Health Financia	al Systems	IU HEALTH STARKE MEMORI	IAL HOSPITAL	In Lie	u of Form CMS-255	52-10	
This report is	required by law (42 USC 1395	g; 42 CFR 413.20(b)). Failu	re to report can resul	t in all interim	FORM APPROVED		
payments made	since the beginning of the co	st reporting period being d	leemed overpayments (42	USC 1395g).	OMB NO. 0938-005	50	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION Provider CCN: 150102 Period: Work From 01/01/2015 Parts							
				To 12/31/2015	Date/Time Prepar 5/26/2016 9:15 a		
PART I - COST	REPORT STATUS						
Provi der	1. [X] Electronically filed	cost report		Date: 5/26/20	16 Time: 9:1	5 am	
use only	2. [] Manually submitted co	st report					
	3. [0] If this is an amended 4. [F] Medicare Utilization.			esubmitted this co	ost report		
Contractor use only	5. [1]Cost Report Status (1) As Submitted (2) Settled without Audit	7. Contractor No. 8. [N] Initial Report for	this Provider CCN 12. [olumn 1 is 4: Ente		
	(3) Settled with Audit	9. [N] Final Report for the	nis Provider CCN	number of tim	es reopened = 0-4	9.	

PART II - CERTIFICATION

(4) Reopened (5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH STARKE MEMORIAL HOSPITAL (150102) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 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.

(Si gned)				
	Offi cer	or	Admi ni strator	of Provider(s)
Title				
Dato				

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	-1, 980	90, 501	-58, 996	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	-1, 980	90, 501	-58, 996	0	200. 00

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

Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150102 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/26/2016 9:14 am 3.00 4. 00 Hospital and Hospital Health Care Complex Address: Street: 102 EAST CULVER RD 1.00 PO Box: 1.00 2.00 City: KNOX State: IN Zip Code: 46534 County: STARKE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Number Number Certi fi ed 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 IU HEALTH STARKE 150102 23844 07/11/1966 Ν 3.00 MEMORIAL HOSPITAL 4.00 Subprovider - IPF 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF III HEALTH STARKE 15U102 Р N 23844 09/06/1989 7.00 N 7 00 MEMORIAL SWING BED 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 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 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 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) 01/01/2015 12/31/2015 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Υ N 22 00 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 §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 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 final uncompensated care payments to be Ν Ν 22.02 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 rural as a result Ν Ν 22.03 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. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 23.00 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. Medi cai d Other In-State In-State Out-of Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 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 column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 0 25.00 0 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

0.00

0. od

0.00

0.00

o. od

0.00

61.04

61.05

61.06

61.05

instructions)

61.04 Enter the number of unweighted primary care/or

surgery allopathic and/or osteopathic FTEs in the current cost reporting period (see instructions).

Enter the difference between the baseline primary

61.04 minus line 61.03). (see instructions)
61.06 Enter the amount of ACA §5503 award that is being

and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line

used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)

Health Financial Systems	IU HEALTH ST	TARKE MEMORI	AL HOSPITA	AL .	In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	πTA	Provi der		eriod: rom 01/01/2015 o 12/31/2015	Worksheet S-2 Part I Date/Time Pre 5/26/2016 9:1	pared:
		Program	n Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1. (00	2. 00	3. 00	4. 00	
61.10 Of the FTEs in line 61.05, speci special ty, if any, and the numbe for each new program. (see instructions) for each new program name, enter program code, enter in column 3, unweighted count and enter in column 3, unweighted count. 61.20 Of the FTEs in line 61.05, speci program special ty, if any, and tresidents for each expanded proginstructions) Enter in column 1, enter in column 2, the program 3, the IME FTE unweighted count 4, direct GME FTE unweighted count	er of FTE residents ructions) Enter in er in column 2, the the IME FTE olumn 4, direct GME fy each expanded the number of FTE gram. (see the program name, code, enter in column and enter in column				0. 00		61. 10
						1. 00	
ACA Provisions Affecting the Hea 62.00 Enter the number of FTE resident					od for which	0.00	62. 00
your hospital received HRSA PCRE 62.01 Enter the number of FTE resident during in this cost reporting pe	funding (see instructs that rotated from a	ctions) a Teaching F	ealth Cent	ter (THC) into			62. 01
Teaching Hospitals that Claim Re	esidents in Nonprovide	er Settings					
63.00 Has your facility trained reside						N Ratio (col. 1/	63. 00
				FTEs Nonprovi der Si te	FTEs in Hospital	(col. 1 + col. 2))	
				1. 00	2.00	3.00	
				This base year	is your cost r	eporting	
64.00 Enter in column 1, if line 63 is in the base year period, the numeresident FTEs attributable to resettings. Enter in column 2 the resident FTEs that trained in year.	Section 5504 of the ACA Base Year FTE Residents in Nonprovider SettingsThis base year is your operiod that begins on or after July 1, 2009 and before June 30, 2010. 64.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the number of unweighted non-primary care resident FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions)					0. 000000	64. 00
	Program Name	Program	n Code	Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.0	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)				0.00	0.00	0. 000000	65.00

applicable column.

Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL	_	l r	n Lieu	of Form	CMS-2552-1
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CO	CN: 150102 Pe Fr	riod: om 01/01/	'2015 F	Vorkshee Part I	t S-2
	To			5/26/201	e Prepared: 6 9:14 am
		V 1. 00		2. 00	
95.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no applicable column.		N	0. 00	N	0. 00 95. 0 96. 0
97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. Rural Providers			0. 00		0.00 97.0
105.00 Does this hospital qualify as a critical access hospital (CAH)? 106.00 If this facility qualifies as a CAH, has it elected the all-inclusive metho for outpatient services? (see instructions)	d of payment	N N			105. 0 106. 0
107.00 If this facility qualifies as a CAH, is it eligible for cost reimbursement training programs? Enter "Y" for yes or "N" for no in column 1. (see instruyes, the GME elimination is not made on Wkst. B, Pt. I, col. 25 and the proreimbursed. If yes complete Wkst. D-2, Pt. II.	ctions) If	N			107. 0
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedu CFR Section §412.113(c). Enter "Y" for yes or "N" for no.		N			108. 0
Physi cal 1.00	Occupati onal 2.00	Speecl 3. 00		Respira 4.00	
109.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N		N	109. 0
440.000	(440			1. 00	
110.00 Did this hospital participate in the Rural Community Hospital Demonstration the current cost reporting period? Enter "Y" for yes or "N" for no.	project (410.	A Demo)for		N	110. 0
Miscellaneous Cost Reporting Information			1. 00	2. 00	3. 00
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or "N" for no in is yes, enter the method used (A, B, or E only) in column 2. If column 2 is 3 either "93" percent for short term hospital or "98" percent for long term psychiatric, rehabilitation and long term hospitals providers) based on the Pub. 15-1, chapter 22, §2208.1.	"E", enter i care (includ	n column es	N		0 115.0
116.00 is this facility classified as a referral center? Enter "Y" for yes or "N" 117.00 is this facility legally-required to carry malpractice insurance? Enter "Y" no.		N" for	N N		116. 0 117. 0
118.00 s the mal practice insurance a claims-made or occurrence policy? Enter 1 if	the policy i	S	1		118. 0
claim-made. Enter 2 if the policy is occurrence.	Premi ums	Losses	S	Insurar	nce
	1. 00	2. 00		3. 00	
118.01 List amounts of malpractice premiums and paid losses:	33, 870	2.00	0	0.00	0 118. 0
		1. 00		2. 00	
118. 02 Are mal practice premiums and paid losses reported in a cost center other th Administrative and General? If yes, submit supporting schedule listing cos and amounts contained therein. 119. OO DO NOT USE THIS LINE		N			118. 0
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold Harmless provi §3121 and applicable amendments? (see instructions) Enter in column 1, "Y" "N" for no. Is this a rural hospital with < 100 beds that qualifies for the Hold Harmless provision in ACA §3121 and applicable amendments? (see instru Enter in column 2, "Y" for yes or "N" for no.	for yes or Outpatient	Υ		Υ	120. 0
121.00 Did this facility incur and report costs for high cost implantable devices patients? Enter "Y" for yes or "N" for no. Transplant Center Information	charged to	Υ			121. 0
		N			125. 0
125.00 Does this facility operate a transplant center? Enter "Y" for yes and "N" for yes enter certification date(s) (mm/dd/yyyy) below	or no. IT	IN			1
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, enter the certifi		IN.			126. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certified in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certific	cation date	N			126. 0 127. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certifing in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certifical in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certifical certifical center.	cation date ation date	N			
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certification column 2.	cation date ation date ation date	IV			127. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification column 2.	cation date ation date ation date tion date in	N			127. 0 128. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certification in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certification in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certification in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification column 1 and termination date, if applicable, in column 2.	cation date ation date ation date tion date in	N			127. 0 128. 0 129. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certification in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certification in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certification column 1 and termination date, if applicable, in column 2.	cation date lation date lation date lition date in fication	N			127. 0 128. 0 129. 0 130. 0
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter the certification in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter the certification in column 1 and termination date, if applicable, in column 2. 129.00 If this is a Medicare certified lung transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, enter the certification column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certification column 1 and termination date, if applicable, in column 2.	cation date ation date ation date tion date in fication tification ation date	N			127. 0 128. 0 129. 0 130. 0

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150102 Period: From 01/01/2015 To 12/31/2015 Part I Date/Time Providers 1.00 2.00 All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 1.00 2.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number. 141.00 Name: INDIANA UNIVERSITY HEALTH INC Contractor's Name: WPS Contractor's Number: 08001	2 epared:
All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office costs on the late of the contractor number. (see instructions) 1.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.	14 am
All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 1.00 2.00 1.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.	
All Providers 140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Y 15H059 chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 1.00 2.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.	140. 00
140.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, Chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 1.00 2.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.	140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions) 1.00 2.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.	140.00
1.00 2.00 3.00 If this facility is part of a chain organization, enter on lines 141 through 143 the name and address of the home office and enter the home office contractor name and contractor number.	
home office and enter the home office contractor name and contractor number.	
	141. 00
142. 00 Street: 340 WEST 10TH STREET PO Box: N/A	142. 00
143. 00 Ci ty: INDI ANAPOLIS State: IN Zi p Code: 46202	143. 00
1.00	4
144.00 Are provider based physicians' costs included in Worksheet A? Y	144. 00
1.00 2.00 145.00 If costs for renal services are claimed on Wkst. A, line 74, are the costs for N	145. 00
inpatient services only? Enter "Y" for yes or "N" for no in column 1. If column 1 is no, does the dialysis facility include Medicare utilization for this cost reporting	145.00
period? Enter "Y" for yes or "N" for no in column 2. 146.00Has the cost allocation methodology changed from the previously filed cost report? N	146. 00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) If	
yes, enter the approval date (mm/dd/yyyy) in column 2.	
1.00	-
147.00 Was there a change in the statistical basis? Enter "Y" for yes or "N" for no.	147. 00
148.00Was there a change in the order of allocation? Enter "Y" for yes or "N" for no. N 149.00Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N	148. 00 149. 00
149.00 Was there a change to the simplified cost finding method? Enter "Y" for yes or "N" for no. N Part A Part B Title V Title XIX	149.00
1.00 2.00 3.00 4.00	
Does this facility contain a provider that qualifies for an exemption from the application of the lower of costs or charges? Enter "Y" for yes or "N" for no for each component for Part A and Part B. (See 42 CFR §413.13)	
155. 00 Hospi tal	155. 00
156. 00 Subprovi der - I PF N N N N	156. 00
157. 00 Subprovi der - I RF N N N N N 158. 00 SUBPROVI DER	157. 00 158. 00
159. 00 SNF N N N N	159. 00
160. 00 HOME HEALTH AGENCY N N N	160. 00
161. 00 CMHC N N N	161. 00
1.00	-
Mul ti campus	1
165.00 Is this hospital part of a Multicampus hospital that has one or more campuses in different CBSAs? N Enter "Y" for ves or "N" for no.	165. 00
Name County State Zip Code CBSA FTE/Campus	
0 1.00 2.00 3.00 4.00 5.00 166.00 f ine 165 is yes, for each 0.00	0144 00
campus enter the name in column	0 166. 00
0, county in column 1, state in	
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	
column 5 (see instructions)	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 s this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. Y	167. 00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. Y 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the	167. 00 0168. 00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions)	0168. 00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under \$1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under \$413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions)	0168.00
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions) Beginning Ending	0168. 00 168. 01
Health Information Technology (HIT) incentive in the American Recovery and Reinvestment Act 167.00 Is this provider a meaningful user under §1886(n)? Enter "Y" for yes or "N" for no. 168.00 If this provider is a CAH (line 105 is "Y") and is a meaningful user (line 167 is "Y"), enter the reasonable cost incurred for the HIT assets (see instructions) 168.01 If this provider is a CAH and is not a meaningful user, does this provider qualify for a hardship exception under §413.70(a)(6)(ii)? Enter "Y" for yes or "N" for no. (see instructions) 169.00 If this provider is a meaningful user (line 167 is "Y") and is not a CAH (line 105 is "N"), enter the transition factor. (see instructions)	0168. 00 168. 01

Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL In Lieu o						
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICAT	FION DATA	Provider CCN:	150102	From 01/01/2015	Worksheet S-2 Part I Date/Time Pre 5/26/2016 9:1	pared:
					1. 00	
171.00 If line 167 is "Y", does this provider have any Medicare cost plans reported on Wkst. S-3, Pt. (see instructions)	N	171. 00				

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150102 Peri od: Worksheet S-2 From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 5/26/2016 9:14 am Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provi der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? Υ 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position RHONDA UTTER 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. Enter the employer/company name of the cost report IU HEALTH 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317. 962. 1093 RUTTER@I UHEALTH. ORG 43.00 report preparer in columns 1 and 2, respectively.

report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provider CCN: 150102 Peri od: Worksheet S-2 From 01/01/2015 To 12/31/2015 Part II Date/Time Prepared: 5/26/2016 9:14 am Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 04/05/2016 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

19.00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of 19.00 other PS&R Report information? If yes, see i nstructi ons. 20.00 If line 16 or 17 is yes, were adjustments 20.00 made to PS&R Report data for Other? Describe the other adjustments: Was the cost report prepared only using the provider's records? If yes, see 21.00 21.00 instructions. 3.00 Cost Report Preparer Contact Information Enter the first name, last name and the title/position MANAGE, REVENUE & 41.00 held by the cost report preparer in columns 1, 2, and 3, REI MBURSEMENT respecti vel y. Enter the employer/company name of the cost report 42.00 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 43.00 Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CC In Lieu of Form CMS-2552-10 Provi der CCN: 150102

						3 12/31/2013	5/26/2016 9: 14	
							I/P Days / 0/P	
							Visits / Trips	
	Component	Worksheet A	No	of Beds	Bed Days	CAH Hours	Title V	
	36pariant	Line Number		0. 2000	Avai I abl e	0/11/ 11041/0		
		1.00		2.00	3. 00	4. 00	5. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30, 00		50		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			50	18, 250	0.00	0	7. 00
7.00	beds) (see instructions)			50	10, 230	0.00	0	7.00
8.00	INTENSIVE CARE UNIT	31. 00		0	0	0.00	0	8. 00
9. 00	CORONARY CARE UNIT	01.00		Ü	Ŭ	0.00	Ŭ	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)			50	18, 250	0.00	o	14. 00
15. 00	CAH visits			50	10, 230	0.00	0	15. 00
16. 00	SUBPROVIDER - IPF						U	16. 00
17. 00	SUBPROVIDER - I RF							17. 00
18. 00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
21.00	HOME HEALTH AGENCY							22. 00
23. 00	i i							23. 00
	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE							24. 00
24. 00		20.00						
24. 10 25. 00	HOSPICE (non-distinct part)	30. 00						24. 10 25. 00
	CMHC - CMHC							
26. 00 26. 25	RURAL HEALTH CLINIC							26. 00 26. 25
	FEDERALLY QUALIFIED HEALTH CENTER			50				26. 25 27. 00
27. 00	Total (sum of lines 14-26)			50				
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31. 00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 01	Total ancillary labor & delivery room							32. 01
22.00	outpatient days (see instructions)							22.00
33. 00	LTCH non-covered days	l l						33. 00

Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CC

Provi der CCN: 150102

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 5/26/2016 9:14 am

1/P Days / 0/P Visits / Trips			_				5/26/2016 9:1	<u>4 am</u>
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see Instructions for col. 2 For the portion of LDP room available beds) 11			I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
1.00		Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 8					Pati ents			
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 1111							10.00	
Hospice days) (see instructions for col. 2 7 7 7 7 7 7 7 7 7	1.00		936	289	1, 648			1. 00
For the portion of LDP room available beds) 2.00 How and other (see instructions) 111 0 2.00 3.00 4.00 How IPF Subprovider 0 0 0 0 4.00 5.00 6.00 Hospital Adults & Peds. Swing Bed SNF 0 0 0 0 0 6.00								
2.00 HMC and other (see instructions)								
3.00	2 00		111					2 00
4. 00 HMO I RF Subprovider 0 0 0 0 0 5. 00 0 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 6. 00 7. 00 7. 00			l l	0				
5.00			١	0				
6. 00 Hospital Adults & Peds. Swing Bed NF 7. 00 Total Adults and Peds. (exclude observation beds) (see instructions) 8. 00 INTENSIVE CARE UNIT 0 0 0 0 0 8. 00 10. 00 BURN INTENSIVE CARE UNIT 10. 00 TOTAL CARE UNIT 11. 00 OTHER SPECIAL CARE UNIT 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 OTHER SPECIAL CARE (SPECIFY) 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 TOTAL CARE UNIT 19. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SKILLED NURSING FACILITY 19. 00 NURSING FACILITY 20. 00 ONUR FACILITY 20. 00 HOME HEALTH AGENCY 21. 00 ONUR HEALTH AGENCY 22. 00 HOME HEALTH AGENCY 24. 10 HOSPICE (non-distinct part) 25. 00 CAMPA C- CAMPE 26. 26. 25 FORERALLY OLULIFIED HEALTH CENTER 27. 00 OSSERVALION BED DEBY SEE TOTAL CAMPE 28. 00 OSSERVALION BED DEBY SEE TOTAL CAMPE 29. 00 OSSERVALION BED DEBY SEE TOTAL CAMPE 29. 00 OSSERVALION SEE TIPS 20. 00 OSSERVALION SEE TIPS 21. 00 OSSERVALION SEE TIPS 22. 00 OSSERVALION SEE TIPS 23. 00 OSSERVALION SEE TIPS 24. 10 OSSERVALION SEE TIPS 25. 00 OMEN SEE TIPS 26. 00 OSSERVALION SEE TIPS 27. 00 TOTAL AGENCY 28. 00 OSSERVALION SEE TIPS 29. 00 AMBULATORY SURGICAL CENTER (D. P.) 29. 00 AMBULATORY SURGICAL CENTER (D. P.) 29. 00 AMBULATORY SURGICAL CENTER (D. P.) 29. 00 OSSERVALION SEE TIPS 29. 00 OSSERVALION SEE SISTRUCTIONS 20. 01 TOTAL AGAILTH SETUCTIONS 20. 01 TOTAL AGAILTH SETUCTIONS 20. 01 TOTAL AGAILTH SEE THE TIPS 20. 00 OSSERVALION SEE			l l	0	0			
7.00			١		-			
beds) (see instructions)			936	- 1	•			
8. 00 INTENSIVE CARE UNIT 0 0 0 0 9.00		· ·			.,			
10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 1	8.00		0	o	C			8. 00
11. 00 SURGICAL INTENSIVE CARE UNIT 11. 00 12. 00 OTHER SPECIAL CARE (SPECIFY) 13. 00 NURSERY 13. 00 NURSERY 15. 00 CAH visits 0 0 0 0 122. 14 14. 00 15. 00 CAH visits 0 0 0 0 0 15. 00 15. 00 15. 00 0 0 0 0 15. 00 15. 00 15. 00 0 0 0 15. 00 0 0 15. 00 15	9.00	CORONARY CARE UNIT						9. 00
12. 00 13. 00 13. 00 13. 00 13. 00 13. 00 14. 00 15. 01 15. 00 15. 00 15. 00 16. 00 15. 00 16. 00 15. 00 16. 00 16. 00 18. 00 19	10.00	BURN INTENSIVE CARE UNIT						10.00
13.00 NURSERY 13.00 14.00 Total (see instructions) 936 289 1,648 0.00 122.14 14.00 15.00 CAH vi sits 0 0 0 0 0 15.00 15.00 CAH vi sits 15.00 16.00 0 0 0 0 0 0 16.00 16.00 17.00 SUBPROVI DER - IPF 18.00 SUBPROVI DER IFF 18.00 SVILLED NURSI NG FACILITY 19.00 SKILLED NURSI NG FACILITY 19.00 NURSI NG FACILITY 19.00 NURSI NG FACILITY 19.00 19.00 0 0 0 0 0 0 0 0 0	11. 00							11. 00
14. 00 Total (see instructions) 936 289 1,648 0.00 122.14 14. 00 15. 00 CAH visits 0 0 0 0 0 15. 00 SUBPROVI DER - IPF 18. 00 SUBPROVI DER - IRF 18. 00 SUBPROVI DER - IRF 19. 00 SKI LLED NURSING FACILITY 19. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 10 HOSPI CE (non-distinct part) 0 0 0 0 0 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25. 00 CMHC - CMHC 27. 00 Observation Bed Days 14 1,019 29. 00 Ambul ance Trips 0 0 0 0 0 0 122. 14 1,009 32. 00 Labor & delivery days (see instruction) 5 Total (sum of lines 14-26) 7 30. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0								12. 00
15. 00 CAH visits								1
16. 00 SUBPROVIDER - IPF 16. 00 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 18. 00 19. 00 SKILLED NURSING FACILITY 19. 00		,	936	289	1, 648	0.00	122. 14	
17. 00 SUBPROVI DER - I RF 17. 00 18. 00 SUBPROVI DER 18. 00 18. 00 19. 00 SUBPROVI DER 19. 00 SUBPROVI DER 19. 00			0	0	C			
18.00 SUBPROVI DER 18.00 19.00								
19. 00								
20.00 NURSING FACILITY 20.00 21.00 21.00 21.00 22.00 22.00 40ME HEALTH AGENCY 22.00 23.00 40MBULATORY SURGICAL CENTER (D.P.) 23.00 24.10 40SPICE 24.10 25.00 24.10 40SPICE 25.00 26.00 26.00 26.00 26.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 26.25 27.00 70 70 70 70 70 70 70								
21.00 OTHER LONG TERM CARE 22.00 HOME HEALTH AGENCY 23.00 AMBULATORY SURGICAL CENTER (D.P.) 24.00 HOSPICE 25.00 CMHC - CMHC 26.00 RURAL HEALTH CLINIC 26.25 FEDERALLY QUALIFIED HEALTH CENTER 27.00 Observation Bed Days 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 21.00 Employee discount days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 21.00								
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 31. 00 Employee (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)								
23. 00 AMBULATORY SURGICAL CENTER (D.P.) 24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions) 31. 02 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)								
24. 00 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 FEDERALLY OUBLIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)								
24. 10 HOSPICE (non-distinct part) 0 0 0 0 0 24. 10 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 0.00 122. 14 27. 00 28. 00 Observation Bed Days 14 1,019 29. 00 Ambulance Trips 0 29. 00 30. 00 Employee discount days (see instruction) 7 30. 00 31. 00 Employee discount days - IRF 0 0 31. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 0 32. 01		1						
25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 30. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions)			o	o	C			
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 26. 25 27. 00 28. 00 29. 00 29. 00 29. 00 30. 00 31. 00 32. 01	25.00	• • •						25. 00
27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days - IRF 32. 00 Labor & delivery days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 14	26.00	RURAL HEALTH CLINIC						26. 00
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 28.00 29.00 30.00 31.00 31.00 32.01	26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
29.00 Ambulance Trips 0 29.00 30.00 Employee discount days (see instruction) 7 30.00 31.00 Employee discount days - IRF 0 31.00 32.00 Labor & delivery days (see instructions) 0 0 0 32.01 Total ancillary labor & delivery room outpatient days (see instructions)	27. 00	Total (sum of lines 14-26)				0.00	122. 14	
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 30.00 31.00 32.00 32.01	28. 00	Observation Bed Days		14	1, 019			28. 00
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 31.00 0 0 0 0 32.00 32.01	29. 00		0					29. 00
32.00 Labor & delivery days (see instructions) 0 0 0 0 32.00 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 0 32.01					7			
32.01 Total ancillary labor & delivery room outpatient days (see instructions) 0 32.01					C			1
outpatient days (see instructions)			0	0	C			
	32. 01				C			32. 01
33. 00 Lich non-covered days 0 33. 00	22 00	1						22 00
	33.00	LICH HOH-covered days	ı Y	I		I	I	J 33. 00

Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CC Provi der CCN: 150102

				''	0 12/31/2013	5/26/2016 9: 14	
		Full Time	<u>'</u>	Di sch	arges		
		Equi val ents			9		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
	Component	Workers	11 ti 0 V	I THE ATTE	TI CI C XIX	Pati ents	
		11, 00	12.00	13.00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	11.00	12.00		14.00	498	1. 00
1.00	8 exclude Swing Bed, Observation Bed and		(270	20	470	1.00
	Hospice days) (see instructions for col. 2						
0.00	for the portion of LDP room available beds)			0.5			0.00
2.00	HMO and other (see instructions)			35	68		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		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						7. 00
	beds) (see instructions)						
8.00	INTEŃSIVE CARE UNIT						8. 00
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
13.00	NURSERY	0.00		201	20	400	
14. 00	Total (see instructions)	0. 00	(296	20	498	14.00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF						16. 00
17. 00	SUBPROVI DER - I RF						17. 00
18. 00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21. 00
22.00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24. 00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
		0. 00					20. 23
27. 00	Total (sum of lines 14-26)	0.00					
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						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provider CCN: 150102 Period: From 01/01/2

| Peri od: | Worksheet S-3 | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | Part II | P

					To	12/31/2015	Date/Time Pre 5/26/2016 9:1	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries		Related to	Wage (col. 4 ÷	
				(from Worksheet A-6)	(col.2 ± col. 3)	Salaries in col. 4	col . 5)	
		1.00	2.00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA							
1 00	SALARI ES	200 00	/ 720 700	17 225	/ 711 5/0	254 050 7/	27.42	1 00
1. 00	Total salaries (see instructions)	200. 00	6, 728, 788	-17, 225	6, 711, 563	254, 050. 76	26. 42	1.00
2. 00	Non-physician anesthetist Part		0	0	0	0.00	0.00	2.00
	A							
3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3.00
4. 00	Physician-Part A -		18, 330	0	18, 330	107. 04	171. 24	4.00
	Admi ni strati ve		,					
4. 01	Physicians - Part A - Teaching		0		0	0.00	l e	
5. 00 6. 00	Physician-Part B Non-physician-Part B		0	_	0	0. 00 0. 00	l e	
7. 00	Interns & residents (in an	21. 00	0	0		0.00		
	approved program)							
7. 01	Contracted interns and		0	0	0	0. 00	0. 00	7. 01
	residents (in an approved programs)							
8. 00	Home office personnel		0	0	0	0.00	0.00	8.00
9. 00	SNF	44. 00	0	0	0	0.00	l .	
10. 00	Excluded area salaries (see		80, 902	0	80, 902	4, 568. 46	17. 71	10.00
	instructions) OTHER WAGES & RELATED COSTS							-
11. 00	Contract labor: Direct Patient		0	0	0	0.00	0.00	11. 00
	Care							
12. 00	Contract Labor: Top Level management and other		0	0	0	0. 00	0.00	12. 00
	management and administrative							
	servi ces							
13. 00	Contract Labor: Physician-Part		407, 788	0	407, 788	2, 380. 12	171. 33	13. 00
14. 00	A - Administrative Home office salaries &		464, 656	0	464, 656	8, 135. 00	57 12	14.00
14.00	wage-related costs		404, 000		404, 030	0, 133.00	37.12	14.00
15. 00	Home office: Physician Part A		0	0	0	0.00	0.00	15. 00
16. 00	- Administrative Home office and Contract		0	0	0	0. 00	0. 00	16. 00
10.00	Physicians Part A - Teaching		0		J	0.00	0.00	10.00
	WAGE-RELATED COSTS							1
17. 00	Wage-related costs (core) (see		1, 673, 118	0	1, 673, 118			17. 00
18. 00	instructions) Wage-related costs (other)		0	0	0			18. 00
10.00	(see instructions)				o o			10.00
19. 00	Excluded areas		26, 928	0	26, 928			19. 00
20. 00	Non-physician anesthetist Part		0	0	0			20. 00
21. 00	Non-physician anesthetist Part		0	0	0			21. 00
	В							
22. 00	Physician Part A -		2, 103	0	2, 103			22. 00
22. 01	Administrative Physician Part A - Teaching		0	0	0			22. 01
23. 00	Physician Part B		0	Ö	Ö			23. 00
24. 00	Wage-related costs (RHC/FQHC)		0	_	0			24. 00
25. 00	Interns & residents (in an approved program)		0	0	0			25. 00
	OVERHEAD COSTS - DIRECT SALARIE	-S						
26. 00	Employee Benefits Department	4. 00	0	0	0	0.00	0.00	26.00
27. 00	Administrative & General	5. 00	856, 899			34, 023. 11	25. 11	
28. 00	Administrative & General under		70, 463	0	70, 463	1, 289. 00	54. 66	28. 00
29. 00	contract (see inst.) Maintenance & Repairs	6. 00	0	0	0	0.00	0.00	29.00
	Operation of Plant	7. 00	374, 953	-200	374, 753	17, 809. 47	21. 04	1
31. 00	Laundry & Linen Service	8. 00	0	0	0	0.00	l e	
32. 00	Housekeepi ng	9. 00	187, 102	-1, 199	185, 903	13, 297. 57	13. 98	
33. 00	Housekeeping under contract (see instructions)		U	0	U	0. 00	0.00	33. 00
34. 00	Di etary	10. 00	185, 284	-134, 274	51, 010	3, 015. 87	16. 91	34.00
35. 00	Dietary under contract (see		0	0	0	0.00	l e	
36. 00	i nstructi ons) Cafeteri a	11. 00	0	122 524	133, 534	7, 947. 22	16. 80	36.00
36. 00 37. 00	Maintenance of Personnel	12. 00	0	133, 534 0	133, 534 N	7, 947. 22 0. 00		
	Nursing Administration	13. 00	32, 407	Ö	32, 407	2, 253. 08	l	38.00
38. 00		44.00	77 775	1 0	77, 775	4, 160. 37	18. 69	39.00
39. 00	Central Services and Supply Pharmacy	14. 00 15. 00	77, 775 195, 227			5, 293. 82		40.00

Health Financial Systems	IU H	IEALTH STARKE N	MEMORIAL HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					From 01/01/2015		
					To 12/31/2015		
						5/26/2016 9: 1	<u>4 am</u>
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2. 00	3. 00	4.00	5. 00	6. 00	
41.00 Medical Records & Medical	16. 00	C	0)	0.00	0.00	41.00
Records Library							
42.00 Social Service	17. 00	C	0)	0.00	0.00	42.00
43.00 Other General Service	18. 00	C) o		0.00	0.00	43. 00

instructions)

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 150102 Peri od: From 01/01/2015 To 12/31/2015 5/26/2016 9:14 am Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . (from Salaries in col . 5) Works<u>heet A-6)</u> 3) col. 4 1.00 4.00 6.00 2.00 5.00 3.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 6, 799, 251 -17, 225 6, 782, 026 255, 339. 76 1.00 26. 56 instructions) 2.00 Excluded area salaries (see 80, 902 80, 902 4, 568. 46 17.71 2.00 0 instructions) 3.00 Subtotal salaries (line 1 6, 718, 349 -17, 225 6, 701, 124 250, 771. 30 26.72 3.00 minus line 2) 4.00 Subtotal other wages & related 872, 444 872, 444 10, 515. 12 82.97 4.00 costs (see inst.) Subtotal wage-related costs 25. 00 5.00 1, 675, 221 C 1, 675, 221 0.00 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 9, 266, 014 -17, 225 9, 248, 789 261, 286. 42 35 40 7.00 Total overhead cost (see 1, 980, 110 -4, 886 1, 975, 224 89, 089. 51 22.17 7.00

Heal th	Financial Systems IU HEALTH STARKE MEMOR	AL HOSPITAL		In Lieu of Form CMS-2552-10		
HOSPI T	AL WAGE RELATED COSTS	Provi der CCN	l: 150102	Peri od:	Worksheet S-3	
				From 01/01/2015		aanad.
				To 12/31/2015	Date/Time Prep 5/26/2016 9:14	
					Amount	ı dılı
					Reported	
					1. 00	
	PART IV - WAGE RELATED COSTS					
	Part A - Core List					
	RETI REMENT COST					
1.00	401K Employer Contributions				0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00			
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)					3.00
4.00	Qualified Defined Benefit Plan Cost (see instructions)				100, 191	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)				993, 790	8. 00
9.00	Prescription Drug Plan				0	9. 00
10.00	Dental, Hearing and Vision Plan				0	10.00
11.00	Life Insurance (If employee is owner or beneficiary)				7, 639	11.00
12.00	.00 Accident Insurance (If employee is owner or beneficiary)					

Health Financial Systems	IU HEALTH STARKE MEMORIAL	HOSPI TAL	In Lieu	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Pro	rovider CCN: 150102	From 01/01/2015	Worksheet S-3 Part V Date/Time Prepared:

		1	0 12/31/2015	Date/lime Pre 5/26/2016 9:1			
	Cost Center Description		Contract Labor		- Cili		
	<u> </u>		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 - IPF				3. 00		
4.00	Subprovi der - I RF				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	Hospi tal -Based SNF				8. 00		
9.00	Hospi tal -Based NF				9. 00		
10.00	Hospi tal -Based OLTC				10.00		
11. 00	Hospi tal -Based HHA				11. 00		
12.00	Separately Certified ASC				12.00		
13.00	Hospi tal -Based Hospi ce				13.00		
14.00	Hospital-Based Health Clinic RHC				14.00		
15.00	Hospital-Based Health Clinic FQHC				15. 00		
16.00	Hospi tal -Based-CMHC				16. 00		
17.00	Renal Dialysis				17. 00		
18. 00	0ther		o	0	18. 00		

Heal th	Financial Systems IU HEALTH STARKE MEMORIA	AL HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CCN		Peri od:	Worksheet S-10	0
				From 01/01/2015 To 12/31/2015	Date/Time Prep 5/26/2016 9:1	
					1. 00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by line :	202 column	8)	0. 266400	1. 00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				4, 057, 405	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3. 00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p		m Medicaid	?	Υ	4. 00
5.00	If line 4 is "no", then enter DSH or supplemental payments from N	Medi cai d			0	5. 00
6.00	Medi cai d charges				20, 732, 967	6. 00
7. 00	Medicaid cost (line 1 times line 6)				5, 523, 262	7. 00
8. 00	Difference between net revenue and costs for Medicaid program (li < zero then enter zero)	ine 7 minus s	sum of lin	es 2 and 5; if	1, 465, 857	8. 00
	State Children's Health Insurance Program (SCHIP) (see instruction	ons for each	line)			
9.00	Net revenue from stand-alone SCHIP				0	9. 00
10.00	Stand-alone SCHIP charges				0	10.00
11.00	Stand-alone SCHIP cost (line 1 times line 10)				0	11. 00
12. 00	, , , , , , , , , , , , , , , , , , ,					
	Other state or local government indigent care program (see instru	ictions for 6	each line)			
13.00	Net revenue from state or local indigent care program (Not included in the inc)	803, 470	13 00
14. 00	Charges for patients covered under state or local indigent care p			,	8, 936, 824	
00	10)	o. og. a (1101	o. aasa		0, 700, 02 .	
15.00					2, 380, 770	15. 00
16. 00	Difference between net revenue and costs for state or local indigent care program (line 15 minus line 13; if < zero then enter zero)					16. 00
	Uncompensated care (see instructions for each line)					
17.00	Private grants, donations, or endowment income restricted to fund	ding charity	care		18, 736	17. 00
18.00	Government grants, appropriations or transfers for support of hos	spital opera	ti ons		0	18. 00
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local 8, 12 and 16)	indigent ca	re program	s (sum of lines	3, 043, 157	19. 00
	12 did 10)	l t	Jni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
			1.00	2. 00	3. 00	
20. 00	Total initial obligation of patients approved for charity care (a charges excluding non-reimbursable cost centers) for the entire 1		1, 395, 48	8 781, 388	2, 176, 876	20. 00
21. 00	Cost of initial obligation of patients approved for charity care		371, 75	8 208, 162	579, 920	21. 00
	times line 20)					
22. 00	Partial payment by patients approved for charity care		7, 64			
23. 00	Cost of charity care (line 21 minus line 22)		364, 10	9 172, 324	536, 433	23. 00
					1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient of imposed on patients covered by Medicaid or other indigent care pr		a Length o	f stay limit	N	24. 00
25. 00			am's Lenat	h of stav limit	0	25. 00
26. 00						
27. 00	Medicare bad debts for the entire hospital complex (see instructi				2, 025, 759 96, 800	
28. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line	,	ine 27)		1, 928, 959	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expense (1716)		,	28)	513, 875	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	(11110-1		_3)	1, 050, 308	
	Total unreimbursed and uncompensated care cost (line 19 plus line	e 30)			4, 093, 465	
57.00	1.0 ca. a oa. ood and anoompondated date coot (11116-17 prus 11116	,			1, 0, 0, 400	51.0

Cost Center Description	Health Financial Systems IU H	HEALTH STARKE MEN	IORIAL HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
Cost Center Description	RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der			Worksheet A	
STACK_2016_9.14_em						Date/Time Pre	nared·
Cost Center Description					10 12/31/2013		
CEDIT CEDIT CEDIT CENTERS	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati		
Ceneral Service Cost Centrers				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
EMERAL SERVICE COST CHITES							
1.00		1.00	2. 00	3. 00	4. 00	5. 00	
2.00 002000 CAP REL COSTS-MYBLE EQUIP 0 0 0 0 0 0 0 0 0			_	1			
3. 00 00300 OHER CAP REL COSTS 0 0 0 3. 00			0	(171, 414		
4.00 004000 EMPLOYEE BENEFITS DEPARTMENT 0 1,137,073 1,137,073 0 1,137,073 4.00			0	(0	-	
5.00		_	0		0	-	
2.00 00700 00700 00FRATI 0.0		1 "					
8.00 005000 LAUNDRY & LINEN SERVICE 0 0 0 0 286, 765 0 0 0 0 0 0 0 0 0		1 ' 1					
9.00 00900 HOUSEKEEPI NG		374, 953	751, 894				
10.0 01000 01000 01000 01000 01000 01000 01000 01000 01000 01000 0100		0	0		٦ ٧		
11.0 01100 01100 0.0	· · · · · · · · · · · · · · · · · · ·	1					1
13. 00 01300 NURSI NC. ADMINISTRATION 32, 407 19, 860 52, 267 0 52, 267 13. 00 14. 00 01400 CINTRAL SERVICES & SUPPLY 77, 775 34, 762 112, 5537 -2, 141 110, 396 14. 00 14. 00 01400 CINTRAL SERVICES & SUPPLY 195, 227 720, 728 915, 955 -640, 516 275, 439 15. 00 16. 00 01500 PHARMACY 0 345, 350 0 345, 350 0 345, 350 16. 00 1600 MEDICAL RECORDS & LI BRARY 195, 227 720, 728 915, 955 -640, 516 275, 439 15. 00 18. 00 18. 00 18. 00 19. 00 0 0 0 0 0 0 18. 00 18. 00 18. 00 18. 00 19. 00 0 0 0 0 0 18. 00 03000 ADULTS & PEDIATRIC S 1, 901, 569 200, 567 1, 360, 568 -173, 410 1, 187, 158 50. 00 18. 00 03000 OPERATI NE ROOM 625, 521 735, 047 1, 360, 568 -173, 410 1, 187, 158 50. 00 18. 00 03000 OPERATI NE ROOM 625, 521 735, 047 1, 360, 568 -173, 410 1, 187, 158 50. 00 18. 00 03000 ARESTHESI OLOGY 0 290, 772 290, 772 0 290, 772 53. 00 18. 00 03000 ARESTHESI OLOGY 0 290, 772 290, 772 0 290, 772 53. 00 18. 00 03000 ARESTHESI OLOGY 0 290, 772 290, 772 0 290, 772 53. 00 18. 00 03000 ARESTHESI OLOGY 0 290, 772 0 290, 772 53. 00 18. 00 03000 ARESTHESI OLOGY 0 290, 772 0 290, 772 53. 00 18. 00 03000 0300 030, 040, 0300 0 30, 059 0 36,		185, 284	113, 826				
14. 00		0	0				
15.00 01500 PIARMACY 195, 227 720, 728 915, 955 -640, 516 275, 439 15. 00 16.00 16.00 16.00 16.00 ENDOMEDICAL RECORDS & LIBRARY 0 345, 350 345, 350 345, 350 345, 350 3.00 3.45, 350 3.00 3		1 ' 1				· ·	
16.00 16.00 16.00 16.00 16.00 18.50 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 350 345, 3		1 ' 1				· ·	
INPATIENT ROUTH RE SERVICE COST CENTERS 1,091,569 200,567 1,292,136 -1,664 1,290,472 30,00 31,00 31,00 3100 INTENSIVE CARE UNIT 0 0 0 0 0 0 31,00 31,00 ANCIL LARY SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0		1 ' 1					
30.00 03000 ADULTS & PEDIATRICS 1,091,569 200,567 1,292,136 -1,664 1,290,472 30.00 31.00 31.00 31.00 ANCILLARY SERVICE COST CENTERS		0	345, 350	345, 350	0	345, 350	16. 00
31.00 03100 INTENSIVE CARE UNIT 0 0 0 0 0 0 31.00							
ANCI LLARY SERVICE COST CENTERS		1					
50. 00		0	0	(0	0	31. 00
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 51.00 053.00 05300 ANESTHESI OLOGY 0 290,772 290,772 290,772 0 290,772 53.00 053.00 05400 RADI OLOGY-DI AGNOSTI C 1,015,750 1,320,882 2,336,632 -24,945 2,311,687 54.00 57.00 05700 CT SCAN 2,718 271,476 274,194 0 274,194 57.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0							
53.00 05300 ANESTHESI OLOGY 0 290, 772 290, 772 290, 772 53.00 54.00 05400 RADI OLOGY - DIAGNOSTI C 1,015,750 1,320,882 2,336,632 -24,945 2,311,687 54.00 55.00 05500 CT SCAN 2,718 271,476 274,194 0 274,194 57.00 58.00 05800 MRI 82,074 159,949 242,023 0 242,023 58.00 60.00 05900 CARDIAC CATHETERI ZATI ON 0 0 0 0 0 0 60.00 06000 LABORATIORY 431,691 740,328 1,172,019 -1,371 1,170,648 60.00 62.00 06200 WHOLE BLOOD 8 PACKED RED BLOOD 0 36,059 36,059 0 36,059 62.00 65.00 06500 CESPI RATORY THERAPY 261,611 45,600 307,211 -283 306,928 65.00 66.00 06600 PHYSI CAL THERAPY 261,611 45,600 307,211 -283 306,928 65.00 67.00 06700 OCCUPATI ONAL THERAPY 122,643 28,828 151,471 0 151,471 67.00 68.00 06800 SPECH PATHOLOGY 111,667 1,177 12,844 0 12,844 68.00 69.00 06900 ELECTROCARDI OLOGY 79,443 41,139 120,582 0 120,582 69.00 71.00 07100 MEIO CAL SUPPLIES CHARGED TO PAT 0 0 0 0 125,262 175,262 71.00 72.00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 0 76.97 O7697 CARDI ACRES TO PATI ENTS 0 0 0 0 0 0 0 76.97 O7697 CARDIA CREHABI LI TATI ON 0 0 0 0 0 0 0 79.00 09000 CLINIC 0 0 0 0 0 0 0 0 79.01 09000 O1000 EMERGENCY 948,061 2,526,882 3,474,943 -663 3,474,280 91.00 91.00 09100 EMERGENCY 948,061 2,526,882 3,474,943 -663 3,474,280 91.00 91.00 09100 EMERGENCY 948,061 2,526,882 3,474,943 -663 3,474,280 91.00 91.00 09100 GHERGENCY 948,061 2,526,882 3,474,943 -663 3,474,280 91.00 91.00 09100 GHERGENCY 948,061 2,526,882 3,474,943 -663 3,474,280 91.00 91.00 09100 GHERGENCY 948,061 2,526,882 3,474,943 -663 3,474,280 91.00 91.00 09100 GHERGENCY 948,061 2,526,882 3		1	735, 047	1, 360, 56	-173, 410	1, 187, 158	
54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 015, 750 1, 320, 882 2, 336, 632 -24, 945 2, 311, 687 54, 00 570. 00 570. 00 570. 00 580.		1	0	(이	0	
57. 00 05700 CT SCAN 2,718 271,476 274,194 0 274,194 57. 00 58. 00 05800 MRI 82,074 159,949 242,023 0 242,023 58. 00 05900 CARDIAC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0		1					•
58. 00 05800 MRI 82, 074 159, 949 242, 023 0 242, 023 58. 00 59. 00 05900 06000 CARDIAC CATHETERIZATION 0 0 0 0 0 0 59. 00 06. 00 06000 LABORATORY 431, 691 740, 328 1,172, 019 -1, 371 1,170, 648 60. 00 6500 RESPIRATORY 142, 643 28, 828 151, 471 0 151, 471 67. 00 68. 00 06600 PISTICAL THERAPY 122, 643 28, 828 151, 471 0 151, 471 67. 00 68. 00 06800 SPECH PATHOLOGY 11, 667 1, 177 12, 844 0 12, 844 68. 00 06900 ELECTROCARDIOLOGY 79, 443 41, 139 120, 582 0 125, 262 125, 262 71. 00 73. 00 07300 RUBIC CHARGED TO PATI ENTS 0 0 0 0 0 0 76. 97 00000 GIFT SERVICE COST CENTERS 18. 00 09000 ELERGENCY 948, 061 2, 526, 882 3, 474, 943 -663 3, 474, 280 91. 00 92.00 09000 EMERGENCY 948, 061 2, 526, 882 3, 474, 943 -663 3, 474, 280 91. 00 93. 00 193. 00 19300 NONPAID WORKERS 0 242, 023 58. 00 0 0 242, 023 58. 00 0 0 0 0 0 0 0 0 0		1 1					
59, 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0		1					
60.00 06000 LABORATORY 431, 691 740, 328 1,172, 019 -1,371 1,170, 648 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD 0 36,059 36,059 0 36,059 0 36,059 62.00 65.00 06500 RESPI RATORY THERAPY 261, 611 45,600 307, 211 -283 306, 928 65.00 66.00 06600 PHYSI CAL THERAPY 65,491 63,240 128,731 -63 128,668 66.00 67.00 06700 OCCUPATI ONAL THERAPY 122,643 28,828 151,471 0 151,471 67.00 68.00 06800 SPECEH PATHOLOGY 11,667 1,177 12,844 0 12,844 68.00 69.00 06900 ELECTROCARDI OLOGY 79,443 41,139 120,582 0 120,582 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0 0 0 125,262 125,262 170.00 72.00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 79,225 79,225 79,225 73.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 76.97 OARDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 0 76.97 OARDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 76.97 OARDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 76.97 OARDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 76.97 OARDI CAL SUPPLIES COST CENTERS 90.00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 76.97 OARDI CAL SUPPLIES COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 6,647,886 12,880,620 19,528,506 16,202 19,544,708 118.00 193.00 19300 ONDRAID WORKERS 0 0 0 0 0 0 193.00 19300 NONPAID WORKERS 0 0 0 0 0 0 193.00 19300 NONPAID WORKERS 0 0 0 0 0 193.00 19300 NONPAID WORKERS 0 0 0 0 0 193.00 19300 THEN NRCC 29,584 93,787 123,371 -16,202 107,109 194.00 194.00 07500 THEN NRCC 29,584 93,787 123,371 -16,202 107,109 194.00 194.00 07500 THEN NRCC 29,584 93,787 123,371 -16,202 107,109 194.00 194.00 07500 THEN NRCC 0 0 0 0 0 0 0 0 0		1	159, 949	242, 02	3 0		
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD 0 36, 059 36, 059 0 36, 059 62. 00 65. 00 06500 RESPI RATORY THERAPY 261, 611 45, 600 307, 211 -283 306, 928 65. 00 66. 00 06600 PHYSI CAL THERAPY 65, 491 63, 240 128, 731 -63 128, 668 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 122, 643 28, 828 151, 471 0 151, 471 67. 00 68. 00 06800 SPEECH PATHOLOGY 11, 667 1, 177 12, 844 0 122, 844 68. 00 69. 00 06900 ELECTROCARDI OLOGY 79, 443 41, 139 120, 582 0 120, 582 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0 0 0 0 125, 262 125, 262 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI NO 0 0 0 0 0 79, 225 79, 225 72. 00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 79, 225 79, 225 72. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 665, 981 665, 981 73. 00 76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 0 0 0 0 76. 97 07697 CARDI AC REHABILITATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		١	0		이		•
65. 00 06500 RESPI RATORY THERAPY 261, 611 45, 600 307, 211 -283 306, 928 65. 00 66. 00 06600 PHYSI CAL THERAPY 65, 491 63, 240 128, 731 -63 128, 668 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 122, 643 28, 828 151, 471 0 151, 471 67. 00 68. 00 06800 SPEECH PATHOLOGY 11, 667 1, 177 12, 844 0 12, 844 68. 00 69900 ELECTROCARDI OLOGY 79, 443 41, 139 120, 582 0 120, 582 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0 0 0 0 125, 262 125, 262 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 79, 225 79, 225 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0		431, 691					•
66. 00 06600 PHYSI CAL THERAPY 65, 491 63, 240 128, 731 -63 128, 668 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 122, 643 28, 828 151, 471 0 151, 471 67. 00 68. 00 06800 SPEECH PATHOLOGY 11, 667 1, 177 12, 844 0 12, 844 68. 00 06900 ELECTROCARDI OLOGY 79, 443 41, 139 120, 582 0 125, 262 125, 262 71. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0 0 0 0 125, 262 125, 262 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 79, 225 79, 225 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 0 0 0		0					•
67. 00 06700 0CCUPATI ONAL THERAPY 122, 643 28, 828 151, 471 0 151, 471 67. 00 68. 00 06800 SPEECH PATHOLOGY 11, 667 1, 177 12, 844 0 12, 844 68. 00 69. 00 06900 ELECTROCARDI OLOGY 79, 443 41, 139 120, 582 0 120, 582 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0 0 0 0 125, 262 125, 262 71. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0							
68. 00 06800 SPEECH PATHOLOGY 11, 667 1, 177 12, 844 0 12, 844 68. 00 69. 00 06900 ELECTROCARDI OLOGY 79, 443 41, 139 120, 582 0 120, 582 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PAT 0 0 0 125, 262 125, 262 71. 00 7200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 79, 225 79, 225 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 79, 225 79, 225 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 0 665, 981 665, 981 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 0 0 76. 97 076. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 ' 1				· ·	
69. 00		122, 643	28, 828			· ·	
71. 00			1, 177				
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 79, 225 79, 225 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 665, 981 665, 981 73. 00 76. 97 076. 9		79, 443	41, 139	120, 58:		· ·	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 665, 981 665, 981 73. 00 76. 97 07697 CARDI AC REHABILI TATI ON 0 0 0 0 0 0 76. 97 00000 CLI NI C 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0				
76. 97		0	0				
OUTPATIENT SERVICE COST CENTERS O	73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		665, 981	665, 981	73. 00
90. 00 09000 CLI NI C 0 0 0 0 0 0 0 0 90. 00 91. 00 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT 92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT 92. 00 NONREI MBURSABLE COST CENTERS 118. 00 NONREI MBURSABLE COST CENTERS 12, 880, 620 19, 528, 506 16, 202 19, 544, 708 118. 00 19000 GI FT FLOWER COFFEE SHOP & CAN 0 0 0 0 190. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 193. 01 19301 WELLNESS CENTER 51, 318 24, 273 75, 591 0 75, 591 193. 01 193. 02 193. 02 19302 RETAI L PHARMACY 0 23, 252 23, 252 0 23, 252 193. 02 194. 00 07950 OTHER NRCC 29, 584 93, 787 123, 371 -16, 202 107, 169 194. 00		0	0	(0	0	76. 97
91. 00 09100 EMERGENCY 948, 061 2, 526, 882 3, 474, 943 -663 3, 474, 280 91. 00 92. 00							
92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT 92. 00 SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) 6, 647, 886 12, 880, 620 19, 528, 506 16, 202 19, 544, 708 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 0 0 0 0 190. 00 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 0 193. 00 193. 01 19301 WELLNESS CENTER 51, 318 24, 273 75, 591 0 75, 591 193. 01 193. 02 19302 RETAIL PHARMACY 0 23, 252 23, 252 0 23, 252 193. 02 194. 00 07950 OTHER NRCC 29, 584 93, 787 123, 371 -16, 202 107, 169 194. 00 194. 00 195		0	0		0	0	90.00
SPECIAL PURPOSE COST CENTERS 118. 00 SUBTOTALS (SUM OF LINES 1-117) 6, 647, 886 12, 880, 620 19, 528, 506 16, 202 19, 544, 708 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 0 0 0 0 193. 00 193. 00 19300 NONPAID WORKERS 0 0 0 0 0 0 193. 00 193. 01 19301 WELLNESS CENTER 51, 318 24, 273 75, 591 0 75, 591 193. 01 193. 02 19302 RETAIL PHARMACY 0 23, 252 23, 252 0 23, 252 193. 02 194. 00 07950 OTHER NRCC 29, 584 93, 787 123, 371 -16, 202 107, 169 194. 00	91. 00 09100 EMERGENCY	948, 061	2, 526, 882	3, 474, 94	-663	3, 474, 280	91.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) 6, 647, 886 12, 880, 620 19, 528, 506 16, 202 19, 544, 708 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CAN 0 0 0 0 0 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 193. 00 19300 URLINESS CENTER 51, 318 24, 273 75, 591 0 75, 591 193. 01 193. 01 19301 WELLNESS CENTER 51, 318 24, 273 75, 591 0 0 75, 591 193. 01 193. 02 19302 RETAI L PHARMACY 0 23, 252 23, 252 0 23, 252 193. 02 194. 00 07950 OTHER NRCC 29, 584 93, 787 123, 371 -16, 202 107, 169 194. 00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT						92.00
NONRE MBURSABLE COST CENTERS 190. 00 19000 GI FT FLOWER COFFEE SHOP & CAN 0 0 0 0 190. 00 193. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 193. 01 19301 WELLNESS CENTER 51, 318 24, 273 75, 591 0 75, 591 193. 01 193. 02 19302 RETAI L PHARMACY 0 23, 252 23, 252 0 23, 252 193. 02 194. 00 07950 OTHER NRCC 29, 584 93, 787 123, 371 -16, 202 107, 169 194. 00	SPECIAL PURPOSE COST CENTERS						
190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 0 0 0 190. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 193. 01 19301 WELLNESS CENTER 51, 318 24, 273 75, 591 0 75, 591 193. 01 193. 02 19302 RETAI L PHARMACY 0 23, 252 23, 252 0 23, 252 193. 02 194. 00 07950 OTHER NRCC 29, 584 93, 787 123, 371 -16, 202 107, 169 194. 00	118.00 SUBTOTALS (SUM OF LINES 1-117)	6, 647, 886	12, 880, 620	19, 528, 50	16, 202	19, 544, 708	118. 00
193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00 193. 01 19301 WELLNESS CENTER 51, 318 24, 273 75, 591 0 75, 591 193. 01 193. 02 19302 RETAI L PHARMACY 0 23, 252 23, 252 0 23, 252 193. 02 194. 00 07950 OTHER NRCC 29, 584 93, 787 123, 371 -16, 202 107, 169 194. 00	NONREI MBURSABLE COST CENTERS						
193. 01 19301 WELLNESS CENTER 51, 318 24, 273 75, 591 0 75, 591 193. 01 193. 02 19302 RETAI L PHARMACY 0 23, 252 23, 252 0 23, 252 193. 02 194. 00 07950 OTHER NRCC 29, 584 93, 787 123, 371 -16, 202 107, 169 194. 00		0	0	(0		
193. 02 19302 RETAIL PHARMACY 0 23, 252 23, 252 0 23, 252 194. 00 07950 OTHER NRCC 29, 584 93, 787 123, 371 -16, 202 107, 169 194. 00	193.00 19300 NONPALD WORKERS	0	0		o o	0	193. 00
193. 02 19302 RETAI L PHARMACY 0 23, 252 23, 252 0 23, 252 193. 02 194. 00 07950 OTHER NRCC 29, 584 93, 787 123, 371 -16, 202 107, 169 194. 00	193.01 19301 WELLNESS CENTER	51, 318	24, 273	75, 59°	1 o	75, 591	193. 01
	193.02 19302 RETAIL PHARMACY	O			2 0	23, 252	193. 02
	194.00 07950 OTHER NRCC	29, 584	93, 787	123, 37	1 -16, 202	107, 169	194. 00
	200.00 TOTAL (SUM OF LINES 118-199)	6, 728, 788	13, 021, 932	19, 750, 720	ol ol	19, 750, 720	200. 00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 150102 | Peri od: | From 01/01/2015

Cost Center Description Adjustments Net Expenses (See A-8) For Allocation 6.00 7.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 72, 794 244, 208 1.00 00200 CAP REL COSTS-MVBLE EQUIP 28, 419 28, 419 2.00 2.00 3.00 00300 OTHER CAP REL COSTS 3.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 191, 241 4 00 54 168 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 4, 677, 723 8, 558, 039 5.00 00700 OPERATION OF PLANT 7.00 1, 118, 339 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 0 8.00 286, 765 00900 HOUSEKEEPI NG 9.00 0 9 00 10.00 01000 DI ETARY 0 83, 538 10.00 11.00 01100 CAFETERI A -73, 380 142, 177 11.00 01300 NURSING ADMINISTRATION 13 00 -1, 028 51, 239 13 00 14.00 01400 CENTRAL SERVICES & SUPPLY 110, 396 14.00 15.00 01500 PHARMACY 0 275, 439 15.00 01600 MEDICAL RECORDS & LIBRARY 345, 350 16, 00 16,00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS -9, 354 1, 281, 118 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM -1, 631 1, 185, 527 50.00 05100 RECOVERY ROOM 51.00 51.00 05300 ANESTHESI OLOGY 53.00 -280, 842 9, 930 53.00 05400 RADI OLOGY-DI AGNOSTI C 2, 302, 275 54.00 -9, 412 54.00 57.00 05700 CT SCAN -327 273, 867 57.00 58.00 05800 MRI -339 241, 684 58.00 05900 CARDIAC CATHETERIZATION 59.00 59.00 06000 LABORATORY -1, 794 60.00 1, 168, 854 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD 0 36, 059 62.00 06500 RESPIRATORY THERAPY -470 65.00 306, 458 65.00 66.00 06600 PHYSI CAL THERAPY 128, 451 66.00 -217 06700 OCCUPATI ONAL THERAPY 151, 261 67.00 -210 67.00 68.00 06800 SPEECH PATHOLOGY -42 12,802 68.00 06900 ELECTROCARDI OLOGY 69.00 -891 119, 691 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PAT -11, 143 114, 119 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 -101 79, 124 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS -5, 390 660, 591 73.00 07697 CARDIAC REHABILITATION 76.97 76. 97 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 91.00 09100 EMERGENCY -1, 904, 643 1, 569, 637 91.00 92 00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 2, 531, 890 22, 076, 598 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 190 00 193. 00 19300 NONPALD WORKERS 0 193. 00 193. 01 19301 WELLNESS CENTER 0 75, 591 193. 01 193. 02 19302 RETAIL PHARMACY 0 23, 252 193. 02 194.00 07950 OTHER NRCC 194. 00 107, 169 200.00 TOTAL (SUM OF LINES 118-199) 2, 531, 890 22, 282, 610 200.00

Health Financial Systems In Lieu of Form CMS-2552-10 IU HEALTH STARKE MEMORIAL HOSPITAL RECLASSI FI CATIONS Provi der CCN: 150102 Peri od: Worksheet A-6 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/26/2016 9:14 am Increases 0ther Cost Center Li ne # Sal ary 2.00 3.00 4.00 5.00 A - RENT 1.00 CAP REL COSTS-BLDG & FIXT 1.00 33, 736 1.00 33, 736 B - CAFETERIA 1.00 CAFETERI A 11.00 133, 534 80, 452 1.00 2.00 CAFETERI A 1, 571 11.00 2.00 133, 534 82, 023 C - DRUGS 1.00 DRUGS CHARGED TO PATIENTS 73.00 0 665, 981 1.00 0 2.00 0.00 0 2.00 3.00 0.00 0 0 3.00 0 0 4.00 0.00 4.00 5.00 0.00 0 0 5.00 0 6.00 0.00 0 6.00 7.00 0 7 00 0 00 0 0 8.00 0.00 8.00 9.00 0.00 0 0 9.00 0 10.00 0.00 0 10.00 0.00 0 11.00 11.00 0 ō 665, 981 - BILLABLE MEDICAL SUPPLIES 71. 00 1.00 1.00 MEDICAL SUPPLIES CHARGED TO 0 125, 262 PAT IMPL. DEV. CHARGED TO 2.00 72.00 0 79, 225 2.00 PATI ENTS 3.00 0.00 3.00 ō 204, 487 H - INTEREST EXPENSE 1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 3, 625 1.00 3, 625 I - PTO USED AS SHORT-TERM DIABILITY 1.00 ADMINISTRATIVE & GENERAL 5.00 0 2,747 1.00 2.00 OPERATION OF PLANT 7.00 0 200 2.00 0 1, 199 3.00 HOUSEKEEPI NG 9.00 3.00 10.00 4.00 DI FTARY 740 4.00 ADULTS & PEDIATRICS 5.00 30.00 0 3, 796 5.00 6.00 RADI OLOGY-DI AGNOSTI C 54.00 0 2, 557 6.00 0 7.00 LABORATORY 60.00 3, 132 7.00 8.00 **EMERGENCY** 91.00 0 2.854 8.00 ō 17, 225

0

o

0

133, 534

28, 863

28, 863

134, 053

134, 053

1, 169, 993

1.00

2.00

1.00

2.00

500.00

7. 00

0.00

1.00

0.00

UTI LI TI ES

OPERATION OF PLANT

K - PROPERTY TAXES

500.00 Grand Total: Increases

CAP REL COSTS-BLDG & FIXT

1.00

2.00

1.00

2.00

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 150102

						5/26/2016 9:14 an
		Decreases				
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.	
	6. 00	7. 00	8. 00	9. 00	10. 00	
	A - RENT					
.00	ADMI NI STRATI VE & GENERAL		0	3 <u>3, 7</u> 36		1
	0		0	33, 736		
	B - CAFETERIA					
00	DI ETARY	10. 00	133, 534	80, 452		1
00	DI ETARY	10. 00	0	<u>1, 5</u> 71	9	2
	0		133, 534	82, 023		
	C - DRUGS					
00	ADMINISTRATIVE & GENERAL	5.00	0	1, 404		1
00	DI ETARY	10.00	0	15	0	2
00	CENTRAL SERVICES & SUPPLY	14. 00	0	1, 881	0	3
00	PHARMACY	15. 00	o	640, 516	o	4
00	ADULTS & PEDIATRICS	30.00	o	1, 664	O	5
00	OPERATING ROOM	50.00	o	6, 554	0	6
00	RADI OLOGY-DI AGNOSTI C	54.00	ol	12, 284		7
00	LABORATORY	60.00	0	654		8
00	RESPIRATORY THERAPY	65. 00	o	283		9
). 00	PHYSI CAL THERAPY	66, 00	0	63		10
. 00	EMERGENCY	91.00	0	663		11
. 00	0		 _	665, 981		'''
	E - BILLABLE MEDICAL SUPPLIES		<u> </u>	003, 701		
00	OPERATION OF PLANT	7. 00	0	37, 371	0	1
00	CENTRAL SERVICES & SUPPLY	14.00	0	260		2
00	OPERATING ROOM	50.00	0	166, 856		3
00	OPERATTING_ROOM			10 <u>0, 8</u> 30		3
	H - INTEREST EXPENSE		U	204, 467		
00		F 00	ما	2 (25	11	1
00	ADMI NI STRATI VE & GENERAL			3,625		1
	U DTO LICED AC CHOPT TERM DI	ADILLEY/	U	3, 625		
00	I - PTO USED AS SHORT-TERM DI		0.747			
00	ADMI NI STRATI VE & GENERAL	5. 00	2, 747	0		1
00	OPERATION OF PLANT	7. 00	200	0		2
00	HOUSEKEEPI NG	9. 00	1, 199	0	O	3
00	DIETARY	10. 00	740	0	0	4
00	ADULTS & PEDIATRICS	30.00	3, 796	0		5
00	RADI OLOGY-DI AGNOSTI C	54.00	2, 557	0	-	6
00	LABORATORY	60.00	3, 132	0		7
00	EMERGENCY	<u>91.</u> 00	2, 854	0		8
	0		17, 225			
	J - UTILITIES					
00	RADI OLOGY-DI AGNOSTI C	54.00	0	12, 661		1
00	OTHER NRCC	194.00	0	1 <u>6, 2</u> 02	0	2
	0		0	28, 863		
	K - PROPERTY TAXES					
00	ADMINISTRATIVE & GENERAL	5.00	0	133, 336	13	1
00	LABORATORY	60.00	ol	717		2
		— — — †	— — 	134, 053		
	Grand Total: Decreases		150, 759	, -00		500

9.00

Reconciling Items

10.00 Total (line 8 minus line 9)

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 150102 Peri od: Worksheet A-7 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/26/2016 9:14 am Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 142, 789 1.00 0 1.00 0 2.00 Land Improvements 4, 448 33,000 33, 000 0 2.00 3.00 1, 509, 571 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 5,009,780 130, 035 130, 035 0 4.00 5.00 Fixed Equipment 0 5.00 0 6.00 Movable Equipment 9, 135, 673 617, 304 617, 304 0 6.00 0 7.00 HIT designated Assets 7.00 0 0 8.00 Subtotal (sum of lines 1-7) 15, 802, 261 780, 339 780, 339 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 15, 802, 261 780, 339 780, 339 10.00 10.00 0 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 142, 789 0 1.00 2.00 Land Improvements 37, 448 0 2.00 3.00 Buildings and Fixtures 1, 509, 571 0 3.00 0 4.00 Building Improvements 5, 139, 815 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 9, 752, 977 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 8.00 16, 582, 600 0 8.00

16, 582, 600

0

Heal th	Financial Systems IU F	HEALTH STARKE M	EMORIAL HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150102	Peri od: From 01/01/2015	Worksheet A-7	
						Date/Time Pre	
						5/26/2016 9:1	4 am
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
					instructions)	instructions)	
		9. 00	10.00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	0ther	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	O	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3.00	Total (sum of lines 1-2)	0	0				3. 00

Heal th	Financial Systems IU H	HEALTH STARKE M	EMORIAL HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
					From 01/01/2015		
					To 12/31/2015	Date/Time Pre 5/26/2016 9:1	pared:
		COMI	 PUTATION OF RAT	TLOS	ALLOCATION OF	OTHER CAPITAL	4 alli
		COM	PUTATION OF RA	1103	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	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	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	1, 689, 808	0	1, 689, 808	0. 101902	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	14, 892, 792	0	14, 892, 792	0. 898098	0	2. 00
3.00	Total (sum of lines 1-2)	16, 582, 600	0	16, 582, 600	1. 000000	0	3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate	cols. 5			
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FIXT	0	0) (75, 870	33, 736	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0) (28, 419	0	2. 00
3.00	Total (sum of lines 1-2)	0	0	(104, 289	33, 736	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	cost center bescription	Titterest		,	Capi tal -Relate		
			Thistructions)	Thisti detroils)	d Costs (see	through 14)	
					instructions)	tili ougii 14)	
		11.00	12.00	13.00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE		12.00	10.00	1 1. 00	10.00	
1.00	CAP REL COSTS-BLDG & FLXT	549	0	134, 053	3 0	244, 208	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	l	1	0	28, 419	
2.00	The state of the s	1	ı	1	ا	20, 417	2.00

0 549

0 0 0

134, 053

0 0 0

244, 208 1. 00 28, 419 2. 00 272, 627 3. 00

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

Heal th Financial Systems

ADJUSTMENTS TO EXPENSES

Provider CCN: 150102
Period:
From 01/01/2015
To 12/31/2015
Pate/Time Prepared:
5/26/2016 9: 14 am

Expense Classification on Worksheet A
To/From Which the Amount is to be Adjusted

					o 12/31/2015	Date/Time Prep 5/26/2016 9:14	
				Expense Classification on		072072010 7.1	T CIII
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	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	B		CAP REL COSTS-BLDG & FIXT	1.00	3.00	1. 00
	COSTS-BLDG & FIXT (chapter 2)		2,212				
2.00	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)		_		0.00		
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
0.00	expenses (chapter 8)		0		0.00	Ĭ	0.00
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
7.00	stations excluded) (chapter		0		0.00	Ĭ	7.00
	21)						
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00	Parking lot (chapter 21)		0		0.00	0	9. 00
10.00	Provi der-based physici an	A-8-2	-2, 218, 159			0	10.00
11 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11. 00
11. 00	(chapter 23)		U		0.00	٥	11.00
12.00	Related organization	A-8-1	5, 512, 856			О	12.00
40.00	transactions (chapter 10)						40.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-73 380	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee		-73, 300	CALLIERIA	0.00	o	15. 00
	and others						
16. 00	Sale of medical and surgical	В	-10, 727	MEDICAL SUPPLIES CHARGED TO PAT	71. 00	0	16. 00
	supplies to other than patients			PAT			
17. 00	Sale of drugs to other than	В	-4, 291	DRUGS CHARGED TO PATIENTS	73. 00	О	17. 00
40.00	patients						40.00
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing school (tuition, fees,		0		0.00	0	19. 00
	books, etc.)						
20.00	Vending machines		0		0.00	0	20. 00 21. 00
21. 00	Income from imposition of interest, finance or penalty		U		0.00	٥	21.00
	charges (chapter 21)						
22. 00	Interest expense on Medicare		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						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24. 00
24.00	therapy costs in excess of	A-0-3	0	THISTORE MERALI	00.00		24.00
	limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	О	26. 00
27.00	COSTS-BLDG & FIXT		0	CAD DEL COSTS MADI E FOLLID	2.00		27.00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		Ü	CAP REL COSTS-MVBLE EQUIP	2.00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00	Physicians' assistant		0		0.00		
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	0	OCCUPATIONAL THERAPY	67. 00		30. 00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30. 99
21 00	instructions)	1 100	^	SDEECH DATHOLOGY	40.00		21 00
31. 00	Adjustment for speech pathology costs in excess of	A-8-3	Ü	SPEECH PATHOLOGY	68. 00		31. 00
	limitation (chapter 14)						
32. 00	,		0		0.00	0	32. 00
33. 00	Depreciation and Interest MEDICALD ASSESSMENT FEE	A	-305 362	ADMINISTRATIVE & GENERAL	5. 00	0	33. 00
	MI SCELLANEOUS I NCOME	B		ADMINISTRATIVE & GENERAL	5. 00		
-							

ADJUSTMENTS TO EXPENSES Provider CCN: 150102 Peri od: Worksheet A-8 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/26/2016 9:14 am Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 35. 00 MI SCELLANEOUS I NCOME -1. 028 NURSI NG ADMI NI STRATI ON 35. 00 В 13.00 -30, 716 ADMINISTRATIVE & GENERAL 36.00 MARKETI NG Α 5.00 0 36.00 37.00 PATIENT PHONES Α -7, 911 ADMINISTRATIVE & GENERAL 5.00 0 37.00 38.00 ADMISSIONS TIME FOR PATIENT -36, 819 ADMI NI STRATI VE & GENERAL 38.00 Α 5.00 PHONES EMPLOYEE BENEFITS -267, 010 EMPLOYEE BENEFITS DEPARTMENT 39 00 4.00 0 39.00 Α 40.00 PUBLIC RELATIONS - MARKETING Α 317 ADMINISTRATIVE & GENERAL 5.00 0 40.00 SELF-INSURANCE OFFSET -9, 354 ADULTS & PEDIATRICS 30.00 41.00 41.00 Α -1, 631 OPERATING ROOM SELF-INSURANCE OFFSET 50.00 41.01 41.01 0 Α -20 ANESTHESI OLOGY 41.02 SELE-LINSURANCE OFFSET Α 53.00 41.02 41.03 SELF-INSURANCE OFFSET -2, 968 RADI OLOGY-DI AGNOSTI C 54.00 41.03 Α 41.04 SELF-INSURANCE OFFSET Α -327 CT SCAN 57.00 41.04 SELF-INSURANCE OFFSET 58.00 41.05 41.05 -339MRI Α 0 -1, 794 LABORATORY 41.06 SELF-INSURANCE OFFSET Α 60.00 41.06 41.07 SELF-INSURANCE OFFSET -470 RESPIRATORY THERAPY 65.00 41.07 SELF-INSURANCE OFFSET 41.08 Α -217 PHYSI CAL THERAPY 66.00 41.08 -210 OCCUPATI ONAL THERAPY 41.09 SELE-INSURANCE OFFSET Α 67.00 0 41.09 41.10 SELF-INSURANCE OFFSET Α -42 SPEECH PATHOLOGY 68.00 ol 41.10 41.11 SELF-INSURANCE OFFSET Α -191 ELECTROCARDI OLOGY 69.00 41.11 SELF-INSURANCE OFFSET -416 MEDICAL SUPPLIES CHARGED TO 41.12 Α 71.00 41.12 PAT SELF-INSURANCE OFFSET -101 I MPL. DEV. CHARGED TO 41. 13 Α 72.00 41.13

PATI ENTS

-2, 191 EMERGENCY

2, 531, 890

-1,099 DRUGS CHARGED TO PATIENTS

41.14

0 41.15

42 00

50.00

73.00

91.00

0.00

Α

Α

TOTAL (sum of lines 1 thru 49)

SELF-INSURANCE OFFSET

SELF-INSURANCE OFFSET

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

41.14

41.15

42 00

50.00

⁽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.

				10 12/31/2013	5/26/2016 9: 1	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAIMED	
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE CAPITAL BLDG	75, 870	0	1. 00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL MME	28, 419	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ADMIN	1, 017, 754	876, 957	3.00
4.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	INTERCOMPANY EXPENSE BENEFIT	1, 459, 442	1, 138, 264	4.00
4.01	5. 00	ADMINISTRATIVE & GENERAL	INTERCOMPANY EXPENSE ADMIN	4, 946, 592	0	4. 01
4.02	15. 00	PHARMACY	INTERCOMPANY PURCHASED SERVI	51, 065	51, 065	4. 02
4.03	16. 00	MEDICAL RECORDS & LIBRARY	INTERCOMPANY PURCHASED SERVI	345, 120	345, 120	4. 03
4.04	60.00	LABORATORY	INTERCOMPANY PURCHASED SERVI	205, 476	205, 476	4.04
5.00	TOTALS (sum of lines 1-4).			8, 129, 738	2, 616, 882	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					
4						

* 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) an	d/or Home Office	
	C	N	D	N	D	
	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 RELATED ORGANIZATION(S) AND/OR HOME OFFICE:						

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

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

6.00	В	0.00 IU HEALTH INC 100.00	6. 00
7.00	В	0. 00 LAPORTE REGIONA 100. 00	7. 00
8. 00		0.00	8. 00
9. 00		0.00	9. 00
10. 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.

Health Financial Systems			IU HEALTH STARKE MEMORIAL HOSPITAL					In Lieu of Form CMS-2552-1			
near th	Financiai syste	HIIS	TO HEALTH STARRE MEMORIAL HOSPITAL						In Lieu of Form CMS-2552-1		
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGAN	IZATIONS AND) HOME	Provi der	CCN: 150102	Peri	od:	Worksheet A	-8-1
OFFICE COSTS From 01/01/2015											
OTTICL	00313							То	12/31/2015	Date/Time P	renared:
									12/01/2010	5/26/2016 9	
	Net	Wkst. A-7 Ref.									
	Adjustments										
	(col. 4 minus										
	col. 5)*										
	6. 00	7. 00									
	A. COSTS INCUR	RED AND ADJUSTI	MENTS REQUIRED	AS A RESUL	T OF TRANS	ACTIONS W	TH RELATED (ORGANI	ZATIONS OR (CLAI MED	
	HOME OFFICE CO	STS:									
1.00	75, 870	9									1. 00
2.00	28, 419	9									2. 00
3.00	140, 797	0									3.00
4 00	321 178	1									4 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.

4.01

4 02

4.03

4.04

5 00

nas not	been posted to worksheet A,	cordinas i and/or 2, the amount arrowable should be mareated in cordinar 4 or this part.	
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	3.		
	6. 00		
	B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

i ci ilibai	To this direction of the transfer of the trans									
6.00	HEALTH SYSTEM		6. 00							
7.00	HEALTH SYSTEM		7. 00							
8.00			8. 00							
9.00			9. 00							
10.00			10.00							
100.00			100.00							

- (1) Use the following symbols to indicate interrelationship to related organizations:
- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- B. Corporation, partnership, or other organization has financial interest in provider.
- $\hbox{\it C. Provider has financial interest in corporation, partnership, or other organization.}\\$
- 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.

4.01

4 02

4.03

4.04

5.00

4, 946, 592

5 512 856

0

0

0

| Peri od: | Worksheet A-8-2 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 150102

					-	Γο 12/31/2015	Date/Time Pre 5/26/2016 9:1	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4. 00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	27, 741	27, 741	0	211, 500		1. 00
2.00	53. 00	ANESTHESI OLOGY	280, 822	280, 822	0	239, 400	0	2. 00
3.00		RADI OLOGY-DI AGNOSTI C	6, 444	6, 444	0	271, 900	0	3. 00
4.00		ELECTROCARDI OLOGY	700	700		211, 500	0	4. 00
5.00	91.00	EMERGENCY	2, 142, 728	1, 734, 940	407, 788	211, 500	2, 363	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7.00	0.00		0	0	0	0	0	7. 00
8.00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10. 00
200.00			2, 458, 435	2, 050, 647	407, 788		2, 363	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8.00	9. 00	12. 00	13.00	14. 00	
1.00		ADMINISTRATIVE & GENERAL	0	0	_	0		
2.00	•	ANESTHESI OLOGY	0	0			0	2. 00
3. 00	•	RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	3. 00
4.00		ELECTROCARDI OLOGY	0	0	0	0	0	4. 00
5. 00		EMERGENCY	240, 276	12, 014	0	0	0	5. 00
6.00	0.00		0	0	0	0	0	6. 00
7. 00	0. 00		0	0	0	0	0	7. 00
8. 00	0.00		0	0	0	0	0	8. 00
9.00	0.00		0	0	0	0	0	9. 00
10.00	0.00		0	0	0	0	0	10.00
200.00		0 1 0 1 (8)	240, 276			0	0	200. 00
	Wkst. A Line #	1	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
1. 00		ADMINISTRATIVE & GENERAL	0	0	0	27, 741		1. 00
2.00		ANESTHESI OLOGY	0	0	0	280, 822		2. 00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	6, 444		3. 00
4.00	69.00	ELECTROCARDI OLOGY	0	0	0	700		4. 00
5.00	91.00	EMERGENCY	0	240, 276	167, 512	1, 902, 452		5. 00
6.00	0.00		0	0	0	0		6. 00
7. 00	0.00	1	l	Ö	0	o		7. 00
8.00	0.00	1	l o	l o	0	o		8. 00
9. 00	0.00		0	l o	0	o		9. 00
10.00	0.00	1	l o	l o	0	o		10. 00
200.00			0	240, 276	167, 512	2, 218, 159		200.00
	•	•	•	•	•			•

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 150102 Peri od: Worksheet B From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/26/2016 9:14 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 244, 208 244 208 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 28, 419 28, 419 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 191, 241 92 1, 192, 123 4.00 00500 ADMINISTRATIVE & GENERAL 2. 957 8, 732, 773 5 00 8 558 039 25 409 5 00 146, 368 7.00 00700 OPERATION OF PLANT 1, 118, 339 78, 525 9, 139 66, 907 1, 272, 910 7.00 1, 111 8.00 00800 LAUNDRY & LINEN SERVICE 995 116 8.00 9.00 00900 HOUSEKEEPI NG 286, 765 949 110 33, 190 321, 014 9.00 01000 DI ETARY 10.00 83.538 9.107 94, 730 10 00 1.868 217 4, 818 11.00 01100 CAFETERI A 142, 177 561 23, 840 171, 396 11.00 01300 NURSING ADMINISTRATION 51, 239 210 5, 786 13.00 24 57, 259 13.00 01400 CENTRAL SERVICES & SUPPLY 110, 396 13, 886 14.00 14.00 3.887 128, 621 452 34, 855 15.00 15.00 01500 PHARMACY 275, 439 1, 537 179 312,010 01600 MEDICAL RECORDS & LIBRARY 345, 350 385 349, 042 16.00 16.00 3, 307 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDLATRICS 1, 281, 118 25, 386 2, 954 194, 208 1, 503, 666 30.00 31.00 03100 INTENSIVE CARE UNIT 0 0 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 185, 527 18, 768 2, 184 111, 677 1, 318, 156 50.00 05100 RECOVERY ROOM 51.00 51.00 C 0 9, 930 53.00 05300 ANESTHESI OLOGY 9.930 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 2, 302, 275 1, 409 180, 890 2, 496, 684 54.00 12, 110 54.00 57.00 05700 CT SCAN 273, 867 1, 064 485 275, 540 57.00 124 58.00 05800 MRI 241, 684 992 257, 444 58.00 115 14,653 05900 CARDIAC CATHETERIZATION 59.00 С Ω 59.00 06000 LABORATORY 1, 168, 854 1, 251, 599 60.00 5, 582 650 76, 513 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD 36, 059 0 36, 059 62.00 06500 RESPIRATORY THERAPY 65.00 306, 458 6, 254 728 46, 707 360, 147 65.00 4, 446 06600 PHYSI CAL THERAPY 128, 451 145, 106 66.00 517 11, 692 66,00 67.00 06700 OCCUPATIONAL THERAPY 151, 261 640 74 21, 896 173, 871 67.00 06800 SPEECH PATHOLOGY 12.802 2, 083 68.00 640 74 15, 599 68 00 69.00 06900 ELECTROCARDI OLOGY 119, 691 1, 234 144 14, 183 135, 252 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 114, 119 71.00 C 0 0 114, 119 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 79, 124 79, 124 72.00 72.00 0 0 0 07300 DRUGS CHARGED TO PATIENTS 660, 591 0 0 660, 591 73.00 Ω 73.00 76.97 07697 CARDIAC REHABILITATION 0 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 0 Ω Ω 0 0 90 00 91.00 09100 EMERGENCY 1, 569, 637 7, 774 905 168, 753 1, 747, 069 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1-117) 22, 076, 598 207, 185 24, 110 1, 177, 679 22, 020, 822 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 72 689 190. 00 617 193. 00 19300 NONPALD WORKERS 0 0 193. 00 0 0 0 193. 01 19301 WELLNESS CENTER 75, 591 O Ω 9, 162 84. 753 193. 01 193. 02 19302 RETAIL PHARMACY 23, 252 0 23, 252 193. 02 153, 094 194. 00 194.00 07950 OTHER NRCC 107, 169 36, 406 4.237 5.282 200.00 0 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 22, 282, 610 244, 208 28, 419 1, 192, 123 22, 282, 610 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 150102

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2015	Part
To 12/31/2015	Date/Time Prepared:
5/26/2016 9:14 am	

				'	0 12/01/2010	5/26/2016 9: 1	4 am
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	'	& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
-	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT					1	1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					1	2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					1	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	8, 732, 773				1	5. 00
7.00	00700 OPERATION OF PLANT	820, 382	2, 093, 292			1	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	716	14, 929		,	1	8.00
9. 00	00900 HOUSEKEEPI NG	206, 891	14, 237	1		1	9. 00
10. 00	01000 DI ETARY	61, 053	28, 040		· · · · · · · · · · · · · · · · · · ·	193, 775	
11. 00	01100 CAFETERI A	110, 464	72, 308			0	11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	36, 903	3, 159		1, 121	0	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	82, 895	58, 331	1		0	14.00
	01500 PHARMACY					0	
15. 00		201, 088	23, 064			0	15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	224, 955	49, 633	3 <u> </u> C	17, 615	0	16. 00
20.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	0(0, 100	200.040	1/ 75/	125 210	100 775	20.00
30.00		969, 102	380, 968	1		193, 775	30.00
31. 00	03100 NTENSI VE CARE UNI T	0	C) <u> </u>	0	0	31. 00
F0 00	ANCILLARY SERVICE COST CENTERS	0.40 5.40	004 (50	J .			F0 00
50.00	05000 OPERATING ROOM	849, 542	281, 659	1	,	0	50.00
51.00	05100 RECOVERY ROOM	0	C	1	_	0	51.00
53.00	05300 ANESTHESI OLOGY	6, 400	101 710	0		0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	1, 609, 092	181, 743			0	54.00
57. 00	05700 CT SCAN	177, 584	15, 967	1	0,007	0	57. 00
58. 00	05800 MRI	165, 921	14, 886	1	0, 200	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	C) C	1 4	0	59. 00
60.00	06000 LABORATORY	806, 647	83, 775	5 C	29, 732	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	23, 240	C) C	0	0	62. 00
65.00	06500 RESPI RATORY THERAPY	232, 112	93, 857	' C	33, 311	0	65. 00
66.00	06600 PHYSI CAL THERAPY	93, 520	66, 726	o C	23, 682	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	112, 059	9, 606		3, 409	0	67. 00
68.00	06800 SPEECH PATHOLOGY	10, 053	9, 606		3, 409	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	87, 169	18, 520		6, 573	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	73, 549	C) c	o	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	50, 995	C		ol	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	425, 746	C		ol	0	73. 00
76. 97	07697 CARDIAC REHABILITATION	0	C		ol	0	76. 97
	OUTPATIENT SERVICE COST CENTERS		_		-		
90.00	09000 CLI NI C	0	C		ol	0	90.00
91. 00	09100 EMERGENCY	1, 125, 974	116, 662		_	0	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	1, 120, 77	1.0,002]	1.7.10.		92. 00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		8, 564, 052	1, 537, 676	16, 756	535, 384	193, 775	118 00
	NONREI MBURSABLE COST CENTERS	0,001,002	1,007,070	,	000,001	1707770	
190.00	19000 GIFT FLOWER COFFEE SHOP & CAN	444	9, 260		3, 287	0	190. 00
	19300 NONPALD WORKERS	0	0	1			193. 00
	19301 WELLNESS CENTER	54, 623	Ċ		أم		193. 01
	19302 RETAIL PHARMACY	14, 986	Č		ام		193. 02
	07950 OTHER NRCC	98, 668	546, 356		3, 471		194. 00
200.00	1	75,000	0 10, 000	1	5, 471		200. 00
200.00	1	0	^	ما ا		Λ	201.00
202.00		8, 732, 773	2, 093, 292	16, 756	542, 142		
202.00	1.0 (34 11103 110 201)	0,702,770	2,070,272	-1 10,700	012,142	175, 115	1-02.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS IU HEALTH STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Worksheet B
Part I
Date/Time Prepared:
5/26/2016 9:14 am Provi der CCN: 150102 Peri od: From 01/01/2015 To 12/31/2015 Cost Center Description CAFETERI A NURSI NG CENTRAL PHARMACY MEDI CAL RECORDS & ADMI NI STRATI ON SERVICES & LI BRARY 16. 00 SUPPLY 11.00 15. 00

		11.00	13. 00	14. 00	15. 00	16. 00	
	GENERAL SERVICE COST CENTERS						
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
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9.00
	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	379, 831					11.00
	01300 NURSI NG ADMI NI STRATI ON	1	102 224				13.00
	01400 CENTRAL SERVICES & SUPPLY	4, 794	103, 236 0	299, 427			
		8, 878	٥,	·	555 054		14.00
	01500 PHARMACY	11, 319	0	187	555, 854		15.00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	0	0	0	641, 245	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	T			T		
30.00	03000 ADULTS & PEDI ATRI CS	83, 095	43, 506	24, 006	0	40, 279	
31. 00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	43, 589	20, 759	124, 261	0	63, 613	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0	2, 475	0	16, 185	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	69, 201	0	16, 856	0	70, 850	54.00
57.00	05700 CT SCAN	0	o	273	o	69, 797	57.00
58.00	05800 MRI	4, 306	o	137	o	22, 972	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	o	0	ol	0	59.00
60.00	06000 LABORATORY	36, 221	0	5, 072	0	96, 268	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD	0	0	0	Ō	1, 707	62. 00
65. 00	06500 RESPIRATORY THERAPY	20, 951	0	4, 198	0	8, 162	
66. 00	06600 PHYSI CAL THERAPY	6, 481	o O	540	0	7, 839	
	06700 OCCUPATI ONAL THERAPY	6, 303	0	416	0	2, 905	
68. 00	06800 SPEECH PATHOLOGY	710	0	146	0	1, 436	68.00
		1	0	1.5	0	•	
	06900 ELECTROCARDI OLOGY	5, 149	0	653	0	21, 628	
	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	76, 430	0	4, 472	
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	2, 748	0	2, 829	
	07300 DRUGS CHARGED TO PATIENTS	0	0	0	555, 854	68, 632	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	1			T		
	09000 CLI NI C	0	0	0	0	0	
	09100 EMERGENCY	69, 068	38, 971	40, 939	0	141, 671	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	370, 065	103, 236	299, 337	555, 854	641, 245	118.00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	0	0	0	190. 00
193.00	19300 NONPALD WORKERS	0	o	0	o	0	193. 00
193. 01	19301 WELLNESS CENTER	4, 661	o	0	ol	0	193. 01
	19302 RETAI L PHARMACY	0	0	5	o		193. 02
	07950 OTHER NRCC	5, 105	0	85	ol .		194. 00
200.00		5, 105	٩	55	Ĭ	O	200.00
201.00	, ,		0	n	٥	0	201.00
202.00		379, 831	103, 236	299, 427	555, 854	641, 245	
202.00	TOTAL (Sum TITIES TTO-201)	3/7,031	103, 230	277, 421	333, 634	041, 240	202.00

Health Financial Systems

IU HEALTH STARKE MEMORIAL HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 150102

Period: Period: Worksheet B

From 01/01/2015

To 12/21/2015

Part I

To 12/21/2015

Part Of Time Propagate

					To 12/31/2015	Date/Time Prepared:
	Cost Center Description	Subtotal	Intern &	Total		5/26/2016 9:14 am
	'	R	esidents Cost			
			& Post			
			Stepdown			
		24.00	Adjustments 25.00	26. 00	_	
	GENERAL SERVICE COST CENTERS	21100	20.00	20.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMI NI STRATI VE & GENERAL					5. 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
13.00	01300 NURSING ADMINISTRATION					13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY					14. 00
15. 00	01500 PHARMACY					15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY					16. 00
30. 00	INPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	2 200 242	0	2 200 24	9	30.00
31. 00	03100 INTENSIVE CARE UNIT	3, 390, 363	0	3, 390, 36	0	31.00
31.00	ANCI LLARY SERVI CE COST CENTERS		<u> </u>	<u> </u>	<i>3</i>	31.00
50.00	05000 OPERATING ROOM	2, 801, 542	0	2, 801, 542	2	50.00
51.00	05100 RECOVERY ROOM	0	o		O	51.00
53. 00	05300 ANESTHESI OLOGY	34, 990	0	34, 99	O	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 508, 928	0	4, 508, 92		54. 00
57. 00	05700 CT SCAN	544, 828	0	544, 82		57. 00
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	470, 949	0	470, 94	9	58. 00 59. 00
60.00	06000 LABORATORY	2, 309, 314	0	2, 309, 31	~	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD	61, 006	0	61, 00		62. 00
65. 00	06500 RESPIRATORY THERAPY	752, 738	o	752, 73		65. 00
66.00	06600 PHYSI CAL THERAPY	343, 894	O	343, 89		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	308, 569	0	308, 569	9	67. 00
68. 00	06800 SPEECH PATHOLOGY	40, 959	0	40, 95		68. 00
69. 00	06900 ELECTROCARDI OLOGY	274, 944	0	274, 94		69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	268, 570	0	268, 570		71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	135, 696 1, 710, 823	0	135, 69 1, 710, 82		72. 00 73. 00
76. 97	07697 CARDIAC REHABILITATION	1,710,623	o		0	76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	9	<u> </u>		5	70.77
90.00	09000 CLI NI C	0	0	(O	90.00
91.00	09100 EMERGENCY	3, 321, 758	0	3, 321, 75	В	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT		0			92. 00
440.00	SPECIAL PURPOSE COST CENTERS	04 070 074	ما	04 070 07	.	110.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	21, 279, 871	0	21, 279, 87	<u> </u>	118. 00
190 00	19000 GIFT FLOWER COFFEE SHOP & CAN	13, 680	O	13, 680		190. 00
	19300 NONPALD WORKERS	13, 030	0			193. 00
	19301 WELLNESS CENTER	144, 037	o	144, 03		193. 01
	19302 RETAIL PHARMACY	38, 243	O	38, 24		193. 02
	07950 OTHER NRCC	806, 779	0	806, 77		194. 00
200.00	, , , , , , , , , , , , , , , , , , ,	0	0		O	200. 00
201.00		0	0		0	201. 00
202.00	TOTAL (sum lines 118-201)	22, 282, 610	0	22, 282, 610	J	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150102

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 5/26/2016 9:14 am

						5/26/2016 9:1	4 am
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7.00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	812, 543					5. 00
7. 00	00700 OPERATION OF PLANT	76, 333	257, 334				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	67	1, 835				8. 00
9. 00	00900 HOUSEKEEPI NG	19, 250	1, 750		23, 094		9. 00
10.00	01000 DI ETARY	5, 681	3, 447		424	13, 824	1
11. 00	01100 CAFETERI A	10, 278	8, 889		1, 093	13, 024	11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	3, 434	388			0	13.00
				0	48		
14.00	01400 CENTRAL SERVICES & SUPPLY	7, 713	7, 171	0	882	0	14.00
15. 00	01500 PHARMACY	18, 710	2, 835		349	0	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	20, 931	6, 102	0	750	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00	03000 ADULTS & PEDIATRICS	90, 170	46, 833		5, 759	13, 824	
31. 00	03100 I NTENSI VE CARE UNIT	0	0	0	0	0	31. 00
	ANCILLARY SERVICE COST CENTERS	, , ,					
50. 00	05000 OPERATING ROOM	79, 046	34, 625	0	4, 258	0	50. 00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300 ANESTHESI OLOGY	595	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	149, 719	22, 342		2, 748	0	54.00
57.00	05700 CT SCAN	16, 523	1, 963	0	241	0	57. 00
58.00	05800 MRI	15, 438	1, 830	0	225	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	75, 055	10, 299	0	1, 267	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	2, 162	0	0	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	21, 597	11, 538	l 0	1, 419	0	65. 00
66.00	06600 PHYSI CAL THERAPY	8, 702	8, 203	l o	1, 009	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	10, 427	1, 181	0	145	0	67.00
68. 00	06800 SPEECH PATHOLOGY	935	1, 181	l o	145	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	8, 111	2, 277		280	0	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	6, 843	2, 2, 7	0	0	0	71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 745	0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	39, 614	0		0	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	37, 014	0	1	0	0	76. 97
10. 71	OUTPATIENT SERVICE COST CENTERS	<u> </u>			<u> </u>		70. 77
90. 00	09000 CLINIC	0	0	0	0	0	90.00
91. 00	09100 EMERGENCY	104, 766	14, 342		1, 764	0	91.00
91.00	09200 OBSERVATION BEDS (NON-DISTINCT	104, 766	14, 342	0	1, 704	U	91.00
92.00	SPECIAL PURPOSE COST CENTERS						92.00
110 00		704 045	100 021	2 012	22 004	12 024	110 00
118. 00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	796, 845	189, 031	3, 013	22, 806	13, 824	118. 00
100.00	NUNKEI MBURSABLE CUSI CENTERS	4.1	1 120	1 0	140		190. 00
	19000 GIFT FLOWER COFFEE SHOP & CAN	41	1, 138		140		
	19300 NONPALD WORKERS	0	0	1	0		193. 00
	19301 WELLNESS CENTER	5, 082	0	0	0		193. 01
	2 19302 RETAIL PHARMACY	1, 394	0] 0	0		193. 02
	07950 OTHER NRCC	9, 181	67, 165	0	148	0	194. 00
200.00	3						200. 00
201.00		0	0	0	0		201. 00
202.00	TOTAL (sum lines 118-201)	812, 543	257, 334	3, 013	23, 094	13, 824	202. 00

Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150102 Peri od: Worksheet B From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 5/26/2016 9:14 am Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL ADMI NI STRATI ON SERVICES & RECORDS & SUPPLY LI BRARY 11. 00 13.00 15.00 14.00 16, 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 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 11.00 01100 CAFETERI A 25, 657 01300 NURSING ADMINISTRATION 10, 704 13.00 324 01400 CENTRAL SERVICES & SUPPLY 14.00 600 22.099 15.00 01500 PHARMACY 765 14 28, 277 16.00 01600 MEDICAL RECORDS & LIBRARY 0 31, 475 INPATIENT ROUTINE SERVICE COST CENTERS 1, 977 30.00 03000 ADULTS & PEDIATRICS 5,612 4, 511 1, 772 0 03100 INTENSIVE CARE UNIT 31.00 0 0 ANCILLARY SERVICE COST CENTERS 2, 944 50.00 05000 OPERATING ROOM 3, 122 2, 152 9, 171 0 51.00 05100 RECOVERY ROOM 0 0 05300 ANESTHESI OLOGY 53.00 0 183 0 0 0 794 05400 RADI OLOGY-DI AGNOSTI C 3, 477 54.00 0 4.674 1.244 05700 CT SCAN 57.00 0 0 20 3, 426 58.00 05800 MRI 291 0 10 1, 127 05900 CARDIAC CATHETERIZATION 59.00 C 0 0 0 0 4, 725 60 00 06000 LABORATORY 0 2 447 374 06200 WHOLE BLOOD & PACKED RED BLOOD 62.00 C C 84 65.00 06500 RESPIRATORY THERAPY 1, 415 310 401 06600 PHYSI CAL THERAPY 66.00 438 40 0 385 06700 OCCUPATI ONAL THERAPY 67.00 426 31 143 68.00 06800 SPEECH PATHOLOGY 48 11 70 06900 ELECTROCARDI OLOGY 0 69.00 348 0 48 1,061 o 71 00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 Ω 5 641 219 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 203 0 139 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 28, 277 3, 368 C 07697 CARDIAC REHABILITATION 76.97 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 91.00

7.00 8.00 9 00 10.00 11.00 13.00 14 00 15.00 16.00 30.00 31.00 50.00 51.00 53.00 54.00 57.00 58.00 59.00 60 00 62.00 65.00 66.00 67.00 68.00 69.00 71 00 72.00 73.00 76.97 90.00 09100 EMERGENCY 4, 041 3, 021 0 6, 957 4,665 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 24, 997 10, 704 22, 093 28, 277 31, 475 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 190. 00 193. 00 19300 NONPALD WORKERS 0 C 0 0 0 193 00 193. 01 19301 WELLNESS CENTER 315 0 0 0 0 193. 01 193. 02 19302 RETAIL PHARMACY 0 0 0 193. 02 194.00 07950 OTHER NRCC 0 194.00 0 345 0 6 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 0 201.00 202.00 TOTAL (sum lines 118-201) 25, 657 10, 704 22, 099 28, 277 31, 475 202. 00

		24. 00	25. 00	26.00		
	GENERAL SERVICE COST CENTERS	21.00	20.00	20.00		
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP					2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					5. 00
7. 00	00700 OPERATION OF PLANT					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11. 00	01100 CAFETERI A					11. 00
13.00	01300 NURSING ADMINISTRATION					13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY					14. 00
	01500 PHARMACY					15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY					16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	238, 226	0	238, 226		30. 00
31.00	03100 INTENSIVE CARE UNIT	0	0	0		31. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM	273, 036	0	273, 036		50. 00
51.00	05100 RECOVERY ROOM	0	0	0		51.00
	05300 ANESTHESI OLOGY	1, 572	0	1, 572		53. 00
	05400 RADI OLOGY-DI AGNOSTI C	558, 927	0	558, 927		54. 00
	05700 CT SCAN	180, 370	0	180, 370		57. 00
	05800 MRI	53, 647	0	53, 647		58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	0		59. 00
	06000 LABORATORY	116, 324	0	116, 324		60. 00
	06200 WHOLE BLOOD & PACKED RED BLOOD	2, 246	0	2, 246		62. 00
	06500 RESPI RATORY THERAPY	54, 532	0	54, 532		65. 00
	06600 PHYSI CAL THERAPY	30, 290	0	30, 290		66. 00
	06700 OCCUPATI ONAL THERAPY	13, 482	0	13, 482		67. 00
	06800 SPEECH PATHOLOGY	3, 106	0	3, 106		68. 00
	06900 ELECTROCARDI OLOGY	31, 122	0	31, 122		69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PAT	12, 703	0	12, 703		71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	5, 087	0	5, 087		72. 00
	07300 DRUGS CHARGED TO PATIENTS	71, 259	0	71, 259		73.00
	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	0	0		76. 97
	09000 CLINIC	0	0	0		90.00
	09100 EMERGENCY	202, 994	0			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT	202, 994	0	202, 994		92.00
92.00	SPECIAL PURPOSE COST CENTERS		U			72.00
118. 00		1, 848, 923	0	1, 848, 923		118. 00
110.00	NONREI MBURSABLE COST CENTERS	1,040,723	<u> </u>	1,040,723		1110.00
190 00	19000 GIFT FLOWER COFFEE SHOP & CAN	2, 008	0	2, 008		190. 00
	19300 NONPALD WORKERS	2,000	0	2,000		193. 00
	19301 WELLNESS CENTER	25, 273	0	25, 273		193. 01
	19302 RETAIL PHARMACY	1, 394	0	1, 394		193. 02
	07950 OTHER NRCC	162, 839	0	162, 839		194. 00
200.00		0	0			200. 00
201.00	, , , , , , , , , , , , , , , , , , ,	o o	Ö			201. 00
202.00	1 1 3	2, 040, 437	0	_		202. 00
50	1	, , - , - , - , - , - , - , - , -	١	, , , , , , , , , , , , , , , , , , , ,	1	1

Heal th	Financial Systems IU	HEALTH STARKE N	IEMORIAL HOSPIT	AL	In Lie	eu of Form CMS-2	<u> 2552-10</u>
COST AL	LOCATION - STATISTICAL BASIS		Provi der	CCN: 150102 F	Peri od:	Worksheet B-1	
				F	From 01/01/2015 o 12/31/2015	D 1 (T) D	
					0 12/31/2015	Date/Time Pre	
		CADITAL DEL	LATED COSTS			5/26/2016 9: 1	4 alli
		CAPITAL REI	LATED COSTS				
	Cook Cooks Doors at or	DIDC 0 FLVT	MADLE FOLLID	EMDLOVEE	D!!!-+!	ADMINI CTDATIVE	
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS			
				SALARI ES)			
		1.00	2.00	4.00	5A	5. 00	
	GENERAL SERVICE COST CENTERS			•			
1.00	00100 CAP REL COSTS-BLDG & FLXT	84, 693					1.00
	00200 CAP REL COSTS-MVBLE EQUIP		84, 693				2. 00
	00400 EMPLOYEE BENEFITS DEPARTMENT	274		1			4.00
	00500 ADMINISTRATIVE & GENERAL	8, 812				12 540 027	5. 00
		1					1
	00700 OPERATION OF PLANT	27, 232				1, 272, 910	7. 00
	00800 LAUNDRY & LINEN SERVICE	345			-	1, 111	
9.00	00900 HOUSEKEEPI NG	329	329	185, 903	3	321, 014	9. 00
10.00	D1000 DI ETARY	648	648	51, 010	0	94, 730	10.00
11.00	D1100 CAFETERI A	1, 671	1, 671	133, 534	0	171, 396	11. 00
13.00	D1300 NURSING ADMINISTRATION	73	73	32, 407	0	57, 259	13.00
	01400 CENTRAL SERVICES & SUPPLY	1, 348	-	1			
	D1500 PHARMACY	533		1		312, 010	
	01600 MEDICAL RECORDS & LIBRARY		ł .	1			
-		1, 147	1, 147) 0	349, 042	16. 00
	NPATIENT ROUTINE SERVICE COST CENTERS	T	1				
	03000 ADULTS & PEDIATRICS	8, 804		1, 087, 773			
31.00	03100 INTENSIVE CARE UNIT	0	0	C	0	0	31.00
F	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	6, 509	6, 509	625, 521	0	1, 318, 156	50.00
51.00	D5100 RECOVERY ROOM	0					51.00
	D5300 ANESTHESI OLOGY	0	1	1	1	9, 930	
	D5400 RADI OLOGY-DI AGNOSTI C	4, 200	1	1	,	2, 496, 684	
		The state of the s					1
	D5700 CT SCAN	369		1		275, 540	
	05800 MRI	344		1		257, 444	1
	D5900 CARDI AC CATHETERI ZATI ON	0		1	0	0	59. 00
60.00	D6000 LABORATORY	1, 936	1, 936	428, 559	0	1, 251, 599	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0	0	C	0	36, 059	62.00
65.00	06500 RESPI RATORY THERAPY	2, 169	2, 169	261, 611	0	360, 147	65. 00
	06600 PHYSI CAL THERAPY	1, 542				145, 106	
	06700 OCCUPATI ONAL THERAPY	222				173, 871	
	06800 SPEECH PATHOLOGY	222				15, 599	
							1
	D6900 ELECTROCARDI OLOGY	428	428	79, 443	0	135, 252	
	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	() 0	114, 119	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	(0	79, 124	72. 00
73.00	D7300 DRUGS CHARGED TO PATLENTS	0	0) C	0	660, 591	73.00
76. 97	D7697 CARDIAC REHABILITATION	0	l o	ıl c	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	1			*		İ
	09000 CLI NI C	0		0	0	0	90.00
	09100 EMERGENCY	2, 696		1		-	
		2,090	2, 090	943, 207	0	1, 747, 009	
	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
	SPECIAL PURPOSE COST CENTERS		T			ı	1
118. 00	SUBTOTALS (SUM OF LINES 1-117)	71, 853	71, 853	6, 596, 339	-8, 732, 773	13, 288, 049	118. 00
1	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT FLOWER COFFEE SHOP & CAN	214	214	C	0	689	190. 00
	19300 NONPALD WORKERS	0		i	0		193. 00
	19301 WELLNESS CENTER	0	1	51, 318			193. 01
	19302 RETAIL PHARMACY			31,310			193. 02
	07950 OTHER NRCC	12 (2)	12 (2)	20 504			
		12, 626	12, 626	29, 584	1	153, 094	1
200.00	Cross Foot Adjustments						200. 00
201.00	Negative Cost Centers						201. 00
202.00	Cost to be allocated (per Wkst. B,	244, 208	28, 419	1, 192, 123	3	8, 732, 773	202. 00
	Part I)						
203.00	Unit cost multiplier (Wkst. B, Part I)	2. 883450	0. 335553	0. 178535	5	0. 644493	203. 00
204.00	Cost to be allocated (per Wkst. B,	2. 000 100	3. 000000	882		812, 543	
207.00	Part II)				-	1 012, 343	207.00
20E 00				0.000133		0.05007	205 00
205. 00	Unit cost multiplier (Wkst. B, Part			0.000132	-	0. 059967	200.00
	11)	Ĺ	I	I		I	I

		HEALTH STARKE N	<u>MEMORIAL HOSPIT</u>	AL	In Lie	u of Form CMS-	
COST A	ALLOCATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
				F	rom 01/01/2015	Dato/Timo Pro	narod:
				1	o 12/31/2015	Date/Time Pre 5/26/2016 9:1	
	Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	T 4111
	oost denter bescription	PLANT	LINEN SERVICE		(PATIENT DA	(FTE)	
		(SQUARE FEET)	(PATIENT DA	(SQOTINE TEET)	YS)	(112)	
		(SQO/IIIL TELT)	YS)		10)		
		7. 00	8.00	9.00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	7.00	10.00	11.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT	48, 375					7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	345	l .				8. 00
9. 00	00900 HOUSEKEEPI NG	329		1			9. 00
10. 00	01000 DI ETARY	648		648			10.00
11. 00	01100 CAFETERI A	1		1		0 557	1
	1 1	1, 671		1, 671		8, 557	1
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	73		73		108	1
		1, 348	l .	1, 348		200	1
15. 00	01500 PHARMACY	533				255	1
16. 00	01600 MEDI CAL RECORDS & LI BRARY	1, 147	0	1, 147	0	0	16. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.004	1 / [[0.004	4 / [1 072	20.00
30.00	03000 ADULTS & PEDI ATRI CS	8, 804				1, 872	•
31. 00	03100 I NTENSI VE CARE UNIT	0	0	0	0	0	31. 00
EO 00	ANCI LLARY SERVI CE COST CENTERS	/ F00		/ 500		000	FO 00
50.00	05000 OPERATING ROOM	6, 509		-,		982	1
51.00	05100 RECOVERY ROOM	0		1		0	
53.00	05300 ANESTHESI OLOGY	0		1		0	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 200		1,200		1, 559	1
57. 00	05700 CT SCAN	369		1 307		0	
58. 00	05800 MRI	344	0	344		97	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	-	0	
60.00	06000 LABORATORY	1, 936	0	1, 936	0	816	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD	0	0	0	0	0	62.00
65.00	06500 RESPI RATORY THERAPY	2, 169	0	2, 169	0	472	65. 00
66. 00	06600 PHYSI CAL THERAPY	1, 542	0	1, 542	0	146	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	222	0	222	0	142	67.00
68.00	06800 SPEECH PATHOLOGY	222	0	222	0	16	68. 00
69.00	06900 ELECTROCARDI OLOGY	428	0	428	0	116	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	2, 696	0	2, 696	0	1, 556	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
	SPECIAL PURPOSE COST CENTERS						1
118.00	SUBTOTALS (SUM OF LINES 1-117)	35, 535	1, 655	34, 861	1, 655	8, 337	118. 00
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT FLOWER COFFEE SHOP & CAN	214	0	214	0		190. 00
	19300 NONPALD WORKERS	0	0	0	0		193. 00
	19301 WELLNESS CENTER	0	0	0	0	105	193. 01
	19302 RETAIL PHARMACY	0	0	0	0		193. 02
194.00	07950 OTHER NRCC	12, 626	0	226	0	115	194. 00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers						201.00
202.00	Cost to be allocated (per Wkst. B,	2, 093, 292	16, 756	542, 142	193, 775	379, 831	202. 00
	Part I)						
203.00		1	l .	1		44. 388337	•
204.00		257, 334	3, 013	23, 094	13, 824	25, 657	204. 00
	Part II)						
205.00	· · · ·	5. 319566	1. 820544	0. 654202	8. 352870	2. 998364	205. 00
	1)	1	l	I			I

Health Financial Systems I	U HEALTH STARKE M	EMORIAL HOSPITA	AL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		'eri od:	Worksheet B-1
				rom 01/01/2015	D 1 (T) D
				o 12/31/2015	Date/Time Prepared: 5/26/2016 9:14 am
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	37 207 2010 7. 14 dill
oost conten becomparen	ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	
		SUPPLY	REQUIS.)	LI BRARY	
	(TOTAL NURS	(COSTED		(GROSS CHAR	
	ING SALAR)	REQUIS.)		GES)	
	13.00	14. 00	15. 00	16.00	
GENERAL SERVICE COST CENTERS					
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
7.00 00700 OPERATION OF PLANT					7. 00
8.00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
13. 00 01300 NURSING ADMINISTRATION	1, 726, 530				13. 00
14.00 01400 CENTRAL SERVICES & SUPPLY	0	773, 303			14. 00
15. 00 01500 PHARMACY	0	482	100		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	C	85, 518, 811	16. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDIATRICS	727, 607	61, 999	C	5, 371, 982	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	C	0	31.00
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	347, 169	320, 920	C	8, 484, 006	50.00
51.00 O5100 RECOVERY ROOM	0	0	C	0	51.00
53. 00 05300 ANESTHESI OLOGY	0	6, 392	C	2, 158, 585	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	43, 533	C	9, 449, 160	54.00
57. 00 05700 CT SCAN	0	705	[C	9, 308, 698	57. 00
58. 00 05800 MRI	0	353	[C	3, 063, 765	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	59. 00
60. 00 06000 LABORATORY	0	13, 098	C	12, 839, 146	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	0	0	C	227, 707	62. 00
65. 00 06500 RESPI RATORY THERAPY	0	10, 841	[C	1, 088, 594	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	1, 394	C	1, 045, 527	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1, 074	C	387, 454	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	376	C	191, 493	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 687	C	2, 884, 507	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	197, 390	C	596, 453	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	7, 097	C	377, 244	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	100	9, 153, 362	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	C	0	76. 97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLI NI C	0	0	C	0	90. 00
91. 00 09100 EMERGENCY	651, 754	105, 730	C	18, 891, 128	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT					92. 00
SPECIAL PURPOSE COST CENTERS					
118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 726, 530	773, 071	100	85, 518, 811	118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0	C	0	190. 00
193. 00 19300 NONPALD WORKERS	0	0	C	0	193. 00
193. 01 19301 WELLNESS CENTER	0	0	C	0	193. 01
193. 02 19302 RETAIL PHARMACY	0	13	[C	0	193. 02
194.00 07950 OTHER NRCC	0	219	C	0	194. 00
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers					201. 00
202.00 Cost to be allocated (per Wkst. B,	103, 236	299, 427	555, 854	641, 245	202. 00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part		0. 387205			203. 00
204.00 Cost to be allocated (per Wkst. B,	10, 704	22, 099	28, 277	31, 475	204. 00
Part II)					
205.00 Unit cost multiplier (Wkst. B, Part	0. 006200	0. 028577	282. 770000	0. 000368	205. 00
)					

COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Р	rovi der		Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/26/2016 9:1	pared: 4 am
				Ti tl	e XVIII	Hospi tal	PPS	
						Costs		
	Cost Center Description	Total Cost		y Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Ac	dj.		Di sal I owance		
		Part I, col.						
		26)	-	00	2.00	4.00	F 00	
	INDATIONE DOUBLING CODY CO CONTEDC	1.00	2.	00	3. 00	4. 00	5. 00	
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	2 200 272	J		2 200 27	2 0	2 200 2/2	20.00
30.00	03000 ADULTS & PEDIATRICS	3, 390, 363	1		3, 390, 36		3, 390, 363	
31.00	03100 NTENSI VE CARE UNI T	0	וי			0 0	0	31. 00
EO 00	ANCILLARY SERVICE COST CENTERS O5000 OPERATING ROOM	2, 801, 542	VI .		2, 801, 54	2 0	2, 801, 542	50.00
50.00	05100 RECOVERY ROOM	2,801,542			2, 801, 54	0	2, 801, 542 0	51.00
53. 00	05300 ANESTHESI OLOGY	34, 990			34, 99	0	34, 990	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 508, 928	1		4, 508, 92		4, 508, 928	
57. 00	05700 CT SCAN	544, 828	1		544, 82		4, 506, 926 544, 828	1
58. 00	05800 MRI	470, 949			470, 94		470, 949	
59. 00	05900 CARDI AC CATHETERI ZATI ON	470, 747	1		470, 74	0 0	470, 949	ı
	06000 LABORATORY	2, 309, 314	1		2, 309, 31	-	2, 309, 314	
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD	61, 006			61, 00		61, 006	
65. 00	06500 RESPIRATORY THERAPY	752, 738		0	752, 73		752, 738	
66. 00	06600 PHYSI CAL THERAPY	343, 894		0	343, 89		343, 894	
67. 00	06700 OCCUPATI ONAL THERAPY	308, 569		0	308, 56		308, 569	67. 00
68. 00	06800 SPEECH PATHOLOGY	40, 959		0	40, 95		40, 959	68. 00
69. 00	06900 ELECTROCARDI OLOGY	274, 944		U	274, 94		274, 944	69. 00
		268, 570			268, 57		268, 570	
	07200 I MPL. DEV. CHARGED TO PATIENTS	135, 696	1		135, 69		135, 696	
73. 00	07300 DRUGS CHARGED TO PATIENTS	1, 710, 823	1		1, 710, 82		1, 710, 823	
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 710, 029	1			0 0	1, 710, 023	1
70.77	OUTPATIENT SERVICE COST CENTERS		<u> </u>			<u> </u>		70.77
90.00	09000 CLINI C	0				0	0	90.00
91. 00	09100 EMERGENCY	3, 321, 758	- 1		3, 321, 75	0	J	
	09200 OBSERVATION BEDS (NON-DISTINCT	1, 295, 383			1, 295, 38		1, 295, 383	
200.00		22, 575, 254		0				
201.00	,	1, 295, 383		Ū	1, 295, 38		1, 295, 383	
202.00		21, 279, 871		0				
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		1	ŭ	, , , , , , , , , , , , , ,	1		

Heal th	Financial Systems IU	HEALTH STARKE M	EMORIAL HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150102	Peri od:	Worksheet C	
					From 01/01/2015 To 12/31/2015	Part I Date/Time Pre	narod:
					10 12/31/2013	5/26/2016 9: 1	
			Ti tl	e XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent		6 Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0.047.507		0.047.50	.=		00.00
30.00	03000 ADULTS & PEDIATRICS	2, 817, 597		2, 817, 59			30.00
31. 00	03100 INTENSI VE CARE UNI T	0			0		31.00
F0 00	ANCILLARY SERVICE COST CENTERS	045 000	7.540.440	0.470.44	0.000400	0.00000	F0 00
50.00	05000 OPERATING ROOM	915, 202	7, 563, 463	8, 478, 66			
51.00	05100 RECOVERY ROOM	0	4 005 000	0 457 00	0.000000		
53.00	05300 ANESTHESI OLOGY	171, 838	1, 985, 388				
54.00	05400 RADI OLOGY-DI AGNOSTI C	356, 259	9, 086, 953				ł
57. 00	05700 CT SCAN	773, 292	8, 529, 546				
58. 00	05800 MRI	119, 554	2, 942, 282				1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	11 2/0 27/	1	0.000000		59.00
60.00	06000 LABORATORY	1, 561, 788	11, 269, 276				60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	43, 018	184, 546				
65. 00	06500 RESPIRATORY THERAPY	631, 427	456, 482				
66.00	06600 PHYSI CAL THERAPY	42, 144	1, 002, 725				1
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	30, 161	357, 049				67. 00 68. 00
69.00		17, 025	174, 347				
71.00	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PAT	368, 047	2, 514, 644				69. 00 71. 00
71.00	07200 I MPL. DEV. CHARGED TO PATIENTS	263, 418 22, 725	332, 660 354, 282				
				1			1
73.00	07300 DRUGS CHARGED TO PATIENTS	2, 606, 084	6, 541, 516				
76. 97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	0	'	0.000000	0. 000000	76. 97
90. 00	09000 CLINIC	0		\	0.00000	0.000000	90.00
90.00	09100 EMERGENCY	1, 207, 993	0 12, 085, 770	1			
	09200 OBSERVATION BEDS (NON-DISTINCT	360, 905	2, 190, 098				
200.00		12, 308, 477	67, 571, 027				200.00
	,	12, 308, 477	07, 571, 027	19,819,50	14		200. 00
201. 00 202. 00		12 200 477	67, 571, 027	79, 879, 50			201.00
202.00	Tiotal (See Histinctions)	12, 308, 477	07, 371, 027	17,017,50	¹⁴	i I	1202. UU

			10 12/31/2015	5/26/2016 9:14 am
		Title XVIII	Hospi tal	PPS
Cost Center Description PP	S Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 I NTENSI VE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS				
50. 00 05000 OPERATI NG ROOM	0. 330423			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51.00
53. 00 05300 ANESTHESI OLOGY	0. 016220			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 477478			54.00
57. 00 05700 CT SCAN	0. 058566			57. 00
58. 00 05800 MRI	0. 153813			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 179978			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	0. 268083			62. 00
65. 00 06500 RESPI RATORY THERAPY	0. 691913			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 329126			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 796903			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 214028			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 095378			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 450562			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 359930			72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0. 187024			73.00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 262474			91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 507794			92. 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	IU HEALTH STARKE M	EMORIAL HOSPIT	AL	In Lie	u of Form CMS-:	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150102	Peri od:	Worksheet C	
					From 01/01/2015	Part I	
					To 12/31/2015		
						5/26/2016 9:1	<u>4 am</u>
			Ti t	le XIX	Hospi tal	PPS	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2. 00	3.00	4. 00	5. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	3, 390, 363		3, 390, 3	63 0	3, 390, 363	30.00
31.00	03100 INTENSIVE CARE UNIT	0			0 0	0	31.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 801, 542		2, 801, 5	42 0	2, 801, 542	50.00
51.00	05100 RECOVERY ROOM	O			0 0	0	51.00
53.00	05300 ANESTHESI OLOGY	34, 990		34, 9	90 0	34, 990	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 508, 928		4, 508, 9	28 0	4, 508, 928	54.00
	05700 CT SCAN	544, 828		544, 8		544, 828	1
	05800 MRI	470, 949		470, 9		470, 949	1
	05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	59.00
	06000 LABORATORY	2, 309, 314		2, 309, 3	14	2, 309, 314	
	06200 WHOLE BLOOD & PACKED RED BLOOD	61, 006		61, 0		61, 006	1
	06500 RESPIRATORY THERAPY	752, 738		752, 7		752, 738	
	06600 PHYSI CAL THERAPY	343, 894		343, 8		343, 894	
	06700 OCCUPATI ONAL THERAPY	308, 569		308, 5		308, 569	1
	06800 SPEECH PATHOLOGY	40, 959		40, 9		40, 959	1
	06900 ELECTROCARDI OLOGY	274, 944		274, 9		274, 944	
	07100 MEDICAL SUPPLIES CHARGED TO PAT	268, 570		268, 5		268, 570	
	07200 IMPL. DEV. CHARGED TO PATIENTS	135, 696		135, 6		135, 696	1
	07300 DRUGS CHARGED TO PATIENTS	1, 710, 823		1, 710, 8		1, 710, 823	
	07697 CARDIAC REHABILITATION	1, 710, 823		1, /10, 8		1, 710, 823	1
		0			0 0	U	76.97
	OUTPATIENT SERVICE COST CENTERS					0	00.00
	09000 CLINI C	0		0 004 7	0 0	0	
	09100 EMERGENCY	3, 321, 758		3, 321, 7			
	09200 OBSERVATION BEDS (NON-DISTINCT	1, 295, 383		1, 295, 3		1, 295, 383	
200.00		22, 575, 254		22,0,0,2			
201.00	l	1, 295, 383		1, 295, 3		1, 295, 383	1
202.00	Total (see instructions)	21, 279, 871	0	21, 279, 8	71 167, 512	21, 447, 383	202. 00

Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 150102 Peri od: Worksheet C From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/26/2016 9:14 am Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 2, 817, 597 2, 817, 597 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 915, 202 7, 563, 463 8, 478, 665 0.330423 0.000000 50.00 05100 RECOVERY ROOM 0.000000 0.000000 51.00 51 00 53.00 05300 ANESTHESI OLOGY 171,838 1, 985, 388 2, 157, 226 0.016220 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 356, 259 9, 086, 953 9, 443, 212 0. 477478 0.000000 54.00 05700 CT SCAN 8, 529, 546 9, 302, 838 0.058566 57.00 773, 292 0.000000 57.00 0. 153813 0.000000 58.00 05800 MRI 119, 554 2, 942, 282 3, 061, 836 58 00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 60.00 06000 LABORATORY 1, 561, 788 11, 269, 276 12, 831, 064 0. 179978 0.000000 60.00 184, 546 06200 WHOLE BLOOD & PACKED RED BLOOD 0. 268083 0.000000 62.00 62.00 43,018 227, 564 06500 RESPIRATORY THERAPY 65.00 631, 427 456, 482 1,087,909 0.691913 0.000000 65.00 06600 PHYSI CAL THERAPY 42, 144 1,002,725 1, 044, 869 0. 329126 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 30, 161 357, 049 387, 210 0.796903 0.000000 67.00 06800 SPEECH PATHOLOGY 174.347 191, 372 0.214028 0.000000 68.00 17.025 68.00 69.00 06900 ELECTROCARDI OLOGY 368, 047 2, 514, 644 2, 882, 691 0.095378 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 596, 078 0.450562 0.000000 71.00 263, 418 332, 660 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 22, 725 354, 282 0.359930 0.000000 72.00 72.00 377,007 07300 DRUGS CHARGED TO PATIENTS 73.00 2, 606, 084 6, 541, 516 9, 147, 600 0.187024 0.000000 73.00 76.97 07697 CARDIAC REHABILITATION 0.000000 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 0.000000 90 00 0 O 09100 EMERGENCY 1, 207, 993 12, 085, 770 13, 293, 763 0. 249873 91.00 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 360, 905 2, 190, 098 2, 551, 003 0.507794 0.000000 92.00 200.00 Subtotal (see instructions) 12, 308, 477 67, 571, 027 79, 879, 504 200.00 201.00 201.00 Less Observation Beds 202.00 Total (see instructions) 12, 308, 477 67, 571, 027 79, 879, 504 202. 00

				To 12/31/2015	Date/Time Pre 5/26/2016 9:1	
			Title XIX	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDIATRICS					30.00
	03100 I NTENSI VE CARE UNI T					31. 00
	ANCILLARY SERVICE COST CENTERS	0.000400				F0.00
	05000 OPERATING ROOM	0. 330423				50.00
	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	0.000000				51. 00 53. 00
		0. 016220 0. 477478				54.00
	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	0. 477478				57.00
	05/00 CT SCAN 05800 MRI	0. 058566				58.00
	05900 CARDI AC CATHETERI ZATI ON	0. 153613				59.00
	06000 LABORATORY	0. 000000				60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD	0. 179978				62.00
	06500 RESPIRATORY THERAPY	0. 691913				65.00
	06600 PHYSI CAL THERAPY	0. 329126				66.00
	06700 OCCUPATI ONAL THERAPY	0. 796903				67. 00
	06800 SPEECH PATHOLOGY	0. 214028				68.00
	06900 ELECTROCARDI OLOGY	0. 095378				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 450562				71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 359930				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 187024				73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000				76. 97
Ī	OUTPATIENT SERVICE COST CENTERS	<u> </u>				
90. 00	09000 CLI NI C	0. 000000				90. 00
91. 00	09100 EMERGENCY	0. 262474				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 507794				92.00
200. 00	Subtotal (see instructions)					200. 00
201.00	Less Observation Beds					201. 00
202.00	Total (see instructions)					202. 00

Health Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY

I U HEALTH STARKE MEMORIAL HOSPITAL CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provider CCI | Peri od: | Worksheet C | From 01/01/2015 | Part | I | To 12/31/2015 | Date/Time Prepared: | Part | | Provi der CCN: 150102

				'	0 12/31/2013	5/26/2016 9:1	
				le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
		(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1 -		Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
μ.	ANCILLARY SERVICE COST CENTERS	0.004.540	070.00/				
	05000 OPERATING ROOM	2, 801, 542	273, 036	2, 528, 506	0	0	
	05100 RECOVERY ROOM	0	0	(0	0	51.00
	05300 ANESTHESI OLOGY	34, 990				0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	4, 508, 928				0	54.00
	05700 CT SCAN	544, 828		1		0	57. 00
	05800 MRI	470, 949	53, 647	417, 302	2 0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59. 00
	06000 LABORATORY	2, 309, 314				0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD	61, 006				0	62.00
	06500 RESPI RATORY THERAPY	752, 738				0	65. 00
	06600 PHYSI CAL THERAPY	343, 894				0	66. 00
	06700 OCCUPATI ONAL THERAPY	308, 569				0	67. 00
	06800 SPEECH PATHOLOGY	40, 959	•			0	68. 00
	06900 ELECTROCARDI OLOGY	274, 944				0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PAT	268, 570	•			0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	135, 696	•			0	72.00
	07300 DRUGS CHARGED TO PATIENTS	1, 710, 823	71, 259	1, 639, 564	1 0	0	73. 00
-	07697 CARDI AC REHABI LI TATI ON	0	0	() 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS		0				00.00
	09000 CLI NI C	0 004 750	000.004	0.440.7(1	0	
	09100 EMERGENCY	3, 321, 758				0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT	1, 295, 383				0	92.00
200.00	Subtotal (sum of lines 50 thru 199)	19, 184, 891					200. 00
201.00	Less Observation Beds	1, 295, 383				l	201. 00
202.00	Total (line 200 minus line 201)	17, 889, 508	1, 610, 697	16, 278, 811	1	1 0	202. 00

						5/26/2016 9:14 am
			Ti t	le XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
		Capital and	(Worksheet C,			
		Operating Cost	Part I, column	Ratio (col.	6	
		Reducti on	8)	/ col. 7)		
		6.00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	2, 801, 542	8, 478, 665	1		50.00
51.00	05100 RECOVERY ROOM	0	0	0.00000	00	51.00
53.00	05300 ANESTHESI OLOGY	34, 990	2, 157, 226			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 508, 928	9, 443, 212	0. 47747	['] 8	54.00
57.00	05700 CT SCAN	544, 828	9, 302, 838	0. 05856	6	57. 00
58.00	05800 MRI	470, 949	3, 061, 836	0. 15381	3	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	00	59. 00
60.00	06000 LABORATORY	2, 309, 314	12, 831, 064	0. 17997	' 8	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	61, 006	227, 564	0. 26808	33	62. 00
65.00	06500 RESPI RATORY THERAPY	752, 738	1, 087, 909	0. 69191	3	65. 00
66.00	06600 PHYSI CAL THERAPY	343, 894	1, 044, 869	0. 32912	26	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	308, 569	387, 210	0. 79690)3	67. 00
68.00	06800 SPEECH PATHOLOGY	40, 959	191, 372	0. 21402	28	68. 00
69.00	06900 ELECTROCARDI OLOGY	274, 944	2, 882, 691	0. 09537	' 8	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	268, 570	596, 078	0. 45056	52	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	135, 696	377, 007	0. 35993	30	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	1, 710, 823	9, 147, 600	0. 18702	24	73. 00
76. 97	07697 CARDIAC REHABILITATION	0	0	0.00000	00	76. 97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0	0	0.00000	00	90.00
91.00	09100 EMERGENCY	3, 321, 758	13, 293, 763	0. 24987	' 3	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	1, 295, 383	2, 551, 003	0. 50779	94	92. 00
200.00	Subtotal (sum of lines 50 thru 199)	19, 184, 891	77, 061, 907	1		200. 00
201.00	Less Observation Beds	1, 295, 383	0)		201. 00
202.00	Total (line 200 minus line 201)	17, 889, 508	77, 061, 907			202. 00

Health Financial Systems IU	HEALTH STARKE N	EMORIAL HOSPI	TAL	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi de		Peri od:	Worksheet D	
				From 01/01/2015 To 12/31/2015		narod:
				10 12/31/2013	5/26/2016 9:1	
		Ti t	le XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	238, 226		0 238, 22	2, 667	89. 32	30.00
31.00 INTENSIVE CARE UNIT	0			0 0	0.00	31.00
200.00 Total (lines 30-199)	238, 226		238, 22	6 2, 667		200. 00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	936	83, 60	4			30.00
31.00 INTENSIVE CARE UNIT	0		0			31. 00
200.00 Total (lines 30-199)	936	83, 60	4			200. 00

lealth Financial Systems	IU HEALTH STARKE MEMORIAL HOSPITA	AL In Lie	u of Form CMS-2552-10

Health Financial Systems IU	HEALTH STARKE N	MEMORIAL HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Pre 5/26/2016 9:1	pared: 4 am
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
		(from Wkst. C,		Program	(column 3 x	
	(from Wkst. B,			. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	273, 036	8, 478, 665			12, 027	50.00
51.00 05100 RECOVERY ROOM	0	0	0.00000		Ĭ	51.00
53. 00 05300 ANESTHESI OLOGY	1, 572					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	558, 927	9, 443, 212	0. 05918	8 205, 677	12, 174	54.00
57. 00 05700 CT SCAN	180, 370	9, 302, 838	0. 01938	9 479, 706	9, 301	57. 00
58. 00 05800 MRI	53, 647	3, 061, 836	0. 01752	1 72, 691	1, 274	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0 0	0	59. 00
60. 00 06000 LABORATORY	116, 324	12, 831, 064	0.00906	6 976, 897	8, 857	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	2, 246	227, 564	0. 00987	0 30, 061	297	62.00
65. 00 06500 RESPIRATORY THERAPY	54, 532	1, 087, 909	0. 05012	6 393, 009	19, 700	65.00
66. 00 06600 PHYSI CAL THERAPY	30, 290	1, 044, 869	0. 02898	9 30, 968	898	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	13, 482	387, 210	0. 03481	8 21, 409	745	67. 00
68.00 06800 SPEECH PATHOLOGY	3, 106	191, 372	0. 01623	0 12, 109	197	68. 00
69. 00 06900 ELECTROCARDI OLOGY	31, 122	2, 882, 691	0. 01079	6 245, 193	2, 647	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	12, 703	596, 078	0. 02131	1 185, 204	3, 947	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 087	377, 007	0. 01349	3, 311	45	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	71, 259	9, 147, 600	0. 00779	0 1, 467, 218	11, 430	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	1	0.00000			1
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	0	0.00000	0 0	0	90.00
91. 00 09100 EMERGENCY	202, 994	13, 293, 763	1		10, 271	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	91, 021		1			92.00
200.00 Total (lines 50-199)	1, 701, 718		1	5, 440, 630		
	,		•	,		

Health Financial Systems IU F	HEALTH STARKE M	EMORIAL HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST			Period: From 01/01/2015 To 12/31/2015		pared: 4 am
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 200. 00 Total (Lines 30-199)	0 0 0	0 0 0		0 0 0	0 0	30. 00 31. 00 200. 00
Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 200. 00 Total (lines 30-199)	2, 667 0 2, 667	0. 00 0. 00		0		30. 00 31. 00 200. 00

Health Financial Systems	IU HEALTH STARKE MEMOR	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150102	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2015	Part IV

THROUGH COSTS	7.7.1.2.1.7.0011.7.11.2.11.7.11.01.2.2.11.1.0	ERVI OL OTTER TAO			-	From 01/01/2015 To 12/31/2015	Date/Time Pre 5/26/2016 9:1	
					e XVIII	Hospi tal	PPS	
Cost Ce	nter Description	Non Physician	Nursi	ng School	Allied Health		Total Cost	
		Anesthetist				Medi cal	(sum of col 1	
		Cost				Education Cost	through col. 4)	
		1.00		2. 00	3.00	4. 00	5. 00	
ANCI LLARY SER	VICE COST CENTERS	1.00		2. 00	0.00	1. 00	0.00	
50. 00 05000 OPERATI	NG ROOM	0		0		0 0	0	50.00
51. 00 05100 RECOVER	Y ROOM	0		0		0	0	51.00
53.00 05300 ANESTHE	SI OLOGY	0		0		0	0	53. 00
54. 00 05400 RADI OLO	GY-DI AGNOSTI C	0		0		0 0	0	54.00
57.00 05700 CT SCAN		0		0		0 0	0	57.00
58.00 05800 MRI		0		0		0 0	0	58. 00
59. 00 05900 CARDI AC	CATHETERI ZATI ON	0		0		0 0	0	59. 00
60. 00 06000 LABORAT	ORY	0		0		0 0	0	60.00
	LOOD & PACKED RED BLOOD	0		0		0 0	0	62. 00
65. 00 06500 RESPI RA		0		0		0	0	65. 00
66. 00 06600 PHYSI CA		0		0		0	0	66. 00
67. 00 06700 OCCUPAT		0		0		0	0	67. 00
68. 00 06800 SPEECH		0		0		0	0	68. 00
69. 00 06900 ELECTRO		0		0		0	0	69. 00
1 1	SUPPLIES CHARGED TO PAT	0		0		0	0	71. 00
	EV. CHARGED TO PATIENTS	0		0	1	0	0	72. 00
	HARGED TO PATIENTS	0		0	1	0	0	73. 00
76. 97 07697 CARDI AC		0)	0	1	0 0	0	76. 97
	RVICE COST CENTERS							00.00
90. 00 09000 CLINIC	OV.		()	0	1	0	0	, , , , , ,
91. 00 09100 EMERGEN				0	1	0	0	91.00
1	TION BEDS (NON-DISTINCT			0]	0	0	, 2. 00
200.00 Total (lines 50-199)	1	기	Ü	1	J 0	0	200. 00

Health Financial Systems	IU HEALTH STARKE MEMORI	IAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150102	Peri od:	Worksheet D

From 01/01/2015 Part IV To 12/31/2015 Date/Time Prepared: THROUGH COSTS 5/26/2016 9:14 am Title XVIII Hospi tal Total Charges Ratio of Cost I npati ent Cost Center Description Total Outpati ent (from Wkst. C, to Charges Outpati ent Ratio of Cost Program Cost (sum of Part I, col. (col. 5 ÷ col to Charges Charges col. 2, 3 and 8) 7) $(col. 6 \div col$ 4) 7) 6.00 7.00 8.00 9.00 10.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 00 0.000000 0.000000 373, 490 50.00 8, 478, 665 51. 00 | 05100 | RECOVERY ROOM 0.000000 0.000000 51.00 05300 ANESTHESI OLOGY 2, 157, 226 0.000000 0.000000 71, 486 53.00 0000000000000000 53.00 05400 RADI OLOGY-DI AGNOSTI C 9, 443, 212 0.000000 0.000000 205, 677 54.00 54.00 0.000000 57.00 05700 CT SCAN 9, 302, 838 0.000000 479, 706 57.00 58.00 05800 MRI 3,061,836 0.000000 0.000000 72, 691 58.00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 06000 LABORATORY 12, 831, 064 0.000000 0.000000 976, 897 60 00 60 00 06200 WHOLE BLOOD & PACKED RED BLOOD 0.000000 62.00 227, 564 0.000000 30, 061 62.00 06500 RESPIRATORY THERAPY 1, 087, 909 0.000000 0.000000 393, 009 65.00 06600 PHYSI CAL THERAPY 1, 044, 869 0.000000 0.000000 66.00 30, 968 66.00 06700 OCCUPATIONAL THERAPY 387, 210 0.000000 0.000000 21, 409 67 00 67 00 68.00 06800 SPEECH PATHOLOGY 191, 372 0.000000 0.000000 12, 109 68.00 06900 ELECTROCARDI OLOGY 2, 882, 691 0.000000 0.000000 245, 193 69.00 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 596, 078 185, 204 71 00 0.000000 0.000000 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 377, 007 0.000000 0.000000 3, 311 72.00 07300 DRUGS CHARGED TO PATIENTS 9, 147, 600 0.000000 0.000000 1, 467, 218 73.00 07697 CARDIAC REHABILITATION 76.97 0.000000 0.000000 76.97 0 OUTPATIENT SERVICE COST CENTERS 0 90. 00 | 09000 | CLI NI C 0.000000 0.000000 0 90.00 91. 00 09100 EMERGENCY 13, 293, 763 0.000000 0.000000 672, 624 91.00 0 2, 551, 003 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 0.000000 0.000000 199, 577 92.00 Total (lines 50-199) 77, 061, 907 5, 440, 630 200. 00 200.00

THROUGH COSTS

					5/26/2016 9:14 am
		Ti tl	e XVIII	Hospi tal	PPS
Cost Center Description	I npati ent	Outpati ent	Outpati ent		
	Program	Program	Program		
	Pass-Through	Charges	Pass-Through		
	Costs (col. 8		Costs (col.	9	
	x col. 10)		x col. 12)		
	11. 00	12. 00	13. 00		
ANCILLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0	2, 543, 944		0	50.00
51.00 05100 RECOVERY ROOM	0	0		0	51.00
53. 00 05300 ANESTHESI OLOGY	0	729, 355		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	2, 213, 516		0	54.00
57. 00 05700 CT SCAN	0	2, 716, 406		0	57. 00
58. 00 05800 MRI	0	875, 418		0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0	59. 00
60. 00 06000 LABORATORY	0	2, 056, 892		0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	0	84, 240		0	62. 00
65. 00 06500 RESPIRATORY THERAPY	0	163, 248		0	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	729		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	1, 007, 320		0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0	159, 728		0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	145, 863		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	2, 479, 679		0	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0	76. 97
OUTPATIENT SERVICE COST CENTERS	<u>'</u>		<u>'</u>	<u> </u>	
90. 00 09000 CLI NI C	0	0		0	90.00
91. 00 09100 EMERGENCY	0	3, 137, 902		0	91. 00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	o	1, 035, 606		0	92. 00
200.00 Total (lines 50-199)	0	19, 349, 846		0	200. 00
			•	•	•

Heal th	Financial Systems IU	HEALTH STARKE N	MEMORIAL HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
					From 01/01/2015	Part V	
					To 12/31/2015	Date/Time Pre	
			T' 11	2071.1.1		5/26/2016 9:1	<u>4 am</u>
				e XVIII	Hospi tal	PPS	
			550 5 1 1	Charges		Costs	
	Cost Center Description		PPS Reimbursed		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.			
		4.00	0.00	(see inst.)	(see inst.)	F 00	
	ANOLILIABY OFFICE OF SOUT OFFITTING	1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			T		0.40 570	
50. 00	05000 OPERATING ROOM	0. 330423			0	840, 578	1
51. 00	05100 RECOVERY ROOM	0. 000000			0	0	51. 00
53.00	05300 ANESTHESI OLOGY	0. 016220			0	11, 830	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 477478			0	1, 056, 905	1
57. 00	05700 CT SCAN	0. 058566			0	159, 089	1
58. 00	05800 MRI	0. 153813			0	134, 651	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59. 00
60.00	06000 LABORATORY	0. 179978	2, 056, 892		0 0	370, 195	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	0. 268083	84, 240		0 0	22, 583	62.00
65.00	06500 RESPI RATORY THERAPY	0. 691913	163, 248		0 0	112, 953	65. 00
66.00	06600 PHYSI CAL THERAPY	0. 329126	0		0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 796903	729		0 0	581	67. 00
68.00	06800 SPEECH PATHOLOGY	0. 214028	0		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 095378	1, 007, 320		0 0	96, 076	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 450562			0 0	71, 967	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 359930	145, 863		0 0	52, 500	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 187024			0 50, 595	463, 759	1
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000		i	0	0	1
	OUTPATIENT SERVICE COST CENTERS		-	l.			1
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90.00
91. 00	09100 EMERGENCY	0. 249873			0 0	784, 077	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 507794			0 0	525, 875	
200.00		0.007771	19, 349, 846		0 50, 595	4, 703, 619	
201.00			17, 517, 646		0 00, 070	1, 700, 017	201. 00
201.00	Only Charges						201.00
202.00			19, 349, 846		0 50, 595	4, 703, 619	202 00
202.00	inet sharges (Trile 200 if Trile 201)	1	17, 547, 646	I	50, 575	4, 700, 017	1202.00

Provi der CCN: 150102

Title XVIII Hospital PPS				1	Го 12/31/2015	Date/Time Prepare 5/26/2016 9:14 a	
Cost Center Description			Ti tl	e XVIII	Hospi tal		
Rel inbursed Services Subject To Ded. & Coins. (See Inst.) Ded. & Coins. D	·	Cos	ts		· · · · · ·		
ANCILLARY SERVICE COST CENTERS	Cost Center Description	Cost	Cost				
Subject To Ded. & Coin s. (see inst.) Subject To Ded. & Coin s. Subject To Ded. & Subject To Ded.		Rei mbursed	Reimbursed				
Ded & Coins, (see inst.) Ded & Coins, (see inst.)		Servi ces	Servi ces Not				
See inst. (see inst.)							
ANCILLARY SERVICE COST CENTERS							
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 0PERATING ROOM 0 0 0 0 0 0 0 0 0		6.00	7. 00				
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0							
53. 00 05300 ANESTHESI OLOGY 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 54. 00 57. 00 05700 CT SCAN 0 0 0 58. 00 05800 MRI 0 0 0 58. 00 59. 00 CABDI AC CATHETERI ZATI ON 0 0 0 69. 00 60. 00 CABDIA CATHETERI ZATI ON 0 0 0 60. 00 62. 00 O6000 LABORATORY 0 0 0 60. 00 65. 00 O6500 RESPI RATORY THERAPY 0 0 0 62. 00 66. 00 O6500 RESPI RATORY THERAPY 0 0 0 66. 00 67. 00 O6700 OCCUPATI ONAL THERAPY 0 0 0 66. 00 67. 00 O6700 OCCUPATI ONAL THERAPY 0 0 0 68. 00 69. 00 O6900 SPECH PATHOLOGY 0 0 0 68. 00 69. 00 O6900 SEECH PATHOLOGY 0 0 0 0 71. 00 O7100 MEDI CAL SUPPLIES CHARGED TO PAT 0 0 0 72. 00 O7200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 70. 97 OARGEDA		0	0)			
54. 00		0	0)			
57. 00 05700 CT SCAN 0 05800 MRI 0 0 0 0 58800 MRI 0 0 0 0 588.00 05800 MRI 0 0 0 0 0 588.00 05800 MRI 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0)			
58. 00 05800 MRI 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 59. 00 60. 00 06000 LABORATORY 0 0 0 60. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD 0 0 62. 00 65. 00 06500 RESPI RATORY THERAPY 0 0 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 0 0 66. 00 67. 00 06600 PHYSI CAL THERAPY 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 69. 00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS		0	0)			
59.00 05900 CARDI AC CATHETERI ZATI ON 0		0	0)			
60. 00 06000 LABORATORY 0 0 0 0 0 62.00 62.00 62.00 WHOLE BLOOD & PACKED RED BLOOD 0 0 0 62.00 65.00 06500 RESPI RATORY THERAPY 0 0 0 0 66.00 66		0	0)			
62. 00	59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0)			
65. 00 06500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 0		0	0)			
66. 00 06600 06700 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0		0	0)			
67. 00		0	0)		65	5. 00
68. 00		0	0)			
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0		0	0)			
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0 0 0 0 72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 73. 00 76. 97 07697 CARDI AC REHABILITATI ON 0 0 0 0 0 0 0 0 0		0	0)			
72. 00 72. 00 72. 00 73. 00 73. 00 73. 00 73. 00 74. 00 74. 00 73. 00 74. 00 74. 00 74. 00 75.		0	0)			
73. 00 76. 97 07697 CARDIAC REHABILITATION 0 0 0 00 076. 97 00UTPATIENT SERVICE COST CENTERS 90. 00 91. 00 91. 00 91. 00 92. 00 92. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 200. 00 00 01 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0)			
76. 97 O7697 CARDI AC REHABILITATION O O O OUTPATI ENT SERVICE COST CENTERS 90. 00 O9000 CLI NI C O O 91. 00 O9100 EMERGENCY O O 92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT O O 200. 00 Subtotal (see instructions) O 9, 462 201. 00 Only Charges Only Charges Only Charges 76. 97 76. 97 90. 00 O 90. 00 O 90. 00 O 91. 00 O 92. 00 93. 00 O 94. 00 94. 00 95. 00 96. 00 97. 00 97. 00 98. 00 99. 00		0	0)			
OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 90.00 91.00 91.00 92.00 09100 EMERGENCY 0 0 0 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 0 0 0 92.00 200.00 Subtotal (see instructions) 0 9, 462 200.00 201.00 Less PBP Clinic Lab. Services-Program 0 001 y Charges 001		0	9, 462	2			
90. 00 09000 CLINIC 0 0 0 0 91. 00 92. 00 09200 095ERVATION BEDS (NON-DISTINCT 0 0 0 0 0 0 0 0 0		0	0)		76	5. 97
91.00 09100 EMERGENCY 0 0 0 0 0 0 0 0 0							
92. 00 09200 085ERVATI ON BEDS (NON-DISTINCT 0 0 0 0 0 0 0 0 0		0	0)			
200.00 Subtotal (see instructions)		0	0)			
201.00 Less PBP Ĉlinic Lab. Servićes-Program 0 0 201.00		0	0)			
Only Charges		0	9, 462	2			
		0				201	1.00
202.00 Net Charges (line 200 +/- line 201) 0 9,462 202.00							
	202.00 Net Charges (line 200 +/- line 201)	0	9, 462	2		202	2. 00

Health Financial Systems	HEALTH STARKE N	MEMORI	AL HOSPIT	AL	In Li€	eu of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	NT ROUTINE SERVICE CAPITAL COSTS				Peri od:	Worksheet D	
					From 01/01/2015 To 12/31/2015		narod:
					10 12/31/2013	5/26/2016 9:1	
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi	ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adj	ustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,			Related Cost			
	Part II, col.			(col . 1 - col			
	26)			2)			
	1.00		2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	238, 226		0	238, 22	6 2, 667	89. 32	30.00
31.00 INTENSIVE CARE UNIT	0				0 0	0.00	31.00
200.00 Total (lines 30-199)	238, 226			238, 22	6 2, 667		200. 00
Cost Center Description	I npati ent	Inp	oati ent				
	Program days	Pr	ogram				
		Capi	tal Cost				
		(col.	5 x col.				
			6)				
	6.00		7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 ADULTS & PEDIATRICS	289		25, 813		·		30.00
31.00 INTENSIVE CARE UNIT	0		0)			31.00
200.00 Total (lines 30-199)	289		25, 813				200. 00

Health Financial Systems IU H	HEALTH STARKE N	MEMORIAL HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2015 To 12/31/2015		
				10 12/31/2015	Date/Time Pre 5/26/2016 9:1	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	Inpati ent	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	273, 036	8, 478, 665			1, 428	
51.00 05100 RECOVERY ROOM	0	0	0.00000	0 0	0	51.00
53. 00 05300 ANESTHESI OLOGY	1, 572	2, 157, 226	0.00072	9, 030	7	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	558, 927	9, 443, 212	0. 05918	8 15, 735	931	54. 00
57. 00 05700 CT SCAN	180, 370	9, 302, 838	0. 01938	9 35, 862	695	57. 00
58. 00 05800 MRI	53, 647	3, 061, 836	0. 01752	1 3, 070	54	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0	0	59. 00
60. 00 06000 LABORATORY	116, 324	12, 831, 064	0.00906	6 71, 948	652	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	2, 246	227, 564	0. 00987	0 1, 274	13	62. 00
65. 00 06500 RESPIRATORY THERAPY	54, 532	1, 087, 909			1, 541	65. 00
66. 00 06600 PHYSI CAL THERAPY	30, 290				42	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	13, 482	387, 210	0. 03481	8 327	11	67.00
68. 00 06800 SPEECH PATHOLOGY	3, 106	191, 372			4	68. 00
69. 00 06900 ELECTROCARDI OLOGY	31, 122	2, 882, 691	0. 01079	6 12, 091	131	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	12, 703				201	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	5, 087					72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	71, 259					
76. 97 07697 CARDI AC REHABI LI TATI ON	0		0.00000			76. 97
OUTPATIENT SERVICE COST CENTERS			0.0000	<u> </u>		70.77
90. 00 09000 CLINIC	0	0	0.00000	0 0	0	90.00
91. 00 09100 EMERGENCY	202, 994				_	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	91, 021					
200. 00 Total (lines 50-199)	1, 701, 718		•	469, 858	· ·	200.00
	.,,,,,,,,	1 11,001,707	ı	1 1077 000	5,5	1====

Health Financial Systems IU F	HEALTH STARKE M	MEMORIAL HOSPIT	AL	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST	TS Provi der		Period: From 01/01/2015 To 12/31/2015		pared: 4 am
			le XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS			•			
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 200. 00 Total (Lines 30-199)	0 0 0	0		0 0 0	0 0 0	30. 00 31. 00 200. 00
Cost Center Description	Total Patient Days	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 200. 00 Total (lines 30-199)	2, 667 0 2, 667	0.00		0 0		30. 00 31. 00 200. 00

Health Financial Systems	IU HEALTH STARKE MEMON	RLAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150102	From 01/01/2015	Worksheet D Part IV Date/Time Prepared:

				Т	o 12/31/2015	Date/Time Prep 5/26/2016 9: 14	
				le XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician Nu	ursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
-	ANCILLARY SERVICE COST CENTERS	1			, , , , , , , , , , , , , , , , , , , ,		
	O5000 OPERATING ROOM	0	0	C	이	01	50. 00
	05100 RECOVERY ROOM	0	0	C	이	01	51. 00
	05300 ANESTHESI OLOGY	0	0	C	이	01	53. 00
	D5400 RADI OLOGY-DI AGNOSTI C	0	0	C	이	01	54.00
	05700 CT SCAN	0	0	C	이	01	57. 00
	05800 MRI	0	0	C	0	01	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0	C	0	01	59. 00
	D6000 LABORATORY	0	0	C	0	01	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD	0	0	C	0	01	62. 00
	06500 RESPI RATORY THERAPY	0	0	C	0	01	65. 00
	06600 PHYSI CAL THERAPY	0	0	C	0	01	66. 00
1	06700 OCCUPATI ONAL THERAPY	0	0	C	0	01	67. 00
	06800 SPEECH PATHOLOGY	0	0	C	0	01	68. 00
	06900 ELECTROCARDI OLOGY	0	0	C	0	01	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		0	01	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	01	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0	01	73.00
	07697 CARDI AC REHABI LI TATI ON	0	0		0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0		0	0	70.00
1	09100 EMERGENCY	0	0	0	0	01	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT	0	0	0	0	0	
200.00	Total (lines 50-199)	0	0	1	0	01	200. 00

Health Financial Systems	IU HEALTH STARKE MEMORI	AL HOSPITAL	In Lie	eu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150102	Peri od:	Worksheet D

	O HEALIN STARRE					u or rorm omb z	2332 10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY S	SERVICE OTHER PAS	S	Provi der		Peri od:	Worksheet D	
THROUGH COSTS					From 01/01/2015 To 12/31/2015	Part IV Date/Time Pre	narod:
					10 12/31/2013	5/26/2016 9:1	
			Ti t	le XIX	Hospi tal	PPS	i aiii
Cost Center Description	Total	Tota		Ratio of Cost		Inpatient	
	Outpati ent		Wkst. C,			Program	
	Cost (sum of			(col. 5 ÷ col		Charges	
	col. 2, 3 and		8)	7)	(col. 6 ÷ col.	ŭ	
	4)				7)		
	6.00		7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS	<u>.</u>						
50. 00 05000 OPERATING ROOM	C		8, 478, 665	0.00000	0. 000000	44, 338	50.00
51. 00 05100 RECOVERY ROOM	C		0	0.00000	0. 000000	0	51.00
53. 00 05300 ANESTHESI OLOGY	C		2, 157, 226	0.00000	0. 000000	9, 030	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C		9, 443, 212	0.00000	0. 000000	15, 735	54.00
57. 00 05700 CT SCAN	C		9, 302, 838	0.00000	0. 000000	35, 862	57.00
58. 00 05800 MRI	C		3, 061, 836	0.00000	0. 000000	3, 070	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	C		0	0.00000	0. 000000	0	59.00
60. 00 06000 LABORATORY	C) 1	2, 831, 064	0.00000	0. 000000	71, 948	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	C		227, 564	0.00000	0. 000000	1, 274	62.00
65. 00 06500 RESPIRATORY THERAPY	C		1,087,909	0.00000	0. 000000	30, 741	65.00
66. 00 06600 PHYSI CAL THERAPY	C		1,044,869	0.00000	0. 000000	1, 441	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	C		387, 210	0.00000	0. 000000	327	67.00
68. 00 06800 SPEECH PATHOLOGY	C		191, 372	0.00000	0. 000000	230	68.00
69. 00 06900 ELECTROCARDI OLOGY	C		2, 882, 691	0.00000	0. 000000	12, 091	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	C		596, 078	0.00000	0. 000000	9, 421	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	C		377, 007	0.00000	0. 000000	3, 208	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	C		9, 147, 600	0.00000	0. 000000	154, 622	73.00
76. 97 07697 CARDIAC REHABILITATION	C		0	0.00000	0. 000000	0	76. 97
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLI NI C	C		0	0.00000	0. 000000	0	90.00
91. 00 09100 EMERGENCY	C) 1	3, 293, 763	0.00000	0. 000000	42, 976	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	C)	2, 551, 003	0.00000	0. 000000	33, 544	92.00
200.00 Total (lines 50-199)	C) 7	7, 061, 907			469, 858	200.00
	•	•		•			•

THROUGH COSTS

				12, 01, 2010	5/26/2016 9:	
		Ti	tle XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Through			
	Costs (col. 8		Costs (col. 9			
	x col. 10)		x col. 12)			
	11. 00	12. 00	13. 00			
ANCI LLARY SERVI CE COST CENTERS			al .	-I		
50. 00 05000 OPERATI NG ROOM	0)		50.00
51. 00 05100 RECOVERY ROOM	0)		51.00
53. 00 05300 ANESTHESI OLOGY	0)		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0)		54.00
57. 00 05700 CT SCAN	0)		57. 00
58. 00 05800 MRI	0)		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0)		59. 00
60. 00 06000 LABORATORY	0		0)		60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD	0		0)		62. 00
65. 00 06500 RESPI RATORY 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	O .		69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0		0	O .		71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		0	O .		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0	O .		73. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0		0	0		76. 97
OUTPATIENT SERVICE COST CENTERS						_
90. 00 09000 CLI NI C	0		0	0		90. 00
91. 00 09100 EMERGENCY	0		0	O .		91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0		0	O .		92. 00
200.00 Total (lines 50-199)	0		0)		200. 00

Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10							2552-10
APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od:	Worksheet D	
					From 01/01/2015 Fo 12/31/2015		nared.
					10 12/31/2013	5/26/2016 9: 1	
			Ti t	le XIX	Hospi tal	PPS	
				Charges		Costs	
	Cost Center Description		PPS Reimbursed		Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins.	Ded. & Coins.		
		4.00	0.00	(see inst.)	(see inst.)	F 00	
	ANOULLARY CERVICE COCT CENTERS	1. 00	2.00	3. 00	4. 00	5. 00	
F0 00	ANCILLARY SERVICE COST CENTERS	0.000400	1 0	457, 40	, ,		
50.00	05000 OPERATI NG ROOM	0. 330423		456, 49		0	00.00
51.00	05100 RECOVERY ROOM	0. 000000		400.00	0	0	1 0 00
53.00	05300 ANESTHESI OLOGY	0. 016220		103, 30		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 477478		449, 86		0	
57. 00	05700 CT SCAN	0. 058566	l .	551, 05		0	07.00
58. 00	05800 MRI	0. 153813		268, 82		0	00.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000		(0	0	59. 00
60.00	06000 LABORATORY	0. 179978		776, 76		0	00.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD	0. 268083	l .	94		_	
65. 00	06500 RESPI RATORY THERAPY	0. 691913		28, 03		0	
66. 00	06600 PHYSI CAL THERAPY	0. 329126		58, 20:		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 796903		40, 42		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 214028		34, 12		0	00.00
69. 00	06900 ELECTROCARDI OLOGY	0. 095378		142, 75		Ŭ	07.00
	07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 450562		16, 06		0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 359930		9, 51		0	1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 187024		480, 22		0	70.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0	(0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	_					
	09000 CLI NI C	0. 000000	l .		0	-	
91. 00	09100 EMERGENCY	0. 249873		1, 097, 51		0	1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	0. 507794	0	266, 55°			1 /2.00
200.00			0	4, 780, 67	5 0	0	200. 00
201.00					0		201. 00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	1	0	4, 780, 67	5 0	0	202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 150102 Peri od: Worksheet D From 01/01/2015 To 12/31/2015 Part V Date/Time Prepared: 5/26/2016 9:14 am Title XIX Hospi tal PPS Costs 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 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 150, 837 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 53. 00 05300 ANESTHESI OLOGY 1,676 0 53 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 214, 802 54.00 57. 00 05700 CT SCAN 32, 273 57.00 0 58.00 05800 MRI 41, 349 58.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 59.00 60. 00 06000 LABORATORY 139, 801 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD 0 62.00 253 62.00 06500 RESPIRATORY THERAPY 19, 398 0 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 19, 156 0 66.00 67.00 06700 OCCUPATI ONAL THERAPY 32, 215 0 67.00 06800 SPEECH PATHOLOGY 68.00 7, 304 0 68.00 06900 ELECTROCARDI OLOGY 0 69.00 13, 615 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 7, 240 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 3, 424 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 89, 814 0 73.00 07697 CARDIAC REHABILITATION 76. 97 76.97 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09100 EMERGENCY 274, 239 91.00 0 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 135, 353 92.00 0 200.00 Subtotal (see instructions) 1, 182, 749 0 200.00 Less PBP Clinic Lab. Services-Program 201.00 201. 00

1, 182, 749

0

202.00

Only Charges

Net Charges (line 200 +/- line 201)

202.00

Health Financial Systems	IU HEALTH STARKE MEMOR	IAL HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150102	Peri od: From 01/01/2015 To 12/31/2015	Date/Time Prepared:
				5/26/2016 9:14 am
		Title XVIII	Hospi tal	PPS

Total 'swing-bed SNF type inpatient days' (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) Through December 31 of the cost reporting period (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Swing-bed NF type inpatient days applicable to title XVII only (including private room days) Through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Medicall years of the cost reporting period (if calendar year, enter 0 on this line) Medicall years of the cost reporting period (if calendar year, enter 0 on this line) Medicall years of the cost reporting period (if calendar year, enter 0 on this line) Medicall years of the cost reporting period (if calendar year, enter 0 on this line) SWING END ADUISTIMEN Medicaler rate for swing-bed SNF services applicable to the Program (excluding swing-bed days) Medicaler rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (in experiting period				10 12,01,2010	5/26/2016 9:1	4 am	
PART I - ALL PROVIDER COMPONENTS Impatition DAYS Impati			Title XVIII	Hospi tal	PPS		
PART - ALL PROVIDER CAMPONERS		Cost Center Description					
Inpattent days (Including private room days, and sating-bed days, excluding neaborn) 2,667 2.00 Inpattent days (Including private room days, sociuting saving-bed and neaborn days) 2,667 2.00 Private room days (including private room days, sociuting saving-bed and neaborn days) 0 3.00 3.00 Private room days (excluding saving-bed and observation bed days) 11 you have only private room days. 11 you have only private room days. 12 13 13 13 13 13 13 13					1. 00		
Inpatient days (Including private room days and sking-bed days, excluding newborn) 2,667 2.00 Inpatient days (Including private room days, excluding sking-bed and newborn days) 2,667 2.00 2.0						1	
2,00 Impattent days (including private room days, excluding swing-bed and newborn days) 2,667 2,00 Private room days (soulding swing-bed and observation bed days). In you have only private room days, and only complete this line. 3,00 1,00	4 00				0 //7	1	
1.00 2.00							
on ont complete this I line. Semi-private room days (excluding swing-bed and observation bed days) Total swing-bod SWF type inpatient days (including private room days) after December 31 of the cost reporting period (I follender year, enter 0 on this I ine) Total swing-bod (I follender year, enter 0 on this I ine) Total swing-bod (I follender year, enter 0 on this I ine) Total swing-bod (I follender year, enter 0 on this I ine) Total swing-bod (I follender year, enter 0 on this I ine) Total swing-bod (I follender year, enter 0 on this I ine) Total inal poded NF type Inpatient days (including private room days) after December 31 of the cost reporting period Total singleder NF type Inpatient days (including private room days) after December 31 of the cost reporting period Total inaptient days including private room days after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) Total inaptient days including private room days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calender year, enter 0 on this I ine) December 31 of the cost reporting period (if calender year, enter 0 on this I ine) Through December 31 of the cost reporting period (if calender year, enter 0 on this I ine) Total inarsery days (title V or XIX only) On Medicary lays (title V or XIX only) On Medicary lays (title V or XIX only) On Medicary lays (title V or XIX only) On Medicary days (title V or XIX only) On Medicary period on the cost reporting period (if calender year, enter 0 on this I ine) On Window Company (title V or XIX only) On Window Company				ivato room dave			
8.00 Semi-private room days (excluding swing-bed and observation bed days) 5.00 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period 6.00 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period 7.01 Total swing-bed SMF type inpatient days (including private room days) through December 31 of the cost reporting period (including private room days) private period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including period (including private room days) after December 31 of the cost reporting period (including perio	3.00). If you have only pr	i vate i ooni days,	U	3.00	
total swing-bed SNF type Inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 100 lotal swing-bed NF type Inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 101 lotal swing-bed NF type Inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 102 lotal swing-bed NF type Inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 103 lotal swing-bed NF type Inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 104 lotal swing-bed SNF type Inpatient days applicable to the Program (excluding swing-bed and newborn days) 105 lotal swing-bed SNF type Inpatient days applicable to the swing-bed SNF type Inpatient days applicable to titles V or XIX only (including private room days) 105 lotal swing-bed NF type Inpatient days applicable to titles V or XIX only (including private room days) 106 lotal nursery days (title V or XIX only) 107 lotal nursery days (title V or XIX only) 108 lotal nursery days (title V or XIX only) 109 lotal nursery days (title V or XIX only) 100 lotal nursery days (title V or XIX only) 101 lotal nursery days (title V or XIX only) 102 lotal nursery days (title V or XIX only) 103 lotal nursery days (title V or XIX only) 104 lotal nursery days (title V or XIX only) 105 lotal nursery days (title V or XIX only) 106 lotal general inpatient routine services applicable to services after December 31 of the cost reporting period (lotal days applicable to SNF type services after December 31 of the cost reporting period (line 6 x III only) 109 lotal swing	4.00	·	days)		1. 648	4. 00	
ceporting period Total swing-bed SN type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed SN type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total swing-bed SN type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Total inpatient days spil cable to this line) Total inpatient days spil cable to the Program (excluding swing-bed and newborn days) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Through December 31 of the cost reporting period (see instructions) Total nursery days (title V or XIX only) Total nursery da	5. 00			r 31 of the cost	0	5. 00	
10 foal swing-bed SNF type Inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 11ne) 10 foal swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 11ne) 10 foal swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this 11ne) 11 foal swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) 12 foal SNF type inpatient days applicable to title XVIII only (including private room days) 13 foal SNF type inpatient days applicable to title XVIII only (including private room days) 14 foal SNF type inpatient days applicable to title XVIII only (including private room days) 15 foal SNF type inpatient days applicable to title XVIII only (including private room days) 16 foal SNF type inpatient days applicable to title XVIII only (including private room days) 17 foal Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) 18 foal Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) 19 foal Swing-bed NF type inpatient days applicable to title SV or XIX only (including private room days) 19 foal Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 10 foal foal private room days applicable to the Program (excluding swing-bed days) 10 foal foal private room days applicable to the Program (excluding private room days) 11 foal Swing-bed NF type inpatient days applicable to services through December 31 of the cost reporting period (including private room days) 12 foal Swing-bed NF type inpatient foal to the Program (excluding swing-bed days) 13 foal Swing-bed NF type services applicable to services after December 31 of the cost reporting period (including private room the private promote private promote private promote private p							
7.00 Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost reporting period (if calendar year, enter 0 on this line) related SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) reporting bed SNF type inpatient days applicable to the Program (excluding swing-bed and rotal inpatient days applicable to the Itle XVIII only (including private room days) after becember 31 of the cost reporting period (see instructions) away of the cost reporting period (see instructions) away of the cost reporting period (see instructions) away of the cost reporting period (if calendar year, enter 0 on this line) becember 31 of the cost reporting period (if calendar year, enter 0 on this line) becember 31 of the cost reporting period (if calendar year, enter 0 on this line) away of the cost reporting period (if calendar year, enter 0 on this line) away of the cost reporting period (if calendar year, enter 0 on this line) away of the cost of the c	6.00		days) after December	31 of the cost	0	6.00	
reporting period Total inpatient days including private room days) after December 31 of the cost reporting period (If calendar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and 936 on the patient days including private room days) Swing-bed SWI type inpatient days applicable to title XVIII only (including private room days) Swing-bed SWI type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days) after December 31 of the cost reporting period (including private room days applicable to services after December 31 of the cost (including private room days applicable to SWI type services after December 31 of the cost reporting period (including private room days applicable to SWI type services after December 31 of the cost reporting period (including private room days applicable to S			3 .				
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if cal endar year, enter 0 on this line) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) Total inpatient days including private room days applicable to the Program (excluding private room days) after through December 31 of the cost reporting period (see instructions) Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after brough December 31 of the cost reporting period (see instructions) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after December 31 of the cost reporting period (see instructions) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) After December 31 of the cost reporting period (lift calendar year, enter 0 on this line) After December 31 of the cost reporting period (lift calendar year, enter 0 on this line) Total nursery days (title V or XIX only) Total nursery days (title V or XIX only) New Care yadys (title V or XIX only) New Care yadys (title V or XIX only) New Care rate for swing-bed SWF services applicable to services through December 31 of the cost open control period of the cost applicable to SWF type services after December 31 of the cost reporting period (line open control period open control p	7.00		days) through December	31 of the cost	0	7. 00	
reporting period (if calendar year, enter 0 on this line) 10 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) 10 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) 11 Down of the cost reporting period (see instructions) 12 Down of the cost reporting period (see instructions) 13 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 13 Swing-bed SWF type inpatient days applicable to titles V or XIX only (including private room days) 14 Swing-bed SWF type inpatient days applicable to titles V or XIX only (including private room days) 15 Swing-bed SWF type inpatient days applicable to titles V or XIX only (including private room days) 16 Swing-bed SWF type inpatient days applicable to the totles V or XIX only (including private room days) 17 Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed days) 18 Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed days) 19 Swing-bed SWF type inpatient days applicable to the Program (excluding swing-bed days) 19 Swing-bed SWF type inpatient days applicable to services through December 31 of the cost of reporting period (line Value of Value					_		
10 10 10 10 10 10 10 10	8.00		days) after December 3	1 of the cost	0	8. 00	
newborn days	0.00		th - Dunning (2004) and		027	0.00	
Swing-bed Swi type Inpatient days applicable to title XVIII only (Including private room days) 10.0	9.00		the Program (excluding	swing-bed and	936	9.00	
through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SNP type inpatient days applicable to title XVIII only (including private room days) after becember 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Medically necessary private room days applicable to titles V or XIX only (including private room days) 15.00 Total nursery days (title V or XIX only) 16.00 Nursery days (title V or XIX only) 17.01 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 18.01 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 18.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 18.01 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 18.01 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 3 vine-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 3 vine-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 vine-bed NF	10 00		v (including private r	nom days)	0	10 00	
11.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendary year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 12.01 13.0	10.00			Join days)	O	10.00	
December 31 of the cost reporting period (if calendar year, enter 0 on this line)	11. 00			oom davs) after	0	11. 00	
through December 31 of the cost reporting period 13.0 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 13.0 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 0 14.0 15							
3.3 ob Swing-bed NF type inpatient days applicable to titles V or XIX only (Including private room days) after December 31 of the cost reporting period (if called andar year, enter 0 on this line) Medically necessary private room days applicable to the Program (excluding swing-bed days) 0.14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0.15.00 0	12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	12.00	
A rice December 31 of the cost reporting period (if callendar year, enter 0 on this line)							
Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.0.0 10.00 Nursery days (title V or XIX only) 0 15.00 10.00 Nursery days (title V or XIX only) 10.	13.00				0	13. 00	
15.00 Total nursery days (title V or XIX only) 10.00 Nursery days (title Vor Vix only) 10.00 Nursery (the Cost only) 10.00							
16.00 Nursery days (title V or XIX only)			(excluding swing-bed	days)	-		
SWING BED ADJUSTMENT 10.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (acre rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (acre rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (acre rate for swing-bed NF services applicable to services through December 31 of the cost reporting period (acre rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (acre rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (acre rate for swing-bed NF services after December 31 of the cost reporting period (acre rate for swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line for x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line for x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line for x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line for x line 19) 26.00 Total swing-bed cost (see instructions) 27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line for x line 19) 26.00 Total swing-bed cost (see instructions) 27.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line for x line 19) 28.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 29.00 Private room charges (excluding swing-bed cost (line 21 minus line 26) 29.00 Private room charges (excluding swing-bed charges) 30.00 Swing-private room charges (fine 30 + line 4) 30.00 Swing-private room charges (fine 30 + line 4) 30.00 Swing-private room charges (fine 30 + line 4) 30.00 Average peri diem private room cost differential (lin							
Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period 0.00 17.0	16.00				0	16.00	
reporting period Medicaid rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period reporting re	17 00		through December 31 o	f the cost	0.00	17 00	
Medicare "rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 19.00 Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period 20.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line general inpatient routine service cost (see instructions) 21.00 Total general inpatient of type services after December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 25.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service cost net of swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 29.00 Average per diem private room per diem charge (line 29 + line 3) 30.00 Average per diem private room charge (line 29 + line 3) 30.00 Average per diem private room charge (line 29 + line 3) 30.00 Average per diem private room charge (line 29 + line 3) 30.00 Average per diem private room cost differential (line 3 x line 31) 27 Inus line 36) 28 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 39.00 Program	17.00		thi dagir becember 31 0	i the cost	0.00	17.00	
reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 10.00 Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 11.00 Total general inpatient routine service cost (see instructions) 12.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 12.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 18) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 12.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 12.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 12.00 General inpatient routine service cost net of swing-bed and observation bed charges) 12.00 General inpatient routine service cost/charge ratio (line 27 * line 28) 12.00 Overage perivate room charges (excluding swing-bed charges) 12.00 Overage perivate room per diem charge (line 29 * line 3) 13.00 Average per diem private room charge differential (line 3 x line 31) 13.00 Overage perivate room per diem charge (line 3 x line 35) 13.00 Overage perivate room cost differential (line 3 x line 31) 13.00 Overage perivate room cost differential (line 3 x line 35) 13.00 Overage perivate room cost differential (line 3 x line 35) 13.00 Overage perivate room cost differential (line 3 x line 35) 13.00 Overage perivate room cost differential (line 3 x line 35) 13.00 Overage perivate room cost differential (line 3 x line 35) 13.00 Overage perivate room cost differential (line 3 x line 35) 13.00 Overage p	18. 00		after December 31 of	the cost	0.00	18. 00	
reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period 10tal general inpatient routine service cost (see instructions) 3, 390, 363 21.0 22.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.01 Total swing-bed cost (see instructions) 27.02 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 PRIVATE ROWD IDFERENTIAL ADJUSTMENT 80.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average private room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room charge differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Average per diem private room cost differential (line 3 x line 38) 40.00 Average per diem private room cost differential (line 3 x line 38) 40.00 Average per diem private room cost differential (line 3 x line 38) 40.00 Average per diem private room cost diff							
Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period reporting period 3,390,363 21.00 22.00 5 x line 17) 33.90 36.30 3390,363 21.00 5 x line 17) 23.00 5 x line 18) 3.390,363 21.00 5 x line 18) 3.390,363 21.00 3.39	19.00	Medicaid rate for swing-bed NF services applicable to services	0.00	19.00			
reporting period Total general inpatient routine service cost (see instructions) 3, 390, 363 21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 32.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) Swing-bed cost (see instructions) Total swing-bed cost (see instructions) Swing-bed cost (see instructions) Swing-bed cost (see instructions) Total swing-bed cost (see instructions) Sw							
Total general inpatient routine service cost (see instructions) 3, 390, 363 21. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23. 00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27. 00 28. 00 29. 00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed charges) 30. 00 30. 00 Semi-private room charges (excluding swing-bed charges) 40. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 Average private room per diem charge (line 29 + line 3) 40. 00 Average per diem private room per diem charge (line 29 + line 3) 40. 00 30. 00 30. 00 30. 00 30. 00 30. 00 30. 00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30. 00 30. 00 Average per diem private room cost differential (line 32 minus line 33) 40. 00 Average per diem private room cost differential (line 32 minus line 33) 40. 00 Average per diem private room cost differential (line 32 minus line 33) 50. 00 Average per diem private room cost differential (line 32 minus line 33) 60. 00 Average per diem private room cost differential (line 32 minus line 35) 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60. 00 60.	20. 00		after December 31 of t	he cost	0. 00	20. 00	
Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average perivate room per diem charge (line 30 + line 4) 30.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 32 minus line 33) 30.00 Average per diem private room cost differential (line 32 minus line 33) 30.00 Average per diem private room cost differential (line 32 minus line 33) 30.00 Average per diem private room cost differential (line 32 minus line 33) 30.00 Average per diem private room cost differential (line 32 minus line 33) 30.00 Average per diem private room cost differential (line 32 minus line 35) 30.00 Average per diem private room cost differential (line 32 minus line 35) 30.00 Average per diem private room cost differential (line 32 minus line 35) 30.00 Average per diem private room cost differential (line 32 minus line 35) 30.00 Average per diem private room cost differential (line 32 minus line 35) 30.00 Average per diem private room cost differential (line 32 minus line 35) 30.00 Average per diem private room cost differential (line 32 minus li	21 00	, , , , , , , , , , , , , , , , , , , ,			2 200 2/2	21 00	
5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service cost per diem charges) Ceneral inpatient routine service cost cost charges (excluding swing-bed charges) Ceneral inpatient routine service cost cost charges (excluding swing-bed charges) Ceneral inpatient routine service cost charges (excluding swing-bed charges) Ceneral inpatient routine service cost charge (line 27 + line 28) Comparison of the cost reporting period (line 28) Ceneral inpatient routine service cost (line 21 minus line 26) Private room charges (excluding swing-bed charges) Ceneral inpatient routine service cost (line 27 + line 28) Comparison of the cost reporting period (line 8 of the cost reportin				ing ported (line			
23.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 Private room charges (excluding swing-bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room per diem charge (line 29 + line 3) 30.00 Average private room per diem charge (line 29 + line 3) 30.00 Average per diem private room charge diefferential (line 32 minus line 33) (see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 34 x line 35) 30.00 Seneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 37 minus line 36) 30.00 PRATI II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Medically necessary private room cost spplicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	22.00		31 Of the Cost report	ing perrou (irne	U	22.00	
x line 18) Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) RRI VATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) Average private room per diem charge (line 29 + line 3) Average per diem private room charge differential (line 30 + line 4) Average per diem private room cost differential (line 32 minus line 33) (see instructions) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) Average per diem private room cost differential (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line	23 00		1 of the cost reporting	n period (line 6	0	23. 00	
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19) 25.00 x line 20) 26.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 Semi-private room charges (excluding swing-bed and observation bed charges) 29.00 Semi-private room charges (excluding swing-bed charges) 29.00 General inpatient routine service cost here of swing-bed charges) 29.00 Average private room per diem charge (line 29 ± line 3) 29.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 29.00 Average per diem private room cost differential (line 34 x line 31) 29.00 Average per diem private room cost differential (line 3 x line 35) 29.00 Average per diem private room cost differential (line 3 x line 35) 29.00 Average per diem private room cost differential (line 3 x line 35) 29.00 Average per diem private room cost differential (line 3 x line 35) 29.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Average per diem private room cost differential (line 3 x line 35) 39.00 Aver	20.00		To the cost reporting	g perrou (rrne o	Ü	20.00	
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) Total swing-bed cost (see instructions) 0 26.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3, 390, 363 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 29.00 Average private room per diem charge (line 29 ÷ line 3) 0.00 Average per diem private room per diem charge (line 30 ÷ line 4) 0.00 32.00 Average per diem private room cost differential (line 34 x line 31) 0.00 33.00 Average per diem private room cost differential (line 34 x line 35) 0.00 37.00 Private room cost differential (line 3 x line 35) 0.00 37.00 Private room cost differential (line 3 x line 35) 0 36.00 Average per diem private room cost differential (line 3 x line 35) 0 36.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) 1, 189, 871 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	24.00	l	31 of the cost reporti	ng period (line	0	24.00	
x line 20) Total swing-bed cost (see instructions) Q26.00 Total swing-bed cost (see instructions) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT Q8.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Q9.00 Private room charges (excluding swing-bed charges) Q8.00 Q9.00 Private room charges (excluding swing-bed charges) Q9.00 Q		7 x line 19)	·				
Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 30. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30. 00 Average private room per diem charge (line 29 ÷ line 3) 30. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 30. 00 30. 00 Average per diem private room cost differential (line 34 x line 31) 30. 00 Average per diem private room cost differential (line 34 x line 31) 30. 00 Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) 37. 00 Average per diem private room cost differential (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) 37. 00 Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) 37. 00 Average per diem private room cost differential (line 3 x line 35) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 9 x line 38) Adjusted general inpatient routine service cost (line 9 x line 38)	25.00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00	
Canceral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3,390,363 27.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT Concernal inpatient routine service charges (excluding swing-bed and observation bed charges) 0 28.00 Private room charges (excluding swing-bed charges) 0 29.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 Semi-private room charges (excluding swing-bed charges) 0 30.00 31.00 Occasional development of the concernation of the concer							
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost per diem (see instructions) 1, 271.23 38.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)							
General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷ line 28) Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) The program inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) O and the program inpatient of the program (line 14 x line 35) O and the program inpatient routine service cost (line 9 x line 38) O and the program (line 14 x line 35) O and the program inpatient routine service cost (line 9 x line 38) O and the program (line 14 x line 35) O and the program (line 14 x line 35) O and the program (line 14 x line 35)	27.00		ine 21 minus line 26)		3, 390, 363	27.00	
Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) 27 minus line 36) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 2 9.00 30.	20 00		and observation had sh	argos)	0	20 00	
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) 37.00 PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 30.00 One of the program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			and observation bed Ch	ai yes)			
31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
Average private room per diem charge (line 29 ÷ line 3) 32.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			line 28)				
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) 37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		·	20)			l	
Average per diem private room charge differential (line 32 minus line 33)(see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 34.00	33. 00	, , , , , , , , , , , , , , , , , , , ,					
Average per diem private room cost differential (line 34 x line 31) 35.00 Private room cost differential adjustment (line 3 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 35.00 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 271.23 38.00 1, 189, 871 39.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	34. 00	, , , , , , , , , , , , , , , , , , , ,	s line 33)(see instruc	tions)		1	
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 390, 363 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 Adjusted general inpatient routine service cost per diem (see instructions) 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	35.00			•			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 271. 23 38.00 Program general inpatient routine service cost (line 9 x line 38) 1, 189, 871 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	36.00	Private room cost differential adjustment (line 3 x line 35)			0	36.00	
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 271. 23 38.00 Program general inpatient routine service cost (line 9 x line 38) 1, 189, 871 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37. 00		d private room cost di	fferential (line	3, 390, 363	37. 00	
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1, 271. 23 38. 00 Program general inpatient routine service cost (line 9 x line 38) 1, 189, 871 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00]	
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,271.23 38.03 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,271.23 38.00 1,189,871 39.00 40.00						1	
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,189,871 39.00 0 40.00				Т			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	38. 00	, , , , , , , , , , , , , , , , , , , ,	•				
		, ,	•				
1. 00 10tal 110gram general 11patrent 100tine Service Cost (11ne 37 + 11ne 40)		, , , , , , , , , , , , , , , , , , , ,	•				
	+ 1.00	Trotal Trogram general impatrent routine service cost (Tille 39 +	1116 40)	ı	1, 107, 0/1	1 41.00	

	Financial Systems IU F ATION OF INPATIENT OPERATING COST	HEALTH STARKE MEMO		CCN: 150102	Period: From 01/01/2015 To 12/31/2015	u of Form CMS-2 Worksheet D-1 Date/Time Pre 5/26/2016 9:1	pared:
			Ti +I	e XVIII	Hospi tal	PPS	4 4111
	Cost Center Description	Total	Total	Average Per		Program Cost	
		Inpatient CostInp				(col. 3 x col.	
		· .		col . 2)		4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42.00	NURSERY (title V & XIX only)						42. 00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	(0.0	00	0	
44. 00	CORONARY CARE UNIT						44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46.00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1 00	
48. 00	Program inpatient ancillary service cost (Wk:	rt D 2 col 2 l	ino 200)			1. 00 1, 408, 022	48. 00
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS			ons)		2, 597, 893	
50. 00	Pass through costs applicable to Program inpa	atient routine ser	vices (from	n Wkst. D, sur	n of Parts I and	83, 604	50.00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillary s	servi ces (fi	om Wkst. D, s	sum of Parts II	100, 983	51.00
52.00	Total Program excludable cost (sum of lines!	50 and 51)				184, 587	52. 00
53.00	Total Program inpatient operating cost exclude	ding capital relat	ed, non-phy	ysician anesth	netist, and	2, 413, 306	
	medical education costs (line 49 minus line!	52) '			·		
	TARGET AMOUNT AND LIMIT COMPUTATION						
54.00	Program di scharges					0	
55. 00	Target amount per discharge					0.00	
56. 00	Target amount (line 54 x line 55)					0	
57. 00	Difference between adjusted inpatient operati	ng cost and targe	et amount (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)					0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period end	ling 1996, i	updated and co	ompounded by the	0. 00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year (rost renort undat	ed by the r	market hasket		0.00	60.00
61. 00	If line 53/54 is less than the lower of lines				the amount by	0.00	61. 00
	which operating costs (line 53) are less than						
	amount (line 56), otherwise enter zero (see i		•	, .	3		
62.00	Relief payment (see instructions)					0	62. 00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instructi	ons)			0	63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST			· · · · · · · · · · · · · · · · · · ·			
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decembe	er 31 of the	e cost reporti	ng period (See	0	64. 00
/E 00	instructions)(title XVIII only)	to often December	21 of the	and reporting	noniad (Coo	0	/E 00
65. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	is after becember	31 OF the G	cost reportinț	g perrou (see	U	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line 64	plus line o	55)(title XVII	I only). For	0	66. 00
	CAH (see instructions)				3,		
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through De	ecember 31 d	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after Dece	ember 31 of	the cost repo	ortina period	0	68. 00
	(line 13 x line 20)				5 1.		
69.00	Total title V or XIX swing-bed NF inpatient i	outine costs (lir	ne 67 + line	e 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY, A	ND ICF/IID	ONLY			
70.00	Skilled nursing facility/other nursing facili	•		•			70. 00
71. 00	Adjusted general inpatient routine service co		e 70 ÷ line	2)			71. 00
72.00	Program routine service cost (line 9 x line			0.57			72.00
73.00	Medically necessary private room cost applicated Dragger general innetiant routing applications						73.00
74. 00 75. 00	Total Program general inpatient routine servi	•			Part II column		74. 00 75. 00
75.00	Capital-related cost allocated to inpatient (26, line 45)	outilie service CC	isis (IIUIII V	VOLKSLIEEL D, F	art II, COIUIIIII		/ 5.00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00
78. 00	Inpatient routine service cost (line 74 minus						78. 00
79. 00	Aggregate charges to beneficiaries for excess	•	ider record	ds)			79. 00
80.00	Total Program routine service costs for compa	arison to the cost	: limitation	n (line 78 mir	nus line 79)		80. 00
81. 00	Inpatient routine service cost per diem limi						81. 00
82. 00	Inpatient routine service cost limitation (li	ne 9 x line 81)					82. 00

Health Financial Systems IU H	HEALTH STARKE M	MEMORIAL HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Prep 5/26/2016 9:14	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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	238, 226	3, 390, 363	0. 07026	1, 295, 383	91, 021	90. 00
91.00 Nursing School cost	0	3, 390, 363	0.00000	1, 295, 383	0	91. 00
92.00 Allied health cost	0	3, 390, 363	0.00000	1, 295, 383	0	92. 00
93.00 All other Medical Education	0	3, 390, 363	0. 000000	1, 295, 383	0	93. 00

Health Financial Systems	IU HEALTH STARKE MEMORIAL HOS	ı of Form CMS-2	2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provi	ider CCN: 150102	From 01/01/2015	Worksheet D-1 Date/Time Prep	nared:
				5/26/2016 9: 14	
		Title XIX	Hospi tal	PPS	

		Title XIX	Hospi tal	5/26/2016 9: 1 PPS	4 am		
	Cost Center Description			1. 00			
	PART I - ALL PROVIDER COMPONENTS						
1. 00 2. 00 3. 00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days	2, 667 2, 667 0	1. 00 2. 00 3. 00				
4. 00 5. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed tays) Total swing-bed SNF type inpatient days (including private room	1, 648 0	4. 00 5. 00				
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room	0	6. 00				
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room reporting period	0	7. 00				
8.00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	0	8. 00				
9. 00	Total inpatient days including private room days applicable to newborn days)	289	9. 00				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions)				10. 00		
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)				11. 00		
12. 00 13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)				12. 00 13. 00		
14. 00	after December 31 of the cost reporting period (if calendar yea Medically necessary private room days applicable to the Program	r, enter O on this line	e)	0	14. 00		
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	(exer during swring bod s	ady 3)	0	15. 00 16. 00		
17. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17. 00		
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18. 00		
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost				19. 00		
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period				20. 00		
21. 00 22. 00	Total general inpatient routine service cost (see instructions)				21. 00 22. 00		
23. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	1 of the cost reporting	g period (line 6	0	23. 00		
24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)				24. 00		
25. 00	Swing-bed cost applicable to NF type services after December 31 \times line 20)	of the cost reporting	period (line 8	0	25. 00		
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	ine 21 minus line 26)		3, 390, 363	26. 00 27. 00		
28. 00 29. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	arges)	0	28. 00 29. 00		
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	30. 00 31. 00		
32. 00 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	32. 00 33. 00		
34. 00 35. 00	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line		tions)	0. 00 0. 00	34. 00 35. 00		
36. 00 37. 00	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	0 3, 390, 363	36. 00 37. 00		
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY						
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	1, 271. 23	20.00				
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38)				38. 00 39. 00		
40.00	Medically necessary private room cost applicable to the Program	(line 14 x line 35)		367, 385 0	40. 00		
41.00	00 Total Program general inpatient routine service cost (line 39 + line 40) 367, 385 41						

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Peri od: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Pre 5/26/2016 9:1	pared:	
			Ti 1	ile XIX	Hospi tal	PPS	4 diii	
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost		
		Inpatient Cost	Inpatient Days		÷	(col. 3 x col.		
		1.00	2.00	col . 2)	4.00	4)		
12 00	NURSERY (title V & XIX only)	1.00	2. 00	3. 00	4. 00	5. 00	42.00	
2.00	Intensive Care Type Inpatient Hospital Units		l .				1 42.00	
3. 00	INTENSIVE CARE UNIT	0	(0.0	0	0	43.00	
4. 00	CORONARY CARE UNIT						44.0	
5. 00	BURN INTENSIVE CARE UNIT						45. 0	
6. 00	SURGICAL INTENSIVE CARE UNIT						46. 0	
7.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47. 0	
	cost center bescription					1. 00		
8. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 200)			124, 010	48. 00	
9. 00	Total Program inpatient costs (sum of lines 4		491, 395	49.00				
	PASS THROUGH COST ADJUSTMENTS							
0. 00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and	25, 813	50.0	
1. 00								
. 00	and IV)	atrent anerra	y services (ii	OIII WKSt. D, S	um or rarts rr	8, 811	51.0	
2. 00	Total Program excludable cost (sum of lines 5	34, 624	52. 0					
3. 00	Total Program inpatient operating cost exclud	456, 771	53.00					
	medical education costs (line 49 minus line 5	52)						
4. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.0	
5. 00	Target amount per discharge	0.00	1					
5. 00	Target amount (line 54 x line 55)	0.00						
7. 00	, , , , , , , , , , , , , , , , , , ,							
8. 00	Bonus payment (see instructions)							
9. 00	Lesser of lines 53/54 or 55 from the cost rep	0.00	59. 0					
0. 00	market basket Lesser of lines 53/54 or 55 from prior year of	0.00	60.0					
1. 00	If line 53/54 is less than the lower of lines				the amount by	0.00	61. 0	
	which operating costs (line 53) are less than					_		
	amount (line 56), otherwise enter zero (see i	nstructions)						
2. 00	Relief payment (see instructions)	0						
3. 00	Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST							
4. 00	Medicare swing-bed SNF inpatient routine cost	na period (See	0	64. 0				
00	instructions) (title XVIII only)		0 0					
5. 00	Medicare swing-bed SNF inpatient routine cost	0	65. 0					
, 00	instructions)(title XVIII only)							
6. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (Tine	64 prus rine 6	os)(title XVII	i oniy). For	0	66. 0	
7. 00	Title V or XIX swing-bed NF inpatient routine	e costs through	n December 31 d	of the cost re	porting period	0	67. 0	
	(line 12 x line 19)	3			. 31			
8. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period						68. 0	
0 00	(line 13 x line 20)	anutina anata /	lina (7 . lina	. (0)		_	40.0	
9. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69. 0	
0. 00	Skilled nursing facility/other nursing facili						70.0	
1. 00	Adjusted general inpatient routine service co	•		•			71.0	
2. 00	Program routine service cost (line 9 x line 7	71)					72. 0	
	Medically necessary private room cost applica						73. 0	
4.00	Total Program general inpatient routine servi	•			ont II oolumn		74.0	
5. 00	Capital-related cost allocated to inpatient r 26, line 45)	outine Service	COSIS (IIOM)	voiksiieet B, P	aιτιι, COTUIIIN		75. 0	
5. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76. 0	
7. 00							77. 0	
3. 00	Inpatient routine service cost (line 74 minus line 77)							
9. 00	Aggregate charges to beneficiaries for excess			•			79. C	
0.00	Total Program routine service costs for compa		cost limitation	n (line 78 min	us line 79)		80.0	
1.00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li		1)				81. C	
2. 00 3. 00	Reasonable inpatient routine service cost inmitation (in		· .				83.0	
			·-/			i	, 50.0	

84.00

85. 00

86.00

87.00

1, 019

1, 271. 23 88. 00

85.00

86.00

84.00 Program inpatient ancillary services (see instructions)

Utilization review - physician compensation (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 IU H	HEALTH STARKE M	EMORIAL HOSPITA	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/26/2016 9:1	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	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	238, 226	3, 390, 363	0. 07026	1, 295, 383	91, 021	90. 00
91.00 Nursing School cost	0	3, 390, 363	0.00000	1, 295, 383	0	91.00
92.00 Allied health cost	0	3, 390, 363	0.00000	1, 295, 383	0	92. 00
93.00 All other Medical Education	0	3, 390, 363	0. 00000	1, 295, 383	0	93. 00

	Financial Systems I U HEALTH STARKE MEMORENT ANCILLARY SERVICE COST APPORTIONMENT			Peri od:	u of Form CMS-2 Worksheet D-3	2002-10
INPAII	ENT ANCILLARY SERVICE COST APPORTIONWENT	Provider		From 01/01/2015	WOLKSHEET D-3	
				To 12/31/2015	Date/Time Pre	pared:
					5/26/2016 9:1	4 am
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos	The state of the s	Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1 00	2.00	2)	
	INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2. 00	3. 00	
30. 00	03000 ADULTS & PEDIATRICS			1, 275, 970		30.00
	03100 INTENSIVE CARE UNIT			1, 273, 770		31.00
31.00	ANCI LLARY SERVI CE COST CENTERS					31.00
50. 00	05000 OPERATI NG ROOM		0. 33042	23 373, 490	123, 410	50.00
51. 00	05100 RECOVERY ROOM		0.00000		0	51.00
53. 00	05300 ANESTHESI OLOGY		0. 01622		1, 160	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 47747		98, 206	
57.00	05700 CT SCAN		0. 05856	479, 706	28, 094	57. 00
58.00	05800 MRI		0. 15381	72, 691	11, 181	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON		0.00000	00	0	59. 00
60.00	06000 LABORATORY		0. 17997	78 976, 897	175, 820	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD		0. 26808	30, 061	8, 059	62.00
65.00	06500 RESPI RATORY THERAPY		0. 69191	393, 009	271, 928	65. 00
66.00	06600 PHYSI CAL THERAPY		0. 32912	26 30, 968	10, 192	66. 00
67.00	06700 OCCUPATI ONAL THERAPY		0. 79690	21, 409	17, 061	67. 00
68.00	06800 SPEECH PATHOLOGY		0. 21402	12, 109	2, 592	68. 00
69.00	06900 ELECTROCARDI OLOGY		0. 09537	78 245, 193	23, 386	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		0. 45056	185, 204	83, 446	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 35993	3, 311	1, 192	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 18702	1, 467, 218	274, 405	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 00000	00	0	76. 97
	OUTPATIENT SERVICE COST CENTERS					
	09000 CLI NI C		0.00000		0	90. 00
	09100 EMERGENCY		0. 26247		176, 546	
02 NN	DOCOD ORSEDVATION PERS (NON DISTINCT		0 50770	100 577	101 244	02 00

0. 262474 0. 507794

199, 577

5, 440, 630

5, 440, 630

1, 408, 022 200. 00

92.00

201. 00 202. 00

101, 344

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT

200.00

201. 00 202. 00

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

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/26/2016 9:1	
		Tit	le XIX	Hospi tal	PPS	1 aiii
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			109, 280	l	30.00
31. 00	03100 INTENSIVE CARE UNIT			0		31.00
	ANCILLARY SERVICE COST CENTERS				1	4
50.00	05000 OPERATING ROOM		0. 33042			
51.00	05100 RECOVERY ROOM		0.00000		0	
53.00	05300 ANESTHESI OLOGY		0. 01622		l e	
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 47747			
57.00	05700 CT SCAN		0. 05856			
58. 00	05800 MRI		0. 15381		l	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0.00000		0	
60.00	06000 LABORATORY		0. 17997			
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD		0. 26808		•	
65. 00	06500 RESPI RATORY THERAPY		0. 69191		21, 270	
66.00	06600 PHYSI CAL THERAPY		0. 32912		474	
67.00	06700 OCCUPATI ONAL THERAPY		0. 79690		261	
68.00	06800 SPEECH PATHOLOGY		0. 21402			
69. 00	06900 ELECTROCARDI OLOGY		0. 09537		1, 153	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT		0. 45056		4, 245	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 35993	· ·		
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 18702	· ·	1	1
76. 97	07697 CARDI AC REHABI LI TATI ON		0.00000	0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS		0.0000	20		00.00
	09000 CLINIC		0.00000		0	
	09100 EMERGENCY		0. 26247			91.00

0. 262474 0. 507794

42, 976 33, 544

469, 858

469, 858

11, 280 91. 00 17, 033 92. 00

124, 010 200. 00 201. 00 202. 00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT

200.00

201. 00 202. 00

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

	ancial Systems I U HEALTH STARKE MEMORI N OF REIMBURSEMENT SETTLEMENT				u of Form CMS-	<u>2552-10</u>
CALCULATIO	IN OF REIMBURSEMENT SETTLEMENT	Provi der		Peri od: From 01/01/2015 To 12/31/2015		epared:
		Ti tl	e XVIII	Hospi tal	5/26/2016 9: 1 PPS	<u>4 am</u>
				1.00	2.00	
PAR	T A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	1. 00	2. 00	
1.00 DRG	Amounts Other than Outlier Payments			0		1.00
	amounts other than outlier payments for discharges occurrinç October 1 (see instructions)	g prior		1, 474, 688		1. 01
1.02 DRG	amounts other than outlier payments for discharges occurring	g on or		258, 920		1. 02
	er October 1 (see instructions) for federal specific operating payment for Model 4 BPCI for			0		1. 03
di se	charges occurring prior to October 1 (see instructions)					
	for federal specific operating payment for Model 4 BPCl for charges occurring on or after October 1 (see instructions)			0		1. 04
2. 00 Out	lier payments for discharges. (see instructions)			16, 725		2. 00
1	lier reconciliation amount lier payment for discharges for Model 4 BPCI (see instruction	ne)		0		2. 01 2. 02
	aged Care Simulated Payments	13)		206, 519		3. 00
	days available divided by number of days in the cost reporti	ng		47. 21		4. 00
	iod (see instructions) rect Medical Education Adjustment					
	count for allopathic and osteopathic programs for the most r			0.00		5. 00
1	t reporting period ending on or before 12/31/1996. (see instruction for allopathic and osteopathic programs which meet the	,		0.00		6. 00
	teria for an add-on to the cap for new programs in accordance	e with 42				
	413.79(e) Section 422 reduction amount to the IME cap as specified und	der 42		0.00		7. 00
CFR	§412. 105(f)(1)(i v)(B)(1)					
CFR	Section 5503 reduction amount to the IME cap as specified ur $\S412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July			0.00		7. 01
1	n see instructions. ustment (increase or decrease) to the FTE count for allopathi	c and		0.00		8. 00
	eopathic programs for affiliated programs in accordance with					
	.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 gust 1, 2002).	FR 50069				
8. 01 The	amount of increase if the hospital was awarded FTE cap slots			0.00		8. 01
	tion 5503 of the ACA. If the cost report straddles July 1, 200 tructions.	011, see				
8. 02 The	amount of increase if the hospital was awarded FTE cap slots			0.00		8. 02
	sed teaching hospital under section 5506 of ACA. (see instruction of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9. 00
and	8,02) (see instructions)	•				
	count for allopathic and osteopathic programs in the current m your records	t year		0.00		10.00
11. 00 FTE	count for residents in dental and podiatric programs.			0.00		11.00
	rent year allowable FTE (see instructions) al allowable FTE count for the prior year.			0. 00 0. 00		12. 00 13. 00
14. 00 Tota	al allowable FTE count for the penultimate year if that year	ended on		0.00		14. 00
4	after September 30, 1997, otherwise enter zero. of Lines 12 through 14 divided by 3.			0.00		15. 00
	ustment for residents in initial years of the program			0.00		16. 00
-	ustment for residents displaced by program or hospital closur	re		0.00		17. 00
-	usted rolling average FTE count rent year resident to bed ratio (line 18 divided by line 4).			0. 00 0. 000000		18. 00 19. 00
20.00 Pri	or year resident to bed ratio (see instructions)			0. 000000		20.00
1	er the lesser of lines 19 or 20 (see instructions) payment adjustment (see instructions)			0. 000000		21. 00 22. 00
	payment adjustment - Managed Care (see instructions)			0		22. 00
	rect Medical Education Adjustment for the Add-on for Section		he MMA	0.00]
	ber of additional allopathic and osteopathic IME FTE resident ts under 42 Sec. 412.105 (f)(1)(iv)(C).	t cap		0.00		23. 00
24. 00 I ME	FTE Resident Count Over Cap (see instructions)			0.00		24. 00
	the amount on line 24 is greater than -O-, then enter the low e 23 or line 24 (see instructions)	wer of		0.00		25. 00
26. 00 Resi	ident to bed ratio (divide line 25 by line 4)			0. 000000		26. 00
	payments adjustment factor. (see instructions) add-on adjustment amount (see instructions)			0. 000000		27. 00 28. 00
	add-on adjustment amount (see First detrois) add-on adjustment amount - Managed Care (see instructions)			0		28. 01
29. 00 Tota	al IME payment (sum of lines 22 and 28)			0		29. 00
	al IME payment - Managed Care (sum of lines 22.01 and 28.01) proportionate Share Adjustment			0		29. 01
30.00 Per	centage of SSI recipient patient days to Medicare Part A pati	ent days		8. 01		30. 00
1 1	e instructions) centage of Medicaid patient days (see instructions)			17. 46		31.00
	of lines 30 and 31			25. 47		32.00
33. 00 AII	owable disproportionate share percentage (see instructions)			10. 23		33.00
	proportionate share adjustment (see instructions)			44, 337		34.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150102	Peri od: From 01/01/2015 To 12/31/2015		
		T: +1 - 20/111		5/26/2016 9:1	
		Title XVIII	Hospi tal Pri or to	PPS On/After	
			October 1	October 1	
		0	1. 00	2. 00	
	Uncompensated Care Adjustment				
35. 00	Total uncompensated care amount (see instructions)			6, 406, 145, 534	
35. 01 35. 02	Factor 3 (see instructions)		0. 000009812	0. 000011127 71, 284	
33. 02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		75, 041	/1, 204	35.02
35. 03	Pro rata share of the hospital uncompensated care payment		56, 127	17, 918	35. 03
	amount (see instructions)				
36. 00	Total uncompensated care (sum of columns 1 and 2 on line		74, 045		36.00
	35.03) Additional payment for high percentage of ESRD beneficiary d	ischarges (lines 40 throug	ıb 16)		-
40. 00	Total Medicare discharges on Worksheet S-3, Part I	racharges (Triles 40 till oug	0		40.00
	excluding discharges for MS-DRGs 652, 682, 683, 684 and				
	685 (see instructions)				
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41.00
41. 01	682, 683, 684 an 685. (see instructions) Total ESRD Medicare covered and paid discharges excluding				41. 01
41.01	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				41.01
42. 00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
	qualify for adjustment)				
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
44. 00	682, 683, 684 an 685. (see instructions) Ratio of average length of stay to one week (line 43		0. 000000		44.00
44.00	divided by line 41 divided by 7 days)		0.000000		44.00
45. 00	Average weekly cost for dialysis treatments (see		0.00		45.00
	instructions)				
46. 00	Total additional payment (line 45 times line 44 times line		0		46.00
47. 00	41.01) Subtotal (see instructions)		1, 868, 715		47.00
48. 00	Hospital specific payments (to be completed by SCH and		1, 663, 907		48. 00
.0. 00	MDH, small rural hospitals only. (see instructions)		1,000,707		10.00
49. 00	Total payment for inpatient operating costs (see		1, 868, 715		49.00
	instructions)		100.074		
50. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		139, 064		50.00
51. 00	Exception payment for inpatient program capital (Wkst. L,		0		51.00
	Pt. III, see instructions)				
52. 00	Direct graduate medical education payment (from Wkst. E-4,		0		52.00
E2 00	line 49 see instructions).				F2 00
53. 00 54. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies		0		53. 00 54. 00
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		ő		55. 00
	line 69)				
56. 00	Cost of physicians' services in a teaching hospital (see		0		56. 00
57. 00	intructions) Routine service other pass through costs (from Wkst. D,		0		57.00
37.00	Pt. III, column 9, lines 30 through 35).		0		37.00
58. 00	Ancillary service other pass through costs from Wkst. D,		0		58.00
	Pt. IV, col. 11 line 200)				
59. 00	Total (sum of amounts on lines 49 through 58)		2, 007, 779		59.00
60. 00 61. 00	Primary payer payments Total amount payable for program beneficiaries (line 59		0 2, 007, 779		60.00
01.00	minus line 60)		2,007,779		01.00
62. 00	Deductibles billed to program beneficiaries		268, 160		62.00
63. 00	Coinsurance billed to program beneficiaries		2, 835		63. 00
64.00	Allowable bad debts (see instructions)		15, 593		64.00
65.00	Adjusted reimbursable bad debts (see instructions)		10, 135		65.00
66. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)		15, 593		66.00
67. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		1, 746, 919		67. 00
68. 00	Credits received from manufacturers for replaced devices		0		68.00
	for applicable to MS-DRGs (see instructions)				
69. 00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69.00
70. 00	96).(For SCH see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				70.00
70. 50	RURAL DEMONSTRATION PROJECT				70. 50
70. 89	Pioneer ACO demonstration payment adjustment amount (see		0		70. 89
	instructions)				
70. 90	HSP bonus payment HVBP adjustment amount (see		0		70. 90
70. 91	instructions) HSP bonus payment HRR adjustment amount (see instructions)				70. 91
70. 9 1 70. 92	Bundled Model 1 discount amount (see instructions)				70. 91
70. 93	HVBP payment adjustment amount (see instructions)		2, 819		70. 93
70. 94	HRR adjustment amount (see instructions)		-8, 111		70. 94
70. 95	Recovery of accelerated depreciation				70. 95

Health Financial Systems	IU HEALTH STARKE MEMORIAL HOSPITAL	In Lieu of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150102 Per	iod: Worksheet E

CALCULATION OF REIMBURSEMENT SETTLEMENT		Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/26/2016 9:1	
	Title XVIII	Hospi tal	PPS	
		Prior to	On/After	
		October 1	October 1	
	0	1. 00	2. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy)	201	360, 508		70. 96
(Enter in column 0 the corresponding federal year for the				
period prior to 10/1)				
70.97 Low volume adjustment for federal fiscal year (yyyy)	201	66, 039		70. 97
(Enter in column 0 the corresponding federal year for the				
period ending on or after 10/1)				
70.98 Low Volume Payment-3		0		70. 98
70.99 HAC adjustment amount (see instructions)		0		70. 99
71.00 Amount due provider (line 67 minus lines 68 plus/minus		2, 168, 174		71. 00
lines 69 & 70)				
71.01 Sequestration adjustment (see instructions)		43, 363		71. 01
72.00 Interim payments		2, 126, 791		72.00
73.00 Tentative settlement (for contractor use only)		0		73.00
74.00 Balance due provider (Program) (line 71 minus lines 71.01,		-1, 980		74. 00
72, and 73)				
75.00 Protested amounts (nonallowable cost report items) in		3, 737		75. 00
accordance with 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 (see		0		90.00
instructions)				
91.00 Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92.00 Operating outlier reconciliation adjustment amount (see		0		92.00
instructions)				
93.00 Capital outlier reconciliation adjustment amount (see		0		93. 00
instructions)				
94.00 The rate used to calculate the time value of money (see		0.00		94. 00
instructions)				
95.00 Time value of money for operating expenses (see		0		95. 00
instructions)				
96.00 Time value of money for capital related expenses (see		0		96. 00
instructions)				
		Prior to 10/1		
		1. 00	2. 00	
HSP Bonus Payment Amount				1
100.00 HSP bonus amount (see instructions)		0	0	100. 00
HVBP Adjustment for HSP Bonus Payment				1
101.00 HVBP adjustment factor (see instructions)		1. 0009643990		
102.00 HVBP adjustment amount for HSP bonus payment (see instructi	ons)	0	0	102. 00
HRR Adjustment for HSP Bonus Payment				1
103.00 HRR adjustment factor (see instructions)		0. 9945		103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instruction	ns)	0	0	104. 00

Health Financial Systems	IU HEALTH STARKE MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150102	From 01/01/2015	Worksheet E Part B Date/Time Prepared: 5/26/2016 9:14 am

			To 12/31/2015	Date/Time Pre 5/26/2016 9:1	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
1.00	Medical and other services (see instructions)			9, 462	1. 00
2.00	Medical and other services reimbursed under OPPS (see instructions)	ons)		4, 703, 619	2.00
3. 00 4. 00	PPS payments Outlier payment (see instructions)			2, 953, 453 74, 666	3. 00 4. 00
5. 00	Enter the hospital specific payment to cost ratio (see instruct	ions)		0.000	•
6. 00	Line 2 times line 5	. 6.16)		0.000	6. 00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	9.00
10. 00 11. 00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 9, 462	10. 00 11. 00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			7, 402	11.00
	Reasonabl e charges				
	Ancillary service charges			50, 595	
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			50, 595	14. 00
15. 00	Aggregate amount actually collected from patients liable for pa	vment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	16. 00
	had such payment been made in accordance with 42 CFR §413.13(e)				
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	1
18.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only	if line 10 eyecode li	no 11) (coo	50, 595	1
19. 00	instructions)	II TITTE 18 exceeds II	ne II) (see	41, 133	19.00
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
21 00	instructions)			0.4/2	21 00
21. 00 22. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see Interns and residents (see instructions)	Instructions)		9, 462	21. 00 22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	,		3, 028, 119	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance (for CAH, see instructions)	CALL !+!)		0	25. 00
26. 00 27. 00	Deductibles and Coinsurance relating to amount on line 24 (for Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl		and 231 (see	686, 990 2, 350, 591	1
27.00	instructions)	us the sum of filles 22	and 25] (See	2, 330, 371	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			2, 350, 591	30.00
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			103 2, 350, 488	1
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE:	5)		2, 330, 400	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34.00	Allowable bad debts (see instructions)			133, 330	1
35. 00	Adjusted reimbursable bad debts (see instructions)			86, 665	1
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		133, 330	1
37. 00	Subtotal (see instructions)			2, 437, 153	
	MSP-LCC reconciliation amount from PS&R			0	
39. 00 39. 50	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) Pioneer ACO demonstration payment adjustment (see instructions)			0	•
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION	a devices (see instruc	(1013)	0	39. 99
40. 00	Subtotal (see instructions)			2, 437, 153	1
40. 01	· · · · · · · · · · · · · · · · · · ·				40. 01
41.00					1
42.00	Tentative settlement (for contractors use only)	2, 297, 909 0	42. 00		
43. 00					43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordanc §115.2	e with CMS Pub. 15-2,	chapter 1,	528	44. 00
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)			0	90. 00
	Outlier reconciliation adjustment amount (see instructions)			0	•
92. 00	The rate used to calculate the Time Value of Money				92.00
	Time Value of Money (see instructions)			0	•
94. UU	Total (sum of lines 91 and 93)		١	0	94. 00

March Marc				t Part A	Par	rt B	
1.00			Tripatrici	t Tart A	1 (1)		
1.00			mm/dd/vvvv	Amount	mm/dd/vvvv	Amount	
1.00							
Interim payments payable on individual bills, either	1.00	Total interim payments paid to provider		2, 126, 791		2, 297, 909	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 1.5 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	2.00			0			2.00
write "NONE" or enter a zero NOL List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER O							
write "NONE" or enter a zero NOL List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER O		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)							
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	3.00	List separately each retroactive lump sum adjustment					3.00
Dayment, If none, write "NONE" or enter a zero. (1) Program to Provider		amount based on subsequent revision of the interim rate					
Program to Provider							
ADJUSTMENTS TO PROVIDER							
3.02 3.03 3.03 3.04 3.05 Provider to Program 3.50 3.50 3.51 3.52 3.53 3.53 3.54 3.59 3.50 3.59 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.00 TENTATIVE TO PROGRAM 0 0 0 3.55 5.02 0 0 0 0 5.05 5.03 Provider to Program 1 TENTATIVE TO PROGRAM 0 0 0 5.55 5.51 5.52 0 0 0 0 5.55 5.55 9 Subtotal (sum of lines 2.01-5.49 minus sum of lines 3.09) Provider to Program 1 TENTATIVE TO PROGRAM 0 0 0 5.55 5.51 5.52 0 0 0 0 0 5.55 5.55 5.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.55-5.99) Determined net settlement amount (balance due) based on the cost report. (1) SETILEMENT TO PROGRAM 1, 980 2, 28, 38, 410 7, 00 Total Medicare program liability (see instructions) 0 1.00 2, 200 NPR Date (Mc/Day/YYr)							
3.03 3.04 3.05 Provider to Program 3.50 3.51 3.51 3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wist. E or Wist. E-3, line and column as appropriate) 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NoNE" or enter a zero. (1) Program to Provider 5.01 Program to Provider 5.02 Description of the settlement amount (balance due) based on the cost report. (1) 5.01 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.55-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 5.01 Total interim payment into provider 1,980	3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.05	3.02			0		0	3. 02
3.05	3.03			0		0	3. 03
Provider to Program	3.04			0		0	3.04
ADJUSTMENTS TO PROGRAM	3.05			0		0	3. 05
3.51 3.52 3.53 0 0 3.55 3.53 0 0 0 3.55 3.54 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3.59 3.50 3		Provider to Program					
3.52 3.53 3.53 3.50 3.60 3.60 3.50	3.50	ADJUSTMENTS TO PROGRAM		0		0	3. 50
3.53 3.54 0 0 0 0 3.50 3.50 3.50 3.50 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 2.126,791 2.297,909 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2.126,791 2.297,909 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2.126,791 2.297,909 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2.126,791 2.297,909 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2.126,791 2.297,909 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2.126,791 2.297,909 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2.126,791 2.297,909 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2.126,791 2.297,909 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2.126,791 2.297,909 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2.126,791 2.297,909 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2.126,791 2.297,909 4.00 5	3.51			0		l ol	3. 51
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) Contractor Normal	3.52			0		o	3. 52
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) 2,126,791 2,297,909 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,126,791 2,297,909 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,126,791 2,297,909 4.00	3.53			0		l ol	3. 53
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) 2,126,791 2,297,909 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,126,791 2,297,909 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 2,126,791 2,297,909 4.00	3.54			0		l ol	3. 54
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		Subtotal (sum of lines 3.01-3.49 minus sum of lines					3. 99
A. 00 Total interim payments (sum of lines 1, 2, and 3.99) 2, 126, 791 2, 297, 909 4. 00							
Ctransfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4.00			2, 126, 791		2, 297, 909	4. 00
appropriate TO BE COMPLETED BY CONTRACTOR							
TO BE COMPLETED BY CONTRACTOR 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							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
Write "NONE" or enter a zero. (1) Program to Provider S. 01 TENTATIVE TO PROVIDER O	5.00	List separately each tentative settlement payment after					5.00
Program to Provider		desk review. Also show date of each payment. If none,					
TENTATIVE TO PROVIDER		write "NONE" or enter a zero. (1)					
5. 02 0 0 0 5. 02		Program to Provider					
5. 03 Provider to Program 5. 50 TENTATIVE TO PROGRAM 0 0 5. 50 5. 51 0 0 0 5. 50 5. 52 0 0 0 5. 50 5. 52 5. 52 0 0 0 5. 50 5. 59 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 0 0 5. 50 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 0 90, 501 6. 00 6. 01 SETTLEMENT TO PROGRAM 1, 980 0 6. 00 7. 00 Total Medicare program liability (see instructions) 2, 124, 811 2, 388, 410 7. 00 Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00	5.01	TENTATI VE TO PROVI DER		0		0	5. 01
Provider to Program	5.02			0		0	5. 02
5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 5.52 0 0 0 5.55 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 5.55 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 0 90,501 6.01 SETTLEMENT TO PROGRAM 1,980 0 6.02 7.00 Total Medicare program liability (see instructions) 2,124,811 2,388,410 7.00	5.03			0		0	5. 03
5.51 0		Provider to Program					
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 NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	5.50	TENTATI VE TO PROGRAM		0		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 0 90,501 6.07 6.02 SETTLEMENT TO PROGRAM 1,980 0 6.02 7.00 Total Medicare program liability (see instructions) 2,124,811 2,388,410 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 51			0		0	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	5.52			0		l ol	5. 52
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	5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		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		5. 50-5. 98)					
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	Determined net settlement amount (balance due) based on					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) 0 1.00 2.00							
7.00 Total Medicare program liability (see instructions) 2,124,811 2,388,410 7.00 Contractor Number (Mo/Day/Yr) 0 1.00 2.00	6.01			0		90, 501	6. 01
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	6.02	SETTLEMENT TO PROGRAM		1, 980		l	6. 02
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	7.00	Total Medicare program liability (see instructions)		2, 124, 811		2, 388, 410	7. 00
0 1.00 2.00					Contractor		
0 1.00 2.00					Number	(Mo/Day/Yr)	
8.00 Name of Contractor			()	1. 00	2. 00	
	8.00	Name of Contractor					8. 00

Health Financial Systems IU HEALTH ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED In Lieu of Form CMS-2552-10

		Component	CCN. 150102	10 12/31/2013	5/26/2016 9: 14	
		Ti tl	e XVIII	Swing Beds - SNF		
		Inpatier	it Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
1.00	T	1. 00	2.00	3. 00	4. 00	
1. 00 2. 00	Total interim payments paid to provider Interim payments payable on individual bills, either			0	0	1. 00 2. 00
2.00	submitted or to be submitted to the contractor for			U	ا	2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3. 02				0	0	3. 02
3. 03 3. 04				0		3. 03 3. 04
3.04				0		3. 04
3.03	Provider to Program			<u> </u>	0	3. 03
3. 50	ADJUSTMENTS TO PROGRAM			0	0	3. 50
3. 51				o	0	3. 51
3.52				0	0	3. 52
3.53				0	0	3.53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4 00	3. 50-3. 98)					4 00
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as			0	0	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR		l			
5. 00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVIDER			0	0	5. 01
5. 02				0	0	5. 02
5.03				0	0	5. 03
E F0	Provider to Program TENTATIVE TO PROGRAM				1 0	E E0
5. 50 5. 51	TENTATIVE TO PROGRAM			0		5. 50 5. 51
5. 51				0		5. 51
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0		5. 99
0. , ,	5. 50-5. 98)					0. ,,
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6.02	SETTLEMENT TO PROGRAM			0	0	6. 02
7. 00	Total Medicare program liability (see instructions)			0	0	7. 00
				Contractor	NPR Date	
)	Number 1.00	(Mo/Day/Yr) 2.00	
8. 00	Name of Contractor		9	1.00	2.00	8. 00
	1			1	' '	2. 20

Heal th	Financial Systems IU HEALTH STARKE MEMOI	RLAL HOSPLTAL	In lie	u of Form CMS-2	2552-10		
CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 150102 Period: From 01/01/2015 To 12/31/2015 For 12/31/2015 From 01/01/2015 From 12/31/2015 From					pared:		
		Title XVIII	Hospi tal	PPS			
				1. 00			
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS						
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION						
1.00	00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14						
2.00	2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12						
3.00	3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2						
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12							
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			79, 879, 504	5.00		
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 li	ne 20		2, 176, 876	6.00		
7.00	CAH only - The reasonable cost incurred for the purchase of ce	rtified HIT technology	Wkst. S-2, Pt. I	0	7.00		
	line 168						
8.00	Calculation of the HIT incentive payment (see instructions)			326, 550	8. 00		
9.00	Sequestration adjustment amount (see instructions)			6, 531	9.00		
10.00	Calculation of the HIT incentive payment after sequestration (see instructions)		320, 019	10.00		
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH						
30.00	Initial/interim HIT payment adjustment (see instructions)			379, 015	30.00		
31.00	Other Adjustment (specify)			0	31.00		
32 00	00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) -58 996						

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

-58, 996 32. 00

Health Financial Systems	IU HEALTH STARKE MEMORI	I AL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN: 150102	Peri od: From 01/01/2015	Worksheet E-2
		Component CCN: 15U102		

		1	5/26/2016 9:1	4 aiii
	Title XVIII	Swing Beds - SNF	PPS	
		Part A	Part B	
		1. 00	2. 00	
COMPUTATION OF NET COST OF COVERED SERVICES				
Inpatient routine services - swing bed-SNF (see instructions))	0	0	1.00
Inpatient routine services - swing bed-NF (see instructions)				2.00
Ancillary services (from Wkst. D-3, col. 3, line 200, for Pai	rt A, and sum of Wkst. D,			3.00
Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see in	nstructions)			
Per diem cost for interns and residents not in approved teach	hing program (see		0.00	4. 00
instructions)				
Program days		O	0	5. 00
Interns and residents not in approved teaching program (see i	instructions)		0	6. 00
Utilization review - physician compensation - SNF optional me	ethod only	0		7. 00
Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		O	0	8. 00
Primary payer payments (see instructions)		0	0	9. 00
Subtotal (line 8 minus line 9)		0	0	10.00
Deductibles billed to program patients (exclude amounts appli	icable to physician	0	0	11.00
professional services)				
Subtotal (line 10 minus line 11)		0	0	12.00
Coinsurance billed to program patients (from provider records	s) (exclude coinsurance	0	0	13.00
for physician professional services)				
80% of Part B costs (line 12 x 80%)			0	14. 00
Subtotal (enter the lesser of line 12 minus line 13, or line	14)	0	0	15. 00
OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
Pioneer ACO demonstration payment adjustment (see instruction	ns)	O	0	16. 50
410A RURAL DEMONSTRATION PROJECT		0		16. 55
Allowable bad debts (see instructions)		0	0	17.00
Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
Allowable bad debts for dual eligible beneficiaries (see ins	tructions)	0	0	18.00
Total (see instructions)		o	0	19.00
Sequestration adjustment (see instructions)		0	0	19. 01
Interim payments		0	0	20.00
Tentative settlement (for contractor use only)		0	0	21.00
Balance due provider/program (line 19 minus lines 19.01, 20,	and 21)	O	0	22. 00
Protested amounts (nonallowable cost report items) in accorda	ance with CMS Pub. 15-2,	O	0	23. 00
chapter 1, §115.2				

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

Provi der CCN: 150102

Peri od: Worksheet G From 01/01/2015 To 12/31/2015 Date/Time Prepared:

			'	0 12/31/2013	5/26/2016 9:1	
	· · · · · · · · · · · · · · · · · · ·	General Fund	Speci fi c	Endowment Fund		
			Purpose Fund			
	CURRENT ACCETC	1. 00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	3, 897, 973		ا	0	1.00
2. 00	Temporary investments	3,077,773		0	0	2.00
3. 00	Notes receivable			_	0	3. 00
4. 00	Accounts receivable	14, 175, 885	1	o	0	4. 00
5.00	Other recei vable	415, 278		0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	-10, 488, 677	d	О	0	6. 00
7.00	Inventory	343, 397	C	0	0	7. 00
8.00	Prepai d expenses	138, 928	C	0	0	8. 00
9.00	Other current assets	0	O C	0	0	9. 00
10. 00	Due from other funds	0	O C		0	10.00
11. 00	Total current assets (sum of lines 1-10)	8, 482, 784	C	0	0	11. 00
40.00	FI XED ASSETS	440.700				40.00
12. 00	Land	142, 789	1	_	0	12.00
13. 00 14. 00	Land improvements Accumulated depreciation	37, 448 -4, 127	1	_	0	13. 00 14. 00
15. 00	Buildings	6, 649, 386	1	0	0	15.00
16. 00	Accumulated depreciation	-3, 104, 631	1	0	0	16.00
17. 00	Leasehold improvements	0, 101, 001	i c	Ö	0	17. 00
18. 00	Accumulated depreciation	l o	o d	o	0	18. 00
19.00	Fi xed equipment	O	d	O	0	19.00
20.00	Accumulated depreciation	0	o c	o	0	20. 00
21.00	Automobiles and trucks	0	o c	O	0	21. 00
22. 00	Accumul ated depreciation	0	C	0	0	22. 00
23. 00	Major movable equipment	9, 752, 977	l .	0	0	23. 00
24. 00	Accumulated depreciation	-6, 904, 127	i	0	0	24. 00
25. 00	Minor equipment depreciable	0	C		0	25. 00
26. 00	Accumulated depreciation	0	0	_	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00 29. 00	Accumulated depreciation Minor equipment-nondepreciable			0	0	28. 00 29. 00
30. 00	Total fixed assets (sum of lines 12-29)	6, 569, 715	1		0	30.00
30.00	OTHER ASSETS	0,307,713	1	9		30.00
31. 00	Investments	0	C	ol	0	31.00
32.00	Deposits on Leases	0	d	0	0	32.00
33.00	Due from owners/officers	0	o c	0	0	33. 00
34.00	Other assets	788, 066	C	0	0	34. 00
35.00	Total other assets (sum of lines 31-34)	788, 066	o c	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	15, 840, 565	C	0	0	36. 00
	CURRENT LIABILITIES	1	1	1		
37. 00	Accounts payable	705, 933	1	0	0	37. 00
38. 00	Salaries, wages, and fees payable	473, 491	C	0	0	38. 00
39. 00	Payroll taxes payable	0	C	0	0	39.00
40. 00 41. 00	Notes and Loans payable (short term) Deferred income	23, 143		0	0	40.00
41.00	Accel erated payments	0		U U	U	41. 00 42. 00
43. 00	Due to other funds		1	0	0	43.00
44. 00	Other current liabilities	65, 959	i c	0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	1, 268, 526				
= =	LONG TERM LIABILITIES	,				1
46.00	Mortgage payable	0	C	0	0	46. 00
47.00	Notes payable	0	o c	O	0	47. 00
48.00	Unsecured Loans	0	C	0	0	48. 00
49.00	Other long term liabilities	24, 579	C	0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	24, 579		0	0	50.00
51. 00	Total liabilites (sum of lines 45 and 50)	1, 293, 105	C	0	0	51.00
	CAPITAL ACCOUNTS		1			
52. 00	General fund balance	14, 547, 460				52.00
53. 00	Specific purpose fund		C			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00 56. 00	Donor created - endowment fund balance - unrestricted Governing body created - endowment fund balance			0		55. 00 56. 00
57. 00	Plant fund balance - invested in plant			٥	0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
55. 55	replacement, and expansion				O	55. 55
59. 00	Total fund balances (sum of lines 52 thru 58)	14, 547, 460	C	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	15, 840, 565	i	o	0	60.00
	59)					

STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 150102 Peri od: Worksheet G-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/26/2016 9:14 am General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 8, 502, 910 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 6,044,550 2.00 3.00 Total (sum of line 1 and line 2) 14, 547, 460 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 14, 547, 460 11.00 0 11.00 12.00 Deductions (debit adjustments) (specify) 0 12.00 00000 13.00 13.00 14.00 14.00 0 15.00 0 15.00 16.00 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 14, 547, 460 19.00 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 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 0 11.00 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 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 18.00 0 0 0 19.00 Fund balance at end of period per balance 19.00

sheet (line 11 minus line 18)

| Peri od: | Worksheet G-2 | From 01/01/2015 | Parts | & II | To 12/31/2015 | Date/Time Prepared: Health Financial Systems 1 U HEAT STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150102

			То		Date/Time Prep 5/26/2016 9:14	
	Cost Center Description	Inpatier	t	Outpati ent	Total	T GIII
		1. 00		2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	5, 440	722		5, 440, 722	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF		0		o	5.00
6.00	Swing bed - NF		0		o	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9.00
10.00	Total general inpatient care services (sum of lines 1-9)	5, 440	722		5, 440, 722	10.00
	Intensive Care Type Inpatient Hospital Services	·				
11.00	INTENSIVE CARE UNIT		0		0	11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of I	ines	0		o	16.00
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	5, 440	722		5, 440, 722	17.00
18. 00	Ancillary services	7, 960	838	53, 236, 758	61, 197, 596	18.00
19. 00	Outpati ent servi ces	1, 219	885	17, 671, 243	18, 891, 128	19.00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21.00	FEDERALLY QUALIFIED HEALTH CENTER		0	o	o	21.00
22. 00	HOME HEALTH AGENCY					22.00
23.00	AMBULANCE SERVICES					23.00
24.00	CMHC					24.00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPI CE					26.00
27. 00	OTHER NONREI MBURSABLE		128	26, 804	26, 932	27.00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	o Wkst. 14,621	573	70, 934, 805	85, 556, 378	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			19, 750, 720		29.00
30.00	ADD (SPECIFY)		0			30.00
31. 00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37.00	DEDUCT (SPECIFY)		0			37.00
38. 00			0			38. 00
39. 00			0			39. 00
40.00			0			40.00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		19, 750, 720		43.00
	to Wkst. G-3, line 4)				l	

	Financial Systems IU HEALTH STARKE MEMOR			u of Form CMS-2	2552-10
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 150102	Peri od:	Worksheet G-3	
			From 01/01/2015 To 12/31/2015	Date/Time Pre	narod:
			10 12/31/2013	5/26/2016 9: 1	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		85, 556, 378	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			60, 316, 385	2. 00
3.00	Net patient revenues (line 1 minus line 2)			25, 239, 993	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43			19, 750, 720	4.00
5.00	Net income from service to patients (line 3 minus line 4)			5, 489, 273	5.00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			3, 076	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	ervi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11.00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			73, 380	14.00
15. 00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other tha	n patients		10, 727	16.00
17.00	Revenue from sale of drugs to other than patients			19, 111	17. 00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21. 00	Rental of vending machines			0	21. 00
22. 00	Rental of hospital space			42, 741	22. 00
23.00	Governmental appropriations			0	23.00
24. 00	MI SCELLANEOUS			406, 242	
25.00	Total other income (sum of lines 6-24)			555, 277	25.00
	Total (line 5 plus line 25)			6, 044, 550	26. 00
27 00	OTHER EXPENSES (SPECIEV)			0	27 00

0 27. 00 0 28. 00

6, 044, 550 29. 00

27.00 OTHER EXPENSES (SPECIFY)
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)

Provider CRX: 150102	Heal th	Financial Systems IU HEALTH STARKE MEMOR	IAL HOSPITAL	In Lie	eu of Form CMS-2	2552-10
PART 1 - FULLY PROSPECTIVE METHOD 1.00				Peri od: From 01/01/2015	Worksheet L Parts I-III Date/Time Pre	pared:
PART 1 - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT 138, 183 1.00			Title XVIII	Hospi tal		
PART 1 - FULLY PROSPECTIVE METHOD CAPITAL FEDERAL AMOUNT 138, 183 1.00						
CAPITAL FEDERAL AMOUNT 138, 183 1.00 1.00 1.00 1.01 1.00		DART I FULLY PROOPERTLYS METUOR			1. 00	
1.01						
1.01	1 00				120 102	1 00
2.00						
2. 01 Model 4 BPC Capital DRG outlier payments 0 2. 01						
Total inpatient days divided by number of days in the cost reporting period (see instructions) 4.00 Number of interns & residents (see instructions) 5.00 Indirect medical education percentage (see instructions) 6.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 0.00 1.01) (see instructions) 7.00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 3.00) (see instructions) 8.00 Percentage of Medicald patient days to total days (see instructions) 8.00 Percentage of Medicald patient days to total days (see instructions) 8.00 Percentage of Medicald patient days to total days (see instructions) 8.00 Percentage of Medicald patient days (see instructions) 8.00 10.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 0.00 8.00 Percentage of Medicald patient days to total days (see instructions) 8.00 Possible disproportionate share adjustment (see instructions) 9.00 10.00 Poggram inpatient routine capital cost (see instructions) 10.00						
4.00 Number of Interns & residents (see Instructions) 0.00 4.00						
5.00 Indirect medical education percentage (see instructions) 6.00 Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions) 7.00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 9.00 India prospective capital patient (see instructions) 9.00 Disproportionate share adjustment (see instructions) 9.01 Disproportionate share adjustment (see instructions) 9.01 Disproportionate share adjustment (see instructions) 9.02 Degram inpatient routine capital cost (see instructions) 9.03 Degram inpatient ancillary capital cost (see instructions) 9.04 Degram inpatient routine capital cost (see instructions) 9.05 Degram inpatient program capital cost (line 1 plus line 2) 9.06 Degram inpatient capital costs (see instructions) 9.07 Degram inpatient capital costs (see instructions) 9.08 Degram inpatient capital costs (see instructions) 9.09 Capital cost for comparison to payments (line 3 x line 4) 9.00 Capital cost for comparison to payments (line 2 x line 6) 9.00 Capital minimum payment level for extraordinary circumstances (line 2 x line 6) 9.00 Capital minimum payment level for extraordinary circumstances (line 2 x line 6) 9.00 Current year comparison of capital minimum payment level to capital payment (from prior year			orting period (see inst	ructions)		
Logical Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)						
1.01) (see instructions) Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 8.00 Percentage of Medicaid patient days to total days (see instructions) 8.00 Al lowable disproportionate share percentage (see instructions) 9.00 Sum of lines 7 and 8 9.00 Sum o				1 11		
7.00 Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line 30) (see instructions) 8.00 Percentage of Medical d patient days to total days (see instructions) 9.00 Sum of lines 7 and 8 9.00 O Sum of lines 7 and 8 9.00 D Sum of lines 7 and 8 9.00 O Sum of lines 7 and 8 9.00 Program inpatient sparred cost (see instructions) 9.00 Program inpatient routine capital cost (see instructions) 9.00 Total inpatient program capital cost (line 1 plus line 2) 9.00 Program inpatient capital cost (see instructions) 9.00 Program inpatient capital cost (line 3 x line 4) 9.00 Program inpatient capital costs (see instructions) 9.00 Applicable exception percentage (see instructions) 9.00 Capital cost for comparison to payments (line 3 x line 4) 9.00 Capital inimum payment level (for extraordinary circumstances (line 2 x line 6) 9.00 Current year capital minimum payment level for extraordinary circumstances (line 2 x line 6) 9.00 Current year capital payments (from Part I, line 12, as applicable) 9.00 Current year capital payments (from Part I, line 12, as applicable) 9.00 Current year capital payments (from Part I, line 12, as applicable) 9.00 Current year capital payments (from Part I, line 12, as applicable) 9.00 Current year capital payments (from Part I, line 12 over capital payment (from prior year on 11.00 current year capital payments (from Part I, li	6.00		sum of lines I and 1.01	, corumns i and	ا	6.00
8.00 Percentage of Medicai d patient days to total days (see instructions) Sum of lines 7 and 8 0.00 9.00 11.00 Allowable disproportionate share percentage (see instructions) 12.00 Total prospective capital payments (see instructions) 139,064 12.00 PART II - PAYMENT UNDER REASONABLE COST 1.00 Program inpatient routine capital cost (see instructions) 1.00 Program inpatient program capital cost (see instructions) 1.00 Capital cost payment factor (see instructions) 1.00 Total inpatient program capital cost (line 1 plus line 2) 1.00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 3.00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (line 1 minus line 2) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level to capital payment (from prior year	7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line			0. 00	7. 00
9.00 Sum of lines 7 and 8 10.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (see instructions) 12.00 Total prospective capital payments (see instructions) 11.00 PART II - PAYMENT UNDER REASONABLE COST 1.00 Program inpatient routine capital cost (see instructions) 1.00 Program inpatient ancillary capital cost (see instructions) 1.00 Total inpatient program capital cost (line 1 plus line 2) 1.00 Capital cost payment factor (see instructions) 1.00 Program inpatient ancillary capital cost (line 3 x line 4) 1.00 Program inpatient capital costs (see instructions) 1.00 Program inpatient capital costs (line 3 x line 4) 1.00 Program inpatient capital costs (line 3 x line 4) 1.00 Applicable exception percentage (see instructions) 1.00 Capital ininimum payment level (ine 5 plus line 7) 1.00 Adjustment to capital ininimum payment level for extraordinary circumstances (line 2 x line 6) 1.00 Carrent year capital payments (from Part 1, line 12, as applicable) 1.00 Current year capital payments (from Part 1, line 12, as applicable) 1.00 Current year capital payments (from Part 1, line 12, as applicable) 1.00 Carryover of accumulated capital minimum payment level over capital payments (from prior year	8 00				0.00	8 00
10.00 Allowable disproportionate share percentage (see instructions) 11.00 Disproportionate share adjustment (see instructions) 12.00 Total prospective capital payments (see instructions) 12.00 Total prospective capital payments (see instructions) PART II - PAYMENT UNDER REASONABLE COST 1.00 Program inpatient routine capital cost (see instructions) 2.00 Program inpatient ancillary capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 3.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital inimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level vover capital payments (from prior year 0 11.00			1013)			
11.00 Disproportionate share adjustment (see instructions) 12.00 Total prospective capital payments (see instructions) PART II - PAYMENT UNDER REASONABLE COST 1.00 Program inpatient routine capital cost (see instructions) 3.00 Total inpatient program capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) DART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (line 3 x line 4) 1.00 PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Carryover of accumulated capital minimum payment level to capital payments (line 8 less line 9) 11.00 Total inpatient spital cost of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Total inpatient capital minimum payment level to capital payments (line 8 less line 9) 11.00 Total inpatient capital minimum payment level to capital payments (line 8 less line 9) 11.00 Total inpatient capital minimum payment level to capital payments (line 8 less line 9) 11.00 Total inpatient capital cost (see instructions) 11.00 Total inpatient capital cost (see instructions) 12.00 Total inpatient capital cost (line 1 plus line 2) 13.00 Total inpatient capital cost (line 1 plus line 2) 13.00 Total inpatient capital cost (line 1 plus line 2) 13.00 Total inpatient capital cost (line 1 plus line 2) 13.00 Total inpatient capital cost (line 1 plus line 2) 13.00 Total inpatient capital cost (line 1 plus line 2)						
139,064 12.00						
PART II - PAYMENT UNDER REASONABLE COST 1. 00 Program inpatient routine capital cost (see instructions) 2. 00 Program inpatient ancillary capital cost (see instructions) 3. 00 Total inpatient program capital cost (line 1 plus line 2) 4. 00 Capital cost payment factor (see instructions) 5. 00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1. 00 Program inpatient capital costs (see instructions) 2. 00 Program inpatient capital costs (see instructions) 3. 00 Net program inpatient capital costs (line 1 minus line 2) 4. 00 Applicable exception percentage (see instructions) 5. 00 Capital cost for comparison to payments (line 3 x line 4) 6. 00 Percentage adjustment for extraordinary circumstances (see instructions) 7. 00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8. 00 Capital minimum payment level (line 5 plus line 7) 9. 00 Current year capital payments (from Part I, line 12, as applicable) 10. 00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11. 00 Carryover of accumulated capital minimum payment level over capital payment (from prior year						
PART II - PAYMENT UNDER REASONABLE COST 1.00 Program inpatient routine capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Carryover of accumulated capital minimum payment level over capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 1.00 Program inpatient capital minimum payment level over capital payment (from prior year 1.00	12.00	prospective capital payments (coo motifactions)			1077001	12.00
1.00 Program inpatient routine capital cost (see instructions) 2.00 Program inpatient ancillary capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) 1.00 PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital inimum payment level for extraordinary circumstances (line 8 less line 9) 9.00 Current year capital payments (from Part I, line 12, as applicable) 11.00 Carryover of accumulated capital minimum payment level over capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year					1. 00	
2.00 Program inpatient ancillary capital cost (see instructions) 3.00 Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year						
Total inpatient program capital cost (line 1 plus line 2) 4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) 1.00 PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) Percentage adjustment for extraordinary circumstances (see instructions) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year	1.00	Program inpatient routine capital cost (see instructions)			0	1. 00
4.00 Capital cost payment factor (see instructions) 5.00 Total inpatient program capital cost (line 3 x line 4) 1.00 PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year	2.00				0	2. 00
PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year	3.00	Total inpatient program capital cost (line 1 plus line 2)			0	3. 00
PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year	4.00	Capital cost payment factor (see instructions)			0	4. 00
PART III - COMPUTATION OF EXCEPTION PAYMENTS 1.00 Program inpatient capital costs (see instructions) 2.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 11.00	5.00	Total inpatient program capital cost (line 3 x line 4)		,	0	5. 00
Program inpatient capital costs (see instructions) 1.00 Program inpatient capital costs (from extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year) 11.00					1. 00	
2.00 Program inpatient capital costs for extraordinary circumstances (see instructions) 3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year						
3.00 Net program inpatient capital costs (line 1 minus line 2) 4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 3.00 4.00 6.00 7.00 6.00 7.00 8.00 9.00 10.00 10.00 11.00 11.00	1.00	Program inpatient capital costs (see instructions)			0	1. 00
4.00 Applicable exception percentage (see instructions) 5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 11.00	2.00	Program inpatient capital costs for extraordinary circumstances	(see instructions)		0	2. 00
5.00 Capital cost for comparison to payments (line 3 x line 4) 6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 5.00 0.00 6.00 7.00 8.00 9.00 0 9.00 0 9.00 1.00 1.00 1.00 1.00 1.00	3.00	Net program inpatient capital costs (line 1 minus line 2)			0	3. 00
6.00 Percentage adjustment for extraordinary circumstances (see instructions) 7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 11.00	4.00				0.00	4. 00
7.00 Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6) 8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 11.00	5.00					5. 00
8.00 Capital minimum payment level (line 5 plus line 7) 9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 11.00	6.00) Percentage adjustment for extraordinary circumstances (see instructions)			0.00	6. 00
9.00 Current year capital payments (from Part I, line 12, as applicable) 10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 11.00	7.00	O Adjustment to capital minimum payment level for extraordinary circumstances (line 2 x line 6)			l ol	7. 00
10.00 Current year comparison of capital minimum payment level to capital payments (line 8 less line 9) 0 10.00 11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 11.00	8.00	Capital minimum payment level (line 5 plus line 7)			0	8. 00
11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year 0 11.00	9.00	Current year capital payments (from Part I, line 12, as applica	bl e)		l ol	9. 00
	10.00				0	10.00
	11. 00		oital payment (from pri	or year	0	11. 00

Net comparison of capital minimum payment level to capital payments (line 10 plus line 11)

Current year exception payment (if line 12 is positive, enter the amount on this line)

Carryover of accumulated capital minimum payment level over capital payment for the following period

14.00

0 12.00 13.00

0

0

0 15.00

0 16.00 0 17.00

Worksheet L, Part III, line 14)

(if line 12 is negative, enter the amount on this line)

15.00 Current year allowable operating and capital payment (see instructions)
16.00 Current year operating and capital costs (see instructions)
17.00 Current year exception offset amount (see instructions)

13.00

14.00