45.00 45.00 65.00 045.00 05.00			1					1
44. 00 04400 SKILLED NURSING FACILITY				•	1			1
45. 00 04500 NURSI NO FACILITY			30, 765	o, 225 0	30, 990	3, 319, 183) 0		1
ANCILLARY SERVICE COST CENTERS			O	0	Č	o o		
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S2.00 05300 05300 05200 05200 05200 053000 053			12, 175, 516	42, 607, 761	34, 963, 279) -22, /10, 240		
53.00 05.0			O	0	d	0	0	1
55.00 05500 RADI OLOGY-THERAPEUTI C			0	0	C	0	-	
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			5, 933, 964	4, 712, 856	10, 646, 820	-2, 494, 176		•
57. 00 05700 CT SCAN 686, 489 1, 068, 669 1, 755, 158 -3, 270 1, 751, 888 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 479, 826 249, 036 728, 862 -202 728, 660 58. 00 05900 CARDI AC CATHETERI ZATI ON 2, 287, 606 7, 709, 290 9, 996, 896 -8, 144, 393 1, 852, 503 59. 00 05900 CARDI AC CATHETERI ZATI ON 2, 287, 606 7, 709, 290 9, 996, 896 -8, 144, 393 1, 852, 503 59. 00 05000 CARDINATORY 2, 606, 565 8, 930, 313 11, 536, 878 -10, 149 11, 526, 729 60. 00 0 0 0 0 0 0 0 0				0		0		
59.00 05900 CARDI AC CATHETERI ZATION 2, 287, 606 7, 709, 290 9, 996, 896 -8, 144, 393 1, 852, 503 59, 00		05700 CT SCAN	686, 489	1, 068, 669	1, 755, 158	-3, 270	1, 751, 888	•
60.00 06000 LABORATORY 2,606,565 8,930,313 11,536,878 -10,149 11,526,729 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1					1
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61. 00			2, 606, 565	8, 930, 313 0	11, 536, 878	- 10, 149 0		
63. 00				Ō	Č	0		1
64. 00 06400 INTRAVENOUS THERAPY 1, 203, 090 746, 823 1, 949, 913 -286, 556 1, 663, 357 64. 00 65. 00 06500 RESPI RATORY THERAPY 1, 768, 705 2, 639, 599 4, 408, 304 -165, 764 4, 242, 540 65. 00 66. 00 06600 PHYSI CAL THERAPY 1, 604, 820 533, 710 2, 138, 530 492 2, 139, 022 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 561, 236 239, 183 800, 419 -796 799, 623 67. 00 68. 00 06800 SPEECH PATHOLOGY 259, 964 64, 884 324, 848 -272 324, 576 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 70. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 0 0, 778, 364 10, 778, 364 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0, 778, 364 10, 778, 364 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 76. 00 03140 CARDI OLOGY 1, 961, 662 736, 529 2, 698, 191 -159, 002 2, 539, 189 76. 00 77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 77. 00 00 00 00 00 0 0 89. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 90. 00 09000 CLINIC 416, 587 122, 182 538, 769 362 539, 131 90. 00 90. 00 90. 00 00 00 00 00 90. 00 00 00 00 00 90. 00 00 00 00 00 90. 00 00 00 00 00 90. 00 00 00 00 00 90. 00 00 00 00 00 90. 00 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00 00 00 90. 00 00	62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0		62. 00
65. 00			1 202 202	74/ 000	1 040 010	0		
66. 00 06600 PHYSI CAL THERAPY 1,604,820 533,710 2,138,530 492 2,139,022 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 561,236 239,183 800,419 -796 799,623 67. 00 68. 00 06800 SPEECH PATHOLOGY 259,964 64,884 324,848 -272 324,576 68. 00 6900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0						1		1
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69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		06700 OCCUPATI ONAL THERAPY	1	239, 183		-796	799, 623	67. 00
70. 00		1	259, 964	64, 884	324, 848	-272	•	1
71. 00		1	0	0		0		1
72. 00				0		10. 778. 364		
74. 00		07200 IMPL. DEV. CHARGED TO PATIENTS	o	Ō	i c			1
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 75. 00 76. 00 0 0 0 0 0 0 0 0 0			0	0	ı c	25, 431, 264		1
76. 00			0	0				
77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 77. 00 0 0 0 77. 00 0 0 0 0 0			1.961 662	736 529	2.698 191	-159 NO2		1
OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 90.00 09000 CLINIC 416,587 122,182 538,769 362 539,131 90.00			1	0	2, 3,3, 1,7	0		
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89. 00 90. 00 09000 CLINIC 416, 587 122, 182 538, 769 362 539, 131 90. 00		OUTPATIENT SERVICE COST CENTERS						1
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RecLass Financial Systems ELKHART GENERAL HOSPITAL							
Cost Center Description	Health Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
To 12/31/2022 Date/Time Prepared: 5/31/2032 12:14 pm	RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CC			Worksheet A	
Cost Center Description						Date/Time Pre	pared:
1.00 2.00 3.00 4.00 5.00 92.00 99.00 9			1				14 pm
1.00 09100 MERGENCY 9,055,112 8,205,690 17,260,802 -96,148 17,164,654 91.00 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 92.00 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 92.00 07400 HOME PROGRAM DIALYSIS 0 0 0 0 0 0 0 0 0 94.00 095.00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 0 95.00 96.00 96.00 09500 AMBULANCE SERVICES 0 0 0 0 0 0 0 0 0 96.00 96.00 97.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 0 0 0 0 96.00 97.00 99.00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 96.00 99.00 99.00 09900 CMHC 0 0 0 0 0 0 0 0 0 0 0 99.00 99.00 99.00 09900 CMHC 0 0 0 0 0 0 0 0 0 0 0 0 0 99.00 99.10 09910 COFF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Cost Center Description	Sal ari es	0ther				
91. 00 09100 BMERGENCY 9. 055, 112 8, 205, 690 17, 260, 802 -96, 148 17, 164, 654 91. 00 92.00 095ERVATI ON BEDS (NON-DISTINCT PART) 92. 00 09200 095ERVATI ON BEDS (NON-DISTINCT PART) 92. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 0 0 0 0 94. 00 94. 00 95. 00				+ COI . 2)	ons (See A-6)		
1.00 2.00 3.00 4.00 5.00							
91. 00 09100 EMERGENCY 9, 055, 112 8, 205, 690 17, 260, 802 -96, 148 17, 164, 654 91. 00 92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART) 9, 055, 112 8, 205, 690 17, 260, 802 -96, 148 17, 164, 654 91. 00 92. 00 00 00 00 00 00 00 00		1 00	2 00	3 00	4.00		
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 0THER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	91 00 09100 EMERGENCY						91 00
94. 00 O7400 HOME PROGRAM DI ALYSIS O O O O O O O O O		7,000,112	0, 203, 070	17, 200, 00.	70, 140	17, 104, 054	
94. 00							72.00
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 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 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 L&R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101. 00 102. 00 10200 OPI 01D TREATMENT PROGRAM 0 0 0 0 0 0 0 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 0 105. 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 0 109. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 0 0 109. 00 111. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 111. 00 113. 00 11300 INTEREST EXPENSE 0 0 0 0 0 0 111. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 115. 00 116. 00 11600 HOSPI CE 0 0 0 0 0 0 0 0 116. 00 11600 HOSPI CE 0 0 0 0 0 0 0 116. 00 11600 HOSPI CE 0 0 0 0 0 0 0 116. 00 116. 00 116. 00 0 0 0 0 0 0 0 0 116. 00 116. 00 116. 00 0 0 0 0 0 0 0 116. 00 116. 00 116. 00 0 0 0 0 0 0 0 0 0		0	0	(0	0	94. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 96. 00 97. 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 0 98. 00 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 0		o	o	(0	0	95.00
98. 00	96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	o	(0	0	
99. 00 09900 CMHC 0 0 0 0 0 0 0 99. 00 99. 10 09910 CORF 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 0 102. 00 10200 OPI 01 D TREATMENT PROGRAM 0 0 0 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 110. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 111. 00 11000 SLET ACQUI SI TI ON 0 0 0 0 111. 00 11000 SLET ACQUI SI TI ON 0 0 0 0 111. 00 11300 INTERST EXPENSE 0 0 0 0 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 116. 00 11600 HOSPI CE 0 0 0 0 0 116. 00 11600 MOSPI CE 0 0 0 0 116. 00 11600 MOSPI CE 0 0 0 0 116. 00 11600 MOSPI CE 0 0 0 0 116. 00 11600 MOSPI CE 0 0 0 0 117. 00 0 0 0 0 0 118. 00 0 0 0 0 0 119. 00 0 0 0 0 110. 00 0 0 0 0 111. 00 0 0 0 0 0 111. 00 0 0 0 0 1	97.00 09700 DURABLE MEDICAL EQUIP-SOLD	o	o	(0	0	97. 00
99. 00	98. 00 09850 OTHER REIMBURSABLE COST CENTERS	o	o	(0	0	98. 00
100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 102. 00 102.00 0PI 0I D TREATMENT PROGRAM 0 0 0 0 0 102. 00 102.00 102		o	o	(0 0	0	99. 00
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	99. 10 09910 CORF	o	o	(0 0	0	99. 10
102. 00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O O O O O O O O O O	100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	o	(0 0	0	100.00
SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE CENTERS SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE CENTERS SPECI	101.00 10100 HOME HEALTH AGENCY	0	0	(0	0	101.00
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 0 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 110. 00 0 0 0 1110. 00 0 0 0 0 0 1110. 00 0 0 0 0 0 0 0	102.00 10200 OPIOID TREATMENT PROGRAM	0	0	(0	0	102. 00
106. 00 10600 HEART ACQUISITION 0 0 0 0 106. 00 107. 00 10700 LI VER ACQUISITION 0 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUISITION 0 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 0 109. 00 110. 00 1100 INTESTINAL ACQUISITION 0 0 0 0 0 0 0 0 110. 00 111. 00 11300 INTEREST EXPENSE 0 0 0 0 0 0 0 113. 00 114. 00 11400 UTILIZATION REVIEW-SNF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 115. 00 0							
107. 00 10700 LI VER ACQUI SITION 0 0 0 0 107. 00 108. 00 10800 LUNG ACQUI SITION 0 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SITION 0 0 0 0 0 0 0 109. 00 110. 00 110. 00 INTESTINAL ACQUI SITION 0 0 0 0 0 0 0 0 110. 00 111. 00 11100 ISLET ACQUI SITION 0 0 0 0 0 0 0 0 0 111. 00 113. 00 11300 INTEREST EXPENSE 0 0 0 0 0 0 0 113. 00 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 0 0 0 0 0 0 0 0 0 0 0 0 0 115. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>-</td> <td></td> <td></td>		0	0		-		
108. 00 10800 LUNG ACQUISITION 0 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 109. 00 110. 00 110. 00 INTESTINAL ACQUISITION 0 111. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 111. 00 114. 00 0 0 0 0 115. 00 0 0 0 0 0 115. 00 0 0 0 0 0 0 0 0 0		0	0	(0 0		
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 110. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 110. 00 111. 00 11100 ISLET ACQUISITION 0 0 0 0 0 0 0111. 00 113. 00 11300 INTEREST EXPENSE 0 0 0 0 0 0113. 00 114. 00 11400 UTILIZATION REVIEW-SNF 0 0 0 0 0114. 00 0 0 0115. 00 0 015. 00 0 015. 00 0 015. 00 0 0 016. 00 0 0 0 016. 00 0 0 0 0 016. 00 0 <td></td> <td>0</td> <td>0</td> <td></td> <td>-</td> <td></td> <td></td>		0	0		-		
110. 00 11000 INTESTINAL ACQUISITION		0	0		ا		
111. 00 11100 ISLET ACQUISITION		0	0		٥		
113. 00 11300 INTEREST EXPENSE		0	0		ا		
114. 00		0	0	(0		
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115. 00 116. 00 11600 HOSPICE 0 0 0 0 0 116. 00			0	(0		
116. 00 11600 HOSPI CE 0 0 0 0 0 116. 00		0	0	(0		
		0	0	(0		
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 98,329,406 221,718,756 320,048,162 48,743 320,096,905 118.00		0	0	(0		
NONDEL MOUDEAU F COCT CENTEDS		98, 329, 406	221, 718, 756	320, 048, 16	2 48, 743	320, 096, 905	J118. 00
NONREI MBURSABLE COST CENTERS			ام				100.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00			0		-		
191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 192. 00 192. 00 192. 00 0 0 0 0 192. 00			0	(0		

41, 372

248, 217 1, 046, 045

99, 665, 040

12, 773 331, 511 4, 383, 276

226, 446, 316

54, 145

579, 728 5, 429, 321

326, 111, 356

0

672

-306 -49, 109 0 192. 00

54, 817 193. 00

579, 422 193. 01 5, 380, 212 194. 00

326, 111, 356 200. 00

192. 00 19200 PHYSICIANS' PRIVATE OFFICES

200.00

193.00 19300 NONPALD WORKERS 193.01 19301 COMMUNITY 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS

TOTAL (SUM OF LINES 118 through 199)

Peri od: From 01/01/2022 To 12/31/2022 Date/Ti me Prepared: 5/31/2023 12:14 pm

Description						5/31/2023 12:	14 pm
			Cost Center Description		Net Expenses		
CREATENLE SERVICE COST CENTERS							
1.00		CENED	AL CEDIUSE COCT SENTEDS	6.00	7.00		
2.00 000000 PRE COSTS-MOREL EQUIP 2, 5-99, 261 3, 767, 921 3, 2.00 3.00 00000 PRE COSTS-MOREL EQUIP 2, 5-99, 261 3, 767, 921 3.00 0.00 00000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 00000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0000 PRE COSTS-MOREL EQUIP 2, 5-90, 261 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.	1 00			1 221 27/	15 001 000		1 00
3.00 000000 INTER-CAP INCLUDES REPORTS 0 1,000 649 4.00 0.00							1
4.00 ODUCING MELTURES EIRCH IS DEPARTMENT 2,2528,151 40,110,543 5,00 5,00 5,000						1	1
5.00 DODGO ADMINISTRATIVE & GENERAL -22, 528, 510 A 0, 110, 643 5, 50 O O. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.				0	l e	•	1
0.00 0.00		1	i e e e e e e e e e e e e e e e e e e e	-22 528 516		1	
7. 0.0 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000				-22, 320, 310		1	
1.00 CORROD LAMBERY & LEWIN STRYLEF 0 777, 486 8 0 0				-538 160		l .	1
9.00 000000		1		000, 100		1	1
10 00 01000 DIETARY 0 0 1,923,570 10 00 10 10 10 10 10 10		1		Ö		1	1
11.00 0 1100 CAFETERIA		1		0		1	
12.00 01200 MAINTENANCE OF PERSONNEL 0 0 12.00 13.00 1		1	l e e e e e e e e e e e e e e e e e e e	-1, 166, 437			1
13.00 01300 MURSING AGMINISTRATION 0 3.406, 133 13.00 15		1		0		1	
14.00 01400 CENTRAL SERVICES & SUPPLY		1		0	3, 406, 133		1
16.00 10-00 MEDICAL RECORDS & LIBRARY 0 0 16.00	14.00	01400	CENTRAL SERVICES & SUPPLY	-11, 950			14. 00
17.00 1700 SOCI AL SERVICE (SPECIFY)	15.00	01500	PHARMACY	-214, 271		1	15. 00
18. 00 01850 OTHER CERRAL SERVICE (SPECIFY) 0 0 0 0 0 0 0 0 0	16.00	01600	MEDICAL RECORDS & LIBRARY	0	0		16. 00
19.00 1900 000Ph/SICI AND AMESTHETISTS 0 0 0 20.0	17. 00	01700	SOCIAL SERVICE	-22, 632	1, 352, 682		17. 00
20. 00 20200 MURSING PROGRAM 0 0 0 21. 00	18.00			0	0		18. 00
21.00 20.00 18. SERVICES_SALARY & FRINKES APPROV 0 22.00		01900	NONPHYSICIAN ANESTHETISTS	0	0		19. 00
22.00		1		0		l .	
23.00		1		0	1	l .	
IMPATIL ENT ROUTINE SERVICE COST CENTERS				0		l .	
30.00 3000 ADULT'S & PEDIATRICS -4, 368, 364 45, 447, 001 31.00	23. 00			-44, 072	124, 480		23. 00
31.00					15 447 004	T	
31.01 30101 NEOMATAL INTENSIVE CARE -132,000 1,966,927 31.01 32.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 33.00 34.						•	
32.00 33200 CORONARY CARE UNIT 0 0 0 33.00 33.00 343.00 343.00		1	l e e e e e e e e e e e e e e e e e e e	_			1
33.00 33.00 BURN INTERSIVE CARE UNIT 0 0 0 34.00 0 34.00 0 34.00 0 34.00 0 34.00 0 34.00 0 34.00 0 34.00 0 34.00 0 34.00 0 34.00 0 34.00 0 34.00 0 34.00				-132,000		1	
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 40. 00 40.		1	l e e e e e e e e e e e e e e e e e e e	0		l .	
40.00 04000 SUBPROVIDER - IPF 0 2,457,940 41.00 0410 SUBPROVIDER - IRF 0 0,99,568 41.00 0410 SUBPROVIDER - IRF 0 0,99,568 41.00 0440 0440 04400 SKILLED NURSING FACILITY 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 0 0 0 0				0		l .	
1.00 0.4100 SUBPROVI DER - 1 IRF				0		l .	
43.00 04300 NURSERY -2,905 3,353,268 43.00 44.00 0440 08.00 0450				0		•	1
44.00 04400 SKILLED NURSING FACILITY				_2 905		•	
45. 00 04500 OURSING FACILITY		1		2, 709		1	
A6. OD O4-GOD OTHER LONG TERM CARE O O O O5-OO OFF-ORT LONG TERM CARE O O5-OO O5-OOO OFF-ORT ING ROOM O5-OO O5-OOO OFF-ORT ING ROOM O O O O O O O O O				0		1	
ANCI LLARY SERVICE COST CENTERS 50.00		1		0			
50.00							
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0	50.00			-9, 788, 186	22, 476, 845		50. 00
53.00 05300 NESTHESI OLOGY 0 0 54.00 05400 RADIOLOGY-DI AGNOSTIC -154,300 7,998,344 55.00 55.00 05500 RADIOLOGY-THERAPEUTIC 0 0 0 55.00 56.00 05600 RADIOLOGY-THERAPEUTIC 0 0 55.00 56.00 05600 RADIOLOGY-THERAPEUTIC 0 0 55.00 57.00 05700 CTSCON 0 1,751,888 57.00 58.00 05800 MARDIAC CATHETER IZATION -2,267 1,850,236 58.00 69.00 06000 LABORATORY -201 11,526,528 60.00 60.01 06010 LABORATORY 0 0 0 61.00 06100 PBP CLI NICAL LAB SERVICES-PRGM ONLY 0 0 0 62.00 06200 MILLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 64.00 06400 PATRAVEROUS THERAPY -1,663,357 66.00 65.00 06500 RESPIRATORY THERAPY -1,95 2,137,027 66.00 66.00 06600 PHYSI CAL THERAPY -1,96	51.00	05100	RECOVERY ROOM	0	0		51.00
54. 00 05400 RADI OLOGY-DI AGNOSTIC -154,300 7,998,344 55. 00 05500 RADI OLOGY-THERAPEUTIC 0 0 0 0 0 0 0 0 0	52.00	05200	DELIVERY ROOM & LABOR ROOM	0	0		52. 00
55 00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 56.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00 66.00<	53.00	05300	ANESTHESI OLOGY	0	0		53. 00
56.00 0500 RADI OI SOTOPE 0 0 56.00 57.00 05700 CT SCAN 57.00 57.00 05700 CT SCAN 57.00 58.00 58.00 58.00 58.00 58.00 58.00 58.00 58.00 58.00 59.00 58.00 59.00 58.00 59.00 58.00 59.00 59.00 59.00 60.01 60.01 60.00 60.00 18.00 18.00 59.00 60.00		1		-154, 300	7, 998, 344		
57.00 05700 07500 07500 07500 07500 07500 07500 0580				0		l .	
58. 00 05800 MGANETI C RESONANCE I MAGING (MRI) 0 728, 660 59. 00 05900 CARDIAC CATHETERIZATION -2, 267 1, 850, 236 59. 00 60. 00 06000 LABORATORY -201 11, 526, 528 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 61. 00 61. 00 06100 PBP CLIN CAL LAB SERVI CES-PRGM ONLY 0 0 61. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0 1, 663, 357 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 1, 663, 357 66. 00 66. 00 06600 PHYSI CAL THERAPY -1, 995 2, 137, 027 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 799, 623 67. 00 68. 00 06900 ELECTROCABULOLOGY 0 324, 576 68. 00 69. 00 06900 ELECTROCABULOLOGY 0 0 0 71. 00 07100 MBUGS CHARGED TO PATIENTS 0 0 0 72. 00 0				0		l .	
59. 00 05900 CARDI AC CATHETERI ZATI ON -2, 267 1, 850, 236 59. 00 60. 00 06000 LABORATORY -201 11, 526, 528 60. 00 60. 01 06001 BLOOD LABORATORY 0 60. 01 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 63. 00 06300 BLOOD STORI NG, PROCESSING & TRANS. 0 0 64. 00 06400 I INTRAVENOUS THERAPY 0 1, 663, 357 64. 00 65. 00 06500 RESPI RATORY THERAPY 0 1, 663, 357 65. 00 66. 00 06600 PHYSI CAL THERAPY -1, 995 2, 137, 027 66. 00 67. 00 06700 OCCUPATI IONAL THERAPY 0 799, 623 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 324, 576 68. 00 69. 00 06900 ELECTROENCEPHALOGRAPHY 0 0 70. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 70. 00 70. 00 07200 IMPL. DEV. CHARGED TO PATI				0			
60. 00 06000 LABORATORY -201 11, 526, 528 60. 00 06 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0		1		0		•	
60. 01 06.001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0							
61. 00		1		-201		1	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0		1		0	•	l .	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0		1		0	•	l .	
64. 00 06400 INTRAVENOUS THERAPY 0 1, 663, 357 65. 00 06500 RESPI RATORY THERAPY 0 4, 242, 540 65. 00 06600 PHYSI CAL THERAPY -1, 995 2, 137, 027 66. 00 06700 06CUPATI ONAL THERAPY 0 799, 623 67. 00 06700 0CCUPATI ONAL THERAPY 0 324, 576 68. 00 06800 SPEECH PATHOLOGY 0 324, 576 68. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0				0	1	l .	1
65. 00 06500 RESPIRATORY THERAPY 0 4,242,540 66. 00 66. 00 PHYSI CAL THERAPY -1,995 2,137,027 66. 00 67. 00 66.00 PHYSI CAL THERAPY 0 799,623 67. 00 68. 00 06700 0CCUPATI ONAL THERAPY 0 799,623 67. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 69. 00 70. 00 71. 00 71. 00 72. 00		1	· ·	0	· -	l .	
66. 00				0			1
67. 00 06700 0CCUPATI ONAL THERAPY 0 799, 623 68. 00 6800 SPEECH PATHOLOGY 0 324, 576 68. 00 6900 ELECTROCARDI OLOGY 0 0 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	l e e e e e e e e e e e e e e e e e e e	-1, 995		•	
69. 00 06900 CLECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		06700	OCCUPATI ONAL THERAPY	0		•	
70. 00	68.00	06800	SPEECH PATHOLOGY	0	324, 576		68. 00
71. 00	69.00	06900	ELECTROCARDI OLOGY	0	0		69. 00
72. 00	70.00	07000	ELECTROENCEPHALOGRAPHY	0	0		70. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 25, 431, 264 73. 00 74. 00 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0	71. 00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	10, 778, 364		71. 00
74. 00	72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	20, 096, 516		72. 00
75. 00				0			
76. 00				0		•	
77. 00 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0 0 0 0 0 0 0 0 0				0	•	l control of the cont	
S8. 00 OBSOO RURAL HEALTH CLINIC O O O S8. 00		1		-105, 988		1	1
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	77. 00			0	0		77. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 09000 CLINIC 90. 00 09450 SLEEP CLINIC 0 492, 277 91. 00 09100 EMERGENCY -3, 170, 433 13, 994, 221 91. 00 09100 CLINIC 91. 00 09100 0	00.05	+		=			00.00
90. 00 09000 CLI NI C 0 539, 131 90. 00 90. 01 04950 SLEEP CLI NI C 0 492, 277 91. 00 09100 EMERGENCY -3, 170, 433 13, 994, 221 91. 00				0		•	
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				_2 170 422		•	
72. 00 0/200 000LNV/11 010 DEDO (11011 1 DICT) 92. 00		1		-5, 170, 433	13, 994, 221		
	72.00	10,200	1 DESCRIPTION DEDG (NON DIGITING) TAKE)	<u> </u>	1	1	1 /2.00

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

Provider CCN: 15-0018

			5/31/2023 1	
Cost Center Description	Adjustments	Net Expenses		
		or Allocation		
	6.00	7. 00		
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 09500 AMBULANCE SERVI CES	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
99. 00 09900 CMHC	0	0		99. 00
99. 10 09910 CORF	0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		100. 00
101. 00 10100 HOME HEALTH AGENCY	0	0		101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0		102. 00
SPECIAL PURPOSE COST CENTERS				—,,,,,
105. 00 10500 KI DNEY ACQUI SI TI ON	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	0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0		109. 00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0		110.00
111. 00 11100 SLET ACQUI SI TI ON	0	0		111.00
113. 00 11300 INTEREST EXPENSE	0	0		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	U	0		115. 00
116.00 11600 HOSPICE 118.00 SUBTOTALS (SUM OF LINES 1 through 117)	41 014 402	270 002 212		116. 00 118. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	-41, 014, 692	279, 082, 213		118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	٥	Λ		190. 00
191. 00 19100 RESEARCH		0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		0		192. 00
193. 00 19300 NONPALD WORKERS		54, 817		193. 00
193. 01 19301 COMMUNI TY		579, 422		193. 00
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	ا	5, 380, 212		194. 00
200.00 TOTAL (SUM OF LINES 118 through 199)	-41, 014, 692	285, 096, 664		200. 00
	, 5, 5,2	_30,0,0,001		1200.00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/31/2023 12:14 pm Provider CCN: 15-0018

					10	5/31/	/2023 12:14 pm
		Increases					
	Cost Center	Li ne #	Salary	Other			
	2. 00 A - I NSURANCE	3. 00	4. 00	5. 00			
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	310, 304			1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	30, 445			2. 00
	0			340, 749			
	B - INTEREST						
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	1, 173, 677			1.00
2. 00	INTEREST EXPENSE	113.00	0	<u>1, 173, 677</u> 2, 347, 354			2. 00
	C - DIETARY		U _I	2, 347, 334			
1.00	CAFETERI A	11. 00	1, 215, 055	1, 371, 284			1. 00
			1, 215, 055	1, 371, 284			
	H - NURSERY						
1. 00	NURSERY	43.00	2, 568, 131	75 <u>2, 1</u> 47			1. 00
	I - ONCOLOGY		2, 568, 131	752, 147			
1. 00	ADULTS & PEDIATRICS	30.00	130, 874	45, 822			1.00
2. 00	RADI OLOGY-DI AGNOSTI C	54. 00	52, 113	18, 246			2. 00
	0		182, 987	64, 068			
	M - DRUGS CHARGED						
1.00	DRUGS CHARGED TO PATIENTS	73. 00	0	21, 027, 543			1.00
2. 00 3. 00	ADMINISTRATIVE & GENERAL	5.00	0	17, 839			2.00
4. 00		0. 00 0. 00	0	0			3. 00 4. 00
5. 00		0.00	0	o			5. 00
6.00		0.00	Ö	0			6. 00
7.00		0.00	0	0			7. 00
8.00		0.00	0	0			8. 00
9.00		0.00	0	0			9.00
10. 00 11. 00		0. 00 0. 00	0	0			10. 00 11. 00
12. 00		0.00	0	o			12.00
13. 00		0.00	o	0			13. 00
14.00		0.00	О	0			14. 00
15. 00		0.00	0	0			15. 00
	O DENT		0	21, 045, 382			
1. 00	N - RENT CAP REL COSTS-BLDG & FIXT	1.00	0	84, 480			1.00
2. 00	CAP REL COSTS-MVBLE EQUIP	2.00	o	564, 723			2. 00
3.00		0. 00	o	0			3. 00
4.00		0. 00	0	0			4. 00
5.00		0.00	0	0			5. 00
6. 00 7. 00		0. 00 0. 00	0	0			6. 00 7. 00
8. 00		0.00	0	0			8.00
9. 00		0.00	ő	0			9. 00
	0			649, 203			
_	0 - SUPPLI ES						
1. 00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	10, 778, 364			1. 00
2. 00	PATIENTS IMPL. DEV. CHARGED TO	72. 00	0	20, 096, 516			2. 00
2.00	PATI ENTS	, 2. 00	Ĭ	20, 0,0,010			2.00
3.00		0. 00	0	0			3. 00
4. 00		0.00	0	0			4.00
5.00		0.00	0	0			5. 00
6. 00 7. 00		0. 00 0. 00	0	0			6. 00 7. 00
8. 00		0.00	0	0			8.00
9. 00		0.00	Ö	Ö			9. 00
10.00		0.00	0	0			10. 00
11.00		0.00	0	0			11.00
12. 00		0.00	0	<u> 0</u> 30, 874, 880			12. 00
	P - DEPRECIATION		U	ου, ο / 4, δδU			
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	15, 570, 706			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	623, 492			2. 00
	0		0	16, 194, 198			
4.00	R - PHARMACY		4 100 ==:1	_1			
1. 00	DRUGS CHARGED TO PATIENTS	7300	4, 403, 721	<u>0</u>			1.00
	S - AMORTIZATION		4, 403, 721	U			
1.00	CAP REL COSTS-BLDG & FIXT	1. 00	Ol	14, 098			1.00
	0			14, 098			
			'				•

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

					5/31/2023 12 5/31/2023 12	epareu. :14 pm
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
	T - BENEFIT					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	58 <u>8, 0</u> 22		1. 00
	0		0	588, 022		
	V - INCENTIVE					
1.00	ADMINISTRATIVE & GENERAL	5. 00	38, 670	0		1. 00
2.00	PHARMACY	15. 00	3, 533	0		2. 00
3.00	NEONATAL INTENSIVE CARE	31. 01	669	0		3. 00
4.00	SUBPROVI DER - I PF	40. 00	1, 119	0		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	3, 365	0		5. 00
6.00	CT SCAN	57. 00	619	0		6. 00
7.00	MAGNETIC RESONANCE I MAGING	58. 00	442	0		7. 00
	(MRI)					
8.00	CARDIAC CATHETERIZATION	59. 00	834	0		8. 00
9.00	I NTRAVENOUS THERAPY	64. 00	1, 929	0		9. 00
10.00	PHYSI CAL THERAPY	66. 00	745	0		10.00
11. 00	CLINIC	90.00	362	0		11. 00
12. 00	NONPALD WORKERS	193. 00	672	0		12. 00
13.00	OTHER NONREIMBURSABLE COST	194. 00	475	0		13. 00
	CENTERS					
14. 00		0. 00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	0	0		16. 00
17. 00		0. 00	0	0		17. 00
18. 00		0. 00	0	0		18. 00
19. 00				0		19. 00
	0		53, 434	0		_
	X - COVID OVERFLOW					
1.00	ADULTS & PEDIATRICS	30.00	8 <u>3, 4</u> 50	10 <u>5, 3</u> 72		1. 00
	0		83, 450	105, 372		
	Y - INTENSIVE	1				
1.00	INTENSIVE CARE UNIT	<u>31.</u> 00	<u>46, 0</u> 60	<u>3, 5</u> 24		1. 00
	TOTALS		46, 060	3, 524		
500.00	Grand Total: Increases	l	8, 552, 838	74, 350, 281		500. 00

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2022
To 12/31/2022 Date/Time Prepared: 5/31/2023 12:14 pm Provider CCN: 15-0018

					10	3 12: 14 pm
		Decreases		0.11		
	Cost Center 6.00	Li ne # 7.00	Sal ary	0ther 9.00	Wkst. A-7 Ref. 10.00	
	A - I NSURANCE	7.00	8. 00	9.00	10.00	
1. 00	ADMI NI STRATI VE & GENERAL	5. 00	0	340, 749	12	1. 00
2.00		0.00	o	0	12	2. 00
	0			340, 749		
	B - INTEREST					
1. 00	I NTEREST EXPENSE	113. 00	0	1, 173, 677	1	1.00
2.00	ADMI NI STRATI VE & GENERAL		0	<u>1, 173, 677</u>		2. 00
	C - DIETARY		U	2, 347, 354		
1. 00	DI ETARY	10.00	1, 215, 055	1, 371, 284	0	1.00
1.00	0		1, 215, 055	1, 371, 284		1.00
	H - NURSERY	<u>'</u>				
1.00	ADULTS & PEDIATRICS	30.00	2, 568, 131	75 <u>2, 1</u> 47		1. 00
	0		2, 568, 131	752, 147		
1 00	I - ONCOLOGY	12.00	102 007	(4.0(0		1 00
1. 00 2. 00	NURSING ADMINISTRATION	13. 00 0. 00	182, 987	64, 068	0	1. 00 2. 00
2.00			182, 987	64, 068		2.00
	M - DRUGS CHARGED		102, 707	01,000		
1.00	PHARMACY	15. 00	0	17, 736, 297	0	1. 00
2.00	ADULTS & PEDIATRICS	30.00	0	141, 424		2. 00
3.00	INTENSIVE CARE UNIT	31.00	0	44, 586		3. 00
4.00	NEONATAL INTENSIVE CARE	31. 01	0	517	0	4. 00
5. 00 6. 00	SUBPROVI DER - I PF SUBPROVI DER - I RF	40. 00 41. 00	0	884 74	0	5. 00 6. 00
7. 00	OPERATING ROOM	50.00	0	354, 398		7. 00
8. 00	RADI OLOGY-DI AGNOSTI C	54.00	ő	955, 040		8. 00
9. 00	CT SCAN	57. 00	O	3, 889		9. 00
10.00	CARDIAC CATHETERIZATION	59.00	O	1, 498, 766	o	10. 00
11. 00	LABORATORY	60.00	0	5, 953	1	11. 00
12. 00	I NTRAVENOUS THERAPY	64.00	0	16, 578	1	12. 00
13.00	RESPIRATORY THERAPY	65.00	0	121, 122	1	13.00
14. 00 15. 00	CARDI OLOGY EMERGENCY	76. 00 91. 00	0	102, 944 62, 910		14. 00 15. 00
13.00	0			21, 045, 382		13.00
	N - RENT	,	-	,		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	183, 481		1. 00
2.00	OPERATION OF PLANT	7. 00	0	3, 421		2. 00
3.00	NURSI NG ADMI NI STRATI ON	13.00	0	5, 686		3. 00
4. 00 5. 00	RADI OLOGY-DI AGNOSTI C ADULTS & PEDI ATRI CS	54. 00 30. 00	0	346, 858 38, 130		4. 00 5. 00
6. 00	INTENSIVE CARE UNIT	31. 00	0	7, 392		6. 00
7. 00	CARDI OLOGY	76.00	o	55, 537		7. 00
8.00	RESPI RATORY THERAPY	65.00	O	8, 580	10	8. 00
9.00	DI ETARY	1000	0	118_		9. 00
	0		0	649, 203		
1 00	O - SUPPLIES	20.00	ol	0/ 120	0	1 00
1. 00 2. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	0	86, 130 186, 078		1. 00 2. 00
3. 00	NEONATAL INTENSIVE CARE	31. 01	0	357		3. 00
4. 00	OPERATING ROOM	50.00	O	22, 356, 273		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	О	1, 266, 002	o	5. 00
6.00	OCCUPATI ONAL THERAPY	67. 00	0	495	0	6. 00
7. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	6, 646, 461		7. 00
8.00	I NTRAVENOUS THERAPY	64.00	0	271, 907		8. 00
9. 00 10. 00	RESPIRATORY THERAPY PHYSICAL THERAPY	65. 00 66. 00	0	35, 537 253	1	9. 00 10. 00
11. 00	EMERGENCY	91. 00	0	24, 743	1	11.00
12. 00	MAGNETIC RESONANCE I MAGING	58. 00	ő	644	1	12.00
	(MRI)		1			
	0		0	30, 874, 880		
4 00	P - DEPRECIATION	- acl	اء	4/ 40: 1		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	16, 194, 198		1.00
2. 00				00 16, 194, 198		2. 00
	R - PHARMACY		J	10, 194, 198		
1. 00	PHARMACY	15. 00	4, 403, 721	0	0	1. 00
	0		4, 403, 721			
	S - AMORTIZATION					
1.00	ADMI NI STRATI VE & GENERAL		0	1 <u>4, 0</u> 98		1. 00
	lo l			14, 098	ı l	I

| Peri od: | Worksheet A-6 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0018

						10 12/31/2022	5/31/2023 12:14 pr
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	T - BENEFIT						
. 00	ADMI NI STRATI VE & GENERAL		0	58 <u>8, 0</u> 22		<u>D</u>	1.
	0		0	588, 022			
	V - INCENTIVE						
00	HOUSEKEEPI NG	9. 00	3, 758	C)	0	1.
00	DI ETARY	10.00	4, 350	C)	0	2.
00	CAFETERI A	11. 00	890	C)	0	3.
00	NURSING ADMINISTRATION	13. 00	4, 238	C)		4.
00	CENTRAL SERVICES & SUPPLY	14.00	219	C)	o	5.
. 00	SOCI AL SERVI CE	17. 00	170	C))	6.
. 00	ADULTS & PEDIATRICS	30.00	7, 736	C)	o	7.
. 00	INTENSIVE CARE UNIT	31.00	1, 676	C)	o	8.
00	SUBPROVI DER - I RF	41.00	6, 766	Ö)	o	9.
0. 00	NURSERY	43.00	1, 095	C)	ol	10.
1. 00	OPERATING ROOM	50.00	7, 577	C)	ol	11.
2. 00	LABORATORY	60.00	4, 196	C)		12.
3. 00	RESPIRATORY THERAPY	65.00	525	C)		13.
4. 00	OCCUPATI ONAL THERAPY	67.00	301	C)		14.
5. 00	SPEECH PATHOLOGY	68. 00	272	C)		15.
5. 00	CARDI OLOGY	76.00	521	C)		16.
7. 00	SLEEP CLINIC	90. 01	343	O			17.
3. 00	EMERGENCY	91.00	8, 495	Ö			18.
9. 00	COMMUNI TY	193. 01	306	0			19.
, 00	0	— — 170. 01	_{53, 434}		 		17.
	X - COVID OVERFLOW		00, 101		1		
00	SUBPROVI DER - I RF	41.00	83, 450	105, 372			1.
00	0		83, 450	105, 372		<u> </u>	
	Y - INTENSIVE		00, 100	100,072			
00	OTHER NONREI MBURSABLE COST	194, 00	46, 060	3, 524			1.
50	CENTERS	1,71.00	10, 000	0, 024	`		''
	TOTALS — — —	+	46, 060			†	
00	Grand Total: Decreases		8, 552, 838	74, 350, 281		+	500.

					То	12/31/2022	Date/Time Prep 5/31/2023 12:	
				Acqui si ti ons	;			
		Begi nni ng	Purchases	Donati on		Total	Di sposal s and	
		Bal ances					Retirements	
		1.00	2. 00	3. 00		4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	T BALANCES						
1.00	Land	3, 846, 371	707, 092		0	707, 092	40	1. 00
2.00	Land Improvements	1, 250, 812	0		0	0	106, 872	2.00
3.00	Buildings and Fixtures	190, 587, 096	0		0	0	2, 527, 321	3. 00
4.00	Building Improvements	72, 697, 567	2, 981, 463		0	2, 981, 463	115, 363	4. 00
5.00	Fixed Equipment	109, 515, 308	6, 152, 425		0	6, 152, 425	58, 836	5. 00
6.00	Movable Equipment	20, 476, 914	385, 254		0	385, 254	0	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	398, 374, 068	10, 226, 234		0	10, 226, 234	2, 808, 432	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	398, 374, 068	10, 226, 234		0	10, 226, 234	2, 808, 432	10.00
		Endi ng Bal ance	Fully					
			Depreci ated					
			Assets					
		6.00	7. 00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET							
1.00	Land	4, 553, 423	0					1. 00
2.00	Land Improvements	1, 143, 940	529, 133					2. 00
3.00	Buildings and Fixtures	188, 059, 775	24, 402, 166					3. 00
4.00	Building Improvements	75, 563, 667	37, 337, 820					4. 00
5.00	Fi xed Equipment	115, 608, 897	50, 615, 057					5. 00
6.00	Movable Equipment	20, 862, 168	17, 952, 822					6.00
7.00	HIT designated Assets	0	0					7. 00
8.00	Subtotal (sum of lines 1-7)	405, 791, 870	130, 836, 998					8. 00
9.00	Reconciling Items	0	0					9. 00
10.00	Total (line 8 minus line 9)	405, 791, 870	130, 836, 998					10. 00

Heal th	Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co	CN: 15-0018	Peri od:	Worksheet A-7	
					From 01/01/2022		
					To 12/31/2022	Date/Time Pre	
				LIMMADY OF CAD	I TAI	5/31/2023 12:	14 pm
			St	UMMARY OF CAP	ITAL		
	Coot Contor Decemintion	Depreciation	Lanca	Interest	I noumanas (ass	Tayon (one	
	Cost Center Description	Depi eci ati on	Lease	Tillerest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00			
	DART II DECONCILIATION OF AMOUNTS FROM WORK				12.00	13. 00	
1 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, CULUM	IN 2, LINES I a	and 2			1 00
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	2	0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0)	0 0	0	3. 00
		SUMMARY 0	F CAPITAL				
		0.11	T 1 1 (1) (-			
	Cost Center Description		Total (1) (sum	ון			
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)		_			
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	IN 2, LINES 1 a	and 2			1
1.00	CAP REL COSTS-BLDG & FLXT	0	0)			1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0)			2. 00
0 00	T 1 1 (C 1: 4 0)	1		NI.			1 0 00

0 0 0

0 0 0

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
RECONG	CILIATION OF CAPITAL COSTS CENTERS		Provider Co		Period: From 01/01/2022 Fo 12/31/2022		pared:
		COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized	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 CE						
1.00	CAP REL COSTS-BLDG & FIXT	384, 929, 703	376, 755	384, 552, 948	0. 948541	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	20, 862, 168					2.00
3.00	Total (sum of lines 1-2)	405, 791, 871					3. 00
		ALLOCATION OF OTHER CAPITAL			SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
		/ 00	d Costs 7.00	through 7)	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	6.00	7.00	8. 00	9.00	10.00	
1.00	CAP REL COSTS-BLDG & FIXT	INILKS	0	(15, 570, 706	647, 958	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	0	0	l '	623, 492		2.00
3.00	Total (sum of lines 1-2)	0	Ö		16, 194, 198		3. 00
			Sl	JMMARY OF CAPI			
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate		
					d Costs (see	through 14)	
		44.00	10.00	10.00	instructions)	45.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	11. 00	12.00	13. 00	14. 00	15. 00	
1.00	CAP REL COSTS-BLDG & FIXT	1, 187, 775	310, 304		-1, 894, 754	15, 821, 989	1. 00
2. 00	CAP REL COSTS-MVBLE EQUIP	1, 107, 773			-63, 847		2.00
3. 00	Total (sum of lines 1-2)	1, 187, 775			-1, 958, 601		
		, , , , , , ,		'	, , , , , , , , , , , , , , , , , , , ,		

| Period: | Worksheet A-8 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared:

					o 12/31/2022	Date/Time Prep 5/31/2023 12:	
				Expense Classification on		3/31/2023 12.	14 piii
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0.00	0	3. 00
	(chapter 2)	_	-				
4. 00	Trade, quantity, and time discounts (chapter 8)	В	0		0.00	0	4. 00
5. 00	Refunds and rebates of expenses (chapter 8)	В	-488, 124	ADMINISTRATIVE & GENERAL	5. 00	0	5. 00
6. 00	Rental of provider space by		0		0.00	0	6. 00
7. 00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	7. 00
	stations excluded) (chapter 21)						
8. 00	Television and radio service		0		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-8, 312, 823			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	987, 651			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00	Cafeteria-employees and guests		-1, 166, 437	CAFETERI A	11.00	0	14.00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
47.00	patients		000 574	DUA DMA OV	45.00		47.00
17. 00	Sale of drugs to other than patients	В	-209, 5/1	PHARMACY	15. 00	0	17. 00
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing and allied health		0		0.00	0	19. 00
	education (tuition, fees, books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
211.00	interest, finance or penalty				5.55		21100
22. 00			0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
25. 00	limitation (chapter 14) Utilization review -		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
23.00	physicians' compensation		0	UTILIZATION REVIEW-SNF	114.00		23.00
26. 00	(chapter 21) Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
	COSTS-MVBLE EQUIP						
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	limitation (chapter 14)			ADULTO A DEDLATRICO			
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	1	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
22.00	limitation (chapter 14)		-				22.22
32. 00	Depreciation and Interest		0		0.00	0	32. 00
33. 00	TELEVI SI ON EXPENSE	Α	0	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00

Provider CCN: 15-0018 Peri od: Worksheet A-8 From 01/01/2022 To 12/31/2022 Date/Time Prepared:

					5 12/31/2022	5/31/2023 12:	
				Expense Classification on	Workshoot A	3/31/2023 12.	14 рііі
				To/From Which the Amount is			
				TO/TTOIL WITCH THE AMOUNT IS	to be Aujusteu		
	0 1 0 1 5 11	D : (0 (0)		0 1 0 1	1 ' "	W . A 7 D C	
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
0.4.00	DUNGLOLAN DEODULTHENT	1.00	2. 00	3.00	4. 00	5. 00	0.4.00
34.00	PHYSI CI AN RECRUI TMENT	A		ADMINISTRATIVE & GENERAL	5. 00	0	
36. 00	LOBBYING EXPENSE	Α		ADMINISTRATIVE & GENERAL	5. 00	0	36. 00
39. 00	MEDICAL STAFF DUES	В		ADMINISTRATIVE & GENERAL	5. 00	0	39. 00
40.00	PAYPHONE REVENUE	В		ADMINISTRATIVE & GENERAL	5. 00	0	40.00
42.00	EMS REVENUE	В	-44, 072	PARAMED ED PRGM	23.00	0	42.00
43.00	TRUSTEE FEE	A	0	ADMINISTRATIVE & GENERAL	5.00	0	43.00
44.00	ENVI RONMENTAL SERVI CES	В	0	HOUSEKEEPI NG	9.00	0	44.00
45.00	PLANT MAINT MISC REVENUE	В	-15, 725	OPERATION OF PLANT	7.00	0	45.00
47.00	PHYSICAL THERAPY MISC REVENUE	В	-1, 995	PHYSI CAL THERAPY	66.00	0	47.00
49.00	I MAGING SERVICES REVENUE	В	0	RADI OLOGY-DI AGNOSTI C	54.00	0	49. 00
49. 01	CARDI OLOGY MI SC REVENUE	В		CARDI OLOGY	76. 00	0	49. 01
49. 02	NURSING ADMIN MISC REVENUE	В		NURSING ADMINISTRATION	13. 00	o o	49. 02
49. 03	NON-ALLOWABLE ADMIN EXPENSES	A		ADMINISTRATIVE & GENERAL	5. 00	ő	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. 05	LACTATION SUPPLIES SALES	B		ADULTS & PEDIATRICS	30.00	0	49. 05
49. 06	REVENUE	В	-1, 460	ADULIS & PEDIATRICS	30.00	U	49.00
40.07	11-1-11-11	В	0	ADULTS & DEDLATRICS	20.00	0	49. 07
49. 07	OTHER ADJUSTMENTS			ADULTS & PEDIATRICS	30.00	_	
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. 09
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	В	-2, 905	NURSERY	43.00	0	49. 19
	PROGRAM						
49. 21	OTHER REVENUE - CATH	В		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	-28, 757	ADMINISTRATIVE & GENERAL	5.00	0	49. 35
49. 37	OTHER REVENUE	В		SOCI AL SERVI CE	17. 00	0	49. 37
49. 38	OTHER REVENUE	В	·	OPERATING ROOM	50.00	0	49. 38
49. 39	OTHER REVENUE	B		LABORATORY	60.00	o	49. 39
49. 40	OTHER REVENUE	B		I NTRAVENOUS THERAPY	64. 00	0	49. 40
49. 41	TO HOME OFFICE - BUILDING	A		CAP REL COSTS-BLDG & FIXT	1. 00	14	
49. 42	TO HOME OFFICE - MME	A		CAP REL COSTS-BEDG & TIXI		14	
		1	·	1	2.00		
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)		-41, 014, 692				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.

Line No. Cost Center Expense Items Amount of Allowable Cost Included in Wks. A, column 5 1.00 2.00 3.00 4.00 5.00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1.00 1.00 CAP REL COSTS-BLDG & FIXT 563, 478 0 1.00 2.00 2.00 CAP REL COSTS-MVBLE EQUIP 2, 633, 108 0 2.00 3.00 5.00 ADMINISTRATIVE & GENERAL 33, 808, 160 0 3.00 4.00 5.00 ADMINISTRATIVE & GENERAL 33, 808, 160 0 3.00 5.00 ADMINISTRATIVE & GENERAL 37, 004, 746 36, 017, 095 5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2, line 13					. 12/31/2022	5/31/2023 12:	
Number N		Li ne No.	Cost Center	Expense Items	Amount of	Amount	
1. 00 2. 00 3. 00 4. 00 5. 00 A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1. 00 1. 00 CAP REL COSTS-BLDG & FIXT 563, 478 0 1. 00 2. 00 CAP REL COSTS-MVBLE EQUIP 2, 633, 108 0 2. 00 3. 00 5. 00 ADMINISTRATIVE & GENERAL 33, 808, 160 0 3. 00 4. 00 5. 00 ADMINISTRATIVE & GENERAL 37, 004, 746 36, 017, 095 4. 00 5. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,					Allowable Cost	Included in	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1. 00 2. 00 2. 00 3. 00 3. 00 4. 00 5. 00 ADMINISTRATIVE & GENERAL 4. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,						Wks. A, column	
A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS: 1. 00 2. 00 2. 00 3. 00 3. 00 4. 00 5. 00 ADMINISTRATIVE & GENERAL 4. 00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,						5	
HOME OFFICE COSTS: 1.00 CAP REL COSTS-BLDG & FIXT 563,478 0 1.00		1. 00	2. 00	3. 00	4. 00	5. 00	
1.00		A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
2.00 CAP REL COSTS-MVBLE EQUIP 2,633,108 0 2.00 33,808,160 0 3.00 4.00 5.00 ADMINISTRATIVE & GENERAL 33,808,160 0 36,017,095 4.00 5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,							
3.00 5.00 ADMINISTRATIVE & GENERAL 33,808,160 0 3.00 4.00 5.00 ADMINISTRATIVE & GENERAL 37,004,746 36,017,095 5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	1.00	1.00	CAP REL COSTS-BLDG & FIXT		563, 478	0	1. 00
4.00 5.00 ADMINISTRATIVE & GENERAL 0 36,017,095 4.00 5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	2.00	2. 00	CAP REL COSTS-MVBLE EQUIP		2, 633, 108	0	2. 00
5.00 TOTALS (sum of lines 1-4). Transfer column 6, line 5 to Worksheet A-8, column 2,	3.00	5. 00	ADMINISTRATIVE & GENERAL		33, 808, 160	0	3. 00
Transfer column 6, line 5 to Worksheet A-8, column 2,	4.00	5. 00	ADMINISTRATIVE & GENERAL		0	36, 017, 095	4.00
Worksheet A-8, column 2,	5.00	TOTALS (sum of lines 1-4).			37, 004, 746	36, 017, 095	5.00
		Transfer column 6, line 5 to					
line 12		Worksheet A-8, column 2,					
ITHE 12.		line 12.					

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

			Related Organization(s) and	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:	-		

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

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

6. 00	В	BEACON HLTH SYS	100.00	0. 00	6. 00
7.00			0.00	0. 00	7. 00
8.00			0. 00	0. 00	8. 00
9.00			0. 00	0. 00	9. 00
10.00			0. 00	0. 00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

Heal th	Financial Syste	ems		ELKHART G	ENERAL	HOSPI TAL				In Li€	eu of Form CMS	S-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANIZATIONS AND	HOME	Provi der	CCN:	15-0018	Peri od:		Worksheet A	-8-1
OFFICE	COSTS									1/01/2022		
									To 1.	2/31/2022		
	N. I	W							L		5/31/2023 1	2: 14 pm
	* *	Wkst. A-7 Ref.										
	Adjustments											
	(col. 4 minus											
	col. 5)*											
	6. 00	7. 00										
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REC	QUIRED AS A RESULT	OF TRA	NSACTI ONS	WI TH	I RELATED C	DRGANI ZA	ATIONS OR	CLAI MED	
	HOME OFFICE CO:	STS:										
1.00	563, 478	10										1. 00
2.00	2, 633, 108	10										2.00
3.00	33, 808, 160	0										3.00
4.00	-36, 017, 095	0										4.00
5.00	987, 651											5.00

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

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

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

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

6.00	6.00
7. 00	7.00
8. 00	8.00
9. 00	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

								10	o 12/31/2022	! Date/lime Pre 5/31/2023 12:	epared:
	Wkst. A Line #	Cost	t Center/Physician	Total	Professi ona	ı	Provi der	Т	RCE Amount	Physi ci an/Prov	14 рііі
		000	I denti fi er	Remuneration	Component		Component		not randant	ider Component	
					'		'			Hours	
	1. 00		2. 00	3.00	4.00		5. 00		6. 00	7. 00	
1.00	30. 00	DR. H		3, 945, 329	3, 945, 3	29		0	0	0	1. 00
2.00	91. 00			1, 384, 202	1, 384, 2	02		0	0	0	2.00
3.00	91. 00	DR. N		148, 250	148, 2	50		0	0	0	3.00
4.00	91. 00	DR. B		637, 731	637, 7	31		0	0	0	4.00
5.00	5. 00	DR. E		151, 012	151, 0	12		0	0	0	5. 00
6. 00	30.00	DR. C		421, 575	421, 5	75		0	0	0	6. 00
7. 00	76. 00	DR. E		105, 988	105, 9	88		0	0	0	7. 00
8. 00	91. 00	DR. E		1, 000, 250	1, 000, 2	50		0	0	0	8. 00
9. 00	50. 00	DR. E		35, 516	35, 5	16		0	0	0	9. 00
10.00	54. 00	DR. E		4, 300	4, 3	00		0	0	0	10.00
11. 00	50.00	DR. 0		196, 670	196, 6	70		0	0	0	11.00
12. 00	54. 00	DR. R		150, 000	150, 0	000		0	0	0	12.00
13. 00	31. 01	DR. N		132, 000	132, 0	000		0	0	0	13.00
200.00				8, 312, 823	8, 312, 8	23		0		0	200.00
	Wkst. A Line #	Cost	t Center/Physician	Unadjusted RCE	5 Percent o	f	Cost of		Provi der	Physician Cost	
			ldenti fi er	Limit	Unadjusted R	CE	Membershi ps	&	Component	of Mal practice	
					Limit		Conti nui ng		Share of col.	Insurance	
							Educati on		12		
	1. 00		2. 00	8. 00	9. 00		12. 00		13. 00	14. 00	
1. 00	30. 00			0		0		0	0	0	
2. 00	91. 00			0		0		0	0	0	2. 00
3.00	91. 00			0		0		0	0	0	
4.00	91. 00			0		0		0	0	0	4. 00
5.00		DR. E		0		0		0	0	0	5.00
6. 00	30. 00			0		0		0	0	0	6. 00
7. 00	76. 00			0		0		0	0	0	7. 00
8. 00	91. 00			0		0		0	0	0	
9. 00	50. 00			0		0		0	0	0	9. 00
10. 00	54. 00			0		0		0	0	0	10.00
11. 00	50. 00			0		0		0	0	0	11. 00
12. 00	54. 00			0		0		0	0	0	12.00
13. 00	31. 01	DR. N		0		0		0	0	0	13.00
200.00				0		0		0	0	0	200.00
	Wkst. A Line #	Cost	t Center/Physician	Provi der	Adjusted RC	E	RCE		Adjustment		
			l denti fi er	Component	Limit		Di sal I owance)			
				Share of col.							
	4.00		0.00	14	1/ 00		47.00	-	40.00		
1 00	1. 00 30. 00	DD II	2. 00	15. 00	16. 00	0	17. 00	0	18.00		1 00
1.00				0		-		-1	3, 945, 329		1.00
2.00	91.00			0		0		0	1, 384, 202		2.00
3.00	91. 00					0		0	148, 250		3.00
4.00	91. 00			0		0		0	637, 731		4.00
5. 00		DR. E		0		0		0	151, 012		5. 00
6.00	30.00			0		0		0	421, 575		6. 00
7.00	76. 00			0		0		0	105, 988		7. 00
8. 00	91. 00			0		0		0	1, 000, 250		8. 00
9.00	50.00			0		0		0	35, 516		9.00
10.00	54.00			0		0		0	4, 300		10.00
11. 00	50.00			0		0		0	196, 670		11.00
12. 00	54. 00			0		0		0	150, 000		12.00
13. 00	31. 01	DK. N		0		0		0	132,000		13. 00
200. 00				0	l	0		0	8, 312, 823	I	200. 00

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

				o 12/31/2022	Date/Time Pre	
		CAPI TAL REI	LATED COSTS		5/31/2023 12:	14 pm
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
cost center beserver on	for Cost	DEDG & TTAT	MVDLL LQ011	BENEFI TS	Subtotal	
	Allocation (from Wkst A			DEPARTMENT		
	col. 7)					
GENERAL SERVICE COST CENTERS	0	1. 00	2. 00	4. 00	4A	
1.00 O0100 CAP REL COSTS-BLDG & FIXT	15, 821, 989	15, 821, 989				1.00
2.00 OO200 CAP REL COSTS-MVBLE EQUIP	3, 787, 921		3, 787, 921			2. 00
4. 00 00400 EMPLOYEE BENEFI TS DEPARTMENT 5. 00 00500 ADMINISTRATIVE & GENERAL	1, 508, 649 40, 110, 543	3, 136 112, 787			40, 312, 485	4. 00 5. 00
6. 00 00600 MAI NTENANCE & REPAI RS	0	0	27,002	02, 133	40, 312, 403	6.00
7. 00 00700 OPERATION OF PLANT	7, 402, 729	3, 389, 757			11, 641, 294	7. 00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	777, 486 3, 778, 913	96, 804 95, 875			897, 466 3, 930, 411	8. 00 9. 00
10. 00 01000 DI ETARY	1, 923, 570	247, 945			2, 249, 350	1
11. 00 01100 CAFETERI A	1, 776, 790	89, 881	21, 518	19, 897	1, 908, 086	
12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON	3, 406, 133	43, 233	10, 350	40, 092	0 3, 499, 808	12. 00 13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	1, 553, 765	347, 676	83, 237	13, 015	1, 997, 693	14. 00
15. 00 O1500 PHARMACY 16. 00 O1600 MEDI CAL RECORDS & LI BRARY	1, 879, 720	133, 671	32, 002		2, 047, 704 0	15. 00 16. 00
17. 00 01700 SOCIAL SERVICE	1, 352, 682	17, 145	1	ή "Ι	1, 388, 937	17. 00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	(0	0	18. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS 20. 00 02000 NURSI NG PROGRAM	0	0	(0	19. 00 20. 00
21. 00 02100 1 &R SERVI CES-SALARY & FRINGES APPRVD	0	0			0	21.00
22. 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	(4.454	0	0	22.00
23. 00 O2300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	124, 480	4, 809	1, 151	1, 010	131, 450	23.00
30. 00 03000 ADULTS & PEDIATRICS	45, 447, 001	2, 970, 414	711, 143	359, 099	49, 487, 657	30. 00
31. 00 03100 INTENSI VE CARE UNI T	11, 287, 541	257, 748			11, 707, 088	
31. 01 03101 NEONATAL INTENSI VE CARE 32. 00 03200 CORONARY CARE UNIT	1, 966, 927	54, 128 0	12, 959	24, 014	2, 058, 028 0	31. 01 32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0	· ·	o	0	33. 00
34.00 03400 SURGI CAL I NTENSI VE CARE UNIT 40.00 04000 SUBPROVI DER - I PF	0 2 457 040	0 252 407	40.490	0 20 549	2 902 474	34. 00 40. 00
40. 00 04000 SUBPROVI DER - I PF 41. 00 04100 SUBPROVI DER - I RF	2, 457, 940 99, 568	253, 497 12, 475			2, 802, 674 117, 010	
43. 00 04300 NURSERY	3, 353, 268	237, 119			3, 686, 596	43. 00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY	0	0			0	44. 00 45. 00
46. 00 O4600 OTHER LONG TERM CARE	0	0		o o	0	46. 00
ANCILLARY SERVICE COST CENTERS	22 47/ 045	1 2/1 014	225 026	104 77/	24 240 472]]
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	22, 476, 845	1, 361, 014 0	325, 838	184, 776	24, 348, 473 0	50. 00 51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	d	o	0	52. 00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	7, 998, 344	0 1, 042, 749	249, 643	0 8 90, 845	0 9, 381, 581	53. 00 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1, 042, 749	249, 043	0	9, 381, 381	
56. 00 05600 RADI 0I SOTOPE	0	0	(0	0	
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	1, 751, 888 728, 660	164, 917 83, 330			1, 966, 706 839, 222	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 850, 236	94, 597			2, 002, 197	59.00
60. 00 06000 LABORATORY	11, 526, 528	126, 121	30, 195	39, 557	11, 722, 401	1
60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	(0	60. 01 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	100 200	(12, 10	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	1, 663, 357 4, 242, 540	180, 389 41, 909			1, 905, 191 4, 321, 324	1
66. 00 06600 PHYSI CAL THERAPY	2, 137, 027	115, 389			2, 304, 396	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	799, 623	55, 406			876, 811	
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	324, 576 0	33, 220 0	7, 953	3, 945	369, 694 0	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	(o	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 778, 364	0	(10, 778, 364	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	20, 096, 516 25, 431, 264	0		67, 116	20, 096, 516 25, 498, 380	72. 00 73. 00
74.00 07400 RENAL DIALYSIS	0	0	(0	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART) 76. 00 03140 CARDI OLOGY	0 2, 433, 201	0 264, 741	63, 381	0 29, 770	0 2, 791, 093	75. 00 76. 00
77. 00 03140 CARDIOLOGY 77. 00 07700 ALLOGENEIC HSCT ACQUISITION	2, 433, 201	264, 741	03, 36		2, 791, 093	77.00
OUTPATIENT SERVICE COST CENTERS						00.00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	•		0	88. 00 89. 00
	1 9		1	<u>, </u>		

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

			To	om 01/01/2022 o 12/31/2022	Date/Time Pre	
		CAPI TAL REL	ATED COSTS		5/31/2023 12:	14 pm
		OALLIAL KEE	LATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost			BENEFITS		
	Allocation			DEPARTMENT		
	(from Wkst A col. 7)					
	0	1. 00	2.00	4. 00	4A	
90. 00 09000 CLI NI C	539, 131	110, 045	26, 346	6, 322	681, 844	90. 00
90. 01 04950 SLEEP CLINIC	492, 277	0	0	5, 053	497, 330	90. 01
91. 00 09100 EMERGENCY	13, 994, 221	386, 936	92, 636	137, 420	14, 611, 213	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92. 00
OTHER REIMBURSABLE COST CENTERS						
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 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	96. 00 97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99. 00 09900 CMHC		0	0	o	0	99. 00
99. 10 09910 CORF	o o	0	0	o	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	0	o	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS		ما		ما		405.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0		105. 00
106.00 10600 HEART ACQUISITION 107.00 10700 LIVER ACQUISITION	0	0	0	U O		106. 00 107. 00
107. 00 10700 ETVER ACQUISITION 108. 00 10800 LUNG ACQUISITION	0	0	0	0		107.00
109. 00 10900 PANCREAS ACQUI SI TI ON		0	0	Ö		109. 00
110. 00 11000 NTESTINAL ACQUISITION	o	0	Ō	ō		110. 00
111.00 11100 I SLET ACQUI SI TI ON	o	0	0	o	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) NONREI MBURSABLE COST CENTERS	279, 082, 213	12, 428, 863	2, 975, 577	1, 492, 266	274, 856, 473	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	O	0	190. 00
191. 00 19100 RESEARCH		0	0	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	l ol	285, 091	68, 253	ol	353, 344	
193. 00 19300 NONPALD WORKERS	54, 817	0	0	628	55, 445	•
193. 01 19301 COMMUNI TY	579, 422	97, 547	23, 354	3, 767	704, 090	193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	5, 380, 212	3, 010, 488	720, 737	15, 875	9, 127, 312	•
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	005 004 444	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	285, 096, 664	15, 821, 989	3, 787, 921	1, 512, 536	285, 096, 664	J202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2022	Part
To 12/31/2022	Date/Time Prepared:
5/31/2023	12:14 pm

				. '		5/31/2023 12:	
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL 5.00	REPAI RS 6. 00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUI P						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	40 212 405					4.00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	40, 312, 485	0	J			5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	1, 917, 158	0	13, 558, 452			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	147, 800	Ö	106, 567			8. 00
9.00	00900 HOUSEKEEPI NG	647, 284	O	105, 544		4, 683, 239	9. 00
10.00	01000 DI ETARY	370, 436	0	272, 951	0	8, 008	10.00
11. 00	01100 CAFETERI A	314, 235	0	98, 946	0	23, 981	11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	0	0	0	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	576, 369	0	47, 593	· · · · · · · · · · · · · · · · · · ·	31, 945	13.00
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	328, 992 337, 228	0	382, 740 147, 153	· · · · · · · · · · · · · · · · · · ·	0 31, 945	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	337, 220	0	147, 133	0	31, 945	16. 00
17. 00	01700 SOCIAL SERVICE	228, 738	Ö	18, 874	0	0	17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	O	0	Ö	0	18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	O	0	o	0	19. 00
20.00	02000 NURSI NG PROGRAM	0	O	0	O	0	20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
23. 00	O2300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	21, 648	0	5, 294	0	8, 008	23. 00
30. 00	03000 ADULTS & PEDIATRICS	8, 149, 884	0	3, 269, 991	514, 944	2, 105, 314	30.00
31. 00	03100 NTENSI VE CARE UNIT	1, 927, 993	Ö	283, 743		271, 533	31.00
31. 01	03101 NEONATAL INTENSIVE CARE	338, 928	O	59, 587	912	10, 678	31. 01
32.00	03200 CORONARY CARE UNIT	0	0	0	O	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	461, 561	0	279, 063		135, 789	40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	19, 270	0	13, 733		831 10, 678	41. 00 43. 00
44. 00	04400 SKI LLED NURSING FACILITY	607, 131	0	261, 034	24, 841	10, 678	44. 00
45. 00	04500 NURSING FACILITY	0	Ö		0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE	0	O	0	ō	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	4, 009, 853	0	1, 498, 277	130, 027	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 ANESTHESIOLOGY	0	0		0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 545, 015	0	1, 147, 913	105, 965	415, 286	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	Ö) 1,117,710	0	0	55. 00
56.00	05600 RADI 0I SOTOPE	0	O	0	O	0	56.00
57.00	05700 CT SCAN	323, 889	O	181, 550	17, 802	63, 890	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	138, 208	0	91, 734		47, 918	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	329, 734	0	104, 137		0	59. 00
60.00		1, 930, 515	0	138, 841	0	63, 890	
60. 01 61. 00	O6001 BLOOD LABORATORY O6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	U) 	U	0	60. 01 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	Ö		o	0	63. 00
64.00	06400 I NTRAVENOUS THERAPY	313, 758	O	198, 582	O	87, 871	64. 00
65.00	06500 RESPI RATORY THERAPY	711, 662	O	46, 135	O	63, 890	65. 00
66. 00	06600 PHYSI CAL THERAPY	379, 502	0	127, 026		63, 890	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	144, 398	0	60, 994	0	31, 945	67. 00
68. 00	06800 SPEECH PATHOLOGY	60, 883	0	36, 571	0	15, 973	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	69. 00 70. 00
70.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 775, 046	0		0	0	70.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	3, 309, 615	0			0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	4, 199, 226	0		o	0	73. 00
74. 00	07400 RENAL DIALYSIS	0	O	0	O	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	O	0	75. 00
76. 00	03140 CARDI OLOGY	459, 654	0	291, 441	27, 955	63, 890	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS						00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	88. 00 89. 00
90.00	09000 CLINIC	112, 290	0	121, 144	9, 324	79, 863	90.00
90. 00	04950 SLEEP CLINIC	81, 903	n	121, 144	9, 324 N	74, 803	90.00
91. 00	09100 EMERGENCY	2, 406, 262	O	425, 960	204, 163	590, 984	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00

| Peri od: | Worksheet B | From 01/01/2022 | Part | | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 |

			''	0 12/31/2022	5/31/2023 12:	
Cost Center Description	ADMI NI STRATI VE			LAUNDRY &	HOUSEKEEPI NG	
	& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
	5. 00	6. 00	7. 00	8. 00	9. 00	
OTHER REIMBURSABLE COST CENTERS	1					
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	1 , 00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	1 ,0.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-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	1 , , ,
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	o	0	0	0	0	110.00
111.00 11100 I SLET ACQUISITION	o	0	0	0	0	111. 00
113.00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o	0	0	0	0	115. 00
116. 00 11600 H0SPI CE	o	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	38, 626, 068	O	9, 823, 118	1, 151, 833	4, 228, 000	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	O	0	0	0	190. 00
191. 00 19100 RESEARCH	o	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	58, 191	O	313, 844	0	63, 890	192. 00
193.00 19300 NONPALD WORKERS	9, 131	O	0	0	0	193. 00
193. 01 19301 COMMUNI TY	115, 954	0	107, 385	0	0	193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	1, 503, 141	0	3, 314, 105	0	391, 349	194. 00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	o	0	0	0	0	201.00
202.00 TOTAL (sum lines 118 through 201)	40, 312, 485	0	13, 558, 452	1, 151, 833	4, 683, 239	202. 00

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0018

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/31/2023 12:14 pm Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL ADMI NI STRATI ON **PERSONNEL** SERVICES & SUPPLY 10.00 11.00 12.00 13.00 14.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00600 MAINTENANCE & REPAIRS 6.00 6.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 2, 900, 745 10 00 01100 CAFETERI A 11.00 2, 345, 248 11.00 0 01200 MAINTENANCE OF PERSONNEL 12.00 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 57, 052 4, 212, 767 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 0 48, 271 2, 757, 696 14.00 0 01500 PHARMACY 15.00 0 15.00 2, 464 0 01600 MEDICAL RECORDS & LIBRARY 0 16.00 0 16.00 17.00 01700 SOCIAL SERVICE 0 17.00 35, 295 12, 974 0 01850 OTHER GENERAL SERVICE (SPECIFY) 0 0 0 18.00 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 19 00 C 0 Λ 19 00 20.00 02000 NURSING PROGRAM C 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 0 0 21.00 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 22.00 22.00 0 02300 PARAMED ED PRGM 23.00 1,840 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 2, 412, 043 607, 377 1, 703, 558 0 30.00 31 00 03100 INTENSIVE CARE UNIT 0 0 31 00 283 519 157, 135 581 444 0 31.01 03101 NEONATAL INTENSIVE CARE 0 28, 823 114, 753 0 31.01 03200 CORONARY CARE UNIT 0 32.00 32.00 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 ol 33.00 0 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 0 0 34.00 40.00 04000 SUBPROVI DER - I PF 198, 114 52, 136 104, 526 0 40.00 04100 SUBPROVI DER - I RF 41.00 7,069 1, 455 0 4, 164 0 41.00 43 00 04300 NURSERY 0 53, 409 O 193, 898 43 00 0 04400 SKILLED NURSING FACILITY 0 44.00 0 0 44.00 04500 NURSING FACILITY 0 0 0 0 45.00 45.00 C 46.00 04600 OTHER LONG TERM CARE 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 0 277, 188 0 617, 175 0 50.00 05100 RECOVERY ROOM 0 0 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 00000000 Λ 0 0 0 52.00 0 05300 ANESTHESI OLOGY 53 00 0 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 178, 957 99, 277 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 05600 RADI OI SOTOPE 0 56, 00 56, 00 0 0 0 57 00 05700 CT SCAN 21,058 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 15, 124 0 0 58.00 59 00 05900 CARDIAC CATHETERIZATION 42, 273 91, 594 59.00 0 06000 LABORATORY 0 60.00 123, 298 0 60.00 0 60.01 06001 BLOOD LABORATORY 0 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 62.00 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 32, 776 117, 738 0 64.00 65.00 06500 RESPIRATORY THERAPY 000000 56, 159 0 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 46, 614 0 0 66,00 06700 OCCUPATI ONAL THERAPY 0 67.00 17, 483 0 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 8, 582 68.00 0 69.00 06900 ELECTROCARDI OLOGY 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 965, 194 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 1, 792, 502 72.00 07300 DRUGS CHARGED TO PATIENTS o 0 73.00 73.00 119, 671 0 07400 RENAL DIALYSIS 0 74 00 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 03140 CARDI OLOGY 0 0 76.00 58, 829 40, 281 0 76.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 77.00 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 89.00 90 00 09000 CLINIC 0 13, 282 0 90 00 42 0 04950 SLEEP CLINIC 90.01 0 11, 214 0 0 90.01 09100 EMERGENCY 91.00 91.00 241,020 531, 343 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0018

Peri od: Worksheet B From 01/01/2022 Part I To 12/31/2022 Date/Time Prepared:

5/31/2023 12:14 pm Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL PERSONNEL ADMI NI STRATI ON SERVICES & **SUPPLY** 10.00 11.00 12.00 13.00 14.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 94.00 09500 AMBULANCE SERVICES 000000 0 95.00 0 0 0 0 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 97.00 0 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 99.00 09900 CMHC 0 0 0 99.00 99. 10 09910 CORF 0 99. 10 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102. 00 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 000000 0 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 0 0 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 107. 00 0 108.00 10800 LUNG ACQUISITION 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 | SLET ACQUISITION 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) 2, 757, <u>696</u> 118. 00 118.00 2, 900, 745 2, 308, 785 0 4, 212, 767 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190, 00 0 0 0 0 0 191. 00 19100 RESEARCH 0 191.00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192. 00 193. 00 19300 NONPALD WORKERS 0 0 0 0 193. 00 1, 480 0 193. 01 19301 COMMUNI TY 0 0 0 193. 01 11, 437 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 23, 546 0 0 194. 00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 201 00 2, 900, 745 0 2, 757, 696 202. 00 202.00 TOTAL (sum lines 118 through 201) 2, 345, 248 4, 212, 767

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2022	Part
To 12/31/2022	Date/Time Prepared:
5/31/2023	12:14 pm Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018

					0 12/31/2022	5/31/2023 12:	
					OTHER GENERAL		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CE (SPECI FY)	NONPHYSI CI AN	
	cost center bescription	FIIANWACI	RECORDS &	SOCIAL SERVICE	(SFECITI)	ANESTHETI STS	
			LI BRARY				
	OFNEDAL CERVILOE COCT OFNEEDS	15. 00	16. 00	17. 00	18. 00	19. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT			I			1. 00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT						6. 00 7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY	2, 566, 494					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	C				16.00
17. 00 18. 00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY)	0	C	1, 684, 818 0			17. 00 18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	ő	C	Ö	Ö	0	19. 00
20. 00	02000 NURSI NG PROGRAM	O	C	0	0		20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	C	0	0		21.00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 02300 PARAMED ED PRGM	0	C			l	22. 00 23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>					20.00
30. 00	03000 ADULTS & PEDIATRICS	1, 018	C	1		l	30. 00
31.00	03100 NTENSIVE CARE UNIT	463	C				31.00
31. 01 32. 00	03101 NEONATAL INTENSIVE CARE 03200 CORONARY CARE UNIT	0	C	11, 849 0		0	31. 01 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	o	C	Ö		1	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	C	0	0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	0	C	75, 716			40.00
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	0	C	1, 589 175, 418		0	41. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	Ö	C	0		ő	44. 00
45. 00	04500 NURSING FACILITY	0	C	0			45. 00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	C	0	0	0	46. 00
50. 00	05000 OPERATI NG ROOM	18, 131	C	0	0	0	50.00
51.00	05100 RECOVERY ROOM	O	C	0	0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	C	0		0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	379	C	0	_	0	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	C	ő	o o	o o	55. 00
56. 00	05600 RADI OI SOTOPE	o	C	0		0	56. 00
57. 00	05700 CT SCAN	0	C	_	_		
58. 00 59. 00	05800 MAGNETI C RESONANCE MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	65	(0	_	0	58. 00 59. 00
60.00	06000 LABORATORY	0	C	ő	o	ő	60.00
60. 01	06001 BLOOD LABORATORY	o	C	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		c.				61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0	0	0	62. 00 63. 00
64. 00	06400 NTRAVENOUS THERAPY	952	C	Ö	o	ő	64. 00
65. 00	06500 RESPI RATORY THERAPY	14, 536	C	0	0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	C	0	0	0	66.00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	(0	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	ő	C	ő	o	ő	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	o	C	0	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 2, 524, 313	C	0	0	0	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	2, 524, 513	C	Ö	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	o	C	Ō	Ō	0	75. 00
76. 00	03140 CARDI OLOGY	6, 267	C			0	76.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	C	0	0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	O	C	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	0	0	0	89. 00
90. 00 90. 01	09000 CLINIC 04950 SLEEP CLINIC		C	0	_	0	90.00
70.01	OH7300 SELET GET INT G	<u>ı</u>	C	0	0	1 0	90. 01

Cost Center Description
RECORDS & LI BRARY 15.00 17.00 18.00 19.00
91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 92. 00 OTHER REI MBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0 0 0 95. 00 95. 00 96. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 0 0 0 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 0 96. 00 97. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 0 0 0 97. 00 98. 00 09800 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 98. 00 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 0 0 0 0 99. 10 100. 00 108 R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 0 0 0 101. 00 102. 00 SPECI AL PURPOSE COST CENTERS 0 0 0 0 0 0 0 0 0 0 102. 00 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 105. 00 106. 00 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 107. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 0 107. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 107. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 107. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 0 107. 00 107. 00 10700 10 VER ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 0 107. 00 107. 00 10700 10 VER ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 107. 00 107. 00 10700 10 VER ACQUI SI TI ON 0 0 0 0 0 0 0 0 0 107. 00 107. 00 107. 00 10700 10 VER ACQUI SI TI ON 0 0 0 0 0 0 0 0 107. 00 107. 00 10700 10 VER ACQUI SI TI ON 0 0 0 0 0 0 0 0 107. 00 107. 00 107. 00 10700 10 VER ACQUI SI TI ON 0 0 0 0 0 0 0 0 107. 00 107.
OTHER REIMBURSABLE COST CENTERS O
94. 00
95. 00
96. 00
97. 00
98. 00
99. 00
99. 10
100. 00 10000 L&R SERVI CES-NOT APPRVD PRGM
101. 00
SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105.00 106.00 106.00 106.00 106.00 106.00 107.00 10
105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 105. 00 106. 00 106. 00 106. 00 107. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 0 107. 00
106. 00 10600 HEART ACQUISITION 0 0 0 0 106. 00 107. 00 107. 00 108. 00 0 0 0 0 0 0 0 107. 00
107.00 10700 LIVER ACQUISITION 0 0 0 0 107.00
108 ON 1080 ON THE ONE ON THE ONE ON THE ONE ON THE ONE
109.00 10900 PANCREAS ACQUISITION 0 0 0 0 109.00
110. 00 11000 INTESTINAL ACQUISITION 0 0 0 110. 00
111. 00 11100 I SLET ACQUI SI TI ON 0 0 1111. 00
113. 00 11300 INTEREST EXPENSE
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 115. 00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 115. 00 116. 00 116. 00 116. 00 0 0 0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117) 2, 566, 494 0 1, 684, 818 0 0 118.00
NONREI MBURSABLE COST CENTERS
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00
191. 0019100 RESEARCH 0 0 0 0 0191. 00
192.0019200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 0 0192.00
193. 00 19300 NONPALD WORKERS 0 0 0 0 193. 00
193. 01 19301 COMMUNI TY 0 0 0 0 193. 01
194. 00 O7950 OTHER NONREIMBURSABLE COST CENTERS O O O O O 194. 00
200.00 Cross Foot Adjustments 0 200.00
201.00 Negative Cost Centers 0 0 0 0 201.00
202.00 TOTAL (sum lines 118 through 201) 2,566,494 0 1,684,818 0 0 202.00

				10	12/31/2022	Date/lime Pre 5/31/2023 12:	
			INTERNS &	RESI DENTS		0,01,2020 12.	
	Cost Center Description	NUDCLNC	CEDVICES CALAD	SERVI CES-OTHER	DADAMED ED	Subtotal	
	cost center bescription	NURSI NG PROGRAM	Y & FRINGES	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 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
6. 00	00600 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 01200 MAI NTENANCE OF PERSONNEL						11.00
12. 00 13. 00	01300 NURSI NG ADMI NI STRATI ON						12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16. 00
17. 00	01700 SOCIAL SERVICE						17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)						18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS						19.00
20. 00 21. 00	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0				20.00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD		U	0			22.00
23. 00	02300 PARAMED ED PRGM			J	168, 240		23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS				100, 210		20.00
30.00	03000 ADULTS & PEDI ATRI CS	0	0	0	0	69, 508, 174	30. 00
31. 00	03100 I NTENSI VE CARE UNI T	0	0	0	0	15, 460, 334	
31. 01	03101 NEONATAL INTENSIVE CARE	0	0	0	0	2, 623, 558	1
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	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	0	0	0	0	4, 116, 810	1
41. 00	04100 SUBPROVI DER - I RF	l ol	0	Ö	o	170, 284	1
43.00	04300 NURSERY	o	0	0	0	5, 013, 005	
44.00	04400 SKILLED NURSING FACILITY	o	0	0	o	0	44. 00
45. 00	04500 NURSING FACILITY	0	0	0	0	0	1
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	O	0	0	0	30, 899, 124	50.00
51. 00	05100 RECOVERY ROOM	l o	0	Ö	o	00,077,121	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	12, 874, 373	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 57. 00	05600	0	0	0	0	0 2, 574, 895	
	05800 MAGNETIC RESONANCE I MAGING (MRI)		0	0	0	1, 144, 253	
59. 00	05900 CARDI AC CATHETERI ZATI ON	l o	0	Ö	Ö	2, 570, 000	1
60.00	06000 LABORATORY	o	0	0	О	13, 978, 945	1
60. 01	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0	61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	0	0	0	0 454 949	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	0	0	0	2, 656, 868 5, 213, 706	
66. 00	06600 PHYSI CAL THERAPY	l o	0	Ö	o	2, 929, 329	
67.00	06700 OCCUPATI ONAL THERAPY	o	0	0	О	1, 131, 631	
68. 00	06800 SPEECH PATHOLOGY	o	0	0	o	491, 703	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	13, 518, 604	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	25, 198, 633 32, 341, 590	
74. 00	07400 RENAL DIALYSIS	o o	0	0	0	0 0	ı
75. 00	07500 ASC (NON-DISTINCT PART)	o	0	0	o	0	75. 00
76.00	03140 CARDI OLOGY	o	0	0	О	3, 739, 410	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77. 00
00.00	OUTPATIENT SERVICE COST CENTERS		0		ما		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	0	0	0	0	1, 017, 789	1
90. 01	04950 SLEEP CLINIC	o	O	0	o	590, 447	
91. 00	09100 EMERGENCY	0	0	0	168, 240	19, 179, 555	91.00

			To	12/31/2022	Date/Time Pre	
					5/31/2023 12:	14 pm
		I NTERNS &	RESI DENTS			
Cook Cooks Doors at a	NUDCLNC	CEDVI CEC CALAD	SERVI CES-OTHER	DADAMED ED	Cb. + - + - I	
Cost Center Description	NURSI NG PROGRAM	Y & FRINGES	PRGM COSTS	PARAMED ED PRGM	Subtotal	
	20. 00	21. 00	22. 00	23. 00	24. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	20.00	21.00	22.00	23.00	24.00	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	(0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES			0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED			o o	0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	(Ö	0	0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	(Ö	0	0	98. 00
99. 00 09900 CMHC	(Ö	0	0	99. 00
99. 10 09910 CORF	(Ö	0	0	99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	(Ö	0	0	100.00
101.00 10100 HOME HEALTH AGENCY		ol o	Ö	o		101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM		o	o	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	<u>'</u>	'				1
105. 00 10500 KIDNEY ACQUISITION	(0	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON		ol o	О	0	0	106. 00
107. 00 10700 LIVER ACQUISITION		ol o	O	0	0	107. 00
108. 00 10800 LUNG ACQUISITION		ol o	О	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	(0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	(0	0	0	0	110. 00
111.00 11100 ISLET ACQUISITION	(0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	(0	0	0	0	115. 00
116. 00 11600 HOSPI CE	(0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	(0	0	168, 240	268, 943, 020	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	(0	0	0	0	190. 00
191. 00 19100 RESEARCH	(0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	(0	0	0	789, 269	
193.00 19300 NONPALD WORKERS	(0	0	0	66, 056	
193. 01 19301 COMMUNI TY	(0	0	0	938, 866	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	(0	0	0	14, 359, 453	
200.00 Cross Foot Adjustments	(0	0	0		200. 00
201.00 Negative Cost Centers	(0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	(0	0	168, 240	285, 096, 664	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | Date/Time Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0018

				To 12/31/2022 Date/lime P 5/31/2023 1	
	Cost Center Description	Intern & Residents Cost & Post Stepdown	Total	573772020	
		Adjustments	07.00		
	GENERAL SERVICE COST CENTERS	25. 00	26. 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 00800 LAUNDRY & LINEN SERVICE				7. 00
8. 00 9. 00	00900 HOUSEKEEPING				8. 00 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 SERVICES & SUPPLY				14. 00
15. 00 16. 00	01500 PHARMACY				15. 00
17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE				16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)		•		18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS				19. 00
20.00	02000 NURSI NG PROGRAM				20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD				21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD				22. 00
23. 00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS				23. 00
30. 00	03000 ADULTS & PEDIATRICS	0	69, 508, 174		30.00
31. 00	03100 INTENSIVE CARE UNIT	O	15, 460, 334		31. 00
31. 01	03101 NEONATAL INTENSIVE CARE	0	2, 623, 558		31. 01
32. 00	03200 CORONARY CARE UNIT	0	0		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		33. 00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	4 114 910		34. 00 40. 00
41. 00	04100 SUBPROVI DER – TPF	0	4, 116, 810 170, 284		41. 00
43. 00	04300 NURSERY	0	5, 013, 005		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 ANCI LLARY SERVICE COST CENTERS	0	0		46. 00
50. 00	05000 OPERATI NG ROOM	0	30, 899, 124		50.00
51.00	05100 RECOVERY ROOM	0	0		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	0	12, 874, 373		54.00
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	0	0		55. 00 56. 00
	05700 CT SCAN		2, 574, 895		57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 144, 253		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	2, 570, 000		59. 00
60.00		0	13, 978, 945		60. 00
60. 01	06001 BLOOD LABORATORY	0	0		60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		63. 00
64. 00	06400 I NTRAVENOUS THERAPY	o	2, 656, 868		64. 00
65.00	06500 RESPI RATORY THERAPY	0	5, 213, 706		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	2, 929, 329		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	1, 131, 631		67. 00
68. 00 69. 00	1	0	491, 703 0		68. 00 69. 00
70.00	1 1	0	0		70.00
71. 00	i i	o	13, 518, 604		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	25, 198, 633		72. 00
73. 00	1 1	0	32, 341, 590		73. 00
74. 00		0	0		74.00
75. 00 76. 00			3, 739, 410		75. 00 76. 00
76.00			3, 739, 410		77.00
50	OUTPATIENT SERVICE COST CENTERS				
88. 00		0	0		88. 00
89.00	1	0	1 017 700		89. 00
90. 00 90. 01	1	0	1, 017, 789 590, 447		90. 00
70.01	15 00000 000 0	<u>ı</u>	0,0, 11,		1 70.01

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

			From 01/01/2022 Part To	repared:
· · · · · · · · · · · · · · · · · · ·			5/31/2023 1	2: 14 pm
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown			
	Adjustments 25.00	26. 00		
91. 00 09100 EMERGENCY	25.00	19, 179, 555		91, 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	17, 177, 555		92.00
OTHER REIMBURSABLE COST CENTERS	<u> </u>			72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES		o		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		o		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	o		97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	o		98. 00
99. 00 09900 CMHC	o	o		99. 00
99. 10 09910 CORF	o	ol		99. 10
100.00 10000 L&R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	o	o		101. 00
102.00 10200 OPIOLD TREATMENT PROGRAM	O	o		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 INTEREST EXPENSE				113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	268, 943, 020		118. 00
NONREI MBURSABLE COST CENTERS	1 a	ما		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190.00
191. 00 19100 RESEARCH	0	700 270		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		789, 269		192.00
193. 00 19300 NONPALD WORKERS 193. 01 19301 COMMUNI TY		66, 056		193. 00 193. 01
193. 01 19301 COMMUNITY 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS		938, 866		193.01
200.00 Cross Foot Adjustments		14, 359, 453 0		200. 00
201.00 Negative Cost Centers				200.00
202.00 TOTAL (sum lines 118 through 201)		285, 096, 664		201.00
202.00 TOTAL (Suill TITIES TTO LITTOUGH 201)	ı V	200, 090, 004		1202.00

| Peri od: | Worksheet B | From 01/01/2022 | Part | I | To | 12/31/2022 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

					To	12/31/2022	Date/Time Prep 5/31/2023 12:	
				CAPI TAL REI	LATED COSTS		373172023 12.	т-т ріп
		Cost Center Description	Directly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
			Assigned New				BENEFI TS	
			Capi tal Rel ated Costs				DEPARTMENT	
			0	1.00	2. 00	2A	4. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT						1. 00
2.00	1	CAP REL COSTS-BEDG & TTXT						2. 00
4.00		EMPLOYEE BENEFITS DEPARTMENT	0	3, 136		3, 887	3, 887	4. 00
5. 00 6. 00		ADMINISTRATIVE & GENERAL MAINTENANCE & REPAIRS	0	112, 787 0		139, 789	160 0	5. 00 6. 00
7. 00	1	OPERATION OF PLANT	0	3, 389, 757		4, 201, 294	96	7. 00
8.00		LAUNDRY & LINEN SERVICE	0	96, 804		119, 980	0	8. 00
9. 00 10. 00	1	HOUSEKEEPI NG DI ETARY	0	95, 875 247, 945	1	118, 828 307, 305	84 47	9. 00 10. 00
11. 00		CAFETERI A	0	89, 881	1	111, 399	51	11. 00
12. 00		MAINTENANCE OF PERSONNEL	0	0	_	0	0	12. 00
13. 00 14. 00		NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY	0	43, 233 347, 676	1	53, 583 430, 913	103 33	13. 00 14. 00
15. 00		PHARMACY	0	133, 671	1	165, 673	6	15. 00
16. 00		MEDICAL RECORDS & LIBRARY	0	0	_	0	0	16. 00
17. 00 18. 00		SOCIAL SERVICE OTHER GENERAL SERVICE (SPECIFY)	0	17, 145 0		21, 250	39 0	17. 00 18. 00
19. 00		NONPHYSICIAN ANESTHETISTS	0	0	Ö	0	0	19. 00
20. 00	1	NURSING PROGRAM	0	0	0	0	0	20. 00
21. 00 22. 00		I&R SERVICES-SALARY & FRINGES APPRVD I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	21. 00 22. 00
23. 00	1	PARAMED ED PRGM	0	4, 809	1, 151	5, 9 60	3	23. 00
		IENT ROUTINE SERVICE COST CENTERS	_					
30. 00 31. 00		ADULTS & PEDIATRICS INTENSIVE CARE UNIT	0	2, 970, 414 257, 748	1	3, 681, 557 319, 455	921 257	30. 00 31. 00
31. 01		NEONATAL INTENSIVE CARE	0	54, 128	1	67, 087	62	31. 01
32. 00		CORONARY CARE UNIT	0	0	0	0	0	32. 00
33. 00 34. 00		BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40. 00	1	SUBPROVI DER - I PF	0	253, 497	60, 689	314, 186	79	40. 00
41. 00	1	SUBPROVI DER - I RF	0	12, 475		15, 462	5	41. 00
43. 00 44. 00	1	NURSERY SKILLED NURSING FACILITY	0	237, 119 0		293, 887	101	43. 00 44. 00
45. 00		NURSING FACILITY	0	0	_	0	0	45. 00
46. 00		OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	0	1, 361, 014	325, 838	1, 686, 852	475	50. 00
51. 00	05100	RECOVERY ROOM	0	0	0	0	0	51. 00
52.00		DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 54. 00	1	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	0	1, 042, 749	249, 643	0 1, 292, 392	0 233	53. 00 54. 00
55. 00		RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56.00	1	RADI OI SOTOPE	0	1/4 017	0	0	0	
57. 00 58. 00		CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	0	164, 917 83, 330	·	204, 400 103, 280	27 19	57. 00 58. 00
59. 00	05900	CARDI AC CATHETERI ZATI ON	0	94, 597		117, 244	89	59. 00
60.00	1	LABORATORY	0	126, 121	30, 195	156, 316	102	60.00
60. 01 61. 00	1	BLOOD LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0	0	60. 01 61. 00
62. 00	06200	WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	О	0	0	62. 00
63.00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	0	100 200	- 1	0 223, 576	0	63. 00
64. 00 65. 00		RESPIRATORY THERAPY	0	180, 389 41, 909	1	51, 942	47 69	64. 00 65. 00
66. 00	06600	PHYSI CAL THERAPY	0	115, 389	27, 625	143, 014	63	66. 00
67. 00		OCCUPATIONAL THERAPY	0	55, 406		68, 671	22	67. 00
68. 00 69. 00		SPEECH PATHOLOGY ELECTROCARDI OLOGY	0	33, 220 0		41, 173 0	10 0	68. 00 69. 00
70. 00		ELECTROENCEPHALOGRAPHY	0	0	ō	0	0	70. 00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENTS DRUGS CHARGED TO PATIENTS	0	0 n	0	0 0	0 172	72. 00 73. 00
74.00	07400	RENAL DIALYSIS	0	Ö	o o	ő	0	74. 00
75.00		ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 00 77. 00	1	CARDIOLOGY ALLOGENEIC HSCT ACQUISITION	0	264, 741 0		328, 122 0	77 0	76. 00 77. 00
	OUTPA	TIENT SERVICE COST CENTERS						
88. 00 89. 00	1	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0	- 1	0	0	88. 00 89. 00
		CLINIC		110, 045		136, 391		90.00
				•				·

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

			Ť	0 12/31/2022	Date/Time Pre 5/31/2023 12:	
		CAPI TAL REI	ATED COSTS		7 07 0 17 2020 121	. , ,
Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	Related Costs	1. 00	2.00	2A	4. 00	
90. 01 04950 SLEEP CLINIC	0	0			13	90. 01
91. 00 09100 EMERGENCY	0	386, 936	92, 636	479, 572	353	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	_	· ·	0	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 MEDI CAL EQUI P-SOLD	0	0	0	0	0	97. 00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 99. 00 09900 CMHC		0	0	0	0	98. 00 99. 00
99. 10 09910 CORF		0	0	0	0	99. 00
100.00 10000 &R SERVICES-NOT APPRVD PRGM		0	0	0	_	100.00
101. 00 10100 HOME HEALTH AGENCY		0	0			101.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	o o	0	_	·		102. 00
SPECIAL PURPOSE COST CENTERS	-,		-	-1		
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	0		111. 00
113. 00 11300 NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)		0	_			114. 00 115. 00
116. 00 11600 HOSPI CE		0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		12, 428, 863	2, 975, 577	15, 404, 440		118. 00
NONREI MBURSABLE COST CENTERS	<u> </u>	12, 420, 003	2, 713, 311	15, 404, 440	3,034	1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191. 00 19100 RESEARCH	0	0	0	·		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	285, 091	68, 253	353, 344	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	2	193. 00
193. 01 19301 COMMUNI TY	0	97, 547	·			193. 01
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS	0	3, 010, 488	720, 737	3, 731, 225	41	194. 00
200.00 Cross Foot Adjustments				0		200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	0	15, 821, 989	3, 787, 921	19, 609, 910	3, 887	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | From 12/31/2022 | From 12/31/2022

					0 12/31/2022	Date/lime Pre 5/31/2023 12:	
	Cost Center Description	ADMI NI STRATI VE		OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL 5.00	REPAI RS 6. 00	PLANT 7. 00	LINEN SERVICE 8.00	9. 00	
	GENERAL SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7. 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	OO4OO EMPLOYEE BENEFITS DEPARTMENT OO5OO ADMINISTRATIVE & GENERAL	139, 949					4. 00 5. 00
6.00	00600 MAINTENANCE & REPAIRS	137, 747	o				6. 00
7. 00	00700 OPERATION OF PLANT	6, 659	Ō	4, 208, 049)		7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	513	0	33, 074	153, 567		8. 00
9.00	00900 HOUSEKEEPI NG	2, 248	0	32, 757		153, 917	9.00
10. 00 11. 00	01000 DI ETARY	1, 287 1, 091	0	84, 714 30, 709		263 788	
12.00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	1,091	0	30, 709	0	788	12.00
13. 00	01300 NURSING ADMINISTRATION	2,002	o	14, 771	0	1, 050	
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 143	0	118, 789		0	1
15. 00	01500 PHARMACY	1, 171	0	45, 671	0	1, 050	15. 00
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	0	C	1	0	
	01700 SOCIAL SERVICE	794	0	5, 858	0	0	
18. 00 19. 00	O1850 OTHER GENERAL SERVICE (SPECIFY) O1900 NONPHYSICIAN ANESTHETISTS	0	0	(0	0	18. 00 19. 00
20. 00	02000 NURSI NG PROGRAM		0		0	0	20.00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	Ö	Ō	Č	0	0	21. 00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	O	C	0	0	22. 00
23. 00	02300 PARAMED ED PRGM	75	0	1, 643	0	263	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	20.241	ما	1 014 007	(0.455	/0.100	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	28, 241 6, 696	0	1, 014, 886 88, 064			1
31. 00	03101 NEONATAL INTENSIVE CARE	1, 177	0	18, 494		351	31.00
32. 00	03200 CORONARY CARE UNIT	0	Ö	10, 17	0	0	
33.00	03300 BURN INTENSIVE CARE UNIT	o	О	C	0	0	33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	C	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	1, 603	0	86, 611			1
41.00	04100 SUBPROVI DER - I RF	67	0	4, 262			41.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	2, 109	0	81, 015	3, 312	351 0	43. 00 44. 00
45. 00	04500 NURSING FACILITY		ő	C	o o	Ö	45. 00
46.00	04600 OTHER LONG TERM CARE	0	0	C	0	0	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	13, 927	0	465, 010			
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0	(0	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY		0		0	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	5, 366	Ō	356, 270	14, 128	13, 649	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	O	C	0	0	55.00
56. 00	05600 RADI OI SOTOPE	0	0		0	0	
57. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 125 480	0	56, 346 28, 471			1
58. 00 59. 00	05900 CARDIAC CATHETERIZATION	1, 145	0	32, 320			1
	06000 LABORATORY	6, 705	ő	43, 091		-	60.00
	06001 BLOOD LABORATORY	0	Ō	,	0	0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0	0	
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	1, 090	0	£1 £33	0	2 000	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	2, 472	0	61, 633 14, 319		2, 888 2, 100	1
66. 00	06600 PHYSI CAL THERAPY	1, 318	Ö	39, 424			1
67.00	06700 OCCUPATI ONAL THERAPY	502	0	18, 930		1, 050	1
68.00	06800 SPEECH PATHOLOGY	211	0	11, 350	0	525	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	C	0	0	
	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 165	0			0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	11, 495 14, 585	ol Ol	() 0	l 0	73.00
74. 00	07400 RENAL DIALYSIS	0	ol	C	o o	l ő	74.00
75.00	07500 ASC (NON-DISTINCT PART)	o	0	C	0	0	75. 00
76.00	03140 CARDI OLOGY	1, 597	o	90, 453	3, 727		1
	107700 ALLOCENELC USCT ACOULSITION	O	0	C	0	0	77. 00
77. 00	07700 ALLOGENEI C HSCT ACQUI SITI ON						4
77. 00	OUTPATIENT SERVICE COST CENTERS		ما			_	1 00 00
77. 00 88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88.00
77. 00 88. 00	OUTPATIENT SERVICE COST CENTERS	0 0 390	0 0 0	37, 599	0 0 0 1. 243	0 0 2, 625	89. 00
77. 00 88. 00 89. 00 90. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	1 -1	0 0 0 0	37, 599	0 0 1, 243 0	1	89. 00 90. 00
77. 00 88. 00 89. 00 90. 00 90. 01 91. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	390	0 0 0 0	37, 599 37, 202	0	2, 625 0	89. 00 90. 00 90. 01

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				''	0 12/31/2022	5/31/2023 12:	
	Cost Center Description	ADMI NI STRATI VE	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
		& GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 00	6. 00	7. 00	8. 00	9. 00	
	OTHER REIMBURSABLE COST CENTERS						1
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	1 / 00
95. 00	09500 AMBULANCE SERVI CES	0	0	0	0	0	70.00
	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
	09910 CORF	0	0	0	0	0	99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
	10100 HOME HEALTH AGENCY	0	0	0	0		101. 00
102.00	10200 OPI OID TREATMENT PROGRAM	0	0	0	0	0	102. 00
	SPECIAL PURPOSE COST CENTERS						
	10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
	10600 HEART ACQUISITION	0	0	0	0		106. 00
107.00	10700 LIVER ACQUISITION	0	0	0	0	0	107. 00
108.00	10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
109.00	10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00	11100 SLET ACQUISITION	0	0	0	0	0	111. 00
113.00	11300 I NTEREST EXPENSE						113. 00
114.00	11400 UTILIZATION REVIEW-SNF						114. 00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116.00	11600 H0SPI CE	0	0	0	0	0	116. 00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	134, 091	0	3, 048, 736	153, 567	138, 955	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0	190. 00
191.00	19100 RESEARCH	0	0	0	0	0	191. 00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	202	0	97, 406	0	2, 100	192. 00
	19300 NONPALD WORKERS	32	0	0	0	0	193. 00
193. 01	19301 COMMUNI TY	403	0	33, 328	0	0	193. 01
194.00	07950 OTHER NONREIMBURSABLE COST CENTERS	5, 221	0	1, 028, 579	0	12, 862	194. 00
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers	0	0	0	0		201. 00
202.00	TOTAL (sum lines 118 through 201)	139, 949	0	4, 208, 049	153, 567	153, 917	202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | 5/31/2023 | 12: 14 pm

					5/31/2023 12:	14 pm
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE O PERSONNEL	F NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	
	10.00	11. 00	12. 00	13. 00	14. 00	
GENERAL SERVICE COST CENTERS						
1. 00	393, 616 0 0 0 0 0 0 0	144, 038 0 3, 504 2, 965 151 0 2, 168 0		0 0 75, 013 0 0 0 0 0 0 0 231 0 0 0 0	553, 843 0 0 0 0 0	1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
21.00 02100 1 &R SERVI CES-SALARY & FRINGES APPRVD 22.00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0			0	21. 00 22. 00
23.00 02300 PARAMED ED PRGM	0	113		0 0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS				-		
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	327, 302 38, 472	37, 303 9, 651		0 30, 335 0 10, 353	0	30. 00 31. 00
31. 01 03101 NEONATAL INTENSIVE CARE	30, 472	1, 770		0 2, 043	0	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 03400 SURGI CAL INTENSIVE CARE UNIT	0	2 202		0 0	0	34.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	26, 883 959	3, 202 89		0 1, 861 0 74	0	40. 00 41. 00
43. 00 04300 NURSERY	0	3, 280		0 3, 453	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0	0	44. 00
45.00 04500 NURSING FACILITY	0	0		0 0	0	45.00
46. 00 O4600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	U	U		0 0	0	46. 00
50. 00 05000 OPERATI NG ROOM	0	17, 024		0 10, 989	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 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	10, 991		0 1, 768	0	53. 00 54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	o	0		0 0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0		0 0	0	56. 00
57.00 05700 CT SCAN 58.00 05800 MAGNETIC RESONANCE MAGING (MRI)	0	1, 293		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 05900 CARDIAC CATHETERIZATION	0	929 2, 596		0 1, 631	0	58. 00 59. 00
60. 00 06000 LABORATORY	0	7, 573		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 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			0	61. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	2, 013		0 2, 096	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0	3, 449		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	2, 863 1, 074			0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	0	527		0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	O	0		0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	193, 845 359, 998	71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	7, 350		0 0	337, 770	73.00
74. 00 07400 RENAL DIALYSIS	0	0		0 0	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75. 00
76. 00 03140 CARDI OLOGY 77. 00 07700 ALLOGENEI C HSCT ACQUI SITI ON	0	3, 613 0	ı	0 717 0 0	0	76. 00 77. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	0 816		U 0 D 1	0	89. 00 90. 00
90. 01 04950 SLEEP CLINIC	o	689		o o	0	90.00
91. 00 09100 EMERGENCY	0	14, 803]	9, 461	0	91. 00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)						92. 00

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0018

Peri od: Worksheet B From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared:

5/31/2023 12:14 pm Cost Center Description DI ETARY CAFETERI A MAINTENANCE OF NURSI NG CENTRAL PERSONNEL ADMI NI STRATI ON SERVICES & **SUPPLY** 10.00 11.00 12.00 13.00 14.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 94.00 09500 AMBULANCE SERVICES 000000 0 95.00 0 0 0 0 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 97.00 0 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 99.00 09900 CMHC 0 0 0 99.00 99. 10 09910 CORF 0 99. 10 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 102.00 10200 OPI OI D TREATMENT PROGRAM 0 102. 00 0 0 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 000000 0 0 0 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 107. 00 0 108.00 10800 LUNG ACQUISITION 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 111.00 0 0 113. 00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 0 116. 00 11600 HOSPI CE 0 0 0 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 553, 843 118. 00 118.00 393, 616 141, 799 0 75,013 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191. 00 19100 RESEARCH 0 0 0 190, 00 0 0 0 0 0 191.00 C 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192. 00 0 193. 00 19300 NONPALD WORKERS 91 0 0 0 193. 00 0 193. 01 19301 COMMUNI TY 0 0 193. 01 702 194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 1, 446 0 0 194. 00 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00 393, 616 0 202.00 TOTAL (sum lines 118 through 201) 144, 038 553, 843 202. 00 75, 013

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2022 | Part II | Date/Time Prepared: | 5/31/2023 | 12:14 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

					0 12/31/2022	5/31/2023 12:	
					OTHER GENERAL		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	SERVI CE (SPECI FY)	NONPHYSI CI AN	
	cost center bescription	FIIANWACI	RECORDS &	SOCIAL SERVICE	(SFLCITT)	ANESTHETISTS	
			LI BRARY				
	Table 1	15.00	16. 00	17. 00	18. 00	19. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	1		I		I	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 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPING						9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 00 14. 00
15. 00	01500 PHARMACY	213, 722					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0				16.00
17. 00	01700 SOCI AL SERVI CE	0	0	30, 340			17. 00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	_		18.00
19. 00 20. 00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM		0	0	0	0	19. 00 20. 00
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD		Ö	Ö	o		21. 00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	O	0	0	0		22. 00
23. 00	02300 PARAMED ED PRGM	0	0	0	0		23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	85	C	22, 625	0	I	30. 00
31. 00	03100 INTENSIVE CARE UNIT	39	0	,			31.00
31. 01	03101 NEONATAL INTENSIVE CARE	0	0	213			31. 01
32. 00	03200 CORONARY CARE UNIT	0	0	0	_		32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0			33. 00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF		0	0 1, 363	_		34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF		Ö	29			41. 00
43.00	04300 NURSERY	O	0	3, 159	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	_		45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	ı o		0	0	L	40.00
50.00	05000 OPERATI NG ROOM	1, 510	C	0	0		50. 00
51.00	05100 RECOVERY ROOM	0	0		_		51.00
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	0	0	0			52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	32	0	0	_		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0		55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0			56. 00
57. 00 58. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	_		57. 00 58. 00
59. 00	05900 CARDIAC CATHETERIZATION	5	0				59.00
60.00	06000 LABORATORY	o	0	ō	0		60.00
60. 01	06001 BLOOD LABORATORY	0	0	0	0		60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		0		61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.		0	0	0		62. 00 63. 00
64. 00	06400 I NTRAVENOUS THERAPY	79	Ö	Ö	o		64. 00
65. 00	06500 RESPI RATORY THERAPY	1, 211	0	0	0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0		66.00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	0	0		67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY		0	0	0		69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	o	0	ō	_		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0		71. 00
72.00	07200 DRUCS CHARGED TO PATIENTS	0	0	0	0		72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	210, 208	0	0	0		73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		0	o	0		75. 00
76. 00	03140 CARDI OLOGY	522	O	Ō	0		76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0		77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC		0	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0		_	•	89.00
90.00	09000 CLI NI C	0	O	Ō		•	90. 00
90. 01	04950 SLEEP CLINIC	0	0	0	0		90. 01

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			T	o 12/31/2022	Date/Time Pre 5/31/2023 12:	pared:
				OTHER GENERAL	3/31/2023 12.	14 piii
				SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN	
		RECORDS &			ANESTHETI STS	
	15.00	LI BRARY	17.00	10.00	10.00	
91. 00 09100 EMERGENCY	15. 00	16. 00	17.00	18. 00	19. 00	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	31	U	0	U		91.00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	o	0	Ō	_	•	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0	0	0		96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	O	0	0	0		97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	O	0	0	0		98. 00
99. 00 09900 CMHC	0	0	0	0		99. 00
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 KI DNEY ACQUI SI TI ON	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	Ü	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	Ü	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	Ü	0	0		110.00
111. 00 11100 SLET ACQUI SI TI ON	0	Ü	0	U		111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00 114. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL 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)	213, 722	0	30, 340	0	_	118. 00
NONREI MBURSABLE COST CENTERS	213,722		30, 340	U	0] 110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH		0	0			191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		0		0		192. 00
193. 00 19300 NONPAI D WORKERS		0		0		193. 00
193. 01 19301 COMMUNI TY		0	0	0		193. 01
194. 00 07950 OTHER NONREI MBURSABLE COST CENTERS		0	o o	0		194. 00
200.00 Cross Foot Adjustments		· ·			0	200. 00
201.00 Negative Cost Centers	O	0	0	0		201. 00
202.00 TOTAL (sum lines 118 through 201)	213, 722	0	30, 340	0		202. 00
				1		'

In Lieu of Form CMS-2552-10

| Period: | Worksheet B | From 01/01/2022 | Part II | Date/Time Prepared: | 5/31/2023 | 12:14 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

				10) 12/31/2022	5/31/2023 12:	
			INTERNS &	RESI DENTS			
	Cost Contan Decemintion	NUDCLNC	CEDVI CEC CALAD	CEDVI CEC OTHER	DADAMED ED	Cubtatal	
	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 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5.00
6. 00	00600 MAINTENANCE & REPAIRS						6. 00
7.00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10. 00 11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION						13. 00
14. 00	01400 CENTRAL SERVICES & 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 NONPHYSICIAN ANESTHETISTS						19. 00
20.00	02000 NURSI NG PROGRAM	0					20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD		0				21. 00
22. 00 23. 00	O2200 1 & R SERVI CES-OTHER PRGM COSTS APPRVD O2300 PARAMED ED PRGM			0	8, 057		22. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS				6, 037		23.00
30. 00	03000 ADULTS & PEDI ATRI CS					5, 281, 100	30. 00
31. 00	03100 INTENSIVE CARE UNIT					496, 002	1
31. 01	03101 NEONATAL INTENSIVE CARE					91, 319	1
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT					0	32. 00 33. 00
34. 00	03400 SURGI CAL INTENSIVE CARE UNIT					0	34.00
40. 00	04000 SUBPROVI DER - I PF					441, 215	1
41. 00	04100 SUBPROVI DER - I RF					21, 662	41. 00
43.00	04300 NURSERY					390, 667	43. 00
44. 00 45. 00	04400 SKILLED NURSING FACILITY					0	44.00
46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE					0	45. 00 46. 00
.0.00	ANCI LLARY SERVI CE COST CENTERS			LI.			10.00
50.00	05000 OPERATING ROOM					2, 213, 123	50. 00
51.00	05100 RECOVERY ROOM					0	51.00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY					0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C					1, 694, 829	1
55.00	05500 RADI OLOGY-THERAPEUTI C					0	55. 00
56. 00	05600 RADI OI SOTOPE					0	56. 00
57. 00	05700 CT SCAN					267, 664	
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON					136, 360 155, 030	
60.00	06000 LABORATORY					215, 887	60.00
60. 01	06001 BLOOD LABORATORY					0	1
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS					0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY					0 293, 422	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY					75, 562	
66. 00	06600 PHYSI CAL THERAPY					189, 835	
67. 00	06700 OCCUPATI ONAL THERAPY					90, 249	1
68. 00	06800 SPEECH PATHOLOGY					53, 796	1
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY					0	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS					200, 010	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS					371, 493	1
73.00	07300 DRUGS CHARGED TO PATIENTS					232, 315	
74.00	07400 RENAL DI ALYSI S					0	1
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY					0 430, 928	1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION					430, 720	1
	OUTPATIENT SERVICE COST CENTERS			. '			
88. 00	08800 RURAL HEALTH CLINIC					0	1
89. 00 90. 00	1 1					170 001	89. 00
90.00	09000 CLI NI C 04950 SLEEP CLI NI C					179, 081 986	1
	09100 EMERGENCY					691, 423	
		1					·

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2022 Part II Provider CCN: 15-0018

				rom 01/01/2022	Part II	
			T	o 12/31/2022	Date/Time Pre 5/31/2023 12:	pared:
		I NITEDNIC 0	RESI DENTS		3/31/2023 12.	14 pili
		I INTERNS &	KL31 DLIVI 3			
Cost Center Description	NURSI NG	SEDVICES SVIVD	SERVI CES-OTHER	PARAMED ED	Subtotal	
cost center bescription	PROGRAM	Y & FRINGES	PRGM COSTS	PRGM	Subtotal	
	20. 00	21.00	22.00	23. 00	24. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	20.00	21.00	22.00	23.00	24.00	92.00
OTHER REIMBURSABLE COST CENTERS						92.00
94. 00 09400 HOME PROGRAM DIALYSIS					0	94. 00
95. 00 09500 AMBULANCE SERVI CES					0	
					0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED						, , , , , ,
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD					0	1
98.00 09850 OTHER REIMBURSABLE COST CENTERS					0	
99. 00 09900 CMHC					0	
99. 10 09910 CORF					0	1 , , ,
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM						100. 00
101.00 10100 HOME HEALTH AGENCY					0	101.00
102.00 10200 OPIOLD TREATMENT PROGRAM					0	102.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION					0	105. 00
106.00 10600 HEART ACQUISITION					0	106. 00
107. 00 10700 LIVER ACQUISITION					0	107. 00
108.00 10800 LUNG ACQUISITION					0	108. 00
109. 00 10900 PANCREAS ACQUISITION						109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON						110.00
111. 00 11100 I SLET ACQUI SI TI ON						111. 00
113. 00 11300 NTEREST EXPENSE					,	113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
						115. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)						
116. 00 11600 HOSPI CE						116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)		0	0	0	14, 213, 958	1118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN						190. 00
191. 00 19100 RESEARCH						191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES					453, 052	
193. 00 19300 NONPALD WORKERS						193. 00
193. 01 19301 COMMUNI TY					155, 344	
194.00 07950 OTHER NONREIMBURSABLE COST CENTERS					4, 779, 374	194. 00
200.00 Cross Foot Adjustments	(0	0	8, 057	8, 057	200. 00
201.00 Negative Cost Centers	(0	0	o	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	(o o	0	8, 057	19, 609, 910	202.00
	•		•	. '		•

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2022 | Part II | To 12/31/2022 | Date/Time Prepared: | From 12/31/2022 Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0018

				10	12/31/2022 Date/lime Pr 5/31/2023 12	
	Cost Center Description	Intern & Residents Cost & Post Stepdown	Total	<u> </u>	, 0, 0 t, 2020 12	
		Adjustments	24.00			
	GENERAL SERVICE COST CENTERS	25. 00	26. 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 MAINTENANCE & REPAIRS					6.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE					7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
12.00	01200 MAINTENANCE OF PERSONNEL					12. 00
13.00	01300 NURSI NG ADMI NI STRATI ON					13. 00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY					14. 00 15. 00
16. 00						16. 00
17. 00	01700 SOCIAL SERVICE					17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)					18. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS					19. 00
20. 00	02000 NURSI NG PROGRAM					20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD 02200 &R SERVICES-OTHER PRGM COSTS APPRVD					21. 00 22. 00
23. 00	1					23. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS					= 20.00
30. 00	03000 ADULTS & PEDIATRICS	0	5, 281, 100			30. 00
31.00	03100 I NTENSI VE CARE UNI T	0	496, 002			31.00
31. 01 32. 00	03101 NEONATAL I NTENSI VE CARE 03200 CORONARY CARE UNI T	0	91, 319 0			31. 01 32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT		0			33. 00
34. 00	03400 SURGI CAL I NTENSI VE CARE UNI T	l o	Ö			34. 00
40.00	04000 SUBPROVI DER - I PF	0	441, 215			40. 00
41. 00	04100 SUBPROVI DER – I RF	0	21, 662			41. 00
43. 00 44. 00	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0	390, 667 0			43. 00 44. 00
45. 00	04500 NURSING FACILITY		o			45. 00
46.00	04600 OTHER LONG TERM CARE	0	0			46. 00
F0 00	ANCILLARY SERVICE COST CENTERS		0.040.400			
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	2, 213, 123 0			50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM		o			52. 00
53.00	05300 ANESTHESI OLOGY	O	O			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	1, 694, 829			54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0			55. 00
56.00	05600	0	267 664			56. 00 57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	267, 664 136, 360			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	O	155, 030			59. 00
60.00	06000 LABORATORY	0	215, 887			60.00
60. 01	06001 BLOOD LABORATORY	0	0			60. 01
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS					61. 00 62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.		0			63. 00
64. 00	06400 I NTRAVENOUS THERAPY	O	293, 422			64. 00
65.00	06500 RESPI RATORY THERAPY	0	75, 562			65. 00
66. 00	06600 PHYSI CAL THERAPY	0	189, 835			66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	90, 249			67. 00 68. 00
69. 00	1		53, 796 0			69. 00
	07000 ELECTROENCEPHALOGRAPHY		Ö			70.00
71. 00		O	200, 010			71. 00
72. 00		0	371, 493			72. 00
73.00		0	232, 315			73.00
74. 00 75. 00		0	0			74. 00 75. 00
76. 00			430, 928			76.00
77. 00		0	0			77. 00
	OUTPATIENT SERVICE COST CENTERS					
88. 00		0	0			88. 00
89. 00 90. 00	1	0	0 179, 081			89. 00 90. 00
90. 01	1	0	986			90. 01
			ı ı			

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2022 Part II Provider CCN: 15-0018

				From 01/01/2022	
	Cost Center Description	Intern & Residents Cost	Total	5/31/2023 13	2: 14 pm
		& Post			
		Stepdown			
		Adjustments 25.00	26. 00		
91. 00	09100 EMERGENCY	25.00	691, 423		91. 00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		091, 423		92.00
92.00	OTHER REIMBURSABLE COST CENTERS	U			72.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0		94.00
	09500 AMBULANCE SERVICES		0		95. 00
	09600 DURABLE MEDICAL EQUIP-RENTED		0		96. 00
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
	09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
	09900 CMHC	0	0		99. 00
	09910 CORF	0	0		99. 10
	10000 I &R SERVICES-NOT APPRVD PRGM	o	Ö		100.00
	10100 HOME HEALTH AGENCY	0	o		101.00
102.00	10200 OPI OI D TREATMENT PROGRAM	0	o		102. 00
	SPECIAL PURPOSE COST CENTERS	·			
105.00	10500 KIDNEY ACQUISITION	0	0		105. 00
106.00	10600 HEART ACQUISITION	o	О		106. 00
107.00	10700 LIVER ACQUISITION	0	О		107. 00
108.00	10800 LUNG ACQUISITION	0	0		108. 00
	10900 PANCREAS ACQUISITION	0	0		109. 00
110.00	11000 INTESTINAL ACQUISITION	0	0		110. 00
	11100 ISLET ACQUISITION	0	0		111. 00
	11300 INTEREST EXPENSE				113. 00
	11400 UTI LI ZATI ON REVI EW-SNF				114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115. 00
	11600 HOSPI CE	0	0		116. 00
118. 00		0	14, 213, 958		118. 00
	NONREI MBURSABLE COST CENTERS				
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		190. 00
	19100 RESEARCH	0	0		191. 00
	19200 PHYSICIANS' PRIVATE OFFICES	0	453, 052		192. 00
	19300 NONPALD WORKERS	0	125		193. 00
	19301 COMMUNITY 07950 OTHER NONREIMBURSABLE COST CENTERS	0	155, 344 4, 779, 374		193. 01 194. 00
200.00		0	4, 779, 374 8, 057		200. 00
200.00	l	0	8, 057		200.00
201.00	9	0	19, 609, 910		201.00
202.00		١	17,007,710		1202.00

| Period: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0018

					o 12/31/2022	Date/Time Prep 5/31/2023 12:	
		CAPITAL REI	LATED COSTS			5/31/2023 12.	14 piii
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS	Reconci I i ati on	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	SALARI ES)	ΕΛ	F 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	4. 00	5A	5. 00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT	681, 071					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP		681, 071				2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	135				044 704 470	4. 00
5. 00 6. 00	00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS	4, 855 0		4, 095, 507	-40, 312, 485	244, 784, 179 0	5. 00 6. 00
7. 00	00700 OPERATION OF PLANT	145, 915	-	2, 455, 927	,	11, 641, 294	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	4, 167	4, 167		0	897, 466	8. 00
9.00	00900 HOUSEKEEPI NG	4, 127	4, 127			3, 930, 411	9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	10, 673 3, 869				2, 249, 350 1, 908, 086	10. 00 11. 00
12. 00	01200 MAI NTENANCE OF PERSONNEL	3,007	0,007	1, 311, 000		1, 300, 000	12. 00
13.00	01300 NURSING ADMINISTRATION	1, 861	1, 861	2, 641, 787	0	3, 499, 808	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	14, 966				1, 997, 693	14.00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	5, 754	5, 754	152, 312	2 0	2, 047, 704	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	738	738	988, 759		1, 388, 937	17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	О		0	0	18. 00
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	C	0	0	19. 00
20. 00 21. 00	02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	(0	0	20. 00 21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0				0	22. 00
23. 00	02300 PARAMED ED PRGM	207	207	66, 546	0	131, 450	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	107.0/4	127.0/4	1 22 ((0.07)		40 407 /57	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	127, 864 11, 095				49, 487, 657 11, 707, 088	30. 00 31. 00
31. 01	03101 NEONATAL INTENSIVE CARE	2, 330				2, 058, 028	31. 01
32.00	03200 CORONARY CARE UNIT	0	0	C	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	10, 912	10, 912	2, 012, 941		0 2, 802, 674	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	537	537	130, 477		117, 010	41. 00
43.00	04300 NURSERY	10, 207	10, 207	2, 598, 896	0	3, 686, 596	43. 00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		0	0	44. 00 45. 00
46. 00	04600 OTHER LONG TERM CARE				,		46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	58, 586		12, 175, 518	0		50.00
51. 00 52. 00	O5100 RECOVERY ROOM O5200 DELIVERY ROOM & LABOR ROOM	0	0			0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	Ö	Ö	d	o o	Ö	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	44, 886	44, 886	5, 986, 077	0	9, 381, 581	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	-	686, 489	o o	1, 966, 706	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 587				839, 222	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	4, 072				2, 002, 197	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	5, 429	5, 429 0	2, 606, 565		11, 722, 401 0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_		0		61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(0	0	62.00
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	7, 765	7, 765	1, 203, 090	0	0 1, 905, 191	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	1, 804				4, 321, 324	65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 967	4, 967			2, 304, 396	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	2, 385				876, 811	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 430	1, 430	259, 964	0	369, 694 0	68. 00 69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		o o	Ö	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	0	10, 778, 364	71. 00
72.00	07200 DRUCS CHARGED TO PATIENTS	0	0	4 422 50	0	20, 096, 516	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0		4, 422, 507		25, 498, 380 0	73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	Ö		o o	Ö	75. 00
76. 00	03140 CARDI OLOGY	11, 396	11, 396	1, 961, 662	2 0	2, 791, 093	76. 00
77. 00	07700 ALLOGENEI C HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	1 0	1 0) 0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		•			

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

			1	o 12/31/2022	Date/lime Pre 5/31/2023 12:	
	CAPITAL REL	ATED COSTS			3/31/2023 12.	T4 piii
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
oost oontor bescription	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	Traction Traction	& GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS			
	1.00	2. 00	SALARI ES) 4. 00	5A	5. 00	
90. 00 09000 CLI NI C	4, 737	4, 737	416, 587			90.00
90. 01 04950 SLEEP CLINIC	0	0	332, 958	0	497, 330	90. 01
91. 00 09100 EMERGENCY	16, 656	16, 656	9, 055, 112	. 0	14, 611, 213	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT 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			l e	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	_			97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	_	1	98.00
99. 00 09900 CMHC 99. 10 09910 CORF	0	0	Ĭ	_	1	99. 00 99. 10
100.00 10000 &R SERVICES-NOT APPRVD PRGM	0	0			1	100.00
101. 00 10100 HOME HEALTH AGENCY	0	Ö	_	_		101. 00
102.00 10200 OPIOID TREATMENT PROGRAM	0	0	0	0	0	102. 00
SPECIAL PURPOSE COST CENTERS	1 0			.1		1405 00
105.00 10500 KIDNEY ACQUISITION 106.00 10600 HEART ACQUISITION	0	0				105. 00 106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0				107. 00
108. 00 10800 LUNG ACQUISITION	0	Ö	Ö	_		108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON	0	0	0	0		110.00
111.00 11100 I SLET ACQUI SI TI ON 113.00 11300 INTEREST EXPENSE	0	0	0	0	0	111. 00 113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115. 00
116. 00 11600 H0SPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	535, 011	535, 011	98, 329, 406	-40, 312, 485	234, 543, 988	118. 00
NONREI MBURSABLE COST CENTERS	0	0	0	0		100 00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 191.00 19100 RESEARCH	0	0				190. 00 191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	12, 272	12, 272			l	1
193. 00 19300 NONPALD WORKERS	. 0	. 0	41, 372	. 0		
193. 01 19301 COMMUNI TY	4, 199				,	
194. 00 07950 OTHER NONREIMBURSABLE COST CENTERS	129, 589	129, 589	1, 046, 045	0	9, 127, 312	
200.00 Cross Foot Adjustments 201.00 Negative Cost Centers						200. 00 201. 00
202.00 Cost to be allocated (per Wkst. B,	15, 821, 989	3, 787, 921	1, 512, 536		40, 312, 485	
Part I)	,	2, . 2 . , . 2 .	1, 512, 522		12, 212, 100	
203.00 Unit cost multiplier (Wkst. B, Part I)	23. 231042	5. 561712			0. 164686	
204.00 Cost to be allocated (per Wkst. B,			3, 887		139, 949	204. 00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part			0. 000039		0. 000572	205 00
II)			0.000037		0.000372	
206.00 NAHE adjustment amount to be allocated						206. 00
(per Wkst. B-2)						207.00
207.00 NAHE unit cost multiplier (Wkst. D, Parts III and IV)						207. 00
1 1. 6	T.		ı	T.	ı	1

Period: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/31/2023 12: 14 pm

	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	5/31/2023 12: DI ETARY	
	cost center bescription	REPAI RS	PLANT	LI NEN SERVI CE	(HOURS OF	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF LAUNDRY)	SERVI CE)		
		6. 00	7. 00	8.00	9. 00	10.00	
1 00	GENERAL SERVICE COST CENTERS		ı	I			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	00600 MAI NTENANCE & REPAI RS	676, 081	F20 144				6.00
7. 00 8. 00	OO7OO OPERATION OF PLANT OO8OO LAUNDRY & LINEN SERVICE	145, 915 4, 167	530, 166 4, 167				7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	4, 127	1		107, 020		9. 00
10. 00	01000 DI ETARY	10, 673		1	183		1
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL	3, 869	3, 869		548 0	0	
13. 00	01300 NURSING ADMINISTRATION	1, 861	1, 861	_	730		
14. 00	01400 CENTRAL SERVICES & SUPPLY	14, 966			0	l	1
15. 00	01500 PHARMACY	5, 754	5, 754	0	730	0	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	738	0 738	0	0	0	16. 00 17. 00
	01850 OTHER GENERAL SERVICE (SPECIFY)	0		o o	0	Ö	18. 00
	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
	02000 NURSI NG PROGRAM	0	0	0	0	0	
21. 00 22. 00	02100 1 & R SERVI CES-SALARY & FRINGES APPRVD 02200 1 & R SERVI CES-OTHER PRGM COSTS APPRVD				0	0	21. 00 22. 00
23. 00	02300 PARAMED ED PRGM	207	207	_	183	· -	1
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDIATRICS	127, 864			48, 110	l	1
31. 00 31. 01	03100 INTENSI VE CARE UNIT 03101 NEONATAL INTENSI VE CARE	11, 095 2, 330	1		6, 205 244	16, 084 0	1
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	10, 912	0 10, 912	0 2 7, 933	0 3, 103	0 11, 239	
41. 00	04100 SUBPROVI DER – TFF	537	537		3, 103		1
43. 00	04300 NURSERY	10, 207	10, 207		244	0	1
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	
40.00	ANCI LLARY SERVI CE COST CENTERS			,, ,	0		40.00
50. 00	05000 OPERATI NG ROOM	58, 586		142, 644	0		
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY			0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	44, 886	44, 886	116, 247	9, 490	0	54.00
55. 00	O5500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 57. 00	05600	7, 099	7, 099	19, 529	1, 460	0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	3, 587			1, 095		1
59. 00	05900 CARDI AC CATHETERI ZATI ON	4, 072			0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY	5, 429	5, 429	0	1, 460	0	60. 00 60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		٥	,	0		61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	
63. 00 64. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0 7 7/5	0	0	0	
65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	7, 765 1, 804			2, 008 1, 460	l	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 967			1, 460	l	1
67. 00	06700 OCCUPATI ONAL THERAPY	2, 385			730	l e	67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	1, 430	1, 430	0	365	0	68. 00 69. 00
	07000 ELECTROENCEPHALOGRAPHY				0	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	o	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS			0	0	0	73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		0	o o	0	ő	1
76. 00	03140 CARDI OLOGY	11, 396		30, 668	1, 460	l	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0] 0	0	0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	0	n	0	Ω	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	o o	0	0	89. 00
90.00	09000 CLINIC	4, 737	4, 737	10, 229	1, 825	l	
90. 01 91. 00	04950 SLEEP CLINIC 09100 EMERGENCY	16, 656	16, 656	223, 973	0 13, 505	0	1
	1	, 300	1 .5, 500	1 223,770	.5,500	ı	1 00

				10) 12/31/2022	5/31/2023 12:	
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	,	REPAI RS	PLANT	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	SERVICE)		
				LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10. 00	
	9200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	THER REIMBURSABLE COST CENTERS						
	9400 HOME PROGRAM DIALYSIS	0	1	ή	0	0	94. 00
	9500 AMBULANCE SERVICES	0	0	0	0	0	95. 00
	9600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
	9700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
	9850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	70.00
	9900 CMHC	0	0	0	0	0	
	9910 CORF	0	0	0	0	0	99. 10
	0000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
	0100 HOME HEALTH AGENCY	0	1	1	0		101. 00
	0200 OPI OI D TREATMENT PROGRAM	0	0	0	0	0	102. 00
	PECIAL PURPOSE COST CENTERS	1					
	0500 KIDNEY ACQUISITION	0		1	0		105. 00
	0600 HEART ACQUISITION	0		1	0		106. 00
	0700 LIVER ACQUISITION	0	1	1	0		107. 00
	0800 LUNG ACQUISITION	0	0	0	0		108. 00
	0900 PANCREAS ACQUISITION	0	0	0	0		109. 00
	1000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
	1100 I SLET ACQUI SI TI ON	0	0	0	0	0	111. 00
	1300 I NTEREST EXPENSE						113. 00
1	1400 UTILIZATION REVIEW-SNF						114. 00
	1500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115. 00
	1600 HOSPI CE	0	0	0	0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	530, 021	384, 106	1, 263, 596	96, 617	164, 559	1118. 00
	ONREI MBURSABLE COST CENTERS						
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		1	0		190. 00
	9100 RESEARCH	0	1	1	1 4/0		191. 00
	9200 PHYSI CI ANS' PRI VATE OFFI CES	12, 272	12, 272	. 0	1, 460		192. 00
	9300 NONPALD WORKERS	4 100	4 100	0	0		193. 00
	9301 COMMUNITY	4, 199			0.043		193. 01
	07950 OTHER NONREIMBURSABLE COST CENTERS	129, 589	129, 589	' 0	8, 943	0	194. 00
200. 00 201. 00	Cross Foot Adjustments						200. 00 201. 00
	Negative Cost Centers		12 550 452	1 151 022	4 (02 220	2 000 745	
202. 00	Cost to be allocated (per Wkst. B, Part I)	0	13, 558, 452	1, 151, 833	4, 683, 239	2, 900, 745	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	25. 573975	0. 911552	43. 760409	17. 627386	202 00
203.00	Cost to be allocated (per Wkst. B,	0.00000			153, 917		1
204.00	Part II)	0	4, 200, 049	155, 567	133, 917	393, 010	204.00
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	7. 937229	0. 121532	1. 438208	2. 391945	205 00
203.00	11)	0.00000	1. 737227	0. 121332	1. 430200	2. 371743	203.00
206, 00	NAHE adjustment amount to be allocated						206. 00
200.00	(per Wkst. B-2)						
207. 00	NAHE unit cost multiplier (Wkst. D,						207. 00
	Parts III and IV)						
		•	•			•	•

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-0018 Peri od: From 01/01/2022 To 12/31/2022 Worksheet B-1 To 12/31/2022 Date/Time Prepared: 5/31/2023 12:14 pm

CENTRAL PHARMACY Cost Center Description CAFETERIA MAINTENANCE OF NURSING

	Cost Center Description	(HOURS OF SERVICE)	(NUMBER HOUSED)	ADMINISTRATION (DIRECT NURS. HRS.)	CENTRAL SERVI CES & SUPPLY (COSTED REQUIS.)	PHARMACY (COSTED REQUIS.)	
	GENERAL SERVICE COST CENTERS	11.00	12.00	13. 00	14. 00	15. 00	
1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING PROGRAM 02100 I&R SERVICES-SALARY & FRINGES APPRVD 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	1, 979, 437 0 48, 153 40, 742 2, 080 0 29, 790 0 0 0 0	0 0 0 0 0 0 0 0	796, 199 0 0 0 2, 452 0 0 0 0	1000 0 0 0 0 0 0 0 0	21, 378, 909 0 0 0 0 0 0 0	1. 00 2. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00
30. 00 31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	512, 640 132, 625 24, 327 0 0 44, 004 1, 228 45, 078 0	0 0 0 0 0 0 0 0	321, 967 109, 891 21, 688 0 0 0 19, 755 787 36, 646 0 0	0 0 0 0 0 0 0 0 0	8, 476 3, 855 0 0 0 0 1 0 0 0 0	30. 00 31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00 44. 00 45. 00 46. 00
50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 60. 01 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 75. 00 76. 00 77. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07000 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03140 CARDI OLOGY 07700 ALLOGENEI C HSCT ACQUI SI TI ON 0UTPATI ENT SERVI CE COST CENTERS	233, 952 0 0 151, 043 0 17, 773 12, 765 35, 679 104, 066 0 27, 664 47, 399 39, 343 14, 756 7, 243 0 0 0 101, 005 0 49, 653	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	116, 644 0 0 0 18, 763 0 0 17, 311 0 0 22, 252 0 0 0 0 0 7, 613	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	151, 028 0 0 0 3, 158 0 0 0 542 0 0 7, 934 121, 087 0 0 0 0 0 21, 027, 543 0 52, 200	60. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 77. 00
88. 00 89. 00 90. 00 90. 01	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0 0 11, 210 9, 465		0 0 8 0	0 0 0 0	0 0 0 0	88. 00 89. 00 90. 00 90. 01

Health Financial Systems ELKHART GENERAL HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0018 Peri od: Worksheet B-1 From 01/01/2022 12/31/2022 Date/Time Prepared: 5/31/2023 12:14 pm Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** (HOURS OF PERSONNEL ADMI NI STRATI ON SERVICES & (COSTED SERVICE) (NUMBER **SUPPLY** REQUIS.) HOUSED) (DIRECT NURS (COSTED REQUIS.) HRS.) 12.00 15.00 11.00 13.00 14.00 3, 085 91. 00 09100 EMERGENCY 203, 426 100, 422 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 94.00 09500 AMBULANCE SERVICES 0 95.00 95.00 00000000 0 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 97.00 0 0 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 99. 10 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100, 00 0 101.00 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 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106. 00 10600 HEART ACQUISITION 0 0 106.00 0 0 0 0 0 107. 00 10700 LIVER ACQUISITION 0 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 0 0 108, 00 109.00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 o O 0 111.00 C 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116, 00 Ω 0 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 948, 662 796, 199 100 21, 378, 909 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00 0 0 0 0 191.00 191. 00 19100 RESEARCH 0 Ω 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 193. 00 1, 249 0 0 193. 01 19301 COMMUNI TY 0 0 0 193. 01 9.653 194.00 07950 OTHER NONREIMBURSABLE COST CENTERS 0 194. 00 19.873 0 0 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 2, 566, 494 202. 00 202.00 Cost to be allocated (per Wkst. B, 2, 345, 248 4, 212, 767 2, 757, 696 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 1.184806 0.000000 5. 291098 27, 576. 960000 0. 120048 203. 00 204.00 Cost to be allocated (per Wkst. B, 144,038 75,013 553, 843 213, 722 204. 00 Part II) 0.009997 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.072767 0.000000 0.094214 5, 538. 430000

206.00

207.00

11)

(per Wkst. B-2)

Parts III and IV)

NAHE adjustment amount to be allocated

NAHE unit cost multiplier (Wkst. D,

206.00

207.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Peri od: From 01/01/2022 To 12/31/2022 Date/Time Prepared: 5/31/2023 12:14 pm Provider CCN: 15-0018

						5/31/2023 12:	14 pm
	Cost Center Description	MEDI CAL RECORDS & LI BRARY (REVENUE)	SOCIAL SERVICE	(TIME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	NURSI NG PROGRAM (ASSI GNED TI ME)	
	CENEDAL CEDALOS COCT CENTEDO	16. 00	17. 00	18. 00	19. 00	20. 00	
1. 00	GENERAL SERVICE COST CENTERS OO100 CAP REL COSTS-BLDG & FIXT		I	I			1.00
2.00	00200 CAP REL COSTS-BLDG & TTXT						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 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY						9. 00 10. 00
11. 00	01100 CAFETERI A						11.00
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	01500 PHARMACY						15. 00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	11, 660				16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	11,000	0			18.00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	Ō	0		19. 00
20.00	02000 NURSI NG PROGRAM	0	0	0		0	20. 00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRVD	0	0	0			21. 00
22. 00 23. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0			22. 00
23.00	02300 PARAMED ED PRGM NPATIENT ROUTINE SERVICE COST CENTERS	0					23. 00
30.00	03000 ADULTS & PEDI ATRI CS	0	8, 695	0	0	0	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	1, 134			0	
31. 01	03101 NEONATAL INTENSIVE CARE	0	82			0	1
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0		_	0	
34. 00	03400 SURGI CAL I NTENSI VE CARE UNI T	0					
40. 00	04000 SUBPROVI DER - I PF	0	524			Ö	
41.00	04100 SUBPROVI DER - I RF	0	11	0	0	0	41. 00
43. 00	04300 NURSERY	0	1, 214		_	0	43. 00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		_	0	44. 00 45. 00
46. 00	04500 OTHER LONG TERM CARE	0					1
.0.00	ANCI LLARY SERVI CE COST CENTERS						1 .0. 00
50.00	05000 OPERATING ROOM	0					1
51.00	05100 RECOVERY ROOM	0	0				
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0	0	0	_	0	52. 00 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	Ö	0	0	1
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
	05700 CT SCAN	0	0	0	0	0	1
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0	0	_	0	
60.00	06000 LABORATORY	Ö	0	Ö	0	Ö	1
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 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0		1
65. 00	06500 RESPI RATORY THERAPY	0	Ö	Ö	0	Ö	1
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 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0	0	0	0	68. 00 69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	Ö	0	Ö	0	Ö	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	Ō	o	0	1
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03140 CARDI OLOGY		0	0	0	0	
	07700 ALLOGENEIC HSCT ACQUISITION		0				1
	OUTPATIENT SERVICE COST CENTERS		·			-	
	08800 RURAL HEALTH CLINIC	0	1				
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				
70.00	10,000 OF IMI O	1 0	1 0	ı	ı U	ı	1 70.00

				10	0 12/31/2022	Date/IIme Pre 5/31/2023 12:	
				OTHER GENERAL		070172020 12.	
				SERVI CE			
Co	ost Center Description	MEDI CAL	SOCIAL SERVICE	(SPECI FY)	NONPHYSI CI AN	NURSI NG	
		RECORDS &		(TIME SPENT)	ANESTHETI STS	PROGRAM	
		LIBRARY	(TIME SPENT)		(ASSI GNED	(ASSI GNED	
	•	(REVENUE)	17.00	10.00	TIME)	TI ME)	
90. 01 04950 SL	EEP CLINIC	16. 00	17. 00	18.00	19. 00 0	20.00	90, 01
91. 00 09100 EM		0	C	1	-	0	
	SSERVATION BEDS (NON-DISTINCT PART)	O			O	O	92.00
	EI MBURSABLE COST CENTERS						72.00
	OME PROGRAM DIALYSIS	0	C	0	0	0	94. 00
1 1	MBULANCE SERVICES	0	Ċ		-	0	95. 00
1 1	JRABLE MEDICAL EQUIP-RENTED	0	C	0	0	0	96. 00
97. 00 09700 DU	JRABLE MEDICAL EQUIP-SOLD	0	C	o	0	0	97. 00
98. 00 09850 OT	THER REIMBURSABLE COST CENTERS	0	C	o	0	0	98. 00
99.00 09900 CM	MHC	0	C	o	0	0	99. 00
99. 10 09910 CO)RF	0	C	o	0	0	99. 10
100.00 10000 I &	R SERVICES-NOT APPRVD PRGM	0	C	0	0	0	100.00
101.00 10100 HO	DME HEALTH AGENCY	0	C	0	0	0	101. 00
	PIOID TREATMENT PROGRAM	0	C	0	0	0	102. 00
	PURPOSE COST CENTERS						
	DNEY ACQUISITION	0	_	•			105. 00
1 1	EART ACQUISITION	0	C	1			106. 00
	VER ACQUISITION	0	C	1	-		107. 00
	JNG ACQUISITION	0	C	0	0		108. 00
	ANCREAS ACQUISITION	0	C	0	0		109. 00
	NTESTINAL ACQUISITION	0		0	0		110.00
1 1	SLET ACQUI SI TI ON	0	C	0	0	0	111.00
	ITEREST EXPENSE ILIZATION REVIEW-SNF						113. 00 114. 00
1 1	MBULATORY SURGICAL CENTER (D.P.)	0	,	0	0	0	115. 00
116. 00 11600 HO		0			-		116. 00
	JBTOTALS (SUM OF LINES 1 through 117)	0	11, 660				118.00
	BURSABLE COST CENTERS	0	11,000	<u>/</u>	٥		1110.00
	FT, FLOWER, COFFEE SHOP & CANTEEN	0	C	0	0	0	190. 00
191. 00 19100 RE		0					191. 00
1 1	HYSI CLANS' PRI VATE OFFI CES	0	Č				192. 00
193. 00 19300 NO		0	Č	o o	0		193. 00
193. 01 19301 CO		0	Ċ	o	0		193. 01
	THER NONREIMBURSABLE COST CENTERS	0	Ċ	o	0		194. 00
1 1	ross Foot Adjustments						200. 00
	egative Cost Centers						201. 00
202. 00 Co	ost to be allocated (per Wkst. B,	0	1, 684, 818	o	0	0	202. 00
Pa	art I)						
1 1	nit cost multiplier (Wkst. B, Part I)	0. 000000	144. 495540	0. 000000	0. 000000	0.000000	
	ost to be allocated (per Wkst. B,	0	30, 340	0	0	0	204. 00
1 1	art II)						
	nit cost multiplier (Wkst. B, Part	0. 000000	2. 602058	0. 000000	0. 000000	0. 000000	205. 00
204 00						^	20/ 00
	AHE adjustment amount to be allocated					0	206. 00
	per Wkst. B-2) AHE unit cost multiplier (Wkst. D,					0. 000000	207 00
	arts III and IV)					0. 000000	207.00
Fa	ares iii unu iv)		1	1			ı

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 15-0018

Peri od: Worksheet B-1 From 01/01/2022 To 12/31/2022 Date/Ti me Prepared:

5/31/2023 12:14 pm INTERNS & RESIDENTS Cost Center Description SERVI CES-SALAR SERVI CES-OTHER PARAMED ED Y & FRINGES PRGM COSTS PRGM (ASSI GNED (ASSI GNED (ASSI GNED TIME) TIME) TIME) 21.00 23.00 22.00 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 7.00 00700 OPERATION OF PLANT 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 12.00 01200 MAINTENANCE OF PERSONNEL 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 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSI NG PROGRAM 20.00 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 0 21 00 22. 00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 02300 PARAMED ED PRGM 23.00 100 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 0 0 0 30.00 03100 INTENSIVE CARE UNIT 0 0 31.00 0000000 31.00 0 31.01 03101 NEONATAL INTENSIVE CARE 31.01 03200 CORONARY CARE UNIT 0 32.00 0 32.00 0 33.00 03300 BURN INTENSIVE CARE UNIT C 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 40.00 0 40.00 0 41.00 C 41 00 04300 NURSERY 43.00 0 43.00 0 04400 SKILLED NURSING FACILITY 0 44.00 0 44.00 0 04500 NURSING FACILITY 45.00 45.00 0 46.00 04600 OTHER LONG TERM CARE 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 50.00 05100 RECOVERY ROOM 000000000000 0 51.00 0 51.00 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 0 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 56.00 05600 RADI OI SOTOPE 56.00 0 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 58 00 58 00 Ω 0 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 0 0 60.00 60.00 06001 BLOOD LABORATORY 0 0 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61 00 61 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62.00 0000000000000000 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0 65 00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 67.00 06800 SPEECH PATHOLOGY 0 68.00 0 68.00 0 06900 ELECTROCARDI OLOGY 69.00 0 69.00 07000 ELECTROENCEPHALOGRAPHY С 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72.00 Ω 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 07400 RENAL DIALYSIS 0 74.00 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 0 76.00 03140 CARDI OLOGY 0 76.00 07700 ALLOGENEIC HSCT ACQUISITION 77.00 77.00 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 0 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 89.00 90. 00 09000 CLINIC 0 0 90.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS | Peri od: | Worksheet B-1 | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: Provider CCN: 15-0018

				11	5/31/2022 Date/lime F 5/31/2023 1	
		INTERNS &	RESIDENTS		3/31/2023	12. 14 piii
		1111211110 0				
	Cost Center Description	SERVI CES-SALAR	SERVI CES-OTHER	PARAMED ED		
		Y & FRINGES	PRGM COSTS	PRGM		
		(ASSI GNED	(ASSI GNED	(ASSI GNED		
		TIME)	TIME)	TIME)		
00.01.0105	Journa Communication of the Co	21. 00	22. 00	23. 00		00.01
	SLEEP CLINIC	0	0	0		90. 01
	EMERGENCY	0	0	100		91. 00 92. 00
	OBSERVATION BEDS (NON-DISTINCT PART) REIMBURSABLE COST CENTERS					92.00
	HOME PROGRAM DIALYSIS	0	0	0		94. 00
	AMBULANCE SERVICES	0	0	0		95. 00
	DURABLE MEDICAL EQUIP-RENTED	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		0	0	0		99. 00
99. 10 09910		0	0	0		99. 10
	I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
	HOME HEALTH AGENCY	0	0	0		101. 00
	OPIOID TREATMENT PROGRAM	0	0	0		102. 00
	AL PURPOSE COST CENTERS	'				
105.00 10500	KIDNEY ACQUISITION	0	0	0		105. 00
106.00 10600	HEART ACQUISITION	0	0	0		106. 00
107. 00 10700	LIVER ACQUISITION	0	0	0		107. 00
108.00 10800	LUNG ACQUISITION	0	0	0		108. 00
	PANCREAS ACQUISITION	0	0	0		109. 00
	INTESTINAL ACQUISITION	0	0	0		110. 00
	ISLET ACQUISITION	0	0	0		111. 00
	INTEREST EXPENSE					113. 00
	UTILIZATION REVIEW-SNF					114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0		115. 00
116.00 11600	l .			0		116. 00
118. 00	SUBTOTALS (SUM OF LINES 1 through 117)	0	0	100		118. 00
	I MBURSABLE COST CENTERS		٥	0		100.00
190.00 19000	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0		190. 00 191. 00
	PHYSICIANS' PRIVATE OFFICES	0	0	0		191.00
	NONPALD WORKERS	0	0	0		193. 00
193. 00 19300		0	0	0		193. 00
-	OTHER NONREIMBURSABLE COST CENTERS	0	0	0		194. 00
200.00	Cross Foot Adjustments		O	O		200. 00
201.00	Negative Cost Centers					201. 00
202.00	Cost to be allocated (per Wkst. B,	0	0	168, 240		202. 00
202.00	Part I)		Ŭ	100, 210		202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	1, 682. 400000		203. 00
204.00	Cost to be allocated (per Wkst. B,	0	0	8, 057		204. 00
	Part II)					
205.00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	80. 570000		205. 00
	11)					
206. 00	NAHE adjustment amount to be allocated			0		206. 00
	(per Wkst. B-2)					
207. 00	NAHE unit cost multiplier (Wkst. D,			0. 000000		207. 00
	Parts III and IV)	1				I

	i Financiai Systems	ELKHART GENER				eu of Form CMS	2552-10
COMPUT	FATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre	nared:
			T: 11			5/31/2023 12:	14 pm
			litle	XVIII	Hospi tal Costs	PPS	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col. 26)					
		1.00	2.00	3.00	4. 00	5. 00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	69, 508, 174	I	69, 508, 17	4 0	69, 508, 174	30.00
31. 00	03100 I NTENSI VE CARE UNI T	15, 460, 334		15, 460, 33			
31. 01	03101 NEONATAL INTENSIVE CARE	2, 623, 558		2, 623, 55	8 0	2, 623, 558	
32. 00 33. 00	03200 CORONARY CARE UNIT	0			0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	34. 00
40.00	04000 SUBPROVI DER - I PF	4, 116, 810		4, 116, 810		4, 116, 810	
41. 00 43. 00	04100 SUBPROVI DER - I RF 04300 NURSERY	170, 284 5, 013, 005		170, 28, 5, 013, 00		170, 284 5, 013, 005	
44. 00	04400 SKILLED NURSING FACILITY	0,013,003		5,013,00	0 0	0,013,003	44. 00
45. 00	04500 NURSING FACILITY	0			0 0	0	45. 00
46. 00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0			0	0	46. 00
50. 00	05000 OPERATING ROOM	30, 899, 124		30, 899, 12	4 0	30, 899, 124	50.00
51.00	05100 RECOVERY ROOM	0			0 0	0	51. 00
52. 00 53. 00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	0			0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY – DI AGNOSTI C	12, 874, 373		12, 874, 37	3 0	_	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			0 0	0	55. 00
56.00	05600	0		2 574 901	0	0	56.00
57. 00 58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 574, 895 1, 144, 253		2, 574, 899 1, 144, 253		2, 574, 895 1, 144, 253	
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 570, 000		2, 570, 000		2, 570, 000	
60.00	06000 LABORATORY	13, 978, 945		13, 978, 94	5 0	13, 978, 945	
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0		2 (5(0()	0	0	63. 00 64. 00
64. 00 65. 00	06500 RESPIRATORY THERAPY	2, 656, 868 5, 213, 706		2, 656, 866 5, 213, 70		2, 656, 868 5, 213, 706	1
66.00	06600 PHYSI CAL THERAPY	2, 929, 329	0	2, 929, 32	9 0	2, 929, 329	66. 00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY	1, 131, 631		1, 131, 63		1, 131, 631	
69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	491, 703 0		491, 70	0 0	491, 703 0	68. 00 69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	70. 00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	13, 518, 604 25, 198, 633		13, 518, 60, 25, 198, 63		13, 518, 604 25, 198, 633	
73. 00	07300 DRUGS CHARGED TO PATIENTS	32, 341, 590		32, 341, 59			
74. 00	07400 RENAL DIALYSIS	0			0 0	0	74. 00
75. 00 76. 00	07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY	0 3, 739, 410		3, 739, 410	0 0		
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0,737,410		1	0 0		
	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	1, 017, 789	•	1, 017, 78	9	1, 017, 789	1
90. 01	04950 SLEEP CLINIC	590, 447		590, 44		590, 447	
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	19, 179, 555 8, 494, 462		19, 179, 55 8, 494, 46		19, 179, 555 8, 494, 462	
72.00	OTHER REIMBURSABLE COST CENTERS	0, 474, 402		0, 474, 40.		0, 474, 402	72.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0	1	•	0	•	94. 00
95. 00 96. 00	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0			0	0	95. 00 96. 00
97. 00		0			0 0	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0			0 0	0	98. 00
99.00	09900	0			0	0	99. 00 99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0					100.00
	10100 HOME HEALTH AGENCY	0			C		
102.00	D10200 OPIOID TREATMENT PROGRAM SPECIAL PURPOSE COST CENTERS	0			0	0	102. 00
105.00	10500 KIDNEY ACQUISITION	0			0	0	105. 00
106.00	10600 HEART ACQUISITION	0				0	106. 00
	D10700 LIVER ACQUISITION D10800 LUNG ACQUISITION	0		!))		107. 00 108. 00
	10900 PANCREAS ACQUISITION				o o		108.00
110.00	11000 INTESTINAL ACQUISITION	0			O O	0	110. 00
	D11100 SLET ACQUISITION D11300 NTEREST EXPENSE	0		'	ט	0	111. 00 113. 00
113.00	DITTOOU TINTENEDT EAFENDE	1	I	I	1	I	1113.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider (CCN: 15-0018	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/31/2023 12:	pared: 14 pm
		Ti tl	e XVIII	Hospi tal	PPS	
		·		Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	

0

1.00

277, 437, 482 8, 494, 462 268, 943, 020

114.00 11400 UTI LI ZATI ON REVI EW-SNF 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116.00 11600 HOSPI CE

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

200. 00 201. 00 202. 00 2.00

3.00

277, 437, 482 8, 494, 462 268, 943, 020 4. 00

5. 00

114. 00

0 115.00

0 113.00 0 116.00 277, 437, 482 200.00 8, 494, 462 201.00 268, 943, 020 202.00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2022 | Part | To 12/31/2022 | Date/Time Prepared: | 5/31/2023 12:14 pm Health Financial Systems

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

		Title	e XVIII	Hospi tal	5/31/2023 12: PPS	14 pm
		Charges				
Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
			+ col . 7)	Ratio	Inpatient Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	143, 057, 603		143, 057, 603			30.00
31. 00 03100 NTENSI VE CARE UNI T	30, 094, 830		30, 094, 830			31. 00
31. 01 03101 NEONATAL INTENSIVE CARE	2, 124, 072		2, 124, 072			31. 01
32. 00 03200 CORONARY CARE UNIT	0		, , , ,			32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0		(33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	(557 050		(557.05(34. 00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	6, 557, 950 222, 601		6, 557, 950 222, 60°			40. 00 41. 00
43. 00 04300 NURSERY	3, 558, 000		3, 558, 000			43. 00
44.00 04400 SKILLED NURSING FACILITY	0					44. 00
45. 00 04500 NURSING FACILITY	0					45. 00
46.00 O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0)		46. 00
50. 00 05000 OPERATING ROOM	31, 514, 460	68, 323, 353	99, 837, 813	0. 309493	0. 000000	50.00
51. 00 05100 RECOVERY ROOM	0	0			0. 000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	0	(0. 000000	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	15, 213, 513	56, 669, 277	71, 882, 790	0. 000000 0. 179102	0. 000000 0. 000000	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	15, 213, 513	00,009,277	/1,002,790		0. 000000	1
56. 00 05600 RADI OI SOTOPE	0	0			0. 000000	
57. 00 05700 CT SCAN	25, 399, 511	49, 954, 959			0. 000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	3, 386, 695	9, 207, 805			0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	15, 439, 666 52, 242, 001	22, 023, 208 32, 472, 847			0. 000000 0. 000000	
60. 01 06001 BLOOD LABORATORY	0	0 32, 472, 047	04, 714, 040	0. 000000	0. 000000	
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 06300 BLOOD STORING, PROCESSING & TRANS.	0	0 570 2/5	4 741 000	0.000000	0.000000	
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	2, 168, 638 20, 661, 690	2, 572, 365 2, 377, 280			0. 000000 0. 000000	
66. 00 06600 PHYSI CAL THERAPY	3, 292, 533	2, 657, 498			0. 000000	
67. 00 06700 OCCUPATI ONAL THERAPY	2, 723, 823	932, 043			0. 000000	
68. 00 06800 SPEECH PATHOLOGY	881, 414	592, 049	1, 473, 463		0. 000000	
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0. 000000 0. 000000	0. 000000 0. 000000	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	47, 817, 227	50, 078, 658	97, 895, 885		0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	60, 928, 997	82, 001, 844			0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	77, 943, 193	108, 951, 842	186, 895, 035		0. 000000	
74. 00 07400 RENAL DIALYSIS	0	0	(0.000000	
75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 03140 CARDI OLOGY	7, 326, 455	18, 359, 674	25, 686, 129	0. 000000 0. 145581	0. 000000 0. 000000	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0	0, 337, 674	25,000,12		0. 000000	
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	(88. 00
90. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	1, 452	1, 124, 318	1, 125, 770	0. 904083	0. 000000	89. 00 90. 00
90. 01 04950 SLEEP CLI NI C	0	2, 405, 125			0. 000000	
91. 00 09100 EMERGENCY	12, 534, 900				0. 000000	91. 00
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART)	3, 111, 745	16, 626, 230	19, 737, 975	0. 430361	0. 000000	92. 00
94. 00 O9400 HOME PROGRAM DI ALYSI S	0	0		0.00000	0. 000000	94. 00
95. 00 09500 AMBULANCE SERVI CES		0	1		0. 000000	1
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	O	0			0. 000000	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0			0. 000000	1
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 99. 00 09900 CMHC	0	0			0. 000000	98. 00 99. 00
99. 10 09910 CORF	0	0				99. 00
100.00 10000 I &R SERVICES-NOT APPRVD PRGM	l ől	Ö	Ò	1		100.00
101.00 10100 HOME HEALTH AGENCY	0	0	1			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 ACQUISITION		0	1			106. 00
107. 00 10700 LI VER ACQUI SI TI ON		0				107. 00
108. 00 10800 LUNG ACQUISITION	0	0	(108. 00
109.00 10900 PANCREAS ACQUISITION 110.00 11000 INTESTINAL ACQUISITION	0	0				109. 00 110. 00
111. 00 11100 I SLET ACQUISITION) 				111.00
113.00 11300 INTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00

Health Financial Systems	ELKHART GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der C		Period: From 01/01/2022	Worksheet C Part I	
				To 12/31/2022	Date/Time Pre 5/31/2023 12:	pared: 14 pm_
		Title	: XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
			+ col. 7)	Rati o	Inpatient	
					Ratio	
	6.00	7. 00	8. 00	9. 00	10.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		O		115. 00
116. 00 11600 HOSPI CE	0	0		c		116. 00
200.00 Subtotal (see instructions)	568, 202, 969	559, 339, 794	1, 127, 542, 76	3		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	568, 202, 969	559, 339, 794	1, 127, 542, 76	3		202. 00

5/31/2023 12:14 pm Title XVIII Hospi tal PPS Cost Center Description PPS Inpatient Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 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 04000 SUBPROVIDER - IPF 40.00 40.00 41.00 04100 SUBPROVIDER - IRF 41.00 43 00 04300 NURSERY 43.00 04400 SKILLED NURSING FACILITY 44.00 44 00 45.00 04500 NURSING FACILITY 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 50.00 0.309493 51.00 05100 RECOVERY ROOM 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0. 179102 54.00 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 56.00 05600 RADI OI SOTOPE 0.000000 56.00 0.034170 05700 CT SCAN 57.00 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.090853 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.068601 59.00 60.00 06000 LABORATORY 0. 165012 60.00 06001 BLOOD LABORATORY 60.01 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0.000000 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 06400 I NTRAVENOUS THERAPY 0.560402 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0. 226299 65.00 06600 PHYSI CAL THERAPY 66.00 0. 492322 66.00 06700 OCCUPATIONAL THERAPY 67 00 0.309538 67 00 06800 SPEECH PATHOLOGY 68.00 0.333706 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.138092 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 72.00 0.176299 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 173047 73.00 74.00 07400 RENAL DIALYSIS 0.000000 74 00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 75.00 76. 00 03140 CARDI OLOGY 0. 145581 76.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 77.00 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. 904083 90.00 04950 SLEEP CLINIC 90.01 90.01 0. 245495 91.00 09100 EMERGENCY 0. 430572 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0. 430361 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94 00 09400 HOME PROGRAM DIALYSIS 0.000000 94 00 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 97.00 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 OPI OID 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 INTESTINAL ACQUISITION 110.00 111.00 11100 I SLET ACQUISITION l111. 00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00

115.00

116.00

116. 00 11600 HOSPI CE

115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)

Heal th Fin	nancial Systems	ELKHART GENERAI	L HOSPI TAL	In Lie	u of Form CMS-	2552-10
COMPUTATIO	ON OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0018	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/31/2023 12:	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202. 00

		OF RATIO OF COSTS TO CHARGES	ELINIANT GENER		CN: 15-0018	Peri od:	Worksheet C	2002 10
						From 01/01/2022 To 12/31/2022	Date/Time Pre	pared:
				Ti tl	e XIX	Hospi tal	5/31/2023 12: PPS	14 pm
						Costs		
		Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE Di cal Lewance	Total Costs	
			(from Wkst. B, Part I, col.	Adj .		Di sal I owance		
			26)					
	LNDAT	IENT ROUTINE SERVICE COST CENTERS	1. 00	2. 00	3.00	4. 00	5. 00	
30. 00		ADULTS & PEDIATRICS	69, 508, 174		69, 508, 17	4 0	69, 508, 174	30.00
31.00	03100	INTENSIVE CARE UNIT	15, 460, 334		15, 460, 33	4 0		31.00
		NEONATAL INTENSIVE CARE CORONARY CARE UNIT	2, 623, 558		2, 623, 55	8 0	2, 623, 558 0	31. 01 32. 00
	1	BURN INTENSIVE CARE UNIT	0			0 0	0	
34.00	03400	SURGICAL INTENSIVE CARE UNIT	0			0 0	0	
40.00		SUBPROVIDER - I PF	4, 116, 810		4, 116, 81			•
41. 00 43. 00		SUBPROVIDER - IRF NURSERY	170, 284 5, 013, 005	l	170, 28 5, 013, 00		170, 284 5, 013, 005	
		SKILLED NURSING FACILITY	0		3,0.0,00	0 0	0	ı
		NURSING FACILITY	0		1	0	0	45. 00
46. 00		OTHER LONG TERM CARE LARY SERVICE COST CENTERS	0			0 0	0	46. 00
50.00		OPERATING ROOM	30, 899, 124		30, 899, 12	4 0	30, 899, 124	50.00
51. 00		RECOVERY ROOM	0	l	1	0 0	0	
		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	0			0 0	0	1
		RADI OLOGY-DI AGNOSTI C	12, 874, 373		12, 874, 37		12, 874, 373	
55.00		RADI OLOGY-THERAPEUTI C	0			0 0	0	55. 00
		RADI OI SOTOPE	0		2 574 00	0 0	0	
57. 00 58. 00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	2, 574, 895 1, 144, 253	l e	2, 574, 89 1, 144, 25		2, 574, 895 1, 144, 253	•
59. 00	1	CARDI AC CATHETERI ZATI ON	2, 570, 000	l e	2, 570, 00	0		•
60.00	1	LABORATORY	13, 978, 945		13, 978, 94		13, 978, 945	•
60. 01 61. 00		BLOOD LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0	0	•
62. 00		WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 0	0	62.00
63. 00		BLOOD STORING, PROCESSING & TRANS.	0			0 0	0	
64.00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	2, 656, 868	ł	2, 656, 86		2, 656, 868	•
65. 00 66. 00		PHYSI CAL THERAPY	5, 213, 706 2, 929, 329	ł	5, 213, 70 2, 929, 32		5, 213, 706 2, 929, 329	
67. 00		OCCUPATI ONAL THERAPY	1, 131, 631		1, 131, 63			
68.00		SPEECH PATHOLOGY	491, 703	l	491, 70		491, 703	
		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0			0 0	0	69. 00 70. 00
	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 518, 604		13, 518, 60	-		
		IMPL. DEV. CHARGED TO PATIENTS	25, 198, 633		25, 198, 63		25, 198, 633	
		DRUGS CHARGED TO PATIENTS RENAL DIALYSIS	32, 341, 590 0	l	32, 341, 59	0 0	32, 341, 590 0	1
		ASC (NON-DISTINCT PART)	0		1	0 0	0	
	1	CARDI OLOGY	3, 739, 410		3, 739, 41		3, 739, 410	
77. 00		ALLOGENEIC HSCT ACQUISITION TIENT SERVICE COST CENTERS	0			0 0	0	77. 00
88. 00		RURAL HEALTH CLINIC	0			0 0	0	88. 00
	1	FEDERALLY QUALIFIED HEALTH CENTER	0		1	0 0	0	89. 00
90. 00 90. 01	1	CLINIC	1, 017, 789		1, 017, 78		1, 017, 789	
	1	SLEEP CLINIC EMERGENCY	590, 447 19, 179, 555		590, 44 19, 179, 55		590, 447 19, 179, 555	
92.00		OBSERVATION BEDS (NON-DISTINCT PART)	8, 494, 462	l	8, 494, 46		8, 494, 462	
04.00		REIMBURSABLE COST CENTERS					0	04.00
		HOME PROGRAM DIALYSIS AMBULANCE SERVICES	0	l		0 0	0	94. 00 95. 00
	1	DURABLE MEDICAL EQUIP-RENTED	0			0 0	0	•
		DURABLE MEDICAL EQUIP-SOLD	0		1	0	0	97. 00
98. 00 99. 00		OTHER REIMBURSABLE COST CENTERS	0			0	0	
99. 10	1		o o			0	0	ł
		I&R SERVICES-NOT APPRVD PRGM	0	ŀ	1	0		100. 00
		HOME HEALTH AGENCY OPIOID TREATMENT PROGRAM	0 0	l		0		101. 00 102. 00
102.00		AL PURPOSE COST CENTERS	0		'	U	0	102.00
	10500	KIDNEY ACQUISITION	0	l	1	0	0	105. 00
		HEART ACQUISITION	0		1	0		106.00
		LIVER ACQUISITION LUNG ACQUISITION	0		1	0		107. 00 108. 00
109.00	10900	PANCREAS ACQUISITION	Ö		1	0	0	109. 00
		INTESTINAL ACQUISITION	0	l	1	0		110.00
		ISLET ACQUISITION INTEREST EXPENSE	0		1	0	0	111. 00 113. 00
		i	T. Control of the Con	1	t .	1	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		Peri od: From 01/01/2022	Worksheet C	
					Date/Time Pre 5/31/2023 12:	
		Ti tl	e XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)					

0

2.00

3.00

277, 437, 482 8, 494, 462 268, 943, 020 4. 00

5. 00

114. 00

0 115. 00 0 116. 00

277, 437, 482 200. 00 8, 494, 462 201. 00 268, 943, 020 202. 00

1. 00

277, 437, 482 8, 494, 462 268, 943, 020

114.00 11400 UTI LI ZATI ON REVI EW-SNF 115.00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116.00 11600 HOSPI CE

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

200. 00 201. 00 202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet C | From 01/01/2022 Part | | To 12/31/2022 Date/Time Prepared: 5/31/2023 12:14 pm Health Financial Systems

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

Coal Center Description						5/31/2023 12:	14 pm
TERM				e XIX	Hospi tal	PPS	
MATERIAL PROPERTY SERVICE COST CENTERS 143, 057, 603 140, 057, 603 30. 00 30.00	Cost Cantar Description	Innationt		Total (col. 6	Cost or Other	TEEDA	
NewTHERN BURTHER SERVICE COST CENTERS	cost center bescription	Tripatrent	outpatrent				
MAYLLER ROUTH S SERVICE COST CENTERS				' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '	1.0.1.0		
30.00 3000 ABUNITS & PEDIATRICS 143,057,053 143,057,053 30.00 3300 175,057,057,057,057,057,057,057,057,057,0		6. 00	7. 00	8. 00	9. 00	10. 00	
31 DO 30100 INTENSIVE CARE UNIT 30,094,830 30,094,830 31,01 331 01 3310 INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 33.00 1 331 01 332 00 3300 CORDARY CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
31 01 33-101 INTENSIVE CARE 2,124,072 2,124,072 3, 00 33. 00							
32.00 0320							
33 00 03300 BURN INTERSIVE CARE UNIT 0 0		2, 124, 072		2, 124, 072			
34.00 03-000 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0	l l	l ő					
41.00 04100 SUBPROVIDER - IRF		O		C			34. 00
43.00 04-000 MURSENY 3.558,000 3.558,000 44.00 44.00 440.00	40. 00 04000 SUBPROVI DER - I PF	6, 557, 950		6, 557, 950			40. 00
44.00 0.0400 SKILLED NIKSH NG FACILITY							
45.00 094500 MRSING FACILITY		3, 558, 000		3, 558, 000			
46.00 04.000 07HER LORN TERRI CARE 0 0 0 0 0 0 0 0 0		0					
MICH LAWY SERVICE COST CENTRES 50.00 GOODO (SPERTING ROOM) 31, 514, 460 68, 323, 353 99, 837, 813 0. 000000 50, 0000000 51, 00 51, 00 6100 RECOVERY ROOM 0 0 0 0. 0000000 0. 0000000 51, 00 52, 00 63500 MICH STRESS GLOC 0. 000000 0. 0000000 0. 0000000 0. 00000 0. 00000 0. 000000 0. 00000 0. 00000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000 0. 000000							
50.00		<u> </u>					10.00
52.00 05.200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0		31, 514, 460	68, 323, 353	99, 837, 813	0. 309493	0. 000000	50.00
53.00		0	0	i e			
54.00 65400 RADIOLORY-DIACRAPEUTIC 15,213,513 56,669,277 71,882,790 0.179102 0.000000 55.00 0.50500 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.000000 55.00 0.0000000 55.00 0.000000 0.000000 55.00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000		0	0	C			
55.00 05.00 05		15 212 512	E/ //O 277	71 000 700			
56.00 05600 RADIOISTOPE 25.399 511 49.944, 999 75.384, 470 0.03010 57.00 57.00 58.00 05600 05.000 05.		15, 213, 513	50, 009, 277	/1,882,790			
57.00 05700 CT SCAN 25, 399, 511 49, 954, 959 72, 77, 805 12, 594, 470 0.034170 0.000000 58, 00 59. 00 05900 05900 02400 ACC ATHETER IZATION 15, 439, 666 22, 023, 208 37, 462, 874 0.06801 0.000000 58, 00 0.000000 0.000			0				
58.00 0.8900 MAGNETIC RESONANCE LINAGING (NRI) 3, 386, 695 9, 207, 805 12, 594, 500 0.00000 26, 000 0.00000 59, 00 0.00000 26, 000 0.00000 26, 000 0.00000 0.00000 0.000000 0.00000 0.000000 0.00000 0.000000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00		25, 399, 511	49, 954, 959				
60.00							
60.01 60.001 BLODD LABORATORY 0 0 0 0 0 0 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0							
0.1 00 06100 PBP CLINI CAL LAB SERVI (CS-PEKB ONLY 0 0 0 0.000000 0.0000		52, 242, 001	32, 472, 847	84, 714, 848			
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0.000000		0	0				
6.3 0.0 66500 BLODD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0		0	0				
64.00 06400 NTRAYENDUS THERAPY 2, 168, 638 2, 572, 265 2, 741, 003 0.560402 0.000000 65.00 65.00 06500 RESPIRATORY THERAPY 20, 661, 690 2, 237, 280 2, 372, 280 2, 372, 280 2, 372, 280 2, 382, 30 3, 970 0.202979 0.000000 65.00 66.00 0.0000			0				
65.00 06500 RESPI RATORY THERAPY 3,92,533 2,371,280 23,038,970 0,226,299 0,000000 65.00 66.00 06600 PHYSICAL THERAPY 3,292,533 32,2 (637,498 5,960,031 0,492322 0,000000 66.00 68.00 06500 05700 0		2, 168, 638	2, 572, 365	4, 741, 003			
67. 00 06700							
68. 00 06800 SPECCH PATHOLOGY 881, 414 592, 049 1, 473, 463 0, 333706 0, 0000000 68. 00		3, 292, 533	2, 657, 498	5, 950, 031			
69 00 06900 064000 064000 0640000 064000000 064000000 064000000 064000000 064000000 064000000 064000000 064000000 0640000000 0640000000 0640000000 0640000000 0640000000 06400000000 0640000000000							
10.00 070000 07000 07000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 070000 0700000 0700000 0700000 0700000 07000000 07000000 070000000 070000000 0700000000		881, 414	592, 049				
17.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 47, 817, 227 50, 078, 658 97, 895, 885 0. 138092 0. 000000 71. 00 72. 00 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 77, 943, 193 108, 951, 842 186, 895, 035 0. 173047 0. 000000 72. 00 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0. 000000 0. 000000 75. 00 76. 00 0. 07500 ASC (NON-DISTINCT PART) 0 0 0 0. 000000 0. 000000 75. 00 76. 00 0. 000000 0. 000000 75. 00 76. 00 0. 000000 0. 000000 75. 00 76. 00 0. 000000 0. 000000 75. 00 77. 00 07700		0	0				
12 O 07200 IMPL DEV CHARGED TO PATIENTS 60, 928, 997 82, 001, 844 142, 930, 841 0, 176299 0, 000000 72, 00 73, 00 7300 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 74, 00 75,		47 817 227	50 078 658	97 895 885			
73. 00 07300 DRIGS CHARGED TO PATIENTS 77, 943, 193 108, 951, 842 186, 895, 035 0.173047 0.000000 73. 00 74. 00 0.07400 RENAL DI ALYSIS 0 0 0 0 0 0.000000 74. 00 75. 00 0.000000 75. 00 0.000							
74.00 07400 REVAL DI IALYSIS 0 0 0 0 0 0 0 0 0							
76. 00 03140 CARDIOLOGY 7, 326, 455 18, 359, 674 25, 686, 129 0. 145581 0. 000000 76. 00 0. 000000 0. 000000 77. 00 0. 00000	74.00 07400 RENAL DIALYSIS	0	0	C			
77.00 07700 ALLOGENEIC HSCT ACQUISITION O O O 0.000000 0.0000		0	0	1			
Name		7, 326, 455	18, 359, 674				
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0		<u> </u>			0.000000	0.000000	77.00
90. 00 09000 CLINIC 1,452 1,124,318 1,125,770 0.904083 0.000000 90.00 90.00 04950 SLEEP CLINIC 0 2,405,125 2,405,125 0.245495 0.000000 90.01 91.00 91.00 EMERGENCY 12,534,900 32,009,419 44,544,319 0.430572 0.000000 91.00 92.00 085ERVATION BEDS (NON-DISTINCT PART) 3,111,745 16,626,230 19,737,975 0.430361 0.000000 92.00 07000000 0.00000		0	C	C	0. 000000	0. 000000	88. 00
90. 01 04950 SLEEP CLINIC 0 2, 405, 125 2, 405, 125 0. 245495 0. 000000 90. 01 91. 00 09100 BERRECRY 12, 534, 900 32, 009, 419 44, 544, 319 0. 430572 0. 000000 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 3, 111, 745 16, 626, 230 19, 737, 975 0. 430361 0. 000000 92. 00 94. 00 O9400 HOME PROGRAM DI ALYSI S 0 0 0 0. 000000 0. 000000 94. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0. 000000 0. 000000 96. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0. 000000 0. 000000 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0. 000000 0. 000000 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0. 000000 0. 000000 98. 00 99. 00 09900 CMHC 0 0 0 0. 000000 0. 000000 99. 00 99. 10 09910 CORF 0 0 0 0 0. 000000 0. 000000 99. 10 100. 00 10000 1 &R 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 SPECIAL PURPOSE COST CENTERS 0 0 0 0 0. 000000 0. 000000 105. 00 105. 00 10500 KI DREY ACQUI SI TI ON 0 0 0 0. 000000 0. 000000 106. 00 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0. 000000 0. 000000 109. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0. 000000 0. 000000 109. 00 101. 00 10100 INTESTI NAL ACQUI SI TI ON 0 0 0. 000000 0. 000000 109. 00 110. 00 111. 00 115ET ACQUI SI TI ON 0 0 0. 000000 0. 000000 111. 00 111. 00 113. 00 11300 INTEREST EXPENSE 0 0 0 0. 000000 0. 000000 111. 00 113. 00 11300 INTEREST EXPENSE 0 0 0 0. 000000 0. 000000 111. 100 113. 00 11300 INTEREST EXPENSE 0 0 0. 000000 0. 000000 0. 111. 00 113. 00 11300 10100000000000000000000000		0	0				
91. 00 09100 EMERGENCY 12,534,900 32,009,419 44,544,319 0.430572 0.000000 91.00 92.00 09SERVATI ON BEDS (NON-DISTINCT PART) 3,111,745 16,626,230 19,737,975 0.430361 0.000000 92.00 09SERVATI ON BEDS (NON-DISTINCT PART) 3,111,745 16,626,230 19,737,975 0.430361 0.000000 92.00 0.000000		1, 452					
92. 00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART) 3,111,745 16,626,230 19,737,975 0.430361 0.000000 92. 00		12 524 000					
OTHER REIMBURSABLE COST CENTERS O							
94. 00		3, 111, 743	10, 020, 230	17, 737, 773	0. 430301	0.000000	72.00
96. 00		0	C	С	0. 000000	0. 000000	94. 00
97. 00		0					
98. 00 09950 OTHER REIMBURSABLE COST CENTERS 0 0 0 0.000000 0.000000 98. 00 99. 00 09900 CMHC 0 0 0 0 0 0 0 0 99. 00 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 99. 10 100. 00 Lar Services-Not Approximately Promised 0 0 0 0 0 0 0 100. 00 101. 00 10100 Home Health Agency 0 0 0 0 0 0 101. 00 101. 00 102. 00 102.00 0PI 0I D TREATMENT PROGRAM 0 0 0 0 0 0 0.000000 105. 00 105. 00 105.00 10		0	0				
99. 00 09900 CMHC 09910 CORF 0 0 0 0 0 0 0 0 0 99. 10 99. 10 09910 CORF 0 0 0 0 0 0 0 0 99. 10 100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0				1
99. 10		0	0			0.000000	1
100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	• • • • • • • • • • • • • • • • • • •		0				
102. 00 10200 OPI OI D TREATMENT PROGRAM O O O O O O O O O		o	0	1			1
SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS SPECIAL PURPOSE COST CENTERS 105.00 10500 KI DNEY ACQUI SI TI ON O O O 0.000000 0.000000 105.00 106.00 106.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 107.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 108.00 109.00 PANCREAS ACQUI SI TI ON O O O 0.000000 0.000000 109.00 109.00 109.00 109.00 107.00 109.00 107.00 109.00 107.00 109.00 107.00 109.00 107.00 109.00 107.00 109.00 107.00 109.00 107.00 109.00 107.00 109.00 107.00 109.00 107.00 109.00 107.00 109.00 107.00 10	101.00 10100 HOME HEALTH AGENCY	o	0	l c			101. 00
105. 00		0	0	C			102. 00
106. 00 106.00 106.00 106.00 106.00 106.00 107. 00 107. 00 107. 00 107. 00 107. 00 108.00			0		0.00000	0 000000	105 00
107. 00 10700 LI VER ACQUI SI TI ON 0 0 0.000000 0.000000 0.000000 107. 00 108. 00 10800 LUNG ACQUI SI TI ON 0 0 0 0.000000 0.000000 108. 00 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0.000000 0.000000 109. 00 110. 00 11000 INTESTI NAL ACQUI SI TI ON 0 0 0.000000 0.000000 110. 00 111. 00 11100 ISLET ACQUI SI TI ON 0 0 0.000000 0.000000 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00							
108.00 10800 LUNG ACQUISITION				1			
109.00 10900 PANCREAS ACQUISITION 0 0 0.000000 0.000000 109.00 110.00 110.00 110.00 110.00 111.			0	1			
111. 00 11100 1 SLET ACQUI SI TI ON 0 0 0. 000000 0. 000000 111. 00 113. 00 11300 1 NTEREST EXPENSE 113. 00		0	0		0. 000000		
113. 00 11300 INTEREST EXPENSE 113. 00		0	0	i e			
		0	0	C	0. 000000	0. 000000	
111.00 11.00 01.212111014 (KEVI EW 500)							
	Jojiii Jojiii Li Zilii Oli Nevi eli Olii	<u>ı </u>		1	I .	l	1

Health Financial Systems	ELKHART GENERA	AL HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider Co		Period: From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Charges Outpatient	Total (col. + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 116.00 11600 HOSPICE 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)	0 0 568, 202, 969 568, 202, 969		1, 127, 542, 76			115. 00 116. 00 200. 00 201. 00 202. 00

5/31/2023 12:14 pm Title XIX Hospi tal PPS Cost Center Description PPS Inpatient Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 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 04000 SUBPROVIDER - IPF 40.00 40.00 04100 SUBPROVI DER - I RF 41.00 41.00 43 00 04300 NURSERY 43.00 04400 SKILLED NURSING FACILITY 44.00 44 00 45.00 04500 NURSING FACILITY 45.00 46.00 04600 OTHER LONG TERM CARE 46.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 50.00 50.00 0.309493 51.00 05100 RECOVERY ROOM 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 52.00 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0. 179102 54.00 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 56.00 05600 RADI OI SOTOPE 0.000000 56.00 0.034170 05700 CT SCAN 57.00 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.090853 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.068601 59.00 60.00 06000 LABORATORY 0. 165012 60.00 06001 BLOOD LABORATORY 60.01 0.000000 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0.000000 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 62.00 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 63.00 06400 I NTRAVENOUS THERAPY 0.560402 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0. 226299 65.00 06600 PHYSI CAL THERAPY 66.00 0. 492322 66.00 06700 OCCUPATIONAL THERAPY 67 00 0.309538 67 00 06800 SPEECH PATHOLOGY 68.00 0.333706 68.00 06900 ELECTROCARDI OLOGY 0.000000 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.138092 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 176299 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0. 173047 73.00 74.00 07400 RENAL DIALYSIS 0.000000 74 00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 75.00 76. 00 03140 CARDI OLOGY 0. 145581 76.00 77.00 07700 ALLOGENEIC HSCT ACQUISITION 0.000000 77.00 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. 904083 90.00 04950 SLEEP CLINIC 90.01 90.01 0. 245495 91.00 09100 EMERGENCY 0.430572 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.430361 92.00 OTHER REIMBURSABLE COST CENTERS 94 00 09400 HOME PROGRAM DIALYSIS 0.000000 94 00 95.00 09500 AMBULANCE SERVICES 0.000000 95.00 96 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 97.00 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 OPI OI D TREATMENT PROGRAM 102 00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0.000000 105.00 106.00 10600 HEART ACQUISITION 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 INTESTINAL ACQUISITION 110.00 0.000000 111.00 11100 I SLET ACQUISITION 0.000000 l111. 00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 115.00

116.00

116. 00 11600 HOSPI CE

Heal th Fin	nancial Systems	ELKHART GENERAI	L HOSPITAL	In Lie	u of Form CMS-	2552-10
COMPUTATIO	ON OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-0018	Peri od: From 01/01/2022 To 12/31/2022	Worksheet C Part I Date/Time Pre 5/31/2023 12:	
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
200.00	Subtotal (see instructions)		·			200. 00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202. 00

 Heal th Financial
 Systems
 ELKHART
 GE

 CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF
 Provider CCN: 15-0018 Peri od: Worksheet C From 01/01/2022 Part II To 12/31/2022 Date/Ti me Prepared: REDUCTIONS FOR MEDICALD ONLY

			10	12/31/2022	5/31/2023 12:	
			e XIX	Hospi tal	PPS	
Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	,		Net of Capital	Reduction	Reduction	
	I, col. 26)	11 col. 26)	Cost (col. 1 -		Amount	
	1.00	2. 00	col . 2) 3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50. 00 05000 OPERATI NG ROOM	30, 899, 124	2, 213, 123	28, 686, 001	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	12, 874, 373	1, 694, 829	11, 179, 544	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 05600 RADI OI SOTOPE	0 574 005	0	0	0	0	56.00
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	2, 574, 895	267, 664 136, 360		0	0	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 144, 253 2, 570, 000	155, 030		0	0	59. 00
60. 00 06000 LABORATORY	13, 978, 945	215, 887		0	0	60.00
60. 01 06001 BLOOD LABORATORY	13, 770, 743	213,007	13, 703, 030	0	0	60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		Ö	0	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 INTRAVENOUS THERAPY	2, 656, 868	293, 422	2, 363, 446	0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	5, 213, 706	75, 562		0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	2, 929, 329	189, 835		0	0	66. 00
67. 00 06700 OCCUPATIONAL THERAPY	1, 131, 631	90, 249		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	491, 703	53, 796	437, 907	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	13, 518, 604	200.010	12 210 504	0	0	70. 00 71. 00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	25, 198, 633	200, 010 371, 493		0	0	71.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	32, 341, 590	232, 315		0	0	73. 00
74. 00 07400 RENAL DIALYSIS	32, 341, 370	232, 313	0	0	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	o	0	0	75. 00
76. 00 03140 CARDI OLOGY	3, 739, 410	430, 928	3, 308, 482	0	0	76.00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0	0	0	0	77.00
OUTPATIENT SERVICE COST CENTERS			1			
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	1 017 700	170.001	0	0	0	89. 00
90. 00 09000 CLI NI C 90. 01 04950 SLEEP CLI NI C	1, 017, 789 590, 447	179, 081 986		0	0	90. 00 90. 01
91. 00 09100 EMERGENCY	19, 179, 555	691, 423		0	0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 494, 462	645, 392		Ö	0	92. 00
OTHER REIMBURSABLE COST CENTERS	97 11 17 192	2.07.51	., ., .,, .,,	-1		
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 MEDI CAL EQUI P-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 99. 10 09910 CORF	0	0		0	0	99. 00 99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	0		0		100.00
102. 00 10200 OPI OI D TREATMENT PROGRAM	o o	Ö		ő		102.00
SPECIAL PURPOSE COST CENTERS			,	<u> </u>		.02.00
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 INTESTINAL ACQUISITION	0	0	0	0		110.00
111. 00 11100 SLET ACQUI SI TI ON 113. 00 11300 NTEREST EXPENSE	0	0		O	0	111. 00 113. 00
113. 00 11300 INTEREST EXPENSE 114. 00 11400 UTLLI ZATI ON REVI EW-SNF						113.00
115. OO 11500 AMBULATORY SURGICAL CENTER (D. P.)		0		Λ	0	114.00
116. 00 11600 HOSPI CE		0		n		116. 00
200.00 Subtotal (sum of lines 50 thru 199)	180, 545, 317	8, 137, 385	172, 407, 932	o		200.00
201.00 Less Observation Beds	8, 494, 462	645, 392		o	0	201. 00
202.00 Total (line 200 minus line 201)	172, 050, 855			o		202. 00
	'		'			

Peri od: Worksheet C From 01/01/2022 Part II To 12/31/2022 Date/Time Prepared: 5/31/2023 12:14 pm Provider CCN: 15-0018 REDUCTIONS FOR MEDICALD ONLY

					5/31/2023 12:	14 pm
			e XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and		Cost to Charge			
	Operating Cost	Part I, column	Ratio (col. 6			
	Reducti on	8)	/ col. 7)			
	6.00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	30, 899, 124	99, 837, 813	0. 309493			50.00
51.00 05100 RECOVERY ROOM	0	0	0.000000			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.000000			52.00
53. 00 05300 ANESTHESI OLOGY			0. 000000			53. 00
•	12 074 272	71 000 700				
· · · · · · · · · · · · · · · · · · ·	12, 874, 373	71, 882, 790				54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0. 000000			55. 00
56. 00 05600 RADI OI SOTOPE	0	0	0.000000			56. 00
57. 00 05700 CT SCAN	2, 574, 895	75, 354, 470	0. 034170			57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 144, 253	12, 594, 500	0. 090853			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	2, 570, 000		0. 068601			59. 00
60. 00 06000 LABORATORY	13, 978, 945					60.00
60. 01 06001 BLOOD LABORATORY	10, 770, 710	01,711,010	0. 000000			60. 01
						•
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0.000000			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	1 0	0. 000000			62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 000000			63. 00
64.00 06400 I NTRAVENOUS THERAPY	2, 656, 868	4, 741, 003	0. 560402			64. 00
65. 00 06500 RESPIRATORY THERAPY	5, 213, 706	23, 038, 970	0. 226299			65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 929, 329	5, 950, 031	0. 492322			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 131, 631					67.00
68. 00 06800 SPEECH PATHOLOGY	491, 703					68. 00
		1,473,403				
69. 00 06900 ELECTROCARDI OLOGY	0		0.000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0. 000000			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 518, 604		0. 138092			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	25, 198, 633		0. 176299			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	32, 341, 590	186, 895, 035	0. 173047			73.00
74.00 07400 RENAL DIALYSIS	0	0	0.000000			74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.000000			75. 00
76. 00 03140 CARDI OLOGY	3, 739, 410	25, 686, 129	0. 145581			76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION			1			77. 00
OUTPATIENT SERVICE COST CENTERS		'				1
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0. 000000			89. 00
90. 00 09000 CLINIC	1, 017, 789					90.00
· ·						90.00
l l	590, 447					•
91. 00 09100 EMERGENCY	19, 179, 555					91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 494, 462	19, 737, 975	0. 430361			92. 00
OTHER REIMBURSABLE COST CENTERS	Т	1				4
94.00 09400 HOME PROGRAM DIALYSIS	0	0				94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	0. 000000			95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.000000			96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0.000000			97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.000000			98. 00
99. 00 09900 CMHC		0	0. 000000			99. 00
99. 10 09910 CORF			0. 000000			99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM						1
	0					100.00
101. 00 10100 HOME HEALTH AGENCY	0					101. 00
102. 00 10200 OPI OI D TREATMENT PROGRAM	0	0	0.000000			102. 00
SPECIAL PURPOSE COST CENTERS						4
105.00 10500 KIDNEY ACQUISITION	0	0	0. 000000			105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	0	0.000000			106. 00
107.00 10700 LIVER ACQUISITION	0	0	0.000000			107. 00
108.00 10800 LUNG ACQUISITION	0	0	0.000000			108.00
109.00 10900 PANCREAS ACQUISITION	n	n	0.000000			109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON		ا ا	0. 000000			110.00
111. 00 11100 SLET ACQUISITION			0. 000000			111.00
· · · · · · · · · · · · · · · · · · ·		Ī	0.000000			
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	J 0	0. 000000			115. 00
116. 00 11600 H0SPI CE	0	0	0. 000000			116. 00
200.00 Subtotal (sum of lines 50 thru 199)	180, 545, 317					200. 00
201.00 Less Observation Beds	8, 494, 462					201. 00
202.00 Total (line 200 minus line 201)	172, 050, 855	941, 927, 707				202. 00
			•			

Health Financial Systems	ELKHART GENER	ΡΔΙ ΗΩΝΡΙΤΔΙ		In lie	eu of Form CMS-	2552_10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL		Provi der C	CN: 15-0018	Period: From 01/01/2022 To 12/31/2022	Worksheet D Part I	epared:
		Ti tl e	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 & PEDI ATRI CS	5, 281, 100	C	5, 281, 10	0 47, 550	111. 06	30.00
31. 00 INTENSIVE CARE UNIT	496, 002		496, 00	6, 134	80. 86	31.00
31. 01 NEONATAL INTENSIVE CARE	91, 319		91, 31			31. 01
32. 00 CORONARY CARE UNIT	0		1,	0 0		
33. 00 BURN INTENSIVE CARE UNIT	0			0	0.00	
34. 00 SURGI CAL INTENSI VE CARE UNI T	0			0 0	0.00	
40. 00 SUBPROVI DER - I PF	441, 215	1	441, 21	5 2, 870		
41. 00 SUBPROVI DER - I RF	21, 662					
43. 00 NURSERY	390, 667		390, 66		l .	1
44.00 SKILLED NURSING FACILITY	370,007		370, 00	0 0		1
45. 00 NURSING FACILITY				0 0		45.00
200.00 Total (lines 30 through 199)	6, 721, 965		6, 721, 96	٥		200.00
Cost Center Description	I npati ent	Inpatient	0, 721, 90	57, 213		200.00
cost center bescriptron	Program days	Program				
	Program days	Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00				
30. 00 ADULTS & PEDIATRICS	12, 163	1, 350, 823				30.00
31. 00 INTENSIVE CARE UNIT	12, 103					31.00
	1, 640		1			1
	0		•			31. 01
32. 00 CORONARY CARE UNIT	0	1	1			32.00
33. 00 BURN INTENSIVE CARE UNIT	0		1			33.00
34. 00 SURGICAL INTENSIVE CARE UNIT	0	0.00	1			34. 00
40. 00 SUBPROVI DER - I PF	208					40. 00
41. 00 SUBPROVI DER - I RF	48		1			41.00
43. 00 NURSERY	0	C	1			43. 00
44.00 SKILLED NURSING FACILITY	0	C)			44. 00
45. 00 NURSING FACILITY	0	(C)			45. 00
200.00 Total (lines 30 through 199)	14, 059	1, 525, 603	3			200. 00

Heal th	Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APP0R1	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0018 F	Peri od:	Worksheet D	
					From 01/01/2022 Fo 12/31/2022	Part II Date/Time Pre	narod:
				'	10 12/31/2022	5/31/2023 12:	14 pm
			Titl∈	XVIII	Hospi tal	PPS	
	Cost Center Description	Capi tal		Ratio of Cost		Capital Costs	
		Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col . 1 ÷ col .	Charges	column 4)	
		Part II, col.	8)	2)			
		26) 1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATI NG ROOM	2, 213, 123	99, 837, 813	0. 022167	9, 871, 783	218, 828	50.00
51. 00	05100 RECOVERY ROOM	0	0	0.000000		0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	l o	1		0	52.00
53. 00	05300 ANESTHESI OLOGY	0	l o	0.000000		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 694, 829	71, 882, 790			97, 745	
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0. 000000		0	55.00
56.00	05600 RADI OI SOTOPE	0	l	0. 000000	0	0	56.00
57. 00	05700 CT SCAN	267, 664	75, 354, 470			24, 890	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	136, 360					
59. 00	05900 CARDI AC CATHETERI ZATI ON	155, 030	37, 462, 874			16, 799	
60.00	06000 LABORATORY	215, 887	84, 714, 848			37, 041	
60. 01	06001 BLOOD LABORATORY	0		0. 000000		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. 000000	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	l	0. 000000	0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	293, 422	4, 741, 003			33, 403	
65.00	06500 RESPI RATORY THERAPY	75, 562	23, 038, 970	0. 003280	6, 337, 441	20, 787	65.00
66.00	06600 PHYSI CAL THERAPY	189, 835	5, 950, 031	0. 031905		35, 588	1
67.00	06700 OCCUPATI ONAL THERAPY	90, 249	3, 655, 866	0. 024686	906, 148	22, 369	67. 00
68.00	06800 SPEECH PATHOLOGY	53, 796	1, 473, 463	0. 036510	288, 138	10, 520	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	0	0. 000000		0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 000000	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	200, 010	97, 895, 885	0. 002043	14, 915, 087	30, 472	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	371, 493	142, 930, 841	0. 002599	22, 356, 405	58, 104	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	232, 315	186, 895, 035	0. 001243	21, 073, 577	26, 194	73. 00
74.00	07400 RENAL DI ALYSI S	0	0	0.000000	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0. 000000		0	75. 00
76. 00	03140 CARDI OLOGY	430, 928	25, 686, 129			37, 159	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	0. 000000	0	0	77. 00
	OUTPATIENT SERVICE COST CENTERS	Т	г				
88. 00	08800 RURAL HEALTH CLINIC	0	0			0	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.00000		0	89. 00
90. 00	09000 CLINIC	179, 081	1, 125, 770			83	
90. 01	04950 SLEEP CLINIC	986	2, 405, 125			0	90. 01
91. 00	09100 EMERGENCY	691, 423	44, 544, 319			52, 079	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	645, 392	19, 737, 975	0. 032698	3 779, 199	25, 478	92.00
04.00	OTHER REIMBURSABLE COST CENTERS	0		0.00000			04.00
94. 00 95. 00	09400 HOME PROGRAM DI ALYSI S		١	0. 000000	0	0	
95. 00 96. 00	09500 AMBULANCE SERVICES		,	0. 000000		0	95. 00 96. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD			0.00000		0	96.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS			0.00000		0	98.00
200.00		8, 137, 385	941, 927, 707		114, 363, 688	·	
200.00	I Total (Titles 50 till ough 177)	0, 137, 303	741,721,701	I	114, 303, 000	130,034	₁ 200.00

Hearth Fillancial Systems	ELKHARI GENER	AL HUSPITAL		III LIE	eu or Form CMS	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PAS	SS THROUGH COS	TS Provider CO	F	Period: From 01/01/2022 To 12/31/2022		pared: 14 pm
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Nursi ng	Nursi ng		Allied Health	All Other	
0001 0011101 20001 1 pt 1 011	Program	Program	Post-Stepdown		Medi cal	
	Post-Stepdown	i i ogi alli	Adjustments	0031	Education Cost	
			Aujustillerits		Luucati oii cost	
	Adjustments	4.00		0.00		
	1A	1.00	2A	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						1
30. 00 03000 ADULTS & PEDIATRICS	0	0	(0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0) (0	0	31.00
31. 01 03101 NEONATAL INTENSIVE CARE	0	0		0	o o	1
32. 00 03200 CORONARY CARE UNIT	0					32. 00
						1
33. 00 03300 BURN INTENSIVE CARE UNIT	0					
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0			0		
40. 00 04000 SUBPROVI DER - I PF	0	0	(0	0	40. 00
41. 00 04100 SUBPROVI DER - I RF	0	0	(0	0	41.00
43. 00 04300 NURSERY	0	l 0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	(0		44.00
45. 00 04500 NURSING FACILITY	0					45. 00
i i	0	0				1
200.00 Total (lines 30 through 199)	0	0	(0		200. 00
Cost Center Description	Swi ng-Bed	Total Costs		Per Diem (col.	Inpatient	
	Adjustment	(sum of cols.	Days	5 ÷ col. 6)	Program Days	
	Amount (see	1 through 3,				
	instructions)	minus col. 4)				
	4. 00	5. 00	6. 00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0	47, 550	0.00	12, 163	30.00
31. 00 03100 I NTENSI VE CARE UNI T	-	0				1
31. 01 03100 NTENSTVE CARE ON T		0	-,			1
		-	1			1
32. 00 03200 CORONARY CARE UNIT		0				
33.00 03300 BURN INTENSIVE CARE UNIT		0	(0.00	0	
34.00 03400 SURGICAL INTENSIVE CARE UNIT		0	(0.00	0	34.00
40. 00 04000 SUBPROVI DER - 1 PF	0	l 0	2, 870	0.00	208	40.00
41. 00 04100 SUBPROVI DER - I RF	0	1 0	102			1
43. 00 04300 NURSERY	· ·	0	1			1
		0	1			1
		-	1			
45. 00 04500 NURSI NG FACILITY		0		0.00		
200.00 Total (lines 30 through 199)		0	59, 215		14, 059	200.00
Cost Center Description	Inpati ent					
	Program					
	Pass-Through					
	Cost (col. 7 x					
	col . 8)					
	9. 00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0					30.00
31. 00 03100 I NTENSI VE CARE UNI T	0					31. 00
31. 01 03101 NEONATAL INTENSIVE CARE	0					31. 01
						1
32. 00 03200 CORONARY CARE UNIT	0	l .				32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0	l .				33. 00
34.00 03400 SURGI CAL 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	0	l .				43. 00
· · · · · · · · · · · · · · · · · · ·						1
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	l .				44. 00
45.00 04500 NURSING FACILITY	0	l .				45. 00
200.00 Total (lines 30 through 199)	0					200. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2022	Part IV
To 12/31/2022	Date/Time Prepared:
5/31/2023	12:14 pm THROUGH COSTS

					12,01,2022	5/31/2023 12:	14 pm
			Ti tl	e XVIII	Hospi tal	PPS	•
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdowr		Adjustments		
			Adjustments				
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	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	(o	0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	()	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	(0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	(0 0	0	56. 00
57.00	05700 CT SCAN	0	(0 0	0	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	(0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	(ol	0 0	0	59. 00
60.00	06000 LABORATORY	0	(ol	0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	(ol	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	(ol	ol o	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0			0 0	0	64.00
65. 00	06500 RESPIRATORY 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	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0		n n	0 0	Ö	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		n n	0 0	Ö	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		n n	0 0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		า	0 0	0	73. 00
74. 00	07400 RENAL DIALYSIS				0 0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)				0 0	0	75. 00
76. 00	03140 CARDI OLOGY				0 0	-	76.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	-	77. 00
77.00	OUTPATIENT SERVICE COST CENTERS			٧١	<u> </u>		77.00
88. 00	08800 RURAL HEALTH CLINIC	0			0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		ก	0 0	•	89. 00
90.00	09000 CLINIC	0		ก	0 0	0	90.00
90. 01	04950 SLEEP CLINIC	0		า	0 0	Ö	90. 01
91. 00	09100 EMERGENCY	0			0 0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	·	3	0	0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS				O _I	0	72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0		ol	0 0	0	94. 00
95. 00	09500 AMBULANCE SERVICES		'	1			95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0			0 0	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-RENTED				0 0	0	97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS				0 0	0	98.00
200.00					0 0		
200.00	Total (Tilles 50 till ough 177)	1	'	71	٥	100, 240	1200.00

THROUGH COSTS

					10 12/31/2022	5/31/2023 12:	
			Title	XVIII	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	'	Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
				ŕ		instructions)	
		4.00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		99, 837, 813	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0		0 (0	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0 (0	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 (0	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		71, 882, 790	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0	0.000000	56. 00
57.00	05700 CT SCAN	0	0		75, 354, 470	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		12, 594, 500	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		37, 462, 874	0.000000	59. 00
60.00	06000 LABORATORY	o	0		84, 714, 848	0.000000	60. 00
60. 01	06001 BLOOD LABORATORY	o	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	o	0		0	0.000000	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	0		0	0.000000	63. 00
64.00	06400 I NTRAVENOUS THERAPY	o	0		4, 741, 003	0.000000	64. 00
65.00	06500 RESPIRATORY THERAPY	o	0		23, 038, 970	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	o	0		5, 950, 031	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	o	0		3, 655, 866	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	o	0		1, 473, 463	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	o	0		0	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	o	0		0	0.000000	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	0		97, 895, 885		71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0		142, 930, 841	0. 000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	o	0		186, 895, 035	0. 000000	73. 00
74.00	07400 RENAL DI ALYSI S	o	0		0	0. 000000	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	o	0		0	•	75. 00
76. 00	03140 CARDI OLOGY	o	0		25, 686, 129		1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	O	0		0	•	77. 00
	OUTPATIENT SERVICE COST CENTERS	·			•	•	1
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0		89. 00
90.00	09000 CLI NI C	o	0		1, 125, 770		90.00
90. 01	04950 SLEEP CLINIC	o	0		2, 405, 125		1
91. 00	09100 EMERGENCY		168, 240	168, 24			91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		00,210		19, 737, 975		
72.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			0 1777077770	0.00000	72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0		0 (0.000000	94. 00
95. 00	09500 AMBULANCE SERVICES		O			0.00000	95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	n	Ω		0	0.000000	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0	1	0	0. 000000	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS		0	ł	0	0. 000000	
200.00		l ol	168, 240	168, 24	941, 927, 707		200. 00
		-1					

| Peri od: | Worksheet D | From 01/01/2022 | Part IV | To 12/31/2022 | Date/Time Prepared: | To 12/31/2022 | THROUGH COSTS

					10 12/31/2022	5/31/2023 12:	
			Title	XVIII	Hospi tal	PPS	р
	Cost Center Description	Outpati ent	Inpatient	Inpatient	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	3	Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	ANCILLARY SERVICE COST CENTERS	1		T		T	
50. 00	05000 OPERATI NG ROOM	0. 000000	9, 871, 783		0 13, 449, 560	l .	
51. 00	05100 RECOVERY ROOM	0. 000000	0	1	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	4, 145, 585	1	0 10, 571, 997		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	0	1	0 0	0	56. 00
57. 00	05700 CT SCAN	0. 000000	7, 007, 343		0 7, 562, 184	l .	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	860, 323		0 1, 642, 174		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	4, 059, 671		0 6, 878, 320		59. 00
60.00	06000 LABORATORY	0. 000000	14, 537, 268		3, 609, 992		
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	539, 716	•	578, 282		64. 00
65. 00	06500 RESPIRATORY THERAPY	0. 000000	6, 337, 441	•	0 449, 498		65. 00
66.00	06600 PHYSI CAL THERAPY	0. 000000	1, 115, 440		0 112, 294	l .	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0.000000	906, 148		0 19, 173		67. 00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0.000000	288, 138 0		0 4, 516 0 0	0	68. 00 69. 00
70.00	1 1	0.000000	0	1	0 0	0	70.00
71.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000 0. 000000	14, 915, 087	•	0 10, 942, 921	0	71.00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	22, 356, 405		0 22, 402, 424		72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 000000	21, 073, 577		0 28, 495, 098		
74.00	07400 RENAL DIALYSIS	0. 000000	21,073,377		0 20, 493, 090	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	1	0 0	0	75. 00
76. 00	03140 CARDI OLOGY	0. 000000	2, 214, 855	1	0 4, 886, 794		76.00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	2, 214, 033		0 4, 666, 774		
77.00	OUTPATIENT SERVICE COST CENTERS	0.000000			0 0	<u> </u>	77.00
88. 00	08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	•	0	Ō	
90.00	09000 CLI NI C	0. 000000	524		236, 077		90.00
90. 01	04950 SLEEP CLINIC	0. 000000	0	•	513, 774	l .	90. 01
91. 00	09100 EMERGENCY	0. 003777	3, 355, 185	12, 67	·		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	779, 199		0 1, 031, 842		
	OTHER REIMBURSABLE COST CENTERS	· · · · · ·		•		•	
94.00	09400 HOME PROGRAM DI ALYSI S	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	98. 00
200.00	Total (lines 50 through 199)		114, 363, 688	12, 67	3 116, 447, 018	11, 558	200. 00

	i Financiai Systems	ELKHART GENER				eu of Form CMS	2552-10
APPOR	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-0018	Peri od: From 01/01/2022 To 12/31/2022	Worksheet D Part V Date/Time Pre 5/31/2023 12:	pared:
						5/31/2023 12:	14 pm
			Title	XVIII	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
			Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		40 440 540			1 4/0 545	
50.00		0. 309493	13, 449, 560	1	0		1
51.00	05100 RECOVERY ROOM	0. 000000	0	1	0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	1	0 0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0	1	0 0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 179102	10, 571, 997		0		
55.00	l l	0. 000000	0	1	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0	0	
57. 00	05700 CT SCAN	0. 034170	7, 562, 184		0		
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 090853	1, 642, 174		0	149, 196	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 068601	6, 878, 320		0 0	471, 860	59. 00
60.00	06000 LABORATORY	0. 165012	3, 609, 992		77 0	595, 692	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0)	0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	1	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. 560402	578, 282		3 0	324, 070	64.00
65. 00	06500 RESPIRATORY THERAPY	0. 226299	449, 498		0 0	101, 721	65, 00
66. 00	06600 PHYSI CAL THERAPY	0. 492322	112, 294		0 0	55, 285	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 309538	19, 173		0 0	5, 935	1
68. 00	06800 SPEECH PATHOLOGY	0. 333706	4, 516	1	0 0	1, 507	1
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0,010	I	0 0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	Ö	70.00
71. 00		0. 138092	10, 942, 921	Ì	0 0	1, 511, 130	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 176299	22, 402, 424	1	0 0	3, 949, 525	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 173047	28, 495, 098		0 16, 122		
74.00	07400 RENAL DIALYSIS	0. 000000	20, 473, 070	ı	0 10, 122	0	1
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0		1
76. 00	03140 CARDI OLOGY	0. 145581	4, 886, 794		0 0		1
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	4,000,794		0 0	·	1
77.00	OUTPATIENT SERVICE COST CENTERS	0.000000		'I	0 0		17.00
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLINIC	0. 904083	236, 077		3 0	213, 433	
90.00	04950 SLEEP CLINIC	1	513, 774		0 0	126, 129	1
	09100 EMERGENCY	0. 245495	· ·	1	0 0		1
91.00		0. 430572	3, 060, 098	1			
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 430361	1, 031, 842	10	09 0	444, 065	92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DI ALYSI S	0. 000000		1	0 0	I	94. 00
	09500 AMBULANCE SERVICES				0		1
95. 00 96. 00		0. 000000 0. 000000	0	J	0 0	0	95. 00 96. 00
	1 1		0				1
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0.000000	0]	0 0	0	
98. 00	1 1	0. 000000	11/ 447 010]	0 0	01 000 07	98. 00
200.00			116, 447, 018	29		21, 223, 967	1
201.00				1	0		201. 00
202.0	Only Charges (Line 200 Line 201)		114 447 010		1/ 1/2	21 222 077	202 00
202.00	Net Charges (line 200 - line 201)		116, 447, 018	29	22 16, 122	21, 223, 967	1202.00

 Heal th Financial
 Systems
 ELKHART
 GENERAL

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provider CCN: 15-0018

				10 12,01,2022	5/31/2023 12:	14 pm
		Title	XVIII	Hospi tal	PPS	· · ·
	Cos					
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7. 00				
ANCILLADY SERVICE COST CENTERS	0.00	7.00				
ANCI LLARY SERVI CE COST CENTERS			I			
50. 00 05000 OPERATI NG ROOM	0	0				50.00
51. 00 05100 RECOVERY ROOM	0	0				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0				52. 00
53. 00 05300 ANESTHESI OLOGY	0	0				53. 00
54. 00 05400 RADI OLOGY-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 I MAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59. 00
60. 00 06000 LABORATORY	16	0				60.00
	1	0				
	0	U				60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	_				61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
64.00 06400 I NTRAVENOUS THERAPY	2	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	0	0				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	Ö				70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0				72.00
	0	2, 790				
	0		1			73.00
74. 00 07400 RENAL DI ALYSI S	0	0				74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0				75. 00
76. 00 03140 CARDI OLOGY	0	0				76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	0				77. 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	75	0				90.00
90. 01 04950 SLEEP CLINIC	0	0	•			90. 01
91. 00 09100 EMERGENCY	0	0				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	47	0				92.00
	47	U				92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0				94. 00
95. 00 09500 AMBULANCE SERVI CES	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
200.00 Subtotal (see instructions)	140	2, 790				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges	[
202.00 Net Charges (line 200 - line 201)	140	2, 790				202. 00
1 1 1 2 3 3 4 (1 1 1 2 2 3 1)		_, _,,,	1			

Health Financial Systems	ELKHART GENER		CN 15 0010		u of Form CMS-: Worksheet D	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL CUS15	Provi der C		Peri od: From 01/01/2022	Part II	
		Component		To 12/31/2022		pared: 14 pm
		Title	e XVIII	Subprovi der - I PF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,		(col . 1 ÷ col	. Charges	column 4)	
	Part II, col. 26)	8)	2)			
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
50. 00 05000 OPERATI NG ROOM	2, 213, 123	99, 837, 813	0. 02216	7 660	15	50.00
51. 00 05100 RECOVERY ROOM	0	0	1		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0	0.00000	0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 694, 829				242	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000		0	
56. 00 05600 RADI 01 SOTOPE	247 444	75 254 470	0.00000		0	
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE MAGING (MRI)	267, 664 136, 360				57 38	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	155, 030		1		0	1
60. 00 06000 LABORATORY	215, 887	84, 714, 848			122	
60. 01 06001 BL00D LABORATORY	0	0 1,711,010	l .	· ·	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	
64. 00 06400 I NTRAVENOUS THERAPY	293, 422				0	
65. 00 06500 RESPI RATORY THERAPY	75, 562	23, 038, 970	l .		3	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	189, 835		0. 03190		124	1
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	90, 249 53, 796		1		118 23	1
69. 00 06900 ELECTROCARDI OLOGY	33, 740	1, 473, 403	ı		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	l .		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	200, 010	97, 895, 885	1		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	371, 493	142, 930, 841	0. 00259	9 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	232, 315	186, 895, 035	0. 00124	3 79, 383	99	73. 00
74. 00 07400 RENAL DI ALYSI S	0		0. 00000		0	
75. 00 07500 ASC (NON-DISTINCT PART)	0	0			0	
76. 00 03140 CARDI OLOGY	430, 928				46	1
77. 00 07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0.00000	0 0	0	77. 00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-			0	
90. 00 09000 CLINI C	179, 081	1, 125, 770	1		0	1
90. 01 04950 SLEEP CLINIC	986			0 0	0	90. 01
91. 00 09100 EMERGENCY	691, 423	44, 544, 319	0. 01552	2 15, 299	237	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	19, 737, 975	0.00000	0 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1	1	0.0000			04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0. 00000	0	0	
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0	0. 00000	0	0	95. 00 96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED					0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		l ő	0.00000		0	
200.00 Total (lines 50 through 199)	7, 491, 993	941, 927, 707		185, 815	1, 124	200. 00
				'		

	inancial Systems	ELKHART GENER				eu of Form CMS-	2552-10
	NAMENT OF INPATIENT/OUTPATIENT ANCILLARY S	SERVICE OTHER PAS	S Provider C	CN: 15-0018	Peri od:	Worksheet D	
THROUGH	COSTS		Component	CCN: 15-S018	From 01/01/2022 To 12/31/2022		pared:
			·			5/31/2023 12:	14 pm
			Titl€	e XVIII	Subprovi der -	PPS	
	Cost Center Description	Non Physician	Nursi ng	Nursi ng	Allied Health	Allied Health	
	·	Anestheti st	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments	0.00	2.4	2 00	
100	NCILLARY SERVICE COST CENTERS	1.00	2A	2.00	3A	3. 00	
	5000 OPERATING ROOM			1	0 0	0	50.00
	5100 RECOVERY ROOM		1	1	0 0		
	5200 DELIVERY ROOM & LABOR ROOM				0 0	0	
	5300 ANESTHESI OLOGY	l c			0 0	0	
54.00 05	5400 RADI OLOGY-DI AGNOSTI C	C	o c		0 0	0	54. 00
55. 00 05	5500 RADI OLOGY-THERAPEUTI C	C) c		0 0	0	55. 00
56.00 05	5600 RADI OI SOTOPE	C) C		0 0	0	
	5700 CT SCAN	C	1		0 0	0	
	5800 MAGNETIC RESONANCE IMAGING (MRI)	C	1		0 0	0	
1	5900 CARDI AC CATHETERI ZATI ON	C	1)	0 0	0	
4	6000 LABORATORY	C	1	1	0 0	0	1
	6001 BLOOD LABORATORY 6100 PBP CLINICAL LAB SERVICES-PRGM ONLY	C	C	'	0 0	0	60. 01 61. 00
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS				0 0	0	
4	6300 BLOOD STORING, PROCESSING & TRANS.					0	
	6400 I NTRAVENOUS THERAPY				0 0	0	
	6500 RESPIRATORY THERAPY	i c			0 0	0	
66.00 06	6600 PHYSI CAL THERAPY	C	o c		0 0	0	66. 00
67. 00 06	6700 OCCUPATIONAL THERAPY) c		0 0	0	67. 00
	6800 SPEECH PATHOLOGY	C)	0 0	0	
	6900 ELECTROCARDI OLOGY	C	1)	0 0	0	
	7000 ELECTROENCEPHALOGRAPHY	C			0 0	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C		2	0 0	0	
	7200 IMPL. DEV. CHARGED TO PATIENTS 7300 DRUGS CHARGED TO PATIENTS				0 0	0	
	7300 RENAL DIALYSIS				0		
	7500 ASC (NON-DISTINCT PART)				0 0	0	
	3140 CARDI OLOGY	C				0	1
	7700 ALLOGENEIC HSCT ACQUISITION				0 0		
	UTPATIENT SERVICE COST CENTERS	_		1		_	1
88. 00 08	8800 RURAL HEALTH CLINIC	C) C		0 0	0	88. 00
89. 00 08	8900 FEDERALLY QUALIFIED HEALTH CENTER	C	C		0 0	0	89. 00
	9000 CLI NI C	C) C		0 0	0	
	4950 SLEEP CLINIC	C) C		0 0	0	
1	9100 EMERGENCY	C	1		0	168, 240	1
92.00 09	9200 OBSERVATION BEDS (NON-DISTINCT PART)	C)	1	UI	1 0	92.00

0 0 0

0 0 0

0

0 0 0

0 0 0

94. 00 95. 00

96.00

0 92.00

0

0 97.00 98. 00 0 168, 240 200. 00

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
94. 00 09400 HOME PROGRAM DIALYSIS
95. 00 09500 AMBULANCE SERVICES

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 | 200.00 | Total (lines 50 through 199)

	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PASS		CN: 15-0018 CCN: 15-S018	Period: From 01/01/2022 To 12/31/2022	Date/Time Pre	
			Title	: XVIII	Subprovider -	5/31/2023 12: PPS	14 pm
	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 4)	Cost (sum of		(col. 5 ÷ col. 7)	
			4)	col s. 2, 3, and 4)	8)	(see	
				and 4)		instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0 99, 837, 813	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		l .	0	0. 000000	
53.00	05300 ANESTHESI OLOGY	0	0		0	0. 000000	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 71, 882, 790	0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0. 000000	
56. 00	05600 RADI OI SOTOPE	0	0	1	0 0	0.000000	
57. 00	05700 CT SCAN	0	0	1	0 75, 354, 470	0.000000	
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0	1	0 12, 594, 500 0 37, 462, 874	0. 000000 0. 000000	
60.00	06000 LABORATORY	0	0		0 37, 462, 874 0 84, 714, 848	0. 000000	
60. 00	06001 BL00D LABORATORY	0	0		0 64, 714, 646	0.00000	
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0			0.00000	61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0. 000000	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	Ö		o o	0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0 4, 741, 003	0.000000	
65.00	06500 RESPIRATORY THERAPY	0	0		0 23, 038, 970	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 5, 950, 031	0. 000000	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 3, 655, 866	0.000000	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0 1, 473, 463	0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0. 000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0. 000000	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	l .	0 97, 895, 885	0. 000000	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 142, 930, 841	0.000000	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 186, 895, 035	0.000000	
74. 00 75. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0. 000000 0. 000000	
76. 00	03140 CARDI OLOGY	0	0	1	0 25, 686, 129	0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0	1	0 23,000,127	0. 000000	
77.00	OUTPATIENT SERVICE COST CENTERS				0 0	0.000000	77.00
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0. 000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		l .	0 0	0.000000	
90.00	09000 CLI NI C	0	0		0 1, 125, 770	0.000000	
90. 01	04950 SLEEP CLINIC	0	0		0 2, 405, 125	0.000000	90. 01
91.00	09100 EMERGENCY	0	168, 240	168, 24	44, 544, 319	0. 003777	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 19, 737, 975	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DI ALYSIS	0	0		0	0. 000000	
95.00	09500 AMBULANCE SERVICES	_	_			0 0000	95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0	0.000000	
	ING A DELICIPARTE MEDICAL FORD D-SOLD	1 0	0	I .	0 0	0.000000	97.00
97. 00 98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0. 000000	

Harlah Firansial Contant	ELIZIADT CENEDA	I HOCDITAL		1		2552 40
Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	ELKHART GENERA	Provider C	CN: 15_0018	Peri od:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS	WICE OTHER TASS	Trovider ex	CIV. 13 0010	From 01/01/2022	Part IV	
		Component	CCN: 15-S018	To 12/31/2022		
		Title	e XVIII	Subprovi der -	5/31/2023 12: PPS	14 рш
		1		I PF		
Cost Center Description	Outpatient Ratio of Cost	Inpatient Program	Inpatient Program	Outpatient Program	Outpatient Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.	charges	Costs (col.		Costs (col. 9	
	7)		x col . 10)		x col . 12)	
	9. 00	10. 00	11.00	12. 00	13. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 000000	660	1	0 0	0	
51. 00 05100 RECOVERY ROOM	0. 000000	0		0 0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	1	0 0	0	52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	•
54. 00 05400 RADI OLOGY - DI AGNOSTI C	0. 000000	10, 271	1	0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0.000000	0		0	0	55. 00
56. 00 05600 RADI OI SOTOPE	0.000000	0	1	0 0	0	56.00
57. 00 05700 CT SCAN	0.000000	15, 993		0 0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000	3, 512	1	9	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0.000000	0		0 0	0	59. 00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0. 000000 0. 000000	47, 726 0	i	0 0	0	60. 00 60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000	U	1	0	ı	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	1	0 0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	941		0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	3, 891		0 0	Ö	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	4, 772	1	0 0	Ö	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	618	1	0 0	Ö	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0	1	0 0	Ō	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0	1	0 0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0	1	0 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	79, 383		0 0	0	73. 00
74. 00 07400 RENAL DI ALYSI S	0. 000000	0)	0 0	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0)	0 0	0	75. 00
76. 00 03140 CARDI OLOGY	0. 000000	2, 749	1	0	0	76. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS	0.000000					00.00
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000	0	1	0 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0. 000000 0. 000000	0	1	0 0	0 0	89. 00 90. 00
90. 00 09000 CET NT C 90. 01 04950 SLEEP CLI NI C	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 003777	15, 299		58 0	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000	13, 277	1	0 0	0	
OTHER REIMBURSABLE COST CENTERS	0.000000		1	0 0	0	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000	0	ı	0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	3. 555556	O	1		ı	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	i	0 0	0	
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 Total (lines 50 through 199)		185, 815		58 0	0	200. 00

Health 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		Period: From 01/01/2022	Worksheet D Part II	
		Component		To 12/31/2022		pared:
		Title	e XVIII	Subprovi der - I RF	PPS	11 pm
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,		(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2.00	3.00	4. 00	5. 00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	2, 213, 123	99, 837, 813	0. 02216	7 0	0	50.00
51. 00 05100 RECOVERY ROOM	2,2.0,.20	0	1		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	Ö	1		0	
53. 00 05300 ANESTHESI OLOGY	0	0	0. 00000		0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 694, 829	71, 882, 790	0. 02357	883	21	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000	0 0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	0	0.00000		0	
57. 00 05700 CT SCAN	267, 664				10	1
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	136, 360		1		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	155, 030				0	
60. 00 06000 LABORATORY	215, 887	84, 714, 848	1	·	16	
60. 01 06001 BLOOD LABORATORY	0	0	0. 00000	0 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	0	0	61. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.			0.00000		0	1
64. 00 06400 NTRAVENOUS THERAPY	293, 422	4, 741, 003	l .		0	1
65. 00 06500 RESPIRATORY THERAPY	75, 562	23, 038, 970			1	65. 00
66. 00 06600 PHYSI CAL THERAPY	189, 835		0. 03190		861	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	90, 249		1		680	1
68.00 06800 SPEECH PATHOLOGY	53, 796		1		229	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0			0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	200, 010		l .		0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	371, 493		l .		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	232, 315		l .		33	1
74. 00 07400 RENAL DI ALYSI S	0		0.00000		0	
75. 00 07500 ASC (NON-DI STI NCT PART) 76. 00 03140 CARDI OLOGY	420,020	0 25 707 120			0	
77. 00 03140 CARDI OLOGY	430, 928				0	1
OUTPATIENT SERVICE COST CENTERS			0.00000	0	0	77.00
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	Ö	-		-	Ö	
90. 00 09000 CLI NI C	179, 081	1, 125, 770	1		0	1
90. 01 04950 SLEEP CLI NI C	986	2, 405, 125	0. 00041	0 0	0	90. 01
91. 00 09100 EMERGENCY	691, 423	44, 544, 319	0. 01552	2 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	19, 737, 975	0.00000	0 0	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0. 00000	0	0	
95. 00 09500 AMBULANCE SERVICES			0.0000		_	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0			0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0	0. 00000 0. 00000		0	
200.00 Total (lines 50 through 199)	7, 491, 993	941, 927, 707		97, 098	_	200.00
	,,,,,,,,,	, , , , , , , , , , , , , , , , , , , ,	1	,,,,,,,,	1,001	,_00.00

	Financial Systems	ELKHART GENER				eu of Form CMS-	2552-10
	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-0018	Peri od:	Worksheet D	
THROUG	GH COSTS		Component	CCN: 15-T018	From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre	nared.
			Component	CON. 15 1010	10 12/31/2022	5/31/2023 12:	14 pm
			Ti tl e	XVIII	Subprovi der -	PPS	
					IRF		
	Cost Center Description	Non Physician		Nursi ng		Allied Health	
		Anesthetist	Program	Program	Post-Stepdown		
		Cost	Post-Stepdown		Adjustments		
		1.00	Adjustments 2A	2.00	3A	3.00	
	ANCILLARY SERVICE COST CENTERS	1.00		2.00	JA JA	3.00	
50.00	05000 OPERATING ROOM	0	C)	0 0	0	50.00
51. 00	05100 RECOVERY ROOM	0		l	0 0	1	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		•	0 0	_	
53. 00	05300 ANESTHESI OLOGY	0			0 0	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	l c		o o	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	0			o o	o o	1
56.00	05600 RADI OI SOTOPE	0	l c		0 0	o o	1
57.00	05700 CT SCAN	0			0 0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	l c		0 0	o o	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59. 00
60.00	06000 LABORATORY	0	C		0 0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	C		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	C)	0 0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0	0	
64. 00	06400 I NTRAVENOUS THERAPY	0	(C)	0 0	0	
65. 00	06500 RESPI RATORY THERAPY	0	C	1	0 0	0	
66. 00	06600 PHYSI CAL THERAPY	0	C		0 0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	C	1	0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C	1	0 0	1 ~	
69.00	06900 ELECTROCARDI OLOGY	0	C	1	0 0	0	
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C	1	0 0	1	1
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	1	0 0	0	1 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0			0 0		73.00
74.00	07400 RENAL DIALYSIS				0 0	0	1
75. 00	07500 ASC (NON-DISTINCT PART)				0 0	0	75.00
76. 00	03140 CARDI OLOGY	0	1	1	0 0	_	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0			0 0	1	
, , . 00	OUTPATIENT SERVICE COST CENTERS			1	<u> </u>	. 0	1 , , . 00
88. 00	08800 RURAL HEALTH CLINIC	0	C)	0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	-	II.	0 0		
90. 00	09000 CLINIC	0		1	0 0		
90. 01	04950 SLEEP CLINIC	0			0 0	o o	1
91. 00	09100 EMERGENCY	0			0 0	168, 240	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 0			0	0	

0 0 0

0 0 0

0 0 0

0

0 0 0

0 0 0

94. 00 95. 00

96.00 97.00 0

98. 00 0 168, 240 200. 00

0 92.00

0

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
94. 00 09400 HOME PROGRAM DIALYSIS
95. 00 09500 AMBULANCE SERVICES

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 | 200.00 | Total (lines 50 through 199)

	<u>Financial Systems</u> TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	ELKHART GENER RVI CF OTHER PASS		CN: 15-0018	Peri od:	u of Form CMS-2 Worksheet D	2332-10
	H COSTS		Component	CCN: 15-T018	From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre 5/31/2023 12:	pared: 14 pm
			Title	XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	All Other	Total Cost	Total	Total Charges		
		Medi cal	(sum of cols.	Outpatient	(from Wkst. C,	to Charges	
		Education Cost	1, 2, 3, and 4)	Cost (sum of cols. 2, 3,		(col. 5 ÷ col. 7)	
			4)	and 4)	8)	(see	
				aa .,		instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0			0 99, 837, 813	0. 000000	
51.00	05100 RECOVERY ROOM	0			0 0	0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0			0 0	0.000000	
53.00	05300 ANESTHESI OLOGY	0			0 0	0.000000	
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	0 0	1		0 71, 882, 790	0.000000	
56. 00	05600 RADI OLOGY - THERAPEUTT C	0			0 0	0. 000000 0. 000000	
57. 00	05700 CT SCAN		1		0 75, 354, 470	0.000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			0 12, 594, 500	0. 000000	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	Ö	l .	0 37, 462, 874	0. 000000	
60.00	06000 LABORATORY	0	l e	•	0 84, 714, 848	0. 000000	
60. 01	06001 BLOOD LABORATORY	0			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	1		0 4, 741, 003	0. 000000	
65.00	06500 RESPI RATORY THERAPY	0			0 23, 038, 970	0. 000000	
66.00	06600 PHYSI CAL THERAPY	0	· -		0 5, 950, 031	0. 000000	
67. 00	06700 OCCUPATI ONAL THERAPY	0			0 3, 655, 866	0. 000000	
68. 00	06800 SPEECH PATHOLOGY	0	0		0 1, 473, 463	0. 000000	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0.000000	
70.00	07000 ELECTROENCEPHALOGRAPHY	0 0	0		0 07 005 005	0.000000	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS				0 97, 895, 885 0 142, 930, 841	0. 000000 0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS				0 186, 895, 035	0.000000	
74. 00	07400 RENAL DIALYSIS	0	0		0 100, 073, 033	0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	ı		0 0	0. 000000	
76. 00	03140 CARDI OLOGY	0			0 25, 686, 129	0. 000000	
77. 00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	l e		0 0	0. 000000	
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0. 000000	
90.00	09000 CLI NI C	0			0 1, 125, 770	0. 000000	
90. 01	04950 SLEEP CLINIC	0	1	4,00	0 2, 405, 125	0.000000	
91.00	09100 EMERGENCY	0	· ·			0.003777	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0		0 19, 737, 975	0. 000000	92. 00
94. 00	09400 HOME PROGRAM DIALYSIS	1 0	0		0 0	0. 000000	94. 00
95. 00	09500 AMBULANCE SERVICES		١			0.00000	95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	n		0 0	0. 000000	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	-		0 0	0. 000000	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	1		0	0. 000000	1
70. UU			"		O O	0.00000	, , , , , ,

APPORTIONMENT OF I	ystems NPATIENT/OUTPATIENT ANCILLARY SE		L HOSPITAL Provider Co	CN: 15-0018	Peri od:	w of Form CMS-: Worksheet D	
THROUGH COSTS			Component (CCN: 15-T018	From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre 5/31/2023 12:	pared: 14 pm
			Title	: XVIII	Subprovi der – I RF	PPS	
Cost	Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col. 7)		Costs (col. x col. 10)	8	Costs (col. 9 x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
ANCILLARY S	ERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
50. 00 05000 OPERA		0. 000000	0		0 0	0	50.00
51. 00 05100 RECOV		0. 000000	0		0 0	0	51.00
	ERY ROOM & LABOR ROOM	0. 000000	0		0 0	0	1
53. 00 05300 ANEST		0. 000000	0		0 0	0	53. 00
54. 00 05400 RADI 0	LOGY-DI AGNOSTI C	0. 000000	883		0 0	0	54. 00
55. 00 05500 RADI 0	LOGY-THERAPEUTI C	0. 000000	0		0 0	0	55. 00
56. 00 05600 RADI 0	SOTOPE	0. 000000	0		0 0	0	56. 00
57. 00 05700 CT SC	AN A	0. 000000	2, 792		0 0	0	57. 00
	TIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58. 00
	AC CATHETERIZATION	0. 000000	0		0	0	
60. 00 06000 LABOR.		0. 000000	6, 134		0	0	
60. 01 06001 BL00D		0. 000000	0		0 0	0	1
	LINICAL LAB SERVICES-PRGM ONLY						61. 00
	BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	
	STORING, PROCESSING & TRANS.	0. 000000	0		0 0	0	
1 1	VENOUS THERAPY	0.000000	0	•	0 0	0	
1 1	RATORY THERAPY	0.000000	205	l .	0 0	0	
66. 00 06600 PHYSI		0.000000	26, 999	l .	0 0	0	
67. 00 06700 0CCUP. 68. 00 06800 SPEEC	ATIONAL THERAPY	0. 000000 0. 000000	27, 535 6, 259	l .	0 0	0	
	ROCARDI OLOGY	0. 000000	0, 239		0 0	0	
	ROENCEPHALOGRAPHY	0. 000000	0		0 0	0	
	AL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	
	DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	
	CHARGED TO PATIENTS	0. 000000	26, 291		0 0	Ō	
74.00 07400 RENAL		0. 000000	0		0 0	0	
	NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
76. 00 03140 CARDI		0. 000000	0		0 0	0	76. 00
77. 00 07700 ALLOG	ENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 00
	SERVICE COST CENTERS						
	HEALTH CLINIC	0. 000000	0	l .	0	0	
	ALLY QUALIFIED HEALTH CENTER	0. 000000	0		0 0	0	
90. 00 09000 CLINI		0. 000000	0		0 0	0	
90. 01 04950 SLEEP		0.000000	0		0 0	0	
91. 00 09100 EMERG		0. 003777	0		0 0	0	
	VATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92. 00
	URSABLE COST CENTERS PROGRAM DIALYSIS	0. 000000	0		0 0	0	94. 00
	ANCE SERVICES	0.000000	Ü		U U	0	95.00
	LE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	
	LE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	
1 1	REIMBURSABLE COST CENTERS	0. 000000	0	1			
98. 00 09850 OTHER	KEINDUKSADLE COST CENTERS		()	1	0 0	0	1 98.00

	Financial Systems	ELKHART GENER			In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der C	CN: 15-0018	Peri od:	Worksheet D	
					From 01/01/2022 To 12/31/2022	Part I Date/Time Pre	nared:
					10 12/31/2022	5/31/2023 12:	
			Ti tI	e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
		Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
		(from Wkst. B,		Related Cost			
		Part II, col.		(col . 1 - col			
		26)		2)			
		1.00	2.00	3. 00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		T _				
	ADULTS & PEDI ATRI CS	5, 281, 100		7 0,20.,		111. 06	
	INTENSIVE CARE UNIT	496, 002		496, 00			
	NEONATAL INTENSIVE CARE	91, 319	l .	91, 31		158. 54	
32. 00	CORONARY CARE UNIT	0			0	0.00	
	BURN INTENSIVE CARE UNIT	0			0	0.00	
	SURGICAL INTENSIVE CARE UNIT	444 045			0 0	0.00	
40.00	SUBPROVIDER - I PF	441, 215		1		153. 73	
	SUBPROVI DER - I RF	21, 662		21, 66		212. 37	
	NURSERY	390, 667		390, 66		197. 01	
	SKILLED NURSING FACILITY	0			0	0.00	
	NURSING FACILITY	0 721 0/5		/ 701 0/	0 0	0.00	45. 00
200.00	Total (lines 30 through 199) Cost Center Description	6, 721, 965 I npati ent	Inpati ent	6, 721, 96	59, 215		200. 00
	cost center bescription	Program days	Program				
		Program days	Capital Cost				
			(col. 5 x col.				
			6)				
		6.00	7.00				
	INPATIENT ROUTINE SERVICE COST CENTERS	1 2.22		1			
	ADULTS & PEDIATRICS	1, 683	186, 914	ļ			30.00
31. 00	INTENSIVE CARE UNIT	44	3, 558	3			31.00
31. 01	NEONATAL INTENSIVE CARE	98	15, 537	,			31. 01
	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	83	12, 760				40. 00
41.00	SUBPROVI DER - I RF	10	2, 124	ı			41.00
43.00	NURSERY	281	55, 360				43.00
44.00	SKILLED NURSING FACILITY	0					44.00
45 00	NURSING FACILITY	1 0	1	ol .			45 00

276, 253

45.00

200. 00

43.00 SUBFROVIDER - TRI 43.00 NURSERY 44.00 SKILLED NURSING FACILITY 45.00 NURSING FACILITY 200.00 Total (lines 30 through 199)

Heal th	Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C	CN: 15-0018	Peri od:	Worksheet D	
					From 01/01/2022 To 12/31/2022	Part II Date/Time Pre	narod:
					10 12/31/2022	5/31/2023 12:	14 pm
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Capi tal	Total Charges			Capital Costs	
		Related Cost	(from Wkst. C,		Program	(column 3 x	
		(from Wkst. B,	Part I, col.	(col . 1 ÷ col	. Charges	column 4)	
		Part II, col.	8)	2)			
		26) 1. 00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATING ROOM	2, 213, 123	99, 837, 813	0. 02216	9, 695, 468	214, 919	50.00
51. 00	05100 RECOVERY ROOM	0	0	1		0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		1		0	52.00
53. 00	05300 ANESTHESI OLOGY	0	l o	0.00000		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 694, 829	71, 882, 790	0. 02357	'8 4, 199, 752	99, 022	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	O	0.00000		0	55. 00
56.00	05600 RADI OI SOTOPE	0	l o	0.00000	0 0	0	56. 00
57.00	05700 CT SCAN	267, 664	75, 354, 470	0. 00355	4, 637, 349	16, 472	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	136, 360	12, 594, 500	0. 01082	648, 138	7, 017	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	155, 030	37, 462, 874	0. 00413	3, 665, 157	15, 166	59. 00
60.00	06000 LABORATORY	215, 887	84, 714, 848	0. 00254	8 10, 106, 435	25, 751	60.00
60. 01	06001 BLOOD LABORATORY	0	0	0.00000	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	0.00000	0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000	0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	293, 422	4, 741, 003			53, 479	64. 00
65. 00	06500 RESPI RATORY THERAPY	75, 562	23, 038, 970	0. 00328	3, 553, 403	11, 655	
66. 00	06600 PHYSI CAL THERAPY	189, 835	5, 950, 031			11, 749	
67. 00	06700 OCCUPATI ONAL THERAPY	90, 249				7, 989	
68. 00	06800 SPEECH PATHOLOGY	53, 796	1, 473, 463			3, 874	
69. 00	06900 ELECTROCARDI OLOGY	0	0	0.00000		0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.00000		0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	200, 010				0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	371, 493	142, 930, 841			0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	232, 315	186, 895, 035			17, 569	
74.00	07400 RENAL DIALYSIS	0	0	0.00000		0	,
75. 00	07500 ASC (NON-DISTINCT PART)	0	05 (0) 100	0.00000		0	
76. 00	03140 CARDI OLOGY	430, 928	25, 686, 129	•		19, 377	
77. 00	07700 ALLOGENEI C HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0.00000	00 0	0	77. 00
88. 00	08800 RURAL HEALTH CLINIC	0		0.00000	00 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		1		0	89. 00
90.00	09000 CLINIC	179, 081	1, 125, 770			0	90.00
90. 00	04950 SLEEP CLINIC	986	2, 405, 125			0	90.00
91. 00	09100 EMERGENCY	691, 423	44, 544, 319	1		39, 241	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	645, 392	19, 737, 975				
72.00	OTHER REIMBURSABLE COST CENTERS	043, 372	17, 737, 773	0.0320	0		72.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.00000	0 0	0	94. 00
95. 00	09500 AMBULANCE SERVICES]			Ĭ	95.00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	n	0. 00000	00	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0		0.00000		ő	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0		0.00000		0	98. 00
200.00		8, 137, 385	941, 927, 707		55, 985, 274	543, 280	
	•	*	<u>-</u>	•	•	=	•

NATE	APPOR	TIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COS	TS Provider C	F	Period: From 01/01/2022	Worksheet D Part III	
Nursing Program Post-Stepdown Adjustments					Т	o 12/31/2022		pared: 14 pm
Program Program Post-Stepdown Adjustments Adjust							PPS	
NPATLENT ROUTINE SERVICE COST CENTERS 1A		Cost Center Description						
Inpart ent Routine Service COST CENTERS 1.00				Program		Cost		
INPATIENT ROUTINE SERVICE COST CENTERS					Adjustments		Education Cost	
INPATI ENT ROUTINE SERVICE COST CENTERS				1.00	24	2.00	2.00	
30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 0 0 0 0		INDATI ENT DOUTINE CEDALCE COCT CENTERS	I IA	1.00		2.00	3.00	
33.00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 0 31.0 32.00 03200 COROMARY CARE UNIT 0 0 0 0 0 31.0 32.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 40.00 04000 SUBPROVI DER - IPF 0 0 0 0 0 0 41.00 04100 SUBPROVI DER - IRF 0 0 0 0 0 0 41.00 04100 SUBPROVI DER - IRF 0 0 0 0 0 0 41.00 04300 SUBPROVI DER - IRF 0 0 0 0 0 0 41.00 04300 SUBPROVI DER - IRF 0 0 0 0 0 0 41.00 04300 SUBPROVI DER - IRF 0 0 0 0 0 0 41.00 04300 SUBPROVI DER - IRF 0 0 0 0 0 0 41.00 04300 SUBPROVI DER - IRF 0 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 45.00 05000 04500 05000 05000 05000 INPATIENT ROUTINE SERVICE COST CENTERS 0 Total Patient Per Diem (col. by Program Days 05000 05000 05000 31.00 03100 03000 ADULTS & PEDIATRICS 0 0 0 0 0 0 0 33.00 033000 NURSING FACILITY 0 0 0 0 0 0 0 0 33.00 033000 03000 NURSING FACILITY 0 0 0 0 0 0 0 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 35.00 03000	20.00				ı			20.00
33.00 03101 NICONATAL INTENSIVE CARE 0 0 0 0 0 0 32.00 32.00 3200 02000 COROMARY CARE UNIT 0 0 0 0 0 0 32.00 32.00 33.00 03000 RURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 33.00 33.00 33.00 03000 RURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0								
32.00 03200 CORONARY CARE UNIT 0 0 0 0 0 0 32.00 33.00 03300 BURN INTERNSIVE CARE UNIT 0 0 0 0 0 0 0 33.00 34.00 03400 SUBPROVIDER - IPF 0 0 0 0 0 0 0 0 41.00 04400								
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 33.0 43.00 03400 SUBPROVIDER - I PF 0 0 0 0 0 0 0 0 41.00 04100 SUBPROVIDER - I PF 0 0 0 0 0 0 0 41.00 04100 SUBPROVIDER - I PF 0 0 0 0 0 0 0 41.00 04100 SUBPROVIDER - I RF 0 0 0 0 0 0 0 41.00 04300 NURSERY 0 0 0 0 0 0 0 41.00 04300 NURSERY 0 0 0 0 0 0 41.00 04300 NURSING FACILITY 0 0 0 0 0 44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 0 0 0 0				_				1
34. 00 03400 SURRICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0				_			1	
40.00 04000 SUBPROVIDER - IPF 0 0 0 0 0 0 0 0 0			0	_				
41.00 04100 SUBPROVIDER - IRF 0 0 0 0 0 0 41.00 43.00 04300 NURSERY 0 0 0 0 0 0 43.00 44.00 04400 SKILLED NURSI NG FACILITY 0 0 0 0 0 0 0 45.00 04500 NURSI NG FACILITY 0 0 0 0 0 0 0 45.00 04500 NURSI NG FACILITY 0 0 0 0 0 0 0 45.00 04500 NURSI NG FACILITY 0 0 0 0 0 0 0 Cost Center Description Swing-Bed Adjustment Amount (See Instructions) Interventions Interventi			0	_			1	
43.00 04300 NURSERY 0 0 0 0 0 0 44.00 44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 45.00 04500 NURSING FACILITY 0 0 0 0 46.00 04500 NURSING FACILITY 0 0 0 0 47.500 04500 NURSING FACILITY 0 0 0 47.500 04500 NURSING FACILITY 0 0 0 0 0 47.500 04500 NURSING FACILITY 0 0 0 0 0 47.500 04500 NURSING FACILITY 0 0 0 0 0 47.500 04500 NURSING FACILITY 0 0 0 0 0 47.500 04500 NURSING FACILITY 0 0 0 0 0 47.500 04500 NURSING FACILITY 0 0 0 0 0 47.500 04500 NURSING FACILITY 0 0 0 0 0 47.500 04500 NURSING FACILITY 0 0 0 0 0 47.500 04500			0					
44.00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	_	· -	_	1	
45.00			0	0	1	_	0	
Total (Lines 30 through 199)			0	_	· ·	_		44. 00
Swing-Bed Adjustment Adjustment Adjustment Aniont (see instructions) Swing-Bed Adjustment Aniont (see instructions) Total (cost of Cost Center Description Service Cost Centers			0	0) C	_	l	45. 00
Adjustment Amount (see Instructions) 1 through 3, 1 through 4, 10 through 3, 1 throu	200.00		0	0	C	, 0		200. 00
INPATIENT ROUTINE SERVICE COST CENTERS 1 through 3, minus col. 4) 3.00 3.000 A0JULTS & PEDIATRICS 0 0 47,550 0.00 1,683 30.00 31.00 INTENSIVE CARE UNIT 0 6,134 0.00 44 31.00 31.01 0.3100 INTENSIVE CARE UNIT 0 5.76 0.00 98 31.00 32.00 0.3200 CORONARY CARE UNIT 0 0 0.00 0.00 0.32.00 0.3200 0.3200 0.000 0.00 0.00 0.32.00 0.3200 0.000 0.00 0.00 0.32.00 0.3200 0.000 0.00 0.00 0.32.00 0.3200 0.000 0.00 0.00 0.32.00 0.3200 0.000 0.00 0.00 0.32.00 0.3200 0.000 0.00 0.00 0.00 0.32.00 0.000 0.00 0.00 0.00 0.32.00 0.000 0.00		Cost Center Description						
INPATIENT ROUTINE SERVICE COST CENTERS 4.00 5.00 6.00 7.00 8.00					Days	5 ÷ col. 6)	Program Days	
INPATIENT ROUTINE SERVICE COST CENTERS								
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 3000								
30.00 03000 ADULTS & PEDIATRICS 0 0 47,550 0.00 1,683 30.00 31.00 03100 INTENSI VE CARE UNIT 0 6,134 0.00 44 31.00 31.01 NEONATAL INTENSIVE CARE 0 576 0.00 98 31.00 32.00 03200 CORONARY CARE UNIT 0 0 0 0.00 0 0.32.00 33.00 33300 BURN INTENSIVE CARE UNIT 0 0 0 0.00 0 0.33.00 33.00 33400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0.00 0 0.00 0 34.00 0.00 0.00 0 0.00 0 0.00 0			4. 00	5. 00	6. 00	7. 00	8. 00	
31.00				1	1			
31. 01 03101 NEONATAL INTENSIVE CARE 0 576 0.00 98 31. 0 32. 00 33200 CORONARY CARE UNIT 0 0 0.00 0.32. 00 33. 00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0.00 0.33. 00 33. 00 33.00 03300 SURGICAL INTENSIVE CARE UNIT 0 0 0.00 0.00 0.33. 00 034.00 SURGICAL INTENSIVE CARE UNIT 0 0 0.00 0.00 0.34. 00 04000 SUBPROVI DER - IPF 0 0 0 2,870 0.00 83 40. 00 41. 00 04100 SUBPROVI DER - IRF 0 0 102 0.00 10 41. 00 44. 00 04400 SKILLED NURSING FACILITY 0 0 0.00 0 281 43. 00 43. 00 04500 NURSING FACILITY 0 0 0.00 0 0.00 0 45. 00 04500 NURSING FACILITY 0 0 0.00 0 0.00 0 45. 00 059, 215 0 0.00 0 0.00 0 0.00 0			0	l .				1
32.00 03200 CORONARY CARE UNIT 0 0 0 0.00 0 32.00				_			l	1
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0.00 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0.00 0 34.00 40.00 04000 SUBPROVIDER - IPF 0 0 0 2,870 0.00 83 40.00 41.00 04100 SUBPROVIDER - IRF 0 0 102 0.00 10 41.00 04300 NURSERY 0 1,983 0.00 281 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 0.00 0 44.00 45.00 04500 NURSING FACILITY 0 0 0 0.00 0 45.00 04500 NURSING FACILITY 0 0 0 0.00 0 59,215 2,199 200.00 Cost Center Description Inpatient Program Pass-Through Cost Center Description Program Pass-Through Cost Center Description Inpatient Program Pass-Through 10				_			l .	1
34. 00		l		0			0	
40. 00				0) C			33. 00
41. 00				0	1			
43. 00			0	0				
A4. 00			0	0			10	41. 00
45. 00				0	1, 983	0.00	281	43.00
Total (lines 30 through 199) 0 59,215 2,199 200.00	44.00	04400 SKILLED NURSING FACILITY		0	C	0.00	0	44.00
Cost Center Description	45.00	04500 NURSING FACILITY		0	C	0.00	0	45. 00
Program Pass-Through Cost (col. 7 x col. 8) 9.00	200.00	Total (lines 30 through 199)		0	59, 215)	2, 199	200.00
Pass-Through Cost (col. 7 x col. 8) 9.00		Cost Center Description						
INPATIENT ROUTINE SERVICE COST CENTERS								
INPATIENT ROUTINE SERVICE COST CENTERS 9.00 30.00 30.00 30.00 ADULTS & PEDIATRICS 0 31.00 31.00 INTENSIVE CARE UNIT 0 31.01 32.00 03200 CORONARY CARE UNIT 0 32.00 32.00 32.00 32.00 32.00 33.00								
9.00 INPATIENT ROUTINE SERVICE COST CENTERS								
INPATIENT ROUTINE SERVICE COST CENTERS 30.00 30.00 ADULTS & PEDIATRICS 0 31.00 31.00 03100 INTENSIVE CARE UNIT 0 31.00 32.00 03200 CORONARY CARE UNIT 0 32.00 32.00 32.00 33.00								
30. 00 03000 ADULTS & PEDIATRICS 0 30. 00 31. 00 31. 01 31. 01 03101 NEONATAL INTENSIVE CARE 0 31. 01 32. 00 03200 CORONARY CARE UNIT 0 32. 00 32. 00 33. 01		INDATI ENT POUTINE CERVI DE COCT DENTERO	9.00					
31. 00 03100 INTENSI VE CARE UNI T	20.00							20.00
31. 01 03101 NEONATAL INTENSIVE CARE 0 31. 0 32. 00 03200 CORONARY CARE UNIT 0 32. 00 33.								1
32. 00 03200 CORONARY CARE UNIT 0 32. 00								1
								1
33 UU								
								33. 00
								34. 00
			0					40.00
			0	1				41. 00
43. 00 04300 NURSERY 0 43. 00	4.3 UU							1 43 00
								1
	44. 00	04400 SKILLED NURSING FACILITY	0					44. 00
200.00 Total (lines 30 through 199) 0 200.00	44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	l .				44. 00 45. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2022	Part IV
To 12/31/2022	Date/Time Prepared:
5/31/2023	12:14 pm THROUGH COSTS

					12,01,2022	5/31/2023 12:	14 pm
			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	(0	0	50. 00
51.00	05100 RECOVERY ROOM	0	(0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	(0 0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	(0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	(0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	(0 0	0	56. 00
57.00	05700 CT SCAN	0	(0 0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	(ol	0 0	0	59. 00
60.00	06000 LABORATORY	0	(ol	ol o	0	60. 00
60. 01	06001 BLOOD LABORATORY	0	Ċ		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	Č		0 0	Ö	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0		á	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	Ö	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0			0 0	0	69. 00
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	0			0 0		70.00
71. 00	I I	0			0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 MPL. DEV. CHARGED TO PATIENTS	0			0 0		71.00
	I I	0			0 0	1	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0			-	0	73. 00
74.00	07400 RENAL DIALYSIS	0	(9	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	(0 0	0	75. 00
76. 00	03140 CARDI OLOGY	0	(0 0	0	76. 00
77. 00	07700 ALLOGENEI C HSCT ACQUISITION	U	(<u>/ </u>	0 0	0	77. 00
00 00	OUTPATIENT SERVICE COST CENTERS			<u> </u>	0 0	0	00 00
88. 00	08800 RURAL HEALTH CLINIC	0	(0 0	1	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(0 0	0	89. 00
90.00	09000 CLINIC	0	(0 0	0	90.00
90. 01	04950 SLEEP CLINIC	0	(0 0	0	90. 01
91.00	09100 EMERGENCY	0	()	0 0	,	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS			J			
94.00	09400 HOME PROGRAM DIALYSIS	0	(7	0	0	94. 00
95.00	09500 AMBULANCE SERVICES	_	_			_	95. 00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED	0	(김	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
200.00	Total (lines 50 through 199)	0	()	0 0	168, 240	200. 00

THROUGH COSTS

					10 12/31/2022	5/31/2023 12:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
	•	Medi cal	(sum of cols.	Outpatient	(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						
50.00	05000 OPERATING ROOM	0	0		0 99, 837, 813	0.000000	50.00
51.00	05100 RECOVERY ROOM	0	0		0	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0.000000	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 71, 882, 790	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0.000000	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0	0.000000	56. 00
57.00	05700 CT SCAN	0	0		0 75, 354, 470	0.000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 12, 594, 500	0.000000	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 37, 462, 874	0.000000	59. 00
60.00	06000 LABORATORY	O	0		0 84, 714, 848	0.000000	60. 00
60. 01	06001 BLOOD LABORATORY	O	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	o	0		0	0.000000	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	o	0		0	0.000000	63. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 4, 741, 003	0.000000	64. 00
65.00	06500 RESPI RATORY THERAPY	O	0		0 23, 038, 970	0.000000	65. 00
66.00	06600 PHYSI CAL THERAPY	O	0		0 5, 950, 031	0.000000	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	O	0		0 3, 655, 866	0.000000	67. 00
68.00	06800 SPEECH PATHOLOGY	O	0		0 1, 473, 463	0.000000	68. 00
69.00	06900 ELECTROCARDI OLOGY	O	0		0 0	0.000000	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	O	0		0 0	0.000000	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 97, 895, 885	0.000000	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 142, 930, 841	0.000000	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 186, 895, 035	0.000000	73. 00
74.00	07400 RENAL DIALYSIS	0	0		0 0	0.000000	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	0.000000	75. 00
76.00	03140 CARDI OLOGY	o	0		0 25, 686, 129		76. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0	0		0 0	0.000000	77. 00
	OUTPATIENT SERVICE COST CENTERS			•	<u> </u>		
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0.000000	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	O	0		0 0	0. 000000	89. 00
90.00	09000 CLI NI C	o	0		0 1, 125, 770	0. 000000	90. 00
90. 01	04950 SLEEP CLINIC	O	0		0 2, 405, 125		1
91. 00	09100 EMERGENCY	O	168, 240	168, 24			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	1	0 19, 737, 975		92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DI ALYSIS	0	0		0 0	0.000000	94.00
95. 00	09500 AMBULANCE SERVICES		· ·				95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0. 000000	96. 00
97. 00	09700 DURABLE MEDI CAL EQUI P-SOLD		0		o o	0. 000000	
98. 00	09850 OTHER REIMBURSABLE COST CENTERS		0		o o	0. 000000	
200.00			168, 240	168, 24	0 941, 927, 707	l .	200. 00
				•		•	•

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2022	Part IV
To 12/31/2022	Date/Time Prepared:
5/31/2023	12:14 pm THROUGH COSTS

					5/31/2023 12:	14 pm
		Ti tl	e XIX	Hospi tal	PPS	•
Cost Center Description	Outpati ent	I npati ent	Inpatient	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col . 6 ÷ col .	g	Costs (col.		Costs (col. 9	
	7)		x col. 10)		x col . 12)	
	9. 00	10.00	11.00	12.00	13.00	
ANCILLARY SERVICE COST CENTERS	1					
50. 00 05000 OPERATI NG ROOM	0. 000000	9, 695, 468		0 25, 827, 707	0	50.00
51. 00 05100 RECOVERY ROOM	0. 000000	0	1	0 0		51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0 0		52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	4, 199, 752		0 9, 610, 966	-	54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	4, 177, 732		0 7,010,700	0	55. 00
56. 00 05600 RADI OI SOTOPE	0. 000000	0		0 0		56. 00
57. 00 05700 CT SCAN	0. 000000	4 (27 240		-		57. 00
	1	4, 637, 349				
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	648, 138		0 1, 459, 653		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	3, 665, 157		0 2, 767, 566		59. 00
60. 00 06000 LABORATORY	0. 000000	10, 106, 435		0 8, 261, 062	0	60. 00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	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	864, 095		0 977, 909	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000	3, 553, 403		0 494, 800	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 000000	368, 234		0 340, 375	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000	323, 621		0 99, 527	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000	106, 107		0 62, 012	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	Ö	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 16, 896		71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	o o	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	14, 134, 431		9, 780, 391	0	73. 00
74. 00 07400 RENAL DIALYSIS	0. 000000	14, 134, 431		0 7,700,371	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0		75. 00
76. 00 03140 CARDI OLOGY	0. 000000	1, 154, 980		0 1, 862, 010		76. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	1, 154, 960	•	0 1, 802, 010		77. 00
OUTPATIENT SERVICE COST CENTERS	0.000000	U		0 0	U	77.00
88.00 08800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
		0	•			
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0		-	_	89. 00
90. 00 09000 CLI NI C	0. 000000	0		0 60, 147	0	90.00
90. 01 04950 SLEEP CLINIC	0.000000	0 500 101		0 389, 583		90. 01
91. 00 09100 EMERGENCY	0. 003777	2, 528, 104				91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 4, 448, 908	0	92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000	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 Total (lines 50 through 199)		55, 985, 274	9, 54	9 90, 401, 363	45, 618	200. 00
•					'	

APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0018	Period: From 01/01/2022	Worksheet D Part V	
					To 12/31/2022		pared: 14 pm
			Ti tl	e XIX	Hospi tal	PPS	p
	·			Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see		Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.			
		1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATING ROOM	0. 309493	25, 827, 707		0 0	7, 993, 495	50.00
51. 00	05100 RECOVERY ROOM	0. 000000			0 0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000			0 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000			0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 179102	9, 610, 966		0 0	1, 721, 343	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. 034170	11, 863, 908		0 0	405, 390	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 090853	1, 459, 653		0 0	132, 614	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 068601	2, 767, 566		0	189, 858	59. 00
60.00	06000 LABORATORY	0. 165012	8, 261, 062		0 0	1, 363, 174	60. 00
60. 01	06001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
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	62. 00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000		•	0	0	63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 560402	977, 909	•	0		64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 226299	· ·	•	0		65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 492322	340, 375		0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 309538	· ·	•	0	,	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 333706	l		0	,	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	0	•	0	1	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000			0	1	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 138092	l		0		
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 176299		•	0		72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 173047	9, 780, 391		0		73.00
74. 00	07400 RENAL DIALYSIS	0.000000	l .		0 0	0	74.00
75. 00 76. 00	07500 ASC (NON-DI STI NCT PART) 03140 CARDI OLOGY	0. 000000 0. 145581	1, 862, 010		0 0	1	75. 00 76. 00
77.00	07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	1,862,010		0 0		77.00
77.00	OUTPATIENT SERVICE COST CENTERS	0.00000			0 0	0	77.00
88. 00	08800 RURAL HEALTH CLINIC						88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER						89. 00
90.00	09000 CLINIC	0. 904083	60, 147		0 0	54, 378	1
90. 01	04950 SLEEP CLINIC	0. 245495			o o		90. 01
91. 00	09100 EMERGENCY	0. 430572			o o		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 430361	4, 448, 908		0 0		
	OTHER REIMBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,				
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000			0 0		94. 00
95.00	09500 AMBULANCE SERVICES	0. 000000	0		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	0	97. 00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	ł		0	0	98. 00
200.00			90, 401, 363	1	0	, ,	
201.00					0		201. 00
000 5	Only Charges		00 101 5:-		-	04 045 05:	000 00
202. 00	Net Charges (line 200 - line 201)	I	90, 401, 363	I	0 0	21, 915, 896	1202.00

Peri od: Worksheet D From 01/01/2022 Part V To 12/31/2022 Date/Time Prepared: 5/31/2023 12:14 pm Provi der CCN: 15-0018

					5/31/2023 12:	14 pm_
		Title	e XIX	Hospi tal	PPS	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Rei mbursed	Rei mbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	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	ol ol				51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	ol				52. 00
53. 00 05300 ANESTHESI OLOGY	0	o o				53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C						1
	0	1 1				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 MAGING (MRI)	0	0				58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	ol ol				59. 00
60. 00 06000 LABORATORY	0	ol ol				60.00
60. 01 06001 BLOOD LABORATORY	0	ol ol				60. 01
		()				1
	0					61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63. 00
64.00 06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00 06500 RESPIRATORY THERAPY	0	o				65.00
66. 00 06600 PHYSI CAL THERAPY	0	ol ol				66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	ol				67.00
68. 00 06800 SPEECH PATHOLOGY	0	ol ol				68. 00
69. 00 06900 ELECTROCARDI OLOGY						69. 00
	0	-				
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73. 00
74.00 07400 RENAL DIALYSIS	0	o o				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	ol ol				75. 00
76. 00 03140 CARDI OLOGY	0	ol				76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	1				77. 00
		<u>'</u>				77.00
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	0	0				90. 01
91. 00 09100 EMERGENCY	0	ol ol				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	ol ol				92.00
OTHER REIMBURSABLE COST CENTERS		·				72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	ol				94. 00
95. 00 09500 AMBULANCE SERVICES	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
200.00 Subtotal (see instructions)	0	ol ol				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	ol ol				202. 00
252. 55 ₁		۱ ۷			!	1232.00

Health Financial Systems	ELVHADT CENER	DAL HOSDITAL		العالما	u of Form CMS	2552 10
Health Financial Systems APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	ELKHART GENER	Provi der C	CN: 15_0018	Peri od:	u of Form CMS-: Worksheet D	2552-10
ALTORITONINENT OF THE ATTENT ANOTEEART SERVICE CALLER	AL 00313	Trovider C	CIV. 13-0010	From 01/01/2022	Part II	
		Component	CCN: 15-S018	To 12/31/2022	Date/Time Pre	pared:
		Ti +I	e XIX	Subprovi der -	5/31/2023 12: PPS	14 pm
		11111	e viv	I PF	FF3	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00 05000 OPERATING ROOM	2, 213, 123	99, 837, 813	0. 02210	57 0	0	50. 00
51.00 05100 RECOVERY ROOM	0	o	0.0000	00	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	O			0	
53. 00 05300 ANESTHESI OLOGY	0	1	1 0.0000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 694, 829				480	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1	0.00000		0	
56. 00 05600 RADI 01 SOTOPE 57. 00 05700 CT SCAN	2/7 //4		1 0.0000		0	1
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	267, 664 136, 360				130 38	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	155, 030		1		0	1
60. 00 06000 LABORATORY	215, 887				1, 050	
60. 01 06001 BLOOD LABORATORY	0		1		0	1
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	_	1 0.0000		0	1
64. 00 06400 I NTRAVENOUS THERAPY	293, 422				0	
65. 00 06500 RESPI RATORY THERAPY	75, 562		1		132	1
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	189, 835		1		80	1
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	90, 249 53, 796		1		34 5	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	33, 740		ı		0	
70. 00 07000 ELECTROENCEPHALOGRAPHY			1		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	200, 010	97, 895, 885	1		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	371, 493	142, 930, 841	0. 00259	99 0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	232, 315	186, 895, 035	0. 00124	442, 875	550	73. 00
74. 00 07400 RENAL DI ALYSI S	0				0	
75. 00 07500 ASC (NON-DISTINCT PART)	0		1 0.0000		0	
76. 00 03140 CARDI OLOGY	430, 928				889	1
77.00 07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS	0	0	0.00000	00 0	0	77. 00
88. 00 08800 RURAL HEALTH CLINIC	1 0	0	0.00000	00 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER					Ö	
90. 00 09000 CLI NI C	179, 081	1, 125, 770	1		Ō	
90. 01 04950 SLEEP CLINIC	986			10 0	0	90. 01
91. 00 09100 EMERGENCY	691, 423	44, 544, 319	0. 01552	192, 641	2, 990	91. 00
92.00 OBSERVATION BEDS (NON-DISTINCT PART)	0	19, 737, 975	0.0000	00 0	0	92.00
OTHER REIMBURSABLE COST CENTERS	1	1		20		04.00
94. 00 09400 HOME PROGRAM DI ALYSI S 95. 00 09500 AMBULANCE SERVI CES	0	0	0.00000	00	0	1
95. 00 09500 AMBULANCE SERVI CES 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0	0. 00000	00	0	95. 00 96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-RENTED		_	i		0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		_	i		0	
200.00 Total (lines 50 through 199)	7, 491, 993	941, 927, 707		1, 205, 428		200. 00
	•		•	*		-

Health Financial Systems	ELKHART GENER				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY	SERVICE OTHER PASS	S Provider C	CN: 15-0018	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-S018	From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre	nared:
		Component	CON. 15 5010	10 12/31/2022	5/31/2023 12:	14 pm
		Ti tl	e XIX	Subprovi der -	PPS	
	I			I PF		
Cost Center Description	Non Physician		Nursi ng		Allied Health	
	Anesthetist Cost	Program	Program	Post-Stepdown		
	COST	Post-Stepdown Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS	1.00	Zn	2.00	J.A.	3.00	
50. 00 05000 OPERATI NG ROOM	0	C		0 0	0	50.00
51. 00 05100 RECOVERY ROOM	0	l c)	0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	C)	0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	C)	0 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C	1	0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	l c)	0 0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0	C)	0 0	0	56. 00
57. 00 05700 CT SCAN	0	C)	0 0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C)	0 0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C)	0 0	0	59. 00
60. 00 06000 LABORATORY	0	C)	0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	C)	0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	5 0	C	1	0	0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	1	0 0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	C	1	0 0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	0	C	1	0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	C	1	0 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	C	1	0 0	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		1	0 0	0	69.00
70. 00 07000 ELECTROCARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	0		1	0 0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			1	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			0 0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0			o o	0	75. 00
76. 00 03140 CARDI OLOGY	0			0 0	0	76. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0		1	o o	-	77. 00
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	C	1	0 0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	c)	0 0	0	89. 00
90. 00 09000 CLI NI C	0	c)	0 0	0	90.00
90. 01 04950 SLEEP CLINIC	0	C)	0 0	0	90. 01
91. 00 09100 EMERGENCY	0	C)	0 0	168, 240	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)) 0		I	0	0	92 00

0 0 0

0 0 0

0 0 0

0

0 0 0

0 0 0

94. 00 95. 00

96.00 97.00 0

98. 00 0 168, 240 200. 00

0 92.00

0

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
94. 00 09400 HOME PROGRAM DIALYSIS
95. 00 09500 AMBULANCE SERVICES

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 | 200.00 | Total (lines 50 through 199)

Through Cost Component COM: 15-5018 Tom 01/01/2023 Part IV Tom 01/01/2023 To 01/01	Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ELKHART GENER		CN: 15_0018	In Lie	worksheet D	2552-10
All Other Medical Cost		SERVICE OTHER TAS			From 01/01/2022	Part IV Date/Time Pre	pared: 14 pm
All Other Medical Education Cost Cost (cum of coils, (sum of coils, (sum of coils, 2, 3, and 4) All Other Cost (sum of coils, 2, 3, 4, 3, 4, 3, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4, 4,			Ti tl	e XIX		PPS	
Education Cost 1, 2, 3, and Cost (sum of cols. 2, 3)	Cost Center Description				Total Charges		
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS		Education Cost					
ANCILLARY SERVICE COST CENTERS			4)		0)		
ANCILLARY SERVICE COST CENTERS							
50.00 05000 0FERTAI N. GROM 0 0 0 0 99, 837, 813 0.000000 51.00 51.00 05100 05200 0FELOVERY ROM 0 0 0 0 0 0 0 0 0		4. 00	5.00	6. 00	7. 00	8. 00	
51.00 05100 RECOVERY ROOM A LABOR ROOM 0 0 0 0 0 0 0 0 0							
52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0				1			
53.00 05300 ANESTHESI DLOGY 0 0 0 0 0 0 0 0 0					-		1
54.00 05400 RADI OLOGY-DI AGNOSTIC 0 0 0 0 71,882,790 0.000000 54.00 0.550 0.5500 RADI DLOGY-THERAPPUTI C 0 0 0 0 0 0 0 0 0 0.000000 55.00 0.5500 RADI DLOGY-THERAPPUTI C 0 0 0 0 0 0 0 0 0 0.000000 56.00 0.570 0.570 0.570 0.570 0.570 0.570 0.570 0.570 0.570 0.570 0.570 0.570 0.570 0.570 0.570 0.570 0.580 0.5800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 12,594,500 0.000000 57.00 0.590		1	ł .	1			
55.00 OSDO RADIO LOCY-THERAPPUTIC 0 0 0 0 0 0 0 0 0	I I		1		-		
56.00 OSCOO RADIO I SOTOPE	I I	_	-	1			
57. 00 05700 CT SCAN 0 0 0 0 75, 354, 470 0.000000 57. 08. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 12, 594, 500 0.000000 58. 00 0.0000000 0.0000000 0.000000 0.0000000 0.000000 0.000000 0.0000000 0.000000 0.00		_	ļ		9		
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 0 0 12, 594, 500 0.0000000 58. 0					-		
59.00 05900 CARDIAC CATHETERI ZATION 0 0 0 37, 462, 874 0.000000 59.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00000 0.00 0.00000 0.00 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.00000 0.000000 0.00000 0.00000 0.00000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000			ļ	1			
60. 00 06000 LABORATORY 0 0 0 0 84,714,848 0.000000 60. 00 60.		o o	ĺ	,			
61, 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 0 0 0 0 0 0 0 0		0	0	j			1
62.00 06200 MPOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0	60. 01 06001 BL00D LABORATORY	0	0)	0 0	0. 000000	60. 01
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0							61.00
64. 00 06400 INTRAVENOUS THERAPY 0 0 0 4, 741, 003 0.000000 64, 06 65. 00 65. 00 66. 00				1	0		
65. 00 06500 RESPI RATORY THERAPY 0 0 0 0 23, 038, 970 0.000000 65, 00 06600 06600 06600 070000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 07000 070000 070000 07000 070000 0700000 0700000 07000000 07000000 07000000 070000000 070000000 0700000000				1	9		
66. 00 06600 PHYSI CAL THERAPY 0 0 0 5,950,031 0.000000 66. 00 67. 00 0 0 0 0 0 3,655,866 0.000000 67. 00 0 0 0 3,655,866 0.000000 67. 00 0 0 0 0 0 0 0 0 0		-	1		., ,		
67. 00 06700 06700 06700 06700 06700 06700 06700 06800				1			
68. 00 06800 SPEECH PATHOLOGY 0 0 0 1,473,463 0.000000 68. 00 69. 00 00 00 00 00 00 00 00			_	1	-,		
69. 00 06900 CLECTROCARDIOLOGY 0 0 0 0 0 0 0 0 0		1					1
70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 0		_	-	1			
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 0 0 97,895,885 0.000000 71. 00 72. 00 73. 00 73.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 142,930,841 0.000000 72. 00 73. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 186,895,035 0.000000 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 0.000000 74. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0.000000 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0.000000 75. 00 07500 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0.000000 75. 00 07700 ALLOGENEIC HSCT ACQUISITION 0 0 0 0 0.000000 75. 00 00 00 00 00 00 00 00			-		9		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 142, 930, 841 0.000000 72. 073. 00 73. 00 73.00 73.00 73.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 74.00 75.00 0.7500 ASC (NON-DISTINCT PART) 0 0 0 0 0.000000 74.00 75.00 0.000000 74.00 76.00 0.000000 74.00 77		_	ĺ	l .	-		1
74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 0		0	0				1
75. 00	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0)	0 186, 895, 035	0. 000000	73. 00
76. 00		_	ı	1			
77. 00 07700 ALLOGENEI C HSCT ACQUISITION 0 0 0 0 0 0 0.000000 77. 00 0 0 0 0.000000 77. 00 0 0 0				l .			
SECTION SERVICE COST CENTERS SECTION SERVICE COST CENTERS SECTION							
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 0 0 0 0		0	0		0 0	0.000000	77. 00
89. 00	OUTPATIENT SERVICE COST CENTERS		1 0	ı		0.000000	00 00
90. 00				1			
90. 01				1	-		
91. 00 09100 EMERGENCY 0 168, 240 168, 240 44, 544, 319 0. 003777 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 0 19, 737, 975 0. 0000000 92. 00 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0. 000000 94. 00 09400 HOME PROGRAM DI ALYSI S 0 0 0 0 0. 000000 95. 00 09500 AMBULANCE SERVI CES 95. 00 96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0. 000000 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0. 000000 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0. 000000 99. 00 09850 09850 09850 0000000000000000000000000000000000							
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART) 0 0 0 19, 737, 975 0.000000 92. 00		_	168, 240	1			91.00
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0					92.00
95. 00 09500 AMBULANCE SERVICES 95. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 0. 000000 96. 00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0. 000000 97. 00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0. 000000 98. 00 0985	OTHER REIMBURSABLE COST CENTERS]
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 0 0 0 0		0	0		0	0. 000000	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 0 0							95. 00
98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0. 000000 98. 00					٥		
		_			٥		
	98.00 09850 OTHER REIMBURSABLE COST CENTERS 200.00 Total (Lines 50 through 199)	0			0		98.00

	Financial Systems ONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI	ELKHART GENERAL	Provider C	CN: 15-0018	Period:	u of Form CMS-2 Worksheet D	2552-10
THROUGH		KVI OL OTILEK TAOS		CCN: 15-S018	From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre 5/31/2023 12:	pared:
-			Ti tl	e XIX	Subprovi der -	PPS	p
	Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Throug		Pass-Through	
		(col. 6 ÷ col.		Costs (col.	8	Costs (col. 9	
		7) 9.00	10. 00	x col . 10) 11.00	12. 00	x col . 12) 13.00	
A	NCILLARY SERVICE COST CENTERS	7.00	10.00	11.00	12.00	13.00	
	5000 OPERATING ROOM	0. 000000	0		0 0	0	50.00
	5100 RECOVERY ROOM	0. 000000	0		0 0	0	1
	5200 DELIVERY ROOM & LABOR ROOM	0. 000000	0	l .	o o	0	
	5300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
	5400 RADI OLOGY-DI AGNOSTI C	0. 000000	20, 376		0 0	0	54.00
	5500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55.00
56.00 0	5600 RADI OI SOTOPE	0. 000000	0		0 0	0	56. 00
57.00 0	5700 CT SCAN	0. 000000	36, 536		0 0	0	57.00
58.00 0	5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	3, 512		0 0	0	58.00
	5900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60.00 0	6000 LABORATORY	0. 000000	412, 239		0	0	60.00
60. 01 0	6001 BLOOD LABORATORY	0. 000000	0		0	0	60. 01
	6100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0	0	62. 00
	6300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	
	6400 I NTRAVENOUS THERAPY	0. 000000	0		0	0	
	6500 RESPI RATORY THERAPY	0. 000000	40, 242		0 0	0	
	6600 PHYSI CAL THERAPY	0. 000000	2, 516	1	0 0	0	
	6700 OCCUPATI ONAL THERAPY	0. 000000	1, 359		0 0	0	
	6800 SPEECH PATHOLOGY	0. 000000	129	•	0 0	0	
	6900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	
	17000 ELECTROENCEPHALOGRAPHY	0.000000	0		0 0	0	
	17100 MEDICAL SUPPLIES CHARGED TO PATIENTS 17200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000 0. 000000	0		0 0	0	
	17300 DRUGS CHARGED TO PATTENTS	0. 000000	442, 875		0 0	0	
	17300 BROGS CHARGED TO PATTENTS	0. 000000	442, 673		0 0	0	
	17500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	
	3140 CARDI OLOGY	0. 000000	53, 003	•	0 0	0	
- 1	7700 ALLOGENEIC HSCT ACQUISITION	0. 000000	00,000			ő	
	UTPATIENT SERVICE COST CENTERS	0.00000			<u> </u>		1
	8800 RURAL HEALTH CLINIC	0. 000000	0		0 0	0	88. 00
	8900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000	0	l .	0 0	0	
	9000 CLI NI C	0. 000000	0		0 0	0	90.00
90. 01 0	4950 SLEEP CLINIC	0. 000000	0		0 0	0	90. 01
91.00 0	9100 EMERGENCY	0. 003777	192, 641	7.	28 0	0	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92. 00
	THER REIMBURSABLE COST CENTERS						1
	9400 HOME PROGRAM DIALYSIS	0. 000000	0		0 0	0	
- 1	9500 AMBULANCE SERVI CES						95. 00
4	9600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	1	0 0	0	
- 1	19700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	
98. 00 0 200. 00	19850 OTHER REIMBURSABLE COST CENTERS	0. 000000	1 205 420	_	0 28 0	0	
	Total (lines 50 through 199)	i l	1, 205, 428	. /			200.00

	Financial Systems	ELKHART GENER				u of Form CMS-2	2552-10
APPOR	TIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der C	CN: 15-0018	Peri od: From 01/01/2022	Worksheet D Part II	
			Component	CCN: 15-T018	To 12/31/2022		pared: 14 pm
			Ti tl	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)	0.00	0.00	4.00	F 00	
	AMOULLARY CERVICE COCT CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
50. 00	ANCI LLARY SERVI CE COST CENTERS	2 212 122	00 027 012	0.0001	57 0	0	50.00
	05000 OPERATI NG ROOM 05100 RECOVERY ROOM	2, 213, 123	1				
51. 00 52. 00	05200 DELIVERY ROOM & LABOR ROOM	0					
52.00	05300 ANESTHESI OLOGY	0	0				
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 694, 829	١	l .		30	
55. 00	05500 RADI OLOGY - THERAPEUTI C	1,094,029	/1,002,790	0.0233		0	
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	0		1		0	
57. 00	05700 CT SCAN	267, 664	1	l .		0	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	136, 360		l .			
59. 00	05900 CARDI AC CATHETERI ZATI ON	155, 030		•		Ő	
60.00	06000 LABORATORY	215, 887				27	60.00
60. 01	06001 BLOOD LABORATORY	0	0.,,,,,,			0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	l o	0. 00000	00	0	
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000	00	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	293, 422	4, 741, 003	0. 06189	90 0	0	64.00
65.00	06500 RESPI RATORY THERAPY	75, 562	23, 038, 970	0. 00328	30 2, 460	8	65.00
66.00	06600 PHYSI CAL THERAPY	189, 835	5, 950, 031	0. 03190	20, 391	651	66.00
67.00	06700 OCCUPATI ONAL THERAPY	90, 249	3, 655, 866	0. 02468	36 22, 079	545	67. 00
68.00	06800 SPEECH PATHOLOGY	53, 796	1, 473, 463			113	
69. 00	06900 ELECTROCARDI OLOGY	0	0			0	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0. 00000		0	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	200, 010				0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	371, 493		l .		0	
73.00	07300 DRUGS CHARGED TO PATIENTS	232, 315	1			27	73.00
74.00	07400 RENAL DIALYSIS	0	_			0	
75.00	07500 ASC (NON-DISTINCT PART)	0	05 (0) 100	0.0000		0	
76.00	03140 CARDI OLOGY	430, 928				0	
77. 00	07700 ALLOGENEI C HSCT ACQUI SI TI ON	0	0	0.00000	00 0	0	77. 00
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	0.0000	00 0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89.00
90.00	09000 CLINIC	179, 081	1	1			
90.00	04950 SLEEP CLINIC	179,081				0	
91.00	09100 EMERGENCY	691, 423		l .			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	091, 423		l .			
,2.00	OTHER REIMBURSABLE COST CENTERS		17, 131, 713	0.0000	50 0		/2.00
94. 00	09400 HOME PROGRAM DIALYSIS	1 0		0.0000	00 0	0	94.00
	09500 AMBULANCE SERVICES		Ĭ	3. 20000		Ĭ	95.00
	09600 DURABLE MEDICAL FOULP-RENTED	0	0	0 00000	00	0	

0.000000 0.000000

83, 659

941, 927, 707

96.00 0 97.00 0 98.00

1, 420 200. 00

95.00 | 09600 | DURABLE MEDICAL EQUIP-RENTED | 97.00 | 09700 | DURABLE MEDICAL EQUIP-SOLD | 98.00 | 09850 | OTHER REIMBURSABLE COST CENTERS | Total (lines 50 through 199)

Health Financial Systems	ELKHART GENER				eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ERVICE OTHER PAS	S Provider C	CN: 15-0018	Peri od:	Worksheet D	
THROUGH COSTS		Component	CCN: 15-T018	From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre	nared:
		Component	CON. 15 1010	10 12/31/2022	5/31/2023 12:	14 pm
		Ti tl	e XIX	Subprovi der -	PPS	
				IRF		
Cost Center Description	Non Physician		Nursi ng		Allied Health	
	Anesthetist Cost	Program	Program	Post-Stepdown		
	COST	Post-Stepdown Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCILLARY SERVICE COST CENTERS	1100		2.00		0.00	
50. 00 05000 OPERATING ROOM	0	C		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	1	0	0	56. 00
57. 00 05700 CT SCAN	0	0	1	0 0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	1	0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)	0	0	59. 00
60. 00 06000 LABORATORY	0	0	1	0	0	60. 00
60. 01 06001 BLOOD LABORATORY	0	0	1	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	1	0 0	_	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0		1	0 0	0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	1	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0	1	0 0	0	65. 00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0	0	1	0 0		66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY	0		1	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY			1	0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		1	0 0	_	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0		1		_	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0			o o	0	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0			0 0	0	73. 00
74. 00 07400 RENAL DIALYSIS	0)	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	o c)	0 0	0	75. 00
76. 00 03140 CARDI OLOGY	0	o c)	0 0	0	76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION	0	O	1	0 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0		1	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0 0	0	89. 00
90. 00 09000 CLI NI C	0	0	1	0 0	0	90. 00
90. 01 04950 SLEEP CLINIC	0	0	1	0	0	70.0.
91. 00 09100 EMERGENCY	0	0	1	0	168, 240	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1 0	II.	1	0	1 0	92.00

0 0 0

0 0 0

0 0 0

0

0 0 0

0 0 0

94. 00 95. 00

96.00 97.00 0

98. 00 0 168, 240 200. 00

0 92.00

0

92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS
94. 00 09400 HOME PROGRAM DIALYSIS
95. 00 09500 AMBULANCE SERVICES

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 | 200.00 | Total (lines 50 through 199)

lealth Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	ELKHART GENER ERVICE OTHER PAS		CN: 15-0018	Peri od:	u of Form CMS-2 Worksheet D	2552-10
THROUGH COSTS				From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre 5/31/2023 12:	pared: 14 pm
		Titl	e XIX	Subprovi der - I RF	PPS	
Cost Center Description	All Other	Total Cost	Total	Total Charges		
	Medical Education Cost	(sum of cols. 1, 2, 3, and	Outpatient Cost (sum of	(from Wkst. C, Part I, col.	to Charges (col. 5 ÷ col.	
	Ludcation cost	4)	col s. 2, 3,	8)	7)	
		,	and 4)		(see	
					instructions)	
ANOLLI ADV. CEDVI OF COCT OFFITEDO	4. 00	5. 00	6. 00	7. 00	8. 00	
ANCI LLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0	0		0 99, 837, 813	0. 000000	50.00
51. 00 05100 RECOVERY ROOM			l .	0 99, 037, 013	0. 000000	
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0		1		0. 000000	
53. 00 05300 ANESTHESI OLOGY	0	O		0 0	0.000000	1
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 71, 882, 790	0. 000000	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0		l .	0	0. 000000	
56. 00 05600 RADI 0I SOTOPE	0		l .	0	0. 000000	
57. 00 05700 CT SCAN	0		l .	0 75, 354, 470	0.000000	
58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI) 59.00 O5900 CARDIAC CATHETERIZATION	0		•	0 12, 594, 500 0 37, 462, 874	0. 000000 0. 000000	
50. 00 06000 LABORATORY				0 84, 714, 848	0.000000	
60. 01 06001 BLOOD LABORATORY	0			0 04, 714, 040	0. 000000	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0.00000	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 4, 741, 003	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	0	_		0 23, 038, 970	0.000000	
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY	0			0 5, 950, 031 0 3, 655, 866	0. 000000 0. 000000	1
68. 00 06800 SPEECH PATHOLOGY	0			0 3, 655, 866 0 1, 473, 463	0.000000	
59. 00 06900 ELECTROCARDI OLOGY	0	_		0 1, 473, 403	0. 000000	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0			0 0	0. 000000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 97, 895, 885	0. 000000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 142, 930, 841	0. 000000	
73.00 07300 DRUGS CHARGED TO PATIENTS	0			0 186, 895, 035	0. 000000	
74. 00 07400 RENAL DI ALYSI S	0	_		0 0	0.000000	
75. 00 07500 ASC (NON-DISTINCT PART) 76. 00 03140 CARDIOLOGY	0		•	0 0 25, 686, 129	0. 000000 0. 000000	
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0			0 25,000,127	0.000000	
OUTPATIENT SERVICE COST CENTERS			L	<u> </u>	0.00000	1 00
38.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0. 000000	88. 00
B9.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0	0. 000000	
90. 00 09000 CLI NI C	0	1		0 1, 125, 770	0. 000000	
90. 01 04950 SLEEP CLINIC	0		1/0 0/	0 2, 405, 125	0.000000	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			44, 544, 319 0 19, 737, 975	0. 003777 0. 000000	
OTHER REIMBURSABLE COST CENTERS				0 17, 737, 773	0.000000	72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0		0 0	0. 000000	94. 00
						95. 00
95. 00 09500 AMBULANCE SERVICES	1					
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0	0. 000000	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED 97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0. 000000	97. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED		0	168, 24	0 0 0		97. 00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	ELKHART GENERA RVICE OTHER PASS	Provi der CO	CN: 15-0018	Peri od:	u of Form CMS-: Worksheet D	2552 10
THROUGH COSTS		Component (CCN: 15-T018	From 01/01/2022 To 12/31/2022	Part IV Date/Time Pre 5/31/2023 12:	epared:
		Ti tl	e XIX	Subprovi der - I RF	PPS	
Cost Center Description	Outpati ent	I npati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col. 7)		Costs (col. x col. 10)	8	Costs (col. 9 x col. 12)	
	9.00	10.00	11.00	12. 00	13.00	
ANCI LLARY SERVI CE 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	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	1, 286		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0 0	0	55. 00
56. 00 05600 RADI 0I SOTOPE	0. 000000	0		0 0	0	56. 00
57. 00 05700 CT SCAN	0. 000000	0		0 0	0	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	1, 756		0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	
60. 00 06000 LABORATORY	0. 000000	10, 614		0	0	
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0	0	
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_			_	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	1
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0		0	0	1
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	
65. 00 06500 RESPIRATORY THERAPY	0. 000000	2, 460		0 0	0	
66.00 06600 PHYSI CAL THERAPY 67.00 06700 OCCUPATI ONAL THERAPY	0. 000000 0. 000000	20, 391 22, 079		0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0. 000000	3, 100		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	3, 100		0 0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0 0	0	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	0		0 0	0	
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000	21, 973		0 0	Ō	
74. 00 07400 RENAL DIALYSIS	0. 000000	0		0 0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
76. 00 03140 CARDI OLOGY	0. 000000	0		0 0	0	76. 00
77. 00 07700 ALLOGENEIC HSCT ACQUISITION	0. 000000	0		0 0	0	77. 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. 003777	0		0 0	0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	92. 00
94. 00 09400 HOME PROGRAM DIALYSIS	0. 000000	0	I	0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0.000000	U		0	U	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		0 0	0	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	0		0 0	0	1
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0		0 0	0	1
	000					

Health Financial Systems	ELKHAR	RT GENERAL HOSPITAL		In Lieu	of Form CMS-2	2552-10
COMPUTATION OF INPATIENT	OPERATING COST	Provi der		om 01/01/2022 12/31/2022	Worksheet D-1 Date/Time Prep 5/31/2023 12:	
		Ti t	le XVIII	Hospi tal	PPS	

			12, 01, 2022	5/31/2023 12:	14 pm
	Coat Contan Decement on	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			47, 550	1. 00
2.00	Inpatient days (including private room days, excluding swing-			47, 550	2.00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	/s). If you have only pr	ivate room days,	0	3. 00
4. 00	Semi-private room days (excluding swing-bed and observation be	ed days)		41, 739	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	0	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
7.00	reporting period (if calendar year, enter 0 on this line)		04 6 11		7 00
7. 00	Total swing-bed NF type inpatient days (including private roor reporting period	n days) through December	31 of the cost	0	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
0.00	reporting period (if calendar year, enter 0 on this line)	. days, arts. becomber o		ŭ	0.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	12, 163	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		nom dave) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		dom days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12.00
	through December 31 of the cost reporting period		-		
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI)			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	iii (excluding swing-bed	uays)	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWI NG BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	os after December 21 of	the cost	0.00	18. 00
10.00	reporting period	es arter becember 31 or	the cost	0.00	16.00
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	s after December 31 of t	he cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		69, 508, 174	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ing period (line	07,000,171	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) Swing-bed cost applicable to NF type services through December	21 of the cost reporti	ng poriod (line	0	24. 00
24.00	7 x line 19)	31 of the cost reporti	ing period (Time	O	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)				
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	lino 21 minus lino 26)		0 69, 508, 174	26. 00 27. 00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	Time 21 minus iine 20)	l	09, 500, 174	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30. 00
31.00	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)			0.00	32.00
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 min	nus lina 33)(saa instruc	tions)	0. 00 0. 00	33. 00 34. 00
35. 00	Average per diem private room cost differential (line 34 x line)		(1013)	0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)	/		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	69, 508, 174	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, 461. 79	38. 00
39. 00	Program general inpatient routine service cost per drem (see	•		17, 779, 752	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			17, 779, 752	41. 00

WIPUI	ATION OF INPATIENT OPERATING COST		Provider CCN		Period: From 01/01/2022	Worksheet D-1		
					To 12/31/2022	5/31/2023 12:		
	Cost Center Description	Total	Ti tl e 2	XVIII Average Per	Hospital Program Days	PPS Program Cost		
		Inpatient Cost I	npatient DaysD	iem (col. 1 col. 2)	÷	(col. 3 x col. 4)		
. 00	NURSERY (title V & XIX only)	1.00	2. 00	3. 00	4. 00 0	5. 00	42	
. 00	Intensive Care Type Inpatient Hospital Unit		<u> </u>	0.0	0 0	0	1 42	
. 00	INTENSIVE CARE UNIT	15, 460, 334	6, 134	2, 520. 4			1	
. 01	NEONATAL INTENSIVE CARE CORONARY CARE UNIT	2, 623, 558	576 0	4, 554. 7 0. 0		0		
	BURN INTENSIVE CARE UNIT	0	0	0.0		0		
00		o	ō	0. 0		0		
00	OTHER SPECIAL CARE (SPECIFY)						47	
	Cost Center Description					1. 00		
00	Program inpatient ancillary service cost (W	/kst. D-3, col. 3,	line 200)			21, 205, 753	48	
01	Program inpatient cellular therapy acquisit				column 1)	0		
00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48.01	(see instructi	ons)		43, 119, 010	49	
00	Pass through costs applicable to Program in	patient routine s	ervices (from \	Wkst. D, sum	of Parts I and	1, 483, 433	50	
						l		
00	Pass through costs applicable to Program in and IV)	patient ancillary	services (from	m Wkst. D, s	um of Parts II	769, 527	51	
00	Total Program excludable cost (sum of lines	50 and 51)				2, 252, 960	52	
00	Total Program inpatient operating cost excl	uding capital rela	ated, non-physi	cian anesth	etist, and	40, 866, 050	53	
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	: 52)						
00	Program di scharges					0	54	
	Target amount per discharge					0.00		
	Permanent adjustment amount per discharge Adjustment amount per discharge (contractor	uco only)				0. 00 0. 00		
00	Target amount (line 54 x sum of lines 55, 5					0.00		
00	Difference between adjusted inpatient opera		get amount (li	ne 56 minus	line 53)	0	5	
00	Bonus payment (see instructions)	I ! FF		. :		0	1 -	
00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket		the cost repor	ting period	enaing 1996,	0. 00	5	
00								
. 00	Continuous improvement bonus payment (if line 53 ÷ line 54 is less than the lowest of lines 55 plus 55.01, or line 59, or line 60, enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1 % of the target amount (line 56), otherwise						6	
00	enter zero. (see instructions) Relief payment (see instructions)					0	62	
00	Allowable Inpatient cost plus incentive pay PROGRAM INPATIENT ROUTINE SWING BED COST	ment (see instruc	tions)			0		
00	Medicare swing-bed SNF inpatient routine co instructions)(title XVIII only)	sts through Decem	ber 31 of the o	cost reporti	ng period (See	0	6	
00	Medicare swing-bed SNF inpatient routine co	sts after Decembe	r 31 of the co	st reporting	period (See	0	6	
00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient rout	ine costs (line 6	4 plus line 65)	(title XVII	l only); for	0	6	
00	CAH, see instructions Title V or XIX swing-bed NF inpatient routi (line 12 x line 19)	ne costs through	December 31 of	the cost re	porting period	0	6	
00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after De	cember 31 of t	ne cost repo	rting period	0	6	
00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER					0	60	
00	Skilled nursing facility/other nursing faci						70	
00	Adjusted general inpatient routine service	cost per diem (li				I	7	
00	Program routine service cost (line 9 x line Medically necessary private room cost appli	•	(line 1/ v line	2 35)		I	72	
00	Total Program general inpatient routine ser		•	J JJ)		I	72	
00	Capital-related cost allocated to inpatient 26, line 45)	•		rksheet B, P	art II, column		7!	
00	Per diem capital-related costs (line 75 ÷ l	. *				I	70	
00	Program capital -related costs (line 9 x lin					I	77	
00	Inpatient routine service cost (line 74 min Aggregate charges to beneficiaries for exce	,	ovi der records')		I	78	
00	Total Program routine service costs for com	parison to the co			us line 79)	I	80	
00	Inpatient routine service cost per diem lim					I	8	
00	Inpatient routine service cost limitation (Reasonable inpatient routine service costs)			I	82	
	Program inpatient ancillary services (see i	•	•			I	84	
. 00	Utilization review - physician compensation					I	85	
1111	Total Program inpatient operating costs (su	m от iines 83 thr	ougn 85)			ı	86	
00	PART IV - COMPUTATION OF OBSERVATION BED PA		· ·					

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	
				From 01/01/2022 To 12/31/2022		pared: 14 pm_
		Title	XVIII	Hospi tal	PPS	
Cost Center Description						
					1.00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				8, 494, 462	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, 281, 100	69, 508, 174	0. 07597	8 8, 494, 462	645, 392	90. 00
91.00 Nursing Program cost	0	69, 508, 174	0. 00000	0 8, 494, 462	0	91.00
92.00 Allied health cost	0	69, 508, 174	0. 00000	0 8, 494, 462	0	92. 00
93.00 All other Medical Education	0	69, 508, 174	0. 00000	0 8, 494, 462	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		Worksheet D-1
	Component CCN: 19	5-S018 From 01/01/2022 To 12/31/2022	
	Title XVII		PPS
		IDE	

		II the XVIII	I PF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			2, 870	1. 00
2. 00	Inpatient days (including private room days, excluding swing-			2, 870	2. 00
3.00	Private room days (excluding swing-bed and observation bed day do not complete this line.	(s). If you have only pri	vate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 870	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
4 00	reporting period	om dava) ofter December 3	11 of the cost	0	<i>(</i> 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	oli days) arter beceilber s	of the cost	U	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
0.00	reporting period	, daya) after December 21	of the cost	0	0.00
8. 00	Total swing-bed NF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	n days) after December 31	or the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	208	9. 00
10.00	newborn days) (see instructions)			0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or 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 ro	oom days) after	0	11. 00
10.00	December 31 of the cost reporting period (if calendar year, er				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	confy (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13.00
44.00	after December 31 of the cost reporting period (if calendar ye		, I		44.00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed o	iays)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0.00	18. 00
40.00	reporting period			0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20.00
21. 00	reporting period Total general inpatient routine service cost (see instructions	-)		4, 116, 810	21 00
22. 00	Swing-bed cost applicable to SNF type services through December		na period (line	4, 110, 810	22. 00
	5 x line 17)	·			
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 reportin	ng period (line	0	24. 00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		4, 116, 810	27. 00
28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	and observation hed cha	rnes)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)		goo,	0	29. 00
30. 00	Semi-private room charges (excluding swing-bed charges)			0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	· line 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 min	nus line 33)(see instruct	i ons)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x lin			0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	4, 116, 810	37. 00
	27 minus line 36) 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	instructions)		1, 434. 43	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			298, 361 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39	•		298, 361	
	, J.	- · · · /	ı	,	

MDLITA							
JWFOTA	ATION OF INPATIENT OPERATING COST		Component	CN: 15-0018 CCN: 15-S018	Peri od: From 01/01/2022 To 12/31/2022 Subprovi der -	Worksheet D-1 Date/Time Pre 5/31/2023 12: PPS	epared
				,	. I PF		
	Cost Center Description	Total Inpatient Cost Ir	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
		1.00	2.00	3. 00	4. 00	5. 00	
	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	C	0.0	00 0	0	42.
3. 00	INTENSIVE CARE UNIT	0	C	0.0	00 0	0	43.
	NEONATAL INTENSIVE CARE	0	C			0	
	CORONARY CARE UNIT	0	C			0	
1	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	C	1		0	
	OTHER SPECIAL CARE (SPECIFY)			0.0	, 9		47.
	Cost Center Description					1.00	
8. 00	Program inpatient ancillary service cost (Wk	st D-3 col 3	line 200)			1. 00 35, 320	48.
	Program inpatient cellular therapy acquisition			III, line 10,	column 1)	00,020	1
	Total Program inpatient costs (sum of lines	41 through 48.01	(see instruc	ctions)		333, 681	49.
0. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	atient routing of	arvicas (fra	n Wkst D cum	n of Parte L and	31, 976	50.
. 00	III)	attent foutine si	ervices (iron	i wkst. D, Suii	TOT PALES I ALIU	31,970	30.
. 00	Pass through costs applicable to Program inp	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	1, 182	51.
00	and IV) Total Program eveludable cost (sum of lines	50 and 51)				22 150	[2
. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		ated, non-phy	sician anesth	netist, and	33, 158 300, 523	
	medical education costs (line 49 minus line]
	TARGET AMOUNT AND LIMIT COMPUTATION					0	J E4
	Program discharges Target amount per discharge					0 0. 00	1
	Permanent adjustment amount per discharge					0.00	
	Adjustment amount per discharge (contractor	use only)					55.
. 00	Target amount (line 54 x sum of lines 55, 55				==.	0	
7. 00 3. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and tar	get amount (I	ine 56 minus	Tine 53)	0 0	
. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from	the cost repo	orting period	endi ng 1996,		59.
0. 00	updated and compounded by the market basket) Expected costs (lesser of line 53 ÷ line 54,	or line EE from	prior year o	act report	indated by the	0.00	60.
). 00	market basket)	or time 55 from	prior year c	ost report, t	poated by the	0.00	00.
1.00	Continuous improvement bonus payment (if lin. 55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x enter zero. (see instructions)	ser of 50% of the	e amount by w	hich operatir	ng costs (line	0	61.
	Relief payment (see instructions)					0	
	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63.
. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	per 31 of the	cost reporti	na period (See	0	64.
	instructions)(title XVIII only)	· ·		•			
. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after Decembe	~ 31 of the d	cost reporting	period (See	0	65.
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	1 plus line 6	55)(title XVII	I only); for	0	66.
	CAH, see instructions			6.11			
. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through I	December 31 c	of the cost re	porting period	0	67.
3. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	cember 31 of	the cost repo	orting period	0	68.
9. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (li	ne 67 + line	e 68)		О	69.
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY,	AND ICF/IID	ONLY			
00	Skilled nursing facility/other nursing facil						70.
. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ie /u ÷ line	۷)			71.
1	Medically necessary private room cost applic		(line 14 x li	ne 35)			73.
1. 00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)				74.
5. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service (costs (from V	vorksheet B, F	art II, column		75.
. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.
. 00	Program capital-related costs (line 9 \times line	76)					77.
. 00	Inpatient routine service cost (line 74 minu		wi dos s	lc)			78.
0.00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 79)		79. 80.
. 00	Inpatient routine service costs for comp.			. (, , ,		81.
2. 00	Inpatient routine service cost limitation (I						82.
1						1	
3. 00 1. 00	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in)				83.

84. 00 85. 00

86.00

0 87.00

87.00 Total observation bed days (see instructions)

Total Program inpatient operating costs (sum of lines 83 through 85)
PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

Health Financial Systems	ELKHART GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
			CCN: 15-S018	From 01/01/2022 To 12/31/2022		
		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	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	441, 215	4, 116, 810	0. 10717	4 0	0	90.00
91.00 Nursing Program cost	o	4, 116, 810	0.00000	0	ol	91.00
92.00 Allied health cost	o	4, 116, 810	0.00000	0 0	ol	92.00
93.00 All other Medical Education	o	4, 116, 810		0 0	0	93. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0018		Worksheet D-1
	Component CCN: 15-T018	From 01/01/2022 To 12/31/2022	
	Title XVIII	Subprovi der -	PPS

		litle XVIII	Subprovider -	PPS	
	Cost Center Description		110	I.	
	T			1. 00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	s excluding newborn)		102	1. 00
2.00	Inpatient days (including private room days, excluding swing-l			102	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		rivate room days,	0	3.00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation be		21 -6 +6+	102	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private roof reporting period	on days) through becembe	er 31 of the cost	0	5. 00
6.00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)	3 .			
7.00	Total swing-bed NF type inpatient days (including private room	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 3	21 of the cost	0	8. 00
8.00	reporting period (if calendar year, enter 0 on this line)	ii days) ai tei beceilibei s	or or the cost	U	6.00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	48	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	room days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruc Swing-bed SNF type inpatient days applicable to title XVIII on	ulv (including private r	nom days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, en		days) arter	O	11.00
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX		te room days)	0	12.00
	through December 31 of the cost reporting period			_	
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	dir (exer during swring bed	days)	0	15. 00
16.00	Nursery days (title V or XIX only)			0	16.00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	of the cost	0. 00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0.00	18. 00
10.00	reporting period		11.0 0001	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	f the cost	0.00	19. 00
	reporting period	6. 5			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	the cost	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	5)		170, 284	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ting period (line	0	
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reportir	ng period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	na period (line	0	24. 00
	7 x line 19)			_	
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
24 00	x line 20)			0	24 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 170, 284	26. 00 27. 00
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(TITIC 21 III TIGS TITIC 20)		170,201	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi -pri vate room charges (excluding swing-bed charges)	11 00)		0	30.00
31. 00 32. 00	General inpatient routine service cost/charge ratio (line 27 - Average private room per diem charge (line 29 ÷ line 3)	÷ 11 ne 28)		0. 000000 0. 00	31. 00 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 mi)	nus line 33)(see instrud	ctions)	0. 00	
35. 00	Average per diem private room cost differential (line 34 x li		,	0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost di	fferential (line	170, 284	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 669. 45	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			80, 134	
40.00	Medically necessary private room cost applicable to the Program			0 124	
41. 00	Total Program general inpatient routine service cost (line 39	+ 111le 40)	ļ	80, 134	41.00

MPUT	ATION OF INPATIENT OPERATING COST	Pr	SPITAL ovider CCN: 15-00	18 Peri od:	wof Form CMS- Worksheet D-1	
		Co	omponent CCN: 15-T(From 01/01/2022 To 12/31/2022	Date/Time Pre	epar
		1.0	Title XVIII	Subprovi der -	5/31/2023 12: PPS	
				I RF		
	Cost Center Description	Total T Inpatient Cost Inpati	otal Average ent Days Diem (co		Program Cost (col. 3 x col.	
			col .	2)	4)	
. 00	NURSERY (title V & XIX only)	1.00 2	2.00 3.0	0 4.00	5. 00 0	42
00	Intensive Care Type Inpatient Hospital Units		ما	0.00]
. 00 . 01	INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE	0	0 0	0. 00 0. 00	0 0	
. 00	CORONARY CARE UNIT	O	o	0.00	0	
. 00	BURN INTENSIVE CARE UNIT	0	О	0. 00	0	45
. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0. 00	0	1
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description					47
			000)		1.00	
. 00 . 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			2 10 column 1)	29, 765 0	48
	Total Program inpatient costs (sum of lines			e 10, corumii 1)	109, 899	
	PASS THROUGH COST ADJUSTMENTS	<u> </u>	<u> </u>			
. 00	Pass through costs applicable to Program inp	oatient routine servio	ces (from Wkst. D	sum of Parts I and	10, 194	50
. 00	Pass through costs applicable to Program inp	oatient ancillary serv	vices (from Wkst.	D, sum of Parts II	1, 851	51
00	and IV)	FO and F1)			40.0:-	
. 00	Total Program excludable cost (sum of lines Total Program inpatient operating cost exclu		non-physician a	nesthetist and	12, 045 97, 854	
. 00	medical education costs (line 49 minus line		Tion physician a	iostricti st, and	77,001] "
00	TARGET AMOUNT AND LIMIT COMPUTATION				0	
. 00 . 00	Program discharges Target amount per discharge				0. 00	
. 01	Permanent adjustment amount per discharge				0.00	
. 02	Adjustment amount per discharge (contractor				0.00	
. 00	Target amount (line 54 x sum of lines 55, 55			1: 52)	0	
. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and target a	allount (True 56 III	nus irrie 53)	0	
. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from the o	cost reporting pe	riod ending 1996,	0.00	
	updated and compounded by the market basket)	ı		_		١.,
. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from prio	or year cost repo	rt, updated by the	0. 00	60
. 00	Continuous improvement bonus payment (if lin				0	61
	55.01, or line 59, or line 60, enter the les 53) are less than expected costs (lines 54 x					
	enter zero. (see instructions)	t oo), or I wor the	target amount (11)	ic 50), otherwise		
. 00	Relief payment (see instructions)				0	1
. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	nent (see instructions	s)		0	63
. 00	Medicare swing-bed SNF inpatient routine cos	sts through December 3	31 of the cost re	porting period (See	0	64
	instructions)(title XVIII only)	Ü				
. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	sts after December 31	of the cost repo	rting period (See	0	65
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64 plu	us line 65)(title	XVIII only); for	0	66
00	CAH, see instructions					
. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	ne costs through becen	mper 31 or the co	st reporting period	0	67
. 00	Title V or XIX swing-bed NF inpatient routin	ne costs after Decembe	er 31 of the cost	reporting period	0	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routing costs (line (67 + lino 60\		0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER N	,			0	09
. 00	Skilled nursing facility/other nursing facil			e 37)		70
. 00	Adjusted general inpatient routine service of		0 ÷ line 2)			71
. 00 . 00	Program routine service cost (line 9 x line Medically necessary private room cost applic		- 14 x line 35)			72
. 00	Total Program general inpatient routine serv					74
. 00	Capital-related cost allocated to inpatient	•		B, Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)				76
. 00	Program capital -related costs (line 9 x line					77
. 00	Inpatient routine service cost (line 74 minu	ıs line 77)				78
. 00	Aggregate charges to beneficiaries for exces)! !:- 70\		79
. 00	Total Program routine service costs for comp		imitation (line 7	s minus line 79)		80
. 00 . 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I					81
. 00	Reasonable inpatient routine service costs (83
. 00	Program inpatient ancillary services (see in	nstructions)				84
						1 .
. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum		05)			85

Health Financial Systems	ELKHART GENERA	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
		•	CCN: 15-T018	From 01/01/2022 To 12/31/2022		
		Title	XVIII	Subprovider - IRF	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	21, 662	170, 284	0. 12721	1 0	0	90.00
91.00 Nursing Program cost	o	170, 284	0.00000	0 0	l ol	91.00
92.00 Allied health cost	o	170, 284	0.00000	0 0	ol	92.00
93.00 All other Medical Education	o	170, 284	0.00000	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	From 01/01/2022	Worksheet D-1 Date/Time Pre 5/31/2023 12:	pared:
	Title XIX	Hospi tal	PPS	
Cost Contar Description				

		Title XIX	Hospi tal	PPS	14 рііі
	Cost Center Description				
				1. 00	
	PART I - ALL PROVIDER COMPONENTS				
1. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	eveluding newborn)		47, 550	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed days)			47, 550	
3.00	Private room days (excluding swing-bed and observation bed day		/ate room days,	0	3. 00
	do not complete this line.	, , , , , , , , , , , , , , , , , , , ,	, ,		
4.00	Semi-private room days (excluding swing-bed and observation be			41, 739	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	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 2	l of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	ili days) arter becember 3	i oi 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
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 31	of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Drogram (eyeluding	swing had and	1, 683	9. 00
9.00	newborn days) (see instructions)	the Program (excluding s	swifig-bed and	1, 003	9.00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	om days)	0	10. 00
	through December 31 of the cost reporting period (see instruct	i ons)	· ·		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		om days) after	0	11. 00
10.00	December 31 of the cost reporting period (if calendar year, er			0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	t only (including private	room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI>	only (including private	room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar ye				
14. 00	Medically necessary private room days applicable to the Progra	nm (excluding swing-bed da	ays)	0	14. 00
15. 00	Total nursery days (title V or XIX only)			1, 983	
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			281	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period	9			
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	ne cost	0.00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through Docombor 21 of	the cost	0.00	19. 00
19.00	reporting period	till dugit beceiliber 31 di	the cost	0.00	19.00
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of the	e cost	0.00	20. 00
	reporting period				
21. 00	Total general inpatient routine service cost (see instructions	•	na norted (line	69, 508, 174	
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 ine 17)	er 31 of the cost reporting	ig period (iine	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
	x line 18)	, -			
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporting	g period (line	0	24. 00
25. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	11 of the cost reporting (period (line 8	0	25. 00
25.00	x line 20)	or the cost reporting i	berroa (Triie o	O	23.00
26.00	Total swing-bed cost (see instructions)			0	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		69, 508, 174	27. 00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed	l and abase (ation had about		0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	and observation bed char	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	Average private room per diem charge (line 29 ÷ line 3)	ŕ		0.00	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		ons)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin	ne 31)		0.00	
36.00	Private room cost differential adjustment (line 3 x line 35)	and private room east diff	Forontial (line	0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	inu private room cost dif	erential (IINe	69, 508, 174	37. 00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJL	STMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see	•		1, 461. 79	
39. 00	Program general inpatient routine service cost (line 9 x line	•		2, 460, 193	
40.00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39	•		0 2, 460, 193	
41.00	Trotal Trogram general impatrent routine service cost (IIIIe 39	11116 40)	l	2,400,193	41.00

		ELWART OFNERAL				6.5. 010.4	
	Financial Systems ATION OF INPATIENT OPERATING COST	ELKHART GENERAL	Provider CC	CN: 15-0018 F	In Lie Period:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2022 Fo 12/31/2022	Date/Time Pre	pared:
			Ti +l (e XIX	Hospi tal	5/31/2023 12: PPS	14 pm
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost Ir	npatient Days	Diem (col. 1 - col. 2)	÷	(col. 3 x col. 4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	5, 013, 005	1, 983	2, 527. 99	9 281	710, 365	42. 00
43. 00	INTENSIVE CARE UNIT	15, 460, 334	6, 134	2, 520. 43	3 44	110, 899	43. 00
	NEONATAL INTENSIVE CARE CORONARY CARE UNIT	2, 623, 558	576 0	4, 554. 79 0. 00		446, 369 0	1
	BURN INTENSIVE CARE UNIT	0	0	0.00		0	•
	SURGICAL INTENSIVE CARE UNIT	0	0	0.00	0	0	
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 00
10.00			11 000)			1.00	10.00
48. 00 48. 01	Program inpatient ancillary service cost (Wk Program inpatient cellular therapy acquisiti			III, line 10,	column 1)	11, 197, 162 0	48. 00 48. 01
	Total Program inpatient costs (sum of lines					14, 924, 988	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp.	atient routine s	ervices (from	Wkst D sum	of Parts L and	261, 369] 50. 00
			•				
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillary	services (fro	om Wkst. D, sı	ım of Parts II	552, 829	51.00
	Total Program excludable cost (sum of lines					814, 198	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phys	sician anesthe	etist, and	14, 110, 790	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
	Program discharges Target amount per discharge					0 0. 00	
	Permanent adjustment amount per discharge					0.00	•
	Adjustment amount per discharge (contractor					0.00	
	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		net amount (Li	ine 56 minus l	ine 53)	0 0	
58. 00	Bonus payment (see instructions)	ing cost and tary	get amount (1)	1110 00 1111 1103 1	1110 00)	0	
59. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or line 55 from	the cost repo	rting period e	endi ng 1996,	0. 00	59. 00
60. 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 from	prior year co	ost report, up	dated by the	0.00	60.00
61. 00	market basket) Continuous improvement bonus payment (if lin	e 53 ± line 54 i	s Less than th	he lowest of L	ines 55 nlus	0	61. 00
01.00	55.01, or line 59, or line 60, enter the les	ser of 50% of the	e amount by w	hich operating	costs (line		01.00
	53) are less than expected costs (lines 54 x enter zero. (see instructions)	60), or 1 % of	the target am	ount (line 56)	, otherwise		
62. 00	Relief payment (see instructions)					0	62. 00
63. 00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instruc	tions)			0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decemb	oer 31 of the	cost reportir	ng period (See	0	64. 00
/F 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	to often December	- 21 of the e	not monomile	nonind (Coo	0	/ F 00
65. 00	instructions)(title XVIII only)	ts arter becember	31 01 1116 0	ust reporting	perrou (see	U	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH, see instructions	ne costs (line 6	4 plus line 6	5)(title XVIII	only); for	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routing	e costs through I	December 31 o	f the cost rep	orting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	a costs after New	cember 31 of	the cost renor	sting period	0	68. 00
00.00	(line 13 x line 20)	e costs after bei	Sember 31 Of	the cost repor	triig perrou		
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70. 00	Skilled nursing facility/other nursing facil						70. 00
	Adjusted general inpatient routine service c		ne 70 ÷ line :	2)			71.00
	Program routine service cost (line 9 x line Medically necessary private room cost applic		(line 14 x li	ne 35)			72.00
74. 00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)				74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service (costs (from W	orksheet B, Pa	art II, column		75. 00
	Per diem capital-related costs (line 75 ÷ li						76. 00
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minu						77. 00 78. 00
	Aggregate charges to beneficiaries for exces		ovi der records	s)			79.00
	Total Program routine service costs for comp.		st limitation	(line 78 minu	ıs line 79)		80.00
	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I						81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (see instructions)				83. 00
	Program inpatient ancillary services (see in Utilization review - physician compensation		=)				84. 00 85. 00
86. 00	Total Program inpatient operating costs (sum						86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST					ļ
87. 00	Total observation bed days (see instructions)				5, 811	87.00

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0018 Period:		Worksheet D-1		
				From 01/01/2022 To 12/31/2022	Date/Time Prep 5/31/2023 12:	pared: 14 pm_
		Title	e XIX	Hospi tal	PPS	
Cost Center Description						
					1. 00	
89.00 Observation bed cost (line 87 x line 88) (se	e instructions)				8, 494, 462	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 (COST					
90.00 Capital -related cost	5, 281, 100	69, 508, 174	0. 07597	8, 494, 462	645, 392	90.00
91.00 Nursing Program cost	0	69, 508, 174	0.00000	0 8, 494, 462	ol	91.00
92.00 Allied health cost	0	69, 508, 174	0.00000	0 8, 494, 462	0	92.00
93.00 All other Medical Education	0	69, 508, 174	0. 00000	0 8, 494, 462	0	93. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0018		Worksheet D-1
	Component CCN: 15-S018	From 01/01/2022 To 12/31/2022	Date/Time Prepared:
			5/31/2023 12:14 pm
	Title XIX	Subprovi der -	PPS
		I PF	

		TI LIE XIX	I PF	FF3	
	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			2, 870	
2.00	Inpatient days (including private room days, excluding swing-berivate room days (excluding swing-bed and observation bed day		vota maam dava	2, 870 0	
3. 00	do not complete this line.	(S). IT you have only pri	vate room days,	U	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		2, 870	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	1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	om days) arter becember s	TO 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
0.00	reporting period	a daya) after December 21	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)	days) after becember 31	or the cost	U	8. 00
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	83	9. 00
10.00	newborn days) (see instructions)			0	10.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		om days)	0	10. 00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	om days) after	0	11.00
40.00	December 31 of the cost reporting period (if calendar year, er				40.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	confy (including private	room days)	0	12. 00
13.00	Swing-bed NF type inpatient days applicable to titles V or XI)	only (including private	room days)	0	13.00
	after December 31 of the cost reporting period (if calendar ye	· · · · · · · · · · · · · · · · · · ·	′		
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	am (excluding swing-bed d	ays)	1 093	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			281	
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 of	the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	he cost	0. 00	18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0.00	19. 00
20. 00	Medical d rate for swing-bed NF services applicable to services reporting period	after December 31 of th	e cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		4, 116, 810	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 173	er 31 of the cost reporti	ng period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00
20.00	x line 18)	or or the dest reperting	por rou (11110 0		20.00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	31 of the cost reportin	g period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3	31 of the cost reporting	period (line 8	0	25. 00
04 00	x line 20)				04 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		0 4, 116, 810	
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	2 20)		1, 110, 010	27.00
	General inpatient routine service charges (excluding swing-bed	d and observation bed cha	rges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	- line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nue lino 22)(soo instruct	i one)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line)	, ,	10115)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	•		0	36.00
37. 00	General inpatient routine service cost net of swing-bed cost a	and private room cost dif	ferential (line	4, 116, 810	37. 00
	27 minus line 36) 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, 434. 43	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Program			119, 058 0	39. 00 40. 00
41. 00	Total Program general inpatient routine service cost (line 39	•		119, 058	

	Financial Systems ATION OF INPATIENT OPERATING COST	ELKHART GENERAL		CN: 15-0018	Peri od:	worksheet D-1	
			Component	CCN: 15-S018	From 01/01/2022 To 12/31/2022	Date/Time Pre	
			Ti tI	e XIX	Subprovi der -	5/31/2023 12: PPS	14 p
	Cost Center Description	Total	Total	Average Per	IPF Program Days	Program Cost	
	oust defiter bescription	Inpatient Cost In				(col . 3 x col . 4) 5.00	
	NURSERY (title V & XIX only)	0	2.00				42
. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	O	0	0.0	00 0	0	43
. 01	NEONATAL INTENSIVE CARE	0	0	0.0	00 0	_	43
. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0			_	
. 00	SURGICAL INTENSIVE CARE UNIT		0	1			
. 00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47
	'					1. 00	
. 00 . 01	Program inpatient ancillary service cost (Wk: Program inpatient cellular therapy acquisition	st. D-3, col. 3,	line 200)	III line 10	column 1)	251, 350 0	
. 00	Total Program inpatient costs (sum of lines				, cordillir r)	370, 408	
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpo	ationt routine so	rvicos (from	Wkst D su	m of Parts L and	12 760	50
			•				
. 00	Pass through costs applicable to Program inpand IV)	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	7, 106	51
. 00	Total Program excludable cost (sum of lines					19, 866	
. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line !		ted, non-phy	sician anestl	hetist, and	350, 542	53
	TARGET AMOUNT AND LIMIT COMPUTATION	<u>52)</u>					
. 00	Program discharges Target amount per discharge					0.00	
. 01	Permanent adjustment amount per discharge					0.00	55
. 02	Adjustment amount per discharge (contractor					0.00	1
. 00	Target amount (line 54 x sum of lines 55, 55 Difference between adjusted inpatient operat		et amount (I	ine 56 minus	line 53)		
. 00	Bonus payment (see instructions)	· ·	·		•	0.00	
. 00	Trended costs (lesser of line 53 ÷ line 54, updated and compounded by the market basket)	or rine 55 from t	ne cost repo	orting period	ending 1996,	0.00	לכ וי
. 00	Expected costs (lesser of line 53 ÷ line 54, market basket)	or line 55 from	prior year o	ost report, u	updated by the	0.00	60
. 00	Continuous improvement bonus payment (if line 55.01 , or line 59 , or line 60 , enter the less 53) are less than expected costs (lines 54 x	ser of 50% of the	amount by w	which operatio	ng costs (line	С	61
. 00	enter zero. (see instructions) Relief payment (see instructions)						62
. 00	Allowable Inpatient cost plus incentive payments	ent (see instruct	i ons)			c	63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts through Decemb	er 31 of the	cost reporti	ing period (See	О	64
. 00	Medicare swing-bed SNF inpatient routine cos	ts after December	31 of the c	ost reporting	g period (See	О	65
. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	ne costs (line 64	plus line 6	5)(title XVI	II only); for	С	66
. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routing	e costs through D	ecember 31 c	of the cost re	eporting period	d	67
. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	e costs after Dec	ember 31 of	the cost repo	orting period	О	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient					0	69
. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil)		70
. 00	Adjusted general inpatient routine service co	•	e 70 ÷ line	2)			71
. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)		line 14 x li	ne 35)			72
. 00	Total Program general inpatient routine serv	ice costs (line 7	2 + line 73)				74
. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service c	osts (from W	lorksheet B, F	Part II, column		75
. 00	Per diem capital-related costs (line 75 ÷ li						76
	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		vider record	ls)			78
. 00	Total Program routine service costs for compa	arison to the cos			nus line 79)		80
. 00	Inpatient routine service cost per diem limit						81
2. 00 3. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (* .					82
1. 00	Program inpatient ancillary services (see in	structions)					84 85
5. 00	Utilization review - physician compensation						

86.00 0 87.00

86.00 Total Program inpatient operating costs (sum of lines 83 through 85)

PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST

Total observation bed days (see instructions)

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	
			CCN: 15-S018	From 01/01/2022 To 12/31/2022	Date/Time Prep 5/31/2023 12:	
		Ti tl	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 (COST					
90.00 Capital -related cost	441, 215	4, 116, 810	0. 10717	4 0	0	90. 00
91.00 Nursing Program cost	0	4, 116, 810	0. 00000	0	i ol	91. 00
92.00 Allied health cost	0	4, 116, 810	0. 00000	0 0	0	92. 00
93.00 All other Medical Education	0	4, 116, 810	0. 00000	0 0	0	93. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0018		Worksheet D-1
	Component CCN: 15-T018	From 01/01/2022 To 12/31/2022	
	Title XIX	Subprovi der -	PPS

		Title XIX	Subprovi der - I RF	PPS	
	Cost Center Description		TKI		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			102	1.00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day	3 /	vato room days	102 0	2. 00 3. 00
3.00	do not complete this line.	ys). If you have only pr	vate room days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be			102	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private ro	om davs) after December :	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	m days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	m days) after December 3	1 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	44,00			0.00
9. 00	Total inpatient days including private room days applicable to	o the Program (excluding	swi ng-bed and	10	9. 00
10. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII on	alv (including private r	nom days)	0	10. 00
	through December 31 of the cost reporting period (see instruc-	tions)			
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	3 1	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 XIX		e room days)	0	12. 00
.2.00	through December 31 of the cost reporting period	t om y (mer daring pri var	s i com dayo,		12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra	· · · · · · · · · · · · · · · · · · ·	′	0	14. 00
15. 00	Total nursery days (title V or XIX only)	(g g		1, 983	
16. 00	Nursery days (title V or XIX only)			281	16. 00
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 o	f the cost	0.00	17. 00
17.00	reporting period	os till odgir becember or o	1 1110 0031	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
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period	S			
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	ne cost	0. 00	20. 00
21. 00	Total general inpatient routine service cost (see instructions	s)		170, 284	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	er 31 of the cost report	ng period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	neriod (line 6	0	23. 00
20.00	x line 18)	or or the deat reporting	9 por rou (11110 0		20.00
24. 00	Swing-bed cost applicable to NF type services through December 7×1 ine 19)	r 31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 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	(line 21 minus line 26)		0 170, 284	26. 00 27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		<u> </u>	170, 201	27.00
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31.00	General inpatient routine service cost/charge ratio (line 27	÷ Line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	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 mi)	nus line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x li	ne 31)		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	170, 284	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 669. 45	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			16, 695	39. 00
40.00	Medically necessary private room cost applicable to the Program	,		1/ /05	40.00
41.00	Total Program general inpatient routine service cost (line 39	+ 11110 40)	ļ	16, 695	41.00

)MPU1	ATION OF INPATIENT OPERATING COST	Provi	der CCN: 15-0018	Peri od:	u of Form CMS-: Worksheet D-1	
		Compo	nent CCN: 15-T018	From 01/01/2022 To 12/31/2022	Date/Time Pre	
			Title XIX	Subprovi der -	5/31/2023 12: PPS	<u>14 p</u>
	Cost Center Description	Total Total	I Average Po	IRF er Program Days	Program Cost	
	5550 551151 55551 Pt. 51	Inpatient Cost Inpatient			(col. 3 x col. 4)	
		1.00 2.00	3.00	4. 00	5. 00	
. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	<u> </u>	0.00	0	42
. 00	INTENSIVE CARE UNIT	0	0 0	0. 00	0	43
. 01	NEONATAL INTENSIVE CARE	0	l l	0. 00	0	
. 00	CORONARY CARE UNIT	0	l l	0.00	0	
. 00	BURN INTENSIVE CARE UNIT	0		0.00	0	
. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)			0.00	Ü	46
. 00	Cost Center Description					4,
. 00	Program inpatient ancillary service cost (Wk	st N=3 col 3 line 20	20)		1. 00 24, 407	48
. 01	Program inpatient cellular therapy acquisiti			0. col umn 1)	24, 407	48
	Total Program inpatient costs (sum of lines			,	41, 102	
00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	ationt routing convices	(from Wkst D s	rum of Dorte L and	2 124	-
. 00	Pass through costs applicable to Program inp III)	atrent routine Services	(TIOHEWKSL. D, S	um of Parts Fand	2, 124	50
. 00	Pass through costs applicable to Program inp	atient ancillary service	es (from Wkst. D,	sum of Parts II	1, 420	51
. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)			3, 544	52
	Total Program inpatient operating cost exclu		on-physician anes	thetist, and	37, 558	
	medical education costs (line 49 minus line	52)				
. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges				0	54
. 00	Target amount per discharge				0.00	
. 01	Permanent adjustment amount per discharge				0.00	55
. 02	Adjustment amount per discharge (contractor				0.00	
. 00	Target amount (line 54 x sum of lines 55, 55			>	0	
. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and target amou	int (line 56 minu	s line 53)	0	
. 00	Trended costs (lesser of line 53 ÷ line 54,	or line 55 from the cost	t renorting peric	nd ending 1996	0. 00	
. 00	updated and compounded by the market basket)		. reporting perro	a charrig 1770,	0.00	"
. 00	Expected costs (lesser of line 53 ÷ line 54,	or line 55 from prior y	year cost report,	updated by the	0. 00	60
. 00	<pre>market basket) Continuous improvement bonus payment (if lir</pre>	e 53 ÷ line 54 is less t	than the lowest c	of lines 55 plus	0	61
	55.01, or line 59, or line 60, enter the les	ser of 50% of the amount	t by which operat	ing costs (line		
	53) are less than expected costs (lines 54 x	60), or 1 % of the targ	jet amount (line	56), otherwise		
. 00	enter zero. (see instructions) Relief payment (see instructions)				0	62
	Allowable Inpatient cost plus incentive paym	ent (see instructions)				63
	PROGRAM INPATIENT ROUTINE SWING BED COST					
. 00	Medicare swing-bed SNF inpatient routine cos	ts through December 31 c	of the cost repor	ting period (See	0	64
. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after December 31 of	the cost reporti	na period (See	0	65
	instructions)(title XVIII only)		the cost report.	g poou (000	· ·	
. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 64 plus l	ine 65)(title XV	'III only); for	0	66
. 00	CAH, see instructions Title V or XIX swing-bed NF inpatient routir	e costs through December	r 31 of the cost	reporting period	0	67
20	(line 12 x line 19)	-			0	
. 00	Title V or XIX swing-bed NF inpatient routin	e costs after December 3	31 of the cost re	porting period	0	68
. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs (line 67 +	+ line 68)		0	69
	PART III - SKILLED NURSING FACILITY, OTHER N	URSING FACILITY, AND ICF	F/IID ONLY	->		4
. 00	Skilled nursing facility/other nursing facil	3	•	7)		70
. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		Tine 2)			71
. 00	Medically necessary private room cost applic		4 x line 35)			73
. 00	Total Program general inpatient routine serv	, S				74
. 00	Capital -related cost allocated to inpatient	routine service costs (f	from Worksheet B,	Part II, column		75
. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)				76
. 00	Program capital related costs (line 9 x line	*				77
. 00	Inpatient routine service cost (line 74 minu					78
. 00	Aggregate charges to beneficiaries for exces					79
. 00	Total Program routine service costs for comp		tation (line 78 m	inus line 79)		80
. 00	Inpatient routine service cost per diem limi					81
. 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (· · · · · · · · · · · · · · · · · · ·				82
. 00	Program inpatient ancillary services (see in	•				84
. 00	Utilization review - physician compensation					85
)			86
. 00	Total Program inpatient operating costs (sum					

Health Financial Systems	ELKHART GENER	AL HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST				Worksheet D-1		
		Component (CCN: 15-T018	From 01/01/2022 To 12/31/2022		
		Ti tl	e XIX	Subprovider - IRF	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	21, 662	170, 284	0. 12721	1 0	0	90.00
91.00 Nursing Program cost	0	170, 284	0. 00000	0	i ol	91.00
92.00 Allied health cost	0	170, 284	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	170, 284	0. 00000	0 0	0	93. 00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der C	CN: 15-0018	Peri od:	Worksheet D-3	
				From 01/01/2022		
				To 12/31/2022	Date/Time Pre	
		T: ±1 -	- \/\/	11! +-1	5/31/2023 12:	14 pm
C+ C+ D		11116	XVIII	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				40, 218, 915		30.00
31.00 03100 INTENSIVE CARE UNIT				8, 122, 860		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
ANCILLARY SERVICE COST CENTERS			•			1
50. 00 05000 OPERATING ROOM			0. 30949	9, 871, 783	3, 055, 248	50. 00
51.00 05100 RECOVERY ROOM			0.00000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM			0.00000		Ō	52. 00
53. 00 05300 ANESTHESI OLOGY			0.00000		ő	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 17910			
55. 00 05500 RADI OLOGY - THERAPEUTI C			0. 00000		742,403	55.00
56. 00 05600 RADI 01 SOTOPE			1		0	56.00
			0.00000		239, 441	
57. 00 05700 CT SCAN			0. 03417			57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)			0.09085		78, 163	
59. 00 05900 CARDI AC CATHETERI ZATI ON			0.06860		278, 497	59. 00
60. 00 06000 LABORATORY			0. 16501			1
60. 01 06001 BL00D 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 0	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.			0.00000	0 0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY			0. 56040	539, 716	302, 458	64. 00
65. 00 06500 RESPI RATORY THERAPY			0. 22629	6, 337, 441	1, 434, 157	65. 00
66. 00 06600 PHYSI CAL THERAPY			0. 49232	22 1, 115, 440	549, 156	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY			0. 30953	906, 148	280, 487	67.00
68. 00 06800 SPEECH PATHOLOGY			0. 33370	288, 138	96, 153	68. 00
69. 00 06900 ELECTROCARDI OLOGY			0.00000	00	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY			0.00000	00	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			0. 13809		2, 059, 654	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS			0. 17629		3, 941, 412	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS			0. 17304		3, 646, 719	
74. 00 07400 RENAL DIALYSIS			0.00000		0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)			0.00000		0	75. 00
76. 00 03140 CARDI OLOGY			0. 14558			
77. 00 07700 ALLOGENEIC HSCT ACQUISITION			0.00000			1
OUTPATIENT SERVICE COST CENTERS			0.00000	0	0	77.00
88. 00 08800 RURAL HEALTH CLINIC			0.00000)O	0	88. 00
			1		0	1
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER			0.00000	504		
90. 00 09000 CLI NI C			0. 90408		474	
90. 01 04950 SLEEP CLINIC			0. 24549		0	90. 01
91. 00 09100 EMERGENCY			0. 43057			1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0. 43036	51 779, 199	335, 337	92. 00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS			0.00000	00	0	
95. 00 09500 AMBULANCE SERVI CES						95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED			0.00000		0	96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD			0.00000		0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS			0.00000	0 0	0	98. 00
200.00 Total (sum of lines 50 through 94 and 9	6 through 98)			114, 363, 688	21, 205, 753	200.00
201.00 Less PBP Clinic Laboratory Services-Pro		(line 61)		0		201. 00
202.00 Net charges (line 200 minus line 201)	_ , , , , , ,	. ,		114, 363, 688		202. 00
			•		•	•

	Financial Systems ELKHART C ENT ANCILLARY SERVICE COST APPORTIONMENT			Period: From 01/01/2022 To 12/31/2022	worksheet D-3 Date/Time Pre	pared:
		Ti tl e	e XVIII	Subprovi der -	5/31/2023 12: PPS	14 pm
	Cost Center Description		Ratio of Cost To Charges	IPF Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2)	
	UNDATUENT POUTLINE CERVI OF COCT OFFITERS		1.00	2. 00	3. 00	
30. 00 31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - I RF 04300 NURSERY ANCILLARY SERVICE COST CENTERS			476, 054		30. 00 31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00
50. 00	05000 OPERATI NG ROOM		0. 30949	3 660	204	50.00
51.00	05100 RECOVERY ROOM		0.00000		0	
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY		0. 00000 0. 00000		0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 17910		1, 840	1
55.00	05500 RADI OLOGY-THERAPEUTI C		0.00000		0	55. 00
56. 00	05600 RADI 0I SOTOPE		0.00000		0	
57. 00 58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 03417 0. 09085		546 319	1
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 06860		0	
60.00	06000 LABORATORY		0. 16501		7, 875	1
60. 01	06001 BLOOD LABORATORY		0.00000		0	60. 01
61. 00 62. 00	O6100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY O6200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 00000 0. 00000		0 0	61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	
64.00	06400 I NTRAVENOUS THERAPY		0. 56040		0	1
65.00	06500 RESPI RATORY THERAPY		0. 22629		213	1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		0. 49232 0. 30953		1, 916 1, 477	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		0. 33370		206	1
69. 00	06900 ELECTROCARDI OLOGY		0. 00000	0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY		0.00000		0	
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 13809 0. 17629		0	
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 17304		13, 737	1
74. 00	07400 RENAL DIALYSIS		0. 00000		0	1
	07500 ASC (NON-DISTINCT PART)		0.00000			1
76. 00	03140 CARDI OLOGY 07700 ALLOGENEI C HSCT ACQUI SI TI ON		0. 14558 0. 00000		400 0	1
77.00	OUTPATIENT SERVICE COST CENTERS		0.00000	0 0		77.00
88. 00	08800 RURAL HEALTH CLINIC		0.00000		0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 90. 01	09000 CLI NI C 04950 SLEEP CLI NI C		0. 90408 0. 24549		0	
91. 00	09100 EMERGENCY		0. 43057			1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 43036		0	1
04.00	OTHER REIMBURSABLE COST CENTERS		0.00000	0 0	0	04.00
94. 00 95. 00	09400 HOME PROGRAM DI ALYSIS 09500 AMBULANCE SERVICES		0.00000	0	0	94. 00 95. 00
	09600 DURABLE MEDI CAL EQUI P-RENTED		0.00000	0 0	0	1

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185, 815

185, 815

97.00

201. 00

202. 00

0 98.00 35, 320 200. 00

98.00 | 09850 | O9850 | Total (sum of lines 50 through 94 and 96 through 98)

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

202.00 | Net charges (line 200 minus line 201)

	F:	ELIVIADT OFNEDAL	LICCOL TAI			6.5. 046.4	0550 40
	Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT	ELKHART GENERAL		CCN: 15-0018	Peri od:	wof Form CMS-2 Worksheet D-3	
TIMI ATT	ENT ANOTEEART SERVICE COST ATTORTTONWENT				From 01/01/2022		
			Component	CCN: 15-T018	To 12/31/2022	Date/Time Pre 5/31/2023 12:	pared:
			Title	e XVIII	Subprovi der - I RF	PPS	тч рііі
	Cost Center Description			Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col.	
				1.00	2. 00	2) 3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS			1		0.00	
30. 00 31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03101 NEONATAL INTENSIVE CARE 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04300 NURSERY				100, 845		30. 00 31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM			0. 30949	93 0	0	50.00
51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 01 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE 05700 CT SCAN 05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 I MPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS			0. 00000 0. 00000 0. 00000 0. 17910 0. 00000 0. 03411 0. 09081 0. 06866 0. 1650 0. 00000 0. 00000 0. 00000 0. 56040 0. 22629 0. 49232 0. 33975 0. 00000 0. 00000 0. 00000 0. 13809 0. 17629 0. 17730 0. 00000	000 000 000 000 000 000 000 000 000 00	0 0 0 158 0 0 95 0 0 1, 012 0 0 0 0 46 13, 292 8, 523 2, 089 0 0 0 0 4, 550	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00
76. 00	07500 ASC (NON-DISTINCT PART) 03140 CARDIOLOGY			0. 00000 0. 14558	31 0	0	76. 00
77. 00	07700 ALLOGENEIC HSCT ACQUISITION OUTPATIENT SERVICE COST CENTERS			0.00000	00 0	0	77. 00
88. 00 89. 00 90. 00 90. 01 91. 00 92. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER			0. 00000 0. 00000 0. 90408 0. 2454 0. 4305 0. 4303	00 33 0 95 0 72 0	0	89. 00 90. 00 90. 01 91. 00

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97, 098

94. 00 95. 00

96.00

98.00 0 29, 765 200. 00

201. 00

202. 00

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0 97.00

202.00

90. 01 | 04950| SLEEP CLINIC 91. 00 | 09100| EMERGENCY 92. 00 | 09200| OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 94. 00 | 09400| HOME PROGRAM DIALYSIS 95. 00 | 09500| AMBULANCE SERVICES

97. 00 O9700 DURABLE MEDICAL EQUIT-30LD
98. 00 O9850 OTHER REIMBURSABLE COST CENTERS
200. 00 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)

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

Health Financial Systems	ELKHART GENERAL HOSPITAL	_	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi de	er CCN: 15-0018	Peri od:	Worksheet D-3	
			From 01/01/2022	Doto/Timo Dro	narod:
			To 12/31/2022	Date/Time Pre 5/31/2023 12:	
	-	Title XIX	Hospi tal	PPS	· · · p
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			27, 382, 346		30. 00
31. 00 03100 INTENSIVE CARE UNIT			6, 709, 759		31. 00
31. 01 03101 NEONATAL INTENSIVE CARE			1, 248, 507		31. 01
32. 00 03200 CORONARY CARE UNIT			0		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT			0		33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT			0		34.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF			0		40. 00 41. 00
43. 00 04300 NURSERY			2, 152, 486		43.00
ANCI LLARY SERVI CE COST CENTERS			2, 132, 400		43.00
50. 00 05000 OPERATI NG ROOM		0. 30949	9, 695, 468	3, 000, 679	50.00
51. 00 05100 RECOVERY ROOM		0.00000		0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		Ö	52. 00
53. 00 05300 ANESTHESI OLOGY		0.00000		Ō	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17910		752, 184	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 00000		0	55. 00
56. 00 05600 RADI 0I SOTOPE		0.00000	00	0	56. 00
57. 00 05700 CT SCAN		0. 0341	4, 637, 349	158, 458	57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 09085	648, 138	58, 885	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 06860	3, 665, 157	251, 433	
60. 00 06000 LABORATORY		0. 1650		1, 667, 683	1
60. 01 06001 BL00D 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. 56040		484, 241	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 22629 0. 49232		804, 132 181, 290	
67. 00 06700 OCCUPATI ONAL THERAPY		0. 4923		100, 173	
68. 00 06800 SPEECH PATHOLOGY		0. 33370		35, 409	68. 00
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. 13809		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 17629		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 17304	17 14, 134, 431	2, 445, 921	73. 00
74.00 07400 RENAL DIALYSIS		0. 00000	00	0	74. 00
75.00 07500 ASC (NON-DISTINCT PART)		0.00000	00	0	75. 00
76. 00 03140 CARDI OLOGY		0. 14558	1, 154, 980	168, 143	76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000	00 0	0	77. 00
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC		0. 00000			
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	1
90. 00 09000 CLI NI C		0. 90408		0	
90. 01 04950 SLEEP CLINIC		0. 24549		1 000 531	90. 01
91. 00 09100 EMERGENCY		0. 4305		1, 088, 531	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)		0. 43036	0	0	92. 00
94. 00 O9400 HOME PROGRAM DI ALYSI S		0.0000	0	0	94. 00
95. 00 09500 AMBULANCE SERVI CES		0.00000	0	U	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0. 00000	00	0	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0. 00000		0	
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0. 00000		Ö	1
200.00 Total (sum of lines 50 through 94 and 9	6 through 98)		55, 985, 274	_	
201.00 Less PBP Clinic Laboratory Services-Pro		1)	0	, , ,	201. 00
202.00 Net charges (line 200 minus line 201)			55, 985, 274		202. 00
		•			

Health Financial Systems ELKHART GENERAL	. HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
	Component	CCN: 15-S018	From 01/01/2022 To 12/31/2022	Date/Time Pre 5/31/2023 12:	
	Ti tl	e XIX	Subprovider -	PPS	
Cost Center Description	•	Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
LANDATI ENT. DOUTLING OFFINIAGE COOT OFFITEDO		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					00.00
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
31. 00 03100 INTENSI VE CARE UNI T					31.00
31. 01 03101 NEONATAL INTENSIVE CARE					31. 01
32. 00 03200 CORONARY CARE UNIT					32.00
33. 00 03300 BURN I NTENSI VE CARE UNI T					33.00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT			2 402 415		34.00
40. 00 04000 SUBPROVI DER - PF			3, 492, 615		40.00
41. 00 04100 SUBPROVI DER - RF					41.00
43. 00 O4300 NURSERY ANCI LLARY SERVI CE COST CENTERS					43. 00
50. 00 05000 OPERATING ROOM		0. 30949	0	0	50. 00
51. 00 05100 RECOVERY ROOM		0. 00000		0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM		0.00000		0	52.00
53. 00 05300 ANESTHESI OLOGY		0.00000		0	53. 00
54. 00 05400 RADI OLOGY - DI AGNOSTI C		0. 17910		3, 649	1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 00000		3, 049	55. 00
56. 00 05600 RADI 01 SOTOPE		0.00000		0	56. 00
57. 00 05700 CT SCAN		0. 03417		1, 248	1
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 09085		319	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0. 06860		0	59.00
60. 00 06000 LABORATORY		0. 16501		68, 024	60.00
60. 01 06001 BLOOD LABORATORY		0. 00000		00,024	60. 01
61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY		0.00000		ő	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		0. 56040		0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0. 22629		9, 107	65.00
66. 00 06600 PHYSI CAL THERAPY		0. 49232		1, 239	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0. 30953		421	67. 00
68. 00 06800 SPEECH PATHOLOGY		0. 33370	129	43	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0.00000	0 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	0 0	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 13809	0	0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 17629		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 17304		76, 638	73. 00
74. 00 07400 RENAL DI ALYSI S		0.00000		0	
75.00 07500 ASC (NON-DISTINCT PART)		0.00000		0	
76. 00 03140 CARDI OLOGY		0. 14558	53, 003	7, 716	76. 00
77.00 07700 ALLOGENEIC HSCT ACQUISITION		0.00000	00	0	77. 00
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC		0.00000		0	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 09000 CLI NI C		0. 90408		0	
90. 01 04950 SLEEP CLINIC		0. 24549		0	90. 01
91 00 09100 EMERGENCY		0.43057	192 641	82 946	91 00

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201. 00

202. 00

82, 946

200.00

201.00

202.00

90. 01 | 04950| SLEEP CLINIC 91. 00 | 09100| EMERGENCY 92. 00 | 09200| OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 94. 00 | 09400| HOME PROGRAM DIALYSIS 95. 00 | 09500| AMBULANCE SERVICES

98. 00 09850 OTHER REIMBURSABLE COST CENTERS
200. 00 Total (sum of lines 50 through 94 and 96 through 98)

Net charges (line 200 minus line 201)

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

96. 00 09600 DURABLE MEDICAL EQUIP-RENTED

Health Financial Systems	ELKHART GENERAL				u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT			CN: 15-0018 CCN: 15-T018	Peri od: From 01/01/2022 To 12/31/2022		pared:
		Ti t	e XIX	Subprovi der - I RF	5/31/2023 12: PPS	14 pm
Cost Center Description			Ratio of Cos To Charges		Inpatient Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
INPATI ENT ROUTINE SERVI CE COST CENTERS 30.00 30300 ADULTS & PEDI ATRI CS 31.00 33100 INTENSI VE CARE UNI T 32.00 03200 CORONARY CARE UNI T 33.00 3300 BURN INTENSI VE CARE UNI T 34.00 03400 SURGI CAL INTENSI VE CARE UNI T 40.00 SUBPROVI DER - I PF 41.00 O4300 NURSERY ANCILLADY SERVI CE COST CENTERS ANCILLADY SERVI CENTER ANCILLADY SERVI CENTER ANCILLADY S				81, 167		30. 00 31. 00 31. 01 32. 00 33. 00 34. 00 40. 00 41. 00 43. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 0PERATI NG ROOM 51. 00 05100 RECOVERY ROOM			0. 3094			1
52. 00 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05700 CT SCAN CT			0. 00000 0. 00000 0. 17910 0. 00000 0. 00000 0. 0341	00 0 02 1, 286 00 0 00 0	0 0 0	53. 00 54. 00 55. 00 56. 00 57. 00
58. 00			0. 0908 0. 0686 0. 1650 0. 0000 0. 0000 0. 0000	01 0 12 10, 614 00 0 00 0	0 1, 751 0 0 0	59. 00 60. 00 60. 01 61. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY			0. 00000 0. 56040 0. 22620 0. 49233 0. 30953	02 0 99 2, 460 22 20, 391 38 22, 079	10, 039 6, 834	64. 00 65. 00 66. 00 67. 00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS			0. 00000 0. 00000 0. 1380 0. 1762 0. 1730	00 0 92 0 99 0 47 21, 973	0 0 0 0 3, 802	70. 00 71. 00 72. 00 73. 00
74. 00			0. 00000 0. 00000 0. 14550 0. 00000	00 0 31 0 00 0	0	75. 00 76. 00 77. 00
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 08SERVATION BEDS (NON-DISTINCT PART)			0. 00000 0. 00000 0. 90400 0. 2454 0. 4305 0. 43030	00 0 33 0 95 0 72 0	0 0 0	89. 00 90. 00 90. 01 91. 00
94. 00			0. 00000 0. 00000	00 0	0	94. 00 95. 00 96. 00

0.000000

0.000000

83, 659

83, 659

0 97.00

98.00 0 24, 407 200. 00

201. 00

202. 00

202.00

97. 00 O9700 DURABLE MEDICAL EQUIT-30LD
98. 00 O9850 OTHER REIMBURSABLE COST CENTERS
200. 00 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)

	Ti ti o VVII I		lloopi tol	5/31/2023 12:	14 pm
			Hospi tal	PPS	
				1. 00	
4 00	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS				4 00
1. 00 1. 01	DRG Amounts Other than Outlier Payments DRG amounts other than outlier payments for discharges occurring prior to Octob instructions)	oer 1 (se	е	0 22, 011, 394	1. 00 1. 01
1. 02	DRG amounts other than outlier payments for discharges occurring on or after Ocinstructions)	ctober 1	(see	7, 886, 876	1. 02
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occu 1 (see instructions)	urring pri	or to October	0	1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for discharges occu October 1 (see instructions)	urring on	or after	0	1. 04
2. 00 2. 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			0	2. 00 2. 01
2. 02 2. 03	Outlier payment for discharges for Model 4 BPCI (see instructions) Outlier payments for discharges occurring prior to October 1 (see instructions)			1 177 450	2. 02 2. 03
2. 03	Outlier payments for discharges occurring pirol to october 1 (see instructions)			1, 177, 450 274, 263	2.03
3.00	Managed Care Simulated Payments			0	3. 00
4. 00	Bed days available divided by number of days in the cost reporting period (see	instruct	ons)	189. 53	4. 00
5. 00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most recent cost repo	ortina ne	riod ending on	0.00	5.00
3.00	or before 12/31/1996. (see instructions)	or tring per	Tod charring on	0.00	3.00
5. 01 6. 00	FTE cap adjustment for qualifing hospitals under §131 of the CAA 2021 (see inst FTE count for allopathic and osteopathic programs that meet the criteria for an			0. 00 0. 00	5. 01 6. 00
0.00	new programs in accordance with 42 CFR 413.79(e)			0.00	0.00
6. 26	Rural track program FTE cap limitation adjustment after the cap-building window the CAA 2021 (see instructions)	v closed u	under §127 of	0. 00	6. 26
7. 00 7. 01	MMA Section 422 reduction amount to the IME cap as specified under 42 CFR §412. ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f			0. 00 0. 00	7. 00 7. 01
7. 02	cost report straddles July 1, 2011 then see instructions. Adjustment (increase or decrease) to the hospital's rural track program FTE lim	, , , , ,	. , . ,	0. 00	7. 02
7.02	track programs with a rural track for Medicare GME affiliated programs in accorand 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 osteopath affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 F			0.00	8. 00
8. 01	1998), and 67 FR 50069 (August 1, 2002). The amount of increase if the hospital was awarded FTE cap slots under § 5503 o			0.00	8. 01
8. 02	report straddles July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed	teachi ng	hospi tal	0.00	8. 02
8. 21	under § 5506 of ACA. (see instructions) The amount of increase if the hospital was awarded FTE cap slots under §126 of	the CAA	2021 (see	0.00	8. 21
9. 00	instructions) Sum of lines 5 and 5.01, plus line 6, plus lines 6.26 through 6.49, minus lines	s 7 and 7.	01, plus or	0.00	9. 00
10. 00	minus line 7.02, plus/minus line 8, plus lines 8.01 through 8.27 (see instructi FTE count for allopathic and osteopathic programs in the current year from your			0.00	10. 00
11. 00	FTE count for residents in dental and podiatric programs.				11. 00
12.00	Current year allowable FTE (see instructions)				12.00
13. 00 14. 00	Total allowable FTE count for the prior year. Total allowable FTE count for the penultimate year if that year ended on or aft	ter Sente	mher 30 1997		13. 00 14. 00
	otherwise enter zero.	co. copto.			
15. 00 16. 00	Sum of lines 12 through 14 divided by 3. Adjustment for residents in initial years of the program (see instructions)				15. 00 16. 00
17. 00	Adjustment for residents displaced by program or hospital closure				17. 00
18. 00	Adjusted rolling average FTE count			0.00	18. 00
19. 00	Current year resident to bed ratio (line 18 divided by line 4).			0. 000000	
20.00	Prior year resident to bed ratio (see instructions)			0.000000	
21. 00 22. 00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0.000000	22.00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
	Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA				
23. 00	Number of additional allopathic and osteopathic IME FTE resident cap slots unde $(f)(1)(iv)(C)$.	er 42 CFR	412. 105	0.00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	24. 00
25. 00	If the amount on line 24 is greater than -0-, then enter the lower of line 23 o instructions)	or line 2	4 (see	0.00	25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00 28. 00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0. 000000 0	27. 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 i	nstructi	ons)	3. 29	30.00
31. 00	Percentage of Medicaid patient days (see instructions)		- /	23. 48	
32. 00	Sum of lines 30 and 31			26. 77	32.00
33.00	Allowable disproportionate share percentage (see instructions)			11. 30	33.00
34. 00	Disproportionate share adjustment (see instructions)			844, 626	34.00

_CULA	TION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0018	Peri od: From 01/01/2022 To 12/31/2022	u of Form CMS-2 Worksheet E Part A Date/Time Pre 5/31/2023 12:	pared
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	2.00	
ι	Incompensated Care Payment Adjustment		1.00	2.00	
	Total uncompensated care amount (see instructions)		7, 192, 008, 710	6, 874, 403, 459	35.
01	Factor 3 (see instructions)		0. 000369867	0. 000327497	35.
	Hospital UCP, including supplemental UCP (If line 34 is zero,	enter zero on this line	2, 660, 085	2, 251, 344	35.
	(see instructions) Pro rata share of the hospital UCP, including supplemental UC	D (soo instructions)	1, 989, 597	567, 463	35.
	Fotal UCP adjustment (sum of columns 1 and 2 on line 35.03)	(see mistractions)	2, 557, 060		36.
	dditional payment for high percentage of ESRD beneficiary di	scharges (lines 40 throu			
00	Total Medicare discharges (see instructions)		0		40.
	Total ESRD Medicare discharges (see instructions)		0		41.
1	Total ESRD Medicare covered and paid discharges (see instruct		0		41.
1	Divide line 41 by line 40 (if less than 10%, you do not quali	fy for adjustment)	0.00		42.
1	Total Medicare ESRD inpatient days (see instructions)		0		43.
	Ratio of average length of stay to one week (line 43 divided days)	by line 41 divided by /	0. 000000		44.
	aays) Average weekly cost for dialysis treatments (see instructions)	0.00		45.
00	Total additional payment (line 45 times line 44 times line 41	. 01)	0		46.
00	Subtotal (see instructions)		34, 751, 669		47.
	Hospital specific payments (to be completed by SCH and MDH, s	mall rural hospitals	0		48.
	only. (see instructions)			Amount	
				1. 00	
00	Total payment for inpatient operating costs (see instructions)		34, 751, 669	49.
00	Payment for inpatient program capital (from Wkst. L, Pt. I an	d Pt. II, as applicable)		2, 466, 526	50.
00	Exception payment for inpatient program capital (Wkst. L, Pt.	III, see instructions)		0	51.
1	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		0	
1	Nursing and Allied Health Managed Care payment			10, 828	1
	Special add-on payments for new technologies			470, 631	
	slet isolation add-on payment	0)		0	
	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6 Cellular therapy acquisition cost (see instructions)	7)		0	1
- 1	Cost of physicians' services in a teaching hospital (see intr	uctions)		0	1
	Routine service other pass through costs (from Wkst. D, Pt. I	•	hrough 35).	0	1
	Ancillary service other pass through costs from Wkst. D, Pt.			12, 673	
	Total (sum of amounts on lines 49 through 58)	•		37, 712, 327	
00	Primary payer payments			46, 189	60
00	Total amount payable for program beneficiaries (line 59 minus	line 60)		37, 666, 138	61.
- 1	00 Deductibles billed to program beneficiaries				62
					63
- 1					64.
	, ,				
4					66.
	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for	annlicable to MS_DRGs (s	ee instructions)	34, 613, 635 0	1
	Outlier payments reconciliation (sum of lines 93, 95 and 96).			0	1
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		- /	0	1
- 1	Rural Community Hospital Demonstration Project (§410A Demonst	ration) adjustment (see	instructions)	0	1
	N95 respirator payment adjustment amount (see instructions)	,		0	70.
1	Demonstration payment adjustment amount before sequestration			0	
1	SCH or MDH volume decrease adjustment (contractor use only)			0	
	Pioneer ACO demonstration payment adjustment amount (see inst	ructions)			70.
1	HSP bonus payment HVBP adjustment amount (see instructions)			0	1
	HSP bonus payment HRR adjustment amount (see instructions)			0	1
	Bundled Model 1 discount amount (see instructions)			0	
93	HVBP payment adjustment amount (see instructions)			0	
	HRR adjustment amount (see instructions)		l l	-69, 917	70.

Health Financial Systems	ELKHART GENERAL	HOSPI TAL		In Lie	u of Form CMS-:	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der	CCN: 15-0018	Peri od: From 01/01/2022 To 12/31/2022	Worksheet E Part A Date/Time Pre 5/31/2023 12:	pared: 14 pm
		Ti tl	e XVIII	Hospi tal	PPS	<u> </u>
			FFY	(yyyy)	Amount	
				0	1. 00	
70.96 Low volume adjustment for federal fisca the corresponding federal year for the		n column 0		0	0	70. 96
70.97 Low volume adjustment for federal fisca the corresponding federal year for the				0	70. 97	

	FFY (yyyy)	Amount	
	0	1.00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	0	0	70. 96
the corresponding federal year for the period prior to 10/1)			
70.97 Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0	0	0	70. 97
the corresponding federal year for the period ending on or after 10/1)			
70.98 Low Volume Payment-3		0	
70.99 HAC adjustment amount (see instructions)		0	
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		34, 543, 718	71. 00
71.01 Sequestration adjustment (see instructions)		435, 251	71. 01
71.02 Demonstration payment adjustment amount after sequestration		0	1
71.03 Sequestration adjustment-PARHM or CHART pass-throughs			71. 03
72.00 Interim payments		33, 242, 987	72. 00
72.01 Interim payments-PARHM or CHART			72. 01
73.00 Tentative settlement (for contractor use only)		0	
73.01 Tentative settlement-PARHM or CHART (for contractor use only)			73. 01
74.00 Balance due provider/program (line 71 minus lines 71.01, 71.02, 72, and		865, 480	74. 00
[73]			
74.01 Balance due provider/program-PARHM or CHART (see instructions)			74. 01
75.00 Protested amounts (nonallowable cost report items) in accordance with		508, 629	75. 00
CMS Pub. 15-2, chapter 1, §115.2			
TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)			
90.00 Operating outlier amount from Wkst. E, Pt. A, line 2, or sum of 2.03		0	90.00
plus 2.04 (see instructions)			
91.00 Capital outlier from Wkst. L, Pt. I, line 2		0	1
92.00 Operating outlier reconciliation adjustment amount (see instructions)		0	
93.00 Capital outlier reconciliation adjustment amount (see instructions)		0	
94.00 The rate used to calculate the time value of money (see instructions)		0.00	
95.00 Time value of money for operating expenses (see instructions)		0	
96.00 Time value of money for capital related expenses (see instructions)		0	96. 00
		10/1 On/After 10/1	
luco p	1.00	2.00	
HSP Bonus Payment Amount			100 00
100.00 HSP bonus amount (see instructions)		0 0	100. 00
HVBP Adjustment for HSP Bonus Payment	0.00000	200000 0 00000000	101 00
101.00 HVBP adjustment factor (see instructions)	0. 00000	•	
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)		0 0	102. 00
HRR Adjustment for HSP Bonus Payment		0000	103. 00
103.00 HRR adjustment factor (see instructions)			104. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	atmont .	0 0	104.00
Rural Community Hospital Demonstration Project (\$410A Demonstration) Adjus			200 00
200.00 Is this the first year of the current 5-year demonstration period under the contunt Current Service and "N" for the cur	ne ZIST		200. 00
Century Cures Act? Enter "Y" for yes or "N" for no. Cost Reimbursement			
201.00 Medicare inpatient service costs (from Wkst. D-1, Pt. II, line 49)			201. 00
202.00 Medicare discharges (see instructions)			201.00
203.00 Case-mix adjustment factor (see instructions)			202.00
Computation of Demonstration Target Amount Limitation (N/A in first year	of the current 5 year de	omonetration	203.00
period)	of the current 5-year de	BIIIOTISTI ATI OTI	
204.00 Medicare target amount			204. 00
205.00 Case-mix adjusted target amount (line 203 times line 204)			205. 00
206.00 Medicare inpatient routine cost cap (line 202 times line 205)			206. 00
Mdiustment to Medicare Part A Innationt Poimbursement]200.00
Adjustment to Medicare Part A Inpatient Reimbursement			
207.00 Program reimbursement under the §410A Demonstration (see instructions)			207. 00
207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59)			207. 00 208. 00
207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 209.00 Adjustment to Medicare IPPS payments (see instructions)			207. 00 208. 00 209. 00
207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 209.00 Adjustment to Medicare IPPS payments (see instructions) 210.00 Reserved for future use			207. 00 208. 00 209. 00 210. 00
207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 209.00 Adjustment to Medicare IPPS payments (see instructions) 210.00 Reserved for future use 211.00 Total adjustment to Medicare IPPS payments (see instructions)			207. 00 208. 00 209. 00
207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 209.00 Adjustment to Medicare IPPS payments (see instructions) 210.00 Reserved for future use 211.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement			207. 00 208. 00 209. 00 210. 00 211. 00
207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 209.00 Adjustment to Medicare IPPS payments (see instructions) 210.00 Reserved for future use 211.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)			207. 00 208. 00 209. 00 210. 00 211. 00
207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 209.00 Adjustment to Medicare IPPS payments (see instructions) 210.00 Reserved for future use 211.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 211) 213.00 Low-volume adjustment (see instructions)	hursement)		207. 00 208. 00 209. 00 210. 00 211. 00 212. 00 213. 00
207.00 Program reimbursement under the §410A Demonstration (see instructions) 208.00 Medicare Part A inpatient service costs (from Wkst. E, Pt. A, line 59) 209.00 Adjustment to Medicare IPPS payments (see instructions) 210.00 Reserved for future use 211.00 Total adjustment to Medicare IPPS payments (see instructions) Comparision of PPS versus Cost Reimbursement 212.00 Total adjustment to Medicare Part A IPPS payments (from line 211)	bursement)		207. 00 208. 00 209. 00 210. 00 211. 00

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0018	Peri od: From 01/01/2022 To 12/31/2022 Worksheet E Part B Date/Time Prepared: 5/31/2023 12:14 pm

	Ti the William		Hooni tol	5/31/2023 12:	14 pm
	Title XVIII		Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			2, 930	1.00
2. 00 3. 00	Medical and other services reimbursed under OPPS (see instructions) OPPS payments			21, 212, 409 21, 686, 661	2. 00 3. 00
4. 00	Outlier payment (see instructions)			57, 093	4.00
4. 01	Outlier reconciliation amount (see instructions)			0,,0,0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instructions)			0. 000	5. 00
6.00	Line 2 times line 5			0	6. 00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8. 00 9. 00	Transitional corridor payment (see instructions) Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 2	200		0 11, 558	8. 00 9. 00
10.00	Organ acquisitions	200		0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			2, 930	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12.00	Ancillary service charges			16, 414	
13. 00 14. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line 69)			0	13. 00 14. 00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			16, 414	14.00
15. 00	Aggregate amount actually collected from patients liable for payment for service	es on a	charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for payment for servi			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00	Total customary charges (see instructions)	مادا مام	11) (000	16, 414	
19. 00	Excess of customary charges over reasonable cost (complete only if line 18 exceed instructions)	eas iine	e II) (See	13, 484	19.00
20. 00	Excess of reasonable cost over customary charges (complete only if line 11 excee	eds line	e 18) (see	0	20. 00
	instructions)		, (
21. 00	g ,			2, 930	
22. 00	· · · · · · · · · · · · · · · · · · ·			0	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instructions)			0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			21, 755, 312	24. 00
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions)			0	25. 00
26. 00	Deductibles and Coinsurance amounts relating to amount on line 24 (for CAH, see	instruc	ctions)	3, 637, 717	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus the sum of lines	nes 22 a	and 23] (see	18, 120, 525	27. 00
	instructions)			_	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 50)			0	28. 00
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)			0 18, 120, 525	29. 00 30. 00
31. 00	Primary payer payments			16, 120, 323	
32. 00				18, 119, 143	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
33. 00				0	33. 00
34. 00	· · · · · · · · · · · · · · · · · · ·			87, 624	
35. 00 36. 00	, ,			56, 956 64, 333	1
37. 00				18, 176, 099	
				2, 777	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			. 0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 75	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 in RECOVERY OF ACCELERATED DEPRECIATION	nstructi	ons)	0	39. 98
39. 99 40. 00	Subtotal (see instructions)			18, 173, 322	39. 99 40. 00
40. 01	Sequestration adjustment (see instructions)			228, 984	1
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	Sequestration adjustment-PARHM or CHART pass-throughs				40. 03
41. 00	Interim payments			18, 169, 718	
41. 01	Interim payments-PARHM or CHART				41. 01
42.00	Tentative settlement (for contractors use only) Tentative settlement-PARHM or CHART (for contractor use only)			0	42. 00 42. 01
42. 01 43. 00	Balance due provider/program (see instructions)			-225, 380	ı
43. 01	Balance due provider/program-PARHM (see instructions)			223, 300	43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 1	15-2, ch	napter 1,	0	44. 00
	§115. 2		·		
	TO BE COMPLETED BY CONTRACTOR				
	, ,			0	1
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00 93. 00				0. 00 0	92. 00 93. 00
	Total (sum of lines 91 and 93)				94.00

Health Financial Systems	ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS	-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provider CCN: 15-0018	Peri od:	Worksheet E	
			From 01/01/2022		
			To 12/31/2022		
				5/31/2023 12	:14 pm_
		Title XVIII	Hospi tal	PPS	
				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 Period: Worksheet E-1
From 01/01/2022 Part I
To 12/31/2022 Date/Time Prepared: 5/31/2023 12:14 pm Provider CCN: 15-0018

Inpatient Part A						5/31/2023 12: 1	14 pm
1.00					Hospi tal	PPS	
1.00			Inpatien	t Part A	Par	rt B	
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.				2.00		4.00	
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, write "NONE" or enter a zero.	1. 00	Total interim payments paid to provider		33, 242, 98	7	18, 169, 718	1. 00
Submitted or to be Submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero							
Services rendered in the cost reporting period. If none, write "NONE" or netre a zero.	2.00						2.00
write "NONE" or enter a zero .0 Ust 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 .0 0 0 0 3.02 .03 .03 0 0 0 0 3.03 .04 0 0 0 0 3.03 .05 0 0 0 0 3.05 Provider to Program							
Section Sect							
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 ADJUSTMENTS TO PROVIDER ADJUSTMENTS TO PROVIDER O	3 00						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	0.00						0.00
Dayment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02 3.03 3.04 0 0 0 3.02 3.03 3.04 0 0 0 3.03 3.04 3.05	3 01				1	0	3 01
3.03 0		THE STATE OF THE PROPERTY OF T					
3. 04 0 0 0 3. 04 3. 05							
3.05							
Provider to Program ADJUSTMENTS TO PROGRAM 0 0 3 . 50 3 . 50 0 0 0 3 . 51 3 . 52 0 0 0 0 3 . 51 3 . 52 0 0 0 0 3 . 51 3 . 53 0 0 0 0 3 . 53 3 . 53 0 0 0 0 3 . 53 3 . 54 0 0 0 0 3 . 53 3 . 54 0 0 0 0 3 . 53 3 . 54 0 0 0 0 3 . 53 3 . 54 0 0 0 0 3 . 53 3 . 54 0 0 0 0 3 . 54 3 . 59 3 . 50 . 3 . 99 0 total (sum of lines 1, 2, and 3. 99) Total interim payments (sum of lines 1, 2, and 3. 99) Total interim payments (sum of lines 1, 2, and 3. 99) Total interim payments (sum of lines 1, 2, and 3. 99) Total interim payments (sum of lines 1, 2, and 3. 99) Total interim payments (sum of lines 1, 2, and 3. 99) Total interim payments (sum of lines 2, 2, and 3. 99) Total interim payments (sum of lines 3, 11 in and column as appropriate) Total Set Compteted Program to West 1 in and column as appropriate) Total Set Compteted Program to Provider Total Set Compteted Program							
3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3.51 3.52 0 0 0 3.51 3.52 3.53 0 0 0 3.53 3.54 0 0 0 3.53 3.59 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 33,242,987 18,169,718 4.00 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 33,242,987 18,169,718 4.00 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 5.01 TENTATI VE TO PROVI DER 0 0 5.02 5.03 Provider to Program TENTATI VE TO PROGRAM 0 0 5.50 5.50 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETILEMENT TO PROGRAM 0 225,380 6.02 7.00 Total Medicare program liability (see instructions) 34,108,467 NPR Date (Mc/Pay/Yrr) Contractor Number (Mc/Pay/Yrr) 1.00 2.00 2.00 Contractor Number (Mc/Pay/Yrr) 1.00 2.00 2.00 2.00 Contractor Number (Mc/Pay/Yrr) 1.00 2.00	3.03	Provider to Program			٧	0	5. 05
3.51	3 50)	0	3 50
3.52 3.53 3.54 3.99 3.50		710000 TIMENTO TO TROOTO IIII					
3.53 3.54 0							
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 33,242,987 18,169,718 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR						1 -1	
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 33.50-3.98) 33.50-3.98) 33.50-3.98) 33.50-3.98) 33.242.987 18.169,718 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 33.242.987 18.169,718 4.00							
3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total interim payments (sum of lines 1, 2, and 3.99) Total Medicare program liability (see instructions) Total Medicare program liabi		Subtotal (sum of lines 3 01_3 49 minus sum of lines				"	
A 0.0	5. 77			,		Ĭ	3. 77
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4 00			33 242 98	7	18 169 718	4 00
appropriate TO BE COMPLETED BY CONTRACTOR	00			00/ 2 12/ 70		10,10,,,10	00
TO BE COMPLETED BY CONTRACTOR S. 00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider TENTATIVE TO PROVIDER O O O O O O O O O O O O O O O O O O							
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					<u> </u>		
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5.00						5. 00
Write "NONE" or enter a zero. (1) Program to Provider S. 01 TENTATI VE TO PROVI DER O O S. 02 S. 02 O O S. 02 S. 03 O O S. 02 S. 03 O O S. 03 O O S. 50 S. 50 O O S. 50 S. 50 O O S. 50 S. 50 O O O S. 50 O O O O O O O O O							
Program to Provider							
S. 02		Program to Provider					
Solution Solution	5. 01	TENTATI VE TO PROVI DER		()	0	5. 01
Provider to Program	5.02			()	0	5.02
TENTATIVE TO PROGRAM 0	5.03			(O	0	5.03
5.51 0		Provider to Program					
5.52 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 865,480 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 225,380 6.02 7.00 Total Medicare program liability (see instructions) 34,108,467 17,944,338 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5.50	TENTATI VE TO PROGRAM)	0	5. 50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 865, 480 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 225, 380 6. 02 7. 00 Total Medicare program liability (see instructions) 34, 108, 467 17, 944, 338 7. 00 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	5. 51						5. 51
5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00				()		
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 865, 480 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 225, 380 6.02 7.00 Total Medicare program liability (see instructions) 34, 108, 467 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		()	0	5. 99
the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) 865, 480 0 225, 380 6. 02 34, 108, 467 Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00							
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00	6.00						6.00
6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00							
7.00 Total Medicare program liability (see instructions) 34,108,467 17,944,338 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							
Number (Mo/Day/Yr) 0 1.00 2.00	7. 00	Total Medicare program liability (see instructions)		34, 108, 46			7. 00
0 1.00 2.00							
0.00 N	0.00		(J	1.00	2.00	0.00
8.00 Name of Contractor 8.00	8.00	Name or Contractor			1	1	8.00

| Component CCN: 15-S018 | To

Title XVIII Subprovider -

Inpatient Part A			IIIIe	AVIII	IPF	PFS	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			I npati en	t Part A		t B	
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			mm/dd/\\\\\	Amount	mm/dd/\\\\\	Amount	
Total interim payments paid to provider 184,786 0 1.00 2.00							
Interim payments payable on individual bills, either subtitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.	1. 00	Total interim payments paid to provider	11.00		0.00		1. 00
Submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero 3.00				0			
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero.							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider		services rendered in the cost reporting period. If none,					
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)		write "NONE" or enter a zero					
For the cost reporting period. Also show date of each papement. If none, write "NONE" or enter a zero. (1)	3.00						3.00
payment. If none, write "NONE" or enter a zero. (1)							
Program to Provider ADJUSTMENTS TO PROVIDER							
ADJUSTMENTS TO PROVIDER							
3.02 3.03 3.04 3.05 3.03 3.04 3.05 3.00 3.03 3.04 3.05 3.00 3.06 3.00 3.03 3.04 3.05 3.50 3.50 3.50 3.50 3.51 3.52 3.53 3.54 3.54 3.59 3.50-3.99 4.00 5.00 5.00 5.00 5.00 6.00 6.00 6.00 6	2 01			0		0	2 01
3.03 0		ADJUSTMENTS TO PROVIDER		_			
3.04 0 0 3.04 3.05							
3.05 Provider to Program				_			
Provider to Program							
3. 50 ADJUSTMENTS TO PROGRAM	3. 03	Provider to Program		0		J	3. 03
3.51	3.50			0		0	3. 50
3.53 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.54 3.55 3.56 3.98 3.50-3.98 3.				0		o	3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 184,786 0 4.00	3.52			0		o	3. 52
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)	3.53			0		0	3. 53
3.50-3.98 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) To Be COMPLETED BY CONTRACTOR	3.54			0		0	3.54
184,786	3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
appropriate TO BE COMPLETED BY CONTRACTOR	4. 00			184, 786		0	4. 00
TO BE COMPLETED BY CONTRACTOR							
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Aiso show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	5 00						5 00
Write "NONE" or enter a zero. (1) Program to Provider S. 01 TENTATIVE TO PROVIDER O O O S. 02 S. 03 O O O S. 02 S. 03 O O O S. 02 S. 03 O O O S. 03 O O S. 05 O O O S. 05 O O S. 05 O O O S. 05 O O O S. 05 O O O O O O O O O	5.00						5.00
Program to Provider							
Solution September Septe							
Solution September Septe	5. 01	TENTATI VE TO PROVI DER		0		0	5. 01
Provider to Program	5.02			0		0	5. 02
TENTATI VE TO PROGRAM	5.03			0		0	5. 03
5.51 5.52 0 0 0 5.51 5.52 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					+		
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) O 1.00 2.00		TENTATI VE TO PROGRAM					
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 0 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 4 0 6. 02 7. 00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00							
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00				0			
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 0 0 6.01 6.02 SETTLEMENT TO PROGRAM 4 0 6.02 7.00 Total Medicare program liability (see instructions) 184,782 0 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99			0		0	5. 99
the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 00						6 00
6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) Number (Mo/Day/Yr) 0 1.00 2.00	0.00						0.00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6 01			n		n	6 01
7.00 Total Medicare program liability (see instructions) 184,782				4			
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				184. 782			
0 1.00 2.00		, and the state of			Contractor	NPR Date	
8.00 Name of Contractor 8.00			()	1. 00	2. 00	
	8.00	Name of Contractor					8. 00

Component CCN: 15-T018

PPS

Title XVIII Subprovi der -

		litie	XVIII	Subprovider - IRF	PPS	
		Innatien	t Part A		rt 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		91, 751		0	1. 00
2.00	Interim payments payable on individual bills, either		0		0	2. 00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
3.00	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		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3.05			0		0	3. 05
	Provider to Program	T			T _	
3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.51			0		0	3. 51 3. 52
3. 52 3. 53			0			3. 52
3. 53 3. 54			0			3. 53
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0			3. 99
3. 77	3. 50-3. 98)		0		U	3.77
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		91, 751		0	4.00
00	(transfer to Wkst. E or Wkst. E-3, line and column as		,,,,,			
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider	ı				
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		U	3.03
5. 50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51	TENTATI VE TO TROGRAM		0		Ö	5. 51
5. 52			0		o o	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		Ö	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		3, 018		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		0		0	6. 02
7. 00	Total Medicare program liability (see instructions)		94, 769		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
0.00	maine of sofiti detoi	I		I	1	0.00

Heal th	Financial Systems ELKHART GENERAL	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 15-0018 Period: From 01/01/2022 Part I To 12/31/2022 Date/T					pared:
		Title XVIII	Hospi tal	5/31/2023 12: PPS	14 piii
		THE XVIII	nospi tui	110	
				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	14		1. 00
2.00	2.00 Medicare days (see instructions)				2. 00
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				
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 l	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					10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	,			1
30.00	Initial/interim HIT payment adjustment (see instructions)				30. 00
31.00	Other Adjustment (specify)				31. 00
22 00	Polones due provider (line 0 (er line 10) minus line 20 and l	ing 21) (and instruction			22 00

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

30. 00 31. 00 32. 00

CALCULATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 15-0018 From 01/01/2022 Part II Component CCN: 15-S018 To 12/31/2022 Date/Time Prepared	Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
Component CCN: 15-S018 To 12/31/2022 Date/Time Prepared	CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0018		
		Component CCN: 15-S018	To 12/31/2022	
		·		5/31/2023 12:14 pm
Title XVIII Subprovider - PPS		Title XVIII	Subprovi der -	PPS
I PF			I PF	

	IPF		
		1.00	
	DATE HE MEDICADE DATE A CEDIMORO LOS DOS	1. 00	
1 00	PART II - MEDICARE PART A SERVICES - IPF PPS	200 142	1 00
1.00	Net Federal IPF PPS Payments (excluding outlier, ECT, and medical education payments)	200, 142	1.00
2.00	Net LPE PPS Outlier Payments	16, 893	
3. 00 4. 00	Net IPF PPS ECT Payments Unweighted intern and resident FTE count in the most recent cost report filed on or before November	0 0. 00	3. 00 4. 00
4.00	15, 2004. (see instructions)	0.00	4.00
4. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0. 00	4. 01
4.01	program or hospital closure, that would not be counted without a temporary cap adjustment under 42	0.00	4.01
	CFR \$412. 424(d)(1)(i)i)(F)(1) or (2) (see instructions)		
5.00	New Teaching program adjustment. (see instructions)	0. 00	5. 00
6.00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new	0.00	•
	teaching program" (see instuctions)		
7.00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	7. 00
	teaching program" (see instuctions)		
8.00	Intern and resident count for IPF PPS medical education adjustment (see instructions)	0.00	8. 00
9.00	Average Daily Census (see instructions)	7. 863014	9. 00
10.00	Teaching Adjustment Factor {((1 + (line 8/line 9)) raised to the power of .5150 -1}.	0.000000	10.00
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)	217, 035	
13.00	Nursing and Allied Health Managed Care payment (see instruction)	0	13. 00
14. 00	Organ acquisition (DO NOT USE THIS LINE)		14. 00
15. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	10.00
16. 00	Subtotal (see instructions)	217, 035	
17. 00	Primary payer payments	0	
18. 00	Subtotal (line 16 less line 17).	217, 035	
19. 00	Deducti bl es	24, 896	
20.00	Subtotal (line 18 minus line 19)	192, 139	
21. 00	Coinsurance	5, 057	
22. 00	Subtotal (line 20 minus line 21)	187, 082	22. 00 23. 00
23. 00 24. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions) Adjusted reimbursable bad debts (see instructions)	0	
25. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	25. 00
26. 00	Subtotal (sum of lines 22 and 24)	187, 082	
27. 00	Direct graduate medical education payments (see instructions)	187, 082	1
28. 00	Other pass through costs (see instructions)	58	
29. 00	Outlier payments reconciliation	0	
30.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	
30. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	
30. 98	Recovery of accelerated depreciation.	Ö	
30. 99	Demonstration payment adjustment amount before sequestration	0	
31. 00	Total amount payable to the provider (see instructions)	187, 140	
31. 01	Sequestration adjustment (see instructions)	2, 358	
31. 02	Demonstration payment adjustment amount after sequestration	0	31. 02
32. 00	Interim payments	184, 786	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)	-4	34.00
35.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	0	35. 00
	§115. 2		
	TO BE COMPLETED BY CONTRACTOR		
50.00	Original outlier amount from Worksheet E-3, Part II, line 2	16, 893	
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
00.05	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19		00.00
99. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 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 HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0018	Peri od: From 01/01/2022	Worksheet E-3
	Component CCN: 15-T018		
	Title XVIII	Subprovi der -	PPS
		I RF	

	IRF		
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS		
. 00	Net Federal PPS Payment (see instructions)	85, 925	1.0
. 00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0441	2. 0
. 00	Inpatient Rehabilitation LIP Payments (see instructions)	10, 053	3.0
. 00	Outlier Payments	0	4. 0
. 00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior to November 15, 2004 (see instructions)	0. 00	5. 0
. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by program or hospital closure, that would not be counted without a temporary cap adjustment under 42 CFR §412.424(d)(1)(iii)(F)(1) or (2) (see instructions)	0.00	5. 0
. 00	New Teaching program adjustment. (see instructions)	0. 00	6.0
. 00	Current year's unweighted FTE count of I&R excluding FTEs in the new program growth period of a "new teaching program" (see instructions)	0. 00	7. 0
. 00	Current year's unweighted I&R FTE count for residents within the new program growth period of a "new teaching program" (see instructions)	0. 00	8. 0
. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0. 00	9. (
0. 00	Average Daily Census (see instructions)	0. 279452	
1. 00	Teaching Adjustment Factor (see instructions)	0. 000000	
2. 00	Teaching Adjustment (see instructions)	0.000000	12.
3. 00	Total PPS Payment (see instructions)	95, 978	
4. 00	Nursing and Allied Health Managed Care payments (see instruction)	0	14. (
5. 00	Organ acquisition (DO NOT USE THIS LINE)		15.
5. 00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.
. 00	Subtotal (see instructions)	95, 978	17.
. 00	Pri mary payer payments	0	18.
. 00	Subtotal (line 17 less line 18).	95, 978	19.
. 00	Deducti bl es	0	20.
. 00	Subtotal (line 19 minus line 20)	95, 978	21.
2. 00	Coi nsurance	0	22.
3. 00	Subtotal (line 21 minus line 22)	95, 978	23.
1. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)	0	24.
5. 00	Adjusted reimbursable bad debts (see instructions)	0	25.
. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26.
. 00	Subtotal (sum of lines 23 and 25)	95, 978	27.
. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	0	28.
. 00	Other pass through costs (see instructions)	0	29.
. 00	Outlier payments reconciliation	0	30.
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.
. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.
. 98	Recovery of accelerated depreciation.	0	31.
. 99	Demonstration payment adjustment amount before sequestration	0	31.
. 00	Total amount payable to the provider (see instructions)	95, 978	
. 01	Sequestration adjustment (see instructions)	1, 209	
. 02	Demonstration payment adjustment amount after sequestration	0	32.
. 00	Interim payments	91, 751	33.
. 00	Tentative settlement (for contractor use only)	0	34.
. 00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	3, 018	35.
. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2	0	36.
	TO BE COMPLETED BY CONTRACTOR		
	Original outlier amount from Wkst. E-3, Pt. III, line 4	0	50.
	Outlier reconciliation adjustment amount (see instructions)	0	51.
2. 00	The rate used to calculate the Time Value of Money	0. 00	
3. 00	Time Value of Money (see instructions)	0	53.
	FOR COST REPORTING PERIODS ENDING AFTER FEBRUARY 29, 2020 AND BEGINNING BEFORE THE END OF THE COVID-19		
9. 00	Teaching Adjustment Factor for the cost reporting period immediately preceding February 29, 2020.	0. 000000 0. 000000	

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0018	Peri od: Worksheet E-3 From 01/01/2022 Part VII To 12/31/2022 Date/Ti me Prepared:

PART VII - CALCULATION OF REINBURSEMENT - ALL OTHER HEALTH SERVICES FOR TITLES V OR XIX SERVICES				10 12/31/2022	5/31/2023 12:	
PART_VII			Title XIX	Hospi tal		
PART VII - CALCULATION OF RET MBUISSMENT - ALL DIFFER HEALTH SERVICES FOR TITLES V OR XIX SERVICES					Outpati ent	
COMPUTATION OF NET COST OF COVERED SERVICES				1. 00	2.00	
Inpatient hospital / SNF/NF services		PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	RVICES FOR TITLES V OR XIX	X SERVICES		
Medical and other services 0 2.00		COMPUTATION OF NET COST OF COVERED SERVICES				
Organ acquisition (certified transplant programs only)	1.00	Inpatient hospital/SNF/NF services		0		1. 00
Subtotal (sum of lines 1, 2 and 3)	2.00	Medical and other services			0	2. 00
Inpatient primary payer payments 0 0 0 0 0 0 0 0 0	3.00	Organ acquisition (certified transplant programs only)		0		3. 00
Outpatient primary payer payments 0 0 0 0 0 7.00	4.00	Subtotal (sum of lines 1, 2 and 3)		0	0	4. 00
Subtotal Cline 4 Tess sum of lines 5 and 6)	5.00			0		5. 00
COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges Routine service charges 8.00 Routine service charges 55,985,274 90, 401, 363 9.00 9.00 Actillary service charges 55,985,274 90, 401, 363 9.00 10.00						
Reasonable Charges 37,493,098 8,00 001 10 10 10 10 10 10	7. 00			0	0	7. 00
8.00 Routine service charges 37, 493,098 90, 401, 363 10.00 00 700 Ancili lary service charges, ent of revenue 55,985,274 90,401,363 10.00 10.						
9.00 Ancil lary service charges 55,985,274 90,401,363 9.00						
10.00 Organ acquisition charges, net of revenue 0 10.0						
11.00 Incentive From target amount computation 93, 478, 372 90, 401, 363 12.00 200 Total reasonable charges (sum of lines 8 through 11) 93, 478, 372 90, 401, 363 12.00 20					90, 401, 363	
12.00 Total reasonable charges (sum of lines 8 through 11) 2.00 CUSTOMARY CHARGES 3.00 Amount actually collected from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CfR §413.13(e) 0.0000000 0.000000 0.0000000 0.00000000				0		1
CUSTOMARY CHARGES 0				02 470 272	00 401 272	
13.00 Amount actually collected from patients liable for payment for services on a charge basis 14.00 Anounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR \$413.13(e) 0.000000 0.000000 15.00 15	12.00			93, 478, 372	90, 401, 363	12.00
basis 10	12 00		s corvi cos on a chargo		0	12 00
14. 00 Amounts that would have been realized from patients Liable for payment for services on a large basis had such payment been made in accordance with 42 CFR §413. 13(e) 0.0000000 0.0000000 0.00000000	13.00		services on a charge	U	U	13.00
a charge basis had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 13 to line 14 (not to exceed 1.000000) 0.000000 0.000000 0.000000 0.000000 0.000000	14 00		navment for services on	0	0	14 00
15.00 Ratio of Fline 13 to line 14 (not to exceed 1.000000) 0.00000000	14.00				O	14.00
16.00 Total customary charges (see instructions) 93, 478, 372 90, 401, 363 16.00 17.00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 93, 478, 372 90, 401, 363 17.00 18.00 Excess of reasonable cost over customary charges (complete only if line 16 exceeds line 0 0 0 0 10 (see instructions) 0 0 0 0 0 19.00 Interns and Residents (see instructions) 0 0 0 0 0 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 0 0 0 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 0 0 0 20.00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 0 0 0 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 0 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 0 20.00 Outlier payments 0 0 0 0 22.00 20.00 Outlier payments 0 0 0 22.00 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 0 20.00 Outlier payments 0 0 0 22.00 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 0 20.00 Outlier payments 0 0 0 22.00 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 0 20.00 Outlier payments 0 0 0 0 20.00 Outlier payments 0 0 0 0 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 0 20.00 Outlier payments 0 0 0 0 20.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 0 20.00 Outlier payments 0 0 0 0	15. 00		.2 0.11 3.10.10(0)	0. 000000	0.000000	15. 00
17. 00 Excess of customary charges over reasonable cost (complete only if line 16 exceeds 93, 478, 372 90, 401, 363 17. 00		,				
Line 4) (see instructions) Excess of reasonable cost over customary charges (complete only if line 4 exceeds line 10) (see instructions) 18.00 10) (see instructions) 10 10 10 10 10 10 10 1			y if line 16 exceeds			
16) (see instructions)						
19, 00 Interns and Residents (see instructions) 0 0 19, 00 20, 00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 20, 00 21, 00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 21, 00 22, 00 Other than outlier payments 0 0 22, 00 23, 00 Outlier payments 0 0 23, 00 24, 00 Program capital payments 0 25, 00 24, 00 25, 00 Qoi tal exception payments (see instructions) 0 25, 00 26, 00 Routine and Ancillary service other pass through costs 9, 549 45, 618 26, 00 27, 00 20, 00 Customary charges (title V or XIX PPS covered services only) 0 9, 549 45, 618 27, 00 20, 00 Titles V or XIX (sum of lines 21 and 27) 0 9, 549 45, 618 29, 00 20, 00 Titles V or XIX (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 9, 549 45, 618 29, 00 31, 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 9, 549 45, 618 31, 00 32, 00 </td <td>18.00</td> <td>Excess of reasonable cost over customary charges (complete onl</td> <td>y if line 4 exceeds line</td> <td>0</td> <td>0</td> <td>18. 00</td>	18.00	Excess of reasonable cost over customary charges (complete onl	y if line 4 exceeds line	0	0	18. 00
20. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 0 20. 00						
21.00 Cost of covered services (enter the lesser of line 4 or line 16) 0 0 0 21.00				-	-	
PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be completed for PPS providers.				-	_	
22. 00 Other than outlier payments 0 0 22. 00 23. 00 Outlier payments 0 0 23. 00 24. 00 Program capital payments 0 24. 00 25. 00 Capital exception payments (see instructions) 0 25. 00 26. 00 Routine and Ancillary service other pass through costs 9, 549 45, 618 26. 00 27. 00 Subtotal (sum of lines 22 through 26) 9, 549 45, 618 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 9, 549 45, 618 27. 00 29. 00 Total amount of REIMBURSEMENT SETTLEMENT 0 0 30. 00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 9, 549 45, 618 31. 00 32. 00 Deductibles 0 0 0 33. 00 33. 00 Coinsurance 0 0 34. 00 34. 00 Allowable bad debts (see instructions) 0 0 35. 00 35. 00 Utilization review <t< td=""><td>21. 00</td><td></td><td></td><td></td><td>0</td><td>21. 00</td></t<>	21. 00				0	21. 00
23.00 Outlier payments 0 0 23.00 24.00 Program capital payments 0 24.00 25.00 Capital exception payments (see instructions) 0 25.00 26.00 Routine and Ancillary service other pass through costs 9,549 45,618 26.00 27.00 Subtotal (sum of lines 22 through 26) 9,549 45,618 27.00 28.00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 9,549 45,618 27.00 29.00 CoMPUTATION OF REIMBURSEMENT SETTLEMENT 0 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 9,549 45,618 31.00 32.00 Deductibles 0 0 0 32.00 33.00 Coinsurance 0 0 33.00 34.00 Allowable bad debts (see instructions) 0 0 35.00 35.00 Utilization review 0 35.00 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines			completed for PPS provide			
24.00 Program capital payments 0 24.00 25.00 Capital exception payments (see instructions) 0 25.00 26.00 Routine and Ancillary service other pass through costs 9,549 45,618 26.00 27.00 Subtotal (sum of lines 22 through 26) 9,549 45,618 27.00 28.00 28.00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 9,549 45,618 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 9,549 45,618 31.00 32.00 Deductibles 0 0 32.00 33.00 Coinsurance 0 0 33.00 40.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 9,549 45,618 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS		1 3		-		
25.00 Capital exception payments (see instructions) 26.00 Routine and Ancillary service other pass through costs 27.00 Subtotal (sum of lines 22 through 26) 28.00 Customary charges (title V or XIX PPS covered services only) 29.00 Titles V or XIX (sum of lines 21 and 27) 29.00 Excess of reasonable cost (from line 18) 30.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 31.00 Deductibles 32.00 Deductibles 33.00 Coinsurance 41.00 Allowable bad debts (see instructions) 35.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Direct graduate medical education payments (from Wkst. E-4) 39.00 Total amount payable to the provider (sum of lines 38 and 39) 45.618 45.618 40.00 41.00 Interim payments 45.618 45.618 40.00 41.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 45.618 26.00 27.00 28.00 28.00 28.00 29.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				-	0	
26.00 Routine and Ancillary service other pass through costs 9,549 45,618 26.00 27.00 Subtotal (sum of lines 22 through 26) 9,549 45,618 27.00 28.00 Customary charges (title V or XIX PPS covered services only) 0 0 28.00 29.00 Titles V or XIX (sum of lines 21 and 27) 9,549 45,618 27.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 9,549 45,618 31.00 32.00 Deductibles 0 0 32.00 33.00 Coi nsurance 0 0 34.00 34.00 Allowable bad debts (see instructions) 0 0 34.00 35.00 Utilization review 0 35.00 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 9,549 45,618 36.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 0 0 37.00 0 39.00 <td< td=""><td></td><td> 9 1 3</td><td></td><td>0</td><td></td><td></td></td<>		9 1 3		0		
27. 00 Subtotal (sum of lines 22 through 26) 9,549 45,618 27. 00 28. 00 Customary charges (title V or XIX PPS covered services only) 0 0 28. 00 28. 00 29. 00 Titles V or XIX (sum of lines 21 and 27) 9,549 45,618 29. 00 20				0 540	4E (10	
28.00 Customary charges (title V or XIX PPS covered services only) 7				·	· ·	
29. 00 Titles V or XIX (sum of lines 21 and 27) 9,549 45,618 29.00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 30. 00 Excess of reasonable cost (from line 18) 0 30.00 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 9,549 45,618 31.00 32. 00 Deductibles 0 0 32.00 33. 00 Coi nsurance 0 0 33.00 34. 00 Allowable bad debts (see instructions) 0 0 34.00 35. 00 Utilization review 0 35.00 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 9,549 45,618 36.00 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 38. 00 Subtotal (line 36 ± line 37) 9,549 45,618 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) 9,549 45,618 40.00 42. 00 Balance due provider/program (line 40 minus line 41) 9,549 <td< td=""><td></td><td></td><td></td><td></td><td></td><td></td></td<>						
COMPUTATION OF REIMBURSEMENT SETTLEMENT 30.00 Excess of reasonable cost (from line 18) 0 0 30.00 31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 9,549 45,618 31.00 32.00 Deductibles 0 0 0 32.00 33.00 Coinsurance 0 0 0 34.00 34.00 Allowable bad debts (see instructions) 0 0 0 34.00 35.00 Utilization review 0 0 35.00 35.00 Utilization review 0 35.00 35.00 Utilization review 0 35.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 0 37.00 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) 9,549 45,618 40.00 Interim payments 0 0 41.00 42.00 Balance due provider/program (line 40 minus line 41) 9,549 45,618 42.00 43.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00		, , , , , , , , , , , , , , , , , , , ,		٩		
30. 00 Excess of reasonable cost (from line 18) 31. 00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 32. 00 Deductibles 33. 00 Coinsurance 34. 00 Allowable bad debts (see instructions) 35. 00 Utilization review 36. 00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 30. 00 0 30. 00 0 30. 00 0 32. 00 0 32. 00 0 32. 00 0 32. 00 0 34. 00 0 34. 00 0 34. 00 0 0 34. 00 0 0 34. 00 0 0 37. 00 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 37. 00 0 45. 618 40. 00 0 40. 00 0 41. 00 0 43. 00 0 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	27.00			7, 547	45, 010	27.00
31.00 Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6) 9, 549 45, 618 31.00 32.00 Deductibles 0 0 32.00 33.00 Coinsurance 0 0 0 33.00 34.00 Allowable bad debts (see instructions) 5.00 Utilization review 36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 88.00 Subtotal (line 36 ± line 37) 9, 549 45, 618 36.00 37.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 9, 549 45, 618 38.00 39.00 Interim payments 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30. 00			0	0	30.00
32.00 Deductibles Coinsurance Allowable bad debts (see instructions) Utilization review Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 7.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Subtotal (line 36 ± line 37) Subtotal (line 36 ± line 37) Direct graduate medical education payments (from Wkst. E-4) O Total amount payable to the provider (sum of lines 38 and 39) 10 Interim payments D Direct graduate medical education payments (from Wkst. E-4) D Direct graduate medical education payments (from Wkst. E-4) D Direct graduate medical education payments (from Wkst. E-4) D Direct graduate medical education payments (from Wkst. E-4) D Direct graduate medical education payments (from Wkst. E-4) D Direct graduate medical education payments (from Wkst. E-4) D Direct graduate medical education payments (from Wkst. E-4) D Direct graduate medical education payments (from Wkst. E-4) D Direct graduate medical education payments (from Wkst. E-4) D Direct graduate medical education payments (from Wkst. E-4) D D D D D D D D D D D D D D D D D D D		, ,)	9, 549		
34.00 Allowable bad debts (see instructions)				0		
35.00 Utilization review 35.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 35.00 35.00 35.00 37.00 9,549 45,618 40.00 9,549 45,618 40.00 41.00 42.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2,	33.00	Coinsurance		o	0	33.00
36.00 Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33) 37.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 9,549 45,618 36.00 37.00 37.00 37.00 37.00 39.549 45,618 36.00 0 0 45,618 36.00 0 45,618 45,618 45,618 45,618 45,618 45,618 45,618 45,618 40.00 41.00 42.00 43.00	34.00	Allowable bad debts (see instructions)		0	0	34.00
37. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 38. 00 Subtotal (line 36 ± line 37) 39. 00 Direct graduate medical education payments (from Wkst. E-4) 40. 00 Total amount payable to the provider (sum of lines 38 and 39) 41. 00 Interim payments 42. 00 Balance due provider/program (line 40 minus line 41) 43. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 0 37. 00 37. 00 37. 00 37. 00 37. 00 37. 00 39. 00 45, 618 45, 618 40. 00 41. 00 42. 00 43. 00 45, 618 42. 00 43. 00	35.00	Utilization review		0		35. 00
38.00 Subtotal (line 36 ± line 37) 39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 9,549 45,618 38.00 9,549 45,618 40.00 41.00 41.00 42.00 43.00	36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	d 33)	9, 549	45, 618	36. 00
39.00 Direct graduate medical education payments (from Wkst. E-4) 40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 39.00 45,618 40.00 41.00 42.00 43.00	37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
40.00 Total amount payable to the provider (sum of lines 38 and 39) 41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 45,618 40.00 41.00 9,549 45,618 40.00 41.00 42.00 43.00				9, 549	45, 618	
41.00 Interim payments 42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 41.00 9,549 45,618 42.00 43.00				0		39. 00
42.00 Balance due provider/program (line 40 minus line 41) 43.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub 15-2, 0 45,618 42.00		, , , , , , , , , , , , , , , , , , , ,		9, 549		
43.00 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub 15-2, 0 0 43.00				0		
Chapter 1, 9115.2	43. 00		nce with CMS Pub 15-2,	0	0	43.00
		Chapter 1, 9115.2		1		I

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 01/01/2022	
	·		5/31/2023 12:14 pm
	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 SER	VICES 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		· · · · · · · · · · · · · · · · · · ·		
	Reasonable Charges				
8.00	Routi ne servi ce charges		0		8. 00
9.00	Ancillary service charges		1, 205, 428	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, 205, 428	0	12. 00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13. 00
	basis	3			
14.00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		1, 205, 428	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only	y if line 16 exceeds	1, 205, 428	0	17. 00
	line 4) (see instructions)				
18.00	Excess of reasonable cost over customary charges (complete only	y if line 4 exceeds line	0	0	18.00
	16) (see instructions)				
19. 00	Interns and Residents (see instructions)		0	0	
20.00	Cost of physicians' services in a teaching hospital (see instr		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	completed for PPS provide			
22. 00	Other than outlier payments		0	0	
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0		25. 00
26. 00	Routine and Ancillary service other pass through costs		728	0	26. 00
27. 00	Subtotal (sum of lines 22 through 26)		728	0	27. 00
28. 00	Customary charges (title V or XIX PPS covered services only)		0	0	28. 00
29. 00	Titles V or XIX (sum of lines 21 and 27)		728	0	29. 00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31. 00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		728	0	31. 00
32.00	Deducti bl es		0	0	32.00
33. 00	Coi nsurance		0	0	33. 00
34.00	Allowable bad debts (see instructions)		0	0	34.00
35. 00	Utilization review		0		35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)	728	0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	37. 00
38. 00	Subtotal (line 36 ± line 37)		728	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)		728	0	40. 00
41. 00	Interim payments		0	0	41.00
42. 00	Balance due provider/program (line 40 minus line 41)		728	0	42. 00
43. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub 15-2,	0	0	43. 00
	chapter 1, §115.2		1		

Health Financial Systems	ELKHART GENERAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0018	Peri od: From 01/01/2022	Worksheet E-3 Part VII
	Component CCN: 15-T018	To 12/31/2022	Date/Time Prepared: 5/31/2023 12:14 pm
	Title XIX	Subprovi der -	PPS

		Title XIX	I RF	PPS	
			Inpatient	Outpati ent	
			1. 00	2. 00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SER	VICES FOR TITLES V OR XIX		2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES	VI 020 1 010 11 1220 1 010 711 7	. 02 020		
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)		o	_	3. 00
4.00	Subtotal (sum of lines 1, 2 and 3)		o	0	4. 00
5.00	Inpatient primary payer payments		o		5. 00
6.00	Outpatient primary payer payments			0	6. 00
7.00	Subtotal (line 4 less sum of lines 5 and 6)		o	0	7. 00
	COMPUTATION OF LESSER OF COST OR CHARGES		-		
	Reasonable Charges				
8.00	Routine service charges		0		8. 00
9.00	Ancillary service charges		83, 659	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)		83, 659	0	12.00
	CUSTOMARY CHARGES				
13.00	Amount actually collected from patients liable for payment for	services on a charge	0	0	13.00
	basis	9			
14.00	Amounts that would have been realized from patients liable for	payment for services on	0	0	14.00
	a charge basis had such payment been made in accordance with 4	2 CFR §413.13(e)			
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0.000000	0.000000	15.00
16.00	Total customary charges (see instructions)		83, 659	0	16. 00
17.00	Excess of customary charges over reasonable cost (complete onl	y if line 16 exceeds	83, 659	0	17.00
	line 4) (see instructions)				
18. 00	Excess of reasonable cost over customary charges (complete onl	y if line 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 instr		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	completed for PPS provide			
22. 00	Other than outlier payments		0	0	22. 00
23. 00	Outlier payments		0	0	23. 00
24. 00	Program capital payments		0		24. 00
25. 00	Capital exception payments (see instructions)		0	0	25. 00
26. 00	Routine and Ancillary service other pass through costs		0	0	26. 00
27. 00 28. 00	Subtotal (sum of lines 22 through 26)		0	0	27. 00 28. 00
29. 00	Customary charges (title V or XIX PPS covered services only)			0	29. 00
29.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		l o	0	29.00
30. 00			O	0	30. 00
31. 00	Excess of reasonable cost (from line 18) Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)			0	31. 00
32. 00	Deductibles			0	32. 00
33. 00	Coinsurance			0	33. 00
34. 00	Allowable bad debts (see instructions)			0	34. 00
35. 00	Utilization review		0	Ü	35. 00
36. 00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and	33)		0	36. 00
37. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	33)		0	37. 00
38. 00	Subtotal (line 36 ± line 37)			0	38. 00
39. 00	Direct graduate medical education payments (from Wkst. E-4)			O	39. 00
40. 00	Total amount payable to the provider (sum of lines 38 and 39)			0	40. 00
41. 00	Interim payments			0	41. 00
42. 00	Balance due provider/program (line 40 minus line 41)			0	42. 00
43. 00	Protested amounts (nonallowable cost report items) in accordan	ce with CMS Pub 15-2		0	43. 00
	chapter 1, §115.2	7 40 10 2,		· ·	
	1 · · · · · · · ·		, ,		1

Heal th	Financial Systems ELKHART	GENERAL HOSPITAL	In Lie	u of Form CMS-2	552-10
OUTLIE	R RECONCILIATION AT TENTATIVE SETTLEMENT	Provider CCN: 15-0018	Peri od:	Worksheet E-5	
			From 01/01/2022 To 12/31/2022	Date/Time Prep 5/31/2023 12:1	
		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 i	nstructions)	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	ee 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

| Period: | Worksheet G | From 01/01/2022 | To 12/31/2022 | Date/Time Prepared: 5/31/2023 12: 14 pm |

oni y)					5/31/2023 12:	14 pm
		General Fund	Specific	Endowment Fund	Plant Fund	
		1.00	Purpose Fund 2.00	3. 00	4. 00	
	CURRENT ASSETS	1	1			
1.00	Cash on hand in banks	11, 227, 000	(0	0	
2. 00 3. 00	Temporary investments Notes receivable	0	(0	
4. 00	Accounts receivable	84, 891, 000	1		0	
5. 00	Other receivable	6, 208, 000		o o	Ö	
6.00	Allowances for uncollectible notes and accounts receivable	-24, 723, 000		0	0	6. 00
7. 00	Inventory	8, 866, 000	(0	0	
8. 00	Prepai d expenses	517, 000	(0	0	
9.00	Other current assets	0		0	0	
10. 00 11. 00	Due from other funds Total current assets (sum of lines 1-10)	86, 986, 000		0	0	
11.00	FIXED ASSETS	00, 900, 000		<u>)</u>	0	111.00
12. 00	Land	4, 553, 000	(0	0	12.00
13. 00	Land improvements	0	(0	0	
14.00	Accumulated depreciation	0	(0	-	
15. 00	Bui I di ngs	264, 767, 000		0	0	
16.00	Accumulated depreciation	-244, 855, 000	1	0	0	
17. 00 18. 00	Leasehold improvements	0	(0	0 0	
19. 00	Accumulated depreciation Fixed equipment	136, 471, 000			0	
20. 00	Accumulated depreciation	130, 471, 000			0	
21. 00	Automobiles and trucks	Ö		o o	Ö	
22. 00	Accumul ated depreciation	0	(0	0	22. 00
23. 00	Major movable equipment	0	(0	0	23.00
24. 00	Accumulated depreciation	0	(0	0	
25. 00	Minor equipment depreciable	0	(0	0	
26.00	Accumulated depreciation	0		0	0	
27. 00 28. 00	HIT designated Assets Accumulated depreciation	0			0	
29. 00	Mi nor equi pment-nondepreci abl e				0	
30. 00	Total fixed assets (sum of lines 12-29)	160, 936, 000				
	OTHER ASSETS					
31. 00	Investments	0	7, 814, 000	0	-	
32. 00	Deposits on Leases	0	(0	0	
33.00	Due from owners/officers	0	9	0	0	1
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)	15, 033, 000 15, 033, 000			0	
36. 00	Total assets (sum of lines 11, 30, and 35)	262, 955, 000				
00.00	CURRENT LIABILITIES	202, 700, 000	7,011,000	<u>, </u>		00.00
37. 00	Accounts payable	27, 800, 000	(0	0	37.00
38. 00	Salaries, wages, and fees payable	0	(0	0	
39. 00	Payroll taxes payable	0	(0	0	
40.00	Notes and Loans payable (short term)	3, 830, 000	9	0	0	
41. 00 42. 00	Deferred income Accel erated payments	0		J O	0	41.00
43.00	Due to other funds	0	,	0	0	1
44. 00	Other current liabilities	2, 597, 000			Ö	
45. 00	Total current liabilities (sum of lines 37 thru 44)	34, 227, 000	•	0		
	LONG TERM LIABILITIES					
46. 00	Mortgage payable	0	(٥ -	0	
47. 00	Notes payable	0		0		
48. 00	Unsecured Loans	E4 227 000	(0	0	
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49)	54, 337, 000 54, 337, 000		-		
51. 00	Total liabilities (sum of lines 45 and 50)	88, 564, 000				
0 00	CAPI TAL ACCOUNTS	1 00/001/000		<u>, </u>		1
52. 00	General fund balance	174, 391, 000				52.00
53. 00	Specific purpose fund		7, 814, 000	O		53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
	Governing body created - endowment fund balance			0	_	56.00
56.00	Diant fund halance invested in plant		I	1	0	
57. 00	Plant fund balance - invested in plant				Λ	
	Plant fund balance - reserve for plant improvement,				0	58.00
57. 00	· ·	174, 391, 000	7, 814, 000	0	0	
57. 00 58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion	174, 391, 000 262, 955, 000				59.00

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0018

0

0

19.00

Peri od: Worksheet G-1 From 01/01/2022 12/31/2022 Date/Time Prepared:

5/31/2023 12:14 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 5. 00 2 00 4 00 1.00 Fund balances at beginning of period 143, 603, 000 8, 861, 000 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 14, 767, 000 2.00 Total (sum of line 1 and line 2) 3.00 158, 370, 000 8, 861, 000 3.00 4.00 ASSETS RELEASED FROM RESTRICTION 80,000 4.00 0 5.00 INVESTMENT INCOME 15,000 0 5.00 6.00 OTHER 15, 926, 000 6.00 0 7.00 0 0 7.00 0 8.00 0 0 8.00 9.00 0 0 9.00 10.00 Total additions (sum of line 4-9) 16, 021, 000 10.00 Subtotal (line 3 plus line 10) 174, 391, 000 11.00 8, 861, 000 11.00 12.00 INVESTMENT LOSS 1, 047, 000 0 12.00 13.00 0 0 0 0 13.00 14.00 0 14.00 0 0 15.00 15.00 0 16.00 0 0 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 1, 047, 000 18.00 Fund balance at end of period per balance 174, 391, 000 19.00 7, 814, 000 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 ASSETS RELEASED FROM RESTRICTION 4.00 4.00 5.00 INVESTMENT INCOME 0 5.00 0 6.00 OTHER 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 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 INVESTMENT LOSS 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00

0

18.00

19.00

Fund balance at end of period per balance

sheet (line 11 minus line 18)

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

			Го 12/31/2022	Date/Time Pre 5/31/2023 12:	
	Cost Center Description	Inpati ent	Outpati ent	Total	
		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	143, 057, 603	3	143, 057, 603	1. 00
2.00	SUBPROVI DER - I PF	6, 557, 950		6, 557, 950	2. 00
3.00	SUBPROVI DER - I RF	222, 60	1	222, 601	3. 00
4.00	SUBPROVI DER				4. 00
5.00	Swing bed - SNF		O	0	5. 00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY			0	7. 00
8.00	NURSING FACILITY		O .	0	8. 00
9.00	OTHER LONG TERM CARE	(O .	0	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)	149, 838, 15	1	149, 838, 154	10. 00
44 00	Intensive Care Type Inpatient Hospital Services	20.004.00	<u> </u>	00 004 000	44.00
11.00	INTENSIVE CARE UNIT	30, 094, 830		30, 094, 830	11.00
11. 01	NEONATAL INTENSIVE CARE	2, 124, 07		2, 124, 072	11. 01
12.00	CORONARY CARE UNIT	· · · · · · · · · · · · · · · · · · ·		0	12.00
13.00	BURN INTENSIVE CARE UNIT			0	13.00
14. 00 15. 00	SURGICAL INTENSIVE CARE UNIT	,	7	0	14. 00 15. 00
16. 00	OTHER SPECIAL CARE (SPECIFY)	22 210 00		22 210 002	16. 00
16.00	Total intensive care type inpatient hospital services (sum of li 11-15)	nes 32, 218, 90	2	32, 218, 902	16.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	182, 057, 056	5	182, 057, 056	17. 00
18. 00	Ancillary services	366, 939, 810			18. 00
19. 00	Outpatient services	15, 648, 09			19. 00
20. 00	RURAL HEALTH CLINIC		0	07,013,107	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	· · · · · · · · · · · · · · · · · · ·			21. 00
22. 00	HOME HEALTH AGENCY		0	Ö	22. 00
23. 00	AMBULANCE SERVICES	1	0	Ö	23. 00
24. 00	CMHC		0	Ö	24. 00
24. 10	CORF		0	Ö	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)	1	0	0	25. 00
26. 00	HOSPI CE		o o	0	26. 00
27. 00	NURSERY	3, 558, 000	0	3, 558, 000	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	Wkst. 568, 202, 969	559, 339, 794	1, 127, 542, 763	28. 00
	G-3, line 1)				
	PART II - OPERATING EXPENSES				
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		326, 111, 356		29. 00
30. 00	ADD (SPECIFY)				30. 00
31. 00					31. 00
32.00					32. 00
33. 00					33. 00
34.00					34.00
35. 00)		35. 00
36. 00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)				37. 00
38. 00		<u> </u>			38. 00
39. 00					39.00
40. 00 41. 00					40. 00 41. 00
41.00	Total deductions (sum of lines 37-41)		^ _		41.00
42.00		transfor	226 111 254		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(to Wkst. G-3, line 4)	ti alisi el	326, 111, 356		43.00
	TO MASE. O O, TITIO T/	I	1	I	I

Heal th	Financial Systems ELKHA	RT GENERAL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0018	Peri od:	Worksheet G-3	
			From 01/01/2022		
			To 12/31/2022	Date/Time Prep 5/31/2023 12:	
	· · · · · · · · · · · · · · · · · · ·			3/31/2023 12.	14 piii
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, col	umn 3, line 28)		1, 127, 542, 763	1. 00
2.00	Less contractual allowances and discounts on patien			804, 535, 544	2. 00
3.00	Net patient revenues (line 1 minus line 2)			323, 007, 219	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part	II, line 43)		326, 111, 356	4. 00
5.00	Net income from service to patients (line 3 minus l	ine 4)		-3, 104, 137	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 miscellaneous com	munication services		0	8. 00
9. 00	Revenue from television and radio service			0	9. 00
10. 00	Purchase di scounts			0	10.00
	Rebates and refunds of expenses			488, 124	1
12.00	Parking lot receipts			0	1
	Revenue from Laundry and Linen service			0	13. 00
	Revenue from meals sold to employees and guests			1, 166, 437	•
	Revenue from rental of living quarters			0	
	Revenue from sale of medical and surgical supplies	to other than patients		0	16. 00
	Revenue from sale of drugs to other than patients			209, 571	1
	Revenue from sale of medical records and abstracts			0	
	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
	Revenue from gifts, flowers, coffee shops, and cant	een		0	20. 00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			0	22. 00
	Governmental appropriations			0	23. 00
24. 00	OTHER			7, 680, 116	24. 00

17, 680, 116 24, 00 8, 327, 752 24, 50 17, 872, 000 25, 00 14, 767, 863 26, 00 863 27, 00 863 28, 00 14, 767, 000 29, 00

24.50 COVID-19 PHE Funding
25.00 Total other income (sum of lines 6-24)

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)

26.00 Total (line 5 plus line 25)

Heal th	Financial Systems ELKHART GENERAL	L HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 15-0018	Peri od: From 01/01/2022 To 12/31/2022	Worksheet L Parts I-III Date/Time Pre 5/31/2023 12:	
		Title XVIII	Hospi tal	PPS	
	DART I FILLY PROCRECTIVE METHOD			1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
1. 00	CAPITAL FEDERAL AMOUNT Capital DRG other than outlier			2, 255, 807	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			2, 233, 607	1. 00
2.00	Capital DRG outlier payments			85. 071	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 re	eporting period (see inst	ructions)	132. 79	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 the 1.01) (see instructions)			0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)		, part A line	3. 29	7. 00
8. 00	Percentage of Medicaid patient days to total days (see instr	uctions)		23. 48	8. 00
9.00	Sum of lines 7 and 8			26. 77	9. 00
10.00	Allowable disproportionate share percentage (see instruction	s)		5. 57	10.00
11.00	Disproportionate share adjustment (see instructions) Total prospective capital payments (see instructions)			125, 648 2, 466, 526	
12.00	Total prospective capital payments (see instructions)			2, 400, 320	12.00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
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	
1 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1 00
1. 00 2. 00	Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circumstan	cos (soo instructions)		0	1. 00 2. 00
3.00	Net program inpatient capital costs (line 1 minus line 2)	ces (see mistractions)		0	3. 00
4. 00	Applicable exception percentage (see instructions)			0.00	4. 00
5.00	Capital cost for comparison to payments (line 3 x line 4)			0	5. 00
6.00	Percentage adjustment for extraordinary circumstances (see i	nstructions)		0.00	6. 00
7.00	Adjustment to capital minimum payment level for extraordinary	y circumstances (line 2 x	: 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		>	0	9. 00
10.00	Current year comparison of capital minimum payment level to			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	Net comparison of capital minimum payment level to capital p	avments (line 10 plus lin	ie 11)	0	12. 00
13. 00	Current year exception payment (if line 12 is positive, ente			0	13. 00
14. 00	Carryover of accumulated capital minimum payment level over			0	14. 00
	(if line 12 is negative, enter the amount on this line)				
15. 00		structions)		0	15. 00
	Current year operating and capital costs (see instructions)			0	16.00
17.00	Current year exception offset amount (see instructions)		ا	0	17. 00