This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 03-31-2022 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0051 Worksheet S Peri od: From 01/01/2019 Parts I-III AND SETTLEMENT SUMMARY 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically prepared cost report Date: 6/29/2020 8:56 am Manually prepared cost report use only

Contractor use only

] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low.

(3) Settled with Audit

(4) Reopened (5) Amended

[1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. [8] 13. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 18. Contractor's Vendor Code:
[18] 19. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[1

number of times reopened = 0-9.

## PART II - CERTIFICATION

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 CHIEF FINANCIAL 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 (15-0051) for the cost reporting period beginning 01/01/2019 and ending 12/31/2019 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.

[ X ]I have read and agree with the above certification statement. I certify that I intend my electronic signature on this certification statement to be the legally binding equivalent of my original signature.

MI CHAEL CRAIG (Si gned)

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

(Dated when report is electronically signed.)

Date

			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	-182, 868	141, 000	0	0	1. 00
2.00	Subprovider - IPF	0	0	0		0	2. 00
3.00	Subprovider - IRF	0	14, 587	-1		0	3. 00
4.00	SUBPROVI DER I						4. 00
5.00	Swing Bed - SNF	0	0	0		0	5. 00
6.00	Swing Bed - NF	0				0	6.00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
200.00	Total	0	-168, 281	140, 999	0	0	200. 00
TL I		Albert Country Country of				!!!	

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.

	1. 00	2.	00	3. 00	
Inpatient PPS Information					
22.00 Does this facility qualify and is it currently receiving payments for	Y	1	V		22. 00
disproportionate share hospital adjustment, in accordance with 42 CFR					
§412.106? In column 1, enter "Y" for yes or "N" for no. Is this					
facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment					
hospital?) In column 2, enter "Y" for yes or "N" for no.					
22.01 Did this hospital receive interim uncompensated care payments for this	Y	,	Y		22. 01
cost reporting 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 cos	t				
reporting period occurring on or after October 1. (see instructions)					
22.02 Is this a newly merged hospital that requires final uncompensated care	N		V		22. 02
payments to be 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	5				
or "N" for no, for the portion of the cost reporting period on or after					
October 1.					
22.03 Did this hospital receive a geographic reclassification from urban to	N	1	V	N	22. 03
rural as a result of the OMB standards for delineating statistical areas	5				
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	_	3 1	V		23. 00
below? In column 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 cos	t				
reporting period different from the method used in the prior cost					
reporting period? In column 2, enter "Y" for yes or "N" for no.	1015			1 0	
In-State   In-State		Out-of	Medi cai d	0ther	
Medi cai d   Medi cai		State	HMO days	Medi cai d	
naid days   eligibl	e   Medicaid	Medicaid		dave	

		I III-State	l III-State	001-01	001-01	wedi cai u	l other l	
		Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
		paid days	eligible	Medi cai d	Medi cai d		days	
			unpai d	paid days	eligible			
			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	2, 621	666	2	58	11, 957	50	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.							

instructions)

			1.00					
ACA Provisions Affecting the Health Resources and Services Administration	(HRSA)							
62.00 Enter the number of FTE residents that your hospital trained in this cost	reporting peri	od for which	0.00	62.00				
your hospital received HRSA PCRE funding (see instructions)								
62.01 Enter the number of FTE residents that rotated from a Teaching Health Cen	ter (THC) into	your hospital	0.00	62. 01				
during in this cost reporting period of HRSA THC program. (see instruction	ns)							
Teaching Hospitals that Claim Residents in Nonprovider Settings	Teaching Hospitals that Claim Residents in Nonprovider Settings							
o3.00 Has your facility trained residents in nonprovider settings during this cost reporting period? Enter N 6								
"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through	"Y" for yes or "N" for no in column 1. If yes, complete lines 64 through 67. (see instructions)							
	Unwei ghted	Unwei ghted	Ratio (col. 1/					
	FTEs	FTEs in	(col. 1 + col.					
	Nonprovi der	Hospi tal	2))					
	Si te							
	1. 00	2. 00	3.00					
Section 5504 of the ACA Base Year FTE Residents in Nonprovider Settings	This base year	is your cost i	reporting					
period that begins on or after July 1, 2009 and before June 30, 2010.								
64.00 Enter in column 1, if line 63 is yes, or your facility trained residents	0.00	0. 00	0. 000000	64.00				
in the base year period, the number of unweighted non-primary care								
resident FTEs attributable to rotations occurring in all nonprovider								
settings. Enter in column 2 the number of unweighted non-primary care								
resident FTEs that trained in your hospital. Enter in column 3 the ratio								
of (column 1 divided by (column 1 + column 2)). (see instructions)								

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0051 Peri od: Worksheet S-2 From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 8:56 am Program Name Program Code Unwei ghted Unwei ghted Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 65.00 Enter in column 1, if line 63 is yes, or your facility 0.000000 65.00 0. 00 0. 00 trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ahted Unwei ghted Ratio (col. 3/ Program Code FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 is yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 is yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

CFR Section §412.113(c). Enter "Y" for yes or "N" for no.					
	Physi cal	Occupati onal	Speech	Respi ratory	
	1.00	2.00	3. 00	4.00	
109.00 If this hospital qualifies as a CAH or a cost provider, are					109. 00
therapy services provided by outside supplier? Enter "Y"					
for yes or "N" for no for each therapy.					
				1.00	

110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes, complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 215, as applicable.

date in column 1 and termination date, if applicable, in column 2. 131.00 If this is a Medicare certified intestinal transplant center, enter the certification 131.00 date in column 1 and termination date, if applicable, in column 2. 132.00 f this is a Medicare certified islet transplant center, enter the certification date 132. 00 in column 1 and termination date, if applicable, in column 2. 133.00 Removed and reserved 133.00 134.00 If this is an organ procurement organization (0P0), enter the 0P0 number 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 defined in CMS Pub. 15-1, 15H059 140.00 chapter 10? Enter "Y" for yes or "N" for no in column 1. If yes, and home office costs are claimed, enter in column 2 the home office chain number. (see instructions)

Health Financial Systems	IU HEALTH BLOO	OMINGTON HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provider CC	CN: 15-0051		/01/2019 2/31/2019	Worksheet S- Part I Date/Time Pr 6/29/2020 8:	epared:
1.00		2. 00			3. 00		JO alli
If this facility is part of a chai	n organization, enter o	on lines 141 thro	ugh 143 the	name and	address	of the	
home office and enter the home off					1 0046	\ <u></u>	
141.00 Name: INDIANA UNIVERSITY HEALTH   142.00 Street: 340 W. 10TH STREET	NC Contractor's Name: PO Box:	WPS	Contrac	tor's Nun	nber: 0810	) [	141. 00 142. 00
143.00 City: INDIANAPOLIS	State:	IN	Zi p Code	۵٠	4620	02-3082	142.00
143. GOJOT CY. TINDI ANA GETS	State.	114	ZIP COU	<u>.                                    </u>	7020	3002	143.00
						1.00	
144.00 Are provider based physicians' cos	sts included in Workshee	et A?				Υ	144. 00
					1 00	0.00	
145.00 If costs for renal services are cl	aimed on Wkst A line	7/ are the costs	for		1. 00 Y	2. 00	145. 00
inpatient services only? Enter "Y" no, does the dialysis facility inc period? Enter "Y" for yes or "N"  146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in yes, enter the approval date (mm/c	for yes or "N" for no clude Medicare utilizati for no in column 2. By changed from the prev n column 1. (See CMS Pub	in column 1. If on for this cost	column 1 is reporting t report?	f	N		146. 00
						1.00	
147.00 Was there a change in the statisti						N	147. 00
148.00 Was there a change in the order of 149.00 Was there a change to the simplifi				r no		N N	148. 00 149. 00
147. 00 was there a change to the simpiffi	ed cost finding method:	Part A	Part B		tle V	Title XIX	147.00
		1.00	2.00		3. 00	4.00	
Does this facility contain a provi	der that qualifies for	an exemption from	m the applic	ation of	the lowe	er of costs	
or charges? Enter "Y" for yes or '	'N" for no for each comp			(See 42			4
155. 00 Hospi tal 156. 00 Subprovi der - TPF		N N	N N		N N	N N	155. 00 156. 00
157. 00 Subprovider - TRF		N N	N N		N	N N	157. 00
158. OO SUBPROVI DER		14	"		14	14	158. 00
159. 00 SNF		N	N		N	N	159. 00
160.00 HOME HEALTH AGENCY		N	N		N	N	160. 00
161. 00 CMHC			N N		N	N	161. 00
						1.00	$\dashv$
Multicampus						1.00	
165.00 Is this hospital part of a Multica	mpus hospital that has	one or more campu	uses in diff	erent CBS	SAs?	N	T165. 00
Enter "Y" for yes or "N" for no.	Nome	County	Ctata 7	in Codo	CDCA	FTF /Compus	
	Name 0	County 1.00	2. 00	i p Code 3.00	CBSA 4. 00	FTE/Campus 5.00	-
166.00 If line 165 is yes, for each	0	1.00	2.00	3.00	4.00		0 166. 00
campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)							
						1.00	+
Health Information Technology (HI	() incentive in the Amer	rican Recovery and	d Reinvestme	ent Act		1.00	
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10 reasonable cost incurred for the h	05 is "Y") and is a mear	ningful user (line		), enter	the	Y	167. 00 168. 00
168.01 If this provider is a CAH and is r exception under §413.70(a)(6)(ii)? 169.00 If this provider is a meaningful u	not a meaningful user, c P Enter "Y" for yes or "	loes this provider N" for no. (see i	nstructions	)	•		168. 01 19169. 00
transition factor. (see instruction		inu is not a CAH (	(1116 100 15	iv ), er	itei tile	9.9	7 107.00
, , , , , , , , , , , , , , , , , , , ,	•			Beg	ji nni ng	Endi ng	
					1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR begins period respectively (mm/dd/yyyy)	peginning date and endir	ng date for the re	eporting				170. 00
					1 00	2.00	
171 00 If line 167 is "V" does this pro-	vider have any days for	individuals oppol	ledin		1. 00 Y	2.00	4 171. 00
171.00 If line 167 is "Y", does this proving section 1876 Medicare cost plans refer yes and "N" for no in column 1876 Medicare days in column 2. (s	reported on Wkst. S-3, F umn 1. If column 1 is ye	t. I, line 2, col	. 6? Enter	on	ī	1, 19	4171.00

			1.00	2.00	3.00	
. 00	Has the provider terminated participation in the Medicare F yes, enter in column 2 the date of termination and in colum		N			2. 0
. 00	voluntary or "I" for involuntary. Is the provider involved in business transactions, including		Y			3. 0
	contracts, with individuals or entities (e.g., chain home of					
	or medical supply companies) that are related to the provious officers, medical staff, management personnel, or members of					
	of directors through ownership, control, or family and other					
	relationships? (see instructions)		)/ (h)	_		
			Y/N 1.00	Type 2. 00	3.00	
	Financial Data and Reports		1.00	2.00	0.00	
. 00	Column 1: Were the financial statements prepared by a Cert		Y	А	03/20/2020	4.0
	Accountant? Column 2: If yes, enter "A" for Audited, "C" or "R" for Reviewed. Submit complete copy or enter date ava					
	column 3. (see instructions) If no, see instructions.	arrabre in				
. 00	Are the cost report total expenses and total revenues diffe		N			5. 0
	those on the filed financial statements? If yes, submit red	conciliation.		Y/N	Legal Oper.	
				1.00	2. 00	
	Approved Educational Activities					
00	Column 1: Are costs claimed for nursing school? Column 2:	If yes, is th	e provider is	N		6.0
00	the legal operator of the program?  Are costs claimed for Allied Health Programs? If "Y" see in	netructions		Υ		7.0
00	Were nursing school and/or allied health programs approved	Ň		8.0		
	cost reporting period? If yes, see instructions.		Ü			
00	Are costs claimed for Interns and Residents in an approved		al education	N		9. 0
0. 00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of		he current	N		10.0
5. 00	cost reporting period? If yes, see instructions.	or renewed in t	ne cui rent			10.0
1. 00	Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11.0
	Teaching Program on Worksheet A? If yes, see instructions.				Y/N	
					1.00	
	Bad Debts					
	Is the provider seeking reimbursement for bad debts? If yes				Y	12.0
3. 00	If line 12 is yes, did the provider's bad debt collection period? If yes, submit copy.	porrey change o	luring this cos	t reporting	N	13. 0
4. 00	1.	ents waived? If	yes, see inst	ructi ons.	N	14. 0
	Bed Complement					
5. 00	Did total beds available change from the prior cost reporti		-		l N rt B	15. 0
		Y/N	t A Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data		1		T	
5. 00	Was the cost report prepared using the PS&R Report only?	N		N		16. 0
b. 00		N		N		16. 0
5. 00	Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R Report used in columns 2 and 4 .(see instructions)	N		N		16. 0
	Was the cost report prepared using the PS&R 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) Was the cost report prepared using the PS&R Report for	N Y	04/01/2020	N Y	04/01/2020	
	Was the cost report prepared using the PS&R 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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If		04/01/2020		04/01/2020	
	Was the cost report prepared using the PS&R 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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date		04/01/2020		04/01/2020	
7. 00	Was the cost report prepared using the PS&R 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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If		04/01/2020		04/01/2020	17. 0
7. 00	Was the cost report prepared using the PS&R 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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed	Υ	04/01/2020	Y	04/01/2020	17.0
7. 00	Was the cost report prepared using the PS&R 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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Υ	04/01/2020	Y	04/01/2020	17.0
7. 00 3. 00	Was the cost report prepared using the PS&R 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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	Y N	04/01/2020	Y N	04/01/2020	17. 0
	Was the cost report prepared using the PS&R 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) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this	Υ	04/01/2020	Y	04/01/2020	16. 00 17. 00 18. 00

	Financial Systems IU HEALTH BLOOMII TAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0051	Period: From 01/01/2019	Worksheet S				
				To 12/31/2019	Date/Time P 6/29/2020 8				
		Descr	i pti on	Y/N	Y/N				
			0	1.00	3. 00				
20. 00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20.00			
		Y/N	Date	Y/N	Date				
		1.00	2.00	3. 00	4. 00				
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00			
					1. 00				
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PT CHILDRENS I	HOSPI TALS)						
22. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions				22.00			
23. 00									
24. 00	Were new leases and/or amendments to existing leases entere	ed into during	this cost re	porting period?		24. 00			
25. 00	If yes, see instructions Have there been new capitalized leases entered into during	the cost repor	rting period?	If yes, see		25. 00			
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period? I	f yes, see		26. 00			
27. 00	instructions. Has the provider's capitalization policy changed during the	e cost reporti	ng period? If	yes, submit		27. 00			
	copy. Interest Expense								
28. 00	Were new Loans, mortgage agreements or Letters of credit en period? If yes, see instructions.	ntered into du	ing the cost	reporti ng		28. 00			
29. 00									
30. 00	00 Has existing debt been replaced prior to its scheduled maturity with new debt? If yes, see								
31. 00	instructions.  Has debt been recalled before scheduled maturity without issuance of new debt? If yes, see instructions.								
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser		ed through co	ntractual		32.00			
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If		33. 00			
	Provi der-Based Physi ci ans								
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rrangement with	n provi der-ba	sed physicians?		34.00			
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		nts with the	provi der-based		35. 00			
				Y/N	Date				
	Home Office Costs			1. 00	2. 00				
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 pr	repared by the	home office?	'		37. 00			
38. 00	If yes, see instructions.  If line 36 is yes, was the fiscal year end of the home off			,		38. 00			
39. 00	the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe			i,		39. 00			
40. 00	see instructions.  If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00			
		1	00	2	00				
	Cost Report Preparer Contact Information			Ζ.					
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA UTTER				41.00			
	respecti vel y.	l							
42. 00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVEF	RSITY HEALTH			42.00			

Heal th	Financial Systems IU HEALTH	H BLOOMI	NGTON HOSPITAL	In Lie	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNA	Provi der CCN:	Period: From 01/01/2019	Worksheet S-2 Part II				
				To 12/31/2019		pared: 6 am		
			3. 00					
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the title/posit	i on	DI RECTOR			41. 00		
	held by the cost report preparer in columns 1, 2, a	nd 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 of the	cost				43.00		
	report preparer in columns 1 and 2, respectively.							

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA Provider CO Provider CCN: 15-0051

					To	12/31/2019	Date/Time Prep 6/29/2020 8:50	
							I/P Days / 0/P	J alli
							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		214	78, 110	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			214	78, 110	0.00	0	7.00
	beds) (see instructions)							
8.00	INTENSIVE CARE UNIT	31. 00		16	5, 840	0.00	0	8.00
9.00	CORONARY CARE UNIT	32. 00		14	5, 110	0.00	0	9.00
10.00	BURN INTENSIVE CARE UNIT							10.00
11. 00	SURGICAL INTENSIVE CARE UNIT							11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 00		18	6, 570	0.00	0	12.00
13.00	NURSERY	43. 00					0	13.00
14.00	Total (see instructions)			262	95, 630	0.00	0	14.00
15.00	CAH visits						0	15.00
16.00	SUBPROVI DER - I PF							16.00
17.00	SUBPROVI DER - I RF	41. 00		16	5, 840		0	17.00
18. 00	SUBPROVI DER	42. 00		0	0		0	18.00
19. 00	SKILLED NURSING FACILITY							19.00
20.00	NURSING FACILITY							20.00
21.00	OTHER LONG TERM CARE							21.00
22. 00	HOME HEALTH AGENCY	101. 00					0	22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00						23.00
24.00	HOSPI CE	116. 00		0	0			24.00
24. 10	HOSPICE (non-distinct part)	30. 00						24. 10
25. 00	CMHC - CMHC							25.00
26.00	RURAL HEALTH CLINIC							26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00					0	26. 25
27. 00	Total (sum of lines 14-26)			278				27.00
28. 00	Observation Bed Days						0	28. 00
29. 00	Ambul ance Tri ps							29. 00
30.00	Employee discount days (see instruction)							30.00
31.00	Employee discount days - IRF							31.00
32.00	Labor & delivery days (see instructions)			12	4, 380			32.00
32. 01	Total ancillary labor & delivery room							32. 01
	outpatient days (see instructions)							
33. 00	LTCH non-covered days							33.00
33. 01	LTCH site neutral days and discharges							33. 01

Peri od: Worksheet S-3
From 01/01/2019 Part I
To 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am

		I/P Days	s / O/P Visits .	/ Trips	Full Time E	o alli	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On	
		6. 00	7. 00	8.00	9. 00	Payrol I 10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	16, 995	1, 212	43, 602		10.00	1. 00
1.00	8 exclude Swing Bed, Observation Bed and	10, 770	1,212	10, 002			1.00
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	6, 931	11, 447				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	403	305				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	16, 995	1, 212	43, 602			7. 00
0.00	beds) (see instructions)	4 404	047	0.700			0.00
8.00	INTENSIVE CARE UNIT	1, 431	917	3, 798			8. 00
9.00	CORONARY CARE UNIT	2, 528	O	3, 605			9. 00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT		283	3, 139			11. 00 12. 00
12. 00 13. 00	NEONATAL INTENSIVE CARE UNIT NURSERY	0	1, 445	3, 139			13. 00
14. 00	Total (see instructions)	20, 954	3, 857	3, 025 57, 169		1, 739. 95	14. 00
15. 00	CAH visits	20, 954	3, 637	37, 109	0.00	1, 739. 93	15. 00
16. 00	SUBPROVIDER - IPF	o o	o l	Ü			16. 00
17. 00	SUBPROVI DER - I RF	1, 789	61	3, 083	0.00	0. 00	
18. 00	SUBPROVI DER	1, 707	01	3, 009 0	0.00		
19. 00	SKILLED NURSING FACILITY		Ĭ	O	0.00	0.00	19. 00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	o	О	0	0.00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)		-		0.00		
24.00	HOSPI CE	o	o	0		0.00	24. 00
24. 10	HOSPICE (non-distinct part)			30			24. 10
25.00	CMHC - CMHC						25. 00
26.00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0.00	26. 25
27.00	Total (sum of lines 14-26)				0.00	1, 739. 95	27. 00
28. 00	Observation Bed Days		108	4, 420			28. 00
29. 00	Ambul ance Tri ps	8, 057					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	50	1, 416			32. 00
32. 01	Total ancillary labor & delivery room			0			32. 01
22.00	outpatient days (see instructions)						22.00
33.00	LTCH non-covered days						33.00
33. UT	LTCH site neutral days and discharges	ı Y	I				33. 01

 
 Heal th Financial
 Systems
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 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 | Peri od: | Worksheet S-3 | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: Provider CCN: 15-0051

Full Time   Discharges   Full Time   Equivalents   Total All   Patients   Nonpal d Workers   Title V   Title XVIII   Title XIX   Total All   Patients   Title V   Nonpal d Workers   Title V   Title XVIII   Title XIX   Total All   Patients   Title V   Nonpal d Workers   Title V   Title XVIII   Title XIX   Total All   Patients   Title V   Nonpal d Workers   Title V   Title XVIII   Title XIX   Total All   Patients   Title X   Total All   Title X   Total All							12/31/2019	6/29/2020 8: 5	
Nonpaid   Workers   Title V   Title XIII   Title XIX   Patients		·	Full Time	<u> </u>		Di sch	arges		
Norkers			Equi val ents				· ·		
10.00   Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed. Observation Bed and Hospice days) (see instructions)   12.00   13.00   14.00   15.00   12.32   1.00   13.00   14.00   15.00   12.32   1.00   15.00   12.32   1.00   15.00   12.32   1.00   15.00   12.32   1.00   15.00   12.32   1.00		Component	Nonpai d	Title V		Title XVIII	Title XIX	Total All	
1.00   Hospit tal Adult ts & Peds. (columns 5, 6, 7 and 8   8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LIDP room avail able beds)   1, 285   2, 306   2, 00								Pati ents	
8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 2.00 Hospital Adults (see instructions) 3.00 Hill O IPF Subprovider 4.00 Hospital Adults & Peds. Swing Bed SNF 5.00 Hospital Adults & Peds. Swing Bed SNF 7.00 beds (see instructions) 8.00 INTENSIVE CARE UNIT CORONARY CARE UNIT SURE INTENSIVE CARE UNIT SURGICAL CORONARY S			11.00	12.00			14. 00		
Hospice days) (see instructions for col. 2   cfor the portion of LDP room available beds)   2.00   HMO and other (see instructions)   0   3.00   0   4.00   HMO IPF Subprovider   23   4.00   5.00   HMO IPF Subprovider   23   4.00   5.00   HMO IRF Subprovider   23   4.00   5.00   Hospital Adults & Peds. Swing Bed SNF   6.00   6.00   Hospital Adults & Peds. Swing Bed NF   6.00   7.00   6.00	1.00				0	4, 429	407	12, 232	1. 00
For the portion of LDP room available beds)   2.00   3.00   3.00   3.00   4.00   4.01   4.0									
2.00									
3.00   HMO IPF Subprovider									
4.00   HMO IRF Subprovider		1				1, 285	2, 306		
5.00		•			-		0		
6.00 Hospital Adults & Peds. Swing Bed NF 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 8.00 INTENSIVE CARE UNIT 9.00 10.00 BURN INTENSIVE CARE UNIT 11.00 SURGICAL INTENSIVE CARE UNIT 12.00 NEONATA LINTENSIVE CARE UNIT 13.00 NEONATAL INTENSIVE CARE UNIT 14.00 Total (see instructions) 15.00 CAH visits 16.00 SUBPROVIDER - IPF 16.00 SUBPROVIDER - IPF 17.00 SUBPROVIDER - IRF 18.00 SUBPRO		•			-		23		
7.00   Total Adults and Peds. (exclude observation beds) (see instructions)   8.00   NTENSIVE CARE UNIT   9.00   1.00					-				
Deds) (see instructions)   8.00   1					-				
8. 00   INTENSIVE CARE UNIT	7.00	,							7.00
9. 00 COROMARY CARE UNIT 10. 00 BURN INTENSIVE CARE UNIT 11. 00 SURGICAL INTENSIVE CARE UNIT 12. 00 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER - IRF 19. 00 SUBURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 HOME HEALTH AGENCY 21. 00 OFFICE (non-distinct part) 22. 00 HOME - ENDER CARE 24. 10 HOSPICE (non-distinct part) 25. 00 CAMC - CAMC 26. 26 FEDERALLY OUALIFIED HEALTH CENTER 27. 00 SUBPROVIDER Bed Soon 31. 00 Employee discount days (see instructions) 32. 00 I Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 I Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 I Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 I Total namination and the search of	0.00				1				0.00
10. 00   BURN INTENSIVE CARE UNIT   11. 00   11. 00   11. 00   SURGICAL INTENSIVE CARE UNIT   11. 00   12. 00   13. 00   14. 00   15. 00   CAH visits					ł				
11.00   SURGICAL INTENSIVE CARE UNIT   12.00   NEONATAL INTENSIVE CARE UNIT   12.00   NURSERY   13.00   NURSERY   13.00   NURSERY   14.00   Total (see instructions)   0.00   0   4,429   407   12,232   14.00   15.00   CAH visits   15   16.00   SUBPROVIDER - IPF   0.00   0   129   1   230   17.00   18.00   SUBPROVIDER   17.00   SUBPROVIDER   18.00   SUBPROVIDER   18.00   0   0   0   0   0   0   18.00   19.00   19.00   SKILLED NURSING FACILITY   20.00   NURSING FACILITY   20.00   NURSING FACILITY   21.00   OTHER LONG TERM CARE   22.00   HOME HEALTH AGENCY   22.00   22.00   HOME HEALTH AGENCY   22.00   AMBULATORY SURGICAL CENTER (D.P.)   0.00   24.00   HOSPICE   0.00   24.10   HOSPICE (non-distinct part)   25.00   CMHC - CMHC   25.00   CMHC - CMHC   25.00   CMHC - CMHC   25.00   26.25   FEDERALLY QUALIFIED HEALTH CENTER   0.00   27.00   Total (sum of lines 14-26)   0.00   28.00   Observation Bed Days   29.00   Ambul ance Trips   28.00   29.00   20.00   2		1			ł				
12. 00 NEONATAL INTENSIVE CARE UNIT 13. 00 NURSERY 14. 00 Total (see instructions) 15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 NURSING FACILITY 20. 00 OTHER LONG TERM CARE 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 HOSPICE 24. 10 HOSPICE 24. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambulance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days 30. 00 LTCH non		1			ł				
13. 00   NURSERY		1			ł				
14. 00 Total (see instructions)					ł				
15. 00 CAH visits 16. 00 SUBPROVIDER - IPF 17. 00 SUBPROVIDER - IRF 18. 00 SUBPROVIDER - IRF 19. 00 SUBPROVIDER 19. 00 SUBPROVIDER 19. 00 SKILLED NURSING FACILITY 19. 00 THER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 23. 00 HOME HEALTH AGENCY 24. 00 HOSPICE 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Trips 30. 00 Empl oyee discount days (see instruction) 31. 00 Empl oyee discount days (see instructions) 31. 00 LTCH non-covered days		1	0.00			4 420	407	12 222	
16.00 SUBPROVIDER - IPF			0.00		۷	4, 429	407	12, 232	
17. 00 SUBPROVIDER - IRF					ł				
18. 00   SUBPROVI DER   0. 00   0   18. 00   19.		1	0.00			120	1	220	
19. 00 20. 00 NURSING FACILITY 21. 00 OTHER LONG TERM CARE 22. 00 HOME HEALTH AGENCY 22. 00 AMBULATORY SURGICAL CENTER (D.P.) 23. 00 4. 00 HOSPICE 4. 10 HOSPICE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 27. 00 RURAL HEALTH OUALIFIED HEALTH CENTER 28. 00 Deservation Bed Days 29. 00 Ambul ance Trips 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  19. 00 20. 00 20. 00 21. 00 22. 00 22. 00 23. 00 24. 00 25. 00 26. 00 26. 00 27. 00 28. 00 29. 00 30. 00 31. 00 Employee discount days (see instructions) 31. 00 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 33. 00 LTCH non-covered days		1	l I		- 1	127			
20.00   NURSING FACILITY   20.00   21.00   21.00   22.00   21.00   22.00   40ME HEALTH AGENCY   0.00   22.00   22.00   40MBULATORY SURGICAL CENTER (D.P.)   0.00   22.		1	0.00		۷		٩	U	
21.00 OTHER LONG TERM CARE  22.00 HOME HEALTH AGENCY  23.00 AMBULATORY SURGICAL CENTER (D.P.)  24.00 HOSPICE  24.10 HOSPICE (non-distinct part)  25.00 CMHC - CMHC  26.00 RURAL HEALTH CLINIC  26.25 FEDERALLY QUALIFIED HEALTH CENTER  27.00 Total (sum of lines 14-26)  29.00 Ambulance Trips  30.00 Employee discount days (see instruction)  31.00 Employee discount days (see instructions)  32.01 Total ancillary labor & delivery room outpatient days (see instructions)  33.00 LTCH non-covered days  0.00  0.00  21.00  22.00  22.00  23.00  24.00  24.00  24.00  25.00  26.25  27.00  26.25  27.00  28.00  29.00  29.00  29.00  30.00  29.00  30.00  29.00  30.00  29.00  30.00  29.00  30.00  20.00  30.00		1			ł				
22. 00 HOME HEALTH AGENCY 23. 00 AMBULATORY SURGICAL CENTER (D. P.) 24. 00 HOSPI CE 24. 10 HOSPI CE (non-distinct part) 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 RURAL HEALTH CLINIC 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 27. 00 Total (sum of lines 14-26) 28. 00 Observati on Bed Days 29. 00 Ambul ance Trips 29. 00 Ambul ance Trips 29. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  0. 00 22. 00 23. 00 24. 00 25. 00 26. 00 26. 25 27. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 29. 00 20. 00 20. 00 20. 00 20. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 24. 00 24. 00 24. 00 25. 00 26. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 20.					ł				
23. 00		1	0.00		ł				
24. 00 HOSPICE			l l		ł				
24. 10 25. 00 CMHC - CMHC 26. 00 RURAL HEALTH CLINIC 26. 00 27. 00 Total (sum of lines 14-26) 28. 00 29. 00 Doservation Bed Days 29. 00 Ambulance Trips 29. 00 30. 00 Employee discount days (see instruction) Employee discount days - IRF 31. 00 Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) 31. 00 LTCH non-covered days  24. 10 25. 00 25. 00 26. 00 27. 00 28. 00 29. 00 27. 00 28. 00 27. 00 28. 00 29. 00 30. 00 28. 00 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 33. 00 33. 00		1			ı				
25. 00 26. 00 RURAL HEALTH CLINIC 26. 00 27. 00 Total (sum of lines 14-26) 28. 00 0 Observation Bed Days 29. 00 30. 00 Employee discount days (see instruction) 31. 00 Employee discount days (see instructions) 32. 00 1 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days  25. 00 26. 00 26. 00 27. 00 28. 00 29. 00 27. 00 28. 00 28. 00 29. 00 29. 00 30. 00 29. 00 30. 00 31. 00 31. 00 32. 00 33. 00 32. 01 33. 00 33. 00 33. 00			0.00		İ				
26. 00 26. 25 FEDERALLY QUALIFIED HEALTH CENTER 26. 00 26. 25 Total (sum of lines 14-26) 0. 00 28. 00 Observation Bed Days 29. 00 Ambul ance Trips Employee discount days (see instruction) Employee discount days - IRF 29. 00 29. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 25. 00 26. 00 26. 00 26. 00 27. 00 28. 00 28. 00 29. 00 29. 00 29. 00 29. 00 29. 00 29. 00 20					i				
26. 25 27. 00 Total (sum of lines 14-26) 28. 00 Observation Bed Days 29. 00 Ambul ance Tri ps Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) 32. 00 Total (sum of lines 14-26) 0. 00 28. 00 29. 00 29. 00 29. 00 30. 00 31. 00 Total ancillary labor & delivery room outpatient days (see instructions) 32. 01 Total ancillary labor & delivery room outpatient days (see instructions) 33. 00 LTCH non-covered days		1			ı				
27.00   Total (sum of lines 14-26)   0.00   27.00   28.00   28.00   29		·	0 00		ı				
28.00 Observation Bed Days 29.00 Ambulance Trips 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 31.00 Total ancillary labor & delivery room outpatient days (see instructions) 32.01 LTCH non-covered days 33.00 LTCH non-covered days			l I		ı				
29.00 30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  29.00 30.00 31.00 31.00 32.00 32.01 33.00					İ				
30.00 Employee discount days (see instruction) 31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  30.00 31.00 31.00 31.00 32.00 32.00 32.01		1			İ				
31.00 Employee discount days - IRF 32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  31.00 32.00									
32.00 Labor & delivery days (see instructions) 32.01 Total ancillary labor & delivery room outpatient days (see instructions) 33.00 LTCH non-covered days  32.00 32.01		1			İ				
32.01 Total ancillary labor & delivery room outpatient days (see instructions)  33.00 LTCH non-covered days  32.01									
outpati ent days (see instructions) 33.00 LTCH non-covered days 0 33.00									
33.00 LTCH non-covered days 0 33.00									
	33.00	1 ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' ' '				0			33.00
	33. 01	LTCH site neutral days and discharges			- [	0			33. 01

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared:

S		Wkst. A Line Number	Amount Reported	Reclassificati on of Salaries	Adj usted Sal ari es	Pai d Hours	6/29/2020 8:50 Average Hourly	- Giii
S		Number	Reported	ion of Salariesi				
S				(from Wkst.	(col.2 ± col.	Related to Salaries in	Wage (col. 4 ÷ col. 5)	
S		1.00	2.00	A-6)	3)	col . 4	, 00	
S	PART II - WAGE DATA	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
1.00 1	SALARI ES	202 201	111 101 505		440 540 070		00.54	
	Total salaries (see instructions)	200. 00	111, 131, 595	-618, 723	110, 512, 872	3, 619, 089. 74	30. 54	1. 00
	Non-physician anesthetist Part		0	0	0	0.00	0.00	2. 00
3.00	Non-physician anesthetist Part		0	0	0	0.00	0. 00	3. 00
I .	Physician-Part A - Administrative		396, 750	0	396, 750	6, 678. 75	59. 40	4. 00
4. 01 F 5. 00 F	Physicians - Part A - Teaching Physician and Non		0 1, 558, 226	0	0 1, 558, 226	0. 00 13, 820. 10		
6.00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	O	0	0.00	0. 00	6. 00
7. 00 I	services Interns & residents (in an approved program)	21. 00	0	0	0	0.00	0. 00	7. 00
ı	Contracted interns and residents (in an approved programs)		0	0	0	0.00	0.00	7. 01
8. 00 i	Home office and/or related organization personnel		0	0	0	0.00	0.00	8. 00
9.00	SNF	44. 00	0	0	0	0.00		
Li	Excluded area salaries (see instructions) DTHER WAGES & RELATED COSTS		11, 709, 943	1, 243, 900	12, 953, 843	500, 443. 87	25. 88	10. 00
11. 00	Contract labor: Direct Patient Care		5, 539, 426	0	5, 539, 426	72, 305. 00	76. 61	11. 00
12. 00 (r	Contract labor: Top level management and other management and administrative services		0	o	0	0.00	0. 00	12. 00
13. 00	Contract Labor: Physician-Part A - Administrative		1, 618, 711	0	1, 618, 711	11, 159. 56	145. 05	13. 00
14. 00 H	h - Administrative Home office and/or related organization salaries and wage-related costs		0	o	0	0.00	0. 00	14. 00
14. 01 H	Home office salaries		34, 047, 267	0	34, 047, 267	907, 090. 93		14. 01
	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		14. 02 15. 00
-	- Administrative		O		0			
	Home office and Contract Physicians Part A - Teaching		0	0	0	0. 00	0. 00	16. 00
16. 01 H	Home office Physicians Part A - Teaching		0	0	0	0.00	0.00	16. 01
16. 02 H	Home office contract Physicians Part A - Teaching WAGE-RELATED COSTS		0	0	0	0.00	0.00	16. 02
17. 00 N	Wage-related costs (core) (see		29, 846, 700	0	29, 846, 700			17. 00
18. 00 N	instructions) Wage-related costs (other)							18. 00
19. 00 E	(see instructions) Excluded areas		4, 412, 951	0	4, 412, 951			19. 00
	Non-physician anesthetist Part A		0	0	0			20. 00
1	Non-physician anesthetist Part B		0	0	0			21. 00
	Physician Part A – Administrative		95, 607	0	95, 607			22. 00
	Physician Part A - Teaching Physician Part B		279, 724	0	0 279, 724			22. 01 23. 00
24. 00 N 25. 00 N	Wage-related costs (RHC/FQHC) Interns & residents (in an		279, 724	0	279, 724 0 0			24. 00 25. 00
25. 50 H	approved program) Home office wage-related		12, 925, 923	0	12, 925, 923			25. 50
25. 51 F	(core) Rel ated organi zati on		0	0	0			25. 51
25. 52 H	wage-related (core) Home office: Physician Part A - Administrative - wage-related (core)		0	O	0			25. 52

| Period: | Worksheet S-3 | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared:

					T	o 12/31/2019	Date/Time Pre 6/29/2020 8:5	
		Wkst. A Line	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Number		on of Salaries			Wage (col. 4 ÷	
			.,	(from Wkst.	(col.2 ± col.	Salaries in	col . 5)	
				A-6)	3)	col. 4	,	
		1.00	2.00	3. 00	4. 00	5. 00	6. 00	
25. 53	Home office: Physicians Part A		0	0	0			25. 53
	- Teaching - wage-related							
	(core)	-						
	OVERHEAD COSTS - DIRECT SALARIE							
26. 00	Employee Benefits Department	4. 00	1, 155, 581				•	26. 00
27. 00	Administrative & General	5. 00	6, 624, 654					
28. 00	Administrative & General under		2, 891, 442	0	2, 891, 442	11, 910. 00	242. 77	28. 00
00.00	contract (see inst.)	, 00	•			0.00		00.00
29. 00	Maintenance & Repairs	6. 00	0 005 405	14 044	0 004 404	0.00	•	29. 00
30.00	Operation of Plant	7. 00	2, 095, 495	-11, 311	2, 084, 184		•	
31.00	Laundry & Linen Service	8. 00	1 777 1/5	0 110	1 7(0 04(	0.00		
32. 00	Housekeepi ng	9. 00	1, 777, 165	-8, 119	1, 769, 046	·		32.00
33. 00	Housekeeping under contract		Ü	0	0	0. 00	0.00	33. 00
34. 00	(see instructions) Dietary	10. 00	2, 204, 112	-862, 827	1, 341, 285	75, 617. 37	17 74	34. 00
	1	10.00	2, 204, 112	-002, 027	1, 341, 203	75, 617. 37 0. 00	•	
35. 00	Di etary under contract (see instructions)		Ü	l o	0	0.00	0.00	35.00
36. 00	Cafeteri a	11. 00	0	835, 906	835, 906	53, 617. 34	15 50	36. 00
37. 00	Maintenance of Personnel	12. 00	0	033, 700	033, 700	0.00	1	
38. 00	Nursing Administration	13. 00	6, 646, 441	-105, 502	6, 540, 939			38. 00
39. 00	Central Services and Supply	14. 00	0,010,111	100,002	0,010,707	0.00	1	
40. 00	Pharmacy	15. 00	5, 507, 601	-497, 322	5, 010, 279			
41. 00	Medical Records & Medical	16. 00	0,007,001	177,022	0,010,2,7	0.00	•	
11.00	Records Library	10.00	O		Ĭ	0.00	0.00	11.00
42.00	Social Service	17. 00	0	0	0	0.00	0.00	42. 00
43.00	Other General Service	18. 00	580, 459	-4, 598	575, 861			43.00
	•			•	•		•	

| Peri od: | Worksheet S-3 | From 01/01/2019 | Part III | To 12/31/2019 | Date/Time Prepared: | Constant of the constant of th Provider CCN: 15-0051

					'	0 12/01/2017	6/29/2020 8: 50	
		Worksheet A	Amount	Reclassi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1. 00	2. 00	3. 00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		112, 464, 811	-618, 723	111, 846, 088	3, 617, 179. 64	30. 92	1.00
	instructions)							
2.00	Excluded area salaries (see		11, 709, 943	1, 243, 900	12, 953, 843	500, 443. 87	25. 88	2.00
	instructions)							
3.00	Subtotal salaries (line 1		100, 754, 868	-1, 862, 623	98, 892, 245	3, 116, 735. 77	31. 73	3.00
	minus line 2)							
4.00	Subtotal other wages & related		41, 205, 404	0	41, 205, 404	990, 555. 49	41. 60	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		42, 868, 230	0	42, 868, 230	0.00	43. 35	5. 00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		184, 828, 502	-1, 862, 623	182, 965, 879	4, 107, 291. 26	44. 55	6. 00
7.00	Total overhead cost (see		29, 482, 950	-1, 257, 169	28, 225, 781	812, 423. 49	34. 74	7. 00
	instructions)							

Health Financial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL	In Lieu of Form CMS-2552		
HOSPITAL WAGE RELATED COSTS		Provider CCN: 15-0051	Peri od:	Worksheet S-3	
			From 01/01/2019		
				Part IV	

	To 12/31/2019	Date/Time Prep 6/29/2020 8:50	
		Amount	
		Reported	
		1. 00	
•	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		1
1.00	401K Employer Contributions	4, 071, 938	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)	6, 172, 233	4. 00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
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)	0	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	14, 605, 498	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	485, 416	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	48, 770	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)	755, 332	13. 00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14. 00
15.00	'Workers' Compensation Insurance	615, 983	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		1
	TAXES		1
17.00	FICA-Employers Portion Only	7, 839, 943	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	20, 562	20. 00
	OTHER		
21.00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		1
22. 00	Day Care Cost and Allowances	0	22. 00
23. 00	Tuition Reimbursement	19, 308	23. 00
24.00	Total Wage Related cost (Sum of lines 1 -23)	34, 634, 983	24. 00
	Part B - Other than Core Related Cost		l
25.00	OTHER WAGE RELATED COSTS (SPECIFY)		25. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10		
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0051	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part V Date/Time Prepared: 6/29/2020 8:56 am	

			6/29/2020 8: 5	
	Cost Center Description	Contract Labor	Benefit Cost	
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	5, 539, 426	34, 634, 983	1.00
2.00	Hospi tal	5, 539, 426	34, 634, 983	2.00
3.00	Subprovi der - I PF			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			8. 00
9. 00	Hospi tal -Based NF			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			14.00
15. 00	Hospital-Based Health Clinic FQHC			15.00
16. 00	Hospi tal -Based-CMHC			16.00
17. 00	Renal Dialysis	0	0	17.00
18. 00	Other	0	0	18.00

Heal th	Financial Systems IU HEALTH BLOOMINGTO	N HOSPITAL		In Lie	u of Form CMS-2	2552-10
		Provider CCN: 15		Peri od:	Worksheet S-1	
				From 01/01/2019 To 12/31/2019	Date/Time Pre	nared·
				12, 31, 231,	6/29/2020 8: 5	
					1. 00	
	Uncompensated and indigent care cost computation					
1. 00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 div Medicaid (see instructions for each line)	rided by line 20	02 column	8)	0. 173988	1. 00
2.00	Net revenue from Medicaid				46, 792, 816	2. 00
3.00	Did you receive DSH or supplemental payments from Medicaid?			10	Y	3. 00
4. 00 5. 00	If line 3 is yes, does line 2 include all DSH and/or supplement If line 4 is no, then enter DSH and/or supplemental payments fr		om Medicai	ď?	Y 0	4. 00 5. 00
6.00	Medicaid charges	oii wedi caru			296, 890, 768	1
7. 00	Medicaid cost (line 1 times line 6)				51, 655, 431	1
8.00	Difference between net revenue and costs for Medicaid program (	line 7 minus su	um of line	es 2 and 5; if	4, 862, 615	8. 00
	< zero then enter zero)					
	Children's Health Insurance Program (CHIP) (see instructions fo	r each line)				
9. 00 10. 00	Net revenue from stand-alone CHIP Stand-alone CHIP charges				0	9. 00 10. 00
11. 00	Stand-alone CHIP cost (line 1 times line 10)					11.00
12. 00	Difference between net revenue and costs for stand-alone CHIP (	line 11 minus l	ine 9; i1	<pre>&lt; zero then</pre>	ő	1
	enter zero)					
	Other state or local government indigent care program (see inst					
13.00	Net revenue from state or local indigent care program (Not incl					13.00
14. 00	Charges for patients covered under state or local indigent care 10)	e program (Not i	nci uded i	n lines 6 or	108, 242	14.00
15. 00	State or local indigent care program cost (line 1 times line 14	.)			18, 833	15. 00
16. 00	Difference between net revenue and costs for state or local ind		gram (line	e 15 minus line	18, 675	
	13; if < zero then enter zero)					
	Grants, donations and total unreimbursed cost for Medicaid, CHI instructions for each line)	P and state/loc	cal indige	ent care program	ns (see	
17. 00	Private grants, donations, or endowment income restricted to fu	inding charity c	care		0	17. 00
18. 00	Government grants, appropriations or transfers for support of h				0	18. 00
19. 00	Total unreimbursed cost for Medicaid, CHIP and state and local 8, 12 and 16)	indigent care	programs	(sum of lines	4, 881, 290	19. 00
		Uni	i nsured	Insured	Total (col. 1	
			ati ents	pati ents	+ col . 2)	
			1. 00	2. 00	3. 00	
20. 00	Uncompensated Care (see instructions for each line) Charity care charges and uninsured discounts for the entire fac	ility 3	30, 238, 468	714, 096	30, 952, 564	20 00
20.00	(see instructions)	in ty	30, 230, 400	714,070	30, 732, 304	20.00
21. 00	Cost of patients approved for charity care and uninsured discou	ınts (see	5, 261, 13	714, 096	5, 975, 227	21. 00
	instructions)					
22. 00	Payments received from patients for amounts previously written	off as	49, 653	0	49, 653	22. 00
23. 00	charity care Cost of charity care (line 21 minus line 22)		5, 211, 478	714, 096	5, 925, 574	33 00
23.00	cost of charity care (fine 2) minus fine 22)		5, 211, 470	714,070	3, 723, 374	23.00
					1. 00	
24. 00	Does the amount on line 20 column 2, include charges for patien		a length o	of stay limit	N	24. 00
25. 00	imposed on patients covered by Medicaid or other indigent care If line 24 is yes, enter the charges for patient days beyond th		e program'	s length of	0	25. 00
	stay limit					
26. 00	Total bad debt expense for the entire hospital complex (see ins	,	>		20, 734, 107	ł
27. 00	Medicare reimbursable bad debts for the entire hospital complex	•			970, 660	•
27. 01 28. 00	Medicare allowable bad debts for the entire hospital complex (s Non-Medicare bad debt expense (see instructions)	ee mstructions	>)		1, 493, 324 19, 240, 783	
29. 00	Cost of non-Medicare and non-reimbursable Medicare bad debt exp	ense (see instr	ructions)		3, 870, 329	
	Cost of uncompensated care (line 23 column 3 plus line 29)		/		9, 795, 903	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus li	ne 30)			14, 677, 193	31.00

		U HEALTH BLOOMING				u of Form CMS-:	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	JE EXPENSES	Provi der CO	1	Period: From 01/01/2019	Worksheet A	
				-	Γο 12/31/2019	Date/Time Pre	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	6/29/2020 8:5 Reclassi fi ed	o alli
	p			+ col . 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	2. 00	3. 00	4. 00	col . 4) 5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		0	1	8, 633, 198	8, 633, 198	
2.00	00200 CAP REL COSTS-MVBLE EQUI P		0		6, 709, 527	6, 709, 527 0	
3. 00 4. 00	OO300 OTHER CAP REL COSTS   OO400 EMPLOYEE BENEFITS DEPARTMENT	1, 155, 581	992, 348	2, 147, 929	19, 026, 968	21, 174, 897	0.00
5. 00	00500 ADMI NI STRATI VE & GENERAL	6, 624, 654	76, 602, 576			82, 235, 827	1
7.00	00700 OPERATION OF PLANT	2, 095, 495	17, 857, 234			13, 176, 915	1
8.00	00800 LAUNDRY & LINEN SERVICE	0	157, 355			148, 148	
9. 00 10. 00	00900   HOUSEKEEPI NG   01000   DI ETARY	1, 777, 165 2, 204, 112	1, 971, 056 2, 133, 033			3, 068, 868 2, 213, 030	
11. 00	01100 CAFETERI A	0	2, 100, 000	(	1, 561, 990	1, 561, 990	
13.00	01300 NURSI NG ADMI NI STRATI ON	6, 646, 441	3, 099, 834				1
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	0	283, 476				1
16. 00	01600 MEDICAL RECORDS & LIBRARY	5, 507, 601	30, 234, 564 109, 656			6, 197, 798 107, 929	
18. 00	01850 SOCIAL SERVICES		0	107,030		0	18. 00
18. 01	01851 CENTRAL STERILIZATION	580, 459	646, 108	1, 226, 56		670, 351	
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	142, 916	56, 405	199, 32	1 156, 899	356, 220	23. 00
30. 00	INPATI ENT ROUTI NE SERVI CE COST CENTERS   03000   ADULTS & PEDI ATRI CS	22, 202, 115	13, 224, 055	35, 426, 170	-7, 228, 784	28, 197, 386	30.00
31. 00	03100 INTENSIVE CARE UNIT	3, 024, 767	1, 544, 829			3, 406, 531	
32.00	03200 CORONARY CARE UNIT	2, 309, 404	958, 429		-739, 626	2, 528, 207	32. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT	1, 644, 666	1, 301, 028			2, 374, 977	
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	1, 029, 342	386, 291	1, 415, 63	-287, 438	1, 128, 195 0	41. 00 42. 00
43. 00	04300 NURSERY		0		731, 623	731, 623	1
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	5, 560, 267	27, 349, 221	32, 909, 488	-23, 522, 196	9, 387, 292	1
50. 01 51. 00	05001   CV SURGERY   05100   RECOVERY   ROOM	3, 106, 378	0 1, 190, 320	4, 296, 698	0 3 -808, 892	0 3, 487, 806	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	2, 917, 033	1, 414, 151			3, 211, 814	1
53.00	05300 ANESTHESI OLOGY	0	0		0	0	1
54. 00	05400 RADI OLOGY - DI AGNOSTI C	3, 185, 209	3, 011, 833			3, 564, 870	
55. 00 56. 00	05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	2, 422, 367	3, 212, 802	5, 635, 169	-2, 254, 018	3, 381, 151 0	1
57. 00	05700 CT SCAN	691, 882	855, 124	1, 547, 00	-732, 506	814, 500	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	435, 523	816, 368			463, 970	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 202, 416	9, 426, 327			1, 626, 984	
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0	15, 563, 272	15, 563, 272		15, 496, 649 0	1
65. 00	06500 RESPI RATORY THERAPY	2, 302, 329	1, 249, 337	3, 551, 666	-1, 047, 908	_	1
66. 00		6, 383, 316	2, 618, 231				
	06700 OCCUPATI ONAL THERAPY	0	0	9	0		67.00
69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	761, 453	922, 417	1, 683, 870	-799, 591	0 884, 279	
70. 00	07000 ELECTROENCEPHALOGRAPHY	168, 544	1, 262, 697		·	1, 252, 283	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		9, 599, 791	9, 599, 791	1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(	16, 813, 013	16, 813, 013	1
73. 00 73. 01	07300 DRUGS CHARGED TO PATIENTS 07302 OP PHARMACY	27, 227	72, 398	99, 62!	29, 589, 303 -15, 716	29, 589, 303 83, 909	1
74. 00	07400 RENAL DI ALYSI S	0	1, 319, 400			1, 289, 982	1
75.00	07500 ASC (NON-DISTINCT PART)	0	0	(	0	0	75. 00
75. 01	03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES	0	0	752.05	0	0	75. 01
76. 97	07697   CARDI AC REHABI LI TATI ON   OUTPATI ENT SERVI CE COST CENTERS	591, 257	161, 795	753, 052	2 -107, 284	645, 768	76. 97
90.00	09000 CLI NI C	1, 440, 620	448, 977	1, 889, 59	-422, 418	1, 467, 179	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	3, 476, 206	2, 019, 862			4, 216, 282	90. 01
90. 02	09002 WOUND CARE CENTER	477, 081	405, 424			582, 594	
90. 03 90. 05	O9003   PAIN CLINIC   O9005   OP PSYCH CLINIC	180, 583 3, 469, 890	245, 356 1, 094, 086			258, 081 4, 151, 839	
91. 00	09100 EMERGENCY	4, 849, 611	5, 879, 458			8, 422, 324	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
04.00	OTHER REIMBURSABLE COST CENTERS		0	Γ ,		0	04.00
	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES	5, 268, 606	3, 493, 659	8, 762, 26!	-2, 049, 498	0 6, 712, 767	
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0, 473, 037	0, 702, 20	0 2,047,470		100.00
	10100 HOME HEALTH AGENCY	o	0		0		101. 00
110 00	SPECIAL PURPOSE COST CENTERS		1 070 500	4 070 50	1 070 500	_	112 22
	11300 INTEREST EXPENSE  11400 UTILIZATION REVIEW-SNF		1, 079, 509 0	1, 079, 509	-1, 079, 509 0		113. 00 114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)		0		o o		115. 00
	11600 HOSPI CE	o	0		0		116. 00

Health Financial Systems	GTON HOSPITAL		In Lie	u of Form CMS-2	2552-10	
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der CC		Peri od:	Worksheet A	
				From 01/01/2019 To 12/31/2019	Date/Time Pre	narod:
			'	12/31/2019	6/29/2020 8:5	
Cost Center Description	Sal ari es	0ther	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	0.00	0.00	4.00	col . 4)	
440.00	1.00	2.00	3.00	4.00	5. 00	110.00
118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	105, 862, 516	236, 670, 301	342, 532, 817	-443, 205	342, 089, 612	118.00
NONREIMBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	125, 497	199, 307	324, 804	-21, 897	202 007	100 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		1, 343, 533			302, 907 2, 151, 661	
190. 01 19001 PROMPTCARE  190. 02 19002 RENTAL PROPERTIES	1, 540, 264	1, 343, 533				190. 01
190. 02 19002 RENTAL PROPERTIES 190. 03 19003 OLCOTT	284, 146	181, 085			375, 446	
190. 04 19004 PHYSI CLAN RECRUITMENT	204, 140	101,000	400, 23	-09, 700		190. 03
190. 05 19005 FOUNDATION	0	4, 805	4, 805	-1, 684		190. 04
190. 06 19006 MARKETI NG	0	4, 603	4, 603	-1,004		190. 05
190. 07 19007 HME STORE	0	2, 308	2, 308	-2,050		190. 00
190. 08 19008 UNUSED SPACE	0	2, 300	2, 300	54, 423	54, 423	
190. 09 19009 CLINI CAL TRI ALS	152, 096	46, 894	198, 990		161, 710	
190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINIC	132, 070	40, 074	170, 770			190. 09
190. 11 19011 COMMUNI TY HEALTH SERVICES	3, 152, 059	2, 768, 186	`	1 1	5, 091, 746	
191. 00 19100  RESEARCH	3, 132, 037	2, 700, 100	3, 720, 240	020, 477		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	15, 017	15, 473	30, 490	-5, 189	25. 301	
193. 00 19300 NONPALD WORKERS	0	, 0	(			193. 00
194. 00 07950 IU HEALTH PAOLI HOSPITAL	o	o	(	697, 081	697, 081	
194. 01 07951 I U HEALTH BEDFORD HOSPITAL	ol	o	(	1, 316, 555	1, 316, 555	
194. 02 07952 I U HEALTH MORGAN HOSPITAL	ol	o	(	ol ol		194. 02
194. 03 07953 I U HEALTH SI P	o	O	(	131, 935	131, 935	194. 03
194.04 07954 HOME CARE	o	35	35			194. 04
194. 05 07955 HOSPI CE	o	18	18	sl ol	18	194. 05
200.00 TOTAL (SUM OF LINES 118 through 199)	111, 131, 595	241, 276, 087	352, 407, 682	2 o	352, 407, 682	200. 00
	•	•				

Heal th	Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2552-
	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der CCN	l: 15-0051	Peri od:	Worksheet A
					From 01/01/2019 To 12/31/2019	
	Cost Center Description	Adjustments	Net Expenses			6/29/2020 8:56 am
	cost center bescription	(See A-8)	For Allocation			
		6. 00	7. 00			
1 00	GENERAL SERVICE COST CENTERS	7.0/0.000	7/4 070			
1. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP	-7, 868, 320 10, 052, 898				1.0
3. 00	00300 OTHER CAP REL COSTS	10, 032, 848				3.0
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	4, 780, 627				4. 0
5.00	00500 ADMINISTRATIVE & GENERAL	-18, 775, 876				5. C
7.00	00700 OPERATION OF PLANT	-60, 493				7.0
8.00	00800 LAUNDRY & LINEN SERVICE	20,000				8.0
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY	-38, 000 -242, 131				9. C 10. C
11. 00	01100 CAFETERI A	-1, 078, 534				11. 0
13.00	01300 NURSING ADMINISTRATION	-79, 248				13. 0
14. 00	01400 CENTRAL SERVICES & SUPPLY	0	11, 966, 748			14. 0
15. 00	1	-11, 588	1			15. C
16.00	01600 MEDI CAL RECORDS & LI BRARY	0				16.0
18.00	01850 SOCIAL SERVICES 01851 CENTRAL STERILIZATION	0				18.0
18. 01 23. 00	02301   PARAMED ED   PRGM-PHARMACY   RESIDENCY	32, 817	,			18.0
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	32,017	307,037			25. 0
30. 00	03000 ADULTS & PEDIATRICS	-5, 081, 135	23, 116, 251			30.0
31. 00	03100 INTENSIVE CARE UNIT	0	3, 406, 531			31. 0
32. 00	03200 CORONARY CARE UNIT	-500				32.0
35.00	02060 NEONATAL INTENSIVE CARE UNIT	-250, 342				35.0
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0				41. C 42. C
43.00	04300 NURSERY		1			43. 0
	ANCILLARY SERVICE COST CENTERS		7017020			1010
50.00	05000 OPERATING ROOM	-1, 354, 201	8, 033, 091			50.0
50. 01	05001 CV SURGERY	0	0			50. C
51.00	05100 RECOVERY ROOM	-3, 543				51.0
52. 00 53. 00	05200   DELIVERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY	0				52. C 53. C
54. 00	05400 RADI OLOGY-DI AGNOSTI C	-348				54.0
55. 00	05500 RADI OLOGY-THERAPEUTI C	-448, 781	2, 932, 370			55. 0
56.00	05600 RADI OI SOTOPE	0	1			56.0
57.00	05700 CT SCAN	0				57. C
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0				58.0
59.00	05900 CARDI AC CATHETERI ZATI ON	20/ 252	1, 626, 984			59.0
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	-396, 253	15, 100, 396			60. 0 64. 0
65. 00	06500 RESPIRATORY THERAPY	-1, 844	2, 501, 914			65. 0
66. 00	06600 PHYSI CAL THERAPY	-436, 497	1			66.0
67. 00	06700 OCCUPATI ONAL THERAPY	0	O			67.0
68. 00	06800 SPEECH PATHOLOGY	0	1			68.0
	06900 ELECTROCARDI OLOGY	-15, 424				69.0
70.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	-326, 205 0	1 1			70. 0 71. 0
	07200 IMPL. DEV. CHARGED TO PATIENTS					71. 0
73. 00	07300 DRUGS CHARGED TO PATIENTS	0				73. 0
73. 01	07302 OP PHARMACY	-400	83, 509			73. 0
74. 00		0				74. 0
75.00	07500 ASC (NON-DISTINCT PART)	0	1			75. C
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 07697 CARDI AC REHABI LI TATI ON	-12				75. 0 76. 9
10. 91	OUTPATIENT SERVICE COST CENTERS	-12	045, 750			70. 9
90. 00	09000 CLI NI C	-32,779	1, 434, 400			90. 0
90. 01	09001 OP ONCOLOGY INFUSION CENTER	-384, 050				90.0
90. 02	1	0				90.0
90. 03		-244				90.0
90.05	09005 OP PSYCH CLINIC	-2, 052, 353				90.0
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	-1, 879, 159	6, 543, 165			91. C 92. C
7Z. UU	OTHER REIMBURSABLE COST CENTERS					92.0
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0			94. 0
95. 00	09500 AMBULANCE SERVI CES	-292, 174	6, 420, 593			95. 0
	10000 I&R SERVICES-NOT APPRVD PRGM	0				100.0
101. 0	10100 HOME HEALTH AGENCY	0	0			101. C
112 0	SPECIAL PURPOSE COST CENTERS	^				112.6
	D11300 INTEREST EXPENSE D11400 UTILIZATION REVIEW-SNF	0	1			113. C  114. C
	11500 AMBULATORY SURGICAL CENTER (D. P.)		1 -1			115. 0
	11600 HOSPI CE		l ol			116. 0
118. 0	SUBTOTALS (SUM OF LINES 1 through 11	7)   -26, 244, 092	315, 845, 520			118. 0

Health Financial Systems IU HEALTH BLORGE RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES

Provi der CCN: 15-0051

| Period: | Worksheet A | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:56 am

			6/29/2020 8:56 am
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6. 00	7. 00	
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	302, 907	190. 00
190. 01 19001 PROMPTCARE	-25, 025	2, 126, 636	190. 01
190. 02 19002 RENTAL PROPERTI ES	0	5, 873	190. 02
190. 03 19003 OLCOTT	0	375, 446	190. 03
190. 04 19004 PHYSICIAN RECRUITMENT	0	0	190. 04
190. 05 19005 FOUNDATI ON	0	3, 121	190. 05
190. 06 19006 MARKETI NG	0	0	190.06
190. 07 19007 HME STORE	0	258	190. 07
190. 08 19008 UNUSED SPACE	0	54, 423	190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	161, 710	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	o	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	5, 091, 746	190. 11
191. 00 19100 RESEARCH	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	25, 301	192. 00
193. 00 19300 NONPALD WORKERS	0	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	697, 081	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	1, 316, 555	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	194. 02
194.03 07953 IU HEALTH SIP	0	131, 935	194. 03
194.04 07954 HOME CARE	0	35	194. 04
194. 05 07955 HOSPI CE	0	18	194. 05
200.00 TOTAL (SUM OF LINES 118 through 199)	-26, 269, 117	326, 138, 565	200. 00

IU HEALTH BLOOMINGTON HOSPITAL

Provider CCN: 15-0051 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am

					6/29/2020 8:	56 am
		Increases				
	Cost Center	Li ne #	Salary	0ther		
	2. 00	3. 00	4. 00	5. 00		
1 00	A - BENEFITS	4.00	ol	10 244 770		1. 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT	0.00	0	19, 244, 770		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5. 00		0.00	Ö	0		5. 00
6. 00		0.00	Ö	o		6. 00
7. 00		0.00	Ö	o		7. 00
8. 00		0.00	o	Ö		8. 00
9. 00		0.00	o	Ō		9. 00
10. 00		0.00	o	O		10.00
11. 00		0.00	O	0		11. 00
12.00		0.00	O	0		12. 00
13.00		0.00	o	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		0.00	0	0		19. 00
20.00		0.00	0	0		20. 00
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0.00	0	0		23. 00 24. 00
24. 00 25. 00		0. 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		0.00	0	o		28. 00
29. 00		0.00	Ö	o		29. 00
30. 00		0.00	o	o		30. 00
31. 00		0.00	o	Ö		31. 00
32. 00		0.00	o	Ö		32. 00
33. 00		0.00	O	0		33. 00
34.00		0.00	O	0		34. 00
35.00		0.00	O	0		35. 00
36.00		0.00	o	0		36. 00
37.00		0.00	0	0		37. 00
38. 00		0.00	0	0		38. 00
39. 00		0.00	0	0		39. 00
40. 00		0.00	•	0		40. 00
	0		0	19, 244, 770		
4 00	B - CAPITAL RELATED	4 00		( 5/0 404		4 00
1.00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	1.00	0	6, 563, 191		1.00
2. 00 3. 00	ADMINISTRATIVE & GENERAL	2. 00 5. 00	0	6, 353, 747 612, 586		2. 00 3. 00
4.00	ADMINISTRATIVE & GENERAL	0.00	0	012, 380		4. 00
5.00		0.00	o	0		5. 00
6. 00		0.00	o	o		6. 00
7. 00		0.00	o	o		7. 00
8.00		0.00	Ö	Ö		8. 00
9. 00		0.00	o	O		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
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		0.00	0	0		20.00
21. 00 22. 00		0. 00 0. 00	0	0		21. 00 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	Ö	o		26. 00
27. 00		0.00	o	o		27. 00
28. 00		0.00	o	o		28. 00
29. 00		0.00	Ö	O		29. 00
30.00		0.00	0	0		30.00
31.00		0.00	0	0		31.00

Health Financial Systems RECLASSIFICATIONS | Period: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:56 am Provider CCN: 15-0051

					6/	/29/2020 8: 56 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3. 00	4. 00	5. 00		
32. 00		0.00	0	0		32.00
33. 00		0.00	0	0		33.00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35. 00
36.00		0.00	0	0		36. 00
37.00		0.00	O	0		37.00
38.00		0.00	0	0		38. 00
39.00		0.00	0	0		39.00
40. 00		0.00	o	0		40. 00
41. 00		0.00	Ö	Ö		41. 00
42. 00		0.00	o	Ö		42. 00
43. 00		0.00	o	Ö		43. 00
43.00			— — — <del>0</del>	13, 529, 524		43.00
	C - BILLABLE MEDICAL SUPPLIES		U	13, 329, 324		
1 00	MEDICAL SUPPLIES CHARGED TO		0	0 500 701		1 00
1. 00	PATIENTS	71. 00	U	9, 599, 791		1.00
2 00	PATTENTS	0.00	0	0		2.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3.00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	O	0		14.00
15. 00		0.00	O	0		15. 00
16. 00		0.00	o	0		16. 00
17. 00		0.00	Ö	Ö		17. 00
18. 00		0.00	o	Ö		18. 00
19. 00	•	0.00	0	0		•
			0	0		19.00
20.00		0.00		-		20.00
21. 00		0.00	0	0		21. 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		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30. 00		0.00	0	0		30. 00
31. 00		0.00	Ö	0		31. 00
32. 00		0.00	o	0		32. 00
JZ. 00			— — — <del>0</del>	9, 599, 791		32.00
	D - NONBILLABLE MEDICAL SUPPL	IFS	U <sub>I</sub>	7, 377, 191		
1 00	CENTRAL SERVICES & SUPPLY	14. 00	ما	11, 943, 196		1 00
1.00	OPERATION OF PLANT		0			1.00
2.00		7. 00	0	3, 794		2.00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	12		3.00
4.00	PARAMED ED PRGM-PHARMACY	23. 00	0	70		4. 00
F 00	RESI DENCY	400 0-	_			
5.00	HME STORE	190. 07	0	4		5. 00
6. 00	CLINICAL TRIALS	190. 09	0	14		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	o	0		15. 00
16. 00		0.00	o	Ö		16. 00
17. 00		0.00	o	0		17. 00
18. 00		0.00	0	0		18. 00
			0	0		
19. 00		0.00		-		19.00
20.00		0.00	0	0		20.00
21. 00		0.00	0	0		21. 00
22. 00		0.00	0	0		22. 00
23. 00		0. 00	0	0		23. 00
24. 00	<u> </u>	0.00	0	0	<u> </u>	24. 00

Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

					6/29/2020 8:	56 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other 5.00		
25. 00	2. 00	3. 00	4.00	5. 00		25. 00
26. 00		0.00	0	0		26. 00
27. 00		0.00	0	0		27. 00
28.00		0.00	0	0		28. 00
29. 00		0.00	0	0		29. 00
30.00		0.00	0	0		30. 00
31. 00		0.00	0	0		31.00
32. 00		0.00	0	0		32.00
33. 00 34. 00		0. 00 0. 00	0	0		33. 00 34. 00
35. 00		0.00	0	0		35. 00
36. 00		0.00	0	0		36. 00
37. 00		0.00	0	0		37. 00
38.00		0.00	0	0		38. 00
39. 00		0.00	0	0		39. 00
	0		0	11, 947, 090		
1. 00	E - IMPLANTS SUPPLIES IMPL. DEV. CHARGED TO	72.00	O	14 012 012		1.00
1.00	PATIENTS	72.00	U	16, 813, 013		1.00
2.00	NURSING ADMINISTRATION	13. 00	0	34		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6. 00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8. 00 9. 00		0. 00 0. 00	0	0		8. 00 9. 00
10. 00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	0	O		13. 00
14.00		0.00	0	0		14. 00
15.00	L	0.00	0	0		15. 00
	0		0	16, 813, 047		
1. 00	F - LEASE EXPENSE CAP REL COSTS-BLDG & FLXT	1.00	0	1, 180, 239		1.00
2. 00	CAP REL COSTS-BEDG & TTXT	2. 00	0	287, 687		2.00
3. 00	WEE GOOTS MVDEE EGOTT	0.00	o	0		3. 00
4. 00		0.00	0	O		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9.00
10. 00 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	0	0		14. 00
	0		0	1, 467, 926		_
4 00	G - BILLABLE DRUGS	70.00	0	00 500 000		4 00
1. 00 2. 00	DRUGS CHARGED TO PATIENTS	73. 00 0. 00	0	29, 589, 303 0		1. 00 2. 00
2. 00 3. 00		0.00	0	0		3. 00
4. 00		0.00	0	0		4. 00
5. 00		0.00	o	o		5. 00
6. 00		0.00	O	0		6. 00
7.00		0.00	0	0		7. 00
8. 00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00 12. 00		0. 00 0. 00	0	0		11. 00 12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	0	0		14. 00
15. 00		0.00	Ö	Ö		15. 00
16.00		0.00	O	0		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		0.00	0	0		20.00
21. 00 22. 00		0. 00 0. 00	0	0		21. 00 22. 00
23. 00		0.00	0	0		23. 00
	1	3. 30	<u> </u>	٥		

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared: Provider CCN: 15-0051

					6/29/2020	
		Increases				
	Cost Center	Li ne #	Sal ary	Other 5 00		
24. 00	2. 00	3.00	4.00	5. 00		24. 00
25. 00		0.00	Ö	Ö		25. 00
26.00		0.00	0	0		26. 00
	O NON BLLLARIE BRUGG		0	29, 589, 303		
1. 00	H - NON-BILLABLE DRUGS NURSING ADMINISTRATION	13. 00	0	811		1.00
2.00	PHARMACY	15. 00	o	869, 250		2. 00
3.00		0.00	O	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	ő	Ö		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10. 00 11. 00		0. 00 0. 00	0	0		10. 00 11. 00
12. 00		0.00	o	o		12. 00
13.00		0.00	О	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	Ö	o		17. 00
18. 00		0.00	0	O		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	Ö		22. 00
23.00		0.00	0	0		23. 00
24. 00		0.00	0	0		24. 00
25. 00		0.00	0	870, 061		25. 00
	J - INTEREST EXPENSE		-1			
1.00	CAP REL COSTS-BLDG & FIXT		0	<u>1, 079, 509</u>		1. 00
	K - PHARMACY RESIDENCY		0	1, 079, 509		
1.00	PARAMED ED PRGM-PHARMACY	23.00	170, 611	13, 052		1.00
	RESI DENCY			·		
2.00			0 170, 611	<u> 0</u> 13, 052		2. 00
	L - PSYCH ADMIN		170, 611	13, 032		
1.00	OP_PSYCH_CLINIC	90.05	232, 463	30, 019		1. 00
	O COETHARE LLOSNOS		232, 463	30, 019		
1. 00	M - SOFTWARE LICENSE CAP REL COSTS-MVBLE EQUIP	2.00	0	71, 733		1.00
2. 00	NEE GOSTS MVDEE EGGTT	0.00	ő	0		2. 00
3.00		0.00	O	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		0.00	•	0		8. 00
	N - CAFETERIA		0	71, 733		
1.00	CAFETERI A	11.00	835, 906	726, 084		1.00
	0		835, 906	726, 084		
1 00	O - SHORT TERM DISABILITY/FLM ADMINISTRATIVE & GENERAL	/A 5.00		19, 083		1 00
1. 00 2. 00	OPERATION OF PLANT	7. 00		11, 311		1. 00 2. 00
3.00	HOUSEKEEPI NG	9.00		8, 119		3. 00
4.00	DIETARY	10.00		15, 985		4. 00
5.00	NURSI NG ADMI NI STRATI ON	13.00		41, 027		5. 00
6. 00 7. 00	PHARMACY CENTRAL STERILIZATION	15. 00 18. 01		20, 726 4, 598		6. 00 7. 00
8.00	ADULTS & PEDIATRICS	30.00		85, 349		8. 00
9.00	INTENSIVE CARE UNIT	31.00		24, 930		9. 00
10. 00 11. 00	CORONARY CARE UNIT NEONATAL INTENSIVE CARE UNIT	32. 00 35. 00		20, 155 4, 354		10. 00 11. 00
12.00	SUBPROVIDER - IRF	41.00		4, 354 1, 325		12.00
13. 00	OPERATING ROOM	50.00		28, 843		13. 00
14.00	RECOVERY ROOM	51.00		36, 521		14. 00
15. 00 16. 00	DELIVERY ROOM & LABOR ROOM RADIOLOGY-DIAGNOSTIC	52. 00 54. 00		21, 967 26, 775		15. 00 16. 00
17. 00	RADI OLOGY-DI AGNOSTI C	55.00		19, 592		17. 00
18. 00	CT SCAN	57. 00		4, 162		18. 00
					<u> </u>	

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 Peri od: From 01/01/2019 To 12/31/2019 Date/Ti me Prepared: 6/29/2020 8:56 am Provider CCN: 15-0051

					6,	/29/2020 8:56 am
		Increases				
	Cost Center	Li ne #	Salary	0ther		
	2. 00	3.00	4. 00	5. 00		
19.00	CARDI AC CATHETERI ZATI ON	59.00		6, 862		19. 00
20.00	RESPIRATORY THERAPY	65.00		367		20.00
21.00	PHYSI CAL THERAPY	66.00		49, 360		21.00
22. 00	ELECTROCARDI OLOGY	69. 00		594		22. 00
23. 00	ELECTROENCEPHALOGRAPHY	70.00		2, 321		23. 00
24. 00	CARDI AC REHABI LI TATI ON	76. 97		3, 937		24. 00
25. 00	CLINIC	90.00		19, 454		25. 00
26. 00	OP ONCOLOGY INFUSION CENTER	90. 01		26, 114		26. 00
27. 00	WOUND CARE CENTER	90. 02		3, 402		27. 00
28. 00	PAIN CLINIC	90. 03		293		28. 00
29. 00	OP PSYCH CLINIC	90. 05		334		29. 00
30. 00	EMERGENCY	91.00		44, 346		30.00
31. 00	AMBULANCE SERVICES	95. 00		48, 567		31.00
32. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00		2, 201		32.00
	CANTEEN					
33. 00	PROMPTCARE	190. 01		7, 267		33.00
34.00	OLCOTT	190. 03		7, 148		34.00
35. 00	COMMUNITY HEALTH SERVICES	1 <u>90.</u> 11		1, 334		35. 00
	0		0	618, 723		
	P - UTILITIES EXPENSE		_1			
1.00	OPERATION OF PLANT	7.00	0	321, 915		1.00
2.00		0.00	0	0		2.00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7. 00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9. 00		0.00	0	0		9. 00
10. 00		0.00	0	0		10. 00
11. 00		0. 00	0	0		11.00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17.00		0.00	0	0		17. 00
18.00		0.00	0	0		18. 00
19.00		0.00	O	0		19. 00
20.00		0.00	O	0		20. 00
21.00		0.00	O	0		21. 00
22.00		0.00	O	0		22. 00
23.00		0.00	O	0		23. 00
24.00		0.00	O	0		24. 00
25.00		0.00	o	0		25. 00
26.00		0.00	o	0		26. 00
27.00		0.00	o	0		27. 00
28.00		0.00	o	0		28. 00
29.00		0.00	O	0		29. 00
30.00		0.00	O	0		30.00
			0	321, 915		
	Q - BCC DEPRECIATION		·			
1.00	RENTAL PROPERTIES	190. 02	0	3, 902		1. 00
2.00	FOUNDATI ON	190. 05	0	3, 121		2. 00
3.00	UNUSED SPACE	190. 08	ol	54, 423		3. 00
	TOTALS	+		61, 446		
	R - OCCUPATIONAL HEALTH ADMIN					
1.00	ADMINISTRATIVE & GENERAL	5. 00	209, 926	0		1. 00
		+	209, 926	<u>0</u>		
	S - NURSERY					
1.00	NURSERY	43.00	641, 908	89, 715		1. 00
2.00		0.00	o	0		2. 00
		+	641, 908	89, 715		
	T - BEDFORD ALLOCATION			- ,		
1.00	IU HEALTH BEDFORD HOSPITAL	194. 01	883, 599	432, 956		1. 00
2.00		0.00	0	0		2.00
3. 00		0.00	o o	ő		3. 00
4. 00		0.00	0	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
7.00			883, 599	432, 956		7.00
	ı- I	ı	300, 077	.52, 755		I

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-1			
RECLASSI FI CATI ONS	Provider CCN: 15-0051	Period: Worksheet A-6 From 01/01/2019			
		To 12/31/2019 Date/Time Prepared:			

					6/29/2020 8:	56 am
		Increases				
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5.00		
	U - PAOLI ALLOCATION					
1.00	IU HEALTH PAOLI HOSPITAL	194. 00	467, 458	229, 623		1. 00
2.00		0.00	0	0		2. 00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
	0		467, 458	229, 623		
	V - LIBERTY BUILDING DEPRECIA	ATI ON				
1.00	IU HEALTH SIP	194. 03	0	131, 935		1. 00
2.00		0.00	0	0		2. 00
	TOTALS			131, 935		
500.00	Grand Total: Increases		3, 441, 871	106, 868, 222		500.00

Health Financial Systems RECLASSIFICATIONS

Provider CCN: 15-0051

In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2019 To 12/31/2019

Date/Time Prepared: 6/29/2020 8:56 am

						6/29/2020 8: 5	o6 am
	2 1 2 1	Decreases	C 1	011			
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
	A - BENEFITS		_				
1.00	ADMI NI STRATI VE & GENERAL	5. 00	0				1.00
2.00	OPERATION OF PLANT	7.00	0				2. 00
3.00	HOUSEKEEPI NG	9. 00	0	577, 694			3. 00
4.00	DI ETARY	10.00	0	493, 293			4. 00
5. 00	NURSING ADMINISTRATION	13. 00	0		1		5. 00
6.00	PHARMACY	15. 00	0	845, 409			6. 00
7. 00	CENTRAL STERILIZATION	18. 01	0	154, 388	0		7. 00
8.00	PARAMED ED PRGM-PHARMACY	23. 00	0	26, 834	0		8. 00
	RESI DENCY						
9.00	ADULTS & PEDIATRICS	30.00	0	3, 771, 873	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	554, 217	0		10.00
11.00	CORONARY CARE UNIT	32.00	0	368, 696	0		11.00
12.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	344, 217	0		12. 00
13.00	SUBPROVI DER - I RF	41.00	0	219, 138	0		13.00
14.00	OPERATING ROOM	50.00	0	948, 058	0		14. 00
15. 00	RECOVERY ROOM	51.00	0	520, 489	o		15. 00
16.00	DELIVERY ROOM & LABOR ROOM	52.00	0	444, 721	o		16. 00
17.00	RADI OLOGY-DI AGNOSTI C	54.00	0	649, 561	o		17. 00
18.00	RADI OLOGY-THERAPEUTI C	55.00	0	410, 853	o		18. 00
19.00	CT SCAN	57. 00	0	122, 668	o		19.00
20.00	MAGNETIC RESONANCE IMAGING	58.00	0	95, 067	o		20.00
	(MRI)			.,	]		
21.00	CARDÍAC CATHETERIZATION	59.00	0	190, 798	o		21. 00
22. 00	RESPIRATORY THERAPY	65.00	0	385, 736			22. 00
23. 00	PHYSI CAL THERAPY	66.00	0	953, 901	o		23. 00
24. 00	ELECTROCARDI OLOGY	69.00	0	135, 404			24. 00
25. 00	ELECTROENCEPHALOGRAPHY	70.00	0	30, 222			25. 00
26. 00	OP PHARMACY	73. 01	0	4, 363			26. 00
27. 00	CARDI AC REHABI LI TATI ON	76. 97	0	98, 263	1		27. 00
28. 00	CLINIC	90.00	0				28. 00
29. 00	OP ONCOLOGY INFUSION CENTER	90. 01	0	563, 129			29. 00
30. 00	WOUND CARE CENTER	90. 02	0	100, 259			30.00
31. 00	PAIN CLINIC	90. 03	0	39, 897	o		31. 00
32. 00	OP PSYCH CLINIC	90. 05	0	591, 147			32. 00
33. 00	EMERGENCY	91.00	0		o		33. 00
34.00	AMBULANCE SERVICES	95.00	0		o		34.00
35. 00	GIFT, FLOWER, COFFEE SHOP &	190.00	0		o		35. 00
	CANTEEN						
36.00	PROMPTCARE	190. 01	0	270, 493	0		36. 00
37.00	OLCOTT	190. 03	0	73, 259	0		37. 00
38. 00	CLINICAL TRIALS	190. 09	0	37, 294	0		38. 00
39. 00	COMMUNITY HEALTH SERVICES	190. 11	0	709, 443	0		39. 00
40. 00	PHYSICIANS' PRIVATE OFFICES	192.00	0		0		40. 00
	0		0	19, 244, 770			
	B - CAPITAL RELATED	1			. 1		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1			1.00
2.00	OPERATION OF PLANT	7.00	0				2. 00
3.00	LAUNDRY & LINEN SERVICE	8.00	0	9, 219			3. 00
4.00	HOUSEKEEPI NG	9. 00	0	7, 489			4. 00
5.00	DI ETARY	10.00	0				5. 00
6.00	NURSING ADMINISTRATION	13. 00	0				6. 00
7. 00	CENTRAL SERVICES & SUPPLY	14. 00	0	559			7. 00
8. 00	PHARMACY	15. 00	0				8. 00
9.00	MEDICAL RECORDS & LIBRARY	16. 00	0	1, 696			9. 00
10. 00	CENTRAL STERILIZATION	18. 01	0				10.00
11. 00	ADULTS & PEDIATRICS	30.00	0	161, 741			11. 00
12. 00	INTENSIVE CARE UNIT	31.00	0	64, 505	0		12. 00
13. 00	CORONARY CARE UNIT	32.00	0	70, 683	0		13. 00
14.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	56, 178			14. 00
15. 00	SUBPROVI DER - I RF	41. 00	0	221	0		15. 00
16.00	OPERATING ROOM	50.00	0	.,,	0		16. 00
17. 00	RECOVERY ROOM	51.00	0	13, 918	0		17. 00
18.00	DELIVERY ROOM & LABOR ROOM	52.00	0	116, 986			18. 00
19. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	848, 898			19. 00
20.00	RADI OLOGY-THERAPEUTI C	55.00	0	1, 165, 556	0		20. 00
21.00	CT SCAN	57.00	0	336, 945	0		21. 00
22.00	MAGNETIC RESONANCE IMAGING	58.00	0	617, 428	0		22. 00
	(MRI)						
23. 00	CARDIAC CATHETERIZATION	59. 00	0				23. 00
24. 00	LABORATORY	60.00	0	42, 559			24. 00
25. 00	RESPIRATORY THERAPY	65.00	0				25. 00
26. 00	PHYSI CAL THERAPY	66.00	0	1			26. 00
27. 00	ELECTROCARDI OLOGY	69.00	0	273, 471	0		27. 00

| Period: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:56 am

				,		0 12/31/2017	6/29/2020 8: 56 am
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
28. 00	ELECTROENCEPHALOGRAPHY	70.00	0				28. 00
29. 00	OP PHARMACY	73. 01	0	1			29. 00
30. 00	CARDIAC REHABILITATION	76. 97	0		1		30.00
31. 00	CLINIC	90.00	0		1		31.00
32. 00	OP ONCOLOGY INFUSION CENTER	90. 01	0	195, 457	1		32.00
33. 00	WOUND CARE CENTER	90.02	0		1		33.00
34. 00	PAIN CLINIC	90. 03	0		1		34. 00
35. 00	OP PSYCH CLINIC	90.05	0				35. 00
36.00	EMERGENCY	91.00	0		1		36.00
37. 00	AMBULANCE SERVICES	95.00	0		1		37. 00
38. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	1, 990	0		38. 00
20.00	CANTEEN	100.01	0	15 07/			20.00
39.00	PROMPTCARE	190. 01	0	15, 976	1		39.00
40.00	RENTAL PROPERTIES	190. 02	0		1		40.00
41.00	OLCOTT	190.03	_				41.00
42.00	HME STORE	190. 07	0				42.00
43. 00	COMMUNITY HEALTH SERVICES	190.11	<u> </u>				43. 00
	C - BILLABLE MEDICAL SUPPLIES	2	U	13, 529, 524			
1.00	NURSING ADMINISTRATION	13.00		1, 971	O		1.00
2. 00	CENTRAL SERVICES & SUPPLY	14. 00		708	1		2. 00
3. 00	PHARMACY	15. 00		8, 008	1		3. 00
4. 00	CENTRAL STERILIZATION	18. 01		3, 000	1		4. 00
5. 00	ADULTS & PEDIATRICS	30.00		212, 961	1		5. 00
6. 00	INTENSIVE CARE UNIT	31.00		48, 875			6. 00
7. 00	CORONARY CARE UNIT	32.00		12, 814	1		7. 00
8. 00	NEONATAL INTENSIVE CARE UNIT	35.00		7, 143			8. 00
9. 00	SUBPROVI DER - I RF	41.00		2, 800	1		9. 00
10. 00	OPERATING ROOM	50.00		4, 430, 643			10.00
11. 00	RECOVERY ROOM	51.00		7, 779			11. 00
12. 00	DELIVERY ROOM & LABOR ROOM	52.00		176, 067			12. 00
13. 00	RADI OLOGY-DI AGNOSTI C	54.00		640, 483			13. 00
14. 00	RADI OLOGY-THERAPEUTI C	55. 00		5, 734	1		14. 00
15. 00	CT SCAN	57.00		10, 923			15. 00
16. 00	MAGNETIC RESONANCE IMAGING	58. 00		758	1		16. 00
	(MRI)						131.32
17.00	CARDÍ AC CATHETERIZATION	59.00		3, 621, 840	o		17. 00
18.00	RESPIRATORY THERAPY	65.00		16, 224	o		18. 00
19.00	PHYSI CAL THERAPY	66.00		17, 247	o o		19. 00
20.00	ELECTROCARDI OLOGY	69.00		54	o		20. 00
21.00	ELECTROENCEPHALOGRAPHY	70.00		1, 145	o o		21. 00
22.00	OP PHARMACY	73. 01		180	o		22. 00
23.00	RENAL DIALYSIS	74.00		8, 383	o		23. 00
24.00	CARDIAC REHABILITATION	76. 97		278	0		24. 00
25.00	CLINIC	90.00		354	0		25. 00
26.00	OP ONCOLOGY INFUSION CENTER	90. 01		185, 345	0		26. 00
27.00	WOUND CARE CENTER	90. 02		17, 119	0		27. 00
28.00	PAIN CLINIC	90. 03		13, 979	0		28. 00
29. 00	EMERGENCY	91.00		86, 622	2 0		29. 00
30.00	AMBULANCE SERVICES	95.00		46, 035	0		30.00
31.00	PROMPTCARE	190. 01		14, 299	0		31.00
32.00	COMMUNITY HEALTH SERVICES	190. 11		20	o o		32. 00
	0			9, 599, 791			
	D - NONBILLABLE MEDICAL SUPPL	LIES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0				1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0				2. 00
3.00	HOUSEKEEPI NG	9. 00	0	93, 804			3. 00
4.00	DI ETARY	10.00	0	17, 666			4. 00
5.00	NURSING ADMINISTRATION	13.00	0	49, 457	0		5. 00
6.00	PHARMACY	15. 00	0	254, 501	0		6. 00
7.00	MEDICAL RECORDS & LIBRARY	16.00	0	31	0		7. 00
8.00	CENTRAL STERILIZATION	18. 01	0	318, 476	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	1, 888, 919			9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	414, 082	0		10. 00
11.00	CORONARY CARE UNIT	32. 00	0	254, 094	0		11. 00
12.00	NEONATAL INTENSIVE CARE UNIT	35. 00	0	155, 171	0		12. 00
13.00	SUBPROVI DER - I RF	41.00	0	63, 889	o		13. 00
14.00	OPERATING ROOM	50.00	0	4, 934, 076	0		14. 00
15.00	RECOVERY ROOM	51.00	0	223, 259	o		15. 00
16.00	DELIVERY ROOM & LABOR ROOM	52.00	0	305, 656	0		16. 00
17.00	RADI OLOGY-DI AGNOSTI C	54.00	0				17. 00
18. 00	RADI OLOGY-THERAPEUTI C	55.00	0				18. 00
19. 00	CT SCAN	57.00	0	131, 933	0		19. 00

| Period: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:56 am

In Lieu of Form CMS-2552-10

						6/29/2020 8	:56 am
		Decreases		0.11			
	Cost Center	Li ne #	Sal ary	Other 0.00	Wkst. A-7 Ref.		
20. 00	6. 00 MAGNETIC RESONANCE I MAGING	7. 00 58. 00	8. 00	9. 00 11, 639	10. 00		20, 00
20.00	(MRI)	36.00	٥	11,039	U		20.00
21. 00	CARDI AC CATHETERI ZATI ON	59.00	0	61, 161	o		21. 00
22. 00	RESPIRATORY THERAPY	65. 00	Ö	459, 004			22. 00
23. 00	PHYSI CAL THERAPY	66.00	O	22, 175	l .		23. 00
24.00	ELECTROCARDI OLOGY	69.00	o	26, 786	0		24. 00
25.00	ELECTROENCEPHALOGRAPHY	70.00	O	76, 449	0		25. 00
26.00	OP PHARMACY	73. 01	0	1, 973	0		26. 00
27. 00	RENAL DIALYSIS	74.00	0	14, 460			27. 00
28. 00	CARDIAC REHABILITATION	76. 97	0	4, 634	I		28. 00
29. 00	CLINIC	90.00	0	818			29. 00
30.00	OP ONCOLOGY INFUSION CENTER	90. 01	0	198, 721	l .		30.00
31.00	WOUND CARE CENTER	90.02	0	72, 514	l .		31. 00
32. 00 33. 00	PAIN CLINIC OP PSYCH CLINIC	90. 03 90. 05	0	36, 375 1, 430	l .		32. 00 33. 00
34. 00	EMERGENCY	91.00	0	880, 069	l .		34.00
35. 00	AMBULANCE SERVICES	95.00	0	193, 942			35. 00
36. 00	PROMPTCARE	190. 01	ő	111, 484	1		36. 00
37. 00	OLCOTT	190. 03	o	1, 412			37. 00
38. 00	COMMUNITY HEALTH SERVICES	190. 11	O	14, 248	l .		38. 00
39.00	PHYSICIANS' PRIVATE OFFICES	192.00	o	210	O		39. 00
	0		0	11, 947, 090			
	E - IMPLANTS SUPPLIES						
1.00	CENTRAL STERILIZATION	18. 01	0	1, 493	l .		1.00
2.00	ADULTS & PEDIATRICS	30.00	0	2, 186	l .		2.00
3.00	INTENSIVE CARE UNIT	31.00	0	713	l .		3. 00
4. 00 5. 00	CORONARY CARE UNIT SUBPROVIDER - IRF	32. 00 41. 00	0	303 190			4. 00 5. 00
6. 00	OPERATING ROOM	50.00	0	11, 745, 636			6.00
7. 00	RECOVERY ROOM	51.00	ő	144			7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	o	249, 477			8. 00
9.00	CT SCAN	57.00	0	1, 253			9. 00
10.00	CARDIAC CATHETERIZATION	59.00	o	4, 805, 492	0		10. 00
11.00	RESPI RATORY THERAPY	65.00	0	166	0		11. 00
12.00	ELECTROENCEPHALOGRAPHY	70.00	0	128	I		12. 00
13. 00	OP ONCOLOGY INFUSION CENTER	90. 01	0	4, 709			13. 00
14.00	WOUND CARE CENTER	90.02	0	1 150	0		14. 00
15. 00	EMERGENCY	91.00	0	<u>1, 1</u> 50 16, 813, 047			15. 00
	F - LEASE EXPENSE		<u> </u>	10, 013, 047			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	21, 876	10		1.00
2.00	OPERATION OF PLANT	7. 00	O	146, 517			2. 00
3.00	CENTRAL SERVICES & SUPPLY	14.00	0	256, 292	0		3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00	0	7, 596	0		4. 00
5.00	LABORATORY	60.00	0	21, 824	l .		5. 00
6.00	RESPIRATORY THERAPY	65.00	0	1, 950	l .		6. 00
7.00	PHYSICAL THERAPY	66.00	0	471, 023	l .		7. 00
8. 00 9. 00	OP ONCOLOGY INFUSION CENTER WOUND CARE CENTER	90. 01 90. 02	0	74, 217 71, 012			8. 00 9. 00
10. 00	PAIN CLINIC	90.02	0	48, 030			10.00
11. 00	OP PSYCH CLINIC	90.05	o	81, 648	l .		11.00
12. 00	AMBULANCE SERVICES	95.00	o	161, 290			12. 00
13.00	PROMPTCARE	190. 01	0	33, 111	l .		13. 00
14.00	COMMUNITY HEALTH SERVICES	190. 11	0	71, 540	o		14. 00
	0		0	1, 467, 926			_
	G - BILLABLE DRUGS						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	94, 672			1.00
2.00	NURSI NG ADMI NI STRATI ON	13.00	0	20 5/2 /07	- 1		2.00
3. 00 4. 00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	28, 562, 697 48			3. 00 4. 00
5.00	INTENSIVE CARE UNIT	31.00	0	22	- 1		5. 00
6. 00	OPERATING ROOM	50.00	ő	79, 421			6. 00
7. 00	DELIVERY ROOM & LABOR ROOM	52.00	Ö	124			7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	Ö	21, 012			8. 00
9. 00	RADI OLOGY-THERAPEUTI C	55.00	Ō	19, 664	l .		9. 00
10.00	CT SCAN	57.00	O	122, 092	l .		10.00
11. 00	MAGNETIC RESONANCE IMAGING	58.00	O	61, 551	O		11. 00
40	(MRI)						4.5
12.00	CARDIAC CATHETERIZATION	59.00	0	64, 702			12.00
13.00	LABORATORY	60.00	0	2, 240			13.00
14. 00 15. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00	0	72 360, 598			14. 00 15. 00
16. 00	RENAL DIALYSIS	74.00	0	300, 396			16. 00
17. 00	CARDI AC REHABI LI TATI ON	76. 97	ő	36			17. 00
			٩		<u> </u>		1

Peri od: Worksheet A-6 From 01/01/2019 To 12/31/2019 Date/Time Prepared:

						6/29/2020 8:	
		Decreases					
	Cost Center	Li ne #	Sal ary	Other	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
18. 00	CLINIC	90.00	0	33, 947			18. 00
19. 00	OP ONCOLOGY INFUSION CENTER	90. 01	0	1, 591			19. 00
20. 00	WOUND CARE CENTER	90. 02	0	10, 643	l .		20. 00
21. 00	PAIN CLINIC	90. 03	0	14, 793			21. 00
22. 00	EMERGENCY	91. 00	0	1, 357	l .		22. 00
23. 00	AMBULANCE SERVICES	95. 00	0	58, 036	l .		23. 00
24. 00	PROMPTCARE	190. 01	0	76, 540	l .		24. 00
25. 00	COMMUNITY HEALTH SERVICES	190. 11	0	3, 296	l .		25. 00
26. 00	PHYSICIANS' PRIVATE OFFICES	1 <u>92.</u> 00	0	64			26. 00
	U NON DILLARIE DDUCS		0	29, 589, 303			_
1. 00	H - NON-BILLABLE DRUGS CENTRAL SERVICES & SUPPLY	14.00	T	2, 365	O		1.00
2.00	CENTRAL SERVICES & SUPPLY	18. 01		2, 303	0		2. 00
3.00	ADULTS & PEDIATRICS	30.00		248, 451			3. 00
4.00	INTENSIVE CARE UNIT	31.00		80, 640			4. 00
5. 00	CORONARY CARE UNIT	32.00		33, 031	l .		5. 00
6. 00	NEONATAL INTENSIVE CARE UNIT	35.00		8, 003			6. 00
7. 00	SUBPROVI DER - I RF	41.00		1, 200	I		7. 00
8. 00	OPERATING ROOM	50.00		56, 557	l .		8. 00
9. 00	RECOVERY ROOM	51. 00		43, 295			9. 00
10.00	DELIVERY ROOM & LABOR ROOM	52. 00		24, 178	l .		10.00
11. 00	RADI OLOGY-DI AGNOSTI C	54.00		44, 211			11. 00
12.00	RADI OLOGY-THERAPEUTI C	55. 00		3, 167	O		12. 00
13.00	CT SCAN	57. 00		6, 660	0		13. 00
14.00	MAGNETIC RESONANCE IMAGING	58. 00		1, 451	0		14. 00
	(MRI)						
15. 00	CARDIAC CATHETERIZATION	59. 00		12, 159			15. 00
16. 00	RESPI RATORY THERAPY	65. 00		7, 461	l .		16. 00
17. 00	ELECTROCARDI OLOGY	69. 00		3, 273			17. 00
18. 00	RENAL DIALYSIS	74. 00		6, 492	l .		18. 00
19. 00	CLINIC	90.00		15, 570	l .		19. 00
20. 00	OP ONCOLOGY INFUSION CENTER	90. 01		53, 846			20. 00
21. 00	PAIN CLINIC	90. 03		638			21. 00
22. 00	EMERGENCY	91. 00		193, 362			22. 00
23. 00	AMBULANCE SERVICES	95.00		23, 452			23. 00
24. 00	PROMPTCARE	190. 01		302			24. 00
25. 00	COMMUNITY HEALTH SERVICES	1 <u>90.</u> 11					25. 00
	J - INTEREST EXPENSE		U U	870, 061			
1.00	INTEREST EXPENSE	113.00	O	1, 079, 509	11		1.00
1.00	n EKEST EKISE	113.00	— —  —	1, 079, 509	' '		1.00
	K - PHARMACY RESIDENCY			1,017,307			
1.00	PHARMACY	15. 00	156, 990	12, 010	0		1.00
2. 00	CLINIC	90.00	13, 621	1, 042			2. 00
	0		170, 611	13, 052			
	L - PSYCH ADMIN		-, -	.,			
1.00	ADULTS & PEDIATRICS	30.00	232, 463	30, 019	0		1.00
	0 — — — — — —		232, 463	30, 019			
	M - SOFTWARE LICENSE						
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	3, 774			1. 00
2.00	NURSING ADMINISTRATION	13. 00	0	49, 493	l .		2. 00
3.00	PHARMACY	15. 00	0	266			3. 00
4.00	RADI OLOGY-THERAPEUTI C	55. 00	0	275			4. 00
5.00	RESPIRATORY THERAPY	65.00	0	1, 650			5. 00
6. 00	AMBULANCE SERVICES	95. 00	0	1, 000	l .		6. 00
7.00	OLCOTT	190. 03	0	15, 000			7. 00
8.00	COMMUNITY HEALTH SERVICES	1 <u>90.</u> 11	0	275			8. 00
	U CAFETEDIA		0	71, 733			
1. 00	N - CAFETERIA	10.00	835, 906	724 004	O		1.00
1.00	DI ETARY		835, 906 835, 906	72 <u>6, 084</u> 726, 084			1.00
	O - SHORT TERM DISABILITY/FLM	ΙΛΛ	030, 900	720, 084			
1.00	ADMINISTRATIVE & GENERAL	5. 00	19, 083	0	O		1.00
2.00	OPERATION OF PLANT	7. 00	11, 311	0			2. 00
3.00	HOUSEKEEPI NG	9. 00	8, 119	0			3. 00
4.00	DI ETARY	10.00	15, 985	0	0		4. 00
5. 00	NURSING ADMINISTRATION	13. 00	41, 027	0	0		5. 00
6.00	PHARMACY	15. 00	20, 726	0	o		6. 00
7. 00	CENTRAL STERILIZATION	18. 01	4, 598	n	o		7. 00
8. 00	ADULTS & PEDIATRICS	30.00	85, 349	0			8. 00
9. 00	INTENSIVE CARE UNIT	31.00	24, 930	0	Ö		9. 00
10.00	CORONARY CARE UNIT	32. 00	20, 155	0			10.00
11. 00	NEONATAL INTENSIVE CARE UNIT	35.00	4, 354	0	o		11. 00
12.00	SUBPROVI DER - I RF	41. 00	1, 325	0	o		12. 00

Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10 | Period: | Worksheet A-6 | From 01/01/2019 | To 12/31/2019 | Date/Time Prepared: 6/29/2020 8:56 am Provider CCN: 15-0051

						6/29/2020 8	:56 am
		Decreases				!	
	Cost Center	Li ne #	Salary		Wkst. A-7 Ref.		
13. 00	6. 00 OPERATING ROOM	7. 00 50. 00	8. 00 28, 843	9.00	10. 00		13. 00
14. 00	RECOVERY ROOM	51. 00		0	0	•	14. 00
15. 00	DELIVERY ROOM & LABOR ROOM	52.00	21, 967	Ö	O		15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	26, 775	0	0		16. 00
17.00	RADI OLOGY-THERAPEUTI C	55.00	19, 592	0	0		17. 00
18. 00	CT SCAN	57. 00	4, 162	0	0		18. 00
19. 00	CARDI AC CATHETERI ZATI ON	59.00	6, 862	0	0		19. 00
20.00	RESPIRATORY THERAPY PHYSICAL THERAPY	65.00	367	0	0		20.00
21. 00 22. 00	ELECTROCARDI OLOGY	66. 00 69. 00	49, 360 594	0	0		21. 00 22. 00
23. 00	ELECTROENCEPHALOGRAPHY	70.00	2, 321	o	Ö		23. 00
24. 00	CARDI AC REHABI LI TATI ON	76. 97	3, 937	Ō	0		24. 00
25.00	CLINIC	90.00	19, 454	0	0		25. 00
26.00	OP ONCOLOGY INFUSION CENTER	90. 01	26, 114	0	0		26. 00
27. 00	WOUND CARE CENTER	90. 02	3, 402	0	0		27. 00
28. 00	PAIN CLINIC	90. 03	293 334	0	0		28. 00
29. 00 30. 00	OP PSYCH CLINIC EMERGENCY	90. 05 91. 00	44, 346	0	0		29. 00 30. 00
31. 00	AMBULANCE SERVICES	95. 00	48, 567	Ö	Ö		31.00
32. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	2, 201	O	0		32. 00
	CANTEEN						
33.00	PROMPTCARE	190. 01	7, 267	0	0		33. 00
34. 00	OLCOTT	190. 03	7, 148	0	0		34. 00
35. 00	COMMUNITY HEALTH SERVICES	1 <u>90.</u> 1 <u>1</u>	<u>1, 334</u> 618, 723	0	0		35. 00
	P - UTILITIES EXPENSE		010, 723	O <sub>I</sub>			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	5	0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	858	0		2. 00
3. 00	HOUSEKEEPI NG	9. 00	0	366	0		3. 00
4.00	NURSI NG ADMI NI STRATI ON	13.00	0	90	0		4.00
5. 00 6. 00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	14 127	0		5. 00 6. 00
7. 00	INTENSIVE CARE UNIT	31.00	0	11	0		7. 00
8. 00	CORONARY CARE UNIT	32.00	Ö	5	Ö		8. 00
9.00	NEONATAL INTENSIVE CARE UNIT	35.00	0	5	0		9. 00
10.00	OPERATING ROOM	50. 00	0	83	0		10. 00
11. 00	RECOVERY ROOM	51. 00	0	8	0		11. 00
12.00	DELIVERY ROOM & LABOR ROOM	52.00	0	11	0		12.00
13. 00 14. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54. 00 55. 00	0	14, 923 166, 030	0		13. 00 14. 00
15. 00	CT SCAN	57. 00	0	32	0		15. 00
16. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	27	O		16. 00
	(MRI)						
17. 00	CARDI AC CATHETERI ZATI ON	59. 00	0	117	0		17. 00
18. 00	RESPIRATORY THERAPY	65.00	0	37	0		18. 00
19. 00 20. 00	PHYSI CAL THERAPY ELECTROCARDI OLOGY	66. 00 69. 00	0	26, 730 5	0		19. 00 20. 00
21. 00	OP ONCOLOGY INFUSION CENTER	90. 01	0	2, 771	0		21. 00
22. 00	PAIN CLINIC	90. 03	0	5, 698	0		22. 00
23.00	OP PSYCH CLINIC	90. 05	0	11	0		23. 00
24.00	EMERGENCY	91. 00	0	21	0		24. 00
25. 00	AMBULANCE SERVICES	95. 00	0	36, 054	0		25. 00
26. 00	PROMPTCARE	190. 01 190. 02	0	34, 041	0		26. 00 27. 00
27. 00 28. 00	RENTAL PROPERTIES FOUNDATION	190. 02 190. 05	0	4, 805	0		28. 00
29. 00	COMMUNITY HEALTH SERVICES	190. 11	o	28, 791	ő		29. 00
30.00	PHYSICIANS' PRIVATE OFFICES	192. 00	0	234	0		30. 00
	0		0	321, 915			
1. 00	Q - BCC DEPRECIATION CAP REL COSTS-BLDG & FIXT	1.00	O	61, 446	9		1.00
2. 00	CAP REL COSTS-BLDG & FIXT	0.00	0	01, 440	0		2. 00
3.00		0.00	o	Ö	Ö		3. 00
	TOTALS		0	61, 446			
	R - OCCUPATIONAL HEALTH ADMIN		222.224		ما		
1. 00	PROMPTCARE	1 <u>90.</u> 01	209, 926 209, 926	0	0		1. 00
	S - NURSERY		207, 720	O <sub>I</sub>			
1.00	ADULTS & PEDIATRICS	30. 00	614, 016	65, 980	0		1. 00
2.00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	27, 892	23, 735	0		2. 00
	T PEDEODD ALLOCATION		641, 908	89, 715			_
1. 00	T - BEDFORD ALLOCATION EMPLOYEE BENEFITS DEPARTMENT	4.00	42, 056	29, 389	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5. 00		265, 790	o		2. 00
3.00	DI ETARY	10. 00		2, 345	o		3. 00
		·		·			

Heal th	Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL			In Lieu of Form CMS-2552-10			
RECLASSI FI CATI ONS				Provider C	CCN: 15-0051	Peri od:	Worksheet A-	6
						From 01/01/2019 To 12/31/2019	Date/Time Pr 6/29/2020 8:	epared: 56 am
	Decreases					1		
	Cost Center	Li ne #	Sal ary		Wkst. A-7 Ref	<u> </u>		
	6. 00	7. 00	8. 00	9. 00	10. 00			
4.00	NURSING ADMINISTRATION	13. 00	43, 768	17, 284		0		4. 00
5.00	PHARMACY	15. 00	242, 804	89, 849		0		5. 00
6.00	PHYSI CAL THERAPY	66.00	32, 525	8, 202		0		6. 00
7.00	CLINIC	90.00	<u></u> 3 <u>6, 5</u> 43	20, 097		0		7. 00
	0		883, 599	432, 956				
	U - PAOLI ALLOCATION							
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	23, 682	16, 549		0		1. 00
2.00	ADMINISTRATIVE & GENERAL	5.00	253, 534	145, 100		0		2. 00
3.00	NURSING ADMINISTRATION	13. 00	20, 707	8, 672		0		3. 00
4.00	PHARMACY	15. 00	76, 802	29, 124		0		4. 00
5.00	PHYSI CAL THERAPY	66.00	76, 311	21, 147		0		5. 00
6.00	CLINIC	90.00	16, 422	9, 031		0		6. 00
	0		467, 458	229, 623				
	V - LIBERTY BUILDING DEPRECIATION							
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	128, 295		9		1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	3, 640		9		2. 00
	TOTALS		0	131, 935				
500.00 Grand Total: Decreases			4, 060, 594	106, 249, 499				500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS

					To 12/31/2019	Date/Time Prep 6/29/2020 8:50	
				Acqui si ti ons		0/27/2020 0.3	o aiii
		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 ASSET	Γ BALANCES					
1.00	Land	19, 741, 447	0	(	0 0	0	1. 00
2.00	Land Improvements	2, 058, 207	0	(	0	0	2. 00
3.00	Buildings and Fixtures	150, 733, 671	0	(	0	0	3. 00
4.00	Building Improvements	11, 327, 645	0	(	0 0	0	4. 00
5. 00	Fi xed Equipment	0	0	(	0	0	5. 00
6. 00	Movable Equipment	138, 770, 538	4, 504, 965	(	4, 504, 965	11, 657, 226	6. 00
7.00	HIT designated Assets	0	0	(	0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	322, 631, 508	4, 504, 965	(	4, 504, 965	11, 657, 226	8. 00
9.00	Reconciling Items	0	0	(	0	0	9. 00
10.00	Total (line 8 minus line 9)	322, 631, 508	4, 504, 965	(	0 4, 504, 965	11, 657, 226	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
			Assets				
	DART I ANALYSIS OF SUANOFS IN SARITAL ASSE	6.00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		al				
1.00	Land	19, 741, 447	0				1.00
2.00	Land Improvements	2, 058, 207	0				2. 00
3.00	Buildings and Fixtures	150, 733, 671	0				3. 00
4.00	Building Improvements	11, 327, 645	0				4.00
5.00	Fi xed Equi pment	0	0				5. 00
6.00	Movable Equipment	131, 618, 277	0				6. 00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	315, 479, 247	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10. 00	Total (line 8 minus line 9)	315, 479, 247	0				10. 00

Heal th	Financial Systems II	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provider CC	CN: 15-0051	Peri od: From 01/01/2019 To 12/31/2019		pared:
			SU	JMMARY OF CAP	PLTAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)		
		9. 00	10.00	11. 00	12. 00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2. 00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00
		SUMMARY O	F CAPITAL				
	Cost Center Description	Other	Total (1) (sum				
	·	Capi tal -Rel ate	of cols. 9				
		d Costs (see	through 14)				
		instructions)					
		14.00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FLXT	0	0				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00
0 00	T 1 1 ( C1: 4 O)			I			

0 0 0

0 0 0

1. 00 2. 00 3. 00

1.00 CAP REL COSTS-BLDG & FLX1
2.00 CAP REL COSTS-MVBLE EQUIP
3.00 Total (sum of lines 1-2)

Heal th	Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der C	F	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	
					1	6/29/2020 8:5	6 am
		COMI	PUTATION OF RAT	110S	ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
			Leases	for Ratio	instructions)		
				(col. 1 - col.			
				2)			
		1.00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	183, 860, 970	0	183, 860, 970	0. 582799	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	131, 618, 277	0	131, 618, 277	0. 417201	0	2.00
3.00	Total (sum of lines 1-2)	315, 479, 247	0	315, 479, 247	1. 000000	0	3.00
		ALLOCA <sup>-</sup>	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Rel ate	col s. 5			
			d Costs	through 7)			
		6. 00	7.00	8. 00	9. 00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS					
1.00	CAP REL COSTS-BLDG & FLXT	0	0	(	7, 838, 618	1, 180, 239	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0	(	16, 403, 005	287, 687	2.00
3.00	Total (sum of lines 1-2)	0	0	(	24, 241, 623	1, 467, 926	3. 00
			Sl	JMMARY OF CAPI	ΓAL		
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	cost contor boson per on		instructions)	,	Capi tal -Rel ate		
					d Costs (see	through 14)	
					instructions)	3	
		11. 00	12.00	13.00	14.00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FLXT	-8, 253, 979	0		0	764, 878	1. 00
2 00	CAD DEL COSTS MADLE FOLLID	1	1	1	71 722		

0 -8, 253, 979

0 0 0

0 71, 733 71, 733

764, 878 16, 762, 425 17, 527, 303

2. 00

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

Peri od: Wo From 01/01/2019 Provider CCN: 15-0051

To 12/31/201							
				Expense Classification on		6/29/2020 8: 50	o am
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description		Amount	Cost Center		Wkst. A-7 Ref.	
1. 00	Investment income - CAP REL	1. 00 A	2. 00 -8, 630, 627	3.00 CAP REL COSTS-BLDG & FLXT	4. 00	5. 00 11	1. 00
2.00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAD DEL COSTS MADLE FOLLD	2.00	0	2 00
2. 00	COSTS-MVBLE EQUIP (chapter 2)		U	CAP REL COSTS-MVBLE EQUIP	2.00	0	2. 00
3. 00	Investment income - other (chapter 2)		0		0. 00	0	3. 00
4.00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0. 00	0	5. 00
6. 00	expenses (chapter 8) Rental of provider space by		0		0.00	0	6. 00
	suppliers (chapter 8)		0				
7. 00	Telephone services (pay stations excluded) (chapter		0		0.00	0	7. 00
0.00	21)		0		0.00		0.00
8. 00	Television and radio service (chapter 21)		Ü		0.00	0	8. 00
9. 00 10. 00	Parking Lot (chapter 21) Provider-based physician	A-8-2	0 -17, 565, 784		0.00	0	9. 00 10. 00
	adj ustment	A-0-2					
11. 00	Sale of scrap, waste, etc. (chapter 23)		0		0.00	0	11. 00
12.00	Related organization	A-8-1	44, 136, 664			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee	1	0		0. 00 0. 00	0	14. 00 15. 00
	and others		0				
16. 00	Sale of medical and surgical supplies to other than		0		0.00	0	16. 00
17. 00	patients Sale of drugs to other than		0		0.00	0	17. 00
17.00	pati ents		0				
18. 00	Sale of medical records and abstracts		0		0.00	0	18. 00
19. 00	Nursing and allied health education (tuition, fees,		0		0. 00	0	19. 00
	books, etc.)						
20. 00 21. 00	Vending machines Income from imposition of		0		0. 00 0. 00	0	20. 00 21. 00
	interest, finance or penalty						
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
	overpayments and borrowings to repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPIRATORY THERAPY	65.00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		24. 00
	limitation (chapter 14)						
25. 00	Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
24 00	(chapter 21) Depreciation - CAP REL		0	CAD DEL COCTO DIDO « FLVT	1 00	0	24 00
26. 00	COSTS-BLDG & FLXT		U	CAP REL COSTS-BLDG & FIXT	1.00	U	26. 00
27. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19. 00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0. 00 67. 00	0	29. 00 30. 00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	O	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of		3		33. 30		50
32. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0. 00	0	32. 00
33. 00	Depreciation and Interest MISCELLANEOUS INCOME	В	-6 932	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	33. 00
	1 2222 333 1133 312		0, 732		1. 30	<u> </u>	

Health Financial Systems ADJUSTMENTS TO EXPENSES Provider CCN: 15-0051 Peri od: Worksheet A-8 

					12/31/2019	6/29/2020 8: 5	
				Expense Classification on	Worksheet A	0,27,2020 0.0	
				To/From Which the Amount is			
					,		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
33. 01	MI SCELLANEOUS I NCOME	В		ADMINISTRATIVE & GENERAL	5.00		33. 01
33. 02	MI SCELLANEOUS I NCOME	В		OPERATION OF PLANT	7. 00		ı
33. 03	MI SCELLANEOUS I NCOME	В		HOUSEKEEPI NG	9. 00		33. 03
33. 04	MI SCELLANEOUS I NCOME	В	-241, 636	1	10. 00		33. 04
33. 05	MI SCELLANEOUS I NCOME	В		NURSING ADMINISTRATION	13. 00		33. 05
33. 06	MI SCELLANEOUS I NCOME	В		PHARMACY	15. 00		33. 06
33. 07	MI SCELLANEOUS I NCOME	В		ADULTS & PEDIATRICS	30.00		33. 07
33. 08	MI SCELLANEOUS I NCOME	В		OPERATING ROOM	50.00		33. 08
33. 09	MI SCELLANEOUS I NCOME	В		LABORATORY	60.00		33. 09
33. 10	MI SCELLANEOUS I NCOME	В		PHYSI CAL THERAPY	66.00		33. 10
33. 10	MI SCELLANEOUS I NCOME	В		ELECTROENCEPHALOGRAPHY	70.00		33. 11
33. 12	MI SCELLANEOUS I NCOME	В		CARDI AC REHABI LI TATI ON	76. 97		33. 12
33. 12	MI SCELLANEOUS I NCOME	В	-32, 779	1	90.00		33. 12
33. 14	MI SCELLANEOUS I NCOME	В	· ·	OP ONCOLOGY INFUSION CENTER	90.00		33. 14
33. 14	MI SCELLANEOUS I NCOME	В		PAIN CLINIC	90.01		33. 14
33. 16	MI SCELLANEOUS I NCOME	В		OP PSYCH CLINIC	90.05		33. 16
33. 17	MI SCELLANEOUS I NCOME	В		AMBULANCE SERVICES	95. 00		33. 17
33. 17	MI SCELLANEOUS I NCOME	В	· ·	PROMPTCARE	190. 01		33. 17
33. 19	ACCRUED PTO	A		i i		-	33. 19
				EMPLOYEE BENEFITS DEPARTMENT	4.00		•
33. 20	ACCRUED PTO ACCRUED PTO	A		NURSI NG ADMI NI STRATI ON	13.00		33. 20
33. 21	UNNECESSARY BORROWING	A		ADULTS & PEDIATRICS	30.00		33. 21 33. 22
33. 22	4	A		CAP REL COSTS-BLDG & FIXT	1.00		
33. 23	TELEPHONE EXPENSE TELEPHONE EXPENSE	A		DIETARY	10.00		
33. 24 33. 25	TELEPHONE EXPENSE	A		PHARMACY ADULTS & PEDIATRICS	15.00		33. 24 33. 25
	1	A	· ·	ł	30.00		•
33. 26	TELEPHONE EXPENSE	A		CORONARY CARE UNIT	32.00		33. 26
33. 27	TELEPHONE EXPENSE	A		RECOVERY ROOM	51.00		33. 27
33. 28	TELEPHONE EXPENSE	A		RESPIRATORY THERAPY	65.00		33. 28
33. 29	TELEPHONE EXPENSE	A		PHYSI CAL THERAPY	66.00		33. 29
33. 30	TELEPHONE EXPENSE	A		OP PHARMACY	73. 01		33. 30
33. 31	TELEPHONE EXPENSE	A		EMERGENCY	91.00		33. 31
33. 32	BENEFIT EXPENSE	A		EMPLOYEE BENEFITS DEPARTMENT	4.00		33. 32
33. 33	CONTRI BUTI ON EXPENSE	A		ADMINISTRATIVE & GENERAL	5. 00		33. 33
33. 34	PHYSICIAN RECRUITMENT	A		ADMINISTRATIVE & GENERAL	5.00		33. 34
33. 35	PHYSICIAN RECRUITMENT	A		RADI OLOGY-DI AGNOSTI C	54.00		33. 35
33. 36	HAF FEES	A		ADMINISTRATIVE & GENERAL	5.00		33. 36
33. 37	CAFETERIA REVENUE	В	-1, 078, 534	1	11.00		33. 37
33. 38	WEGMILLER CAPITALIZED INTEREST	A		CAP REL COSTS-BLDG & FLXT	1.00		33. 38
33. 39	1983 CAPITALIZED INTEREST	A		CAP REL COSTS-BLDG & FLXT	1.00		33. 39
33. 40	OTHER CARRYFORWARD ADJUSTMENTS			CAP REL COSTS-BLDG & FIXT	1.00		33. 40
33. 41	PENALTY TAX	A		ADMINISTRATIVE & GENERAL	5.00		33. 41
	PENALTY TAX	A		OPERATION OF PLANT	7. 00		33. 42
	START UP COSTS	A		ADMINISTRATIVE & GENERAL	5.00		
	UNWONTED SITUATIONS	A		ADMINISTRATIVE & GENERAL	5.00		1
33. 45	NONALLOWABLE MARKETING	A		ADMINISTRATIVE & GENERAL	5. 00		
33. 46	NONALLOWABLE MARKETING	A	-840	PARAMED ED PRGM-PHARMACY	23. 00	0	33. 46
22 47	NONALLOWARIE MARKETING	_	24	RESI DENCY	20.00	_	22 47
33. 47	NONALLOWABLE MARKETING	A		ADULTS & PEDIATRICS	30.00		
33. 48	NONALLOWABLE MARKETING	A		OPERATING ROOM	50.00		33. 48
33. 49	I			OP PSYCH CLINIC	90.05		33. 49
33. 50	1		· ·	AMBULANCE SERVICES	95.00		33. 50
33. 51	SIP PHARMACY RESIDENCY	A	33, 65/	PARAMED ED PRGM-PHARMACY	23. 00	0	33. 51
50. 00	TOTAL (sum of lines 1 three 40)		26 240 117	RESI DENCY			50.00
SU. UU	TOTAL (sum of lines 1 thru 49)		-26, 269, 117				50. 00
	(Transfer to Worksheet A, column 6, line 200.)						
	COLUMNI O, TITLE 200. )	1				l	L

<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.

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

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

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

Provider CCN: 15-0051 Period: From 01/01/2019 To 12/31/2019 Date/Time Prepared: (40/2020 0.55)

				10 12/31/2019	6/29/2020 8: 5	
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
		MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OR	GANIZATIONS OR	CLAI MED	
	HOME OFFICE COSTS:					
1.00			HO ALLOCATION	2, 440, 099	1, 079, 509	1. 00
2.00		CAP REL COSTS-MVBLE EQUIP	HO ALLOCATION	10, 052, 898	0	2.00
3.00	•	l .	HO ALLOCATION	24, 866, 531	50, 137	3.00
4.00			HO ALLOCATION	56, 354, 034	52, 311, 436	4.00
4. 01		EMERGENCY	SIP ER	6, 279, 464	2, 415, 280	4. 01
4.02			SHARED EMPLOYEES	818, 419	818, 419	4. 02
4.03	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEES	4, 408, 438	4, 408, 438	4. 03
4.04	35. 00	NEONATAL INTENSIVE CARE UNIT	SHARED EMPLOYEES	549, 724	549, 724	4.04
4.05	50.00	OPERATING ROOM	SHARED EMPLOYEES	1, 797, 320	1, 797, 320	4.05
4.06	51. 00	RECOVERY ROOM	SHARED EMPLOYEES	54, 660	54, 660	4.06
4.07	55. 00	RADI OLOGY-THERAPEUTI C	SHARED EMPLOYEES	521, 917	521, 917	4.07
4.08	57. 00	CT SCAN	SHARED EMPLOYEES	17, 500	17, 500	4. 08
4.09	60.00	LABORATORY	SHARED EMPLOYEES	14, 520, 554	14, 520, 554	4.09
4. 10	66. 00	PHYSI CAL THERAPY	SHARED EMPLOYEES	-97, 926	-97, 926	4. 10
4. 11	70.00	ELECTROENCEPHALOGRAPHY	SHARED EMPLOYEES	1, 018, 056	1, 018, 056	4. 11
4. 12	90. 01	OP ONCOLOGY INFUSION CENTER	SHARED EMPLOYEES	480, 973	480, 973	4. 12
4. 13	90. 05	OP PSYCH CLINIC	SHARED EMPLOYEES	50, 585	50, 585	4. 13
4. 14	91.00	EMERGENCY	SHARED EMPLOYEES	53, 863	53, 863	4. 14
4. 16	95. 00	AMBULANCE SERVICES	SHARED EMPLOYEES	131, 290	131, 290	4. 16
4. 17	190. 01	PROMPTCARE	SHARED EMPLOYEES	411, 479	411, 479	4. 17
4. 18	190. 09	CLINICAL TRIALS	SHARED EMPLOYEES	-5, 950	-5, 950	4. 18
4. 19	190. 11	COMMUNITY HEALTH SERVICES	SHARED EMPLOYEES	29, 028	29, 028	4. 19
4. 20	192. 00	PHYSICIANS' PRIVATE OFFICES	SHARED EMPLOYEES	9, 113	9, 113	4. 20
5.00	0		0	124, 762, 069	80, 625, 405	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.

			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	ED 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	C		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.

OFFICE	C0515				To 12/31/2019	Date/Time Pre 6/29/2020 8:5	epared: 56 am
	Net	Wkst. A-7 Ref.					
	Adjustments						
	(col. 4 minus						
	col. 5)*						
	6. 00	7. 00					
			MENTS REQUIRED AS A RESULT OF TRA	NSACTIONS WITH RELATED O	RGANIZATIONS OR (	CLAI MED	
	HOME OFFICE CO						
1.00	1, 360, 590						1.00
2.00	10, 052, 898						2.00
3.00	24, 816, 394						3.00
4.00	4, 042, 598						4.00
4. 01	3, 864, 184	0					4. 01
4. 02	[ C	0					4. 02
4.03	( C	0					4. 03
4.04	C	0					4. 04
4.05	C	0					4. 05
4.06	C	0					4.06
4.07	[ C	0					4. 07
4.08	[ C	0					4. 08
4.09	[ C	0					4. 09
4. 10	[ C	0					4. 10
4. 11	[ C	0					4. 11
4. 12	[ C	0					4. 12
4. 13	[ C	0					4. 13
4. 14	[ C	0					4. 14
4. 16	[ C	0					4. 16
4. 17	[ C	0					4. 17
4. 18	[ C	0					4. 18
4. 19	[ C	0					4. 19
4. 20	[ C	0					4. 20
5.00	44, 136, 664						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.

Related Organization(s) and/or Home Office		
Type of Business		
6. 00		
B. INTERRELATIONSHIP TO RELAT	ED 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		8. 00
9.00		9. 00
9. 00 10. 00 100. 00		10. 00
100.00		100. 00

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT Provider CCN: 15-0051 

						To 12/31/2019	Date/Time Pre 6/29/2020 8:5	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
				· ·	•		Hours	
	1. 00	2.00	3.00	4.00	5. 00	6. 00	7. 00	
1.00	5. 00	ADMINISTRATIVE & GENERAL	3, 434, 049	3, 434, 049	0	211, 500	0	1. 00
2.00	30.00	ADULTS & PEDIATRICS	5, 131, 688	5, 053, 551	78, 137	211, 500	970	2. 00
3.00	35. 00	NEONATAL INTENSIVE CARE UNIT	540, 301	250, 342	289, 959	169, 700	4, 441	3. 00
4.00	50.00	OPERATING ROOM	1, 353, 263	1, 353, 263	0	246, 400	O	4. 00
5.00	55. 00	RADI OLOGY-THERAPEUTI C	448, 781	448, 781	0	271, 900	o	5. 00
6.00	66.00	PHYSI CAL THERAPY	269, 650	180, 885	88, 765	211, 500	326	6. 00
7.00	69. 00	ELECTROCARDI OLOGY	58, 861		43, 437	181, 300		7. 00
8.00	70.00	ELECTROENCEPHALOGRAPHY	281, 205	281, 205	0	271, 900	o	8. 00
9.00	90. 05	OP PSYCH CLINIC	1, 024, 649	749, 473	275, 176	181, 300	4, 979	9. 00
10.00	91.00	EMERGENCY	5, 743, 195	5, 743, 195		211, 500		10.00
200.00			18, 285, 642					200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of	Provi der	Physician Cost	
		I denti fi er	Limit	Unadjusted RCE	Memberships &	Component	of Mal practice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1. 00	2. 00	8. 00	9. 00	12. 00	13. 00	14. 00	
1.00	•	ADMINISTRATIVE & GENERAL	0	1	0	0		1. 00
2.00		ADULTS & PEDIATRICS	98, 632				0	2. 00
3.00		NEONATAL INTENSIVE CARE UNIT	362, 326	18, 116	0	0	0	3. 00
4.00		OPERATING ROOM	0	0	0	0	0	4. 00
5.00		RADI OLOGY-THERAPEUTI C	0	0	0	0	0	5. 00
6.00		PHYSI CAL THERAPY	33, 149		0	0	0	6. 00
7.00		ELECTROCARDI OLOGY	63, 629	3, 181	0	0	0	7. 00
8.00		ELECTROENCEPHALOGRAPHY	0	0	0	0	0	8. 00
9.00		OP PSYCH CLINIC	433, 987	21, 699	0	0	0	9. 00
10.00	91. 00	EMERGENCY	0	0	0	0	0	10.00
200.00			991, 723		0	0	0	200. 00
	Wkst. A Line #	J	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	1. 00	2.00	14 15. 00	16. 00	17. 00	18. 00		
1. 00		ADMI NI STRATI VE & GENERAL	15.00		17.00	3, 434, 049		1. 00
2. 00		ADULTS & PEDIATRICS		98, 632	0	5, 053, 551		2. 00
3. 00		NEONATAL INTENSIVE CARE UNIT		362, 326	0			3. 00
4. 00		OPERATING ROOM		302, 320	0	250, 342 1, 353, 263		4. 00
5.00		RADI OLOGY-THERAPEUTI C			0	448, 781		5. 00
6. 00		PHYSI CAL THERAPY		33, 149	55, 616			6. 00
7. 00		ELECTROCARDI OLOGY		63, 629	ეე, 010	15, 424		7. 00
7. 00 8. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY		03, 029	0	15, 424 281, 205		7. 00 8. 00
8. 00 9. 00	•	OP PSYCH CLINIC		433, 987	0	749, 473		9. 00
9. 00 10. 00	•	EMERGENCY		433, 987	0	749, 473 5, 743, 195		9. 00 10. 00
200.00	91.00	EWERGENCY		001 722	-			200.00
∠∪∪. ∪∪	I	1	I	991, 723	55, 616	17, 565, 784		200.00

In Lieu of Form CMS-2552-10
Worksheet B
Part I
B1/2019 Date/Time Prepared:
6/29/2020 8:56 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS IU HEALTH BLOOMINGTON HOSPITAL Provider CCN: 15-0051 Peri od: From 01/01/2019 To 12/31/2019 CAPITAL RELATED COSTS

			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Net Expenses	BLDG & FLXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	cost center beserver on	for Cost	DEDG & TTXT	WVDEE EQUIT	BENEFI TS	Subtotal	
		Allocation			DEPARTMENT		
		(from Wkst A					
		col. 7)	1.00	2.00	4. 00	4A	
	GENERAL SERVICE COST CENTERS		1.00	2.00	4. 00	47	
1.00	00100 CAP REL COSTS-BLDG & FLXT	764, 878	764, 878				1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP	16, 762, 425		16, 762, 425			2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	25, 955, 524	l		26, 099, 359		4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	63, 459, 951	146, 298		1, 451, 858	68, 429, 493	5. 00
7.00	00700 OPERATION OF PLANT	13, 116, 422			497, 115 0	16, 552, 078	7.00
8. 00 9. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	148, 148 3, 030, 868	l		421, 949	181, 091 3, 524, 122	8. 00 9. 00
10. 00	01000 DI ETARY	1, 970, 899	l .		319, 921	2, 456, 269	1
11. 00	01100 CAFETERI A	483, 456	l		199, 379	805, 874	11. 00
13.00	01300 NURSING ADMINISTRATION	8, 166, 689			1, 560, 132	10, 068, 741	13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	11, 966, 748		106, 496	0	12, 077, 865	14. 00
15. 00	01500 PHARMACY	6, 186, 210			1, 195, 042	7, 473, 904	15. 00
16. 00 18. 00	01600 MEDI CAL RECORDS & LI BRARY 01850 SOCI AL SERVI CES	107, 929	2, 870 0	66, 144 0	0	176, 943 0	16. 00 18. 00
18. 00	01851 CENTRAL STERI LI ZATI ON	670, 351	2, 645	-	137, 353	871, 299	1
23. 00	02301 PARAMED ED PRGM-PHARMACY RESIDENCY	389, 037			74, 782	486, 251	1
	INPATIENT ROUTINE SERVICE COST CENTERS	,			, ,		
30. 00	03000 ADULTS & PEDIATRICS	23, 116, 251	98, 484	2, 269, 521	5, 073, 344	30, 557, 600	30. 00
31. 00	03100 INTENSIVE CARE UNIT	3, 406, 531	8, 739		715, 515	4, 332, 175	31. 00
32. 00	03200 CORONARY CARE UNIT	2, 527, 707	11, 450		546, 027	3, 349, 053	1
35. 00 41. 00	02060   NEONATAL   INTENSIVE CARE UNIT   04100   SUBPROVIDER -   RF	2, 124, 635			391, 244	2, 655, 440	1
41.00	04200 SUBPROVI DER	1, 128, 195	10, 342	238, 333	245, 201 0	1, 622, 071 0	41. 00 42. 00
43. 00	04300 NURSERY	731, 623	l ~	1 4	153, 107	981, 697	43. 00
	ANCILLARY SERVICE COST CENTERS			,			
50. 00	05000 OPERATING ROOM	8, 033, 091	41, 770	962, 561	1, 319, 344	10, 356, 766	50. 00
50. 01	05001 CV SURGERY	0	0	-	0	0	50. 01
51.00	05100 RECOVERY ROOM	3, 484, 263	l		732, 216	4, 287, 333	1
52. 00 53. 00	05200   DELIVERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY	3, 211, 814	28, 407 0	654, 616	683, 873	4, 578, 710 0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	3, 564, 522	1	381, 634	753, 343	4, 716, 060	•
55. 00	05500 RADI OLOGY-THERAPEUTI C	2, 932, 370	l		573, 105	3, 973, 236	
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	814, 500	1, 147	26, 438	164, 034	1, 006, 119	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	463, 970	l		103, 880	607, 541	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	1, 626, 984			285, 161	2, 044, 611	1
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	15, 100, 396	14, 861 0	342, 457 0	0	15, 457, 714 0	60. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	2, 501, 914	l ~	-	549, 059	3, 077, 966	
66. 00	06600 PHYSI CAL THERAPY	6, 910, 625	l		1, 484, 803	8, 592, 450	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	868, 855	l				
	07000 ELECTROENCEPHALOGRAPHY	926, 078	3, 682	84, 840	39, 647	1, 054, 247	1
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 599, 791 16, 813, 013	0	0	0	9, 599, 791 16, 813, 013	
73. 00	07300 DRUGS CHARGED TO PATIENTS	29, 589, 303		0	0	29, 589, 303	
73. 01	1 1	83, 509	l	Ö	6, 494	90, 003	
74.00	1	1, 289, 982	l .	15, 443	0	1, 306, 095	1
75.00		0	0	0	0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	75. 01
76. 97		645, 756	3, 197	73, 669	140, 086	862, 708	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	1 424 400	17 007	412, 207	222 002	2 107 507	00.00
90. 00 90. 01		1, 434, 400 3, 832, 232			323, 092 822, 909	2, 187, 586 5, 045, 116	1
90. 01		582, 594	l		112, 981	791, 070	ı
90. 03	1 1	257, 837			43, 002	362, 184	ı
90. 05	09005 OP PSYCH CLINIC	2, 099, 486			882, 998	3, 230, 444	•
91. 00	1	6, 543, 165	22, 518	518, 919	1, 146, 142	8, 230, 744	1
92. 00						0	92.00
04.00	OTHER REIMBURSABLE COST CENTERS	_	^			^	04.00
	09400   HOME   PROGRAM DI ALYSI S   09500   AMBULANCE   SERVI CES	6, 420, 593	12, 036	277, 372	1, 245, 073	0 7, 955, 074	
	10000 I &R SERVICES-NOT APPRVD PRGM	0, 420, 593	12,030	211,372	1, 240, 0/3		100.00
	10100 HOME HEALTH AGENCY	0	Ö	ő	0		101.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113. 00
114. 00	D 11400 UTILIZATION REVIEW-SNF	1					114. 00

			To	om 01/01/2019 o 12/31/2019	Part I Date/Time Prep 6/29/2020 8:50	
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	Subtotal	
	0	1.00	2.00	4. 00	4A	
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE 118. 00 SUBTOTALS (SUM OF LINES 1 through 117)	0 0 315, 845, 520	0 0 695, 576	0 0 16, 029, 220	0 0 24, 574, 690	0	115. 00 116. 00 118. 00
NONREIMBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	302, 907	802	18, 481	29, 408	351, 598	100 00
190. 01 19001 PROMPTCARE	2, 126, 636	5, 473		315, 576	2, 573, 818	
190. 02 19002 RENTAL PROPERTIES	5, 873	15, 101	120, 133	013, 370	20, 974	
190. 03 19003 OLCOTT	375, 446	2, 339	ő	66, 069	443, 854	
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	o o	0		190. 04
190. 05 19005 FOUNDATION	3, 121	1, 021	0	0	4, 142	190. 05
190. 06 19006 MARKETI NG	o	0	0	0	0	190. 06
190. 07 19007 HME STORE	258	0	0	0	258	190. 07
190. 08 19008 UNUSED SPACE	54, 423	0	0	0	54, 423	190. 08
190. 09 19009 CLINI CAL TRIALS	161, 710	425	0	36, 278	198, 413	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0		190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	5, 091, 746	12, 096	0	751, 505	5, 855, 347	190. 11
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	25, 301	0	0	3, 582	28, 883	
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	697, 081	8, 872	204, 448	111, 497	1, 021, 898	
194.01 07951 IU HEALTH BEDFORD HOSPITAL	1, 316, 555	16, 670	384, 143	210, 754	1, 928, 122	
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0		194. 02
194. 03 07953 IU HEALTH SIP	131, 935	383	0	0	132, 318	
194.04 07954 HOME CARE	35	2, 041	0	0		194. 04
194. 05 07955 HOSPI CE	18	4, 079	0	0		194. 05
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	00/ 400 5/5	0	0	0/ 000 050		201. 00
202.00   TOTAL (sum lines 118 through 201)	326, 138, 565	764, 878	16, 762, 425	26, 099, 359	326, 138, 565	202.00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2019 Part I
To 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am

				''	0 12/31/2019	6/29/2020 8: 5	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	2.22	10.00	
	CENEDAL CEDVICE COCT CENTEDS	5. 00	7. 00	8.00	9. 00	10. 00	
1. 00	GENERAL SERVICE COST CENTERS O0100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00	00200 CAP REL COSTS-MVBLE EQUIP					ı	2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT					ı	4.00
5. 00	00500 ADMINISTRATIVE & GENERAL	68, 429, 493				ı	5. 00
7.00	00700 OPERATION OF PLANT	4, 395, 073	20, 947, 151			ı	7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	48, 085	58, 524	287, 700		1	8. 00
9.00	00900 HOUSEKEEPI NG	935, 760	126, 674	25	4, 586, 581	1	9. 00
10. 00		652, 213	293, 926		I	3, 411, 205	10.00
11. 00		213, 984	218, 582	1	.,	0	11.00
13. 00		2, 673, 553	607, 432		0	0	13.00
14. 00		3, 207, 035	197, 404	1	0	0	14.00
15. 00 16. 00		1, 984, 546	164, 600	1	l .	0	15.00
18. 00		46, 984	122, 605		16, 709	0	16. 00 18. 00
18. 00	01851 CENTRAL STERI LI ZATI ON	231, 356	112, 978	1, 008	0	0	18. 01
23. 00	1	129, 114	39, 851		l .	0	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1277	07,001		٥١		
30.00		8, 113, 962	4, 206, 832	90, 243	2, 146, 670	2, 749, 877	30.00
31.00	03100 INTENSIVE CARE UNIT	1, 150, 322	373, 301	12, 282	167, 089	239, 531	31.00
32. 00	03200 CORONARY CARE UNIT	889, 274	489, 113	9, 219	0	227, 359	32. 00
35. 00	1	705, 099	247, 935	1	l .	0	35. 00
41. 00	1	430, 709	441, 778	1	133, 671	194, 438	41. 00
42. 00	1	0	170.015	0	0	0	42.00
43. 00		260, 670	172, 265	3, 068	78, 114	0	43. 00
50. 00	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM	2, 750, 032	1, 784, 224	28, 021	434, 430	0	50.00
50. 00	05001 CV SURGERY	2, 750, 032	1, 704, 224	20,021	434, 430	0	50.00
51. 00		1, 138, 416	125, 875	1		0	51.00
52. 00		1, 215, 785	1, 213, 410	1	264, 835	0	52.00
53. 00		0	, _ · · · , · · · · · · · · · · · · · ·	0	0	0	53. 00
54.00		1, 252, 255	707, 405	21, 799	133, 671	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	1, 055, 013	830, 991	301	O	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	C	0	0	0	56. 00
57. 00		267, 155	49, 006	1	0	0	57. 00
58. 00		161, 320	70, 512		0	0	58. 00
59. 00		542, 906	235, 329	1	0	0	59. 00
60. 00		4, 104, 487	634, 786	1	66, 835	0	60.00
64. 00		0	C	0	0	0	64.00
65. 00	1	817, 292	47, 952	1	41 770	0	65.00
66. 00		2, 281, 553	350, 015	37	41, 772	0	66.00
67. 00 68. 00	1	0			0	0	67. 00 68. 00
69. 00	1	292, 214	89, 111	3, 865	133, 671	0	69.00
70. 00	1	279, 934	157, 262	1	133, 07 1	Ö	70.00
71. 00		2, 549, 033	, 2.02 C	ol o	100, 253	0	71.00
72. 00	1	4, 464, 359	C	o	0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	7, 856, 848	C	0	50, 127	0	73. 00
73. 01	07302 OP PHARMACY	23, 898	C	0	0	0	73. 01
74. 00	1	346, 807	28, 626	0	0	0	74. 00
75. 00		0	C	0	0	0	75. 00
75. 01		0	404 555	0	0	0	75. 01
76. 97		229, 075	136, 555	0	U U	0	76. 97
90. 00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	580, 870	764, 076	0	٥	0	90.00
90.00		1, 339, 630	692, 801	1	·	0	90.00
90. 01		210, 053	169, 649		33, 418	0	90.01
90. 03		96, 171	108, 982		0, 110	0	90. 03
90. 05		857, 780	440, 507	1	o	0	90. 05
91. 00		2, 185, 509	961, 879	1	685, 063	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		•			ı	92.00
	OTHER REIMBURSABLE COST CENTERS						l
94. 00		0	C	0	·	0	94. 00
	09500 AMBULANCE SERVICES	2, 112, 311	514, 143	15, 502	0	0	95. 00
	0 10000 I &R SERVI CES-NOT APPRVD PRGM	0	C	0	0		100. 00
101. 0	0 10100 HOME HEALTH AGENCY	0	C	0	0	0	101. 00
110 0	SPECIAL PURPOSE COST CENTERS				ı		112 00
	0 11300 INTEREST EXPENSE					1	113. 00 114. 00
	O 11400 UTILIZATION REVIEW-SNF O 11500 AMBULATORY SURGICAL CENTER (D.P.)		r				115.00
	0 11600 HOSPICE						116.00
118. 0	1	65, 078, 445	17, 986, 896	287, 700	4, 544, 809	3, 411, 205	
	NONREI MBURSABLE COST CENTERS		, , , , , , , , , ,	20,,,00	., ., ., ., .,	2,, 200	
190.0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	93, 360	34, 257	7 0	0	0	190. 00
	· · · · ·			•			

					6/29/2020 8:56 am
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY
	& GENERAL	PLANT	LINEN SERVICE		
	5. 00	7.00	8. 00	9. 00	10.00
190. 01 19001 PROMPTCARE	683, 426	233, 804	0	0	0 190. 01
190. 02 19002 RENTAL PROPERTIES	5, 569	645, 067	0	0	0 190. 02
190. 03 19003 0LC0TT	117, 857	99, 901	0	0	0 190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	1, 100	43, 593	0	0	0 190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190.07 19007 HME STORE	69	0	0	0	0 190. 07
190. 08 19008 UNUSED SPACE	14, 451	0	0	41, 772	0 190. 08
190. 09 19009 CLI NI CAL TRI ALS	52, 685	18, 164	0	0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190.11 19011 COMMUNITY HEALTH SERVICES	1, 554, 770	516, 686	0	0	0 190. 11
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	7, 669	0	0	0	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	271, 345	378, 968	0	0	0 194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	511, 974	712, 055	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	35, 134	16, 347	0	0	0 194. 03
194.04 07954 HOME CARE	551	87, 186	0	0	0 194. 04
194. 05 07955 HOSPI CE	1, 088	174, 227	0	0	0 194. 05
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	68, 429, 493	20, 947, 151	287, 700	4, 586, 581	3, 411, 205 202. 00

			10	12/31/2019	Date/lime Pre 6/29/2020 8:5	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	10.00	
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 ADMINISTRATIVE & GENERAL						5. 00
7.00 00700 OPERATION OF PLANT						7. 00
8. 00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9.00
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A	1, 246, 377					10. 00 11. 00
13. 00   01300   NURSI NG ADMINI STRATI ON	73, 708	13, 423, 454				13. 00
14. 00   01400 CENTRAL SERVICES & SUPPLY	73, 700	13, 423, 434	15, 482, 304			14. 00
15. 00   01500   PHARMACY	47, 416	Ö	109, 036	9, 780, 155		15. 00
16. 00 01600 MEDICAL RECORDS & LIBRARY	0	o	12	0	363, 253	16. 00
18. 00   01850   SOCI AL   SERVI CES	0	o	0	0	0	18. 00
18. 01   01851 CENTRAL STERI LI ZATI ON	11, 250	o	131, 446	O	0	18. 01
23. 00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY	3, 285	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		_				
30. 00   03000   ADULTS & PEDI ATRI CS	285, 819	5, 665, 763	744, 742	79, 506	35, 874	30. 00
31. 00 03100 INTENSIVE CARE UNIT	37, 444	744, 100	167, 720	25, 895	4, 356	31. 00
32. 00 03200 CORONARY CARE UNIT	30, 746	630, 062	103, 247	10, 607	4, 010	32. 00
35. 00   02060   NEONATAL   INTENSIVE CARE UNIT	19, 789	421, 621	64, 646	2, 570	2, 955	35. 00
41. 00   04100   SUBPROVI DER -   RF 42. 00   04200   SUBPROVI DER	14, 497 0	300, 083	25, 539	385	1, 373 0	41. 00 42. 00
43. 00   04300   NURSERY	7, 942	185, 737	22, 422	349	877	43. 00
ANCI LLARY SERVI CE COST CENTERS	7, 742	105, 757	22, 422	347	077	43.00
50. 00   05000   OPERATING ROOM	60, 193	879, 531	2, 154, 816	18, 161	45, 070	50.00
50. 01   05001 CV SURGERY	0	0	0	0	0	50. 01
51. 00   05100   RECOVERY ROOM	36, 745	798, 661	93, 467	13, 903	6, 856	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	33, 177	604, 456	134, 718	7, 689	7, 509	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	37, 361	150, 661	71, 875	14, 197	9, 988	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	25, 925	75, 401	189, 918	1, 017	21, 107	55. 00
56. 00   05600   RADI 0I SOTOPE	0	0	0	0	0	56. 00
57. 00   05700   CT   SCAN	7, 698	0	54, 018	2, 139	5, 588	57. 00
58. 00   05800   MAGNETIC RESONANCE I MAGING (MRI)	4, 540	200 005	5, 267	466	2, 109	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON 60. 00   06000   LABORATORY	12, 811 54, 251	200, 905	200, 985 0	3, 904	14, 682 24, 065	59. 00 60. 00
64. 00   06400   NTRAVENOUS THERAPY	04, 251	0	0	0	24, 003	64. 00
65. 00 06500 RESPIRATORY THERAPY	25, 715	0	186, 525	2, 396	2, 778	65.00
66. 00 06600 PHYSI CAL THERAPY	63, 355	106	9, 421	2, 370	6, 235	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	o	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	О	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	10, 120	33, 291	11, 984	1, 051	4, 986	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	2, 554	0	31, 055	0	2, 531	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	3, 750, 907	0	18, 185	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	6, 569, 323	0	27, 222	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	9, 501, 525	50, 489	
73. 01   07302   OP   PHARMACY	162	0	771	0	0	73. 01
74.00   07400   RENAL DIALYSIS 75.00   07500   ASC (NON-DISTINCT PART)	0	0	6, 061	2, 085	958	74. 00 75. 00
75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0	0	0	75. 00
76. 97 07697 CARDI AC REHABI LI TATI ON	6, 910	68, 894	2, 154	0	792	76. 97
OUTPATIENT SERVICE COST CENTERS	0, 710	00, 074	2, 154	<u> </u>	172	70.77
90. 00 09000 CLI NI C	14, 549	130, 182	1, 659	5, 000	582	90. 00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	38, 669	708, 408	85, 957	17, 291	6, 870	90. 01
90. 02 09002 WOUND CARE CENTER	5, 550	129, 804	31, 141	O	1, 590	90. 02
90. 03   09003   PAIN CLINIC	2, 239	38, 971	14, 975	205	619	90. 03
90. 05   09005   OP PSYCH CLINIC	34, 642	90, 982	854	0	906	90. 05
91. 00   09100   EMERGENCY	66, 938	1, 359, 776	371, 401	62, 091	41, 336	91. 00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92. 00
OTHER REIMBURSABLE COST CENTERS	_	_1	_			
94. 00   09400   HOME   PROGRAM DI ALYSI S	05 700	0	01 (25	7 521	10.755	94. 00
95. 00   09500   AMBULANCE SERVI CES	85, 792	0	81, 635	7, 531	10, 755	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM 101.00 10100 HOME HEALTH AGENCY	0	0	0	0		100. 00 101. 00
SPECIAL PURPOSE COST CENTERS	U	U U	U	U	0	101.00
113. 00 11300 I NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. )	0	o	0	ol	0	115. 00
116. 00 11600 HOSPI CE	0	o	0	o	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	1, 161, 792	13, 217, 395	15, 429, 697	9, 779, 963	363, 253	118. 00

				12/31/2019	6/29/2020 8:56 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL
		ADMI NI STRATI ON	SERVICES &		RECORDS &
			SUPPLY		LI BRARY
	11. 00	13. 00	14. 00	15. 00	16. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	3, 468		0	0	0 190. 00
190. 01 19001 PROMPTCARE	16, 296	46, 630	45, 374	97	0 190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	0	0 190. 02
190. 03 19003 OLCOTT	3, 581	985	620	0	0 190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	0	0	0	0	0 190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190. 07 19007 HME STORE	0	0	0	0	0 190. 07
190. 08 19008 UNUSED SPACE	0	0	0	0	0 190. 08
190. 09 19009 CLI NI CAL TRI ALS	2, 075	13, 366	0	0	0 190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	47, 637	145, 078	6, 531	95	0 190. 11
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	82	0	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	3, 865		0	0	0 194. 00
194. 01 07951 I U HEALTH BEDFORD HOSPITAL	7, 663	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	0	0	0	0 194. 03
194. 04 07954 HOME CARE	0	0	0	0	0 194. 04
194. 05 07955 HOSPI CE	0	0	0	0	0 194. 05
200.00 Cross Foot Adjustments					200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00   TOTAL (sum lines 118 through 201)	1, 246, 377	13, 423, 454	15, 482, 304	9, 780, 155	363, 253 202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051

				Т	o 12/31/2019	Date/Time Prep 6/29/2020 8:50	
		OTHER GENE	RAL SERVICE			0/24/2020 8.3	J alli
	Cost Center Description	SOCI AL SERVI CES	CENTRAL STERI LI ZATI ON	PARAMED ED PRGM-PHARMACY RESI DENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	OFNEDAL CEDIU OF COST OFNEDO	18. 00	18. 01	23.00	24. 00	25. 00	
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00	O1100 CAFETERIA O1300 NURSING ADMINISTRATION O1400 CENTRAL SERVICES & SUPPLY O1500 PHARMACY						1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
16. 00 18. 00 18. 01 23. 00	01850 SOCIAL SERVICES 01851 CENTRAL STERILIZATION	0	1, 359, 337				16. 00 18. 00 18. 01 23. 00
30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY	C C C C C C C C C C C C C C C C C C C	0 0 0 0 0 0 0	0 0 0 0 0	7, 254, 215 5, 742, 690 4, 122, 013 3, 171, 582	0 0 0 0 0 0	30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00
50. 00 50. 01 51. 00 52. 00 53. 00 54. 00 55. 00 57. 00 58. 00 69. 00 64. 00 66. 00 67. 00 68. 00 70. 00 71. 00 72. 00 73. 01 74. 00 75. 01 76. 97	05001 CV SURGERY 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06400 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 07200 IMPL. DEV. CHARGED TO PATI ENTS 07302 OP PHARMACY 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	000000000000000000000000000000000000000	0 6, 526, 087 8, 159, 314 0 7, 119, 052 6, 172, 909 0 1, 391, 723 851, 755 3, 276, 410 20, 342, 188 0 4, 160, 624 11, 344, 944 0 0 1, 680, 787 1, 530, 418 16, 018, 169 27, 873, 917 47, 706, 793 114, 834 1, 690, 632 0	0 0 0 0 0 0 0 0	50. 00 50. 01 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 69. 00 66. 00 66. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 73. 00 75. 01 76. 97
90. 00 90. 01 90. 02 90. 03 90. 05 91. 00 92. 00	09000 CLINIC 09001 OP ONCOLOGY INFUSION CENTER 09002 WOUND CARE CENTER 09003 PAIN CLINIC 09005 OP PSYCH CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	C C C C	0 0 3, 465 0 315 0 945		3, 684, 504 7, 977, 791 1, 375, 740 624, 661 4, 656, 115 14, 012, 406	0 0 0 0 0 0	90. 00 90. 01 90. 02 90. 03 90. 05 91. 00 92. 00
95. 00 100. 0 101. 0	OTHER REIMBURSABLE COST CENTERS  09400 HOME PROGRAM DI ALYSI S  09500 AMBULANCE SERVI CES  010000 I &R SERVI CES-NOT APPRVD PRGM  010100 HOME HEALTH AGENCY  SPECI AL PURPOSE COST CENTERS	( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( ) ( )	0	0 0 0	0 10, 782, 743 0 0	0	94. 00 95. 00 100. 00 101. 00
	0 11300 INTEREST EXPENSE  0 11400 UTILIZATION REVIEW-SNF						113. 00 114. 00

			To	12/31/2019	
	OTHER GENER	AL CEDVICE			6/29/2020 8:56 am
	OTHER GENER	KAL SERVICE			
Cost Center Description	SOCI AL	CENTRAL	PARAMED ED	Subtotal	Intern &
cost center bescriptron	SERVI CES		PRGM-PHARMACY		Residents Cost
	SERVI SES	OTERN ET ZATTON	RESI DENCY		& Post
			INEOI DENOT		Stepdown
					Adjustments
	18. 00	18. 01	23. 00	24. 00	25. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	0	0 115. 00
116. 00 11600 HOSPI CE	0	0	0	0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	1, 357, 552	658, 501	306, 820, 041	0 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	482, 683	
190. 01 19001 PROMPTCARE	0	0	0	3, 599, 445	0 190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	671, 610	
190. 03 19003 OLCOTT	0	0	0	666, 798	
190. 04 19004 PHYSI CLAN RECRUI TMENT	0	0	0	0	0 190. 04
190. 05 19005 FOUNDATI ON	0	0	0	48, 835	0 190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0 190. 06
190. 07 19007 HME STORE	0	1, 470	0	1, 797	0 190. 07
190. 08 19008 UNUSED SPACE	0	0	0	110, 646	
190. 09 19009 CLINICAL TRIALS	0	0	0	284, 703	
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	315	0	8, 126, 459	0   190. 11
191. 00 19100 RESEARCH	0	0	0	0	0 191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	36, 634	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	1, 676, 076	
194. 01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	3, 159, 814	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0 194. 02
194. 03 07953 IU HEALTH SIP	0	0	0	183, 799	
194. 04 07954 HOME CARE	0	0	0	89, 813	
194. 05 07955 HOSPI CE	0	0	0	179, 412	
200.00 Cross Foot Adjustments			0	0	0 200. 00
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00 TOTAL (sum lines 118 through 201)	O	1, 359, 337	658, 501	326, 138, 565	0 202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2019 | Part I | To 12/31/2019 | Date/Time Prepared: | 6/29/2020 8:56 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051

COST CENTRY PERCEIPT ON OFFICES   26.00			6/29/2020 8: 56 am
DEBENDED SERVICE USIST CENTERS   1.00	Cost Center Description		0, 2, 2020 0, 00 diiii
1.00   001000 CAP REL COSTS-BULDE & FIXT   2.00   0.00000 CAP REL COSTS-BULDE   2.00   0.00000 CAP REL COSTS-BULDE   2.00   0.00000 CAP REL COSTS-BULDE   2.00   0.00000 CAP REL COSTS-BULDE   2.00   0.00000 CAP REL COSTS-BULDE   2.00   0.00000 CAP REL COSTS CAP REL C		26. 00	
2 00 00000 CAP REL COSTS-MYNEL EQUIP 4 00 00000 REPOYDE PRIEFFE TO			
4 00   00000   DEPROVED FRAME SERVICE   5 00   00000   DEPARTED SERVICE   9 00   00000   DEPARTED SERVICE   9 00   00000   DEPARTED SERVICE   9 00   00000   DEPARTED SERVICE   9 00   000000   DEPARTED SERVICE   9 00   00000   DEPARTED SERVICE   9 00   DEPARTED SERVICE   9			
5.00   00000   CARRIN ISTRICTIVE SECURICE   5.00	1 1		
7.00   000000   INDIRESTRET PLING 9.00   INDIREST	1 1		
8.00   000000   LAURORY & LINEN SERVICE   9.00   00000   10000   1 FEACE   9.00   10.	l i		
9.00   00900	I I		
10.00   10000   LETARY	1 1		
11.00   01100   CAFETERIA     11.00	1 1		
13.00   10300   MURS INA CAME IN STRATION   13.00   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   1500   PURABACY   15.00   PURABACY	1 1		
14.00   01400  CENTRAL SERVICES & SUPPLY   14.00   15.00   10150  PINAMACY   15.00   15.00   10150  PINAMACY   15.00	I I		
15.00   1950   PHARMACY	I I		
16.00   O1400   MEDICAL RECORDS & LIBRARY     16.00   0180   01	· · · · · · · · · · · · · · · · · · ·		
18.00   01850   COLTAL STERVICES   18.00   18.00   18.00   10.00   18.00   1	· · · · · · · · · · · · · · · · · · ·		
18.0   10   1851   CENTRAL STEPLITZATION     23.0   23.0   2030   2030   PARAMED ED PROCEPUR-PHARMACY RESIDENCY     23.0   23.	l i		
23.00	l +		
REPATIENT BOUTTIME SERVICE COST CENTERS   30.00	1 1		
30.00			23. 00
31.00		E4 (7/ 000	20.00
32.00			
35.00   20500   NEONATAL INTERISIVE CARE UNIT   4,122,013   35.00   42.00			
1.00   0.100   SUBPROVIDER - 1 INF			
42 00   4200   MURSERY   1,713,900   43.00			
43.00   ASOO NURSERY   1,713,900   43.00			
ANCILLARY SERVICE COST CENTERS   50.00   50.		-	
50.00   05000   0FEART ING ROOM   19,757,089   50.00   55.01   05001   CV SURGERY   6,752,087   55.00   55.01   05001   RECOVERY ROOM   6,526,087   55.00   55.00   15.00   ELIVERY ROOM   6,526,087   55.00   55.00   55.00   05200   ANESTHESI OLOGY   0   0   55.00   55.00   55.00   05200   ANESTHESI OLOGY   0   0   55.00   05500   ANESTHESI OLOGY   0   0   55.00   05500   ANESTHESI OLOGY   0   0   55.00   0   0   55.00   0   0   0   0   0   0   0   0   0		1, /13, 960	43.00
50.0     50.0   CV SURGERY   0   51.0   55		10 757 000	FO. 00
15.1.00   05.100   RECOVERY ROOM   6.6.526.087   51.00   53.00   53.00   05.300   DELIVERY ROOM   8.159,314   52.00   53.00   53.00   05.500   ARSTHESI CLOCY   0.00   55.00   55.00   05.500   RADI DLOGY-THERAPEUTIC   6.172,909   55.00   55.00   05.500   RADI DLOGY-THERAPEUTIC   6.172,909   55.00   57.00   05.00   05.00   RADI DLOGY-THERAPEUTIC   6.172,909   55.00   57.00   05.00   05.00   MAINTER CRESONANCE IMAGING (MRI )   81.755   55.00   05.00   05.00   MAINTER CRESONANCE IMAGING (MRI )   81.755   55.00   05.00   05.00   MAINTER CRESONANCE IMAGING (MRI )   81.755   59.00   05.00   05.00   LADRATORY THERAPY   0.00   05.00   LADRATORY THERAPY   0.00   05.00   06.00   DADRATORY THERAPY   0.00   06.00   NESPI PRIATORY THERAPY   0.00   06.00   PHYSICAL THERAPY   0.00   06.00   PHYSICAL THERAPY   0.00   06.00   PHYSICAL THERAPY   0.00   06.00   PHYSICAL THERAPY   0.00   06.00   PHYSICAL THERAPY   0.00   06.00   PHYSICAL THERAPY   0.00   06.0	I I		
S2.00	l +	-	
53.00   05300   AIRSTRIESI OLOCY   54.00   55.00   655.00   ASDIOLOGY - THERAPEUTIC   7, 119, 052   55.00   655.00   ASDIOLOGY - THERAPEUTIC   6, 172, 909   55.00   656.00   ASDIOLOGY - THERAPEUTIC   7, 119, 052   55.00   656.00   ASDIOLOGY - THERAPEUTIC   7, 119, 052   55.00   656.00   ASDIOLOGY - THERAPEUTIC   7, 119, 052   55.00   656.00   ASDIOLOGY - THERAPEUTIC   7, 119, 052   55.00   656.00   ASDIOLOGY - THERAPEUTIC   7, 119, 052   55.00   656.00   ASDIOLOGY - THERAPEUTIC   7, 119, 052   55.00   656.00   ASDIOLOGY - THERAPEUTIC   7, 119, 052   7, 100, 059.00   ASDIOLOGY - THERAPEUTIC   7, 119, 052   7, 100, 059.00   ASDIOLOGY - 7, 119, 052   7, 100, 059.00   ASDIOLOGY - 7, 119, 052   7, 100, 059.00   ASDIOLOGY - 7, 119, 052   7, 100, 059.00   ASDIOLOGY - 7, 119, 052   7, 100, 059.00   ASDIOLOGY - 7, 119, 052   7, 100, 059.00   ASDIOLOGY - 7, 100, 059.00   ASDIOLOGY	I I		
54.00   05400   RADIOLOGY-DIAGNOSTIC   7, 119, 052   55.00   55.00   05500   RADIOLOGY-PIHERAPEUTIC   6, 172, 909   55.00   55.00   05500   RADIOLOGY-PIHERAPEUTIC   6, 172, 909   55.00   55.00   05500   RADIOLOGY-PIHERAPEUTIC   6, 172, 909   55.00   55.00   05500   RADIOLOGY-PIHERAPEUTIC   7, 119, 052   55.00   55.00   05500   RADIOLOGY-PIHERAPEUTIC   7, 179, 1723   55.00   55.00   05500   RADIOLOGY-PIHERAPEUTIC   7, 179, 1723   55.00   55.00   05500   RADIOLOGY-PIHERAPEUTIC   7, 179, 170, 170, 170, 170, 170, 170, 170, 170	· · · · · · · · · · · · · · · · · · ·		
55.00   OS500   RADIO LOGY-THERAPEUTIC   6, 172, 909   55.00   56.00	1 1	- 1	
56.00   OSGOO   RADIO II SOTOPE	1 1		
57.00   05700   CT SCAN   55.00   55.00   05900   CARDI AC CATHETERI PATI ON   3, 276, 410   59.00   05900   CARDI AC CATHETERI PATI ON   3, 276, 410   60.00   0600   LABORATORY   20, 342, 188   60.00   0600   LABORATORY   66.00   064.00   06400   INTRAVENOUS THERAPY   0   06.00   06500   RESPIR PATORY THERAPY   0, 624   06.50   06500   RESPIR PATORY THERAPY   0   06.70	1 1		
S8.0   OSBOO   MAGNETI C RESONANCE IMAGING (MRI)   S81, 755   S9.00   OSBOO   CARDIAC CATHETERIZATION   3, 276, 410   S9.00   OSBOO   CARDIAC CATHETERIZATION   3, 276, 410   S9.00   OSBOO   CARDIAC CATHETERIZATION   3, 276, 410   S9.00   OSBOO   CARDIAC CATHETERIZATION   3, 276, 410   OSBOO   OSBOO   CARDIAC CATHETERIZATION   OSBOO   OSBO	1 1	-1	
59.00   059000   CARDITAC CATHETERIZATION   3, 276, 410   60.00   06000   06000   LABORATORY   20, 342, 188   60.00   06.00   06.000   06.000   CASONO   CSPIRATORY   164, 000   66.00   06.000   06.000   CSPIRATORY   164, 000   66.00   06.000   06.000   CSPIRATORY   164, 000   06.00   06.000   06.000   CSPIRATORY   164, 000   06.000   07.000	I I		
60.00   0.0000   LABORATORY   20.342, 188   60.00   64.00   0.400   NITRANENDUS THERAPY   0.00   65.00   0.500   0.550   0.5			
64. 00   06400   INTRAVENDUS THERAPY   0   65. 00   065.00   06500   RESPIRATORY THERAPY   11, 344, 944   66. 00   066.00   066	· · · · · · · · · · · · · · · · · · ·		
65. 00   06500   RESPIRATORY THERAPY   4, 160, 624   66. 00   06600   PHYSICAL THERAPY   11, 344, 944   66. 00   06700   0CCUPATI ONAL THERAPY   0   06. 00   06900   0CCUPATI ONAL THERAPY   1, 680, 787   0   68. 00   06900   DECENTROCARDIOLOGY   1, 680, 787   69. 00   070. 00   07000   DELECTROCARDIOLOGY   1, 680, 787   69. 00   070. 00   07000   ELECTROCARDIOLOGY   1, 680, 787   70. 00   07000   ELECTROCARDIOLOGY   1, 680, 787   70. 00   070. 00   07000   ELECTROCARDIOLOGY   1, 60, 18, 169   71. 00   071. 00   071.00	1 1		
66.00   06600   06600   PMSI CAL THERAPY   11, 344, 944   66.00   67.00   67.00   67.00   67.00   68.0	l i		
67. 00   06700   06200   06800   SPECH PATHOLOGY   0 0   68. 00   06800   SPECH PATHOLOGY   0 0   06800   SPECH PATHOLOGY   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	l +		
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0	· · · · · · · · · · · · · · · · · · ·		
69.00   06900   ELECTROCARDIOLOGY   1,680,787   70.00   70.0		- 1	
70. 00   07000   ELECTROENCEPHALGGRAPHY   1, 530, 418   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATIENTS   16, 018, 169   71. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   27, 873, 917   72. 00   7300   07200   IMPL. DEV. CHARGED TO PATIENTS   27, 873, 917   72. 00   7300   07300   DRUGS CHARGED TO PATIENTS   47, 706, 793   73. 00   73.01   07302   DP PHARMACY   114, 834   73. 01   74. 00   07400   RENAL DIALYSIS   1, 690, 632   74. 00   07500   ASC (NON-DISTINCT PART)   0   07500   ASC (NON-DISTINCT PART)   0   07507   CARDIA C REHABILLITATION   1, 307, 088   75. 01   07507   CARDIA C REHABILLITATION   1, 307, 088   76. 97   07697   CARDIA C REHABILLITATION   1, 307, 088   76. 97   07697   CARDIA C REHABILLITATION   1, 307, 088   76. 97   07697   CARDIA C REHABILLITATION   1, 307, 088   07607   09000		-	
71. 00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS   16. 018, 169   72. 00   07200   IMPL. DEV. CHARGED TO PATIENTS   27. 873, 917   72. 00   07300   DRUGS CHARGED TO PATIENTS   47, 706, 793   73. 00   73. 01   07302   DP HARMACY   114. 834   73. 01   07302   DP HARMACY   114. 834   73. 01   07302   DP HARMACY   74. 00   75. 00   75. 01   07500   ASC (NON-DISTINCT PART)   0   75. 00   75. 01   07550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0   75. 00   75. 01   07550   PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES   0   75. 00   75. 01   07507   CARDIA C REHABIL LITATI ON   1, 307, 088   76. 97   7047   CARDIA C REHABIL LITATI ON   1, 307, 088   76. 97   7047   CARDIA C REHABIL LITATI ON   1, 307, 791   90. 00   09000   CLI NI C   90. 00   90000   CLI NI C   90. 00   90000   09000	1 1		
72. 00 07200 IMPL DEV. CHARGED TO PATIENTS 27,873,917 73. 00 07300 DRUGS CHARGED TO PATIENTS 47,706,793 73. 01 07302 DP PHARMACY 114,834 73. 01 74. 00 07400 RENAL DI ALYSI S 1,690,632 74. 00 07500 ASC (NON-DI STINCT PART) 0 075. 01 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 75. 00 75. 01 03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 0 75. 01 07697 CARDI AC REHABI LI TATI ON 1,307,088 76. 97 77. 97 97 97 97 97 97 97 97 97 97 97 97 97			
73. 00   07300   DRUGS CHARGED TO PATIENTS   47, 706, 793   73. 00   07300   07900   DRUGS CHARGED TO PATIENTS   47, 706, 793   73. 01   07302   07 PHARMACY   114, 834   74. 00   07400   RENAL DI ALYSIS   1, 690, 632   75. 00   07500   ASC (NON-DI STINCT PART)   0   0   75. 00   07500   ASC (NON-DI STINCT PART)   0   0   07500   ASC (NON-DI STINCT PART)   0   0   07697   CARDI AC REHABILITATION   1, 307, 088   76. 97   07697   CARDI AC REHABILITATION   1, 307, 088   76. 97   0   0   0   0   0   0   0   0   0			
73. 01   07302   0P PHARMACY			
74. 00 75. 00 76. 97 76			
75. 00   07500   ASC (NON-DI STI NCT PART)   0   75. 00   75. 01   75. 00   75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   75. 01   76. 97   07697   CARDI AC REHABI LITATI ON   1, 307, 088   76. 97   00179ATI ENT SERVI CE COST CENTERS   90. 00   900. 01   09000   CLI NI C   3, 684, 504   90. 01   90. 01   09001   OP ONCOLOGY INFUSI ON CENTER   7, 977, 791   90. 01   90. 02   09002   WOUND CARE CENTER   1, 375, 740   90. 02   09002   WOUND CARE CENTER   1, 375, 740   90. 03   90. 05   09005   OP PSYCH CLI NI C   624, 661   90. 05   91. 00   09100   EMERGENCY   14, 012, 406   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   95. 00   09400   HOME PROGRAM DI ALYSI S   0   09400   HOME PROGRAM DI ALYSI S   0   09500   AMBULANCE SERVI CES   10, 782, 743   95. 00   100. 00   10000   I & SERVI CES-NOT APPRVD PRGM   0   101. 00   10100   HOME HEALTH AGENCY   0   101. 00   10100   HOME HEALTH AGENCY   0   101. 00   113.00   I NTEREST EXPENSE   113. 00   115. 00   11500   AMBULATORY SURGI CAL CENTER (D. P. )   0   115. 00   11500   AMBULATORY SURGI CAL CENTER (D. P. )   0   115. 00   11500   AMBULATORY SURGI CAL CENTER (D. P. )   0   115. 00   11500   AMBULATORY SURGI CAL CENTER (D. P. )   0   116. 00   1			
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGÍ CAL SERVI CES 0 70697 CARDI AC REHABI LITATI ON 1,307,088 76 97 07697 CARDI AC REHABI LITATI ON 1,307,088 76 97 07197 CARDI AC REHABI LITATI ON 1,307,088 76 97 07197 CARDI AC REHABI LITATI ON 1,307,088 76 97 07197 CARDI AC REHABI LITATI ON 1,307,088 76 97 07197 7719 7719 7719 7719 7719 7719			
76. 97 O7697 CARDI AC REHABILITATION 1, 307, 088 76. 97 OUTPATT ENT SERVICE COST CENTERS  90. 00 09000 CLINI C 90.00 90001 OP ONCOLOGY INFUSI ON CENTER 7, 977, 791 90. 01 90. 01 09001 OP ONCOLOGY INFUSI ON CENTER 7, 977, 791 90. 01 90. 02 09002 WOUND CARE CENTER 1, 375, 740 90. 02 90. 03 09003 PAIN CLINI C 624, 661 90. 05 91. 00 09005 OP PSYCH CLINI C 4, 656, 115 90. 05 91. 00 09100 EMERGENCY 14, 012, 406 91. 00 92. 00 09200 IOSSERVATI ON BEDS (NON-DISTINCT PART) 91. 00 94. 00 09200 IOSSERVATI ON BEDS (NON-DISTINCT PART) 92. 00 094. 00 09400 HOME PROGRAM DI ALYSI S 92. 00 95. 00 09500 AMBULANCE SERVI CES 10, 782, 743 95. 00 100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM 0 100. 00 110. 00 10100 HOME HEALTH AGENCY 0 101. 00 1114. 00 11400 UTILIZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P. ) 0 115. 00 116. 00 11500 IMBULATORY SURGI CAL CENTER (D. P. ) 0 115. 00 116. 00 11500 IMBULASABLE COST CENTERS 118. 00 NONREI MBURSABLE COST CENTERS 1190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 482, 683	, , ,	-	
OUTPATI ENT SERVICE COST CENTERS   90.00	· · · · · · · · · · · · · · · · · · ·	-1	
90. 00		1, 307, 088	76. 97
90. 01 09001 0P ONCOLOGY INFUSION CENTER 7, 977, 791 90. 01 90. 02 09002 WOUND CARE CENTER 1, 375, 740 90. 02 90. 03 09003 PAIN CLINIC 624, 661 90. 03 90. 05 09005 0P PSYCH CLINIC 4, 656, 115 90. 05 91. 00 09100 EMERGENCY 14, 012, 406 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92. 00 0700 09400 HOME PROGRAM DIALYSIS 0 94. 00 95. 00 09500 AMBULANCE SERVICES 10, 782, 743 95. 00 100. 00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100. 00 101. 00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100. 00 101. 00 11400 UTI LI ZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P. ) 0 115. 00 116. 00 SUBTOTALS (SUM OF LINES 1 through 117) 306, 820, 041  100. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 482, 683		2 (04 504	00.00
90. 02   09002   WOUND CARE CENTER   1, 375, 740   90. 02   90. 03   09003   PAI N CLINIC   624, 661   90. 03   90. 05   09005   0P PSYCH CLINIC   4, 656, 115   90. 05   91. 00   09100   EMERGENCY   14, 012, 406   91. 00   92. 00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   92. 00   09400   HOME PROGRAM DIALYSIS   0   94. 00   09400   HOME PROGRAM DIALYSIS   0   95. 00   09500   AMBULANCE SERVICES   10, 782, 743   95. 00   100. 00   10000   1 &R SERVICES-NOT APPRVD PRGM   0   100. 00   101. 00   10100   HOME HEALTH AGENCY   0   101. 00   10100   HOME HEALTH AGENCY   0   101. 00   1300   INTEREST EXPENSE   113. 00   11300   INTEREST EXPENSE   114. 00   11400   UTILIZATION REVIEW-SNF   114. 00   115. 00   11500   AMBULATORY SURGICAL CENTER (D.P.)   0   115. 00   11500   AMBULATORY SURGICAL CENTER (D.P.)   0   116. 00   116. 00   SUBTOTALS (SUM OF LINES 1 through 117)   306, 820, 041   NONREI MBURSABLE COST CENTERS   190. 00   19000   GIFT, FLOWER, COFFEE SHOP & CANTEEN   482, 683   190. 00	90. 01   09001   00   0000   000   MEUSLON   CENTED		
90. 03			
90. 05			
91. 00   99100   EMERGENCY   14, 012, 406   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   92. 00   07HER REI MBURSABLE COST CENTERS   94. 00   09400   HOME PROGRAM DI ALYSI S   0   94. 00   95.00   AMBULANCE SERVI CES   10, 782, 743   95. 00   100. 00   1 &R SERVI CES-NOT APPRVD PRGM   0   100. 00   10100   HOME HEALTH AGENCY   0   101. 00   SPECI AL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   114. 00   11400   UTI LI ZATI ON REVI EW-SNF   114. 00   115. 00   AMBULATORY SURGI CAL CENTER (D. P. )   0   116. 00   11600   HOSPI CE   0   116. 00   11600   HOSPI CE   0   116. 00   118. 00   SUBTOTALS (SUM OF LI NES 1 through 117)   306, 820, 041   NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   482, 683   190. 00			
92. 00   09200   OBSERVATI ON BEDS (NON-DISTINCT PART)   0	1 1		
OTHER REI MBURSABLE COST CENTERS   O   O9400   HOME PROGRAM DI ALYSI S   O   O9500   O9500   AMBULANCE SERVI CES   10, 782, 743   O55, 00   O9500   AMBULANCE SERVI CES   O   O9500		14, 012, 406	
94. 00 95. 00 100. 00 100. 00 100. 00 101. 00			92.00
95. 00			0.4.00
100. 00   10000   1&R SERVI CES-NOT APPRVD PRGM   0   100. 00   10100   HOME HEALTH AGENCY   0   101. 00   SPECIAL PURPOSE COST CENTERS   113. 00   11300   I NTEREST EXPENSE   114. 00   11400   UTI LI ZATI ON REVI EW-SNF   114. 00   11500   AMBULATORY SURGI CAL CENTER (D. P. )   0   115. 00   116. 00   1000   HOSPI CE   0   0   116. 00   118. 00   SUBTOTALS (SUM OF LI NES 1 through 117)   306, 820, 041   NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   482, 683   190. 00		-1	
101. 00	· · · · · · · · · · · · · · · · · · ·		
SPECIAL PURPOSE COST CENTERS   113. 00   11300   INTEREST EXPENSE   114. 00   11400   UTI LI ZATI ON REVI EW-SNF   114. 00   11500   AMBULATORY SURGI CAL CENTER (D. P.)   0   115. 00   116. 00   11600   HOSPI CE   0   0   116. 00   118. 00   SUBTOTALS (SUM OF LI NES 1 through 117)   306, 820, 041   18. 00   NONREI MBURSABLE COST CENTERS   190. 00   19000   GI FT, FLOWER, COFFEE SHOP & CANTEEN   482, 683   190. 00		-1	
113. 00 114.00 114.00 114.00 115. 00 115. 00 115. 00 115. 00 116. 00 116. 00 116. 00 116. 00 117. 00 118. 00 119. 00 119. 00 119. 00 119. 00 119. 00 119. 00		0	101. 00
114. 00 115. 00 115. 00 116. 00 116. 00 118. 00  NONREI MBURSABLE COST CENTERS  114. 00 115. 00 115. 00 115. 00 115. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 118. 00 118. 00 118. 00 118. 00 118. 00 118. 00 118. 00 118. 00 118. 00 118. 00 118. 00 118. 00 118. 00 118. 00 118. 00 118. 00			
115. 00	· · · · · · · · · · · · · · · · · · ·		
116. 00			
118. 00     SUBTOTALS (SUM OF LINES 1 through 117)     306, 820, 041       NONREI MBURSABLE COST CENTERS       190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN     482, 683       190. 00		0	
NONREI MBURSABLE COST CENTERS  190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 482, 683 190. 00		0	
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 482, 683 190. 00		306, 820, 041	118. 00
190. 01   1900			
	190. U1 19001 PKUMPICAKE	3, 599, 445	[190. 01

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0051	From 01/01/2019	Worksheet B Part I Date/Time Prepared:

		To 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am
Cost Center Description	Total	
	26.00	
190. 02 19002 RENTAL PROPERTIES	671, 610	190. 02
190. 03 19003 OLCOTT	666, 798	190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	190. 04
190. 05 19005 FOUNDATI ON	48, 835	190. 05
190. 06 19006 MARKETI NG	0	190. 06
190. 07 19007 HME STORE	1, 797	190. 07
190. 08 19008 UNUSED SPACE	110, 646	190. 08
190. 09 19009 CLINICAL TRIALS	284, 703	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	8, 126, 459	190. 11
191. 00 19100 RESEARCH	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	36, 634	192. 00
193.00 19300 NONPALD WORKERS	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	1, 676, 076	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	3, 159, 814	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	194. 02
194.03 07953 IU HEALTH SIP	183, 799	194. 03
194.04 07954 HOME CARE	89, 813	194. 04
194. 05 07955 HOSPI CE	179, 412	194. 05
200.00 Cross Foot Adjustments	0	200. 00
201.00 Negative Cost Centers	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	326, 138, 565	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

CANT FALL RELATED COSTS    COST Center Description
Company   Comp
DEFERENCE SERVICE COST CENTERS
CHINDM STRVILE COST CHITES   1.00 00100 CAP REL COSTS-MEE EDUIN   1.00 00100 CAP REL COSTS-MEE EDUIN   1.00 00100 CAP REL COSTS-MEE EDUIN   1.00 00100 CAP REL COSTS-MEE EDUIN   1.00 00100 CAP REL COSTS-MEE EDUIN   1.00 00100 CAP REL COSTS-MEE EDUIN   1.00 00100 CAP REL COSTS-MEE EDUIN   1.00 00100 CAP REL COSTS-MEE EDUIN   1.00 00100 CAP REL COSTS-MEE EDUIN   1.00 00100 CAP REL COSTS-MEE EDUIN   1.00 00100 CAP REL COSTS-MEE EDUIN   1.00 00100 CAP REL COSTS-MEE EDUIN   1.00 00100 CAP REL COSTS-MEE EDUIN   1.00 00100 CAP REL COSTS-MEE EDUIN   1.00 00100 CAP REL COSTS-MEE PER PER PER PER PER PER PER PER PER P
2.00
4.00   0.0400   DAPPLOVER BEREFITS DEPARTMENT   0   5.982   137, 893   143, 835   143,
0.000   0.00
2,00
8.00   0800   LANIDRY & LINEN SERVICE   0   1,370   31,573   32,943   0   8.00   0900   0000   DISTARY   0   6.881   188,568   166,449   1,762   10.00   11.00   0100   CAFTERN A   0   5.117   17,922   33,770   311,305   2,255   9.00   11.00   0100   CAFTERN A   0   5.117   17,922   33,770   311,305   1.762   10.00   11.00   11.00   0100   CAFTERN A   1.762   10.00   11.00   11.00   0100   CAFTERN A   1.762   10.00   11.00   11.00   0100   CAFTERN A   1.762   10.00   11.00   11.00   0100   CAFTERN A SERVICES & SUPPLY   0   4.21   4.21   4.00   03,70   031,300   311,300   03.
9.00 09000   MUSEKEEPI NG
11-10-00   11-00   CAFETERIA   0   5.117   117, 922   123, 030   1.008   11.00   13.00
13.00   01300   MURSI ING ADMIN SITRATION   0
14.00   01400 (PENTRAL SERVICES & SUPPLY   0   4,672   10.6,496   111,117   0   14.00   16.0
15.00   01500   PHARMACY   0   3, 853   88, 799   92, 652   6, 584   15.00   16.00   16.00   01600   BELOAL RECORDS & LIBRARY   0   2, 870   66, 144   69, 014   10   10   10   10   10   10   10
16.00   01600   MEDICAL RECORDS & LIBRARY   0   2,870   66,144   69,014   0   16.00   18.00   01851   SOCIAL SERVICES   0   0   0   0   0   0   18.00   18.00   01851   SOCIAL SERVICES   0   0   0   0   0   0   18.00   01851   SOCIAL SERVICE COST CENTERS   12,710   0201   MPATE ENT ROUTINE SERVICE COST CENTERS   12,645   0   98,484   2,269,521   2,368,005   28,003   30.00   30.00   30.00   03.000   03.010   03.011   58 PEDIATRIC S   0   98,484   2,269,521   2,368,005   28,003   30.00   31.00   03.0000   03.000   03.0000   03.0000   03.0000   03.0000   03.0000   03.0000   03.0000   03.0000
18.0   10851   CENTRAL STERILLIZATION   0   2.645   60,950   63,595   757   18.0   18.0   19.0   19.0   19.0   19.3   21,499   22,432   412   23.0   19.0
23. 00   02301   PARAMED ED PROJA-PHARMACY RESIDENCY   0   933   21, 499   22, 432   412   23. 00
INPATI ENT ROUTH NE SERVICE COST CENTERS   0   98, 484   2, 269, 521   2, 368, 005   28, 003   30, 00   310, 00   30100   AULTS A. PEDITATIC S.   0   98, 739   201, 390   210, 129   3, 942   31, 00   320, 00   3200   CORDARY CARE UNIT   0   11, 450   26,8,669   275, 319   3, 008   32, 00   320, 00   3200   CORDARY CARE UNIT   0   15, 504   133, 757   139, 561   2, 155   38, 00   42, 00
30.00   03000 ADULTS & PEDIATRICS   0   98, 484   2, 269, 521   2, 368, 005   28, 003   30.00   32.00   32.00   intensive Care Unit T   0   8,739   201, 129   3, 492   31.00   32.00   32.00   COROMARY CARE UNIT   0   511, 450   263, 869   275, 319   3, 008   32.00   32.00   AUGUSTA CARE UNIT   0   5,804   133, 757   139, 561   2,555   35.00   32.00   AUGUSTA CARE UNIT   0   5,804   133, 757   139, 561   2,555   35.00   32.00   AUGUSTA CARE UNIT   0   5,804   133, 757   139, 561   2,555   35.00   32.00   41.00
32.00   032000   CORONARY CARE UNIT   0   11, 450   263, 860   275, 310   3, 008   32.00     32.00   041000   NEONATAL INTENSIVE CARE UNIT   0   5,500   133, 757   139, 561   2,155   34.00     42.00   04200   SUBPROVI DER   0   0   0   0   0   0   0     42.00   04200   SUBPROVI DER   0   0   0   0   0   0   0   0     AND OLIVERY   0   0   4,033   92,934   96,967   843   43.00     AND OLIVERY   0   0   0   0   0   0   0   0   0     AND OLIVERY   0   0   0   0   0   0   0   0   0     AND OLIVERY   0   0   0   0   0   0   0   0   0
15. 00   02060   NEOMATAL INTENSIVE CARE UNIT   0   5. 80.4   133, 757   139, 561   2, 155   36. 00   42. 00   0. 00
11. 00   04100   SUBPROVI DER   1 PF   0   10. 342   238, 333   248, 675   1,351   41. 00   04. 20   04200   SUBPROVI DER   0   0   4. 033   92, 934   96, 967   84. 34. 20   04200   SUBPROVI DER   0   0   0   0   0   0   0   0   0
42.00   O4200   SUBROVI DER   0   0   0   0   0   0   0   42.00
ANCILLARY SERVICE COST CENTERS   50.00   50.00   0   0   0   0   0   0   0   0   0
50.00   05000  0FERATI NG ROOM
SOLD   OSDOI   CV SURGERY   O
S1-00   OSTOON RECOVERY ROOM   COUPATION
S2.00   05200   DELIVERY ROOM & LABOR ROOM   0   28,407   654,616   683,023   3,767   52.00
S4.00   O5400 RADI OLOGY-DI ACNOSTIC   O   16, 561   381, 634   398, 195   4, 150   54, 00   55.00   05500 RADI OLOGY-THERAPEUTIC   O   19, 454   448, 307   467, 761   3, 157   55. 00   56. 00   05600 RADI OLOGY-THERAPEUTIC   O   0   0   0   0   0   0   0   0   0
55.00   05500   RADI OLOGY-THERAPEUTIC   0   19, 454   448, 307   467, 761   3, 157   55.00   05600   0500   0   0   0   0   0   0   0
56. 00   05.
57.00   05700   CT SCAN   0   05800   MAGNETIC RESONANCE IMAGING (MRI)   0   1, 147   26, 438   27, 585   904   57, 00
58.00         05800 MAGNETIC RESONANCE I IMAGING (MRI)         0         1,651         38,040         39,691         572         58,00           69.00         05900 CARDIAC CATHETERIZATION         0         5,509         126,957         132,466         1,571         59,00           60.00         06000 LABORATORY         0         14,861         342,457         357,318         0         60.00           64.00         06400 I INTRAVENOUS THERAPY         0
60.0 0 06000 LABORATORY 0 0 14,861 342,457 357,318 0 60.00 64.00 06400 INTRAVENOUS THERAPY 0 0 1.123 25,870 26,993 3.025 65.00 06500 RESPIRATORY THERAPY 0 1.123 25,870 26,993 3.025 65.00 06500 RESPIRATORY THERAPY 0 8,194 188,828 197,022 8,180 66.00 66.00 66600 PHYSICAL THERAPY 0 8,194 188,828 197,022 8,180 66.00 67.00 00 07.00 00 0 0 0 0 0 0 0 0 0 0 0 0
64.00   06400   NTRAVENOUS THERAPY   0   0   0   0   0   0   0   0   0
65.00   06500   RESPI RATORY THERAPY   0   1, 123   25, 870   26, 993   3, 025   65. 00   66. 00   06600   06000   070
66.00   06600   PHYSI CAL THERAPY   0   8, 194   188, 828   197, 022   8, 180   66. 00   67. 00   670   0   0   0   0   0   0   0   0   0
68. 00   06800   SPEECH PATHOLOGY   0   0   0   0   0   0   68. 00   69. 00   06900   ELECTROCARDI OLOGY   0   2,086   48,074   50,160   1,000   69. 00   07000   ELECTROENCEPHALOGRAPHY   0   3,682   84,840   88,522   218   70. 00   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   0   73. 01   07302   OP PHARMACY   0   0   0   0   0   74. 00   07400   RENAL DI ALYSIS   0   670   15,443   16,113   0   74. 00   75. 00   07500   ASC (NON-DI STI NCT PART)   0   0   0   0   0   0   76. 97   07697   CARDI ACT REHABI LITATI ON   0   3,197   73,669   76,866   772   76. 97   76. 97   07697   CARDI ACT REHABI LITATI ON   0   3,197   73,669   76,866   772   76. 97   790. 01   09001   OP ONCOLOGY I NFUSI ON CENTER   0   16,219   373,756   389,975   4,533   90. 01   790. 02   09002   WOUND CARE CENTER   0   16,219   373,756   389,975   4,533   90. 01   790. 03   09003   PAI N CLINI C   0   2,551   58,794   61,345   237   90. 03   790. 04   00   00   0   0   0   0   791. 00   09100   EMERGENCY   0   22,518   518,919   541,437   6,314   91. 00   792. 00   09005   OP PSYCH CLINI C   0   22,518   518,919   541,437   6,314   91. 00   791. 00   09100   BERGENCY   0   0   0   0   0   792. 00   09400   HOME PROGRAM DI ALYSI S   0   0   0   0   794. 00   09400   HOME PROGRAM DI ALYSI S   0   0   0   0   795. 00   09500   AMBULANCE SERVICES   0   12,036   277,372   289,408   6,859   95. 00
69. 00 06900 ELECTROCARDI OLOGY 0 2,086 48,074 50,160 1,000 69. 00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 3,682 84,840 88,522 218 70. 00 70. 00 70. 00 ELECTROENCEPHALOGRAPHY 0 3,682 84,840 88,522 218 70. 00 71. 00 70. 00 FLOCAL SUPPLIES CHARGED TO PATIENTS 0 0 0 0 0 0 0 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 71. 00 0 0 0 0 0 0 0 0 72. 00 73.
70. 00   07000   ELECTROENCEPHALOGRAPHY   0   3, 682   84, 840   88, 522   218   70. 00   71. 00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0   0   0   0   0   0   0   71. 00   72. 00   72.00   07200   IMPL. DEV. CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   72. 00   73. 00   07300   DRUGS CHARGED TO PATI ENTS   0   0   0   0   0   0   0   0   0
71.00   07100   MEDI CAL SUPPLIES CHARGED TO PATI ENTS   0
73. 00
73. 01   07302   0P PHARMACY   0   0   0   0   0   0   36   73. 01     74. 00   07400   RENAL DI ALYSI S   0   670   15, 443   16, 113   0   74. 00     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   0   0   0   0     76. 97   07697   CARDI AC REHABI LI TATI ON   0   3, 197   73, 669   76, 866   772     76. 97   0000   0000   0000   0000   0000   0000   0000     90. 01   09000   01   NI C   0   0000   0000   0000   0000   0000     90. 01   09001   0P ONCOLOGY I NFUSI ON CENTER   0   16, 219   373, 756   389, 975   4, 533   90. 01     90. 02   09002   WOUND CARE CENTER   0   3, 972   91, 523   95, 495   622   90. 02     90. 03   09003   PAI N CLI NI C   0   2, 551   58, 794   61, 345   237   90. 03     90. 05   09005   0P PSYCH CLI NI C   0   10, 313   237, 647   247, 960   4, 864   90. 05     91. 00   09100   EMERGENCY   0   22, 518   518, 919   541, 437   6, 314   91. 00     92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   0   0   0   0     94. 00   09400   HOME PROGRAM DI ALYSI S   0   0   0   0   0   0   94. 00     95. 00   09500   AMBULANCE SERVI CES   0   12, 036   277, 372   289, 408   6, 859   95. 00     76. 90   76. 90   76. 90   76. 90   76. 90   95. 00     77. 90   90. 90. 90. 90. 90. 90. 90. 90. 90. 90.
74. 00
75. 00
76. 97   07697   CARDI AC REHABI LI TATI ON   0   3, 197   73, 669   76, 866   772   76. 97
OUTPATIENT SERVICE COST CENTERS   O
90. 00   09000   CLINIC   0   17, 887   412, 207   430, 094   1, 780   90. 00   90. 01   09001   0P ONCOLOGY INFUSION CENTER   0   16, 219   373, 756   389, 975   4, 533   90. 01   90. 02   09002   WOUND CARE CENTER   0   3, 972   91, 523   95, 495   622   90. 02   90. 03   09003   PAI N CLINIC   0   2, 551   58, 794   61, 345   237   90. 03   90. 05   09005   0P SYCH CLINIC   0   10, 313   237, 647   247, 960   4, 864   90. 05   91. 00   91. 00   EMERGENCY   0   22, 518   518, 919   541, 437   6, 314   91. 00   92. 00   09500   OBSERVATION BEDS (NON-DISTINCT PART)   0   0   0   0   92. 00   09400   HOME PROGRAM DIALYSIS   0   0   0   0   0   0   94. 00   95. 00   09500   AMBULANCE SERVICES   0   12, 036   277, 372   289, 408   6, 859   95. 00   00. 00   0
90. 01
90. 02   09002   WOUND CARE CENTER   0   3, 972   91, 523   95, 495   622   90. 02   90. 03   09003   PAI N CLINIC   0   2, 551   58, 794   61, 345   237   90. 03   90. 05   09005   OP PSYCH CLINIC   0   10, 313   237, 647   247, 960   4, 864   90. 05   91. 00   09100   EMERGNCY   0   22, 518   518, 919   541, 437   6, 314   91. 00   92. 00   OSSERVATION BEDS (NON-DISTINCT PART)   0   92. 00   0THER REI MBURSABLE COST CENTERS   0   0   0   0   0   94. 00   95. 00   09500   AMBULANCE SERVICES   0   12, 036   277, 372   289, 408   6, 859   95. 00
90. 05   09005   0P PSYCH CLINIC   0   10, 313   237, 647   247, 960   4, 864   90. 05   91. 00   09100   EMERGENCY   0   22, 518   518, 919   541, 437   6, 314   91. 00   92. 00   09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   92. 00   0000   OTHER REI MBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   94. 00   95. 00   09500   AMBULANCE SERVI CES   0   12, 036   277, 372   289, 408   6, 859   95. 00   00000   000000
91. 00   09100   EMERGENCY   0   22,518   518,919   541,437   6,314   91.00   92.00     09200   OBSERVATI ON BEDS (NON-DI STI NCT PART)   0   92.00     0000   OTHER REI MBURSABLE COST CENTERS   0   0   0   0   0   0   0   0   0
92. 00   09200   0BSERVATI ON BEDS (NON-DI STINCT PART)   0   92. 00   0THER REI MBURSABLE COST CENTERS   0   0   0   0   0   94. 00   95. 00   09500   AMBULANCE SERVI CES   0   12, 036   277, 372   289, 408   6, 859   95. 00   0   0   0   0   0   0   0   0   0
OTHER REI MBURSABLE COST CENTERS         0         0         0         0         0         94.00           94. 00         09500         AMBULANCE SERVI CES         0         12,036         277,372         289,408         6,859         95.00
95. 00 09500 AMBULANCE SERVICES 0 12, 036 277, 372 289, 408 6, 859 95. 00
100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM
SPECIAL PURPOSE COST CENTERS
113. 00 11300 INTEREST EXPENSE 113. 00
114. 00   11400   UTI LI ZATI ON REVI EW-SNF 115. 00   11500   AMBULATORY SURGI CAL CENTER (D. P. ) 0 0 0 0 15. 00
of of of of of the section of the se

ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051 Peri od: Worksheet B From 01/01/2019 Part II Date/Time Prepared: 12/31/2019 6/29/2020 8:56 am CAPITAL RELATED COSTS BLDG & FIXT **EMPLOYEE** Cost Center Description Directly MVBLE EQUIP Subtotal Assigned New **BENEFITS** DEPARTMENT Capi tal Related Costs 0 1.00 2.00 2A 4.00 116. 00 11600 HOSPI CE 0 116. 00 0 SUBTOTALS (SUM OF LINES 1 through 117) 0 695, 576 16, 029, 220 16, 724, 796 135, 435 118, 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 802 18, 481 19, 283 162 190. 00 1, 739 190. 01 190. 01 19001 PROMPTCARE 5, 473 126, 133 131, 606 190. 02 19002 RENTAL PROPERTIES 15, 101 15, 101 0 190.02 O 190. 03 19003 OLCOTT 0 364 190. 03 2, 339 2, 339 190. 04 19004 PHYSI CI AN RECRUITMENT 0 0 190. 04 190. 05 19005 FOUNDATION 0 1.021 0 190. 05 1 021 190. 06 19006 MARKETI NG 0 0 190.06 190. 07 19007 HME STORE 0 190. 07 190. 08 19008 UNUSED SPACE 0 0 190. 08 0 190. 09 19009 CLINICAL TRIALS 0 200 190. 09 425 425 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 0 190. 10 190. 11 19011 COMMUNITY HEALTH SERVICES 12, 096 0 12, 096 4, 140 190. 11 191. 00 19100 RESEARCH 0 191.00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 20 192. 00 C 0 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 194.00 07950 IU HEALTH PAOLI HOSPITAL 8, 872 204, 448 213, 320 614 194. 00 1, 161 194. 01 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 384, 143 400, 813 16, 670 0 194. 02 194. 02 07952 I U HEALTH MORGAN HOSPI TAL 0 194. 03 07953 IU HEALTH SIP 383 0 383 0 194. 03 194.04 07954 HOME CARE 2, 041 0 2,041 0 194. 04 194. 05 07955 HOSPI CE 0 0 194. 05 4,079

0

4,079

764, 878

16, 762, 425

200.00

0 201. 00

143, 835 202. 00

0

17, 527, 303

200.00

201.00

202.00

Cross Foot Adjustments

Negative Cost Centers

TOTAL (sum lines 118 through 201)

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0051

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2019 Part II
To 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am

						6/29/2020 8:5	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL 5.00	7. 00	LINEN SERVICE 8.00	9. 00	10.00	
	GENERAL SERVICE COST CENTERS	3.00	7.00	8.00	9.00	10.00	
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	0 505 (00					4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	3, 525, 682 226, 449	3, 167, 729				5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	2, 478	3, 167, 729 8, 850				8.00
9. 00	00900 HOUSEKEEPI NG	48, 214	19, 156	1	141, 004		9. 00
10.00	01000 DI ETARY	33, 604	44, 449		270	245, 538	10.00
11. 00		11, 025	33, 055	1	244	0	11. 00
13. 00		137, 750	91, 859		0	0	13. 00
14. 00		165, 237	29, 852		0	0	14.00
15. 00 16. 00	1 1	102, 250 2, 421	24, 892 18, 541	1	514	0	15. 00 16. 00
18. 00		2, 421	10, 541		0	0	18. 00
18. 01	01851 CENTRAL STERI LI ZATI ON	11, 920	17, 085	155	ō	0	18. 01
23. 00		6, 652	6, 026	0	O	0	23. 00
	I NPATIENT ROUTINE SERVICE COST CENTERS						
30.00		418, 024	636, 179	1	l	197, 936	30.00
31. 00 32. 00	1 1	59, 268 45, 818	56, 452 73, 966	1	· · · · · · · · · · · · · · · · · · ·	17, 241 16, 365	31. 00 32. 00
35. 00	I I	36, 329	37, 494	1		0, 303	35.00
41. 00	l i	22, 192	66, 808	1	4, 109	13, 996	41. 00
42.00	04200 SUBPROVI DER	o	0	0	o	0	42. 00
43.00		13, 431	26, 051	472	2, 401	0	43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	1 44 (04	0/0 040	1 010	40.05/		
50. 00 50. 01	05000 OPERATING ROOM 05001 CV SURGERY	141, 691	269, 819	4, 312	l	0	50. 00 50. 01
51. 00	i i	58, 655	19, 035	1		0	51.00
52. 00	• • • • • • • • • • • • • • • • • • •	62, 641	183, 498	1	8, 142	0	52. 00
53.00		O	0	0	o	0	53. 00
54.00	1	64, 520	106, 977			0	54. 00
55. 00	1	54, 358	125, 666		0	0	55. 00
56. 00 57. 00		13, 765	7, 411	0	0	0	56. 00 57. 00
58. 00		8, 312	10, 663			0	58.00
59. 00		27, 972	35, 588			0	59.00
60.00	1 1	211, 477	95, 995	1	l .	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00		42, 110	7, 252	1	0	0	65. 00
66.00	• • • • • • • • • • • • • • • • • • •	117, 553	52, 931	1	1, 284	0	66.00
67. 00 68. 00	i i		0			0	67. 00 68. 00
69. 00	i i	15, 056	13, 476	595	4, 109	0	69.00
70.00	l l	14, 423	23, 782	1	o	0	70.00
71. 00		131, 335	0	0	3, 082	0	71. 00
72. 00		230, 019	0	1		0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	404, 811	0	0	1, 541	0	73.00
73. 01 74. 00	l i	1, 231 17, 869	4, 329		0	0	73. 01 74. 00
75. 00		17,009	4, 327			0	75. 00
75. 01		o	0	o o	o	0	75. 01
76. 97		11, 803	20, 651	0	o	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90. 00 90. 01		29, 928	115, 547			0	90. 00 90. 01
90.01		69, 022 10, 823	104, 769 25, 655	1	1, 284 1, 027	0	90.01
90. 02		4, 955	16, 481	1	1, 027	0	90.02
90. 05		44, 196	66, 616	1	o	0	90. 05
91. 00	09100 EMERGENCY	112, 605	145, 460	7, 190	21, 061	0	91.00
92. 00	,						92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400   HOME PROGRAM DI ALYSI S   09500   AMBULANCE SERVI CES	108, 833	77, 751	0 2, 385	·	0	94. 00 95. 00
	010000 I&R SERVICES-NOT APPRVD PRGM	100, 633	77,751	2, 303			100.00
	010100 HOME HEALTH AGENCY		0	ol ö	l ől		101.00
	SPECIAL PURPOSE COST CENTERS						1
	0 11300   NTEREST EXPENSE					<del></del>	113. 00
	0 11400 UTILIZATION REVIEW-SNF	_	=	_	_	-	114.00
	D 11500 AMBULATORY SURGICAL CENTER (D. P. ) D 11600 HOSPICE		0	0	o o		115.00
116.0	1 1	3, 353, 025	2, 720, 067	0 44, 271	139, 720	245, 538	116. 00 118. 00
1 10.0	NONREI MBURSABLE COST CENTERS	3, 333, 025	2, 720, 007	44,2/1	137, 720	243, 330	1.10.00
190.0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 810	5, 180	0	0	0	190. 00
		· '			<b>'</b>		

202.00

ALLOCATION OF CAPITAL RELATED COSTS

TOTAL (sum lines 118 through 201)

Provider CCN: 15-0051

Peri od: Worksheet B From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared:

141, 004

44, 271

245, 538 202. 00

6/29/2020 8:56 am ADMINISTRATIVE OPERATION OF Cost Center Description LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9. 00 10.00 5.00 7.00 8.00 190. 01 19001 PROMPTCARE 35, 212 35, 357 0 190, 01 0 0 190. 02 19002 RENTAL PROPERTIES 0 190. 02 287 97, 550 0 0 190. 03 19003 OLCOTT 6,072 15, 107 0 190. 03 0 190. 04 19004 PHYSI CI AN RECRUITMENT 0 0 190. 04 190. 05 19005 FOUNDATION 190. 06 19006 MARKETING 0 57 6, 592 0 190. 05 o 0 190.06 0 C 190. 07 19007 HME STORE 0 0 190. 07 190. 08 19008 UNUSED SPACE 0 0 190. 08 745 284 1, 0 190. 09 19009 CLINI CAL TRI ALS 0 190, 09 2, 747 2.714 0 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 190. 10 0 190. 11 19011 COMMUNITY HEALTH SERVICES 80, 107 78, 136 0 0 0 190. 11 0 191. 00 19100 RESEARCH 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192.00 395 0 193. 00 19300 NONPALD WORKERS 0 0 0 0 0 0 193. 00 194.00 07950 IU HEALTH PAOLI HOSPITAL 13, 981 57, 309 0 0 194.00 0 194. 01 194. 01 07951 IU HEALTH BEDFORD HOSPITAL 107,680 26, 379 194.02 07952 IU HEALTH MORGAN HOSPITAL 0 0 194. 02 194.03 07953 IU HEALTH SIP 1,810 2, 472 0 0 194. 03 194. 04 07954 HOME CARE 194. 05 07955 HOSPI CE 13, 185 0 0 194. 04 28 0 0 0 194. 05 56 26, 347 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 0 201.00

3, 525, 682

3, 167, 729

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0051

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared:

			10	12/31/2019	Date/lime Pre 6/29/2020 8:5	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	o din
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	13.00	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 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
8.00   00800   LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9.00
10. 00   01000   DI ETARY 11. 00   01100   CAFETERI A	168, 461					10. 00 11. 00
13. 00   O1300   NURSI NG   ADMI NI STRATI ON	9, 962	590, 089				13.00
14. 00   01400   CENTRAL SERVICES & SUPPLY	7, 702	370,007	306, 206			14. 00
15. 00 01500 PHARMACY	6, 409	o	2, 157	235, 044		15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	О	0	o	90, 490	16. 00
18. 00   01850   SOCIAL SERVICES	0	o	0	o	0	18. 00
18. 01   01851   CENTRAL STERILIZATION	1, 521	0	2, 600	0	0	18. 01
23. 00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY	444	0	0	0	0	23. 00
INPATIENT ROUTINE SERVICE COST CENTERS			4. 700			
30. 00   03000   ADULTS & PEDI ATRI CS	38, 629	249, 063	14, 730	1, 911	8, 881	30.00
31. 00   03100   INTENSIVE CARE UNIT 32. 00   03200   CORONARY CARE UNIT	5, 061 4, 156	32, 710 27, 697	3, 317 2, 042	622 255	1, 078 993	31. 00 32. 00
35. 00   03200   CORONART CARE UNIT	2, 675	18, 534	2, 042 1, 279	62	732	35.00
41. 00   04100   SUBPROVI DER -   I RF	1, 959	13, 191	505	9	340	41.00
42. 00   04200   SUBPROVI DER	0	0	0	ó	0	42. 00
43. 00   04300   NURSERY	1, 073	8, 165	443	8	217	43. 00
ANCILLARY SERVICE COST CENTERS	· ·		'			
50.00   05000 OPERATING ROOM	8, 136	38, 664	42, 619	436	11, 158	50. 00
50. 01   05001   CV   SURGERY	0	0	0	0	0	50. 01
51. 00   05100   RECOVERY ROOM	4, 966	35, 109	1, 849	334	1, 697	51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	4, 484	26, 572	2, 665	185	1, 859	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00   05400 RADI OLOGY THERAPEUT C	5, 050	6, 623	1, 422	341	2, 473	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C 56. 00   05600   RADI OI SOTOPE	3, 504 0	3, 315 0	3, 756 0	24	5, 225 0	55. 00 56. 00
57. 00   05700   CT   SCAN	1, 040	0	1, 068	51	1, 383	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	614	0	104	11	522	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	1, 732	8, 832	3, 975	94	3, 635	59. 00
60. 00 06000 LABORATORY	7, 333	0	0	o	5, 958	60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	O	0	o	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	3, 476	0	3, 689	58	688	65. 00
66. 00 06600 PHYSI CAL THERAPY	8, 563	5	186	0	1, 544	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	1 4/3	0	0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	1, 368	1, 463	237	25	1, 234	69.00
70.00   07000   ELECTROENCEPHALOGRAPHY 71.00   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	345	0	614 74, 187	0	626 4, 502	70. 00 71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0		129, 921	0		72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	o	0	228, 350	13, 060	
73. 01 07302 OP PHARMACY	22	O	15	0	0	73. 01
74.00 07400 RENAL DIALYSIS	0	О	120	50	237	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	0	0	0	0	75. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	934	3, 029	43	0	196	76. 97
OUTPATIENT SERVICE COST CENTERS				1		
90. 00   09000   CLI NI C	1, 966		33	120	144	90.00
90. 01   09001   OP ONCOLOGY INFUSION CENTER	5, 227	31, 141	1, 700	416	1, 701	90. 01
90. 02   09002   WOUND CARE CENTER 90. 03   09003   PALN CLINIC	750 303	5, 706 1, 713	616 296	0	394 153	90. 02 90. 03
90. 05   09005   OP   PSYCH   CLINIC	4, 682	4, 000	17	0	224	90.05
91. 00   09100   EMERGENCY	9, 047	59, 775	7, 346	1, 492	10, 234	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	,,,,,,	37,773	7,010	., ., _	10,201	92.00
OTHER REIMBURSABLE COST CENTERS	l.	l	,			
94.00 O9400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	11, 596	o	1, 615	181	2, 663	95. 00
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0		100. 00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS	T	-	П	Т		446 5-
113. 00 11300   INTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF	_		_			114.00
115. 00 11500  AMBULATORY SURGI CAL CENTER (D. P. ) 116. 00 11600  HOSPI CE	0	0	0	0		115. 00 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	157, 027	581, 030	305, 166	235, 040		
1.1.10	157,027	001,000	555, 100	200, 040	70, 470	1

					6/29/2020 8: 5	<u>6 am</u>
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14. 00	15. 00	16. 00	
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	469		0	0		190. 00
190. 01 19001 PROMPTCARE	2, 203	2, 050	897	2		190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	0		190. 02
190. 03 19003 OLCOTT	484	43	12	0	0	190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	0	0	0	0	190. 04
190. 05 19005 FOUNDATI ON	0	0	0	0	0	190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0	190. 06
190. 07 19007 HME STORE	0	0	0	0	0	190. 07
190. 08 19008 UNUSED SPACE	0	0	0	0	0	190. 08
190. 09 19009 CLI NI CAL TRI ALS	281	588	0	0	0	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	6, 439	6, 378	129	2	0	190. 11
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	2	0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	522	0	0	0	0	194. 00
194. 01 07951 IU HEALTH BEDFORD HOSPITAL	1, 036	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	0	0	0	0	194. 03
194.04 07954 HOME CARE	0	0	0	0	0	194. 04
194. 05 07955 HOSPI CE	0	0	0	0	0	194. 05
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	0	0	201. 00
202.00 TOTAL (sum lines 118 through 201)	168, 461	590, 089	306, 206	235, 044	90, 490	202. 00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet B | From 01/01/2019 | Part II | To 12/31/2019 | Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

					o 12/31/2019	Date/lime Pre 6/29/2020 8:5	
		OTHER GENER	RAL SERVICE			072772020 0.0	o dili
	Cost Center Description	SOCI AL SERVI CES	CENTRAL STERI LI ZATI ON	PARAMED ED PRGM-PHARMACY RESI DENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		18. 00	18. 01	23. 00	24.00	25. 00	
	GENERAL SERVICE COST CENTERS						
1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00	OO100 CAP REL COSTS-BLDG & FIXT OO200 CAP REL COSTS-MVBLE EQUIP OO400 EMPLOYEE BENEFITS DEPARTMENT OO500 ADMINISTRATIVE & GENERAL OO700 OPERATION OF PLANT OO800 LAUNDRY & LINEN SERVICE OO900 HOUSEKEEPING O1000 DIETARY						1. 00 2. 00 4. 00 5. 00 7. 00 8. 00 9. 00 10. 00
11. 00 13. 00 14. 00 15. 00	01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY						11. 00 13. 00 14. 00 15. 00
16. 00 18. 00 18. 01 23. 00	01600 MEDICAL RECORDS & LIBRARY   01850 SOCIAL SERVICES   01851 CENTRAL STERILIZATION   02301 PARAMED ED PRGM-PHARMACY RESIDENCY	0 0 0	97, 633				16. 00 18. 00 18. 01 23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00	03000   ADULTS & PEDIATRICS   03100   INTENSIVE CARE UNIT   03200   CORONARY CARE UNIT   02060   NEONATAL INTENSIVE CARE UNIT   04100   SUBPROVIDER - IRF   04200   SUBPROVIDER   O4300   NURSERY	0 0 0 0 0	0 0 0 0		4, 041, 243 396, 847 451, 038 239, 122 374, 218 0 150, 130	0 0 0 0 0	30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00
	ANCILLARY SERVICE COST CENTERS	_					
50. 00 50. 01 51. 00	O5000 OPERATING ROOM   O5001 CV SURGERY   O5100 RECOVERY ROOM	0 0 0	0		1, 631, 269 0 200, 354	0 0	50. 00 50. 01 51. 00
52. 00 53. 00 54. 00	O5200   DELI VERY ROOM & LABOR ROOM   O5300   ANESTHESI OLOGY   O5400   RADI OLOGY-DI AGNOSTI C	0 0			985, 121 0 597, 486	0 0 0	52. 00 53. 00 54. 00
55. 00 56. 00 57. 00	O5500   RADI OLOGY-THERAPEUTI C   O5600   RADI OI SOTOPE   O5700   CT   SCAN	0 0	0 0		666, 812 0 53, 207	0 0 0	55. 00 56. 00 57. 00
58. 00 59. 00 60. 00	05800 MAGNETIC RESONANCE IMAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY	0 0	0 1, 063 0		60, 489 217, 770 680, 144	0	58. 00 59. 00 60. 00
64. 00 65. 00 66. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	0	0		0 87, 291 387, 274	0	64. 00 65. 00 66. 00
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY	0			0 0 0 88, 723	0	67. 00 68. 00 69. 00
70. 00 71. 00 72. 00	07000 ELECTROCARDIOLOGI 07000 ELECTROCARDIOLOGI 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 0 0	204 0 0		128, 734 213, 106 366, 679 647, 762	0 0	70. 00 71. 00 72. 00 73. 00
74. 00 75. 00	07302 OP PHARMACY 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0 0 0 0	0 0 0 0		1, 304 38, 718 0 0	0 0 0 0	73. 01 74. 00 75. 00 75. 01
	07697 CARDIAC REHABILITATION  OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	0	-		114, 294 585, 335	0	76. 97 90. 00
90. 01 90. 02 90. 03	09001 OP ONCOLOGY INFUSION CENTER 09002 WOUND CARE CENTER 09003 PAIN CLINIC	0	0 249 23		609, 964 141, 337 85, 511	0	90. 01 90. 02 90. 03
	09005 OP PSYCH CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	0 68		372, 559 922, 029	0 0	90. 05 91. 00 92. 00
95. 00 100. 00	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0 0 0 0	0		0 501, 291 0 0		94. 00 95. 00 100. 00 101. 00
	SPECIAL PURPOSE COST CENTERS   11300   INTEREST EXPENSE   11400   UTI LI ZATI ON REVIEW-SNF						113. 00 114. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2019 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

			T	o 12/31/2019	
	OTHER GENER	DAI SEDVICE			6/29/2020 8:56 am
	OTTIER GENER	VAL SERVICE			
Cost Center Description	SOCI AL	CENTRAL	PARAMED ED	Subtotal	Intern &
5550 5511011 B5551 1 p 11 511	SERVI CES		PRGM-PHARMACY		Residents Cost
			RESI DENCY		& Post
					Stepdown
					Adjustments
	18. 00	18. 01	23. 00	24. 00	25. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0 115. 00
116. 00 11600 HOSPI CE	0	0		0	0 116. 00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	0	97, 504	0	16, 037, 161	0 118. 00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		29, 904	0 190. 00
190. 01 19001 PROMPTCARE	0	0		209, 066	
190. 02 19002 RENTAL PROPERTIES	0	0		112, 938	
190. 03 19003 OLCOTT	0	0		24, 421	0 190. 03
190. 04 19004 PHYSI CLAN RECRUI TMENT	0	0		0	0 190. 04
190. 05 19005 FOUNDATI ON	0	0		7, 670	0 190. 05
190. 06 19006 MARKETI NG	0	0		0	0 190. 06
190. 07 19007 HME STORE	0	106		110	0 190. 07
190. 08 19008 UNUSED SPACE	0	0		2, 029	
190. 09 19009 CLINI CAL TRI ALS	0	0		6, 955	
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0		0	0 190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	23		187, 450	0 190. 11
191. 00 19100 RESEARCH	0	0		0	0 191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		417	0 192. 00
193. 00 19300 NONPALD WORKERS	0	0		0	0 193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0		285, 746	
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	0		537, 069	0 194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0		0	0 194. 02
194.03 07953 IU HEALTH SIP	0	0		4, 665	
194.04 07954 HOME CARE	0	0		15, 254	
194. 05 07955 HOSPI CE	0	0		30, 482	
200.00 Cross Foot Adjustments			35, 966	35, 966	
201.00 Negative Cost Centers	0	0	0	0	0 201. 00
202.00   TOTAL (sum lines 118 through 201)	0	97, 633	35, 966	17, 527, 303	0 202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2019 Part II
To 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

				6/29/2020 8:5	
		Cost Center Description	Total		
	CENED	AL CEDIU CE COCT CENTERC	26. 00		
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT			1.00
2. 00	1	CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	1	ADMINISTRATIVE & GENERAL			5. 00
7.00	1	OPERATION OF PLANT			7. 00
8. 00 9. 00	1	LAUNDRY & LINEN SERVICE HOUSEKEEPING			8. 00 9. 00
10.00	1	DI ETARY			10.00
11. 00	1	CAFETERI A			11.00
13.00		NURSING ADMINISTRATION			13. 00
14.00	1	CENTRAL SERVICES & SUPPLY			14. 00
15.00	1	PHARMACY			15. 00
16. 00 18. 00	1	MEDICAL RECORDS & LIBRARY			16. 00 18. 00
18. 00	1	SOCIAL SERVICES CENTRAL STERILIZATION			18. 01
23. 00	1	PARAMED ED PRGM-PHARMACY RESIDENCY			23. 00
		IENT ROUTINE SERVICE COST CENTERS	<u>'</u>		
30. 00	1	ADULTS & PEDIATRICS	4, 041, 243		30. 00
31.00	1	INTENSIVE CARE UNIT	396, 847		31.00
32. 00 35. 00		CORONARY CARE UNIT NEONATAL INTENSIVE CARE UNIT	451, 038		32. 00 35. 00
41. 00	1	SUBPROVIDER - IRF	239, 122 374, 218		41. 00
42. 00	1	SUBPROVI DER	0		42. 00
43.00	1	NURSERY	150, 130		43. 00
		LARY SERVICE COST CENTERS			
50.00		OPERATING ROOM	1, 631, 269		50.00
50. 01	1	CV SURGERY	200 254		50. 01 51. 00
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	200, 354 985, 121		51.00
53. 00	1	ANESTHESI OLOGY	703, 121		53. 00
54.00	1	RADI OLOGY-DI AGNOSTI C	597, 486		54. 00
55.00	05500	RADI OLOGY-THERAPEUTI C	666, 812		55. 00
56. 00	1	RADI OI SOTOPE	0		56. 00
57. 00	1	CT SCAN	53, 207		57. 00
58. 00 59. 00	1	MAGNETIC RESONANCE IMAGING (MRI) CARDIAC CATHETERIZATION	60, 489 217, 770		58. 00 59. 00
60.00	1	LABORATORY	680, 144		60.00
64. 00	1	I NTRAVENOUS THERAPY	0		64. 00
65.00	06500	RESPI RATORY THERAPY	87, 291		65. 00
66. 00		PHYSI CAL THERAPY	387, 274		66. 00
67.00	1	OCCUPATIONAL THERAPY	0		67. 00
68. 00 69. 00	1	SPEECH PATHOLOGY ELECTROCARDI OLOGY	88, 723		68. 00 69. 00
70.00	1	ELECTROENCEPHALOGRAPHY	128, 734		70. 00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS	213, 106		71. 00
72. 00		IMPL. DEV. CHARGED TO PATIENTS	366, 679		72. 00
		DRUGS CHARGED TO PATIENTS	647, 762		73. 00
	1	OP PHARMACY	1, 304		73. 01
74. 00 75. 00		RENAL DIALYSIS ASC (NON-DISTINCT PART)	38, 718 0		74. 00 75. 00
75. 00	1	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		75. 00
	1	CARDI AC REHABI LI TATI ON	114, 294		76. 97
		TIENT SERVICE COST CENTERS			
90.00	1	CLINIC	585, 335		90.00
90. 01 90. 02		OP ONCOLOGY INFUSION CENTER WOUND CARE CENTER	609, 964		90. 01 90. 02
90. 02		PAIN CLINIC	141, 337 85, 511		90. 02
90. 05		OP PSYCH CLINIC	372, 559		90. 05
91.00		EMERGENCY	922, 029		91.00
92.00		OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
		REIMBURSABLE COST CENTERS			
		HOME PROGRAM DIALYSIS AMBULANCE SERVICES	0 501, 291		94. 00 95. 00
	1	I &R SERVICES-NOT APPRVD PRGM	501, 291		100.00
		HOME HEALTH AGENCY	0		101.00
250		AL PURPOSE COST CENTERS	<u> </u>		]
	11300	I NTEREST EXPENSE			113. 00
		UTILIZATION REVIEW-SNF			114. 00
	1	AMBULATORY SURGICAL CENTER (D. P.)	0		115.00
116.00		HOSPICE   SUBTOTALS (SUM OF LINES 1 through 117)	16, 037, 161		116. 00 118. 00
110.00		IMBURSABLE COST CENTERS	10, 037, 101		1, 10. 00
190.00		GIFT, FLOWER, COFFEE SHOP & CANTEEN	29, 904		190. 00
190. 01	19001	PROMPTCARE	209, 066		190. 01

		6/29/2020 8:56 am
Cost Center Description	Total	
	26. 00	
190. 02 19002 RENTAL PROPERTIES	112, 938	190. 02
190. 03 19003 OLCOTT	24, 421	190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	190. 04
190. 05 19005 FOUNDATI ON	7, 670	190. 05
190. 06 19006 MARKETI NG	0	190. 06
190.07 19007 HME STORE	110	190. 07
190. 08 19008 UNUSED SPACE	2, 029	190. 08
190. 09 19009 CLINICAL TRIALS	6, 955	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	187, 450	190. 11
191. 00 19100 RESEARCH	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	417	192. 00
193. 00 19300 NONPALD WORKERS	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	285, 746	194. 00
194. 01 07951 IU HEALTH BEDFORD HOSPITAL	537, 069	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	194. 02
194. 03 07953 IU HEALTH SIP	4, 665	194. 03
194. 04 07954 HOME CARE	15, 254	194. 04
194. 05 07955 HOSPI CE	30, 482	194. 05
200.00 Cross Foot Adjustments	35, 966	200.00
201.00 Negative Cost Centers	0	201. 00
202.00   TOTAL (sum lines 118 through 201)	17, 527, 303	202. 00

	•	U HEALTH BLOOMI				Wardiahaat D. 1	
COST A	LLOCATION - STATISTICAL BASIS		Provi der CO		Period: From 01/01/2019	Worksheet B-1	
				-	To 12/31/2019		
		CAPITAL REI	LATED COSTS			6/29/2020 8:5	o alli
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
		(SQUARE FEET)	(SQUARE FEET)	BENEFITS		& GENERAL	
				DEPARTMENT (GROSS		(ACCUM. COST)	
				SALARI ES)			
		1.00	2.00	4.00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	899, 384	1				1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	7, 034	855, 308 7, 034		n		2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL	172, 026	1			257, 709, 072	5. 00
7. 00	00700 OPERATION OF PLANT	143, 704				16, 552, 078	1
8.00	00800 LAUNDRY & LINEN SERVICE	1, 611			0 0	181, 091	8. 00
9.00	00900 HOUSEKEEPI NG	3, 487				3, 524, 122	
10.00	01000 DI ETARY	8, 091	1				
11. 00 13. 00	01100   CAFETERI A   01300   NURSI NG   ADMI NI STRATI ON	6, 017 16, 721	1				
14. 00	01400 CENTRAL SERVI CES & SUPPLY	5, 434	1		o o		
15. 00	01500 PHARMACY	4, 531	1		9 0	1	
16. 00	01600 MEDICAL RECORDS & LIBRARY	3, 375	3, 375		0 0	176, 943	
18.00	01850 SOCIAL SERVICES	0	_		0		
18. 01	01851 CENTRAL STERILIZATION	3, 110 1, 097	1				
23. 00	02301   PARAMED ED PRGM-PHARMACY RESIDENCY   INPATIENT ROUTINE SERVICE COST CENTERS	1,097	1, 097	313, 52	7 0	480, 251	23.00
30. 00	03000 ADULTS & PEDIATRICS	115, 803	115, 803	21, 270, 28	7 0	30, 557, 600	30.00
31.00	03100 INTENSIVE CARE UNIT	10, 276	•			1	1
32. 00	03200 CORONARY CARE UNIT	13, 464					1
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	6, 825	•				1
41. 00 42. 00	04100  SUBPROVI DER	12, 161					1
43.00	04300 NURSERY	4, 742	1				
10.00	ANCI LLARY SERVI CE COST CENTERS	1,712	1, 712	011,70	<u> </u>	701,077	10.00
50.00	05000 OPERATING ROOM	49, 115	49, 115	5, 531, 42	4 0	10, 356, 766	50.00
50. 01	05001 CV SURGERY	0	1		0 0		50. 01
51.00	05100 RECOVERY ROOM	3, 465	1				
52. 00 53. 00	05200   DELIVERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY	33, 402	33, 402	2, 867, 17	0	4, 578, 710 0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	19, 473	19, 473	3, 158, 43	4 0	1	
55. 00	05500 RADI OLOGY-THERAPEUTI C	22, 875				3, 973, 236	
56.00	05600 RADI OI SOTOPE	0	0		0 0	0	1
57. 00	05700 CT SCAN	1, 349				1, 006, 119	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 941	1				
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	6, 478 17, 474	1		4 O	_, -, ,	
64. 00	06400 I NTRAVENOUS THERAPY	17, 474	0		0 0		
	06500 RESPI RATORY THERAPY	1, 320	1, 320	2, 301, 96	2 0	3, 077, 966	
66.00	06600 PHYSI CAL THERAPY	9, 635	9, 635	6, 225, 120	0 0	8, 592, 450	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	
68. 00 69. 00	06800   SPEECH   PATHOLOGY   06900   ELECTROCARDI OLOGY	0	0	7/0.05	0	1 100 404	
70.00	07000 ELECTROCARDI OLOGY	2, 453 4, 329				1, 100, 494 1, 054, 247	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	100, 22	0 0	9, 599, 791	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	16, 813, 013	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	29, 589, 303	1
73. 01	07302 OP PHARMACY	0	1	27, 22	7 0	90, 003	1
74. 00 75. 00	07400  RENAL DI ALYSI S   07500  ASC (NON-DI STI NCT PART)	788	1		0	1, 306, 095 0	
75. 00 75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0	]	0 0	· -	75. 00
76. 97	07697 CARDI AC REHABILITATION	3, 759	3, 759	587, 320			
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	21, 033					
90. 01	09001 OP ONCOLOGY INFUSION CENTER	19, 071	1			5, 045, 116	
90. 02	O9002   WOUND CARE CENTER   O9003   PAIN CLINIC	4, 670 3, 000	1			791, 070 362, 184	
90. 03	09005 OP PSYCH CLINIC	12, 126	1				
91. 00	09100 EMERGENCY	26, 478				1	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	·	,				92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DI ALYSI S	0	0	5 000 55	0	7 055 074	
	09500 AMBULANCE SERVICES  10000 I&R SERVICES-NOT APPRVD PRGM	14, 153	14, 153		9 0	7, 955, 074	95.00
	10000 HOME HEALTH AGENCY		, 0 n	1	0 0	<b>l</b>	101.00
	SPECIAL PURPOSE COST CENTERS				-, 0		1 55
	11300 I NTEREST EXPENSE						113. 00
114.00	11400 UTILIZATION REVIEW-SNF	<u> </u>	<u> </u>	<u> </u>		<u> </u>	114. 00

In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am CAPITAL RELATED COSTS MVBLE EQUIP Reconciliation ADMINISTRATIVE Cost Center Description BLDG & FIXT **EMPLOYEE** (SQUARE FEET) (SQUARE FEET) **BENEFITS** & GENERAL (ACCUM. COST) DEPARTMENT (GROSS SALARI ES) 1.00 2.00 5. 00 5A 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 0 0 116.00 11600 HOSPI CE 0 116.00 SUBTOTALS (SUM OF LINES 1 through 117) 118.00 817, 896 817, 896 103, 030, 769 -68, 429, 493 245, 088, 851 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 943 351, 598 190. 00 943 123 296 2, 573, 818 190. 01 190. 01 19001 PROMPTCARE 0 6,436 6, 436 1, 323, 071 190. 02 19002 RENTAL PROPERTIES 17, 757 0 20, 974 190. 02 190. 03 19003 OLCOTT 443, 854 190. 03 2,750 0 276, 998 0 190. 04 19004 PHYSI CI AN RECRUITMENT 0 190, 04 Ω 0 190. 05 19005 FOUNDATION 1, 200 0 4, 142 190. 05 190. 06 19006 MARKETI NG 0 0 190. 06 0 0 0 0 0 0 0 0 0 0 0 0 0 190. 07 19007 HME STORE 258 190. 07 0 0 190.08 19008 UNUSED SPACE 54, 423 190. 08 0 Ω 190. 09 19009 CLINICAL TRIALS 500 0 152, 096 198, 413 190. 09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 190. 10 190. 11 19011 COMMUNITY HEALTH SERVICES 5, 855, 347 190. 11 0 3, 150, 725 14, 223 191. 00 19100 RESEARCH C 0 191 00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 15, 017 28, 883 192. 00 193. 00 19300 NONPALD WORKERS 0 0 193. 00 194.00|07950|IU HEALTH PAOLI HOSPITAL 10.432 10.432 467, 458 1, 021, 898 194. 00 194.01 07951 IU HEALTH BEDFORD HOSPITAL 1, 928, 122 194. 01 19, 601 19,601 883, 599 194. 02 07952 IU HEALTH MORGAN HOSPITAL 0 194. 02 0 194. 03 07953 IU HEALTH SIP 132, 318 194. 03 450 0 0 194. 04 07954 HOME CARE 2, 400 C 0 2, 076 194. 04 194. 05 07955 HOSPI CE 4, 796 C 0 4, 097 194. 05 200.00 Cross Foot Adjustments 200. 00 Negative Cost Centers 201.00 201.00 26, 099, 359 68, 429, 493 202. 00 202.00 Cost to be allocated (per Wkst. B, 764, 878 16, 762, 425 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.850447 19. 598116 0.238518 0. 265530 203. 00 204.00 Cost to be allocated (per Wkst. B, 3, 525, 682 204. 00 143, 835 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 0.001314 0. 013681 205. 00 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

207. 00

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

COST A	ALLOCATION - STATISTICAL BASIS		Provi der CC		Period: From 01/01/2019 To 12/31/2019	Worksheet B-1 Date/Time Pre	pared:
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF	HOUSEKEEPI NG (HOURS OF SERVI CE)		6/29/2020 8:5 CAFETERI A (MANHOURS)	
		7. 00	LAUNDRY) 8.00	9. 00	10.00	11. 00	
	GENERAL SERVICE COST CENTERS	7.00	0.00	7. 00	10.00	11.00	
1. 00 2. 00 4. 00 5. 00 7. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT	576, 620					1. 00 2. 00 4. 00 5. 00 7. 00
8. 00 9. 00 10. 00 11. 00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	1, 611 3, 487 8, 091 6, 017	1, 353, 188 117 119 0	10, 98 2 1	1 54, 088 9 0	3, 314, 930	
13. 00 14. 00 15. 00 16. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY	16, 721 5, 434 4, 531 3, 375	93 0 3, 070 0	4		196, 038 0 126, 109 0	14. 00 15. 00 16. 00
18. 00 18. 01 23. 00	01850 SOCIAL SERVICES 01851 CENTRAL STERILIZATION 02301 PARAMED ED PRGM-PHARMACY RESIDENCY INPATIENT ROUTINE SERVICE COST CENTERS	3, 110 1, 097	0 4, 740 0		0 0 0 0 0 0	·	18. 01 23. 00
30. 00 31. 00 32. 00 35. 00 41. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 02060 NEONATAL INTENSIVE CARE UNIT 04100 SUBPROVIDER - IRF	115, 803 10, 276 13, 464 6, 825 12, 161	424, 450 57, 768 43, 361 9, 210 33, 105		0 3, 798 0 3, 605 0 0	760, 182 99, 587 81, 773 52, 632 38, 558	31. 00 32. 00 35. 00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	0 4, 742	0 14, 430	18	0 0 0	0 21, 123	42. 00 43. 00
50. 00 50. 01 51. 00 52. 00 53. 00	O5000   OPERATING ROOM   O5001   CV SURGERY   O5100   RECOVERY ROOM   O5200   DELIVERY ROOM & LABOR ROOM   O5300   ANESTHESI OLOGY	49, 115 0 3, 465 33, 402	131, 796 0 116, 791 67, 180	63	0 0	160, 093 0 97, 728 88, 238	50. 01 51. 00 52. 00
54. 00 55. 00 56. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	19, 473 22, 875 0	102, 533 1, 418 0	32	0 0 0	0 99, 366 68, 951 0	54. 00 55. 00 56. 00
57. 00 58. 00 59. 00 60. 00	05700 CT SCAN 05800 MAGNETIC RESONANCE I MAGING (MRI) 05900 CARDIAC CATHETERIZATION 06000 LABORATORY	1, 349 1, 941 6, 478 17, 474	0 0 25, 733 237 0	16	0 0 0 0 0 0	20, 474 12, 074 34, 073 144, 288	58. 00 59. 00 60. 00
64. 00 65. 00 66. 00 67. 00 68. 00	06400   NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	1, 320 9, 635 0	0 0 172 0 0	10	0 0 0 0 0 0 0 0 0 0	0 68, 392 168, 502 0 0	65. 00 66. 00 67. 00 68. 00
71. 00 72. 00	06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 453 4, 329 0 0	18, 181 0 0 0	24	0 0 0 0	26, 917 6, 793 0 0	71. 00 72. 00
73. 00 73. 01 74. 00 75. 00	07302 OP PHARMACY 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0 0 788 0	0 0 0 0		0 0 0 0 0 0 0 0	0 432 0 0	73. 01 74. 00 75. 00
75. 01 76. 97	03550 PSYCHIATRI C/PSYCHOLOGI CAL SERVI CES 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS	3, 759	0		0 0 0	0 18, 377	
90. 00 90. 01 90. 02 90. 03	09000 CLINIC 09001 OP ONCOLOGY INFUSION CENTER 09002 WOUND CARE CENTER 09003 PAIN CLINIC	21, 033 19, 071 4, 670 3, 000	0 6, 004 0	10 8		38, 694 102, 846 14, 762 5, 955	90. 01 90. 02
90. 05 91. 00 92. 00	09005 OP PSYCH CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	12, 126 26, 478	0 219, 767	1, 64	0 0	92, 136 178, 032	90. 05
95. 00 100. 00	09400 HOME PROGRAM DIALYSIS 09500 AMBULANCE SERVICES 10000 I&R SERVICES-NOT APPRVD PRGM 10100 HOME HEALTH AGENCY	0 14, 153 0 0	0 72, 913 0 0		0 0 0 0 0 0 0 0		94. 00 95. 00 100. 00 101. 00
114. 00 115. 00	SPECIAL PURPOSE COST CENTERS  11300 INTEREST EXPENSE  11400 UTI LI ZATI ON REVI EW-SNF  11500 AMBULATORY SURGI CAL CENTER (D. P. )	0	0		0 0		113. 00 114. 00 115. 00
116.00	11600   HOSPICE   SUBTOTALS (SUM OF LINES 1 through 117)	495, 132	0 1, 353, 188	10, 88	0 0 54, 088		116. 00 118. 00

In Lieu of Form CMS-2552-10 Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A PLANT LINEN SERVICE (HOURS OF (PATIENT DAYS) (MANHOURS) SERVICE) (SQUARE FEET) (POUNDS OF LAUNDRY) 7. 00 11.00 9.00 10.00 8.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 9, 225 190. 00 943 0 43, 342 190. 01 0 190. 01 19001 PROMPTCARE 6, 436 0 0 190. 02 19002 RENTAL PROPERTIES 17, 757 0 0 190. 02 190. 03 19003 OLCOTT 2,750 0 9, 525 190. 03 0 0 0 0 0 0 0 0 0 0 190. 04 19004 PHYSI CI AN RECRUITMENT 0 0 0 190. 04 190. 05 19005 FOUNDATI ON 0 190. 05 1, 200 0 0 0 0 190.06 190. 06 19006 MARKETI NG 0 0 190. 07 19007 HME STORE 0 0 0 0 190. 07 190. 08 19008 UNUSED SPACE 0 100 0 190. 08 190. 09 19009 CLINI CAL TRI ALS 190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINI C 5, 520 190. 09 500 0 0 0 0 0 190. 10 190. 11 19011 COMMUNITY HEALTH SERVICES 14, 223 126, 698 190. 11 0 191. 00 19100 RESEARCH 0 0 191.00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192. 00 0 193. 00 19300 NONPALD WORKERS 0 0 0 193. 00 194.00 07950 IU HEALTH PAOLI HOSPITAL 0 0 10, 280 194. 00 10, 432 20, 382 194. 01 194. 01 07951 I U HEALTH BEDFORD HOSPITAL 0 0 19,601 0 194. 02 07952 IU HEALTH MORGAN HOSPITAL 0 0 194. 02 194. 03 07953 IU HEALTH SIP 450 0 0 0 0 194. 03 194. 04 07954 HOME CARE 0 0 194. 04 2,400 0 0 194. 05 07955 HOSPI CE o 0 194, 05 4, 796 O C 200.00 Cross Foot Adjustments 200.00 Negative Cost Centers 201.00 201. 00 202.00 20, 947, 151 287, 700 Cost to be allocated (per Wkst. B, 4, 586, 581 3, 411, 205 1, 246, 377 202. 00 Part I) 203 00 Unit cost multiplier (Wkst. B, Part I) 36 327479 0 212609 417 721403 0. 375989 203. 00 63 067686 204.00 Cost to be allocated (per Wkst. B, 3, 167, 729 141,004 245, 538 168, 461 204. 00 44, 271 Part II) 205.00 Unit cost multiplier (Wkst. B, Part 5. 493616 0.032716 12.841894 4.539602 0. 050819 205. 00 II)206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2) 207.00 NAHE unit cost multiplier (Wkst. D, 207.00 Parts III and IV)

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am OTHER GENERAL SERVI CE Cost Center Description NURSI NG CENTRAL **PHARMACY** MEDI CAL SOCI AL SERVI CES ADMI NI STRATI ON SERVICES & (COSTED RECORDS & REQUIS.) LI BRARY (TIME SPENT) SUPPLY (DI RECT NURS. (COSTED (GROSS REQUISITIONS) CHARGES) HRS.) 15.00 18. 00 13.00 14.00 16.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 00700 OPERATION OF PLANT 7.00 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10 00 10 00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 1, 526, 587 13.00 01400 CENTRAL SERVICES & SUPPLY 39, 624, 226 14.00 14.00 279, 058 15.00 01500 PHARMACY 0 30, 456, 995 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 0 31 1, 763, 459, 842 16.00 01850 SOCIAL SERVICES 0 18.00 18.00 01851 CENTRAL STERILIZATION 0 0 18.01 18.01 336, 414 0 23.00 02301 PARAMED ED PRGM-PHARMACY RESIDENCY C 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 644, 341 1, 906, 037 247, 593 174, 146, 407 0 30.00 03100 INTENSIVE CARE UNIT 31.00 84.623 429, 249 80.640 21, 143, 724 0 31.00 32.00 03200 CORONARY CARE UNIT 71,654 264, 243 33.031 19, 463, 811 0 32.00 165, 451 02060 NEONATAL INTENSIVE CARE UNIT 47, 949 8,003 14, 343, 759 35.00 35.00 0 04100 SUBPROVIDER - IRF 6, 666, 705 41.00 34, 127 65, 363 1, 200 41.00 0 42.00 04200 SUBPROVI DER 0 42.00 04300 NURSERY 43.00 21, 123 57, 386 1,087 4, 255, 008 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 100, 025 5, 514, 874 56, 557 218, 787, 385 0 50.00 05001 CV SURGERY 50.01 0 50.01 05100 RECOVERY ROOM 90,828 239, 212 43, 295 33, 282, 990 51.00 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 68.742 344, 788 23.946 36, 449, 736 0 52.00 05300 ANESTHESLOLOGY 53 00 Λ 53 00 54.00 05400 RADI OLOGY-DI AGNOSTI C 17.134 183, 951 44, 211 48, 485, 347 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 8,575 486, 062 3, 167 102, 460, 394 0 55.00 05600 RADI OI SOTOPE 56.00 56.00 0 05700 CT SCAN 27, 124, 672 57.00 57.00 0 138, 250 6,660 0 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 13, 479 1, 451 10, 238, 031 0 58.00 59.00 05900 CARDIAC CATHETERIZATION 22,848 514, 386 12, 159 71, 271, 504 0 59.00 06000 LABORATORY 60 00 0 C 116, 822, 802 0 60 00 06400 INTRAVENOUS THERAPY 64.00 0  $\cap$ 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 477, 377 7, 461 13, 486, 657 0 65.00 66.00 06600 PHYSI CAL THERAPY 12 24, 111 30, 268, 169 0 66.00 0 06700 OCCUPATIONAL THERAPY 67 00 0 67 00 0 0 68.00 06800 SPEECH PATHOLOGY 0 0 68.00 06900 ELECTROCARDI OLOGY 30, 671 3, 273 24, 203, 388 69.00 69.00 3, 786 0 70.00 07000 ELECTROENCEPHALOGRAPHY 79, 481 12, 284, 137 0 70.00 0 0 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 9, 599, 791 88, 275, 917 71.00 71 00 0 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 16, 813, 013 132, 146, 163 0 72.00 07300 DRUGS CHARGED TO PATIENTS 29, 589, 302 245, 190, 649 73.00 73.00 07302 OP PHARMACY 0 1, 973 73.01 0 73.01  $\cap$ 07400 RENAL DIALYSIS 0 74.00 15, 511 6.492 4, 651, 447 0 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 75.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 75.01 75 01 0 0 07697 CARDIAC REHABILITATION 7,835 5, 512 0 0 76.97 76.97 3, 843, 815 OUTPATIENT SERVICE COST CENTERS 90.00 90.00 09000 CLI NI C 14,805 4, 246 15, 570 2, 823, 831 0 09001 OP ONCOLOGY INFUSION CENTER 219, 992 90. 01 90.01 80.564 53, 846 33, 351, 109 0 09002 WOUND CARE CENTER 79, 699 90.02 14, 762 7, 718, 975 90.02 0 0 90.03 09003 PAIN CLINIC 4, 432 38, 325 638 3,003,422 0 90.03 09005 OP PSYCH CLINIC 90.05 10, 347 2, 186 4, 398, 493 90.05 09100 EMERGENCY 950, 536 193, 362 200, 661, 722 91.00 91.00 154, 641 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 94.00 09500 AMBULANCE SERVICES 208, 930 0 95.00 95.00 23, 452 52, 209, 673 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 C 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | NTEREST EXPENSE l113. 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2019 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am OTHER GENERAL SERVI CE MEDI CAL Cost Center Description NURSI NG CENTRAL **PHARMACY** SOCI AL ADMI NI STRATI ON (COSTED RECORDS & SERVI CES SERVICES & REQUIS.) LI BRARY (TIME SPENT) SUPPLY (DI RECT NURS. (COSTED (GROSS HRS.) REQUISITIONS) CHARGES) 13.00 14.00 15.00 16.00 18. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115. 00 0 0 116. 00 11600 HOSPI CE 0 116.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 1, 503, 153 39, 489, 588 30, 456, 397 1, 763, 459, 842 0 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190, 00 C 190. 01 19001 PROMPTCARE 302 0 0 190. 01 5, 303 116, 127 190. 02 19002 RENTAL PROPERTIES 0 0 0 190. 02 190. 03 19003 OLCOTT 0 0 190. 03 1,587 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 112 190. 04 19004 PHYSI CI AN RECRUITMENT 0 0 190, 04 0 C 0 190. 05 190. 05 19005 FOUNDATI ON 0 C 0 190. 06 19006 MARKETI NG 0 0 0 0 190.06 190. 07 19007 HME STORE 0 0 0 190. 07 0 190.08 19008 UNUSED SPACE 0 0 190. 08 0 Ω 190. 09 19009 CLINICAL TRIALS 1,520 0 0 0 190. 09 190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC 0 0 190. 10 190. 11 19011 COMMUNITY HEALTH SERVICES 16, 499 0 190. 11 16, 714 296 191. 00 19100 RESEARCH 0 0 0 191.00 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 210 0 192.00 193. 00 19300 NONPALD WORKERS 0 0 0 0 193. 00 194.00|07950|IU HEALTH PAOLI HOSPITAL 0 0 194. 00 0 0 194.01 07951 IU HEALTH BEDFORD HOSPITAL 0 0 194. 01 0 0 194. 02 07952 IU HEALTH MORGAN HOSPITAL 0 0 0 194. 02 194. 03 07953 IU HEALTH SIP 0 194. 03 0 0 194. 04 07954 HOME CARE 0 0 0 194. 04 194. 05 07955 HOSPI CE 0 0 194. 05 200.00 Cross Foot Adjustments 200. 00 201.00 Negative Cost Centers 201. 00 9, 780, 155 0 202. 00 202.00 Cost to be allocated (per Wkst. B, 13, 423, 454 15, 482, 304 363, 253 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 8. 793114 0.390728 0.321114 0.000206 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, 235, 044 0 204. 00 590.089 306, 206 90.490 Part II) 0.000000 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.386541 0.007728 0.007717 0.000051 II) 206.00 NAHE adjustment amount to be allocated 206.00 (per Wkst. B-2)

207. 00

207.00

NAHE unit cost multiplier (Wkst. D,

Parts III and IV)

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 Period: Worksheet B-1 From 01/01/2019 To 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am Provider CCN: 15-0051

					6/29/2020 8: 56	6 am
			OTHER GENERAL			
			SERVI CE			
		Cost Center Description	CENTRAL	PARAMED ED		
			(TIME SPENT)	RESI DENCY		
			(ITWL SELNI)	(TIME SPENT)		
			18. 01	23.00		
		AL SERVICE COST CENTERS	1			
1.00		CAP REL COSTS MAYRIE FOULD				1.00
2. 00 4. 00	1	CAP REL COSTS-MVBLE EQUIP EMPLOYEE BENEFITS DEPARTMENT				2. 00 4. 00
5. 00	1	ADMINISTRATIVE & GENERAL				5. 00
7.00	1	OPERATION OF PLANT				7. 00
8.00		LAUNDRY & LINEN SERVICE				8. 00
9.00	1	HOUSEKEEPI NG				9. 00
10.00		DIETARY				10.00
11. 00 13. 00	1	CAFETERIA NURSING ADMINISTRATION				11. 00 13. 00
14. 00		CENTRAL SERVICES & SUPPLY				14. 00
15. 00		PHARMACY				15. 00
16.00	01600	MEDICAL RECORDS & LIBRARY				16.00
18. 00	1	SOCIAL SERVICES				18. 00
18. 01	1	CENTRAL STERILIZATION	64, 725			18. 01
23. 00		PARAMED ED PRGM-PHARMACY RESIDENCY   ENT ROUTINE SERVICE COST CENTERS	0	100		23. 00
30. 00		ADULTS & PEDIATRICS	0	0		30. 00
31.00		INTENSIVE CARE UNIT	0	0		31. 00
32. 00	1	CORONARY CARE UNIT	0	0		32. 00
35. 00		NEONATAL INTENSIVE CARE UNIT	0	0		35. 00
41. 00 42. 00	1	SUBPROVI DER - I RF SUBPROVI DER	0	0		41. 00 42. 00
43. 00	1	NURSERY	39	0		43. 00
		LARY SERVICE COST CENTERS				
50.00		OPERATING ROOM	59, 321	0		50.00
50. 01		CV SURGERY	0	0		50. 01
51. 00 52. 00	1	RECOVERY ROOM DELIVERY ROOM & LABOR ROOM	4, 035	0		51. 00 52. 00
53. 00	1	ANESTHESI OLOGY	0	Ö		53. 00
54.00	05400	RADI OLOGY-DI AGNOSTI C	180	0		54.00
55. 00	1	RADI OLOGY-THERAPEUTI C	0	0		55. 00
56. 00 57. 00	1	RADI OI SOTOPE CT SCAN	0	0		56. 00 57. 00
58. 00	1	MAGNETIC RESONANCE IMAGING (MRI)	0	0		58. 00
59. 00	1	CARDI AC CATHETERI ZATI ON	705	0		59. 00
60. 00	1	LABORATORY	0	0		60. 00
64. 00	1	I NTRAVENOUS THERAPY	0	0		64. 00
65. 00 66. 00	1	RESPI RATORY THERAPY PHYSI CAL THERAPY	0	0		65. 00 66. 00
67. 00	1	OCCUPATIONAL THERAPY	0	0		67. 00
68. 00	1	SPEECH PATHOLOGY	0	0		68. 00
69. 00		ELECTROCARDI OLOGY	0	0		69. 00
70. 00 71. 00		ELECTROENCEPHALOGRAPHY	135	0		70. 00 71. 00
71.00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	0	0		71.00
73. 00		DRUGS CHARGED TO PATIENTS	Ö	100		73. 00
73. 01		OP PHARMACY	0	0		73. 01
74.00	1	RENAL DIALYSIS	0	0		74. 00
75. 00 75. 01	1	ASC (NON-DISTINCT PART) PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		75. 00 75. 01
76. 97	1	CARDI AC REHABI LI TATI ON	0	0		76. 97
	OUTPA	TIENT SERVICE COST CENTERS				
90.00		CLI NI C	0	0		90.00
90. 01 90. 02		OP ONCOLOGY INFUSION CENTER	0	0		90. 01 90. 02
90. 02		WOUND CARE CENTER PAIN CLINIC	165 15	0		90. 02
90. 05	4	OP PSYCH CLINIC	0	0		90. 05
91.00		EMERGENCY	45	0		91. 00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)				92. 00
94. 00		REIMBURSABLE COST CENTERS HOME PROGRAM DIALYSIS		0		94. 00
	1	AMBULANCE SERVICES	0	0		95. 00
		I &R SERVICES-NOT APPRVD PRGM	0	0		100.00
101.00		HOME HEALTH AGENCY	0	0		101. 00
112 00		AL PURPOSE COST CENTERS INTEREST EXPENSE				112 00
	1	UTILIZATION REVIEW-SNF				113. 00 114. 00
		AMBULATORY SURGICAL CENTER (D. P. )	0	0		115. 00

Peri od: From 01/01/2019

			To 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am	:
	OTHER GENERAL		1 372772020 0.00 4	
	SERVI CE	5.55		
Cost Center Description	CENTRAL	PARAMED ED		
	STERI LI ZATI ON			
	(TIME SPENT)	RESIDENCY (TIME SPENT)		
	18. 01	23. 00		
116. 00 11600 HOSPI CE	0		116.00	00
118.00 SUBTOTALS (SUM OF LINES 1 through 117)	64, 640	100	118.00	00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190. 00	00
190. 01 19001 PROMPTCARE	0	0	190. 0°	)1
190. 02 19002 RENTAL PROPERTI ES	0	0	190. 02	)2
190. 03 19003 OLCOTT	0	0	190. 03	)3
190. 04 19004 PHYSICIAN RECRUITMENT	0	0	190. 04	)4
190. 05 19005 FOUNDATI ON	0	0	190. 0	)5
190. 06 19006 MARKETI NG	0	0	190. 00	)6
190. 07 19007 HME STORE	70	0	190. 0 <sup>-</sup>	)7
190. 08 19008 UNUSED SPACE	0	0	190. 08	)8
190. 09 19009 CLI NI CAL TRI ALS	0	0	190. 0	)9
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	190. 10	0
190. 11 19011 COMMUNITY HEALTH SERVICES	15	0	190. 1°	1
191. 00 19100 RESEARCH	0	0	191. 00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	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 IU HEALTH BEDFORD HOSPITAL	0	0	194. 0 <sup>-</sup>	
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	194. 02	
194.03 07953 IU HEALTH SIP	0	0	194. 03	
194.04 07954 HOME CARE	0	0	194. 04	
194. 05 07955 HOSPI CE	0	0	194. 0	
200.00 Cross Foot Adjustments			200. 00	
201.00 Negative Cost Centers			201. 00	
202.00 Cost to be allocated (per Wkst. B, Part I)	1, 359, 337	658, 501	202. 00	)0
203.00 Unit cost multiplier (Wkst. B, Part I)	21. 001730	6, 585. 010000	203. 00	00
204.00 Cost to be allocated (per Wkst. B,	97, 633	35, 966	204. 00	00
Part II)				
205.00 Unit cost multiplier (Wkst. B, Part	1. 508428	359. 660000	205. 00	)()
206.00 NAHE adjustment amount to be allocated		0	206. 00	)()
(per Wkst. B-2)				
207.00 NAHE unit cost multiplier (Wkst. D,		0. 000000	207. 00	Ю
Parts III and IV)				

near th	Titialiciai Systems	U HEALTH DECOM	NOTON HOST TIAL		III LI C	u or roriii cws	2332-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der Co		Period: From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
			T: 41 -		11! +-1	6/29/2020 8: 5	<u>6 am </u>
			IIIIE	XVIII	Hospi tal	PPS	
	0 1 0 1 5 11	T		T 1 1 0 1	Costs	T     0	
	Cost Center Description	Total Cost	Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	0.00		4.00		
	LABORT FAIT DOUTLAS OFFICE OF CONT. OFFITEDO	1.00	2. 00	3. 00	4. 00	5. 00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	F4 (7( 000	ı	F4 (7/ 00		E4 (7( 000	
30.00	03000 ADULTS & PEDIATRICS	54, 676, 888		54, 676, 88		54, 676, 888	1
31. 00	03100 I NTENSI VE CARE UNI T	7, 254, 215		7, 254, 21		7, 254, 215	1
32. 00	03200 CORONARY CARE UNIT	5, 742, 690		5, 742, 69		5, 742, 690	
35. 00	02060 NEONATAL INTENSIVE CARE UNIT	4, 122, 013		4, 122, 01		4, 122, 013	
41. 00	04100 SUBPROVI DER - I RF	3, 171, 582		3, 171, 58		3, 171, 582	
42. 00	04200 SUBPROVI DER	0			0 0	0	
43. 00	04300 NURSERY	1, 713, 960		1, 713, 96	0 0	1, 713, 960	43.00
	ANCILLARY SERVICE COST CENTERS		,	,			1
50.00	05000  OPERATI NG ROOM	19, 757, 089		19, 757, 08	9 0	19, 757, 089	50.00
50. 01	05001 CV SURGERY	0			0 0	0	50. 01
51.00	05100 RECOVERY ROOM	6, 526, 087		6, 526, 08	7 0	6, 526, 087	
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 159, 314		8, 159, 31	4 0	8, 159, 314	52.00
53.00	05300 ANESTHESI OLOGY	0			0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 119, 052		7, 119, 05	2 0	7, 119, 052	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	6, 172, 909		6, 172, 90	9 0	6, 172, 909	55.00
56.00	05600 RADI OI SOTOPE	0			o o	0	56.00
57.00	05700 CT SCAN	1, 391, 723		1, 391, 72	3 0	1, 391, 723	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	851, 755		851, 75	5 0	851, 755	
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 276, 410		3, 276, 41		3, 276, 410	
60. 00	06000 LABORATORY	20, 342, 188		20, 342, 18		20, 342, 188	1
64. 00	06400 I NTRAVENOUS THERAPY	20,012,100		1	o o	0	1
65. 00	06500 RESPI RATORY THERAPY	4, 160, 624	1	4, 160, 62	-	4, 160, 624	
66. 00	06600 PHYSI CAL THERAPY	11, 344, 944				11, 400, 560	1
67. 00	06700 OCCUPATI ONAL THERAPY	11, 544, 744		11, 544, 74	0 33,010	0 11, 400, 300	1
68. 00	06800 SPEECH PATHOLOGY				0	0	
69. 00	06900 ELECTROCARDI OLOGY	1, 680, 787	0	1, 680, 78	7 0	1, 680, 787	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 530, 418		1, 530, 41		1, 530, 418	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 018, 169					1
71. 00				16, 018, 16		16, 018, 169	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	27, 873, 917		27, 873, 91		27, 873, 917	
73. 00	07300 DRUGS CHARGED TO PATIENTS	47, 706, 793		47, 706, 79		47, 706, 793	1
73. 01	07302 OP PHARMACY	114, 834		114, 83		114, 834	1
74.00	07400 RENAL DIALYSIS	1, 690, 632		1, 690, 63		1, 690, 632	1
75. 00	07500 ASC (NON-DISTINCT PART)	0			0 0	0	
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		4 007 00	0	0	
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 307, 088		1, 307, 08	8 0	1, 307, 088	76. 97
	OUTPATIENT SERVICE COST CENTERS	T	T	T	.1 _1		
90. 00	09000 CLI NI C	3, 684, 504		3, 684, 50		3, 684, 504	
90. 01	09001 OP ONCOLOGY INFUSION CENTER	7, 977, 791		7, 977, 79		7, 977, 791	
90. 02	09002 WOUND CARE CENTER	1, 375, 740		1, 375, 74		1, 375, 740	1
	09003 PAIN CLINIC	624, 661		624, 66	1 0	624, 661	90. 03
90. 05	09005 OP PSYCH CLINIC	4, 656, 115		4, 656, 11	5 0	4, 656, 115	90. 05
	09100 EMERGENCY	14, 012, 406		14, 012, 40		14, 012, 406	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 032, 524		5, 032, 52	4	5, 032, 524	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0			0 0		94. 00
95.00	09500 AMBULANCE SERVI CES	10, 782, 743		10, 782, 74		10, 782, 743	95.00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0			o  l		100.00
	10100 HOME HEALTH AGENCY	0		1	o		101.00
	SPECIAL PURPOSE COST CENTERS				<u> </u>		1
113.00	11300 I NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF			1			114. 00
	11500 AMBULATORY SURGICAL CENTER (D.P.)			1		0	115 00

311, 852, 565

306, 820, 041

5, 032, 524

311, 852, 565

306, 820, 041

5, 032, 524

0 115.00 0 116.00

311, 908, 181 200. 00 5, 032, 524 201. 00 306, 875, 657 202. 00

55, 616

55, 616

200.00

201.00

202.00

115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPI CE

Subtotal (see instructions)

Less Observation Beds Total (see instructions)

Health Financial Systems

IU HEALTH BLOOMINGTON HOSPITAL

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0051
Period:
From 01/01/2019
To 12/31/2019
Period:
Prow 01/01/2019
To 12/31/2019
Period:
Part I
Date/Time Prepared:
6/29/2020 8:56 am
PPS

Cost Center Description
Inpatient Outpatient Total (col. 6 Cost or Other TEFRA

			Title	XVIII	Hospi tal	PPS	<u> </u>
			Charges		·		
	Cost Center Description	I npati ent	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	
	IENT ROUTINE SERVICE COST CENTERS						
	ADULTS & PEDI ATRI CS	137, 501, 476		137, 501, 476			30. 00
4	INTENSIVE CARE UNIT	21, 143, 724		21, 143, 724			31. 00
	CORONARY CARE UNIT	19, 463, 811		19, 463, 811			32.00
	NEONATAL INTENSIVE CARE UNIT	14, 343, 759		14, 343, 759			35. 00
4	SUBPROVI DER - I RF	6, 666, 705		6, 666, 705	1		41.00
4	SUBPROVI DER NURSERY	4 255 000		4 255 200			42.00
	LARY SERVICE COST CENTERS	4, 255, 008		4, 255, 008			43. 00
50. 00 05000	OPERATING ROOM	89, 470, 162	129, 317, 223	218, 787, 385	0. 090303	0. 000000	50. 00
	CV SURGERY	07, 470, 102	127, 317, 223	210, 707, 303		0. 000000	
	RECOVERY ROOM	7, 312, 308	25, 970, 682			0. 000000	
	DELIVERY ROOM & LABOR ROOM	33, 403, 978	3, 045, 758			0. 000000	
1	ANESTHESI OLOGY	0	0,010,700			0. 000000	
	RADI OLOGY-DI AGNOSTI C	18, 788, 958	29, 696, 389			0. 000000	
1	RADI OLOGY-THERAPEUTI C	4, 898, 897	97, 561, 497			0. 000000	
	RADI OI SOTOPE	0	0		1	0. 000000	
	CT SCAN	9, 725, 284	17, 399, 388	27, 124, 672		0.000000	
	MAGNETIC RESONANCE IMAGING (MRI)	2, 809, 825	7, 428, 206			0.000000	
	CARDI AC CATHETERI ZATI ON	27, 214, 940	44, 056, 564			0. 000000	
60.00 06000	LABORATORY	44, 003, 024	72, 819, 778		0. 174129	0.000000	60.00
	I NTRAVENOUS THERAPY	O	0			0.000000	64. 00
65. 00 06500	RESPI RATORY THERAPY	11, 138, 124	2, 348, 533	13, 486, 657	0. 308499	0. 000000	65.00
66.00 06600	PHYSI CAL THERAPY	14, 037, 984	16, 230, 185	30, 268, 169	0. 374814	0. 000000	66. 00
67. 00 06700	OCCUPATI ONAL THERAPY	0	0	0	0. 000000	0. 000000	67. 00
	SPEECH PATHOLOGY	0	0	0		0. 000000	
	ELECTROCARDI OLOGY	12, 706, 520	11, 496, 868	24, 203, 388	0. 069444	0. 000000	
	ELECTROENCEPHALOGRAPHY	2, 430, 920	9, 853, 217			0. 000000	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	30, 804, 839	57, 471, 078			0. 000000	
	IMPL. DEV. CHARGED TO PATIENTS	87, 835, 032	44, 311, 131			0. 000000	
	DRUGS CHARGED TO PATIENTS	68, 055, 170	177, 135, 479			0. 000000	1
	OP PHARMACY	0	0			0. 000000	
	RENAL DIALYSIS	3, 859, 453	791, 994			0.000000	
	ASC (NON-DISTINCT PART)	0	0	0		0.000000	
	PSYCHIATRIC/PSYCHOLOGICAL SERVICES	204 040	0 2 440 0EE	0 042 015		0.000000	
	CARDIAC REHABILITATION TIENT SERVICE COST CENTERS	394, 960	3, 448, 855	3, 843, 815	0. 340050	0. 000000	76. 97
	CLINIC	35, 644	2, 788, 187	2, 823, 831	1. 304789	0. 000000	90.00
1	OP ONCOLOGY INFUSION CENTER	2, 172, 235	31, 178, 874			0. 000000	
1	WOUND CARE CENTER	39, 286	7, 679, 689			0. 000000	1
	PAIN CLINIC	6, 311	2, 997, 111			0. 000000	
	OP PSYCH CLINIC	8, 702	4, 389, 791			0. 000000	
	EMERGENCY	44, 345, 598	156, 316, 124			0. 000000	
	OBSERVATION BEDS (NON-DISTINCT PART)	897, 946	35, 746, 985			0. 000000	
	REIMBURSABLE COST CENTERS	2117112	20,110,100				1
	HOME PROGRAM DI ALYSI S	O	0	0	0.000000	0.000000	94. 00
	AMBULANCE SERVICES	157, 303	52, 052, 370				
100.00 10000	I&R SERVICES-NOT APPRVD PRGM	o	0	0			100.00
101.00 10100	HOME HEALTH AGENCY	o	0	0			101.00
SPECI	AL PURPOSE COST CENTERS						]
113. 00 11300	INTEREST EXPENSE						113. 00
	UTILIZATION REVIEW-SNF						114. 00
115.00 11500	AMBULATORY SURGICAL CENTER (D. P.)	0	0	0			115. 00
116. 00 11600		0	0	0			116. 00
200. 00	Subtotal (see instructions)	719, 927, 886	1, 043, 531, 956	1, 763, 459, 842			200. 00
201.00	Less Observation Beds						201. 00
202. 00	Total (see instructions)	719, 927, 886	1, 043, 531, 956	1, 763, 459, 842			202. 00

6/29/2020 8:56 am Title XVIII Hospi tal PPS PPS Inpatient Cost Center Description Ratio 11 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 30.00 31.00 03100 INTENSIVE CARE UNIT 31.00 32.00 03200 CORONARY CARE UNIT 32.00 35.00 02060 NEONATAL INTENSIVE CARE UNIT 35.00 41. 00 | 04100 | SUBPROVI DER - I RF 41.00 42.00 04200 SUBPROVI DER 42.00 04300 NURSERY 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0. 090303 50.00 05001 CV SURGERY 50.01 0.000000 50.01 05100 RECOVERY ROOM 51.00 0. 196079 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0. 223851 52.00 05300 ANESTHESI OLOGY 0.000000 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 54.00 0. 146829 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.060247 55.00 05600 RADI OI SOTOPE 0.000000 56.00 56.00 57.00 05700 CT SCAN 0.051308 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58 00 0.083195 58 00 59.00 05900 CARDIAC CATHETERIZATION 0.045971 59.00 06000 LABORATORY 60.00 0. 174129 60.00 06400 I NTRAVENOUS THERAPY 0.000000 64.00 64.00 65.00 06500 RESPIRATORY THERAPY 0. 308499 65.00 66.00 06600 PHYSI CAL THERAPY 0. 376652 66.00 06700 OCCUPATIONAL THERAPY 67.00 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0.069444 69.00 07000 ELECTROENCEPHALOGRAPHY 0. 124585 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0. 181456 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0. 210932 72.00 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0.194570 73.00 07302 OP PHARMACY 0.000000 73. 01 73.01 74.00 07400 RENAL DIALYSIS 0.363464 74 00 07500 ASC (NON-DISTINCT PART) 75.00 0.000000 75.00 75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0.000000 75.01 07697 CARDIAC REHABILITATION 76. 97 0.340050 76. 97 OUTPATIENT SERVICE COST CENTERS 1. 304789 90.00 09000 CLI NI C 90.00 09001 OP ONCOLOGY INFUSION CENTER 90. 01 0. 239206 90.01 90 02 09002 WOUND CARE CENTER 0.178228 90.02 09003 PAIN CLINIC 90.03 0.207983 90.03 90.05 09005 OP PSYCH CLINIC 1. 058571 90.05 91.00 09100 EMERGENCY 0.069831 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 0. 137332 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 94.00 95. 00 09500 AMBULANCE SERVICES 0. 206528 95.00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 SPECIAL PURPOSE COST CENTERS 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.) 115.00 116. 00 11600 HOSPI CE 116.00 200.00 Subtotal (see instructions) 200. 00

201. 00

202.00

201.00

202.00

Less Observation Beds

Total (see instructions)

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0051 Peri od: Worksheet C From 01/01/2019 Part I Date/Time Prepared: 12/31/2019 6/29/2020 8:56 am Title XIX Hospi tal PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 4. 00 1.00 2.00 3.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 30 00 03000 ADULTS & PEDIATRICS 54, 676, 888 54, 676, 888 54, 676, 888 03100 INTENSIVE CARE UNIT 7, 254, 215 7, 254, 215 0 7, 254, 215 31.00 31.00 03200 CORONARY CARE UNIT 5, 742, 690 0 32.00 5, 742, 690 5, 742, 690 32.00 02060 NEONATAL INTENSIVE CARE UNIT 0 4, 122, 013 35.00 4, 122, 013 4, 122, 013 35, 00 04100 SUBPROVI DER - I RF 0 41.00 3, 171, 582 3, 171, 582 3, 171, 582 41.00 42.00 04200 SUBPROVI DER 0 0 42.00 04300 NURSERY 1, 713, 960 1, 713, 960 1, 713, 960 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 19, 757, 089 19, 757, 089 0 19, 757, 089 50.00 50.01 05001 CV SURGERY 0 50.01 0 51.00 05100 RECOVERY ROOM 6, 526, 087 6, 526, 087 6, 526, 087 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 8, 159, 314 8, 159, 314 8, 159, 314 52.00 53.00 05300 ANESTHESI OLOGY 0 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 7, 119, 052 7, 119, 052 54.00 7, 119, 052 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55 00 6, 172, 909 6, 172, 909 6, 172, 909 55 00 56.00 05600 RADI OI SOTOPE Λ 56.00 57.00 05700 CT SCAN 1, 391, 723 1, 391, 723 0 1, 391, 723 57.00 0 05800 MAGNETIC RESONANCE IMAGING (MRI) 58.00 851, 755 851, 755 851, 755 58.00 05900 CARDIAC CATHETERIZATION 3, 276, 410 3, 276, 410 3, 276, 410 59 00 59 00 60.00 06000 LABORATORY 20, 342, 188 20, 342, 188 0 20, 342, 188 60.00 06400 INTRAVENOUS THERAPY 64.00 64.00 0 65 00 06500 RESPIRATORY THERAPY 4, 160, 624 4. 160. 624 0 4. 160. 624 65 00 06600 PHYSI CAL THERAPY 66.00 11, 344, 944 11, 344, 944 55, 616 11, 400, 560 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 06800 SPEECH PATHOLOGY 68.00 0 68.00 0 0 1, 680, 787 06900 ELECTROCARDI OLOGY 0 69 00 1, 680, 787 1, 680, 787 69 00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 1,530,418 1, 530, 418 1, 530, 418 70.00 16, 018, 169 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 16, 018, 169 16, 018, 169 71.00 71.00 0 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 27, 873, 917 27, 873, 917 27, 873, 917 72.00 47, 706, 793 73.00 07300 DRUGS CHARGED TO PATIENTS 47, 706, 793 47, 706, 793 73 00 73.01 07302 OP PHARMACY 114,834 114, 834 0 114, 834 73.01 07400 RENAL DIALYSIS 0 74.00 1, 690, 632 1, 690, 632 1, 690, 632 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 75.01 0 0 0 75 01 1, 307, 088 07697 CARDIAC REHABILITATION 1, 307, 088 1, 307, 088 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 3, 684, 504 90.00 09000 CLINIC 90.00 3, 684, 504 3, 684, 504 09001 OP ONCOLOGY INFUSION CENTER 7, 977, 791 0 90.01 7, 977, 791 7, 977, 791 90 01 90.02 09002 WOUND CARE CENTER 1, 375, 740 1, 375, 740 0 1, 375, 740 90.02 90. 03 09003 PAIN CLINIC 624, 661 624, 661 0 624, 661 90.03 09005 OP PSYCH CLINIC 0 90.05 4, 656, 115 4, 656, 115 4, 656, 115 90.05 09100 EMERGENCY 91.00 14, 012, 406 14, 012, 406 14, 012, 406 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 5, 032, 524 5, 032, 524 5, 032, 524 92.00 OTHER REIMBURSABLE COST CENTERS 94 00 09400 HOME PROGRAM DIALYSIS Λ 94 00 95. 00 09500 AMBULANCE SERVICES 10, 782, 743 10, 782, 743 10, 782, 743 95.00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 C 101.00 10100 HOME HEALTH AGENCY 0 0 101.00 SPECIAL PURPOSE COST CENTERS

0

311, 852, 565

306, 820, 041

5, 032, 524

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55, 616

55, 616

311, 852, 565

306, 820, 041

5.032.524

113.00

114. 00

0 115, 00

0 116.00

311, 908, 181 200. 00

306, 875, 657 202. 00

5, 032, 524 201. 00

113. 00 11300 | INTEREST EXPENSE

116. 00 11600 HOSPI CE

200.00

201.00

202.00

114.00 11400 UTILIZATION REVIEW-SNF

115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)

Less Observation Beds

Total (see instructions)

Subtotal (see instructions)

COMPUT	TATION OF RATIO OF COSTS TO CHARGES		Provi der C	CN: 15-0051	Peri od:	Worksheet C	
					From 01/01/2019 To 12/31/2019	Part I Date/Time Pre 6/29/2020 8:5	pared:
			Ti tl	e XIX	Hospi tal	PPS	o alli
			Charges				
	Cost Center Description	I npati ent	Outpati ent		Cost or Other	TEFRA	
				+ col. 7)	Ratio	Inpati ent	
						Ratio	
		6. 00	7. 00	8. 00	9. 00	10. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00		137, 501, 476		137, 501, 47			30. 00
31. 00	1	21, 143, 724		21, 143, 72			31. 00
32. 00		19, 463, 811		19, 463, 81			32. 00
35. 00	1	14, 343, 759		14, 343, 75			35. 00
41. 00		6, 666, 705		6, 666, 70	5		41. 00
42.00	1	0			0		42. 00
43.00		4, 255, 008		4, 255, 00	8		43. 00
	ANCILLARY SERVICE COST CENTERS						
50. 00		89, 470, 162	129, 317, 223	218, 787, 38		0. 000000	
50. 01	05001 CV SURGERY	0	0		0. 000000	0. 000000	
51. 00	1	7, 312, 308	25, 970, 682			0. 000000	
52.00		33, 403, 978	3, 045, 758	36, 449, 73	6 0. 223851	0. 000000	52. 00
53.00		0	0	l .	0. 000000	0. 000000	
54.00		18, 788, 958	29, 696, 389			0. 000000	
55.00		4, 898, 897	97, 561, 497	102, 460, 39		0. 000000	
56.00		0	0		0. 000000	0. 000000	
57.00		9, 725, 284	17, 399, 388	27, 124, 67	0. 051308	0. 000000	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 809, 825	7, 428, 206	10, 238, 03	0. 083195	0.000000	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	27, 214, 940	44, 056, 564	71, 271, 50	0. 045971	0.000000	59. 00
60.00	06000 LABORATORY	44, 003, 024	72, 819, 778	116, 822, 80	0. 174129	0.000000	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0. 000000	0.000000	64. 00
65.00	06500 RESPI RATORY THERAPY	11, 138, 124	2, 348, 533	13, 486, 65	7 0. 308499	0. 000000	65. 00
66. 00		14, 037, 984	16, 230, 185	30, 268, 16		0. 000000	
67. 00		0	0		0. 000000	0. 000000	
68. 00		0	0	l .	0. 000000	0. 000000	
69. 00	l l	12, 706, 520	11, 496, 868			0. 000000	
70.00	1	2, 430, 920	9, 853, 217			0. 000000	
71. 00		30, 804, 839	57, 471, 078			0. 000000	
72.00		87, 835, 032	44, 311, 131			0. 000000	
73. 00		68, 055, 170	177, 135, 479	245, 190, 64		0. 000000	
73. 01	07302 OP PHARMACY	0	0		0. 000000	0. 000000	
74.00	1	3, 859, 453	791, 994	4, 651, 44		0. 000000	
75. 00		0	0		0. 000000	0. 000000	
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0. 000000	0. 000000	
76. 97		394, 960	3, 448, 855	3, 843, 81	5 0. 340050	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS	T		T			
90.00		35, 644					
90. 01	09001 OP ONCOLOGY INFUSION CENTER	2, 172, 235	31, 178, 874				
90. 02	1	39, 286	7, 679, 689				
90. 03		6, 311	2, 997, 111			0. 000000	
90. 05		8, 702	4, 389, 791			0. 000000	
	09100 EMERGENCY	44, 345, 598				0. 000000	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	897, 946	35, 746, 985	36, 644, 93	1 0. 137332	0. 000000	92.00
	OTHER REIMBURSABLE COST CENTERS			T			
	09400 HOME PROGRAM DIALYSIS	0	0		0.000000	0.000000	
95.00	09500 AMBULANCE SERVICES	157, 303	52, 052, 370	52, 209, 67	0. 206528	0. 000000	1
	D 10000 I &R SERVICES-NOT APPRVD PRGM	0	0		0		100.00
101.00	0 10100 HOME HEALTH AGENCY	0	0		0		101. 00
112 00	SPECIAL PURPOSE COST CENTERS			1			112 00
	0 11300   NTEREST EXPENSE						113.00
	0 11400 UTILIZATION REVIEW-SNF		^				114.00
	0 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0				115.00
200.00	0 11600 HOSPICE 	710 027 004	1, 043, 531, 956	1 762 450 04			116. 00 200. 00
200.00		117,721,000	1, 043, 331, 930	1, 703, 439, 84	-		200.00
201.00	1 1	719 927 886	1, 043, 531, 956	1 763 459 94	2		201.00
202.00	1.513. (55551. 451. 615)	, , , , , , , , , , , , , , , , ,	., 5.5, 551, 750	1 .,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		ı	1-02.00

				10 12/31/2019	6/29/2020 8: 56	
			Title XIX	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
	03100 INTENSIVE CARE UNIT				l l	31. 00
32. 00	03200 CORONARY CARE UNIT					32. 00
	02060 NEONATAL INTENSIVE CARE UNIT				1	35. 00
41. 00	04100 SUBPROVI DER - I RF					41. 00
42.00	04200 SUBPROVI DER					42. 00
43. 00	04300 NURSERY					43. 00
F0 00	ANCILLARY SERVICE COST CENTERS	0.000000				F0 00
50.00	05000 OPERATING ROOM	0. 090303				50.00
50. 01	05001 CV SURGERY	0.000000				50. 01
	05100 RECOVERY ROOM	0. 196079				51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 223851				52.00
53.00	05300 ANESTHESI OLOGY	0.000000				53.00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0. 146829			•	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 060247			•	55. 00
56.00	05600 RADI OI SOTOPE	0.000000			•	56.00
57. 00	05700 CT SCAN	0. 051308				57. 00
58. 00 59. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 083195			•	58. 00 59. 00
60.00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	0. 045971 0. 174129				
64. 00	06400 I NTRAVENOUS THERAPY	0. 174129				60. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0. 308499			•	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 376652				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. 069444				69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 124585				70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 124305			l l	71. 00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 210932				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 194570			1	73. 00
	07302 OP PHARMACY	0. 000000				73. 01
	07400 RENAL DI ALYSI S	0. 363464				74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000				75. 01
	07697 CARDI AC REHABI LI TATI ON	0. 340050				76. 97
	OUTPATIENT SERVICE COST CENTERS	2.2.2222				
90.00	09000 CLI NI C	1. 304789			9	90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0. 239206			· ·	90. 01
90. 02	09002 WOUND CARE CENTER	0. 178228			,	90. 02
90. 03	09003 PAIN CLINIC	0. 207983			,	90. 03
90. 05	09005 OP PSYCH CLINIC	1. 058571			Ç	90. 05
91.00	09100 EMERGENCY	0. 069831			Ç	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 137332			Ç	92. 00
	OTHER REIMBURSABLE COST CENTERS					
	09400 HOME PROGRAM DIALYSIS	0. 000000			Ç	94. 00
95.00	09500 AMBULANCE SERVICES	0. 206528			Ç	95. 00
	10000 I&R SERVICES-NOT APPRVD PRGM					00.00
101.00	10100 HOME HEALTH AGENCY				10	01. 00
	SPECIAL PURPOSE COST CENTERS					
	11300   NTEREST EXPENSE					13. 00
	11400 UTILIZATION REVIEW-SNF				•	14. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)					15. 00
	11600 H0SPI CE					16. 00
200.00	,					00.00
201.00						01. 00
202.00	Total (see instructions)				20	02. 00

Health Financial Systems

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

I U HEALTH BLOOMINGTON HOSPITAL RATIOS NET OF Provider CO In Lieu of Form CMS-2552-10

Period: Worksheet C
From 01/01/2019 Part II
To 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am Provider CCN: 15-0051

				'	0 12/01/201/	6/29/2020 8:5	6 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	, , , , , , , , , , , , , , , , , , ,	(Wkst. B, Part				Reduction	
		I, col. 26)		Cost (col. 1 -		Amount	
		1, 0011 20)	11 0011 20)	col . 2)		7 0	
		1.00	2.00	3.00	4. 00	5. 00	
ΔΝ	NCILLARY SERVICE COST CENTERS	1.00	2.00	0.00	1.00	0.00	
	5000 OPERATING ROOM	19, 757, 089	1, 631, 269	18, 125, 820	0	0	50. 00
	5000 OF ERATTING ROOM 5001 CV SURGERY	17, 737, 007	1,031,207	1			50.00
	5100 RECOVERY ROOM	4 524 007	1				51.00
		6, 526, 087	200, 354			-	
	5200 DELIVERY ROOM & LABOR ROOM	8, 159, 314	l				52. 00
	5300 ANESTHESI OLOGY	0	C	_	_	1	53. 00
	5400 RADI OLOGY-DI AGNOSTI C	7, 119, 052				-	54. 00
	5500 RADI OLOGY-THERAPEUTI C	6, 172, 909	666, 812	5, 506, 097		-	55. 00
	5600 RADI OI SOTOPE	0	[ C	C	0	0	56. 00
57. 00 05	5700 CT SCAN	1, 391, 723	53, 207	1, 338, 516	0	0	57.00
58. 00 05	5800 MAGNETIC RESONANCE IMAGING (MRI)	851, 755	60, 489	791, 266	0	0	58. 00
59. 00 05	5900 CARDI AC CATHETERI ZATI ON	3, 276, 410	217, 770	3, 058, 640	0	0	59. 00
60.00 06	6000 LABORATORY	20, 342, 188	680, 144	19, 662, 044	0	0	60.00
	5400 INTRAVENOUS THERAPY	0	C	1		0	64.00
	5500 RESPI RATORY THERAPY	4, 160, 624	87, 291	4, 073, 333	0		65. 00
	6600 PHYSI CAL THERAPY	11, 344, 944	387, 274				66. 00
	5700 OCCUPATI ONAL THERAPY	11,011,711	007,27	1		-	67. 00
	5800 SPEECH PATHOLOGY	0	ĺ	1	_	1	68. 00
	5900 ELECTROCARDI OLOGY	1, 680, 787	· -	· ·	_	-	69.00
						-	1
	7000 ELECTROENCEPHALOGRAPHY	1, 530, 418			_	-	70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 018, 169	l			1	71. 00
	7200 IMPL. DEV. CHARGED TO PATIENTS	27, 873, 917	366, 679				72. 00
	7300 DRUGS CHARGED TO PATIENTS	47, 706, 793				1	73. 00
	7302 OP PHARMACY	114, 834		1		1	73. 01
	7400 RENAL DIALYSIS	1, 690, 632	38, 718				74. 00
	7500 ASC (NON-DISTINCT PART)	0	[ C	C	_	_	75. 00
75. 01   03	3550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C	C	0	0	75. 01
76. 97 07	7697 CARDIAC REHABILITATION	1, 307, 088	114, 294	1, 192, 794	0	0	76. 97
OU	JTPATIENT SERVICE COST CENTERS						
90.00 09	9000 CLI NI C	3, 684, 504	585, 335	3, 099, 169	0	0	90.00
90. 01 09	9001 OP ONCOLOGY INFUSION CENTER	7, 977, 791	609, 964	7, 367, 827	0	0	90. 01
90. 02 09	9002 WOUND CARE CENTER	1, 375, 740	141, 337	1, 234, 403	0	0	90. 02
90. 03 09	9003 PAIN CLINIC	624, 661	85, 511	539, 150	0	0	90. 03
	9005 OP PSYCH CLINIC	4, 656, 115				0	90. 05
	9100 EMERGENCY	14, 012, 406					91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 032, 524					92.00
	THER REIMBURSABLE COST CENTERS	0,002,021	071,707	1, 000, 000	,		72.00
	9400 HOME PROGRAM DIALYSIS	0		C	0	0	94. 00
	9500 AMBULANCE SERVICES	10, 782, 743	۱ -	-			
	0000 I&R SERVICES-NOT APPRVD PRGM	10, 762, 743	1	1			100.00
	l e e e e e e e e e e e e e e e e e e e	0					
	0100 HOME HEALTH AGENCY	0		<u> </u>	0	0	101. 00
	PECIAL PURPOSE COST CENTERS						111 00
	1300 I NTEREST EXPENSE						113.00
	1400 UTI LI ZATI ON REVI EW-SNF						114. 00
	1500 AMBULATORY SURGICAL CENTER (D. P.)	0	C		0		115. 00
	1600 HOSPI CE	0	C	l c	0		116. 00
200. 00	Subtotal (sum of lines 50 thru 199)	235, 171, 217					200. 00
201. 00	Less Observation Beds	5, 032, 524					201. 00
202.00	Total (line 200 minus line 201)	230, 138, 693	10, 384, 563	219, 754, 130	0	0	202. 00

Peri od: Worksheet C From 01/01/2019 Part II To 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am Provi der CCN: 15-0051 Peri od: REDUCTIONS FOR MEDICALD ONLY

						6/29/2020 8: 5	6 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	<b>'</b>	Capital and	(Worksheet C.	Cost to Charge			
				Ratio (col. 6			
		Reduction	8)	/ col . 7)			
		6. 00	7.00	8.00			
	ANCILLARY SERVICE COST CENTERS	0.00	7.00	0.00			
50. 00	05000 OPERATING ROOM	19, 757, 089	218, 787, 385	0. 090303			50.00
		1					
50. 01	05001 CV SURGERY	0	_	0.000000			50. 01
51.00	05100 RECOVERY ROOM	6, 526, 087					51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 159, 314					52. 00
53.00	05300 ANESTHESI OLOGY	0		0.000000			53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	7, 119, 052	48, 485, 347				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	6, 172, 909	102, 460, 394				55. 00
56.00	05600  RADI 0I SOTOPE	0	0	0.000000			56. 00
57.00	05700 CT SCAN	1, 391, 723	27, 124, 672	0. 051308			57. 00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	851, 755	10, 238, 031	0. 083195			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	3, 276, 410					59. 00
60.00	06000 LABORATORY	20, 342, 188					60.00
64. 00	06400 I NTRAVENOUS THERAPY	20,012,100		l			64. 00
65. 00	06500 RESPI RATORY THERAPY	4, 160, 624	_				65. 00
66. 00	06600 PHYSI CAL THERAPY	11, 344, 944					66.00
67. 00	06700 OCCUPATI ONAL THERAPY	11, 344, 744					67. 00
		_	_				
68. 00	06800 SPEECH PATHOLOGY	1 (00 707	_	0.000000			68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 680, 787					69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 530, 418					70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 018, 169					71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	27, 873, 917					72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	47, 706, 793					73. 00
73. 01	07302 OP PHARMACY	114, 834		0.000000			73. 01
74.00	07400 RENAL DIALYSIS	1, 690, 632	4, 651, 447				74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000			75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.000000			75. 01
76. 97	07697 CARDIAC REHABILITATION	1, 307, 088	3, 843, 815	0.340050			76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	3, 684, 504	2, 823, 831	1. 304789			90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	7, 977, 791	33, 351, 109	0. 239206			90. 01
90. 02	09002 WOUND CARE CENTER	1, 375, 740	7, 718, 975	0. 178228			90. 02
90. 03	09003 PAIN CLINIC	624, 661					90. 03
90. 05	09005 OP PSYCH CLINIC	4, 656, 115					90. 05
91. 00	09100 EMERGENCY	14, 012, 406					91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 032, 524					92.00
72.00	OTHER REIMBURSABLE COST CENTERS	3,032,324	30, 044, 731	0.137332			72.00
94. 00	09400 HOME PROGRAM DIALYSIS	T 0	0	0.000000			94. 00
	09500 AMBULANCE SERVICES	10, 782, 743					95.00
	10000 I &R SERVICES-NOT APPRVD PRGM	0		0.000000			100.00
101.00	10100 HOME HEALTH AGENCY	0	0	0.000000			101. 00
	SPECIAL PURPOSE COST CENTERS		1	1			
	11300   I NTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11500   AMBULATORY SURGICAL CENTER (D. P. )	0	0				115. 00
	11600 H0SPI CE	0	0	0. 000000			116. 00
200.00	Subtotal (sum of lines 50 thru 199)	235, 171, 217	1, 560, 085, 359				200. 00
201.00	Less Observation Beds	5, 032, 524	0				201. 00
202.00	Total (line 200 minus line 201)	230, 138, 693	1, 560, 085, 359				202. 00
		•	•	•	•		•

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	Provi der C		Period: Worksheet D			
				rom 01/01/2019		
			'	o 12/31/2019	Date/Time Pre 6/29/2020 8:5	
		Ti tl e	e XVIII	Hospi tal	PPS	O dili
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost		,	
	Part II, col.		(col. 1 - col.			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	·					
30.00 ADULTS & PEDIATRICS	4, 041, 243	C	4, 041, 243	48, 022	84. 15	30.00
31.00 INTENSIVE CARE UNIT	396, 847	'	396, 847	3, 798	104. 49	31. 00
32.00 CORONARY CARE UNIT	451, 038	3	451, 038	3, 605	125. 11	32.00
35.00 NEONATAL INTENSIVE CARE UNIT	239, 122		239, 122	3, 139	76. 18	35. 00
41. 00 SUBPROVI DER - I RF	374, 218	c c	374, 218	3, 083	121. 38	41.00
42. 00 SUBPROVI DER	0	ol c		0	0.00	42.00
43. 00 NURSERY	150, 130		150, 130	3, 025	49. 63	43.00
200.00 Total (lines 30 through 199)	5, 652, 598		5, 652, 598	64, 672		200.00
Cost Center Description	I npati ent	Inpati ent				
·	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	16, 995	1, 430, 129				30. 00
31.00 INTENSIVE CARE UNIT	1, 431	149, 525	5			31.00
22 OO CODONADY CARE UNIT	2 520	21/ 270	N.			22 00

2, 528

1, 789

22, 743

316, 278

2, 113, 081

32. 00

35.00

41. 00 42. 00

43. 00 200. 00

32. 00 CORONARY CARE UNIT
35. 00 NEONATAL INTENSIVE CARE UNIT

42.00 SUBPROVI DER 43.00 NURSERY 200.00 Total (lines 30 through 199)

41. 00 | SUBPROVI DER - I RF

lealth Financial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL	In Lie	u of Form CMS-2552-10

	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Pre 6/29/2020 8:5	pared: 6 am
		Ti tl e	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cost	I Inpati ent	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1. 00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS		T	T	T		
50. 00   05000   OPERATI NG ROOM	1, 631, 269				282, 745	
50. 01   05001   CV   SURGERY	0		0.00000		0	50. 01
51. 00   05100   RECOVERY ROOM	200, 354				18, 449	
52.00 05200 DELIVERY ROOM & LABOR ROOM	985, 121	36, 449, 736			3, 989	
53. 00   05300   ANESTHESI OLOGY	0		0.00000		0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	597, 486		1		106, 128	
55. 00 05500 RADI OLOGY-THERAPEUTI C	666, 812				15, 063	
56. 00   05600   RADI 0I SOTOPE	0		0. 00000		0	56. 00
57. 00   05700   CT   SCAN	53, 207				8, 688	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	60, 489				6, 319	
59. 00 05900 CARDI AC CATHETERI ZATI ON	217, 770		1		30, 715	
60. 00   06000   LABORATORY	680, 144	116, 822, 802			101, 968	
64. 00 06400 I NTRAVENOUS THERAPY	0	0	0. 00000		0	64. 00
65. 00 06500 RESPI RATORY THERAPY	87, 291	13, 486, 657	1		30, 850	
66. 00 06600 PHYSI CAL THERAPY	387, 274				49, 180	
67. 00 06700 OCCUPATI ONAL THERAPY	0	1	0.0000		0	
68.00 06800 SPEECH PATHOLOGY	0		0. 00000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	88, 723				22, 779	
70. 00 07000 ELECTROENCEPHALOGRAPHY	128, 734				10, 753	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	213, 106				31, 193	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	366, 679		1		109, 226	
73.00 07300 DRUGS CHARGED TO PATIENTS	647, 762		1		72, 889	
73. 01 07302 OP PHARMACY	1, 304		0.00000		0	73. 01
74. 00   07400   RENAL DI ALYSI S	38, 718				18, 038	
75. 00   07500   ASC (NON-DISTINCT PART)	0	-	1 0.0000		0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0.00000		0	75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON	114, 294	3, 843, 815	0. 02973	5 173, 579	5, 161	76. 97
OUTPATIENT SERVICE COST CENTERS	T 505 005					
90. 00   09000   CLI NI C	585, 335				5, 523	
90. 01 09001 OP ONCOLOGY INFUSION CENTER	609, 964				17, 263	
90. 02   09002   WOUND CARE CENTER	141, 337				369	
90. 03   09003   PALN CLINIC	85, 511	3, 003, 422	1		2	90. 03
90. 05   09005   OP PSYCH CLINIC	372, 559				417	90.05
91. 00 09100 EMERGENCY	922, 029				89, 545	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	371, 959	36, 644, 931	0. 01015	0 383, 105	3, 889	92.00
OTHER REIMBURSABLE COST CENTERS			0.00000			04.00
94. 00   09400   HOME   PROGRAM DI ALYSI S	0		0. 00000	이 이	0	
95. 00   09500   AMBULANCE SERVICES	10 055 004	1 507 075 (0)		204 055 242	1 041 444	95. 00
200.00   Total (lines 50 through 199)	10, 255, 231	1, 507, 875, 686	1	204, 055, 242	1, 041, 141	1200. UU

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

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS						
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS		F	eriod: rom 01/01/2019 o 12/31/2019	6/29/2020 8:5	pared: 6 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Post-Stepdown Adjustments		Post-Stepdown Adjustments	Cost	All Other Medical Education Cost	
INPATIENT ROUTINE SERVICE COST CENTERS	1A	1.00	2A	2. 00	3. 00	
30. 00   03000   ADULTS & PEDIATRICS   31. 00   03100   INTENSIVE CARE UNIT   32. 00   03200   CORONARY CARE UNIT   35. 00   02060   NEONATAL INTENSIVE CARE UNIT   41. 00   04100   SUBPROVIDER   - IRF   42. 00   04200   SUBPROVIDER   43. 00   04300   NURSERY   200. 00   Total (lines 30 through 199)   Cost Center Description	Swing-Bed Adjustment Amount (see	Total Costs (sum of cols.  1 through 3,	0 0 0 0 0 0		0 0 0 0 0 0 0 Inpatient Program Days	31. 00 32. 00 35. 00 41. 00
	instructions)	minus col. 4)	6.00	7. 00	8. 00	
INPATIENT ROUTINE SERVICE COST CENTERS     30. 00	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00	000000000000000000000000000000000000000	48, 022 3, 798 3, 605 3, 139 3, 083 0	0. 00 0. 00 0. 00 0. 00 0. 00 0. 00 0. 00	16, 995 1, 431 2, 528 0 1, 789 0	31. 00 32. 00 35. 00 41. 00 42. 00
30. 00   03000   ADULTS & PEDIATRICS   31. 00   03100   INTENSIVE CARE UNIT   32. 00   03200   CORONARY CARE UNIT   35. 00   02060   NEONATAL INTENSIVE CARE UNIT   41. 00   04100   SUBPROVIDER - IRF   42. 00   04200   SUBPROVIDER   43. 00   04300   NURSERY   Total (lines 30 through 199)	000000000000000000000000000000000000000					30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00 200. 00

| Peri od: | Worksheet D | Part IV | To | 12/31/2019 | Date/Time Prepared: | Control of the prepared: | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Pa Provider CCN: 15-0051 THROUGH COSTS

				0 12/31/2019	6/29/2020 8: 5	
		Ti tl e	e XVIII	Hospi tal	PPS	o an
Cost Center Description	Non Physician			Allied Health		
'	Anesthetist	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3. 00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	(	C	) (	0	0	50. 00
50. 01  05001  CV SURGERY		) c	) (	0	0	50. 01
51.00   05100   RECOVERY ROOM		) c	) (	0	0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM		o c	) (	0	0	52.00
53. 00   05300   ANESTHESI OLOGY		o c	) (	0	0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		) c	) (	0	0	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C		) c	) (	0	0	55. 00
56. 00   05600   RADI 0I SOTOPE		) c	) (	0	0	56. 00
57.00  05700   CT SCAN		) c	) (	0	0	57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)		o  c	) (	0	0	58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON		o  c	) (	0	0	59. 00
60. 00   06000   LABORATORY		o  c	) (	0	0	60.00
64. 00   06400   I NTRAVENOUS THERAPY		o  c	) (	0	0	64. 00
65. 00   06500   RESPI RATORY THERAPY	(	o  c	) (	0	0	65. 00
66. 00  06600 PHYSI CAL THERAPY		) c	) (	0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY		) C	) (	0	0	67. 00
68. 00 06800 SPEECH PATHOLOGY		) C	) (	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		) C		0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY		) c		0	0	70. 00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0	0	71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	(			0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	(			0	658, 501	73. 00
73. 01 07302 OP PHARMACY				0	0	73. 01
74. 00   07400   RENAL DI ALYSI S				0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)				0	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES					0	75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON		) C	) (	) 0	0	76. 97
OUTPATIENT SERVICE COST CENTERS  90, 00 09000 CLINIC			) (	) 0	0	90.00
90. 00   09000   CLINIC 90. 01   09001   OP ONCOLOGY INFUSION CENTER					0	90.00
90. 02 09002 WOUND CARE CENTER					0	90.01
90. 03   09003   PAIN CLINIC					0	90.02
90. 05   09005   OP PSYCH CLINIC					0	90.05
91. 00   09100   EMERGENCY					0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			1		Ö	92.00
OTHER REIMBURSABLE COST CENTERS		21		7		72.00
94. 00 09400 HOME PROGRAM DI ALYSI S				0	0	94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50 through 199)		ol c		o	658, 501	
	•	•	•		•	

APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provider CCN: 15-0051 Peri od: Worksheet D From 01/01/2019 THROUGH COSTS Part IV 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am Title XVIII Hospi tal All Other Ratio of Cost Cost Center Description Total Cost Total Total Charges to Charges Medi cal (from Wkst. C, (sum of cols. Outpati ent Education Cost 1, 2, 3, and Cost (sum of Part I, col. (col. 5 ÷ col 8) 4) col s. 2. 3. 7) and 4) (see instructions) 4.00 5.00 6.00 7. 00 8.00 ANCILLARY SERVICE COST CENTERS 0 50.00 05000 OPERATING ROOM 218, 787, 385 0.000000 50.00 50.01 05001 CV SURGERY 0 0 0.000000 50.01 51.00 05100 RECOVERY ROOM 00000000000000000000000 0 0 33, 282, 990 0.000000 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 36, 449, 736 0.000000 52 00 52 00 53.00 05300 ANESTHESI OLOGY 0 0 0.000000 53.00 54. 00 | 05400 | RADI OLOGY-DI AGNOSTI C 48, 485, 347 0.000000 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 102, 460, 394 0.000000 55 00 0 56.00 05600 RADI OI SOTOPE 0 0.000000 56.00 57.00 05700 CT SCAN 27, 124, 672 0.000000 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 58.00 0 10, 238, 031 0.000000 58.00 05900 CARDI AC CATHETERI ZATI ON 0 71 271 504 0.000000 59 00 59 00 60.00 06000 LABORATORY 116, 822, 802 0.000000 60.00 06400 INTRAVENOUS THERAPY 0.000000 64.00 64.00 06500 RESPIRATORY THERAPY 13, 486, 657 0.000000 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 30, 268, 169 0.000000 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 0 0.000000 67.00 06800 SPEECH PATHOLOGY 0.000000 68.00 68.00 06900 ELECTROCARDI OLOGY 0 0 24, 203, 388 0.000000 69.00 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 Ω 12, 284, 137 0.000000 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 88, 275, 917 0.000000 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 132, 146, 163 0.000000 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 658, 501 658, 501 245, 190, 649 0.002686 73.00 07302 OP PHARMACY 0.000000 73.01 0 73 01 0 07400 RENAL DIALYSIS 0 4, 651, 447 0.000000 74.00 74.00 0 07500 ASC (NON-DISTINCT PART) 75.00 0 0 0.000000 75.00 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0.000000 75.01 0 75.01 07697 CARDIAC REHABILITATION 76. 97 0 0 3, 843, 815 0.000000 76.97 OUTPATIENT SERVICE COST CENTERS 0 90.00 09000 CLI NI C 0 0 2, 823, 831 0.000000 90.00 0 09001 OP ONCOLOGY INFUSION CENTER 0 0.000000 90 01 90 01 C 33, 351, 109 09002 WOUND CARE CENTER 90.02 C 0 7, 718, 975 0.000000 90.02 0 09003 PAIN CLINIC 90. 03 0 0 3, 003, 422 0.000000 90.03 09005 OP PSYCH CLINIC 90.05 0 4, 398, 493 0.000000 90.05 0 09100 EMERGENCY 0 0 91.00 C 200, 661, 722 0.000000 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 36, 644, 931 0.000000 92.00

0

658, 501

0

658, 501 1, 507, 875, 686

94.00

95.00

200.00

0.000000

OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

09400 HOME PROGRAM DIALYSIS

95. 00 09500 AMBULANCE SERVICES

94 00

Health Financial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL		In Lieu of Form CMS-2552-10
ADDODEL ONMENT OF LADATIENT (OUTDATIENT	MICH LARY CERVILOE OTHER DACC	D CON 15 0051	D!!	Wasaliala a a b

Peri od: From 01/01/2019 To 12/31/2019 Worksheet D Part IV APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS THROUGH COSTS Date/Time Prepared: 6/29/2020 8:56 am Title XVIII Hospi tal **PPS** Cost Center Description Outpati ent Inpatient Inpati ent Outpati ent Outpati ent Program Ratio of Cost Program Program Program to Charges Pass-Through Pass-Through Charges Charges  $(col. 6 \div col$ Costs (col. Costs (col. x col. 10) x col. 12) 7) 13. 00 9.00 10.00 11. 00 12.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0.000000 50.00 37, 921, 840 31, 448, 325 0 0 50.01 05001 CV SURGERY 0.000000 0 50.01 05100 RECOVERY ROOM 0.000000 0 51.00 51.00 3, 064, 685 6, 576, 661 0 05200 DELIVERY ROOM & LABOR ROOM 0.000000 0 52.00 52.00 147, 575 0 17.541 05300 ANESTHESI OLOGY 0.000000 0 53.00 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.000000 8, 612, 155 0 8, 421, 143 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 2, 314, 501 42, 757, 527 0 55.00 05600 RADI OI SOTOPE 0.000000 0 56 00 0 56 00 0 5, 177, 404 57.00 05700 CT SCAN 0.000000 4, 428, 388 0 57.00 58.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 0.000000 1,069,499 1, 739, 147 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0.000000 10, 054, 124 0 15, 953, 347 0 59.00 0 06000 LABORATORY 0.000000 60 00 17, 514, 304 8, 542, 594 60 00 0 64.00 06400 I NTRAVENOUS THERAPY 0.000000 0 0 64.00 06500 RESPIRATORY THERAPY 65.00 0.000000 4, 766, 612 674, 821 0 65.00 06600 PHYSI CAL THERAPY 3, 843, 675 109, 951 66 00 0.000000 0 66 00 67.00 06700 OCCUPATIONAL THERAPY 0.000000 0 67.00 06800 SPEECH PATHOLOGY 0.000000 0 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0.000000 6, 213, 531 3, 836, 265 69.00 0 07000 ELECTROENCEPHALOGRAPHY 1, 026, 092 0 70 00 0.000000 2, 820, 792 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0.000000 12, 921, 822 0 19, 219, 429 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0.000000 39, 360, 896 16, 776, 744 72.00 0 73.00 07300 DRUGS CHARGED TO PATIENTS 0.002686 27, 588, 541 74, 103 73, 414, 618 197, 192 73.00 07302 OP PHARMACY 0.000000 73.01 73 01 0 0 0 07400 RENAL DIALYSIS 74.00 0.000000 2, 167, 045 0 285, 004 0 74.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 75.00 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 75. 01 0.000000 0 75.01 07697 CARDIAC REHABILITATION 0 76.97 0.000000 173, 579 1, 334, 035 0 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 90 00 09000 CLI NI C 0.000000 26, 645 1, 142, 981 09001 OP ONCOLOGY INFUSION CENTER 0.000000 943, 923 0 12, 856, 323 90.01 90.01 0 09002 WOUND CARE CENTER 0 90 02 0.000000 20, 131 1, 634, 113 Λ 90 02 09003 PAIN CLINIC 0.000000 748, 797 90.03 90.03 09005 OP PSYCH CLINIC 0 90.05 0.000000 4, 925 501, 012 0 90.05 09100 EMERGENCY 19, 487, 574 0 91.00 0.000000 32, 497, 106 91.00 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0.000000 383, 105 14, 414, 509 0 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0.000000 0 0 94.00 95. 00 09500 AMBULANCE SERVICES 95 00

204, 055, 242

74, 103

302, 900, 189

197, 192 200. 00

200.00

Total (lines 50 through 199)

Heal th	Financial Systems I	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORT	TONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0051	Peri od:	Worksheet D	
					From 01/01/2019	Part V	
					To 12/31/2019	Date/Time Pre 6/29/2020 8:5	parea:
			Ti +l o	xVIII	Hospi tal	PPS	o alli
			11110	Charges	nospi tai	Costs	
	Cost Center Description	Cost to Charge	DDC Doimburcod		Cost	PPS Services	
	Cost Center Description	Ratio From	Servi ces (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not	(See Hist.)	
		Part I, col. 9	11151.)	Subject To	Subject To		
		rait i, coi. 9		Ded. & Coins			
				(see inst.)	(see inst.)		
		1. 00	2. 00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
50. 00	05000 OPERATI NG ROOM	0. 090303	31, 448, 325		0 0	2, 839, 878	50.00
50. 01	05001 CV SURGERY	0. 000000	01, 110, 020		0 0	0	50. 01
51. 00	05100 RECOVERY ROOM	0. 196079	6, 576, 661		1 0	1, 289, 545	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0. 223851	17, 541		0 0	3, 927	
53. 00	05300 ANESTHESI OLOGY	0. 000000	17, 541		0 0	0, 727	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0. 146829	8, 421, 143		1 0	1, 236, 468	1
55. 00	05500 RADI OLOGY - THERAPEUTI C	0. 140829	42, 757, 527		0 0	2, 576, 013	
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	0. 000247	42, 737, 327		0 0	2, 370, 013	1
57. 00	05700 CT SCAN	0. 051308	5, 177, 404		0 0	265, 642	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)				0 0		
59.00		0. 083195	1, 739, 147		-	144, 688	
	05900 CARDI AC CATHETERI ZATI ON	0. 045971	15, 953, 347	10.04	-	733, 391	
60.00	06000 LABORATORY	0. 174129	8, 542, 594	10, 84		1, 487, 513	
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	(74.004		0	0	
65. 00	06500 RESPI RATORY THERAPY	0. 308499	674, 821		0	208, 182	1
66. 00	06600 PHYSI CAL THERAPY	0. 374814	109, 951		0	41, 211	
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0	0	
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0	0	
69. 00	06900 ELECTROCARDI OLOGY	0. 069444	3, 836, 265	•	0 0	266, 406	
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 124585	2, 820, 792	l .	0	351, 428	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 181456	19, 219, 429		0	3, 487, 481	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 210932	16, 776, 744		0	3, 538, 752	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 194570	73, 414, 618		0 121, 174	14, 284, 282	
73. 01	07302 OP PHARMACY	0. 000000	0		0	0	
74. 00	07400 RENAL DI ALYSI S	0. 363464	285, 004	2	.9 0	103, 589	
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 340050	1, 334, 035		0 0	453, 639	76. 97
	OUTPATIENT SERVICE COST CENTERS	1					
90.00	09000 CLI NI C	1. 304789	1, 142, 981		3 45	1, 491, 349	1
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0. 239206	12, 856, 323			3, 075, 310	•
90. 02	09002 WOUND CARE CENTER	0. 178228	1, 634, 113			291, 245	
90. 03	09003 PAIN CLINIC	0. 207983	748, 797		0	155, 737	1
90. 05	09005 OP PSYCH CLINIC	1. 058571	501, 012		0	530, 357	
91. 00	09100 EMERGENCY	0. 069831	32, 497, 106		0 27	2, 269, 305	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 137332	14, 414, 509		1 0	1, 979, 573	92. 00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000			0		94. 00
95. 00	09500 AMBULANCE SERVI CES	0. 206528			0		95. 00
200.00	,		302, 900, 189	15, 98	121, 254	43, 104, 911	
201.00					0		201. 00
	Only Charges					40	
202.00	Net Charges (line 200 - line 201)		302, 900, 189	15, 98	121, 254	43, 104, 911	J202. 00

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0051 Peri od: Worksheet D From 01/01/2019 Part V Date/Time Prepared: 12/31/2019 6/29/2020 8:56 am Title XVIII Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 0 50.00 50.01 05001 CV SURGERY 0000000000 0 50.01 51. 00 05100 RECOVERY ROOM 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 0 52.00 53. 00 | 05300 | ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 0 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58 00 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 60.00 06000 LABORATORY 1,888 0 60.00 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 000000000000 06500 RESPIRATORY THERAPY 65.00 0 65.00 66.00 06600 PHYSI CAL THERAPY 0 66.00 06700 OCCUPATI ONAL THERAPY 67.00 67.00 68.00 06800 SPEECH PATHOLOGY 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 72.00 0 07300 DRUGS CHARGED TO PATIENTS 73.00 23.577 73.00 73. 01 07302 OP PHARMACY 0 73.01 07400 RENAL DIALYSIS 11 74.00 0 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 75.01 0 75.01 76. 97 07697 CARDIAC REHABILITATION 76.97 OUTPATIENT SERVICE COST CENTERS 09000 CLI NI C 90.00 90.00 59 09001 OP ONCOLOGY INFUSION CENTER 54 90. 01 90.01 09002 WOUND CARE CENTER 0 90. 02 869 90.02 09003 PAIN CLINIC 90.03 0 90.03 0 09005 OP PSYCH CLINIC 0 90.05 0 90.05 91.00 09100 EMERGENCY 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 0 92.00

0

2.827

2,827

0

23,640

23, 640

94.00

95.00

200.00

201. 00

202.00

OTHER REIMBURSABLE COST CENTERS

Subtotal (see instructions) Less PBP Clinic Lab. Services-Program

Net Charges (line 200 - line 201)

09400 HOME PROGRAM DIALYSIS

Only Charges

95. 00 09500 AMBULANCE SERVICES

94.00

200.00

201.00

202.00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0051 CCN: 15-T051	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Pre 6/29/2020 8:5	pared:
		Title	· XVIII	Subprovi der  - I RF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost (from Wkst. B,	(from Wkst. C, Part I, col.		Program . Charges	(column 3 x column 4)	
	Part II, col.	8)	2)	. Charges	COT dillit 4)	
	26)					
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00   05000   OPERATING ROOM	1, 631, 269		0. 00745		279	
50. 01   05001   CV   SURGERY	0	0	0.0000		0	50. 01
51.00   05100   RECOVERY ROOM	200, 354				72	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	985, 121	36, 449, 736	l .		0	52. 00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000		0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	597, 486		0. 01232		499	
55. 00   05500   RADI OLOGY-THERAPEUTI C	666, 812	102, 460, 394			28	
56. 00   05600   RADI OI SOTOPE	0	07 104 (70	0.00000		0	
57.00   05700   CT SCAN 58.00   05800   MAGNETIC RESONANCE IMAGING (MRI)	53, 207 60, 489	27, 124, 672 10, 238, 031	0. 00196 0. 00590		80 26	
59. 00   05900   CARDI AC CATHETERI ZATI ON	217, 770				0	59.00
60. 00   06000   LABORATORY	680, 144		0. 00582		1, 833	
64. 00 06400 I NTRAVENOUS THERAPY	000, 144	110,022,002	0.00000		1,033	64.00
65. 00 06500 RESPIRATORY THERAPY	87, 291	13, 486, 657	0.00647		232	65.00
66. 00   06600   PHYSI CAL THERAPY	387, 274	30, 268, 169	0. 01279		46, 637	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0077277	00,200,107	•		0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	Ö	0.00000		Ō	68. 00
69. 00 06900 ELECTROCARDI OLOGY	88, 723	24, 203, 388	0.00366	56 25, 722	94	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	128, 734	12, 284, 137	0. 01048	6, 747	71	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	213, 106	88, 275, 917	0.00241	14 65, 919	159	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	366, 679		0. 00277	75 3, 685	10	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	647, 762	245, 190, 649	0. 00264	12 627, 111	1, 657	73. 00
73. 01   07302   OP PHARMACY	1, 304		0. 00000		0	73. 01
74. 00   07400   RENAL DI ALYSI S	38, 718		0. 00832		1, 227	74. 00
75. 00   07500   ASC (NON-DISTINCT PART)	0	0	0.00000		0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.00000		0	75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON	114, 294	3, 843, 815	0. 02973	35 46, 803	1, 392	76. 97
90. 00 O9000 CLINIC	E0E 22E	2 022 021	0.20720	24	0	00.00
90. 00   09000   CLINIC 90. 01   09001   OP ONCOLOGY INFUSION CENTER	585, 335 609, 964		0. 20728		0	
90. 02   09002   WOUND CARE CENTER	141, 337	33, 351, 109 7, 718, 975			0	90.01
90. 02   09002   WOUND CARE CENTER 90. 03   09003   PAIN CLINIC	85, 511	3, 003, 422	0.0183		0	90. 02
90. 05   09005   OP PSYCH CLINIC	372, 559		l .		0	90.05
91. 00   09100   EMERGENCY	922, 029				152	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	722,027		0.00000		0	1
OTHER REIMBURSABLE COST CENTERS		20,01.,701	2. 23000			1
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.00000	00 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50 through 199)	9, 883, 272	1, 507, 875, 686		5, 091, 561	54, 448	200. 00

Health Financial Systems	IU HEALTH BLOOMINGT	TON HOSPITAL	In Lieu of Form CMS-2552-10		
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0051 Component CCN: 15-T051	From 01/01/2019	Worksheet D Part IV Date/Time Prepared: 6/29/2020 8:56 am	
		Ti +Lo V/// / /	Subprovi dor	DDC	

			Ti tl e	e XVIII	Subprovi der -	PPS	<u> </u>
	Cost Center Description				Allied Health	Allied Health	
		Anesthetist	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
	ANOULLARY CERVICE COCT CENTERS	1. 00	2A	2. 00	3A	3. 00	
FO 00	ANCI LLARY SERVI CE COST CENTERS	1 0				0	F0 00
50.00	05000 OPERATING ROOM	0	0	1		0	50.00
50. 01	05001 CV SURGERY	0	0			0	50. 01
51.00	05100 RECOVERY ROOM				0	0	51.00
52. 00 53. 00	05200   DELI VERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY				0	0	52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C				0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C					0	55. 00
56. 00	05600 RADI OI SOTOPE					0	56. 00
57. 00	05700 CT SCAN					0	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)					0	58. 00
59. 00	05900 CARDIAC CATHETERIZATION					0	59. 00
60. 00	06000 LABORATORY					0	60.00
64. 00	06400 I NTRAVENOUS THERAPY					0	64. 00
65. 00	06500 RESPIRATORY THERAPY					0	65. 00
66. 00	06600 PHYSI CAL THERAPY					0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY					0	67. 00
	06800 SPEECH PATHOLOGY	0				0	68. 00
	06900 ELECTROCARDI OLOGY					0	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0	l o		o o	0	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0			0	0	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	o		0	0	72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	o c		0	658, 501	73. 00
73. 01	07302 OP PHARMACY	0	0	) (	0	0	73. 01
74.00	07400 RENAL DIALYSIS	0	0	) (	0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	) (	0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	) (	0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	)	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	_			0	90. 00
	09001 OP ONCOLOGY INFUSION CENTER	0	0	)	0	0	90. 01
	09002 WOUND CARE CENTER	0	0	)	0	0	90. 02
	09003 PAIN CLINIC	0	0	)	0	0	90. 03
	09005 OP PSYCH CLINIC	0	0		0	0	90. 05
91.00	09100 EMERGENCY	0		)	0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		(	)	0	92. 00
04.00	OTHER REIMBURSABLE COST CENTERS						04.00
	09400 HOME PROGRAM DIALYSIS	0	0	(	0	0	94. 00
95. 00 200. 00	O9500 AMBULANCE SERVICES   Total (Lines 50 through 199)	0	o	) (	0	658, 501	95. 00
200.00	Tiotal (Titles 50 tillough 199)	1	'I	'I	ال ال	000, 501	<sub>1</sub> 200.00

Heal th	Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY S				Peri od:	Worksheet D	
	SH COSTS			F	rom 01/01/2019	Part IV	
			Component	CCN: 15-T051   T	Γο 12/31/2019		
			Ti +Lo	xVIII	Subprovi der -	6/29/2020 8: 5 PPS	<u>6 am</u>
			11116	; AVIII	I RF	FF3	
	Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost	,	Cost (sum of		(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS		1		1		
50. 00	05000 OPERATING ROOM	0	0				
50. 01	05001 CV SURGERY	0	0			0.000000	1
51. 00	05100 RECOVERY ROOM	0	0			l e	1
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	(		l e	1
53. 00	05300 ANESTHESI OLOGY	0	0	(		0.000000	1
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	0	(		l e	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	(			1
56. 00	05600 RADI OI SOTOPE	0	0	(		0.000000	1
57. 00 58. 00	05700 CT SCAN	0	0	(			
59. 00	05800   MAGNETIC RESONANCE I MAGING (MRI)   05900   CARDIAC CATHETERIZATION	0	0			0.000000	1
60.00	06000 LABORATORY	0	0			l e	1
64. 00	06400 I NTRAVENOUS THERAPY	0				0.000000	1
65. 00	06500 RESPI RATORY THERAPY		0				
66. 00	06600 PHYSI CAL THERAPY						
67. 00	06700 OCCUPATI ONAL THERAPY	0				0. 000000	•
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0. 000000	1
69. 00	06900 ELECTROCARDI OLOGY	0	0		24, 203, 388	l	1
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0			0.000000	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0			l	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0			l	•
73.00	07300 DRUGS CHARGED TO PATIENTS	0	658, 501	658, 501		l	1
73. 01	07302 OP PHARMACY	0	0	. (		0.000000	1
74.00	07400 RENAL DI ALYSI S	0	0	(	4, 651, 447	0.000000	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	(	0	0.000000	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	(	0	0.000000	75. 01
76. 97	07697 CARDIAC REHABILITATION	0	0	(	3, 843, 815	0.000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000  CLI NI C	0	0	(	2, 823, 831	0.000000	90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	0	(	33, 351, 109		
90. 02	09002 WOUND CARE CENTER	0	0	(	.,,	l e	
90. 03	09003 PAIN CLINIC	0	0	(			
90. 05	09005 OP PSYCH CLINIC	0	0	(	.,	l	1
91. 00	09100 EMERGENCY	0	0	(		l	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	(	36, 644, 931	0.000000	92.00

658, 501

0.000000

658, 501 1, 507, 875, 686

94.00 95.00

200. 00

200.00

92. 00 | 09200 | 085ERVATION BEDS (NON-DISTINCT PART) |
OTHER REIMBURSABLE COST CENTERS |
94. 00 | 09400 | HOME PROGRAM DI ALYSIS |
95. 00 | 09500 | AMBULANCE SERVICES |

Total (lines 50 through 199)

Heal th	Financial Systems	U HEALTH BLOOMIN	IGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
APP0RT	TONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	Provi der Co		Peri od:	Worksheet D	
THROUG	H COSTS		Component		From 01/01/2019 To 12/31/2019	Part IV Date/Time Pre 6/29/2020 8:5	pared: 6 am
			Title	· XVIII	Subprovi der - I RF	PPS	
	Cost Center Description	Outpati ent	Inpatient	Inpati ent	Outpati ent	Outpati ent	
	·	Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through	Charges	Pass-Through	
		(col. 6 ÷ col.	_	Costs (col. 8		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9.00	10.00	11.00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	37, 484	(	0	0	50.00
50. 01	05001 CV SURGERY	0. 000000	0		o	0	50. 01
51.00	05100 RECOVERY ROOM	0. 000000	12, 034	(	o	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	. 0	(	o	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	40, 495		0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	4, 287			0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	0			0	56. 00
57. 00	05700 CT SCAN	0. 000000	40, 604			0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	4, 475			0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	., ., 0			0	59. 00
60.00	06000 LABORATORY	0. 000000	314, 848			0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0.1,010			0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	35, 856			0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	3, 644, 903			0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0, 0 , , , 0 0			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0			0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	25, 722			0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	6, 747		1	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	65, 919		-	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	3, 685		1	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 002686	627, 111	1, 684	-	0	73. 00
73. 01	07302 OP PHARMACY	0. 000000	027,	., 55		0	73. 01
74. 00	07400 RENAL DIALYSIS	0. 000000	147, 448			0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	117, 110			0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		1	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	46, 803			0	1
70. 77	OUTPATIENT SERVICE COST CENTERS	0.000000	+0, 003		<u> </u>	0	70. 77
90.00	09000 CLINI C	0. 000000	0		0	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0. 000000	0			0	90. 01
90. 01	09002 WOUND CARE CENTER	0. 000000	0			0	90. 02
90. 02	09003 PAIN CLINIC	0. 000000	0		-	0	90. 02
90. 05	09005 OP PSYCH CLINIC	0. 000000	0		-	0	90.05
91. 00	09100 EMERGENCY	0. 000000	33, 140	1	·	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	33, 140			0	
12.00	OTHER DELIMINISTRATION BEDS (NON-DISTINCT PART)	0.000000			, U		1 /2.00

0. 000000

5, 091, 561

0

1, 684

0

0 94.00 95.00 0 200.00

91. 00 | 09100 | EMERGENCY 92. 00 | 09200 | DSSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS 94. 00 | 09500 | AMBULANCE SERVI CES 200. 00 | Total (Lines 50 through 199)

Health Financial Systems	IU HEALTH BLOOMING	TON HOSPITAL	In Lie	u of Form CMS-2552-10
APPORTIONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND VACCINE COST	Provider CCN: 15-0051 Component CCN: 15-T051	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Prepared: 6/29/2020 8:56 am

			·			6/29/2020 8:5	<u>6 am</u>
			Title	xVIII	Subprovi der -	PPS	
					I RF		
				Charges		Costs	
	Cost Center Description	Cost to Charge			Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subj ect To		
				Ded. & Coins.			
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000  OPERATI NG ROOM	0. 090303	0		0	0	50.00
50. 01	05001 CV SURGERY	0. 000000	0		0	0	50. 01
51.00	05100 RECOVERY ROOM	0. 196079	0		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 223851	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 146829	0		0 0	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 060247	0		0 0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0. 000000	0		0	0	56. 00
57. 00	05700 CT SCAN	0. 051308	0		0	0	1
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 083195	0		0 0	· -	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 045971	0	l .	0 0	l ő	
60. 00	06000 LABORATORY	0. 174129	0	l .	0 0	·	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	0	64. 00
65. 00	06500 RESPIRATORY THERAPY	0. 308499	0		0 0	0	1
		1	0		0 0	· -	
66. 00	06600 PHYSI CAL THERAPY	0. 374814	-		-	ľ	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0.000000	0		0	ľ	67. 00
68. 00	06800 SPEECH PATHOLOGY	0.000000	0	l .	0	· -	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 069444	0		0	· -	69. 00
	07000 ELECTROENCEPHALOGRAPHY	0. 124585	0		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 181456	0	•	0	1	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 210932	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 194570	0		0 116	0	73. 00
73. 01	07302 OP PHARMACY	0. 000000	0		0	0	73. 01
74.00	07400 RENAL DIALYSIS	0. 363464	0		0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 340050	0		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS						1
90.00	09000 CLI NI C	1. 304789	0		0 0	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0. 239206	0		0 0	0	90. 01
	09002 WOUND CARE CENTER	0. 178228	0		0	0	90. 02
90. 03	09003 PAIN CLINIC	0. 207983	0		0	0	1
90. 05	09005 OP PSYCH CLINIC	1. 058571	0		0 0	0	1
91. 00	09100 EMERGENCY	0. 069831	0		0 0	·	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 137332	0		o o	· -	1
72.00	OTHER REIMBURSABLE COST CENTERS	0. 137332			0 0	0	72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0. 000000			ol		94. 00
95. 00	09500 AMBULANCE SERVICES	0. 206528			0		95.00
		0. 200528	0			_	1
200.00			0	1			200.00
201. 00					0		201. 00
202 22	Only Charges		^			_	202 00
202. 00	Net Charges (line 200 - line 201)	1	0	T .	0 116	l 0	202. 00

Health Financial Systems	П	IU HEALTH BLOOMINGTON HOSPITAL					2552-10
APPORTI ONMENT OF MEDICAL,	OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-0051	Peri od: From 01/01/2019	Worksheet D Part V	
			Component (	CCN: 15-T051	To 12/31/2019	Date/Time Prep 6/29/2020 8:50	
			Title	XVIII	Subprovi der - I RF	PPS	
		C+-					

			11 (16	2 VALLE	I RF	FF3	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Rei mbursed	Rei mbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7. 00				
	ANCILLARY SERVICE COST CENTERS						1
1	05000 OPERATING ROOM	0		1			50.00
1	05001 CV SURGERY	0		1			50. 01
1	05100 RECOVERY ROOM	0	-	1			51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	[ C	)			52. 00
	05300 ANESTHESI OLOGY	0	[ C	)			53. 00
	05400 RADI OLOGY-DI AGNOSTI C	0	-	1			54.00
	05500 RADI OLOGY-THERAPEUTI C	0	1	1			55. 00
	05600 RADI 0I S0T0PE	0	( C	)			56. 00
	05700 CT SCAN	0	C	)			57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	)			58. 00
	05900 CARDI AC CATHETERI ZATI ON	0	C	)			59. 00
60. 00	06000 LABORATORY	0	C				60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	C				64. 00
65. 00	06500 RESPI RATORY THERAPY	0	C				65. 00
66. 00	06600 PHYSI CAL THERAPY	0	C				66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	C				67. 00
68. 00	06800 SPEECH PATHOLOGY	0	C				68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	C				69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	C				70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C				71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	C				72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	23	3			73.00
73. 01	07302 OP PHARMACY	0	C				73. 01
74. 00	07400 RENAL DIALYSIS	0	C				74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	C				75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C				75. 01
76. 97	07697 CARDIAC REHABILITATION	0	C				76. 97
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	C	)			90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	C				90. 01
90. 02	09002 WOUND CARE CENTER	0	C				90. 02
90. 03	09003 PAIN CLINIC	0	C				90. 03
90. 05	09005 OP PSYCH CLINIC	0	C				90. 05
91. 00	09100 EMERGENCY	0	C				91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C				92.00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0	C				94. 00
95. 00	09500 AMBULANCE SERVICES	0					95.00
200.00	Subtotal (see instructions)	0	23	3			200. 00
201.00	Less PBP Clinic Lab. Services-Program	0					201. 00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	0	23	B			202. 00

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	. COSTS	Provi der C	F	Period: From 01/01/2019 Fo 12/31/2019		pared: 6 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capital Related Cost (from Wkst. B,	Swing Bed Adjustment	Reduced Capital Related Cost	Days	Per Diem (col. 3 / col. 4)	
	Part II, col.		(col . 1 - col .			
	26) 1. 00	2.00	2) 3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
30. 00 ADULTS & PEDIATRICS	4, 041, 243	0	4, 041, 243	48, 022	84. 15	30.00
31. 00 INTENSIVE CARE UNIT	396, 847		396, 847			
32. 00   CORONARY CARE UNIT	451, 038	l .	451, 038		<b>l</b>	
35. 00 NEONATAL INTENSIVE CARE UNIT	239, 122	l .	239, 122		•	
41. 00 SUBPROVI DER - I RF	374, 218	l .	374, 218		•	
42. 00 SUBPROVI DER	374,210		) 374, 210			42.00
43. 00 NURSERY	150, 130		150, 130	-		
200.00 Total (lines 30 through 199)	5, 652, 598	l .	5, 652, 598		•	200.00
Cost Center Description	Inpati ent	Inpati ent	0,002,070	01,072		200.00
2001 2011 20001 1 pt 1 011	Program days	Program				
	og. a dayo	Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7.00	1			
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 212	101, 990	)	-		30.00
31.00 INTENSIVE CARE UNIT	917	95, 817	'			31.00
32. 00   CORONARY CARE UNIT	0	0	)			32. 00
35.00 NEONATAL INTENSIVE CARE UNIT	283	21, 559	)			35. 00
41. 00 SUBPROVI DER - I RF	61	7, 404				41. 00
42, 00 SUBPROVI DER		0	)			42.00

1, 445 3, 918

o

7, 404 0

71, 715 298, 485

41. 00 42. 00

43. 00 200. 00

42.00 SUBPROVI DER 43.00 NURSERY 200.00 Total (lines 30 through 199)

				From 01/01/2019 To 12/31/2019	Part II Date/Time Prep 6/29/2020 8:50	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
'	Related Cost	(from Wkst. C,	to Charges	Program	column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)	·				
	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			-			
0. 00 05000 OPERATING ROOM	1, 631, 269	218, 787, 385	0. 00745	66 926, 313	6, 907	50.00
0. 01  05001 CV SURGERY	0		0.00000	ol ol	0	50. 01
1. 00 05100 RECOVERY ROOM	200, 354	33, 282, 990	0. 00602	20 82, 277	495	51.00
2. 00 05200 DELIVERY ROOM & LABOR ROOM	985, 121	36, 449, 736		827, 535	22, 366	52.00
3. 00 05300 ANESTHESI OLOGY	0		0.00000	ol ol	0	53.00
4. 00   05400 RADI OLOGY-DI AGNOSTI C	597, 486	48, 485, 347	1		5, 257	54.00
5. 00   05500 RADI OLOGY-THERAPEUTI C	666, 812		1			
6. 00   05600   RADI OI SOTOPE	0		0.00000	·	0	
7. 00   05700   CT   SCAN	53. 207		1		384	
8.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	60, 489	, , , , ,	1	·	444	
9. 00 05900 CARDI AC CATHETERI ZATI ON	217, 770			·	1, 009	
0. 00   06000   LABORATORY	680, 144		1		8, 220	
4. 00 06400 I NTRAVENOUS THERAPY	000,111	110,022,002	0.00000		0, 220	
5. 00 06500 RESPI RATORY THERAPY	87, 291	13, 486, 657			3, 222	
6. 00   06600   PHYSI CAL THERAPY	387, 274				1, 719	
7. 00 06700 OCCUPATI ONAL THERAPY	307, 274				1, 717	
8. 00   06800   SPEECH PATHOLOGY		_	0.00000		0	
9. 00 06900 ELECTROCARDI OLOGY	88, 723		1		736	
0. 00 07000 ELECTROCARDI OLOGI 0. 00 07000 ELECTROENCEPHALOGRAPHY	128, 734					
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	213, 106		1		1, 254 1, 451	
			1			
2.00   07200   IMPL. DEV. CHARGED TO PATIENTS 3.00   07300   DRUGS CHARGED TO PATIENTS	366, 679		1		3, 896	
	647, 762		1		6, 166	
3. 01   07302   0P   PHARMACY	1, 304	l .	0.00000		0	
4. 00   07400   RENAL DI ALYSI S	38, 718				1, 043	
5. 00 07500 ASC (NON-DISTINCT PART)	0		0.00000		0	
5. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	_	0.040.04	0.00000		0	
6. 97 O7697 CARDI AC REHABI LI TATI ON	114, 294	3, 843, 815	0. 02973	7, 349	219	76. 97
OUTPATIENT SERVICE COST CENTERS	FOF 225	2 022 024	0.20720	) d		1 00 00
0. 00   09000   CLI NI C	585, 335				0	
0. 01   09001   OP ONCOLOGY   INFUSION CENTER	609, 964				1, 129	
0. 02 09002 WOUND CARE CENTER	141, 337				0	
0. 03   09003   PAIN CLINIC	85, 511	3, 003, 422			0	
0. 05   09005   0P   PSYCH   CLINIC	372, 559		1		44	
1. 00   09100   EMERGENCY	922, 029				5, 165	
2. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	371, 959	36, 644, 931	0. 01015	50 31, 142	316	92.00
OTHER REIMBURSABLE COST CENTERS	-	T -		-1	_	
4. 00 09400 HOME PROGRAM DIALYSIS	0	(	0.00000	00 0	0	1
5. 00 09500 AMBULANCE SERVICES	10, 255, 231	1			. '	95.00

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

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER	PASS THROUGH COS		F	eriod: rom 01/01/2019 o 12/31/2019	6/29/2020 8:5	pared: 6 am
			e XIX	Hospi tal	PPS	
Cost Center Description	Post-Stepdown Adjustments		Allied Health Post-Stepdown Adjustments	Cost	All Other Medical Education Cost	
INPATIENT ROUTINE SERVICE COST CENTERS	1A	1. 00	2A	2. 00	3. 00	
30. 00   03000   ADULTS & PEDIATRICS   31. 00   03100   INTENSIVE CARE UNIT   32. 00   03200   CORONARY CARE UNIT   35. 00   02060   NEONATAL INTENSIVE CARE UNIT   41. 00   04100   SUBPROVIDER   - IRF   42. 00   04200   SUBPROVIDER   43. 00   04300   O4300   O4300   O4300   Cost Center Description   Cost Center Description	Swing-Bed Adjustment Amount (see	Total Costs (sum of cols. 1 through 3,			0 0 0 0 0 0 0 0 Inpatient Program Days	31. 00 32. 00 35. 00 41. 00 42. 00
	instructions)	minus col. 4)		7.00		
INPATIENT ROUTINE SERVICE COST CENTERS	4. 00	5. 00	6. 00	7. 00	8. 00	
30. 00   03000   ADULTS & PEDIATRICS   31. 00   03100   INTENSIVE CARE UNIT   32. 00   03200   CORONARY CARE UNIT   35. 00   02060   NEONATAL INTENSIVE CARE UNIT   41. 00   04100   SUBPROVIDER - IRF   42. 00   04200   SUBPROVIDER   43. 00   04300   NURSERY   Total (lines 30 through 199)	0 0	0 0		0.00 0.00 0.00 0.00 0.00 0.00	1, 212 917 0 283 61 0 1, 445 3, 918	31. 00 32. 00 35. 00 41. 00 42. 00
Cost Center Description	Inpatient Program Pass-Through Cost (col. 7 x col. 8) 9.00					
INPATIENT ROUTINE SERVICE COST CENTERS  30. 00 03000 ADULTS & PEDIATRICS						30.00
30. 00 03000 ADDLIS & PEDIALICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 35. 00 02060 NEONATAL INTENSIVE CARE UNIT 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY 200. 00 Total (lines 30 through 199)	000000000000000000000000000000000000000					30. 00 31. 00 32. 00 35. 00 41. 00 42. 00 43. 00 200. 00
1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	'	1				

| Peri od: | Worksheet D | Part IV | To | 12/31/2019 | Date/Time Prepared: | Control of the prepared: | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Pa 
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CO
 Provider CCN: 15-0051 THROUGH COSTS

					10 12/31/2019	6/29/2020 8:50	
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
	Cost Center Description	Non Physician			I Allied Health	Allied Health	
	·	Anestheti st	Post-Stepdown		Post-Stepdown		
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	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	0	0	)	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0	)	0	0	56. 00
57.00	05700 CT SCAN	0	0	)	0 0	0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	)	0 0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	)	0 0	0	59. 00
60.00	06000 LABORATORY	0	0	)	0 0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	)	0 0	0	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	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	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	)	0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	)	0 0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	658, 501	73.00
73. 01	07302 OP PHARMACY	0	0		0	0	73. 01
74.00	07400 RENAL DIALYSIS	0	0		0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	75. 01
76. 97	07697 CARDIAC REHABILITATION	0	0		0 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS				_		
90.00	09000 CLI NI C	0	0	1	0	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	0	)	0	0	90. 01
90. 02	09002 WOUND CARE CENTER	0	0	)	0	0	90. 02
90. 03	09003 PAIN CLINIC	0	0	)	0 0	0	90. 03
90. 05	09005 OP PSYCH CLINIC	0	0	)	0 0	0	90. 05
91. 00	09100 EMERGENCY	0	0	)	0 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94. 00	09400 HOME PROGRAM DIALYSIS	0	0	)	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	0	)	0 0	658, 501	200. 00

Health Financial Systems I U HEALTH BLOOMING APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS In Lieu of Form CMS-2552-10 IU HEALTH BLOOMINGTON HOSPITAL Worksheet D Part IV Date/Time Prepared: 6/29/2020 8:56 am Provider CCN: 15-0051 Peri od: From 01/01/2019 To 12/31/2019 THROUGH COSTS Title XIX Hospital PPS
Total Charges Ratio of Cost
(from Wkst C. to Charges Cost Center Description All Other Total Cost Total

		Medi cal	(sum of cols.		(from Wkst. C,		
		Education Cost	1, 2, 3, and	Cost (sum of	Part I, col.	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	ANCILLARY SERVICE COST CENTERS						
50. 00	05000 OPERATING ROOM	0	0	0	218, 787, 385	0. 000000	50.00
50. 01	05001 CV SURGERY	0	0	0	0	0. 000000	50. 01
51.00	05100 RECOVERY ROOM	0	0	0	33, 282, 990	0.000000	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	36, 449, 736	0.000000	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0	0	0.000000	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	48, 485, 347	0.000000	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	102, 460, 394	0.000000	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0.000000	56.00
57.00	05700 CT SCAN	0	0	0	27, 124, 672	0.000000	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0	10, 238, 031	0.000000	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	71, 271, 504	0.000000	59.00
60.00	06000 LABORATORY	0	0	0	116, 822, 802	0.000000	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0.000000	64.00
65.00	06500 RESPI RATORY THERAPY	0	0	0	13, 486, 657	0.000000	65.00
66.00	06600 PHYSI CAL THERAPY	0	0	0	30, 268, 169	0.000000	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0.000000	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	0.000000	68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	24, 203, 388	0.000000	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	12, 284, 137	0.000000	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	88, 275, 917	0.000000	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	132, 146, 163	0.000000	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	658, 501	658, 501	245, 190, 649	0. 002686	73.00
	07302 OP PHARMACY	0	0	0	0	0.000000	73. 01
	07400 RENAL DI ALYSI S	0	0	0	4, 651, 447	0.000000	74.00
	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0.000000	75.00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0. 000000	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	3, 843, 815	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90. 00	09000 CLI NI C	0	0	0	2, 823, 831	0. 000000	90. 00
	09001 OP ONCOLOGY INFUSION CENTER	0	0	0	33, 351, 109		90. 01
90. 02	09002 WOUND CARE CENTER	0	0	0	7, 718, 975	0. 000000	90. 02
90. 03	09003 PAIN CLINIC	0	0	0	3, 003, 422	0. 000000	90. 03
90. 05	09005 OP PSYCH CLINIC	0	0	0	4, 398, 493	0. 000000	90. 05
91. 00	09100 EMERGENCY	0	0	0	200, 661, 722	0. 000000	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	0	36, 644, 931	0. 000000	92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0. 000000	94. 00
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	658, 501	658, 501	1, 507, 875, 686		200. 00

| Peri od: | Worksheet D | Part IV | To | 12/31/2019 | Date/Time Prepared: | Control of the prepared: | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Part IV | Pa 
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 Provider CO
 Provider CCN: 15-0051 THROUGH COSTS

					10 12/31/2019	6/29/2020 8:50	
			Titl	e XIX	Hospi tal	PPS	o am
	Cost Center Description	Outpati ent	Inpatient	Inpatient	Outpati ent	Outpati ent	
		Ratio of Cost	Program	Program	Program	Program	
		to Charges	Charges	Pass-Through		Pass-Through	
		(col. 6 ÷ col.	J	Costs (col.		Costs (col. 9	
		7)		x col. 10)		x col. 12)	
		9. 00	10.00	11. 00	12.00	13.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 000000	926, 313		0 0	0	50. 00
50. 01	05001 CV SURGERY	0. 000000	0		0 0	0	50. 01
51.00	05100 RECOVERY ROOM	0. 000000	82, 277		0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	827, 535		0 0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	426, 596		0 0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	81, 806		0 0	0	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000	0		0 0	0	56. 00
57.00	05700 CT SCAN	0. 000000	195, 765		0 0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	75, 075		0 0	0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000	330, 347		0 0	0	59. 00
60.00	06000 LABORATORY	0. 000000	1, 411, 929		0 0	0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0. 000000	0		0 0	o	64. 00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	497, 816		0 0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	134, 315		0 0		66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	Ö	67. 00
68. 00	06800 SPEECH PATHOLOGY	0. 000000	0		0 0		68. 00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000	200, 857		0 0	Ö	69.00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	119, 612		0 0		70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	601, 008		0 0	Ö	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	1, 403, 973		0 0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 002686	2, 333, 984		59 0	Ö	73. 00
73. 01	07302 OP PHARMACY	0. 000000	0	-, -	0 0	0	73. 01
74. 00	07400 RENAL DI ALYSI S	0. 000000	125, 328		0 0	Ö	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0 0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0 0	-	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	7, 349		0 0		76. 97
	OUTPATIENT SERVICE COST CENTERS		.,			_	
90.00	09000 CLI NI C	0. 000000	0		0 0	0	90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0. 000000	61, 704		0 0		90. 01
90. 02	09002 WOUND CARE CENTER	0. 000000	0		0 0	Ö	90. 02
90. 03	09003 PAIN CLINIC	0. 000000	0		0 0	0	90. 03
90. 05	09005 OP PSYCH CLINIC	0. 000000	516		0 0	Ö	90. 05
91. 00	09100 EMERGENCY	0. 000000	1, 123, 995		0 0		91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	31, 142		0 0	-	92. 00
, 2. 50	OTHER REIMBURSABLE COST CENTERS	2. 222300	3., 112		-1 0		1 2.00
94.00	09400 HOME PROGRAM DI ALYSI S	0. 000000	0		0 0	0	94. 00
95. 00	09500 AMBULANCE SERVI CES		· ·				95. 00
200.00			10, 999, 242	6, 20	0	n	200. 00
	, (	1	-, ,	0,2		,	

Heal th	Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORT	TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provi der C		Peri od:	Worksheet D	
			Component		From 01/01/2019 To 12/31/2019	Part II Date/Time Pre 6/29/2020 8:5	
			Ti tl	e XIX	Subprovi der - I RF	PPS	<del>o um</del>
	Cost Center Description	Capi tal	Total Charges	Ratio of Cost		Capital Costs	
	occi contor boson per on		(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,		(col. 1 ÷ col		column 4)	
		Part II, col.	8)	2)	3		
		26)		,			
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS		•				
50.00	05000 OPERATING ROOM	1, 631, 269	218, 787, 385	0. 00745	6 0	0	50. 00
50. 01	05001 CV SURGERY	C	0	0. 00000	0 0	0	50. 01
51.00	05100 RECOVERY ROOM	200, 354	33, 282, 990	0. 00602	0 0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	985, 121	36, 449, 736	0. 02702	7 0	0	52. 00
53.00	05300 ANESTHESI OLOGY			0. 00000	0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	597, 486	48, 485, 347	0. 01232		28	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	666, 812				0	55. 00
56.00	05600 RADI OI SOTOPE			0. 00000		0	56. 00
57. 00	05700 CT SCAN	53, 207	27, 124, 672	•		1	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	60, 489		0.00590		0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	217, 770		0. 00305		0	59. 00
60.00	06000 LABORATORY	680, 144		0. 00582		29	60.00
64.00	06400 I NTRAVENOUS THERAPY	C		0. 00000	·	0	64.00
65.00	06500 RESPIRATORY THERAPY	87, 291	13, 486, 657	0. 00647		0	65. 00
66.00	06600 PHYSI CAL THERAPY	387, 274		0. 01279	5 140, 770	1, 801	66.00
67. 00	06700 OCCUPATI ONAL THERAPY			0. 00000		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	C	ol	0. 00000	0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	88, 723	24, 203, 388	•		0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	128, 734		0. 01048		0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	213, 106		0. 00241		3	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	366, 679	132, 146, 163	0. 00277		0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	647, 762			2 34, 305	91	73. 00
73. 01	07302 OP PHARMACY	1, 304	0	0. 00000	0 0	0	73. 01
74.00	07400 RENAL DIALYSIS	38, 718	4, 651, 447	0. 00832	4 0	0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)			0. 00000		0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	C	0	0. 00000	0 0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	114, 294	3, 843, 815	0. 02973	5 0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		•			
90.00	09000 CLI NI C	585, 335	2, 823, 831	0. 20728	4 0	0	90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	609, 964	33, 351, 109	0. 01828	9 0	0	90. 01
90. 02	09002 WOUND CARE CENTER	141, 337	7, 718, 975	0. 01831	0 0	0	90. 02
90. 03	09003 PAIN CLINIC	85, 511	3, 003, 422	0. 02847	1 0	0	90. 03
90. 05	09005 OP PSYCH CLINIC	372, 559	4, 398, 493	0. 08470	2 0	0	90. 05
91.00	09100 EMERGENCY	922, 029	200, 661, 722	0. 00459	5 0	0	91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	C	36, 644, 931	0. 00000	0 0	0	92. 00
	OTHER RELIMBURSABLE COST CENTERS			·			I

9, 883, 272 1, 507, 875, 686

0.000000

0

184, 272

0 94.00 95.00 1,953 200.00

09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Health Financial Systems	IU HEALTH BLOOMING	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0051 Component CCN: 15-T051	Peri od: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Prepared: 6/29/2020 8:56 am
•		T1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0 1 1 1	200

			T: ±1	- VIV	Cb	0/27/2020 0.5	o alli
			11 11	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description	Non Physician	Nursing School	Nursing School	Allied Health	Allied Health	
	cost center bescription	Anesthetist	Post-Stepdown		Post-Stepdown	Airred hearth	
		Cost	Adjustments		Adjustments		
		1.00	2A	2.00	3A	3. 00	
	ANCILLARY SERVICE COST CENTERS	1.00	1 2/1	2.00	- Ort	0.00	
50.00	05000 OPERATI NG ROOM				0	0	50.00
50. 01	05001 CV SURGERY				0 0	0	50. 01
51. 00	05100 RECOVERY ROOM					0	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					0	55. 00
56. 00	05600 RADI OI SOTOPE					0	56.00
57. 00	05700 CT SCAN					0	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)					0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON					0	59.00
60.00	06000 LABORATORY					0	60.00
64. 00	06400 I NTRAVENOUS THERAPY				0 0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY				0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY				0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY				0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY				0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY				0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY				0	0	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C			0	0	71. 00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS				0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	( c			0	658, 501	73.00
73. 01	07302 OP PHARMACY		) (		0	0	73. 01
74.00	07400 RENAL DIALYSIS		) (		0	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)		) (		0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	(	) (	) (	0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	C	) (	) (	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS		_				
90. 00	09000 CLI NI C	C		1	0	0	90. 00
	09001 OP ONCOLOGY INFUSION CENTER	C	) (		0	0	90. 01
	09002 WOUND CARE CENTER	C	) (		0	0	90. 02
90. 03	09003 PAIN CLINIC		) (		0	0	90. 03
	09005 OP PSYCH CLINIC				0	0	90. 05
91. 00	09100 EMERGENCY	0	)		0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		)		)	0	92.00
04.60	OTHER REIMBURSABLE COST CENTERS		\ \		J -	_	04.00
94. 00	09400 HOME PROGRAM DI ALYSI S	C		۱ (	0	0	94. 00
95.00	09500 AMBULANCE SERVICES		,	,		/50 504	95. 00
200.00	Total (lines 50 through 199)	(	)  (	η (	0	658, 501	1200.00

	cial Systems   I IT OF INPATIENT/OUTPATIENT ANCILLARY SE	U HEALTH BLOOMI			Peri od:	wof Form CMS-: Worksheet D	2552-10
THROUGH COST		NVIOL UIILN PAS	FIOVIDE C	JIV. 13-0031	From 01/01/2019	Part IV	
1111100011 0001			Component		To 12/31/2019		pared:
			Ti tl	e XIX	Subprovider -	PPS	o um
	Cost Center Description	All Other	Total Cost	Total		Ratio of Cost	
		Medi cal	(sum of cols.	Outpati ent	(from Wkst. C,	to Charges	
		Education Cost		Cost (sum of	· ·	(col. 5 ÷ col.	
			4)	col s. 2, 3,	8)	7)	
				and 4)		(see	
						instructions)	
		4. 00	5. 00	6. 00	7. 00	8. 00	
	LARY SERVICE COST CENTERS		-				l
	OPERATI NG ROOM	0	0		0 218, 787, 385	0.000000	
	CV SURGERY	0	0		0 0	0. 000000	1
	RECOVERY ROOM	0	0		0 33, 282, 990	l e	
	DELIVERY ROOM & LABOR ROOM	0	0		0 36, 449, 736		
	ANESTHESI OLOGY	0	0		0	0. 000000	1
	RADI OLOGY-DI AGNOSTI C	0	0		0 48, 485, 347	0. 000000	
	RADI OLOGY-THERAPEUTI C	0	0		0 102, 460, 394		
	RADI OI SOTOPE	0	0		0	0. 000000	
	CT SCAN	0	0		0 27, 124, 672	0. 000000	
	MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 10, 238, 031	0. 000000	
	CARDI AC CATHETERI ZATI ON	0	0		0 71, 271, 504	0. 000000	
•	LABORATORY	0	0		0 116, 822, 802	0. 000000	
	I NTRAVENOUS THERAPY	0	0		0	0. 000000	
	RESPI RATORY THERAPY	0	0		0 13, 486, 657	0. 000000	
	PHYSI CAL THERAPY	0	0		0 30, 268, 169		
	OCCUPATIONAL THERAPY	0	0		0	0. 000000	
	SPEECH PATHOLOGY	0	0		0	0. 000000	
	ELECTROCARDI OLOGY	0	0		0 24, 203, 388	l	
•	ELECTROENCEPHALOGRAPHY	0	0		0 12, 284, 137	0. 000000	
	MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 88, 275, 917	0. 000000	
	IMPL. DEV. CHARGED TO PATIENTS	0	0		0 132, 146, 163	0. 000000	
	DRUGS CHARGED TO PATIENTS	0	658, 501	658, 50	1 245, 190, 649		
	OP PHARMACY	0	0		0	0. 000000	
	RENAL DIALYSIS	0	0		0 4, 651, 447	0. 000000	
75. 00 07500	ASC (NON-DISTINCT PART)	0	0		0	0.000000	75. 00
75. 01   03550	PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0.000000	75. 01
	CARDI AC REHABI LI TATI ON	0	0		0 3, 843, 815	0. 000000	76. 97
	TIENT SERVICE COST CENTERS						
	CLINIC	0			0 2, 823, 831	0.000000	
	OP ONCOLOGY INFUSION CENTER	0	0		0 33, 351, 109	<b>l</b>	
	WOUND CARE CENTER	0	0		0 7, 718, 975		
90. 03 09003	PAIN CLINIC	0	0		0 3, 003, 422	0. 000000	90. 03
90. 05 09005	OP PSYCH CLINIC	0	0		0 4, 398, 493		90. 05
91.00 09100	EMERGENCY	0	0		0 200, 661, 722	0. 000000	91.00
92.00 09200	OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 36, 644, 931	0. 000000	92. 00
	REIMBURSABLE COST CENTERS						
	HOME PROGRAM DIALYSIS	0	0		0 0	0. 000000	
	AMBULANCE SERVICES						95. 00
200.00	Total (lines 50 through 199)	0	658, 501	658, 50	1 1, 507, 875, 686		200.00

	IONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEI H COSTS	RVICE OTHER PASS	Provider Component (		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pre 6/29/2020 8:5	
			Ti tI	e XIX	Subprovi der – I RF	PPS	
	Cost Center Description	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7) 9.00	Inpatient Program Charges	Inpatient Program Pass-Through Costs (col. {   x col. 10)   11.00	Outpatient Program Charges	Outpatient Program Pass-Through Costs (col. 9 x col. 12) 13.00	
	ANCILLARY SERVICE COST CENTERS	<u> </u>			<u>'</u>		
50.00	05000 OPERATI NG ROOM	0. 000000	0		0 0	0	50. 00
50. 01	05001 CV SURGERY	0. 000000	0		0	0	50. 01
51.00	05100 RECOVERY ROOM	0. 000000	0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 000000	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 000000	2, 263		0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	0		0	0	55. 00
56.00	05600   RADI OI SOTOPE   05700   CT   SCAN	0.000000	0		0 0	0	56.00
57. 00 58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000 0. 000000	744 0		0 0	0	57. 00 58. 00
59. 00	05900 CARDIAC CATHETERIZATION	0. 000000	0		0 0	0 0	59.00
60.00	06000 LABORATORY	0. 000000	4, 931		0 0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000	4, 731		0 0	0	64.00
65. 00	06500 RESPI RATORY THERAPY	0. 000000	0		0 0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 000000	140, 770		0 0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 000000	0		0 0	0	67.00
68.00	06800 SPEECH PATHOLOGY	0. 000000	0		0 0	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000	0		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000	1, 259		0	0	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000	0		0	0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	0. 002686	34, 305		2 0	0	73. 00
73. 01	07302 OP PHARMACY	0. 000000	0		0	0	73. 01
74. 00	07400 RENAL DI ALYSI S	0. 000000	0		0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0		0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000	0		0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 000000	0		0 0	0	76. 97
00 00	OUTPATIENT SERVICE COST CENTERS  09000 CLINIC	0.000000	0		0 0		00.00
90. 00 90. 01	09000 CLINIC 09001 OP ONCOLOGY INFUSION CENTER	0. 000000 0. 000000	0		0 0	0	
90.01	09002 WOUND CARE CENTER	0. 000000	0			0	90.01
	09002 WOOND CARE CENTER	0. 000000	0		0 0	0	1
	109005 PATH CLINIC	0.000000	0		0 0	0	

0. 000000

0. 000000

0. 000000

0. 000000

0

92

0

184, 272

0

90.05

0 94.00 95.00 0 200.00

0 91. 00

0 92.00

90. 05 09005 OP PSYCH CLINIC

94. 00 | 09400 | HOME PROGRAM DI ALYSI S 95. 00 | 09500 | AMBULANCE SERVI CES

91.00

92.00

200.00

09100 EMERGENCY
09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS

Total (lines 50 through 199)

Health Financial Systems	IU HEALTH BLOOMINGTON	N HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST	Р	Provider CCN: 15-0051	Peri od: From 01/01/2019	Worksheet D-1	
			To 12/31/2019	Date/Time Prep 6/29/2020 8:50	
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	

		Title XVIII	Hospi tal	6/29/2020 8: 50 PPS	<u>6 am</u>
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS				
	I NPATI ENT DAYS				
1. 00 2. 00 3. 00	Inpatient days (including private room days and swing-bed days, excluding newborn) Inpatient days (including private room days, excluding swing-bed and newborn days) Private room days (excluding swing-bed and observation bed days). If you have only private room days,			48, 022 48, 022 0	1. 00 2. 00 3. 00
4. 00 5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost				4. 00 5. 00
6.00	reporting period Total swing-bed SNF type inpatient days (including private roc reporting period (if calendar year, enter 0 on this line)	m days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	0	7. 00
8. 00	Total swing-bed NF type inpatient days (including private room reporting period (if calendar year, enter 0 on this line)	days) after December 3	l of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to newborn days) (see instructions)			16, 995	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or through December 31 of the cost reporting period (see instruct		oom days)	0	10. 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or December 31 of the cost reporting period (if calendar year, er	iter O on this line)	,	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including private	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar years).	ear, enter O on this line	e)	0	13. 00
14. 00 15. 00	Medically necessary private room days applicable to the Progra Total nursery days (title V or XIX only)	m (excluding swing-bed	days)	0	14. 00 15. 00
16. 00					16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	s through December 31 o	the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0. 00	18. 00
19. 00	Medicald rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0. 00	19. 00
20. 00	Medicald rate for swing-bed NF services applicable to services reporting period	after December 31 of t	ne cost	0. 00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through Decembe		ng period (line	54, 676, 888 0	21. 00 22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	g period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December $ 7 \times 1 $ ine 19)	31 of the cost reporti	ng period (line	0	24. 00
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	1 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		0 54, 676, 888	26. 00 27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			2., 3.0, 500	
	General inpatient routine service charges (excluding swing-bed	and observation bed cha	arges)	0	
29. 00	Private room charges (excluding swing-bed charges)			0	29. 00
30. 00 31. 00	Semi-private room charges (excluding swing-bed charges) General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	30. 00 31. 00
32. 00	Average private room per diem charge (line 29 ÷ line 3)	11116 20)		0.00000	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
34. 00	Average per diem private room charge differential (line 32 mir	us line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		., 0,13)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	,		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost a 27 minus line 36)	and private room cost di	ferential (line	54, 676, 888	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	STMENTS			
38. 00 39. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line	•		1, 138. 58 19, 350, 167	38. 00 39. 00
40. 00	Medically necessary private room cost applicable to the Progra	•		0	40.00
41. 00	Total Program general inpatient routine service cost (line 39			19, 350, 167	41.00

		U HEALTH BLOOMI!		N 45 6254		eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC	CN: 15-0051	Period: From 01/01/2019		
					To 12/31/2019	Date/Time Prep 6/29/2020 8:50	
	Cook Cooker December 1	T-+-1	_	XVIII	Hospi tal	PPS	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		1.00	2.00	col . 2)	4.00	4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3. 00 0. 0	4. 00	5. 00	42. 00
	Intensive Care Type Inpatient Hospital Units		0 700			0.700.004	
43. 00 44. 00	INTENSIVE CARE UNIT	7, 254, 215 5, 742, 690	3, 798 3, 605	1, 910. 0 1, 592. 9			
45.00	BURN INTENSIVE CARE UNIT	5,7.12,676	0, 000	., 0,2.	2, 323	1, 027, 000	45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT NEONATAL INTENSIVE CARE UNIT	4, 122, 013	3, 139	1, 313. 1	6 0		46. 00 47. 00
47.00	Cost Center Description	4, 122, 013	3, 137	1, 313.	0	O	47.00
48. 00	Program inpatient ancillary service cost (Wk	st D 2 col 2	Line 200)			1. 00 31, 312, 664	48. 00
	Total Program inpatient costs (sum of lines			ns)		57, 423, 108	•
FO 00	PASS THROUGH COST ADJUSTMENTS	-41441		William D. Trim	-£ D 1	1 005 022	F0 00
50. 00	Pass through costs applicable to Program inp	atient routine	services (Trom	WKST. D, SUM	OT Parts I and	1, 895, 932	50.00
51. 00	Pass through costs applicable to Program inp	atient ancillar	y services (fr	om Wkst. D, s	um of Parts II	1, 115, 244	51. 00
52. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)				3, 011, 176	52. 00
53. 00	Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	etist, and	54, 411, 932	53. 00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
	Program di scharges					0	
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1
57. 00	Difference between adjusted inpatient operat	ing cost and ta	rget amount (I	ine 56 minus	line 53)	0	57. 00
58. 00 59. 00	0 Bonus payment (see instructions)						58. 00 59. 00
37.00	market basket			•	impounded by the		
60. 00 61. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00	ı
01.00	which operating costs (line 53) are less that						01.00
62.00	amount (line 56), otherwise enter zero (see instructions)  Relief payment (see instructions)					0	62. 00
	00 Allowable Inpatient cost plus incentive payment (see instructions)					o o	
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST  Medicare swing-bed SNF inpatient routine costs through December 31 of the cost reporting period (See						64. 00
	instructions)(title XVIII only)						
65. 00	Medicare swing-bed SNF inpatient routine cos instructions) (title XVIII only)	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions)  O Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period					0	67. 00
40.00	(line 12 x line 19)	o costs often D	ocombor 21 of	the cost rone	erting ported		40.00
00.00	O   Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)					0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient routine costs (line 67 + line 68)					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NURSING FACILITY, AND ICF/IID ONLY Skilled nursing facility/other nursing facility/ICF/IID routine service cost (line 37)						70. 00
71. 00 72. 00	,,						71. 00 72. 00
73. 00							73. 00
74.00	Total Program general inpatient routine serv	•		arkahaat D. F	low+ II oolumn		74.00
75. 00	Capital-related cost allocated to inpatient routine service costs (from Worksheet B, Part II, column 26, line 45)					75. 00	
76.00	Per diem capital related costs (line 75 ÷ li	,					76.00
77. 00 78. 00	Program capital-related costs (line 9 x line 76)   Inpatient routine service cost (line 74 minus line 77)						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess costs (from provider records)					79. 00	
80. 00 81. 00	Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79) Inpatient routine service cost per diem limitation					80. 00 81. 00	
82. 00	Inpatient routine service cost limitation (line 9 x line 81)						82. 00
83. 00 84. 00							83. 00 84. 00
85.00							85. 00
86. 00	0 Total Program inpatient operating costs (sum of lines 83 through 85) PART IV - COMPUTATION OF OBSERVATION BED PASS THROUGH COST					86. 00	
87. 00	Total observation bed days (see instructions					4, 420	87. 00
88.00	Adjusted general inpatient routine cost per Observation bed cost (line 87 x line 88) (se	•	line 2)			1, 138. 58 5, 032, 524	
U7. UU	longer ration her cost (Time of x Time 88) (Se	e manuchons)				J, USZ, SZ4	J 07. UU

Health Financial Systems	J HEALTH BLOOMINGTON HOSPITAL			In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Period: Worksheet D-		
				From 01/01/2019 To 12/31/2019	Date/Time Prep 6/29/2020 8:50	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	4, 041, 243	54, 676, 888	0. 07391	1 5, 032, 524	371, 959	90.00
91.00 Nursing School cost	0	54, 676, 888	0.00000	5, 032, 524	0	91.00
92.00 Allied health cost	0	54, 676, 888	0.00000	5, 032, 524	0	92.00
93.00 All other Medical Education	0	54, 676, 888	0. 000000	5, 032, 524	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10		
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0051	Peri od: From 01/01/2019	Worksheet D-1	
	Component CCN: 15-T051	To 12/31/2019	Date/Time Prepared: 6/29/2020 8:56 am	
	Title XVIII	Subprovi der -	PPS	

		II the Aviii	I RF	FF3	
	Cost Center Description				
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 083	1.00
2.00	Inpatient days (including private room days, excluding swing-b			3, 083 0	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days, do not complete this line.				3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 083	4. 00
5.00	Total swing-bed SNF type inpatient days (including private roo		31 of the cost	0	5. 00
4 00	reporting period	om dava) aftar Dagambar 3	11 of the cost	0	4 00
6. 00	Total swing-bed SNF type inpatient days (including private roor reporting period (if calendar year, enter 0 on this line)	om days) after becember 3	or the cost	0	6. 00
7.00	Total swing-bed NF type inpatient days (including private room	n 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)	n days) after December 31	of the cost	0	8. 00
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	1, 789	9. 00
	newborn days) (see instructions)				
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII or		nom davs) after	o	11. 00
	December 31 of the cost reporting period (if calendar year, er	nter 0 on this line)	Join days) ares.	Ĭ	00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI)	( only (including private	e 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 XI)	( only (including private	room days)	o	13. 00
13.00	after December 31 of the cost reporting period (if calendar ye			ŏ	13.00
14.00	Medically necessary private room days applicable to the Progra	am (excluding swing-bed d	lays)	0	14.00
15.00	Total nursery days (title V or XIX only)			0	15.00
16. 00	Nursery days (title V or XLX only) SWING BED ADJUSTMENT			0	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service	es through December 31 of	the cost	0.00	17. 00
	reporting period				
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of t	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
	reporting period	g			
20. 00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of th	ne cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	:)		3, 171, 582	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ng period (line	0, 171, 002	22. 00
	5 x line 17)				
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	31 of the cost reporting	period (line 6	0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reportin	ng period (line	0	24. 00
	7 x line 19)	•			
25. 00	Swing-bed cost applicable to NF type services after December 3 x line 20)	31 of the cost reporting	period (line 8	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)		3, 171, 582	27. 00
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT		\		00.00
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cha	irges)	0	28. 00 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	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	
33. 00 34. 00	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mir	nue lina 33)(saa instruct	i one)	0. 00 0. 00	
35. 00	Average per diem private room cost differential (line 34 x line)		.1 0113)	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 a	and private room cost dif	ferential (line	3, 171, 582	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, 028. 73	
39. 00	Program general inpatient routine service cost (line 9 x line	•		1, 840, 398	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39			0 1, 840, 398	40. 00 41. 00
<del>-</del> 1. 00	Trocal Trogram general impatrent routine service cost (IIIIe 37		ı	1, 040, 370	<del>-</del> 1. 00

	Financial Systems IL	J HEALTH BLOOMIN	NGTON HOSPITAL		In Lie	eu of Form CMS-2 Worksheet D-1	
COMPUT	ATTON OF INPATTENT OPERATING COST			CCN: 15-0051 CCN: 15-T051	From 01/01/2019 To 12/31/2019	Date/Time Pre	pared:
			Title	e XVIII	Subprovider -	6/29/2020 8: 5 PPS	<u>6 am</u>
	Cost Center Description	Total Inpatient Costl	Total npatient Davs	Average Per Diem (col. 1		Program Cost (col. 3 x col.	
		1. 00	2. 00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	0	0				42. 00
43. 00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	0	O	0. (	00 0	0	43.00
44. 00	CORONARY CARE UNIT	0	O	1		0	44. 00
45. 00 46. 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT						45. 00 46. 00
	NEONATAL INTENSIVE CARE UNIT	0	C	0.	00 0	0	47. 00
	Cost Center Description					1.00	
48. 00	Program inpatient ancillary service cost (Wks					1, 662, 353	•
49. 00	Total Program inpatient costs (sum of lines 4 PASS THROUGH COST ADJUSTMENTS	11 through 48)(	see instructio	ons)		3, 502, 751	49. 00
50.00	Pass through costs applicable to Program inpa	atient routine s	services (from	n Wkst. D, sur	m of Parts I and	217, 149	50.00
51. 00		atient ancillar	v services (fr	om Wkst. D. s	sum of Parts II	56, 132	51.00
	and IV)		, , , , , , , , , , , , , , , , , , , ,				
52. 00 53. 00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		ated non-phy	vsician anestl	netist and	273, 281 3, 229, 470	1
	medical education costs (line 49 minus line 5					5, ==1, 115	
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55. 00	Target amount per discharge						55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ng cost and tai	rget amount (L	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)	· ·			ŕ	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost repmarket basket	porting period (	ending 1996, u	ipdated and co	ompounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year of					0.00	60.00
61. 00	If line 53/54 is less than the lower of lines which operating costs (line 53) are less than					0	61.00
	amount (line 56), otherwise enter zero (see i		3 (TITIES 54 X	00), 01 1% 0	the target		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive payme	ant (see instru	ctions)				62. 00 63. 00
03.00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	03.00
64. 00	Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)	ts through Decer	mber 31 of the	e cost reporti	ng period (See	0	64. 00
65. 00		ts after Decembe	er 31 of the c	ost reporting	g period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routin	na costs (lina /	64 nlue line 6	5)(+i+la YVII	II only) For	0	66. 00
00.00	CAH (see instructions)	ie costs (Title t	54 prus rine c	os)(title xvii	ir only). To		00.00
67. 00	Title V or XIX swing-bed NF inpatient routine (line 12 x line 19)	e costs through	December 31 c	of the cost re	eporting period	0	67. 00
68. 00	Title V or XIX swing-bed NF inpatient routine	e costs after De	ecember 31 of	the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient i	routine costs (I	ine 67 + line	68)		0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facili				<b>)</b>		70.00
71. 00	Adjusted general inpatient routine service of				,		71.00
72. 00 73. 00	Program routine service cost (line 9 x line 3 Medically necessary private room cost applications)	,	(lino 14 v li	no 25)			72. 00 73. 00
74. 00	Total Program general inpatient routine servi						74.00
75. 00	Capital-related cost allocated to inpatient (26, line 45)	routine service	costs (from W	lorksheet B, I	Part II, column		75. 00
76. 00	Per diem capital-related costs (line 75 ÷ lin	ne 2)					76. 00
77. 00 78. 00							77. 00 78. 00
79. 00	Inpatient routine service cost (line 74 minus Aggregate charges to beneficiaries for excess	.*	rovi der record	ls)			79. 00
80.00	.00 Total Program routine service costs for comparison to the cost limitation (line 78 minus line 79)						80.00
81. 00 82. 00	Inpatient routine service cost per diem limit Inpatient routine service cost limitation (li		)				81. 00 82. 00
83. 00	Reasonable inpatient routine service costs (s	see instructions					83. 00
84. 00 85. 00	Program inpatient ancillary services (see ins Utilization review - physician compensation		ns)				84. 00 85. 00
86. 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	Adjusted general inpatient routine cost per	diem (line 27 ÷	line 2)			0.00	88. 00
89. 00	Observation bed cost (line 87 x line 88) (see	e instructions)				0	89.00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2019		
		Component (	CN: 15-1051	To 12/31/2019	Date/Time Prep 6/29/2020 8:50	oarea: 6 am
		Title	XVIII	Subprovi der -	PPS	J dili
		11 11 0	XVIII	IRF	113	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	374, 218	3, 171, 582	0. 11799	1 0	0	90.00
91.00 Nursing School cost	0	3, 171, 582	0.00000	0 0	0	91.00
92.00 Allied health cost	0	3, 171, 582	0. 00000	0	0	92.00
93.00 All other Medical Education	0	3, 171, 582	0. 00000	0 0	0	93.00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	eu of Form CMS-	2552-10	
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0051	Peri od: From 01/01/2019	Worksheet D-1	
		To 12/31/2019	Date/Time Pre 6/29/2020 8:5	
	Title XIX	Hospi tal	PPS	
Cost Center Description				
			1. 00	
PART I - ALL PROVIDER COMPONENTS				

	Title XIX Hospital	PPS	
	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, 022	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	48, 022	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)	43, 602	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cos	t 0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
0.00	reporting period (if calendar year, enter 0 on this line)		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)	1 212	0.00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)	1, 212	9. 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	o	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
	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) through December 31 of the cost reporting period	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	o	13. 00
13.00	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		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)	3, 025	15.00
16. 00	Nursery days (title V or XIX only)	1, 445	16. 00
47.00	SWING BED ADJUSTMENT	0.00	47.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period	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
	reporting period		.0.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	54, 676, 888	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (lin	e 0	22. 00
22.00	5 x line 17)	,	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line x line 18)	6 0	23. 00
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
26. 00	X line 20)   Total swing-bed cost (see instructions)	o	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	54, 676, 888	27. 00
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	2.17 2.12 7 22 2	
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	29. 00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
32. 00 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	32. 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 (lin	e 54, 676, 888	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)	1, 138. 58	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	1, 379, 959	39. 00
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	40. 00
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	1, 379, 959	

Heal th	Financial Systems I	U HEALTH BLOOMING	STON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CC		Period: From 01/01/2019	Worksheet D-1	
					To 12/31/2019	Date/Time Pre	
			Ti +I	e XIX	Hospi tal	6/29/2020 8: 50 PPS	<u> </u>
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
		Inpatient Cost In	npatient Days		÷	(col. 3 x col.	
		1.00	2.00	col . 2) 3.00	4. 00	4) 5. 00	
42. 00	NURSERY (title V & XIX only)	1, 713, 960	3, 025	566. 6			42. 00
42.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT	7, 254, 215	3, 798	1, 910. 0	1 917	1 751 470	42.00
43. 00 44. 00	CORONARY CARE UNIT	5, 742, 690	3, 798 3, 605	1, 910. 0		1, 751, 479 0	43. 00 44. 00
45. 00		3,112,213	-,	.,			45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT	4 122 012	2 120	1 212 1	6 283	371, 624	46. 00
47.00	NEONATAL INTENSIVE CARE UNIT  Cost Center Description	4, 122, 013	3, 139	1, 313. 1	0  203	371,024	47.00
						1. 00	
48. 00	Program inpatient ancillary service cost (Wk Total Program inpatient costs (sum of lines			ne)		1, 868, 390 6, 190, 189	
49.00	PASS THROUGH COST ADJUSTMENTS	41 (111 Ough 40) (Se	e mstructro	115)		0, 190, 109	49.00
50.00	Pass through costs applicable to Program inp	oatient routine se	ervices (from	Wkst. D, sum	of Parts I and	291, 081	50.00
51. 00	<pre>         Pass through costs applicable to Program ing</pre>	natient ancillary	services (fr	nm Wkst D si	ım of Parts II	78, 243	51. 00
01.00	and IV)	acrone unor rary	301 11 003 (11	om with b, si	am or rares rr	70,210	
52.00	Total Program excludable cost (sum of lines					369, 324	
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line	9 1	atea, non-pny:	sician anestn	etist, and	5, 820, 865	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	,					
54. 00 55. 00	Program discharges Target amount per discharge					0	54. 00 55. 00
56. 00	Target amount (line 54 x line 55)					0.00	56. 00
57. 00	Difference between adjusted inpatient operat	ing cost and targ	get amount (li	ine 56 minus I	ine 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	porting ported or	odina 1006 u	ndated and co	mpounded by the	0 00	58. 00 59. 00
39.00	market basket	eportring perrou er	idi iig 1996, u	puateu anu coi	iipounded by the	0.00	39.00
60.00	Lesser of lines 53/54 or 55 from prior year					0.00	60.00
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		(	00), 0. 1% 0.	the tallget		
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ont (soo instruct	tions)			0	62. 00 63. 00
03.00	PROGRAM I NPATIENT ROUTINE SWING BED COST	ient (see mstruct	i ons)			U	03.00
64. 00		sts through Decemb	oer 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos</pre>	sts after December	31 of the c	nst renortina	neriod (See	0	65. 00
00.00	instructions) (title XVIII only)						00.00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line 64	1 plus line 6	5)(title XVII	only). For	0	66. 00
67. 00	,	ne costs through [	December 31 o	f the cost re	porting period	0	67. 00
(0.00	(line 12 x line 19)						
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	ne costs after Dec	cember 31 or	tne cost repo	rting perioa	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER N Skilled nursing facility/other nursing facil						70. 00
71.00	Adjusted general inpatient routine service of	-					71.00
72. 00	Program routine service cost (line 9 x line						72. 00
73. 00 74. 00	Medically necessary private room cost application of the cost application of t			ne 35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient			orksheet B, Pa	art II, column		75. 00
7/ 00	26, line 45)	2)					7/ 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minu	ıs line 77)					78. 00
79.00	Aggregate charges to beneficiaries for exces	` '		<b>*</b> .	is line 70)		79. 00
80. 00 81. 00	Total Program routine service costs for comp Inpatient routine service cost per diem limi		st iimitatiON	(1116 10 111111	us IIIIC /9)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ine 9 x line 81)					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in	•	)				83. 00 84. 00
85. 00	Utilization review - physician compensation		s)				85. 00
86. 00	Total Program inpatient operating costs (sum	of lines 83 thro					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					4, 420	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷ l	ine 2)			1, 138. 58	88. 00
89. 00	Observation bed cost (line 87 x line 88) (se	ee instructions)				5, 032, 524	89. 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 CC		Peri od:	Worksheet D-1	
				From 01/01/2019 To 12/31/2019	Date/Time Prep 6/29/2020 8:50	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH (	COST					
90.00 Capital -related cost	4, 041, 243	54, 676, 888	0. 07391	1 5, 032, 524	371, 959	90.00
91.00 Nursing School cost	0	54, 676, 888	0.00000	5, 032, 524	0	91.00
92.00 Allied health cost	0	54, 676, 888	0.00000	5, 032, 524	0	92.00
93.00 All other Medical Education	0	54, 676, 888	0. 00000	5, 032, 524	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provider CCN: 15-0051	Peri od: From 01/01/2019	Worksheet D-1
	Component CCN: 15-T05	To 12/31/2019	Date/Time Prepared: 6/29/2020 8:56 am
	Title XIX	Subprovi der -	PPS
		IDE	

Debt 1. 1.000 DR CREAMPORNINS  1.00  Impatient days (including private room days and saing bed days, excluding nestorn) Inpatient days (including private room days, excluding seting bed and neaborn days) 1.00 Impatient days (including private room days, excluding seting bed and neaborn days) 1.00 Impatient days (including private room days, excluding seting bed and neaborn days) 1.00 Impatient days (including private room days, excluding seting bed and neaborn days) 1.00 Impatient days (including private room days) 1.00 Impatient days (incl			II the XIX	I RF	FF3	
NAME     ALL PROVIDER COMPONENTS		Cost Center Description				
INPARTIENT DAYS		DADT I ALL DDOVIDED COMPONENTS			1.00	
1.00   Inpatt ent days (Including private room days and swing-bed days, excluding newborn)   3.083   2.00						
Private room days (excluding swing-bed and observation bed days). If you have only private room days   0   3.003	1.00		s, excluding newborn)		3, 083	1. 00
do not complete finis line.  4. 05 Sell-private room days (excluding swing-bed and observation bed days)  1. 10 Total swing-bed SW type inpatient days. (Including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line)  7. 00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line)  8. 00 Total swing-bed W type inpatient days (including private room days) becember 31 of the cost proporting period (if calendar year, enter 0 on this line)  9. 00 Total swing-bed W type inpatient days (including private room days) after December 31 of the cost proporting period (if calendar year, enter 0 on this line)  10. 00 Saing-bed SW type inpatient days applicable to the Program (excluding swing-bed and newbork days) (see instructions)  11. 00 Saing-bed SW type inpatient days applicable to this swing-bed swing-bed and proporting period (see instructions)  12. 00 Saing-bed SW type inpatient days applicable to this swing-bed						
5.08 Semi-private room days (excluding swing-bed And observation bed days) 5.08 Total swing-bed SK type inpatient days (including private room days) after December 31 of the cost proporting period (if cale ander year, enter 0 on this 11 ne) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period (if cale ander year, enter 0 on this 11 ne) 7.00 Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost proporting period (if cale ander year, enter 0 on this 11 ne) 7.00 Total inpatient days including private room days) after December 31 of the cost proporting period (if cale ander year, enter 0 on this 11 ne) 7.00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and proposed SW type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if cale ander year, enter 0 on this 11 ne) 7.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if cale ander year, enter 0 on this 11 ne) 7.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 7.01 Total inversery days (if it is V or XIX only (including private room days) 7.02 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 7.01 Total private room days applicable to services through December 31 of the cost reporting period (if cale ander year, enter 0 on this 11 ne) 7.01 Medically necessary private room days applicable to services through December 31 of the cost reporting period (in the Swing-bed NF services applicable to services through December 31 of the cost reporting period (in the Swing-bed NF services applicable to services through December 31 of the cost reporting period (line 3 x x in the 1) 7.00 Medical rate for swing-bed NF services applicable to services after December 31 of	3. 00		(s). If you have only pri	vate room days,	0	3. 00
Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost operating period (if call-endar year, enter 0 on this line) reporting period (if call-endar year) reporting period (if call-endar year) reporting period (if call-endar year) reporting period (if call-endar year) reporting period (if call-endar year) reporting period (if call-endar year) reporting period (if call-endar year) reporting period (if period year) reporting period (if call-endar year) reporting period (if period year) reporting peri	4 00		ed days)		3 083	4 00
1   Total swing-bed SMF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   7.00				31 of the cost		
reporting period (if calendar year, enter 0 on this line) 7. 00 Total swing-bed Ni type Inpatient days (Including private room days) through December 31 of the cost 8. 00 Total swing-bed Ni type Inpatient days (Including private room days) after December 31 of the cost 9. 00 Total swing-bed Ni type Inpatient days (Including private room days) after December 31 of the cost 10. 00 Swing-bed SNF type Inpatient days applicable to the Program (excluding swing-bed and 10. 00 Swing-bed SNF type Inpatient days applicable to the Program (excluding swing-bed and 10. 00 Swing-bed SNF type Inpatient days applicable to the Program (excluding private room days) 11. 00 Swing-bed SNF type Inpatient days applicable to the Program (excluding private room days) 11. 00 Swing-bed SNF type Inpatient days applicable to the Program (excluding private room days) 11. 00 Swing-bed SNF type Inpatient days applicable to titles V or XIX only (Including private room days) 12. 00 Swing-bed NF type Inpatient days applicable to titles V or XIX only (Including private room days) 13. 00 Swing-bed NF type Inpatient days applicable to the Program (excluding swing-bed days) 14. 00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 15. 00 Total nursery days (Litle V or XIX only) 17. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 18. 00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 19. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 Medical drate for swing-bed SNF services applicable to services after December 31 of the cost 19. 00 North of the cost 19. 00 Nor						
Total saring-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period   Total saring-bed NF type inpatient days (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)   Total inpatient days including private room days applicable to the Program (excluding swing-bed and   0   0.00   Total inpatient days including private room days applicable to the Program (excluding swing-bed and   0   0.00   Swing-bed SNF type inpatient days applicable to the Itle XVII in utility (including private room days) after   0   10.00   Swing-bed SNF type inpatient days applicable to title XVII in utility (including private room days) after   0   11.00   Swing-bed SNF type inpatient days applicable to title XVII in utility (including private room days) after   0   12.00   Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)   12.00   13.00   Swing-bed WF type inpatient days applicable to titles V or XIX only (including private room days)   12.00   13.00   Swing-bed WF type inpatient days applicable to titles V or XIX only (including private room days)   13.00   13.0	6. 00		om days) after December 3	1 of the cost	0	6. 00
reporting period	7 00		days) through December	31 of the cost	0	7 00
reporting pieriod (if Calendar year, enter 0 on this line)  10. 00 Total inpatient days including private room days applicable to the Program (excluding swing-bed and newborn days) (see instructions)  10. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)  11. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after on through December 31 of the cost reporting period (see instructions)  12. 00 Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after of through December 31 of the cost reporting period to the XVIII only (including private room days) after of through December 31 of the cost reporting period (swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 3.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 3.00 Swing-bed NF type inpatient days applicable to title XVIII only (including private room days) after 3.00 Swing-bed NF type inpatient days applicable to the Program (excluding swing-bed days) 1.1. 00	7.00		radys) through becomber	01 01 110 0031		7.00
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newborn days) (see Instructions)   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00   0   10.00	0.00				(1	0.00
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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)  12.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  13.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)  14.00 Medical Iv necessary private room days applicable to titles V or XIX only (including private room days)  15.00 Total nursery days (title V or XIX only)  15.00 Total nursery days (title V or XIX only)  17.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including swing-bed days)  18.00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost reporting period (including period days)  19.00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period (including period days)  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including period days)  19.00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost reporting period (including period days)  19.00 Medical dar for the ord swing-bed NF services applicable to services after December 31 of the cost reporting period (including period days)  19.00 Medical dar farte for swing-bed NF services applicable to services after December 31 of the cost reporting period (including period days)  19.00 Medical dar farte for swing-bed NF services applicable to services after December 31 of the cost reporting period (line S x line 17)  20.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line S x line 18)  21.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (l	10.00		nly (including private ro	om days)	0	10. 00
December 31 of the cost reporting period (if calendar year, enter 0 on this line)   12.00		through December 31 of the cost reporting period (see instruct	i ons)			
12.00   Swing-bed NF type Inpatient days applicable to titles V or XIX only (including private room days)   0   12.00	11. 00	Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private ro	om days) after	0	11. 00
through December 31 of the cost reporting period 31.00 Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days) 0 13.00 fafter December 31 of the cost reporting period (if callendar year, enter 0 on this line) 14.00 Medically necessary private room days applicable to the Program (excluding swing-bed days) 0 14.00 15.00 Total nursery days (title V or XIX only) 1 1,445 16.00 Nursery days (title V or XIX only) 1 1,445 16.00 Nursery days (title V or XIX only) 1 1,405 16.00 Nursery days (title V or XIX only) 1 1,405 1 1,00 Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost 1 0,00 Proporting period 1 0,00 Medicare rate for swing-bed NF services applicable to services after December 31 of the cost 1 0,00 Proporting period 1 0,00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 1 0,00 Proporting period 2 0,00 Medical drate for swing-bed NF services applicable to services after December 31 of the cost 2 0,00 Swing-bed cost applicable to SNF type services through December 31 of the cost 2 0,00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 2 0,00 Medical drate for swing-bed SNF type services through December 31 of the cost reporting period (line 6 x line 18) 3 0,00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 3 0,00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20) 5 0 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20) 5 0 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 20) 5 0 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 5 0 Swing-bed cost applicable to NF type services after December 31 of the cost reporting peri	12 00			room days)	0	12 00
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14.00   Medically necessary private room days applicable to the Program (excluding swing-bed days)   0   14.00   16.00   10.	13.00	Swing-bed NF type inpatient days applicable to titles V or XI>			0	13. 00
15.00   Total nursery days (title V or XIX only)   15.00   1,445   16.00   16.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   17.00   18.00   1		1 91 \	· · · · ·	,	ا	
1.445   16.00   Nursery days (title v or XIX only)   1.445   16.00   17.00   17.00   18.00   18.00   18.00   18.00   18.00   18.00   19.00			am (excluding swing-bed d	ays)		
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reporting period  18. 00 Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period 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) 3,171.582 21.00 22.00 Sing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 5. Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) 24.00 7. Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18) 24.00 7. Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 3, 171, 582 27.00 Recental inpatient routine service costs net of swing-bed cost (line 21 minus line 26) 3, 171, 582 27.00 Recental inpatient routine service cost net of swing-bed and observation bed charges) 28.00 Private room charges (excluding swing-bed charges) 0.20 0.00 20.00 Recental inpatient routine service cost/charge ratio (line 27 + line 28) 0.00 0.00 30.00 Recental inpatient routine service cost/charge ratio (line 27 + line 28) 0.00 0.00 30.00 Recental inpatient routine service cost/charge ratio (line 27 + line 28) 0.00 0.00 30.00 Recental inpatient routine service cost december 30 Recental Recental Recental Recental Recental Recental Recental Recental Recental Recental Recental Recental Recental Recental Recental Recental Recental Recental Rec					.,	,
18. 00   Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost reporting period   19. 00   19. 0	17. 00		es through December 31 of	the cost	0.00	17. 00
reporting period Medical drate for swing-bed NF services applicable to services through December 31 of the cost 0.00 19.00 reporting period 20.00 Medical drate 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) 3.171.582 21.00 Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line 5 x line 17) 22.00 Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18) Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 6 x line 19) 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 7 x line 19) 25.00 Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20) 25.00 Total swing-bed cost (see instructions) 26.00 Total swing-bed cost (see instructions) 3.171.582 77.00 Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26) 3.171.582 77.00 Private room charges (excluding swing-bed charges) 0.29.00 Semi-private room charges (excluding swing-bed charges) 0.29.00 Semi-private room charges (excluding swing-bed charges) 0.29.00 Semi-private room per diem charge (line 29 + line 3) 0.000 32.00 Average per inprivate room per diem charge (line 29 + line 3) 0.000 33.00 Average per diem private room cost differential (line 30 x line 4) 0.000 33.00 Average per diem private room cost differential (line 3 x line 35) 0.000 Average per diem private room cost differential (line 3 x line 35) 0.000 Average per diem private room cost differential (line 3 x line 35) 0.000 Average per diem private room cost differential (line 3 x line 35) 0.000 Average per diem private room cost differential (line 3 x line 35) 0.000 Average per diem private room cost differential (line 3 x line 35) 0.000 Average per diem private room cost diffe	10 00	' 3 '	os after December 21 of t	ho cost	0.00	10 00
19.00   Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period   20.00   20	10.00		arter becomber 31 or t	ne cost	0.00	10.00
20.00   Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period   21.00   Total general inpatient routine service cost (see instructions)   3,171,582   21.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 5 x line 17)   23.00   Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 6 x line 18)   24.00   Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   25.00   Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)   26.00   Total swing-bed cost (see instructions)   26.00   27.00   Ceneral inpatient routine service cost net of swing-bed cost (line 21 minus line 26)   3,171,582   27.00   27.00   PRI VATE ROOM DIFFERENTIAL ADJUSTMENT   28.00   Ceneral inpatient routine service charges (excluding swing-bed and observation bed charges)   28.00   29.00   2	19. 00	Medicaid rate for swing-bed NF services applicable to services	s through December 31 of	the cost	0.00	19. 00
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5 x line 17)  Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6 x line 18)  24.00  Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 7 x line 19)  25.00  Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 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)  General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  Semi-private room charges (excluding swing-bed charges)  December 31 of the cost reporting period (line 8 x line 20)  27.00  28.00  29.00  Private ROOM DIFFERENTIAL ADJUSTMENT  Semi-private room charges (excluding swing-bed charges)  December 31 of the cost reporting period (line 8 x line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  Semi-private room charges (excluding swing-bed charges)  December 31 of the cost reporting period (line 8 x line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  Semi-private room charges (excluding swing-bed charges)  December 31 of the cost reporting period (line 8 x line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENT  December 31 of the cost reporting period (line 8 x line 21 minus line 26)  Private room charges (excluding swing-bed cost (line 21 minus line 26)  Private room charges (excluding swing-bed charges)  December 31 of the cost reporting period (line 8 x line 21 minus line 26)  PRIVATE ROOM DIFFERENTIAL ADJUSTMENTS  PRIVATE ROOM DIFFERENTIAL ADJUSTMENTS  PRIVATE ROOM DIFFERENTIAL ADJUSTMENTS  PRIVATE ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFERENTIAL ROOM DIFFE	21. 00		5)		3, 171, 582	21. 00
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24. 00  24. 00  7 x line 19)  25. 00  8 wing-bed cost applicable to NF type services through December 31 of the cost reporting period (line 8 7 x line 19)  26. 00  26. 00  7 total swing-bed cost (see instructions)  26. 00  27. 00  28. 00  29. 00  29. 00  20. 00	23.00		31 of the cost reporting	perrou (Trile o	o l	23.00
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x line 20) 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  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) OPTIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) OPTIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 General inpatient routine service charges (excluding swing-bed and observation bed charges) OPTIVATE ROOM DIFFERENTIAL ADJUSTMENT  28.00 Semi-private room charges (excluding swing-bed charges) OPTIVATE ROOM DIFFERENTIAL ADJUSTMENT  29.00 Private room charges (excluding swing-bed charges) OPTIVATE ROOM DIFFERENTIAL ADJUSTMENTS  Average private room charges (excluding swing-bed cost and private room cost differential (line 30 + line 4) OPTIVATE ROOM DIFFERENTIAL ADJUSTMENTS  Adjusted general inpatient routine service cost per diem charge (line 30 + line 31) OPTIVATE ROOM DIFFERENTIAL ADJUSTMENTS  Adjusted general inpatient routine service cost per diem charge (line 31 + line 32) OPTIVATE ROOM DIFFERENTIAL ADJUSTMENTS  Adjusted general inpatient routine service cost per diem charge (line 34 x line 35) OPTIVATE ROOM DIFFERENTIAL ADJUSTMENTS  Adjusted general inpatient routine service cost per diem charge (line 34 x line 35) OPTIVATE ROOM DIFFERENTIAL ADJUSTMENTS  ADJUSTM	05.00	l				05.00
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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-pri vate room charges (excluding swing-bed charges)  30. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  31. 00 General inpatient routine service cost/charge ratio (line 27 + line 28)  32. 00 Average pri vate room per diem charge (line 29 + line 3)  33. 00 Average semi-pri vate room per diem charge (line 30 + line 4)  34. 00 Average per diem pri vate room charge differential (line 32 minus line 33) (see instructions)  35. 00 Average per diem pri vate room cost differential (line 34 x line 31)  36. 00 Pri vate room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 171, 582)  38. 00 Adjusted general inpatient routine service cost per diem (see instructions)  39. 00 Program general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 28. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  29. 00  20. 00  30. 00  31. 00  32. 00  32. 00  32. 00  33. 00  Average per diem private room cost differential (line 32 minus line 33)(see instructions)  0 .00 33. 00  34. 00  35. 00  36. 00 Private room cost differential (line 3 x line 31)  0 .00 35. 00  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 171, 582)  37. 00  38. 00 Algusted general inpatient routine service cost per diem (see instructions)  38. 00 Algusted general inpatient routine service cost (line 9 x line 38)  38. 00 Algusted general inpatient routine service cost (line 9 x line 38)  39. 00 Algusted general inpatient routine service cost (line 9 x line 38)  40. 00 Medically necessary pri	26. 00					
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29. 00 Pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  30. 00 Semi-pri vate room charges (excluding swing-bed charges)  31. 00 Average pri vate room per diem charge (line 27 ÷ line 28)  32. 00 Average pri vate room per diem charge (line 30 ÷ line 4)  32. 00 Average per diem private room charge differential (line 32 minus line 33)(see instructions)  32. 00 Average per diem private room cost differential (line 34 x line 31)  33. 00 Average per diem private room cost differential (line 3 x line 35)  34. 00 Private room cost differential adjustment (line 3 x line 35)  36. 00 Private room cost differential adjustment (line 3 x line 35)  37. 00 General inpatient routine service cost net of swing-bed cost and private room cost differential (line 3, 171, 582)  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)  40. 00 Medically necessary private room cost applicable to the Program (line 14 x line 35)  0 40. 00	20.00					20.00
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	41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		62, 753	41.00

		J HEALTH BLOOMING			In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider CC		Peri od: From 01/01/2019	Worksheet D-1	
			·	CCN: 15-T051	To 12/31/2019	6/29/2020 8:5	
				e XIX	Subprovi der - I RF	PPS	
	Cost Center Description	Total Inpatient Cost Ir	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
42. 00	NURSERY (title V & XIX only)	1.00	2.00	3. 00	4.00	5. 00	42. 00
42.00	Intensive Care Type Inpatient Hospital Units	l ol	O <sub>I</sub>	0. (	0	0	42.00
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	0. ( 0. (		l .	
45. 00	BURN INTENSIVE CARE UNIT			0. (	0		45. 00
46.00	SURGICAL INTENSIVE CARE UNIT		0	0.4	00 0		46.00
47.00	NEONATAL INTENSIVE CARE UNIT   Cost Center Description	0	0	0.0	0	0	47. 00
40.00	Drogram i proti est escillary comi co cost (Mile	n+ D 2 and 2	Line 200)			1.00	40.00
48. 00 49. 00	Program inpatient ancillary service cost (Wk: Total Program inpatient costs (sum of lines - PASS THROUGH COST ADJUSTMENTS			ns)		61, 153 123, 906	
50.00	Pass through costs applicable to Program inp	atient routine s	ervices (from	Wkst. D, sur	n of Parts I and	7, 404	50. 00
51. 00	Pass through costs applicable to Program inpand IV)	atient ancillary	services (fr	om Wkst. D, s	sum of Parts II	2, 045	51. 00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				9, 449	52. 00
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line		ated, non-phy	sician anesth	netist, and	114, 457	53. 00
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54.00
55.00	Target amount per discharge					0.00	55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operati	ing cost and tare	net amount (1	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)				ŕ	0	1
59. 00	Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the market basket						
60.00							60.00
61. 00	which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target						61. 00
62. 00	amount (line 56), otherwise enter zero (see instructions) 62.00 Relief payment (see instructions)						62. 00
63. 00	63.00 Allowable Inpatient cost plus incentive payment (see instructions)						63. 00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cost instructions) (title XVIII only)	ts through Decemb	ber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decembe	r 31 of the c	ost reportino	period (See	0	65. 00
66. 00	<pre>instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routing</pre>	ne costs (line 6	4 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through I	December 31 o	f the cost re	eporting period	0	67. 00
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after De	cember 31 of	the cost repo	orting period	0	68. 00
69. 00	Total title V or XIX swing-bed NF inpatient					0	69. 00
70. 00	PART III - SKILLED NURSING FACILITY, OTHER NU Skilled nursing facility/other nursing facil	<u>.</u>					70. 00
71. 00	Adjusted general inpatient routine service co	ost per diem (li		,			71. 00
72. 00 73. 00	Program routine service cost (line 9 x line Medically necessary private room cost applications)	,	(line 14 v li	ne 35)			72. 00 73. 00
74. 00	Total Program general inpatient routine serv		•	110 00)			74. 00
75. 00	Capital-related cost allocated to inpatient 26, line 45)		costs (from W	orksheet B, F	Part II, column		75. 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li    Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus	s line 77)					78. 00
79. 00 80. 00							79. 00 80. 00
81. 00							81.00
82. 00 83. 00	Inpatient routine service cost limitation (I		<b>)</b>				82. 00 83. 00
83.00	Reasonable inpatient routine service costs (: Program inpatient ancillary services (see in:		)				84.00
85. 00	Utilization review - physician compensation	(see instructions					85. 00
86.00	Total Program inpatient operating costs (sum PART IV - COMPUTATION OF OBSERVATION BED PASS		ougn 85)				86. 00
87. 00	Total observation bed days (see instructions)	)				0	
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see	•	ııne 2)			l e	88. 00 89. 00
. ==	,	,				,	

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2019 To 12/31/2019		
		Ti tl	e XIX	Subprovi der – I RF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	374, 218	3, 171, 582	0. 11799	1 0	0	90.00
91.00 Nursing School cost	0	3, 171, 582	0. 00000	0	0	91.00
92.00 Allied health cost	0	3, 171, 582	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	3, 171, 582	0. 00000	0	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL			In Lieu of Form CMS-2552-10
INDATIENT ANGLE ADVICE COCT ADDODTIONMENT		D: CON 15 0051	D!!	W

Heal th Finar	ncial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL		In Li€	eu of Form CMS-2	2552-10
	NCILLARY SERVICE COST APPORTIONMENT		Provi der Co	CN: 15-0051	Peri od:	Worksheet D-3	
					From 01/01/2019		
					To 12/31/2019	Date/Time Pre	pared:
			<b></b>	201111		6/29/2020 8:5	<u>6 am</u>
			litle	XVIII	Hospi tal	PPS	
	Cost Center Description			Ratio of Cos	•	Inpatient	
				To Charges		Program Costs	
					Charges	(col. 1 x col.	
				1.00	0.00	2)	
LAIDAT	THENT POLITIME CERVILOE COCT OFNITERS			1.00	2. 00	3. 00	
	I ENT ROUTINE SERVICE COST CENTERS			ı	F4 0F2 01F	I	20.00
1	ADULTS & PEDIATRICS				54, 853, 015	l .	30.00
	INTENSIVE CARE UNIT				9, 859, 259	l .	31.00
	CORONARY CARE UNIT				8, 565, 092		32. 00
	NEONATAL INTENSIVE CARE UNIT				40 510		35. 00
	SUBPROVIDER - IRF				48, 510		41. 00
	SUBPROVI DER				0		42.00
	NURSERY						43. 00
	LARY SERVICE COST CENTERS			1 0 0003	02 27 021 040	2 424 454	E0 00
1	OPERATING ROOM			0.0903			1
1	CV SURGERY			0.0000		0	
1	RECOVERY ROOM			0. 1960 0. 2238			1
	DELIVERY ROOM & LABOR ROOM			•			1
	ANESTHESI OLOGY   RADI OLOGY-DI AGNOSTI C			0.0000		_	
	l e e e e e e e e e e e e e e e e e e e			0. 1468			1
	RADI OLOGY-THERAPEUTI C			0.0602			1
	RADI OI SOTOPE			0.0000		_	56.00
	CT SCAN			0.0513			1
	MAGNETIC RESONANCE I MAGING (MRI)			0. 0831			1
	CARDI AC CATHETERI ZATI ON			0.0459			1
	LABORATORY			0. 1741			1
1	I NTRAVENOUS THERAPY			0.0000		1 470 405	
	RESPI RATORY THERAPY			0. 3084			1
	PHYSI CAL THERAPY			0. 3766			1
	OCCUPATIONAL THERAPY			0.0000		0	1
	SPEECH PATHOLOGY ELECTROCARDI OLOGY			0.0000			68. 00 69. 00
1	ELECTROCARDI OLOGI			0. 0694 0. 1245			1
1	MEDICAL SUPPLIES CHARGED TO PATIENTS	•		0. 1245			1
1	IMPL. DEV. CHARGED TO PATIENTS	•		0. 1814			
1	DRUGS CHARGED TO PATTENTS			0. 2109			
	OP PHARMACY			0. 1943		0, 307, 402	1
1	RENAL DIALYSIS			0. 3634			1
	ASC (NON-DISTINCT PART)			0. 0000		787, 043	1
	PSYCHIATRIC/PSYCHOLOGICAL SERVICES			0.0000		0	1
	CARDI AC REHABILI TATI ON			0.3400			
	TIENT SERVICE COST CENTERS			0. 3400	30 173, 377	37,020	70. 77
	CLINIC			1. 3047	89 26, 645	34, 766	90.00
-	OP ONCOLOGY INFUSION CENTER			0. 2392			1
	WOUND CARE CENTER			0. 1782			1
	PAIN CLINIC			0. 2079			1
	OP PSYCH CLINIC			1. 0585			1
	EMERGENCY			0. 0698			
	OBSERVATION BEDS (NON-DISTINCT PART)			0. 1373			1
	REIMBURSABLE COST CENTERS			0. 1073	, 555, 105	52,515	1
	HOME PROGRAM DIALYSIS			0.0000	00 0	0	94. 00
	AMBULANCE SERVICES						95. 00
200. 00	Total (sum of lines 50 through 94 ar	nd 96 through 98)			204, 055, 242	31, 312, 664	1
201. 00	Less PBP Clinic Laboratory Services-		(line 61)		0		201. 00
202. 00	Net charges (line 200 minus line 201				204, 055, 242		202. 00
- 1	, , , , , , , , , , , , , , , , , , , ,	-		•	, , , , , , , , , , , , , , , , , , , ,	•	

Heal th	ı Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der Co	CN: 15-0051	Peri od:	Worksheet D-3	
		Component (	CCN: 15-T051	From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:5	pared: 6 am
		Ti tl e	XVIII	Subprovi der - I RF	PPS	
	Cost Center Description		Ratio of Cos	t Inpatient	Inpati ent	
			To Charges	Program Charges	Program Costs (col. 1 x col. 2)	
			1.00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00	03000 ADULTS & PEDIATRICS			0		30. 00
31. 00	03100 I NTENSI VE CARE UNI T			0		31. 00
32. 00	03200 CORONARY CARE UNIT			0		32. 00
35. 00	02060 NEONATAL INTENSIVE CARE UNIT			0 000 000		35. 00
41.00	04100 SUBPROVI DER - I RF			3, 882, 388		41.00
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY			0		42. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00	05000 OPERATING ROOM		0. 09030	37, 484	3, 385	50.00
50. 00	05000 OF ERATTING ROOM		0.00000		0, 303	50. 00
51. 00	05100 RECOVERY ROOM		0. 19607		-	
52. 00	05200 DELIVERY ROOM & LABOR ROOM		0. 22385			52.00
53. 00	05300 ANESTHESI OLOGY		0.00000		0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 14682		5, 946	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 06024	7 4, 287	258	55. 00
56.00	05600 RADI OI SOTOPE		0. 00000	00	0	56. 00
57. 00	05700 CT SCAN		0. 05130			
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 08319		372	
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 04597		0	59. 00
60.00	06000 LABORATORY		0. 17412			1
64.00	06400 I NTRAVENOUS THERAPY		0.00000		0	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY		0. 30849			65. 00
67. 00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY		0. 37665 0. 00000			66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY		0.00000		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY		0.06944		-	•
70. 00	07000 ELECTROENCEPHALOGRAPHY		0. 12458			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 18145			71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 21093			72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 19457	0 627, 111	122, 017	73. 00
73. 01	07302 OP PHARMACY		0. 00000	00	0	73. 01
74.00	07400 RENAL DIALYSIS		0. 36346	147, 448	53, 592	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		0. 00000		0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0. 00000		0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 34005	46, 803	15, 915	76. 97
	OUTPATIENT SERVICE COST CENTERS					
90.00			1. 30478			90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER		0. 23920			90. 01

0.178228

0.207983

1.058571

0.069831

0.137332

0.000000

33, 140

5, 091, 561

5, 091, 561

0 90.02

90.03

91.00

94.00

95.00

201.00

202. 00

0 90.05

0 92.00

1, 662, 353 200. 00

2, 314

90. 02 09002 WOUND CARE CENTER

09003 PAIN CLINIC

09100 EMERGENCY

09005 OP PSYCH CLINIC

94. 00 09400 HOME PROGRAM DIALYSIS

95. 00 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART)

Net charges (line 200 minus line 201)

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61)

OTHER REIMBURSABLE COST CENTERS

90.03

90.05

91.00

92.00

200.00

201.00

Health Financial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL	In Lie	u of Form CMS-2552-10
INDATI ENT ANGLE ADVICEDULOE COCT ADDODTI ONMENT		D ' 1 OON 45 OOE4	D . I	W I I I D O

		ICILLARY SERVICE COST APPORTIONMENT	Provi der C		Peri od:	Worksheet D-3	
INPAII	ENI A	NCILLARY SERVICE COST APPORTIONMENT	Provider C	CN. 13-0031	From 01/01/2019		
					To 12/31/2019		nared:
					10 12/31/2017	6/29/2020 8:5	6 am
			Ti tl	e XIX	Hospi tal	PPS	<u> </u>
		Cost Center Description	11 61	Ratio of Cos		Inpati ent	
		cost center bescription		To Charges	Program	Program Costs	
				To charges			
					Charges	(col . 1 x col .	
				4.00	0.00	2)	
	I			1.00	2. 00	3. 00	
	INPAI	IENT ROUTINE SERVICE COST CENTERS				1	
30. 00		ADULTS & PEDIATRICS			4, 418, 286		30. 00
31. 00		INTENSIVE CARE UNIT			1, 048, 197		31.00
32.00	03200	CORONARY CARE UNIT			123, 962		32.00
35.00	02060	NEONATAL INTENSIVE CARE UNIT			1, 127, 046		35. 00
41.00	04100	SUBPROVI DER - I RF			0		41.00
42.00		SUBPROVI DER			0		42.00
43. 00		NURSERY			235, 924		43. 00
10.00		LARY SERVICE COST CENTERS		1	200, 721		10.00
50. 00		OPERATI NG ROOM		0. 0903	926, 313	83, 649	50.00
50. 00		CV SURGERY		0.0000			ı
							1
51.00		RECOVERY ROOM		0. 1960			
52. 00		DELIVERY ROOM & LABOR ROOM		0. 2238			
53.00		ANESTHESI OLOGY		0.0000		0	53. 00
54.00		RADI OLOGY-DI AGNOSTI C		0. 1468			
55.00	05500	RADI OLOGY-THERAPEUTI C		0.0602	17 81, 806	4, 929	55.00
56.00	05600	RADI OI SOTOPE		0.0000	00	0	56. 00
57.00	05700	CT SCAN		0. 0513	08 195, 765	10, 044	57. 00
58. 00	05800	MAGNETIC RESONANCE IMAGING (MRI)		0. 0831			
59. 00	05900	CARDI AC CATHETERI ZATI ON		0. 0459			
60.00		LABORATORY		0. 1741			
		INTRAVENOUS THERAPY		0.0000		243, 030	
64. 00						-	64. 00
65.00		RESPI RATORY THERAPY		0. 3084			
66. 00		PHYSI CAL THERAPY		0. 3766			
67. 00		OCCUPATIONAL THERAPY		0.0000			67. 00
68. 00		SPEECH PATHOLOGY		0.0000		0	
69. 00		ELECTROCARDI OLOGY		0.0694	14 200, 857	13, 948	69. 00
70.00	07000	ELECTROENCEPHALOGRAPHY		0. 1245	35 119, 612	14, 902	70. 00
71.00	07100	MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 1814	601, 008	109, 057	71. 00
72.00	07200	IMPL. DEV. CHARGED TO PATIENTS		0. 2109	1, 403, 973	296, 143	72. 00
73.00		DRUGS CHARGED TO PATIENTS		0. 1945	70 2, 333, 984	454, 123	73.00
73. 01		OP PHARMACY		0.0000		0	1
74. 00		RENAL DIALYSIS		0. 3634		45, 552	
75. 00		ASC (NON-DISTINCT PART)		0.0000			
75. 01		PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.0000		Ö	75. 01
76. 97		CARDI AC REHABI LI TATI ON		0. 3400			
10. 71	OUTDA	TIENT SERVICE COST CENTERS		0.3400	7, 347	2,477	70. 77
90. 00		CLINIC		1 2047	20	1 0	90.00
				1. 3047		1	
90. 01		OP ONCOLOGY INFUSION CENTER		0. 2392			
90. 02		WOUND CARE CENTER		0. 1782		0	
90. 03		PAIN CLINIC		0. 2079		0	
90. 05		OP PSYCH CLINIC		1. 0585			
91.00	09100	EMERGENCY		0. 0698	1, 123, 995		
92.00	09200	OBSERVATION BEDS (NON-DISTINCT PART)		0. 1373	31, 142	4, 277	92.00
		REIMBURSABLE COST CENTERS					
94.00		HOME PROGRAM DIALYSIS		0.0000	00	0	94. 00
95. 00		AMBULANCE SERVICES					95. 00
200.00		Total (sum of lines 50 through 94 and 96 through 98)			10, 999, 242	1, 868, 390	
201.00		Less PBP Clinic Laboratory Services-Program only charges	(line 61)		.5, ,,,, 242	1, 555, 576	201.00
201.00	1	Net charges (line 200 minus line 201)	, (TITIE OT)		10, 999, 242		202.00
202.00	-1	mot sharges (Title 200 millios Title 201)		1	10, 777, 242	I	1202.00

	F:	LIL UEALTH DI COMMINISTON MOCDITA			6.5. 0116.	0550 40
	Financial Systems ENT ANCILLARY SERVICE COST APPORTIONMENT	IU HEALTH BLOOMINGTON HOSPITA	CCN: 15-0051	Period:	eu of Form CMS-2 Worksheet D-3	
INIAII	ENT ANGIELANT SERVICE 6031 ATTORTTONWENT			From 01/01/2019		
		Component	CCN: 15-T051	To 12/31/2019	Date/Time Pre 6/29/2020 8:5	pared:
-		Ti	tle XIX	Subprovi der - I RF	PPS	<del>o un</del>
	Cost Center Description		Ratio of Cos		Inpati ent	
	, , , , , , , , , , , , , , , , , , ,		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
			1.00	0.00	2)	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		1.00	2. 00	3. 00	
30. 00	03000 ADULTS & PEDIATRICS			0	4	30.00
31. 00	03100 INTENSIVE CARE UNIT			Ö	1	31.00
32. 00	03200 CORONARY CARE UNIT			0	1	32. 00
35.00	02060 NEONATAL INTENSIVE CARE UNIT			0	,	35. 00
41.00	04100 SUBPROVI DER - I RF			128, 100	,	41. 00
42.00	04200 SUBPROVI DER			0	,	42. 00
43.00	04300 NURSERY			0		43. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM		0. 0903			
50. 01 51. 00	05001 CV SURGERY 05100 RECOVERY ROOM		0.0000			
51.00	05200 DELIVERY ROOM & LABOR ROOM		0. 1960 0. 2238			
53. 00	05300 ANESTHESI OLOGY		0. 2238			
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 1468		-	
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 0602		0	55. 00
56.00	05600 RADI OI SOTOPE		0.0000		0	56. 00
57.00	05700 CT SCAN		0. 0513	08 744	38	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 0831	95 0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 0459		0	
60.00	06000 LABORATORY		0. 1741		1	
64.00	06400   NTRAVENOUS THERAPY		0.0000		1	64.00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY		0. 3084 0. 3766		0 53, 021	65. 00 66. 00
67. 00	06700 OCCUPATI ONAL THERAPY		0.0000		1	1
68. 00	06800 SPEECH PATHOLOGY		0.0000		1	1
69. 00	06900 ELECTROCARDI OLOGY		0.0694		Ō	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 1245		0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	5	0. 1814	56 1, 259	228	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 2109		0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 1945		1	
73. 01	07302 OP PHARMACY		0.0000		0	
74. 00	07400 RENAL DIALYSIS		0. 3634		_	
75. 00 75. 01	07500   ASC (NON-DISTINCT PART)   03550   PSYCHIATRIC/PSYCHOLOGICAL SERVICES		0. 0000 0. 0000		0	
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 3400			1
70. 77	OUTPATIENT SERVICE COST CENTERS		0.3400	30  0		70. 77
90.00	09000 CLI NI C		1. 3047	89 0	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER		0. 2392	06 0	0	1
90. 02	09002 WOUND CARE CENTER		0. 1782		0	
90. 03	09003 PAIN CLINIC		0. 2079		1	
90.05	09005 OP PSYCH CLINIC		1. 0585		1	
91.00	09100 EMERGENCY		0.0698		_	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 1373	32 0	0	92.00

0.000000

184, 272

184, 272

94.00

95.00

201.00

202. 00

61, 153 200. 00

Total (sum of lines 50 through 94 and 96 through 98)

Less PBP Clinic Laboratory Services-Program only charges (line 61) Net charges (line 200 minus line 201)

OTHER REIMBURSABLE COST CENTERS

94. 00 09400 HOME PROGRAM DIALYSIS

95. 00 09500 AMBULANCE SERVICES

200.00

201.00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form	CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	Peri od: From 01/01/2019 Part A To 12/31/2019 Date/Ti me 6/29/2020	e Prepared:

PRS				10 12/31/2019	0/29/2020 8:5	
MART A - INPATE INF HOSPITAL SERVICES WORE IPPS   1.00   BRS Amounts other than outlier payments for discharges occurring prior to October 1 (see   32, 312, 464   1.01   1.02   1.02   1.02   1.02   1.03			Title XVIII	Hospi tal		
MART A - INPATE INF HOSPITAL SERVICES WORE IPPS   1.00   BRS Amounts other than outlier payments for discharges occurring prior to October 1 (see   32, 312, 464   1.01   1.02   1.02   1.02   1.02   1.03						
1.00   DRG Amounts other than outlier payments for discharges occurring prior to October 1 (see   32, 312, 484   1.01   DRG Amounts other than outlier payments for discharges occurring on or after October 1 (see   32, 312, 484   1.01   DRG For Federal specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (see instructions)   1.08   DRG For Federal specific operating payment for Model 4 BPCI for discharges occurring on or after 0.1   0.00   1.00   1.00   0.00		DADT A LABOUT HOODITH OFFINIORS INDED LIDE			1. 00	
1.01   1.02   1.03					0	1 00
1.0.2   DRG amounts other than outlier payments for discharges occurring on or after October 1 (see Instructions)   1.0.2		DRG amounts other than outlier payments for discharges occurr	ing prior to October 1 (	see		1. 00
DRC For Federial specific operating payment for Model 4 BPCI for discharges occurring prior to October 1 (See Instructions)   0.00	1.02	DRG amounts other than outlier payments for discharges occurr	ing on or after October	1 (see	10, 963, 222	1. 02
DR6 for federal specific operating payment for Model 4 BPCI for discharges occurring on or after   0   1.04	1. 03	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	prior to October	0	1. 03
2.00         Outlier payments for discharges (see instructions)         2.00           2.01         Outlier preconcil lation amount         0         2.01           2.02         Outlier payments for discharges occurring prior to October 1 (see instructions)         91,983         2.02           2.02         Outlier payments for discharges occurring prior to October 1 (see instructions)         283,877         2.00           3.00         Managed Care Similated Payments         283,877         2.00           4.00         Autlier payments for discharges occurring on or after October 1 (see instructions)         283,877         2.00           5.00         Managed Care Similated Payments         4.00         4.00         4.00           6.00         Term count for all opaths of the payments of the managed of the payments	1. 04	DRG for federal specific operating payment for Model 4 BPCI fo	or discharges occurring	on or after	0	1. 04
2.02         Outlier payment for discharges cocurring prior to October 1 (see instructions)         90         2.03           2.03         Outlier payments for discharges occurring on or after October 1 (see instructions)         283,877         2.04           3.00         Managed Gare Simula total Payments         0         3.03         8.03         9.03         3.03         8.03         9.03         3.03         9.03         3.03         9.03         3.03         9.03         3.03         9.03         3.03         9.03         3.03         3.03         9.03         3		Outlier payments for discharges. (see instructions)				2.00
0utilier payments for discharges occurring prior to October 1 (see instructions)			i ana)			
20.4   Outlier payments for discharges occurring on or after October 1 (see instructions)   0.0						
Managed Care Simulated Payments   0   3.00						
Bed days available divided by number of days in the cost reporting period (see Instructions)   261.81   4.00			(see Histructions)			ł
Indirect Medical Education Adjustment			rting period (see instru	ctions)		ł
or before 12/31/1996. (see instructions)  6. 00 FTE count for all oppathic and osteopathic programs that meet the criteria for an add-on to the cap for new programs in accordance with 42 CFR 413.79(e)  7. 00 MM. Section 422 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(8)(2) If the cost report straddles July 1, 2011 then see instructions and steepathic report straddles July 1, 2011 then see instructions affiliated programs in accordance with 42 CFR 813.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).  8. 01 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  8. 02 The amount of increase if the hospital was awarded FTE cap slots under \$ 5503 of the ACA. If the cost under \$ 5506 of ACA. (see instructions).  9. 03 Sum of lines \$ plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8, 01 and 8, 02) (see 0.00 of 10.00 of 1187tructions).  10. 00 FTE count for residents and osteopathic programs in the current year from your records.  10. 01 The found for residents in dental and poolistric programs.  10. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions).  10. 02 The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under \$ 5506 of ACA. (see instructions).  10. 03 Total all all all on the FTE (see instructions).  10. 04 The found for residents and dental and poolistric programs.  10. 05 The found for residents and dental and poolistric programs.  10. 05 The found for residents and dental and poolistric programs.  10. 01 Total all combile FTE count for the prior year.  10. 02 The found for the prior year.  10. 03 The found for the prior year.  10. 04 Just ment for residents and splaced by program or hospital closure.  10. 05 The found for program or hospital closure.  10. 06 The found for the prior year year.  10. 07 The fou		Indirect Medical Education Adjustment				
new programs in accordance with 42 CFR 413.79(e) 7.00 MM Section 422 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(1) 7.01 ACA § 5503 reduction amount to the IME cap as specified under 42 CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July 1, 2011 then see instructions. 8.00 Adjustment (increase or decrease) to the FTE count for all lopathic and osteopathic programs for a FTI listed programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002). 8.01 The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions. 8.02 The amount of increase if the hospital was awarded FTE cap slots under § 5506 of ACA. (see instructions) 9.03 Sun of lines § plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions) 10.00 FTE count for allopathic and osteopathic programs in the current year from your records 10.00 ITE count for residents in dental and podiatric programs. 10.00 Current year allowable FTE (see instructions) 10.01 Total allowable FTE count for the prior year. 10.02 Sun of lines § plus be finally 14 divided by 3. 10.03 Sun of lines § 12 through 14 divided by 3. 10.04 Adjustment for residents in initial years of the program 10.05 Adjustment for residents in initial years of the program 10.00 Current year reliated to be a ratio (10 the 18 divided by line 4). 10.00 Current year reliated to be a ratio (10 the 18 divided by line 4). 10.00 Current year residents to be a ratio (see instructions) 10.00 Current year resident to be dratio (see instructions) 10.00 Current year resident to be dratio (see instructions) 10.00 Current year resident to be dratio (see instructions) 10.00 Current year resident to be dratio (see instructions) 10.00 Current year resident to be dratio (see instructions) 10.00 Current year resident to be dratio (see instructions) 10.00 Current year resident to be dratio (see instruction		or before 12/31/1996. (see instructions)	, ,			
ACA \$ 5503 reduction amount to the IME cap as specified under 42 CFR \$412.105(f)(1)(iv)(B)(2) if the cost report straddle sully 1, 2011 then see instructions.		new programs in accordance with 42 CFR 413.79(e)		·		
Adjustment (Increase or decrease) to the FTE count for all lopathic and osteopathic programs for affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50069 (August 1, 2002).						7. 00 7. 01
affiliated programs in accordance with 42 CFR 413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 FR 50609 (August 1, 2002).						
The amount of increase if the hospital was awarded FTE cap slots under § 5503 of the ACA. If the cost report straddles July 1, 2011, see instructions.  The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)  9.00   Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)  10.00   FTE count for allopathic and osteopathic programs in the current year from your records  10.00   FTE count for residents in dental and podiatric programs.  10.00   Total allowable FTE count for the prior year.  10.00   Total allowable FTE count for the prior year.  10.00   Total allowable FTE count for the prount timate year if that year ended on or after September 30, 1997, otherwise enter zero.  10.00   Adjustment for residents displaced by program or hospital closure  10.00   Adjustment for residents displaced by program or hospital closure  10.00   Adjustment for residents displaced by program or hospital closure  10.00   Current year resident to bed ratio (line 18 divided by 1ine 4).  10.00   Current year resident to bed ratio (line 18 divided by 1ine 4).  10.00   Enter the lesser of lines 19 or 20 (see instructions)  10.00   Enter the lesser of lines 19 or 20 (see instructions)  10.00   Enter the lesser of lines 19 or 20 (see instructions)  10.00   Enter the lesser of lines 19 or 20 (see instructions)  10.00   Enter the lesser of lines 10 (line 18 divided or for \$422 of the MMA.  10.00   IME payment adjustment for the Addonn for \$422 of the MMA.  10.00   IME add-on adjustment amount (see instructions)  10.00   Enter the lesser of lines 2 (see instructions)  10.00   Enter the lesser of lines 2 (see instructions)  10.00   Enter the lesser of lines 2 (see instructions)  10.00   Enter the lesser of lines 2 (see instructions)  10.00   Enter the lesser of lines 2 (see instructions)  10.00   Enter the lesser of lines 2 (see instructions)  10.00   Enter the lesser of lines 2 (see instructions)  10.00   Enter th	8. 00	affiliated programs in accordance with 42 CFR 413.75(b), 413.	0.00	8. 00		
The amount of increase if the hospital was awarded FTE cap slots from a closed teaching hospital under § 5506 of ACA. (see instructions)  Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see instructions)  10.00 FTE count for allopathic and osteopathic programs in the current year from your records  11.00 FTE count for residents in dental and podlatric programs.  12.00 Corrent year allowable FTE (see instructions)  13.00 Total allowable FTE count for the prior year.  14.00 Total allowable FTE count for the prior year.  15.00 Sum of lines 12 through 14 divided by 3.  16.00 Adjustment for residents in initial years of the program  16.00 Adjustment for residents displaced by program or hospital closure  17.00 Adjustment for residents displaced by program or hospital closure  18.00 Adjustment for residents (see instructions)  19.00 Current year resident to bed ratio (line 18 divided by line 4).  19.00 Enter the lesser of lines 19 or 20 (see instructions)  10.00 Enter the lesser of lines 19 or 20 (see instructions)  10.00 Enter the lesser of lines 19 or 20 (see instructions)  10.00 IME payment adjustment - Managed Care (see instructions)  10.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105  10.00 Resident to bed ratio (divide line 25 by line 4)  10.00 One resident to bed ratio (divide line 25 by line 4)  10.00 One Resident to bed ratio (divide line 25 by line 4)  10.00 One Resident to bed ratio (divide line 25 by line 4)  10.00 One Resident to bed ratio (divide line 25 by line 4)  10.00 One Resident to bed ratio (divide line 25 by line 4)  10.00 One Resident to bed ratio (divide line 25 by line 4)  10.00 One Resident to bed ratio (divide line 25 by line 4)  10.00 One Resident to bed ratio (divide line 25 by line 4)  10.00 One Resident to bed ratio (divide line 25 by line 4)  10.00 One Resident to bed ratio (divide line 25 by line 4)  10.00 One Resident to bed ratio (divide line 25 by line 4)  10.00 One Resident to bed ratio (divide	8. 01	The amount of increase if the hospital was awarded FTE cap slo	0. 00	8. 01		
Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (8, 8,01 and 8,02) (see   0.00   9.00   10.00   10.00   11.0	8. 02	The amount of increase if the hospital was awarded FTE cap sl	0. 00	8. 02		
10.00   FTE count for allopathic and osteopathic programs in the current year from your records   0.00   10.00   11.00   11.00   12.00   Current year allowable FTE (see instructions)   0.00   12.00   13.00   13.00   10.10   13.0	9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus line	0. 00	9. 00		
12.00 Current year allowable FTE (see instructions) 13.00 Total allowable FTE count for the prior year. 14.00 Total allowable FTE count for the prior year. 15.00 Sum of lines 12 through 14 divided by 3. 16.00 Adjustment for residents in initial years of the program 17.00 Adjustment for residents displaced by program or hospital closure 18.00 Adjustment for residents displaced by program or hospital closure 19.00 Current year resident to bed ratio (line 18 divided by line 4). 19.00 Current year resident to bed ratio (line 18 divided by line 4). 19.00 Current year resident to bed ratio (see instructions) 19.00 Prior year resident to bed ratio (see instructions) 10.00 IME payment adjustment (see instructions) 10.00 IME payment adjustment (see instructions) 10.00 IME payment adjustment (see instructions) 10.00 IME payment adjustment - Managed Care (see instructions) 10.00 IME payment adjustment on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 10.00 IME payments adjustment factor. (see instructions) 20.00 Resident to bed ratio (divide line 25 by line 4) 20.00 IME payments adjustment factor. (see instructions) 20.00 IME payments adjustment factor. (see instructions) 20.00 IME payments adjustment factor. (see instructions) 20.00 IME payments adjustment factor. (see instructions) 20.00 IME payments adjustment factor. (see instructions) 20.00 IME payments adjustment factor. (see instructions) 20.00 IME payments adjustment factor. (see instructions) 20.00 IME payments adjustment amount (see instructions) 20.00 IME payments adjustment amount (see instructions) 20.00 IME payments adjustment amount (see instructions) 20.00 IME payments adjustment amount (see instructions) 20.00 IME payments Amanaged Care (see instructions) 20.00 IME payments Amanaged Care (see instructions) 20.00 IME payments Amanaged Care (see instructions) 20.00 IME payments Amanaged Care (see instructions) 20.00 IME payments Amanaged Care (see instructions) 20.00 IME payments Amanaged Care (see instructions) 20.00 IME payme		FTE count for allopathic and osteopathic programs in the curr		ı		
13.00 Total allowable FTE count for the prior year.  14.00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, on the therwise enter zero.  15.00 Sum of lines 12 through 14 divided by 3.  16.00 Adjustment for residents in initial years of the program 0.00 15.00 16.00 17.00 18.00 18.00 19.00						ı
14. 00 Total allowable FTE count for the penultimate year if that year ended on or after September 30, 1997, otherwise enter zero.  15. 00 Sum of lines 12 through 14 divided by 3.  16. 00 Adjustment for residents in initial years of the program  17. 00 Adjustment for residents displaced by program or hospital closure  18. 00 Adjustment for residents displaced by program or hospital closure  19. 00 Current year resident to bed ratio (line 18 divided by line 4).  19. 00 Prior year resident to bed ratio (see instructions)  19. 00 Enter the lesser of lines 19 or 20 (see instructions)  10. 00 IME payment adjustment (see instructions)  10. 00 IME payment adjustment (see instructions)  10. 00 IME payment adjustment of the Add-on for § 422 of the MMA  23. 00 IME FTE Resident Count Over Cap (see instructions)  24. 00 IME FTE Resident Count Over Cap (see instructions)  25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26. 00 Resident to bed ratio (divide line 25 by line 4)  27. 00 IME payments adjustment factor. (see instructions)  28. 01 IME add-on adjustment amount (see instructions)  10. 00 O00000  27. 00 IME add-on adjustment amount - Managed Care (see instructions)  10. 00 O00000  28. 00 O00000  29. 00 Total IME payment - Managed Care (see instructions)  10. 00 O00000  29. 00 O00000  29. 00 O000000  29. 00 O000000000000000000000000000000000		, , , , , , , , , , , , , , , , , , ,				ı
Otherwise enter zero.   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 closure   0.00   17.00   18.00   18.00   18.00   19.00		, ,				
15.00   Sum of lines 12 through 14 divided by 3.   0.00   15.00   16	14. 00		ar ended on or after Sep	tember 30, 1997,	0.00	14.00
16.00       Adj ustment for residents in initial years of the program       0.00       16.00         17.00       Adj ustment for residents displaced by program or hospital closure       0.00       17.00         18.00       Adj usted rolling average FTE count       0.00       18.00         19.00       Current year resident to bed ratio (see instructions)       0.000000       19.00         20.00       Prior year resident to bed ratio (see instructions)       0.000000       20.00         21.00       Inter the lesser of lines 19 or 20 (see instructions)       0.000000       21.00         22.01       IME payment adj ustment - Managed Care (see instructions)       0       22.00         1 IME payment adj ustment - Managed Care (see instructions)       0       22.00         2.00       IME payment adj ustment for the Add-on for § 422 of the MMA       0         2.10       Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105       0.00         2.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00         25.00       If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see       0.00         26.00       Resident to bed ratio (divide line 25 by line 4)       0.00         27.00       IME payment adjustment amount (see instr	15 00				0.00	15 00
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19.00 Current year resident to bed ratio (line 18 divided by line 4).  20.00 Prior year resident to bed ratio (see instructions)  20.00 Enter the lesser of lines 19 or 20 (see instructions)  21.00 IME payment adjustment (see instructions)  22.01 IME payment adjustment - Managed Care (see instructions)  23.00 IME payment adjustment - Managed Care (see instructions)  23.00 IME payment adjustment - Managed Care (see instructions)  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME payments adjustment factor. (see instructions)  29.00 IME payments adjustment amount (see instructions)  20.00 IME payments adjustment amount - Managed Care (see instructions)  20.00 IME payments adjustment amount - Managed Care (see instructions)  20.00 IME payments adjustment amount - Managed Care (see instructions)  20.00 IME payments adjustment amount - Managed Care (see instructions)  20.00 IME payments adjustment amount - Managed Care (see instructions)  20.00 IME payments adjustment amount - Managed Care (see instructions)  20.00 IME payments - Managed Care (see instructions)  20.00 IME payments - Managed Care (see instructions)  20.00 IME payments - Managed Care (see instructions)  20.00 IME payments - Managed Care (see instructions)  20.00 IME payments - Managed Care (see instructions)  20.00 IME payments - Managed Care (see instructions)  20.00 IME payments - Managed Care (see instructions)  20.00 IME payments - Managed Care (see instructions)  20.00 IME payments - Managed Care (see instructions)  20.00 IME payments - Managed Care (see instructions)  20.00 IME payments - Managed Care (see instructions)  20.00 IME payments - Managed Care (see instructions)  20.00 IME payments - Managed Care (see instructions)  20.00 IME payments - Managed Care (see instructions)  20.00 IME payments - Managed Care (see		, , , , , , , , , , , , , , , , , , , ,	341 6			
20.00 Prior year resident to bed ratio (see instructions) 21.00 Enter the lesser of lines 19 or 20 (see instructions) 22.00 IME payment adjustment (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 22.01 IME payment adjustment - Managed Care (see instructions) 22.01 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 24.00 IME FTE Resident Count Over Cap (see instructions) 25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see 25.00 Resident to bed ratio (divide line 25 by line 4) 27.00 IME payments adjustment factor. (see instructions) 28.00 IME add-on adjustment amount (see instructions) 28.01 IME add-on adjustment amount (see instructions) 29.00 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment (sum of lines 22 and 28) 29.01 Total IME payment - Managed Care (see instructions) 20.00 Disproportionate Share Adjustment 20.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 20.00 Sincological patient days (see instructions) 20.01 Sincological patient days (see instructions) 20.02 Sincological patient days (see instructions) 20.03 Sincological patient days (see instructions) 20.04 Sincological patient days (see instructions) 20.05 Sincological patient days (see instructions) 20.06 Sincological patient days (see instructions) 20.07 Sincological patient days (see instructions) 20.08 Sincological patient days (see instructions) 20.09 Sincological patient days (see instructions) 20.00 Sincological patient days (see instructions) 20.00 Sincological patient days (see instructions) 20.00 Sincological patient days (see instructions) 20.00 Sincological patient days (see instructions) 20.00 Sincological patient days (see instructions) 20.00 Sincological patient days (see instructions) 20.00 Sincological pa		, ,	)			
21.00 Enter the lesser of lines 19 or 20 (see instructions)  22.00 IME payment adjustment (see instructions)  1 IME payment adjustment - Managed Care (see instructions)  1 Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23.00 IME FTE Resident Count Over Cap (see instructions)  24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  1 instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.01 IME add-on adjustment amount (see instructions)  29.00 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  1 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  Percentage of Medicaid patient days (see instructions)  5 .23 30.00  20.000000  21.00  22.01  22.01  22.01  23.00  24.00  25.00  26.00  26.00  27.00  28.00  29		,	, .			
22.00   IME payment adjustment (see instructions)	21. 00					
22. 01 IME payment adjustment - Managed Care (see instructions) Indirect Medical Education Adjustment for the Add-on for § 422 of the MMA  23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412.105 (f)(1)(iv)(C).  24. 00 IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26. 00 Resident to bed ratio (divide line 25 by line 4) 0. 0000000 27. 00 1ME payments adjustment factor. (see instructions) 0. 0000000 27. 00 1ME add-on adjustment amount (see instructions) 0. 0000000 27. 00 1ME add-on adjustment amount - Managed Care (see instructions) 0. 28. 01 1ME add-on adjustment amount - Managed Care (see instructions) 0. 28. 01 29. 01 1Total IME payment ( sum of lines 22 and 28) 0. 29. 01 1Total IME payment - Managed Care (sum of lines 22.01 and 28.01) 0. 01 0. 02 03. 02 03. 03 04. 05 05 06. 06. 07 06. 07 07 08. 07 08. 07 09. 07 09. 07 09. 07 09. 07 09. 07 09. 07 09. 08. 08. 09. 09. 09. 09. 09. 09. 09. 09. 09. 09						22. 00
23. 00 Number of additional allopathic and osteopathic IME FTE resident cap slots under 42 CFR 412. 105  (f) (1) (iv) (C).  24. 00 IME FTE Resident Count Over Cap (see instructions)  25. 00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see  instructions)  26. 00 Resident to bed ratio (divide line 25 by line 4)  27. 00 IME payments adjustment factor. (see instructions)  28. 00 IME add-on adjustment amount (see instructions)  29. 01 IME payment ( sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  20. 00 Valve (CFR 412. 105  0. 00 24. 00  24. 00  25. 00  0. 00 000  26. 00  27. 00  28. 00  29. 01  10 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		IME payment adjustment - Managed Care (see instructions)			0	
24.00 IME FTE Resident Count Over Cap (see instructions)  25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  5.23 30.00  Percentage of Medicaid patient days (see instructions)  24.00  25.00  26.00  27.00  28.01  28.01  29.01  2	23. 00			FR 412. 105	0.00	23. 00
25.00 If the amount on line 24 is greater than -0-, then enter the lower of line 23 or line 24 (see instructions)  26.00 Resident to bed ratio (divide line 25 by line 4)  27.00 IME payments adjustment factor. (see instructions)  28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  20.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  5.23 30.00 Percentage of Medicaid patient days (see instructions)  26.21 31.00	24 00				0.00	24 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)       0.000000       28.00         28.01       IME add-on adjustment amount - Managed Care (see instructions)       0.00000       28.01         29.00       Total IME payment (sum of lines 22 and 28)       0.00000       29.00         29.01       Total IME payment - Managed Care (sum of lines 22.01 and 28.01)       0.00000       29.01         Disproportionate Share Adjustment       9.01         30.00       Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)       5.23       30.00         31.00       Percentage of Medicaid patient days (see instructions)       26.21       31.00		If the amount on line 24 is greater than -O-, then enter the	lower of line 23 or line	24 (see		
27. 00 IME payments adjustment factor. (see instructions)  28. 00 IME add-on adjustment amount (see instructions)  28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 01 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  27. 00  28. 01  29. 01  20. 02  20. 01  20. 02  20. 02  20. 02  20. 03  20. 03  20. 04  20. 05  20. 06  20. 07  20. 07  20. 07  20. 07  20. 08  20. 08  20. 09  20. 00  21. 00  22. 00  23. 00  24. 00  25. 00  26. 21  27. 00  28. 00  29	24 00				0.000000	24 00
28.00 IME add-on adjustment amount (see instructions)  28.01 IME add-on adjustment amount - Managed Care (see instructions)  29.00 Total IME payment (sum of lines 22 and 28)  29.01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  5.23 30.00  31.00 Percentage of Medicaid patient days (see instructions)  28.00  28.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01  29.01						
28. 01 IME add-on adjustment amount - Managed Care (see instructions)  29. 00 Total IME payment (sum of lines 22 and 28)  29. 01 Total IME payment - Managed Care (sum of lines 22. 01 and 28. 01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  30. 00 Percentage of Medicaid patient days (see instructions)  28. 01  29. 00  29. 01  29. 01  29. 01  29. 01  29. 01  29. 01  20. 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 29.00  Disproportionate Share Adjustment  30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions) 5.23 30.00  31.00 Percentage of Medicaid patient days (see instructions) 26.21 31.00			1			•
29. 01 Total IME payment - Managed Care (sum of lines 22.01 and 28.01)  Disproportionate Share Adjustment  30. 00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  5. 23 30. 00  Percentage of Medicaid patient days (see instructions)  29. 01  29. 01  29. 01			)			•
30.00 Percentage of SSI recipient patient days to Medicare Part A patient days (see instructions)  5.23 30.00 Percentage of Medicaid patient days (see instructions)  5.23 30.00 Percentage of Medicaid patient days (see instructions)		Total IME payment - Managed Care (sum of lines 22.01 and 28.0	1)			29. 01
31.00 Percentage of Medicaid patient days (see instructions) 26.21 31.00	20.00	UI Sproporti onate Share Adjustment		±:>	F 00	20.00
			atient days (see instruc	tions)		1
37 OO 1500 OF LINES 30 300 31						1
			`			1
33.00 Allowable disproportionate share percentage (see instructions)  15.15   33.00   34.00   Disproportionate share adjustment (see instructions)  1,639,066   34.00			)			
1, 039, 000   34. 00	J4. UU	יטן אין סיף אין טוומניפי אומויים מען עאַנווויפוונ (אַפּפּי דוואַנו עפנדו טוואַ)			1, 037, 000	1 34.00

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0051	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Pre 6/29/2020 8:50	
		Title XVIII	Hospi tal	PPS	
			Prior to 10/1 1.00	2.00	
	Uncompensated Care Adjustment		1.00	2.00	
5. 00	Total uncompensated care amount (see instructions)			8, 350, 599, 096	1
5. 01	Factor 3 (see instructions)		0. 000480022	0. 000361201	1
5. 02	Hospital uncompensated care payment (If line 34 is zero, ente instructions)	er zero on this line) (se	e 3, 971, 161	3, 016, 243	35.
5. 03	Pro rata share of the hospital uncompensated care payment amo	ount (see instructions)	2, 970, 210	758, 181	35.
6. 00	Total uncompensated care (sum of columns 1 and 2 on line 35.0		3, 728, 391		36.
0. 00	Additional payment for high percentage of ESRD beneficiary di Total Medicare discharges on Worksheet S-3, Part I excluding		gh 46)		40.
). 00	652, 682, 683, 684 and 685 (see instructions)	ur scharges for MS-DNOS			40.
1. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 6	683, 684 an 685. (see	0		41.
4 04	instructions)	DD0 (50 (00 (00 (00			
1. 01	Total ESRD Medicare covered and paid discharges excluding MS- an 685. (see instructions)	-UKGS 652, 682, 683, 684	0		41.
2. 00	Divide line 41 by line 40 (if less than 10%, you do not quali	fy for adjustment)	0.00		42.
3. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652, 68	32, 683, 684 an 685. (see	0		43.
4. 00	instructions) Ratio of average length of stay to one week (line 43 divided	by line 41 divided by 7	0. 000000		44.
4. 00	days)	by Time 41 divided by 7	0.00000		44.
5. 00	Average weekly cost for dialysis treatments (see instructions	•	0.00		45.
6. 00	Total additional payment (line 45 times line 44 times line 41	1. 01)	40, 027, 002		46.
7. 00 8. 00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and MDH, s	small rural hospitals	49, 837, 993 0		47. 48.
0. 00	only. (see instructions)	smarr rarar riospi tars			10.
				Amount	
9. 00	Total payment for inpatient operating costs (see instructions	2)		1. 00 49, 837, 993	10
0.00	Payment for inpatient program capital (from Wkst. L, Pt. I an	•		3, 771, 813	
1. 00	Exception payment for inpatient program capital (Wkst. L, Pt.			0	1
2. 00	Direct graduate medical education payment (from Wkst. E-4, li	ne 49 see instructions).		0	
3. 00 4. 00	Nursing and Allied Health Managed Care payment Special add-on payments for new technologies			59, 038 0	1
4. 01	Islet isolation add-on payment			0	1
5. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, line 6	59)		0	
5. 00	Cost of physicians' services in a teaching hospital (see intr	•		0	
7.00	Routine service other pass through costs (from Wkst. D, Pt. I		hrough 35).	74 103	1 .
3. 00 9. 00	Ancillary service other pass through costs from Wkst. D, Pt. Total (sum of amounts on lines 49 through 58)	IV, Col. II II ne 200)		74, 103 53, 742, 947	
). 00	Primary payer payments			10, 538	
1.00	Total amount payable for program beneficiaries (line 59 minus	s line 60)		53, 732, 409	61.
2. 00	Deductibles billed to program beneficiaries			4, 506, 940	
3. 00 1. 00	Coinsurance billed to program beneficiaries Allowable bad debts (see instructions)			89, 312 418, 793	
5. 00	Adjusted reimbursable bad debts (see instructions)			418, 793 272, 215	
5. 00	Allowable bad debts for dual eligible beneficiaries (see inst	tructions)		170, 372	1
7. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63)			49, 408, 372	67.
3.00	Credits received from manufacturers for replaced devices for			0	
0.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	(101 300 See HISH uction	)   S	0	1
. 50	Rural Community Hospital Demonstration Project (§410A Demonst	tration) adjustment (see	instructions)	0	
. 87	Demonstration payment adjustment amount before sequestration	•	•	0	70.
). 88	SCH or MDH volume decrease adjustment (contractor use only)	trustions)		0	1
	Pioneer ACO demonstration payment adjustment amount (see inst HSP bonus payment HVBP adjustment amount (see instructions)	tructions)		0	70. 70.
				0	
0. 90	[HSP bonus payment HRR adjustment amount (see instructions)			•	
). 90 ). 91	HSP bonus payment HRR adjustment amount (see instructions) Bundled Model 1 discount amount (see instructions)			0	70.
0. 89 0. 90 0. 91 0. 92 0. 93 0. 94				0 -108, 877 0	70

Heal th	Financial Systems	IU HEALTH BLOOMINGT	TON HOSPITAL	-	In Lie	u of Form CMS-:	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT		Provider C	CN: 15-0051	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part A Date/Time Pre 6/29/2020 8:5	pared: 6 am
			Ti tl e	e XVIII	Hospi tal	PPS	
	·			FFY	(yyyy)	Amount	
					0	1. 00	
	Low volume adjustment for federal fiscal y the corresponding federal year for the per	iod prior to 10/1)			0	0	70. 96
	Low volume adjustment for federal fiscal y the corresponding federal year for the per				0	0	70. 97

		FFY (	уууу)	Amount	
		0		1. 00	
70.96 Low volume adjus	stment for federal fiscal year (yyyy) (Enter in column 0	0		0	70. 96
the correspondir	ng federal year for the period prior to 10/1)				
70. 97 Low volume adjus	stment for federal fiscal year (yyyy) (Enter in column 0	0		0	70. 97
	ng federal year for the period ending on or after 10/1)				
70. 98 Low Volume Payme				0	70. 98
1				0	70. 99
1 ,	amount (see instructions)			40 200 405	
	der (line 67 minus lines 68 plus/minus lines 69 & 70)			49, 299, 495	•
1 .	ljustment (see instructions)			985, 990	•
71.02 Demonstration pa	ayment adjustment amount after sequestration			0	71. 02
71.03 Sequestration ad	ljustment-PARHM pass-throughs				71. 03
72.00 Interim payments				48, 496, 373	72. 00
72. 01 Interim payments				10, 170, 070	72. 01
				_	
*	ement (for contractor use only)			0	
	ement-PARHM (for contractor use only)				73. 01
74.00 Balance due prov	vider/program (line 71 minus lines 71.01, 71.02, 72, and			-182, 868	74.00
73)					
74. 01 Bal ance due prov	vider/program-PARHM (see instructions)				74. 01
	s (nonallowable cost report items) in accordance with			988, 036	
	chapter 1, §115.2			700, 030	73.00
	BY CONTRACTOR (lines 90 through 96)			_	
90.00 Operating outlie	er amount from Wkst. E, Pt. A, line 2, or sum of 2.03			0	90. 00
pl us 2.04 (see i	nstructions)				
91.00 Capital outlier	from Wkst. L, Pt. I, line 2			0	91.00
	er reconciliation adjustment amount (see instructions)			0	92.00
1.	reconciliation adjustment amount (see instructions)	i		0	93. 00
1	calculate the time value of money (see instructions)			0. 00	
95.00 Time value of mo	oney for operating expenses (see instructions)			0	95. 00
96.00 Time value of mo	oney for capital related expenses (see instructions)			0	96.00
			Prior to 10/1	On/After 10/1	
			1. 00	2. 00	
HSP Bonus Paymen	t Amount				
	Tilloant				
	(see instructions)		O	0	100 00
100.00 HSP bonus amount	•		0	0	100. 00
100.00 HSP bonus amount HVBP Adjustment	for HSP Bonus Payment				
100.00 HSP bonus amount HVBP Adjustment 101.00 HVBP adjustment	for HSP Bonus Payment factor (see instructions)		0. 0000000000	0. 0000000000	101. 00
100.00 HSP bonus amount HVBP Adjustment 101.00 HVBP adjustment	for HSP Bonus Payment			0. 0000000000	
100.00 HSP bonus amount HVBP Adjustment 101.00 HVBP adjustment 102.00 HVBP adjustment	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions)		0. 0000000000	0. 0000000000	101. 00
100.00 HSP bonus amount HVBP Adjustment 101.00 HVBP adjustment 102.00 HVBP adjustment HRR Adjustment f	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) or HSP Bonus Payment		0. 0000000000	0. 0000000000	101. 00 102. 00
100.00 HSP bonus amount HVBP Adjustment 101.00 HVBP adjustment 102.00 HVBP adjustment HRR Adjustment f 103.00 HRR adjustment	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) for HSP Bonus Payment factor (see instructions)		0.0000000000	0. 000000000 0 0. 0000	101. 00 102. 00 103. 00
100. 00 HSP bonus amount HVBP Adjustment 101. 00 HVBP adjustment 102. 00 HVBP adjustment HRR Adjustment f 103. 00 HRR adjustment f 104. 00 HRR adjustment a	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions)		0. 0000000000	0. 000000000 0 0. 0000	101. 00 102. 00
100.00 HSP bonus amount HVBP Adjustment 101.00 HVBP adjustment 102.00 HVBP adjustment HRR Adjustment f 103.00 HRR adjustment f 104.00 HRR adjustment a Rural Community	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) or HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) Hospital Demonstration Project (§410A Demonstration) Adj		0.0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00
100.00 HSP bonus amount HVBP Adjustment 101.00 HVBP adjustment 102.00 HVBP adjustment HRR Adjustment f 103.00 HRR adjustment f 104.00 HRR adjustment a Rural Community 200.00 Is this the firs	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) Hospital Demonstration Project (§410A Demonstration) Adj st year of the current 5-year demonstration period under		0.0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00
100.00 HSP bonus amount HVBP Adjustment 101.00 HVBP adjustment 102.00 HVBP adjustment HRR Adjustment f 103.00 HRR adjustment f 104.00 HRR adjustment a Rural Community 200.00 Is this the firs	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) or HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) Hospital Demonstration Project (§410A Demonstration) Adj		0.0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00
100.00 HSP bonus amount HVBP Adjustment 101.00 HVBP adjustment 102.00 HVBP adjustment HRR Adjustment f 103.00 HRR adjustment f 104.00 HRR adjustment a Rural Community 200.00 Is this the firs	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) Hospital Demonstration Project (§410A Demonstration) Adj st year of the current 5-year demonstration period under ct? Enter "Y" for yes or "N" for no.		0.0000000000	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00
100.00 HSP bonus amount HVBP Adjustment 101.00 HVBP adjustment 102.00 HVBP adjustment HRR Adjustment f 103.00 HRR adjustment f 104.00 HRR adjustment a Rural Community 200.00 Is this the firs Century Cures Ad Cost Reimburseme	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) Hospital Demonstration Project (§410A Demonstration) Adj st year of the current 5-year demonstration period under st? Enter "Y" for yes or "N" for no.		0.0000000000	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
100. 00 HSP bonus amount HVBP Adjustment 101. 00 HVBP adjustment 102. 00 HVBP adjustment HRR Adjustment f 103. 00 HRR adjustment f 104. 00 HRR adjustment f 200. 00 Is this the first Century Cures Ad Cost Reimburseme 201. 00 Medicare inpatie	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) or HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) Hospital Demonstration Project (§410A Demonstration) Adjust year of the current 5-year demonstration period under ct? Enter "Y" for yes or "N" for no. Interest service costs (from Wkst. D-1, Pt. II, line 49)		0.0000000000	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
100. 00 HSP bonus amount HVBP Adjustment 101. 00 HVBP adjustment 102. 00 HVBP adjustment HRR Adjustment f 103. 00 HRR adjustment f 104. 00 HRR adjustment f 200. 00 Is this the first Century Cures Ac Cost Reimburseme 201. 00 Medicare inpatication	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) or HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) Hospital Demonstration Project (§410A Demonstration) Adj st year of the current 5-year demonstration period under st? Enter "Y" for yes or "N" for no. nt ent service costs (from Wkst. D-1, Pt. II, line 49) rges (see instructions)		0.0000000000	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
100. 00 HSP bonus amount HVBP Adjustment 101. 00 HVBP adjustment 102. 00 HVBP adjustment 103. 00 HRR adjustment f 104. 00 HRR adjustment f 104. 00 HRR adjustment f 200. 00 Is this the first century Cures Accost Reimburseme 201. 00 Medicare inpatic 202. 00 Medicare dischar 203. 00 Case-mix adjustment 203. 00 Case-mix adjustment 204. 00 Medicare dischar 205. 00 Medicare dischar 205. 00 Medicare dischar 206. 00 Medicare dischar 207. 00 Medicare dischar	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) for HSP Bonus Payment factor (see instructions) factor (see instructions) factor (see instructions) factor (see instructions) factor (see instructions) Hospital Demonstration Project (§410A Demonstration) Adj fix year of the current 5-year demonstration period under fixt? Enter "Y" for yes or "N" for no.  Int for service costs (from Wkst. D-1, Pt. II, line 49) fixes (see instructions) factor (see instructions)	the 21st	0. 0000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00
100. 00 HSP bonus amount HVBP Adjustment 101. 00 HVBP adjustment 102. 00 HRR adjustment f 103. 00 HRR adjustment f 104. 00 HRR adjustment f 104. 00 HRR adjustment f 200. 00 Is this the first Century Cures Accost Reimburseme 201. 00 Medicare inpatic 202. 00 Medicare dischar 203. 00 Case-mix adjustment Computation of D	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) or HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) Hospital Demonstration Project (§410A Demonstration) Adj st year of the current 5-year demonstration period under st? Enter "Y" for yes or "N" for no. nt ent service costs (from Wkst. D-1, Pt. II, line 49) rges (see instructions)	the 21st	0. 0000000000 0 0. 0000 0	0. 000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
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100. 00 HSP bonus amount HVBP Adjustment 101. 00 HVBP adjustment 102. 00 HRR adjustment f 103. 00 HRR adjustment f 104. 00 HRR adjustment f 104. 00 HRR adjustment f 200. 00 Is this the first Century Cures Accost Reimburseme 201. 00 Medicare inpatic 202. 00 Medicare dischar 203. 00 Case-mix adjustment Computation of D	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) Hospital Demonstration Project (§410A Demonstration) Adj st year of the current 5-year demonstration period under ct? Enter "Y" for yes or "N" for no. nt ent service costs (from Wkst. D-1, Pt. II, line 49) rges (see instructions) ment factor (see instructions) memonstration Target Amount Limitation (N/A in first year	the 21st	0. 0000000000 0 0. 0000 0	0.000000000 0 0.0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00
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100. 00 HSP bonus amount HVBP Adjustment 101. 00 HVBP adjustment 102. 00 HVBP adjustment HRR Adjustment f 103. 00 HRR adjustment f 104. 00 HRR adjustment f 104. 00 HRR adjustment f 200. 00 Is this the first century Cures Ac Cost Reimburseme 201. 00 Medicare inpatic f 202. 00 Medicare dischar computation of Deperiod) 204. 00 Medicare target 205. 00 Case-mix adjuster	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) or HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) Hospital Demonstration Project (§410A Demonstration) Adj st year of the current 5-year demonstration period under ct? Enter "Y" for yes or "N" for no. nt ent service costs (from Wkst. D-1, Pt. II, line 49) rges (see instructions) hent factor (see instructions) hemonstration Target Amount Limitation (N/A in first year) amount and target amount (line 203 times line 204)	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00
100. 00 HSP bonus amount HVBP Adjustment 101. 00 HVBP adjustment 102. 00 HVBP adjustment HRR Adjustment f 103. 00 HRR adjustment f 104. 00 HRR adjustment f 104. 00 HRR adjustment f 200. 00 Is this the first century Cures Ac Cost Reimburseme 201. 00 Medicare inpatication of Deperiod) 204. 00 Medicare target 205. 00 Case-mix adjustment f 206. 00 Medicare inpatication of Case-mix adjustment f 206. 00 Medicare inpatication of Case-mix adjustment f 206. 00 Medicare inpatication of Case-mix adjustment f 206. 00 Medicare inpatication of Case-mix adjustment f 206. 00 Medicare inpatication of Case-mix adjustment f 206. 00 Medicare inpatication of Case-mix adjustment f 206. 00 Medicare inpatication of Case-mix adjustment f 206. 00 Medicare inpatication of Case-mix adjustment f 206. 00 Medicare inpatication of Case-mix adjustment f 206. 00 Medicare inpatication of Case-mix adjustment f 207. 00 Medicare inpatication of Case-mix adjustment f 208. 00 Medicare inpatication of Case-mix adjustment f 209	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) or HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) amount for HSP bonus payment (see instructions) Hospital Demonstration Project (§410A Demonstration) Adj st year of the current 5-year demonstration period under st? Enter "Y" for yes or "N" for no. int ent service costs (from Wkst. D-1, Pt. II, line 49) rges (see instructions) ment factor (see instructions) memonstration Target Amount Limitation (N/A in first year amount and target amount (line 203 times line 204) ent routine cost cap (line 202 times line 205)	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00
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100. 00 HSP bonus amount HVBP Adjustment 101. 00 HVBP adjustment 102. 00 HVBP adjustment HRR Adjustment HRR Adjustment HRR Adjustment 104. 00 HRR adjustment ARR Adjustment 104. 00 HRR adjustment ARR Adjustment 200. 00 Is this the first Century Cures AC Cost Reimburseme 201. 00 Medicare inpation 202. 00 Medicare discharactorischer Adjustment 203. 00 Case-mix adjustment 204. 00 Medicare target 205. 00 Case-mix adjustment 206. 00 Medicare inpation Adjustment to Medicare Part ARR Adjustment to Medicare Part ARR 209. 00 Adjustment to Medicare Part ARR 209. 00 Reserved for fut 211. 00 Total adjustment	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) or HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) amount for HSP bonus payment (see instructions) Hospital Demonstration Project (§410A Demonstration) Adj st year of the current 5-year demonstration period under out: Enter "Y" for yes or "N" for no. Interest service costs (from Wkst. D-1, Pt. II, line 49) ages (see instructions) ment factor (see instructions) memonstration Target Amount Limitation (N/A in first year amount and target amount (line 203 times line 204) and troutine cost cap (line 202 times line 205) dicare Part A Inpatient Reimbursement sement under the §410A Demonstration (see instructions) inpatient service costs (from Wkst. E, Pt. A, line 59) active use to Medicare IPPS payments (see instructions)	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00
100. 00 HSP bonus amount HVBP Adjustment 101. 00 HVBP adjustment 102. 00 HVBP adjustment HVBP adjustment HRR Adjustment for the second	for HSP Bonus Payment factor (see instructions) amount for HSP bonus payment (see instructions) for HSP Bonus Payment factor (see instructions) factor (see instructions) factor (see instructions) factor (see instructions) factor (see instructions) factor HSP bonus payment (see instructions) factor HSP bonus payment (see instructions) factor HSP bonus payment (see instructions) factor HSP bonus payment (see instructions) factor HSP bonus Payment (see instructions) factor HSP bonus Payment (see instruction) factor HSP bonus Payment (see instruction) for HSP bonus Payment (see instructions) factor HSP bonus Payment (see instructions) factor HSP bonus Payment (see instructions) factor HSP bonus Payment (see instructions) factor HSP Bonus Payment (see instructions)	the 21st	0. 0000000000 0 0. 0000 0	0. 0000000000 0 0. 0000 0	101. 00 102. 00 103. 00 104. 00 200. 00 201. 00 202. 00 203. 00 204. 00 205. 00 206. 00 207. 00 208. 00 209. 00 211. 00
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In Lieu of Form CMS-2552-10

Period: Worksheet E
From 01/01/2019 Part A Exhibit 4
To 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am Health Financial Systems

LOW VOLUME CALCULATION EXHIBIT 4 Provider CCN: 15-0051

						0 12/31/2019	6/29/2020 8: 5	
					XVIII	Hospi tal	PPS	
		W/S E, Part A   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)	
		0	1.00	2.00	3.00	4. 00	5. 00	
1. 00	DRG amounts other than outlier	1. 00	0	0	0		0	1. 00
1. 01	payments DRG amounts other than outlier	1. 01	32, 312, 454	0	32, 312, 454		32, 312, 454	1. 01
1. 02	payments for discharges occurring prior to October 1 DRG amounts other than outlier	1. 02	10, 963, 222	O		10, 963, 222	10, 963, 222	1. 02
	payments for discharges occurring on or after October		,,				,,	
1. 03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	0		0	1. 03
1. 04	DRG for Federal specific operating payment for Model 4 BPCl occurring on or after October 1	1. 04	0	0		0	0	1. 04
2. 00	Outlier payments for discharges (see instructions)	2. 00						2. 00
2. 01	Outlier payments for discharges for Model 4 BPCI	2. 02	0	0	0	0	0	2. 01
2. 02	Outlier payments for discharges occurring prior to October 1 (see instructions)	2. 03	910, 983	0	910, 983		910, 983	2. 02
2. 03	Outlier payments for discharges occurring on or after October 1 (see instructions)	2. 04	283, 877	0		283, 877	283, 877	2. 03
3.00	Operating outlier reconciliation	2. 01	0	0	0	0	0	3. 00
4. 00	Managed care simulated payments	3. 00	0	0	0	0	0	4. 00
	Indirect Medical Education Adju							
5. 00	Amount from Worksheet E, Part A, line 21 (see instructions)	21. 00	0. 000000	0. 000000	0. 000000	0. 000000		5. 00
6.00	IME payment adjustment (see instructions)	22. 00	0	0	0	0	0	6. 00
6. 01	IME payment adjustment for managed care (see	22. 01	О	0	0	О	0	6. 01
	instructions) Indirect Medical Education Adju	  stment for the	Add-on for Se	ction 422 of th	ne MMA			
7.00	IME payment adjustment factor	27. 00	0. 000000	0. 000000	0.00000	0. 000000		7. 00
8. 00	(see instructions) IME adjustment (see	28. 00	0	0	0	0	0	8. 00
8. 01	instructions) IME payment adjustment add on for managed care (see	28. 01	O	O	0	O	0	8. 01
9. 00	<pre>instructions) Total IME payment (sum of lines 6 and 8)</pre>	29. 00	0	0	0	0	0	9. 00
9. 01	Total IME payment for managed care (sum of lines 6.01 and	29. 01	0	0	0	0	0	9. 01
	8.01) Di sproporti onate Share Adjustmo	nt 2nt						ł
10. 00	Allowable disproportionate share percentage (see	33. 00	0. 1515	0. 1515	0. 1515	0. 1515		10. 00
11. 00	<pre>instructions) Disproportionate share adjustment (see instructions)</pre>	34.00	1, 639, 066	0	1, 223, 834	415, 232	1, 639, 066	11. 00
11. 01	Uncompensated care payments  Additional payment for high per	36.00	3, 728, 391	0 di scharges	2, 970, 210	758, 181	3, 728, 391	11. 01
12. 00	Total ESRD additional payment	46. 00	O	ol scriai ges	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	49, 837, 993 0	0 0	37, 417, 481 0	12, 420, 512 0	49, 837, 993 0	13. 00 14. 00
15. 00	(see instructions) Total payment for inpatient operating costs (see	49. 00	49, 837, 993	0	37, 417, 481	12, 420, 512	49, 837, 993	15. 00
16. 00	<pre>instructions) Payment for inpatient program capital (from Wkst. L, Pt. I, if applicable)</pre>	50. 00	3, 771, 813	O	2, 835, 734	936, 079	3, 771, 813	16. 00

LOW VO	LOW VOLUME CALCULATION EXHIBIT 4			Provi der CCN: 15-0051		Period: From 01/01/2019 To 12/31/2019	Date/Time Prepared: 6/29/2020 8:56 am	
					XVIII	Hospi tal	PPS	
		W/S E, Part A		Pre/Post	Period Prior		Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
	<u></u>	0	1.00	2. 00	3. 00	4. 00	5. 00	
17. 00	Special add-on payments for new technologies	54. 00	0	0		0 0	0	17. 00
17. 01	Net organ aquisition cost							17. 01
17. 02	Credits received from manufacturers for replaced	68. 00	0	0		0	О	17. 02
18. 00	devices for applicable MS-DRGs Capital outlier reconciliation adjustment amount (see		0	0		0	0	18. 00
19 00	instructions)			0	40, 253, 21	5 13, 356, 591	53, 609, 806	19 00
17.00	JOODIOTILE	W/S L, line	(Amounts from		10, 200, 21	10,000,071	00,007,000	17.00
		, 0 2,	L)					
		0	1.00	2.00	3.00	4. 00	5. 00	
20. 00	Capital DRG other than outlier	1. 00	3, 503, 119	0	2, 629, 07		3, 503, 119	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1. 01	0	0		0	0	20. 01
21.00	Capital DRG outlier payments	2. 00	38, 189	0	33, 66	8 4, 521	38, 189	21. 00
21. 01	Model 4 BPCI Capital DRG outlier payments	2. 01	0	0	·	0	0	21. 01
22. 00	Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.0000	0.000	0. 0000		22. 00
23. 00	Indirect medical education adjustment (see instructions)	6. 00	0	0		0	0	23. 00
24. 00	Allowable disproportionate share percentage (see	10. 00	0. 0658	0. 0658	0. 065	0. 0658		24. 00
	instructions)							
25. 00	Disproportionate share adjustment (see instructions)	11. 00	230, 505	0	172, 99	3 57, 512	230, 505	25. 00
26. 00	Total prospective capital payments (see instructions)	12. 00	3, 771, 813	0	2, 835, 73	936, 079	3, 771, 813	26. 00
	payments (see thisti detrons)	W/S E, Part A	(Amounts to E.					
		line	Part A)					
		0	1.00	2.00	3.00	4. 00	5. 00	
27. 00	Low volume adjustment factor				0.00000	0.000000		27. 00
28. 00	Low volume adjustment (transfer amount to Wkst. E,	70. 96				0	0	28. 00
29. 00	Pt. A, line) Low volume adjustment (transfer amount to Wkst. E,	70. 97				0	0	29. 00
100 00	Pt. A, line) Transfer low volume		Y					100. 00
100.00	adjustments to Wkst. E, Pt. A.		'					1.50. 00

Provider CCN: 15-0051

Peri od:

HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULATION EXHIBIT 5

From 01/01/2019 Part A Exhibit 5 Date/Time Prepared: 12/31/2019 6/29/2020 8:56 am Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on 10/01 A. line Wkst. E, Pt. after 10/01 and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1.00 1. 00 DRG amounts other than outlier payments for 1.01 1.01 32, 312, 454 32, 312, 454 32, 312, 454 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 10. 963. 222 10, 963, 222 10, 963, 222 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 1.03 0 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 0 1.04 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 2.01 **BPCI** 2 02 Outlier payments for discharges occurring 2 03 910 983 910 983 910 983 2 02 prior to October 1 (see instructions) Outlier payments for discharges occurring on 2.03 2.04 283, 877 283, 877 283, 877 2.03 or after October 1 (see instructions) 3.00 Operating outlier reconciliation 2.01 0 3.00 Managed care simulated payments 4.00 3.00 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) IME payment adjustment (see instructions) 6.00 22.00 0 0 0 6.00 IME payment adjustment for managed care (see 0 6.01 22.01 0 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 IME payment adjustment factor (see 27. 00 0.000000 0.000000 0.000000 7.00 instructions) 8 00 IME adjustment (see instructions) 28 00 8 00 0 0 0 0 8.01 IME payment adjustment add on for managed 28.01 0 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 29.00 9.00 0 0 9.00 Total IME payment for managed care (sum of 9.01 29.01 C 0 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0.1515 0.1515 0.1515 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 1, 639, 066 1, 223, 834 415, 232 1, 639, 066 11.00 instructions) 11.01 3, 728, 391 2, 970, 210 Uncompensated care payments 36, 00 758, 181 3, 728, 391 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12.00 Total ESRD additional payment (see 46. 00 12.00 instructions) 47.00 13 00 49, 837, 993 37, 417, 481 12, 420, 512 49, 837, 993 Subtotal (see instructions) 13 00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 49.00 49, 837, 993 37, 417, 481 12, 420, 512 49, 837, 993 15.00 15.00 (see instructions) 16.00 Payment for inpatient program capital (from 50 00 3.771.813 2 835 734 936, 079 3, 771, 813 16.00 Wkst. L, Pt. I, if applicable) 17.00 Special add-on payments for new technologies 54.00 17.00 0 17.01 Net organ acquisition cost 17.01 Credits received from manufacturers for 68.00 0 17.02 17.02 0 replaced devices for applicable MS-DRGs 18.00 Capital outlier reconciliation adjustment 93.00 0 18.00 amount (see instructions) 19.00 SUBTOTAL 40, 253, 215 13, 356, 591 53, 609, 806 19. 00

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10								
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:5	pared:		
		Title	XVIII	Hospi tal	PPS			
	Wkst. L, line	(Amt. from Wkst. L)						
	0	1.00	2.00	3. 00	4. 00			
20.00 Capital DRG other than outlier	1.00	3, 503, 119	2, 629, 07	3 874, 046	3, 503, 119	20.00		
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0	0	20. 01		
21.00 Capital DRG outlier payments	2.00	38, 189	33, 66	8 4, 521	38, 189	21.00		
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0		0 0	0	21. 01		
22.00 Indirect medical education percentage (see instructions)	5. 00	0. 0000	0.000	0.0000		22. 00		
23.00   Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23. 00		
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0658	0.065	0. 0658		24. 00		
25.00 Disproportionate share adjustment (see	11.00	230, 505	172, 99	57, 512	230, 505	25. 00		
26.00 Total prospective capital payments (see instructions)	12.00	3, 771, 813	2, 835, 73	936, 079	3, 771, 813	26. 00		
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)						
	0	1.00	2.00	3. 00	4. 00			
27.00 28.00 Low volume adjustment prior to October 1 29.00 Low volume adjustment on or after October 1	70. 96 70. 97	0		0	0	27. 00 28. 00 29. 00		
30.00 HVBP payment adjustment (see instructions)	70. 93	-108, 877	-81, 02	-27, 849				
30.01 HVBP payment adjustment for HSP bonus	70. 90	0	-01, 02	0 0	0	30. 00		
payment (see instructions) 31.00 HRR adjustment (see instructions) 31.01 HRR adjustment for HSP bonus payment (see	70. 94 70. 91	0		0 0	0	31. 00 31. 01		
instructions)	70.71					01.01		
, mari dett onsy					(Amt. to Wkst. E, Pt. A)			
	0	1.00	2.00	3. 00	4. 00			
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32. 00		
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00		

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	Peri od: From 01/01/2019 To 12/31/2019	Worksheet E Part B Date/Time Prepared: 6/29/2020 8:56 am

			127 017 2017	6/29/2020 8:5	
		Title XVIII	Hospi tal	PPS	
	DADT D. MEDICAL AND OTHER HEALTH CERVICES			1. 00	
1. 00	PART B - MEDICAL AND OTHER HEALTH SERVICES  Medical and other services (see instructions)			26, 467	1.00
2. 00	Medical and other services (see Instructions)  Medical and other services reimbursed under OPPS (see instruction	ns)		42, 907, 719	2.00
3. 00	OPPS payments	13)		40, 500, 964	3. 00
4. 00	Outlier payment (see instructions)			162, 892	4. 00
4. 01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruction	ons)		0.000	5. 00
6.00	Line 2 times line 5			0	6.00
7.00	Sum of lines 3, 4, and 4.01, divided by line 6			0.00	7. 00
8.00	Transitional corridor payment (see instructions)			0	8. 00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		197, 192	9. 00
10.00	Organ acquisitions			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			26, 467	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			137, 241	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		137, 241	13.00
14. 00	Total reasonable charges (sum of lines 12 and 13)	07)		137, 241	14. 00
11.00	Customary charges			107, 211	11.00
15. 00	Aggregate amount actually collected from patients liable for paym	ment for services on a	charge basis	0	15. 00
16.00	Amounts that would have been realized from patients liable for pa			0	16.00
	had such payment been made in accordance with 42 CFR §413.13(e)		Ü		
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17. 00
18. 00	Total customary charges (see instructions)			137, 241	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only i	f line 18 exceeds lir	ie 11) (see	110, 774	19. 00
	instructions)		40) (		
20. 00	Excess of reasonable cost over customary charges (complete only i	T line ii exceeds iir	ie 18) (see	0	20. 00
21. 00	instructions) Lesser of cost or charges (see instructions)			26, 467	21. 00
22. 00	Interns and residents (see instructions)			20, 407	22. 00
23. 00	Cost of physicians' services in a teaching hospital (see instruct	tions)		0	23. 00
24. 00	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	,		40, 861, 048	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00	Deductibles and coinsurance amounts (for CAH, see instructions)			2, 267	25. 00
26.00	Deductibles and Coinsurance amounts relating to amount on line 24	l (for CAH, see instru	ıcti ons)	7, 203, 566	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus	the sum of lines 22	and 23] (see	33, 681, 682	27. 00
	instructions)			_	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line	50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30. 00 31. 00	Subtotal (sum of lines 27 through 29)			33, 681, 682 6, 726	30. 00 31. 00
32. 00	Primary payer payments Subtotal (line 30 minus line 31)			33, 674, 956	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)			33, 074, 730	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)			0	33. 00
34. 00	Allowable bad debts (see instructions)			1, 073, 215	
35.00	Adjusted reimbursable bad debts (see instructions)			697, 590	35. 00
36.00	Allowable bad debts for dual eligible beneficiaries (see instruct	ti ons)		861, 354	36. 00
37.00	Subtotal (see instructions)			34, 372, 546	37. 00
38. 00	MSP-LCC reconciliation amount from PS&R			11	38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions)				39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	39. 97
39. 98	Partial or full credits received from manufacturers for replaced	devices (see instruct	ions)	445	39. 98
39. 99	RECOVERY OF ACCELERATED DEPRECIATION			0	39. 99
40.00	Subtotal (see instructions)			34, 372, 535 687, 451	40.00
40. 01 40. 02	Sequestration adjustment (see instructions)  Demonstration payment adjustment amount after sequestration			067, 431	40. 01 40. 02
40. 02	Sequestration adjustment-PARHM pass-throughs			Ü	40. 02
41. 00	Interim payments			33, 544, 084	1
41. 01	Interim payments-PARHM			00, 011, 001	41. 01
42. 00	Tentative settlement (for contractors use only)			0	42.00
42. 01	Tentative settlement-PARHM (for contractor use only)				42. 01
43.00	Balance due provider/program (see instructions)			141, 000	43. 00
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordance	with CMS Pub. 15-2, c	chapter 1,	11, 209	44. 00
	§115. 2				
00.05	TO BE COMPLETED BY CONTRACTOR				00.55
90.00	Original outlier amount (see instructions)			0	90.00
91.00	Outlier reconciliation adjustment amount (see instructions)			0 0. 00	91.00
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92. 00 93. 00
	Total (sum of lines 91 and 93)			0	94.00
00	1 (			O	

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 1	15-0051 Peri od: From 01/01/2019	Worksheet E
	Component CCN:	15-T051 To 12/31/2019	
	Title XVI	III Subprovider -	PPS

		Title XVIII	Subprovi der - I RF	PPS	
				1. 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instructions)	tions)		23	1. 00 2. 00
3. 00	OPPS payments	ti ons)		0	3.00
4. 00	Outlier payment (see instructions)			0	4. 00
4.01	Outlier reconciliation amount (see instructions)			0	4. 01
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	ı
6. 00 7. 00	Line 2 times line 5 Sum of lines 3, 4, and 4.01, divided by line 6			0 0. 00	
8. 00	Transitional corridor payment (see instructions)			0.00	ł
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	V, col. 13, line 200		Ö	ł
10.00	Organ acqui si ti ons			0	10.00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			23	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12. 00	Reasonable charges Ancillary service charges			116	12. 00
13. 00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 69)		0	1
14.00	Total reasonable charges (sum of lines 12 and 13)	,		116	14. 00
	Customary charges				
15. 00	Aggregate amount actually collected from patients liable for particular to the particular form and the particular forms a			0	
16. 00	Amounts that would have been realized from patients liable for had such payment been made in accordance with 42 CFR §413.13(		n a chargebasis	0	16. 00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)	-,		0. 000000	17. 00
18. 00	Total customary charges (see instructions)			116	18. 00
19. 00	Excess of customary charges over reasonable cost (complete onl	y if line 18 exceeds li	ne 11) (see	93	19. 00
20. 00	<pre>instructions) Excess of reasonable cost over customary charges (complete onl</pre>	y if line 11 exceeds li	ne 18) (see	0	20. 00
04.00	instructions)				04.00
	Lesser of cost or charges (see instructions) Interns and residents (see instructions)			23	1
	Cost of physicians' services in a teaching hospital (see insti	ructions)		0	1
	Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	,		Ō	1
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25. 00	Deductibles and coinsurance amounts (for CAH, see instructions	•		0	
26. 00 27. 00	Deductibles and Coinsurance amounts relating to amount on line			0 23	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)    instructions	orus the sum of filles 22	anu 23] (See	23	27. 00
28. 00	Direct graduate medical education payments (from Wkst. E-4, Ii	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			23	•
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			0 23	31. 00 32. 00
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	CES)		25	32.00
33.00	Composite rate ESRD (from Wkst. I-5, line 11)	,		0	33. 00
	Allowable bad debts (see instructions)			0	
	Adjusted reimbursable bad debts (see instructions)			0	
36. 00 37. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	uctions)		0 23	
	MSP-LCC reconciliation amount from PS&R			0	
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39. 00
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	5)			39. 50
39. 97	Demonstration payment adjustment amount before sequestration			0	ı
39. 98 39. 99	Partial or full credits received from manufacturers for replace RECOVERY OF ACCELERATED DEPRECIATION	ced devices (see instruc	tions)	0	39. 98 39. 99
	Subtotal (see instructions)			23	
40. 01	Sequestration adjustment (see instructions)			0	40. 01
40. 02	Demonstration payment adjustment amount after sequestration			0	40. 02
40. 03	1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 - 1 -				40. 03
41. 00	Interim payments			24	•
41.01	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41. 01 42. 00
42. 00	Tentative settlement-PARHM (for contractor use only)			١	42. 00
43.00	Balance due provider/program (see instructions)			-1	
43. 01	Balance due provider/program-PARHM (see instructions)				43. 01
44. 00	Protested amounts (nonallowable cost report items) in accordar §115.2	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0 00	
92.00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0. 00 0	1
	Total (sum of lines 91 and 93)			0	
			'	'	

In Lieu of Form CMS-2552-10

Period: Worksheet E-1
From 01/01/2019 Part I
To 12/31/2019 Date/Time Prepared: 6/29/2020 8:56 am Health Financial Systems IU HEA ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provider CCN: 15-0051

			XVIII	Hospi tal	PPS	
					110	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		48, 384, 47		33, 412, 584	1. 00
2.00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none,				0	2. 00
3.00	write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
	ADJUSTMENTS TO PROVIDER	07/31/2019	111, 90	07/31/2019	131, 500	3. 01
3. 02	ADJUSTIMENTS TO FROVIDER	07/31/2019		0	131, 300	3. 02
3. 02						3. 02
				0		
3. 04				0	0	3. 04 3. 05
3. 05	Durand date to Durantee			J	U	3. 05
	Provider to Program ADJUSTMENTS TO PROGRAM				0	2 50
	ADJUSTMENTS TO PROGRAM			~	1 - 1	3. 50
3. 51				O	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3. 54				0	0	3. 54
	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		111, 90		131, 500	3. 99
	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		48, 496, 37	3	33, 544, 084	4. 00
	TO BE COMPLETED BY CONTRACTOR					
	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider					
	TENTATI VE TO PROVI DER			O	0	5. 01
5.02			(	O	0	5. 02
5. 03				0	0	5. 03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM		(	O	0	5. 50
5. 51			(	O	0	5. 51
5. 52			(	O	0	5. 52
	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			D	0	5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1) SETTLEMENT TO PROVIDER				141, 000	6. 01
	SETTLEMENT TO PROGRAM		100.00	0	141,000	6. 01
	Total Medicare program liability (see instructions)		182, 86 48, 313, 50		33, 685, 084	7. 00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		(	)	1. 00	2.00	
8. 00	Name of Contractor					8. 00

Component CCN: 15-T051

Title XVIII

Inpatient Part A			Title	XVIII	Subprovi der - I RF	PPS	
1.00   Total Interim payments paid to provider   1.00   2.00   3.00   4.00   1.00   1.00   1.00   1.00   1.00   1.00   1.00   2.00   3.00   4.00   2.00   1.00   1.00   1.00   2.00   1.00   1.00   2.00			Inpatien	t Part A	Par	t B	
Total interim payments paid to provider   2,756,483   24 1.00   2.00			mm/dd/yyyy		mm/dd/yyyy		
InterIm payments payable on Individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or neter a zero.			1. 00				
amount based on subsequent revision of the interin rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider  3.01 3.02 3.03 3.04 3.05 Provider to Program  3.50 ADJUSTMENTS TO PROVIDER  ADJUSTMENTS TO PROVIDER  ADJUSTMENTS TO PROGRAM  0 0 3.02 3.03 3.04 3.05 Provider to Program  3.51 3.52 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 3.53 3.54 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 3.53 3.54 0 0 0 3.55 3.59 3.50 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 3.50 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 3.50 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 3.50 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 3.50 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 3.50 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 3.50 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 ADJUSTMENTS TO PROGRAM  0 0 0 3.55 ADJUSTMENTS TO PROGRAM  10 FEET COMPLETED BY CONTRACTOR  FOR COMPLETED BY CONTRACTOR  FOR COMPLETED BY CONTRACTOR  FOR COMPLETED BY CONTRACTOR  FURTHER TO PROVIDER  5.00 FOR COMPLETED BY CONTRACTOR  FURTHER TO PROVIDER  5.00 FOR COMPLETED BY CONTRACTOR  FURTHER TO PROVIDER  5.00 FOR COMPLETED BY CONTRACTOR  FOR COMPLETED BY CONTRACTOR  FURTHER TO PROVIDER  5.00 FOR COMPLETED BY CONTRACTOR  FURTHER TO PROVIDER  5.00 FOR COMPLETED BY CONTRACTOR  5.00 FOR COMPLETED BY CONTRACTOR  FURTHER TO PROVIDER  5.00 FOR COMPLETED BY CONTRACTOR  6.00 FOR COMPLETED BY CONTRACTOR  6.00 FOR COMPLETED BY CONTRACTOR  6.00 FOR COMPLETED BY CONTRACTOR  7.00 FURTHER TO PROVIDER  14,587 FOR CONTRACTOR  8.00 FOR COMPLETED BY CONTRACTOR  8.00 FOR COMPLETED BY CONTRACTOR  8.00 FOR COMPLETED BY CONTRACTOR  8.00 FOR COMPLETED BY CONTRACTOR  8.00 FOR COMPLETED BY CONTRACTOR  8.00 FOR COMPLETED BY CONTRACTOR  8.00 FOR COMPLETED BY CONTRACTOR  8.00 FOR COMPLETED BY CONTRACTOR  9.00 FOR COMPLETED BY CO	2. 00	Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero					2. 00
3.02   0	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)					3. 00
3.03   0   0   0   3.03   3.04   3.05   0   0   0   3.05   3.04   3.05   0   0   0   3.05	3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3. 04	3.02			0		0	3. 02
3.05	3.03			0		0	3. 03
Provider to Program   ADJUSTMENTS TO PROGRAM   0   0   3.50	3.04						
ADJUSTMENTS TO PROGRAM	3.05			0		0	3. 05
3.51   3.52   3.53   0   0   0   3.51   3.52   3.53   3.53   0   0   0   3.53   3.53   3.54   0   0   0   3.53   3.54   3.59   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   2,756,483   24   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   5.00   ECOMPLETED BY CONTRACTOR					1		
3.52   0   0   3.52   0   0   0   3.52   0   0   0   3.53   3.54   0   0   0   3.54   0   0   0   3.54   3.59   3.50 - 3.98   0   0   0   3.54   3.50 - 3.98   0   0   0   3.54   3.50 - 3.98   0   0   0   3.54   3.50 - 3.98   0   0   0   3.54   3.50 - 3.98   0   0   0   3.59   3.50 - 3.98   0   0   0   0   3.59   3.50 - 3.98   0   0   0   0   0   0   0   0   0		ADJUSTMENTS TO PROGRAM		· -			
3.53   3.54   0 0 0 0 3.53   3.54   0 0 0 0 3.53   3.59   3.50-3.98   0 0 0 0 3.59   3.50-3.98   0 0 0 0 3.59   3.50-3.98   0 0 0 0 3.59   0 0 0 3.59   0 0 0 3.59   0 0 0 3.59   0 0 0 3.59   0 0 0 3.59   0 0 0 0 3.59   0 0 0 0 3.59   0 0 0 0 3.59   0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
3.54   3.99   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   4.00   Total interim payments (sum of lines 1, 2, and 3.99)   2,756,483   24   4.00   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR							
Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)   Contractor Number (1.00 to 1.00 to							
3.50-3.98    Total interim payments (sum of lines 1, 2, and 3.99)   (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)   To BE COMPLETED BY CONTRACTOR							
Ctransfer to Wkst. E or Wkst. E-3, line and column as appropriate)   TO BE COMPLETED BY CONTRACTOR		3. 50-3. 98)		_			
List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)   Program to Provider	4. 00	(transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 756, 483		24	4. 00
TENTATI VE TO PROVI DER	5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
Solid	E 04						E 04
5.03   Provider to Program   S.50   TENTATIVE TO PROGRAM   O   O   S.50     5.51   O   O   O   S.51     5.52   O   O   O   S.51     5.52   Subtotal (sum of lines 5.01-5.49 minus sum of lines   S.50-5.98     6.00   Determined net settlement amount (balance due) based on the cost report. (1)     6.01   SETTLEMENT TO PROVIDER   SETTLEMENT TO PROGRAM   O   SETTLEMENT TO PROGRAM   O   O     7.00   Total Medicare program liability (see instructions)   Determined net settlement amount (balance due) based on the cost report. (1)     6.01   SETTLEMENT TO PROGRAM   O   O   O     7.00   Total Medicare program liability (see instructions)   O   O		TENTATIVE TO PROVIDER					
Provider to Program							
TENTATI VE TO PROGRAM	5.05	Provider to Program				0	5. 03
5.51   0	5 50			0		0	5 50
5.52   0 0 5.52   5.99   Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)   6.00   Determined net settlement amount (balance due) based on the cost report. (1)   6.01   SETTLEMENT TO PROVIDER   14,587   0 6.01   6.02   SETTLEMENT TO PROGRAM   0   1 6.02   7.00   Total Medicare program liability (see instructions)   2,771,070   Contractor Number (Mo/Day/Yr)   Number (Mo/Day/Yr)   Contractor Number (Mo/Day/Yr)   Number (Mo/Day/Yr)   Contractor Number (Mo/Day/Yr)							
5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on the cost report. (1) 6. 01 SETTLEMENT TO PROVIDER 14, 587 0 6. 01 6. 02 SETTLEMENT TO PROGRAM 0 16. 02 7. 00 Total Medicare program liability (see instructions) 2, 771, 070 23 7. 00  Contractor NPR Date (Mo/Day/Yr) 0 1. 00 2. 00				l o		0	5. 52
6.00 Determined net settlement amount (balance due) based on the cost report. (1) 6.01 SETTLEMENT TO PROVIDER 14,587 0 6.01 6.02 SETTLEMENT TO PROGRAM 0 1 6.02 7.00 Total Medicare program liability (see instructions) 2,771,070 Contractor Number (Mo/Day/Yr)  0 1.00 2.00				0		0	
6. 01   SETTLEMENT TO PROVIDER   14, 587   0   6. 01   6. 02   SETTLEMENT TO PROGRAM   0   1   6. 02   7. 00   Total Medicare program liability (see instructions)   2, 771, 070	6. 00	Determined net settlement amount (balance due) based on					6. 00
6.02 SETTLEMENT TO PROGRAM 7.00 Total Medicare program liability (see instructions)  Contractor Number (Mo/Day/Yr)  0 1.00 2.00	6. 01			14, 587		l ol	6. 01
7.00 Total Medicare program liability (see instructions)  2,771,070  Contractor NPR Date (Mo/Day/Yr)  0 1.00 2.00						1	
Number         (Mo/Day/Yr)           0         1.00         2.00	7.00	Total Medicare program liability (see instructions)		2, 771, 070		23	7. 00
		-					
8.00 Name of Contractor 8.00			(	)	1. 00	2. 00	
	8.00	Name of Contractor					8. 00

Heal th	Financial Systems IU HEALTH BLOOMING	TON HOSPITAI	Inlie	u of Form CMS-	2552_10	
	CALCULATION OF REIMBURSEMENT SETTLEMENT FOR HIT  Provider CCN: 15-0051   Period: From 01/01/2019   To 12/31/2019   For 12/31/2019   From 01/01/2019   From 12/31/2019   From 1					
		Title XVIII	Hospi tal	6/29/2020 8:5 PPS	<u>6 am</u>	
		Title XVIII	nospi tai	113		
				1. 00		
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				1	
1.00	Total hospital discharges as defined in AARA §4102 from Wkst.	S-3, Pt. I col. 15 line	14		1.00	
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	-12			2. 00	
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00	
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	-12			4. 00	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200				5. 00	
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20			6.00	
7. 00	CAH only - The reasonable cost incurred for the purchase of cline 168	ertified HIT technology	Wkst. S-2, Pt. I		7. 00	
8. 00	Calculation of the HIT incentive payment (see instructions)				8.00	
9. 00	Seguestration adjustment amount (see instructions)				9. 00	
10. 00						
. 5. 66	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions)				30.00	
	Other Adjustment (specify)				31.00	
	22.00 Palance due provider (line 9 (or line 10) minus line 20 and line 21) (see instructions)					

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

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0051	Peri od:	Worksheet E-3
		From 01/01/2019	
	Component CCN: 15-T051	To 12/31/2019	Date/Time Prepared:
			6/29/2020 8:56 am
	Title XVIII	Subprovi der -	PPS
		IDE	

	IRF	110	
		1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS	1.00	
1.00	Net Federal PPS Payment (see instructions)	2, 322, 085	1. 00
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)	0. 0259	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)	101, 707	3. 00
4.00	Outlier Payments	426, 866	4. 00
5.00	Unweighted intern and resident FTE count in the most recent cost reporting period ending on or prior	0.00	5.00
	to November 15, 2004 (see instructions)		
5. 01	Cap increases for the unweighted intern and resident FTE count for residents that were displaced by	0.00	5. 01
	program or hospital closure, that would not be counted without a temporary cap adjustment under 42		
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)		
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
8. 00	teaching program" (see instructions) Current year's unweighted I&R FTE count for residents within the new program growth period of a "new	0.00	8. 00
8.00	teaching program" (see instructions)	0.00	8.00
9. 00	Intern and resident count for IRF PPS medical education adjustment (see instructions)	0.00	9. 00
10. 00	Average Daily Census (see instructions)	8. 446575	
11. 00	Teaching Adjustment Factor (see instructions)	0.000000	
12. 00	Teaching Adjustment (see instructions)	0	12. 00
13. 00	Total PPS Payment (see instructions)	2, 850, 658	13.00
14.00	Nursing and Allied Health Managed Care payments (see instruction)	0	14.00
15.00	Organ acqui si ti on (DO NOT USE THIS LINE)	ı	15.00
16.00	Cost of physicians' services in a teaching hospital (see instructions)	0	16.00
17. 00	Subtotal (see instructions)	2, 850, 658	17.00
18. 00	Primary payer payments	0	18.00
19. 00	Subtotal (line 17 less line 18).	2, 850, 658	
20. 00	Deducti bl es	9, 548	
21. 00	Subtotal (line 19 minus line 20)	2, 841, 110	
22. 00	Coinsurance	16, 027	22. 00
23. 00	Subtotal (line 21 minus line 22)	2, 825, 083	
24. 00 25. 00	Allowable bad debts (exclude bad debts for professional services) (see instructions)  Adjusted reimbursable bad debts (see instructions)	1, 316 855	
26. 00	Allowable bad debts for dual eligible beneficiaries (see instructions)	0	26. 00
27. 00	Subtotal (sum of lines 23 and 25)	2, 825, 938	
28. 00	Direct graduate medical education payments (from Wkst. E-4, line 49)	2, 023, 730	28. 00
29. 00	Other pass through costs (see instructions)	1, 684	29. 00
30. 00	Outlier payments reconciliation	0	30.00
31.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0	31.00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions)	0	31.50
31. 99	Demonstration payment adjustment amount before sequestration	0	31. 99
32.00	Total amount payable to the provider (see instructions)	2, 827, 622	
32. 01	Sequestration adjustment (see instructions)	56, 552	
32. 02	Demonstration payment adjustment amount after sequestration	0	32. 02
33. 00	Interim payments	2, 756, 483	33. 00
34. 00	Tentative settlement (for contractor use only)	0	34. 00
35.00	Balance due provider/program (line 32 minus lines 32.01, 32.02, 33, and 34)	14, 587	35. 00
36. 00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1,	17, 880	36. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR		
50. 00		426, 866	50. 00
	Outlier reconciliation adjustment amount (see instructions)	420, 800	51. 00
52. 00	The rate used to calculate the Time Value of Money	- 1	
	Time Value of Money (see instructions)	0	53. 00
	· · · · · · · · · · · · · · · · · · ·	- 1	

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

Provider CCN: 15-0051

Peri od: Worksheet G
From 01/01/2019
To 12/31/2019 Date/Ti me Prepared: 6/29/2020 8:56 am

——————————————————————————————————————					6/29/2020 8:5	<u>6 am</u>
		General Fund		Endowment Fund	Plant Fund	
		1.00	Purpose Fund	2.00	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1. 00	Cash on hand in banks	298, 471, 888	0	0	0	1.00
2. 00	Temporary investments	0	Ö	_		2.00
3.00	Notes recei vabl e	0	o	0	0	3. 00
4.00	Accounts receivable	64, 177, 124	0	0	0	4. 00
5.00	Other recei vable	-4, 720, 343	0	0	0	5. 00
6.00	Allowances for uncollectible notes and accounts receivable	0	0	0	0	6. 00
7.00	Inventory	6, 564, 763	l .	0	0	7. 00
8. 00	Prepai d expenses	8, 807, 839	1	0	0	8. 00
9. 00	Other current assets	0	0	0	0	9. 00
10.00	Due from other funds	0	0	0	0	10.00
11. 00	Total current assets (sum of lines 1-10)	373, 301, 271	0	0	0	11. 00
10.00	FI XED ASSETS	10 741 447	1	0	0	10.00
12. 00 13. 00	Land improvements	19, 741, 447 2, 058, 207	1	_	0	12. 00 13. 00
14. 00	Accumulated depreciation	-1, 958, 102	1	_	0	14.00
15. 00	Buildings	162, 061, 316	1	_	0	15. 00
16. 00	Accumulated depreciation	-141, 956, 279	1	0	Ö	16.00
17. 00	Leasehold improvements	0	Ö	0	Ö	17. 00
18. 00	Accumulated depreciation	-6, 024, 867			Ō	18. 00
19.00	Fi xed equipment	0	o	0	0	19.00
20.00	Accumulated depreciation	0	0	0	0	20.00
21.00	Automobiles and trucks	3, 696, 056	0	0	0	21. 00
22. 00	Accumulated depreciation	-2, 835, 284	0	0	0	22. 00
23. 00	Major movable equipment	127, 922, 223	l .	0	0	23. 00
24. 00	Accumul ated depreciation	-105, 174, 668	i	_	0	24. 00
25. 00	Mi nor equi pment depreci abl e	0	0	_	0	25. 00
26. 00	Accumul ated depreciation	0	0	0	0	26. 00
27. 00	HIT designated Assets	0		0	0	27. 00
28. 00	Accumulated depreciation	0		0	0	28. 00
29. 00 30. 00	Minor equipment-nondepreciable	E7 E20 040	0	_	0	29. 00 30. 00
30.00	Total fixed assets (sum of lines 12-29) OTHER ASSETS	57, 530, 049	1 0	U	0	30.00
31. 00	Investments	29, 874, 468	0	0	0	31.00
32. 00	Deposits on Leases	27, 67 1, 100	Ö			32.00
33. 00	Due from owners/officers	0	Ö	_	0	33. 00
34.00	Other assets	311, 347, 754	0	0	0	34.00
35.00	Total other assets (sum of lines 31-34)	341, 222, 222	0	0	0	35. 00
36.00	Total assets (sum of lines 11, 30, and 35)	772, 053, 542	0	0	0	36. 00
	CURRENT LIABILITIES					
37. 00	Accounts payable	24, 717, 940		0	_	37. 00
38. 00	Salaries, wages, and fees payable	11, 468, 029	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, 855, 000	0	0	0	40.00
41. 00	Deferred income	0		O	0	41.00
42.00	Accel erated payments	0		0	_	42.00
43. 00 44. 00	Due to other funds Other current liabilities	4, 387, 412	0	0	0	43. 00 44. 00
45. 00	Total current liabilities (sum of lines 37 thru 44)	42, 428, 381	i	_		45.00
45.00	LONG TERM LIABILITIES	42, 420, 301	1 0	U	0	45.00
46. 00	Mortgage payable	1 0	0	0	0	46. 00
47. 00	Notes payable	0		_	_	47. 00
48. 00	Unsecured Loans	0	Ö	_		48. 00
49. 00	Other long term liabilities	42, 262, 799		-	Ō	49. 00
50.00	Total long term liabilities (sum of lines 46 thru 49)	42, 262, 799	l .	0	0	50.00
51.00	Total liabilities (sum of lines 45 and 50)	84, 691, 180	0	0	0	51.00
	CAPI TAL ACCOUNTS					
52.00	General fund balance	687, 362, 362				52. 00
53. 00	Specific purpose fund		0			53. 00
54. 00	Donor created - endowment fund balance - restricted			0		54.00
55. 00	Donor created - endowment fund balance - unrestricted			0		55. 00
56. 00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant	1			0	57.00
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
59. 00	replacement, and expansion Total fund balances (sum of lines 52 thru 58)	607 242 242	0		0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	687, 362, 362 772, 053, 542	l .			60.00
55.00	[59]	, , 2, 033, 342				00.00
	1917	I	I	1	ı	ı

STATEMENT OF CHANGES IN FUND BALANCES

Provider CCN: 15-0051

Peri od: Worksheet G-1 From 01/01/2019 To 12/31/2019 Date/Ti me Prepared:

6/29/2020 8:56 am General Fund Special Purpose Fund Endowment Fund 1.00 3.00 4. 00 5. 00 2 00 1.00 Fund balances at beginning of period 589, 567, 450 0 1.00 2.00 Net income (loss) (from Wkst. G-3, line 29) 172, 958, 502 2.00 3.00 Total (sum of line 1 and line 2) 762, 525, 952 0 3.00 4.00 DONATED PP&E 51, 934 0 0 4.00 5.00 ROUNDI NG 0 5.00 6.00 0 6.00 0 7.00 0 0 0 7.00 0 8.00 8.00 0 9.00 0 9.00 10.00 Total additions (sum of line 4-9) 51, 940 10.00 Subtotal (line 3 plus line 10) 11.00 762, 577, 892 11.00 0 UNRESTRICTED FUND BALANCE 12.00 75, 215, 530 0 12.00 13.00 13.00 14.00 0 0 0 0 14.00 0 15.00 15.00 0 16.00 0 16.00 17.00 17.00 18.00 Total deductions (sum of lines 12-17) 75, 215, 530 18.00 Fund balance at end of period per balance 19.00 687, 362, 362 19.00 sheet (line 11 minus line 18) Endowment Fund Plant Fund 7. 00 8.00 6. 00 1.00 Fund balances at beginning of period 0 0 1.00 Net income (loss) (from Wkst. G-3, line 29) 2.00 2.00 3.00 Total (sum of line 1 and line 2) 0 0 3.00 DONATED PP&E 4.00 4.00 5.00 ROUNDI NG 0 5.00 0 6.00 6.00 7. 00 0 7 00 8.00 0 8.00 9.00 9.00 10.00 Total additions (sum of line 4-9) 0 0 10.00 11.00 0 0 Subtotal (line 3 plus line 10) 11.00 12.00 UNRESTRICTED FUND BALANCE 12.00 13.00 13.00 14.00 0 14.00 0 15.00 15.00 16.00 16.00 17.00 17.00 Total deductions (sum of lines 12-17) 0 18.00 18.00 Fund balance at end of period per balance 0 0 19.00 19.00 sheet (line 11 minus line 18)

Health Financial Systems 100 STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provider CCN: 15-0051

			10	12/31/2019	6/29/2020 8: 56	
	Cost Center Description	Inp	pati ent	Outpati ent	Total	
	·		1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal	14	1, 756, 484		141, 756, 484	1.00
2.00	SUBPROVI DER - I PF					2.00
3.00	SUBPROVI DER - I RF		6, 666, 705		6, 666, 705	3.00
4.00	SUBPROVI DER		0		0	4.00
5.00	Swing bed - SNF		0		0	5.00
6.00	Swing bed - NF		0		0	6.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE					9. 00
10.00	Total general inpatient care services (sum of lines 1-9)	14	8, 423, 189		148, 423, 189	10.00
	Intensive Care Type Inpatient Hospital Services					
11. 00	INTENSIVE CARE UNIT	2	21, 143, 724		21, 143, 724	11.00
12.00	CORONARY CARE UNIT	1	9, 463, 811		19, 463, 811	12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGICAL INTENSIVE CARE UNIT					14.00
15. 00	NEONATAL INTENSIVE CARE UNIT	1	4, 343, 759		14, 343, 759	15.00
16. 00	Total intensive care type inpatient hospital services (sum of	lines 5	4, 951, 294		54, 951, 294	16.00
	11-15)					
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	20	3, 374, 483		203, 374, 483	17.00
18. 00	Ancillary services		8, 890, 375		1, 219, 273, 201	18.00
19. 00	Outpati ent services	4	7, 505, 722	241, 096, 760	288, 602, 482	19. 00
20.00	RURAL HEALTH CLINIC		0	0	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY			0	0	22.00
23. 00	AMBULANCE SERVICES		157, 303	52, 052, 370	52, 209, 673	23.00
24. 00	CMHC					24.00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )		0	0	0	25.00
26. 00	HOSPI CE		0	0	0	26.00
27. 00	OTHER NRCC		0	9, 430, 419	9, 430, 419	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst. 71	9, 927, 883	1, 052, 962, 375	1, 772, 890, 258	28. 00
	G-3, line 1)					
	PART II - OPERATING EXPENSES					
	Operating expenses (per Wkst. A, column 3, line 200)			352, 407, 682		29. 00
30. 00	ADD (SPECIFY)		0			30.00
31. 00			0			31. 00
32. 00			0			32.00
33. 00			0			33.00
34. 00			0			34.00
35. 00			0			35.00
36. 00	Total additions (sum of lines 30-35)			0		36. 00
37. 00	DEDUCT (SPECIFY)		0			37. 00
38. 00			0			38. 00
39. 00			0			39. 00
40. 00			0			40. 00
41. 00			0			41. 00
42. 00	Total deductions (sum of lines 37-41)			0		42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42 to Wkst. G-3, line 4)	!)(transfer		352, 407, 682		43. 00

	Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu				
STATEM	ENT OF REVENUES AND EXPENSES	Provider CCN: 15-0051	Peri od:	Worksheet G-3	
			From 01/01/2019 To 12/31/2019	Date/Time Pre	nanad.
			To 12/31/2019	6/29/2020 8:50	
	· · · · · · · · · · · · · · · · · · ·			0/2//2020 0.30	O dill
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, li	ne 28)		1, 772, 890, 258	1. 00
2.00	Less contractual allowances and discounts on patients' accou	ints		1, 296, 639, 224	2.00
3.00	Net patient revenues (line 1 minus line 2)			476, 251, 034	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	2 43)		352, 407, 682	4. 00
5.00	Net income from service to patients (line 3 minus line 4)			123, 843, 352	5. 00
	OTHER INCOME				
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	on services		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10.00	Purchase di scounts			0	10.00
11.00	Rebates and refunds of expenses			0	11. 00
12.00	Parking lot receipts			0	12. 00
13.00	Revenue from Laundry and Linen service			0	13. 00
14.00	Revenue from meals sold to employees and guests			0	14. 00
15.00	Revenue from rental of living quarters			0	15. 00
16.00	Revenue from sale of medical and surgical supplies to other	than 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			o l	22. 00
	Governmental appropriations			0	23. 00
0.4.00	W COEL LANGUE LANGUE			40 445 450	04.00

49, 115, 150 24. 00

172, 958, 502 29. 00

0 27.00

25. 00 26. 00

28.00

49, 115, 150 172, 958, 502

24. 00 MI SCELLANEOUS I NCOME

27. 00 OTHER EXPENSES (SPECIFY)

25.00 Total other income (sum of lines 6-24)
26.00 Total (line 5 plus line 25)

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)

		EALTH BLOOMINGTON HOSPITAL		u of Form CMS-2	2552-10
CALCUL	CALCULATION OF CAPITAL PAYMENT Provider CCN: 15-0051 Period:		Peri od: From 01/01/2019	Worksheet L Parts I-III	
			To 12/31/2019	Date/Time Pre	
		T: +1 - W///	11: +-1	6/29/2020 8:5	6 am
		Title XVIII	Hospi tal	PPS	
				1. 00	
	PART I - FULLY PROSPECTIVE METHOD				
	CAPITAL FEDERAL AMOUNT				
1. 00	Capital DRG other than outlier			3, 503, 119	1.00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	1. 01
2. 00				38, 189	
2. 01				0	
3. 00				152. 22	
4. 00				0.00	
5.00	Indirect medical education percentage (see instructions)			0.00	
6. 00	Indirect medical education adjustment (multiply line 5 by the sum of lines 1 and 1.01, columns 1 and 1.01) (see instructions)			0	6. 00
7. 00	Percentage of SSI recipient patient days to Medicare Part A patient days (Worksheet E, part A line			5. 23	7. 00
3. 00	30) (see instructions) 0   Percentage of Medicaid patient days to total days (see instructions)			26. 21	8.00
9. 00				31.44	
10.00				6. 58	
11. 00				230, 505	
12. 00				3, 771, 813	
	DART LL DAVMENT UNDER REACONABLE COST			1. 00	
1. 00	PART II - PAYMENT UNDER REASONABLE COST Program inpatient routine capital cost (see ins	tructions)		0	1.00
2. 00	Program inpatient ancillary capital cost (see in			0	
3.00	Total inpatient program capital cost (see II			0	
4. 00	Capital cost payment factor (see instructions)	us Title 2)		0	1
5. 00	Total inpatient program capital cost (line 3 x l	line 4)		0	1
J. 00	Trotal impatront program capital cost (Time o x i	THE I		Ü	0.00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instruction			0	1
2. 00	Program inpatient capital costs for extraordinal			0	
3.00	Net program inpatient capital costs (line 1 minu			0	0.00
1.00	Applicable exception percentage (see instruction			0.00	
5.00	Capital cost for comparison to payments (line 3			0	0.00
5. 00 7. 00	Percentage adjustment for extraordinary circums Adjustment to capital minimum payment level for		v lino 4)	0.00	
7. 00 3. 00	Capital minimum payment level (line 5 plus line		x iiile o)	)   0	
9. 00	Current year capital payments (from Part I, line			0	
7. UU				Ĭ	
10.00	Current year comparison of capital minimum payme	ent level to canital navments (line Q	less line 0)	0	10.00

11.00

0 12.00

0 13.00 14.00

0

0 15.00

0 16.00 0 17.00

11.00 Carryover of accumulated capital minimum payment level over capital payment (from prior year

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

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

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

Worksheet L, Part III, line 14)

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

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

13.00