## PART II - CERTIFICATION

(4) Reopened(5) Amended

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

## CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH BLOOMINGTON HOSPITAL (150051) 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.

Officer or Administrator of Provider(s)

Title

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	308, 218	-115, 383	1, 698	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	56, 694	0		0	3.00
4.00	SUBPROVI DER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	0	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8.00
9.00	HOME HEALTH AGENCY I	0	0	910		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	364, 912	-114, 473	1, 698	0	200.00

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

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provi der CCN: 150051 Peri od: Worksheet S-2 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/27/2016 1:53 pm 3.00 4.00 Hospital and Hospital Health Care Complex Address: P0 Box: 1149 1.00 Street: 601 WEST SECOND STREET 1.00 Ci ty: BLOOMI NGTON 2.00 State: IN Zip Code: 47402 County: MONROE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) 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 IU HEALTH BLOOMINGTON 150051 14020 07/01/1966 Ν 3.00 1 HOSPI TAI Subprovi der - IPF 4.00 4.00 Subprovi der - IRF IU HEALTH BLOOMINGTON 15T051 14020 5 10/01/2002 N Р Р 5.00 5.00 HOSPI TAL Subprovi der - (Other) 6.00 6.00 Swing Beds - SNF 7.00 7.00 Swing Beds - NF 8.00 8.00 9.00 Hospital-Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospital -Based HHA IU HEALTH BLOOMINGTON 157011 14020 07/01/1996 Ρ Ν 12.00 HOME HEALTH Separately Certified ASC 13.00 13 00 IU HEALTH BLOOMINGTON 14.00 Hospi tal -Based Hospi ce 151509 14020 03/13/1991 14.00 HOSPI CE Hospital-Based Health Clinic - RHC 15.00 16.00 Hospital -Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17 00 17. 10 Hospi tal -Based (CORF) I 17.10 Renal Dialysis 18.00 18.00 19.00 Other 19.00 From: To 2.00 1.00 01/01/2015 12/31/2015 20.00 Cost Reporting Period (mm/dd/yyyy) 20.00 21.00 Type of Control (see instructions) 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate N 22.00 Υ share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter ' 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 Υ Υ 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) 22.02 Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on lor after October 1. 22.03 Did this hospital receive a geographic reclassification from urban to rural as a result N Ν 22 03 of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method enter "Y" for yes or "N" for no. used in the prior cost reporting period? In column 2, In-State In-State Out-of Out-of Medi cai d 0ther HMO days Medi cai d Medi cai d Medi cai d State paid days el i gi bl e Medi cai d Medi cai d davs unpai d paid days el i gi bl e days unpai d 1.00 2. 00 3. 00 4. 00 5. 00 6. 00 24.00 If this provider is an IPPS hospital, enter the 5. 300 1. 581 5.346 402 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.

Health Financial Systems IU HEALTH	BLOOMI N	GTON HOSPITAL			In Lieu	ı of For	m CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	ATA	Provi der	Provider CCN: 150051 Period: From 01/01			Worksheet S-2 D1/2015 Part I		
						/31/2015 Date/Ti me Prep 5/27/2016 1:53		
	In-Stat		Out-of	Out-of	Medi ca	id 0	ther	o piii
	Medicai paid da		State Medicaid	State Medicaid	HMO da	- I	li cai d lays	
		unpai d	pai d days	el i gi bl e unpai d			Ţ	
	1.00	2. 00	3.00	4. 00	5. 00	) 6	o. 00	
25.00 If this provider is an IRF, enter the in-state Medicaid paid days in column 1, the in-state	2	227 132	0	0		6		25. 00
Medicaid eligible unpaid days in column 2,								
out-of-state Medicaid days in column 3, out-of-state Medicaid eliqible unpaid days in column 4, Medicaid								
HMO paid and eligible but unpaid days in column 5.								
				<u>Urban/R</u> 1.0		Date of 2.0		
26.00 Enter your standard geographic classification (not w			ginning of t		1			26. 00
cost reporting period. Enter "1" for urban or "2" fo 27.00 Enter your standard geographic classification (not w			d of the cos	t	1			27. 00
reporting period. Enter in column 1, "1" for urban o enter the effective date of the geographic reclassif			ppl i cabl e,					
35.00 If this is a sole community hospital (SCH), enter th			CH status in		0			35.00
effect in the cost reporting period.				Begi nı	ni na:	Endi	na.	
	<del></del>			1. (		2. (		
36.00 Enter applicable beginning and ending dates of SCH s of periods in excess of one and enter subsequent dat		subscript line	36 for numb	er				36.00
37.00 If this is a Medicare dependent hospital (MDH), ente		umber of perio	ds MDH statu	s	0			37.00
is in effect in the cost reporting period.  38.00 If line 37 is 1, enter the beginning and ending date	s of MDH	l status. If I	ine 37 is					38. 00
greater than 1, subscript this line for the number o enter subsequent dates.	f period	ls in excess o	f one and					
enter subsequent dates.				Y/		Y/		
39.00 Does this facility qualify for the inpatient hospita	l paymen	nt adiustment	for low volu	1. (		2. ( N		39.00
hospitals in accordance with 42 CFR §412.101(b)(2)(i	i)? Énte	er in column 1	"Y" for yes					
or "N" for no. Does the facility meet the mileage re CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes				)				
40.00 Is this hospital subject to the HAC program reductio "N" for no in column 1, for discharges prior to Octo	n adjust	ment? Enter "	Y" for yes o	r N	ı	N		40.00
no in column 2, for discharges on or after October 1			yes or in it	JI				
					1. 00	XVIII 2. 00	3. 00	
Prospective Payment System (PPS)-Capital					_			45.00
45.00 Does this facility qualify and receive Capital payme with 42 CFR Section §412.320? (see instructions)	nt ror a	ii sproporti ona	te snare in	accordance	N	Y	N	45.00
46.00 Is this facility eligible for additional payment exc pursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46. 00
Pt. III.	t. L, Ft	III allu WKS	t. L-1, Ft.	i tili ougii				
47.00 Is this a new hospital under 42 CFR §412.300 PPS cap 48.00 Is the facility electing full federal capital paymen					N N	N N	N N	47. 00 48. 00
Teachi ng Hospi tal s		<del></del>				1		
56.00 Is this a hospital involved in training residents in or "N" for no.	approve	ed GME program	s? Enter "Y	for yes	N			56.00
57.00 If line 56 is yes, is this the first cost reporting					1			57.00
GME programs trained at this facility? Enter "Y" fo is "Y" did residents start training in the first mon	th of th	nis cost repor	ting period?	Enter "Y				
for yes or "N" for no in column 2. If column 2 is " "N", complete Wkst. D, Parts III & IV and D-2, Pt. I			t E-4. If co	lumn 2 is				
58.00 If line 56 is yes, did this facility elect cost reim	bursemen	nt for physici	ans' servi ce	s as				58. 00
defined in CMS Pub. 15-1, chapter 21, §2148? If yes, 59.00 Are costs claimed on line 100 of Worksheet A? If ye			, Pt. I.		N			59.00
60.00 Are you claiming nursing school and/or allied health	costs f	or a program	that meets t		N			60.00
provider-operated criteria under §413.85? Enter "Y"	Y/N	<u>or "N" for n</u> IME	o. (see inst Direct GME		IE	Di rect	t GME	
	1.00	2. 00	3. 00	4. (	00	5. (	20	
61.00 Did your hospital receive FTE slots under ACA	N N	2.00	3.00	4.	0. 00	5. (		61.00
section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)								
61.01 Enter the average number of unweighted primary care		0.00	0.	00				61.01
FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see								
instructions)		0. 00		00				61. 02
61.02 Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs,		0.00	]	00				01.02
and primary care FTEs added under section 5503 of ACA). (see instructions)								
, , , , , , , , , , , , , , , , , , ,	' '			'	'		'	

Health Financial Systems IU HEALTH	BL OOM!	NGTON HOSPITAL		In lie	u of Form CMS-2	2552_10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA			F	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I	pared:
	Y/N	IME	Direct GME	I ME	Direct GME	
	1. 00	2.00	3. 00	4. 00	5. 00	
61.03 Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)		0.00	0.0	O		61.03
61.04 Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).		0.00	0.0	o		61.04
61.05 Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)		0. 00	0.0	O		61.05
61.04 minus fine 61.03). (see instructions) 61.06 Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0. 00	0.0	0		61.06
	Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
(4.40.05.11.575.1.11.44.05		1. 00	2. 00	3. 00	4.00	(1.10
<ul> <li>61. 10 Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.</li> <li>61. 20 Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name, enter in column 2, the program code, enter in column 3, the IME FTE unweighted count and enter in column 4, direct GME FTE unweighted count.</li> </ul>				0.00		61. 20
					1. 00	-
ACA Provisions Affecting the Health Resources and Ser 62.00 Enter the number of FTE residents that your hospital	trai ne	d in this cost		riod for which		62.00
your hospital received HRSA PCRE funding (see instruction of the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression of the property of the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression of the number of the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression of the number of FTE residents that rotated from a during in this cost reporting period of the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression of the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression of the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression of the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression of the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC progression of the number of FTE residents in Nonprovide from the number of FTE residents in	a Teach gram. (	ing Health Cen see instructio		your hospital	0.00	62. 01
63.00 Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this c			N	63. 00
			Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base vea	2.00 ris vour cost	2.00 reporting	
period that begins on or after July 1, 2009 and before			o zaco you			

	divided by (column 3 + column 4)). (see instructions)								
						1.00	2.00	3.00	
	Inpatient Psychiatric Facility F	PPS							
70.00	Is this facility an Inpatient Ps	sychiatric Facility (	IPF), or does it cont	ain an IPF sub	provi der?	N			70.00
	Enter "Y" for yes or "N" for no.								
71.00	.00   If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most   0								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)) Cc	olumn 2: Did this faci	ility train residents	in a new teac	hi ng				
	program in accordance with 42 CF	R 412.424 (d)(1)(iii)	)(D)? Enter "Y" for y	es or "N" for	no.				
	Column 3: If column 2 is Y, indi	cate which program ye	ear began during this	cost reportin	g period.				
	(see instructions)								
	Inpatient Rehabilitation Facilit	ty PPS							
75.00	Is this facility an Inpatient Re	habilitation Facility	y (IRF), or does it c	ontain an IRF		Υ			75.00
	subprovider? Enter "Y" for yes	and "N" for no.							

your hospital. Enter in column

Health Financial Systems IU HEALTH BLOOMIN	NGTON HOSPITAL		In	Lieu of	Form (	CMS-2552	-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA		CCN: 150051	Peri od: From 01/01/2 To 12/31/2	Wor 2015 Par 2015 Date	ksheet t I e/Time		ed:
76.00 If line 75 yes: Column 1: Did the facility have an approved recent cost reporting period ending on or before November 1: no. Column 2: Did this facility train residents in a new tector (CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no indicate which program year began during this cost reporting	5, 2004? Enter aching program . Column 3: I1	"Y" for yes n in accordan column 2 is	or "N" for ce with 42 Y,		00 3 N	0 76.	. 00
T. 0. 11. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1. 1					1.00		
Long Term Care Hospital PPS  80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.  TEFRA Providers	nter	N N		. 00 . 00			
85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) 86.00 Did this facility establish a new Other subprovider (exclude §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	ed unit) under	42 CFR Sect	i on		N		. 00 . 00
87.00 Is this hospital a "subclause (II)" LTCH classified under se for yes or "N" for no.	ection 1886(d)	(1) (B) (i v) (I		'	N	87.	. 00
			1. 00		XI X 2. 00		
Title V and XIX Services							
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.					Υ		. 00
91.00 Is this hospital reimbursed for title V and/or XIX through full or in part? Enter "Y" for yes or "N" for no in the app	licable column	١.	N		N		. 00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (dinstructions) Enter "Y" for yes or "N" for no in the application of the facility for the facil	able column.	, ,	N		N		. 00
93.00 Does this facility operate an ICF/IID facility for purposes "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,			N N		N N		. 00
applicable column.  95.00   If line 94 is "Y", enter the reduction percentage in the applicable column.				0. 00		0. 00 95.	
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yeapplicable column.			N	0.00	N		. 00
97.00 If line 96 is "Y", enter the reduction percentage in the ap	plicable colum	nn.		0. 00		<u>0. 00</u> 97.	. 00
105.00 Does this hospital qualify as a critical access hospital (C. 106.00 If this facility qualifies as a CAH, has it elected the all		hod of payme	nt			105. 106.	
for outpatient services? (see instructions)  107.00 If this facility qualifies as a CAH, is it eligible for costraining programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col	n 1. (see inst	ructions) If				107.	. 00
reimbursed. If yes complete Wkst. D-2, Pt. II.  108.00 s this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	CRNA fee sche	edul e? See 4	2 N			108.	. 00
	Physi cal	Occupati ona		Res	spi rato	ory	
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	1. 00	2. 00	3.00		4.00	109.	. 00
					1.00		
110.00 Did this hospital participate in the Rural Community Hospit: the current cost reporting period? Enter "Y" for yes or "N"		on project (	410A Demo)fo	-	N	110.	. 00
				1.00 2.	00 3	. 00	
Miscellaneous Cost Reporting Information  115.00 Is this an all-inclusive rate provider? Enter "Y" for yes o 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 provide Pub. 15-1, chapter 22, §2208.1.	. If column 2 nt for long te	is "E", ente erm care (inc	r in column ludes	N		0 115.	. 00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insu			r "N" for	Y		116. 117.	
no. 118.00 s the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	licy? Enter 1	if the polic	y is	2		118.	. 00

Health Financial Systems IU HEALTH BLOOMIN	GTON HOSPITAL		In Lie	u of Form CN	IS-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		eriod: rom 01/01/2015	Worksheet S Part I	S-2
			o 12/31/2015	Date/Time F	
		Premi ums	Losses	5/27/2016	
		Pi eiiii uiiis	LUSSES	Insurance	·
		1.00	2.00	2.00	
118.01 List amounts of malpractice premiums and paid losses:		1.00	2.00	3. 00	0118.01
The refer to the man practice promitants and para recession		0777270			0,10,01
110 000			1. 00	2. 00	110.00
118.02 Are malpractice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting sched			N		118. 02
and amounts contained therein.	idic iristing c	cost centers			
119.00 DO NOT USE THIS LINE					119. 00
120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold			N	N	120. 00
§3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu					
Hold Harmless provision in ACA §3121 and applicable amendmen					
Enter in column 2, "Y" for yes or "N" for no.					
121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no.	intable device	es charged to	Y		121. 00
Transplant Center Information					
125.00 Does this facility operate a transplant center? Enter "Y" fo	or yes and "N"	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below.		6'			10/ 00
126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 2		rication date			126. 00
127.00 If this is a Medicare certified heart transplant center, ent		cation date			127. 00
in column 1 and termination date, if applicable, in column 2					
128.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 2		fication date			128. 00
129.00 If this is a Medicare certified lung transplant center, ente		cation date in			129. 00
column 1 and termination date, if applicable, in column 2.					
130.00 If this is a Medicare certified pancreas transplant center,		ti fi cati on			130. 00
date in column 1 and termination date, if applicable, in col 131.00 If this is a Medicare certified intestinal transplant center		rertification			131.00
date in column 1 and termination date, if applicable, in col		ser ti i i eati en			101.00
132.00 If this is a Medicare certified islet transplant center, ent		fication date			132. 00
in column 1 and termination date, if applicable, in column 2 133.00 If this is a Medicare certified other transplant center, ent		Fication data			133. 00
in column 1 and termination date, if applicable, in column 2		ication date			133.00
134.00 If this is an organ procurement organization (OPO), enter th		in column 1			134.00
and termination date, if applicable, in column 2.					
All Providers  140.00 Are there any related organization or home office costs as d	defined in CMS	S Pub 15_1	Υ	15H059	140. 00
chapter 10? Enter "Y" for yes or "N" for no in column 1. If			'	1311037	140.00
are claimed, enter in column 2 the home office chain number.		ctions)			
1.00 2.00  If this facility is part of a chain organization, enter on I		nugh 1/3 the no	3.00	of the home	2
office and enter the home office contractor name and contract		Jugii 145 the ne	une and address	or the nome	
141.00 Name: IU HEALTH PARTNERS Contractor's Name: WIS	CONSIN PHYSIC	CIAN Contractor	's Number: 0810	1	141. 00
	RVI CES				142.00
142. 00 Street: 340 WEST TENTH STREET PO Box: 143. 00 Ci ty: INDI ANAPOLI S State: IN		Zip Code:	4620	2-3082	142.00
The solor ty.		<u> </u>	1020	2 0002	1 101 00
				1.00	
144.00 Are provider based physicians' costs included in Worksheet A	\?			Y	144. 00
			1. 00	2. 00	
145.00 If costs for renal services are claimed on Wkst. A, line 74,			Y		145.00
inpatient services only? Enter "Y" for yes or "N" for no in					
no, does the dialysis facility include Medicare utilization period? Enter "Y" for yes or "N" for no in column 2.	Tor this cost	reporting			
146.00 Has the cost allocation methodology changed from the previou	ısly filed cos	st report?	N		146. 00
Enter "Y" for yes or "N" for no in column 1. (See CMS Pub. 1					
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 y	ves or "N" for	no.		1. 00 N	147. 00
147.00 Was there a change in the statistical basis? Enter "Y" for y 148.00 Was there a change in the order of allocation? Enter "Y" for 149.00 Was there a change to the simplified cost finding method? En	yes or "N" f	for no.			147. 00 148. 00 149. 00

HOSPITAL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DATA	Provi der (	CCN: 150051	From	od: 01/01/2015 12/31/2015	Worksheet S- Part I Date/Time Pr 5/27/2016 1:	epared:
		Part A	Part B	3	Title V	Title XIX	
		1. 00	2. 00		3. 00	4. 00	
Does this facility contain a pro							
or charges? Enter "Y" for yes or	"N" for no for each compo	nent for Part A	and Part	B. (See	42 CFR §41	3. 13)	
155. 00 Hospi tal		N I	N		N	N	155.00
156. 00 Subprovi der – TPF		N	N		N	N	156.00
157. 00 Subprovi der – TRF		N	N		N	N	157.00
158. 00 SUBPROVI DER							158.00
159. 00 SNF		N I	N		N	N	159.00
160.00HOME HEALTH AGENCY		Y	Υ		N I	N	160.00
161. 00 CMHC			N		N	N	161.00
161. 10 CORF			N		N	N	161. 10
							101111
						1, 00	_
Multicampus						1.00	
165.00 Is this hospital part of a Multi Enter "Y" for yes or "N" for no.	campus hospital that has o	ne or more camp	uses in di	fferent	CBSAs?	N	165. 00
<b>,</b> , , , , , , , , , , , , , , , , , ,	Name	County	State	Zip Code	e 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	00 166. 00
						1. 00	
Health Information Technology (F	IIT) incentive in the Ameri	can Recovery an	d Reinvest	ment Act	t		
67.00 Is this provider a meaningful us						Υ	167. 0
168.00 If this provider is a CAH (line			e 167 is "`	Y"), ent	ter the		0168.0
reasonable cost incurred for the							
168.01 If this provider is a CAH and is					ardshi p		168. 0
exception under §413.70(a)(6)(ii	)? Enter "Y" for yes or "N	" for no. (see i	instructio	ns)			
	user (line 167 is "Y") and	d is not a CAH	(line 105	is "N"),	enter the	0. 2	25 169. 0
169.00 If this provider is a meaningful							
169.00 If this provider is a meaningful transition factor. (see instruct	i ons)			В	Begi nni ng	Endi ng	
	i ons)						
transition factor. (see instruct	,				1. 00	2.00	
transition factor. (see instruct	beginning date and ending	date for the re	eporti ng	10	1. 00 0/03/2015	2. 00 12/31/2015	170. 0
transition factor. (see instruct	beginning date and ending	date for the ro	eporti ng	10			170.00

	<del></del>	J HEALTH BLOOMINGTON HOSPITAL			eu of Form CMS-	
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE Provi der	F	eriod: rom 01/01/2015 o 12/31/2015		epared:
				Y/N	Date	JJ pili
	General Instruction: Enter Y for all YES res	ponses. Enter N for all NO re	esponses. Ente	1.00	2.00 the	-
	mm/dd/yyyy format.					
	COMPLETED BY ALL HOSPITALS Provider Organization and Operation					+
1.00	Has the provider changed ownership immediate reporting period? If yes, enter the date of			N		1.00
	reporting period? IT yes, enter the date of	the change in cordini 2. (see	Y/N	Date	V/I	
2. 00	Has the provider terminated participation in	the Medicare Drogram? If	1. 00 N	2. 00	3. 00	2.00
2.00	yes, enter in column 2 the date of terminati		IN IN			2.00
3. 00	voluntary or "I" for involuntary. Is the provider involved in business transac	tions including management	Υ			3.00
3. 00	contracts, with individuals or entities (e.g	., chain home offices, drug	·			3.00
	or medical supply companies) that are relate officers, medical staff, management personne					
	of directors through ownership, control, or					
	relationships? (see instructions)		Y/N	Туре	Date	
			1.00	2. 00	3. 00	
4. 00	Financial Data and Reports Column 1: Were the financial statements pre	pared by a Certified Public	Υ	A	I	4.00
1. 00	Accountant? Column 2: If yes, enter "A" for	Audited, "C" for Compiled,		,,		1.00
	or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see inst					
5. 00	Are the cost report total expenses and total	revenues different from	N			5. 00
	those on the filed financial statements? If	yes, submit reconciliation.		Y/N	Legal Oper.	
	la constant de la con			1. 00	2. 00	
6. 00	Approved Educational Activities  Column 1: Are costs claimed for nursing sch	nool? Column 2: If yes, is t	he provider is	N		6.00
7.00	the legal operator of the program?	-	·			7.00
7. 00 8. 00	Are costs claimed for Allied Health Programs Were nursing school and/or allied health pro		d during the	Y N		7. 00 8. 00
9. 00	cost reporting period? If yes, see instructi Are costs claimed for Interns and Residents		cal aducation	N		9.00
7. 00	program in the current cost report? If yes,		car education	IN		7.00
10.00	Was an approved Intern and Resident GME prog cost reporting period? If yes, see instructi	ram initiated or renewed in one	the current	N		10.00
11. 00	Are GME cost directly assigned to cost cente	ers other than I & R in an App	proved	N		11.00
	Teaching Program on Worksheet A? If yes, see	Instructions.			Y/N	
	Dod Dobto				1. 00	
12. 00	Bad Debts Is the provider seeking reimbursement for ba	d debts? If yes, see instruc	tions.		Y	12.00
13.00	If line 12 is yes, did the provider's bad de period? If yes, submit copy.	ebt collection policy change	during this co	st reporting	N	13.00
14. 00	If line 12 is yes, were patient deductibles	and/or co-payments wai ved? I	f yes, see ins	tructions.	N	14. 00
15. 00	Bed Complement Did total beds available change from the pri	or cost reporting period? If	vos socinst	rueti enc	N	15. 00
13.00	pro total beds avairable change from the pri	Cost reporting perrou: 11	Par	t A	Part B	13.00
		Description 0	Y/N 1.00	2. 00	Y/N 3. 00	
	PS&R Data			2.00		
16. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes,		N		N	16. 00
	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		Υ	04/12/2016	Y	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					
18. 00	2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments		N		N	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					
19. 00	this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments		l N		N N	19.00
17.00	made to PS&R Report data for corrections of		IN IN		IN IN	17.00
	other PS&R Report information? If yes, see instructions.					
20. 00	If line 16 or 17 is yes, were adjustments		N		N	20.00
	made to PS&R Report data for Other? Describe the other adjustments:					
	Time other day astillettes.	I	I	I	I	I

	Financial Systems IU AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	I HEALTH BLOOMINGTO ESTIONNAIRE		CCN: 150051	Peri od: From 01/01/2015 To 12/31/2015		-2
					10 12/31/2013	5/27/2016 1:	53 pm
					art A	Part B	
		Description	on	Y/N	Date	Y/N	
21 00	Was the east report proposed only using the	0		1.00	2. 00	3. 00 N	21.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.			N		N	21.00
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPI	TALS ONLY (EXCEPT (	CHILDRENS HO	OSPLTALS)		1. 00	
	Capital Related Cost	TALS SIVET (EASELT)	JIII EDILEIVO TI	301 1 17120)			
	Have assets been relifed for Medicare purpos						22. 00
23. 00	Have changes occurred in the Medicare deprec	iation expense due	to appraisa	als made dur	ing the cost		23. 00
24 00	reporting period? If yes, see instructions. Were new leases and/or amendments to existing	a Loacos ontorod i	nto durina :	this cost so	norting ported?		24.00
24.00	If yes, see instructions	g reases entered ri	into durring	till's cost re	portring perrou?		24.00
25. 00	Have there been new capitalized leases enter	ed into during the	cost repor	ting period?	'If yes, see		25. 00
	instructions.				-		
26. 00	Were assets subject to Sec. 2314 of DEFRA acq	uired during the c	ost reporti	ng period? I	f yes, see		26.00
27 00	instructions. Has the provider's capitalization policy cha	nged during the co	st renortino	n neriod? If	ves submit		27. 00
27.00	copy.	nged darring the co.	or reporting	g period: ii	yes, sabili t		27.00
	Interest Expense						
28. 00	Were new Loans, mortgage agreements or lette	rs of credit enter	ed into duri	ing the cost	reporti ng		28. 00
20.00	period? If yes, see instructions. Did the provider have a funded depreciation :	account and/as ban	d funda (Dal	h+ Comilao D	locomic Fund)		29.00
29.00	treated as a funded depreciation account? If			ot service k	eserve Funa)		29.00
30. 00	Has existing debt been replaced prior to its			debt? If yes	, see		30.00
	instructions.	,	,	,			
31.00	Has debt been recalled before scheduled matu	rity without issua	nce of new (	debt? If yes	, see		31.00
	instructions. Purchased Services						
	Have changes or new agreements occurred in pa	atient care service	es furnishe	d through co	ntractual		32.00
32.00	arrangements with suppliers of services? If			a tili odgir co	inti actual		32.00
33. 00	If line 32 is yes, were the requirements of			g to competi	tive bidding? If	,	33.00
	no, see instructions.						
	Provi der-Based Physi ci ans						
34.00	Are services furnished at the provider facilifyes, see instructions.	ity under an arran	gement with	provi der-ba	sea physicians?		34.00
35. 00	If line 34 is yes, were there new agreements	or amended existing	na agreemen	ts with the	provi der-based		35.00
	physicians during the cost reporting period?				•		
					Y/N	Date	

			11 00	2.00	4			
	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 p	repared by the home office?			37.00			
	If yes, see instructions.							
38.00					38.00			
	the provider? If yes, enter in column 2 the fiscal year en							
39. 00	If line 36 is yes, did the provider render services to oth	ner chain components? If yes,			39. 00			
	see instructions.							
40. 00	3.1, J.1, J.1							
	i nstructi ons.							
		1. 00	2.	00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/position	STEVE	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		317. 962. 1035	SHOWELL7@I UHEA	LTH. ORG	43.00			
	report preparer in columns 1 and 2, respectively.							

Heal th	Financial Systems IU	HEALIH BLOOMING	TON HOSPITAL		In Lieu	of Form CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der CCN: 1500			Worksheet S-2	
						Part II	
				To 12.		Date/Time Pre	
		5 . 5			5	5/27/2016 1:5	3 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	04/12/2016					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
10.00	made to PS&R Report data for additional						10.00
	claims that have been billed but are not						
	included on the PS&R Report used to file						
	this cost report? If yes, see instructions.						
10 00	If line 16 or 17 is yes, were adjustments						19. 00
19.00	made to PS&R Report data for corrections of						19.00
	other PS&R Report information? If yes, see						
	instructions.						
20.00							20.00
20. 00	If line 16 or 17 is yes, were adjustments						20. 00
	made to PS&R Report data for Other? Describe						
21 00	the other adjustments:						21 00
21. 00	Was the cost report prepared only using the						21. 00
	provider's records? If yes, see						
	instructions.						
		_	2 22				
	01.0		3. 00				
	Cost Report Preparer Contact Information		114.055				44 00
41.00	Enter the first name, last name and the title		ANAGER				41.00
	held by the cost report preparer in columns	1, 2, and 3,					
	respecti vel y.						
42.00	Enter the employer/company name of the cost	report					42.00
	preparer.						
43.00	Enter the telephone number and email address						43.00
	report preparer in columns 1 and 2, respecti	vel y.					

| Period: | Worksheet S-3 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared: 
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA
 Provider (
 Provi der CCN: 150051

					To	12/31/2015	Date/Time Pre 5/27/2016 1:5	
							I/P Days /	5 piii
							0/P Visits /	
							Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
	'	Line Number			Avai I abl e			
		1. 00		2. 00	3. 00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30. 00		241	87, 965	0. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2. 00	HMO and other (see instructions)							2. 00
3. 00	HMO IPF Subprovider							3. 00
4. 00	HMO IRF Subprovider						_	4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			241	87, 965	0. 00	0	7. 00
	beds) (see instructions)	04.00						0.00
8. 00	INTENSIVE CARE UNIT	31.00		16		0.00	0	8.00
9.00	CORONARY CARE UNIT	32.00		0	-	0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT	33.00		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)	42.00					0	12.00
13.00	NURSERY	43. 00		257	02.005	0.00	0	13. 00 14. 00
14. 00 15. 00	Total (see instructions) CAH visits			257	93, 805	0. 00	0	15.00
16. 00	SUBPROVIDER - IPF	40. 00		0	0		0	16.00
17. 00	SUBPROVIDER - IPF	41. 00		16			0	17. 00
18. 00	SUBPROVI DER	42.00		0			0	18.00
19. 00	SKILLED NURSING FACILITY	44. 00		0	_		0	19.00
20. 00	NURSING FACILITY	45. 00		0	0		0	20.00
21. 00	OTHER LONG TERM CARE	46. 00		0	0		O	21.00
22. 00	HOME HEALTH AGENCY	101.00		O			0	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P. )	115. 00					O	23. 00
24. 00	HOSPI CE	116.00		0	31, 915			24.00
24. 10	HOSPICE (non-distinct part)	30.00		Ü	01,710			24. 10
25. 00	CMHC - CMHC	99.00					0	25. 00
25. 10	CMHC - CORF	99. 10					0	25. 10
26. 00	RURAL HEALTH CLINIC	88. 00					0	26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			273				27. 00
28.00	Observation Bed Days						0	28. 00
29.00	Ambul ance Trips							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			0	0	ļ		32.00
32.01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days					ļ		33. 00

Health Financial Systems I U HEALTH I HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provi der CCN: 150051

			( 2 (2 ) ) )			<u>  5/27/2016 1:5</u>	3 pm
		I/P Days	/ O/P Visits	/ Tri ps	Full Time E	Equi val ents	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
				Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	19, 337	1, 551	44, 885			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)	3, 098	7, 962				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO IRF Subprovider	229	355				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5.00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6.00
7.00	Total Adults and Peds. (exclude observation	19, 337	1, 551	44, 885			7.00
	beds) (see instructions)						
8.00	INTENSIVE CARE UNIT	2, 648	229	3, 949			8.00
9.00	CORONARY CARE UNIT	O	O	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		2, 502	4, 718			13.00
14. 00	Total (see instructions)	21, 985	4, 282	53, 552		1, 758. 71	14.00
15. 00	CAH visits	21,700	0	0	0.00	1,700.71	15.00
16. 00	SUBPROVIDER - I PF	0	0	0	0.00	0.00	1
17. 00	SUBPROVIDER - I RF	1, 734	10	2, 821	0.00	0.00	•
18. 00	SUBPROVI DER	1, 734	0	2,021		0.00	1
19. 00	SKILLED NURSING FACILITY	0	0	0		0.00	
20. 00	NURSING FACILITY	o l	0	0		0.00	•
21. 00	OTHER LONG TERM CARE		J	0		0.00	1
22. 00	HOME HEALTH AGENCY	11, 841	742	20, 558		0.00	
23. 00	l e	11, 041	742	20, 336	0.00	0.00	l
	AMBULATORY SURGICAL CENTER (D. P. )	00 (05	0.7	04 045			•
24. 00	HOSPI CE	28, 685	37	31, 915	0. 00	0. 00	
24. 10	HOSPICE (non-distinct part)	0	0	0			24. 10
25. 00	CMHC - CMHC	0	0	0		0.00	
25. 10	CMHC - CORF	0	0	0		0.00	1
26. 00	RURAL HEALTH CLINIC	0	0	0		0. 00	ı
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	1, 758. 71	27. 00
28. 00	Observation Bed Days		632	4, 020			28. 00
29. 00	Ambulance Trips	7, 237					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	402	648			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
	,	. '	'				•

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA

Provider CCN: 150051 Peri od: Worksheet S-3 From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/27/2016 1:53 pm Full Time Di scharges Equi val ents Title XVIII Total All Component Nonpai d Title V Title XIX Workers Pati ents 12. 00 13.00 14.00 11.00 15.00 13, 796 Hospital Adults & Peds. (columns 5, 6, 7 and 4, 452 384 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds)

HOSPITAL WAGE INDEX INFORMATION Provi der CCN: 150051 Peri od: Worksheet S-3 From 01/01/2015 Part II 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm Worksheet A Amount Recl assi fi cat Adj usted Paid Hours Average Hourly Wage (col. 4 ÷ col. 5) Line Number Reported ion of Sal ari es Related to Sal ari es (col. 2 ± col. Salaries in (from 3) col. 4 Worksheet A-6)6.00 1. 00 2.00 4.00 5.00 3.00 PART II - WAGE DATA SALARI ES 1.00 Total salaries (see 200.00 101, 968, 743 -613, 842 101, 354, 901 3, 658, 124. 49 27.71 1.00 instructions) 2.00 Non-physician anesthetist Part 0 C 0 0.00 0.00 2.00 3.00 Non-physician anesthetist Part 0 Ω 0 0.00 0.00 3.00 Physician-Part A -0 4.00 0.00 0.00 4.00 Administrative 4.01 Physicians - Part A - Teaching 0 0.00 0.00 4.01 5.00 Physician-Part B 0 0.00 0.00 5.00 6.00 Non-physician-Part B 0 0.00 0.00 6.00 7.00 Interns & residents (in an 21.00 0 0.00 0.00 7.00 approved program) 7.01 7 01 Contracted interns and 0 0.00 0.00 residents (in an approved programs) 8.00 Home office personnel 0 0.00 0.00 8.00 44.00 9.00 SNF 0.00 9.00 0 0.0099, 555 10.00 Excluded area salaries (see 14, 965, 337 15, 064, 892 95, 202. 79 158. 24 10.00 instructions) OTHER WAGES & RELATED COSTS 3, 458, 735 11 00 Contract labor: Direct Patient 3 458 735 0 52 157 63 66 31 11 00 Care 12.00 Contract Labor: Top Level C 0 0.00 0.00 12.00 0 management and other management and administrative servi ces Contract Labor: Physician-Part 1, 038, 077 0 1, 038, 077 9, 036. 37 13.00 114.88 13.00 A - Administrative 14.00 Home office salaries & 21, 301, 295 C 21, 301, 295 537, 471. 73 39. 63 14.00 wage-related costs 15.00 Home office: Physician Part A 0 0 0.00 0.00 15.00 Administrative 16.00 Home office and Contract 0 C 0 0.00 0.00 16.00 Physicians Part A - Teaching WAGE-RELATED COSTS 17.00 Wage-related costs (core) (see 26, 251, 761 0 26, 251, 761 17.00 instructions) 18.00 Wage-related costs (other) 0 C 0 18.00 (see instructions) 19.00 19.00 Excluded areas 928, 892 928, 892 20.00 Non-physician anesthetist Part 20.00 C 21.00 Non-physician anesthetist Part 0 C 0 21.00 22.00 22.00 Physician Part A -Administrative 22.01 Physician Part A - Teaching 0 0 22.01 23.00 Physician Part B 0 C 0 23.00 24.00 Wage-related costs (RHC/FQHC) 0 0 24.00 Interns & residents (in an 25.00 25.00 approved program) OVERHEAD COSTS - DIRECT SALARIES Employee Benefits Department 4.00 3, 225, 228 -1, 163 3, 224, 065 30, 389. 88 106. 09 26.00 10, 097, 195 27.00 Administrative & General 5.00 115, 887 10, 213, 082 258, 312. 94 39. 54 27.00 28.00 Administrative & General under 1, 034, 675 1, 034, 675 24, 082, 25 42.96 28.00 contract (see inst.) 29.00 Maintenance & Repairs 6.00 0.00 0.00 29.00 Operation of Plant 99, 978. 69 30.00 7.00 2, 492, 555 -8, 787 2, 483, 768 24.84 30.00 31.00 Laundry & Linen Service 8.00 0.00 31.00 0.00 32.00 Housekeepi ng 9.00 1, 482, 791 -10.9631, 471, 828 119, 153. 14 12. 35 32 00 Housekeeping under contract 0.00 33.00 33.00 0.00 (see instructions) Dietary 10.00 2,003,651 -726, 444 77, 309. 92 34.00 1, 277, 207 16. 52 34.00 0.00 35.00 Dietary under contract (see 0.00 35.00 instructions) 36.00 Cafeteri a 11.00 713, 480 713, 480 57, 352. 90 12. 44 36. 00 37.00 Maintenance of Personnel 12.00 0.00 0.00 37.00 31. 92 38. 00 -8, 963 38.00 Nursing Administration 13.00 3, 354, 455 3, 345, 492 104, 800, 46

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL In Lieu of					u of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION			Provi der		Peri od:	Worksheet S-3	
					From 01/01/2015		
					To 12/31/2015	Date/Time Pre 5/27/2016 1:5	
	Wasalsalaa a 4 A	A	D!! 6:+	A -1: +1	Dat al Harrisa		3 piii
	Worksheet A		Reclassi fi cat		Paid Hours	Average	
	Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
			(from	3)	col. 4	col. 5)	
			Worksheet				
			A-6)				
	1.00	2. 00	3. 00	4.00	5. 00	6. 00	
39.00 Central Services and Supply	14. 00	1, 167	0	1, 16	7 49. 73	23. 47	39.00
40.00 Pharmacy	15. 00	4, 435, 834	-47, 008	4, 388, 82	6 116, 333. 20	37. 73	40.00
41.00 Medical Records & Medical	16. 00	0	0		0.00	0.00	41.00
Records Library							
42.00 Social Service	17. 00	0	0		0. 00	0. 00	42.00
43.00 Other General Service	18. 00	376, 462	-1, 964	374, 49	8 22, 710. 51	16. 49	43.00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE INDEX INFORMATION	Provi der CCN: 150051	Period: Worksheet S-3

						rom 01/01/2015 o 12/31/2015		
		Worksheet A	Amount	Reclassi fi cat	Adjusted	Paid Hours	Average	
		Line Number	Reported	ion of	Sal ari es	Related to	Hourly Wage	
			·	Sal ari es	(col.2 ± col.	Salaries in	(col. 4 ÷	
				(from	3)	col. 4	col. 5)	
				Worksheet				
				A-6)				
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		103, 003, 418	-613, 842	102, 389, 576	3, 682, 206. 74	27. 81	1.00
	instructions)							
2.00	Excluded area salaries (see		14, 965, 337	99, 555	15, 064, 892	95, 202. 79	158. 24	2.00
	instructions)							
3. 00	Subtotal salaries (line 1		88, 038, 081	-713, 397	87, 324, 684	3, 587, 003. 95	24. 34	3.00
	minus line 2)							
4. 00	Subtotal other wages & related		25, 798, 107	0	25, 798, 107	598, 665. 73	43. 09	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		26, 251, 761	0	26, 251, 761	0. 00	30. 06	5.00
	(see inst.)							
6. 00	Total (sum of lines 3 thru 5)		140, 087, 949			1 ' '		6.00
7. 00	Total overhead cost (see		28, 504, 013	24, 075	28, 528, 088	910, 473. 62	31. 33	7. 00
	instructions)							

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 150051	Period: Worksheet S-3 From 01/01/2015 Part IV
		To 12/31/2015 Date/Time Prepared:

	To 12/31/2015	Date/Time Pre 5/27/2016 1:5	
		Amount	O
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		
	RETI REMENT COST		
1.00	401K Employer Contributions	4, 927, 311	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6.00
7.00	Employee Managed Care Program Administration Fees	0	7.00
	HEALTH AND INSURANCE COST		
8.00	Health Insurance (Purchased or Self Funded)	13, 910, 844	8. 00
9.00	Prescription Drug Plan	45, 658	9. 00
10.00	Dental, Hearing and Vision Plan	437, 288	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	67, 798	11.00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	155, 285	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	1, 455	15.00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16.00
	Non cumulative portion)		
	TAXES		
17.00	FICA-Employers Portion Only	7, 185, 353	17.00
18.00	Medicare Taxes - Employers Portion Only	0	18.00
19.00	Unempl oyment Insurance	0	19.00
20.00	State or Federal Unemployment Taxes	106, 706	20.00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21.00
	instructions))		
22. 00		0	22.00
	Tuition Reimbursement	342, 953	23.00
24.00	Total Wage Related cost (Sum of lines 1 -23)	27, 180, 651	24.00
	Part B - Other than Core Related Cost		
25.00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25.00

Health Financial Systems	IU HEALTH BLOOMINGTON H	HOSPI TAL	In Lieu	of Form CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Pr	rovider CCN:	Peri od: From 01/01/2015	

		To	12/31/2015	Date/Time Pre 5/27/2016 1:5	
	Cost Center Description		Contract	Benefit Cost	
			Labor		
			1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost				
	Hospital and Hospital-Based Component Identification:				
1.00	Total facility's contract labor and benefit cost		3, 458, 735	27, 180, 653	1.00
2.00	Hospi tal		3, 458, 735	27, 180, 653	2.00
3.00	Subprovi der - I PF		0	0	3.00
4.00	Subprovi der - I RF		0	0	4.00
5.00	Subprovi der - (Other)		0	0	5.00
6.00	Swing Beds - SNF		0	0	6.00
7.00	Swing Beds - NF		0	0	7.00
8.00	Hospi tal -Based SNF		0	0	8. 00
9. 00	Hospi tal -Based NF		0	0	9. 00
10.00	Hospi tal -Based OLTC				10.00
11.00	Hospi tal -Based HHA		0	0	11.00
12.00	Separately Certified ASC		0	0	12.00
13.00	Hospi tal -Based Hospi ce		0	0	13.00
14.00	Hospital-Based Health Clinic RHC		0	0	14.00
15.00	Hospital-Based Health Clinic FOHC		0	0	15.00
16.00	Hospi tal -Based-CMHC		0	0	16.00
16. 10	Hospi tal -Based-CMHC 10		0	0	16. 10
17.00	Renal Dialysis		0	0	17.00
18. 00	Other		О	0	18. 00

	Financial Systems IL	J HEALTH BLOOMI			<u>In Lie</u> eriod:	u of Form CMS-2 Worksheet S-4	
TIOWL T	ILALITI AGLINCI STATISTICAL DATA			F	rom 01/01/2015 o 12/31/2015	Date/Time Pre	pared:
					Home Health	5/27/2016 1: 5 PPS	3 pm
					Agency I		
0. 00	County				MONROE 1.	00	0.00
		Ti tle V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5. 00	
1 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0					1.00
1. 00 2. 00	Unduplicated Census Count (see instructions)	0.00	,	40.00	857.00	1, 511. 00	1
				Number of Empi	oyees (Full II	me Equivalent)	
			er of hours in I work week	) Staff	Contract	Total	
		(	0	1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40.00				3.00
4.00	Director(s) and Assistant Director(s)		40.00	0. 58	0. 00	0. 58	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			10. 27 11. 51			5. 00 6. 00
7. 00 8. 00	Nursing Supervisor Physical Therapy Service			15. 39 6. 94			7. 00 8. 00
9. 00 10. 00	Physical Therapy Supervisor Occupational Therapy Service			0. 00 2. 07	0. 00	0.00	9. 00 10. 00
11.00	Occupational Therapy Supervisor			0.00	0. 00	0.00	11. 00
12. 00 13. 00	Speech Pathology Service Speech Pathology Supervisor			0. 29 0. 00			•
14. 00 15. 00	Medical Social Service Medical Social Service Supervisor			0. 00 0. 00			•
16. 00 17. 00	Home Heal th Ai de Home Heal th Ai de Supervisor			1. 17	0. 00	1. 17	16. 00
18. 00	NONREI MBURSABLE			20. 56			•
19. 00	HOME HEALTH AGENCY CBSA CODES  Enter in column 1 the number of CBSAs where			5			19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced during this cost reporting period (line 20			14020			20.00
20. 01	contains the first code).			26900			20. 01
20. 02				50031			20. 02
20. 03 20. 04				50032 99915			20. 03 20. 04
		Full Ep Without	pisodes With Outliers	LUPA Epi sodes	PEP Only	Total (cols.	
		Outliers 1.00	2.00	3.00	Epi sodes 4. 00	1-4) 5. 00	
21. 00	PPS ACTIVITY DATA Skilled Nursing Visits	5, 182	687	169	115	6, 153	21.00
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	651, 308 3, 375	85, 624	21, 416	14, 607	772, 955	22. 00
24.00	Physical Therapy Visit Charges	467, 737	10, 984	7, 000	3, 624	489, 345	24. 00
25. 00 26. 00	Occupational Therapy Visits Occupational Therapy Visit Charges	1, 252 174, 388					
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	73 10, 642	l .			79 11, 555	27. 00 28. 00
29. 00 30. 00	Medical Social Service Visits Medical Social Service Visit Charges	128 26, 102	l .	1			
31.00	Home Health Aide Visits	489	135	5 1	6	631	31.00
32. 00 33. 00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	27, 952 10, 499					32. 00 33. 00
34. 00	29, and 31) Other Charges	0	C	1	_	1	34.00
35. 00	Total Charges (sum of lines 22, 24, 26, 28, 30, 32, and 34)	1, 358, 129	110, 842	31, 037		1, 520, 963	35. 00
36. 00	Total Number of Episodes (standard/non outlier)	670		82	7	759	36. 00
	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	29, 156	21 11, 539	•	4 841	25 43, 329	

Heal th	n Financial Systems	11	J HEALTH BLOOMI	NGTON	I HOSPITAL		In lie	eu of Form CMS-2	2552-10
	TAL I DENTIFICATION DATA		TIERETH BEGOMI		Provi der	CCN: 150051	Peri od: From 01/01/2015 To 12/31/2015	Worksheet S-9 Parts I & II	pared:
							Hospi ce I		
		Unduplicated Days							
		Title XVIII	Title XIX	SI No	e XVIII killed ursing	Title XIX Nursing Facility	All Other	Total (sum of cols. 1, 2 & 5)	
		1. 00	2. 00		3.00	4.00	5. 00	6. 00	
	PART I - ENROLLMENT DAYS								
1.00	Continuous Home Care	0	0		0	)	0 0	0	1.00
2.00	Routine Home Care	26, 937	0		0		0 0	26, 937	2.00
3.00	Inpatient Respite Care	425	0		0		0 0	425	3.00
4.00	General Inpatient Care	1, 323	0		0	)	0 0	1, 323	4.00

0

0.00

0

0

0.00

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609

28, 685

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7.00

8.00

9.00

0

0.00

0.00

609

28, 685

5.00

6.00

7.00

8.00

9.00

Total Hospice Days Part II - CENSUS DATA

Hospi ce Care

to Medicare

5/line 6)

Number of Patients Receiving

Total Number of Unduplicated Continuous Care Hours Billable

Average Length of Stay (line

Unduplicated Census Count

Heal th	Financial Systems IU HEALTH BLOOMINGTON	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
		Provi der CC		Peri od:	Worksheet S-1	
				From 01/01/2015		
			[	To 12/31/2015	Date/Time Pre 5/27/2016 1:5	
					3/2//2010 1.5	3 PIII
					1. 00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 divid	ded by line	e 202 column	า 8)	0. 226106	1.00
	Medicaid (see instructions for each line)					
2. 00	Net revenue from Medicaid				8, 996, 380	2.00
3. 00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplemental p		om Medicaio	d'?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments from N	Medicaid			0	5.00
6.00	Medicaid charges				86, 747, 432	6.00
7.00	Medicaid cost (line 1 times line 6)	7!	E 1!-	0 5. 1.6.	19, 614, 115	7.00
8. 00	Difference between net revenue and costs for Medicaid program (li < zero then enter zero)	ne / minus	s sum or iir	ies 2 and 5; if	10, 617, 735	8. 00
	State Children's Health Insurance Program (SCHIP) (see instruction	one for one	h lino)			
9. 00	Net revenue from stand-alone SCHIP	ons for eac	in Title)		0	9. 00
10.00					Ö	10.00
11. 00	Stand-alone SCHIP cost (line 1 times line 10)				Ö	
12. 00		ine 11 min	nus line 9:	if < zero then	0	12.00
	enter zero)		,			
	Other state or local government indigent care program (see instru	uctions for	each line)			
13.00	Net revenue from state or local indigent care program (Not include	ded on line	es 2, 5 or 9	9)	13, 639, 659	13.00
14.00	Charges for patients covered under state or local indigent care p	orogram (No	ot included	in lines 6 or	91, 329, 873	14.00
	10)					
15. 00	State or local indigent care program cost (line 1 times line 14)				20, 650, 232	
16. 00	Difference between net revenue and costs for state or local indig	gent care p	orogram (lir	ne 15 minus line	7, 010, 573	16. 00
	13; if < zero then enter zero)					
17. 00	Uncompensated care (see instructions for each line)  Private grants, donations, or endowment income restricted to func	dina obosit			0	17. 00
18. 00	Government grants, appropriations or transfers for support of hos	9	,			18.00
19.00				ns (sum of lines	-	
19.00	8, 12 and 16)	That gent c	care program	iis (suii oi iiiles	17,020,300	19.00
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
	I=		1.00	2.00	3. 00	
20. 00	Total initial obligation of patients approved for charity care (a		24, 681, 36	9 5, 096, 143	29, 777, 512	20.00
21. 00	charges excluding non-reimbursable cost centers) for the entire 1 Cost of initial obligation of patients approved for charity care		5, 580, 60	1 152 240	4 722 075	21. 00
21.00	times line 20)	(TITIE I	3, 360, 60	6 1, 152, 269	6, 732, 875	21.00
22. 00	Partial payment by patients approved for charity care	ŀ	48	0	480	22.00
	Cost of charity care (line 21 minus line 22)		5, 580, 12		6, 732, 395	
20.00	Toole or sharry sairs (Trills 21 million Trills 22)		0/ 000/ 12	1, 102, 20,	0,702,070	20.00
					1. 00	
24. 00	Does the amount in line 20 column 2 include charges for patient of		d a Length o	of stay limit	N	24. 00
05.00	imposed on patients covered by Medicaid or other indigent care pr				_	25. 00
25. 00						
	Total bad debt expense for the entire hospital complex (see instructions had debt for the entire hospital complex (see instructions)				23, 794, 304	
27. 00	Medicare bad debts for the entire hospital complex (see instructi		line 27)		481, 521	27.00
28. 00 29. 00	Non-Medicare and non-reimbursable Medicare bad debt expense (line		,	. 20)	23, 312, 783	
30.00		126 (11116 1	i tilles iine	= 20)	5, 271, 160 12, 003, 555	
	Total unreimbursed and uncompensated care cost (line 19 plus line	30)			29, 631, 863	
31.00	Trotal differmout sed and uncompensated care cost (Title 19 prus Title	5 30)			27, 031, 003	31.00

		J HEALTH BLOOMING				u of Form CMS-2	2552-10
RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	OF EXPENSES	Provi der	F	Period: From 01/01/2015 Fo 12/31/2015	Worksheet A  Date/Time Pre 5/27/2016 1:5	pared:
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificat ions (See A-6)	Reclassified Trial Balance (col. 3 +-	y piii
		1. 00	2. 00	3.00	4.00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	0.00	1. 00	0.00	
1. 00	00100 CAP REL COSTS-BLDG & FIXT		0	(	10, 093, 055		
2. 00 3. 00	00200 CAP REL COSTS-MVBLE EQUIP 00300 OTHER CAP REL COSTS		0		10, 595, 192	10, 595, 192 0	2. 00 3. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	3, 225, 228	3, 381, 439	6, 606, 66	7 17, 518, 945	1	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	10, 097, 195	84, 813, 912				5. 00
6. 00	00600 MAI NTENANCE & REPAI RS	0	0	(14, 070, (0	٥	0	6.00
7. 00 8. 00	OO7OO  OPERATION OF PLANT   OO8OO  LAUNDRY & LINEN SERVICE	2, 492, 555	8, 778, 079 659, 010				7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG	1, 482, 791	1, 198, 070	2, 680, 86	-617, 911	2, 062, 950	
10.00	01000 DI ETARY	2, 003, 651	2, 329, 325	4, 332, 976			
11. 00 12. 00	O1100   CAFETERI A   O1200   MAI NTENANCE OF PERSONNEL	0	0		1, 481, 041	1, 481, 041	11. 00 12. 00
13. 00	01300 NURSI NG ADMI NI STRATI ON	3, 354, 455	1, 821, 037	5, 175, 492	-722, 182	4, 453, 310	
14. 00	01400 CENTRAL SERVICES & SUPPLY	1, 167	155, 215				
15. 00 16. 00	O1500   PHARMACY   O1600   MEDICAL RECORDS & LIBRARY	4, 435, 834	18, 920, 140 345, 996			1	
17. 00	01700 SOCIAL SERVICE		0 343, 770	343, 770	0 0	0	
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	(	0	0	18. 00
18. 01 19. 00	O1851   CENTRAL STERILIZATION   O1900   NONPHYSICIAN ANESTHETISTS	376, 462	308, 274	684, 736	-253, 650	431, 086	18. 01 19. 00
20.00	02000 NURSI NG SCHOOL		0			0	1
21. 00	02100 I &R SERVICES-SALARY & FRINGES APPRVD	0	0	(	0	0	21.00
22. 00 23. 00	02200   1 & R SERVI CES-OTHER PRGM COSTS APPRVD   02300   PARAMED ED PRGM-PHARMACY RESIDENCY	0	0		0 46, 030	0 46, 030	22. 00 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	l ol	0	1	7 46, 030	46, 030	23.00
30.00	03000 ADULTS & PEDIATRICS	20, 326, 249	9, 934, 607				
31.00	03100 I NTENSI VE CARE UNI T	2, 575, 286	1, 630, 582	4, 205, 868	-858, 952	3, 346, 916	
32. 00 33. 00	03200 CORONARY CARE UNIT	0	0			0	32. 00 33. 00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	Ö	0		0	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0 207 042	1 105 013	0	0	40.00
41. 00 42. 00	O4100   SUBPROVI DER	797, 071	307, 942 0	1, 105, 013	-236, 683	868, 330 0	1
43. 00	04300 NURSERY	1, 169, 821	615, 831	1, 785, 652	-374, 893	1	
44.00	04400 SKILLED NURSING FACILITY	0	0	(	0	0	
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0			0	45. 00 46. 00
	ANCILLARY SERVICE COST CENTERS	-			-		
50. 00 50. 01	05000 OPERATING ROOM 05001 CV SURGERY	6, 075, 690	19, 716, 094	25, 791, 784	-17, 603, 259	8, 188, 525 0	1
51. 00		903, 198	246, 851	1, 150, 049	-173, 561		
	05200 DELIVERY ROOM & LABOR ROOM	2, 770, 652	1, 604, 871			3, 356, 233	
53.00		0 2, 953, 905	0	E E20 423	0	0	
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	2, 953, 905	2, 574, 517 2, 134, 044				1
56.00	05600 RADI OI SOTOPE	0	0	, , ,		0	
57.00	05700 CT SCAN	565, 665	648, 191				1
58. 00 59. 00	05800   MAGNETI C RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	316, 423 1, 017, 312	264, 091 6, 897, 325				1
60.00	06000 LABORATORY	0	10, 069, 763				
60. 01	06001 BLOOD LABORATORY	0	0	(	0	0	
60. 02 61. 00	06002 PHYSI CI AN LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY	0	0			0	60.02
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	Ö	Ò	o o	ő	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(	0	0	63.00
64. 00 65. 00	06400   I NTRAVENOUS THERAPY   06500   RESPI RATORY THERAPY	76, 472 1, 601, 520	162, 073 796, 752			125, 754 1, 781, 414	
66.00	06600 PHYSI CAL THERAPY	7, 039, 511	3, 322, 324				
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(	0	0	
68. 00 69. 00	06800  SPEECH PATHOLOGY   06900  ELECTROCARDI OLOGY	682, 247	609, 233	1, 291, 480	0 -200, 551	0 1, 090, 929	68. 00 69. 00
70.00	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	940, 507	342, 300				
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		9, 246, 483	9, 246, 483	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	765, 405	0 442, 433	1 207 929	10, 692, 449		
74.00	07400 RENAL DIALYSIS	0	442, 433 33, 142				
75.00	07500 ASC (NON-DISTINCT PART)	0	0	(	0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	1, 398, 060	549, 146				
76. 97	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	696, 749	185, 858	882, 607	7 –120, 970	761, 637	76. 97
88. 00	08800 RURAL HEALTH CLINIC	0	0		0	0	88. 00

Health Financial Systems	I HEALTH BLOOMIN	GTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C				Peri od:	Worksheet A	
				From 01/01/2015	5	
				To 12/31/2015	Date/Time Pre 5/27/2016 1:5	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Reclassi fied	J piii
			+ col . 2)	ions (See	Trial Balance	
			,	A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89. 00
90. 00   09000   CLI NI C	1, 614, 344	554, 007	2, 168, 35		1, 527, 638	90.00
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION   BEDS (NON-DISTINCT PART)	4, 001, 487	2, 894, 876	6, 896, 36	3 -1, 501, 858	5, 394, 505	91. 00 92. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
94. 00 09400 HOME PROGRAM DIALYSIS	٥	0		n n	0	94.00
95. 00 09500 AMBULANCE SERVICES	4, 292, 426	2, 473, 914	6, 766, 34	0 -1, 465, 490	_	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	5,755,51	0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0		0 0	Ō	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	o	0		0	0	98. 00
99. 00 09900 CMHC	o	0		0	0	99. 00
99. 10   09910   CORF	0	0		0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
101.00 10100 HOME HEALTH AGENCY	3, 925, 799	2, 986, 613	6, 912, 41	2 -1, 362, 790	5, 549, 622	101. 00
SPECIAL PURPOSE COST CENTERS			Т			
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0		105.00
106. 00 10600  HEART ACQUI SITI ON 107. 00 10700  LI VER ACQUI SITI ON	0	0		0		106. 00 107. 00
107.00 10700 EI VER ACQUISITION 108.00 10800 LUNG ACQUISITION	0	0				107.00
109. 00 10900 PANCREAS ACQUISITION		0				109.00
110. 00 11000   NTESTINAL ACQUISITION		0				110.00
111. 00 11100   SLET ACQUISITION		0		0		111.00
113. 00 11300   NTEREST EXPENSE		1, 388, 681	1, 388, 68	1 -490, 065	898, 616	
114. 00 11400 UTILIZATION REVIEW-SNF	o	0	1, 222, 22	0 0		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	o	0		0	0	115.00
116. 00 11600 HOSPI CE	2, 723, 921	2, 431, 129	5, 155, 05	-1, 204, 136	3, 950, 914	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	98, 742, 623	198, 527, 687	297, 270, 31	2, 346, 783	299, 617, 093	
NONREI MBURSABLE COST CENTERS				_		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	64, 044	108, 157			•	1
190. 01 19001 PROMPTCARE	1, 034, 493	1, 162, 562	2, 197, 05		1, 450, 045	
190. 02 19002 RENTAL PROPERTIES	0	105, 239	105, 23		50, 090	1
190. 03 19003 OLCOTT	250, 531	107, 669			285, 358	1
190. 04 19004 PHYSI CI AN RECRUI TMENT	F70 474	211 547	l	0 432, 811	432, 811	
190. 05 19005 FOUNDATI ON 190. 06 19006 MARKETI NG	579, 474	311, 567	891, 04	1 -145, 022 0 265, 734	746, 019 265, 734	
190. 07 19007 HME STORE	812, 369	2, 294, 304	3, 106, 67			
190. 08 19008 UNUSED SPACE	012, 309	2, 294, 304 N		0 323, 967	323, 967	
190. 09 19009 CLINI CAL TRI ALS	178, 456	266, 484	444, 94		386, 708	
190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINIC	302, 753	125, 828	428, 58		322, 457	
191. 00 19100 RESEARCH	0	0	120,00	0 0	•	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	0		o o		192.00
193. 00 19300 NONPALD WORKERS	o	0		o o		193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	o	0		0	0	194.00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	o	0		0 0		194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	90	9			194. 02
194. 03 07953 IU HEALTH SIP	4, 000	23, 481	27, 48			194. 03
200.00   TOTAL (SUM OF LINES 118-199)	101, 968, 743	203, 033, 068	305, 001, 81	1 0	305, 001, 811	200. 00

Provi der CCN: 150051

Peri od: Worksheet A From 01/01/2015 Date/Time Prepared: 5/27/2016 1:53 pm

COST CENTER DESCRIPTION   CSR A-B)   CSR A					5/27/2016 1:5	
SENERAL SERVICE COST CENTERS   6.00   7.00		Cost Center Description				
GENERAL SERVICE COST CENTERS			(See A-8)			
GENERAL SERVICE COST CENTERS   1.00			6.00			
2.00 002000 CAP REL COSTS-MVBLE EQUIP 615, 400 0 11, 240, 592 0 0 0 0 0 0 0 0 0 0 0 0 1 0 0 0 0 0 0		GENERAL SERVICE COST CENTERS				
3.00   0.0350  OTHER CAP REL COSTS   0   0   0   0   0   0   0   0   0		ł I	1		1	1.00
4.00   00-400   IMPLOYEE BENEFITS DEPARTMENT   3.399, 2008   52, 72-24, 82-0   6.00   000-000 JAMI NISTRATIVE & GENERAL   -21.886, 548   52, 72-22, 25-9   8.00   000-000 JAMI NISTRATIVE & GENERAL   -21.886, 548   52, 72-22, 25-9   8.00   000-000 JAMI NISTRATIVE & GENERAL   -22.37.766   3.98, 70-2   8.00   000-000 JAMI NISTRATIVE & GENERAL   -22.37.766   3.98, 70-2   9.00   000-000 JAMI NISTRATIVE & GENERAL   -22.37.766   3.98, 70-2   9.00   000-000 JAMI NISTRATIVE & GENERAL   -22.37.766   3.98, 70-2   9.00   000-000 JEFAT   -2.300 JAMI NISTRATION   -2.20, 72.200 JAMI NISTRATION   -2.200 JAMI NISTRATION					l .	2.00
5.00 005000 ADMIN STRANTLY & GENERAL				-	I .	3. 00 4. 00
0.000   00000   00000   00000   00000   00000   00000   00000   000000					l e e e e e e e e e e e e e e e e e e e	5.00
7. 00 00700   OPERATION OF PLANT   .794, 052   9, 923, 939     8. 00 00800   LAUNDRY & LINEN SERVICE   .223, 766   398, 702     9. 00 00900   HOUSEKEPIN S			21,000,540	1 1		6.00
9.00   00900   100SEKEEPI NG			-784, 052	9, 923, 939		7.00
10.00   01000   01500   01500   01500   02500   0150	8.00	00800 LAUNDRY & LINEN SERVICE	-223, 786	398, 702		8.00
11.00   01100   CAPETERIA						9. 00
12.00   01200   MAINTENANCE OF PERSONNEL   0   0   1   14.00   01400   OLENTRAL SERVICES & SUPPLY   -25.113   4, 428, 197   1   14.00   01400   OLENTRAL SERVICES & SUPPLY   -38, 812   4, 927, 706   1   16.00   01600   PHARMACY   -38, 812   4, 927, 706   1   17.00   01700   SOCIAL SERVICE   0   0   0   345, 954   1   17.00   01700   SOCIAL SERVICE   0   0   0   0   1   18.00   01850   OTHER GENERAL SERVICE (SPECIFY)   0   0   0   0   1   18.01   01851   CENTRAL STERVILEZ (SPECIFY)   0   0   0   0   1   18.01   01851   CENTRAL STERVILEZ (SPECIFY)   0   0   0   0   0   1   19.00   01900   MURSI ING SCHOOL   0   0   0   0   0   1   19.00   01900   MURSI ING SCHOOL   0   0   0   0   0   0   0   0   2   2						10.00
13.00   01300   NURSI NG ADMINISTRATION   -25.113   4, 428, 197   1   1   1   1   1   1   1   1   1		1	-1, 606, 424	-125, 383		11.00
14. 00   01400   CENTRAL SERVI CES & SUPPLY   0   11, 837, 904   1   15.00			_25 113	4 428 197		12. 00 13. 00
15.00   01500   PHARMACY   -38, 812   4, 927, 706   1   1   1   1   1   1   1   1   1			25, 119			14.00
10.0   01600 MEDICAL RECORDS & LIBRARY   0   345,954   1   1   1   1   1   1   1   1   1		1	-38, 812			15.00
18.00   01850   OTHER CEMERAL SERVICE (SPECIFY)   0   0   0   13.086   13	16.00	01600 MEDICAL RECORDS & LIBRARY				16.00
18. 01   01851   CENTRAL STERILIZATION			0	0		17. 00
19.00   01900   NORPHYSIC   AN ANESTHETISTS   0   0   0   22		1 1	0	0		18. 00
20. 00   02000   NURSING SCHOOL   2   2   1   1   1   1   1   1   1   1		1	0	431, 086		18. 01
21 00   02100   IAR SERVI CES-SALARY & FRINCES APPRVD   0   0   0   22   22   20   02200   IAR SERVI CES-OTHER PRGM COSTS APPRVD   0   0   0   0   23   24   26   26   26   26   26   26   26		1 I	0	0		19. 00 20. 00
22.00   0.2200   IAR SERVICES-OTHER PRGM COSTS APPRVD   0   0   0   0   2   2   3.00   22.300   PARAMED ED PRGM-PHARMACY RESIDENCY   0   46.030			0	0		21.00
23.00   02300   PARAMED ED PROM-PHARMACY RESIDENCY   0   46,030   2     INPATIENT ROUTI NE SERVICE COST CENTERS   30.00   03000   ADULTS & PEDIATRICS   -367,085   24,766,078   31.00   03100   INTENSI VE CARE UNIT   0   3,346,916   33.20   03200   CORONARY CARE UNIT   0   0   0   0   3.340,916   33.40   03200   CORONARY CARE UNIT   0   0   0   0   3.340,00   03200   SUBRO INTENSI VE CARE UNIT   0   0   0   0   0   3.340,00   03400   SUBPROVI DER - IPF   0   0   0   0   0   0   0   0   0			0	Ö		22.00
30. 00 03000 ADULTS & PEDIATRICS		1 I	0	46, 030		23.00
31.00   03100   NTENSI VE CARE UNIT		INPATIENT ROUTINE SERVICE COST CENTERS				
32.00   03200   COROMARY CARE UNIT   0   0   0   3   3   3   3   0   0   3   0   0		ł I			1	30.00
33.00   03300   BURN I NTENSI VE CARE UNI T   0   0   0   0   33.00   03400   SURGI CAL I NTENSI VE CARE UNI T   0   0   0   0   0   0   0   0   0				3, 346, 916		31.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 0 40. 00 04000 SUBPROVI DER - I PF 0 0 868, 330 44 41. 00 04100 SUBPROVI DER - I IFF 0 0 868, 330 44 42. 00 04200 SUBPROVI DER 0 0 0 0 43. 00 04200 SUBPROVI DER 0 0 0 0 44. 00 04400 SVI LLED NURSI NG FACI LI TY 0 0 0 0 45. 00 04400 SVI LLED NURSI NG FACI LI TY 0 0 0 0 46. 00 04400 SVI LLED NURSI NG FACI LI TY 0 0 0 0 46. 00 04600 NURSI NG FACI LI TY 0 0 0 0 0 47. 00 04600 NURSI NG FACI LI TY 0 0 0 0 0 48. 188, 525 5 50. 00 05000 PERATI NG ROOM 0 8, 188, 525 5 51. 00 05000 PERATI NG ROOM 0 976, 488 55. 00 05000 PERATI NG ROOM -15, 070 3, 341, 163 55. 00 05300 ANESTHESI OLOGY 0 0 550 05300 ANESTHESI OLOGY 0 0 550 05300 ANESTHESI OLOGY 0 0 550 05000 RADI OLOGY-THERAPEUTI C -61, 560 3, 193, 351 55. 00 05500 RADI OLOGY-THERAPEUTI C -61, 560 3, 193, 351 55. 00 05500 RADI OLOGY-THERAPEUTI C -61, 560 3, 193, 351 55. 00 05500 RADI OLOGY-THERAPEUTI C -61, 560 3, 193, 351 55. 00 05500 RADI OLOGY-THERAPEUTI C -61, 560 3, 193, 351 55. 00 05500 RADI OLOGY-THERAPEUTI C -61, 560 3, 193, 351 55. 00 05500 RADI OLOGY-THERAPEUTI C -61, 560 3, 193, 351 55. 00 05500 CT SCAN 0 0 860, 571 55. 00 05000 LABORATORY 0 0 860, 571 55. 00 05000 LABORATORY 0 0 1, 513, 688 55. 00 05000 LABORATORY 0 0 1, 513, 688 55. 00 05000 LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		32. 00 33. 00
40. 00   04000   SUBPROVI DER - I PF   0   0   868, 330   44. 00   04200   SUBPROVI DER   1RF   0   0   868, 330   44. 00   04200   SUBPROVI DER   0   0   0   0   0   0   0   0   0			0	0		34.00
41. 00 04100 SUBPROVI DER - I RF 0 868, 330 4 42. 00 04200 SUBPROVI DER 0 0 0 43. 00 04300 NURSERY -8, 429 1, 402, 330 4 44. 00 04400 SKI LLED NURSI NG FACI LI TY 0 0 0 45. 00 04500 NURSI NG FACI LI TY 0 0 0 46. 00 04600 OTHER LONG TERM CARE 0 0 47. 00 05000 OPERATI NG ROOM 0 0 48. 188, 525 5 50. 01 05001 CV SURGERY 0 0 0 51. 00 05100 RECOVERY ROOM 0 976, 488 5 52. 00 05200 DELI VERY ROOM LABOR ROOM -15, 070 3, 341, 163 5 53. 00 05300 ANESTHESI OLOGY 0 0 5 54. 00 05400 RADI OLOGY-DI AGNOSTI C -727 3, 677, 537 5 55. 00 05500 RADI OLOGY-DI AGNOSTI C -61, 560 3, 193, 351 5 60. 00 05600 RADI OLOGY-DI AGNOSTI C -61, 560 3, 193, 351 5 60 00 05600 RADI OLOGY-DI AGNOSTI C -61, 560 3, 193, 351 5 60 00 05600 RADI OLOGY-DI AGNOSTI C -61, 560 3, 193, 351 5 60 00 05600 RADI OLOGY-DI AGNOSTI C -61, 560 3, 193, 351 5 60 00 05600 RADI OLOGY-DI AGNOSTI C -61, 560 3, 193, 351 5 60 00 05600 RADI OLOGY-DI AGNOSTI C -61, 560 3, 193, 351 5 60 00 05600 RADI OLOGY-DI AGNOSTI C -61, 560 3, 193, 351 5 60 00 05600 RADI OLOGY-DI AGNOSTI C -61, 560 3, 193, 351 5 60 00 05600 RADI OLOGY-DI AGNOSTI C -61, 560 3, 193, 351 5 60 00 05600 LABORATORY 0 0 0 660 0 LABORATORY -600 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	Ö		40.00
43. 00		1 1	0	868, 330		41.00
44. 00	42.00		0	0		42.00
45. 00				1, 402, 330		43.00
46.00   04600   OTHER LONG TERM CARE   0   0   0     4				0		44. 00 45. 00
ANCI LLARY SERVI CE COST CENTERS   50.00   05000   0FERATI NG ROOM   0   8, 188, 525   50.01   05001   CV SURGERY   0   0   0   0   50.01   05001   CV SURGERY   0   0   0   0   0   50.00   05.00   RECOVERY ROOM   0   0   0   0   0   0   0   0   0				1	l .	46.00
50. 01       05001       CV SURGERY       0       0       0       51. 00       05100       RECOVERY ROOM       0       976, 488       5         52. 00       05200       DELI VERY ROOM & LABOR ROOM       -15, 070       3, 341, 163       5         53. 00       05300       ANESTHESI OLOGY       0       0       0         54. 00       05400       RADI OLOGY-DI AGNOSTI C       -727       3, 677, 537       5         55. 00       05500       RADI OLOGY-THERAPEUTI C       -61, 560       3, 193, 351       5         56. 00       05600       RADI OLOGY-THERAPEUTI C       -61, 560       0       0       0         57. 00       05700       CT SCAN       0       0       0       5         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       459, 284       5         59. 00       05900       CARDI AC CATHETERI ZATI ON       0       1, 513, 688       5         60. 01       06000       LABORATORY       -263, 602       9, 775, 638       6         60. 02       06000       PHYSI CI AN LABORATORY       0       0       0       6         61. 00       06100       PBP CLI NI CAL LAB SERVI CES-PRGM ONLY       0	10.00			<u> </u>		10.00
51. 00       05100       RECOVERY ROOM       0       976, 488         52. 00       05200       DELIVERY ROOM & LABOR ROOM       -15, 070       3, 341, 163         53. 00       05300       ANESTHESI OLOGY       0       0         54. 00       05400       RADI OLOGY-DI AGNOSTI C       -727       3, 677, 537         55. 00       05500       RADI OLOGY-THERAPEUTI C       -61, 560       3, 193, 351         56. 00       05600       RADI OLOGY-THERAPEUTI C       -61, 560       3, 193, 351         57. 00       05700       CT SCAN       0       0         59. 00       05700       CT SCAN       0       860, 571         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       459, 284         59. 00       05900       CARDI AC CATHETERI ZATI ON       0       1, 513, 688         60. 01       06000       LABORATORY       -263, 602       9, 775, 638         60. 02       06000       PHYSI CI AN LABORATORY       0       0         61. 00       06100       PBP CLI NI CAL LAB SERVI CES-PRGM ONLY       0       0         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0         63. 00       06300 <td>50.00</td> <td></td> <td>0</td> <td>8, 188, 525</td> <td></td> <td>50.00</td>	50.00		0	8, 188, 525		50.00
52. 00       05200       DELI VERY ROOM & LABOR ROOM       -15,070       3,341,163       5.         53. 00       05300       ANESTHESI OLOGY       0       0       5.         54. 00       05400       RADI OLOGY-DI AGNOSTI C       -727       3,677,537       5.         55. 00       05500       RADI OLOGY-THERAPEUTI C       -61,560       3,193,351       5.         56. 00       05600       RADI OI SOTOPE       0       0       0         57. 00       05700       CT SCAN       0       860,571       5.         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       459,284       5.         59. 00       05900       CARDI AC CATHETERI ZATI ON       0       1,513,688       5.         60. 01       06000       LABORATORY       -263,602       9,775,638       6.         60. 02       06000       DABORATORY       0       0       6.         61. 00       06100       PBP CLI NI CAL LAB SERVI CES-PRGM ONLY       0       0       0         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0         63. 00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0			0		•	50. 01
53. 00       05300       ANESTHESI OLOGY       0       0       5         54. 00       05400       RADI OLOGY-DI AGNOSTI C       -727       3, 677, 537       5         55. 00       05500       RADI OLOGY-THERAPEUTI C       -61, 560       3, 193, 351       5         56. 00       05600       RADI OI SOTOPE       0       0       0         57. 00       05700       CT SCAN       0       860, 571       5         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       459, 284       5         59. 00       05900       CARDI AC CATHETERI ZATI ON       0       1, 513, 688       5         60. 00       06000       LABORATORY       -263, 602       9, 775, 638       6         60. 01       060001       BLOOD LABORATORY       0       0       6         60. 02       060002       PHYSI CI AN LABORATORY       0       0       6         61. 00       06100       PBP CLI NI CAL LAB SERVI CES-PRGM ONLY       0       0       6         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0       6         63. 00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0 <td< td=""><td></td><td>1 I</td><td>15.070</td><td></td><td></td><td>51.00</td></td<>		1 I	15.070			51.00
54. 00       05400       RADI OLOGY-DI AGNOSTI C       -727       3,677,537       5.         55. 00       05500       RADI OLOGY-THERAPEUTI C       -61,560       3,193,351       5.         56. 00       05600       RADI OI SOTOPE       0       0       5.         57. 00       05700       CT SCAN       0       860,571       5.         58. 00       05800       MAGNETI C RESONANCE I MAGI NG (MRI)       0       459,284       5.         59. 00       05900       CARDI AC CATHETERI ZATI ON       0       1,513,688       5.         60. 00       06000       LABORATORY       -263,602       9,775,638       6.         60. 01       06001       BLOOD LABORATORY       0       0       6.         60. 02       06002       PHYSI CI AN LABORATORY       0       0       6.         61. 00       06100       PBP CLI NI CAL LAB SERVI CES-PRGM ONLY       0       0       6.         62. 00       06200       WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0         63. 00       06300       BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0			-15,0/0			52. 00 53. 00
55. 00       05500 RADI OLOGY-THERAPEUTI C       -61,560       3,193,351       5         56. 00       05600 RADI OI SOTOPE       0       0       5         57. 00       05700 CT SCAN       0       860,571       5         58. 00       05800 MAGNETI C RESONANCE IMAGING (MRI)       0       459,284       5         59. 00       05900 CARDI AC CATHETERI ZATI ON       0       1,513,688       5         60. 01       06000 LABORATORY       -263,602       9,775,638       6         60. 01       06001 BLOOD LABORATORY       0       0       6         60. 02       06002 PHYSI CI AN LABORATORY       0       0       6         61. 00       06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY       0       0       6         62. 00       06200 WHOLE BLOOD & PACKED RED BLOOD CELLS       0       0       0       6         63. 00       06300 BLOOD STORI NG, PROCESSI NG & TRANS.       0       0       0       6			-727	-	I .	54.00
56. 00   05600   RADI OI SOTOPE   0 0   0   57. 00   05700   CT SCAN   0   860, 571   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI ) 0   459, 284   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   1, 513, 688   60. 00   06000   LABORATORY   -263, 602   9, 775, 638   66. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0						55.00
58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI)   0   459, 284   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   1,513, 688   560. 00   06000   LABORATORY   -263, 602   9,775, 638   660. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0	56. 00					56.00
59. 00     05900     CARDI AC CATHETERI ZATI ON     0     1,513,688       60. 00     06000     LABORATORY     -263,602     9,775,638       60. 01     06001     BLOOD LABORATORY     0     0       60. 02     06002     PHYSI CI AN LABORATORY     0     0       61. 00     06100     PBP CLI NI CAL LAB SERVI CES-PRGM ONLY     0     0       62. 00     06200     WHOLE BLOOD & PACKED RED BLOOD CELLS     0     0       63. 00     06300     BLOOD STORI NG, PROCESSI NG & TRANS.     0     0		1 I	0		1	57.00
60. 00   06000   LABORATORY   -263, 602   9, 775, 638   66 60. 01   06001   BLOOD LABORATORY   0   0   60. 02   06002   PHYSI CI AN LABORATORY   0   0   61. 00   06100   PBP   CLI NI CAL LAB SERVI CES-PRGM ONLY   0   0   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   64. 00   06300   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   65. 00   06300   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   66. 00   06300						58.00
60. 01   06001   BLOOD LABORATORY   0 0 0   60. 02   06002   PHYSI CI AN LABORATORY   0 0 0   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0 0 0   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 I	_		•	59.00
60. 02   06002   PHYSI CI AN LABORATORY   0 0 0   61. 00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0 0 0   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0 0 0   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0 0 0   0   0   0   0   0   0   0						60. 00 60. 01
61. 00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY   0   0   0   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   0   0   0		1 1	1	-		60.02
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   6.		1 I	0	Ö		61.00
		06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	o		62.00
64. 00   06400   I NTRAVENOUS THERAPY   -24, 110   101, 644   6.			0	0		63.00
			-24, 110			64.00
		ł ł	422 103			65.00
				1		66. 00 67. 00
		1			•	68.00
		1		"		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY -7, 300 1, 036, 005 7	70.00	07000 ELECTROENCEPHALOGRAPHY	-7, 300			70.00
			0			71.00
			1			72.00
		1 I				73.00
		1 I				74. 00 75. 00
				-	I and the second	75.00
			1			76. 97
OUTPATIENT SERVICE COST CENTERS		OUTPATIENT SERVICE COST CENTERS				
					·	88.00
89.00  08900  FEDERALLY QUALIFIED HEALTH CENTER   0 0   8	89.00	U8900 FEDERALLY QUALIFIED HEALIH CENIER	1 0	<u> </u> 0	1	89.00

Health FinancialSystemsIU HEALTH BLORECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES Peri od: Worksheet A From 01/01/2015 Date/Time Prepared: Provi der CCN: 150051

			10   12/31/2015   Date/11 me Pro	
Cost Center Description	Adjustments	Net Expenses	072772010 1.0	70
,	(See A-8)	For		
		Allocation		
	6. 00	7. 00		
90. 00  09000  CLI NI C	-120, 497	1, 407, 141		90.00
91. 00   09100   EMERGENCY	314, 914	5, 709, 419		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
OTHER REIMBURSABLE COST CENTERS				4
94.00 09400 HOME PROGRAM DIALYSIS	0		i e	94.00
95. 00 09500 AMBULANCE SERVI CES	-197, 974	5, 102, 876		95. 00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		96. 00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
99. 00  09900  CMHC	0	0	l .	99. 00
99. 10   09910   CORF	0	0	l .	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	1	l .	100. 00
101.00 10100 HOME HEALTH AGENCY	-218, 617	5, 331, 005		101. 00
SPECIAL PURPOSE COST CENTERS				4
105. 00 10500 KI DNEY ACQUI SI TI ON	0			105. 00
106. 00 10600 HEART ACQUISITION	0		1	106. 00
107.00 10700 LIVER ACQUISITION	0	0		107. 00
108. 00 10800 LUNG ACQUI SI TI ON	0	0		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	1	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	1	110. 00
111.00 11100 ISLET ACQUISITION	0	1	•	111. 00
113.00 11300 INTEREST EXPENSE	-898, 616		l .	113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0		I .	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115. 00
116. 00 11600 HOSPI CE	0	3, 950, 914		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	-21, 453, 095	278, 163, 998		118. 00
NONREI MBURSABLE COST CENTERS	·			4
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		•	190. 00
190. 01 19001 PROMPTCARE	-75, 017		•	190. 01
190. 02 19002 RENTAL PROPERTIES	0		•	190. 02
190. 03 19003 OLCOTT	0		•	190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	432, 811	•	190. 04
190. 05 19005 FOUNDATI ON	0	746, 019	•	190. 05
190. 06 19006 MARKETI NG	0	200, 70	•	190. 06
190. 07 19007 HME STORE	-783, 769			190. 07
190. 08 19008 UNUSED SPACE	0	,	1	190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	386, 708		190. 09
190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINIC	0	322, 457	1	190. 10
191. 00 19100 RESEARCH	0	0	l control of the cont	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		192.00
193. 00 19300 NONPALD WORKERS	0	0		193.00
194. 00 07950 IU HEALTH PAOLI HOSPITAL	19, 324, 896		•	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	41, 594, 253			194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	18, 084, 812			194. 02
194. 03 07953 I U HEALTH SI P	0	.,	•	194. 03
200.00   TOTAL (SUM OF LINES 118-199)	56, 692, 080	361, 693, 891		200. 00

Health Financial Systems RECLASSIFICATIONS IU HEALTH BLOOMINGTON HOSPITAL Provider CCN: 150051 Period: Worksheet A-6
From 01/01/2015
To 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm

					5/27/2016 1:	
		Increases				
	Cost Center 2.00	Li ne #	Sal ary	Other 5.00		
	A - DEPRECIATION	3. 00	4. 00	5. 00		
1. 00	CAP REL COSTS-BLDG & FIXT	1. 00	0	7, 617, 540		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	9, 459, 970		2.00
	TOTALS		0	17, 077, 510		
1 00	B - LEASE	1 00		2 055 747		1.00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1. 00 2. 00		2, 055, 746 445, 474		1.00 2.00
3. 00	INTENSIVE CARE UNIT	31.00		297		3.00
4.00		0.00	O	0		4.00
5. 00		0. 00	0	0		5. 00
6. 00 7. 00		0. 00 0. 00	0	0		6. 00 7. 00
8. 00		0.00	0	0		8.00
9. 00		0.00	O	Ö		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	Ö	Ö		14. 00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16.00
17. 00 18. 00		0. 00 0. 00	0	0		17. 00 18. 00
19. 00		0.00	0	0		19.00
20.00		0.00	0	O		20.00
21.00		0.00	•	0		21.00
	TOTALS C - PROPERTY TAX		0	2, 501, 517		
1. 00	CAP REL COSTS-BLDG & FLXT	1. 00	ol	229, 229		1.00
2. 00		0. 00	Ō	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4.00
5. 00 6. 00		0. 00 0. 00	0	0		5. 00 6. 00
7. 00		0. 00	Ö	Ö		7. 00
8.00	L	000	0	0		8. 00
	TOTALS D - INTEREST		0	229, 229		
1. 00	CAP REL COSTS-BLDG & FLXT	1.00		490, 065		1.00
	TOTALS			490, 065		
1 00	E - PHARMACY RESIDENCY	00.00	44 000	4 050		1.00
1. 00	PARAMED ED PRGM-PHARMACY RESIDENCY	23. 00	41, 080	4, 950		1. 00
	TOTALS		41, 080	4, 950		
	F - I NSURANCE					
1. 00 2. 00	CAP REL COSTS-MVBLE EQUIP HME STORE	2. 00 190. 07		531, 219 42, 751		1. 00 2. 00
3. 00	TIME STOKE	0.00	0	42, 731		3.00
4.00		0. 00	0	0		4. 00
5. 00		0.00	0	0		5. 00
	TOTALS G - BENEFITS		0	573, 970		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	17, 834, 576		1.00
2.00	CENTRAL SERVICES & SUPPLY	14. 00	0	216		2. 00
3.00		0.00	0	0		3.00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6. 00		0. 00	o	Ö		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	0	0		11.00
12.00		0. 00	Ö	0		12.00
13.00		0. 00	O	0		13.00
14.00		0.00	0	0		14.00
15. 00 16. 00		0. 00 0. 00	0	0		15. 00 16. 00
17. 00		0.00	0	0		17. 00
18.00		0. 00	0	0		18. 00
19.00		0.00	0	0		19.00
20. 00 21. 00		0. 00 0. 00	0	0		20. 00 21. 00
22. 00		0.00	o	0		22.00
		· · · · · · · · · · · · · · · · · · ·	'	'		

Health Financial Systems RECLASSIFICATIONS IU HEALTH BLOOMINGTON HOSPITAL Provider CCN: 150051 

					10	12/ 51/ 2015	5/27/2016 1:53 pm
		Increases			· .		
	Cost Center	Li ne #	Sal ary	0ther			
22.00	2.00	3.00	4. 00	5. 00			22.00
23. 00 24. 00		0. 00 0. 00	0	0			23. 00 24. 00
25. 00		0.00	0				25. 00
26. 00		0. 00	0				26.00
27. 00		0. 00	0				27. 00
28.00		0.00	0	0			28. 00
29.00		0.00	0				29. 00
30.00		0. 00	0				30.00
31.00		0.00	0				31.00
32.00		0.00	0				32.00
33. 00 34. 00		0. 00 0. 00	0				33. 00 34. 00
35.00		0.00	0				35.00
36. 00		0.00	0				36.00
37. 00		0. 00	0				37. 00
38.00		0.00	0				38.00
39.00	L	0.00	0				39.00
	TOTALS			17, 834, 792			
	H - COMPUTER LICENSE	2 20		100 074			1.00
1.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	182, 971			1.00
2. 00 3. 00		0. 00 0. 00	0				2. 00 3. 00
4. 00		0.00	0				4.00
5. 00		0.00	0				5.00
6. 00		0. 00	0				6.00
7. 00		0. 00	0	Ö			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
	TOTALS		0	182, 971			
1 00	I - RECRUITING PHYSICIAN RECRUITMENT	190. 04		432, 811			1 00
1. 00 2. 00	PHISICIAN RECRUITIMENT	0.00	0				1. 00 2. 00
3. 00		0.00	0				3.00
4. 00		0. 00	0				4.00
	TOTALS			432, 811			
	J - CAFE						
1. 00	CAFETERI A	1100	71 <u>3, 4</u> 80				1.00
	TOTALS		713, 480	767, 561			
1. 00	K - UTILITIES OPERATION OF PLANT	7. 00		355, 448			1.00
2. 00	DELIVERY ROOM & LABOR ROOM	52. 00		6, 409			2.00
3. 00	BEET VERT ROOM & ENDOR ROOM	0.00	0	· ·			3.00
4.00		0.00	0				4.00
5.00		0.00	0	0			5.00
6.00		0. 00	0	0			6. 00
7. 00		0. 00	0				7. 00
8. 00		0.00	0	١			8.00
9. 00 10. 00		0. 00 0. 00	0				9. 00 10. 00
11. 00		0.00	0	0			11.00
12. 00		0.00	0				12.00
13. 00		0. 00	0	Ö			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
	TOTALS		0	361, 857			
1. 00	L - MARKETI NG MARKETI NG	190. 06		265, 734			1.00
2. 00	WARRETTING	0.00	0	1			2.00
3. 00		0.00	0				3.00
4. 00		0.00	0	- 1			4.00
5. 00		0. 00	0	Ö			5. 00
6.00		0. 00	0	0			6. 00
7. 00		0.00	0	0			7. 00
	TOTALS		0	265, 734			
1 00	M - BCC DEPRECIATION	100.00		20,000			1 00
1. 00	UNUSED SPACE	190.08		20, 802 20, 802			1.00
	N - LIBERTY BUILDING DEPRECIA	ATI ON	0	20, 602			
1. 00	UNUSED SPACE	190. 08		131, 719			1.00
2. 00		0.00	0	0			2.00
	TOTALS — — — —	— — <del>- 1</del> †	<u> </u>	131, 719			
	·						

Health Financial Systems RECLASSIFICATIONS Period: Worksheet A-6
From 01/01/2015
To 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm Provi der CCN: 150051

					10	/27/2016 1:53 pm
		Increases			•	
	Cost Center	Li ne #	Salary	0ther		
	2.00 0 - SHORT-TERM DI SABILITY	3. 00	4. 00	5. 00		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00		1, 163		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00		36, 803		2.00
3. 00	OPERATION OF PLANT	7. 00		8, 787		3.00
4.00	HOUSEKEEPI NG	9. 00		10, 963		4.00
5.00	DI ETARY	10. 00		12, 964		5. 00
6.00	NURSING ADMINISTRATION	13. 00		8, 963		6.00
7.00	PHARMACY	15. 00		5, 928		7.00
8. 00	CENTRAL STERILIZATION	18. 01		1, 964		8.00
9.00	ADULTS & PEDI ATRI CS	30.00		187, 232		9.00
10.00	INTENSIVE CARE UNIT	31.00		21, 832		10.00
11.00	SUBPROVI DER – I RF	41. 00		5, 325		11.00
12. 00 13. 00	NURSERY OPERATING ROOM	43. 00 50. 00		7, 099 46, 237		12.00
14. 00	RECOVERY ROOM	51. 00		2, 331		14.00
15. 00	DELIVERY ROOM & LABOR ROOM	52. 00		10, 735		15. 00
16. 00	RADI OLOGY-DI AGNOSTI C	54. 00		13, 870		16.00
17. 00	RADI OLOGY-THERAPEUTI C	55. 00		6, 255		17. 00
18.00	CT SCAN	57. 00		4, 134		18. 00
19.00	MAGNETIC RESONANCE IMAGING	58. 00		1, 394		19.00
	(MRI)					
20.00	CARDI AC CATHETERI ZATI ON	59. 00		8, 277		20.00
21. 00	RESPI RATORY THERAPY	65. 00		13, 700		21.00
22. 00	PHYSI CAL THERAPY	66. 00		40, 870		22.00
23.00	ELECTROCARDI OLOGY	69. 00		15, 959		23. 00
24. 00	ELECTROENCEPHALOGRAPHY	70.00		9, 508		24.00
25. 00 26. 00	DRUGS CHARGED TO PATIENTS	73. 00		5, 983		25. 00 26. 00
20.00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	75. 01		3, 741		20.00
27. 00	CARDI AC REHABI LI TATI ON	76. 97		834		27. 00
28. 00	CLI NI C	90.00		5, 976		28.00
29. 00	EMERGENCY	91.00		34, 733		29. 00
30.00	AMBULANCE SERVICES	95. 00		22, 942		30.00
31.00	HOME HEALTH AGENCY	101. 00		8, 945		31.00
32.00	HOSPI CE	116. 00		18, 929		32.00
33.00	PROMPTCARE	190. 01		277		33.00
34.00	HME STORE	1 <u>90.</u> 07		29, 189		34.00
	TOTALS		0	613, 842		
1. 00	P - ANTI COAGULATI ON HOME HEALTH AGENCY	101.00	296, 772	0		1.00
1.00	TOTALS	101.00	296, 772	0		1.00
	Q - CHILDREN'S THERAPY ANNEX	RENT	270, 112	O <sub>I</sub>		
1. 00	UNUSED SPACE	190. 08		171, 446		1.00
	TOTALS			171, 446		
	R - URGENT CARE BILLING					
1.00	ADMINISTRATIVE & GENERAL	5. 00	152, 690	0		1.00
	TOTALS		152, 690	0		
	S - BILLABLE DRUGS					
1.00	DRUGS CHARGED TO PATIENTS	73. 00		18, 938, 310		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4. 00 5. 00		0. 00 0. 00	0	0		4. 00 5. 00
6. 00		0.00	0	0		6.00
7. 00		0.00	o	o		7. 00
8. 00		0. 00	o	Ö		8.00
9. 00		0. 00	o	Ö		9.00
10.00		0. 00	O	0		10.00
11.00		0. 00	О	0		11.00
12.00		0. 00	O	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
17.00		0.00	0	0		17.00
18.00		0. 00 0. 00	0	0		18.00
19. 00 20. 00		0.00	0	0		19. 00 20. 00
21. 00	1	0.00	0	0		21. 00
21.00	1	0.00	0	0		21.00
23. 00		0.00	0	0		23. 00
24. 00		0. 00	o	Ö		24.00
25. 00		0. 00	Ö	Ö		25. 00
26.00		0.00	О	0		26.00

Health Financial Systems RECLASSIFICATIONS IU HEALTH BLOOMINGTON HOSPITAL Provider CCN: 150051 Period: Worksheet A-6
From 01/01/2015
To 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm

					6 1:53 pm
	Cost Contor	Increases	Salary	Othor	
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00	
27. 00	2. 00	0.00	4.00	0	27. 00
28. 00		0.00	0	0	28. 00
	TOTALS		0	18, 938, 310	
	T - NON-BILLABLE DRUGS				
1.00	PHARMACY	15. 00		5, 961	1.00
2. 00 3. 00	1	0. 00 0. 00	0	0	2.00 3.00
4. 00		0.00	0	0	4. 00
5. 00		0. 00	O	0	5. 00
	TOTALS			5, 961	
	U - BILLABLE IMPLANTS				
1. 00	I MPL. DEV. CHARGED TO	72. 00		10, 692, 449	1.00
2. 00	PATI ENTS	0. 00	o	0	2. 00
3. 00		0.00	0	0	3.00
4. 00		0.00	0	0	4.00
5. 00		0.00	O	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 11. 00	1	0. 00 0. 00	0	0	10. 00 11. 00
12. 00		0.00	o	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
17.00		0.00	0	0	17.00
18.00		0.00	0	0	18.00
19. 00 20. 00		0. 00 0. 00	0	0	19. 00 20. 00
20.00	TOTALS — — — —		<del> </del>	10, 692, 449	20.00
	V - BILLABLE SUPPLIES	L	<u> </u>	10/072/117	
1.00	OPERATION OF PLANT	7. 00		624	1.00
2. 00	LAUNDRY & LINEN SERVICE	8. 00		6, 229	2. 00
3.00	CENTRAL SERVICES & SUPPLY	14.00		2, 124	3.00
4.00	PHARMACY	15. 00 30. 00		121	4.00
5. 00 6. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	31. 00		62, 432 30, 849	5. 00 6. 00
7. 00	SUBPROVI DER - I RF	41.00		4, 206	7.00
8. 00	RECOVERY ROOM	51.00		3, 789	8. 00
9.00	ELECTROCARDI OLOGY	69. 00		1, 282	9. 00
10.00	MEDICAL SUPPLIES CHARGED TO	71. 00		9, 246, 483	10.00
11 00	PATI ENTS	04.00		7 050	11 00
11. 00 12. 00	EMERGENCY HOSPI CE	91. 00 116. 00		7, 058 1, 403	11. 00 12. 00
13. 00	HME STORE	190. 07		41, 137	13. 00
14. 00	Time STORE	0.00	0	0	14. 00
15.00		0.00	0	0	15.00
16.00		0. 00	0	0	16.00
17. 00		0. 00	0	0	17. 00
18.00		0.00	0	0	18.00
19. 00 20. 00		0. 00 0. 00	0	0	19. 00 20. 00
20.00		0.00	0	0	20.00
22. 00		0.00	0	0	22.00
23. 00		0.00	0	0	23. 00
24.00		0.00	0	0	24.00
25.00		0. 00	0	0	25. 00
26.00		0.00	0	0	26. 00
27. 00		0.00	0	0	27.00
28. 00		000	0	0 9, 407, 737	28. 00
	W - NON-BILLABLE SUPPLIES		U <sub>I</sub>	7, 407, 737	
1. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	11, 808, 432	1.00
2. 00	IU HEALTH SIP	194. 03	0	14	2.00
3.00		0.00	0	0	3.00
4. 00 5. 00		0. 00 0. 00	0	0	4. 00 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

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 5/27/2016 1:53 pm Provi der CCN: 150051

					5/2//2016 1:53 pm
		Increases			
	Cost Center	Li ne #	Sal ary	0ther	
	2. 00	3.00	4. 00	5. 00	
10.00		0.00	0	0	10.
11.00		0.00	0	0	11.
12.00		0.00	o	0	12.
13.00		0.00	0	0	l l
14. 00		0.00	0	0	l l
15. 00		0.00	0	0	l l
16. 00		0.00	0	0	
17. 00		0.00	0	0	l l
18. 00		0.00	0	0	l l
19. 00	•	0.00	0	0	
20.00	+	0.00	0	0	
				0	l l
21.00		0.00	0		
22.00		0.00	0	0	
23.00		0.00	0	0	
24.00		0.00	0	0	
25.00		0.00	0	0	
26.00		0.00	0	0	
27.00		0.00	0	0	
28. 00		0.00	0	0	
29.00		0.00	0	0	
30.00		0.00	0	0	30.
31.00		0.00	0	0	31.
32.00		0.00	0	0	32.
33.00		0.00	0	0	33.
34.00		0.00	0	0	34.
35.00		0.00	0	0	35.
36.00		0.00	0	0	l l
37. 00		0.00	0	0	
38. 00	1	0.00	0	0	l l
39. 00		0.00	n	0	
40. 00		0.00	0	0	l l
41. 00		0.00	0	0	
<del>4</del> 1.00	TOTALS — — — —	<del>                                     </del>	0	11, 808, 446	
	X - RENAL DIALYSIS		U	11, 000, 440	
1. 00		74.00	ما	700 425	1.
1.00	RENAL DI ALYSI S	<del>                                     </del>	뜻		
F00 00	TOTALS		1 204 022	799, 625	
500.00	Grand Total: Increases		1, 204, 022	93, 313, 304	500.

Health Financial Systems RECLASSIFICATIONS Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 5/27/2016 1:53 pm Provi der CCN: 150051

						5/27/2016 1:	53 pm
		Decreases				<b>.</b>	
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref.		
	6.00	7. 00	8. 00	9. 00	10. 00		
1. 00	A - DEPRECIATION ADMINISTRATIVE & GENERAL	5. 00	0	17, 077, 510	9		1.00
2. 00	ADWINISTRATIVE & GENERAL	0. 00	0	17,077,510	9		2.00
2.00	TOTALS — — — —						2.00
	B - LEASE		<u> </u>	17,077,010			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00		117, 788	10		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00		126, 965	10		2.00
3.00	OPERATION OF PLANT	7. 00		379, 400	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8. 00		2, 455	0		4.00
5.00	CENTRAL SERVICES & SUPPLY	14. 00		129, 208	0		5. 00
6.00	ADULTS & PEDIATRICS	30. 00		10, 028	0		6. 00
7.00	RADI OLOGY-DI AGNOSTI C	54.00		8, 084	0		7. 00
8. 00	LABORATORY	60. 00		26, 902	0		8. 00
9. 00	I NTRAVENOUS THERAPY	64. 00		50, 000	0		9. 00
10.00	RESPI RATORY THERAPY	65. 00		15, 091	0		10.00
11.00	PHYSI CAL THERAPY	66. 00		515, 385	0		11.00
12.00	ELECTROENCEPHALOGRAPHY	70.00		299	0		12.00
13. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	75. 01		147, 990	0		13. 00
14. 00	SERVI CES CLI NI C	90. 00		25, 430	0		14.00
15. 00	AMBULANCE SERVICES	95. 00 95. 00		116, 608	0		15. 00
16. 00	HOME HEALTH AGENCY	101. 00		54, 592	0		16.00
17. 00	HOSPI CE	116. 00		227, 154	0		17. 00
18. 00	PROMPTCARE	190. 01		92, 995	0		18. 00
19. 00	FOUNDATION	190. 05		31, 303	0		19. 00
20. 00	HME STORE	190. 07		357, 915	0		20.00
21. 00	MORGAN OP BEHAVIORAL HEALTH	190. 10		65, 925	0		21.00
	CLINIC						
	TOTALS			2, 501, 517			
	C - PROPERTY TAX						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	980	13	•	1.00
2. 00	OPERATION OF PLANT	7. 00	0	19, 550			2.00
3. 00	RADI OLOGY-THERAPEUTI C	55. 00	0	7, 338	0		3. 00
4. 00	LABORATORY	60.00	0	3, 427	0		4.00
5. 00	I NTRAVENOUS THERAPY	64. 00	0	30, 064	0		5.00
6.00	PHYSI CAL THERAPY	66. 00	0	12, 381	0		6.00
7.00	PROMPTCARE	190. 01 190. 02	0	100, 340	0		7.00
8. 00	RENTAL PROPERTIES TOTALS	190.02		5 <u>5, 1</u> 49 229, 229			8. 00
	D - INTEREST		<u> </u>	227,227			
1.00	INTEREST EXPENSE	113. 00		490, 065	11		1.00
	TOTALS			490, 065			
	E - PHARMACY RESIDENCY						
1.00	PHARMACY	15. 00	41, 080	<u>4, 9</u> 50			1.00
	TOTALS		41, 080	4, 950			_
	F - I NSURANCE						
1.00	ADMINISTRATIVE & GENERAL	5. 00		569, 668			1.00
2.00	I NTRAVENOUS THERAPY	64. 00		1, 120			2.00
3.00	PHYSICAL THERAPY HOME HEALTH AGENCY	66.00		1, 448			3.00
4. 00 5. 00	PROMPTCARE	101. 00 190. 01		926 808			4. 00 5. 00
5.00	TOTALS	— — 1 <del>30.</del> 01		573, 970			3.00
	G - BENEFITS		J	373, 970			
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	1, 104, 988	0		1.00
2. 00	OPERATION OF PLANT	7. 00	O	501, 881	0		2.00
3. 00	HOUSEKEEPI NG	9. 00	o	536, 045	0		3. 00
4.00	DI ETARY	10.00	0	454, 310	0		4.00
5.00	NURSING ADMINISTRATION	13. 00	0	486, 300	0		5.00
6.00	PHARMACY	15. 00	О	641, 045	0		6.00
7.00	CENTRAL STERILIZATION	18. 01	0	106, 594	0		7. 00
8.00	ADULTS & PEDIATRICS	30. 00	0	3, 597, 555	0		8. 00
9.00	INTENSIVE CARE UNIT	31. 00	0	472, 885	0		9. 00
10.00	SUBPROVI DER - I RF	41. 00	0	194, 617	0		10.00
11.00	NURSERY	43. 00	0	212, 990			11.00
12.00	OPERATING ROOM	50.00	0	1, 063, 235	0		12.00
13.00	RECOVERY ROOM	51. 00	0	129, 548			13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	0	452, 277	0		14.00
15.00	RADI OLOGY THERAPEUTI C	54. 00 55. 00	0	634, 880	0		15.00
16. 00 17. 00	RADI OLOGY-THERAPEUTI C CT SCAN	55. 00 57. 00	0	337, 493 104, 635			16. 00 17. 00
17.00	MAGNETIC RESONANCE I MAGING	57. 00 58. 00	0	104, 635 52, 509			18.00
10.00	(MRI)	36.00	٩	52, 509			10.00
19. 00	CARDIAC CATHETERIZATION	59. 00	0	155, 918	0		19. 00
20. 00	I NTRAVENOUS THERAPY	64. 00	Ö	14, 719		•	20.00
			-1	.,	,	•	• • •

Health Financial Systems
RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 5/27/2016 1:53 pm Provi der CCN: 150051

						5/27/2016 1:	53 pm
		Decreases				I	
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
21. 00	RESPI RATORY THERAPY	65. 00	0	315, 259			21.00
22. 00	PHYSI CAL THERAPY	66. 00	0	1, 265, 199			22. 00
23.00	ELECTROCARDI OLOGY	69. 00	0	112, 711	0		23. 00
24. 00	ELECTROENCEPHALOGRAPHY	70. 00	0	200, 965			24. 00
25.00	DRUGS CHARGED TO PATIENTS	73. 00	0	114, 223			25. 00
26. 00	PSYCHI ATRI C/PSYCHOLOGI CAL	75. 01	0	229, 457	0		26. 00
	SERVI CES						
27. 00	CARDIAC REHABILITATION	76. 97	0	114, 417	0		27. 00
28. 00	CLINIC	90. 00	0	289, 651	0		28. 00
29.00	EMERGENCY	91. 00	0	701, 230			29. 00
30.00	AMBULANCE SERVICES	95. 00	0	1, 047, 169			30.00
31.00	HOME HEALTH AGENCY	101. 00	0	1, 072, 971	0		31.00
32.00	HOSPI CE	116. 00	0	575, 657	0		32.00
33.00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	24, 025	0		33. 00
	CANTEEN						
34.00	PROMPTCARE	190. 01	0	226, 664	0		34.00
35.00	OLCOTT	190. 03	0	49, 765			35. 00
36.00	FOUNDATI ON	190. 05	0	94, 051	0		36. 00
37.00	HME STORE	190. 07	0	72, 190	0		37. 00
38.00	CLINICAL TRIALS	190. 09	0	34, 565	0		38. 00
39.00	MORGAN OP BEHAVIORAL HEALTH	190. 10	0	40, 199	0		39. 00
	CLINIC						
	TOTALS		0	17, 834, 792			_
	H - COMPUTER LICENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		8, 321	14		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00		88, 850			2.00
3.00	OPERATION OF PLANT	7. 00		2, 140			3.00
4.00	RADI OLOGY-DI AGNOSTI C	54.00		1, 286			4. 00
5.00	CT SCAN	57.00		35, 381			5. 00
6.00	PHYSI CAL THERAPY	66. 00		7, 314			6.00
7.00	AMBULANCE SERVICES	95.00	ĺ	150			7. 00
8.00	HOME HEALTH AGENCY	101.00		864			8. 00
9.00	OLCOTT	190. 03		15, 000			9. 00
10.00	CLINICAL TRIALS	190, 09		23, 665			10.00
	TOTALS			182, 971			
	I - RECRUITING	<u> </u>					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00		63, 159	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	İ	368, 189	0		2.00
3.00	PHARMACY	15. 00		370	0		3.00
4.00	ADULTS & PEDIATRICS	30.00		1, 093			4.00
	TOTALS			432, 811			
	J - CAFE		· · · · · · · · · · · · · · · · · · ·		l		
1.00	DI ETARY	10.00	713, 480	767, 561	0		1.00
	TOTALS		713, 480	767, 561			
	K - UTILITIES		.,				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00		4, 476	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	į	19, 842			2.00
3. 00	LAUNDRY & LINEN SERVICE	8. 00	į	792			3.00
4. 00	DI ETARY	10. 00	į	130			4. 00
5. 00	RADI OLOGY-DI AGNOSTI C	54.00	į	8, 523			5. 00
6. 00	RADI OLOGY-THERAPEUTI C	55. 00	į	160, 098			6. 00
7. 00	LABORATORY	60.00	İ	194	0		7. 00
8. 00	INTRAVENOUS THERAPY	64. 00		2, 995			8. 00
9. 00	PHYSI CAL THERAPY	66. 00	İ	54, 024	0		9. 00
10.00	PSYCHI ATRI C/PSYCHOLOGI CAL	75. 01		9, 744	0	l .	10.00
. 5. 55	SERVI CES	, 5. 51		,,,,,			
11. 00	CLI NI C	90. 00		3, 677	0		11.00
12. 00	AMBULANCE SERVICES	95.00		25, 401	0		12.00
13. 00	HOME HEALTH AGENCY	101.00		33, 023			13. 00
14. 00	HOSPI CE	116. 00		19, 565			14. 00
15. 00	PROMPTCARE	190. 01		13, 309			15. 00
16. 00	FOUNDATI ON	190. 05		6, 064		l .	16. 00
13.00	TOTALS			361, 857			10.00
	L - MARKETING		U	301, 037			+
1 00	ADMINISTRATIVE & GENERAL	5. 00		251, 602	0		1.00
1. 00 2. 00	DI ETARY	10. 00		251, 602 404	0	l e e e e e e e e e e e e e e e e e e e	2.00
	1					l e e e e e e e e e e e e e e e e e e e	1
3.00	PHYSI CAL THERAPY	66.00		2, 331	0		3.00
4.00	CLINIC	90.00		266	0		4.00
5. 00	HOME HEALTH AGENCY	101.00		26	0		5.00
6. 00	HOSPI CE	116.00		37	0		6.00
7. 00	FOUNDATI ON	1 <u>90.</u> 05		1 <u>1, 068</u>			7. 00
	TOTALS	ļ	0	265, 734		I	1

Health Financial Systems RECLASSIFICATIONS

Period: Worksheet A-6
From 01/01/2015
To 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm

						5/27/201	6 1: 53 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6.00 M - BCC DEPRECIATION	7. 00	8. 00	9. 00	10. 00		
1. 00	CAP REL COSTS-MVBLE EQUIP	2. 00		20, 802	9		1.00
1.00	TOTALS			20, 802			1.00
	N - LIBERTY BUILDING DEPRECIA	TI ON	1				
1.00	CAP REL COSTS-BLDG & FIXT	1.00		128, 079			1.00
2. 00	CAP REL COSTS-MVBLE EQUIP			<u>3, 6</u> 40			2. 00
	TOTALS  0 - SHORT-TERM DI SABILITY		0	131, 719			
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	1, 163		0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	36, 803		O		2.00
3.00	OPERATION OF PLANT	7. 00	8, 787		0		3.00
4.00	HOUSEKEEPI NG	9. 00	10, 963		0		4.00
5.00	DI ETARY	10. 00	12, 964		0		5. 00
6. 00	NURSI NG ADMI NI STRATI ON	13. 00	8, 963		0		6.00
7. 00	PHARMACY	15. 00	5, 928		0		7.00
8. 00	CENTRAL STERI LI ZATI ON	18. 01	1, 964		0		8.00
9. 00 10. 00	ADULTS & PEDIATRICS INTENSIVE CARE UNIT	30. 00 31. 00	187, 232 21, 832		0		9. 00 10. 00
11. 00	SUBPROVI DER - I RF	41. 00	5, 325		0		11.00
12. 00	NURSERY	43. 00	7, 099		O		12.00
13.00	OPERATING ROOM	50.00	46, 237		0		13.00
14.00	RECOVERY ROOM	51.00	2, 331		0		14.00
15.00	DELIVERY ROOM & LABOR ROOM	52. 00	10, 735		0		15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	13, 870		0		16. 00
17. 00	RADI OLOGY-THERAPEUTI C	55. 00	6, 255		0		17. 00
18. 00	CT SCAN	57. 00	4, 134		0		18. 00
19. 00	MAGNETIC RESONANCE IMAGING	58. 00	1, 394		0		19. 00
20. 00	(MRI) CARDI AC CATHETERI ZATI ON	59. 00	8, 277		0		20.00
21. 00	RESPIRATORY THERAPY	65. 00	13, 700		0		21.00
22. 00	PHYSI CAL THERAPY	66.00	40, 870		0		22.00
23. 00	ELECTROCARDI OLOGY	69. 00	15, 959		0		23. 00
24. 00	ELECTROENCEPHALOGRAPHY	70. 00	9, 508		O		24.00
25.00	DRUGS CHARGED TO PATIENTS	73. 00	5, 983		0		25. 00
26.00	PSYCHI ATRI C/PSYCHOLOGI CAL	75. 01	3, 741		0		26. 00
	SERVI CES						
27. 00	CARDI AC REHABI LI TATI ON	76. 97	834		0		27. 00
28. 00	CLI NI C	90.00	5, 976		0		28. 00
29. 00 30. 00	EMERGENCY AMBULANCE SERVICES	91. 00 95. 00	34, 733		0		29.00
30.00	HOME HEALTH AGENCY	101.00	22, 942 8, 945		0		30. 00 31. 00
32. 00	HOSPI CE	116. 00	18, 929		0		32.00
33. 00	PROMPTCARE	190. 01	277		0		33.00
34. 00	HME STORE	190. 07	29, 189		0		34.00
	TOTALS		613, 842				
	P - ANTI COAGULATI ON						
1.00	CLINIC	9000	29 <u>6, 7</u> 72	0			1.00
	TOTALS	DENT	296, 772	0			
1 00	Q - CHILDREN'S THERAPY ANNEX			171 44/			1.00
1. 00	CAP REL COSTS-BLDG & FIXT TOTALS			17 <u>1, 4</u> 46 171, 446			1.00
	R - URGENT CARE BILLING		U <sub>I</sub>	171, 440			
1.00	PROMPTCARE	190. 01	152, 690	0	0		1.00
	TOTALS	— — <del>1701</del> °†	152, 690	— — <u> </u>			
	S - BILLABLE DRUGS	<u> </u>			'		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00		75, 242	0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00		2, 024	0		2. 00
3.00	HOUSEKEEPI NG	9. 00		240			3. 00
4. 00	NURSI NG ADMI NI STRATI ON	13. 00		424			4.00
5. 00	PHARMACY	15. 00		17, 636, 045			5. 00
6. 00	ADULTS & PEDIATRICS	30.00		2, 256			6.00
7. 00 8. 00	INTENSIVE CARE UNIT NURSERY	31. 00 43. 00		308 173			7. 00 8. 00
9. 00	OPERATI NG ROOM	50.00		54, 035			9.00
	DELIVERY ROOM & LABOR ROOM	52. 00		269			10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54. 00		51, 721	0		11.00
12. 00	RADI OLOGY-THERAPEUTI C	55. 00		6, 729	-		12.00
13.00	CT SCAN	57. 00		90, 383			13.00
14.00	MAGNETIC RESONANCE IMAGING	58. 00		57, 050			14.00
	(MRI)						
15.00	CARDI AC CATHETERI ZATI ON	59. 00		106, 136			15.00
16.00	PHYSI CAL THERAPY	66.00		31, 903			16.00
17. 00 18. 00	ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	69. 00 70. 00		72, 632 451			17. 00 18. 00
10.00		70.00	I	431	١	l	1 10.00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Peri od: From 01/01/2015 To 12/31/2015 Date/Ti me Prepared: 5/27/2016 1:53 pm Provi der CCN: 150051

20.00   ABDI AC REHABILITATION   76.97							5/27/2016 1:53 pm
10.00   ERMAL DI ALYSIS   7.4.00   8.00   9.00   10.			Decreases				
19.00   16.004   10.14751   7.6.07   10.00   10.00   22.00   22.00   26.004   22.00   26.004   22.00   22.00   26.004   22.00   22.0							
20.00   ARDI AC REHABIL L'ATTON   70.977   80   0   22   22   20   DERRECES   10   20   20   20   20   20   20   20				8. 00			
21.00   CLINIC   0.00   0.00   0.00   0.00   2.22   0.00   2.22   0.00   0.22   0.00   0.22   0.00   0.22   0.00   0.22   0.00   0.22   0.00   0.22   0.00			· ·				19.00
DERCENCY   91,00   2,329   0   22,20   0   22,20   0   22,20   0   22,20   0   48,000   22,20   0   22,20   0   22,20   0   22,20   0   22,20   0   22,20   0   22,20   0   22,20   0   22,20   0   22,20   0   22,20   0   22,20   0   22,20   0   22,20   0   22,20   0			· ·				20.00
American   American			· ·		· ·		21. 00 22. 00
24.00   MISS HEALTH ACREY   101.00   311.849   0   22.00   MISS HEALTH ACREY   170.01   171.102   0   0   22.00   MISS HEALTH ACREY   170.01   171.102   0   0   22.00   MISS HEALTH ACRES HE   170.01   171.102   0   0   22.00   MISS HEALTH ACRES HEALTH			· ·				23.00
DISPLICE   16.00   269.333   0   22   27.00   HILE STORE   190.01   77.102   0   27.00   HILE STORE   190.01   77.00   17.00   27.00   1						- 1	24.00
26.00   PROMPTCARE   190.01   71,102   0   22, 28, 290   0   27, 28, 290   0   27, 28, 290   0   27, 28, 290   0   27, 28, 290   0   27, 28, 290   0   27, 28, 290   0   27, 28, 290   0   27, 28, 290   0   27, 28, 290   0   27, 28, 290   0   27, 28, 290   0   28, 28, 28, 28, 28, 28, 28, 28, 28, 28,					· ·	-1	25. 00
22.00   MESTORE   190.07		1	· ·			- 1	26.00
U   HEALTH S   F   194						o	27. 00
T							28. 00
DOC   OPERATING NOOM				0			
2.00 MAJOR LORGY-LU ARMOSTIC		T - NON-BILLABLE DRUGS					
OFFICIAL SERVICES   STATE	1.00	OPERATING ROOM	50. 00		998		1. 00
A   O   MACRITIC RESONANCE IMACING   S9.00   CARDIAC CARTITICATION   59.00   TOTALS			· ·				2.00
CMR1   Description   September   Septemb			i i				3.00
5.00   CARDÍAC, CATHETER ZATION   59.00   1,592   0   0   1.592	4. 00		58. 00		649	0	4.00
TOTALS  U - BILLADLE IMPLANTS  1 - 00		1. /	50.00		4 500		
U - BILLABLE IMPLANTS	5.00		59.00			9	5.00
1.00   ADMINISTRATIVE & CEMERAL   5.00   1.252   0   0   0   0   0   0   0   0   0				U	5, 961		
2.00   NURSING ADMINISTRATION   13.00   24.556   0   24.00   4.00	1 00		5 00		1 252		1 00
3.00 CENTRAL SERVICES & SUPPLY 4.00 PHARMACY 5.00 7 0 0 5.00 CENTRAL STERL I ZATI ON 18.01 4.00 1 5.00 CENTRAL STERL I ZATI ON 18.01 4.00 1 5.00 CENTRAL STERL I ZATI ON 18.01 4.00 1 5.00 CENTRAL STERL I ZATI ON 18.01 4.00 1 5.00 OR SAD STATI ON STATE OF STATI ON STATE OF STATI ON STATE OF STATI ON STATE OF STATI ON STATE OF STATE OF STATI ON STATE OF S							1.00
1.00   PHARMACY							3.00
5.00   CENTRAL STERIL LIZATION   18.01   4.031   0   5.7					7		4.00
0.00   ADULTS & PEDIATRICS   30.00   3.353   0   6.00   8.00					4 031	- 1	5. 00
7. 0.0 INTENSIVE CARE UNIT 31.00 4,300 0 8  8.0 0 SUBPROVIDER - 18F 41.00 58 0 8  9. 0.0 OPERATING ROBU 50.00 8,738,762 0 11  11. 0.0 CR JOHN 50.00 50.00 124,246 0 11  11. 0.0 CR JOHN 50.00 11,208 0 11  12. 0.0 CARDIAL CATHETERIZATION 59.00 1,645,217 0 11  13. 0.0 INTERVENUES THERAPY 66.00 12,69 0 11  15. 0.0 DRUGS CHARGED TO PATIENTS 73.00 6,507 0 11  15. 0.0 DRUGS CHARGED TO PATIENTS 73.00 6,507 0 11  17. 0.0 EMERGENCY 91.00 13.00 11  18. 0.0 HOME HEALTH AGENCY 91.00 13.00 0 11  19. 0.0 PROMPTCARE 190.01 1.00 13.0 0 11  19. 0.0 DRUGS CHARGED TO PATIENTS 74.00 13.0 0 11  19. 0.0 DRUGS CHARGED TO PATIENTS 75.0 0 12  10. 0.0 LITTLE STRIPLY							6. 00
Subprovider - IRF						- 1	7. 00
9.00   DPERATING ROOM   50.00   8,738,762   0   10.00   11.00   CT SCAN   57.00   1.208   0   11.00   12.00   CT SCAN   57.00   1.208   0   11.00   12.00   CATHETERIZATION   59.00   1.645,217   0   11.00   CT SCAN		l l				8.00	
10. 00   RADIOLOGY-DIAGNOSTIC   54. 00   244, 246   0   11. 00   12. 00   CARDIAC CATHETER ZATION   59. 00   1, 645, 217   0   1. 1   12. 00   CARDIAC CATHETER ZATION   59. 00   1, 645, 217   0   1. 1   14. 00   PHYSICAL THERAPY   64. 00   2.69   0   1. 1   15. 00   PRUSIC CHARGED TO PATIENTS   73. 00   6, 507   0   1. 1   15. 00   RENAL DIALYSIS   74. 00   5.88   0   1. 1   15. 00   RENAL DIALYSIS   74. 00   3. 166   0   1. 1   17. 00   EMERGENCY   91. 00   3. 166   0   1. 1   19. 00   PROMPTCARE   190. 01   1. 005   0   1. 0   19. 00   PROMPTCARE   190. 01   1. 005   0   1. 0   10. 00   PROMPTCARE   190. 01   1. 005   0   1. 0   10. 00   TOTALS   1. 005   0   1. 0						- 1	9. 00
11. 00   CT SCAN   57. 00   1. 208   0   1. 12. 00							10.00
12.00   CARDI AC CATHETER (ZATI ON   59.00   1,645,217   0   1.1					· ·		11.00
13.00   INTRAVENOUS THERAPY   64.00   2.69   0   1.1							12.00
15.00   DRUGS CHARGED TO PATIENTS   73.00   6.507   0   115   16.00   RENAL DI ALYSIS   74.00   55   0   117   17.00   EMERGENCY   91.00   3,166   0   117   17.00							13.00
15.00   DRUGS CHARGED TO PATIENTS   73.00   6,507   0   115   16.00   REARL DIALYSIS   74.00   58   0   117   17.00   EMERGENCY   91.00   3,166   0   130   0   181   18.00   HOWE HEALTH AGENCY   101.00   130   0   181   19.00   DRUMPTCARE   190.01   2   0   0   181   19.00   0   181   19.00   0   0   181   19.00   0   0   0   0   0   181   19.00   0   0   0   0   0   0   0   0   0						O	14.00
17.00   MERGENCY   91.00   3.166   0   17.80   18.00   19.00	15.00	DRUGS CHARGED TO PATIENTS	· ·			o	15.00
18. 00   HOME HEALTH AGENCY	16.00	RENAL DIALYSIS	· ·			o	16.00
19. 00	17.00	EMERGENCY	91.00		3, 166	o	17. 00
20.00   DLCOTT	18.00	HOME HEALTH AGENCY	101.00		130	o	18.00
TOTALS	19.00	PROMPTCARE	190. 01		2	o	19.00
V - BILLABLE SUPPLIES	20.00	OLCOTT	190. 03			0	20.00
1. 00 EMPLOYEE BENEFITS DEPARTMENT				0	10, 692, 449		
2. 00   ADMINISTRATIVE & GENERAL   5. 00   15, 153   0   3. 00   HOUSEKEEPING   9. 00   155   0   0   3. 00   0   155   0   0   3. 00   0   1540   0   0   4. 00   0   140   0   0   4. 00   0   140   0   0   4. 00   0   140   0   0   4. 00   0   140   0   0   140   0   0   140   0   0   140   0   0   140   0   0   140   0   0   140   0   0   140   0   0   140   0   0   140   0   0   140   0   0   140   0   0   140   0   0   140   0   0   140   0   0   0   140   0   140   0   140   0   140   0   140   0   140   0   0   0   0   0   0   0   0   0							
3. 00 HOUSEKEEPING 9. 00 155 0 24   4. 00 DI ETARY 10. 00 140 0 4   5. 00 NURSI NG ADMINI STRATI ON 13. 00 75, 895 0 6   6. 00 CENTRAL STERI LI ZATI ON 18. 01 7, 201 0 7   7. 00 NURSERY 43. 00 12, 121 0 7   8. 00 OPERATI NG ROOM 50. 00 3, 912, 661 0 9   9. 00 DELI VERY ROOM & LABOR ROOM 52. 00 236, 761 0 9   10. 00 RADI OLOGY-THERAPEUTI C 54. 00 741, 681 0 10   11. 00 RADI OLOGY-THERAPEUTI C 55. 00 5, 110 0 11   12. 00 CT SCAN 57. 00 7, 792 0 11   13. 00 CARDI AC CATHETERI ZATI ON 59. 00 4, 081, 037 0 1   15. 00 RESPI RATORY THERAPY 64. 00 51 0   16. 00 PHYSI CAL THERAPY 65. 00 11, 545 0 1   16. 00 PHYSI CAL THERAPY 66. 00 56, 891 0 1   17. 00 ELECTROENCEPHALOGRAPHY 70. 00 56, 891 0 1   18. 00 DRUGS CHARGED TO PATI ENTS 73. 00 99, 608 0 1   19. 00 REMAL DI ALYSIS 74. 00 392 0   20. 00 PSYCHI ATRI C./PSYCHOLOGI CAL 55. 01 SERVI CES 95. 00 21. 01   21. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 22   22. 00 CLI NI C 90. 00 57. 767 0 22   23. 00 AMBULANCE SERVI CES 95. 00 21. 610 0 22   24. 00 HOME HEALTH AGENCY 101. 00 1   25. 00 PROMPTCARE 190. 01 4, 337 0 2   26. 00 OLCOTT 190. 03 3, 512 0 2   27. 00 FOUNDATI ON 190. 05 2, 536 0 2   27. 00 FOUNDATI ON 190. 05 2, 536 0 1   27. 00 FOUNDATI ON 190. 05 2, 536 0 1   27. 00 FOUNDATI ON 190. 05 2, 536 0 1   28. 00 IU HEALTH MORGAN HOSPI TAL 194. 02	1.00	EMPLOYEE BENEFITS DEPARTMENT	· ·		64		1.00
4. 00 DI ETARY 10. 00 140 0 5. 00 NURSI NG ADMINISTRATION 13. 00 75, 895 0 6. 00 CENTRAL STERI LI ZATI ON 18. 01 7, 201 0 7. 00 NURSERY 43. 00 12, 121 0 8. 00 OPERATI NG ROOM 50. 00 3, 912, 661 0 9. 00 DELI VERY ROOM & LABOR ROOM 52. 00 236, 761 0 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 741, 681 0 11. 00 RADI OLOGY-THERAPEUTI C 55. 00 5, 110 0 11. 00 CT SCAN 57. 00 7, 792 0 12. 00 CT SCAN 57. 00 7, 792 0 13. 00 CARDI AC CATHETERI ZATI ON 59. 00 4, 081, 037 0 14. 00 INTRAVENOUS THERAPY 64. 00 51 15. 00 RESPI RATORY THERAPY 65. 00 11, 545 0 16. 00 PHYSI CAL THERAPY 66. 00 56, 891 0 17. 00 ELECTROENFALOGRAPHY 70. 00 5. 370 0 18. 00 DRUGS CHARGED TO PATI ENTS 73. 00 99, 608 0 18. 00 DRUGS CHARGED TO PATI ENTS 73. 00 99, 608 0 18. 00 DRUGS CHARGED TO PATI ENTS 75. 01 SERVI CES 21. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 22. 00 CLI NI C 90. 00 5. 767 0 23. 00 AMBULANCE SERVI CES 95. 00 21, 610 0 24. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 24. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 25. 00 PROMPTCARE 190. 01 99. 00 25. 370 0 26. 00 OLOTT 190. 03 3, 512 0 27. 00 FOUNDATI ON 190. 05 2. 536 0 10. HEALTH MORGAN HOSPI TAL 194. 02			i i				2.00
5. 00 NURSING ADMINISTRATION 13. 00 75, 895 0 6. 00 CENTRAL STERILIZATION 18. 01 7, 201 0 7,							3.00
6. 00 CENTRAL STERI LIZATION 18. 01 7, 201 0 7. 00 NURSERY 43. 00 12, 121 0 8. 00 OPERATING ROOM 50. 00 3, 912, 661 0 9. 00 DELI VERY ROOM & LABOR ROOM 52. 00 236, 761 0 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 741, 681 0 11. 00 RADI OLOGY-THERAPEUTI C 55. 00 741, 681 0 12. 00 CT SCAN 57. 00 7, 792 0 13. 00 CARDI AC CATHETERI ZATI ON 59. 00 4, 081, 037 0 14. 00 INTRAVENOUS THERAPY 64. 00 51 0 15. 00 RESPI RATORY THERAPY 65. 00 11, 545 0 16. 00 PHYSI CAL THERAPY 66. 00 56, 891 0 17. 00 ELECTROENCEPHALOGRAPHY 70. 00 5, 370 0 18. 00 DRUGS CHARGED TO PATIENTS 73. 00 99, 608 0 19. 00 RENAL DI ALYSI S 74. 00 392 0 20. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 75. 01 SERVI CES 21. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 22. 00 CLI NI C 90. 00 5, 767 0 23. 00 AMBULANCE SERVI CES 95. 00 21, 610 0 24. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 25. 00 PROMPTCARE 190. 01 4, 337 0 26. 00 OLCOTT 190. 03 3, 512 0 27. 00 FOUNDATI ON 190. 05 2, 256 0 10 HEALTH MORGAN HOSPI TAL 194. 02 90 0							4.00
7. 00 NURSERY							5. 00
8. 00 OPERATING ROOM 50. 00 3,912,661 0 88 9. 00 DELIVERY ROOM & LABOR ROOM 52. 00 236,761 0 9. 00 DELIVERY ROOM & LABOR ROOM 52. 00 236,761 0 9. 00 DELIVERY ROOM & LABOR ROOM 52. 00 236,761 0 9. 00 11. 00 RADI OLOGY-THERAPEUTI C 55. 00 5. 110 0 11. 00 RADI OLOGY-THERAPEUTI C 55. 00 5. 110 0 11. 00 11.						- 1	6.00
9. 00 DELI VERY ROOM & LABOR ROOM 10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 11. 00 RADI OLOGY-DI AGNOSTI C 55. 00 55. 00 5, 110 0 12. 00 CT SCAN 57. 00 7, 792 0 13. 00 CARDI AC CATHETERI ZATI ON 14. 00 INTRAVENOUS THERAPY 66. 00 15. 00 17. 00 18. 00 PHYSI CAL THERAPY 66. 00 17. 00 18. 00 DRUGS CHARGED TO PATI ENTS 73. 00 19. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 19. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 20. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 21. 00 CARDI AC REHABI LI TATI ON 22. 00 CARDI AC REHABI LI TATI ON 24. 00 HOME HEALTH AGENCY 101. 00 PROMPTCARE 190. 01 24. 00 HOME HEALTH AGENCY 101. 00 25. 00 PROMPTCARE 190. 01 26. 00 PCONTT							7.00
10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 741, 681 0 10 11. 00 RADI OLOGY-THERAPEUTI C 55. 00 5, 110 0 11 12. 00 CT SCAN 57. 00 7, 792 0 12 13. 00 CARDI AC CATHETERI ZATI ON 59. 00 4, 081, 037 0 13 14. 00 INTRAVENOUS THERAPY 64. 00 51 0 14 15. 00 RESPI RATORY THERAPY 65. 00 11, 545 0 16 16. 00 PHYSI CAL THERAPY 66. 00 56, 891 0 16 17. 00 ELECTROENCEPHALOGRAPHY 70. 00 5, 370 0 17 18. 00 DRUGS CHARGED TO PATIENTS 73. 00 99, 608 0 18 19. 00 RENAL DI ALYSI S 74. 00 392 0 19 20. 00 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 20 21. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 21 22. 00 CLI NI C 90. 00 21, 610 0 22 24. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 22 24. 00 HOME HEALTH AGENCY 101. 00 12 25. 00 PROMPTCARE 190. 01 4, 337 0 22 26. 00 OLCOTT 190. 03 3, 512 0 22 27. 00 FOUNDATI ON 190. 05 2, 536 0 12 28. 00 IU HEALTH MORGAN HOSPI TAL 194. 02 90 0							8.00
11. 00 RADI OLOGY-THERAPEUTI C 55. 00 5, 110 0 112 00 CT SCAN 57. 00 7, 792 0 12 13. 00 CARDI AC CATHETERI ZATI ON 59. 00 4, 081, 037 0 13 14. 00 INTRAVENOUS THERAPY 64. 00 51 0 14 15. 00 RESPI RATORY THERAPY 65. 00 11, 545 0 15. 00 PHYSI CAL THERAPY 66. 00 56, 891 0 16. 00 PHYSI CAL THERAPY 66. 00 56, 891 0 16. 00 PHYSI CAL THERAPY 70. 00 5, 370 0 17 18. 00 DRUGS CHARGED TO PATI ENTS 73. 00 99, 608 0 18 18 19. 00 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 75. 01 58 0 20 15 16 17 17 18. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 21 18. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 21 18. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 21 18. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 21 18. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 22 18. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 22 18. 00 CARDI AC REHABI LI TATI ON 76. 97 95. 00 21, 610 0 22 18. 00 PROMPTCARE 190. 01 4, 337 0 25 10 10 10 115 0 24 10 10 10 10 10 10 10 115 0 10 10 115 0 10 10 10 115 0 10 10 10 10 10 10 10 10 115 0 10 10 10 10 10 10 10 10 10 10 10 10 1			l l		· ·		9.00
12. 00 CT SCAN 57. 00 7, 792 0 12 13. 00 CARDI AC CATHETERI ZATI ON 59. 00 4, 081, 037 0 13 14. 00 I INTRAVENOUS THERAPY 64. 00 51 0 14 15. 00 RESPI RATORY THERAPY 65. 00 11, 545 0 16. 00 PHYSI CAL THERAPY 66. 00 56, 891 0 17 17. 00 ELECTROENCEPHALOGRAPHY 70. 00 5, 370 0 17 18. 00 DRUGS CHARGED TO PATI ENTS 73. 00 99, 608 0 18 19. 00 RENAL DI ALYSI S 74. 00 392 0 19 20. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 75. 01 58 0 22 21. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 21 22. 00 CLI NI C 90. 00 21, 610 0 22 24. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 22 24. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 22 25. 00 PROMPTCARE 190. 01 99. 03 2, 536 0 22 26. 00 OLCOTT 190. 03 3, 512 0 22 28. 00 IU HEALTH MORGAN HOSPI TAL 194. 02 90 0 0 12							10.00
13. 00 CARDI AC CATHETERI ZATI ON 59. 00 4, 081, 037 0 14. 00 INTRAVENOUS THERAPY 64. 00 51 0 14. 15. 00 RESPI RATORY THERAPY 65. 00 11. 545 0 15. 00 PHYSI CAL THERAPY 66. 00 56, 891 0 16. 00 PHYSI CAL THERAPY 70. 00 56, 891 0 17. 00 ELECTROENCEPHALOGRAPHY 70. 00 5, 370 0 17. 00 DRUGS CHARGED TO PATI ENTS 73. 00 99, 608 0 18. 00 DRUGS CHARGED TO PATI ENTS 73. 00 99, 608 0 18. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 75. 01 58 0 20. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 75. 01 58 0 20. 00 CLI NI C 90. 00 5, 767 0 22. 00 CLI NI C 90. 00 5, 767 0 22. 00 CLI NI C 90. 00 21, 610 0 23. 00 AMBULANCE SERVI CES 95. 00 21, 610 0 22. 00 PROMPTCARE 190. 01 4, 337 0 22. 00 PROMPTCARE 190. 01 4, 337 0 22. 00 CLOTT 190. 03 3, 512 0 7. 00 FOUNDATI ON 190. 05 2, 536 0 10 HEALTH MORGAN HOSPI TAL 194. 02 90 0 12.						- 1	11.00
14. 00 INTRAVENOUS THERAPY 64. 00 51 0 14. 15. 00 RESPIRATORY THERAPY 65. 00 11, 545 0 15. 00 PHYSI CAL THERAPY 66. 00 56, 891 0 16. 00 PHYSI CAL THERAPY 66. 00 56, 891 0 16. 00 PHYSI CAL THERAPY 70. 00 5, 370 0 17. 00 ELECTROENCEPHALOGRAPHY 70. 00 5, 370 0 17. 00 PHYSI CHARGED TO PATI ENTS 73. 00 99, 608 0 18. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 75. 01 58 0 20. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 75. 01 58 0 20. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 75. 01 58 0 20. 00 CLI NI C 90. 00 5, 767 0 22. 00 CLI NI C 90. 00 5, 767 0 22. 00 CLI NI C 90. 00 21, 610 0 23. 00 AMBULANCE SERVI CES 95. 00 21, 610 0 23. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 24. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 24. 00 OLCOTT 190. 03 3, 512 0 26. 00 OLCOTT 190. 03 3, 512 0 26. 00 FOUNDATI ON 190. 05 2, 536 0 27. 00 FOUNDATI ON 190. 05 2, 536 0 27. 00 FOUNDATI ON 190. 05 2, 536 0 28. 00 IU HEALTH MORGAN HOSPITAL 194. 02 90 0							12. 00 13. 00
15. 00 RESPIRATORY THERAPY 65. 00 11, 545 0 156, 891 0 16. 00 PHYSI CAL THERAPY 66. 00 56, 891 0 17. 00 ELECTROENCEPHALOGRAPHY 70. 00 5, 370 0 17. 00 PRUGS CHARGED TO PATIENTS 73. 00 99, 608 0 18. 00 PRUGS CHARGED TO PATIENTS 74. 00 392 0 19. 00 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 20. 00 CLI NI C 90. 00 5, 767 0 22. 00 CLI NI C 90. 00 5, 767 0 22. 00 AMBULANCE SERVI CES 95. 00 21, 610 0 23. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 24. 00 HOME HEALTH AGENCY 190. 01 4, 337 0 25. 00 PROMPTCARE 190. 01 4, 337 0 26. 00 PROMPTCARE 190. 03 3, 512 0 26. 00 FOUNDATI ON 190. 05 2, 536 0 27. 00 FOUNDATI ON 190. 05 2, 536 0 27. 00 FOUNDATI ON 190. 05 2, 536 0 27. 00 FOUNDATI ON 190. 05 2, 536 0 27. 00 FOUNDATI ON 194. 02 90 0 0							13.00
16. 00 PHYSI CAL THERAPY 66. 00 56, 891 0 16 17. 00 ELECTROENCEPHALOGRAPHY 70. 00 5, 370 0 17 18. 00 DRUGS CHARGED TO PATIENTS 73. 00 99, 608 0 18 19. 00 RENAL DI ALYSI S 74. 00 392 0 19 20. 00 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 20 21. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 21 22. 00 CLI NI C 90. 00 5, 767 0 22 23. 00 AMBULANCE SERVI CES 95. 00 21, 610 0 23 24. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 22 25. 00 PROMPTCARE 190. 01 4, 337 0 22 27. 00 FOUNDATI ON 190. 05 2, 536 0 27 28. 00 I U HEALTH MORGAN HOSPI TAL 194. 02 90 0			t t			- 1	15.00
17. 00 ELECTROENCEPHALOGRAPHY 70. 00 5, 370 0 17. 18. 00 DRUGS CHARGED TO PATIENTS 73. 00 99, 608 0 18. 00 REMAL DI ALYSIS 74. 00 392 0 19. 00 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 20. 00 CLI NI C 90. 00 5, 767 0 22. 00 CLI NI C 90. 00 21, 610 0 23. 00 AMBULANCE SERVI CES 95. 00 21, 610 0 22. 00 PROMPTCARE 190. 01 4, 337 0 22. 00 PROMPTCARE 190. 01 4, 337 0 22. 00 OLCOTT 190. 03 3, 512 0 22. 00 POUNDATI ON 190. 05 2, 536 0 27. 00 FOUNDATI ON 190. 05 2, 536 0 27. 00 FUNDATI ON 190. 05 2, 536 0 27. 00 I U HEALTH MORGAN HOSPI TAL 194. 02 90 0 0					· ·		16.00
18. 00 DRUGS CHARGED TO PATIENTS 73. 00 99, 608 0 19. 00 REMAL DI ALYSIS 74. 00 392 0 20. 00 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 21. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 22. 00 CLI NI C 90. 00 5, 767 0 23. 00 AMBULANCE SERVI CES 95. 00 21, 610 0 24. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 25. 00 PROMPTCARE 190. 01 4, 337 0 26. 00 DLCOTT 190. 03 3, 512 0 27. 00 FOUNDATI ON 190. 05 2, 536 0 28. 00 I U HEALTH MORGAN HOSPI TAL 194. 02 90 0						- 1	17. 00
19. 00 RENAL DI ALYSI S 74. 00 392 0 19 20. 00 PSYCHI ATRI C/PSYCHOLOGI CAL 75. 01 58 0 20 21. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 21 22. 00 CLI NI C 90. 00 5, 767 0 22 23. 00 AMBULANCE SERVI CES 95. 00 21, 610 0 23 24. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 24 25. 00 PROMPTCARE 190. 01 4, 337 0 25 26. 00 OLCOTT 190. 03 3, 512 0 26 27. 00 FOUNDATI ON 190. 05 2, 536 0 27 28. 00 I U HEALTH MORGAN HOSPI TAL 194. 02 90 0							18.00
20. 00 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 21. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 21 22. 00 CLI NI C 90. 00 5, 767 0 22 23. 00 AMBULANCE SERVI CES 95. 00 21, 610 0 23 24. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 24 25. 00 PROMPTCARE 190. 01 4, 337 0 25 26. 00 OLCOTT 190. 03 3, 512 0 26 27. 00 FOUNDATI ON 190. 05 2, 536 0 27 28. 00 I U HEALTH MORGAN HOSPI TAL 194. 02 90 0						- 1	19.00
SERVI CES  21. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 22. 00 CLI NI C 90. 00 5, 767 0 23. 00 AMBULANCE SERVI CES 95. 00 21, 610 0 24. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 25. 00 PROMPTCARE 190. 01 4, 337 0 26. 00 OLCOTT 190. 03 3, 512 0 27. 00 FOUNDATI ON 190. 05 2, 536 0 28. 00 I U HEALTH MORGAN HOSPI TAL 194. 02 90 0							20.00
21. 00 CARDI AC REHABI LI TATI ON 76. 97 84 0 21 22. 00 CLI NI C 90. 00 5, 767 0 22 23. 00 AMBULANCE SERVI CES 95. 00 21, 610 0 23 24. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 24 25. 00 PROMPTCARE 190. 01 4, 337 0 25 26. 00 OLCOTT 190. 03 3, 512 0 26 27. 00 FOUNDATI ON 190. 05 2, 536 0 27 28. 00 I U HEALTH MORGAN HOSPI TAL 194. 02 90 0			, 5. 51			٩	23.00
22. 00     CLINIC     90.00     5,767     0     22       23. 00     AMBULANCE SERVICES     95.00     21,610     0     23       24. 00     HOME HEALTH AGENCY     101.00     100,115     0     24       25. 00     PROMPTCARE     190.01     4,337     0     25       26. 00     OLCOTT     190.03     3,512     0     26       27. 00     FOUNDATION     190.05     2,536     0     27       28. 00     IU HEALTH MORGAN HOSPITAL     194.02     90     0     28	21.00		76. 97		84	o	21.00
23. 00 AMBULANCE SERVICES 95. 00 21, 610 0 23 24. 00 HOME HEALTH AGENCY 101. 00 100, 115 0 24 25. 00 PROMPTCARE 190. 01 4, 337 0 25 26. 00 OLCOTT 190. 03 3, 512 0 26 27. 00 FOUNDATION 190. 05 2, 536 0 27 28. 00 I U HEALTH MORGAN HOSPITAL 194. 02 90 0							22. 00
24. 00     HOME HEALTH AGENCY     101. 00     100, 115     0     24       25. 00     PROMPTCARE     190. 01     4, 337     0     25       26. 00     OLCOTT     190. 03     3, 512     0     26       27. 00     FOUNDATI ON     190. 05     2, 536     0     27       28. 00     I U HEALTH MORGAN HOSPI TAL     194. 02     90     0     28		1	i i			- 1	23. 00
25. 00     PROMPTCARE     190. 01     4, 337     0     25       26. 00     OLCOTT     190. 03     3, 512     0     26       27. 00     FOUNDATI ON     190. 05     2, 536     0     27       28. 00     I U HEALTH MORGAN HOSPITAL     194. 02     90     0     0			· ·				24.00
26. 00     OLCOTT     190. 03     3, 512     0     26. 00       27. 00     FOUNDATION     190. 05     2, 536     0     27. 00       28. 00     I U HEALTH MORGAN HOSPITAL     194. 02     90     0     0			· ·			o	25. 00
27. 00     FOUNDATION     190. 05     2,536     0       28. 00     I U HEALTH MORGAN HOSPITAL     194. 02     90     0			· ·			o	26.00
	27.00	FOUNDATI ON				o	27. 00
TOTALS 0 9, 407, 737	28.00	IU HEALTH MORGAN HOSPITAL	1 <u>94.</u> 02				28.00
		TOTALS — — — — —			9, 407, 737		

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Provi der CCN: 150051

						5/27/2016	1: 53 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
	W - NON-BILLABLE SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	46, 581	0	1	1.00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	28, 342			2. 00
3.00	OPERATION OF PLANT	7. 00	0	15, 744	0		3.00
4.00	LAUNDRY & LINEN SERVICE	8. 00	0	39, 504	. 0		4.00
5.00	HOUSEKEEPI NG	9. 00	0	81, 471	0		5. 00
6.00	DI ETARY	10. 00	0	36, 351	0		6. 00
7.00	NURSING ADMINISTRATION	13. 00	0	135, 007	0		7. 00
8.00	PHARMACY	15. 00	0	72, 041		1	8. 00
9.00	MEDICAL RECORDS & LIBRARY	16. 00	0	42		1	9. 00
10.00	CENTRAL STERILIZATION	18. 01	0	135, 824			10.00
11.00	ADULTS & PEDIATRICS	30.00	0	1, 575, 840	0		11. 00
12.00	INTENSIVE CARE UNIT	31.00	0	412, 605		i e	12.00
13.00	SUBPROVI DER - I RF	41. 00	0	46, 214			13.00
14.00	NURSERY	43. 00	0	149, 609		i e	14.00
15.00	OPERATING ROOM	50.00	0	3, 833, 568		i e	15.00
16.00	RECOVERY ROOM	51. 00	0	47, 802		l .	16.00
17.00	DELIVERY ROOM & LABOR ROOM	52. 00	0	336, 392	0		17. 00
18.00	RADI OLOGY-DI AGNOSTI C	54.00	0	158, 419			18. 00
19.00	RADI OLOGY-THERAPEUTI C	55. 00	0	405, 930	0		19. 00
20.00	CT SCAN	57.00	0	112, 482	0		20.00
21. 00	MAGNETIC RESONANCE IMAGING (MRI)	58. 00	0	11, 022	0		21.00
22.00	CARDÍ AC CATHETERI ZATI ON	59. 00	0	411, 049	0		22. 00
23.00	INTRAVENOUS THERAPY	64. 00	0	13, 573	0		23. 00
24.00	RESPI RATORY THERAPY	65. 00	0	274, 963	0		24. 00
25.00	PHYSI CAL THERAPY	66. 00	0	156, 813	0		25. 00
26.00	ELECTROCARDI OLOGY	69. 00	0	16, 490	0		26. 00
27.00	ELECTROENCEPHALOGRAPHY	70. 00	0	32, 417	0		27. 00
28.00	DRUGS CHARGED TO PATIENTS	73. 00	0	107, 362	. 0		28. 00
29.00	RENAL DIALYSIS	74. 00	0	24, 357	0		29. 00
30. 00	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	75. 01	0	1, 618	0		30.00
31.00	CARDIAC REHABILITATION	76. 97	0	6, 389	0		31.00
32.00	CLINIC	90. 00	0	8, 158	0		32.00
33.00	EMERGENCY	91. 00	0	802, 191	0		33. 00
34.00	AMBULANCE SERVICES	95. 00	0	195, 384	. 0		34.00
35.00	HOME HEALTH AGENCY	101. 00	0	85, 066	0		35.00
36.00	HOSPI CE	116. 00	0	113, 793	0		36. 00
37. 00	GIFT, FLOWER, COFFEE SHOP & CANTEEN	190. 00	0	8	0		37. 00
38.00	PROMPTCARE	190. 01	O	84, 763	0		38. 00
39.00	OLCOTT	190. 03	O	3, 560	0		39. 00
40.00	HME STORE	190. 07	О	1, 789, 700			40.00
41.00	CLINICAL TRIALS	190. 09	О	2	. 0		41.00
	TOTALS	1		11, 808, 446			
	X - RENAL DIALYSIS						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	799, 625	0		1.00
	TOTALS		0	799, 625			
500.00	Grand Total: Decreases		1, 817, 864	92, 699, 462			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 150051

| Peri od: | Worksheet A-7 | From 01/01/2015 | Part | To 12/31/2015 | Date/Time Prepared:

				I	o 12/31/2015	Date/lime Pre 5/27/2016 1:5	
				Acqui si ti ons		1072772010 1.0	J Pill
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	19, 760, 652	0	0	0	0	1.00
2.00	Land Improvements	2, 074, 567	0	0	0	2, 045	
3.00	Buildings and Fixtures	156, 047, 066	0	0	0	1, 536, 240	3.00
4.00	Building Improvements	2, 315, 155	6, 324, 992	0	6, 324, 992	210, 106	
5.00	Fi xed Equi pment	19, 910, 257	561, 515	0	561, 515		5.00
6.00	Movable Equipment	123, 092, 597	48, 346, 492	0	48, 346, 492	74, 762	6. 00
7.00	HIT designated Assets	0	0	0	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	323, 200, 294	55, 232, 999	0	55, 232, 999		
9.00	Reconciling Items	0	0	0	0	0	9. 00
10.00	Total (line 8 minus line 9)	323, 200, 294		0	55, 232, 999	1, 823, 153	10.00
		Endi ng	Fully				
		Bal ance	Depreci ated				
		( 00	Assets				
	DART I ANALYCIC OF CHANGES IN CARLTAL ACCE	6.00	7. 00				
1 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE		0				1 00
1.00	Land	19, 760, 652	0				1.00
2.00	Land Improvements	2, 072, 522	0				2.00
3.00	Buildings and Fixtures	154, 510, 826	0				3.00
4.00	Building Improvements	8, 430, 041	0				4.00
5.00	Fixed Equipment	20, 471, 772	0				5.00
6.00	Movable Equipment	171, 364, 327	0				6.00
7.00	HIT designated Assets	0 140	0				7.00
8.00	Subtotal (sum of lines 1-7)	376, 610, 140	0				8.00
9. 00 10. 00	Reconciling Items	274 410 140	0				9.00
10.00	Total (line 8 minus line 9)	376, 610, 140	U	I			10.00

Heal th	n Financial Systems	U HEALTH BLOOMINGTON HOSPITAL			In Lieu of Form CMS-2552-10			
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150051	Peri od:	Worksheet A-7		
					From 01/01/2015 To 12/31/2015		pared:	
						5/27/2016 1:5		
SUMMARY OF CAPITAL								
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see		
					(see instructions)	instructions)		
		9. 00	10. 00	11.00	12.00	13.00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORKSHEET A, COLUMN 2, LINES 1 and 2							
1.00	CAP REL COSTS-BLDG & FLXT	0	0		0	0	1.00	
2. 00	CAP REL COSTS-MVBLE EQUIP	0	0	1	0	0	2.00	
3. 00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1)					
		Capi tal -Relat	(sum of cols.					
		ed Costs (see	9 through 14)					
		instructions)						
		14. 00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	RKSHEET A, COLUI	MN 2, LINES 1	and 2				
1. 00	CAP REL COSTS-BLDG & FIXT	0	0	1		ļ	1.00	
2. 00	CAP REL COSTS-MVBLE EQUIP	0	0	1		ļ	2.00	
3. 00	Total (sum of lines 1-2)	0	0	1		ļ	3.00	

Heal th	n Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet A-7 Part III Date/Time Prep 5/27/2016 1:53	pared:
		COMI	PUTATION OF RA	TIOS	ALLOCATION OF	OTHER CAPITAL	•
Cost Center Description		Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)	Ratio (see instructions)	I nsurance	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS O		_				
1.00	CAP REL COSTS-BLDG & FIXT	184, 774, 041		184, 774, 04			1.00
2. 00 3. 00	CAP REL COSTS-MVBLE EQUIP Total (sum of lines 1-2)	191, 836, 099 376, 610, 140		191, 836, 09 376, 610, 14		0	2. 00 3. 00
3.00	Total (Suiii of Titles 1-2)	ALLOCATION OF OTHER CAPITAL		SUMMARY OF CAPITAL		3.00	
		ALLOCATION OF OTHER CALITIES			SUIVIIVIART		
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel at	cols. 5	,		
			ed Costs	through 7)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS O	ENTERS			+		
1.00	CAP REL COSTS-BLDG & FIXT	0	0	1	0 10, 050, 547		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0		1	0 10, 080, 928	· ·	2.00
3.00	Total (sum of lines 1-2)	0	J		0 20, 131, 475	2, 501, 220	3. 00
			St	JMMARY OF CAPI	IAL		
	Cost Center Description	Interest	Insurance	Taxes (see	0ther	Total (2)	
			(see	instructions)	Capi tal -Rel at		
			instructions)		ed Costs (see	9 through 14)	
		11.00	12.00	12.00	instructions)	15.00	
	PART III - RECONCILIATION OF CAPITAL COSTS O	11. 00	12. 00	13.00	14. 00	15. 00	
1. 00	CAP REL COSTS-BLDG & FLXT	485, 754	0	229, 22	9 0	12, 821, 276	1. 00
2. 00	CAP REL COSTS-BLDG & FIXT	465, 754	ł .		0 182, 971		2. 00
3.00	Total (sum of lines 1-2)	485, 754		1			3. 00
3.00	Total (Suil Of TITIES 1-2)	1 405, 754	] 331, 217	1 227, 22	/ 102, 7/1	24,001,000	3.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 150051

					From 01/01/2015 To 12/31/2015	Date/Time Pre	
				Expense Classification of	n Worksheet A	5/27/2016 1:5	3 pm
				To/From Which the Amount is	s to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
		(2) 1. 00	2. 00	3.00	4. 00	Ref. 5. 00	
1. 00	Investment income - CAP REL	1. 00		CAP REL COSTS-BLDG & FLXT	1.00	0.00	1. 00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2.00
3. 00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other		C		0. 00	0	3.00
	(chapter 2)		C				
4. 00	Trade, quantity, and time discounts (chapter 8)		C		0.00	0	4.00
5. 00	Refunds and rebates of expenses (chapter 8)		C		0.00	0	5. 00
6. 00	Rental of provider space by		C		0. 00	0	6.00
7. 00	suppliers (chapter 8) Telephone services (pay		C		0.00	0	7.00
	stations excluded) (chapter						
8. 00	21) Television and radio service		C		0.00	0	8. 00
9. 00	(chapter 21) Parking Lot (chapter 21)		C		0. 00	0	9.00
10.00	Provi der-based physi ci an	A-8-2	-13, 841, 255		0.00	0	
11. 00	adjustment Sale of scrap, waste, etc.		C		0.00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	27, 283, 014			0	12.00
	transactions (chapter 10)	Α σ 1	27, 203, 014			_	
13. 00 14. 00	Laundry and linen service Cafeteria-employees and guests	В	-536, 300	CAFETERI A	0. 00 11. 00	0	
15. 00	Rental of quarters to employee and others		C		0.00	0	15.00
16. 00	Sale of medical and surgical		C		0. 00	0	16.00
	supplies to other than patients						
17. 00	Sale of drugs to other than patients		C		0. 00	0	17.00
18. 00	Sale of medical records and		C		0. 00	0	18.00
19. 00	abstracts Nursing school (tuition, fees,		C		0.00	0	19.00
20. 00	books, etc.) Vending machines				0. 00	0	20.00
21. 00	Income from imposition of		C		0.00	0	ı
	interest, finance or penalty charges (chapter 21)						
22. 00			C		0.00	0	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65. 00		23. 00
24. 00	limitation (chapter 14)	A-8-3		PHYSI CAL THERAPY	66. 00		24.00
24.00	therapy costs in excess of	A-0-3	C	PHISICAL THERAPT	66.00		24.00
25. 00	limitation (chapter 14) Utilization review –		C	UTILIZATION REVIEW-SNF	114. 00		25. 00
	physicians' compensation						
26. 00	(chapter 21) Depreciation - CAP REL		C	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL		C	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27.00
	COSTS-MVBLE EQUIP	1				0	
28. 00 29. 00	Non-physician Anesthetist Physicians' assistant		C	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	67. 00		30.00
00	limitation (chapter 14)			ADULTO A DESCRIPTION			00
30. 99	Hospice (non-distinct) (see instructions)		С	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00		A-8-3	C	SPEECH PATHOLOGY	68. 00		31.00
	limitation (chapter 14)						
	Trim tation (chapter 14)						<u> </u>

In Lieu of Form CMS-2552-10 Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL Provider CCN: 150051 ADJUSTMENTS TO EXPENSES Peri od: Worksheet A-8 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm Expense Classification on Worksheet A To/From Which the Amount is to be Adjusted Basis/Code Line # Wkst. A-7 Cost Center Description Amount Cost Center (2) Ref. 1. 00 2.00 3.00 4.00 5.00 32.00 CAH HIT Adjustment for 0.00 32.00 Depreciation and Interest MISCELLANEOUS INCOME 33.00 В -47, 799 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.00 -919, 107 ADMINISTRATIVE & GENERAL MISCELLANEOUS INCOME 33.01 В 5.00 33.01 MISCELLANEOUS INCOME -784, 052 OPERATION OF PLANT 7.00 33.02 33.02 В MISCELLANEOUS INCOME -223, 786 LAUNDRY & LINEN SERVICE 33.03 В 8.00 33.03 MISCELLANEOUS INCOME -307, 478 DI ETARY 10.00 33.04 33.04 В O 33.05 MISCELLANEOUS INCOME В -25, 113 NURSING ADMINISTRATION 13.00 33.05 33.06 MISCELLANEOUS INCOME В -45, 717 PHARMACY 15.00 33.06 33.07 MISCELLANEOUS INCOME -14, 642 ADULTS & PEDIATRICS 30.00 33.07 В MISCELLANEOUS INCOME -8, 429 NURSERY 33.08 В 43.00 33.08 33.09 MISCELLANEOUS INCOME -15,070 DELIVERY ROOM & LABOR ROOM 52.00 В 33.09 -727 RADI OLOGY-DI AGNOSTI C 33. 10 MISCELLANEOUS INCOME В 54.00 33.10 -22, 760 RADI OLOGY-THERAPEUTI C 33.11 MISCELLANEOUS INCOME В 55.00 0 33.11 690 LABORATORY 33. 12 MISCELLANEOUS INCOME В 60.00 33.12 33.13 MISCELLANEOUS INCOME В -24, 110 INTRAVENOUS THERAPY 64.00 33.13 MISCELLANEOUS INCOME -495, 030 PHYSI CAL THERAPY 33.14 33.14 В 66.00 MISCELLANEOUS INCOME 33. 15 -7, 300 ELECTROENCEPHALOGRAPHY 0 В 70.00 33.15 33. 16 MISCELLANEOUS INCOME В -1, 890 PSYCHI ATRI C/PSYCHOLOGI CAL 75.01 33.16 SERVI CES MISCELLANEOUS INCOME 33.17 В -60, 263 CARDIAC REHABILITATION 76.97 0 33.17 MISCELLANEOUS INCOME -120, 497 CLI NI C 90.00 33 18 0 33.18 B 33. 19 MISCELLANEOUS INCOME В -197, 974 AMBULANCE SERVICES 95.00 33.19 MISCELLANEOUS INCOME -218, 617 HOME HEALTH AGENCY 101.00 33. 20 В 33, 21 MISCELLANEOUS INCOME В -75, 017 PROMPTCARE 190.01 0 33. 21 MISCELLANEOUS INCOME -783, 769 HME STORE 190.07 ol 33. 22 B 33.22 -1, 900, 653 ADMINISTRATIVE & GENERAL 33. 23 ACCELERATED DEPRECIATION 5.00 33.23 Α 33.24 ACCRUED PTO Α -2, 499, 243 EMPLOYEE BENEFITS DEPARTMENT 4.00 33.24 UNNECESSARY BORROWING -898, 616 I NTEREST EXPENSE 33. 25 113.00 0 33, 25 Α UNNECESSARY BORROWING 33 26 Α -641 ADMINISTRATIVE & GENERAL 5.00 33 26 33. 27 TV DEPRECIATION Α -8, 298 CAP REL COSTS-BLDG & FIXT 1.00 33.27 33. 28 TELEPHONE EXPENSE Α -276 PHYSI CAL THERAPY 66.00 0 33.28 NON-ALLOWABLE PATIENT -37, 192 ADMINISTRATIVE & GENERAL 33.29 33.29 Α 5.00 REI MBURSEMENT 33.30 BENEFIT EXPENSE Α -19, 542, 027 EMPLOYEE BENEFITS DEPARTMENT 4.00 0 33.30 CONTRIBUTION EXPENSE -3, 000 ADMINISTRATIVE & GENERAL 33.31 Α 5.00 0 33.31 PHYSICIAN RECRUITMENT -368, 189 ADMINISTRATIVE & GENERAL 5.00 ol 33.32 33.32 Α -12, 027, 855 ADMINISTRATIVE & GENERAL 33.33 HAF FEES Α 5.00 33.33 UBI TAX 33. 34 Α -250, 044 LABORATORY 60.00 33.34 -225, 001 ADMINISTRATIVE & GENERAL 33. 35 UBI TAX Α 5.00 33.35 PHYSICIAN COMPENSATION -322, 335 ELECTROCARDI OLOGY 69 00 33 36 33 36 Α 33.37 **GUEST MEALS** В -1, 070, 124 CAFETERI A 11.00 33.37 33. 38 PENSI ON EXPENSE 8, 214, 228 EMPLOYEE BENEFITS DEPARTMENT 33.38 Α 4.00 -343 CAP REL COSTS-BLDG & FIXT 33.39 WEGMILLER CAPITALIZED INTEREST 11 33.39 Α 1.00 1983 CAPITALIZED INTEREST -3, 968 CAP REL COSTS-BLDG & FIXT 11 33.40 Α 1.00 33.40 33. 41 OTHER CARRYFORWARD ADJUSTMENTS 153, 996 CAP REL COSTS-BLDG & FIXT 1.00 33.41 Α 22, 859 CAP REL COSTS-BLDG & FIXT 9 33.42 HHA USEFUL LIFE 1.00 33.42 Α -18, 584 ADMINISTRATIVE & GENERAL ol 33 43 PENALTY TAX 5 00 33 43 Α PAOLI HOSPITAL OPERATING 33.44 19, 324, 896 I U HEALTH PAOLI HOSPITAL 194.00 33.44 Α **EXPENSE** BEDFORD HOSPITAL OPERATING 41, 594, 253 I U HEALTH BEDFORD HOSPI TAL 33.45 Α 194.01 33.45 **EXPENSE** MORGAN HOSPITAL OPERATING 18,084,812 IU HEALTH MORGAN HOSPITAL 33.46 Α 194.02 33.46 **EXPENSE** PAOLI CAH HIT ADJUSTMENT FOR -33, 577 CAP REL COSTS-MVBLE EQUIP 33.47 Α 2.00 33.47 33.48 0 0 00 33.48 0 33.49 0.00 0 33.49 33.50 0.00 33.50 000000 33.51 33.51 0.00 33. 52 0.00 0 33, 52 33.53 0.00 33.53 33.54 0.00 33.54 33.55 0.00 0 33.55

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Provi der CCN: 150051 Peri od: From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm Peri od: Worksheet A-8

						5/2//2016 1:5	3 pili
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adiusted		
	Cost Center Description	Basis/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	oost conten bescription	(2)	7 illoure	Cost center	Line "	Ref.	
			2.00	2.00	4 00		
		1. 00	2. 00	3. 00	4. 00	5. 00	
33. 58			0		0.00	0	
33. 59			0		0.00	0	33. 59
33. 60			0		0.00	0	33. 60
33. 61			0		0.00	0	1
33. 62			0		0.00	0	
			0				
33. 63			0		0.00	0	
33. 64			0		0.00	0	33. 64
33. 65			0		0.00	0	33. 65
33. 66			0		0.00	0	33. 66
33. 67			n		0.00	0	1
33. 68			0		0.00	0	1
			0			_	
33. 69			0		0.00	0	
33. 70			0		0.00	0	
33. 71			0		0.00	0	33. 71
33. 72			0		0.00	0	33. 72
33. 73			0		0.00	0	33. 73
33. 74			0		0. 00	0	1
33. 75			0		0.00	0	1
			0			-	
33. 76			0		0.00	0	
33. 77			0		0.00	0	
33. 78			0		0.00	0	33. 78
33. 79			0		0.00	0	33. 79
33. 80			n		0.00	0	1
33. 81					0.00	0	
					0.00	_	1
33. 82			0			0	
33. 83			0		0.00	0	
33. 84			0		0.00	0	
33. 85			0		0.00	0	33. 85
33. 86			n		0.00	0	1
	TAL (sum of lines 1 thru 49)		56, 692, 080		3.00	Ü	50.00
			30, 072, 000				30.00
	ransfer to Worksheet A,						
	lumn 6, line 200.)						

<sup>(1)</sup> Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).

A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

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

OFFICE COSTS

OFFICE COSTS

OFFICE COSTS

OFFICE COSTS

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				10 12/31/2015	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	
	A. COSTS INCURRED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OF	R CLAIMED HOME	
	OFFICE COSTS:					
1. 00		CAP REL COSTS-BLDG & FIXT	IU HEALTH HOME OFFICE EXP AL	1	0	1.00
2. 00		CAP REL COSTS-MVBLE EQUIP	IU HEALTH HOME OFFICE EXP AL		0	2.00
3. 00		EMPLOYEE BENEFITS DEPARTMENT	IU HEALTH HOME OFFICE EXP AL		·	3.00
4. 00		ADMINISTRATIVE & GENERAL	IU HEALTH HOME OFFICE EXP AL	1		4. 00
4. 01		DI ETARY	IU HEALTH HOME OFFICE EXP AL		-50	4. 01
4. 02		PHARMACY	IU HEALTH HOME OFFICE EXP AL		-6, 905	4. 02
4.03		ADULTS & PEDIATRICS	IU HEALTH HOME OFFICE EXP AL		616, 987	4.03
4.04		NURSERY	IU HEALTH HOME OFFICE EXP AL		108, 024	4.04
4. 05		OPERATING ROOM	IU HEALTH HOME OFFICE EXP AL		197, 954	4.05
4.06		LABORATORY	IU HEALTH HOME OFFICE EXP AL	1		
4.07		PHYSI CAL THERAPY	IU HEALTH HOME OFFICE EXP AL		249, 942	4.07
4. 08		EMERGENCY	IU HEALTH SOUTHERN IN PHYSIC	1	0	4. 08
4. 09		AMBULANCE SERVICES	IU HEALTH HOME OFFICE EXP AL	1		
4. 10	1	INTEREST EXPENSE	IU HEALTH HOME OFFICE EXP AL	1, 388, 681	1, 388, 681	4. 10
4. 11	0.00	l e		0	0	4. 11
4. 12	0.00	l .		0	0	4. 12
4. 13	0.00	F		0	0	4. 13
4. 14	0.00	l .		0	0	4. 14
4. 15	0.00			0	0	4. 15
5.00	0		0	79, 775, 133	52, 492, 119	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.

 			nour a bo riiai oatoa rii ooraiiii		
			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	С		0.00	IU HEALTH SIP	0.00	6. 00
7.00	С		0.00	IU HEALTH PAOLI	0.00	7. 00
8.00	В	IU HEALTH	0.00		0.00	8. 00
9.00			0.00		0.00	9. 00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

leal th	Financial Syste	ems	IU HEALTH BLOOMIN	NGTON HOSPITAL	In Lieu	u of Form CMS-2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 150051	Peri od:	Worksheet A-8-1
OFFICE	COSTS				From 01/01/2015	5 . 7
					To 12/31/2015	Date/Time Prepared: 5/27/2016 1:53 pm
	Net	Wkst. A-7 Ref.				372772010 1.33 piii
	Adjustments	WKSt. A 7 KCI.				
	(col. 4 minus					
	col. 5)*					
	6.00	7. 00				
	A. COSTS INCUR	RED AND ADJUST	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME
	OFFICE COSTS:					
1. 00	2, 563, 975	9				1.00
2. 00	678, 977	9				2.00
3. 00	17, 274, 049	0				3.00
4. 00	1, 167, 104	0				4.00
4. 01	50	0				4. 01
4. 02	6, 905	0				4. 02
4. 03	0	0				4. 03
4. 04	0	0				4.04
4. 05	0	0				4. 05
4. 06	0	0				4. 06
4. 07	0	0				4. 07
4. 08	5, 591, 954	0				4. 08
4. 09	0	0				4.09
4. 10	0	0				4. 10
4. 11	0	0				4. 11
4. 12	0	0				4. 12
4. 13	0	0				4. 13

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

4.14

4.15

5.00

	Related Organization(s) and/or Home Office						
	Type of Business						
	6. 00						
В	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	PHYSICIAN GROUP	6.00
7. 00 8. 00	HOSPI TAL	7.00
		8.00
9. 00 10. 00		9.00
10.00		10.00
100.00		100.00

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

4.14

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5.00

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27, 283, 014

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Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 150051 Period: From 01/01/20

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

					'	0 12/31/2015	5/27/2016 1:5	
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component Hours	
	1.00	2.00	3. 00	4. 00	5. 00	6. 00	7. 00	
1. 00		ADMINISTRATIVE & GENERAL	1, 600, 008	1, 600, 008		171, 400	0	
2. 00		ADMINISTRATIVE & GENERAL	554, 245			204, 100	0	
3.00		ADMINISTRATIVE & GENERAL	994, 442			204, 100	0	3.00
4. 00 5. 00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	2, 062, 224 753, 500			171, 400 200, 300	0	4. 00 5. 00
6. 00		ADMINISTRATIVE & GENERAL	339, 058			204, 100	1, 170	
7. 00		ADMINISTRATIVE & GENERAL	007,000	1		136, 700	0	
8.00	5. 00	ADMINISTRATIVE & GENERAL	577, 850	577, 850	0	231, 100	0	8. 00
9.00		EMERGENCY	5, 277, 040	5, 277, 040	0	171, 400	0	9. 00
10.00		ADMINISTRATIVE & GENERAL	137, 943			171, 400	0	10.00
11.00		RADI OLOGY-THERAPEUTI C	38, 800			231, 100	0	11.00
12. 00 13. 00		LABORATORY ADULTS & PEDIATRICS	308, 568 350, 392		000,000	219, 500 142, 500	2, 789 178	
14. 00		PSYCHI ATRI C/PSYCHOLOGI CAL	440, 115			142, 500	206	
11.00	70.01	SERVI CES	110,110	110,000	20, 202	112,000	200	11.00
15.00	5. 00	ADMINISTRATIVE & GENERAL	267, 853	267, 853	0	142, 500	0	15.00
16.00		ADMINISTRATIVE & GENERAL	154, 899			152, 100	0	16. 00
17. 00		ADULTS & PEDIATRICS	14, 246			142, 500	0	17. 00
18.00		ADMINISTRATIVE & GENERAL	163, 714			142, 500	0	18.00
19. 00	/5.01	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	137, 930	19, 479	118, 451	142, 500	2, 418	19. 00
20. 00	69.00	ELECTROCARDI OLOGY	107, 511	32, 925	74, 585	142, 500	1, 443	20.00
21. 00		ADMINISTRATIVE & GENERAL	62, 500			219, 500	0	1
22.00	66. 00	PHYSI CAL THERAPY	126, 887	126, 887	0	136, 700	0	22. 00
200.00			14, 469, 725					200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Unadjusted RCE Limit		Cost of	Provi der	Physician Cost of Malpractice	
		rdentiffer	LIIIII	Limit	Memberships & Continuing	Component Share of col.	Insurance	
				Er iiii t	Education	12	Trisur unce	
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00		ADMINISTRATIVE & GENERAL	0		-	0	0	
2. 00 3. 00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	0		-	0	0	2. 00 3. 00
4. 00		ADMINISTRATIVE & GENERAL				0	0	
5. 00		ADMINISTRATIVE & GENERAL	0		o o	Ö	o o	
6.00		ADMINISTRATIVE & GENERAL	114, 806	5, 740	0	0	0	6.00
7.00		ADMINISTRATIVE & GENERAL	0	C	-	0	0	
8.00		ADMINISTRATIVE & GENERAL	0	(	0	0	0	8.00
9.00		EMERGENCY	0		0	0	0	
10. 00 11. 00	•	ADMINISTRATIVE & GENERAL RADIOLOGY-THERAPEUTIC			-	0	0	10.00 11.00
12. 00		LABORATORY	294, 320	1	,	0	0	12.00
13. 00		ADULTS & PEDIATRICS	12, 195			0	0	13. 00
14.00	75. 01	PSYCHI ATRI C/PSYCHOLOGI CAL	14, 113	706	0	0	0	14. 00
		SERVICES			_	_	_	
15.00		ADMINISTRATIVE & GENERAL	0			0	0	
16. 00 17. 00		ADMINISTRATIVE & GENERAL ADULTS & PEDIATRICS	0	· ·	1	0	0	
18. 00		ADDITS & FEDIATRICS ADMINISTRATIVE & GENERAL		1		0	0	1
19. 00		PSYCHI ATRI C/PSYCHOLOGI CAL	165, 656	8, 283		Ö	Ö	1
		SERVI CES						
20.00		ELECTROCARDI OLOGY	98, 859	4, 943	0	0	0	20.00
21. 00		ADMI NI STRATI VE & GENERAL	0		0	0	0	
22. 00 200. 00		PHYSICAL THERAPY	699, 949	·	,	0	0	22. 00 200. 00
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	U	200.00
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1 00	2.00	14	17.00	17.00	10.00		
1. 00	1.00	2. 00 ADMI NI STRATI VE & GENERAL	15. 00	16. 00	17. 00	18. 00 1, 600, 008		1.00
2. 00		ADMINISTRATIVE & GENERAL	0		o o	554, 245		2.00
3. 00		ADMINISTRATIVE & GENERAL	0		0	994, 442		3. 00
4.00	5. 00	ADMINISTRATIVE & GENERAL	0	(	0	2, 062, 224		4.00
5.00		ADMINISTRATIVE & GENERAL	0		0	753, 500		5.00
6.00		ADMINISTRATIVE & GENERAL	0	114, 806	224, 252	224, 252		6.00
7.00		ADMINISTRATIVE & GENERAL			9	577.050		7.00
8. 00 9. 00		ADMINISTRATIVE & GENERAL EMERGENCY				577, 850 5, 277, 040		8. 00 9. 00
10.00		ADMINISTRATIVE & GENERAL				137, 943	1	10.00
11. 00		RADI OLOGY-THERAPEUTI C				38, 800		11.00
12. 00		LABORATORY	Ö	294, 320	14, 248	14, 248		12.00
13.00	30.00	ADULTS & PEDIATRICS	0	12, 195	7, 039	338, 197		13.00

Health Financial Syste	ems	IU HEALTH BLOOM	IINGTON HOSPITA	L	In Lie	eu of Form CMS-	2552-10
PROVI DER BASED PHYSI C	AN ADJUSTMENT		Provi der		Period: From 01/01/2015	Worksheet A-	8-2
					To 12/31/2015	Date/Time Pro 5/27/2016 1:	
Wkst. A Line #	Cost Center/Physician Identifier	Provider Component Share of col.	Adjusted RCE Limit	RCE Di sal I owance	Adj ustment		

							3/2//2010 1.33 pill	
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
			14					
	1. 00	2.00	15. 00	16. 00	17. 00	18. 00		
14.00	75. 01	PSYCHI ATRI C/PSYCHOLOGI CAL	0	14, 113	9, 169	426, 002	14. 0	0
		SERVI CES						
15.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	0	267, 853	15. 0	10
16.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	0	154, 899	16.0	10
17.00	30.00	ADULTS & PEDIATRICS	0	0	0	14, 246	17. 0	10
18.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	0	163, 714	18.0	10
19.00	75. 01	PSYCHI ATRI C/PSYCHOLOGI CAL	0	165, 656	0	19, 479	19.0	0
		SERVI CES						
20.00	69. 00	ELECTROCARDI OLOGY	0	98, 859	0	32, 926	20.0	10
21.00	5. 00	ADMINISTRATIVE & GENERAL	0	0	0	62, 500	21. 0	10
22.00	66. 00	PHYSI CAL THERAPY	0	0	0	126, 887	22. 0	10
200.00			0	699, 949	254, 708	13, 841, 255	200. 0	10

| Peri od: | Worksheet B | From 01/01/2015 | Part | | To | 12/31/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150051

					To 12/31/2015	Date/Time Pre 5/27/2016 1:5	
			CAPI TAL REI	LATED COSTS		372772010 1.3	3 piii
	Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	cost center bescription	for Cost	DEDO & TIXI	WVDEL EQUIT	BENEFI TS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A col. 7)					
		0	1.00	2.00	4. 00	4A	
1 00	GENERAL SERVICE COST CENTERS	10 001 07/	12 021 274				1 00
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	12, 821, 276 11, 240, 592	l '	11, 240, 59	2		1. 00 2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	27, 524, 820	40, 384	157, 13	4 27, 722, 338		4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	52, 722, 259	2, 365, 808	1	2, 885, 237	60, 695, 006 0	5. 00 6. 00
6. 00 7. 00	00600 MAI NTENANCE & REPAIRS 00700 OPERATION OF PLANT	9, 923, 939	1, 704, 509		9	13, 750, 132	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	398, 702	245, 472	166, 14	4 0	810, 318	8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	2, 062, 950 2, 053, 172				2, 581, 238 2, 735, 093	9. 00 10. 00
11. 00	01100 CAFETERI A	-125, 383				2, 735, 093	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0	0	12.00
13. 00 14. 00	01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	4, 428, 197 11, 837, 904	164, 481 73, 366			5, 750, 085 11, 961, 256	13. 00 14. 00
15. 00	01500 PHARMACY	4, 927, 706			1, 251, 466		•
16. 00	01600 MEDICAL RECORDS & LIBRARY	345, 954	99, 878	75, 80	3 0	521, 635	
17. 00 18. 00	01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0		0	0	17. 00 18. 00
18. 01	01851 CENTRAL STERILIZATION	431, 086	57, 984	39, 24	5 5 105, 797	634, 113	18. 01
19. 00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	1	0	0	19.00
20. 00 21. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0		0	0	20.00
22. 00	02200   &R SERVICES-OTHER PRGM COSTS APPRVD	0	ő		0	Ö	22.00
23. 00	02300 PARAMED ED PRGM-PHARMACY RESIDENCY	46, 030	0		0 0	46, 030	23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	24, 766, 078	2, 303, 442	1, 491, 01	9 5, 689, 334	34, 249, 873	30.00
31. 00	03100 INTENSIVE CARE UNIT	3, 346, 916	l '			4, 389, 542	31.00
32.00	03200 CORONARY CARE UNIT	0	0		0	0	32.00
33. 00 34. 00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0		0 0	0	33. 00 34. 00
40. 00	04000 SUBPROVI DER - I PF	0	Ö		0	0	40.00
41.00	04100 SUBPROVI DER - I RF	868, 330	226, 735	153, 46	2 223, 671	1, 472, 198	41.00
42. 00 43. 00	04200  SUBPROVI DER 04300  NURSERY	1, 402, 330	110, 953	75, 09	7 328, 474	0 1, 916, 854	42. 00 43. 00
44. 00	04400 SKILLED NURSING FACILITY	0	0		0	0	44.00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0		0	0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS	0	0	'	<u>J</u>	0	46.00
50.00	05000 OPERATING ROOM	8, 188, 525	920, 064	622, 73	1, 703, 345	11, 434, 665	
50. 01 51. 00	05001   CV SURGERY   05100   RECOVERY ROOM	976, 488	0 64, 603	43, 72	0 5 254, 499	0 1, 339, 315	50. 01 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	3, 341, 163					
53. 00	05300 ANESTHESI OLOGY	0	0		0 0	0	
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	3, 677, 537 3, 193, 351	352, 118 426, 491			5, 138, 556 4, 484, 054	
56. 00	05600 RADI OI SOTOPE	0, 173, 331	0	200,00	0 0	0	56.00
57. 00	05700 CT SCAN	860, 571	25, 151			1, 061, 380	57.00
58. 00 59. 00	05800   MAGNETIC RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	459, 284 1, 513, 688	36, 189 120, 778			608, 964 2, 001, 269	58. 00 59. 00
60.00	06000 LABORATORY	9, 775, 638	l '			10, 297, 565	•
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60.01
60. 02 61. 00	06002 PHYSI CI AN LABORATORY 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY	0	0	1	0	0 0	60. 02 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	Ö	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	0	63.00
64. 00 65. 00	06400   NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	101, 644 1, 781, 414	l e	29, 78	21, 604 1 448, 566	123, 248 2, 284, 372	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	7, 621, 673	l '			10, 199, 460	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	735, 668	45, 735	34, 11	0 188, 229	0 1, 003, 742	68. 00 69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 036, 005	68, 332			1, 413, 597	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 246, 483	l e		0	9, 246, 483	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	10, 692, 449 19, 818, 448	l	88, 59	9 214, 540	10, 692, 449 20, 230, 116	72. 00 73. 00
74.00	07400 RENAL DIALYSIS	807, 414				832, 050	74.00
75. 00 75. 01	07500 ASC (NON-DISTINCT PART) 03550 PSYCHIATRIC/PSYCHOLOGICAL SERVICES	1 110 069	0	04 41	0 393, 901	1 601 270	75. 00 75. 01
75. 01 76. 97	07697 CARDI AC REHABI LI TATI ON	1, 110, 968 701, 374		96, 41 52, 45		1, 601, 279 1, 020, 515	1
	•						

COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150051 Peri od: Worksheet B From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/27/2016 1:53 pm CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost BENEFLTS DEPARTMENT Allocation (from Wkst A col. 7) 0 1.00 2.00 4. 00 4A OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 88 00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 89.00 0 90.00 09000 CLI NI C 1, 407, 141 87, 691 370, 531 1,865,363 90.00 09100 EMERGENCY 91.00 5, 709, 419 493, 667 7, 657, 840 91.00 334, 130 1, 120, 624 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS C 0 94 00 09500 AMBULANCE SERVICES 5, 102, 876 189, 297 178, 599 95.00 1, 206, 146 6, 676, 918 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 0 0 0 0 0 97.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 98 00 0 Ω 0 0 99.00 09900 CMHC 0 0 0 0 99.00 99. 10 09910 CORF 0 0 0 99.10 C 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 100.00 0 0 0 0 101.00 10100 HOME HEALTH AGENCY 1, 190, 366 7, 013, 436 101. 00 5, 331, 005 282, 612 209, 453 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105.00 106. 00 10600 HEART ACQUISITION 0 0 0 0 106.00 0 107.00 10700 LIVER ACQUISITION 0 0 0 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 0 108.00 0 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110 00 C 111.00 11100 | 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.) 01115.00 116. 00 11600 HOSPI CE 3, 950, 914 89, 419 186, 701 764, 171 4, 991, 205 116. 00 SUBTOTALS (SUM OF LINES 1-117) 276, 379, 049 118. 00 118.00 278, 163, 998 12, 365, 644 10, 771, 208 26, 862, 405 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 148, 168 17, 582 11, 900 195, 743 190. 00 18 093 181, 073 190. 01 19001 PROMPTCARE 1, 375, 028 159, 745 249, 035 1, 964, 881 190. 01 190. 02 19002 RENTAL PROPERTIES 78, 940 50,090 0 129, 030 190. 02 190. 03 19003 OLCOTT 442, 109 190. 03 285.358 34, 703 51, 272 70,776 190. 04 19004 PHYSI CI AN RECRUITMENT 432, 811 190. 04 432, 811 190. 05 19005 FOUNDATI ON 746, 019 0 81, 356 163, 704 991, 079 190. 05 190. 06 19006 MARKETI NG 265, 734 265, 734 190. 06 487, 300 190. 07 190. 07 19007 HME STORE 185, 286 80, 763 221, 251 190. 08 19008 UNUSED SPACE 323, 967 148,093 79, 589 551, 649 190. 08 190. 09 19009 CLINICAL TRIALS 386, 708 50, 415 437, 123 190. 09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 322, 457 0 85. 529 407, 986 190, 10 0 191. 00 19100 RESEARCH 0 0 191, 00 C 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 0 193.00 194.00 07950 IU HEALTH PAOLI HOSPITAL 19, 324, 896 0 0 19, 324, 896 194. 00 0 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 41, 594, 253 0 0 0 41, 594, 253 194. 01 194. 02 07952 I U HEALTH MORGAN HOSPITAL 18, 084, 812 0 18, 084, 812 194. 02 0 0 194.03 07953 IU HEALTH SIP 0 5, 436 194, 03 4.306 1, 130

361, 693, 891

12, 821, 276

11, 240, 592

27, 722, 338

0 200.00

0 201.00

361, 693, 891 202. 00

200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118-201)

Peri od: Worksheet B From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm Provi der CCN: 150051

Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	5/27/2016 1: 5 HOUSEKEEPI NG	
cost deliter bescription	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
GENERAL SERVICE COST CENTERS	5. 00	6. 00	7.00	8. 00	9. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FIXT						1.00
2.00   OO200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00   00500   ADMI NI STRATI VE & GENERAL	60, 695, 006					5.00
6.00   00600 MAINTENANCE & REPAIRS 7.00   00700 OPERATION OF PLANT	2, 772, 645	0	16, 522, 777			6. 00 7. 00
8. 00   00800   LAUNDRY & LI NEN SERVI CE	163, 397	0	400, 044	1, 373, 759		8.00
9. 00   00900   HOUSEKEEPI NG	520, 494	Ö	105, 951	0		9. 00
10. 00   01000 DI ETARY	551, 518	0	366, 438	8, 384	13, 019	10.00
11. 00   01100   CAFETERI A	53, 293	0	182, 824	6, 218	l	11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL	1 150 47/	0	0	0	0	12.00
13. 00   01300   NURSI NG   ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY	1, 159, 476 2, 411, 927	0	511, 160 119, 563	0	0 15, 316	13. 00 14. 00
15. 00   01500   PHARMACY	1, 246, 375	0	117, 303	0	13, 310	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY	105, 185	l e	182, 520	0	8, 934	16.00
17.00 01700 SOCIAL SERVICE	0	0	0	0	0	17. 00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18. 00
18. 01   01851   CENTRAL STERI LI ZATI ON	127, 866	0	94, 496	0	0	18. 01
19. 00   01900   NONPHYSI CI AN ANESTHETI STS 20. 00   02000   NURSI NG SCHOOL	0	0	0	0	0	19.00
20.00   02000   NURSI NG SCHOOL 21.00   02100   1 &R SERVI CES-SALARY & FRI NGES APPRVD		0	0	0	0	20. 00 21. 00
22. 00   02200   L&R SERVI CES-OTHER PRGM COSTS APPRVD	0	0	0	0	Ö	22.00
23. 00   02300   PARAMED ED   PRGM-PHARMACY   RESI DENCY	9, 282	Ö	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	6, 906, 316	0		399, 912	1, 356, 488	30.00
31. 00   03100   INTENSI VE CARE UNIT	885, 129	0	312, 232	101, 269	l .	31.00
32.00   03200   CORONARY CARE UNIT 33.00   03300   BURN INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00   03400   SURGI CAL   I NTENSI VE CARE UNI T		0	0	0		34.00
40. 00   04000   SUBPROVI DER - I PF	0	0	0	0	0	40.00
41. 00   04100   SUBPROVI DER -   I RF	296, 861	Ö	369, 507	33, 628	1	41.00
42. 00   04200   SUBPROVI DER	0	0	0	0	0	42. 00
43. 00   04300   NURSERY	386, 524	0	180, 819	6, 870	132, 483	43.00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45. 00 04500 NURSI NG FACI LI TY	0	0	0	0	0	45.00
46. 00 O4600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	1 0	<u> </u>	0	U	l 0	46. 00
50. 00 05000 OPERATING ROOM	2, 305, 743	0	1, 499, 419	167, 633	228, 464	50.00
50. 01   05001   CV   SURGERY	0	0	0	0	0	50. 01
51.00   05100   RECOVERY ROOM	270, 066	0			16, 082	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	1, 049, 060	0	1, 051, 246	143, 886		52.00
53. 00   05300   ANESTHESI OLOGY 54. 00   05400   RADI OLOGY-DI AGNOSTI C	1, 036, 164	0	670 162	0 76, 877	0 75, 559	53. 00 54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	904, 187	0	670, 163 695, 048			
56. 00   05600 RADI OI SOTOPE	0	ĺ	075, 040	13, 704	13, 2,4	56.00
57. 00 05700 CT SCAN	214, 022	0	40, 989	0	5, 871	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	122, 795	0	58, 976	0	8, 424	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	403, 546			41, 706	l .	
60. 00   06000   LABORATORY	2, 076, 452	0	543, 094	0	1, 787	60.00
60. 01   06001   BLOOD LABORATORY 60. 02   06002   PHYSI CI AN LABORATORY	0	0		0	0	60. 01 60. 02
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0		U	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	О	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	24, 852	0	0	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	460, 632	0	71, 708		0	65.00
66. 00   06600 PHYSI CAL THERAPY 67. 00   06700 OCCUPATI ONAL THERAPY	2, 056, 670	0	1, 047, 053	53, 843	61, 519	
67. 00   06700   OCCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0	0	0	0	0 0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	202, 400	0	82, 130	29, 705		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	285, 045	Ö	111, 360		0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 864, 507	0	0	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 156, 079	l e	0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	4, 079, 302		213, 330	0	87, 812	73.00
74. 00   07400   RENAL DI ALYSI S	167, 779	0	23, 943	0	511	74.00
75. 00   07500   ASC (NON-DISTINCT PART) 75. 01   03550   PSYCHIATRIC/PSYCHOLOGICAL SERVICES	322, 890		232, 138	0	0	75. 00 75. 01
76. 97   07697   CARDI AC REHABI LI TATI ON	205, 782	0		0	0	76. 97
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	376, 141 1, 544, 165		211, 143 804, 523		0 357, 884	90. 00 91. 00
7.1. 00   0 / 100   EMEROENOT	1, 544, 105	<u> </u>	1 004, 323	213, 101	1 337, 304	, , , , , , ,

| Peri od: | Worksheet B | From 01/01/2015 | Part | | To | 12/31/2015 | Date/Time Prepared:

			To	o 12/31/2015	Date/Time Pre 5/27/2016 1:5	
Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	os pili
cost center bescription	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE	HOUSEKEELLING	
	5. 00	6.00	7. 00	8. 00	9. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.00	0.00		2. 22	,,,,,,	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	1, 346, 367	0	430, 033	49, 426	0	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99. 00 09900 CMHC	0	0	0	0	0	99.00
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	1, 414, 224	0	504, 323	0	0	101.00
SPECIAL PURPOSE COST CENTERS						1
105. 00 10500 KI DNEY ACQUI SI TI ON	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 I SLET ACQUI SI TI ON	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		115. 00
116. 00 11600 HOSPI CE	1, 006, 452	0		18, 452		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	43, 491, 610	0	15, 584, 227	1, 368, 874	3, 204, 365	118. 00
NONREI MBURSABLE COST CENTERS						
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	39, 471	0		0		190. 00
190. 01 19001 PROMPTCARE	396, 208	0	,	4, 885		190. 01
190. 02 19002 RENTAL PROPERTIES	26, 018	0	-	0		190. 02
190. 03 19003 OLCOTT	89, 149	0	83, 558	0		190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	87, 274	0	0	0		190. 04
190. 05 19005 FOUNDATION	199, 846	0	195, 889	0		190. 05
190. 06 19006 MARKETI NG	53, 584	0	104 4/1	0		190.06
190. 07 19007 HME STORE 190. 08 19008 UNUSED SPACE	98, 262	0	194, 461 0	0		190. 07 190. 08
190. 08 19008 UNUSED SPACE 190. 09 19009 CLI NI CAL TRI ALS	111, 237	0		0		190. 08
190. 19 19009 CLINICAL TRIALS  190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	88, 144 82, 268	0		0		190. 09
191. 00 19100 RESEARCH	02, 200	0	-	0		191. 00
191.00 19100 RESEARCH 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES		0		0		191.00
193. 00 19300 NONPALD WORKERS		0	_	0		193. 00
194. 00 07950 IU HEALTH PAOLI HOSPITAL	3, 896, 769	0	0	0		194.00
194. 01 07951 IU HEALTH BEDFORD HOSPITAL	8, 387, 358	0	0	0		194. 01
194. 02 07952 I U HEALTH MORGAN HOSPITAL	3, 646, 712	l o	0	0		194. 02
194. 03 07953 I U HEALTH SI P	1, 096	1 0		0		194. 02
200.00 Cross Foot Adjustments	1,070			J		200.00
201.00 Negative Cost Centers	0	0	n	0	n	201.00
202.00 TOTAL (sum lines 118-201)	60, 695, 006	Ö	16, 522, 777	1, 373, 759		
1 . (2	, , , , , , , , ,	'	=	,, . 0 /	.,, 500	

Provi der CCN: 150051

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2015	Part
To 12/31/2015	Date/Time Prepared:
5/27/2016	1:53 pm

DECEMBER   DECEMBER		DI ETADY	OAFETER! A	'	0 12/31/2015	5/27/2016 1:5	
SERIORAL SERVICE_DOST_CENTERS	Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI O	CENTRAL SERVI CES &	
1.00   GOOD CAP REL COSTS-ENTERS		10.00	11 00	12.00			
1.00   00000 CAP REL COSTS-GLIDE & FIXT	GENERAL SERVICE COST CENTERS	10.00	11.00	12.00	13.00	14.00	
4 - 00   00000   DEPLOYEE REPRETEYS OFFERMENT	1.00 O0100 CAP REL COSTS-BLDG & FLXT						1.00
DOSED   ADMINISTRATE & CEMERAL							
0.000   DOCOM MAIN REPARTMENT   0.000   0.00							
0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000							
8. 00   00000   LAURDRY & LINEN SERVICE							
10.00   01000   DETARY   3.674,452   10.00   10.00   11.00							
11.00 01000 CAPETERIA							
12.00   1200   MAINTENANCE OF PERSONNEL   0			540.000				
13.00   01300  MIRSIN KS ADMIN STRATION   0   17, 832   0   7, 439, 553   13, 00   15.00   01500  PHARMACY   0   0   0   0   0   0   14, 509, 071   15.00   15.00   01500  PHARMACY   0   0   0   0   0   0   15.00		0	513, 008				
14.00   01400   CENTRAL SERVICES & SUPPLY   0   9   0   14,508,071   14,00   15.00   15.00   16.00   01600   MEDICAL RECORDS & LIBRARY   0   0   0   0   0   12   16,00   17.00   17		0	17 832	l .	7 438 553		
16. 00   1600   BEDICAL RECORDS & LIBRARY   0   0   0   0   12   16. 00   17. 00   170		Ö	9	Ö	0	14, 508, 071	
17.00   01700   SOCIAL SERVICE (SPECIFY)   0   0   0   0   0   0   17.00   18.01   01851   CENTRAL STEPLI LIZATION   0   3.864   0   0   0   37.507   18.01   01851   CENTRAL STEPLI LIZATION   0   3.864   0   0   0   0   0   20.00   02000   MIRSI NG SCHOOL   0   0   0   0   0   0   0   20.00   02000   MIRSI NG SCHOOL   0   0   0   0   0   0   0   20.00   02000   MIRSI NG SCHOOL   0   0   0   0   0   0   0   20.00   02000   MIRSI NG SCHOOL   0   0   0   0   0   0   0   20.00   02000   MIRSI NG SCHOOL   0   0   0   0   0   0   0   20.00   02300   PAGMED ED   0   0   0   0   0   0   0   0   20.00   02300   PAGMED ED   0   0   0   0   0   0   0   0   20.00   02300   PAGMED ED   0   0   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   20.00   NEW THE REDIATION SCHOOL   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL   0   0   0   0   0   0   0   20.00   03000   ADULTI S REDIATION SCHOOL	15. 00 01500 PHARMACY	0	19, 794	O	0	4, 901, 790	15.00
18.00   01850   OTHER CENERAL SERVICE (SPECIFY)   0   0   0   0   0   0   0   0   0		0	0	0	0		
18. DI 01851 [CENTRAL STERILI ZATION 0 0 3, 864 0 0 0 37, 597 18. DI 19. 00 1900 (MONPHYS) CIAN MASSTHETISTS 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	0	0		
19.00   01900   NON-PHYSIC IAN AMESTHETISTS   0   0   0   0   0   0   0   0   0		0	3 864		0		
20.00		0	0, 004		0		
22.00		O	0	O	O		
23.00		0	0	O	0	-	
INPATI_ENT_ROUTINE_SERVICE_COST_CENTERS   3, 184, 384   136, 713   0   3, 229, 461   403, 941   30.00   30.00   03000 ADULTS & PEDIATRICS   3, 184, 384   136, 713   0   3, 229, 461   403, 941   30.00   31.00   31.00   03100   INTENSI VE_CARE_UNIT   0   0   0   0   0   0   0   32.00   32.00   33.00   33.00   0300 BURN INTENSI VE_CARE_UNIT   0   0   0   0   0   0   0   33.00   34		0	0	0	0		
30.00		O <sub>I</sub>	0		0	0	23.00
31.00   03100   INTENSI VE CARE UNIT   285, 863   16, 443   0   450, 68B   134, 426   31.00   32.00   33200   03300   034000   03400   03400		3. 184. 384	136, 713	0	3, 229, 461	493. 941	30.00
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 33.00 40.00 0400.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 40.00 40.00 0400.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 40.00 41.00 0410.0 SUBPROVI DER 1 PF 0 0 0 0 0 149,268 13,286 41.00 41.00 0410.0 SUBPROVI DER 1 PF 0 0 0 0 0 0 0 0 42.00 42.00 0420.0 SUBPROVI DER 1 PF 0 0 0 0 0 0 0 42.00 43.00 0430.0 NURSENY 0 0 6,020 0 214,394 44.586 43.00 44.00 0440.0 SKI LLED NURSI NG FACI LITY 0 0 0 0 0 0 0 45.00 46.00 0440.0 NURSI NG FACI LITY 0 0 0 0 0 0 0 0 45.00 46.00 0460.0 NURSI NG FACI LITY 0 0 0 0 0 0 0 0 0 45.00 46.00 0460.0 NURSI NG FACI LITY 0 0 0 0 0 0 0 0 0 45.00 46.00 0460.0 NURSI NG FACI LITY 0 0 0 0 0 0 0 0 0 45.00 46.00 0460.0 THE LONG TERNI CARE 0 0 0 0 0 0 0 0 0 50.01 50.01 0500.01 OSCOOL OVER LONG TERNI CARE 0 0 0 0 0 0 0 0 0 50.01 51.00 0500.01 OFFICE LONG TERNI CARE 0 0 0 0 0 0 0 0 0 50.01 51.00 0500.01 OFFICE COST CENTERS 50.00 0500.01 OFFICE COST CENTERS 50.00 0500.01 DELOVERY ROOM 0 0 5.14.2 0 156,415 14,795 51.00 51.00 0510.00 DELOVERY ROOM 5 0 0 0 0 0 0 50.01 51.00 0510.00 DELIVERY ROOM 5 1.00 0 0 0 0 0 50.01 51.00 0510.00 DELIVERY ROOM 5 1.00 0 0 0 0 55.00 53.00 0530.0 ANESTHESI OLOGY 0 0 0 0 11,14.62 64,137 46,526 50.00 0550.00 RADIOLOGY-THERAPEUTI C 0 10,837 0 0 111,462 64,137 46,526 50.00 0550.00 RADIOLOGY-THERAPEUTI C 0 10,837 0 0 111,462 64,137 46,526 50.00 0550.00 RADIOLOGY-THERAPEUTI C 0 10,810 0 51,475 114,550 55.00 55.00 0550.00 RADIOLOGY-THERAPEUTI C 0 10,810 0 51,475 114,550 55.00 55.00 0550.00 RADIOLOGY-THERAPEUTI C 0 10,810 0 51,475 114,550 55.00 55.00 0550.00 RADIOLOGY-THERAPEUTI C 0 10,810 0 51,475 114,550 55.00 55.00 0550.00 RADIOLOGY-THERAPEUTI C 0 10,810 0 51,475 114,550 55.00 55.00 0550.00 RADIOLOGY-THERAPEUTI C 0 10,810 0 51,475 114,550 55.00 55.00 0550.00 RADIOLOGY-THERAPEUTI C 0 10,810 0 51,475 114,550 55.00 55.00 0550.00 RADIOLOGY-THERAPEUTI C 0 10,810 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						· ·	
34.00   03400   SURGICAL INTENSIVE CARE UNIT   0   0   0   0   0   34.00	32.00 03200 CORONARY CARE UNIT	0	0	O	0	0	32.00
40, 00   04000   SUBPROVI DER   1PF   0   0   0   0   40, 00   0   40, 00   0   40, 00   0   40, 00   0   0   0   0   0   0   0   0		0	0	0	0		
141.00   04100   SUBPROVI DER   1RF		0	0		0		
42.00   04200   SUBPROVIDER		204 205	5 191		149 268		
43. 00   04300   NURSERY		204, 203	0, 171		147, 200		
45. 00   04500   NURSI NG FACILITY   0 0 0 0 0 0 0 0 0 0 45. 00		0	6, 020	O	214, 394		
46. 00   04600   01600   0   0   0   0   0   0   0   0   0		0	0	O	0		
ANCIL LARY SERVICE COST CENTERS   SO. 00   SO. 00   SO. 00   SO. 01   SO. 00   SO. 00   SO. 00   SO. 01   SO. 00   SO. 00   SO. 01   SO. 01   SO. 00   SO. 01   SO.		- 1	0	l ~	0		
50.00   05000   05000   05000   0   0   0		U	0		ı o	0	46.00
50.01   05001   05001   05001   05001   05001   05001   0500   05001		0	35, 818	С	743, 584	1, 114, 557	50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   15,927   0   476,526   99,313   52.00		0	0	O	0		50. 01
53.00   05300   AMESTHESI OLOGY   0   0   0   0   0   53.00		0		O		· ·	
54. 00   05400   RADI OLOGY-THERAPEUTI C   0   18, 373   0   111, 462   64, 137   55. 00   55. 00   05500   RADI OLOGY-THERAPEUTI C   0   10, 810   0   51, 475   114, 503   55. 00   55. 00   05600   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   0   0   55. 00   55. 00   05600   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   0   0   55. 00   55. 00   05700   CT SCAN   0   0   0   0   0   0   0   0   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0   1, 737   0   0   0   19, 210   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0   1, 737   0   0   0   0   19, 210   58. 00   05900   CARDI AC CATHETERI ZATI ON   0   6, 244   0   153, 668   147, 219   59. 00   06. 00   0   0   0   0   0   0   0   0   0		0	15, 927	0	476, 526		
55. 00   05500   RADI OLOGY-THERAPEUTIC   0   10,810   0   51,475   114,503   55. 00   56. 00   05600   RADI OLOGY-THERAPEUTIC   0   0   0   0   0   0   0   0   0		0	10 373		111 462		
56. 00   05600   RADI OI SOTOPE   0   0   0   0   0   56. 00		0					
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 1,737 0 0 159, 200 05900 CARDIAC CATHETERIZATION 0 6,244 0 153, 668 147, 219 59. 00 6000 CARDIAC CATHETERIZATION 0 6,244 0 153, 668 147, 219 59. 00 60. 01 06001 BLOOD LABORATORY 0 488 0 0 0 374, 248 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		O	0	O	0	.,	
59,00   05900   CARDI AC CATHETERI ZATI ON   0   6, 244   0   153,668   147, 219   59,00		0		O	0		
60. 00   06000   LABORATORY   0   488   0   0   374, 248   60. 00   60. 01   60. 01   60. 01   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0		0		0	0		
60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0		0		1	153, 668		
60. 02 06002 PHYSI CI AN LABORATORY 0 0 0 0 0 0 0 0 60. 02 61. 00 62. 00 62.0 00 06100 PBP CLI IN CAL LAB SERVI CES-PRGM ONLY 61. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	400		0		
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   62. 00   63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   0   0   0   63. 00   64. 00   06400   INTRAVENOUS THERAPY   0   579   0   13, 157   4, 177   64. 00   65. 00   06500   RESPI RATORY THERAPY   0   9, 266   0   0   78, 023   65. 00   06600   PHYSI CAL THERAPY   0   41, 673   0   147, 308   52, 412   66. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   3, 921   0   29, 875   24, 975   69. 00   70. 00   07000   ELECTROCARDI OLOGY   0   5, 851   0   13   9, 780   70. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0   2, 959, 777   72. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   2, 959, 777   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   8, 175   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   0   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   7, 083   0   65, 696   448   75. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   0   3, 884   0   40, 559   1, 848   76. 97   00   0   0   0   0   0   0   0   0	1	o	0	Ö	Ö		
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0   63.00   64.00   06400   NTRAVENOUS THERAPY   0   5779   0   13, 157   4, 177   64.00   65.00   06500   RESPI RATORY THERAPY   0   9, 266   0   0   78, 023   65.00   06600   PHYSI CAL THERAPY   0   41, 673   0   147, 308   52, 412   66.00   66.00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   67.00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   68.00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   69.00   06900   ELECTROCARDI OLOGY   0   3, 921   0   29, 875   24, 975   69.00   70.00   07000   ELECTROCARDI OLOGY   0   5, 851   0   13   9, 780   70.00   71.00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0   2, 559, 519   71.00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   2, 959, 777   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   4, 659   0   134, 095   33, 755   73.00   74.00   07400   RENAL DI ALYSI S   0   0   0   0   0   75.00   75.01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   7, 083   0   65, 696   448   75.01   76.97   07697   CARDI AC REHABI LI TATI ON   0   3, 884   0   40, 559   1, 848   0UTPATI ENT SERVI CE COST CENTERS   80.00   0   0   0   0   0   0   0   0   89.00   08800   RURAL HEALTH CLINI C   0   0   0   0   0   0   99.00	61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
64. 00   06400   INTRAVENOUS THERAPY   0   579   0   13, 157   4, 177   64. 00   65. 00   06500   RESPIRATORY THERAPY   0   9, 266   0   0   78, 023   65. 00   66. 00   06600   PHYSI CAL THERAPY   0   41, 673   0   147, 308   52, 412   66. 00   67. 00   06700   00   0   0   0   0   0   0   0   0		0	0	0	0		
65. 00		0	0 570		12 157		
66. 00   06600   PHYSI CAL THERAPY   0   41, 673   0   147, 308   52, 412   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   3, 921   0   29, 875   24, 975   69. 00   70. 00		0		1 0	13, 137		
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   3, 921   0   29, 875   24, 975   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   5, 851   0   13   9, 780   70. 00   71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0   0   0   0   2, 559, 519   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   2, 959, 777   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   134, 095   33, 755   73. 00   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   0   8, 175   74. 00   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   75. 00   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   7, 083   0   65, 696   448   75. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   0   3, 884   0   40, 559   1, 848   88. 00   08800   RURAL HEALTH CLI NI C   0   0   0   0   0   88. 00   89. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0   0   0   0   0   0   89. 00		Ö		Ö	147, 308		
69. 00   06900   ELECTROCARDI OLOGY   0   3, 921   0   29, 875   24, 975   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   5, 851   0   13   9, 780   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   2, 559, 519   71. 00   72. 00   72. 00   MPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   2, 959, 777   72. 00   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   4, 659   0   134, 095   33, 755   73. 00   74. 00   74. 00   75.		0	0	O	0		•
70. 00         07000         ELECTROENCEPHALOGRAPHY         0         5, 851         0         13         9, 780         70. 00           71. 00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0         0         2, 559, 519         71. 00           72. 00         07200         IMPL. DEV. CHARGED TO PATI ENTS         0         0         0         0         2, 959, 777         72. 00           73. 00         07300         DRUGS CHARGED TO PATI ENTS         0         4, 659         0         134, 095         33, 755         73. 00           74. 00         07400         RENAL DI ALYSIS         0         0         0         0         8, 175         74. 00           75. 00         07500         ASC (NON-DI STI NCT PART)         0         0         0         0         0         0         75. 00           75. 01         03550         PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES         0         7, 083         0         65, 696         448         75. 01           76. 97         OARDI AC REHABI LI TATI ON         0         3, 884         0         40, 559         1, 848         76. 97           0UTPATI ENT SERVI CE COST CENTERS         0         0         0		0	0	0	0		
71. 00		0		0			
72. 00         07200         IMPL. DEV. CHARGED TO PATIENTS         0         0         0         2,959,777         72. 00           73. 00         07300         DRUGS CHARGED TO PATIENTS         0         4,659         0         134,095         33,755         73. 00           74. 00         07400         RENAL DI ALYSIS         0         0         0         0         0         8,175         74. 00           75. 00         07500         ASC (NON-DI STINCT PART)         0         0         0         0         0         0         75. 00           75. 01         03550         PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES         0         7,083         0         65,696         448         75. 01           76. 97         OARDI AC REHABI LI TATI ON         0         3,884         0         40,559         1,848         76. 97           0UTPATI ENT SERVI CE COST CENTERS         0         0         0         0         0         88.00           89. 00         08900         FEDERALLY QUALI FI ED HEALTH CENTER         0         0         0         0         0         0         89.00		0	5, 851 0		13		
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   4,659   0   134,095   33,755   73.00   74.00   07400   RENAL DI ALYSIS   0   0   0   0   0   0   75.00   75.00   07500   ASC (NON-DI STINCT PART)   0   0   0   0   0   0   0   75.00   75.01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   7,083   0   65,696   448   75.01   76.97   07697   CARDI AC REHABI LI TATI ON   0   3,884   0   40,559   1,848   76.97   077697   07		0	0		0		
74. 00   07400   RENAL DI ALYSI S   0   0   0   0   8, 175   74. 00   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   75. 00   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   7, 083   0   65, 696   448   75. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   0   3, 884   0   40, 559   1, 848   76. 97   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   0000   00000   00000   000000		o	4, 659		134, 095		
75. 01   03550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0   7, 083   0   65, 696   448   75. 01   76. 97   76. 97   07697   CARDI AC REHABI LI TATI ON   0   3, 884   0   40, 559   1, 848   76. 97   0000000000000000000000000000000000	74. 00   07400   RENAL DI ALYSI S	0	0	0	O	8, 175	74.00
76. 97   07697   CARDI AC REHABILITATION   0   3, 884   0   40, 559   1, 848   76. 97   0   0   0   0   0   0   88. 00   89. 00   0   0   0   0   0   89. 00   89. 00   0   0   0   0   0   89. 00   0   0   0   0   0   0   0   0   89. 00   0   0   0   0   0   0   0   0   0		0	0	0	0		
OUTPATIENT SERVICE COST CENTERS           88.00         08800 RURAL HEALTH CLINIC         0         0         0         0         0         88.00           89.00         08900 FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0         0         0         0         89.00					,		
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		U	3, 884	1	40, 559	1, 848	10.97
89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0   89.00		O	0	О	O	0	88. 00
90. 00  09000  CLI NI C   0  7, 689  0  83, 841  5, 482   90. 00	89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	O	0	0	89. 00
	90. 00  09000 CLINIC	0	7, 689	<u> </u> 0	83, 841	5, 482	90.00

Provi der CCN: 150051

| Peri od: | Worksheet B | From 01/01/2015 | Part I | Date/Time Prepared: |

			1	0 12/31/2015	Date/IIme Pre   5/27/2016 1:5	
Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	J piii
555t 5511t61 55551 pt. 511		0,11 2 1 2 1 1 1 1	OF PERSONNEL	ADMI NI STRATI O	SERVICES &	
				N	SUPPLY	
	10. 00	11. 00	12.00	13. 00	14. 00	
91. 00   09100   EMERGENCY	0	27, 366	0	668, 869	256, 896	91.00
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00   09500 AMBULANCE SERVICES	0	37, 140	0	739	76, 828	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	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00   09900   CMHC	0	0	0	0	0	99. 00
99. 10  09910 CORF	0	0	0	0	0	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	26, 172	0	213, 449	131, 994	101.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KIDNEY ACQUISITION	0	0	0	0		105.00
106.00 10600 HEART ACQUISITION	0	0	0	0	0	106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	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 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	17, 966	0	263, 947	125, 376	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3, 674, 452	496, 808	0	7, 398, 489	13, 961, 467	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	829	1		2	190. 00
190. 01 19001 PROMPTCARE	0	6, 524	i	33, 981	43, 309	
190. 02 19002 RENTAL PROPERTIES	0	0	0	0		190. 02
190. 03 19003 OLCOTT	0	1, 458	0	131		190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	0	0		190. 04
190. 05 19005 FOUNDATI ON	0	2, 502	0	0	0	190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0	190. 06
190. 07 19007 HME STORE	0	2, 991	0	294	495, 882	1
190. 08 19008 UNUSED SPACE	0	0	0	0		190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	954		5, 408		190. 09
190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINIC	0	928	l .	250		190. 10
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	0		194.00
194. 01 07951 I U HEALTH BEDFORD HOSPI TAL	0	0	0	0		194. 01
194. 02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0		
194. 03 07953 I U HEALTH SI P	0	14	0	0	6, 415	194. 03
200.00 Cross Foot Adjustments					_	200.00
201.00 Negative Cost Centers	0	0	0	0		201.00
202.00   TOTAL (sum lines 118-201)	3, 674, 452	513, 008	0	7, 438, 553	14, 508, 071	1202.00

Provi der CCN: 150051

				OTHER GENE	<u>  5/27/2016 1: 5</u> RAL SERVICE	3 pm
Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	(SPECI FY)	CENTRAL	
cost center bescription	PHARWACT	RECORDS &	SERVI CE	(SPECIFT)	STERI LI ZATI ON	
	15.00	LI BRARY	17.00	10.00	10.01	
GENERAL SERVICE COST CENTERS	15. 00	16. 00	17. 00	18. 00	18. 01	
1.00 O0100 CAP REL COSTS-BLDG & FIXT						1. 00
2. 00   00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500   ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00   00600 MAI NTENANCE & REPAI RS						6. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00   00800   LAUNDRY & LI NEN SERVI CE 9.00   00900   HOUSEKEEPI NG						8. 00 9. 00
9. 00   00900  HOUSEKEEPI NG 10. 00   01000  DI ETARY						9. 00 10. 00
11. 00   01100   CAFETERI A						11. 00
12. 00 01200 MAI NTENANCE OF PERSONNEL						12.00
13. 00   01300   NURSI NG   ADMI NI STRATI ON 14. 00   01400   CENTRAL   SERVI CES & SUPPLY						13. 00 14. 00
15. 00 01500 PHARMACY	12, 348, 995					15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	O	818, 286				16.00
17. 00   01700   SOCI AL SERVI CE	0	0	0			17.00
18. 00   01850 OTHER GENERAL SERVICE (SPECIFY) 18. 01   01851 CENTRAL STERILIZATION	0	0	0	C	897, 936	18. 00 18. 01
19. 00 01900 NONPHYSI CI AN ANESTHETI STS		0	ő	C	0,77,730	19. 00
20. 00   02000 NURSI NG SCH00L	o	0	0	C	0	20.00
21. 00   02100   1 &R SERVICES-SALARY & FRINGES APPRVD	0	0	0	C	0	21.00
22. 00   02200   1&R SERVI CES-OTHER PRGM COSTS APPRVD 23. 00   02300   PARAMED ED PRGM-PHARMACY RESIDENCY	0	0	0	C	_	22. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	<u> </u>		<u> </u>			23.00
30. 00 03000 ADULTS & PEDIATRICS	0	71, 409		C	,	30. 00
31. 00 03100 INTENSIVE CARE UNIT	0	10, 991	0	0	1, 056	31.00
32.00   03200   CORONARY CARE UNIT 33.00   03300   BURN INTENSIVE CARE UNIT	0	0	0	0	0	32. 00 33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	Ö	0	Ö	C	Ö	34.00
40. 00   04000   SUBPROVI DER -   PF	0	0	0	C	0	40.00
41. 00   04100   SUBPROVI DER -   I RF 42. 00   04200   SUBPROVI DER	0	3, 038	0	C	746 0	41. 00 42. 00
43. 00   04300   NURSERY		6, 856	0	C	1, 274	43.00
44.00 04400 SKILLED NURSING FACILITY	o	0	0	C	0	44.00
45. 00 04500 NURSING FACILITY	0	0	0	C	0	45.00
46.00 O4600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0	0	C	0	46. 00
50. 00   05000   OPERATING   ROOM	0	125, 012	0	C	868, 765	50.00
50. 01   05001   CV   SURGERY	0	0	0	C	0	50. 01
51.00   05100   RECOVERY ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	0	16, 309	0	C	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   53.00   05300   ANESTHESIOLOGY		21, 787 0	0	0	404	52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	Ö	30, 029	Ö	C	777	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	45, 272	0	C	0	55.00
56. 00   05600  RADI 0I SOTOPE 57. 00   05700  CT SCAN	0	0 22, 062	0	C	0	56. 00 57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		5, 255	0	C	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	O	43, 640	0	C	3, 417	59. 00
60. 00 06000 LABORATORY	0	86, 917	0	C	0	60.00
60. 01   06001   BL00D   LABORATORY 60. 02   06002   PHYSI CI AN   LABORATORY	0	0	0	C	0	60. 01 60. 02
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		J		Č		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	C	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
64. 00   06400   I NTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY		533 7, 171	0	0	0 2, 485	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	o	19, 746	Ö	C	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	C	0	67.00
68. 00   06800   SPEECH   PATHOLOGY   69. 00   06900   ELECTROCARDI OLOGY	0	0 14, 889	0	C	0	68. 00 69. 00
70. 00   07000   ELECTROCARDI OLOGY		14, 889	0	0	2, 951	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29, 288	O	C	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	63, 371	0	C	0	72.00
73. 00   07300   DRUGS CHARGED TO PATIENTS 74. 00   07400   RENAL DI ALYSI S	12, 348, 995	93, 377 2, 252		C	0	73. 00 74. 00
75. 00   07500   ASC (NON-DISTINCT PART)	0	2, 232	0	C	0	75.00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	O	1, 838	0	C	0	75. 01
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0	1, 982	0	C	0	76. 97
88. 00   08800   RURAL HEALTH CLINIC	0	0	0	C	0	88. 00
	, 9		·			

COST ALLOCATION - GENERAL SERVICE COSTS

Provi der CCN: 150051

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

5/27/2016 1:53 pm OTHER GENERAL SERVICE SOCI AL Cost Center Description **PHARMACY** MEDI CAL (SPECI FY) CENTRAL STERI LI ZATI ON RECORDS & SERVI CE LI BRARY 15. 00 16.00 17.00 18.00 18.01 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 90.00 09000 CLI NI C 0 875 0 0 90.00 0 0 09100 EMERGENCY 0 57, 177 0 2,019 91 00 91 00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 00 94.00 0 0 0 09500 AMBULANCE SERVICES 0 95.00 95.00 25, 633 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0000 0 0 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 98 00 0 Ω 0 99.00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 o 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 KI DNEY ACQUI SI TI ON 0 0 0 0 105.00 0 0 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106.00 107.00 10700 LIVER ACQUISITION 0 0 107.00 108. 00 10800 LUNG ACQUISITION 0 0 0 108.00 0 0 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 0 111.00 11100 I SLET ACQUISITION 0 C 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 C 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1-117) 118.00 12, 348, 995 818, 286 0 ol 895, 761 118.00 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 01 19001 PROMPTCARE 0 0 0 0 0 190. 01 190. 02 19002 RENTAL PROPERTIES 0 190.02 0000000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 190. 03 19003 OLCOTT 0 190. 03 0 190. 04 19004 PHYSI CI AN RECRUI TMENT 0 0 0 190, 04 190. 05 19005 FOUNDATI ON 0 0 190.05 0 190. 06 19006 MARKETI NG 0 0 190.06 190. 07 19007 HME STORE 0 0 190.07 0 0 190. 08 19008 UNUSED SPACE 0 190.08 190. 09 19009 CLINICAL TRIALS 0 0 0 190.09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 0 190. 10 0 191. 00 19100 RESEARCH 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 194.00 07950 IU HEALTH PAOLI HOSPITAL 0 0 194, 00 0 194. 01 07951 I U HEALTH BEDFORD HOSPI TAL 0 0 0 194. 01 194. 02 07952 IU HEALTH MORGAN HOSPITAL 0 0 0 194. 02 0 2, 175 194. 03 194. 03 07953 IU HEALTH SIP 0 0 0 Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 0 201.00 0 897, 936 202. 00 202.00 TOTAL (sum lines 118-201) 12, 348, 995 818, 286

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2015 | Part I | Date/Time Prepared: | Provi der CCN: 150051

COST CORTOR DOSCRIPTION   NORMENSICE ARE MURES INC   SERVICES-CHIEF   PROM. COSTS					Т	o 12/31/2015	Date/Time Pre 5/27/2016 1:5	
AMESTRETISTS   SCHOOL   RY & FRINCES   PROM DOSTS   PROM - PRINCES   PROM DOSTS   PROM - PRINCES   PROM DOSTS   PROM DOS					INTERNS &	RESI DENTS		
DEBUTAL SERVICE DOST CENTERS   19.00   20.00   21.00   22.00   22.00   25.00		Cost Center Description					PRGM-PHARMACY	
CHIEFMAN SERVICE DOST CENTERS			19 00	20.00	21 00	22 00		
2.00   00000 CAP REL COSTS-AVMILE FOUR		GENERAL SERVICE COST CENTERS	17100	20.00	200	22.00	20.00	
4.00   0.0010   DIAMPLY EMPRITY DEPARTMENT								1
0.0000   DOSOO   ADMINISTRATIVE & CEMERAL								1
0.00   0.000   MAIN METAMORE & REPAIR IS   0.00								1
8. 00   00000   DAURDORY & LINEN SERVICE   9. 00   10.00   010000   DETARY   11.00								1
9.00 0900  BUSEREEPING		00700 OPERATION OF PLANT						1
10.00   1000G   GETARY		00800 LAUNDRY & LINEN SERVICE						8. 00
11.00   01.00   CAFFEER       11.00   13.00								•
12.00   01200   MAISTEANDER OF PERSONNEL   12.00   13.00   1								1
13.00   1300   MURSI NS. ADMIN STRATION     14.00   1400								
15.00   10500   PHANNACY     16.00								•
16.00   1600   IEDICAL, RECORDS & LIBRARY     16.00   17.00   1700   1800   1800   1810   1	14.00	01400 CENTRAL SERVICES & SUPPLY						14.00
17.00   17.00   17.00   17.00   17.00   18.1								1
18. 00   01850   OTHER CEMERAL SERVICE (SPECIFY)   18. 00   19. 00   19.00								1
18. DI   01851   CENTRAL STERILL ZATION     18. OI   19. OI   20								•
19.00   01900   NOMINYSI CLAN AMESTHETISTS   0   2.00   20.0								•
20.00   02000 NURSING SCHOOL   22.00   22.00   22.00   22.00   22.00   22.00   23.50   28.5 SERVI CES-SALARY & FRINGES APPRVD   22.00   22.00   22.00   23.0			o					•
22.00   02200  RAR SERVICES-OTHER PROM COSTS APPROV   55, 312   23.00   2030  PARAMED ED PROGNED-HARMARCY   85   10.00   30.00   0.00				0				•
23.00   02300   PARAMED ED PROM_PHARMACY RESIDENCY					0			•
INPATI ENT ROUTH NE SERVICE COST CENTERS   0						0		•
30. 00   030000   030000   030000   03000   03000   03000   03000   03000   03000   0310000   0310000   0310000   0310000   0310000   0310000   0310000   0310000   03100000   03100000   0310000000000	23. 00						55, 312	23.00
31 00   03100   INTERSIVE CARE UNIT	30 00			0		O	0	30 00
32. 00 03200 CORONARY CARE UNIT 0 0 0 0 0 32. 00 33. 00 03300 DURN INTENSIVE CARE UNIT 0 0 0 0 0 0 33. 00 34. 00 03400 SURNG ICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 34. 00 41. 00 03400 SUBRON IDER 1 PF 0 0 0 0 0 0 0 0 0 44. 00 41. 00 04100 SUBPROVIDER 1 PF 0 0 0 0 0 0 0 0 0 44. 00 41. 00 04100 SUBPROVIDER 1 PF 0 0 0 0 0 0 0 0 0 0 42. 00 42. 00 04200 SUBPROVIDER 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1		1			1
34. 00 03400 SURGI CAL INTENSIVE CARE UNIT 0 0 0 0 0 0 34. 00 040. 00 4000 SUBPROVIDER - 1 PF 0 0 0 0 0 0 0 0 40. 00 40.		1	0	0	o	0		1
40.00   04000   SUBPROVI DER - 1   PF   0 0 0 0 0 0 0 0 1.4 1.00   41.00   04100   SUBPROVI DER - 1   RF   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	0	0	33.00
41.00   04100   SUBPROVI DER -   IRF   0 0 0 0 0 0 0 2.2 00   42.00   04200   SUBPROVI DER   0 0 0 0 0 0 0 2.2 00   43.00   04300   NURSERY   0 0 0 0 0 0 0 0 0 2.4 00   44.00   04400   SKI LLED NURSI NG FACILITY   0 0 0 0 0 0 0 0 0 0 4.4 00   44.00   04400   SKI LLED NURSI NG FACILITY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0	0	0		1
42.00   04200   04200   SUBROVIDER			0	0		0		1
43. 00   04300   NURSERY				0		0		ı
44.00   04400   SKILLED NURSING FACILITY   0 0 0 0 0 0 0 0 0 0 45.00   45.00   04500 NURSING FACILITY   0 0 0 0 0 0 0 0 0 0 45.00   46.00   04600   04600   04600   04600   046.00   ANCILLARY SERVICE COST CENTERS			0	0		0		1
46. 00   046.00   046.00   0   0   0   0   0   0   0   0   0			o	0		0		•
ANCILLARY SERVICE COST CENTERS			1					•
50.00   05000   05000   05000   0   0   0	46. 00		0	0	) <u> </u>	0	0	46. 00
50.01   05001   CV SURGERY   0   0   0   0   0   0   50.01	50.00						0	50.00
51.00   05100   RECOVERY ROOM			1		1			•
53.00   05300   ANESTHESI OLOGY   0   0   0   0   0   53.00   54.00   05400   RADI OLOGY-DI AGNOSTI C   0   0   0   0   0   0   54.00   55.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   55.00   56.00   05500   RADI OLOGY-THERAPEUTI C   0   0   0   0   0   0   0   57.00   05700   CT SCAN   0   0   0   0   0   0   0   0   58.00   05800   MAGNETI C RESONANCE   IMAGI NG (MRI )   0   0   0   0   0   0   59.00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   60.00   06000   LABDRATORY   0   0   0   0   0   0   0   60.01   06000   BLOOD ARDIACTORY   0   0   0   0   0   0   0   60.01   06001   BLOOD LABORATORY   0   0   0   0   0   0   61.00   06000   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   62.00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   63.00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   0   64.00   06400   PSPICIAL THERAPY   0   0   0   0   0   0   65.00   06600   PSPICIAL THERAPY   0   0   0   0   0   0   66.00   06600   PSPICIAL THERAPY   0   0   0   0   0   0   67.00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   68.00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   0   69.00   06700   ELECTROCABIOLOGY   0   0   0   0   0   71.00   07000   ELECTROCABIOLOGY   0   0   0   0   0   72.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   74.00   07400   RENAL DI ALYSI S   0   0   0   0   0   75.01   03550   PSYCHI ATRI (CPSYCHOLOGI CAL SERVI CES   0   0   0   0   0   0   76.01   07400   RENAL DI ALYSI S   0   0   0   0   0   0   76.07   07697   CARDIA CREHABILI TATI ON   0   0   0   0   0   76.07   07697   CARDIA CREHABILI TATI ON   0   0   0   0   0   76.07   07697   CARDIA CREHABILI TATI ON   0   0   0   0   0   76.07   07697   CARDIA CREHABILI TATI ON   0   0   0   0   0   76.07   07697   CARDIA CREHABILI TATI ON   0   0   0   0   0   76.07   07697   CARDIA CREHABILI TATI ON   0   0   0   0   76.07   07697   CARDIA CREHABILI TATI ON   0   0   0   0   0			o	0		0		ł
54. 00   05400   RADI OLOGY-DI AGNOSTI C	52.00	05200 DELIVERY ROOM & LABOR ROOM	o	0	0	0	0	52.00
55. 00   05500   RADI OLOGY-THERAPEUTI C			0	0	0	0	_	•
56.00   05600   RADI OI SOTOPE   0 0 0 0 0 0 0 0 0 56.00			0	0		0		
57. 00   05700   CT SCAN   0   0   0   0   0   0   0   57. 00   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI ) 0   0   0   0   0   0   0   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   0   60. 00   06000   LABORATORY   0   0   0   0   0   0   0   60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   60. 02   06002   PHYSI CI AN LABORATORY   0   0   0   0   0   0   61. 00   06100   PSP CLI NI CAL LAB SERVI CES-PRGM ONLY   61. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   0   0   0   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   67. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   68. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   71. 00   07000   ELECTROCARDI OLOGY   0   0   0   0   72. 00   07000   RELECTROENCEPHALOGRAPHY   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   74. 00   07400   RENAL DILAYSIS   0   0   0   0   75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   75. 01   07500   ASC (NON-DISTINCT PART)   0   0   0   0   75. 01   07507   CARDI AC REHABI LI TATION   0   0   0UTPATI ENT SERVICE COST CENTERS			0	0		0		
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 59. 00 60. 00 06000 LABRORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0		0	_	
59.00   05900   CARDI AC CATHETERI ZATI ON   0   0   0   0   0   59.00			l o	Ö		Ö	_	
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	) o	0	0	59.00
60. 02   06002   PHYSI CI AN LABORATORY   0   0   0   0   0   0   60. 02   61. 00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY   61. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   64. 00   06400   INTRAVENOUS THERAPY   0   0   0   0   0   65. 00   06500   RESPIRATORY THERAPY   0   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   67. 00   06600   OCCUPATI ONAL THERAPY   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   70. 00   07000   ELECTROCARDI OLOGY   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   75. 01   07500   ASC (NON-DI STI INCT PART)   0   0   0   0   76. 97   07697   CARDI AL RICHARD SERVICES   0   0   0   0   0   0   0   0   0   0   0			0	0	0	0		1
61. 00			0	0		0		
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 0 0 0 0 62. 00 63. 00 64. 00 6400 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 63. 00 64. 00 640. 00 6400 INTRAVENOUS THERAPY 0 0 0 0 0 0 0 65. 00 65. 00 6500 RESPIRATORY THERAPY 0 0 0 0 0 0 0 0 66. 00 66. 00 66. 00 6600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 66. 00 67. 00 66. 00 6600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 66. 00 67. 00 68. 00 69. 00 6000 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00			١	U	)	U	U	1
63. 00			0	0		0	0	
65. 00			o o	0		0		1
66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   70. 00   07000   ELECTROCARDI OLOGY   0   0   0   0   0   0   71. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   75. 01   07500   ASC (NON-DI STINCT PART)   0   0   0   0   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   000   076. 97   000TPATI ENT SERVI CE COST CENTERS	64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 0 0 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 55, 312 73. 00 74. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 55, 312 73. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 0 75. 01 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 0 0 76. 97 OUTPAȚI ENT SERVI CE COST CENTERS			0	0	0	0		1
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   0   0   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   0   0   0   0   0   72. 00   072. 00   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   0   0   0   0   75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   76. 97   OUTPATIENT SERVI CE COST CENTERS			0	0		0		
69. 00 06900   ELECTROCARDI OLOGY   0 0 0 0 0 0 0 69. 00 70. 00 70. 00 70. 00 70. 00 70. 00 70. 00 9 0 0 0 0 0 0 0 0 0 0 0 70. 00 70. 00 71. 00 71. 00 71. 00 72. 00 72. 00 73. 00 73. 00 74. 00 74. 00 74. 00 75. 0			0	0		0		1
70. 00				0		0		
71. 00				0		o		
73. 00   07300   DRUGS CHARGED TO PATIENTS   0   0   0   0   55, 312   73. 00   74. 00   07400   RENAL DI ALYSIS   0   0   0   0   0   74. 00   75. 00   07500   ASC (NON-DI STINCT PART)   0   0   0   0   0   0   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   76. 97   OT697   CARDI AC REHABI LI TATI ON   0   0   0   0   00   00   00   00			0	0	) 0	O		•
74. 00			0	0	) 0	0		
75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   75. 00   75. 01   03550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0   0   0   0   0   0   76. 97   07697   CARDI AC   REHABILITATION   0   0   0   0   0   00TPATI ENT   SERVI CE   COST   CENTERS			0	0	0	0		1
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 0 0 75. 01 76. 97 07697 CARDI AC REHABI LI TATI ON 0 0 0 0 76. 97 OUTPAȚI ENT SERVI CE COST CENTERS			0	0				1
76. 97 O 7697 CARDIAC REHABILITATION 0 0 0 0 0 76. 97 OUTPATIENT SERVICE COST CENTERS				0			_	
OUTPATIENT SERVICE COST CENTERS				0		ol		•
88. 00  08800  RURAL HEALTH CLINIC   0 0 0 0 88. 00		OUTPATIENT SERVICE COST CENTERS	. ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~ ~					
	88. 00	08800 RURAL HEALTH CLINIC	0	0	)  C	0	0	88.00

					5/2//2016 1:5	<u>3 pm</u>
			INTERNS &	RESI DENTS		
Occident Description	NONDUNCT OF AN	NUDCLNO	CEDVILOEC CALA	CEDVI OFC. OTHE	DADAMED ED	
Cost Center Description	NONPHYSI CI AN	NURSI NG		SERVI CES-OTHE	PARAMED ED	
	ANESTHETI STS	SCH00L	RY & FRINGES	R PRGM COSTS	PRGM-PHARMACY RESI DENCY	
	19. 00	20. 00	21. 00	22. 00	23.00	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	20.00		22.00	23.00	89.00
90. 00   09000   CLINIC	0	0		0	ő	•
91. 00 09100 EMERGENCY	l ol	0		0	Ö	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	]		_			92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	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	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	
99. 10 09910 CORF	0	0	0	0	0	
100. 00 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
101. 00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS						105.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0		105.00
106.00 10600 HEART ACQUISITION 107.00 10700 LIVER ACQUISITION	0	0	0	0		106. 00 107. 00
107. 00 10700 ETVER ACQUISITION 108. 00 10800 LUNG ACQUISITION		0		0		107.00
109. 00 10900 PANCREAS ACQUISITION		0	0	0		108.00
110. 00 11000   NTESTINAL ACQUISITION		0	0	0		110, 00
111. 00 11100   SLET ACQUI SI TI ON		0	0	0		111.00
113. 00 11300   NTEREST EXPENSE		Ü	Ĭ	J		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P. )	o	0	0	0	0	115.00
116. 00 11600 HOSPI CE	O	0	0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	O	0	0	0	55, 312	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0		190. 00
190. 01 19001 PROMPTCARE	0	0	0	0		190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	0		190. 02
190. 03 19003 OLCOTT	0	0	0	0		190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	0	0		190. 04
190. 05 19005 FOUNDATI ON	0	0		0		190.05
190. 06 19006 MARKETI NG	0	0	0	0		190.06
190. 07 19007 HME STORE	0	0	0	0		190. 07 190. 08
190. 08 19008  UNUSED SPACE 190. 09 19009  CLI NI CAL TRI ALS		0	· ·	0		190. 08
190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINIC		0	0	0		190. 09
191. 00 19100 RESEARCH		0		0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES		0	· ·	0	-	192.00
193. 00 19300 NONPALD WORKERS		0		0		193.00
194. 00 07950 IU HEALTH PAOLI HOSPITAL		0		0		194.00
194. 01 07951 I U HEALTH BEDFORD HOSPITAL	0	0		0		194. 01
194. 02 07952 IU HEALTH MORGAN HOSPITAL	0	0	o o	0		194. 02
194. 03 07953 I U HEALTH SI P		0		o o		194. 03
200.00 Cross Foot Adjustments		0	Ö	o		200.00
201.00 Negative Cost Centers	o	0	Ō	0		201. 00
202.00 TOTAL (sum lines 118-201)	0	0		0	55, 312	ł
·	•			•		

| Period: | Worksheet B | From 01/01/2015 | Part | To | 12/31/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150051

				To 12/31/2015 Pate/Time Pr	
Cost Center Description	Subtotal	Intern &	Total	5/27/2016 1:	33 piii
		Residents			
		Cost & Post Stepdown			
		Adjustments			
GENERAL SERVICE COST CENTERS	24. 00	25. 00	26. 00		
1.00 O0100 CAP REL COSTS-BLDG & FLXT					1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT					4.00
5. 00   00500   ADMINI STRATI VE & GENERAL 6. 00   00600   MAI NTENANCE & REPAI RS					5. 00 6. 00
7. 00 00700 OPERATION OF PLANT					7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE					8.00
9. 00   00900   HOUSEKEEPI NG 10. 00   01000   DI ETARY					9.00
11. 00 01100 CAFETERI A					11.00
12.00 01200 MAINTENANCE OF PERSONNEL					12.00
13.00 O1300 NURSING ADMINISTRATION 14.00 O1400 CENTRAL SERVICES & SUPPLY					13.00
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY					14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY					16.00
17. 00   01700   SOCI AL   SERVI CE					17. 00
18. 00   01850 OTHER GENERAL SERVICE (SPECIFY) 18. 01   01851 CENTRAL STERILIZATION					18. 00 18. 01
19. 00 01900 NONPHYSICIAN ANESTHETISTS					19.00
20. 00   02000   NURSI NG SCHOOL					20.00
21.00   02100   1&R SERVICES-SALARY & FRINGES APPRVD 22.00   02200   1&R SERVICES-OTHER PRGM COSTS APPRVD					21.00
22.00   02200   1 &R SERVICES-OTHER PRGM COSTS APPRVD 23.00   02300   PARAMED ED PRGM-PHARMACY RESIDENCY					22. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS	53, 630, 455	1			30.00
31. 00   03100   INTENSIVE CARE UNIT 32. 00   03200   CORONARY CARE UNIT	6, 813, 550 0	1 .1	6, 813, 5	0	31. 00 32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	Ö		Ö	33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0	o		0	34.00
40. 00   04000   SUBPROVI DER - I PF 41. 00   04100   SUBPROVI DER - I RF	2, 635, 485	0	2, 635, 4	0	40. 00 41. 00
42. 00   04200   SUBPROVI DER	2, 033, 483	1	2,035,4	0	42.00
43. 00   04300   NURSERY	2, 897, 980	o	2, 897, 9	980	43.00
44.00 04400 SKILLED NURSING FACILITY	0			0	44.00
45. 00   04500   NURSING FACILITY 46. 00   04600   OTHER LONG TERM CARE	0	1		0	45. 00 46. 00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATING ROOM	18, 523, 660	1	18, 523, 6		50.00
50. 01   05001   CV SURGERY 51. 00   05100   RECOVERY ROOM	0 1, 923, 407	-	1, 923, 4	0 .07	50. 01 51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	8, 438, 218	1	8, 438, 2		52.00
53. 00   05300   ANESTHESI OLOGY	0	1		0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C	7, 222, 097 6, 334, 587	1			54. 00 55. 00
56. 00   05600 RADI OI SOTOPE	0, 334, 387	1		0	56.00
57.00   05700   CT   SCAN	1, 405, 560	1	1, 405, 5		57.00
58.00   O5800   MAGNETI C RESONANCE I MAGING (MRI) 59.00   O5900   CARDI AC CATHETERI ZATI ON	825, 361	1	825, 3		58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON   60. 00   06000   LABORATORY	3, 058, 038 13, 380, 551		3, 058, 0 13, 380, 5		59. 00 60. 00
60. 01   06001   BL00D   LABORATORY	0	1		0	60. 01
60. 02 06002 PHYSI CI AN LABORATORY	0	0		0	60.02
61.00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	61. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	Ö		o o	63.00
64. 00 06400 I NTRAVENOUS THERAPY	166, 546	1	166, 5		64.00
65. 00   06500   RESPI RATORY   THERAPY   66. 00   06600   PHYSI CAL   THERAPY	2, 913, 657 13, 679, 684	1	2, 913, 6 13, 679, 6		65. 00 66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	13, 077, 004	1	13, 077, 0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	o		0	68. 00
69. 00   06900  ELECTROCARDI OLOGY 70. 00   07000  ELECTROENCEPHALOGRAPHY	1, 416, 908 1, 840, 174	1	1, 416, 9 1, 840, 1		69. 00 70. 00
71. 00  07000  ELECTROENCEPHALOGRAPHY 71. 00  07100  MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 840, 174	1	1, 840, 1		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	15, 871, 676	1	15, 871, 6		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	37, 280, 753	1	37, 280, 7		73.00
74.00   07400   RENAL DIALYSIS 75.00   07500   ASC (NON-DISTINCT PART)	1, 034, 710	1	1, 034, 7	(10) (0)	74. 00 75. 00
75. 00   07500   ASC (NON-DISTINCT FART)  75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 231, 372	-	2, 231, 3	71	75. 00
76. 97 07697 CARDIAC REHABILITATION	1, 400, 879	1			76. 97
88. 00   OBBOO RURAL HEALTH CLINIC	0	ol		0	88.00
33. 33 JOSOO NORME HEALTH OLIVEO		·i	<u>I</u>	<u> </u>	1 00.00

| Peri od: | Worksheet B | From 01/01/2015 | Part | | To | 12/31/2015 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 150051

			To		Time Prepared: 2016 1:53 pm
Cost Center Description	Subtotal	Intern &	Total	3/21/	2016 1. 33 pili
oust center beservet on	Subtotal	Resi dents	Total		
		Cost & Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26. 00		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89. 00
90. 00   09000   CLI NI C	2, 550, 534	0			90.00
91. 00 09100 EMERGENCY	11, 591, 840	0	11, 591, 840		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0			92. 00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0		94. 00
95. 00 09500 AMBULANCE SERVICES	8, 643, 084	0			95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0,010,001	Ö			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	l o	Ö	Ö		97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
99. 00 09900 CMHC	0	0	0		99.00
99. 10  09910 CORF	0	0	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0		100.00
101.00 10100 HOME HEALTH AGENCY	9, 303, 598	0	9, 303, 598		101.00
SPECIAL PURPOSE COST CENTERS					
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0			105.00
106. 00 10600 HEART ACQUISITION	0	0	-		106.00
107. 00 10700 LIVER ACQUISITION 108. 00 10800 LUNG ACQUISITION	0	0	_		107. 00 108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0		108.00
110.00 11000    NTESTINAL ACQUISITION	0	0	0		110.00
111. 00 11100   SLET ACQUISITION	0	0	0		111.00
113. 00 11300   NTEREST EXPENSE			Ü		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0		115.00
116. 00 11600 HOSPI CE	6, 909, 696	0			116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	257, 623, 857	0	257, 623, 857		118. 00
NONREI MBURSABLE COST CENTERS					
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN	268, 016	0			190.00
190. 01 19001 PROMPTCARE	2, 885, 777	0	_,,		190. 01
190. 02 19002  RENTAL PROPERTI ES 190. 03 19003  OLCOTT	155, 048 617, 390	0			190. 02 190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	520, 085	0			190.03
190. 05 19005 FOUNDATION	1, 389, 316	0	,		190.05
190. 06 19006 MARKETI NG	319, 318	Ö	319, 318		190.06
190. 07 19007 HME STORE	1, 279, 190	0	1, 279, 190		190. 07
190. 08 19008 UNUSED SPACE	662, 886	0	662, 886		190. 08
190. 09 19009 CLINICAL TRIALS	531, 640	0	531, 640		190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	491, 432	0	491, 432		190. 10
191. 00 19100 RESEARCH	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0 00 001	0	-		193.00
194. 00 07950 I U HEALTH PAOLI HOSPITAL	23, 221, 665	0	,,		194.00
194.01 07951 IU HEALTH BEDFORD HOSPITAL 194.02 07952 IU HEALTH MORGAN HOSPITAL	49, 981, 611	0			194. 01 194. 02
194. 02 07952 TO HEALTH MORGAN HOSPITAL 194. 03 07953 TU HEALTH SIP	21, 731, 524 15, 136	0	21, 731, 524 15, 136		194. 02
200.00 Cross Foot Adjustments	15, 130	0	15, 130		200. 00
201.00 Negative Cost Centers		0	_		201.00
202.00 TOTAL (sum lines 118-201)	361, 693, 891	ő			202. 00
		- 1			1

| 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 1:53 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150051

					12/31/2013	5/27/2016 1:5	3 pm
			CAPI TAL REI	LATED COSTS			
			DI DO A FILVE	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		ENDLOVEE	
	Cost Center Description	Directly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
		Assigned New				BENEFI TS	
		Capi tal				DEPARTMENT	
		Related Costs 0	1. 00	2. 00	2A	4. 00	
	GENERAL SERVICE COST CENTERS		1.00	2.00	ZN	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	40, 384	157, 134	197, 518	197, 518	4.00
5.00	00500 ADMINISTRATIVE & GENERAL	0	2, 365, 808	2, 721, 702	5, 087, 510	20, 559	5.00
6.00	00600 MAINTENANCE & REPAIRS	0	0	0	0	0	6.00
7.00	00700 OPERATION OF PLANT	0	1, 704, 509	1, 420, 010	3, 124, 519	5, 000	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	0	245, 472	166, 144	411, 616	0	8. 00
9. 00	00900 HOUSEKEEPI NG	0	58, 488	1	102, 491	2, 963	9. 00
10.00	01000 DI ETARY	0	168, 918		321, 105	2, 571	10.00
11. 00	01100 CAFETERI A	0	112, 183	1	188, 113	1, 436	11.00
12.00	01200 MAI NTENANCE OF PERSONNEL	0	0	1	0 0 7 7 7 7 7 7 7 7 9	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	164, 481		376, 773	6, 734	13.00
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	73, 366 1, 864		123, 022 1, 864	2 8, 917	14. 00 15. 00
	01600 MEDICAL RECORDS & LIBRARY	0	99, 878	1	175, 681	0, 917	16.00
17. 00	01700 SOCIAL SERVICE	0	77, 070		173,001	0	17. 00
	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	Ö	Ö	0	18.00
18. 01	01851 CENTRAL STERI LI ZATI ON	0	57, 984	39, 246	97, 230	754	18. 01
	1 t	0	0	0	0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0	0	o	0	20.00
21.00	02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0	0	o	0	21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0	0	0	22. 00
23.00	02300 PARAMED ED PRGM-PHARMACY RESIDENCY	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	0	2, 303, 442		3, 794, 461	40, 524	30.00
31. 00 32. 00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	0	191, 590 0		321, 265	5, 140 0	31.00
33. 00	03300 BURN INTENSIVE CARE UNIT	0	0		0	0	32. 00 33. 00
34. 00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0	0	34.00
40. 00	04000 SUBPROVI DER – I PF	0	0	0	Ö	0	40.00
41. 00	04100 SUBPROVI DER – I RF	0	226, 735	153, 462	380, 197	1, 594	41.00
42.00	04200 SUBPROVI DER	0	0	0	o	0	42.00
43.00	04300 NURSERY	0	110, 953	75, 097	186, 050	2, 341	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
FO 00	ANCILLARY SERVICE COST CENTERS	1 0	020 074	(22.721	1 540 705	10 107	F0 00
50. 00 50. 01	O5000   OPERATI NG ROOM   O5001   CV SURGERY	0	920, 064	622, 731 0	1, 542, 795	12, 137 0	50. 00 50. 01
51. 00	05100 RECOVERY ROOM	0	64, 603	_	108, 328	1, 813	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	645, 059		1, 081, 657	5, 556	
53.00	05300 ANESTHESI OLOGY	0	0 10, 007	0	0	0, 000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	352, 118	278, 329	630, 447	5, 918	
55.00	05500 RADI OLOGY-THERAPEUTI C	0	426, 491	288, 664	715, 155	4, 101	55.00
56.00	05600  RADI 0I SOTOPE	0	0	0	o	0	56.00
57.00	05700 CT SCAN	0	25, 151	17, 023	42, 174	1, 130	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	36, 189		60, 683	634	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	120, 778	1	202, 525	2, 031	
60.00	06000 LABORATORY	0	296, 372		521, 927	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0	_	0	0	60.01
60. 02 61. 00	06002 PHYSI CI AN LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY	0	0		O O	0	60. 02 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	0	0		o O	154	64.00
65. 00	06500 RESPIRATORY THERAPY	0	24, 611	29, 781	54, 392	3, 196	
66.00	06600 PHYSI CAL THERAPY	0	165, 786	1	600, 643	14, 088	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	1	0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	o	0	68.00
		0	45, 735	34, 110	79, 845	1, 341	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	68, 332	46, 249	114, 581	1, 874	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	O	0	71. 00
	1 1	0	0	0	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	108, 529	1	197, 128	1, 529	
	07400 RENAL DIALYSIS		14, 692	1	24, 636	0	
75. 00 75. 01	07500   ASC (NON-DI STI NCT PART)   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	_	96, 410	0 2, 807	75. 00 75. 01
	07697 CARDI AC REHABI LI TATI ON	0	_		122, 542		76. 97
. 3 ,	1	'	, 5,501	52, .50	.22, 5 12	., .01	, ,

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150051

			10	12/31/2015	5/27/2016 1:5	
		CAPLTAL REI	LATED COSTS		3/2//2010 1.3	J pili
		ONITINE KEI	LATED COSTS			
Cost Center Description	Di rectly	BLDG & FLXT	MVBLE EQUIP	Subtotal	EMPLOYEE	
oust deliter bescription	Assigned New	DEDO & TIXI	WVDEL EQUIT	Subtotal	BENEFITS	
	Capi tal				DEPARTMENT	
	Related Costs				DEFARIMENT	
	0	1. 00	2. 00	2A	4. 00	
OUTPATIENT SERVICE COST CENTERS	0	1.00	2.00	ZA	4.00	
88. 00   08800   RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
	0	0	1	0	0	89.00
	0			- 1	_	
90. 00   09000   CLI NI C	0	0	07,071	87, 691	2, 640	90.00
91. 00   09100   EMERGENCY	0	493, 667	334, 130	827, 797	7, 985	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	1 1	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	189, 297	178, 599	367, 896	8, 594	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	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	o	o	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	282, 612	- 1	492, 065		101.00
SPECIAL PURPOSE COST CENTERS		202,012	2077 100	1,72,7000	0, 102	
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105.00
106. 00 10600 HEART ACQUISITION	0	0		Ö		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	Ö	1	ő		107.00
108. 00 10800 LUNG ACQUISITION		0	0	0		107.00
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		1
	0	0	۷	U		111.00
113. 00 11300   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	0	0		115.00
116. 00 11600 HOSPI CE	0	89, 419		276, 120		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	12, 365, 644	10, 771, 208	23, 136, 852	191, 391	118.00
NONRE MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17, 582		29, 482		190. 00
190. 01 19001 PROMPTCARE	0	159, 745		340, 818		190. 01
190. 02 19002 RENTAL PROPERTIES	0	78, 940	0	78, 940	0	190. 02
190. 03 19003 OLCOTT	0	51, 272	34, 703	85, 975	504	190. 03
190. 04 19004 PHYSI CLAN RECRUI TMENT	0	0	0	0	0	190. 04
190. 05 19005 FOUNDATI ON	0	0	81, 356	81, 356	1, 166	190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0	190.06
190. 07 19007 HME STORE	0	0	80, 763	80, 763	1, 577	190. 07
190. 08 19008 UNUSED SPACE	0	148, 093		227, 682		190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	0		0		190. 09
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	Ö	1	Ö		190. 10
191. 00 19100 RESEARCH	0	i o	Ö	ő		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	Ö	ő		192.00
193. 00 19300 NONPALD WORKERS		) ^	0	0		193.00
193. 00 19300 NONPATO WORKERS 194. 00 07950 IU HEALTH PAOLI HOSPITAL			0	0		194.00
194. 00 07950 TU HEALTH PAOLI HOSPITAL 194. 01 07951 TU HEALTH BEDFORD HOSPITAL				-		1
		0	1	0		194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0		194. 02
194. 03 07953 I U HEALTH SI P	0	0	0	0		194. 03
200.00 Cross Foot Adjustments		_		0		200.00
201.00 Negative Cost Centers	_	0	0	0		201.00
202.00   TOTAL (sum lines 118-201)	0	12, 821, 276	11, 240, 592	24, 061, 868	197, 518	202.00

Provider CCN: 150051 Period:

Cost Center Peace   Pitton					1	0 12/31/2015	Date/lime Pre   5/27/2016 1:5	
		Cost Center Description						
EREBRIAL SERVICE COST CENTERS  1. 00 COOLOGO CAP REL COST SERVICE EDUTY 2. 00 COOLOGO CAP REL COST SERVICE EDUTY 3. 00 COOLOGO CAN REL COST SERVICE EDUTY 4. 00 COOLOGO CAN SEL COST SERVICE 4. 00 COOLOGO CAN SEL COST SERVICE 5. 00 COOLOGO CAN SEL COST SEL COST SERVICE 5. 00 COOLOGO CAN SEL COST SEL CO							0.00	
1.00   00000 CAP REL COSTS-BLOC & FIXT   1.00   1		GENERAL SERVICE COST CENTERS	5.00	6.00	7.00	8.00	9.00	
0.000 DOMO PRINCYCE BERKET IS DEPARTEMENT   5, 108 000   6, 000	1.00							1.00
5.00   0.0000   AMM IN STRATI VE & CEMERAL   5.708, 0.00   0.00   0.0000   0.00   0.0000   0.00   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000000	2.00							2.00
0.000   0.000   MINTERNANCE & REPAIR S   0   0   0.3, 362, 859   7   0.000   7.000								•
0.0000   0.00000   0.00000   0.00000   0.00000   0.00000000			5, 108, 069					•
0.00   0.0000   JAUNDAY & LINEN SERVICE   13, 751   0   81, 420   500, 787   70, 822   8, 00   0.0000   0.0000   DETARY   46, 415   0   74, 551   3, 092   693   10, 00   10, 00   0.0000   DETARY   46, 415   0   74, 551   3, 092   693   10, 00		1	0	1	2 242 050			•
0.000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000000				1				•
10.00   10000   11 FTANY			1	-				•
12.00   01.00   04.01   TREMINEC OF PERSONNEL   0   0   0   0   0   0   12.00   13.0				· -		_		•
13.00   0.300   MURSH NG ADMINI STRATION	11.00	01100 CAFETERI A	4, 485	0	37, 210	2, 294	340	11.00
14.00   01400  CENTRAL SERVICES & SUPPLY   202, 963   0   24, 335   0   0   15, 00   016, 00   017, 00   017, 00   017, 00   017, 00   018, 00		1	_	1	_	0	0	1
15.00   15.00   PHARMACY   10.4   R92   0   0   0   0   15.00   17.0		1	1	1		0	•	
16. 00 10400 MEDICAL RECORDS & LIBRARY		1	1	1		0		1
17.00   01700   SOCIAL SERVICE (SPECIFY)			1	1	J	0	•	ı
18.00   01850   OTHER CENERAL SERVICE (SPECIFY)   0   0   0   0   0   0   18 00   18 01   19 00   19 00   19 00   0   19 00   0   19 00   0   19 00   0   19 00   0   19 00   0   19 00   0   0   0   0   0   0   0   0   0				-		0		1
19. 00   01900   NON-HYSIC IAN AMESTHETISTS   0   0   0   0   0   0   20.00   20.00   20.00   0200   MISSIN SCRION   0   0   0   0   0   0   0   0   0			-	1		Ö		ı
20. 00			10, 761	0	19, 233	0	0	18. 01
21.00			0	0	0	0	0	1
22.00			0	0	0	0	1	1
23.00   0.2300   PARAMED ED PROIL-PHARMACY RESIDENCY   781			0	-	0	0	1	1
INPATI ENT ROUTH NE_SERVICE COST CENTERS   30.00   0.00   0.00   0.01   TATES   1.7   2.25   0.00   0.00   0.01   TATES   1.7   2.05   0.00   0.00   0.01				1	0	0	1	•
30.00   03000   ADULTS & PEDIATRICS   581,220   0   730,687   147,531   72,236   30.00   33.00   03200   INTENSIVE CARE UNIT   74,491   0   63,548   37,359   12,331   30.00   33.00   03300   CORROMARY CARE UNIT   0   0   0   0   0   0   0   33.00   33.00   33.00   03300   BURN INTENSIVE CARE UNIT   0   0   0   0   0   0   0   33.00   03300   SURGICAL INTENSIVE CARE UNIT   0   0   0   0   0   0   0   0   0	23.00		701	<u> </u>	0			23.00
32.00   03200   03200   03200   0300   032.00   032.00   033.00   033.00   03300   03400   0	30.00		581, 220	0	730, 687	147, 531	72, 236	30.00
33. 00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 33.00 0 34.00 0340 00 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00		74, 491	0	63, 548	37, 359	12, 031	31.00
34. 00   03400   SUBRON CAL INTENSIVE CARE UNIT   0   0   0   0   0   0   34. 00			0	0	0	0		•
40.00   04000   04000   0   0   0   0   0			0	0	0	0	1	•
141.00   04100   SUBPROVI DER - 1 IRF   24, 983   0   75, 205   12, 405   4, 663   41.00     42.00   04200   SUBPROVI DER   0   0   0   0   0   0   0     44.00   04400   SKILLED NURSING FACILITY   0   0   0   0   0   0   0     45.00   04500   OKSILLED NURSING FACILITY   0   0   0   0   0   0   0     46.00   04500   OKSILLED NURSING FACILITY   0   0   0   0   0   0   0     46.00   04500   OKSILLED NURSING FACILITY   0   0   0   0   0   0   0   0     46.00   OKSILLED NURSING FACILITY   0   0   0   0   0   0   0   0   0     46.00   OKSILLED NURSING FACILITY   0   0   0   0   0   0   0   0   0		1	0	0	0	0	1	•
42.00   04200   04200   0440		1	24 983	-	75 205	12 405	1	1
43.00   04300   NURSERY   32,529   0   36,802   2,534   7,055   43.00   44.00   04400   SKILLED NURSING FACILITY   0   0   0   0   0   0   0   44.00   44.00   04400   OHLOO   STEM CARE   0   0   0   0   0   0   0   44.00   44.00   04600   OHLOO   TEM CARE   0   0   0   0   0   0   0   45.00    **NOTICE TO THE ROOM   194.046   0   3.05,175   61,841   12,167   50.00   50.00   OSDOI   OFSDATI ING ROOM   194.046   0   3.05,175   61,841   12,167   50.00   50.01   OSDOI   OFSDATI ING ROOM   22,728   0   21,428   0   856   51.00   51.00   OSDOI   OFSDATI ING ROOM   22,728   0   213,959   53,080   20,160   52.00   52.00   OSDOI			1	· -	75, 203	0		1
45. 00   04500   NURSI NG FACILITY			32, 529	o	36, 802	2, 534	-	1
46. 00   04600   04600   05   0   0   0   0   0   0   0   0	44.00		0	0	0	0	0	44.00
ANCILLARY SERVICE COST CENTERS   194,046			1	1	0	0	1	1
50.00	46. 00		] 0	0	0	0	0	46.00
50.01   05001   CV SURGERY   0	50.00		194 046	0	305 175	61 841	12 167	50.00
52.00   05200   05200   05200   05200   05200   05200   0530			1	1				1
53.00   05300   AMESTHESI OLOGY   0   0   0   0   0   53.00	51.00	05100 RECOVERY ROOM	22, 728	o	21, 428	0	856	51.00
54. 00   05400   RADI OLOGY-DI AGNOSTIC   87, 201   0   136, 397   28, 360   4, 024   54, 00   55. 00   05500   RADI OLOGY-THERAPEUTIC   76, 094   0   141, 462   5, 889   707   55. 00   05500   RADI OLOGY-THERAPEUTIC   0   0   0   0   0   0   0   0   0			88, 287	0	213, 959	53, 080	20, 160	1
55.00			-	l ĭ	0	0	-	1
56.00   05600   RADIOI SOTOPE   0 0 0 0 0 0 0 56.00				0				1
57, 00   05700   CT SCAN   18, 012   0   8, 342   0   313   57, 00   58, 00   05800   MAGNETI C RESONANCE IMAGING (MRI ) 10, 334   0   12, 003   0   449   25, 80   05900   CARDIAC CATHETERI ZATI ON   33, 962   0   40, 061   15, 386   3, 222   59, 00   060, 00   06000   LABORATORY   174, 750   0   110, 535   0   95   60, 00   060, 00   0   0   0   0   0   0   0   0			76, 094	0	141, 462	5, 889 0		1
58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)   10, 334   0   12,003   0   449   58.00     59.00   05900   CARDIAC CATHETERIZATION   33,962   0   40,061   15,386   3,222   59.00     60.00   06000   LABORATORY   174,750   0   110,535   0   95   60.00     60.01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0     60.02   06002   PHYSI CIAN LABORATORY   0   0   0   0   0   0   0     60.01   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY   61.00     62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   0     63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   0   0   0     64.00   06400   INTRAVENOUS THERAPY   2,092   0   0   0   0   0     65.00   06500   RESPIRATORY THERAPY   38,766   0   14,595   0   0   0     66.00   06500   RESPIRATORY THERAPY   173,085   0   213,105   19,863   3,276     66.00   06600   PSPECH PATHOLOGY   0   0   0   0   0     68.00   06800   SPEECH PATHOLOGY   0   0   0   0   0     69.00   06900   ELECTROCARDIOLOGY   17,034   0   16,716   10,958   1,346   69,00     70.00   07000   ELECTROCARDIOLOGY   17,034   0   16,716   10,958   1,346   69,00     70.00   07000   MEDICAL SUPPLIES CHARGED TO PATIENTS   156,913   0   0   0   0   0     70.00   73.00   07300   DRUGS CHARGED TO PATIENTS   181,451   0   0   0   0   0   0     72.00   07300   DRUGS CHARGED TO PATIENTS   181,451   0   0   0   0   0   0     70.00   73.00   07300   DRUGS CHARGED TO PATIENTS   181,451   0   0   0   0   0   0     70.00   75.01			18. 012	0	8. 342	0	-	1
60. 00   06000   LABORATORY						0		
60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0				0				
60. 02   06002   PHYSI CI AN LABORATORY   0   0   0   0   0   0   60. 02   61. 00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   61. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   0   0   0   0   64. 00   06400   INTRAVENDUS THERAPY   2, 092   0   0   0   0   0   65. 00   06600   RESPI RATORY THERAPY   38, 766   0   14, 595   0   0   66. 00   06600   RESPI RATORY THERAPY   173, 085   0   213, 105   19, 863   3, 276   66. 00   66. 00   06600   SPEECH PATHOLOGY   0   0   0   0   0   67. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   69. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   17, 034   0   16, 716   10, 958   1, 346   69. 00   71. 00   07000   ELECTROENCEPHALOGRAPHY   23, 989   0   22, 665   0   0   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   156, 913   0   0   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   181, 451   0   0   0   0   74. 00   07400   RENAL DI ALYSI S   14, 120   0   4, 873   0   27   74. 00   75. 01   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   75. 01   75. 01   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   75. 01   76. 97   07697   CARDI AC REHABILI TATI ON   17, 318   0   25, 707   0   0   0   79. 00   09000   CLINI C   COST CENTERS   0   0   0   0   0   89. 00   08900   RURAL HEALTH CLINI C   0   0   0   0   0   99. 00   09000   CLINI C   0   0   0   0   0   99. 00   09000   CLINI C   0   0   0   0   99. 00   09000   CLINI C   0   0   0   0   0   99. 00   09000   CLINI C   0   0   0   0   99. 00   09000   CLINI C   0   0   0   0   99. 00   09000   CLINI C   0   0   0   99. 00   09000   CLINI C   0   0   0   0   99. 00   09000   CLINI C   0   0   0   0   99. 00   09000   CLINI C   0   0   0   99. 00   09000   CLINI C   0   0   0   0   99. 00   09000   CLINI C   0   0   0   99. 00   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000   09000			174, 750	0	110, 535	0	95	1
61. 00			0	0	0	0		1
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   62. 00   63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   0   0   0   0   64. 00   06400   INTRAVENOUS THERAPY   2,092   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   38,766   0   14,595   0   0   66. 00   06600   PHYSI CAL THERAPY   173,085   0   213,105   19,863   3,276   66. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   17,034   0   16,716   10,958   1,346   69.00   70. 00   07000   ELECTROENEPHALOGRAPHY   23,989   0   22,665   0   0   70.00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   156,913   0   0   0   0   0   72. 00   07200   IMPL DEV. CHARGED TO PATI ENTS   181,451   0   0   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   181,451   0   0   0   0   0   74. 00   07400   ERNAL DI ALYSIS   14,120   0   4,873   0   27   74.00   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   27,174   0   47,247   0   0   75.01   76. 97   07697   CARDI AC REHABI LI TATI ON   17,318   0   25,707   0   0   0   88. 00   08800   RURAL HEALTH CLINI C   0   0   0   0   99. 00   09000   CLINI C   0   0   0   0   90. 00   09000   CLINI C   0   0   0   90. 00   09000   CLINI C   0   0   0   90. 00   09000   CLINI C   0   0   90. 00   09000   CLINI C   0   0   0   90. 00   09000   CLINI C   0   0   90. 00   09000   CLINI C   0   0   0   90. 00   09000   CLINI C   0   0   90. 00   09000   CLINI C   0   0   0   90. 00   09000   CLINI C   0   0   90. 00   09000   CLINI C   0   0   0   90. 00   09000   CLINI C   0   0   90. 00   09000   CLINI C   0   0   0   90. 00   09000   CLINI C   0   0   90. 00   09000   CLINI C   0   0   0   90. 00   09000			0	0	0	0	0	
63. 00			0	0	0	0	0	•
64. 00			0	o o	0	0		
66. 00   06600   PHYSI CAL THERAPY   173, 085   0   213, 105   19, 863   3, 276   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   17, 034   0   16, 716   10, 958   1, 346   69. 00   07000   ELECTROENCEPHALOGRAPHY   23, 989   0   22, 665   0   0   070. 00   070. 00   071. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   156, 913   0   0   0   0   0   0   0   0   0		· · · · · · · · · · · · · · · · · · ·	2, 092	o	0	0		•
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   0   67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   17, 034   0   16, 716   10, 958   1, 346   69. 00   70. 00   07000   ELECTROENCEPHALOGRAPHY   23, 989   0   22, 665   0   0   70. 00   71. 00   72. 00   72. 00   72. 00   72. 00   72. 00   1MPL. DEV. CHARGED TO PATIENTS   156, 913   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   181, 451   0   0   0   0   0   72. 00   73. 00   07400   RENAL DI ALYSIS   14, 120   0   4, 873   0   27   74. 00   75. 00   75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   75. 00   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   27, 174   0   47, 247   0   0   75. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   17, 318   0   25, 707   0   0   0   0   0   0   0   0   0	65.00	06500 RESPIRATORY THERAPY	38, 766	0	14, 595	0	0	65.00
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 17, 034 0 16, 716 10, 958 1, 346 69. 00 70. 00 07000 ELECTROECEPHALOGRAPHY 23, 989 0 22, 665 0 0 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 156, 913 0 0 0 0 0 72. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 181, 451 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 343, 305 0 43, 419 0 4, 676 73. 00 74. 00 07400 RENAL DI ALYSI S 14, 120 0 4, 873 0 27 74. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 0 75. 00 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 27, 174 0 47, 247 0 0 75. 01 76. 97 07697 CARDI AC REHABI LI TATI ON 17, 318 0 25, 707 0 0 76. 97 0UTPATI ENT SERVI CE COST CENTERS  88. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 42, 974 0 0 90. 00 90. 00 09000 CLI NI C 31, 655 0 42, 974 0 0 0 90. 00				1		19, 863		1
69. 00   06900   ELECTROCARDI OLOGY   17, 034   0   16, 716   10, 958   1, 346   69. 00   70.			0	· -	0	0	•	
70. 00         07000         ELECTROENCEPHALOGRAPHY         23, 989         0         22, 665         0         0         70. 00           71. 00         07100         MEDI CAL SUPPLIES CHARGED TO PATIENTS         156, 913         0         0         0         0         71. 00           72. 00         07200         IMPL. DEV. CHARGED TO PATIENTS         181, 451         0         0         0         0         0         72. 00           73. 00         07300         DRUGS CHARGED TO PATIENTS         343, 305         0         43, 419         0         4, 676         73. 00           74. 00         07400         RENAL DI ALYSI S         14, 120         0         4, 873         0         27         74. 00           75. 00         07500         ASC (NON-DI STI NCT PART)         0         0         0         0         0         0         0         75. 00           75. 01         03550         PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES         27, 174         0         47, 247         0         0         75. 01           76. 97         OT697         CARDI AC REHABI LI TATI ON         17, 318         0         25, 707         0         0         0         0         0         0         88. 00 <td></td> <td>l</td> <td>17 024</td> <td>1</td> <td>16 716</td> <td>10.050</td> <td>-</td> <td>1</td>		l	17 024	1	16 716	10.050	-	1
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   156, 913   0   0   0   0   0   71. 00   72. 00   72. 00   07200   MPL. DEV. CHARGED TO PATIENTS   181, 451   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   343, 305   0   43, 419   0   4, 676   73. 00   74. 00   07400   RENAL DI ALYSIS   14, 120   0   4, 873   0   27   74. 00   75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   0   75. 00   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   27, 174   0   47, 247   0   0   75. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   17, 318   0   25, 707   0   0   76. 97   00TPATIENT SERVI CE COST CENTERS   88. 00   08900   RURAL HEALTH CLINI C   0   0   0   0   0   88. 00   89. 00   09000   CLINI C   31,655   0   42,974   0   0   90. 00   0   0   0   0   0   0   0   0								
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   181, 451   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   343, 305   0   43, 419   0   4, 676   73. 00   74. 00   07400   RENAL DI ALYSIS   14, 120   0   4, 873   0   27   74. 00   75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   0   0   75. 00   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   27, 174   0   47, 247   0   0   75. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   17, 318   0   25, 707   0   0   76. 97   00TPATI ENT SERVI CE COST CENTERS   88. 00   08900   RURAL HEALTH CLINI C   0   0   0   0   0   88. 00   89. 00   09000   CLINI C   31,655   0   42,974   0   0   90. 00   0   0   0   0   0   0   0   0					22,000	0	•	
74. 00 07400 RENAL DI ALYSI S 75. 00 07500 ASC (NON-DI STI NCT PART) 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 97 07697 CARDI AC REHABI LI TATI ON 77. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 78. 00 07697 CARDI AC REHABI LI TATI ON 79. 00 07697 CARDI AC REHABI LI TATI ON 70 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1	o	0	0	0	1
75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   75. 00   75. 01   03550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   27, 174   0   47, 247   0   0   75. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   17, 318   0   25, 707   0   0   76. 97	73.00	07300 DRUGS CHARGED TO PATIENTS	343, 305				4, 676	73.00
75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   27, 174   0   47, 247   0   0   75. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   17, 318   0   25, 707   0   0   76. 97				1				
76. 97   07697   CARDI AC REHABILITATION   17, 318   0   25, 707   0   0   76. 97			-	1	_	0		1
OUTPATI ENT SERVICE COST CENTERS           88.00         08800 RURAL HEALTH CLINIC         0         0         0         0         0         88.00           89.00         08900 FEDERALLY QUALIFIED HEALTH CENTER         0         0         0         0         0         0         89.00           90.00         09000 CLINIC         31,655         0         42,974         0         0         90.00						0	•	
88. 00   08800   RURAL HEALTH CLINIC   0 0 0 0 0 89.00   89.00   90.00   09000   CLINIC   31,655   0 42,974   0 0 90.00	10.71		17,318	<u> </u>	25, 707	0	1 0	10.71
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 89.00 90.00 09000 CLINIC 31,655 0 42,974 0 0 90.00	88. 00		0	O	0	0	0	88. 00
	89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1	0	0	1	1
91. UU  U91UU  EMERGENCY   129, 954  0  163, 744  79, 352  19, 059  91. 00								
	91.00	U7 I UU  EMEKGENCT	129, 954	ı U	163, /44	19, 352	19, 059	91.00

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To | 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150051

			To	12/31/2015	Date/Time Pre 5/27/2016 1:5	
Cost Center Description	ADMI NI STRATI V	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	3 pili
cost center bescription	E & GENERAL	REPAI RS	PLANT	LINEN SERVICE	HOUSEREELLING	
	5. 00	6.00	7.00	8. 00	9. 00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.00	0.00	7.00	0.00	71.00	92.00
OTHER REIMBURSABLE COST CENTERS						72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	113, 307	0	87, 524	18, 233	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	0	o	o	0	97. 00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10   09910   CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	119, 018	0	102, 644	o	0	101.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	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 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	84, 701	0	91, 494	6, 807	1, 958	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	3, 660, 162	0	3, 171, 838	504, 985	170, 645	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 322	l e		0		190. 00
190. 01 19001 PROMPTCARE	33, 344		,	1, 802		190. 01
190. 02 19002 RENTAL PROPERTIES	2, 190	0	0	0		190. 02
190. 03 19003 OLCOTT	7, 503	0	17, 006	0		190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	7, 345	l e	0	0		190. 04
190. 05 19005 FOUNDATI ON	16, 819	l e	39, 869	0		190. 05
190. 06 19006 MARKETI NG	4, 510	ł	0	0		190. 06
190. 07 19007 HME STORE	8, 269	0	39, 578	0		190. 07
190. 08 19008 UNUSED SPACE	9, 361	0	0	0		190. 08
190. 09 19009 CLI NI CAL TRI ALS	7, 418	0	0	0		190. 09
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	6, 924	0	0	0		190. 10
191. 00 19100 RESEARCH	0	0	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
193. 00 19300 NONPALD WORKERS	227 042	0	0	U		193.00
194. 00 07950 IU HEALTH PAOLI HOSPITAL 194. 01 07951 IU HEALTH BEDFORD HOSPITAL	327, 943 705, 968			0		194. 00 194. 01
	1	l e	0	U		
194.02 07952 IU HEALTH MORGAN HOSPITAL 194.03 07953 IU HEALTH SIP	306, 899 92			U		194. 02 194. 03
200.00 Cross Foot Adjustments	92	١	1	۷	0	200.00
201.00   Cross Foot Adjustments 201.00   Negative Cost Centers		_		0	_	200.00
202.00   TOTAL (sum lines 118-201)	5, 108, 069		3, 362, 859	506, 787	170, 822	
202.00   TOTAL (Suil TITIES 110-201)	3, 100, 009	ı	J 3, 302, 639	300, 767	170,022	1202.00

Provi der CCN: 150051

	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI O N	5/27/2016 1:5 CENTRAL SERVICES & SUPPLY	3 pm
		10. 00	11. 00	12.00	13.00	14.00	
1 0/	GENERAL SERVICE COST CENTERS						1. 00
1. 00 2. 00 4. 00 5. 00 6. 00	0 00200 CAP REL COSTS-MVBLE EQUIP 0 00400 EMPLOYEE BENEFITS DEPARTMENT 0 00500 ADMINISTRATIVE & GENERAL						2. 00 4. 00 5. 00 6. 00
7. 00 8. 00 9. 00	0 00700 OPERATION OF PLANT 0 00800 LAUNDRY & LINEN SERVICE 0 00900 HOUSEKEEPING	448, 458					7. 00 8. 00 9. 00 10. 00
11. ( 12. (	00 01100 CAFETERI A	0	187, 943 0	C			11. 00 12. 00
13. 0 14. 0	00 01400 CENTRAL SERVICES & SUPPLY	0	6, 533 3	C	591, 655 0	351, 161	13. 00 14. 00
15. ( 16. (	00 01600 MEDICAL RECORDS & LIBRARY	0	7, 252 0	C	o	118, 648 0	15. 00 16. 00
17. ( 18. (	00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	17. 00 18. 00
18. 0 19. 0 20. 0	00 01900 NONPHYSICIAN ANESTHETISTS	0	1, 416 0		0	910 0 0	18. 01 19. 00 20. 00
21. ( 22. (	00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	0	0		0	0	21. 00 22. 00
23. (	1 1	o o	0	C	0	0	23. 00
30.0	00 03000 ADULTS & PEDIATRICS	388, 646	50, 082	C	256, 869	11, 956	30.00
31. 0 32. 0	00 03200 CORONARY CARE UNIT	34, 889 0	6, 024 0	C		3, 254 0	31. 00 32. 00
33. 0 34. 0	00 03400 SURGICAL INTENSIVE CARE UNIT	0	0	0	0	0	33. 00 34. 00
40. 0 41. 0	00 04100 SUBPROVI DER - I RF	24, 923	1, 902		11, 873	0 322	40. 00 41. 00
42. 0 43. 0 44. 0	00 04300 NURSERY	0	2, 206		17, 053	0 1, 111 0	42. 00 43. 00 44. 00
45. 0 46. 0	00 04500 NURSING FACILITY	0	0			0	45. 00 46. 00
	ANCILLARY SERVICE COST CENTERS	<u> </u>	<u> </u>		,		10.00
50. 0 50. 0		0	13, 122 0	C		26, 977 0	50. 00 50. 01
51. 0 52. 0	1	0	1, 884 5, 835	C C		358 2, 380	51. 00 52. 00
53. 0 54. 0	00 05400 RADI OLOGY-DI AGNOSTI C	0 0	0 6, 731	C	0 8, 866	0 1, 552	53. 00 54. 00
55. 0 56. 0	00 05600 RADI 0I SOTOPE	0	3, 960 0	C	0 4, 094 0 0	2, 771 0	55. 00 56. 00
57. 0 58. 0	00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 155 636	C	o	1, 406 465	58.00
59. 0 60. 0 60. 0	00 06000 LABORATORY	0	2, 287 179 0	0	12, 223	3, 563 9, 058 0	59. 00 60. 00 60. 01
60. 0 61. 0	02 06002 PHYSICIAN LABORATORY	0	0	C	o o	0	60. 01 61. 00
62. 0 63. 0	00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	C	0	0	62. 00 63. 00
64. 0 65. 0	00 06400 I NTRAVENOUS THERAPY	0	212 3, 395	C	1, 046	101 1, 888	64. 00 65. 00
66. 0 67. 0	1 1	0	15, 267 0	C	) 11, 717 ) 0	1, 269 0	66. 00 67. 00
68. 0 69. 0	00 06900 ELECTROCARDI OLOGY	0	0 1, 437	C	0 2, 376	0 604	68. 00 69. 00
70. ( 71. (	00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	2, 144 0	C	0 0	237 61, 951	70.00 71.00
72. ( 73. (	00 07300 DRUGS CHARGED TO PATIENTS	0 0	0 1, 707	0	0 10, 666	71, 639 817	72.00 73.00
74. ( 75. (	00 07500 ASC (NON-DISTINCT PART)	0 0	0	) C	0	198 0	74. 00 75. 00
75. 0 76. 9		0	2, 595 1, 423	C		11 45	75. 01 76. 97
88. 0	00 08800 RURAL HEALTH CLINIC	0	0	C	0	0	88. 00
89. 0 90. 0	· · · · · · · · · · · · · · · · · · ·	0	0 2, 817	C		0 133	89. 00 90. 00

Provi der CCN: 150051

DIETARY   CAFETERIA   MAINTENANCE   CAFETERIA   MAINTENANCE   CAFETERIA   MAINTENANCE   CAFETERIA   CAFETERIA   MAINTENANCE   CAFETERIA   CAFETERIA   MAINTENANCE   CAFETERIA   CAFETERI				'	0 12/01/2010	5/27/2016 1:5	3 pm
10.00   09100   BMRCENCY   00.00   11.00   12.00   13.00   14.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.00   14.00   15.00   1	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG		
10.00   09100  EMERCENCY   0   10.00   11.00   12.00   13.00   14.00   19.00   10.00				OF PERSONNEL	ADMI NI STRATI O	SERVICES &	
97. 00   09100  GMERCENEY   0   10,026  0   53,201  6,218  91,00   92,00   920,00   930,00   950,00   950,00   950,00   950,00   940,00					N	SUPPLY	
92. 00   09200   09200   0958VATI ON BEDS (NON-DISTINCT PART)   94. 00   09400   HOWE PROGRAM DIALYSIS   0 0 0 0 0 0 0 95. 00   95. 00   09500   ABBULANCE SERVI CES   0 0 13, 607 0 0 5. 00   95. 00   95. 00   09500   OURABEL MEDICAL EQUIP-RENTED   0 0 0 0 0 0 0 97. 00   97. 00   97. 00   97. 00   97. 00   097. 00		10.00	11. 00	12.00	13.00	14.00	
OTHER REIMBURSABLE COST CENTERS	91. 00   09100   EMERGENCY	0	10, 026	C	53, 201	6, 218	91.00
94.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
95.00   095.00   AUBULANCE SERVICES   0   13, 607   0   59   1, 860   95.00   96.00   96.00   096.00	OTHER REIMBURSABLE COST CENTERS						
96. 00   096.00   000000	94.00 09400 HOME PROGRAM DIALYSIS	0	0	C	0	0	94.00
97. 00   097.00   097.00   098.00   098.00   098.00   099	95. 00 09500 AMBULANCE SERVICES	0	13, 607	C	59	1, 860	95.00
98. 00 09950 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0 0 0 99. 10 099. 00 10000 CMFC 0 0 0 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 0 0 0 0 0 100. 00 0 100. 00 100. 00 100. 00 10000 CMF SERVICES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0 100. 00 100.	96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	C	0	0	96.00
99. 00   09900   CMHC   0   0   0   0   0   0   0   0   0	97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	C	0	0	97.00
99.10   09910   0987   008F   0   0   0   0   0   0   0   0   0	98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	C	0	0	98.00
100.00   1	99. 00 09900 CMHC	0	0	l c	0	0	99.00
101.00   10100   HOME   HEALTH AGENCY   0   9,588   0   16,977   3,195   101.00   105.00	99. 10   09910   CORF	0	0	l c	0	0	99. 10
101.00   10100   HOME   HEALTH AGENCY   0   9,588   0   16,977   3,195   101.00   105.00	100.00 10000 I&R SERVICES-NOT APPRVD PRGM	O	0	l c	0	0	100.00
105. 00   10500   KI DNEY ACQUISITION		0	9, 588		16, 977	3, 195	101.00
106.00   10600   ILERART ACQUISITION	SPECIAL PURPOSE COST CENTERS	<u> </u>		•			
107.00   10700   LIVER ACQUISITION	105. 00 10500 KIDNEY ACQUISITION	0	0	C	0	0	105.00
107.00   10700   LIVER ACQUISITION	106. 00 10600 HEART ACQUISITION	o	0		o	0	106.00
108.00   10800   LUNG ACQUISITION		o	0		o	0	107.00
110.00   11000   NTESTI NAL ACQUI SI TION		o	0		o	0	108.00
110.00   11000   NTESTI NAL ACQUI SI TION		o	0		o		1
111.00   111		o	0		o		
113. 00   11300   INTEREST EXPENSE		o	0		o		
114. 00   11400   UTILLIZATI ON REVIEW-SNF							1
115. 00   11500   AMBULATORY SURGICAL CENTER (D. P. )							1
116. 00   11600   HOSPI CE   SUBTOTALS (SUM OF LINES 1-117)   448, 458   182, 007   0   588, 469   337, 932   118. 00   182, 007   0   588, 469   337, 932   118. 00   182, 007   0   588, 469   337, 932   118. 00   182, 007   182,		o	0		o	0	115.00
118. 00   SUBTOTALS (SUM OF LINES 1-117)   448, 458   182, 007   0   588, 469   337, 932   118. 00   NONRE IMBURSABLE COST CENTERS   0   304   0   0   0   190. 00		o	6, 582		20, 994	3, 035	116.00
NONREI MBURSABLE COST CENTERS   190 00   190000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   0   304   0   0   0   0   190 00   190		448, 458		•			1
190. 01 19001 PROMPTCARE 0 0 2, 390 0 2, 703 1, 048 190. 01 190. 02 19002 RENTAL PROPERTIES 0 0 0 0 0 0 190. 02 19002 RENTAL PROPERTIES 0 0 0 0 0 0 190. 02 190. 02 190. 03 19003 0LCOTT 0 0 534 0 10 24 190. 03 190. 04 190. 04 190. 04 190. 05 19005 FOUNDATI ON 0 0 0 0 0 0 0 190. 04 190. 06 190. 06 190. 06 190. 06 190. 06 190. 06 190. 06 190. 06 190. 06 190. 08 190. 08 190. 08 190. 08 190. 09 190.			, , , , , , , , , , , , , , , , , , , ,		,		
190. 02 19002 RENTAL PROPERTIES 0 0 0 190. 02 19003 OLCOTT 0 534 0 10 24 190. 03 190. 04 190.04 PHYSI CI AN RECRUI TMENT 0 0 0 0 0 0 190. 04 190.05 19005 FOUNDATI ON 0 917 0 0 0 190. 05 190. 06 190.06 190.06 190.06 190.06 190.06 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.07 190.08 190.08 190.09 UNUSED SPACE 0 0 0 0 0 0 0 190. 08 190.09 190.09 CLI NI CAL TRI ALS 0 350 0 430 0 190. 09 190.09 190.00 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 0 192. 00 192. 00 192.00 PHYSI CI ANS PRI VATE OFFI CES 0 0 0 0 0 0 0 193. 00 194. 00 195. 0	190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN	0	304	C	0	0	190.00
190. 03 19003 OLCOTT 0 534 0 10 24 190. 03 190. 04 19004 PHYSI CI AN RECRUITMENT 0 0 0 0 0 0 190. 04 190. 05 19005 FOUNDATI ON 0 0 917 0 0 0 0 190. 05 190. 06 19006 MARKETI NG 0 0 0 0 0 0 190. 05 190. 06 190. 06 190. 07 19007 HME STORE 0 1,096 0 23 12,002 190. 07 190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 190. 09	190. 01 19001 PROMPTCARE	o	2, 390	l	2, 703	1, 048	190. 01
190. 04 19004 PHYSI CI AN RECRUI TMENT 0 0 0 0 0 190. 04 190. 05 19005 FOUNDATI ON 0 9177 0 0 0 190. 05 190. 06 19006 MARKETI NG 0 0 0 0 0 0 190. 06 190. 06 190. 07 19007 HME STORE 0 1,096 0 23 12,002 190. 07 190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 190. 09 190.09 CLI NI CAL TRI ALS 0 350 0 430 0 190. 09 190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLI NI C 0 340 0 20 0 190. 10 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 191. 00 192. 00 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 193. 00 194. 00 194. 01 07951 IU HEALTH PAOLI HOSPI TAL 0 0 0 0 0 0 0 194. 02 194. 01 07951 IU HEALTH BEDFORD HOSPI TAL 0 0 0 0 0 0 194. 02 194. 03 07953 IU HEALTH MORGAN HOSPI TAL 0 0 0 0 0 0 155 194. 03 200. 00 Cross Foot Adjustments	190. 02 19002 RENTAL PROPERTI ES	o	0	l c	o	0	190. 02
190. 04 19004 PHYSI CI AN RECRUI TMENT 0 0 0 0 0 190. 04 190. 05 19005 FOUNDATI ON 0 9177 0 0 0 190. 05 190. 06 19006 MARKETI NG 0 0 0 0 0 0 190. 06 190. 06 190. 07 19007 HME STORE 0 1,096 0 23 12,002 190. 07 190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 190. 09 190.09 CLI NI CAL TRI ALS 0 350 0 430 0 190. 09 190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLI NI C 0 340 0 20 0 190. 10 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 191. 00 192. 00 192.00 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 0 193. 00 194. 00 194. 01 07951 IU HEALTH PAOLI HOSPI TAL 0 0 0 0 0 0 0 194. 02 194. 01 07951 IU HEALTH BEDFORD HOSPI TAL 0 0 0 0 0 0 194. 02 194. 03 07953 IU HEALTH MORGAN HOSPI TAL 0 0 0 0 0 0 155 194. 03 200. 00 Cross Foot Adjustments	190. 03 19003 OLCOTT	o	534	l c	10	24	190. 03
190. 05 19005 FOUNDATION 0 917 0 0 0 190. 05 190. 06 190. 06 19006 MARKETING 0 0 0 0 0 0 190. 06 190. 06 190. 07 19007 HME STORE 0 1,096 0 23 12,002 190. 07 190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 0 190. 08 190.09 19009 CLINICAL TRIALS 0 0 350 0 430 0 190. 09 190. 09 19009 CLINICAL TRIALS 0 0 350 0 0 430 0 190. 09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 340 0 20 0 190. 10 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 193. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 194. 00 07950 IU HEALTH PAOLI HOSPI TAL 0 0 0 0 0 0 0 194. 00 194. 01 194. 01 1979 IU HEALTH BEDFORD HOSPI TAL 0 0 0 0 0 0 0 194. 02 194. 02 07952 IU HEALTH MORGAN HOSPI TAL 0 0 0 0 0 0 195. 194. 02 194. 03 07953 IU HEALTH SIP 0 5 0 0 5 0 0 155 194. 03 200. 00 0 0 0 0 155 194. 03 200. 00		o			o	0	190. 04
190. 07 19007 HME STORE 0 1,096 0 23 12,002 190. 07 190. 08 190.08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 190. 09 19009 CLINICAL TRIALS 0 350 0 430 0 190. 09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 340 0 20 0 190. 10 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 192. 00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 192. 00 193. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 194. 00 07950 I U HEALTH PAOLI HOSPI TAL 0 0 0 0 0 0 0 194. 01 194. 02 07952 I U HEALTH MORGAN HOSPI TAL 0 0 0 0 0 0 0 194. 02 194. 03 07953 I U HEALTH MORGAN HOSPI TAL 0 0 0 0 0 0 0 194. 02 194. 03 07953 I U HEALTH MORGAN HOSPI TAL 0 0 0 0 0 0 0 194. 02 194. 03 07953 I U HEALTH MORGAN HOSPI TAL 0 0 0 0 0 0 194. 03 07953 200. 00 0 0 0 1555 194. 03 200. 00	190. 05 19005 FOUNDATI ON	O	917		o	0	190. 05
190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 190. 09 19009 CLINICAL TRIALS 0 350 0 430 0 190. 09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 340 0 20 0 190. 10 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 192. 00 193. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 194. 00 07950 I U HEALTH PAOLI HOSPI TAL 0 0 0 0 0 0 0 194. 01 194. 01 19751 I U HEALTH BEDFORD HOSPI TAL 0 0 0 0 0 0 0 194. 01 194. 01 194. 02 07952 I U HEALTH MORGAN HOSPI TAL 0 0 0 0 0 0 194. 02 194. 03 07953 I U HEALTH MORGAN HOSPI TAL 0 0 0 0 0 0 194. 02 194. 03 07953 I U HEALTH SIP 0 5 0 0 155 194. 03 200. 00 0 0 0 0 0 0 0 0 155 194. 03 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	190. 06 19006 MARKETI NG	O	0	l c	o	0	190.06
190. 08 19008 UNUSED SPACE 0 0 0 0 0 0 190. 08 190. 09 19009 CLINICAL TRIALS 0 350 0 430 0 190. 09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 340 0 20 0 190. 10 191. 00 19100 RESEARCH 0 0 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 0 192. 00 193. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 194. 00 07950 I U HEALTH PAOLI HOSPI TAL 0 0 0 0 0 0 0 194. 01 194. 01 19751 I U HEALTH BEDFORD HOSPI TAL 0 0 0 0 0 0 0 194. 01 194. 01 194. 02 07952 I U HEALTH MORGAN HOSPI TAL 0 0 0 0 0 0 194. 02 194. 03 07953 I U HEALTH MORGAN HOSPI TAL 0 0 0 0 0 0 194. 02 194. 03 07953 I U HEALTH SIP 0 5 0 0 155 194. 03 200. 00 0 0 0 0 0 0 0 0 155 194. 03 200. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		o	1, 096	l c	23	12, 002	190. 07
190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINI C 0 340 0 20 0 190. 10 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 194. 00 07950 I U HEALTH PAOLI HOSPI TAL 0 0 0 0 0 0 194. 00 194. 01		o			o		
190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINI C 0 340 0 20 0 190. 10 191. 00 19100 RESEARCH 0 0 0 0 0 0 191. 00 192. 00 192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 0 0 193. 00 194. 00 195. 00 194. 00 195.	190. 09 19009 CLI NI CAL TRI ALS	o	350		430	0	190. 09
191. 00   19100   RESEARCH	190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	o	340			0	190. 10
193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 194. 00 07950 I U HEALTH PAOLI HOSPI TAL 0 0 0 0 0 194. 00 194. 01 07951 I U HEALTH BEDFORD HOSPI TAL 0 0 0 0 0 194. 01 194. 02 07952 I U HEALTH MORGAN HOSPI TAL 0 0 0 0 0 194. 02 194. 03 07953 I U HEALTH SI P 0 5 0 0 155 194. 03 200. 00 Cross Foot Adjustments	191. 00 19100 RESEARCH	o	0		o	0	191.00
193. 00   19300   NONPAI D WORKERS		o	0		0	0	192.00
194. 00   07950   IU HEALTH PAOLI HOSPITAL   0 0 0 0 0 194. 00 194. 01   194. 02   07952   IU HEALTH BEDFORD HOSPITAL   0 0 0 0 0 194. 01   194. 02   07952   IU HEALTH MORGAN HOSPITAL   0 0 0 0 0 194. 02   194. 03   07953   IU HEALTH SIP   0 5 0 0 155   194. 03   200. 00   Cross Foot Adjustments   200. 00   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0		0	0	193.00
194. 01 07951   IU HEALTH BEDFORD HOSPITAL 0 0 0 0 0 194. 01 194. 02 07952   IU HEALTH MORGAN HOSPITAL 0 0 0 0 0 194. 02 194. 03 07953   IU HEALTH SIP 0 5 0 0 155 194. 03 200. 00   Cross Foot Adjustments 2 200. 00		0	0		o		
194. 02 07952   IU HEALTH MORGAN HOSPITAL 0 0 0 0 194. 02 194. 03 07953   IU HEALTH SIP 0 5 0 0 155 194. 03 200. 00   Cross Foot Adjustments 200. 00			0	l ä	ol		
194. 03 07953   U HEALTH SIP 0 5 0 0 155 194. 03 200. 00 Cross Foot Adjustments 200. 00		0	0	l d	o		
200.00 Cross Foot Adjustments 200.00			5	0	ol		
			· ·	]		.00	
201.00    Negative Cost Centers   0  45,935  0  0  0  01201.00	201.00 Negative Cost Centers		45, 935		ol	0	201.00
202.00 TOTAL (sum lines 118-201) 448, 458 233, 878 0 591, 655 351, 161 202.00		448, 458		•	591, 655	351, 161	202.00

Provi der CCN: 150051

Cost Center Description					10 12/31/2015	Date/lime Pre 5/27/2016 1:5	
SECOND   18.99   18.90   18.					OTHER GENE		
15.00   16.00   17.00   18.90   18.90   18.01	Cost Center Description	PHARMACY	RECORDS &		(SPECI FY)		
1.00		15. 00		17. 00	18. 00	18. 01	
2.00   DOZOGLE LAP REL COSTS - WINEL EGUIL   4.00   DOZOGLE LAP PREL COSTS - WINEL EGUIL   4.00   DOZOGLE LAP PREL COSTS - WINEL EGUIL   4.00   DOZOGLE LAP PREL COSTS - WINEL EGUIL   4.00   DOZOGLE LANDRY & LINEN SERVICE   7.00   DOZOGLE DEVERTOR   7.0							1.00
7.00   00700  DEPART 100 OF PLANT   8.00   9.00   0.00	2.00   00200   CAP REL COSTS-MVBLE EQUIP 4.00   00400   EMPLOYEE BENEFITS DEPARTMENT 5.00   00500   ADMINISTRATIVE & GENERAL						2. 00 4. 00 5. 00
10.00   1000Q   GETARY     10.00   1000Q   CAFERINA     11.00   11.0	7.00 00700 OPERATION OF PLANT						7. 00
12.00   01200   MAINTENANCE OF PERSONNEL   13.00   13.00   1300   01400   CERTRAL SERVICES & SUPPLY   14.00   15.00	10. 00 01000 DI ETARY						10.00
15.00	12.00 O1200 MAI NTENANCE OF PERSONNEL 13.00 O1300 NURSI NG ADMI NI STRATI ON						12. 00 13. 00
17.00   01700   SOCI AL SERVICE (SPECIFY)   0   0   0   0   17.00     18.00   01850   CHINER CREATED. SERVICE (SPECIFY)   0   0   0   0   130, 304     18.01   01851   CENTRAL STERLI LEZITION   0   0   0   0   0   0   19.00     19.00   1090   MONRYYSI CLAN ARESTHETISTS   0   0   0   0   0   0   0   0     19.00   1090   MONRYYSI CLAN ARESTHETISTS   0   0   0   0   0   0   0   0     19.00   1090   MONRYYSI CLAN ARESTHETISTS   0   0   0   0   0   0   0   0     19.00   1090   MONRYYSI CLAN ARESTHETISTS   0   0   0   0   0   0   0   0     19.00   1090   MONRYYSI CLAN ARESTHETISTS   0   0   0   0   0   0   0   0     22.00   2200   18.00   MONRYYSI CLAN ARESTHETISTS   0   0   0   0   0   0   0   0     23.00   2300   MONRYSI CLAN ARESTHETISTS   0   0   0   0   0   0   0   0     19.00   MONRYSI CLAN ARESTHETISTS   0   0   0   0   0   0   0   0     19.00   MONRYSI CLAN ARESTHETISTS   0   0   0   0   0   0   0   0   0     19.00   MONRYSI CLAN ARESTHETISTS   0   0   0   0   0   0   0   0   0	15. 00   01500   PHARMACY	241, 573					
18. 00   01850   OTHER GENERAL SERVICE (SPECIFY)   0   0   0   0   130,304   18. 00   19. 00   0   0   0   0   0   0   0   130,304   18. 00   19. 00   0   0   0   0   0   0   0   0   0		0	222, 157 0		0		
19. 00   01900   NON-HYSIC IAN AIRESTRETISTS   0   0   0   0   0   0   0   0   0	18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0		0 (	130 304	
21.00   02100   RR SERVICES-SALARY & FRINCES APPRIVD   0   0   0   0   0   22.00   02200   RR SERVICES-SOHIER PREMIC COSTS APPRIVD   0   0   0   0   0   0   0   22.00   02200   RR SERVICES-SOHIER PREMIC COSTS APPRIVD   0   0   0   0   0   0   0   0   0	19.00 01900 NONPHYSICIAN ANESTHETISTS	0	0		0 (	0	19. 00
23. 00   02300   PARAMED ED PROMPHARMACY RESIDENCY   0   0   0   0   23. 00	21.00 02100 I&R SERVICES-SALARY & FRINGES APPRVD	1 -1	0		o o	0	21.00
30.00   03000  ADULTS & PEDIATRICS   0   19,403   0   0   1,722   30.00   31.00   331.00	23. 00 02300 PARAMED ED PRGM-PHARMACY RESIDENCY	1	-			•	
32.00   03200   CORONARY CARE UNIT   0 0 0 0 0 0 32.00		0	19, 403		0 (	1, 722	30.00
34.00   0.340.0   SURGI CAL INTENSIVE CARE UNIT   0   0   0   0   0   34.00	+ I	-1				1	
40.00   0.000   0.000   0.00		0	0	•	-		
42.00   04200   04200   SUBPROVIDER	40. 00   04000   SUBPROVI DER - I PF	0	0		-	0	40. 00
44. 00 04400 SKILLED NURSING FACILITY 0 0 0 0 0 0 0 44. 00 45. 00 04500 NURSING FACILITY 0 0 0 0 0 0 0 0 45. 00 46. 00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 0 0 46. 00 ANCILLARY SERVICE COST CENTERS  50. 00 10 05000 OPERATING ROOM 0 33, 775 0 0 126, 070 50. 01 05001 OV SURGERY 0 0 0 0 0 0 0 50. 01 51. 00 05100 RECOVERY ROOM 0 4, 431 0 0 0 0 51. 00 52. 00 05200 DELIVERY ROOM & LABOR ROOM 0 4, 431 0 0 0 0 55. 00 53. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 55. 00 54. 00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 133 54. 00 55. 00 05500 ROOLOGY-THERAPEUTI C 0 0 8, 160 0 0 113 54. 00 55. 00 05500 RADIOLOGY-THERAPEUTI C 0 0 12, 301 0 0 0 0 55. 00 55. 00 05500 RADIOLOGY-THERAPEUTI C 0 0 12, 301 0 0 0 0 55. 00 55. 00 05500 RADIOLOGY-THERAPEUTI C 0 0 12, 301 0 0 0 55. 00 55. 00 05500 RADIOLOGY-THERAPEUTI C 0 1, 428 0 0 0 55. 00 55. 00 05500 RADIOLOGY-THERAPEUTI C 0 1, 428 0 0 0 55. 00 55. 00 05500 CASCOLOGO LABORATIONY 0 1, 428 0 0 0 55. 00 60.00 05000 LABORATIONY 0 1, 428 0 0 0 55. 00 60.00 05000 LABORATIONY 0 23, 618 0 0 496 59. 00 60.01 06001 BLOOD LABORATIONY 0 0 23, 618 0 0 0 0 0 60. 01 60.02 06002 PHYSI CIA NI LABORATIONY 0 0 0 0 0 0 0 60. 01 60.02 06002 PHYSI CIA NI LABORATIONY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	42. 00   04200   SUBPROVI DER	0	0		0 (	0	42.00
44. 00   04600   OTHER LONG TERM CARE   0   0   0   0   0   0   0   0   0	44.00 04400 SKILLED NURSING FACILITY	-	0		-	0	44.00
50.00	46. 00 04600 OTHER LONG TERM CARE	-	-		~		
50.01   05001   CV SURGERY   0   0   0   0   0   0   50.01			33 775		0 (	126 070	50 00
52.00   05200   DELIVERY ROOM & LABOR ROOM   0   5,920   0   0   59   52.00	50. 01   05001 CV SURGERY		0			0	50. 01
53.00   05300   ANESTHESIOLOGY		0			0 (		
55.00   05500   RADI OLOGY_THERAPEUTI C   0   12, 301   0   0   0   55.00		0	5, 920		0 0	1	
56.00   05600   RADI OI SOTOPE   0   0   0   0   0   0   56.00		-1			~		
57. 00   05700   CT SCAN   0   5,995   0   0   0   57. 00		0			٩	1	
59. 00 05900 CARDIAC CATHETERIZATION 0 11,858 0 0 496 59. 00 60. 00 06000 LABORATORY 0 0 23,618 0 0 0 60. 00 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0 0 60. 00 60. 01 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0 0 60. 01 60. 02 61. 00 60. 02 61. 00 60. 02 61. 00 60. 02 61. 00 6100 69B CLI NI CAL LAB SERVI CES-PRGM ONLY 61. 00 62. 00 0 0 0 0 0 0 0 0 0 0 0 62. 00 61. 00 62. 00 0 0 0 0 0 0 0 0 0 0 0 0 63. 00 63. 00 63.00 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 0 0 64. 00 64. 00 64. 00 64. 00 64. 00 65. 00 6500 RESPI RATORY THERAPY 0 0 145 0 0 0 0 64. 00 65. 00 6500 RESPI RATORY THERAPY 0 0 1,949 0 0 361 65. 00 66. 00 6600 PHYSI CAL THERAPY 0 0 5,366 0 0 0 0 0 66. 00 66. 00 66. 00 6600 PHYSI CAL THERAPY 0 0 5,366 0 0 0 0 0 67. 00 68. 00 69. 00 6900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 68. 00 69. 00 6900 ELECTROCARDI OLOGY 0 0 4,046 0 0 0 0 0 69. 00 69. 00 67. 00 07000 ELECTROENEPHALOGRAPHY 0 3,146 0 0 0 0 0 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 7,958 0 0 0 71. 00 72. 00 730. 00 DRUGS CHARGED TO PATIENTS 0 17, 220 0 0 0 0 0 0 0 0 0 0 0 72. 00 73. 00 07400 RENAL DI ALYSI S 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		l o	- 1		0	1	
60. 00 06000 LABORATORY 0 0 23, 618 0 0 0 60. 00 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0			0 0		
60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					0 0	1	
61. 00	i i	o	0		0 (	1	
62. 00		0	0	'	0	0	
64. 00		o	0		o	0	
65. 00		0	0		0 (	1	
66. 00 06600 PHYSI CAL THERAPY 0 5,366 0 0 0 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 4,046 0 0 0 0 0 68. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 3,146 0 0 0 428 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 7,958 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 17, 220 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 241,573 25,373 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 612 0 0 0 74. 00 75. 01 07		0			0 0		
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 4, 046 0 0 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 3, 146 0 0 0 428 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 7, 958 0 0 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 17, 220 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 241, 573 25, 373 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 612 0 0 0 74. 00 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 499 0 0 0 75. 01 76. 97 OUTPATIENT SERVI CE COST CENTERS					0	1	
69. 00 06900 ELECTROCARDI OLOGY 0 4, 046 0 0 0 0 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 3, 146 0 0 428 70. 00 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS 0 7, 958 0 0 0 71. 00 72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 17, 220 0 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 241, 573 25, 373 0 0 0 0 73. 00 74. 00 07400 RENAL DI ALYSI S 0 612 0 0 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 75. 00 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 499 0 0 0 76. 97 0UTPATIENT SERVI CE COST CENTERS		O	0		0 (	1	
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   3, 146   0   0   428   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   7, 958   0   0   0   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   17, 220   0   0   0   0   72. 00   07300   DRUGS CHARGED TO PATIENTS   241, 573   25, 373   0   0   0   0   0   73. 00   074. 00   074.00   RENAL DI ALYSIS   0   612   0   0   0   0   0   0   0   0   0		0	0 4 046		0 0	•	
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   17, 220   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   241, 573   25, 373   0   0   0   0   73. 00   74. 00   07400   RENAL DI ALYSIS   0   612   0   0   0   0   0   74. 00   075. 00   075. 00   075. 00   075. 01   075. 01   075. 01   075. 01   075. 01   076. 07   076. 0							
73. 00   07300   DRUGS CHARGED TO PATI ENTS   241, 573   25, 373   0   0   0   73. 00   74. 00   74. 00   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   0   0   0		O			0 (		
74. 00   07400   RENAL DI ALYSI S   0   612   0   0   0   74. 00   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   0   0   0		241 573			0 (	•	
75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   0   0   75. 00   75. 01   03550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0   499   0   0   0   0   76. 97   07697   CARDI AC REHABI LI TATI ON   0   539   0   0   0   0UTPATI ENT   SERVI CE   COST   CENTERS		241, 3/3			o o		
76. 97   07697   CARDI AC REHABILITATION   0   539   0   0   0   76. 97   0   0   0   0   0   0   0   0   0	75.00 07500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
OUTPATIENT SERVICE COST CENTERS	l	1			O (	l l	
88. 00  08800  RURAL HEALTH CLINIC   0  0  0 0 88. 00	OUTPATIENT SERVICE COST CENTERS	<u> </u>	337	'			, 5. 7,
	88. 00  08800 RURAL HEALTH CLINIC	0	0		0  (	0	88.00

ALLOCATION OF CAPITAL RELATED COSTS

Provi der CCN: 150051

Peri od: Worksheet B From 01/01/2015 Part II To 12/31/2015 Date/Time Prepared:

5/27/2016 1:53 pm OTHER GENERAL SERVICE SOCI AL Cost Center Description **PHARMACY** MEDI CAL (SPECI FY) CENTRAL STERI LI ZATI ON RECORDS & SERVI CE LI BRARY 15. 00 16.00 17.00 18.00 18.01 89. 00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 90.00 09000 CLI NI C 0 238 0 0 90.00 0 0 09100 EMERGENCY 0 15, 536 0 293 91 00 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 0 94.00 94.00 0 0 0 09500 AMBULANCE SERVICES 6, 965 0 95.00 95.00 0 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 00000 0 0 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 09850 OTHER REIMBURSABLE COST CENTERS 0 98.00 98 00 0 Ω 0 99.00 09900 CMHC 0 0 99.00 99. 10 09910 CORF 0 o 0 99. 10 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 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 KI DNEY ACQUI SI TI ON 0 0 0 0 105.00 0 0 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106.00 107.00 10700 LIVER ACQUISITION 0 0 107.00 108. 00 10800 LUNG ACQUISITION 0 0 0 108.00 0 0 109.00 10900 PANCREAS ACQUISITION 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 110.00 0 0 111.00 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 C 0 0 116. 00 11600 HOSPI CE 0 0 0 116.00 SUBTOTALS (SUM OF LINES 1-117) 129, 988 118.00 118.00 241, 573 222, 157 0 ol NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 01 19001 PROMPTCARE 0 0 0 0 0 190. 01 190. 02 19002 RENTAL PROPERTIES 0 190.02 000000000000000 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 190. 03 19003 OLCOTT 0 190. 03 0 190. 04 19004 PHYSI CI AN RECRUI TMENT 0 0 190, 04 190. 05 19005 FOUNDATI ON 0 0 190.05 0 190. 06 19006 MARKETI NG 0 0 190.06 190. 07 19007 HME STORE 0 0 190.07 0 190. 08 19008 UNUSED SPACE 0 190.08 190. 09 19009 CLINICAL TRIALS 0 0 0 190.09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 0 190. 10 0 191. 00 19100 RESEARCH 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 193.00 0 194.00 07950 IU HEALTH PAOLI HOSPITAL 0 194, 00 0 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 0 0 0 194. 01 194. 02 07952 IU HEALTH MORGAN HOSPITAL 0 0 0 194. 02 316 194.03 194. 03 07953 IU HEALTH SIP 0 0 C Cross Foot Adjustments 200.00 200.00 201.00 Negative Cost Centers 0 201.00 0 130, 304 202. 00 202.00 TOTAL (sum lines 118-201) 241, 573 222, 157

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150051

COST CORTOR DESCRIPTION  AND PRINCES AS EST DOILTS  10 GROUND CARRY SERVICE DOST CRITICES  10 GROUND CARRY SERVICE SERVICES  10 GROUND CARRY SERVICE SERVICES  11 GROUND CARRY SERVICE SERVICES  12 GROUND CARRY SERVICES  12 GROUND CARRY SERVICES  13 GROUND CARRY SERVICES  14 GROUND CARRY SERVICES  15 GROUND CARRY SERVICES  16 GROUND CARRY SERVICES  17 GROUND CARRY SERVICES  18 GROUND CARRY SERVICES  18 GROUND CARRY SERVICES  19 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  11 GROUND CARRY SERVICES  11 GROUND CARRY SERVICES  12 GROUND CARRY SERVICES  13 GROUND CARRY SERVICES  14 GROUND CARRY SERVICES  15 GROUND CARRY SERVICES  16 GROUND CARRY SERVICES  17 GROUND CARRY SERVICES  17 GROUND CARRY SERVICES  18 GROUND CARRY SERVICES  18 GROUND CARRY SERVICES  18 GROUND CARRY SERVICES  19 GROUND CARRY SERVICES  19 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  10 GROUND CARRY SERVICES  11 GROUND CARRY SERVICES  11 GROUND CARRY SERVICES  11 GROUND CARRY SERVICES  11 GROUND CARRY SERVICES  11 GROUND CARRY SERVICES  11 GROUND CARRY SERVICES  11 GROUND CARRY SERVICES  12 GROUND CARRY SERVICES  13 GROUND CARRY SERVICES  14 GROUND CARRY SERVICES  15 GROUND CARRY SERVICES  16 GROUND CARRY SERVICES  17 GROUND CARRY SERVICES  17 GROUND CARRY SERVICES  17 GROUND CARRY SERVICES  18 GROUND CARRY SERVICES  18 GROUND CARRY SERVICES  18 GROUND CARRY SERVICES  18 GROUND CARRY SERV					'	0 12/31/2015	5/27/2016 1:5	
REPRIENT SERVICE COST CENTERS   19.00   20.00   21.00   22.00   23.0					INTERNS &	RESI DENTS		
REPAIRAL SERVICE COST CENTERS   19.00   20.00   21.00   22.00   23.0		Cost Center Description	NONPHYSI CI AN	NURSLNG	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
FINE PAIR   SERVICE COST CENTERS   19.00   20.00   21.00   22.00   23.00		Cost Genter Bescription						
ERHEMAL SERVICE OST CENTERS 1 00 00000 OP REL COSTS-ALGO & FIXT 0 2.0 00 00000 ANIM STRATURE & CEREBAL 2.0 00 00000 ANIM STRATURE & CEREBAL 3.0 00 00000 ANIM STRATURE & CEREBAL 3.0 00 00000 ANIM STRATURE & CEREBAL 3.0 00 00000 OP STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE STRATURE 3.0 00 00000 OP STRATURE STRATURE STRATURE 3.0 00 00000 OP STRATURE STR								
1.00   1.00		OFNEDAL CERVILOR COCT OFNITERS	19. 00	20. 00	21.00	22. 00	23. 00	
2.00	1 00				<u> </u>			1 00
0.0400   DIMEDIONE BENEFITS DEPARTWORT		1 1						1
0.00   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0		1 1						1
0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000   0.00000   0.000000   0.00000000		1 1						5. 00
B. DO   OBROD   LAMBRY & LINEN STRVICE   B. DO   O   ODROD   DETARY   B. DO   O   ODROD   DETARY   B. DO   DETARY   B. DO   ODROD   DETARY   B. DO   DET								1
0.00   0.0000   0.00000   0.00000   0.00000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.0000   0.0000   0.0000   0.0000   0.0000   0.0000   0.00000   0.00000   0.00000   0.00000   0.00000   0.000000   0.00000000		1 1						1
11.00   01100   CAFETERIA     11.00		l l						1
12.00   10200   MAI NETHANCE OF PERSONNEL   12.00   14.00	10.00	01000 DI ETARY						10.00
13.00		l l						1
14. 00   01400 (ENTRAL, SERVICES & SUPPLY   15. 00   15.00   15.00   01600 MEDICAL, RECORDS & LIBRARY   16. 00   17. 00   17.00   17		l l						1
15. 00   10500   PHARBARCY   10. 00		1						1
17.00   17700   SOCIAL SERVICE     17.00   18.00   1		1						•
18. 00   01850  CHER CEMPERAL SERVICE (SPECIFY)   18. 01   19. 0								1
18. DI   01851   CENTRAL STERL LI ZATION     18. DI   19. OU   1								1
19. 00   01900   NON-HYSIC CAM ARESTHETISTS   0   0   20. 00   2		· · · · · · · · · · · · · · · · · · ·						1
21.00   02100   RR SERVICES-SALARY & FRINGES APPRVD   0   22.00   220   02300   PARSENT   CSS-OTHER PREGU COSTS APPRVD   0   781   73.00   180   781		l l	0					1
22.00   02200   RAR SERVICES-OTHER PROM COSTS APPRIVE   781   23.00   1   1   1   1   1   1   1   1   1		1 1		C				•
23. 00		1 1			0	0		1
INPATIENT ROUTINE SERVICE COST CENTERS   30.00   31.						0	781	•
33.00	20.00						, , ,	20.00
32.00   03200   CORONARY CARE UNIT   33.00   33.00   03300   03400		1 1						1
33.00   03300   BURN INTERSIVE CARE UNIT   34.00   40.00   04000   SURGICAL INTERSIVE CARE UNIT   40.00   41.00   04100   SURGICAL INTERSIVE CARE UNIT   41.00   41.00   04100   SUBRROVI DER - I PF   41.00   42.00   04200   04200   SUBRROVI DER - I RF   45.00   43.00   04300   NURSENT   43.00   43.00   04300   NURSENT   45.00   44.00   04400   SKILLED NURSING FACILITY   45.00   46.00   04400   SKILLED NURSING FACILITY   45.00   46.00   04600   OHER LONG TERM CARE   45.00   46.00   04600   OHER LONG TERM CARE   46.00   46.00   04600   OHER LONG TERM CARE   46.00   46.00   04600   OHER LONG TERM CARE   46.00   46.00   05000   OPERATING ROOM   55.00   05000   OPERATING ROOM   55.00   05000   DELIVERY ROOM & LABOR ROOM   55.00   05000   DELIVERY ROOM & LABOR ROOM   55.00   05000   DELIVERY ROOM & LABOR ROOM   55.00   05000   OPERATING ROOM   55.00   05000   ORDIOLOGY-THERAPEUTIC   56.00   05000   RADIOLOGY-THERAPEUTIC   56.00   05000   RADIOLOGY-THERAPEUT		1 1						1
34. 00   03400   SURGICAL INTENSIVE CARE UNIT		1 1						1
41.00		1 1						1
42.00   04200   SUBPROVI DER   42.00     43.00   04300   NURSERY   44.00     44.00   04400   SKILLED NURSING FACILITY   44.00     45.00   04500   NURSING FACILITY   44.00     46.00   04600   OHER LONG TERM CARE   46.00     AND   OHER LONG TERM CARE   50.00     S0.01   OSCOLO DELI VERY ROOM   50.01     S0.00   OSCOLO DELI VERY ROOM & LABOR ROOM   51.00     S0.00   OSCOLO DELI VERY ROOM & LABOR ROOM   52.00     S0.00   OSCOLO DELI VERY ROOM & LABOR ROOM   52.00     S0.00   OSCOLO RADIOLOGY-THERAPEUTIC   54.00     S0.00   OSCOLO RADIOLOGY-THERAPEUTIC   54.00     S0.00   OSCOLO RADIOLOGY-THERAPEUTIC   55.00     S0.00   OSCOLO RADIOLOGY-THERAPEUTIC   55.00     S0.00   OSCOLO RADIOLOGY-THERAPEUTIC   56.00     S0.00   OSCOLO RADIOLOGY   56.00     S0.00   OSCOLO RADI		1 1						1
43. 00   04300 NURSERY   43. 00   44. 00   04400 SKILLED NURSING FACILITY   45. 00   45. 00   04500 NURSING FACILITY   45. 00   46. 00   04500 NURSING FACILITY   45. 00   46. 00   04600 OTHER LONG TERM CARE   46. 00   08000 OTHER LONG TERM CARE   46. 00   08500 OTHER LONG TERM CARE   46. 00   08500 OTHER LONG TERM CARE   46. 00   08500 OTHER   46. 00   08500 OTHER CARE   46. 00   08500 OTHER CARE   46. 00   08500 OTHER   46. 00   08500 OTHER   46. 00   08500 OTHER   4		i i						1
44. 00 44.00   04400   SKILLED NURSING FACILITY   45. 00 45. 00   0450		1 1						1
46. 00   04600   OTHER LONG TERM CARE     46. 00   ANCILLARY SERVICE COST CENTERS		1 1						1
ANCI LLARY SERVICE COST CENTERS   50.00		1						1
50. 00   050	46. 00							46.00
51.00   05100   RECOVERY ROOM	50.00							50.00
52.00   05200   DELIVERY ROOM & LABOR ROOM   52.00   05300   ARESTHESI OLOGY   53.00   54.00   05400   RADIO LOGY-DIAGNOSTI C   54.00   55.00   05500   RADIO LOGY-THERAPEUTI C   55.00   05500   RADIO LOGY-THERAPEUTI C   55.00   05500   RADIO LOGY-THERAPEUTI C   55.00   05700   CT SCAN   57.00   57.00   05700   CT SCAN   57.00   05700   CT SCAN   58.00   05800   RADIO LAGORATORY   58.00   05800   RADIO LABORATORY   59.00   05900   CARDIAC CATHETERI ZATI ON   59.00   05900   CARDIAC CATHETERI ZATI ON   59.00   06000   LABORATORY   60.01   06001   BLODD LABORATORY   60.01   06002   PHYSI CI AN LABORATORY   60.02   06002   PHYSI CI AN LABORATORY   60.02   06002   PHYSI CI AN LABORATORY   61.00   06000   06000   LABORATORY   61.00   06000   06000   DROBE BLOOD & PACKED RED BLOOD CELLS   62.00   06300   BLOOD STORING, PROCESSING & TRANS.   63.00   06300   BLOOD STORING, PROCESSING & TRANS.   63.00   06300   BLOOD STORING, PROCESSING & TRANS.   64.00   06400   PHYSI CAL THERAPY   66.00   06500   RESPIRATORY THERAPY   66.00   06500   RESPIRATORY THERAPY   66.00   06500   RESPIRATORY THERAPY   66.00   06500   RESPIRATORY THERAPY   67.00   06700   0CUPATI ONAL THERAPY   67.00   069.00   06900   ELECTROCARDIOLOGY   68.00   06900   DELECTROCARDIOLOGY   69.00   07100   ELECTROCARDIOLOGY   69.00   07100   ELECTROCARDIOLOGY   69.00   07100   ELECTROCARDIOLOGY   77.00   07100   DELECTROCARDIOLOGY   77.00   07100   ELECTROCARDIOLOGY   77.00   07100   RESPIRATORY THERTS   77.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   77.00   07.00	50. 01	l l						50. 01
53.00   05300   ANESTHESI OLOGY   53.00   54.00   54.00   65400   ABIO OLOGY-DIA GNOSTI C   55.00   55.00   65500   RADI OLOGY-THERAPEUTI C   55.00   65.00   05600   RADI OLOGY-THERAPEUTI C   57.00   65.00   05800   MAGNETI C RESONANCE   IMAGI NG (MRI )   58.00   05900   CARDI AC CATHETERI ZATI ON   59.00   05900   CARDI AC CATHETERI ZATI ON   60.00   06.0		l l						1
54. 00		l l						•
55. 00       05500   RADI OL GGY-THERAPEUTI C       55. 00         56. 00       05600   RADI OL SOTOPE       56. 00         57. 00       05700   CT SCAN       57. 00         59. 00       05900   CARDI AC CATHETER I ZATI ON       58. 00         60. 00       06000   LABORATORY       60. 00         60. 01       06001   BLOOD LABORATORY       60. 01         60. 02       06002   PHYSI CI AN LABORATORY       61. 02         61. 00       06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY       61. 02         62. 00       06200   WHOLE BLOOD & PACKED RED BLOOD CELLS       62. 00         63. 00       06300   BLOOD STORI NG, PROCESSI NG & TRANS.       63. 00         64. 00       06400   INTRAVENOUS THERAPY       64. 00         65. 00       06500   RESPI RATORY THERAPY       65. 00         66. 00       06600   PHYSI CAL THERAPY       66. 00         67. 00       06700   OCCUPATI ONAL THERAPY       67. 00         68. 00       06800   SPEECH PATHOLOGY       68. 00         69. 00       6900   LECTROCARDI OLOGY       69. 00         71. 00       07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS       71. 00         72. 00       07200   IMPL. DEV. CHARGED TO PATI ENTS       72. 00         74. 00       07400   RENAL DI AL		l l						•
57. 00  58. 00  58. 00  58. 00  58. 00  58. 00  58. 00  58. 00  58. 00  58. 00  58. 00  58. 00  58. 00  58. 00  58. 00  58. 00  60. 00  60. 00  60. 00  60. 00  60. 00  60. 00  60. 01  60. 01  60. 01  60. 02  60. 01  60. 02  61. 00  62. 00  62. 00  63. 00  64. 00  64. 00  64. 00  64. 00  65. 00  66. 00  67. 00  68. 00  69. 00  69. 00  69. 00  70. 00								1
58. 00       05800   MAGNETI C RESONANCE I MAGI NG (MRI )       58. 00         59. 00       05900   CARDI AC CATHETERI ZATI ON       59. 00         60. 00       06000   LABORATORY       60. 00         60. 01       06001   BLOOD LABORATORY       60. 01         61. 00       06002   PHYSI CI AN LABORATORY       60. 02         61. 00       06100   PBP CI IN I CAL LAB SERVICES-PRGM ONLY       61. 00         62. 00       06200   WHOLE BLOOD & PACKED RED BLOOD CELLS       62. 00         63. 00       06300   BLOOD STORI NG, PROCESSI NG & TRANS.       63. 00         64. 00       06400   INTRAVENOUS THERAPY       64. 00         65. 00       06500   RESPI RATORY THERAPY       65. 00         66. 00       06600   PHYSI CAL THERAPY       66. 00         67. 00       06600   PHYSI CAL THERAPY       67. 00         68. 00       06800   SPEECH PATHOLOGY       67. 00         69. 00       06900   ELECTROCARDI OLOGY       69. 00         70. 00       07000   ELECTROCARDI OLOGY       69. 00         71. 00       07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS       71. 00         72. 00       07200   IMPL. DEV. CHARGED TO PATI ENTS       72. 00         73. 00       07300 DRUGS CHARGED TO PATI ENTS       73. 00         75. 01		1 1						•
59. 00       05900 CARDI AC CATHETERI ZATI ON       59. 00         60. 00       06000 LABORATORY       60. 00         60. 01       06001 BLOOD LABORATORY       60. 01         60. 02       06002 PHYSI CI AN LABORATORY       60. 02         61. 00       06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY       61. 00         62. 00       06200 WHOLE BLOOD & PACKED RED BLOOD CELLS       62. 00         63. 00       06300 BLOOD STORI NG, PROCESSI NG & TRANS.       63. 00         64. 00       06400 INTRAVENOUS THERAPY       64. 00         65. 00       06500 RESPI RATORY THERAPY       65. 00         66. 00       06600 PHYSI CAL THERAPY       67. 00         67. 00       06700 OCCUPATI ONAL THERAPY       67. 00         68. 00       06800 SPEECH PATHOLOGY       68. 00         69. 00       06900 ELECTROCARDI OLOGY       68. 00         69. 00       06900 ELECTROENCEPHALOGRAPHY       70. 00         71. 00       07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS       72. 00         73. 00       07300 DRUGS CHARGED TO PATI ENTS       73. 00         74. 00       07400 RENAL DI ALYSI S       74. 00         75. 01       03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES       75. 01         76. 97       7697 CARDI AC REHABI LI TATI								1
60. 00		1 1						•
60. 02 06002 PHYSI CI AN 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. 63. 00 64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 69. 00 07000 ELECTROCARDI OLOGY 69. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 70. 00 71. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 72. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 75. 00 07500 ASC (NON-DISTI NCT PART) 75. 00 75. 01 07507 CARDI AC REHABI LI TATI ON 0UTPATI ENT SERVI CE COST CENTERS		1 1						1
61. 00		1 1						1
62. 00		1 1						1
63. 00 06300 BL00D STORING, PROCESSING & TRANS. 64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPIRATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY 66. 00 06700 0CCUPATI ONAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY 69. 00 07000 ELECTROENCEPHALOGRAPHY 71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENTS 73. 00 07300 DRUGS CHARGED TO PATI ENTS 74. 00 07400 RENAL DI ALYSIS 75. 00 07500 ASC (NON-DI STINCT PART) 76. 97 0UTPATI ENT SERVI CE COST CENTERS		1 1						1
65. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00 67. 00 67. 00 68. 00 68. 00 68. 00 69								1
66. 00 67. 00 660 PHYSI CAL THERAPY 67. 00 67. 00 67. 00 68. 00 68. 00 68. 00 68. 00 69. 00 69. 00 69. 00 70. 00 70. 00 71. 00 71. 00 71. 00 72. 00 73. 00 73. 00 74. 00 74. 00 75. 00 75. 00 75. 00 75. 00 75. 01 75. 01 75. 01 75. 01 76. 97 0017PATIENT SERVICE COST CENTERS		1 1						1
67. 00								1
68. 00 69. 00 69. 00 69. 00 70. 00 70. 00 71. 00 71. 00 71. 00 72. 00 73. 00 73. 00 74. 00 75. 01 75. 01 75. 01 76. 97 00179ATIENT SERVICE COST CENTERS		i i						1
70. 00   07000   ELECTROENCEPHALOGRAPHY   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   73. 00   07400   RENAL DI ALYSIS   74. 00   07500   ASC (NON-DISTINCT PART)   74. 00   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   75. 01   076. 97   00TPATIENT SERVI CE COST CENTERS		l l						1
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   73. 00   07400   RENAL DI ALYSIS   74. 00   07500   ASC (NON-DI STINCT PART)   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   75. 01   07697   CARDI AC REHABI LI TATI ON   00TPATIENT SERVI CE COST CENTERS		l l						1
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   72. 00   73. 00   07300   DRUGS CHARGED TO PATIENTS   73. 00   74. 00   07400   RENAL DI ALYSIS   74. 00   07500   ASC (NON-DI STINCT PART)   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   75. 01   07697   CARDI AC REHABILI TATI ON   0UTPATIENT SERVI CE COST CENTERS   76. 97		l l						•
73. 00   07300   DRUGS CHARGED TO PATI ENTS   73. 00   74. 00   74. 00   75. 00   75. 00   75. 00   75. 01   75. 01   76. 97   007697   CARDI AC REHABI LI TATI ON   007697   CARDI AC REHABI LI TATI ON   007697   0007								1
75. 00   07500   ASC (NON-DISTINCT PART)   75. 00   75. 01   03550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   75. 01   76. 97   00TPATIENT SERVI CE COST CENTERS   76. 97   00TPATIENT SERVI CE COST CENTERS		l l			1			1
75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   75. 01   76. 97   001   00								1
76. 97 O7697 CARDI AC REHABI LI TATI ON TOUTPATI ENT SERVI CE COST CENTERS 76. 97								1
OUTPATIENT SERVICE COST CENTERS		l l						1
88. 00  08800 RURAL HEALTH CLINIC   88. 00	**	OUTPATIENT SERVICE COST CENTERS						
	88. 00	08800 RURAL HEALTH CLINIC			<u> </u>			88. 00

| 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 1:53 pm Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150051

						5/27/2016 1:5	3 pm
				INTERNS &	RESI DENTS		
Cost	t Center Description	NONPHYSI CI AN	NURSI NG	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
		ANESTHETI STS	SCH00L	RY & FRINGES	R PRGM COSTS	PRGM-PHARMACY	
						RESI DENCY	
		19. 00	20. 00	21. 00	22. 00	23. 00	
	ERALLY QUALIFIED HEALTH CENTER						89. 00
90. 00 09000 CLI N							90.00
91.00 09100 EMER							91.00
	ERVATION BEDS (NON-DISTINCT PART)						92.00
	MBURSABLE COST CENTERS						
	E PROGRAM DIALYSIS						94.00
	ULANCE SERVICES						95.00
	ABLE MEDICAL EQUIP-RENTED						96.00
	ABLE MEDICAL EQUIP-SOLD						97. 00
	ER REIMBURSABLE COST CENTERS						98. 00
99.00 09900 CMHC							99. 00
99. 10 09910 CORF							99. 10
	SERVICES-NOT APPRVD PRGM						100.00
101. 00 10100 HOME							101.00
	URPOSE COST CENTERS						
105. 00 10500 KI DN							105.00
106. 00 10600 HEAF							106.00
107. 00 10700 LI VE							107. 00
108. 00 10800 LUNG	G ACQUISITION						108.00
	CREAS ACQUISITION						109. 00
	ESTINAL ACQUISITION						110.00
111. 00 11100 I SLE							111.00
113. 00 11300 I NTE							113. 00
	LIZATION REVIEW-SNF						114. 00
115. 00 11500 AMBL	ULATORY SURGICAL CENTER (D. P.)						115.00
116. 00 11600 HOSF							116.00
	TOTALS (SUM OF LINES 1-117)	0	0	0	0	0	118. 00
	RSABLE COST CENTERS						
190. 00 19000 GI FT	T, FLOWER, COFFEE SHOP & CANTEEN						190.00
190. 01 19001 PROM	MPTCARE						190. 01
190. 02 19002 RENT							190. 02
190. 03 19003 OLCO							190. 03
190. 04 19004 PHYS	SICIAN RECRUITMENT						190. 04
190. 05 19005 FOUN	NDATI ON						190. 05
190. 06 19006 MARK	KETI NG						190. 06
190. 07 19007 HME	STORE						190. 07
190. 08 19008 UNUS	SED SPACE						190. 08
190. 09 19009 CLI N	NI CAL TRI ALS						190. 09
190. 10 19010 MORG	GAN OP BEHAVIORAL HEALTH CLINIC						190. 10
191. 00 19100 RESE	EARCH						191.00
192.00 19200 PHYS	SICIANS' PRIVATE OFFICES						192.00
193. 00 19300 NONE	PAID WORKERS						193.00
	HEALTH PAOLI HOSPITAL						194. 00
194. 01 07951 IU F	HEALTH BEDFORD HOSPITAL						194. 01
	HEALTH MORGAN HOSPITAL						194. 02
194. 03 07953 IU F							194. 03
	ss Foot Adjustments	o	0	0	0	781	200.00
201. 00 Nega	ative Cost Centers	o	0	0	0	0	201.00
202. 00 TOTA	AL (sum lines 118-201)	o	0	0	0	781	202.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150051

				T	o 12/31/2015 Date/Time Pre 5/27/2016 1:5	
	Cost Center Description	Subtotal	Intern &	Total	372772010 1.	J piii
			Residents			
			Cost & Post			
			Stepdown Adjustments			
		24. 00	25. 00	26.00		
	GENERAL SERVICE COST CENTERS	I				
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT			-		2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					5.00
6. 00	00600 MAI NTENANCE & REPAI RS					6. 00
7. 00	00700 OPERATION OF PLANT		•			7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00	00900 HOUSEKEEPI NG					9. 00
10.00	01000 DI ETARY					10.00
11. 00 12. 00	01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL					11. 00 12. 00
13. 00	1 1					13.00
14. 00	1 1					14.00
15.00	01500 PHARMACY					15. 00
16. 00	1 1					16. 00
	01700 SOCIAL SERVICE					17. 00
	01850 OTHER GENERAL SERVICE (SPECIFY)					18.00
18. 01	01851 CENTRAL STERI LI ZATI ON 01900 NONPHYSI CI AN ANESTHETI STS					18. 01 19. 00
20. 00	1 1					20.00
21. 00	1 1					21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD					22. 00
23.00					<u> </u>	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	1	6, 095, 337	0			30.00
31. 00 32. 00	+ +	596, 988 0	0			31. 00 32. 00
33. 00	+ +	0	0	1		33.00
34. 00	+ +	0	0	Ō		34.00
40.00	04000 SUBPROVI DER - I PF	0	0	0		40.00
41.00		539, 001	0			41.00
42.00	+ I	0	0	1		42.00
43. 00 44. 00	+ I	289, 729	0			43. 00 44. 00
45. 00	+ I	0	0	1		45. 00
46. 00	1 1	0	Ö			46. 00
	ANCILLARY SERVICE COST CENTERS			,		
50.00	1 1	2, 387, 249	0			50.00
50. 01 51. 00		0 174, 267	0	1		50. 01 51. 00
52. 00		1, 514, 795	0	1		52.00
53.00	05300 ANESTHESI OLOGY	0	Ö			53.00
54.00		917, 769	0			54.00
	05500 RADI OLOGY-THERAPEUTI C	966, 534	0	966, 534		55.00
56.00	I I	70 527	0			56.00
57. 00 58. 00	1 1	78, 527 86, 632	0	78, 527 86, 632		57. 00 58. 00
	05900 CARDI AC CATHETERI ZATI ON	327, 614	0			59.00
60.00	1 1	840, 162	0			60.00
60. 01	06001 BLOOD LABORATORY	0	0	0		60. 01
	06002 PHYSI CI AN LABORATORY	0	0	0		60. 02
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					61.00
63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06300 BLOOD STORING, PROCESSING & TRANS.	0	) 			62. 00 63. 00
	06400 I NTRAVENOUS THERAPY	3, 750	0	3, 750		64.00
65. 00	+ I	118, 542	0			65.00
66.00	06600 PHYSI CAL THERAPY	1, 057, 679	0	1, 057, 679		66.00
	06700 OCCUPATI ONAL THERAPY	0	0	1		67.00
	06800 SPEECH PATHOLOGY	105 700	0	1		68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	135, 703 169, 065	0	1,		69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	226, 822	0	226, 822		70.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	270, 310	Ö			72.00
	07300 DRUGS CHARGED TO PATIENTS	870, 193				73. 00
	07400 RENAL DI ALYSI S	44, 466	0	1 ,		74.00
	07500 ASC (NON-DISTINCT PART)	0	0	1		75. 00
75. 01	1 1	181, 968	0			75. 01
10.91	O7697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	172, 201	0	172, 201		76. 97
88. 00	08800 RURAL HEALTH CLINIC	0	0	0		88. 00
			·			·

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To | 12/31/2015 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 150051

			T		:/Time Prepared: :/2016 1:53 pm
Cost Center Description	Subtotal	Intern &	Total	3721	72010 1.33 pili
oust center beservet on	Subtotal	Resi dents	Total		
		Cost & Post			
		Stepdown			
		Adjustments			
	24. 00	25. 00	26. 00		
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89. 00
90. 00  09000  CLI NI C	174, 817	0			90.00
91. 00   09100   EMERGENCY	1, 313, 165	0	1, 313, 165		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			92.00
OTHER REIMBURSABLE COST CENTERS		٥	0		04.00
94. 00   09400   HOME PROGRAM DIALYSIS 95. 00   09500   AMBULANCE SERVICES	0 618, 045	0			94. 00 95. 00
96. 00   09600 DURABLE MEDICAL EQUIP-RENTED	018, 045	0			95.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED	0	0	0		97.00
98. 00   09850 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
99. 00   09900   CMHC	0	0	0		99.00
99. 10 09910 CORF	0	o	0		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	ő	0		100.00
101. 00 10100 HOME HEALTH AGENCY	751, 969	Ö			101.00
SPECIAL PURPOSE COST CENTERS		-			
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0		105.00
106.00 10600 HEART ACQUISITION	0	0	0		106.00
107.00 10700 LIVER ACQUISITION	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0		108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0		110.00
111.00 11100 ISLET ACQUISITION	0	0	0		111. 00
113.00 11300 INTEREST EXPENSE					113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	_	_	_		114. 00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.)	0	0	0		115.00
116. 00 11600 HOSPI CE	497, 136	0			116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	21, 420, 435	0	21, 420, 435		118. 00
190. 00 19000 GLFT, FLOWER, COFFEE SHOP & CANTEEN	39, 246	0	39, 246		190. 00
190. 01 19001 PROMPTCARE	472, 616	0			190.00
190. 02 19002 RENTAL PROPERTIES	81, 130	0	,		190. 02
190. 03 19003 OLCOTT	111, 556	o			190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	7, 345	0	7, 345		190. 04
190. 05 19005 FOUNDATION	140, 127	0	140, 127		190. 05
190. 06 19006 MARKETI NG	4, 510	0	4, 510		190.06
190. 07 19007 HME STORE	143, 308	o	143, 308		190. 07
190. 08 19008 UNUSED SPACE	237, 043	0	237, 043		190. 08
190. 09 19009 CLINICAL TRIALS	8, 557	0	8, 557		190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	7, 893	0	7, 893		190. 10
191. 00 19100 RESEARCH	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0		193. 00
194. 00 07950 IU HEALTH PAOLI HOSPITAL	327, 943	0	327, 943		194. 00
194. 01 07951 I U HEALTH BEDFORD HOSPITAL	705, 968	0	705, 968		194. 01
194. 02 07952 IU HEALTH MORGAN HOSPITAL	306, 899	0			194. 02
194. 03 07953 I U HEALTH SI P	576	0	576		194. 03
200.00 Cross Foot Adjustments	781	0	,		200.00
201.00 Negative Cost Centers 202.00 TOTAL (sum lines 118-201)	45, 935 24, 061, 868	0			201. 00 202. 00
202.00   TOTAL (SUIII TITIES TTO-201)	24,001,008	ų v	24, 001, 608	I	J2U2. UU

	<u> </u>	U HEALTH BLOOMI				u of Form CMS-2	
COST	ALLOCATION - STATISTICAL BASIS		Provi der		eriod: rom 01/01/2015	Worksheet B-1	
					o 12/31/2015	Date/Time Pre	pared:
		CAPITAL RE	LATED COSTS			5/27/2016 1:5	3 pm
		CALL TAL KE	LATED COSTS				
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	
				DEPARTMENT		(ACCUM. COST)	
				(GROSS SALARI ES)			
		1. 00	2.00	4. 00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	687, 674					1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	2, 166	890, 755 12, 452	•			2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	126, 891	1			300, 998, 885	5.00
6. 00	00600 MAI NTENANCE & REPAI RS	0	1		0	0	6.00
7. 00	00700 OPERATION OF PLANT	91, 422	112, 528	2, 483, 768	0	13, 750, 132	7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	13, 166	1		_		
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	3, 137				_, -,,	
11. 00	01100 CAFETERI A	9, 060 6, 017				,	1
12. 00	01200 MAINTENANCE OF PERSONNEL	0,017		710, 100	Ö		12.00
13.00	01300 NURSING ADMINISTRATION	8, 822	16, 823	3, 345, 492	0	5, 750, 085	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	3, 935				11, 961, 256	
15. 00 16. 00	01500 PHARMACY	100	<b>1</b>	4, 429, 906			
17. 00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	5, 357	1		_	02.7000	1
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)		Ö		Ö	0	18.00
18. 01	01851 CENTRAL STERILIZATION	3, 110	3, 110	374, 498	0	634, 113	
19. 00	01900 NONPHYSICIAN ANESTHETISTS	0	0	C	0	0	19.00
20.00		0	0	C	0	0	20.00
21. 00 22. 00	02100   &R SERVICES-SALARY & FRINGES APPRVD 02200   &R SERVICES-OTHER PRGM COSTS APPRVD	0			0	0	21. 00 22. 00
	02300 PARAMED ED PRGM-PHARMACY RESIDENCY		1				•
20.00	INPATIENT ROUTINE SERVICE COST CENTERS					10,000	20.00
30.00	03000 ADULTS & PEDIATRICS	123, 546		20, 139, 017	0	34, 249, 873	
31.00	03100 I NTENSI VE CARE UNI T	10, 276	10, 276	2, 553, 454	0		
32. 00 33. 00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0			0	0	32. 00 33. 00
34. 00	03400 SURGICAL INTENSIVE CARE UNIT				0	0	34.00
40. 00	04000 SUBPROVI DER – I PF	0	Ö	Ċ	Ö	Ö	40.00
41.00	04100 SUBPROVI DER - I RF	12, 161	12, 161	791, 746	0	1, 472, 198	
42.00	04200 SUBPROVI DER	0	0	C	0		
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	5, 951	5, 951	1, 162, 722	0	1, 916, 854 0	43. 00 44. 00
45. 00	04500 NURSING FACILITY				0		45.00
46. 00	04600 OTHER LONG TERM CARE	0	Ö	d			ı
	ANCILLARY SERVICE COST CENTERS	_	,	,		,	
	05000 OPERATING ROOM	49, 348	1				
	05001 CV SURGERY 05100 RECOVERY ROOM	3, 465	1	_			
52. 00		34, 598					
53.00	05300 ANESTHESI OLOGY	0	1				53.00
54.00		18, 886					
55.00	05500 RADI OLOGY-THERAPEUTI C	22, 875	22, 875				
56. 00 57. 00	05600 RADI 0I SOTOPE 05700 CT SCAN	1, 349	1, 349	561, 531	_	· -	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 941	1			608, 964	•
59. 00	05900 CARDI AC CATHETERI ZATI ON	6, 478	1			2, 001, 269	59.00
60.00	06000 LABORATORY	15, 896	17, 874	C	0		60.00
60. 01	06001 BLOOD LABORATORY	0	0	C	0	0	1
60. 02 61. 00	06002 PHYSI CI AN LABORATORY 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY	0	0	C	0	0	60. 02 61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	0	62.00
63. 00	1 1	0	Ö	i c	Ö	Ö	ı
64.00	06400 I NTRAVENOUS THERAPY	0	0	76, 472	0	123, 248	64.00
65.00	06500 RESPI RATORY THERAPY	1, 320					1
66. 00 67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	8, 892	1	6, 998, 641		10, 199, 460 0	1
68. 00	1				0		ı
69. 00	06900 ELECTROCARDI OLOGY	2, 453	2, 703	666, 288			
70.00	07000 ELECTROENCEPHALOGRAPHY	3, 665	3, 665		0	1, 413, 597	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	C	_		
72. 00 73. 00		5, 821	0 7, 021	759, 422	0		1
74.00	07400 RENAL DIALYSIS	788	1				
75. 00		0	l .		Ö		75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	.,			1, 601, 279	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	3, 759	4, 157	695, 915	0	1, 020, 515	76. 97

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
			<u> </u>	From 01/01/2015	D. I. (T' D.	
				Γο 12/31/2015	Date/Time Pre	
	CADLTAL DEL	ATED COSTS			5/27/2016 1:5	) DIII
CAPITAL RELATED COSTS						
Cost Center Description	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Doconci Li ati o	ADMINISTRATIV	
Cost Center Description						
	(SQUARE FEET)	(SQUARE FEET)	BENEFITS	n	E & GENERAL	
			DEPARTMENT		(ACCUM. COST)	
			(GROSS			
			SALARI ES)			
	1. 00	2. 00	4. 00	5A	5. 00	
OUTPATIENT SERVICE COST CENTERS		1	ı	. 1		
88.00 08800 RURAL HEALTH CLINIC	0	0	(	0	0	
89.00  08900  FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0	<b>l</b>	
90. 00  09000  CLI NI C	0	6, 949	1, 311, 596	6 0	1, 865, 363	90.00
91. 00   09100   EMERGENCY	26, 478	26, 478	3, 966, 754	1 0	7, 657, 840	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	)					92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	(	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	10, 153	14, 153	4, 269, 484	1 0	6, 676, 918	
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	(	0	0	1
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	1			0	1
98. 00 09850 OTHER REIMBURSABLE COST CENTERS					0	1
99. 00   09900   CMHC					0	1
99. 10   09910  CORF					· -	
	0	0		0	0	
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	15 150	0		0		100.00
101. 00 10100 HOME HEALTH AGENCY	15, 158	16, 598	4, 213, 626	5 0	7, 013, 436	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	(	0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0	0	(	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	(	0	0	107.00
108.00 10800 LUNG ACQUISITION	0	0	(	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	(	0	0	109.00
110.00 11000 INTESTINAL ACQUISITION	0	l o		0	0	110.00
111.00 11100 I SLET ACQUI SI TI ON	0	0		0		111.00
113. 00 11300   NTEREST EXPENSE		Ĭ	`	1	Ĭ	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	1		0	n	115.00
116. 00 11600 HOSPI CE	4, 796	14, 795	2, 704, 992		4, 991, 205	1
118.00 SUBTOTALS (SUM OF LINES 1-117)						1
	663, 236	853, 559	95,000,073	-60, 695, 006	215, 684, 043	1110.00
NONREI MBURSABLE COST CENTERS	0.42	0.42	(4.04	1	105 740	100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	943		1			1
190. 01 19001 PROMPTCARE	8, 568		881, 526			
190. 02 19002 RENTAL PROPERTIES	4, 234			0		
190. 03 19003 OLCOTT	2, 750	2, 750	250, 531			
190. 04 19004 PHYSI CLAN RECRUI TMENT	0	0	(	0		
190. 05 19005  FOUNDATI ON	0	6, 447	579, 474	1 0	991, 079	190. 05
190. 06 19006 MARKETI NG	0	0	(	0	265, 734	190.06
190.07 19007 HME STORE	0	6, 400	783, 180	0	487, 300	190. 07
190. 08 19008 UNUSED SPACE	7, 943	6, 307	(	0	551, 649	190.08
190. 09 19009 CLI NI CAL TRI ALS	0	0	178, 456	6 0	437, 123	190.09
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0			407, 986	190. 10
191. 00 19100 RESEARCH	0	0		0		191.00
192. 00 19200 PHYSICIANS' PRIVATE OFFICES	0				l	192.00
193. 00 19300 NONPALD WORKERS					l	193. 00
	0				l e	1
194. 00 07950 IU HEALTH PAOLI HOSPITAL	0	0		0		
194. 01 07951 I U HEALTH BEDFORD HOSPITAL	0	0	1	0		
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	(	0		
194. 03 07953 IU HEALTH SIP	0	0	4, 000	0	5, 436	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,	12, 821, 276	11, 240, 592	27, 722, 338	3	60, 695, 006	202.00
Part I)			1			
203.00 Unit cost multiplier (Wkst. B, Part	1) 18. 644410	12. 619174	0. 282504	1	0. 201645	203.00
204.00 Cost to be allocated (per Wkst. B,			197, 518		5, 108, 069	
Part II)						1
205.00 Unit cost multiplier (Wkst. B, Part			0. 002013	3	0. 016970	205.00
	•		•	•		-

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150051 

			To	12/31/2015	Date/Time Pre 5/27/2016 1:5	
Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	<u>р</u>
	REPAIRS (SQUARE FEET)	PLANT (SQUARE FEET)	LINEN SERVICE (POUNDS OF	(HOURS OF SERVICE)	(MEALS SERVED)	
		, ,	LAUNDRY)	ŕ		
GENERAL SERVICE COST CENTERS	6. 00	7.00	8. 00	9. 00	10. 00	
1. 00 O0100 CAP REL COSTS-BLDG & FLXT						1. 00
2. 00   00200   CAP REL COSTS-MVBLE EQUIP						2. 00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00   00500   ADMI NI STRATI VE & GENERAL 6. 00   00600   MAI NTENANCE & REPAI RS						5. 00 6. 00
7. 00 00700 OPERATION OF PLANT	0	543, 788	3			7. 00
8. 00 00800 LAUNDRY & LINEN SERVICE	0	13, 166				8. 00
9. 00   00900  HOUSEKEEPI NG 10. 00   01000  DI ETARY	0	3, 487 12, 060	•	12, 566 51	220, 714	9. 00 10. 00
11. 00   01100   CAFETERI A		6, 017		25	0	11.00
12.00 01200 MAINTENANCE OF PERSONNEL	0	0	0	o	0	12.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	16, 823		0	0	13.00
14. 00   01400   CENTRAL SERVI CES & SUPPLY 15. 00   01500   PHARMACY	0	3, 935 0	1	60	0	14. 00 15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	6, 007	1	35	0	16.00
17. 00 01700 SOCIAL SERVICE	0	0	0	0	0	17.00
18. 00   01850   OTHER GENERAL SERVICE (SPECIFY) 18. 01   01851   CENTRAL STERILIZATION	0	0 3, 110		0	0	18. 00 18. 01
19. 00 01900 NONPHYSI CLAN ANESTHETI STS		3, 110		0	0	19. 00
20. 00   02000 NURSI NG SCHOOL	0	0	0	o	0	20.00
21. 00 02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	0	0	0	0	21.00
22. 00   02200   1&R SERVI CES-OTHER PRGM COSTS APPRVD 23. 00   02300   PARAMED ED PRGM-PHARMACY RESI DENCY	0			0	0	22. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		0	,j O <sub>1</sub>		0	23.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	-,		5, 314	191, 277	30. 00
31. 00   03100   INTENSI VE CARE UNI T	0	10, 276	129, 672	885	17, 171	31.00
32. 00   03200   CORONARY CARE UNIT 33. 00   03300   BURN INTENSIVE CARE UNIT	0	0		0	0	32. 00 33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T	0	Ö	Ö	o	0	34. 00
40. 00   04000   SUBPROVI DER - I PF	0	0	0	0	0	40.00
41. 00   04100   SUBPROVI DER -   I RF	0	12, 161	43, 059	343	12, 266 0	41.00
42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY		5, 951	8, 797	519	0	42. 00 43. 00
44.00 04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45. 00 04500 NURSING FACILITY	0	l .	0	0	0	45.00
46. 00   04600   OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0	0	0	0	46. 00
50. 00 05000 OPERATING ROOM	0	49, 348	214, 648	895	0	50.00
50. 01   05001 CV SURGERY	0	_	٦	0	0	50. 01
51. 00   05100   RECOVERY ROOM 52. 00   05200   DELI VERY ROOM & LABOR ROOM	0	3, 465 34, 598		63 1, 483	0	51. 00 52. 00
53. 00   05300   ANESTHESI OLOGY		0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	22, 056		296	0	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	22, 875	20, 442	52	0	55.00
56. 00   05600  RADI 0I SOTOPE 57. 00   05700  CT SCAN		1, 349		23	0	56. 00 57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 941		33	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	6, 478		237	0	59.00
60. 00   06000  LABORATORY 60. 01   06001  BLOOD LABORATORY		17, 874	0	/	0	60. 00 60. 01
60. 02 06002 PHYSI CI AN LABORATORY		Ö	o o	Ö	0	60.02
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
63. 00   06300   BLOOD STORING, PROCESSING & TRANS. 64. 00   06400   INTRAVENOUS THERAPY		0		0	0	63. 00 64. 00
65. 00 06500 RESPIRATORY THERAPY	0	2, 360	Ö	o	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	0	34, 460	68, 944	241	0	66.00
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0	0		0	0	67. 00 68. 00
69. 00   06900   SPEECH PATHOLOGY		2, 703	38, 036	99	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY		3, 665		ó	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	O	0	71.00
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS		0 7, 021	0	0  344	0	72. 00 73. 00
74. 00   07400   RENAL DI ALYSI S		7,021		2	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	О	0	75.00
75. 01   03550  PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 97   07697  CARDI AC REHABI LI TATI ON	0	,		0	0	75. 01
OUTPATIENT SERVICE COST CENTERS		4, 157	<u> </u>	U	0	76. 97
88. 00 08800 RURAL HEALTH CLINIC	0			0	0	88. 00
89.00  08900  FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00

COST ALLO	CATION - STATISTICAL BASIS		Provi der		eri od:	Worksheet B-1	
					rom 01/01/2015 o 12/31/2015		nared.
				'	0 12/31/2013	5/27/2016 1:5	3 pm
	Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		REPAI RS	PLANT	LINEN SERVICE	(HOURS OF	(MEALS	
		(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	SERVICE)	SERVED)	
				LAUNDRY)			
		6. 00	7. 00	8. 00	9. 00	10.00	
	OO CLINIC	0	-,	l .	_	_	1
1	OO EMERGENCY	0	26, 478	275, 430	1, 402	0	
	00 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	ER REIMBURSABLE COST CENTERS	_		1			4
	00 HOME PROGRAM DIALYSIS	0	0		_	_	
	00 AMBULANCE SERVICES	0	14, 153	63, 288	0	0	
	OO DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	
1	OO DURABLE MEDICAL EQUIP-SOLD	0	0		0	0	
98. 00   098 99. 00   099	50 OTHER REIMBURSABLE COST CENTERS	0	0		0	0	
99. 10 099	l e		0		0	0	1
	00 I&R SERVICES-NOT APPRVD PRGM	0	0		0	0	1
1	00 HOME HEALTH AGENCY	0	16, 598		0		101.00
	CLAL PURPOSE COST CENTERS	0	10, 370	1	0	0	1101.00
	OO KI DNEY ACQUI SI TI ON	0	0	C	0	0	105.00
	OO HEART ACQUISITION	0	0			l .	106.00
1	OO LI VER ACQUI SI TI ON	0	0	l c	0		107.00
	OO LUNG ACQUISITION	0	0	l č	0	l .	108.00
	OO PANCREAS ACQUISITION	0	0	l č	0	l .	109.00
	OO INTESTINAL ACQUISITION	0	Ö	d	0		110.00
	OO ISLET ACQUISITION	0	O		0	0	111.00
	00 INTEREST EXPENSE						113.00
114. 00 114	OO UTILIZATION REVIEW-SNF						114.00
115. 00 115	OO AMBULATORY SURGICAL CENTER (D.P.)	0	0	c c	0	0	115.00
116. 00 116	00 HOSPI CE	0	14, 795	23, 627	144	0	116.00
118. 00	SUBTOTALS (SUM OF LINES 1-117)	0	512, 899	1, 752, 799	12, 553	220, 714	118.00
NON	REIMBURSABLE COST CENTERS						ĺ
190. 00 190	OO GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	943	C	13	0	190.00
	01 PROMPTCARE	0	14, 349	6, 255	0	0	190. 01
	02 RENTAL PROPERTIES	0	0	C	0	0	
190. 03 190		0	2, 750	C	0		190. 03
	04 PHYSI CI AN RECRUI TMENT	0	0	C	0		190. 04
	05 FOUNDATI ON	0	6, 447		0		190. 05
1	06 MARKETI NG	0	0		0		190.06
1	07 HME STORE	0	6, 400		0		190.07
	08 UNUSED_SPACE 09 CLINICAL_TRIALS	0	0		0		190.08
	10 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0		0	0	190. 09 190. 10
	00 RESEARCH	0	0		0	l .	190. 10
	00 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	l .	191.00
	OO NONPALD WORKERS	0			0	l .	193.00
1	50 IU HEALTH PAOLI HOSPITAL	0	0		0	l .	194.00
	51 I U HEALTH BEDFORD HOSPITAL	0	0		0	l .	194. 01
	52 IU HEALTH MORGAN HOSPITAL	0	١				194. 02
	53 IU HEALTH SIP	0	ĺ		0		194. 03
200. 00	Cross Foot Adjustments					Ĭ	200.00
201. 00	Negative Cost Centers						201.00
202. 00	Cost to be allocated (per Wkst. B,	0	16, 522, 777	1, 373, 759	3, 207, 683	3, 674, 452	
	Part I)	_		',''.'	1, 201, 100		
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	30. 384593	0. 780965	255. 266831	16. 648024	203.00
204.00	Cost to be allocated (per Wkst. B,	0	3, 362, 859				
	Part II)						
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	6. 184136	0. 288102	13. 593984	2. 031851	205.00
	[11]			1			

	LLOCATION - STATISTICAL BASIS	HEALIH BLOOMI			eri od:	Worksheet B-1	
CU31 F	RELUCATION - STATISTICAL DASIS		Provider	F	rom 01/01/2015	Date/Time Pre	
						5/27/2016 1:5	
	Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	
		(MANHOURS)	OF PERSONNEL (NUMBER	ADMI NI STRATI O N	SERVICES & SUPPLY	(COSTED REQUIS.)	
			HOUSED)	(DI RECT NURS.	(TIME SPENT)	KEQUI 3. )	
			,	HRS. )	(******		
		11. 00	12. 00	13. 00	14. 00	15. 00	
1 00	GENERAL SERVICE COST CENTERS	I		1			1 00
1. 00 2. 00	OO100   CAP REL COSTS-BLDG & FIXT   OO200   CAP REL COSTS-MVBLE EQUIP			-			1. 00 2. 00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					I	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL					I	5.00
6.00	00600 MAINTENANCE & REPAIRS					I	6. 00
7.00	00700 OPERATION OF PLANT					l	7.00
8. 00 9. 00	OO800   LAUNDRY & LI NEN SERVI CE   OO900   HOUSEKEEPI NG						8. 00 9. 00
10.00	01000 DI ETARY					l	10.00
11. 00	01100 CAFETERI A	3, 015, 004				l	11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	)		I	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	104, 800	0	1, 188, 434		I	13.00
14. 00 15. 00	O1400   CENTRAL SERVI CES & SUPPLY   O1500   PHARMACY	50 116, 333	0	0		100	14. 00 15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	110, 333			17, 700, 143	0	16.00
17. 00	01700 SOCI AL SERVI CE	0	Ö	Ö	0	0	17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18. 00
	01851 CENTRAL STERI LI ZATI ON	22, 711	0	0	135, 824	0	18. 01
19. 00 20. 00	01900   NONPHYSI CI AN ANESTHETI STS   02000   NURSI NG SCHOOL	0	0	0	0	0	19. 00 20. 00
21.00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0			0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRVD	0	Ö	Ö	0	0	22.00
23.00	02300 PARAMED ED PRGM-PHARMACY RESIDENCY	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	000 470		545.044			
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	803, 478 96, 639	0	515, 961 72, 005		0	30. 00 31. 00
32. 00	03200 CORONARY CARE UNIT	0,037		0	405, 025	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	O	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	47.004	0	40.00
41. 00 42. 00	O4100   SUBPROVI DER	30, 507	0	23, 848	47, 996	1 0	41. 00 42. 00
43. 00	04300 NURSERY	35, 382		34, 253	165, 766	1 0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	O	0	0	0	44.00
45.00	04500 NURSING FACILITY	0	0	0	-	0	45.00
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0	0	)  0	0	0	46.00
50.00	05000 OPERATING ROOM	210, 508	0	118, 800	4, 026, 435	0	50.00
50. 01	05001 CV SURGERY	0	0	1	_	0	50. 01
51.00	05100 RECOVERY ROOM	30, 219	l	,		0	
	05200   DELI VERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY	93, 602	0	1	355, 164	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	107, 979		1	231, 700	0	
55. 00	05500 RADI OLOGY-THERAPEUTI C	63, 531	Ö	8, 224		0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57. 00	05700 CT SCAN	18, 536	0	0		0	57.00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	10, 207	0	0	69, 398	0	58. 00 59. 00
60.00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	36, 696 2, 868	ł	24, 551	531, 843 1, 352, 002	1 0	60.00
60. 01	06001 BLOOD LABORATORY	0	Ö	Ö	0	ő	60.01
60. 02	06002 PHYSI CI AN LABORATORY	0	0	0	0	0	60. 02
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					1	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	
63. 00 64. 00	06300   BLOOD STORING, PROCESSING & TRANS.   06400   INTRAVENOUS THERAPY	3, 405	0	2, 102	15, 090	0	63. 00 64. 00
65.00	06500 RESPIRATORY THERAPY	54, 460		2, 102	281, 864	0	65.00
66.00	06600 PHYSI CAL THERAPY	244, 915	O	23, 535		0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0 222	0	68.00
69. 00 70. 00	06900  ELECTROCARDI OLOGY   07000  ELECTROENCEPHALOGRAPHY	23, 046 34, 389	0	4,773	90, 223 35, 332	0	69. 00 70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	ĺ	0	9, 246, 483	ő	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	10, 692, 449	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	27, 384	0	21, 424		100	•
74.00	07400 RENAL DIALYSIS	0	0	0	29, 534	0	
75. 00 75. 01	07500   ASC (NON-DISTINCT PART)   03550   PSYCHIATRIC/PSYCHOLOGICAL SERVICES	41, 627		10, 496	0 1, 618	0	75. 00 75. 01
76. 97	07697 CARDI AC REHABILI TATI ON	22, 826	0			0	1
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	. 0	88. 00

		J TILALTIT BLOOMI					
COST A	LLOCATION - STATISTICAL BASIS		Provi der	CCN: 150051   P	eri od:	Worksheet B-1	
					rom 01/01/2015		
					o 12/31/2015	Date/Time Pre	pared:
						5/27/2016 1:5	3 pm
	Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	
	<b>'</b>	(MANHOURS)	OF PERSONNEL	ADMI NI STRATI O	SERVICES &	(COSTED	
		(WANTOOKS)				REQUIS.)	
			(NUMBER	N	SUPPLY	REQUIS.)	
			HOUSED)	(DI RECT NURS.	(TIME SPENT)		
				HRS. )			
		11. 00	12. 00	13.00	14. 00	15.00	
00.00	OOOOO FEDERALLY OHALLELED HEALTH CENTER	0					00.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	1	1		_		
	09000 CLI NI C	45, 188		13, 395	19, 804	0	90.00
91.00	09100 EMERGENCY	160, 835	0	106, 863	928, 059	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)					1	92.00
	OTHER REIMBURSABLE COST CENTERS					-	72.00
		T	_	1 _	T		
	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES	218, 278	0	118	277, 548	0	95.00
96 00	09600 DURABLE MEDICAL EQUIP-RENTED	1	l n	l o	0	l 0	96.00
				٥		l ő	
	09700 DURABLE MEDI CAL EQUI P-SOLD	0	0		U		97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00	09900 CMHC	0	0	0	0	0	99.00
99 10	09910 CORF	1	l n	l o	0	0	99. 10
			0			_	
	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100.00
101.00	10100 HOME HEALTH AGENCY	153, 817	0	34, 102	476, 841	0	101.00
	SPECIAL PURPOSE COST CENTERS	•					1
	10500 KI DNEY ACQUI SI TI ON	1	0	0	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	0	0	0	107.00
108 00	10800 LUNG ACQUISITION	1	l n	l o	0	1 0	108.00
	10900 PANCREAS ACQUISITION			٥			
		0	0	0	U		109.00
	11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00	11100   SLET ACQUISITION	0	0	1 0	0	1 0	111.00
	11300   NTEREST EXPENSE					1	113.00
		-				1	
	11400 UTI LI ZATI ON REVI EW-SNF					1	114. 00
115.00	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0	115.00
116 00	11600 HOSPI CE	105, 586	0	42, 170	452, 931	0	116.00
118.00	l e e e e e e e e e e e e e e e e e e e	2, 919, 802	Ö				118.00
		2, 919, 602		1, 102, 033	50, 437, 012	100	1110.00
	NONREI MBURSABLE COST CENTERS						1
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 871	0	0	8	0	190.00
190 01	19001 PROMPTCARE	38, 340	0	5, 429	156, 458	0	190. 01
	19002 RENTAL PROPERTIES	00,0.0	ا م	1 0, 12,	100, 100		190. 02
		0 5/0	0		0 5 ( 0		
	19003 OLCOTT	8, 568	0	21	3, 560		190. 03
190. 04	19004 PHYSI CI AN RECRUI TMENT	0	0	0	0	1 0	190. 04
190 05	19005 FOUNDATION	14, 703	0	1 0	0	1 0	190. 05
	19006 MARKETI NG	11,700		٥			190.06
	l e e e e e e e e e e e e e e e e e e e	0	0	0			
190. 07	19007 HME STORE	17, 578	0	47	1, 791, 415	0	190. 07
190. 08	19008 UNUSED SPACE	0	0	0	0	1 0	190. 08
	19009 CLINICAL TRIALS	5, 609	l n	864	38	1	190.09
							190. 10
	19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	5, 453	0	40			
191. 00	19100 RESEARCH	0	0	0	0	0	191. 00
192 00	19200 PHYSICIANS' PRIVATE OFFICES	0	l o	1	0	0	192.00
	19300 NONPAI D WORKERS		ا م	0	0		193.00
		0	0		0	1	
194.00	07950 IU HEALTH PAOLI HOSPITAL	0	0	0	0		194. 00
194. 01	07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	0	1 0	194.01
	07952 IU HEALTH MORGAN HOSPITAL	0	0	l o	0		194. 02
	07953 IU HEALTH SIP	1	1				1
	l e e e e e e e e e e e e e e e e e e e	80	0	0	23, 175	1	
200.00	Cross Foot Adjustments					1	200.00
201.00	Negative Cost Centers					1	201.00
202.00	Cost to be allocated (per Wkst. B,	513, 008	0	7, 438, 553	14, 508, 071	12, 348, 995	
202.00		313,000	I	1, 430, 333	14, 300, 071	12, 340, 793	202.00
	Part I)					1	
203.00	Unit cost multiplier (Wkst. B, Part I)	0. 170152	0. 000000	6. 259122	0. 276810	123, 489. 95000	203. 00
						0	I
204.00	Cost to be allocated (per Wkst. B,	233, 878	0	591, 655	351, 161	241, 573	204 00
204.00		233, 070	l	371,000	331, 101	241, 3/3	[-07.00
005 05	Part II)	0.0000	0 0005	0 4075 : :	0.00/	0 445 7000	005 00
205.00	Unit cost multiplier (Wkst. B, Part	0. 062336	0. 000000	0. 497844	0. 006700	2, 415. 730000	∠05.00
	11)					1	

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 150051 

				'	o 12/31/2015	Date/lime Pre   5/27/2016 1:5	
				OTHER GENE	RAL SERVICE	0,27,2010 1.0	J piii
	Cost Center Description	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE (TIME SPENT)	(SPECIFY) (TIME SPENT)	CENTRAL STERILIZATION (TIME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED	
		(GROSS				TIME)	
		REVENUE) 16. 00	17. 00	18. 00	18. 01	19. 00	
	GENERAL SERVICE COST CENTERS	10.00	17.00	10.00	10.01	17.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00 5. 00	00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL						4. 00 5. 00
6. 00	00600 MAINTENANCE & REPAIRS			•			6.00
7. 00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9.00
10. 00 11. 00	01000  DI ETARY  01100  CAFETERI A						10.00 11.00
12. 00	01200 MAINTENANCE OF PERSONNEL						12.00
13.00	01300 NURSING ADMINISTRATION						13.00
14.00	01400   CENTRAL SERVI CES & SUPPLY   01500   PHARMACY						14.00
15. 00 16. 00	01600 MEDICAL RECORDS & LIBRARY	1, 128, 382, 514					15. 00 16. 00
17. 00	01700 SOCIAL SERVICE	0	0				17.00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0			18. 00
18. 01	01851 CENTRAL STERI LI ZATI ON	0	0	0			18. 01
19. 00 20. 00	01900   NONPHYSI CI AN ANESTHETI STS   02000   NURSI NG SCHOOL	0	0	0	0	0	19. 00 20. 00
21. 00	02100 I &R SERVI CES-SALARY & FRI NGES APPRVD	0	Ö	ő	O		21.00
22. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRVD	0	0	0			22. 00
23. 00	02300 PARAMED ED PRGM-PHARMACY RESIDENCY	0	0	0	0		23. 00
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	98, 494, 741	0	0	382	0	30.00
31.00	03100   NTENSI VE CARE UNI T	15, 160, 291	0	1			31.00
32.00	03200 CORONARY CARE UNIT	0	0	0		1	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	0	_	· -	33.00
34. 00 40. 00	03400  SURGICAL INTENSIVE CARE UNIT   04000  SUBPROVIDER - IPF	0	)   0	0	0	•	34. 00 40. 00
41. 00	04100 SUBPROVI DER - I RF	4, 190, 982	Ö	Ö	24	Ö	41.00
42.00	04200 SUBPROVI DER	0	0	0	-	•	42.00
43. 00 44. 00	04300 NURSERY 04400 SKILLED NURSING FACILITY	9, 456, 956	0	0		0 0	43. 00 44. 00
45. 00	04500 NURSING FACILITY	0	0				45.00
46.00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
FO 00	ANCILLARY SERVICE COST CENTERS	170 100 054		ı	27.0/5	1 0	1 50 00
50. 00 50. 01	05000   OPERATI NG ROOM   05001   CV SURGERY	172, 139, 054	0				50. 00 50. 01
51.00	05100 RECOVERY ROOM	22, 494, 835	Ö	Ö	Ö	Ö	51.00
	05200 DELIVERY ROOM & LABOR ROOM	30, 050, 434	0	_			52.00
	05300 ANESTHESI OLOGY	0	0	0			53.00
55.00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	41, 419, 927 62, 444, 096	)   0	0	25 0		54. 00 55. 00
56.00	05600 RADI OI SOTOPE	0	Ö	Ö	Ö	Ö	56.00
57. 00	05700 CT SCAN	30, 430, 071	0	0	0		57.00
58. 00 59. 00	05800   MAGNETIC RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	7, 247, 587 60, 192, 727	0	0	0 110		58. 00 59. 00
60.00	06000 LABORATORY	119, 886, 202	0		0		60.00
60. 01	06001 BLOOD LABORATORY	0	0	O		•	60. 01
60. 02	06002 PHYSI CI AN LABORATORY	0	0	0	0	0	60.02
61. 00 62. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	61.00 62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	•	63.00
64.00	06400 I NTRAVENOUS THERAPY	735, 624	0	Ō	0	•	64.00
	06500 RESPI RATORY THERAPY	9, 891, 660		0	80		65.00
66.00	06600 PHYSI CAL THERAPY	27, 236, 336	0	0	0	· -	66.00
67. 00 68. 00	O6700   OCCUPATI ONAL THERAPY   O6800   SPEECH PATHOLOGY	0	0	n	0	0 0	67. 00 68. 00
69.00	06900 ELECTROCARDI OLOGY	20, 536, 760		Ö	0	0	69.00
	07000 ELECTROENCEPHALOGRAPHY	15, 968, 683		0	95		70.00
	07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   07200   IMPL. DEV. CHARGED TO PATIENTS	40, 396, 576 87, 408, 699		0	0	0 0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATIENTS	128, 795, 373	0			0	1
74.00	07400 RENAL DIALYSIS	3, 106, 544	0	o	0	0	74.00
	07500 ASC (NON-DISTINCT PART)	0	0	0		0	1
75. 01 76. 97	03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   07697   CARDI AC REHABI LI TATI ON	2, 534, 851 2, 734, 177	0	0			
10. 71	JOSOFF ON THE PROPERTY OF THE	2,734,177	· · · · · ·	·1 0		1 0	1 70. 77

Health Financial Systems

IU HEALTH BLOOMINGTON HOSPITAL

In Lieu of Form CMS-2552-10

COST ALLOCATION - STATISTICAL BASIS

Provider CCN: 150051

Period:
From 01/01/2015
To 12/31/2015

Date/Time Prepared:
5/27/2016 1: 53 pm

OTHER GENERAL SERVICE

				1	0 12/31/2015	5/27/2016 1:5	
				OTHER GENE	RAL SERVICE		
	Cost Center Description	MEDI CAL RECORDS & LI BRARY (GROSS REVENUE)	SOCIAL SERVICE (TIME SPENT)	(SPECIFY) (TIME SPENT)	CENTRAL STERILIZATION (TIME SPENT)	NONPHYSI CI AN ANESTHETI STS (ASSI GNED TI ME)	
		16. 00	17. 00	18. 00	18. 01	19. 00	
	TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC		0	0	0	0	88. 00
	FEDERALLY QUALIFIED HEALTH CENTER	0	0	•			
	CLINIC	1, 207, 395	0	Ō		0	1
	EMERGENCY	78, 865, 393	0	0	65	0	
	OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	REIMBURSABLE COST CENTERS HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
	AMBULANCE SERVICES	35, 356, 540	Ö	l .		ő	1
	DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
	DURABLE MEDI CAL EQUI P-SOLD	0	0	0	0	0	97.00
98. 00   09850 99. 00   09900	OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	
99. 10 09910	•	0	0	0	0	0	1
	I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
	HOME HEALTH AGENCY	0	0	0	0	0	101.00
	AL PURPOSE COST CENTERS KIDNEY ACQUISITION		0	0	0	0	105.00
	HEART ACQUISITION	0	0	1			106.00
	LIVER ACQUISITION	0	0	0	0		107.00
	LUNG ACQUISITION	0	0	0	0		108.00
	PANCREAS ACQUISITION INTESTINAL ACQUISITION	0	0	0	0		109. 00 110. 00
	ISLET ACQUISITION	0	0		0		111.00
	INTEREST EXPENSE						113.00
	UTILIZATION REVIEW-SNF						114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0		115.00
116. 00 11600 118. 00	SUBTOTALS (SUM OF LINES 1-117)	1, 128, 382, 514	0				116. 00 118. 00
	IMBURSABLE COST CENTERS	17 1207 0027 011			20,001		
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 00
190. 01 19001	•	0	0	•			190. 01
190. 02 19002	RENTAL PROPERTIES	0	0	0			190. 02 190. 03
	PHYSICIAN RECRUITMENT	0	Ö	Ö	0		190. 04
190. 05 19005		0	0	0	0	0	190. 05
190. 06 19006	l .	0	0	0	0		190.06
190. 07 19007	UNUSED SPACE	0	0	0	0		190. 07 190. 08
	CLINICAL TRIALS	0	0	0	0		190.00
190. 10 19010	MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	Ö	0		190. 10
191. 00 19100		0	0	0			191. 00
	PHYSICIANS' PRIVATE OFFICES	0	0	0			192.00
	NONPALD WORKERS IU HEALTH PAOLI HOSPITAL	0	0	0			193. 00 194. 00
	IU HEALTH BEDFORD HOSPITAL	0	Ö	Ö			194. 01
	IU HEALTH MORGAN HOSPITAL	0	0	0	0	0	194. 02
	IU HEALTH SIP	0	0	0	70	0	194. 03
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers			•			200. 00 201. 00
201.00	Cost to be allocated (per Wkst. B,	818, 286	0	0	897, 936	n	201.00
	Part I)	3.3,200					
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000725	0. 000000	0.000000			1
204.00	Cost to be allocated (per Wkst. B, Part II)	222, 157	0	0	130, 304	0	204. 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000197	0. 000000	0. 000000	4. 508165	0. 000000	205.00
	II)						1

Heal th	n Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2552-10
COST	ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1
					From 01/01/2015 Fo 12/31/2015	Date/Time Prepared:
			LAITEDNIC	DECLIDENTS		5/27/2016 1:53 pm
			INTERNS &	RESI DENTS		
	Cost Center Description	NURSI NG	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
	, , , , , , , , , , , , , , , , , , ,	SCH00L	RY & FRINGES	R PRGM COSTS	PRGM-PHARMACY	
		(ASSI GNED	(ASSI GNED	(ASSI GNED	RESI DENCY	
		TIME)	TIME)	TIME)	(COSTED	
		20. 00	21. 00	22.00	REQUIS. ) 23. 00	
	GENERAL SERVICE COST CENTERS	20.00	21.00	22.00	23.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT					1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP					2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
5.00	00500 ADMINISTRATIVE & GENERAL					5.00
6. 00 7. 00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT					6.00
8. 00	00800 LAUNDRY & LINEN SERVICE					8.00
9. 00	00900 HOUSEKEEPI NG					9.00
10.00						10.00
11.00						11.00
12.00						12.00
13. 00 14. 00						13.00
15. 00						15.00
16. 00						16.00
17. 00						17.00
18. 00						18.00
18. 01						18. 01
19.00						19.00
20. 00 21. 00		0				20.00
22. 00				ή ,		22.00
23. 00				`	100	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30.00	03000 ADULTS & PEDIATRICS	0			0	30.00
31. 00	1	0			0	
32.00	1	0	(	1	0	
33. 00 34. 00		0		1	0 0	33.00
40. 00						40.00
41. 00		0				41.00
42.00	04200 SUBPROVI DER	0	(		0	42.00
43.00		0	(		0	43.00
44. 00		0			-	44.00
45. 00 46. 00		0			0 0	l l
40.00	ANCI LLARY SERVI CE COST CENTERS			<u> </u>	5  0	40.00
50.00		0	(		0	50.00
50. 01	05001 CV SURGERY	0	(		0	50.01
	05100 RECOVERY ROOM	0	(		0	51.00
52.00		0	(		0	52.00
53.00		0			0	53.00
54. 00 55. 00						54. 00 55. 00
56. 00		0				56.00
57.00		0			0	57.00
58.00		0	(		0	58.00
59. 00		0	(		0	59.00
60.00		0			0	60.00
60. 01		0			0	60.01
60. 02 61. 00		0		ή '		60.02
62. 00		0			0	62.00
63. 00		0			0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	(		0	64.00
65.00	1	0	(		0	65.00
66.00		0			0	66.00
67. 00 68. 00					0	67.00
69.00						69.00
70. 00		0		ol d	o o	70.00
71. 00					o o	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	(	) (	0	72.00
73. 00		0	(		100	73.00
74.00		0	9		0	74.00
75. 00 75. 01	07500 ASC (NON-DISTINCT PART)				0	75.00
75. 01 76. 97						75. 01 76. 97
- 3. 77	The state of the s	1		· 1	- 1	1 70.77

	*	HEALIH BLOOMI				U OT FORM CMS-2552-IC
CUST ALLUCA	TION - STATISTICAL BASIS		Provider		Period: From 01/01/2015	Worksheet B-1
				Т	o 12/31/2015	Date/Time Prepared:
			INTERNS &	RESI DENTS		5/27/2016 1:53 pm
	Cost Center Description	NURSI NG		SERVI CES-OTHE		
		SCHOOL (ASSI GNED	RY & FRINGES (ASSIGNED	R PRGM COSTS (ASSIGNED	PRGM-PHARMACY RESI DENCY	
		TIME)	TIME)	TIME)	(COSTED	
					REQUIS.)	
		20. 00	21. 00	22.00	23. 00	
	ATIENT SERVICE COST CENTERS			1		
	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	0	0	C	1	88. 00   89. 00
	CLINIC	0			1	90.00
	EMERGENCY	Ö	0	i c	ol ol	91.00
	OBSERVATION BEDS (NON-DISTINCT PART)					92. 00
	R REIMBURSABLE COST CENTERS	_		1 -		
	HOME PROGRAM DIALYSIS	0	0	C		94. 00 95. 00
	AMBULANCE SERVICES DURABLE MEDICAL EQUIP-RENTED	0			1	96.00
	DURABLE MEDICAL EQUIP-SOLD	o o			1	97.00
	OTHER REIMBURSABLE COST CENTERS	Ō	0	d	o	98.00
99.00 09900		0	0	C	o	99.00
99. 10 09910	•	0	0	C	1	99. 10
	O I&R SERVICES-NOT APPRVD PRGM HOME HEALTH AGENCY	0		C		100. 00 101. 00
	AL PURPOSE COST CENTERS	U		1	)  0	101.00
	KIDNEY ACQUISITION	0	0	C	0	105. 00
	HEART ACQUISITION	0	0	C		
	LIVER ACQUISITION	0	0	C		
	LUNG ACQUISITION	0	0	C	1	108.00
	PANCREAS ACQUISITION INTESTINAL ACQUISITION	0	0	C	0	109. 00 110. 00
	ISLET ACQUISITION	0	1 0			111.00
	INTEREST EXPENSE	J			ή	113. 00
114. 00 11400	UTILIZATION REVIEW-SNF					114. 00
	AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0	115. 00
116. 00 11600	•	0	0	C		116.00
118. 00	SUBTOTALS (SUM OF LINES 1-117) EIMBURSABLE COST CENTERS	0	0	C	100	118. 00
	GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	C	0	190. 00
	PROMPTCARE	0	0	c		190. 01
	RENTAL PROPERTIES	0	0	C		190. 02
190. 03 19003		0	0	C	0	190. 03
	PHYSICIAN RECRUITMENT FOUNDATION	0	0			190. 04 190. 05
190. 06 19006		0	1 0			190.03
190. 07 19007		o o			ol ol	190.07
190. 08 19008	B UNUSED SPACE	0	0	C	0	190. 08
	CLINICAL TRIALS	0	0	C	1	190. 09
	MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	C		190. 10
191. 00 19100	PHYSICIANS' PRIVATE OFFICES	0	0	1	1	
	NONPALD WORKERS	0				192.00
	IU HEALTH PAOLI HOSPITAL	o o		1	-	
	I IU HEALTH BEDFORD HOSPITAL	0	0	C		194. 01
	IU HEALTH MORGAN HOSPITAL	0	0	C	0	
	B IU HEALTH SIP	0	0	C	0	194. 03
200. 00 201. 00	Cross Foot Adjustments Negative Cost Centers					200. 00 201. 00
202.00	Cost to be allocated (per Wkst. B,	0	O	d	55, 312	
202. 00	Part I)				33, 312	202.00
203. 00	Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000	0.000000	553. 120000	
204. 00	Cost to be allocated (per Wkst. B,	0	0	· C	781	204. 00
30E 00	Part II)	0.000000	0.00000	0 000000	7 010000	205 00
205. 00	Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000	7. 810000	205. 00
I	1,	!		ı		1

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	1:53 pm

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150051

			'	0 12/31/2013	5/27/2016 1:5	
		Titl	e XVIII	Hospi tal	PPS	
Cost Center Description	Total Cost	Therapy Limit	Total Costs	Costs RCE	Total Costs	
cost center bescription	(from Wkst.	Adj.	Total costs	Di sal I owance	10141 00313	
	B, Part I,	1				
	col. 26)	2.00	2.00	4.00	F 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	2. 00	3. 00	4.00	5. 00	
30. 00 03000 ADULTS & PEDI ATRI CS	53, 630, 455	i	53, 630, 455	7, 039	53, 637, 494	30.00
31.00 03100 INTENSIVE CARE UNIT	6, 813, 550	1	6, 813, 550		6, 813, 550	31.00
32.00 03200 CORONARY CARE UNIT	0	)	0	0	0	32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	1	0	0	0	33.00
34. 00   03400   SURGI CAL   INTENSI VE CARE UNI T 40. 00   04000   SUBPROVI DER -   IPF	0			0	0	34. 00 40. 00
41. 00   04100   SUBPROVI DER -   RF	2, 635, 485		2, 635, 485	0	2, 635, 485	41.00
42. 00   04200   SUBPROVI DER	0		0	0	0	42.00
43. 00   04300   NURSERY	2, 897, 980	)	2, 897, 980	0	2, 897, 980	43.00
44.00   04400   SKILLED NURSING FACILITY	0		0	0	0 0	44.00
45. 00   04500   NURSING FACILITY 46. 00   04600   OTHER LONG TERM CARE				0	0	45. 00 46. 00
ANCI LLARY SERVICE COST CENTERS		1				10.00
50.00 05000 OPERATING ROOM	18, 523, 660	)	18, 523, 660	0	18, 523, 660	1
50. 01   05001 CV SURGERY	0	l .	1 000 407	U	0	50.01
51.00   05100   RECOVERY ROOM 52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 923, 407 8, 438, 218		1, 923, 407 8, 438, 218		1, 923, 407 8, 438, 218	51. 00 52. 00
53. 00   05300   ANESTHESI OLOGY	0, 430, 210		0, 430, 210	0	0, 430, 210	53.00
54. 00   05400 RADI OLOGY-DI AGNOSTI C	7, 222, 097	1	7, 222, 097	0	7, 222, 097	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	6, 334, 587	l .	6, 334, 587	0	6, 334, 587	55. 00
56. 00   05600   RADI OI SOTOPE	1 405 540		1 405 540	0	1 405 570	56.00
57. 00   05700   CT SCAN 58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	1, 405, 560 825, 361		1, 405, 560 825, 361	0	1, 405, 560 825, 361	57. 00 58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	3, 058, 038	<b>1</b>	3, 058, 038	0	3, 058, 038	59.00
60. 00 06000 LABORATORY	13, 380, 551		13, 380, 551		13, 394, 799	60.00
60. 01   06001   BLOOD   LABORATORY	0	)	0	0	0	60. 01
60. 02 06002 PHYSI CLAN LABORATORY	0	1	0	0	0	60.02
61.00   06100   PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS				0	0	61. 00 62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0			0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	166, 546	1	166, 546		166, 546	64.00
65. 00 06500 RESPIRATORY THERAPY	2, 913, 657	1	_, ,		2, 913, 657	65.00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	13, 679, 684	0	13, 679, 684	0	13, 679, 684 0	66. 00 67. 00
68. 00 06800 SPEECH PATHOLOGY				0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 416, 908		1, 416, 908	0	1, 416, 908	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 840, 174	1	1, 840, 174		1, 840, 174	1
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00   07200   MPL. DEV. CHARGED TO PATIENTS	13, 699, 797	1	13, 699, 797		13, 699, 797	
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS 73.00   07300   DRUGS CHARGED TO PATIENTS	15, 871, 676 37, 280, 753	1	15, 871, 676 37, 280, 753		15, 871, 676 37, 280, 753	72. 00 73. 00
74. 00   07400   RENAL DI ALYSI S	1, 034, 710	1	1, 034, 710		1, 034, 710	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	)	0	_	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 231, 372		2, 231, 372			
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	1, 400, 879		1, 400, 879	0	1, 400, 879	76. 97
88. 00 08800 RURAL HEALTH CLINIC	0	)	С	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l .	0	-		89. 00
90. 00   09000   CLI NI C 91. 00   09100   EMERGENCY	2, 550, 534		2, 550, 534			
91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	11, 591, 840 4, 409, 015	1	11, 591, 840 4, 409, 015		11, 591, 840 4, 409, 015	91. 00 92. 00
OTHER REIMBURSABLE COST CENTERS	4, 407, 013	1	4, 407, 013		4, 407, 013	72.00
94.00 09400 HOME PROGRAM DIALYSIS	0		C	0	0	94.00
95. 00 09500 AMBULANCE SERVI CES	8, 643, 084		8, 643, 084	0	8, 643, 084	
96. 00   09600   DURABLE   MEDI CAL   EQUI P-RENTED 97. 00   09700   DURABLE   MEDI CAL   EQUI P-SOLD	0			0	0	96.00
98. 00   09700   DURABLE MEDICAL EQUIP-SOLD  98. 00   09850   OTHER REIMBURSABLE COST CENTERS				0	0	97. 00 98. 00
99. 00   09900   CMHC	0			Ü	Ö	99.00
99. 10   09910   CORF	0	)	0		0	99. 10
100. 00 10000 I &R SERVICES-NOT APPRVD PRGM	0	)	0			
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	9, 303, 598		9, 303, 598		9, 303, 598	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0				0	105.00
106. 00 10600 HEART ACQUI SI TI ON	0	l .			0	106.00
107.00 10700 LIVER ACQUISITION	0		0			107.00
108.00 10800 LUNG ACQUI SI TI ON	0	]				108.00
109. 00 10900 PANCREAS ACQUISITION 110. 00 11000 INTESTINAL ACQUISITION	0					109. 00 110. 00
111. 00 11100 I SLET ACQUISITION						111.00
113.00 11300 INTEREST EXPENSE	<u> </u>	<u> </u>	<u> </u>		<u> </u>	113.00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL				In Lieu of Form CMS-2552-10		
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der	CCN: 150051	Peri od: From 01/01/2015	Worksheet C	
						Date/Time Pre 5/27/2016 1:5	epared: 3 pm
			Ti tl	e XVIII	Hospi tal	PPS	
					Costs		
Cost Center Description	Total Cost	Thera	apy Limit	Total Costs	RCE	Total Costs	
	(from Wkst.		Adj .		Di sal I owance		
	B, Part I,						
	col. 26)						
	1. 00		2. 00	3. 00	4. 00	5. 00	

6, 909, 696 262, 032, 872 4, 409, 015

257, 623, 857

0

6, 909, 696

262, 032, 872 4, 409, 015 257, 623, 857

30, 456

30, 456

114.00 0 115.00

6, 909, 696 116. 00

262, 063, 328 200. 00 4, 409, 015 201. 00 257, 654, 313 202. 00

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

Subtotal (see instructions)
Less Observation Beds

Total (see instructions)

200. 00 201. 00 202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet C
From 01/01/2015	Part
To 12/31/2015	Date/Time Prepared:
5/27/2016	1:53 pm

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150051

						0 12/31/2015	5/27/2016 1:5	
				Charges	e XVIII	Hospi tal	PPS	
		Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	LNDAT	THE POLITIME CERVILOR COCK OF STEEDS	6. 00	7. 00	8. 00	9. 00	10.00	
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	84, 810, 384		84, 810, 384			30.00
31.00		INTENSIVE CARE UNIT	15, 160, 291		15, 160, 291			31.00
32.00		CORONARY CARE UNIT	0		0			32.00
33. 00		BURN INTENSIVE CARE UNIT	0		0			33.00
34.00		SURGICAL INTENSIVE CARE UNIT	0		0			34.00
40. 00 41. 00		SUBPROVI DER - I PF SUBPROVI DER - I RF	4, 190, 982		4, 190, 982			40. 00 41. 00
42. 00		SUBPROVI DER	0		1 4, 170, 702			42.00
43.00	04300	NURSERY	9, 456, 956		9, 456, 956			43.00
44.00		SKILLED NURSING FACILITY	0		0			44.00
45. 00	1	NURSING FACILITY	0		0			45. 00 46. 00
46. 00		OTHER LONG TERM CARE  LARY SERVICE COST CENTERS	<u> </u>		1 0			46.00
50.00		OPERATING ROOM	71, 267, 813	100, 871, 241	172, 139, 054	0. 107609	0. 000000	50.00
50. 01		CV SURGERY	0	0	1		0. 000000	1
51.00		RECOVERY ROOM	6, 892, 780	15, 602, 055			0.000000	
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM  ANESTHESIOLOGY	28, 118, 879 0	1, 931, 555 0		0. 280802 0. 000000	0. 000000 0. 000000	
54. 00		RADI OLOGY-DI AGNOSTI C	11, 565, 731	29, 854, 196	_	0. 174363	0. 000000	54.00
55.00		RADI OLOGY-THERAPEUTI C	3, 392, 793	59, 051, 303	62, 444, 096	0. 101444	0. 000000	1
56.00		RADI OI SOTOPE	0	0	0	0.000000	0.000000	1
57. 00 58. 00		CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	11, 659, 250 2, 966, 850	18, 770, 821 4, 280, 737		0. 046190 0. 113881	0. 000000 0. 000000	1
59. 00		CARDI AC CATHETERI ZATI ON	24, 644, 698	35, 548, 029			0. 000000	
60.00	1	LABORATORY	50, 559, 794	69, 326, 408	119, 886, 202		0. 000000	
60. 01		BLOOD LABORATORY	0	0	0	0.000000	0.000000	
60. 02 61. 00		PHYSICIAN LABORATORY PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0. 000000 0. 000000	0. 000000 0. 000000	60. 02 61. 00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS	Ö	Ö	ő	0. 000000	0. 000000	1
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	0	0	0	0. 000000	0. 000000	1
64.00		I NTRAVENOUS THERAPY	928	734, 696			0. 000000	
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	8, 281, 347 10, 503, 392	1, 610, 313 16, 732, 944			0. 000000 0. 000000	1
67.00		OCCUPATIONAL THERAPY	0 10, 303, 372	10, 732, 744			0. 000000	
68. 00		SPEECH PATHOLOGY	0	0	0	0. 000000	0. 000000	68. 00
69. 00		ELECTROCARDI OLOGY	9, 273, 041	11, 263, 719			0. 000000	•
70. 00 71. 00	1	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 158, 284 19, 587, 159	11, 810, 399 20, 809, 417			0. 000000 0. 000000	70. 00 71. 00
71.00	1	IMPL. DEV. CHARGED TO PATIENTS	51, 675, 569	35, 733, 130			0. 000000	1
73. 00		DRUGS CHARGED TO PATIENTS	66, 638, 401	62, 156, 972			0. 000000	1
74.00		RENAL DIALYSIS	3, 106, 544	0			0. 000000	
75. 00		ASC (NON-DISTINCT PART)	0	0 514 (21	1		0.000000	
		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   CARDI AC REHABI LI TATI ON	20, 220 347, 082	2, 514, 631 2, 387, 095			0. 000000 0. 000000	
, 0. , ,		TIENT SERVICE COST CENTERS	0177002	2,00,,070	27.01717.	0.0.2007	0.00000	70.77
88. 00		RURAL HEALTH CLINIC	0	0				88. 00
89. 00 90. 00		FEDERALLY QUALIFIED HEALTH CENTER   CLINIC	0 33, 045	0 1, 174, 350	_	2. 112427	0. 000000	89. 00 90. 00
91.00		EMERGENCY	14, 425, 901	64, 439, 492			0. 000000	
92.00		OBSERVATION BEDS (NON-DISTINCT PART)	1, 605, 106	12, 079, 251			0. 000000	1
		REIMBURSABLE COST CENTERS	T		1			
94. 00 95. 00		HOME PROGRAM DIALYSIS AMBULANCE SERVICES	0 33, 265	0 35, 323, 275			0. 000000 0. 000000	
96.00	1	DURABLE MEDICAL EQUIP-RENTED	33, 203	33, 323, 273	35, 356, 540	0. 244455	0. 000000	1
97.00		DURABLE MEDICAL EQUIP-SOLD	o	0	0	0. 000000	0. 000000	
98. 00		OTHER REIMBURSABLE COST CENTERS	0	0	0	0. 000000	0. 000000	1
99. 00 99. 10			0	0	0			99. 00 99. 10
		I&R SERVICES-NOT APPRVD PRGM	0	0	_			100.00
	10100	HOME HEALTH AGENCY	0	3, 866, 826	3, 866, 826			101. 00
		AL PURPOSE COST CENTERS			1	I .		
		KIDNEY ACQUISITION	0	0				105. 00 106. 00
		HEART ACQUISITION   LIVER ACQUISITION		0	0			106.00
		LUNG ACQUISITION		0	Ö			108.00
		PANCREAS ACQUISITION	0	0	0			109. 00
		INTESTINAL ACQUISITION	0	0	0			110.00
		ISLET ACQUISITION   INTEREST EXPENSE		O	0			111. 00 113. 00
		UTILIZATION REVIEW-SNF						114.00
			·					

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/27/2016 1:5	epared: 53 pm
		Ti tl	e XVIII	Hospi tal	PPS	
		Charges				
Cost Center Description	Inpatient	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	·		+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00
116. 00 11600 H0SPI CE	0	7, 144, 650	7, 144, 65	0		116.00
200.00 Subtotal (see instructions)	514, 376, 485	625, 017, 505	1, 139, 393, 99	0		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	514, 376, 485	625, 017, 505	1, 139, 393, 99	0		202. 00

Title XVIII

		Title XVIII	Hospi tal	PPS	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDI ATRI CS					30.00
31.00 03100 INTENSIVE CARE UNIT					31.00
32. 00 03200 CORONARY CARE UNIT					32.00
33.00 03300 BURN INTENSIVE CARE UNIT					33.00
34.00 03400 SURGI CAL INTENSI VE 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 O4400 SKILLED NURSING FACILITY					44.00
45.00 O4500 NURSING FACILITY					45. 00
46.00 O4600 OTHER LONG TERM CARE					46. 00
ANCILLARY SERVICE COST CENTERS					
50. 00   05000   OPERATI NG ROOM	0. 107609				50.00
50. 01   05001   CV   SURGERY	0. 000000				50. 01
51.00  05100   RECOVERY ROOM	0. 085504				51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0. 280802				52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 174363				54.00
55. 00  05500  RADI OLOGY-THERAPEUTI C	0. 101444				55.00
56. 00   05600   RADI 0I SOTOPE	0. 000000				56.00
57.00  05700 CT SCAN	0. 046190				57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 113881				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 050804				59.00
60. 00 06000 LABORATORY	0. 111729				60.00
60. 01   06001   BLOOD   LABORATORY	0. 000000				60. 01
60. 02 06002 PHYSI CI AN LABORATORY	0. 000000				60.02
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	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
	1 1				•
	0. 226401				64.00
65. 00 06500 RESPIRATORY THERAPY	0. 294557				65.00
66. 00   06600   PHYSI CAL THERAPY	0. 502259				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. 068994				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 115236				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 339133				71.00
72.00 O7200 MPL. DEV. CHARGED TO PATIENTS	0. 181580				72.00
73.00   07300   DRUGS CHARGED TO PATIENTS	0. 289457				73.00
74. 00   07400   RENAL DI ALYSI S	0. 333074				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000				75.00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 883895				75. 01
76. 97   07697   CARDIAC   REHABILITATION	0. 512359				76. 97
OUTPATIENT SERVICE COST CENTERS					
88.00 08800 RURAL HEALTH CLINIC					88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER					89. 00
90. 00   09000   CLI NI C	2. 112427				90.00
91. 00 09100 EMERGENCY	0. 146983				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 322194				92.00
OTHER REIMBURSABLE COST CENTERS					
94. 00 09400 HOME PROGRAM DIALYSIS	0. 000000				94.00
95. 00 09500 AMBULANCE SERVICES	0. 244455				95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000				96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000				97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000				98.00
99. 00   09900   CMHC	0.00000				99.00
99. 10   09910   CORF					99. 10
100.00 10000 I &R SERVICES-NOT APPRVD PRGM					100.00
101. 00 10100 HOME HEALTH AGENCY					101.00
SPECIAL PURPOSE COST CENTERS					101.00
105. 00 10500 KI DNEY ACQUI SI TI ON					105. 00
106. 00 10600 HEART ACQUISITION					106.00
107. 00 10700 LIVER ACQUISITION					107.00
107.00 10700 EI VER ACQUISITION 108.00 10800 LUNG ACQUISITION	1				
					108.00
109. 00 10900 PANCREAS ACQUISITION					109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON					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.)					115.00
116. 00 11600 H0SPI CE					116. 00

Health Fin	ancial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL	In Lieu	u of Form CMS-	2552-10
COMPUTATIO	ON OF RATIO OF COSTS TO CHARGES		Provider CCN: 150051	Peri od: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/27/2016 1:5	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient				
		Ratio				
		11. 00				
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202 00	Total (see instructions)					202 00

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	1:53 pm

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150051

Title XIX   Hospital   PPS	30. 00 31. 00 32. 00 33. 00 34. 00 40. 00
Cost Center Description  Total Cost (from Wkst. B, Part I, col. 26)  INPATIENT ROUTINE SERVICE COST CENTERS  Total Cost Adj.  Therapy Limit Adj.  Total Costs Disallowance  Adj.  Total Costs Disallowance  Disallowance  Total Costs Adj.  Total Costs Disallowance  Disallowance  Total Costs Disallowance  Disallowance  Total Costs Disallowance  Disallowance  Total Costs Disallowance  Total Costs Disallowance  Disallowance	31.00 32.00 33.00 34.00
B, Part I,	31.00 32.00 33.00 34.00
COI . 26)	31.00 32.00 33.00 34.00
INPATIENT ROUTINE SERVICE COST CENTERS	31.00 32.00 33.00 34.00
	31.00 32.00 33.00 34.00
	31.00 32.00 33.00 34.00
31. 00   03100   I NTENSI VE CARE UNI T   6, 813, 550   6, 813, 550   0   6, 813, 550	33. 00 34. 00
32.00 03200 CORONARY CARE UNIT 0 0 0 0	34.00
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0	
34.00   03400   SURGICAL INTENSIVE CARE UNIT   0   0   0	40.00
40. 00   04000   SUBPROVI DER - I PF   0   0   0   0	
41. 00   04100   SUBPROVI DER -   1RF   2, 635, 485   2, 635, 485   0   2, 635, 485	41.00
42. 00   04200  SUBPROVI DER 0 0 0 0 0	42.00
43. 00   04300   NURSERY	43. 00 44. 00
44.00   04400   SKI LLED NURSING FACILITY   0   0   0   0   45.00   04500   NURSING FACILITY   0   0   0   0   0   0   0   0   0	45.00
46. 00   04600   OTHER LONG TERM CARE   0   0   0	46.00
ANCI LLARY SERVICE COST CENTERS	.0.00
50. 00 05000 OPERATI NG ROOM 18, 523, 660 18, 523, 660 0 18, 523, 660	50.00
50. 01   05001   CV SURGERY   0   0   0	50. 01
51. 00   05100   RECOVERY ROOM   1, 923, 407   1, 923, 407   0   1, 923, 407	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM   8, 438, 218   8, 438, 218   0   8, 438, 218	52.00
53. 00   05300   ANESTHESI OLOGY	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 7, 222, 097 7, 222, 097 0 7, 222, 097 55. 00   05500   RADI OLOGY-THERAPEUTI C 6, 334, 587 6, 334, 587 0 6, 334, 587	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C   6, 334, 587   6, 334, 587   0 6, 334, 587   56. 00   05600   RADI OI SOTOPE   0   0   0   0   0	55. 00 56. 00
57. 00   05700   CT   SCAN	57.00
58.00   05800  MAGNETIC RESONANCE I MAGI NG (MRI)   825, 361   825, 361   0   825, 361	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON 3, 058, 038 3, 058, 038 0 3, 058, 038	59.00
60. 00 06000 LABORATORY 13, 380, 551 13, 380, 551 14, 248 13, 394, 794	60.00
60. 01   06001   BLOOD LABORATORY   0   0   0	60. 01
60. 02   06002   PHYSI CI AN LABORATORY 0 0 0 0	60.02
61. 00   06100  PBP CLINICAL LAB SERVICES-PRGM ONLY   0   0   0   0	61.00
62. 00   06200  WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   0   0   0	62.00
63. 00   06300   BLOOD STORI NG, PROCESSI NG & TRANS.   0   0   0   0   0   0   0   0   0	63. 00 64. 00
65. 00   06500   RESPI RATORY THERAPY   2, 913, 657   0 2, 913, 657   0 2, 913, 657	65.00
66. 00   06600   PHYSI CAL THERAPY   13, 679, 684   0   13, 679, 684   0   13, 679, 684	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0	67. 00
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0	68.00
69. 00   06900   ELECTROCARDI OLOGY   1, 416, 908   1, 416, 908   0   1, 416, 908	69.00
70. 00   07000   ELECTROENCEPHALOGRAPHY 1, 840, 174 1, 840, 174 0 1, 840, 174	70.00
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   13, 699, 797   13, 699, 797   0   13, 699, 797	71.00
72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   15, 871, 676   15, 871, 676   0   15, 871, 676   0   15, 871, 676	72.00
73. 00   07300   DRUGS CHARGED TO PATI ENTS   37, 280, 753   37, 280, 753   0 37, 280, 755   74. 00   07400   RENAL DI ALYSI S   1, 034, 710   1, 034, 710   0 1, 034, 710	73.00
74. 00   07400   RENAL DI ALYSI S   1, 034, 710   1, 034, 710   0   1, 034, 710   0   0   0   0   0   0   0   0   0	74. 00 75. 00
75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   2, 231, 372   2, 231, 372   9, 169   2, 240, 54	
76. 97   07697   CARDI AC REHABI LI TATI ON 1, 400, 879 1, 400, 879 0 1, 400, 879	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   0	89. 00
90. 00   09000   CLINIC   2, 550, 534   2, 550, 534   0 2, 550, 534   11, 504, 046   14, 504, 04	90.00
91. 00   09100   EMERGENCY   11, 591, 840   11, 591, 840   0   11, 591, 840   0   14, 400, 045   0   0   0   0   0   0   0   0   0	91.00
92. 00   09200  0BSERVATI ON BEDS (NON-DI STI NCT PART)   4, 409, 015   4, 409, 015   4, 409, 015   4, 409, 015	92.00
94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0	94.00
95. 00   09500   AMBULANCE SERVI CES   8, 643, 084   8, 643, 084   0   8, 643, 084	95. 00
96. 00   09600  DURABLE MEDICAL EQUIP-RENTED   0   0   0	96.00
97. 00   09700   DURABLE MEDICAL EQUIP-SOLD   0   0   0   0	97.00
98.00   09850   OTHER REIMBURSABLE COST CENTERS   0   0   0	98.00
99. 00   09900   CMHC   0   0	99.00
99. 10   09910   CORF	99. 10
100.00 10000   1 &R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	100.00
101. 00 10100 HOME HEALTH AGENCY 9, 303, 598 9, 303, 598 9, 303, 598 9, 303, 598	101.00
	105. 00
	106.00
	107.00
108.00 10800 LUNG ACQUISITION 0 0 0	108. 00
	109. 00
	110.00
	111.00
113. 00 11300 INTEREST EXPENSE	113. 00

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2015 To 12/31/2015		pared:
		Tit	le XIX	Hospi tal	PPS	о рііі
				Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	RCE Di sal I owance	Total Costs	
	1. 00	2.00	3. 00	4. 00	5. 00	
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 116.00 11600 HOSPICE 200.00 Subtotal (see instructions) 201.00 Less Observation Beds 202.00 Total (see instructions)	6, 909, 696 262, 032, 872 4, 409, 015 257, 623, 857	0	4, 409, 01	2 30, 456	6, 909, 696 262, 063, 328 4, 409, 015	200. 00 201. 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	1:53 pm

COMPUTATION OF RATIO OF COSTS TO CHARGES Provi der CCN: 150051

						0 12/31/2015	5/27/2016 1:5	
				Tit Charges	le XIX	Hospi tal	PPS	
		Cost Center Description	I npati ent	Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
	Lubar	LEUT DOUTLINE OFDIN OF COOT OFNITEDO	6. 00	7. 00	8.00	9. 00	10.00	
30. 00		I ENT ROUTINE SERVICE COST CENTERS ADULTS & PEDIATRICS	84, 810, 384		84, 810, 384			30.00
31.00		INTENSIVE CARE UNIT	15, 160, 291		15, 160, 291			31.00
32.00		CORONARY CARE UNIT	0		0			32.00
33. 00		BURN INTENSIVE CARE UNIT	0		0			33.00
34.00		SURGICAL INTENSIVE CARE UNIT	0		0			34.00
40. 00 41. 00		SUBPROVI DER - I PF SUBPROVI DER - I RF	4, 190, 982		4, 190, 982			40. 00 41. 00
42. 00		SUBPROVI DER	4, 170, 702		1 4, 170, 702			42.00
43.00	04300	NURSERY	9, 456, 956		9, 456, 956			43.00
44.00		SKILLED NURSING FACILITY	0		0			44.00
45. 00	1	NURSING FACILITY	0		0			45. 00 46. 00
46. 00		OTHER LONG TERM CARE  LARY SERVICE COST CENTERS	<u> </u>		1 0			46.00
50.00		OPERATI NG ROOM	71, 267, 813	100, 871, 241	172, 139, 054	0. 107609	0. 000000	50.00
50. 01		CV SURGERY	0	0	1		0. 000000	1
51.00		RECOVERY ROOM	6, 892, 780	15, 602, 055			0.000000	
52. 00 53. 00		DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	28, 118, 879 0	1, 931, 555 0		0. 280802 0. 000000	0. 000000 0. 000000	
54. 00		RADI OLOGY-DI AGNOSTI C	11, 565, 731	29, 854, 196	_	0. 174363	0. 000000	54.00
55.00		RADI OLOGY-THERAPEUTI C	3, 392, 793	59, 051, 303	62, 444, 096	0. 101444	0. 000000	1
56.00		RADI OI SOTOPE	0	10 770 001	0	0.000000	0.000000	1
57. 00 58. 00		CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	11, 659, 250 2, 966, 850	18, 770, 821 4, 280, 737		0. 046190 0. 113881	0. 000000 0. 000000	1
59. 00		CARDI AC CATHETERI ZATI ON	24, 644, 698	35, 548, 029			0. 000000	
60.00	1	LABORATORY	50, 559, 794	69, 326, 408	119, 886, 202		0. 000000	
60. 01		BLOOD LABORATORY	0	0	0	0.000000	0.000000	
60. 02 61. 00		PHYSICIAN LABORATORY   PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0. 000000 0. 000000	0. 000000 0. 000000	60. 02 61. 00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELLS		0	ő	0. 000000	0. 000000	1
63.00	06300	BLOOD STORING, PROCESSING & TRANS.	О	0	0	0. 000000	0. 000000	1
64.00		I NTRAVENOUS THERAPY	928	734, 696			0. 000000	
65. 00 66. 00		RESPI RATORY THERAPY PHYSI CAL THERAPY	8, 281, 347 10, 503, 392	1, 610, 313 16, 732, 944			0. 000000 0. 000000	1
67.00		OCCUPATI ONAL THERAPY	0	10, 732, 744			0. 000000	
68. 00		SPEECH PATHOLOGY	o	0	0	0. 000000	0. 000000	68. 00
69. 00		ELECTROCARDI OLOGY	9, 273, 041	11, 263, 719			0. 000000	•
70. 00 71. 00	1	ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENTS	4, 158, 284 19, 587, 159	11, 810, 399 20, 809, 417			0. 000000 0. 000000	70. 00 71. 00
71.00	1	IMPL. DEV. CHARGED TO PATIENTS	51, 675, 569	35, 733, 130			0. 000000	1
73. 00		DRUGS CHARGED TO PATIENTS	66, 638, 401	62, 156, 972			0. 000000	1
74.00		RENAL DIALYSIS	3, 106, 544	0			0. 000000	
75. 00		ASC (NON-DISTINCT PART)	0	0 514 (21	1		0.000000	
		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES CARDI AC REHABI LI TATI ON	20, 220 347, 082	2, 514, 631 2, 387, 095			0. 000000 0. 000000	
, 0. , ,		TIENT SERVICE COST CENTERS	0177 002	2,00,,070	27.01717.	0.0.2007	0.00000	70.77
88. 00		RURAL HEALTH CLINIC	0	0			0. 000000	1
89. 00 90. 00		FEDERALLY QUALIFIED HEALTH CENTER	0 33, 045	0 1, 174, 350		0.000000	0. 000000 0. 000000	1
91.00		EMERGENCY	14, 425, 901	64, 439, 492			0. 000000	
92.00		OBSERVATION BEDS (NON-DISTINCT PART)	1, 605, 106	12, 079, 251			0. 000000	
04.00		REIMBURSABLE COST CENTERS		_	I -	0.00005=	0.00005	04.55
94. 00 95. 00	1	HOME PROGRAM DIALYSIS AMBULANCE SERVICES	0 33, 265	0 35, 323, 275			0. 000000 0. 000000	94. 00 95. 00
96.00		DURABLE MEDICAL EQUIP-RENTED	33, 203	03, 323, 273	35, 330, 340	0. 244433	0. 000000	1
97.00	1	DURABLE MEDICAL EQUIP-SOLD	o	0	0		0. 000000	
98. 00		OTHER REIMBURSABLE COST CENTERS	0	0	0	0. 000000	0. 000000	1
99. 00 99. 10		•	0	0	0			99. 00 99. 10
		I&R SERVICES-NOT APPRVD PRGM		0				100.00
	10100	HOME HEALTH AGENCY	ō	3, 866, 826	3, 866, 826			101. 00
		AL PURPOSE COST CENTERS			1	I .		
		KIDNEY ACQUISITION HEART ACQUISITION	0	0				105. 00 106. 00
		LIVER ACQUISITION		0	0			107.00
		LUNG ACQUISITION		0	Ö			108.00
		PANCREAS ACQUISITION	0	0	0			109. 00
		INTESTINAL ACQUISITION	0	0	0			110.00
		ISLET ACQUISITION   INTEREST EXPENSE	ا	0	0			111. 00 113. 00
		UTILIZATION REVIEW-SNF						114.00

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2015 To 12/31/2015		epared:
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	I npati ent	Charges Outpati ent	Total (col. 6 + col. 7)	Cost or Other Ratio	TEFRA I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10. 00	
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 116.00 11600 HOSPICE	0	7, 144, 650	) 7, 144, 65	0		115. 00 116. 00
200.00 Subtotal (see instructions) 201.00 Less Observation Beds	514, 376, 485	625, 017, 505	1, 139, 393, 99	0		200. 00 201. 00
202.00 Total (see instructions)	514, 376, 485	625, 017, 505	1, 139, 393, 99	o		202. 00

		T: +I - VIV	11: 4-1	5/27/2016 1:53 pm
Cost Center Description	PPS Inpatient	Title XIX	Hospi tal	PPS
oost denter beserver on	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				20.00
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   NTENSI VE CARE UNI T				30.00
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 -   I RF 42. 00   04200   SUBPROVI DER				41.00
43. 00   04300   NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44.00
45.00 04500 NURSING FACILITY				45. 00
46. 00 O4600 OTHER LONG TERM CARE				46. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	0. 107609			50.00
50. 01   05001   CV   SURGERY	0. 000000			50.00
51. 00   05100   RECOVERY ROOM	0. 085504			51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 280802			52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 174363			54. 00 55. 00
56. 00   05600   RADI 0LOGY - THERAPEUTI C	0. 101444 0. 000000			56.00
57. 00 05700 CT SCAN	0. 046190			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 113881			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 050804			59.00
60. 00   06000   LABORATORY	0. 111729			60.00
60. 01   06001   BL00D LABORATORY 60. 02   06002   PHYSI CLAN LABORATORY	0. 000000 0. 000000			60. 01
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	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. 226401			64.00
65. 00   06500   RESPI RATORY THERAPY 66. 00   06600   PHYSI CAL THERAPY	0. 294557 0. 502259			65. 00 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. 068994			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 115236			70.00
71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS 72.00   07200   IMPL. DEV. CHARGED TO PATIENTS	0. 339133 0. 181580			71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 181380			73.00
74. 00   07400   RENAL DI ALYSI S	0. 333074			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 883895			75. 01
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	0. 512359			76. 97
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	2. 112427			90.00
91. 00   09100   EMERGENCY	0. 146983			91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0. 322194			92. 00
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000			94.00
95. 00 09500 AMBULANCE SERVICES	0. 244455			95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000			97. 00
98. 00   09850   OTHER REIMBURSABLE COST CENTERS 99. 00   09900   CMHC	0. 000000			98. 00 99. 00
99. 10   09910 CORF				99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM				100.00
101.00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				105
105. 00 10500 KI DNEY ACQUI SI TI ON				105. 00 106. 00
106. 00 10600 HEART ACQUISITION 107. 00 10700 LIVER ACQUISITION				106.00
108. 00 10800 LUNG ACQUISITION				108.00
109.00 10900 PANCREAS ACQUISITION				109. 00
110. 00 11000 INTESTINAL ACQUISITION				110.00
111. 00 11100   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
·	•			· · ·

Health Financial Systems	IU HEALTH BLOOMI	NGTON	ON HOSPITAL In Lieu of Form CMS			2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES			Provi der CCN: 150051	Peri od: From 01/01/2015	Worksheet C	
					Part I Date/Time Pro 5/27/2016 1:	
			Title XIX	Hospi tal	PPS	
Cost Center Description	PPS Inpatient					
	Ratio					
	11. 00					
200.00 Subtotal (see instructions)						200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)						202.00

Health Financial Systems IU HEALTH BLOOM CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Peri od: Worksheet C From 01/01/2015 Part II To 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm Provi der CCN: 150051 REDUCTIONS FOR MEDICALD ONLY

					12,01,2010	5/27/2016 1:5	3 pm
				le XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost	Capital Cost	Operati ng	Capi tal	Operati ng	
		(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
		Part I, col.	Part II col.	Capital Cost		Reduction	
		26)	26)	(col. 1 -		Amount	
		4.00	0.00	col . 2)	4 00	F 00	
	ANCILLARY SERVICE COST CENTERS	1. 00	2. 00	3. 00	4. 00	5. 00	
50.00	05000 OPERATING ROOM	18, 523, 660	2, 387, 249	16, 136, 411	0	0	50.00
	05000 OPERATTING ROOM	10, 523, 000	2, 307, 249		0		50.00
	05100 RECOVERY ROOM	1, 923, 407	_	_	0	0	51.00
	05200 DELIVERY ROOM & LABOR ROOM	8, 438, 218	1		0	ĺ	52.00
	05300 ANESTHESI OLOGY	0, 100, 210	1,011,770	0,720,120	0	Ö	53.00
	05400 RADI OLOGY-DI AGNOSTI C	7, 222, 097	917, 769	6, 304, 328	0	0	54.00
	05500 RADI OLOGY-THERAPEUTI C	6, 334, 587			O	0	55.00
56.00	05600 RADI 0I S0T0PE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	1, 405, 560	78, 527	1, 327, 033	0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	825, 361	86, 632	738, 729	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	3, 058, 038	327, 614	2, 730, 424	0	0	59.00
60.00	06000 LABORATORY	13, 380, 551	840, 162	12, 540, 389	0	0	60.00
	06001 BLOOD LABORATORY	0	0	0	0	0	60. 01
	06002 PHYSICIAN LABORATORY	0	0	0	0	0	60. 02
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	0	0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0	0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	63.00
	06400 I NTRAVENOUS THERAPY	166, 546			0	0	64.00
	06500 RESPI RATORY THERAPY	2, 913, 657			0	0	65.00
	06600 PHYSI CAL THERAPY	13, 679, 684	1, 057, 679	12, 622, 005	0	0	66.00
4	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
	06800  SPEECH PATHOLOGY 06900  ELECTROCARDI OLOGY	1 414 000	125 702	1 201 205	0	0 0	68. 00 69. 00
	07000 ELECTROCARDI OLOGI 07000 ELECTROENCEPHALOGRAPHY	1, 416, 908 1, 840, 174	1		0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 699, 797			0		70.00
4	07200 IMPL. DEV. CHARGED TO PATIENTS	15, 871, 676			0	Ö	72.00
	07300 DRUGS CHARGED TO PATIENTS	37, 280, 753	1		0	Ö	73.00
	07400 RENAL DIALYSIS	1, 034, 710			0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 231, 372	181, 968	2, 049, 404	0	0	75. 01
	07697 CARDI AC REHABI LI TATI ON	1, 400, 879	172, 201	1, 228, 678	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS				ما		00.00
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	l	
	09000 CLINIC	2, 550, 534	_	_	0	0	90.00
	09100 EMERGENCY	11, 591, 840			0	0	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 409, 015			0	0	92.00
-	OTHER REIMBURSABLE COST CENTERS		, , , , , , , , , , , , , , , , , , , ,		- 1		
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
	09500 AMBULANCE SERVICES	8, 643, 084	618, 045	8, 025, 039	0	0	95.00
	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	
	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	
	09850 OTHER REIMBURSABLE COST CENTERS 09900 CMHC	0	0	1	0	0	
	09910 CORF	0	0	- 1	0		99. 00 99. 10
	10000 I&R SERVICES-NOT APPRVD PRGM	0		1	0		100.00
4	10100 HOME HEALTH AGENCY	9, 303, 598		- 1	0	l e	101.00
	SPECIAL PURPOSE COST CENTERS	7,000,070	701,707	0,001,027			1101.00
	10500 KI DNEY ACQUI SI TI ON	0	0	0	0	0	105.00
106.00	10600 HEART ACQUISITION	0	0	0	0	0	106.00
	10700 LIVER ACQUISITION	0	0	0	0	0	107.00
	10800 LUNG ACQUISITION	0	0	0	0		108. 00
4	10900 PANCREAS ACQUISITION	0	0	0	0		109.00
	11000 INTESTINAL ACQUISITION	0	0	0	0		110.00
	11100   SLET ACQUISITION	0	0	0	0	0	111.00
	11300 INTEREST EXPENSE 11400 UTILIZATION REVIEW-SNF	1					113. 00 114. 00
	11500 AMBULATORY SURGICAL CENTER (D.P.)		_		Λ	0	115.00
	11600 HOSPI CE	6, 909, 696	497, 136	6, 412, 560	n		116.00
200.00	Subtotal (sum of lines 50 thru 199)	196, 055, 402	· ·		o		200.00
201.00	Less Observation Beds	4, 409, 015			0	0	201.00
202. 00	Total (line 200 minus line 201)	191, 646, 387			O	0	202. 00

Health Financial Systems IU HEALTH BLOOCALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF Peri od: Worksheet C From 01/01/2015 Part II To 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm Provi der CCN: 150051 REDUCTIONS FOR MEDICALD ONLY

		T1.			5/27/2016 1:5	3 pm
			le XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and	(Worksheet C,	Cost to			
	Operati ng	Part I,	Charge Ratio			
	Cost	column 8)	(col. 6 /			
	Reducti on		col. 7)			
	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	18, 523, 660	172, 139, 054	0. 107609			50.00
50. 01   05001   CV   SURGERY	0	0	0.000000			50. 01
51.00   05100   RECOVERY ROOM	1, 923, 407	22, 494, 835				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	8, 438, 218					52.00
53. 00   05300   ANESTHESI OLOGY	0, 430, 210		0. 000000			53.00
	-	1				
54. 00   05400   RADI OLOGY - DI AGNOSTI C	7, 222, 097					54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	6, 334, 587					55.00
56. 00   05600   RADI OI SOTOPE	0	1	0.00000			56.00
57. 00  05700   CT   SCAN	1, 405, 560		0. 046190			57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	825, 361					58. 00
59. 00  05900  CARDI AC CATHETERI ZATI ON	3, 058, 038	60, 192, 727	0. 050804			59.00
60. 00   06000   LABORATORY	13, 380, 551	119, 886, 202	0. 111610			60.00
60. 01   06001   BLOOD LABORATORY	0	0	0.000000			60. 01
60. 02 06002 PHYSI CLAN LABORATORY	0	0	0. 000000			60.02
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0				61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		١	0. 000000			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63.00
	-	1				
64. 00 06400 I NTRAVENOUS THERAPY	166, 546					64.00
65. 00 06500 RESPI RATORY THERAPY	2, 913, 657					65.00
66. 00 06600 PHYSI CAL THERAPY	13, 679, 684					66.00
67. 00  06700 OCCUPATI ONAL THERAPY	0					67.00
68.00   06800   SPEECH PATHOLOGY	0	0	0. 000000			68.00
69. 00   06900   ELECTROCARDI OLOGY	1, 416, 908	20, 536, 760	0. 068994			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 840, 174	15, 968, 683	0. 115236			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	13, 699, 797					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	15, 871, 676					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	37, 280, 753					73.00
74. 00 07400 RENAL DIALYSIS	1, 034, 710					74.00
	1					
75. 00 07500 ASC (NON-DISTINCT PART)	0		0.000000			75.00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	2, 231, 372					75. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 400, 879	2, 734, 177	0. 512359			76. 97
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
89.00  08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 000000			89. 00
90. 00  09000   CLI NI C	2, 550, 534	1, 207, 395	2. 112427			90.00
91. 00   09100   EMERGENCY	11, 591, 840	78, 865, 393	0. 146983			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 409, 015	13, 684, 357	0. 322194			92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0. 000000			94.00
95. 00 09500 AMBULANCE SERVICES	8, 643, 084	_				95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0, 043, 004		0. 000000			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	-	1				97.00
	0		0.000000			
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 000000			98.00
99. 00   09900   CMHC	0	0	0. 000000			99.00
99. 10   09910   CORF	0					99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	-	0. 000000			100.00
101.00 10100 HOME HEALTH AGENCY	9, 303, 598	3, 866, 826	2. 406004			101.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0.000000			105.00
106. 00 10600 HEART ACQUISITION	0	0	0.000000			106.00
107. 00 10700 LIVER ACQUISITION	0	ł .	0. 000000			107.00
108. 00 10800 LUNG ACQUISITION	0	0	0. 000000			108.00
109. 00 10900 PANCREAS ACQUISITION		١	0. 000000			109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON			0. 000000			110.00
111.00 11100 I SLET ACQUI SI TI ON			0. 000000			111.00
113. 00 11300   INTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	_	_				114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0.000000			115.00
116. 00 11600 HOSPI CE	6, 909, 696					116. 00
200.00 Subtotal (sum of lines 50 thru 199)		1, 025, 775, 377				200. 00
201.00 Less Observation Beds	4, 409, 015					201. 00
202.00 Total (line 200 minus line 201)	191, 646, 387	1, 025, 775, 377				202. 00
			'			

Health Financial Systems  APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	IU HEALTH BLOOMI TAL COSTS			Peri od:	u of Form CMS-: Worksheet D	2552-10
				From 01/01/2015	Part I	
				To 12/31/2015	Date/Time Pre 5/27/2016 1:5	epared:
		Ti tl	e XVIII	Hospi tal	PPS	о рііі
Cost Center Description	Capi tal	Swi ng Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col. 2)			
	1. 00	2.00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	6, 095, 337		0,0,0,00		124. 64	
31.00   INTENSIVE CARE UNIT	596, 988		596, 98	8 3, 949	151. 17	
32. 00 CORONARY CARE UNIT	0	)		0 0	0. 00	
33.00 BURN INTENSIVE CARE UNIT	0	)		0	0.00	
34.00 SURGICAL INTENSIVE CARE UNIT	0	)		0	0. 00	
40. 00 SUBPROVI DER - I PF	0	0	1	0 0	0. 00	
41. 00 SUBPROVI DER - I RF	539, 001	0	539, 00	1 2, 821	191. 07	41.00
42. 00 SUBPROVI DER	0	0		0 0	0.00	42.00
43. 00 NURSERY	289, 729	y e	289, 72	9 4, 718	61. 41	43.00
44.00 SKILLED NURSING FACILITY	0	)		0 0	0.00	44.00
45.00 NURSING FACILITY	0	)		0 0	0.00	45.00
200.00 Total (lines 30-199)	7, 521, 055		7, 521, 05	5 60, 393		200.00
Cost Center Description	I npati ent	I npati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	19, 337	, , , , , ,				30.00
31.00 INTENSIVE CARE UNIT	2, 648	400, 298				31.00
32. 00   CORONARY CARE UNIT	0	0				32.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33.00
34.00 SURGICAL INTENSIVE CARE UNIT	0	0				34.00
40. 00 SUBPROVI DER - I PF	0	0				40.00
41. 00 SUBPROVI DER - I RF	1, 734	331, 315				41.00
42. 00 SUBPROVI DER	0	0				42.00
43 00 NURSERY						43 00

41.00 42. 00 43. 00 44. 00

45. 00 200. 00

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

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL	-	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 150051	Peri od:	Worksheet D	
				From 01/01/2015	Part II	nonod.
				To 12/31/2015	Date/Time Pre 5/27/2016 1:5	pareu: 3 nm
		Ti tl	e XVIII	Hospi tal	PPS	о рііі
Cost Center Description	Capi tal	Total Charges			Capital Costs	
0001 001101 20001 pt 011	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)		,	
	col. 26)	,	,			
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	2, 387, 249	172, 139, 054			471, 659	50.00
50. 01  05001  CV SURGERY	0	0	0. 00000		0	50. 01
51.00  05100   RECOVERY ROOM	174, 267	22, 494, 835			25, 432	
52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 514, 795	30, 050, 434			7, 737	
53. 00   05300   ANESTHESI OLOGY	0	0	0. 00000		0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	917, 769	41, 419, 927			137, 954	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	966, 534	62, 444, 096			33, 493	
56. 00   05600   RADI OI SOTOPE	0	0	0. 00000		0	56.00
57. 00   05700   CT   SCAN	78, 527	30, 430, 071	0. 00258		14, 934	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	86, 632	7, 247, 587			16, 444	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	327, 614	60, 192, 727			59, 492	59.00
60. 00   06000   LABORATORY	840, 162	119, 886, 202			163, 282	
60. 01 06001 BLOOD LABORATORY	0	0	0.00000		0	60. 01
60. 02 06002 PHYSI CI AN LABORATORY	0	0	0. 00000	00	0	60.02
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	_	_			_	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000		0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	3, 750	735, 624			4	64.00
65. 00 06500 RESPI RATORY THERAPY	118, 542	9, 891, 660			57, 413	
66. 00 06600 PHYSI CAL THERAPY	1, 057, 679	27, 236, 336			117, 145	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000		0	67.00
68. 00   06800   SPEECH PATHOLOGY 69. 00   06900   ELECTROCARDI OLOGY	125 703	0 524 740	0.00000		0	68.00
69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOGRAPHY	135, 703	20, 536, 760	1		34, 447	69.00
71. 00   07000  ELECTROENCEPHALOGRAPHY 71. 00   07100  MEDICAL SUPPLIES CHARGED TO PATIENTS	169, 065 226, 822	15, 968, 683 40, 396, 576			22, 821 51, 393	70.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	270, 310	87, 408, 699			82, 071	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	870, 193	128, 795, 373			205, 076	73.00
74. 00   07400   RENAL DI ALYSI S	44, 466	3, 106, 544			203, 070	74.00
75. 00   07500   ASC (NON-DISTINCT PART)	144, 400	3, 100, 344	0.00000		21, 747	75.00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	181, 968	2, 534, 851	1		723	75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	172, 201	2, 734, 177			10, 457	76. 97
OUTPATIENT SERVICE COST CENTERS	172,201	2,754,177	0.00270	100,032	10, 437	70.77
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.00000	00 0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000		0	89.00
90. 00   09000   CLINIC	174, 817	1, 207, 395	1		3, 921	90.00
91. 00   09100   EMERGENCY	1, 313, 165	78, 865, 393			125, 208	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	501, 036	13, 684, 357			33, 636	92.00
OTHER REIMBURSABLE COST CENTERS					22, 222	
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	00 0	0	94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	О	0. 00000	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	Ō	0.00000		0	97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0.00000		0	98.00
200.00 Total (lines 50-199)	12, 533, 266	979, 407, 361		178, 615, 950	1, 696, 489	200.00

Health Financial Systems	J HEALTH BLOOMIN	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST	ΓS Provi der		Peri od:	Worksheet D	
				From 01/01/2015 To 12/31/2015	Part III	nonod.
				To 12/31/2015	Date/Time Pre 5/27/2016 1:5	pareu: 3 nm
		Ti tl	e XVIII	Hospi tal	PPS	о ріп
Cost Center Description	Nursi ng .	Allied Health	All Other	Swi ng-Bed	Total Costs	
, , , , , , , , , , , , , , , , , , ,	School	Cost	Medi cal	Adjustment	(sum of cols.	
			Educati on	Amount (see	1 through 3,	
			Cost	instructions)	minus col. 4)	
	1. 00	2.00	3.00	4.00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		0	0	31.00
32. 00 03200 CORONARY CARE UNIT	0	0		0	0	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 - 1 PF	0	0		0	0	40.00
41. 00   04100   SUBPROVI DER - I RF	O	0		0	0	41.00
42. 00   04200   SUBPROVI DER	0	0		0 0	0	42.00
43. 00   04300   NURSERY	O	0		0	0	43.00
44.00 04400 SKILLED NURSING FACILITY	O	0		0	0	44.00
45.00 04500 NURSING FACILITY	O	0		0	0	45.00
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem	I npati ent	I npati ent		
	Days	(col. 5 ÷	Program Days	Program		
		col. 6)		Pass-Through		
				Cost (col. 7		
				x col. 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS	40.005	0.00	10.00	7		00.00
30. 00 03000 ADULTS & PEDIATRICS	48, 905	0.00				30.00
31. 00   03100   INTENSI VE CARE UNI T	3, 949	0.00				31.00
32. 00 03200 CORONARY CARE UNIT	0	0.00		0		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0	0.00		0		33.00
34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0	0.00		0		34.00
40. 00   04000   SUBPROVI DER -   PF	0 001	0.00		0		40.00
41. 00   04100   SUBPROVI DER -   I RF	2, 821	0.00		4 0		41.00
42. 00   04200   SUBPROVI DER	0	0.00		0		42.00
43. 00   04300   NURSERY	4, 718	0.00		0		43.00
44. 00 04400 SKILLED NURSING FACILITY	0	0.00		0		44.00
45. 00 04500 NURSING FACILITY	(0.000)	0. 00		0		45.00
200.00   Total (lines 30-199)	60, 393		23, 71	9 0		200.00

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2015	Part IV
To 12/31/2015	Date/Time Prepared:
5/27/2016 1:53 pm	Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider ( Provi der CCN: 150051 THROUGH COSTS

					.0 12,01,2010	5/27/2016 1:5	3 pm
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Allied Healt	h All Other	Total Cost	
		Anesthetist	School		Medi cal	(sum of col 1	
		Cost			Educati on	through col.	
					Cost	4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0		0	0	50.00
50. 01	05001 CV SURGERY	0	0		0	0	50. 01
51.00	05100 RECOVERY ROOM	0	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	o	0		0	0	55.00
56.00	05600 RADI OI SOTOPE	o	0		0	0	56.00
57.00	05700 CT SCAN	o	0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	o	0		0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	o	0		0	0	59.00
60.00	06000 LABORATORY	o	0		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	0	60. 01
60. 02	06002 PHYSICIAN LABORATORY	0	0		0	0	60.02
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.		0		0	1	63.00
64. 00	06400 I NTRAVENOUS THERAPY		0		0		64.00
65. 00	06500 RESPIRATORY THERAPY		0		0	ol ö	65. 00
66. 00	06600 PHYSI CAL THERAPY		0		0	1	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0		0		67. 00
68. 00	06800 SPEECH PATHOLOGY		0				68. 00
69. 00	06900 ELECTROCARDI OLOGY		0		0	1	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY		0		0	1	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0		71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0				71.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0		0	1	73.00
74.00	07400 RENAL DIALYSIS		0		0	1	74.00
75. 00	07500 ASC (NON-DISTINCT PART)		0		0	1	74. 00 75. 00
75. 00 75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0		0	1	75. 00 75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON		0		0		76. 97
70. 77	OUTPATIENT SERVICE COST CENTERS	l o			U	)  0	70. 77
88. 00	08800 RURAL HEALTH CLINIC	0	0		0 0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0	•	0		89. 00
90.00	09000 CLINIC	0	0		0		90.00
91.00	09100 EMERGENCY	0	0		0	1	90.00
91.00	1 1		0		0	1	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	l ol			U	)  0	92.00
94. 00	09400 HOME PROGRAM DI ALYSIS	0	0		0 0	0	94. 00
95.00	09500 AMBULANCE SERVICES		Ü			Ί	94. 00 95. 00
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED		0		0	0	95. 00 96. 00
96.00	09700 DURABLE MEDICAL EQUIP-RENTED		0			1	96.00 97.00
98.00	1 1		0		-	1	
98. 00 200. 00	O9850 OTHER REIMBURSABLE COST CENTERS   Total (lines 50-199)		0		0 0	1	98. 00 200. 00
∠∪∪. ∪(	ol lintai (iiiles 50-199)	ı V	Ü	1	Ol (	ין	200.00

 
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGT

 APPORTIONMENT
 OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 | Peri od: | Worksheet D | From 01/01/2015 | Part IV | To | 12/31/2015 | Date/Time | Prepared: | From 01/01/2014 | From 01/2014 rovi der CCN: 150051 THROUGH COSTS

				'	0 12/31/2013	5/27/2016 1:5	
			Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati ent	
	·	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
		Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
		col . 2, 3 and	col. 8)	col. 7)	(col. 6 ÷	Ŭ	
		4)			col. 7)		
		6. 00	7. 00	8. 00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS			,			
50. 00	05000 OPERATING ROOM	0	172, 139, 054			34, 010, 587	50.00
50. 01	05001 CV SURGERY	0			· •	0	50. 01
51.00	05100 RECOVERY ROOM	0				3, 282, 854	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	30, 050, 434		I I	153, 487	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0. 000000		0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	41, 419, 927		I I	6, 225, 911	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	62, 444, 096			2, 163, 901	55.00
56.00	05600 RADI OI SOTOPE	0	0 400 074	0.000000	I	0	56.00
57.00	05700 CT SCAN	0	30, 430, 071	0.000000		5, 786, 212	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	7, 247, 587		l I	1, 375, 712	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0	60, 192, 727			10, 930, 010	59.00
60.00		0	119, 886, 202		l I	23, 299, 401	60.00
60. 01	06001 BLOOD LABORATORY	0	0		l I	0	60.01
60.02	O6002   PHYSI CI AN LABORATORY   O6100   PBP   CLINI CAL LAB   SERVI CES-PRGM   ONLY	0	U	0. 000000	0.000000	0	60. 02 61. 00
61. 00 62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 000000	0. 000000	0	62.00
63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0	63.00
64. 00	06400 I NTRAVENOUS THERAPY		Ĭ		I I	870	64.00
65. 00	06500 RESPIRATORY THERAPY	0	9, 891, 660		I I	4, 790, 779	65.00
66. 00	06600 PHYSI CAL THERAPY	0	27, 236, 336			3, 016, 633	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	27, 230, 330	1		3, 010, 033	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	•	· •	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	-	•		5, 212, 856	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	15, 968, 683	•	· •	2, 155, 527	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	40, 396, 576			9, 152, 824	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0		•	1	26, 543, 003	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	128, 795, 373	0. 000000	0. 000000	30, 354, 708	73.00
74.00	07400 RENAL DIALYSIS	0	3, 106, 544		0. 000000	1, 519, 312	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	1		0	75.00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	2, 534, 851	0. 000000	0.000000	10, 068	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	2, 734, 177	0. 000000	0.000000	166, 032	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	1, 207, 395			27, 084	90.00
91.00	09100 EMERGENCY	0			l I	7, 519, 522	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	13, 684, 357	0. 000000	0. 000000	918, 657	92.00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	0. 000000	0. 000000	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	0.00000	I I	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	070 407 241	0. 000000	0. 000000	170 (15 050	98.00
200.00	Total (lines 50-199)	0	979, 407, 361	I	ı I	178, 615, 950	<b>∠</b> 00.00

THROUGH COSTS

Inpatient
Program   Program   Program   Program   Program   Program   Program   Pass-Through Costs (col 8 x col 10)   11.00   12.00   13.00   10.00   13.00   10.00
Pass-Through Costs (col   8 x col   10)
ANCILLARY SERVICE COST CENTERS
ANCILLARY SERVICE COST CENTERS   11.00   12.00   13.00
ANCILLARY SERVICE COST CENTERS   11.00   12.00   13.00
ANCILLARY SERVICE COST CENTERS
ANCI LLARY SERVICE COST CENTERS   St.
50.00
50. 01   05001   07 SURGERY   0   0   0   0   55. 01
51.00   05100   RECOVERY ROOM   0   3, 286, 828   0   51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM   0   18,002   0   52.00   53. 00   05300   ANESTHESI OLOGY   0   0   0   0   53. 00   05400   RADI OLOGY-DI AGNOSTI C   0   10, 315, 667   0   55. 00   05500   RADI OLOGY-THERAPEUTI C   0   28, 326, 361   0   55. 00   05500   RADI OLOGY-THERAPEUTI C   0   28, 326, 361   0   57. 00   05700   CT SCAN   0   0   0   58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI )   0   1, 158, 409   0   59. 00   05900   CARDI AC CATHETERI ZATI ON   0   11, 309, 134   0   60. 01   06000   LABORATORY   0   0   0   60. 01   06000   LABORATORY   0   0   0   60. 01   06000   DABORATORY   0   0   0   60. 02   06000   PHYSI CIAN LABORATORY   0   0   0   61. 00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   0   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   63. 00   06300   LODO STORI NG, PROCESSI NG & TRANS.   0   0   0   64. 00   06400   NTRAVENOUS THERAPY   0   49, 966   0   65. 00   06600   PHYSI CAL THERAPY   0   49, 966   0   66. 00   06600   PHYSI CAL THERAPY   0   49, 466   0   67. 00   06700   OCCUPATI ONAL THERAPY   0   49, 466   0   68. 00   06600   PHYSI CAL THERAPY   0   49, 466   0   69. 00   06600   PHYSI CAL THERAPY   0   49, 466   0   69. 00   06600   PHYSI CAL THERAPY   0   49, 466   0   69. 00   06600   PHYSI CAL THERAPY   0   49, 466   0   69. 00   06600   PHYSI CAL THERAPY   0   49, 466   0   69. 00   06600   PHYSI CAL SUPPLIES CHARGED TO PATI ENTS   0   3, 423, 983   0   69. 00   07000   ELECTROCARDI OLOGY   0   8, 051, 162   0   69. 00   07000   ELECTROCARDI OLOGY   0   3, 423, 983   0   69. 00   07000   07000   ELECTROCARDI OLOGY   0   0   69. 00   07000
53. 00   05300   ANESTHESI OLOGY   0   0   0   53. 00
54. 00         05400 RADI OLOGY-DI AGNOSTI C         0         10, 315, 667         0         54. 00           55. 00         05500 RADI OLOGY-THERAPEUTI C         0         28, 326, 361         0         55. 00           56. 00         05500 RADI OLOGY-THERAPEUTI C         0         0         0         56. 00           57. 00         05700 CT SCAN         0         5, 317, 153         0         57. 00           58. 00         05800 MAGNETI C RESONANCE I MAGI NG (MRI )         0         1, 158, 409         0         58. 00           59. 00         05900 CARDI AC CATHETERI ZATI ON         0         11, 309, 134         0         59. 00           60. 00         06000 LABORATORY         0         7, 718, 108         0         60. 00           60. 01         06001 BLOD LABORATORY         0         0         0         60. 01           60. 02         06002 PHYSI CI AN LABORATORY         0         0         0         60. 00           61. 00         06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY         0         0         0         60. 02           61. 00         06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY         0         0         0         62. 00           62. 00         06200 WHOLE BLOOD & PACKED RED BLOOD & RED BLOO
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 28, 326, 361 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 56. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 56. 00 57. 00 05700 CT SCAN 0 57. 00 58. 00 05800 MAGNETI C RESONANCE I MAGI NG (MRI ) 0 1, 158, 409 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 11, 309, 134 0 60. 00 60. 00 6000 LABORATORY 0 7, 718, 108 0 60. 00 60. 01 06001 BLOOD LABORATORY 0 0 0 0 0 60. 01 60. 02 06002 PHYSI CI AN LABORATORY 0 0 0 0 0 60. 01 60. 03 06002 PHYSI CI AN LABORATORY 0 0 0 0 0 60. 00 63. 00 06002 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 62. 00 63. 00 06300 BLOOD STORING, PROCESSI NG & TRANS. 0 0 0 64. 00 64. 00 6400 INTRAVENOUS THERAPY 0 494, 966 0 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 2, 435, 483 0 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 2, 435, 483 0 66. 00 67. 00 06600 PHYSI CAL THERAPY 0 2, 435, 483 0 66. 00 68. 00 06600 PHYSI CAL THERAPY 0 0 8, 051, 162 0 66. 00 69. 00 06900 ELECTROCARDI OLOGY 0 8, 051, 162 0 69. 00 69. 00 06900 ELECTROCARDI OLOGY 0 8, 051, 162 0 69. 00 71. 00 07000 ELECTROCARDI OLOGY 0 70. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 7, 629, 050 0 71. 00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 7, 629, 050 0 71. 00 75. 00 07300 DRUGS CHARGED TO PATI ENTS 0 7, 629, 050 0 73. 00 75. 00 07500 ASC (NON-DI STI NCT PART) 0 0 0 0 75. 01 75. 01 07550 0 07507 ASC (NON-DI STI NCT PART) 0 0 0 0 75. 01 75. 01 07550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 466, 794 0 75. 01 76. 97 07697 CARDI AC REHABI LI TATI ON 0 1, 010, 278
56. 00 05600 RADI OI SOTOPE 0 0 5.6.00 57.00 05700 CT SCAN 0 5.7.00 05700 CT SCAN 0 5.7.00 05700 CT SCAN 0 5.7.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI ) 0 1.158, 409 0 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI ) 0 1.158, 409 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 11, 309, 134 0 59.00 06000 LABORATORY 0 7.718, 108 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
57. 00 05700 CT SCAN 58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 59. 00 05900 CARDIA C CATHETERI ZATION 60. 00 06000 LABORATORY 60. 01 06001 BLOOD LABORATORY 60. 02 06002 PHYSI CI AN LABORATORY 61. 00 06100 PHYSI CI AN LABORATORY 61. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY 76. 00 06500 RESPI RATORY THERAPY 77. 00 06700 0CCUPATI ONAL THERAPY 77. 00 06900 PHYSI CAL THERAPY 77. 00 06900 ELECTROCARDI OLOGY 77. 00 06900 ELECTROCARDI OLOGY 77. 00 07000 ELECTROCARDI OLOGY 77. 00 07000 ILECTROCARDI OLOGY 77. 00 07000 IMEDI CAL SUPPLIES CHARGED TO PATI ENTS 77. 00 07500 JASC (NON-DI STINCT PART) 78. 00 07500 JASC (NON-DI STINT) PART) 78. 00 07500 JASC (NON-DI STI
58. 00         05800         MAGNETIC RESONANCE IMAGING (MRI)         0         1,158,409         0         58. 00           59. 00         05900         CARDIAC CATHETERIZATION         0         11, 309, 134         0         59. 00           60. 01         06000         LABORATORY         0         0         0         0         0           60. 01         06001         BLOOD LABORATORY         0
59. 00       05900 CARDI AC CATHETERI ZATI ON       0       11, 309, 134       0       59. 00         60. 00       06000 LABORATORY       0       7, 718, 108       0       60. 01         60. 01       06001 BLOOD LABORATORY       0       0       0       60. 01         60. 02       06002 PHYSI CI AN LABORATORY       0       0       0       60. 02         61. 00       06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY       61. 00       62. 00       62. 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       62. 00         64. 00       06400 INTRAVENOUS THERAPY       0       312, 864       0       64. 00         65. 00       06500 RESPI RATORY THERAPY       0       494, 966       0       65. 00         66. 00       06600 PHYSI CAL THERAPY       0       2, 435, 483       0       66. 00         67. 00       06700 CCUPATI ONAL THERAPY       0       0       0       0         69. 00       06800 SPEECH PATHOLOGY       0       0       0       67. 00         69. 00       06900 ELECTROCARDI OLOGY       0       <
60. 00   06000   LABORATORY   0   7,718,108   0   60. 00   60. 01   60. 01   60. 01   8L00D LABORATORY   0   0   0   0   0   0   0   0   0
60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0
60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0
60. 02 06002 PHYSI CI AN LABORATORY 0 0 0 0 0 60.02 61.00 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0 0 0 0 0 63.00 8L00D STORI NG, PROCESSI NG & TRANS. 0 0 0 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0 312,864 0 66.00 65.00 06500 RESPI RATORY THERAPY 0 494,966 0 65.00 06600 PHYSI CAL THERAPY 0 0 2,435,483 0 66.00 66.00 06600 PHYSI CAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
61. 00
62. 00
63. 00
64. 00
65. 00
66. 00   06600   PHYSI CAL THERAPY   0   2, 435, 483   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   8, 051, 162   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   3, 423, 083   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   7, 629, 050   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   16, 071, 656   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   21, 356, 578   0   74. 00   07400   RENAL DI ALYSI S   0   0   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   466, 794   0   76. 97   07697   CARDI AC REHABI LI TATI ON   0   1, 010, 278   0   76. 90   0   0   76. 97
67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   688. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   0   688. 00   69. 00   06900   ELECTROCARDI OLOGY   0   8, 051, 162   0   0   0   0   0   0   0   0   0
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   8, 051, 162   0   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   3, 423, 083   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   7, 629, 050   0   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   16, 071, 656   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   0   21, 356, 578   0   74. 00   07400   RENAL DIALYSIS   0   0   0   75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   75. 01   03550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0   466, 794   0   76. 97   07697   CARDI AC REHABI LI TATI ON   0   1, 010, 278   0   76. 90   0   0   76. 97
69. 00   06900   ELECTROCARDI OLOGY   0   8, 051, 162   0   070.00
70. 00     07000     ELECTROENCEPHALOGRAPHY     0     3, 423, 083     0     70. 00       71. 00     07100     MEDI CAL SUPPLIES CHARGED TO PATIENTS     0     7, 629, 050     0     71. 00       72. 00     07200     I MPL. DEV. CHARGED TO PATIENTS     0     16, 071, 656     0     72. 00       73. 00     07300     DRUGS CHARGED TO PATIENTS     0     21, 356, 578     0     0     73. 00       74. 00     07400     RENAL DI ALYSIS     0     0     75. 00       75. 01     03550     PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES     0     466, 794     0     75. 01       76. 97     07697     CARDI AC REHABI LI TATI ON     0     1, 010, 278     0     76. 97
71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   7, 629, 050   0   0   0   0   0   0   0   0   0
72. 00     07200     I MPL. DEV. CHARGED TO PATI ENTS     0     16, 071, 656     0     72. 00       73. 00     07300     DRUGS CHARGED TO PATI ENTS     0     21, 356, 578     0     73. 00       74. 00     07400     RENAL DI ALYSI S     0     0     0     74. 00       75. 00     07500     ASC (NON-DI STI NCT PART)     0     0     0     75. 00       75. 01     03550     PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES     0     466, 794     0     75. 01       76. 97     07697     CARDI AC REHABI LI TATI ON     0     1, 010, 278     0     76. 97
73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   21, 356, 578   0   73. 00   74. 00   74. 00   75. 00   0   0   0   0   0   0   0   0   0
74. 00   07400   RENAL DI ALYSI S   0 0 0 0 0 75. 00 75. 00 75. 00   075. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0
75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   75. 00   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   466, 794   0   75. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   0   1, 010, 278   0   76. 97
75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   0   75. 00   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   466, 794   0   75. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   0   1, 010, 278   0   76. 97
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 466, 794 0 75. 01 76. 97 07697 CARDI AC REHABI LI TATI ON 0 1, 010, 278 0 76. 97
76. 97 O7697 CARDI AC REHABI LI TATI ON 0 1, 010, 278 0 76. 97
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   390, 639   0   90. 00
91. 00   09100   EMERGENCY
92. 00   09200  0BSERVATI ON BEDS (NON-DI STI NCT PART)   0   5, 189, 861   0   92. 00
OTHER REIMBURSABLE COST CENTERS
94. 00   09400   HOME   PROGRAM DI ALYSIS   0   0   0   94. 00
95. 00   09500   AMBULANCE SERVI CES   95. 00
96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0   0   96. 00
97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD   0   0   97. 00
98. 00   09850   OTHER REIMBURSABLE COST CENTERS   0   0   98. 00
200.00   Total (lines 50-199)   0  171,870,239  0   200.00

APPOR	TIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	D VACCINE COST	Provi der	F	rom 01/01/2015	Worksheet D Part V	
					o 12/31/2015	Date/Time Pre 5/27/2016 1:5	pared: 3 nm
			Ti tl	e XVIII	Hospi tal	PPS	<u>o p</u>
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Services (see	Servi ces	Servi ces Not		
		Worksheet C,	inst.)	Subject To	Subject To		
		Part I, col.		Ded. & Coins.	Ded. & Coins.		
		9	2.00	(see inst.)	(see inst.)	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5.00	
50. 00	05000 OPERATING ROOM	0. 107609	23, 930, 160	C	0	2, 575, 101	50.00
50. 01	05001 CV SURGERY	0. 000000				2,070,101	50.01
51. 00	05100 RECOVERY ROOM	0. 085504		l .		281, 037	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 280802		l .	-	5, 055	52.00
53. 00	05300 ANESTHESI OLOGY	0. 000000		d	0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 174363	10, 315, 667	l c	0	1, 798, 671	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 101444		l c	0	2, 873, 539	55.00
56.00	05600 RADI OI SOTOPE	0. 000000	0	ol c	0	0	56.00
57.00	05700 CT SCAN	0. 046190	5, 317, 153	C	0	245, 599	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 113881	1, 158, 409	ď	0	131, 921	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 050804	11, 309, 134	C	0	574, 549	59.00
60.00	06000 LABORATORY	0. 111610				861, 418	60.00
60. 01	06001 BLOOD LABORATORY	0. 000000		C	-	0	60. 01
60. 02	06002 PHYSI CI AN LABORATORY	0. 000000		· ·	-	0	60. 02
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000		C		_	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000		C		0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000		C	-	70.022	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 226401	312, 864	1	-	70, 833	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0. 294557 0. 502259	494, 966	l .		145, 796	65.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000			-	1, 223, 243 0	66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0.00000			-	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 068994		1	_	555, 482	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 115236				394, 462	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 339133		l .	-	2, 587, 263	71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 181580			0	2, 918, 291	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 289457	21, 356, 578	1	119, 693	6, 181, 811	73.00
74.00	07400 RENAL DIALYSIS	0. 333074		C		0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	d c	0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 880277	466, 794	- C	0	410, 908	75. 01
76. 97	07697 CARDIAC REHABILITATION	0. 512359	1, 010, 278	C	0	517, 625	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 CLINIC	2. 112427		1		825, 196	90.00
91.00	09100 EMERGENCY	0. 146983		1	,	2, 007, 494	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 322194	5, 189, 861	2, 943	0	1, 672, 142	92.00
94. 00	OTHER REIMBURSABLE COST CENTERS  09400 HOME PROGRAM DI ALYSI S	0. 000000	I	T C	1		94.00
95. 00	09500 AMBULANCE SERVICES	0. 244455					95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 244433				0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			_	0	97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			n n	n	98.00
200.00		3. 000300	171, 870, 239	13, 392	119, 693	28, 857, 436	
201.00				0	0	, ,	201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		171, 870, 239	13, 392	119, 693	28, 857, 436	202.00

| Peri od: | Worksheet D | From 01/01/2015 | Part V | Date/Time Prepared: 5/27/2016 1:53 pm Provi der CCN: 150051

Cost Center Description					5/27/2016 1:53 pm
Cost Center Description			Title XVIII	Hospi tal	PPS
Rel Imbursed   Services   Subject To   Ded & Colns   Services   Subject To   Ded & Colns   Services   Not   Subject   No		Costs			
Services   Subject To   Ded. & Col ns.   Subject To   Ded. & Col	Cost Center Description	Cost	Cost		
Subject To   Ded & Colins   (See inst.)		Reimbursed Re	ei mbursed		
Subject To   Ded & Colins   (See inst.)		Servi ces Ser	rvices Not		
Ded. & Col Ins.   Ose					
See Inst.   (see Inst. )   (see Inst. )					
AMCILLARY SERVICE COST CENTERS					
ANCILLARY SERVICE COST CENTERS					
50.00   05000   0FEATI NC ROOM	ANCILLADY SEDVICE COST CENTEDS	0.00	7.00		
50.01					F0.00
51.00   OS100   RECOVERY ROOM & LABOR ROOM   O   O   O   S2.00		· · · · · · · · · · · · · · · · · · ·			
52.00   OSZOO   DELLYERY ROOM & LABOR ROOM   0   0   53.00     53.00   OSZOO   ORAD   LOGY   0   0   0   0     54.00   OSZOO   RADIOLOGY-HERAPEUTIC   0   0   0   0     55.00   OSZOO   RADIOLOGY-HERAPEUTIC   0   0   0   0     56.00   OSZOO   RADIOLOGY-HERAPEUTIC   0   0   0   0     57.00   OSZOO   CTS CARN   0   0   0   0   0     58.00   OSSOO   MACHTIC RESONANCE   IMAGI NG (NRI )   0   0   0   0     59.00   OSZOO   CARDIA   CCATHETER! ZATI (NN					
53.0   05300   OS300   ANESTHESI OLOGY   0   0   0   54.00		1			
54.00   05.00   05.00   ADDI OLOGY-DI AGNOSTIC   0 0 0   55.00   05.		0	0		
55.00   05500   RADIO LOCY-THERAPEUTIC		0	0		53.00
56. 00   05000   RADIO I SOTOPE   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	0		54.00
57. 00   05700   CT SCAN   57. 00   58. 00   58. 00   58. 00   59. 00   60. 00   6	55. 00   05500   RADI OLOGY-THERAPEUTI C	0	O		55.00
57. 00   05700   CT SCAN   57. 00   58. 00   58. 00   58. 00   59. 00   60. 00   6	56. 00   05600 RADI OI SOTOPE	o	ol		56.00
SB. 00   S			ol		
59.00   05900   CARDIAC CATHETREI ZATION   0   0   0   0   0   0   0   0   0		1			
60. 00   06000   LABORATORY   00   00   06001   BLODD LABORATORY   00   00   00   06001   BLODD LABORATORY   00   00   00   06001   BLODD LABORATORY   00   00   00   06001		1	-		
60.01   GOOT   BLOOD LABORATORY   0   0   0   60.01   60.02   GOOD2 PHYSI CIAN LABORATORY   0   0   0   60.02   61.00   GOOD2 PHYSI CIAN LABORATORY   0   0   0   61.00   62.00   GOOD2 PHYSI CIAN LABORATORY   0   0   0   62.00   63.00   GOOD3   BLOOD STORING, PROCESSING & TRANS.   0   0   0   63.00   63.00   GOOD3   BLOOD STORING, PROCESSING & TRANS.   0   0   0   64.00   GOOD4   GOOD4   GOOD4   GOOD4   GOOD4   65.00   GOOD5   GESPI RATORY THERAPY   0   0   0   0   65.00   GOSOO   RESPI RATORY THERAPY   0   0   0   0   66.00   GOSOO   RESPI RATORY THERAPY   0   0   0   0   67.00   GOTO0   GOCUPATI JONAL THERAPY   0   0   0   0   68.00   GOSOO   RESPI RATORY THERAPY   0   0   0   0   69.00   GOSOO   GESPI RATORY THERAPY   0   0   0   0   69.00   GOSOO   ELECTROCERDI OLOGY   0   0   0   69.00   GOSOO   MPL. DEV. CHARGED TO PATIENTS   69   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT700   MPL. DEV. CHARGED TO PATIENTS   0   0   0   67.00   OT7	· · · · · · · · · · · · · · · · · · ·	1			
60. 02   06002   PHYSI CIAN LABDRATORY   0   0   61. 00   61. 00   06100   PBP CLINICAL LAB SERVICES-PRCM ONLY   0   62. 00   62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   63. 00   63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   64. 00   64. 00   06400   INTRAVIOUS THERAPY   0   0   0   64. 00   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   66. 00   06600   OFFICIAL THERAPY   0   0   0   0   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0   68. 00   06600   PHYSI CLA THERAPY   0   0   0   0   69. 00   06600   SPECET PATHOLOGY   0   0   0   69. 00   06600   SPECET PATHOLOGY   0   0   0   69. 00   06600   ELECTROCARDIOLOGY   0   0   0   69. 00   07000   ELECTROCARDIOLOGY   0   0   0   69. 00   07000   OTTOOL ELECTROENCEPHALOGRAPHY   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   72. 00   73. 00   07300   PRUSC CHARGED TO PATI ENTS   0   0   74. 00   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   75. 01   07500   ASC (NON-DI STI NCT PART)   0   0   0   75. 01   07500   ASC (NON-DI STI NCT PART)   0   0   0   76. 07   07697   CARDIOL CHARGED TO PATI ENTS   0   0   0   76. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   76. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   76. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   76. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   77. 00   07500   ORGONO   ORGON		1	-1		
61. 00   06100   PBP CLINICAL LAB SERVICES-PROMINY   0   62. 00   06.20   WHOLE BILO DO & PACKED RED BLOOD CELLS   0   0   0   0   0   0   0   0   0		1			
62. 00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0   0   0   0   0   0		1	٥Į		
63. 00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0   64. 00   64. 00   06400   INTRAVENDUS THERAPY   0   0   0   0   65. 00   06500   RESPI RATORY THERAPY   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   66. 00   06600   PHYSI CAL THERAPY   0   0   0   0   67. 00   06700   0CCUPATIONAL THERAPY   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   69. 00   06900   ELECTROCARDIOLOGY   0   0   0   69. 00   06900   ELECTROCARDIOLOGY   0   0   0   69. 00   07000   ELECTROCARDIOLOGY   0   0   0   70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   69   0   0   72. 00   07200   IMPLE. DEV. CHARGED TO PATIENTS   0   0   0   73. 00   07300   DRUGS CHARGED TO PATIENTS   1, 251   34, 646   73. 00   74. 00   07400   RENAL DIALYSIS   1, 251   34, 646   73. 00   75. 01   03550   PSYCHI ATRIC/PSYCHOLOGI CAL SERVICES   0   0   75. 01   75. 01   03550   PSYCHI ATRIC/PSYCHOLOGI CAL SERVICES   0   0   75. 01   76. 97   07697   CARDIA CR EHABIL LIATION   0   0   0   76. 97   07697   CARDIA CR EHABIL LIATION   0   0   0   76. 90   09000   ELECTRALLY QUALIFIED HEALTH CENTER   0   0   0   79. 00   09000   DEBERRALTY QUALIFIED HEALTH CENTER   0   0   0   79. 00   09000   DEBERRALTY OLIVIFIED   0   0   0   79. 00   09000   0000   0000   0000   0000   0000   0000   79. 00   09000   0000   0000   0000   0000   0000   79. 00   09000   0000   0000   0000   0000   79. 00   09000   0000   0000   0000   0000   79. 00   09000   0000   0000   0000   79. 00   09000   00000   00000   00000   79. 00   09000   00000   00000   79. 00   09000   00000   00000   79. 00   09000   00000   00000   79. 00   09000   00000   00000   79. 00   09000   00000   00000   79. 00   00000   00000   00000   79. 00   00000   00000   00000   79. 00   00000   00000   00000   79. 00   00000   00000   00000   79. 00   00000   00000   00000   79. 00   00000   00000   00000   79. 00   000000   000000   79. 00   00000   0000000   79. 00   000000   000000   79. 00   0000000000		1			
64. 00   06400   NTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0		0	0		62.00
65. 00   06500   RESPIRATORY THERAPY   0   0   0   0   0   0   0   0   0		0	0		63.00
66. 00   06600   PHYSICAL THERAPY   0   0   0   0   66. 00   67. 00   06700   0CCUPATI ONAL THERAPY   0   0   0   0   0   68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   69. 00   06900   ELECTROCARDI OLOGY   0   0   0   0   70. 00   70000   ELECTROCARDI OLOGY   0   0   0   0   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   0   0   75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0   76. 97   07697   CARDI AC REHABI LITATI ON   0   0   0   76. 97   07697   CARDI AC REHABI LITATI ON   0   0   0   77. 00   09900   EDERALLY QUALIFIED HEALTH CENTER   0   0   0   79. 00   09900   EDERALLY QUALIFIED HEALTH CENTER   0   0   79. 00   09900   CLINI C   0   0   70. 00   09000   CLINI C   0   0   70. 00   09000   CLINI C   0   0   70. 00   09000   DURABLE MEDI CAL EQUI P-RENTED   0   0   70. 00   09000   DURABLE MEDI CAL EQUI P-RENTED   0   0   70. 00   09000   DURABLE MEDI CAL EQUI P-RENTED   0   0   70. 00   09000   Subtotal (see instructions)   2, 929   34, 646   200. 00   201. 00   Clini C   Case part of the contraction of the contr	64.00   06400   I NTRAVENOUS THERAPY	0	0		64. 0
67. 00 66700 OCCUPATIONAL THERAPY 0 0 0 0 68. 00 68. 00 06800 SPECCH PATHOLOGY 0 0 0 0 69. 00 06900 ELECTROCARDIOLOGY 0 0 0 0 70. 00 07000 ELECTROCROEPHALLOGRAPHY 0 0 0 0 71. 00 07000 MEDI CAL SUPPLIES CHARGED TO PATIENTS 69 0 71. 00 72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 0 72. 00 73. 00 07300 DRUGS CHARGED TO PATIENTS 1, 251 34, 646 73. 00 74. 00 07400 RENAL DIALYSIS 0 0 0 0 75. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 75. 00 75. 01 03550 PSYCHIATRI CYPSYCHOLOGI CAL SERVICES 0 0 0 76.97 CARDIAC REHABILITATION 0 0 0 0 76.97 CARDIAC REHABILITATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	65. 00 06500 RESPIRATORY THERAPY	O	0		65.00
68. 00	66. 00   06600 PHYSI CAL THERAPY	o	ol		66.00
68. 00	67. 00 06700 OCCUPATI ONAL THERAPY	l ol	ol		67.00
69. 00   06900   ELECTROCARDI OLOGY		1	ō		
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   0   0   0   0   0   0   0   0		· · · · · · · · · · · · · · · · · · ·			
71. 00		1 1	-1		
72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   0   0   0   0   0   0   0   0		· · · · · · · · · · · · · · · · · · ·			
73. 00		1	-1		
74. 00		1 1	-1		
75. 00		1			
75. 01			-1		
76. 97    O7697   CARDIAC REHABILITATION   O O O					
SB. 00   OBSOO   RURAL HEALTH CLINIC   O   O   O   O	75. 01  03550  PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		75.0
88. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 89. 00 90. 00 90. 00 90. 00 90. 00 91. 00 91. 00 92. 00 92. 00 93. 00 94. 00 95. 00 96. 00 96. 00 97. 00 97. 00 97. 00 97. 00 97. 00 97. 00 97. 00 97. 00 97. 00 97. 00 97. 00 98. 00 98. 00 99	76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0		76. 9
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 90. 00 90.	OUTPATIENT SERVICE COST CENTERS				
90. 00   09000   CLINIC   0   0   0   0   91. 00   91. 00   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   948   0   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   948   0   92. 00   09400   HOME PROGRAM DIALYSIS   0   0   0   94. 00   95. 00   95. 00   95. 00   95. 00   96. 00   96. 00   96. 00   96. 00   96. 00   96. 00   97. 00   09700   DURABLE MEDICAL EQUIP-RENTED   0   0   0   96. 00   97. 00   09850   OTHER REIMBURSABLE COST CENTERS   0   0   0   97. 00   98. 00   09850   OTHER REIMBURSABLE COST CENTERS   0   0   0   0   98. 00   09850   OTHER REIMBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0	88.00 08800 RURAL HEALTH CLINIC	0	0		88. 00
90. 00   09000   CLINIC   0   0   0   0   91. 00   91. 00   91. 00   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   948   0   92. 00   09200   0BSERVATION BEDS (NON-DISTINCT PART)   948   0   92. 00   09400   HOME PROGRAM DIALYSIS   0   0   0   94. 00   95. 00   95. 00   95. 00   95. 00   96. 00   96. 00   96. 00   96. 00   96. 00   96. 00   97. 00   09700   DURABLE MEDICAL EQUIP-RENTED   0   0   0   96. 00   97. 00   09850   OTHER REIMBURSABLE COST CENTERS   0   0   0   97. 00   98. 00   09850   OTHER REIMBURSABLE COST CENTERS   0   0   0   0   98. 00   09850   OTHER REIMBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0	89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	l ol	ol		89.00
91. 00   09100   EMERGENCY   0   0   0   0   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   948   0   92. 00   071HER REIMBURSABLE COST CENTERS   94. 00   09400   HOME PROGRAM DIALYSIS   0   0   0   95. 00   95. 00   95. 00   95. 00   96. 00   97. 00   97. 00   09700   DURABLE MEDICAL EQUIP-RENTED   0   0   0   97. 00   97. 00   09700   DURABLE MEDICAL EQUIP-SOLD   0   0   97. 00   98. 00   09850   OTHER REIMBURSABLE COST CENTERS   0   0   0   97. 00   98. 00   09850   OTHER REIMBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0		1	ol		
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   948   0   0   0   0   0   0   0   0   0	· ·	1			
OTHER REIMBURSABLE COST CENTERS   94.00   09400   HOME PROGRAM DI ALYSIS   0   0   0   95.00   95.00   09500   AMBULANCE SERVICES   0   95.00   96.00   09600   DURABLE MEDICAL EQUIP-RENTED   0   0   0   0   97.00   97.00   09700   DURABLE MEDICAL EQUIP-SOLD   0   0   0   97.00   98.00   09850   OTHER REIMBURSABLE COST CENTERS   0   0   0   98.00   200.00   Subtotal (see instructions)   2,929   34,646   200.00   201.00   Unit of the control of the con		· -			
94. 00   09400   HOME PROGRAM DI ALYSIS   0 0 95.00   95.00   95.00   95.00   96.00   96.00   96.00   96.00   97.00   97.00   98.00		748	U		92.00
95. 00   95. 00   96. 00   96. 00   96. 00   97. 00   97. 00   97. 00   97. 00   98.			ما		04.0
96. 00   97. 00   97. 00   97. 00   98. 00   98. 00   98. 00   98. 00   90.		1	U		
97. 00   09700   DURABLE MEDICAL EQUIP-SOLD   0   0   0   98. 00   09850   OTHER REIMBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0	1 1	· ·	_		
98. 00   09850   OTHER REIMBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0		1	- 1		
200.00   Subtotal (see instructions)   2,929   34,646   200.00   201.00   Charges   201.00		- I	0		
201.00 Less PBP Ĉlinic Lab. Services-Program 0 001 y Charges		· -	0		98.00
Only Charges	200.00 Subtotal (see instructions)	2, 929	34, 646		200. 0
Only Charges	201.00 Less PBP Clinic Lab. Services-Program	0			201. 00
		2, 929	34, 646		202. 00

Health Financial Systems	J HEALTH BLOOMI	NGTON	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS		Provi der	CCN: 150051	Peri od:	Worksheet D	
			Component	t CCN: 15T051	From 01/01/2015 To 12/31/2015		
			Ti tl	e XVIII	Subprovi der - I RF	PPS	· ·
Cost Center Description	Capi tal	Total	Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(fro	om Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, 1	Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	CC	ol. 8)	col. 2)			
	col. 26)						
	1. 00	] :	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS							
50. 00   05000 OPERATING ROOM	2, 387, 249	172	2, 139, 054	0. 01386	50, 315	698	50.00
50. 01   05001   CV   SURGERY	0		0	0. 00000	0 0	0	50. 01
51.00   05100   RECOVERY ROOM	174, 267	2:	2, 494, 835	0. 00774	4, 875	38	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 514, 795	30	0, 050, 434	0. 05040	155	8	52.00
53. 00   05300   ANESTHESI OLOGY	0		0	0. 00000	00	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	917, 769	4	1, 419, 927	0. 02215	58 27, 578	611	54.00

Health Financial Systems	IU HEALTH BLOOMINGTO	N HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150051	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2015	

Component CCN: 15T051 To 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm Title XVIII Subprovi der **IRF** Cost Center Description Non Physician Nursi ng Allied Health All Other Total Cost Anestheti st (sum of col 1 School Medi cal Cost Educati on through col. Cost 1.00 2.00 3.00 4. 00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 0 0 0 50.01 05001 CV SURGERY C 0 50.01 05100 RECOVERY ROOM 0 0 51.00 51.00 00000000000 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 52.00 0 0 53.00 05300 ANESTHESI OLOGY 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 55.00 0 56.00 05600 RADI OI SOTOPE 0 56.00 0 57.00 05700 CT SCAN 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 59.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 0 06000 LABORATORY 60.00 C 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 06002 PHYSICIAN LABORATORY 0 0 0 60.02 0 0 60.02 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61 00 61 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0000000000000000 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 0 0 0 0 0 0 0 0 0 0 0 64.00 06500 RESPIRATORY THERAPY 0 65 00 0 65 00 0 0 06600 PHYSI CAL THERAPY 66.00 0 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69 00 06900 FLECTROCARDLOLOGY 0 0 69 00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 0 74.00 0 0 0 07500 ASC (NON-DISTINCT PART) 75.00 0 0 75.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 75 01 0 75.01 07697 CARDIAC REHABILITATION 0 76.97 0 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 0 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89 00 0 0 90.00 09000 CLI NI C 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 92.00 0 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94.00 95.00 09500 AMBULANCE SERVICES 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 C 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 0 0 97.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 0 200.00 Total (lines 50-199) 0 200.00

Health Financial Systems	IU HEALTH BLOOMINGTO	N HOSPITAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150051	Peri od: From 01/01/2015	Worksheet D Part IV
Timoodii 60313		Component CCN: 15T051	To 12/31/2015	Date/Time Prepared: 5/27/2016 1:53 pm
		Title XVIII	Subprovi der -	PPS

		T; +1	e XVIII	Cubarovi dor	5/2//2016 1: 5 PPS	3 pm
		11 (1	e viiii	Subprovi der - I RF	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost		I npati ent	
	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col . 6 ÷	3	
	4)	ĺ	<u> </u>	col. 7)		
	6. 00	7. 00	8. 00	9. 00	10. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	,			50, 315	50.00
50. 01  05001 CV SURGERY	0	l e	1 0.00000		0	50. 01
51.00   05100   RECOVERY ROOM	0	22, 494, 835			4, 875	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	30, 050, 434			155	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	1 0,00000		0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0				27, 578	
55. 00   05500   RADI OLOGY-THERAPEUTI C	0	62, 444, 096			54	55.00
56. 00   05600   RADI 0I SOTOPE	0	0	0. 000000	0. 000000	0	56.00
57. 00   05700   CT   SCAN	0	30, 430, 071	0.000000	0. 000000	19, 019	57.00
58.00   05800 MAGNETIC RESONANCE IMAGING (MRI)	0	7, 247, 587	0.000000	0. 000000	9, 926	58.00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	60, 192, 727	0. 000000	0. 000000	39, 495	59.00
60. 00   06000   LABORATORY	0	119, 886, 202	0. 000000	0. 000000	634, 327	60.00
60. 01   06001   BLOOD   LABORATORY	0	0	0. 000000	0. 000000	0	60. 01
60. 02 06002 PHYSICIAN LABORATORY	0	0	0. 000000	0. 000000	0	60.02
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 000000	0. 000000	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	735, 624			43	64.00
65. 00 06500 RESPIRATORY THERAPY	0				42, 403	65.00
66. 00 06600 PHYSI CAL THERAPY	0	27, 236, 336	0. 000000	0. 000000	2, 996, 575	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.000000		0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	1		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	20, 536, 760	1		31, 951	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				16, 089	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	40, 396, 576			26, 062	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	87, 408, 699			19, 955	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	128, 795, 373			777, 233	
74.00 07400 RENAL DIALYSIS	0		1		25, 079	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	1		0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	2, 534, 851	•		1	75. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	, ,	•		1, 056	76. 97
OUTPATIENT SERVICE COST CENTERS		2//01/1//	0.00000	0.00000	1,000	70.77
88. 00 08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	l			0	89. 00
90. 00 09000 CLI NI C	0	1, 207, 395			921	90.00
91. 00 09100 EMERGENCY	0		l e		5, 425	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				6, 954	92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 000000	0. 000000	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	1		0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	O			0	98.00
200.00 Total (lines 50-199)	0	979, 407, 361			4, 735, 491	200.00
	•	•	•	. '	•	•

Health Financial Systems	IU HEALTH BLOOMINGTON	N HOSPITAL	In Lieu	ı of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150051	Peri od: From 01/01/2015	Worksheet D
Inkough COSTS		Component CCN: 15T051		
		Title XVIII	Subprovi der -	PPS

		Ti t	le XVIII	Subprovi der -	PPS	
Cook Cooker Description		0	0	I RF		
Cost Center Description	Inpatient	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through Costs (col. 8	Charges	Pass-Through Costs (col.			
	x col . 10)		x col. 12)	9		
	11.00	12. 00	13.00			
ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00			
50. 00 05000 OPERATING ROOM	0		0	0		50.00
50. 01   05001   CV   SURGERY	o		o	0		50. 01
51.00 05100 RECOVERY ROOM	o		o	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o		o	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 01 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	0		60. 01
60. 02 06002 PHYSI CI AN LABORATORY	0		0	0		60.02
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   69. 00   06900   ELECTROCARDI OLOGY	0		0	0		68.00
69. 00   06900   ELECTROCARDI OLOGY 70. 00   07000   ELECTROENCEPHALOGRAPHY	0			0		69. 00 70. 00
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0		71.00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS				0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS				0		73.00
74. 00   07400   RENAL DI ALYSI S	0			0		74.00
75. 00 07500 ASC (NON-DISTINCT PART)				0		75.00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES			o	o		75. 01
76. 97   07697   CARDI AC   REHABI LI TATI ON			o	0		76. 97
OUTPATIENT SERVICE COST CENTERS	-1		-1			1
88.00 08800 RURAL HEALTH CLINIC	0		0	0		88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	o		o	0		89.00
90. 00   09000   CLI NI C	0		0	0		90.00
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 DI ALYSIS	0		0	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 MEDI CAL EQUI P-SOLD	0		0	0		97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0		0	0		98.00
200.00   Total (lines 50-199)	0		0	0		200.00

Health Financial Systems  APPORTIONMENT OF INPATIENT ROUTINE SERVICE C	ADLIAN COSTS			In Lie	u of Form CMS-1	2552-10
APPORTIONMENT OF INPATTENT ROUTINE SERVICE C	APITAL CUSTS	Provider		From 01/01/2015	Worksheet D Part I	
				To 12/31/2015	Date/Time Pre 5/27/2016 1:5	epared:
		Ti t	le XIX	Hospi tal	PPS	70 рііі
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost	Adjustment	Capi tal	Days	(col. 3 /	
	(from Wkst.		Related Cost		col. 4)	
	B, Part II,		(col. 1 -			
	col. 26)		col . 2)			
	1.00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS		.1		- 10 oosl	101.11	
30. 00 ADULTS & PEDIATRICS	6, 095, 337		0,070,00		124. 64	
31. 00 I NTENSI VE CARE UNI T	596, 988		596, 98	8 3, 949	151. 17	
32. 00 CORONARY CARE UNIT	0	<u>'</u>			0.00	
33. 00 BURN INTENSIVE CARE UNIT	0	<u>'</u>			0.00	
34. 00 SURGICAL INTENSIVE CARE UNIT	0				0.00	
40. 00 SUBPROVI DER - I PF	500 001	0	F00.00	0 0	0.00	
41. 00 SUBPROVI DER - I RF	539, 001		539, 00		191. 07	
42. 00 SUBPROVI DER	200 720		200 72	0 0	0.00	
43.00 NURSERY 44.00 SKILLED NURSING FACILITY	289, 729		289, 72		61. 41	
44.00   SKILLED NURSING FACILITY 45.00   NURSING FACILITY				0 0	0. 00 0. 00	
200.00 Total (lines 30-199)	7, 521, 055		7, 521, 05	5 60, 393		200.00
Cost Center Description	Inpatient	Inpatient	7, 521, 05	5 00, 393		200.00
cost center bescription	Program days	Program				
	Fi Ogi alii days	Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7.00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 551	193, 317				30.00
31. 00 INTENSIVE CARE UNIT	229	34, 618				31.00
32. 00 CORONARY CARE UNIT	0	0				32.00
33.00 BURN INTENSIVE CARE UNIT		0				33.00
34.00 SURGICAL INTENSIVE CARE UNIT		0				34.00
40. 00 SUBPROVI DER - I PF	0	0				40.00
41. 00 SUBPROVI DER - I RF	10	1, 911				41.00
42 OO SURDPOVI DEP		٠ ،	1			12 00

153, 648

383, 494

2, 502

0 4, 292

41.00 42. 00 43. 00

44.00 45. 00 200. 00

42. 00 SUBPROVI DER 43. 00 NURSERY

44.00 SKILLED NURSING FACILITY
45.00 NURSING FACILITY
200.00 Total (lines 30-199)

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-1								
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITAL COST		Provi der	CCN: 150051	Peri od:	Worksheet D			
				From 01/01/2015				
				To 12/31/2015	Date/Time Pre 5/27/2016 1:5	pared: 3 nm		
-		Ti t	le XIX	Hospi tal	PPS	о ріп		
Cost Center Description	Capi tal	Total Charges			Capital Costs			
5551 551161 25551 Pt. 6.1	Related Cost	(from Wkst.	to Charges	Program	(column 3 x			
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)			
	B, Part II,	col. 8)	col . 2)	3.00				
	col. 26)	,	,					
	1. 00	2.00	3.00	4. 00	5. 00			
ANCILLARY SERVICE COST CENTERS			•	<u>'</u>				
50. 00 05000 OPERATING ROOM	2, 387, 249	172, 139, 054	0. 01386	1, 253, 775	17, 387	50.00		
50. 01   05001   CV   SURGERY	0	0	0. 00000	00	0	50. 01		
51.00   05100   RECOVERY   ROOM	174, 267	22, 494, 835	0. 00774	17 144, 286	1, 118	51.00		
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 514, 795	30, 050, 434	0. 05040	796, 574	40, 154	52.00		
53. 00   05300   ANESTHESI OLOGY	0	0	0.00000	0 0	0	53.00		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	917, 769	41, 419, 927	0. 02215	318, 000	7, 046	54.00		
55. 00 05500 RADI OLOGY-THERAPEUTI C	966, 534	62, 444, 096	0. 01547	78 63, 621	985	55.00		
56. 00   05600   RADI 0I SOTOPE	0	0	0. 00000	00	0	56.00		
57. 00 05700 CT SCAN	78, 527	30, 430, 071	0. 00258	372, 731	962	57.00		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	86, 632	7, 247, 587			1, 287	58.00		
59. 00 05900 CARDI AC CATHETERI ZATI ON	327, 614	60, 192, 727			4, 111	59.00		
60. 00   06000   LABORATORY	840, 162	119, 886, 202				60.00		
60. 01   06001   BLOOD   LABORATORY	0	0	0.00000		0	60. 01		
60. 02 06002 PHYSI CI AN LABORATORY	0	0	1		0	60.02		
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			0.0000		Ĭ	61.00		
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	0	0	62.00		
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 00000		o o	63.00		
64. 00 06400 I NTRAVENOUS THERAPY	3, 750	735, 624			o o	64.00		
65. 00 06500 RESPIRATORY THERAPY	118, 542	9, 891, 660			-	65.00		
66. 00 06600 PHYSI CAL THERAPY	1, 057, 679	27, 236, 336				66.00		
67. 00 06700 OCCUPATI ONAL THERAPY	1,037,077	27, 230, 330	0. 00000		0	67.00		
68. 00 06800 SPEECH PATHOLOGY	0	0	0. 00000		Ö	68.00		
69. 00 06900 ELECTROCARDI OLOGY	135, 703	20, 536, 760	1		1, 980	69.00		
70. 00 07000 ELECTROENCEPHALOGRAPHY	169, 065	15, 968, 683	1		1, 657	70.00		
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	226, 822	40, 396, 576		1	2, 739	71.00		
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	270, 310	87, 408, 699	1	1	1, 457	72.00		
73. 00 07300 DRUGS CHARGED TO PATIENTS	870, 193	128, 795, 373		1	18, 708	73.00		
74. 00   07400   RENAL DI ALYSI S	44, 466	3, 106, 544		1	1, 053	74.00		
75. 00   07500   ASC (NON-DISTINCT PART)	1 44, 400	3, 100, 344	0.00000	1	0	75.00		
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	181, 968	2, 534, 851	0. 07178		33	75.00		
76. 97 07697 CARDI AC REHABI LI TATI ON	172, 201	2, 734, 177			798	76. 97		
OUTPATIENT SERVICE COST CENTERS	172, 201	2,734,177	0.00270	12,071	7 70	70.77		
88. 00 08800 RURAL HEALTH CLINIC	O	0	0.00000	00 0	0	88. 00		
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 00000			89.00		
90. 00   09000   CLI NI C	174, 817	1, 207, 395	1		95	90.00		
91. 00   09100   EMERGENCY	1, 313, 165	78, 865, 393				91.00		
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	501, 036	13, 684, 357	0. 03661	1	1, 859	92.00		
OTHER REIMBURSABLE COST CENTERS	301, 030	13,004,337	0.03001	30,774	1,037	72.00		
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	00 0	0	94.00		
95. 00   09500   AMBULANCE SERVICES		0	0.00000	0	· ·	95.00		
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 00000	0	0	96.00		
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED		0	0.00000			97.00		
98. 00   09850   OTHER REIMBURSABLE COST CENTERS	0	0	0.00000		0	98.00		
200.00 Total (lines 50-199)	12, 533, 266	979, 407, 361	1	11, 367, 220	-			
200.00   Total (TITIES 30-177)	12, 333, 200	777, 407, 301	I	11, 307, 220	142,044	<sub>1</sub> 200.00		

Health Financial Systems	J HEALTH BLOOMIN	NGTON HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	ASS THROUGH COST	ΓS Provi der		Peri od:	Worksheet D	
				From 01/01/2015 To 12/31/2015	Part III	nanad.
				To 12/31/2015	Date/Time Pre 5/27/2016 1:5	epareu: 3 nm
		Ti t	le XIX	Hospi tal	PPS	и ри
Cost Center Description	Nursi ng	Allied Health	All Other	Swi ng-Bed	Total Costs	
· ·	School	Cost	Medi cal	Adjustment	(sum of cols.	
			Educati on	Amount (see	1 through 3,	
			Cost	instructions)	minus col. 4)	
	1. 00	2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00   03000   ADULTS & PEDI ATRI CS	0	0		0	0	00.00
31.00   03100   INTENSIVE CARE UNIT	0	0		0	0	000
32. 00   03200   CORONARY CARE UNIT	0	0		0	0	
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 - 1 PF	0	0		0	0	40.00
41. 00   04100   SUBPROVI DER - I RF	0	0		0	0	41.00
42. 00   04200   SUBPROVI DER	0	0		0	0	42.00
43. 00   04300   NURSERY	0	0		0	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
200.00 Total (lines 30-199)	0	0		0	0	200.00
Cost Center Description	Total Patient	Per Diem	Inpatient	I npati ent		
	Days	(col. 5 ÷	Program Days			
		col. 6)		Pass-Through		
				Cost (col. 7		
				x col. 8)		
LAIDATLENT DOUTLAG CERVI OF COCT OFATERS	6. 00	7. 00	8. 00	9. 00		
30.00 O3000 ADULTS & PEDIATRICS	48, 905	0.00	1, 55	1 0		30.00
31. 00   03100   NTENSIVE CARE UNIT	3, 949	0.00				31.00
32. 00   03200   CORONARY CARE UNIT	3, 949	0.00		0 0		32.00
33. 00   03300   BURN INTENSIVE CARE UNIT		0.00		0		32.00
34. 00   03400   SURGI CAL INTENSI VE CARE UNIT	0	0.00		0		34.00
	0	0.00		0		
40. 00   04000   SUBPROVI DER - I PF 41. 00   04100   SUBPROVI DER - I RF	2, 821	0.00		0		40. 00 41. 00
	2, 821	0.00		0		
42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY	4 710			0		42. 00 43. 00
	4, 718	0.00		0 0		43.00
44.00   04400   SKILLED NURSING FACILITY 45.00   04500   NURSING FACILITY		0. 00 0. 00		0		45.00
	40 202	0.00		0		
200.00   Total (lines 30-199)	60, 393		4, 29	2 0		200.00

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2015	Part IV
To 12/31/2015	Date/Time Prepared:
5/27/2016 1:53 pm	Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider ( Provi der CCN: 150051 THROUGH COSTS

						5/27/2016 1:5	3 pm
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician	Nursi ng	Allied Healt	h All Other	Total Cost	
		Anesthetist	School		Medi cal	(sum of col 1	
		Cost			Educati on	through col.	
					Cost	4)	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	l .	0	•	50.00
50. 01	05001 CV SURGERY	0	0		0	1	50. 01
51. 00	05100 RECOVERY ROOM	0	0		0	1	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	_	54.00
55.00	05500  RADI OLOGY-THERAPEUTI C	0	0		0	0	55.00
56. 00	05600  RADI 0I SOTOPE	0	0		0 0	1	56.00
57. 00	05700 CT SCAN	0	0		0	1	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 0	_	59. 00
60. 00	06000 LABORATORY	0	0		0	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0	1	60. 01
60. 02	06002 PHYSI CI AN LABORATORY	0	0		0	0	60. 02
61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61. 00
62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	1	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0	1	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0 0	1	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	0		0 0		66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	1	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0 0		69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	1	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	_	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	_	73.00
74.00	07400 RENAL DI ALYSI S	0	0		0	1	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0 0	1	75.00
75. 01 76. 97	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0 0		75. 01 76. 97
70. 97	07697 CARDI AC REHABI LI TATI ON	l d	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	•			89. 00
90.00	09000 CLINIC		0				90.00
91. 00	09100 EMERGENCY		0			1	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0			1	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	J U			O C	0	72.00
94. 00	09400 HOME PROGRAM DI ALYSIS	0	0		ol c	0	94.00
95.00	09500 AMBULANCE SERVI CES		Ü		٦	1	94. 00 95. 00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0		o c	0	96. 00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0			1	97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS		0			_	98.00
200.00	1 1		0			1	200.00
200.00	1.000 (11100 00 177)	١	O	I	<u>-</u> 1		_55.00

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2015	Part IV
To 12/31/2015	Date/Time Prepared:
5/27/2016 1:53 pm	Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider ( Provi der CCN: 150051 THROUGH COSTS

			'	0 12/01/2010	5/27/2016 1:5	
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati ent	
· ·	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
	Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
	col. 2, 3 and	col. 8)	col. 7)	(col. 6 ÷	Ü	
	4)			col. 7)		
	6. 00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	172, 139, 054	•	1	1, 253, 775	50.00
50. 01  05001 CV SURGERY	0				0	50. 01
51.00   05100   RECOVERY ROOM	0	22, 494, 835			144, 286	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	30, 050, 434	0.000000	0. 000000	796, 574	52.00
53. 00   05300   ANESTHESI OLOGY	0	C	0.00000		0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	41, 419, 927			318, 000	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0	62, 444, 096	0. 000000	0.000000	63, 621	55.00
56. 00   05600 RADI 0I SOTOPE	0	C	0.000000	0. 000000	0	56.00
57. 00   05700 CT SCAN	0	30, 430, 071	0.000000	0.000000	372, 731	57.00
58.00   05800 MAGNETIC RESONANCE IMAGING (MRI)	0	7, 247, 587	0.000000	0. 000000	107, 645	58.00
59. 00   05900 CARDI AC CATHETERI ZATI ON	0	60, 192, 727	0. 000000	0.000000	755, 287	59.00
60. 00   06000   LABORATORY	0	119, 886, 202	0. 000000	0.000000	2, 009, 465	60.00
60. 01   06001   BLOOD   LABORATORY	0	C	0. 000000	0.000000	0	60. 01
60. 02 06002 PHYSI CI AN LABORATORY	0	l c	0. 000000	0. 000000	0	60. 02
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	l c	0. 000000	0. 000000	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0				0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	735, 624			0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	9, 891, 660			364, 103	65.00
66. 00 06600 PHYSI CAL THERAPY	0	27, 236, 336	1		300, 179	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0				0	67.00
68.00 06800 SPEECH PATHOLOGY	0	l c	•		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	20, 536, 760	•	l l	299, 591	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	15, 968, 683	•	1	156, 541	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	40, 396, 576			487, 853	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	87, 408, 699		1	471, 064	72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	128, 795, 373	•		2, 769, 069	73. 00
74. 00   07400   RENAL DI ALYSI S	0	3, 106, 544	1		73, 552	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0,110,01	1		0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	2, 534, 851	•		463	75. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0		•		12, 671	76. 97
OUTPATIENT SERVICE COST CENTERS			1			
88. 00 08800 RURAL HEALTH CLINIC	0	C	0.000000	0.000000	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89. 00
90. 00  09000  CLINIC	0	1, 207, 395			653	90.00
91. 00 09100 EMERGENCY	0				559, 323	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				50, 774	92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	C	0.000000	0.000000	0	94.00
95. 00 09500 AMBULANCE SERVICES					Ü	95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0		0. 000000	0. 000000	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	l c	1		0	97. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	l c			0	98. 00
200.00 Total (lines 50-199)	Ö	_	1		11, 367, 220	
	1	, , , , , , , , , , , , , , , , , , , ,	1	'		

Peri od: Worksheet D
From 01/01/2015 Part IV
To 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm THROUGH COSTS

		Ti t	le XIX	Hospi tal	PPS	ло ріп —	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent	1103pi tai	113	
	cost center bescription	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		9	criai ges	9			
		Costs (col. 8		Costs (col. 9			
		x col . 10) 11.00	12. 00	x col . 12)	-		
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	13. 00			
50. 00	05000 OPERATING ROOM		C	) (			50.00
							1
50. 01	05001 CV SURGERY	0	C				50.01
51.00	05100 RECOVERY ROOM	0	C				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	C				52.00
53.00	05300 ANESTHESI OLOGY	0	C	1			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	C	1			54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	C	1			55. 00
56. 00	05600 RADI OI SOTOPE	0	C	0			56.00
57. 00	05700 CT SCAN	0	C				57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	1			58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	C	1			59. 00
60.00	06000 LABORATORY	0	C	1			60.00
60. 01	06001 BLOOD LABORATORY	0	C	) C			60. 01
60. 02	06002 PHYSI CI AN LABORATORY	0	C	)  C			60. 02
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C	) C			62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	C	) C			63.00
64.00	06400 I NTRAVENOUS THERAPY	0	C	) C			64.00
65.00	06500 RESPI RATORY THERAPY	0	C	) C			65.00
66.00	06600 PHYSI CAL THERAPY	0	C	) C			66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	C	) C			67.00
68.00	06800 SPEECH PATHOLOGY	0	C	) C			68. 00
69.00	06900 ELECTROCARDI OLOGY	0	C	) C			69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	C	) C			70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	) C			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C	) C			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	C	) C			73.00
74.00	07400 RENAL DIALYSIS	0	C	) C			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	C	) C			75.00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C	) C			75. 01
76. 97	07697 CARDIAC REHABILITATION	0	C	0			76. 97
	OUTPATIENT SERVICE COST CENTERS						
88. 00	08800 RURAL HEALTH CLINIC	0	C	) C			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C	) C			89. 00
90.00	09000 CLI NI C	0	C	) C			90.00
91.00	09100 EMERGENCY	0	C	) C			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C	) C			92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	C	0			94.00
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	C	) C			96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0	C	) C			97.00
98. 00	09850 OTHER REIMBURSABLE COST CENTERS	0	C	) C			98. 00
200.00	Total (lines 50-199)	0	C	)  C			200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	1	Period: From 01/01/2015 Fo 12/31/2015	Worksheet D   Part V   Date/Time Pre	pared:
					5/27/2016 1:5	3 pm
		lit	le XIX	Hospi tal	PPS	
Coot Conton Dogorintian	Coot to	PPS	Charges	Coot	Costs	
Cost Center Description	Cost to	Reimbursed	Cost Reimbursed	Cost Reimbursed	PPS Services	
	Charge Ratio From	Services (see	Servi ces	Servi ces Not	(see inst.)	
	Worksheet C,	inst.)	Subject To	Subject To		
	Part I, col.	11131.)	Ded. & Coins.	Ded. & Coins.		
	9		(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. 107609	0	2, 823, 41	1 0	0	50.00
50. 01 05001 CV SURGERY	0. 000000	0		0	0	50. 01
51.00 05100 RECOVERY ROOM	0. 085504	0	459, 923	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 280802	0	132, 558	0	0	52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000	0		o	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 174363	0	1, 205, 490	o	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 101444	0	1, 241, 942	0	0	55.00
56. 00   05600 RADI 0I SOTOPE	0. 000000	0		o	0	56.00
57. 00 05700 CT SCAN	0. 046190	0	610, 52°	0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 113881	0	145, 983	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 050804	0	433, 704	1 0	0	59.00
60. 00   06000   LABORATORY	0. 111610	0	1, 370, 88	0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0	(	0	0	60. 01
60. 02 06002 PHYSI CLAN LABORATORY	0. 000000	0	(	0	0	60.02
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0	(	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0	(	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 226401	0	4, 930	0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0. 294557	0	68, 26°	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 502259	0	952, 232	0	0	66.00
67. 00  06700 OCCUPATI ONAL THERAPY	0. 000000	0	(	0	0	67.00
68. 00  06800 SPEECH PATHOLOGY	0. 000000	0	(	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 068994	0	302, 014	1 0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 115236	0			0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 339133	0			0	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 181580	0			0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 289457	0			0	73. 00
74. 00   07400   RENAL DI ALYSI S	0. 333074	0	•		0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000	0	•	-	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 880277	0			0	75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 512359	0	21, 49	1 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS	0.000000		1		0	00.00
88. 00   08800   RURAL HEALTH CLINIC	0.000000				_	88.00
89.00   08900   FEDERALLY QUALIFIED HEALTH CENTER 90.00   09000   CLINIC	0.000000	_	37, 250	0	0	89. 00 90. 00
91. 00   09100   EMERGENCY	2. 112427 0. 146983	0   0	•		0	90.00
92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)	0. 146983	0			0	91.00
OTHER REIMBURSABLE COST CENTERS	0. 322194		424, 34	0	U	92.00
94. 00 09400 HOME PROGRAM DIALYSIS	0. 000000					94.00
95. 00 09500 AMBULANCE SERVICES	0. 244455	0	1			95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000	Ö			0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000	Ö	i		0	97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	0			0	98.00
200.00 Subtotal (see instructions)	0.00000	0		1		200.00
201.00 Less PBP Clinic Lab. Services-Program			17,050,000			201.00
Only Charges			]			
202.00 Net Charges (line 200 +/- line 201)		0	17, 856, 866	0	0	202.00
	'	•		'		

| Peri od: | Worksheet D | From 01/01/2015 | Part V | Date/Time Prepared: 5/27/2016 1:53 pm Provi der CCN: 150051

					5/27/2016 1:5	3 pm
		Ti tl	e XIX	Hospi tal	PPS	
	Costs					
Cost Center Description	Cost	Cost				
	Reimbursed F	Reimbursed				
	Servi ces Se	ervices Not				
	Subject To S	Subject To				
	Ded. & Coins. De	d. & Coins.				
		see inst.)				
	6.00	7. 00				
ANCILLARY SERVICE COST CENTERS	0.00	7.00				
50. 00 05000 OPERATING ROOM	303, 824	0				50. 00
50. 01   05001 CV SURGERY	0	o				50.00
	·	•				
51. 00 05100 RECOVERY ROOM	39, 325	0				51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	37, 223	0				52.00
53. 00   05300   ANESTHESI OLOGY	0	0				53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	210, 193	0				54.00
55. 00  05500  RADI OLOGY-THERAPEUTI C	125, 988	0				55.00
56. 00   05600   RADI 01 SOTOPE	0	0				56.00
57. 00  05700   CT   SCAN	28, 200	0				57.00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	16, 625	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	22, 034	o				59.00
60. 00 06000 LABORATORY	153, 004	o				60.00
60. 01   06001   BLOOD   LABORATORY	0	o				60. 01
60. 02 06002 PHYSI CI AN LABORATORY	o	o				60. 02
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		o <sub>l</sub>				61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	l ő	o				62. 00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.		o				63.00
	1 -1	- 1				
64. 00 06400 I NTRAVENOUS THERAPY	1, 116	0				64.00
65. 00   06500   RESPI RATORY THERAPY	20, 107	0				65.00
66. 00   06600   PHYSI CAL THERAPY	478, 267	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	20, 837	0				69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	37, 657	0				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	141, 976	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	230, 864	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	695, 351	o				73.00
74.00 07400 RENAL DIALYSIS	0	o				74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	o				75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	14, 783	o				75. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	11, 013	o				76. 97
OUTPATIENT SERVICE COST CENTERS	11,015	<u> </u>				70.77
88. 00 08800 RURAL HEALTH CLINIC	0	0				88. 00
		- 1				89. 00
	1 -1	0				
90. 00 09000 CLI NI C	78, 701	0				90.00
91. 00   09100   EMERGENCY	468, 261	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	136, 786	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
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0				96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	o				97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	o				98. 00
200.00 Subtotal (see instructions)	3, 272, 135	o				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0	-				201. 00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	3, 272, 135	o				202. 00
1 1 3 2 3 3 4 4 3 3 4 4 4 4 4 4 4 4 4 4 4 4		٦				

Health Financial Systems	J HEALTH BLOOMI	NGTO	N HOSDITAI		In lie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		140101		CCN: 150051	Peri od:	Worksheet D	2332 10
			Component		From 01/01/2015 To 12/31/2015		pared: 3 pm
			Ti t	le XIX	Subprovi der – I RF	PPS	
Cost Center Description	Capi tal	Tota	Charges	Ratio of Cos		Capital Costs	
	Related Cost	(fr	om Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C,	Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	С	ol. 8)	col. 2)			
	col. 26)						
	1. 00		2. 00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS							

Cost Center Description	Capi tal		Ratio of Cost	I npati ent	Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col . 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col. 2)			
	col. 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	2, 387, 249	172, 139, 054		C	0	1 00.00
50. 01  05001 CV SURGERY	0	0	0.000000	C	0	50. 01
51.00  05100   RECOVERY ROOM	174, 267	22, 494, 835		C	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 514, 795	30, 050, 434		C	0	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0.000000	C	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	917, 769	41, 419, 927	0. 022158	C	0	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	966, 534	62, 444, 096	0. 015478	C	0	55.00
56. 00   05600   RADI OI SOTOPE	0	0	0.000000	C	0	56.00
57. 00   05700 CT SCAN	78, 527	30, 430, 071	0. 002581	C	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	86, 632	7, 247, 587	0. 011953	C	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	327, 614	60, 192, 727	0.005443	C	0	59.00
60. 00 06000 LABORATORY	840, 162			C	0	60.00
60. 01   06001   BLOOD   LABORATORY	0		I	C	0	60. 01
60. 02 06002 PHYSI CLAN LABORATORY	0	0	0.000000	C	0	60.02
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_				61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 000000	C	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 000000	C	1	63.00
64. 00   06400   NTRAVENOUS THERAPY	3, 750	735, 624		C	1	64.00
65. 00 06500 RESPIRATORY THERAPY	118, 542	·		C	1	65.00
66. 00   06600   PHYSI CAL THERAPY	1, 057, 679			C	1	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	1,037,077		1	C	1	67.00
68. 00   06800   SPEECH PATHOLOGY	0		0.000000			68.00
69. 00   06900   ELECTROCARDI OLOGY	135, 703	20, 536, 760				69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	169, 065			C	ή	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	226, 822			C	1	71.00
72. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	270, 310			C	1	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	870, 193			(		73.00
73. 00 07300 DR0GS CHARGED TO PATTENTS  74. 00 07400 RENAL DIALYSIS	44, 466			C	ή	74.00
	44, 466		1	(	1	1
		1	0.00000	_	ή	75.00
75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	181, 968			C		75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON	172, 201	2, 734, 177	0. 062981		) 0	76. 97
OUTPATIENT SERVICE COST CENTERS	1 0	1 0	0.000000		V 0	00.00
88. 00   08800   RURAL HEALTH CLINIC 89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER	0	0	0.000000	C		
	_		0.00000	C	1	
90. 00   09000   CLI NI C	174, 817			C	1	90.00
91. 00   09100   EMERGENCY	1, 313, 165		1	C	1	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	13, 684, 357	0.000000	C	) 0	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DI ALYSI S	0	0	0. 000000	C	0	
95. 00   09500   AMBULANCE SERVI CES		_				95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		C		
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD	0	0	0.00000	C	0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 000000	C	1	
200.00 Total (lines 50-199)	12, 032, 230	979, 407, 361		C	0 (	200.00

Health Financial Systems	IU HEALTH BLOOMINGTO	In Lieu of Form CMS-2552-1		
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 150051	Peri od:	Worksheet D
THROUGH COSTS		0	From 01/01/2015	

Component CCN: 15T051 | To 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm Title XIX Subprovi der PPS **IRF** Nursi ng Cost Center Description Non Physician Allied Health All Other Total Cost Anestheti st (sum of col 1 School Medi cal Cost Educati on through col. Cost 1. 00 2.00 3.00 4. 00 5.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 0 0 0 0 50.01 05001 CV SURGERY C 0 50.01 05100 RECOVERY ROOM 0 0 51.00 51.00 00000000000 0 0 0 0 0 0 0 0 0 0 05200 DELIVERY ROOM & LABOR ROOM 0 0 52.00 52.00 0 0 53.00 05300 ANESTHESI OLOGY 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 55.00 0 56.00 05600 RADI OI SOTOPE 0 0 56.00 57.00 05700 CT SCAN 0 0 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 0 59.00 05900 CARDIAC CATHETERIZATION 0 0 59.00 0 06000 LABORATORY 60.00 C 0 60.00 60.01 06001 BLOOD LABORATORY 0 0 60.01 06002 PHYSICIAN LABORATORY 0 0 0 60.02 0 60.02 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61 00 61 00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0000000000000000 0 0 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 64.00 0 0 0 0 0 0 0 0 0 0 0 64.00 06500 RESPIRATORY THERAPY 0 65 00 0 65 00 0 0 06600 PHYSI CAL THERAPY 66.00 0 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 69 00 06900 FLECTROCARDLOLOGY 0 0 69 00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 0 72.00 0 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 0 74.00 07400 RENAL DIALYSIS 0 0 74.00 0 0 0 07500 ASC (NON-DISTINCT PART) 75.00 0 0 75.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 75 01 0 75.01 07697 CARDIAC REHABILITATION 0 76.97 0 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 0 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 89 00 0 0 90.00 09000 CLI NI C 0 0 0 0 90.00 91.00 09100 EMERGENCY 0 0 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0 0 92.00 92.00 0 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 94.00 95.00 09500 AMBULANCE SERVICES 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 0 0 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 97.00 0 0 97.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 0 200.00 Total (lines 50-199) 0 200.00

Не	ealth Financial Systems	IU HEA	LTH BLOOMINGTON	N HOSPITAL		In Lieu	of Form CMS-2552-10
	PPORTIONMENT OF INPATIENT/OUTPATIENT HROUGH COSTS	ANCILLARY SERVICE	OTHER PASS		CCN: 150051 CCN: 15T051	1/01/2015 2/31/2015	Worksheet D Part IV Date/Time Prepared: 5/27/2016 1:53 pm

Cost Center Description					component	1 0011. 101001	0 12/01/2010	5/27/2016 1:5	
Cost Center Description					Title XIX		Subprovi der -		
ANCILLARY SERVICE COST CENTERS									
Cost   Cost		Cost Center Description						•	
COI				· `				J	
A)			*			,		Charges	
NACI LLARY SERVICE COST CENTERS			1.	CC	ol. 8)	col. 7)	,		
AMCILLARY SERVICE COST CENTERS					7.00	0.00		10.00	
50.00   05000   05000   07000   070000   0   070000   0		ANCILLARY SERVICE COST CENTERS	6.00		7.00	8.00	9.00	10.00	
50.00     05001   CV SURGERY   0				17	2 120 054	0.00000	0.00000	0	E0 00
51.00   05100   RECOVERY ROOM   0   22, 494, 835   0.000000   0.000000   0   52 00   52.00   05200   0.000000   0.000000   0.52 00   0.000000   0.000000   0.52 00   0.000000   0.000000   0.52 00   0.000000   0.000000   0.52 00   0.000000   0.000000   0.000000   0.52 00   0.000000   0.000000   0.000000   0.54 00   0.55 00   0.000000   0.000000   0.000000   0.55 00   0.000000   0.000000   0.000000   0.000000   0.55 00   0.000000   0.000000   0.000000   0.000000   0.55 00   0.000000   0.000000   0.000000   0.55 00   0.000000   0.000000   0.000000   0.55 00   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000			1	l .				_	
52.00   05200   05200   05200   05200   05200   05200   05300   05300   05300   05300   05300   05300   05300   05300   05300   05300   05300   0550				ŀ	ū			_	
53.00   05300   ABSTHESI OLOCY   0   0   0   0   0   0   0   0   0				l .					1
S4. 00   05400   RADIO LOGY-DIAGNOSTIC   0   41, 419, 927   0.000000   0.000000   0.55, 00   055, 00   05500   RADIOLOGY-THERAPEUTIC   0   62, 444, 90   0.000000   0.000000   0.56, 00   0.56, 00   0.000000   0.000000   0.56, 00   0.56, 00   0.000000   0.000000   0.56, 00   0.000000   0.57, 00   0.57, 00   0.57, 00   0.57, 00   0.57, 00   0.57, 00   0.57, 00   0.57, 00   0.57, 00   0.57, 00   0.57, 00   0.57, 00   0.57, 00   0.57, 00   0.59, 00   0.000000   0.58, 00   0.000000   0.000000   0.58, 00   0.000000   0.000000   0.59, 00   0.000000   0.000000   0.59, 00   0.000000   0.000000   0.59, 00   0.000000   0.000000   0.000000   0.59, 00   0.000000			-	"	0, 030, 434 N			_	
55. 00   05500   RADIO LOGY-THERAPEUTIC			_	4	1 419 927			_	
56.00   05600   RADIO I SOTOPE   0 0 0 0 0.000000   0.000000   0.57.00   057.00   CT SCON   CT								_	
57.00   05700   CT SCAN   0   05800   MAGNETIC RESONANCE IMAGING (MRI )   0   7, 247, 277   0, 0000000   0, 0000000   0   58, 00   05800   MAGNETIC RESONANCE IMAGING (MRI )   0   7, 247, 277   0, 0000000   0, 0000000   0   58, 00   0   0   0   0   0   0   0   0   0			-		0			_	
58.00   05800   MAGNETIC RESONANCE I IMAGI NG (MRI )   0   7, 247, 5877   0.000000   0.000000   0   58.00   59.00   06000   CARDITEREI ZATI ON   0   0.000000   0.000000   0   60.000   60.01   06000   LABORATORY   0   0   119, 886, 202   0.000000   0.000000   0   60.000   60.01   06000   LABORATORY   0   0   0.000000   0.000000   0   60.000   60.02   06000   PHYSI CI JAN LABORATORY   0   0   0.000000   0.000000   0   60.000   61.00   06100   PHYSI CI JAN LABORATORY   0   0   0.000000   0.000000   0   60.000   62.00   06200   WHOLE B LEOOD & PACKED RED BLOOD CELLS   0   0   0.000000   0.000000   0   60.000   63.00   06300   RIDOD & STORI NG, PROCESSI NG & TRANS.   0   0   0.000000   0.000000   0.000000   0			0	3	0. 430. 071			0	
59.00   05900   CARDI AC CATHETER ZATI ON   0   60, 192, 7277   0 0.000000   0 0.000000   0   60, 00			0					0	
60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0			0					0	
60. 01   06001   BLOOD LABORATORY   0   0   0   0   0   0   0   0   0			1					0	
61.00   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   61.00   062.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0 0 0 0.000000   0.000000   0.62.00   063.00   06300   BLOOD STORI NG, PROCESSING & TRANS.   0 0 0.000000   0.000000   0.000000   0.63.00   064.00   0.000000   0.000000   0.64.00   0.000000   0.000000   0.65.00   0.000000   0.000000   0.000000   0.65.00   0.000000	60. 01	06001 BLOOD LABORATORY	0			0. 000000		0	60. 01
62.00   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   0   0   0   0.000000   0.000000   0	60. 02	06002 PHYSICIAN LABORATORY	0		0	0. 000000	0. 000000	0	60. 02
63.00   06300   BLOOD STORING, PROCESSING & TRANS.   0   0   0,000000   0,000000   0   63.00   64.00   06400   INTRAVENOUS THERAPY   0   735,624   0,000000   0,000000   0   64.00   65.00   06500   RESPI RATORY THERAPY   0   9,891,660   0,000000   0,000000   0   65.00   66.00   06600   PHYSI CAL THERAPY   0   27,236,336   0,000000   0,000000   0   66.00   67.00   06700   OCUPATI ONAL THERAPY   0   0   0,000000   0,000000   0   67.00   68.00   06800   SPEECH PATHOLOGY   0   0,000000   0,000000   0   68.00   69.00   06900   ELECTROCARDI OLOGY   0   20,536,760   0,000000   0,000000   0   69.00   71.00   07000   ELECTROCARDI OLOGY   0   15,968,683   0,000000   0,000000   0   69.00   72.00   07000   ELECTROCARDI OLOGY   0   20,536,760   0,000000   0,000000   0   70.00   72.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   40,396,576   0,000000   0,000000   0   71.00   72.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   87,408,699   0,000000   0,000000   0   72.00   73.00   07300   DRUGS CHARGED TO PATI ENTS   0   37,106,544   0,000000   0,000000   0   73.00   74.00   07400   RENAL DI ALYSI S   0   3,106,544   0,000000   0,000000   0   74.00   75.01   07500   ASC (NON-DI STI NCT PART)   0   0,000000   0,000000   0   75.01   76.97   07697   CARDI AC REHABI LI TATI ON   0   2,734,177   0,000000   0,000000   0   90.00   76.90   08800   RURAL HEALTH CLINI C   0   0,000000   0,000000   0   90.00   76.00   09000   CLINI C   0   0,000000   0,000000   0   90.00   77.00   09000   EREGENCY   0   78,865,393   0,000000   0,000000   0   91.00   77.00   09000   DURABLE MEDI CAL EQUI P-RENTED   0   0,000000   0,000000   0   95.00   77.00   09600   DURABLE MEDI CAL EQUI P-RENTED   0   0,000000   0,000000   0   96.00   77.00   09700   DURABLE MEDI CAL EQUI P-RENTED   0   0,000000   0,000000   0   96.00   77.00   09500   ONBALE MEDI CAL EQUI P-RENTED   0   0,000000   0,000000   0   96.00   77.00   09500   ONBALE MEDI CAL EQUI P-RENTED   0   0,000000   0,000000   0   96.00   77.00   09500   ONBALE MEDI CAL EQUI P-RENTED	61. 00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY							61.00
64.00   06400   INTRAVENOUS THERAPY   0   735, 624   0.000000   0.000000   0   64.00   65.00   06500   RESPIRATORY THERAPY   0   9,891,660   0.000000   0.000000   0   65.00   66.00   06600   PHYSI CAL THERAPY   0   27, 236,336   0.000000   0.000000   0   66.00   67.00   06700   OCCUPATI ONAL THERAPY   0   0   0.000000   0.000000   0.000000   0	62. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0		0	0. 000000	0. 000000	0	62.00
65. 00   06500   RESPI RATORY THERAPY   0   9, 891, 660   0. 000000   0. 000000   0   65. 00   66. 00   06600   PHYSI CAL THERAPY   0   27, 236, 336   0. 000000   0. 000000   0   66. 00   67. 00   06700   0CUPATI ONAL THERAPY   0   0   0   0. 000000   0. 000000   0	63. 00	06300 BLOOD STORING, PROCESSING & TRANS.	0		0	0. 000000	0. 000000	0	63.00
66. 00   06600   PHYSI CAL THERAPY   0   27, 236, 336   0.000000   0.000000   0   66. 00   67. 00   06700   OCCUPATI ONAL THERAPY   0   0   0.000000   0.000000   0.000000   0.67. 00   68. 00   06800   SPEECH PATHOLOGY   0   0   0.000000   0.000000   0.68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   20, 536, 760   0.0000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000	64.00	06400 I NTRAVENOUS THERAPY	0		735, 624	0.000000	0. 000000	0	64.00
67. 00   06700   OCCUPATI ONAL THERAPY   O   O   0.000000   0.000000   O   67. 00   68. 00   06800   SPEECH PATHOLOGY   O   O   0.000000   O   0.000000   O   68. 00   69. 00   06900   ELECTROCARDI OLOGY   O   D   0.000000   O   0.000000   O   69. 00   70. 00   07000   CLECTROENCEPHALOGRAPHY   O   15, 968, 683   O   0.000000   O   0.000000   O   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   O   40, 396, 576   O   0.000000   O   0.000000   O   71. 00   72. 00   07200   IMPL. DEV. CHARGED TO PATI ENTS   O   87, 408, 699   O   0.000000   O   0.000000   O   73. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   O   87, 408, 699   O   0.000000   O   0.000000   O   73. 00   74. 00   07400   RENAL DI ALYSI S   O   3, 106, 544   O   0.000000   O   0.000000   O   74. 00   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   O   2, 534, 851   O   0.000000   O   0.000000   O   75. 01   76. 97   07697   CARDI AC REHABI LI TATI ON   O   2, 734, 177   O   0.000000   O   0.000000   O   76. 97   00   07690   DRURAL HEALTH CLI NI C   O   O   O   0.000000   O   0.000000   O   99. 00   99. 00   08900   FEDERALLY QUALI FI ED HEALTH CENTER   O   O   O   0.000000   O   0.000000   O   99. 00   99. 00   09000   CLI NI C   O   78, 865, 393   O   0.000000   O   0.000000   O   99. 00   99. 00   09000   CLI NI C   O   0   0.000000   O   0.000000   O   99. 00   99. 00   09400   DRERGENCY   O   78, 865, 393   O   0.000000   O   0.000000   O   99. 00   99. 00   09400   DRERGENCY   O   0   0.000000   O   0.000000   O   99. 00   99. 00   09400   DRABLE MEDI CAL EQUI P-SOLD   O   O   O   0.000000   O   0.000000   O   99. 00   99. 00   09400   DURABLE MEDI CAL EQUI P-SOLD   O   O   O   0.000000   O   0.000000   O   98. 00   99. 00   09800   DURABLE MEDI CAL EQUI P-SOLD   O   O   0.000000   O   0.000000   O   98. 00   99. 00   09800   O   O   0.000000   O   0.000000   O   0.000000   O   98. 00			0		9, 891, 660	0.000000	0. 000000	0	65.00
68.00 06800 SPEECH PATHOLOGY 0 0 0.000000 0.000000 0 68.00 69.00 69.00 69000 ELECTROCARDI OLOGY 0 20,536,760 0.000000 0.0000000 0 69.00 70.00 70.00 70.00 ELECTROENCEPHALOGRAPHY 0 15,968,683 0.000000 0.000000 0 70.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 0 40,396,576 0.000000 0.000000 0 71.00 72.00 7300 DRUGS CHARGED TO PATI ENTS 0 87,408,699 0.000000 0.000000 0 72.00 73.00 7300 DRUGS CHARGED TO PATI ENTS 0 128,795,373 0.000000 0.000000 0 73.00 74.00 07400 RENAL DI ALYSI S 0 3,106,544 0.000000 0.000000 0 75.00 75.00 75.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 2,534,851 0.000000 0.000000 0 75.01 76.97 07697 CARDI AC REHABI LI TATI ON 0 2,734,177 0.000000 0.000000 0 76.97 00 000000 0.000000 0 75.01 76.97 07697 CARDI AC REHABI LI TATI CRITER 0 0 0.000000 0.000000 0 88.00 89.00 PSYCHI ATRI CRITER DELATH CENTER 0 0.000000 0.000000 0.000000 0 91.00 99.00 0.000000 0.000000 0 91.00 99.00 0.000000 0.000000 0 91.00 99.00 0.000000 0.000000 0.000000 0 91.00 99.00 0.000000 0.000000 0.000000 0 91.00 99.00 0.000000 0.000000 0 91.00 99.00 0.000000 0.000000 0 91.00 99.00 0.000000 0.000000 0 91.00 99.00 0.000000 0.000000 0 91.00 99.00 0.000000 0.000000 0 91.00 99.00 0.000000 0.000000 0 91.00 99.00 0.000000 0.000000 0 91.00 99.00 0.000000 0.000000 0 91.00 99.00 0.000000 0.000000 0 91.00 0.000000 0 91.00 0.000000 0.000000 0 91.00 0.000000 0 92.00 0.000000 0.000000 0 91.00 0.000000 0 92.00 0.000000 0.000000 0 91.00 0.000000 0 91.00 0.000000 0 91.00 0.000000 0.000000 0 91.00 0.000000 0 91.00 0.000000 0 91.00 0.000000 0 91.00 0.000000 0 91.00 0.000000 0 91.00 0.000000 0 91.00 0.000000 0 0.000000 0 91.00 0.000000 0 91.00 0.000000 0 91.00 0.000000 0 91.00 0.000000 0 91.00 0.000000 0 0.000000 0 0.000000 0 91.00 0.000000 0 0.000000 0 0.000000 0 0.000000				l .	7, 236, 336			0	
69.00   06900   ELECTROCARDI OLOGY   0   20,536,760   0.000000   0.000000   0   69.00   70.00   07000   ELECTROCENCEPHALOGRAPHY   0   15,968,683   0.000000   0.000000   0.70.00   71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   0   40,396,576   0.000000   0.000000   0.70.00   72.00   07200   IMPL. DEV. CHARGED TO PATIENTS   0   87,408,699   0.000000   0.000000   0.72.00   73.00   07300   DRUGS CHARGED TO PATIENTS   0   128,795,373   0.000000   0.000000   0.73.00   74.00   07400   RENAL DI ALYSIS   0   3,106,544   0.000000   0.000000   0.75.00   75.01   03550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0   2,534,851   0.000000   0.000000   0.75.01   76.97   07697   CARDI AC REHABI LI TATI ON   0   2,734,177   0.000000   0.000000   0.76.97   0UTPATIENT SERVI CE COST CENTERS   88.00   08800   RURAL HEALTH CLINI C   0   0   0.000000   0.000000   0.000000   0.90000   0.90000   79.00   09900   CLINI C   0   0   0.000000   0.000000   0.90000   0.90000   0.90000   79.00   09100   EMERGENCY   0   78,865,393   0.000000   0.000000   0.90000   0.90000   79.00   09200   OSSERVATI ON BEDS (NON-DI STINCT PART)   0   13,684,357   0.000000   0.000000   0.000000   0.90000   79.00   09400   HOME PROGRAM DI ALYSI S   0   0   0.000000   0.000000   0.000000   0.000000   79.00   09400   HOME PROGRAM DI ALYSI S   0   0   0.000000   0.000000   0.000000   0.000000   79.00   09700   DURABLE MEDI CAL EQUI P-SOLD   0   0   0.000000   0.000000   0.000000   0.000000   76.90   09800   OTHER REI MBURSABLE COST CENTERS   0   0   0.000000   0.0				l .	_			_	
70.00				l .	Ū			_	
71. 00			-					_	
72. 00								_	
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 128, 795, 373 0.000000 0.000000 0 73. 00 74. 00 07400 RENAL DIALYSIS 0 3, 106, 544 0.000000 0.000000 0 74. 00 75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0.000000 0.000000 0 75. 00 75. 01 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 2, 534, 851 0.000000 0.000000 0 75. 01 76. 97 07697 CARDIA CA REHABILITATION 0 2, 734, 177 0.000000 0.000000 0 75. 01 0017PATIENT SERVI CE COST CENTERS  88. 00 08900 RURAL HEALTH CLINIC 0 0 0.000000 0.000000 0 88. 00 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0.000000 0.000000 0 89. 00 90. 00 09000 CLINIC 0 0 1, 207, 395 0.000000 0.000000 0 90. 00 91. 00 09100 EMERGENCY 0 78, 865, 393 0.000000 0.000000 0 91. 00 92. 00 09200 DBSERVATION BEDS (NON-DISTINCT PART) 0 13, 684, 357 0.000000 0.000000 0 92. 00 075. 01 075. 01 075. 01 075. 01 075. 01 075. 01 075. 01 075. 01 07697 CARDIAC REHABILITATION 0 1, 207, 395 0.000000 0.000000 0 99. 00 09000 CLINIC 0 0 1, 207, 395 0.000000 0.000000 0 99. 00 091. 00 09100 EMERGENCY 0 78, 865, 393 0.000000 0.000000 0 99. 00 092. 00 DBSERVATION BEDS (NON-DISTINCT PART) 0 13, 684, 357 0.000000 0.000000 0 92. 00 075. 01 075. 0				1				_	
74. 00 07400 RENAL DI ALYSIS 0 0 3, 106, 544 0.000000 0.000000 0 74. 00 75. 00 07500 ASC (NON-DI STINCT PART) 0 0 0 0.000000 0.000000 0 75. 00 03500 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 2, 534, 851 0.000000 0.000000 0 75. 00 076. 97 07697 CARDI AC REHABILI TATI ON 0 2, 734, 177 0.000000 0.000000 0 76. 97 0000000 0 0.000000 0 0 0.000000 0 0 0.000000								_	
75. 00   07500   ASC (NON-DISTINCT PART)   0   0   0.000000   0.000000   0.000000   0.75. 00   075. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   2,534,851   0.000000   0.000000   0.000000   0.75. 01   076.97   076.9				l .				_	
75. 01								_	
76. 97   07697   CARDI AC REHABI LI TATI ON   0   2, 734, 177   0.000000   0.000000   0   76. 97     0UTPATI ENT SERVI CE COST CENTERS     0   0   0.000000   0.000000   0   88. 00     89. 00   08900   FEDERALLY QUALI FIED HEALTH CENTER   0   0   0.000000   0.000000   0   99. 00     90. 00   09000   CLI NI C   0   1, 207, 395   0.000000   0.000000   0   99. 00     91. 00   09100   EMERGENCY   0   78, 865, 393   0.000000   0.000000   0   91. 00     92. 00   09200   0BSERVATI ON BEDS (NON-DI STI NCT PART)   0   13, 684, 357   0.000000   0.000000   0   92. 00     07HER REI MBURSABLE COST CENTERS   0   0   0.000000   0.000000   0   94. 00     95. 00   09500   AMBULANCE SERVI CES   96. 00   0.9600   DURABLE MEDI CAL EQUI P-RENTED   0   0.000000   0.000000   0.000000   0.96. 00     97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD   0   0.000000   0.000000   0.000000   0.97. 00     98. 00   09850   OTHER REI MBURSABLE COST CENTERS   0   0   0.0000000   0.0000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.0000000   0.000					_			_	
SECTION   SERVICE COST CENTERS   SECTION				l .				_	
88. 00   08800   RURAL HEALTH CLINIC   0   0   0   0   0   0   0   0   0			0		2, /34, 1//	0.000000	0.000000	U	10.91
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER   0   0   0   0.000000   0.000000   0				I	0	0.00000	0.00000	0	00 00
90. 00   09000   CLINIC   0   1,207,395   0.000000   0.000000   0   90.00   91. 00   09100   EMERGENCY   0   78,865,393   0.000000   0.000000   0   91.00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   13,684,357   0.000000   0.000000   0   92.00				l .	-				
91. 00   09100   EMERGENCY   0   78, 865, 393   0.000000   0.0000000   0   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   13, 684, 357   0.000000   0.000000   0   92. 00				l .	-			_	
92. 00   09200   0BSERVATI ON BEDS (NON-DISTINCT PART)   0   13, 684, 357   0.000000   0.000000   0   92. 00									
OTHER REIMBURSABLE COST CENTERS           94. 00         09400 HOME PROGRAM DI ALYSIS         0         0.0000000         0.000000         0.000000         0.00000								_	
94. 00   09400   HOME PROGRAM DI ALYSIS   0   0.000000   0.000000   0.94. 00   95. 00   95. 00   96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0   0.000000   0.000000   0.000000   0.96. 00   97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD   0   0.000000   0.000000   0.000000   0.97. 00   98. 00   09850   OTHER REI MBURSABLE COST CENTERS   0   0.0000000   0.000000   0.0000000   0.000000   0.000000   0.000000   0.00000000					3,004,337	0.00000	0.000000	0	72.00
95. 00   9500   AMBULANCE SERVICES   95. 00   96. 00   96. 00   97. 00   97. 00   98. 00   9850   OTHER REIMBURSABLE COST CENTERS   95. 00   98. 00			0		0	0.000000	0.000000	0	94 00
96. 00   09600   DURABLE MEDI CAL EQUI P-RENTED   0   0.000000   0.000000   0   96. 00   97. 00   97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD   0   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.000000   0.0000000   0.000000   0.00000000					Ü		3. 223000		
97. 00   09700   DURABLE MEDI CAL EQUI P-SOLD   0   0.000000   0.000000   0   97. 00   98. 00   09850   OTHER REI MBURSABLE COST CENTERS   0   0.000000   0.000000   0.000000   0			0		0	0. 000000	0. 000000	O	
98. 00   09850   OTHER REIMBURSABLE COST CENTERS   0   0.000000   0.000000   0   98. 00			-						
				ŀ	0			_	
			0	97	9, 407, 361			0	

Health Financial Systems	IU HEALTH BLOOMINGTON	N HOSPITAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 150051	Peri od: From 01/01/2015	Worksheet D	
THROUGH COSTS		Component CCN: 15T051	To 12/31/2015	Date/Time Prepared: 5/27/2016 1:53 pm	
		Title XIX	Subprovi der -	PPS	

		"	tie xix	Supprovider -	PPS
Cost Center Description	Inpati ent	Outpati ent	Outpati ent	I RF	
cost center bescription	Program	Program	Program		
	Pass-Through	Charges	Pass-Through		
	Costs (col. 8	char ges	Costs (col.		
	x col . 10)		x col . 12)	7	
	11.00	12. 00	13.00		
ANCILLARY SERVICE COST CENTERS	11.00	12.00	13.00		
50. 00 05000 OPERATI NG ROOM	l ol		ol	0	50.00
50. 01   05001   CV   SURGERY			ol	0	50. 01
51. 00   05100   RECOVERY ROOM			ol	Ö	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM				0	52.00
53. 00   05300   ANESTHESI OLOGY				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C				0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C				n	55. 00
56. 00   05600   RADI OI SOTOPE				0	56.00
57. 00 05700 CT SCAN				0	57.00
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI)				0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON				0	59.00
60. 00   06000   LABORATORY				0	60.00
60. 01   06001   BLOOD   LABORATORY	0			0	60.00
60. 02   06002   PHYSI CI AN LABORATORY	0			0	60.02
	١		٩	U	61.00
			0	0	62.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0	
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 RESPIRATORY THERAPY	0			0	65.00
66. 00   06600   PHYSI CAL THERAPY	0		0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0			0	67.00
68. 00   06800   SPEECH PATHOLOGY	0		0	0	68.00
69. 00   06900   ELECTROCARDI OLOGY	0		0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0		0	0	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0		0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0		0	0	73.00
74. 00   07400   RENAL DI ALYSI S	0		0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0		0	0	75.00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0	0	75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON	0		0	0	76. 97
OUTPATIENT SERVICE COST CENTERS			0	ol	00.00
88.00   08800 RURAL HEALTH CLINIC 89.00   08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0	0	88. 00 89. 00
90. 00   09000   FEDERALLY QUALIFIED HEALTH CENTER				0	90.00
				0	90.00
			0		
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	J U		U	0	92.00
94. 00 09400 HOME PROGRAM DIALYSIS	l ol		0	0	94.00
95. 00   09500   AMBULANCE SERVI CES	١		ď	O .	95.00
96. 00   09600   DURABLE   MEDI CAL   EQUI P-RENTED	0		0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-RENTED					97.00
			0	0	98.00
98.00   09850   OTHER REIMBURSABLE COST CENTERS 200.00   Total (lines 50-199)	0		0	0	200.00
200.00    10tal (111165 00-177)	١		Ч	Υ <sub> </sub>	<sub>1</sub> 200.00

Health Financial Systems	IU HEALTH BLOOMINGTO	N HOSPITAL	In Lieu	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 150051	Peri od:	Worksheet D-1	
			From 01/01/2015		
			To 12/31/2015	Date/Time Pre	pared:
				5/27/2016 1:5	3 pm
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NDATI ENT. DAVC					

		Title XVIII	Hospi tal	PPS	
	Cost Center Description		-	1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1. 00	Inpatient days (including private room days and swing-bed days,			48, 905	1.00
2.00	Inpatient days (including private room days, excluding swing-be Private room days (excluding swing-bed and observation bed days		ivete meem days	48, 905	2.00
3. 00	do not complete this line.	). IT you have only pr	ivate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation bed	days)		44, 885	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	days) through Decembe	r 31 of the cost	0	5. 00
4 00	reporting period Total swing-bed SNF type inpatient days (including private room	daya) aftar Dagambar	21 of the cost	0	4 00
6. 00	reporting period (if calendar year, enter 0 on this line)	days) at ter becember	31 Of the Cost	U	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	days) through December	31 of the cost	0	7.00
	reporting period			_	
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	1 of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	19, 337	9. 00
	newborn days)		3		
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days)	0	10.00
11. 00	through December 31 of the cost reporting period (see instructi Swing-bed SNF type inpatient days applicable to title XVIII onl		nom davs) after	0	11.00
00	December 31 of the cost reporting period (if calendar year, ent		days, a.ts.	Ü	
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12.00
12 00	through December 31 of the cost reporting period	only (including privot	a maam daya)	0	13.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			U	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
17 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to services	through December 31 o	if the cost	0.00	17. 00
17.00	reporting period	through becomber 31 c	THE COST	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0. 00	18. 00
10 00	reporting period	through Docombon 21 of	the east	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	thi ough beceiliber 31 of	the cost	0.00	19. 00
20.00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20.00
04 00	reporting period			50 (07 101	
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December	31 of the cost report	ing period (line	53, 637, 494 0	21. 00 22. 00
22.00	5 x line 17)	or or the cost report	riig perroa (iriid	O	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	g period (line 6	0	23. 00
24.00	X line 18)	21 of the cost resert!	ng ported (line	0	24.00
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	31 of the cost reporti	ng period (iine	0	24. 00
25.00		of the cost reporting	period (line 8	0	25.00
	x line 20)			_	
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ino 21 minus lino 26)		0 53, 637, 494	26.00
27.00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	The 21 millius Title 20)		33, 037, 474	27.00
28. 00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	1: 20)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0.000000	1
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 minu	e lina 33)(eaa instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line	, ,	iti ona)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	01)	1	0.00	36.00
37. 00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	53, 637, 494	37.00
200	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
20.00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS		-	1 007 77	20.00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see i Program general inpatient routine service cost (line 9 x line 3			1, 096. 77 21, 208, 241	38. 00 39. 00
40.00	Medically necessary private room cost applicable to the Program			21, 200, 241	40.00
	Total Program general inpatient routine service cost (line 39 +			21, 208, 241	
			'		

	reporting period		
18.00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	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 the cost	0.00	20.00
	reporting period		
21.00	Total general inpatient routine service cost (see instructions)	53, 637, 494	21.00
22.00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting 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 reporting period (line d	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)	0	26.00
27.00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	53, 637, 494	27.00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 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	
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	53, 637, 494	37.00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 096. 77	
	Program general inpatient routine service cost (line 9 x line 38)	21, 208, 241	
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)	21, 208, 241	41.00

	Financial Systems IU ATION OF INPATIENT OPERATING COST	HEALTH BLOOMI		CCN: 150051	Peri od:	u of Form CMS-2 Worksheet D-1	
					From 01/01/2015 To 12/31/2015	Date/Time Pre 5/27/2016 1:5	
				e XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2.00	3.00	4. 00	5. 00	
42.00		0	C	0.0	0 0	0	42.00
	Intensive Care Type Inpatient Hospital Units						
43. 00 44. 00		6, 813, 550		1		4, 568, 833	1
45.00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	_			0	
	SURGICAL INTENSIVE CARE UNIT	0		1		0	
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description						
48. 00	Program inpatient ancillary service cost (Wk	s+ D 2 col 1	2 line 200)			1. 00 31, 174, 236	48.00
49. 00	, ,			ons)		56, 951, 310	
17.00	PASS THROUGH COST ADJUSTMENTS	rr till odgir 10)	(300 111311 4011	ons)		00, 701, 010	17.00
50.00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, sur	m of Parts I and	2, 810, 462	50.00
51. 00	Pass through costs applicable to Program inpland IV)	atient ancilla	ry services (f	rom Wkst. D, s	sum of Parts II	1, 696, 489	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				4, 506, 951	52.00
53.00	Total Program inpatient operating cost exclu		elated, non-ph	ysician anestl	netist, and	52, 444, 359	
	medical education costs (line 49 minus line	52)		-			]
F4 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	]   54. 00
55. 00						0 00	55.00
56.00						0.00	1
57.00	Difference between adjusted inpatient operat	ing cost and ta	arget amount (	line 56 minus	line 53)	0	1
58. 00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996,	updated and co	ompounded by the	0.00	59.00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	rost renort III	ndated by the	market hasket		0.00	60.00
61.00	If line 53/54 is less than the lower of line				the amount by	0.00	1
	which operating costs (line 53) are less tha		ts (lines 54 x	60), or 1% of	f the target ´		
(2.00	amount (line 56), otherwise enter zero (see	instructions)				0	62.00
	00 Relief payment (see instructions) 00 Allowable Inpatient cost plus incentive payment (see instructions)						
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST	(300 1113111	40110113)			0	63.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost reporti	ing period (See	0	64.00
/F 00	instructions)(title XVIII only)	+£+ D	L 01 -E +L-			0	/ - 00
65. 00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	is after Decemi	ber 31 of the	cost reportino	g period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
	CAH (see instructions)		·				
67. 00	Title V or XIX swing-bed NF inpatient routin (line 12 x line 19)	e costs through	h December 31	of the cost re	eporting period	0	67.00
68 00	Title V or XIX swing-bed NF inpatient routin	e costs after l	December 31 of	the cost ren	orting period	0	68.00
00.00	(line 13 x line 20)			3331 . 354	or tring port ou	· ·	
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NI				\ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \ \		70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c				)		70.00
72. 00	Program routine service cost (line 9 x line	,	11110 70 1 11110	2)			72.00
73. 00	Medically necessary private room cost applic						73.00
74.00	Total Program general inpatient routine serv	,		•	0		74.00
75. 00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (from	worksneet B, F	Part II, column		75.00
76. 00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
77. 00	Program capital-related costs (line 9 x line	76)					77.00
78.00	1 .			1.3			78.00
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp			*.	nus lina 70)		79.00
80.00	Inpatient routine service costs for comp		cost iimi tatio	ii (iiile /o IIIII	ius IIIIC /9)		81.00
82. 00	1 .		1)				82.00
83. 00	Reasonable inpatient routine service costs (	see instructio	* .				83.00
84.00	Program inpatient ancillary services (see in		>				84.00
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum	•					85. 00 86. 00
JU. UU	PART IV - COMPUTATION OF OBSERVATION BED PASS		iii ougii oo)				1 00.00
	Total observation bed days (see instructions					4, 020	87.00
87. 00							1
88. 00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	,			1, 096. 77 4, 409, 015	1

Health Financial Systems	HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/27/2016 1:5	pared: 3 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line	column 2	Observation	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	6, 095, 337	53, 637, 494	0. 11363	9 4, 409, 015	501, 036	90.00
91.00 Nursing School cost	0	53, 637, 494	0.00000	0 4, 409, 015	0	91.00
92.00 Allied health cost	0	53, 637, 494	0.00000	0 4, 409, 015	0	92.00
93.00 All other Medical Education	0	53, 637, 494	0. 00000	0 4, 409, 015	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOS	SPI TAL	In Lieu	of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Prov	ovider CCN: 150051		Worksheet D-1
	Comp			Date/Time Prepared: 5/27/2016 1:53 pm
		Title XVIII	Subprovi der - I RF	PPS

		I RF		
	Cost Center Description		4 00	
	PART I - ALL PROVIDER COMPONENTS		1. 00	
	INPATIENT DAYS			
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)		2, 821	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)		2, 821	2. 00
3.00	Private room days (excluding swing-bed and observation bed days). If you have only pri	vate room days,	0	3.00
	do not complete this line.			
4.00	Semi-private room days (excluding swing-bed and observation bed days)		2, 821	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December	31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 3	1 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)	T OF THE COST	O	0.00
7.00	Total swing-bed NF type inpatient days (including private room days) through December	31 of the cost	0	7. 00
	reporting period			
8. 00	Total swing-bed NF type inpatient days (including private room days) after December 31	of the cost	0	8. 00
0.00	reporting period (if calendar year, enter 0 on this line)	owing had and	1 724	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding newborn days)	swing-bed and	1, 734	9. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private ro	om davs)	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 only (including private ro	om 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		U	13.00
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed d		0	14.00
15.00		. 3 . 7	0	15.00
16.00	Nursery days (title V or XIX only)		0	16.00
	SWING BED ADJUSTMENT			
17. 00		the cost	0. 00	17. 00
10 00	reporting period	ho cost	0.00	10.00
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of t reporting period	THE COST	0.00	18. 00
19. 00	Medical d rate for swing-bed NF services applicable to services through December 31 of	the cost	0.00	19. 00
	reporting period			
20.00		e cost	0.00	20. 00
	reporting period		0 (05 (05	
21. 00 22. 00	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December 31 of the cost reporti	ng ported (lind	2, 635, 485	21. 00 22. 00
22.00	5 x line 17)	ng perrou (irne	0	22.00
23. 00		period (line 6	0	23. 00
	x line 18)	' '		
24.00		g period (line	0	24.00
05.00	7 x line 19)			05.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting x line 20)	period (line 8	0	25. 00
26. 00			0	26. 00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)		2, 635, 485	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		_,,	
28.00	General inpatient routine service charges (excluding swing-bed and observation bed cha	rges)	0	28. 00
	Private room charges (excluding swing-bed charges)		0	
30.00	Semi-private room charges (excluding swing-bed charges)		0	
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)		0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instruct	ions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	. 5.15)	0.00	35. 00
36. 00			0	36.00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost dif	ferential (line	2, 635, 485	37. 00
	27 minus line 36)			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY			
20 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS	T	024.24	20 00
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see instructions)  Program general inpatient routine service cost (line 9 x line 38)		934. 24 1, 619, 972	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)		1, 019, 972	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)		1, 619, 972	
		'		•

	Financial Systems IU ATION OF INPATIENT OPERATING COST	HEALTH BLOOMIN		- CCN: 150051	In Lie	u of Form CMS-2 Worksheet D-1	
COMPO	ATTON OF INFATIENT OFENATING COST			t CCN: 15T051	From 01/01/2015 To 12/31/2015		
			Ti tl	e XVIII	Subprovi der -	5/27/2016 1:5 PPS	3 pm
	Cost Center Description	Total	Total	Average Per	I RF	Program Cost	
	cost center bescription	Inpatient Cost	Inpatient Days	Diem (col. ÷ col. 2)	9	(col. 3 x col. 4)	
42.00	NUDCEDY (+; +l o V & VIV only)	1. 00	2. 00	3.00	4.00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(	0. (	0	0	42.00
	INTENSIVE CARE UNIT	0	(	•			
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	(	1		0	
46.00	SURGICAL INTENSIVE CARE UNIT	0	C	0.0	00 0	0	
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
40.00	·		11 200			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines			ons)		1, 858, 508 3, 478, 480	1
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inputers	atient routine :	servi ces (fro	m Wkst. D, su	m of Parts I and	331, 315	50.00
51.00	Pass through costs applicable to Program inp.	atient ancillar	y services (f	rom Wkst. D,	sum of Parts II	129, 547	51.00
52.00	and IV) Total Program excludable cost (sum of lines					460, 862	•
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		lated, non-ph	ysician anest	hetist, and	3, 017, 618	53.00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55.00	Target amount per discharge					0.00	1
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	rget amount (	line 56 minus	line 53)	0	56. 00 57. 00
58.00	Bonus payment (see instructions)	9			,	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period (	endi ng 1996,	updated and c	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	1
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61.00
	amount (line 56), otherwise enter zero (see		_ (		g		,,,,,,
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mher 31 of th	e cost renort	ing period (See	0	64.00
65. 00	instructions)(title XVIII only)	J		•	31	0	65. 00
	instructions)(title XVIII only)			·			
66. 00	Total Medicare swing-bed SNF inpatient routil CAH (see instructions)	•	·		3,	0	
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	•					67. 00
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after Do	ecember 31 of	the cost rep	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
70.00	Skilled nursing facility/other nursing facil	ity/ICF/IID rou	tine service	cost (line 37	)		70. 00
71. 00 72. 00	Adjusted general inpatient routine service of Program routine service cost (line 9 x line		ine 70 ÷ line	2)			71. 00 72. 00
	Medically necessary private room cost applications	,	(line 14 x l	ine 35)			73.00
74. 00 75. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		•	Part II, column		74. 00 75. 00
76. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	ne 2)					76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line   Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	1 .		rovi der recor	ds)			79.00
80. 00 81. 00	Total Program routine service costs for comp. Inpatient routine service cost per diem limi		ost limitatio	n (line 78 mi	nus line 79)		80. 00 81. 00
82.00	Inpatient routine service cost per diem inmi		)				82.00
83.00	Reasonable inpatient routine service costs (		s)				83.00
84. 00 85. 00	Program inpatient ancillary services (see in: Utilization review - physician compensation		ns)				84. 00 85. 00
	Total Program inpatient operating costs (sum	of lines 83 th					86. 00
87.00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•	line 2)				88. 00 89. 00
07.00	Longer Agricult ped coar (Title 01 x Title 00) (26	c manuchons)				1	1 07.00

Health Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 01/01/2015 To 12/31/2015		pared: 3 pm
		Ti tl	e XVIII	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	539, 001	2, 635, 485	0. 20451	7 0	0	90.00
91.00 Nursing School cost	0	2, 635, 485	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2, 635, 485	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 635, 485	0. 00000	0 0	0	93.00

Heal th	Financial Systems	IU HEALTH BLOOMINGTON	I HOSPITAL	In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Provi der CCN: 150051	Peri od: From 01/01/2015	Worksheet D-1	
				To 12/31/2015	Date/Time Pre 5/27/2016 1:5	pared: 3 pm
			Title XIX	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room days	s and swing-bed days,	excluding newborn)		48, 905	1.00
2.00						2.00
3. 00	Private room days (excluding swing-bed and do not complete this line.	observation bed days	). If you have only p	orivate room days,	0	3.00

	Cost Center Description	1.00	
	PART I - ALL PROVIDER COMPONENTS	1. 00	
	INPATIENT DAYS		
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	48, 905	1.00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	48, 905	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)	44, 885	4.00
5.00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	0	5. 00
,	reporting period		,
6. 00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
7.00	reporting period	٥	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, 551	9.00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	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 only (including private room days) after	0	11. 00
12 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)		12 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) through December 31 of the cost reporting period	0	12.00
13. 00	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)	ĭ	13.00
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
	Total nursery days (title V or XIX only)	4, 718	15. 00
	Nursery days (title V or XIX only)	2, 502	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0. 00	17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	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)	53, 637, 494	21. 00
	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting 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 reporting period (line 🕯	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
05.00	7 x line 19)		05.00
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00	Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	53, 637, 494	
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	33, 037, 474	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
	Private room charges (excluding swing-bed charges)	0	29.00
	Semi-private room charges (excluding swing-bed charges)	o	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
	Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00	
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0. 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	36.00
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	53, 637, 494	37. 00
	27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
38. 00	Adjusted general inpatient routine service cost per diem (see instructions)	1, 096. 77	38. 00
	Program general inpatient routine service cost (line 9 x line 38)	1, 701, 090	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40.00
	Total Program general inpatient routine service cost (line 39 + line 40)	1, 701, 090	
	· · · · · · · · · · · · · · · · · · ·	'	

	Financial Systems IU ATION OF INPATIENT OPERATING COST	TIETETTI BEGGIIII	NGTON HOSPITAL Provi der	CCN: 150051 P	eri od:	u of Form CMS-2 Worksheet D-1	
					rom 01/01/2015 o 12/31/2015	Date/Time Pre 5/27/2016 1:5	
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 ÷ col. 2)	Program Days	Program Cost (col. 3 x col. 4)	
		1. 00	2. 00	3.00	4.00	5. 00	
42.00	NURSERY (title V & XIX only)	2, 897, 980				1, 536, 828	42.00
	Intensive Care Type Inpatient Hospital Units						
43.00	INTENSIVE CARE UNIT	6, 813, 550				395, 114	
44.00	4	0				0	
45.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	ŀ			0	45. 00 46. 00
	OTHER SPECIAL CARE (SPECIFY)	O	0	0.00	l o	١	47.00
11100	Cost Center Description						
						1. 00	
48.00	Program inpatient ancillary service cost (Wk			,		2, 205, 781	48.00
49. 00	Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS	41 through 48)	(see instructi	ons)		5, 838, 813	49.00
50. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst D sum	of Parts L and	381, 583	50.00
00.00			33. 1. 333 (1. 3.		0	33.,333	00.00
51.00	Pass through costs applicable to Program inp	atient ancilla	ry services (f	rom Wkst. D, si	um of Parts II	142, 844	51.00
E2 00	and IV)	FO and F1)				F04 407	E0 00
52. 00 53. 00	Total Program excludable cost (sum of lines I Total Program inpatient operating cost exclu		elated non-nh	vsician andeth	atist and	524, 427 5, 314, 386	52. 00 53. 00
55.00	medical education costs (line 49 minus line		статей, поп-рп	yardran anestik	Just, and	5, 514, 500	33.00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					1
	Program di scharges					0	
55.00							55.00
56.00	,		(	F/!	1: 52)	0	
57. 00 58. 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	arget amount (	THE SO III HUS I	THE 53)	0	57. 00 58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi na 1996	undated and cor	mpounded by the		
07.00	market basket	por tring por roa	onaring 17707	2paaroa aa oo.		0.00	07.00
60.00							60.00
61. 00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		ts (lines 54 x	60), or 1% of	the target		
62. 00	00 Relief payment (see instructions)					0	62.00
	00 Allowable Inpatient cost plus incentive payment (see instructions)						63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64. 00	Medicare swing-bed SNF inpatient routine cos	ts through Dec	ember 31 of th	e cost reportin	ng period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	ts after Decemb	her 31 of the	rost renorting	neriod (See	o	65.00
00.00	instructions)(title XVIII only)	to arter becom	ber or or the	sost reporting	perrou (see	١	00.00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line	55)(title XVIII	l only). For	0	66.00
	CAH (see instructions)			6.11		ا	
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	n December 31	of the cost rep	porting period	0	67.00
68. 00	Title V or XIX swing-bed NF inpatient routing	e costs after l	December 31 of	the cost repor	rtina period	0	68.00
	(line 13 x line 20)				9 p	-	
69. 00	Total title V or XIX swing-bed NF inpatient					0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER NU						70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of						70.00
72.00	Program routine service cost (line 9 x line		ittle 70 ÷ ittle	2)			72.00
73.00	Medically necessary private room cost application		m (line 14 x l	ne 35)			73.00
74.00	Total Program general inpatient routine serv	•					74.00
75. 00	Capital-related cost allocated to inpatient	routine service	e costs (from	Norksheet B, Pa	art II, column		75.00
76. 00	26, line 45)  Per diem capital-related costs (line 75 ÷ li	no 2)					76.00
77. 00	Program capital related costs (line 9 x line	,					77.00
78. 00	Inpatient routine service cost (line 74 minus						78.00
79. 00	Aggregate charges to beneficiaries for excess	, ,		*.			79.00
80.00	, ,		cost limitatio	າ (line 78 minu	us line 79)		80.0
81. 00 82. 00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (I		1)				81.0
83.00	Reasonable inpatient routine service cost in ill tation (i		* .				83.0
84. 00	Program inpatient ancillary services (see in		,				84.00
85. 00	Utilization review - physician compensation		ons)				85.00
			hrough 85)				86.00
86. 00	DART IV COMPUTATION OF ORDERVATION REP DAG	S THROUGH COST					I
	PART IV - COMPUTATION OF OBSERVATION BED PASS					4 000	07 00
86. 00 87. 00 88. 00	Total observation bed days (see instructions)	)	÷ line 2\			4, 020 1, 096. 77	

Health Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015		
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	6, 095, 337	53, 637, 494	0. 11363	9 4, 409, 015	501, 036	90.00
91.00 Nursing School cost	0	53, 637, 494	0.00000	0 4, 409, 015	0	91.00
92.00 Allied health cost	0	53, 637, 494	0.00000	0 4, 409, 015	0	92.00
93.00 All other Medical Education	0	53, 637, 494	0. 00000	0 4, 409, 015	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 150051		Worksheet D-1
	Component CCN: 15TO5	From 01/01/2015 To 12/31/2015	
	Title XIX	Subprovi der -	PPS
		IRF	

NATE   ALL REWOLDER COMPONENTS			I RF		
		Cost Center Description	-	1 00	
Impact In It Mays   Including private room days and seing-bed days, excluding newborm)   2,827   1,00   Inpact ient days (Including private room days, excluding safing-bed and newborm days)   2,827   2,00   0,0		DART I - ALL DROWLDER COMPONENTS		1.00	
1,000   Impatient days (including private room days and swing-bed days, excluding newborn)					
Inipatient days (including private room days, excluding saring-bed and nesborn days)   1.7 you have and private room days.   0.3.00	1. 00			2, 821	1.00
do not complote this line.  4. 00 Sell-private room days (excluding saling-bed and observation bed days)  1. 00 Intal saving-bed SWF type inpartient days. (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total saving-bed WF type inpartient days. (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  7. 00 Total saving-bed WF type inpartient days. (including private room days) shrough Becember 31 of the cost reporting period (if calendar year, enter 0 on this line)  8. 00 Total saving-bed WF type inpartient days. (including private room days) after December 31 of the cost reporting period on this line)  9. 00 Total saving-bed WF type inpartient days applicable to the Program (excluding swing-bed and near total saving-bed WF type inpartient days applicable to the Program (excluding swing-bed and near total saving-bed SWF type inpartient days applicable to title XVIII only (including private room days)  10. 00 Saving-bed SWF type inpartient days applicable to title XVIII only (including private room days)  11. 00 Saving-bed SWF type inpartient days applicable to title XVIII only (including private room days)  12. 00 Saving-bed SWF type inpartient days applicable to title XVIII only (including private room days)  13. 00 Saving-bed SWF type inpartient days applicable to title XVIII only (including private room days)  14. 00 SWF type inpartient days applicable to title XVIII only (including private room days)  15. 00 SWF type inpartient days applicable to title XVIII only (including private room days)  16. 00 SWF type inpartient days applicable to title XVIII only (including private room days)  17. 00 SWF type inpartient days applicable to title XVIII only (including private room days)  18. 00 SWF type inpartient days applicable to title XVIII only (including private room days)  18. 00 SWF type inpartient days applicable to title XVIII only (including private room days)  18. 00 S				·	2.00
	3.00	Private room days (excluding swing-bed and observation bed days). If you have only pri	vate room days,	0	3.00
Total "swing-bed SNF type inpatient days (including private room days) through December 31 of the cost cost proporting period (if cal endar year, enter 0 on this line) cost in the cost reporting period (if cal endar year, enter 0 on this line) cost in the cost reporting period (if cal endar year, enter 0 on this line) cost reporting period (if cal endar year, enter 0 on this line) cost reporting period (if cal endar year, enter 0 on this line) cost reporting period (if cal endar year, enter 0 on this line) cost reporting period (if cal endar year, enter 0 on this line) cost reporting period (if cal endar year, enter 0 on this line) cost reporting period (if cal endar year, enter 0 on this line) cost period (if cal endar year, enter 0 on this line) cost period (if cal endar year, enter 0 on this line) cost period (if cal endar year, enter 0 on this line) cost period (if cal endar year, enter 0 on this line) cost period (if cal endar year, enter 0 on this line) cost period (if cal endar year, enter 0 on this line) cost period (if cal endar year, enter 0 on this line) cost period (if cal endar year, enter 0 on this line) cost period (if cal endar year, enter 0 on this line) cost period (if cal endar year, enter 0 on this line) cost period (if cal endar year, enter 0 on this line) cost period (if cal endar year, enter 0 on this line) cost period (if cal endar year, enter 0 on this line) cost cost cost cost cost cost cost cost			_		
reporting period (if calendar year, enter 0 on this line)  7.00  7					1
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newborn days   10.00   Non-bed SMF type inpatient days applicable to title XVIII only (including private room days)   0   10.00   11.00   Non-bed SMF type inpatient days applicable to title XVIII only (including private room days) after   0   11.00   11.00   11.00   Non-bed SMF type inpatient days applicable to title XVIII only (including private room days) after   12.00   SMing-bed NF type inpatient days applicable to title XVIII only (including private room days)   0   12.00   13.00					
10.00   Swing-bed SMr type inpatient days applicable to title XVIII only (including private room days)   0   10.00	9. 00		swing-bed and	10	9.00
through December 31 of the cost reporting period (see instructions)  1.00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)  1.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.01 (1.02) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.02 (1.03) Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  1.03 (1.04) Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days)  1.06 (1.08) Construction of the cost reporting period (if calendar year, enter 0 on this line)  1.09 (1.00) Medical ly necessary private room days applicable to the Program (excluding swing-bed days)  1.00 (1.00) Medical reproved the Vite V or XIX only)  1.00 (1.00) Medical reproved the Vite V or XIX only)  1.00 (1.00) Medical reproved SNF services applicable to services through December 31 of the cost one reporting period (including period of the cost of the cost of the cost of the cost of the cost of the cost of the cost of the vite V or XIX only (including period of the cost of the cos	10 00		om dave)	0	10 00
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13.00   Swing-bed NF type inpatient days applicable to titles V or XIX only V (Including private room days)   0   13.00	12.00		e room days)	0	12.00
after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   14,00   14,00   15.00   10   10   10   10   10   10   10	40.00				40.00
14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   16.00   Nursery days (title V or XIX only)   2.502   16.00   Nursery days (title V or XIX only)   2.502   16.00   Nursery days (title V or XIX only)   2.502   16.00   Nursery days (title V or XIX only)   2.502   16.00   Nursery days (title V or XIX only)   2.502   16.00   Nursery days (title V or XIX only)   2.502   16.00   17.00   17.00   18.00   18.00   18.00   18.00   19.00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19.00   Medicare rate for swing-bed NF services applicable to services after December 31 of the cost   0.00   19.00	13. 00			0	13.00
15.00   Total nursery days (title V or XIX only)   2,502   16.00	1/ 00			0	14 00
16.00   Nursery days (title v or XIX only)   2,502   16.00			lays)		
SWING BED ADJUSTMENT		,			1
reporting period Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (December 31 of the cost reporting period reporting period (December 31 of the cost reporting beriod (December 31 of the cost reporting beriod (December 31 of the cost reporting beriod (December 3			,	,	
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9. 00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20. 00   20. 0	18. 00		the cost	0. 00	18. 00
reporting period  Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period (20.00 Total general inpatient routine service cost (see instructions)  2. 635, 485  21. 00  22. 00  23. 00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)  24. 00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 18)  24. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 18)  25. 00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)  26. 00 Total swing-bed cost (see instructions)  27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28. 00 Total swing-bed cost (see instructions)  29. 00 Private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 Semi-private room per diem charge (line 29 + line 3)  31. 00 Average per diem private room per diem charge (line 30 + line 4)  32. 00 Average per diem private room cost differential (line 34 x line 31)  33. 00 Average per diem private room cost differential (line 34 x line 31)  34. 00 Average per diem private room cost differential (line 34 x line 31)  35. 00 General inpatient routine service cost per diem (see instructions)  36. 00 FORGAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Program general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  39. 00 Program general inpatient routine service cost per diem (see instructions)  30. 00 Program general inpatient routine service cost per diem (see instru	10 00		the cost	0.00	10.00
Medical drate for swing-bed NF services applicable to services after December 31 of the cost reporting period   2.00   20.00	19.00		the cost	0.00	19.00
reporting period Total general inpatient routine service cost (see instructions) 22.00 22.00 23.00 24.00 25.00 26.00 26.00 27.00 27.00 28.00 28.00 29.	20. 00		ne cost	0.00	20.00
22.00   Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   26.00   Total swing-bed cost (see instructions)   0 26.00   27.00   General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   2, 635, 485   28.00   General inpatient routine service charges (excluding swing-bed and observation bed charges)   0 29, 00 0   29.00   Private room charges (excluding swing-bed charges)   0 29, 00 0   30.00   Semi-private room charges (excluding swing-bed charges)   0 29, 00 0   31.00   General inpatient routine service cost/charge ratio (line 27 + line 28)   0 0, 000   32.00   Average private room per diem charge (line 29 + line 3)   0 0, 00   33.00   Average semi-private room per diem charge (line 29 + line 3)   0 0, 00   34.00   Average per diem private room cost differential (line 30 + line 4)   0 0, 00   35.00   Average per diem private room cost differential (line 34 x line 31)   0 0, 00   36.00   Private room cost differential adjustment (line 3 x line 35)   0 36, 00   37.00   Program general inpatient routine service cost per diem (see instructions)   934.24   38.00   Adjusted general inpatient routine service cost per diem (see instructions)   9, 342   39.00   Program general inpatient routine service cost per diem (see instructions)   0 40, 00   39.00   Program general inpatient routine service cost per diem (see instructions)   0 40, 00   39.00   Program general inpatient routine service cost per diem (see instructions)   0 40, 00   39.00   Program general inpatient routine service cost per diem (see instructions)   0 40, 00   39.00   Program general inpatient r					
5 x line 17)  23.00					1
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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) 0 26.00  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 2, 635, 485 27.00  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) 0 29.00  29.00 Private room charges (excluding swing-bed charges) 0 29.00  30.00 Semi-private room charges (excluding swing-bed charges) 0 29.00  31.00 General inpatient routine service cost/charge ratio (line 27 * line 28) 0.0000031.00  32.00 Average private room per diem charge (line 29 * line 3) 0.00  33.00 Average semi-private room charge differential (line 32 minus line 33)(see instructions) 0.00  34.00 Average per diem private room cost 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  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,635,485) 37.00  27 minus line 36) PART II - HOSPITAL AND SUBPROVI DERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions) 934.24  39.00 Program general inpatient routine service cost per diem (see instructions) 934.24  39.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00	22.00	,	noried (line (	0	22.00
24.00 Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00 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)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  31.00 Average peri diem private room per diem charge (line 30 + line 4)  32.00 Average per diem private room cost differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 635, 485)  37.00 Average per diem private room cost differential (line 3 x line 35)  38.00 Agiusted general inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  38.00 Program general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	23.00		j periou (iille o	U	23.00
7 x line 19)  25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 vine 20)  26.00 Total swing-bed cost (see instructions)  27.00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  32.00 Average semi-private room per diem charge (line 29 ÷ line 3)  33.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  34.00 Average per diem private room cost differential (line 3x line 31)  35.00 Average per diem private room cost differential (line 3x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 635, 485)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 635, 485)  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  39.00 Program general inpatient routine service cost per diem (see instructions)  934. 24  934. 24  934. 24  934. 24  934. 24  94. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)	24.00		na period (line	0	24.00
x line 20)  26.00 Total swing-bed cost (see instructions) Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges) Ceneral inpatient routine service charges (excluding swing-bed charges) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 27 ÷ line 28) Ceneral inpatient routine service cost/charge ratio (line 28 ± line 28) Ceneral inpatient routine service cost/charge (line 30 ÷ line 4) Ceneral inpatient routine service cost (line 30 ± line 4) Ceneral inpatient routine service cost (line 30 ± line 31) Ceneral inpatient routine service cost (line 32 minus line 33)(see instructions) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 635, 485) Ceneral inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 635, 485) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost per diem (see instructions) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 38) Ceneral inpatient routine service cost (line 9 x line 31) Ceneral inpatient routine service cost (line 9 x line 31) Ceneral inpatient routine service cost (line 9 x			.9		
Total swing-bed cost (see instructions)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  General inpatient routine service charges (excluding swing-bed and observation bed charges)  Private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  Semi-private room charges (excluding swing-bed charges)  General inpatient routine service cost/charge ratio (line 27 + line 28)  Average private room per diem charge (line 29 + line 3)  Average per diem private room per diem charge (line 30 + line 4)  Average per diem private room cost differential (line 32 minus line 33)(see instructions)  Average per diem private room cost differential (line 34 x line 31)  Average per diem private room cost differential (line 3 x line 35)  Private room cost differential adjustment (line 3 x line 35)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00  Adjusted general inpatient routine service cost (line 9 x line 38)  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O 40. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O 26. 00  Condition 27 minus line 36)  Program general inpatient routine service cost (line 9 x line 38)  O 40. 00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  O 40. 00	25.00		period (line 8	0	25. 00
27. 00 General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28. 00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29. 00 Pri vate room charges (excluding swing-bed charges)  30. 00 Semi-private room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  30. 00 Average private room per diem charge (line 29 + line 3)  30. 00 Average semi-private room per diem charge (line 30 + line 4)  30. 00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 34 x line 31)  30. 00 Average per diem private room cost differential (line 3 x line 35)  30. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adj usted general inpatient routine service cost (line 9 x line 38)  38. 00 Program general inpatient routine service cost (line 9 x line 38)  39. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00				_	
PRI VATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  9.00 Pri vate room charges (excluding swing-bed charges)  30.00 Semi-pri vate room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average pri vate room per diem charge (line 29 ÷ line 3)  32.00 Average semi-pri vate room per diem charge (line 30 ÷ line 4)  33.00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  34.00 Average per diem pri vate room cost differential (line 34 x line 31)  35.00 Average per diem pri vate room cost differential (line 34 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and pri vate room cost differential (line 2, 635, 485)  37.00 General inpatient routine service cost per diem (see instructions)  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  9.34.24 38.00  Program general inpatient routine service cost (line 9 x line 38)  9.34.24 39.00  Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28.00  28.00  29.00  20.00  30.00		, ,			1
28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges)  29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  30.00 Average private room per diem charge (line 29 + line 3)  32.00 Average semi-private room per diem charge (line 29 + line 3)  33.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  34.00 Average per diem private room cost differential (line 34 x line 31)  35.00 Average per diem private room cost differential (line 34 x line 31)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 635, 485)  37.00 PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  9.34.24 38.00  Program general inpatient routine service cost (line 9 x line 38)  9.34.24 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	27.00			2, 035, 485	27.00
29.00 Private room charges (excluding swing-bed charges)  30.00 Semi-private room charges (excluding swing-bed charges)  31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28)  32.00 Average private room per diem charge (line 29 ÷ line 3)  33.00 Average semi-private room per diem charge (line 29 ÷ line 3)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 635, 485)  37.00 PART II - HOSPITAL AND SUBPROVI DERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  93.40 Program general inpatient routine service cost (line 9 x line 38)  940.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.0	28 00		arges)	0	28 00
30.00 Semi-private room charges (excluding swing-bed charges) 31.00 General inpatient routine service cost/charge ratio (line 27 ÷ line 28) 32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 635, 485)  Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0			900)		1
32.00 Average private room per diem charge (line 29 ÷ line 3) 33.00 Average semi-private room per diem charge (line 30 ÷ line 4) 34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions) 35.00 Average per diem private room cost differential (line 34 x line 31) 36.00 Private room cost differential adjustment (line 3 x line 35) 37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 635, 485)  Adjusted general inpatient routine service cost per diem (see instructions) 38.00 Adjusted general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0.00 32.					1
33.00 Average semi-private room per diem charge (line 30 ÷ line 4)  34.00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 635, 485)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost (line 9 x line 38)  Program general inpatient routine service cost (line 9 x line 38)  93.42 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)		0.000000	31.00
34.00 Average per diem private room charge differential (line 32 minus line 33) (see instructions)  35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 635, 485)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  934.24  39.00 Program general inpatient routine service cost (line 9 x line 38)  9, 342  90.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					1
35.00 Average per diem private room cost differential (line 34 x line 31)  36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 635, 485)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  934.24 38.00  Program general inpatient routine service cost (line 9 x line 38)  9, 342 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0					1
36.00 Private room cost differential adjustment (line 3 x line 35)  37.00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2,635,485)  27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY  PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  934.24  39.00 Program general inpatient routine service cost (line 9 x line 38)  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			i ons)		1
37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 2, 635, 485 27 minus line 36)  PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38. 00 Adjusted general inpatient routine service cost per diem (see instructions) 934. 24 38. 00 Program general inpatient routine service cost (line 9 x line 38) 9, 342 39. 00 40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40. 00					1
27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  934.24 38.00 Program general inpatient routine service cost (line 9 x line 38)  9,342 39.00 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00			ferential (line		•
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)  934.24 38.00  Program general inpatient routine service cost (line 9 x line 38)  9,342 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00	57.00		. S. S. C. C. C. C. C. C. C. C. C. C. C. C. C.	2, 555, 465	07.00
PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  38.00 Adjusted general inpatient routine service cost per diem (see instructions)  934.24 38.00  Program general inpatient routine service cost (line 9 x line 38)  9,342 39.00  40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40.00					
39.00 Program general inpatient routine service cost (line 9 x line 38) 40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 9,342 39.00 0 40.00		PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS			
40.00 Medically necessary private room cost applicable to the Program (line 14 x line 35) 0 40.00					1
					1
41. 00   Total Flogram general Hipatrent Toutine Service Cost (Tine 39 + Tine 40)		1			
	41.00	Trotal Trogram general impatrent routine service cost (ITHE 37 + ITHE 40)	l	9, 342	41.00

	ATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
			Componen	t CCN: 15T051	From 01/01/2015		
			'	le XIX	Subprovi der -	5/27/2016 1:5 PPS	3 pm
		T. I. I			I RF		
	Cost Center Description	Total Inpatient Cost	Total I npati ent Days	Average Per Diem (col. ÷ col. 2)		Program Cost (col. 3 x col. 4)	
42.00	NUDCEDY (+; +Lo V & VLV only)	1. 00	2.00	3.00	4. 00 00 0	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	U		0.	00  0	0	42.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	•			43.00 44.00
	BURN INTENSIVE CARE UNIT	0	C	1		0	
	SURGICAL INTENSIVE CARE UNIT	0	C	0.	00 0	0	
47.00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47.00
49.00	Program inpatient ancillary service cost (Wks	s+ D 2 col 3	2 Line 200)			1. 00	48. 00
	Program inpatient ancirrary service cost (we Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS			ons)			49.00
50. 00	Pass through costs applicable to Program inpa	atient routine	services (fro	m Wkst. D, su	um of Parts I and	1, 911	50.00
51. 00	<pre>III) Pass through costs applicable to Program inpa and IV)</pre>	atient ancillar	ry services (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines 5						52.00
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line 5 TARGET AMOUNT AND LIMIT COMPUTATION		elated, non-ph	ysician anest	thetist, and	7, 431	53.00
	Program di scharges						54.00
	Target amount per discharge Target amount (line 54 x line 55)					0.00	55. 00 56. 00
	Difference between adjusted inpatient operati	ing cost and ta	arget amount (	line 56 minus	s line 53)	ő	
58.00 Bonus payment (see instructions) 59.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the						0.00	58. 00 59. 00
market basket  60.00 Lesser of lines 53/54 or 55 from prior year cost report, updated by the market basket						0. 00	60.00
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						0	61.00
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	instructions)				0	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instru	uctions)				63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts through Dece	ember 31 of th	e cost report	ting period (See	0	64.00
65. 00	Medicare swing-bed SNF inpatient routine cost instructions)(title XVIII only)	ts after Decemb	per 31 of the	cost reportir	ng period (See	0	65.00
66. 00	Total Medicare swing-bed SNF inpatient routing CAH (see instructions)	ne costs (line	64 plus line	65)(title XVI	II only). For	0	66.00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	n December 31	of the cost r	reporting period	0	67.00
	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)			'	porting period		68. 00
69. 00	Total title V or XIX swing-bed NF inpatient r PART III - SKILLED NURSING FACILITY, OTHER NU					0	69.00
	Skilled nursing facility/other nursing facili	ity/ICF/IID rou	utine service	cost (line 37	7)		70.00
	Adjusted general inpatient routine service of Program routine service cost (line 9 x line 7	,	ine /U ÷ line	: 2)			71.00
73. 00	Medically necessary private room cost applica	abĺe to Program					73.00
74. 00 75. 00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r 26, line 45)	•		,	Part II, column		74. 00 75. 00
	Per diem capital-related costs (line 75 ÷ lin	,					76.00
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77.00
79. 00	Aggregate charges to beneficiaries for excess	s costs (from p		*.			79.00
	Total Program routine service costs for comparing the routine service cost per diem limit		cost limitatio	n (line 78 mi	nus line 79)		80.00
82. 00	Inpatient routine service cost limitation (li	ine 9 x line 81	*				82.00
	Reasonable inpatient routine service costs (s		ns)				83. 00 84. 00
	Program inpatient ancillary services (see ins Utilization review - physician compensation		ons)				85.00
	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS	of lines 83 th					86.00
	Total observation bed days (see instructions)					0	
87. 00			: line 2)			'	88.00

Health Financial Systems		In Lie	u of Form CMS-2	2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
		Component		From 01/01/2015 To 12/31/2015		
		Ti t	le XIX	Subprovi der -	PPS	
				I RF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observati on	Bed Pass	
		27)		Bed Cost	Through Cost	
		·		(from line	(col. 3 x	
				89)	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	539, 001	2, 635, 485	0. 20451	7 0	0	90.00
91.00 Nursing School cost	0	2, 635, 485	0.00000	0 0	0	91.00
92.00 Allied health cost	0	2, 635, 485	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 635, 485	0. 00000	0 0	0	93.00

Health Financial Systems	IU HEALTH BLOOMINGTON	I HOSPITAL	In Lieu	ı of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der CCN: 150051	Peri od: From 01/01/2015	Worksheet D-3

12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm Title XVIII Hospi tal Cost Center Description Ratio of Cost Inpati ent I npati ent Program Costs To Charges Program Charges (col. 1 x col. 2) 1.00 2.00 3. 00 INPATIENT ROUTINE SERVICE COST CENTERS 38. 214, 299 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 8, 326, 926 31.00 03200 CORONARY CARE UNIT 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34 00 0 34 00 40.00 04000 SUBPROVI DER - I PF 40.00 41.00 04100 SUBPROVI DER - I RF 578, 312 41.00 04200 SUBPROVI DER 42.00 42.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0. 107609 34, 010, 587 3, 659, 845 50.00 05001 CV SURGERY 0.000000 50.01 50.01 0 51.00 05100 RECOVERY ROOM 0.085504 3, 282, 854 280, 697 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.280802 153, 487 43,099 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 |05400| RADI OLOGY-DI AGNOSTI C 6, 225, 911 1, 085, 569 54 00 0.174363 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.101444 2, 163, 901 219, 515 55.00 05600 RADI 0I SOTOPE 0.000000 56, 00 56.00 05700 CT SCAN 5, 786, 212 267, 265 57.00 0.046190 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0.113881 1, 375, 712 156, 667 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.050804 10, 930, 010 555, 288 59.00 60.00 06000 LABORATORY 0.111729 23, 299, 401 2, 603, 219 60.00 60 01 06001 BLOOD LABORATORY 0.000000 60 01 0 0 06002 PHYSI CI AN LABORATORY 60.02 0.000000 0 0 60.02 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61.00 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 ol 62.00 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0.000000 0 Ω 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.226401 870 197 64.00 4, 790, 779 65.00 06500 RESPIRATORY THERAPY 0. 294557 1, 411, 157 65.00 66 00 06600 PHYSI CAL THERAPY 0.502259 3, 016, 633 1, 515, 131 66 00 06700 OCCUPATI ONAL THERAPY 67.00 0.000000 0 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.068994 5, 212, 856 359, 656 69.00 07000 ELECTROENCEPHALOGRAPHY 0.115236 248, 394 70 00 2, 155, 527 70 00 0.339133 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 9, 152, 824 3, 104, 025 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.181580 26, 543, 003 4, 819, 678 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.289457 30, 354, 708 8, 786, 383 73.00 07400 RENAL DIALYSIS 1, 519, 312 74 00 0.333074 506, 043 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 75.00 0 75.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.883895 10,068 8,899 75.01 07697 CARDIAC REHABILITATION 0.512359 166, 032 85, 068 76.97 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 CLINIC 2.112427 27.084 57.213 90.00 7, 519, 522 91.00 09100 EMERGENCY 0.146983 1, 105, 242 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.322194 918, 657 295, 986 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0.000000 0 94.00 95.00 09500 AMBULANCE SERVICES 95.00 96 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00 0.000000 0 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 Λ 98.00 200.00 Total (sum of lines 50-94 and 96-98) 31, 174, 236 200. 00 178, 615, 950 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 201.00 202.00 Net Charges (line 200 minus line 201) 178, 615, 950 202.00

INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der		Peri od:	Worksheet D-3	3
			From 01/01/2015 To 12/31/2015	Date/Time Pre 5/27/2016 1:5	epared:
	Ti ti	le XVIII	Subprovider -	PPS	. о р
Cost Center Description		Ratio of Cos To Charges	t Inpatient Program Charges	Inpatient Program Costs (col. 1 x	
		1.00	2.00	col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00   03000   ADULTS & PEDIATRICS 31. 00   03100   INTENSIVE CARE UNIT 32. 00   03200   CORONARY CARE UNIT 33. 00   03300   BURN   INTENSIVE CARE UNIT 34. 00   03400   SURGICAL   INTENSIVE CARE UNIT 40. 00   04000   SUBPROVIDER -   IPF 41. 00   04100   SUBPROVIDER -   IRF			629, 329 3, 467 0 0 0 0 0 1, 975, 761		30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00
42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY			0		42.00
ANCI LLARY SERVI CE COST CENTERS					3.00
50. 00   05000   OPERATING ROOM   50. 01   05001   CV SURGERY   51. 00   05100   RECOVERY ROOM   52. 00   05200   DELIVERY ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY   54. 00   05400   RADI OLOGY-DI AGNOSTI C   05500   RADI OLOGY-THERAPEUTI C   05600   RADI OLOGY-THERAPEUTI C   05600   CT SCAN   05700   CT SCAN   05800   MAGNETI C RESONANCE I MAGING (MRI )   05900   CARDI AC CATHETERI ZATI ON   06001   BLOOD LABORATORY   06001   BLOOD LABORATORY   06002   PHYSI CI AN LABORATORY   06100   PBP CLI NI CAL LAB SERVI CES-PRGM ONLY   06200   WHOLE BLOOD & PACKED RED BLOOD CELLS   03. 00   06400   INTRAVENOUS THERAPY   06500   RESPI RATORY THERAPY   06500   PHYSI CAL THERAPY   06700   OCCUPATI ONAL THERAPY   06700   OCCUPATI ONAL THERAPY   06900   ELECTROCARDI OLOGY   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   07200   IMPL. DEV. CHARGED TO PATI ENTS   07300   DRUGS CHARGED TO PATI ENTS   07400   RENDI ACR CHARGED TO PATI ENTS   07400   RESPI ACI CHARGED TO PATI ENTS   07500   ASC (NON-DI STI NCT PART)   03550   PSYCHI ACI C/PSYCHOLOGI CAL SERVI CES   07697   CARDI AC REHABI LI TATI ON		0. 10760 0. 00000 0. 08550 0. 28080 0. 00000 0. 17436 0. 10144 0. 00000 0. 04619 0. 11388 0. 05080 0. 11172 0. 00000 0. 00000 0. 00000 0. 00000 0. 22640 0. 29455 0. 50225 0. 00000 0. 00000 0. 06899 0. 11523 0. 33913 0. 18158 0. 28945 0. 33307 0. 000000 0. 88389 0. 51235	00	5, 414 0 417 44 0 4, 809 5 0 878 1, 130 2, 007 70, 873 0 0 0 0 0 10 12, 490 1, 505, 057 0 0 2, 204 1, 854 8, 838 3, 623 224, 976 8, 353 0 1	50. 01 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 60. 01 60. 02 61. 00 62. 00 64. 00 65. 00 66. 00 67. 00 68. 00 67. 00 67. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 01
OUTPATIENT SERVICE COST CENTERS 88. 00   08800   RURAL HEALTH CLINIC		0.00000	10	0	88.00
89. 00   08900   FEDERALLY QUALIFIED HEALTH CENTER 90. 00   09000   CLINIC 91. 00   09100   EMERGENCY 92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)		0. 00000 0. 00000 2. 11242 0. 14698 0. 32219	900 27 921 33 5, 425	0 1, 946 797 2, 241	89.00 90.00 91.00
OTHER REIMBURSABLE COST CENTERS  94. 00   09400   HOME   PROGRAM   DI ALYSIS		0.00000	00 0	0	94.00
95.00 O9500 AMBULANCE SERVICES 96.00 O9600 DURABLE MEDICAL EQUIP-RENTED 97.00 O9700 DURABLE MEDICAL EQUIP-SOLD		0. 00000 0. 00000	00 0	0	95.00 96.00 97.00
98.00   09850   OTHER REIMBURSABLE COST CENTERS 200.00   Total (sum of lines 50-94 and 96-98)		0.00000	00 0 4, 735, 491	0 1, 858, 508	

1, 858, 508 200. 00 201. 00 202. 00

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

200. 00 201. 00 202. 00

Health Financial Systems	IU HEALTH BLOOMINGTON	N HOSPI TAL	In Lieu	ı of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der CCN: 150051	Peri od: From 01/01/2015	Worksheet D-3

12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm Title XIX Hospi tal Cost Center Description Ratio of Cost Inpati ent I npati ent Program Costs To Charges Program Charges (col. 1 x col. 2) 1.00 2.00 3. 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 3, 642, 507 30.00 31.00 03100 INTENSIVE CARE UNIT 952, 069 31.00 03200 CORONARY CARE UNIT 32.00 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 34 00 0 34 00 40.00 04000 SUBPROVI DER - I PF 40.00 41.00 04100 SUBPROVI DER - I RF 90,874 41.00 04200 SUBPROVI DER 42.00 42.00 04300 NURSERY 43.00 634, 245 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 0. 107609 1, 253, 775 134, 917 50.00 50.01 05001 CV SURGERY 0.000000 50.01 0 12, 337 51.00 05100 RECOVERY ROOM 0.085504 144, 286 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0.280802 796, 574 223, 680 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 318,000 55, 447 54 00 0.174363 54 00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.101444 63, 621 6, 454 55.00 05600 RADI 0I SOTOPE 0.000000 56, 00 0 56.00 05700 CT SCAN 372, 731 17, 216 57.00 0.046190 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.113881 12, 259 58.00 107, 645 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0.050804 755, 287 38, 372 59.00 60.00 06000 LABORATORY 0.111729 2,009,465 224, 516 60.00 60 01 06001 BLOOD LABORATORY 0.000000 0 60 01 0 06002 PHYSI CI AN LABORATORY 60.02 0.000000 0 0 60.02 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 0.000000 0 61.00 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 0.000000 ol 62.00 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0.000000 0 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 0.226401 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 0. 294557 364, 103 107, 249 65.00 300, 179 66 00 06600 PHYSI CAL THERAPY 0.502259 150, 768 66 00 06700 OCCUPATI ONAL THERAPY 67.00 0.000000 0 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0.068994 299, 591 20,670 69.00 07000 ELECTROENCEPHALOGRAPHY 0.115236 18,039 70 00 156, 541 70 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 487, 853 71.00 0.339133 165, 447 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.181580 471, 064 85, 536 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.289457 2, 769, 069 801, 526 73.00 07400 RENAL DIALYSIS 74 00 0.333074 73, 552 24, 498 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 75.00 75.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.883895 463 409 75.01 07697 CARDIAC REHABILITATION 0.512359 12,671 6, 492 76.97 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 Ω 89.00 90.00 09000 CLINIC 1.379 2.112427 653 90.00 559, 323 91.00 09100 EMERGENCY 0.146983 82.211 91 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 0.322194 50, 774 16, 359 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0.000000 0 94.00 95.00 09500 AMBULANCE SERVICES 95.00 96 00 09600 DURABLE MEDICAL EQUIP-RENTED 0.000000 0 0 96.00 09700 DURABLE MEDICAL EQUIP-SOLD 97.00 97.00 0.000000 0 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0.000000 Λ 98.00 200.00 Total (sum of lines 50-94 and 96-98) 2, 205, 781 200.00 11, 367, 220 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 201.00 202.00 Net Charges (line 200 minus line 201) 11, 367, 220 202.00

			'	12/01/2010	5/27/2016 1:5	
		Ti tl	e XVIII	Hospi tal	PPS	
				1.00	0.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	1.00	2. 00	
1. 00	DRG Amounts Other than Outlier Payments			O		1.00
1. 01	DRG amounts other than outlier payments for discharges occurring	g prior		31, 026, 435		1. 01
	to October 1 (see instructions)	5 1				
1. 02	DRG amounts other than outlier payments for discharges occurring	g on or		9, 407, 651		1. 02
1 00	after October 1 (see instructions)					1 00
1. 03	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)			٩		1. 03
1. 04	DRG for federal specific operating payment for Model 4 BPCI for			0		1. 04
	discharges occurring on or after October 1 (see instructions)					
2.00	Outlier payments for discharges. (see instructions)			3, 866, 288		2.00
2. 01	Outlier reconciliation amount			0		2. 01
2. 02	Outlier payment for discharges for Model 4 BPCI (see instruction	ins)		0		2.02
3. 00 4. 00	Managed Care Simulated Payments  Bed days available divided by number of days in the cost report	i na		245. 99		3. 00 4. 00
4.00	period (see instructions)	ing		243. 77		4.00
	Indirect Medical Education Adjustment			· · · · · · · · · · · · · · · · · · ·		
5.00	FTE count for allopathic and osteopathic programs for the most			0.00		5. 00
	cost reporting period ending on or before 12/31/1996. (see instr					
6. 00	FTE count for allopathic and osteopathic programs which meet the			0.00		6. 00
	criteria for an add-on to the cap for new programs in accordanc CFR 413.79(e)	e with 42				
7. 00	MMA Section 422 reduction amount to the IME cap as specified ur	der 42		0.00		7. 00
7.00	CFR §412. 105(f) (1) (i v) (B) (1)			0.00		7.00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified u	nder 42		0.00		7. 01
	CFR $\S412.105(f)(1)(iv)(B)(2)$ If the cost report straddles July	1, 2011				
0.00	then see instructions.			0.00		0.00
8. 00	Adjustment (increase or decrease) to the FTE count for allopath osteopathic programs for affiliated programs in accordance with			0.00		8. 00
	413.75(b), 413.79(c)(2)(i v), 64 FR 26340 (May 12, 1998), and 67					
	(August 1, 2002).					
8. 01	The amount of increase if the hospital was awarded FTE cap slot	s under		0.00		8. 01
	section 5503 of the ACA. If the cost report straddles July 1, 2	011, see				
0.00	instructions.	o from o		0.00		8. 02
8. 02	The amount of increase if the hospital was awarded FTE cap slot closed teaching hospital under section 5506 of ACA. (see instru			0.00		8.02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9.00
	and 8,02) (see instructions)	<b>V</b> -1 -1 -				
10.00	FTE count for allopathic and osteopathic programs in the currer	t year		0.00		10. 00
44.00	from your records					44.00
11. 00 12. 00	FTE count for residents in dental and podiatric programs.			0. 00 0. 00		11. 00 12. 00
13. 00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00		13.00
14. 00	Total allowable FTE count for the penultimate year if that year	ended on		0.00		14. 00
	or after September 30, 1997, otherwise enter zero.					
15. 00	Sum of lines 12 through 14 divided by 3.			0.00		15. 00
16. 00	Adjustment for residents in initial years of the program			0.00		16. 00
17.00	Adjustment for residents displaced by program or hospital closu	re		0.00		17.00
18.00				0.00		18.00
19.00	Current year resident to bed ratio (line 18 divided by line 4).			0.000000		19.00
20. 00 21. 00	Prior year resident to bed ratio (see instructions) Enter the lesser of lines 19 or 20 (see instructions)			0. 000000 0. 000000		20. 00 21. 00
22. 00	IME payment adjustment (see instructions)			0.000000		22.00
22. 01	IME payment adjustment - Managed Care (see instructions)			o		22. 01
	Indirect Medical Education Adjustment for the Add-on for Section	n 422 of	the MMA			
23. 00	Number of additional allopathic and osteopathic IME FTE resider	t cap		0.00		23. 00
	slots under 42 Sec. 412.105 (f)(1)(iv)(C).					
24. 00	IME FTE Resident Count Over Cap (see instructions)	war of		0.00		24.00
25. 00	If the amount on line 24 is greater than -0-, then enter the lo line 23 or line 24 (see instructions)	wer or		0.00		25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000		26. 00
27. 00	IME payments adjustment factor. (see instructions)			0. 000000		27. 00
28.00	IME add-on adjustment amount (see instructions)			0		28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0		28. 01
29. 00	Total IME payment ( sum of lines 22 and 28)			0		29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29. 01
20.00	Disproportionate Share Adjustment	lont J				20.00
30. 00	Percentage of SSI recipient patient days to Medicare Part A pat (see instructions)	rent days		5. 59		30. 00
31.00	Percentage of Medicaid patient days (see instructions)			23. 33		31.00
32. 00	Sum of lines 30 and 31			28. 92		32.00
33. 00	Allowable disproportionate share percentage (see instructions)			13. 07		33. 00
34.00	Disproportionate share adjustment (see instructions)			1, 321, 184		34.00

Title XVIII   Page 101   Page 1		ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150051	Peri od: From 01/01/2015	Worksheet E Part A	10
Incompensated Care Adjustment					Date/Time Pre	
Increasemented Care Adjustment			Title XVIII		PPS	
35.00   Total uncompensated care amount (see instructions)		Uncomponented Care Adjustment	0	1.00	2. 00	
3.5.01	35. 00			7, 647, 644, 885	6, 406, 145, 534	35.00
### enfer zero on this Line) (see instructions)  5.00 // Common the state of the hospital uncompensated care payment amount (see instructions)  5.00 // Common the state of the hospital uncompensated care payment amount (see instructions)  5.00 // Common the state of the state o		Factor 3 (see instructions)		0. 000334662	0. 000345252	
3.6 or   3   20   20   20   20   20   20   20	35. 02			2, 559, 373	2, 211, 732	35. 02
anount (See Instructions)   36.00   Total compensated care (sum of columns 1 and 2 on line   2,470.224   36.00   36.00   Total compensated care (sum of columns 1 and 2 on line   2,470.224   36.00	35. 03			1, 914, 270	555, 954	35. 03
85.03   Section   District   Section   Secti	0/ 00	,			·	0, 00
10.00   Total Medicare discharges on Worksheet S-3, Part	36.00			2, 470, 224		36.00
occluding discharges for MS-PRGS 652, 682, 683, 694 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 682, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 682, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 682, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 682, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 682, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 682, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 682, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 683, 684 and 685 (see instructions)   depth of the complete sext utiling MS-DRGS 652, 683, 684 and 685, 684, 684, 684, 684, 684, 684, 684, 684	40.00		ischarges (lines 40 throu			1 40 00
1.00   Total ESRD Medicare di scharges excluding MS-DRGS   652, 683, 684 an 685, Gese instructions)   682, 683, 684 an 685, Gese instructions)   41.01	10.00	excluding discharges for MS-DRGs 652, 682, 683, 684 and				10.00
1.01   Total ESRO Medicare covered and paid discharges excluding   MS-DROS 652, 662, 683, 684 and 685, Gase instructions)   42.00   42.00   42.00   43.00   43.00   43.00   43.00   43.00   43.00   44.00   43.00   44.00	41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652,		0		41. 00
42.00   Invide   Ine 41 by   Ine 40 (If less than 10%, you do not qualify for adjustment)   43.00   43.00   43.00   43.00   622, 633, 684 an 685, (see instructions)   44.00   622, 633, 684 an 685, (see instructions)   44.00   622, 633, 684 an 685, (see instructions)   45.00   622, 633, 684 an 685, (see instructions)   45.00   626, 633, 684 an 685, (see instructions)   45.00   622, 683, 684 an 685, (see instructions)   46.00   622, 683, 684 an 685, (see instructions)   46.00   622, 683, 684, 684, 684, 684, 684, 684, 684, 684	41. 01			0		41. 01
quality for adjustment	42 00			0.00		42 00
682, 683, 684 an 685. (see Instructions)   44.00   44.00   44.00   45.00   44.00   4		qualify for adjustment)		0.00		
divided by Ilné 41 divided by 7 days   45.00	43.00			0		43.00
45.00 Average weekly cost for dialysis treatments (see instructions) 10tal additional payment (line 45 times line 44 times line 46.00 17.00 Total additional payment (line 45 times line 44 times line 47.00 Subtotal (see instructions) 48.00 Hospital specific payments (to be completed by SCH and MBH, small rural hospitals only (see instructions) 48.00 Hospital specific payments (to be completed by SCH and MBH, small rural hospitals only (see instructions) 50.00 Payment for inpatient program capital (from Wkst. L., Pt. I and Pt. II.) as applicable) 51.00 Exception payment for inpatient program capital (Wkst. L., Pt. II.) and Pt. III. see instructions) 52.00 Direct graduate medical education payment (from Wkst. E4. Fig. 11. II. see instructions) 52.00 Direct graduate medical education payment (from Wkst. E4. Fig. 12.00 Direct graduate medical education payment (from Wkst. E4. Fig. 13.00 Nursing and Allied Heal th Managed Care payment 55.00 Nursing and Allied Heal th Managed Care payment 60 Special add-on payments for new technologies 75.00 Net organ acquisition cost (Wkst. D4 Pt. III., col. 1, 0.00 physicians' services in a teaching hospital (see Intructions) 75.00 Pour line service other pass through costs from Wkst. D. Ft. III., column 9, Ilnes 30 through 35). 75.00 Pour line service other pass through costs from Wkst. D. Ft. III., column 9, Ilnes 30 through 35). 75.00 Pour service other pass through costs from Wkst. D. Ft. III., column 9, Ilnes 49 through 58) 75.70 Pour service other pass through costs from Wkst. D. Ft. III., column 9, Ilnes 49 through 58) 75.70 Pour service other pass through costs from Wkst. D. Ft. III., column 9, Ilnes 49 through 58) 75.70 Pour service other pass through costs from Wkst. D. Ft. III., column 9, Ilnes 49 through 58) 75.70 Pour service other pass through costs from Wkst. D. Ft. III., column 9, Ilnes 49 through 58) 75.70 Pour service other pass through costs from Wkst. D. Ft. III., column 9, Ilnes 49 through 58) 75.70 Pour service other pass through costs from Wkst. D. Ft.	44. 00			0. 000000		44.00
46.00   Total additional payment (line 45 times line 44 times line 41.101)   41.101   48.091,782   47.00   48.00   48.01,782   47.00   48.00   48.01   48.001,782   48.001,782   49.00   48.	45.00	Average weekly cost for dialysis treatments (see		0. 00		45. 00
47.00   Subtotal (see instructions)   48.091.782   47.00   48.00   4	46. 00	Total additional payment (line 45 times line 44 times line		0		46. 00
MDH, small rural hospitals only. (see instructions)   49.00   74	47. 00	Subtotal (see instructions)		48, 091, 782		47. 00
49.00   Total payment for inpatient operating costs (see instructions)   48.091,782   49.00   50.00   Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II. as applicable)   51.00   Exception payment for inpatient program capital (Wkst. L, Pt. III.) see instructions)   52.00   Exception payment for inpatient program capital (Wkst. L, Pt. III.) see instructions)   52.00   Fr. III. see instructions)   52.00   Fr. III. see instructions)   60.00   52.00   Fr. III. see instructions)   75.00	48. 00			0		48. 00
50.00   Payment for inpatient program capital (From Wkst. L., Pt. I and Pt. II, as applicable)   51.00   Exception payment for inpatient program capital (Wkst. L., Pt. III, see instructions)   52.00   51.00   52.00   51.00   52.	49. 00	Total payment for inpatient operating costs (see		48, 091, 782		49. 00
51.00   Exception payment for inpatient program capital (Wkst. L. P. Pt. III. see instructions)   52.00   Direct graduate medical education payment (from Wkst. E-4, III. see instructions)   52.00   Ine 49 see instructions)   52.00   Ine 49 see instructions)   53.00   Nursing and Allied Health Managed Care payment   0   53.00   53.00   Nursing and Allied Health Managed Care payment   0   0   53.00   55.00   Net organ acquisition cost (Mkst. D-4 Pt. III. col. 1, III. 69)   0   55.00   Net organ acquisition cost (Mkst. D-4 Pt. III. col. 1, III. 69)   0   0   0   0   0   0   0   0   0	50.00	Payment for inpatient program capital (from Wkst. L, Pt. I		3, 672, 753		50. 00
52.00   Direct graduate medical education payment (From Wkst. E-4, larl 49 see instructions)   S3.00   S5.00   Nursing and Allied Health Managed Care payment   S6.00   S5.00   S6.00   S6.0	51. 00	Exception payment for inpatient program capital (Wkst. L,		0		51.00
53.00   Nursing and Allied Health Managed Care payment   54.00   55.00   18,832   54.00   55.00   Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)   Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)   55.00   Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 69)   56.00   Social add-on payments for color of physicians' services in a teaching hospital (see intructions)   1.00   1	52.00			0		52.00
54 00       Special add-on payments for new technologies       55.00         55.00       Interest of physicians' services in a teaching hospital (see intructions)       0         56.00       Cost of physicians' services in a teaching hospital (see intructions)       0         57.00       Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).       0         58.00       Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)       0         59.00       Total (sum of amounts on lines 49 through 58)       51,783,367       59.00         61.00       Total amount payable for program beneficiaries (line 59 minus line 60)       51,756,189       61.00         62.00       Deductibles billed to program beneficiaries       4,242,960       62.00         63.00       Coinsurance billed to program beneficiaries       78,750       63.00         65.00       Adjusted reimbursable bad debts (see instructions)       251,505       64.00         66.00       Allowable bad debts (see instructions)       251,505       66.00         67.00       Subtotal (line 61 plus line 65 minus lines 62 and 63)       47,597,957       67.00         68.00       Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)       0       68.00         69.00       Outlier paymen	53. 00			0		53.00
11ne 69   Cost of physicians' services in a teaching hospital (see intructions)   56.00   Cost of physicians' services in a teaching hospital (see intructions)   57.00   Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).   58.00   Ancillary service other pass through costs from Wkst. D, Pt. IV. col. 11 line 200)   59.00   Total (sum of amounts on lines 49 through 58)   51,783,367   59.00   70.11 line 200)   70.11 line 60)   70.11 line 60   70.11		Special add-on payments for new technologies		18, 832		54.00
56.00         Cost of physicians' services in a teaching hospital (see intructions)         0         56.00         1         56.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         57.00         58.00         57.00         58.00         58.00         51.783,367         59.00         59.00         59.00         51.783,367         59.00         59.00         59.00         51.783,367         59.00         59.00         51.783,367         59.00         59.00         51.783,367         59.00         59.00         51.783,367         59.00         59.00         51.783,367         59.00         59.00         51.783,367         59.00         59.00         51.783,367         59.00         59.00         51.756,189         61.00         61.00         61.00         61.00         61.00         61.00         61.00         61.00         61.00         61.00         61.00         62.00         62.00         62.00         62.00         62.00         63.00         63.00         63.00         64.00         64.00         64.00         65.00         64.00         65.00         65.00 <td>55. 00</td> <td></td> <td></td> <td>0</td> <td></td> <td>55.00</td>	55. 00			0		55.00
57.00   Routine service other pass through costs (from Wkst. D, Pt. III, column 9, lines 30 through 35).   58.00   Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)   58.00   70 tal (sum of amounts on lines 49 through 58)   51,783,367   59.00   70 tal (sum of amounts on lines 49 through 58)   51,756,189   61.00   70 tal amount payable for program beneficiaries (line 59 minus line 60)   62.00   Deductibles billed to program beneficiaries   4,242,960   62.00   63.00   63.00   63.00   64.00   64.00   64.00   65.00   64.00   65.00   64.00   65.00   64.00   65.00   65.00   64.00   65.00   65.00   64.00   65.00   65.00   66.00   65.00   66.0	56. 00	Cost of physicians' services in a teaching hospital (see		0		56. 00
58.00       Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)       58.00         59.00       Total (sum of amounts on lines 49 through 58)       51,783,367         60.00       Primary payer payments       27,178         61.00       Total amount payable for program beneficiaries (line 59 minus line 60)       51,756,189         62.00       Deductibles billed to program beneficiaries       4,242,960         63.00       Coinsurance billed to program beneficiaries       78,750         63.00       Coinsurance billed to program beneficiaries       78,750         64.00       Allowable bad debts (see instructions)       251,505         65.00       Adjusted reimbursable bad debts (see instructions)       163,478         65.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       163,478         65.00       Allowable bad debts for dual eligible beneficiaries (see instructions)       0         68.00       Credits received from manufacturers for replaced devices for applicable to MS-DRSs (see instructions)       0         69.00       Untilier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)       0         70.00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0         70.90       Pioneer ACO demonstration payment adjustment amount (see instructions)       0	57. 00			0		57.00
Pt. IV, col. 11 line 200) 59.00 Total (sum of amounts on lines 49 through 58) 60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 62.00 Deductibles billed to program beneficiaries 63.00 Coinsurance billed to program beneficiaries 64.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 69.00 RURAL DEMONSTRATION PROJECT 70.00 OTHER ADJUSTIMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.90 HSP bonus payment HVBP adjustment amount (see instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 70.92 Bundled Model 1 discount amount (see instructions) 70.93 HWBP payment adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.95 HRR adjustment amount (see instructions) 70.96 HRR adjustment amount (see instructions) 70.97 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.90 HRR adjustment amount (see instructions) 70.91 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.90 HRR adjustment amount (see instructions) 70.90 HRR adjustment amount (see instructions) 70.90 HRR adjustment amount (see instructions)	58 00			0		58 00
60.00 Primary payer payments 61.00 Total amount payable for program beneficiaries (line 59 minus line 60) 62.00 Deductibles billed to program beneficiaries 63.00 Coinsurance billed to program beneficiaries 63.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 69.00 OUTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.90 HSP bonus payment HVBP adjustment amount (see instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 70.92 Bundled Model 1 discount amount (see instructions) 70.93 HVBP payment adjustment amount (see instructions) 70.94 HVRP adjustment amount (see instructions) 70.94 HVBP payment adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.94		Pt. IV, col. 11 line 200)				
61. 00 Total amount payable for program beneficiaries (line 59 minus line 60) 62. 00 Deductible so billed to program beneficiaries 63. 00 Coinsurance billed to program beneficiaries 63. 00 Allowable bad debts (see instructions) 65. 00 Allowable bad debts (see instructions) 66. 00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67. 00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68. 00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69. 00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 69. 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70. 50 RURAL DEMONSTRATION PROJECT 70. 89 Pioneer ACO demonstration payment adjustment amount (see instructions) 70. 90 HSP bonus payment HVBP adjustment amount (see instructions) 70. 91 HSP bonus payment HRR adjustment amount (see instructions) 70. 92 Bundled Model 1 discount amount (see instructions) 70. 93 HVBP payment adjustment amount (see instructions) 70. 94 HRR adjustment amount (see instructions) 70. 94 HRR adjustment amount (see instructions) 70. 94 HRR adjustment amount (see instructions) 70. 94 HRR adjustment amount (see instructions) 70. 94 HRR adjustment amount (see instructions) 70. 94 HRR adjustment amount (see instructions) 70. 94 HRR adjustment amount (see instructions) 70. 94 HRR adjustment amount (see instructions) 70. 94						
62.00 Deductibles billed to program beneficiaries 63.00 Coinsurance billed to program beneficiaries 64.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRSc (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 69.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.50 RURAL DEMONSTRATION PROJECT 70.89 Pioneer ACO demonstration payment adjustment amount (see instructions) 70.90 HSP bonus payment HVBP adjustment amount (see instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 70.92 Bundled Model 1 discount amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.95 HRR adjustment amount (see instructions) 70.96 HRR adjustment amount (see instructions) 70.97 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99		Total amount payable for program beneficiaries (line 59				
63.00 Coinsurance billed to program beneficiaries 64.00 Allowable bad debts (see instructions) 65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 69.00 THER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.50 RURAL DEMONSTRATION PROJECT 70.90 Pioneer ACO demonstration payment adjustment amount (see instructions) 70.91 HSP bonus payment HVBP adjustment amount (see instructions) 70.92 HVBP payment adjustment amount (see instructions) 70.93 HVBP payment adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.94	62. 00			4, 242, 960		62.00
65.00 Adjusted reimbursable bad debts (see instructions) 66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.80 RURAL DEMONSTRATION PROJECT 70.89 Pioneer ACO demonstration payment adjustment amount (see instructions) 70.90 HSP bonus payment HVBP adjustment amount (see instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 80 HSP bonus payment amount (see instructions) 81 HSP bonus payment amount (see instructions) 82 HVBP payment adjustment amount (see instructions) 83 HRR adjustment amount (see instructions) 84 HRR adjustment amount (see instructions) 95 HRR adjustment amount (see instructions) 96 HRR adjustment amount (see instructions) 96 HRR adjustment amount (see instructions) 96 HRR adjustment amount (see instructions) 97 HRR adjustment amount (see instructions) 98 HRR adjustment amount (see instructions) 99 HRR adjustment amount (see instructions) 90 HRR adjustment amount (see instructions) 90 HRR adjustment amount (see instructions) 90 HRR adjustment amount (see instructions) 91 HRR adjustment amount (see instructions)	63.00	Coinsurance billed to program beneficiaries		78, 750		63.00
66.00 Allowable bad debts for dual eligible beneficiaries (see instructions) 67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.50 RURAL DEMONSTRATION PROJECT 70.89 Pioneer ACO demonstration payment adjustment amount (see instructions) 70.90 HSP bonus payment HVBP adjustment amount (see instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 70.92 Bundled Model 1 discount amount (see instructions) 70.93 HVBP payment adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.95 HVBP payment adjustment amount (see instructions) 70.96 HRR adjustment amount (see instructions) 70.97 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions)				· ·		
67.00 Subtotal (line 61 plus line 65 minus lines 62 and 63) 68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions) 69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions) 70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 70.50 RURAL DEMONSTRATION PROJECT 70.89 Pioneer ACO demonstration payment adjustment amount (see instructions) 70.90 HSP bonus payment HVBP adjustment amount (see instructions) 70.91 HSP bonus payment HRR adjustment amount (see instructions) 70.92 Bundled Model 1 discount amount (see instructions) 70.93 HVBP payment adjustment amount (see instructions) 70.94 HRR adjustment amount (see instructions) 70.95 At 70.96 70.99 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions) 70.99 HRR adjustment amount (see instructions)		, , , , , , , , , , , , , , , , , , , ,				
68.00 Credits received from manufacturers for replaced devices for applicable to MS-DRGs (see instructions)  69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  70.50 RURAL DEMONSTRATION PROJECT  70.89 Pioneer ACO demonstration payment adjustment amount (see instructions)  70.90 HSP bonus payment HVBP adjustment amount (see instructions)  70.91 HSP bonus payment HRR adjustment amount (see instructions)  70.92 Bundled Model 1 discount amount (see instructions)  70.93 HVBP payment adjustment amount (see instructions)  70.94 HRR adjustment amount (see instructions)  70.95 Assume the manufacturers for replaced devices  0 68.00  69.00  69.00  70.00  70.00  70.50  70.89  70.90  70.91  70.92  70.91  70.92  70.93 HVBP payment adjustment amount (see instructions)  70.94  70.94	67. 00			47, 597, 957		67. 00
69.00 Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)  70.00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)  70.50 RURAL DEMONSTRATION PROJECT  70.89 Pioneer ACO demonstration payment adjustment amount (see instructions)  70.90 HSP bonus payment HVBP adjustment amount (see instructions)  70.91 HSP bonus payment HRR adjustment amount (see instructions)  70.92 Bundled Model 1 discount amount (see instructions)  70.93 HVBP payment adjustment amount (see instructions)  70.94 HRR adjustment amount (see instructions)  70.95	68. 00	Credits received from manufacturers for replaced devices		0		68. 00
70. 00       OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)       0       70. 00         70. 50       RURAL DEMONSTRATION PROJECT       0       70. 50         70. 89       Pi oneer ACO demonstration payment adjustment amount (see instructions)       0       70. 89         70. 90       HSP bonus payment HVBP adjustment amount (see instructions)       0       70. 90         70. 91       HSP bonus payment HRR adjustment amount (see instructions)       0       70. 91         70. 92       Bundled Model 1 discount amount (see instructions)       0       70. 92         70. 93       HVBP payment adjustment amount (see instructions)       45, 644       70. 93         70. 94       HRR adjustment amount (see instructions)       -12, 418       70. 94	69. 00	Outlier payments reconciliation (sum of lines 93, 95 and		0		69. 00
70. 50 RURAL DEMONSTRATION PROJECT 70. 89 Pi oneer ACO demonstration payment adjustment amount (see instructions) 70. 90 HSP bonus payment HVBP adjustment amount (see instructions) 70. 91 HSP bonus payment HRR adjustment amount (see instructions) 70. 92 Bundled Model 1 discount amount (see instructions) 70. 93 HVBP payment adjustment amount (see instructions) 70. 94 HRR adjustment amount (see instructions) 70. 94 HRR adjustment amount (see instructions) 70. 94 HRR adjustment amount (see instructions) 70. 94	70. 00			0		70.00
instructions)  70. 90 HSP bonus payment HVBP adjustment amount (see instructions)  70. 91 HSP bonus payment HRR adjustment amount (see instructions)  70. 92 Bundled Model 1 discount amount (see instructions)  70. 93 HVBP payment adjustment amount (see instructions)  70. 94 HRR adjustment amount (see instructions)  70. 94 HRR adjustment amount (see instructions)  70. 94 HRR adjustment amount (see instructions)  70. 94 HRR adjustment amount (see instructions)	70. 50	RURAL DEMONSTRATION PROJECT		0		70. 50
instructions)  70.91 HSP bonus payment HRR adjustment amount (see instructions)  8 Bundled Model 1 discount amount (see instructions)  9 To. 92  10 To. 92  10 To. 94  11 HSP payment adjustment amount (see instructions)  12 To. 94  13 To. 94		instructions)				
70. 92Bundled Model 1 discount amount (see instructions)070. 9270. 93HVBP payment adjustment amount (see instructions)45, 64470. 9370. 94HRR adjustment amount (see instructions)-12, 41870. 94	/0. 90	' '		0		/0.90
70. 93       HVBP payment adjustment amount (see instructions)       45,644       70.93         70. 94       HRR adjustment amount (see instructions)       -12,418       70.94		HSP bonus payment HRR adjustment amount (see instructions)		0		
70. 94 HRR adjustment amount (see instructions) -12, 418 70. 94		, , , , , , , , , , , , , , , , , , ,		0 4E (44		70. 92
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	Financial Systems IU HEALTH BLOOMIN			u of Form CMS-2	<u> 2552-10</u>
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150051	Peri od: From 01/01/2015 To 12/31/2015		
		Title XVIII	Hospi tal	PPS	
			Prior to	On/After	
			October 1	October 1	
		0	1. 00	2. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period prior to 10/1)		0 0		70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in column 0 the corresponding federal year for the period ending on or after 10/1)		0 0		70. 97
70. 98			0		70. 98
70. 99	HAC adjustment amount (see instructions)		0		70. 99
71. 00	Amount due provider (line 67 minus lines 68 plus/minus lines 69 & 70)		47, 631, 183		71.00
71.01	Sequestration adjustment (see instructions)		952, 624		71. 01
72.00	Interim payments		46, 370, 341		72.00
73.00	Tentative settlement (for contractor use only)		0		73.00
74. 00	72, and 73)		308, 218		74.00
75. 00	accordance with CMS Pub. 15-2, chapter 1, §115.2		7, 954, 638		75. 00
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)				1
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see instructions)		0		90.00
91.00	Capital outlier from Wkst. L, Pt. I, line 2		0		91.00
92. 00	Operating outlier reconciliation adjustment amount (see instructions)		0		92.00
93. 00	Capital outlier reconciliation adjustment amount (see instructions)		0		93. 00
94. 00	The rate used to calculate the time value of money (see linstructions)		0. 00		94.00
95. 00			0		95. 00
96. 00	Time value of money for capital related expenses (see linstructions)		0		96. 00
	Thisti detrons)		Prior to 10/1	On/After 10/1	
			1.00	2.00	

Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Peri od: Worksheet E From 01/01/2015 Part A Exhi bit 4 To 12/31/2015 Date/Ti me Prepared: 5/27/2016 1:53 nm Provi der CCN: 150051

						) 12/31/2015	5/27/2016 1:5	
		W/C F D+ A	A		e XVIII	Hospi tal	PPS	
		line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Peri od On/After 10/01	Total (Col 2 through 4)	
1 00	Inno.	0	1. 00	2. 00	3.00	4. 00	5. 00	1 00
1. 00	DRG amounts other than outlier payments	1. 00	0	0	0	O	0	1.00
1. 01	DRG amounts other than outlier payments for discharges	1. 01	31, 026, 435	0	31, 026, 435	0	31, 026, 435	1. 01
1. 02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	9, 407, 651	0	0	9, 407, 651	9, 407, 651	1. 02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to	1. 03	0	0	0	0	0	1. 03
1. 04	October 1 DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0	0	0	0	0	1. 04
2. 00	Outlier payments for	2. 00	3, 866, 288	0	3, 114, 649	751, 639	3, 866, 288	2. 00
2. 01	discharges (see instructions) Outlier payments for	2. 02	0	0	О	0	0	2. 01
3. 00	discharges for Model 4 BPCI Operating outlier	2. 01	0	0	0	0	0	3.00
4. 00	reconciliation Managed care simulated	3. 00	0	0	0	0	0	4.00
4.00	payments				٩			4.00
5. 00	Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5.00
6. 00	A, line 21 (see instructions) IME payment adjustment (see	22. 00	0	0	0	0	0	6. 00
6. 01	instructions) IME payment adjustment for	22. 01	0	0	0	0	0	6. 01
	managed care (see instructions)		- Add 6 C					
7. 00	Indirect Medical Education Adjustment factor	27. 00	0. 000000	0.000000	0. 000000	0. 000000		7.00
8. 00	(see instructions)  IME adjustment (see	28. 00	0.00000	0. 000000	0. 000000	0. 000000	0	8.00
8. 01	instructions) IME payment adjustment add on	28. 01	0	0	0	0	0	8. 01
9. 00	for managed care (see instructions) Total IME payment (sum of	29. 00	0	0	0	0	0	9. 00
9. 01	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	0	0	0	9. 01
	8. 01)	ont.						
10. 00	Disproportionate Share Adjustm Allowable disproportionate share percentage (see	33. 00	0. 1307	0. 1307	0. 1307	0. 1307		10.00
11. 00	instructions) Disproportionate share	34. 00	1, 321, 184	0	1, 013, 789	307, 395	1, 321, 184	11. 00
11. 01	adjustment (see instructions) Uncompensated care payments	36. 00	2, 470, 224	0	1, 914, 270	555, <b>9</b> 54	2, 470, 224	11. 01
12. 00	Additional payment for high pe Total ESRD additional payment	rcentage of ES 46.00	RD beneficiary	di scharges 0	0	0	0	12. 00
	(see instructions)				-			
13. 00 14. 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47. 00 48. 00	48, 091, 782 0	0	37, 069, 143 0	11, 022, 639 0	48, 091, 782 0	13.00 14.00
15. 00	(see instructions) Total payment for inpatient operating costs (see instructions)	49. 00	48, 091, 782	0	37, 069, 143	11, 022, 639	48, 091, 782	15. 00
16. 00	Payment for inpatient program capital	50. 00	3, 672, 753	0	2, 824, 274	848, 479	3, 672, 753	16. 00
17. 00	Special add-on payments for new technologies	54. 00	18, 832	0	15, 657	3, 175	18, 832	17. 00
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for replaced devices for applicable MS-DRGs	55. 00 68. 00	0	0	0	0	0	

	Financial Systems	IL	HEALTH BLOOMI				u of Form CMS-2	2552-10
LOW VO	DLUME CALCULATION EXHIBIT 4			Provi der		Period: From 01/01/2015 To 12/31/2015		pared:
				Ti tl	e XVIII	Hospi tal	PPS	
		W/S E, Part A line	Amounts (from E, Part A)	Pre/Post Entitlement	Period Prior to 10/01	Period On/After 10/01	Total (Col 2 through 4)	
		0	1. 00	2.00	3.00	4. 00	5. 00	
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	0	0		0 0	0	18. 00
19.00	SUBTOTAL			0	39, 909, 07	4 11, 874, 293	51, 783, 367	19.00
		W/S L, line	(Amounts from L)					
		0	1. 00	2. 00	3. 00	4. 00	5. 00	
20. 00 20. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier		3, 233, 216 0	0	_,,	9 753, 707 0 0	3, 233, 216 0	20. 00 20. 01
21. 00 21. 01	Capital DRG outlier payments Model 4 BPCI Capital DRG outlier payments	2. 00 2. 01	244, 251 0	0 0	244, 25	1 49, 248 0 0	293, 499 0	21. 00 21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0. 0000	0.000	0. 0000		22. 00
	Indirect medical education adjustment (see instructions)	6. 00	0	0		0 0	0	20.00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0604	0. 0604	0.060	0. 0604		24.00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	195, 286	0	149, 76	45, 524	195, 286	25.00
26. 00	Total prospective capital payments (see instructions)	12. 00	3, 672, 753	0	2, 824, 27	4 848, 479	3, 672, 753	26. 00
		W/S E, Part A	(Amounts to					
		line	E, Part A) 1.00	2.00	2.00	4.00	F 00	
27. 00	Low volume adjustment factor	0	1.00	2. 00	3. 00 0. 00000	4. 00 0. 000000	5. 00	27.00
28. 00	Low volume adjustment ractor Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96				0.00000	0	
29. 00	Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	0	29. 00

100.00

Pt. A, line)
100.00 Transfer low volume adjustments to Wkst. E, Pt. A.

HOSPI I	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Exhibi Date/Time Pre 5/27/2016 1:5	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3. 00	4. 00	
1. 00 1. 01	DRG amounts other than outlier payments DRG amounts other than outlier payments for	1. 00 1. 01	31, 026, 435			31, 026, 435	1. 00 1. 01
1. 02	discharges occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October 1	1. 02	9, 407, 651		9, 407, 651	9, 407, 651	1.02
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October	1. 03	0		0	0	1.03
1. 04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1. 04	0		0	0	1.04
2. 00	Outlier payments for discharges (see instructions)	2. 00	3, 866, 288	3, 114, 64	9 751, 639	3, 866, 288	2.00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0		0	0	2. 01
3.00	Operating outlier reconciliation	2. 01	0		0	0	3.00
4. 00	Managed care simulated payments Indirect Medical Education Adjustment	3. 00	0		0 0	0	4.00
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 00000	0. 000000		5.00
6.00	IME payment adjustment (see instructions)	22. 00	0		0 0	0	6.00
6. 01	IME payment adjustment for managed care (see instructions) Indirect Medical Education Adjustment for the		0 oction 422 of	the MMA	0 0	0	6. 01
7. 00	IME payment adjustment factor (see	27. 00	0. 000000		0. 000000		7.00
	instructions)		0.00000	0.0000	0.00000	0	8.00
8. 00 8. 01	IME adjustment (see instructions) IME payment adjustment add on for managed care (see instructions)	28. 00 28. 01	0		0 0	0	8. 01
9. 00	Total IME payment (sum of lines 6 and 8)	29. 00	0		0 0	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29. 01	0		0	0	9. 01
10. 00	Disproportionate Share Adjustment Allowable disproportionate share percentage	33. 00	0. 1307	0. 130	7 0. 1307		10.00
10.00	(see instructions)	33.00	0.1307	0.130	0. 1307		10.00
11. 00	Disproportionate share adjustment (see instructions)	34. 00	1, 321, 184	1, 013, 78	9 307, 395	1, 321, 184	11.00
11. 01		36. 00	2, 470, 224	1, 914, 27	0 555, 954	2, 470, 224	11. 01
12.00	Additional payment for high percentage of ESI		di scharges	ı			12.00
12. 00	Total ESRD additional payment (see instructions)	46. 00			0		12.00
13.00	Subtotal (see instructions)	47. 00	48, 091, 782	37, 069, 14	3 11, 022, 639		
14. 00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48. 00	C		0	0	14.00
15. 00	Total payment for inpatient operating costs (see instructions)	49. 00	48, 091, 782	37, 069, 14	3 11, 022, 639	48, 091, 782	15. 00
16.00	Payment for inpatient program capital	50. 00	3, 672, 753		2 799, 231	3, 672, 753	
17.00	Special add-on payments for new technologies		18, 832	15, 65	_  _		
17. 01 17. 02	Net organ aquisition cost Credits received from manufacturers for	55. 00 68. 00			0 0	0	1
17.02	replaced devices for applicable MS-DRGs	00.00					17.02
18. 00	Capital outlier reconciliation adjustment amount (see instructions)	93. 00	O		0 0	0	18. 00
19. 00	SUBTOTAL		1	39, 958, 32	2 11, 825, 045	51, 783, 367	19.00

Health Financial Syst	tems Il	J HEALTH BLOOMI	NGTON	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL ACQUIRED CO	NDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5		Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Exhibi Date/Time Pre 5/27/2016 1:5	pared:
				Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. L, line	•	nt. from kst. L)				
		0		1.00	2.00	3. 00	4. 00	
20 00 0: +-1 000 -4	Character and the control of the con	1 00		2 222 217	2 470 50	752 707	2 222 247	20.00

						5/2//2016 1:5	3 pm
			Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from				
		0	Wkst. L) 1.00	2.00	3. 00	4. 00	
20.00	Capital DRG other than outlier	1, 00					20.00
20.00			3, 233, 216	2, 479, 509	753, 707	3, 233, 216	
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	(	0	0	20. 01
21. 00	Capital DRG outlier payments	2. 00	244, 251	244, 25	0	244, 251	
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	(	0	0	
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.0000	0.0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	(	0	0	23. 00
24. 00	Allowable disproportionate share percentage (see instructions)	10. 00	0. 0604	0. 0604	0. 0604		24. 00
25. 00	Disproportionate share adjustment (see instructions)	11. 00	195, 286	149, 762	45, 524	195, 286	25. 00
26. 00	Total prospective capital payments (see linstructions)	12. 00	3, 672, 753	2, 873, 522	799, 231	3, 672, 753	26. 00
	[TIISTI ucti ons)	Wkst. E, Pt.	(Amt. from				
		A, line	Wkst. E, Pt. A)				
		0	1, 00	2.00	3. 00	4. 00	
27. 00							27. 00
28. 00	Low volume adjustment prior to October 1	70. 96	l o	(		0	
29. 00	Low volume adjustment on or after October 1	70. 97	l o	Ì	1	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	45, 644	4, 654	40, 990		
30. 01	HVBP payment adjustment for HSP bonus	70. 90	13,044	4,00-	10,770	13,044	30. 01
30.01	payment (see instructions)	70. 90	0	`	)	١	30.01
31. 00	HRR adjustment (see instructions)	70. 94	-12, 418	-12, 418	0	-12, 418	31.00
31. 00	HRR adjustment for HSP bonus payment (see	70. 91	-12,410	-12,410		-12, 410	1
31.01	instructions)	70. 71		`			31.01
						(Amt. to	
						Wkst. E, Pt.	
						A)	
		0	1. 00	2. 00	3. 00	4. 00	
32.00	HAC Reduction Program adjustment (see	70. 99		(	0	0	32.00
	instructions)						
100.00	Transfer HAC Reduction Program adjustment to		N				100.00
	Wkst. E, Pt. A.						

Health Financial Systems	IU HEALTH BLOOMINGTO	N HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 150051	Peri od: From 01/01/2015 To 12/31/2015	Worksheet E Part B Date/Time Prepared: 5/27/2016 1:53 pm
		T' 11 . \\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\\	11	2

			10 12/31/2015	5/27/2016 1:5	
		Title XVIII	Hospi tal	PPS	э рш
		11 11 11 11 11 11	110001 101	1	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00	Medical and other services (see instructions)			37, 575	1.00
2.00	Medical and other services reimbursed under OPPS (see instructi	i ons)		28, 857, 436	2.00
3.00	PPS payments			27, 763, 581	3.00
4.00	Outlier payment (see instructions)			1, 193, 906	
5.00	Enter the hospital specific payment to cost ratio (see instruction	tions)		0.000	5.00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of line 3 plus line 4 divided by line 6			0.00	7.00
8.00	Transitional corridor payment (see instructions)			0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV	V, 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)			37, 575	11.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonable charges				
12.00	Ancillary service charges			133, 085	1
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lir	ne 69)		0	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)			133, 085	14.00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for pa	3	•	0	
16. 00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16. 00
47.00	had such payment been made in accordance with 42 CFR §413.13(e)	)			47.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18.00	Total customary charges (see instructions)	1611 10	44) (	133, 085	1
19. 00	Excess of customary charges over reasonable cost (complete only	y if line 18 exceeds li	ne 11) (see	95, 510	19. 00
00.00	instructions)	1611 44	40) (		00.00
20. 00	Excess of reasonable cost over customary charges (complete only	y if time it exceeds it	ne 18) (See	0	20.00
21 00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH see	inatruationa)		27 575	21 00
21. 00	Interns and residents (see instructions)	This tructions)		37, 575	
22. 00	,	uati ana)		0	
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)		28, 957, 487	23.00
24.00	Total prospective payment (sum of lines 3, 4, 8 and 9)  COMPUTATION OF REIMBURSEMENT SETTLEMENT			20, 937, 407	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			779	25. 00
26. 00	Deductibles and Coinsurance relating to amount on line 24 (for	CAH see instructions	١	5, 260, 291	1
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl			23, 733, 992	1
27.00	instructions)	rus the sum of filles 2.	2 and 25] (366	23, 733, 772	27.00
28. 00	Direct graduate medical education payments (from Wkst. E-4, lir	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			o o	29.00
30. 00	Subtotal (sum of lines 27 through 29)			23, 733, 992	
31. 00	Primary payer payments			10, 066	1
	Subtotal (line 30 minus line 31)			23, 723, 926	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)			
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33.00
34.00	Allowable bad debts (see instructions)			481, 089	
35.00	Adjusted reimbursable bad debts (see instructions)			312, 708	35.00
36.00	Allowable bad debts for dual eligible beneficiaries (see instru	uctions)		445, 048	
37.00		,		24, 036, 634	
	MSP-LCC reconciliation amount from PS&R			-634	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)	)		0	
39. 98	Partial or full credits received from manufacturers for replace		ctions)	18, 375	
39. 99	RECOVERY OF ACCELERATED DEPRECIATION		,	0	
40.00	Subtotal (see instructions)		24, 037, 268	1	
40.01	, ,		480, 745		
41.00				23, 671, 906	1
42.00				0	42.00
43.00	,		-115, 383	43.00	
44.00	Protested amounts (nonallowable cost report items) in accordance	ce 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			0.00	
93.00	Time Value of Money (see instructions)			0	
94.00	Total (sum of lines 91 and 93)			0	94.00

Health Financial Systems IU HEAL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1 From 01/01/2015 Part I To 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm Provi der CCN: 150051

					5/27/2016 1:53	3 pm
			e XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		46, 370, 341		23, 671, 906	1.00
2.00	Interim payments payable on individual bills, either		(	)	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01	ADJUSTMENTS TO PROVIDER		(		0	3. 01
3. 02			(		0	3. 02
3. 03			(		0	3. 03
3.04			(		0	3.04
3. 05			(	)	0	3. 05
	Provider to Program					
3. 50	ADJUSTMENTS TO PROGRAM		(		0	3. 50
3. 51			(		0	3. 51
3. 52			(		0	3. 52
3. 53			(		0	3. 53
3. 54			(		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		(	)	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		46, 370, 341		23, 671, 906	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after					5. 00
5.00	desk review. Also show date of each payment. If none,					5.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					
5. 01	TENTATI VE TO PROVI DER		(		0	5. 01
5. 02	TENTATIVE TO TROVIDER				0	5. 02
5. 03					0	5. 03
0.00	Provider to Program			<u> </u>		0.00
5. 50	TENTATI VE TO PROGRAM		(		0	5. 50
5. 51					ا ا	5. 51
5. 52			(		ا ا	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines		(		ا ا	5. 99
	5. 50-5. 98)					
6.00	Determined net settlement amount (balance due) based on					6.00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		308, 218	3	0	6. 01
6. 02	SETTLEMENT TO PROGRAM		, (		115, 383	6. 02
7. 00	Total Medicare program liability (see instructions)		46, 678, 559		23, 556, 523	7. 00
				Contractor	NPR Date	
				Number	(Mo/Day/Yr)	
		(	)	1.00	2.00	
8.00	Name of Contractor					8.00

Health Financial Systems	IU HEALTH BLOOMINGTON	N HOSPI TAL	In Lieu	u of Form CMS-2552-10
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SI	ERVI CES RENDERED	Provi der CCN: 150051 Component CCN: 15T051		Worksheet E-1 Part I Date/Time Prepared: 5/27/2016 1:53 pm

Title XVIII Subprovi der -**IRF** 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 2, 861, 458 1.00 2.00 Interim payments payable on individual bills, either 2.00 0 submitted or to be submitted to the contractor for services rendered in the cost reporting period. 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 ADJUSTMENTS TO PROVIDER 3.01 3.01 0 3.02 3.02 0 3.03 0 3.03 3.04 0 0 3.04 0 3.05 3.05 Provider to Program 3.50 ADJUSTMENTS TO PROGRAM 0 0 3.50 3. 51 0 0 3.51 0 3.52 0 3.52 3.53 0 3.53 3.54 0 0 3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 0 0 3.99 3. 50-3. 98) Total interim payments (sum of lines 1, 2, and 3.99) 4.00 2, 861, 458 0 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 TENTATI VE TO PROVIDER O n 5.01 0 0 5.02 5.02 5.03 0 0 5.03 Provider to Program 5.50 TENTATI VE TO PROGRAM 5.50 O n 5. 51 0 0 5.51 5. 52 0 0 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 0 0 5.99 5, 50-5, 98) 6.00 Determined net settlement amount (balance due) based on 6.00 the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 56, 694 6.01 0 6.02 SETTLEMENT TO PROGRAM 0 6.02 Total Medicare program liability (see instructions) 2, 918, 152 7.00 7.00 Λ NPR Date Contractor Number (Mo/Day/Yr) 0 1.00 2.00

8. 00

8.00 Name of Contractor

Provider CCN: 150051   Period: From 01/01/2015   To 12/31/2015   To 12/31/2015   Part II   Part II   Provider CCN: 150051   Period: From 01/01/2015   To 12/31/2015   Part II   Part II   Provider CCN: 150051   Part II   Part II   Part II   Provider CCN: 150051   Part II   Part II   Part II   Provider CCN: 150051   Part II	Heal th	Financial Systems IU HEALTH BLOOMINGTO	ON HOSPITAL	In Lie	u of Form CMS-2	2552-10	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS  HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION  1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  1.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  2.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  3.00 Total inpatient days from Wkst. C, Pt. I, col. 8 sum of lines 1, 8-12  4.00 Total hospital charges from Wkst. C, Pt. I, col. 8 line 200  5.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I  0 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I  0 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I  0 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAI culation of the HIT incentive payment (see instructions)  597, 202 8.00  9.00 Sequestration adjustment amount (see instructions)  11, 944 9.00  10.00 Calculation of the HIT incentive payment after sequestration (see instructions)  585, 258 10.00  1NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Initial / interim HIT payment adjustment (see instructions)  0 Total hospital charges from Wkst. S-3, Pt. I col. 6 sum of lines 1, 8-12  1.00 Total hospital charges from Wkst. S-3, Pt. I col. 6 sum of lines 1, 8-12  1.00 Total hospital charges from Wkst. S-3, Pt. I col. 6 line 2  3.00 Total hospital charges from Wkst. S-10, col. 6 line 2  3.00 Total hospital charges from Wkst. S-10, col. 6 line 2  3.00 Total hospital charges from Wkst. S-10, col. 6 line 2  3.00 Total hospital charges from Wkst. S-10, col. 6 line 2  3.00 Total hospital charges from Wkst. S-10, co		From 01/01/2015 Part II To 12/31/2015 Date/Time Pro 5/27/2016 1:5					
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION  1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  3.098 3.00  4.00 Total inpatient days from S-3, Pt. I, col. 8 sum of lines 1, 8-12  48,834 4.00  5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00  8.00 Calculation of the HIT incentive payment (see instructions)  597,202 8.00  9.00 Sequestration adjustment amount (see instructions)  Calculation of the HIT incentive payment after sequestration (see instructions)  10.00 Initial /interim HIT payment adjustment (see instructions)  Total hospital charges from Wkst. S-10, col. 3 line 20  7.00 Calculation of the HIT incentive payment (see instructions)  597,202 8.00  10.00 Initial /interim HIT payment adjustment (see instructions)  Total hospital charges from Wkst. S-10, col. 3 line 20  7.00 Calculation of the HIT incentive payment (see instructions)  597,202 8.00  10.00 Initial /interim HIT payment adjustment (see instructions)  585,258  30.00 Other Adjustment (specify)							
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION  1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  4.00 Total inpatient days from S-3, Pt. I, col. 8 line 20  5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I or 7.00 In 168  8.00 Calculation of the HIT incentive payment (see instructions)  5.00 Sequestration adjustment amount (see instructions)  Calculation of the HIT incentive payment after sequestration (see instructions)  1.00 Initial /interim HIT payment adjustment (see instructions)  30.00 Other Adjustment (specify)							
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION  1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12  5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I  9.00 Sequestration of the HIT incentive payment (see instructions)  9.00 Sequestration adjustment amount (see instructions)  10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Other Adjustment (specify)  583,560 30.00  31.00 Other Adjustment (specify)					1. 00		
Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14  13,796  2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12  5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I  8.00 Calculation of the HIT incentive payment (see instructions)  9.00 Sequestration adjustment amount (see instructions)  10.00 Calculation of the HIT incentive payment after sequestration (see instructions)  10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Other Adjustment (specify)  583,560 30.00  31.00							
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12  3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2  4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12  5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200  6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I							
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 583,560 30.00 31.00 Other Adjustment (specify)				e 14			
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12  Total hospital charges from Wkst C, Pt. I, col. 8 line 200  Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 line 168  8.00 Calculation of the HIT incentive payment (see instructions) 597, 202 8.00  9.00 Sequestration adjustment amount (see instructions) 11, 944 9.00 line Algorithm HIT incentive payment after sequestration (see instructions) 585, 258 line Algorithm HIT payment adjustment (see instructions) 583, 560 30.00 31.00 Other Adjustment (specify) 0 31.00							
Total hospital charges from Wkst C, Pt. I, col. 8 line 200  Total hospital charity care charges from Wkst. S-10, col. 3 line 20  7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 line 168  8.00 Calculation of the HIT incentive payment (see instructions) 597,202 8.00  9.00 Sequestration adjustment amount (see instructions) 111,944 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 585,258 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Initial/interim HIT payment adjustment (see instructions) 583,560 30.00 31.00 Other Adjustment (specify)							
6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 597, 202 8.00 9.00 Sequestration adjustment amount (see instructions) 11, 944 9.00 line Algorithm HIT incentive payment after sequestration (see instructions) 585, 258 line Through HIT payment adjustment (see instructions) 583, 560 30.00 31.00 Other Adjustment (specify) 0 31.00							
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 line 168  8.00 Calculation of the HIT incentive payment (see instructions) 597, 202 8.00  9.00 Sequestration adjustment amount (see instructions) 11, 944 9.00  10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Initial/interim HIT payment adjustment (see instructions) 583, 560 30.00  31.00 Other Adjustment (specify) 0 31.00							
I ine 168   Sequestration of the HIT incentive payment (see instructions)   Sequestration adjustment amount (see instructions)   Sequestration of the HIT incentive payment after sequestration (see instructions)   11, 944   9.00   Calculation of the HIT incentive payment after sequestration (see instructions)   S85, 258   10.00   INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH   Sequestration (see instructions)   S83, 560   30.00   31.00   Other Adjustment (specify)   0   31.00					29, 777, 512		
9.00 Sequestration adjustment amount (see instructions) 11,944 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 1NPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Initial/interim HIT payment adjustment (see instructions) 31.00 Other Adjustment (specify)  583,560 30.00 31.00	7. 00		rtified HIT technology	Wkst. S-2, Pt. I	0	7. 00	
10.00 Calculation of the HIT incentive payment after sequestration (see instructions)  INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Initial/interim HIT payment adjustment (see instructions)  31.00 Other Adjustment (specify)  10.00  585, 258  30.00  31.00	8.00	Calculation of the HIT incentive payment (see instructions)			597, 202	8.00	
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH  30.00 Initial/interim HIT payment adjustment (see instructions)  31.00 Other Adjustment (specify)  583,560 30.00 31.00	9.00	Sequestration adjustment amount (see instructions)			11, 944	9.00	
30.00 Initial/interim HIT payment adjustment (see instructions) 583,560 30.00 31.00 Other Adjustment (specify) 0 31.00	10.00	Calculation of the HIT incentive payment after sequestration (	see instructions)		585, 258	10.00	
31.00 Other Adjustment (specify) 0 31.00		INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
	30.00	Initial/interim HIT payment adjustment (see instructions)			583, 560	30.00	
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 1,698 32.00	31.00	Other Adjustment (specify)			0	31.00	
	32.00	Balance due provider (line 8 (or line 10) minus line 30 and li	ne 31) (see instruction	ns)	1, 698	32.00	

Heal th	Financial Systems IU HEALTH BLOOMING	TON HOSPITAL	In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 150051	Peri od:	Worksheet E-3	
			From 01/01/2015	Part III	
		Component CCN: 15T051	To 12/31/2015	Date/Time Pre 5/27/2016 1:5	
		Title XVIII	Subprovi der -	PPS	<u>5 piii                                 </u>
			I KI		
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1. 00	Net Federal PPS Payment (see instructions)		2, 436, 314		
2. 00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0347	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			120, 598	
4. 00	Outlier Payments		442, 721		
5. 00	Unweighted intern and resident FTE count in the most recent of to November 15, 2004 (see instructions)	cost reporting period e	nding on or prior	0.00	5. 00
5. 01	Cap increases for the unweighted intern and resident FTE cour	nt for residents that we	re displaced by	0.00	5. 01
	program or hospital closure, that would not be counted withou				
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	. 3 . 3			l
6.00	New Teaching program adjustment. (see instructions)			0.00	6.00
7.00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth	period of a "new	0.00	7.00
	teaching program" (see instructions)	, , ,			l
8.00	Current year's unweighted I&R FTE count for residents within	the new program growth	period of a "new	0.00	8.00
	teaching program" (see instructions)				
9.00	Intern and resident count for IRF PPS medical education adjus	stment (see instructions	)	0.00	9. 00
10.00	Average Daily Census (see instructions)			7. 728767	10.00
11.00	Teaching Adjustment Factor (see instructions)			0.000000	11.00
12.00	Teaching Adjustment (see instructions)			0	12.00
13.00	Total PPS Payment (see instructions)			2, 999, 633	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruct	i on)		0	14.00
15.00	Organ acquisition (DO NOT USE THIS LINE)				15.00
16.00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	16.00
17.00	Subtotal (see instructions)			2, 999, 633	17. 00
18.00	Primary payer payments			0	18.00
19.00	Subtotal (line 17 less line 18).			2, 999, 633	19.00

Health Financial Systems

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

Provi der CCN: 150051

Period: Worksheet G From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm

				12/01/2010	5/27/2016 1:5	3 pm
		General Fund	Speci fi c	Endowment	Plant Fund	
			Purpose Fund	Fund		
		1. 00	2.00	3. 00	4. 00	
4 00	CURRENT ASSETS	170 011 000		ام		4 00
1.00	Cash on hand in banks	173, 011, 820		0	0	1.00
2.00	Temporary investments	0	0	0	0	2.00
3.00	Notes recei vable	U E1 770 405	0	0	0	3.00
4. 00 5. 00	Accounts recei vabl e  Other recei vabl e	51, 779, 495		0	0	4. 00 5. 00
6. 00	Allowances for uncollectible notes and accounts receivable	1, 128, 025	1	0	0	6.00
7. 00	Inventory	5, 044, 584		0	0	7. 00
8. 00	Prepai d expenses	1, 461, 997		0	0	8. 00
9. 00	Other current assets	1, 401, 777		0	Ö	9. 00
10.00	Due from other funds	0	Ö	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	232, 425, 921		Ö	Ö	11. 00
	FIXED ASSETS		<u> </u>			
12.00	Land	19, 760, 652	0	0	0	12.00
13.00	Land improvements	2, 072, 522	0	0	0	13.00
14.00	Accumulated depreciation	-1, 634, 807	0	0	0	14.00
15. 00	Bui I di ngs	162, 786, 564		0	0	15.00
16. 00	Accumulated depreciation	-107, 419, 544		0	0	16. 00
17. 00	Leasehold improvements	5, 912, 983		0	0	17. 00
18. 00	Accumulated depreciation	-4, 623, 369		0	0	18. 00
19. 00	Fi xed equipment	20, 471, 772		0	0	19. 00
20.00	Accumulated depreciation	-18, 999, 662		0	0	20.00
21. 00	Automobiles and trucks	350, 229		0	0	21.00
22. 00	Accumulated depreciation	0	-	0	0	22.00
23. 00	Maj or movable equipment	169, 440, 904		0	0	23. 00
24. 00	Accumulated depreciation	-154, 667, 770		0	0	24. 00
25. 00	Minor equipment depreciable	0	0	0	0	25. 00
26. 00 27. 00	Accumulated depreciation HIT designated Assets	0	0	0	0	26. 00 27. 00
28. 00	Accumulated depreciation	0	0	0	0	28.00
29. 00	Mi nor equi pment-nondepreci abl e		0	0	0	29. 00
30.00	Total fixed assets (sum of lines 12-29)	93, 450, 474		0	0	30.00
30.00	OTHER ASSETS	73, 430, 474	<u> </u>	<u> </u>	0	30.00
31. 00	Investments	177, 450, 825	0	0	0	31. 00
32. 00	Deposits on Leases	0		Ö	Ö	32. 00
33.00	Due from owners/officers	o	0	O	0	33. 00
34.00	Other assets	13, 775, 287	0	O	0	34.00
35.00	Total other assets (sum of lines 31-34)	191, 226, 112	0	0	0	35.00
36.00	Total assets (sum of lines 11, 30, and 35)	517, 102, 507	0	0	0	36.00
	CURRENT LI ABI LI TI ES					
37.00	Accounts payable	20, 685, 750		0	0	37.00
38. 00	Salaries, wages, and fees payable	10, 466, 030	0	0	0	38. 00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	1, 543, 055	0	0	0	40.00
41.00	Deferred income	0	0	0	0	41.00
42.00	Accel erated payments	0				42.00
43. 00 44. 00	Due to other funds Other current liabilities	7, 828, 664	0	0	0	43. 00 44. 00
45.00	Total current liabilities (sum of lines 37 thru 44)	40, 523, 499		0	-	44. 00 45. 00
43.00	LONG TERM LIABILITIES	40, 323, 477	<u> </u>	<u> </u>	0	43.00
46. 00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	Ö	- 1	Ö	Ö	47. 00
48. 00	Unsecured Loans	Ö	l o	Ö	Ö	48. 00
49.00	Other long term liabilities	44, 967, 177	0	0	0	49.00
50.00	Total long term liabilities (sum of lines 46 thru 49	44, 967, 177		0	0	50.00
51.00	Total liabilites (sum of lines 45 and 50)	85, 490, 676	0	0	0	51.00
	CAPITAL ACCOUNTS					
52.00	General fund balance	431, 611, 831				52.00
53.00	Specific purpose fund		0			53.00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55.00
56.00	Governing body created - endowment fund balance			0	-	56.00
57.00	Plant fund balance - invested in plant				0	57.00
58. 00	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58. 00
59. 00	Total fund balances (sum of lines 52 thru 58)	431, 611, 831	0	0	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	517, 102, 507		o N	0	60.00
55. 55	[59]	3.7, 102, 307	l ~	Ĭ	ا ا	55.00
		•	. '	'	'	•

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES In Lieu of Form CMS-2552-10 Provi der CCN: 150051

					То	12/31/2015	Date/Time Pre 5/27/2016 1:5	
		Genera	Fund	Speci al	Pur	pose Fund	Endowment Fund	·
		1. 00	2. 00	3. 00		4. 00	5. 00	
1. 00	Fund balances at beginning of period	1.00	359, 928, 051	0.00		0	0.00	1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		71, 683, 778					2.00
3.00	Total (sum of line 1 and line 2)		431, 611, 829			0		3.00
4.00	ROUNDI NG	2			0		0	4. 00
5.00		0			0		0	5. 00
6. 00		0			0		0	6. 00
7.00		0			0		0	7.00
8. 00 9. 00		0			0		0	8. 00 9. 00
10.00	Total additions (sum of line 4-9)	U	2		U	0	U	10.00
11. 00	Subtotal (line 3 plus line 10)		431, 611, 831			0		11.00
12. 00	Deductions (debit adjustments) (specify)	0	101, 011, 001		0	Ĭ	0	12.00
13. 00	, (, (, (, ),	Ö			0		0	13. 00
14.00		О			0		0	14.00
15.00		o			0		0	15.00
16.00		0			0		0	16. 00
17. 00		0			0		0	17. 00
18.00	,		0			0		18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)		431, 611, 831			0		19. 00
	sheet (Title II illitius IIIle 18)	Endowment	PI ant	Fund				
		Fund						
1 00		6. 00	7. 00	8. 00				1 00
1.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29)	0			0			1.00
2. 00 3. 00	Total (sum of line 1 and line 2)	0			0			2.00 3.00
4. 00	ROUNDI NG	o o	0		U			4.00
5. 00	indensiting		0					5. 00
6.00			0					6.00
7.00			0					7. 00
8.00			0					8. 00
9.00			0					9. 00
10.00	Total additions (sum of line 4-9)	0			0			10.00
11.00	Subtotal (line 3 plus line 10)	0			0			11.00
12. 00 13. 00	Deductions (debit adjustments) (specify)		0					12. 00 13. 00
14. 00			0					14.00
15. 00			0					15.00
16. 00			0					16.00
17. 00			0					17. 00
18.00	Total deductions (sum of lines 12-17)	o			0			18.00
19. 00	Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			19. 00

| Peri od: | Worksheet G-2 | From 01/01/2015 | Parts | & II | To 12/31/2015 | Date/Time Prepared: Health Financial Systems 10 H
STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 150051

			To 12/31/201	5 Date/Time Pre 5/27/2016 1:5	
	Cost Center Description	I npati ent	Outpati ent	Total	) pili
	oust defiter bescription	1. 00	2.00	3. 00	
	PART I - PATIENT REVENUES	1.00	2.00	0.00	
	General Inpatient Routine Services				1
1.00	Hospi tal	95, 342, 22	24	95, 342, 224	1.00
2.00	SUBPROVI DER - I PF		0	0	1
3.00	SUBPROVI DER - I RF	4, 188, 47	75	4, 188, 475	3.00
4.00	SUBPROVI DER		0	0	1
5.00	Swing bed - SNF		0	0	5.00
6.00	Swing bed - NF		0	0	6.00
7.00	SKILLED NURSING FACILITY		0	0	7.00
8.00	NURSING FACILITY		0	0	8.00
9.00	OTHER LONG TERM CARE		0	0	9.00
10.00	Total general inpatient care services (sum of lines 1-9)	99, 530, 69	99	99, 530, 699	10.00
	Intensive Care Type Inpatient Hospital Services				1
11.00	INTENSIVE CARE UNIT	15, 157, 65	51	15, 157, 651	11.00
12.00	CORONARY CARE UNIT		0	0	12.00
13.00	BURN INTENSIVE CARE UNIT		0	0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT		0	0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15.00
16.00	Total intensive care type inpatient hospital services (sum of lines	15, 157, 65	51	15, 157, 651	16.00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	114, 688, 35	50	114, 688, 350	17. 00
18. 00	Ancillary services	383, 947, 37			
19. 00	Outpati ent servi ces	15, 916, 50	07 77, 022, 02	92, 938, 536	1
20. 00	RURAL HEALTH CLINIC			0	1
21. 00	FEDERALLY QUALIFIED HEALTH CENTER			0	
22. 00	HOME HEALTH AGENCY		3, 866, 82		1
23. 00	AMBULANCE SERVICES	51, 09	1		
24. 00	CMHC			0	
24. 10	CORF		-	0	
25. 00	AMBULATORY SURGICAL CENTER (D. P. )			0	
26.00	HOSPI CE		0 7, 144, 65		
27. 00	OTHER (SPECIFY)		0	0 0	
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	514, 603, 32	624, 790, 65	4 1, 139, 393, 983	28. 00
	G-3, line 1) PART II - OPERATING EXPENSES				-
29. 00	Operating expenses (per Wkst. A, column 3, line 200)		305, 001, 81	1	29. 00
30.00	ADD (SPECIFY)		0	'	30.00
31.00	ADD (SI ECITY)		0		31.00
32. 00			0		32.00
33. 00			0		33.00
34. 00			0		34.00
35. 00			0		35.00
36. 00	Total additions (sum of lines 30-35)		-	o	36.00
37. 00	DEDUCT (SPECIFY)		0	<u> </u>	37.00
38. 00	(3. 23)	1	0		38.00
39. 00		1	Ö		39.00
40.00			0		40.00
41. 00		1	o		41.00
42. 00	Total deductions (sum of lines 37-41)	1		ol	42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfe	r	305, 001, 81	1	43.00
	to Wkst. G-3, line 4)				

Heal th	Financial Systems IU HEALTH BLOOMINGTO	ON HOSPITAL	In Lie	u of Form CMS-2	2552-10		
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 150051	Peri od:	Worksheet G-3			
			From 01/01/2015				
			To 12/31/2015				
				5/27/2016 1:5	3 pm		
				1. 00			
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	28)		1, 139, 393, 983	1. 00		
2.00	Less contractual allowances and discounts on patients' account			779, 531, 925	2.00		
3.00	Net patient revenues (line 1 minus line 2)			359, 862, 058			
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 4	3)		305, 001, 811	4.00		
5.00	Net income from service to patients (line 3 minus line 4)	,		54, 860, 247	5.00		
	OTHER INCOME						
6.00	Contributions, donations, bequests, etc			0	6.00		
7.00	Income from investments			0	7. 00		
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 th	an patients		0	16.00		
17.00	Revenue from sale of drugs to other than patients	·		0	17.00		
18.00	Revenue from sale of medical records and abstracts			0	18. 00		
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00		
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00		
21.00	Rental of vending machines			0	21.00		
22.00	Rental of hospital space			0	22. 00		
23.00	Governmental appropriations			0	23. 00		
24.00	OTHER INCOME			16, 823, 531	24.00		
25.00	Total other income (sum of lines 6-24)			16, 823, 531	25.00		
	Total (line 5 plus line 25)			71, 683, 778	26.00		
27 00	OTHED EVDENSES (SDECLEV)			0	27 00		

0 27.00

28.00 0 71, 683, 778 29. 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)

0

0

0

0

1, 439, 157

5, 549, 648

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-218, 643

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1, 439, 157

5, 331, 005

17.00

18.00

19.00

20.00

21.00

22.00

23.00

24.00

Column, 6 line 24 should agree with the Worksheet A, column 3, line 101, or subscript as applicable.

0

0

0

0

0

0

-3, 685

-1, 362, 789

Private Duty Nursing

Day Care Program

Homemaker Service

24.00 Total (sum of lines 1-23)

23.00 All Others (specify)

Health Promotion Activities

Home Delivered Meals Program

17.00

18.00

19.00

20.00

21.00

22.00

Clinic

0

0

0

0

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12.00

13.00

14.00

15.00

16.00

17.00

18. 00 19. 00

20.00

21.00

12.00

13.00

14.00

15.00

16.00

17.00

18.00

19.00

20.00

21 00

Drugs

Clinic

DMF

Supplies (see instructions)

HHA NONREIMBURSABLE SERVICES

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

Respiratory Therapy

Day Care Program

Private Duty Nursing

Health Financial Systems	IL	HEALTH BLOOMI	NGTON HOSPIT	AL	In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - HHA STATISTICAL BAS	SIS		Provi de	er CCN: 150051	Peri od:	Worksheet H-1	
			HHA CCN		From 01/01/2015 To 12/31/2015	Part II Date/Time Pre 5/27/2016 1:5	
					Home Health	PPS	
					Agency I		
	Capital Rel	ated Costs					
	BI dgs &	Movabl e	PI ant	·	Reconciliatio		
	Fixtures (SQUARE FEET)	Equipment (DOLLAR	Operation 8 Maintenance	, ,	n	e & General (ACCUM. COST)	

				_		Agency	·	
		Capi tal Rel	ated Costs					
					_			
		BI dgs &	Movabl e	PI ant		Reconciliatio		
		Fi xtures	Equi pment	Operation &	n (MILEAGE)	n	e & General	
		(SQUARE FEET)	(DOLLAR	Mai ntenance			(ACCUM. COST)	
			VALUE)	(SQUARE FEET)				
		1. 00	2. 00	3. 00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS							
1.00	Capital Related - Bldg. &	0				0		1.00
	Fixtures							l
2.00	Capital Related - Movable		0			0		2.00
	Equi pment							ĺ
3.00	Plant Operation & Maintenance	o	0	0		0		3.00
4.00	Transportation (see	o	0	0	0			4.00
	instructions)							l
5.00	Administrative and General	o	0	l	l o	-1, 902, 564	3, 428, 441	5.00
	HHA REIMBURSABLE SERVICES					, , , , , , , , , , , , , , , , , , , ,		
6.00	Skilled Nursing Care	0	0	0	0	0	1, 199, 843	6.00
7. 00	Physical Therapy	o	0	0	0	0	530, 503	
8. 00	Occupational Therapy	0	0	0	1	0	166, 821	
9. 00	Speech Pathology		0		١	0	19, 403	
10.00	Medical Social Services	١	0		١	0	34, 588	
11. 00	Home Heal th Ai de	0	0	٥		0	38, 126	
12. 00	Supplies (see instructions)	0	0			0	30, 120	
13. 00	1	0	0			0	0	
	Drugs DMF	0	0			0	_	
14.00		0	0		0	0	0	14.00
	HHA NONREI MBURSABLE SERVI CES	_1		_	_	_	_	
15. 00	Home Dialysis Aide Services	0	0	0	0	0	0	1
16. 00	Respi ratory Therapy	0	0	0	0	0	0	16. 00
17. 00	Private Duty Nursing	0	0	0	0	0	0	17. 00
18.00	Clinic	0	0	0	0	0	0	18. 00
19.00	Health Promotion Activities	0	0	0	0	0	0	19.00
20.00		0	0	0	0	0	0	20.00
21.00	Home Delivered Meals Program	0	0	0	0	0	0	21.00
22.00	Homemaker Service	0	0	0	0	0	0	22.00
23.00	All Others (specify)	o	0	0	0	0	1, 439, 157	23. 00
24.00	Total (sum of lines 1-23)	o	0	0	0	-1, 902, 564	3, 428, 441	24.00
25. 00	Cost To Be Allocated (per	l	0	1 0	1 0		1, 902, 564	
	Worksheet H-1, Part I)	]	·	]	]			
26, 00	Unit Cost Multiplier	0. 000000	0. 000000	0. 000000	0. 000000		0. 554936	26, 00
	1 p. 1	1 2,000000	2.000000	1 2.000000	1 2.000000	1	3.00.700	,

Peri od: Worksheet H-2
From 01/01/2015 Part I
To 12/31/2015 Date/Time Prepared: 5/27/2016 1:53 pm

Home Heal th PPS Provi der CCN: 150051 HHA CCN: 157011

						Home Health	PPS	
			CAPI TAL REI	ATED COSTS		Agency I		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	ADMINISTRATIV E & GENERAL	
		0	1. 00	2.00	4.00	4A	5. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	0 1, 865, 679 824, 898 259, 396 30, 170 53, 782 59, 283 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	135, 525 22, 560 1, 119 0 0 4, 102 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	91, 729 15, 269 757 0 0 0 2, 776 0 0 0 0 0 0 0 0 0 0 0 0 0	111, 009 338, 960 149, 869 47, 127 5, 481 36, 741 10, 771 0 0 0 0 0 0 0 0 0	338, 263 2, 242, 468 976, 643 306, 523 35, 651 90, 523 76, 932 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	68, 209 452, 182 196, 935 61, 809 7, 189 18, 254 15, 513 0 0 0 0 0 0 0 0	
	of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPI NG	DI ETARY	CAFETERI A	
		6. 00	7. 00	8. 00	9.00	10.00	11. 00	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 000 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	220, 865 36, 765 1, 823 0 0 6, 685 0 0 0 0 0 0 0 0 238, 185 504, 323	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	3, 316 7, 592 2, 104 731 103 84 1, 907 0 0 0 0 0 0 0 0 10, 335 26, 172	19. 00

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems IU HEAL ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Worksheet H-2 Part I Date/Time Prepared: 5/27/2016 1:53 pm Provi der CCN: 150051 Peri od: From 01/01/2015 To 12/31/2015 HHA CCN: 157011

							3/2//2010 1.3	о р
						Home Health Agency I	PPS	
	Cost Center Description	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SOCI AL	
		OF PERSONNEL	ADMI NI STRATI O	SERVICES &		RECORDS &	SERVI CE	
			N	SUPPLY		LI BRARY		
1 00		12. 00	13. 00	14. 00	15. 00	16.00	17. 00	1 00
1.00	Administrative and General	0	13, 025	0		0	0	1.00
2. 00 3. 00	Skilled Nursing Care	0	163, 846	0		0	0	2. 00 3. 00
4. 00	Physical Therapy Occupational Therapy		0	0		0 0	0	4.00
5. 00	Speech Pathology		0	0	i e	0 0	0	5.00
6. 00	Medical Social Services	0	0	0		0 0	Ö	6.00
7. 00	Home Health Aide	0	0	0		0 0	0	7.00
8.00	Supplies (see instructions)	0	0	42, 332		0 0	0	8. 00
9.00	Drugs	0	0	89, 632		0	0	9. 00
10.00	DME	0	0	30		0	0	10.00
11.00	Home Dialysis Aide Services	0	0	0		0	0	11.00
12. 00 13. 00	Respiratory Therapy Private Duty Nursing	0	0	0		0 0	0	12. 00 13. 00
14. 00	Clinic		0	0		0 0		14.00
15. 00	Health Promotion Activities	0	0	0		0 0	0	15.00
16. 00	Day Care Program	0	0	0		o o	Ō	16.00
17.00	Home Delivered Meals Program	0	0	0		0 0	0	17.00
18.00	Homemaker Service	0	0	0		0 0	0	18.00
19. 00	All Others (specify)	0	36, 578	0		0	0	19.00
20.00	Total (sum of lines 1-19) (2)	0	213, 449	131, 994		0 0	0	20.00
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum							21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
		OTHER GENER	RAL SERVICE			INTERNS &		
						DESTREMES		
	Cost Center Description	(SPECLEY)	CENTRAL	NONPHYSI CI AN	NURSI NG	RESI DENTS	SERVI CES-OTHE	
	Cost Center Description	(SPECI FY)	CENTRAL STERI LI ZATI ON	NONPHYSI CI AN ANESTHETI STS	NURSI NG SCHOOL	RESI DENTS SERVI CES-SALA RY & FRI NGES	SERVICES-OTHE R PRGM COSTS	
	Cost Center Description	(SPECI FY) 18. 00				SERVI CES-SALA		
1.00	Administrative and General	, ,	STERI LI ZATI ON 18. 01 0	ANESTHETI STS 19. 00	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES 21.00	R PRGM COSTS 22.00	
2.00	Administrative and General Skilled Nursing Care	18. 00	STERI LI ZATI ON 18. 01 0	ANESTHETI STS 19. 00	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES 21. 00 0 0 0	R PRGM COSTS 22.00 0	2.00
2. 00 3. 00	Administrative and General Skilled Nursing Care Physical Therapy	18. 00	18. 01 0 0 0	ANESTHETI STS 19. 00	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES 21.00	R PRGM COSTS 22.00 0 0	2. 00 3. 00
2. 00 3. 00 4. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy	18. 00	STERI LI ZATI ON  18. 01  0  0  0  0 0	ANESTHETI STS 19. 00	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES 21. 00 0 0 0	R PRGM COSTS  22.00  0 0 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	18. 00	STERI LI ZATI ON  18. 01  0  0  0  0  0  0	ANESTHETI STS 19. 00	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES 21. 00 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0	2.00 3.00 4.00 5.00
2. 00 3. 00 4. 00 5. 00 6. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	18. 00	STERI LI ZATI ON  18. 01  0  0  0  0 0	ANESTHETI STS 19. 00	SCH00L 20.00	SERVI CES-SALA RY & FRI NGES 21. 00 0 0 0	R PRGM COSTS  22.00  0 0 0 0 0	2. 00 3. 00 4. 00
2. 00 3. 00 4. 00 5. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	18. 00	STERI LI ZATI ON  18. 01  0  0  0  0  0  0  0	ANESTHETI STS 19. 00	SCH00L 20.00	SERVI CES-SALA RY & FRI NGES 21.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	18. 00	18. 01 0 0 0 0 0 0 0 0 0 0 0	ANESTHETI STS 19. 00	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES 21.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME	18. 00	18. 01 0 0 0 0 0 0 0 0 0 0 0 0	ANESTHETI STS 19. 00	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES  21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services	18. 00	STERI LI ZATI ON  18. 01  0  0  0  0  0  0  0  0  0  0  0  0	ANESTHETI STS 19. 00	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES  21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	18. 00	18. 01 0 0 0 0 0 0 0 0 0 0 0 0	ANESTHETI STS 19. 00	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES  21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	18. 00	STERI LI ZATI ON  18. 01  0  0  0  0  0  0  0  0  0  0  0  0	ANESTHETI STS 19. 00	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES  21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	18. 00	STERI LI ZATI ON  18. 01  0  0  0  0  0  0  0  0  0  0  0  0	ANESTHETI STS 19. 00	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES  21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	18. 00	STERI LI ZATI ON  18. 01  0  0  0  0  0  0  0  0  0  0  0  0	ANESTHETI STS 19. 00	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES  21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	STERI LI ZATI ON  18. 01  0  0  0  0  0  0  0  0  0  0  0  0	19. 00  19. 00  0  0  0  0  0  0  0  0  0  0  0  0	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES  21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service	18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	18. 01 0 0 0 0 0 0 0 0 0 0 0 0 0	19. 00  19. 00  0  0  0  0  0  0  0  0  0  0  0  0	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES  21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify)	18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	STERILI ZATI ON  18. 01  0  0  0  0  0  0  0  0  0  0  0  0	19. 00  19. 00  0  0  0  0  0  0  0  0  0  0  0  0	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES  21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2)	18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	STERILI ZATI ON  18. 01  0  0  0  0  0  0  0  0  0  0  0  0	19. 00  19. 00  0  0  0  0  0  0  0  0  0  0  0  0	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES  21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	STERILI ZATI ON  18. 01  0  0  0  0  0  0  0  0  0  0  0  0	19. 00  19. 00  0  0  0  0  0  0  0  0  0  0  0  0	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES  21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	STERILI ZATI ON  18. 01  0  0  0  0  0  0  0  0  0  0  0  0	19. 00  19. 00  0  0  0  0  0  0  0  0  0  0  0  0	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES  21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	STERILI ZATI ON  18. 01  0  0  0  0  0  0  0  0  0  0  0  0	19. 00  19. 00  0  0  0  0  0  0  0  0  0  0  0  0	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES  21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	18. 00 0 0 0 0 0 0 0 0 0 0 0 0 0	STERILI ZATI ON  18. 01  0  0  0  0  0  0  0  0  0  0  0  0	19. 00  19. 00  0  0  0  0  0  0  0  0  0  0  0  0	SCH00L 20. 00	SERVI CES-SALA RY & FRI NGES  21.00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	R PRGM COSTS  22. 00  0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 00 3. 00 4. 00 5. 00 6. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Provider CCN: 150051 Peri od: Worksheet H-2 From 01/01/2015 Part I Date/Time Prepared: HHA CCN: 157011 12/31/2015 To 5/27/2016 1:53 pm Home Health PPS Agency I PARAMED ED Allocated HHA Total HHA Cost Center Description Subtotal Intern & Subtotal PRGM-PHARMACY A&G (see Part Resi dents Costs **RESI DENCY** Cost & Post II) Stepdown Adjustments 23. 00 24. 00 25. 00 26.00 27. 00 28. 00 1.00 Administrative and General 1.00 643, 678 643.678 0 2, 902, 853 2.00 Skilled Nursing Care 2, 902, 853 215, 763 3, 118, 616 2.00 3.00 Physical Therapy 0 1, 177, 505 1, 177, 505 87, 522 1, 265, 027 3.00 Occupational Therapy 0 369, 063 0 369, 063 27, 432 396, 495 4.00 4.00 0 Speech Pathology 3, 192 5.00 5.00 42, 943 42, 943 46, 135 6.00 Medical Social Services 108, 861 0 108, 861 8,091 116, 952 6.00 7.00 Home Health Aide 0 101, 037 101, 037 7, 510 108, 547 7.00 Supplies (see instructions) 42, 332 3, 146 0 0 45, 478 8.00 8 00 42, 332 89, 632 0 89, 632 96, 294 9.00 Drugs 6,662 9.00 10.00 DMF 30 30 32 10.00 0 11.00 Home Dialysis Aide Services 0 0 0 0 0 0 0 0 0 11.00 Respiratory Therapy 0 0 0 12.00 12.00 0 Private Duty Nursing 13.00 0 0 0 13.00 14.00  $\operatorname{CI}\operatorname{i}\operatorname{ni}\operatorname{c}$ 0 0 0 14.00 Health Promotion Activities 0 0 15.00 0 0 15.00 0 0 0 16.00 16.00 Day Care Program 17.00 Home Delivered Meals Program 0 0 0 0 17.00 Homemaker Service 0 18.00 0 0 0 18.00 0 All Others (specify) 3, 825, 664 0 3, 825, 664 284, 358 4, 110, 022 19.00 0 19 00 20.00 Total (sum of lines 1-19) (2) 9, 303, 598 9, 303, 598 643, 678 9, 303, 598 20.00 Unit Cost Multiplier: column 0.074328 21.00 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101. (2) Columns O through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems	IU HEALTH BLOOMINGTO	N HOSPITAL	u of Form CMS-2552-10	
ALLOCATION OF GENERAL SERVICE COSTS TO	O HHA COST CENTERS STATISTICAL	Provider CCN: 150051	Peri od:	Worksheet H-2
BASIS			From 01/01/2015	
		HHA CCN: 157011	To 12/31/2015	Date/Time Prepared:
				5/27/2016 1:53 pm

Home Health Agency I CAPITAL RELATED COSTS MAINTENANCE & BLDG & FIXT MVBLE FOLLE **EMPLOYEE** Reconciliatio ADMINISTRATIV Cost Center Description (SQUARE FEET) (SQUARE FEET) **BENEFITS** E & GENERAL **REPAIRS** DEPARTMENT (ACCUM. COST) (SQUARE FEET) (GROSS SALARIES) 2.00 1.00 6.00 4.00 5A 5.00 1.00 Administrative and General 7, 269 7, 269 392, 948 0 338, 263 1.00 0 2.00 Skilled Nursing Care 1, 210 1, 210 1, 199, 842 0 2, 242, 468 0 2.00 530, 503 0 3.00 3 00 976, 643 ol Physical Therapy 60 60 0 4.00 Occupational Therapy 0 0 166, 820 306, 523 0 4.00 Speech Pathology 5.00 0 0 19, 403 0 35, 651 5.00 0 0 6.00 Medical Social Services 0 130, 055 90, 523 6.00 0 7 00 Home Health Aide 220 220 38, 126 76, 932 7 00 8.00 Supplies (see instructions) 0 0 0 8.00 9.00 0 0 0 0 9.00 Drugs 0 DME. 0 0 0 10.00 10.00 0 0 0 0 0 11.00 Home Dialysis Aide Services 0 11.00 12.00 Respiratory Therapy 0 0 o 12.00 Private Duty Nursing 0 13.00 13.00 0 0 0 0 14.00 Clinic 0 14.00 0 15.00 Health Promotion Activities C 15 00 0 0 o 16.00 Day Care Program 16.00 17.00 Home Delivered Meals Program 0 0 0 0 17.00 Homemaker Service 18.00 0 0 0 0 18.00 2, 946, 433 19.00 All Others (specify) 6, 399 7.839 1, 735, 929 19.00 Total (sum of lines 1-19) 16, 598 4, 213, 626 7, 013, 436 20.00 20.00 15, 158 Total cost to be allocated 1, 414, 224 21.00 282, 612 209.453 1, 190, 366 21.00 12. 619171 0. 282504 0. 201645 0.000000 22.00 Unit cost multiplier 18.644412 22.00 Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A MAI NTENANCE PLANT LINEN SERVICE (HOURS OF (MEALS (MANHOURS) OF PERSONNEL (SQUARE FEET) (POUNDS OF SERVICE) SERVED) (NUMBER LAUNDRY) HOUSED) 7. 00 9.00 10.00 11. 00 8.00 12.00 1.00 Administrative and General 7, 269 0 0 19, 489 1.00 2.00 Skilled Nursing Care 1, 210 0000000000000000000 0 0 44, 617 2.00 0 Physi cal Therapy 0 12, 363 3.00 3.00 0 60 O 4.00 Occupational Therapy 0 0 0 4, 297 4.00 Speech Pathology 5.00 0 608 5.00 6.00 Medical Social Services 0 0 0 494 6.00 0 0 220 0 11, 205 7.00 Home Health Aide 7.00 0 8.00 Supplies (see instructions) 0 0 0 8.00 9.00 0 0 0 0 9.00 Drugs 0 0 0 10.00 10.00 DMF 0 Home Dialysis Aide Services 11.00 0 11.00 12.00 Respiratory Therapy 0 0 0 0 12.00 13.00 Private Duty Nursing 0 13.00 0 0 0 0 14.00 Clinic O 14.00 15.00 Health Promotion Activities 0 15.00 16.00 Day Care Program 0 0 16.00 0 0 0 o 17.00 Home Delivered Meals Program 17.00 0 18.00 Homemaker Service 0 C 0 18.00 19.00 All Others (specify) 7, 839 C 60, 744 19.00 Total (sum of lines 1-19) 16, 598 0 0 153, 817 20.00 20.00 Total cost to be allocated 21.00 21.00 504, 323 0 26, 172 30. 384564 0.000000 0.000000 0.000000 0.000000 22.00 22.00 Unit cost multiplier 0.170150

Health Financial Systems	IU HEALTH BLOOMINGTO	N HOSPITAL	u of Form CMS-2552-10	
ALLOCATION OF GENERAL SERVICE COSTS TO	O HHA COST CENTERS STATISTICAL	Provider CCN: 150051	Peri od:	Worksheet H-2
BASIS			From 01/01/2015	
		HHA CCN: 157011	To 12/31/2015	Date/Time Prepared:
				5/27/2016 1:53 pm

Home Health **PPS** Agency I OTHER GENERAL SERVI CE CENTRAL Cost Center Description NURSI NG PHARMACY MEDICAL SOCI AL (SPECIFY) ADMI NI STRATI O SERVICES & (COSTED RECORDS & SERVI CE (TIME SPENT) Ν SUPPLY REQUIS.) LI BRARY (TIME SPENT) (DIRECT NURS. (TIME SPENT) (GROSS HRS.) REVENUE) 14.00 15.00 17.00 18.00 13.00 16.00 1.00 Administrative and General 2, 081 0 0 0 1.00 0 2.00 Skilled Nursing Care 26, 177 0 0 0 2.00 0 0 0 3.00 3 00 Physical Therapy 0 O 0 0 0 4.00 Occupational Therapy 0 4.00 Speech Pathology 5.00 0 0 5.00 0 0 0 6.00 Medical Social Services 0 0 0 6.00 0 0 0 7 00 Home Health Aide 0 7 00 8.00 Supplies (see instructions) 152, 930 0 8.00 9.00 323, 804 0 0 9.00 Drugs 107 0 0 10.00 10.00 DMF 0 0 0 0 0 0 11.00 Home Dialysis Aide Services 0 0 11.00 12.00 Respiratory Therapy 0 0 0 12.00 0 0 13.00 Private Duty Nursing 13.00 0 0 0 0 0 0 0 14.00 0 14.00 Clinic 0 15.00 Health Promotion Activities C 15 00 16.00 Day Care Program 0 16.00 17.00 Home Delivered Meals Program 0 0 0 0 17.00 0 0 Homemaker Service 0 18.00 0 0 18.00 19.00 All Others (specify) 5,844 0 C 19.00 Total (sum of lines 1-19) 34, 102 0 0 20.00 20.00 476, 841 Total cost to be allocated 213, 449 131, 994 21.00 0 21.00 6. 259134 0. 276809 0.000000 0.000000 0.000000 0.000000 22.00 Unit cost multiplier 22.00 OTHER GENERAL INTERNS & RESIDENTS SERVI CE Cost Center Description SERVI CES-SALA SERVI CES-OTHE PARAMED ED CENTRAL NONPHYSI CI AN NURSI NG STERI LI ZATI ON **ANESTHETI STS** SCHOOL RY & FRINGES R PRGM COSTS PRGM-PHARMACY (ASSI GNED **RESI DENCY** (ASSI GNED (TIME SPENT) (ASSI GNED (ASSI GNED TIME) TIME) TIME) TIME) (COSTED REQUIS.) 18. 01 19. 00 20. 00 21.00 22. 00 23.00 1.00 0 00 0 0 Administrative and General 1.00 2.00 Skilled Nursing Care C 2.00 3.00 Physical Therapy 0 0 0 3.00 0000000000000000 0 0 0 Occupational Therapy 0 4.00 0 0 4.00 Speech Pathology 0 5.00 0 5.00 6.00 Medical Social Services 0 6.00 0 0 7.00 Home Heal th Aide 0 0 0 7.00 Supplies (see instructions) 0 0 8.00 0 8.00 0 0 0 9.00 Drugs 0 9.00 10.00 DMF 0 10.00 0 11.00 Home Dialysis Aide Services 0 0 0 0 0 0 11.00 Respiratory Therapy 0 0 12 00 12 00 0 13.00 Private Duty Nursing 0 13.00 0 14.00 Clinic 0 0 0 14.00 Health Promotion Activities 0 0 0 0 15.00 15.00 0 0 0 0 16.00 Day Care Program 16.00 17.00 Home Delivered Meals Program 0 0 0 0 17.00 0 0 0 18.00 Homemaker Service 0 0 18.00 0 0 0 o 19.00 19 00 All Others (specify) C O 0 20.00 Total (sum of lines 1-19) 0 C 0 0 20.00 Total cost to be allocated 21.00 22.00 Unit cost multiplier 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 22.00

Heal th	Financial Systems	11.	HEALTH BLOOMI	NGTON HOSPITA	L	In Lie	u of Form CMS-2	2552-10
	TONMENT OF PATIENT SERVICE COST		HERETT BEGGIN	Provi de	CCN: 150051	Peri od: From 01/01/2015	Worksheet H-3	
				HHA CCN	157011	To 12/31/2015	Date/Time Pre 5/27/2016 1:5	
				Ti t	le XVIII	Home Health Agency I	PPS	<u>o piii                                   </u>
	Cost Center Description	From, Wkst.	Facility	Shared	Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	Costs (from Wkst. H-2,	Ancillary Costs (from	Costs (cols 1 + 2)	•	Per Visit (col. 3 ÷	
		20, 11110	Part I)	Part II)	' ' 2)		col . 4)	
	T	0	1. 00	2. 00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF	THE PROGRAM LI	MITATION COST, C	OR BENEFICIARY	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2.00			3, 118, 6	·	269. 68	1.00
2.00	Physi cal Therapy	3. 00			0 1, 265, 0		224. 89	
3. 00 4. 00	Occupational Therapy Speech Pathology	4. 00 5. 00			0 396, 4 <sup>1</sup> 0 46, 1 <sup>1</sup>		206. 19 331. 91	3. 00 4. 00
5. 00	Medical Social Services	6. 00			116, 9		473. 49	5.00
6. 00	Home Health Aide	7. 00			108, 5		102. 40	
7. 00	Total (sum of lines 1-6)		5, 051, 772		0 5, 051, 7	72 20, 558		7. 00
					Program Visi	ts		
					Р	art B		
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject	_		
	, , , , , , , , , , , , , , , , , , , ,		,		to	Deducti bl es		
					Deducti bl es	**		
		0	1. 00	2. 00	Coi nsurance	4.00	5. 00	
	Limitation Cost Computation			2.00	0.00		0.00	
8.00	Skilled Nursing Care		14020		0 4, 3			8. 00
8. 01	Skilled Nursing Care		26900			26		8. 01
8. 02 8. 03	Skilled Nursing Care Skilled Nursing Care		50031 50032		0 1, 3	61		8. 02 8. 03
8. 04	Skilled Nursing Care		99915			86		8. 04
9.00	Physi cal Therapy		14020		0 2, 4	08		9.00
9. 01	Physi cal Therapy		26900			28		9. 01
9. 02 9. 03	Physical Therapy Physical Therapy		50031 50032		•	54 05		9. 02 9. 03
9. 04	Physical Therapy		99915			34		9. 04
10.00	Occupational Therapy		14020			19		10.00
10. 01	Occupational Therapy		26900			26		10. 01
10. 02	Occupational Therapy		50031		•	52		10.02
10. 03 10. 04	Occupational Therapy Occupational Therapy		50032 99915			85 24		10. 03 10. 04
11. 00	Speech Pathology		14020			45		11.00
11. 01	Speech Pathology		26900		o	1		11. 01
11. 02	Speech Pathology		50031			16		11. 02
11. 03	Speech Pathology		50032 99915		0	6 11		11.03
11. 04 12. 00	Speech Pathology Medical Social Services		14020		- 1	12		11. 04 12. 00
12. 01			26900		0	1		12. 01
12. 02	·		50031		0	24		12. 02
12. 03	1		50032		0	5		12.03
	Medical Social Services Home Health Aide		99915 14020		0 3	1 47		12. 04 13. 00
13. 00 13. 01	Home Health Aide		26900		0	3		13.00
13. 02	1		50031		0 2	50		13. 02
13. 03	Home Health Aide		50032		•	20		13.03
	Home Heal th Ai de		99915			11		13.04
14.00	Total (sum of lines 8-13)	I		l	0 11, 8	41		14.00

	Financial Systems		J HEALTH BLOOMI				u of Form CMS-2	
APPORT	TIONMENT OF PATIENT SERVICE COST	15		Provi der	CCN: 150051	Period: From 01/01/2015	Worksheet H-3 Part I	3
				HHA CCN:	157011	To 12/31/2015		pared
				Ti tl	e XVIII	Home Health Agency I	PPS	ло ріпі
	Cost Center Description	From Wkst.	Facility	Shared	Total HHA	Total Charges		
		H-2 Part I,	Costs (from	Ancillary	Costs (cols		÷ col. 4)	
		col. 28, line	Wkst. H-2, Part I)	Costs (from Part II)	1 + 2)	Record)		
		0	1.00	2.00	3.00	4. 00	5. 00	
F 00	Supplies and Drugs Cost Comput		45 470	14.40	1 (0.1	70 20 750	2 / 42077	1 15 6
5. 00 6. 00		8. 00 9. 00						
0. 00	10031 Of Brugs		Program Visits		Cost of	74 0	0.000000	10.0
					Servi ces			
	Cost Contor Doscription	Part A	Par Not Subject	t B Subject to	Part A	Part B Not Subject	Subject to	
	Cost Center Description	Part A	to	Deductibles &		to	Deductibles &	
			Deductibles &	Coi nsurance		Deductibles &	Coi nsurance	
			Coi nsurance	2.22		Coi nsurance	11.00	
	PART I - COMPUTATION OF LESSER	6.00	7.00	8.00	9.00	10.00	11.00	
	COST LIMITATION	OF AUGREGATE	ROUNAWI GUST, I	HOUNEUNIE UI' I	HE I NOOKAW LI	mi iAiron cosi, c	A DENETTOTARY	
. 00	Cost Per Visit Computation Skilled Nursing Care	1 0	6, 153			0 1, 659, 341		1. (
. 00	Physical Therapy	Ö	3, 529			0 793, 637		2.0
. 00	Occupational Therapy	0	1, 306			0 269, 284		3.0
. 00	Speech Pathology Medical Social Services	0	79 143			0 26, 221		4.0
. 00 . 00	Home Health Aide		631			0 67, 709 0 64, 614		5. ( 6. (
. 00	Total (sum of lines 1-6)	Ö	11, 841			0 2, 880, 806		7.0
	Cost Center Description							
	Limitation Cost Computation	6. 00	7. 00	8. 00	9.00	10. 00	11. 00	
3. 00	Limitation Cost Computation Skilled Nursing Care							8.0
3. 01	Skilled Nursing Care							8.0
. 02	Skilled Nursing Care							8.0
. 03 . 04	Skilled Nursing Care Skilled Nursing Care							8. (
. 00	Physical Therapy							9. (
. 01	Physi cal Therapy							9. (
. 02	Physical Therapy							9. (
. 03 . 04	Physical Therapy Physical Therapy							9. ( 9. (
0.00	Occupational Therapy							10.
0. 01	Occupational Therapy							10. (
0. 02	Occupational Therapy							10.
0. 03	Occupational Therapy Occupational Therapy							10. 10.
	Speech Pathology							11.
1. 01								11.
1. 02								11.
1. 03 1. 04	Speech Pathology							11.
2. 00	Speech Pathology Medical Social Services							11. 12.
2. 01	Medical Social Services							12.
2. 02	Medical Social Services							12.
2. 03	Medical Social Services							12.
2. 04 3. 00	Medical Social Services Home Health Aide							12. 13.
3. 00	Home Health Aide							13.
3. 02	1							13.0
3. 03	Home Health Aide							13.0
	Home Health Aide	I	l	I	1			13. (
3.04	Total (sum of lines 8-13)							14.

Heal th	Financial Systems	IL	J HEALTH BLOOMI	NGTON HOSPITA	ıL	In Lie	u of Form CMS-	2552-10
	TIONMENT OF PATIENT SERVICE COS				CCN: 150051	Peri od:	Worksheet H-3	
				HHA CCN:	157011	From 01/01/2015 To 12/31/2015	Part I Date/Time Pre 5/27/2016 1:5	epared:
				Ti t	le XVIII	Home Health Agency I	PPS	о рш
		Progr	ram Covered Cha	arges	Cost of Services			
	Cost Center Description	Part A	Par Not Subject to Deductibles & Coinsurance	Subject to Deductibles Coinsurance		Part B Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	
		6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	Supplies and Drugs Cost Comput			I	_1	_1	_	
15. 00 16. 00	1	0	0	<b>.</b>	0 0	0 0	C	
	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00						_
	PART I - COMPUTATION OF LESSER COST LIMITATION	OF AGGREGATE	PROGRAM COST, A	AGGREGATE OF	THE PROGRAM L	IMITATION COST, C	R BENEFICIARY	
	Cost Per Visit Computation							1
1.00	Skilled Nursing Care	1, 659, 341						1.00
2.00	Physical Therapy	793, 637						2.00
3. 00 4. 00	Occupational Therapy Speech Pathology	269, 284 26, 221						3. 00 4. 00
5. 00	Medical Social Services	67, 709						5.00
6.00	Home Health Aide	64, 614						6.00
7. 00	Total (sum of lines 1-6)	2, 880, 806						7. 00
	Cost Center Description	12. 00						1
	Limitation Cost Computation	12.00						
8.00	Skilled Nursing Care							8. 00
8. 01	Skilled Nursing Care							8. 01
8. 02 8. 03	Skilled Nursing Care Skilled Nursing Care	•						8. 02 8. 03
8. 04	Skilled Nursing Care							8.04
9. 00	Physical Therapy							9.00
9. 01	Physi cal Therapy							9. 01
9. 02	Physi cal Therapy							9. 02
9. 03	Physi cal Therapy							9. 03
9. 04	Physical Therapy Occupational Therapy							9. 04
10. 00 10. 01	Occupational Therapy							10.00
10. 02	Occupational Therapy							10.02
10. 03								10. 03
	Occupational Therapy							10. 04
11.00	Speech Pathology							11.00
11. 01	Speech Pathology							11.01
11. 02 11. 03	. 03							11. 02
11. 04	. 03							11. 04
12. 00	. 03							12.00
12. 01	Medical Social Services							12. 01
12. 02	1							12.02
12. 03	Medical Social Services							12.03
12. 04 13. 00	Medical Social Services Home Health Aide							12. 04 13. 00
13. 00	Home Health Aide							13.00
13. 02	Home Health Aide							13. 02
13. 03	Home Health Aide							13. 03
	Home Heal th Ai de							13.04
14. ()()	Total (sum of lines 8-13)	1						14.00

Heal th	Financial Systems	HEALTH BLOOMI	NGTON HOSP	TAL	-		In Lie	u of Form CMS-2	2552-10	
APPOR	FIONMENT OF PATIENT SERVICE COST	ΓS		Provi	der	CCN: 150051	Period: From 01/0	1 /2015	Worksheet H-3	
				нна с	CN:	157011		31/2015		
					Γitl	e XVIII	Home He	al th	PPS	
							Agenc	y I		
	Cost Center Description	From Wkst. C,	Cost to	Total H	Α	HHA Shared	Transf	er to		
		Part I, col.	Charge Ratio	Charge (f	^om	Ancillary	Part	l as		
		9, line		provi de	-	Costs (col.	1 Indi ca	ated		
				records	)	x col. 2)				
		0	1. 00	2.00		3.00	4. C	00		
	PART II - APPORTIONMENT OF COS	T OF HHA SERVI	CES FURNISHED I	BY SHARED H	IOSP	ITAL DEPARTME	NTS			
1.00	Physi cal Therapy	66.00	0. 502259		С	)	0 col . 2,	line 2	. 00	1.00
2.00	Occupational Therapy	67.00	0. 000000		C		0 col . 2,	line 3.	. 00	2.00
3.00	Speech Pathology	68.00	0. 000000		C		0 col . 2,	line 4.	. 00	3.00
4.00	Cost of Medical Supplies	71.00	0. 339133	43	329	14, 69	94 col . 2,	line 1	5. 00	4.00
5. 00	Cost of Drugs	73. 00	0. 289457		C	)	0 col . 2,	line 1	6. 00	5. 00

alth Financial Systems LCULATION OF HHA REIMBURSEME		BLOOMINGTON HOSPITAL Provider	CCN: 150051	Peri od:	u of Form CMS-2 Worksheet H-4	
EGGENTION OF THE RETIREDUNGENE	JAT SETTELMENT			From 01/01/2015	Part I-II	
		HHA CCN:	157011	To 12/31/2015	Date/Time Pre 5/27/2016 1:5	
		Ti tl e	e XVIII	Home Health	PPS	, с р
				Agency I	t B	
			Part A	Not Subject	Subject to	
				to	Deductibles &	
				Deductibles &	Coi nsurance	
			1. 00	Coi nsurance 2.00	3. 00	-
PART I - COMPUTATION OF	THE LESSER OF REASONABLE COST	OR CUSTOMARY CHARGE		2.00	J. 00	$\vdash$
Reasonable Cost of Part						
	vices (see instructions)			0 0	l	
Total charges				0 0	0	2
Customary Charges  Amount actually collect	ed from patients liable for pa	vment for services		0 0	0	3
on a charge basis (from		J				
	been realized from patients li			0 0	0	4
for services on a charg with 42 CFR §413.13(b)	ge basis had such payment been	made in accordance				
	e 4 (not to exceed 1.000000)		0. 0000	0. 000000	0. 000000	
0 Total customary charges				0 0	0	1
	ry charges over total reasonab	le cost (complete		0 0	0	7
only if line 6 exceeds Excess of reasonable co	line 1) ost over customary charges (com	nloto only if lino		0 0	0	8
1 exceeds line 6)	st over customary charges (com	iprete only it fille		o o		
O Primary payer amounts				0 0		9
				Part A	Part B	
				Servi ces 1.00	Servi ces 2.00	
PART II - COMPUTATION O	F HHA REIMBURSEMENT SETTLEMENT					
00 Total reasonable cost (	,			0		
1	: - Full Episodes without Outli : - Full Episodes with Outliers			0	1, 910, 207 52, 864	
00 Total PPS Reimbursement	•			0	33, 448	
00 Total PPS Reimbursement	•			0	8, 615	
	oursement - Full Episodes with	Outliers		0	20, 152	
1	oursement - PEP Episodes			0	3, 284	
00  Total Other Payments				0	0	1
00 DMF Payments					Ö	
1				0		
00 Oxygen Payments 00 Prosthetic and Orthotic				0	ő	
00 Oxygen Payments 00 Prosthetic and Orthotic 00 Part B deductibles bill	ed to Medicare patients (exclu	de coi nsurance)		0	0	2
00 Oxygen Payments 00 Prosthetic and Orthotic 00 Part B deductibles bill 00 Subtotal (sum of lines	ed to Medicare patients (exclu 10 thru 20 minus line 21)	de coi nsurance)		0	0 0 2, 028, 570	21 22
00 Oxygen Payments 00 Prosthetic and Orthotic 00 Part B deductibles bill 00 Subtotal (sum of lines 00 Excess reasonable cost	ed to Medicare patients (exclu 10 thru 20 minus line 21) (from line 8)	de coi nsurance)		0 0 0	0 0 2, 028, 570 0	21 22 23
00 Oxygen Payments 00 Prosthetic and Orthotic 00 Part B deductibles bill 00 Subtotal (sum of lines 00 Excess reasonable cost 00 Subtotal (line 22 minus	ed to Medicare patients (exclu 10 thru 20 minus line 21) (from line 8)	,		0	0 0 2, 028, 570	21 22 23 24
Oxygen Payments Prosthetic and Orthotic Part B deductibles bill Subtotal (sum of lines Excess reasonable cost Subtotal (line 22 minus Coinsurance billed to p Net cost (line 24 minus	ed to Medicare patients (exclu 10 thru 20 minus line 21) (from line 8) s line 23) program patients (from your rec s line 25)	,		0	0 0 2, 028, 570 0 2, 028, 570 0	21 22 23 24 25 26
Oxygen Payments Prosthetic and Orthotic Part B deductibles bill Subtotal (sum of lines Excess reasonable cost Subtotal (line 22 minus Coinsurance billed to p Net cost (line 24 minus Reimbursable bad debts	ed to Medicare patients (exclu 10 thru 20 minus line 21) (from line 8) s line 23) program patients (from your red s line 25) (from your records)	ords)		0	0 0 2, 028, 570 0 2, 028, 570 0	21 22 23 24 25 26 27
Oxygen Payments Prosthetic and Orthotic Part B deductibles bill Subtotal (sum of lines Excess reasonable cost Subtotal (line 22 minus Coinsurance billed to p Net cost (line 24 minus Reimbursable bad debts Reimbursable bad debts	ed to Medicare patients (exclu 10 thru 20 minus line 21) (from line 8) s line 23) program patients (from your rec s line 25) (from your records) for dual eligible beneficiarie	ords) s (see instructions)	ı	0	0 0 2, 028, 570 0 2, 028, 570 0 2, 028, 570	21 22 23 24 25 26 27 28
Oxygen Payments Prosthetic and Orthotic Part B deductibles bill Subtotal (sum of lines Excess reasonable cost Subtotal (line 22 minus Coinsurance billed to p Net cost (line 24 minus Reimbursable bad debts Reimbursable bad debts Total costs - current co	ed to Medicare patients (exclu 10 thru 20 minus line 21) (from line 8) s line 23) program patients (from your red s line 25) (from your records)	ords) s (see instructions)	ı	0	0 0 2, 028, 570 0 2, 028, 570 0 2, 028, 570	21 22 23 24 25 26 27 28
Oxygen Payments Prosthetic and Orthotic Part B deductibles bill Subtotal (sum of lines Excess reasonable cost Subtotal (line 22 minus Coinsurance billed to p Net cost (line 24 minus Reimbursable bad debts Reimbursable bad debts Total costs - current co OTHER ADJUSTMENTS (SEE	ed to Medicare patients (exclu- 10 thru 20 minus line 21) (from line 8) s line 23) orogram patients (from your red s line 25) (from your records) for dual eligible beneficiaries cost reporting period (line 26	ords) s (see instructions) plus line 27)		0 0	0 0 2, 028, 570 0 2, 028, 570 0 2, 028, 570	21 22 23 24 25 26 27 28 29 30
Oxygen Payments Prosthetic and Orthotic Part B deductibles bill Subtotal (sum of lines Excess reasonable cost Subtotal (line 22 minus Coinsurance billed to p Net cost (line 24 minus Reimbursable bad debts Reimbursable bad debts Total costs - current co OTHER ADJUSTMENTS (SEE Pioneer ACO demonstrati Subtotal (see instructi	ed to Medicare patients (exclu- 10 thru 20 minus line 21) (from line 8) s line 23) program patients (from your red s line 25) (from your records) for dual eligible beneficiarie cost reporting period (line 26 INSTRUCTIONS) (SPECIFY) on payment adjustment (see insons)	ords) s (see instructions) plus line 27)		0 0 0 0 0 0	2, 028, 570 0 2, 028, 570 0 2, 028, 570 0 2, 028, 570 2, 028, 570 0 0 2, 028, 570	21 22 23 24 25 26 27 28 29 30 30
Oxygen Payments Prosthetic and Orthotic Part B deductibles bill Subtotal (sum of lines Excess reasonable cost Subtotal (line 22 minus Coinsurance billed to p Net cost (line 24 minus Reimbursable bad debts Reimbursable bad debts Total costs - current c OTHER ADJUSTMENTS (SEE Pioneer ACO demonstrati Subtotal (see instructi Sequestration adjustmen	ed to Medicare patients (exclu- 10 thru 20 minus line 21) (from line 8) sline 23) program patients (from your recolling 25) (from your records) for dual eligible beneficiaries cost reporting period (line 26 INSTRUCTIONS) (SPECIFY) on payment adjustment (see insons) at (see instructions)	ords) s (see instructions) plus line 27)		0 0 0 0 0 0	2, 028, 570 0 2, 028, 570 0 2, 028, 570 2, 028, 570 2, 028, 570 0 0 2, 028, 570 40, 553	21 22 23 24 25 26 27 28 29 30 30 31
Oxygen Payments Prosthetic and Orthotic Part B deductibles bill Subtotal (sum of lines Excess reasonable cost Subtotal (line 22 minus Coinsurance billed to p Net cost (line 24 minus Reimbursable bad debts Reimbursable bad debts Total costs - current c OTHER ADJUSTMENTS (SEE Pioneer ACO demonstrati Subtotal (see instructi Sequestration adjustmen Interim payments (see i	ed to Medicare patients (exclu- 10 thru 20 minus line 21) (from line 8) s line 23) program patients (from your recolline 25) (from your records) for dual eligible beneficiaries cost reporting period (line 26 INSTRUCTIONS) (SPECIFY) on payment adjustment (see insons) it (see instructions) nstructions)	ords) s (see instructions) plus line 27)		0 0 0 0 0 0 0	2, 028, 570 2, 028, 570 0 2, 028, 570 2, 028, 570 2, 028, 570 0 2, 028, 570 40, 553 1, 987, 107	21 22 23 24 25 26 27 28 29 30 31 31 32
Oxygen Payments Prosthetic and Orthotic Part B deductibles bill Subtotal (sum of lines Excess reasonable cost Subtotal (line 22 minus Coinsurance billed to p Net cost (line 24 minus Reimbursable bad debts Reimbursable bad debts OTotal costs - current c OTHER ADJUSTMENTS (SEE Pioneer ACO demonstrati Subtotal (see instructi Sequestration adjustmen Interim payments (see i Tentative settlement (f	ed to Medicare patients (exclu- 10 thru 20 minus line 21) (from line 8) s line 23) program patients (from your recolline 25) (from your records) for dual eligible beneficiaries cost reporting period (line 26 INSTRUCTIONS) (SPECIFY) on payment adjustment (see insons) it (see instructions) nstructions)	ords) s (see instructions) plus line 27) tructions)		0 0 0 0 0 0	2, 028, 570 0 2, 028, 570 0 2, 028, 570 2, 028, 570 2, 028, 570 0 0 2, 028, 570 40, 553	21 22 23 24 25 26 27 28 29 30 31 31 32 33

150051 | Peri od: From 01/01/2015 | Date/Time Prepared: 5/27/2016 1:53 pm PROGRAM BENEFICIARIES HHA CCN:

				Home Health Agency I	PPS	<u>5 piii                                 </u>
		Inpatie	nt Part A		rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider			0	1, 987, 107	1. 00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3. 01				0	0	3. 01
3. 02				0	0	3. 02
3. 03				0	0	3.03
3. 04 3. 05				0	0	3. 04 3. 05
3. 03	Provider to Program					3. 03
3.50				0	0	3.50
3. 51				0	0	3. 51
3. 52 3. 53				0	0	3. 52 3. 53
3. 54				0		3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)					
4. 00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate,			0	1, 987, 107	4. 00
	line 32)					
	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				0	0	5. 01
5. 02				0	0	5. 02
5. 03	Provider to Program			0	0	5. 03
5. 50	11 ovi dei 10 11 ogi alli			0	0	5. 50
5. 51				0	0	5. 51
5. 52				0	0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6. 00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER			0	910	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	0 1, 988, 017	6. 02 7. 00
7. 00	Total Medicare program liability (see instructions)			Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
0.00	Name of Contractor		0	1.00	2. 00	0.00
8. 00	Name of Contractor			1	1 1	8. 00

Health Financial Systems	IU HEALTH BLOOMINGTO	N HOSPI TAL	In Lieu of Form CMS-2552-10
CALCULATION OF DELIABURGARIE DAD DERTO	TITLE WILL DART D	D	Western L. E.

Part I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B	Heal th	Financial Systems IU HEALTH BLOOMINGTON	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B	CALCUL	ATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B			Worksheet I-5	
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B   1.00   2.00   1.00   2.00   1.00   2.00   1.00   2.00						
PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B			-	Γο 12/31/2015		
NATE   CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B   Total expenses related to care of program beneficiaries (see instructions)					5/27/2016 1:5	3 pm
NATE   CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B   Total expenses related to care of program beneficiaries (see instructions)				1 00	2.00	
1.00   Total expenses related to care of program beneficiaries (see instructions)		DADT I CALCULATION OF DELMBUDSABLE BAD DERTS TITLE VVIII D	ADT D	1.00	2.00	
2.00	1 00					1 00
2.01   Total payment due (from Wkst. 1-4, col. 6.01, line 11) (see instructions)   2.02   Total payment due (from Wkst. 1-4, col. 6.02, line 11) (see instructions)   2.02   2.03   Total payment due (see instructions)   0   0   2.03   2.04   Outlier payments   0   0   2.04   Outlier payments   0   0   3.00   Oeductible billed to Medicare (Part B) patients (see instructions)   0   0   3.00   Oeductible billed to Medicare (Part B) patients (see instructions)   3.01   Oeductibles billed to Medicare (Part B) patients (see instructions)   3.02   Oeductibles billed to Medicare (Part B) patients (see instructions)   0   0.303   Oeductibles billed to Medicare (Part B) patients (see instructions)   0   0.303   Oeductibles billed to Medicare (Part B) patients (see instructions)   0   0.303   Oedications   Oedicate (Part B) patients (see instructions)   0   0.00   Oedicate (Part B) Patients (See Instructions)   0   Oedicate (Part B) Patients (See Instructions)   0   Oedicate (Part B) Patients (See Instructions)   0   Oedicate (Part B) Patients (See Instructions)   Oedicate (Part B) Patients (See				0	0	
2. 02   Total payment due (From Wkst. 1-4, col. 6.02, line 11) (see instructions)   2. 02   2   2   2   2   2   2   2   2   2					U	
Total payment due (see instructions)  2.04  Outlier payments  0.02.03  2.04  Outlier payments  0.03.00  Deductibles billed to Medicare (Part B) patients (see instructions)  0.03.01  Deductibles billed to Medicare (Part B) patients (see instructions)  Deductibles billed to Medicare (Part B) patients (see instructions)  3.02  3.03  Total deductibles billed to Medicare (Part B) patients (see instructions)  0.03.03  4.00  Coinsurance billed to Medicare (Part B) patients (see instructions)  0.04.00  Coinsurance billed to Medicare (Part B) patients  Coinsurance billed to Medicare (Part B) patients  Coinsurance billed to Medicare (Part B) patients (see instructions)  4.01  Coinsurance billed to Medicare (Part B) patients (see instructions)  4.02  Coinsurance billed to Medicare (Part B) patients (see instructions)  4.03  Total coinsurance billed to Medicare (Part B) patients (see instructions)  5.00  Bad debts for deductibles and coinsurance, net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2013  Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013  Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014  5.03  Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014  5.05  Total bad debts (see instructions)  0.05  0.06  0.07  0.07  0.08  Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)  0.09  0.00						
2.04 Outlier payments 3.00 Deductibles billed to Medicare (Part B) patients (see instructions) 3.01 Deductibles billed to Medicare (Part B) patients (see instructions) 3.02 Deductibles billed to Medicare (Part B) patients (see instructions) 3.03 Total deductibles billed to Medicare (Part B) patients (see instructions) 4.00 Coinsurance billed to Medicare (Part B) patients 5.01 Coinsurance billed to Medicare (Part B) patients 6.02 A.03 Total deductibles developed by a patients (see instructions) 7.04 Coinsurance billed to Medicare (Part B) patients (see instructions) 8.05 Total coinsurance billed to Medicare (Part B) patients (see instructions) 8.06 Deductibles and coinsurance (Part B) patients (see instructions) 8.07 Total coinsurance billed to Medicare (Part B) patients (see instructions) 8.08 Deductibles and coinsurance net of bad debt recoveries 8.00 Deductibles and coinsurance net of bad debt recoveries on the secoveries on the sec			uctions)	0	0	
3.00 Deductible's billed to Medicare (Part B) patients (see instructions) 3.01 Deductibles billed to Medicare (Part B) patients (see instructions) 3.02 Deductibles billed to Medicare (Part B) patients (see instructions) 3.01 Total deductibles billed to Medicare (Part B) patients (see instructions) 4.00 Coinsurance billed to Medicare (Part B) patients 4.01 Coinsurance billed to Medicare (Part B) patients (see instructions) 4.02 Coinsurance billed to Medicare (Part B) patients (see instructions) 4.03 Total coinsurance billed to Medicare (Part B) patients (see instructions) 4.04 Total coinsurance billed to Medicare (Part B) patients (see instructions) 4.05 Total coinsurance billed to Medicare (Part B) patients (see instructions) 5.00 Bad debts for deductibles and coinsurance, net of bad debt recoveries 5.01 Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012 5.02 Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014 5.03 Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014 5.04 100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014 5.05 Total bad debts (sum of line 5 through line 5.04) 6.00 Allowable bad debts for deal eligible beneficiaries (see instructions) 7.00 Reimbursable bad debts for deal eligible beneficiaries (see instructions) 9.00 Program payment (see instructions) 10.00 Unrecovered from Medicare (Part B) patients (see instructions) 11.00 Part III - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE				0	O	
3.01 Deductibles billed to Medicare (Part B) patients (see instructions) 3.02 Deductibles billed to Medicare (Part B) patients (see instructions) 3.02 Total deductibles billed to Medicare (Part B) patients (see instructions) 4.00 Coinsurance billed to Medicare (Part B) patients (see instructions) 6.01 Coinsurance billed to Medicare (Part B) patients (see instructions) 7.02 Coinsurance billed to Medicare (Part B) patients (see instructions) 7.03 Total coinsurance billed to Medicare (Part B) patients (see instructions) 7.04 Coinsurance billed to Medicare (Part B) patients (see instructions) 7.05 Deductibles and coinsurance (Part B) patients (see instructions) 7.06 Bad debts for deductibles and coinsurance, net of bad debt recoveries 8.00 Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012 8.02 Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013 8.03 Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014 8.04 100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014 8.05 Total bad debts (sum of line 5 through line 5.04) 8.06 Allowable bad debts (see instructions) 9.07 Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions) 9.08 Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions) 9.00 Program payment (see instructions) (transfer to Worksheet E, Part B, line 33) 9.00 Unrecovered from Medicare (Part B) patients (see instructions) 11.00 Part II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			one)	0	0	
3.02 Deductibles billed to Medicare (Part B) patients (see instructions) 3.03 Total deductibles billed to Medicare (Part B) patients (see instructions) 4.00 Coinsurance billed to Medicare (Part B) patients 4.01 Coinsurance billed to Medicare (Part B) patients (see instructions) 4.02 Coinsurance billed to Medicare (Part B) patients (see instructions) 4.03 Total coinsurance billed to Medicare (Part B) patients (see instructions) 5.00 Bad debts for deductibles and coinsurance, net of bad debt recoveries 5.01 Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2011 but before 1/1/2012 5.02 Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013 5.03 Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2012 but before 1/1/2013 5.03 Transition period 3 (52-57%) bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2013 but before 1/1/2014 5.04 100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014 5.05 Total bad debts (sum of line 5 through line 5.04) 6.00 Allowable bad debts (see instructions) 7.00 Reimbursable bad debts for dual eligible beneficiaries (see instructions) 8.00 Net deductibles and coinsurance billed to Medicare (Part B) patients (see 10.00 Instructions) 9.00 Program payment (see instructions) (10.00 Unrecovered from Medicare (Part B) patients (see instructions) 10.00 Unrecovered from Medicare (Part B) patients (see instructions) 11.00 Part II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE		·	,		U	
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recoveries for services rendered on or after 1/1/2013 but before 1/1/2014  5.04 100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for services rendered on or after 1/1/2014  5.05 Total bad debts (sum of line 5 through line 5.04)  6.00 Allowable bad debts (see instructions)  7.00 Reimbursable bad debts for dual eligible beneficiaries (see instructions)  8.00 Net deductibles and coinsurance billed to Medicare (Part B) patients (see instructions)  9.00 Program payment (see instructions)  9.00 Unrecovered from Medicare (Part B) patients (see instructions)  10.00 Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)  0 PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE	5 03				0	5.03
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services rendered on or after 1/1/2014  5.05 Total bad debts (sum of line 5 through line 5.04)  6.00 Allowable bad debts (see instructions)  7.00 Reimbursable bad debts for dual eligible beneficiaries (see instructions)  8.00 Net deductibles and coinsurance billed to Medicare (Part B) patients (see  9.00 Program payment (see instructions)  9.00 Unrecovered from Medicare (Part B) patients (see instructions)  10.00 Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)  11.00  PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE	5 04			0	0	5.04
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PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			E. Part B. Line 33)	0		
	20			<u> </u>		1
	12.00			0		12.00
13.00 Total composite costs (from Wkst. I-4, col. 2, line 11) 0 13.00		, , , , , , , , , , , , , , , , , , , ,		o		13.00
14.00 Facility specific composite cost percentage (line 13 divided by line 12) 0.000000 14.00			line 12)	0.000000		14.00

Health Financial Systems I	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
ANALYSIS OF PROVIDER-BASED HOSPICE COSTS		Provi der		Peri od:	Worksheet K	
				From 01/01/2015		
		Hospi ce	CCN: 151509	To 12/31/2015		
					5/27/2016 1:5	3 pm
				Hospi ce I		
	Sal ari es	Employee	Transportati	o Contracted	0ther	
	(from Wkst.	Benefits	n (see inst.	) Services		
	K-1)	(from Wkst.		(from Wkst.		
		V 2)		V 2)		

						5/2//2016 1:5	3 piii
					Hospi ce I		
		Sal ari es	Empl oyee	Transportatio		0ther	
		(from Wkst.	Benefits	n (see inst.)	Servi ces		
		K-1)	(from Wkst.		(from Wkst.		
			K-2)		K-3)		
		1. 00	2. 00	3. 00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.			0		0	1.00
2.00	Capital Related Costs-Movable Equip.			0		0	2.00
3.00	Plant Operation and Maintenance	0	C	0	0	0	3.00
4.00	Transportation - Staff	0	C	0	0	0	4.00
5.00	Volunteer Service Coordination	0	C	0	0	0	5.00
6.00	Administrative and General	105, 115	C	89, 835	227, 187	2, 114, 107	6.00
	INPATIENT CARE SERVICE						1
7.00	Inpatient - General Care	929, 974	C	0	0	0	7.00
8.00	Inpatient - Respite Care	164, 785	C	0	0	0	8.00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	0	C	) 0	0	0	9.00
10.00	Nursing Care	949, 170	C	ol o	0	0	10.00
11. 00	Nursing Care-Continuous Home Care	0	Č		-	0	11.00
12. 00	Physical Therapy	3, 727	Č		0	Ö	12.00
13. 00	Occupational Therapy	3, 727	0		0	0	13.00
14. 00	Speech/ Language Pathology	0			0	0	14.00
15. 00	Medical Social Services	286, 957			0	0	15.00
16. 00	Spiritual Counseling	75, 319			_	0	16.00
17. 00	, .	182, 656				0	17.00
	Di etary Counseling	102,000			_		
18.00	Counseling - Other	2/ 210	C	٦ - "		0	18.00
19. 00	Home Health Aide and Homemaker	26, 219	C	٦ -	_	0	19.00
20.00	HH Ai de & Homemaker - Cont. Home Care	0	C		-	0	20.00
21.00	Other	0	C	) 0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS	1					
	Drugs, Biological and Infusion Therapy	0	C			0	22. 00
23. 00	Anal gesi cs	0	C	1	_	0	23. 00
24.00	Sedatives / Hypnotics	0	C	0	-	0	24.00
25. 00	Other - Specify	0	C	0	_	0	25. 00
26. 00	Durable Medical Equipment/Oxygen	0	C	0	_	0	26. 00
27. 00	Patient Transportation	0	C	0	0	0	27. 00
28. 00	I maging Services	0	C	) 0	0	0	28. 00
29. 00	Labs and Diagnostics	0	C	0	0	0	29. 00
30.00	Medical Supplies	0	C	0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	C	0	0	0	31.00
32.00	Radiation Therapy	0	C	0	0	0	32.00
33.00	Chemotherapy	0	C	0	0	0	33.00
34.00	Other	0	C	0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	C	0	0	0	35.00
36.00	Volunteer Program Costs	0	C	0	0	0	36.00
37.00	Fundrai si ng	0	C	0	0	0	37.00
38. 00	Other Program Costs	0	C	ol o	0	0	38. 00
	Total (sum of lines 1 thru 38)	2, 723, 922	C	89, 835	227, 187	2, 114, 107	

Heal th	Financial Systems II	I HEALTH BLOOMI	NGTON HOSPITAL		In lie	eu of Form CMS-:	2552-10
	SIS OF PROVIDER-BASED HOSPICE COSTS	J. I.E.I.E.III. BEGGIIII		CCN: 150051	Peri od:	Worksheet K	2002 .0
			Hospi ce (	CCN: 151509	From 01/01/2015 To 12/31/2015		epared:
					Hospi ce I	072772010 1.0	о ріп
		Total (cols. 1-5)	Recl assi fi cat i on	Subtotal (col. 6 ± col. 7)	Adj ustments	Total (col. 8 ± col. 9)	
		6. 00	7. 00	8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0	0		0 0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0	0		0	0	2.00
3.00	Plant Operation and Maintenance	0	0		0	0	
4.00	Transportation - Staff	0	0		0	0	1
5.00	Volunteer Service Coordination	0	0		0	_	
6. 00	Administrative and General	2, 536, 244	-1, 179, 570	1, 356, 67	<sup>'</sup> 4 0	1, 356, 674	6.00
	INPATIENT CARE SERVICE		1				
7. 00	Inpatient - General Care	929, 974		921, 25			
8. 00	Inpati ent - Respi te Care	164, 785	-1, 546	163, 23	39 0	163, 239	8.00
9. 00	VISITING SERVICES Physician Services		0		0 0	0	0.00
10.00	Nursing Care	949, 170	_	940, 26			
11. 00	Nursing Care-Continuous Home Care	949, 170	-0, 904		0 0		1
12. 00	Physical Therapy	3, 727	-35	3, 69	-	_	
13. 00	Occupational Therapy	3, 727	-33		0 0	· ·	1
14. 00	Speech/ Language Pathology						14.00
15. 00	Medical Social Services	286, 957	-2, 692	284, 26	5 0	284, 265	
16. 00	Spiritual Counseling	75, 319	, , , , ,	74, 61		74, 612	
17. 00	Di etary Counsel i ng	182, 656		180, 94		180, 943	
18. 00	Counseling - Other	0	0		0		1
19. 00	Home Health Aide and Homemaker	26, 219	-246	25, 97	'3	25, 973	
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0		1
21.00	Other	0	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy	0	1		0	_	1
23.00	Anal gesi cs	0	0		0	_	
24.00	Sedatives / Hypnotics	0	0		0	0	1 = 00
25. 00	Other - Specify	0	0		0	_	
26. 00	Durable Medical Equipment/Oxygen	0	0		0	_	1 20.00
27. 00	Pati ent Transportati on	0	0		0	_	
28. 00	I maging Services	0	0		0	0	1 20.00
29. 00	Labs and Diagnostics	0	0		0	0	
30.00	Medi cal Supplies	0	0		0	0	00.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	
32.00	Radi ati on Therapy		0		0	0	02.00
33.00	Chemotherapy		0		0 0	0	
34. 00	Other		0		<u>U</u>	0	34.00

5, 155, 051

0

-1, 204, 137

0 0 0

0

3, 950, 914

0 35.00

0

0 3, 950, 914 39.00

> 36.00 37. 00 38. 00

36.00 | Volunteer Program Costs

HOSPICE NONREIMBURSABLE SERVICE

Bereavement Program Costs

38.00 Other Program Costs 39.00 Total (sum of lines 1 thru 38)

35.00

37.00 Fundraising

Health Financial Systems	IU HEALTH BLOOMINGTON	N HOSPITAL		In Lieu	ı of Form CMS-2552-10
HOSPICE COMPENSATION ANALYSIS SALARIES AND WAGE	S	Provi der CCN	: 150051	Peri od: From 01/01/2015	Worksheet K-1

Provider CCN: 150051 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/2015 | Period: From 01/01/20

			nospi ce c	JON. 131309	10 12/31/2013	5/27/2016 1:5	
					Hospi ce I		
		Admi ni strator	Di rector	Soci al Servi ces	Supervi sors	Nurses	
		1. 00	2. 00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance	0	0		0 0	0	3.00
4.00	Transportation - Staff	0	0		0 0	0	4.00
5.00	Volunteer Service Coordination	0	0		0 0	0	5.00
6.00	Administrative and General	0	5, 007		0 0	0	6.00
	INPATIENT CARE SERVICE						
7.00	Inpatient - General Care	0	0		0	929, 974	7. 00
8.00	Inpatient - Respite Care	0	0		0	164, 785	8. 00
	VISITING SERVICES						
9.00	Physi ci an Servi ces	0	0		0	0	9. 00
10. 00	Nursi ng Care	0	0		0 64, 322	884, 848	10.00
11. 00	Nursing Care-Continuous Home Care	0	0		0	0	11. 00
12.00	Physi cal Therapy	0	0		0	0	12.00
13.00	Occupational Therapy	0	0		0	0	13.00
14. 00	Speech/ Language Pathology	0	0		0	0	14.00
15. 00	Medical Social Services	0	0		0	0	15. 00
16. 00	Spiritual Counseling	0	75, 319		0	0	16. 00
17. 00	Di etary Counsel i ng	0	0		0 0	0	17. 00
18. 00	Counseling - Other	0	0		0	0	18. 00
19. 00	Home Health Aide and Homemaker	0	0		0 0	0	19. 00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	20.00
21. 00	Other	0	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
							22.00
23. 00	Anal gesi cs						23. 00
24. 00	1						24.00
25. 00	Other - Specify						25.00
26.00	Durable Medical Equipment/Oxygen						26.00
27. 00	Pati ent Transportation	0	0		0	0	27.00
28. 00	I maging Services	0	0		0	0	28.00
29. 00	Labs and Diagnostics	0	0		0	0	29.00
30.00	Medical Supplies	0	0		0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0	•	0	0	31.00
32.00	Radiation Therapy	0	0		0	0	32.00
33.00	Chemotherapy	0	0		0	0	33.00
34. 00	Other HOSPICE NONREIMBURSABLE SERVICE	<u> </u>	0		0 0	0	34.00
25 00		0	0	I	0 0	0	35. 00
36.00	Bereavement Program Costs Volunteer Program Costs		0		0 0	0	36.00
36.00	Fundrai si ng		0		0 0	0	37.00
38.00	Other Program Costs		0		0 0	0	38.00
	Total (sum of lines 1 thru 38)		80, 326		0 64, 322	_	
37.00	Trotal (Sam of Filles 1 till a 50)	١	00, 320	I	04, 322	1, 7/7, 00/	1 37.00

Heal th	Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
HOSPI C	E COMPENSATION ANALYSIS SALARIES AND WAGES	S	Provi der	CCN: 150051	Peri od:	Worksheet K-1	
			Hospi ce (	CCN: 151509	From 01/01/2015 To 12/31/2015		
					Hospi ce I		
		Total Therapi sts	Ai des	All-Other	Total (1)		
		6. 00	7. 00	8. 00	9. 00		
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.						1.00
2.00	Capital Related Costs-Movable Equip.						2.00
3.00	Plant Operation and Maintenance		0		0		3.00
4.00	Transportation - Staff		0		0		4.00

		lotal	Ai des	All-Other	Total (1)	
		Therapists 6.00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	6.00	9.00	
1. 00	Capital Related Costs-Bldg and Fixt.					1.00
2. 00	Capital Related Costs-Brug and Trxt.					2.00
3. 00	Plant Operation and Maintenance		0	0		3.00
	·		0	0	0	
4.00	Transportation - Staff		0	0	0	4.00
5.00	Volunteer Service Coordination		0	100 100	105 115	5.00
6. 00	Administrative and General		0	100, 108	105, 115	6.00
7 00	I NPATI ENT CARE SERVI CE	1	ما	0	000 074	7.00
7.00	Inpatient - General Care		0	0	929, 974	7.00
8. 00	Inpatient - Respite Care		0	0	164, 785	8.00
0.00	VI SI TI NG SERVI CES	T	ما			0.00
9. 00	Physi ci an Servi ces		0	0	0	9.00
10.00	Nursing Care		0	0	949, 170	
11. 00	3		0	0	0	11.00
12. 00		3, 727	0	0	3, 727	12.00
	Occupational Therapy	0	0	0	0	13.00
14. 00		0	0	0	0	14. 00
	Medical Social Services		0	286, 957	286, 957	15. 00
	Spiritual Counseling		0	0	75, 319	
	Dietary Counseling		0	182, 656	182, 656	17.00
	Counseling - Other		0	0	0	18.00
19. 00			26, 219	0	26, 219	19.00
	HH Aide & Homemaker - Cont. Home Care		0	0	0	20.00
21. 00			0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS					
22. 00	Drugs, Biological and Infusion Therapy					22.00
23. 00						23.00
24.00	Sedatives / Hypnotics					24.00
25. 00	Other - Specify					25. 00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0	0	0	27. 00
28.00	I maging Services		0	0	0	28.00
29. 00	Labs and Diagnostics		0	0	0	29.00
30.00	Medi cal Supplies		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)		0	0	0	31.00
32.00	Radi ati on Therapy		0	0	0	32.00
33.00	Chemotherapy		o	0	o	33.00
34.00	Other		o	0	o	34.00
	HOSPICE NONREIMBURSABLE SERVICE					
35.00	Bereavement Program Costs		0	0	0	35. 00
36.00	Volunteer Program Costs		0	0	ol	36.00
37.00	g .		o	0	ol	37.00
38. 00			o	0	ol	38.00
	Total (sum of lines 1 thru 38)	3, 727	26, 219	569, 721	2, 723, 922	
						'

HOSPI C	E COMPENSATION ANALYSIS CONTRACTED SERVICES/F	PURCHASED SERVI	CES	Provi der	CCN: 150051		ri od:	Worksheet K	(-3	
					20N 1F1F00		om 01/01/2015	D-+- /T: F	·	
				Hospi ce (	CCN: 151509	То	12/31/2015	Date/Time F 5/27/2016 1	rrej	oarea:
							Hospi ce I	3/2//2010 1	ı. J.	J PIII
		Admi ni strator	Di	rector	Soci al		Supervi sors	Nurses		
		Admi III Str ator		100101	Servi ces		Super VI sor s	1101 303		
		1. 00		2. 00	3.00		4. 00	5. 00		
	GENERAL SERVICE COST CENTERS				•					
1.00	Capital Related Costs-Bldg and Fixt.									1.00
2.00	Capital Related Costs-Movable Equip.								l	2.00
3.00	Plant Operation and Maintenance	0		0		0	o		0	3.00
4.00	Transportation - Staff	0		0		0	o		0	4.00
5.00	Volunteer Service Coordination	0		0		0	o		0	5.00
6.00	Administrative and General	0		0		0	o		0	6.00
	INPATIENT CARE SERVICE						•			
7.00	Inpatient - General Care	0		0		0	0		0	7.00
8.00	Inpatient - Respite Care	0		0		0	o		0	8.00
	VISITING SERVICES					•				
9.00	Physi ci an Servi ces	0		0		0	0		0	9.00
10.00	Nursi ng Care	0		0		0	0		0	10.00
11.00	Nursing Care-Continuous Home Care	0		0		0	o		0	11.00
12.00	Physi cal Therapy	0		0		0	o		0	12.00
13.00	Occupational Therapy	0		0		0	o		0	13.00
14.00	Speech/ Language Pathology	0		0		0	0		0	14.00
15.00	Medical Social Services	0		0		0	o		0	15.00
16.00	Spiritual Counseling	0		0		0	o		0	16.00
17.00	Di etary Counsel i ng	0		0		0	0		0	17.00
18.00	Counseling - Other	0		0		0	0		0	18.00
19.00	Home Health Aide and Homemaker	0		0		0	0		0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0		0		0	0		0	20.00
21.00	Other	0		0		0	0		0	21.00
	OTHER HOSPICE SERVICE COSTS									
22.00	Drugs, Biological and Infusion Therapy									22.00
23.00	Anal gesi cs									23.00
24.00	Sedatives / Hypnotics									24.00
25.00	Other - Specify									25.00
26.00	Durable Medical Equipment/Oxygen									26.00
27.00	Pati ent Transportation	0		0		0	0		0	27.00
28. 00	I maging Services	0		0		0	0		0	28.00
29. 00	Labs and Diagnostics	0		0		0	0		0	29.00
30.00	Medical Supplies	0		0		0	0		0	30.00
31.00	Outpatient Services (including E/R Dept.)	0		0		0	0		0	31.00
32.00	Radiation Therapy	0		0		0	0		0	32.00
33.00	Chemotherapy	0		0		0	0		0	33.00
34.00	Other	0		0		0	0		0	34.00
	HOSPICE NONREIMBURSABLE SERVICE									
35. 00	Bereavement Program Costs	0		0		0	0		0	35.00
36. 00	Volunteer Program Costs	0		0		0	0		0	36.00
37. 00	Fundrai si ng	0		0		0	0		0	37.00
38. 00	Other Program Costs	0		0		0	0		0	38. 00
39. 00	Total (sum of lines 1 thru 38)	0		0		0	0		0	39. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10
HOCDLOE COMPENSATION ANALYSIS CONT	FRACTER CERVILOEC (RUROUMCER CERVILOEC   D	A Device West device Co

	E COMPENSATION ANALYSIS CONTRACTED SERVICES/	PURCHASED SERVICE		CCN: 150051	Peri od: From 01/01/2015 To 12/31/2015	
		Total	Ai des	All-Other	Total (1)	
		Therapi sts	711 400	7.1.7 0 21.10.1	10141 (1)	
		6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS					
1. 00 2. 00 3. 00 4. 00	Capital Related Costs-Bldg and Fixt. Capital Related Costs-Movable Equip. Plant Operation and Maintenance Transportation - Staff		C		0 0 0	1. 00 2. 00 3. 00 4. 00
5.00	Volunteer Service Coordination		C		0	5.00
6. 00	Administrative and General		C	227, 18	37 227, 187	6. 00
7 00	I NPATI ENT CARE SERVI CE	1				7.00
7.00	Inpatient - General Care		C	1	0 0	
8. 00	Inpatient - Respite Care		C	)	0 0	8.00
9. 00	VISITING SERVICES Physician Services		C	\	0 0	9.00
10. 00	Nursi ng Care		C	•		
11. 00	Nursing Care-Continuous Home Care		0		0 0	11.00
	Physical Therapy	0	C	1	0 0	i i
13. 00	Occupational Therapy		C	•	0 0	13.00
	Speech/ Language Pathology	0	C	1	0 0	14.00
	Medical Social Services		C		0 0	15.00
	Spiritual Counseling		C		0 0	16.00
	Di etary Counsel i ng		C		0 0	
	Counseling - Other		C		0 0	18.00
	Home Health Aide and Homemaker		C		0 0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		C		0 0	20.00
21.00	Other		C		0 0	21.00
	OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy					22. 00
	Anal gesi cs					23.00
	Sedatives / Hypnotics					24.00
	Other - Specify					25. 00
	Durable Medical Equipment/Oxygen		_			26.00
	Patient Transportation		C	)	0 0	
	I maging Services		C	)	0	28.00
	Labs and Diagnostics		C	2	0 0	29.00
	Medical Supplies		C		0 0	30.00
31.00	Outpatient Services (including E/R Dept.)		C		0 0	31. 00 32. 00
33. 00	Radiation Therapy Chemotherapy		C	1		
34. 00	Other		0		0 0	
34.00	HOSPI CE NONREI MBURSABLE SERVI CE			′1	0 0	34.00
35. 00	Bereavement Program Costs		C	)	0 0	35.00
	Volunteer Program Costs		C		0 0	36.00
	Fundrai si ng		C		0 0	37.00
	Other Program Costs		C		0 0	38.00
	Total (sum of lines 1 thru 38)	O	C	227, 18	227, 187	39.00

			nospi ce c	CN. 131304	10 12/31/2013	5/27/2016 1:5	
					Hospi ce I	0,2,,2010 110	<u> </u>
			CAPI TAL RE	LATED COST	1100 1100		
		NET EXPENSES	BUILDINGS &	MOVABLE	PLANT	TRANSPORTATIO	
		FOR COST	FIXTURES	EQUI PMENT	OPERATION &	N	
		ALLOCATION		Luoi i iii.	MAINT.		
		0	1.00	2.00	3. 00	4. 00	
	GENERAL SERVICE COST CENTERS	1					
1.00	Capital Related Costs-Bldg and Fixt.	0	0				1.00
2. 00	Capital Related Costs-Movable Equip.	0	ŭ		0		2.00
3. 00	Plant Operation and Maintenance		0		o o		3.00
4. 00	Transportation - Staff		0		0		4.00
5. 00	Volunteer Service Coordination		0		0		5.00
6. 00	Administrative and General	1, 356, 674	0		o o		6.00
0.00	I NPATI ENT CARE SERVI CE	1, 330, 074			0		0.00
7. 00	Inpatient - General Care	921, 250	0		0 0	0	7.00
8. 00	Inpatient - Respite Care	163, 239	0		o o		8.00
0.00	VISITING SERVICES	103, 237			0		0.00
9. 00	Physician Services		0		0 0	0	9.00
10.00	Nursing Care	940, 266	0		o o		10.00
11. 00	Nursing Care-Continuous Home Care	740, 200	0		0 0		11.00
12. 00	Physical Therapy	3, 692	0		0 0		12.00
13. 00	Occupational Therapy	3, 092	0		0 0		13. 00
		0	· ·		٥		
14.00	Speech/ Language Pathology	204 2/5	0		0		14.00
15.00	Medical Social Services	284, 265	0		0	1	15.00
16.00	Spiritual Counseling	74, 612	0		0	_	16.00
17.00	Di etary Counsel i ng	180, 943	0		0	1	17.00
18.00	9	0 0 0 0 7 0	0		0	0	18.00
19.00	Home Health Aide and Homemaker	25, 973	0		0	1	19.00
20.00	HH Ai de & Homemaker - Cont. Home Care	0	0		0		20.00
21. 00		0	0		0 0	0	21. 00
22.00	OTHER HOSPICE SERVICE COSTS		0			1 0	22.00
	Drugs, Biological and Infusion Therapy	0	0		0		22.00
23. 00	Anal gesi cs	0	0		0		23.00
24.00	71	0	0		0	1	24.00
25.00	Other - Specify	0	0		0	1	25. 00
26.00	Durable Medical Equipment/Oxygen	0	0		0	1	26.00
27. 00	Pati ent Transportati on	0	0		0		27. 00
28. 00	I maging Services	0	0		0	1	28. 00
29. 00	Labs and Diagnostics	0	0		0	0	29. 00
30. 00	Medical Supplies	0	0		0	1	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0		31.00
32. 00	Radiation Therapy	0	0		0		32.00
33.00	Chemotherapy	0	0		0		33.00
34.00	Other	0	0		0 0	0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE	.1			_		
	Bereavement Program Costs	0	0		0	-	35.00
36.00	Volunteer Program Costs	0	0		0		36.00
37.00	Fundraising	0	0		0	1	37.00
38. 00	3	0	0		0		38. 00
39. 00	Total (sum of lines 1 thru 38)	3, 950, 914	0		0 0	0	39. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu	of Form CMS-2552-10
COST ALLOCATION - HOSPICE GENERAL SERVICE COST	Provi der CCN: 150051	Peri od:	Worksheet K-4

Hospi ce CCN: 151509 To 12/31/2015 Part I Date/Time Prepared: 5/27/2016 1:53 pm Hospi ce I VOLUNTEER SUBTOTAL ADMI NI STRATI V TOTAL (col. SERVI CES (cols. 0 - 5)E & GENERAL  $5A \pm col.$  6) COORDI NATOR 7.00 5.00 5A 6.00 GENERAL SERVICE COST CENTERS 1.00 Capital Related Costs-Bldg and Fixt. 1.00 2 00 2.00 Capital Related Costs-Movable Equip. 3.00 Plant Operation and Maintenance 3.00 4.00 Transportation - Staff 4.00 5.00 Volunteer Service Coordination 5.00 Administrative and General 0 1, 356, 674 1, 356, 674 6.00 6.00 INPATIENT CARE SERVICE Inpatient - General Care Inpatient - Respite Care 7.00 0 921, 250 481, 773 1, 403, 023 7.00 0 163, 239 85, 367 248, 606 8.00 8.00 VISITING SERVICES 9.00 Physician Services 0 9.00 0 10.00 Nursing Care 940, 266 491, 718 1, 431, 984 10.00 11.00 Nursing Care-Continuous Home Care 11.00 0 12.00 Physical Therapy 00000000 3, 692 1,931 5, 623 12.00 13.00 Occupational Therapy 13.00 Speech/ Language Pathology Medical Social Services 14.00 14.00 0 0 284, 265 148, 658 432, 923 15.00 15.00 16.00 Spiritual Counseling 74, 612 39, 019 113, 631 16.00 180, 943 17.00 Dietary Counseling 94, 625 275, 568 17.00 Counseling - Other 18.00 18.00 C 0 19.00 Home Health Aide and Homemaker 25, 973 13, 583 39, 556 19.00 0 20.00 HH Aide & Homemaker - Cont. Home Care 0 0 20.00 21.00 0ther 21.00 0 OTHER HOSPICE SERVICE COSTS 0 22.00 Drugs, Biological and Infusion Therapy 0 0 22.00 Anal gesi cs 0 23.00 000000000000 0 23.00 Sedatives / Hypnotics 0 0 24.00 0 24.00 0 Other - Specify 0 0 25.00 25.00 26.00 Durable Medical Equipment/Oxygen 0 26.00 0 0 27.00 Patient Transportation 0 0 27.00 Imaging Services 28 00 0 0 28 00 0 29.00 Labs and Diagnostics 29.00 0 30.00 Medical Supplies 0 0 30.00 0 0 31.00 Outpatient Services (including E/R Dept.) 0 31.00 0 0 32 00 Radiation Therapy 0 32 00 0 33.00 33.00 Chemotherapy 0 34.00 34.00 HOSPICE NONREIMBURSABLE SERVICE 35.00 0 0 Bereavement Program Costs 0 0 35.00 0 0 0 0 36.00 Volunteer Program Costs 0 0 36.00 37.00 Fundrai si ng 0 0 0 37.00 0 38.00 Other Program Costs 38.00 0

3, 950, 914

3, 950, 914

39.00

39.00 Total (sum of lines 1 thru 38)

						5/27/2016 1:5	3 pm
					Hospi ce I		
		CAPITAL RE	LATED COST				
		BUI LDI NGS &	MOVABLE	PLANT	TRANSPORTATI 0	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	N (MILEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
				FT.)		(HOURS)	
		1. 00	2.00	3.00	4. 00	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0	0				2.00
3.00	Plant Operation and Maintenance	0	0		0		3.00
4. 00	Transportation - Staff	0	0		o o		4.00
5. 00	Volunteer Service Coordination	0	0	•	o o	0	5.00
6. 00	Administrative and General	0	0	•	o o		
0.00	INPATIENT CARE SERVICE				<u> </u>		0.00
7. 00	Inpatient - General Care	0	0		0 0	0	7.00
8. 00	Inpatient - Respite Care	0			o o		8.00
0.00	VISITING SERVICES	0	0		0	0	0.00
9. 00	Physician Services	0	0		0 0	0	9.00
10.00	Nursing Care		0	•	0 0		10.00
11. 00	Nursing Care-Continuous Home Care		0			_	11.00
		0	0	1	0 0	_	12.00
12.00	Physical Therapy	0	_	1	-	-	
13.00	Occupational Therapy	0	0		-	_	13.00
14.00	Speech/ Language Pathology	0	0		0	_	14.00
15.00	Medical Social Services	0	0	1	0		15.00
16.00	Spiritual Counseling	0	0		0	0	16.00
17. 00	Di etary Counsel i ng	0	0		0	_	17.00
18. 00	Counseling - Other	0	0	l .	0	0	18.00
19. 00	Home Health Aide and Homemaker	0	0	•	0	0	19.00
20. 00	HH Aide & Homemaker - Cont. Home Care	0	0		0		20.00
21. 00	Other	0	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22. 00	Drugs, Biological and Infusion Therapy	0	0		0		22. 00
	Anal gesi cs	0	0		0		23. 00
24. 00	Sedatives / Hypnotics	0	0		0	_	1
25.00	1 3	0	0		0	0	25. 00
26.00	Durable Medical Equipment/Oxygen	0	0		0		26. 00
27.00	Pati ent Transportation	0	0		0	0	27. 00
28.00	I maging Services	0	0		0 0	0	28. 00
29.00	Labs and Diagnostics	0	0		0 0	0	29. 00
30.00	Medical Supplies	0	0		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32.00	Radi ati on Therapy	0	0		o o	0	32.00
33.00	Chemotherapy	0	0		o o	0	33.00
34.00	Other	0	0		o o	0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE						1
35.00	Bereavement Program Costs	0	0		0 0	0	35.00
36.00	Volunteer Program Costs	0	0		0 0	0	36.00
37. 00	Fundrai si ng	0	ĺ	1	o o	Ō	37. 00
38. 00	Other Program Costs	0	0	1	o o	ő	38.00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)	0	0		ol o	ő	39.00
	Unit Cost Multiplier	0. 000000	0. 000000	0. 00000	0. 000000	-	
	The state of the s	,		,			

						5/27/2016 1:5	3 pm
					Hospi ce I		
		RECONCI LI ATI O					
		N	E & GENEI				
			(ACC. COS	ST)			
		6A	6. 00				
	GENERAL SERVICE COST CENTERS						
1.00	Capital Related Costs-Bldg and Fixt.	0					1.00
2.00	Capital Related Costs-Movable Equip.	0					2.00
3.00	Plant Operation and Maintenance	0					3.00
4.00	Transportation - Staff	0					4.00
5.00	Volunteer Service Coordination						5.00
6.00	Administrative and General	-1, 356, 674	2, 594	. 240			6.00
	INPATIENT CARE SERVICE	,					
7.00	Inpatient - General Care	0	921	, 250			7.00
8.00	Inpatient - Respite Care	0	l .	, 239			8.00
	VI SI TI NG SERVI CES	_		, == - 1			
9. 00	Physician Services	0		0			9.00
10.00	Nursing Care	0	l .	, 266			10.00
11. 00	Nursing Care-Continuous Home Care	0	,	0			11.00
12. 00	Physical Therapy	0	2	, 692			12.00
13. 00	Occupational Therapy		٦	0			13.00
14. 00	Speech/ Language Pathology						14.00
15. 00	Medical Social Services		204	, 265			15.00
16. 00	Spiritual Counseling	0		, 612			16.00
		0	l .				
17.00	Di etary Counseling	0	180	, 943			17.00
18.00	Counseling - Other	0	2.5	072			18.00
19.00	Home Health Aide and Homemaker	0	ł	, 973			19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	l .	0			20.00
21. 00	Other	0		0			21.00
	OTHER HOSPICE SERVICE COSTS		1				
22. 00	Drugs, Biological and Infusion Therapy	0	l .	0			22.00
23. 00	Anal gesi cs	0		0			23. 00
24.00	Sedatives / Hypnotics	0	1	0			24.00
25.00	Other - Specify	0	1	0			25. 00
26. 00	Durable Medical Equipment/Oxygen	0	1	0			26.00
27. 00	Pati ent Transportation	0	1	0			27. 00
28. 00	I maging Services	0	1	0			28. 00
29. 00	Labs and Diagnostics	0		0			29. 00
30.00	Medical Supplies	0		0			30.00
31.00	Outpatient Services (including E/R Dept.)	0	1	0			31.00
32.00	Radiation Therapy	0	1	0			32.00
33.00	Chemotherapy	0		0			33.00
34.00	Other	0		0			34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0		0			35. 00
36.00	Volunteer Program Costs	0	l .	o			36.00
37.00	Fundrai si ng	0		o			37.00
38. 00	Other Program Costs	0		o			38.00
39. 00	Cost to be Allocated (per Wkst. K-4, Part I)	1	1, 356	, 674			39.00
	Unit Cost Multiplier	1		2956			40.00
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Health Financial Systems IU HEALTH BALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS 150051 | Peri od: | Worksheet K-5 | From 01/01/2015 | Part I | To 12/31/2015 | Date/Time Prepared: 5/27/2016 1:53 pm Provi der CCN: 150051 Hospi ce CCN:

						5/2//2016 1:5	3 PIII
					Hospi ce I		
			CAPI TAL REL	LATED COSTS			
	Cost Center Description	Hospice Trial	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
		Bal ance (1)			BENEFITS		
					DEPARTMENT		
		0	1.00	2.00	4. 00	4A	
1.00	Administrative and General		89, 419	186, 701	29, 489	305, 609	1.00
2.00	Inpatient - General Care	1, 403, 023	0	0	260, 895	1, 663, 918	2.00
3.00	Inpatient - Respite Care	248, 606	0	0	46, 229	294, 835	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	1, 431, 984	0	0	266, 282	1, 698, 266	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physi cal Therapy	5, 623	0	0	1, 046	6, 669	7.00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	432, 923	0	0	80, 503	513, 426	10.00
11.00	Spiritual Counseling	113, 631	0	0	21, 130	134, 761	11.00
12.00	Di etary Counseling	275, 568	0	0	51, 242	326, 810	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	39, 556	0	0	7, 355	46, 911	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	o	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	o	0	17. 00
18.00	Anal gesi cs	0	0	0	o	0	18. 00
19.00	Sedatives / Hypnotics	0	0	0	o	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22. 00
23.00	I maging Services	O	0	0	0	0	23. 00
24.00	Labs and Diagnostics	O	0	0	0	0	24.00
25.00	Medical Supplies	O	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	o	0	0	0	0	26.00
27.00	Radi ati on Therapy	o	0	0	0	0	27. 00
28.00	Chemotherapy	O	0	0	o	0	28. 00
29.00	Other	O	0	0	o	0	29. 00
30.00	Bereavement Program Costs	0	0	0	o	0	30.00
31.00	Volunteer Program Costs	o	0	0	o	0	31.00
32.00	Fundrai si ng	o	0	0	o	0	32.00
33.00	Other Program Costs	o	0	0	o	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	3, 950, 914	89, 419	186, 701	764, 171	4, 991, 205	34.00
35.00	Unit Cost Multiplier (see instructions)					0.000000	

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL ALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provider ( Provi der CCN: 150051 Hospi ce CCN: 151509

						372772010 1.3	O PIII
					Hospi ce I		
	Cost Center Description		MAINTENANCE &		LAUNDRY &	HOUSEKEEPI NG	
		E & GENERAL	REPAI RS	PLANT	LINEN SERVICE		
		5. 00	6. 00	7. 00	8. 00	9. 00	
1.00	Administrative and General	61, 625		449, 540	18, 452	36, 758	1
2.00	Inpatient - General Care	335, 521		0	0	0	
3.00	Inpatient - Respite Care	59, 452	0	0	0	0	3.00
4.00	Physi ci an Servi ces	0	0	0	0	0	4. 00
5.00	Nursing Care	342, 446	0	0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physi cal Therapy	1, 345	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8.00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	103, 530	0	0	0	0	10.00
11. 00	Spiritual Counseling	27, 174	0	0	0	0	11.00
12.00	Di etary Counsel i ng	65, 900	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	9, 459	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	0	0	17.00
18.00	Anal gesi cs	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	0	0	21.00
22.00	Pati ent Transportation	0	0	0	0	0	22.00
23.00	I maging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25. 00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radi ati on Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28. 00
29.00	Other	0	0	0	0	0	29.00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	l 0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32.00
33. 00	Other Program Costs		Ō	l o	0	Ō	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1, 006, 452	0	449, 540	18, 452	36, 758	ł
	Unit Cost Multiplier (see instructions)	1			,	,	35.00
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Health Financial Systems IU HEALTH BALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS 150051 | Peri od: | Worksheet K-5 | From 01/01/2015 | Part I | To 12/31/2015 | Date/Time Prepared: 5/27/2016 1:53 pm Provi der CCN: 150051 Hospi ce CCN:

			5/2//2016 1:53					
				Hospi ce I				
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL		
				OF PERSONNEL	ADMI NI STRATI O	SERVICES &		
					N	SUPPLY		
		10.00	11. 00	12.00	13.00	14.00		
1. 00	Administrative and General	0	1, 313	C	6, 509	0	1.00	
2.00	Inpatient - General Care	o	4, 442		80, 323	20	2.00	
3.00	Inpatient - Respite Care	o	1, 084		19, 616	0	3.00	
4.00	Physi ci an Servi ces	ol	0		0	0	4.00	
5.00	Nursing Care	o	5, 916		157, 499	0	5.00	
6.00	Nursing Care-Continuous Home Care	o	0		0	0	6.00	
7.00	Physical Therapy	o	4		0	0	7. 00	
8.00	Occupational Therapy	o	0		0	0	8.00	
9.00	Speech/ Language Pathology	o	0		0	0	9. 00	
10.00	Medical Social Services	o	2, 574		0	0	10.00	
11.00	Spiritual Counseling	o	541		0	0	11.00	
12.00	Di etary Counseling	o	24		0	0	12.00	
13.00	Counseling - Other	o	0		0	0	13.00	
14.00	Home Health Aide and Homemaker	l ol	2, 068		o	0	14.00	
15.00	HH Aide & Homemaker - Cont. Home Care	o	0		0	0	15.00	
16. 00	Other	O	0	l c	0	0	16.00	
17.00	Drugs, Biological and Infusion Therapy	o	0		0	94, 149	17. 00	
18.00	Anal gesi cs	o	0		0	0	18. 00	
19.00	Sedatives / Hypnotics	o	0		0	0	19.00	
20.00	Other - Specify	o	0		0	0	20.00	
21.00	Durable Medical Equipment/Oxygen	o	0		0	201	21.00	
22.00	Patient Transportation	o	0	0	0	0	22. 00	
23.00	I maging Services	o	0	0	0	0	23. 00	
24.00	Labs and Diagnostics	o	0	0	0	312	24.00	
25.00	Medical Supplies	o	0	0	0	30, 694	25. 00	
26.00	Outpatient Services (including E/R Dept.)	o	0		0	0	26.00	
27.00	Radi ati on Therapy	o	0	0	0	0	27.00	
28.00	Chemotherapy	o	0	0	0	0	28. 00	
29.00	Other	o	0		0	0	29. 00	
30.00	Bereavement Program Costs	o	0		0	0	30.00	
31.00	Volunteer Program Costs	o	0		0	0	31.00	
32.00	Fundrai si ng	o	0		0	0	32.00	
33.00	Other Program Costs	o	0	0	0	0	33.00	
34.00	Total (sum of lines 1 thru 33) (2)	o	17, 966	0	263, 947	125, 376	34.00	
35.00	, , , ,						35.00	
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Health Financial Systems IU HEALTH BALLOCATION OF GENERAL SERVICE COSTS TO HOSPICE COST CENTERS Provi der CCN: 150051 | Peri od: From 01/01/2015 | Part I | Date/Time Prepared: 5/27/2016 1:53 pm

						5/2//2016 1:5	3 pm
					Hospi ce I		
					OTHER GEN	IERAL SERVI CE	
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	(SPECI FY)	CENTRAL	
			RECORDS &	SERVI CE		STERI LI ZATI ON	
			LI BRARY				
		15. 00	16. 00	17. 00	18. 00	18. 01	
1.00	Administrative and General	0	0		0	0	
2.00	Inpatient - General Care	0	0		0	0	
3.00	Inpatient - Respite Care	0	0		0	0	
4.00	Physi ci an Servi ces	0	0		0	0	
5.00	Nursi ng Care	0	0		0	0	1
6.00	Nursing Care-Continuous Home Care	0	0		0	0	
7.00	Physi cal Therapy	0	0		0	0	
8.00	Occupational Therapy	0	0		0	0	
9. 00	Speech/ Language Pathology	0	0		0	0	
10.00	Medical Social Services	0	0		0	0	
11. 00	Spiritual Counseling	0	0		0	0	
12.00	Dietary Counseling	0	0		0	0	
13.00	Counseling - Other	0	0		0	0	
14.00	Home Health Aide and Homemaker	0	0		0	0	
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	15.00
16.00	Other	0	0		0	0	
17. 00	Drugs, Biological and Infusion Therapy	0	0		0	0	
18. 00	Anal gesi cs	0	0		0	0	
19. 00	Sedatives / Hypnotics	0	0		0	0	
20.00	Other - Specify	0	0		0	0	20.00
21. 00	Durable Medical Equipment/Oxygen	0	0		0	0	
22.00	Patient Transportation	0	0		0	0	
23. 00	I maging Services	0	0		0	0	
24. 00	Labs and Diagnostics	0	0		0	0	
25.00	Medical Supplies	0	0		0	0	
26. 00	Outpatient Services (including E/R Dept.)	0	0		0	0	
27. 00	Radiation Therapy	0	0		0	0	
28. 00	Chemotherapy	0	0		0	0	28. 00
29. 00	Other	0	0		0	0	
30.00	Bereavement Program Costs	0	0		0	0	
31.00	Volunteer Program Costs	0	0		0	0	
32.00	Fundraising	0	0		0	0	
33.00	Other Program Costs	0	0		0	0	
34.00	Total (sum of lines 1 thru 33) (2)	0	0		0	0	
35. 00	Unit Cost Multiplier (see instructions)						35.00

Provi der CCN: 150051 Hospi ce CCN: 151509

						07 277 2010 1.0	0 0111
					Hospi ce I		
				INTERNS &	RESI DENTS		
	Cost Center Description	NONPHYSI CI AN	NURSI NG	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	
		ANESTHETI STS	SCH00L	RY & FRINGES	R PRGM COSTS	PRGM-PHARMACY	
						RESI DENCY	
		19. 00	20.00	21.00	22.00	23. 00	
1.00	Administrative and General	0	0	0	0	0	1.00
2.00	Inpatient - General Care	o	0	l 0	0	0	2.00
3.00	Inpatient - Respite Care	o	0	0	0	0	3.00
4.00	Physician Services	o	0		0	0	4.00
5.00	Nursi ng Care	l ol	0	l	0	l ol	5.00
6.00	Nursing Care-Continuous Home Care	o	0		0	l ol	6.00
7. 00	Physical Therapy	0	0	0	0	l ol	1
8.00	Occupational Therapy	0	0	0	0	0	
9. 00	Speech/ Language Pathology		0	0	0	0	9.00
10.00	Medical Social Services		0		o o	l ol	
11. 00	Spiritual Counseling		0	l o	o o	0	11.00
12. 00	Di etary Counsel i ng		0	l o	o o	0	12.00
13. 00	Counseling - Other		0		i o	0	13.00
14. 00	Home Health Aide and Homemaker		0				•
15. 00	HH Ai de & Homemaker - Cont. Home Care		0				1
16. 00	Other		0			0	16.00
17. 00	Drugs, Biological and Infusion Therapy		0				17.00
18. 00	Anal gesi cs		0				18.00
	Sedatives / Hypnotics		0		0		•
	Other - Specify	0	0				20.00
21.00	Durable Medical Equipment/Oxygen	0	0				20.00
	1 1 33	0	0				
22.00	Pati ent Transportati on	0	0		0	0	22.00
23.00	I maging Services	0	0		0	0	1
24.00	Labs and Diagnostics	0	0	0	0	0	24.00
25.00	Medical Supplies	0	0	0	0	0	25.00
26. 00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27. 00	Radiation Therapy	0	0	0	0	0	
28. 00	Chemotherapy	0	0	0	0	0	28. 00
29. 00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31. 00	Volunteer Program Costs	0	0	0	0	0	1
32.00	Fundrai si ng	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	0	0	0	0	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

						5/27/2016 1:5	3 pm
					Hospi ce I		
	Cost Center Description	Subtotal	Intern &	Subtotal	Allocated	Total Hospice	
		(col s. 4A-23)	Residents	(cols. 24 ±	Hospi ce A&G	Costs (cols.	
			Cost & Post	25)	(See Part II)	26 ± 27)	
			Stepdown				
			Adjustments				
		24. 00	25. 00	26.00	27. 00	28. 00	
1.00	Administrative and General	879, 806					1.00
2.00	Inpatient - General Care	2, 084, 224	0	2, 084, 224	304, 103	2, 388, 327	2.00
3.00	Inpatient - Respite Care	374, 987	0	374, 987	54, 713	429, 700	3.00
4.00	Physician Services	0	0	0	0	0	4.00
5.00	Nursing Care	2, 204, 127	0	2, 204, 127	321, 600	2, 525, 727	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6.00
7.00	Physi cal Therapy	8, 018	0	8, 018	1, 170	9, 188	7.00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9.00
10.00	Medical Social Services	619, 530	0	619, 530	90, 394	709, 924	10.00
11.00	Spiritual Counseling	162, 476	0	162, 476	23, 706	186, 182	11.00
12.00	Di etary Counseling	392, 734	0	392, 734	57, 303	450, 037	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	58, 438	0	58, 438	8, 527	66, 965	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	94, 149	0	94, 149	13, 737	107, 886	17.00
18.00	Anal gesi cs	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	201	0	201	29	230	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	I maging Services	0	0	0	0	0	23. 00
24.00	Labs and Diagnostics	312	0	312	46	358	24.00
25.00	Medical Supplies	30, 694	0	30, 694	4, 478	35, 172	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radi ati on Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28. 00
29.00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32.00
33. 00	Other Program Costs	0	Ō	ĺ	0	Ö	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	6, 909, 696	0	6, 909, 696		6, 909, 696	34.00
35.00	Unit Cost Multiplier (see instructions)				0. 145907		35.00
			•	•	1		,

CAPITAL RELATED COSTS   BLDG & FIXT   MVBLE EQUIP (SQUARE FEET)   CSQUARE FE			nospi ce c	7014.	0 12/01/2010	5/27/2016 1:5	
Cost Center Description					Hospi ce I		
Cost Center Description		CAPI TAL REL	ATED COSTS		i i		
SQUARE FEET    SQUA							
SOUARE FEET   SOUARE FEET	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliatio	ADMI NI STRATI V	
1.00		(SQUARE FEET)	(SQUARE FEET)	BENEFI TS	n	E & GENERAL	
1.00   Administrative and General   1.00   2.00   5A   5.00		,	,	DEPARTMENT		(ACCUM, COST)	
1.00				(GROSS			
1.00							
1.00		1, 00	2.00		5A	5. 00	
3.00	1.00 Administrative and General	4, 796			0		1.00
3.00   Inpatient - Respite Care   0   0   163,239   0   294,835   3.00   0   0.00	2.00 Inpatient - General Care	0	0	921, 250	0	1, 663, 918	2.00
4. 00   Physician Services   0   0   0   0   0   0   0   0   0		0	0				3.00
5.00         Nursing Care         0         0         940,266         0         1,698,266         5.00           6.00         Nursing Care-Continuous Home Care         0		0	0	C		•	
6.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 6.60 0 7.00 Physical Therapy 0 0 0 0 3,692 0 6,669 7.00 8.00 Occupational Therapy 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0	0	940. 266	o C	1, 698, 266	5. 00
7.00 Physical Therapy		0	n	,		1	
8.00   Occupational Therapy   0   0   0   0   0   0   0   0   0		0	o o	3 692		1	
9.00         Speech/ Language Pathology         0         0         0         0         0         0         9.00           10.00         Medical Social Services         0         0         284,265         0         513,426         0         10.00           11.00         Spiritual Counseling         0         0         74,612         0         134,761         11.00           12.00         Dietary Counseling         0         0         0         0         326,810         12.00           13.00         Counseling - Other         0         0         0         0         0         12.00           14.00         Home Heal th Aide and Homemaker         0         0         0         0         0         12.00           15.00         HH Aide & Homemaker - Cont. Home Care         0         0         0         0         0         0         0         15.00           16.00         Other         0         0         0         0         0         0         0         0         0         0         15.00           17.00         Drugs, Biological and Infusion Therapy         0         0         0         0         0         0         17.00	3	0	n			1	
10.00   Medical Social Services   0   0   284,265   0   513,426   10.00     11.00   Spiritual Counseling   0   0   0   74,612   0   134,761   11.00     12.00   Dietary Counseling   0   0   180,942   0   326,810   12.00     13.00   Counseling - Other   0   0   0   0   0   0   0     14.00   Home Heal th Aide and Homemaker   0   0   0   0   0   0   13.00     15.00   HH Aide & Homemaker - Cont. Home Care   0   0   0   0   0   0   0     16.00   Other   0   0   0   0   0   0   0   0     17.00   Drugs, Biological and Infusion Therapy   0   0   0   0   0   0   15.00     18.00   Anal gesics   0   0   0   0   0   0   0     19.00   Sedatives / Hypnotics   0   0   0   0   0   0     10.00   Other - Specify   0   0   0   0   0   0   0     10.00   Other - Specify   0   0   0   0   0   0     10.00   Durable Medical Equipment/Oxygen   0   0   0   0   0     22.00   Patient Transportation   0   0   0   0   0   0     23.00   Labs and Diagnostics   0   0   0   0   0   0     25.00   Medical Supplies   0   0   0   0   0     26.00   Outpatient Services (including E/R Dept.)   0   0   0   0   0     27.00   Radiation Therapy   0   0   0   0   0   0     28.00   Chemotherapy   0   0   0   0   0     29.00   Other Program Costs   0   0   0   0   0     31.00   Volunteer Program Costs   0   0   0   0     32.00   Total (csm of lines 1 thru 33) (2)   4,796   19,591   2,698,368   4,991,205   34.00     35.00   Total (csm of lines 1 thru 33) (2)   4,796   34.90   764,171   1,006,452   35.00     35.00   Total (csm of lines 1 thru 33) (2)   4,796   36.00   0   0   0   0     36.00   Total (csm of lines 1 thru 33) (2)   4,796   36.00   0   0   0   0     37.00   Total cost to be allocated   89,419   186,701   764,171   1.00		0	_	Č	_	1	
11. 00       Spiritual Counseling       0       0       74, 612       0       134, 761       11. 00         12. 00       Dietary Counseling       0       0       0       0       326, 810       12. 00         13. 00       Counseling - Other       0       0       0       0       0       0       0       0       13. 00         14. 00       Home Health Aide and Homemaker       0       0       0       0       0       0       46, 911       14. 00         15. 00       HH Aide & Homemaker - Cont. Home Care       0       0       0       0       0       0       0       0       15. 00         17. 00       Other       0       0       0       0       0       0       0       0       17. 00         18. 00       Anal gesics       0       0       0       0       0       0       0       17. 00         18. 00       Anal gesics       0       0       0       0       0       0       0       18. 00         20. 00       Other - Specify       0       0       0       0       0       0       0       0       0       0       0       0       0 <t< td=""><td></td><td>0</td><td>Ĭ</td><td>284 265</td><td>1</td><td>1</td><td></td></t<>		0	Ĭ	284 265	1	1	
12. 00   Di etary Counseling		0	_				
13. 00         Counseling - Other         0         0         0         0         13.00           14. 00         Home Health Aide and Homemaker         0         0         25,973         0         46,911         14.00           15. 00         HH Aide & Homemaker - Cont. Home Care         0         0         0         0         0         0         15.00           16. 00         Other         0         0         0         0         0         0         16.00           17. 00         Drugs, Biological and Infusion Therapy         0         0         0         0         0         17.00           18. 00         Anal gesics         0         0         0         0         0         17.00           18. 00         Anal gesics         0         0         0         0         0         17.00           18. 00         Anal gesics         0         0         0         0         0         19.00           20. 00         Other - Specify         0         0         0         0         0         0         20.00           21. 00         Durable Medical Equipment/Oxygen         0         0         0         0         0         21.00 <td></td> <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td>		0					
14.00       Home Health Aide and Homemaker       0       0       25,973       0       46,911       14.00         15.00       HHH Aide & Homemaker - Cont. Home Care       0       0       0       0       0       15.00         16.00       Other       0       0       0       0       0       0       15.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       0       0       17.00         19.00       Sedati ves / Hypnotics       0       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       0       19.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       0       21.00         22.00       Patient Transportation       0       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       0       22.00         24.00       Labs and Diagnostics       0       0       0       <		1	_				
15.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       0       0       15.00         16.00       Other       0       0       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       0       0       0       19.00         21.00       Durable Medical Equipment/Oxygen       0		-	_	_		1	
16.00       Other       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       0       0       17.00         19.00       Sedatives / Hypnotics       0       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       0       0       0       19.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       0       0       0       20.00         22.00       Patient Transportation       0       0       0       0       0       0       21.00         23.00       Imaging Services       0       0       0       0       0       0       22.00         24.00       Labs and Diagnostics       0       0       0       0       0       22.00         25.00       Medical Supplies       0       0       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0<		_	Ŭ	23, 773		1	
17. 00       Drugs, Biological and Infusion Therapy       0       0       0       17. 00         18. 00       Anal gesics       0       0       0       0       0       18. 00         19. 00       Sedatives / Hypnotics       0       0       0       0       0       19. 00         20. 00       Other - Specify       0		0	_				
18.00       Analgesics       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       0       19.00         20.00       Other - Specify       0		0	_	_	_	-	
19.00   Sedatives / Hypnotics   0   0   0   0   0   19.00   20.00   Other - Specify   0   0   0   0   0   0   21.00   Durable Medical Equipment/Oxygen   0   0   0   0   22.00   Patient Transportation   0   0   0   0   23.00   Imaging Services   0   0   0   0   24.00   Labs and Diagnostics   0   0   0   0   25.00   Medical Supplies   0   0   0   0   26.00   Outpatient Services (including E/R Dept.)   0   0   0   0   27.00   Radiation Therapy   0   0   0   0   28.00   Chemotherapy   0   0   0   0   29.00   Other   0   0   0   30.00   Bereavement Program Costs   0   0   0   0   31.00   Volunteer Program Costs   0   0   0   32.00   33.00   Total (sum of lines 1 thru 33) (2)   4,796   19,591   2,698,368   4,991,205   35.00   37.00   Total cost to be allocated   89,419   186,701   764,171   1,006,452   35.00		0	_	_	1	1	
20.00       Other - Specify       0       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       0       0       21.00         22.00       Pati ent Transportation       0       0       0       0       0       0       22.00         23.00       Imagi ng Servi ces       0       0       0       0       0       0       0       23.00         24.00       Labs and Di agnosti cs       0       0       0       0       0       0       0       24.00         25.00       Medi cal Suppl i es       0       0       0       0       0       0       24.00         25.00       Outpati ent Servi ces (including E/R Dept.)       0       0       0       0       0       0       0       0       0       25.00         26.00       Outpati ent Servi ces (including E/R Dept.)       0       0       0       0       0       0       0       0       0       0       0       0       25.00         27.00       Radi ati on Therapy       0       0       0       0       0       0       0       0       0		0	_	-	1	_	
21.00       Durable Medical Equipment/Oxygen       0       0       0       0       21.00         22.00       Patient Transportation       0       0       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       0       0       0       0       24.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       0       0       0       0       25.00         27.00       Radiation Therapy       0       0       0       0       0       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       0       0       0       0       0       0       22.00         30.00       Bereavement Program Costs       0       0       0       0       0       0       0       0       0 <td></td> <td>0</td> <td>_</td> <td>-</td> <td></td> <td>_</td> <td></td>		0	_	-		_	
22.00       Patient Transportation       0       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       0       0       25.00         27.00       Radiation Therapy       0       0       0       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       0       0       0       27.00         28.00       Other       0       0       0       0       0       0       0       28.00         29.00       Other       0		0	_	_	1	_	
23.00       I maging Services       0       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       0       0       0       0       25.00         27.00       Radiation Therapy       0       0       0       0       0       0       0       27.00       0       0       0       0       0       27.00       28.00       0       0       0       0       0       0       0       27.00       0       0       0       0       0       0       0       0       27.00       0		0				1	
24.00       Labs and Diagnostics       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       0       0       0       28.00         29.00       Other       0       0       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       0       0       0       0       30.00         31.00       Vol unteer Program Costs       0       0       0       0       0       0       0       31.00         33.00       Other Program Costs       0		0	_	-		1	
25.00       Medical Supplies       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       0       25.00         27.00       Radiation Therapy       0       0       0       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       0       0       28.00         29.00       Other       0       0       0       0       0       0       29.00         30.00       Bereavement Program Costs       0       0       0       0       0       0       0       30.00         31.00       Volunteer Program Costs       0       0       0       0       0       0       31.00         32.00       Fundraising       0       <		0	_	_		_	
26. 00       Outpati ent Services (including E/R Dept.)       0       0       0       0       26. 00         27. 00       Radi ati on Therapy       0       0       0       0       0       27. 00         28. 00       Chemotherapy       0       0       0       0       0       0       28. 00         29. 00       Other       0       0       0       0       0       0       29. 00         30. 00       Bereavement Program Costs       0       0       0       0       0       0       30. 00         31. 00       Vol unteer Program Costs       0       0       0       0       0       0       0       30. 00         32. 00       Fundraising       0       0       0       0       0       0       0       0       0       0       0       0       33. 00         34. 00       Total (sum of lines 1 thru 33) (2)       4,796       19,591       2,698,368       4,991,205       34. 00         35. 00       Total cost to be allocated       89,419       186,701       764,171       1,006,452       35. 00		0	_			1	
27. 00       Radiation Therapy       0       0       0       0       27. 00         28. 00       Chemotherapy       0       0       0       0       0       28. 00         29. 00       Other       0       0       0       0       0       0       29. 00         30. 00       Bereavement Program Costs       0       0       0       0       0       0       30. 00         31. 00       Volunteer Program Costs       0       0       0       0       0       0       31. 00         32. 00       Fundraising       0       0       0       0       0       0       0       31. 00         33. 00       Other Program Costs       0       0       0       0       0       0       0       33. 00         34. 00       Total (sum of lines 1 thru 33) (2)       4, 796       19, 591       2, 698, 368       4, 991, 205       34. 00         35. 00       Total cost to be allocated       89, 419       186, 701       764, 171       1, 006, 452       35. 00		0	_	_	1	1	
28. 00     Chemotherapy     0     0     0     0     0     28. 00       29. 00     Other     0     0     0     0     0     29. 00       30. 00     Bereavement Program Costs     0     0     0     0     0     0     30. 00       31. 00     Vol unteer Program Costs     0     0     0     0     0     0     31. 00       32. 00     Fundraising     0     0     0     0     0     0     33. 00       33. 00     Other Program Costs     0     0     0     0     0     0     33. 00       34. 00     Total (sum of lines 1 thru 33) (2)     4,796     19,591     2,698,368     4,991,205     34. 00       35. 00     Total cost to be allocated     89,419     186,701     764,171     1,006,452     35. 00		0					
29.00     Other     0     0     0     0     29.00       30.00     Bereavement Program Costs     0     0     0     0     30.00       31.00     Vol unteer Program Costs     0     0     0     0     0     0     31.00       32.00     Fundraising     0     0     0     0     0     0     0     32.00       33.00     Other Program Costs     0     0     0     0     0     0     0     33.00       34.00     Total (sum of lines 1 thru 33) (2)     4,796     19,591     2,698,368     4,991,205     34.00       35.00     Total cost to be allocated     89,419     186,701     764,171     1,006,452     35.00	1 3	0	_	_	1	1	
30.00     Bereavement Program Costs     0     0     0     0     30.00       31.00     Volunteer Program Costs     0     0     0     0     0     31.00       32.00     Fundraising     0     0     0     0     0     0     32.00       33.00     Other Program Costs     0     0     0     0     0     33.00       34.00     Total (sum of lines 1 thru 33) (2)     4,796     19,591     2,698,368     4,991,205     34.00       35.00     Total cost to be allocated     89,419     186,701     764,171     1,006,452     35.00		0	0	_	_	_	
31.00     Volunteer Program Costs     0     0     0     0     31.00       32.00     Fundraising     0     0     0     0     0     32.00       33.00     Other Program Costs     0     0     0     0     0     33.00       34.00     Total (sum of lines 1 thru 33) (2)     4,796     19,591     2,698,368     4,991,205     34.00       35.00     Total cost to be allocated     89,419     186,701     764,171     1,006,452     35.00		0	0	_	1	1	
32.00     Fundraising     0     0     0     0     0     32.00       33.00     Other Program Costs     0     0     0     0     0     33.00       34.00     Total (sum of lines 1 thru 33) (2)     4,796     19,591     2,698,368     4,991,205     34.00       35.00     Total cost to be allocated     89,419     186,701     764,171     1,006,452     35.00		0	ŭ	_	1	1	
33.00 Other Program Costs 0 0 0 0 0 33.00 34.00 Total (sum of lines 1 thru 33) (2) 4,796 19,591 2,698,368 4,991,205 34.00 35.00 Total cost to be allocated 89,419 186,701 764,171 1,006,452 35.00		0	0	C	0	1	
34.00     Total (sum of lines 1 thru 33) (2)     4,796     19,591     2,698,368     4,991,205     34.00       35.00     Total cost to be allocated     89,419     186,701     764,171     1,006,452     35.00		0	0	C	0	1	
35. 00 Total cost to be allocated 89, 419 186, 701 764, 171 1, 006, 452 35. 00		0	0	C	0	1	
		1					
36.00  Unit Cost Multiplier (see instructions)   18.644495  9.529937  0.283197    0.201645  36.00							
	36.00  Unit Cost Multiplier (see instructions)	18. 644495	9. 529937	0. 283197	1	0. 201645	36.00

 
 Provi der CCN:
 150051
 Peri od: From 01/01/2015
 Worksheet K-5

 Hospi ce CCN:
 151509
 To
 12/31/2015
 Date/Ti me Prepared: 5/27/2016 1: 53 pm
 STATISTICAL BASIS

Cost Center Description						5/2//2016 1:53	3 pm	
REPAIRS   (SQUARE FEET)   (S						Hospi ce I		
COUARE FEET   COUARE FEET		Cost Center Description	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
1.00   Administrative and General   0   0   19,591   23,627   144   0   1.00     1.00   Inpatient - General Care   0   0   0   0   0   0     2.00   Inpatient - General Care   0   0   0   0   0   0     3.00   Inpatient - Respite Care   0   0   0   0   0   0     4.00   Physician Services   0   0   0   0   0   0     5.00   Nursing Care   0   0   0   0   0   0     6.00   Nursing Care   0   0   0   0   0   0     6.00   Nursing Care   0   0   0   0   0   0     7.00   Physical Therapy   0   0   0   0   0     8.00   Occupational Therapy   0   0   0   0   0     8.00   Occupational Therapy   0   0   0   0   0     9.00   Speech/ Language Pathology   0   0   0   0   0     9.00   Speech/ Language Pathology   0   0   0   0   0     9.00   Spiritual Counseling   0   0   0   0   0     10.00   Medical Social Services   0   0   0   0   0     11.00   Spiritual Counseling   0   0   0   0   0     12.00   Dietary Counseling   0   0   0   0   0     13.00   Counseling - Other   0   0   0   0   0     14.00   Hid Alde & Homemaker   0   0   0   0   0     15.00   Hid Alde & Homemaker - Cont. Home Care   0   0   0   0   0     16.00   Other   0   0   0   0   0   0     18.00   Analgesics   0   0   0   0   0   0     19.00   Sedatives / Hypnotics   0   0   0   0   0     19.00   Sedatives / Hypnotics   0   0   0   0   0     19.00   Sedatives / Hypnotics   0   0   0   0   0     19.00   Sedatives / Hypnotics   0   0   0   0   0     19.00   Sedatives / Hypnotics   0   0   0   0   0     19.00   Sedatives / Hypnotics   0   0   0   0   0     19.00   Sedatives / Hypnotics   0   0   0   0   0     19.00   Sedatives / Hypnotics   0   0   0   0   0     19.00   Sedatives / Hypnotics   0   0   0   0   0     19.00   Sedatives / Hypnotics   0   0   0   0     19.00			REPAI RS	PLANT	LINEN SERVICE	(HOURS OF	(MEALS	
1.00			(SQUARE FEET)	(SQUARE FEET)	(POUNDS OF	SERVICE)	SERVED)	
1.00			,	ĺ	LAUNDRY)		ŕ	
2.00 Inpatient - General Care			6. 00	7. 00	8.00	9. 00	10.00	
3.00   Inpatient - Respite Care	1.00	Administrative and General	0	19, 591	23, 62	7 144	0	1.00
4.00 Physician Services 0 Nursing Care 0 0 0 0 0 0 0 0 0 0 0 0 5.00 7.00 Physical Therapy 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00	Inpatient - General Care	0	C		0	0	2.00
5.00         Nursing Care         0         0         0         0         0         5.00           6.00         Nursing Care-Continuous Home Care         0	3.00	Inpatient - Respite Care	0	C		0	0	3.00
6. 00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	4.00	Physician Services	0	C		0	0	4.00
7. 00 Physical Therapy	5.00	Nursing Care	0	C		0	0	5.00
8.00   Occupational Therapy   0   0   0   0   0   0   0   0   0	6.00	Nursing Care-Continuous Home Care	0	C		0	0	6.00
9.00   Speech / Language Pathology   0   0   0   0   0   0   0   0   10.00   10.00   Medical Social Services   0   0   0   0   0   0   11.00   11.00   Spiritual Counseling   0   0   0   0   0   0   11.00   12.00   Dietary Counseling   0   0   0   0   0   0   13.00   Counseling - Other   0   0   0   0   0   0   14.00   Home Health Aide and Homemaker   0   0   0   0   0   0   15.00   HH Aide & Homemaker - Cont. Home Care   0   0   0   0   0   0   16.00   Other   0   0   0   0   0   0   0   17.00   Drugs, Biological and Infusion Therapy   0   0   0   0   0   0   18.00   Anal gesics   0   0   0   0   0   0   19.00   Sedatives / Hypnotics   0   0   0   0   0   0   20.00   Other - Specify   0   0   0   0   0   0   21.00   Durable Medical Equipment/Oxygen   0   0   0   0   0   22.00   Patient Transportation   0   0   0   0   0   23.00   Imaging Services   0   0   0   0   0   24.00   Labs and Diagnostics   0   0   0   0   0   25.00   Medical Supplies   0   0   0   0   0   26.00   Outpatient Services (including E/R Dept.)   0   0   0   0   27.00   Radiation Therapy   0   0   0   0   0   28.00   Other Chemotherapy   0   0   0   0   29.00   Other	7.00	Physi cal Therapy	0	C		0	0	7.00
10.00   Medical Social Services	8.00	Occupational Therapy	0	C	)	0	0	8.00
11.00   Spiritual Counseling   0   0   0   0   0   0   11.00   12.00   Dietary Counseling   0   0   0   0   0   0   13.00   Counseling - Other   0   0   0   0   0   14.00   Home Health Aide and Homemaker   0   0   0   0   0   15.00   HH Aide & Homemaker - Cont. Home Care   0   0   0   0   0   16.00   Other   0   0   0   0   0   0   17.00   Drugs, Biological and Infusion Therapy   0   0   0   0   0   18.00   Anal gesics   0   0   0   0   0   19.00   Sedatives / Hypnotics   0   0   0   0   0   19.00   Sedatives / Hypnotics   0   0   0   0   20.00   Other - Specify   0   0   0   0   21.00   Durable Medical Equipment/Oxygen   0   0   0   0   22.00   Patient Transportation   0   0   0   0   23.00   Labs and Diagnostics   0   0   0   0   24.00   Labs and Diagnostics   0   0   0   0   25.00   Medical Supplies   0   0   0   0   27.00   Radiation Therapy   0   0   0   0   28.00   Chemotherapy   0   0   0   0   29.00   Other   0   0   20.00   0   20.00   0   0   20.00   0   0   20.00   0   20.00   0   0   20.00   0   20.00   0   0   20.00   0   20.00   0   20.00   0   20.00   0   20.00   0   20.00   0   20.00   0   20.00   0   20.00	9.00	Speech/ Language Pathology	0	C	)	0	0	9.00
12.00 Di etary Counseling 0 0 0 0 0 0 12.00 13.00 Counseling - Other 0 0 0 0 0 0 0 13.00 14.00 Home Health Aide and Homemaker 0 0 0 0 0 0 0 14.00 15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 0 0 15.00 16.00 Other 0 0 0 0 0 0 0 0 0 0 15.00 17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 0 0 0 0 18.00 17.00 Sedatives / Hypnotics 0 0 0 0 0 0 0 18.00 18.00 Other - Specify 0 0 0 0 0 0 0 0 0 0 19.00 20.00 Other - Specify 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10.00	Medical Social Services	0	C	)	0	0	10.00
13.00   Counseling - Other   0   0   0   0   0   13.00   14.00   Home Health Aide and Homemaker   0   0   0   0   0   14.00   15.00   HH Aide & Homemaker - Cont. Home Care   0   0   0   0   0   15.00   16.00   Other   0   0   0   0   0   0   15.00   17.00   Drugs, Biological and Infusion Therapy   0   0   0   0   0   0   17.00   18.00   Analgesics   0   0   0   0   0   0   18.00   19.00   Sedatives / Hypnotics   0   0   0   0   0   19.00   20.00   Other - Specify   0   0   0   0   0   19.00   21.00   Durable Medical Equipment/Oxygen   0   0   0   0   0   21.00   22.00   Patient Transportation   0   0   0   0   0   22.00   23.00   Labs and Diagnostics   0   0   0   0   0   23.00   24.00   Labs and Diagnostics   0   0   0   0   0   25.00   25.00   Medical Supplies   0   0   0   0   0   25.00   26.00   Outpatient Services (including E/R Dept.)   0   0   0   0   0   28.00   29.00   Chemotherapy   0   0   0   0   0   0   28.00   29.00   Other   0   0   0   0   0   0   0   29.00   Other   0   0   0   0   20.00   0   0   0   0   20.00   0   0   0   0   20.00   0   0   0   0   20.00   0   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   20.00   0   0   0   20.00   0   0   0   20.00   0   0   20.00   0   0   20.00   0   0   20.00   0   0   20.00   0   0   0   20.0	11.00	Spiritual Counseling	0	C	)	0	0	11.00
14.00       Home Heal th Ai de and Homemaker       0       0       0       0       14.00         15.00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       0       0       15.00         16.00       Other       0       0       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       0       17.00       0       0       18.00       0       0       17.00       0       0       19.00       0       0       19.00       0	12.00	Di etary Counseling	0	C	)	0	0	12.00
15. 00       HH Ai de & Homemaker - Cont. Home Care       0       0       0       0       0       15. 00         16. 00       Other       0       0       0       0       0       0       0       16. 00         17. 00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       0       17. 00         18. 00       Anal gesics       0       0       0       0       0       0       0       17. 00         19. 00       Sedatives / Hypnotics       0       0       0       0       0       0       0       18. 00         20. 00       Other - Specify       0	13.00	Counseling - Other	0	C	)	0	0	13.00
16.00       Other       0       0       0       0       0       16.00         17.00       Drugs, Biological and Infusion Therapy       0       0       0       0       0       0       17.00         18.00       Anal gesics       0       0       0       0       0       0       18.00         19.00       Sedatives / Hypnotics       0       0       0       0       0       0       19.00         20.00       Other - Specify       0 <td< td=""><td>14.00</td><td>Home Health Aide and Homemaker</td><td>0</td><td>C</td><td>)</td><td>0</td><td>0</td><td>14.00</td></td<>	14.00	Home Health Aide and Homemaker	0	C	)	0	0	14.00
17. 00       Drugs, Biological and Infusion Therapy       0       0       0       0       17. 00         18. 00       Anal gesics       0       0       0       0       0       0       18. 00         19. 00       Sedatives / Hypnotics       0       0       0       0       0       0       19. 00         20. 00       Other - Specify       0	15.00	HH Aide & Homemaker - Cont. Home Care	0	C	)	0	0	15.00
18. 00       Anal gesics       0       0       0       0       18. 00         19. 00       Sedati ves / Hypnotics       0       0       0       0       0       19. 00         20. 00       Other - Specify       0 </td <td>16.00</td> <td>Other</td> <td>0</td> <td>C</td> <td>)</td> <td>0</td> <td>0</td> <td>16.00</td>	16.00	Other	0	C	)	0	0	16.00
18.00       Anal gesics       0       0       0       0       0       18.00         19.00       Sedati ves / Hypnotics       0       0       0       0       0       0       19.00         20.00       Other - Specify       0	17.00	Drugs, Biological and Infusion Therapy	0	C	)	0	0	17.00
19.00       Sedatives / Hypnotics       0       0       0       0       0       19.00         20.00       Other - Specify       0       0       0       0       0       0       0       0       20.00         21.00       Durable Medical Equipment/Oxygen       0       0       0       0       0       0       0       0       21.00         22.00       Patient Transportation       0       0       0       0       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       0       0       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       0       0       0       0       0	18.00		0	C	)	0	0	18.00
21. 00       Durable Medical Equipment/Oxygen       0       0       0       0       0       21. 00         22. 00       Patient Transportation       0       0       0       0       0       0       0       22. 00         23. 00       Imaging Services       0       0       0       0       0       0       0       23. 00         24. 00       Labs and Diagnostics       0       0       0       0       0       0       24. 00         25. 00       Medical Supplies       0       0       0       0       0       0       0       25. 00         26. 00       Outpatient Services (including E/R Dept.)       0       0       0       0       0       0       0       0       0       27. 00         27. 00       Radiation Therapy       0       0       0       0       0       0       0       0       28. 00         29. 00       Other       0       <	19.00		0	C	)	0	0	19.00
22.00       Patient Transportation       0       0       0       0       0       22.00         23.00       Imaging Services       0       0       0       0       0       23.00         24.00       Labs and Diagnostics       0       0       0       0       0       24.00         25.00       Medical Supplies       0       0       0       0       0       0       25.00         26.00       Outpatient Services (including E/R Dept.)       0       0       0       0       0       0       26.00         27.00       Radiation Therapy       0       0       0       0       0       27.00         28.00       Chemotherapy       0       0       0       0       0       28.00         29.00       Other       0       0       0       0       0       0       29.00	20.00	Other - Specify	0	C	)	0	0	20.00
23.00     Imaging Services     0     0     0     0     0     23.00       24.00     Labs and Diagnostics     0     0     0     0     0     24.00       25.00     Medical Supplies     0     0     0     0     0     0     25.00       26.00     Outpatient Services (including E/R Dept.)     0     0     0     0     0     0     26.00       27.00     Radiation Therapy     0     0     0     0     0     0     28.00       28.00     Chemotherapy     0     0     0     0     0     0     28.00       29.00     Other     0     0     0     0     0     0     29.00	21.00	Durable Medical Equipment/Oxygen	0	C	)	0	0	21.00
24. 00     Labs and Diagnostics     0     0     0     0     0     24. 00       25. 00     Medical Supplies     0     0     0     0     0     25. 00       26. 00     Outpatient Services (including E/R Dept.)     0     0     0     0     0     26. 00       27. 00     Radiation Therapy     0     0     0     0     0     0     27. 00       28. 00     Chemotherapy     0     0     0     0     0     0     28. 00       29. 00     Other     0     0     0     0     0     0     0     29. 00	22.00	Patient Transportation	0	C	)	0	0	22.00
25. 00     Medical Supplies     0     0     0     0     0     25. 00       26. 00     Outpatient Services (including E/R Dept.)     0     0     0     0     0     26. 00       27. 00     Radiation Therapy     0     0     0     0     0     0     27. 00       28. 00     Chemotherapy     0     0     0     0     0     0     28. 00       29. 00     Other     0     0     0     0     0     0     29. 00	23.00	I maging Services	0	C	)	0	0	23.00
26. 00     Outpatient Services (including E/R Dept.)     0     0     0     0     26. 00       27. 00     Radiation Therapy     0     0     0     0     0     27. 00       28. 00     Chemotherapy     0     0     0     0     0     0     28. 00       29. 00     Other     0     0     0     0     0     0     29. 00	24.00	Labs and Diagnostics	0	C	)	0	0	24.00
26. 00     Outpatient Services (including E/R Dept.)     0     0     0     0     26. 00       27. 00     Radiation Therapy     0     0     0     0     0     27. 00       28. 00     Chemotherapy     0     0     0     0     0     0     28. 00       29. 00     Other     0     0     0     0     0     0     29. 00	25.00	Medical Supplies	0	C	)	0	0	25.00
28. 00   Chemotherapy	26.00		0	C	)	0	0	26.00
29.00 Other 0 0 0 0 29.00	27.00	Radi ati on Therapy	0	C	)	0	0	27.00
	28.00	Chemotherapy	0	C	)	0	0	28.00
30 00 Reneavement Program Costs	29.00	Other	0	C	)	0	0	29.00
	30.00	Bereavement Program Costs	0	d	)	0	ol	30.00
31.00 Volunteer Program Costs 0 0 0 0 0 31.00	31.00		0	l c	)	0	0	31.00
32.00 Fundraising 0 0 0 0 0 32.00	32.00		0	l c	)	0	0	32.00
33.00 Other Program Costs 0 0 0 0 0 33.00			0	C		0	ol	
34.00 Total (sum of lines 1 thru 33) (2) 0 19,591 23,627 144 0 34.00			0	19, 591	23, 62	7 144	l ol	
35.00 Total cost to be allocated 0 449,540 18,452 36,758 0 35.00			0	·			1	
36.00 Unit Cost Multiplier (see instructions) 0.000000 22.946251 0.780971 255.263889 0.000000 36.00	36.00	Unit Cost Multiplier (see instructions)	0. 000000	22. 946251	0. 78097	1 255. 263889	0. 000000	36.00

STATISTICAL BASIS

			·			5/27/2016 1:5	3 pm
					Hospi ce I		
	Cost Center Description	CAFETERI A	MAI NTENANCE	NURSI NG	CENTRAL	PHARMACY	
		(MANHOURS)	OF PERSONNEL	ADMI NI STRATI O	SERVICES &	(COSTED	
			(NUMBER	N	SUPPLY	REQUIS.)	
			HOUSED)	(DI RECT NURS.	(TIME SPENT)		
				HRS. )			
		11. 00	12. 00	13.00	14.00	15. 00	
1.00	Administrative and General	7, 717	0	1, 040	0	0	1.00
2.00	Inpatient - General Care	26, 103	0	12, 833	53	0	2.00
3.00	Inpatient - Respite Care	6, 370	0	3, 134	0	0	3.00
4.00	Physi ci an Servi ces	0	0	0	0	0	4.00
5.00	Nursi ng Care	34, 767	0	25, 163	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0	0	0	0	6. 00
7.00	Physi cal Therapy	25	0	0	0	0	7.00
8.00	Occupational Therapy	0	0	0	0	0	8. 00
9.00	Speech/ Language Pathology	0	0	0	0	0	9. 00
10.00	Medical Social Services	15, 130		0	0	0	10.00
11.00	Spiritual Counseling	3, 180	0	0	0	0	11.00
12.00	Di etary Counseling	140	0	0	0	0	12.00
13.00	Counseling - Other	0	0	0	0	0	13.00
14.00	Home Health Aide and Homemaker	12, 153	0	0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00	Other	0	0	0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0	0	254, 670	0	17.00
18.00	Anal gesi cs	0	0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0	0	0	0	19.00
20.00	Other - Specify	0	0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0	0	545	0	21.00
22.00	Patient Transportation	0	0	0	0	0	22.00
23.00	I maging Services	0	0	0	0	0	23.00
24.00	Labs and Diagnostics	0	0	0	843	0	24.00
25.00	Medical Supplies	0	0	0	83, 027	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00	Radiation Therapy	0	0	0	0	0	27.00
28.00	Chemotherapy	0	0	0	0	0	28. 00
29.00	Other	0	0	0	0	0	29. 00
30.00	Bereavement Program Costs	0	0	0	0	0	30.00
31.00	Volunteer Program Costs	0	0	0	0	0	31.00
32.00	Fundrai si ng	0	0	0	0	0	32.00
33.00	Other Program Costs	0	0	0	0	0	33. 00
34.00	Total (sum of lines 1 thru 33) (2)	105, 585		42, 170	339, 138	0	34.00
35.00	Total cost to be allocated	17, 966			125, 376	0	35. 00
36.00	Unit Cost Multiplier (see instructions)	0. 170157	0. 000000	6. 259118	0. 369690	0.000000	36. 00

MEDICAL RECORDS & SERVICE   CIIME SPENT)   CENTRAL STERILIZATION (TIME SPENT)   CIME SPENT   CIME SPENT)   CIME SPENT   CIME						5/27/2016 1:5	3 pm
MEDICAL RECORDS & LIBRARY (GROSS REVENUE)   16.00   17.00   18.00   18.01   19.00   1.00					Hospi ce I		
MEDICAL RECORDS & LIBRARY (GROSS REVENUE)   16.00   17.00   18.00   18.01   19.00   1.00	·			OTHER GENE	RAL SERVICE		
RECORDS & LIBRARY (GROSS REVENUE)   18.00   18.01   19.00   1.0							
RECORDS & LIBRARY (GROSS REVENUE)   18.00   18.01   19.00   1.0	Cost Center Description	MEDICAL	SOCI AI	(SPECLEV)	CENTRAL	NONPHYSICIAN	
LIBRARY (GROSS REVENUE)   CIIME SPENT) (ASSIGNED TIME)   CIIME SPENT) (GROSS REVENUE)   16.00   17.00   18.00   18.01   19.00	cost center bescription						
Care   Care				(ITWL SILNI)			
RÈVENUE   16.00   17.00   18.00   19.00   19.00   1.00			(ITWE SPENT)		(ITWE SPENT)	,	
16.00						IIME)	
1.00       Administrative and General       0       0       0       0       0       1.00         2.00       Inpatient - General Care       0							
2.00     Inpatient - General Care     0		16. 00	17. 00				
3.00       Inpatient - Respite Care       0       0       0       0       0       3.00         4.00       Physician Services       0       0       0       0       0       0       0       4.00         5.00       Nursing Care       0       0       0       0       0       0       0       5.00         6.00       Nursing Care-Continuous Home Care       0	1	0	0	0	0	0	1.00
4.00       Physician Services       0       0       0       0       4.00         5.00       Nursing Care       0       0       0       0       0       5.00         6.00       Nursing Care-Continuous Home Care       0 <t< td=""><td>2.00   Inpatient - General Care</td><td>0</td><td>0</td><td>0</td><td>0</td><td>0</td><td>2.00</td></t<>	2.00   Inpatient - General Care	0	0	0	0	0	2.00
5.00         Nursing Care         0         0         0         0         0         5.00           6.00         Nursing Care-Continuous Home Care         0         0         0         0         0         0         0         0         6.00           7.00         Physical Therapy         0         0         0         0         0         0         0         7.00           8.00         Occupational Therapy         0         0         0         0         0         8.00           9.00         Speech/ Language Pathology         0         0         0         0         0         9.00	3.00 Inpatient - Respite Care	0	0	0	0	0	3.00
5.00         Nursing Care         0         0         0         0         0         5.00           6.00         Nursing Care-Continuous Home Care         0         0         0         0         0         0         0         0         6.00           7.00         Physical Therapy         0         0         0         0         0         0         0         7.00           8.00         Occupational Therapy         0         0         0         0         0         8.00           9.00         Speech/ Language Pathology         0         0         0         0         0         9.00	4.00 Physician Services	o	0	0	0	0	4.00
6.00 Nursing Care-Continuous Home Care 0 0 0 0 0 0 0 6.00 7.00 Physical Therapy 0 0 0 0 0 0 0 7.00 8.00 Occupational Therapy 0 0 0 0 0 0 0 8.00 9.00 Speech/ Language Pathology 0 0 0 0 0 0 0 9.00		0	0	0	0	0	5.00
7.00   Physical Therapy		0	0	0	0	0	•
8.00 Occupational Therapy 0 0 0 0 0 8.00 9.00 Speech/ Language Pathology 0 0 0 0 0 9.00		0	0	ĺ	n		•
9.00   Speech/ Language Pathology   0   0   0   0   9.00		0	0		0		1
		0	0	0	-	_	
		0	0	0	0	_	•
		U	0	0	0	_	
11.00   Spiritual Counseling   0   0   0   11.00		0	0	0	· ·	_	
12.00 Dietary Counseling 0 0 0 0 12.00		0	0	Ĭ	-	_	
13.00   Counseling - Other   0   0   0   0   13.00	13.00   Counseling - Other	0	0	0	0	0	13.00
14.00   Home Health Aide and Homemaker 0 0 0 0 0 14.00	14.00 Home Health Aide and Homemaker	0	0	0	0	0	14.00
15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0 0 15.00	15.00 HH Aide & Homemaker - Cont. Home Care	0	0	0	0	0	15.00
16.00 Other 0 0 0 0 16.00	16.00 Other	0	0	0	0	0	16.00
17.00 Drugs, Biological and Infusion Therapy 0 0 0 0 0 17.00	17 00 Drugs Biological and Infusion Therapy	0	0	0	0	0	17 00
18.00 Anal gesi cs 0 0 0 0 0 18.00		0	0	0	0		
19. 00   Sedatives / Hypnotics   0   0   0   19. 00	3 4 4	0	0	١	0	-	
20. 00   Other - Specify   0   0   0   0   20. 00		0	0	Ĭ	-	-	
		0	0	0			
		0	U	0	-		
22.00 Patient Transportation 0 0 0 0 0 22.00		0	0	0	-	-	
23.00   Imagi ng Servi ces   0 0 0 0 0 23.00		0	0	0			
24.00 Labs and Diagnostics 0 0 0 0 0 24.00		0	0	_	-		
25. 00   Medical Supplies   0   0   0   0   25. 00		0	0	0	0	0	25. 00
26.00   Outpatient Services (including E/R Dept.)   0   0   0   0   26.00	26.00 Outpatient Services (including E/R Dept.)	0	0	0	0	0	26.00
27.00 Radiation Therapy 0 0 0 0 0 27.00	27.00 Radiation Therapy	0	0	0	0	0	27.00
28. 00 Chemotherapy 0 0 0 0 28. 00	28.00 Chemotherapy	o	0	0	0	l 0 <sup>1</sup>	28. 00
29.00 Other 0 0 0 0 0 29.00		0	0	0	0		1
30.00 Bereavement Program Costs 0 0 0 0 0 0 30.00	1	0	0	ĺ	n	_	
31. 00   Vol unteer   Program Costs   0   0   0   31. 00		0 0	0		0		
32. 00   Fundrai si ng		0	0				1
		0	0			_	
33. 00 Other Program Costs 0 0 0 0 33. 00		0	0	0	0		•
34.00 Total (sum of lines 1 thru 33) (2) 0 0 0 0 0 34.00	1 ' ' ' '	0	0	0	0	_	
35.00 Total cost to be allocated 0 0 0 0 0 35.00		0	0	0 0	0	-	1
36.00   Unit Cost Multiplier (see instructions)   0.000000  0.000000  0.000000  0.000000  0.000000  36.00	36.00  Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0. 000000	0.000000	0. 000000	36.00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITA	AL In	Lieu of Form CMS-2552-10
ALLOCATION OF GENERAL SERVICE COSTS TO STATISTICAL BASIS	HOSPI CE COST CENTERS Provi de	r CCN: 150051   Period: From 01/01/2	Worksheet K-5 015 Part II
	Hospi ce	CCN: 151509 To 12/31/2	015 Date/Time Prepared:

			Hospi	ce con:	151509 10	0 12/31/2015	5/27/2016 1:5	pared: 3 pm
						Hospi ce I	0. 0	
			INTERN	S & RES	SI DENTS			
	Cost Center Description	NURSI NG	SERVI CES-S	ALA SEF	RVI CES-OTHE	PARAMED ED		
	occi contor boson per on	SCHOOL	RY & FRING			PRGM-PHARMACY		
		(ASSI GNED	(ASSI GNE		(ASSI GNED	RESI DENCY		
		TIME)	TIME)		TIME)	(COSTED		
		I I WL	1111112)		11 WL)	REQUIS.)		
		20. 00	21. 00		22. 00	23. 00		
1. 00	Administrative and General	20.00		0	22.00	23.00		1. 00
2. 00	Inpatient - General Care	0	ŀ	0	0	0		2.00
3. 00	Inpatient - Respite Care	0			0	0		3.00
4. 00	Physician Services	0			0	0		4.00
5. 00		0		0	0	0		5.00
	Nursing Care	0		O O	0	٦		
6.00	Nursing Care-Continuous Home Care	0		0	0	0		6.00
7. 00	Physi cal Therapy	0		O]	0	0		7. 00
8. 00	Occupational Therapy	0		0	0	0		8.00
9. 00	Speech/ Language Pathology	0	l	0	0	0		9. 00
10. 00	Medical Social Services	0		O	0	0		10.00
11. 00	Spiritual Counseling	0		0	0	0		11.00
12.00	Dietary Counseling	0	l	0	0	0		12.00
13.00	Counseling - Other	0		0	0	0		13.00
14. 00	Home Health Aide and Homemaker	0		0	0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		0	0	0		15.00
16.00	Other	0		0	0	0		16.00
17.00	Drugs, Biological and Infusion Therapy	0		0	0	0		17.00
18. 00	Anal gesi cs	0		0	0	0		18.00
19.00	Sedatives / Hypnotics	0		0	0	0		19.00
20.00	Other - Specify	0		0	0	0		20.00
21.00	Durable Medical Equipment/Oxygen	0		o	0	O		21.00
22.00	Patient Transportation	0		o	0	o		22.00
23. 00	I maging Services	0		o	0	0		23.00
24.00	Labs and Diagnostics	0		0	0	0		24.00
25. 00	Medical Supplies	0		o	0	0		25. 00
26. 00	Outpatient Services (including E/R Dept.)	0		0	0	0		26. 00
27. 00	Radi ati on Therapy	0		0	0	0		27. 00
28. 00	Chemotherapy	0		0	0	0		28.00
29. 00	Other	0			0	0		29.00
30.00	Bereavement Program Costs	0			0	0		30.00
30.00	Volunteer Program Costs				0	0		30.00
					0	0		
32.00	Fundrai si ng	0		O O	0	0		32.00
33.00	Other Program Costs	0		U	0	0		33.00
34.00	Total (sum of lines 1 thru 33) (2)	0		U	0	0		34.00
35. 00	Total cost to be allocated	0		U	0	0		35.00
36. 00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000	0000	0. 000000	0. 000000		36.00

Heal th	Financial Systems	IU HEALTH BLOOMINGTO	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	TATION OF TOTAL HOSPICE SHARED COSTS		Provi der		Peri od:	Worksheet K-5	
			Hospice (		From 01/01/2015 To 12/31/2015		nanad.
			ноѕргсе с	CN: 151509	10 12/31/2015	5/27/2016 1:5	pareu: 3 nm
					Hospi ce I	0,2,,,20,0,,,,0	<u>o p</u>
	Cost Center Description	Wkst	. C, Part	Cost to	Total Hospice	Hospi ce	
		1,	col . 11	Charge Ratio	Charges	Shared	
			line		(Provi der	Ancillary	
					Records)	Costs (cols.	
						1 x 2)	
	T		0	1. 00	2. 00	3. 00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY		66. 00			0	1.00
2.00	OCCUPATI ONAL THERAPY		67.00	0. 00000	0 0	0	2.00
3.00	SPEECH PATHOLOGY		68. 00		0 0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS		73.00		7 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00	0. 00000	0 0	0	5.00
6.00	LABORATORY		60.00	0. 11172	.9 0	0	6.00
6. 01	BLOOD LABORATORY		60. 01	0. 00000	0 0	0	6. 01
6. 02	PHYSI CI AN LABORATORY		60. 02	0. 00000	0 0	0	6. 02
7.00	MEDICAL SUPPLIES CHARGED TO PATIENTS		71.00		3 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00				8. 00
9.00	RADI OLOGY-THERAPEUTI C		55.00	0. 10144	.4 0	0	9. 00
10.00	OTHER ANCILLARY SERVICE COST CENTERS		76.00			ļ	10.00
10. 97	CARDI AC REHABI LI TATI ON		76. 97	0. 51235	9 0	0	10. 97
11. 00	Totals (sum of lines 1-10)					0	11.00

Heal th	Financial Systems IU HEALTH BLOOMI	NGTON HOSPITAL	=	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF HOSPICE PER DIEM COST	Provi der	CCN: 150051	Peri od:	Worksheet K-6	
		Hospi ce	CCN: 151509	From 01/01/2015 To 12/31/2015		
				Hospi ce I		
		Title XVIII	Title XIX	Other	Total	
		1.00	2.00	3. 00	4. 00	
1.00	Total cost (see instructions)				6, 909, 696	1.00
2.00	Total Unduplicated Days (Worksheet S-9, column 6, line 5)				28, 685	2.00
3.00	Average cost per diem (line 1 divided by line 2)				240. 88	3.00
4. 00	Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	28, 685				4. 00
5.00	Aggregate Medicare cost (line 3 time line 4)	6, 909, 643	:			5.00
6. 00	Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)			0		6. 00
7.00	Aggregate Medicaid cost (line 3 time line 60)			0		7.00
8.00	Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	(				8. 00
9.00	Aggregate SNF cost (line 3 time line 8)	(				9. 00
10.00	Unduplicated NF Days (Worksheet S-9, column 4, line 5)			0		10.00
11.00	Aggregate NF cost (line 3 times line 10)			0		11.00
12.00	Other Unduplicated days (Worksheet S-9, column 5, line 5)			0		12.00
13. 00	Aggregate cost for other days (line 3 times line 12)		1	0		13.00

Heal th	Financial Systems IU HEALTH BLOOMINGTO	ON HOSPITAL	In Lie	u of Form CMS-:	2552-10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 150051	Peri od: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III	pared:
		Title XVIII	Hospi tal	PPS	э рііі
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
4 00	CAPITAL FEDERAL AMOUNT			0.000.047	4 00
1. 00 1. 01	Capital DRG other than outlier Model 4 BPCI Capital DRG other than outlier			3, 233, 216 0	1
2. 00	Capital DRG outlier payments		244, 251	2.00	
2. 00	Model 4 BPCI Capital DRG outlier payments			244, 231	1
3.00	Total inpatient days divided by number of days in the cost rep	orting period (see ins	tructions)	135. 57	
4.00	Number of interns & residents (see instructions)	3   1   (1   1	,	0. 00	4.00
5.00	Indirect medical education percentage (see instructions)			0. 00	5.00
6.00	Indirect medical education adjustment (multiply line 5 by the	sum of lines 1 and 1.0	1, columns 1 and	0	6.00
	1.01)(see instructions)				
7. 00	Percentage of SSI recipient patient days to Medicare Part A pa	tient days (Worksheet	E, part A line	5. 59	7. 00
8. 00	30) (see instructions) Percentage of Medicaid patient days to total days (see instruc	tions)		23. 33	8.00
9. 00	Sum of lines 7 and 8	ti ons)		28. 92	
10.00	Allowable disproportionate share percentage (see instructions)			6. 04	
11. 00	Disproportionate share adjustment (see instructions)			195, 286	
12. 00	1 ' '		3, 672, 753		
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST			1.00	
1.00	Program inpatient routine capital cost (see instructions)			0	1.00
2.00	Program inpatient ancillary capital cost (see instructions)			0	
3.00	Total inpatient program capital cost (line 1 plus line 2)			0	
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1. 00	Program inpatient capital costs (see instructions)			0	
2.00	Program inpatient capital costs for extraordinary circumstance	s (see instructions)		0	
3. 00 4. 00	Net program inpatient capital costs (line 1 minus line 2) Applicable exception percentage (see instructions)			0 0. 00	
5. 00	Capital cost for comparison to payments (line 3 x line 4)			0.00	
6. 00	Percentage adjustment for extraordinary circumstances (see ins	tructions)		0.00	
7. 00	Adjustment to capital minimum payment level for extraordinary		x line 6)	0.00	1
8.00	Capital minimum payment level (line 5 plus line 7)		,	0	8.00
9.00	Current year capital payments (from Part I, line 12, as applic	abl e)		0	9.00
10.00	Current year comparison of capital minimum payment level to ca	pital payments (line 8	less line 9)	0	10.00
11. 00	Carryover of accumulated capital minimum payment level over ca Worksheet L, Part III, line 14)	pital payment (from pr	ior year	0	11.00
12. 00	Net comparison of capital minimum payment level to capital pay	ments (line 10 plus li	ne 11)	0	12.00
13. 00	Current year exception payment (if line 12 is positive, enter			0	
14. 00	Carryover of accumulated capital minimum payment level over ca			0	14.00
15. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (see inst	0	15. 00		
16. 00	, , , , , , , , , , , , , , , , , , , ,	1 40 (1 0113)		0	
	Current year exception offset amount (see instructions)			_	17. 00
	1 3 11 11 11 11 11 11 11 11 11 11 11 11		ļ		