Heal th Financia	al Systems	IU HEALTH BLACKFO	RD HOSPI TAL	In Lieu	u of Form CMS-2552-10
This report is	required by law (42 USC 139	5g; 42 CFR 413.20(b)). Fai	lure to report can resu	lt in all interim	FORM APPROVED
payments made	since the beginning of the c	ost reporting period being	deemed overpayments (4	2 USC 1395g).	OMB NO. 0938-0050 EXPIRES 05-31-2019
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX SUMMARY	COST REPORT CERTIFICATION	Provider CCN: 15-1302	Period: From 01/01/2016 To 12/31/2016	Worksheet S Parts I-III Date/Time Prepared: 5/24/2017 12:55 pm
PART I - COST	REPORT STATUS				
Provi der	1. [X] Electronically file	d cost report		Date: 5/24/20	17 Time: 12:55 pm
use only	2. [] Manually submitted of 3. [0] If this is an amendo 4. [F] Medicare Utilization	ed report enter the number	of times the provider r _" for low.	resubmitted this co	ost report
Contractor use only	 5. [1] Cost Report Status (1) As Submitted (2) Settled without Audit (3) Settled with Audit (4) Reopened (5) Amended 		11. pr this Provider CCN 12.		

PART II - CERTIFICATION

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MISREPRESENTATION OF 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 OF INDIRECTLY OF A KICKBACK OR WERE OTHERWISE ILLEGAL, CRIMINAL, CIVIL AND ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT MAY RESULT.

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH BLACKFORD HOSPITAL (15-1302) for the cost reporting period beginning 01/01/2016 and ending 12/31/2016 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si	ar	ned)

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

05/25/2017 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	-86, 036	-196, 048	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	27, 711	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	-58, 325	-196, 048	0	0	200.00

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

	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I		BLACKFORD	HOSPI TA Provi der		5 1202	Peri od:	In Lieu		rm CMS- eet S-2	
позет 1	AL AND HUSPITAL HEALTH CARE COMPLEX I	DENTIFICATION DA		PLOVEU	CCN. I	5-1302	From 01/01	/2016 /2016	Part I	ime Pre	
	1.00			-			10 12/3			017 7:1	
	1.00 Hospital and Hospital Health Care Co		00	3.	00			4.00			
1.00	Street: 410 PILGRIM STREET	P0 Box:									1.00
2.00	City: HARTFORD CITY	State: I Component Na		p Code: 4 CCN	47348 CBSA	Provi der	ty: BLACKFO - Date		ent Sys	tem (P	2.00
					umber	Туре	Certified	1 <u> </u>	<u>, 0, or</u>	N)	
		1.00		2.00	3.00	4.00	5.00	V 6. 00	XVIII 7.00		-
	Hospital and Hospital-Based Componen		2	2.00	3.00	4.00	5.00	0.00	7.00	8.00	
3.00	Hospi tal	IU HEALTH BLACKFO	DRD 15	51302	99915	1	02/10/200	O N	0	0	3.00
4.00	Subprovider - IPF	HOSPI TAL									4.00
5.00	Subprovider - IRF										5.00
6.00 7.00	Subprovider - (Other) Swing Beds - SNF	BLACKFORD COMMUNI	ту 15	5Z302	99915		02/10/200	οΝ	0	0	6.00
		SWING BED					02/10/200				
8.00 9.00	Swing Beds - NF Hospital-Based SNF										8.00
10.00	Hospi tal -Based NF										10.00
11.00	Hospi tal -Based OLTC										11.00
12.00 13.00	Hospital-Based HHA Separately Certified ASC										12.00
14.00	Hospi tal -Based Hospi ce										14.00
15.00 16.00	Hospital-Based Health Clinic - RHC Hospital-Based Health Clinic - FQHC										15.00
17.00	Hospi tal -Based (CMHC) I										17.00
18.00	Renal Dialysis Other										18.00
19.00	Jotner						From	n:	To):	19.00
							1.0			00	00.00
20. 00 21. 00	Cost Reporting Period (mm/dd/yyyy) Type of Control (see instructions)						01/01/	2016	12/31	/2016	20.00
22.00	Inpatient PPS Information Does this facility qualify and is it								1	N	22.00
	share hospital adjustment, in accord for yes or "N" for no. Is this facil										
	amendment hospital?) In column 2, en	ter "Y" for yes o	r "N" for	no.		. , .					
22. 01	Did this hospital receive interim un period? Enter in column 1, "Y" for y						N		ſ	N	22.01
	reporting period occurring prior to	October 1. Enter	in column :	2, "Y" fo	or yes	or "N"					
	for no for the portion of the cost r (see instructions)	eporting period o	ccurring o	n or afte	er Octo	ober 1.					
22. 02	Is this a newly merged hospital that						N		I	N	22. 02
	determined at cost report settlement or "N" for no, for the portion of th	•				2	S				
	in column 2, "Y" for yes or "N" for						n				
22. 03	or after October 1. Did this hospital receive a geograph	i c roclassi fi cati	on from ur	han to ri	ural a	s a rosul	t N		,	N	22.03
22.03	of the OMB standards for delineating								1	N	22.03
	in column 1, "Y" for yes or "N" for										
	prior to October 1. Enter in column cost reporting period occurring on o										
	hospital contain at least 100 but no			unted in	accord	dance wit	h				
23.00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me			/or 25 be	elow? I	In column		2	1	N	23.00
	1, enter 1 if date of admission, 2 i	J .			5						
	method of identifying the days in th used in the prior cost reporting per										
			In-State	In-Stat		ut-of	Out-of	Medi ca)ther	
			Medicaid paid days	Medicai eligibl		State di cai d	State Medicaid	HMO da	<i>y</i>	di cai d days	
				unpai d			eligible				
		-	1.00	days 2.00		3.00	unpai d 4. 00	5.00		6.00	-
	If this provider is an IPPS hospital		0		0	0	0	0.00	0	0.00	24.00
24.00	in-state Medicaid paid days in colum										
24.00	Medicaid eligible unnaid days in col										
24.00	Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c				1						
24.00	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai	d days in column									
24.00	out-of-state Medicaid paid days in c	d days in column t unpaid days in									
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th	d days in column t unpaid days in column 6. e in-state	0	-	0	0	0		0		25. 00
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the	d days in column t unpaid days in column 6. e in-state in-state	0		0	0	0		0		25.00
24. 00 25. 00	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col out-of-state Medicaid days in column	d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state	0	-	0	0	0		0		25.00
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	d days in column t unpaid days in column 6. e in-state in-state umn 2, 3, out-of-state umn 4, Medicaid	0		0	0	0		0		25. OC

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tus at the end r rural. If ap in column 2. of periods SC ubscript line mber of period ransitional pa r "N" for no. status. If li s in excess of t adjustment f r in column 1 ts in accordan for no. (see i ment? Enter "Y nter "Y" for y nstructions)	of the cost plicable, H status in 36 for number s MDH status yment in (see ne 37 is one and or low volume "Y" for yes ce with 42 nstructions) " for yes or	1.00 2 2 2 3 3 4 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5 5	2.00 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	26.00 27.00 35.00 36.00 37.00 37.01 38.00
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r rural. If ap in column 2. of periods SC ubscript line mber of period ransitional pa r "N" for no. status. If li s in excess of t adjustment f r in column 1 ts in accordan for no. (see i ment? Enter "Y nter "Y" for y nstructions)	plicable, H status in 36 for number s MDH status yment in (see ne 37 is one and or low volume "Y" for yes ce with 42 nstructions) " for yes or	Begi nni ng: 1. 00 N Y/N 1. 00 N	Endi ng: 2.00 2.00 Y/N 2.00 N	35. 00 36. 00 37. 00 37. 01 38. 00
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status. If li s in excess of t adjustment f r in column 1 ts in accordan for no. (see i ment? Enter "Y nter "Y" for y nstructions)	ne 37 is one and or low volume "Y" for yes ce with 42 nstructions) " for yes or	1.00 N	2.00 N	_
t adjustment f r in column 1 ts in accordan for no. (see i ment? Enter "Y nter "Y" for y nstructions)	or low volume "Y" for yes ce with 42 nstructions) " for yes or	1.00 N	2.00 N	39.00
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r in column 1 ts in accordan for no. (see i ment? Enter "Y nter "Y" for y nstructions)	"Y" for yes ce with 42 nstructions) " for yes or			39.00
ment? Enter "Y nter "Y" for y nstructions)	" for yes or	Ν	N	1
· · · · · ·				40.00
		V 1.0		
i sproporti onat	e share in acc	cordance N	N N	45.00
			N N	46.00
			N N N N	47.00 48.00
d GME programs	? Enter "Y"	for yes N		56.00
"N" for no in is cost report lete Worksheet	column 1. If ing period? I	column 1 Enter "Y"		57.00
t for physicia	ns' services a	as		58.00
	Pt. I.	N		59.00
1 0		N		60.00
<u>or "N" for no</u> IME	<u>. (see instrue</u> Direct GME	IME	Direct GME	
2.00	3.00	4.00	5.00	
		0.00	u 0.00	0 61.00
0.00	0.0	d		61.01
0.00	0.0	d		61.02
0. 00	0.0	d		61.03
0.00	0.0	o		61.04
0. 00	0.0	c		61. 05
	III and Wkst hter "Y for yes "Y" for yes d GME programs uring which re "N" for no in is cost report lete Worksheet olicable. t for physicia e Wkst. D-5. ete Wkst. D-5. hter wkst. D-5. hter no IME 2.00 0.00 0.00 0.00	III and Wkst. L-1, Pt. I Inter "Y for yes or "N" for no. If GME programs? Enter "Y" in If of no in column 1. If is cost reporting period? If iete Worksheet E-4. If columed in the physicians' services are weather that meets the or "N" for no. (see instruction in the program that meets the or "N" for no. (see instruction in the program that meets the or "N" for no. (see instruction in the program that meets the or "N" for no. (see instruction in the program that meets the or "N" for no. (see instruction in the program that meets the or "N" for no. (see instruction in the program that meets the or "N" for no. (see instruction in the program that meets the or "N" for no. (see instruction in the program that meets the or "N" for no. (see instruction in the program that meets the or "N" for no. (see instruction in the program that meets the or "N" for no. (see instruction in the program that meets the or "N" for no. (see instruction in the program that meets the or "N" for no. (see instruction in the program that meets the or "N" for no. (see instruction in the program that meets the or "N" for no. (see instruction in the program in the program that meets the or "N" for no. (see instruction in the program in the program that meets the or "N" for no. (see instruction in the program in the progr	III and Wkst. L-1, Pt. I through nter "Y for yes or "N" for no. N mter "Y for yes or "N" for no. N d GME programs? Enter "Y" for yes N d GME programs? Enter "Y" for yes N uring which residents in approved "N" for no in column 1. If column 1 is cost reporting period? Enter "Y" is cost reporting period? Enter "Y" iete Worksheet E-4. If column 2 is olicable. t for physicians' services as eWst. D-5. ete Wkst. D-2, Pt. I. N or "N" for no. (see instructions) N IME Direct GME IME 2.00 3.00 4.00 0.00 0.00 0.00 0.00 0.00 0.00	III and Wkst. L-1, Pt. I through nter "Y for yes or "N" for no. N N N N d GME programs? Enter "Y" for yes N N N N d GME programs? Enter "Y" for yes N N N N d GME programs? Enter "Y" for yes N N N N d GME programs? Enter "Y" for yes N N N N d GME programs? Enter "Y" for yes N N N N d GME programs? Enter "Y" for yes N N N N d GME programs? Enter "Y" for yes N N N N is cost reporting period? Enter "Y" If column 1 Is cost reporting period? Enter "Y" N N is cost reporting period? Enter "Y" N N N N N tor physicians' services as N N N N N N or "N" for no. (see instructions) IME Direct GME IME Direct GME 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00<

OSPITAL AND HOSPITAL H	s EALTH CARE COMPI			FORD HOSPITAL Provider CC		eri od:	u of Form CMS-2 Worksheet S-2	
					Fr Tc	com 01/01/2016 0 12/31/2016	Part I Date/Time Pre 5/23/2017 7:1	
			Y/N	IME	Direct GME	IME	Direct GME	
			1.00	2.00	3.00	4.00	5.00	
.06 Enter the amount used for cap reli care or general s	ef and/or FTEs	that are nonprimary		0. 00	0.00			61.
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	-
				1.00	2.00	3.00	4.00	
specialty, if any for each new prog column 1, the pro program code, ent	r, and the numbe ram. (see instr gram name, ente er in column 3, and enter in co	fy each new program r of FTE residents uctions) Enter in r in column 2, the the IME FTE lumn 4, direct GME				0.00	0.00	61.
.20 Of the FTEs in li program special ty residents for eac instructions) Ent enter in column 2	ne 61.05, speci r, if any, and t h expanded prog er in column 1, r, the program c weighted count	he number of FTE ram. (see the program name, ode, enter in column and enter in column				0. 00	0. 00	61.
							1.00	-
		Ith Resources and Ser						
		s that your hospital funding (see instruc		in this cost	reporting peri	od for which	0.00	62.
.01 Enter the number during in this co	of FTE resident st reporting pe	s that rotated from a riod of HRSA THC prog sidents in Nonprovide	a Teachi gram. (s	<u>see instruction</u>		your hospital	0.00	62.
8.00 Has your facility	r trained reside	nts in nonprovider se umn 1. If yes, comple	ettings	during this co		eriod? Enter	N	63.
					Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	r
					1.00	2.00	3.00	
		r FTE Residents in No uly 1, 2009 and befor			his base year	is your cost r	eporting	
in the base year resident FTEs att settings. Enter resident FTEs tha	period, the num ributable to ro in column 2 the t trained in yo	yes, or your facilit ber of unweighted nor tations occurring in number of unweighted ur hospital. Enter in 1 + column 2)). (see	n-priman all nor d non-pr n column	ry care nprovider imary care n 3 the ratio	0.00		0. 000000	64.
		Program Name	Pro	ogram Code	Unweighted FTEs Nonprovider Site		Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		2.00	3. 00	4.00	5.00	
5.00 Enter in column 1 is yes, or your f trained residents year period, the associated with p FTEs for each pri program in which residents. Enter the program code, column 3, the num unweighted primar residents attribu rotations occurri non-provider sett column 4, the num unweighted primar	Tacility in the base program name rimary care you trained in column 2, enter in ber of y care FTE table to ng in all ings. Enter in ber of				0. 00	0.00	0. 000000	

	Financial Systems		H BLACKFORD HOSPITA			u of Form CMS-2	
HOSPI TA	L AND HOSPITAL HEALTH CARE COMPI	_EX IDENTIFICATION DA	.TA Provi der	F	eriod: rom 01/01/2016 o 12/31/2016		pared:
				Unweighted FTEs Nonprovider Site	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
5	Section 5504 of the ACA Current	Year FTF Residents in	n Nonprovider Setti	<u> </u>	2.00 pr.cost_reporti	3.00	
66.00 E F F F	beginning on or after July 1, 20 Enter in column 1 the number of TEs attributable to rotations o Enter in column 2 the number of TEs that trained in your hospit	10 unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	ry care resident rovider settings. ry care resident 3 the ratio of	0.00			66. 00
	column 1 divided by (column 1 +	Program Name	Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
		1.00		Site			
r S W E C r C t r C U U T S S C	inter in column 1, the program 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 livided by (column 3 + column 4)). (see instructions)	1.00	2.00	3.00	<u>4.00</u> 0.00	5.00 0.000000	67.00
4	()). (see Instructions)						
I	npatient Psychiatric Facility P	DS			1.0	0 2.00 3.00	
70.00 E 71.00 r 4 p	s this facility an Inpatient Ps Enter "Y" for yes or "N" for no f line 70 yes: Column 1: Did th recent cost report filed on or b 22 CFR 412.424(d)(1)(iii)(c)) Co orogram in accordance with 42 CF column 3: If column 2 is Y, indi (see instructions)	ychiatric Facility (I e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	pproved GME teaching 004? Enter "Y" for lity train residen 0(D)? Enter "Y" for	, g program in the yes or "N" for r ts in a new teach yes or "N" for r	most no. (see ni ng no.	0	70. 00 71. 00
75.00 I	npatient Rehabilitation Facilit s this facility an Inpatient Re	<u>y PPS</u> habilitation Facility	(IRF), or does it	contain an IRF	N		75.00
76.00 r r	subprovider? Enter "Y" for yes f line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility XFR 412.424 (d)(1)(iii)(D)? Ente ndicate which program year bega	and "N" for no. e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	pproved GME teaching ember 15, 2004? Ent new teaching progra for no. Column 3:	g program in the er "Y" for yes o am in accordance If column 2 is Y,	r "N" for with 42	0	76.00
						1.00	
80. 00 81. 00	ong Term Care Hospital PPS s this a long term care hospita s this a LTCH co-located within Y" for yes and "N" for no. "EFRA Providers				period? Enter	N N	80. 00 81. 00
85.00 I 86.00 D	is this a new hospital under 42 d this facility establish a ne 413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider ((excluded unit) und			N	85. 00 86. 00
87.00 I	s this hospital a "subclause (I for yes or "N" for no.			d)(1)(B)(iv)(II)1	? Enter "Y"	Ν	87.00
					V	XI X	
T	itle V and XIX Services				1.00	2.00	
	Does this facility have title V Yes or "N" for no in the applica		hospital services?	Enter "Y" for	N	Y	90.00
91.00 Ĭ	s this hospital reimbursed for	title V and/or XIX th			N	N	91.00
92.00 A	full or in part? Enter "Y" for y Are title XIX NF patients occupy	ing title XVIII SNF b	oeds (dual certifica			N	92.00
93.00 E	nstructions) Enter "Y" for yes Does this facility operate an IC Y" for yes or "N" for no in the	F/IID facility for pu applicable column.	urposes of title V a		N	N	93. 00
	Does title V or XIX reduce capit applicable column.	al cost? Enter "Y" fo	or yes, and "N" for	no in the	N	N	94.00

	Provider CO	CN: 15-1302	Period: From 01/01/ To 12/31/	2016	u of Form Workshee Part I Date/Tim 5/23/201	t S-2 e Prepar	red:
			V		XI X		Cann
	11 11 1		1.00		2.00		
P5.00 If line 94 is "Y", enter the reduction percentage in the ap Does title V or XIX reduce operating cost? Enter "Y" for ye applicable column.			0. 00 N		0.00 N		95.0 96.0
77.00 If line 96 is "Y", enter the reduction percentage in the ap Rural Providers		1.	0.00		0.00		97.0
05.00 Does this hospital qualify as a critical access hospital (C 06.00 If this facility qualifies as a CAH, has it elected the all for outpatient services? (see instructions)		nod of paymen	t N)5.0)6.0
07.00 If this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col reimbursed. If yes complete Wkst. D-2, Pt. II.	nn 1. (see insti	ructions) If	t			10	07.0
08.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.				-	Dessions		08.0
	Physi cal 1.00	Occupationa 2.00	I Speec 3.00		Respi ra 4.00		
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.		N	N		N		09. 0
10.00 Did this hospital participate in the Rural Community Hospit the current cost reporting period? Enter "Y" for yes or "N"		on project (4	10A Demo)fo	-	1.00 N		10. 0
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 15.00 Is this an all-inclusive rate provider? Enter "Y" for yes o is yes, enter the method used (A, B, or E only) in column 2 3 either "93" percent for short term hospital or "98" perce psychiatric, rehabilitation and long term hospitals provide	2. If column 2 i ent for long te	is "E", enter rm care (incl	in column udes	N		0 11	15.0
Pub.15-1, chapter 22, §2208.1. 16.00 s this facility classified as a referral center? Enter "Y" 17.00 s this facility legally-required to carry malpractice insu			"N" for	N N			16. 0 17. 0
no. 18.00 Is the malpractice insurance a claims-made or occurrence po claim-made. Enter 2 if the policy is occurrence.	olicy? Enter 1 i	if the policy	is	1		11	18.0
		Premi ums	Losse	S	Insurar	ıce	
18.01 List amounts of malpractice premiums and paid losses:		1.00	2.00				
To. OTELEST amounts of marpractice premiums and pard rosses.					3.00		10.0
		31,6		0		011	18. C
Administrative and General? If yes, submit supporting sche and amounts contained therein.		than the		0		0 11	18. 0
Administrative and General? If yes, submit supporting sche and amounts contained therein. 19.00D0 NOT USE THIS LINE	edule listing co d Harmless prov n column 1, "Y" qualifies for th	than the ost centers vision in ACA ' for yes or ne Outpatient	86 1.00 N	0		0 11	18. C
Administrative and General? If yes, submit supporting sche and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impl	edule listing co d Harmless prov n column 1, "Y qualifies for tl nnts? (see instr	than the ost centers vision in ACA ' for yes or ne Outpatient ructions)	86 1.00 N	0	2.00	0 11 11 11 12	18. 0 19. 0 20. 0
Administrative and General? If yes, submit supporting sche and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t	d Harmless pro n column 1, "Y qualifies for th ents? (see instr antable devices P Enter "Y" for	than the ost centers vision in ACA ' for yes or ne Outpatient ructions) s charged to yes or "N"	86 1.00 N	0	2.00	0 11 11 11 12 12	18. C 19. C 20. C 21. C
 Administrative and General? If yes, submit supporting sche and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. Transplant Center Information 	edule listing co d Harmless prov n column 1, "Y jualifies for th ents? (see instr antable devices P Enter "Y" for the Worksheet A	than the ost centers ' for yes or ne Outpatient ructions) s charged to yes or "N" line number	86 1.00 N N Y	0	2.00	0 11 11 12 12 12	18. C 19. C 20. C 21. C 22. C
Administrative and General? If yes, submit supporting sche and amounts contained therein. 19.00 DO NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, e	d Harmless prov n column 1, "Y gualifies for th ents? (see instr antable devices ? Enter "Y" for the Worksheet A for yes and "N" enter the certi	than the ost centers ' for yes or ne Outpatient ructions) s charged to yes or "N" line number	86 1.00 N N Y N	0	2.00	0 11 11 12 12 12 12 12	18. 0 19. 0 20. 0 21. 0 22. 0 22. 0
 Administrative and General? If yes, submit supporting sche and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column 	d Harmless prov n column 1, "Y ualifies for ti ents? (see instr antable devices 2 Enter "Y" for the Worksheet A for yes and "N" enter the certifi 2.	than the ost centers vision in ACA ' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date	86 1.00 N N Y N	0	2.00	0 11 11 12 12 12 12 12 12 12	18. 0 18. 0 19. 0 220. 0 221. 0 225. 0 225. 0 226. 0 227. 0
 Administrative and General? If yes, submit supporting sche and amounts contained therein. 19.00 D0 NOT USE THIS LINE 20.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 21.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 22.00 Does the cost report contain state health or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. Transplant Center Information 25.00 Does this facility operate a transplant center? Enter "Y" fyes, enter certification date(s) (mm/dd/yyyy) below. 26.00 If this is a Medicare certified kidney transplant center, e in column 1 and termination date, if applicable, in column 27.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 28.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 	d Harmless pro- n column 1, "Y gualifies for the ents? (see instr antable devices 2 Enter "Y" for the Worksheet A for yes and "N" enter the certifi 2. ther the certifi 2.	than the bost centers vision in ACA ' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date	86 1.00 N N Y N	0	2.00	0 11 11 12 12 12 12 12 12 12 12 12 12 12	18. 0 19. 0 20. 0 21. 0 22. 0 22. 0 22. 0 26. 0 26. 0 27. 0 28. 0
 Administrative and General? If yes, submit supporting sche and amounts contained therein. 19:00 D0 NOT USE THIS LINE 20:00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 21:00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 22:00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. Transplant Center Information 25:00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 26:00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 27:00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 29:00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 29:00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 29:00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 29:00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 29:00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 20:00 If this is a Medicare certified liver transplant center, entin column 1 and termination date, if applicable, in column 	d Harmless province of the second sec	than the ost centers vision in ACA ' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date cation date i	86 1.00 N N Y N	0	2.00	0 11 11 12 12 12 12 12 12 12 12 12 12 12 1	18. 0 19. 0 20. 0 21. 0 22. 0 25. 0 26. 0 27. 0 28. 0 29. 0
and amounts contained therein. 119.00 D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hol §3121 and applicable amendments? (see instructions) Enter i "N" for no. Is this a rural hospital with < 100 beds that q Hold Harmless provision in ACA §3121 and applicable amendme Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impl patients? Enter "Y" for yes or "N" for no. 122.00 Does the cost report contain state heal th or similar taxes? for no in column 1. If column 1 is "Y", enter in column 2 t where these taxes are included. Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" f yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 128.00 If this is a Medicare certified liver transplant center, en in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, ent in column 1 and termination date, if applicable, in column 129.00 If this is a Medicare certified liver transplant center, ent	d Harmless prov n column 1, "Y gualifies for the ents? (see instr antable devices 2 Enter "Y" for the Worksheet A for yes and "N" enter the certifi 2. ther the certifi 2. ther the certifi 2. ther the certifi 2. enter the certifi	than the ost centers vision in ACA ' for yes or ne Outpatient ructions) s charged to yes or "N" line number for no. If fication date ication date ication date i tification	86 1.00 N N Y N	0	2.00	0 11 11 11 12 12 12 12 12 12 12	18. 0 19. 0 20. 0 21. 0 22. 0 25. 0 26. 0

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLES	IU HEALTH BLACK	ORD HOSPITAL	N· 15_1302	Peri od		u of Form CMS- Worksheet S-2	
HOST THE AND HOST THE HEALTH CARE COMPLET	TDENTITICATION DATA		M. 15-1502	From O	1/01/2016	Part I	
				To 1	2/31/2016	Date/Time Pre 5/23/2017 7:1	
122 00 6 this is a Madisson south find at					1.00	2.00	122.00
133.00 If this is a Medicare certified ot in column 1 and termination date,			cation dat	te			133.00
134.00 If this is an organ procurement or and termination date, if applicable	ganization (OPO), enter th		n column 1	1			134.00
Al I Provi ders							1
140.00 Are there any related organization chapter 10? Enter "Y" for yes or "	N" for no in column 1. If	yes, and home	office cos		Y	15H059	140.00
are claimed, enter in column 2 the 1.00			Tons)		3.00		
If this facility is part of a chai			ugh 143 th	e name an		of the	
home office and enter the home off						-	
141.00Name: IU HEALTH, INC 142.00Street: 340 W. 10TH STREET	Contractor's Name: WP PO Box:	S	Contra	actor's Nu	mber: 0810	1	141.00 142.00
143. 00 City: INDIANAPOLIS	State: IN		Zip Co	ode:	4620	4	143.00
						1.00	111.00
144.00 Are provider based physicians' cos	ts included in Worksheet A	4?				Y	144.00
					1.00	2.00	-
145.00 If costs for renal services are cla	aimed on Wkst. A, line 74,	are the costs	s for		Y		145.00
inpatient services only? Enter "Y" no, does the dialysis facility inc				5			
period? Enter "Y" for yes or "N"							
146.00 Has the cost allocation methodolog Enter "Y" for yes or "N" for no in				lf	Ν		146.00
yes, enter the approval date (mm/d		13-2, chapter 4	10, 34020)				
						1.00	4.47.00
147.00 Was there a change in the statistic 148.00 Was there a change in the order of						N N	147.00 148.00
149.00 Was there a change to the simplific				for no.		N	149.00
	g	Part A	Part E		itle V	Title XIX	
		1.00	2.00		3.00	4.00	
Does this facility contain a provi or charges? Enter "Y" for yes or "							
155.00Hospi tal		N	N	D. (Jee 4.	N	N	155.00
156.00 Subprovider - IPF		Ν	N		N	N	156.00
157.00 Subprovider - IRF		N	N		N	N	157.00
158. 00 SUBPROVI DER 159. 00 SNF		N	N		N	N	158.00 159.00
160.00HOME HEALTH AGENCY		N N	N N		N N	N N	160.00
161. 00 CMHC			N		N	N	161.00
						1.00	
Multicampus 165.00Is this hospital part of a Multica	mpus hospital that has one	e or more campu	uses in dif	fferent CE	BSAs?	N	165.00
Enter "Y" for yes or "N" for no.	Name	County	State	7in Codo	CBSA	FTE/Campus	
	0	County 1.00	2.00	Zip Code 3.00	4. 00	5.00	-
166.00 If line 165 is yes, for each			2.00	0.00			166.00
campus enter the name in column							
0, county in column 1, state in column 2, zip code in column 3,							
CBSA in column 4, FTE/Campus in							
column 5 (see instructions)							
						4.00	-
Health Information Technology (HIT) incentive in the America	an Recovery and	A Reinvest	ment Act		1.00	
167.00 Is this provider a meaningful user	under §1886(n)? Enter "	" for yes or "	'N" for no.	Merri Act		Y	167.00
168.00 If this provider is a CAH (line 10	5 is "Y") and is a meaning	gful user (line			the		168.00
reasonable cost incurred for the H		,		- ·			
168.01 If this provider is a CAH and is necessary exception under §413.70(a)(6)(ii)?					ishi p		168. 01
169.00 If this provider is a meaningful us					enter the	0.00	169.00
transition factor. (see instruction				-			

Health Financial Systems	IU HEALTH BLACKFOR	RD HOSPI TAL	In Lie	u of Form CMS-	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIF	FICATION DATA	Provider CCN: 15-1302	Period: From 01/01/2016	Worksheet S-2 Part I	2
			To 12/31/2016		
			Begi nni ng	Endi ng	
			1.00	2.00	
170.00 Enter in columns 1 and 2 the EHR beginning period respectively (mm/dd/yyyy)	date and ending dat	e for the reporting	10/01/2016	12/31/2016	170.00
					1
			1.00	2.00	
171.00 If line 167 is "Y", does this provider have section 1876 Medicare cost plans reported "Y" for yes and "N" for no in column 1. If 1876 Medicare days in column 2. (see instru	on Wǩst. S-3, Pt. I, column 1 is yes, en	line 2, col. 6? Enter	n	33	3171.00

PITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1302	Peri od:	Worksheet S-	2
			From 01/01/2016 To 12/31/2016		epared
				5/23/2017 7:	<u>19 am</u>
			Y/N	Date	_
			1.00	2.00	_
General Instruction: Enter Y for all YES responses. Enter N	I for all NO re	sponses. Ente	er all dates in t	the	
mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS					-
Provider Organization and Operation					-
0 Has the provider changed ownership immediately prior to the	e beginning of	the cost	N		1.
reporting period? If yes, enter the date of the change in c	5 5				1 .
		Y/N	Date	V/I	
		1.00	2.00	3.00	
0 Has the provider terminated participation in the Medicare F	Program? If	N			2.
yes, enter in column 2 the date of termination and in colum	nn 3, "V" for				
voluntary or "I" for involuntary.					
0 Is the provider involved in business transactions, includir		Y			3.
contracts, with individuals or entities (e.g., chain home of	offices, drug				
or medical supply companies) that are related to the provid					
officers, medical staff, management personnel, or members of directors through ownership, control, or family and other					
relationships? (see instructions)					
		Y/N	Туре	Date	
		1.00	2.00	3.00	-
Financial Data and Reports					
0 Column 1: Were the financial statements prepared by a Cert	ified Public	Y	A	03/10/2017	4.
Accountant? Column 2: If yes, enter "A" for Audited, "C" f	for Compiled,				
or "R" for Reviewed. Submit complete copy or enter date ava	ailable in				
column 3. (see instructions) If no, see instructions.					
0 Are the cost report total expenses and total revenues diffe		N			5.
those on the filed financial statements? If yes, submit rec	conciliation.				
			Y/N	Legal Oper.	
Approved Educational Activition			1.00	2.00	
Approved Educational Activities 0 Column 1: Are costs claimed for nursing school? Column 2:	lf voc ic th	o providor is	s N		6.
the legal operator of the program?	TT yes, is th				0.
0 Are costs claimed for Allied Health Programs? If "Y" see in	structions		Ν		7.
0 Were nursing school and/or allied health programs approved		during the	N		8.
cost reporting period? If yes, see instructions.		during the			0.
0 Are costs claimed for Interns and Residents in an approved	graduate medic	al education	Ν		9.
program in the current cost report? If yes, see instruction					
00 Was an approved Intern and Resident GME program initiated o	or renewed in t	he current	N		10.
cost reporting period? If yes, see instructions.					
00 Are GME cost directly assigned to cost centers other than I	& R in an App	roved	N		11.
Teaching Program on Worksheet A? If yes, see instructions.					
				Y/N	_
Bad Debts				1.00	-
00 Is the provider seeking reimbursement for bad debts? If yes	s soo instruct	Long		Y	1 12.
00 If line 12 is yes, did the provider's bad debt collection p			ost reporting	N N	13.
period? If yes, submit copy.	birtey change u	uning this co	ist reporting	IN IN	15.
00 If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	ves, see ins	structions.	N	14.
Bed Complement					
00 Did total beds available change from the prior cost reporti	ng period? If	yes, see inst	ructions.	N	15.
	Par	t A	Par	t B	
	Y/N	Date	Y/N	Date	
	1.00	2.00	3.00	4.00	
PS&R Data	1	1	- 1	I.	
00 Was the cost report prepared using the PS&R Report only?	N		N		16.
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)					
00 Was the cost report prepared using the PS&R Report for	Y	04/01/2017	Y	04/01/2017	17.
totals and the provider's records for allocation? If	'	04/01/2017	1	04/01/2017	''.
either column 1 or 3 is yes, enter the paid-through date					
in columns 2 and 4. (see instructions)					
00 If line 16 or 17 is yes, were adjustments made to PS&R	N		Ν		18
Report data for additional claims that have been billed					
but are not included on the PS&R Report used to file this					
but are not merdded on the roak keport doed to mre this	1				
cost report? If yes, see instructions.					
cost report? If yes, see instructions. 00 If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19.
cost report? If yes, see instructions.	N		N		19.

Health Financial Systems

In Lieu of Form CMS-2552-10

DODL TA	Financial Systems IU HEALTH BLACK	KFORD HOSPITAL		In Lie	eu of Form CMS	S-2552-1
IOSPI TA	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	F	Period: From 01/01/2016 Fo 12/31/2016	Date/Time P	repared:
			·	V/ /N	5/23/2017 7	:19 am
			iption	Y/N	Y/N	_
	LE Line 1/ en 17 is use adjustments made to DCOD		0	1.00	3.00	20.00
	If line 16 or 17 is yes, were adjustments made to PS&R			N	N	20.00
	Report data for Other? Describe the other adjustments:	V /N	Data	V /N	Data	_
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
	Was the cost report prepared only using the provider's	N		N		21.00
	records? If yes, see instructions.					_
					1.00	
C	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE				1.00	
	Capital Related Cost	LET GHILDKENS I	IUSFITALS)			_
	Have assets been relifed for Medicare purposes? If yes, see	o instructions			N	22.00
	Have changes occurred in the Medicare depreciation expense		sale mada durir	a the cost	N	22.00
		uue to apprais	sais liidue uurri	ig the cost	IN IN	23.00
1	reporting period? If yes, see instructions.	od into during	this seat mans	sting popied?	N	24.00
	Were new leases and/or amendments to existing leases entere	ed into during	this cost repo	orting period?	N	24.00
	If yes, see instructions	46		6		25 00
	Have there been new capitalized leases entered into during	the cost repor	ting period? I	r yes, see	N	25.00
	instructions.					
	Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period? IT	yes, see	N	26.00
	instructions.			and a submitte		07.00
	Has the provider's capitalization policy changed during the	e cost reportin	ig period? IT y	es, submit	N	27.0
	copy.					_
	Interest Expense					
	Were new loans, mortgage agreements or letters of credit en	ntered into dur	ring the cost r	reporting	N	28.0
	period? If yes, see instructions.			- 0		
	Did the provider have a funded depreciation account and/or		ebt Service Res	serve Fund)	N	29.0
	treated as a funded depreciation account? If yes, see instr	ructions				
	Has existing debt been replaced prior to its scheduled mate	urity with new	debt? If yes,	see	N	30.0
	instructions.					
	Has debt been recalled before scheduled maturity without is	ssuance of new	debt? If yes,	see	N	31.0
-	instructions.					
	Purchased Services					
	Have changes or new agreements occurred in patient care se		ed through cont	ractual	N	32.0
	arrangements with suppliers of services? If yes, see instru					
	If line 32 is yes, were the requirements of Sec. 2135.2 app	plied pertainin	ng to competiti	ve bidding? If		33.0
	no, see instructions.				L	
	Provi der-Based Physi ci ans					
	Are services furnished at the provider facility under an an	rrangement with	n provi der-base	ed physi ci ans?	Y	34. C
	If yes, see instructions.					
	If line 34 is yes, were there new agreements or amended exi		nts with the pr	rovi der-based	N	35. C
	physicians during the cost reporting period? If yes, see in	nstructions.	-	N/ (1)		
				Y/N		
					Date	
				1.00	2.00	
	Home Office Costs			1.00		
6.00 🛙	Were home office costs claimed on the cost report?			1.00 Y		
6.00 7.00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu	repared by the	home office?	1.00		36.0
6. 00 1 7. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions.			1.00 Y Y		37.0
6. 00 7. 00 8. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes , was the fiscal year end of the home offi	fice different	from that of	1.00 Y		37.0
6. 00 7. 00 8. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end	fice different d of the home of	from that of office.	1.00 Y Y N		37. (38. (
6. 00 7. 00 8. 00 9. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe	fice different d of the home of	from that of office.	1.00 Y Y		37. 0 38. 0
6. 00 7. 00 8. 00 9. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.	fice different d of the home o er chain compor	from that of office. nents? If yes,	1.00 Y Y N Y		37. (38. (39. (
6. 00 7. 00 8. 00 9. 00 0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	fice different d of the home o er chain compor	from that of office. nents? If yes,	1.00 Y Y N		37. (38. (39. (
6. 00 7. 00 8. 00 9. 00 0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions.	fice different d of the home o er chain compor	from that of office. nents? If yes,	1.00 Y Y N Y		37. 0 38. 0 39. 0
6. 00 7. 00 8. 00 9. 00 0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home off the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the	fice different d of the home o er chain compor home office?	from that of office. nents? If yes, If yes, see	1.00 Y Y N Y N	2.00	
6. 00 7. 00 8. 00 9. 00 0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions.	fice different d of the home o er chain compor home office?	from that of office. nents? If yes,	1.00 Y Y N Y N		37. (38. (39. (
6. 00 1 7. 00 8. 00 9. 00 0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pully yes, see instructions. If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	fice different d of the home o er chain compor home office?	from that of office. nents? If yes, If yes, see	1.00 Y Y N Y N 2.	2.00	37. (38. (39. (40. (
6. 00 1 7. 00 8. 00 9. 00 5. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pu If yes, see instructions. If line 36 is yes, was the fiscal year end of the home offi the provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to othe see instructions. If line 36 is yes, did the provider render services to the instructions.	fice different d of the home o er chain compor home office?	from that of office. nents? If yes, If yes, see	1.00 Y Y N Y N	2.00	37. (38. (39. (40. (
6. 00 1 7. 00 8. 00 9. 00 5. 00 1. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pully yes, see instructions. If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information	fice different d of the home o er chain compor home office?	from that of office. nents? If yes, If yes, see	1.00 Y Y N Y N 2.	2.00	37. (38. (39. (40. (
6. 00 7. 00 8. 00 9. 00 0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pulling see instructions. If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	fice different d of the home o er chain compor home office?	from that of office. nents? If yes, If yes, see	1.00 Y Y N Y N 2.	2.00	37. (38. (39. (40. (
6. 00 7. 00 8. 00 9. 00 0. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pulling see instructions. If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	fice different d of the home o er chain compor home office?	from that of office. nents? If yes, If yes, see 00	1.00 Y Y N Y N 2.	2.00	37. (38. (39. (40. (41. (
6. 00 1 7. 00 1 8. 00 1 9. 00 1 1. 00 1 1. 00 1 2. 00 1	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pulling see instructions. If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively.	fice different d of the home of er chain compor home office?	from that of office. nents? If yes, If yes, see 00	1.00 Y Y N Y N 2.	2.00	37. (38. (39. (
6. 00 7. 00 8. 00 9. 00 1. 00 1. 00 1. 00	Were home office costs claimed on the cost report? If line 36 is yes, has a home office cost statement been pulling see instructions. If line 36 is yes, was the fiscal year end of the home office provider? If yes, enter in column 2 the fiscal year end If line 36 is yes, did the provider render services to other see instructions. If line 36 is yes, did the provider render services to the instructions. If line 36 is yes, did the provider render services to the instructions. Cost Report Preparer Contact Information Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3, respectively. Enter the employer/company name of the cost report	fice different d of the home of er chain compor home office?	from that of office. nents? If yes, If yes, see 00	1.00 Y Y N Y N 2.	2.00	37. (38. (39. (40. (41. (

Heal th	Financial Systems IU HEALTH B	LACKFORD HOSPI TAL				In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		Provi	der CCN: 15-1302		eri od:	Worksheet S-2		
						rom 01/01/2016 o 12/31/2016		pared: 9 am	
				3.00					
	Cost Report Preparer Contact Information								
41.00	Enter the first name, last name and the title/position		DI RECTOR,	GOVERNMENT				41.00	
	held by the cost report preparer in columns 1, 2, and 3	,	PROGRAMS						
	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 cos	t						43.00	
	report preparer in columns 1 and 2, respectively.								

		U HEALTH BLACK		N 1E 1000		eu of Form CMS-2	
HUSPII	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC,	AL DATA	Provider CC	JN: 15-1302	Period: From 01/01/2016 To 12/31/2016		pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A	No. of Beds	Bed Days	CAH Hours	Title V	
		Line Number		Avai I abl e			
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30. 00	15	5, 4	90 23, 760. 00	0	1.00
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	
6.00	Hospital Adults & Peds. Swing Bed NF					0	•
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		15	5, 4	90 23, 760. 00	0	
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGI CAL I NTENSI VE CARE UNI T						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		15	F 4			13.00
14.00 15.00	Total (see instructions) CAH visits		15	5, 4	90 23, 760. 00	0	14.00
16.00	SUBPROVIDER - IPF					0	16.00
17.00	SUBPROVIDER - IRF						17.00
18.00	SUBPROVI DER						18.00
19.00	SKILLED NURSING FACILITY						19.00
20.00	NURSING FACILITY						20.00
21.00	OTHER LONG TERM CARE						21.00
22.00	HOME HEALTH AGENCY						22.00
23.00	AMBULATORY SURGICAL CENTER (D. P.)						23.00
24.00	HOSPI CE						24.00
24.10	HOSPICE (non-distinct part)	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)		15				27.00
28.00	Observation Bed Days					0	28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)		0		0		32.00
32. 01	Total ancillary labor & delivery room						32.01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.0

OSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	CN: 15-1302	Period: From 01/01/2016 To 12/31/2016		pared
		I/P Days	/ O/P Visits	/ Trips	Full Time	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	705	5		90	10.00	1. C
. 00	HMO and other (see instructions)	119	48				2.0
. 00	HMO I PF Subprovi der	0	48				3.0
. 00	HMO I RF Subprovi der	0	0				4.0
. 00	Hospital Adults & Peds. Swing Bed SNF	918	0	0	18		5.0
. 00	Hospital Adults & Peds. Swing Bed NF	710	0		75		6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 623	5	2, 0			7.0
00	INTENSIVE CARE UNIT						8.
00	CORONARY CARE UNI T						9.
. 00	BURN INTENSIVE CARE UNIT						10.
. 00	SURGI CAL I NTENSI VE CARE UNI T						11.
2. 00	OTHER SPECIAL CARE (SPECIFY)						12.
8. 00	NURSERY						13.
. 00	Total (see instructions)	1, 623	5	2, 0	83 0.00	93.25	
. 00	CAH visits	0	0		0		15.
. 00	SUBPROVIDER - IPF						16.
. 00	SUBPROVIDER – IRF						17.
. 00	SUBPROVI DER						18.
. 00	SKILLED NURSING FACILITY						19.
. 00	NURSING FACILITY						20.
. 00	OTHER LONG TERM CARE						21.
. 00	HOME HEALTH AGENCY						22.
. 00	AMBULATORY SURGICAL CENTER (D. P.)						23.
. 00	HOSPI CE						24.
. 10	HOSPICE (non-distinct part)	0	0		0		24.
. 00	CMHC - CMHC						25.
. 00	RURAL HEALTH CLINIC						26.
. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00		
. 00	Total (sum of lines 14-26)				0.00	93.25	
. 00	Observation Bed Days		30	1.	46		28.
. 00	Ambul ance Tri ps	0					29.
. 00	Employee discount days (see instruction)				0		30.
. 00	Employee discount days - IRF				0		31.
. 00	Labor & delivery days (see instructions)	0	0		0		32.
. 01	Total ancillary labor & delivery room outpatient days (see instructions)	_			0		32.
. 00	LTCH non-covered days	0					33

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CO	CN: 15-1302	Period: From 01/01/2016 To 12/31/2016	u of Form CMS-2 Worksheet S-3 Part I Date/Time Pre 5/23/2017 7:19	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF		0		05 1 37 12 0 0	437	1.00 2.00 3.00 4.00 5.00 6.00
7.00 8.00 9.00 10.00 11.00 12.00 13.00	Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (con instructions)	0.00		2		427	7.00 8.00 9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00 18.00 20.00 21.00 22.00 23.00 24.00 24.10 25.00 26.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D. P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC	0. 00	0	21	5 1	437	14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 10 25. 00 26. 00
26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	FEDERALLY QUALIFIED HEALTH CENTER FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days	0. 00 0. 00					28. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01 33. 00

Heal th	Financial Systems IU HEALTH BLACKFOR	D HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA	Provider CC	CN: 15-1302	Peri od:	Worksheet S-1	0
				From 01/01/2016 To 12/31/2016		pared [.]
					5/23/2017 7:1	
					1.00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 column 3 di	vided by li	ne 202 colum	ı 8)	0. 432379	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				1, 077, 384	2.00
3.00	Did you receive DSH or supplemental payments from Medicaid?				N	3.00
4.00	If line 3 is "yes", does line 2 include all DSH or supplementa		from Medicai	1?		4.00
5.00	If line 4 is "no", then enter DSH or supplemental payments fro	m Medicaid			0	5.00
5.00	Medicaid charges				7, 466, 834	6.00
7.00 3.00	Medicaid cost (line 1 times line 6)	(line 7 min		and E. if	3, 228, 502 2, 151, 118	7.00
3.00	Difference between net revenue and costs for Medicaid program < zero then enter zero)	(The / min	us sum of ffr	ies z and s; TT	2, 151, 118	8.00
	Children's Health Insurance Program (CHIP) (see instructions f	or each lin	e)		I	
9.00	Net revenue from stand-al one CHIP		-/		0	9.00
10.00	Stand-al one CHIP charges				0	10.00
1.00	Stand-alone CHIP cost (line 1 times line 10)				0	11.00
12.00	Difference between net revenue and costs for stand-alone CHIP	(line 11 mi	nus line 9; i	f < zero then	0	12.00
	enter zero)					
	Other state or local government indigent care program (see ins				1	
3.00	Net revenue from state or local indigent care program (Not inc					13.00
4.00	Charges for patients covered under state or local indigent car	e program (Not included	in lines 6 or	0	14.00
F 00	10)				0	15 00
15.00 16.00	State or local indigent care program cost (line 1 times line 1 Difference between net revenue and costs for state or local in		program (Li	o 15 minus lino		1 .0.00
0.00	13; if < zero then enter zero)	urgent care	program (TT		0	10.00
	Uncompensated care (see instructions for each line)				1	
17.00	Private grants, donations, or endowment income restricted to f	unding char	ity care		0	17.00
8.00	Government grants, appropriations or transfers for support of				0	18.00
19.00	Total unreimbursed cost for Medicaid , CHIP and state and loca	l indigent	care program	s (sum of lines	2, 151, 118	19.00
	8, 12 and 16)	_				
			Uni nsured	Insured	Total (col. 1	
			patients	patients	+ col . 2)	
0.00	Charity and the set of failing (and instructions	、 、	1.00	2.00	3.00	20.00
20.00	Charity care charges for the entire facility (see instructions Cost of patients approved for charity care (line 1 times line		1, 272, 1 550, 0			
22.00	Partial payment by patients approved for charity care (The Times The	20)	550, 0 19, 6			
22.00			530, 4			
5.00			550, 4	10, 303	540,704	23.00
					1.00	
4.00	Does the amount in line 20 column 2 include charges for patien	t days beyo	nd a length o	of stay limit		24.00
	imposed on patients covered by Medicaid or other indigent care					
25.00	If line 24 is "yes," charges for patient days beyond an indig			h of stay limit	0	25.00
26.00	Total bad debt expense for the entire hospital complex (see in				745, 392	
27.00	Medicare bad debts for the entire hospital complex (see instru				211, 458	
28.00	Non-Medicare and non-reimbursable Medicare bad debt expense (I			20)	533, 934	
29.00	Cost of non-Medicare and non-reimbursable Medicare bad debt ex	pense (line	i times line	28)	230, 862	
30.00	Cost of uncompensated care (line 23 column 3 plus line 29)	ino 20)			779, 646	
31.00	Total unreimbursed and uncompensated care cost (line 19 plus l	rne 30)			2, 930, 764	31.00

Health Financial Systems	IU HEALTH BLACKFO				u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CC		Period: From 01/01/2016	Worksheet A	
				To 12/31/2016	Date/Time Pre 5/23/2017 7:1	pared:
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
GENERAL SERVICE COST CENTERS				-		
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT		24, 502	24, 50		877, 786	
2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP		0		0 0	0	2.00
3.00 00300 OTHER CAPITAL RELATED COSTS		0		0 0	0	3.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT	7, 965	922, 989	930, 95		965, 331	4.00
5. 01 00570 ADMI TTI NG	116, 573	9, 250	125, 82		125, 509	•
5. 02 00590 OTHER ADMIN AND GENERAL	446, 536	3, 010, 756	3, 457, 29		3, 407, 157	5.02
7.00 00700 OPERATION OF PLANT	126, 110	1,047,583	1, 173, 69		696, 774	7.00
9.00 00900 HOUSEKEEPI NG	161, 683	112, 967	274,65		256, 299	•
10. 00 01000 DI ETARY	165,067	100, 838	265, 90		147, 299	•
11. 00 01100 CAFETERI A	0	0		0 110, 325	110, 325	
13.00 01300 NURSING ADMINISTRATION	256, 593	28, 400	284, 99		283, 862	•
14.00 01400 CENTRAL SERVICES & SUPPLY	0	-9, 139	-9, 13		258, 217	
15.00 01500 PHARMACY	0	765, 158	765, 15	8 -322,616	442, 542	15.00
INPATIENT ROUTINE SERVICE COST CENTERS	1 (00 004	055 440	4 055 00	4 400 704	1 744 000	1 00 00
30. 00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	1, 600, 384	255, 440	1, 855, 82	4 -109, 731	1, 746, 093	30.00
50. 00 05000 OPERATING ROOM	271, 630	179, 199	450, 82	9 -98, 578	352, 251	50.00
53. 00 05300 ANESTHESI OLOGY	0	107, 897	107, 89		93, 820	•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	516, 365	781, 453	1, 297, 81		1, 100, 078	
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	1,027,221	1, 027, 22	-15, 250	1, 011, 971	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	
65. 00 06500 RESPI RATORY THERAPY	456, 180	52, 735	508, 91	-39,688	469, 227	65.00
65. 01 06501 SLEEP LAB	0	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	237, 612	50, 227	287, 83	57, 924	229, 915	
67.00 06700 OCCUPATI ONAL THERAPY	54, 257	0	54, 25		67, 664	•
68.00 06800 SPEECH PATHOLOGY	5, 226	0	5, 22		5, 226	•
69.00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		28, 599	28, 599	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0	0		0 779	779	•
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		357, 525	357, 525	73.00
76. 00 03140 CARDI OLOGY	0	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	20, 634	13, 240	33, 87	4 -5,007	28, 867	76.97
OUTPATIENT SERVICE COST CENTERS	· · · · ·			· · · ·		1
90. 00 09000 CLI NI C	51, 369	13, 613	64, 98	2 -6, 185	58, 797	90.00
91.00 09100 EMERGENCY	1, 707, 056	822, 586	2, 529, 64	2 -133, 400	2, 396, 242	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SPECIAL PURPOSE COST CENTERS]
113.00 11300 INTEREST EXPENSE		0		0 C	0	113.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	6, 201, 240	9, 316, 915	15, 518, 15	5 0	15, 518, 155	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 C	0	190. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
200.00 TOTAL (SUM OF LINES 118-199)	6, 201, 240	9, 316, 915	15, 518, 15	5 0	15, 518, 155	200.00

ECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provider CCN:	15-1302	Period: From 01/ To 12/	01/2016 31/2016	Worksheet Date/Time 5/23/2017	Prepared
	Cost Center Description	5	Net Expenses or Allocation 7.00				0,20,2011	
	GENERAL SERVICE COST CENTERS	0.00	7.00					
. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	114, 256	992, 042					1.0
. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	0					2.0
. 00	00300 OTHER CAPITAL RELATED COSTS	0	0					3.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	195, 407	1, 160, 738					4.0
. 00	00570 ADMI TTI NG	-14	125, 495					5.0
. 02	00590 OTHER ADMIN AND GENERAL	-56, 045	3, 351, 112					5.0
. 02	00700 OPERATION OF PLANT	277, 656	974, 430					7.0
. 00	00900 HOUSEKEEPING	9,869	266, 168					9.0
0.00	01000 DI ETARY	-22, 637	124, 662					10.0
1.00	01100 CAFETERI A	-23, 077	87, 248					11.0
3.00								13.0
	01300 NURSI NG ADMI NI STRATI ON	1, 868	285, 730					
4.00	01400 CENTRAL SERVICES & SUPPLY	0	258, 217					14.0
5.00	01500 PHARMACY	279, 747	722, 289					15.0
~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	1 74(000					- 20 0
0. 00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	0	1, 746, 093					30.0
0. 00	05000 OPERATING ROOM	E 104	257 277					FO (
		5, 126	357, 377					50.0
3.00	05300 ANESTHESI OLOGY	-93, 769	51					53.0
4.00	05400 RADI OLOGY-DI AGNOSTI C	125, 286	1, 225, 364					54.0
7.00	05700 CT SCAN	0	0					57.0
8.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0					58.0
9.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	0						59. 0 60. 0
0.00	06001 BLOOD LABORATORY	0	1, 011, 971					60.0
0.01		0	0					
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	14 750	-					62.0
5.00	06500 RESPI RATORY THERAPY	16, 759	485, 986					65.0
5.01	06501 SLEEP LAB	10 7/0	0					65.0
6.00	06600 PHYSI CAL THERAPY	18, 769	248, 684					66.0
7.00	06700 OCCUPATIONAL THERAPY	0	67, 664					67.0
8.00		0	5, 226					68.0
9.00	06900 ELECTROCARDI OLOGY	0	0					69.0
1.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	28, 599					71.0
	07200 I MPL. DEV. CHARGED TO PATIENT	0	779					72.0
3.00	07300 DRUGS CHARGED TO PATIENTS	0	357, 525					73.0
6.00	03140 CARDI OLOGY	0	0					76.0
6. 97	07697 CARDI AC REHABI LI TATI ON	-640	28, 227					76. 9
0. 00	OUTPATI ENT SERVICE COST CENTERS	0	58, 797					90.0
1.00	09100 EMERGENCY							
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	-778, 631	1, 617, 611					91.0
2.00	SPECIAL PURPOSE COST CENTERS	I I	1					92.0
12 00	11300 INTEREST EXPENSE	0	0					112 0
13.00 18.00		69, 930						113. C
10.00	SUBTOTALS SUB OF LINES 1-117 NONREI MBURSABLE COST CENTERS	09, 930	15, 588, 085					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0					190. 0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	0					190.0
92.00 00.00		69, 930	15, 588, 085					200. 0

				From 01/01/2 To 12/31/2	2016 Date/Time Pr
	Increases				5/23/2017 7:
Cost Center	Line #	Salary	Other		
2.00 A - CAFETERIA	3.00	4.00	5.00		
CAFETERI A	11.00	70, 689	39, 636		
		70, 689	39,636		
B - MEDI CAL SUPPLI ES					
OTHER ADMIN AND GENERAL	5.02	0	750		
CENTRAL SERVICES & SUPPLY	14.00	0	267, 376		
MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	71.00	0	28, 599		
IMPL. DEV. CHARGED TO	72.00	0	779		
PATIENT	, 21 00	Ŭ			
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00 0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00 0.00	0	0		
		0	<u>297, 504</u>		
C - DRUGS CHARGED TO PATIENTS		0	277,004		
OTHER ADMIN AND GENERAL	5.02	0	672		
PHARMACY	15.00	О	18, 025		
RESPI RATORY THERAPY	65.00	0	438		
DRUGS CHARGED TO PATIENTS	73.00	0	357, 525		
	0. 00 0. 00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	О	0		
	0.00	0	0		
		0	376, 660		
D - LEASE EXPENSE NEW CAP REL COSTS-BLDG &	1.00	0	40, 685		
FIXT	1.00	0	40, 005		
0		o	40, 685		
E - EMPLOYEE BENEFITS					
EMPLOYEE BENEFITS DEPARTMENT	4.00	0	43, 172		
	0.00 0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0. 00 0. 00	0	0		
	0.00	0	0		
	0.00	0	0		
0			43, 172		
F - DEPRECIATION					
NEW CAP REL COSTS-BLDG &	1.00	0	799, 623		
FIXT	0.00	o	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	O		
	0.00	0	0		
	0. 00 0. 00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	Ō		
	0.00	0	0		
	0.00	0	0		

Heal th	Financial Systems		IU HEALTH BLACH	KFORD HOSPI TAL		In Lieu of Form CMS-2552-10		
RECLASS	RECLASSI FI CATI ONS			Provider C	CN: 15-1302	Period: From 01/01/2016	Worksheet A-	6
						To 12/31/2016	Date/Time Pr 5/23/2017 7:	epared: 19 am
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	G - OUTPATIENT THERAPY							
1.00	OCCUPATI ONAL THERAPY	67.00	13, 034	373				1.00
	0		13, 034	373				
	H - AUTO & PROPERTY INSURANCE							
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	12, 976				1.00
	FIXT							
	0		0	12, 976				
500.00	Grand Total: Increases		83, 723	1, 610, 629				500.00

Health Financial Systems RECLASSIFICATIONS

IU	HEALTH	BLACKFORD	HOSPI TAL

In Lieu of Form CMS-2552-10

Provider CCN: 15-1302

 Peri od:
 Worksheet A-6

 From 01/01/2016
 Date/Time Prepared:

 To
 12/31/2016
 Date/Time Prepared:

						0 12/31/2016 Date/11me 5/23/2017	
	Cont Conton	Decreases	Calarry	0+6			
	Cost Center 6.00	Line # 7.00	Salary 8.00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - CAFETERIA		0.00	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	10100		
1.00	DI ETARY	<u>10.</u> 00	7 <u>0, 6</u> 89	3 <u>9, 6</u> 36			1.00
	O B – MEDI CAL SUPPLI ES		70, 689	39, 636			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	130	0		1.00
2.00	ADMI TTI NG	5.01	0	52			2.00
3.00	OPERATION OF PLANT	7.00	0	23	0		3.00
4.00	HOUSEKEEPING	9.00	0	18, 059	0		4.00
5.00 6.00	DI ETARY NURSI NG ADMI NI STRATI ON	10.00 13.00	0	899 402	0		5. 00 6. 00
7.00	PHARMACY	15.00	0	3, 127	0		7.00
8.00	ADULTS & PEDIATRICS	30.00	0	60, 568	0		8.00
9.00	OPERATING ROOM	50.00	0	66, 509			9.00
10. 00 11. 00	ANESTHESI OLOGY RADI OLOGY-DI AGNOSTI C	53.00 54.00	0	12, 762 27, 357	0		10.00
12.00	RESPI RATORY THERAPY	65.00	0	28,665	0		12.00
13.00	PHYSI CAL THERAPY	66.00	0	2, 471	0		13.00
14.00	CARDI AC REHABI LI TATI ON	76. 97	0	819	0		14.00
15.00		90.00	0	3, 820			15.00
16.00	EMERGENCY	<u>91.00</u>	<u>0</u>	7 <u>1,841</u> 297,504	0		16.00
	C - DRUGS CHARGED TO PATIENTS	;	<u> </u>	277, 304			
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	7, 112			1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	20			2.00
3.00 4.00	PHARMACY ADULTS & PEDIATRICS	15.00 30.00	0	327, 462 8, 854	0		3.00 4.00
4.00 5.00	OPERATING ROOM	50.00	0	1, 791	0		5.00
6.00	ANESTHESI OLOGY	53.00	0	319	0		6.00
7.00	RADI OLOGY-DI AGNOSTI C	54.00	0	24, 466	0		7.00
8.00	PHYSICAL THERAPY	66.00	0	5	0		8.00
9.00 10.00	CLINIC EMERGENCY	90.00 91.00	0	905 5, 726			9.00 10.00
10.00	0		— — — 0	376, 660			10.00
	D – LEASE EXPENSE						
1.00	PHYSICAL THERAPY	<u>66.</u> 00	<u>0</u>	40, 685 40, 685			1.00
	E - EMPLOYEE BENEFITS		U	40, 885			
1.00	ADMI TTI NG	5.01	0	262			1.00
2.00	OTHER ADMIN AND GENERAL	5.02	0	4, 027	0		2.00
3.00 4.00	OPERATION OF PLANT HOUSEKEEPING	7.00 9.00	0	319 292	0		3.00 4.00
4.00 5.00	DI ETARY	10.00	0	402	0		5.00
6.00	NURSING ADMINISTRATION	13.00	0	729	0		6.00
7.00	ADULTS & PEDIATRICS	30.00	0	2, 833	0		7.00
8.00	OPERATING ROOM	50.00	0	506	0		8.00
9.00 10.00	RADI OLOGY-DI AGNOSTI C CARDI AC REHABI LI TATI ON	54.00 76.97	0	1, 248 48	0		9.00 10.00
11.00		90.00	0	119			11.00
12.00	EMERGENCY	<u>91.</u> 00	0	3 <u>2, 3</u> 87	0		12.00
			0	43, 172			
1.00	F - DEPRECIATION EMPLOYEE BENEFITS DEPARTMENT	4.00	0	1, 553	9		1.00
2.00	OTHER ADMIN AND GENERAL	5.02	0	34, 554			2.00
3.00	OPERATION OF PLANT	7.00	0	476, 577			3.00
4.00	DIETARY	10.00	0	6, 980			4.00
5.00 6.00	PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	10, 052 37, 476			5. 00 6. 00
7.00	OPERATING ROOM	50.00	0	29, 772			7.00
8.00	ANESTHESI OLOGY	53.00	0	996			8.00
9.00	RADI OLOGY-DI AGNOSTI C	54.00	0	144, 669			9.00
10. 00 11. 00	LABORATORY RESPI RATORY THERAPY	60.00 65.00	0	15, 250 11, 461	0		10. 00 11. 00
12.00	PHYSICAL THERAPY	66. 00	0	1, 356	0		12.00
13.00	CARDI AC REHABI LI TATI ON	76.97	Ö	4, 140	0		13.00
14.00	CLINIC	90.00	0	1, 341			14.00
15.00	EMERGENCY	<u>91.00</u>	<u>o</u>	<u>23, 446</u> 799, 623			15.00
	U G - OUTPATIENT THERAPY		U	199, 623			
1.00	PHYSICAL THERAPY	66.00	13,034				1.00
			13, 034	373			
1.00	H - AUTO & PROPERTY INSURANCE OTHER ADMIN AND GENERAL	5.02	0	12, 976	12		1.00
1.00				12, 976			1.00
500.00	Grand Total: Decreases		83, 723	1, 610, 629			500.00

Heal th	Financial Systems	U HEALTH BLACK	έωρη μωςρίτδι		Inlie	eu of Form CMS-2	2552-10
	ILLIATION OF CAPITAL COSTS CENTERS	U HEALTH BEACK	Provi der C		Period: From 01/01/2016 To 12/31/2016	Worksheet A-7 Part I	pared:
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	190, 324	0		0 0	0	1.00
2.00	Land Improvements	274, 136	0		0 0	14, 700	2.00
3.00	Buildings and Fixtures	15, 007, 745	0		0 0	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	5, 195, 575	119, 833		0 119, 833	46, 921	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20, 667, 780	119, 833		0 119, 833	61, 621	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	20, 667, 780	119, 833		0 119, 833	61, 621	10.00
		Endi ng Bal ance	Fully				
		5	Depreciated				
			Assets				
		6.00	7.00	1			
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	F BALANCES		•			
1.00	Land	190, 324	0				1.00
2.00	Land Improvements	259, 436	0				2.00
3.00	Buildings and Fixtures	15, 007, 745	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	5, 268, 487	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	20, 725, 992	0				8.00
9.00	Reconciling Items	20, 120, 172	0				9.00
10.00	Total (line 8 minus line 9)	20, 725, 992	0				10.00
10.00		20,720,772	0	I			1 10.00

Heal th	Financial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider CO	CN: 15-1302	Peri od:	Worksheet A-7	
					From 01/01/2016 To 12/31/2016		narod
					10 12/31/2010	5/23/2017 7:19	9 am
			SL	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	``	
		0.00	10.00	11.00		instructions)	
		9.00	10.00	11.00	12.00	13.00	
4 00	PART II - RECONCILIATION OF AMOUNTS FROM WORK			na 2			1 00
1.00	NEW CAP REL COSTS-BLDG & FIXT	24, 502	0		0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	24, 502			0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cast Castas Description	0 + 1	Tatal (1) (aum				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	15.00				
	DADT LL DECONCLULATION OF ANOUNTS FROM WOR	14.00	15.00				
4 00	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM					1 00
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	24, 502				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	24, 502				3.00

Health Financial Systems	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F	Period: From 01/01/2016 Fo 12/31/2016	Worksheet A-7 Part III Date/Time Prep 5/23/2017 7:19	
	COM	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPI TAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio (col. 1 - col. 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS C		1				
1.00 NEW CAP REL COSTS-BLDG & FIXT	20, 725, 992		20, 725, 992		0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	(0. 000000	0	2.00
3.00 Total (sum of lines 1-2)	20, 725, 992		20, 725, 992		0	3.00
	ALLOCA	TION OF OTHER (CAPITAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	1	-				
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	(938, 381	40, 685	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	(0	0	2.00
3.00 Total (sum of lines 1-2)	0	0	(938, 381	40, 685	3.00
		SL	JMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)			
				d Costs (see	through 14)	
	11.00	10.00	10.00	instructions)	45.00	
PART III - RECONCILIATION OF CAPITAL COSTS C	11.00	12.00	13.00	14.00	15.00	
1.00 NEW CAP REL COSTS-BLDG & FIXT		12, 976			992, 042	1.00
2.00 NEW CAP REL COSTS-BEDG & TTXT	0				992, 042 0	2.00
3.00 Total (sum of lines 1-2)	0	-			992, 042	3.00
		1 12,770			,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0.00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL

Heal th	Financial Systems	IL	J HEALTH BLACK	FORD HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES			Provider CCN: 15-1302	Period: From 01/01/2016 To 12/31/2016		pared:
				Expense Classification o To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center		Wkst. A-7 Ref.	
1.00	Investment income - NEW CAP	1.00	2.00	3.00 NEW CAP REL COSTS-BLDG &	4.00	5.00	1.00
1.00	REL COSTS-BLDG & FIXT (chapter		0	FIXT	1.00	0	1.00
2.00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		0	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.00
3.00	2) Investment income - other		0		0.00	0	3.00
4.00	(chapter 2) 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
	expenses (chapter 8)		0				
6.00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6.00
7.00	Telephone services (pay stations excluded) (chapter 21)		0		0.00	0	7.00
8.00	Television and radio service (chapter 21)		0		0.00	0	8.00
9. 00 10. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	0 -839, 690		0.00	0 0	9. 00 10. 00
11.00	adjustment Sale of scrap, waste, etc.		0		0.00	0	11.00
12.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	2, 414, 263			0	12.00
13.00	Laundry and linen service		0		0.00		
14. 00 15. 00	Cafeteria-employees and guests Rental of quarters to employee		-33,072	CAFETERI A	11.00 0.00		
16. 00	and others 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
	patients		0				
18.00	Sale of medical records and abstracts		0		0.00	0	
19.00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19.00
20. 00 21. 00	Vending machines Income from imposition of interest, finance or penalty	В	-22, 637 0	DI ETARY	10. 00 0. 00		
22.00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		0		0.00	0	22.00
23.00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	0	RESPI RATORY THERAPY	65.00		23.00
24.00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSICAL THERAPY	66.00		24.00
25. 00	limitation (chapter 14) Utilization review - physicians' compensation		0	*** Cost Center Deleted ***	114.00		25.00
26.00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT		0	NEW CAP REL COSTS-BLDG & FIXT	1.00	0	26.00
27.00	Depreciation - NEW CAP REL			NEW CAP REL COSTS-MVBLE	2.00	0	27.00
28.00	COSTS-MVBLE EQUIP Non-physician Anesthetist			EQUIP *** Cost Center Deleted ***			28.00
29. 00 30. 00	Physicians' assistant Adjustment for occupational therapy costs in excess of	A-8-3	0 0	OCCUPATI ONAL THERAPY	0.00 67.00		29.00 30.00
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31.00	Adjustment for speech pathology costs in excess of	A-8-3	0	SPEECH PATHOLOGY	68.00		31.00
32.00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest	A		NEW CAP REL COSTS-BLDG & FLXT	1.00	9	32.00

Heal th	Financial Systems	Ι	U HEALTH BLACK	FORD HOSPITAL	In Lie	u of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2016 To 12/31/2016	Date/Time Pre	naradi
					10 12/31/2010	5/23/2017 7:19	9 am
				Expense Classification or	n Worksheet A		-
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4,00	5, 00	
33.00	MARKETING/ADVERTISING COSTS	A		OTHER ADMIN AND GENERAL	5.02		33.00
34.00	MI SCELLANEOUS I NCOME	В		OTHER ADMIN AND GENERAL	5.02	0	
35.00	MI SCELLANEOUS I NCOME	В	-1,070	NURSING ADMINISTRATION	13.00	0	35.00
36.00	MI SCELLANEOUS I NCOME	В	-673	PHYSI CAL THERAPY	66.00	0	36.00
37.00	MI SCELLANEOUS I NCOME	В	-20	EMERGENCY	91.00	0	37.00
38.00	EMPLOYEE BENEFITS	A	-886, 015	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	38.00
39.00	NON-ALLOWABLE PATIENT	A	-2,560	OTHER ADMIN AND GENERAL	5.02	0	39.00
	REIMBURSEMENT						
	PTO EXPENSE ALLOCATION	A		OTHER ADMIN AND GENERAL	5.02		
	CHARITY CONTRIBUTIONS	A		OTHER ADMIN AND GENERAL	5.02		1
42.00	PHYSICIAN MALPRACTICE	A	-16, 606	OTHER ADMIN AND GENERAL	5.02	0	42.00
12 00	PHYSICIAN MALPRACTICE	А	22 220	EMERGENCY	91.00	0	43.00
45.00	INSURANCE	~	-33, 330	LINERGENCT	91.00	0	45.00
44.00	HOSPITAL ASSESSMENT FEES	А	-330, 898	OTHER ADMIN AND GENERAL	5.02	0	44. OC
45.00	MARKETING/ADVERTISING COSTS	А	-14	ADMI TTI NG	5.01	0	45. OC
50.00	TOTAL (sum of lines 1 thru 49)		69, 930				50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)						

(1) Description - all chapter references in this column pertain to CMS Pub. 15-1.
(2) Basis for adjustment (see instructions).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	IU HEALTH BLAC	CKFORD HOSPI TAL	In Lie	eu of Form CMS-	2552-10
STATEM	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HO	ME Provider CCN: 15-1302	Period:	Worksheet A-8	3–1
OFFICE	COSTS			From 01/01/2016		
				To 12/31/2016		
	Line No.	Cost Center	Expense Items	Amount of	5/23/2017 7:1 Amount	9 am
	LITIE NO.	COST Center	Expense i tellis	Allowable Cost		
					Wks. A, column	
					5 s x, s corumn	
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUST					
	HOME OFFICE COSTS:					
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	BUILDING CAPITAL-HOME OFFICE	125, 404	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS-HOME OFFIC	1,084,580	3, 158	2.00
3.00	5.02	OTHER ADMIN AND GENERAL	A&G-HOME OFFICE & BALL	2, 928, 572	2, 467, 953	3.00
4.00	7.00	OPERATION OF PLANT	PLANT- BALL	372, 748	95, 092	4.00
4.01	9.00	HOUSEKEEPING	HOUSEKEEPI NG-BALL	9, 869	0	4.01
4.02	10.00	DI ETARY	DI ETARY-BALL	15, 108	15, 108	4.02
4.03	11.00	CAFETERIA	CAFETERI A-BALL	9, 995	0	4.03
4.04	13.00	NURSING ADMINISTRATION	NURSING ADMIN-BALL	2, 938	0	4.04
4.05	15.00	PHARMACY	PHARMACY-BALL	689, 110	409, 363	4.05
4.06	30.00	ADULTS & PEDIATRICS	SHARED EMPLOYEE EXP-BALL	14, 792	14, 792	4.06
4.07	50.00	OPERATING ROOM	SHARED EMPLOYEE EXP-BALL	17, 795	12,669	4.07
4.08	54.00	RADI OLOGY-DI AGNOSTI C	SHARED EMPLOYEE EXP-BALL	473, 468		4.08
4.09	60.00	LABORATORY	SHARED EMPLOYEE EXP-BALL	955, 853	955, 853	4.09
4.10			SHARED EMPLOYEE EXP-BALL	477, 108		4.10
4.11			SHARED EMPLOYEE EXP-BALL	297, 739		4.11
4.12			SHARED EMPLOYEE EXP-BALL	54, 257	54, 257	4.12
4.13		SPEECH PATHOLOGY	SHARED EMPLOYEE EXP-BALL	5, 226	5, 226	4.13
4.14		CARDI AC REHABI LI TATI ON	SHARED EMPLOYEE EXP-BALL	1, 529		4.14
4.15			SHARED EMPLOYEE EXP-BALL	1, 361	1, 361	4.15
4.16			SHARED EMPLOYEE EXP-BALL	4, 466	4, 466	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4. 18
4, 19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
4.21	0.00			0	0	4. 21
4.22	0.00			0	0	4. 22
4.23	0.00			0	0	4.23
5.00	0		0	7, 541, 918	5, 127, 655	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.

nuo no	been posted to norresheet n,	containing if and of 2, the amount	it unionable sh	bara be that cated the containt i	or this part.	
				Related Organization(s) and/	or Home Office	
						1
						1
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	i i
	1.00	2.00	3.00	4.00	5.00	
	B INTERPELATIONSHIP TO PELAT	TED OPCANIZATION(S) AND/OP HO		·		

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

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

6.00	В	0. 00 I U HEALTH 100. 00	6.00
7.00	В	0. 00 BALL HOSPI TAL 100. 00	7.00
8.00		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.

Heal th	Financial Syste	ems	IU HEALTH BLACKFO	RD HOSPI TAL	In Lieu	of Form CMS-2552-10
		SERVICES FROM	RELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1302		Worksheet A-8-1
OFFICE	COSTS				From 01/01/2016 To 12/31/2016	Date/Time Prepared:
			,			5/23/2017 7:19 am
	Net	Wkst. A-7 Ref.				
	Adjustments					
	(col. 4 minus					
	col. 5)*		-			
	6.00	7.00				
			MENTS REQUIRED AS A RESULT OF TRA	ANSACTIONS WITH RELATED	ORGANIZATIONS OR C	LAIMED
1 00	HOME OFFICE CO					1.00
1.00	125, 404					1.00
2.00	1, 081, 422					2.00
3.00	460, 619					3.00
4.00	277, 656					4.00
4.01	9, 869					4.01
4.02	0	-				4.02
4.03	9, 995					4.03
4.04	2, 938					4.04
4.05	279, 747					4. 05
4.06	0					4.06
4.07	5, 126					4.07
4.08	125, 286	0				4. 08
4.09	0	-				4.09
4.10	16, 759					4. 10
4.11	19, 442	0				4. 11
4.12	0					4. 12
4.13	0	0				4.13
4.14	0	0				4.14
4.15	0	0				4. 15
4.16	0	-				4. 16
4.17	0	0				4. 17
4.18	0	0				4. 18
4.19	0	0				4. 19
4.20	0	0				4. 20
4.21	0	0				4. 21
4.22	0	0				4. 22
4.23	0	0				4. 23

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

5.00

	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

	HOSPI TAL	6.00
	HOSPI TAL	7.00
8.00		8.00
9. 00 10. 00		9.00
		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.

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

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

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

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

5.00

2, 414, 263

То	od: 1 01/01/2016 12/31/2016 CE Amount 6.00 0 0 0 0 0 0 0 0 0 0 0 0	Date/Time Pre 5/23/2017 7:1 Physi ci an/Prov i der Component Hours 7:00 0 0 0	epared:
I denti fi er Remunerati on Component Component 1.00 2.00 3.00 4.00 5.00 1.00 53.00 ANESTHESI OLOGY 93, 769 93, 769 0 2.00 54.00 RADI OLOGY-DI AGNOSTI C 150, 000 0 150, 000 3.00 60.00 LABORATORY 36, 000 0 36, 000 4.00 76.97 CARDI AC REHABI LI TATI ON 640 640 0 5.00 91.00 EMERGENCY 1, 028, 400 745, 281 283, 119 6.00 0.00 0 0 0 0 0	6.00 0 0 0 0 0 0 0 0 0 0	Physician/Prov ider Component Hours 7.00 0 0 0 0 0 0	1.00 2.00 3.00 4.00
1.00 53.00 ANESTHESI OLOGY 93,769 93,769 0 2.00 54.00 RADI OLOGY-DI AGNOSTI C 150,000 0 150,000 3.00 60.00 LABORATORY 36,000 0 36,000 4.00 76.97 CARDI AC REHABI LI TATI ON 640 640 0 5.00 91.00 EMERGENCY 1,028,400 745,281 283,119 6.00 0 0 0 0 0 0	0 0 0 0 0 0	7.00 0 0 0 0 0 0	2.00 3.00 4.00
1.00 53.00 ANESTHESI OLOGY 93,769 93,769 0 2.00 54.00 RADI OLOGY-DI AGNOSTI C 150,000 0 150,000 3.00 60.00 LABORATORY 36,000 0 36,000 4.00 76.97 CARDI AC REHABI LI TATI ON 640 640 0 5.00 91.00 EMERGENCY 1,028,400 745,281 283,119 6.00 0 0 0 0 0 0	0 0 0 0 0 0	0 0 0 0 0	2.00 3.00 4.00
2. 00 54. 00 RADI OLOGY-DI AGNOSTI C 150, 000 0 150, 000 3. 00 60. 00 LABORATORY 36, 000 0 36, 000 4. 00 76. 97 CARDI AC REHABI LI TATI ON 640 640 0 5. 00 91. 00 EMERGENCY 1, 028, 400 745, 281 283, 119 6. 00 0.00 0 0 0 0 0		0 0 0	2.00 3.00 4.00
3. 00 60. 00 LABORATORY 36, 000 0 36, 000 4. 00 76. 97 CARDI AC REHABILI TATI ON 640 640 0 5. 00 91. 00 EMERGENCY 1, 028, 400 745, 281 283, 119 6. 00 0.00 0 0 0 0	0 0 0 0	0 0 0	3.00 4.00
4. 00 76. 97 CARDI AC REHABI LI TATI ON 640 640 0 5. 00 91. 00 EMERGENCY 1, 028, 400 745, 281 283, 119 6. 00 0.00 0 0 0 0	0 0 0	0	4.00
5. 00 91. 00 EMERGENCY 1, 028, 400 745, 281 283, 119 6. 00 0.00 0 0 0 0 0	0	0	
6.00 0.00 0 0 0	0	-	5.00
	0	0	1 00
	0		6.00
		-	7.00
	0	0	8.00
9.00 0.00 0 0	0		9.00
	0	-	10.00
200.00 1, 308, 809 839, 690 469, 119	Duran di alaur	0	200.00
	Provi der	Physician Cost	
	Component are of col.	of Malpractice Insurance	
Education	12	Thisurance	
1.00 2.00 8.00 9.00 12.00	13.00	14.00	
1.00 53.00ANESTHESI OLOGY 0 0 0	0		1.00
2.00 54.00RADI OLOGY-DI AGNOSTI C 0 0	0		2.00
3.00 60.00 LABORATORY 0 0 0	0		3.00
4. 00 76. 97 CARDI AC REHABI LI TATI ON 0 0 0	0		4.00
5.00 91.00 EMERGENCY 0 0 0	0	0	5.00
	0	0	6,00
	0	0	7.00
8.00 0.00 0 0	0	0	8,00
9.00 0.00 0 0	0	0	9.00
	0		10.00
200.00 0 0	0	0	
Wkst. A Line # Cost Center/Physician Provider Adjusted RCE RCE A	djustment		
Identifier Component Limit Disallowance	5		
Share of col.			
14			
1.00 2.00 15.00 16.00 17.00	18.00		
1.00 53.00 ANESTHESI OLOGY 0 0 0	93, 769	1	1.00
2. 00 54. 00 RADI 0LOGY-DI AGNOSTI C 0 0 0	0		2.00
3. 00 60. 00 LABORATORY 0 0 0	0		3.00
4. 00 76. 97 CARDI AC REHABI LI TATI ON 0 0 0	640		4.00
5. 00 91. 00 EMERGENCY 0 0 0	745, 281	1	5.00
	0		6.00
7.00 0.00 0 0 0	0		7.00
	0		8.00
9.00 0.00 0 0 0	0		9.00
	0		10.00
200.00 0 0	839, 690	1	200. 00

CUST A	LLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1302	Period: From 01/01/2016	Worksheet B Part I	
					To 12/31/2016		pared:
			CAPI TAL REL	ATED COSTS		572572017 7.1	7 0111
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS DEPARTMENT	ADMI TTI NG	
		col. 7) 0	1.00	2.00	4.00	5.01	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	992, 042	992, 042				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0			0		2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1, 160, 738	0		0 1, 160, 738		4.00
5.01	00570 ADMI TTI NG	125, 495	14, 435		0 21, 848	161, 778	5.01
5.02	00590 OTHER ADMIN AND GENERAL	3, 351, 112	72, 060		0 83, 689	0	5. 02
7.00	00700 OPERATION OF PLANT	974, 430	296, 155		0 23, 635	0	7.00
9.00	00900 HOUSEKEEPI NG	266, 168	13, 175		0 30, 302	0	9.00
10.00	01000 DI ETARY	124, 662	27, 140		0 17, 688	0	10.00
11.00	01100 CAFETERI A	87, 248	20, 336		0 13, 248	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	285, 730	2, 876		0 48, 090	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	258, 217	15, 130		0 0	0	14.00
	01500 PHARMACY	722, 289	10, 281		0 0	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	· · · ·					1
30.00	03000 ADULTS & PEDI ATRI CS	1, 746, 093	142, 805		0 299, 942	14, 277	30. 00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	357, 377	97, 979		0 50, 909	11, 379	50.00
53.00	05300 ANESTHESI OLOGY	51	0		0 0	438	53.00
	05400 RADI OLOGY-DI AGNOSTI C	1, 225, 364	76, 195		0 96, 777	34, 169	
	05700 CT SCAN	0	0		0 0	0	1
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	o		0 0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	o		0 0	0	59.00
	06000 LABORATORY	1,011,971	20, 787		0 0	25, 338	
	06001 BLOOD LABORATORY	0	0		0 0	0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	
	06500 RESPIRATORY THERAPY	485, 986	7, 875		0 85, 497	8, 325	
	06501 SLEEP LAB	0	,, 0, 0		0 0	0,020	
	06600 PHYSI CAL THERAPY	248, 684	45, 315		0 42,090	4, 362	
	06700 OCCUPATI ONAL THERAPY	67,664	4, 379		0 12,612	575	
	06800 SPEECH PATHOLOGY	5, 226	4, 377		0 979	91	68.00
	06900 ELECTROCARDI OLOGY	0,220	0		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28, 599	0		0 0	312	
	07200 I MPL. DEV. CHARGED TO PATIENT	779	0		0 0	111	
	07300 DRUGS CHARGED TO PATIENTS	357, 525	0		0 0	17, 094	
	03140 CARDI OLOGY	0	0		0 0	0	
	07697 CARDI AC REHABI LI TATI ON	28, 227	4, 906		0 3, 867	1, 634	
10. 71	OUTPATIENT SERVICE COST CENTERS	20,227	4, 900		0 3,007	1,034	10. 77
90 00	09000 CLINIC	58, 797	43, 717		0 9, 628	4 150	90.00
	09100 EMERGENCY	1, 617, 611	71, 572		0 319, 937	39, 523	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	1,017,011	/1, 5/2		5 517,757	57, 525	92.00
72.00	SPECIAL PURPOSE COST CENTERS	11	1				72.00
113 00	11300 I NTEREST EXPENSE	1					113.00
118.00		15, 588, 085	987, 118		0 1, 160, 738	161, 778	
. 10. 00	NONREI MBURSABLE COST CENTERS	10, 000, 000	707, 110		1,100,700	101, 770	1
190 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4, 924		0 0	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	4, 724		0 0		190.00
							1172. UU
192.00		0	Ű		-		
	Cross Foot Adjustments	Ū	0		0 0		200.00

COST	ALLOCATION - GENERAL SERVICE COSTS		Provider C	CN: 15-1302	Period:	Worksheet B	
					From 01/01/2016 To 12/31/2016	Part I Date/Time Pre 5/23/2017 7:1	
	Cost Center Description	Subtotal	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	HOUSEKEEPI NG	DI ETARY	
		5A. 01	5. 02	7.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02	00590 OTHER ADMIN AND GENERAL	3, 506, 861	3, 506, 861				5.02
7.00	00700 OPERATION OF PLANT	1, 294, 220	375, 678	1, 669, 89	98		7.00
9.00	00900 HOUSEKEEPI NG	309, 645	89, 882	36, 10	435, 631		9.00
10.00	01000 DI ETARY	169, 490	49, 199	74, 37	19, 830	312, 890	10.00
11.00		120, 832	35, 074	55, 72	14, 859	0	11.00
13.00	01300 NURSING ADMINISTRATION	336, 696	97, 734	7, 88	2, 101	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	273, 347	79, 346	41, 46	11,055	0	14.00
15.00		732, 570	212, 646			0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS		, =		,		
30.00		2, 203, 117	639, 503	391, 32	25 104, 342	312, 890	30.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00		517, 644	150, 259	268, 48	38 71, 589	0	50.00
53.00		489	142		0 0	0	
54.00		1, 432, 505	415, 819		55, 673	0	
57.00		0			0 0	0	
58.00		0	0		0 0	0	
59.00		0	0		0 0	0	
60.00		1, 058, 096	307, 138	56, 96	53 15, 188	0	
60.01	06001 BLOOD LABORATORY	., 000, 070	007,100	00,70	0 0	0	
62.00		0	0		0 0	0	1
65.00		587,683	170, 589	21, 58		0	
65.01	06501 SLEEP LAB	007,000	., 6, 66,	2.,00	0 0	0	
66.00		340, 451	98, 824	124, 17	75 33, 110	0	
67.00		85, 230	24, 740			0	
68.00		6, 296	1, 828		0 0	0	
69.00		0,2,0	1, 020		0 0	0	
71.00		28, 911	8, 392		0 0	0	
72.00		890	258			0	
73.00		374, 619	108, 742		0 0	0	
76.00		0	100, 742	1	0 0	0	
76.97		38, 634	11, 214			0	
70. 77	OUTPATIENT SERVICE COST CENTERS	50, 054	11, 214	1 13, 42	5, 304	0	/0. //
90.00		116, 292	33, 757	119, 79	97 31, 942	0	90.00
90.00		2, 048, 643	594, 668			0	
92.00		2,048,043	594,000	170, 12	5 52, 274	0	92.00
92.00	SPECIAL PURPOSE COST CENTERS	0					92.00
112 0	0 11300 INTEREST EXPENSE	1		1			113.00
118.0		15, 583, 161	3, 505, 432	1 454 40	432, 033	312, 890	
110.0	NONREIMBURSABLE COST CENTERS	10,000,101	3, 000, 432	1, 656, 40	432,033	312, 890	110.00
100 0	019000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 924	1, 429	13, 49	3, 598	0	190.00
	019200 PHYSICIANS' PRIVATE OFFICES	4,924	1, 429				
200.0		0	U	1	0 0	0	192.00 200.00
		0	~			~	
201.0 202.0		15, 588, 085	3, 506, 861	1, 669, 89	0 0 98 435,631	0 312, 890	201.00
		1 15 588 0851	3.506.861	1 1.009.85	70I 435.03	312.890	1202.00

COST /	2	IU HEALTH BLACK				u of Form CMS-	2552-10
CUSI A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC		Period: From 01/01/2016	Worksheet B Part I	
					To 12/31/2016	Date/Time Pre	epared:
						5/23/2017 7:1	9 am
	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	Subtotal	
			ADMI NI STRATI ON				
		11.00	13.00	SUPPLY 14.00	15.00	24.00	
	GENERAL SERVICE COST CENTERS	11.00	13.00	14.00	15.00	24.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1 1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02	00590 OTHER ADMIN AND GENERAL						5.02
7.00	00700 OPERATION OF PLANT						7.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	226, 492					11.00
13.00	01300 NURSING ADMINISTRATION	9, 348	453, 759				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	405, 20			14.00
15.00	01500 PHARMACY	0	0	4, 81	15 985, 715		15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	98,009	240, 497	65, 65	50 22, 949	4, 078, 282	30.00
50.00	ANCI LLARY SERVI CE COST CENTERS	11, 415	36, 314	68, 61	1, 315	1, 125, 639	50.00
53.00	05300 ANESTHESI OLOGY	11, 415	30, 314	17, 37		1, 125, 839	•
54.00	05400 RADI OLOGY-DI AGNOSTI C	29,062	0	37, 11		2, 183, 723	
57.00	05700 CT SCAN	27,002	0	57, 11	0 0	2, 105, 725	1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60.00	06000 LABORATORY	0	0	27, 38	-	1, 464, 769	
60.01	06001 BLOOD LABORATORY	0	0	27,00	0 0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	22, 272	0	39, 01		846, 896	
65.01	06501 SLEEP LAB	0	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	6, 823	0	3, 02	25 0	606, 408	
67.00	06700 OCCUPATI ONAL THERAPY	1, 935	0	22		127, 327	
68.00	06800 SPEECH PATHOLOGY	164	0		0 0	8, 288	
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	39, 55	59 0	76, 862	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0	1, 06	50 0	2, 208	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		0 938, 453	1, 421, 814	73.00
76.00	03140 CARDI OLOGY	0	0		0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	1, 214	5, 777	1, 00	03 0	74, 868	76.97
	OUTPATIENT SERVICE COST CENTERS				-		
90.00	09000 CLINIC	3, 969		5, 20		328, 683	
91.00	09100 EMERGENCY	42, 281	155, 820	95, 17	73 15, 030	3, 200, 034	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	T					
440 5	11300 INTEREST EXPENSE	1			005 71-		113.00
		22/ 102				15, 564, 640	
113. 00 118. 00	SUBTOTALS (SUM OF LINES 1-117)	226, 492	453, 759	405, 20	985, 715	10,001,010	110.00
118.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	1		405, 20			
118.00 190.00	SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	405, 20	0 0	23, 445	190.00
118.00 190.00 192.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFICES	1		405, 20		23, 445 0	190. 00 192. 00
118.00 190.00 192.00 200.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFICES Cross Foot Adjustments	0	0	405, 20	0 0	23, 445 0 0	190. 00 192. 00 200. 00
118.00 190.00 192.00	SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES Cross Foot Adjustments Negative Cost Centers	0	0 0 0	405, 20	0 0 0 0 0 0	23, 445 0 0	190. 00 192. 00 200. 00 201. 00

COST ALLOCATION - GENERAL SERVICE COSTS Provider CDC: 15-1302 Provider CDC: 15-1302 Worksheet 8 From 0/01/2016 From 0/01/2016 Worksheet 8 From 0/01/201	Heal th	Financial Systems	IU HEALTH BLACKFO	ORD HOSPITAL		In Lieu of Form CM	IS-2552-10	
To 12/31/2016 Date String Date String Cost Center Description Arbsit Arbsit Stepdoon Arbsit All subments Arbsit Stepdoon Arbsit Stepdoon 1.00 Cost Center Description Arbsit Arbsit Stepdoon 1.00 Cost Cost Center Description Arbsit Arbsit Stepdoon 1.00 Cost Cost Center Description Arbsit Arbsit Arbsit 0.00 Cost Cost Center Description 25.00 26.00 1.1 0.00 Cost Cost Center Description 1.0 Stepdoon 2.1 0.00 Description Brown Core Flag Stepdoon 2.1 Stepdoon 1.00 District Plank Arbsit Stepdoon 2.1 Stepdoon 1.00 District Plank Arbsit Stepdoon 1.1 Stepdoon 1.00 District Plank Arbsit Stepdoon 1.1 Stepdoon 1.00 District Plank Arbsit Stepdoon 1.1 Stepdoon 1.00 Distret Plank				Provider C	CN: 15-1302		3	
Cost Center Description Intern & Residents Cost Stepdon Tatal Intern & Residents Cost Stepdon CenterAL SERVICE COST CENTERS 20.00 20.00 20.00 20.00 CenterAL SERVICE COST CENTERS 20.00 20.00 20.00 20.00 Cost Control Cost Centers 0.00 20.00 20.00 20.00 Cost Control Cost Centers 0.00 20.00 20.00 20.00 Cost Control Cost Centers 0.00 20.00 20.00 20.00 Cost Cost Centers 0.00 20.00 20.00 20.00 Cost Cost Centers 0.00 20.00 20.00 20.00 20.00 <								
Cost Center Description Intern & Registers Total Registers Total Registers 1.00 Cost Center Description Intern & Registers 26.00 26.00 1.00 Cost Cost Centers 26.00 26.00 26.00 2.00 Cost Cost Centers 20.00 26.00 26.00 26.00 2.00 Cost Cost Centers 20.00 26.00 26.00 26.00 2.00 Cost Cost Centers 30.00 30.00 30.00 30.00 30.00 3.00						10 12/31/2016 Date/11me F	Prepared: 7.19 am	
Residents Cost S Post Stepdoon 100 DOIDON EX CAP REL COST - SING & FIXT 25.00 26.00 2.00 DOUDON EX CAP REL COST - SING & FIXT 2.00 2.00 2.00 DOUDON EX CAP REL COST - SING & FIXT 2.00 2.00 2.00 2.00 DOUDON EX CAP REL COST - SING & FIXT 2.00 2.0		Cost Center Description	Intern &	Total		372372017		
Stepdoon Adj ustments 25:00 26:00 1:00 ODTOD NEW CAP REL COSTS - BUBLE & FLXT 20:00 2:00 ODZOD NEW CAP REL COSTS - BUBLE & FLXT 20:00 2:00 ODZOD NEW CAP REL COSTS - BUBLE & FLXT 20:00 4:00 ODZOD NEW CAP REL COSTS - BUBLE & FLXT 20:00 5:01 ODSTOD NEW CAP REL COSTS - BUBLE & FLXT 20:00 0:00 ODZOD OTHER BENEFITS DEPARTMENT 50:00 5:02 DOSDO OTHER THIP NG 90:00 0:00 ODZOD OTHER THIP NG 90:00 0:00 ODSOD OTHER THIP NG 10:00 11:00 OTSOD OTHER ALL SERVICE COST CENTERS 0 30:00 OTSOD OPHAINARCY 13:00 MANULARY SERVICE COST CENTERS 10:00 50:00 OTSOD OPHAINARCY 0 MANULARY SERVICE COST CENTERS 10:00 50:00 OTSOD OPHAIN NE SCRUCE NOST CENTERS 10:00 50:00 OTSOD OPHAIN NE NACH I NG NGNI 0 11:00 51:00 OTSOD OPHAIN NE SCRUCE COST CENTERS 10:00 10:00								
Adl ustments Adl ustments Adl ustments 0 00100 NEW CAP REL COST CENTERS 1 1 2.00 1 2.00 2.00 1 2.00			& Post					
CENERAL SERVICE COST CENTERS 25.00 26.00 1.00 00100 NEW CAP REL COSTS-BLUC & FLXT 1.0 2.00 00200 NEW CAP REL COSTS-BLUC & FLXT 2.0 4.00 00400 FWE CAP REL COSTS-MURE FOULP 4.0 5.01 00570 (DTER CAP REL COSTS-MURE FOULP 5.0 5.02 00590 (DTER ATI NO PO PLANT 5.0 7.00 00700 (PERATI ON PO PLANT 7.0 9.00 00090 (AULSERF IN RATION 1.1 11.00 01100 (DTERATI ON PC RENATION 1.1 11.00 01100 (DTERATI ON PC RENATION 1.1 11.00 01100 (DENTER SERVICE COST CENTERS 0 4.078, 282 30.0 000000 ADULTS & PEDIATRICS 0 1.125, 639 50.0 50			Stepdown					
GENERAL SERVICE COST CENTERS 1.0 0.00 00000 (NEW CAP, REL COSTS-MUBLE FOULP 2.0 0.00 00000 (DENCOVE) ENERFITS DEPARTMENT 5.0 5.01 00570 AMUTTIN GO PLANT 7.0 0.00 00000 (DUESECEEP) NG 7.0 10.00 01000 (DUEAFEERIA ALSTAND 11.1 11.00 01000 (DEFINAL SERVICE S SUPPLY 11.1 15.00 01000 (DEFINAL SERVICE SCOST CENTERS 11.125, 639 30.00 01000 (DPERATIN IN SERVICE COST CENTERS 11.125, 639 30.00 05300 (DPERATIN IN SERVICE COST CENTERS 11.125, 639 30.00 0500 (DPERATIN IN SERVICE COST CENTERS 11.125, 639 35.00 0500 (DERIA TIN IN SIGNATIC 0 1.125, 639 35.00 0500 (DERIA TIN IN SIGNATIC 0 1.8, 839 35.00 0500 (CADAL CATHETSI DPENATICS 1.127, 639 35.00 0500 (CADAL CATHE			Adjustments					
1.00 00100 NEW CAP REL COSTS-BLIDG & FLXT 1.0 2.00 00200 NEW CAP REL COSTS-MUELE GOILP 2.0 4.00 00400 NEW CAP REL COSTS-MUELE GOILP 4.0 5.10 05500 OTHER ADM IT ING 5.0 5.02 005900 OTHER ADM IT ING 5.0 7.00 00700 OPERATION OF PLANT 9.0 9.00 009000 INUES KEEPI NG 10.0 11.00 01100 CAFETER IA 11.0 11.00 01400 CENTRAL SERVICE S SUPPLY 11.0 11.00 01400 CENTRAL SERVICE COST CENTERS 0 11.00 01500 OPERATINON CHARMEST 11.125, 639 12.00 05300 OPERATING NOM 0 1.125, 639 13.00 05300 ANESTHESI CLOGY 0 1.8, 839 13.00 05300 ANESTHESI CLOGY 0 1.464, 769 0.00 05000 CLAROHARCE INAGING (MRI) 0 0 15.00 0500 CLAROHARCE INAGING (MRI) 0 0 15.00 0500 CLAROHARCE INAGING (MRI) 0 0 15.00 0500 CLAROHARCE INAGING (MRI) <t< td=""><td></td><td></td><td>25.00</td><td>26.00</td><td></td><td></td><td></td></t<>			25.00	26.00				
2.00 002200 NEW CAP REL COSTS-WALLE EQUIP 4.0 4.00 00400 ENPLOYCE BENEFITS DEPARTMENT 5.0 5.01 00570 ADMITTING 5.0 5.02 00570 ODMITTING 5.0 7.00 00700 OPERATION OF PLANT 7.0 9.00 00900 HUSEKEEPING 9.0 10.00 01000 OLETARY 10.0 11.00 01100 CAPTERIA 11.0 11.00 01000 CAPTERIA SERVICES & SUPPLY 13.0 13.00 01300 NUBSI NG ADMINISTATION 13.0 14.00 14.00 CHARD CENTRAL SERVICE COST CENTERS 0 MACILLARY SERVICES & SUPPLY 15.0 50.00 05000 OPERATING ROOM 0 1.125, 639 50.00 05000 OPERATING ROOM 0 1.125, 639 53.0 50.00 05000 OPERATING ROOM 0 1.125, 639 53.0 50.00 05000 OPERATING ROOM 0 1.464, 769 60.0 60.00 0000 CARDINC CANTRE SENTINE READING (MRI) 0 0 60.0 50.00 05000 MARDITELSTROOM <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>								
4.00 00400 EWPLOYEE BENEFITS DEPARTMENT 4.0 5.01 00570 ADMITTING 5.0 5.02 00590 OTHER ADMIN AND GENERAL 7.0 7.00 00700 OPERATION OF PLANT 7.0 9.00 00900 HOUSKEEPING 10.0 11.00 01100 CAPTERIA 5.0 12.00 01200 OPERATION ON PLANT 10.0 13.00 01300 OINESING ADMINISTRATION 13.0 13.00 01400 CENTRAL SERVICE COST CENTERS 11.0 13.00 01400 OPERATING NOM 0 1.125,639 13.00 01300 OPERATING NOM 0 1.125,639 5.0 13.00 01300 OPERATING NOM 0 1.125,639 5.0 13.00 01300 OPERATING NOM 0 1.125,639 5.0 13.00 0100 OPERATING NOM 0 0 1.8,839 5.0 13.00 01300 OPERATING NOM 0 0 1.464,769 60.0 13.00 0100 CAROTARY 0 0 0 50.0 50.0 50.0 50.0 50.0 50.0 50.0 50.0 50.0 50.0	1.00						1.00	
5.01 00570 ADMITTING 5.0 5.02 00570 OTHER ADMIN AND GENERAL 5.0 7.00 00700 OPERATION OF PLANT 5.0 7.00 0000 OHUSEKEEPING 7.0 7.00 01000 OILTARY 11.0 7.00 01000 OLETARY 11.0 7.00 01000 OLETARY 11.0 7.00 01000 CENTRAL SERVICES & SUPPLY 13.0 7.00 01000 OLETARY 13.0 7.00 01000 OLETARY 13.0 7.00 01000 OLETARY 5.0 7.00 01000 OLETARY SERVICES & SUPPLY 15.0 7.00 01000 OLETARY SERVICES & SUPPLY 15.0 7.00 03000 ADESTHESI OLOGY 0 11.125, 639 7.00 05000 ORSON ARESTHESI OLOGY 0 11.8, 839 7.00 0500 OLOGON ARESTHESI OLOGY 0 11.464, 769 60.0 7.00 0000 CARDIA CCATHITER TRAING (MRI) 0 0 60.0 7.00 0500 OLESCHATTER TRAING (MRI) 0 0 60.0 7.00 000 OLESCHATTER CENTRER 0 60.0 60.0	2.00						2.00	
5. 02 00590 OTHER ADMIN AND CENERAL 5. 0 7. 00 0700 0FEAT 9.00 10. 00 1000 FEAT 9.00 10. 00 1000 FEAT 9.00 10. 00 1000 NEST 9.00 10. 00 1000 FEAT 10.00 10. 00 1000 NEST 8.00 10. 00 1000 NEST 8.00 10. 00 1000 FEAT 11.00 10. 00 1000 FEAT 11.00 10. 00 SERVICE COST CENTERS 0 1.125, 639 0. 00 SERVICE COST CENTERS 0 1.125, 639 50.0 50. 00 SERVICE CARDIAC CATHETER LANGIN MERCINCE 0 1.125, 639 50.0 51. 00 SERVICE CARDIAC CATHETER LANGIN MERCINCE 0 0 50.0 52. 00 SERVICE COST CENTERS 0 0 1.125, 639 50.0 53. 00 SERVICE	4.00						4.00	
7. 00 00700 (PERATION OF PLANT 7. 0 9.00 00000 (HUISEKEEPING 9. 0 10.00 01000 (AFETERI A 10. 0 11.00 01100 (AFETERI A 11. 0 11.00 0100 (CAFTERI A 11. 0 11.00 0100 (CAFTERI A 11. 0 11.00 01500 (PLATARY 11. 0 11.00 01500 (PLATARY ROUTI NE SERVICE COST CENTERS 0 30.00 03000 (ADULTS & PEDIATRICS 0 1, 125, 639 51.00 05000 (PERATINS ROM 0 1, 125, 639 50. 0 52.00 05300 (ARGOT CE COST CENTERS 0 1, 40, 789 50. 0 53.00 05300 (RADIOLOST CENTERS) 0 18, 839 50. 0 50. 0 53.00 0500 (CARDI RADOT CHAROST CE COST CENTERS) 0 0 50. 0 50. 0 50. 0 50. 0 50. 0 50. 0 50. 0 50. 0 50. 0 50. 0 50. 0 50. 0 50. 0 50. 0 </td <td>5.01</td> <td>00570 ADMI TTI NG</td> <td></td> <td></td> <td></td> <td></td> <td>5. 01</td>	5.01	00570 ADMI TTI NG					5. 01	
9 0.00 00900 HUSEKEEPING 0.00 HIERARY 1.00 HIERARY 1.00 HIERARY 1.00 HIERARY 0.00 HIERARY 1.00 H	5.02	00590 OTHER ADMIN AND GENERAL					5.02	
10.00 010000 DETRAY 10.0 11.00 01000 CAFETERIA 11.0 13.00 01300 NURSING ADMINISTRATION 13.0 14.00 DIADO CENTRAL SERVICES & SUPPLY 13.0 15.00 DIADO CENTRAL SERVICE COST CENTERS 30.00 30.00 D3000 ANCILLARY SERVICE COST CENTERS 30.00 ANCILLARY SERVICE COST CENTERS 0 4.076,282 30.00 ANCILLARY SERVICE COST CENTERS 0 1.125,639 50.0 53.00 053000 ADD RADINGEY LINE ROOM 0 1,125,639 53.0 54.00 S4000 RADIOLOGY-DIAGNOSTIC 0 2,183,723 54.0 56.00 DS5000 CARDIA CCATHETERI ZATION 0 0 55.0 68.00 DS6000 LABORATORY 0 1,464,769 60.0 60.01 BAORIA CATHETERIZATION 0 0 60.0 60.0 60.00 CADOLA CATHETERIZ ATION 0 0 60.0 60.0 60.0 60.0 60.0 60.0 60.0 60.0 60.0 60.0 60.0 60.0 60.0 60.0	7.00	00700 OPERATION OF PLANT					7.00	
11.00 01100 CAFETERIA 11.0 13.00 01300 NURSING ADMINISTRATION 13.0 14.00 01400 CENTRAL SERVICES & SUPPLY 14.0 15.00 15000 15000 1500 16.00 03000 AURSING ADMINISTRATION 14.0 16.00 15000 1500 1500 0.00 03000 AURSING COST CENTERS 0 4.078,282 50.00 05000 AURSING COST CENTERS 0 1,125,639 50.00 05000 AURSING COST CENTERS 0 1,23,723 51.00 05000 CT SCAN 0 0 0 52.00 05000 CARDIA CCATHETERI ZATION 0 0 0 53.00 0500 CARDIA CCATHETERI ZATION 0 0 0 54.00 05000 CARDIA CCATHETERI ZATION 0 0 0 59.00 0500 CARDIA CCATHETERI ZATION 0 0 0 60.01 16000 LABORATORY 0 1,464,769 60.0 61.00 DABORATORY 0 1,21,327 67.0 65.01 06500 SEEPI ARATHERAPY 0 60.	9.00	00900 HOUSEKEEPI NG					9.00	
13.00 D1300 JUSSING ADMINISTRATION 13.0 14.00 O1400 CENTAL SERVICES & SUPPLY 14.0 15.00 D1500 PHARMACY 15.0 INPATIENT ROUTINE SERVICE COST CENTERS 0 4.078,282 30.0 0.00 03000 ADULTS & PEDIATRICS 0 4.078,282 30.0 ANCILLARY SERVICE COST CENTERS 0 1.125,639 53.0 53.00 53.00 05300 ADRSTICS 0 2.183,723 54.0 54.0 54.00 55000 CRESTINES IOLOGY 0 18.839 53.1 55.2 55.0	10.00	01000 DI ETARY					10.00	
14.00 OH00 CENTRAL.SERVICES & SUPPLY 14.0 15.00 DISOO PHARMACY 15.0 18.00 OSOOO ADULTS & PEDIATRICS 0 4.078, 282 AMCILLARY SERVICE COST CENTERS 0 1.125, 639 30.0 50.00 OSOOO ANDULTS & NOM 0 1.125, 639 53.0 51.00 OSOOO CARDIACTS & CONT CENTERS 54.0 55.0 55.0 52.00 OSOOO CARDIACTS & CANANCE I MAGING (MRI) 0 0 55.0 50.00 OSOOO CARDIACT CATHETER IZATION 0 0 55.0 50.00 OSOOO CARDIACT CATHETER IZATION 0 0 60.0 60.01 BOOOD ELDOD LABORATORY 0 1, 464, 769 60.0 60.00 OSOOO RESPIR TANTY THERAPY 0 846, 896 65.0 65.00 OSOO RESPIR TANTY THERAPY 0 60.40 66.0 66.00 OSOOO RESPIR TANTY THERAPY 0 127, 327 67.0 67.00 OSOOO RESPIR TANTY THERAPY 0 60.40 66.0 66.00 OSOOO SEDECH PARTY THERAPY 0 127, 327 67.0	11.00	01100 CAFETERI A					11.00	
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192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 192.00 200.00 Cross Foot Adjustments 0 0 200.00					1			
200.00 Cross Foot Adjustments 0 0 200.00 201.00 Negative Cost Centers 0 0 201.00			0	23, 445			190.00	
201.00 Negative Cost Centers 0 0 0 201.0			0	0			192.00	
				0				
202.00 [101AL (SUM LINES 118-201) [0] 15,588,085] [202.0				0			201.00	
	202.00	ין וטואב (SUM LINES 118-201)	I O	15, 588, 085	I		J202. 00	

Heal th Financial Systems	IU HEALTH BLACK		N. 15 1202		u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CO	JN: 15-1302	Period: From 01/01/2016 To 12/31/2016		epared: 9 am
		CAPI TAL REL	ATED COSTS		0,20,201, 11	
Cost Center Description	Di rectl y Assi gned New Capi tal Rel ated Costs	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS	-11					
1.00 00100 NEW CAP REL COSTS-BLDG & FIXT 2.00 00200 NEW CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00570 ADMITTING 5.02 00590 OTHER ADMIN AND GENERAL 7.00 00700 OPERATION OF PLANT 9.00 0HUSEKEEPING	0 0 0	0 14, 435 72, 060 296, 155 13, 175		0 0 0 14, 435 0 72, 060 0 296, 155 0 13, 175	0 0 0 0	5. 01 5. 02 7. 00
10. 00 01000 DI ETARY	0	13, 175			-	
11. 00 01100 CAFETERI A	0	27, 140 20, 336		0 27, 140 0 20, 336		11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON	0	20, 330		0 2,876	0	
14.00 01400 CENTRAL SERVICES & SUPPLY	0	15, 130		0 15, 130		
15. 00 01500 PHARMACY	0	10, 281		0 10, 281	0	15.00
INPATIENT ROUTINE SERVICE COST CENTERS		1 4 0 0 0 5		0 440.005		
30. 00 03000 ADULTS & PEDI ATRI CS ANCI LLARY SERVI CE COST CENTERS	0	142, 805		0 142, 805	0	30.00
50. 00 05000 OPERATI NG ROOM	0	97, 979		0 97, 979	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	76, 195		0 76, 195	0	54.00
57.00 05700 CT SCAN	0	0		0 0	0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0	20, 787		0 20, 787	0	
60. 01 06001 BLOOD LABORATORY	0	20, 787		0 20, 787	0	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	
65. 00 06500 RESPIRATORY THERAPY	0	7, 875		0 7,875	0	65.00
65. 01 06501 SLEEP LAB	0	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0	45, 315		0 45, 315	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	4, 379		0 4, 379	0	
68. 00 06800 SPEECH PATHOLOGY	0	0		0 0	0	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 72. 00 07200 I MPL. DEV. CHARGED TO PATI ENT	0	0		0 0	0	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
76. 00 03140 CARDI OLOGY	0	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	4, 906		0 4, 906	0	
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	43, 717		0 43, 717	0	
91. 00 09100 EMERGENCY	0	71, 572		0 71, 572		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
SPECIAL PURPOSE COST CENTERS			[1112 00
113.00 11300 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1-117)	0	987, 118		0 987, 118	0	113.00 118.00
NONREI MBURSABLE COST CENTERS		,,,,,,,,		, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	4, 924		0 4, 924	0	190.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
200.00 Cross Foot Adjustments				0		200.00
201.00 Negative Cost Centers		0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	0	992, 042	I	0 992, 042	0	202.00

ALLOCA	TION OF CAPITAL RELATED COSTS		Provider C	CN: 15-1302	Period: From 01/01/2016 To 12/31/2016	Worksheet B Part II Date/Time Pre 5/23/2017 7:1	epared: 9 am
	Cost Center Description	ADMI TTI NG	OTHER ADMIN AND GENERAL	OPERATION OF PLANT	HOUSEKEEPI NG	DI ETARY	
		5.01	5.02	7.00	9.00	10.00	
+	GENERAL SERVICE COST CENTERS						
	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG	14, 435					5.01
	00590 OTHER ADMIN AND GENERAL	0	72, 060				5. 02
	00700 OPERATION OF PLANT	0	7, 720				7.00
	00900 HOUSEKEEPI NG	0	1, 847	6, 57	70 21, 592		9.00
	01000 DI ETARY	0	1, 011		33 983	42, 667	10.00
11.00	01100 CAFETERI A	0	721	10, 14	1 736	0	11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	0	2, 008	1, 43	34 104	0	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	1, 631	7, 54	15 548	0	14.00
15.00	01500 PHARMACY	0	4, 370	5, 12	27 372	0	15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						1
30.00	03000 ADULTS & PEDI ATRI CS	1, 274	13, 136	71, 20)9 5, 173	42, 667	30. 00
	ANCILLARY SERVICE COST CENTERS						1
50.00	05000 OPERATI NG ROOM	1,015	3, 088	48, 85	57 3, 548	0	50.00
53.00	05300 ANESTHESI OLOGY	39	3		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	3,049	8, 545	37, 99	2, 759	0	54.00
	05700 CT SCAN	0	0		0 0	0	57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
	06000 LABORATORY	2, 261	6, 312	10, 36	56 753	0	
	06001 BLOOD LABORATORY	0	0,01		0 0	0	
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	
	06500 RESPI RATORY THERAPY	743	3, 506			0	
	06501 SLEEP LAB	0	0,000	0,,,,	0 0	0	
	06600 PHYSI CAL THERAPY	389	2, 031	22, 59		0	
	06700 OCCUPATI ONAL THERAPY	51	508			0	
	06800 SPEECH PATHOLOGY	8	38		0 0	0	
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28	172		0 0	0	
	07200 I MPL. DEV. CHARGED TO PATIENT	10	5		0 0	0	
	07300 DRUGS CHARGED TO PATIENTS	1, 525	2, 235		0 0	0	
	03140 CARDI OLOGY	1, 525	2, 233		0 0	0	
	07697 CARDI AC REHABI LI TATI ON	146	230	2, 44	ů v	0	
	OUTPATIENT SERVICE COST CENTERS	140	230	2,44	170	0	70. 7
	09000 CLINIC	370	694	21, 80	1, 583	0	90.00
	09100 EMERGENCY						
		3, 527	12, 220	35, 68	39 2, 592	0	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS			1			112 00
	11300 I NTEREST EXPENSE	14 405	70.001	004.44	0 01 111	10 / / 7	113.00
118.00		14, 435	72, 031	301, 41	19 21, 414	42, 667	1118.00
	NONREI MBURSABLE COST CENTERS				470		100 07
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	29				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
200.00	Cross Foot Adjustments						200.00
201.00	Negative Cost Centers	0	0		0 0		201.00
202.00	TOTAL (sum lines 118-201)	14, 435	72,060	303, 87	75 21, 592	42, 667	1202 00

ALLOCA	Financial Systems TION OF CAPITAL RELATED COSTS		Provider CC	N: 15-1302	Peri od: From 01/01/2016 To 12/31/2016	u of Form CMS-: Worksheet B Part II Date/Time Pre 5/23/2017 7:1	pared:
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	Subtotal	
		11.00	13.00	14.00	15.00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02	00590 OTHER ADMIN AND GENERAL						5.02
7.00	00700 OPERATION OF PLANT						7.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	31, 934					11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 318	7, 740				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	0	24, 8	54		14.00
15.00	01500 PHARMACY	0	0	29	95 20, 445		15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	13, 819	4, 102	4, 02	27 476	298, 688	30.00
	ANCI LLARY SERVICE COST CENTERS						1
50.00	05000 OPERATING ROOM	1,609	619	4, 20)9 27	160, 951	50.00
53.00	05300 ANESTHESI OLOGY	0	0	1, 00	55 17	1, 124	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	4,098	0	2, 2	76 99	135, 016	
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	1, 68	30 O	42, 159	60.00
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	3, 140	0	2, 39	93 0	21, 869	
65.01	06501 SLEEP LAB	0	0	, -	0 0	0	
66.00	06600 PHYSI CAL THERAPY	962	0	18	36 0	73, 120	
67.00	06700 OCCUPATI ONAL THERAPY	273			14 0	7, 568	
68.00	06800 SPEECH PATHOLOGY	23	-		0 0	69	
69.00	06900 ELECTROCARDI OLOGY	0			0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	-	2, 42		2,626	
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	-			80	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	-	· · · · ·	0 19, 465	23, 225	
76.00	03140 CARDI OLOGY	0	-		0 0	20, 220	1
76.97	07697 CARDI AC REHABI LI TATI ON	171	99		52 0	8, 238	
/0. //	OUTPATIENT SERVICE COST CENTERS	1/1	,,,		<u> </u>	0,230	/0. //
90.00	09000 CLINIC	560	262	3.	19 49	69, 354	90.00
90.00 91.00	09100 EMERGENCY	5, 961	2,658	5, 8		140, 368	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5, 701	2,050	5, 0.	57 512	140, 300	92.00
72.00	SPECIAL PURPOSE COST CENTERS						72.00
112 00	11300 I NTEREST EXPENSE	1					113.00
118.00		31, 934	7, 740	24, 8	54 20, 445	984, 455	
110.00	NONREIMBURSABLE COST CENTERS	51,934	, 740	24, 03	20, 445	704, 400	110.00
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	7 507	190.00
							•
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
200.00		_					200.00
201.00		0	0	24, 8	0 0 54 20, 445		201.00
202.00	TOTAL (sum lines 118-201)	31, 934	7, 740				

	Financial Systems	IU HEALTH BLACKFO				MS-2552-10
ALLUCA	TION OF CAPITAL RELATED COSTS		Provider CC	CN: 15-1302	Period: Worksheet From 01/01/2016 Part II	В
					To 12/31/2016 Date/Time 5/23/2017	Prepared:
	Cost Center Description	Intern &	Total		372372011	
		Residents Cost & Post				
		Stepdown				
		Adjustments				
		25.00	26.00			
	GENERAL SERVICE COST CENTERS					
	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
	00570 ADMITTING					5.01
	00590 OTHER ADMIN AND GENERAL 00700 OPERATION OF PLANT					5. 02 7. 00
	00900 HOUSEKEEPING					9.00
	01000 DI ETARY					10.00
	01100 CAFETERIA					11.00
	01300 NURSING ADMINISTRATION					13.00
	01400 CENTRAL SERVICES & SUPPLY					14.00
15.00	01500 PHARMACY					15.00
	INPATIENT ROUTINE SERVICE COST CENTERS					
	03000 ADULTS & PEDI ATRI CS	0	298, 688			30.00
	ANCI LLARY SERVI CE COST CENTERS	1 1				
	05000 OPERATI NG ROOM	0	160, 951			50.00
	05300 ANESTHESI OLOGY	0	1, 124			53.00
	05400 RADI OLOGY-DI AGNOSTI C 05700 CT SCAN	0	135, 016 0			54.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0			57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0			59.00
	06000 LABORATORY	0	42, 159			60.00
	06001 BLOOD LABORATORY	0	0			60.01
1	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0			62.00
65.00	06500 RESPI RATORY THERAPY	0	21, 869			65.00
65. 01	06501 SLEEP LAB	0	0			65.01
	06600 PHYSI CAL THERAPY	0	73, 120			66.00
	06700 OCCUPATI ONAL THERAPY	0	7, 568			67.00
	06800 SPEECH PATHOLOGY	0	69			68.00
	06900 ELECTROCARDI OLOGY	0	0			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENT	0	2, 626 80			71.00
	07300 DRUGS CHARGED TO PATIENTS	0	23, 225			73.00
	03140 CARDI OLOGY	0	23, 223			76.00
	07697 CARDI AC REHABI LI TATI ON	0	8, 238			76.97
	OUTPATIENT SERVICE COST CENTERS	-1				
90.00	09000 CLI NI C	0	69, 354			90.00
91.00	09100 EMERGENCY	0	140, 368			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				92.00
	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					113.00
118.00		0	984, 455			118.00
	NONREIMBURSABLE COST CENTERS	0	7 507			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	7, 587 0			190. 00 192. 00
192 001		0	-			
	Cross Foot Adjustments		0			200 00
192.00 200.00 201.00		0	0			200. 00 201. 00

ST ALLOCATION - STATISTICAL BASIS		Provider CC	CN: 15-1302	Peri od:	Worksheet B-1	2552
				From 01/01/2016 To 12/31/2016	Date/Time Pre	pare
	CAPI TAL REL	ATED COSTS			5/23/2017 7:1	<u>9 am</u>
Cost Center Description	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFI TS	ADMI TTI NG (GROSS	Reconciliation	
		(DOLLAR VALUE)	DEPARTMENT	CHARGES)		
	FEET)		(GROSS			
	1.00	2.00	<u>SALARI ES)</u> 4.00	5. 01	5A. 02	-
GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	5.01	JR. 02	
00 00100 NEW CAP REL COSTS-BLDG & FIXT	52, 782					1
00 00200 NEW CAP REL COSTS-MVBLE EQUIP		0	(100 0	75		2
00 00400 EMPLOYEE BENEFITS DEPARTMENT 01 00570 ADMITTING	0	0	6, 193, 27			4
01 00570 ADMITTING 02 00590 OTHER ADMIN AND GENERAL	768 3, 834	0	116, 53 446, 53			
00 00700 OPERATI ON OF PLANT	15, 757	0	126, 1		0, 300, 001	
00 00900 HOUSEKEEPING	701	0	161, 68		0	
. 00 01000 DI ETARY	1, 444	0	94, 37		0	10
. 00 01100 CAFETERI A	1, 082	0	70, 68		0	
00 01300 NURSING ADMINISTRATION	153	0	256, 59		0	
. 00 01400 CENTRAL SERVICES & SUPPLY	805	0		0 0	0	
01500 PHARMACY	547	0		0 0	0	15
0. 00 03000 ADULTS & PEDIATRICS	7, 598	0	1, 600, 38	34 3, 176, 807	0	30
ANCI LLARY SERVICE COST CENTERS	1,070	0	1,000, 30	3, 170, 007	0	1 30
0. 00 05000 OPERATI NG ROOM	5, 213	0	271, 63	2, 531, 981	0	50
. 00 05300 ANESTHESI OLOGY	0	0		0 97, 534	0	53
. 00 05400 RADI OLOGY-DI AGNOSTI C	4,054	0	516, 36	55 7, 603, 172	0	54
. 00 05700 CT SCAN	0	0		0 0	0	
0.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	
0. 00 05900 CARDIAC CATHETERIZATION	0	0		0 5 (20, 110	0	
0. 00 06000 LABORATORY 0. 01 06001 BLOOD LABORATORY	1, 106 0	0		0 5, 638, 118 0 0		
2. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	
00 06500 RESPIRATORY THERAPY	419	0	456, 18	-	0	
0. 01 06501 SLEEP LAB	0	0		0 0	0	65
0. 00 06600 PHYSI CAL THERAPY	2, 411	0	224, 57	78 970, 725	0	66
00 06700 OCCUPATI ONAL THERAPY	233	0	67, 29	91 127, 897	0	67
8. 00 06800 SPEECH PATHOLOGY	0	0	5, 22			
	0	0		0 0	0	
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 2. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 69, 369 0 24, 721	0	
00 07200 TMPL. DEV. CHARGED TO PATTENT	0	0		0 3, 803, 838		
00 03140 CARDI OLOGY	0	0		0 0,000,000	0	
97 07697 CARDI AC REHABI LI TATI ON	261	0	20, 63	34 363, 552	0	
OUTPATIENT SERVICE COST CENTERS			·	· ·		
0. 00 09000 CLINIC	2, 326	0	51, 36	59 923, 479	0	90
. 00 09100 EMERGENCY	3, 808	0	1, 707, 05	56 8, 793, 866	0	91
2. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)						92
SPECIAL PURPOSE COST CENTERS 3. 00 11300 INTEREST EXPENSE						113
8.00 SUBTOTALS (SUM OF LINES 1-117)	52, 520	0	6, 193, 27	75 35, 997, 650	-3, 506, 861	
NONREI MBURSABLE COST CENTERS	02,020		0,170,21	00, 777, 000	0,000,001	1.10
0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	262	0		0 0	0	190
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192
0.00 Cross Foot Adjustments						200
1.00 Negative Cost Centers						201
2.00 Cost to be allocated (per Wkst. B,	992, 042	0	1, 160, 73	38 161, 778		202
Part I)	10 705000	0,000000	0 1074	0 004404		200
U3.00Unit cost multiplier (Wkst. B, Part I)V4.00Cost to be allocated (per Wkst. B,	18. 795082	0. 000000	0. 18741	0.004494 0 14,435		203 204
Part II)				14, 435		204
5.00 Unit cost multiplier (Wkst. B, Part			0.0000	0. 000401		205
			5. 00000	5, 555 101		1-00

ST ALLC	OCATION - STATISTICAL BASIS		Provider CC		Period: From 01/01/2016	Worksheet B-1	
					To 12/31/2016	Date/Time Pre 5/23/2017 7:1	
	Cost Center Description	OTHER ADMIN	OPERATION OF	HOUSEKEEPING	DI ETARY	CAFETERI A	7 0
		AND GENERAL	PLANT	(SQUARE	(MEALS	(FTE' S)	
		(ACCUM. COST)	(SQUARE	FEET)	SERVED)	()	
		(FEET)	,	,		
		5.02	7.00	9.00	10.00	11.00	
GEI	NERAL SERVICE COST CENTERS						
	100 NEW CAP REL COSTS-BLDG & FIXT						1 1
00 00	200 NEW CAP REL COSTS-MVBLE EQUIP						2
	400 EMPLOYEE BENEFITS DEPARTMENT						4
	570 ADMI TTI NG						5
	590 OTHER ADMIN AND GENERAL	12, 081, 224					5
	700 OPERATION OF PLANT	1, 294, 220					7
	900 HOUSEKEEPING	309, 645		31, 72	2		9
	000 DI ETARY	169, 490					10
	100 CAFETERI A	120, 832				6, 905	
	300 NURSI NG ADMI NI STRATI ON	336, 696				285	
	400 CENTRAL SERVICES & SUPPLY	273, 347				0	
	500 PHARMACY	732, 570		54		0	
	PATIENT ROUTINE SERVICE COST CENTERS	132,310	547			0	- ''
	000 ADULTS & PEDIATRICS	2, 203, 117	7, 598	7, 59	100	2, 988	30
	CILLARY SERVICE COST CENTERS	2,203,117	1, 370	1, 3,	100	2,700	- 50
	000 OPERATI NG ROOM	517, 644	5, 213	5, 21	3 0	348	50
	300 ANESTHESI OLOGY	489			0 0	0	
	400 RADI OLOGY-DI AGNOSTI C						
		1, 432, 505	4, 054	4, 05		886	
	700 CT SCAN	0	0		0 0	0	
	800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	
	900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
	000 LABORATORY	1, 058, 096	1, 106	1, 10		0	
	001 BLOOD LABORATORY	0	0		0 0	0	
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	
	500 RESPI RATORY THERAPY	587, 683				679	
	501 SLEEP LAB	0	0		0 0	0	
	600 PHYSI CAL THERAPY	340, 451	2, 411	2, 41		208	66
	700 OCCUPATI ONAL THERAPY	85, 230		23		59	67
00 06	800 SPEECH PATHOLOGY	6, 296	0		0 0	5	68
00 06	900 ELECTROCARDI OLOGY	0	0		0 0	0	69
00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	28, 911	0		0 0	0	7
00 07	200 IMPL. DEV. CHARGED TO PATIENT	890	0		0 0	0	72
00 07	300 DRUGS CHARGED TO PATIENTS	374, 619	0	1	0 0	0	73
00 03	140 CARDI OLOGY	0	0	1	0 0	0	76
97 07	697 CARDI AC REHABI LI TATI ON	38, 634	261	26	0	37	76
OU	TPATIENT SERVICE COST CENTERS			•			1
00 09	000 CLINIC	116, 292	2, 326	2, 32	6 0	121	7 90
00 09	100 EMERGENCY	2,048,643				1, 289	91
	200 OBSERVATION BEDS (NON-DISTINCT PART)	_, ,	-,			.,	92
	ECIAL PURPOSE COST CENTERS	1					1.1
	300 I NTEREST EXPENSE						113
3.00	SUBTOTALS (SUM OF LINES 1-117)	12, 076, 300	32, 161	31, 46	0 100	6, 905	
	NREI MBURSABLE COST CENTERS	12,070,000	02,101	01,10		0, 700	1
	000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	4, 924	262	26	02 0	0	190
	200 PHYSI CLANS' PRI VATE OFFICES	4, 924			0 0		192
). 00 19.	Cross Foot Adjustments		0			0	200
. 00	Negative Cost Centers	2 50/ 0/4	1 / / 0 000	405 40	1 212 000	00/ 400	201
2.00	Cost to be allocated (per Wkst. B,	3, 506, 861	1, 669, 898	435, 63	312, 890	226, 492	202
	Part I)	0 00007.	E1 E00E01	10 7007-		00.004450	
3.00	Unit cost multiplier (Wkst. B, Part I)	0. 290274		13. 73277		32.801159	
1.00	Cost to be allocated (per Wkst. B,	72,060	303, 875	21, 59	42, 667	31, 934	204
	Part II)						
5.00	Unit cost multiplier (Wkst. B, Part	0.005965	9. 372205	0. 68066	426. 670000	4.624765	1005

	Financial Systems LOCATION - STATISTICAL BASIS	IU HEALTH BLACKE	Provi der CC	N: 15-1302	In Lieu of Form C Period: Worksheet	
					From 01/01/2016 To 12/31/2016 Date/Time 5/23/2017	Prepared: 7.19 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY		
		ADMI NI STRATI ON	SERVICES &	(COSTED		
		(FTE'S)	SUPPLY (COSTED	REQUIS.)		
			REQUIS.)			
		13.00	14.00	15.00		
	GENERAL SERVICE COST CENTERS		•			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT					4.00
	00570 ADMI TTI NG					5.01
	00590 OTHER ADMIN AND GENERAL					5.02
	00700 OPERATION OF PLANT					7.00
	00900 HOUSEKEEPI NG					9.00
	01000 DI ETARY 01100 CAFETERI A					10.00
	01300 NURSI NG ADMI NI STRATI ON	2, 749				13.00
	01400 CENTRAL SERVICES & SUPPLY	2,749	297, 688			13.00
	01400 CENTRAL SERVICES & SUFFET	0	3, 537	375, 53	31	14.00
	INPATIENT ROUTINE SERVICE COST CENTERS	0	5, 557	575, 5	51	15.00
	03000 ADULTS & PEDI ATRI CS	1, 457	48, 230	8, 74	43	30.00
+	ANCI LLARY SERVICE COST CENTERS	1,107	10,200	0,,,		
	05000 OPERATI NG ROOM	220	50, 408	50	01	50.00
	05300 ANESTHESI OLOGY	0	12, 762		19	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	27, 265	1, 8	12	54.00
	05700 CT SCAN	0	0		0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	59.00
60.00	06000 LABORATORY	0	20, 118		0	60.00
60.01	06001 BLOOD LABORATORY	0	0		0	60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	62.00
	06500 RESPI RATORY THERAPY	0	28, 665		0	65.00
	06501 SLEEP LAB	0	0		0	65.01
	06600 PHYSI CAL THERAPY	0	2, 222		0	66.00
	06700 OCCUPATI ONAL THERAPY	0	163		0	67.00
	06800 SPEECH PATHOLOGY	0	0		0	68.00
	06900 ELECTROCARDI OLOGY	0	0		0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	29, 062 779		0	71.00
	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	0	0	357, 52	•	72.00
	03140 CARDI OLOGY	0	0	557, 52	0	76.00
	07697 CARDI AC REHABI LI TATI ON	35	737		0	76.97
	OUTPATIENT SERVICE COST CENTERS	55	/3/			/0. //
	09000 CLINIC	93	3, 820	9(05	90.00
	09100 EMERGENCY	944	69, 920	5, 72		91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0,,,,20	0, , ,		92.00
	SPECIAL PURPOSE COST CENTERS	1				
	11300 I NTEREST EXPENSE					113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	2, 749	297, 688	375, 53	31	118.00
	NONREI MBURSABLE COST CENTERS			· · · · · · · · · · · · · · · · · · ·		
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0	190. 00
192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	192.00
200.00	Cross Foot Adjustments					200.00
201.00	Negative Cost Centers					201.00
202.00	Cost to be allocated (per Wkst. B,	453, 759	405, 208	985, 7 ⁻	15	202.00
000 05	Part I)	4/5 0/00-		o /o:		000 5-
203.00	Unit cost multiplier (Wkst. B, Part I)	165. 063296	1. 361184	2. 6248		203.00
204.00	Cost to be allocated (per Wkst. B,	7,740	24, 854	20, 44	45	204.00
205.00	Part II) Unit cost multiplier (Wkst. B, Part	2. 815569	0. 083490	0.05444	42	205.00

Health F	-inancial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-:	2552-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 7:1	pared: 9 am
			Title	XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	,	Total Costs	RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
	NPATIENT ROUTINE SERVICE COST CENTERS	-1	1	1	-		-
	3000 ADULTS & PEDIATRICS	4, 078, 282		4, 078, 28	2 0	0	30.00
	NCI LLARY SERVI CE COST CENTERS	1	1				-
	5000 OPERATING ROOM	1, 125, 639		1, 125, 63		-	
	05300 ANESTHESI OLOGY	18, 839		18, 83		0	
	5400 RADI OLOGY-DI AGNOSTI C	2, 183, 723		2, 183, 72	3 0	0	
	5700 CT SCAN	0			0 0	0	
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	
	05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	07100
	06000 LABORATORY	1, 464, 769		1, 464, 76	9 0	0	00.00
	06001 BLOOD LABORATORY 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 0	0	
	06500 RESPIRATORY THERAPY	846, 896		846, 89	4 0	0	
	06501 SLEEP LAB	040, 090	0	040, 09	0 0	0	
	06600 PHYSI CAL THERAPY	606, 408	0	606, 40	8 0	0	
	6700 OCCUPATI ONAL THERAPY	127, 327		127, 32		0	
	6800 SPEECH PATHOLOGY	8, 288		8, 28		0	•
	6900 ELECTROCARDI OLOGY	0,200			0 0	0	
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	76, 862		76, 86	°	0	•
	07200 I MPL. DEV. CHARGED TO PATI ENT	2, 208		2, 20		0	•
	7300 DRUGS CHARGED TO PATIENTS	1, 421, 814		1, 421, 81		0	
	03140 CARDI OLOGY	0			0 0	0	•
	07697 CARDI AC REHABI LI TATI ON	74, 868		74, 86	8 0	0	•
	UTPATIENT SERVICE COST CENTERS						1
	99000 CLI NI C	328, 683		328, 68	3 0	0	90.00
91.00 0	09100 EMERGENCY	3, 200, 034		3, 200, 03	4 0	0	91.00
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART)	288, 179		288, 17	9	0	92.00
S	PECIAL PURPOSE COST CENTERS						
	1300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	15, 852, 819	0	15, 852, 81	9 0		200.00
201.00	Less Observation Beds	288, 179		288, 17			201.00
202.00	Total (see instructions)	15, 564, 640	0	15, 564, 64	0 0	0	202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	IU HEALTH BLACK	Provi der C	CN: 15-1302	Peri od:	eu of Form CMS- Worksheet C	
				From 01/01/2016		
				To 12/31/2016	Date/Time Pre 5/23/2017 7:1	epared: 9 am
	1		XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other		
			+ col. 7)	Rati o	Inpati ent	
	(00	7.00	0.00	0.00	Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			2 (52 5	45		1 20 00
30. 00 03000 ADULTS & PEDIATRICS	2, 653, 545		2, 653, 54	45		30.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM	210,402	2 212 400	2 521 0		0.00000	50.00
	218, 493	2, 313, 488				
	17, 199	80, 335				
54. 00 05400 RADI OLOGY-DI AGNOSTI C	301,090	7, 302, 082				
57.00 05700 CT SCAN	0	0		0 0.00000		
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0.00000		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	F (00 4)	0 0.00000		
60. 00 06000 LABORATORY	827, 851	4, 810, 267	5, 638, 1			
60. 01 06001 BLOOD LABORATORY	0	0		0 0.00000		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0.00000		
65. 00 06500 RESPIRATORY THERAPY	581, 933	1, 270, 443				
65. 01 06501 SLEEP LAB	0	0		0 0.00000		
66.00 06600 PHYSI CAL THERAPY	186, 041	784, 684				
67. 00 06700 OCCUPATI ONAL THERAPY	73, 223	54, 674				
58.00 06800 SPEECH PATHOLOGY	19, 257	958				
59. 00 06900 ELECTROCARDI OLOGY	0	0		0 0.00000		
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	6, 518	62, 851				
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 354	21, 367				
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 733, 822	2, 070, 016				
76. 00 03140 CARDI OLOGY	0	0		0 0.00000		
76. 97 07697 CARDI AC REHABI LI TATI ON	0	363, 552	363, 5	52 <u>0.20593</u> 5	0. 000000	76.9
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLI NI C	0	923, 479				
91.00 09100 EMERGENCY	54, 510	8, 739, 356				
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 044	513, 218	523, 20	62 0. 550736	0. 000000	92.00
SPECIAL PURPOSE COST CENTERS	1 1		1		1	
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	6, 686, 880	29, 310, 770	35, 997, 6	50		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	6, 686, 880	29, 310, 770	35, 997, 6	50		202.00

Health Financial Systems	IU HEALTH BLACKFO	RD HOSPI TAL	In Lieu of Form CMS-2552-1			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1302	Peri od: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/23/2017 7:1	pared: 9 am	
		Title XVIII	Hospi tal	Cost		
Cost Center Description	PPS Inpatient					
	Ratio					
	11.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS					30.00	
ANCILLARY SERVICE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0. 000000				50.00	
53.00 05300 ANESTHESI OLOGY	0. 000000				53.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00	
57.00 05700 CT SCAN	0. 000000				57.00	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000				58.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000				59.00	
60. 00 06000 LABORATORY	0.000000				60,00	
60. 01 06001 BLOOD LABORATORY	0, 000000				60.01	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000				62.00	
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00	
65. 01 06501 SLEEP LAB	0. 000000				65.01	
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00	
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00	
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00	
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00	
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000				72.00	
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00	
76. 00 03140 CARDI OLOGY	0.000000				76.00	
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000				76.97	
OUTPATIENT SERVICE COST CENTERS	0.000000				/0. 7/	
90. 00 09000 CLINIC	0.000000				90.00	
91. 00 09100 EMERGENCY	0. 000000				91.00	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				92.00	
SPECIAL PURPOSE COST CENTERS	0.000000				72.00	
113. 00 11300 I NTEREST EXPENSE					113.00	
200.00 Subtotal (see instructions)					200.00	
200.00 Subtotal (see Instructions) 201.00 Less Observation Beds					200.00	
201.00 Total (see instructions)					201.00	
					202.00	

Health Financial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Pre 5/23/2017 7:1	pared: 9 am
		Ti tl	e XIX	Hospi tal	Cost	
			ľ	Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	,		RCE Di sal I owance	Total Costs	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1	1	-		
30. 00 03000 ADULTS & PEDIATRICS	4, 078, 282		4, 078, 28	2 0	4, 078, 282	30.00
ANCI LLARY SERVI CE COST CENTERS	4 405 (00	1	1 405 (6		4 405 (00	50.00
50. 00 05000 OPERATI NG ROOM	1, 125, 639		1, 125, 63		1, 125, 639	
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	18,839		18, 83		18, 839	
57. 00 05700 CT SCAN	2, 183, 723		2, 183, 72	3 0	2, 183, 723 0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	1
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	1
60. 00 06000 LABORATORY	1, 464, 769		1, 464, 76	0 0	1, 464, 769	
60. 01 06001 BLOOD LABORATORY	1,404,707		1,404,70	0 0	1, 404, 709	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0				0	
65. 00 06500 RESPIRATORY THERAPY	846, 896	0	846, 89	6 0	846, 896	
65. 01 06501 SLEEP LAB	010,070			0 0	010,070	1
66. 00 06600 PHYSI CAL THERAPY	606, 408		606, 40	8 0	606, 408	
67.00 06700 OCCUPATI ONAL THERAPY	127, 327		127, 32		127, 327	
68.00 06800 SPEECH PATHOLOGY	8, 288		8, 28		8, 288	
69. 00 06900 ELECTROCARDI OLOGY	0			0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	76, 862		76, 86	2 0	76, 862	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	2, 208		2, 20	8 0	2, 208	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 421, 814		1, 421, 81	4 0	1, 421, 814	73.00
76. 00 03140 CARDI OLOGY	0			0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	74, 868		74, 86	8 0	74, 868	76.97
OUTPATIENT SERVICE COST CENTERS				_		
90. 00 09000 CLINIC	328, 683		328, 68	3 0	328, 683	90.00
91. 00 09100 EMERGENCY	3, 200, 034		3, 200, 03	4 0	3, 200, 034	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	288, 179		288, 17	9	288, 179	92.00
SPECIAL PURPOSE COST CENTERS			1			
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	15, 852, 819					
201.00 Less Observation Beds	288, 179		288, 17		288, 179	
202.00 Total (see instructions)	15, 564, 640	0	15, 564, 64	0 0	15, 564, 640	202.00

Health Financial Systems	IU HEALTH BLACK	ORD HOSPITAL		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 7:1	pared: 9 am
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent		6 Cost or Other		
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS					1	
30. 00 03000 ADULTS & PEDI ATRI CS	2, 653, 545		2, 653, 54	45		30.00
ANCI LLARY SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·		I		1	
50.00 05000 OPERATI NG ROOM	218, 493	2, 313, 488				
53. 00 05300 ANESTHESI OLOGY	17, 199	80, 335				
54.00 05400 RADI OLOGY-DI AGNOSTI C	301, 090	7, 302, 082	7, 603, 1			
57.00 05700 CT SCAN	0	0		0 0.000000		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000		
60. 00 06000 LABORATORY	827, 851	4, 810, 267	5, 638, 1			
60. 01 06001 BLOOD LABORATORY	0	0		0 0.000000	0. 000000	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0.000000	0. 000000	62.00
65. 00 06500 RESPI RATORY THERAPY	581, 933	1, 270, 443	1, 852, 3	0. 457194	0. 000000	65.00
65. 01 06501 SLEEP LAB	0	0		0 0.000000	0. 000000	65.01
66. 00 06600 PHYSI CAL THERAPY	186, 041	784, 684	970, 72	0. 624696	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	73, 223	54, 674	127, 89	0. 995543	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	19, 257	958	20, 2	0. 409993	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0.000000	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	6, 518	62, 851	69, 30	1. 108017	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	3, 354	21, 367	24, 72	0. 089317	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 733, 822	2,070,016	3, 803, 83	0. 373784	0. 000000	73.00
76. 00 03140 CARDI OLOGY	0	0		0 0.000000	0. 000000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	363, 552	363, 55	0. 205935	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	923, 479	923, 4	0. 355918	0.00000	90.00
91. 00 09100 EMERGENCY	54, 510	8, 739, 356			0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	10, 044	513, 218				
SPECIAL PURPOSE COST CENTERS	,	2.2,210		0.00000		1
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	6, 686, 880	29, 310, 770	35, 997, 65	50		200.00
201.00 Less Observation Beds	0,000,000	27,010,110				201.00
202.00 Total (see instructions)	6, 686, 880	29, 310, 770	35, 997, 6	50		202.00
	0,000,000	27,010,110	1 00, 777, 00		I.	1-02.00

Health Financial Systems	IU HEALTH BLACKFO	RD HOSPI TAL	In Lieu of Form CMS-2552-10			
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1302	Period: From 01/01/2016 To 12/31/2016	Worksheet C Part I Date/Time Prepared: 5/23/2017 7:19 am		
		Title XIX	Hospi tal	Cost		
Cost Center Description	PPS Inpatient Ratio 11.00					
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDI ATRI CS				30.00		
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	0.000000			50.00		
53. 00 05300 ANESTHESI OLOGY	0.000000			53.00		
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.000000			54.00		
57.00 05700 CT SCAN	0.000000			57.00		
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0.000000			58.00		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000			59.00		
60. 00 06000 LABORATORY	0.000000			60.00		
60. 01 06001 BLOOD LABORATORY	0.000000			60, 01		
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00		
65. 00 06500 RESPIRATORY THERAPY	0.000000			65.00		
65. 01 06501 SLEEP LAB	0.000000			65.01		
66. 00 06600 PHYSI CAL THERAPY	0.000000			66.00		
67.00 06700 OCCUPATI ONAL THERAPY	0.000000			67.00		
68. 00 06800 SPEECH PATHOLOGY	0.000000			68.00		
69. 00 06900 ELECTROCARDI OLOGY	0.000000			69.00		
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00		
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00		
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00		
76. 00 03140 CARDI OLOGY	0.000000			76.00		
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000			76.97		
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0.000000			90.00		
91.00 09100 EMERGENCY	0.000000			91.00		
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00		
SPECIAL PURPOSE COST CENTERS						
113. 00 11300 I NTEREST EXPENSE				113.00		
200.00 Subtotal (see instructions)				200.00		
201.00 Less Observation Beds				201.00		
202.00 Total (see instructions)				202.00		
	1			1		

Health Financial Systems	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016		pared: 9 am
			XVIII	Hospi tal	Cost	
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	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATI NG ROOM	160, 951	2, 531, 981				
53. 00 05300 ANESTHESI OLOGY	1, 124	97, 534	0. 01152	2, 401	28	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	135, 016	7, 603, 172	0. 01775	8 152, 689	2, 711	54.00
57.00 05700 CT SCAN	0	0	0.00000	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0 0	0	59.00
60.00 06000 LABORATORY	42, 159	5, 638, 118	0.00747	7 392, 291	2, 933	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0 0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	21, 869	1, 852, 376	0. 01180	242, 281	2, 860	65.00
65.01 06501 SLEEP LAB	0	0	0. 00000	0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	73, 120	970, 725	0. 07532	26, 230	1, 976	66.00
67.00 06700 OCCUPATI ONAL THERAPY	7, 568	127, 897	0. 05917	3 7, 251	429	67.00
68.00 06800 SPEECH PATHOLOGY	69	20, 215	0. 00341	3 10, 875	37	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2,626	69, 369	0. 03785	6 1, 785	68	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	80		0.00323	6 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	23, 225			665, 366	4,063	73.00
76. 00 03140 CARDI OLOGY	0	0	0.00000		0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	8, 238	363, 552			0	76.97
OUTPATIENT SERVICE COST CENTERS	2,200			· · · ·		1
90. 00 09000 CLINIC	69, 354	923, 479	0.07510	01 0	0	90.00
91. 00 09100 EMERGENCY	140, 368				17	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	21, 106				0	
200.00 Total (lines 50-199)	706, 873			1, 537, 970	17, 393	200. 00

Health Financial Systems	rstems IU HEALTH BLACKFORD HOSPITAL In Lieu					2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTH THROUGH COSTS		6 Provider C		Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Allied Healt		Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1		1	1	L	
50.00 O5000 OPERATING ROOM	0	C		0 0	0	
53.00 05300 ANESTHESI OLOGY	0	C		0 0	0	53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0 0	0	54.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0	C		0 0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
65.01 06501 SLEEP LAB	0	0		0 0	0	65.01
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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76. 00 03140 CARDI OLOGY	0	0		0 0	0	76.00
76. 97 07697 CARDIAC REHABILITATION	0	0		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	-			_		
90. 00 09000 CLINIC	0	C		0 0	0	
91. 00 09100 EMERGENCY	0	C		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0 0	0	
200.00 Total (lines 50-199)	0	C		0 0	0	200. 00

Health Financial Systems	u of Form CMS-2	2552-10				
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PASS	S Provider C		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2016		
				Го 12/31/2016	Date/Time Pre 5/23/2017 7:1	
			xviii	Hospi tal	Cost	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.		
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVICE COST CENTERS		-	1	1		
50. 00 05000 OPERATI NG ROOM	0	2, 531, 981			35, 728	
53. 00 05300 ANESTHESI OLOGY	0	97, 534	0.00000	0. 000000	2, 401	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	7, 603, 172			152, 689	54.00
57.00 05700 CT SCAN	0	0	0.00000	0. 000000	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000	0. 000000	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0. 000000	0	59.00
60. 00 06000 LABORATORY	0	5, 638, 118	0.00000	0. 000000	392, 291	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0. 000000	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.00000	0. 000000	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 852, 376	0.00000	0. 000000	242, 281	65.00
65. 01 06501 SLEEP LAB	0	0	0.00000	0. 000000	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0	970, 725	0.00000	0. 000000	26, 230	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	127, 897	0.00000	0. 000000	7, 251	67.00
68.00 06800 SPEECH PATHOLOGY	0	20, 215	0.00000	0. 000000	10, 875	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0.00000	0. 000000	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	69, 369	0.00000	0. 000000	1, 785	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	24, 721	0.00000	0. 000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	3, 803, 838	0.00000	0. 000000	665, 366	73.00
76. 00 03140 CARDI OLOGY	0	0	0.00000	0. 000000	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	363, 552	0.00000	0. 000000	0	76.97
OUTPATIENT SERVICE COST CENTERS		·	·			
90. 00 09000 CLI NI C	0	923, 479	0.00000	0. 000000	0	90.00
91.00 09100 EMERGENCY	0	8, 793, 866	0.00000	0. 000000	1, 073	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	523, 262	0.00000	0. 000000		92.00
200.00 Total (lines 50-199)	0	33, 344, 105			1, 537, 970	200. 00

Health Financial Systems IU HEALTH BLACKFORD HOSPITAL In Lieu of Form CMS-:						
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SET THROUGH COSTS	RVICE OTHER PASS	Provider C	CN: 15-1302	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Pre	parod:
				10 12/31/2010	5/23/2017 7: 1	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVI CE COST CENTERS	1		1			
50.00 O5000 OPERATI NG ROOM	0	C		0		50.00
53.00 05300 ANESTHESI OLOGY	0	C		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C		0		54.00
57.00 05700 CT SCAN	0	C		0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0		59.00
60. 00 06000 LABORATORY	0	C		0		60.00
60.01 06001 BLOOD LABORATORY	0	C		0		60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0		62.00
65. 00 06500 RESPI RATORY THERAPY	0	C		0		65.00
65.01 06501 SLEEP LAB	0	C		0		65. 01
66. 00 06600 PHYSI CAL THERAPY	0	0		0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0		73.00
76. 00 03140 CARDI OLOGY	0	C		0		76.00
76. 97 07697 CARDIAC REHABILITATION	0	0		0		76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	C		0		90.00
91.00 09100 EMERGENCY	0	C		0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0		92.00
200.00 Total (lines 50-199)	0	C		0		200. 00

	IU HEALTH BLACK	ORD HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	O VACCINE COST	Provider C	CN: 15-1302	Peri od:	Worksheet D	
				From 01/01/2016 To 12/31/2016	Part V Date/Time Pre	nared
				10 12/01/2010	5/23/2017 7:1	9 am
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see		Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0. 444569	0	646, 34	15 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 193153	0			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 287212	0	2, 211, 34		0	54.00
57. 00 05700 CT SCAN	0. 000000	0	2, 211, 3-	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0			0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 259798	0	1, 455, 81		0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0	1,433,0		0	60.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0			0	62.00
65. 00 06500 RESPIRATORY THERAPY	0. 457194	0	493, 99	28 0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0	473, 7	0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 624696	0	327, 57		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 995543	0	15, 74		0	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 409993	0	,	0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 108017	0	20, 51	6 0	0	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 089317	0	8, 7		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 373784	0	741, 45		0	73.00
76. 00 03140 CARDI OLOGY	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 205935	0	187, 65		0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 355918	0	622, 68	36 0	0	90.00
91.00 09100 EMERGENCY	0. 363894	0	2, 266, 24	16 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 550736	0	213, 78	39 0	0	92.00
200.00 Subtotal (see instructions)		0	9, 226, 96	55 165	0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0	9, 226, 96	55 165	0	202.00

Heal th	Financial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-	-2552-10
APPORT	APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider C		Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre 5/23/2017 7:	epared: 19 am
			Title	XVIII	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
		Ded. & Coins.	Ded. & Coins.				
		(see inst.)	(see inst.)	-			
		6.00	7.00				
	ANCI LLARY SERVICE COST CENTERS		-	1			-
	05000 OPERATING ROOM	287, 345		1			50.00
	05300 ANESTHESI OLOGY	2, 901	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	635, 125	C				54.00
	05700 CT SCAN	0	C				57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
	06000 LABORATORY	378, 219	0				60.00
	06001 BLOOD LABORATORY	0	0				60. 01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
	06500 RESPI RATORY THERAPY	225, 853	0				65.00
	06501 SLEEP LAB	0	0				65.01
	06600 PHYSI CAL THERAPY	204, 634					66.00
	06700 OCCUPATI ONAL THERAPY	15, 676					67.00
	06800 SPEECH PATHOLOGY	0	0				68.00
	06900 ELECTROCARDI OLOGY	0	0				69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	22, 732					71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	784		1			72.00
	07300 DRUGS CHARGED TO PATIENTS	277, 143		1			73.00
	03140 CARDI OLOGY	0	-				76.00
	07697 CARDI AC REHABI LI TATI ON	38, 645	0)			76.97
	OUTPATIENT SERVICE COST CENTERS	1	I				
	09000 CLI NI C	221, 625		1			90.00
	09100 EMERGENCY	824, 673		1			91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	117, 741					92.00
200.00		3, 253, 096	62				200.00
201.00		0					201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)	3, 253, 096	62	1			202.00

Health Financial Systems	IU HEALTH BLACKF	ORD HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider CO	CN: 15-1302	Period:	Worksheet D	
		Component	CON. 15 7202	From 01/01/2016 To 12/31/2016	Part V	nored.
		component (CCN: 15-Z302	To 12/31/2016	Date/Time Pre 5/23/2017 7:1	pared: 9 am
		Title	XVIII	Swing Beds - SNF		
			Charges		Costs	
Cost Center Description	Cost to ChargeP	PS Reimbursed	Cost	Cost	PPS Services	
	Ratio From S	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	· · · · ·					
50.00 05000 OPERATI NG ROOM	0. 444569	0		0 0	-	
53. 00 05300 ANESTHESI OLOGY	0. 193153	0		0 0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 287212	0		0 0	0	
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 259798	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 457194	0		0 0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 624696	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 995543	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0, 409993	0		0 0	0	1
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 108017	0		0 0	0	1
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.089317	0		0 0	0	1
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 373784	0		0 0	0	1
76. 00 03140 CARDI OLOGY	0. 000000	0		0 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 205935	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS	01200700			<u> </u>		
90. 00 09000 CLINIC	0. 355918	0		0 0	0	90.00
91.00 09100 EMERGENCY	0. 363894	0		0 0	0	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 550736	0		0 0	0	
200.00 Subtotal (see instructions)		0		0 0	-	200.00
201.00 Less PBP Clinic Lab. Services-Program		0		0 0	Ű	201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)		0		0 0	0	202.00
		-	1		-	

Health Financial Systems	U HEALTH BLACK	FORD HOSPITAL		In Lieu	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider C	CN: 15-1302 CCN: 15-Z302	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre 5/23/2017 7:1	epared:
		Title	XVIII	Swing Beds - SNF	Cost	
	Cos			<u>1</u>		
Cost Center Description	Cost	Cost				
'	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS	,					-
50. 00 05000 OPERATI NG ROOM	0	0				50.00
53.00 05300 ANESTHESI OLOGY	0	0				53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
65.01 06501 SLEEP LAB	0	0				65.01
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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76. 00 03140 CARDI OLOGY	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS	,					-
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges		_				
202.00 Net Charges (line 200 +/- line 201)	0	0	l			202.00

	IU HEALTH BLACKF	ORD HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1302	Peri od:	Worksheet D	
				From 01/01/2016	Part V	
				To 12/31/2016	Date/Time Pre 5/23/2017 7:1	pared: 9 am
		Titl	e XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins	. Ded. & Coins.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 444569	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 193153	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 287212	0		0 0	0	54.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 259798	0		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000	0		0 0	0	1
65. 00 06500 RESPI RATORY THERAPY	0. 457194	0		0 0	0	1
65. 01 06501 SLEEP LAB	0. 000000	0		0 0	0	1
66. 00 06600 PHYSI CAL THERAPY	0. 624696	0		0 0	0	1
67.00 06700 OCCUPATI ONAL THERAPY	0. 995543	0		0 0	0	
68. 00 06800 SPEECH PATHOLOGY	0. 409993	0		0 0	0	1
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	1
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 108017	0		0 0	0	1
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 089317	0		0 0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 373784	0		0 0	0	1
76.00 03140 CARDI OLOGY	0. 000000	0		0 0	0	1
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 205935	0		0 0	0	
OUTPATIENT SERVICE COST CENTERS	0.200700					/0. //
90. 00 09000 CLINIC	0. 355918	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0. 363894	0		0 0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 550736	0		0 0	0	
200.00 Subtotal (see instructions)	0.000700	0		0 0	-	200.00
201.00 Less PBP Clinic Lab. Services-Program		0		0 0	0	201.00
Only Charges				0		
202.00 Net Charges (line 200 +/- line 201)		0		0 0	0	202.00
	1 1	0	I.			

Health Financial Systems	U HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1302	Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre 5/23/2017 7:	
		Titl	e XIX	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	Cost	Cost				
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						_
50. 00 05000 OPERATI NG ROOM	0	-				50.00
53.00 05300 ANESTHESI OLOGY	0	0				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	0				54.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	0	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
65. 00 06500 RESPI RATORY THERAPY	0	0				65.00
65.01 06501 SLEEP LAB	0	0				65.01
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
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0				73.00
76. 00 03140 CARDI OLOGY	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0				76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	0				90.00
91.00 09100 EMERGENCY	0	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0				92.00
200.00 Subtotal (see instructions)	0	0				200. 00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 +/- line 201)	0	0	1			202.00

MPUT.	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1302	Period: From 01/01/2016	Worksheet D-1	
			To 12/31/2016	Date/Time Pre 5/23/2017 7:1	
	Cost Conton Deparintian	Title XVIII	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				-
00	Inpatient days (including private room days and swing-bed da	ays, excluding newborn)		2, 229	1 1
00	Inpatient days (including private room days, excluding swing	-bed and newborn days)		1, 136	2
00	Private room days (excluding swing-bed and observation bed d	lays). If you have only pr	rivate room days,	0	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation	hed days)		990	4
00	Total swing-bed SNF type inpatient days (including private r		er 31 of the cost	918	
	reporting period				
00	Total swing-bed SNF type inpatient days (including private r	room days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private ro	oom days) through December	31 of the cost	175	7
	reporting period			170	'
00	Total swing-bed NF type inpatient days (including private ro	oom days) after December 3	31 of the cost	0	8
	reporting period (if calendar year, enter 0 on this line)			705	
00	Total inpatient days including private room days applicable newborn days)	to the Program (excluding	y swing-bed and	705	9
00	Swing-bed SNF type inpatient days applicable to title XVIII	only (including private r	room days)	918	10
	through December 31 of the cost reporting period (see instru	icti ons)		_	
00	Swing-bed SNF type inpatient days applicable to title XVIII December 31 of the cost reporting period (if calendar year,		room days) after	0	1
00	Swing-bed NF type inpatient days applicable to titles V or X		e room davs)	0	12
	through December 31 of the cost reporting period				
00	Swing-bed NF type inpatient days applicable to titles V or X			0	13
00	after December 31 of the cost reporting period (if calendar Medically necessary private room days applicable to the Prog			0	14
	Total nursery days (title V or XIX only)	and cover during swring bed	uuys)	0	
	Nursery days (title V or XIX only)			0	16
00	SWING BED ADJUSTMENT	and through December 21	f the east		1 1.
00	Medicare rate for swing-bed SNF services applicable to servi reporting period	ces through becember 31 c	DI LINE COST		1
00	Medicare rate for swing-bed SNF services applicable to servi	ces after December 31 of	the cost		18
00	reporting period Medicaid rate for swing-bed NF services applicable to servic	es through December 31 of	the cost	137.32	19
	reporting period	-			
00	Medicaid rate for swing-bed NF services applicable to servic reporting period	ces after December 31 of t	the cost	0.00	20
00	Total general inpatient routine service cost (see instructio	ons)		4, 078, 282	2
00	Swing-bed cost applicable to SNF type services through Decem		ing period (line	0	
~~	5 x line 17)			0	
00	Swing-bed cost applicable to SNF type services after Decembe x line 18)	er 31 of the cost reportir	ng period (iine 6	0	23
00	Swing-bed cost applicable to NF type services through Decemb	per 31 of the cost reporti	ng period (line	24, 031	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25
	x line 20)		, por ou (rino o	Ũ	-
00	Total swing-bed cost (see instructions)			1, 836, 007	
00	General inpatient routine service cost net of swing-bed cost	: (line 21 minus line 26)		2, 242, 275	27
00	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-b	ped and observation bed ch	arges)	0	28
	Private room charges (excluding swing-bed charges)			0	
00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27	′÷line 28)		0.000000	
00 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
00	Average per diem private room charge differential (line 32 m		ctions)	0.00	
00	Average per diem private room cost differential (line 34 x l	ine 31)		0.00	35
00	Private room cost differential adjustment (line 3 x line 35)		for an and the second s	0	
00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	and private room cost di	TTEPENTIAL (LINE	2, 242, 275	37
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
_	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST AD				
	Adjusted general inpatient routine service cost per diem (se	,		1,973.83	
	Program general inpatient routine service cost (line 9 x lin	ie 30)		1, 391, 550	1 3
	Medically necessary private room cost applicable to the Prog	aram (line 14 x line 35)		0	40

MPUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1302	Period: From 01/01/2016	Worksheet D-1	1
				To 12/31/2016		
			XVIII	Hospi tal	Cost	_
Cost Center Description	Total Inpatient Costl	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
. 00 NURSERY (title V & XIX only)						42.
Intensive Care Type Inpatient Hospital Uni 00 INTENSIVE CARE UNIT	ts		1	-	-	43.
. 00 CORONARY CARE UNIT						43.
00 BURN INTENSIVE CARE UNIT						45.
00 SURGICAL INTENSIVE CARE UNIT						46.
00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	-
00 Program inpatient ancillary service cost (Wkst. D-3. col. 3.	Line 200)			552, 022	2 48.
00 Total Program inpatient costs (sum of line			ons)		1, 943, 572	
PASS THROUGH COST ADJUSTMENTS						
00 Pass through costs applicable to Program i	npatient routine s	services (from	n Wkst. D, sur	n of Parts I and	C	50.
<pre>1111) 00 Pass through costs applicable to Program i</pre>	nnationt ancillary	, services (fr	om Wkst D	cum of Parts II	C	51
and IV)	inpatrent and rials		UII WKSt. D, .			/ 31
00 Total Program excludable cost (sum of line					C	
00 Total Program inpatient operating cost exc		ated, non-phy	vsician anestl	netist, and	C	53
medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	ie 52)					-
00 Program di scharges					C	54
00 Target amount per discharge					0.00	
00 Target amount (line 54 x line 55)					C	56
00 Difference between adjusted inpatient oper	ating cost and tar	get amount (I	ine 56 minus	line 53)	0	
00 Bonus payment (see instructions)00 Lesser of lines 53/54 or 55 from the cost	reporting pariod	nding 1004	indated and o	mounded by the	0. 00	
market basket	reporting period e	enuing 1990, t	ipuateu anu co	Silipourided by the	0.00	09
00 Lesser of lines 53/54 or 55 from prior year	ir cost report, upo	dated by the m	narket basket		0.00	60
.00 If line 53/54 is less than the lower of li					C	61
which operating costs (line 53) are less t amount (line 56), otherwise enter zero (se		s (lines 54 x	60), or 1% of	f the target		
.00 Relief payment (see instructions)	e mstructrons)				C	62
00 Allowable Inpatient cost plus incentive pa	yment (see instruc	ctions)			0	
PROGRAM INPATIENT ROUTINE SWING BED COST						
.00 Medicare swing-bed SNF inpatient routine c	osts through Decen	nber 31 of the	e cost reporti	ng period (See	1, 811, 976	64
instructions)(title XVIII only) 00 Medicare swing-bed SNF inpatient routine c	osts after Decembe	er 31 of the c	ost reportin	n period (See	C	65
instructions)(title XVIII only)					-	
00 Total Medicare swing-bed SNF inpatient rou	itine costs (line 6	64 plus line 6	5)(title XVI	l only). For	1, 811, 976	66
CAH (see instructions) 00 Title V or XIX swing-bed NF inpatient rout	ino costo through	December 21	f the cost r	porting poriod	C	67
(line 12 x line 19)	The costs through	December 31 C	in the cost in	eporting period		07.
.00 Title V or XIX swing-bed NF inpatient rout	ine costs after De	ecember 31 of	the cost repo	orting period	C	68
(line 13 x line 20)			(0)			
.00 Total title V or XIX swing-bed NF inpatier PART III - SKILLED NURSING FACILITY, OTHER			,		0) 69.
00 Skilled nursing facility/other nursing fac)		70
00 Adjusted general inpatient routine service						71
.00 Program routine service cost (line 9 x lir						72
.00 Medically necessary private room cost appl						73
00 Total Program general inpatient routine se 00 Capital-related cost allocated to inpatier	•			Part II column		74
26, line 45)			ISTRUCT D, I	a. e. r., corumit		'
00 Per diem capital-related costs (line 75 ÷	line 2)					76
00 Program capital -related costs (line 9 x li						77
00 Inpatient routine service cost (line 74 mi 00 Aggregate charges to beneficiaries for exc	,	ovider rocord	(c)			78
00 Total Program routine service costs for co	• •		· · · · · · · · · · · · · · · · · · ·	nus line 79)		80
00 Inpatient routine service cost per diem li	•					81
00 Inpatient routine service cost limitation		1				82
00 Reasonable inpatient routine service costs	•	5)				83
00 Program inpatient ancillary services (see						84
00 Utilization review - physician compensation 00 Total Program inpatient operating costs (s						85
PART IV - COMPUTATION OF OBSERVATION BED P		cagir 00)				
. 00 Total observation bed days (see instruction					146	87
.00 Adjusted general inpatient routine cost pe	er diem (line 27 ÷	line 2)			1, 973. 83	
.00 Observation bed cost (line 87 x line 88) (288, 179	

Health Financial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2016	Worksheet D-1		
				To 12/31/2016			
		Title	XVIII	Hospi tal	Cost		
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	298, 688	4, 078, 282	0. 07323	9 288, 179	21, 106	90.00	
91.00 Nursing School cost	0	4, 078, 282	0.00000	0 288, 179	0	91.00	
92.00 Allied health cost	0	4, 078, 282	0.00000	0 288, 179	0	92.00	
93.00 All other Medical Education	0	4, 078, 282	0.00000	0 288, 179	0	93.00	

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1302	Period: From 01/01/2016	Worksheet D-1	
		Title XIX	To 12/31/2016	Date/Time Prep 5/23/2017 7:10	
	Cost Center Description		Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
20	INPATIENT DAYS	avoluding nouhann)		2, 229	1
00 00	Inpatient days (including private room days and swing-bed days Inpatient days (including private room days, excluding swing-			2, 229	
00	Private room days (excluding swing-bed and observation bed day		rivate room days,	0	
	do not complete this line.		J .		
00	Semi-private room days (excluding swing-bed and observation be			990	
00	Total swing-bed SNF type inpatient days (including private roo reporting period	om days) through Decemb	er 31 of the cost	918	5
00	Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	-			
00	Total swing-bed NF type inpatient days (including private room	n days) through Decembe	r 31 of the cost	175	7
00	reporting period Total swing-bed NF type inpatient days (including private room	n dave) after December	21 of the cost	0	6
50	reporting period (if calendar year, enter 0 on this line)	i days) al ter beceniber	ST OF THE COST	0	
00	Total inpatient days including private room days applicable to	o the Program (excluding	g swing-bed and	5	9
	newborn days)				
00	Swing-bed SNF type inpatient days applicable to title XVIII of		room days)	0	10
00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on		room days) after	0	1
00	December 31 of the cost reporting period (if calendar year, en		dago) artor		·
00	Swing-bed NF type inpatient days applicable to titles V or XIX	K only (including priva	te room days)	0	1:
00	through December 31 of the cost reporting period	Contra (including privo	to room day(c)	0	1:
00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar ye			0	'
00	Medically necessary private room days applicable to the Progra			0	14
00	Total nursery days (title V or XIX only)		-	0	
00	Nursery days (title V or XIX only)			0	10
00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to service	es through December 31 (of the cost		11
00	reporting period	es through becomen er			
00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost		18
00	reporting period	s through December 21 o	f the cost	0.00	1
00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through becember 31 0	I the cost	0.00	
00	Medicaid rate for swing-bed NF services applicable to services	s after December 31 of	the cost	0.00	20
	reporting period				
00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ting pariod (line	4, 078, 282	
00	5 x line 17)	er 31 of the cost repor	ting period (ine	0	22
00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportion	ng period (line 6	0	23
	x line 18)				
00	Swing-bed cost applicable to NF type services through December	r 31 of the cost report	ing period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December 3	31 of the cost reportin	g period (line 8	0	25
-	x line 20)	· · · · · · · · · · · · · · · · · · ·			
00	Total swing-bed cost (see instructions)	(1) 01 1 11		1, 822, 717	
00	General inpatient routine service cost net of swing-bed cost PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	(line 21 minus line 26)		2, 255, 565	2
00	General inpatient routine service charges (excluding swing-bed	d and observation bed c	harges)	0	2
00	Private room charges (excluding swing-bed charges)		5	0	
00	Semi-private room charges (excluding swing-bed charges)			0	
00	General inpatient routine service cost/charge ratio (line 27 -	÷line 28)		0.000000	
00 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0.00 0.00	
00	Average per diem private room charge differential (line 32 min	nus line 33)(see instru	ctions)	0.00	
00	Average per diem private room cost differential (line 34 x lin		-	0.00	
00	Private room cost differential adjustment (line 3 x line 35)			0	
00	General inpatient routine service cost net of swing-bed cost a	and private room cost d	itterential (line	2, 255, 565	37
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	JSTMENTS			1
	Adjusted general inpatient routine service cost per diem (see	instructions)		1, 985. 53	
00	Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progra	-		9, 928 0	

Heal th	Financial Systems	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	F	Period: From 01/01/2016 To 12/31/2016		
			T; +1	e XIX	Hospi tal	5/23/2017 7:10 Cost	9 am
	Cost Center Description	Total	Total	Average Per	Program Days	Program Cost	
			Inpatient Days	Diem (col. 1 ↔ col. 2)		(col. 3 x col. 4)	
42.00	NUDCEDV (+; +Lo V & VIV only)	1.00	2.00	3.00	4.00	5.00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units		<u> </u>				42.00
43.00	INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
						1.00	
	Program inpatient ancillary service cost (Wk					5, 972	48.00
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ns)		15, 900	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D. sum	of Parts I and	0	50.00
	Pass through costs applicable to Program inp					0	51.00
	and IV)		,				
52.00	Total Program excludable cost (sum of lines					0	52.00
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		erated, non-pny	sician anestne	etist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
	Program discharges					0	
	Target amount per discharge						55.00
	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	arget amount (1	ine 56 minus l	ine 53)	0	56.00 57.00
	Bonus payment (see instructions)		inger amount (i		The 55)	0	58.00
	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, u	pdated and com	pounded by the	0.00	59.00
(0.00	market basket	aget report up	datad by the m	arkat baakat		0.00	(0.00
	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				he amount by	0.00	60. 00 61. 00
	which operating costs (line 53) are less that					-	
	amount (line 56), otherwise enter zero (see	instructions)				_	
	Relief payment (see instructions)	opt (coo instru	uctions)			0	62.00 63.00
03.00	Allowable Inpatient cost plus incentive paym PROGRAM INPATIENT ROUTINE SWING BED COST					0	03.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reportir	ng period (See	0	64.00
4E 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	te after Decemb	or 21 of the e	act reporting	noried (See	0	45 00
65.00	instructions) (title XVIII only)	its after Decemb	ber 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 XVIII	only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31 o	f the cost rep	orting period	0	67.00
(0.00	(line 12 x line 19)	C + D)	***			(0.00
68.00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	le costs arter D	ecemper 31 or	the cost repor	ting 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 N Skilled nursing facility/other nursing facil						70.00
	Adjusted general inpatient routine service of						71.00
72.00	Program routine service cost (line 9 x line	71)					72.00
73.00	Medically necessary private room cost applic			ne 35)			73.00
74.00 75.00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient			lorksheet B Pa	urt II column		74.00 75.00
/ 5. 00	26, line 45)	routine service		Unksheet b, it			/ 5. 00
	Per diem capital-related costs (line 75 ÷ li	,					76.00
	Program capital -related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	provi der record	s)			78.00 79.00
80.00	Total Program routine service costs for comp	• •		· · · ·	ıs line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82.00	Inpatient routine service cost limitation (I		· .				82. 00 83. 00
	Reasonable inpatient routine service costs (Program inpatient ancillary services (see in		13)				83.00 84.00
	Utilization review - physician compensation		ons)				85.00
86.00	Total Program inpatient operating costs (sum		nrough 85)				86. 00
87 00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					144	87.00
	Adjusted general inpatient routine cost per		line 2)			140	
	Observation bed cost (line 87 x line 88) (se	•	,			289, 887	

Health Financial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CC		Period: From 01/01/2016	Worksheet D-1	
				To 12/31/2016		
		Titl	e XIX	Hospi tal	Cost	
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	298, 688	4, 078, 282	0.07323	9 289, 887	21, 231	90.00
91.00 Nursing School cost	0	4, 078, 282	0.00000	289, 887	0	91.00
92.00 Allied health cost	0	4, 078, 282	0.00000	289, 887	0	92.00
93.00 All other Medical Education	0	4, 078, 282	0. 00000	289, 887	0	93.00

eal th Financial Systems IU HEALTH BLACKFORD F NPATIENT ANCILLARY SERVICE COST APPORTIONMENT Pr	OSPITAL	CN: 15-1302	Peri od:	eu of Form CMS- Worksheet D-3	
	ovraer oc	10 1002	From 01/01/2016		
			To 12/31/2016		
				5/23/2017 7:1	19 am
	litle	XVIII	Hospi tal	Cost	_
Cost Center Description		Ratio of Cos		Inpatient	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col. 2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	-
30. 00 03000 ADULTS & PEDIATRICS			1, 262, 168	2	30. 0
ANCI LLARY SERVICE COST CENTERS			1,202,100	<u>/</u>	- 50.0
50. 00 05000 OPERATI NG ROOM		0. 4445	35, 728	15, 884	50. C
53. 00 05300 ANESTHESI OLOGY		0. 1931			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2872			
57. 00 05700 CT SCAN		0.0000			
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000			
9. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000			
0. 00 06000 LABORATORY		0. 2597		-	
50. 01 06001 BLOOD LABORATORY		0.0000			
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000			
55. 00 06500 RESPI RATORY THERAPY		0. 4571		110, 769	
5. 01 06501 SLEEP LAB		0.0000			
6. 00 06600 PHYSI CAL THERAPY		0.6246		16, 386	66.0
7. 00 06700 OCCUPATI ONAL THERAPY		0.9955			
8.00 06800 SPEECH PATHOLOGY		0.4099	73 10, 875		
9. 00 06900 ELECTROCARDI OLOGY		0.0000	00 00		69. (
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 1080	17 1, 785	1, 978	3 71. (
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.0893	17 (0	
3.00 07300 DRUGS CHARGED TO PATIENTS		0.37378	665, 366	248, 703	3 73.0
6. 00 03140 CARDI OLOGY		0.0000	00 00	0 0	76. (
6. 97 07697 CARDIAC REHABILITATION		0. 20593	35 0	0	76. 9
OUTPATIENT SERVICE COST CENTERS				•	
0. 00 09000 CLI NI C		0. 3559	18 (0	90.0
1.00 09100 EMERGENCY		0.3638	94 1, 073	390	91. (
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0.5507	36 (0	
00.00 Total (sum of lines 50-94 and 96-98)			1, 537, 970	552, 022	200.
201.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)		(201. (
202.00 Net Charges (line 200 minus line 201)			1, 537, 970		202.0

J	U HEALTH BLACKFORD HOSPITAL			eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CCN		Peri od:	Worksheet D-3	3
	Component CC		From 01/01/2016 To 12/31/2016		nared
	· ·			5/23/2017 7:1	9 am
	Title		Swing Beds - SNF		
Cost Center Description	R	Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
	-	1,00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			0	1	30.00
ANCI LLARY SERVICE COST CENTERS			0		30.00
50. 00 05000 OPERATING ROOM		0. 44456	9 0	0	50.00
53. 00 05300 ANESTHESI OLOGY		0. 19315		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 28721		-	
57. 00 05700 CT SCAN		0.00000		0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.00000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000	0 0	0	59.00
60. 00 06000 LABORATORY		0. 25979	195, 052	50, 674	60.00
60. 01 06001 BLOOD LABORATORY		0.0000	0 0	0	60. 0 ⁴
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000	0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY		0.45719		98, 004	
65. 01 06501 SLEEP LAB		0.0000		0	
66. 00 06600 PHYSI CAL THERAPY		0. 62469			
67.00 06700 OCCUPATI ONAL THERAPY		0. 99554			
68.00 06800 SPEECH PATHOLOGY		0.40999		3, 174	
69. 00 06900 ELECTROCARDI OLOGY		0.0000		0	
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		1.10801		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.08931		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 37378		255, 213	
76. 00 03140 CARDI OLOGY		0.00000		-	
76. 97 07697 CARDI AC REHABI LI TATI ON OUTPATI ENT SERVI CE COST CENTERS		0. 20593	5 0	0	76.9
90. 00 09000 CLINIC		0, 35591	8 0	0	90.00
91. 00 09100 EMERGENCY		0.36389		0	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 55073		0	
200.00 Total (sum of lines 50-94 and 96-98)			1, 361, 918		
201.00 Less PBP Clinic Laboratory Services-Pro	gram only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			1, 361, 918	1	202.00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC	CN: 15-1302	Period:	Worksheet D-3	3
			From 01/01/2016 To 12/31/2016		narod
			10 12/31/2010	5/23/2017 7:1	
	Titl	e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00		2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			10.000		
30. 00 03000 ADULTS & PEDI ATRI CS			10, 083		30.00
ANCI LLARY SERVICE COST CENTERS		0.4445	(0)		50.00
50. 00 05000 OPERATING ROOM		0.4445		0	
53.00 05300 ANESTHESI OLOGY		0. 1931		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2872			
57.00 05700 CT SCAN		0.0000		0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
60. 00 06000 LABORATORY		0. 2597			
60. 01 06001 BLOOD LABORATORY		0.0000		0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0.4571			
65. 01 06501 SLEEP LAB		0.0000		0	
66.00 06600 PHYSI CAL THERAPY		0. 6246		0	
67.00 06700 OCCUPATIONAL THERAPY		0. 9955		0	07.00
68.00 06800 SPEECH PATHOLOGY		0.4099		0	
69.00 06900 ELECTROCARDI OLOGY		0.0000		0	
71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS		1.1080		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.0893		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3737			
76. 00 03140 CARDI OLOGY		0.0000		0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0.20593	35 0	0	76.97
90. 00 09000 CLINIC		0, 3559	10 0	0	90.00
91. 00 09100 EMERGENCY		0.3638		-	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5507		0	
200.00 Total (sum of lines 50-94 and 96-98)		0. 5507.	16, 680	-	200.00
201.00 Less PBP Clinic Laboratory Services-Pr	couram only charges (line 61)		10,000	5, 772	200.00
202.00 Net Charges (line 200 minus line 201)	ogram only charges (The OT)		16, 680		201.00
202.00 met ondriges (The 200 minus The 201)		I	10,000	1	1202.00

Health Financial Systems IU HEALTH BLACKFC	RD HOSPITAL			In Lie	u of Form CMS-:	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1302		ri od:	Worksheet D-3	
	Component	CCN: 15-Z302	Fro	om 01/01/2016 12/31/2016	Date/Time Pre	narod
	component	CCN. 13-2302	10	12/ 51/ 2010	5/23/2017 7:1	
	Titl	e XIX		ng Beds - SNF		
Cost Center Description		Ratio of Cos		Inpati ent	Inpati ent	
		To Charges		Program	Program Costs	
				Charges	(col. 1 x col.	
		1.00	_	0.00	2)	
		1.00		2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				0		20.00
30. 00 03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS				0		30.00
50. 00 05000 OPERATI NG ROOM		0. 4445	40	0	0	50.00
53. 00 05300 ANESTHESI OLOGY		0. 4445		0	0	53.00
54. 00 05400 RADI 0L0GY-DI AGNOSTI C		0. 2872		0	0	54.00
57. 00 05700 CT SCAN		0. 2872		0	0	57.00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	0	59.00
60. 00 06000 LABORATORY		0. 2597		0	0	60.00
60. 01 06001 BLOOD LABORATORY		0.0000		0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	0	62.00
65. 00 06500 RESPIRATORY THERAPY		0. 4571		0	0	65.00
65. 01 06501 SLEEP LAB		0.0000		0	0	65.01
66. 00 06600 PHYSI CAL THERAPY		0. 6246	96	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY		0. 9955	43	0	0	67.00
68.00 06800 SPEECH PATHOLOGY		0. 4099	93	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY		0.0000	00	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1.1080	17	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 0893		0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3737	84	0	0	73.00
76. 00 03140 CARDI OLOGY		0.0000		0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 2059	35	0	0	76.97
OUTPATIENT SERVICE COST CENTERS		1				
90. 00 09000 CLINIC		0. 3559		0	0	
91.00 09100 EMERGENCY		0. 3638		0	0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 5507	36	0	0	
200.00 Total (sum of lines 50-94 and 96-98)	(1) (3)			0	0	200.00
201.00 Less PBP Clinic Laboratory Services-Program only charge	s (line 61)			0		201.00
202.00 Net Charges (line 200 minus line 201)		I		0		202.00

LCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1302	Period: From 01/01/2016 To 12/31/2016		
		Title XVIII	Hospi tal	Cost	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
00	Medical and other services (see instructions)	uctions)		3, 253, 158 0	1. (2. (
00 00	Medical and other services reimbursed under OPPS (see instru PPS payments			0	3.0
00	Outlier payment (see instructions)			0	4. (
00	Enter the hospital specific payment to cost ratio (see inst	ructions)		0.000	5.0
00 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0.00	6. (7. (
00 00	Transitional corridor payment (see instructions)			0.00	8.0
00	Ancillary service other pass through costs from Wkst. D, Pt.	. IV, col. 13, line 200		0	9. (
	Organ acqui si ti ons			0	10.
. 00	Total cost (sum of lines 1 and 10) (see instructions) COMPUTATION OF LESSER OF COST OR CHARGES			3, 253, 158	11.0
	Reasonable charges				
. 00	Ancillary service charges			0	12. (
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4,	line 69)		0	13.
. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.
. 00	Aggregate amount actually collected from patients liable for	r payment for services or	a charge basis	0	15.
	Amounts that would have been realized from patients liable	1 3	0	0	16.
00	had such payment been made in accordance with 42 CFR §413.13	3(e)		0,000000	17
	Ratio of line 15 to line 16 (not to exceed 1.000000) Total customary charges (see instructions)			0. 000000 0	17. 18.
	Excess of customary charges over reasonable cost (complete (only if line 18 exceeds l	ine 11) (see	0	19.
	instructions)	-			
. 00	Excess of reasonable cost over customary charges (complete d	only if line 11 exceeds l	ine 18) (see	0	20.
. 00	instructions) Lesser of cost or charges (line 11 minus line 20) (for CAH s	see instructions)		3, 285, 690	21.
	Interns and residents (see instructions)	,		0	22.
	Cost of physicians' services in a teaching hospital (see ins	structions)		0	23.
. 00	Total prospective payment (sum of lines 3, 4, 8 and 9) COMPUTATION OF REIMBURSEMENT SETTLEMENT			0	24.
. 00	Deductibles and coinsurance (for CAH, see instructions)			31, 660	25.
	Deductibles and Coinsurance relating to amount on line 24 (1	for CAH, see instructions	5)	1, 553, 307	26.
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26)) plus the sum of lines 2	2 and 23] (see	1, 700, 723	27.
. 00	instructions) Direct graduate medical education payments (from Wkst. E-4,	line 50)		0	28.
	ESRD direct medical education costs (from Wkst. E-4, line 36			0	20.
	Subtotal (sum of lines 27 through 29)			1, 700, 723	30.
	Primary payer payments			1, 586	
. 00	Subtotal (line 30 minus line 31) ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERV	VI CES)		1, 699, 137	32.
. 00	Composite rate ESRD (from Wkst. 1-5, line 11)	VICES)		0	33.
	Allowable bad debts (see instructions)			283, 511	
	Adjusted reimbursable bad debts (see instructions)			184, 282	
	Allowable bad debts for dual eligible beneficiaries (see ins	structions)		395, 613	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			1, 883, 419 0	37. 38.
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	39.
	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	39.
	Partial or full credits received from manufacturers for repl		uctions)	0	39.
. 99	RECOVERY OF ACCELERATED DEPRECIATION		,	n	39.
	Subtotal (see instructions)			1, 883, 419	40.
. 01	Sequestration adjustment (see instructions)			37, 668	40.
. 00	Interim payments			2, 041, 799	41.
	Tentative settlement (for contractors use only)			0	
	Balance due provider/program (see instructions) Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub 15-2	chanter 1	-196, 048 0	43. 44.
. 00	§115. 2				
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)	、 		0	90.
	Outlier reconciliation adjustment amount (see instructions))		0	
. 00	The rate used to calculate the Time Value of Money			0. 00 0	
00	Time Value of Money (see instructions)				

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1302	Period: From 01/01/2016 To 12/31/2016		
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	тв	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider 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 List separately each retroactive lump sum adjustment		1, 745, 07	72 0	2, 041, 799 0	1.00 2.00 3.00
3.00	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER	06/30/2016	113, 20	00	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
3.05	Provider to Program			0	0	3.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51
3.52				0	0	3.52
3.53 3.54				0	0	3.53 3.54
3. 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		113, 20		0	3. 99
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 858, 27	72	2, 041, 799	4.00
5.00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5.00
5.00	desk review. Al so show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5. 00
5.01	TENTATI VE TO PROVIDER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5.03
	Provider to Program					
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.51
5.51				0	0	5.52
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	5.9
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6.01	SETTLEMENT TO PROVIDER			0	0	6.0
6.02	SETTLEMENT TO PROGRAM		86, 03		196, 048	6. 02
7.00	Total Medicare program liability (see instructions)		1, 772, 23		1, 845, 751	7.00
				Contractor Number	NPR Date (Mo/Day/Yr)	
		C		1.00	2.00	

VALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared
			20111		5/23/2017 7:1	9 am
		Inpati en		Swing Beds - SNF	Cost T B	
		l	LPAILA	Pai	LD	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
00	Total interim payments paid to provider		2, 130, 39	C	0	1. (
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,		(C	0	2. (
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					3. (
	payment. If none, write "NONE" or enter a zero. (1)					
01	Program to Provider ADJUSTMENTS TO PROVIDER	06/30/2016	180, 80		0	3. (
02		00/ 30/ 2010		0	0	3.
03					0	3.
04			(D	0	3.
05			(0	0	3.
	Provider to Program			-	1	
50	ADJUSTMENTS TO PROGRAM				0	3.
51 52					0	3.
52 53				0	0	
54				0	0	3.
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)		180, 80	D	0	3.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 311, 19	C	0	4.
	TO BE COMPLETED BY CONTRACTOR					1
00	List separately each tentative settlement payment after					5.
	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
D1	Program to Provider TENTATIVE TO PROVIDER				0	5.
02					0	
)3				0	0	5.
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	5.
51					0	
52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines					5
17	5. 50-5. 98)		,			[.] .
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
D1	SETTLEMENT TO PROVIDER		27, 71	1	0	6.
)2	SETTLEMENT TO PROGRAM			C	0	
00	Total Medicare program liability (see instructions)		2, 338, 90		0	7.
				Contractor Number	NPR Date (Mo/Day/Yr)	
	Name of Contractor	C)	1.00	2.00	8.

Heal th	Financial Systems IU HEALTH BLACK	FORD HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1302	Peri od: From 01/01/2016 To 12/31/2016		
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	Cost	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATI				
1.00	Total hospital discharges as defined in AARA §4102 from Wks		e 14	437	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1,	8-12		705	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			119	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1,	8-12		990	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			35, 997, 650	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3			1, 332, 504	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of line 168	certified HIT technology	Wkst. S-2, Pt. I	0	7.00
8.00	Calculation of the HIT incentive payment (see instructions)			0	8.00
9.00	Sequestration adjustment amount (see instructions)			0	9.00
10.00	Calculation of the HIT incentive payment after sequestratio	n (see instructions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH	· · · ·			
30.00	Initial/interim HIT payment adjustment (see instructions)			0	30.00
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30 and	line 31) (see instruction	ns)	0	32.00

Heal th	Financial Systems IU HEALTH BLA	CKFORD HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1302	Peri od:	Worksheet E-2	
			From 01/01/2016		
		Component CCN: 15-Z302	To 12/31/2016	Date/Time Pre 5/23/2017 7:10	
		Title XVIII	Swing Beds - SNF		<u>/ uiii</u>
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructi	ons)	1, 830, 096	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructio	ns)			2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for		573, 054	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, se				
4.00	Per diem cost for interns and residents not in approved t	eaching program (see		0.00	4.00
	instructions)			_	
5.00	Program days		918	0	5.00
6.00	Interns and residents not in approved teaching program (s			0	6.00
7.00	Utilization review - physician compensation - SNF optiona	I method only	0		7.00
8.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2, 403, 150	0	
9.00	Primary payer payments (see instructions)		0 100 150	0	
10.00	Subtotal (line 8 minus line 9)		2, 403, 150	0	10. 00 11. 00
11.00	Deductibles billed to program patients (exclude amounts a professional services)	ppi cable to physician	0	0	11.00
12.00	Subtotal (line 10 minus line 11)		2, 403, 150	0	12.00
13.00	Coinsurance billed to program patients (from provider rec	ords) (exclude coinsurance	25, 760	0	13.00
	for physician professional services)				
14.00	80% of Part B costs (line 12 x 80%)			0	
15.00	Subtotal (enter the lesser of line 12 minus line 13, or l	ine 14)	2, 377, 390	-	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	-	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instruc	tions)	0	0	101.00
16.55	410A RURAL DEMONSTRATION PROJECT		0		16. 55
17.00	Allowable bad debts (see instructions)		14, 221	-	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		9, 244	0	
18.00	Allowable bad debts for dual eligible beneficiaries (see	instructions)	14, 221	0	
19.00	Total (see instructions)		2, 386, 634	0	19.00
19.01	Sequestration adjustment (see instructions)		47, 733		19.01
20.00	Interim payments		2, 311, 190	0	20.00
21.00	Tentative settlement (for contractor use only)		0	0	
22.00	Balance due provider/program (line 19 minus lines 19.01,		27, 711	0	22.00
23.00	Protested amounts (nonallowable cost report items) in acc	ordance with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2		1 1		I

Heal th	Financial Systems	IU HEALTH BLACKFO	RD HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING I	BEDS	Provider CCN: 15-1302 Component CCN: 15-Z302	Period: From 01/01/2016 To 12/31/2016	Worksheet E-2 Date/Time Pre	
					5/23/2017 7:1	19 am
			Title XIX	Swing Beds - SNF		
				Part A	Part B	
	COMPUTATION OF NET COST OF COVERED SERVICES			1.00	2.00	
1.00	Inpatient routine services - swing bed-SNF			0		1.00
2.00	Inpatient routine services - swing bed-SNF			0	1	2.00
3.00	Ancillary services (from Wkst. D-3, col. 3,	· /	t A and sum of Wkst D	0	1	3.00
5.00	Part V, cols. 6 and 7, line 202, for Part E			0	1	5.00
4.00	Per diem cost for interns and residents not			0.00	1	4.00
	instructions)			0.00	1	
5.00	Program days			0	1	5.00
6.00	Interns and residents not in approved teach	ning program (see i	nstructions)	0	1	6.00
7.00	Utilization review - physician compensation			0	1	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lir		5	0	1	8.00
9.00	Primary payer payments (see instructions)	,		0	1	9.00
10.00	Subtotal (line 8 minus line 9)			0	1	10.00
11.00	Deductibles billed to program patients (exc	clude amounts appli	cable to physician	0	1	11.00
	professional services)				1	
12.00	Subtotal (line 10 minus line 11)			0	1	12.00
13.00	Coinsurance billed to program patients (fro	om provider records) (excl ude coi nsurance	0	1	13.00
	for physician professional services)				1	
14.00	80% of Part B costs (line 12 x 80%)			0	1	14.00
15.00	Subtotal (enter the lesser of line 12 minus		14)	0	1	15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI			0	1	16.00
16.50	Pioneer ACO demonstration payment adjustmer	nt (see instruction	s)	0	1	16.50
16.55	410A RURAL DEMONSTRATION PROJECT			0	1	16.55
17.00	Allowable bad debts (see instructions)			0	1	17.00
17.01	Adjusted reimbursable bad debts (see instru	,		0	1	17.01
18.00	Allowable bad debts for dual eligible benef	ficiaries (see inst	ructions)	0	1	18.00
19.00	Total (see instructions)			0	1	19.00
19.01	Sequestration adjustment (see instructions)			0		19.01
20.00	Interim payments			0		20.00
21.00	Tentative settlement (for contractor use or Balance due provider/program (line 19 minus		and 21)	0		21.00 22.00
22.00 23.00	Protested amounts (nonallowable cost report			0		22.00
23.00	chapter 1, §115.2	Litems) in accorda	TICE WILLII CMS PUD. 15-2,	0	1	23.00
	101.00 201 17 3110.2			i I		1

LCUL	Financial Systems IU HEALTH BL. ATION OF REIMBURSEMENT SETTLEMENT	ACKFORD HOSPITAL Provider CCN: 15-1302	Peri od:	u of Form CMS-2 Worksheet E-3	
			From 01/01/2016		
			To 12/31/2016	Date/Time Pre 5/23/2017 7:19	
		Title XVIII	Hospi tal	Cost	7 am
				1.00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MED	ICARE PART A SERVICES - COST	REIMBURSEMENT		
00	Inpatient services			1, 943, 572	
00	Nursing and Allied Health Managed Care payment (see inst	ructions)		0	
00	Organ acqui si ti on			0	
00	Subtotal (sum of lines 1 through 3)			1, 943, 572	
00	Primary payer payments	>		0	
00	Total cost (line 4 less line 5). For CAH (see instructio COMPUTATION OF LESSER OF COST OR CHARGES	ns)		1, 963, 008	6.
	Reasonable charges				-
00	Routi ne servi ce charges			0	7.
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	
. 00	Total reasonable charges			0	
	Customary charges				
. 00	Aggregate amount actually collected from patients liable	for payment for services on	a charge basis	0	1 11.
. 00	Amounts that would have been realized from patients liab	1 5	5	0	12.
	had such payment been made in accordance with 42 CFR 413		5		
. 00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0. 000000	13
. 00	Total customary charges (see instructions)			0	14
. 00	Excess of customary charges over reasonable cost (comple	te only if line 14 exceeds li	ne 6) (see	0	15
	instructions)				
. 00	Excess of reasonable cost over customary charges (comple	te only if line 6 exceeds lin	e 14) (see	0	16
~ ~	instructions)				
. 00	Cost of physicians' services in a teaching hospital (see	instructions)		0	17
00	COMPUTATION OF REIMBURSEMENT SETTLEMENT	at E 4 Lina 40)		0	1 18
. 00	Direct graduate medical education payments (from Workshe Cost of covered services (sum of lines 6, 17 and 18)	et E-4, TTHE 49)		1, 963, 008	
. 00	Deductibles (exclude professional component)			1, 963, 008	
. 00	Excess reasonable cost (from line 16)			172, 550	
. 00	Subtotal (line 19 minus line 20 and 21)			1, 790, 472	
. 00	Coi nsurance			0	
. 00	Subtotal (line 22 minus line 23)			1, 790, 472	
. 00	Allowable bad debts (exclude bad debts for professional	services) (see instructions)		27, 588	1
. 00	Adjusted reimbursable bad debts (see instructions)	····, (······,		17, 932	
. 00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		27, 588	27
. 00	Subtotal (sum of lines 24 and 25, or line 26)	<i>.</i>		1, 808, 404	
. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instru	ctions)		0	29
. 99	Recovery of Accel erated Depreciation			0	29
. 00	Subtotal (see instructions)			1, 808, 404	
. 01	Sequestration adjustment (see instructions)			36, 168	
. 00	1 5			1, 858, 272	
. 00	Tentative settlement (for contractor use only)			0	
. 00	Balance due provider/program (line 30 minus lines 30.01,			-86, 036	
. 00	Protested amounts (nonallowable cost report items) in ac	cordance with CMS Pub. 15-2,	chapter 1,	167, 067	34

MCRI F32 - 10. 5. 160. 2

	SHEET (If you are nonproprietary and do not maintain e accounting records, complete the General Fund column	Provider C	CN: 15-1302	Period: From 01/01/2016	Worksheet G	
ла-туре у)	e accounting records, complete the General Fund column			To 12/31/2016		
		General Fund	Specific Purpose Fund		Plant Fund	
CU	RRENT ASSETS	1.00	2.00	3.00	4.00	-
	ash on hand in banks	8, 416, 934		0 0	0	1 1
	emporary investments	0		0 0	0	
00 No	otes receivable	C		0 0	0	3
	ccounts receivable	1, 528, 896		0 0	0	4
	her recei vabl e	-436, 398		0 0	0	
	lowances for uncollectible notes and accounts receivable	0		0 0	0	
	nventory	253, 038		0 0	0	
	repaid expenses Ther current assets	89, 464		0 0	0	
	le from other funds	0		0 0	0	
	otal current assets (sum of lines 1-10)	9, 851, 934		0 0	0	
	XED ASSETS	7,001,701		0		1
	and	190, 324		0 0	0	12
00 La	and improvements	259, 436		0 0	0	13
	ccumulated depreciation	-247, 840		0 0	0	
	ui I di ngs	15,007,745		0 0	0	
	ccumulated depreciation	-7, 893, 774		0 0	0	
	easehold improvements	0		0 0 0 0	0	
	ccumulated depreciation xed equipment				0	
	ccumulated depreciation	0		0 0	0	
	itomobiles and trucks	C		0 0	0	
. 00 Ac	ccumulated depreciation	C		0 0	0	22
. 00 Ma	ajor movable equipment	5, 280, 116		0 0	0	23
	ccumulated depreciation	-4, 081, 582		0 0	0	
	nor equipment depreciable	C		0 0	0	
	ccumulated depreciation	0		0 0	0	1
	T designated Assets	0		0 0 0 0	0	
	ccumulated depreciation nor equipment-nondepreciable			0 0	0	
	otal fixed assets (sum of lines 12-29)	8, 514, 425		0 0	0	
	HER ASSETS	0,011,120	1	<u> </u>		
	nvestments	C		0 0	0	31
. 00 De	eposits on Leases	C		0 0	0	32
	ue from owners/officers	C		0 0	0	
	ther assets	0		0 0	0	
	otal other assets (sum of lines 31-34)			0 0	0	
	otal assets (sum of lines 11, 30, and 35) RRENT LIABILITIES	18, 366, 359		0 0	0	36
	ccounts payable	425, 728	1	0 0	0	37
	alaries, wages, and fees payable	431, 222		0 0	0	
	ayroll taxes payable	C		0 0	0	
	otes and loans payable (short term)	C		0 0	0	40
	eferred income	C		0 0	0	41
1	ccelerated payments	C				42
	ue to other funds	0		0 0	0	
	ther current liabilities	1, 236, 325		0 0	0	
	otal current liabilities (sum of lines 37 thru 44) NG TERM LIABILITIES	2, 093, 275	1	0 0	0	45
	prtgage payable	0		0 0	0	46
	otes payable	0		0 0	0	
	nsecured Loans	0		0 0	0	
	her long term liabilities	19, 924		0 0	0	
	otal long term liabilities (sum of lines 46 thru 49)	19, 924		0 0	0	
	otal liabilities (sum of lines 45 and 50)	2, 113, 199		0 0	0	51
	PITAL ACCOUNTS	1/ 252 1/0				1 - /
	eneral fund balance becific purpose fund	16, 253, 160		0		52
	ponor created - endowment fund balance - restricted			<u> </u>		54
	phor created - endowment fund balance - unrestricted			0		55
1	overning body created - endowment fund balance			0		56
1	ant fund balance - invested in plant				0	
	ant fund balance - reserve for plant improvement,				0	
	eplacement, and expansion					
	otal fund balances (sum of lines 52 thru 58)	16, 253, 160		0 0	0	
. 00 Tc	otal liabilities and fund balances (sum of lines 51 and	18, 366, 359	1	0 0	0	60

	2	U HEALTH BLACKF		N 15 1000			eu of Form	552-10	
STATEMENT OF CHANGES IN FUND BALANCES			Provider CC	N: 15-1302	From 01/01/2016		Worksheet G-1 Date/Time Prepared: 5/23/2017 7:19 am		
		General	Fund	Speci al	Pur	pose Fund	Endowment		
1.00	Fund balances at beginning of period	1.00	2.00 15,509,270	3.00		4.00	5.00		1.00
	Net income (loss) (from Wkst. G-3, line 29)		743, 890			Ĺ			2.00
	Total (sum of line 1 and line 2)		16, 253, 160			C	b		3.00
4.00	ROUNDING	0			0			0	4.00
5.00		0			0			0	5.00
6.00		0			0			0	6.00
7.00		0			0			0	7.00
8.00 9.00		0			0			0	8.00 9.00
	Total additions (sum of line 4-9)	0	0		0	C		0	9.00 10.00
	Subtotal (line 3 plus line 10)		16, 253, 160			(11.00
	Deductions (debit adjustments) (specify)	0	10,200,100		0			0	12.00
13.00		0			0			0	13.00
14.00		0			0			0	14.00
15.00		0			0			0	15.00
16.00		0			0			0	16.00
17.00 18.00	Total deductions (sum of lines 12-17)	0	0		0	C		0	17.00 18.00
	Fund balance at end of period per balance		16, 253, 160						18.00
	sheet (line 11 minus line 18)		10, 200, 100			C			17.00
		Endowment Fund	PI ant	Fund					
		6.00	7.00	8.00					
1.00	Fund balances at beginning of period	0			0				1.00
2.00	Net income (loss) (from Wkst. G-3, line 29)								
									2.00
	Total (sum of line 1 and line 2)	0			0				3.00
4.00	Total (sum of line 1 and line 2) ROUNDING	О	0		0				3.00 4.00
4.00 5.00	· · · · · · · · · · · · · · · · · · ·	0	0		0				3.00 4.00 5.00
4.00 5.00 6.00	· · · · · · · · · · · · · · · · · · ·	0	0 0 0		0				3.00 4.00 5.00 6.00
4.00 5.00	· · · · · · · · · · · · · · · · · · ·	0	0		0				3.00 4.00 5.00
4.00 5.00 6.00 7.00	· · · · · · · · · · · · · · · · · · ·	0	0		0				3.00 4.00 5.00 6.00 7.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00	ROUNDING Total additions (sum of line 4-9)	0	0		0				3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00	ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0 0	0 0 0 0 0						$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00 \end{array}$
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	ROUNDING Total additions (sum of line 4-9)	0 0 0	0		0				$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00 \end{array}$
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0 0	0 0 0 0 0		0				$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00 \end{array}$
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0 0	0 0 0 0 0		0				$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00 \end{array}$
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00	ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0 0	0 0 0 0 0		0				$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00 \end{array}$
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10)	0 0 0	0 0 0 0 0		0				$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$
$\begin{array}{c} 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$	ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17)	0 0 0	0 0 0 0 0		0 0				$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ \end{array}$
$\begin{array}{c} 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ \end{array}$	ROUNDING Total additions (sum of line 4–9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0 0 0 0 0	0 0 0 0 0		0				$\begin{array}{c} 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ \end{array}$

Health Financial Systems IU HEALTH BI STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		FORD HOSPITAL Provider CCN: 15-1302		Peri od:	u of Form CMS-2 Worksheet G-2	
STATE	ILINE OF FATEINE REVENUES AND OFERATING EXCENSES		50. 13-1302	From 01/01/2016 To 12/31/2016	Parts I & II	pared:
	Cost Center Description		Inpati ent	Outpati ent	Total	
			1.00	2.00	3.00	
	PART I - PATIENT REVENUES General Inpatient Routine Services					+
1.00	Hospi tal		2, 653, 54	15	2, 653, 545	1 1.00
2.00	SUBPROVIDER - IPF		2,000,0		2,000,010	2.00
3.00	SUBPROVIDER - IRF					3.00
4.00	SUBPROVI DER					4.00
5.00	Swing bed - SNF			0	0	5.00
6.00	Swing bed - NF			0	0	1 0.00
7.00	SKILLED NURSING FACILITY					7.00
8.00	NURSING FACILITY					8.00
9.00	OTHER LONG TERM CARE		2 (52 5	4		9.00
10.00	Total general inpatient care services (sum of lines 1-9)		2, 653, 54	45	2, 653, 545	10.00
11.00	Intensive Care Type Inpatient Hospital Services					11.00
12.00	CORONARY CARE UNIT					12.00
13.00	BURN INTENSIVE CARE UNIT					13.00
14.00	SURGI CAL I NTENSI VE CARE UNI T					14.00
15.00	OTHER SPECIAL CARE (SPECIFY)					15.00
16.00	Total intensive care type inpatient hospital services (sum of	⁻ lines		0	0	
	11-15)					
17.00	Total inpatient routine care services (sum of lines 10 and 16	5)	2, 653, 54	45	2, 653, 545	17.00
18.00	Ancillary services		4, 023, 29		32, 820, 843	
19.00	Outpatient services		10, 04			
20.00	RURAL HEALTH CLINIC			0 0	0	
21.00 22.00	FEDERALLY QUALIFIED HEALTH CENTER			0 0	0	21.00
22.00	HOME HEALTH AGENCY AMBULANCE SERVICES					22.00
23.00	CMHC					23.00
24.00	AMBULATORY SURGICAL CENTER (D. P.)					25.00
26.00	HOSPICE					26.00
27.00	OTHER (PHYSICIAN REVENUE)			0 1, 731, 771	1, 731, 771	27.00
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	3 to Wkst.	6, 686, 88		37, 729, 421	28.00
	G-3, line 1)					
	PART II - OPERATING EXPENSES			-		
29.00	Operating expenses (per Wkst. A, column 3, line 200)			15, 518, 155		29.00
30.00	ADD (SPECIFY)			0		30.00
31.00				0		31.00
32.00 33.00				0		32.00
33.00				0		33.00
34.00				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 4	12)(transfer		15, 518, 155		43.00
	to Wkst. G-3, line 4)					1

	2	U HEALTH BLACKFORD HOSPI TAL			2552-10
STATEMENT OF REVENUES AND EXPENSES		Provider CCN: 15-1302	Peri od:	Worksheet G-3	
From 01/01/2016 To 12/31/2016			Date/Time Pre	nared	
			10 12/31/2010	5/23/2017 7:1	
				1.00	
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			37, 729, 421 21, 599, 481	1.00 2.00
2.00		Less contractual allowances and discounts on patients' accounts			
3.00	Net patient revenues (line 1 minus line 2)			16, 129, 940	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43)			15, 518, 155	
5.00	Net income from service to patients (line 3 minus line 4)			611, 785	5.00
	OTHER INCOME		1		
6.00	Contributions, donations, bequests, etc			0	6.00
7.00	Income from investments				7.00
8.00	Revenues from telephone and other miscellaneous communication services				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 t	han patients		0	16.00
17.00	Revenue from sale of drugs to other than patients			0	17.00
18.00	Revenue from sale of medical records and abstracts			0	18.00
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00
21.00	Rental of vending machines			0	21.00
22.00	Rental of hospital space			0	22.00
23.00	Governmental appropriations			0	23.00
24.00	MI SCELLANEOUS I NCOME			132, 105	24.00
25.00	Total other income (sum of lines 6-24)			132, 105	25.00
26.00	Total (line 5 plus line 25)			743, 890	
27.00	OTHER EXPENSES (SPECIFY)			0	27.00
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00
29.00	Net income (or loss) for the period (line 26 minus line 28)			743, 890	29.00