Health Financial Systems	ANA ORTHOPAED	C HOSPI TAL, LLC		In Lie	u of Form CMS	5-2552-10
This report is required by law (42 USC 1395g; 42 CF			an result in			
payments made since the beginning of the cost report	ting period bei			1395g).	OMB NO. 0938	3-0050
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT	RT CERTIFICATIO	N Provider CCN:		i od:	Worksheet S	
AND SETTLEMENT SUMMARY			To	m 01/01/2014 12/31/2014	Parts I-III Date/Time Pr	repared:
					5/20/2015 12	2:45 pm
PART I - COST REPORT STATUS				D-+- E (20 (20	4F T:	10.45.88
Provider 1. [X] Electronically filed cost repuse only 2. [] Manually submitted cost report				Date: 5/20/20	15 IIme:	12:45 pm
3. [0] If this is an amended report		er of times the pr	ovider resubr	nitted this c	ost report	
4. [ F ] Medicare Utilization. Enter "	F" for full or	"L" for low.				
	Recei ved:		10. NPR [		<b>.</b> .	
use only (1) As Submitted 7. Contra (2) Settled without Audit 8. [N]	actor No. Initial Report	for this Provider	CCN 12 [ 0 ]	actor's Vendo If line 5 co	or Code: olumn 1 is 4 <sup>.</sup>	4 Enter
(3) Settled with Audit 9. [N]	Final Report fo	or this Provider C	CN	number of tim	mes reopened	= 0-9.
(4) Reopened						
(5) Amended						
PART II - CERTIFICATION						
MISREPRESENTATION OF FALSIFICATION OF ANY INFORMATION	ON CONTAINED IN	THIS COST REPORT	MAY BE PUNIS	HABLE BY CRIM	MINAL, CIVIL	AND
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UND						
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY OF		A KICKBACK OR WEI	RE OTHERWI SE	ILLEGAL, CRIM	MINAL, CIVIL	AND
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MA	T RESULT.					
CERTIFICATION BY OFFICER OR ADMINIS	STRATOR OF PROV	I DER(S)				
I HEREBY CERTIFY that I have read the above						
electronically filed or manually submitted Expenses prepared by INDIANA ORTHOPAEDIC HO						
01/01/2014 and ending $12/31/2014$ and to the						
correct, complete and prepared from the boo						
instructions, except as noted. I further c	2			0	0 0	
provision of health care services, and that compliance with such laws and regulations.	the services i	dentified in this	cost report	were provide	din	
compriance with such raws and regulations.						
	(Si gn	ed)				
	( 9		r Administra	tor of Provic	ler(s)	
		Title				
		Date				
		T: +1 - \//				
Cost Center Description	Title V	Title XVI Part A	Part B	ніт	Title XIX	
	1.00	2.00	3.00	4.00	5.00	
PART III - SETTLEMENT SUMMARY						
1.00 Hospital	0	0	0	0		0 1.00
2.00 Subprovider - IPF	0	0	0			0 2.00
3.00 Subprovider - IRF 5.00 Swing bed - SNF	0	0	0			0 3.00 0 5.00
6.00 Swing bed - NF	0	0	0			0 6.00
8.00 NURSING FACILITY	0					0 8.00
200. 00 Total	0	0	0	0		0 200. 00
The above amounts represent "due to" or "due from"						<u> </u>
According to the Paperwork Reduction Act of 1995, no displays a valid OMB control number. The valid OMB						
required to complete and review the information col						
instructions, search existing resources, gather the						
have any comments concerning the accuracy of the till 7500 Security Boulevard Attn: PRA Report Clearance						CMS,
ATTN: PRA REPORT CLEARANCE	ULTICER Mail	NUD 14-26-05 Bal	LIMORE Marv	u ann 71744-18	501	

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.

							From 01/0 To 12/3	1/2014 1/2014			
	1.00	2.	00		3.00			4.00	1 37 1 37 20	15 0.4	
	Hospital and Hospital Health Care Com										
00	Street: 8450 NORTHWEST BOULEVARD	PO Box:	N 7		44070	0					1.
0	City: INDIANAPOLIS	State: I Component Na		ip Code CCN	CBSA	Provi de	r Date	Paym	ent Syste	m (P	2.
		component Na		umber	Number	Type	Certifie		Γ, 0, or		
								V	XVIII	XIX	1
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
	Hospital and Hospital-Based Component			501/0	0 ( 0 0 0		00,00,000			0	
00	•	NDI ANA ORTHOPAEL IOSPI TAL, LLC		50160	26900	1	03/23/200	05 N	P	0	3.
0	Subprovider - IPF	IOSI I IAE, EEG									4.
0	Subprovider - IRF										5.
0	Subprovider - (Other)										6.
00	Swing Beds - SNF										7.
00 00	Swing Beds - NF Hospital-Based SNF										8.
00	Hospi tal -Based NF										10.
00	Hospi tal -Based OLTC										11.
00	Hospital-Based HHA										12.
00	Separately Certified ASC Hospital-Based Hospice										13.
00 00	Hospital-Based Health Clinic - RHC										14.   15.
	Hospital -Based Health Clinic - FQHC										16.
00	Hospital-Based (CMHC) I										17.
00	Renal Dialysis										18.
00	Other						Fro	m.	To:		19.
							1. (		2.0		1
00	Cost Reporting Period (mm/dd/yyyy)						01/01,	/2014	12/31/	2014	20.
00	Type of Control (see instructions)							5			21.
00	Inpatient PPS Information Does this facility qualify and is it	currently receiv	ing navmen	ts for	disprop	ortionate	e N		N		22.
00	share hospital adjustment, in accorda								11		22.
	for yes or "N" for no. Is this facili	ty subject to 42	CFR Secti	on §412							
~ -	amendment hospital?) In column 2, ent										
01	Did this hospital receive interim unc period? Enter in column 1, "Y" for ye						N		N		22.
	reporting period occurring prior to C										
	for no for the portion of the cost re										
~~	(see instructions)										00
02	Is this a newly merged hospital that determined at cost report settlement?						N N		N		22.
	or "N" for no, for the portion of the	cost reporting	period pri	or to (	)ctober	1. Enter					
	in column 2, "Y" for yes or "N" for n	o, for the porti	on of the	cost re	eporting	period o	on				
02	or after October 1. Did this hospital receive a geographi	a rad accificati	on from ur	han to	rural a		t N		N		22.
03	of the OMB standards for delineating								IN IN		22.
	in column 1, "Y" for yes or "N" for n	o for the portio	n of the c	cost rep	orting	peri od					
	prior to October 1. Enter in column 2						ne				
	cost reporting period occurring on or hospital contain at least 100 but not						h				
	42 CFR 412.105)? Enter in column 3, "			antea	ii accor	dance m					
00	Which method is used to determine Med						ו ו	2	N		23.
	<ol> <li>enter 1 if date of admission, 2 if method of identifying the days in thi</li> </ol>						L				
	used in the prior cost reporting peri										
			In-State	In-St	ate C	)ut-of	Out-of	Medi ca		her	
			Medi cai d	Medic		State	State	HMO da		i cai d	
			paid days	eligi unpa		edicaid id days	Medicaid eligible			ays	
				day			unpai d				
	D		1.00	2.0		3.00	4.00	5.00		. 00	
00	If this provider is an IPPS hospital,		C		0	0	0		0	0	24.
	in-state Medicaid paid days in column Medicaid eligible unpaid days in colu										
	out-of-state Medicaid paid days in co										
	out-of-state Medicaid eligible unpaid	days in column									
	4, Medicaid HMO paid and eligible but										
00	column 5, and other Medicaid days in		C		0	0	o		0		25.
00	If this provider is an IRF, enter the Medicaid paid days in column 1, the i		C	1		U	0				∠5.
	Medicaid eligible unpaid days in colu										
	out-of-state Medicaid days in column			1							
	Medicaid eligible unpaid days in colu					1	1				

			IC HOSPITAL, LL	c	I	n Lieu	of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ΑΤΑ	Provi der	F	eriod: rom 01/01/ o 12/31/		Workshe Part I Date/Ti 5/15/20	me Pre	
					Urban/Rur 1.00		Date of 2.(	<u> </u>	
26.00	Enter your standard geographic classification (not w			ginning of the	1.00	1	2.0		26.00
27.00	cost reporting period. Enter "1" for urban or "2" fo Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban o	age) sta r "2" fo	atus at the end or rural. If ap			1			27.00
35.00	enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter th effect in the cost reporting period.			CH status in		0			35.00
					Begi nni 1. 00		Endi 2. (		
36.00	Enter applicable beginning and ending dates of SCH s		Subscript line	36 for number	1.00		2.0		36.00
37.00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), ente in effect in the cost reporting period.		umber of period	ds MDH status		О			37.00
38.00	Enter applicable beginning and ending dates of MDH s of periods in excess of one and enter subsequent dat		Subscript line	38 for number					38.00
					Y/N		Y/		
39.00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet the mileage re CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	i)? Ente quiremen	er in column 1 nts in accordar	"Y" for yes nce with 42	1.00 N		2.0 N		39.00
40.00	Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 1	n adjus <sup>.</sup> ber 1. I	tment? Enter "\ Enter "Y" for y	/" for yes or	N		Ν		40. 00
						V 1.00	XVIII 2.00	XI X 3.00	
	Prospective Payment System (PPS)-Capital								
	Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exc					N	N	N	45. 00 46. 00
	pursuant to 42 CFR §412.348(f)? If yes, complete Wks Pt. III.	t. L, P <sup>.</sup>	t. III and Wkst	t. L-1, Pt. I <sup>-</sup>	through				
	Is this a new hospital under 42 CFR §412.300 PPS cap Is the facility electing full federal capital paymen Teaching Hospitals					N N	N N	N N	47.00 48.00
56.00	Is this a hospital involved in training residents in or "N" for no.	approve	ed GME programs	s? Enter "Y" 1	For yes	N			56.00
	If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	ryeson thofth Y", comp I, ifap	r "N" for no ir his cost report plete Worksheet pplicable.	n column 1. If ting period? I t E-4. If colur	column 1 Enter "Y" nn 2 is				57.00
	If line 56 is yes, did this facility elect cost reim defined in CMS Pub. 15-1, § 2148? If yes, complete W	kst. D-!	5.		as				58.00
	Are costs claimed on line 100 of Worksheet A? If ye Are you claiming nursing school and/or allied health	costs	for a program t			N N			59. 00 60. 00
	provider-operated criteria under §413.85? Enter "Y"	for yes Y/N	s or "N" for no IME	b. (see instruc Direct GME	ctions) IME		Di rect	GMF	
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	<u>1.00</u> N	2.00	3.00	4.00	0.00	5.0		61.00
61. 01	column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.0	þ				61. 01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.0	þ				61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.0	b				61. 03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.0	þ				61.04
61.05	current cost reporting period. (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0.00	0.0	þ				61.05
61.06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0.00	0.0					61.06

HOSPI TAL AND	) HOSPI TAL HEALTH CARE COMPI	_EX IDENTIFICATION DA	ТА	Provi der	F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-2 Part I Date/Time Pre 5/15/2015 8:4	pared:
			Progra	n Name	Program Code	Unweighted IME FTE Count		
1			1. (	00	2.00	3.00	4.00	
specia for ex colum progra unwei FTE ur 51.20 Of the progra reside instru enter	e FTEs in line 61.05, speci alty, if any, and the numbe ach new program. (see instr n 1, the program name, ente am code, enter in column 3, ghted count and enter in co nweighted count. e FTEs in line 61.05, speci am specialty, if any, and t ents for each expanded prog uctions) Enter in column 1, in column 2, the program c e IME FTE unweighted count	r of FTE residents uctions) Enter in r in column 2, the the IME FTE lumn 4, direct GME fy each expanded he number of FTE ram. (see the program name, ode, enter in column				0.00		61. 10
4, di 1	rect GME FTE unweighted cou	nt.						
							1.00	-
ACA PI	rovisions Affecting the Hea	Ith Resources and Ser	vices Admin	ni strati on	(HRSA)		1.00	
52.00 Enter	the number of FTE resident	s that your hospital	trained in			iod for which	0.00	62.00
2.01 Enter	nospital received HRSA PCRE the number of FTE resident g in this cost reporting pe	s that rotated from a	a Teaching H			your hospital	0.00	62. 0 <sup>.</sup>
3.00 Has yo	ing Hospitals that Claim Re our facility trained reside or yes or "N" for no in col	nts in nonprovider se	ettings duri			period? Enter	N	63.0
1 1				07. (300	Unwei ghted	Unwei ghted	Ratio (col. 1/	
					FTEs Nonprovider Site	FTEs in Hospital	(col. 1 + col. 2))	
					1.00	2.00	3.00	
	on 5504 of the ACA Base Yea d that begins on or after J				inis base year	is your cost r	eporting	
54.00 Enter in the reside settin reside	in column 1, if line 63 is e base year period, the num ent FTEs attributable to ro ngs. Enter in column 2 the ent FTEs that trained in yo olumn 1 divided by (column	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter ir 1 + column 2)). (see	trained r p-primary ca all nonprov non-primar column 3 1	residents are vider rycare the ratio	0.00			
		Program Name	Program	n Code	Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00	2. (	00	3.00	4.00	5.00	
is yes traind year p associ FTEs 1 progra residd the p colum unweig residd residd rotati non-p colum unweig	in column 1, if line 63 s, or your facility ed residents in the base beriod, the program name lated with primary care for each primary care am in which you trained ents. Enter in column 2, rogram code, enter in n 3, the number of ghted primary care FTE ents attributable to ions occurring in all rovider settings. Enter in n 4, the number of ghted primary care ent FTEs that trained in nospital. Enter in column				0.00	0.00	0. 000000	65.00

	Financial Systems		THOPAEDIC HO				n Lie	u of For		
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	ATA	Provi der		Period: From 01/01. To 12/31.			me Pre	pared:
					Unweighted	Unwei gh	ited	5/15/20 Ratio (c		) am
					FTĔs	FTES	in	(col. 1	+ col.	
					Nonprovi der Si te	Hospi t	ai	2)	)	
					1.00	2.00		3.0		
	Section 5504 of the ACA Current beginning on or after July 1, 20		n Nonprovide	er Setting	sEffecti ve	for cost re	eporti	ng perio	ods	
66.00	Enter in column 1 the number of	unweighted non-primar			0.0	00	0.00	0.	000000	66.00
	FTEs attributable to rotations o Enter in column 2 the number of									
	FTEs that trained in your hospit (column 1 divided by (column 1 +			of						
		Program Name	Program	n Code	Unwei ghted	Unwei gh	ted	Ratio (c	:ol. 3/	
					FTEs Nonprovider	FTEs Hospit		(col. 3 4)		
					Si te	nospi t	a	4)	)	
(7.00		1.00	2.0	00	3.00	4.00		5.0		(7.00
67.00	Enter in column 1, the program name associated with each of				0.0	00	0.00	0.	000000	67.00
	your primary care programs in									
	which you trained residents. Enter in column 2, the program									
	code. Enter in column 3, the									
	number of unweighted primary care FTE residents attributable									
	to rotations occurring in all									
	non-provider settings. Enter in column 4, the number of									
	unweighted primary care									
	resident FTEs that trained in your hospital. Enter in column									
	5, the ratio of (column 3									
	divided by (column 3 + column 4)). (see instructions)									
							1.00	0 2.00	3 00	
	Inpatient Psychiatric Facility F						1.00	2.00	0.00	
70.00	ls this facility an Inpatient Ps Enter "Y" for yes or "N" for no		IPF), or doe	s it conta	ain an IPF su	oprovi der?	N			70.00
71.00	If line 70 yes: Column 1: Did th	e facility have an ap							0	71.00
	recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co									
	program in accordance with 42 CF	R 412.424 (d)(1)(iii)	)(D)?Enter	"Y" for ye	es or "N" for	no.				
	Column 3: If column 2 is Y, ente reporting period covers the begi									
	or subsequent academic years of	the new teaching prog	gram in exis	tence, en	ter 5. (see					
	instructions) For cost reporting reporting period covers the begi									
	teaching program in existence, e	nter 6 in column 3. (			Joan o' Joan o'					
75 00	<u>Inpatient Rehabilitation Facilit</u> Is this facility an Inpatient Re		v (IRF) or	does it co	ontain an IRF		N			75.00
	subprovider? Enter "Y" for yes	and "N" for no.								
76.00	If line 75 yes: Column 1: Did th recent cost reporting period end	2 1		5 1	5				0	76.00
	no. Column 2: Did this facility	train residents in a	new teachir	g program	in accordance	e with 42				
	CFR 412.424 (d)(1)(iii)(D)? Ente 1, 2, or 3, in column 3. (see in									
	of the fourth year, enter 4 in c	olumn 3, or if the fi	ifth or subs	equent aca	ademic years	of the new				
	teaching program in existence, e on or after October 1, 2012, if									
	any subsequent academic year of			0	0					
	instructions)						<u> </u>			
	<u> </u>							1.0	00	
80, 00	Long Term Care Hospital PPS Is this a long term care hospita	(LTCH)? Enter "Y"	for yes and	"N" for u	no.			N		80.00
	Is this a LTCH co-located within					g period? E	nter	N		81.00
	"Y" for yes and "N" for no. TEFRA Providers							I		
	Is this a new hospital under 42						no.	N		85.00
86.00	Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider ( r yes and "N" for no.	(excluded un	it) under	42 CFR Section	on				86.00

Health Financial Systems INDIANA ORTHOPAEDI	C HOSPI TAL, LLC	0	١n	Lieu of Form	CMS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	1	Period: From 01/01/20 To 12/31/20	014 Date/Tim	t S-2 e Prepared: 5 8:40 am
	·		V	XI X	
Title V and XIX Services			1.00	2.00	,
90.00 Does this facility have title V and/or XIX inpatient hospita yes or "N" for no in the applicable column.	I services? Er	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through t full or in part? Enter "Y" for yes or "N" for no in the appl			Ν	Y	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (du instructions) Enter "Y" for yes or "N" for no in the applica		on)? (see		N	92.00
93.00 Does this facility operate an ICF/MR facility for purposes o "Y" for yes or "N" for no in the applicable column.		XIX? Enter	N	N	93.00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.	and "N" for no	o in the	N	N	94.00
95.00 If line 94 is "Y", enter the reduction percentage in the app 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.			N O	. 00 N	0.00 95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	licable columr	ı.	0	. 00	0.00 97.00
105.00 Does this hospital qualify as a Critical Access Hospital (CA 106.00 If this facility qualifies as a CAH, has it elected the all-		ad of normant	N		105.00
for outpatient services? (see instructions) 107.00[Column 1: If this facility qualifies as a CAH, is it eligib		1 5			107.00
for I &R training programs? Enter "Y" for yes or "N" for no instructions) If yes, the GME elimination would not be on Wk	in column 1.	(see			107.00
the program would be cost reimbursed. If yes complete Wkst.	D-2, Pt. II. (	Column 2: If			
this facility is a CAH, do I&Rs in an approved medical educa CAH's excluded IPF and/or IRF unit? Enter "Y" for yes or "					
instructions) 108.00 is this a rural hospital qualifying for an exception to the	CRNA fee sched	dul e? See 42	N		108.00
CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Physi cal	Occupati onal	Speech	Respi ra	
109.00  f this hospital qualifies as a CAH or a cost provider, are	<u> </u>	2.00 N	3.00 N	4.00 N	109.00
therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					
		I	I	1.00	
110.00 Did this hospital participate in the Rural Community Hospita	I Demonstratio	on project (41	OA Demo)for	1.00 N	110.00
the current cost reporting period? Enter "Y" for yes or "N"	for no.				
			1	1.00 2.00	3.00
Miscellaneous Cost Reporting Information 115.00[s this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no ir	column 1 If	column 1	N	0 115.00
is yes, enter the method used (A, B, or E only) in column 2.	lf column 2 i	s "E", enter	in column		
3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider					
Pub.15-1, §2208.1. 116.00 Is this facility classified as a referral center? Enter "Y"				N	116.00
117.00 Is this facility legally-required to carry malpractice insur no.	ance? Enter "\	(" for yes or	"N" for	Y	117.00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 i			1	118.00
		Premiums	Losses	Insurar	nce
118.01 List amounts of malpractice premiums and paid losses:		1.00 230,50	2.00	3.00	0 118. 01
118.02 Are malpractice premiums and paid losses reported in a cost	center other t	than the	1.00 N	2.00	118.02
Administrative and General? If yes, submit supporting sched and amounts contained therein.					
119.00 DO NOT USE THIS LINE					119.00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in			N	N	120.00
"N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendmen	alifies for th	ne Outpatient			
Enter in column 2, "Y" for yes or "N" for no.					
121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	ntable devices	s charged to	Y		121.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" fo	r yes and "N"	for no. If	N		125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en	iter the certif	ication date			126.00
in column 1 and termination date, if applicable, in column 2					127.00
127.00  f this is a Medicare certified heart transplant center, ent in column 1 and termination date, if applicable, in column 2					127.00

SPITAL AND HOSPITAL HEALTH CARE COMPLE	I NDI ANA ORTHOP X I DENTIFICATION DATA	Provi der	CCN: 150160		/01/2014 2/31/2014	Worksheet S- Part I Date/Time Pr 5/15/2015 8:	epared:
					1.00	2.00	-
8.00 If this is a Medicare certified li			cation date	;			128.0
in column 1 and termination date, 9.00 If this is a Medicare certified Lu			sation date	in			129.0
column 1 and termination date, if							129.0
0.00 If this is a Medicare certified pa			tification				130. 0
date in column 1 and termination of 1.00 If this is a Medicare certified in			ertification				131.0
date in column 1 and termination of							
2.00 If this is a Medicare certified is			cation date	9			132.0
in column 1 and termination date, 3.00 If this is a Medicare certified of			cation date				133.0
in column 1 and termination date,	if applicable, in colu	mn 2.					
4.00 If this is an organ procurement or and termination date, if applicabl		r the OPO number	n column 1				134.0
All Providers							
0.00 Are there any related organization					Y		140. 0
chapter 10? Enter "Y" for yes or " are claimed, enter in column 2 the				s			
1.00		2.00			3.00	I	
If this facility is part of a chai				name and	address	of the	
home office and enter the home off 1.00Name:	Contractor name an			tor's Num	ber:		141.0
2.00 Street:	PO Box:						142.0
3. 00 Ci ty:	State:		Zip Cod	le:			143. C
						1.00	-
4.00 Are provider based physicians' cos						N	144. C
5.00 If costs for renal services are cl only? Enter "Y" for yes or "N" for		line 74, are the	costs for in	npatient s	servi ces	N	145. C
	no.						_
					1.00	2.00	-
6.00 Has the cost allocation methodolog	gy changed from the pre				1.00 N	2.00	146. 0
	gy changed from the pre n column 1. (See CMS Pu					2.00	 146. 0
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<ul> <li>6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in</li> <li>7.00 Was there a change in the statisti</li> <li>8.00 Was there a change in the order of</li> </ul>	y changed from the pre n column 1. (See CMS Pu column 2. cal basis? Enter "Y" f allocation? Enter "Y"	b. 15-2, § 4020) for yes or "N" for for yes or "N" fo	fyes, ente no. prno.	er	N N N	2.00	147. C 148. C
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<ul> <li>6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in</li> <li>7.00 Was there a change in the statisti</li> <li>8.00 Was there a change in the order of</li> <li>9.00 Was there a change to the simplifino.</li> <li>Does this facility contain a provior charges? Enter "Y" for yes or '5.00 Hospital</li> <li>6.00 Subprovider - IPF</li> <li>7.00 Subprovider - IRF</li> <li>8.00 SUBPROVIDER</li> <li>9.00 SNF</li> <li>0.00 HOME HEALTH AGENCY</li> <li>1.00 CMHC</li> </ul> Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column	y changed from the pre n column 1. (See CMS Pu column 2. cal basis? Enter "Y" f allocation? Enter "Y" ed cost finding method der that qualifies for 'N" for no for each com 'N" for no for each com ampus hospital that has Name	b. 15-2, § 4020) for yes or "N" for for yes or "N" for ? Enter "Y" for ye Part A 1.00 an exemption fro ponent for Part A N N N N N N N N N N N N N	f yes, enterno. or no. es or "N" for Part B 2.00 m the applic and Part B. N N N N N N N N N N N N N	er Dr Cation of (See 42 Ferent CB: (i p Code	N N N 3.00 The I owe CFR \$413 N N N N N SAs? CBSA	Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. C 148. C 149. C 155. C 156. C 157. C 158. C 159. C 160. C 161. C 165. C
<ul> <li>6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifino.</li> <li>Does this facility contain a provior charges? Enter "Y" for yes or '5.00 Hospital</li> <li>6.00 Subprovider - IPF</li> <li>7.00 Subprovider - IRF</li> <li>8.00 SUBPROVIDER</li> <li>9.00 SNF</li> <li>0.00 HOME HEALTH AGENCY</li> <li>1.00 CMHC</li> <li>Multicampus</li> <li>5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.</li> <li>6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,</li> </ul>	y changed from the pre n column 1. (See CMS Pu column 2. cal basis? Enter "Y" f allocation? Enter "Y" ed cost finding method der that qualifies for 'N" for no for each com 'N" for no for each com ampus hospital that has Name	b. 15-2, § 4020) for yes or "N" for for yes or "N" for ? Enter "Y" for ye Part A 1.00 an exemption fro ponent for Part A N N N N N N N N N N N N N	f yes, enterno. or no. es or "N" for Part B 2.00 m the applic and Part B. N N N N N N N N N N N N N	er Dr Cation of (See 42 Ferent CB: (i p Code	N N N 3.00 The I owe CFR \$413 N N N N N SAs? CBSA	Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. ( 148. ( 149. () 155. () 156. () 157. () 158. () 157. () 158. () 160. () 161. () 165. ()
<ul> <li>6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in 7.00 Was there a change in the statisti 8.00 Was there a change in the order of 9.00 Was there a change to the simplifino.</li> <li>Does this facility contain a provior charges? Enter "Y" for yes or " 5.00 Hospital</li> <li>6.00 Subprovider - IPF</li> <li>7.00 Subprovider - IRF</li> <li>8.00 SUBPROVIDER</li> <li>9.00 SNF</li> <li>0.00 HOME HEALTH AGENCY</li> <li>1.00 CMHC</li> <li>Multicampus</li> <li>5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.</li> <li>6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in</li> </ul>	y changed from the pre n column 1. (See CMS Pu column 2. cal basis? Enter "Y" f allocation? Enter "Y" ed cost finding method der that qualifies for 'N" for no for each com 'N" for no for each com ampus hospital that has Name	b. 15-2, § 4020) for yes or "N" for for yes or "N" for ? Enter "Y" for ye Part A 1.00 an exemption fro ponent for Part A N N N N N N N N N N N N N	f yes, enterno. or no. es or "N" for Part B 2.00 m the applic and Part B. N N N N N N N N N N N N N	er Dr Cation of (See 42 Ferent CB: (i p Code	N N N 3.00 The I owe CFR \$413 N N N N N SAs? CBSA	Title XIX 4.00 r of costs 3.13) N N N N N N N N N N N N FTE/Campus 5.00 0.0	147. ( 148. ( 149. () 155. () 156. () 157. () 158. () 157. () 158. () 160. () 161. () 165. ()
<ul> <li>6. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in</li> <li>7. 00 Was there a change in the statisti</li> <li>8. 00 Was there a change in the order of</li> <li>9. 00 Was there a change to the simplifino.</li> <li>Does this facility contain a provior charges? Enter "Y" for yes or '5. 00 Hospital</li> <li>6. 00 Subprovider - IPF</li> <li>7. 00 Subprovider - IRF</li> <li>8. 00 SUBPROVIDER</li> <li>9. 00 SNF</li> <li>0. 00 HOME HEALTH AGENCY</li> <li>1. 00 CMHC</li> </ul> Multicampus 5. 00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	y changed from the pre- n column 1. (See CMS Pu column 2. cal basis? Enter "Y" f allocation? Enter "Y" ed cost finding method der that qualifies for 'N" for no for each com 'N" for no for each com mpus hospital that has Name 0	b. 15-2, § 4020) for yes or "N" for for yes or "N" for ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	f yes, enterno. no. pr no. es or "N" for Part B 2.00 m the applic and Part B. N N N N N N N N N N N N N	Ti Cation of (See 42 Cation of (See 42) Cation (See	N N N 3.00 The I owe CFR \$413 N N N N N SAs? CBSA	Title XIX 4.00 er of costs 3.13) N N N N N N N N N N N N N	147. ( 148. ( 149. () 155. () 156. () 157. () 158. () 157. () 158. () 160. () 161. () 165. ()
<ul> <li>6.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no ir the approval date (mm/dd/yyyy) in</li> <li>7.00 Was there a change in the statisti</li> <li>8.00 Was there a change in the order of</li> <li>9.00 Was there a change to the simplifino.</li> </ul> Does this facility contain a provior charges? Enter "Y" for yes or '5.00 Hospital 6.00 Subprovider - IPF 7.00 Subprovider - IRF 8.00 SUBPROVIDER 9.00 SNF 0.00 HOME HEALTH AGENCY 1.00 CMHC Multicampus 5.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 7.00 Is this provider a meaningful user	y changed from the pre n column 1. (See CMS Pu column 2. cal basis? Enter "Y" f allocation? Enter "Y" ed cost finding method der that qualifies for 'N" for no for each com ampus hospital that has Name 0 () incentive in the Ame under Section §1886(n	b. 15-2, § 4020) for yes or "N" for for yes or "N" for ? Enter "Y" for yes Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	f yes, enterno. no. or no. es or "N" for Part B 2.00 n the applic and Part B. N N N N N N N N N N N N N	er Ti Cation of Cation of (See 42 Cation of Cation of Catio	N N N N N N N N N N N N N N	Ti tl e XI X 4.00 er of costs 5.13) N N N N N N N N N N N N N	147. C 148. C 149. C 155. C 156. C 157. C 158. C 159. C 160. C 161. C 165. C 0 166. C
<ul> <li>6. 00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in the approval date (mm/dd/yyyy) in</li> <li>7. 00 Was there a change in the statisti</li> <li>8. 00 Was there a change in the order of</li> <li>9. 00 Was there a change to the simplifino.</li> <li>Does this facility contain a provior charges? Enter "Y" for yes or '5. 00 Hospital</li> <li>6. 00 Subprovider - IPF</li> <li>7. 00 Subprovider - IRF</li> <li>8. 00 SUBPROVIDER</li> <li>9. 00 SNF</li> <li>0. 00 HOME HEALTH AGENCY</li> <li>1. 00 CMHC</li> </ul> Multicampus 5. 00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no. 6. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	y changed from the pre- n column 1. (See CMS Pu column 2. cal basis? Enter "Y" f allocation? Enter "Y" ed cost finding method der that qualifies for "N" for no for each com ampus hospital that has Name 0 0 0 1) incentive in the Ame - under Section \$1886(n 25 is "Y") and is a mea	b. 15-2, § 4020) for yes or "N" for for yes or "N" for ? Enter "Y" for ye Part A 1.00 an exemption from ponent for Part A N N N N N N N N N N N N N	f yes, enterno. no. or no. es or "N" for Part B 2.00 n the applic and Part B. N N N N N N N N N N N N N	er Ti Cation of Cation of (See 42 Cation of Cation of Catio	N N N N N N N N N N N N N N	Ti tl e XI X 4.00 er of costs 5.13) N N N N N N N N N N N N N	147. ( 148. ( 149. () 155. () 155. () 157. () 157. () 157. () 157. () 157. () 157. () 157. () 160. () 161. () 165.

Health Financial Systems	INDIANA ORTHOPAEDIC H	OSPI TAL, LLC	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DATA	Provider CCN: 150160	Period:	Worksheet S-2	2
			From 01/01/2014 To 12/31/2014		pared:
				5/15/2015 8:4	
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR begi period respectively (mm/dd/yyyy)	nning date and ending date	for the reporting			170.00
				1.00	
171.00 If line 167 is "Y", does this provide Medicare cost plans reported on Wkst. (see instructions)				N	171.00

5PT I	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE Provi de	er CCN: 150160	Period: From 01/01/2014 To 12/31/2014	Date/Time Pre	epared
				Y/N	5/15/2015 8:4	40 am
				1.00	Date 2.00	
	General Instruction: Enter Y for all YES resp	onses. Enter N for all NO	responses. Ente			
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation	· · · · · · ·	<u> </u>			
00	Has the provider changed ownership immediatel reporting period? If yes, enter the date of t			N		1.
	reporting periods in yes, enter the date of t	the change in cordinin 2. (Se	Y/N	Date	V/I	
			1.00	2.00	3.00	
00	Has the provider terminated participation in	the Medicare Program? If	N			2.
	yes, enter in column 2 the date of termination	n and in column 3, "V" for				
	voluntary or "I" for involuntary.		N N			
00	Is the provider involved in business transact contracts, with individuals or entities (e.g.					3.
	or medical supply companies) that are related					
	officers, medical staff, management personnel					
	of directors through ownership, control, or f					
	relationships? (see instructions)					
			Y/N	Туре	Date	
			1.00	2.00	3.00	
)0	Financial Data and Reports Column 1: Were the financial statements prep	ared by a Cortified Dublie	Y	A		4.
0	Accountant? Column 2: If yes, enter "A" for			A		4.
	or "R" for Reviewed. Submit complete copy or					
	column 3. (see instructions) If no, see instr					
0	Are the cost report total expenses and total		N			5.
	those on the filed financial statements? If y	ves, submit reconciliation.		N/ (N)		
				Y/N 1.00	Legal Oper. 2.00	
	Approved Educational Activities			1.00	2.00	
0	Column 1: Are costs claimed for nursing scho	ol? Column 2: If yes, is	the provider is	s N		6.
	the legal operator of the program?	<b>5</b>				
00	Are costs claimed for Allied Health Programs?			N		7.
00	Were nursing school and/or allied health prog		ed during the	N		8.
0	cost reporting period? If yes, see instruction			N		
00	Are costs claimed for Intern-Resident program yes, see instructions.	is claimed on the current c	ost report? IT	N		9.
00	Was an Intern-Resident program been initiated	or renewed in the current	cost reporting	a N		10.
00	period? If yes, see instructions.	i of renewed in the current	cost reporting			10.
00	Are GME cost directly assigned to cost center	rs other than I & R in an A	pproved	N		11.
	Teaching Program on Worksheet A? If yes, see	instructions.				
					Y/N	
	Bad Debts				1.00	
00	Is the provider seeking reimbursement for bac	debts? If ves see instru	ctions		N	12.
00	If line 12 is yes, did the provider's bad deb			ost reportina	N	13.
	period? If yes, submit copy.					
00	If line 12 is yes, were patient deductibles a	nd/or co-payments waived?	If yes, see ins	structions.	N	14.
	Bed Complement				1	
00	Did total beds available change from the pric	or cost reporting period? I			N	15.
		Description	Y/N	art A Date	Part B Y/N	_
		0	1.00	2.00	3.00	
	PS&R Data					
00	Was the cost report prepared using the PS&R		Y	01/21/2015	Y	16.
	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)					
			N		N	17.
00	,					
00	Was the cost report prepared using the PS&R					
00	,					
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns					1
	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)					
	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments		N		N	18.
	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional		Ν		N	18.
	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not		Ν		N	18.
	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file		N		N	18.
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not		N		N	
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.					
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00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions. If line 16 or 17 is yes, were adjustments					
00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.		N		N	19.

Heal th	Financial Systems INC	I ANA ORTHOPAED	IC HOSPITAL, LL	С	In Lie	eu of Form CMS	-2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE			CCN: 150160 P F	veriod: rom 01/01/2014 o 12/31/2014	Date/Time Pr	epared:
				Par	t A	5/15/2015 8: Part B	40 am
		Descri	ntion	Y/N	Date	Y/N	
		C		1.00	2.00	3.00	
21.00	Was the cost report prepared only using the	, c	)	N 1.00	2.00	N 3.00	21.00
	provider's records? If yes, see instructions.						
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	ALS ONLY (EXCE	PT CHILDRENS H	Ο SPI ΤΔΙ S)		1.00	-
	Capital Related Cost	ALS UNET (LAGE		03111723/			_
22.00	Have assets been relifed for Medicare purpose	s? If ves see	instructions			N	22.00
	Have changes occurred in the Medicare depreci			als made durin	a the cost	N	23.00
23.00	reporting period? If yes, see instructions.	atton expense			g the cost		23.00
24.00	Were new leases and/or amendments to existing If yes, see instructions	g leases entere	ed into during	this cost repo	rting period?	N	24.00
25.00	Have there been new capitalized leases entere	ed into during	the cost repor	ting period? I	f yes, see	N	25.00
26.00	instructions. Were assets subject to Sec. 2314 of DEFRA acqu	i rod duri na th	o cost roporti	ng pariod2 lf	NOC 500	N	26.00
20.00	instructions.	uned during th	le cost reporti	ng period? II	yes, see	IN	20.00
27.00	Has the provider's capitalization policy char copy.	nged during the	e cost reportir	ng period?lfy	es, submit	N	27.00
	Interest Expense						
28.00	Were new loans, mortgage agreements or letter	rs of credit en	itered into dur	ing the cost r	eporting	N	28.00
29.00	period? If yes, see instructions. Did the provider have a funded depreciation a		•	bt Service Res	erve Fund)	N	29.00
30.00	treated as a funded depreciation account? If Has existing debt been replaced prior to its			dobt? If yos	500	N	30.00
30.00	instructions.	schedul ed liatu	in ty with new	debt? IT yes,	366	IN IN	30.00
31.00	Has debt been recalled before scheduled matur	ity without is	suance of new	debt? If yes,	see	N	31.00
	instructions. Purchased Services					<u> </u>	
32.00	Have changes or new agreements occurred in pa	atient care ser	vices furnishe	d through cont	ractual	N	32.00
02.00	arrangements with suppliers of services? If y			a through cont	laotaal		02.00
33.00	If line 32 is yes, were the requirements of S	Sec. 2135.2 app	lied pertainir	g to competiti	ve bidding? If		33.00
	no, see instructions.				-		
	Provider-Based Physicians					•	
34.00	Are services furnished at the provider facili	ty under an ar	rangement with	provi der-base	d physi ci ans?	N	34.00
	If yes, see instructions.						
35.00	If line 34 is yes, were there new agreements	or amended exi	sting agreemer	its with the pr	ovi der-based		35.00
	physicians during the cost reporting period?	lf yes, see in	istructions.				
					Y/N	Date	
					1.00	2.00	
	Home Office Costs				1	I	
	Were home office costs claimed on the cost re	•			N		36.00
37.00	If line 36 is yes, has a home office cost sta	atement been pr	epared by the	home office?			37.00
20 00	If yes, see instructions. If line 36 is yes , was the fiscal year end o	of the home off	ico difforant	from that of			38.00
30.00	the provider? If yes, enter in column 2 the f						30.00
39.00	If line 36 is yes, did the provider render se see instructions.						39.00
40.00	If line 36 is yes, did the provider render se instructions.	ervices to the	home office?	lfyes, see			40.00
			1.	00	2.	00	-
	Cost Report Preparer Contact Information				2.		
	Enter the first name, last name and the title	e/position	RENEE		ESSLI NGER		41.00
	held by the cost report preparer in columns						
	respectively.	., _, and o,					
42.00	Enter the employer/company name of the cost r	report	BKD, LLP				42.00
	preparer.						
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectively $\left( 1,1,2,2,2,3,2,3,2,3,3,3,3,3,3,3,3,3,3,3,$		317-383-3768		RESSLI NGER@BKD	. COM	43.00

		ANA ORTHOPAEDI				u of Form CMS-	
OSPI I.	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STIONNALRE	Provi de	r CCN: 150160	Period: From 01/01/2014 To 12/31/2014	Worksheet S-2 Part II Date/Time Pre 5/15/2015 8:4	pared
		Part B					
		Date					
		4.00					
	PS&R Data						
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	01/21/2015					16. (
7.00	instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)						17. (
8. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.						18.
9. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.						19.
0. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20.
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.						21.
		-		3.00			
	Cost Report Preparer Contact Information			5.00			
1.00	Enter the first name, last name and the title held by the cost report preparer in columns ' respectively.		SENI OR MANAGI	ING CONSULTANT			41.
2.00	Enter the employer/company name of the cost r preparer.	report					42.
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						43.

iospi t	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA		Provi der	CCN: 150160	Fr	eriod: rom 01/01/2014	Worksheet S Part I		
						To	12/31/2014	Date/Time P	rep	bared
						L		5/15/2015 8 I/P Days / 0/		Jam
								Visits / Trip		
	Component	Worksheet A	No	of Beds	Bed Days		CAH Hours	Title V		
	component	Line Number		0. 2000	Avai I abl e					
		1.00		2.00	3.00		4.00	5.00		
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		38	13, 8	70	0.00		0	1. (
	8 exclude Swing Bed, Observation Bed and									
	Hospice days)(see instructions for col. 2									
	for the portion of LDP room available beds)									
. 00	HMO and other (see instructions)									2.
. 00	HMO I PF Subprovi der									3. (
. 00	HMO I RF Subprovider									4.
. 00	Hospital Adults & Peds. Swing Bed SNF								0	5.
. 00	Hospital Adults & Peds. Swing Bed NF			20	10.0		0.00		0	6.
. 00	Total Adults and Peds. (exclude observation			38	13, 8	/0	0.00		0	7.
. 00	beds) (see instructions) INTENSIVE CARE UNIT									8.
. 00	CORONARY CARE UNIT									0. 9.
. 00 D. 00	BURN INTENSIVE CARE UNIT									7. 10.
1.00	SURGI CAL I NTENSI VE CARE UNI T									11.
2.00	OTHER SPECIAL CARE (SPECIFY)									12.
3.00	NURSERY									13.
4.00	Total (see instructions)			38	13, 8	70	0.00		0	14.
5.00	CAH visits			00	1070		0100		o	15.
6.00	SUBPROVIDER - IPF									16.
7.00	SUBPROVIDER - IRF									17.
8.00	SUBPROVI DER								1	18.
9.00	SKILLED NURSING FACILITY									19.
0. 00	NURSING FACILITY	45.00		0	1	0			0	20.
1.00	OTHER LONG TERM CARE				1					21.
2.00	HOME HEALTH AGENCY									22.
3.00	AMBULATORY SURGICAL CENTER (D. P.)									23.
4.00	HOSPI CE									24.
4. 10	HOSPICE (non-distinct part)	30.00								24.
5.00	CMHC - CMHC									25.
6.00	RURAL HEALTH CLINIC									26.
6. 25	FEDERALLY QUALIFIED HEALTH CENTER									26.
7.00	Total (sum of lines 14-26)			38						27.
8.00	Observation Bed Days								0	28.
9.00	Ambul ance Trips									29.
0.00	Employee discount days (see instruction)									30.
1.00	Employee discount days - IRF			~						31.
2.00	Labor & delivery days (see instructions)			0		0				32.
2. 01	Total ancillary labor & delivery room									32.
	outpatient days (see instructions) LTCH non-covered days									33.

OSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	F	eriod: rom 01/01/2014 o 12/31/2014	Worksheet S-3 Part I Date/Time Pre 5/15/2015 8:4	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2	2, 269	96	6, 078			1.00
	for the portion of LDP room available beds)						
. 00	HMO and other (see instructions)	16	0				2.00
. 00	HMO I PF Subprovider	0	0				3.00
. 00	HMO I RF Subprovider	0	0				4.00
. 00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
. 00	Hospital Adults & Peds. Swing Bed NF	2.240	96	0			6.00
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	2, 269	90	6, 078			7.00
. 00	INTENSIVE CARE UNIT						8.00
. 00	CORONARY CARE UNIT						9.00
0. 00	BURN INTENSIVE CARE UNIT						10.00
1.00	SURGI CAL INTENSI VE CARE UNI T						11.00
2.00	OTHER SPECIAL CARE (SPECIFY)						12.00
3.00	NURSERY						13.00
4.00	Total (see instructions)	2, 269	96	6, 078	0.00	288.22	
5.00	CAH visits	0	0	0			15.00
6.00	SUBPROVIDER - IPF						16.00
7.00	SUBPROVIDER - IRF						17.0
8.00 9.00	SUBPROVIDER SKILLED NURSING FACILITY						18.0 19.0
9.00 0.00	NURSING FACILITY		0	0	0.00	0.00	
1.00	OTHER LONG TERM CARE		0	0	0.00	0.00	20.0
2.00	HOME HEALTH AGENCY						22.00
3.00	AMBULATORY SURGICAL CENTER (D. P. )						23.0
4.00	HOSPI CE						24.00
4.10	HOSPICE (non-distinct part)	o	0	0			24.10
5.00	CMHC - CMHC						25.0
6.00	RURAL HEALTH CLINIC						26.0
6. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 2
7.00	Total (sum of lines 14-26)				0.00	288.22	27.0
8.00	Observation Bed Days		48	937			28.00
9.00	Ambulance Trips	0					29.00
0. 00	Employee discount days (see instruction)			0			30.00
1. 00	Employee discount days - IRF			0			31.0
2.00	Labor & delivery days (see instructions)	0	0	0			32.00
2. 01	Total ancillary labor & delivery room			0			32.01
	outpatient days (see instructions) LTCH non-covered days	0					33.00

HOSPI 1	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 150160	Period: From 01/01/2014 To 12/31/2014	Worksheet S-3 Part I Date/Time Prep 5/15/2015 8:40	
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0		70 40	2, 703	1.00
2.00 3.00 4.00 5.00 6.00 7.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)				0 0		2.00 3.00 4.00 5.00 6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						8.00 9.00 10.00 11.00 12.00
14.00 15.00 16.00 17.00 18.00 19.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY	0. 00	0	9	70 40	2, 703	14.00 15.00 16.00 17.00 18.00
20.00 21.00 22.00 23.00 24.00 24.10 25.00 26.00 26.25	NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0.00					20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00 26. 25
27.00 28.00 29.00 30.00 31.00 32.00 32.01	Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0. 00					27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00

03911.	AL WAGE INDEX INFORMATION			Provi der	F	Period: From 01/01/2014 To 12/31/2014		pared:
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adj usted Sal ari es (col . 2 ± col . 3)		Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
. 00	Total salaries (see	200.00	18, 300, 298	B 0	18, 300, 298	599, 495. 00	30. 53	1.00
. 00	instructions) Non-physician anesthetist Part		C	0	C	0.00	0. 00	2.00
. 00	A Non-physician anesthetist Part B		C	0	C	0.00	0.00	3. 00
. 00	Physician-Part A - Administrative		C	0 0	C	0.00	0.00	4.00
. 01	Physicians - Part A - Teaching		C	0	C			
. 00 . 00	Physician-Part B Non-physician-Part B		0	0		0.00		
. 00	Interns & residents (in an	21.00				0.00		
	approved program)	211 00				0100	0.00	
. 01	Contracted interns and residents (in an approved		C	0 0	C	0.00	0.00	7.01
. 00	programs) Home office personnel		C	0	C	0.00	0.00	8.00
. 00	SNF	44.00	C	0 0	C			
0. 00	Excluded area salaries (see instructions) OTHER WAGES & RELATED COSTS		C	0	(	0.00	0.00	10.00
1. 00	Contract Labor: Direct Patient		856, 735	j 0	856, 735	17, 100. 00	50. 10	11.00
2.00	Care Contract Labor: Top Level		C	0	C	0.00	0. 00	12.00
	management and other management and administrative services							
3. 00	Contract Labor: Physician-Part		C	0	C	0.00	0.00	13.00
4.00	A - Administrative Home office salaries & wage-related costs		3, 917, 678	3 O	3, 917, 678	137, 096. 00	28. 58	14.00
5.00	Home office: Physician Part A - Administrative		C	0 0	C	0.00	0. 00	15.00
6. 00	Home office and Contract Physicians Part A - Teaching		C	0 0	C	0.00	0.00	16.00
	WAGE-RELATED COSTS							
7.00	Wage-related costs (core) (see instructions)		4, 773, 991	0	4, 773, 991			17.00
8. 00	Wage-related costs (other) (see instructions)		C	0	C			18.00
	Excluded areas		C	0	C			19.00
0.00	Non-physician anesthetist Part A Non physician anesthetist Part		ſ		(			20.00
2. 00	Non-physician anesthetist Part B Physician Part A -		ſ		(			21.00
	Administrative Physician Part A - Teaching		ſ					22.00
	Physician Part B		C	0				23.00
4.00	Wage-related costs (RHC/FQHC)		C	-	C	)		24.00
5.00	Interns & residents (in an approved program)		C	0	C	)		25.00
	OVERHEAD COSTS - DIRECT SALARIE	S		<u> </u>				-
6.00	Employee Benefits Department	4.00	2, 580		2, 580			
7.00 8.00	Administrative & General Administrative & General under	5.00	2, 194, 412 356, 597		2, 194, 412 356, 597			
0.00	contract (see inst.)		000,077	0	000,077	1,007.00	227.20	20.00
9.00	Maintenance & Repairs	6.00	C	0	(	0.00		
0. 00 1. 00	Operation of Plant Laundry & Linen Service	7.00 8.00				0.00		30.00 31.00
2.00	Housekeeping	9.00	C			0.00		
3.00	Housekeeping under contract		562, 645	5 O	562, 645			
4.00	(see instructions) Dietary	10.00	C	0	C	0.00	0, 00	34.00
5.00	Dietary under contract (see instructions)	10.00	775, 827		775, 827			35.00
6. 00	Cafeteri a	11.00	C	-	C			
7.00 8.00	Maintenance of Personnel	12.00	C			0.00		37.00 38.00
	Nursing Administration	13.00	L	γ <sub>1</sub> U	l C			1 30.00
9.00	Central Services and Supply	14.00	C	0 0	(	0.00	0.00	39.00

Health Financial Systems	I ND	I ANA ORTHOPAED	DIC HOSPITAL, LL	с	In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					rom 01/01/2014		
					To 12/31/2014	Date/Time Prep 5/15/2015 8:40	<u>) am</u>
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid 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	480, 765	0	480, 765	20, 591. 00	23. 35	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	0	(	0.00	0.00	43.00

Heal th	Financial Systems	I ND	I ANA ORTHOPAED	DIC HOSPITAL, LL	C	In Lie	eu of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION					Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/15/2015 8:40	) am
		Worksheet A		Recl assi fi cati			Average Hourly	
		Line Number	Reported	on of Salaries			Wage (col. 4 ÷	
				(from	(col.2 ± col.		col. 5)	
				Worksheet A-6)		col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		19, 995, 367	0	19, 995, 36	7 676, 134. 00	29.57	1.00
	instructions)							
2.00	Excluded area salaries (see instructions)		0	0		0 0.00	0.00	2.00
3.00	Subtotal salaries (line 1 minus line 2)		19, 995, 367	0	19, 995, 36	7 676, 134. 00	29. 57	3.00
4.00	Subtotal other wages & related costs (see inst.)		4, 774, 413	0	4, 774, 41	3 154, 196. 00	30. 96	4.00
5.00	Subtotal wage-related costs (see inst.)		4, 773, 991	0	4, 773, 99	1 0.00	23. 88	5.00
6.00	Total (sum of lines 3 thru 5)		29, 543, 771	0	29, 543, 77	1 830, 330. 00	35.58	6.00
7.00	Total overhead cost (see instructions)		4, 372, 826	0	4, 372, 82	6 182, 867. 00	23. 91	7.00

OSPI T	AL WAGE RELATED COSTS	Provider CCN:	150160	Period: From 01/01/2014 To 12/31/2014	Date/Time Prep 5/15/2015 8:40	pare
					Amount	
					Reported	
					1.00	
	PART IV - WAGE RELATED COSTS Part A - Core List					
	RETIREMENT COST					
. 00	401K Employer Contributions				609, 637	1.
. 00	Tax Sheltered Annuity (TSA) Employer Contribution				009, 037	1. 2.
. 00	Nongualified Defined Benefit Plan Cost (see instructions)				0	2. 3.
. 00	Qualified Defined Benefit Plan Cost (see instructions)				0	3. 4.
. 00	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)				0	4.
00	401K/TSA Plan Administration fees				0	5.
00	Legal /Accounting/Management Fees-Pension Plan				0	5. 6.
00	Employee Managed Care Program Administration Fees				0	7.
00	HEALTH AND INSURANCE COST				0	/.
00	Health Insurance (Purchased or Self Funded)				2, 574, 788	8
00	Prescription Drug Plan				2, 374, 788	9
00	Dental, Hearing and Vision Plan				0	10
. 00	Life Insurance (If employee is owner or beneficiary)				-	-
. 00	Accident Insurance (If employee is owner or beneficiary)				30, 318	12
. 00	Disability Insurance (If employee is owner or beneficiary)				73, 829	
. 00	Long-Term Care Insurance (If employee is owner or beneficiary)				/ 3, 02 /	
. 00	'Workers' Compensation Insurance				0	14
. 00	Retirement Health Care Cost (Only current year, not the extrac	rdi parv accrual	roqui ro	d by EASP 106	0	16
. 00	Non cumulative portion)	in unitar y acciluar	require	u by IA35 100.	0	10
	TAXES					
. 00	FICA-Employers Portion Only				1, 334, 512	17
. 00	Medicare Taxes - Employers Portion Only				0	18
. 00	Unemployment Insurance				0	19
. 00	State or Federal Unemployment Taxes				150, 907	
	OTHER					
. 00	Executive Deferred Compensation (Other Than Retirement Cost Reinstructions))	ported on lines	; 1 throu	gh 4 above. (see	0	21
. 00	Day Care Cost and Allowances				0	22
. 00	Tui ti on Rei mbursement				0	23
I. 00	Total Wage Related cost (Sum of lines 1 -23)				4, 773, 991	-
	Part B - Other than Core Related Cost				.,, , , , ,	

Heal th	Financial Systems	NDIANA ORTHOPAEDIC HO	OSPI TAL, LLC	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CCN: 150160	Peri od:	Worksheet S-3	
				From 01/01/2014 To 12/31/2014		aarad
				To 12/31/2014	5/15/2015 8:40	
	Cost Center Description			Contract Labor		
	· · · · · · · · · · · · · · · · · · ·			1.00	2.00	
	PART V - Contract Labor and Benefit Cost					
	Hospital and Hospital-Based Component Identi	i fi cati on:				
1.00	Total facility's contract labor and benefit	cost		0	0	1.00
2.00	Hospi tal			0	0	2.00
3.00	Subprovider - IPF					3.00
4.00	Subprovider - IRF					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	Hospital-Based SNF					8.00
9.00	Hospital-Based NF			0	0	9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA					11.00
12.00	Separately Certified ASC					12.00
13.00	Hospital-Based Hospice					13.00
14.00	Hospital-Based Health Clinic RHC					14.00
15.00	Hospital-Based Health Clinic FQHC					15.00
16.00	Hospital-Based-CMHC					16.00
17.00	Renal Dialysis					17.00
18.00	Other			0	0	18.00

Heal th	Financial Systems IND	I ANA ORTHOPAEDI C HOSPI	TAL, LLC		In Lie	u of Form CMS-2	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA		ovider CCN: 15016			Worksheet S-10	
					/01/2014	Data /Tima Dray	norod.
				To 12	/31/2014	Date/Time Pre 5/15/2015 8:40	
		-				1.00	
	Uncompensated and indigent care cost computat			->			
1.00	Cost to charge ratio (Worksheet C, Part I lin	ne 202 column 3 divideo	d by line 202 col	umn 8)		0. 315815	1.00
2 00	Medicaid (see instructions for each line) Net revenue from Medicaid					626, 282	2.00
2.00 3.00	Did you receive DSH or supplemental payments	from Modi coi d2				020, 282 Y	3.00
4.00	If line 3 is "yes", does line 2 include all D		ments from Medic	Sh ie		N	4.00
4.00 5.00	If line 4 is "no", then enter DSH or suppleme			aru:		784, 304	5.00
6.00	Medi cai d charges	inter payments from mee				5, 617, 157	6.00
7.00	Medicaid cost (line 1 times line 6)					1, 773, 982	7.00
8.00	Difference between net revenue and costs for	Medicaid program (line	e 7 minus sum of	lines 2 and	d 5; if	363, 396	8.00
	< zero then enter zero)						
	State Children's Health Insurance Program (SC	HIP) (see instructions	s for each line)				
9.00	Net revenue from stand-alone SCHIP					0	9.00
	Stand-alone SCHIP charges					0	10.00
	Stand-alone SCHIP cost (line 1 times line 10)					0	11.00
12.00	Difference between net revenue and costs for	stand-alone SCHIP (lir	ne 11 minus line	9; if < ze	ro then	0	12.00
	enter zero)						
12 00	Other state or local government indigent care Net revenue from state or local indigent care					0	13.00
13.00 14.00	Charges for patients covered under state or I				s 6 or	0	13.00
14.00	10)	ocal indigent care pro			5 0 01	0	14.00
15.00	State or local indigent care program cost (li	ne 1 times line 14)				0	15.00
16.00	Difference between net revenue and costs for		nt care program (	line 15 mii	nus line	0	16.00
	13; if < zero then enter zero)		··· ··· · ··· · ··· · · · · · · · · ·			-	
	Uncompensated care (see instructions for each	line)					
17.00	Private grants, donations, or endowment incom	ne restricted to fundir	ng charity care			0	17.00
18.00	Government grants, appropriations or transfer					0	18.00
19.00	Total unreimbursed cost for Medicaid , SCHIP	and state and local ir	ndigent care prog	grams (sum (	oflines	363, 396	19.00
	8, 12 and 16)		Uni nsur	od Ind	sured	Total (col. 1	
			patient		ients	+ col. 2)	
			1.00		. 00	3.00	
20.00	Total initial obligation of patients approved	for charity care (at		5, 370	0	855, 370	20.00
	charges excluding non-reimbursable cost cente						
21.00	Cost of initial obligation of patients approv	ved for charity care (I	ine 1 270	), 139	0	270, 139	21.00
	times line 20)						
22.00	Partial payment by patients approved for char	rity care		3, 144	0	38, 144	
23.00	Cost of charity care (line 21 minus line 22)		237	1, 995	0	231, 995	23.00
						1 00	
24.00	Does the amount in line 20 column 2 include c	barges for patient day	ic hoverd a longt	b of ctor	limit	1.00 N	24.00
24.00	imposed on patients covered by Medicaid or ot			II UI SLAY	1 I IIII L	IN	24.00
25 00	If line 24 is "yes," charges for patient day			enath of sta	av limit	0	25.00
	Total bad debt expense for the entire hospita				.,	2, 714, 418	
	Medicare bad debts for the entire hospital co					2, , 11, 110	27.00
28.00	Non-Medicare and non-reimbursable Medicare ba					2, 714, 418	
29.00	Cost of non-Medicare and non-reimbursable Med	1	,			857, 254	
30.00	Cost of uncompensated care (line 23 column 3	plus line 29)		-		1, 089, 249	30.00
31.00	Total unreimbursed and uncompensated care cos	st (line 19 plus line 3	30)			1, 452, 645	31.00

RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES         Provider CCN: 150160         Period: Provider CCN: 150160         Worksheet A from 10/01/2014 To 12/31/2014           Cost Center Description         Salaries         Other         Total (col. 1 et al. 20)         Reclassificati Sister Cassificati Balance (col. 4)         Worksheet A Date/Time Propared: Sister Cassificati Balance (col. 4)           1.00         2.00         3.00         4.00         5.00           00100 NEW CAP REL COSTS-BLDG & FIXT         14,380,283         -765,975         13,614,308         1.00           0.00         00400 EWE CAP REL COSTS-BLDG & FIXT         14,380,283         -765,975         13,614,308         1.00           0.00         00400 DEWE CAP REL COSTS-MBLE EQU P         14,422,522,9330         17,423,742         628,448         18,052,190         5.00           0.00         000 OD FERATION OF PLANT         2,194,412         15,229,330         17,427,59,321         223,351         10.00           12.00         12.00         1,482,672         1,482,672         1,427,831         1.00         0         0         0         0         0         0         0         0         12,20         13,02         1,227,831         1,200         13,02         1,237,331         1,247,831         10,00         0         0	Heal th	Financial Systems INC	I ANA ORTHOPAEDI	C HOSPI TAL, LL	С	In Lie	u of Form CMS-2	2552-10
Cost Center Description         Sal aries         Other         Total (col. 2)         Total (col. 2)         Date/Time Prepared: (Col. 3)         Cost Center Description           1.00         2.00         0.000         8.000         3.00         4.00         5.00           1.00         2.00         3.00         4.00         5.00	RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der			Worksheet A	
CENERAL SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           1.00         00100 NEW CAP REL COST CENTERS         1.00         2.00         3.00         4.00         5.00           1.00         00200 NEW CAP REL COST SENDG & FIXT         14,380,283         -765,975         13,614,308         1.00           2.00         00200 NEW CAP REL COSTS-MULE EQUIP         14,380,283         -765,975         13,614,308         2.00           4.00         00400 EMPLOYEE BENETIS DEPARTMENT         2,580         4,904,422         4,909,002         0         4,909,002         0         4,909,002         0         4,909,002         0         4,909,002         0         4,909,002         0         0,90700         00700 OPERATIVE & & GENERAL         2,194,412         14,836         144,356         137,527         301,883         10.00         0         0         0         0         0         0         1.247,831         11.00           12.00         1200 MAINTENANCE OF PERSONNEL         0         0         0         0         0         0         0         14.00           14.00         0100 OCENTRAL SERVICE COST CENTERS         30.00         0         0         0         0         0         14.00						To 12/31/2014	5/15/2015 8:4	
Image: Construct of the service cost centers         Image: Cost centers         Image: Cost centers         Image:		Cost Center Description	Sal ari es	Other				
CENERAL SERVICE COST CENTERS         Col. 4)           1.00         2.00         3.00         4.00         5.00           1.00         00100 NEW CAP REL COSTS-BLOG & FIXT         14,380,283         14,380,283         -765,975         13,614,308         1.00           2.00         00200 NEW CAP REL COSTS-BUG & FIXT         2,580         4,906,422         4,909,002         0         4.00         2.00           3.00         0000 DEW CAP REL COSTS-WBLE EQUIP         2,580         4,906,422         4,909,002         0         4,909,002         4.00         0					+ col. 2)	ons (See A-6)		
Image: 1.00         2.00         3.00         4.00         5.00           1.00         00100 NEW CAP REL COSTS CENTERS         14,380,283         -765,975         13,614,308         1,00         2.00           0.000 NEW CAP REL COSTS-MUBLE EQUIP         0 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
GENERAL SERVICE COST CENTERS         Image: Cost Cent								
1.00         OD100         NEW CAP REL COSTS-INDEC & FIXT         14, 380, 283         14, 380, 283         -765, 975         13, 614, 308         1.00           2.00         00200 NEW CAP REL COSTS-INDEL EQUIP         0			1.00	2.00	3.00	4.00	5.00	
2.00         O200         NEW CAP REL COSTS-HWBLE EQUIP         0				11.000.000	44,000,00		10 (11 000	
4. 00         00400         EMPLOYEE BENEFITS DEPARTMENT         2,580         4,906,422         4,909,002         0         4,909,002         4,000           5.00         00500         ADMINISTRATIVE & GENERAL         2,194,412         15,229,330         17,423,742         628,448         18,052,190         5.00           10.00         01000         DIETARY         0         1,482,672         1,482,672         -1,259,321         223,351         10.00           11.00         10100         CETERIA         0         0         0         0         12,203         11,247,831         11.247,831         11.247,831         11.00           12.00         01300         NURSI NG ADMINI STRATI ON         0         0         0         0         12.00           14.00         01400         CENTRAL SERVICES & SUPPLY         480,765         72,126         552,891         0         552,891         16.00           16.00         01400         CENTRAL SERVICE COST CENTERS         3,624,729         663,641         4,288,370         0         4,288,370         30.00         45.00           30.00         05000         DEPRATI NC ROOM         8,528,909         6,256,411         14,785,323         -411,928         14,373,395         50.00					14, 380, 28			
5.00         00500         ADMI NI STRATI VE & GENERAL         2, 194, 412         15, 229, 330         17, 423, 742         628, 448         18, 052, 190         5.00           7.00         00700         OPERATI ON OF PLANT         0         164, 356         164, 356         137, 527         301, 883         7.00           10.00         01000         DI ETARY         0         1, 482, 672         -1, 259, 321         223, 351         10.00           11.00         CAFETERI A         0         0         0         0         12.00<				-			-	
7.00       00700       OPERATI ON OF PLANT       0       164,356       137,527       301,883       7.00         10.00       01000       DETARY       0       1,482,672       1,482,672       1,259,321       223,351       10.00         11.00       0100       CAFETERIA       0       0       0       1,247,831       11.247,831       11.247,831       11.247,831       11.247,831       11.247,831       11.247,831       11.200       12.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       12.00       13.00       01400       CENTRAL SERVICES & SUPPLY       0								
10.00       01000       DETARY       0       1, 482, 672       -1, 259, 321       223, 351       10.00         11.00       01000       CAFETERIA       0       0       0       1, 247, 831								
11.00       01100       CAFETERIA       0       0       0       1,247,831       1,207       1,247,831       1,00       1,01       1,01       1,01       1,01       1,01       1,01       1,01 </td <td></td> <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>			0					
12.00       01200       MAI NTENANCE OF PERSONNEL       0			0	1, 482, 672	1, 482, 67			
13.00       01300       NURSI NG ADMINI STRATI ON       0       0       0       0       0       13.00         14.00       01400       CENTRAL SERVI CES & SUPPLY       0       0       0       0       0       0       14.00         16.00       MEICAL RECORDS & LIBRARY       480,765       72,126       552,891       0       552,891       0       552,891       0       552,891       0       652,891       0       652,891       0       652,891       0       652,891       0       652,891       0       652,891       0       652,891       0       652,891       0       650,90       0 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 1, 247, 831</td> <td></td> <td></td>			0	0		0 1, 247, 831		
14.00       01400       CENTRAL SERVICES & SUPPLY       0			0	0		0 0		
16.00       MEDI CAL RECORDS & LI BRARY       480,765       72,126       552,891       0       552,891       16.00         INPATI ENT ROUTI NE SERVICE COST CENTERS         30.00       OJOOD ADULTS & PEDI ATRI CS       3,624,729       663,641       4,288,370       0       428,370       30.00         45.00       O4500 NURSI NG FACILITY       0       0       0       0       0       0       0       50.00         50.00       OS000 OPERATI NG ROOM       8,528,909       6,256,414       14,785,323       -411,928       14,373,395       50.00         51.00       OS000 ARDI OLOGY-DI AGNOSTI C       651,111       999,143       1,650,254       411,928       2,062,182       54.00         60.00       O6000 LABORATORY       0       1,085,188       0       1,085,188       0       1,085,188       60.00         60.00       O6000 LABORATORY       2,619,426       280,303       2,899,729       0       2,899,729       0       2,899,729       0       2,199,729       11,775       73.00         71.00       OT200       IMEL DEV. CHARGED TO PATI ENTS       0       2,792,916       0       2,792,916       2,792,916       2,792,916       2,792,916       2,792,916       2,792,916       2,792,916 <td></td> <td></td> <td>0</td> <td>0</td> <td></td> <td>0 0</td> <td></td> <td></td>			0	0		0 0		
INPATI ENT ROUTI NE SERVICE COST CENTERS           30. 00         03000[ADULTS & PEDI ATRI CS         3, 624, 729         663, 641         4, 288, 370         0         4, 288, 370         <	14.00		0	0		0 0	e e	
30. 00       03000       ADULTS & PEDIATRICS       3, 624, 729       663, 641       4, 288, 370       0       4, 288, 370       0	16.00		480, 765	72, 126	552, 89	0 0	552, 891	16.00
45. 00       04500       NURSI NG FACI LITY       0 <th0< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></th0<>								
ANCILLARY SERVICE COST CENTERS           50. 00         05000         OPERATING ROOM         8, 528, 909         6, 256, 414         14, 785, 323         -411, 928         14, 373, 395         50. 00           53. 00         05300         ANESTHESI OLOGY         0         276, 317         276, 317         0         276, 317         53. 00           54. 00         05400         RADI OLOGY-DI AGNOSTI C         651, 111         999, 143         1, 650, 254         411, 928         2, 062, 182         54. 00           60. 00         06000         LABORATORY         0         1, 085, 188         1, 085, 188         0         1, 085, 188         60. 00           66. 00         06600         PHYSI CAL THERAPY         2, 619, 426         280, 303         2, 899, 729         0         2, 899, 729         66. 00           67. 00         06700         OCUPATI ONAL THERAPY         198, 366         13, 409         211, 775         0         211, 775         67. 00           71. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         2, 824, 314         -18, 611, 852         5, 212, 462         71. 00           73. 00         07300         DRUGS CHARGED TO PATI ENTS         0         2, 792, 916         2, 792, 916         2, 792, 91					4, 288, 37			
50. 00       05000       0PERATI NG ROOM       8, 528, 909       6, 256, 414       14, 785, 323       -411, 928       14, 373, 395       50. 00         53. 00       05300       ANESTHESI OLOGY       0       276, 317       276, 317       0       276, 317       53. 00         54. 00       05400       RADI OLOGY-DI AGNOSTI C       651, 111       999, 143       1, 650, 254       411, 928       2, 062, 182       54. 00         60. 00       06000       LABORATORY       0       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       1, 075       0       211, 775       0       211, 775       0       211, 775       0       211, 775       0       211, 775       0       211, 775       0       2, 792, 916       2, 792, 916       2, 792, 916       2, 792, 916       2, 792, 916       2, 792, 916       2, 792, 916       2, 792, 916       2, 7	45.00		0	0		0 0	0	45.00
53.00       05300       ANESTHESI OLOGY       0       276, 317       276, 317       0       276, 317       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       651, 111       999, 143       1, 650, 254       411, 928       2, 062, 182       54.00         60.00       06000       LABORATORY       0       1, 085, 188       1, 085, 188       0       1, 085, 188       0       1, 085, 188       0       0       2, 899, 729       0       2, 899, 729       66.00         66.00       06000       DCCUPATI ONAL THERAPY       2, 619, 426       280, 303       2, 899, 729       0       2, 899, 729       66.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       23, 824, 314       23, 824, 314       -18, 611, 852       5, 212, 462       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0       2, 792, 916       2, 792, 916       73.00         0172.00       07200       DRUGS CHARGED TO PATI ENTS       0       2, 792, 916       2, 792, 916       73.00       73.00         0172.00       07300       DRUGS CHARGED TO PATI ENTS       0       2, 792, 916       2, 792, 916       73.00       73.00         0173.00								
54.00       05400       RADI OLOGY-DI AGNOSTI C       651, 111       999, 143       1, 650, 254       411, 928       2, 062, 182       54.00         60.00       06000       LABORATORY       0       1, 085, 188       1, 085, 188       0       1, 085, 188       0       0, 2, 899, 729       0       2, 899, 729       66.00         66.00       06600       PHYSI CAL THERAPY       2, 619, 426       280, 303       2, 899, 729       0       2, 899, 729       66.00         67.00       0CCUPATI ONAL THERAPY       198, 366       13, 409       211, 775       0       211, 775       67.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       23, 824, 314       -18, 611, 852       5, 212, 462       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0       2, 792, 916       2, 792, 916       2, 792, 916       73.00         0       07300       DRUGS CHARGED TO PATI ENTS       0       2, 792, 916       2, 792, 916       73.00       2, 792, 916       73.00         92.00       SPECI AL PURPOSE COST CENTERS       90, 727, 132       -11, 490       90, 715, 642       18.00         18.00       90000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       90								
60.00       06000       LABORATORY       0       1,085,188       1,085,188       0       1,085,188       60.00         66.00       06600       PHYSI CAL THERAPY       2,619,426       280,303       2,899,729       0       2,899,729       66.00         67.00       06700       OCCUPATI ONAL THERAPY       198,366       13,409       211,775       0       211,775       67.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       23,824,314       -18,611,852       5,212,462       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENTS       0       2,792,916       0       2,792,916       72.00       72.00       0       2,792,916       0       2,792,916       73.00       0       2,792,916       0       2,792,916       73.00       0       2,792,916       0       2,792,916       73.00       0       2,792,916       0       2,792,916       73.00       0       2,792,916       0       2,792,916       73.00       0       2,792,916       0       2,792,916       73.00       0       2,792,916       0       1,005,1642       18.00       18.00,298       72,426,834       90,727,132       -11,490       90,715,642       18.00			Ű					
66.00       06600       PHYSI CAL THERAPY       2, 619, 426       280, 303       2, 899, 729       0       2, 899, 729       66.00         67.00       06700       OCCUPATI ONAL THERAPY       198, 366       13, 409       211, 775       0       211, 775       67.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       23, 824, 314       -18, 611, 852       5, 212, 462       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0       0       18, 611, 852       72.00       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0       2, 792, 916       0       2, 792, 916       73.00         0       0       0       18, 611, 852       72.00       73.00         0       0       2, 792, 916       0       2, 792, 916       0       2, 792, 916       73.00         0       0       0       2, 792, 916       0       2, 792, 916       0       2, 792, 916       73.00         0       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART)       90, 727, 132       -11, 490       90, 715, 642       118.00         118.00       SUBTOTALS (SUM OF LINES 1-117)       18, 300, 298       72, 426, 834       90, 727, 132<			651, 111					
67.00       06700       0CCUPATI ONAL THERAPY       198,366       13,409       211,775       0       211,775       67.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       23,824,314       -18,611,852       5,212,462       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATI ENT       0       0       0       18,611,852       18,611,852       72.00       73.00         07300       DRUGS CHARGED TO PATI ENTS       0       2,792,916       2,792,916       0       2,792,916       73.00         017200       DRUGS CHARGED TO PATI ENTS       0       2,792,916       2,792,916       0       2,792,916       73.00         017200       DRUGS CHARGED TO PATI ENTS       0       2,792,916       2,792,916       0       2,792,916       73.00         017200       DRUGS CHARGED TO PATI ENTS       0       2,792,916       2,792,916       0       2,792,916       73.00         92.00       DSEVENATI ON BEDS (NON-DI STI NCT PART)        90,715,642       18.00       90,715,642       18.00       18.00       90,727,132       -11,490       90,715,642       18.00         118.00       SUBTOTALS (SUM OF LINES 1-117)       18,300,298       72,426,834			-					
71. 00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0       23, 824, 314       -18, 611, 852       5, 212, 462       71. 00         72. 00       07200       IMPL. DEV. CHARGED TO PATI ENT       0       0       0       18, 611, 852       18, 611, 852       72. 00         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0       2, 792, 916       2, 792, 916       0       2, 792, 916       73. 00         00TPATI ENT SERVICE COST CENTERS       0       2, 792, 916       2, 792, 916       0       2, 792, 916       73. 00         92. 00       OSERVATI ON BEDS (NON-DI STI NCT PART)       92. 00       92. 00       92. 01       92. 00       90, 727, 132       -11, 490       90, 715, 642       118. 00         NONREI MBURSABLE COST CENTERS         190. 00       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       11, 490       90, 715, 642       118. 00         194. 00       07950       OTHER NONREI MBURSABLE COST CENTERS       0       443, 761       443, 761       0       443, 761       194. 00       391, 586       391, 586       391, 586       194. 01								
72. 00       07200       IMPL. DEV. CHARGED TO PATIENT       0       0       0       18, 611, 852       18, 611, 852       72. 00         73. 00       07300       DRUGS CHARGED TO PATIENTS       0       2, 792, 916       2, 792, 916       0       2, 792, 916       73. 00         92. 00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       92. 00			198, 366					
73.00       07300       DRUGS CHARGED TO PATIENTS       0       2,792,916       2,792,916       0       2,792,916       73.00         0UTPATIENT SERVICE COST CENTERS       0       2,792,916       2,792,916       0       2,792,916       73.00         92.00       0BSERVATI ON BEDS (NON-DI STINCT PART)       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       92.00       90.715,642       118.00       90,715,642       118.00       90,715,642       118.00       118.00       90,715,642       118.00       118.00       10.00       0       0       11,490       90,715,642       118.00       118.00       119.00       0       0       0       11,490       10.00       11,490       10.00       11,490       10.00       11,490       10.00       11,490       10.00       11,490       10.00       11,490       10.00       114.00 <t< td=""><td>71.00</td><td></td><td>0</td><td>23, 824, 314</td><td>23, 824, 31</td><td></td><td></td><td></td></t<>	71.00		0	23, 824, 314	23, 824, 31			
OUTPATI ENT SERVICE COST CENTERS         92.00           09200         OBSERVATI ON BEDS (NON-DI STI NCT PART)         92.00           SPECIAL PURPOSE COST CENTERS         92.00           118.00         SUBTOTALS (SUM OF LINES 1-117)         18,300,298         72,426,834         90,727,132         -11,490         90,715,642         118.00           NONREI MBURSABLE COST CENTERS         90.00         190.00         GIFT, FLOWER, COFFEE SHOP & CANTEEN         0         0         11,490         11,490         190.00           194.00         07950         OTHER NONREI MBURSABLE COST CENTERS         0         443,761         0         443,761         194.00         194.01         0         391,586         391,586         0         391,586         194.01			0	0			18, 611, 852	
92.00       09200       OBSERVATI ON BEDS (NON-DI STINCT PART)       92.00         SPECIAL PURPOSE COST CENTERS       90,727,132       -11,490       90,715,642         118.00       SUBTOTALS (SUM OF LINES 1-117)       18,300,298       72,426,834       90,727,132       -11,490       90,715,642         118.00       NONREI MBURSABLE COST CENTERS       118.00       0       0       11,490       10,00         190.00       IGFT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       11,490       190.00         194.00       07950       OTHER NONREI MBURSABLE COST CENTERS       0       341,761       443,761       0       443,761       194.00         194.01       07951       NNS       0       391,586       391,586       0       391,586       194.01	73.00		0	2, 792, 916	2, 792, 91	6 0	2, 792, 916	73.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1-117)         18, 300, 298         72, 426, 834         90, 727, 132         -11, 490         90, 715, 642           100.00         INONREI MBURSABLE COST CENTERS         0         0         0         11, 490         11, 490         190.00           190.00         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         11, 490         11, 490         190.00           194.00         07950         OTHER NONREI MBURSABLE COST CENTERS         0         443, 761         0         443, 761         194.00         194.01         194.01         194.01         0         391, 586         391, 586         0         391, 586         194.01						_		
SUBTOTALS         Subtop	92.00							92.00
NONRE I MBURSABLE         COST         CENTERS           190. 00         19000         GIFT,         FLOWER,         COFFEE         SHOP & CANTEEN         0         0         0         11, 490         190. 00           194. 00         07950         OTHER         NORE I MBURSABLE         COST         CENTERS         0         443, 761         0         443, 761         194. 00           194. 01         07950         NNS         0         391, 586         391, 586         0         391, 586         194. 01						-		
190. 00         GIFT,         FLOWER,         COFFEE         SHOP & CANTEEN         0         0         11,490         11,490         190. 00           194. 00         07950         OTHER NONREI MBURSABLE COST CENTERS         0         443,761         443,761         0         443,761         194. 00           194. 01         07951         NNS         0         391,586         391,586         0         391,586         194. 01	118.00		18, 300, 298	72, 426, 834	90, 727, 13	-11, 490	90, 715, 642	118.00
194.00         07950         OTHER NONREI MBURSABLE COST CENTERS         0         443, 761         0         443, 761         194.00           194.01         07951         NNS         0         391, 586         391, 586         0         391, 586         194.01								
194. 01 07951 NNS 0 391, 586 0 391, 586 194. 01			0	-				
			0	443, 761				
200. 00           TOTAL (SUM OF LINES 118-199)         18, 300, 298         73, 262, 181         91, 562, 479         0         91, 562, 479         200. 00			0					
	200.00	TOTAL (SUM OF LINES 118-199)	18, 300, 298	73, 262, 181	91, 562, 47	<sup>'9</sup> 0	91, 562, 479	200. 00

Health Financial Systems INDIANA ORTHOPAEDIC HOSPITAL, LLC In Lieu of Form CMS	-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Provider CCN: 150160 Period: Worksheet A	
From 01/01/2014	
To 12/31/2014 Date/Time Pr	repared:
5/15/2015 8:	<u>40 am</u>
Cost Center Description Adjustments Net Expenses	
(See A-8) For Allocation	
6.00 7.00	_
GENERAL SERVICE COST CENTERS	
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 387, 774 14, 002, 082	1.00
2. 00 00200 NEW CAP REL COSTS-MVBLE EQUIP 0 0 0	2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 782,053 5,691,055	4.00
5. 00 00500 ADMINI STRATI VE & GENERAL -2, 416, 290 15, 635, 900	5.00
7. 00 00700 OPERATION OF PLANT 0 301, 883	7.00
10. 00 01000 DI ETARY -18, 905 204, 446	10.00
11. 00 01100 CAFETERIA -361, 301 886, 530	11.00
12.00 01200 MAINTENANCE OF PERSONNEL 0 0	12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 0 0	13.00
14.00 01400 CENTRAL SERVICES & SUPPLY 0 0	14.00
16. 00 01600 MEDICAL RECORDS & LI BRARY -14, 573 538, 318	16.00
INPATIENT ROUTINE SERVICE COST CENTERS	
30. 00 03000 ADULTS & PEDI ATRI CS -1, 360 4, 287, 010	30.00
45. 00 04500 NURSING FACILITY 0 0 0	45.00
ANCI LLARY SERVICE COST CENTERS	
50. 00 05000 OPERATING ROOM 0 14, 373, 395	50.00
53. 00 05300 ANESTHESI OLOGY 0 276, 317	53.00
54. 00 05400 RADI 0LOGY-DI AGNOSTI C 0 2, 062, 182	54.00
60. 00 06000 LABORATORY 0 1,085, 188	60.00
66. 00 06600 PHYSI CAL THERAPY 0 2, 899, 729	66.00
67.00 06700 OCCUPATI ONAL THERAPY 0 211, 775	67.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 5, 212, 462	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT 0 18, 611, 852	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 2, 792, 916	73.00
OUTPATIENT SERVICE COST CENTERS	
92. 00 09200/0BSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
118.00 SUBTOTALS (SUM OF LINES 1-117) -1,642,602 89,073,040	118.00
NONREI MBURSABLE COST CENTERS	$\dashv$
190. OO 19000 G FT, FLOWER, COFFEE SHOP & CANTEEN 0 11, 490	190.00
194. OOI07950 OTHER NONREI MBURSABLE COST CENTERS 424, 194 867, 955	194.00
194. 01 07951 NNS 0 391, 586	194.00
200.00 TOTAL (SUM OF LINES 118-199) -1, 218, 408 90, 344, 071	200.00
	1200.00

	Financial Systems SIFICATIONS		I ANA ORTHOPAEDI		CCN: 150160	Peri od:	u of Form CMS Worksheet A-	
						From 01/01/2014 To 12/31/2014	Date/Time Pr 5/15/2015 8:	epared:
		Increases					0, 10, 2010 01	
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	A - CAFETERIA EXPENSE							
1.00	CAFETERI A	11.00	0	1, 247, 831				1.00
	0		0	1, 247, 831				
	C - A&G EXPENSE							
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	6 <u>5, 8</u> 03				1.00
	0		0	65, 803				
	D - PLANT OPERATIONS EXPENSE							
1.00	OPERATION OF PLANT	7.00	0	<u>137, 5</u> 27				1.00
	0		0	137, 527				
	E - IMPLANTABLE DEVICE RECLAS							_
1.00	IMPL. DEV. CHARGED TO	72.00	0	18, 611, 852				1.00
	PATI ENT	+	+					
	0		0	18, 611, 852				_
	F - GIFT SHOP EXPENSE							_
1.00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	11, 490				1.00
	<u>CANTEEN</u>	+						
		00	U	11, 490				-
1.00	G - HOUSEKEEPING CONTRACT LAB	5.00	ol	E40 44E				1.00
1.00	ADMI NI STRATI VE & GENERAL		<del>0</del>	562, 645				1.00
	H - RADI OLOGY RECLASS		0	562, 645	<u> </u>			-
1.00	RADI OLOGY - DI AGNOSTI C	54.00	411, 928	0				1.00
1.00			411,928	0				1.00
	Grand Total: Increases		411, 928	20, 637, 148				500.00

LASSI FI CATI ONS			Provi der	CCN: 150160	Period: From 01/01/2014	Worksheet A-6
					To 12/31/2014	Date/Time Prepar 5/15/2015 8:40 a
	Decreases					
Cost Center	Line #	Salary	Other	Wkst. A-7 Ref	· .	
6.00	7.00	8.00	9.00	10.00		
A - CAFETERIA EXPENSE						
0 DI ETARY	10.00	0	1, 247, 831		0	1
0		0	1, 247, 831			
C - A&G EXPENSE	<u>.</u>					
0 NEW CAP REL COSTS-BLDG &	1.00	0	65, 803		9	1
<u>FIX</u> T						
0		0	65, 803			
D - PLANT OPERATIONS EXPENSE						
0 NEW CAP REL COSTS-BLDG &	1.00	0	137, 527		9	1
FLXT						
		0	137, 527		1	
E - IMPLANTABLE DEVICE RECLASS						
0 MEDI CAL SUPPLI ES CHARGED TO	71.00	0	18, 611, 852		0	1
PATI ENTS						
			18, 611, 852		1	
F - GIFT SHOP EXPENSE	<b>I</b>	1		1		
0 DI ETARY	10,00	0	11, 490		0	1
		0	11, 490		-	
G - HOUSEKEEPING CONTRACT LABO	R		,			
0 NEW CAP REL COSTS-BLDG &	1.00	0	562, 645	1	0	1
FLXT		0	002,010			
	+		562, 645		1	
H - RADI OLOGY RECLASS	I		, 010	ı		
0 OPERATING ROOM	50,00	411, 928	0		0	1
		411, 928	0	<u>├── ── </u>	7	
.00 Grand Total: Decreases		411, 928	20, 637, 148			500

Heal th	Financial Systems ING	DI ANA ORTHOPAED	IC HOSPITAL, LL	С	In Lie	eu of Form CMS-2	2552-10
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150160	Period: From 01/01/2014 To 12/31/2014		pared:
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES				•	
1.00	Land	778, 901	0		0 0	0	1.00
2.00	Land Improvements	127, 756	3, 910		0 3, 910	0	2.00
3.00	Buildings and Fixtures	0	0		0 0	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	23, 699, 432	823, 474		0 823, 474	138, 777	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	24, 606, 089	827, 384		0 827, 384	138, 777	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	24, 606, 089	827, 384		0 827, 384	138, 777	10.00
		Endi ng Bal ance	Fully				
		-	Depreci ated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	778, 901	0				1.00
2.00	Land Improvements	131, 666	0				2.00
3.00	Buildings and Fixtures	0	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	24, 384, 129	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	25, 294, 696	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	25, 294, 696	0				10.00

Heal th	Health Financial Systems IND		IC HOSPITAL, LL	С	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/15/2015 8:4	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)	Taxes (see instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	N 2, LINES 1 a	INES 1 and 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	2, 197, 874	11, 820, 781	45, 07	86, 254	230, 298	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0	(	0 0	0	2.00
3.00	Total (sum of lines 1-2)	2, 197, 874	11, 820, 781	45, 07	86, 254	230, 298	3.00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions) 14.00		-			
			15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM					
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	14, 380, 283				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	14, 380, 283				3.00

Health Financial Systems IND	I ANA ORTHOPAED	DIC HOSPITAL, LL	.C	In Lie	eu of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2014 Fo 12/31/2014		bared:
	COM	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
PART III - RECONCILIATION OF CAPITAL COSTS CE	1.00	2.00	3.00	4.00	5.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT	910, 567	0	910, 56	0. 035998	0	1.00
2.00 NEW CAP REL COSTS BEDG & TTAT	24, 384, 129		24, 384, 129			2.00
3.00 Total (sum of lines 1-2)	25, 294, 696		25, 294, 690			3.00
	ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITA					
Cost Center Description	Taxes	Other Capital-Relate d Costs	Total (sum of cols.5 through 7)	Depreciation	Lease	
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE	NTERS					
1.00 NEW CAP REL COSTS-BLDG & FIXT 2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0			2, 378, 289 0 0 2, 378, 289	0	1.00 2.00 3.00
	0	SI	JMMARY OF CAPI		11, 202, 103	3.00
Cost Center Description	Interest	Insurance (see instructions)		Other Capital-Relate d Costs (see instructions)	Total (2) (sum of cols. 9 through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 NEW CAP REL COSTS-BLDG & FIXT	45, 076			3 0	14, 002, 082	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	0 45, 076	-			0 14, 002, 082	2.00 3.00
5.00 [TOTAL (Sum OF TIMES T-2)	45,076	00, 254	- 230, 290	ы О	14, 002, 062	3.00

DJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2014 To 12/31/2014	Date/Time Pre 5/15/2015 8:4	
				Expense Classification o		571572015 8:4	
				To/From Which the Amount is	to be Adjusted		
	Cost Conton Decerintion	Dacia (Cada (2)	Amount	Cost Contor	Line #	Wkst. A-7 Ref.	
	Cost Center Description	1.00	Amount 2.00	Cost Center 3.00	4.00	5.00	
00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-11, 412	NEW CAP REL COSTS-BLDG & FLXT	1.00	9	1.
00	Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter 2)		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.
00	Investment income - other		C		0.00	0	3.
00	(chapter 2) Trade, quantity, and time		(		0.00	0	4.
00	discounts (chapter 8) Refunds and rebates of		(		0.00	0	5
00	expenses (chapter 8) Rental of provider space by		ſ		0.00	0	6
	suppliers (chapter 8)						
00	Telephone services (pay stations excluded) (chapter		C		0.00	0	7
00	21) Television and radio service (chapter 21)		C		0.00	0	8
00	Parking lot (chapter 21)		(		0.00		
. 00	Provider-based physician adjustment	A-8-2	(			0	
. 00	Sale of scrap, waste, etc. (chapter 23)		(	D	0.00	0	11
. 00	Related organization transactions (chapter 10)	A-8-1	-745, 336			0	12
. 00	Laundry and linen service		)		0.00		
. 00 . 00	Cafeteria-employees and guests Rental of quarters to employee	В	-361, 301	CAFETERI A	11.00 0.00		
00	and others Sale of medical and surgical supplies to other than		C		0.00	0	16
. 00	patients Sale of drugs to other than		(		0.00	0	17
00	patients Sale of medical records and	В	573	MEDICAL RECORDS & LIBRARY	16.00		
	abstracts	D					
00	Nursing school (tuition, fees, books, etc.)		(		0.00	0	19
	Vending machines Income from imposition of		(		0.00 0.00		
	interest, finance or penalty charges (chapter 21)					-	
. 00	Interest expense on Medicare overpayments and borrowings to		(		0.00	0	22
. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	*** Cost Center Deleted ***	65.00		23
	limitation (chapter 14)				(/ 22		
. 00	Adjustment for physical therapy costs in excess of	A-8-3	(	PHYSI CAL THERAPY	66.00		24
. 00	limitation (chapter 14) Utilization review - physicians' compensation		(	*** Cost Center Deleted ***	114.00		25
. 00	(chapter 21) Depreciation - NEW CAP REL		ſ	NEW CAP REL COSTS-BLDG &	1.00	0	26
	COSTS-BLDG & FIXT			FIXT			
00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP			NEW CAP REL COSTS-MVBLE EQUIP	2.00		
00	Non-physician Anesthetist Physicians' assistant		(	)*** Cost Center Deleted *** )	19.00 0.00		28 29
	Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	67.00		30
. 99	limitation (chapter 14) Hospice (non-distinct) (see		(	ADULTS & PEDIATRICS	30.00		30
	instructions) Adjustment for speech	A-8-3	(	*** Cost Center Deleted ***	68.00		31
	pathology costs in excess of limitation (chapter 14)						
. 00	CAH HIT Adjustment for Depreciation and Interest		(		0.00	0	32

Heal th	Financial Systems	I ND	I ANA ORTHOPAED	DIC HOSPITAL, LLC	In Lie	eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 150160	Peri od:	Worksheet A-8	
					From 01/01/2014 To 12/31/2014		
				Expense Classification c	n Worksheet A		
				To/From Which the Amount is	s to be Adjusted		
	Cost Contor Description	Pacic/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	Cost Center Description	1.00	2.00	3.00	4,00	5.00	
33.00	LOBBYING EXPENSE OFFSET	A		ADMI NI STRATI VE & GENERAL	4.00		33.00
33.00	MARKETING EXPENSE OFFSET	A		ADMINI STRATI VE & GENERAL	5.00		33.00
33.02	APPLICATION FEE REVENUE	B		ADMINI STRATI VE & GENERAL	5.00		33.02 33.06
33.00	PENALTIES REVENUE	B		ADMI NI STRATI VE & GENERAL	5.00		33.00
33.07	CATERING SERVICE REVENUE	В			10.00		33.07 33.08
33.09	MISC. MEDICAL REVENUE	В		MEDI CAL RECORDS & LI BRARY	16.00		33.09
33. 10	GIFT AND DONATION EXPENSE OFFSET	В	-593	ADMI NI STRATI VE & GENERAL	5.00	0	33. 10
33.11	GIFT AND DONATION EXPENSE	A	-1, 360	ADULTS & PEDIATRICS	30.00	0	33. 11
	OFFSET						
33.14	LEARNING LAB REVENUE	A	-15, 711	ADMINISTRATIVE & GENERAL	5.00	0	33.14
50.00	TOTAL (sum of lines 1 thru 49)		-1, 218, 408				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Heal th	Financial Systems	I NDI ANA ORTHOPAE	AEDI C HOSPI TAL, LLC I			n Lieu of Form CMS-2552-10			
STATEME	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ЛE	Provider CCN: 150160	Peri od:	Worksheet A-8	-1		
OFFI CE	COSTS				From 01/01/2014 To 12/31/2014	Date/Time Pre	narad		
					10 12/31/2014	5/15/2015 8:4			
	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 ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIME								
	HOME OFFICE COSTS:								
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	OI CRO	2	386, 923	0	1.00		
2.00	5.00	ADMINISTRATIVE & GENERAL	OI CHA	ARGEBACKS	5, 193, 817	5, 193, 817	2.00		
3.00	1.00	NEW CAP REL COSTS-BLDG & FIX	NNS		391, 586	387, 557	3.00		
4.00	5.00	ADMINISTRATIVE & GENERAL	OIE MA	ANAGEMENT FEE	3, 917, 678	7, 206, 721	4.00		
4.01	5.00	ADMINISTRATIVE & GENERAL	OIE A8	&G	938, 274	0	4.01		
4.02	4.00	EMPLOYEE BENEFITS DEPARTMENT	OIE BE	ENEFITS	782, 053	0	4.02		
4.03	194.00	OTHER NONREIMBURSABLE COST C	MARKET	T I NG	424, 194	0	4.03		
4.04	1.00	NEW CAP REL COSTS-BLDG & FIX	OIE CF	RC	8, 234	0	4.04		
5.00	0		0		12, 042, 759	12, 788, 095	5.00		
* The	amounts on lines 1-4 (and sub	oscripts as appropriate) are t	ransfe	erred in detail to Wor	ksheet A, column	6, lines as			

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

			Related Organization(s) and/or Home Office						
Symbol (1)	Name	Percentage of	Name	Percentage of					
		Ownershi p		Ownershi p					
1.00 2.00		3.00	4.00	5.00					
 B. INTERRELATIONSHIP TO 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	С	OI PRACTICE	0.00	0.00	6.00
7.00	С	NNS	100.00	0.00	7.00
8.00	С	OI ENTERPRI SES	0.00	0.00	8.00
9.00			0.00	0.00	9.00
10.00			0.00	0.00	10.00
100.00	G. Other (financial or				100.00
	non-financial) specify:				

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

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

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

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

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

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

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

Health Financial Systems	INDIANA ORTHOPAEDIC HO	In Lieu of Form CMS-2552-1		
STATEMENT OF COSTS OF SERVICES F OFFICE COSTS	FROM RELATED ORGANIZATIONS AND HOME		From 01/01/2014	Worksheet A-8-1 Date/Time Prepared:

					5/15/2015 8:40 am	im
Net	Wkst. A-7 Ref.					
Adjustments						
(col. 4 minus						
col. 5)*						
6.00	7.00					
A. COSTS INCURF	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANS	SACTIONS WITH RELATED C	RGANIZATIONS OR CI	_AI MED	
386, 923	9				1.	1. 00
0	0				2.	2.00
4, 029	10				3.	3.00
-3, 289, 043	0				4.	4.00
938, 274	0				4.	4. 01
782, 053	0				4.	4. 02
424, 194	0				4.	4.03
8, 234	9				4.	4.04
-745, 336					5.	5.00
	Adj ustments (col. 4 mi nus col. 5)* 6.00 A. COSTS INCURR HOME OFFICE COS 386,923 0 4,029 -3,289,043 938,274 782,053 424,194 8,234	Adj ustments (col. 4 mi nus col. 5)* 6.00 7.00 A. COSTS I NCURRED AND ADJUSTM HOME OFFICE COSTS: 386,923 9 0 0 4,029 10 -3,289,043 0 938,274 0 782,053 0 424,194 0	Adj ustments (col. 4 mi nus col. 5)*       A         6.00       7.00         A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANS HOME OFFICE COSTS:         386,923       9         0       0         4,029       10         -3,289,043       0         938,274       0         782,053       0         424,194       0         8,234       9	Adj ustments (col. 4 minus col. 5)*       Adjustments         6.00       7.00         A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED CONS HOME OFFICE COSTS:         386,923       9         0       0         4,029       10         -3,289,043       0         938,274       0         782,053       0         424,194       0         8,234       9	Net         Wkst. A-7 Ref.           Adj ustments (col. 4 mi nus col. 5)*	Net Adjustments (col. 4 minus col. 5)*         Wkst. A-7 Ref.           6.00         7.00           A. COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS:           386,923         9           0         0           4,029         10           -3,289,043         0           938,274         0           782,053         0           424,194         0           8,234         9

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

nas not	been posted to worksheet A,	corumns r anu/or	Z, LIE	allount	arrowabre	Shourd	be find cated	TH COLUMN 4	01 11	ins part.	
	Related Organization(s)										
	and/or Home Office										
	Type of Ducinaco	-									
	Type of Business										
	6.00										
B	3. INTERRELATIONSHIP TO RELA	FED 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.

1 CT IIID GT		
6.00		6.00
7.00		7.00
8.00 9.00		8.00
9.00		9.00
10. 00 100. 00		10.00
100.00	10	00.00

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

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

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

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

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

organi zati on.

E. Individual is director, officer, administrator, or key person of provider and related organization.
 F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provider.

Heal th	Financial Systems IN	DI ANA ORTHOPAED	IC HOSPITAL, LLO	2		In Lie	u of Form CMS-2	2552-10
	ALLOCATION - GENERAL SERVICE COSTS			CCN: 150160			Worksheet B Part I Date/Time Pre 5/15/2015 8:4	pared:
			CAPI TAL REL	ATED COSTS				
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	NEW BLDG & FIXT	NEW MVBLE EQUI P	BEI	PLOYEE NEFI TS ARTMENT	Subtotal	
		0	1.00	2.00		4.00	4A	
	GENERAL SERVICE COST CENTERS							
1.00 2.00 4.00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	14, 002, 082 0 5, 691, 055	14, 002, 082 0		0	5, 691, 055		1.00 2.00 4.00
5.00 7.00 10.00	00500 ADMI NI STRATI VE & GENERAL 00700 OPERATI ON OF PLANT 01000 DI ETARY	15, 635, 900 301, 883 204, 446	492, 847 1, 943, 369 160, 766		0 0 0	682, 517 0 0	16, 811, 264 2, 245, 252 365, 212	
11.00 12.00 13.00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	886, 530 0 0	248, 618 0 0		0 0	0	1, 135, 148 0 0	
14.00	01400 CENTRAL SERVICES & SUPPLY 01600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	0 538, 318	214, 608 33, 335		0	0 149, 530	214, 608 721, 183	14.00
30. 00 45. 00	03000 ADULTS & PEDIATRICS 04500 NURSI NG FACI LI TY ANCI LLARY SERVI CE COST CENTERS	4, 287, 010 0	2, 553, 774 0		0	1, 127, 381 0	7, 968, 165 0	30. 00 45. 00
50,00	05000 OPERATING ROOM	14, 373, 395	6, 593, 766		0	2, 524, 591	23, 491, 752	50.00
53.00	05300 ANESTHESI OLOGY	276, 317	0, 393, 700		0	2, 324, 371	23, 491, 732	
54.00	05400 RADI OLOGY-DI AGNOSTI C	2,062,182	693, 192		0	330, 632	3, 086, 006	
60,00	06000 LABORATORY	1, 085, 188	131, 229		0	030, 032	1, 216, 417	
	06600 PHYSI CAL THERAPY	2, 899, 729	809, 906		0	814, 707	4, 524, 342	
67.00	06700 OCCUPATI ONAL THERAPY	211,775	007,700		0	61, 697	273, 472	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5, 212, 462	0		0	01,077	5, 212, 462	
		18, 611, 852	0		0	0	18, 611, 852	
	07300 DRUGS CHARGED TO PATIENTS	2, 792, 916	109, 287		0	0	2, 902, 203	
10100	OUTPATIENT SERVICE COST CENTERS	2///2///0	1077207				2,702,200	/ 0/ 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						0	92.00
	SPECIAL PURPOSE COST CENTERS	00.070	10 004					
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	89, 073, 040	13, 984, 697		0	<u>5, 691, 055</u>	89, 055, 655	118.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 490	17, 385		0	0	28, 875	190.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	867, 955	0		0	0	867, 955	
	07951 NNS	391, 586	0		0	0	391, 586	
200.00		,	Ű		-	0		200.00
201.00			0		0	0		201.00
202.00		90, 344, 071	14, 002, 082		0	5, 691, 055		

Hoal th	Financial Systems IN	DI ANA ORTHOPAED		C	Inlie	eu of Form CMS-2	2552-10
	LLOCATION - GENERAL SERVICE COSTS	DIANA ORTHOLAED			Peri od:	Worksheet B	2002 10
					From 01/01/2014		
					To 12/31/2014	Date/Time Pre 5/15/2015 8:4	
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	DIETARY	CAFETERI A	MAINTENANCE OF	
		& GENERAL	PLANT	01217411	0/11 21 211 //	PERSONNEL	
		5.00	7.00	10.00	11.00	12.00	
	GENERAL SERVICE COST CENTERS	-					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	16, 811, 264					5.00
7.00	00700 OPERATION OF PLANT	513, 316	2, 758, 568				7.00
10.00	01000 DI ETARY	83, 496	38, 344	487, 05	2		10.00
11.00	01100 CAFETERI A	259, 521	59, 298		0 1, 453, 967		11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	12.00
13.00	01300 NURSING ADMINISTRATION	0	0		0 0	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	49,064	51, 186		0 0	0	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	164, 879	7, 951		0 58, 262	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
30.00	03000 ADULTS & PEDIATRICS	1, 821, 706	609, 099	487, 05	2 331, 341	0	30.00
45.00	04500 NURSING FACILITY	0	0		0 0	0	45.00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	5, 370, 729	1, 572, 676	1	0 780, 331	0	50.00
53.00	05300 ANESTHESI OLOGY	63, 172	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	705, 532	165, 333		0 57, 946	0	54.00
60.00	06000 LABORATORY	278, 101	31, 299		0 0	0	60.00
66.00	06600 PHYSI CAL THERAPY	1, 034, 369	193, 170		0 212, 327	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	62, 522	0		0 13, 760	0	67.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 191, 689	0		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	4, 255, 097	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	663, 510	26, 066		0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS						1
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
118.00	SUBTOTALS (SUM OF LINES 1-117)	16, 516, 703	2, 754, 422	487, 05	2 1, 453, 967	0	118.00
	NONREIMBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	6, 601	4, 146		0 0	0	190.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	198, 434			0 0		194.00
	07951 NNS	89, 526	0		0 0		194. 01
200.00							200. 00
201.00		0	0		0 0		201.00
202.00	TOTAL (sum lines 118-201)	16, 811, 264	2, 758, 568	487, 05	2 1, 453, 967	0	202.00

Hoal th	Financial Systems IN	IDI ANA ORTHOPAEDI		ſ	Inlie	u of Form CMS-2	2552-10
	LLOCATION - GENERAL SERVICE COSTS			CCN: 150160	Period: From 01/01/2014	Worksheet B Part I	2332-10
					To 12/31/2014	Date/Time Pre 5/15/2015 8:4	
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	Subtotal	Intern &	
		ADMI NI STRATI ON	SERVICES & SUPPLY	RECORDS & LI BRARY		Residents Cost & Post	
			JUFFLI	LIDKAKI		Stepdown	
						Adjustments	
		13.00	14.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					l	4.00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
10.00	01000 DI ETARY					l	10.00
11.00	01100 CAFETERI A					l	11.00
	01200 MAINTENANCE OF PERSONNEL					l	12.00
	01300 NURSI NG ADMI NI STRATI ON	0				l	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	314, 858				14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0	952, 27	/5	L	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	0	0			0	30.00
45.00	04500 NURSING FACILITY	0	0		0 0	0	45.00
	ANCI LLARY SERVI CE COST CENTERS			515.05			
	05000 OPERATING ROOM	0	0			0	50.00
53.00	05300 ANESTHESI OLOGY	0	0	37, 42		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	80, 88		0	54.00
60.00	06000 LABORATORY 06600 PHYSI CAL THERAPY	0	0	14, 02		0	60.00
66.00 67.00	06700 OCCUPATIONAL THERAPY	0	0	52, 18 3, 90		0	66.00 67.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	314, 858			0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	314, 636 0	147, 37		-	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	35, 68		0	73.00
75.00	OUTPATIENT SERVICE COST CENTERS	0	0	55, 00	5, 027, 437	0	75.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		0	314, 858	952, 27	75 88, 756, 948	0	118.00
110.00	NONREI MBURSABLE COST CENTERS		011,000	,02,21	0 00,700,710		110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 39,622	0	190.00
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 1,066,389		194.00
	07951 NNS	o	0		0 481, 112		194.01
200.00					0		200.00
201.00		0	0		0 0	0	201.00
202.00	TOTAL (sum lines 118-201)	0	314, 858	952, 27	75 90, 344, 071	0	202.00
				-			

Health Financial Systems IN COST ALLOCATION - GENERAL SERVICE COSTS	DI ANA ORTHOPAEDI C	Provider CCN: 150160	Peri od:	Worksheet B	
COST ALLOCATION - GENERAL SERVICE COSTS			From 01/01/2014	Part I	
			To 12/31/2014	Date/Time Pro	epared:
Cost Center Description	Total			5/15/2015 8:4	40 am
	26.00				
GENERAL SERVICE COST CENTERS					
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00 00500 ADMINI STRATI VE & GENERAL					5.00
7.00 00700 OPERATION OF PLANT					7.00
10. 00 01000 DI ETARY					10.00
11. 00 01100 CAFETERI A					11.00
12.00 01200 MAINTENANCE OF PERSONNEL					12.00
13.00 01300 NURSING ADMINISTRATION					13.00
14.00 01400 CENTRAL SERVICES & SUPPLY					14.00
16.00 01600 MEDICAL RECORDS & LIBRARY					16.00
INPATIENT ROUTINE SERVICE COST CENTERS	1				
30. 00 03000 ADULTS & PEDIATRICS	11, 251, 067				30.00
45.00 04500 NURSING FACILITY	0				45.00
ANCI LLARY SERVI CE COST CENTERS	1				
50.00 05000 OPERATI NG ROOM	31, 730, 740				50.00
53. 00 05300 ANESTHESI OLOGY	376, 914				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	4, 095, 706				54.00
60. 00 06000 LABORATORY	1, 539, 839				60.00
66. 00 06600 PHYSI CAL THERAPY	6, 016, 391				66.00
67.00 06700 OCCUPATI ONAL THERAPY	353, 657				67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 750, 852				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	23, 014, 323				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	3, 627, 459				73.00
OUTPATIENT SERVICE COST CENTERS	1				-
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)					92.00
SPECIAL PURPOSE COST CENTERS	00.754.040				-
118.00 SUBTOTALS (SUM OF LINES 1-117)	88, 756, 948				118.00
NONREI MBURSABLE COST CENTERS	20 ( 22				100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	39, 622				190.00
194.00 07950 OTHER NONREI MBURSABLE COST CENTERS	1,066,389				194.00
194. 01 07951 NNS	481, 112				194.01
200.00 Cross Foot Adjustments	0				200.00
201.00 Negative Cost Centers	0				201.00
202.00   TOTAL (sum lines 118-201)	90, 344, 071				202.00

ALLOCA	TION OF CAPITAL RELATED COSTS		Provi der	CCN: 150160		riod: om 01/01/2014 12/31/2014	Worksheet B Part II Date/Time Pre 5/15/2015 8:4	
			CAPI TAL REL	ATED COSTS				
	Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUI P		Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	1	0	1.00	2.00		2A	4.00	
	GENERAL SERVICE COST CENTERS	1						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT							1.0
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP							2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0	0	0	4.0
5.00	00500 ADMI NI STRATI VE & GENERAL	0	492, 847		0	492, 847	0	5.0
7.00	00700 OPERATION OF PLANT	0	1, 943, 369		0	1, 943, 369	0	7.0
10.00	01000 DI ETARY	0	160, 766		0	160, 766	0	10.0
11.00	01100 CAFETERIA	0	248, 618		0	248, 618	0	11.0
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0	0	0	12.0
	01300 NURSI NG ADMI NI STRATI ON	0	0		0	0	0	13.0
	01400 CENTRAL SERVICES & SUPPLY	0	214, 608		0	214, 608	0	14.0
16.00	01600 MEDI CAL RECORDS & LI BRARY	0	33, 335		0	33, 335	0	16. C
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	0	2, 553, 774		0	2, 553, 774	0	20 0
	04500 NURSING FACILITY	0	2, 553, 774		0	2, 553, 774	0	30. C
45.00	ANCI LLARY SERVICE COST CENTERS	0	U		U		0	45.0
50.00	05000 OPERATING ROOM	0	6, 593, 766		0	6, 593, 766	0	50. C
53.00	05300 ANESTHESI OLOGY	0	0, 373, 700		0	0, 373, 700	0	53.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	693, 192		0	693, 192	0	54.0
50.00	06000 LABORATORY	0	131, 229		0	131, 229	0	60.0
6.00	06600 PHYSI CAL THERAPY	0	809, 906		0	809, 906	0	66.0
57.00	06700 OCCUPATI ONAL THERAPY	0	007,700		0	007,700	0	67.0
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		õ	0	0	71.0
	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0	0	0	72.0
	07300 DRUGS CHARGED TO PATIENTS	0	109, 287		õ	109, 287	0	73.0
0.00	OUTPATIENT SERVICE COST CENTERS		10,720,7		-	1077207		
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				1	0		92.0
	SPECIAL PURPOSE COST CENTERS	1				-1		
18.00		0	13, 984, 697		0	13, 984, 697	0	118.0
	NONREI MBURSABLE COST CENTERS							
90.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17, 385		0	17, 385	0	190. (
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0	0	0	194. (
	07951 NNS	0	0		0	0		194. (
200.00						0	-	200. (
201.00	3		0		0	0	0	201.0
202.00		0	14,002,082		0	14,002,082	0	202.0

Heal th	Financial Systems IN	IDI ANA ORTHOPAED	DIC HOSPITAL, LL	.C	In Lie	eu of Form CMS-:	2552-10
	TION OF CAPITAL RELATED COSTS				Period: From 01/01/2014 To 12/31/2014	Date/Time Pre 5/15/2015 8:4	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	PLANT	DI ETARY		MAINTENANCE OF PERSONNEL	
		5.00	7.00	10.00	11.00	12.00	
	GENERAL SERVICE COST CENTERS			1		1	
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT	100.017					4.00
	00500 ADMI NI STRATI VE & GENERAL	492, 847					5.00
	00700 OPERATION OF PLANT	15, 048					7.00
	01000 DI ETARY	2, 448					10.00
	01100 CAFETERIA	7,608			0 298, 324		11.00
	01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	12.00
	01300 NURSING ADMINISTRATION	0	0	0	0 0	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	1, 438			0 0	0	14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	4, 833	5, 644	-	0 11, 954	0	16.00
	INPATIENT ROUTINE SERVICE COST CENTERS			1		1	
	03000 ADULTS & PEDIATRICS	53, 403					30.00
45.00	04500 NURSING FACILITY	0	0	)	0 0	0	45.00
	ANCI LLARY SERVICE COST CENTERS					-	
	05000 OPERATI NG ROOM	157, 471			0 160, 109		50.00
	05300 ANESTHESI OLOGY	1, 852			0 0		53.00
	05400 RADI OLOGY-DI AGNOSTI C	20, 682			0 11, 889		54.00
	06000 LABORATORY	8, 152			0 0		60.00
	06600 PHYSI CAL THERAPY	30, 322			0 43, 565		66.00
	06700 OCCUPATI ONAL THERAPY	1,833		)	0 2, 823		67.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	34, 934			0 0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	124, 737			0 0	-	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	19, 451	18, 505	,	0 0	0	73.00
	OUTPATIENT SERVICE COST CENTERS		1	1		1	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	_		1			
118.00		484, 212	1, 955, 473	190, 43	36 298, 324	0	118.00
	NONREI MBURSABLE COST CENTERS	_					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	194			0 0		190. 00
	07950 OTHER NONREI MBURSABLE COST CENTERS	5, 817			0 0		194.00
	07951 NNS	2,624	0		0 0	0	194. 01
200.00							200. 00
201.00		0	,		0 0		201.00
202.00	TOTAL (sum lines 118-201)	492, 847	1, 958, 417	190, 43	36 298, 324	0	202.00

Heal th	Financial Systems IN	DI ANA ORTHOPAEDI	C HOSPITAL.LL	С	In Lie	u of Form CMS-2	2552-10
	TION OF CAPITAL RELATED COSTS		Provi der	CCN: 150160	Period: From 01/01/2014 To 12/31/2014	Worksheet B Part II Date/Time Pre 5/15/2015 8:4	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	MEDI CAL RECORDS & LI BRARY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		13.00	14.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERIA						11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0					13.00
	01400 CENTRAL SERVICES & SUPPLY	0	252, 385				14.00
	01600 MEDI CAL RECORDS & LI BRARY	0	202,000		56		16.00
101.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			00,70			10100
30, 00	03000 ADULTS & PEDIATRICS	0	0	1, 97	70 3, 299, 991	0	30.00
	04500 NURSI NG FACI LI TY	0	0		0 0,277,77	0	45.00
10.00	ANCI LLARY SERVICE COST CENTERS	ч Ч		1			10.00
50.00	05000 OPERATING ROOM	0	0	30, 22	26 8, 058, 077	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0	2, 18		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	4, 72		0	54.00
60.00	06000 LABORATORY	0	0	8		0	60.00
	06600 PHYSI CAL THERAPY	0	0	3, 05		0	66.00
	06700 OCCUPATI ONAL THERAPY	0	0	22		0	67.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	252, 385			0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	202, 300	8,6		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0	2, 08		0	73.00
73.00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	0	2,00	147, 320	0	73.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1		1		0	92.00
92.00	SPECIAL PURPOSE COST CENTERS			1		0	92.00
118.00		0	252, 385	EE 7/	4 12 072 110	0	118.00
118.00	NONREIMBURSABLE COST CENTERS	0	252, 385	55, 76	56 13, 973, 118	0	118.00
100.00				1	0 20 522		100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 20, 523		190.00
	07950 OTHER NONREI MBURSABLE COST CENTERS	0	0		0 5, 817		194.00
	07951 NNS	0	0		0 2, 624		194.01
200.00			-		0		200.00
201.00		0	050.005				201.00
202.00	TOTAL (sum lines 118-201)	0	252, 385	55, 76	14, 002, 082	0	202.00

Heal th Financi al	Syste	ems	
ALLOCATION OF CA	DITAL		~

In Lieu of Form CMS-2552-10

Heal th	Financial Systems IN	DIANA ORTHOPAEDIC	HOSPITAL, LLC	In Lieu	i of Form CMS-	2552-10
ALLOCA	ATION OF CAPITAL RELATED COSTS		Provider CCN: 150160	Peri od:	Worksheet B	
				From 01/01/2014	Part II	
				To 12/31/2014	Date/Time Pre	epared:
		<b>- - - -</b>			5/15/2015 8:4	0 am
	Cost Center Description	Total				
		26.00				
	GENERAL SERVICE COST CENTERS	1 1				-
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 NEW 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	00700 OPERATION OF PLANT					7.00
10.00	01000 DI ETARY					10.00
11.00	01100 CAFETERI A					11.00
12.00	01200 MAINTENANCE OF PERSONNEL					12.00
13.00	01300 NURSING ADMINISTRATION					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY					14.00
	01600 MEDICAL RECORDS & LIBRARY					16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1 1				
30, 00	03000 ADULTS & PEDIATRICS	3, 299, 991				30.00
45.00	04500 NURSING FACILITY	0				45.00
	ANCI LLARY SERVICE COST CENTERS	-				
50.00	05000 OPERATI NG ROOM	8, 058, 077				50.00
	05300 ANESTHESI OLOGY	4,039				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	847, 866				54.00
	06000 LABORATORY	162, 421				60.00
	06600 PHYSI CAL THERAPY	1, 023, 982				66.00
	06700 OCCUPATI ONAL THERAPY	4, 884				67.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	289, 180				71.00
	07200 I MPL. DEV. CHARGED TO PATI ENT	133, 350				72.00
	07300 DRUGS CHARGED TO PATIENTS	149, 328				73.00
75.00	OUTPATIENT SERVICE COST CENTERS	147, 320				/ 3.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1				92.00
72.00	SPECIAL PURPOSE COST CENTERS					72.00
118.00		13, 973, 118				118.00
110.00	NONREI MBURSABLE COST CENTERS	13, 773, 110				1118.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	20, 523				190.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	5, 817				190.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	2, 624				194.00
200.00		2, 024				200.00
						200.00
201.00		14 002 002				
202.00	)   TOTAL (sum lines 118-201)	14, 002, 082				202.00

	ancial Systems INE ATION - STATISTICAL BASIS	DI ANA ORTHOPAED		CCN: 150160	Peri od:	u of Form CMS- Worksheet B-1	
JST ALLUU	ATTON - STATISTICAL BASIS		Provider	CCN: 150160	From 01/01/2014	WORKSneet B-I	
					To 12/31/2014	Date/Time Pre	epare
		CAPITAL REI	ATED COSTS			5/15/2015 8:4	io an
	Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconci l i ati on	ADMI NI STRATI VE	
		FLXT	EQUI P	BENEFITS		& GENERAL	
			(DOLLAR VALUE)	DEPARTMENT		(ACCUM. COST)	
		(	()	(GROSS		(	
				SALARI ES)			
		1.00	2.00	4.00	5A	5.00	
GENE	ERAL SERVICE COST CENTERS						
	DO NEW CAP REL COSTS-BLDG & FIXT	165, 918				l	1
00 0020	DO NEW CAP REL COSTS-MVBLE EQUIP		0			l	2
00 0040	DO EMPLOYEE BENEFITS DEPARTMENT	0	0	18, 297, 71	8	l	4
00 0050	DO ADMINISTRATIVE & GENERAL	5, 840	0	2, 194, 41	2 -16, 811, 264	73, 532, 807	5
	DO OPERATION OF PLANT	23, 028	0		0 0	2, 245, 252	7
0.00 0100	DO DI ETARY	1, 905	0		0 0	365, 212	10
	DO CAFETERI A	2, 946	0		0 0	1, 135, 148	11
	DO MAINTENANCE OF PERSONNEL	0	0		0 0	0	12
. 00 0130	DO NURSI NG ADMI NI STRATI ON	0	0		0 0	0	13
. 00 0140	DO CENTRAL SERVICES & SUPPLY	2, 543	0		0 0	214, 608	14
	DO MEDICAL RECORDS & LIBRARY	395	0	480, 76	5 0	721, 183	16
	ATLENT ROUTINE SERVICE COST CENTERS						
	DO ADULTS & PEDIATRICS	30, 261	0			7, 968, 165	30
	DO NURSING FACILITY	0	0		0 0	0	45
	LLARY SERVICE COST CENTERS	1	-		- 1		
	DO OPERATING ROOM	78, 133	0	8, 116, 98		23, 491, 752	
	DO ANESTHESI OLOGY	0	-		0 0	276, 317	
	DO RADI OLOGY-DI AGNOSTI C	8, 214		1, 063, 03	39 0	3, 086, 006	
	DO LABORATORY	1, 555			0 0	1, 216, 417	
	DO PHYSI CAL THERAPY	9, 597		2, 619, 42		4, 524, 342	
	DO OCCUPATI ONAL THERAPY	0	0	198, 36		273, 472	
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	5, 212, 462	
	DO IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	18, 611, 852	
	DO DRUGS CHARGED TO PATIENTS	1, 295	0		0 0	2, 902, 203	73
	PATIENT SERVICE COST CENTERS	1					
	DO OBSERVATION BEDS (NON-DISTINCT PART)					. <u> </u>	92
	CIAL PURPOSE COST CENTERS		-				1
8.00	SUBTOTALS (SUM OF LINES 1-117)	165, 712	0	18, 297, 71	8 -16, 811, 264	72, 244, 391	1118
	REIMBURSABLE COST CENTERS					00.075	1.00
	DO GIFT, FLOWER, COFFEE SHOP & CANTEEN	206			0 0	28, 875	
	50 OTHER NONREI MBURSABLE COST CENTERS	0			0 0	867, 955	
4.010795	· · ·	0	0		0 0	391, 586	
0.00	Cross Foot Adjustments						200
1.00	Negative Cost Centers	14 002 002		E (01 05		1/ 011 0/4	201
02.00	Cost to be allocated (per Wkst. B,	14, 002, 082	0	5, 691, 05	00	16, 811, 264	202
03.00	Part I) Unit cost multiplier (Wkst. B, Part I)	84. 391579	0. 000000	0 21107	)E	0 220/22	200
4.00	Cost to be allocated (per Wkst. B,	04. 3915/9	0.00000	0. 31102	0	0. 228623	
4.00	Part II)				U	492, 847	204
05.00	Unit cost multiplier (Wkst. B, Part			0.00000	20	0. 006702	205
15.00	II)	1		0.00000		0.000702	1200

Heal th Financia	I Systems INE	I ANA ORTHOPAED	I C HOSPI TAL, LL	С	In Lie	u of Form CMS-2	2552-10
	N - STATISTICAL BASIS		Provi der	CCN: 150160	Peri od:	Worksheet B-1	
					From 01/01/2014		
					To 12/31/2014	5/15/2015 8:4	
Cos	st Center Description	OPERATION OF	DI ETARY	CAFETERI A	MAINTENANCE OF		
		PLANT	(MEALS SERVED)	(HOURS)		ADMI NI STRATI ON	
		(SQUARE FEET)			(NUMBER		
					HOUSED)	(DIRECT NRSING	
						HRS)	
		7.00	10.00	11.00	12.00	13.00	
GENERAL S	SERVICE COST CENTERS						
1.00 00100 NEW	N CAP REL COSTS-BLDG & FIXT						1.00
2.00 00200 NEW	N CAP REL COSTS-MVBLE EQUIP						2.00
4.00 00400 EMF	PLOYEE BENEFITS DEPARTMENT			1			4.00
5.00 00500 ADM	MINISTRATIVE & GENERAL						5.00
7.00 00700 OPE	ERATION OF PLANT	137,050					7.00
10.00 01000 DIE		1, 905	100				10.00
11.00 01100 CAF		2,946	0		8		11.00
	NTENANCE OF PERSONNEL	2, 710	0	010,00	0 0		12.00
	RSING ADMINISTRATION	0	0		0 0	0	
	NTRAL SERVICES & SUPPLY	2, 543	0		0 0	0	
	DI CAL RECORDS & LI BRARY	395	0				
	T ROUTI NE SERVI CE COST CENTERS	373	0	20, 39	0	0	10.00
	JLTS & PEDIATRICS	30, 261	100	117, 10	2 0	0	30.00
	RSING FACILITY	0	0		0 0	0	45.00
	Y SERVICE COST CENTERS	70,400		075.70			50.00
	ERATI NG ROOM	78, 133	0	275, 78		0	
	ESTHESI OLOGY	0	0		0 0	0	
	DI OLOGY-DI AGNOSTI C	8, 214	0	20, 47	9 0	0	
60.00 06000 LAE		1, 555	0		0 0	0	
	YSI CAL THERAPY	9, 597	0	75, 04		0	
	CUPATI ONAL THERAPY	0	0	4, 86	3 0	0	
	DICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 I MF	PL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRL	JGS CHARGED TO PATIENTS	1, 295	0		0 0	0	73.00
OUTPATI EN	NT SERVICE COST CENTERS						
92.00 09200 OBS	SERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL F	PURPOSE COST CENTERS						
118.00 SUE	BTOTALS (SUM OF LINES 1-117)	136, 844	100	513, 85	8 0	0	118.00
NONREI MBL	URSABLE COST CENTERS						
190.00 19000 GI F	FT, FLOWER, COFFEE SHOP & CANTEEN	206	0		0 0	0	190.00
	HER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.00
194.0107951 NNS		0	0		0 0	0	194.01
	- oss Foot Adjustments	-	-		-		200.00
	gative Cost Centers						201.00
	st to be allocated (per Wkst. B,	2, 758, 568	487, 052	1, 453, 96	7 0	<u>م</u>	202.00
	rt [)	2,750,500	407,032	1,400,70	0	0	202.00
	t cost multiplier (Wkst. B, Part I)	20. 128187	4, 870. 520000	2. 82951	1 0. 000000	0. 000000	202 00
	st to be allocated (per Wkst. B, Part I)	1, 958, 417	190, 436				203.00
	rt II)	1, 900, 417	190, 430	270, 32	4 0		204.00
	t cost multiplier (Wkst. B, Part	14. 289799	1, 904. 360000	0. 58055	7 0. 000000	0. 000000	205 00
205.00 011		14.207/99	1, 704. 300000	0. 0000		0.00000	205.00
		l	I	I	I	I	1

COST ALL	i nanci al Systems INE OCATI ON - STATI STI CAL BASI S		Provi de	er CCN: 150160	Peri od:	u of Form CMS-2552- Worksheet B-1
CUST ALL	OCATION - STATISTICAL DASIS		FIOVICE	1 CON. 150100	From 01/01/2014	WULKSHEEL D-1
					To 12/31/2014	Date/Time Prepared 5/15/2015 8:40 am
	Cost Center Description	CENTRAL	MEDI CAL			
		SERVICES &	RECORDS &			
		SUPPLY	LI BRARY			
		(COSTED	(GROSS			
		REQUIS.)	CHARGES)	_		
CE	ENERAL SERVICE COST CENTERS	14.00	16.00			
	D100 NEW CAP REL COSTS-BLDG & FIXT					1.
	D200 NEW CAP REL COSTS-DEDG & TTXT					2.
	0400 EMPLOYEE BENEFITS DEPARTMENT					4.
	0500 ADMI NI STRATI VE & GENERAL					5.
	0700 OPERATION OF PLANT					7.
	1000 DI ETARY					10.
	1100 CAFETERIA					11.
	1200 MAINTENANCE OF PERSONNEL					12.
	1300 NURSING ADMINISTRATION					13.
14.00 01	1400 CENTRAL SERVICES & SUPPLY	100				14.
16.00 01	1600 MEDICAL RECORDS & LIBRARY	0	281, 040, 7	55		16.
I N	NPATIENT ROUTINE SERVICE COST CENTERS					
30.00 03	3000 ADULTS & PEDIATRICS	0	9, 948, 1	02		30.
	4500 NURSING FACILITY	0		0		45.
	ICI LLARY SERVI CE COST CENTERS					
	5000 OPERATING ROOM	0	152, 049, 7			50.
	5300 ANESTHESI OLOGY	0	11, 046, 4			53.
	5400 RADI OLOGY-DI AGNOSTI C	0	23, 875, 1			54.
	5000 LABORATORY	0	4, 138, 6			60.
	6600 PHYSI CAL THERAPY	0	15, 402, 3			66.
	5700 OCCUPATIONAL THERAPY	0	1, 151, 9			67.
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7200 IMPL. DEV. CHARGED TO PATIENT	100 0	9, 398, 6 43, 498, 6			71.
	7300 DRUGS CHARGED TO PATIENTS	0	43, 498, 6 10, 531, 1			72.
	JTPATIENT SERVICE COST CENTERS	U	10, 551, 1	50		13.
	2200 OBSERVATION BEDS (NON-DISTINCT PART)					92.
	PECIAL PURPOSE COST CENTERS					
118.00	SUBTOTALS (SUM OF LINES 1-117)	100	281,040,7	55		118.
	DNREIMBURSABLE COST CENTERS					
	2000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0		190.
	7950 OTHER NONREIMBURSABLE COST CENTERS	0		0		194.
194.0107	7951 NNS	0		0		194.
200.00	Cross Foot Adjustments					200.
201.00	Negative Cost Centers					201.
202.00	Cost to be allocated (per Wkst. B,	314, 858	952, 2	75		202.
	Part I)					
203.00	Unit cost multiplier (Wkst. B, Part I)	3, 148. 580000	0. 0033			203.
204.00	Cost to be allocated (per Wkst. B,	252, 385	55, 7	66		204.
205 00	Part II)	2 522 050000	0.0001			0.05
205.00	Unit cost multiplier (Wkst. B, Part	2, 523. 850000	0. 0001	981		205.

	J	INDIANA ORTHOPAED				u of Form CMS-	2552-10
COMPUTA	ATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150160	Period: From 01/01/2014 To 12/31/2014		
			Titl	e XVIII	Hospi tal	PPS	_
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	11, 251, 067		11, 251, 00	57 0	11, 251, 067	30.00
45.00	04500 NURSING FACILITY	0			0 0	0	45.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	31, 730, 740		31, 730, 74	40 0	31, 730, 740	50.00
53.00	05300 ANESTHESI OLOGY	376, 914		376, 91	14 0	376, 914	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4, 095, 706		4, 095, 70	06 0	4, 095, 706	54.00
60.00	06000 LABORATORY	1, 539, 839		1, 539, 83	39 0	1, 539, 839	60.00
66.00	06600 PHYSI CAL THERAPY	6, 016, 391	0	6, 016, 39	91 0	6, 016, 391	66.00
67.00	06700 OCCUPATI ONAL THERAPY	353, 657		353, 65	57 0	353, 657	67.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 750, 852		6, 750, 8	52 0	6, 750, 852	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	23, 014, 323		23, 014, 32	23 0	23, 014, 323	72.00
	07300 DRUGS CHARGED TO PATIENTS	3, 627, 459		3, 627, 4	59 0	3, 627, 459	73.00
-	OUTPATIENT SERVICE COST CENTERS		1	1			
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 502, 817		1, 502, 8		1, 502, 817	
200.00		90, 259, 765				90, 259, 765	
201.00	Less Observation Beds	1, 502, 817		1, 502, 8	17	1, 502, 817	
202.00	Total (see instructions)	88, 756, 948	0	88, 756, 94	48 0	88, 756, 948	202.00

Health Financial Systems	INDIANA ORTHOPAED	IC HOSPITAL, LL	С	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2014 Fo 12/31/2014		
		Ti tl	e XVIII	Hospi tal	PPS	o um
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA Inpatient Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	8, 753, 309		8, 753, 309	9		30.00
45.00 04500 NURSING FACILITY	0		(			45.00
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	57, 906, 778			0. 208687	0.00000	
53. 00 05300 ANESTHESI OLOGY	3, 923, 329	7, 123, 082	11, 046, 41	0. 034121	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	435, 098	23, 440, 026	23, 875, 124	4 0. 171547	0.00000	54.00
60. 00 06000 LABORATORY	2, 052, 416	2, 086, 249	4, 138, 66	5 0. 372062	0.00000	60.00
66. 00 06600 PHYSI CAL THERAPY	2, 236, 758	13, 165, 587	15, 402, 34	5 0. 390615	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	106, 968	1, 044, 944	1, 151, 912	0. 307017	0.00000	67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 579, 382	5, 819, 242	9, 398, 624	4 0. 718281	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	16, 566, 082	26, 932, 597	43, 498, 679	0. 529081	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 876, 177	6, 654, 981	10, 531, 158	0. 344450	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	56,069	1, 138, 724	1, 194, 793	3 1. 257805	0.00000	92.00
200.00 Subtotal (see instructions)	99, 492, 366	181, 548, 389	281, 040, 75	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	99, 492, 366	181, 548, 389	281, 040, 75	5		202.00

Heal th F	inancial Systems II	NDI ANA ORTHOPAEDI C	C HOSPI TAL, LLC	In Lieu	u of Form CMS-	2552-10
COMPUTAT	ION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150160	Period: From 01/01/2014 To 12/31/2014	Worksheet C Part I Date/Time Pre	pared.
				10 12/01/2011	5/15/2015 8:4	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11.00				
	NPATIENT ROUTINE SERVICE COST CENTERS	1				
	3000 ADULTS & PEDIATRICS					30.00
	4500 NURSING FACILITY					45.00
	VCI LLARY SERVI CE COST CENTERS					
	5000 OPERATING ROOM	0. 208687				50.00
	5300 ANESTHESI OLOGY	0. 034121				53.00
	5400 RADI OLOGY-DI AGNOSTI C	0. 171547				54.00
	6000 LABORATORY	0. 372062				60.00
	6600 PHYSI CAL THERAPY	0. 390615				66.00
	6700 OCCUPATI ONAL THERAPY	0. 307017				67.00
71.00 0	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 718281				71.00
72.00 0	7200 IMPL. DEV. CHARGED TO PATIENT	0. 529081				72.00
	7300 DRUGS CHARGED TO PATIENTS	0. 344450				73.00
	UTPATIENT SERVICE COST CENTERS					
92.00 0	9200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 257805				92.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

		NDI ANA ORTHOPAED				u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 150160	Peri od:	Worksheet C	
					From 01/01/2014 To 12/31/2014		norod
					10 12/31/2014	5/15/2015 8:4	
			Ti t	le XIX	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	- 1	1				
	03000 ADULTS & PEDIATRICS	11, 251, 067		11, 251, 00	57 0	11, 251, 067	
	04500 NURSING FACILITY	0			0 0	0	45.00
	ANCI LLARY SERVI CE COST CENTERS	- 1	i	1			
	05000 OPERATING ROOM	31, 730, 740		31, 730, 74		31, 730, 740	
	05300 ANESTHESI OLOGY	376, 914		376, 91		376, 914	
	05400 RADI OLOGY-DI AGNOSTI C	4, 095, 706		4, 095, 70		4, 095, 706	
	06000 LABORATORY	1, 539, 839		1, 539, 83		1, 539, 839	
	06600 PHYSI CAL THERAPY	6, 016, 391		6, 016, 39		6, 016, 391	
	06700 OCCUPATI ONAL THERAPY	353, 657		353, 65		353, 657	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 750, 852		6, 750, 8		6, 750, 852	
	07200 IMPL. DEV. CHARGED TO PATIENT	23, 014, 323		23, 014, 32		23, 014, 323	
	07300 DRUGS CHARGED TO PATIENTS	3, 627, 459		3, 627, 4	59 0	3, 627, 459	73.00
	OUTPATIENT SERVICE COST CENTERS		I				
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 502, 817		1, 502, 81		1, 502, 817	
200.00		90, 259, 765				90, 259, 765	
201.00		1, 502, 817		1, 502, 8		1, 502, 817	
202.00	Total (see instructions)	88, 756, 948	0	88, 756, 94	18 0	88, 756, 948	202.00

Health Financial Systems	NDI ANA ORTHOPAED	IC HOSPITAL, LL	С	In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	i	Period: From 01/01/2014 To 12/31/2014		
		Tit	le XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS	8, 753, 309		8, 753, 30	9		30.00
45.00 04500 NURSING FACILITY	0		(	C		45.00
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	57, 906, 778			5 0. 208687	0.00000	
53. 00 05300 ANESTHESI OLOGY	3, 923, 329	7, 123, 082	11, 046, 41	0. 034121	0.00000	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	435, 098	23, 440, 026	23, 875, 12	4 0. 171547	0.00000	
60. 00 06000 LABORATORY	2, 052, 416	2, 086, 249	4, 138, 66	5 0. 372062	0.00000	60.00
66. 00 06600 PHYSI CAL THERAPY	2, 236, 758	13, 165, 587	15, 402, 34	5 0. 390615	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	106, 968	1, 044, 944	1, 151, 91	2 0. 307017	0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 579, 382	5, 819, 242	9, 398, 62	4 0. 718281	0.00000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	16, 566, 082	26, 932, 597	43, 498, 67	9 0. 529081	0.00000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	3, 876, 177	6, 654, 981	10, 531, 15	B 0. 344450	0.00000	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	56, 069	1, 138, 724	1, 194, 793	3 1. 257805	0.00000	92.00
200.00 Subtotal (see instructions)	99, 492, 366	181, 548, 389	281, 040, 75	5		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	99, 492, 366	181, 548, 389	281, 040, 75	5		202.00

COMPUTATION OF RATIO OF COSTS TO CHARGES         Provider CCN: 150160         Period: From 01/01/2014 To 12/31/2014         Worksheet C Pate/Time Prepared: 5/15/2015 8:40 am           Image: Cost Center Description         PPS Inpatient Ratio         Title XIX         Hospital         Cost           Image: Cost Center Description         PPS Inpatient Ratio         Title XIX         Hospital         Cost           Image: Cost Center Description         PPS Inpatient Ratio         30.00         30.00         30.00           Image: Cost Center Description         0.00         0.00         0.00         0.00         0.00           Image: Cost Center Description         PPS Inpatient Ratio         30.00         30.00         30.00           Image: Cost Center Description         0.000000         50.00         50.00         50.00         50.00           Image: Cost Center Description         0.000000         50.00         50.00         50.00         50.00           S0.00         05200         PRETHESI OLOGY         0.000000         50.00         50.00         50.00           S0.00         05400         RADIOLGS CHARGED TO PATIENT         0.000000         54.00         60.00         60.00         60.00         60.00         67.00         67.00         67.00         71.00         71.00	Health Financial Systems	IDI ANA ORTHOPAEDI C	HOSPI TAL, LLC	In Lieu	u of Form CMS-:	2552-10
To         12/31/2014         Date/Time Prepared: 5/15/2015 8:40 am           Cost Center Description         PPS Inpatient Ratio         Title XIX         Hospital         Cost           11.00         0000 ADULTS & PEDIATRICS         30.00         30.00         30.00         45.00         04500 NURSING FACILITY         45.00           ANCILLARY SERVICE COST CENTERS         30.00         05000 OPERATING ROOM         0.000000         50.00 <t< td=""><td>COMPUTATION OF RATIO OF COSTS TO CHARGES</td><td></td><td>Provider CCN: 150160</td><td></td><td></td><td></td></t<>	COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150160			
Cost Center Description         PPS Inpatient Ratio         Title XIX         Hospital         Cost           30.00         03000         ADULTS & PEDI ATRICS         11.00         30.00         30.00         30.00         ANCILLARY SERVICE COST CENTERS         30.00         45.00         04500         NURSING FACILLITY         45.00         45.00         50.00						narad
Title XIX         Hospital         Cost           Cost Center Description         PPS Inpatient Ratio 11.00				10 12/31/2014		
Ratio         Ratio           11.00         11.00           30.00         03000 ADULTS & PEDIATRICS         30.00           45.00         04500 NURSI NG FACILITY         45.00           ANCILLARY SERVICE COST CENTERS         50.00         05000 OPERATING ROM         0.000000           53.00         05300 ANESTHESI OLOGY         0.000000         53.00           54.00         05400 RADI OLOGY-DI AGNOSTI C         0.000000         54.00           66.00         06600 LABORATORY         0.000000         64.00           67.00         06700 OCCUPATI ONAL THERAPY         0.000000         66.00           67.00         06700 ICAL SUPPLIES CHARGED TO PATIENTS         0.000000         71.00           72.00         07300 DRUGS CHARGED TO PATIENTS         0.000000         73.00           72.00         07300 DRUGS CHARGED TO PATIENTS         0.000000         73.00           72.00         09200 OBSERVATI ON BEDS (NON-DI STINCT PART)         0.000000         73.00           701.00         LESS Observation Beds         200.00         201.00         201.00			Title XIX	Hospi tal		<u> </u>
INPATI ENT ROUTI NE SERVICE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRICS         30. 00           45. 00         04500 NURSI NG FACI LI TY         45. 00           ANCI LLARY SERVICE COST CENTERS         50. 00           50. 00         05000 OPERATI NG ROOM         0. 000000           53. 00         05300 ANESTHESI OLOGY         0. 000000           54. 00         05400 RADI OLOGY -DI AGNOSTI C         0. 000000           54. 00         06400 LABORATORY         0. 000000           66. 00         06600 LABORATORY         0. 000000           67. 00         06700 OCCUPATI ONAL THERAPY         0. 000000           67. 00         07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0. 000000           71. 00         07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0. 000000           73. 00         07300 DRUGS CHARGED TO PATI ENTS         0. 000000         73. 00           72. 00         09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)         0. 000000         73. 00           70. 00         09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)         0. 000000         73. 00           701. 00         Less Observati on Beds         201. 00         201. 00	Cost Center Description	PPS Inpatient				
INPATI ENT ROUTI NE SERVI CE COST CENTERS         30.00           30.00         03000 ADULTS & PEDI ATRI CS         30.00           45.00         04500 NURSI NG FACI LI TY         45.00           ANCI LLARY SERVI CE COST CENTERS         50.00         05000 [PERATI ING ROOM         0.000000           53.00         05000 [PERATI ING ROOM         0.000000         50.00           54.00         05000 [PERATI ING ROOM         0.000000         53.00           54.00         05400 [RADI OLOGY - DI AGNOSTI C         0.000000         54.00           66.00         06000 [LABORATORY         0.000000         60.00           66.00         06700 [OCUPATI ONAL THERAPY         0.000000         66.00           67.00         0CUPATI ONAL THERAPY         0.000000         67.00           71.00         07100 [MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0.000000         67.00           72.00         07200 [MPL. DEV. CHARGED TO PATI ENTS         0.000000         71.00           72.00         07300 [DRUGS CHARGED TO PATI ENTS         0.000000         73.00           07300 [DRUGS CHARGED TO PATI ENTS         0.000000         73.00           001700 [MEDI CAL SUPPLI ES COST CENTERS         92.00         09200 [OBSERVATI ON BEDS (NON-DI STINCT PART)         0.000000         92.00						
30.00       03000       ADULTS & PEDIATRICS       30.00         45.00       04500       NURSING FACILITY       45.00         ANCILLARY SERVICE COST CENTERS       50.00       05000       OPERATING ROOM       0.000000         53.00       05300       ANSTHESI OLOGY       0.000000       53.00         54.00       05400       RADIOLOGY-DI AGNOSTI C       0.000000       54.00         60.00       06600       LABORATORY       0.000000       60.00         64.00       06600       PHYSI CAL THERAPY       0.000000       60.00         67.00       06700 OCCUPATI ONAL THERAPY       0.000000       67.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       71.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       73.00         001201 MPL IENT SERVICE COST CENTERS       0.000000       73.00       73.00         002000       085EVATI ON BEDS (NON-DI STINCT PART)       0.000000       200.00         200.00       Subtotal (see instructions)       200.00       201.00		11.00				
45.00       NURSI NG FACI LI TY       45.00         ANCI LLARY SERVI CE COST CENTERS       50.00         50.00       05000       OPERATI NG ROOM       0.000000         53.00       05300       ANESTHESI OLOGY       0.000000       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000       60.00         66.00       06600       LABORATORY       0.000000       60.00         66.00       06700       OCCUPATI ONAL THERAPY       0.000000       67.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       72.00         72.00       07200       DRUGS CHARGED TO PATI ENTS       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       72.00         73.00       092000       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       92.00         200.00       Subtotal (see instructions)       200.00       201.00       201.00						
ANCI LLARY SERVICE COST CENTERS           50.00         05000         OPERATING ROOM         0.000000         50.00           53.00         05300         ANESTHESI OLOGY         0.000000         53.00           54.00         05400         RADI OLOGY-DI AGNOSTI C         0.000000         54.00           60.00         06000         LABORATORY         0.000000         60.00           66.00         06600         PHYSI CAL THERAPY         0.000000         66.00           67.00         06700         OCCUPATI ONAL THERAPY         0.000000         67.00           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0.000000         71.00           72.00         07200 I MPL.         DEV.         CHARGED TO PATI ENT         0.000000           00TPATI ENT SERVICE COST CENTERS         0.000000         73.00         73.00           00200         09SERVATI ON BEDS (NON-DI STINCT PART)         0.000000         72.00           200.00         Subtotal (see instructions)         200.00         200.00           201.00         Less Observation Beds         201.00         201.00						
50.00       05000       OPERATING ROOM       0.000000       50.00         53.00       05300       ANESTHESI OLOGY       0.000000       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000       54.00         60.00       06000       LABORATORY       0.000000       60.00         66.00       06600       PHYSI CAL THERAPY       0.000000       66.00         67.00       06700       0CCUPATI ONAL THERAPY       0.000000       67.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       73.00         0UTPATI ENT SERVI CE COST CENTERS       0.000000       73.00       92.00         00SERVATI ON BEDS (NON-DI STINCT PART)       0.000000       92.00       92.00         200.00       Subtotal (see instructions)       200.00       201.00       201.00						45.00
53.00       05300       ANESTHESI OLOGY       0.000000       53.00         54.00       05400       RADI OLOGY-DI AGNOSTI C       0.000000       54.00         60.00       06000       LABORATORY       0.000000       60.00         66.00       06600       PHYSI CAL THERAPY       0.000000       66.00         67.00       0700       OCCUPATI ONAL THERAPY       0.000000       67.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENTS       0.000000       72.00         73.00       DTUGS CHARGED TO PATI ENTS       0.000000       73.00         00TPATI ENT SERVICE COST CENTERS       0.000000       72.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       92.00         200.00       Subtotal (see instructions)       200.00       201.00       201.00						
54.00       05400       RADI 0LOGY-DI AGNOSTI C       0.00000       54.00         60.00       06000       LABORATORY       0.000000       60.00         66.00       06600       PHYSI CAL THERAPY       0.000000       66.00         67.00       06700       OCCUPATI 0NAL THERAPY       0.000000       67.00         71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       0.000000       72.00         73.00       07000       DRUGS CHARGED TO PATI ENTS       0.000000       72.00         73.00       07000       DSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       72.00         92.00       09200       OBSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       92.00         200.00       Subtotal (see instructions)       200.00       201.00       201.00						
60.00         06000         LABORATORY         0.00000         60.00           66.00         06600         PHYSI CAL THERAPY         0.000000         66.00           67.00         06700         OCCUPATI ONAL THERAPY         0.000000         67.00           71.00         07100         MEDI CAL SUPPLIES CHARGED TO PATI ENTS         0.000000         71.00           72.00         07200         IMPL. DEV. CHARGED TO PATI ENT         0.000000         72.00           73.00         07000         DRUGS CHARGED TO PATI ENTS         0.000000         72.00           73.00         07300         DRUGS CHARGED TO PATI ENTS         0.000000         72.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STI NCT PART)         0.000000         92.00           200.00         Subtotal (see instructions)         200.00         201.00         201.00						
66.00       06600       PHYSI CAL THERAPY       0.000000       66.00         67.00       06700       OCCUPATI ONAL THERAPY       0.000000       67.00         71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       72.00         0UTPATI ENT SERVICE COST CENTERS       0.000000       92.00         200.00       Subtotal (see instructions)       92.00         201.00       Less Observation Beds       201.00						
67. 00       06700       OCCUPATI ONAL THERAPY       0.000000       67. 00         71. 00       07100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0.000000       71. 00         72. 00       07200       IMPL. DEV. CHARGED TO PATI ENT       0.000000       72. 00         73. 00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       72. 00         00TPATI ENT SERVICE COST CENTERS       0.000000       92. 00         92. 00       09200       0BSERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       92. 00         200. 00       Subtotal (see instructions)       200. 00       201. 00       201. 00	60. 00 06000 LABORATORY	0.000000				60.00
71.00       07100       MEDI CAL SUPPLI ES CHARGED TO PATI ENTS       0.000000       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATI ENT       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATI ENTS       0.000000       73.00         0UTPATI ENT SERVI CE COST CENTERS       0.000000       92.00         92.00       095ERVATI ON BEDS (NON-DI STI NCT PART)       0.000000       92.00         200.00       Subtotal (see instructions)       200.00       201.00		0.000000				66.00
72.00       07200       I MPL. DEV. CHARGED TO PATIENT       0.000000       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0.000000       73.00         0UTPATIENT SERVICE COST CENTERS       0.000000       92.00         92.00       09200       OBSERVATION BEDS (NON-DISTINCT PART)       0.000000       92.00         200.00       Subtotal (see instructions)       200.00       201.00       201.00	67.00 06700 OCCUPATI ONAL THERAPY	0.000000				67.00
73.00         07300         DRUGS CHARGED TO PATIENTS         0.000000         73.00           0UTPATIENT SERVICE COST CENTERS         0.000000         92.00         92.00           92.00         09200         0BSERVATION BEDS (NON-DISTINCT PART)         0.000000         92.00           200.00         Subtotal (see instructions)         200.00         201.00         201.00	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000				71.00
OUTPATIENT SERVICE COST CENTERS92.0009200OBSERVATION BEDS (NON-DISTINCT PART)0.00000092.00200.00Subtotal (see instructions)200.00200.00201.00Less Observation Beds201.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000				72.00
92.00         09200         0BSERVATI ON BEDS (NON-DI STINCT PART)         0.000000         92.00           200.00         Subtotal (see instructions)         200.00         200.00         201.00	73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
200.00Subtotal (see instructions)200.00201.00Less Observation Beds201.00	OUTPATIENT SERVICE COST CENTERS					
201.00 Less Observation Beds 201.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00
	200.00 Subtotal (see instructions)					200.00
202.00 Total (see instructions) 202.00	201.00 Less Observation Beds					201.00
	202.00 Total (see instructions)					202.00

Health Financial Systems IN	DI ANA ORTHOPAED	DIC HOSPITAL, LL	.C	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Period:	Worksheet D	
				From 01/01/2014 To 12/31/2014		pared:
					5/15/2015 8:4	<u>O am</u>
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	3, 299, 991	C	3, 299, 99	7, 015	470. 42	30.00
45.00 NURSING FACILITY	0			0 0	0.00	45.00
200.00 Total (lines 30-199)	3, 299, 991		3, 299, 99	7, 015		200.00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS	·					
30. 00 ADULTS & PEDI ATRI CS	2,269	1,067,383				30.00
45.00 NURSING FACILITY	0	C				45.00
200.00 Total (lines 30-199)	2, 269	1,067,383				200.00

Health Financial Systems INI	DI ANA ORTHOPAED	IC HOSPI	I TAL, LL	С	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Pr	ovi der	CCN: 150160	Period:	Worksheet D	
					From 01/01/2014 To 12/31/2014		pared:
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total C	harges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from W	kst. 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	2.0	00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS							
50.00 05000 OPERATING ROOM	8, 058, 077	152, 0	049, 735	0.0529	96 16, 529, 995	876, 024	50.00
53. 00 05300 ANESTHESI OLOGY	4,039	11, 0	046, 411	0.00036	56 737, 517	270	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	847, 866	23,8	875, 124	0. 0355	13 198, 805	7,060	54.00
60. 00 06000 LABORATORY	162, 421	4,1	138, 665	0. 03924	45 692, 621	27, 182	60.00
66. 00 06600 PHYSI CAL THERAPY	1, 023, 982	15, 4	402, 345	0. 06648	844, 787	56, 163	66.00
67.00 06700 OCCUPATI ONAL THERAPY	4, 884	1, 1	151, 912	0. 00424	40 35, 881	152	67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	289, 180	9,3	398, 624	0. 03076	58 1, 134, 637	34, 911	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	133, 350	43,4	498, 679	0.00306	66 10, 684, 929	32, 760	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	149, 328	10, 5	531, 158	0.01418	30 1, 341, 573	19, 024	73.00
OUTPATIENT SERVICE COST CENTERS							1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	440, 784	1, 1	194, 793	0.36892	21 56, 069	20, 685	92.00
200.00 Total (lines 50-199)	11, 113, 911		287, 446		32, 256, 814	1, 074, 231	200.00
					,		

Health Financial Systems	NDI ANA ORTHOPAE	DIC HOS	SPI TAL, LL	.C	In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS	STS	Provi der		Period: From 01/01/2014 To 12/31/2014		
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allie	d Health	All Other	Swi ng-Bed	Total Costs	
		(	Cost	Medi cal	Adjustment	(sum of cols.	
				Education Cos	t Amount (see	1 through 3,	
					instructions)	minus col. 4)	
	1.00	2	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	0	D I	C		0 0	0	30.00
45.00 04500 NURSING FACILITY	0	D	C	)	0	0	45.00
200.00 Total (lines 30-199)	0	D	0		0	0	200.00
Cost Center Description	Total Patient	Per Di	em (col.	Inpatient	Inpati ent		
	Days	5 ÷	col. 6)	Program Days	Program		
					Pass-Through		
					Cost (col. 7 x		
					col. 8)		
	6.00		7.00	8.00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS							
30. 00 03000 ADULTS & PEDI ATRI CS	7,015	5	0.00	2, 26	9 0		30.00
45.00 04500 NURSING FACILITY	0	D	0.00		0 0		45.00
200.00   Total (lines 30-199)	7, 015	5		2, 26	9 0		200. 00

Health Financial Systems	NDI ANA ORTHOPAED	IC HOSPITAL, LL	.C	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	6 Provi der	CCN: 150160	Period: From 01/01/2014	Worksheet D Part IV	
THROUGH COSTS				To 12/31/2014	Date/Time Pre	
					5/15/2015 8:4	<u>0 am</u>
	_		e XVIII	Hospi tal	PPS	
Cost Center Description		Nursing School	Allied Healt		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 SERVI CE COST CENTERS	·					
50.00 05000 OPERATI NG ROOM	0	0	)	0 0	0	50.00
53.00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
60. 00 06000 LABORATORY	0	0		0 0	0	60.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS	- ·		•	- ·		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	)	0 0	0	92.00
200.00 Total (lines 50-199)	0	0		0 0	0	200. 00

Health Financial Systems IN	DI ANA ORTHOPAED	IC HOSPITAL, LL	C	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	S Provider		Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2014	Part IV	
				To 12/31/2014		
		T: +1	a VV/111	lloopital	5/15/2015 8:4	<u>o am</u>
	<b>.</b>		e XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges			Inpatient	
		(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of		(col. 5 ÷ col		Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	152, 049, 735	0.00000	0.000000	16, 529, 995	50.00
53.00 05300 ANESTHESI OLOGY	0	11, 046, 411	0.00000	0. 000000	737, 517	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	23, 875, 124	0.00000	0.000000	198, 805	54.00
60. 00 06000 LABORATORY	0	4, 138, 665	0.00000	0.000000	692, 621	60.00
66. 00 06600 PHYSI CAL THERAPY	0	15, 402, 345	0.00000	0.000000	844, 787	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	1, 151, 912	0.00000	0.000000	35, 881	67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	9, 398, 624	0.00000	0.000000	1, 134, 637	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	43, 498, 679	0.00000	0. 000000	10, 684, 929	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	10, 531, 158	0.00000	0.000000	1, 341, 573	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	1, 194, 793	0.00000	0.000000	56, 069	92.00
200.00 Total (lines 50-199)	0	272, 287, 446			32, 256, 814	200. 00

Health Financial Systems IN	DI ANA ORTHOPAEDI	C HOSPITAL, LL	с	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der	CCN: 150160	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2014		
				To 12/31/2014		
					5/15/2015 8:4	<u>o am</u>
			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			
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	16, 251, 321		0		50.00
53.00 05300 ANESTHESI OLOGY	0	1,081,364	1	0		53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	4,076,035		0		54.00
60. 00 06000 LABORATORY	0	175, 563		0		60.00
66. 00 06600 PHYSI CAL THERAPY	0	4, 615		0		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	9,078		0		67.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	712, 696		0		71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0	1,027,122		0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	974, 335		0		73.00
OUTPATIENT SERVICE COST CENTERS	0	774, 333	I	0		/3.00
	0	170 5/0	1	0		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	170, 563		0		92.00
200.00   Total (lines 50-199)	0	24, 482, 692		U		200.00

Health Financial Systems IN	DI ANA ORTHOPAED	IC HOSPITAL, LL	С	In Lie	eu of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 150160	Period: From 01/01/2014 To 12/31/2014		
		Titl	e XVIII	Hospi tal	PPS	
			Charges	•	Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS		44.054.004	1		0.004.400	
50. 00 05000 OPERATING ROOM	0. 208687			0 0	3, 391, 439	
53. 00 05300 ANESTHESI OLOGY	0. 034121			0 0	36, 897	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 171547			0 0	699, 232	
60. 00 06000 LABORATORY	0. 372062			0 0	65, 320	
66. 00 06600 PHYSI CAL THERAPY	0. 390615			0 0	1, 803	
67.00 06700 OCCUPATI ONAL THERAPY	0. 307017			0 0	2, 787	67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 718281			0 0	511, 916	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 529081			0 0	543, 431	•
73. 00 O7300 DRUGS CHARGED TO PATIENTS	0. 344450	974, 335		0 0	335, 610	73.00
OUTPATIENT SERVICE COST CENTERS	1 057005	170.540			014 505	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	1. 257805			0 0	214, 535	
200.00 Subtotal (see instructions)		24, 482, 692		0 0	5, 802, 970	
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		24 402 402			E 000 070	202.00
202.00  Net Charges (line 200 +/- line 201)	1	24, 482, 692	I	0 0	5, 802, 970	JZUZ. 00

Health Financial Systems IN	DI ANA ORTHOPAEL	DIC HOSPITAL, LL	C	In Lie	u of Form CMS-25	52-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST		CCN: 150160	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepa 5/15/2015 8:40	
	-		e XVIII	Hospi tal	PPS	
		sts	-			
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces Subj ect To	Services Not Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	-			
ANCI LLARY SERVI CE COST CENTERS		1	1			
50. 00 05000 OPERATI NG ROOM	C	) (			!	50.00
53. 00 05300 ANESTHESI OLOGY	C				!	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	C	0 0				54.00
60. 00 06000 LABORATORY	C	0 0				60.00
66. 00 06600 PHYSI CAL THERAPY	C	0 0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	C		D			67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C		D			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	C					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	C	) (	)			73.00
OUTPATIENT SERVICE COST CENTERS	1	T	1			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	0	D			92.00
200.00 Subtotal (see instructions)						00.00
201.00 Less PBP Clinic Lab. Services-Program					20	01.00
0nly Charges 202.00 Net Charges (line 200 +/- line 201)	C				20	02.00

Health Financial Systems IN	DI ANA ORTHOPAED	IC HOSPITAL, LL	С	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	) VACCINE COST	Provi der	CCN: 150160	Period: From 01/01/2014 To 12/31/2014		
		Ti t	le XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0. 208687		2, 065, 39		0	
53. 00 05300 ANESTHESI OLOGY	0. 034121		171, 72		0	00.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 171547		827, 59		0	01100
60. 00 06000 LABORATORY	0. 372062		53, 84		0	00.00
66. 00 06600 PHYSI CAL THERAPY	0. 390615	-	153, 34		0	
67.00 06700 OCCUPATIONAL THERAPY	0. 307017	0	12, 05		0	07100
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 718281	0	129, 33	35 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 529081	0	589, 19	95 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 344450	0	234, 99	99 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1. 257805	0		0 0	0	1 12:00
200.00 Subtotal (see instructions)		0	4, 237, 48	32 0	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0	4, 237, 48	32 0	0	202.00

Health Financial Systems IN	DI ANA ORTHOPAED	DIC HOSPITAL, LL	С	In Lie	u of Form CMS-25	552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 150160	Period: From 01/01/2014 To 12/31/2014	Worksheet D Part V Date/Time Prepa 5/15/2015 8:40	
			le XIX	Hospi tal	Cost	
		sts	-			
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To Ded. & Coins.	Subject To Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00	-			
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00	1			
50. 00 05000 OPERATI NG ROOM	431,020	0				50.00
53. 00 05300 ANESTHESI OLOGY	5,859	0				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	141, 972	0				54.00
60. 00 06000 LABORATORY	20, 032	0				60.00
66. 00 06600 PHYSI CAL THERAPY	59, 898	0				66.00
67.00 06700 OCCUPATI ONAL THERAPY	3, 701	0				67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	92, 899	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	311, 732	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	80, 945	0				73.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	1, 148, 058	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0				2	201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	1, 148, 058	0	1		2	202.00

	ATION OF INPATIENT OPERATING COST	Provider CCN: 150160	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Pre 5/15/2015 8:40	pare
		Title XVIII	Hospi tal	PPS	·0 all
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days	oveluding nowhern)		7, 015	1 1
00 00	Inpatient days (including private room days, excluding swing-bed days			7,015	
00	Private room days (excluding swing-bed and observation bed day		ivate room days,	0	
~~	do not complete this line.			( 070	
00 00	Semi-private room days (excluding swing-bed and observation be Total swing-bed SNF type inpatient days (including private roo		or 31 of the cost	6, 078 0	
	reporting period	all days) thi dagn becombe		0	
00	Total swing-bed SNF type inpatient days (including private roo	m days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	davs) through December	31 of the cost	0	7
50	reporting period	r days) (ni odgri becember	ST OF the cost	0	'
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8
20	reporting period (if calendar year, enter 0 on this line)	the Dreaman (avaluding	owing had and	2.240	
00	Total inpatient days including private room days applicable to newborn days)	the Program (excluding	swing-bed and	2, 269	9
00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days)	0	10
~~	through December 31 of the cost reporting period (see instruct			0	1 1 1
. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		oom days) arter	0	11
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
	through December 31 of the cost reporting period				
00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	13
00	Medically necessary private room days applicable to the Progra			0	14
00	Total nursery days (title V or XIX only)	× 5 5	3 /	0	15
. 00	Nursery days (title V or XIX only)			0	16
. 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	s through December 31 c	of the cost	0.00	1 1 7
. 00	reporting period	s through becember 51 c	the cost	0.00	
. 00	Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost	0.00	18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	10
. 00	reporting period	through becember 51 of	the cost	0.00	17
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
. 00	reporting period	)		11, 251, 067	21
. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ing period (line	11, 251, 067	
	5 x line 17)	· · · · · · · · · · · · · · · · · · ·		-	
. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23
. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
	7 x line 19)		3	0	
. 00	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	period (line 8	0	25
. 00	x line 20) Total swing-bed cost (see instructions)			0	26
	General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		11, 251, 067	
	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4)	us line 22) (cos instru-	tions)	0.00	
	Average per diem private room charge differential (line 32 min Average per diem private room cost differential (line 34 x lin			0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)			0.00	
. 00	General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	11, 251, 067	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PART IT - HUSPITAL AND SUBPROVIDERS UNLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU:	STMENTS			1
~ ~	Adjusted general inpatient routine service cost per diem (see			1, 603. 86	38
00				0 (00 450	39
. 00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	-		3, 639, 158 0	1

COMPUTATION OF HEATLENT OPERATING COST         Provider         Description         Provider         Description         Description         Description         Description           Cost Conter Description         Total         Fragment Days         Program Cost         Prost         Program Cost         Program Cost<			I ANA ORTHOPAED				u of Form CMS-2	2552-10
It is a virial         It is a virial         It is a virial         It is a virial         Program Cost           Cost Center Description         Index (cost Input) in the Virial         Average Per Program Cost         Program Cost           2         0         INBSEPY (111 or V & XIX only)         Index (cost Input) in the Virial         Average Per Program Cost           4         0         INDSEPY (111 or V & XIX only)         Index (cost Input)         Average Per Program Cost           4         0         INDSEPY (111 or V & XIX only)         Index (cost Input)         Average Per Program Cost           4         0         INDSEPY (111 or V & XIX only)         Index (cost Input)         Average Per Program Cost           4         0         INDSEPY (111 or V & XIX only)         Index (cost Input)         Average Per Program Cost           4         0         INDSEPY (111 or V & XIX only)         Index (cost Input)         Average Per Program Cost           4         0         Index (cost Input)         Index (cost Input)         Average Per Program Per	COMPUT	ATION OF INPATIENT OPERATING COST		Provi der			Worksheet D-1	
Lotal         Total         Total         Name of the protein         Perspective protein         Perspective protein           42.00         Text Protein         Name of the protein         Perspective protein         Perspective protein         Perspective protein           42.00         Text Protein         Name of the protein         Name of the protein         Name of the protein         Name of the protein           42.00         Text Protein         Name of the protein         Name of the protein         Name of the protein         Name of the protein           42.00         Cost Control         Name of the protein         Name of the protein         Name of the protein         Name of the protein           43.00         Cost Control         Name of the protein         Name of the protein         Name of the protein         Name of the protein           40.00         Cost Control         Name of the protein         Name of the protein         Name of the protein         Name of the protein           40.00         Cost Control         Name of the protein         Name of the protein         Name of the protein         Name of the protein           51.00         Prost I name of the protein inpattent ancillary service (from Nat. 1. Sum of Parts II and 1. OAM, 233         Name of the protein inpattent ancillary service (from Nat. 1. Sum of Parts II and 1. OAM, 231         Name of the protein </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>Date/Time Pre</td> <td>pared:</td>							Date/Time Pre	pared:
Cost Center Description         Intal Impatient Dost Inpatient May Merge Performance Performance Unit Dost Inpatient Merge Performance Unit Dost Inpatient Dost Inpatient Operant Inpatient Performance Unit Dost Inpatient Dost Inpatient Operant Inpatient Operformance Oper				Ti tl	e XVIII	Hospi tal		u am
Image: Instant version: Call 100         Image: Version: Call 100 <th< td=""><td></td><td>Cost Center Description</td><td>Total</td><td></td><td></td><td></td><td>Program Cost</td><td></td></th<>		Cost Center Description	Total				Program Cost	
Image: The state of t			Inpatient Cost	Inpatient Days		+		
42.00         INUSPERF (11 THE V & XX X ONLY)         42.00           11000000 Care Type Inputtement Insegitation Units         43.00           43.00         INTERSIVE CARE UNIT         43.00           43.00         INTERSIVE CARE UNIT         43.00           40.00         INTERSIVE CARE UNIT         45.00           40.00         UNISIENT INTERSIVE CARE UNIT         45.00           40.00         INTERSIVE CARE UNIT         46.00           40.01         INTERSIVE CARE UNIT         47.00           40.01         Intel Inputtent costs (sum of lines 50 and 51)         1.074.231         51.00           51.00         Program Inputtent operating cost excluding capital related, non-physician anesthetist, and tradits and tra			1.00	2.00		4, 00		
41.00       INTERSIVE CAE UNIT       41.00         42.00       INTERSIVE CAE UNIT       41.00         43.00       ORDER/CAEE UNIT       41.00         45.00       BURNITERSIVE CAE UNIT       41.00         45.00       DESCRIPTION       42.00         45.00       Cost Center Description       47.00         7.00       Train Program Inpatient costs (cum of lines 41 through 80 (cum instructions)       11,108,374 (85.00         45.00       Train Program Inpatient costs (cum of lines 50 and 51)       1,007,333       50.00         51.00       Pess through costs applicable to Program Inpatient accillary services (from Wist. 0. sum of Parts I and I.007,333       1,007,333       50.00         51.00       Pess through costs applicable to Program inpatient accillary services (from Wist. 0. sum of Parts I and I.007,333       1,007,333       50.00         52.00       Ioral Program accutation cost (sum of lines 50 and 51)       2,141,614       52.00       50.00         53.00       Target anount (line 64 ki line 65)       50.00       50.00       50.00       50.00         54.00       Target anount (line 50 form the cost reporting period ending 1996, updated and compounded by the arket basket       0.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00       50.00	42.00							42.00
44.00       COBOMERY CARE UNIT       44.00         64.00       UNIT INSUE CARE UNIT       44.00         64.00       UNIT INSUE CARE UNIT       44.00         64.00       UNIT INSUE CARE UNIT       45.00         64.00       UNIT INSUE CARE UNIT       5.00         65.00       Instructions)       11.017,274       48.00         67.00       Instructions)       1.027,233       50.00         67.00       Program Inpatient costs (sum of Fines 59 and 51)       1.047,233       51.00         67.00       Fragma discharges       0.00       55.00         67.00       Fragma discharges       0.00       55.00       55.00         67.00       Fragma discharges       0.00	42.00			[	1			42.00
45.00       BURN INTERSIVE CARE UNIT       45.00         45.00       SURGIAL INTERSIVE CARE UNIT       45.00         47.00       OTHER SPECIAL CARE (SPECIFY)       47.00         47.00       Total Program Inpattent accillary service cost (Wkst D-3, col. 3, line 200)       11.00         46.00       Program Inpattent accillary service cost (Wkst D-3, col. 3, line 200)       11.00, 374       48.00         50.00       Program Inpattent costs (um O lines 41 through 48) (see instructions)       14.14/27.521       51.00         50.00       Program Inpattent poprating cost applicable to Program Inpattent ancillary services (from Wkst. D, sum of Parts I and Information Costs (Um O' lines 50 and 51)       1.074.231       51.00         50.00       Total Program Inpattent operating cost and target anount (line 56 minus line 53)       53.00       12.065.918       53.00         50.00       Target amount (ine 45 k line 55)       59 or 60 enter the leaser of 50% of the amount by merice and target anount (line 56 minus line 53)       56.00       56.00         50.01       Target amount (ine 51 line 51/n cost report, updated by the market basket       0.00       58.00       56.00       57.00       58.00       58.00       58.00       58.00       58.00       58.00       58.00       58.00       58.00       58.00       58.00       58.00       58.00       58.00       58.00								
47.00       OTHER SPECIAL CARE (SPECIFY)       47.00         47.00       OTHER SPECIAL CARE (SPECIFY)       1.00         48.00       Program inpatient ancillary sorvice cost (Whit D-3. col. 3, line 200)       1.00         49.00       Program inpatient ancillary sorvice cost (Whit D-3. col. 3, line 200)       11, 08, 374 48.00         49.00       Prost through costs applicable to Program inpatient routine services (from West. 0, sum of Parts I I I ord, 283       10.07, 231 51.00         50.00       Prost through costs applicable to Program inpatient ancillary services (from West. 0, sum of Parts I I I ord, 283       10.07, 231 51.00         50.00       Target amount per discharge       0.00       2.141.61 52.00         50.00       Target amount per discharge       0.00 55.00       0.00 55.00         50.00       Target amount per discharge       0.00 65.00       0.00 55.00         50.00       Target amount per discharge       0.00 60.00       0.00 65.00         50.00       Difference barbeen adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.50 60         50.00       Difference barbeen adjusted inpatient cost reporting period dending 1996, updated and compounded by the amount by which operating posts (line 53) are less than expected costs (lines 54 x 60), or 1% of the amount by which operating protosts (line 53) are less than expected costs (line 53 of the cost reporting period (See 10.00       0.00								
Cost Center Description         1.00           48.00         Program inputiont ancillary service cost (West: D-3, col: 3, Line 200)         11, 1708, 374         48.00           47.00         Total Program inputiont costs (sum of Lines 41 through 49) (see instructions)         11, 474, 532         49.00           50.00         Pass through costs applicable to Program inputient ancillary services (from West: D, sum of Parts II         1, 047, 333         50.00           61.01         Pass through costs applicable cost (sum of lines 50 and 51)         2, 141, 145         50.00           63.00         Total Program inputient operating cost excluding capital related, non-physician anesthetist, and education costs (line 69 and sciences)         50.01         12, 663, 918         53.00           54.00         Program inputient operating cost excluding capital related, non-physician anesthetist, and education costs (line 69 and sciences)         0.60         55.00           55.00         Difference beleven and sciences (5)         0.00         55.00         0.00         55.00         12, 663, 918         50.00         60.00         59.00         60.00         59.00         60.00         59.00         60.00         59.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00								
40.00       Frogram inputient ancillary service cost (WkSt D-3, col. 3, line 200)       11, 106, 314       48.00         49.00       Frogram inputient costs (sum of lines 41 through 48)(see instructions)       14, 147, 532       48.00         49.00       Program inputient costs (sum of lines 51 through costs applicable to Program inputient routine services (from Wkst. 0, sum of Parts II and IV)       10, 667, 333       50.00         10.00       Pass through costs applicable to Program inputient ancillary services (from Wkst. 0, sum of Parts II and IV)       1, 667, 335       51.00         10.01       Distal Program excluable cost (sum of lines 50 and 51)       2, 141, 644       52.00       10, 667, 335       51.00         53.00       Torget meanut per discharge       0.00       0.00       55.00       0.00	47.00							47.00
40.00       Total Program inpatient costs (sum of Lines 41 through 48) (see instructions)       14.747,552       40.00         PASS Through costs applicable to Program inpatient routine services (from Wkst. D. sum of Parts II       1.067,383       50.00         51.00       Pass through costs applicable to Program inpatient ancillary services (from Wkst. D. sum of Parts II       1.074,231       51.00         52.00       Total Program excluduable cost (sum of Lines 50 and 51)       2.141.614       52.00         52.00       Total Program excluduable cost (sum ins line 52)       7.01.61.61       52.00         53.00       Drogram excluduable cost (sum ins line 52)       7.01.61.61       52.00         54.00       Program discharges       0.00       52.00         50.01       Dregt amount (ine 54 x line 35)       56.00         50.02       Disserverstructions)       0.00       58.00         50.01       Disserverstructions)       0.00       58.00         50.01       Disserverstructions)       0.00       58.00         50.02       Disserverstructions)       0.00       58.00         50.03       Disserverstructions)       0.00       58.00         50.04       Disserverstructions)       0.00       58.00         50.05       Disserverstructions)       0.00 <td< td=""><td></td><td>cost center bescription</td><td></td><td></td><td></td><td></td><td>1.00</td><td></td></td<>		cost center bescription					1.00	
NAST INROGEN COST ADJUSTMENTS         50.00         PASS THROUGH COST ADJUSTMENTS           1113         11.007.333         50.00           1115         Program inpatient ancillary services (from West. D. sum of Parts II         1.074.231           51.00         Program inpatient persting casts applicable to Program inpatient ancillary services (from West. D. sum of Parts II         1.074.231           51.00         Total Program inpatient operating capt tal related, non-physician anesthetist, and madical education costs (line 40 minus line 52)         1.2,605.918           52.00         Torget anount per discharge         0           54.00         Program discharges         0           55.00         Barget amount per discharge         0           56.01         Brograte mount per discharge         0           56.00         Berus payment (see instructions)         0           56.00         Berus payment (see instructions)         0           57.00         Difference between adjusted inpatient operating period ending 1996, updated and compounded by the 0.00         0           57.00         Difference between adjusted inpatient crout free costs report, updated by the market basket         0.00           57.00         Difference between adjusted inpatient crout free costs for perstructions)         0         64.00           57.01         Difference between adjusted inpa					-		11, 108, 374	
50.00       Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I and 1.067,383       1.067,383       50.00         51.00       Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and 1.067,383       1.074,231       1	49.00		41 through 48)(	<u>(see instructio</u>	ons)		14, 747, 532	49.00
111)       111)       111)       111)       111)         1100       Pass through costs applicable to Program inpatient ancillary services (from Wkst. D., sum of Parts II and IV)       11,074,231       51.00         1100       Total Program excludable cost (sum of lines 50 and 51)       12,465,916       12,465,916       12,465,916         1110       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and 12,665,916       12,665,916       12,665,916         1110       Total Program excludable cost (sum of lines 50 and 51)       12,665,916       12,665,916       12,665,916         1100       Program discharges       0,00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       55.00       56.00	50 00		atient routine	services (from	wkst D sum	of Parts L and	1 067 383	50 00
and IV)       2.111, 614       52.00       Total Program excludable cost (sum of lines 50 and 51)       7.111, 614       72.05, 918       75.00         15.00       Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medication costs (line 54 minus line 52)       70.00       72.05, 918       75.00         54.00       Program excluded is charge       0.0       54.00       75.00       70.00       75.00								
53.00       Total Program inpatient operating cost excluding capital related. non-physician anesthetist, and medical education costs (line 49 minus line 52)       12.605,918       53.00         TARGET AMOUNT AND LIMIT COMPUTATION       12.605,918       53.00         64.00       Program discharge       0       64.00         65.00       Target amount (line 54 x line 55)       0       56.00       56.00         67.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0       56.00         67.00       Deprogram for the startuctions)       0       67.00       0       0.00       56.00         67.00       Difference between adjusted inpatient oper cost report, updated by the market basket       0.00       60.00 <t< td=""><td></td><td>and IV)</td><td></td><td>ry services (fr</td><td>rom Wkst. D, su</td><td>um of Parts II</td><td></td><td></td></t<>		and IV)		ry services (fr	rom Wkst. D, su	um of Parts II		
medical education costs (line 49 minus line 52)         0           TARGET #AUXIT XAN UNIT COMPUTATION         0           54.00         Program discharges         0           55.00         Target amount per discharge         0.00           56.01         Target amount per discharges         0.00           56.01         Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)         0           56.00         Dispet amount per discharges         0.00           60.01         Dispet amount (see instructions)         0           61.01         Lisses of 1 lines 53/54 or 55 from prior year cost report, updated by the market basket         0.00           62.00         Relief payment (see instructions)         0           63.00         PROGRAM INPATIENT ROUTINE SMI K0ED COST         0           64.00         Medicare saing-bed SF inpatient routine costs through December 31 of the cost reporting period (See instructions)         0           63.00         Total wedicare saing-bed SF inpatient routine costs through December 31 of the cost reporting period         0           64.00         Medicare saing-bed SF inpatient routine costs (line 64 plus line 65) (tite XVIII only). For         0           65.00         Tatget amount per saing-bed SF inpatient routine costs (line 67 + line 68)         0           66.00         Titt				lated non nhu	cial an anasth	tict and		
TARGET AUOUNT AND LIMIT COMPUTATION         100       Program discharges       0         55.00       Target amount (per discharge       0.00         55.00       Target amount (line 54 x line 55)       0.00         57.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00         58.00       Lesser of lines 53/54 or 55 from the cost report, updated by the market basket       0.00         60.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00         61.00       IF lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00         61.00       IF line 53/54 is lises than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by 0       61.00         62.00       Relife payment (see instructions)       0       62.00         62.00       Mail omdit line 53/5 is is is mone toors line costs through December 31 of the cost reporting period (See instructions)(tite Will poil)       63.00         64.00       Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)       64.00         65.00       Tat Wedicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (tite XVIII only). For CAH (see instructions)       64.00         66.00       Tat Wedicare swing-bed SNF inpatient routine costs (line 67 + line 68)	55.00			erateu, non-pny		etist, anu	12,000,910	55.00
55. 00       Target amount (ine 54 x line 55)       0.00       55. 00         56. 00       Target amount (ine 54 x line 55)       0.00       55. 00         57. 00       DIfference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00       55. 00         57. 00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0.00       55. 00         58. 00       Discourd target amount (line 54 x line 55)       0.00       57. 00       0.00       57. 00         59. 00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market besket       0.00       60. 00       61. 00       61. 00       61. 00       61. 00       61. 00       61. 00       62. 00       63. 00       62. 00       64. 00       64. 00       64. 00       64. 00       65. 00<		TARGET AMOUNT AND LIMIT COMPUTATION						
56.00       Target amount (Line 54 x line 55)       0       56.00       57.00       0       56.00       55.00								
57.00       Difference between adjusted inpatient operating cost and target amount (line 56 minus line 53)       0       57.00         58.00       Bonus payment (see instructions)       0       58.00         59.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       00         60.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       61.00         61.00       If lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60.00         62.00       Relief payment (see instructions)       0       62.00         62.00       Relief payment (see instructions)       0       63.00         70.00       Relief payment (see instructions)       0       64.00         60.00       Relief saymen-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVII only)       64.00         60.00       Total markine market basket       0       65.00         60.00       Total model care swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)       64.00         61.00       Total mellocare swing-bed NF inpatient routine costs (line 64 plus line 65) (title XVII only). For Cost (line 13 x line 20)       66.00         60.00       Total denursing facility/oter Nursing f								
59:00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       59:00         60:00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60:00         60:00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       61:00         61:00       If lines 53/54 is less than the lower of lines 55. 59:00 for the anount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount line for the cost report (line 51/54 is low line to cost plus incentive payment (see instructions)       0       61:00         62:00       Relief payment (see instructions)       0       63:00         70:00       Relief payment (see instructions)       0       64:00         60:00       Not market basket       0       66:00         61:00       Market by inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)       66:00         60:00       Total medicare swing-bed NF inpatient routine costs after December 31 of the cost reporting period (see CH or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       66:00         70:00       RAII tell vor XIX swing-bed NF inpatient routine costs (line 7 + line 2)       70:00       70:00         70:00       Naitel anursing facility/Oter NuxBN FACILITY, OTHER NURSING FACILITY, AND (CFAWR ONLY       <			ng cost and ta	arget amount (I	ine 56 minus l	ine 53)		
market basket       0.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>-</td> <td></td>							-	
60.00       Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket       0.00       60.0	59.00		porting period	ending 1996, u	pdated and con	npounded by the	0.00	59.00
which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target amount (line 56), otherwise enter zero (see instructions)       0       62.00         62.00       Relief payment (see instructions)       0       62.00         63.00       Allowable (npatient cost) put sincentive payment (see instructions)       0       63.00         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       64.00         65.00       Instructions (title XVIII only)       65.00       65.00         66.00       Cost (see instructions)       0       67.00         66.00       Total Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       66.00         67.00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       67.00         68.00       Title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       69.00         70.00       Skilled nursing facility/other nursing facility/ICF/WR routine service cost (line 37)       70.00       71.00         71.00       Medically necessary private room cost applicable to Program (line 14 x line 35)       72.00         73.00       Program routine service cost (line 75 + line 2)       74.00         74.00 <td< td=""><td>60.00</td><td></td><td>cost report, up</td><td>dated by the m</td><td>narket basket</td><td></td><td>0.00</td><td>60.00</td></td<>	60.00		cost report, up	dated by the m	narket basket		0.00	60.00
amount (line 56), otherwise enter zero (see instructions)       0       62.00       63.00       62.00       63.00       64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       64.00       65.00       65.00       65.00       65.00       66.00       65.00       66.00       66.00       67.00       66.00       67.00       66.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       67.00       68.00	61.00						0	61.00
62.00       Relief payment (see instructions)       0       62.00       62.00         63.00       Allowable inpatient cost plus incentive payment (see instructions)       0       63.00         64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (tile XVIII only)       64.00         65.00       Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)       65.00         66.00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For Cost (See instructions)       66.00         67.00       Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 12 x line 19)       67.00         68.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0         69.00       Total title V or XIX swing-bed NF inpatient routine costs (line 74 + line 68)       0         70.00       Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)       71.00         71.00       Adjusted general inpatient routine service costs (from Ya + line 2)       72.00         72.00       Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)       73.00         71.00       Adjusted general inpatient routine service costs (from Ya + line 35)       74.00				s (lines 54 x	60), or 1% of	the target		
63.00       Allowable inpatient cost plus incentive payment (see instructions)       0       63.00         PROGRAM INPATENT ROUTINE SWING BED COST       64.00       Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)       64.00         66.00       Total Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)       66.00       66.00         67.00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (Ine 12 x line 19)       67.00         68.00       Total title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (Ine 13 x line 20)       68.00         69.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       69.00         70.00       Title V or XIX swing-bed NF inpatient routine costs (line 70 + line 20)       70.00       68.00         70.00       Title D NURSING FACLITY, OTHER NURSING FACLITY, NON ICF/MR ONLY       70.00       71.00         71.00       Allusted general inpatient routine service costs (line 70 + line 2)       71.00         72.00       Fattle D NURSING FACLITY, OTHER NURSING FACLITY, NON ICF/MR ONLY       72.00         73.00       Total title V or XIX swing-bed S(line 75 + line 71)       73.00         74.00       Total Program general inpa	62.00		listi de li olisj				0	62.00
64.00       Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See instructions) (title XVIII only)       64.00         65.00       Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions) (title XVIII only)       65.00         66.00       Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65) (title XVIII only). For CAH (see instructions)       66.00         67.00       Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)       0         68.00       Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)       0       68.00         69.00       Total title V or XIX swing-bed NF inpatient routine service cost (line 70 + line 2)       70.00       69.00         70.00       Skilled nursing facility/other nursing facility/CHR routine service costs (line 70 + line 35)       71.00       72.00         70.00       Total Program routine service cost applicable to Program (line 14 x line 35)       73.00       74.00         70.00       Capital -related costs (line 75 + line 2)       76.00       76.00       76.00         70.00       Inpatient routine service costs (from provider records)       79.00       79.00       79.00         70.00       Capital -related costs (line 75 + line 2)       76.00       79.00       79.00       79.00		Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)			0	63.00
instructions)(title XVIII only)65.00Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only). For CAH (see instructions)065.0066.00Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)066.0067.00Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)067.0068.00Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)068.0069.00Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND (EF/MR ONLY70.0070.00Skilled nursing facility/tofter nursing facility/tofter/Mr routine service cost (line 37) 71.0070.0071.00Adjusted general inpatient routine service cost (line 70 + line 2) 72.0071.0072.00Total Program general inpatient routine service costs (line 72 + line 73) 73.0074.0075.00Capital -related costs (line 75 + line 2) 77.0076.0076.00Total Program capital -related costs (line 75 + line 76) 78.0077.0078.00Total Program routine service cost for comparison to the cost limitation (line 78 minus line 79) 81.0078.0079.00Readient routine service cost (see instructions) 81.0081.0082.00Reasonable inpatient routine service cost (see instructions) 83.0084.0079.00Readient routine service cost (see	64 00		ts through Dece	mber 31 of the	cost reportir	a period (See	0	64 00
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CAH (see instructions)67.00Title V or XLX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)67.0067.00Title V or XLX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)68.0068.00Total title V or XLX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)68.0069.00Total title V or XLX swing-bed NF inpatient routine costs (line 67 + line 68)069.00PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY70.0070.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)70.0071.00Adjusted general inpatient routine service costs (line 74 + line 73)72.0073.00Gedically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)76.0075.00Per diem capital-related costs (line 75 + line 2)76.0077.00Program routine service costs (from provider records)79.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Inpatient routine service costs (see instructions)81.0081.00Program inpatient ancillary services (see instructions)83.0082.00Resonable inpatient operating costs (see instructions)84.0083.00Program routine service costs (see instructions)84.0084.00Program inpatie	66 00		ne costs (line	64 plus line 6	5)(title XVIII	only) For	0	66 00
(line 12 x line 19)68.00(line 12 x line 19)68.00(line 13 x line 20)68.00(line 13 x line 20)69.00PART 111 - SKILED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY069.0069.0069.00PART IV - COMPUTATION OF 0BSERVATION BED PASS THROUGH COST70.0070.0070.0070.0070.0070.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)70.0071.0071.00Adjusted general inpatient routine service costs (line 72 + line 73)72.0072.00Program coptine service cost (line 75 + line 2)73.0073.00Capital -related costs (line 75 + line 2)75.0074.00Per diem capital -related costs (line 75 + line 2)77.0075.00Aggregate charges to beneficiaries for excess costs (from provider records)78.0079.00Nggregate charges to cost per diem limitation81.0081.00Inpatient routine service cost (see instructions)82.0084.00Program inpatient ancillary services (see instructions)83.0085.00Utilization review - physician compensation (see instructions)84.0085.00Total Pogram inpatient operating costs (sum of lines 83 through 85)86.0086.00Total Pogram inpatient operation bed days (see instructions)88.0087.00Total Program inpatient operation (see instructions)85.0088.00Adjusted general inpat	00.00					511 3) 1 61		00.00
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69.00Total title V or XiX swing-bed NF inpatient routine costs (line 67 + line 68)69.00PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/MR ONLY70.0000Skilled nursing facility/OtF/MR routine service cost (line 37)71.0071.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)72.0073.00Medically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital -related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)76.0076.00Per diem capital -related costs (line 75 + line 2)76.0077.00Program capital -related costs (line 74 minus line 77)77.0078.00Inpatient routine service costs for comparison to the cost limitation (line 78 minus line 79)80.0080.00Inpatient routine service costs (see instructions)81.0081.00Hogram inpatient ancillary services (see instructions)82.0083.00Program inpatient ancillary service (see instructions)83.0084.00Program inpatient operating costs (sum of lines 83 through 85)84.0085.00Total Program inpatient optime costs (see instructions)85.0086.00Total Deservation bed days (see instructions)85.0087.00Adjusted general inpatient routine cost per diem (line 27 + line 2)76.0088.00Adjusted general inpatient routine cost per diem (line 27 + line 2)87.0088.00 <t< td=""><td>68.00</td><td>5 1</td><td>e costs after D</td><td>ecember 31 of</td><td>the cost repor</td><td>rting period</td><td>0</td><td>68.00</td></t<>	68.00	5 1	e costs after D	ecember 31 of	the cost repor	rting period	0	68.00
70.00Skilled nursing facility/other nursing facility/ICF/MR routine service cost (line 37)70.0071.00Adjusted general inpatient routine service cost per diem (line 70 + line 2)71.0072.00Program routine service cost (line 9 x line 71)73.0073.00Medically necessary private room cost applicable to Program (line 14 x line 35)73.0074.00Total Program general inpatient routine service costs (line 72 + line 73)74.0075.00Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)76.0076.00Per diem capital -related costs (line 75 + line 2)76.0077.00Program routine service cost (line 74 minus line 77)78.0079.00Aggregate charges to beneficiaries for excess costs (from provider records)79.0080.00Inpatient routine service cost (see instructions)80.0081.00Reasonable inpatient routine service costs (see instructions)81.0082.00Reasonable inpatient operating costs (sum of lines 83 through 85)85.0086.00Total Program inpatient operating costs (sum of lines 27 + line 2)93787.00Adjusted general inpatient operating cost (see methods)86.00	69.00		routine costs (	[line 67 + line	e 68)		0	69.00
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PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST         87.00         Total observation bed days (see instructions)         937         88.00         Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)         1,603.86				ons)				
87.00Total observation bed days (see instructions)93787.0088.00Adjusted general inpatient routine cost per diem (line 27 ÷ line 2)1,603.8688.00		Total Program inpatient operating costs (sum	of lines 83 th					86.00
88.00 Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) 1,603.86 88.00	87 00						027	87 00
				line 2)			1, 603. 86	88.00
	89.00	Observation bed cost (line 87 x line 88) (see	e instructions)				1, 502, 817	89.00

Health Financial Systems IN	DI ANA ORTHOPAED	IC HOSPITAL, LL	C	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				To 12/31/2014	Date/Time Pre 5/15/2015 8:4	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	3, 299, 991	11, 251, 067	0. 29330	5 1, 502, 817	440, 784	90.00
91.00 Nursing School cost	0	11, 251, 067	0.00000	0 1, 502, 817	0	91.00
92.00 Allied health cost	0	11, 251, 067	0.00000	0 1, 502, 817	0	92.00
93.00 All other Medical Education	0	11, 251, 067	0.00000			93.00

OMPUT	ATION OF INPATIENT OPERATING COST	rovider CCN: 150160	Period: From 01/01/2014 To 12/31/2014	Worksheet D-1 Date/Time Pre	pare
		Title XIX	Hospi tal	5/15/2015 8:40 Cost	u am
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	INPATIENT DAYS			7.045	
	Inpatient days (including private room days and swing-bed days, exc Inpatient days (including private room days, excluding swing-bed ar			7, 015 7, 015	
	Private room days (excluding private room days, excluding swing-bed and observation bed days).		ivate room davs.	7,015	3
	do not complete this line.	in jou navo onij pi	i vato i com adjo,		
00	Semi-private room days (excluding swing-bed and observation bed day			6, 078	4
00	Total swing-bed SNF type inpatient days (including private room day reporting period	ys) through Decembe	r 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private room day	vs) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private room days	s) through December	31 of the cost	0	7
00	reporting period Total swing-bed NF type inpatient days (including private room days	s) after December ?	1 of the cost	0	8
50	reporting period (if calendar year, enter 0 on this line)	3) al tel December 3	T OF the cost	0	
00	Total inpatient days including private room days applicable to the	Program (excluding	swing-bed and	96	9
00	newborn days)	including and und	and daysa)	~	10
00	Swing-bed SNF type inpatient days applicable to title XVIII only (i through December 31 of the cost reporting period (see instructions)		oom days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII only (i		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year, enter (				
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only through December 31 of the cost reporting period	y (including privat	e room days)	0	12
00	Swing-bed NF type inpatient days applicable to titles V or XIX only	v (including privat	e room days)	0	13
	after December 31 of the cost reporting period (if calendar year, e				
	Medically necessary private room days applicable to the Program (ex	xcluding swing-bed	days)	0	
	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)			0	
	SWING BED ADJUSTMENT			0	10
	Medicare rate for swing-bed SNF services applicable to services the	rough December 31 c	f the cost	0.00	17
. 00	reporting period Medicare rate for swing-bed SNF services applicable to services af	tor Docombor 21 of	the cost	0.00	10
. 00	reporting period	ter beceniber 51 01	the cost	0.00	
. 00	Medicaid rate for swing-bed NF services applicable to services through reporting period	ough December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services afte	er December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instructions)	<b>.</b>		11, 251, 067	
. 00	Swing-bed cost applicable to SNF type services through December 31 5 x line 17)	of the cost report	ing period (line	0	22
. 00	Swing-bed cost applicable to SNF type services after December 31 of	f the cost reportir	g period (line 6	0	23
	x line 18)				
. 00	Swing-bed cost applicable to NF type services through December 31 ( 7 x line 19)	of the cost reporti	ng period (line	0	24
00	Swing-bed cost applicable to NF type services after December 31 of	the cost reportinc	period (line 8	0	25
	x line 20)				
	Total swing-bed cost (see instructions)	04		0	
	General inpatient routine service cost net of swing-bed cost (line PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	21 minus line 26)		11, 251, 067	27
	General inpatient routine service charges (excluding swing-bed and	observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)		3 ,	0	29
	Semi-private room charges (excluding swing-bed charges)	22)		0	30
	General inpatient routine service cost/charge ratio (line 27 ÷ line	e 28)		0.00000	31
	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	
	Average per diem private room charge differential (line 32 minus li	ine 33)(see instruc	tions)	0.00	
	Average per diem private room cost differential (line 34 x line 31)	)		0.00	
	Private room cost differential adjustment (line 3 x line 35)	rivata room asst -!	fforontial (li	0	36
. 00	General inpatient routine service cost net of swing-bed cost and pr 27 minus line 36)	iivate room cost di	inerential (IINe	11, 251, 067	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMEN			4 (00	
	Adjusted general inpatient routine service cost per diem (see inst Program general inpatient routine service cost (line 9 x line 38)	ructions)		1, 603. 86 153, 971	
	Medically necessary private room cost applicable to the Program (li	ine 14 x line 35)		153, 971	40
. 00					

		DI ANA ORTHOPAED					u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Prov	i der		Period: From 01/01/2014	Worksheet D-1	
						To 12/31/2014	Date/Time Pre	pared:
				Ti t	le XIX	Hospi tal	5/15/2015 8:40 Cost	<u>0 am</u>
	Cost Center Description	Total	Total		Average Per	Program Days	Program Cost	
		Inpatient Cost	Inpati ent	Days		÷	(col. 3 x col.	
		1.00	2.00		col. 2) 3.00	4.00	4) 5.00	
42.00	NURSERY (title V & XIX only)							42.00
42.00	Intensive Care Type Inpatient Hospital Units							42.00
43.00 44.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T							43.00 44.00
	BURN INTENSIVE CARE UNIT							45.00
	SURGI CAL I NTENSI VE CARE UNI T							46.00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description							47.00
							1.00	
	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4				nc)		319, 250 473, 221	48.00 49.00
49.00	PASS THROUGH COST ADJUSTMENTS		See Thisti	uctio	115)		473, 221	49.00
50.00	Pass through costs applicable to Program inpa	atient routine	servi ces	(from	Wkst. D, sum	of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inpa	atient ancillar	y service	s (fr	om Wkst. D, s	um of Parts II	0	51.00
52.00	and IV) Total Program excludable cost (sum of lines 5	50 and 51)					0	52.00
	Total Program inpatient operating cost exclude		lated, no	n-phy	sician anesth	etist, and	0	53.00
	medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION	52)						
54.00	Program di scharges						0	54.00
55.00	Target amount per discharge						0.00	55.00
	Target amount (line 54 x line 55)	ing post and to	sact omou	n+ (1	ing E( minuc	line E2)	0	56.00
	Difference between adjusted inpatient operati Bonus payment (see instructions)	ing cost and ta	rget amou	nt (i	The so minus	The 53)	0	57.00 58.00
59.00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 19	96, u	pdated and co	mpounded by the	0.00	
60.00	market basket Lesser of lines 53/54 or 55 from prior year of	cost roport un	dated by	tho m	arkot baskot		0.00	60.00
	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		s (lines	54 x	60), or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)					0	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instru	ictions)				0	63.00
( 1 . 0.0	PROGRAM INPATIENT ROUTINE SWING BED COST		1 01	6.11				( 1 00
64.00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts through Dece	emper 31 o	rtne	cost reporti	ng period (see	0	64.00
65.00	Medicare swing-bed SNF inpatient routine cost	ts after Decemb	er 31 of	the c	ost reporting	period (See	0	65.00
66.00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routir	ne costs (line	64 plus l	ine 6	5)(title XVII	lonly) For	0	66.00
00.00	CAH (see instructions)			i ne o				
67.00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December	31 o	f the cost re	porting period	0	67.00
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs after D	ecember 3	1 of	the cost repo	rting period	0	68.00
69.00	Total title V or XIX swing-bed NF inpatient r						0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili							70.00
71.00	Adjusted general inpatient routine service co	2						71.00
72.00	Program routine service cost (line 9 x line 7				25)			72.00
73.00 74.00	Medically necessary private room cost applica Total Program general inpatient routine servi							73.00 74.00
75.00	Capital -related cost allocated to inpatient r					art II, column		75.00
74 00	26, line 45)							74 00
76.00 77.00	Per diem capital-related costs (line 75 ÷ lir Program capital-related costs (line 9 x line							76.00 77.00
78.00	Inpatient routine service cost (line 74 minus	,						78.00
79.00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa					ic line 70)		79.00
80.00 81.00	Inpatient routine service cost per diem limit					us ITTIE 79)		80.00 81.00
82.00	Inpatient routine service cost limitation (li	ne 9 x line 81						82.00
83.00	Reasonable inpatient routine service costs (s		s)					83.00
84.00 85.00	Program inpatient ancillary services (see ins Utilization review - physician compensation (		ins)					84.00 85.00
	Total Program inpatient operating costs (sum	of lines 83 th						86.00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions)						937	87.00
87.00	Adjusted general inpatient routine cost per o		line 2)				937 1, 603. 86	
89.00	Observation bed cost (line 87 x line 88) (see	e instructions)					1, 502, 817	89.00

Health Financial Systems IN	DI ANA ORTHOPAED	DIC HOSPITAL, LL	C	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2014	Worksheet D-1	
				To 12/31/2014	Date/Time Pre 5/15/2015 8:4	
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(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	3, 299, 991	11, 251, 067	0. 29330	5 1, 502, 817	440, 784	90.00
91.00 Nursing School cost	0	11, 251, 067	0.00000	0 1, 502, 817	0	91.00
92.00 Allied health cost	0	11, 251, 067	0.00000	0 1, 502, 817	0	92.00
93.00 All other Medical Education	0	11, 251, 067	0.00000			93.00

Health Financial Systems INDIANA ORTHOPAEDIC H	OSPI TAL, LL	.C	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150160	Period:	Worksheet D-3	
			From 01/01/2014 To 12/31/2014	Date/Time Pre	narod
			10 12/31/2014	5/15/2015 8:4	
	Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1			
30. 00 03000 ADULTS & PEDI ATRI CS			3, 115, 368		30.00
ANCI LLARY SERVI CE COST CENTERS		0.000/	1/ 500 005	0.440.505	F0 00
		0. 2086			
53. 00 05300 ANESTHESI OLOGY		0.0341			
54. 00 05400 RADI OLOGY-DI AGNOSTI C 60. 00 06000 LABORATORY		0. 1715			
		0.3720			
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 OCCUPATI ONAL THERAPY		0. 3906			
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0.3070			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7182			
73. 00 07200 DRUGS CHARGED TO PATIENT		0. 3290			
OUTPATIENT SERVICE COST CENTERS		0. 3444	1, 341, 373	402, 105	73.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 2578	56,069	70, 524	02 00
200.00 Total (sum of lines 50-94 and 96-98)		1.2370	32, 256, 814		
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		02, 200, 014		200.00
202.00 Net Charges (line 200 minus line 201)			32, 256, 814		201.00
		I	32,200,011	I	202.00

Health Financial Systems INDIANA ORTHOPAEDIC H	HOSPI TAL, LL	.C	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150160	Period:	Worksheet D-3	
			From 01/01/2014 To 12/31/2014	Date/Time Pre	nared
			10 12/31/2014	5/15/2015 8:4	0 am
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	100 (00		
30. 00 03000 ADULTS & PEDIATRICS			198, 630		30.00
ANCI LLARY SERVI CE COST CENTERS		0.000/	07 (04 (0)	122 420	
		0. 2086			
53. 00   05300  ANESTHESI OLOGY 54. 00   05400  RADI OLOGY-DI AGNOSTI C		0.0341			
		0. 1715			1
		0.3720			1
66. 00 06600 PHYSI CAL THERAPY		0.3906			66.00 67.00
67. 00 06700 OCCUPATIONAL THERAPY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 3070			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		0. 7182			1
73. 00 07200 DRUGS CHARGED TO PATIENT		0. 3290			
OUTPATIENT SERVICE COST CENTERS		0. 3444	50,775	17,000	/3.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		1. 2578	05 0	0	92.00
200.00 Total (sum of lines 50-94 and 96-98)		1.2370	1, 105, 610	-	
201.00 Less PBP Clinic Laboratory Services-Program only charges	(line 61)		1, 103, 010		201.00
202.00 Net Charges (line 200 minus line 201)	(		1, 105, 610		202.00
			,	,	

_CUL	Financial Systems INDIANA ORTHOPAEDIC H ATION OF REIMBURSEMENT SETTLEMENT	OSPITAL, LL Provider	CCN: 150160	Peri od: From 01/01/2014 To 12/31/2014	u of Form CMS- Worksheet E Part A Date/Time Pre 5/15/2015 8:4	epared
		Ti tl	e XVIII	Hospi tal	PPS	iu ani
				1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	1.00	2.00	
00	DRG Amounts Other than Outlier Payments			0		1.0
)1	DRG amounts other than outlier payments for discharges occurrin to October 1 (see instructions)	g prior		8, 967, 593		1.0
)2	DRG amounts other than outlier payments for discharges occurrin	g on or		2, 989, 198		1.0
)3	after October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1.0
/5	discharges occurring prior to October 1 (see instructions)			0		
)4	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0		1.0
00	Outlier payments for discharges. (see instructions)			108, 136		2.0
)1	Outlier reconciliation amount	`		0		2.0
)2 )0	Outlier payment for discharges for Model 4 BPCI (see instruction Managed Care Simulated Payments	ns)		0		2.0
00	Bed days available divided by number of days in the cost report	i ng		35.43		4.0
	period (see instructions)					
00	Indirect Medical Education Adjustment FTE count for allopathic and osteopathic programs for the most	recent		0.00		5.0
	cost reporting period ending on or before 12/31/1996. (see instr	uctions)				
00	FTE count for allopathic and osteopathic programs which meet th criteria for an add-on to the cap for new programs in accordance			0.00		6.0
	CFR 413.79(e)	e wi tii 42				
00	MMA Section 422 reduction amount to the IME cap as specified un	der 42		0.00		7.0
)1	CFR §412.105(f)(1)(iv)(B)(1) ACA Section 5503 reduction amount to the IME cap as specified u	nder 42		0.00		7.0
	CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July					
00	then see instructions. Adjustment (increase or decrease) to the FTE count for allopath	ic and		0.00		8. (
0	osteopathic programs for affiliated programs in accordance with			0.00		0.
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67	FR 50069				
)1	(August 1, 2002). The amount of increase if the hospital was awarded FTE cap slot	s under		0.00		8.
	section 5503 of the ACA. If the cost report straddles July 1, 2					
)2	instructions. The amount of increase if the hospital was awarded FTE cap slot	s from a		0.00		8. (
/2	closed teaching hospital under section 5506 of ACA. (see instru			0.00		0.
00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines	(8, 8,01		0.00		9. (
00	and 8,02) (see instructions) FTE count for allopathic and osteopathic programs in the currer	t year		0.00		10. (
~~	from your records			0.00		
00 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)			0. 00 0. 00		11. (
00	Total allowable FTE count for the prior year.			0.00		13.
00	Total allowable FTE count for the penultimate year if that year	ended on		0.00		14.
00	or after September 30, 1997, otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00		15.
00	Adjustment for residents in initial years of the program			0.00		16.
00 00	Adjusment for residents displaced by program or hospital closur Adjusted rolling average FTE count	e		0. 00 0. 00		17. 18.
	Current year resident to bed ratio (line 18 divided by line 4).			0.00000		19.
00	Prior year resident to bed ratio (see instructions)			0.00000		20.
00	Enter the lesser of lines 19 or 20 (see instructions)			0.00000		21.
00 01	IME payment adjustment (see instructions) IME payment adjustment - Managed Care (see instructions)			0		22.
	Indirect Medical Education Adjustment for the Add-on for Sectio		the MMA			
00	Number of additional allopathic and osteopathic IME FTE residen slots under 42 Sec. 412.105 (f)(1)(iv)(C).	t cap		0.00		23.
00	IME FTE Resident Count Over Cap (see instructions)			0.00		24.
00	If the amount on line 24 is greater than -O-, then enter the lo	wer of		0.00		25.
00	line 23 or line 24 (see instructions) Resident to bed ratio (divide line 25 by line 4)			0. 000000		26.
	IME payments adjustment factor. (see instructions)			0. 000000		27.
	IME add-on adjustment amount (see instructions)			0		28.
01 00	IME add-on adjustment amount - Managed Care (see instructions) Total IME payment ( sum of lines 22 and 28)			0		28.
01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29.
00	Disproportionate Share Adjustment	lont -		0.00		
00	Percentage of SSI recipient patient days to Medicare Part A pat (see instructions)	ient days		0.00		30.
00	Percentage of Medicaid patient days (see instructions)			0.00		31.
	Sum of Lines 30 and 31			0.00		32.
00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			0.00		33. 34.

.CULA	TION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150160	Period: From 01/01/2014	Worksheet E Part A	
			To 12/31/2014		
		Title XVIII	Hospi tal	PPS	U alli
			Prior to	On/After	
	-	0	0ctober 1 1.00	0ctober 1 2.00	
	Jncompensated Care Adjustment				
	Total uncompensated care amount (see instructions)		9, 046, 380, 143		
	Factor 3 (see instructions) Hospital uncompensated care payment (Ifline 34 is zero,		0. 000003376	0. 000004358 0	35. 35.
02	enter zero on this line) (see instructions)		0	0	35.
03	Pro rata share of the hospital uncompensated care payment		0	0	35.
	amount (see instructions)				24
00	Total uncompensated care (sum of columns 1 and 2 on line 35.03)		0		36
	Additional payment for high percentage of ESRD beneficiary d	ischarges (lines 40 throu	gh 46)		
00	Total Medicare discharges on Worksheet S-3, Part I		0		40
	excluding discharges for MS-DRGs 652, 682, 683, 684 and 685 (see instructions)				
	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41
	682, 683, 684 an 685. (see instructions)				
	Total ESRD Medicare covered and paid discharges excluding		0		41
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions) Divide line 41 by line 40 (if less than 10%, you do not		0.00		42
	qualify for adjustment)				
00	Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43
00	682, 683, 684 an 685. (see instructions) Ratio of average length of stay to one week (line 43		0. 000000		44
	divided by line 41 divided by 7 days)				
00	Average weekly cost for dialysis treatments (see		0.00		45
00	instructions) Total additional payment (line 45 times line 44 times line		0		46
00	41.01)		0		
	Subtotal (see instructions)		12, 064, 927		47
	Hospital specific payments (to be completed by SCH and		0		48
	MDH, small rural hospitals only.(see instructions) Total payment for inpatient operating costs (see		12, 064, 927		49
	instructions)				
	Payment for inpatient program capital (from Wkst. L, Pt. I		987, 528		50
	and Pt. II, as applicable) Exception payment for inpatient program capital (Wkst. L,		0		51
	Pt. III, see instructions)				
00	Direct graduate medical education payment (from Wkst. E-4,		0		52
00	line 49 see instructions). Nursing and Allied Health Managed Care payment		0		53
	Special add-on payments for new technologies		0		54
00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55
00	line 69) Cost of physicians' services in a teaching hospital (see		0		56
00	intructions)				
00	Routine service other pass through costs (from Wkst. D,		0		57
00	Pt. III, column 9, lines 30 through 35). Ancillary service other pass through costs from Wkst. D,		0		58
	Pt. IV, col. 11 line 200)				
	Total (sum of amounts on lines 49 through 58)		13, 052, 455		59
	Primary payer payments Total amount payable for program beneficiaries (line 59		0 13, 052, 455		60 61
	minus line 60)		15, 052, 455		
	Deductibles billed to program beneficiaries		1, 124, 736		62
	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)		0		63 64
	Adjusted reimbursable bad debts (see instructions)		0		65
	Allowable bad debts for dual eligible beneficiaries (see		0		66
00	instructions) Subtotal (line 61 plus line 65 minus lines 62 and 63)		11 007 710		67
	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices		11, 927, 719 0		67
	for applicable to MS-DRGs (see instructions)				
00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69
00	96). (For SCH see instructions) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		n		70
	RURAL DEMONSTRATI ON PROJECT		0		70
89	Pioneer ACO demonstration payment adjustment amount (see		0		70
90	instructions) HSP bonus payment HVBP adjustment amount (see		_		70
<i>^</i>	instructions)				
	HSP bonus payment HRR adjustment amount (see instructions)		0		70
	Bundled Model 1 discount amount (see instructions)		0		70
	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)		41, 325 0		70 70
	Recovery of accel erated depreciation		0		70

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150160		riod: om 01/01/2014 12/31/2014		
		Title XVIII		Hospi tal	PPS	
				Prior to October 1	On/After October 1	
		0		1.00	2.00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the		0	0		70.96
70. 97	period prior to 10/1) Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)		0	0		70. 97
70. 98	Low Volume Payment-3			0		70.98
	HAC adjustment amount (see instructions)			0		70.99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)			11, 969, 044		71.00
71.01	Sequestration adjustment (see instructions)			239, 381		71.01
72.00	Interim payments			11, 729, 663		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, 72, and 73)			0		74.00
75.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2			0		75.00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)			0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2			0		91.00
92.00	Operating outlier reconciliation adjustment amount (see instructions)			0		92.00
93.00	Capital outlier reconciliation adjustment amount (see instructions)			0		93.00
	The rate used to calculate the time value of money (see instructions)			0.00		94.00
	Time value of money for operating expenses (see instructions)			0		95.00
96.00	Time value of money for capital related expenses (see instructions)			0		96.00
					On/After 10/1	
				1.00	2.00	
	HSP Bonus Payment Amount					1
100.00	HSP bonus amount (see instructions) HVBP Adjustment for HSP Bonus Payment			0	0	100. 00
101.00	HVBP adjustment factor (see instructions)			0	0	101.00
102.00	HVBP adjustment amount for HSP bonus payment (see instructio HRR Adjustment for HSP Bonus Payment	ns)		0	0	102.00
103.00	HRR adjustment factor (see instructions)			0.0000	0,0000	103, 00
	HRR adjustment amount for HSP bonus payment (see instruction	c)		0		104.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	ovider CCN: 150160	Period: From 01/01/2014 To 12/31/2014	Worksheet E Part B Date/Time Pre	pared:
		Title XVIII	Hospi tal	5/15/2015 8:4 PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			0	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instructions) PPS payments			5, 802, 970 5, 738, 280	2.00 3.00
4.00	Outlier payment (see instructions)			0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions	5)		0.000	
6.00 7.00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0. 00	6.00 7.00
8.00	Transitional corridor payment (see instructions)			0	
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, co	ol. 13, line 200		0	
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0	10.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES			0	111.00
	Reasonabl e charges				
	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, line 69, col. 4	1)		0	
	Total reasonable charges (sum of lines 12 and 13)	,		0	
	Customary charges		· · · ·	_	
15.00 16.00	Aggregate amount actually collected from patients liable for paymen Amounts that would have been realized from patients liable for paym			0	15.00 16.00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)	lent for services c	a chargebasi s	0	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00 19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if	lino 19 ovcoode li	no 11) (coo	0	18.00 19.00
19.00	instructions)	TTHE TO EXCEEUS TT	ne 11) (see	0	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) Lesser of cost or charges (line 11 minus line 20) (for CAH see inst	ructions)		0	21.00
	Interns and residents (see instructions)			0	21.00
	Cost of physicians' services in a teaching hospital (see instruction	ons)		0	
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			5, 738, 280	24.00
25.00	Deductibles and coinsurance (for CAH, see instructions)			0	25.00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for CAH,			1, 227, 640	
27.00	Subtotal {(lines 21 and 24 minus the sum of lines 25 and 26) plus t CAH, see instructions)	the sum of lines 22	and 23} (for	4, 510, 640	27.00
28.00	Direct graduate medical education payments (from Wkst. E-4, line 50	))		0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29) Primary payer payments			4, 510, 640 5, 314	•
	Subtotal (line 30 minus line 31)			4, 505, 326	1
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions)			0	
36.00	Allowable bad debts for dual eligible beneficiaries (see instruction	ons)		0	36.00
	Subtotal (see instructions)			4, 505, 326	
	MSP-LCC reconciliation amount from PS&R OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	38.00 39.00
	Pioneer ACO demonstration payment adjustment (see instructions)			0	39.50
	Partial or full credits received from manufacturers for replaced de	evices (see instruc	tions)	0	39.98
	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 4, 505, 326	39.99 40.00
	Sequestration adjustment (see instructions)			90, 107	
	Interim payments			4, 415, 219	
42.00 43.00	Tentative settlement (for contractors use only) Balance due provider/program (see instructions)			0	42.00 43.00
43.00	Protested amounts (nonallowable cost report items) in accordance wi	th CMS Pub. 15-2,	chapter 1,	0	1
	§115. 2	·	•		
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	92.00
92.00 93.00	Time Value of Money (see instructions)			0	93.00

IALYS	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150160	Period: From 01/01/2014 To 12/31/2014		
		Ti tl	e XVIII	Hospi tal	PPS	
		Inpatier	t Part A	Pai	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		11, 729, 6	63	4, 415, 219	1.
00	Interim payments payable on individual bills, either			0	0	2.
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
~~	write "NONE" or enter a zero					
00	List separately each retroactive lump sum adjustment					3.
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider		1		1	
01	ADJUSTMENTS TO PROVIDER			0	0	3
)2				0	0	3
03				0	0	3
)4				0	0	3
)5				0	0	3
	Provider to Program	1	1			
50	ADJUSTMENTS TO PROGRAM			0	0	3
51				0	0	3
52				0	0	3
53 54				0	0	3
99 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines			0	0	3
,,	3, 50-3, 98)			0	0	5
00	Total interim payments (sum of lines 1, 2, and 3.99)		11, 729, 6	63	4, 415, 219	4
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR	I				
00	List separately each tentative settlement payment after					5
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1) Program to Provider					
)1	TENTATI VE TO PROVIDER			0	0	5
)2				0	0	5
)3				0	0	5
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5
51				0	0	5
52				0	0	5
99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5
0	5.50-5.98)					,
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER			0	0	6
02	SETTLEMENT TO PROGRAM			0	0	6
00	Total Medicare program liability (see instructions)		11, 729, 6	-	4, 415, 219	7
-			, , , , , , , , , , , , , , , , , , , ,	Contractor	NPR Date	
				Number 1.00	(Mo/Day/Yr)	
			C			

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 150160	Period: From 01/01/2014 To 12/31/2014	Worksheet E-3 Part VII Date/Time Pre 5/15/2015 8:4	pared:
		Title XIX	Hospi tal	Cost	
			I npati ent	Outpati ent	
				2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVI COMPUTATION OF NET COST OF COVERED SERVICES	CES FUR TITLES V UR A	IX SERVICES		
. 00	Inpatient hospital/SNF/NF services		473, 221		1.00
2.00	Medical and other services			1, 148, 058	
3.00	Organ acquisition (certified transplant centers only)		0		3.00
1.00	Subtotal (sum of lines 1, 2 and 3)		473, 221	1, 148, 058	
5.00	Inpatient primary payer payments		0	0	5.00
5.00 7.00	Outpatient primary payer payments Subtotal (line 4 less sum of lines 5 and 6)		473, 221	0 1, 148, 058	
. 00	COMPUTATION OF LESSER OF COST OR CHARGES		473, 221	1, 140, 030	1 7.00
	Reasonable Charges				1
3. 00	Routine service charges		198, 630		8.00
9.00	Ancillary service charges		1, 105, 610	4, 237, 482	9.00
0.00	Organ acquisition charges, net of revenue		0		10.00
1.00	Incentive from target amount computation		0		11.00
2.00	Total reasonable charges (sum of lines 8 through 11)		1, 304, 240	4, 237, 482	12.00
3.00	CUSTOMARY CHARGES Amount actually collected from patients liable for payment for s	ervices on a charge	0	0	13.00
	basi s	0			
4.00	Amounts that would have been realized from patients liable for p a charge basis had such payment been made in accordance with 42		n 0	0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
6.00	Total customary charges (see instructions)		1, 304, 240	4, 237, 482	16.00
7.00	Excess of customary charges over reasonable cost (complete only	if line 16 exceeds	831, 019	3, 089, 424	17.00
8.00	line 4) (see instructions) Excess of reasonable cost over customary charges (complete only	if line 4 exceeds lin	e O	0	18.00
	16) (see instructions)				
	Interns and Residents (see instructions)		0	0	19.00
	Cost of physicians' services in a teaching hospital (see instruc		0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16) PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be co		473, 221	1, 148, 058	21.00
22.00	Other than outlier payments	impreted for FF3 provis	0	0	22.00
	Outlier payments		0	0	23.00
	Program capital payments		0		24.00
25.00	Capital exception payments (see instructions)		0		25.00
26.00	Routine and Ancillary service other pass through costs		0	0	
27.00	Subtotal (sum of lines 22 through 26)		0	0	
	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27) COMPUTATION OF REIMBURSEMENT SETTLEMENT		473, 221	1, 148, 058	29.00
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		473, 221	1, 148, 058	
32.00	Deducti bl es		0	0	
	Coinsurance		0	0	
	Allowable bad debts (see instructions)		0	0	34.00
35.00	Utilization review		0		35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 3	33)	473, 221	1, 148, 058	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		470.001	0	37.00
38.00	Subtotal (line 36 ± line 37) Direct graduate modical education payments (from Wkst E 4)		473, 221	1, 148, 058	
39.00 10.00	Direct graduate medical education payments (from Wkst. E-4) Total amount payable to the provider (sum of lines 38 and 39)		0 473, 221	1, 148, 058	39.00 40.00
1. 00	Interim payments		475, 221 476, 782	1, 148, 058	
12.00	Balance due provider/program (line 40 minus line 41)		-3, 561	3, 561	1
13.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub 15-2.	0	0,001	1
	chapter 1, §115.2		Ĭ	Ū	

LANCE	Financial Systems INDIANA ORTHOPAED E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column onl	Provi der	CCN: 150160	Period: From 01/01/2014	u of Form CMS- Worksheet G	
inu-t		(y)		To 12/31/2014	Date/Time Pre 5/15/2015 8:4	
		General Fund	Specific Purpose Fund	Endowment Fund		
		1.00	2.00	3.00	4.00	
1	CURRENT ASSETS					
00	Cash on hand in banks	16, 920, 863			0	
0	Temporary investments Notes receivable	0			0	
	Accounts receivable	34, 281, 163			0	
00	Other receivable	0		0	0	
0	Allowances for uncollectible notes and accounts receivable	-18, 498, 497	(	o o	0	6
00	Inventory	970, 608	(	0 0	0	
00	Prepai d expenses	733, 460		0 0	0	
00	Other current assets	65,000		0	0	
00 00	Due from other funds Total current assets (sum of lines 1-10)	112, 609 34, 585, 206			0	
00	FIXED ASSETS	34, 383, 200	·	<u> </u>	0	1''
00	Land	4, 472, 195	(	0 0	0	1 12
	Land improvements	2, 317, 237		o o	0	13
00	Accumulated depreciation	0		0 0	0	14
	Buildings	0	(	0 0	0	
	Accumulated depreciation	0		0 0	0	
00 00	Leasehold improvements	0			0	
	Accumulated depreciation Fixed equipment	0			0	
	Accumulated depreciation				0	
	Automobiles and trucks	0		0 0	0	21
	Accumulated depreciation	0		0 0	0	
00	Major movable equipment	24, 384, 129	(	0 0	0	23
00	Accumulated depreciation	-17, 568, 917	(	0 0	0	24
00	Minor equipment depreciable	0		0 0	0	
00	Accumulated depreciation	0		0 0	0	
	HIT designated Assets	0			0	
	Accumul ated depreciation Minor equipment-nondepreciable	0			0	
	Total fixed assets (sum of lines 12-29)	13, 604, 644		0	0	
	OTHER ASSETS	1	· · · · · ·			
00	Investments	0	(	0 0	0	31
00	Deposits on Leases	0		0 0	0	
00	Due from owners/officers	0		0 0	0	
00	Other assets	0		0 0	0	
00	Total other assets (sum of lines 31-34)	48, 189, 850			0	
00	Total assets (sum of lines 11, 30, and 35) CURRENT LIABILITIES	48, 189, 850		0	0	36
00	Accounts payable	4, 102, 826	(	0 0	0	37
00	Salaries, wages, and fees payable	2, 791, 284		0	0	
00	Payroll taxes payable	0		o o	0	39
00	Notes and Loans payable (short term)	0	(	0 0	0	40
	Deferred income	0	(	0 0	0	
00	Accel erated payments	0				42
	Due to other funds	3, 847			0	
00	Other current liabilities Total current liabilities (sum of lines 37 thru 44)	466, 033 7, 363, 990			0	
. 00	LONG TERM LIABILITIES	7, 303, 990		<u> </u>	0	4.
. 00	Mortgage payable	0	(	0 0	0	46
. 00	Notes payable	3, 962, 686		0 0	0	
. 00	Unsecured Loans	0	(	0 0	0	
00	Other long term liabilities	0		0 0	0	
00	Total long term liabilities (sum of lines 46 thru 49	3, 962, 686		0 0	0	
00	Total liabilites (sum of lines 45 and 50)	11, 326, 676	(	0 0	0	51
00	CAPITAL ACCOUNTS General fund balance	36, 863, 174				52
00	Specific purpose fund	30,003,174				53
00	Donor created - endowment fund balance - restricted			0		54
00	Donor created - endowment fund balance - unrestricted			0		55
00	Governing body created - endowment fund balance			0		56
00	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion					
00	Total fund balances (sum of lines 52 thru 58)	36, 863, 174		0 0	0	
00	Total liabilities and fund balances (sum of lines 51 and	48, 189, 850	(	0 IL	0	60

Heal th	Financial Systems ING	DI ANA ORTHOPAEDI	C HOSPI TAL, LL	С	In Lie	u of Form CMS-2	2552-10
STATEN	IENT OF CHANGES IN FUND BALANCES		Provi der	CCN: 150160	Period: From 01/01/2014 To 12/31/2014	Worksheet G-1 Date/Time Pre 5/15/2015 8:40	
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
		1.00	2,00	3.00	4.00	5.00	
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) DISTRIBUTIONS &MEMBERSHIP REDEEMED Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2: 00 33, 954, 370 51, 115, 133 85, 069, 503 0 85, 069, 503 48, 206, 329 36, 863, 174			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 8. \ 00\\ 9. \ 00\\ 10. \ 00\\ 11. \ 00\\ 12. \ 00\\ 12. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 15. \ 00\\ 15. \ 00\\ 15. \ 00\\ 16. \ 00\\ 17. \ 00\\ 18. \ 00\\ 19. \ 00\\ \end{array}$
		Endowment Fund	PI ant	Fund			
1.00	Fund halfsame at heritarian of paried	6.00	7.00	8.00	0		1.00
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify)	0	0 0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) DISTRIBUTIONS &MEMBERSHIP REDEEMED Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0 0	0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150160	Period: From 01/01/2 To 12/31/2	014 Pa 014 Da	rksheet G-2 rts I & II te/Time Pre 15/2015 8:4	pared
	Cost Center Description		I npati ent	Outpati er	nt	Total	
			1.00	2.00		3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services						
. 00	Hospi tal		9, 948, 1	02		9, 948, 102	
2.00	SUBPROVIDER - IPF						2.0
3.00	SUBPROVIDER - IRF						3. (
1.00	SUBPROVI DER						4.0
5.00	Swing bed - SNF			0		0	5.0
5.00	Swing bed - NF			0		0	6.0
7.00	SKILLED NURSING FACILITY						7.0
3.00	NURSING FACILITY			0		0	
9.00	OTHER LONG TERM CARE						9.0
0.00	Total general inpatient care services (sum of lines 1-9)		9, 948, 1	02		9, 948, 102	10. (
	Intensive Care Type Inpatient Hospital Services						
1.00	INTENSIVE CARE UNIT						11. (
2.00	CORONARY CARE UNI T						12.0
3.00	BURN INTENSIVE CARE UNIT						13.
4.00	SURGICAL INTENSIVE CARE UNIT						14.
15.00	OTHER SPECIAL CARE (SPECIFY)						15.
6.00	Total intensive care type inpatient hospital services (sum of I	i nes		0		0	16.
	11-15)						
7.00	Total inpatient routine care services (sum of lines 10 and 16)		9, 948, 1	02		9, 948, 102	17.
8.00	Ancillary services		90, 674, 7	68 180, 417,	885	271, 092, 653	18.
9.00	Outpatient services			0	0	0	19.0
20.00	RURAL HEALTH CLINIC			0	0	0	20. (
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21. (
22.00	HOME HEALTH AGENCY						22. (
23.00	AMBULANCE SERVI CES						23. (
24.00	СМНС						24.0
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.0
26.00	HOSPI CE						26.0
27.00	OTHER (SPECIFY)			0	0	0	27.0
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	100, 622, 8	70 180, 417,	885	281, 040, 755	28.0
	G-3, line 1)						
	PART II - OPERATING EXPENSES						
29.00	Operating expenses (per Wkst. A, column 3, line 200)			91, 562,	479		29.
30.00	ADD (SPECIFY)			0			30.
31.00				0			31.
32.00				0			32.
33.00				0			33.
34.00				0			34.
35.00				0			35.
36.00	Total additions (sum of lines 30-35)				0		36.
37.00	DEDUCT (SPECIFY)			0			37.
38.00				0			38.
39.00				0			39.
10.00				0			40.
1.00				0			41.
12.00	Total deductions (sum of lines 37-41)			-	0		42.
13.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		91, 562,	479		43.
	to Wkst. G-3, line 4)	(chanor of		,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,			'0.

STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 150160	Period:	Worksheet G-3	
STATEM	ENT OF REVENUES AND EXTENSES		From 01/01/2014	worksheet 0-5	
			To 12/31/2014	Date/Time Prep	
				<u>5/15/2015</u> 8: 40	) am
			-	1.00	
1 00	Tetel actions groups (from What C. 2. Deat L. selvers 2. Line	- 20)		1.00	1 00
1.00 2.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line			281, 040, 755	1.00 2.00
	Less contractual allowances and discounts on patients' account	15		140, 026, 608	
3.00	Net patient revenues (line 1 minus line 2) Less total operating expenses (from Wkst. G-2, Part II, line 4	12)		141, 014, 147	3.00 4.00
4.00		+3)		91, 562, 479 49, 451, 668	4.00
5.00	Net income from service to patients (line 3 minus line 4) OTHER INCOME			49, 451, 008	5.00
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			11, 412	7.00
8.00	Revenues from telephone and other miscellaneous communication	sorvi cos		0	8.00
9.00	Revenue from television and radio service	Services		0	9.00
10.00	Purchase di scounts			0	10.0
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 quests			-	
15.00	Revenue from rental of Living quarters			0	15.0
16.00	Revenue from sale of medical and surgical supplies to other th	nan natients		0	16.0
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			Ő	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			22, 396	
21.00	Rental of vending machines			0	21.0
22.00	Rental of hospital space			0	22.0
23.00	Governmental appropriations			0	23.0
24.00	APPLICATION FEE & LEARNING LAB			37, 361	24.0
24.01	OTHER MISCELLANEOUS INCOME			1, 253, 391	24.0
25.00	Total other income (sum of lines 6-24)			1, 663, 465	
26.00	Total (line 5 plus line 25)			51, 115, 133	
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			51, 115, 133	

ALCUL	ATION OF CAPITAL PAYMENT	Provi der CCN: 150160	Period: From 01/01/2014 To 12/31/2014		
		Title XVIII	Hospi tal	PPS	
				1.00	
	PART I - FULLY PROSPECTIVE METHOD				-
	CAPITAL FEDERAL AMOUNT			057 445	1 1
	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier			957, 445 0	1. 1.
	Capital DRG outlier payments			30, 083	
	Model 4 BPCI Capital DRG outlier payments			00,000	2.
	Total inpatient days divided by number of days in the cost r	eporting period (see inst	ructions)	16.65	
. 00	Number of interns & residents (see instructions)		,	0.00	4.
. 00	Indirect medical education percentage (see instructions)			0.00	5.
. 00	Indirect medical education adjustment (multiply line 5 by th	e sum of lines 1 and 1.01	)	0	6.
00	Percentage of SSI recipient patient days to Medicare Part A 30) (see instructions)		, part A line	0.00	7.
00	Percentage of Medicaid patient days to total days (see instr	uctions)		0.00	-
	Sum of lines 7 and 8	- )		0.00	
	Allowable disproportionate share percentage (see instruction Disproportionate share adjustment (line 10 times the sum of			0.00	
	Total prospective capital payments (sum of lines 1, 1.01, 2,	· · · · · · · · · · · · · · · · · · ·		987, 528	
				1.00	
	PART II - PAYMENT UNDER REASONABLE COST				
	Program inpatient routine capital cost (see instructions)			0	
	Program inpatient ancillary capital cost (see instructions) Total inpatient program capital cost (line 1 plus line 2)			0	2.
00	Capital cost payment factor (see instructions)			0	4.
	Total inpatient program capital cost (line 3 x line 4)			0	
00				0	0.
			·	1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
	Program inpatient capital costs (see instructions)			0	
00	Program inpatient capital costs for extraordinary circumstan	ces (see instructions)		0	2.
	Net program inpatient capital costs (line 1 minus line 2)			0	
	Applicable exception percentage (see instructions)			0.00	
00 00	Capital cost for comparison to payments (line 3 x line 4)	nctructions)		0	5.
	Percentage adjustment for extraordinary circumstances (see i Adjustment to capital minimum payment level for extraordinar		line 6)	0. 00 0	6. 7.
	Capital minimum payment level (line 5 plus line 7)			0	
00		i cabl e)		0	9
00 00				0	
00 00 00	Current year capital payments (from Part I, line 12, as appl	-	less line 9)	01	
00 00 00 . 00		capital payments (line 8		0	11.
00 00 00 . 00 . 00	Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over	capital payments (line 8 capital payment (from pri	or year	-	12.
00 00 . 00 . 00 . 00 . 00 . 00	Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente	capital payments (line 8 capital payment (from pri ayments (line 10 plus lin r the amount on this line	or year le 11) e)	0 0 0	12. 13.
00 00 00 0. 00 1. 00 2. 00 3. 00 4. 00	Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over (if line 12 is negative, enter the amount on this line)	capital payments (line 8 capital payment (from pri ayments (line 10 plus lin r the amount on this line capital payment for the f	or year le 11) e)	0 0 0 0	12. 13. 14.
00 00 00 0. 00 1. 00 2. 00 3. 00 4. 00	Current year capital payments (from Part I, line 12, as appl Current year comparison of capital minimum payment level to Carryover of accumulated capital minimum payment level over Worksheet L, Part III, line 14) Net comparison of capital minimum payment level to capital p Current year exception payment (if line 12 is positive, ente Carryover of accumulated capital minimum payment level over	capital payments (line 8 capital payment (from pri ayments (line 10 plus lin r the amount on this line capital payment for the f	or year le 11) e)	0 0 0	12 13 14 15

Health Financial Systems ING	DI ANA ORTHOPAED	DIC HOSPITAL.LL	с	In Lie	u of Form CMS-	2552-10
ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIR			CCN: 150160	Period: From 01/01/2014 To 12/31/2014	Worksheet L-1 Part I Date/Time Pre 5/15/2015 8:4	epared:
		Capital Rel	ated Costs			
Cost Center Description	Extraordi nary Capi tal	NEW CAP REL COSTS-BLDG &	NEW CAP REL COSTS-MVBLE	Subtotal	EMPLOYEE BENEFI TS	
	Related Costs	FLXT	EQUI P		DEPARTMENT	
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS	0	0	1			1 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	0	0		0		1.00
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP	0			0	0	2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	0	
5.00 00500 ADMINI STRATI VE & GENERAL	0	0		0 0	0	
7.00 00700 OPERATION OF PLANT	0	0		0 0	0	
10. 00 01000 DI ETARY	0	0		0 0	0	
11. 00 01100 CAFETERI A	0	0		0 0	0	
12.00 01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	
13.00 01300 NURSING ADMINISTRATION	0	0		0 0	0	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	0		0 0	0	
16.00 01600 MEDI CAL RECORDS & LI BRARY	0	0		0 0	0	16.00
INPATIENT ROUTINE SERVICE COST CENTERS						-
30. 00 03000 ADULTS & PEDI ATRI CS	0			0 0	0	
45.00 04500 NURSING FACILITY	0	0		0 0	0	45.00
ANCI LLARY SERVICE COST CENTERS						-
50.00 05000 OPERATING ROOM	0	-		0 0	0	
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
60. 00 06000 LABORATORY	0	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
OUTPATIENT SERVICE COST CENTERS						
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS						
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0		0 0	0	118.00
NONREI MBURSABLE COST CENTERS	•	•			• •	1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
194.0007950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0	0	194.00
194.01 07951 NNS	0	0		0 0		194.01
200.00 Cross Foot Adjustments				1	-	200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 Total (sum of lines 118 and 190-201)	0	0		0 0		202.00
203.00 Total Statistical Basis		165, 918		0 0	18, 297, 718	
204.00 Unit Cost Multiplier		0. 000000				
	I				0.00000	

ALLOCATION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIRCUMSTANCES         Provider CCN: 150160         Period: From 01/01/201 To 12/31/201         Period: Part I Do T2/31/201         Period: Det TIME Propared: 5/15/2018. 4.0 am           Cost Center Description         ADMI MISTRATIVE & GENERAL. SERVICE COST CENTERS         0         DIETARY         CAFETERIA Monite Cost Sectors for the propared: 5/15/2018         DIETARY         DI	Health Financial Systems IN	DI ANA ORTHOPAED	IC HOSPITAL, LL	С	In Li	eu of Form CMS-	2552-10
& GENERAL         PLANT         PERSONNEL           1.00         OTION RWI CAP REL COSTS - GR & FLXT         5.00         10.00         11.00         12.00           2.00         002001 NEW CAP REL COSTS - MURLE EQUIP         1.00         1.00         1.00         1.00           4.00         004000 EMPLOYEE BENEFT IS DEPARTMENT         0         1.00         1.00         4.00           5.00         00500 ADMI NI STRATIVE & GENERAL         0         0         7.00         10.00           10.00         00500 ADMI NI STRATIVE & GENERAL         0         0         0         10.00           11.00         01000 CHETARY         0         0         0         0         10.00           12.00         1000 COUNC INTARTATIVE & SUPPLY         0         0         0         0         11.00           12.00         01000 CENTRAL SERVICES & SUPPLY         0         0         0         0         13.00           14.00         01000 CENTRAL SERVICES & SUPPLY         0         0         0         0         14.00           15.00         00000 OPERATINE SERVICE COST CENTRES         0         0         0         0         53.00           16.00         14.00         0         0         0					From 01/01/201 To 12/31/201	4 Part I 4 Date/Time Pre 5/15/2015 8:4	epared: 10 am
CENERAL SERVICE COST CENTERS         Image: Cost Service Cost Service Service Cost Service Service Cost Ser	Cost Center Description			DI ETARY	CAFETERI A		
1.00         ODION NEW CAP REL COSTS-BLOC & FIXT         1.00           2.00         O2000 NEW CAP REL COSTS-BLOC & FIXT         0           4.00         O4400 EMPLOYEE BENEFITS DEPARTMENT         0           5.00         00500 ADM IN STRATIVE & GENERAL         0           7.00         00700 OPERATION OF PLANT         0         0           10.00         1000 CAFETERIA         0         0         10.00           10.00         1000 CAFETERIA         0         0         0         11.00           12.00         000 NURSI NG ADMIN ISTRATION         0         0         0         0         11.00           13.00         01400 CENTRAL SERVICES & SUPPLY         0         0         0         0         14.00         14.00           16.00         10300 ADM INSTRATICS         0         0         0         0         0         0         14.00           16.00         10300 ADMIN STRATICS         0		5.00	7.00	10.00	11.00	12.00	
2.00         00200 NEW CAP REL COSTS-MURLE EQUIP         2.00           4.00         00400 EMPLOYE BENEFITS DENARTIMENT         0           5.00         00500 ADMI NI STRATI VE & GENERAL         0           7.00         00700 OPERATI (N OF PLANT         0         0           7.00         00100 OL ETARY         0         0         0           10.00         01100 (AFETERIA         0         0         0         0           12.00         12.00         0         0         0         0         0         0           12.00         01300 NURSI NG ADMI NI STRATI ON         0         0         0         0         0         0         0         13.00           14.00         01600 CENTRAL SERVICES & SUPLY         0         0         0         0         0         0         14.00           16.00         01600 ADULTS & PEDI ATIR CS         0	GENERAL SERVICE COST CENTERS						
4.00         00400         EMPLOYEE BEMETITS DEPARTMENT         4.00           5.00         00500         ADM IN STRATIVE & GENERAL         0         7.00           10.00         00000         DETARY         0         0         7.00           11.00         01000         DETARY         0         0         0         0         10.00         0         10.00         10.00         0         0         10.00         0	1.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
5.00         OSSO0         ADM NI STRATIVE & GENERAL         0         5.00           7.00         OTOO         OPERATION OF PLANT         0         0         7.00           10.00         OTOO         OPERATION OF PLANT         0         0         0         10.00           10.00         OTOO         OPERATION OF PLANT         0         0         0         10.00           11.00         OTOO         OPERATION OF PLANT         0         0         0         0         10.00           12.00         120.00         ADM NI STRATION         0         0         0         0         11.00           13.00         OTOOM ALVIETRANCE OF PERSONNEL         0         0         0         0         13.00           14.00         OTOOM CENTRAL SERVICES & SUPPLY         0	2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
7.00         00700         OPERATION OF PLANT         0         0         10.00           10.00         D1000         DETARY         0         0         0         10.00           11.00         D1100         CAFETERIA         0         0         0         0         10.00           12.00         D1200         MAINTENANCE         OF PERSONNEL         0         0         0         0         11.00           13.00         D1300         NURSING ADMINISTRATION         0         0         0         0         0         13.00           14.00         D1400         CENTRAL SERVICES & SUPPLY         0         0         0         0         14.00           16.00         D1600         MEDICAL RECORDS & LIBBARY         0	4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
10.00       01000       DETARY       0       0       0       10.00         11.00       01100       CAFETERIA       0       0       0       0       11.00         12.00       01200       MAINTENANCE OF PERSONNEL       0       0       0       0       0       11.00         13.00       01300       NURSI NG ADMIN ISTRATI ON       0       0       0       0       0       0       12.00         14.00       1400       CHAROQ CENTRAL SERVI CES & SUPPLY       0       0       0       0       0       0       14.00         16.00       1600       MEDI CAL RECORDS & LIBRARY       0       0       0       0       0       16.00         16.00       0	5. 00 00500 ADMINI STRATI VE & GENERAL	0					5.00
11.00         01100         CAFETERIA         0         0         0         0         0         0         11.00           12.00         01300         MAINTENANCE OF PERSONNEL         0	7.00 00700 OPERATION OF PLANT	0	0				7.00
12.00       01200 MAINTENANCE OF PERSONNEL       0       0       0       0       0       12.00         13.00       01300 NURSING ADMINISTRATION       0       0       0       0       0       13.00         14.00       01400 (ENTRAL SERVICES & SUPPLY       0	10. 00 01000 DI ETARY	0	0		0		10.00
13.00       NURSI NG ADMI NI STRATI ON       0       0       0       0       0       0       0       13.00         14.00       O1400       CENTRAL SERVICES & SUPPLY       0	11. 00 01100 CAFETERI A	0	0		0	o	11.00
13.00       NURSI NG ADMI NI STRATI ON       0       0       0       0       0       0       0       13.00         14.00       O1400       CENTRAL SERVICES & SUPPLY       0	12.00 01200 MAINTENANCE OF PERSONNEL	0	l o		0	ol c	12.00
14.00       01400       CENTRAL SERVICES & SUPPLY       0		0	0		0	ol c	1
16.00         MEDI CAL RECORDS & LIBRARY         0         0         0         0         0         16.00           INPATI ENT ROUTI NE SERVICE COST CENTERS         0		0	0		0		1
INPATI ENT ROUTINE SERVICE COST CENTERS         0		0			0		
30.00       G3000 ADULTS & PEDIATRICS       0 <t< td=""><td></td><td></td><td></td><td></td><td>0</td><td></td><td>10100</td></t<>					0		10100
45.00       04500       NURSING FACILITY       0 </td <td></td> <td>0</td> <td>0</td> <td></td> <td>0</td> <td></td> <td>30.00</td>		0	0		0		30.00
ANCILLARY SERVICE COST CENTERS           50. 00         05000         OPERATI NG ROOM         0         0         0         0         0         50. 00           53. 00         05300         ANESTHESI OLOGY         0         0         0         0         53. 00           54. 00         05400         RADI OLOGY – DI AGNOSTI C         0         0         0         0         53. 00           60. 00         06000         LABORATORY         0         0         0         0         0         66. 00           60. 00         66000         PHYSI CAL THERAPY         0         0         0         0         66. 00           67. 00         06700         0CUPATI ONAL THERAPY         0         0         0         0         67. 00         0         0         0         67. 00         0         0         0         71. 00         72. 00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0         0         0         0         0         0         0         0         0         0         0         0         73. 00         0         0         0         0         0         0         0         0         0         0         0         0							1
50.00         05000         0PERATING ROOM         0         0         0         0         0         0         0         0         0         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         50.00         53.00         50.00         60.00         0         0         0         0         0         0         0         0         0         0         0         53.00         54.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         60.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         67.00         73.00         73.00         73.00         73.00         7				1	0		10.00
53.00       05300       ANESTHESI OLOGY       0       0       0       53.00         54.00       RADI OLOGY - DI AGNOSTI C       0       0       0       0       54.00         60.00       C6000       LABORATORY       0       0       0       0       64.00         66.00       O6600       LABORATORY       0       0       0       0       0       60.00         66.00       O6600       PHYSI CAL THERAPY       0       0       0       0       66.00         67.00       O6700       OCCUPATI ONAL THERAPY       0       0       0       0       67.00         71.00       O7100       MEDI CAL SUPPLIES CHARGED TO PATI ENTS       0       0       0       0       71.00         72.00       IMPL, DEV. CHARGED TO PATI ENT       0       0       0       0       0       0       73.00         0       07300       DRUGS CHARGED TO PATI ENTS       0       0       0       0       0       0       73.00       73.00       0       0       0       0       0       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00       73.00		0	0		0		50.00
54.00       05400       RADI OLOGY-DI AGNOSTI C       0		0			-		
60.00       06000       LABORATORY       0					0		
66.00         06600         PHYSI CAL THERAPY         0         0         0         0         0         0         66.00           67.00         06700         OCCUPATI ONAL THERAPY         0					0	-	1
67.00       06700       OCCUPATIONAL THERAPY       0       0       0       0       67.00         71.00       07100       MEDICAL SUPPLIES CHARGED TO PATIENTS       0       0       0       0       0       71.00         72.00       07200       IMPL.       DEV. CHARGED TO PATIENT       0       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       0       72.00         00       0       0       0       0       0       0       0       72.00         00       0       0       0       0       0       0       0       73.00         00       0       0       0       0       0       0       0       73.00         00       0       0       0       0       0       0       0       73.00         92.00       08SERVATI ON BEDS (NON-DI STINCT PART)         92.00       92.00         SPECI AL PURPOSE COST CENTERS          92.00       0        92.00         180.00       SUBTOTALS (SUM OF LINES 1-117)       0       0       0		0			0	-	
71.00       07100       MEDI CAL SUPPLIES CHARGED TO PATIENTS       0       0       0       0       71.00         72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       0       73.00         0       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       0       73.00         0       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       0       73.00         0       09200       DBSERVATION BEDS (NON-DI STINCT PART)        92.00       92.00       92.00         SPECIAL PURPOSE COST CENTERS         118.00       SUBTOTALS (SUM OF LINES 1-117)       0       0       0       0       118.00         NONREI MBURSABLE COST CENTERS         190.00       19000       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190.00         194.01       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       194.01       200.00         200.00       Cross Foot Adjustments		0			0	-	
72.00       07200       IMPL. DEV. CHARGED TO PATIENT       0       0       0       0       0       72.00         73.00       07300       DRUGS CHARGED TO PATIENTS       0       0       0       0       0       0       72.00         00       000       DRUGS CHARGED TO PATIENTS       0       0       0       0       0       0       0       73.00         01       000       000       000       0       0       0       0       0       0       0       0       0       0       73.00         01       0000       000000000000000000000000000000000000		0			0	° .	
73.00         07300         DRUGS CHARGED TO PATIENTS         0         0         0         0         0         73.00           OUTPATIENT SERVICE COST CENTERS         92.00         09200         000000000000000000000000000000000000		0			0	-	
OUTPATI ENT SERVICE COST CENTERS         92.00           92.00         09200         OBSERVATI ON BEDS (NON-DI STINCT PART)         92.00           SPECI AL PURPOSE COST CENTERS         92.00         0		0			0	-	
92.00       09200   OBSERVATI ON BEDS (NON-DI STINCT PART)       92.00         SPECI AL PURPOSE COST CENTERS         118.00       SUBTOTALS (SUM OF LINES 1-117)       0       <		0	0		0		/3.00
SPECIAL PURPOSE COST CENTERS           118.00         SUBTOTALS (SUM OF LINES 1-117)         0							
Substant				1			92.00
NONREI MBURSABLE COST CENTERS           190.00         GI FT, FLOWER, COFFEE SHOP & CANTEEN         0         0         0         0         190.00           194.00         07950         OTHER NONREI MBURSABLE COST CENTERS         0         0         0         0         194.00           194.01         07950         OTHER NONREI MBURSABLE COST CENTERS         0         0         0         0         194.00           194.01         07951         NNS         0         0         0         0         194.00           200.00         Cross Foot Adjustments         0         0         0         200.00         201.00         202.00         0         0         0         0         202.00         0         0         0         202.00         0         0         0         202.00         0         0         0         202.00         0         0         202.00         0         0         202.00         0         0         203.00         0         203.00         513,858         0         203.00			0		0		110.00
190.00       GI FT, FLOWER, COFFEE SHOP & CANTEEN       0       0       0       0       190.00         194.00       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       194.00         194.01       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       194.00         194.01       07951       NNS       0       0       0       0       194.01         200.00       Cross Foot Adjustments       0       0       0       200.00       201.00         201.00       Negative Cost Centers       0       0       0       0       201.00         202.00       Total (sum of Lines 118 and 190-201)       0       0       0       0       202.00         203.00       Total Statistical Basis       73, 532, 807       137, 050       100       513, 858       0       203.00		0	0		0		118.00
194.00       07950       OTHER NONREI MBURSABLE COST CENTERS       0       0       0       0       194.00         194.01       07951       NNS       0       0       0       0       194.01         200.00       Cross Foot Adjustments				1	0		100.00
194. 01         07951         NNS         0         0         0         0         194. 01           200. 00         Cross Foot Adjustments		0			-		
200.00         Cross Foot Adjustments         200.00         200.00           201.00         Negative Cost Centers         0         0         0         201.00           202.00         Total (sum of lines 118 and 190-201)         0         0         0         0         202.00           203.00         Total Statistical Basis         73,532,807         137,050         100         513,858         0         203.00		0	0		0		
201.00         Negative Cost Centers         0         0         0         0         201.00           202.00         Total (sum of lines 118 and 190-201)         0         0         0         0         0         202.00           203.00         Total Statistical Basis         73, 532, 807         137, 050         100         513, 858         0         203.00		0	0		0		
202.00         Total (sum of lines 118 and 190-201)         0         0         0         0         0         202.00           203.00         Total Statistical Basis         73, 532, 807         137, 050         100         513, 858         0         203.00							
203. 00 Total Štatistical Basis 73, 532, 807 137, 050 100 513, 858 0 203. 00		0	0		U		
		0	0		0		1
204.00   Unit Cost Multiplier   0.000000  0.000000  0.000000  0.000000  0.000000  0.000000 204.00							
	204.00   Unit Cost Multiplier	0. 000000	U. 000000	0.0000	0.00000	U 0.00000	204.00

Heal th	Financial Systems IN	DI ANA ORTHOPAEDI	IC HOSPITAL, LL	С	In Lie	eu of Form CMS-	2552-10
	TION OF ALLOWABLE COSTS FOR EXTRAORDINARY CIR			CCN: 150160	Peri od:	Worksheet L-1	
					From 01/01/2014 To 12/31/2014		narod
					10 12/31/2014	5/15/2015 8:4	
	Cost Center Description	NURSI NG	CENTRAL	MEDI CAL	Subtotal	Intern &	
		ADMI NI STRATI ON	SERVICES &	RECORDS &		Residents Cost	
			SUPPLY	LI BRARY		& Post	
						Stepdown	
						Adjustments	
		13.00	14.00	16.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS	1 1					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
12.00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0				14.00
16.00	01600 MEDICAL RECORDS & LIBRARY	0	0		0		16.00
	INPATIENT ROUTINE SERVICE COST CENTERS	1					
30.00	03000 ADULTS & PEDIATRICS	0	0		0 0		
45.00	04500 NURSING FACILITY	0	0		0 0	0	45.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0 0		
53.00	05300 ANESTHESI OLOGY	0	0		0 0		
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	
60.00	06000 LABORATORY	0	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	0	0		0 0	0	
67.00	06700 OCCUPATIONAL THERAPY	0	0		0 0	0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
92.00	OUTPATIENT SERVICE COST CENTERS 09200 OBSERVATION BEDS (NON-DISTINCT PART)						
92.00	SPECIAL PURPOSE COST CENTERS						92.00
118.00		0	0	[	0 0	0	118.00
110.00	NONREI MBURSABLE COST CENTERS	0	0		0 0	0	110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190.00
	07950 OTHER NONREIMBURSABLE COST CENTERS	0	0		0 0		194.00
	07950 OTHER NORRET MORE TWO REAL COST CENTERS	0	0				194.00
200.00		0	0		0		200.00
200.00		0	0		0 0		200.00
201.00		0	0				201.00
202.00		0	100	281, 040, 7	а а		202.00
203.00		0. 000000	0, 000000				203.00
201.00		0.000000	0.00000	0.0000	~~	I	

26	otal	Provider CCN: 150160		Worksheet L-1 Part I Date/Time Prepare
26			To 12/31/2014	Date/Time Prepare
26				5/15/2015 8:40 an
26	5.00		-l	571572015 6.40 al
GENERAL SERVICE COST CENTERS				
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT				1
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP				2
. 00 00400 EMPLOYEE BENEFITS DEPARTMENT				4
5. 00 00500 ADMI NI STRATI VE & GENERAL				5
. 00 00700 OPERATION OF PLANT				7
0. 00 01000 DI ETARY				10
1. 00 01100 CAFETERIA				11
2. 00 01200 MAINTENANCE OF PERSONNEL				12
3. 00 01300 NURSI NG ADMI NI STRATI ON				13
4. 00 01400 CENTRAL SERVICES & SUPPLY				14
6. 00 01600 MEDICAL RECORDS & LIBRARY				14
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				
0. 00 03000 ADULTS & PEDIATRICS	0			30
5. 00 04500 NURSING FACILITY	0			45
ANCI LLARY SERVICE COST CENTERS	0			40
0. 00 05000 OPERATI NG ROOM	0			50
3. 00 05300 OPERATING ROOM	o			53
4. 00 05400 RADI OLOGY-DI AGNOSTI C	o			54
0. 00 06000 LABORATORY	0			60
6. 00 06600 PHYSI CAL THERAPY	0			66
7. 00 06700 OCCUPATIONAL THERAPY	0			67
	0			71
	-			
2. 00 07200 I MPL. DEV. CHARGED TO PATI ENT	0			72
3. 00 07300 DRUGS CHARGED TO PATIENTS	0			73
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)				92
SPECIAL PURPOSE COST CENTERS	0			110
18.00 SUBTOTALS (SUM OF LINES 1-117)	0			118
NONREI MBURSABLE COST CENTERS 20. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0			190
90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 94.00 07950 OTHER NONREI MBURSABLE COST CENTERS	0			190
94. 00 07950 OTHER NONRETMBURSABLE COST CENTERS				194
	0			
00.00 Cross Foot Adjustments	0			200
01.00 Negative Cost Centers	0			201
02.00 Total (sum of lines 118 and 190-201)	0			202
03.00 Total Statistical Basis				203
04.00 Unit Cost Multiplier				20