Heal th Financia	al Systems INDIANA UNIVERSITY HE	ALTH BEDFORD	In Lie	u of Form CMS-2552-10
This report is	required by law (42 USC 1395g; 42 CFR 413.20(b)). Fail	ure to report can resul	t in all interim	FORM APPROVED
payments made	since the beginning of the cost reporting period being	deemed overpayments (42	2 USC 1395g).	OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION SUMMARY	Provi der CCN: 151328	Peri od: From 01/01/2015 To 12/31/2015	
PART I - COST	REPORT STATUS			
Provi der use only	1. [X]Electronically filed cost report 2. []Manually submitted cost report		Date: 5/27/20	
	3. [0] If this is an amended report enter the number of 4. [F] Medicare Utilization. Enter "F" for full or "L"		esubmitted this c	ost report
Contractor use only	5. [1]Cost Report Status 6. Date Received: (1) As Submitted 7. Contractor No. (2) Settled without Audit 8. [N] Initial Report for (3) Settled with Audit 9. [N] Final Report for the contraction of the contract	this Provider CCN 12.		

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 INDI ANA UNIVERSITY HEALTH BEDFORD (151328) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si gned))					
		Offi cer	or	Admi ni strator	of	Provi der(s)
	Title					
	IIIIe					
	Date					

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	992, 893	615, 692	0	0	1. 00
2.00	Subprovi der - IPF	0	0	0		0	2. 00
3.00	Subprovi der - I RF	0	0	0		0	3. 00
4.00	SUBPROVI DER I	0	0	0		0	4. 00
5.00	Swing bed - SNF	0	145, 516	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7. 00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11. 00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11. 00
12.00	CMHC I	0		0		0	12. 00
200.00	Total	0	1, 138, 409	615, 692	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.

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151328 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/27/2016 1:57 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: Street: 2900 WEST SIXTEENTH STREET 1.00 PO Box: 1.00 2.00 City: BEDFORD State: IN Zip Code: 47421-County: LAWRENCE 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 INDIANA UNIVERSITY 151328 99915 10/01/2005 Ν 0 0 3.00 HEALTH BEDEORD Subprovider - IPF 4.00 4 00 5.00 Subprovider - IRF 5.00 Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF IU HEALTH BEDFORD -99915 O 157328 10/01/2005 N 0 7 00 7.00 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 LCF/LLD 10.01 10.01 11.00 Hospi tal -Based OLTC 11.00 Hospi tal -Based HHA 12.00 12.00 Separately Certified ASC 13 00 13 00 14.00 Hospi tal -Based Hospi ce 14.00 Hospital-Based Health Clinic - RHC 15.00 15.00 16.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital-Based (CMHC) I 17.00 17. 10 Hospital-Based (CORF) I 17.10 18.00 Renal Dialysis 18.00 19.00 Other 19. 00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2015 12/31/2015 20.00 Type of Control (see instructions) 21.00 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 Ν share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.06(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 Ν Ν 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) Is this a newly merged hospital that requires final uncompensated care payments to be determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes 22 02 Ν 22.02 Ν 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 N 22.03 Ν 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 23 00 3 N 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 In-State In-State Out-of Out-of Medi cai d 0ther HMO days Medi cai d Medi cai d Medi cai d State State paid days Medi cai d Medi cai d eligible days unpai d pai d days el i gi bl e days unpai d 1 00 2 00 3 00 5 00 6 00 4 00 24.00 If this provider is an IPPS hospital, enter the 0 0 0 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.

HO251 I	Financial Systems INDIANA UNITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA			CCN: 151328	Peri od:	In Lieu		eet S-2	
					From 01/01/2015 Part I To 12/31/2015 Date/Time F 5/27/2016 1			ime Pre	pared:
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medi cai d el i gi bl e unpai d	Medicai HMO day	/s Med	ther di cai d days	
25.00	hour and a second	1.00	2. 00	3. 00	4. 00	5. 00		5. 00	05.01
25. 00	If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid days in column 3, out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5.	C	0	0	0		0		25. 00
					Urban/k	dural S	Date of 2.0		
26. 00	Enter your standard geographic classification (not wa		at the beg	inning of t	he	2			26. 00
27. 00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wareporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassification.	age) status - "2" for r	ural. If ap		it	2			27. 0
35. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		0	- E 1		35. 0
					Begi n		Endi 2. (
36. 00	Enter applicable beginning and ending dates of SCH stop of periods in excess of one and enter subsequent date		cript line	36 for numb	er				36. 0
	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.	the numbe			IS	0			37.0
38.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38. 0
					1.		Y/ 2. (
39. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(ii or "N" for no. Does the facility meet the mileage rec CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes)? Enter i quirements	n column 1 in accordar	"Y" for yes nce with 42	;	I	N		39. 0
40. 00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob no in column 2, for discharges on or after October 1.	n adjustmen oer 1. Ente	t? Enter "Y r "Y" for y	" for yes o	or N	I V	XVIII	I XI X	40.0
						1.00	2. 00	3.00	
45. 00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital paymen	nt for disp	roporti onat	re share in	accordance	l N	l N	N	45. 0
46. 00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment excepursuant to 42 CFR §412.348(f)? If yes, complete Wkst	eption for	extraordi na	ıry circumst	ances	N	N	N	46. 0
47. 00 48. 00	Pt. III. Is this a new hospital under 42 CFR §412.300 PPS capils the facility electing full federal capital payment					N N	N N	N N	47. 0 48. 0
56. 00	Teaching Hospitals Is this a hospital involved in training residents in	annroved G	ME programs	? Enter "Y	" for ves	l N	T	T	56. 0
	or "N" for no. If line 56 is yes, is this the first cost reporting programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first month for yes or "N" for no in column 2. If column 2 is "N"	oeriod duri yes or "N th of this	ng which re " for no ir cost report	esidents in n column 1. ing period?	approved If column ' ' Enter "Y'				57. 0
F0 00	"N", complete Wkst. D, Parts III & IV and D-2, Pt. II If line 56 is yes, did this facility elect cost reimb	, if appli	cabl e.			N			58. 0
	defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	complete W	kst. D-5.		:s as				
	Are costs claimed on line 100 of Worksheet A? If yes				he	N N			59. 0 60. 0
59. 00	Are you claiming nursing school and/or allied health	_	"N" for no	. (see inst			Di rec	t GME	
59. 00	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"		IME	Direct GM	- I N		DITEC	COME	
59. 00		Y/N	IME	Direct GM					
59. 00 60. 00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y"		1 ME 2. 00	Direct GM	4.		5. (61. 0
59. 00 60. 00 61. 00	provider-operated criteria under §413.85? Enter "Y" Did your hospital receive FTE slots under ACA	Y/N		3. 00		00	5. (61. 0

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 151328 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/27/2016 1:57 pm Unwei ghted Unwei ghted Program Name Program Code Ratio (col. (col. 3 + col FTEs FTEs in Hospi tal 4)) Nonprovi der Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 65.00 65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF N 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems INDIANA UNIVERSITY HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		RD CCN: 151328	Peri od: From 01/01/2015		2		
			To 12/31/2015	Date/Time Pr 5/27/2016 1:			
				072772010 1.	J pin		
Long Term Care Hospital PPS				1.00			
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes	and "N" for	no.		N	80.00		
81.00 Is this a LTCH co-located within another hospital for part or "Y" for yes and "N" for no.			ng period? Enter	N N	81. 00		
TEFRA Providers 85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)		,		N	85. 00		
86.00 Did this facility establish a new Other subprovider (excluded §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no. 87.00 Is this hospital a "subclause (II)" LTCH classified under sec	,			N	86. 00		
for yes or "N" for no.	.troii 1880(u)	(1) (6) (1 0) (1			87.00		
			V 1. 00	XI X 2. 00			
Title V and XIX Services			1.00	2.00			
90.00 Does this facility have title V and/or XIX inpatient hospital	servi ces? E	nter "Y" for	N	Υ	90.00		
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through th	e cost repor	t either in	N	N	91. 00		
full or in part? Enter "Y" for yes or "N" for no in the appli 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dua	ıl certificat			N	92. 00		
instructions) Enter "Y" for yes or "N" for no in the applicable 93.00 Does this facility operate an ICF/IID facility for purposes of "N" for this facility for purposes of "N" for this facility for purposes of "N" for this facility for the purpose of "N" for the purpo		d XIX? Enter	N	N	93. 00		
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, a	nd "N" for n	o in the	N	N	94. 00		
95.00 If line 94 is "Y", enter the reduction percentage in the appl	applicable column. 25.00 If line 94 is "Y", enter the reduction percentage in the applicable column. 26.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the N						
applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the appl	icable colum	n.	0. 00	0. 0	97. 00		
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (CAH	1) 2		Y		105.00		
106.00 f this facility qualifies as a CAH, has it elected the all-i for outpatient services? (see instructions)		hod of payme	1		106. 00		
107.00 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.	1. (see inst	ructions) If			107. 00		
108.00 Is this a rural hospital qualifying for an exception to the C CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	RNA fee sche	dul e? See 42	2 N		108. 00		
CIN Section 3412. 113(c). Enter 1 101 yes of in 101 ho.	Physi cal	Occupati on	al Speech	Respi ratory			
100 001 0 11 1 1 1 1 1	1.00	2.00	3.00	4.00	100.00		
109.00 f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109. 00		
				1.00	-		
110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" f		on project (410A Demo)for	N	110.00		
			1.0	0 2.00 3.00			
Miscellaneous Cost Reporting Information							
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers	If column 2 for long te	is "E", ente rm care (incl	in column udes	0	115. 00		
Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" f 117.00 s this facility legally-required to carry malpractice insura			N Y		116. 00 117. 00		
no. 118.00 Is the malpractice insurance a claims-made or occurrence poli	cy? Enter 1	if the policy	y is 1		118. 00		
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	Insurance			
		1. 00	2.00	3. 00			
118.01 List amounts of malpractice premiums and paid losses:		99, 6	592)	0 118. 01		

Enter "Y" for yes or "N" for no in column 1. (See CMS Pub.					
yes, enter the approval date (mm/dd/yyyy) in column 2.					
				1. 00	
147.00 Was there a change in the statistical basis? Enter "Y" for	N	147. 00			
148.00 Was there a change in the order of allocation? Enter "Y" for	r yes or "N" fo	or no.		N	148. 00
149.00 Was there a change to the simplified cost finding method? En	nter "Y" for ye	es or "N" for n	0.	N	149. 00
	Part A	Part B	Title V	Title XIX	
	1.00	2.00	3.00	4.00	
Does this facility contain a provider that qualifies for an	r of costs	4			
or charges? Enter "Y" for yes or "N" for no for each compon	ent for Part A	and Part B. (S	See 42 CFR §413	. 13)	
155. 00 Hospi tal	Υ	Y	N	N	155. 00
156.00 Subprovider - IPF	N	N	N	N	156. 00
157.00 Subprovider - IRF	N	N	N	N	157. 00
158. 00 SUBPROVI DER					158. 00
159. 00 SNF	Υ	N	N	N	159. 00
160.00 HOME HEALTH AGENCY	N	N	N	N	160. 00
161. 00 CMHC		N	N	N	161. 00
161. 10 CORF		N	N	N	161. 10

Health Financial Systems		RSITY HEALTH BEDFO)RD		In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DATA	Provi der	CCN: 15132	From O	: 1/01/2015 2/31/2015		epared:
						1.00	
Multicampus 165.00 Is this hospital part of a Multicam Enter "Y" for yes or "N" for no.	npus hospital that ha	s one or more cam	ouses in di	fferent CE	3SAs?	N	165. 00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3. 00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)						0.0	0 166. 00
						1. 00	
Health Information Technology (HIT)) incentive in the Am	erican Recovery a	nd Rei nves	tment Act		1.00	
167.00 Is this provider a meaningful user						Υ	167. 00
168.00 If this provider is a CAH (line 109 reasonable cost incurred for the HI	is "Y") and is a me	aningful user (li			the		0168.00
168.01 If this provider is a CAH and is no exception under §413.70(a)(6)(ii)?					lshi p		168. 01
169.00 If this provider is a meaningful us transition factor. (see instruction		and is not a CAH	(line 105				0169. 00
					gi nni ng	Endi ng	
1-					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR be period respectively (mm/dd/yyyy)	eginning date and end	ing date for the	reporti ng	10,	/03/2015	12/31/2015	170. 00
						1.00	+
171.00 If line 167 is "Y", does this provi	der have any days fo	r individuals enro	olled in se	ection 1876)	Y	171. 00
Medicare cost plans reported on Wks (see instructions)							

		Descri pti on	Y/N	Date	Y/N	
		0	1.00	2. 00	3. 00	
·	PS&R Data					
16.00	Was the cost report prepared using the PS&R		N		N	16. 00
	Report only? If either column 1 or 3 is yes,				I	
	enter the paid-through date of the PS&R				I	
	Report used in columns 2 and 4 (see				I	
	instructions)				I	
17.00	Was the cost report prepared using the PS&R		Y	04/02/2016	Υ	17. 00
	Report for totals and the provider's records				I	
	for allocation? If either column 1 or 3 is				I	
	yes, enter the paid-through date in columns				I	
	2 and 4. (see instructions)				I	
18. 00	If line 16 or 17 is yes, were adjustments		N		N	18. 00
	made to PS&R Report data for additional				I	
	claims that have been billed but are not				I	
	included on the PS&R Report used to file				I	
	this cost report? If yes, see instructions.				I	
19.00	If line 16 or 17 is yes, were adjustments		N		N	19. 00
	made to PS&R Report data for corrections of				I	
	other PS&R Report information? If yes, see				I	
	i nstructi ons.				I	
20.00	If line 16 or 17 is yes, were adjustments		N		N	20. 00
	made to PS&R Report data for Other? Describe				I	
	the other adjustments:				I	

In Lieu of Form CMS-2552-10 HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 151328 Peri od: Worksheet S-2 From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 5/27/2016 1:57 pm Part A Part B Description Y/N Date Y/N 0 1.00 2.00 3.00 21.00 Was the cost report prepared only using the Ν 21 00 Ν provider's records? If yes, see instructions 1.00 COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCEPT CHILDRENS HOSPITALS) Capital Related Cost Have assets been relifed for Medicare purposes? If yes, see instructions 22.00 22.00 Ν Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost 23.00 Ν 23.00 reporting period? If yes, see instructions. 24.00 Were new leases and/or amendments to existing leases entered into during this cost reporting period? Ν 24.00 If ves. see instructions Have there been new capitalized leases entered into during the cost reporting period? If yes, see Ν 25.00 25.00 instructions. 26.00 Were assets subject to Sec. 2314 of DEFRA acquired during the cost reporting period? If yes, see Ν 26,00 instructions. 27 00 Has the provider's capitalization policy changed during the cost reporting period? If yes, submit Ν 27.00 сору. Interest Expense 28.00 Were new loans, mortgage agreements or letters of credit entered into during the cost reporting N 28.00 period? If yes, see instructions. Did the provider have a funded depreciation account and/or bond funds (Debt Service Reserve Fund) Ν 29.00 treated as a funded depreciation account? If yes, see instructions Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see Ν 30.00 instructions. 31.00 Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see Ν 31.00 instructions. Purchased Services 32.00 Have changes or new agreements occurred in patient care services furnished through contractual N 32.00 arrangements with suppliers of services? If yes, see instructions. If line 32 is yes, were the requirements of Sec. 2135.2 applied pertaining to competitive bidding? If Ν 33.00 33.00 no, see instructions. Provi der-Based Physicians Are services furnished at the provider facility under an arrangement with provider-based physicians? Υ 34.00 If yes, see instructions. Iffine 34 is yes, were there new agreements or amended existing agreements with the provider-based Ν 35.00 physicians during the cost reporting period? If yes, see instructions. Y/N Date 1.00 2.00 Home Office Costs 36, 00 Were home office costs claimed on the cost report? 36, 00 37.00 If line 36 is yes, has a home office cost statement been prepared by the home office? 37.00 If yes, see instructions. If line 36 is yes, was the fiscal year end of the home office different from that of 38.00 N 38.00 the provider? If yes, enter in column 2 the fiscal year end of the home office. If line 36 is yes, did the provider render services to other chain components? If yes, 39.00 39.00 N see instructions. 40.00 If line 36 is yes, did the provider render services to the home office? If yes, see Ν 40.00 instructions. 1.00 2.00 Cost Report Preparer Contact Information 41.00 Enter the first name, last name and the title/position STFVF HOWELL 41.00 held by the cost report preparer in columns 1, 2, and 3, respecti vel y. 42.00 | Enter the employer/company name of the cost report INDIANA UNIVERSITY HEALTH 42.00 preparer. 43.00 Enter the telephone number and email address of the cost 317-962-1035 SHOWELL7@I UHEALTH. ORG 43.00 report preparer in columns 1 and 2, respectively.

report preparer in columns 1 and 2, respectively.

HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE Provi der CCN: 151328 Peri od: Worksheet S-2 From 01/01/2015 To 12/31/2015 Part II Date/Time Prepared: 5/27/2016 1:57 pm Part B Date 4.00 PS&R Data 16.00 Was the cost report prepared using the PS&R 16.00 Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 . (see instructions) 17.00 Was the cost report prepared using the PS&R 04/02/2016 17.00 Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) 18.00 | If line 16 or 17 is yes, were adjustments 18.00 made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.

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

Provi der CCN: 151328

Peri od: Worksheet S-3 From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm

								5/27/2016 1:5	7 pm
								I/P Days / O/P	
								Visits / Trips	
	Component	Worksheet A	No.	of Bed	ls	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			19	6, 935	72, 408. 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				19	6, 935	72, 408. 00	0	7. 00
	beds) (see instructions)								
8. 00	INTENSIVE CARE UNIT	31. 00			6	2, 190	20, 736. 00	0	8. 00
9.00	CORONARY CARE UNIT	32. 00			0	0	0.00	0	9. 00
10.00	BURN INTENSIVE CARE UNIT	33. 00			0	0	0.00	0	10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	34. 00			0	0	0.00	0	11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)								12. 00
13.00	NURSERY	43. 00						0	13. 00
14. 00	Total (see instructions)				25	9, 125	93, 144. 00	0	14. 00
15. 00	CAH visits							0	15. 00
16. 00	SUBPROVI DER - I PF	40. 00			0	0		0	16. 00
17. 00	SUBPROVI DER - I RF	41. 00			0	0		0	17. 00
18. 00	SUBPROVI DER	42. 00			0	0		0	18. 00
19. 00	SKILLED NURSING FACILITY	44. 00			0	0		0	19. 00
	NURSING FACILITY	45. 00			0	0		0	20. 00
	I CF/MR	45. 01			0	0	0. 00	0	20. 01
21. 00	OTHER LONG TERM CARE	46. 00			0	0			21. 00
22. 00	HOME HEALTH AGENCY	101. 00						0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00							23. 00
24. 00	HOSPI CE	116. 00			0	0			24. 00
24. 10	HOSPICE (non-distinct part)	30. 00							24. 10
25. 00	CMHC - CMHC	99. 00						0	25. 00
25. 10	CMHC - CORF	99. 10						0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00						0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						0	26. 25
27. 00	,				25				27. 00
28. 00	Observation Bed Days							0	28. 00
29. 00	Ambul ance Tri ps								29. 00
30. 00	Employee discount days (see instruction)								30. 00
31. 00	Employee discount days - IRF								31. 00
32. 00	Labor & delivery days (see instructions)				0	0			32. 00
32. 01	Total ancillary labor & delivery room								32. 01
	outpatient days (see instructions)								
33. 00	LTCH non-covered days								33. 00

Heal th Fi nancialSystemsINDIANA UNIVERSITY HEALTH BEDFORDHOSPITALAND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATAProvider COMPLEX STATISTICAL DATA

Provi der CCN: 151328

			1 2 12 111 11			5/27/2016 1:5	/ pm
		I/P Days	/ O/P Visits	/ Trips	Full Time E	equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	omponent	I TO XVIII	11 110 7117	Patients	& Residents	Payrol I	
		6.00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	1, 972	112	3, 016		10.00	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)	401	77				2. 00
3.00	HMO I PF Subprovi der	o	O				3. 00
4.00	HMO IRF Subprovider	o	O				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	259	O	259			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		O	83			6. 00
7.00	Total Adults and Peds. (exclude observation	2, 231	112	3, 358			7. 00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	565	28	862			8. 00
9.00	CORONARY CARE UNIT	o	0	0			9. 00
10.00	BURN INTENSIVE CARE UNIT	o	0	0			10.00
11.00	SURGICAL INTENSIVE CARE UNIT	o	0	0			11. 00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		0	0			13.00
14.00	Total (see instructions)	2, 796	140	4, 220	0.00	209. 65	14.00
15.00	CAH visits	o	0	0			15. 00
16.00	SUBPROVIDER - IPF	o	0	0	0.00	0.00	16. 00
17. 00	SUBPROVI DER - I RF	o	O	0	0.00	0.00	17. 00
18.00	SUBPROVI DER	o	O	0	0.00	0.00	18. 00
19.00	SKILLED NURSING FACILITY	o	O	0	0.00	0.00	19. 00
20.00	NURSING FACILITY		o	0	0.00	0.00	20. 00
20. 01	I CF/MR	0	0	0	0.00	0.00	20. 01
21.00	OTHER LONG TERM CARE			0	0.00	0.00	21.00
22.00	HOME HEALTH AGENCY	0	0	0	0.00	0.00	22. 00
23.00	AMBULATORY SURGICAL CENTER (D. P.)				0.00	0.00	23. 00
24.00	HOSPI CE	0	0	0	0.00	0.00	24.00
24. 10	HOSPICE (non-distinct part)	0	0	23			24. 10
25.00	CMHC - CMHC	0	0	0	0.00	0.00	25. 00
25. 10	CMHC - CORF	0	0	0	0.00	0.00	25. 10
26.00	RURAL HEALTH CLINIC	0	0	0		0.00	26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	209. 65	27. 00
28. 00	Observation Bed Days		61	883			28. 00
29. 00	Ambul ance Tri ps	0					29. 00
30.00	Employee discount days (see instruction)			0			30.00
31.00	Employee discount days - IRF			0			31. 00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 01	Total ancillary labor & delivery room			0			32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33. 00

33.00

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 151328

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

5/27/2016 1:57 pm Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 14.00 12.00 13.00 11.00 15.00 1.00 Hospital Adults & Peds. (columns 5, 6, 7 and 625 36 1,031 1.00 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 92 2 00 HMO and other (see instructions) 24 2 00 3.00 HMO IPF Subprovider 3.00 HMO IRF Subprovider 4.00 4.00 5.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed NF 6.00 6.00 7.00 Total Adults and Peds. (exclude observation 7.00 beds) (see instructions) INTENSIVE CARE UNIT 8.00 8.00 CORONARY CARE UNIT 9.00 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 0 625 36 1,031 14.00 CAH visits 15.00 15.00 SUBPROVIDER - IPF 0.00 16.00 16.00 0 0 SUBPROVIDER - IRF 0 0 0 17.00 0.00 0 17.00 18.00 SUBPROVI DER 0.00 0 0 0 0 18.00 SKILLED NURSING FACILITY 19.00 0.00 19.00 20 00 NURSING FACILITY 0 00 20 00 20.01 ICF/MR 0.00 0 0 0 0 20.01 21.00 OTHER LONG TERM CARE 0.00 21.00 HOME HEALTH AGENCY 22.00 0.00 22.00 AMBULATORY SURGICAL CENTER (D. P.) 23.00 0 00 23 00 24.00 HOSPI CE 0.00 24.00 24. 10 HOSPICE (non-distinct part) 24. 10 25.00 CMHC - CMHC 0.00 25.00 CMHC - CORF 25. 10 25.10 0.00 26.00 RURAL HEALTH CLINIC 0.00 26.00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0.00 26.25 Total (sum of lines 14-26) 0.00 27.00 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 Employee discount days - IRF 31.00 31.00 32.00 Labor & delivery days (see instructions) 32.00 Total ancillary labor & delivery room 32.01 32.01 outpatient days (see instructions)

33.00 LTCH non-covered days

	Financial Systems INDIANA UNIVERSITY HEALT			In Lie	u of Form CMS-2	
HOSPI 7	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der (CCN: 151328	Peri od:	Worksheet S-10	0
				From 01/01/2015 To 12/31/2015	Date/Time Pre	nared:
				10 12/31/2013	5/27/2016 1:5	7 pm
					1. 00	
	Uncompensated and indigent care cost computation					
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	led by lin	ne 202 column	1 8)	0. 279504	1.00
2.00	Medicaid (see instructions for each line) Net revenue from Medicaid				2, 633, 757	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				2, 633, 737 N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p	avments f	from Medicaio	17	IN	4.00
5. 00	If line 4 is "no", then enter DSH or supplemental payments from N		Tom meareare	· ·	0	5. 00
6. 00	Medicaid charges				15, 884, 827	6.00
7.00	Medicaid cost (line 1 times line 6)				4, 439, 873	7. 00
8.00	Difference between net revenue and costs for Medicaid program (li	ne 7 minu	us sum of lir	es 2 and 5; if	1, 806, 116	8. 00
	< zero then enter zero)					
	State Children's Health Insurance Program (SCHIP) (see instruction	ns for ea	nch line)		_	
9.00	Net revenue from stand-alone SCHIP				0	9.00
10. 00 11. 00	Stand-alone SCHIP charges Stand-alone SCHIP cost (line 1 times line 10)				0	10. 00 11. 00
12.00	Difference between net revenue and costs for stand-alone SCHIP (I	ina 11 mi	nus line 0:	if / zero then	0	12.00
12.00	lenter zero)	1116 11 1111	ilus Title 7,	TI \ Zelo then	O	12.00
	Other state or local government indigent care program (see instru	ctions fo	or each line)			
13.00	Net revenue from state or local indigent care program (Not include				1, 873, 299	13. 00
14.00	Charges for patients covered under state or local indigent care p	rogram (N	Not included	in lines 6 or	14, 409, 993	14. 00
	[10]					
15.00	State or local indigent care program cost (line 1 times line 14)			45 1 11	4, 027, 651	
16. 00	Difference between net revenue and costs for state or local indig 13; if < zero then enter zero)	jent care	program (III	ie 15 minus line	2, 154, 352	16. 00
	Uncompensated care (see instructions for each line)					!
17. 00	Private grants, donations, or endowment income restricted to fund	ling chari	tv care		0	17. 00
18. 00	Government grants, appropriations or transfers for support of hos				0	18. 00
19.00	Total unreimbursed cost for Medicaid , SCHIP and state and local			s (sum of lines	3, 960, 468	19. 00
	8, 12 and 16)					
			Uni nsured	Insured	Total (col. 1	
		-	patients 1.00	pati ents 2.00	+ col . 2) 3.00	
20.00	Total initial obligation of patients approved for charity care (a	t full	2, 413, 98		3, 284, 180	20. 00
20.00	charges excluding non-reimbursable cost centers) for the entire f		2, 415, 70	070, 177	3, 204, 100	20.00
21.00	Cost of initial obligation of patients approved for charity care		674, 71	7 243, 224	917, 941	21.00
	times line 20)					
22. 00	13 31 11		29, 79		77, 881	
23. 00	Cost of charity care (line 21 minus line 22)		644, 92	25 195, 135	840, 060	23. 00
					4 00	
24. 00	Does the amount in line 20 column 2 include charges for patient d	lave bayor	ad a Langth o	of ctoy limit	1. 00 N	24. 00
24.00	imposed on patients covered by Medicaid or other indigent care pr		id a religiti c	ii Stay IIIIII t	įΝ	24.00
25. 00	If line 24 is "yes," charges for patient days beyond an indigent		ogram's Lenat	h of stay limit	0	25. 00
26. 00	Total bad debt expense for the entire hospital complex (see instr		5		6, 820, 655	
27. 00	Medicare bad debts for the entire hospital complex (see instructi				389, 175	l
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (line	26 minus	s line 27)		6, 431, 480	
		(1:	1 +: 1:	20)	1 707 (04	29. 00
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt expen	ise (Trne	I times iine	: 28)	1, 797, 624	
29. 00 30. 00	Cost of non-medicare and non-reimbursable medicare bad debt expen Cost of uncompensated care (line 23 column 3 plus line 29) Total unreimbursed and uncompensated care cost (line 19 plus line	•	I times iine	: 28)	1, 797, 624 2, 637, 684 6, 598, 152	30.00

	Financial Systems IND SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	IANA UNIVERSITY H F EXPENSES			In Lie Period:	u of Form CMS-2 Worksheet A	2552-10
REOLIN	SOLITOR AND ADDICATED OF THE DIETHOLD	- EM ENGEG	T T O V T GET	F	From 01/01/2015 to 12/31/2015	Date/Time Pre	
	Cost Center Description	Sal ari es	0ther	Total (col. 1 + col. 2)	Reclassifications (See A-6)	5/27/2016 1:5 Reclassified Trial Balance	7 pm
				(1 (01. 2)	ons (see A b)	(col. 3 +-	
		1.00	2. 00	3. 00	4. 00	col . 4) 5.00	
1. 00	GENERAL SERVICE COST CENTERS OO100 NEW CAP REL COSTS-BLDG & FIXT		٥		1, 401, 700	1, 401, 700	1. 00
2.00	00200 NEW CAP REL COSTS-BEDG & TTXT		0		1, 101, 829		2. 00
3.00	00300 OTHER CAPITAL RELATED COSTS	270 / 55	1 504 220	1 0/5 075	0	2 245 012	3.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	279, 655 1, 351, 471	1, 586, 220 9, 731, 523			3, 245, 012 9, 963, 991	4. 00 5. 00
7.00	00700 OPERATION OF PLANT	401, 408	2, 223, 366	2, 624, 774	-146, 562	2, 478, 212	7. 00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0 350, 990	50, 837 277, 560			50, 099 537, 468	8. 00 9. 00
10. 00	01000 DI ETARY	348, 834	290, 646			340, 107	10.00
11.00	01100 CAFETERIA	0	0		241, 868	241, 868	11.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON	1, 110, 618	319, 228	1, 429, 846	-131, 295	0 1, 298, 551	12. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	43, 568	347, 345	390, 913	-20, 330	370, 583	14. 00
15. 00 16. 00	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	260, 119	4, 848, 714 0	5, 108, 833	-2, 966, 234	2, 142, 599 0	15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	o o	Ö		51, 004	51, 004	17. 00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL	0	0		0	0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0			0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0	C	0	0	22. 00
23. 00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0) 0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	1, 978, 402	438, 180			2, 183, 659	30. 00
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	936, 775	211, 906	1, 148, 681	-122, 409	1, 026, 272 0	31.00
32.00	03300 BURN INTENSIVE CARE UNIT	0 0	0			0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	C	0	0	34. 00
40. 00 41. 00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0	0			0	40. 00 41. 00
42. 00	04200 SUBPROVI DER	o	Ö		o o	0	42. 00
43.00	04300 NURSERY	0	0		0	0	43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0			0	44. 00 45. 00
45. 01	04510 I CF/MR	0	0	C	0	0	45. 01
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0) 0	0	46. 00
50. 00	05000 OPERATING ROOM	1, 352, 782	775, 058			1, 558, 373	50. 00
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	71, 673	19, 550 0	91, 223		81, 301 0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	o	0	Č	o o	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	1, 677, 650	1, 446, 879	3, 124, 529	-527, 783	2, 596, 746 0	54.00
56. 00	05600 RADI OLOGI - THERAPEUTI C	100, 066	206, 135	306, 201	-95, 136	211, 065	55. 00 56. 00
57. 00	05700 CT SCAN	0	0	C	0	0	57. 00
58. 00 59. 00	05800 MAGNETI C RESONANCE I MAGING (MRI) 05900 CARDI AC CATHETERI ZATI ON	0	0			0	58. 00 59. 00
60. 00	06000 LABORATORY	926, 881	1, 997, 456	2, 924, 337	-79, 375	2, 844, 962	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	C	0	0	60. 01 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	О	0			0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	C	0	0	63.00
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY		0			0	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	915, 397	143, 911	1, 059, 308	-78, 954	980, 354	66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0			0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 073, 398	472, 793	1, 546, 191	-193, 154	1, 353, 037	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C	0	0	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT		0		50, 305 95, 975	50, 305 95, 975	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	C	3, 023, 586	3, 023, 586	73. 00
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0			0	74. 00 75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		19, 855	19, 855	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS		٦				00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	88. 00 89. 00
90. 00	09000 CLI NI C	0	0		ol ol	0	90. 00
90. 01 91. 00	09001 CLINIC - DIABETES 09100 EMERGENCY	76, 582 1, 309, 910	29, 103 891, 205			96, 191 2, 034, 339	90. 01 91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 307, 710	071, 200	2,201,113	100, 770	2,004,009	92.00
-					'		

Health Financial Systems IND	OLANA UNIVERSITY	HEALTH BEDFOR	RD.	In Lie	u of Form CMS-:	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der	CCN: 151328	Peri od:	Worksheet A	
				From 01/01/2015 To 12/31/2015	Date/Time Pre	narod
				10 12/31/2013	5/27/2016 1:5	
Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassificati	Reclassi fied	
			+ col. 2)	ons (See A-6)		
					(col. 3 +-	
	1.00	2.00	3. 00	4. 00	col . 4) 5.00	
OTHER REIMBURSABLE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
94. 00 09400 HOME PROGRAM DIALYSIS	0	0		0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	o	o		0 0	ő	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	o		0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	O	0		0 0	0	97. 00
99. 00 09900 CMHC	O	o		0 0	0	99. 00
99. 10 09910 CORF	0	0		0 0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101. 00
SPECIAL PURPOSE COST CENTERS				_1		
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0		0		106.00
107.00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION	0	0		0		107. 00 108. 00
109. 00 10900 PANCREAS ACQUISITION		0		0		108.00
110. 00 11000 NTESTINAL ACQUISITION		0		0		1109.00
111. 00 11100 SLET ACQUI SI TI ON		0				111.00
113. 00 11300 NTEREST EXPENSE		0		0		113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	o	o		0 0		114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	O		0 0	0	115. 00
116. 00 11600 HOSPI CE	O	0		0 0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	14, 566, 179	26, 307, 615	40, 873, 79	94 505, 249	41, 379, 043	118. 00
NONRE MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	7, 773	8, 054	15, 82	-7, 464		190. 00
191. 00 19100 RESEARCH	0	0		0 0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	114	350, 370	350, 48	-343, 422		192. 00
192. 01 19201 VACANT SPACE	0	0		0		192. 01
193. 00 19300 NONPALD WORKERS	0	151 120	151 17	0 110 547		193. 00
194.00 07950 MARKETING/PUBLIC RELATIONS 194.01 07951 CLARIAN HOME CARE	0	151, 130	151, 13	-118, 547	32, 583	194. 00
194. 01 07951 CLARTAN HOME CARE 194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED	145, 185	57, 806	202, 99	91 -35, 792		
194. 03 07953 HOME CARE	145, 165	24		24 -35, 792		194. 02
200.00 TOTAL (SUM OF LINES 118-199)	1 9	27	4		ı	1. / 1. 00

Provi der CCN: 151328

				5/27/2016 1:5	
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation		
	OFNEDAL CEDIU OF COCT OFNITEDO	6. 00	7. 00		
1 00	GENERAL SERVICE COST CENTERS	155 (70	1 557 270		1 00
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP	155, 679		•	1.00
3. 00	1	-198, 636 0	903, 193	l .	3.00
	00300 OTHER CAPITAL RELATED COSTS	_		l .	4. 00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL	103, 762 5, 470, 022		•	5.00
7. 00	00700 OPERATION OF PLANT	-139		1	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	-139	2, 478, 073 50, 099		8.00
9. 00	00900 HOUSEKEEPING	0	537, 468	l .	9. 00
10.00	01000 DI ETARY	319		1	10.00
11. 00	01100 CAFETERI A	-105, 742	340, 426		11.00
		-105, 742	136, 126 0		12.00
12. 00 13. 00	01200 MAI NTENANCE OF PERSONNEL	4 422	_	l .	13.00
	01300 NURSING ADMINISTRATION	-4, 432		l .	1
14. 00 15. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	0	370, 583 2, 142, 599	•	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0			16.00
17. 00	1	0			17. 00
17.00	01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	0	51, 004		19.00
20. 00	02000 NURSING SCHOOL	0	0		20.00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD	0	0		21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	0		22.00
23. 00	02300 PARAMED ED PRGM	0		l .	23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS		U		23.00
30. 00	03000 ADULTS & PEDIATRICS	-3, 643	2, 180, 016		30.00
31. 00	03100 I NTENSI VE CARE UNI T	-3, 643		•	31.00
32.00	03200 CORONARY CARE UNIT	0		l .	32.00
33. 00	03300 BURN INTENSIVE CARE UNIT		0		33.00
34. 00	03400 SURGI CAL INTENSI VE CARE UNIT		0		34.00
40. 00	04000 SUBPROVI DER – I PF	0	0		40.00
41. 00	04100 SUBPROVI DER – TPF	0	0		41.00
42. 00	04200 SUBPROVI DER		0		42.00
43. 00	04300 NURSERY		0		43. 00
44. 00	04400 SKILLED NURSING FACILITY		0		44. 00
45. 00	04500 NURSING FACILITY	0	0		45. 00
45. 00	04510 I CF/MR	0	0		45. 00
46. 00	04600 OTHER LONG TERM CARE	0	0	l .	46.00
40.00	ANCILLARY SERVICE COST CENTERS		U U		40.00
50. 00	05000 OPERATING ROOM	-596, 642	961, 731		50.00
51. 00	05100 RECOVERY ROOM	0	81, 301		51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	01,301		52.00
53. 00	05300 ANESTHESI OLOGY		0		53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-169, 014	2, 427, 732		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	107,011	2, 127, 732		55. 00
56. 00	05600 RADI OI SOTOPE	0	211, 065		56.00
57. 00	05700 CT SCAN	0	211,000		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		58.00
59. 00		0	o o		59.00
60.00	1	-163, 391	2, 681, 571		60.00
60. 01	06001 BLOOD LABORATORY	0			60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	o o		62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	J 0		63.00
64. 00	06400 I NTRAVENOUS THERAPY	0			64. 00
65. 00	06500 RESPIRATORY THERAPY	0			65. 00
66. 00	06600 PHYSI CAL THERAPY	-1, 230	979, 124		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	1, 230	7,7,124		67. 00
68. 00	06800 SPEECH PATHOLOGY	1	ا م		68. 00
69. 00	06900 ELECTROCARDI OLOGY	-21, 303	1, 331, 734		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	21,303	1, 551, 754		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1	50, 305		71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENT	1	95, 975	1	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	1	3, 023, 586	•	73.00
74. 00			3, 023, 300		74.00
75. 00	07500 ASC (NON-DISTINCT PART)				75. 00
76. 97	07697 CARDI AC REHABILITATION	0	19, 855		76. 97
. 0. 77	OUTPATIENT SERVICE COST CENTERS		17,000		1 / /
88. 00	08800 RURAL HEALTH CLINIC	0	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	89. 00
90. 00	09000 CLINIC	1	ا م		90.00
90. 01	09001 CLINIC - DIABETES	1	96, 191		90. 01
91. 00	09100 EMERGENCY	143, 852	2, 178, 191		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 302	_, ., ., ., .,		92.00
00	OTHER REIMBURSABLE COST CENTERS	1			1
94. 00		0	0		94. 00
50	1		1	1	1

 Heal th Financial
 Systems
 INDIANA UNIVERSITY
 HEALTH BEDFORD

 RECLASSIFICATION
 AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES
 Provider CO
 In Lieu of Form CMS-2552-10 Provi der CCN: 151328

			5/27/2016 1:5	
Cost Center Description		Net Expenses		
		or Allocation		
	6.00	7. 00		
95. 00 09500 AMBULANCE SERVI CES	0	0		95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
99. 00 09900 CMHC	0	0		99. 00
99. 10 09910 CORF	0	0		99. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	U		101. 00
SPECIAL PURPOSE COST CENTERS				105 00
105. 00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION	0	0		105. 00 106. 00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		106.00
108. 00 10800 LUNG ACQUISITION	0	0		107.00
109. 00 10900 PANCREAS ACQUISITION	0	0		108.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0		1109.00
111. 00 11100 SLET ACQUISITION		0		111.00
113. 00 11300 NTEREST EXPENSE		0		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	0		114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	4, 609, 462	45, 988, 505		118. 00
NONREI MBURSABLE COST CENTERS	.,,			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	8, 363		190. 00
191. 00 19100 RESEARCH	o	O		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	7, 062		192. 00
192. 01 19201 VACANT SPACE	0	0		192. 01
193. 00 19300 NONPALD WORKERS	0	0		193. 00
194.00 07950 MARKETING/PUBLIC RELATIONS	1, 568	34, 151		194. 00
194.01 07951 CLARIAN HOME CARE	0	0		194. 01
194.02 07952 BLOOMNGTN AMBULANCE AND OCC MED	0	167, 199		194. 02
194. 03 07953 HOME CARE	0	0		194. 03
200.00 TOTAL (SUM OF LINES 118-199)	4, 611, 030	46, 205, 280		200. 00

I NDI ANA UNI VERSI TY HEALTH BEDFORD

Provi der CCN: 151328 Health Financial Systems RECLASSIFICATIONS

Peri od: From 01/01/2015 To 12/31/2015

Date/Time Prepared: 5/27/2016 1:57 pm

		Increases			5/2//2016 1:3) / piii
	Cost Center	Li ne #	Salary	Other		
	2.00	3.00	4. 00	5. 00		
	A - BENEFITS	0.00		0.00		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 385, 881		1.00
2.00		0. 00	Ö	0		2. 00
3.00		0.00	Ö	Ö		3. 00
4. 00		0.00	o	Ö		4. 00
5.00		0.00	O	0		5. 00
6.00		0.00	o	0		6. 00
7.00		0.00	o	0		7. 00
8.00		0.00	o	0		8. 00
9.00		0.00	o	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15. 00		0. 00	0	0		15. 00
16. 00		0. 00	0	0		16. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	0	0		19. 00
20.00		0.00	0	0		20.00
21. 00			— — o	<u>0</u> 1, 385, 881		21. 00
	B - DI ETARY/CAFETERI A		U	1, 305, 881		1
1. 00	CAFETERI A	11. 00	144, 975	96, 893		1.00
1.00	CAFETERIA		144, 975 144, 975	9 <u>6, 8</u> 93 96, 893		1.00
	C - CAPITAL LEASE		144, 975	70, 073		-
	NEW CAP REL COSTS-MVBLE	2.00	O	60, 393		1.00
1.00	EQUI P	2.00	Ĭ	00, 070		1.00
2.00	PHYSICIANS' PRIVATE OFFICES	192.00	0	263, 223		2. 00
3.00		0.00	o	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	O	0		5. 00
6.00		0.00	o	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12.00		0. 00	0	0		12. 00
13.00		0.00	0	0		13. 00
	TOTALS		0	323, 616		_
	D - CARDI OLOGY	7, 07	05 45/	0.700		1 00
1. 00	CARDIAC REHABILITATIONTOTALS	<u>76.</u> 97	2 <u>5, 4</u> 56 25, 456	3, 733 3, 733		1.00
	E - MME DEPR EXPENSE		25, 456	3, 733		-
1.00	NEW CAP REL COSTS-BLDG &	1. 00	ol	1, 545, 518		1.00
1.00	FIXT	1.00	ď	1, 545, 516		1.00
2.00	NEW CAP REL COSTS-MVBLE	2. 00	o	1, 037, 134		2. 00
	EQUI P					
3.00		0.00	O	0		3.00
4.00		0.00	o	0		4. 00
5.00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8. 00		0. 00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11.00
12. 00 13. 00		0. 00 0. 00	0	0		12. 00 13. 00
14. 00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16. 00		0.00	o	0		16. 00
17. 00		0.00	o	0		17. 00
18. 00		0.00	o	0		18. 00
19. 00		0.00	o	0		19. 00
20. 00		0.00	o	Ö		20. 00
21. 00		0.00	o	o		21. 00
22. 00		0.00	o	0		22. 00
23. 00		0.00	ō	Ō		23. 00
24.00		0.00	О	0		24. 00
25. 00		<u>0.</u> 00	0	0		25. 00
	$\overline{0}$ $=$ $=$ $=$ $=$ $=$		<u> </u>	2, 582, 652		

Heal th	Financial Systems	I ND	IANA UNIVERSITY	/ HEALTH BEDFORD)	In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provi der (CCN: 151328	Peri od:	Worksheet A-	6
						From 01/01/2015 To 12/31/2015	Date/Time Pr	anarad:
						10 12/31/2013	5/27/2016 1:	
		Increases						
	Cost Center	Li ne #	Sal ary	Other				
	2. 00 F - BI LLABLE DRUGS	3. 00	4. 00	5. 00				
1. 00	DRUGS CHARGED TO PATIENTS	73. 00	0	3, 023, 586				1.00
2. 00	BROOS STANGED TO TANTENTS	0.00	0	0, 020, 000				2. 00
3.00		0.00	O	Ō				3. 00
4.00		0.00	О	0				4. 00
5.00		0.00	0	0				5. 00
6.00		0. 00	0	0				6. 00
7. 00		0.00	0	0				7. 00
8.00		0.00	0	0				8. 00
9. 00 10. 00		0. 00 0. 00	0	0				9. 00 10. 00
11. 00		0.00	o	0				11.00
11.00			— — ŏ	3, 023, 586				11.00
	G - IMPLANT SUPPLIES							
1.00	IMPL. DEV. CHARGED TO	72. 00	0	95, 975				1. 00
0.00	PATI ENT	0.00						0.00
2.00		0.00	0	0				2. 00 3. 00
3. 00			0	<u></u> 95, 975				3.00
	H - MARKETING		<u> </u>	75, 775				
1.00	MARKETING/PUBLIC RELATIONS	194. 00	0	8, 719				1. 00
2.00		0.00	0	0				2. 00
3.00		0.00	•	0				3. 00
	TOTALS		0	8, 719				-
1. 00	I - BILLABLE MEDICAL SUPPLIES ADMINISTRATIVE & GENERAL	5. 00	0	28, 985				1.00
2.00	DI ETARY	10.00	0	919				2.00
3.00	PHARMACY	15. 00	Ö	34, 973				3. 00
4.00	MEDICAL SUPPLIES CHARGED TO	71. 00	0	50, 305				4. 00
	PATI ENTS							
5.00		0.00	0	0				5. 00
6. 00 7. 00		0. 00 0. 00	0	0				6. 00 7. 00
7. 00 8. 00		0.00	0	0				8. 00
9. 00		0.00	0	0				9. 00
10.00		0.00	Ö	Ö				10.00
11. 00		0.00	0	0				11. 00
	0		0	115, 182				
1 00	J - PROPERTY INSURANCE NEW CAP REL COSTS-BLDG &	1 00	٥	27, 709				1 00
1. 00	FIXT	1.00	0	27, 709				1. 00
2.00	NEW CAP REL COSTS-MVBLE	2. 00	0	4, 302				2. 00
	EQUI P							
	TOTALS		0	32, 011				
1 00	K - PROPERTY TAXES	1 00	٥	22 202				1 00
1. 00	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	33, 293				1. 00
2.00		0.00	0	0				2. 00
	TOTALS			33, 293				
	L - SOCIAL WORKER							
1. 00	SOCI AL SERVI CE	<u>17.</u> 00	<u>51, 004</u>	0				1. 00
	TOTALS M - HO MARKETING		51, 004	0				-
1.00	ADMINISTRATIVE & GENERAL	5.00	0	112, 540				1.00
1.00	TOTALS		— — ŏ	112, 540				1.00
	N - MITCHELL CLINIC LEASE EXP			,				1
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	58, 403				1. 00
	FIXT	+						
500 00	TOTALS Grand Total: Increases		0 221, 435	58, 403 7, 872, 484				500.00
300.00	prana rotar. Thereases	I	221, 430	7,072,404				1 300. 00

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

						5/27/2016 1:	
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
1 00	A - BENEFITS		0	(0. (14			1 00
1.00	ADMINISTRATIVE & GENERAL	5.00	0	69, 614			1.00
2.00	OPERATION OF PLANT	7.00	0	45, 882	l .		2.00
3.00	HOUSEKEEPI NG	9.00	0	90, 013	l .		3.00
4.00	DI ETARY	10.00	0	47, 167	l .		4.00
5. 00	NURSING ADMINISTRATION	13.00	0	109, 679	l .		5. 00
6.00	CENTRAL SERVICES & SUPPLY	14.00	0	8, 486	l .		6.00
7.00	PHARMACY	15.00	0	30, 333	l .		7. 00
8.00	ADULTS & PEDIATRICS	30.00	0	200, 878 83, 109	l .		8. 00
9. 00	INTENSIVE CARE UNIT	31.00	0				9.00
10.00	OPERATING ROOM	50.00	0	122, 492	l .		10.00
11. 00 12. 00	RECOVERY ROOM RADIOLOGY-DIAGNOSTIC	51. 00 54. 00	0	8, 903	l .		11. 00 12. 00
13. 00	RADI OI SOTOPE	56.00	0	189, 264 9, 292			13. 00
14. 00	LABORATORY	60.00	0	2, 856			14. 00
15. 00	PHYSI CAL THERAPY	66.00	0				15. 00
16. 00	ELECTROCARDI OLOGY	69.00	0	64, 077 139, 550	-		16. 00
18. 00	CLINIC - DIABETES	90. 01	0	9, 381	0		18. 00
19. 00	EMERGENCY	91.00	0	122, 371			19. 00
20. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	7, 464			20.00
20.00	CANTEEN	170.00	O	7, 404	١		20.00
21. 00	BLOOMNGTN AMBULANCE AND OCC	194. 02	0	25, 070	o		21. 00
21.00	MED SECOND THE SECOND S	171.02	J	20,010			21.00
	0 — — — —		— — ₀	1, 385, 881			
	B - DIETARY/CAFETERIA			170007001			
1.00	DI ETARY	10.00	144, 975	96, 893	0		1.00
	0		144, 975	96, 893			
	C - CAPITAL LEASE			,	l l		
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	263, 223	9		1.00
	FLXT						
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	423	0		2. 00
3.00	ADMINISTRATIVE & GENERAL	5. 00	0	14, 755	0		3. 00
4.00	NURSING ADMINISTRATION	13. 00	0	1, 221	0		4. 00
5.00	PHARMACY	15. 00	0	423	0		5. 00
6.00	ADULTS & PEDIATRICS	30.00	0	738	0		6. 00
7.00	INTENSIVE CARE UNIT	31.00	0	366	0		7. 00
8.00	OPERATING ROOM	50.00	0	17, 608	0		8. 00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	22, 586	0		9. 00
10.00	PHYSI CAL THERAPY	66.00	0	421	0		10.00
11.00	ELECTROCARDI OLOGY	69. 00	0	423	0		11. 00
12.00	EMERGENCY	91.00	0	749	0		12. 00
13.00	MARKETING/PUBLIC RELATIONS	194. 00	0	680	0		13. 00
	TOTALS			323, 616			
	D - CARDIOLOGY						
1.00	ELECTROCARDI OLOGY	69. 00	25, 456	3, 733	0		1. 00
	TOTALS		25, 456	3, 733			
	E - MME DEPR EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	6, 321	9		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 051, 610	9		2. 00
3.00	OPERATION OF PLANT	7.00	0	100, 680	0		3. 00
4.00	LAUNDRY & LINEN SERVICE	8.00	0	738			4. 00
5.00	HOUSEKEEPI NG	9. 00	0	1, 069			5. 00
6.00	DI ETARY	10.00	0	11, 110			6. 00
7.00	NURSING ADMINISTRATION	13. 00	0	20, 248	l .		7. 00
8.00	CENTRAL SERVICES & SUPPLY	14.00	0	9, 269	l .		8. 00
9.00	PHARMACY	15. 00	0	6, 554	l .		9. 00
10.00	ADULTS & PEDIATRICS	30.00	0	26, 181			10. 00
11. 00	INTENSIVE CARE UNIT	31.00	0	38, 826	I		11. 00
12.00	OPERATING ROOM	50. 00	0	243, 130			12. 00
13.00	RECOVERY ROOM	51.00	0	154	0		13. 00
14. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	290, 515			14. 00
15. 00	RADI OI SOTOPE	56.00	0	49, 460			15. 00
16. 00	LABORATORY	60.00	0	76, 519			16. 00
17. 00	PHYSI CAL THERAPY	66.00	0	11, 846	l .		17. 00
18. 00	ELECTROCARDI OLOGY	69. 00	0	23, 456	1		18. 00
19. 00	CARDIAC REHABILITATION	76. 97	0	9, 326			19. 00
20.00	CLINIC - DIABETES	90. 01	0	113			20. 00
21. 00	EMERGENCY	91.00	0	37, 451	l .		21. 00
22. 00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	548, 242	l .		22. 00
23. 00	MARKETING/PUBLIC RELATIONS	194. 00	0	11, 703	l .		23. 00
24. 00	BLOOMNGTN AMBULANCE AND OCC	194. 02	0	8, 107	0		24. 00
0.5	MED						
25. 00	HOME CARE	194.03	0	24			25. 00
	Įυ		0	2, 582, 652			1

Peri od: From 01/01/2015 To 12/31/2015

Date/Time Prepared: 5/27/2016 1:57 pm

COST CENTER*			Decreases				3/2//2010 1.	7 0111
		0+ 0+		C-1	0+1	WI+ A 7 D-6		
F - BILLABLE BRUGS								
1.00 OLETARY			7.00	8.00	9.00	10.00		
2.00 PHARMACY								
3.00 OPERATING ROOM 50.00 0 25.42 0 4.00 0.00 0.05 0.00 4.00 0.00 0.05 0.00 4.00 0	1.00	DI ETARY	10.00		147			1.00
A 00 ADD (LOSY-DI AGNOSTIC 54, 00 0 22, 142 0 5,00 6,00 9HYSICAL THERAPY 66,00 0 14,648 0 5,00 6,00 7,00 61,00 7,00 61,00 7,00 61,00 7,00 61,00 7,00 61,00 7,00 61,00 7,00 61,00 7,00 61,00 7,00 61,00 7	2.00	PHARMACY	15. 00	0	2, 963, 875	0		2. 00
5.00 ARDIOL SOTOPE 5.00 0 31,648 0 6.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 7.00 8.00 7.00 8.00 7.00 7.00 8.00 7.	3.00	OPERATING ROOM	50.00	ol	254	Ō		3.00
5.00 ARDIOL SOTOPE 5.00 0 31,648 0 6.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 1.00 7.00 7.00 8.00 7.00 8.00 7.00 7.00 8.00 7.	4 00	RADI OLOGY-DI AGNOSTI C	54 00	0	22 142	0		4 00
6.00 PHYSICAL THERAPY		I			·	-		
RECEPTROCARDIOLOGY						-		
0.00 CARDI AC RELIABILITATION 76. 97 0 8 0 0 9.00		1				-		
9.00 BURGERICY 91.00 0 340 0 9.00 11.00 MARKTINICA/PUBLIC RELATIONS 194.00 0 2,412 0 11.00 BLOOWINSTN AMBULANCE AND OCC 194.02 0 2,615 0 11.00 BLOOWINSTN AMBULANCE AND OCC 194.02 0 2,615 0 11.00 CENTRAL SERVICES & SUPPLY 14.00 0 209 0 1.00 2.00 ADULTS & PEDIATRICS 30.00 0 2 2 0 2.00 3.00 OPERATING ROOM 50.00 0 95.764 0 3.00 10.00 ADMINISTRATIVE & GENERAL 5.00 0 8.568 0 1.00 2.00 PHARMACY 15.00 0 22 0 2.00 3.00 RADIOLOGY-DIAGNOSTIC 54.00 0 1.79 0 3.00 3.00 RADIOLOGY-DIAGNOSTIC 54.00 0 8.719 3.00 RADIOLOGY-DIAGNOSTIC 54.00 0 2.00 3.00 RADIOLOGY-DIAGNOSTIC 54.00 0 3.00 3.00 RADIOLOGY-DIAGNOSTIC 54.00 0 2.00 3.00 ADULTS & PEDIATRICS 30.00 0 5.124 0 3.00 3.00 ADULTS & PEDIATRICS 30.00 0 5.124 0 3.00 3.00 ADULTS & PEDIATRICS 30.00 0 5.124 0 3.00 3.00 ADULTS & PEDIATRICS 30.00 0 5.124 0 3.00 3.00 RADIOLOGY-DIAGNOSTIC 54.00 0 5.124 0 3.00 3.00 ADULTS & PEDIATRICS 30.00 0 5.124 0 3.00 3.00 ADULTS & PEDIATRICS 30.00 0 5.124 0 3.00 3.00 ADULTS & PEDIATRICS 30.00 0 5.124 0 3.00 3.00 ADULTS & PEDIATRICS 30.00 0 5.124 0 3.00 3.00 ADULTS & PEDIATRICS 30.00 0 5.124 0 3.00 3.00 ADULTS & PEDIATRICS 56.00 0 3.147 0 7.00 3.00 ADULTS & PEDIATRICS 56.00 0 3.20 0 3.00 PERCATING ROOM 50.00 50.00 50.00 3.00 PERCATING ROOM		1		- 1		-		4
10.00 MARKETI NG/PUBLIC RELATIONS 194.02 0 2.342 0 11.00		1		۳		-		4
11.00	9. 00	EMERGENCY	91.00	0	340	0		9. 00
MED	10.00	MARKETING/PUBLIC RELATIONS	194. 00	0	2, 343	0		10.00
MED	11. 00	BLOOMNGTN AMBULANCE AND OCC	194. 02	0	2, 615	0		11.00
0 0 3,023,596 0 1.00					·			
C - IMPLANT SUPPLIES					3 023 586			1
1.00		-		<u> </u>	3, 023, 300			
2.00 ADULTS & PEDIATRICS 30.00 0 2 0 3.00 0 2.00 3.00 0 0 2.57,64 0 0 0 0 0 0 0 0 0	1 00		14 00	ام	200	0		1 00
3.00 OPERATIN ROOM		I			209			
Name					2			
H - MARKETING ADMINISTRATIVE & GENERAL 5.00 0 8,568 0 1.00 2.00	3. 00	OPERATING ROOM	50.00			0		3.00
1.00		0		0	95, 975			
2. 00 PHARMACY 15. 00 0 122 0 3. 00 RADI OLOGY-DI AGNOSTIC 54. 00 0 129 0 10TOTALS 1. 01 LILLABLE MEDI CAL SUPPLIES 1. 00 LINES ING ADMINISTRATI ON 13. 00 0 147 0 2. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 2. 366 0 2. 00 4. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 5. 124 0 3. 30 4. 00 INTENSI VE CARE UNIT 31. 00 0 108 0 4. 00 OPERATI NG ROOM 50. 00 0 90.219 0 5. 00 6. 00 RECOVERY ROOM 51. 00 0 865 0 6. 00 RECOVERY ROOM 51. 00 0 865 0 0 6. 00 ROOM RADIOLOGY-DI AGNOSTIC 54. 00 0 3. 147 0 7. 00 RADIOLOGY-DI AGNOSTIC 54. 00 0 4. 736 0 8. 00 9. 00 PHYSI CAL THERAPY 66. 00 0 4. 736 0 8. 00 9. 00 PHYSI CAL THERAPY 66. 00 0 4. 44 0 0 10. 00 11. 00 ELECTROCARD IOLOGY 69. 00 0 4. 44 0 0 10. 00 11. 00 EMERGENCY 91. 00 0 5. 865 0 11. 00 0 DO		H - MARKETING						
2. 00 PHARMACY 15. 00 0 122 0 3. 00 RADI OLOGY-DI AGNOSTIC 54. 00 0 129 0 10TOTALS 1. 01 LILLABLE MEDI CAL SUPPLIES 1. 00 LINES ING ADMINISTRATI ON 13. 00 0 147 0 2. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 2. 366 0 2. 00 4. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 5. 124 0 3. 30 4. 00 INTENSI VE CARE UNIT 31. 00 0 108 0 4. 00 OPERATI NG ROOM 50. 00 0 90.219 0 5. 00 6. 00 RECOVERY ROOM 51. 00 0 865 0 6. 00 RECOVERY ROOM 51. 00 0 865 0 0 6. 00 ROOM RADIOLOGY-DI AGNOSTIC 54. 00 0 3. 147 0 7. 00 RADIOLOGY-DI AGNOSTIC 54. 00 0 4. 736 0 8. 00 9. 00 PHYSI CAL THERAPY 66. 00 0 4. 736 0 8. 00 9. 00 PHYSI CAL THERAPY 66. 00 0 4. 44 0 0 10. 00 11. 00 ELECTROCARD IOLOGY 69. 00 0 4. 44 0 0 10. 00 11. 00 EMERGENCY 91. 00 0 5. 865 0 11. 00 0 DO	1.00	ADMINISTRATIVE & GENERAL	5, 00	0	8, 568	0		1.00
3.00		1						2 00
TOTALS								4
1 - BILLABLE MEDICAL SUPPLIES	3.00							3.00
1. 0.0 NURSING ADMINISTRATION 13. 0.0 147 0 2. 0.0 CENTRAL SERVICES & SUPPLY 14. 0.0 0 2,366 0 2. 0.0 CENTRAL SERVICES & SUPPLY 14. 0.0 0 2,366 0 4. 0.0 INTENSIVE CARE UNIT 31. 0.0 0 108 0 4. 0.0 INTENSIVE CARE UNIT 31. 0.0 0 108 0 6. 0.0 RECOVERY ROOM 50. 0.0 0 90,219 0 6. 0.0 RECOVERY ROOM 51. 0.0 0 865 0 7. 0.0 RADIOLOGY-DIAGNOSTIC 54. 0.0 0 3,147 0 7. 0.0 8. 0.0 RADIOLOGY-DIAGNOSTIC 54. 0.0 0 3,147 0 7. 0.0 9. 0.0 PHYSICAL THERAPY 66. 0.0 0 4,736 0 8. 0.0 10. 0.0 LECTROCARDIOLOGY 69. 0.0 0 44 0 0 9. 0.0 11. 0.0 EMERGENCY 91. 0.0 0 155,865 0 11. 0.0 2. 0.0 DIAGNOSTIVE & GENERAL 5. 0.0 0 32,011 9 2. 0.0 TOTALS 0 0 32,011 9 2. 0.0 ELECTROCARDIOLOGY 69. 0.0 0 32,011 9 3. 0.0 ADMINISTRATIVE & GENERAL 5. 0.0 0 32,011 9 3. 0.0 ADMINISTRATIVE & GENERAL 5. 0.0 0 32,011 9 3. 0.0 ADMINISTRATIVE & GENERAL 5. 0.0 0 32,011 9 3. 0.0 ADMINISTRATIVE & GENERAL 5. 0.0 0 12,010 0				U	0, / 19			-
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6.00 RECOVERY ROOM 51.00 0 865 0 6.00 7.00 RADI OLOGY-DI AGNOSTI C 54.00 0 3.147 0 0 7.00 RADI OLOGY-DI AGNOSTI C 54.00 0 3.147 0 0 7.00 9.00 PHYSI CAL THERAPY 66.00 0 4.736 0 9.00 10.00 ELECTROCARDI OLOGY 69.00 0 44 0 0 10.00 11.00 ELECTROCARDI OLOGY 69.00 0 44 0 0 11.00 D PROPERTY I NSURANCE	4.00	INTENSIVE CARE UNIT	31.00	0	108	0		4. 00
6.00 RECOVERY ROOM 51.00 0 865 0 6.00 7.00 RADI OLOGY-DI AGNOSTI C 54.00 0 3.147 0 0 7.00 RADI OLOGY-DI AGNOSTI C 54.00 0 3.147 0 0 7.00 9.00 PHYSI CAL THERAPY 66.00 0 4.736 0 9.00 10.00 ELECTROCARDI OLOGY 69.00 0 44 0 0 10.00 11.00 ELECTROCARDI OLOGY 69.00 0 44 0 0 11.00 D PROPERTY I NSURANCE	5.00	OPERATING ROOM	50.00	o	90, 219	0		5.00
7. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 3, 147 0 8. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 3, 147 0 8. 00 RADI OLOGY-DI AGNOSTI C 56. 00 0 4, 736 0 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 9. 00 10. 00 10. 00 11. 00 ELECTROCARDI OLOGY 69. 00 0 44 0 0 10. 00 11. 00 11. 00 EMERGENCY 91. 00 0 15, 865 0 11. 00				0		0		1
8. 00 RADI OI SOTOPE 56. 00 0 4, 736 0 9. 00 PHYSI CAL THERAPY 66. 00 0 2, 561 0 9. 00 10. 00 ELECTROCARDI OLOGY 69. 00 0 444 0 110. 00 EMERGENCY 91. 00 0 5, 865 0 11. 00 EMERGENCY 91. 00 0 115, 182 J J - PROPERTY I NSURANCE				-		-		1
9. 00 PHYSI CAL THERAPY 66. 00 0 2, 561 0 9. 00 10. 00 ELECTROCARDI OLOGY 69. 00 0 44 0 10. 00 11. 00 EMERGENCY 91. 00 0 5, 865 0 0 0 11. 00 11. 00 ADMINISTRATI VE & GENERAL 5. 00 0 32, 011 9 1. 00 2. 00 TOTALS 0 0 32, 011 7 9 2. 00 10. 00 32, 011 7 9 2. 00 10. 00 0 0 0 0 9 1. 00 10. 00 0 0 0 9 1. 00 10. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				۳				
10. 00 ELECTROCARDI OLOGY 69. 00 0 44 0 10. 00 11. 00 EMERGENCY 91. 00 0 5, 865 0 J - PROPERTY I NSURANCE								
11. 00 EMERGENCY 91. 00 0 5,865 0 11. 00 0 115,182					· ·			1
1. 00		1				-		
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 32, 011 9 1. 00	11. 00	EMERGENCY	<u>91.</u> 00		<u>5, 8</u> 65	0		11.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 32, 011 9 2. 00 TOTALS 0 0 32, 011		0		0	115, 182			
2. 00 TOTALS K - PROPERTY TAXES 1. 00 ADMI NI STRATI VE & GENERAL 1. 00 ELECTROCARDI OLOGY TOTALS L - SOCI AL WORKER 1. 00 ADMI NI STRATI VE & GENERAL 1. 00 ADMI NI STRATI VE & GENERAL 1. 00 ADMI NI STRATI VE & GENERAL 1. 00 MARKETI NG 1. 00 MARKETI NG 1. 00 MARKETI NG DI 12, 540 N - MI TCHELL CLI NI C LEASE EXP PHYSI CI ANS' PRI VATE OFFI CES 1. 00 58, 403 1. 00 TOTALS 1. 00 TOTALS		J - PROPERTY INSURANCE						
2. 00 TOTALS K - PROPERTY TAXES 1. 00 ADMI NI STRATI VE & GENERAL 1. 00 ELECTROCARDI OLOGY TOTALS L - SOCI AL WORKER 1. 00 ADMI NI STRATI VE & GENERAL 1. 00 ADMI NI STRATI VE & GENERAL 1. 00 ADMI NI STRATI VE & GENERAL 1. 00 MARKETI NG 1. 00 MARKETI NG 1. 00 MARKETI NG DI 12, 540 N - MI TCHELL CLI NI C LEASE EXP PHYSI CI ANS' PRI VATE OFFI CES 1. 00 58, 403 1. 00 TOTALS 1. 00 TOTALS	1.00	ADMINISTRATIVE & GENERAL	5, 00	0	32, 011	9		1.00
TOTALS					0			4
K - PROPERTY TAXES	2.00	TOTALS — — — —	— — 		$$ $$ $\frac{3}{2}$ $\frac{5}{011}$	— — <u> </u>		2.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 0 32, 966 9 1. 00 2. 00 ELECTROCARDI OLOGY 69. 00 0 327 0 2. 00 TOTALS 0 33, 293 L - SOCI AL WORKER 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 51, 004 0 0 0 1. 00 TOTALS 51, 004 0 0 1. 00 M - HO MARKETI NG 1. 00 MARKETI NG/PUBLI C RELATI ONS 194. 00 0 112, 540 0 1. 00 TOTALS 0 112, 540 0 1. 00 N - MITCHELL CLINI C LEASE EXP 1. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 58, 403 10 TOTALS 0 58, 403 10				U _I	32, 011			-
2. 00 ELECTROCARDI OLOGY 69. 00 0 327 0 2. 00 10TALS 0 33, 293	4 00			ام	20.044	0		4 00
TOTALS					·			
L - SOCI AL WORKER 1. 00 ADMI NI STRATI VE & GENERAL 5. 00 51, 004 0 0 1. 00 TOTALS 51, 004 0 0 1. 00 M - HO MARKETI NG 1. 00 MARKETI NG/PUBLI C RELATI ONS 194. 00 0 112, 540 0 1. 00 TOTALS 0 112, 540 0 1. 00 N - MITCHELL CLINIC LEASE EXP 1. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 0 58, 403 10 1. 00 TOTALS 0 58, 403 10 1. 00	2. 00		<u>69.</u> 00	0		0		2.00
1. 00 ADMI NI STRATI VE & GENERAL 5. 00 51, 004 0 0 0 1 1. 00 TOTALS 51, 004 0 0 1 1. 00 MARKETI NG 1. 00 MARKETI NG/PUBLI C RELATI ONS 194. 00 0 112, 540 0 1 1. 00 TOTALS 0 112, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 540 1 1. 00 1 12, 54		TOTALS		0	33, 293			
TOTALS		L - SOCIAL WORKER						
TOTALS	1.00	ADMINISTRATIVE & GENERAL	5.00	51, 004	0	0		1.00
M - HO MARKETING 1. 00 MARKETING/PUBLIC RELATIONS 194.00 0 112,540 0 1 TOTALS 0 112,540 1 N - MITCHELL CLINIC LEASE EXP 1. 00 PHYSICIANS' PRIVATE OFFICES 192.00 0 58,403 10 TOTALS 0 58,403 10								
1. 00 MARKETING/PUBLIC RELATIONS 194.00 0 112, 540 0 1 TOTALS 0 112, 540 1 N - MITCHELL CLINIC LEASE EXP 1. 00 PHYSICIANS' PRIVATE OFFICES 192.00 0 58, 403 10 TOTALS 0 58, 403 10				3.733.1				
TOTALS 0 112, 540 N - MITCHELL CLINIC LEASE EXP 1. 00 PHYSICIANS' PRIVATE OFFICES 192.00 0 58, 403 10 1.00 TOTALS 0 58, 403 10	1 00		104 00	ام	112 E40	0		1 00
N - MITCHELL CLINIC LEASE EXP 1. 00 PHYSICIANS' PRIVATE OFFICES 192.00 0 58,403 10 1. 00 TOTALS 0 58,403	1.00		194.00					1.00
1. 00 PHYSI CI ANS' PRI VATE OFFI CES 192. 00 58, 403 10 1. 00 TOTALS 0 58, 403				0]	112, 540			4
TOTALS 0 58, 403								
2 27/12	1.00		192.00			10		1.00
		TOTALS		o	58, 403			
	500.00	Grand Total: Decreases		221, 435	7, 872, 484			500.00
		•	. '			. '		•

10.00 Total (line 8 minus line 9)

10.00

RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 151328 Peri od: Worksheet A-7 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/27/2016 1:57 pm Acqui si ti ons Begi nni ng Di sposal s and Purchases Donati on Total Bal ances Retirements 2.00 3.00 4. 00 1 00 5 00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 931, 334 0 1.00 0 2.00 Land Improvements 1, 174, 400 0 2.00 14, 290, 100 0 3.00 639, 150 639, 150 3.00 Buildings and Fixtures 0 0 4.00 Building Improvements 3, 582, 066 194, 965 194, 965 0 4.00 5.00 Fixed Equipment 1, 863, 226 45, 641 0 45, 641 5.00 0 6.00 Movable Equipment 20, 806, 377 2, 082, 536 2, 082, 536 2, 075, 256 6.00 0 7.00 HIT designated Assets 0 7.00 0 8.00 Subtotal (sum of lines 1-7) 42, 647, 503 2, 962, 292 2, 962, 292 2, 075, 256 8.00 9.00 Reconciling Items 0 9.00 2<u>, 075, 256</u> Total (line 8 minus line 9) 42, 647, 503 10.00 2, 962, 292 0 2, 962, 292 10.00 Endi ng Bal ance Fully Depreciated Assets 6.00 7.00 PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET BALANCES 1.00 Land 931, 334 0 1.00 2.00 Land Improvements 1, 174, 400 0 2.00 14, 929, 250 3.00 Buildings and Fixtures 0 3.00 0 4.00 Building Improvements 3, 777, 031 4.00 5.00 Fi xed Equipment 1, 908, 867 0 5.00 Movable Equipment 6.00 20, 813, 657 0 6.00 7.00 HIT designated Assets 0 7.00 Subtotal (sum of lines 1-7) 8.00 43, 534, 539 0 8.00 9.00 Reconciling Items 9.00

43, 534, 539

0

0

0

15. 00

0

0

1.00

2.00

3.00

14.00

PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2

NEW CAP REL COSTS-BLDG & FIXT

NEW CAP REL COSTS-MVBLE EQUIP

Total (sum of lines 1-2)

1.00

2.00

3.00

Heal th	n Financial Systems IND	IANA UNIVERSIT	Y HEALTH BEDFOR	RD	In Lie	eu of Form CMS-:	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	F	Period: From 01/01/2015 Fo 12/31/2015	Worksheet A-7 Part III Date/Time Pre 5/27/2016 1:5	pared:
		COMI	PUTATION OF RAT	TIOS	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capitalized Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	Insurance	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	NEW CAP REL COSTS-BLDG & FIXT	22, 720, 880		22, 720, 880			
2.00	NEW CAP REL COSTS-MVBLE EQUIP	20, 813, 657		20, 813, 657			2. 00
3.00	Total (sum of lines 1-2)	43, 534, 537		43, 534, 537			3. 00
		ALLOCA ⁻	TION OF OTHER (CAPI TAL	SUMMARY C	F CAPITAL	
	Cost Center Description	Taxes	Other	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 CI	NTERS					
1.00	NEW CAP REL COSTS-BLDG & FLXT	0	0) (1, 498, 976		
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0) (964, 879	0	2. 00
3.00	Total (sum of lines 1-2)	0)	2, 463, 855	58, 403	3. 00
			Sl	JMMARY OF CAPI	TAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
			instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
					d Costs (see	through 14)	
					instructions)		
		11. 00	12.00	13. 00	14. 00	15. 00	
	DART III DECONCIIIATION OF CARITAL COSTS CI	NTEDC					1

0 -61, 686 -61, 686

PART III - RECONCILIATION OF CAPITAL COSTS CENTERS
NEW CAP REL COSTS-BLDG & FIXT

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

0 0 0

0 0 0

1, 557, 379 1. 00 903, 193 2. 00 2, 460, 572 3. 00

0 0 0

1.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES INDIANA UNIVERSITY HEALTH BEDFORD

Provider CCN: 151328 In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: Worksheet A-8 From 01/01/2015 Date/Time Prepared: 5/27/2016 1:57 pm

					To 12/31/2015	Date/Time Prep 5/27/2016 1:5	
				Expense Classification on To/From Which the Amount is		0,2,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	, p
				TO/FI OIII WITCH THE AMOUNT IS	to be Adjusted		
	Cost Contor Dosorintion	Pacis/Codo (2)	Amount	Cost Contor	line #	Mkst A 7 Dof	
	Cost Center Description	1. 00	Amount 2.00	Cost Center 3.00	Li ne # 4. 00	Wkst. A-7 Ref. 5.00	
R	nvestment income - NEW CAP REL COSTS-BLDG & FIXT (chapter		C	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1. 00
2. 00 I	?) nvestment income - NEW CAP EL COSTS-MVBLE EQUIP (chapter		C	NEW CAP REL COSTS-MVBLE EQUIP	2. 00	0	2. 00
3. 00 I	?) nvestment income - other chapter 2)		C		0.00	0	3. 00
4.00 T	rade, quantity, and time liscounts (chapter 8)		C		0. 00	0	4. 00
5.00 R	defunds and rebates of		C		0.00	0	5. 00
6.00 R	expenses (chapter 8) Pental of provider space by		C		0. 00	0	6. 00
7.00 T	suppliers (chapter 8) Telephone services (pay Stations excluded) (chapter		C		0.00	0	7. 00
8.00 T	elevision and radio service		C		0.00	0	8. 00
9. 00 P	chapter 21) Parking Lot (chapter 21) Provider-based physician	A-8-2	-2, 279, 281		0. 00	0 0	9. 00 10. 00
11. 00 S	djustment ale of scrap, waste, etc. chapter 23)		C		0.00	0	11. 00
12. 00 R	lelated organization ransactions (chapter 10)	A-8-1	10, 664, 054			0	12. 00
13. 00 L	aundry and linen service		C		0.00	0	13. 00
	Cafeteria-employees and guests Rental of quarters to employee		C		0. 00 0. 00	0	14. 00 15. 00
16. 00 S	and others Sale of medical and surgical Supplies to other than		C		0. 00	0	16. 00
17. 00 S	eatients Sale of drugs to other than		C		0.00	0	17. 00
	patients Sale of medical records and		C		0.00	0	18. 00
1	bstracts Uursing school (tuition, fees,		C		0.00	0	19. 00
	oooks, etc.) /ending machines		(0.00	0	20. 00
21. 00 I	ncome from imposition of nterest, finance or penalty		C		0.00	O	21. 00
22. 00 I	charges (chapter 21) nterest expense on Medicare overpayments and borrowings to		C		0.00	0	22. 00
23. 00 A	repay Medicare overpayments adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65. 00		23. 00
24. 00 A	imitation (chapter 14) djustment for physical herapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66. 00		24. 00
25. 00 U	imitation (chapter 14) Hilization review – Hysicians' compensation		C	UTILIZATION REVIEW-SNF	114. 00		25. 00
(chapter 21) Depreciation - NEW CAP REL		C	NEW CAP REL COSTS-BLDG &	1.00	0	26. 00
C	COSTS-BLDG & FLXT Depreciation - NEW CAP REL			FIXT NEW CAP REL COSTS-MVBLE	2.00	0	
C	COSTS-MVBLE EQUIP			EQUI P			
	lon-physician Anesthetist Physicians' assistant		C	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30. 00 A	djustment for occupational herapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	67. 00		30. 00
	imitation (chapter 14) Hospice (non-distinct) (see		C	ADULTS & PEDIATRICS	30.00		30. 99
31. 00 A	nstructions) djustment for speech	A-8-3		SPEECH PATHOLOGY	68. 00		31. 00
ļi.	eathology costs in excess of imitation (chapter 14)		,		0.00	2	22.00
	CAH HIT Adjustment for Depreciation and Interest			/	0.00	0	32. 00

0 00

0.00

0.00

0.00

0.00

0.00

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O 45 14

ol

45.15

45. 16

45.17 0

45.18

45.19 45. 20

50 00

ADJUSTMENTS TO EXPENSES Provider CCN: 151328 Peri od: Worksheet A-8 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Cost Center Description Basis/Code (2) Amount Cost Center Line # Wkst. A-7 Ref. 1.00 2.00 3.00 4.00 5.00 33.00 BENEFITS -2, 290, 678 EMPLOYEE BENEFITS DEPARTMENT 33. 00 4.00 Α CABLE TV -3, 643 ADULTS & PEDIATRICS 34.00 Α 30.00 0 34.00 35.00 0.00 35.00 37.00 CABLE TV -1, 230 PHYSI CAL THERAPY 66.00 37.00 Α CABLE TV -1. 009 ELECTROCARDI OLOGY 69.00 38 00 ol 38 00 Α 39.00 CABLE TV Α -489 ADMINISTRATIVE & GENERAL 5.00 39.00 40.00 CABLE TV Α -139 OPERATION OF PLANT 7.00 40.00 41.00 MISC INCOME В -90, 857 ADMI NI STRATI VE & GENERAL 5.00 41.00 O MISC INCOME 319 DI ETARY 42.00 В 10.00 42.00 43.00 MISC INCOME В -105, 742 CAFETERI A 11.00 43.00 -4, 432 NURSING ADMINISTRATION 44.00 MISC INCOME В 13.00 44.00 MISC INCOME -150RADI OLOGY-DI AGNOSTI C 45 00 45 00 В 54 00 45.01 MISC INCOME В -19, 917 ELECTROCARDI OLOGY 69.00 45.01 45.02 0.00 45.02 45.03 PHONE -20, 410 ADMINISTRATIVE & GENERAL 45.03 Α 5.00 0 -1,842 EMPLOYEE BENEFITS DEPARTMENT 45.04 PHONE 4.00 Α O 45.04 45.05 PHONE Α -1, 785 NEW CAP REL COSTS-BLDG & 1.00 45.05 FLXT 45.06 45.06 PHONE Α -1, 767 NEW CAP REL COSTS-MVBLE 2.00 EQUI P -43, 630 ADMI NI STRATI VE & GENERAL 45 07 RECUITING 5 00 O 45 07 Α 1,568 MARKETING/PUBLIC RELATIONS 45.08 NRCC Α 194.00 0 45.08 45.09 HAF -840, 482 ADMI NI STRATI VE & GENERAL 5.00 45.09 Α 45.10 HIT DEPR Α -281, 376 NEW CAP REL COSTS-MVBLE 2.00 45. 10 EQUI P INVESTMENT INCOME -4, 366 ADMI NI STRATI VE & GENERAL 45 11 В 5.00 45 11 -61, 686 NEW CAP REL COSTS-MVBLE EQUI P 45.12 INVESTMENT INCOME 2.00 11 45. 12 В 45.13 0 0.00 0 45.13

0000

0

4, 611, 030

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

(2) Basis for adjustment (see instructions).

TOTAL (sum of lines 1 thru 49)

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

45 14

45.15

45. 16

45.17

45.18

45.19

45.20

50 00

B. Amount Received - if cost cannot be determined.

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

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

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

STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIONS AND HOME Provider CCN: 151328 Peri od: Worksheet A-8-1 From 01/01/2015 OFFICE COSTS 12/31/2015 Date/Time Prepared:

					5/27/2016 1:5	
	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	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:	I	I		_	
1. 00		l .	HO ALLOCATIONS CAPITAL COSTS	157, 464		1. 00
2.00	1		HO ALLOCATIONS CAPITAL COSTS	146, 193		2. 00
3.00	1		HO ALLOCATIONS EMPLOYEE BENE	2, 396, 282		3. 00
3. 01	•		RELATED PARTY INTEREST EXP	34, 566	· ·	3. 01
3. 02	•	ADMINISTRATIVE & GENERAL	HO ALLOCATION CORPORATE ADMI	4, 532, 759		3. 02
4.00	•	ADMINISTRATIVE & GENERAL	SHARED EMPLOYEES	650, 973	· ·	4. 00
4. 01	•	OPERATION OF PLANT	SHARED EMPLOYEES	30, 636	· ·	
4.02	10.00	DI ETARY	SHARED EMPLOYEES	22, 606	22, 606	
4.03	1	NURSING ADMINISTRATION	SHARED EMPLOYEES	50, 320	50, 320	4. 03
4.04		OPERATING ROOM	SHARED EMPLOYEES	93	93	4.04
4.05	54. 00	RADI OLOGY-DI AGNOSTI C	SHARED EMPLOYEES	172, 371	172, 371	4. 05
4.06	60.00	LABORATORY	SHARED EMPLOYEES	1, 954, 086	1, 954, 086	4.06
4.07	66.00	PHYSI CAL THERAPY	SHARED EMPLOYEES	124, 804	124, 804	4.07
4.08	69. 00	ELECTROCARDI OLOGY	SHARED EMPLOYEES	1, 267	1, 267	4. 08
4.09	90. 01	CLINIC - DIABETES	SHARED EMPLOYEES	9, 954	9, 954	4. 09
4. 10	5. 00	ADMINISTRATIVE & GENERAL	MKTG	0	112, 540	4. 10
4. 11	91.00	EMERGENCY	BLOOMI NGTON ER	2, 017, 531	523, 672	4. 11
4. 12	5. 00	ADMINISTRATIVE & GENERAL	BLOOMINGTON ADMIN ALLOC	8, 387, 358	0	4. 12
5.00	0		0	20, 689, 263	10, 025, 209	5. 00

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

Book postou to her nomest /ij						
			Related Organization(s) and/	or Home Office		
Symbol (1)	Name	Percentage of	Name	Percentage of	i	
		Ownershi p		Ownershi p	i	
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 I U HEALTH, I NC. 50.0	6. 00
7.00	F	0.00 IUH BLOOMINGTO 50.0	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 organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

0 4.01 0 4.01 4.02 0 0 4.02 0 4.03 0 4 03 0 0 4.04 4.04 4.05 0 0 4.05 0 4.06 0 4.06 0 0 4 07 4 07 4.08 0 4.08 4.09 0 0 4.09 0 4.10 -112, 540 4.10 0 4.11 1, 493, 859 4. 11 4.12 8, 387, 358 0 4.12 5.00 10, 664, 054 5.00 The amounts on lines 1-4 (and subscripts as appropriate) are transferred in detail to Worksheet A, column 6, lines as

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

	ated Organization(s) nd/or Home Office		
	Type of Business		
	6. 00		
B. INT	ERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6.00	HOME OFFICE	6. 00
7.00	HEALTHCARE	7.00
8.00		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.

INDIANA UNIVERSITY HEALTH BEDFORD Health Financial Systems In Lieu of Form CMS-2552-10 PROVIDER BASED PHYSICIAN ADJUSTMENT Provi der CCN: 151328 Peri od: Worksheet A-8-2 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er Component ider Component Remuneration Component Hours 7.00 1. 00 2.00 3.00 4.00 5. 00 6. 00 1.00 5. 00 ADMI NI STRATI VE & GENERAL 108, 750 1.00 108, 750 0 0 2.00 50.00 OPERATING ROOM 596, 642 596, 642 0 2.00 3.00 54. 00 RADI OLOGY-DI AGNOSTI C 171,000 168, 864 0 3.00 2, 136 163, 391 4.00 60. 00 LABORATORY 163, 391 0 0 0 0 4.00 0 69. 00 ELECTROCARDI OLOGY 5.00 1, 267 377 890 0 5.00 6.00 91. 00 EMERGENCY 2, 017, 531 1, 350, 007 667, 524 6.00 0 7.00 0.00 0 0 0 7.00 0 0 0.00 8.00 0 8.00 0 0 0 9.00 0.00 0 0 9.00 10.00 0.00 0 10.00 2, 279, 281 3, 058, 581 779, 300 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of Identi fi er Limit Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col. Insurance Educati on 12 1. 00 2.00 8.00 9.00 12. 00 13.00 14.00 5. 00 ADMINISTRATIVE & GENERAL 1.00 0 0 0 0 1.00 2.00 50.00 OPERATING ROOM 0 0 0 0 0 2.00 3.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 3.00 0 0 0 0 4.00 60. 00 LABORATORY 0 0 0 0 0 4.00 69. 00 ELECTROCARDI OLOGY 5.00 0 5.00 0 6.00 91. 00 EMERGENCY 0 0 0 6.00 7.00 0.00 0 0 7.00 0 0 0 0.00 8.00 0 8.00 0.00 0 9.00 9.00 0 10.00 0.00 0 0 10.00 200 00 200 00

200.00			0	0	0	0	0 200.00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	
		I denti fi er	Component	Li mi t	Di sal I owance		
			Share of col.				
			14				
	1. 00	2. 00	15. 00	16. 00	17. 00	18. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	0	0	1.00
2.00	50.00	OPERATING ROOM	0	0	0	596, 642	2.00
3.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	168, 864	3.00
4.00	60.00	LABORATORY	0	0	0	163, 391	4.00
5.00	69. 00	ELECTROCARDI OLOGY	0	0	0	377	5. 00
6.00	91.00	EMERGENCY	0	0	0	1, 350, 007	6. 00
7.00	0.00		0	0	0	0	7.00
8.00	0.00		0	0	0	0	8. 00
9.00	0.00		0	0	0	0	9.00
10.00	0.00		0	0	0	0	10.00
200.00			0	0	0	2, 279, 281	200. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 151328 | Period: | Worksheet B | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

				To	12/31/2015	Date/Time Pre 5/27/2016 1:5	
			CAPITAL REL	ATED COSTS		10,27,20.0	, ja
Co	ost Center Description	Net Expenses	NEW BLDG &	NEW MVBLE	EMPLOYEE	Subtotal	
	ost center bescription	for Cost	FIXT	EQUI P	BENEFITS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7) 0	1. 00	2.00	4. 00	4A	
GENERAL	SERVICE COST CENTERS	-		_, , , ,			
1 1	EW CAP REL COSTS-BLDG & FIXT	1, 557, 379	1, 557, 379				1. 00
	EW CAP REL COSTS-MVBLE EQUIP	903, 193 3, 348, 774	4 114	903, 193	2 254 105		2.00
	WPLOYEE BENEFITS DEPARTMENT DMINISTRATIVE & GENERAL	15, 434, 013	4, 114 245, 392	3, 297 196, 680	3, 356, 185 302, 266	16, 178, 351	4. 00 5. 00
	PERATION OF PLANT	2, 478, 073	164, 069	131, 500	93, 299	2, 866, 941	7. 00
8. 00 00800 LA	AUNDRY & LINEN SERVICE	50, 099	0	0	0	50, 099	8. 00
	OUSEKEEPI NG	537, 468	20, 624	16, 530	81, 580	656, 202	9.00
10. 00 01000 DI	I E I ARY AFETERI A	340, 426 136, 126	18, 238 35, 158	14, 618 28, 179	47, 383 33, 696	420, 665 233, 159	10. 00 11. 00
	AINTENANCE OF PERSONNEL	130, 120	35, 156	20, 179	33, 696	233, 139	12.00
	URSI NG ADMI NI STRATI ON	1, 294, 119	37, 842	30, 330	258, 140	1, 620, 431	13. 00
	ENTRAL SERVICES & SUPPLY	370, 583	8, 974	7, 193	10, 126	396, 876	14. 00
15. 00 01500 PH		2, 142, 599	16, 366	13, 117	60, 459	2, 232, 541	
	EDICAL RECORDS & LIBRARY OCIAL SERVICE	51, 004	0	0	0 11, 855	0 62, 859	16. 00 17. 00
1 1	ONPHYSICIAN ANESTHETISTS	0	ő	0	0	02, 037	19.00
20. 00 02000 NI	URSING SCHOOL	O	0	0	О	0	20. 00
	&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	0	0	21. 00
	&R SERVICES-OTHER PRGM COSTS APPRVD ARAMED ED PRGM	0	0	0	0	0	22. 00 23. 00
	NT ROUTINE SERVICE COST CENTERS	l ol	<u> </u>	U	<u> </u>	0	23.00
	DULTS & PEDIATRICS	2, 180, 016	91, 527	73, 358	459, 842	2, 804, 743	30.00
	NTENSIVE CARE UNIT	1, 026, 272	25, 485	20, 426	217, 734	1, 289, 917	31.00
1 1	ORONARY CARE UNIT	0	0	0	0	0	32.00
1 1	URN INTENSIVE CARE UNIT URGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
1 1	UBPROVIDER - IPF		0	0	o	0	40.00
1 1	UBPROVI DER - I RF	Ö	Ō	0	ō	0	41.00
1 1	UBPROVI DER	0	0	0	0	0	42. 00
43. 00 04300 NI		0	0	0	0	0	43.00
	KILLED NURSING FACILITY URSING FACILITY		0	0	0	0	44. 00 45. 00
45. 01 04510 I (o	o	0	Ö	0	45. 01
	THER LONG TERM CARE	0	0	0	0	0	46. 00
	RY SERVICE COST CENTERS PERATING ROOM	0/1 721	110 242	95, 652	214 424	1 401 151	FO 00
1 1	ECOVERY ROOM	961, 731 81, 301	119, 342 0	95, 652	314, 426 16, 659	1, 491, 151 97, 960	50. 00 51. 00
	ELIVERY ROOM & LABOR ROOM	0	Ö	Ö	0	0	52.00
1 1	NESTHESI OLOGY	0	O	0	o	0	53. 00
1 1	ADI OLOGY-DI AGNOSTI C	2, 427, 732	121, 720	97, 558	389, 935	3, 036, 945	54.00
	ADI OLOGY-THERAPEUTI C ADI OI SOTOPE	211, 065	0	0	23, 258	0 234, 323	55. 00 56. 00
57. 00 05700 C		0	o	0	25, 250	254, 325	57. 00
	AGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
	ARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
	ABORATORY LOOD LABORATORY	2, 681, 571	38, 018	30, 472	215, 434	2, 965, 495 0	60. 00 60. 01
	BP CLINICAL LAB SERVICES-PRGM ONLY		o l	U	ď	0	61.00
	HOLE BLOOD & PACKED RED BLOOD CELLS	0	o	0	О	0	62. 00
63. 00 06300 BI	LOOD STORING, PROCESSING & TRANS.	0	О	0	О	0	63. 00
	NTRAVENOUS THERAPY	0	0	0	0	0	64.00
	ESPI RATORY THERAPY HYSI CAL THERAPY	979, 124	38, 846	31, 135	212, 765	0 1, 261, 870	65. 00 66. 00
1 1	CCUPATI ONAL THERAPY	0	0	0	212, 703	0	67. 00
	PEECH PATHOLOGY	0	0	0	0	0	68. 00
	LECTROCARDI OLOGY	1, 331, 734	47, 073	37, 729	243, 572	1, 660, 108	
	LECTROENCEPHALOGRAPHY	0	0	0	0	0 E0 30E	70.00
	EDICAL SUPPLIES CHARGED TO PATIENTS WPL. DEV. CHARGED TO PATIENT	50, 305 95, 975	ol Ol	0	O O	50, 305 95, 975	•
	RUGS CHARGED TO PATIENTS	3, 023, 586	ol	o	ő	3, 023, 586	1
74.00 07400 RE	ENAL DIALYSIS	0	o	0	o	0	74. 00
	SC (NON-DISTINCT PART)	0	0	0	0	0	75.00
	ARDIAC REHABILITATION ENT SERVICE COST CENTERS	19, 855	18, 013	14, 437	5, 917	58, 222	76. 97
	URAL HEALTH CLINIC	O	ol	0	ol	0	88. 00
89. 00 08900 FE	EDERALLY QUALIFIED HEALTH CENTER		o	Ö	o	0	89. 00
90. 00 09000 CI		0	0	0	0	0	90.00
90. 01 09001 Cl	LINIC - DIABETES	96, 191	4, 218	3, 381	17, 800	121, 590	90.01

34, 151

167, 199

46, 205, 280

22, 890

52, 103

1, 557, 379

75, 387 194. 00

253, 047 194. 02

46, 205, 280 202. 00

0 194. 01

0 194. 03 0 200. 00

0 201. 00

0

33, 745

3, 356, 185

18, 346

903, 193

0

0

0

194. 00 07950 MARKETI NG/PUBLI C RELATIONS

194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

194. 01 07951 CLARIAN HOME CARE

194.03 07953 HOME CARE

200.00

201.00

202.00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

		_		, ,		5/27/2016 1:5	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		5. 00	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS			1			
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	16, 178, 351					5. 00
7.00	00700 OPERATION OF PLANT	1, 544, 693	4, 411, 634	l.			7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	26, 993	0	77, 092			8. 00
9.00	00900 HOUSEKEEPI NG	353, 558	79, 547	1	1, 089, 307	747 241	9.00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A	226, 652 125, 625	70, 343 135, 604		28, 681 55, 289	746, 341 0	10. 00 11. 00
12. 00	01200 MAINTENANCE OF PERSONNEL	123, 023	133,004	0	0	0	12.00
13. 00	01300 NURSI NG ADMI NI STRATI ON	873, 080	145, 954	0	59, 509	0	13. 00
14.00	01400 CENTRAL SERVICES & SUPPLY	213, 835	34, 614	0	14, 113	0	14. 00
15. 00	01500 PHARMACY	1, 202, 882	63, 123	0	25, 737	0	15.00
16. 00 17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	33, 868	0	0	0	0	16. 00 17. 00
19. 00	· · · · · · · · · · · · · · · · · · ·	33,808	0		0	0	19.00
20. 00	+ I	0	Ö	Ö	o	0	20.00
21. 00	· · · · · · · · · · · · · · · · · · ·	0	0	0	o	0	21. 00
22. 00	02200 I &R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	0) 0	0	0	23. 00
30. 00		1, 511, 182	353, 017	30, 110	143, 934	593, 638	30.00
31. 00		695, 001	98, 295		40, 077	152, 703	31.00
32. 00	03200 CORONARY CARE UNIT	0	0	0	o	0	32. 00
33.00	+ I	0	0	0	0	0	33.00
34. 00 40. 00	03400 SURGI CAL INTENSI VE CARE UNIT 04000 SUBPROVI DER - I PF	0	0	0	0	0	34. 00 40. 00
41. 00	04100 SUBPROVIDER - I RF	0	1 0	0	0	0	41.00
42. 00	04200 SUBPROVI DER	0	Ö	o o	o	0	42.00
43.00	04300 NURSERY	0	0	0	0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44. 00
45. 00		0	0	0	0	0	45. 00
45. 01 46. 00	04510 CF/MR 04600 OTHER LONG TERM CARE	0	1 0	0	0	0	45. 01 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS			,, ,	<u> </u>		70.00
50.00		803, 425	460, 299	3, 334	187, 675	0	50. 00
51. 00	05100 RECOVERY ROOM	52, 780	0	504	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY - DI AGNOSTI C	1, 636, 283	469, 471	6, 944	191, 414	0	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0, 744	0	0	55. 00
56.00	05600 RADI OI SOTOPE	126, 252	0	412	0	0	56. 00
57. 00	· · · · · · · · · · · · · · · · · · ·	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	0	0	58. 00
59. 00 60. 00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	1, 597, 794	146, 636		59, 787	0	59. 00 60. 00
60. 01	1 1	0	140,030	o o	0	0	60. 01
61.00	1 I						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62. 00
63. 00	·	0	0	0	0	0	63.00
64. 00 65. 00	1 1	0	0		0	0	64. 00 65. 00
66. 00	1 1	679, 889	149, 828	3, 744	61, 088	0	66. 00
67.00	1 1	0	0	0	0	0	67.00
68. 00		0	0	0	o	0	68. 00
69.00		894, 458	181, 560	0	74, 026	0	69.00
70. 00 71. 00		27, 104	0	3, 561	0	0	70. 00 71. 00
71.00	1	51, 711	0	, 3, 361 0		0	71.00
73. 00		1, 629, 093	0	Ö	Ö	0	73. 00
74.00		0	0	0	o	0	74. 00
75. 00		0		0	0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	31, 370	69, 476	0	28, 327	0	76. 97
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	n	0		n	0	88. 00
89. 00				Ö		0	89.00
90. 00	09000 CLI NI C	0	0	Ō	o	0	90.00
90. 01	· · · · · · · · · · · · · · · · · · ·	65, 512	16, 269		6, 633	0	90. 01
91.00		1, 377, 896	159, 961	20, 916	65, 220	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS			1			92.00
94. 00		0	0	0	0	0	94. 00
95. 00		0		1			

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Worksheet B
Part I
Date/Time Prepared:
5/27/2016 1:57 pm Provi der CCN: 151328 Peri od: From 01/01/2015 To 12/31/2015 Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY

	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7.00	8. 00	9. 00	10.00	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
99. 00 09900 CMHC	0	0	0	0	0	99.00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	o	0	О	0	108. 00
109. 00 10900 PANCREAS ACQUISITION	0	o	0	О	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	o	0	О	0	110. 00
111.00 11100 I SLET ACQUI SI TI ON	0	o	0	О	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTILIZATION REVIEW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	o	0	О	0	115. 00
116. 00 11600 HOSPI CE	0	o	0	О	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	15, 780, 936	2, 633, 997	77, 092	1, 041, 510	746, 341	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	12, 763	28, 943	0	11, 801	0	190. 00
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	207, 694	1, 459, 451	0	0	0	192. 00
192. 01 19201 VACANT SPACE	0	0	0	0	0	192. 01
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 MARKETING/PUBLIC RELATIONS	40, 618	88, 285	0	35, 996	0	194. 00
194.01 07951 CLARIAN HOME CARE	0	0	0	0	0	194. 01
194.02 07952 BLOOMNGTN AMBULANCE AND OCC MED	136, 340	200, 958	0	0	0	194. 02
194.03 07953 HOME CARE	0	0	0	0	0	194. 03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	o	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	16, 178, 351	4, 411, 634	77, 092	1, 089, 307	746, 341	202. 00
	•	·	,	·	·	

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

 LTH BEDFORD
 In Lieu of Form CMS-2552-10

 Provi der CCN: 151328
 Peri od: From 01/01/2015 | Part I To 12/31/2015 | Part I Date/Time Prepared: Provided to 12/31/2015 | Part I Date/Time Prepared: Part I Date/Time Prepared: Provided to 12/31/2015 | Part I Date/Time Prepared: Par

				10	0 12/31/2015	Date/lime Pre 5/27/2016 1:5	
	Cost Center Description	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	/ piii
		11.00	12.00	13.00	14. 00	15. 00	
	GENERAL SERVICE COST CENTERS		1				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8.00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A	549, 677					11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	0 744 760			12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	42, 789 6, 583	l .	2, 741, 763	666 021		13. 00 14. 00
15. 00	01500 PHARMACY	13, 166	l .		666, 021 0	3, 537, 449	
16. 00	01600 MEDI CAL RECORDS & LI BRARY	0	l o	o o	0	0,007,117	16. 00
17. 00	01700 SOCIAL SERVICE	3, 291		Ö	0	0	17. 00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	0	0	0	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0		0	0	0	22. 00
23.00	02300 PARAMED ED PRGM INPATIENT ROUTINE SERVICE COST CENTERS	0	0	0	0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	115, 205		1, 170, 264	0	0	30.00
31. 00	03100 NTENSI VE CARE UNI T	39, 498	l .		Ö	0	31. 00
32.00	03200 CORONARY CARE UNIT	0	O	0	0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33. 00
34.00	03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF	0		0	0	0	40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0			0	0	41. 00 42. 00
43. 00	04300 NURSERY	0			0	0	43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	l o	o o	0	0	44. 00
45.00	04500 NURSING FACILITY	0	O	o	0	0	45. 00
45. 01	04510 CF/MR	0	0	0	0	0	45. 01
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	42, 789	0	434, 670	0	0	50. 00
51. 00	05100 RECOVERY ROOM	3, 291	l .	1		0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	85, 578	0	0	0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00 57. 00	05600	3, 291			0	0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0	0	58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	C	o	0	0	
60.00	06000 LABORATORY	3, 291	0	0	0	0	60. 00
	06001 BLOOD LABORATORY	0	0	0	0	0	
61.00							61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0	0	62.00
64. 00	06400 I NTRAVENOUS THERAPY	0			0	0	63. 00 64. 00
65. 00	06500 RESPI RATORY THERAPY	0		o o	0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	39, 498	O	Ö	0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	o	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	52, 664	0	0	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0		0	220 041	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0			229, 041 436, 980	0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	0			430, 460	3, 537, 449	
74. 00	07400 RENAL DI ALYSI S	0		o o	0	0	1
75.00	07500 ASC (NON-DISTINCT PART)	0	o	0	0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	6, 583	0	0	0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	1	1	J	ام		00.00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	88. 00 89. 00
90.00		0	n o		0	0	90.00
90. 01	09001 CLINIC - DIABETES	3, 291	0		o	0	90.00
	09100 EMERGENCY	69, 121	l .	702, 159	o	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
04.00	OTHER REIMBURSABLE COST CENTERS	1 -	1 -		51		04.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 151328 Peri od: Worksheet B From 01/01/2015 Part I 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** PERSONNEL ADMI NI STRATI ON SERVICES & **SUPPLY** 11. 00 12.00 13.00 15.00 14.00 95. 00 09500 AMBULANCE SERVICES 95. 00 0 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 0 0 0 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 97.00 0 99. 00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 0 99. 10 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105. 00 0 0 0 0 0 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 106. 00 107. 00 10700 LIVER ACQUISITION 0 0 107. 00 0 οĺ 108.00 10800 LUNG ACQUISITION 0 0 108. 00 0 109. 00 10900 PANCREAS ACQUISITION 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 0 111.00 111.00 11100 I SLET ACQUISITION 0 0 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116, 00 C \cap 0 118.00 SUBTOTALS (SUM OF LINES 1-117) 529, 929 0 2, 741, 763 666, 021 3, 537, 449 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 3, 291 0 0 190. 00 191. 00 19100 RESEARCH 0 0 0 191.00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 0 192. 00 192. 01 19201 VACANT SPACE 0 0 0 192. 01 0 0 0 193. 00 19300 NONPALD WORKERS 0 0 193.00 194. 00 07950 MARKETING/PUBLIC RELATIONS 0 0 0 194. 00 0

16, 457

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2, 741, 763

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666, 021

0 194. 01

0 194. 02

0 194. 03

0 201.00

3, 537, 449 202. 00

200.00

194. 01 07951 CLARIAN HOME CARE

194.03 07953 HOME CARE

200.00

201.00

202.00

194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

Provider CCN: 151328

Peri od:

From 01/01/2015

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

In Lieu of Form CMS-2552-10
Worksheet B

Part I

Date/Time Prepared: 12/31/2015 5/27/2016 1:57 pm INTERNS & **RESI DENTS** MEDI CAL SOCIAL SERVICE NONPHYSICIAN NURSING SCHOOL SERVICES-SALAR Cost Center Description RECORDS & ANESTHETI STS Y & FRINGES LI BRARY 19.00 16.00 17.00 20.00 21.00 GENERAL SERVICE COST CENTERS 1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 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 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15 00 15 00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17.00 100,018 17.00 0 01900 NONPHYSICIAN ANESTHETISTS 19 00 0 19 00 20.00 02000 NURSING SCHOOL 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 0 21.00 21.00 0 22.00 0 02200 I &R SERVICES-OTHER PRGM COSTS APPRVD 22.00 02300 PARAMED ED PRGM 23 00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 79, 555 30.00 0 0 31.00 03100 INTENSIVE CARE UNIT 0000000000 20.463 0 0 0 0 0 0 0 0 0 0 31.00 03200 CORONARY CARE UNIT 0 32 00 32 00 C 0 0 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 34.00 04000 SUBPROVIDER - IPF 0 40.00 0 0 40.00 04100 SUBPROVI DER - I RF 0 41.00 Ω 0 41.00 42.00 04200 SUBPROVI DER 0 42.00 0 04300 NURSERY 0 43.00 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 0 44.00 0 45 00 04500 NURSING FACILITY Ω 0 45 00 04510 I CF/MR 0 0 45.01 45.01 0 0 0 46.00 04600 OTHER LONG TERM CARE 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 n 0 0 0 50.00 51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 52.00 05300 ANESTHESI OLOGY 0 0 53.00 Λ 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 00000000 0 0 0 0 0 0 0 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 0 56.00 05600 RADI OI SOTOPE 0 0 56.00 0 57.00 05700 CT SCAN 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 59.00 0 06000 LABORATORY 0 60.00 C 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0000000000000 0 0 0 0 0 0 0 0 0 0 62.00 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 65.00 0 66 00 06600 PHYSI CAL THERAPY Ω 0 0 66 00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 0 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 06900 ELECTROCARDI OLOGY 0 69.00 69.00 0 70 00 07000 ELECTROENCEPHALOGRAPHY 0 70 00 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 73.00 0 07400 RENAL DIALYSIS Ω 74.00 0 74.00 0 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 07697 CARDIAC REHABILITATION ol 76.97 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 89.00 0 0 90.00 09000 CLI NI C 0 0 0 90.00 0 09001 CLINIC - DIABETES 90.01 90 01 0 0 91.00 09100 EMERGENCY 0 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00

| Peri od: | Worksheet B | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 15/2016 | Part | | Pa Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 151328

				0 12/31/2015	5/27/2016 1:5	
					INTERNS &	
					RESI DENTS	
Cost Center Description	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	NURSING SCHOOL	SERVI CES-SALAR	
	RECORDS &		ANESTHETI STS		Y & FRINGES	
	LI BRARY					
	16.00	17. 00	19. 00	20.00	21. 00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	C	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0	C	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	0	0	97. 00
99. 00 09900 CMHC	0	0	C	0	0	99. 00
99. 10 09910 CORF	0	0	C	o	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	C	o	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	C	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	C	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	C	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	C	0	0	107. 00
108.00 10800 LUNG ACQUISITION	0	0	C	o	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	C	o	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0		o	0	110.00
111.00 11100 I SLET ACQUI SITION	0	0		ol	0	111. 00
113. 00 11300 I NTEREST EXPENSE						113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	l c	ol	0	115. 00
116, 00 11600 HOSPI CE	0	0		o	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	100, 018	C	o		118. 00
NONREI MBURSABLE COST CENTERS		· · · · · · · · · · · · · · · · · · ·	<u>'</u>	'		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	0	190. 00
191. 00 19100 RESEARCH	0	0	l c	o	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	l c	o	0	192. 00
192. 01 19201 VACANT SPACE	0	0	l c	ol	0	192. 01
193. 00 19300 NONPALD WORKERS	0	0	l c	ol	0	193. 00
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	l c	ol	0	194. 00
194. 01 07951 CLARI AN HOME CARE	0	0	l c	ol	0	194. 01
194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED	0	0		ol		194. 02
194. 03 07953 HOME CARE	0	0		ol	0	194. 03
200.00 Cross Foot Adjustments				ol		200. 00
201.00 Negative Cost Centers	0	0		ol		201. 00
202.00 TOTAL (sum lines 118-201)	0	100, 018	l c	o		202. 00
	1	,	'	, -,		

COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 151328 Peri od: Worksheet B From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/27/2016 1:57 pm INTERNS & **RESI DENTS** SERVI CES-OTHER PARAMED ED Subtotal Intern & Total Cost Center Description PRGM COSTS **PRGM** Residents Cost & Post Stepdown Adjustments 22.00 23. 00 24.00 25.00 26.00 GENERAL SERVICE COST CENTERS 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 1 00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5 00 00500 ADMINISTRATIVE & GENERAL 5 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 00900 HOUSEKEEPI NG 9.00 9.00 01000 DI ETARY 10 00 10.00 11.00 01100 CAFETERI A 11.00 01200 MAINTENANCE OF PERSONNEL 12.00 12.00 01300 NURSING ADMINISTRATION 13.00 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 17.00 19 00 01900 NONPHYSICIAN ANESTHETISTS 19 00 02000 NURSING SCHOOL 20.00 20.00 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 22.00 22, 00 02300 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 6, 801, 648 6, 801, 648 30.00 03100 INTENSIVE CARE UNIT 0 0 2, 744, 755 0 2, 744, 755 31.00 31.00 0 32.00 03200 CORONARY CARE UNIT C C 0 Ω 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 000000 0 0 0 0 0 0 0 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34.00 40.00 04000 SUBPROVIDER - IPF 0 0 40.00 04100 SUBPROVIDER - IRF 41.00 41.00 42.00 04200 SUBPROVI DER 0 0 0 42.00 04300 NURSERY 0 43 00 C Λ 43 00 44.00 04400 SKILLED NURSING FACILITY C 0 0 44.00 0 04500 NURSING FACILITY 0 0 45.00 0 0 45.00 04510 | CF/MR 45.01 45.01 0 0 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 3, 423, 343 3, 423, 343 50.00 0 05100 RECOVERY ROOM 000000000000 0 187 971 51 00 187 971 51 00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 C 0 52.00 53.00 05300 ANESTHESI OLOGY o 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 5, 426, 635 5, 426, 635 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 0 55 00 56.00 05600 RADI OI SOTOPE 364, 278 0 364, 278 56.00 05700 CT SCAN 0 57.00 57.00 0 0 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 05900 CARDIAC CATHETERIZATION 59 00 0 0 59 00 60.00 06000 LABORATORY 0 4, 773, 003 0 4, 773, 003 60.00 06001 BLOOD LABORATORY 60.01 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 62 00 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 0 06400 I NTRAVENOUS THERAPY 0000000000 0 64.00 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0 65 00 0 66.00 06600 PHYSI CAL THERAPY 2, 195, 917 2, 195, 917 66.00 06700 OCCUPATIONAL THERAPY 0 67.00 C 67.00 0 06800 SPEECH PATHOLOGY 68.00 68.00 0 2, 862, 816 06900 ELECTROCARDI OLOGY 69.00 2, 862, 816 69 00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 71 00 310, 011 0 310, 011 07200 IMPL. DEV. CHARGED TO PATIENT 584, 666 584, 666 72.00 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 0 8, 190, 128 8, 190, 128 73.00 0 07400 RENAL DIALYSIS 0 0 74.00 74.00 0 o 75.00 07500 ASC (NON-DISTINCT PART) C O 75.00 07697 CARDIAC REHABILITATION 193, 978 76.97 0 0 193, 978 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89.00 89.00 0 0 0 09000 CLINIC 0 0 90 00 \cap Λ 90 00 90.01 09001 CLINIC - DIABETES 0 213, 295 213, 295 90.01

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 151328 Peri od: Worksheet B From 01/01/2015 Part I 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm INTERNS & **RESI DENTS** PARAMED ED Cost Center Description SERVI CES-OTHER Subtotal Intern & Total PRGM COSTS PRGM Residents Cost & Post Stepdown Adjustments 22. 00 23. 00 24.00 25. 00 26.00 91. 00 09100 EMERGENCY 4, 952, 639 4, 952, 639 91.00 0 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 000000 95.00 09500 AMBULANCE SERVICES 0 0 0 95.00 0 0 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 09900 CMHC 0 99.00 0 0 0 99.00 99. 10 09910 CORF 0 99. 10 0 0 0 100.00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 SPECIAL PURPOSE COST CENTERS 0 105. 00 105. 00 10500 KIDNEY ACQUISITION 00000 0 0 0 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 108. 00 0 109. 00 10900 PANCREAS ACQUISITION C 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0 0 116. 00 11600 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 0 0 118.00 0 43, 225, 083 43, 225, 083 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 80, 486 190. 00 00000000000000 80, 486 0 191. 00 19100 RESEARCH 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 2, 052, 623 192. 00 0 2, 052, 623 0 192.01 192. 01 19201 VACANT SPACE 0 0 0 193. 00 19300 NONPALD WORKERS 0 193.00 194. 00 07950 MARKETI NG/PUBLI C RELATIONS 0 240, 286 194. 00 240, 286 194. 01 07951 CLARIAN HOME CARE 0 194. 01 194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED 0 606, 802 194. 02 606, 802 0 194. 03 07953 HOME CARE 0 0 194. 03 C 0 200.00 200.00 Cross Foot Adjustments 0 0 201.00 Negative Cost Centers 0 0 0 201. 00 202.00 TOTAL (sum lines 118-201) 46, 205, 280 46, 205, 280 202. 00

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151328 Peri od: Worksheet B From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 5/27/2016 1:57 pm CAPITAL RELATED COSTS Directly NEW BLDG & NEW MVBLE Subtotal **EMPLOYEE** Cost Center Description Assigned New FIXT **FOULP BENEFITS** DEPARTMENT Capi tal Related Costs 1.00 2.00 2A 4.00 0 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4, 114 3, 297 7, 411 7, 411 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 0 0 0 245, 392 196, 680 442, 072 5.00 667 00700 OPERATION OF PLANT 295, 569 7 00 131, 500 206 7 00 164, 069 00800 LAUNDRY & LINEN SERVICE 8.00 n 8.00 9.00 00900 HOUSEKEEPI NG 20, 624 16, 530 37, 154 180 9.00 01000 DI ETARY 0 0 32, 856 10 00 18 238 14 618 105 10 00 01100 CAFETERI A 11.00 35, 158 28, 179 63, 337 74 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 13.00 01300 NURSING ADMINISTRATION 0 0 37, 842 30, 330 68, 172 570 13.00 01400 CENTRAL SERVICES & SUPPLY 8, 974 7, 193 14 00 14 00 16, 167 22 15.00 01500 PHARMACY 16, 366 13, 117 29, 483 133 15.00 01600 MEDICAL RECORDS & LIBRARY 0000 16.00 0 16.00 01700 SOCIAL SERVICE 17.00 0 0 26 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 O 19 00 C 0 19 00 20.00 02000 NURSING SCHOOL C 0 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 21.00 0 21.00 02200 & SERVICES-OTHER PRGM COSTS APPRVD 0 0 ol 22.00 0 22.00 02300 PARAMED ED PRGM 23.00 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 0 91, 527 73.358 164, 885 1,019 30.00 0 03100 INTENSIVE CARE UNIT 31.00 25, 485 20, 426 45, 911 481 31.00 03200 CORONARY CARE UNIT 32.00 C 0 32 00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 33.00 0000000 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 0 0 40.00 0 0 41.00 0 Ω 41.00 04200 SUBPROVI DER 42.00 42.00 0 43.00 04300 NURSERY 0 0 43.00 04400 SKILLED NURSING FACILITY 0 44 00 Λ 44 00 0 45.00 04500 NURSING FACILITY 0 0 45.00 0 o 45.01 04510 I CF/MR 0 O 45.01 04600 OTHER LONG TERM CARE 46.00 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 119. 342 95, 652 214.994 694 50.00 51.00 05100 RECOVERY ROOM 0 37 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 \cap 0 0 52.00 0 53.00 05300 ANESTHESI OLOGY 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 121, 720 97, 558 219, 278 861 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 0 0 05600 RADI OI SOTOPE 56.00 0 0 51 56.00 57.00 05700 CT SCAN C 0 0 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 58.00 05900 CARDIAC CATHETERIZATION 59 00 59 00 0 0 0 60.00 06000 LABORATORY 38, 018 30, 472 68, 490 475 60.00 06001 BLOOD LABORATORY 0 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 0 0 62 00 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. C 0 0 0 63.00 0 06400 INTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 Ω 65.00 06600 PHYSI CAL THERAPY 470 66.00 38.846 31, 135 69.981 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 06900 ELECTROCARDI OLOGY 69.00 47.073 37, 729 84, 802 538 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73 00 C 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 C 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 76.97 07697 CARDIAC REHABILITATION 18, 013 32, 450 13 76. 97 14, 437 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0 0 0 89.00 0 09000 CLINIC 90.00 90.00 0 0 0 09001 CLINIC - DIABETES 90.01 4, 218 3.381 7 599 39 90.01 91. 00 09100 EMERGENCY 41, 473 33, 241 74,714 672 91.00

TOTAL (sum lines 118-201)

202.00

Provider CCN: 151328

Peri od:

From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 5/27/2016 1:57 pm CAPITAL RELATED COSTS NEW BLDG & **EMPLOYEE** Cost Center Description Directly NEW MVBLE Subtotal Assigned New **BENEFITS** FIXT **FOULP** DEPARTMENT Capi tal Related Costs 0 1.00 2.00 2A 4.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 0 00000 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 0 99. 00 09900 CMHC 0 99.00 0 0 99. 10 09910 CORF 0 0 99. 10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 o 0 0 100.00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 105. 00 0 0 00000 0 0 106. 00 10600 HEART ACQUISITION 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 107.00 0 108.00 10800 LUNG ACQUISITION 0 0 108. 00 0 109. 00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 Ω 111.00 11100 I SLET ACQUISITION 0 0 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114. 00 0 115.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 116. 00 11600 HOSPI CE 0 0 116. 00 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 1,096,492 878, 833 1, 975, 325 7, 333 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 4 190, 00 0 7.504 6.014 13.518 191. 00 19100 RESEARCH 00000000 0 191.00 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192.00 378, 390 0 378, 390 192. 01 19201 VACANT SPACE 0 192. 01 0 0 193. 00 19300 NONPALD WORKERS 0 193. 00 0 194.00 07950 MARKETING/PUBLIC RELATIONS 22, 890 18, 346 0 194. 00 41, 236 194. 01 07951 CLARI AN HOME CARE 0 194. 01 0 194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED 74 194 02 52, 103 0 52, 103 194.03 07953 HOME CARE 0 0 194. 03 200.00 Cross Foot Adjustments 200. 00 0 Negative Cost Centers 201.00 0 201. 00 0

1, 557, 379

903, 193

2, 460, 572

7, 411 202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 151328

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: | 5/27/2016 1:57 pm

		A DAMA MATRIA TA ME	005047101105		HOUGEVEENING	5/27/2016 1:5	7 pm
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	
		5. 00	7. 00	8. 00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	0.00	7100	0.00	7. 00	10.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMI NI STRATI VE & GENERAL	442, 739					5. 00
7.00	00700 OPERATION OF PLANT	42, 273	338, 048				7.00
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	739 9, 676	6, 095	739			8. 00 9. 00
10.00	01000 DI ETARY	6, 203	5, 390	1	1, 398		10.00
11. 00	01100 CAFETERI A	3, 438		1	2, 695		11.00
12. 00	01200 MAI NTENANCE OF PERSONNEL	0	, ,	ol o	0	Ö	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	23, 893	11, 184	0	2, 901	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	5, 852	2, 652	0	688	0	14. 00
15. 00	01500 PHARMACY	32, 919	4, 837	0	1, 255	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	C	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	927	C	0	0	0	17. 00
19.00	01900 NONPHYSI CLAN ANESTHETI STS	0		0	0	0	19.00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0			0	0	20. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0			0		22.00
23. 00	02300 PARAMED ED PRGM	0	Č		0	o o	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	_	-				
30.00	03000 ADULTS & PEDIATRICS	41, 356	27, 050	288	7, 017	36, 550	30. 00
31. 00	03100 INTENSIVE CARE UNIT	19, 020	7, 532	73	1, 954	9, 402	31.00
32.00	03200 CORONARY CARE UNIT	0	C	0	0	0	32. 00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	C	0	0	0	33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT	0	C	0	0	0	34.00
40.00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF	0		0	0	0	40.00
41. 00 42. 00	04100 SUBPROVI DER - TRF	0			0	0	41. 00 42. 00
43. 00	04300 NURSERY	0			0		42.00
44. 00	04400 SKILLED NURSING FACILITY	0			0		44. 00
45. 00	04500 NURSING FACILITY	0		ol ö	0	l o	45. 00
45. 01	04510 I CF/MR	0	C	o o	0	Ö	45. 01
46.00	04600 OTHER LONG TERM CARE	0	C	0	0	0	46. 00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	21, 987	35, 271	1			50.00
51.00	05100 RECOVERY ROOM	1, 444	C		_	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0	0	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	44, 772	35, 974	67	9, 332		53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	144,772	33, 7/4	5	⁷ , 332	0	55.00
56. 00	05600 RADI OI SOTOPE	3, 455	Ċ		0	o o	56.00
57. 00	05700 CT SCAN	0	C	o o	0	Ö	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	0	0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	C	0	0	0	59. 00
60.00	06000 LABORATORY	43, 726	11, 236	0	2, 915	0	60.00
60. 01	06001 BLOOD LABORATORY	0	C	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	62.00
63. 00 64. 00	06400 I NTRAVENOUS THERAPY	0			0	0	63. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0			0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	18, 606	11, 481	1	_		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C	0	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	C	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	24, 478	13, 912	0	3, 609	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	742	C	34	0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	1, 415	C	0	0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	44, 583	C	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0		0	0	0	74.00
75. 00 76. 97	07500 ASC (NON-DISTINCT PART) 07697 CARDIAC REHABILITATION	0 858	5, 324	, 0	1, 381	0	75. 00 76. 97
70. 97	OUTPATIENT SERVICE COST CENTERS	000	5, 324	<u> </u>	1, 301		70.97
88. 00	08800 RURAL HEALTH CLINIC	0	(n	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				0	Ö	89. 00
90. 00	09000 CLINIC	0	Ċ	o o	o	Ö	90.00
90. 01	09001 CLINIC - DIABETES	1, 793	1, 247	0	323	0	90. 01
91. 00	09100 EMERGENCY	37, 708			3, 180	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DI ALYSI S	0		1			94.00
95. 00	09500 AMBULANCE SERVICES	0	C	0	0	0	95. 00

200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

200.00

0 201. 00

45, 952 202. 00

0

53, 105

739

ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151328 Peri od: Worksheet B From 01/01/2015 Part II 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm ADMINISTRATIVE OPERATION OF Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9. 00 5.00 7.00 8.00 10.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96. 00 0 0 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0 C 0 0 99.00 09900 CMHC 0 0 0 0 99.00 0 0 99. 10 09910 CORF 0 99. 10 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY 0 0 100.00 Ω 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 105. 00 0 0 106, 00 0 107.00 10700 LIVER ACQUISITION 0 0 0 0 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 109, 00 0 0 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 111. 00 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 431, 863 201, 833 50, 775 45, 952 118. 00 118.00 739 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 349 575 0 190. 00 2, 218 0 191. 00 19100 RESEARCH 0 0 191.00 0 0 192.00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 5,684 111, 833 0 192. 01 19201 VACANT SPACE 0 0 192. 01 193. 00 19300 NONPALD WORKERS 0 0 193.00 194. 00 07950 MARKETI NG/PUBLIC RELATIONS 6, 765 0 0 194.00 1, 755 1.112 194. 01 07951 CLARI AN HOME CARE 0 0 194. 01 0 194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED 3,731 15, 399 0 0 0 194. 02 194.03 07953 HOME CARE 0 0 0 194. 03

442, 739

338, 048

| Peri od: | Worksheet B | From 01/01/2015 | Part II | To 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS I NDI ANA UNI VERSI TY HEALTH BEDFORD

Provi der CCN: 151328

CAST FIRST MAINTENANCE OF PROCESSION PRINCE				To	12/31/2015	Date/Time Pre 5/27/2016 1:5	
CENTRAL SERVICE COST CENTERS 1.0	Cost Center Description	CAFETERI A			SERVICES &		, ,
1.00 1.00	OFFICE OF	11.00	12.00	13.00	14. 00	15. 00	
33.00 03300 NTENSIVE CARE UNIT	1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.00 00500 ADMINISTRATIVE & GENERAL 7.00 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DIETARY 11.00 01100 CAFETERIA 12.00 01200 MAINTENANCE OF PERSONNEL 13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 01600 MEDICAL RECORDS & LIBRARY 17.00 01700 SOCIAL SERVICE 19.00 01900 NONPHYSICIAN ANESTHETISTS 20.00 02000 L&R SERVICES-SALARY & FRINGES APPRVD 22.00 02200 L&R SERVICES-OTHER PRGM COSTS APPRVD 23.00 02300 PARAMED ED PRGM	0 6, 222 957 1, 915 0 479 0 0	0 0 0 0 0 0 0 0	0 0 0 0 0 0	26, 338 0 0 0 0 0 0 0	0 0 0 0 0	1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00
50.00 0500	31. 00	5, 744 0 0 0 0 0 0 0 0 0		16, 528 0	0	0 0 0 0 0 0 0 0	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 89. 00 90. 00	50. 00 05000 0PERATING ROOM 51. 00 05100 RECOVERY ROOM 8 LABOR ROOM 52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OLOGY-THERAPEUTI C 57. 00 05700 CT SCAN 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 59. 00 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 66. 00 06600 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROCARDI OLOGY 70. 00 07000 ELECTROCARDI OLOGY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 RUSS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STINCT PART) 00 00 00 00 00 00 00	479 0 0 12, 445 0 479 0 0 479 0 0 0 5, 744 0 7, 658 0 0 0		1, 377 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	60. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97
OTHER REIMBURSABLE COST CENTERS	89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 90. 01 09001 CLINIC - DIABETES 91. 00 09100 EMERGENCY	0 0 479	0 0 0 0	0 0	0 0 0 0	0 0	88. 00 89. 00 90. 00 90. 01 91. 00 92. 00
	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	

194. 01 07951 CLARIAN HOME CARE

194.03 07953 HOME CARE

200.00

201.00

202.00

194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 151328 Peri od: Worksheet B From 01/01/2015 Part II 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm Cost Center Description CAFETERI A MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** PERSONNEL ADMI NI STRATI ON SERVICES & **SUPPLY** 11. 00 12.00 13.00 15.00 14.00 95. 00 09500 AMBULANCE SERVICES 95. 00 0 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 00000 0 0 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 97.00 0 99. 00 09900 CMHC 0 0 99.00 0 99. 10 09910 CORF 0 99. 10 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 105. 00 0 0 0 0 0 106. 00 10600 HEART ACQUISITION 0 0 0 0 0 106. 00 107. 00 10700 LIVER ACQUISITION 0 0 107. 00 0 0 108.00 10800 LUNG ACQUISITION 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 111.00 111.00 11100 I SLET ACQUISITION 0 0 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116, 00 C \cap 0 SUBTOTALS (SUM OF LINES 1-117) 118.00 77,063 0 112, 942 26, 338 70, 542 118. 00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 479 0 0 190. 00 191. 00 19100 RESEARCH 0 191.00 0 0 0 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192. 00 0 0 192. 01 19201 VACANT SPACE 0 0 0 192. 01 0 0 0 193. 00 19300 NONPALD WORKERS 0 0 193.00 194.00 07950 MARKETING/PUBLIC RELATIONS 0 0 0 0 194. 00

2,393

79. 935

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112, 942

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26, 338

0 194. 01

0 194. 02

0 194. 03

0 201.00

70, 542 202. 00

200.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

					0 12/31/2015	5/27/2016 1:5	
						I NTERNS & RESI DENTS	
	Cost Center Description	MEDI CAL	SOCIAL SERVICE		NURSING SCHOOL	SERVI CES-SALAR	
		RECORDS & LI BRARY		ANESTHETI STS		Y & FRINGES	
		16. 00	17. 00	19. 00	20.00	21. 00	
	GENERAL SERVICE COST CENTERS			1			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT			•			2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL			•			5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 12. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL						11. 00 12. 00
13. 00	I I			•			13. 00
14. 00	1						14. 00
15. 00	01500 PHARMACY						15.00
16. 00		C	1				16. 00
17. 00	1	C	1, 432				17. 00
19. 00 20. 00	1)		19. 00 20. 00
21. 00	I I				0	0	21. 00
22. 00		d	Ö				22. 00
23. 00	02300 PARAMED ED PRGM	C	0				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	_		1			
30.00	+ I	C		1			30.00
31. 00 32. 00	1 1		l l	1			31. 00 32. 00
33. 00	1 1		1				33. 00
34. 00	+ I	d	Ö				34. 00
40.00	04000 SUBPROVI DER - I PF	c	0				40.00
41. 00	+ I	C	0				41. 00
42. 00	+ I		0				42.00
43. 00 44. 00	+ I		1				43. 00 44. 00
45. 00	+ I		1				45. 00
45. 01	04510 I CF/MR	C	 				45. 01
46. 00		C	0				46.00
E0.00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM) 0				FO 00
50. 00 51. 00	1		 				50. 00 51. 00
52. 00			-				52. 00
53.00	I I	C	0				53.00
54. 00	1	C	0				54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	C	0				55. 00
56. 00 57. 00	05600 RADI 0I SOTOPE 05700 CT SCAN						56. 00 57. 00
58. 00							58. 00
59. 00		d	1				59. 00
60.00	1	c	0				60.00
60. 01	06001 BLOOD LABORATORY	C	0				60. 01
61.00		_					61.00
62. 00 63. 00	1 1						62. 00 63. 00
64. 00	1 1						64. 00
65. 00	1 1	Ċ	0				65. 00
66. 00	1 1	C	0				66. 00
67. 00	1 1	C	0				67. 00
68. 00	1		0				68. 00
69. 00 70. 00	1 1	'					69. 00 70. 00
71.00			0				71.00
72. 00	I I		o o				72. 00
73.00	I I	C	0				73.00
	07400 RENAL DIALYSIS	C .	0				74.00
75. 00 76. 97	1 1 2		1				75. 00 76. 97
10.91	OUTPATIENT SERVICE COST CENTERS		<u>'i</u> 0				10.71
88. 00		C	0				88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	d					89. 00
90. 00		C	0				90.00
90. 01	I I		0				90. 01
91. 00 92. 00	1 I		,	1			91. 00 92. 00
72.00	12.23 OSSERTION OF BEBO (NON BISTING)	<u> </u>	I	I .	I	I .	

194. 01 07951 CLARIAN HOME CARE

194. 03 07953 HOME CARE

200.00

201.00

202.00

194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED

Cross Foot Adjustments

TOTAL (sum lines 118-201)

Negative Cost Centers

194. 01

194. 02

194. 03

0 200.00

0 201. 00

0 202.00

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 151328 Peri od: Worksheet B From 01/01/2015 Part II 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm INTERNS & **RESI DENTS** NONPHYSICIAN NURSING SCHOOL SERVICES-SALAR Cost Center Description MEDI CAL SOCIAL SERVICE Y & FRINGES RECORDS & **ANESTHETISTS** LI BRARY 17.00 19.00 21.00 16.00 20.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 0 0 0 0 0 94.00 95. 00 09500 AMBULANCE SERVICES 0 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 99. 00 09900 CMHC 0 99.00 99. 10 09910 CORF 0 99.10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105.00 0 106.00 10600 HEART ACQUISITION 0 106.00 107. 00 10700 LIVER ACQUISITION 0 107. 00 0 0 0 0 108.00 10800 LUNG ACQUISITION 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 109. 00 110.00 11000 INTESTINAL ACQUISITION 0 110.00 111.00 11100 | SLET ACQUISITION 111 00 113.00 11300 I NTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115. 00 116. 00 11600 HOSPI CE 0 116. 00 C SUBTOTALS (SUM OF LINES 1-117) 118.00 0 1, 432 0 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190.00 0 0 0 0 0 0 0 191. 00 19100 RESEARCH 191. 00 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 192. 00 192. 01 19201 VACANT SPACE 0 192. 01 193. 00 19300 NONPALD WORKERS 0 193. 00 194.00 07950 MARKETING/PUBLIC RELATIONS 0 194. 00

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	THATCHAR SYSTEMS THO OF CAPITAL RELATED COSTS		Provi der	CCN: 151328 F	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Pre 5/27/2016 1:5	pared:
	Cost Center Description	I NTERNS & RESI DENTS SERVI CES-OTHER PRGM COSTS	PARAMED ED PRGM	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	Total	
	T	22.00	23. 00	24. 00	25. 00	26. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 20. 00 21. 00 22. 00 23. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRVD 02200 PARAMED ED PRGM	0	0				2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 19. 00 20. 00 21. 00 22. 00 23. 00
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 45. 01 46. 00	INPATI ENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDI ATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04500 ICF/MR 04600 OTHER LONG TERM CARE			344, 264 106, 938 C C C C C C C C		344, 264 106, 938 0 0 0 0 0 0 0 0	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00
	ANCILLARY SERVICE COST CENTERS				-1		
50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 01 61. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00 76. 97	05000 OPERATING ROOM 05100 RECOVERY ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06000 LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06900 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07200 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS			306, 254 3, 342 3, 342 322, 729 3, 989 3, 989 127, 321 0 109, 296 109, 296 134, 997 0 9, 834 18, 695 115, 125 0 40, 983		306, 254 3, 342 0 0 322, 729 0 3, 989 0 0 127, 321 0 0 109, 296 0 0 134, 997 0 9, 834 18, 695 115, 125 0 0 40, 983	51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 59. 00 60. 00 60. 01 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00
89. 00 90. 00	08900 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09001 CLINIC - DIABETES			11, 480	0 0	0 0 0 11, 480	89. 00 90. 00

Health Financial Systems

2, 460, 572

2, 460, 572 202. 00

202.00

TOTAL (sum lines 118-201)

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151328 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm CAPITAL RELATED COSTS Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE** Reconciliation ADMINISTRATIVE **FOULP** BENEFITS & GENERAL FIXT (SQUARE (ACCUM. (SQUARE FEET) DEPARTMENT FEET) (GROSS COST) SALARI ES) 1.00 2.00 5A 5. 00 4.00 GENERAL SERVICE COST CENTERS 1 00 00100 NEW CAP REL COSTS-BLDG & FIXT 193 841 1 00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 140, 259 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 512 512 14, 439, 596 4.00 00500 ADMINISTRATIVE & GENERAL 1, 300, 467 5 00 30 543 -16, 178, 351 30 026 929 5 00 30 543 7.00 00700 OPERATION OF PLANT 20, 421 20, 421 401, 408 2, 866, 941 8.00 00800 LAUNDRY & LINEN SERVICE 50, 099 00900 HOUSEKEEPI NG 2,567 350, 990 0 656, 202 9.00 2.567 0 01000 DI ETARY 2, 270 203.859 10 00 2.270 420, 665 11.00 01100 CAFETERI A 4, 376 4, 376 144, 975 0 233, 159 01200 MAINTENANCE OF PERSONNEL 12.00 0 01300 NURSING ADMINISTRATION 4,710 4, 710 1, 110, 618 1, 620, 431 13.00 396, 876 14.00 01400 CENTRAL SERVICES & SUPPLY 1, 117 1, 117 43, 568 15.00 01500 PHARMACY 2,037 2,037 260, 119 0 2, 232, 541 01600 MEDICAL RECORDS & LIBRARY 16.00 0 01700 SOCIAL SERVICE 0 62, 859 17.00 C 51,004 19 00 01900 NONPHYSICIAN ANESTHETISTS 0 C C Ω 02000 NURSING SCHOOL 0 0 0 20.00 0 21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD 0 C 0 o 0 0 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 C 0 02300 PARAMED ED PRGM 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 392 11, 392 1, 978, 402 2, 804, 743 03100 INTENSIVE CARE UNIT 31.00 3, 172 0 1, 289, 917 3, 172 936, 775 32.00 03200 CORONARY CARE UNIT 0 0 0 Ω 03300 BURN INTENSIVE CARE UNIT 33.00 0 0 0 0 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 40.00 04000 SUBPROVIDER - IPF C 0 0 0 04100 SUBPROVIDER - IRF 41.00 04200 SUBPROVI DER 42.00 0 0 0 0 0 04300 NURSERY 0 43 00 C Λ 0 44.00 04400 SKILLED NURSING FACILITY 0 04500 NURSING FACILITY 0 0 0 45.00 0 04510 | CF/MR 45.01 0 0 04600 OTHER LONG TERM CARE 46.00 0 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 14, 854 14, 854 1, 352, 782 1, 491, 151 0 05100 RECOVERY ROOM 97, 960 51 00 C 71,673 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 C C 0 0 53.00 05300 ANESTHESI OLOGY o 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 15, 150 1, 677, 650 3, 036, 945 15, 150 05500 RADI OLOGY-THERAPEUTI C 55 00 Ω 0 56.00 05600 RADI OI SOTOPE 0 100,066 0 234, 323 05700 CT SCAN 0 0 57.00 0 C 0 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 0 05900 CARDIAC CATHETERIZATION 59 00 0 0 0 60.00 06000 LABORATORY 4, 732 926, 881 0 2, 965, 495 4,732 06001 BLOOD LABORATORY 60.01 60.01 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62 00 0 C 0 0 0 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 06400 I NTRAVENOUS THERAPY 0 64.00 0 0 06500 RESPIRATORY THERAPY 0 65.00 0 0 0 0 66.00 06600 PHYSI CAL THERAPY 4,835 4,835 915, 397 1, 261, 870 06700 OCCUPATIONAL THERAPY 0 67.00 0 06800 SPEECH PATHOLOGY 68.00 0 06900 ELECTROCARDI OLOGY 5, 859 1,047,942 69.00 5.859 1, 660, 108 07000 ELECTROENCEPHALOGRAPHY 70.00 C 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71 00 0 0 50, 305 07200 IMPL. DEV. CHARGED TO PATIENT 0 95, 975 72.00 0 C 73.00 0 C 0 3, 023, 586

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151328 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm CAPITAL RELATED COSTS Reconciliation ADMINISTRATIVE Cost Center Description NEW BLDG & NEW MVBLE **EMPLOYEE BENEFITS** FIXT **FOULP** & GENERAL (SQUARE (SQUARE FEET) DEPARTMENT (ACCUM. FEET) (GROSS COST) SALARI ES) 1.00 2.00 5A 5. 00 4.00 91. 00 09100 EMERGENCY 5, 162 5, 162 1, 309, 910 2, 557, 366 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 0 0 0 09500 AMBULANCE SERVICES 0 0 95.00 95 00 Ω 0 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 0 99.00 09900 CMHC 0 0 0 0 0 99.00 99. 10 09910 CORF 0 99. 10 Ω 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 C 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 0 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105 00 0 0 0 0 0 106.00 10600 HEART ACQUISITION 0 0 0 0 106.00 107. 00 10700 LIVER ACQUISITION 0 0 107. 00 0 0 108.00 10800 LUNG ACQUISITION 0 0 108. 00 0 109. 00 10900 PANCREAS ACQUISITION C 0 0 109 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0 116. 00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1-117)
NONREI MBURSABLE COST CENTERS 118.00 136, 476 136, 476 14, 286, 524 -16, 178, 351 29, 289, 329 118. 00 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 23, 688 190. 00 934 934 7, 773 0 191. 00 19100 RESEARCH C 0 191.00 C 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 385, 478 192. 00 47.097 C 114 0 192.01 192. 01 19201 VACANT SPACE C 0 0 0 193.00 19300 NONPALD WORKERS 0 0 193.00 194. 00 07950 MARKETING/PUBLIC RELATIONS 75, 387 194. 00 2,849 2, 849 0 194. 01 07951 CLARI AN HOME CARE 0 194. 01 194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED 145, 185 253, 047 194. 02 6, 485 194.03 07953 HOME CARE 0 194. 03 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00 202.00 Cost to be allocated (per Wkst. B, 1, 557, 379 903, 193 3, 356, 185 16, 178, 351 202. 00 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 6. 439466 0. 232429 0. 538795 203. 00 8.034312 204.00 Cost to be allocated (per Wkst. B, 7, 411 442, 739 204. 00 Part II) 0. 014745 205. 00 205.00 Unit cost multiplier (Wkst. B, Part 0.000513 II)

Health Financial Systems In Lieu of Form CMS-2552-10 INDIANA UNIVERSITY HEALTH BEDFORD COST ALLOCATION - STATISTICAL BASIS Provider CCN: 151328 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A LINEN SERVICE PLANT (SQUARE FEET) (MEALS (FTF) (SQUARE (POUNDS OF SERVED) LAUNDRY) FFFT) 9.00 10.00 11.00 7.00 8.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 142, 365 7 00 00800 LAUNDRY & LINEN SERVICE 218, 158 8.00 8.00 00900 HOUSEKEEPI NG 9.00 2.567 86, 216 9.00 10.00 01000 DI ETARY 2, 270 2.270 46, 720 10.00 01100 CAFETERI A 167 11.00 4.376 4, 376 11.00 01200 MAINTENANCE OF PERSONNEL 0 12.00 Ω 12.00 13.00 01300 NURSING ADMINISTRATION 4,710 4,710 0 13 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 1, 117 1, 117 0 14.00 01500 PHARMACY 0 15.00 2.037 2.037 15.00 01600 MEDICAL RECORDS & LIBRARY 16,00 C 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 17.00 01900 NONPHYSICIAN ANESTHETISTS 0 19.00 0 0 0 19.00 0 02000 NURSING SCHOOL 20.00 Ω 0 0 20 00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 21.00 C 0 0 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 0 0 0 0 22.00 22.00 02300 PARAMED ED PRGM 23.00 23.00 0 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 11, 392 85, 206 11, 392 37, 161 35 30.00 31.00 03100 INTENSIVE CARE UNIT 3, 172 21, 414 3, 172 9, 559 12 31.00 32 00 03200 CORONARY CARE UNIT O 0 0 32 00 03300 BURN INTENSIVE CARE UNIT 33.00 0 C 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 34.00 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 0 0 0 0 0 0 40.00 41 00 0 Ω 0 41 00 04200 SUBPROVI DER 42.00 0 0 42.00 04300 NURSERY 0 0 43.00 43.00 0 0 44.00 04400 SKILLED NURSING FACILITY 0 0 0 44.00 0 04500 NURSING FACILITY Ω 45.00 0 45.00 45. 01 04510 I CF/MR 0 C 0 0 0 45.01 04600 OTHER LONG TERM CARE ol 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50 00 14.854 0 13 50.00 05000 OPERATING ROOM 9.436 14.854 05100 RECOVERY ROOM 1, 427 0 51.00 51.00 52 00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 0 0 0 0 52.00 05300 ANESTHESI OLOGY 53.00 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 15, 150 19,649 15, 150 26 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 C 0 55.00 56.00 05600 RADI OI SOTOPE 0 0 56.00 1.166 05700 CT SCAN 57.00 0 C 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 0 C 0 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 0 59.00 06000 LABORATORY 60.00 4.732 4.732 60.00 60.01 06001 BLOOD LABORATORY 0 C Ω 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS 63.00 0 C 0 0 63.00 64.00 06400 INTRAVENOUS THERAPY 0 0 0 64.00 65.00 06500 RESPIRATORY THERAPY 65.00 06600 PHYSI CAL THERAPY 10, 595 12 66.00 4.835 4.835 66.00 06700 OCCUPATI ONAL THERAPY 67.00 \cap 0 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 C C 06900 ELECTROCARDI OLOGY 69.00 5,859 5,859 16 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 10,077 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 74 00 07400 RENAL DIALYSIS 0 Ω 0 74 00 0 75.00 07500 ASC (NON-DISTINCT PART) 0 C \cap 0 75.00 07697 CARDIAC REHABILITATION 76. 97 76.97 242 0 2.242 OUTPATIENT SERVICE COST CENTERS 88 00 88 00 08800 RURAL HEALTH CLINIC 0 0 Ω 0 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 C 0 0 0 89.00 09000 CLI NI C 0 90.00 90.00 90.01 09001 CLINIC - DIABETES 525 525 0 90. 01 09100 EMERGENCY 0 91 00 5, 162 59, 188 5.162 21 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00

Health Financial Systems In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151328 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A PLANT LINEN SERVICE (SQUARE FEET) (MEALS (FTE) SERVED) (SQUARE (POUNDS OF FFFT) LAUNDRY) 10.00 9.00 11.00 7.00 8.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 0 95.00 09500 AMBULANCE SERVICES 00000 0 0 0 0 0 0 95.00 0 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 96.00 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 09900 CMHC 0 0 99.00 99. 00 0 99. 10 09910 CORF 99. 10 0 0 0 100.00 10000 I &R SERVI CES-NOT APPRVD PRGM 0 0 100.00 C 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 0 0 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 105. 00 0 106.00 10600 HEART ACQUISITION 0 C 0 106. 00 107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 0 108. 00 109.00 10900 PANCREAS ACQUISITION 0 0 109, 00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 0 111.00 0 113.00 11300 INTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 116. 00 11600 HOSPI CE 0 116. 00 118.00 SUBTOTALS (SUM OF LINES 1-117) 85.000 218, 158 46, 720 82, 433 161 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 1 190. 00 934 934 0 191.00 191. 00 19100 RESEARCH Ω 0 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192. 00 47,097 0 0 192. 01 19201 VACANT SPACE 0 0 192. 01 193. 00 19300 NONPALD WORKERS 0 193. 00 0 0 0 194.00 07950 MARKETING/PUBLIC RELATIONS 0 194. 00 2.849 2.849 0 194. 01 194. 01 07951 CLARIAN HOME CARE 0 194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED 0 0 5 194. 02 6, 485 194.03 07953 HOME CARE 0 o 0 194. 03 200 00 Cross Foot Adjustments 200 00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 4, 411, 634 77, 092 1, 089, 307 549, 677 202. 00 746, 341 Part I) Unit cost multiplier (Wkst. B, Part I) 30. 988192 3, 291. 479042 203. 00 203.00 15. 974765 0.353377 12.634627 204.00 Cost to be allocated (per Wkst. B, 338, 048 739 53, 105 45, 952 79, 935 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 2. 374516 0.003387 0.615953 0. 983562 478. 652695 205. 00 II)

	ALLOCATION - STATISTICAL BASIS	DIANA UNI VERSI I		CCN: 151328 Pe	eri od:	Worksheet B-1	
				Fi To	rom 01/01/2015 o 12/31/2015		
	Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	5/27/2016 1:5 MEDI CAL	7 pm
	oust deliter bescriptron		ADMI NI STRATI ON		(COSTED	RECORDS &	
		(NUMBER	(0) 0507	SUPPLY	REQUIS.)	LI BRARY	
		HOUSED)	(DI RECT NRSI NG HRS)	(COSTED REQUIS.)		(GROSS CHARGES)	
		12.00	13.00	14. 00	15. 00	16. 00	
4 00	GENERAL SERVICE COST CENTERS	T	I				
1. 00 2. 00	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP						1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING						8. 00 9. 00
10. 00	01000 DI ETARY						10.00
11. 00	01100 CAFETERI A						11. 00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0.2				12.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY		82	146, 280			13. 00 14. 00
15. 00	01500 PHARMACY		Ö	0	100		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	0	16. 00
17. 00	01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
19. 00 20. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL		0	0	0	0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRINGES APPRVD		o		0	0	21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0		0	0	0	22. 00
23. 00	02300 PARAMED ED PRGM	0	0	0	0	0	23. 00
30. 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	1 0	35	0	0	0	30.00
31. 00	03100 I NTENSI VE CARE UNI T				0	0	31.00
32. 00	03200 CORONARY CARE UNIT	0	0	0	0	0	32. 00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
34. 00 40. 00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF		0] 0	0	0	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF		Ö	0	0	0	41. 00
42.00	04200 SUBPROVI DER	0	0	0	0	0	42. 00
43.00	04300 NURSERY	0	0	0	0	0	43. 00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY		0] 0	0	0	44. 00 45. 00
45. 01	04510 I CF/MR		Ö	Ö	0	0	45. 01
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	1 0	13	0	0	0	50.00
51. 00	05100 RECOVERY ROOM		1	Ö	0	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 55. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C		0] 0	0	0	54. 00 55. 00
56. 00	05600 RADI OI SOTOPE		Ö	Ö	0	0	1
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION	0	0	0	0	0	58. 00 59. 00
60.00	06000 LABORATORY		0	0	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	O	0	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 63. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	62.00
64. 00	06400 I NTRAVENOUS THERAPY		0	0	0	0	64.00
65. 00	06500 RESPIRATORY THERAPY		o	o	Ō	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66.00
67. 00 68. 00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY		0	0	0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY				0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		O	o	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	50, 305	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS		0	95, 975 0	0 100	0	72. 00 73. 00
74. 00	07400 RENAL DI ALYSI S		o		0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
88. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER				0	0	
90.00	09000 CLI NI C	0	0	0	0	0	90.00
90. 01	09001 CLINIC - DIABETES	0	0	0	0	0	90. 01
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)		21		O	0	91. 00 92. 00
	1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1	1			i	

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151328 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm Cost Center Description MAINTENANCE OF NURSI NG CENTRAL **PHARMACY** MEDI CAL PERSONNEL ADMI NI STRATI ON SERVICES & (COSTED RECORDS & (NUMBER **SUPPLY** REQUIS.) LI BRARY (COSTED HOUSED) (DI RECT (GROSS NRSING HRS) REQUIS.) CHARGES) 12.00 15.00 13.00 14.00 16.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 94.00 0 09500 AMBULANCE SERVICES 0000 0 95.00 0 95.00 0 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 97.00 0 0 99. 00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 99. 10 0 Ω 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 105. 00 0 0 0 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106. 00 107. 00 10700 LIVER ACQUISITION 0 0 107.00 0 0 0 0 108.00 10800 LUNG ACQUISITION 0 0 108 00 Ω 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 111.00 0 113.00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115.00 0 116. 00 11600 HOSPI CE 0 0 0 116.00 C 0 SUBTOTALS (SUM OF LINES 1-117) 118.00 0 82 146, 280 100 0 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 0000000 0 0 191.00 191. 00 19100 RESEARCH 0 0 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 192.00 0 192. 01 19201 VACANT SPACE 0 0 0 192. 01 0 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 194. 00 07950 MARKETING/PUBLIC RELATIONS 0 0 194.00 0 0 194. 01 07951 CLARIAN HOME CARE 0 0 0 194. 01 194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED 0 0 0 194. 02 0 194.03 07953 HOME CARE 0 0 0 0 194. 03 C Cross Foot Adjustments 200 00 200.00 201.00 Negative Cost Centers 201.00 0 202.00 202.00 Cost to be allocated (per Wkst. B, 0 2, 741, 763 666, 021 3, 537, 449 Part I) 4. 553056 0. 000000 203. 00 203.00 Unit cost multiplier (Wkst. B, Part I) 35, 374. 490000 0.000000 33, 436. 134146

0.000000

112, 942

1, 377. 341463

26, 338

0.180052

70, 542

705.420000

0 204.00

0.000000 205.00

204.00

205.00

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Part II)

11)

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 151328

Peri od: Worksheet B-1 From 01/01/2015

12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm INTERNS & RESIDENTS SOCIAL SERVICE NONPHYSICIAN NURSI NG SCHOOL SERVI CES-SALAR SERVI CES-OTHER Cost Center Description Y & FRINGES **ANESTHETISTS** PRGM COSTS (ASSI GNED (ASSI GNED (ASSLGNED (TIME (ASSI GNED SPENT) TIME) TIME) TIME) TIME) 19.00 20.00 21.00 22.00 17.00 GENERAL SERVICE COST CENTERS 00100 NEW CAP REL COSTS-BLDG & FIXT 1.00 1.00 00200 NEW 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 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 01100 CAFETERI A 11.00 11.00 12.00 01200 MAINTENANCE OF PERSONNEL 12.00 13.00 01300 NURSING ADMINISTRATION 13.00 01400 CENTRAL SERVICES & SUPPLY 14 00 14 00 15.00 01500 PHARMACY 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 01700 SOCIAL SERVICE 17.00 4.223 17.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 Ω 19 00 20.00 02000 NURSING SCHOOL 0 0 20.00 02100 I &R SERVICES-SALARY & FRINGES APPRVD 0 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRVD 22.00 0 0 22.00 02300 PARAMED ED PRGM 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3.359 30.00 03100 INTENSIVE CARE UNIT 0 0 31.00 864 0 0 31.00 οĺ 32.00 03200 CORONARY CARE UNIT 0 Ω 0 32 00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 33.00 33.00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0000000 34.00 04000 SUBPROVIDER - IPF 0 40.00 0 40.00 0 04100 SUBPROVI DER - I RF 0 41.00 C 0 41.00 04200 SUBPROVI DER 42.00 42.00 43.00 04300 NURSERY 0 0 0 43.00 04400 SKILLED NURSING FACILITY 0 44 00 C 0 44 00 0 45.00 04500 NURSING FACILITY 0 0 45.00 0 o 45.01 04510 I CF/MR C 0 O 45.01 04600 OTHER LONG TERM CARE 46.00 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 0 0 50.00 00000000000 05100 RECOVERY ROOM 0 0 0 51.00 51.00 0 0 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 Λ 52.00 0 53.00 05300 ANESTHESI OLOGY 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 0 55.00 0 55.00 0 56.00 05600 RADI OI SOTOPE 0 0 56.00 57.00 05700 CT SCAN 0 57.00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 58.00 05900 CARDIAC CATHETERIZATION 0 59 00 59 00 Ω 0 60.00 06000 LABORATORY 0 0 60.00 06001 BLOOD LABORATORY 0 0 0 60.01 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS O 62 00 00000000 0 0 0 0 0 0 0 0 62 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 63.00 06400 INTRAVENOUS THERAPY 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 0 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 0 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 0 69.00 0 0 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0000 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 0 0 72.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 73.00 74.00 07400 RENAL DIALYSIS 0 0 0 74.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 0 75.00 07697 CARDIAC REHABILITATION 0 0 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 0 89 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 09000 CLI NI C 0 90.00 0 90.00 0 09001 CLINIC - DIABETES 90.01 0 Ω 90.01 91. 00 09100 EMERGENCY 0 0 0 0 91.00

	SPENT)	TIME)	TIME)	TI ME)	TIME)	
	17. 00	19. 00	20. 00	21. 00	22. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						1
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	o	0	0	0	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	o	0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	o	0	0	0	97. 00
99. 00 09900 CMHC	0	o	0	0	0	99. 00
99. 10 09910 CORF	0	o	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	o	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	o	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						1
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105. 00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111.00
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	4, 223	0	0	0	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
192. 01 19201 VACANT SPACE	0	0	0	0		192. 01
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 MARKETING/PUBLIC RELATIONS	0	0	0	0		194. 00
194.01 07951 CLARIAN HOME CARE	0	0	0	0		194. 01
194.02 07952 BLOOMNGTN AMBULANCE AND OCC MED	0	0	0	0		194. 02
194. 03 07953 HOME CARE	0	0	0	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B, Part I)	100, 018	0	0	0	0	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	23. 684111	0. 000000	0.000000	0. 000000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B,	1, 432	О	0	0	0	204. 00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part	0. 339095	0. 000000	0. 000000	0. 000000	0. 000000	205. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10 Provi der CCN: 151328

COST CENTER DESCRIPTION	7/2016 1: 57 pm 1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
CASSIGNED TIME) 23.00	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
SENERAL SERVICE COST CENTERS 23.00	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
SENERAL SERVICE COST CENTERS	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT	2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
4.00 Octoo Octoo	4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
5.00	5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
7.00 00700 00FBATI ON OF PLANT 00 00000 000000	7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
8. 00	8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
10. 00 01000 DITARY 01100 CAFETERIA 12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON 14. 00 1400 CENTRAL SERVI CES & SUPPLY 15. 00 01500 PHARMACY 16. 00 1600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCI AL SERVI CE 17. 00 01700 SOCI AL SERVI CE 17. 00 01700 SOCI AL SERVI CE 17. 00 01700 NURSI NG SCHOOL 17. 00 01700 NURSI NG FACI LITY 0 01700 NU	10. 00 11. 00 12. 00 13. 00 14. 00
11. 00	11. 00 12. 00 13. 00 14. 00
12.00	12. 00 13. 00 14. 00
13.00 01300 NURSI NG ADMIN ISTRATI ON 01400 CENTRAL SERVI CES & SUPPLY 16.00 01500 PHARMACY 17.00 01500 PHARMACY 17.00 01500 PHARMACY 17.00 01700 SOCIAL SERVI CES 17.00 01700 SOCIAL SERVI CE 17.00 01700 NONPHYSI CI AN ANESTHETI STS 17.00 01700 NURSI NG SCHOOL 18.7 SERVI CES-SALARY & FRI NGES APPRVD 18.00 18.00 18.00 18.7 SERVI CES-SALARY & FRI NGES APPRVD 18.00 18.0	13. 00 14. 00
15.00	I
16.00 1600 MEDI CAL RECORDS & LIBRARY 17.00 10700 SOCI AL SERVI CE 19.00 10900 NONPHYSI CI AN AMESTHETI STS 20.00 20200 NURSI NG SCHOOL 21.00 20700 IAR SERVI CES-ALARY & FRI NGES APPRVD 22.00 23.00 23.00 RARAMED ED PROM 0 0	15 NN
17. 00	
19. 00 01900 NONPHYSI CI AN ANESTHETI STS 20. 00 02000 NURSI NG SCHOOL 22. 00 02200 1&R SERVI CES-SALARY & FRI NGES APPRVD 22. 00 02200 1&R SERVI CES-OTHER PRGM COSTS APPRVD 23. 00 02300 PARAMED ED PRGM 0 0	16. 00 17. 00
21. 00	19. 00
22. 00 02200 Lar Services-Other Prgm Costs Apprvd 0	20. 00
23. 00 02300 PARAMED ED PRGM 0 INPATI ENT ROUTI NE SERVICE COST CENTERS 0 0 0 0 0 0 0 0 0	21. 00
INPATI ENT ROUTINE SERVICE COST CENTERS	22. 00
30. 00 03000 ADULTS & PEDIATRICS 0 0 31.00 03100 INTENSI VE CARE UNIT 0 0 0 0 0 0 0 0 0	25.00
32. 00 03200 CORONARY CARE UNIT 0 0 0 0 0 0 0 0 0	30.00
33. 00 03300 BURN INTENSIVE CARE UNIT 0 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 40. 00 04000 SUBPROVIDER - I PF 0 41. 00 04100 SUBPROVIDER - I RF 0 42. 00 04200 SUBPROVIDER 0 43. 00 04300 NURSERY 0 44. 00 04400 SKI LLED NURSING FACILITY 0 45. 00 04500 NURSING FACILITY 0 45. 00 04500 NURSING FACILITY 0 46. 00 04600 OTHER LONG TERM CARE 0 40. 00 04600 OTHER LONG TERM CARE 0 40. 00 05000 OPERATING ROOM 0 51. 00 05100 RECOVERY ROOM 0 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 53. 00 05300 ANESTHESI OLOGY 0 54. 00 05400 RADIOLOGY-DIAGNOSTIC 0 55. 00 05500 RADIOLOGY-THERAPEUTIC 0 56. 00 05600 RADIOLOGY-THERAPEUTIC 0 57. 00 05500 RADIOLOGY-THERAPEUTIC 0 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 59. 00 05900 CARDIAC CATHETERIZATION 0	31. 00
34. 00	32.00
40. 00	33. 00 34. 00
42. 00	40. 00
43. 00	41. 00
44. 00	42.00
45. 00	43. 00 44. 00
45. 01	45. 00
ANCI LLARY SERVI CE COST CENTERS 50. 00	45. 01
50. 00	46. 00
51. 00	FO 00
52. 00	50. 00 51. 00
54. 00	52.00
55. 00	53. 00
56. 00	54.00
57. 00 05700 CT SCAN 0 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 059. 00 05900 CARDIAC CATHETERIZATION 0	55. 00 56. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0 59. 00 05900 CARDIAC CATHETERIZATION 0	57. 00
	58. 00
60. 00 106000 LABORA LORY 0	59. 00
	60.00
60. 01 06001 BLOOD LABORATORY 0	60. 01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	63. 00
64. 00 06400 I NTRAVENOUS THERAPY 0	64.00
65. 00 06500 RESPI RATORY THERAPY	65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY 0	67. 00
68. 00 06800 SPEECH PATHOLOGY 0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0	70.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT 0	71.00
73.00 O7300 DRUGS CHARGED TO PATIENTS 0	73. 00
74. 00 07400 RENAL DI ALYSI S 0	74.00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0 0	75. 00 76. 97
76. 97 O7697 CARDI AC REHABI LITATION O OUTPATI ENT SERVI CE COST CENTERS	76. 97
88. 00 08800 RURAL HEALTH CLI NI C 0	88. 00
89. 00 08900 FEDERALLY QUALI FI ED HEALTH CENTER 0	89. 00
90. 00 09000 CLINI C	
90. 01 09001 CLINI C - DI ABETES 0 91. 00 09100 EMERGENCY 0	90.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	90. 00 90. 01
	90.00

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151328 Peri od: Worksheet B-1 From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm Cost Center Description PARAMED ED PRGM (ASSI GNED TIME) 23.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 95.00 09500 AMBULANCE SERVICES 00000 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 99. 00 09900 CMHC 99.00 99. 10 09910 CORF 99.10 100.00 10000 I &R SERVI CES-NOT APPRVD PRGM 100.00 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 105.00 0 0 0 0 0 106.00 10600 HEART ACQUISITION 106.00 107. 00 10700 LIVER ACQUISITION 107. 00 108.00 10800 LUNG ACQUISITION 108.00 109.00 10900 PANCREAS ACQUISITION 109.00 110.00 11000 INTESTINAL ACQUISITION 110.00 111.00 11100 I SLET ACQUISITION 0 111. 00 113. 00 11300 | NTEREST EXPENSE 113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 0 116. 00 11600 HOSPI CE 116. 00 SUBTOTALS (SUM OF LINES 1-117) 0 118.00 118 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 00 0 0 0 0 0 0 0 191. 00 19100 RESEARCH 191. 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 192. 00 192. 01 19201 VACANT SPACE 192. 01 193. 00 19300 NONPALD WORKERS 193. 00 194. 00 07950 MARKETING/PUBLIC RELATIONS 194. 00 194. 01 194. 01 07951 CLARI AN HOME CARE 194. 02 07952 BLOOMNGTN AMBULANCE AND OCC MED 194. 02 194.03 07953 HOME CARE 0 194. 03 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 202.00 Cost to be allocated (per Wkst. B, 0 202. 00 Part I) Unit cost multiplier (Wkst. B, Part I) 203.00 203.00 0.000000 204.00 Cost to be allocated (per Wkst. B, 204. 00 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.000000 205.00

II)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 151328

							5/27/2016 1:5	7 pm
				Ti tl	e XVIII	Hospi tal	Cost	
		Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
			1.00	2.00	3.00	4. 00	5. 00	
	I NPAT	IENT ROUTINE SERVICE COST CENTERS						
30. 00		ADULTS & PEDIATRICS	6, 801, 648	ł	6, 801, 648	0	0	30. 00
31.00		INTENSIVE CARE UNIT	2, 744, 755		2, 744, 755	0	0	31.00
32. 00 33. 00		CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0		0	0	0	32. 00 33. 00
34. 00		SURGICAL INTENSIVE CARE UNIT	0] 0	0	0	34.00
40. 00	1	SUBPROVI DER - I PF	0		Ö	o	0	40. 00
41.00		SUBPROVI DER - I RF	0		0	o	0	41. 00
42.00	1	SUBPROVI DER	0		0	0	0	42. 00
43. 00 44. 00		NURSERY SKILLED NURSING FACILITY	0		0	0	0	43. 00 44. 00
45. 00		NURSING FACILITY	0		0	0	0	45. 00
45. 01	1	I CF/MR	0		Ō	Ö	0	45. 01
46. 00		OTHER LONG TERM CARE	0		0	0	0	46. 00
F0 00		LARY SERVICE COST CENTERS	2 400 040		0 400 040			F0 00
50. 00 51. 00		OPERATING ROOM RECOVERY ROOM	3, 423, 343 187, 971		3, 423, 343 187, 971	0	0	50. 00 51. 00
52. 00		DELIVERY ROOM & LABOR ROOM	0		0	ő	0	52. 00
53.00		ANESTHESI OLOGY	0		0	O	0	53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	5, 426, 635		5, 426, 635	0	0	54. 00
55. 00		RADI OLOGY-THERAPEUTI C	0		0	0	0	55. 00
56. 00 57. 00	1	RADI OI SOTOPE CT SCAN	364, 278		364, 278	0	0	56. 00 57. 00
58. 00		MAGNETIC RESONANCE IMAGING (MRI)	0		l ő	Ö	0	58.00
59. 00		CARDI AC CATHETERI ZATI ON	0		0	o	0	59. 00
60. 00		LABORATORY	4, 773, 003		4, 773, 003	0	0	60. 00
60. 01		BLOOD LABORATORY	0		0	0	0	60. 01
61. 00 62. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0	0	61. 00 62. 00
63. 00		BLOOD STORING, PROCESSING & TRANS.	0		Ö	Ö	0	63. 00
64.00		I NTRAVENOUS THERAPY	0		0	o	0	64. 00
65.00		RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00 67. 00		PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	2, 195, 917	0	2, 195, 917 0	0	0	66. 00 67. 00
68. 00		SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00		ELECTROCARDI OLOGY	2, 862, 816		2, 862, 816	o	0	69. 00
70. 00		ELECTROENCEPHALOGRAPHY	0		0	0	0	70. 00
71.00		MEDICAL SUPPLIES CHARGED TO PATIENTS	310, 011		310, 011	0	0	71.00
72. 00 73. 00		IMPL. DEV. CHARGED TO PATIENT DRUGS CHARGED TO PATIENTS	584, 666 8, 190, 128		584, 666 8, 190, 128	0	0	72. 00 73. 00
74. 00	07400	RENAL DIALYSIS	0, 170, 120		0, 170, 120	o	0	74.00
75. 00	07500	ASC (NON-DISTINCT PART)	0		0	0	0	75. 00
76. 97		CARDI AC REHABI LI TATI ON	193, 978		193, 978	0	0	76. 97
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	1 0		Ι ο	٥	0	88. 00
89. 00		FEDERALLY QUALIFIED HEALTH CENTER	0		0	o o	0	
90. 00		CLI NI C	0		0	o	0	90.00
90. 01		CLINIC - DIABETES	213, 295	l e	213, 295	0	0	90. 01
91. 00 92. 00		EMERGENCY OBSERVATION BEDS (NON-DISTINCT PART)	4, 952, 639	l e	4, 952, 639	0	0	91. 00 92. 00
92.00		REIMBURSABLE COST CENTERS	1, 442, 045		1, 442, 045		0	92.00
94.00		HOME PROGRAM DIALYSIS	0		0	0	0	94. 00
95. 00		AMBULANCE SERVICES	0		0	0	0	95. 00
96.00		DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96. 00 97. 00
97. 00 99. 00		DURABLE MEDICAL EQUIP-SOLD	0] 0 0	٩	0	
99. 10	1	•	0		Ö		0	
100.00	10000	I&R SERVICES-NOT APPRVD PRGM	0		0			100. 00
101.00		HOME HEALTH AGENCY	0		0		0	101. 00
105 00		AL PURPOSE COST CENTERS KIDNEY ACQUISITION	0		0		0	105. 00
		HEART ACQUISITION	0		Ö			106. 00
107.00	10700	LIVER ACQUISITION	0		0		0	107. 00
		LUNG ACQUISITION	0		0			108. 00
		PANCREAS ACQUISITION INTESTINAL ACQUISITION	0		0			109. 00 110. 00
		ISLET ACQUISITION			0			111.00
		INTEREST EXPENSE					O	113. 00
		UTILIZATION REVIEW-SNF						114. 00
115.00	11500	AMBULATORY SURGICAL CENTER (D. P.)	0		0		0	115. 00

Health Financial Systems	NDIANA UNIVERSIT	DIANA UNIVERSITY HEALTH BEDFORD			In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2015 Fo 12/31/2015	Worksheet C Part I Date/Time Pre			
		Ti +1	e XVIII	Hospi tal	5/27/2016 1:5 Cost	7 pm		
		11 (1	E VIIII	Costs	COST			
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			
116.00 11600 HOSPICE 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)	44, 667, 128 1, 442, 045 43, 225, 083	5	44, 667, 129 1, 442, 049 43, 225, 089	5	0	116. 00 200. 00 201. 00 202. 00		

Provider CCN: 151328

Peri od:

From 01/01/2015

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

Date/Time Prepared: 12/31/2015 5/27/2016 1:57 pm Title XVIII Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 5, 552, 688 5, 552, 688 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 3, 103, 839 3, 103, 839 31.00 03200 CORONARY CARE UNIT 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34 00 34 00 40.00 04000 SUBPROVIDER - IPF 0 40.00 41.00 04100 SUBPROVIDER - IRF 0 0 41.00 04200 SUBPROVI DER 42.00 42.00 0 04300 NURSERY 0 43.00 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 45.00 04500 NURSING FACILITY 45.00 0 04510 I CF/MR 0 45.01 45.01 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 873, 933 15, 841, 521 17, 715, 454 0.193240 0.000000 50.00 05100 RECOVERY ROOM 0.084112 0.000000 51 00 235, 588 1, 999, 181 2, 234, 769 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 53.00 31, 672, 938 05400 RADI OLOGY-DI AGNOSTI C 1, 695, 554 29, 977, 384 0.171333 0.000000 54.00 54.00 0.000000 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 56.00 05600 RADI OI SOTOPE 125, 866 1, 349, 290 1, 475, 156 0.246942 0.000000 56.00 57.00 05700 CT SCAN 0.000000 0.000000 57.00 58 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0 000000 58 00 0 05900 CARDIAC CATHETERIZATION 59.00 0.000000 0.000000 59.00 06000 LABORATORY 3, 789, 990 23, 381, 890 27, 171, 880 0.175660 0.000000 60.00 60.00 60.01 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 0 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 0 0.000000 0.000000 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0.000000 0.000000 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0.000000 0.000000 63.00 64 00 06400 INTRAVENOUS THERAPY 0 C 0 0.000000 0 000000 64 00 06500 RESPIRATORY THERAPY 65.00 0.000000 0.000000 65.00 06600 PHYSI CAL THERAPY 469, 308 3, 898, 421 4, 367, 729 0.502759 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0.000000 67.00 06800 SPEECH PATHOLOGY 68 00 0.000000 0.000000 68 00 1, 514, 386 69.00 06900 ELECTROCARDI OLOGY 8, 269, 558 9, 783, 944 0. 292603 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 672, 636 1, 998, 907 2, 671, 543 0.116042 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 915645 72 00 15, 459 623, 070 638, 529 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 598, 774 19, 438, 127 25, 036, 901 0.327122 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0.000000 75.00 0 07697 CARDIAC REHABILITATION 76.97 0 577, 907 577, 907 0.335656 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0 0 89.00 0.000000 90 00 09000 CLI NI C 0 0 0.000000 90 00 09001 CLINIC - DIABETES 36, 700 5. 811853 0.000000 90.01 36, 700 90.01 91.00 09100 EMERGENCY 581, 263 17, 776, 417 18, 357, 680 0.269786 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 48, 215 4, 203, 098 4, 251, 313 0.339200 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0.000000 94.00 09500 AMBULANCE SERVICES 0 0 95.00 C 0.000000 0.000000 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED Ω 0 0.000000 0.000000 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 0 0.000000 0.000000 97.00 97.00 0 99. 00 09900 CMHC 0 99.00 0 0 99.10 09910 CORF 0 99.10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 C 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 C 0 105.00 0 0 106.00 10600 HEART ACQUISITION 106.00 107. 00 10700 LIVER ACQUISITION 0 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 113.00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 116.00 11600 HOSPI CE 0 0 116. 00

Health Fin	Health Financial Systems		IDIANA UNIVERSITY HEALTH BEDFORD			In Lieu of Form CMS-2552-10			
COMPUTATIO	ON OF RATIO OF COSTS TO CHARGES		Provi	der		Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/27/2016 1:5		
				Ti tl	e XVIII	Hospi tal	Cost		
			Charges	5					
	Cost Center Description	I npati ent	Outpati e	nt		Cost or Other	TEFRA		
					+ col. 7)	Ratio	Inpatient		
							Ratio		
		6.00	7. 00		8. 00	9. 00	10.00		
200.00	Subtotal (see instructions)	25, 277, 499	129, 371	, 471	154, 648, 97	0		200. 00	
201. 00	Less Observation Beds							201. 00	
202. 00	Total (see instructions)	25, 277, 499	129, 371	, 471	154, 648, 97	0		202. 00	

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 5/27/2016 1:57 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES INDIANA UNIVERSITY HEALTH BEDFORD
Provider CCN: 151328

			Title XVIII	Hospi tal	5/2//2016 1: Cost	5/ pm
	Cost Center Description	PPS Inpatient	THE AVIII	1103pi tui	0031	
	p	Ratio				
	T	11.00				
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT					30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT					32.00
33. 00	03300 BURN INTENSIVE CARE UNIT					33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT					34.00
40. 00	04000 SUBPROVI DER - I PF					40. 00
41.00	04100 SUBPROVI DER - I RF					41. 00
42.00	04200 SUBPROVI DER					42. 00
43.00	04300 NURSERY					43. 00
44. 00	04400 SKILLED NURSING FACILITY					44. 00
45. 00	04500 NURSING FACILITY					45. 00
45. 01	04510 CF/MR					45. 01
46. 00	04600 OTHER LONG TERM CARE					46. 00
50. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0. 000000				50.00
51.00	05100 RECOVERY ROOM	0. 000000				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000				52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55. 00
56.00	05600 RADI 01 SOTOPE	0. 000000				56. 00
57. 00	05700 CT SCAN	0. 000000				57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000				58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59. 00
60.00	06000 LABORATORY	0.000000				60.00
60. 01	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000				60. 01
61. 00 62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000 0. 000000				61. 00 62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000				63. 00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000				64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000				65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000				66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000				67. 00
68.00	06800 SPEECH PATHOLOGY	0. 000000				68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000				69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000				70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000				72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0.000000				73.00
74. 00 75. 00	07400 RENAL DI ALYSI S	0.000000				74.00
76. 97	O7500 ASC (NON-DISTINCT PART) O7697 CARDIAC REHABILITATION	0. 000000 0. 000000				75. 00 76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	0.000000				10. 97
88. 00	08800 RURAL HEALTH CLINIC					88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
90.00	09000 CLI NI C	0. 000000				90.00
90. 01	09001 CLINIC - DIABETES	0. 000000				90. 01
91.00	09100 EMERGENCY	0. 000000				91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000				92. 00
04.00	OTHER REIMBURSABLE COST CENTERS	0.000000				1 04 00
	09400 HOME PROGRAM DIALYSIS	0.000000				94.00
	09500 AMBULANCE SERVI CES 09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000 0. 000000				95. 00 96. 00
	09700 DURABLE MEDICAL EQUIP-RENTED	0. 000000				97.00
	09900 CMHC	0.000000				99. 00
	09910 CORF					99. 10
	10000 L&R SERVICES-NOT APPRVD PRGM					100.00
101.00	10100 HOME HEALTH AGENCY					101.00
	SPECIAL PURPOSE COST CENTERS					
105.00	10500 KIDNEY ACQUISITION					105. 00
	10600 HEART ACQUISITION					106. 00
	10700 LIVER ACQUISITION					107. 00
	10800 LUNG ACQUISITION					108. 00
	10900 PANCREAS ACQUISITION					109.00
	11000 I NTESTI NAL ACQUI SI TI ON					110.00
	11100 I SLET ACQUI SI TI ON					111.00
	11300 INTEREST EXPENSE					113.00
	11400 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D.P.)					114. 00 115. 00
	111500 AMBULATORY SURGICAL CENTER (D. P.)					116.00
200.00						200.00
201.00						201. 00
	1					

Health Financial Systems	INDIANA UNIVERSITY HEALTH BEDFORD		In Lieu of Form CMS-2552-1		552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 151328	Peri od: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepa 5/27/2016 1:57	
		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
202.00 Total (see instructions)				2	202. 00

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES INDIANA UNIVERSITY HEALTH BEDFORD

Provider CCN: 151328

			'	0 12/31/2015	5/27/2016 1:5	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
	26)					
	1. 00	2. 00	3.00	4. 00	5. 00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS 30. 00 03000 ADULTS & PEDI ATRI CS	6, 801, 648		6, 801, 648		6, 801, 648	30.00
31. 00 03000 ADDETS & PEDIATRICS	2, 744, 755	ł	2, 744, 755		2, 744, 755	31.00
32. 00 03200 CORONARY CARE UNIT	2,744,733		2, 744, 733	0	2, 744, 733	32. 00
33.00 03300 BURN INTENSIVE CARE UNIT	0		0	0	0	33. 00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0		0	0	0	34. 00
40. 00 04000 SUBPROVI DER - PF	0)	0	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF 42. 00 04200 SUBPROVI DER	0		0	0	0	41. 00 42. 00
43. 00 04300 NURSERY				0		43. 00
44.00 04400 SKILLED NURSING FACILITY	0		0	0	0	44. 00
45.00 04500 NURSING FACILITY	0		0	0	0	45. 00
45. 01 04510 I CF/MR	0	2	0	0	0	45. 01
46. 00 O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	1	0	0	0	46. 00
50. 00 05000 OPERATI NG ROOM	3, 423, 343		3, 423, 343	0	3, 423, 343	50. 00
51.00 05100 RECOVERY ROOM	187, 971		187, 971	0	187, 971	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0)	0	0	0	52.00
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	E 424 42E)	0 E 424 42E	0	0	53. 00 54. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C	5, 426, 635		5, 426, 635	0	5, 426, 635 0	55.00
56. 00 05600 RADI 0I SOTOPE	364, 278		364, 278	0	364, 278	56. 00
57. 00 05700 CT SCAN	0)	0	0	0	57. 00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0)	0	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	4 772 003)	4 772 003	0	0	59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	4, 773, 003		4, 773, 003	0	4, 773, 003 0	60. 00 60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		Ö	0	Ö	61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0)	0	0	0	62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0)	0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	0		0	0	0 0	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	2, 195, 917	,	2, 195, 917	0	2, 195, 917	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	Ö	0	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	2, 862, 816		2, 862, 816	0	2, 862, 816	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	310, 011	'	310, 011	0	310, 011	70. 00 71. 00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	584, 666		584, 666	0	584, 666	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	8, 190, 128	3	8, 190, 128	0	8, 190, 128	73. 00
74. 00 07400 RENAL DI ALYSI S	0		0	0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART) 76. 97 07697 CARDIAC REHABILITATION	193, 978		193, 978	0	0 193, 978	75. 00 76. 97
OUTPATIENT SERVICE COST CENTERS	175,770	1	175, 770		173, 770	70. 77
88. 00 08800 RURAL HEALTH CLINIC	0)	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0)	0	0	0	89. 00
90. 00 09000 CLINIC 90. 01 09001 CLINIC - DIABETES	213, 295)	213, 295	0	0 213, 295	90. 00 90. 01
91. 00 09100 EMERGENCY	4, 952, 639		4, 952, 639		4, 952, 639	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	1, 442, 045		1, 442, 045		1, 442, 045	92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSIS 95. 00 09500 AMBULANCE SERVICES	0)	0	0	0 0	94. 00 95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		l .		0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD			ĺ	0	Ö	97. 00
99. 00 09900 CMHC	0)	0		0	99. 00
99. 10 09910 CORF	0	l .	0		0	99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0	l .	0			100. 00 101. 00
SPECIAL PURPOSE COST CENTERS		1				101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0)	0		0	105. 00
106. 00 10600 HEART ACQUI SI TI ON	0		0			106. 00
107.00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION	0				•	107. 00 108. 00
108. 00 10800 LUNG ACQUISTION 109. 00 10900 PANCREAS ACQUISTION	0					108.00
110. 00 11000 I NTESTI NAL ACQUISITION			0			110. 00
111.00 11100 I SLET ACQUI SI TI ON	0		0		0	111. 00
113. 00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	,	0		n	114. 00 115. 00
	1	1	1	<u>I</u>	<u> </u>	1

Heal th Fina	ncial Systems	DIANA UNIVERSITY HEALTH BEDFORD				In Lieu of Form CMS-2552-10		
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES			Provi der		Peri od: From 01/01/2015	Worksheet C Part I	
						To 12/31/2015	Date/Time Pre 5/27/2016 1:5	
				Ti t	le XIX	Hospi tal	Cost	
						Costs		
	Cost Center Description	Total Cost	Ther	apy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,		Adj .		Di sal I owance		
		Part I, col.		-				
		26)						
		1. 00		2.00	3.00	4. 00	5. 00	
116. 00 11600	0 HOSPI CE	C				0	0	116. 00
200. 00	Subtotal (see instructions)	44, 667, 128	3	0	44, 667, 12	8 0	44, 667, 128	200. 00
201.00	Less Observation Beds	1, 442, 045	i[1, 442, 04	5	1, 442, 045	201. 00
202. 00	Total (see instructions)	43, 225, 083		0	43, 225, 08	3 0	43, 225, 083	202. 00

Provider CCN: 151328

Peri od:

From 01/01/2015

COMPUTATION OF RATIO OF COSTS TO CHARGES

Part I

Date/Time Prepared: 12/31/2015 5/27/2016 1:57 pm Title XIX Hospi tal Cost Charges Cost Center Description Inpati ent Outpati ent Total (col. 6 Cost or Other **TFFRA** + col . 7) Ratio Inpati ent Ratio 6.00 7.00 8.00 9. 00 10.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 5, 552, 688 5, 552, 688 30.00 30.00 31.00 03100 INTENSIVE CARE UNIT 3, 103, 839 3, 103, 839 31.00 03200 CORONARY CARE UNIT 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34 00 34 00 40.00 04000 SUBPROVIDER - IPF 0 40.00 41.00 04100 SUBPROVIDER - IRF 0 0 41.00 04200 SUBPROVI DER 42.00 42.00 0 04300 NURSERY 0 43.00 43.00 44.00 04400 SKILLED NURSING FACILITY 0 0 44.00 45.00 04500 NURSING FACILITY 45.00 0 04510 I CF/MR 0 45.01 45.01 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 1, 873, 933 15, 841, 521 17, 715, 454 0.193240 0.000000 50.00 05100 RECOVERY ROOM 0.084112 0.000000 51 00 235, 588 1, 999, 181 2, 234, 769 51 00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0.000000 52.00 05300 ANESTHESI OLOGY 0.000000 0.000000 53.00 53.00 31, 672, 938 05400 RADI OLOGY-DI AGNOSTI C 1, 695, 554 29, 977, 384 0.171333 0.000000 54.00 54.00 0.000000 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55.00 56.00 05600 RADI OI SOTOPE 125, 866 1, 349, 290 1, 475, 156 0.246942 0.000000 56.00 57.00 05700 CT SCAN 0.000000 0.000000 57.00 58 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 0 000000 58 00 0 05900 CARDIAC CATHETERIZATION 59.00 0.000000 0.000000 59.00 06000 LABORATORY 3, 789, 990 23, 381, 890 27, 171, 880 0.175660 0.000000 60.00 60.00 60.01 60.01 06001 BLOOD LABORATORY 0.000000 0.000000 0 0 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 0 0.000000 0.000000 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0.000000 0.000000 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0.000000 0.000000 63.00 64 00 06400 INTRAVENOUS THERAPY 0 C 0 0.000000 0 000000 64 00 06500 RESPIRATORY THERAPY 65.00 0.000000 0.000000 65.00 06600 PHYSI CAL THERAPY 469, 308 3, 898, 421 4, 367, 729 0.502759 0.000000 66.00 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 0.000000 67.00 06800 SPEECH PATHOLOGY 68 00 0.000000 0.000000 68 00 1, 514, 386 69.00 06900 ELECTROCARDI OLOGY 8, 269, 558 9, 783, 944 0. 292603 0.000000 69.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0.000000 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 672, 636 1, 998, 907 2, 671, 543 0.116042 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 0. 915645 72 00 15, 459 623, 070 638, 529 0.000000 72 00 73.00 07300 DRUGS CHARGED TO PATIENTS 5, 598, 774 19, 438, 127 25, 036, 901 0.327122 0.000000 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0.000000 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 0.000000 75.00 0 07697 CARDIAC REHABILITATION 76.97 0 577, 907 577, 907 0.335656 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0.000000 0.000000 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 0.000000 0.000000 89.00 0 0 90 00 09000 CLI NI C 0 0 0.000000 0.000000 90 00 09001 CLINIC - DIABETES 36, 700 5.811853 0.000000 90.01 36, 700 90.01 91.00 09100 EMERGENCY 581, 263 17, 776, 417 18, 357, 680 0.269786 0.000000 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 48, 215 4, 203, 098 4, 251, 313 0.339200 0.000000 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0.000000 94.00 09500 AMBULANCE SERVICES 0 0 95.00 C 0.000000 0.000000 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED Ω 0 0.000000 0.000000 96.00 0 09700 DURABLE MEDICAL EQUIP-SOLD 0 0.000000 0.000000 97.00 97.00 0 99. 00 09900 CMHC 0 99.00 0 0 99.10 09910 CORF 0 99.10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 C 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KIDNEY ACQUISITION 0 C 0 105.00 0 0 106.00 10600 HEART ACQUISITION 106.00 107. 00 10700 LIVER ACQUISITION 0 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 111.00 11100 I SLET ACQUISITION 0 0 111.00 113.00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 116.00 11600 HOSPI CE 0 0 116. 00

Heal th Finan	cial Systems IND	NDIANA UNIVERSITY HEALTH BEDFORD			In Lieu of Form CMS-2552-10			
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES			Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/27/2016 1:5	
				Ti t	le XIX	Hospi tal	Cost	
			CI	harges				
	Cost Center Description	I npati ent	0ut	patient		Cost or Other	TEFRA	
					+ col. 7)	Ratio	Inpatient Ratio	
		6.00		7. 00	8. 00	9. 00	10.00	
200.00	Subtotal (see instructions)	25, 277, 499	12	9, 371, 471	154, 648, 97	0		200. 00
201. 00	Less Observation Beds							201. 00
202. 00	Total (see instructions)	25, 277, 499	12	9, 371, 471	154, 648, 97	0		202. 00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: | 5/27/2016 1:57 pm Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES INDIANA UNIVERSITY HEALTH BEDFORD
Provider CCN: 151328

		Title XIX	Hospi tal	5/2//2016 1:5/ pm Cost
Cost Center Description	PPS Inpatient	THE MIX	поэрг саг	0031
, , , , , , , , , , , , , , , , , , ,	Ratio			
	11. 00			
30. 00 O3000 ADULTS & PEDIATRICS	T T			30.00
31. 00 03100 NTENSI VE CARE UNIT				31. 00
32. 00 03200 CORONARY CARE UNIT				32.00
33.00 03300 BURN INTENSIVE CARE UNIT				33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34.00
40. 00 04000 SUBPROVI DER - PF				40.00
41. 00 04100 SUBPROVI DER - 1 RF				41. 00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY				42. 00 43. 00
44. 00 04400 SKILLED NURSING FACILITY				44. 00
45. 00 04500 NURSING FACILITY				45. 00
45. 01 04510 I CF/MR				45. 01
46.00 O4600 OTHER LONG TERM CARE				46. 00
ANCILLARY SERVICE COST CENTERS	0.000000			50.00
50. 00 05000 OPERATING ROOM	0.000000			50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000 0. 000000			51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI OI SOTOPE	0. 000000			56. 00
57. 00 05700 CT SCAN	0. 000000			57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000			59.00
60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY	0.000000			60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000 0. 000000			61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63. 00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000			65. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000			68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0.000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000 0. 000000			71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
74. 00 07400 RENAL DIALYSIS	0. 000000			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76. 97
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0.000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000			89. 00
90. 00 09000 CLI NI C 90. 01 09001 CLI NI C - DI ABETES	0. 000000 0. 000000			90.00
91. 00 09100 EMERGENCY	0. 000000			91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000			92.00
OTHER REI MBURSABLE COST CENTERS				72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000			94. 00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97. 00
99. 00 09900 CMHC				99.00
99. 10 09910 CORF 100. 00 10000 L&R SERVI CES-NOT APPRVD PRGM				100.00
101. 00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				
105. 00 10500 KIDNEY ACQUISITION				105. 00
106.00 10600 HEART ACQUISITION				106. 00
107.00 10700 LIVER ACQUISITION				107. 00
108.00 10800 LUNG ACQUISITION				108. 00
109. 00 10900 PANCREAS ACQUISITION				109. 00
110. 00 11000 INTESTINAL ACQUISITION				110.00
111.00 11100 I SLET ACQUI SI TI ON				111.00
113. 00 11300 INTEREST_EXPENSE 114. 00 11400 UTI LI ZATI ON_REVI EW-SNF				113. 00 114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115. 00
116. 00 11600 HOSPI CE				116. 00
200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201. 00
•				•

Health Financial Systems	NDIANA UNIVERSITY HE	ALTH BEDFORD	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 151328	Peri od: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/27/2016 1:5		
		Title XIX	Hospi tal	Cost		
Cost Center Description	PPS Inpatient					
	Ratio					
	11. 00					
202.00 Total (see instructions)					202. 00	

Heal th	Financial Systems IND	IANA UNIVERSIT	Y HEAI	_TH BEDFOR	RD	In Li€	eu of Form CMS-	2552-10
APPORT	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS		Provi der	CCN: 151328	Peri od:	Worksheet D	
						From 01/01/2015	Part II	
						To 12/31/2015	Date/Time Pre	pared:
							5/27/2016 1:5	7 pm
					e XVIII	Hospi tal	Cost	
	Cost Center Description	Capi tal			Ratio of Cos		Capital Costs	
				Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part		(col. 1 ÷ col	. Charges	column 4)	
		Part II, col.		8)	2)			
		26)						
	T	1. 00		2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS				,		,	
50.00	05000 OPERATI NG ROOM	306, 254		7, 715, 454				1
51. 00	05100 RECOVERY ROOM	3, 342	<u>:</u>	2, 234, 769			140	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0		0	0. 00000		0	52. 00
53.00	05300 ANESTHESI OLOGY	0		0	0. 00000	00	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	322, 729	3	1, 672, 938	0. 01018	820, 815	8, 363	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0		0	0.0000	00	0	55. 00
56.00	05600 RADI OI SOTOPE	3, 989		1, 475, 156	0. 00270	71, 278	193	56.00
57.00	05700 CT SCAN	0		0	0. 00000	00	0	57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	ol .	0	0. 00000	00 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0		0	0.0000	00 0	0	59. 00
60.00	06000 LABORATORY	127, 321	2	7, 171, 880	0.00468		9, 911	60.00
60. 01	06001 BLOOD LABORATORY	1	ا	0	0.0000		0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		1	ū	0.0000			61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		J	0	0. 00000	0	0	62. 00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		1	0	0. 00000		١	63. 00
64. 00	06400 I NTRAVENOUS THERAPY		1	0	0. 00000		0	64. 00
65. 00	06500 RESPIRATORY THERAPY		()	0	0. 00000			65. 00
66. 00	06600 PHYSI CAL THERAPY	109, 296	1	4, 367, 729	0. 0250		6, 440	1
67. 00	06700 OCCUPATI ONAL THERAPY	107, 270	()	4, 307, 729	0. 0230		0, 440	67.00
68. 00	06800 SPEECH PATHOLOGY		()	0	0. 00000		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	134, 997		0 702 044	0.0000		1	
70. 00	07000 ELECTROENCEPHALOGRAPHY	134, 997	J	9, 783, 944				69. 00 70. 00
	1 1	0.024	'	0 471 540	0.00000		0	
71. 00	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	9, 834		2, 671, 543	0.00368			
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	18, 695		638, 529	0. 0292			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	115, 125	4	5, 036, 901	0. 00459			73.00
74.00	07400 RENAL DIALYSIS	0	1	0	0.0000		0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	1	0	0. 00000		-	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	40, 983	il	577, 907	0. 0709	16 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS				T		T	
88. 00	08800 RURAL HEALTH CLINIC	0	1	0	0. 00000		-	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0. 00000		0	89. 00
90.00	09000 CLI NI C	0	1	0	0. 00000		0	90. 00
90. 01	09001 CLINIC - DIABETES	11, 480		36, 700	0. 31280		0	90. 01
91. 00	09100 EMERGENCY	167, 707		8, 357, 680	0. 0091:			91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	77, 964		4, 251, 313	0. 0183	3, 212	59	92. 00
	OTHER REIMBURSABLE COST CENTERS							
94.00	09400 HOME PROGRAM DIALYSIS	0		0	0.00000	00	0	
95.00	09500 AMBULANCE SERVICES							95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0. 00000	00	0	96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0		0	0. 00000	00	0	97. 00
200.00	Total (lines 50-199)	1, 449, 716	14	5, 992, 443		8, 762, 802	68, 054	200. 00

 Heal th Financial APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 INDIANA UNIVERSITY HEALTH BEDFORD

INDIANA UNIVERSITY HEALTH BEDFORD

Provider CC Provi der CCN: 151328 THROUGH COSTS

					.0 .2,0.,20.0	5/27/2016 1:5	7 pm
				e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursing School	Allied Healt	n 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				_		
50.00	05000 OPERATI NG ROOM	0	(•	0		50. 00
51. 00	05100 RECOVERY ROOM	0	(0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	(0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	(0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	(0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	(0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	(0	0	56. 00
57. 00	05700 CT SCAN	0	(0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	(0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	()	0	0	59. 00
60.00	06000 LABORATORY	0	()	0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	()	0	0	60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	(0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	(0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	(0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	(0	0	65. 00
66.00	06600 PHYSI CAL THERAPY	0	(0	0	66. 00
67.00	06700 OCCUPATI ONAL THERAPY	0	(0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	(0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	(0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	(0 0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	(0 0	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	(0 0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	(0 0	0	73. 00
74.00	07400 RENAL DIALYSIS	0	(0 0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	(0 0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	()	0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	()	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	()	0	0	89. 00
90.00	09000 CLI NI C	0	()	0	0	90.00
90. 01	09001 CLINIC - DIABETES	0	()	0	0	90. 01
91.00	09100 EMERGENCY	0	(0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	()	0 0	0	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	(0	0	94.00
95. 00	09500 AMBULANCE SERVI CES						95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	()	0	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	()	0	0	97. 00
200.00	Total (lines 50-199)	0	()	0	0	200. 00

Heal th	Financial Systems INI	DIANA UNIVERSIT	Y HEALTH BEDFO	RD	In Lie	u of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS			CCN: 151328	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV	pared:
				e XVIII	Hospi tal	Cost	
	Cost Center Description	Total		Ratio of Cost		Inpati ent	
		Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
		Cost (sum of		(col. 5 ÷ col		Charges	
		col. 2, 3 and	8)	7)	(col . 6 ÷ col .		
		4)			7)	40.00	
	ANOULL ARY OFRIGO SOOT OFFITTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
	ANCILLARY SERVICE COST CENTERS	1 .	47.745.45.4	1 0 00000	0 000000	700 000	
	05000 OPERATI NG ROOM	C	1				1
	05100 RECOVERY ROOM		2, 234, 769	1			1
	05200 DELIVERY ROOM & LABOR ROOM			0.00000			
	05300 ANESTHESI OLOGY) (0.00000			00.00
	05400 RADI OLOGY - DI AGNOSTI C		31, 672, 938				
	05500 RADI OLOGY-THERAPEUTI C)	0.00000			
	05600 RADI OI SOTOPE		1, 475, 156				1
	05700 CT SCAN			0.00000			
	05800 MAGNETIC RESONANCE I MAGING (MRI)			0.00000			
	05900 CARDI AC CATHETERI ZATI ON) (0.00000		-	07.00
	06000 LABORATORY		27, 171, 880				
60. 01	06001 BLOOD LABORATORY			0.00000	0. 000000	0	00.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS)	0.00000			
	06300 BLOOD STORING, PROCESSING & TRANS.)	0. 00000			
	06400 I NTRAVENOUS THERAPY)	0.00000			64. 00
	06500 RESPI RATORY THERAPY)	0.00000			65. 00
66.00	06600 PHYSI CAL THERAPY		4, 367, 729				
	06700 OCCUPATI ONAL THERAPY	C) (0.00000			
	06800 SPEECH PATHOLOGY	C) (0.00000			
	06900 ELECTROCARDI OLOGY	C	9, 783, 944				1
	07000 ELECTROENCEPHALOGRAPHY	(C) (0.00000			
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	(C	2, 671, 543				
	07200 IMPL. DEV. CHARGED TO PATIENT	(C	638, 529			· ·	1
	07300 DRUGS CHARGED TO PATIENTS	(25, 036, 901				
	07400 RENAL DI ALYSI S	()	0. 00000		0	1
	07500 ASC (NON-DISTINCT PART)	(C) (0.00000		0	, , , , , ,
7/ 07	07/07 CADDLAC DELIABLE LEATLON	1	L L L L L L L L L L L L L L L L L L L		0 000000		7/07

0

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09100 EMERGENCY

95. 00 | 09500 | AMBULANCE SERVICES

OUTPATIENT SERVICE COST CENTERS

OTHER REIMBURSABLE COST CENTERS

09600 DURABLE MEDICAL EQUIP-RENTED

Total (lines 50-199)

09400 HOME PROGRAM DIALYSIS

97. 00 09700 DURABLE MEDICAL EQUIP-SOLD

08900 FEDERALLY QUALIFIED HEALTH CENTER

09200 OBSERVATION BEDS (NON-DISTINCT PART)

07697 CARDIAC REHABILITATION

08800 RURAL HEALTH CLINIC

09001 CLINIC - DIABETES

| Period: | Worksheet D | From 01/01/2015 | Part IV | To | 12/31/2015 | Date/Time | Prepared: | 5/27/2016 | 1:57 pm | THROUGH COSTS

						5/27/2016 1:5	7 pm
				e XVIII	Hospi tal	Cost	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through	n		
		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	0		0		50.00
51.00	05100 RECOVERY ROOM	o	0		0		51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	o	0		0		52.00
53.00	05300 ANESTHESI OLOGY	0	0		0		53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	o	0	ol .	0		55. 00
56. 00	05600 RADI OI SOTOPE	0	0		0		56.00
57. 00	05700 CT SCAN	0	0		0		57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (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
60. 01	06001 BLOOD LABORATORY		0		0		60. 01
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		O	1	9		61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		0		62.00
63. 00	I I		0		0		63.00
64. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0		•
65. 00	06400 I NTRAVENOUS THERAPY	0	0		0		64.00
	06500 RESPI RATORY THERAPY	0	U	(-		65. 00
66.00	06600 PHYSI CAL THERAPY	0	U	(0		66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	U	<u>'</u>	9		67. 00
68. 00	06800 SPEECH PATHOLOGY	0	Ü	2	0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	Ü		0		69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0)	0		70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0)	0		71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0	0)	0		72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0)	0		73. 00
74. 00	07400 RENAL DIALYSIS	0	0)	0		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0		75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0)	0		76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	l .	0		88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0)	0		89. 00
90.00	09000 CLI NI C	0	0)	0		90. 00
90. 01	09001 CLINIC - DIABETES	0	0)	0		90. 01
91. 00	09100 EMERGENCY	0	0)	0		91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0)	0		92. 00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	O		0		94. 00
95. 00	09500 AMBULANCE SERVICES						95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0		96. 00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0		97. 00
200.00	Total (lines 50-199)	0	0)	0		200. 00

						5/27/2016 1:5	7 pm
			Ti tl	e XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Contor Doscription	Cost to Charge	DDC Doimburged		Cost	PPS Servi ces	
	Cost Center Description		PPS Reimbursed				
		Ratio From	Servi ces (see	Rei mbursed	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 OPERATI NG ROOM	0. 193240	0	3, 958, 037	0	0	50.00
51. 00	05100 RECOVERY ROOM	0. 173240				0	51.00
	I I					_	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		-	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 171333	0	10, 317, 205	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0	C	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 246942	0	635, 287	0	0	56. 00
57. 00	05700 CT SCAN	0. 000000	0		0	Ö	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000			0	0	58.00
				1	0	_	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0	0	59. 00
60.00	06000 LABORATORY	0. 175660	0		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000	0	C	0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000		0	0		61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	l d	ol	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	0	0	0	63.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	Ö	1	0	Ö	64. 00
	06500 RESPIRATORY THERAPY	0. 000000	0		١	0	65.00
65.00			1	l ~		_	
66. 00	06600 PHYSI CAL THERAPY	0. 502759			0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000		1	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0	0	0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 292603	0	2, 967, 239	0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0	l c	0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 116042	0	566, 026	0	o	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENT	0. 915645	0			0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 327122	_			Ö	73. 00
74.00	07400 RENAL DIALYSIS	0. 000000	0			0	74.00
				1	-	_	
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000			-	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 335656	0	268, 770	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0. 000000				0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90.00	09000 CLI NI C	0. 000000		1	0	0	90.00
90. 01	09001 CLINIC - DIABETES	5. 811853	0		, , , , , , , , , , , , , , , , , , ,	0	90. 01
	09100 EMERGENCY					0	
91.00		0. 269786					91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 339200	0	2, 104, 333	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0.000000		0			94.00
95.00	09500 AMBULANCE SERVICES	0. 000000		C			95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	0		O	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000		1	n	Ö	
200.00	I I	0.00000	0	1	23, 407	-	200. 00
200.00	1 /	1		42, 237, 233	23, 407	ا ا	200.00
∠∪1. ∪(1			i U		∠U 1. UU
202 20	Only Charges		_	42 220 255	22 427	,	202 00
202.00	Net Charges (line 200 +/- line 201)	1	0	42, 239, 255	23, 407	, 01	202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151328 Peri od: Worksheet D From 01/01/2015 Part V Date/Time Prepared: 12/31/2015 5/27/2016 1:57 pm Title XVIII Hospi tal Cost 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 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 764, 851 0 50.00 51.00 05100 RECOVERY ROOM 37, 171 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 52 00 0 05300 ANESTHESI OLOGY 53.00 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 1, 767, 678 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05600 RADI OI SOTOPE 56.00 156, 879 0 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59 00 59 00 0 0 60.00 06000 LABORATORY 1, 459, 775 0 60.00 60.01 06001 BLOOD LABORATORY 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 0 06600 PHYSI CAL THERAPY 540, 973 66.00 0 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 868, 223 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 65,683 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 77, 122 O 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 1, 896, 708 73.00 7, 657 74.00 07400 RENAL DIALYSIS C 74.00 75.00 75.00 07500 ASC (NON-DISTINCT PART) 07697 CARDIAC REHABILITATION 76. 97 90, 214 0 76. 97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 0 89.00 09000 CLI NI C 90.00 90.00 0 0 09001 CLINIC - DIABETES 90.01 57.043 0 90.01 91.00 09100 EMERGENCY 1, 538, 318 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 713, 790 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 95.00 09500 AMBULANCE SERVICES 0 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00 200.00 Subtotal (see instructions) 10, 034, 428 7,657 200.00 201.00 Less PBP Clinic Lab. Services-Program 201.00 Only Charges Net Charges (line 200 +/- line 201) 10, 034, 428 202. 00 202.00 7,657

APPORT	I ONMEN	T OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151328	Peri od:	Worksheet D	
				Component	+ CCN, 1E7220	From 01/01/2015	Part V	nonod.
				componen	t CCN: 15Z328	To 12/31/2015	Date/Time Pre 5/27/2016 1:5	
				Ti +I	e XVIII	Swing Beds - SNF		/ pili
				11 (1	Charges	Swifig beus - Sivi	Costs	
		Cost Conton Decemintion	Coot to Change	DDC Doimburgood		Cost	PPS Services	
		Cost Center Description	Cost to Charge		Doimburged	Rei mbursed		
			Ratio From	Services (see	Rei mbursed		(see inst.)	
			Worksheet C,	inst.)	Servi ces	Services Not		
			Part I, col. 9		Subject To	Subject To		
					Ded. & Coins			
			1.00	2.00	(see inst.)	(see inst.)	F 00	
	ANOLL	ADV. CEDVI OF COCT OFNITEDO	1.00	2.00	3. 00	4. 00	5. 00	
FO 00		ARY SERVICE COST CENTERS	0.102240		ı		0	FO 00
50.00		OPERATI NG ROOM	0. 193240		1	0	0	
51. 00		RECOVERY ROOM	0. 084112	0	1	0 0	0	
52. 00		DELIVERY ROOM & LABOR ROOM	0. 000000	0	1	0	0	
53.00		ANESTHESI OLOGY	0. 000000	0	1	0	0	53. 00
54.00		RADI OLOGY-DI AGNOSTI C	0. 171333	0)	0	0	54. 00
55.00	05500	RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
56.00	05600	RADI OI SOTOPE	0. 246942	0)	0 0	0	56. 00
57.00	05700	CT SCAN	0. 000000	0)	0	0	57.00
58.00	05800	MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0	1	o o	0	58. 00
59.00		CARDI AC CATHETERI ZATI ON	0. 000000)	o o	0	59.00
60.00	06000	LABORATORY	0. 175660	l 0)	o o	0	60.00
60. 01	1	BLOOD LABORATORY	0. 000000	l o	1	ol ol	0	60. 01
61. 00	1	PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	Ĭ			ı	61.00
62. 00	1	WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
63. 00		BLOOD STORING, PROCESSING & TRANS.	0. 000000	1		0 0	Ö	63.00
64. 00		INTRAVENOUS THERAPY	0. 000000			0 0	0	64.00
65. 00	1	RESPIRATORY THERAPY	0. 000000			0 0	0	65.00
	1			1	1	-1	-	1
66.00		PHYSI CAL THERAPY	0. 502759		1	-1	0	66.00
67. 00	1	OCCUPATIONAL THERAPY	0. 000000	0	1	0	0	67. 00
68. 00		SPEECH PATHOLOGY	0. 000000	0	1	0	0	68. 00
69. 00	4	ELECTROCARDI OLOGY	0. 292603	0	1	0 0	0	69. 00
70. 00		ELECTROENCEPHALOGRAPHY	0. 000000	0	1	0	0	70. 00
71. 00		MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 116042	0		0	0	71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENT	0. 915645	0)	0	0	72. 00
73.00		DRUGS CHARGED TO PATIENTS	0. 327122	0	1	0	0	73. 00
74.00	07400	RENAL DIALYSIS	0. 000000	0		0	0	74. 00
75.00	07500	ASC (NON-DISTINCT PART)	0. 000000	0)	0 0	0	75. 00
76. 97	07697	CARDI AC REHABI LI TATI ON	0. 335656	0)	0 0	0	76. 97
	OUTPA ⁻	FLENT SERVICE COST CENTERS						1
88.00	08800	RURAL HEALTH CLINIC	0.000000				0	88. 00
89. 00	08900	FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
90.00		CLINIC	0. 000000	1	,	0	0	1
90. 01		CLINIC - DIABETES	5. 811853				Ö	
91. 00		EMERGENCY	0. 269786	l ~		0 0	Ö	91.00
92. 00	1	OBSERVATION BEDS (NON-DISTINCT PART)	0. 339200			0 0	0	1
72.00		REIMBURSABLE COST CENTERS	0. 33 7200		1	0	0	1 72.00
94. 00		HOME PROGRAM DI ALYSIS	0. 000000		I	0		94. 00
95. 00		AMBULANCE SERVICES	0. 000000		1	0	I	95.00
95. 00 96. 00	1	DURABLE MEDICAL EQUIP-RENTED	0. 000000	0	J	0 0	0	
96. 00 97. 00				l ~]		0	
		DURABLE MEDICAL EQUIP-SOLD	0. 000000]		·	1 / / / 00
200.00	1	Subtotal (see instructions)	-		1	0 0	0	200.00
201.00	ן	Less PBP Clinic Lab. Services-Program			1	0	I	201. 00
	1	Only Charges	1	l	I		1	1

0 202. 00

202.00

Only Charges Net Charges (line 200 +/- line 201)

 Heal th Financial
 Systems
 INDIANA UNIVERSIT

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES
 AND VACCINE COST

				5/27/2016 1:57 pm
		Title XVII	I Swing Beds - SNF	Cost
	Costs			
Cost Center Description	Cost	Cost		
	Reimbursed Rei	imbursed		
	Servi ces Serv	vices Not		
		bject To		
		& Coins.		
		e inst.)		
	6.00	7.00		
ANCI LLARY SERVI CE COST CENTERS	0.00	7.00		
50. 00 05000 OPERATING ROOM	0	0		50.00
51. 00 05100 RECOVERY ROOM		o		
	1			51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	0	0		52. 00
53. 00 05300 ANESTHESI OLOGY	0	0		53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		54. 00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		55. 00
56. 00 05600 RADI 0I SOTOPE	0	0		56.00
57. 00 05700 CT SCAN	0	0		57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	o	0		58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	l ol	o		59. 00
60. 00 06000 LABORATORY		0		60.00
60. 01 06001 BLOOD LABORATORY	o	0		60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0		62. 00
	-	0		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	-1		63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0		64. 00
65. 00 06500 RESPI RATORY THERAPY	0	0		65. 00
66. 00 06600 PHYSI CAL THERAPY	0	0		66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		67. 00
68.00 06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	O	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	o	ol		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0		72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0		73. 00
74. 00 07400 RENAL DI ALYSI S		0		74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	o		75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON		o		76. 97
OUTPATIENT SERVICE COST CENTERS	<u> </u>	<u> </u>		70. 47
	O	0		00.00
88. 00 08800 RURAL HEALTH CLINIC		0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		89. 00
90. 00 09000 CLI NI C	0	0		90. 00
90. 01 09001 CLINIC - DIABETES	0	0		90. 01
91. 00 09100 EMERGENCY	0	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		92. 00
OTHER REIMBURSABLE COST CENTERS				
94. 00 09400 HOME PROGRAM DIALYSIS	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	l ol			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	o		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	o		97. 00
200.00 Subtotal (see instructions)		ol o		200. 00
201.00 Less PBP Clinic Lab. Services-Program		٧		201. 00
Only Charges				201.00
202.00 Net Charges (line 200 +/- line 201)	o	o		202. 00
202.00	١	٥Į		1202.00

0 202.00

9, 696, 371

0

202.00

Net Charges (line 200 +/- line 201)

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151328 Peri od: Worksheet D From 01/01/2015 Part V Date/Time Prepared: 12/31/2015 5/27/2016 1:57 pm Title XIX Hospi tal Cost 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 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 185, 951 0 50.00 51.00 05100 RECOVERY ROOM 5,881 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52 00 52 00 0 05300 ANESTHESI OLOGY 53.00 0 0 53.00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 467, 698 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 05600 RADI OI SOTOPE 0 56.00 18, 959 56.00 57.00 05700 CT SCAN 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 0 58.00 05900 CARDIAC CATHETERIZATION 59 00 59 00 0 0 60.00 06000 LABORATORY 315, 636 0 60.00 60.01 06001 BLOOD LABORATORY 0 60.01 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 62 00 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 63.00 06400 INTRAVENOUS THERAPY 0 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 0 06600 PHYSI CAL THERAPY 0 66.00 282.748 66.00 67.00 06700 OCCUPATIONAL THERAPY 67.00 06800 SPEECH PATHOLOGY 0 68.00 68.00 06900 ELECTROCARDI OLOGY 69.00 155, 549 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 31, 386 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENT 72.00 23,822 0 72.00 07300 DRUGS CHARGED TO PATIENTS 315, 494 0 73.00 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 75.00 75.00 07500 ASC (NON-DISTINCT PART) 0 07697 CARDIAC REHABILITATION 76. 97 2, <u>615</u> 76. 97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 89.00 09000 CLI NI C 90.00 90.00 0 0 09001 CLINIC - DIABETES 90.01 8, 270 0 90.01 91.00 09100 EMERGENCY 416,608 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 51, 698 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00

0

0

2, 282, 315

2, 282, 315

0

0

0

0

95.00

96.00

97.00

200.00

201.00

202. 00

95.00

96.00

97.00

200.00

201.00

202.00

09500 AMBULANCE SERVICES

Only Charges

09600 DURABLE MEDICAL EQUIP-RENTED

Subtotal (see instructions)

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

09700 DURABLE MEDICAL EQUIP-SOLD

Health Financial Systems	INDIANA UNIVERSITY HEALTH BED	FORD	In Lie	u of Form CMS-2	552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi d	er CCN: 151328	Peri od: From 01/01/2015	Worksheet D-1	
			To 12/31/2015	Date/Time Prep 5/27/2016 1:5	
	Ti	itle XVIII	Hospi tal	Cost	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
1.00 Inpatient days (including private ro	om days and swing-bed days, excludi	ng newborn)		4, 241	1.00
2.00 Inpatient days (including private ro	om davs, excluding swing-bed and r	newborn days)		3. 899	2.00

		Cost Center Description	COST	
			1. 00	
		PART I - ALL PROVIDER COMPONENTS		
		INPATIENT DAYS		
	1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 241	1.00
	2. 00 3. 00	Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,	3, 899 0	2. 00 3. 00
	3.00	do not complete this line.	٥	3.00
	4. 00	Semi-private room days (excluding swing-bed and observation bed days)	3, 016	4. 00
ļ	5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	259	5. 00
		reporting period		
(6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	83	7. 00
	7.00	report in a peri od	03	7.00
	8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
		reporting period (if calendar year, enter 0 on this line)		
•	9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	1, 972	9. 00
	10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	259	10.00
	10.00	through December 31 of the cost reporting period (see instructions)	259	10.00
	11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
		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)	0	12. 00
	13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
	13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	٥	13.00
	14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
	15. 00	Total nursery days (title V or XIX only)	0	15. 00
	16. 00	Nursery days (title V or XIX only)	0	16. 00
		SWING BED ADJUSTMENT		47.00
	17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period		17. 00
	18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
	10.00	report in giperiod		10.00
	19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	134. 09	19. 00
		reporting period		
-	20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0. 00	20. 00
	21. 00	reporting period Total general inpatient routine service cost (see instructions)	6, 801, 648	21. 00
	22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0, 001, 010	22. 00
		5 x line 17)		
:	23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	04.00	x line 18)	11 120	24.00
•	24. 00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)	11, 129	24.00
	25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
		x line 20)		
	26. 00	Total swing-bed cost (see instructions)	434, 107	26. 00
	27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6, 367, 541	27. 00
	28. 00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	20 00
	29. 00		0	28. 00 29. 00
	30.00	Semi -pri vate room charges (excluding swing-bed charges)	0	30.00
;	31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	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 minus line 33) (see instructions)	0.00	34.00
	35. 00 36. 00	Average per diem private room cost differential (line 34 x line 31) Private room cost differential adjustment (line 3 x line 35)	0. 00 0	35. 00 36. 00
	36.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	6, 367, 541	37.00
•		27 minus line 36)	5, 557, 541	07.00
		PART II - HOSPITAL AND SUBPROVIDERS ONLY		
		PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 633. 12	38. 00
	39.00	Program general inpatient routine service cost (line 9 x line 38)	3, 220, 513	39. 00 40. 00
	40. 00 41. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35) Total Program general inpatient routine service cost (line 39 + line 40)	0 3, 220, 513	
-			5, 225, 515	

27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6, 367, 541	27.00
	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	31.00
32.00	Average private room per diem charge (line 29 ÷ line 3)	0.00	32.00
33.00	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 minus line 33)(see instructions)	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 and private room cost differential (line	6, 367, 541	37.00
	27 minus line 36)		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, 633. 12	38.00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	3, 220, 513	39.00
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	3, 220, 513	41.00

Heal th	Financial Systems IND	IANA UNIVERSIT	Y HEALTH	BEDFOF	RD		In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Pro	vi der	CCN: 151328		riod: om 01/01/2015	Worksheet D-1	
						To		Date/Time Pre 5/27/2016 1:5	
		T			e XVIII	Ц,	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Tota Inpati en				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)	0		0		. 00	0		42. 00
	Intensive Care Type Inpatient Hospital Units								
43.00	INTENSIVE CARE UNIT	2, 744, 755	ł.	862	3, 184		565	1, 799, 056 0	ł
44. 00 45. 00	CORONARY CARE UNIT	0	1	0		. 00	0	0	
46. 00	SURGICAL INTENSIVE CARE UNIT	Ö	I I	0		. 00	0	Ö	46. 00
	OTHER SPECIAL CARE (SPECIFY)	-							47. 00
	Cost Center Description							1. 00	
48. 00	Program inpatient ancillary service cost (Wks	st. D-3, col. 3	3, line 20	00)				2, 217, 909	48. 00
49. 00	Total Program inpatient costs (sum of lines a PASS THROUGH COST ADJUSTMENTS				ns)			7, 237, 478	49. 00
50. 00								0	50. 00
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	ry servic	es (fr	om Wkst. D,	sum	of Parts II	0	51.00
52.00	Total Program excludable cost (sum of lines!							0	
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line !		elated, n	on-phy	sician anes	thet	ist, and	0	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION								
54.00	, 3							0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)							0.00	55. 00 56. 00
57. 00	Difference between adjusted inpatient operati	ng cost and ta	arget amo	unt (I	ine 56 minu	s li	ne 53)	0	•
58.00	Bonus payment (see instructions)	5	3				,	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost rep	porting period	endi ng 1	996, u	pdated and	comp	ounded by the	0.00	59. 00
(0.00	market basket		.do+od b	+ 6 0 m	ankat baaka	_		0.00	40.00
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year of line 53/54 is less than the lower of lines						e amount by	0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target								0 00
	amount (line 56), otherwise enter zero (see instructions)								
62.00	Relief payment (see instructions)							0	
63. 00	Allowable Inpatient cost plus incentive paymer PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see mstrt	actions)					0	63. 00
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31	of the	cost repor	ti ng	period (See	422, 978	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	per 31 of	the c	ost reporti	ng p	eriod (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi</pre>	ne costs (line	64 plus	line 6	5)(title XV	111	only). For	422, 978	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	n Decembe	r 31 o	f the cost	repo	rting period	0	67. 00
	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	· ·					0 .	0	68. 00
69. 00	(line 13 x line 20)					por t	ing period	0	
07.00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU								0 7. 00
70. 00	Skilled nursing facility/other nursing facili	ty/ICF/IID rou	utine ser	vi ce c	ost (line 3	7)			70. 00
71.00	Adjusted general inpatient routine service co		ine 70 ÷	line	2)				71.00
72. 00 73. 00	Program routine service cost (line 9 x line 1 Medically necessary private room cost applications)		n (lino 1	1 ~ 1:	ne 35)				72. 00 73. 00
74. 00	Total Program general inpatient routine servi				ne 33)				74.00
75. 00	Capital-related cost allocated to inpatient (26, line 45)				orksheet B,	Par	t II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)							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		arovi dan	rocard	e)				78. 00 79. 00
79. 00 80. 00	Aggregate charges to beneficiaries for excess Total Program routine service costs for compa					i ทบร	line 79)		80.00
	Inpatient routine service cost per diem limit			011	(,		81. 00
82. 00	Inpatient routine service cost limitation (li	ne 9 x line 8	* .						82. 00
83. 00	Reasonable inpatient routine services costs (ns)						83.00
84. 00 85. 00	Program inpatient ancillary services (see insultilization review - physician compensation		nns)						84. 00 85. 00
86. 00)					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	THROUGH COST							
87. 00	Total observation bed days (see instructions)							883	
88. 00 89. 00	Adjusted general inpatient routine cost per of Observation bed cost (line 87 x line 88) (see	•						1, 633. 12 1, 442, 045	1
57.00	Topost varion bed cost (Time of X Time oo) (Set	z matructions,	,					1, 442, 043	1 07.00

Health Financial Systems IND	IANA UNIVERSIT	Y HEALTH BEDFOR	RD	In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2015	Worksheet D-1	
				Fo 12/31/2015		
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	344, 264	6, 367, 541	0. 05406	1, 442, 045	77, 964	90. 00
91.00 Nursing School cost	0	6, 367, 541	0.000000	1, 442, 045	0	91.00
92.00 Allied health cost	0	6, 367, 541	0. 000000	1, 442, 045	0	92. 00
93.00 All other Medical Education	0	6, 367, 541	0. 000000	1, 442, 045	0	93. 00

	Financial Systems INDIANA UNIVERSITY HE			u of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST	Provi der CCN: 151328	Peri od:	Worksheet D-1	
			From 01/01/2015 To 12/31/2015	Date/Time Prep 5/27/2016 1:5	
		Title XIX	Hospi tal	Cost	7 рііі
	Cost Center Description	THE XIX	nospi tui	0031	
	oust defited beschiption			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days	. excludina newborn)		4, 241	1.00
2.00	Inpatient days (including private room days, excluding swing-b			3, 899	2. 00
3.00	Private room days (excluding swing-bed and observation bed day		ivate room days	0	3. 00
3. 00	do not complete this line.	sy. It you have only pr	rvate room days,	Ö	0.00
4.00	Semi-private room days (excluding swing-bed and observation be	d days)		3, 016	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	259	5. 00
3. 00	reporting period	m days) tim odgir becembe	. 01 01 1110 0031	207	0.00
6. 00	Total swing-bed SNF type inpatient days (including private roo	m days) after December	31 of the cost	0	6.00
5. 00	reporting period (if calendar year, enter 0 on this line)	m days) arter becomber	01 01 110 0031	J	0.00
7. 00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	83	7. 00
, , 00	reporting period	dayo, tili oagii boooliiboi	0. 0. 1.10 0001	00	,
3. 00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8.00
	reporting period (if calendar year, enter 0 on this line)			_	
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	112	9.00
	newborn days)	9 (9	9		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on	0	10.00		
	through December 31 of the cost reporting period (see instructions)				
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		oom days) after	0	11. 00
	December 31 of the cost reporting period (if calendar year, en	ter 0 on this line)	•		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12.00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX			0	13.00
	after December 31 of the cost reporting period (if calendar ye				
	Medically necessary private room days applicable to the Progra	m (excluding swing-bed	days)	0	
	Total nursery days (title V or XIX only)			0	
16. 00	Nursery days (title V or XIX only)			0	16. 00
	SWING BED ADJUSTMENT				
17. 00	Medicare rate for swing-bed SNF services applicable to service	s through December 31 o	f the cost		17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost		18. 00
	reporting period				
19. 00	Medicaid rate for swing-bed NF services applicable to services	through December 31 of	the cost	0. 00	19. 00
	reporting period				
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20. 00
	reporting period				
	Total general inpatient routine service cost (see instructions			6, 801, 648	
22. 00	Swing-bed cost applicable to SNF type services through Decembe	r 31 of the cost report	ing period (line	0	22. 00
	5 x line 17)			_	
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	g period (line 6	0	23. 00
	x line 18)				
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24.00
\F	7 x line 19)			=	05 55
25. 00	Swing-bed cost applicable to NF type services after December 3	or the cost reporting	period (line 8	0	25. 00
	x line 20)				1

	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	4, 241	1. 00
2. 00	Inpatient days (including private room days, excluding swing-bed and newborn days)	3, 899	2. 00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
	do not complete this line.		
4.00	Semi-private room days (excluding swing-bed and observation bed days)	3, 016	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	259	5. 00
	reporting period		
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	83	7. 00
	reporting period	_	
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	110	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days)	112	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
10.00	through December 31 of the cost reporting period (see instructions)	O	10.00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11.00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	J	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
	through December 31 of the cost reporting period		
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15. 00	Total nursery days (title V or XIX only)	0	15.00
16. 00	Nursery days (title V or XIX only)	0	16. 00
	SWING BED ADJUSTMENT		
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
19. 00	reporting period	0.00	10.00
19.00	Medical drate 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 the cost	0.00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	6, 801, 648	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0,001,010	22. 00
22.00	5 x line 17)	ŭ.	22.00
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
	x line 20)		
26. 00	Total swing-bed cost (see instructions)	423, 672	
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	6, 377, 976	27.00
20.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	0	20.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	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
	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	
	Average private room per diem charge (line 29 ÷ line 3)		32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	6, 377, 976	37. 00
	27 minus line 36)	=, 3, 770	
	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 per diem (see instructions)	1, 635. 80	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	183, 210	
40.00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41.00	Total Program general inpatient routine service cost (line 39 + line 40)	183, 210	41.00
	·		

		ieu of Form CMS-2	
COMPUT	FATION OF INPATIENT OPERATING COST Provider CCN: 151328 Period: From 01/01/201 To 12/31/201		pared:
	Title XIX Hospital Cost Center Description Total Total Average Per Program Days	Cost	
	Inpatient Cost Inpatient Days Diem (col. 1 ÷ col. 2)	(col. 3 x col. 4)	
42.00	1.00 2.00 3.00 4.00 NURSERY (title V & XIX only) 0 0 0.00	5.00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	0 0	42.00
43.00	INTENSIVE CARE UNIT 2,744,755 862 3,184.17 2	89, 157	43. 00
44. 00		0	44. 00
45. 00 46. 00		0 0	45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)		47. 00
	Cost Center Description	1.00	
48. 00	Program inpatient ancillary service cost (Wkst. D-3, col. 3, line 200)	271, 087	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions) PASS THROUGH COST ADJUSTMENTS	543, 454	49. 00
50. 00	Pass through costs applicable to Program inpatient routine services (from Wkst. D, sum of Parts I an III)	d 0	50.00
51. 00	Pass through costs applicable to Program inpatient ancillary services (from Wkst. D, sum of Parts II and IV)	0	51. 00
52. 00	Total Program excludable cost (sum of lines 50 and 51)	0	
53. 00	Total Program inpatient operating cost excluding capital related, non-physician anesthetist, and medical education costs (line 49 minus line 52)	0	53. 00
E4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges	0	54.00
55. 00		0.00	1
56.00	Target amount (line 54 x line 55)	0	56. 00
57. 00		0	
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by th	e 0.00	58. 00 59. 00
(0.00	market basket	0.00	
60. 00 61. 00		0.00	60. 00 61. 00
01.00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target		000
(2.00	amount (line 56), otherwise enter zero (see instructions)		(2.00
62. 00 63. 00		0	
	PROGRAM INPATIENT ROUTINE SWING BED COST	1 0	
64. 00	instructions)(title XVIII only)		
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)	0	
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For CAH (see instructions)	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period (line 12 x line 19)	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68) PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY	0	69. 00
70. 00	Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)		70. 00
71.00	Adjusted general inpatient routine service cost per diem (line 70 ÷ line 2)		71.00
72. 00 73. 00	Program routine service cost (line 9 x line 71) Medically necessary private room cost applicable to Program (line 14 x line 35)		72. 00 73. 00
74. 00	Total Program general inpatient routine service costs (line 72 + line 73)		74.00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ line 2)		76. 00
77. 00 78. 00	Program capital -related costs (line 9 x line 76)		77. 00 78. 00
79. 00	Inpatient routine service cost (line 74 minus line 77) Aggregate charges to beneficiaries for excess costs (from provider records)		79.00
80.00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)		80. 00
81.00	Inpatient routine service cost per diem limitation		81.00
82. 00 83. 00	Inpatient routine service cost limitation (line 9 x line 81) Reasonable inpatient routine service costs (see instructions)		82. 00 83. 00
84. 00	Program inpatient ancillary services (see instructions)		84. 00
85.00	Utilization review - physician compensation (see instructions)		85. 00
86. 00	Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST		86. 00
87. 00	Total observation bed days (see instructions)	883	1
88. 00 89. 00	Adjusted general inpatient routine cost per diem (line 27 ÷ line 2) Observation bed cost (line 87 x line 88) (see instructions)	1, 635. 80 1, 444, 411	
57.00	1 2000 Table St. Sour Court (Title Of A Title Oo) (300 That deliver)	1, 777, 711	1 57.00

Health Financial Systems IND	IANA UNIVERSIT	Y HEALTH BEDFOR	!D	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period: From 01/01/2015	Worksheet D-1	
				Γο 12/31/2015	Date/Time Pre 5/27/2016 1:5	
		Ti t	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (COST					
90.00 Capital -related cost	344, 264	6, 377, 976	0. 05397	7 1, 444, 411	77, 965	90. 00
91.00 Nursing School cost	0	6, 377, 976	0.00000	1, 444, 411	0	91.00
92.00 Allied health cost	0	6, 377, 976	0.00000	1, 444, 411	0	92. 00
93.00 All other Medical Education	0	6, 377, 976	0.00000	1, 444, 411	0	93. 00

Health Financial Systems INDIANA UNIVERSITY HEAL	TH BEDFO	RD	In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151328	Peri od:	Worksheet D-3	
			From 01/01/2015		
			To 12/31/2015		
	T' 11	207111		5/27/2016 1:5	/ pm
	11 11	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			2, 938, 866		30. 00
31.00 03100 INTENSIVE CARE UNIT			1, 979, 590		31.00
32. 00 03200 CORONARY CARE UNIT			0		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT			0		34.00
40. 00 04000 SUBPROVI DER - 1 PF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1932	738, 300	142, 669	50.00
51.00 05100 RECOVERY ROOM		0. 0841			1
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 00000		l o	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17133			1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 00000		0	55.00
56. 00 05600 RADI 0I SOTOPE		0. 24694			
57. 00 05700 CT SCAN		0. 00000		0	57.00
				0	58.00
58. 00 05800 MAGNETI C RESONANCE I MAGING (MRI)		0.00000			
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59. 00
60. 00 06000 LABORATORY		0. 17566			1
60. 01 06001 BLOOD LABORATORY		0.00000		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0. 00000		0	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0. 00000		0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0.00000		0	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 5027		129, 392	
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000	00	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0.00000	00	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 29260	964, 972	282, 354	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 11604	404, 758	46, 969	71.00
72.00 07200 MPL. DEV. CHARGED TO PATIENT		0. 91564	3, 874	3, 547	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 32712	22 3, 258, 066	1, 065, 785	73. 00
74. 00 07400 RENAL DI ALYSI S		0.00000	00	0	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)		0.00000	00 0	0	75. 00
76. 97 O7697 CARDÍ AC REHABI LI TATI ON		0. 3356		0	76. 97
OUTPATIENT SERVICE COST CENTERS				•	
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0.00000		0	
90. 00 09000 CLI NI C		0.00000		0	
90. 01 09001 CLINIC - DIABETES		5. 8118		0	90. 01
91. 00 09100 EMERGENCY		0. 26978			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 33920			
OTHER REIMBURSABLE COST CENTERS		0.0072	0,2.2	., 0,0	72.00
94. 00 09400 HOME PROGRAM DI ALYSI S		0.00000	00	0	94. 00
95. 00 09500 AMBULANCE SERVI CES		0.00000	0	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0. 00000	0	0	
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED		0.00000		0	97.00
		0.00000		-	
	ino (1)		8, 762, 802	2, 217, 909	1
	THE OI)		9 762 902		201. 00 202. 00
202.00 Net Charges (line 200 minus line 201)		1	8, 762, 802	I	1202.00

	nanciai systems Indiana university heal				eu of Form CMS	
I NPATI ENT	ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	
		0		From 01/01/2015		
		componen	t CCN: 15Z328	Го 12/31/2015		
		T: +1	o VVIIII C	wing Dodo CNI	5/27/2016 1:5	/ piii
	Cook Cooker Doorwinking	11 (1		Swing Beds - SNF	*	
	Cost Center Description		Ratio of Cost		Inpatient	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1. 00	2. 00	3. 00	
I NF	PATIENT ROUTINE SERVICE COST CENTERS					
30.00 030	DOO ADULTS & PEDIATRICS			0		30.00
31. 00 031	100 INTENSIVE CARE UNIT			0		31.00
1	200 CORONARY CARE UNIT			0		32. 00
1	BOO BURN INTENSIVE CARE UNIT			0		33. 00
1	400 SURGI CAL INTENSI VE CARE UNI T					34. 00
1	OOO SUBPROVI DER - I PF					40. 00
4						1
	100 SUBPROVI DER - I RF			0		41.00
	200 SUBPROVI DER			Ü		42. 00
	800 NURSERY					43. 00
	CILLARY SERVICE COST CENTERS					1
50.00 050	OOO OPERATING ROOM		0. 193240	7, 620	1, 472	50. 00
51.00 051	100 RECOVERY ROOM		0. 084112	2 0	0	51.00
52. 00 052	200 DELIVERY ROOM & LABOR ROOM		0.000000	0	0	52. 00
53. 00 053	BOO ANESTHESI OLOGY		0.000000	0	0	53. 00
	100 RADI OLOGY-DI AGNOSTI C		0. 171333		4, 381	54.00
	500 RADI OLOGY-THERAPEUTI C		0. 000000		0	55. 00
	600 RADI OLSOTOPE		0. 246942		0	56. 00
			1			1
1	700 CT SCAN		0.000000		0	57. 00
1	BOO MAGNETIC RESONANCE IMAGING (MRI)		0.000000		0	58. 00
59. 00 059	900 CARDI AC CATHETERI ZATI ON		0.000000	0	0	59. 00
60.00 060	DOO LABORATORY		0. 175660	130, 557	22, 934	60.00
60. 01 060	001 BLOOD LABORATORY		0.000000	0	0	60. 01
61. 00 061	100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.000000	0	0	61. 00
62. 00 062	200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.000000		0	62. 00
1	BOO BLOOD STORING, PROCESSING & TRANS.		0. 000000		Ō	63. 00
4	100 I NTRAVENOUS THERAPY		0. 000000		o o	64. 00
1	500 RESPI RATORY THERAPY		0. 000000		ő	65. 00
1			1			1
1	500 PHYSI CAL THERAPY		0. 502759			1
1	700 OCCUPATI ONAL THERAPY		0. 000000		0	67.00
	BOO SPEECH PATHOLOGY		0.000000		0	68. 00
	900 ELECTROCARDI OLOGY		0. 292603		12, 282	
	DOO ELECTROENCEPHALOGRAPHY		0.000000	0	0	70. 00
71.00 071	100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 116042	10, 320	1, 198	71.00
72. 00 072	200 IMPL. DEV. CHARGED TO PATIENT		0. 91564!	5 0	0	72. 00
	BOO DRUGS CHARGED TO PATIENTS		0. 327122	2 355, 709	116, 360	73. 00
	100 RENAL DIALYSIS		0. 000000		0	74. 00
1	500 ASC (NON-DISTINCT PART)		0. 000000			75. 00
1	597 CARDI AC REHABI LI TATI ON		0. 335656			76. 97
			0. 333030	J 0	0	70. 77
	PATIENT SERVICE COST CENTERS		1 0 00000		1 0	00.00
	BOO RURAL HEALTH CLINIC		0. 000000		0	88. 00
	900 FEDERALLY QUALIFIED HEALTH CENTER		0. 000000		0	
	DOO CLI NI C		0.000000	0	0	
90. 01 090	DO1 CLINIC - DIABETES		5. 811853	3 0	0	90. 01
91.00 091	100 EMERGENCY		0. 269786	5 0	0	91.00
92. 00 092	200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 339200	0	0	92. 00
	HER REIMBURSABLE COST CENTERS			•	•	1
	400 HOME PROGRAM DIALYSIS		0.000000	0	0	94. 00
	500 AMBULANCE SERVICES		3.000000			95. 00
4			0.00000		0	
	500 DURABLE MEDICAL EQUIP-RENTED		0.000000			96.00
	700 DURABLE MEDICAL EQUIP-SOLD		0.000000		0	97. 00
200.00	Total (sum of lines 50-94 and 96-98)			654, 212	200, 085	
201.00	Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		0		201. 00
202.00	Net Charges (line 200 minus line 201)			654, 212		202. 00

Health Financial Systems INDIANA UNIVERSITY HEAL	TH BEDFO	RD	In Lie	eu of Form CMS-	2552-10
	Provi der	CCN: 151328	Peri od:	Worksheet D-3	
			From 01/01/2015		
			To 12/31/2015		
	-			5/27/2016 1:5	/ pm
	111	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2. 00	3. 00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS			224, 085		30. 00
31.00 03100 INTENSIVE CARE UNIT			105, 022		31.00
32. 00 03200 CORONARY CARE UNIT			0		32. 00
33.00 03300 BURN INTENSIVE CARE UNIT			0		33. 00
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT			0		34.00
40. 00 04000 SUBPROVI DER - I PF			0		40.00
41. 00 04100 SUBPROVI DER - I RF			0		41.00
42. 00 04200 SUBPROVI DER			0		42.00
43. 00 04300 NURSERY			0		43. 00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATI NG ROOM		0. 1932	97, 764	18, 892	50.00
51. 00 05100 RECOVERY ROOM		0. 0841			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM		0.00000		0	52.00
53. 00 05300 ANESTHESI OLOGY		0. 00000		l o	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 17133			1
55. 00 05500 RADI OLOGY-THERAPEUTI C		0. 00000		0	55.00
56. 00 05600 RADI OI SOTOPE		0. 24694		2, 875	
57. 00 05700 CT SCAN		0. 00000	· ·	2,073	57.00
					58.00
		0.00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.00000		0	59. 00
60. 00 06000 LABORATORY		0. 17566			1
60. 01 06001 BLOOD LABORATORY		0.00000		0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		0	61. 00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.00000		0	62. 00
63.00 O6300 BLOOD STORING, PROCESSING & TRANS.		0.00000		0	63. 00
64. 00 06400 I NTRAVENOUS THERAPY		0.00000	00	0	64. 00
65. 00 06500 RESPI RATORY THERAPY		0.00000	00	0	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 5027	6, 457	3, 246	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		0.00000	00	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		0.00000	00	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 29260	3 84, 044	24, 592	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		0.00000	00	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 11604	12 54, 175	6, 287	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 91564	15 2, 827	2, 589	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 32712			73.00
74. 00 07400 RENAL DI ALYSI S		0.00000		0	74. 00
75. 00 O7500 ASC (NON-DISTINCT PART)		0. 00000			75. 00
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 33565			76. 97
OUTPATIENT SERVICE COST CENTERS		0.0000	,0 0		70.77
88. 00 08800 RURAL HEALTH CLINIC		0.00000	00 0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000			
90. 00 09000 CLI NI C		0. 00000		0	
90. 01 09001 CLI NI C - DI ABETES		5. 8118		Ö	90. 01
91. 00 09100 EMERGENCY		0. 26978			
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 33920	· ·		
· · · · · · · · · · · · · · · · · · ·		0. 33920	2, 904	1,005	92.00
OTHER REIMBURSABLE COST CENTERS		0.0000	20		04.00
94. 00 09400 HOME PROGRAM DIALYSIS 95. 00 09500 AMBULANCE SERVICES		0. 00000	00 0	0	94. 00 95. 00
		0.0000	20		
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED		0.00000		0	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD		0.00000		0	97. 00
200.00 Total (sum of lines 50-94 and 96-98)			1, 131, 750	271, 087	
201.00 Less PBP Clinic Laboratory Services-Program only charges (I	ıne 61)		0		201. 00
202.00 Net Charges (line 200 minus line 201)		1	1, 131, 750	l	202. 00

Health Financial Systems	INDIANA UNIVERSITY HEA	LTH BEDFORD	In Lie	u of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provider CCN: 151328	Peri od:	Worksheet D_3

From 01/01/2015 То Component CCN: 15Z328 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm Title XIX Swing Beds - SNF Cost Inpatient Cost Center Description Ratio of Cost Inpati ent To Charges Program Program Costs (col. 1 x col Charges 2) 1.00 2.00 3.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 30.00 0 0 0 0 0 0 0 03100 INTENSIVE CARE UNIT 31.00 31 00 32.00 03200 CORONARY CARE UNIT 32.00 03300 BURN INTENSIVE CARE UNIT 33.00 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34.00 34.00 40.00 04000 SUBPROVI DER - I PF 40.00 41.00 04100 SUBPROVIDER - IRF 41.00 42.00 04200 SUBPROVI DER 42.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 193240 50.00 51.00 05100 RECOVERY ROOM 0.084112 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0.000000 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0.171333 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 55 00 0 55 00 56.00 05600 RADI OI SOTOPE 0. 246942 0 56.00 57.00 05700 CT SCAN 0.000000 0 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0.000000 58.00 0 05900 CARDIAC CATHETERIZATION 59 00 0.000000 59 00 0 60.00 06000 LABORATORY 0.175660 0 60.00 60.01 06001 BLOOD LABORATORY 0.000000 60.01 61 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 61 00 0 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 62.00 0.000000 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0.000000 0 63.00 63.00 64.00 06400 INTRAVENOUS THERAPY 0.000000 0 64.00 06500 RESPIRATORY THERAPY 65 00 0.000000 65 00 0 66.00 06600 PHYSI CAL THERAPY 0.502759 0 66.00 06700 OCCUPATIONAL THERAPY 0.000000 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 06900 ELECTROCARDI OLOGY 69 00 0.292603 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0.000000 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0.116042 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0.915645 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 0.327122 0 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 75.00 07697 CARDIAC REHABILITATION 0 76.97 0.335656 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 09000 CLI NI C 90.00 90.00 0.000000 0 09001 CLINIC - DIABETES 0 90.01 5.811853 0 90.01 91.00 09100 EMERGENCY 0.269786 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.339200 0 0 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0.000000 0 94.00 94.00 0 09500 AMBULANCE SERVICES 95.00 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 0.000000 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0.000000 0 97.00 200.00 Total (sum of lines 50-94 and 96-98) 0 200.00 0 Less PBP Clinic Laboratory Services-Program only charges (line 61) 201.00 201.00 Net Charges (line 200 minus line 201) 202.00

202.00

Health Financial Systems	INDIANA UNIVERSITY HEALTH BEDFORD	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15132	From 01/01/2015	Worksheet E Part B Date/Time Prepared: 5/27/2016 1:57 pm

			To 12/31/2015	Date/Time Pre 5/27/2016 1:5	
		Title XVIII	Hospi tal	Cost	<u>, Ми</u>
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1. 00	Medical and other services (see instructions)			10, 042, 085	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	ons)		0	2. 00
3.00	PPS payments			0	3. 00
4.00	Outlier payment (see instructions)			0	4. 00
5.00	Enter the hospital specific payment to cost ratio (see instruct	i ons)		0.000	5.00
6. 00 7. 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0. 00	6. 00 7. 00
8.00	Transitional corridor payment (see instructions)			0.00	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 acqui si ti ons			0	10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			10, 042, 085	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges		T	0	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Iin	e 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	0 0.7		0	
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pa				15. 00
16. 00	Amounts that would have been realized from patients liable for		n a chargebasis	0	16. 00
17. 00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0.000000	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	if line 18 exceeds li	ne 11) (see	0	19. 00
	instructions)				
20. 00	Excess of reasonable cost over customary charges (complete only	if line 11 exceeds li	ne 18) (see	0	20. 00
21. 00	<pre>instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see</pre>	instructions)		10, 142, 506	21. 00
22. 00	Interns and residents (see instructions)	riisti deti olis)		0 10, 142, 300	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)			0	24. 00
05.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		T	FO 04.4	05.00
25. 00 26. 00	Deductibles and coinsurance (for CAH, see instructions) Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions)		58, 014 6, 770, 073	
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			3, 314, 419	
	instructions)		, ,		
28. 00	Direct graduate medical education payments (from Wkst. E-4, lin	e 50)		0	
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
30. 00 31. 00	Subtotal (sum of lines 27 through 29) Primary payer payments			3, 314, 419 706	
32. 00	Subtotal (line 30 minus line 31)			3, 313, 713	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	S)			
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	
34. 00	Allowable bad debts (see instructions)			560, 086	
35. 00 36. 00	Adjusted reimbursable bad debts (see instructions) Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		364, 056 488, 384	
	Subtotal (see instructions)	eti olis)		3, 677, 769	
	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)			0	39. 50
39. 98	Partial or full credits received from manufacturers for replace	d devices (see instruc	tions)	0	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			2 477 740	39. 99 40. 00
40. 00 40. 01	Sequestration adjustment (see instructions)			3, 677, 769 73, 555	
41. 00	Interim payments			2, 988, 522	
42.00	Tentative settlement (for contractors use only)			0	1
43.00	Balance due provider/program (see instructions)			615, 692	43. 00
44. 00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90. 00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00	The rate used to calculate the Time Value of Money				92.00
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)		ļ	0	94. 00

(Mo/Day/Yr)

2 00

8.00

Number

1 00

0

Peri od:

Provider CCN: 151328 Worksheet E-1 From 01/01/2015 Part I 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm Title XVIII Hospi tal Cost Inpatient Part A Part B mm/dd/yyyy mm/dd/yyyy Amount Amount 1.00 2.00 3.00 4.00 1.00 Total interim payments paid to provider 5, 673, 978 2, 988, 522 1. 00 2.00 Interim payments payable on individual bills, either 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 3.01 ADJUSTMENTS TO PROVIDER 0 0 3.01 0 3.02 0 3.02 3.03 0 3.03 0 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 3.51 0 0 3.52 3.52 0 3.53 3.53 0 0 3.54 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 Ω 3.99 3.50-3.98) 5, 673, 978 2, 988, 522 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropri ate) TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after 5.00 desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 0 0 5.01 5.02 0 0 5.02 0 5.03 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 0 0 5.50 5.51 0 0 5. 51 0 5.52 0 5.52 5. 99 0 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 5.99 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) SETTLEMENT TO PROVIDER 6.01 992, 893 615, 692 6.01 6 02 SETTLEMENT TO PROGRAM 6.02 7.00 Total Medicare program liability (see instructions) 6, 666, 871 3, 604, 214 7.00 Contractor NPR Date

8.00 Name of Contractor

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 ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED

Inpatient Part A						5/27/2016 1:5	7 pm
1.00							
1.00 Total interim payments paid to provider 1.00 2.00 3.00 4.00 1.00			Inpatien	t Part A	Par	t B	
1.00 Total interim payments paid to provider 2.00 Interim payments paid to provider 3.00							
InterIm payments payable on Individual Bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero.			1. 00				
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 sech retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 3.01 3.02 0							1. 00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero the interim rate for the Cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)	2. 00			(O .	0	2. 00
### WORLE OF enter a zero 1.							
List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider ADJUSTMENTS TO PROVIDER 3.01 3.02 3.03 3.04 3.05 3.05 3.06 3.07 3.07 3.08 3.09 3.09 3.09 3.09 3.00 3.00 3.00 3.00	2 00						2 00
For the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	3.00						3.00
Bayment. If none, write "NONE" or enter a zero. (1) Program to Provider		for the cost reporting period. Also show date of each					
Program to Provider ADJUSTMENTS TO PROVIDER 0 0 0 3.0 3.0 3.0 3.0 3.0 3.0 3.0 4							
3.02 0							
3.04 0	3.01	ADJUSTMENTS TO PROVIDER		(D	0	3. 01
3.05	3.02			(D	0	3. 02
3.50	3.03			(D	0	3. 03
Provider to Program ADJUSTMENTS TO PROGRAM O O 3.5							3. 04
3.50 ADJUSTMENTS TO PROGRAM	3. 05			(0	3. 05
3.51 3.52 3.53 0 0 0 3.5 3.53 0 0 0 3.5 3.53 0 0 0 3.5 3.54 0 0 0 3.5 3.55 0 0 0 3.5 3.57 3.59 3.50-3.98 4.00 Total interim payments (sum of lines 1, 2, and 3.99)					-1	_	
3.52 3.53 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.50,018 0.0 3.50-3.98) 4.00 Total interim payments (sum of lines 1, 2, and 3.99) 4.50,018 0.0 4.0		ADJUSTMENTS TO PROGRAM					3. 50
3.53 3.54 0 0 0 3.5						-	
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 465,018 0 3.5 3.50-3.98) 400 Total interim payments (sum of lines 1, 2, and 3.99) 465,018 0 4.0 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)							
3.50-3.98 Total Interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR		Subtotal (sum of lines 3 01-3 40 minus sum of lines					3. 99
4.00 Total interim payments (sum of lines 1, 2, and 3.99) 465,018 0 4.00 (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	3. 77			,			J. 77
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR	4.00			465, 018	3	0	4.00
TO BE COMPLETED BY CONTRACTOR		(transfer to Wkst. E or Wkst. E-3, line and column as					
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					_		
Write "NONE" or enter a zero. (1) Program to Provider	5.00						5. 00
Program to Provider							
TENTATI VE TO PROVIDER							
5. 02	E 01				7		E 01
Description		TENTATIVE TO PROVIDER					5. 01
Provider to Program							5. 02
TENTATI VE TO PROGRAM 0	0.00	Provider to Program			21	0	0.00
5. 52 0 0 5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 145, 516 0 6. 00 6. 02 SETTLEMENT TO PROGRAM 0 0 0 7. 00 Total Medicare program liability (see instructions) 610, 534 0 7. 00 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	5. 50			(0	5. 50
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 145, 516 0 6. 0 6. 02 SETTLEMENT TO PROGRAM 0 0 6. 0 7. 00 Total Medicare program liability (see instructions) 610, 534 0 7. 0 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00	5. 51			(0	5. 51
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00	5. 52			(0	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		()	0	5. 99
the cost report. (1) SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) 145, 516 0 6. 0 0 7. 0 Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00							
6. 01 SETTLEMENT TO PROVIDER 6. 02 SETTLEMENT TO PROGRAM 7. 00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1. 00 2. 00	6.00						6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions) Contractor Number (Mo/Day/Yr) 0 1.00 2.00	. 01			145 54			/ 01
7.00 Total Medicare program Liability (see instructions) 610,534 0 7.00 Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00				·		_	6. 01
Contractor NPR Date (Mo/Day/Yr) 0 1.00 2.00							6. 02
Number (Mo/Day/Yr) 0 1.00 2.00	7.00	Total Medicare program Hability (see Instructions)		610, 534			7.00
0 1.00 2.00							
			()			
	8. 00	Name of Contractor					8. 00

Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD In Lieu					2552-10	
CALCUL	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT Provider CCN: 151328 Period:					
			From 01/01/2015			
			To 12/31/2015	Date/Time Prep 5/27/2016 1:5		
		Title XVIII	Hospi tal	Cost	/ рііі	
		THE XVIII	1103pi tai	0031		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS			1.00		
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION					
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3 Pt L col 15 Line	14	1, 031	1. 00	
2. 00					2. 00	
3.00					3. 00	
4. 00					4. 00	
5. 00						
6. 00	Total hospital charity care charges from Wkst. S-10, col. 3 lin	ne 20		154, 648, 970 3, 284, 180		
7. 00	CAH only - The reasonable cost incurred for the purchase of cer		Wkst. S-2. Pt. I	0	7. 00	
	line 168			-		
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	200 Ralance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions)					

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

0 30.00 0 31.00 0 32.00

Health Financial Systems	INDIANA UNIVERSITY HEA	LTH BEDFORD		In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWING BEDS	Provi der CCN	: 151328		Worksheet E-2
				From 01/01/2015	
		Component CC	N: 15Z328	To 12/31/2015	Date/Time Prepared:
		· ·			5/27/2016 1:57 pm

		'		5/27/2016 1:5	, 7 pm
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		427, 208	0	1. 00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		202, 086	0	3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst				
4.00	Per diem cost for interns and residents not in approved teaching	g program (see		0.00	4. 00
	instructions)				
5.00	Program days		259	0	5. 00
6.00	Interns and residents not in approved teaching program (see ins			0	1 0.00
7.00	Utilization review - physician compensation - SNF optional method	od only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		629, 294	0	
9.00	Primary payer payments (see instructions)		0	0	
10.00	Subtotal (line 8 minus line 9)		629, 294	0	
11. 00	Deductibles billed to program patients (exclude amounts applical	ole to physician	0	0	11. 00
	professional services)				
12.00	Subtotal (line 10 minus line 11)		629, 294	0	
13.00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	6, 300	0	13. 00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 14))	622, 994	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	1
	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0	0	
	Adjusted reimbursable bad debts (see instructions)		0	0	1
18. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)	0	0	18. 00
19.00	Total (see instructions)		622, 994	0	19. 00
19. 01	Sequestration adjustment (see instructions)		12, 460	0	19. 01
	Interim payments		465, 018	0	20. 00
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, and	d 21)	145, 516	0	22. 00
23.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	0	0	23. 00
	chapter 1, §115.2				

Health Financial Systems	INDIANA UNIVERSITY HE	ALTH BEDFORD	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	- SWING BEDS	Provi der CCN: 151328	Peri od: From 01/01/2015	Worksheet E-2
		Component CCN: 15Z328	To 12/31/2015	Date/Time Prepared: 5/27/2016 1:57 pm

		Compensary Colv. 102020	10 12/01/2010	5/27/2016 1:5	
		Title XIX	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		0		1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)		0		2. 00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		0		3. 00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst				
4.00	Per diem cost for interns and residents not in approved teachin	g program (see	0.00		4. 00
	instructions)				
5.00	Program days		0		5. 00
6.00	Interns and residents not in approved teaching program (see ins		0		6. 00
7.00	Utilization review - physician compensation - SNF optional meth	od only	0		7. 00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		0		8. 00
9.00	Primary payer payments (see instructions)		0		9. 00
10. 00	Subtotal (line 8 minus line 9)		0		10. 00
11. 00	Deductibles billed to program patients (exclude amounts applica	ble to physician	0		11. 00
	professional services)		_		
	Subtotal (line 10 minus line 11)		0		12. 00
13. 00	Coinsurance billed to program patients (from provider records) for physician professional services)	(excl ude coi nsurance	0		13. 00
14 00	80% of Part B costs (line 12 x 80%)		0		14.00
	Subtotal (enter the lesser of line 12 minus line 13, or line 14)			15.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,			16.00
	Pioneer ACO demonstration payment adjustment (see instructions)				16. 50
	410A RURAL DEMONSTRATION PROJECT				16. 55
	Allowable bad debts (see instructions)		0		17. 00
	Adjusted reimbursable bad debts (see instructions)		0		17. 01
	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)	0		18. 00
	Total (see instructions)	01.0.0)	0		19. 00
	Sequestration adjustment (see instructions)		0		19. 01
	Interim payments		0		20.00
	Tentative settlement (for contractor use only)		0		21.00
	Balance due provider/program (line 19 minus lines 19.01, 20, an	d 21)			22. 00
	Protested amounts (nonallowable cost report items) in accordance				23. 00
20.00	chapter 1, §115.2	S			

Health Financial Systems	INDIANA UNIVERSITY HEA	LTH BEDFORD	In Lie	u of Form CMS-2	2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 151328	Peri od: From 01/01/2015 To 12/31/2015	Worksheet E-3 Part V Date/Time Prep 5/27/2016 1:5	pared:
		Title XVIII	Hospi tal	Cost	
				1. 00	

PART V - CALCULATION OF REINBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REINBURSEMENT 1.00					5/27/2016 1:5	/ pm
PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT			Title XVIII	Hospi tal	Cost	
PART V - CALCILATION OF BELINBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT						
PART V - CALCULATION OF BELIMBURSEMENT SETTLEMENT FOR MEDICARE PART A SERVICES - COST REIMBURSEMENT					1 00	
Inpatient services		DART V - CALCULATION OF DELMBURGEMENT SETTLEMENT FOR MEDICARE D	ADT A SERVICES - COST	DEL MRI IDSEMENT	1.00	
2.00	1 00		ANT A SERVICES - COST	KETWIDOKSEWENT	7 227 470	1 00
Organ acquisition 0 3.00			-)			
3.00 Subtotal 'sum of lines 1 through 3 7, 237, 478 4, 0.0 0.0			5)		-	
Primary payer payments					•	0.00
Consideration of Lasser of Cost of Charges Computation of Lasser of Cost of Charges Computation of Lasser of Cost of Charges Cost						
COMPUTATION OF LISSER OF COST OR CHARGES Reasonable charges Reasonable charges Routine service charges 0					ŭ	
Reasonable charges 0	6.00				7, 309, 853	6. 00
Routine service charges		COMPUTATION OF LESSER OF COST OR CHARGES				
Ancillary service charges 0 8.00 9.00 10.00 10.00 10.10		Reasonable charges				
Ancillary service charges 0 8. 00 9. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 00 10. 10. 00 10.	7.00	Routine service charges			0	7. 00
0.00					0	
10. 00 Total reasonable charges 0 10. 00 Customary charges 0 10. 00 Customary charges 0 11. 00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 11. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 12. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 12. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 12. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 12. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 12. 00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 12. 00 13. 00 14. 00 15. 0					-	
Customary charges Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 11.00 12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 12.00 13.00 Ratio of line 11 to line 12 (not to exceed 1.000000) 0.000000 13.00 14.00 Total customary charges (see instructions) 0.014.00 15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see 0.015.00 instructions) 0.000000 16.00 Excess of customary charges over reasonable cost (complete only if line 6 exceeds line 14) (see 0.00000) 16.00 Excess of customary charges over reasonable cost (complete only if line 6 exceeds line 14) (see 0.00000) 16.00 Excess of creasonable cost over customary charges (complete only if line 6 exceeds line 14) (see 0.00000) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see 0.00000) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see 0.00000) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see 0.00000) 16.00 Excess of reasonable reasonable services (sum of lines 6, 17 and 18) 17.00 Excess of reasonable reas					- 1	
11.00 Aggregate amount actually collected from patients liable for payment for services on a charge basis 0 12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis 0 12.00 had such payment been made in accordance with 42 CFR 413.13(e) 12.00 Ratio of line 11 to line 12 (not to exceed 1.000000) 0.000000 13.00 15.00 Excess of customary charges (see instructions) 0.14.00 Total customary charges (see instructions) 0.15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 15.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Excess reasonable cost (physicians' services (sum of lines 6, 17 and 18) 17.00 Excess reasonable cost (sex lude professional component) 18.00 Excess reasonable cost (from line 16) 18.00 Excess reasonable cost (from line 16) 18.00 Excess reasonable cost (from line 16) 18.00 Excess reasonable cost (from line 20 and 21) 18.00 Excess reasonable cost (from line 20 and 21) 18.00 Excess reasonable cost (from line 20 and 21) 18.00 Excess reasonable cost (from line 20 and 21) 18.00 Excess reasonable cost (from line 20 and 21) 18.00 Excess reasonable cost (from line 20 and 21) 18.00 Excess reasonable cost (from line 20 and 21) 18.00 Excess reasonable cost (from line 20 and 21) 18.00 Excess reasonable cost (from line 20 and 21) 18.00 Excess reasonable cost (from line 20 and 21) 18.00 Excess reasonable cost (from line 20 and 21) 18.00 Excess reasonable cost (from line 20 and 2	10.00				U	10.00
12.00 Amounts that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordance with 42 CFR 413.13(e) 0.000000 13.00 14.00 15.00 16.00 16.00 16.00 17	11 00				0	11 00
had such payment been made in accordance with 42 CFR 413.13(e) Ratio of line 11 to line 12 (not to exceed 1.000000) 13.00 14.00 15.00 Excess of customary charges (see instructions) 0.14.00 15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 15.00 1						
13. 00	12.00		payment for services o	n a charge basis	0	12.00
14.00 Total customary charges (see instructions) 15.00 Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Excess of physicians' services in a teaching hospital (see instructions) 18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 20.00 Deductibles (exclude professional component) 21.00 Excess reasonable cost (from line 16) 22.00 Subtotal (line 19 minus line 20 and 21) 23.00 Coinsurance 24.00 Subtotal (line 22 minus line 23) 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 27.00 Allowable bad debts (exclude bad debts (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 30.01 Sequestration adjustment (see instructions) 30.02 Subtotal (see instructions) 30.03 Subtotal (see instructions) 30.04 Subtotal (see instructions) 30.05 Context (see instructions) 30.06 Subtotal (sum of lines 24 and 25, or line 26) 30.00 Subtotal (sum of lines 26) 30.00 Subtotal (sum of lines 26) 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (for contractor use only) 30.02 Fortested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see instructions) 16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see instructions) 17.00 Cost of physicians' services in a teaching hospital (see instructions) 18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 19.00 Cost of covered services (sum of lines 6, 17 and 18) 20.00 Deductibles (exclude professional component) 10.00 Excess reasonable cost (from line 16) 10.00 Excess reasonable cost (from line 16) 10.00 Excess reasonable cost (from line 20 and 21) 10.00 Coinsurance 10.00 Subtotal (line 22 minus line 23) 10.01 Allowable bad debts (exclude bad debts for professional services) (see instructions) 10.00 Adjusted reimbursable bad debts (see instructions) 10.01 Allowable bad debts for dual eligible beneficiaries (see instructions) 10.01 Excess reasonable cost (from line 23) 10.02 Coinsurance 10.03 Coinsurance 10.04 Oxide (see instructions) 10.05 Cost of covered services) 10.06 Excess reasonable cost (from line 24) 10.07 Excess reasonable cost (from line 24) 10.08 Excess reasonable cost (from line 24) 10.09 Excess reasonable cost (from line 24) 11.00 Excess reasonable cost (from line 26) 12.00 Coinsurance 13.00 Excess reasonable cost (from line 20) 14.00 Oxide (see instructions) 15.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 10.00 Excess reasonable cost (from line 26) 12.00 Excess reasonable cost (from line 26) 13.00 Excess reasonable cost (from line 26) 14.00 Excess reasonable cost (from line 26) 15.00 Excess reasonable cost (from line 26) 16.00 Excess reasonable cost (from line 26) 18.00 Excess reaso		Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13. 00
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16.00 Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 14) (see 16.00 16.00 17	15.00	Excess of customary charges over reasonable cost (complete only	if line 14 exceeds li	ne 6) (see	0	15. 00
17.00		instructions)				
17. 00 Cost of physicians' services in a teaching hospital (see instructions) 0 17. 00 COMPUTATION OF REIMBURSEMENT SETTLEMENT 0 18. 00 19.	16.00	Excess of reasonable cost over customary charges (complete only	if line 6 exceeds lin	e 14) (see	0	16. 00
COMPUTATION OF REIMBURSEMENT SETTLEMENT		instructions)		, ,		
COMPUTATION OF REIMBURSEMENT SETTLEMENT	17.00	Cost of physicians' services in a teaching hospital (see instru	ctions)		0	17. 00
18.00 Direct graduate medical education payments (from Worksheet E-4, line 49) 0 18.00 19.00 Cost of covered services (sum of lines 6, 17 and 18) 7, 309, 853 19.00 20.00 Deductibles (exclude professional component) 531, 412 20.00 21.00 Excess reasonable cost (from line 16) 0 21.00 22.00 Subtotal (line 19 minus line 20 and 21) 6,778, 441 22.00 23.00 Coinsurance 630 23.00 24.00 Subtotal (line 22 minus line 23) 6,777, 811 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 38,644 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 25,119 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 32,286 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 6,802,930 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29.50 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 6,802,930 20.00 30.01 Sequestration adjustment (see instructions)			,			
19.00 Cost of covered services (sum of lines 6, 17 and 18) 20.00 Deductibles (exclude professional component) 21.00 Excess reasonable cost (from line 16) 22.00 Subtotal (line 19 minus line 20 and 21) 23.00 Coinsurance 24.00 Subtotal (line 22 minus line 23) 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 25.00 Allowable bad debts (exclude bad debts (see instructions) 27.00 Allowable bad debts (see instructions) 28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (see instructions) 30.00 Sequestration adjustment (see instructions) 30.01 Tontative settlement (for contractor use only) 30.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 31.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	18 00		line 49)		0	18 00
20. 00 Deductibles (exclude professional component) 21. 00 Excess reasonable cost (from line 16) 22. 00 Subtotal (line 19 minus line 20 and 21) 23. 00 Coinsurance 24. 00 Subtotal (line 22 minus line 23) 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 99 Pioneer ACO demonstration payment adjustment (see instructions) 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 30. 01 Sequestration adjustment (see instructions) 31. 00 Tentative settlement (for contractor use only) 32. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,			11116 17)		-	
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22. 00 Subtotal (line 19 minus line 20 and 21) 6,778,441 22. 00 23. 00 Coinsurance 630 23. 00 24. 00 Subtotal (line 22 minus line 23) 6,777,811 24. 00 25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 38,644 25. 00 26. 00 Adjusted reimbursable bad debts (see instructions) 25,119 26. 00 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 32,286 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 6,802,930 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 50 29. 50 Recovery of Accelerated Depreciation 0 29. 50 29. 99 Recovery of Accelerated Depreciation 0 29. 99 30. 01 Subtotal (see instructions) 6,802,930 30. 00 30. 01 Interim payments 5,673,978 31. 00 32. 00 Tentative settlement (for contractor use only) 992,893 33. 00 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34. 00						
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24.00 Subtotal (line 22 minus line 23) 6,777,811 24.00 25.00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 38,644 25.00 26.00 Adjusted reimbursable bad debts (see instructions) 25,119 26.00 27.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 32,286 27.00 28.00 Subtotal (sum of lines 24 and 25, or line 26) 6,802,930 28.00 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 029.00 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 029.50 29.99 Recovery of Accelerated Depreciation 029.99 30.00 Subtotal (see instructions) 6,802,930 30.00 31.00 Interim payments 136,059 30.01 32.00 Tentative settlement (for contractor use only) 5,673,978 10.00 33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 992,893 33.00 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 034.00						
25. 00 Allowable bad debts (exclude bad debts for professional services) (see instructions) 26. 00 Adjusted reimbursable bad debts (see instructions) 27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 29. 99 Recovery of Accelerated Depreciation 30. 01 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 31. 00 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,						
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27. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 32, 286 27. 00 28. 00 Subtotal (sum of lines 24 and 25, or line 26) 6, 802, 930 28. 00 29. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 0 29. 00 29. 50 Pioneer ACO demonstration payment adjustment (see instructions) 0 29. 50 29. 99 Recovery of Accelerated Depreciation 0 29. 99 30. 01 Subtotal (see instructions) 6, 802, 930 30. 00 30. 01 Interim payments 136, 059 30. 01 31. 00 Interim payments 5, 673, 978 31. 00 32. 00 Tentative settlement (for contractor use only) 0 32. 00 33. 00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 992, 893 33. 00 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34. 00	25. 00	Allowable bad debts (exclude bad debts for professional service	s) (see instructions)		38, 644	25. 00
28.00 Subtotal (sum of lines 24 and 25, or line 26) 29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pioneer ACO demonstration payment adjustment (see instructions) 29.99 Recovery of Accelerated Depreciation 30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 6, 802, 930 28.00 29.00 29.50 6, 802, 930 30.00 29.99 6, 802, 930 30.00 19.50 30.00 19	26.00	Adjusted reimbursable bad debts (see instructions)			25, 119	26. 00
29.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 29.50 Pi oneer ACO demonstration payment adjustment (see instructions) 29.99 Recovery of Accelerated Depreciation 30.01 Sequestration adjustment (see instructions) 31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 29.00 29.00 29.50 6,802,930 30.00 5,673,978 31.00 992,893 33.00 992,893 33.00	27.00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)		32, 286	27. 00
29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 99 Recovery of Accelerated Depreciation 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 31. 00 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 29. 50 0 29. 50 0 29. 50 0 29. 50 0 29. 99 6, 802, 930 30. 00 136, 059 30. 01 5, 673, 978 31. 00 992, 893 33. 00 34. 00	28.00	Subtotal (sum of lines 24 and 25, or line 26)			6, 802, 930	28. 00
29. 50 Pi oneer ACO demonstration payment adjustment (see instructions) 29. 99 Recovery of Accelerated Depreciation 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 31. 00 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 29. 50 0 29. 50 0 29. 50 0 29. 50 0 29. 99 6, 802, 930 30. 00 136, 059 30. 01 5, 673, 978 31. 00 992, 893 33. 00 34. 00	29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29. 00
29. 99 30. 00 Subtotal (see instructions) 30. 01 Sequestration adjustment (see instructions) 31. 00 Interim payments 32. 00 Tentative settlement (for contractor use only) 33. 00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34. 00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 29. 99 6, 802, 930 30. 00 136, 059 30. 01 5, 673, 978 31. 00 922, 893 33. 00 992, 893 33. 00		, , , ,			0	29 50
30.00 Subtotal (see instructions) 30.01 Sequestration adjustment (see instructions) 31.00 Interim payments Tentative settlement (for contractor use only) 32.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 6, 802, 930 30.00 136, 059 30.01 5, 673, 978 31.00 9 32.00 992, 893 33.00 992, 893 33.00					-	
30.01 Sequestration adjustment (see instructions) 31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 30.01 136,059 30.01 5,673,978 31.00 92.00 32.00 32.00 32.00 33.00 992,893 33.00					-	
31.00 Interim payments 32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 5,673,978 31.00 922,893 33.00 924,893 33.00						
32.00 Tentative settlement (for contractor use only) 33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00		, ,				
33.00 Balance due provider/program (line 30 minus lines 30.01, 31, and 32) 992,893 33.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00						
34.00 Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, 0 34.00						
			•			
§115. 2	34. 00		e with CMS Pub. 15-2,	chapter 1,	0	34. 00
		[9115. 2				

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

Provider CCN: 151328 | Period: From 01/01/201

				1270172010	5/27/2016 1:5	7 pm
		General Fund	Speci fi c	Endowment Fund	Plant Fund	
			Purpose Fund	2.22	4 00	
	AUDDENT AGGETS	1.00	2. 00	3. 00	4. 00	
1 00	CURRENT ASSETS	22 5/0 714			0	1 00
1.00	Cash on hand in banks	22, 569, 714) (0	1.00
2.00	Temporary investments	0		-		2.00
3.00	Notes recei vable	U F / 10 / 17	1	0	0	3.00
4.00	Accounts receivable	5, 619, 617		0	0	4.00
5.00	Other receivable	-771, 004		0	0	5.00
6.00	Allowances for uncollectible notes and accounts receivable	022 520		0	0	6.00
7.00	Inventory Prepaid expenses	832, 538		0	0	7.00
8. 00 9. 00	' '	181, 847		0	0	8.00
	Other current assets Due from other funds	0	1	1		9.00
10.00		0 422 712		-	0	10.00
11. 00	Total current assets (sum of lines 1-10)	28, 432, 712	! (0	0	11. 00
12.00	FI XED ASSETS	021 224	. (0		12.00
12.00	Land	931, 334			0	12.00
13.00	Land improvements Accumulated depreciation	1, 174, 400	1	-		13.00
14.00		-931, 535	1	-	0	14.00
15. 00	Buildings	14, 929, 250	1	-	0	15. 00 16. 00
16.00	Accumulated depreciation	-8, 884, 030	1	-	0	
17. 00	Leasehold improvements	3, 777, 030	1	1		17.00
18.00	Accumulated depreciation	-2, 512, 316		1	0	18.00
19. 00	Fixed equipment	1, 908, 867	1		0	19.00
20.00	Accumulated depreciation	-1, 829, 795	1		0	20.00
21. 00	Automobiles and trucks	0		-	0	21.00
22. 00	Accumulated depreciation	00.040.450		-	0	22.00
23. 00	Major movable equipment	20, 813, 658	1	0	0	23. 00
24. 00	Accumulated depreciation	-15, 268, 735		0	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0		0	0	25. 00
26. 00	Accumul ated depreciation	0		0	0	26. 00
27. 00	HIT designated Assets	0		0	0	27. 00
28. 00	Accumul ated depreciation	0)	1	0	28. 00
29. 00	Mi nor equi pment-nondepreci abl e	0)	-	0	29. 00
30. 00	Total fixed assets (sum of lines 12-29)	14, 108, 128	3 (0	0	30. 00
	OTHER ASSETS					
31. 00	Investments	3, 552, 909		-	-	31. 00
32. 00	Deposits on Leases	0)	-	0	32. 00
33. 00	Due from owners/officers	0) (0	0	33. 00
34.00	Other assets	15, 475	6	0	0	34.00
35. 00	Total other assets (sum of lines 31-34)	3, 568, 384	. (0	0	35. 00
36. 00	Total assets (sum of lines 11, 30, and 35)	46, 109, 224	. (0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	2, 471, 905		0		37. 00
38. 00	Salaries, wages, and fees payable	1, 130, 541		0	0	38. 00
39. 00	Payroll taxes payable	0) (0	0	39. 00
40.00	Notes and Loans payable (short term)	114, 001		0	0	40. 00
41. 00	Deferred income	0) (0	0	41. 00
42.00	Accel erated payments	0)			42. 00
43.00	Due to other funds	2, 961, 739) (0	0	43. 00
44.00	Other current liabilities	0) (0	0	44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	6, 678, 186		0	0	45. 00
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0) (0	0	46. 00
47.00	Notes payable	319, 445		0	0	47. 00
48.00	Unsecured Loans	0)	0	0	48. 00
49.00	Other long term liabilities	56, 846		0	0	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49	376, 291		0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	7, 054, 477	' (0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	39, 054, 747	'			52.00
53.00	Specific purpose fund					53. 00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57.00	Plant fund balance - invested in plant				0	57. 00
58.00	Plant fund balance - reserve for plant improvement,				0	58. 00
	repl acement, and expansion					
59.00	Total fund balances (sum of lines 52 thru 58)	39, 054, 747	' (0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	46, 109, 224	. (0	0	60.00
	[59]		[

In Lieu of Form CMS-2552-10 Health Financial Systems INDIANA UNIVERSITY HEALTH BEDFORD STATEMENT OF CHANGES IN FUND BALANCES Provi der CCN: 151328 Peri od: Worksheet G-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 1:57 pm General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 36, 943, 022 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 6, 484, 851 2.00 3.00 Total (sum of line 1 and line 2) 43, 427, 873 0 3.00 4.00 0 Additions (credit adjustments) (specify) 0 4.00 0 0 0 0 5.00 0 5.00 6.00 6.00 0 7.00 0 7.00 0 8.00 0 8.00 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 10.00 Subtotal (line 3 plus line 10) 43, 427, 873 11.00 0 11.00 INTERCO TRANSFER 12.00 4, 373, 126 0 12.00 13.00 13.00 14.00 0 14.00 0 0 0 0 15.00 0 15.00 16.00 0 16.00 17.00 17.00 4, 373, 126 18.00 Total deductions (sum of lines 12-17) 18.00 Fund balance at end of period per balance 19.00 39, 054, 747 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 Total (sum of line 1 and line 2) 3.00 0 0 3.00 4.00 Additions (credit adjustments) (specify) 4.00 5.00 0 5.00 0 6.00 6.00 7.00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 INTERCO TRANSFER 12.00

0

0

0

0

0

13.00

14.00

15.00

16.00

17.00

18.00

19.00

13.00 14.00

15.00

16.00

17.00

18.00

19.00

Total deductions (sum of lines 12-17)

sheet (line 11 minus line 18)

Fund balance at end of period per balance

39.00

40.00

41.00

42.00

43.00

In Lieu of Form CMS-2552-10 Health Financial Systems STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 151328 Peri od: Worksheet G-2 From 01/01/2015 Parts I & II Date/Time Prepared: 12/31/2015 5/27/2016 1:57 pm Cost Center Description Inpati ent Outpati ent Total 1.00 2. 00 3.00 PART I - PATIENT REVENUES General Inpatient Routine Services 1.00 Hospi tal 5, 552, 688 5, 552, 688 1.00 2.00 SUBPROVIDER - IPF 0 2.00 SUBPROVIDER - IRF 0 3.00 0 3 00 0 4.00 SUBPROVI DER 0 4.00 0 5.00 Swing bed - SNF 0 5.00 Swing bed - NF 6.00 0 0 6.00 SKILLED NURSING FACILITY 0 7.00 0 7.00 8.00 NURSING FACILITY 0 Ω 8.00 8.01 ICF/MR 0 0 8.01 9 00 OTHER LONG TERM CARE 0 9 00 0 Total general inpatient care services (sum of lines 1-9) 10.00 5, 552, 688 5, 552, 688 10.00 Intensive Care Type Inpatient Hospital Services 11.00 INTENSIVE CARE UNIT 3, 103, 839 3, 103, 839 11.00 CORONARY CARE UNIT 12 00 12 00 0 0 BURN INTENSIVE CARE UNIT 13.00 0 0 13.00 14.00 SURGICAL INTENSIVE CARE UNIT 0 0 14.00 OTHER SPECIAL CARE (SPECIFY) 15.00 15.00 Total intensive care type inpatient hospital services (sum of lines 3, 103, 839 3, 103, 839 16.00 16.00 17.00 Total inpatient routine care services (sum of lines 10 and 16) 8, 656, 527 8, 656, 527 17.00 107, 355, 256 123, 346, 749 18.00 Ancillary services 15, 991, 493 18.00 22, 016, 215 Outpatient services 19.00 19.00 629, 477 22, 645, 692 20.00 RURAL HEALTH CLINIC C 0 20.00 21.00 FEDERALLY QUALIFIED HEALTH CENTER 0 0 21.00 0 HOME HEALTH AGENCY 22.00 22.00 0 AMBULANCE SERVICES 23.00 0 0 23.00 24.00 CMHC 0 0 24.00 0 24. 10 CORF 0 24.10 ol 25.00 AMBULATORY SURGICAL CENTER (D. P.) 0 25.00 0 0 26.00 HOSPI CE Λ 26.00 27.00 PHYSICIAN PRACTICE 1, 185, 646 1, 185, 646 27.00 25, 277, 497 155, 834, 614 28.00 Total patient revenues (sum of lines 17-27) (transfer column 3 to Wkst. 130, 557, 117 28.00 G-3, line 1) PART II - OPERATING EXPENSES 29.00 Operating expenses (per Wkst. A, column 3, line 200) 41, 594, 250 29.00 ADD (SPECIFY) 30.00 30.00 31.00 0 31.00 0 32.00 32.00 0 33.00 33.00 34.00 0 34.00 0 35, 00 35.00 Total additions (sum of lines 30-35) 36.00 0 36.00 37.00 DEDUCT (SPECIFY) 37.00 38.00 0 38.00

0

0

41, 594, 250

39.00

40.00

41.00

42.00

43.00

Total deductions (sum of lines 37-41)

to Wkst. G-3, line 4)

Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer

Hoal th	Financial Systems INDIANA UNIVERSITY HEA	ITH REDEADD	Inlie	u of Form CMS-2	0552_10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 151328	Peri od:	Worksheet G-3	2332-10
STATEN	ENT OF REVENUES AND EXTENSES	Trovider con. 131320	From 01/01/2015 To 12/31/2015		
				1. 00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line 2	28)		155, 834, 614	1. 00
2.00	Less contractual allowances and discounts on patients' accounts			108, 803, 024	2. 00
3. 00	Net patient revenues (line 1 minus line 2)			47, 031, 590	3. 00
4. 00	Less total operating expenses (from Wkst. G-2, Part II, line 43))		41, 594, 250	
5. 00	Net income from service to patients (line 3 minus line 4)	,		5, 437, 340	
	OTHER I NCOME		<u>'</u>	, , , , , , , , , , , , , , , , , , , ,	
6.00	Contributions, donations, bequests, etc			0	6. 00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication se	ervi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking Lot receipts			0	12.00
13.00	Revenue from laundry and linen service			0	13.00
14.00	Revenue from meals sold to employees and guests			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 than	n 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			1, 047, 511	24. 00
25.00	Total other income (sum of lines 6-24)			1, 047, 511	25. 00
26.00	Total (line 5 plus line 25)			6, 484, 851	26. 00
27 00	OTHER EXPENSES (SPECIEV)			0	27 00

0 27. 00

6, 484, 851 29. 00

28.00

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)

27. 00 OTHER EXPENSES (SPECIFY)