PART II - CERTIFICATION

(4) Reopened(5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH STARKE MEMORIAL HOSPITAL (150102) for the cost reporting period beginning 01/01/2016 and ending 02/29/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

Officer or Administrator of Provider(s)

Title

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	4, 785	29, 096	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - IRF	0	0	0		0	3. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
200.00	Total	0	4, 785	29, 096	0	0	200. 00

The above amounts represent "due to" or "due from" the applicable program for the element of the above complex indicated.

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 150102 Peri od: Worksheet S-2 From 01/01/2016 Part I 02/29/2016 Date/Time Prepared: 7/28/2016 7:42 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 102 EAST CULVER RD 1.00 PO Box: 1.00 2.00 City: KNOX State: IN Zip Code: 46534 County: STARKE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, T, 0, or N) Certi fi ed Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 Hospi tal IU HEALTH STARKE 150102 99915 07/11/1966 Ν 3.00 MEMORIAL HOSPITAL Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 6.00 Subprovider - (Other) 6.00 Swing Beds - SNF III HEALTH STARKE 15U102 99915 Р N 7.00 09/06/1989 7 00 N MEMORIAL SWING BED 8.00 Swing Beds - NF 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA 12.00 Separately Certified ASC 13.00 13.00 14.00 Hospi tal -Based Hospi ce 14 00 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18 00 19.00 Other 19.00 From: To: 1.00 2 00 20.00 Cost Reporting Period (mm/dd/yyyy) 20.00 01/01/2016 02/29/2016 21.00 Type of Control (see instructions) 21.00 2 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Υ N 22 00 share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y' for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν Ν 22.03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column 3 N 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2, enter "Y" for yes or "N" for no. Medi cai d Other In-State In-State Out-of Out-of Medi cai d Medi cai d State State HMO days Medi cai d paid days el i gi bl e Medi cai d Medi cai d days unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6.00 24.00 If this provider is an IPPS hospital, enter the 24.00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6. 25.00 If this provider is an IRF, enter the in-state 0 0 0 ol 25.00 0 Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.

applicable column.

OSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		eriod: rom 01/01/20		
		To	02/29/20	016 Date/	Time Prepar 2016 7:42 p
			V)	XI X
5.00 If line 94 is "Y", enter the reduction percentage in the app	olicable colum	n	1. 00 0. 00		2. 00 0. 00 95
Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	or "N" for n	o in the	N		N 96
7.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers		n.	0. 00	0	0.00 97
15.00 Does this hospital qualify as a critical access hospital (CA) 16.00 If this facility qualifies as a CAH, has it elected the all- for outpatient services? (see instructions)		hod of payment	N N		105
17.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see inst	ructions) If	N		107
08.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N		108
	Physi cal 1.00	Occupational 2.00	Speech 3.00		i ratory I. 00
9.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N N	N		N 109
				1	. 00
0.00 Did this hospital participate in the Rural Community Hospita		on project (410	A Demo)for		N 110
the current cost reporting period? Enter "Y" for yes or "N"	for no.				
			1	1.00 2.00	3.00
Miscellaneous Cost Reporting Information 5.00 st this an all-inclusive rate provider? Enter "Y" for yes or	"N" for no i	n column 1 lf	column 1	N I	0 115
is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider	If column 2 nt for long te	is "E", enter i rm care (includ	n column les	N	
	,	ne derrin tron i	11 01115		
Pub. 15-1, chapter 22, §2208.1. 6.00 s this facility classified as a referral center? Enter "Y" 7.00 s this facility legally-required to carry malpractice insur	for yes or "N	" for no.		N N	116
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6.00 Is this facility classified as a referral center? Enter "Y" 7.00 Is this facility legally-required to carry malpractice insur no. 8.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence. 8.01 List amounts of malpractice premiums and paid losses: 8.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched and amounts contained therein. 9.00 DO NOT USE THIS LINE 10.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that quelled Hold Harmless provision in ACA §3121 and applicable amendmenter in column 2, "Y" for yes or "N" for no. 11.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. 12.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 the where these taxes are included. Transplant Center Information 15.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 16.00 If this is a Medicare certified kidney transplant center, ent in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in column 1 and termination date, if applicable, in column 2 in col	for yes or "N rance? Enter " icy? Enter 1 center other dule listing control of the listing	" for no. Y" for yes or " if the policy i Premiums 1.00 5,328 than the ost centers vision in ACA " for yes or he Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date cation date in tification	N" for s Losses 2.00 1.00 N	N 1 Inst	117 118 urance 0 0 118 2.00 118 7 120 122 122 123 124 125

Health Financial Systems	IU HEALTH STARKE M	IEMORIAL HOSPITA	AL	In Lie	eu of Form CMS	S-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi der	CCN: 150102	Peri od:	Worksheet S	-2
				From 01/01/2016 To 02/29/2016		repared.
				10 02, 27, 2010	7/28/2016 7:	
				1. 00	2.00	
133.00 If this is a Medicare certified oth	ner transplant center, en	ter the certifi	cation date	1.00	2.00	133. 00
in column 1 and termination date, i	• •					101.00
134.00 If this is an organ procurement organ date, if applicable		he OPO number i	n column 1			134. 00
All Providers	, TH COLUMN 2.					
140.00 Are there any related organization				Y	15H059	140. 00
chapter 10? Enter "Y" for yes or "N are claimed, enter in column 2 the				5		
1.00	2.0		1 013)	3. 00		
If this facility is part of a chair				name and address	of the	
home office and enter the home offi 141.00 Name: INDIANA UNIVERSITY HEALTH				or's Number: 080	n01	— 141. 00
142. 00 Street: 340 WEST 10TH STREET	PO Box: N/		Contract	or 3 Number, 000	01	142. 00
143.00 Ci ty: I NDI ANAPOLI S	State: I N		Zi p Code	: 462	02	143. 00
					1.00	_
144.00 Are provider based physicians' cost	s included in Worksheet	Δ2			1. 00 Y	144. 00
144. OUNT C PROVIDER BUSEU PHYSI CI ans Cost	THE dece TH WOTKSHEET	Α:			'	144.00
				1. 00	2.00	
145.00 If costs for renal services are cla inpatient services only? Enter "Y"				N		145. 00
no, does the dialysis facility incl						
period? Enter "Y" for yes or "N" f		101 11113 0031	reporting			
146.00 Has the cost allocation methodology				N		146. 00
Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/do		15-2, chapter 4	10, §4020) It	-		
lyes, enter the approval date (min de	27 yyyy) 111 GOT amit 2.					
					1.00	
147.00 Was there a change in the statistic 148.00 Was there a change in the order of					N N	147. 00 148. 00
149.00 Was there a change to the simplifie		,		no.	N	149. 00
		Part A	Part B	Title V	Title XIX	
		1.00	2.00	3.00	4.00	
Does this facility contain a providor charges? Enter "Y" for yes or "N						
155. 00 Hospi tal	Ter ne rer caen compon	N	N N	N N	N	155. 00
156.00 Subprovider - IPF		N	N	N	N	156. 00
157. 00 Subprovi der - I RF		N	N	N	N	157. 00
158. 00 SUBPROVI DER 159. 00 SNF		N	N	N	N	158. 00 159. 00
160. OOHOME HEALTH AGENCY		N	N	N	N	160. 00
161. 00 CMHC			N	N	N	161. 00
					1.00	
Multicampus					1.00	
165.00 Is this hospital part of a Multican	npus hospital that has on	e or more campu	ses in diffe	erent CBSAs?	N	165. 00
Enter "Y" for yes or "N" for no.	Nome	County	C+a+a 7:	n Code CDCA	FTF /Compus	
-	Name 0	County 1.00	State Zi	p Code CBSA 3. 00 4. 00	FTE/Campus 5.00	
166.00 If line 165 is yes, for each	0	1.00	2.00	1.00	_	00 166. 00
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)						
					1.00	
Health Information Technology (HIT)) incentive in the Americ	an Recovery and	d Reinvestmer	nt Act	1. 00	
167.00 Is this provider a meaningful user				it not	Υ	167. 00
168.00 If this provider is a CAH (line 105	is "Y") and is a meanin	gful user (line		, enter the		0168.00
reasonable cost incurred for the HI	•	,	aualify f-	a bandahin		140.01
168.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)?						168. 01
169.00 If this provider is a meaningful us	ser (line 167 is "Y") and				0.	25 169. 00
transition factor. (see instruction	ns)					

Health Financial Systems	u of Form CMS-	2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMP	_EX IDENTIFICATION DATA	Provider CCN: 150102	Peri od:	Worksheet S-2	
			From 01/01/2016	Part I	
			To 02/29/2016	Date/Time Pre	
				7/28/2016 7:4	2 pm
			Begi nni ng	Endi ng	
			1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR period respectively (mm/dd/yyyy)		for the reporting	10/01/2014	09/30/2015	170. 00
				1.00	1
171.00 If line 167 is "Y", does this pr	ovider have any days for indivi	duals enrolled in secti	on 1876	Υ	171. 00
Medicare cost plans reported on	Wkst. S-3, Pt. I, line 2, col.	6? Enter "Y" for yes a	nd "N" for no.		
(see instructions)					

	Financial Systems IU HEALTH STARKE MEMORIA AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE F	Provi der	CCN: 150102	Period: From 01/01/2016		
				To 02/29/2016	7/28/2016 7:4	
				Y/N	Date	
	General Instruction: Enter Y for all YES responses. Enter N for a	II NO ro	enoneoe Ent	1.00	2.00	
	mm/dd/yyyy format.	III NO IE	sponses. Ente	er arr dates in t	ne	
	COMPLETED BY ALL HOSPITALS					
	Provider Organization and Operation					
1. 00	Has the provider changed ownership immediately prior to the begin			N		1. 00
	reporting period? If yes, enter the date of the change in column	2. (see	Y/N	Date	V/I	
			1.00	2. 00	3. 00	
2. 00	Has the provider terminated participation in the Medicare Program	n? I f	N N	2.00	3.00	2.00
	yes, enter in column 2 the date of termination and in column 3, "					
	voluntary or "I" for involuntary.					
. 00	Is the provider involved in business transactions, including mana		Y			3. 00
	contracts, with individuals or entities (e.g., chain home offices or medical supply companies) that are related to the provider or					
	officers, medical staff, management personnel, or members of the					
	of directors through ownership, control, or family and other simi	lar				
	relationships? (see instructions)					
			Y/N	Type	Date	
	Financial Data and Donorto		1.00	2. 00	3. 00	_
1. 00	Financial Data and Reports Column 1: Were the financial statements prepared by a Certified	Public	Υ	A		4.00
r. 00	Accountant? Column 2: If yes, enter "A" for Audited, "C" for Com			^		7.00
	or "R" for Reviewed. Submit complete copy or enter date available					
	column 3. (see instructions) If no, see instructions.					
5. 00	Are the cost report total expenses and total revenues different f		N			5. 00
	those on the filed financial statements? If yes, submit reconcili	ation.		Y/N	Legal Oper.	
				1. 00	2. 00	
	Approved Educational Activities					
5.00	Column 1: Are costs claimed for nursing school? Column 2: If ye	s, is th	ne provider is	s N		6.00
	the legal operator of the program?					
7.00	Are costs claimed for Allied Health Programs? If "Y" see instruct			N		7. 00
3. 00	Were nursing school and/or allied health programs approved and/or cost reporting period? If yes, see instructions.	renewed	auring the	N		8. 00
9. 00	Are costs claimed for Interns and Residents in an approved gradua	ite medic	cal education	N		9. 00
	program in the current cost report? If yes, see instructions.					
10.00	Was an approved Intern and Resident GME program initiated or rene	ewed in t	he current	N		10.00
	cost reporting period? If yes, see instructions.					14.00
11. 00	Are GME cost directly assigned to cost centers other than I & R i Teaching Program on Worksheet A? If yes, see instructions.	n an App	proved	N		11. 00
	reaching Frogram on worksheet A: IT yes, see this tructions.				Y/N	
					1.00	
	Bad Debts			,		
	Is the provider seeking reimbursement for bad debts? If yes, see				Υ	12. 00
13. 00	If line 12 is yes, did the provider's bad debt collection policy	change c	during this co	ost reporting	N	13. 00
4 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles and/or co-payments wa	ivod2 Lf	Evos sooin	structions	N	14 00
4.00	Bed Complement	ii veur 11	yes, see in	Structions.	N	14. 00
15. 00	Did total beds available change from the prior cost reporting per	iod? If	ves. see ins	tructions.	Υ	15. 00
2.00	The state of the s		rt A	Par		1
		Y/N	Date	Y/N	Date	
		. 00	2.00	3. 00	4. 00	
	PS&R Data		_			4
	IWas the cost report prepared using the DCOD Depart only?	N	1	N		16.00
6. 00	Was the cost report prepared using the PS&R Report only?	IN		"		10.00

	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 .(see					
	instructions)					
17. 00	Was the cost report prepared using the PS&R Report for	Υ	05/31/2016	Υ	05/31/2016	17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19. 00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

### Provider CN 150102 Period: Provider CN 150102 Period: Provider CN 150102 Period: Period	Heal th	Financial Systems IU HEALTH STARKE N	MEMORIAL HOSPIT	AL	In Lie	eu of Form CM	IS-2552-10
20.00 If I line 16 or 17 lis yes, were adjustments made to PSSR N N N N N 20.00					Peri od: From 01/01/2016	Worksheet S Part II Date/Time F	6-2 Prepared:
Page				•			
Report data for Other? Describe the other adjustments: 1.00	20.00	LE Line 1/ no 17 in one many adjustments and to DCOD)			20.00
21.00 Was the cost report prepared only using the provider's N 2.00 3.00 4.00	20.00				IN .	I N	20.00
21.00 Was the cost report prepared only using the provider's N N 21.00 CAMPLETER BY COST RETURNINGS AND TERM HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) 1.00		Report data for other: bescribe the other adjustments.	Y/N	Date	Y/N	Date	
records? If yes, see Instructions. 1.00							
COMPLETED BY COST RETURBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related CoSt Capital Related CoSt 22.00 Have assets been relife for Medicare purposes? If yes, see instructions 32.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N N N N N N N N N N N N N N N N N N N	21. 00		N		N		21. 00
COMPLETED BY COST RETURBURSED AND TERRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related CoSt Capital Related CoSt 22.00 Have assets been relife for Medicare purposes? If yes, see instructions 32.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N N N N N N N N N N N N N N N N N N N						1 00	
Capital Related Cost 22.00 Have changes occurred in the Medicare purposes? If yes, see instructions 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost N 23.00 Were new Leases and/or amendments to existing leases entered into during this cost reporting period? N 24.00 Were new Leases and/or amendments to existing leases entered into during this cost reporting period? N 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see N 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Instructions N 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Has the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 28.00 Were new Loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 31.00 Has debt been excelled before scheduled maturity without issuance of new debt? If yes, see N 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 33.00 Highes of Services N 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians? Y 34.00 Fire Sease Physicians And the provider of the cost reporting period? If yes, see instructions. N 35.00 If fine 34 is yes, were there new agreements or amended existing agreements with the provider-based N 35.00 If fine 34 is		COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE	EPT CHILDRENS H	OSPI TALS)		1.00	
23.00 Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.00 If yes, see instructions. 25.00 Have there been new capital zed leases entered into during the cost reporting period? If yes, see N 26.00 Macrosticions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, see N 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, see instructions. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 31.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see N 31.00 Has existing debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 32.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see Instructions. 32.00 If I ine 32 is yes, were ther new agreements or amended existing agreements with the provider-based Physicians 34.00 Are services furnished at the provider facility under an arrangement with provider-based physicians during the cost reporting period? If yes, see Instructions. 35.00 If I ine 34 is yes, were there new agreements or amended existing agreements with the provider-based Physicians during the cost reporting period? If yes, see Instructions. 36.00 Were home office costs 37.00 I if ine 34 is yes, were there new agreements or amended existing agreemen		Capital Related Cost					
reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.00 If yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see N 25.00 Instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Instructions. 28.00 The remainded separate in the provider in patient care services furnished through contractual arrangements with suppliers of services? If yes, see instructions. 30.00 If I line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If no posses instructions in the provider in the prov	22. 00					N	22. 00
24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? N 24.00 If yes, see instructions 25.00 Have there been new capitalized leases entered into during the cost reporting period? If yes, see N 25.00 Instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see N 26.00 Instructions. 27.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Copy. 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, submit N 27.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 28.00 Treated as a funded depreciation account? If yes, see Instructions of the provider have a funded depreciation account? If yes, see Instructions of the provider have a funded depreciation account? If yes, see Instructions of the provider have a funded depreciation account? If yes, see Instructions of the provider have a funded depreciation account? If yes, see Instructions of the provider have a funded depreciation account? If yes, see Instructions of the provider have a funded depreciation account? If yes, see Instructions of the provider have a funded depreciation account? If yes, see Instructions of the provider have a funded depreciation account? If yes, see Instructions of the provider have a funded depreciation account? If yes, see Instructions of the provider have a funded depreciation account? If yes, see Instructions. 28.00 Have changes or new agreements occurred in patient care services furnished through contractual arrangements with suppliers of services? If yes, see Instructions. 29.00 If I in a 31 is yes, were the report report report report report report report report repord? If yes, see Instructions. 29.00 If I in a 31 is yes, were there new agreements or amended existing agreements with the provider-based physicians? I yes, see Instructions. 29.00 If I in a 3	23. 00		due to apprais	als made duri	ng the cost	N	23. 00
If yes, see instructions							
So to lave there been new capitalized leases entered into during the cost reporting period? If yes, see N 25.00	24.00		ed into during	this cost rep	porting period?	N	24.00
instructions. 2.0.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see instructions. 2.7.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit N 27.00 Copy. Interest Expense 2.8.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. 2.9.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) N 29.00 treated as a funded depreciation account? If yes, see instructions or instructions. 3.0.01 Has existing debt been replaced prior to its Scheduled maturity with new debt? If yes, see N 30.00 instructions. 3.1.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see N 31.00 Has debt submitted in patient care services furnished through contractual N 32.00 Has changes or new agreements occurred in patient care services furnished through contractual N 32.00 Has debt submitted in Suppliers of services? If yes, see instructions. 32.00 If I in 32 is yes, were the requirements of Sec. 2135. 2 applied pertaining to competitive bidding? If N 33.00 If I in 32 is yes, were the requirements of Sec. 2135. 2 applied pertaining to competitive bidding? If N 33.00 If I in 32 is yes, were the reporting period? If yes, see instructions. 40.00 If I in 36 is yes, see instructions. 40.00 If I in 36 is yes, has a home office cost statement been prepared by the home office? 41.00 I in 36 is yes,	25 00		the cost repor	ting period?	If ves see	N	25 00
26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see 17.00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit 18.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting 28.00 Period? If yes, see instructions. 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 29.00 Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 30.00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see 30.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see 30.00 Have changes or new agreements occurred in patient care services furnished through contractual 30.00 If I in a 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 30.00 If I in a 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If 30.00 If I in a 34 is yes, were there new agreements or amended existing agreements with the provider-based Physicians? 30.00 If I in a 34 is yes, were there new agreements or amended existing agreements with the provider-based 30.00 If I in a 34 is yes, were there new agreements or amended existing agreements with the provider-based 30.00 If I in a 34 is yes, were there new agreements or amended existing agreements with the provider-based 30.00 If I in a 34 is yes, were there new agreements or amended existing agreements with the provider-based 30.00 If I in a 34 is yes, were there new agreements or amended existing agreements with the provider-based 30.00 I in a 34 is yes, were there new agreements or amended existing agreements with the provider-based 30.00 I in a 34 is yes, were there new agreements or amended existing agreements with the pro	25.00		the cost repor	ang perrou!	11 yes, see		23.00
Instructions 1	26.00		he cost reporti	ng period? If	f yes, see	N	26. 00
Sopy Interest Expense		instructions.	·	0 .			
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| Peri od: | Worksheet S-3 | From 01/01/2016 | Part | To 02/29/2016 | Date/Time Prepared: Health Financial Systems I U HEALTH STARKE MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CC Provi der CCN: 150102

						10 02/29/2016	7/28/2016 7: 4	
							I/P Days / 0/P	E piii
							Visits / Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1.00		2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		50	3, 00	0.00	0	1. 00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days) (see instructions for col. 2							
	for the portion of LDP room available beds)							
2.00	HMO and other (see instructions)							2. 00
3.00	HMO IPF Subprovider							3. 00
4.00	HMO IRF Subprovider							4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7.00	Total Adults and Peds. (exclude observation			50	3, 00	0. 00	0	7. 00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		0	1	0. 00	0	8. 00
9.00	CORONARY CARE UNIT							9. 00
10.00	BURN INTENSIVE CARE UNIT							10. 00
11. 00	SURGI CAL INTENSI VE CARE UNI T							11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)							12. 00
13. 00	NURSERY						_	13. 00
14.00	Total (see instructions)			50	3, 00	0.00	l e	14. 00
15. 00	CAH visits						0	15. 00
16.00	SUBPROVI DER - I PF							16. 00
17. 00	SUBPROVI DER - I RF							17. 00
18.00	SUBPROVI DER							18. 00
19. 00	SKILLED NURSING FACILITY							19. 00
20. 00	NURSING FACILITY							20. 00
21. 00	OTHER LONG TERM CARE							21. 00
22. 00	HOME HEALTH AGENCY							22. 00
23. 00 24. 00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE							23. 00 24. 00
24. 00	HOSPICE (non-distinct part)	30. 00						24. 00
25. 00	CMHC - CMHC	30.00						25. 00
26. 00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER							26. 25
27. 00	Total (sum of lines 14-26)			50				27. 00
28. 00	Observation Bed Days			30	1		0	28. 00
29. 00	Ambulance Trips						· ·	29. 00
30. 00	Employee discount days (see instruction)							30. 00
31. 00	Employee discount days - IRF							31. 00
32. 00	Labor & delivery days (see instructions)			0		0		32. 00
32. 01	Total ancillary labor & delivery room			O				32. 00
52.01	outpatient days (see instructions)							52.01
33. 00	LTCH non-covered days							33. 00
		'	1		•	1	'	1

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 150102

Peri od: Worksheet S-3 From 01/01/2016 Part I To 02/29/2016 Date/Time Prepared:

7/28/2016 7:42 pm Full Time Equivalents I/P Days / O/P Visits / Trips Title XVIII Component Title XIX Total All Total Interns Employees On Pati ents & Residents Payrol I 7.00 8.00 10.00 6.00 9.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 138 234 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2 00 HMO and other (see instructions) 2 00 29 35 3.00 HMO IPF Subprovider 0 C 3.00 HMO IRF Subprovider 4.00 0 4.00 Hospital Adults & Peds. Swing Bed SNF 0 0 5.00 5.00 0 Hospital Adults & Peds. Swing Bed NF 0 6.00 0 6.00 7.00 Total Adults and Peds. (exclude observation 138 234 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 0 0 8.00 9.00 CORONARY CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 10.00 11.00 SURGICAL INTENSIVE CARE UNIT 11.00 12.00 OTHER SPECIAL CARE (SPECIFY) 12.00 13.00 NURSERY 13.00 113.03 14.00 Total (see instructions) 138 234 0.00 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 16.00 16.00 SUBPROVIDER - IRF 17.00 17.00 18.00 SUBPROVI DER 18.00 19.00 SKILLED NURSING FACILITY 19.00 20 00 NURSING FACILITY 20 00 21.00 OTHER LONG TERM CARE 21.00 22.00 HOME HEALTH AGENCY 22.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 HOSPI CE 24.00 24 00 24. 10 HOSPICE (non-distinct part) 0 0 0 24. 10 25.00 CMHC - CMHC 25.00 26.00 RURAL HEALTH CLINIC 26, 00 FEDERALLY QUALIFIED HEALTH CENTER 26. 25 26.25 27.00 Total (sum of lines 14-26) 0.00 113.03 27.00 28.00 Observation Bed Days 31 146 28.00 29.00 29.00 Ambul ance Trips 30.00 Employee discount days (see instruction) 0 30.00 31.00 Employee discount days - IRF 0 31.00 Labor & delivery days (see instructions) 0 32.00 32.00 C Total ancillary labor & delivery room 0 32.01 32.01 outpatient days (see instructions)

33.00 LTCH non-covered days

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part | To 02/29/2016 | Date/Time Prepared: Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CC Provi der CCN: 150102

				10	02/29/2016	7/28/2016 7:4	
		Full Time	<u> </u>	Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	44	0	90	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			10	14		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				0		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12. 00
13.00	NURSERY						13. 00
14.00	Total (see instructions)	0. 00	0	44	0	90	
15.00	CAH visits						15. 00
16.00	SUBPROVI DER - I PF						16. 00
17.00	SUBPROVI DER - I RF						17. 00
18.00	SUBPROVI DER						18. 00
19.00	SKILLED NURSING FACILITY						19. 00
20.00	NURSING FACILITY						20. 00
21.00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY						22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23. 00
24.00	HOSPI CE						24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER						26. 25
27.00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Trips						29. 00
30.00	Employee discount days (see instruction)						30. 00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION

Provi der CCN: 150102 | Peri od: From 01/01/2016

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part II | To 02/29/2016 | Date/Time Prepared:

Mark Section Processor Amount						To	02/29/2016	Date/Time Pre 7/28/2016 7:4	
Walf 1 - 866E BM Salaries 100 200 3.00 4.00 5.00 5.00 6.00								Average Hourly	, p
DMM: 11 - 390E DMA 1.00 2.00 3.00 4.00 5.00 6.00			Line Number	Reported					
Part								COI . 3)	
1.00 Total saturities (see 200.00 1, 155, 452 -688 1, 154, 464 39, 184 79 29 40 10 10 10 11 11 11 11 11 11 11 11 11 11			1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
Total salaries (see 200.00 1,155,452 -988 1,154,464 39,184,79 29,46 1,0									
2.00 Sent-mysic in annesthetist Part 0 0 0 0 0 0 0 0 0	1.00		200. 00	1, 155, 452	-988	1, 154, 464	39, 184. 79	29. 46	1.00
3.00 Non-physician anesthetist Part 0 0 0 0 0 0 0 0 0		instructions)		_	_				
1.00	2.00			C	0	0	0.00	0.00	2. 00
4. diministrative	3.00	I		C	o	О	0.00	0.00	3. 00
4. diministrative	4 00	B		0.000		0.000	05.00	400.00	4 00
1.01 Physicians - Part A - Teaching 0 0 0 0 0 0 0 0 0	4.00	, ,		3, 333	0	3, 333	25.00	133. 32	4.00
Moniphysic is in-Part 8	4.01			C	0	0	0.00	0.00	4. 01
1.00 Interins & residents (in an approved program) 1.00 0 0 0 0 0 0 0 0 0	5.00			-	_	1			
Description			21 00	C		0		l .	
residents (in an approved programs)	7.00		21.00				0.00	0.00	7.00
8. 00 Hole of Price personnel 44.00 0 0 0 0 0 0 0 0 0	7. 01			C	0	0	0. 00	0. 00	7. 01
Nome									
10.00 Excluded area salaries (see 4,507 0 4,507 358.40 12.58 10.0	8.00			C	0	0	0.00	0.00	8. 00
Instructions	9.00		44. 00	4 503	0	0			ı
DIFFER WAGES & RELATED COSTS	10.00			4, 507	0	4, 507	358. 40	12.58	10.00
12.00 Carre Carr		OTHER WAGES & RELATED COSTS							
12.00 Contract Labor: Top Level management and other management and administrative services	11. 00			C	0	0	0.00	0. 00	11. 00
management and other management and other management and admin strative services	12. 00			C	0	o	0.00	0.00	12.00
3		management and other							
13.00 Contract Labor: Physician a-Part									
A - Administrative	13. 00			92, 936	0	92, 936	539. 00	172. 42	13. 00
wage-related costs		A - Administrative							
15.00 Home office: Physician Part A 0 0 0 0 0.00 0.00 0.00 15.0	14. 00			77, 443	0	77, 443	1, 356. 00	57. 11	14. 00
16.00	15. 00			C	0	О	0.00	0.00	15. 00
Physicians Part A - Teaching	1/ 00						0.00	0.00	1/ 00
WAGE_RELATED COSTS	16.00			C		0	0.00	0.00	16.00
Instructions 18.00 Wage-rel ated costs (other) (see instructions) 2,780 0 0 0 0 0 0 0 0 0		WAGE-RELATED COSTS			1				
18.00 Wage-related costs (other) (see instructions)	17. 00			309, 535	0	309, 535			17. 00
19.00 Excluded areas	18. 00			C	0	О			18. 00
20.00					_				
A				2, 780		2, 780			
B	20.00	A		C	ĺ				20.00
Administrative	21. 00	Non-physician anesthetist Part		C	0	0			21. 00
Administrative	22 00	Physician Part A -		233	0	233			22. 00
23.00 Physician Part B 0 0 0 0 0 24.00 25.00 Interns & residents (in an approved program) 0 0 0 0 0 0 0 25.00 Interns & residents (in an approved program) 0 0 0 0 0 0 0 0 0									
24.00 Wage-related costs (RHC/FQHC) 1nterns & residents (in an approved program) 0 0 0 0 0 0 0 25.00				-	_	0			22. 01
25. 00 Interns & residents (in an approved program) 25. 00 25. 00 26. 00 27. 00 27. 00 27. 00 27. 00 28. 00 27. 00 28. 00 27. 00 28. 00 28. 00 27. 00 28. 00		1 J				0			24.00
OVERHEAD COSTS - DIRECT SALARIES 26. 00 Empl oyee Benefit s Department 4.00 0 0 0.00 0.00 26.00 27.00 26.00 0 0.00 0.00 26.00 27.00 27.00 28.00 Administrative & General under contract (see inst.) 0 0 0 0.00 0.00 28.00 28.00 28.00 0 0 0.00 0.00 28.00 28.00 0 0 0 0.00 0.00 28.00 28.00 0 0 0 0.00 0 0.00 29.00 28.00 0 <t< td=""><td>25. 00</td><td>Interns & residents (in an</td><td></td><td>C</td><td>0</td><td>0</td><td></td><td></td><td>25. 00</td></t<>	25. 00	Interns & residents (in an		C	0	0			25. 00
26. 00			<u> </u>						
28. 00 Administrative & General under contract (see inst.) 0 0 0 0 0 0 0 0 0	26. 00			C	0	0	0.00	0.00	26. 00
Contract (see inst.) Contract (see inst.)	27. 00		5. 00	134, 188	0	134, 188			
29. 00 Maintenance & Repairs 6. 00 0 0 0 0.00 0.00 29. 00 30. 00 Operation of Plant 7. 00 65, 100 0 65, 100 2, 699. 49 24. 12 30. 0 31. 00 Laundry & Linen Service 8. 00 0 0 0 0.00 0.00 0.00 31. 0 32. 00 Housekeeping 9. 00 28, 905 -534 28, 371 2, 000. 14 14. 18 32. 0 33. 00 Housekeeping under contract (see instructions) 10. 00 30, 477 -22, 379 8, 098 447. 00 18. 12 34. 0 35. 00 Di etary under contract (see instructions) 0 0 0 0.00 0.00 0.00 0.00 0.00 35. 0 36. 00 Cafeteria 11. 00 0 22, 379 22, 379 1, 235. 00 18. 12 36. 0 37. 00 Maintenance of Personnel 12. 00 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00	28. 00			C	0	0	0.00	0.00	28.00
31. 00 Laundry & Linen Service	29. 00	Maintenance & Repairs	6. 00	C	0	О	0.00	0.00	29. 00
32. 00 Housekeeping	30. 00			65, 100	0	65, 100			
33. 00 Housekeeping under contract (see instructions) 34. 00 Di etary 35. 00 Di etary under contract (see instructions) 36. 00 Cafeteria 37. 00 Maintenance of Personnel 38. 00 Nursing Administration 39. 00 Central Services and Supply 10. 00 30, 477 -22, 379 0 0 0 0 0 0 0 0 0 0 0 0 0				28 9 05	0 -534	0 28 371		l .	
34. 00 Di etary 10. 00 30, 477 -22, 379 8, 098 447. 00 18. 12 34. 0 35. 00 Di etary under contract (see instructions) 11. 00 0 0 0 0 0 0 0 0 0	33. 00		7. 00	20, 900 C	0	20, 371		l .	•
35. 00 Di etary under contract (see instructions) 36. 00 Cafeteria 37. 00 Maintenance of Personnel 38. 00 Nursing Administration 39. 00 Central Services and Supply 35. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 '	40.00	00 477					
instructions) 36.00 Cafeteria			10. 00	30, 477	-22, 379	8, 098			
36.00 Cafeteria 11.00 0 22,379 22,379 1,235.00 18.12 36.0 37.00 Maintenance of Personnel 12.00 0 0 0 0 0.00 0.00 37.0 38.00 Nursing Administration 13.00 7,712 0 7,712 298.23 25.86 38.0 39.00 Central Services and Supply 14.00 12,183 0 12,183 642.00 18.98 39.0	55.00			C			0.00	0.00	33.00
38.00 Nursing Administration 13.00 7,712 0 7,712 298.23 25.86 38.0 39.00 Central Services and Supply 14.00 12,183 0 12,183 642.00 18.98 39.0	36.00			C	22, 379	22, 379			
39.00 Central Services and Supply 14.00 12,183 0 12,183 642.00 18.98 39.0				7 710	0	0 7 712			
	39. 00	,			1				
	40. 00				1				

Health Financial Systems	IU H	EALTH STARKE	MEMORIAL HOSPI	ΓAL	In Lie	u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					From 01/01/2016		
				'	To 02/29/2016	Date/Time Pre	pared:
						7/28/2016 7: 4	2 pm
	Worksheet A	Amount	Recl assi fi cati			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		0		0.00	0. 00	41. 00
Records Library							
42.00 Social Service	17. 00				0.00	0.00	42. 00
43.00 Other General Service	18. 00) (c		0.00	0.00	43.00

instructions)

HOSPITAL WAGE INDEX INFORMATION Worksheet S-3 Part III Date/Time Prepared: Provi der CCN: 150102 Peri od: From 01/01/2016 To 02/29/2016 7/28/2016 7:42 pm Worksheet A Amount Recl assi fi cati Adj usted Pai d Hours Average Hourly Line Number Reported on of Salaries Sal ari es Related to Wage (col. 4 ÷ (col . 2 ± col . col. 5) (from Salaries in Worksheet A-6) 3) col. 4 1.00 2.00 4.00 6.00 5.00 3.00 PART III - HOSPITAL WAGE INDEX SUMMARY 1.00 Net salaries (see 1, 155, 452 -988 1, 154, 464 39, 184. 79 29. 46 1.00 instructions) 2.00 Excluded area salaries (see 4,507 0 4, 507 358. 40 12. 58 2.00 instructions) 3.00 Subtotal salaries (line 1 1, 150, 945 -988 1, 149, 957 38, 826. 39 29.62 3.00 minus line 2) 4.00 Subtotal other wages & related 170, 379 0 170, 379 1, 895. 00 89.91 4.00 costs (see inst.) Subtotal wage-related costs 5.00 309, 768 C 309, 768 0.00 26. 94 5.00 (see inst.) Total (sum of lines 3 thru 5) 6.00 6.00 1, 631, 092 -988 1, 630, 104 40, 721. 39 40 03 7.00 Total overhead cost (see 311, 695 -534 311, 161 13, 061. 17 23.82 7.00

HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150102	Peri od:	Worksheet S-3	
		From 01/01/2016	Part IV	
		To 02/29/2016	Date/Time Pre	oared:
			7/28/2016 7:4	2 pm
			Amount	

	10 32/27/2010	7/28/2016 7: 42	
		Amount	
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	0	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	14, 978	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5. 00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	155, 281	8. 00
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	30, 047	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	9, 207	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	988	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	8, 084	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		1
	TAXES		
17.00	FICA-Employers Portion Only	85, 582	17. 00
18.00	Medicare Taxes - Employers Portion Only	0	18. 00
19.00	Unempl oyment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	0	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		ł
22. 00	Day Care Cost and Allowances	0	22. 00
23.00	Tuition Reimbursement	8, 381	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	312, 548	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	IU HEALTH STARKE MEMORIAL HOSPITAL	In Lie	u of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 150102	From 01/01/2016	Worksheet S-3 Part V Date/Time Prepared: 7/28/2016 7:42 pm

		''	0 02/29/2010	7/28/2016 7: 4:	
	Cost Center Description		Contract Labor	Benefit Cost	
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		0	0	1.00
2.00	Hospi tal		0	0	2.00
3.00	Subprovi der - I PF				3. 00
4.00	Subprovi der - I RF				4. 00
5.00	Subprovider - (Other)		0	0	5. 00
6.00	Swing Beds - SNF		0	0	6. 00
7.00	Swing Beds - NF		0	0	7. 00
8.00	Hospi tal -Based SNF				8. 00
9.00	Hospi tal -Based NF				9. 00
10.00	Hospi tal -Based OLTC				10.00
11. 00	Hospi tal -Based HHA				11.00
12.00	Separately Certified ASC				12.00
13.00	Hospi tal -Based Hospi ce				13.00
14.00	Hospital-Based Health Clinic RHC				14.00
15. 00	Hospital-Based Health Clinic FQHC				15.00
16.00	Hospi tal -Based-CMHC				16.00
17. 00	Renal Dialysis				17.00
18. 00	Other		0	0	18. 00

Heal th	Financial Systems IU HEALTH STARKE MEMORIA	L HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
HOSPI T	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der	CCN: 150102	Peri od:	Worksheet S-10	0
				From 01/01/2016 To 02/29/2016	Date/Time Prep 7/28/2016 7:4:	
					1. 00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divided Medicaid (see instructions for each line)	led by li	ne 202 column	8)	0. 310821	1. 00
2.00	Net revenue from Medicaid				447, 214	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				Υ	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p	ayments	from Medicaio	?	Υ	4. 00
5.00	If line 4 is "no", then enter DSH or supplemental payments from N	ledi cai d			0	
6.00	Medi cai d charges				3, 872, 331	6. 00
7. 00	Medicaid cost (line 1 times line 6)				1, 203, 602	7. 00
8. 00	Difference between net revenue and costs for Medicaid program (li	ne 7 min	us sum of lir	es 2 and 5; if	756, 388	8. 00
	<pre>< zero then enter zero) State Children's Health Insurance Program (SCHIP) (see instruction</pre>	ns for e	ach line)			
9.00	Net revenue from stand-alone SCHIP				0	9. 00
10.00	Stand-al one SCHIP charges				0	10. 00
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				0	
12. 00	Difference between net revenue and costs for stand-alone SCHIP (I enter zero)	ine 11 m	inus line 9;	if < zero then	0	12. 00
	Other state or local government indigent care program (see instru					
13. 00	Net revenue from state or local indigent care program (Not include					13. 00
14. 00	Charges for patients covered under state or local indigent care p 10)	rogram (Not included	in lines 6 or	0	14. 00
15. 00	State or local indigent care program cost (line 1 times line 14)				0	
16. 00	Difference between net revenue and costs for state or local indig 13; if < zero then enter zero)	jent care	program (lir	e 15 minus line	0	16. 00
	Uncompensated care (see instructions for each line)					
17. 00	Private grants, donations, or endowment income restricted to fund					17. 00
18. 00	Government grants, appropriations or transfers for support of hos				0	
19. 00	Total unreimbursed cost for Medicaid , SCHIP and state and local 8, 12 and 16)	i ndi gent	care progran	is (sum of lines	756, 388	19.00
			Uni nsured pati ents	Insured patients	Total (col. 1 + col. 2)	
			1.00	2.00	3. 00	
20. 00	Total initial obligation of patients approved for charity care (a charges excluding non-reimbursable cost centers) for the entire f		119, 49	89, 385	208, 877	20. 00
21. 00	Cost of initial obligation of patients approved for charity care times line 20)		37, 14	27, 783	64, 924	21. 00
22. 00	,		62	6, 897	7, 526	22. 00
23. 00			36, 51		·	
					1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient of		nd a length o	f stay limit	N	24. 00
25 22	imposed on patients covered by Medicaid or other indigent care pr	9				25 22
25. 00	If line 24 is "yes," charges for patient days beyond an indigent			n or stay limit	0	
26. 00		,			35, 612	
27. 00			c line 27)		38, 050	1
28. 00 29. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line Cost of non-Medicare and non-reimbursable Medicare bad debt exper			. 201	-2, 438 -758	
30.00		136 (1111B	i times title	20)	56, 640	
	Total unreimbursed and uncompensated care cost (line 19 plus line	30)			813, 028	
31.00	1.0 ca. a oa. ood and anodispondated early coost (11110-17 prus 11110	. 50)			010,020	1 31.00

Heal th	Financial Systems IU H	HEALTH STARKE MEMO	DRIAL HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der		Peri od:	Worksheet A	
					From 01/01/2016 To 02/29/2016	7/28/2016 7:4	
	Cost Center Description	Sal ari es	0ther		Reclassi fi cati	Recl assi fi ed	
				+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +- col. 4)	
		1.00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1. 00	00100 CAP REL COSTS-BLDG & FLXT		0		25, 504	25, 504	1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP		0		0 25, 304	25, 304	2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	230, 183		-	230, 183	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	134, 188	580, 599			688, 855	5. 00
7. 00	00700 OPERATION OF PLANT	65, 100	145, 263			214, 300	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	O	0		0	0	8. 00
9.00	00900 HOUSEKEEPI NG	28, 905	18, 286	47, 19	1 -554	46, 637	9. 00
10.00	01000 DI ETARY	30, 477	23, 239		6 -39, 444	14, 272	10.00
11.00	01100 CAFETERI A	0	0		39, 444	39, 444	11. 00
13.00	01300 NURSING ADMINISTRATION	7, 712	1, 692	9, 40	4 0	9, 404	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	12, 183	5, 496			106, 091	14. 00
15. 00	01500 PHARMACY	33, 130	144, 379			46, 447	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	57, 520	57, 52	0 0	57, 520	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	181, 090	34, 749			206, 753	30.00
31. 00	03100 NTENSI VE CARE UNI T	0	0		0 0	0	31. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS	115 070	100 22/	225 10	- (4.770	1/0 227	FO 00
50.00	05000 OPERATING ROOM	115, 879	109, 226 0		-64, 778 0	160, 327	50.00
51. 00 53. 00	05100 RECOVERY ROOM 05300 ANESTHESI OLOGY	0	52, 874		-	0 52, 259	51. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	169, 990	242, 114			397, 905	54.00
57. 00	05700 CT SCAN	107, 770	38, 706			38, 706	57.00
58. 00	05800 MRI	13, 613	26, 810		-	40, 423	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	13, 013	20, 010		0	0, 423	59.00
60. 00	06000 LABORATORY	86, 438	142, 536		-	225, 553	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD	0	8, 930			8, 930	62.00
65. 00	06500 RESPI RATORY THERAPY	46, 422	8, 049			51, 587	65. 00
66. 00	06600 PHYSI CAL THERAPY	12, 587	40, 512			53, 264	66.00
67.00	06700 OCCUPATI ONAL THERAPY	20, 919	1, 586			22, 505	67. 00
68.00	06800 SPEECH PATHOLOGY	3, 659	269	3, 92	8 0	3, 928	68. 00
69.00	06900 ELECTROCARDI OLOGY	28, 299	7, 899	36, 19	-278	35, 920	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		14, 373	14, 373	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		979	979	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		146, 632	146, 632	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	T		Г			
90.00	09000 CLI NI C	0	0		0	0	90.00
91.00	09100 EMERGENCY	160, 354	439, 555	599, 90 ¹	9 -18, 415	581, 494	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT						92. 00
110 00	SPECIAL PURPOSE COST CENTERS	1 150 045	2 2/0 472	2 511 41	7 0 770	2 520 105	110 00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	1, 150, 945	2, 360, 472	3, 511, 41	7 8, 778	3, 520, 195	J 18. UU
100.00	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0		0 (0	1 190. 00
	19300 NONPALD WORKERS	0	0		0	-	190.00
	19301 WELLNESS CENTER		38				193. 00
	19302 RETAIL PHARMACY		8, 222				193. 01
	07950 OTHER NRCC	4, 507	14, 749			18, 476	•
200.00	1	1, 155, 452	2, 383, 481			3, 538, 933	
200.00	1.0 (00 0 2	., .00, 102	2,000,101	3,000,70	-, 0	5,000,700	1-00.00

Health FinancialSystemsIU HEALTH STARKE MEMORIAL HOSPITALRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSESProvider CC In Lieu of Form CMS-2552-10 Provi der CCN: 150102

				7/28/2016	
	Cost Center Description	Adjustments	Net Expenses	77 237 2010	12
	'		For Allocation		
		6. 00	7. 00		
	GENERAL SERVICE COST CENTERS				
1.00	00100 CAP REL COSTS-BLDG & FIXT	12, 336	37, 840	•	1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	4, 737	4, 737		2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	-284	229, 899	•	4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 203, 232	1, 892, 087		5. 00
7. 00	00700 OPERATION OF PLANT	0	214, 300	•	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	0	l .	8. 00
9. 00	00900 HOUSEKEEPI NG	0	46, 637	•	9. 00
10.00	01000 DI ETARY	0	14, 272	•	10.00
11. 00	01100 CAFETERI A	-12, 743	26, 701		11. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	-320	9, 084	1	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	-1, 387	104, 704	•	14.00
15. 00	01500 PHARMACY	-544	45, 903		15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	57, 520		16. 00
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		00/ 750	I	
30.00	03000 ADULTS & PEDIATRICS	0	206, 753		30. 00
31. 00	03100 NTENSIVE CARE UNIT	0	0		31. 00
FO 00	ANCI LLARY SERVI CE COST CENTERS		1/0 227		
50.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	0	160, 327	•	50.00
51. 00 53. 00	I I	E2 2E0	0	•	51. 00 53. 00
54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	-52, 259	- 1	1	54.00
57. 00	05700 CT SCAN		397, 905 38, 706	•	57.00
58. 00	05800 MRI		40, 423		58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON		40, 423	•	59.00
60. 00	06000 LABORATORY	-1, 412	224, 141	l .	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD	-1,412	8, 930		62.00
65. 00	06500 RESPI RATORY THERAPY	-250	51, 337		65. 00
66. 00	06600 PHYSI CAL THERAPY	-3, 134	50, 130	•	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	-3, 134	22, 505	•	67. 00
68. 00	06800 SPEECH PATHOLOGY		3, 928	1	68. 00
69. 00	06900 ELECTROCARDI OLOGY	-610	35, 310	•	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0.0	14, 373		71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	979	1	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	146, 632	1	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		76. 97
	OUTPATIENT SERVICE COST CENTERS	-1			
90.00	09000 CLI NI C	0	0		90.00
91. 00	09100 EMERGENCY	-331, 270	250, 224	l .	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT				92.00
	SPECIAL PURPOSE COST CENTERS				1 = 1 = 1
118.00		816, 092	4, 336, 287		118. 00
	NONREI MBURSABLE COST CENTERS			1	
190.00	19000 GIFT FLOWER COFFEE SHOP & CAN	0	0		190. 00
	19300 NONPALD WORKERS	o	0		193. 00
193. 01	19301 WELLNESS CENTER	0	38		193. 01
193. 02	19302 RETAIL PHARMACY	0	224		193. 02
	07950 OTHER NRCC	-53, 837	-35, 361		194. 00
200.00	TOTAL (SUM OF LINES 118-199)	762, 255	4, 301, 188		200. 00
		•			

2.00

1.00

500.00

RECLASSI FI CATIONS Provi der CCN: 150102 Peri od: Worksheet A-6 From 01/01/2016 02/29/2016 Date/Time Prepared: 7/28/2016 7:42 pm Increases Cost Center 0ther Li ne # Sal ary 2.00 3.00 4.00 5.00 A - RENT EXPENSE 1.00 CAP REL COSTS-BLDG & FIXT 1.00 195 1.00 TOTALS 195 B - MEALS 1.00 CAFETERI A 11.00 22, 379 17, 065 1.00 TOTALS 17, 065 22, 379 C - DRUGS DRUGS CHARGED TO PATIENTS 1.00 73.00 146, 632 1.00 2.00 0.00 0 0 2.00 3.00 0.00 0 0 3.00 4.00 0.00 0 0 4.00 0 0 5.00 0.00 5.00 6.00 0.00 0 0 6.00 7.00 0.00 o 0 7.00 8.00 0.00 0 0 8.00 TOTALS ō 146, 632 D - SUPPLIES CENTRAL SERVICES & SUPPLY 1.00 14.00 0 103, 764 1.00 PHYSICAL THERAPY 0 2.00 66.00 165 2.00 3.00 0.00 0 0 3.00 4.00 0.00 0 0 4.00 0 5.00 0.00 0 5.00 6.00 0.00 0 0 6.00 7.00 0.00 0 7.00 0 8.00 0.00 0 8.00 9.00 0.00 0 9.00 10.00 0.00 0 0 10.00 11.00 0.00 0 0 11.00 12.00 12.00 0.00 0 0 TOTALS 0 103, 929 E - BILLABLE SUPPLIES 1.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 15, 352 1.00 IPAT TOTALS ō 15, 352 F - IMPLANTABLE DEVICES 1.00 IMPL. DEV. CHARGED TO 72.00 0 979 1.00 PATI ENTS ō TOTALS 979 H - INTEREST EXPENSE 1.00 CAP REL COSTS-BLDG & FIXT 1. 00 309 1.00 309 I - PTO USED AS STD 1.00 HOUSEKEEPI NG 9.00 0 534 1.00 2.00 ADULTS & PEDIATRICS 30.00 0 14 2.00 3.00 RADI OLOGY-DI AGNOSTI C 54.00 0 440 3.00 988 TOTALS J - UTILITY EXPENSE

0

0

ō

22, 379

3, 958

3, 958

25, 000

25,000

314, 407

7.00

0.00

1. 00

1.00

2.00

1.00

OPERATION OF PLANT

K - PROPERTY TAX

500.00 Grand Total: Increases

CAP REL COSTS-BLDG & FIXT

TOTALS

TOTALS

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 150102

						7/28/2016 Date/Time F	
		Decreases		•			
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
Α	- RENT EXPENSE						
1.00 AD	OMINISTRATIVE & GENERAL	5. 00	0	195	10		1. 0
TO	OTALS						
В	- MEALS		<u>. </u>				
1.00 DI	ETARY	10.00	22, 379	17, 065	0		1.00
TO	OTALS		22, 379	17, 065		1	İ
С	- DRUGS			•		1	
1.00 PH	IARMACY	15. 00	0	131, 053	0		1.00
2.00 AD	OULTS & PEDIATRICS	30.00	o	280			2. 0
	PERATING ROOM	50, 00	0	686			3. 00
	ADI OLOGY-DI AGNOSTI C	54.00	Ō	6, 458		l .	4. 00
	ABORATORY	60.00	Ö	92		l .	5. 00
	SPI RATORY THERAPY	65.00	o	10			6. 00
	MERGENCY	91.00	o	55	-		7. 00
	ETAIL PHARMACY	193. 02	o	7, 998			8. 00
	OTALS	— — 173. 0 2 +	— — ŏ	146, 632		1	0.0
	- SUPPLI ES		<u> </u>	140, 032			
	DMINISTRATIVE & GENERAL	5. 00	ol	428	0		1.00
	PERATION OF PLANT	7. 00	0				2. 00
	DUSEKEEPING	9. 00	0	21			3. 00
			-	554 9			
	JARMACY	15.00	0	,	0	l .	4. 0
	OULTS & PEDIATRICS	30.00	0	8, 806		l .	5. 00
	PERATING ROOM	50.00	0	64, 092		l e e e e e e e e e e e e e e e e e e e	6. 0
	IESTHESI OLOGY	53. 00	O	615		l .	7. 0
	ADI OLOGY-DI AGNOSTI C	54.00	0	4, 563		l .	8. 00
	ABORATORY	60.00	0	3, 329		l .	9. 00
	SPI RATORY THERAPY	65. 00	0	2, 874		l .	10.00
	ECTROCARDI OLOGY	69. 00	0	278		l .	11. 00
	MERGENCY	<u>91.</u> 00	0	1 <u>8, 3</u> 60			12. 0
TO	DTALS		0	103, 929			
E	- BILLABLE SUPPLIES						
1.00 CE	ENTRAL SERVICES & SUPPLY	14. 00	0	15, 352	0		1. 00
TO	OTALS			15, 352			
F	- IMPLANTABLE DEVICES						
1.00 ME	DICAL SUPPLIES CHARGED TO	71.00	0	979	0		1.0
PA	AT .						
ТО	OTALS			₉₇₉			1
Н	- INTEREST EXPENSE						
	OMINISTRATIVE & GENERAL	5. 00	0	309	11		1.00
	OTALS	— — 					
	- PTO USED AS STD	<u> </u>	<u> </u>	007			
	OUSEKEEPI NG	9.00	534	0	0		1.0
	OULTS & PEDIATRICS	30.00	14	0			2. 00
	ADI OLOGY-DI AGNOSTI C	54.00	440	0			3. 0
	OTALS					4	3.00
	- UTILITY EXPENSE		700		1		
		E4 00	ما	2 170		I	1 0
	ADI OLOGY-DI AGNOSTI C	54.00	0	3, 178			1. 0
	THER NRCC	194.00				1	2. 0
	OTALS			3, 958			
	- PROPERTY TAX				1	1	
	OMI NI STRATI VE & GENERAL		•	2 <u>5, 0</u> 00			1.00
	TALS		0	25, 000		1	
500.00 Gr	and Total: Decreases		23, 367	313, 419			500.00

Reconciling Items

10.00 Total (line 8 minus line 9)

9.00

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 150102 Peri od: Worksheet A-7 From 01/01/2016 Part I Date/Time Prepared: 02/29/2016 7/28/2016 7:42 pm Acqui si ti ons Begi nni ng Purchases Total Di sposal s and Donati on Bal ances Retirements 2.00 3.00 4. 00 5. 00 1 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 142, 789 1.00 0 1.00 37, 448 0 2.00 Land Improvements 0 0 2.00 0 3.00 1, 509, 571 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 5, 139, 815 4, 517 4, 517 0 4.00 5.00 Fixed Equipment 0 0 5.00 0 6.00 Movable Equipment 9, 752, 977 16, 532 0 6.00 16, 532 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 16, 582, 600 21, 049 21, 049 0 8.00 9.00 Reconciling Items 0 0 9.00 Total (line 8 minus line 9) 16, 582, 600 21, 049 10.00 10.00 0 21, 049 0 Endi ng Bal ance Fully Depreci ated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 142, 789 0 1.00 2.00 Land Improvements 37, 448 0 2.00 3.00 Buildings and Fixtures 1, 509, 571 0 3.00 0) 4.00 Building Improvements 5, 144, 332 4.00 5.00 Fi xed Equipment 0 5.00 Movable Equipment 0 6.00 9, 769, 509 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 8.00 16, 603, 649 0 8.00

16, 603, 649

0

Heal th	Financial Systems IU F	HEALTH STARKE M	EMORIAL HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150102	Peri od:	Worksheet A-7	
					From 01/01/2016 To 02/29/2016	Part II Date/Time Pre	pared.
						7/28/2016 7: 4	
			Sl	JMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	'	·			instructions)	instructions)	
		9. 00	10. 00	11. 00	12. 00	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
		Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
	1	14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
3. 00	Total (sum of lines 1-2)	0	0				3. 00

Heal th	Financial Systems IU H	HEALTH STARKE M	EMORIAL HOSPIT	AL.	In Lie	u of Form CMS-:	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Peri od:	Worksheet A-7	
					From 01/01/2016		
					Γο 02/29/2016	Date/Time Pre 7/28/2016 7:4	
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	Z piii
		COM	FUTATION OF KA	1103	ALLOCATION OF	OTTICK CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col.			
				2)			
		1. 00	2.00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00	CAP REL COSTS-BLDG & FIXT	6, 834, 140	0	6, 834, 140	0. 411605	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	9, 769, 509	0	9, 769, 509	0. 588395	0	2. 00
3.00	Total (sum of lines 1-2)	16, 603, 649	0	16, 603, 649	1. 000000	0	3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY 0	F CAPITAL	
	Cost Center Description	Taxes	0ther	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
			d Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0)	12, 645	195	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0) (4, 737	0	
3.00	Total (sum of lines 1-2)	0	0)	17, 382	195	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	, , , , , , , , , , , , , , , , , , ,				Capi tal -Relate		
			,		d Costs (see	through 14)	
					instructions)	3 .,	
		11. 00	12.00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS CE	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	C	25, 000	0 0	37, 840	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0) (0	4, 737	2. 00

0 0 0

0 0 0

25, 000

0 0 0

4, 737 2. 00 42, 577 3. 00

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

AL HOSPITAL In Lieu of Form CMS-2552-10

Provider CCN: 150102 | Period: | Worksheet A-8 | From 01/01/2016 | To 02/29/2016 | Date/Time Prepared: Health Financial Systems
ADJUSTMENTS TO EXPENSES

				To	o 02/29/2016		
				Expense Classification on	Worksheet A	7/28/2016 7: 42	2 pm
				To/From Which the Amount is			
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2. 00	3.00	4. 00	5. 00	
1. 00	Investment income - CAP REL COSTS-BLDG & FIXT (chapter 2)	В	-309	CAP REL COSTS-BLDG & FIXT	1.00	11	1. 00
2.00	Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		0		0. 00	0	3. 00
3.00	(chapter 2)		0		0.00		3.00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
0.00	suppliers (chapter 8)		0		0.00		0.00
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0. 00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0. 00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-390, 730			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0. 00	0	11. 00
12. 00	(chapter 23) Related organization	A-8-1	1, 306, 720			0	12. 00
12.00	transactions (chapter 10)	A-0-1	1, 300, 720				12.00
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	B B	12 742	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee		-12, 743	CALLIENTA	0.00	0	15. 00
16. 00	and others Sale of medical and surgical	В	1 207	CENTRAL SERVICES & SUPPLY	14. 00	0	16. 00
10.00	supplies to other than	В	-1, 307	CENTRAL SERVICES & SUFFEI	14.00		10.00
17. 00	patients Sale of drugs to other than	В	544	PHARMACY	15. 00	0	17. 00
17.00	pati ents		-544	FIIANWACI	13.00		17.00
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing school (tuition, fees,		0		0. 00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of		0		0.00	0	21. 00
	interest, finance or penalty charges (chapter 21)						
22. 00	Interest expense on Medicare		0		0. 00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66. 00		24. 00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	*** Cost Center Deleted ***	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1.00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP						
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		0	*** Cost Center Deleted ***	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	67. 00		30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	Ω	SPEECH PATHOLOGY	68. 00		31. 00
500	pathology costs in excess of	5 5	0		33.00		500
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32. 00
	Depreciation and Interest						
33. 00 33. 01	MEDICALD ASSESSMENT FEE - 2015 EXCESS STARKE BENEFITS	A A		ADMINISTRATIVE & GENERAL EMPLOYEE BENEFITS DEPARTMENT	5. 00 4. 00	0	33. 00 33. 01
	1		1,014	1	1. 30	· <u> </u>	

From 01/01/2016

			T	o 02/29/2016	Date/Time Pre 7/28/2016 7:4	
			Expense Classification on	Worksheet A		
			To/From Which the Amount is			
				,		
Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	1.00	2.00	3.00	4. 00	5. 00	
33. 02 ADVERTISING	А	-8, 307	ADMINISTRATIVE & GENERAL	5. 00	0	33. 02
33. 03 MI SCELLANEOUS I NCOME	В	-459	ADMINISTRATIVE & GENERAL	5. 00	0	33. 03
33. 04 MI SCELLANEOUS I NCOME	В	-320	NURSING ADMINISTRATION	13.00	0	33. 04
33. 05 MI SCELLANEOUS I NCOME	В	-3, 134	PHYSI CAL THERAPY	66.00	0	33. 05
33.06 TELEPHONE EXPENSE	A	-1, 219	ADMINISTRATIVE & GENERAL	5. 00	0	33. 06
33.07 PATIENT REGISTRATION - PHONES	A	-6, 091	ADMINISTRATIVE & GENERAL	5. 00	0	33. 07
33.08 I/C MISCELLANEOUS REVENUE	В	-53, 837	OTHER NRCC	194. 00	0	33. 08
50.00 TOTAL (sum of lines 1 thru 49)		762, 255				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.

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME
OFFICE COSTS

Provider CCN: 150102
Period:
From 01/01/2016
To 02/29/2016 Date/Time Prepared:
7/28/2016 7: 42 pm

					7/28/2016 7:4	2 pm
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2.00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTM	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE CAPITAL BLDG	12, 645	0	1.00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE CAPITAL MME	4, 737	0	2.00
3.00	5. 00	ADMINISTRATIVE & GENERAL	HOME OFFICE ADMIN	1, 421, 347	136, 239	3.00
4.00	4. 00	EMPLOYEE BENEFITS DEPARTMENT	INTERCOMPANY EXPENSE BENEFIT	4, 230	0	4.00
4.02	15. 00	PHARMACY	INTERCOMPANY PURCHASED SERVI	9, 060	9, 060	4. 02
4.03	16. 00	MEDICAL RECORDS & LIBRARY	INTERCOMPANY PURCHASED SERVI	57, 520	57, 520	4. 03
4.04	60.00	LABORATORY	INTERCOMPANY PURCHASED SERVI	43, 983	43, 983	4.04
4.05	66. 00	PHYSI CAL THERAPY	INTERCOMPANY PURCHASED SERVI	130	130	4. 05
5.00	TOTALS (sum of lines 1-4).			1, 553, 652	246, 932	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

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

			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	В	0.00 IU HEALTH INC 100.00	6. 00
7.00	В	0. 00 LAPORTE REGIONA 100. 00	7. 00
8. 00		0.00	8. 00
9. 00		0.00	9. 00
10. 00		0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

Heal th	Financial Syste	ems	11	U HEALTH ST.	ARKE MEMORI	AL HOSPIT	ΓAL			In Lie	u of Form C	MS-2	552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGAN	IZATIONS AN	ND HOME	Provi der	CCN: 150		Peri c		Worksheet	A-8-	1
OFFICE	COSTS									01/01/2016	Doto/Timo	Dece	anad.
									lo	02/29/2016	Date/Time 7/28/2016		
	Net	Wkst. A-7 Ref.											
	Adjustments												
	(col. 4 minus												
	col. 5)*												
	6. 00	7. 00											
	A. COSTS INCUR	RED AND ADJUSTN	MENTS REQUIRED	AS A RESUL	LT OF TRANS	ACTIONS W	TH RELA	ATED OI	RGANI.	ZATIONS OR (CLAI MED		
	HOME OFFICE CO	STS:											
1.00	12, 645	9											1.00
2.00	4, 737	9											2.00
3.00	1, 285, 108	0											3.00
4.00	4, 230	0											4.00

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

4.02

4 03

4.04

4.05

5 00

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

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

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

i ci ilibai	Schieffe dider title XVIII.	
6.00	HEALTH SYSTEM	6. 00
7.00	HEALTH SYSTEM	7. 00
8.00		8. 00
9.00		9. 00
10.00		10.00
100.00		100.00

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

4.02

4 03

4.04

4.05

5.00

0

0

0

1, 306, 720

0

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 150102

						10 02/29/2016	7/28/2016 7:4	eparea: 12 nm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1. 00	2. 00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	5, 083	4, 833	250	159, 800	2	1. 00
2.00	53. 00	ANESTHESI OLOGY	52, 259	52, 259	0	167, 500	0	2. 00
3.00	60.00	LABORATORY	3, 333	0	3, 333	159, 800	25	3. 00
4.00	65. 00	RESPI RATORY THERAPY	250	250	0	159, 800	0	4. 00
5.00	69.00	ELECTROCARDI OLOGY	610	610	0	159, 800	0	5. 00
6.00	91, 00	EMERGENCY	372, 526	279, 840	92, 686			6. 00
7.00	0.00			0	0	0		7. 00
8.00	0.00			o o	0	0	0	8. 00
9.00	0.00			0	0	0	0	9. 00
10.00	0.00				0	0	0	10.00
200.00			434, 061	337, 792	96, 269	_	564	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of	Provi der	Physician Cost	
		I denti fi er	Li mi t	Unadjusted RCE		Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9.00	12. 00	13. 00	14. 00	
1.00		ADMINISTRATIVE & GENERAL	154	. 8	0	0		1. 00
2.00	53. 00	ANESTHESI OLOGY	C	0	0	0	0	2. 00
3.00		LABORATORY	1, 921	96	0	0	0	3. 00
4.00		RESPI RATORY THERAPY	C	0	0	0	0	4. 00
5.00	69. 00	ELECTROCARDI OLOGY	C	0	0	0	0	5. 00
6.00	91.00	EMERGENCY	41, 256	2, 063	0	0	0	6. 00
7.00	0.00		C	0	0	0	0	7. 00
8.00	0.00		C	0	0	0	0	8. 00
9.00	0.00		C	0	0	0	0	9. 00
10. 00	0.00		C) 0	0	0	1	10. 00
200.00			43, 331			0	0	200. 00
	Wkst. A Line #		Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00	-	
1. 00		ADMINISTRATIVE & GENERAL	15.00	15.00		4, 929		1. 00
2.00		ANESTHESI OLOGY		134	70	52, 259		2.00
3.00		LABORATORY		1, 921	1, 412	1, 412		3. 00
4.00		RESPI RATORY THERAPY		1, 921	1,412	250		4. 00
4. 00 5. 00		ELECTROCARDI OLOGY				610		5. 00
6.00		EMERGENCY		41, 256	51, 430			6.00
7. 00	0.00	4		41, 250	01, 430	331,270		7. 00
8. 00	0.00					0		8. 00
9. 00	0.00	4						9. 00
9. 00 10. 00	0.00	4						10.00
200.00	0.00			43, 331	52, 938	390, 730		200.00
200.00	1		1	ղ 45, 331	∫ ວ∠, 938	1 370, /30	1	∠∪∪. ∪∪

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS IU HEALTH STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 Worksheet B Part I Date/Time Prepared: 7/28/2016 7:42 pm Provi der CCN: 150102 Peri od: From 01/01/2016 To 02/29/2016 CAPITAL RELATED COSTS Cost Center Description Net Expenses | BLDG & FIXT | MVBLE EQUIP EMPLOYEE Subtotal

	Cost Center Description	for Cost Allocation (from Wkst A	BLDG & FLXI	MARTE EGGLA	BENEFITS DEPARTMENT	Subtotal	
		col. 7)	1. 00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS	Ŭ	1.00	2.00	1. 00	17.1	
1.00	00100 CAP REL COSTS-BLDG & FIXT	37, 840	37, 840				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	4, 737	,	4, 737			2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	229, 899	122	·	230, 036		4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	1, 892, 087	3, 937		26, 738	1, 923, 255	5. 00
7. 00	00700 OPERATION OF PLANT	214, 300	12, 167		12, 972	240, 966	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	0	154		.2, ,,2	173	8.00
9. 00	00900 HOUSEKEEPI NG	46, 637	147	18	5, 653	52, 455	1
	01000 DI ETARY	14, 272	275		1, 614	16, 195	
	01100 CAFETERI A	26, 701	761	95	4, 459	32, 016	
	01300 NURSING ADMINISTRATION	9, 084	33		1, 537	10, 658	1
	01400 CENTRAL SERVICES & SUPPLY	104, 704	602		2, 428	107, 809	1
	01500 PHARMACY	45, 903	238		6, 601	52, 772	15. 00
	01600 MEDICAL RECORDS & LIBRARY	57, 520	512		0	58, 096	•
. 0. 00	INPATIENT ROUTINE SERVICE COST CENTERS	0,7020	5.2	5.	<u></u>	30, 375	10.00
30.00	03000 ADULTS & PEDIATRICS	206, 753	3, 934	492	36, 081	247, 260	30.00
	03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
	ANCILLARY SERVICE COST CENTERS			·	-1		
50.00	05000 OPERATING ROOM	160, 327	2, 908	364	23, 090	186, 689	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0	0	o	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	397, 905	1, 877	235	33, 784	433, 801	54.00
57.00	05700 CT SCAN	38, 706	165	21	0	38, 892	57.00
58.00	05800 MRI	40, 423	154	19	2, 712	43, 308	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59.00
60.00	06000 LABORATORY	224, 141	865	108	17, 223	242, 337	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	8, 930	0	0	0	8, 930	62.00
65.00	06500 RESPI RATORY THERAPY	51, 337	969	121	9, 250	61, 677	65. 00
66.00	06600 PHYSI CAL THERAPY	50, 130	689	86	2, 508	53, 413	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	22, 505	99	12	4, 168	26, 784	67.00
68.00	06800 SPEECH PATHOLOGY	3, 928	99	12	729	4, 768	68. 00
69.00	06900 ELECTROCARDI OLOGY	35, 310	191	24	5, 639	41, 164	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	14, 373	0	0	0	14, 373	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	979	0	0	o	979	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	146, 632	0	0	0	146, 632	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0	-	0	0	90. 00
	09100 EMERGENCY	250, 224	1, 205	151	31, 952	283, 532	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT					0	92. 00
	SPECIAL PURPOSE COST CENTERS						
118. 00		4, 336, 287	32, 103	4, 019	229, 138	4, 328, 934	1118. 00
100 00	NONREIMBURSABLE COST CENTERS 19000 GIFT FLOWER COFFEE SHOP & CAN	0	96	12	ol	100	190. 00
	19300 NONPALD WORKERS	0	90	0	ol Ol		190.00
	19301 WELLNESS CENTER	38	0	0	0		193. 00
	19302 RETAIL PHARMACY	224	0		0		193. 01
	07950 OTHER NRCC	-35, 361	5, 641	706	898	-28, 116	
200.00		-33, 301	5, 041	,00	070		200. 00
200.00			0	n	0		201.00
202.00	9	4, 301, 188	37, 840	4, 737	-1		1
	, , , , , , , , , , , , , , , , , , , ,	1, 55.7.50	3.,310	., ,	200, 000	.,,	,

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 150102

Peri od: Worksheet B From 01/01/2016 Part I To 02/29/2016 Date/Time Prepared: 7/28/2016 7: 42 pm

						7/28/2016 7:4	2 pm
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	1, 923, 255					5. 00
7.00	00700 OPERATION OF PLANT	192, 614	433, 580				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	138	3, 092	3, 403			8. 00
9.00	00900 HOUSEKEEPI NG	41, 929	2, 949	0	97, 333		9. 00
10.00	01000 DI ETARY	12, 945	5, 521	0	1, 698	36, 359	10.00
11.00	01100 CAFETERI A	25, 592	15, 264	0	4, 696	0	11. 00
13.00	01300 NURSING ADMINISTRATION	8, 519	654	0	201	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	86, 176	12, 082	0	3, 717	0	14. 00
15.00	01500 PHARMACY	42, 183	4, 777	0	1, 470	0	15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY	46, 439	10, 280	0	3, 163	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>	·				
30.00	03000 ADULTS & PEDI ATRI CS	197, 645	78, 909	3, 403	24, 276	36, 359	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	. 0	0	0	31. 00
	ANCILLARY SERVICE COST CENTERS				-		
50.00	05000 OPERATING ROOM	149, 228	58, 339	0	17, 947	0	50.00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	346, 757	37, 644	0	11, 580	0	54.00
57. 00	05700 CT SCAN	31, 088	3, 307		1, 017	0	57. 00
58. 00	05800 MRI	34, 618			948	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60.00	06000 LABORATORY	193, 710	17, 352		5, 338	0	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	7, 138	0	1	0	0	62.00
65. 00	06500 RESPIRATORY THERAPY	49, 301	19, 441	0	5, 980	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	42, 695	13, 821		4, 252	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	21, 410			612	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	3, 811	1, 990		612	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	32, 904	3, 836		1, 180		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	11, 489	0		0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	783			0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	117, 209			0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	ō	0	0	76. 97
, 0. , ,	OUTPATIENT SERVICE COST CENTERS				<u> </u>		70.77
90.00	09000 CLINIC	0	0	0	0	0	90.00
91. 00	09100 EMERGENCY	226, 639	-	_	7, 433	Ö	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	220,007	2.7.0.	Ĭ	,,	Ŭ	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
118.00		1, 922, 960	318, 495	3, 403	96, 120	36, 359	118 00
110.00	NONREI MBURSABLE COST CENTERS	1, 722, 700	010, 170	0, 100	70, 120	00,007	1110.00
190 00	19000 GIFT FLOWER COFFEE SHOP & CAN	86	1, 918	0	590	0	190. 00
	19300 NONPAI D WORKERS	0	1, 710		0		193. 00
	19301 WELLNESS CENTER	30	Ö		0		193. 01
	19302 RETAIL PHARMACY	179		ő	0		193. 02
	07950 OTHER NRCC	0	113, 167		623		194. 00
200.00	l l		113, 107		023		200.00
201.00	, ,	0	0	0	0	n	201. 00
202.00	1 1 3	1, 923, 255	433, 580		97, 333		
202.00	1.01.12 (34 11.133 110 201)	., ,20,200	100,000	3, 703	,,, 555	00,007	,_02.00

From 01/01/2016 Part I Date/Time Prepared: 02/29/2016 7/28/2016 7:42 pm Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL ADMI NI STRATI ON SERVICES & RECORDS & SUPPLY LI BRARY 11. 00 13.00 15.00 14.00 16, 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 77, 568 11.00 01300 NURSING ADMINISTRATION 831 13.00 13.00 20,863 01400 CENTRAL SERVICES & SUPPLY 14.00 1.787 211, 571 14 00 15.00 01500 PHARMACY 2, 173 19 103, 394 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 117, 978 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 8, 507 30.00 30.00 03000 ADULTS & PEDIATRICS 15,007 9,869 18, 101 0 03100 INTENSIVE CARE UNIT 31.00 31.00 0 0 ANCILLARY SERVICE COST CENTERS 3, 998 50.00 05000 OPERATING ROOM 11, 261 50.00 9,812 100, 188 0 51.00 05100 RECOVERY ROOM 0 0 51.00 05300 ANESTHESI OLOGY 53.00 1, 264 0 0 0 2, 963 53.00 05400 RADI OLOGY-DI AGNOSTI C 13, 974 14, 517 54.00 0 9, 380 54.00 05700 CT SCAN 14, 193 57.00 0 0 0 57.00 58.00 05800 MRI 888 0 0 3,835 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 0 0 59.00 60 00 06000 LABORATORY 0 6,843 20, 335 60 00 8.344 06200 WHOLE BLOOD & PACKED RED BLOOD 62.00 C C 177 62.00 65.00 06500 RESPIRATORY THERAPY 4, 230 5, 908 1, 904 65.00 06600 PHYSI CAL THERAPY 66.00 1,787 0 2, 314 66.00 0 06700 OCCUPATIONAL THERAPY 67.00 1, 381 0 807 67.00 68.00 06800 SPEECH PATHOLOGY 328 0 309 68.00 06900 ELECTROCARDI OLOGY 0 69.00 2, 105 0 571 4, 136 69.00 0 71 00 07100 MEDICAL SUPPLIES CHARGED TO PAT Ω 29, 545 937 71 00 0 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 2,012 0 444 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 103, 394 12, 133 73.00 73.00 C 07697 CARDIAC REHABILITATION 76.97 0 0 76.97 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 0 90.00 09100 EMERGENCY 13, 926 6, 996 37, 740 0 19, 206 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 76, 573 20, 863 211, 571 103, 394 117, 978 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 190. 00 193. 00 19300 NONPALD WORKERS 0 0 193.00 0 C 0 193. 01 19301 WELLNESS CENTER 29 0 0 0 0 193. 01 193. 02 19302 RETAIL PHARMACY 0 0 0 193. 02 194.00 07950 OTHER NRCC 0 194.00 0 0 966 0

77, 568

20, 863

211, 571

103, 394

200. 00

0 201.00

117, 978 202. 00

200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150102 Peri od: Worksheet B From 01/01/2016 Part I 02/29/2016 Date/Time Prepared: 7/28/2016 7:42 pm Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adj ustments 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 01100 CAFETERI A 11.00 11 00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16 00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 30.00 639, 336 639, 336 03100 INTENSIVE CARE UNIT 31.00 0 31 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 537, 462 537, 462 50.00 51. 00 | 05100 | RECOVERY ROOM 0 51.00 53. 00 05300 ANESTHESI OLOGY 0 4. 227 4 227 53 00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 867, 653 867, 653 54.00 57. 00 05700 CT SCAN 88, 497 88, 497 57.00 0 58.00 05800 MRI 86,680 86, 680 58.00 05900 CARDIAC CATHETERIZATION 59 00 0 59 00 0 494, 259 494, 259 60.00 06000 LABORATORY 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD 16, 245 62.00 16, 245 62.00 06500 RESPIRATORY THERAPY 148, 441 148, 441 65.00 65.00 06600 PHYSI CAL THERAPY 0 118, 282 118, 282 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 52, 984 0 52, 984 67.00 06800 SPEECH PATHOLOGY 11,818 11, 818 68.00 68.00 85, 896 85, 896 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 71.00 56, 344 56.344 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 4, 218 4, 218 72.00 07300 DRUGS CHARGED TO PATIENTS 379, 368 0 379, 368 73.00 73.00 07697 CARDIAC REHABILITATION 76.97 0 76.97 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 91.00 09100 EMERGENCY 619, 636 0 619, 636 91.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 0 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 4, 211, 346 0 4, 211, 346 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 190.00 2,702 0 2, 702 193. 00 19300 NONPALD WORKERS C 193.00 193. 01 19301 WELLNESS CENTER 97 0 97 193. 01 193. 02 19302 RETAIL PHARMACY 193. 02 403 0 403 194.00 07950 OTHER NRCC 86,640 0 86,640 194. 00 200.00 Cross Foot Adjustments 0 200. 00 0 0 201.00 Negative Cost Centers 201. 00

4, 301, 188

4, 301, 188

202. 00

202.00

TOTAL (sum lines 118-201)

Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10

ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 150102 | Period: From 01/01/2016 | Part II | To 02/29/2016 | Date/Time Prepared:

				Io	02/29/2016	Date/lime Pre 7/28/2016 7:4	
			CAPLTAL REI	ATED COSTS		17/20/2010 7.4	Z piii
	Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs					
	OFNEDAL CEDIU OF COCT OFNEDO	0	1. 00	2.00	2A	4. 00	
1 00	GENERAL SERVI CE COST CENTERS	1					1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	122	15	137	137	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	122, 405	3, 937		126, 835	16	5.00
7. 00	00700 OPERATION OF PLANT	15, 822	12, 167	l	29, 516	8	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	15, 022	154		173	0	8.00
9. 00	00900 HOUSEKEEPING	154	147		319	3	9.00
10.00	01000 DI ETARY	379	275		688	1	10.00
11. 00	01100 CAFETERI A	0	761	95	856	3	11.00
13. 00	01300 NURSI NG ADMINI STRATI ON	1, 150	33	l	1, 187	1	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 100	602	1	677	1	14. 00
15. 00	01500 PHARMACY	367	238	1	635	4	15. 00
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	512	64	576	0	16. 00
	INPATIENT ROUTINE SERVICE COST CENTERS		0.12	0.1	3,5		
30.00	03000 ADULTS & PEDIATRICS	5, 709	3, 934	492	10, 135	22	30.00
31.00	03100 INTENSIVE CARE UNIT	0	0	1	0	0	31.00
	ANCILLARY SERVICE COST CENTERS	•		,			
50.00	05000 OPERATING ROOM	20, 720	2, 908	364	23, 992	14	50. 00
51.00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	57, 779	1, 877	235	59, 891	20	54.00
57.00	05700 CT SCAN	28, 560	165	21	28, 746	0	57. 00
58. 00	05800 MRI	5, 601	154		5, 774	2	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	-	0	0	59. 00
60.00	06000 LABORATORY	3, 448	865		4, 421	10	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD	0	0	-	0	0	62. 00
65. 00	06500 RESPI RATORY THERAPY	651	969	1	1, 741	6	65. 00
66. 00	06600 PHYSI CAL THERAPY	4, 398	689		5, 173	1	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	66	99		177	2	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	99		111	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 935	191	l	3, 150	3	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	0		0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	9, 119	-		10, 475	19	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT	7, 117	1, 203	131	10, 475	17	92.00
72.00	SPECIAL PURPOSE COST CENTERS				<u> </u>		72.00
118.00		279, 263	32, 103	4, 019	315, 385	136	118. 00
110.00	NONREI MBURSABLE COST CENTERS	217,203	32, 103	4,017	313, 303	130	1110.00
190.00	19000 GIFT FLOWER COFFEE SHOP & CAN	0	96	12	108	0	190. 00
	19300 NONPALD WORKERS	0	0		0		193. 00
	19301 WELLNESS CENTER	0	0	1	0		193. 01
	19302 RETAIL PHARMACY	0	Ō	0	0		193. 02
	07950 OTHER NRCC	10, 318	5, 641	706	16, 665		194. 00
200.00	1				0		200. 00
201.00			0	0	0	0	201. 00
202.00	TOTAL (sum lines 118-201)	289, 581	37, 840	4, 737	332, 158	137	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150102

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part II | To 02/29/2016 | Date/Time Prepared: | 7/28/2016 7:42 pm

						7/28/2016 7:4	2 pm
	Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FLXT						1. 00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMINISTRATIVE & GENERAL	126, 851					5. 00
7.00	00700 OPERATION OF PLANT	12, 704	42, 228				7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	9	301				8.00
9. 00	00900 HOUSEKEEPI NG	2, 766	287		3, 375		9.00
10.00	01000 DI ETARY	854	538	1	59	2, 140	10.00
11. 00		1, 688	1, 487		163	0	11. 00
13. 00		562	64		7	0	13. 00
14. 00		5, 684	1, 177		129	0	14. 00
15. 00		2, 782	465			0	15.00
16. 00	1	3, 063	1, 001			0	16.00
16.00		3,003	1,001	1 0	110	0	16.00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	13, 036	7, 685	483	842	2, 140	30.00
		13,036	/, 685 	1			
31. 00	03100 INTENSIVE CARE UNIT ANCILLARY SERVICE COST CENTERS	0	0	<u> </u>	U U	0	31.00
50. 00		9, 843	F (02	0	(22	0	50.00
			5, 682	1	622		
51.00		0	0	1		0	51.00
53.00		0	0	0		0	53. 00
54.00		22, 870	3, 666	1		0	54.00
57. 00		2, 050	322		35	0	57. 00
58. 00		2, 283	300			0	58. 00
59. 00		0	0	0	-	0	59. 00
60.00		12, 776	1, 690	0	185	0	60.00
62.00		471	0	0	0	0	62. 00
65.00		3, 252	1, 893	0		0	65. 00
66.00		2, 816	1, 346		147	0	66. 00
67.00		1, 412	194	0	21	0	67. 00
68.00	06800 SPEECH PATHOLOGY	251	194	0	21	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	2, 170	374	0	41	0	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	758	0	0	0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	52	0	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 731	0	0	o	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	o	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	0	0	0	0	0	90.00
91.00	09100 EMERGENCY	14, 948	2, 353	0	258	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT						92.00
	SPECIAL PURPOSE COST CENTERS				<u>'</u>		ĺ
118.00		126, 831	31, 019	483	3, 333	2, 140	118. 00
	NONREI MBURSABLE COST CENTERS	<u> </u>			· · · · · · · · · · · · · · · · · · ·		
190.00	0 19000 GIFT FLOWER COFFEE SHOP & CAN	6	187	0	20	0	190. 00
193.00	0 19300 NONPALD WORKERS	0	0	0	o	0	193. 00
193. 0°	1 19301 WELLNESS CENTER	2	0	0	o	0	193. 01
	2 19302 RETAIL PHARMACY	12	0	o	ol		193. 02
	007950 OTHER NRCC	0	11, 022	0	22		194. 00
200.00			, 322			ū	200. 00
201.00		0	n	0	n	0	201. 00
202.00	1 1 3	126, 851	42, 228	483	3, 375		202. 00
_32.0	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	.23,301		1	3, 3, 9	2, . 10	,

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0 194.00

0 201.00

4, 750 202. 00

200.00

Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150102 Peri od: Worksheet B From 01/01/2016 Part II Date/Time Prepared: 02/29/2016 7/28/2016 7:42 pm Cost Center Description CAFETERI A NURSI NG CENTRAL **PHARMACY** MEDI CAL ADMI NI STRATI ON SERVICES & RECORDS & SUPPLY LI BRARY 11. 00 13.00 15.00 14.00 16, 00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FIXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9 00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 4, 197 11.00 01300 NURSING ADMINISTRATION 1,866 13.00 13.00 45 01400 CENTRAL SERVICES & SUPPLY 97 14.00 7.765 14 00 15.00 01500 PHARMACY 118 C 4, 056 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 4, 750 16.00 INPATIENT ROUTINE SERVICE COST CENTERS 343 30.00 30.00 03000 ADULTS & PEDIATRICS 811 882 664 0 03100 INTENSIVE CARE UNIT 0 31.00 31.00 0 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 358 0 454 50.00 531 3, 678 51.00 05100 RECOVERY ROOM 0 C 0 51.00 05300 ANESTHESI OLOGY 0 119 53.00 0 46 0 0 0 0 0 0 0 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 585 54.00 756 54.00 344 05700 CT SCAN 57.00 0 0 0 572 57.00 58.00 05800 MRI 48 0 0 155 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 C 0 59.00 06000 LABORATORY 60 00 451 0 251 814 60 00 06200 WHOLE BLOOD & PACKED RED BLOOD 0 62.00 0 \cap 62.00 65.00 06500 RESPIRATORY THERAPY 229 217 77 65.00 06600 PHYSI CAL THERAPY 66.00 97 93 66.00 0 06700 OCCUPATIONAL THERAPY 75 33 67.00 C 0 67.00 68.00 06800 SPEECH PATHOLOGY 18 0 12 68.00 0 06900 ELECTROCARDI OLOGY 69.00 114 0 21 167 69.00 71 00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 Ω 1 084 38 71 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 0 74 0 18 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 4,056 489 73.00 07697 CARDIAC REHABILITATION 76.97 0 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 0 0 90.00 09100 EMERGENCY 753 626 1, 385 0 774 91.00 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 4, 143 1, 866 7, 765 4, 056 4, 750 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT FLOWER COFFEE SHOP & CAN 0 190. 00

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7, 765

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4, 056

193. 00 19300 NONPALD WORKERS

193. 01 19301 WELLNESS CENTER

193. 02 19302 RETAIL PHARMACY

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

194.00 07950 OTHER NRCC

200.00

201.00

202.00

202.00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150102 Peri od: Worksheet B From 01/01/2016 Part II Date/Time Prepared: 02/29/2016 7/28/2016 7:42 pm Cost Center Description Subtotal Intern & Total Residents Cost & Post Stepdown Adj ustments 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 00800 LAUNDRY & LINEN SERVICE 8.00 8.00 9.00 00900 HOUSEKEEPI NG 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16 00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 30.00 37,043 37, 043 03100 INTENSIVE CARE UNIT 31.00 0 31 00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 45, 174 0 45, 174 50.00 51. 00 | 05100 | RECOVERY ROOM 0 51.00 C 53. 00 05300 ANESTHESI OLOGY 0 53.00 165 165 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 88, 534 88, 534 54.00 31, 725 57. 00 05700 CT SCAN 31, 725 57.00 0 58.00 05800 MRI 8,595 8, 595 58.00 05900 CARDIAC CATHETERIZATION 59 00 0 59 00 06000 LABORATORY 60.00 20, 598 20, 598 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD 478 62.00 478 62.00 06500 RESPIRATORY THERAPY 7, 622 65.00 7.622 65.00 06600 PHYSI CAL THERAPY 66.00 9.673 9.673 66.00 67.00 06700 OCCUPATIONAL THERAPY 1, 914 1, 914 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 607 607 6, 040 69.00 06900 ELECTROCARDI OLOGY 6.040 0 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 0 71.00 1,880 1,880 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 144 144 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 12, 276 0 12, 276 73.00 07697 CARDIAC REHABILITATION 76.97 0 76.97 0 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 90.00 91.00 09100 EMERGENCY 31, 591 0 31, 591 91.00 09200 OBSERVATION BEDS (NON-DISTINCT 92.00 Λ 92.00 SPECIAL PURPOSE COST CENTERS 118.00 SUBTOTALS (SUM OF LINES 1-117) 304, 059 0 304, 059 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT FLOWER COFFEE SHOP & CAN 190.00 321 0 321 193. 00 19300 NONPALD WORKERS 0 C 193.00 193. 01 19301 WELLNESS CENTER 0 193. 01 4 4 193. 02 19302 RETAIL PHARMACY 193. 02 0 12 12 194.00 07950 OTHER NRCC 27, 762 0 27, 762 194. 00 200.00 Cross Foot Adjustments 0 200. 00 0 0 201.00 Negative Cost Centers 201. 00 0 0

332, 158

332, 158

202.00

TOTAL (sum lines 118-201)

Heal th	Financial Systems IU	HEALTH STARKE N	MEMORI AL	HOSPI T	AL	In Lie	u of Form CMS-	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Pr	ovi der	CCN: 150102	Peri od:	Worksheet B-1	
						From 01/01/2016 Fo 02/29/2016	Date/Time Pro	narod:
						10 02/29/2010	7/28/2016 7: 4	2 pm
		CAPI TAL REI	LATED CO	STS				
	Cost Center Description	BLDG & FIXT	MVBLE	EQUI P	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE	FEET)	BENEFITS		& GENERAL	
					DEPARTMENT		(ACCUM. COST)	
					(GROSS			
					SALARI ES)			
		1.00	2. (00	4. 00	5A	5. 00	
1 00	GENERAL SERVICE COST CENTERS	04 (00						1 00
1.00	00100 CAP REL COSTS-BLDG & FIXT	84, 693						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUI P	07.4		84, 693				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	274	1	274			0 40/ 040	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	8, 812	1	8, 812				1
7.00	00700 OPERATION OF PLANT	27, 232		27, 232			240, 966	
8.00	00800 LAUNDRY & LINEN SERVICE	345		345		-	173	1
9.00	00900 HOUSEKEEPI NG	329	1	329			52, 455	1
10.00	01000 DI ETARY	616	1	616			16, 195	1
11.00	01100 CAFETERI A	1, 703		1, 703				1
13.00	01300 NURSI NG ADMI NI STRATI ON	73	1	73			10, 658	1
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 348	1	1, 348				1
15. 00	01500 PHARMACY	533		533				1
16. 00	O1600 MEDICAL RECORDS & LIBRARY INPATIENT ROUTINE SERVICE COST CENTERS	1, 147		1, 147		0	58, 096	16. 00
20.00	03000 ADULTS & PEDIATRICS	8, 804		0.004	181, 076		247.260	30.00
30.00	03100 INTENSIVE CARE UNIT	8,804	1	8, 804 0				
31.00	ANCI LLARY SERVICE COST CENTERS	0	'	U		0	0	31. 00
50. 00	05000 OPERATING ROOM	6, 509	1	6, 509	115, 879	9 0	186, 689	50.00
51. 00	05100 RECOVERY ROOM	0, 509	1	0, 509				1
53.00	05300 ANESTHESI OLOGY		1	0				1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	4, 200	1	4, 200	169, 550		l	1
57. 00	05700 CT SCAN	369	1	4, 200 369	109, 550		38, 892	1
58. 00	05800 MRI	344		344	13, 613	3 0		1
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	1	044	13,013		43, 300	1
60. 00	06000 LABORATORY	1, 936	1	1, 936	86, 438	3 0	· -	1
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD	1, 730	1	1, 750	(8, 930	•
65. 00	06500 RESPIRATORY THERAPY	2, 169	1	2, 169	· ·	-		1
66. 00	06600 PHYSI CAL THERAPY	1, 542		1, 542				1
67. 00	06700 OCCUPATI ONAL THERAPY	222	1	222				1
68. 00	06800 SPEECH PATHOLOGY	222		222	3, 659		1	1
69. 00	06900 ELECTROCARDI OLOGY	428	1	428			41, 164	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	0		0	20,27	o o	1	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		0				1
73. 00	07300 DRUGS CHARGED TO PATIENTS	0		0	(0	l	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	l .	0		0		1
	OUTPATIENT SERVICE COST CENTERS		1	-				
90.00	09000 CLI NI C	0		0	(0	0	90.00
91.00	09100 EMERGENCY	2, 696	,	2, 696	160, 354	1 0	283, 532	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT							92.00
	SPECIAL PURPOSE COST CENTERS		•			*		1
118.00	SUBTOTALS (SUM OF LINES 1-117)	71, 853		71, 853	1, 149, 957	-1, 923, 255	2, 405, 679	118. 00
	NONREI MBURSABLE COST CENTERS					_		
	19000 GIFT FLOWER COFFEE SHOP & CAN	214		214	(0	108	190. 00
	19300 NONPALD WORKERS	0		0	(0		193. 00
	19301 WELLNESS CENTER	0		0	(0		193. 01
	19302 RETAIL PHARMACY	0)	0	(0		193. 02
	07950 OTHER NRCC	12, 626		12, 626	4, 50	7 28, 116	0	194. 00
200.00	, ,							200. 00
201.00								201. 00
202.00	71	37, 840		4, 737	230, 036	5	1, 923, 255	202. 00
	Part I)							
203.00	1 1	0. 446790	0.	. 055931	i		0. 799342	
204.00					137	7	126, 851	204. 00
205 55	Part II)				0.0001:		0 05055	205 22
205.00					0. 000119	7	0. 052722	205.00
	1)	I	1		I	1	I	I

Health Financial Systems		HEALTH STARKE N	<u>MEMORIAL HOSPIT</u>	AL	In Lie	u of Form CMS	<u> 2552-10</u>
COST ALLOCATION - STATISTICAL	BASIS		Provi der		eri od:	Worksheet B-1	
					rom 01/01/2016	Doto/Time Dro	nonod.
				1	o 02/29/2016	Date/Time Pre 7/28/2016 7:4	
Cost Center Descri	nti on	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	_ piii
3031 3011131 203011	p :	PLANT	LINEN SERVICE		(TOTAL PATIENT	(FTE)	
			(TOTAL PATIENT	(DAYS)	(–)	
		,	DAYS)		,		
		7. 00	8.00	9. 00	10.00	11. 00	
GENERAL SERVICE COST CEN	ITERS			•			
1.00 00100 CAP REL COSTS-BLDG							1.00
2.00 00200 CAP REL COSTS-MVBL	E EQUIP						2. 00
4.00 00400 EMPLOYEE BENEFITS							4.00
5.00 00500 ADMINISTRATIVE & G	ENERAL						5.00
7.00 00700 OPERATION OF PLANT		48, 375					7.00
8.00 00800 LAUNDRY & LINEN SE		345	l .				8. 00
9. 00 00900 HOUSEKEEPI NG		329		1			9. 00
10. 00 01000 DI ETARY		616		616	l l		10.00
11. 00 01100 CAFETERIA		1, 703		1, 703	l l	8, 032	
13. 00 01300 NURSI NG ADMI NI STRA	TLON	73		73	l l	86	1
14. 00 01400 CENTRAL SERVI CES &		1, 348		1, 348	1	185	1
15. 00 01500 PHARMACY	301121	533	l .			225	
16. 00 01600 MEDI CAL RECORDS &	LIRRARY	1, 147				0	
I NPATI ENT ROUTI NE SERVI C		1, 147		1, 177	<u> </u>		10.00
30. 00 03000 ADULTS & PEDIATRIC		8, 804	234	8, 804	234	1, 554	30.00
31. 00 03100 NTENSI VE CARE UNI		0,004				1, 554	1
ANCI LLARY SERVI CE COST O			0		<u>'l</u>		31.00
50. 00 05000 OPERATING ROOM	LIVIERS	6, 509	0	6, 509	ol	1, 016	50.00
51. 00 05100 RECOVERY ROOM		0, 307		0, 509		1,010	1
53. 00 05300 ANESTHESI OLOGY					-	0	
	1.0			1	-		
1 1	10	4, 200		4, 200		1, 447	1
57. 00 05700 CT SCAN		369		369		0	
58. 00 05800 MRI	ATLON	344	0	344		92	
59. 00 05900 CARDI AC CATHETERI Z	ATTON	0	0	0		0	
60. 00 06000 LABORATORY	ED DED DI 00D	1, 936	0	1, 936	0	864	
62. 00 06200 WHOLE BLOOD & PACK		0	0	0	0	0	
65. 00 06500 RESPIRATORY THERAP	Y	2, 169	l .	2, 169		438	
66. 00 06600 PHYSI CAL THERAPY		1, 542	l .	1, 542		185	
67. 00 06700 OCCUPATIONAL THERA	PY	222	l .	222		143	
68.00 06800 SPEECH PATHOLOGY		222		222		34	
69. 00 06900 ELECTROCARDI OLOGY		428	0	428	이	218	
71.00 07100 MEDICAL SUPPLIES C		0	0	C	0	0	71. 00
72.00 07200 I MPL. DEV. CHARGED	TO PATIENTS	0	0	C	0	0	72. 00
73.00 07300 DRUGS CHARGED TO P		0	0	C	0	0	73. 00
76. 97 07697 CARDIAC REHABILITA	TI ON	0	0	C	0	0	76. 97
OUTPATIENT SERVICE COST	CENTERS						
90. 00 09000 CLI NI C		0	0	C	0	0	90.00
91.00 09100 EMERGENCY		2, 696	0	2, 696	0	1, 442	91.00
92.00 09200 OBSERVATION BEDS (NON-DI STI NCT						92.00
SPECIAL PURPOSE COST CEN	ITERS						
118.00 SUBTOTALS (SUM OF	LINES 1-117)	35, 535	234	34, 861	234	7, 929	118. 00
NONREI MBURSABLE COST CEN	ITERS						
190.00 19000 GIFT FLOWER COFF	EE SHOP & CAN	214	0	214	. 0	0	190. 00
193.00 19300 NONPALD WORKERS		0	0		ol	0	193. 00
193. 01 19301 WELLNESS CENTER		0	0		ol ol	3	193. 01
193. 02 19302 RETAIL PHARMACY		0	0		ol		193. 02
194.00 07950 OTHER NRCC		12, 626	0	226	ا		194. 00
200.00 Cross Foot Adjustm	ents	12,020				.00	200. 00
201.00 Negative Cost Cent							201. 00
202.00 Cost to be allocat		433, 580	3, 403	97, 333	36, 359	77 560	202. 00
Part I)	ed (per wkst. b,	433, 360	3, 403	77, 333	30, 339	11, 500	202.00
	er (Wkst. B, Part I)	8. 962894	14. 542735	2. 757231	155. 380342	9. 657371	203 00
204.00 Cost to be allocat							204. 00
Part II)	eu (pei wkst. B,	42, 228	483	3, 3/5	2, 140	4, 197	204.00
	or (Wkst P Post	0.070000	2 04 4102	0.005/0/	0 145300	0 500505	205 00
205.00 Unit cost multipli	ei (WKSt. B, Part	0. 872930	2. 064103	0. 095606	9. 145299	0. 522535	205.00
11)		l	I	I	1		I

Health Financial Systems IU	HEALTH STARKE MI	EMORIAL HOSPITA	AL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150102	Peri od:	Worksheet B-1
				From 01/01/2016 To 02/29/2016	Date/Time Prepared:
				02/2//2010	7/28/2016 7: 42 pm
Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
	ADMI NI STRATI ON	SERVICES &	(COSTED REQUIS.)	RECORDS &	
	(TOTAL NURS	SUPPLY (COSTED	REQUIS.)	LI BRARY (GROSS	
	ING SALAR)	REQUIS.)		CHARGES)	
	13. 00	14.00	15. 00	16.00	
GENERAL SERVICE COST CENTERS					
1.00 O0100 CAP REL COSTS-BLDG & FIXT					1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUI P					2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL					4. 00 5. 00
7. 00 00700 OPERATION OF PLANT					7.00
8. 00 00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 00900 HOUSEKEEPI NG					9. 00
10. 00 01000 DI ETARY					10. 00
11. 00 01100 CAFETERI A					11. 00
13.00 01300 NURSING ADMINISTRATION	341, 003				13. 00
14.00 O1400 CENTRAL SERVICES & SUPPLY	0	102, 926			14. 00
15. 00 01500 PHARMACY	0	9	10		15. 00
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	0		0 13, 549, 102	16. 00
30. 00 03000 ADULTS & PEDIATRICS	161, 311	0.007		077 017	20,00
30.00 03000 ADULTS & PEDIATRICS 31.00 03100 NTENSIVE CARE UNIT	101, 311	8, 806 0		0 977, 017 0 0	30. 00 31. 00
ANCI LLARY SERVI CE COST CENTERS	<u> </u>			0	31.00
50. 00 05000 OPERATING ROOM	65, 343	48, 740		0 1, 293, 368	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	51. 00
53. 00 05300 ANESTHESI OLOGY	0	615		0 340, 348	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	4, 563		0 1, 667, 277	54.00
57. 00 05700 CT SCAN	0	0		0 1, 630, 023	57. 00
58. 00 05800 MRI	0	0		0 440, 406	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	59.00
60. 00 06000 LABORATORY	0	3, 329		0 2, 334, 818	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD 65. 00 06500 RESPIRATORY THERAPY	0	2, 874		0 20, 352 0 218, 652	62. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY		2, 0/4		0 265, 812	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0		0 92, 732	67. 00
68. 00 06800 SPEECH PATHOLOGY	o	0		0 35, 497	68. 00
69. 00 06900 ELECTROCARDI OLOGY	O	278		0 474, 992	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	o	14, 373		0 107, 597	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	979		0 50, 956	72. 00
73.00 O7300 DRUGS CHARGED TO PATIENTS	0	0	10		73. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0		0 0	76. 97
90. 00 09000 CLI NI C	O	O		0 0	90.00
91. 00 09100 EMERGENCY	114, 349	18, 360		0 0 0 2, 205, 762	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	114, 347	10, 300		2, 203, 702	92.00
SPECIAL PURPOSE COST CENTERS					72. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	341, 003	102, 926	10	0 13, 549, 102	118. 00
NONREI MBURSABLE COST CENTERS		·			
190.00 19000 GIFT FLOWER COFFEE SHOP & CAN	0	0		0 0	190. 00
193.00 19300 NONPALD WORKERS	0	0		0 0	193. 00
193. 01 19301 WELLNESS CENTER	0	0		0	193. 01
193. 02 19302 RETAIL PHARMACY	0	0		0	193. 02
194. 00 07950 OTHER NRCC	0	0		0	194. 00
200.00 Cross Foot Adjustments					200.00
201.00 Negative Cost Centers 202.00 Cost to be allocated (per Wkst. B,	20, 863	211, 571	103, 39	4 117, 978	201. 00 202. 00
Part I)	20, 603	211, 3/1	103, 39	4 117, 970	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 061181	2. 055564	1, 033. 94000	0. 008707	203. 00
204.00 Cost to be allocated (per Wkst. B,	1, 866	7, 765	4, 05		204. 00
Part II)					
205.00 Unit cost multiplier (Wkst. B, Part	0. 005472	0. 075443	40. 56000	0. 000351	205. 00
			l		

COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der	F	eriod: rom 01/01/2016 o 02/29/2016	Worksheet C Part I Date/Time Pre 7/28/2016 7:4	
		Ti tl	e XVIII	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	1			
30. 00 03000 ADULTS & PEDI ATRI CS	639, 336	ł .	639, 336		639, 336	
31. 00 03100 I NTENSI VE CARE UNI T	0		C	0	0	31. 00
ANCI LLARY SERVI CE COST CENTERS	F27 4/2	I	F07.4/0		F27 4/2	
50. 00 05000 OPERATI NG ROOM	537, 462		537, 462		537, 462	
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	4 227		4 227		4 227	
54. 00 05400 RADI OLOGY - DI AGNOSTI C	4, 227 867, 653		4, 227 867, 653		4, 227 867, 653	
57. 00 05700 CT SCAN	88, 497		88, 497		88, 497	
58. 00 05700 CT 3CAN	86, 680		86, 680		86, 680	
59. 00 05900 CARDI AC CATHETERI ZATI ON	00,000		00,000		00, 000	
60. 00 06000 LABORATORY	494, 259		494, 259	٩	495, 671	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD	16, 245		16, 245		16, 245	
65. 00 06500 RESPIRATORY THERAPY	148, 441	0	148, 441		148, 441	
66. 00 06600 PHYSI CAL THERAPY	118, 282	0	118, 282		118, 282	
67. 00 06700 OCCUPATI ONAL THERAPY	52, 984		52, 984		52, 984	
68. 00 06800 SPEECH PATHOLOGY	11, 818		11, 818		11, 818	
69. 00 06900 ELECTROCARDI OLOGY	85, 896		85, 896		85, 896	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	56, 344		56, 344		56, 344	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 218		4, 218	o	4, 218	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	379, 368		379, 368	o	379, 368	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0				0	1
OUTPATIENT SERVICE COST CENTERS	·					
90. 00 09000 CLI NI C	0		C	0	0	90.00
91. 00 09100 EMERGENCY	619, 636		619, 636	51, 430	671, 066	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	245, 639		245, 639		245, 639	
200.00 Subtotal (see instructions)	4, 456, 985		.,,			
201.00 Less Observation Beds	245, 639		245, 639		245, 639	
202.00 Total (see instructions)	4, 211, 346	0	4, 211, 346	52, 842	4, 264, 188	202. 00

Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 150102 Peri od: Worksheet C From 01/01/2016 Part I 02/29/2016 Date/Time Prepared: 7/28/2016 7:42 pm Title XVIII Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 573, 015 573, 015 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 74, 427 1, 218, 941 1, 293, 368 0. 415552 0.000000 50.00 05100 RECOVERY ROOM 0.000000 0.000000 51.00 51 00 53.00 05300 ANESTHESI OLOGY 13, 396 326, 952 340, 348 0.012420 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 72, 791 1, 594, 486 1, 667, 277 0.520401 0.000000 54.00 05700 CT SCAN 132, 431 1, 497, 592 1, 630, 023 0.054292 57.00 0.000000 57.00 05800 MRI 421, 984 440, 406 0. 196818 0.000000 58.00 18, 422 58 00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 60.00 06000 LABORATORY 333, 587 2, 001, 231 2, 334, 818 0. 211691 0.000000 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD 8, 982 11, 370 20, 352 0.798202 0.000000 62.00 62.00 06500 RESPIRATORY THERAPY 65.00 139, 737 78, 915 218, 652 0.678892 0.000000 65.00 06600 PHYSI CAL THERAPY 9, 427 256, 385 265, 812 0.444984 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 10, 359 82, 373 92, 732 0.571367 0.000000 67.00 06800 SPEECH PATHOLOGY 5. 195 30, 302 35, 497 0.332930 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69, 163 405, 829 474, 992 0.180837 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 46, 095 61, 502 107, 597 0. 523658 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 50, 956 50, 956 0.082777 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 272242 73.00 407, 184 986, 309 1, 393, 493 0.000000 73.00 76.97 07697 CARDIAC REHABILITATION 0.000000 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 0.000000 90 00 0 O 09100 EMERGENCY 214, 379 1, 991, 383 2, 205, 762 0.280917 0.000000 91.00 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 27,020 376, 982 404, 002 0.608014 0.000000 92.00 200.00 Subtotal (see instructions) 2, 155, 610 11, 393, 492 13, 549, 102 200.00 Less Observation Beds 201.00 201.00

2, 155, 610

11, 393, 492

13, 549, 102

202. 00

202.00

Total (see instructions)

			To 02/29/2016	Date/Ti me Prepared: 7/28/2016 7:42 pm
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Rati o			
	11.00			
I NPATIENT ROUTINE SERVICE COST CENTERS	T			
30. 00 03000 ADULTS & PEDI ATRI CS				30.00
31. 00 03100 I NTENSI VE CARE UNI T				31. 00
ANCILLARY SERVICE COST CENTERS	T			
50. 00 05000 OPERATI NG ROOM	0. 415552			50.00
51. 00 05100 RECOVERY ROOM	0. 000000			51. 00
53. 00 05300 ANESTHESI OLOGY	0. 012420			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 520401			54. 00
57. 00 05700 CT SCAN	0. 054292			57. 00
58. 00 05800 MRI	0. 196818			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59. 00
60. 00 06000 LABORATORY	0. 212295			60. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	0. 798202			62. 00
65. 00 06500 RESPI RATORY THERAPY	0. 678892			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 444984			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 571367			67. 00
68.00 06800 SPEECH PATHOLOGY	0. 332930			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 180837			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 523658			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 082777			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 272242			73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90. 00
91. 00 09100 EMERGENCY	0. 304233			91. 00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT	0. 608014			92. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

COMPUTATION OF RATIO OF COSTS TO CHARGES	MLACIII STANNE W	Provi der	CCN: 150102 F	Period: From 01/01/2016 To 02/29/2016	Worksheet C Part I Date/Time Pre 7/28/2016 7:4	pared:
		Ti t	le XIX	Hospi tal	PPS	
				Costs		
Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
	(from Wkst. B,	Adj .		Di sal I owance		
	Part I, col.					
	26)	0.00	0.00	4.00	F 00	
LAIDATLENT DOUTLAG CEDIA OF COCT CENTEDO	1. 00	2. 00	3. 00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	400.004		/ / / / / / / / / / / / / / / / / / / /		/00.00/	
30. 00 03000 ADULTS & PEDI ATRI CS	639, 336		639, 336		639, 336	
31. 00 O3100 I NTENSI VE CARE UNI T	0		(0	0	31. 00
ANCILLARY SERVICE COST CENTERS	507.440			ا.	507.440	
50. 00 05000 OPERATI NG ROOM	537, 462		537, 462		537, 462	
51. 00 05100 RECOVERY ROOM	0		(1	0	
53. 00 05300 ANESTHESI OLOGY	4, 227		4, 227		4, 227	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	867, 653		867, 653		867, 653	
57. 00 05700 CT SCAN	88, 497		88, 497		88, 497	
58. 00 05800 MRI	86, 680		86, 680		86, 680	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		(1	0	
60. 00 06000 LABORATORY	494, 259		494, 259		495, 671	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	16, 245		16, 245		16, 245	
65. 00 06500 RESPI RATORY THERAPY	148, 441	0	148, 441		148, 441	
66. 00 06600 PHYSI CAL THERAPY	118, 282	0	118, 282		118, 282	
67. 00 06700 OCCUPATI ONAL THERAPY	52, 984	0	52, 984		52, 984	
68. 00 06800 SPEECH PATHOLOGY	11, 818	0	11, 818		11, 818	
69. 00 06900 ELECTROCARDI OLOGY	85, 896		85, 896	0	85, 896	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	56, 344		56, 344	0	56, 344	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	4, 218		4, 218	0	4, 218	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	379, 368		379, 368	0	379, 368	73. 00
76. 97 07697 CARDIAC REHABILITATION	0		(0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0		(0	0	90.00
91. 00 09100 EMERGENCY	619, 636		619, 636	51, 430	671, 066	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	245, 639		245, 639		245, 639	92.00
200.00 Subtotal (see instructions)	4, 456, 985	0	4, 456, 985	52, 842	4, 509, 827	200.00
201.00 Less Observation Beds	245, 639		245, 639		245, 639	
202.00 Total (see instructions)	4, 211, 346	0	4, 211, 346	52, 842	4, 264, 188	202. 00
		•	•			•

Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10 COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 150102 Peri od: Worksheet C From 01/01/2016 Part I 02/29/2016 Date/Time Prepared: 7/28/2016 7:42 pm Title XIX Hospi tal PPS Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other TFFRA I npati ent + col . 7) Ratio Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 573, 015 573, 015 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 74, 427 1, 218, 941 1, 293, 368 0. 415552 0.000000 50.00 05100 RECOVERY ROOM 0.000000 0.000000 51.00 51 00 53.00 05300 ANESTHESI OLOGY 13, 396 326, 952 340, 348 0.012420 0.000000 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 72, 791 1, 594, 486 1, 667, 277 0.520401 0.000000 54.00 05700 CT SCAN 132, 431 1, 497, 592 1, 630, 023 0.054292 57.00 0.000000 57.00 05800 MRI 421, 984 440, 406 0. 196818 0.000000 58.00 18, 422 58 00 59.00 05900 CARDIAC CATHETERIZATION 0.000000 0.000000 59.00 60.00 06000 LABORATORY 333, 587 2, 001, 231 2, 334, 818 0. 211691 0.000000 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD 8, 982 11, 370 20, 352 0.798202 0.000000 62.00 62.00 06500 RESPIRATORY THERAPY 65.00 139, 737 78, 915 218, 652 0.678892 0.000000 65.00 06600 PHYSI CAL THERAPY 9, 427 256, 385 265, 812 0.444984 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 10, 359 82, 373 92, 732 0.571367 0.000000 67.00 06800 SPEECH PATHOLOGY 5. 195 30, 302 35, 497 0.332930 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 69, 163 405, 829 474, 992 0.180837 0.000000 69.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 46, 095 61, 502 107, 597 0. 523658 0.000000 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 50, 956 50, 956 0.082777 0.000000 72.00 72.00 07300 DRUGS CHARGED TO PATIENTS 0. 272242 73.00 407, 184 986, 309 1, 393, 493 0.000000 73.00 76.97 07697 CARDIAC REHABILITATION 0.000000 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLINIC 0.000000 0.000000 90 00 0 O 09100 EMERGENCY 214, 379 1, 991, 383 2, 205, 762 0.280917 0.000000 91.00 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 27,020 376, 982 404, 002 0.608014 0.000000 92.00 200.00 Subtotal (see instructions) 2, 155, 610 11, 393, 492 13, 549, 102 200.00 Less Observation Beds 201.00 201.00 202.00 Total (see instructions) 2, 155, 610 11, 393, 492 13, 549, 102 202. 00

			To 02/29/2016	Date/Time Prepared: 7/28/2016 7:42 pm
		Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpati ent		<u> </u>	
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30.00
31. 00 03100 I NTENSI VE CARE UNIT				31.00
ANCILLARY SERVICE COST CENTERS				
50.00 05000 OPERATING ROOM	0. 415552			50. 00
51.00 05100 RECOVERY ROOM	0. 000000			51.00
53. 00 05300 ANESTHESI OLOGY	0. 012420			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 520401			54.00
57. 00 05700 CT SCAN	0. 054292			57. 00
58. 00 05800 MRI	0. 196818			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 212295			60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	0. 798202			62. 00
65. 00 06500 RESPI RATORY THERAPY	0. 678892			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 444984			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 571367			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 332930			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 180837			69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 523658			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 082777			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 272242			73. 00
76. 97 07697 CARDIAC REHABILITATION	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0. 000000			90.00
91. 00 09100 EMERGENCY	0. 304233			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 608014			92.00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
202.00 Total (see instructions)				202. 00

Health Financial Systems

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

I U HEALTH STARKE MEMORIAL HOSPITAL CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Provider CCI | Peri od: | Worksheet C | From 01/01/2016 | Part | I | To 02/29/2016 | Date/Time Prepared: Provi der CCN: 150102

					10 02/29/2010	7/28/2016 7:4	
				le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost		Operating Cos ⁻		Operating Cost	
		(Wkst. B, Part				Reduction	
		I, col. 26)	II col. 26)	Cost (col. 1	-	Amount	
				col . 2)			
		1.00	2. 00	3. 00	4. 00	5. 00	
	NCILLARY SERVICE COST CENTERS	507.440		100.00			
	5000 OPERATING ROOM	537, 462	45, 174	492, 288	3 0	0	00.00
	5100 RECOVERY ROOM	0	0		0	0	51.00
	5300 ANESTHESI OLOGY	4, 227	165			0	53. 00
	5400 RADI OLOGY-DI AGNOSTI C	867, 653				0	54. 00
	5700 CT SCAN	88, 497	31, 725			0	57. 00
	5800 MRI	86, 680	8, 595	78, 08!	0	0	58. 00
	5900 CARDI AC CATHETERI ZATI ON	0	0	(0	0	59. 00
	6000 LABORATORY	494, 259				0	60.00
	6200 WHOLE BLOOD & PACKED RED BLOOD	16, 245				0	62. 00
	6500 RESPI RATORY THERAPY	148, 441	7, 622			0	65. 00
	6600 PHYSI CAL THERAPY	118, 282				0	66. 00
	6700 OCCUPATI ONAL THERAPY	52, 984		1		0	67. 00
	6800 SPEECH PATHOLOGY	11, 818				0	68. 00
	6900 ELECTROCARDI OLOGY	85, 896				0	69. 00
	7100 MEDICAL SUPPLIES CHARGED TO PAT	56, 344				0	71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	4, 218				0	72. 00
	7300 DRUGS CHARGED TO PATIENTS	379, 368	12, 276			0	73. 00
_	7697 CARDIAC REHABILITATION	0	0	(0	0	76. 97
	UTPATIENT SERVICE COST CENTERS	_		1	_1		
	9000 CLI NI C	0	0	1	0	0	
	9100 EMERGENCY	619, 636				0	
	9200 OBSERVATION BEDS (NON-DISTINCT	245, 639				0	
200.00	Subtotal (sum of lines 50 thru 199)	3, 817, 649					200. 00
201.00	Less Observation Beds	245, 639				-	201. 00
202. 00	Total (line 200 minus line 201)	3, 572, 010	267, 016	3, 304, 99	4 0	0	202. 00

Peri od: Worksheet C
From 01/01/2016 Part II
To 02/29/2016 Part II
Date/Time Prepared: 7/28/2016 7:42 pm REDUCTIONS FOR MEDICALD ONLY

						7/28/2016 7:42 pm
				le XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges			
		Capital and	(Worksheet C,			
			Part I, column		6	
		Reduction	8)	/ col. 7)		
		6. 00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM	537, 462	1, 293, 368	1		50.00
	05100 RECOVERY ROOM	0	0	0. 00000		51.00
	05300 ANESTHESI OLOGY	4, 227	340, 348	1		53.00
	05400 RADI OLOGY-DI AGNOSTI C	867, 653				54.00
	05700 CT SCAN	88, 497	1, 630, 023	0.05429	92	57.00
58.00	05800 MRI	86, 680	440, 406	0. 1968	18	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	00	59. 00
60.00	06000 LABORATORY	494, 259	2, 334, 818	0. 21169	91	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	16, 245	20, 352	0. 79820	02	62. 00
65.00	06500 RESPI RATORY THERAPY	148, 441	218, 652	0. 67889	92	65. 00
66.00	06600 PHYSI CAL THERAPY	118, 282	265, 812	0. 44498	34	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	52, 984	92, 732	0. 57136	57	67. 00
68.00	06800 SPEECH PATHOLOGY	11, 818	35, 497	0. 33293	30	68. 00
69.00	06900 ELECTROCARDI OLOGY	85, 896	474, 992	0. 18083	37	69. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PAT	56, 344	107, 597	0. 52365	58	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	4, 218	50, 956	0. 08277	77	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	379, 368	1, 393, 493	0. 27224	12	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0. 00000	00	76. 97
	OUTPATIENT SERVICE COST CENTERS				·	
90.00	09000 CLI NI C	0	0	0.00000	00	90.00
91.00	09100 EMERGENCY	619, 636	2, 205, 762	0. 28091	17	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT	245, 639	404, 002	0.60801	14	92. 00
200.00	Subtotal (sum of lines 50 thru 199)	3, 817, 649	12, 976, 087	1		200. 00
201.00	Less Observation Beds	245, 639	0)		201. 00
202.00	Total (line 200 minus line 201)	3, 572, 010	12, 976, 087			202. 00

Health Financial Systems	HEALTH STARKE MEMORIAL HOSPITAL In Lieu of Form CMS					2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od:	Worksheet D	
				From 01/01/2016 To 02/29/2016		narad.
				To 02/29/2016	Date/Time Pre 7/28/2016 7:4	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	37, 043	C	37, 04	380	97. 48	30. 00
31.00 INTENSIVE CARE UNIT	0			0	0.00	31. 00
200.00 Total (lines 30-199)	37, 043		37, 04	380		200. 00
Cost Center Description	I npati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6.00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	138	13, 452	2	·	·	30.00
31.00 INTENSIVE CARE UNIT	0	(31.00
200.00 Total (lines 30-199)	138	13, 452	2			200. 00

Financial Systems	IU HEALTH STARKE MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2552-10
				1

APPORTI ONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COSTS Provider CCN: 150102 From 01/01/2016 From 01/01/2016 Part III Date/Time Prepared: 7/28/2016 7:42 pm Part III Date/Time Prepared: 7/28/	Health Financial Systems	J HEALTH STARKE N	MEMORIAL HOSPIT	ΓAL	In Lie	eu of Form CMS-2	2552-10
Capit tal Related Cost (from Wkst. B, Part I, col. Part II, par	APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPI	TAL COSTS			From 01/01/2016 To 02/29/2016	Part II Date/Time Pre 7/28/2016 7:4	
Related Cost (from Wkst. R) Part II, col. 1 + col. Charges Col unn 3 x col unn 4)							
CFrom Wisst B, Part I, col. Col. 1 - Col. Charges Column 4) Part II, col. 26) 1.00 2.00 3.00 4.00 5.00	Cost Center Description						
Part II. col. 26 1.00 2.00 3.00 4.00 5.00							
ANCILLARY SERVICE COST CENTERS					. Charges	column 4)	
NOTE			8)	2)			
ANCILLARY SERVICE COST CENTERS 50.00							
50. 00 05000 OPERATING ROOM 45, 174 1, 293, 368 0. 034927 16, 461 575 50. 00 51. 00 05100 RECOVERY ROOM 0 0. 000000 0 0. 51. 00 53. 00 05300 ANESTHESI OLOGY 165 340, 348 0. 000485 4, 949 2 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 88, 534 1, 667, 277 0. 053011 36, 895 1, 959 54. 00 57. 00 05700 CT SCAN 31, 725 1, 630, 023 0. 019463 73, 186 1, 424 57. 00 58. 00 05800 MRI 8, 595 440, 406 0. 019516 9, 958 194 58. 00 60. 00 06000 LABORATORY 20, 598 2, 334, 818 0. 008822 174, 157 1, 536 60. 00 65. 00 06500 RESPI RATORY THERAPY 7, 622 218, 652 0. 034859 79, 257 2, 763 65. 00 66. 00 06600 PHYSI CAL THERAPY 9, 673 265, 812 0. 034859 79, 257 2, 763 66. 00 67. 0	ANGULARY OFRIGO COOT OFFITTED	1.00	2.00	3.00	4. 00	5.00	
51. 00 0 5100 RECOVERY ROOM 0 0.000000 0 0 51. 00 53. 00 05300 ANESTHESI OLOGY 165 340,348 0.000485 4,949 2 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 88,534 1,667,277 0.053101 36,895 1,959 440,55 54.00 0.014463 73,186 1,424 57.00 58.00 0.05700 CT SCAN 31,725 1,630,023 0.019463 73,186 1,424 57.00 58.00 0.0800 MRI 8,595 440,406 0.019516 9,958 194 58.00 69.00 0.000000 0 0.000000 0 0 0.000000 0 0 0.000000 0 0 0.000000 0 0 0 0.000000 0 0 0.000000 0 0 0 0 0.00000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 <		1 45 45	1 200 0/4		=		
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54. 00 05400 RADI OLOGY-DI AGNOSTI C 88, 534 1, 667, 277 0.053101 36, 895 1, 959 54. 00 57. 00 05700 CT SCAN 31, 725 1, 630, 023 0.019463 73, 186 1, 424 57. 00 58. 00 05900 MRI 8,595 440, 406 0.019516 9,958 194 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0.000000 0 0 0 0.000000 0		() (0	
57. 00 05700 CT SCAN 31,725 1,630,023 0.019463 73,186 1,424 57. 00 58. 00 05800 MRI 8,595 440,406 0.019516 9,958 194 58. 00 59. 00 05900 CARDIAC CATHETERIZATION 0 0 0.000000 0 0.59.00 60. 00 06000 LABORATORY 20,598 2,334,818 0.008822 174,157 1,536 60. 00 65. 00 06200 WHOLE BLOOD & PACKED RED BLOOD 478 20,352 0.023487 4,434 104 62. 00 65. 00 06500 RESPIRATORY THERAPY 7,622 218,652 0.034859 79,257 2,763 65. 00 66. 00 06600 PHYSI CAL THERAPY 9,673 265,812 0.036390 7,014 255 66. 00 67. 00 06700 OCCUPATIONAL THERAPY 1,914 92,732 0.020640 8,728 180 67. 00 68. 00 06800 SPEECH PATHOLOGY 607 35,497 0.017100 5,195 89 68. 00 69. 00 06900 ELECTROCARDIOLOGY 6,040 474,992 0.012716 37,122 472 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 1,880 107,597 0.017473 33,422 584 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 144 50,956 0.002826 0 0 72. 00 07300 DRUGS CHARGED TO PATIENTS 12,276 1,393,493 0.008810 221,245 1,949 73. 00 076. 97 07697 CARDIAC REHABILITATION 0 0 0.000000 0 0 76. 97 00 09000 CLINIC 0 0 0.000000 0 0 0 0.000000 0 0 0.000000				•		•	
58. 00 05800 MRI MRI 8,595 MRI 440,406 O. 0.019516 9,958 O. 0.019516 9,958 O. 0.0590 O. 0.00000 194 S8. 00 58. 00 59. 00 0.000000 O. 0.00000 0.0000000 0.000000 0.000000 0.00				•			
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0.000000 0 0 59.00 60.00 06000 LABORATORY 20,598 2,334,818 0.008822 174,157 1,536 60.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD 478 20,352 0.023487 4,434 104 62.00 65.00 06500 RESPI RATORY THERAPY 7,622 218,652 0.034859 79,257 2,763 65.00 66.00 06600 PHYSI CAL THERAPY 9,673 265,812 0.036390 7,014 255 66.00 67.00 06700 OCCUPATI ONAL THERAPY 1,914 92,732 0.020640 8,728 180 67.00 68.00 06800 SPEECH PATHOLOGY 607 35,497 0.017100 5,195 89 68.00 69.00 69.00 ELECTROCARDI OLOGY 6,040 474,992 0.012716 37,122 472 69.00 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 1,880 107,597 0.017473 33,422 584 71.00 73				•			
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62. 00		,	(
65. 00		•					
66. 00 06600 PHYSI CAL THERAPY 9, 673 265, 812 0. 036390 7, 014 255 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 1, 914 92, 732 0. 020640 8, 728 180 67. 00 68. 00 06800 SPECH PATHOLOGY 607 35, 497 0. 017100 5, 195 89 68. 00 69. 00 06900 ELECTROCARDI OLOGY 6, 040 474, 992 0. 012716 37, 122 472 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 1, 880 107, 597 0. 017473 33, 422 584 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 144 50, 956 0. 002826 0 0. 72. 00 72. 00 07300 DRUGS CHARGED TO PATIENTS 12, 276 1, 393, 493 0. 008810 221, 245 1, 949 73. 00 76. 97 000000 CARDI AC REHABI LI TATI ON 0 0. 000000 0 0. 000000 0 0						l	
67. 00 06700 0CCUPATI ONAL THERAPY 1, 914 92, 732 0. 020640 8, 728 180 67. 00 68. 00 06800 SPECH PATHOLOGY 607 35, 497 0. 017100 5, 195 89 68. 00 69. 00 06900 ELECTROCARDI OLOGY 6, 040 474, 992 0. 012716 37, 122 472 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 1, 880 107, 597 0. 017473 33, 422 584 71. 00 72. 00 73. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 144 50, 956 0. 002826 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 12, 276 1, 393, 493 0. 008810 221, 245 1, 949 73. 00 76. 97 CARDI AC REHABI LI TATI ON 0 0 0. 000000 0 0 76. 97 000000 0 0 0. 000000 0 0							
68. 00 06800 SPEECH PATHOLOGY 607 35, 497 0. 017100 5, 195 89 68. 00 69. 00 06900 ELECTROCARDI OLOGY 6, 040 474, 992 0. 012716 37, 122 472 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 1, 880 107, 597 0. 017473 33, 422 584 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 144 50, 956 0. 002826 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 12, 276 1, 393, 493 0. 008810 221, 245 1, 949 73. 00 76. 97 OAGRI AC REHABILITATION 0 0 0. 000000 0 0 76. 97 OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0 0. 000000 0 0 90. 00 91. 00 09100 EMERGENCY 31, 591 2, 205, 762 0. 014322 104, 020 1, 490 91. 00 92. 00 09200 0BSERVATI ON BEDS (NON-DI STINCT 14, 232 404, 002 0. 035228 13, 229 466 92. 00							
69. 00 06900 ELECTROCARDI OLOGY 6, 040 474, 992 0. 012716 37, 122 472 69. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 1, 880 107, 597 0. 017473 33, 422 584 71. 00 72. 00							
71. 00						l .	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 144 50,956 0.002826 0 0 72. 00 73. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 12,276 1,393,493 0.008810 221,245 1,949 73. 00 76. 97 07697 CARDI AC REHABILITATION 0 0 0.000000 0 0 76. 97 000000 0 0 0 0 0 0 0							
73. 00 07300 DRUGS CHARGED TO PATIENTS 12, 276 1, 393, 493 0. 008810 221, 245 1, 949 73. 00 76. 97 07697 CARDI AC REHABILITATION 0 0 0. 000000 0 0 0 76. 97 0UTPATIENT SERVICE COST CENTERS 0 0. 000000 0 0 0 91. 00 09100 EMERGENCY 31, 591 2, 205, 762 0. 014322 104, 020 1, 490 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 14, 232 404, 002 0. 035228 13, 229 466 92. 00						l	
76. 97 O CARDI AC REHABILITATION O O O. 000000 O O O O. 076. 97 OUTPATIENT SERVICE COST CENTERS 90. 00 O O O O O O O O O O O O O O O O O				•			
OUTPATIENT SERVICE COST CENTERS 90. 00 09000 CLINIC 0 0.000000 0.000000 0 0 90. 00 91. 00 09100 EMERGENCY 31, 591 2, 205, 762 0.014322 104, 020 1, 490 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT 14, 232 404, 002 0.035228 13, 229 466 92. 00		12, 276	1, 393, 493	•			
90. 00) (0.00000	0 0	0	76. 97
91. 00 09100 EMERGENCY 31, 591 2, 205, 762 0. 014322 104, 020 1, 490 91. 00 92. 00 09200 09SERVATI ON BEDS (NON-DI STI NCT 14, 232 404, 002 0. 035228 13, 229 466 92. 00							1
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT 14, 232 404, 002 0. 035228 13, 229 466 92. 00		_	1				
	1			•			
200. 00 Total (lines 50-199) 281, 248 12, 976, 087 829, 272 14, 042 200. 00						l e	
	200.00 Total (lines 50-199)	281, 248	12, 976, 087	7	829, 272	14, 042	200.00

APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PASS THROUGH COSTS Provider CCN: 150102 Period: Worksheet D	
From 01/01/2016 Part III To 02/29/2016 Date/Time Prepared	·d·
7/28/2016 7: 42 pm	
Title XVIII Hospital PPS	
Cost Center Description Nursing School Allied Health All Other Swing-Bed Total Costs	
Cost Medical Adjustment (sum of cols.	
Education Cost Amount (see 1 through 3,	
instructions) minus col. 4)	
1.00 2.00 3.00 4.00 5.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30.00 03000 ADULTS & PEDIATRICS 0 0 0 0 0 30.0	
31.00 03100 INTENSIVE CARE UNIT 0 0 0 31.0	
200.00 Total (lines 30-199) 0 0 0 200.0	00
Cost Center Description Total Patient Per Diem (col. Inpatient Inpatient	
Days 5 ÷ col. 6) Program Days Program	
Pass-Through Pass-Through	
Cost (col. 7 x	
6.00 7.00 8.00 9.00	
INPATIENT ROUTINE SERVICE COST CENTERS	
30.00 03000 ADULTS & PEDIATRICS 380 0.00 138 0 30.0	00
31.00 03100 INTENSI VE CARE UNIT 0 0.00 0 31.0	00
200.00 Total (lines 30-199) 380 138 0 200.0	00

Health Financial Systems	IU HEALTH STARKE MEMOI	RLAL HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150102	From 01/01/2016	Worksheet D Part IV Date/Time Prepared:

				1	o 02/29/2016	Date/Time Pre 7/28/2016 7:4	
			Ti tl	e XVIII	Hospi tal	PPS	•
	Cost Center Description	Non Physician	Nursing School	Allied Health	All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1					
	05000 OPERATING ROOM	0	0)	0	0	50. 00
	05100 RECOVERY ROOM	0	0)	0	0	51. 00
	05300 ANESTHESI OLOGY	0	0)	0	0	53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
	05700 CT SCAN	0	0)	0	0	57. 00
	05800 MRI	0	0		0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
	06000 LABORATORY	0	0		0	0	60.00
	06200 WHOLE BLOOD & PACKED RED BLOOD	0	0		0	0	62. 00
	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
	07100 MEDICAL SUPPLIES CHARGED TO PAT	0	Ü		0	0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	Ü		0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	Ü		0	0	73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0) () 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS				.l		
	09000 CLI NI C	0	Ü)	0	0	70.00
	09100 EMERGENCY	0	0		0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT	0	0			0	
200.00	Total (lines 50-199)	0	0	ıl (기 이	0	200. 00

Health Financial Systems	IU HEALTH STARKE MEMORIAL HOSPITAL			eu of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILL	RY SERVICE OTHER PASS	Provi der CCN: 150102	Peri od:	Worksheet D

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERTHROUGH COSTS	VICE OTHER PAS	S	Provi der		Period: From 01/01/2016 To 02/29/2016	Worksheet D Part IV Date/Time Pre 7/28/2016 7:4	
			Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Total			Ratio of Cos		I npati ent	
	Outpati ent		Wkst. C,			Program	
	Cost (sum of	Part		(col. 5 ÷ col		Charges	
	col. 2, 3 and		8)	7)	(col . 6 ÷ col .		
	4)				7)	10.00	
ANOLLI ADV. CEDVI OF COCT. CENTEDO	6. 00		7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS	0	ı	1 202 2/0	0.00000	0.00000	1/ 1/1	
50. 00 05000 OPERATING ROOM 51. 00 05100 RECOVERY ROOM	0		1, 293, 368	1		16, 461	50. 00 51. 00
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY	0		340, 348	0. 00000 0. 00000		0 4, 949	
53. 00 05300 ANESTHESTOLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		340, 348 1, 667, 277	1		36, 895	
57. 00 05700 CT SCAN	0		1, 630, 023	1		73, 186	
58. 00 05800 MRI	0		440, 406			9, 958	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		440, 400	1		7, 750 O	59.00
60. 00 06000 LABORATORY	0		2, 334, 818			174, 157	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD	0		20, 352	l .		4, 434	
65. 00 06500 RESPIRATORY THERAPY	0		218, 652	1		79, 257	
66. 00 06600 PHYSI CAL THERAPY	0		265, 812			7, 014	
67. 00 06700 OCCUPATI ONAL THERAPY	0		92, 732			8, 728	
68. 00 06800 SPEECH PATHOLOGY	0		35, 497			5, 195	
69. 00 06900 ELECTROCARDI OLOGY	0		474, 992			37, 122	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0		107, 597			33, 422	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		50, 956	1		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		1, 393, 493	1		221, 245	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0		0	0.00000	0. 000000	0	76. 97
OUTPATIENT SERVICE COST CENTERS							ĺ
90. 00 09000 CLI NI C	0		0	0.00000	0. 000000	0	90.00
91. 00 09100 EMERGENCY	0		2, 205, 762	0.00000	0. 000000	104, 020	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0		404, 002	0.00000	0. 000000	13, 229	
200.00 Total (lines 50-199)	0	1	2, 976, 087			829, 272	200.00

In Lieu of Form CMS-2552-10

| Period: | Worksheet D |
| From 01/01/2016 | Part IV |
| To 02/29/2016 | Date/Time Prepared: | 7/28/2016 | 7:42 pm | THROUGH COSTS

						7/28/2016 7:4	42 pm
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8		Costs (col. 9			
		x col. 10)		x col. 12)			
		11. 00	12. 00	13. 00			
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	363, 894	· c)		50.00
51.00	05100 RECOVERY ROOM	0	0) c			51.00
53.00	05300 ANESTHESI OLOGY	0	102, 502	c c			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	372, 156	d c)		54. 00
57.00	05700 CT SCAN	0	440, 064	. c)		57. 00
58.00	05800 MRI	0	84, 972	c c)		58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0	ol c)		59. 00
60.00	06000 LABORATORY	o	332, 585	c)		60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD	O	8, 338	c)		62. 00
65.00	06500 RESPI RATORY THERAPY	0	20, 425	l c)		65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	l c)		66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	l c)		67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	l c)		68. 00
69. 00	06900 ELECTROCARDI OLOGY	o	152, 121	1 0)		69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT	o	23, 410	1)		71. 00
		o	8, 643	1)		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	o	234, 457)		73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	o	0)		76. 97
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			•		
90.00	09000 CLI NI C	0	0	C)		90.00
91. 00	09100 EMERGENCY	o	490, 334				91.00
	· ·	o	162, 031	1			92.00
200.00		0	2, 795, 932	1)		200. 00

Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL In Lieu of Form CMS-2552-10							
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Peri od: From 01/01/2016	Worksheet D Part V		
				To 02/29/2016		pared.	
				02/2//2010	7/28/2016 7:4	2 pm	
		Ti tl	e XVIII	Hospi tal	PPS		
			Charges		Costs		
Cost Center Description	Cost to Charge			Cost	PPS Services		
	Ratio From	Servi ces (see	Reimbursed	Rei mbursed	(see inst.)		
	Worksheet C,	inst.)	Servi ces	Services Not			
	Part I, col. 9		Subject To	Subject To			
			Ded. & Coins.				
	4.00	0.00	(see inst.)	(see inst.)	F 00		
ANCILLARY CERVICE COCT CENTERS	1.00	2.00	3. 00	4. 00	5. 00		
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	0.415550	2/2 004	Ι	0	151 017	50.00	
50.00 05000 0PERATI NG ROOM 51.00 05100 RECOVERY ROOM	0. 415552 0. 000000			0 0	151, 217	1	
		l .		0	0 1, 273		
	0. 012420			0	1, 273 193, 670		
	0. 520401 0. 054292	372, 156		0			
				0	23, 892		
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 196818 0. 000000			0	16, 724	1	
	0. 000000	332, 585		0	70.405		
60. 00 06000 LABORATORY				0	70, 405		
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD 65. 00 06500 RESPIRATORY THERAPY	0. 798202 0. 678892			0	6, 655		
66. 00 06600 PHYSI CAL THERAPY	0. 678892	20, 425		0	13, 866		
		0		0	0		
· · · · · · · · · · · · · · · · · · ·	0. 571367	0		0	_	1	
· · · · · · · · · · · · · · · · · · ·	0. 332930 0. 180837			0	0		
69. 00 06900 ELECTROCARDIOLOGY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 523658	152, 121 23, 410		0	27, 509 12, 259		
72. 00 07200 MPL. DEV. CHARGED TO PATIENTS	0. 523658	8, 643		0	715		
73. 00 07300 DRUGS CHARGED TO PATIENTS				0 10, 089			
76. 97 07697 CARDIAC REHABILITATION	0. 272242 0. 000000			0 10, 089	63, 829 0	1	
OUTPATIENT SERVICE COST CENTERS	0.000000			U U	U	70.97	
90. 00 09000 CLINIC	0. 000000			0	0	90.00	
91. 00 09100 EMERGENCY	0. 280917	490, 334		0 0	137, 743		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 608014			0	98, 517		
200.00 Subtotal (see instructions)	0.008014	2, 795, 932		0 10, 089	818, 274		
201.00 Less PBP Clinic Lab. Services-Program		2, 173, 732		0 10,009	010, 274	201. 00	
Only Charges						201.00	
202.00 Net Charges (line 200 +/- line 201)		2, 795, 932		0 10, 089	818, 274	202. 00	
1 1 2 2 3 3 2 4 3 2 3 3 3 3 3 3 3 3 3 3 3 3	1	, , , , , , , , , , , , , , , , , , , ,	1	1 .,	· · · · · ·		

Provi der CCN: 150102

Title XVIII Hospital PPS					10 02/2//2010	7/28/2016 7: 42 pm
Cost Center Description			Ti tl	e XVIII	Hospi tal	PPS
Reimbursed Services Not Subject To Ded. & Colns See inst.)		Cos	sts			
Services Subject To Ded. & Coins. Sevices Subject To Ded. & Subject To	Cost Center Description	Cost	Cost			
Subject To Ded. & Coin s. Cose inst. Subject To Ded. & Coin s. Cose inst. See inst. See inst. To Ded. & Coin s. Cose inst. See inst. To Ded. & Coin s. Cose inst. See inst. To Ded. & Coin s. Cose inst. See inst. To Ded. & Coin s. Cose inst. To Ded. & Coin s. Coin s. Ded. & Coin s. Coin s. Ded. & Ded. Ded. & Ded.						
Ded. & Coi ns. See inst. Ded. & Coi ns. Ded. Ded. & Coi ns. Ded. Ded. Ded. Ded. Ded. Ded. Ded. Ded.						
ANCI LLARY SERVICE COST CENTERS 6.00 7.00						
ANCILLARY SERVICE COST CENTERS						
ANCILLARY SERVICE COST CENTERS						
50.00 05000 0FERATING ROOM 0 0 0 0 0 0 0 0 0	ANOLULARY CERVI OF COCT OFNITERS	6.00	7.00			
51.00			1 0	I		F0.00
53. 00 05300 ANESTHESI OLOGY 0 0 0 54.00 ADI OLOGY-DI AGNOSTI C 0 0 0 55.00 05700 CT SCAN 0 0 0 0 0 55.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0		0	0			
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 57. 00 57. 00 57. 00 57. 00 57. 00 58. 00 05800 MRI 0 0 0 0 0 0 0 0 0		0	0			
57. 00 05700 CT SCAN 0 0 0 0 58. 00 58. 00 58. 00 58. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 59. 00 60. 0		0	0			
58. 00 05800 MRI 0 0 0 0 59. 00 60.00		0				
59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 0 0						
60.00 06000 LABORATORY 0 0 0 0 62.00 WHOLE BLOOD & PACKED RED BLOOD 0 0 0 0 62.00 WHOLE BLOOD & PACKED RED BLOOD 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0				
62. 00						
65. 00	I I					•
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PAT 0 0 0 72. 00 07200 IMPL DEV. CHARGED TO PATI ENTS 0 0 0 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 2,747 73. 00 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 76. 97 0000 O9100 EMERGENCY 0 0 79. 00 09100 EMERGENCY 0 0 79. 00 09200 O9SERVATI ON BEDS (NON-DI STI NCT 0 0 70. 00 O100 CLESS PBP CLI in ic Lab. Services-Program 0 70. 00 Onl y Charges 0 0 70. 00 00 00		0				
67. 00						
68. 00						
69. 00 71. 00 771. 00 771. 00 772. 00 772. 00 773. 00 773. 00 773. 00 774. 075. 075. 075. 075. 075. 075. 075. 075	· · · · · · · · · · · · · · · · · · ·	0				
71. 00		0	0			
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 0 0 0 0 0 0	· · · · · · · · · · · · · · · · · · ·	0	0			•
73. 00 76. 97 07697 0		0	0			
76. 97 O7697 CARDI AC REHABILITATION O O O O O O O O O O O O O O O O O O		0	2.747			
90. 00 91. 00 92. 00 920. 00 920. 00 921. 00 921. 00 921. 00 922. 00 923. 00 924. 00 925. 00 925. 00 926. 00 927. 00 927. 00 927. 00 928. 00 928. 00 928. 00 928. 00 928. 00 928. 00 928. 00 929. 00 929. 00 929. 00 9200.		0		i		76. 97
91. 00	OUTPATIENT SERVICE COST CENTERS					
92. 00 09200 08SERVATI ON BEDS (NON-DISTINCT 0 0 200. 00 201. 00 0 0 0 0 0 0 0 0 0	90. 00 09000 CLI NI C	0	0			90.00
200.00 Subtotal (see instructions) 0 2,747 200.00 Less PBP Clinic Lab. Services-Program 0 0nly Charges	91. 00 09100 EMERGENCY	0	0			91.00
201.00 Less PBP Clinic Lab. Services-Program 0 201.00 Only Charges	92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0	0			92. 00
Only Charges	200.00 Subtotal (see instructions)	0	2, 747			200. 00
		0				201. 00
202.00 Net Charges (line 200 +/- line 201) 0 2,747 202.00						
	202.00 Net Charges (line 200 +/- line 201)	0	2, 747			202. 00

Health Financial Systems IU	HEALTH STARKE N	MEMORI	AL HOSPIT	AL	In l	_i eu	of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS		Provi der		Peri od:		Worksheet D	
					From 01/01/20 To 02/29/20		Part I Date/Time Pre	narod:
					10 02/29/20	10	7/28/2016 7:4	
			Ti t	le XIX	Hospi tal		PPS	
Cost Center Description	Capi tal	Sw	ing Bed	Reduced	Total Patie	nt F	Per Diem (col.	
	Related Cost	Adj	ustment	Capi tal	Days		3 / col. 4)	
	(from Wkst. B,			Related Cost				
	Part II, col.			(col. 1 - col				
	26)			2)				
	1.00		2.00	3. 00	4. 00		5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 ADULTS & PEDI ATRI CS	37, 043		C	37, 04	3	380	97. 48	30. 00
31.00 INTENSIVE CARE UNIT	0				0	0	0.00	31.00
200.00 Total (lines 30-199)	37, 043			37, 04	3	380		200. 00
Cost Center Description	I npati ent	Ιn	pati ent					
	Program days	P	rogram					
		Capi	tal Cost					
		(col.	5 x col.					
			6)					
	6.00		7. 00					
INPATIENT ROUTINE SERVICE COST CENTERS								
30. 00 ADULTS & PEDI ATRI CS	0		C					30. 00
31.00 INTENSIVE CARE UNIT	0		C					31.00
200.00 Total (lines 30-199)	0		C)				200. 00

ıl th Financi al	Systems	IU HEALTH STARKE MEMORI	AL HOSPIT	ΓAL	In Li	eu of Form CMS-2552-10

Health Financial Systems IU	HEALTH STARKE N	MEMORI AL	HOSPI T	AL	I	n Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Pr			Period: From 01/01 To 02/29	/2016	Worksheet D Part II Date/Time Pre 7/28/2016 7:4	
				le XIX	Hospi ta	al	PPS	
Cost Center Description	Capi tal			Ratio of Cos			Capital Costs	
	Related Cost				Progra		(column 3 x	
	(from Wkst. B,			(col. 1 ÷ col	. Charge	es	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	45, 174	1, 2	293, 368			1, 338		
51.00 05100 RECOVERY ROOM	0		0	0.00000		0	0	51.00
53. 00 05300 ANESTHESI OLOGY	165	l	340, 348	•		5, 148	2	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	88, 534		667, 277			7, 709	940	54.00
57. 00 05700 CT SCAN	31, 725		530, 023	1		2, 404	436	57. 00
58. 00 05800 MRI	8, 595	4	440, 406	1		5, 975	117	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	1	0	0.00000		0	0	59. 00
60. 00 06000 LABORATORY	20, 598	2, 3	334, 818			6, 912	502	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	478		20, 352	0. 02348	i7	0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	7, 622	2	218, 652	0. 03485	9 2	6, 293	917	65. 00
66. 00 06600 PHYSI CAL THERAPY	9, 673	2	265, 812	0. 03639	0	402	15	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	1, 914		92, 732	0. 02064	.0	402	8	67.00
68. 00 06800 SPEECH PATHOLOGY	607		35, 497	0. 01710	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	6, 040	4	474, 992	0. 01271	6	9, 331	119	69. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	1, 880	1	107, 597	0. 01747	3	6,075	106	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	144		50, 956	0. 00282	:6	0	0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	12, 276	1, 3	393, 493	0. 00881	0 7	7, 303	681	73. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	i .	0	0. 00000	0	0	0	76. 97
OUTPATIENT SERVICE COST CENTERS	•			•				
90. 00 09000 CLI NI C	0		C	0.00000	0	0	0	90.00
91. 00 09100 EMERGENCY	31, 591	2, 2	205, 762	0. 01432	2 3	5, 813	513	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT	14, 232	4	404, 002	0. 03522	8	4, 830	170	92. 00
200.00 Total (lines 50-199)	281, 248	12, 9	976, 087	'	29	9, 935	5, 621	200. 00

Health Financial Systems IU I	HEALTH STARKE M	MEMORIAL HOSPIT	AL	In Li€	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COS	TS Provi der		Period: From 01/01/2016 To 02/29/2016		pared:
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Nursing School	Cost	All Other Medical Education Cos		Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2. 00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	•			<u>'</u>	•	
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 200. 00 Total (lines 30-199)	0 0	0		0 0 0	0 0	30. 00 31. 00 200. 00
Cost Center Description	Total Patient Days 6.00	Per Diem (col. 5 ÷ col. 6)	Inpatient Program Days 8.00	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00		
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 200. 00 Total (lines 30-199)	380 0 380	0.00	1	0 0		30. 00 31. 00 200. 00

Health Financial Systems	IU HEALTH STARKE MEMORI	AL HOSPITAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150102		Worksheet D	
THROUGH COSTS			From 01/01/2016	Part IV	

THROUG		S	WICE UTHER PAS	3	Pi ovi dei		From 01/01/2016 To 02/29/2016		pared: 2 pm
						le XIX	Hospi tal	PPS	
		Cost Center Description	Non Physician Anesthetist	Nursi	ng School	Allied Healt	h All Other Medical	Total Cost (sum of col 1	
			Cost				Education Cost	through col.	
			1.00		2.00	3.00	4. 00	5. 00	
	ANCI LI	LARY SERVICE COST CENTERS							
		OPERATING ROOM	C		C		0	0	50. 00
51.00		RECOVERY ROOM	C		C)	0	0	51.00
53.00		ANESTHESI OLOGY	C)	C)	0	0	53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	C		C)	0	0	54. 00
57. 00		CT SCAN	C		C		0	0	57. 00
58. 00	05800		C		C		0	0	58. 00
59. 00		CARDI AC CATHETERI ZATI ON	C		C		0	0	59. 00
60.00		LABORATORY	C		C)	0	0	60. 00
62.00		WHOLE BLOOD & PACKED RED BLOOD	C)	C		0	0	62. 00
65. 00		RESPI RATORY THERAPY	C)	C		0	0	65. 00
66. 00		PHYSI CAL THERAPY	C)	C		0	0	66. 00
67. 00		OCCUPATIONAL THERAPY	C)	C		0	0	67. 00
		SPEECH PATHOLOGY	C)	C		0	0	68. 00
		ELECTROCARDI OLOGY	C)	C		0	0	69. 00
		MEDICAL SUPPLIES CHARGED TO PAT	C)	C		0	0	71. 00
		IMPL. DEV. CHARGED TO PATIENTS	C)	C		0	0	72. 00
		DRUGS CHARGED TO PATIENTS	C)	C		0	0	73. 00
76. 97		CARDIAC REHABILITATION	C		C)	0 0	0	76. 97
		TIENT SERVICE COST CENTERS							
90. 00		CLI NI C	C)	C)	0	0	90. 00
		EMERGENCY	C)	C)	0	0	91. 00
	1	OBSERVATION BEDS (NON-DISTINCT	C)	C)	0	0	92. 00
200.00)	Total (lines 50-199))	C)	0	0	200.00

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

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PAS			CCN: 150102	Period: From 01/01/2016 To 02/29/2016	Worksheet D Part IV Date/Time Pre	
						7/28/2016 7: 4	2 pm
				le XIX	Hospi tal	PPS	
Cost Center Description	Total			Ratio of Cost		I npati ent	
	Outpati ent		Wkst. C,				
	Cost (sum of	1		(col . 5 ÷ col	9	Charges	
	col. 2, 3 and		8)	7)	(col . 6 ÷ col .		
	4)		7.00	0.00	7)	10.00	
ANCILL ADV. SEDVICE COST SENTEDS	6. 00		7. 00	8. 00	9. 00	10. 00	
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		VI.	1 202 260	0.00000	0. 000000	31, 338	50.00
		()	1, 293, 368	0.00000			51.00
51. 00 05100 RECOVERY ROOM 53. 00 05300 ANESTHESI OLOGY		()	340, 348			0	
53. 00 05300 ANESTHESTOLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C		()	340, 348 1, 667, 277			5, 148 17, 709	
57. 00 05700 CT SCAN			1, 630, 023			22, 404	
58. 00 05700 CT SCAN		()	440, 406			5. 975	
59. 00 05900 CARDI AC CATHETERI ZATI ON		()	440, 400	0.00000		5, 9/5	59.00
60. 00 06000 LABORATORY		()	2, 334, 818			56, 912	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD			20, 352			30, 412	62.00
65. 00 06500 RESPIRATORY THERAPY			20, 352			26, 293	
66. 00 06600 PHYSI CAL THERAPY		()	265, 812			402	
67. 00 06700 OCCUPATI ONAL THERAPY		()	92, 732			402	
68. 00 06800 SPEECH PATHOLOGY		ál –	35, 497			0	
69. 00 06900 ELECTROCARDI OLOGY		()	474, 992			9, 331	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT		()	107, 597			6, 075	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS		ál –	50, 956			0,073	1
73. 00 07300 DRUGS CHARGED TO PATIENTS		S)	1, 393, 493			77. 303	
76. 97 07697 CARDI AC REHABI LI TATI ON		S)	1, 373, 473	0.00000			
OUTPATIENT SERVICE COST CENTERS		<u>′1 </u>		0.00000	0. 000000		70. 77
90. 00 09000 CLI NI C			0	0.00000	0. 000000	0	90.00
91. 00 09100 EMERGENCY			2, 205, 762				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT			404, 002			•	92.00
200.00 Total (lines 50-199)	0	1	2, 976, 087		3.00000	299, 935	
	1			1	1		

THROUGH COSTS

					02,27,2010	7/28/2016 7:	
			Title	XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati e	ent (Outpati ent			
	Program	Progra		Program			
	Pass-Through	Charge		ass-Through			
	Costs (col. 8			osts (col. 9			
	x col. 10)			x col. 12)			
ANGLE ARY OFRILL OF COOT OFFITERS	11. 00	12. 00		13. 00			
ANCILLARY SERVICE COST CENTERS			ما				
50. 00 05000 OPERATI NG ROOM	0		0	0			50.00
51. 00 05100 RECOVERY ROOM	0		0	0			51.00
53. 00 05300 ANESTHESI OLOGY	0		0	0			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0		0	0			54.00
57. 00 05700 CT SCAN	0		0	0			57. 00
58. 00 05800 MRI	0		0	0			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		0	0			59. 00
60. 00 06000 LABORATORY	0		0	0			60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD	0		0	0			62. 00
65. 00 06500 RESPIRATORY THERAPY	0		0	0			65. 00
66. 00 06600 PHYSI CAL THERAPY	0		0	0			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0		0	0			67. 00
68. 00 06800 SPEECH PATHOLOGY	0		O	0			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		O	0			69. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0		O	0			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		O	0			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0		0	0			73. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON	0		0	0			76. 97
OUTPATIENT SERVICE COST CENTERS							4
90. 00 09000 CLI NI C	0		O	0			90.00
91. 00 09100 EMERGENCY	0		0	0			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0		0	0			92.00
200.00 Total (lines 50-199)	0		0	0			200. 00

Health Financial Systems	HEALTH STARKE N	MEMORIAL HOSPIT	AL	In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		1	Period: From 01/01/2016 To 02/29/2016	Date/Time Pre 7/28/2016 7:4	pared: 2 pm
		Ti t	le XIX	Hospi tal	PPS	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see		Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0. 415552		345, 37	9 0	0	00.00
51. 00 05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
53. 00 05300 ANESTHESI OLOGY	0. 012420	0	86, 85	7 0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 520401	0	308, 34	7 0	0	54.00
57. 00 05700 CT SCAN	0. 054292	0	340, 53	6 0	0	57.00
58. 00 05800 MRI	0. 196818	0	117, 50	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59.00
60. 00 06000 LABORATORY	0. 211691	0	534, 99	7 0	0	60.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD	0. 798202	0	3, 03	2 0	0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 678892	0	16, 08	2 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 444984	l o	75, 90	7 0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 571367	0	49, 34		0	1
68. 00 06800 SPEECH PATHOLOGY	0. 332930	0	20, 66		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 180837	0	102, 68		0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	0. 523658	0	13, 30		0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 082777	0	15, 32		0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 272242	l o			0	1
76. 97 O7697 CARDIAC REHABILITATION	0. 000000			0	0	
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	0. 000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 280917	l	840, 70		0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT	0. 608014	l	89, 88		0	1
200.00 Subtotal (see instructions)	0.000011	0				200.00
201.00 Less PBP Clinic Lab. Services-Program		Ĭ	3, 233, 00		Ĭ	201. 00
Only Charges]			
202.00 Net Charges (line 200 +/- line 201)		0	3, 235, 03	2 0	0	202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provi der CCN: 150102 Peri od: Worksheet D From 01/01/2016 To 02/29/2016 Part V Date/Time Prepared: 7/28/2016 7:42 pm Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 143, 523 0 50.00 51.00 05100 RECOVERY ROOM 0 51.00 53. 00 05300 ANESTHESI OLOGY 1.079 0 53.00 54. 00 | 05400 | RADI OLOGY-DI AGNOSTI C 0 160, 464 54.00 57. 00 05700 CT SCAN 18, 488 57.00 0 58.00 05800 MRI 23, 126 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 60. 00 06000 LABORATORY 113, 254 0 60.00 06200 WHOLE BLOOD & PACKED RED BLOOD 0 62.00 2, 420 62.00 0 06500 RESPIRATORY THERAPY 10, 918 65 00 65 00 66.00 06600 PHYSI CAL THERAPY 33, 777 66.00 67.00 06700 OCCUPATI ONAL THERAPY 28, 195 0 67.00 06800 SPEECH PATHOLOGY 68.00 6,880 0 68.00 06900 ELECTROCARDI OLOGY 0 18, 570 69.00 69.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT 6, 967 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1, 268 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 74, 727 07697 CARDIAC REHABILITATION 76. 97 76.97 0 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 0 90.00 09100 EMERGENCY 236, 167 91.00 0 91.00

54, 649

934, 472

934, 472

0

0

0

92.00

200.00

201. 00

202.00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT

Only Charges

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

200.00

201.00

202.00

Health Financial Systems	IU HEALTH STARKE MEMORI	AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150102	Peri od: From 01/01/2016	Worksheet D-1	
			To 02/29/2016	Date/Time Pre 7/28/2016 7:4	
		Title XVIII	Hospi tal	PPS	
Cost Contor Description					

		Title XVIII	Hospi tal	7/28/2016 7: 4 PPS	2 pm
	Cost Center Description		·	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
1 00	I NPATI ENT DAYS			200	1 00
1. 00 2. 00	Inpatient days (including private room days and swing-bed days, Inpatient days (including private room days, excluding swing-be			380 380	1. 00 2. 00
3. 00	Private room days (excluding swing-bed and observation bed days		vate room days,	0	3. 00
	do not complete this line.				
4.00	Semi-private room days (excluding swing-bed and observation bed		- 21 -6	234	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	5. 00
6. 00	Total swing-bed SNF type inpatient days (including private room	days) after December 3	31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)				
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room	davs) after December 3	1 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swi ng-bed and	138	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	nom dave)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructi		Join days)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	oom days) after	0	11. 00
12.00	December 31 of the cost reporting period (if calendar year, ent			0	10.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including private	e room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar yea				
14. 00 15. 00	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	(excluding swing-bed	days)	0	14. 00 15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
.0.00	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17. 00
18. 00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 21 of	the cost	0.00	18. 00
10.00	reporting period	arter becember 31 or	the cost	0.00	16.00
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	after December 31 of th	ne cost	0.00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions)			639, 336	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December	31 of the cost reporti	na period (line	034, 330	22.00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reporting	g period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	31 of the cost reportio	na period (line	0	24. 00
21.00	7 x line 19)	or or the cost reporter	ig perrou (irrie	· ·	21.00
25. 00	Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25. 00
26. 00	x line 20) Total swing-bed cost (see instructions)			0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (ine 21 minus line 26)		639, 336	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	•		0.00	32. 00
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33. 00
34.00	Average per diem private room charge differential (line 32 minu	s line 33)(see instruc	tions)	0.00	34.00
35.00	Average per diem private room cost differential (line 34 x line	31)		0.00	35. 00
36. 00	Private room cost differential adjustment (line 3 x line 35)			0	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	639, 336	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			
20 00	Adjusted general inpatient routine service cost per diem (see i			1 400 44	20 00
38. 00 39. 00	Program general inpatient routine service cost per diem (see i	•		1, 682. 46 232, 179	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Program	•		232, 179	40.00
	Total Program general inpatient routine service cost (line 39 +	•		232, 179	
	, J J production of the control of t	*	'	-=1 1	

COMPUT	ATION OF INPATIENT OPERATING COST	HEALTH STARKE M	Provi d	der	CCN: 150102	Period:	Worksheet D-1	
						From 01/01/2016 To 02/29/2016	Date/Time Pre	nared·
			_				7/28/2016 7: 4	
	Cost Center Description	Total	Total	ı tı	e XVIII Average Per	Hospital Program Days	PPS Program Cost	
	Cost Conten Description	Inpatient Cost		ays			(col. 3 x col.	
		1.00	2. 00		col . 2) 3.00	4. 00	<u>4)</u> 5. 00	
2. 00	NURSERY (title V & XIX only)	1.00	2.00		3.00	4.00	5.00	42. 00
	Intensive Care Type Inpatient Hospital Units							
3. 00	INTENSIVE CARE UNIT	0		0	0.0	00	0	
4.00	CORONARY CARE UNIT							44.00
5. 00 6. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT							45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)							47. 00
7.00	Cost Center Description							47.00
	Social solitor poson pri on						1. 00	
8. 00	Program inpatient ancillary service cost (Wks						260, 327	
9. 00	Total Program inpatient costs (sum of lines A PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instruc	tio	ns)		492, 506	49.00
0. 00	Pass through costs applicable to Program inpa	atient routine	services (f	rom	Wkst. D, sum	of Parts I and	13, 452	50.00
1. 00	<pre>III) Pass through costs applicable to Program inpa</pre>	atient ancillar	y services	(fr	om Wkst. D, s	sum of Parts II	14, 042	51. 00
2. 00	and IV) Total Program excludable cost (sum of lines!	50 and 51)					27, 494	52. 00
3. 00	Total Program inpatient operating cost exclud	ding capital re	lated, non-	phy	sician anesth	etist, and	465, 012	
	medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION	52)						
4. 00	Program discharges						0	54.00
5. 00	Target amount per discharge						0.00	
6. 00	Target amount (line 54 x line 55)						0	
7. 00	Difference between adjusted inpatient operati	ing cost and ta	rget amount	(1	ine 56 minus	line 53)	0	57.00
8. 00	Bonus payment (see instructions)						0	58.00
9. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period	endi ng 1996	, u	pdated and co	empounded by the	0. 00	59. 00
0. 00	Lesser of lines 53/54 or 55 from prior year (cost report un	dated by th	ne m	arket basket		0.00	60.00
1. 00	If line 53/54 is less than the lower of lines					the amount by	0	
	which operating costs (line 53) are less than							
	amount (line 56), otherwise enter zero (see i	nstructions)				-		
2. 00	Relief payment (see instructions)						0	
3. 00	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)				0	63.00
4. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of	the	cost reporti	ng period (See	0	64.00
4. 00	instructions)(title XVIII only)	ts through beec	iliber 31 of	tric	cost reporti	ing period (see	O	04.00
5. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts after Decemb	er 31 of th	ie c	ost reporting	period (See	0	65.00
6. 00	Total Medicare swing-bed SNF inpatient routing	ne costs (line	64 plus lin	e 6	5)(title XVII	I only). For	0	66. 00
7. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 3	1 o	f the cost re	porting period	0	67. 00
8. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	a costs after D	ocombor 21	of	the cost rone	erting ported	0	69 00
8.00	(line 13 x line 20)	e costs after b	ecember 31	01	the cost repo	orting period	U	68. 00
9. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU						0	69. 00
0. 00	Skilled nursing facility/other nursing facili							70.00
1. 00	Adjusted general inpatient routine service co	,			, ,			71.00
2. 00	Program routine service cost (line 9 x line							72.00
3. 00	Medically necessary private room cost application				ne 35)			73. 00
4. 00	Total Program general inpatient routine servi	,		,				74.00
5. 00	Capital-related cost allocated to inpatient	routine service	costs (fro	m W	orksheet B, P	art II, column		75.00
5. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)						76. 00
7. 00	Program capital-related costs (line 9 x line							77. 00
3. 00	Inpatient routine service cost (line 74 minus	•						78. 00
9. 00	Aggregate charges to beneficiaries for excess	, ,			•			79.00
0. 00	Total Program routine service costs for compa		ost limitat	i on	(line 78 min	us line 79)		80.00
	Innatient routine service cost per diem limi:							81 N

						7/28/2016 7:4	2 pm
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total npatient Days		Program Days	Program Cost (col. 3 x col.	
		1.00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42.00	NURSERY (title V & XIX only)	1.00	2.00	3.00	4.00	3.00	42. 00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	0	0	0.00	0	0	43. 00
44.00	CORONARY CARE UNIT						44. 00
45.00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00							47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wk	c+ D 2 col 2	line 200)			1. 00	48. 00
49. 00	Total Program inpatient costs (sum of lines		,	ns)		492, 506	
17. 00	PASS THROUGH COST ADJUSTMENTS	Tr trii ougir 10) (s	see matraetre	113)		172,000	17.00
50.00	Pass through costs applicable to Program inp	atient routine s	services (from	Wkst. D, sum	of Parts I and	13, 452	50.00
	111)						
51. 00	Pass through costs applicable to Program inp	atient ancillary	y services (fr	om Wkst. D, su	m of Parts II	14, 042	51. 00
F0 00	and IV)	FO F4)				07.404	F0 00
52.00	Total Program excludable cost (sum of lines				±: _ ±	27, 494	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-pny	sician anestne	tist, and	465, 012	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	32)					
54.00	Program di scharges					0	54.00
	Target amount per discharge					0.00	
56.00	Target amount (line 54 x line 55)					0	56. 00
57.00	Difference between adjusted inpatient operat	ing cost and tar	get amount (I	ine 56 minus I	ine 53)	0	57. 00
58. 00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period e	endi ng 1996, u	pdated and com	pounded by the	0.00	59. 00
(0.00	market basket		da+ad by +ba m	ankat baakat		0.00	(0.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of line				ho amount by	0.00	60.00
01.00	which operating costs (line 53) are less than					0	01.00
	amount (line 56), otherwise enter zero (see		3 (1111C3 54 X	00), 01 1% 01	the target		
62.00	Relief payment (see instructions)	,				0	62. 00
63.00	Allowable Inpatient cost plus incentive paym	ent (see instrud	ctions)			0	63. 00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Decer	mber 31 of the	cost reportin	g period (See	0	64. 00
45.00	instructions)(title XVIII only)		04 6 11				/ F 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts arter Decembe	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line 6	64 plus line 6	5)(title XVIII	only) For	0	66. 00
00.00	CAH (see instructions)		5. p. uoo o	0)((::::0 /	o y) o.		00.00
67.00	Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 c	f the cost rep	orting period	0	67. 00
	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after De	ecember 31 of	the cost repor	ting period	0	68. 00
40.00	(line 13 x line 20)	routing goots (ino (7 i lino	(0)		0	(0.00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER N					0	69. 00
70 00	Skilled nursing facility/other nursing facil						70.00
71.00	Adjusted general inpatient routine service of						71.00
72. 00	Program routine service cost (line 9 x line			•			72. 00
73.00	Medically necessary private room cost applic	able to Program	(line 14 x li	ne 35)			73. 00
74.00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)				74. 00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	orksheet B, Pa	rt II, column		75. 00
7/ 00	26, line 45)	2)					7/ 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line	,					76. 00 77. 00
78.00	Inpatient routine service cost (line 74 minu						78.00
79. 00	Aggregate charges to beneficiaries for exces		ovi der record	5)			79.00
80. 00	Total Program routine service costs for compa			•	s line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82. 00	Inpatient routine service cost limitation ()				82. 00
83. 00	Reasonable inpatient routine service costs (83. 00
84.00	Program inpatient ancillary services (see in						84. 00
85. 00	Utilization review - physician compensation						85. 00
86. 00	Total Program inpatient operating costs (sum		ough 85)				86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS						
87. 00	Total observation bed days (see instructions	•	1: 2)			146	
88. 00 89. 00	Adjusted general inpatient routine cost per of the servation had cost (line 87 v line 88) (see		rine 2)			1, 682. 46 245, 639	
07.00	Observation bed cost (line 87 x line 88) (se	e matructions)				240, 039	J 07. UU

Health Financial Systems IU H	HEALTH STARKE M	MEMORIAL HOSPIT	AL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2016 To 02/29/2016	Date/Time Prep 7/28/2016 7:43	
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	37, 043	639, 336	0. 05794	0 245, 639	14, 232	90. 00
91.00 Nursing School cost	0	639, 336	0.00000	0 245, 639	0	91.00
92.00 Allied health cost	0	639, 336	0.00000	0 245, 639	0	92.00
93.00 All other Medical Education	0	639, 336	0. 00000	0 245, 639	0	93. 00

Health Financial Systems	IU HEALTH STARKE MEMORIAL HOSPITAL	u of Form CMS-2	552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150102	From 01/01/2016	Worksheet D-1 Date/Time Prep 7/28/2016 7:42	
	Title XIX	Hospi tal	PPS	
Cost Center Description				

Cost Center Description 1.00			Title XIX	Hospi tal	7/28/2016 7: 4 PPS	2 pm
PART 1 - ALL PROVIDER COMPONENTS 1.00		Cost Center Description	II tie xix	поѕрі таі	PPS	
IMPARTIANT DAYS					1. 00	
Inpatient days (including private room days and saling-bed days, excluding newborn) 380 1.00						
Impatient days (including private room days, excluding saing-bed and neaborn days) 300 2.00	1 00		excluding newborn)		380	1 00
do not complete this line. 4. 00 Semi-private room days (excluding saring-bed and observation bed days) through December 31 of the cost 7. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0. 0.						
5.00 Total swinp-bot SRF type inpatient days (including private room days) after December 31 of the cost proporting period of the swinp-bot SRF (facilitating private room days) after December 31 of the cost proporting period of the swinp-bot SRF (facilitating private room days) after December 31 of the cost proporting period of the swinp-bot SRF (facilitating private room days) after December 31 of the cost proporting period of the swinp-bot NF type inpatient days (including private room days) after December 31 of the cost proporting period (facilitating period (facilit		Private room days (excluding swing-bed and observation bed days		vate room days,	0	3. 00
1 Total 'swing-bed SNF 'type inpatient days' (including private room days) after December 31 of the cost reporting period of Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 9.00 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 10.00 Saing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 11.00 Saing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 11.00 Saing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and newborn days) 11.00 Swing-bed SNF type inpatient days applicable to trille SVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 14.00 Exceeding 10 of the cost reporting period (if calendar year, enter 0 on this line) 15.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 16.00 Nursery days (title V or XIX only) 17.00 Wedicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (if calendar year, enter 0 on this line) 18.00 Wedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (ine 2 x on x only) 18.00 Wedicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (line 2 x on x only) 18.00 Swing-bed cost a		· ·				
reporting period (if calledar year, enter 0 on this line) 7.00 Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost 7.00 Total swing-bed in type inpatient days (including private room days) after December 31 of the cost 7.00 Total inpatient days including private room days) after December 31 of the cost 7.00 Total inpatient days including private room days) after December 31 of the cost 7.00 Total inpatient days including private room days) after December 31 of the cost 7.00 newborn days) 10.00 Swing-bed SMF type inpatient days applicable to the Program (excluding swing-bed and 7.00 newborn days) 11.00 Swing-bed SMF type inpatient days applicable to itrie XVIII only (including private room days) after 11.00 through December 31 of the cost reporting period (see instructions) 11.00 Swing-bed SMF type inpatient days applicable to tritle XVIII only (including private room days) after 11.00 Swing-bed SMF type inpatient days applicable to tritle XVIII only (including private room days) after 11.00 Swing-bed SMF type inpatient days applicable to tritle XVIII only (including private room days) after 11.00 Swing-bed SMF type inpatient days applicable to tritle XVIII only (including private room days) after 11.00 Swing-bed SMF type inpatient days applicable to tritle XVIII only (including private room days) after 11.00 Swing-bed SMF type inpatient days applicable to tritle XVIII only (including private room days) after 11.00 Swing-bed SMF type inpatient days applicable to tritle XVIII only (including private room days) after 11.00 SWing-bed SMF type inpatient days applicable to the Program (excluding swing-bed days) 11.00 SWing-bed SMF type services applicable to services through December 31 of the cost reporting period (including type type type type type type type type				. 21 of the cost		
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.01 Total inpatient days including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.01 Total inpatient days including private room days applicable to the Program (excluding swing-bed and nexporting period (if calendar year, enter 0 on this line) 7.02 Swing-bed SNF type inpatient days applicable to the Program (excluding swing-bed and nexporting period (if calendar year, enter 0 on this line) 7.03 Swing-bed SNF type inpatient days applicable to the Program (excluding private room days) after 10 becomes 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.04 Exclusive type inpatient days applicable to titles V or XIX only (including private room days) after 10 becomes 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.05 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 7.06 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 7.07 Total investry days (title V or XIX only) 7.08 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 7.09 Total investry days (title V or XIX only) 7.00 Medical care rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (incer rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (incer rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (incer rate for swing-bed SNF services after December 31 of the cost reporting period (line 2 2.00 XIIII) 7.00 SNR GED ADUSIMENT 7.00 SN	5.00		days) trii dugir beceiibei	31 Of the Cost	0	3.00
Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 7.00 Itotal inpatient days including private room days applicable to the Program (excluding swing-bed and local inpatient days applicable to the the Program (excluding swing-bed and local inpatient days applicable to title XVIII only (including private room days) through December 31 of the cost reporting period (see instructions) 7.00 Swing-bed SWF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line) 8.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) after through December 31 of the cost reporting period to titles V or XIX only (including private room days) 8.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 8.01 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 8.02 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 8.03 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 9.04 Swing-bed NF type inpatient days applicable to services through December 31 of the cost of reporting period (including private room days applicable to services after December 31 of the cost of the cost reporting period (including private room days) 8.00 New York (including private room days applicable to services after December 31 of the cost reporting period (including private room days applicable to SWF type services after December 31 of the cost reporting period (including private room days applicable to SWF type services after December 31 of the cost reporting period (i	6.00		days) after December 3	31 of the cost	0	6. 00
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7 x line 19) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	24.00		21 of the cost managetin	na novind (line	_	24.00
25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28.00 Private ROOM DIFFERENTIAL ADJUSTMENT 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average per diem private room cost differential (line 32 minus line 33) (see instructions) 34.00 Average per diem private room cost differential (line 34 x line 31) 35.00 Average per diem private room cost differential (line 34 x line 31) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 639, 336 on 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 39.00 Program general inpatient routine service cost (line 9 x line 38) 0 0 39.00 Medically necessary private room cost diplicable to the Program (line 14 x line 35) 0 40.00	24.00		31 of the cost reportin	ig period (Title	0	24.00
26.00 Total swing-bed cost (see instructions) 27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 30.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 30.00 Average private room per diem charge (line 29 ÷ line 3) 30.00 Average semi-private room per diem charge (line 30 ÷ line 4) 30.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 30.00 Average per diem private room cost differential (line 34 x line 31) 30.00 Average per diem private room cost differential (line 3 x line 35) 30.00 Frivate room cost differential adjustment (line 3 x line 35) 30.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 639, 336 and 27 minus line 36) 30.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 30.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	25. 00	1	of the cost reporting	period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRIVATE ROOM DIFFERENTIAL ADJUSTMENT 28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges) Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 + line 28) Average private room per diem charge (line 29 + line 3) Average semi-private room per diem charge (line 30 + line 4) Average per diem private room charge differential (line 32 minus line 33)(see instructions) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 34 x line 31) Average per diem private room cost differential (line 3 x line 35) Private room cost differential adjustment (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 35) Average per diem private room cost differential (line 3 x line 36) Private room cost differential adjustment (line 3 x line 35) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions) Adjusted general inpatient routine service cost per diem (see instructions)						
PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges) 9. 00 Private room charges (excluding swing-bed charges) 30. 00 Semi-private room charges (excluding swing-bed charges) 31. 00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32. 00 Average private room per diem charge (line 29 ÷ line 3) 33. 00 Average semi-private room per diem charge (line 30 ÷ line 4) 34. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35. 00 Average per diem private room cost differential (line 34 x line 31) 36. 00 Private room cost differential adjustment (line 3 x line 35) 37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 639, 336 37. 00 38. 00 Ajusted general inpatient routine service cost per diem (see instructions) 39. 00 Program general inpatient routine service cost (line 9 x line 38) 0 39. 00 0 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 28. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 23. 00 24. 00 25. 00 26. 00 27. minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) 20. 03. 03. 03 20. 040. 00 27. Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00						
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 29.00 Private room charges (excluding swing-bed charges) 30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 32.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 639, 336) 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 0 39.00 Program general inpatient routine service cost (line 9 x line 38) 0 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	27.00		ine 21 minus line 26)		639, 336	27.00
29.00 Pri vate room charges (excluding swing-bed charges) 30.00 Semi-pri vate room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average pri vate room per diem charge (line 29 + line 3) 33.00 Average semi-pri vate room per diem charge (line 30 + line 4) 34.00 Average per diem pri vate room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem pri vate room cost differential (line 34 x line 31) 36.00 Pri vate room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 639, 336 27 minus line 36) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 9 Program general inpatient routine service cost (line 9 x line 38) 0 Medically necessary pri vate room cost applicable to the Program (line 14 x line 35) 0 Joon 30.00 31.00 32.00 32.00 34.00 35.00 36.00 37.00 36.00 37.00 37.00 38.00 39.00 40.00	28. 00		and observation bed cha	arges)	0	28. 00
31.00 General inpatient routine service cost/charge ratio (line 27 + line 28) 32.00 Average private room per diem charge (line 29 + line 3) 33.00 Average semi-private room per diem charge (line 30 + line 4) 34.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 639, 336) 27 minus line 36) PART II - HOSPI TAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 9 Program general inpatient routine service cost (line 9 x line 38) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				g/		
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 639, 336 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 .00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00 32.00	30.00	Semi -pri vate room charges (excluding swing-bed charges)			0	30. 00
33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 639, 336 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) 0 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	31. 00
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 639, 336 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost (line 9 x line 38) Program general inpatient routine service cost (line 9 x line 38) Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 .00 34.00 35.00 36.00 36.00 37.00 37.00 27 minus line 36) PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 0 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32. 00
35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 639, 336 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,682.46 38.00 39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 639, 336 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 36.00 37.00 37.00 38.00 38.00 40.00				tions)		
37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 37.00 40.00		,	31)			
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,682.46 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 0 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00		1	d networks ' ''	Efononti - L (L)		
PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,682.46 38.00 39.00 Program general inpatient routine service cost (line 9 x line 38) 0 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	37.00		a private room cost di	rrerential (line	639, 336	37.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS 38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,682.46 38.00 Program general inpatient routine service cost (line 9 x line 38) 0 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00						
38.00 Adjusted general inpatient routine service cost per diem (see instructions) 1,682.46 39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 1,682.46 38.00 39.00 40.00			TMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00	38. 00				1, 682. 46	38. 00
		, ,	•			
41.00 lotal Program general inpatient routine service cost (line 39 + line 40) 0 41.00		, , , , , , , , , , , , , , , , , , , ,	•			•
	41.00	liotal Program general inpatient routine service cost (line 39 +	rine 40)	l	0	41.00

COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2016	Worksheet D-1	
					Го 02/29/2016	Date/Time Pre 7/28/2016 7:4	
				tle XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Costl	Total	Average Per	Program Days	Program Cost (col. 3 x col.	
		Impatrent costi	ilpati eiit bays	col. 2)		4)	
		1.00	2. 00	3.00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42. 00
43. 00	INTENSIVE CARE UNIT	0	(0.00	0	0	43. 00
44. 00	CORONARY CARE UNIT						44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT						45. 00 46. 00
46.00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description	.		'			
10.00	D		11, 200)			1. 00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wks Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS			ons)		94, 781 94, 781	1
50. 00	Pass through costs applicable to Program inpa	atient routine :	services (from	m Wkst. D, sum	of Parts I and	0	50. 00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fi	rom Wkst. D, su	um of Parts II	5, 621	51. 00
52. 00	Total Program excludable cost (sum of lines !	50 and 51)				5, 621	52. 00
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5		ated, non-phy	ysician anesthe	etist, and	89, 160	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00	Program di scharges					0	54. 00
55. 00 56. 00	Target amount (Line E4 v Line E5)					0. 00 0	55. 00 56. 00
57. 00							57.00
58. 00							58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1996, เ	updated and cor	mpounded by the	0.00	59. 00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						60.00
61. 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 instructions) Relief payment (see instructions)					0	62. 00
63. 00	Allowable Inpatient cost plus incentive payment (see instructions)						63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST				1 1 (0		
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decei	mber 31 of the	e cost reportir	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cost	ts after Decembe	er 31 of the d	cost reporting	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing</pre>	ne costs (line	64 plus line (65)(title XVIII	only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 o	of the cost rep	porting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	e costs after Do	ecember 31 of	the cost repor	rting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient i			•	ing points	0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID	ONLY			
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service co	-					70. 00 71. 00
72. 00	Program routine service cost (line 9 x line 3		THE 70 + TITLE	2)			72.00
73. 00	Medically necessary private room cost applica	able to Program					73. 00
74.00	Total Program general inpatient routine servi	•			art II column		74.00
75. 00	Capital-related cost allocated to inpatient (26, line 45)	outine service	COSIS (TROM)	worksneet B, Pa	artii, COTUMN		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ lin						76. 00
77.00	Program capital -related costs (line 9 x line						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovider record	ds)			78. 00 79. 00
80.00	Total Program routine service costs for compa			•	us line 79)		80.00

		1.00	2.00	3.00	4.00	5.00	
42. 00	NURSERY (title V & XIX only)						42. 00
	Intensive Care Type Inpatient Hospital Units						
	INTENSIVE CARE UNIT	0	0	0.00	0	0	43. 00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45. 00
	SURGICAL INTENSIVE CARE UNIT						46. 00
47.00	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description	1 00					
49.00	Program inpatient ancillary service cost (Wks	s+ D 2 col 2) line 200)	-		1. 00 94, 781	48. 00
48. 00 49. 00	Total Program inpatient costs (sum of lines			ine)		94, 781	•
47.00	PASS THROUGH COST ADJUSTMENTS	+1 till odgil +0) (See mistraction	113)		74, 701	77.00
50. 00	Pass through costs applicable to Program inpa	atient routine	services (from	Wkst D sum o	of Parts L and	0	50.00
00.00		atront routine	301 11 003 (11 011	i intot. D, odin t	or runto r una	١	00.00
51. 00	Pass through costs applicable to Program inpa	atient ancillar	y services (fr	om Wkst. D, sur	m of Parts II	5, 621	51.00
	and IV)						
52.00	Total Program excludable cost (sum of lines!	50 and 51)				5, 621	52. 00
53.00	Total Program inpatient operating cost exclude	ding capital re	elated, non-phy	sician anesthe	tist, and	89, 160	53.00
	medical education costs (line 49 minus line !	52)					
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program di scharges					0	
	Target amount per discharge					0.00	
	Target amount (line 54 x line 55)			. =	50)	0	
	Difference between adjusted inpatient operati	ng cost and ta	irget amount (i	ine 56 minus ii	ne 53)	0	57. 00
58. 00 59. 00	Bonus payment (see instructions)	anting nonlad	anding 100/	undated and some	anumded by the	0	58. 00 59. 00
59.00	Lesser of lines 53/54 or 55 from the cost remarket basket	borting period	ending 1996, u	ipuateu anu com	bounded by the	0. 00	59.00
60.00	Lesser of lines 53/54 or 55 from prior year (rost renort un	ndated by the m	arket hasket		0.00	60.00
	If line 53/54 is less than the lower of lines				ne amount by	0.00	61.00
01.00	which operating costs (line 53) are less than					١	01.00
	amount (line 56), otherwise enter zero (see		.5 (111105 01 %	00)	tilo tal got		
62.00	Relief payment (see instructions)	,				0	62. 00
63.00	Allowable Inpatient cost plus incentive payme	ent (see instru	ıctions)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reporting	g period (See	0	64. 00
	instructions)(title XVIII only)						
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting p	period (See	0	65. 00
	instructions)(title XVIII only)					_ '	
66. 00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66. 00
47.00	CAH (see instructions)	s costs through	Docombor 21 o	f the cost son	orting ported	0	67. 00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs till ough	i beceiliber 31 c	ii the cost repo	or tring period	ا ا	67.00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after D	ecember 31 of	the cost repor	ting period	0	68. 00
00.00	(line 13 x line 20)	o costs arter b	recember of or	the cost repor	tring period	١	00.00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	: 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NU						
70.00	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	ıtine service c	ost (line 37)			70. 00
	Adjusted general inpatient routine service co						71. 00
72.00	Program routine service cost (line 9 x line	71)					72. 00
73.00	Medically necessary private room cost applica						73. 00
74. 00	Total Program general inpatient routine servi						74. 00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from W	lorksheet B, Pai	rt II, column		75. 00
7, 00	26, line 45)	0)					- ,
76. 00	Per diem capital-related costs (line 75 ÷ li						76. 00
77. 00	Program capital -related costs (line 9 x line						77. 00 78. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess		rovidor rocord	lc)			
80. 00	Total Program routine service costs for compa	, ,		· .	s lino 70)		79. 00 80. 00
			ost iiiii tatioi	(TITIE 76 IIITIU	5 11116 /7)		81. 00
82. 00							82. 00
							83. 00
84. 00	Program inpatient ancillary services (see in		-,			 	84. 00
85. 00	Utilization review - physician compensation		ons)			 	85. 00
86. 00	Total Program inpatient operating costs (sum					 	86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PASS		<u> </u>				1
87.00	Total observation bed days (see instructions)					146	87. 00
88. 00	Adjusted general inpatient routine cost per		line 2)			1, 682. 46	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				245, 639	89. 00

Health Financial Systems IU	HEALTH STARKE N	MEMORIAL HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2016 To 02/29/2016		
	_	Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	37, 043	639, 336	0. 05794	0 245, 639	14, 232	90.00
91.00 Nursing School cost	C	639, 336	0.00000	0 245, 639	0	91.00
92.00 Allied health cost	C	639, 336	0.00000	0 245, 639	0	92.00
93.00 All other Medical Education	c	639, 336	0. 00000	0 245, 639	0	93. 00

	Financial Systems IU HEALTH STARKE MEMORI				eu of Form CMS-2	<u> 2552-10</u>
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150102	Peri od: From 01/01/2016	Worksheet D-3	
				To 02/29/2016		nared·
				10 02/2//2010	7/28/2016 7: 4	
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS		1	011.000	ı	
30. 00	03000 ADULTS & PEDI ATRI CS			214, 993		30. 00
31. 00	03100 NTENSI VE CARE UNI T			0		31. 00
	ANCI LLARY SERVI CE COST CENTERS			- 0 4 4 4 4		
50.00	05000 OPERATI NG ROOM		0. 4155		6, 840	50.00
51.00	05100 RECOVERY ROOM		0.00000		0	51.00
53. 00	05300 ANESTHESI OLOGY		0. 01242	·		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 52040	·		54.00
57. 00	05700 CT SCAN		0. 05429			57. 00
58. 00	05800 MRI		0. 1968			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59. 00
60.00	06000 LABORATORY		0. 21229		36, 973	60.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD		0. 79820	·		62.00
65. 00	06500 RESPI RATORY THERAPY		0. 67889			65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 44498	·		
67. 00	06700 OCCUPATI ONAL THERAPY		0. 57136			67. 00
68. 00	06800 SPEECH PATHOLOGY		0. 33293			68. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 18083			69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT		0. 5236			71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 0827		0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 27224			73. 00
76. 97	07697 CARDI AC REHABI LI TATI ON		0.00000	00 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS					
$\Omega \Omega$	DODOO CLINIC		0 00000	nol o	1	

0. 000000 0. 304233 0. 608014

104, 020

13, 229

829, 272

829, 272

0 90.00

91.00

92.00

201. 00

202. 00

31, 646

8, 043

260, 327 200. 00

90. 00 09000 CLINIC

200.00

201. 00 202. 00

91. 00 09100 EMERGENCY

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT

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

INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150102	Peri od:	Worksheet D-3	
				From 01/01/2016 To 02/29/2016		pared:
		Ti t	le XIX	Hospi tal	PPS	<u> 2 piii </u>
	Cost Center Description		Ratio of Cos		Inpati ent	
	·		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS			55, 899		30. 00
31. 00	03100 INTENSIVE CARE UNIT			0		31. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATING ROOM		0. 41555		13, 023	50.00
51.00	05100 RECOVERY ROOM		0.00000		0	51.00
53.00	05300 ANESTHESI OLOGY		0. 01242		64	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 52040		9, 216	
57. 00	05700 CT SCAN		0. 05429		1, 216	57.00
58. 00	05800 MRI		0. 19681		1, 176	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59. 00
60.00	06000 LABORATORY		0. 21229		12, 082	60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD		0. 79820		0	62.00
65.00	06500 RESPI RATORY THERAPY		0. 67889		17, 850	65. 00
66. 00	06600 PHYSI CAL THERAPY		0. 44498		179	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0. 57136		230	67. 00
68. 00	06800 SPEECH PATHOLOGY		0. 33293		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0. 18083		1, 687	69. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PAT		0. 52365		3, 181	
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 08277		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 27224		21, 045	73.00
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 00000	00 0	0	76. 97
	OUTPAȚI ENT SERVI CE COST CENTERS					
	09000 CLI NI C		0. 00000		0	90.00
	09100 EMERGENCY		0. 30423		10, 895	
02 NN	100200 OPSEDVATION PEDS (NON DISTINCT		0 6000	1 4 020	2 027	02 00

0. 000000 0. 304233 0. 608014

35, 813 4, 830

299, 935

299, 935

92.00

2, 937

94, 781 200. 00 201. 00 202. 00

92. 00 09200 OBSERVATION BEDS (NON-DISTINCT

200.00

201. 00 202. 00

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

Health Financial Systems	IU HEALTH STARKE MEMOR	IAL HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150102	From 01/01/2016	Worksheet E Part A Date/Time Prepared:

PAST A				10 02/29/2010	7/28/2016 7: 42	
NATE A - INDATE INFORMER HOSP TRAL SERVICES WIDER 1PPS 0 1.00 DRG amounts other than outli er payments for discharges occurring prior to October 1 (see 26,84 1.01 1.02 DRG amounts other than outli er payments for discharges occurring on or after October 1 (see 1.02 DRG amounts other than outli er payments for discharges occurring on or after October 1 (see 1.02 DRG for ForGedral specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see 1.03 1.04			Title XVIII	Hospi tal		
NATE A - INDATE INFORMER HOSP TRAL SERVICES WIDER 1PPS 0 1.00 DRG amounts other than outli er payments for discharges occurring prior to October 1 (see 26,84 1.01 1.02 DRG amounts other than outli er payments for discharges occurring on or after October 1 (see 1.02 DRG amounts other than outli er payments for discharges occurring on or after October 1 (see 1.02 DRG for ForGedral specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see 1.03 1.04						
DR6 Amounts Other than Outlier Payments 0 1.00 1.00 1.01 1.0					1. 00	
DRG amounts other than outlier payments for discharges occurring on or after October 1 (see 206, 484 1.01						
Instructions 1.02 Rot promotes other than outlier payments for discharges occurring on or after October 1 (see 0 1.02 1.03 Rot For Toders 1.04 1.03 1.		,				
DRG amounts other than outlier payments for discharges occurring on or after October 1 (see DRC for federal speed fic operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions) DRC for federal speed fic operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) DRC for federal speed fic operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions) DRC for federal speed fic operating payment for discharges (see instructions) October 1 (see instructions) DRC for federal speed fic operating payment for discharges (see instructions) October 1 (see instructions) October 1 (see instructions) October 1 (see instructions) October 1 (see instructions) October 2 (see instructions) October	1. 01		g prior to October 1 (see	266, 484	1. 01
Instructions 1.00 Richard Specific operating payment for Model 4 BPCI for discharges occurring prior to October 0 1.03 1.09 Richard 1.09 Ri	4 00	,	61 0 1 1			4 00
1.03 1.08	1.02		g on or after October	1 (see	0	1.02
1 (see instructions) 1.04 DNS for Tederal specific operating payment for Model 4 BPCI for discharges occurring on or after 2.00 Dutil er payments for discharges. (see instructions) 2.01 Dutil er payments for discharges. (see instructions) 2.02 Dutil er payments for discharges. (see instructions) 2.03 Dutil er payments for discharges. (see instructions) 2.04 Dutil er payments for discharges. (see instructions) 2.05 Dutil er payments for discharges. (see instructions) 2.06 Dutil er payments for discharges. (see instructions) 2.07 Dutil er payments for discharges. (see instructions) 2.08 Dutil er payments for discharges. (see instructions) 2.09 Dutil er payments for discharges. (see instructions) 3.00 Sungage Care Simulated Payments 3.00 Sungage Care Simulated Simulated Simulated	1 00	,				1 00
1.04 Oktober Issel Instructions 0 1.04	1.03		discharges occurring	prior to october	U	1.03
October 1 (see Instructions) 0 2.00 2.00 2	1 04		discharges occurring	on or after		1 04
2.00	1.04		di schai ges occurring	on or arter	ا	1.04
2.01 Outlier reconciliation amount 0 2.01	2 00				0	2 00
2.02 Outlier payment for discharges for Model 4 BPCI (see instructions) 0 2.02 4.00 Bed days available divided by number of days in the cost reporting period (see instructions) 47.57 5.00 FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on on before 12/31/1996, (see instructions) 0.00 0.00 5.00 6.00 FTE count for all opathic and osteopathic programs which meet the criteria for an add-on to the cap 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 7.00 0.00 0.00 0.00 0.00 0.00 7.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 <t< td=""><td></td><td>, ,</td><td></td><td></td><td>-</td><td></td></t<>		, ,			-	
Managed Care Simulated Payments			ne)		-	
Bed days available divided by number of days in the cost reporting period (see instructions) 47.57 4.00 Indirect Medical Education Adjustment 5.00 FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996 (see instructions) 5.00 FTE count for all opathic and osteopathic programs which meet the criteria for an add-on to the cap force 12/31/1996 (see instructions) 7.00 FTE count for all opathic and osteopathic programs which meet the criteria for an add-on to the cap force 12/31/1996 (see instructions) 7.00 FTE count for all opathic and osteopathic programs for the most recent cost reporting period ending on the force 12/31/1996 (see instructions) 7.00 FTE count for all opathic and osteopathic programs for all opathic cost report of the force as a first interpretation of force as a first inter		1 3	113)		-	_
Indirect Medical Education Adjustment		· ·	ing pariod (see instru	otions)	-	
FIE count for all opathic and osteopathic programs for the most recent cost reporting period ending on or before 12/31/1996, see instructions)	4.00		ing period (see mistru	ctions)	47. 37	4.00
or before 12/31/1996, (see instructions) or before 12/31/1996, (see instructions) or before 12/31/1996, (see instructions) 7. 00 MMA Section 427 creduction amount to the lME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) 7. 01 MA Section 427 creduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) 16 the cost report straddles July 1, 2011 then see instructions. 8. 00 Adjustment (increase or decrease) to the FTE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR \$413.75(0), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8. 01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see Instructions) 9. 03 Sun of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 p. 00 linstructions) 10. 06 Tier count for liopathic and osteopathic programs in the current year from your records 0.00 plus of lines in the land and podiatric programs. 10. 00 Treate lines are all pashle FTE count for the prior year. 10. 01 Total all onable FTE count for the prior year. 10. 02 Current year all onable FTE count for the prior year if that year ended on or after September 30, 1997. 10. 03 Unique to the program of the program of the program 0.00 plus of lines 12 through 14 divided by 3. 10. 04 Adjustment for residents displaced by program or hospital closure 0.00 plus on the program	F 00		recent cost reporting	noriad anding on	0.00	F 00
FTE count for allopathic and osteopathic programs which meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e) 7.00	5.00		recent cost reporting	period ending on	0.00	5.00
For new programs in accordance with 42 CFR 413.79(e) 7.00 MMA Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) 17.01 ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) 18.00 ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) 18.01 His decost report straddles July 1, 2011 then see instructions. 8.02 Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions) 9.00 Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 1.00 minus of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 1.00 minus of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 1.00 minus of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 1.00 minus of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 1.00 minus of lines 6 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 1.00 minus lines (8, 8,01 and 8,0	/ 00	· · · · · · · · · · · · · · · · · · ·	o onitonio for on odd	an ta tha aan	0.00	/ 00
7.00 MMA Section 522 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) 0.00 7.00 7.01 ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) 0.00 7.00 8.00 All pathemet (increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b). 413.79(c)(2)(iv), 64 FR 26340 (May 12. 1999), and 67 FR 50009 (August 1. 2002). 0.00 8.00 8.01 The amount of increase if the hospital was awarded FIE cap slots under section 5503 of the ACA. If the cost report straddie sully 1, 2011, see instructions. 0.00 8.01 8.02 The amount of increase if the hospital was awarded FIE cap slots from a closed teaching hospital under section 5506 of ACA. (See instructions) 0.00 8.02 9.00 Sum of Lines 5 plus 6 minus Lines (7 and 7.01) plus/minus Lines (8, 8, 01 and 8, 02) (see 0.00 9.00 10.00 FIE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00 10.00 FIE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00 10.00 FIE count for allopathic and osteopathic programs in the current year from your records 0.00 10.00 12.00	6.00		e criteria for an add-	on to the cap	0.00	6.00
7.01 ACA Section 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(10)(8)(2) 0.00 7.01 8.00 Adjustment (Increase or decrease) to the FIE count for all opathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 0.00 8.01 8.01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddle S July 1, 2011, see instructions. 0.00 8.01 8.02 The amount of increase if the hospital was awarded FTE cap slots sfrom a closed teaching hospital under section 5506 of ACA. (see instructions) 0.00 8.02 9.0 Sum of Lines 5 plus 6 minus Lines (7 and 7.01) plus/minus Lines (8, 8,01 and 8,02) (see instructions) 0.00 10.00 11.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 Current year all owable FTE (see instructions) 0.00 12.00 13.00 Total all owable FTE count for the prior year. 0.00 12.00 14.00 Total all owable FTE count for the prior year. 0.00 12.00 <td>7 00</td> <td></td> <td> 42 CED C412 10F(F)</td> <td>(1) (!) (D) (1)</td> <td>0.00</td> <td>7 00</td>	7 00		42 CED C412 10F(F)	(1) (!) (D) (1)	0.00	7 00
If the cost report straddles July 1, 2011 then see Instructions.		· · ·	- , ,			
Adjustment (increase or decrease) to the FTE count for allopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).	7.01)(1)(1V)(B)(2)	0.00	7.01
affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).						
1998), and 67 FR 50069 (August 1, 2002).	8.00				0.00	8.00
8.01 The amount of increase if the hospital was awarded FTE cap slots under section 5503 of the ACA. If the cost report straddies July 1, 2011, see instructions. The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under section 5506 of ACA. (see instructions)			(c)(2)(iv), 64 FR 2634	0 (May 12,		
the cost report straddles July 1, 2011, see instructions. 8.02 9.02 9.03 9.04 9.05 9.05 9.06 9.07 10.00						
Background	8. 01		s under section 5503 o	f the ACA. If	0. 00	8. 01
under section 5506 of ACA. (see instructions) under section 5506 of ACA. (see instructions) 0.00 9.00 10.00 FIE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 11.00 FIE count for residents in dental and podiatric programs. 0.00 11.00 12.00 Current year allowable FIE (see instructions) 0.00 12.00 13.00 Total allowable FIE count for the prior year. 0.00 13.00 14.00 Total allowable FIE count for the penul timate year if that year ended on or after September 30, 1997, 0.00 14.00 15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 Adjustment for residents in initial years of the program 0.00 15.00 17.00 Adjustment for residents in initial years of the program 0.00 17.00 18.00 Adjusted rolling average FIE count 0.00 0.00 0.00 19.00 Current year resident to bed ratio (see instructions) 0.000000 0.00 0.000000 0.00 10.00 IME payment adjustment (see instructions) 0.000000 0.00 0.0000000 0.00 0.0000000 0.00 0.00 0.0000000 2.00 0.00 0.00 <		, , , , , , , , , , , , , , , , , , ,				
Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see 0.00 9.00 10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 FTE count for residents in dental and podiatric programs. 0.00 12.00 13.00 10.00 12.00 13.00 10.01 10.00 10.0	8. 02		s from a closed teachi	ng hospi tal	0. 00	8. 02
instructions) 1.0 00 FTE count for allopathic and osteopathic programs in the current year from your records 1.0 00 FTE count for residents in dental and podiatric programs. 2.0 00 Current year allowable FTE (see instructions) 3.0 0 Total allowable FTE count for the prior year. 3.0 0 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, one of the thing of the prior year. 3.0 0 Total allowable FTE count for the penul timate year if that year ended on or after September 30, 1997, one of the thing of the program of the progra		· · · · · · · · · · · · · · · · · · ·				
10.00 FTE count for all opathic and osteopathic programs in the current year from your records 0.00 10.00	9. 00		(8, 8,01 and 8,02) (see	0. 00	9. 00
11.00 FTE count for residents in dental and podiatric programs. 0.00 11.00 12.00 12.00 12.00 13.00 10.01 13.00 10.01 13.00 10.01 13.00 10.01 13.00 10.01 13.00 10.01 13.00 10.01 13.00 10.01 13.00 10.01 13.00 10.01 13.00 10.01 13.00 10.01 13.00 10.01 13.00 10.01 10.01 10.00 1		,				
12.00 Current year allowable FTE (see instructions) 0.00 12.00 13.00 10.00 13.00 10.00			t year from your recor	ds		
13.00 Total allowable FTE count for the prior year. 0.00 13.00 14.00 15.00 15.00 16.00	11. 00	FTE count for residents in dental and podiatric programs.			0. 00	11. 00
14.00	12.00	Current year allowable FTE (see instructions)			0. 00	12.00
Otherwise enter zero. Othe	13.00	Total allowable FTE count for the prior year.			0.00	13.00
15.00 Sum of lines 12 through 14 divided by 3. 0.00 15.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 16.00 17.00 18.00 18.00 18.00 18.00 19	14.00	Total allowable FTE count for the penultimate year if that year	ended on or after Sep	tember 30, 1997,	0.00	14.00
16.00 Adjustment for residents in initial years of the program 0.00 16.00 17.00 Adjustment for residents displaced by program or hospital closure 0.00 17.00 17.00 18.00 17.00 18.00 Adjustment for resident displaced by program or hospital closure 0.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 17.00 18.00 19.00 18.00 18.00 19.00 19.00 18.00 19.00		otherwise enter zero.				
17.00	15.00	Sum of lines 12 through 14 divided by 3.			0.00	15.00
17.00	16.00	Adjustment for residents in initial years of the program			0.00	16. 00
18. 00 Adjusted rolling average FTE count 0.00 18. 00 19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 01 IME payment adjustment (see instructions) 0.000000 22. 00 1 Indirect Medical Education Adjustment For the Add-on for Section 422 of the MMA 0.000000 23. 00 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 0.00 23. 00 25. 00 IME FTE Resident Count Over Cap (see instructions) 0.00 24. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 25. 00 26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27. 00 27. 00 IME payments adjustment amount - Managed Care (see instructions) 0.000000 27. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0.28. 01 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) <td></td> <td></td> <td>re</td> <td></td> <td>0.00</td> <td>17. 00</td>			re		0.00	17. 00
19. 00 Current year resident to bed ratio (line 18 divided by line 4). 0.000000 19. 00 20. 00 Prior year resident to bed ratio (see instructions) 0.000000 20. 00 21. 00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21. 00 22. 01 IME payment adjustment (see instructions) 0.000000 22. 00 22. 01 IME payment adjustment - Managed Care (see instructions) 0.00 22. 01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 0.00 23. 00 (f)(1)(iv)(c). 0.00 23. 00 (f)(1)(iv)(c). 0.00 24. 00 25. 00 IME FTE Resident Count Over Cap (see instructions) 0.00 25. 00 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 0.00 25. 00 26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 27. 00 0.000000 27. 00 28. 01 IME payments adjustment factor. (see instructions) 0.000000 27. 00 0.00000 27. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0.00000 0.00000 28. 01						
20.00 Prior year resident to bed ratio (see instructions) 0.000000 20.00 21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.0000000 21.00 0.0000000 21.00 0.0000000 21.00 0.0000000 21.00 0.0000000 22.00 0.0000000 22.00 0.0000000 22.00 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.000000 0.000000 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.00000000		,				
21.00 Enter the lesser of lines 19 or 20 (see instructions) 0.000000 21.00 22.00 IME payment adjustment (see instructions) 0.22.00 22.01 IME payment adjustment - Managed Care (see instructions) 0.22.01 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 24.00 IME FTE Resident Count Over Cap (see instructions) 0.000 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 27.00 IME payments adjustment amount (see instructions) 0.000000 27.00 28.01 IME padd-on adjustment amount (see instructions) 0.000000 28.01 29.01 IME add-on adjustment amount - Managed Care (see instructions) 0.00000 29.00 29.01 IME payment - Managed Care (sum of lines 22 and 28) 0.000000 29.00 29.01 Disproportionate Share Adjustment 0.000000 0.00000000000000000000000		· · · · · · · · · · · · · · · · · · ·				
22.00 IME payment adjustment (see instructions)						
22. 01 IME payment adjustment - Managed Care (see instructions) 10 Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 24. 00 IME FTE Resident Count Over Cap (see instructions) 25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see		· · · · · · · · · · · · · · · · · · ·				
Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 0.00 23.00 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 0.00 24.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0.00 25.00 instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26.00 IME payments adjustment factor. (see instructions) 0.000000 27.00 IME payments adjustment amount (see instructions) 0.28.00 IME add-on adjustment amount (see instructions) 0.28.01 IME add-on adjustment amount - Managed Care (see instructions) 0.28.01 Total IME payment (sum of lines 22 and 28) 0.29.01 Total IME payment (sum of lines 22 and 28) 0.29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0.29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 1.4.96 31.00 Sum of lines 30 and 31 22.97 32.00 33.00 Allowable disproportionate share percentage (see instructions) 8.17 33.00						
Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 Sec. 412.105 (f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 10.00 24.00 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME payments adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30.00 Sum of lines 30 and 31 30.00 Allowable disproportionate share percentage (see instructions) 8.17 33.00	22.01		n 122 of the MMA		U	22.01
(f)(1)(iv)(C). 24.00 IME FTE Resident Count Over Cap (see instructions) 1	22.00			410 105	0.00	22.00
24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions) 26.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount - Managed Care (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 29.01 Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 31.10 Sum of lines 30 and 31 32.2.97 32.00	23.00		it cap stots under 42 S	ec. 412.105	0.00	23.00
25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 0. 00 25. 00 instructions) 26. 00 Resident to bed ratio (divide line 25 by line 4) 27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22. 01 and 28. 01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Sum of lines 30 and 31 22. 97 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 8. 17 33. 00	04.00				0.00	04.00
instructions		, ,				
26. 00 Resident to bed ratio (divide line 25 by line 4) 0.000000 26. 00 27. 00 IME payments adjustment factor. (see instructions) 0.000000 27. 00 28. 00 IME add-on adjustment amount (see instructions) 0 28. 00 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 0 28. 01 29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 00 29. 01 Total IME payment - Managed Care (sum of lines 22. 01 and 28. 01) 0 29. 01 Disproportionate Share Adjustment 9 29. 01 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 8. 01 30. 00 31. 00 Percentage of Medicaid patient days (see instructions) 14. 96 31. 00 32. 00 Sum of lines 30 and 31 22. 97 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 8. 17 33. 00	25.00	· · · · · · · · · · · · · · · · · · ·	wer of line 23 or line	24 (see	0.00	25.00
27. 00 IME payments adjustment factor. (see instructions) 28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Allowable disproportionate share percentage (see instructions) 33. 00 Percentage of Medicaid patient days (see instructions) 33. 00 Allowable disproportionate share percentage (see instructions) 34. 00 Percentage of Medicaid patient days (see instructions) 35. 00 Percentage of Medicaid patient days (see instructions) 36. 01 Percentage of Medicaid patient days (see instructions) 37. 00 Percentage of Medicaid patient days (see instructions) 38. 01 Percentage of Medicaid patient days (see instructions) 39. 00 Percentage of Medicaid patient days (see instructions)						
28. 00 IME add-on adjustment amount (see instructions) 28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 33. 00 Percentage of Medicaid patient days (see instructions) 34. 10 Percentage of Medicaid patient days (see instructions) 35. 00 Sum of lines 30 and 31 36. 00 Percentage of Medicaid patient days (see instructions) 37. 00 Percentage of Medicaid patient days (see instructions) 38. 01 Sum of lines 30 and 31 39. 00 Percentage of Medicaid patient days (see instructions)		· · · · · · · · · · · · · · · · · · ·				
28. 01 IME add-on adjustment amount - Managed Care (see instructions) 29. 00 Total IME payment (sum of lines 22 and 28) 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 30. 01 Percentage of Medicaid patient days (see instructions) 30. 02 Sum of lines 30 and 31 30. 03 Percentage of Medicaid patient days (see instructions) 30. 00 Sum of lines 30 and 31 30. 00 Percentage of Medicaid patient days (see instructions) 30. 00 Sum of lines 30 and 31 30. 00 Percentage of Medicaid patient days (see instructions)		IME payments adjustment factor. (see instructions)			0. 000000	
29. 00 Total IME payment (sum of lines 22 and 28) 0 29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0 29. 01 Disproportionate Share Adjustment 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 8. 01 30. 00 31. 00 Sum of lines 30 and 31 22. 97 32. 00 33. 00 Allowable disproportionate share percentage (see instructions) 8. 17 33. 00	28. 00	IME add-on adjustment amount (see instructions)			0	28. 00
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31. 00 Percentage of Medicaid patient days (see instructions) 32. 00 Sum of lines 30 and 31 33. 00 Allowable disproportionate share percentage (see instructions) 30. 01 29. 01 30. 00 31. 00 32. 00 32. 00 33. 00 34. Iowable disproportionate share percentage (see instructions) 32. 00	28. 01			0	28. 01	
Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 31.00 32.00 Sum of lines 30 and 31 32.00 33.00 Allowable disproportionate share percentage (see instructions) 32.00 Sum of lines 30 and 31	29.00			0	29. 00	
Disproportionate Share Adjustment 30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 33.00 Allowable disproportionate share percentage (see instructions) 30.00 20.00 Sum of lines 30 and 31 31.00 20.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 32.00 Allowable disproportionate share percentage (see instructions)	29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0	29. 01
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 30.00 Percentage of Medicaid patient days (see instructions) 31.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 8.01 30.00 21.00 32.00 32.00 32.00 32.00 32.00 33.00 Allowable disproportionate share percentage (see instructions)		Disproportionate Share Adjustment				
31.00 Percentage of Medicaid patient days (see instructions) 32.00 Sum of lines 30 and 31 32.00 Allowable disproportionate share percentage (see instructions) 14.96 31.00 22.97 32.00 33.00 Allowable disproportionate share percentage (see instructions) 8.17 33.00	30.00		ient days (see instruc	tions)	8. 01	30.00
32.00 Sum of lines 30 and 31 22.97 32.00 Allowable disproportionate share percentage (see instructions) 8.17 33.00			J : (: : : : : : : : : : : : : : : : : :	<i>'</i>		
33.00 Allowable disproportionate share percentage (see instructions) 8.17 33.00						
5.7 55 5.7 5p. 5p. 1. 5.1.4 to 51.4 to 44.3 45 this it 40 this is						
	55	(000 (100 000)		ļ	5, .10	55

	Financial Systems I U HEALTH STARKE MEMORIA ATION OF REIMBURSEMENT SETTLEMENT	L HOSPITAL Provider CCN: 150102	Period: From 01/01/2016 To 02/29/2016		pared:
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1		
	Uncompensated Care Adjustment		1. 00	2. 00	
35. 00 35. 01 35. 02	Total uncompensated care amount (see instructions) Factor 3 (see instructions)	ero on this line)	6, 406, 145, 534 0. 000011127 71, 284	0. 000000000 0. 0000000000	35. 01
35. 03 36. 00	Pro rata share of the hospital uncompensated care payment amount Total uncompensated care (sum of columns 1 and 2 on line 35.03)	<u> </u>	11, 686 11, 686		35. 03 36. 00
40. 00	Additional payment for high percentage of ESRD beneficiary discha Total Medicare discharges on Worksheet S-3, Part I excluding disc		o (1975)		40. 00
41. 00	652, 682, 683, 684 and 685 (see instructions) Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, instructions)	684 an 685. (see	0		41. 00
41. 01		652, 682, 683, 684	0		41. 01
42. 00 43. 00	Divide line 41 by line 40 (if less than 10%, you do not qualify f Total Medicare ESRD inpatient days excluding MS-DRGs 652, 682, 6 instructions)		0.00		42. 00 43. 00
44. 00	Ratio of average length of stay to one week (line 43 divided by I days)	ine 41 divided by 7	0. 000000		44. 00
45. 00 46. 00 47. 00 48. 00	Average weekly cost for dialysis treatments (see instructions) Total additional payment (line 45 times line 44 times line 41.01) Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, small only. (see instructions)		0. 00 0 283, 613 256, 517		45. 00 46. 00 47. 00 48. 00
	John y. (See Tristi detrois)			Amount	
49. 00	Total payment for inpatient operating costs (see instructions)			1. 00 283, 613	49. 00
50. 00 51. 00 52. 00 53. 00 54. 00 55. 00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt Exception payment for inpatient program capital (Wkst. L, Pt. III Direct graduate medical education payment (from Wkst. E-4, line 4 Nursing and Allied Health Managed Care payment Special add-on payments for new technologies Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)	, see instructions) 9 see instructions).		21, 310 0 0 0 0 0	50. 00 51. 00 52. 00 53. 00 54. 00 55. 00
56. 00 57. 00 58. 00 59. 00 60. 00	Cost of physicians' services in a teaching hospital (see intructi Routine service other pass through costs (from Wkst. D, Pt. III, Ancillary service other pass through costs from Wkst. D, Pt. IV, Total (sum of amounts on lines 49 through 58) Primary payer payments	column 9, lines 30 th	nrough 35).	0 0 0 304, 923 0	57. 00 58. 00
61. 00 62. 00 63. 00 64. 00	Total amount payable for program beneficiaries (line 59 minus lir Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)	e 60)		304, 923 45, 052 0 15, 746	62. 00 63. 00 64. 00
65. 00 66. 00 67. 00 68. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instruct Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices for appl		ee instructions)	10, 235 6, 491 270, 106 0	66. 00
69. 00 70. 00 70. 50 70. 88	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) RURAL DEMONSTRATION PROJECT SCH or MDH volume decrease adjustment	SCH see instructions	5)	0 0 0	70. 00 70. 50
70. 89 70. 90 70. 91	Pioneer ACO demonstration payment adjustment amount (see instruct HSP bonus payment HVBP adjustment amount (see instructions) HSP bonus payment HRR adjustment amount (see instructions)	i ons)		0 0 0	70. 89 70. 90 70. 91
	Bundled Model 1 discount amount (see instructions) HVBP payment adjustment amount (see instructions)			0 1, 438	

0 70.95

70. 91 70. 92 1, 438 70. 93 0 70 °

70.93 HVBP payment adjustment amount (see instructions)
70.94 HRR adjustment amount (see instructions)
70.95 Recovery of accelerated depreciation

Health Financial Systems IU HEALTH STARKE				u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der	CCN: 150102	Period: From 01/01/2016	Worksheet E Part A	
			To 02/29/2016	Date/Time Pre	pared:
	Ti +I	e XVIII	Hospi tal	7/28/2016 7: 4 PPS	2 pm
	11 (1		(yyyy)	Amount	
			0	1. 00	
70.96 Low volume adjustment for federal fiscal year (yyyy) (Enter	er in column O		2016	65, 776	70, 96
the corresponding federal year for the period prior to 10.				•	
70.97 Low volume adjustment for federal fiscal year (yyyy) (Ent			0	0	70. 97
the corresponding federal year for the period ending on o	r after 10/1)				
70. 98 Low Volume Payment-3				0	70. 98
70.99 HAC adjustment amount (see instructions)	(0 0 70)			0	70. 99
71.00 Amount due provider (line 67 minus lines 68 plus/minus lines	nes 69 & 70)			337, 320	
71.01 Sequestration adjustment (see instructions) 72.00 Interim payments				325, 789	71. 01 72. 00
72.00 Interim payments 73.00 Tentative settlement (for contractor use only)				325, 769	73.00
74.00 Balance due provider (Program) (line 71 minus lines 71.01	72 and 73)			4, 785	
75.00 Protested amounts (nonallowable cost report items) in according to the cost report items.				652	75.00
CMS Pub. 15-2, chapter 1, §115.2	or dance in th				70.00
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 in				0	92. 00
93.00 Capital outlier reconciliation adjustment amount (see ins				0	93. 00
94.00 The rate used to calculate the time value of money (see in				0.00	94. 00
95.00 Time value of money for operating expenses (see instruction				0	95. 00
96.00 Time value of money for capital related expenses (see ins	tructions)		D: 1 10/1	0 (4.6) 40 (4	96. 00
			Prior to 10/1	2 00	

	1. 00	2. 00	
HSP Bonus Payment Amount			
100.00 HSP bonus amount (see instructions)	0	0	100. 00
HVBP Adjustment for HSP Bonus Payment			l
101.00 HVBP adjustment factor (see instructions)	1.0053960754	0.0000000000	101. 00
102.00 HVBP adjustment amount for HSP bonus payment (see instructions)	0	0	102. 00
HRR Adjustment for HSP Bonus Payment			l
103.00 HRR adjustment factor (see instructions)	1. 0000	0.0000	103. 00
104.00 HRR adjustment amount for HSP bonus payment (see instructions)	0	0	104.00

In Lieu of Form CMS-2552-10

Period:	Worksheet E
From 01/01/2016	Part A Exhibit 4
To 02/29/2016	Date/Time Prepared:
7/28/2016 7:42 pm	Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provi der CCN: 150102

					'	0 02/29/2016	7/28/2016 7: 4:	
	,				e XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1.00	2.00	3.00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	0			1. 00
1. 01	payments DRG amounts other than outlier	1. 01	266, 484	0	266, 484	0	266, 484	1. 01
1. 02	payments for discharges occurring prior to October 1 DRG amounts other than outlier	1. 02	0	0	0	0	0	1. 02
1. 02	payments for discharges occurring on or after October	1. 02	J	S	Ÿ		C	1. 02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0	0	0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0	0	0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00	0	0	0	0	0	2. 00
2. 01	Outlier payments for	2. 02	0	0	0	0	0	2. 01
3.00	discharges for Model 4 BPCI Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4.00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
5. 00	Amount from Worksheet E, Part	ustment 21.00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
5.00	A, line 21 (see instructions)	21.00	0.000000	0.000000	0.000000	0.00000		3.00
6. 00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	0	0	0	0	0	6. 01
	instructions)		. Add 6 C-	-+: 122 - - +	L - 1414 A			
7. 00	Indirect Medical Education Adju	27. 00	0. 000000	0. 000000	0. 000000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0.00000	0	8. 00
	instructions)		0	0	0	0		
8. 01	IME payment adjustment add on for managed care (see instructions)	28. 01	O	0	0	0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	O	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0	0	0	0	0	9. 01
	Di sproporti onate Share Adjustme	ent						
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 0817	0. 0817	0. 0817	0. 0817		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34. 00	5, 443	0	5, 443	0	5, 443	11. 00
11. 01	Uncompensated care payments	36. 00	11, 686	0	11, 686	0	11, 686	11. 01
	Additional payment for high per	centage of ESF		di scharges			,	
12. 00	Total ESRD additional payment (see instructions)	46. 00	0	0	0	0	0	12. 00
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments	47. 00 48. 00	283, 613 256, 517	0 0	283, 613 256, 517		283, 613 256, 517	
	(completed by SCH and MDH, small rural hospitals only.) (see instructions)							
15. 00	Total payment for inpatient operating costs (see	49. 00	283, 613	0	283, 613	0	283, 613	15. 00
16. 00	instructions) Payment for inpatient program capital	50. 00	21, 310	0	21, 310	0	21, 310	16. 00
17. 00	Special add-on payments for new technologies	54.00	0	0	0	0	0	17. 00
17. 01	Net organ aquisition cost	55.00	0	0	0	_	0	17. 01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68. 00	0	0	0	0	0	17. 02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0	0	0	0	18. 00
		<u> </u>	ı I	l	<u> </u>	T .		1

near th	Titianciai Systems	101	ILALIII STARKE W			III LI C	u or rorm cws	2332-10
LOW VO	LUME CALCULATION EXHIBIT 4					Period: From 01/01/2016 To 02/29/2016	Date/Time Pre 7/28/2016 7:4	pared:
				Ti tl	e XVIII	Hospi tal	PPS	
		W/S E, Part A	Amounts (from	Pre/Post	Period Prior	Peri od	Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01	through 4)	
		0	1.00	2. 00	3.00	4. 00	5. 00	
19. 00	SUBTOTAL			C	304, 92	3 0	304, 923	19. 00
		W/S L, line	(Amounts from					
			L)					
		0	1. 00	2. 00	3.00	4. 00	5. 00	
20.00	Capital DRG other than outlier		21, 310	C	21, 31	0 0	21, 310	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	C)	0 0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	0	C		0 0	0	21.00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	C)	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.0000	0.000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	C)	0 0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0000	0.0000	0. 000	0. 0000		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	0	С		0	0	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	21, 310	C	21, 31	0 0	21, 310	26. 00
			(Amounts to E,					
		line	Part A)					
		0	1.00	2. 00	3. 00	4. 00	5. 00	
	Low volume adjustment factor				0. 21571			27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96			65, 77	6	65, 776	28. 00
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	o	29. 00
100.00	Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

Health Financial Systems	IU HEALTH STARKE MEMORIAL HOSPITAL		In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN:	150102	From 01/01/2016	Worksheet E Part B Date/Time Prepared: 7/28/2016 7:42 pm

			To 02/29/2016	Date/Time Pre	
		Title XVIII	Hospi tal	7/28/2016 7: 4 PPS	<u> 2 piii </u>
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			2, 747	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		818, 274	2. 00
3.00	PPS payments			407, 247	3. 00
4.00	Outlier payment (see instructions)	i ana)		7, 255 0. 000	4.00
5. 00 6. 00					5. 00 6. 00
7. 00	Sum of line 3 plus line 4 divided by line 6			0 0. 00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	, col. 13, line 200		0	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			2, 747	11. 00
	Reasonable charges				
12. 00	Ancillary service charges			10, 089	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	e 69)		0	13. 00
14. 00	Total reasonable charges (sum of lines 12 and 13)			10, 089	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for pa	vment for services on	a charge hasis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			Ö	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)	. 3	J		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	
18. 00	Total customary charges (see instructions)	if line 10 evenede li	no 11) (coo	10, 089	18.00
19. 00	Excess of customary charges over reasonable cost (complete only instructions)	II Time 18 exceeds II	ne II) (See	7, 342	19. 00
20.00	, and the second				20. 00
21. 00	instructions) 0 Lesser of cost or charges (line 11 minus line 20) (for CAH see instructions)				21. 00
22. 00	Interns and residents (see instructions)	riisti deti olis)		2, 747 0	22. 00
23.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			414, 502	24. 00
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	25. 00
25. 00 26. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions)		0 107, 708	26.00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl		and 23] (see	309, 541	ı
	instructions)		- ,		
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	28. 00
29. 00 30. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0 309, 541	29. 00 30. 00
31.00	Subtotal (sum of lines 27 through 29) Primary payer payments			19	31.00
32. 00	Subtotal (line 30 minus line 31)			309, 522	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00 35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			42, 792 27, 815	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		34, 803	ł
37. 00	Subtotal (see instructions)	o :		337, 337	
38. 00	MSP-LCC reconciliation amount from PS&R			0	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pi oneer ACO demonstration payment adjustment (see instructions)	d doubless (see i petrus	+: ana)	0	39. 50
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	d devices (see instruc	tions)	0	39. 98 39. 99
40. 00	Subtotal (see instructions)			337, 337	40.00
40. 01				6, 747	1
41.00				301, 494	41.00
42. 00	` * * * * * * * * * * * * * * * * * * *		0	42.00	
43.00	Balance due provider/program (see instructions)	o with CMC Dub 1E 2	chantar 1	29, 096	43.00
44. 00	00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		87	44. 00	
	TO BE COMPLETED BY CONTRACTOR				
90.00	Original outlier amount (see instructions)	<u> </u>		0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0. 00 0	92. 00 93. 00
	Total (sum of lines 91 and 93)			0	
00	1 (2 2				

Health Financial Systems IU HEALTH STARKE MEMORIAL HOSPITAL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CC Provi der CCN: 150102

	Ti tl	e XVIII	Hospi tal	PPS	
	Inpatien	nt Part A	Par	rt B	
	/ 1 1 /		/ 1 1 /		
	mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy	Amount	
1.00 Total interim payments paid to provider	1.00	325, 789	3. 00	4. 00 301, 494	1. 00
2.00 Interim payments payable on individual bills, either		325, 789		301, 494	2. 00
submitted or to be submitted to the contractor for				ا	2.00
services rendered in the cost reporting period. If none,					
write "NONE" or enter a zero					
3.00 List separately each retroactive lump sum adjustment					3. 00
amount based on subsequent revision of the interim rate					0.00
for the cost reporting period. Also show date of each					
payment. If none, write "NONE" or enter a zero. (1)					
Program to Provider					
3. 01 ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 02		0		0	3. 02
3. 03		0		0	3. 03
3. 04		0		0	3. 04
3. 05		0		0	3. 05
Provider to Program					
3.50 ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51		0		0	3. 51
3. 52		0		0	3. 52
3. 53		0		0	3. 53
3. 54		0		0	3. 54
3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98)		0		0	3. 99
4.00 Total interim payments (sum of lines 1, 2, and 3.99)		325, 789		301, 494	4. 00
(transfer to Wkst. E or Wkst. E-3, line and column as		323, 707		301, 474	4.00
appropriate)					
TO BE COMPLETED BY CONTRACTOR					
5.00 List separately each tentative settlement payment after					5. 00
desk review. Also show date of each payment. If none,					
write "NONE" or enter a zero. (1)					
Program to Provider					
5. 01 TENTATI VE TO PROVI DER		0		0	5. 01
5. 02		0		0	5. 02
5. 03		0		0	5. 03
Provider to Program		1			
5. 50 TENTATI VE TO PROGRAM		0		0	5. 50
5. 51		0		0 0	5. 51
5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines		0			5. 52 5. 99
5. 50-5. 98)					5. 99
6.00 Determined net settlement amount (balance due) based on		•			6. 00
the cost report. (1)					0.00
6. 01 SETTLEMENT TO PROVIDER		4, 785		29, 096	6. 01
6. 02 SETTLEMENT TO PROGRAM		0		0	6. 02
7.00 Total Medicare program liability (see instructions)		330, 574		330, 590	
			Contractor	NPR Date	
			Number	(Mo/Day/Yr)	
	(0	1. 00	2.00	
8.00 Name of Contractor					8. 00

Health Financial Systems I U HEALT ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

		Component	1 CCN. 150102 1	0 02/29/2010	7/28/2016 7:4	
		Ti tl	e XVIII Sı	wing Beds - SNF	PPS	
		I npati er	nt Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		0		0	1.00
2.00	Interim payments payable on individual bills, either		0		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	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		_	
3. 01	ADJUSTMENTS TO PROVIDER		0		0	
3. 02			0		0	
3. 03			0		0	
3.04			0		0	
3.05			0		0	3.05
2 50	Provider to Program ADJUSTMENTS TO PROGRAM		1	1	1 0	, ,
3.50	ADJUSTMENTS TO PROGRAM		0		0	
3.51					0	
3. 52 3. 53					0	0.02
3. 54					0	
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines				0	
3. 99	3. 50-3. 98)				0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		0		0	4.00
1. 00	(transfer to Wkst. E or Wkst. E-3, line and column as					". 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR	•	,			1
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		0		0	
5.02			0		0	
5.03			0		0	5. 03
	Provi der to Program		1	T	T -	
5. 50	TENTATI VE TO PROGRAM		0		0	1
5. 51			0		0	1 0.0.
5. 52			0		0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		0		0	5. 99
4 00	5. 50-5. 98)					/ 00
6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		0		0	6. 01
6. 02	SETTLEMENT TO PROGRAM				0	
7. 00	Total Medicare program liability (see instructions)				0	
7.00	Trotal most out o program trabitity (300 thotal detroits)			Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
			0	1. 00	2.00	
8. 00	Name of Contractor					8. 00

Heal th	Financial Systems IU HEALTH STARKE MEMOR	I AL HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150102	Peri od: From 01/01/2016 To 02/29/2016	Worksheet E-1 Part II Date/Time Pre 7/28/2016 7:4:	
		Title XVIII	Hospi tal	PPS	
				1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst. S		14	0	1. 00
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12				0	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			0	3. 00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-1	2		0	4. 00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			0	5. 00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 lir	ne 20		0	6.00
7. 00	CAH only - The reasonable cost incurred for the purchase of cer line 168	tified HIT technology	Wkst. S-2, Pt. I	0	7. 00
8.00	Calculation of the HIT incentive payment (see instructions)			0	8. 00
9.00	Sequestration adjustment amount (see instructions)			0	9. 00
10.00	Calculation of the HIT incentive payment after sequestration (s	see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	-			
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32 00	Balance due provider (Line 8 (or Line 10) minus Line 30 and Lin	ne 31) (see instruction	را د	0	32 00

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

0 32.00

Health Financial Systems	IU HEALTH STARKE MEMOR	AL HOSPITAL		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN	l: 150102		Worksheet E-2
				From 01/01/2016	
		Component CC	N: 15U102	To 02/29/2016	Date/Time Prepared:
		·			7/28/2016 7:42 pm

Title XVIII Swing Beds - SNF PPS Part A Part B Part A Part B Part A Part B Part B Part A Part B			Compenent Con. 100102	02/2//2010	7/28/2016 7:4	
1.00			Title XVIII S	wing Beds - SNF		
COMPUTATION OF NET COST OF COVERED SERVICES Inpatient routine services - swing bed-SNF (see instructions) 1.00 Inpatient routine services - swing bed-SNF (see instructions) 2.00 Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions) 3.00 Per diem cost for interns and residents not in approved teaching program (see instructions) 0.00 4.00 Instructions) 0.00 4.00 Instructions 0.00 4.00 Interns and residents not in approved teaching program (see instructions) 0.00 0.0						
1.00				1. 00	2. 00	
2.00 Inpatient routine services - swing bed-NF (see instructions) 3.00 Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions) 4.00 Per diem cost for interns and residents not in approved teaching program (see instructions) 5.00 Program days 6.00 Interns and residents not in approved teaching program (see instructions) 7.00 Utilization review - physician compensation - SNF optional method only 8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 9.00 Primary payer payments (see instructions) 9.00 Subtotal (line 8 minus line 9) 9.00 Subtotal (line 8 minus line 9) 9.01 Object of the color of						
3.00 Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A, and sum of Wkst. D, Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions)				0	0	
Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see instructions) 4.00 Per diem cost for interns and residents not in approved teaching program (see instructions) 5.00 Program days 6.00 Interns and residents not in approved teaching program (see instructions) 7.00 Utilization review - physician compensation - SNF optional method only 8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 9.00 Primary payer payments (see instructions) 10.00 Subtotal (line 8 minus line 9) 10.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 14.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.55 Pioneer ACO demonstration payment adjustment (see instructions) 17.01 Adjusted reimbursable bad debts (see instructions) 18.00 Allowable bad debts (see instructions) 19.01 Total (see instructions) 19.02 Total (see instructions) 10.03 Eventation adjustment (see instructions) 10.04 Interim payments 10.05 Protested amounts (for contractor use only) 10.06 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,						2. 00
4.00 Per diem cost for interns and residents not in approved teaching program (see instructions) 5.00 Program days 6.00 Interns and residents not in approved teaching program (see instructions) 7.00 Utilization review - physician compensation - SNF optional method only 8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 9.00 Primary payer payments (see instructions) 9.00 Primary payer payments (see instructions) 9.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 9.00 Subtotal (line 10 minus line 1) 11.00 Deductibles billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 Subtotal (line 10 minus line 11) 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.55 410A RURAL DEMONSTRATION PROJECT 17.00 Allowable bad debts (see instructions) 18.00 Allowable bad debts (see instructions) 19.01 Adjusted reimbursable bad debts (see instructions) 19.01 Total (see instructions) 19.01 Sequestration adjustment (see instructions) 19.02 Total (see instructions) 19.03 Equestration adjustment (see instructions) 19.04 Interim payments 19.05 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 19.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 19.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	3.00					3. 00
instructions) Program days 6.00 Interns and residents not in approved teaching program (see instructions) 7.00 Utilization review - physician compensation - SNF optional method only 8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 9.00 Primary payer payments (see instructions) 9.00 Primary payer payments (see instructions) 10.00 Subtotal (line 8 minus line 9) 11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 14.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Pi oneer ACO demonstration payment adjustment (see instructions) 16.55 AloA RURAL DEMONSTRATION PROJECT 17.00 Allowable bad debts (see instructions) 18.00 Allowable bad debts (see instructions) 19.00 Total (see instructions) 10.01 Allowable bad debts (see instructions) 10.02 Subtotal (see instructions) 10.03 Protested amounts (for ontractor use only) 19.00 Total (see instructions) (see instructions) in accordance with CMS Pub. 15-2, o 22.						
5.00 Program days 6.00 Interns and residents not in approved teaching program (see instructions) 7.00 Utilization review - physician compensation - SNF optional method only 8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 9.00 Primary payer payments (see instructions) 9.00 Primary payer payments (see instructions) 9.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Ploneer ACO demonstration payment adjustment (see instructions) 10.10 Allowable bad debts (see instructions) 10.11 Allowable bad debts (see instructions) 10.12 Allowable bad debts for dual eligible beneficiaries (see instructions) 10.11 Total (see instructions) 10.12 Sequestration adjustment (see instructions) 10.13 Sequestration adjustment (see instructions) 10.14 Sequestration adjustment (see instructions) 10.15 Sequestration adjustment (see instructions) 10.16 Sequestration adjustment (see instructions) 10.17 Sequestration adjustment (see instructions) 10.18 Sequestration adjustment (see instructions) 10.19 Sequestration adjustment (see instructions) 11.10 Sequestration adjustment (for contractor use only) 12.20 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 12.30 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	4. 00	11	g program (see		0. 00	4. 00
6.00 Interns and residents not in approved teaching program (see instructions) 7.00 Utilization review - physician compensation - SNF optional method only 9.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 9.00 Subtotal (line 8 minus line 9) 11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.55 410A RURAL DEMONSTRATION PROJECT 17.00 Allowable bad debts (see instructions) 18.00 Allowable bad debts (see instructions) 19.00 Total (see instructions) 20.00 Interim payments 20.00 Interim payments 20.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 22.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,						
7.00 Utilization review - physician compensation - SNF optional method only 8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 9.00 Primary payer payments (see instructions) 10.00 Subtotal (line 8 minus line 9) 11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 14.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 17.00 Pioneer ACO demonstration payment adjustment (see instructions) 18.00 Allowable bad debts (see instructions) 19.01 Adjusted reimbursable bad debts (see instructions) 10.01 Adjusted reimbursable bad debts (see instructions) 10.02 Total (see instructions) 10.03 Coulon (see instructions) 10.04 Invalide bad debts (see instructions) 10.05 Interim payments 10.06 Interim payments 10.07 Total (see instructions) 10.08 Interim payments 10.09 Coulon (see instructions) 10.00 Interim payments 10.00 Protested amounts (line 19 minus lines 19.01, 20, and 21) 10.01 Protested amounts (nonal lowable cost report items) in accordance with CMS Pub. 15-2,				0		5. 00
8.00 Subtotal (sum of lines 1 through 3 plus lines 6 and 7) 9.00 Primary payer payments (see instructions) 0 0 9. 10.00 Subtotal (line 8 minus line 9) 11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.55 410A RURAL DEMONSTRATION PROJECT 17.00 Allowable bad debts (see instructions) 19.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 19.00 Total (see instructions) 19.01 Sequestration adjustment (see instructions) 20.00 Interim payments 20.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 21.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 20.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 20.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 20.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 20.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 20.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 20.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 20.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 20.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 20.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 20.00 Protested amounts (nonallowable cost report items)		11 9 1	,		0	6. 00
9.00 Primary payer payments (see instructions) 0 0 9. 10.00 Subtotal (line 8 minus line 9) 0 10. 11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.55 410A RURAL DEMONSTRATION PROJECT 17.00 Allowable bad debts (see instructions) 18.00 Allowable bad debts (see instructions) 19.00 Total (see instructions) 19.00 Total (see instructions) 19.00 Total (see instructions) 20.00 Interim payments 20.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,			od only	0		7. 00
10.00 Subtotal (line 8 minus line 9) 11.00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 10.50 Pioneer ACO demonstration payment adjustment (see instructions) 10.50 Pioneer ACO demonstration payment adjustment (see instructions) 10.51 Allowable bad debts (see instructions) 10.52 Allowable bad debts (see instructions) 10.53 Adjusted reimbursable bad debts (see instructions) 10.54 Allowable bad debts for dual eligible beneficiaries (see instructions) 10.55 Allowable bad debts for dual eligible beneficiaries (see instructions) 10.56 Sequestration adjustment (see instructions) 10.57 Cotal (see instructions) 10.59 Cotal (see instructions) 10.50 Total (see instructions) 10.50 Total (see instructions) 10.51 Sequestration adjustment (see instructions) 10.52 Cotal Sequestration adjustment (see instructions) 10.55 Allowable bad debts for dual eligible beneficiaries (see instructions) 10.50 Total (see instructi				0		
11. 00 Deductibles billed to program patients (exclude amounts applicable to physician professional services) 12. 00 Subtotal (line 10 minus line 11) 13. 00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14. 00 80% of Part B costs (line 12 x 80%) 15. 00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16. 50 Pioneer ACO demonstration payment adjustment (see instructions) 17. 01 Adjusted reimbursable bad debts (see instructions) 18. 00 Allowable bad debts (see instructions) 19. 00 Total (see instructions) 10 O 17. 11 O 17 O 17 O 17 O 17 O 18 O 18 O 19 O 19 O 19 O 19 O 19 O 19				0	-	
professional services) 12.00 Subtotal (line 10 minus line 11) 13.00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.55 410A RURAL DEMONSTRATION PROJECT 17.00 Allowable bad debts (see instructions) 18.00 Allowable bad debts (see instructions) 19.00 Total (see instructions) 10.01 Total (see instructions) 10.02 Sequestration adjustment (see instructions) 10.03 Interim payments 10.04 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,		,		0	-	
12. 00 Subtotal (line 10 minus line 11) 13. 00 Coinsurance billed to program patients (from provider records) (exclude coinsurance for physician professional services) 14. 00 80% of Part B costs (line 12 x 80%) 15. 00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16. 50 Pioneer ACO demonstration payment adjustment (see instructions) 16. 55 410A RURAL DEMONSTRATION PROJECT 17. 00 Allowable bad debts (see instructions) 18. 00 Allowable bad debts (see instructions) 19. 01 Total (see instructions) 19. 00 Total (see instructions) 19. 01 Dequestration adjustment (see instructions) 19. 01 Total (see instructions) 19. 01 Total (see instructions) 19. 01 Dequestration adjustment (see instructions) 19. 01 Dequestration adjustment (see instructions) 19. 01 Dequestration adjustment (see instructions) 19. 02 Dequestration adjustment (for contractor use only) 20. 02 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 21. 02 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	11. 00		ble to physician	0	0	11. 00
for physician professional services) 14.00 80% of Part B costs (line 12 x 80%) 15.00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.55 410A RURAL DEMONSTRATION PROJECT 17.00 Allowable bad debts (see instructions) 18.00 Allowable bad debts (see instructions) 19.00 Total (see instructions) 19.01 Sequestration adjustment (see instructions) 20.00 Interim payments 11.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 10 O 14. 11.00 O 14. 12.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 10 O 15-2. 11.00 O 14. 12.00 D 15-2. 12.00 D 16-2. 13.00 O 16-2. 14.00 O 16-2. 15.00 O 16-2. 16. 17.00 O 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	12. 00			0	0	12. 00
for physician professional services) 14. 00 80% of Part B costs (line 12 x 80%) 15. 00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16. 50 Pioneer ACO demonstration payment adjustment (see instructions) 16. 55 410A RURAL DEMONSTRATION PROJECT 17. 00 Allowable bad debts (see instructions) 18. 00 Allowable bad debts (see instructions) 19. 00 Total (see instructions) 19. 01 Total (see instructions) 19. 01 Sequestration adjustment (see instructions) 20. 00 Interim payments 21. 00 Tentative settlement (for contractor use only) 22. 00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 23. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	0	0	13. 00
15. 00 Subtotal (enter the lesser of line 12 minus line 13, or line 14) 16. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16. 50 Pi oneer ACO demonstrati on payment adjustment (see instructions) 16. 55 410A RURAL DEMONSTRATION PROJECT 17. 00 Allowable bad debts (see instructions) 18. 00 Allowable bad debts (see instructions) 19. 00 Total (see instructions) 19. 01 Total (see instructions) 19. 01 Sequestrati on adjustment (see instructions) 19. 01 Interim payments 21. 00 Tentative settlement (for contractor use only) 22. 00 Balance due provider/program (line 19 minus lines 19. 01, 20, and 21) 23. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,			•			
16.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 16.50 Pi oneer ACO demonstration payment adjustment (see instructions) 16.55 410A RURAL DEMONSTRATION PROJECT 17.00 Allowable bad debts (see instructions) 17.01 Adjusted reimbursable bad debts (see instructions) 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 19.00 Total (see instructions) 19.01 Sequestration adjustment (see instructions) 19.02 Interim payments 20.00 Interim payments 21.00 Tentative settlement (for contractor use only) 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	14.00	80% of Part B costs (line 12 x 80%)			0	14.00
16.50 Pioneer ACO demonstration payment adjustment (see instructions) 16.55 410A RURAL DEMONSTRATION PROJECT 17.00 Allowable bad debts (see instructions) 18.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 19.00 Total (see instructions) 19.01 Sequestration adjustment (see instructions) 19.02 Interim payments 20.00 Interim payments 10.00 Tentative settlement (for contractor use only) 21.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 22.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	15.00	Subtotal (enter the lesser of line 12 minus line 13, or line 14)	0	0	15. 00
16. 55 410A RURAL DEMONSTRATION PROJECT 17. 00 Allowable bad debts (see instructions) 18. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 19. 00 Total (see instructions) 19. 01 Sequestration adjustment (see instructions) 19. 01 Interim payments 20. 00 Interim payments 10 Definition of the provider of the program (line 19 minus lines 19. 01, 20, and 21) 21. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16. 00
17. 00 Allowable bad debts (see instructions) 17. 01 Adjusted reimbursable bad debts (see instructions) 18. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 19. 00 Total (see instructions) 19. 01 Sequestration adjustment (see instructions) 20. 00 Interim payments 21. 00 Tentative settlement (for contractor use only) 22. 00 Balance due provider/program (line 19 minus lines 19. 01, 20, and 21) 23. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2,	16. 50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16. 50
17. 01 Adjusted reimbursable bad debts (see instructions) 18. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 19. 00 Total (see instructions) 19. 01 Sequestration adjustment (see instructions) 20. 00 Interim payments 21. 00 Totative settlement (for contractor use only) 22. 00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 23. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 17. 18. 00 0 17. 19. 01 0 0 0 18. 0 0 0 19. 0 0 0 19. 0 0 0 0 0 0 0 0 0	16. 55	410A RURAL DEMONSTRATION PROJECT		0		16. 55
18. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 19. 00 Total (see instructions) 19. 01 Sequestration adjustment (see instructions) 20. 00 Interim payments 21. 00 Totative settlement (for contractor use only) 22. 00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 23. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 18. 0 0 19. 0 0 19. 0 0 0 19. 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17.00	Allowable bad debts (see instructions)		0	0	17. 00
19.00 Total (see instructions) Sequestration adjustment (see instructions) 19.01 Sequestration adjustment (see instructions) 10.00 Interim payments 10.00 Total (see instructions) 10.00	17. 01	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
19.01 Sequestration adjustment (see instructions) 20.00 Interim payments 1.00 Tentative settlement (for contractor use only) 22.00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 19. 0 20. 0 21. 0 22. 0 23.	18.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)	0	0	18. 00
20. 00 Interim payments 0 0 20. 21. 00 Tentative settlement (for contractor use only) 0 0 21. 22. 00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 0 0 22. 23. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 23.	19.00	Total (see instructions)		0	0	19. 00
21. 00 Tentative settlement (for contractor use only) 22. 00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 23. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 21.	19.01	Sequestration adjustment (see instructions)		0	0	19. 01
22. 00 Balance due provider/program (line 19 minus lines 19.01, 20, and 21) 0 0 22. 23. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 23.	20.00	Interim payments		0	0	20.00
23.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, 0 0 23.	21.00	Tentative settlement (for contractor use only)		0	0	21. 00
	22.00	Balance due provider/program (line 19 minus lines 19.01, 20, an	d 21)	0	0	22. 00
chapter 1, §115.2	23. 00		e with CMS Pub. 15-2,	0	0	23. 00
		chapter 1, §115.2		1		l

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

Provi der CCN: 150102

Peri od: Worksheet G From 01/01/2016 To 02/29/2016 Date/Time Prepared:

			'	0 02/29/2010	7/28/2016 7:4	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1.00	Cash on hand in banks	2, 111, 142	· O	0	0	1.00
2.00	Temporary investments	0	0	0	0	2. 00
3.00	Notes receivable	0	0	0	0	3. 00
4.00	Accounts receivable	14, 616, 742	2 0	0	0	4. 00
5.00	Other recei vable	492, 477	1	0	0	5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	-11, 162, 812		0	0	6. 00
7.00	Inventory	339, 600		0	0	7. 00
8.00	Prepai d expenses	74, 763		0	0	8.00
9. 00 10. 00	Other current assets Due from other funds			0	0	9. 00 10. 00
11. 00	Total current assets (sum of lines 1-10)	6, 471, 912			0	11.00
11.00	FIXED ASSETS	0,471,912		U O	0	11.00
12. 00	Land	142, 789	0	0	0	12. 00
13. 00	Land improvements	37, 448	1	0	0	13. 00
14.00	Accumul ated depreciation	-4, 868	1	0	0	14. 00
15.00	Bui I di ngs	1, 509, 571	0	0	0	15. 00
16.00	Accumulated depreciation	-412, 273	0	0	0	16. 00
17. 00	Leasehold improvements	6, 082, 400		-	0	17. 00
18. 00	Accumul ated depreciation	-2, 780, 940	1		0	18. 00
19. 00	Fixed equipment	0	0	-	0	19.00
20. 00	Accumulated depreciation	0	0	0	0	20.00
21. 00 22. 00	Automobiles and trucks	0		0	0	21. 00 22. 00
23. 00	Accumulated depreciation Major movable equipment	9, 769, 509		0	0	23. 00
24. 00	Accumulated depreciation	-7, 104, 976	1	0	0	24.00
25. 00	Mi nor equi pment depreci abl e	7, 104, 770		0	0	25. 00
26. 00	Accumulated depreciation	0		_	0	26.00
27. 00	HIT designated Assets	Ö	Ö	0	0	27. 00
28.00	Accumulated depreciation	0	0	0	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0	0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	7, 238, 660	0	0	0	30. 00
	OTHER ASSETS	_	_		_	
31. 00	Investments	0	0		0	31.00
32. 00	Deposits on Leases	0	0	-	0	32.00
33. 00	Due from owners/officers	0	0		0	33.00
34. 00 35. 00	Other assets Total other assets (sum of lines 31-34)		0	-	0	34. 00 35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	13, 710, 572			0	36.00
30.00	CURRENT LIABILITIES	13,710,372		ı	<u> </u>	30.00
37.00	Accounts payable	-1, 089, 508	8 0	0	0	37. 00
38.00	Salaries, wages, and fees payable	-540, 731	1	0	0	38. 00
39.00	Payroll taxes payable	-27, 642	2	0	0	39. 00
40.00	Notes and Loans payable (short term)	-45, 342	2 0	0	0	40. 00
41.00	Deferred income	0	0	0	0	41. 00
42. 00	Accel erated payments	0				42. 00
43.00	Due to other funds	-86, 268	1	0	0	43. 00
44. 00	Other current liabilities	1 700 401	0		0	
45. 00	Total current liabilities (sum of lines 37 thru 44) LONG TERM LIABILITIES	-1, 789, 491	0	0	0	45. 00
46. 00	Mortgage payable	1) 0	0	0	46. 00
47. 00	Notes payable			-	0	47. 00
48. 00	Unsecured Loans	0			Ö	48. 00
49.00	Other long term liabilities	0	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49)	0	0	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	-1, 789, 491	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	15, 500, 063	3			52. 00
53. 00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56.00
57. 00	Plant fund balance - invested in plant		1		0	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	15, 500, 063		0	0	59. 00
60. 00	Total liabilities and fund balances (sum of lines 51 and	13, 710, 572		l ol	0	60.00
	59)		1			
				'		

19.00

STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 150102 Peri od: Worksheet G-1 From 01/01/2016 02/29/2016 Date/Time Prepared: 7/28/2016 7:42 pm General Fund Special Purpose Fund Endowment Fund 1.00 2.00 3.00 4. 00 5. 00 1.00 Fund balances at beginning of period 14, 547, 460 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) -7, 969 2.00 3.00 Total (sum of line 1 and line 2) 14, 539, 491 0 3.00 4 00 Additions (credit adjustments) (specify) 0 0 4.00 5.00 DECREASE IN LIABILITIES 3, 082, 596 0 5.00 6.00 INTERCOMPANY CONTRIBUTIONS 7, 969 6.00 0 7.00 0 0 7.00 0 8.00 0 0 8.00 0 9.00 0 0 9.00 10.00 Total additions (sum of line 4-9) 3, 090, 565 10.00 Subtotal (line 3 plus line 10) 17, 630, 056 11 00 0 11.00 12.00 Deductions (debit adjustments) (specify) 0 0 12.00 13.00 DECREASE IN ASSETS 2, 129, 993 13.00 14.00 0 14.00 0 0 0 15.00 0 15.00 16.00 0 0 16.00 17.00 0 17.00 2, 129, 993 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 15, 500, 063 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 6.00 7. 00 8.00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 Additions (credit adjustments) (specify) 4.00 4.00 5.00 DECREASE IN LIABILITIES 0 5.00 INTERCOMPANY CONTRIBUTIONS 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 10.00 11.00 0 Subtotal (line 3 plus line 10) 0 11.00 12.00 Deductions (debit adjustments) (specify) 12.00 DECREASE IN ASSETS 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 18.00 18.00 0

0

0

19.00

Fund balance at end of period per balance

sheet (line 11 minus line 18)

Health Financial Systems 1 U HEAT STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES

			To	02/29/2016	Date/Time Prep 7/28/2016 7:4:	
	Cost Center Description		Inpatient	Outpati ent	Total	2 pm
	'		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		573, 015		573, 015	1. 00
2.00	SUBPROVI DER - I PF					2. 00
3.00	SUBPROVI DER - I RF					3. 00
4.00	SUBPROVI DER					4. 00
5.00	Swing bed - SNF		0		0	5. 00
6.00	Swing bed - NF		0		0	6. 00
7.00	SKILLED NURSING FACILITY					7. 00
8.00	NURSING FACILITY					8. 00
9.00	OTHER LONG TERM CARE		F70 04F		F70 04F	9. 00
10. 00	Total general inpatient care services (sum of lines 1-9)		573, 015		573, 015	10. 00
11. 00	Intensive Care Type Inpatient Hospital Services INTENSIVE CARE UNIT		0	T	0	11. 00
12. 00	CORONARY CARE UNIT		U		U	12.00
13. 00	BURN INTENSIVE CARE UNIT					13. 00
14. 00	SURGICAL INTENSIVE CARE UNIT					14. 00
15. 00	OTHER SPECIAL CARE (SPECIFY)					15. 00
16. 00	Total intensive care type inpatient hospital services (sum of I	ines	0		0	16. 00
10.00	11-15)	11103	J		O	10.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		573, 015		573, 015	17. 00
18. 00	Ancillary services		1, 341, 197	9, 025, 126	10, 366, 323	18. 00
19. 00	Outpatient services		241, 399	2, 368, 365	2, 609, 764	
	RURAL HEALTH CLINIC		0	0	0	20. 00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	O	0	21. 00
22.00	HOME HEALTH AGENCY					22. 00
23.00	AMBULANCE SERVICES					23. 00
24.00	CMHC					24. 00
25.00	AMBULATORY SURGICAL CENTER (D. P.)					25. 00
26.00	HOSPI CE					26. 00
27. 00	PROFESSI ONAL		538	1, 014, 941	1, 015, 479	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 t	o Wkst.	2, 156, 149	12, 408, 432	14, 564, 581	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
29. 00	Operating expenses (per Wkst. A, column 3, line 200)			3, 538, 933		29. 00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32. 00			0			32. 00
33. 00 34. 00			0			33. 00 34. 00
35. 00			0			35. 00
36. 00	Total additions (sum of lines 30-35)		U	0		36.00
37. 00	DEDUCT (SPECIFY)		0	۷		37. 00
38. 00	DEDUCT (SECOTE)		0			38. 00
39. 00			0			39. 00
40. 00			0			40.00
41. 00			0			41. 00
42. 00	Total deductions (sum of lines 37-41)		٥	o		42. 00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer		3, 538, 933		43. 00
	to Wkst. G-3, line 4)	,				
		•				

Heal th	Financial Systems IU HEALTH STARKE MEMOR	RIAL HOSPITAL	In lie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 150102	Peri od:	Worksheet G-3	2002 10
01711211			From 01/01/2016 To 02/29/2016	Date/Time Pre 7/28/2016 7:4	
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		14, 564, 581	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			11, 147, 854	
3. 00	Net patient revenues (line 1 minus line 2)			3, 416, 727	3. 00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43	3)		3, 538, 933	
5. 00	Net income from service to patients (line 3 minus line 4)	-,		-122, 206	5. 00
	OTHER I NCOME		<u>'</u>	,	
6.00	Contributions, donations, beguests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication s	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12.00
13.00	Revenue from Laundry and Linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			0	14.00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other that	an patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18. 00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21. 00
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	MI SCELLANEOUS I NCOME			114, 237	24. 00
25.00	Total other income (sum of lines 6-24)			114, 237	25. 00
26.00	Total (line 5 plus line 25)			-7, 969	26. 00
27 00	OTHER EXPENSES (SPECIEV)			0	27 00

27.00 OTHER EXPENSES (SPECIFY)
28.00 Total other expenses (sum of line 27 and subscripts)
29.00 Net income (or loss) for the period (line 26 minus line 28)

0 27. 00 28. 00 -7, 969 29. 00

CALCIII	Financial Systems IU HEALTH STARK ATION OF CAPITAL PAYMENT	E MEMORIAL HOSPITAL Provider CCN: 150102	Peri od:	u of Form CMS-2 Worksheet L	2002-10
CALCUL	ATION OF CAPITAL PAYMENT	Provider CCN: 150102	From 01/01/2016 To 02/29/2016	Parts I-III	pared:
				7/28/2016 7: 4	
	<u> </u>	Title XVIII	Hospi tal	PPS	
				4 00	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				1
1.00	Capital DRG other than outlier			21, 310	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			21, 310	1. 01
2. 00	Capital DRG outlier payments			0	
2. 01	Model 4 BPCI Capital DRG outlier payments			0	2. 01
3. 00	Total inpatient days divided by number of days in the co	st reporting period (see inst	ructions)	3. 90	3.00
4.00	Number of interns & residents (see instructions)	ar reper in a particular	,	0.00	
5. 00	Indirect medical education percentage (see instructions)			0.00	
6.00	Indirect medical education adjustment (multiply line 5 b		, columns 1 and	0	
	1.01) (see instructions)				
7.00	Percentage of SSI recipient patient days to Medicare Par	t A patient days (Worksheet E	, part A line	0.00	7.00
	30) (see instructions)				
8.00	Percentage of Medicaid patient days to total days (see i	nstructions)		0. 00	8. 00
9.00	Sum of lines 7 and 8			0. 00	
10. 00	Allowable disproportionate share percentage (see instruc	tions)		0. 00	
11. 00	Disproportionate share adjustment (see instructions)			0	
12. 00	Total prospective capital payments (see instructions)			21, 310	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instructions			0	
2.00	Program inpatient ancillary capital cost (see instruction			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)		0	3. 00
	Capital cost payment factor (see instructions)			0	4. 00
4.00				0	5.00
4. 00 5. 00	Total inpatient program capital cost (line 3 x line 4)				
	Total Inpatient program capital cost (Tine 3 x Tine 4)			1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS			1.00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions)			0	
5. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum			0	1. 00
1. 00 2. 00 3. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2			0 0	1. 00 2. 00 3. 00
1. 00 2. 00 3. 00 4. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions))		0 0 0 0.00	1. 00 2. 00 3. 00 4. 00
1. 00 2. 00 3. 00 4. 00 5. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4)		0 0 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4 Percentage adjustment for extraordinary circumstances (s) ee instructions)		0 0 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4 Percentage adjustment for extraordinary circumstances (s Adjustment to capital minimum payment level for extraord) ee instructions)	(line 6)	0 0 0 0.00 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4 Percentage adjustment for extraordinary circumstances (s Adjustment to capital minimum payment level for extraord Capital minimum payment level (line 5 plus line 7)) ee instructions) inary circumstances (line 2 x	cline 6)	0 0 0 0.00 0 0.00	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4 Percentage adjustment for extraordinary circumstances (s Adjustment to capital minimum payment level for extraord Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as) ee instructions) inary circumstances (line 2 x applicable)	ŕ	0 0 0 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
5. 00 1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4 Percentage adjustment for extraordinary circumstances (s Adjustment to capital minimum payment level for extraord Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level) ee instructions) inary circumstances (line 2 x applicable) to capital payments (line 8	less line 9)	0 0 0 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4 Percentage adjustment for extraordinary circumstances (s Adjustment to capital minimum payment level for extraord Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level Carryover of accumulated capital minimum payment level) ee instructions) inary circumstances (line 2 x applicable) to capital payments (line 8	less line 9)	0 0 0 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
5.00 1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00	PART III - COMPUTATION OF EXCEPTION PAYMENTS Program inpatient capital costs (see instructions) Program inpatient capital costs for extraordinary circum Net program inpatient capital costs (line 1 minus line 2 Applicable exception percentage (see instructions) Capital cost for comparison to payments (line 3 x line 4 Percentage adjustment for extraordinary circumstances (s Adjustment to capital minimum payment level for extraord Capital minimum payment level (line 5 plus line 7) Current year capital payments (from Part I, line 12, as Current year comparison of capital minimum payment level) ee instructions) inary circumstances (line 2 x applicable) to capital payments (line 8 ver capital payment (from pri	less line 9) or year	0 0 0 0.00 0 0.00 0	1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00

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

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

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

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

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

0 12.00

0 13.00

14.00

0 15.00 0 16.00 0 17.00

13.00

14.00