Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 This report is required by law (42 USC 1395g; 42 CFR 413.20(b)). Failure to report can result in all interim FORM APPROVED payments made since the beginning of the cost reporting period being deemed overpayments (42 USC 1395g). OMB NO. 0938-0050 EXPIRES 05-31-2019 HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REPORT CERTIFICATION | Provider CCN: 15-0051 Worksheet S Peri od: From 01/01/2016 Parts I-III AND SETTLEMENT SUMMARY 12/31/2016 Date/Time Prepared: 5/24/2017 10:17 am PART I - COST REPORT STATUS Provi der 1. [ X ] Electronically filed cost report Date: 5/24/2017 Time: 10:17 am use only ] Manually submitted cost report ] If this is an amended report enter the number of times the provider resubmitted this cost report ] Medicare Utilization. Enter "F" for full or "L" for low. [1] Cost Report Status
[1] As Submitted
[2] Settled without Audit
[3] Settled with Audit
[4] Date Received:
[5] To. NPR Date:
[6] 10. NPR Date:
[7] 11. Contractor's Vendor Code:
[7] 12. [8] Final Report for this Provider CCN
[9] [8] Final Report for this Provider CCN
[10] NPR Date:
[11] 12. Contractor's Vendor Code:
[11] 12. [8] 13. Contractor's Vendor Code:
[12] 13. NPR Date:
[13] 14. Contractor's Vendor Code:
[14] 15. Contractor's Vendor Code:
[15] 16. NPR Date:
[16] 17. Contractor's Vendor Code:
[17] 18. Contractor's Vendor Code:
[18] 19. Contractor's Vendor Code:
[19] 19. Contractor's Vendor Code:
[1 Contractor use only (3) Settled with Audit number of times reopened = 0-9.

## PART II - CERTIFICATION

(4) Reopened (5) Amended

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH BLOOMINGTON HOSPITAL (15-0051) 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.

(Signed)

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER

Title

05/24/2017

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	688, 575	259, 878	4, 915	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	32, 204	0		0	3. 00
4.00	SUBPROVI DER I						4. 00
5.00	Swing bed - SNF	0	0	0		0	5. 00
6.00	Swing bed - NF	0				0	6. 00
9.00	HOME HEALTH AGENCY I	0	0	-1		0	9. 00
200.00	Total	0	720, 779	259, 877	4, 915	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.

Health Financial Systems HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0051 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/23/2017 10:42 am 3.00 4.00 Hospital and Hospital Health Care Complex Address: 1.00 Street: 601 WEST SECOND STREET P0 Box: 1149 1.00 2.00 City: BLOOMINGTON State: IN Zip Code: 47402 County: MONROE 2.00 Component Name CCN CBSA Provi der Date Payment System (P, Certi fi ed T, 0, or N) Number Number Type XVIII XIX 1.00 2.00 3.00 4.00 5.00 6.00 | 7.00 | 8.00 Hospital and Hospital-Based Component Identification: 3.00 IU HEALTH BLOOMINGTON 150051 14020 07/01/1966 Ν Р Р 3.00 1 HOSPI TAI Subprovi der - IPF 4.00 4 00 5.00 Subprovider - IRF IU HEALTH BLOOMINGTON 15T051 14020 5 10/01/2002 Ν Р Ρ 5.00 HOSPI TAL 6.00 Subprovi der - (Other) 6.00 Swi ng Beds - SNF Swi ng Beds - NF 7.00 7.00 8.00 8.00 9.00 Hospi tal -Based SNF 9.00 Hospi tal -Based NF 10.00 10.00 Hospi tal -Based OLTC 11.00 11.00 12.00 Hospi tal -Based HHA IU HEALTH BLOOMINGTON 157011 14020 07/01/1996 Ν Ρ Ν 12.00 HOME HEALTH Separately Certified ASC 13.00 13.00 IU HEALTH BLOOMINGTON 151509 14020 14.00 Hospi tal -Based Hospi ce 03/13/1991 14.00 HOSPI CE 15.00 Hospital-Based Health Clinic - RHC 15.00 Hospital-Based Health Clinic - FQHC 16.00 17.00 Hospital -Based (CMHC) I 17.00 18.00 Renal Dialysis 18.00 19.00 Other 19.00 From: To: 1.00 2.00 20.00 Cost Reporting Period (mm/dd/yyyy) 01/01/2016 12/31/2016 20.00 Type of Control (see instructions) 21.00 2 21.00 Inpatient PPS Information Does this facility qualify and is it currently receiving payments for disproportionate 22.00 22.00 N share hospital adjustment, in accordance with 42 CFR §412.106? In column 1, enter "Y" for yes or "N" for no. Is this facility subject to 42 CFR Section §412.106(c)(2)(Pickle amendment hospital?) In column 2, enter "Y" for yes or "N" for no. 22.01 Did this hospital receive interim uncompensated care payments for this cost reporting 22.01 period? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period occurring prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Is this a newly merged hospital that requires final uncompensated care payments to be Ν Ν 22.02 determined at cost report settlement? (see instructions) Enter in column 1, "Y" for yes or "N" for no, for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no, for the portion of the cost reporting period on or after October 1. 22. 03 Did this hospital receive a geographic reclassification from urban to rural as a result Ν 22.03 Ν of the OMB standards for delineating statistical areas adopted by CMS in FY2015? Enter in column 1, "Y" for yes or "N" for no for the portion of the cost reporting period prior to October 1. Enter in column 2, "Y" for yes or "N" for no for the portion of the cost reporting period occurring on or after October 1. (see instructions) Does this hospital contain at least 100 but not more than 499 beds (as counted in accordance with 42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no. 23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column Ν 23.00 1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method used in the prior cost reporting period? In column 2 enter "Y" for yes or "N" fo<u>r no</u>. In-State In-State Out-of Out-of Medi cai d Other Medi cai d Medi cai d State State HMO days Medi cai d Medi cai d paid days el i gi bl e Medi cai d days unpai d paid days el i gi bl e unpai d days 1.00 2.00 3. 00 4.00 5.00 6.00 24.00 | If this provider is an IPPS hospital, enter the 1, 505 876 11, 347 24. 00 in-state Medicaid paid days in column 1, in-state Medicaid eligible unpaid days in column 2, out-of-state Medicaid paid days in column 3 out-of-state Medicaid eligible unpaid days in column 4, Medicaid HMO paid and eligible but unpaid days in column 5, and other Medicaid days in column 6.

	for yes or "N" for no in column 2. If column 2 is "Y", complete Worksheet E-4. If column 2 is "N", complete Wkst. D, Parts III & IV and D-2, Pt. II, if applicable.										
58. 00	00 If line 56 is yes, did this facility elect cost reimbursement for physicians' services as defined in CMS Pub. 15–1, chapter 21, §2148? If yes, complete Wkst. D-5.										
59. 00	Are costs claimed on line 100 of Worksheet A? If yes			Pt. I.		N			59. 00		
	Are you claiming nursing school and/or allied health provider-operated criteria under §413.85? Enter "Y"	tions)	Υ			60. 00					
	provider operated erriteria under 3110.00. Enter 1	Y/N	IME	Direct GME	IME		Di rect	GME			
		1. 00	2. 00	3. 00	4. 00		5. 00	0			
61. 00 61. 01	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see	N	0. 00	0.00	(	0.00		0. 00	61. 00		
MCDI E3	instructions)										

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HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DA	TA	Provi der CC		eriod: rom 01/01/2016 o 12/31/2016	Worksheet S-2 Part I Date/Time Pre 5/23/2017 10:	pared:
			Y/N	IME	Direct GME	IME	Direct GME	
			1. 00	2. 00	3. 00	4. 00	5. 00	
	Enter the current year total unwei FTE count (excluding OB/GYN, gener and primary care FTEs added under ACA). (see instructions) Enter the base line FTE count for and/or general surgery residents, determining compliance with the 75	ral surgery FTEs, section 5503 of primary care which is used for		0.00				61. 02
61. 04	instructions) Enter the number of unweighted pri surgery allopathic and/or osteopat current cost reporting period. (see	mary care/or hic FTEs in the		0.00	0.00			61. 04
	Enter the difference between the k and/or general surgery FTEs and th primary care and/or general surger 61.04 minus line 61.03). (see inst	paseline primary ne current year's ry FTE counts (line		0.00	0.00			61. 05
	Enter the amount of ACA §5503 awar used for cap relief and/or FTEs th care or general surgery. (see inst	rd that is being nat are nonprimary		0.00				61. 06
			Pro	ogram Name	Program Code	Unweighted IME FTE Count	Direct GME FTE  Count	
				1. 00	2. 00	3.00	4.00	
	Of the FTEs in line 61.05, specify specialty, if any, and the number for each new program. (see instruction of the program code, enter in column 3, the unweighted count and enter in coluFTE unweighted count.	of FTE residents tions) Enter in in column 2, the the IME FTE umn 4, direct GME				0.00		61. 10
61. 20	Of the FTEs in line 61.05, specify program specialty, if any, and the residents for each expanded prograinstructions) Enter in column 1, tenter in column 2, the program cod 3, the IME FTE unweighted count and 4, direct GME FTE unweighted count	e number of FTE nm. (see the program name, de, enter in column nd enter in column				0.00	0. 00	61. 20
							1.00	
42.00	ACA Provisions Affecting the Healt					ad far which	0.00	(2.00
	Enter the number of FTE residents your hospital received HRSA PCRE f Enter the number of FTE residents during in this cost reporting peri	funding (see instruction that rotated from a code of HRSA THC proc	ctions) a Teachi gram. (s	ng Health Cent see instruction	ter (THC) into			62.00
63. 00	Teaching Hospitals that Claim Resi Has your facility trained resident				ost reporting m	period? Enter	N	63. 00
	"Y" for yes or "N" for no in colum	nn 1. If yes, comple	ete line	es 64-67. (see				
					Unwei ghted FTEs Nonprovi der Si te	Unwei ghted FTEs in Hospi tal	Ratio (col. 1/ (col. 1 + col. 2))	
	Cootion FEOA of the ACA Dear Y	ETE Dool doots !: N		lon Cott!	1. 00	2.00	3.00	
64. 00	period that begins on or after Jul Enter in column 1, if line 63 is y in the base year period, the numbe	5504 of the ACA Base Year FTE Residents in Nonprovider Settings- hat begins on or after July 1, 2009 and before June 30, 2010. column 1, if line 63 is yes, or your facility trained residents ase year period, the number of unweighted non-primary care FTEs attributable to rotations occurring in all nonprovider			0.00			64.00
	settings. Enter in column 2 the r resident FTEs that trained in your of (column 1 divided by (column 1	number of unweighted hospital. Enter in	d non-pr n column instruc	imary care 3 the ratio	Unweighted	Unwei ghted	Ratio (col. 3/	
		Ü	PIT		FTEs Nonprovi der Si te	FTES in Hospital	(col. 3 + col. 4))	
		1. 00		2. 00	3. 00	4. 00	5. 00	

HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-0051 Peri od: Worksheet S-2 From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/23/2017 10:42 am Program Code Unwei ghted Unwei ghted Program Name Ratio (col. (col. 3 + col FTEs FTEs in Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3.00 4.00 5.00 0. 00 0. 00 0.000000 65.00 65.00 Enter in column 1, if line 63 is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code, enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Unwei ghted Unwei ghted Ratio (col. 1/ FTEs FTEs in (col. 1 + col Nonprovi der Hospi tal 2)) Si te 1.00 2.00 3.00 Section 5504 of the ACA Current Year FTE Residents in Nonprovider Settings--Effective for cost reporting periods beginning on or after July 1, 2010 Enter in column 1 the number of unweighted non-primary care resident 0.00 0. 00 0.000000 66.00 FTEs attributable to rotations occurring in all nonprovider settings. Enter in column 2 the number of unweighted non-primary care resident FTEs that trained in your hospital. Enter in column 3 the ratio of (column 1 divided by (column 1 + column 2)). (see instructions) Program Name Unwei ghted Ratio (col. 3/ Program Code Unwei ahted FTES FTEs in (col. 3 + col Nonprovi der Hospi tal 4)) Si te 1.00 2.00 3. 00 4.00 5.00 67.00 Enter in column 1, the program 0.000000 67.00 0.00 0.00 name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)) (see instructions) 1.00 2.00 3.00 Inpatient Psychiatric Facility PPS Is this facility an Inpatient Psychiatric Facility (IPF), or does it contain an IPF subprovider? 70.00 Enter "Y" for yes or "N" for no. 71.00 If line 70 yes: Column 1: Did the facility have an approved GME teaching program in the most O 71.00 recent cost report filed on or before November 15, 2004? Enter "Y" for yes or "N" for no. (see 42 CFR 412.424(d)(1)(iii)(c)) Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions) Inpatient Rehabilitation Facility PPS 75.00 Is this facility an Inpatient Rehabilitation Facility (IRF), or does it contain an IRF 75.00 subprovider? Enter "Y" for yes and "N" for no. If line 75 yes: Column 1: Did the facility have an approved GME teaching program in the most Ν Ν 0 76.00 recent cost reporting period ending on or before November 15, 2004? Enter "Y" for yes or "N" for no. Column 2: Did this facility train residents in a new teaching program in accordance with 42 CFR 412.424 (d)(1)(iii)(D)? Enter "Y" for yes or "N" for no. Column 3: If column 2 is Y, indicate which program year began during this cost reporting period. (see instructions)

Health Financial Systems IU HEALTH BLOOM!! HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	NGTON HOSPITAL Provider C		Period: From 01/01/2016 To 12/31/2016		-2 repared:
Long Term Care Hospital PPS				1.00	
80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes 81.00 Is this a LTCH co-located within another hospital for part of "Y" for yes and "N" for no.			ng period? Enter	N N	80. 00 81. 00
TEFRA Providers  85.00 Is this a new hospital under 42 CFR Section §413.40(f)(1)(i)  86.00 Did this facility establish a new Other subprovider (exclude		,		N	85. 00 86. 00
§413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.  87.00 Is this hospital a "subclause (II)" LTCH classified under se for yes or "N" for no.	ection 1886(d)	(1)(B)(iv)(I	I)? Enter "Y"	N	87. 00
TOT YES OF IN TOT ITO.			V 1. 00	XI X 2. 00	
Title V and XIX Services		. "."			
90.00 Does this facility have title V and/or XIX inpatient hospital yes or "N" for no in the applicable column.	al services? E	nter "Y" for	N	Y	90.00
91.00 Is this hospital reimbursed for title V and/or XIX through 1 full or in part? Enter "Y" for yes or "N" for no in the appl	the cost repor icable column	t either in	N	N	91.00
92.00 Are title XIX NF patients occupying title XVIII SNF beds (duinstructions) Enter "Y" for yes or "N" for no in the applications		ion)? (see		N	92. 00
93.00 Does this facility operate an ICF/IID facility for purposes "Y" for yes or "N" for no in the applicable column.		d XIX? Enter	N	N	93. 00
94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, applicable column.			N	N	94.00
95.00   If line 94 is "Y", enter the reduction percentage in the app 96.00   Does title V or XIX reduce operating cost? Enter "Y" for yes			0. 00 N	0. 00 N	95. 00 96. 00
applicable column.  97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	olicable colum	n.	0. 00	0.00	97. 00
105.00 Does this hospital qualify as a critical access hospital (CA 106.00) of this facility qualifies as a CAH, has it elected the all-		hod of payme	N nt		105. 00 106. 00
for outpatient services? (see instructions)  107.00 If this facility qualifies as a CAH, is it eligible for cost training programs? Enter "Y" for yes or "N" for no in column yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.  108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	n 1. (see inst 25 and the p	ructions) If rogram is co	st		107. 00
join Section 3412. 113(e). Effect 1 101 yes of N 101 flo.	Physi cal	Occupati on	al Speech	Respi ratory	/
100 00 6 this best tell must fire an a CAN are a cost against a	1. 00	2. 00	3. 00	4.00	100.00
109.00  f this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.					109. 00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospitathe current cost reporting period? Enter "Y" for yes or "N"	al Demonstrati	on project (	410A Demo)for	N	110. 00
, , , , , , , , , , , , , , , , , , ,					
Miscellaneous Cost Reporting Information			1. 0	0 2.00 3.0	U
115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percer psychiatric, rehabilitation and long term hospitals provider Pub. 15-1, chapter 22, §2208.1.	If column 2 nt for long te	is "E", ente rm care (inc	rin column Iudes	0	115. 00
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insur			r "N" for N		116. 00 117. 00
118.00 Is the mal practice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1	if the polic	y is 1		118. 00
,		Premi ums	Losses	Insurance	
		1.00	2.00	3. 00	
118.01 List amounts of malpractice premiums and paid losses:		590,	168	0	0 118. 01

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

Health Financial Systems	IU HEALTH BLO	OMINGTON HOSPITAL			In Lie	u of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA	Provi der CCI	N: 15-005	From C	1/01/2016	Worksheet S- Part I Date/Time Pr 5/23/2017 10	epared:
						1. 00	-
Mul ti campus							
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	mpus hospital that has	one or more campu	ses in di	ifferent C	BSAs?	N	165. 00
	Name	County	State	Zip Code	CBSA	FTE/Campus	
	0	1. 00	2. 00	3.00	4. 00	5. 00	
166.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions)	) incentive in the Ame	erican Recovery and	Rei nves	tment Act		1.00	00 166. 00
167.00 Is this provider a meaningful user						Υ	167. 00
168.00 If this provider is a CAH (line 10 reasonable cost incurred for the H			167 is '	"Y"), ente	r the		0168.00
168.01 If this provider is a CAH and is rexception under §413.70(a)(6)(ii)?	Enter "Y" for yes or	"N" for no. (see i	nstructio	ons)	·		168. 01
169.00 If this provider is a meaningful utransition factor. (see instruction		and is not a CAH (	line 105	is "N"),	enter the	0. 2	25169. 00
				B€	egi nni ng	Endi ng	
					1. 00	2. 00	
170.00 Enter in columns 1 and 2 the EHR k	eginning date and endi	ng date for the re	porting	10	/01/2016	12/31/2016	170. 00
					1. 00	2.00	+
171.00 If line 167 is "Y", does this prov section 1876 Medicare cost plans r "Y" for yes and "N" for no in colu 1876 Medicare days in column 2. (s	eported on Wkst. S-3, mn 1. If column 1 is y	Pt. I, line 2, col	. 6? Ente		Y		39 171. 00

		Part A		Par		
		Y/N	Date	Y/N	Date	
		1.00	2.00	3. 00	4. 00	
	PS&R Data					
16.00	Was the cost report prepared using the PS&R Report only?	N		N		16. 00
	If either column 1 or 3 is yes, enter the paid-through					
	date of the PS&R Report used in columns 2 and 4 (see					
	instructions)					
17.00	Was the cost report prepared using the PS&R Report for	Y	04/03/2017	Y	04/03/2017	17. 00
	totals and the provider's records for allocation? If					
	either column 1 or 3 is yes, enter the paid-through date					
	in columns 2 and 4. (see instructions)					
18.00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18. 00
	Report data for additional claims that have been billed					
	but are not included on the PS&R Report used to file this					
	cost report? If yes, see instructions.					
19.00	If line 16 or 17 is yes, were adjustments made to PS&R	N		N		19. 00
	Report data for corrections of other PS&R Report					
	information? If yes, see instructions.					

HOSPI T	Financial Systems IU HEALTH BLOOMI AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE		CN: 15-0051	Period: From 01/01/2016	Worksheet S	
				To 12/31/2016	Date/Time P 5/23/2017 1	
		Descr	i pti on	Y/N	Y/N	
			0	1.00	3. 00	
20.00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. 00
		Y/N	Date	Y/N	Date	
	lui i	1.00	2. 00	3. 00	4. 00	
21. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.	N		N		21. 00
					1. 00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXCE Capital Related Cost	PT CHILDRENS I	HOSPI TALS)			
22. 00	Have assets been relifed for Medicare purposes? If yes, see	instructions				22. 00
23. 00	Have changes occurred in the Medicare depreciation expense reporting period? If yes, see instructions.		sals made dur	ing the cost		23. 00
24. 00	Were new leases and/or amendments to existing leases entere If yes, see instructions	ed into during	this cost re	porting period?		24. 00
25. 00	Have there been new capitalized leases entered into during	the cost repor	ting period?	If yes, see		25. 00
26. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acquired during th	ne cost reporti	ng period? I	f yes, see		26. 00
27. 00	instructions. Has the provider's capitalization policy changed during the	cost reportin	ng period? If	yes, submit		27. 00
	Copy. Interest Expense					
28. 00	Were new Loans, mortgage agreements or Letters of credit en period? If yes, see instructions.	itered into du	ing the cost	reporti ng		28. 00
29. 00	Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see instr		ebt Service R	eserve Fund)		29. 00
30. 00	Has existing debt been replaced prior to its scheduled matu		debt? If yes	, see		30. 00
31. 00	<pre>instructions. Has debt been recalled before scheduled maturity without is instructions.</pre>	suance of new	debt? If yes	s, see		31. 00
32. 00	Purchased Services Have changes or new agreements occurred in patient care ser	vices furnishe	ed through co	ntractual		32. 00
33. 00	arrangements with suppliers of services? If yes, see instru If line 32 is yes, were the requirements of Sec. 2135.2 app no, see instructions.		ng to competi	tive bidding? If		33. 00
	Provi der-Based Physi ci ans					
34. 00	Are services furnished at the provider facility under an ar If yes, see instructions.	rangement with	n provi der-ba	sed physicians?		34. 00
35. 00	If line 34 is yes, were there new agreements or amended exi physicians during the cost reporting period? If yes, see in		nts with the	provi der-based		35. 00
				Y/N	Date	
	Home Office Costs			1. 00	2. 00	
36. 00	Were home office costs claimed on the cost report?					36. 00
37. 00	If line 36 is yes, has a home office cost statement been pr If yes, see instructions.	epared by the	home office?			37. 00
38. 00	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					38. 00
39. 00	If line 36 is yes, did the provider render services to othe see instructions.			i.		39. 00
40. 00	If line 36 is yes, did the provider render services to the instructions.	home office?	If yes, see			40. 00
		1	00	2	00	
	Cost Report Preparer Contact Information			Ζ.		
41. 00	Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA		UTTER		41. 00
	respecti vel y.	INDIANA UNIVERSITY HEALTH				
42. 00	Enter the employer/company name of the cost report preparer.	INDIANA UNIVEF	RSITY HEALTH			42. 00

Heal th	Financial Systems IU HEALTH	BLOOMI	NGTON HOSPITAL	In Lieu of Form CMS-2552-10			
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAII	Provider CCN: 15-00	Peri od:	Worksheet S-2	!		
				From 01/01/2016 Fo 12/31/2016		pared: 42 am	
			3. 00				
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title/position	n	DI RECTOR			41.00	
	held by the cost report preparer in columns 1, 2, and	13,					
	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 c	cost				43.00	
	report preparer in columns 1 and 2, respectively.						

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0051

					To	12/31/2016			
							5/23/2017 10   I/P Days / 0/		2 alli
	Component	Worksheet A	No of Dod	Bed Days		CAH Hours	<u>Visits / Trip</u> Title V	บร	
	Component		No. of Bed	,		CAH HOUIS	ii tie v		
		Line Number 1.00	2.00	Avai I abl 3. 00	е	4. 00	5. 00	$\dashv$	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00			206	0.00	3.00	0	1. 00
1.00	8 exclude Swing Bed, Observation Bed and	30.00		41 88,	200	0.00		٧l	1.00
	Hospice days) (see instructions for col. 2								
	for the portion of LDP room available beds)								
2.00	HMO and other (see instructions)							ł	2. 00
3. 00	HMO IPF Subprovider							ł	3. 00
4. 00	HMO IRF Subprovider							ł	4. 00
5.00	· ·							0	5. 00
6.00	Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF							0	
			_	41	201	0.00			6. 00
7. 00	Total Adults and Peds. (exclude observation		4	41 88,	206	0. 00		0	7. 00
0.00	beds) (see instructions)	31. 00		1/	856	0.00		0	0.00
8.00	INTENSIVE CARE UNIT	31.00		16 5,	000	0.00		۷	8. 00
9.00	CORONARY CARE UNIT							l	9.00
10.00	BURN INTENSIVE CARE UNIT							l	10.00
11.00	SURGICAL INTENSIVE CARE UNIT							ł	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	42.00							12.00
13.00	NURSERY	43. 00		F.7	0/0	0.00		0	13.00
14.00	Total (see instructions)		4	57 94,	062	0. 00		0	14.00
15.00	CAH visits							0	15. 00
16.00	SUBPROVIDER - I PF	44.00		4.	05/				16.00
17. 00	SUBPROVIDER - IRF	41. 00		16 5,	856			0	17. 00
18.00	SUBPROVI DER	42. 00		O	0			0	18. 00
19. 00	SKILLED NURSING FACILITY							-	19. 00
20.00	NURSING FACILITY							-	20.00
21. 00	OTHER LONG TERM CARE	404.00							21. 00
22. 00	HOME HEALTH AGENCY	101. 00						0	22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115. 00		_	_				23. 00
24. 00	HOSPI CE	116. 00		0	0				24. 00
24. 10	HOSPICE (non-distinct part)	30. 00							24. 10
25. 00	CMHC - CMHC								25. 00
26. 00	RURAL HEALTH CLINIC								26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	89. 00						0	26. 25
27. 00	Total (sum of lines 14-26)		2	73					27. 00
28. 00	Observation Bed Days							0	28. 00
29. 00	Ambul ance Tri ps								29. 00
30.00	Employee discount days (see instruction)								30.00
31. 00	, ,								31. 00
32.00	Labor & delivery days (see instructions)			0	0				32.00
32. 01									32. 01
	outpatient days (see instructions)								
33. 00	LTCH non-covered days								33. 00

In Lieu of Form CMS-2552-10

Period: Worksheet S-3
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/23/2017 10: 42 am 
 Heal th Financial
 Systems
 I U HEALTH

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 Provider CCN: 15-0051

				-		5/23/2017 10:	42 am
		I/P Days	s / O/P Visits	/ Trips	Full Time		
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Companient	THE XVIII	TI LI C XIX	Pati ents	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		629	43, 100			1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	4, 793	10, 719				2. 00
3.00	HMO IPF Subprovider	0	0				3. 00
4.00	HMO IRF Subprovider	224	381				4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF	0	0	0			5. 00
6.00	Hospital Adults & Peds. Swing Bed NF		0	0			6. 00
7. 00	Total Adults and Peds. (exclude observation	17, 051	629	43, 100			7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT	2, 692	696	4, 074			8. 00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)		4 740	0 470			12.00
13.00		40.740	1, 742	3, 478		4 757 40	13.00
14. 00	Total (see instructions)	19, 743	3, 067	50, 652	0.00	1, 757. 40	
15. 00	CAH visits	0	0	0			15. 00
16.00	SUBPROVIDER - I PF	2 010	1.4	2 144	0.00	0.00	16. 00
17. 00 18. 00	SUBPROVI DER	2, 018	14	3, 144	0. 00 0. 00		
19. 00	SKILLED NURSING FACILITY		U	Ü	0.00	0.00	19.00
20. 00	NURSING FACILITY						20.00
21. 00							21.00
22. 00	HOME HEALTH AGENCY	8, 725	454	15, 579	0.00	0.00	
23. 00	I .	0, 723	404	15, 579	0.00		
24. 00		22, 574	80	24, 463	0.00		1
24. 00	HOSPICE (non-distinct part)	22, 374	00	24, 403	0.00	0.00	24. 00
25. 00		J		0			25. 00
26. 00	RURAL HEALTH CLINIC						26.00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	
27. 00	l .	J		O	0.00		1
28. 00			655	5, 558		1,707.10	28. 00
29. 00	1	7, 433		0,000			29. 00
30. 00	The state of the s	,,		0			30.00
31. 00				0			31. 00
32. 00	1 ' 3	0	79	781			32. 00
32. 01				0			32. 01
	outpatient days (see instructions)			· ·			
33. 00	LTCH non-covered days	0					33. 00
	•				•	•	

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: | To 12/31/2017 | 
 Heal th Financial
 Systems
 I U HEALTH

 HOSPITAL
 AND HOSPITAL HEALTH CARE COMPLEX
 STATISTICAL DATA
 IU HEALTH BLOOMINGTON HOSPITAL Provider CCN: 15-0051

				10	) 12/31/2010	5/23/2017 10:4	
		Full Time		Di sch	arges		
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12.00	13. 00	14. 00	15. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	4, 117	306	13, 796	1. 00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)			893	2, 294		2. 00
3.00	HMO IPF Subprovider				0		3. 00
4.00	HMO IRF Subprovider				34		4. 00
5.00	Hospital Adults & Peds. Swing Bed SNF						5. 00
6.00	Hospital Adults & Peds. Swing Bed NF						6. 00
7.00	Total Adults and Peds. (exclude observation						7. 00
	beds) (see instructions)						
8. 00	INTENSIVE CARE UNIT						8. 00
9.00	CORONARY CARE UNIT						9. 00
10. 00	BURN INTENSIVE CARE UNIT						10. 00
11. 00	SURGICAL INTENSIVE CARE UNIT						11. 00
12. 00	OTHER SPECIAL CARE (SPECIFY)						12.00
13. 00	NURSERY						13.00
14. 00	Total (see instructions)	0. 00	0	4, 117	306	13, 796	14. 00
15. 00	CAH visits						15. 00
16. 00	SUBPROVI DER - I PF						16.00
17. 00	SUBPROVI DER - I RF	0. 00	0	194	3	242	17. 00
18. 00	SUBPROVI DER	0. 00	0		0	0	18.00
19. 00	SKILLED NURSING FACILITY						19.00
20. 00	NURSING FACILITY						20.00
21. 00	OTHER LONG TERM CARE						21. 00
22. 00	HOME HEALTH AGENCY	0. 00					22. 00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0. 00					23. 00
24. 00	HOSPI CE	0. 00					24. 00
24. 10	HOSPICE (non-distinct part)						24. 10
25. 00	CMHC - CMHC						25. 00
26. 00	RURAL HEALTH CLINIC						26. 00
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0. 00					26. 25
27. 00	Total (sum of lines 14-26)	0. 00					27. 00
28. 00	Observation Bed Days						28. 00
29. 00	Ambul ance Tri ps						29. 00
30. 00	Employee discount days (see instruction)						30.00
31. 00	Employee discount days - IRF						31. 00
32. 00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room						32. 01
00.5-	outpatient days (see instructions)						
33.00	LTCH non-covered days						33. 00

Provider CCN: 15-0051

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet S-3 | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: | To 12/31/2016 | Date/Time Prepared: | To 12/31/2016 | Date/Time Prepared: | To 12/31/2017 | To 12

						3 12/31/2010	Date/lime Pre 5/23/2017 10:	
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)			Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2. 00	3.00	4.00	5. 00	6. 00	
	PART II - WAGE DATA SALARIES							1
1.00	Total salaries (see	200. 00	97, 325, 241	4, 120, 697	101, 445, 938	3, 060, 219. 00	33. 15	1.00
2. 00	instructions) Non-physician anesthetist Part		0	0	0	0.00	0. 00	2. 00
3. 00	Non-physician anesthetist Part		0	0	0	0. 00	0. 00	3. 00
4. 00	Physician-Part A - Administrative		0	0	0	0. 00	0. 00	4. 00
4. 01 5. 00	Physicians - Part A - Teaching Physician and Non		0	0	0	0. 00 0. 00		
6. 00	Physician-Part B Non-physician-Part B for hospital-based RHC and FQHC		0	0	0	0.00	0.00	6. 00
7. 00	services Interns & residents (in an	21. 00	0	0	0	0.00	0. 00	7. 00
7. 01	approved program) Contracted interns and residents (in an approved programs)		0	0	О	0.00	0.00	7. 01
8. 00	Home office and/or related organization personnel		0	0	0	0.00	0. 00	8. 00
9. 00 10. 00	SNF Excluded area salaries (see	44. 00	0 10, 686, 945	0 4, 600, 698	0 15, 287, 643	0. 00 595, 165. 00		
	instructions) OTHER WAGES & RELATED COSTS							
11. 00	Contract Labor: Direct Patient Care		5, 026, 806	0	5, 026, 806	74, 974. 00	67. 05	11. 00
12. 00	Contract labor: Top level management and other management and administrative		0	0	0	0.00	0. 00	12.00
13. 00	services Contract Labor: Physician-Part A - Administrative		1, 261, 454	0	1, 261, 454	15, 152. 00	83. 25	13. 00
14. 00	Home office and/or related orgainzation salaries and wage-related costs		26, 601, 713	0	26, 601, 713	814, 250. 00	32. 67	14. 00
14. 01	Home office salaries		0	О	О	0.00		14. 01
14. 02 15. 00	Related organization salaries Home office: Physician Part A		0	0	0	0. 00 0. 00		1
16. 00	- Administrative Home office and Contract Physicians Part A - Teaching		0	0	0	0.00	0. 00	16. 00
17. 00	WAGE-RELATED COSTS Wage-related costs (core) (see		27, 535, 263	0	27, 535, 263			17. 00
18. 00	instructions) Wage-related costs (other) (see instructions)		0	0	0			18. 00
19. 00 20. 00	Excluded areas Non-physician anesthetist Part		4, 262, 913 0	0	4, 262, 913 0			19. 00 20. 00
21. 00	A Non-physician anesthetist Part		0	0	О			21. 00
22. 00	B Physician Part A - Administrative		0	О	О			22. 00
22. 01	Physician Part A - Teaching		0	0	0			22. 01
23.00	Physician Part B		0	· -	0			23. 00
24. 00 25. 00	Wage-related costs (RHC/FQHC) Interns & residents (in an approved program)		0		0			24. 00 25. 00
25. 50 25. 51	Home office wage-related Related orgainzation		0		0			25. 50 25. 51
25. 52	wage-related Home office: Physician Part A		0	0	О			25. 52
25 52	- Administrative - wage-related							25 52
25. 53	Home office & Contract Physicians Part A - Teaching - wage-related	··c		0	0			25. 53
26. 00	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	4. 00	1, 817, 097	-434	1, 816, 663	28, 923. 00	62. 81	26. 00
	Administrative & General	5. 00	7, 548, 433	ł				27. 00

| Peri od: | Worksheet S-3 | From 01/01/2016 | Part II | Date/Time Prepared: | 5/23/2017 | 10: 42 am Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0051

						5/23/2017 10:4	42 am
	Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col . 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
28.00 Administrative & General	under	2, 373, 675	0	2, 373, 675	12, 196. 00	194. 63	28. 00
contract (see inst.)							
29.00 Maintenance & Repairs	6. 00	0	0	0	0.00		29. 00
30.00 Operation of Plant	7.00	2, 517, 635	-12, 490	2, 505, 145	98, 127. 00	25. 53	30. 00
31.00 Laundry & Linen Service	8. 00	0	0	0	0.00	0. 00	31. 00
32. 00 Housekeepi ng	9. 00	1, 719, 889	-14, 312	1, 705, 577	126, 340. 00	13. 50	32. 00
33.00 Housekeeping under contr	act	0	0	0	0.00	0.00	33.00
(see instructions)							
34.00 Dietary	10.00	2, 126, 853	-916, 093	1, 210, 760	78, 124. 00	15. 50	34.00
35.00 Dietary under contract (	see	0	0	0	0.00	0.00	35. 00
instructions)							
36.00 Cafeteria	11.00	0	905, 827	905, 827	58, 936. 00	15. 37	36. 00
37.00 Maintenance of Personnel	12. 00	0	0	0	0.00	0.00	37. 00
38.00 Nursing Administration	13. 00	4, 163, 276	-18, 202	4, 145, 074	127, 570. 00	32. 49	38. 00
39.00 Central Services and Sup	pply 14.00	0	0	0	0.00	0.00	39. 00
40.00 Pharmacy	15. 00	4, 729, 593	-269, 615	4, 459, 978	124, 443. 00	35. 84	40. 00
41.00 Medical Records & Medica	16. 00	0	0	0	0.00	0.00	41.00
Records Library							
42.00 Social Service	17. 00	0	0	0	0.00	0.00	42.00
43.00 Other General Service	18. 00	387, 716	0	387, 716	22, 925. 00	16. 91	43.00

Health Financial Systems
HOSPITAL WAGE INDEX INFORMATION Provider CCN: 15-0051

							5/23/201/ 10:4	42 am_
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Pai d Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col . 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2. 00	3.00	4. 00	5. 00	6. 00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY						
1.00	Net salaries (see		99, 698, 916	4, 120, 697	103, 819, 613	3, 072, 415. 00	33. 79	1.00
	instructions)							
2.00	Excluded area salaries (see		10, 686, 945	4, 600, 698	15, 287, 643	595, 165. 00	25. 69	2.00
	instructions)							
3.00	Subtotal salaries (line 1		89, 011, 971	-480, 001	88, 531, 970	2, 477, 250. 00	35. 74	3.00
	minus line 2)							
4.00	Subtotal other wages & related		32, 889, 973	0	32, 889, 973	904, 376. 00	36. 37	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		27, 535, 263	0	27, 535, 263	0.00	31. 10	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		149, 437, 207	-480, 001	148, 957, 206	3, 381, 626. 00	44. 05	6.00
7.00	Total overhead cost (see		27, 384, 167	-173, 724	27, 210, 443	885, 680. 00	30. 72	7.00
	instructions)							

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10		
HOSPITAL WAGE RELATED COSTS	Provi der CCN: 15-0051	From 01/01/2016	Worksheet S-3 Part IV Date/Time Prepared:	

	To 12/31/2016	Date/Time Prep 5/23/2017 10:4	
		Amount	12 (
		Reported	
		1. 00	
	PART IV - WAGE RELATED COSTS		
	Part A - Core List		1
	RETI REMENT COST		
1.00	401K Employer Contributions	3, 822, 075	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contribution	0	2. 00
3.00	Nonqualified Defined Benefit Plan Cost (see instructions)	0	3. 00
4.00	Qualified Defined Benefit Plan Cost (see instructions)	6, 037, 233	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External Organization)		1
5.00	401K/TSA Plan Administration fees	0	5.00
6.00	Legal /Accounting/Management Fees-Pension Plan	0	6. 00
7.00	Employee Managed Care Program Administration Fees	0	7. 00
	HEALTH AND INSURANCE COST		1
8.00	Health Insurance (Purchased or Self Funded)	12, 570, 528	8. 00
8. 01	Health Insurance (Self Funded without a Third Party Administrator)	0	8. 01
8. 02	Health Insurance (Self Funded with a Third Party Administrator)	0	8. 02
8. 03	Health Insurance (Purchased)	0	8. 03
9.00	Prescription Drug Plan	0	9. 00
10.00	Dental, Hearing and Vision Plan	1, 689, 860	10.00
11.00	Life Insurance (If employee is owner or beneficiary)	59, 182	11. 00
12.00	Accident Insurance (If employee is owner or beneficiary)	0	12.00
13.00	Disability Insurance (If employee is owner or beneficiary)	716, 583	13.00
14.00	Long-Term Care Insurance (If employee is owner or beneficiary)	0	14.00
15.00	'Workers' Compensation Insurance	0	15. 00
16.00	Retirement Health Care Cost (Only current year, not the extraordinary accrual required by FASB 106.	0	16. 00
	Non cumulative portion)		
	TAXES		
	FICA-Employers Portion Only	6, 910, 602	17. 00
	Medicare Taxes - Employers Portion Only	0	
	Unemployment Insurance	0	19. 00
20.00	State or Federal Unemployment Taxes	-7, 886	20.00
	OTHER		
21. 00	Executive Deferred Compensation (Other Than Retirement Cost Reported on Lines 1 through 4 above. (see	0	21. 00
	instructions))		1
	Day Care Cost and Allowances	0	22. 00
	Tuition Reimbursement	0	23. 00
24. 00	Total Wage Related cost (Sum of lines 1 -23)	31, 798, 177	24. 00
	Part B - Other than Core Related Cost		
25. 00	OTHER WAGE RELATED COSTS (SPECIFY)	0	25. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form	m CMS-2552-10
HOSPITAL CONTRACT LABOR AND BENEFIT COST	Provi der CCN: 15-0051	Peri od: Worksher From 01/01/2016 Part V To 12/31/2016 Date/Tip	

		0 12/31/2016	5/23/2017 10: 4	
	Cost Center Description	Contract Labor		
		1. 00	2. 00	
	PART V - Contract Labor and Benefit Cost			
	Hospital and Hospital-Based Component Identification:			
1.00	Total facility's contract labor and benefit cost	5, 026, 806	31, 798, 177	1. 00
2.00	Hospi tal	5, 026, 806	31, 798, 177	2. 00
3.00	Subprovi der - I PF			3. 00
4.00	Subprovi der - I RF	0	0	4. 00
5.00	Subprovi der - (Other)	0	0	5. 00
6.00	Swing Beds - SNF	0	0	6.00
7.00	Swing Beds - NF	0	0	7. 00
8.00	Hospi tal -Based SNF			8. 00
9.00	Hospi tal -Based NF			9. 00
10.00	Hospi tal -Based OLTC			10.00
11. 00	Hospi tal -Based HHA	0	0	11.00
12.00	Separately Certified ASC	0	0	12.00
13.00	Hospi tal -Based Hospi ce	0	0	13.00
14.00	Hospital-Based Health Clinic RHC			14.00
15.00	Hospital-Based Health Clinic FQHC			15.00
16.00	Hospi tal -Based-CMHC			16.00
17.00	Renal Di al ysi s	0	0	17.00
18. 00	Other	0	0	18. 00

		J HEALTH BLOOMII				eu of Form CMS-2	2552-10
HOME I	HEALTH AGENCY STATISTICAL DATA		Provi der Company	F	eriod: rom 01/01/2016 o 12/31/2016	Worksheet S-4	nanad.
			Component	CCN: 15-7011 T		5/23/2017 10:	
					Home Health Agency I	PPS	
					1.	00	
0.00	County	T: 11 V	T' 11 \0.011		MONROE		0. 00
		Title V 1.00	Title XVIII 2.00	Title XIX 3.00	0ther 4.00	Total 5.00	
1. 00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	1, 392	87	938	2, 417	1. 00
2.00	Unduplicated Census Count (see instructions)	0. 00	487. 00	23.00	520.00	1, 030. 00	2. 00
				Number of Empl	oyees (Full Ti	me Equivalent)	
		Enter the number		Staff	Contract	Total	
		your normal	work week				
		0		1.00	2. 00	3. 00	
3. 00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40. 00	0.00	0.00	0.00	3. 00
4.00	Director(s) and Assistant Director(s)		.0.00	0.00	0.00	0.00	4. 00
5. 00 6. 00	Other Administrative Personnel Direct Nursing Service			5. 89 23. 36		l .	5. 00 6. 00
7. 00 8. 00	Nursi ng Supervi sor			0. 00 5. 31	0. 00 0. 00	l e	7. 00 8. 00
9. 00	Physical Therapy Service Physical Therapy Supervisor			0.00		l e	9. 00
10. 00 11. 00	Occupational Therapy Service Occupational Therapy Supervisor			1. 46 0. 00		l e	
12. 00	Speech Pathology Service			0.00	0.00	0.00	12. 00
13. 00 14. 00	Speech Pathology Supervisor Medical Social Service			0. 00 0. 69		l e	13. 00 14. 00
15. 00	Medical Social Service Supervisor			0.00	0.00	0.00	15. 00
16. 00 17. 00	Home Health Aide Home Health Aide Supervisor			0. 93 0. 00		l .	16. 00 17. 00
18. 00	NONREIMBURSABLE HOME HEALTH AGENCY CBSA CODES			0.00	0. 00	0.00	18. 00
19. 00	Enter in column 1 the number of CBSAs where			3			19. 00
	you provided services during the cost reporting period.						
20. 00	List those CBSA code(s) in column 1 serviced			14020			20. 00
	during this cost reporting period (line 20 contains the first code).						
20. 01 20. 02				26900 99915			20. 01 20. 02
20.02		Full Ep			DED 0 1	T	20.02
		Outliers		LUPA Epi sodes	PEP Only Epi sodes	Total (cols. 1-4)	
	PPS ACTIVITY DATA	1.00	2. 00	3.00	4. 00	5. 00	
21. 00	Skilled Nursing Visits	4, 038	351				
22. 00 23. 00	Skilled Nursing Visit Charges Physical Therapy Visits	495, 283 2, 659	43, 639 14	48			22. 00 23. 00
24. 00 25. 00	Physical Therapy Visit Charges Occupational Therapy Visits	354, 922 872	1, 906	6, 106 9	3, 105 11	1	
26. 00	Occupational Therapy Visit Charges	117, 460	1, 090	1		121, 158	26. 00
27. 00 28. 00	Speech Pathology Visits Speech Pathology Visit Charges	32 4, 771	0	0	0	32 4, 771	27. 00 28. 00
29. 00	Medical Social Service Visits	136	8	3	1	148	29. 00
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	26, 780 316	1, 554 10			29, 097 327	30. 00 31. 00
32. 00 33. 00	Home Health Aide Visit Charges	17, 486	558 391			l	32. 00
	Total visits (sum of lines 21, 23, 25, 27, 29, and 31)	8, 053	391				
34. 00 35. 00		0 1, 016, 702	0 48, 747	· ·		0 1, 098, 817	34. 00 35. 00
	30, 32, and 34)		.5, . 17				
36. 00	Total Number of Episodes (standard/non outlier)	511		64			
37. 00 38. 00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	23, 902	11 1, 825	1	0 396	l .	37. 00 38. 00
-2.00	app. j ona. god	23,702	., 320	0,700	370	2.7,201	,

Heal th	Financial Systems	IL	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI T	AL-BASED HOSPICE IDENTIFICATION	DATA		Provi der C	CN: 15-0051	Peri od:	Worksheet S-9	
				Hospi ce CCI	N: 15-1509	From 01/01/2016 To 12/31/2016	PARTS I THROUD Date/Time Pre 5/23/2017 10:	pared:
						Hospi ce I		
		Unduplicated						
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursi ng		col s. 1, 2 &	
				Nursi ng	Facility		5)	
		1. 00	2.00	Facility 3.00	4.00	5. 00	/ 00	
	PART I - ENROLLMENT DAYS FOR CO					5.00	6. 00	
1. 00	Hospice Continuous Home Care	JST REPURITING P	EKTUDS BEGINNI	NG BEFURE UCTU	BER 1, 2015			1.00
2.00	Hospice Routine Home Care							2.00
3.00	Hospice Inpatient Respite Care							3.00
4. 00	Hospice General Inpatient Care							4.00
5. 00	Total Hospice Days							5. 00
	Part II - CENSUS DATA FOR COST	REPORTING PERI	ODS BEGINNING	BEFORE OCTOBER	1. 2015			1
6.00	Number of patients receiving				,			6.00
	hospi ce care							
7.00	Total number of unduplicated							7. 00
	Continuous Care hours billable							
	to Medicare							
8. 00	Average Length of Stay (line 5							8. 00
0.00	/ line 6)							0.00
9.00	Unduplicated census count							9. 00
NOTE:	Parts I and II, columns 1 and 2	also include	the days repor	ted in columns	3 and 4.			
				Title XVIII	Title XIX	Other	Total (sum of	
							col s. 1	
							through 3)	
				1.00	2. 00	3. 00	4. 00	
	PART III - ENROLLMENT DAYS FOR	COST REPORTING	PERIODS BEGIN	NING ON OR AFT	ER OCTOBER 1,			
10.00	Hospice Continuous Home Care			0		0 0	0	1
11.00	Hospice Routine Home Care			21, 169		1, 583		11.00
12.00	Hospice Inpatient Respite Care			348		0 10		12.00
13.00	The second secon			1, 057		37 216		13.00
14.00	Total Hospice Days PART IV - CONTRACTED STATISTICA	I DATA FOR COC	T DEDODTING DE	22, 574		80 1, 809 R OCTOBER 1, 2015		14. 00
15 00	Hospice Inpatient Respite Care	AL DATA FOR COS	DI KEPUKIING PE	CKLOD2 REGINNIN				15. 00
	Hospice General Inpatient Care					0 0	0	
10.00	mospi de denerar impatrient dare			1	I	9	0	1 10.00

		BLOOMINGTON HOSPITAL			u of Form CMS-2	
HOSPI	TAL UNCOMPENSATED AND INDIGENT CARE DATA	Provi der Co	CN: 15-0051	Peri od: From 01/01/2016	Worksheet S-10	0
				To 12/31/2016	Date/Time Pre 5/23/2017 10:	
					1. 00	
	Uncompensated and indigent care cost computation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I line 202 col	umn 3 divided by li	ne 202 colum	า 8)	0. 213825	1.00
	Medicaid (see instructions for each line)					
2.00	Net revenue from Medicaid				32, 378, 354	2. 00
3.00	Did you receive DSH or supplemental payments from Medi				N	3. 00
4.00	If line 3 is "yes", does line 2 include all DSH or sup		from Medicai	d?		4. 00
5.00	If line 4 is "no", then enter DSH or supplemental paym	ments from Medicaid			0	
6.00	Medi cai d charges				227, 953, 740	
7.00	Medicaid cost (line 1 times line 6)				48, 742, 208	7. 00
8. 00	Difference between net revenue and costs for Medicaid < zero then enter zero)	program (line 7 min	us sum of li	nes 2 and 5; if	16, 363, 854	8. 00
	Children's Health Insurance Program (CHIP) (see instru	uctions for each lin	e)			
9.00	Net revenue from stand-alone CHIP				0	9. 00
10.00					0	
11. 00	3				0	11. 00
12. 00		one CHIP (line 11 mi	nus line 9;	f < zero then	0	
	enter zero)	•				
	Other state or local government indigent care program	(see instructions f	or each line	)		
13.00	Net revenue from state or local indigent care program				0	13. 00
14.00	Charges for patients covered under state or local indi	gent care program (	Not included	in lines 6 or	0	14. 00
	10)				_	
15.00			<b>41.1</b>	45 1 11	0	
16.00	Difference between net revenue and costs for state or 13; if < zero then enter zero)	local indigent care	program (III	ne 15 minus iine	0	16. 00
	Uncompensated care (see instructions for each line)					
17 00	Private grants, donations, or endowment income restrict	cted to funding char	ity care		0	17. 00
18. 00		9	,		0	
19. 00	3			s (sum of lines	16, 363, 854	
. ,	8, 12 and 16)	and room margone	oa. o p. og. a	3 (34 31 111133	.0,000,00.	
			Uni nsured	Insured	Total (col. 1	
			pati ents	pati ents	+ col . 2)	
			1.00	2. 00	3. 00	
20. 00			23, 670, 0			•
21. 00		nes line 20)	5, 061, 2		5, 204, 407	
22. 00			317, 8		418, 472	
23. 00	Cost of charity care (line 21 minus line 22)		4, 743, 4	31 42, 504	4, 785, 935	23.00
					1. 00	
24. 00	Does the amount in line 20 column 2 include charges for	or patient days beyo	nd a Length	of stay limit	N	24. 00
	imposed on patients covered by Medicaid or other indig	gent care program?	S	Ĭ		
25. 00						25. 00
26. 00						26. 00
					664, 547	•
28. 00			,		12, 333, 883	
29. 00		1 ,	1 times line	e 28)	2, 637, 293	
30.00		,			7, 423, 228	•
	Total unreimbursed and uncompensated care cost (line 1				23, 787, 082	

	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provi der Co	CN: 15-0051 F	Peri od:	Worksheet A	
				] 	From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 10:	pared: 42 am
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
						col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2. 00	3. 00	4. 00	5. 00	
1.00	00100 CAP REL COSTS-BLDG & FIXT		0	(	16, 560, 126		
2.00	00200 CAP REL COSTS-MVBLE EQUI P		0	(		5, 850, 205	
3. 00 4. 00	OO300 OTHER CAP REL COSTS   OO400 EMPLOYEE BENEFITS DEPARTMENT	1, 817, 097	7, 521, 390	9, 338, 487	0 7 16, 643, 990	0 25, 982, 477	
5. 00	00500 ADMI NI STRATI VE & GENERAL	7, 548, 433	88, 793, 221			88, 159, 834	
7. 00	00700 OPERATION OF PLANT	2, 517, 635	16, 776, 200			9, 455, 294	
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	1 710 000	235, 188			210, 812	
10.00	01000 DI ETARY	1, 719, 889 2, 126, 853	1, 429, 747 2, 245, 009				1
11.00	01100 CAFETERI A	0	0	(		1, 622, 185	11.0
13.00	01300 NURSING ADMINISTRATION	4, 163, 276	1, 670, 520				
14. 00 15. 00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	4, 729, 593	171, 187 21, 191, 709			9, 975, 762 5, 173, 217	
16. 00	01600 MEDICAL RECORDS & LIBRARY	4,727,373	326, 578				
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	(	0	0	
18. 01	01851 CENTRAL STERILIZATION	387, 716	467, 663				
23. 00	02300   PARAMED ED PRGM-PHARMACY RESIDENCY   I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	1, 717	1, 71	252, 963	254, 680	23. 0
30. 00		20, 956, 932	10, 945, 254	31, 902, 186	-5, 967, 993	25, 934, 193	30.00
31. 00		2, 672, 191	1, 748, 524			3, 464, 601	
41. 00 42. 00	O4100   SUBPROVI DER -   RF   O4200   SUBPROVI DER	913, 818	423, 503	1, 337, 32	-224, 691	1, 112, 630 0	1
43. 00	04300 NURSERY	1, 544, 150	1, 718, 161	3, 262, 31	-442, 918	_	
50. 00	ANCILLARY SERVICE COST CENTERS  05000 OPERATING ROOM	4, 372, 936	22, 604, 936	26, 977, 872	-19, 932, 045	7, 045, 827	50.00
50. 01	05001 CV SURGERY	0	0	2 505 54	0	0	50.0
51. 00 52. 00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	2, 746, 830 2, 591, 092	838, 717 1, 632, 909			3, 089, 618 3, 221, 839	
53. 00	05300 ANESTHESI OLOGY	0	0	1, 22 1, 00	0	0, 221, 007	1
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 274, 947	3, 500, 457				
55. 00 56. 00	05500  RADI OLOGY-THERAPEUTI C   05600  RADI OI SOTOPE	2, 178, 480	2, 322, 038	4, 500, 518		3, 408, 110 0	1
57. 00	05700 CT SCAN	598, 762	1, 078, 826		-	1, 007, 884	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	391, 624	661, 144				
59.00	05900 CARDI AC CATHETERI ZATI ON	1, 081, 150	7, 482, 890		-6, 881, 507	1, 682, 533	
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	365	10, 213, 012 0			10, 096, 619 0	1
65. 00	06500 RESPIRATORY THERAPY	1, 874, 165	1, 016, 097	1	-		
66. 00	06600 PHYSI CAL THERAPY	6, 311, 242	2, 444, 486			7, 173, 184	66. 0
67. 00 68. 00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0		0	0	
69. 00		782, 455	590, 133	1, 372, 588	-424, 238	_	
	07000 ELECTROENCEPHALOGRAPHY	190, 657	998, 938			1, 028, 566	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	(	7, 885, 795	7, 885, 795	
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	0	(	13, 899, 799 22, 466, 617	13, 899, 799 22, 466, 617	
73. 00	07302 OP PHARMACY	318, 188	1, 957, 187	2, 275, 375		345, 457	1
74. 00	07400 RENAL DIALYSIS	o	937, 513			913, 894	1
75.00	07500 ASC (NON-DISTINCT PART)	0	0	(	0	0	1
75. 01 76. 97	03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   07697   CARDI AC REHABI LI TATI ON	650, 838	0 178, 753	829, 59	-120, 358	709, 233	75. 0 76. 9
70. 77	OUTPATIENT SERVICE COST CENTERS	030, 030	170, 733	027, 37	120, 330	707, 233	70.7
90.00	09000 CLI NI C	1, 143, 399	315, 949			1, 422, 097	
90. 01	09001 OP ONCOLOGY INFUSION CENTER	1, 038, 052	719, 707	1, 757, 759		1, 177, 218	
90. 02 90. 03	09002 WOUND CARE CENTER 09003 PAIN CLINIC	785, 334 238, 657	748, 944 192, 937			1, 155, 484 285, 843	
90. 05	09005 OP PSYCH CLINIC	1, 384, 533	502, 518			1, 816, 711	
91.00	09100 EMERGENCY	4, 500, 825	3, 803, 081	8, 303, 906	132, 798	8, 436, 704	
92.00	O9200   OBSERVATION BEDS (NON-DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS						92.0
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0	(	0	0	94. 0
	09500 AMBULANCE SERVICES	4, 623, 763	3, 005, 777	7, 629, 540	-1, 934, 099	5, 695, 441	
	10000 I &R SERVICES-NOT APPRVD PRGM	0	0	(0)	0		100.0
101.00	10100   HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	0	692	692	2  0	692	101. 0
113.00	11300 I NTEREST EXPENSE		1, 314, 118	1, 314, 118	-1, 314, 118	0	113. 0
114.00	11400 UTILIZATION REVIEW-SNF	0	0		0	0	114. 0
	11500   AMBULATORY SURGICAL CENTER (D. P. )   11600   HOSPICE	0	0	(	0		115. 00 116. 00
118.00	l l	92, 175, 877	224, 727, 330	316, 903, 207	1, 690, 512		
50	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	-,,	., , 550		., ., ., .,	-, -, -, 0, , 1,	

Health Financial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL	In Lie	u of Form CMS-2552-10
DEGLACCIELOATION AND AD HIGTMENTS OF	TOLAL DALANOE OF EVDENCES	D ' 1 OON 45 OO54	D : 1	W

Health Financial Systems	IU HEALTH BLOOMING	GTON HOSPITAL	TON HOSPITAL In			2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provider CC		Peri od:	Worksheet A	
				From 01/01/2016 to 12/31/2016	Date/Time Pre	nared:
		_			5/23/2017 10:	
Cost Center Description	Sal ari es	0ther		Recl assi fi cati	Recl assi fi ed	
			+ col . 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
	1.00	2. 00	3.00	4. 00	col . 4) 5.00	
NONREI MBURSABLE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	51, 116	74, 896	126, 012	-12, 483	113, 529	190 00
190. 01/19001 PROMPTCARE	959, 702	1, 266, 764			1, 649, 962	
190. 02 19002 RENTAL PROPERTIES	0	85, 080			21, 047	
190. 03 19003 OLCOTT	251, 804	115, 672			296, 721	
190. 04 19004 PHYSICIAN RECRUITMENT	0	O	(	o	0	190. 04
190. 05 19005 FOUNDATI ON	612, 853	334, 021	946, 874	-180, 188	766, 686	190. 05
190. 06 19006 MARKETI NG	0	0	(	149, 600	149, 600	190. 06
190. 07 19007 HME STORE	328, 800	87, 514	416, 314	-42, 127	374, 187	
190. 08 19008 UNUSED SPACE	0	0	(	0		190. 08
190. 09 19009 CLI NI CAL TRI ALS	276, 757	264, 245			487, 692	
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	181, 330	73, 888	·		196, 666	
190. 11 19011 COMMUNITY HEALTH SERVICES	2, 487, 002	1, 555, 875	4, 042, 877	-782, 120	3, 260, 757	
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	(			191. 00 192. 00
193. 00 19300 NONPALD WORKERS		0	(			192.00
194. 00 07950  IU HEALTH PAOLI HOSPITAL		0	(			193.00
194. 01 07951 I U HEALTH BEDFORD HOSPITAL		0	(			194. 00
194. 02 07952 I U HEALTH MORGAN HOSPITAL		0	(	ol ol		194. 02
194. 03 07953 I U HEALTH SI P		43	43	-40		194. 03
200.00 TOTAL (SUM OF LINES 118-199)	97, 325, 241	228, 585, 328	325, 910, 569	o	325, 910, 569	200. 00

Provider CCN: 15-0051

Peri od: Worksheet A From 01/01/2016 Date/Time Prepared: 5/23/2017 10:42 am

				5/23/2017 10:	
	Cost Center Description	Adjustments	Net Expenses		
			For Allocation	1	
CENE	RAL SERVICE COST CENTERS	6. 00	7. 00		
	O CAP REL COSTS-BLDG & FIXT	1, 004, 404	17, 564, 530		1.00
	O CAP REL COSTS-MVBLE EQUIP	2, 295, 473	8, 145, 678	1	2. 00
	O OTHER CAP REL COSTS	0	0		3. 00
	O EMPLOYEE BENEFITS DEPARTMENT	-3, 632, 463	22, 350, 014	l .	4. 00
	O ADMINISTRATIVE & GENERAL	-31, 505, 372	56, 654, 462	l .	5. 00
	O OPERATION OF PLANT	-642, 718	8, 812, 576		7. 00
	O LAUNDRY & LINEN SERVICE	-84, 841	125, 971	l .	8.00
	O HOUSEKEEPING O DIETARY	0 -236, 381	2, 475, 151 1, 950, 273		9. 00 10. 00
	O CAFETERI A	-1, 129, 877	492, 308	l .	11.00
	O NURSI NG ADMINI STRATI ON	219, 350	5, 117, 276		13. 00
	O CENTRAL SERVICES & SUPPLY	0	9, 975, 762		14. 00
15. 00 0150	O PHARMACY	-46, 525	5, 126, 692		15. 00
16. 00 0160	O MEDICAL RECORDS & LIBRARY	1, 975, 674	2, 299, 052	2	16. 00
	O OTHER GENERAL SERVICE (SPECIFY)	0	0	1	18. 00
1	1 CENTRAL STERILIZATION	0	483, 900	l control of the cont	18. 01
	O PARAMED ED PRGM-PHARMACY RESIDENCY	0	254, 680	)	23. 00
	TIENT ROUTINE SERVICE COST CENTERS O ADULTS & PEDIATRICS	-477, 995	25, 456, 198	5	30.00
	O INTENSIVE CARE UNIT	-477, 445	3, 464, 601		31.00
	O SUBPROVI DER - I RF	0	1, 112, 630	l .	41. 00
	O SUBPROVI DER	l o	0		42. 00
	O NURSERY	-233, 460	2, 585, 933	3	43.00
ANCI	LLARY SERVICE COST CENTERS				
1	O OPERATING ROOM	-1, 054	7, 044, 773	l .	50.00
	1 CV SURGERY	0	0		50. 01
	O RECOVERY ROOM	0	3, 089, 618	1	51.00
	O DELIVERY ROOM & LABOR ROOM O ANESTHESIOLOGY	0	3, 221, 839		52.00
	O RADI OLOGY-DI AGNOSTI C	-400	4, 043, 634		53. 00 54. 00
	O RADI OLOGY-THERAPEUTI C	-2, 148	3, 405, 962	l .	55. 00
	O RADI OI SOTOPE	0	0, 100, 702		56.00
	O CT SCAN	0	1, 007, 884	1	57.00
58. 00 0580	O MAGNETIC RESONANCE IMAGING (MRI)	0	626, 682	2	58. 00
	O CARDI AC CATHETERI ZATI ON	0	1, 682, 533		59. 00
1	O LABORATORY	388, 615	10, 485, 234		60.00
1	O I NTRAVENOUS THERAPY	0	0 0 0 7 0 7 0	1	64.00
	O RESPI RATORY THERAPY	127 720	2, 067, 070	l .	65. 00
	O PHYSI CAL THERAPY O OCCUPATI ONAL THERAPY	-136, 720	7, 036, 464	<del>†</del>	66. 00 67. 00
	O SPEECH PATHOLOGY	0	0		68. 00
	O ELECTROCARDI OLOGY	-55, 433	892, 917	7	69. 00
	O ELECTROENCEPHALOGRAPHY	-23,000	1, 005, 566		70.00
71. 00 0710	O MEDICAL SUPPLIES CHARGED TO PATIENTS	0	7, 885, 795	5	71. 00
	O IMPL. DEV. CHARGED TO PATIENTS	0	13, 899, 799		72. 00
	O DRUGS CHARGED TO PATIENTS	0	22, 466, 617		73. 00
	2 OP PHARMACY	0	345, 457		73. 01
	O RENAL DIALYSIS	0	913, 894	1	74.00
	O ASC (NON-DISTINCT PART) O PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0	0		75. 00 75. 01
	7 CARDI AC REHABI LI TATI ON	-9, 104	700, 129		76. 97
	ATIENT SERVICE COST CENTERS	7, 101	700, 127		70.77
90. 00 0900	O CLI NI C	-42, 783	1, 379, 314	4	90.00
	1 OP ONCOLOGY INFUSION CENTER	24, 110	1, 201, 328		90. 01
	2 WOUND CARE CENTER	-362, 461	793, 023	1	90. 02
	3 PAIN CLINIC	0	285, 843		90. 03
	5 OP PSYCH CLINIC	-36, 445	1, 780, 266	l .	90. 05
	O EMERGENCY	-1, 777, 442	6, 659, 262	2	91. 00 92. 00
	O OBSERVATION BEDS (NON-DISTINCT PART) R REIMBURSABLE COST CENTERS				92.00
	O HOME PROGRAM DIALYSIS	0	0		94. 00
	O AMBULANCE SERVI CES	-217, 477	5, 477, 964	1	95. 00
	O I &R SERVICES-NOT APPRVD PRGM	0	0		100.00
	O HOME HEALTH AGENCY	3, 502, 898	3, 503, 590		101. 00
SPEC	IAL PURPOSE COST CENTERS				
	0 I NTEREST EXPENSE	0	O	1	113. 00
	O UTI LI ZATI ON REVI EW-SNF	0	0		114.00
	O AMBULATORY SURGICAL CENTER (D. P. )	0	4 100 444		115.00
116. 00 1160 118. 00		4, 102, 444	4, 102, 444	•	116. 00 118. 00
	SUBTOTALS (SUM OF LINES 1-117) EIMBURSABLE COST CENTERS	-27, 141, 131	291, 452, 588	<b>)</b>	1110.00
	O GIFT, FLOWER, COFFEE SHOP & CANTEEN	O	113, 529		190. 00
	1 PROMPTCARE	-19, 750			190. 01
	•				<u> </u>

Health Financial Systems IU HEALTH BLORECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES IU HEALTH BLOOMINGTON HOSPITAL Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/23/2017 10: 42 am Provi der CCN: 15-0051

			3/23/2017 TO: 42 dill
Cost Center Description	Adjustments	Net Expenses	
	(See A-8)	For Allocation	
	6.00	7. 00	
190. 02 19002 RENTAL PROPERTIES	0	21, 047	190. 02
190. 03 19003 OLCOTT	0	296, 721	190. 03
190. 04 19004 PHYSI CLAN RECRUI TMENT	0	0	190. 04
190. 05 19005 FOUNDATI ON	0	766, 686	190. 05
190. 06 19006 MARKETI NG	0	149, 600	190. 06
190. 07 19007 HME STORE	0	374, 187	190. 07
190. 08 19008 UNUSED SPACE	0	0	190. 08
190. 09 19009 CLI NI CAL TRI ALS	0	487, 692	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	196, 666	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	-174, 141	3, 086, 616	190. 11
191. 00 19100 RESEARCH	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	o	192. 00
193. 00 19300 NONPALD WORKERS	0	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	10, 400, 972	10, 400, 972	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	14, 805, 317	14, 805, 317	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	7, 712, 812	7, 712, 812	194. 02
194.03 07953 IU HEALTH SIP	0	3	194. 03
200.00 TOTAL (SUM OF LINES 118-199)	5, 584, 079	331, 494, 648	200. 00

IU HEALTH BLOOMINGTON HOSPITAL Provider CCN: 15-0051 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/23/2017 10:42 am

					5/23/2017 10	1: 42 am
	Coot Contor	Increases	Colomy	O+box		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
	A - BENEFITS	3.00	4.00	5.00		
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	ol	16, 896, 573		1.00
2. 00	EWI LOTEL BENEFIT TO BETAKTIMENT	0.00	o	0, 070, 373		2. 00
3. 00		0.00	o	0		3. 00
4. 00		0.00	o	O		4. 00
5. 00		0.00	o	0		5. 00
6. 00		0.00	o	0		6. 00
7. 00		0.00	o	0		7. 00
8.00		0.00	ol	Ō		8. 00
9. 00		0.00	o	Ō		9. 00
10.00		0.00	o	0		10.00
11. 00		0.00	o	Ō		11. 00
12. 00		0.00	o	Ō		12. 00
13.00		0.00	O	0		13. 00
14.00		0.00	0	0		14.00
15.00		0.00	0	0		15. 00
16.00		0.00	0	0		16. 00
17.00		0.00	О	0		17. 00
18.00		0.00	O	0		18. 00
19.00		0.00	O	0		19. 00
20.00		0. 00	0	0		20. 00
21.00		0. 00	0	0		21. 00
22.00		0.00	0	0		22. 00
23.00		0.00	0	0		23. 00
24.00		0.00	O	0		24. 00
25.00		0.00	O	0		25. 00
26.00		0. 00	0	0		26. 00
27.00		0. 00	0	0		27. 00
28.00		0. 00	0	0		28. 00
29.00		0. 00	0	0		29. 00
30.00		0.00	0	0		30. 00
31.00		0.00	0	0		31. 00
32.00		0.00	0	0		32. 00
33.00		0.00	0	0		33. 00
34.00		0.00	0	0		34.00
35.00		0.00	0	0		35. 00
36.00		0.00	0	0		36. 00
37.00		0. 00	0	0		37. 00
38. 00		0. 00	0	0		38. 00
39. 00		0. 00	0	0		39. 00
40.00		0. 00	0	0		40. 00
41. 00		0.00	0	0		41. 00
42.00		0.00	0	0		42. 00
	TOTALS		0	16, 896, 573		
	B - CAPITAL RELATED			40 70/ 004		
1.00	CAP REL COSTS-BLDG & FIXT	1.00	0	13, 786, 881		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	5, 415, 957		2.00
3.00		0.00	0	0		3. 00
4.00		0.00	0	0		4.00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0. 00 0. 00	0	0		7. 00
8. 00 9. 00		0.00	0	0		8. 00 9. 00
9. 00 10. 00		0.00	0			10.00
11. 00		0.00	0	0		11. 00
12. 00		0.00	0	0		12. 00
13. 00		0.00	0	0		13. 00
14. 00		0.00	o	0		14. 00
15. 00		0.00	o	Ö		15. 00
16. 00		0.00	o	0		16. 00
17. 00		0.00	0	0		17. 00
18. 00		0.00	0	0		18. 00
19. 00		0.00	o	0		19. 00
20. 00		0.00	o	0		20. 00
21. 00		0.00	o	o		21. 00
22. 00		0.00	o	0		22. 00
23. 00		0.00	o	0		23. 00
24. 00		0.00	o	0		24. 00
25. 00		0.00	o	o		25. 00
26. 00		0.00	Ö	Ö		26. 00
27. 00		0.00	Ö	o		27. 00
28. 00		0.00	o	0		28. 00
29. 00		0.00	o	O		29. 00
	1		-1	-1		

IU HEALTH BLOOMINGTON HOSPITAL Provider CCN: 15-0051 Health Financial Systems RECLASSIFICATIONS In Lieu of Form CMS-2552-10
Worksheet A-6 Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/23/2017 10:42 am

						5/23/2017 10: 4	2 am_
2.00			Increases				
30.00   0.00   0.00   0.00   0.00   33.00   34							
31.00	20.00	2. 00					20.00
32, 00							
33, 00							
34.00							
35.00							
30 00							
37.00   0.00							
33.00 40.00				-	_		
39-00				-			
40.00				-	•		
1.00							
1.00				-			
1.00							
TOTAL S.   COLOR   C					1		
Company   Comp	43.00	TOTALS					43.00
LANDRY & LINEN SERVICE					17, 202, 030		
2 00 MARIMACY 15.00 0 10.623 2 00 3.00 NURSENDER 155 CHARGED TO 71.00 0 7,885,795	1 00			(	4 126		1 00
3. 00   MURSERY   43. 00   0   3.511   3. 00   4.00   MURSERY   44. 00   MEDICAL SUPPLIES CHARGED TO   71. 00   0   7, 885, 795   4.00   4.00   6.00							
## COLOR   MEDICAL SUPPLIES CHARGED TO   71.00   0   7.885,795		II					
ATTENTS							
5.00   MUE STORE   190, 07   0   29, 633   6.00   7.00   8.800   9.00   0   0   0   0   0   1.00   1.00   1.00   1.00   1.00   1.00   1.10   1.00   1.10   1.00   1.10   1.00   1.10   1	4.00		71.00		7,003,773		4.00
COMMUNITY HEALTH SERVICES	5 00	l e	190 07	(	29 633		5 00
7. 00							
8.00   0.00   0.00   0   0   0   0   0		Services		-			
9.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 10.00 11.00 1							
10. 00   10. 00   0. 00   0   0   0   11. 00   12. 00   13. 00   12. 00   13. 00   14. 00   14. 00   15. 00   0   0   0   0   0   0   14. 00   15. 00   15. 00   16. 00   0   0   0   0   0   0   16. 00   16. 00   16. 00   16. 00   16. 00   17. 00   18. 00   18. 00   18. 00   19. 00   0   0   0   0   0   0   18. 00   19. 00							
11. 00							
12.00							
13. 00     0. 00   0   0   0   0   13. 00   14. 00   15. 00   16. 00   0. 00   0   0   0   0   16. 00   17. 00   18. 00   17. 00   0. 00   0. 00   0. 00   0. 00   0. 00   17. 00   18. 00   19. 00   0. 00   0. 00   0. 00   0. 00   19. 0							
14. 00 15. 00 16. 00 16. 00 17. 00 18. 00 19. 00 19. 00 19. 00 19. 00 19. 00 20. 00 20. 00 21. 00 22. 00 23. 00 24. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 29. 00 29. 00 20							
15.00							
16.00							
17, 00   18, 00   0, 00   0   0   0   17, 00   18, 00   19, 00							
18. 00 19. 00 20. 00 20. 00 21. 00 22. 00 22. 00 23. 00 24. 00 25. 00 26. 00 27. 00 28. 00 29. 00 20							
19,00 20,00 21,00 22,00 23,00 24,00 25,00 26,00 27,00 28,00 29,00 27,00 28,00 29,00 27,00 28,00 29,00 29,00 29,00 20,00 20,00 20,00 20,00 20,00 21,00 22,00 23,00 24,00 25,00 26,00 26,00 27,00 28,00 29,00 28,00 29,00 20,00 20,00 20,00 20,00 20,00 20,00 20,00 20,00 21,00 22,00 28,00 29,00 20,00 21,00 22,00 23,00 24,00 25,00 26,00 27,00 28,00 29,00 29,00 29,00 20,00							
20. 00     0. 00   0. 00   0. 00   22. 00							
21.00     0.00   0   0   0   0   22.00   23.00   24.00   22.00   23.00   24.00   22.00   24.00   24.00   24.00   24.00   26.							
22 00   23 00   24 00   23 00   23 00   24 00   25 00   25 00   25 00   26 00   26 00   26 00   27 00   28 00   27 00   28 00   28 00   29 00   20 0							
23. 00   0.00   0.00   0   0.0							
24. 00				-			
25.00   26.00   27.00   28.00   27.00   28.00   29.0							
26. 00 27. 00 27. 00 27. 00 0. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0				-	•		
27.00   28.00   0.00   0   0   0   0   27.00   28.00   29.00   10TALS   D - BILLABLE DRUGS							
28. 00   29. 00				-	•		
29.00							
TOTALS   D - BILLABLE DRUGS   T - ST					1		
D - BILLABLE DRUGS   CENTRAL SERVICES & SUPPLY   14.00   0   7,508   22.00   3.00   0   0   0   0   0   0   0   0   0	27.00	TOTALS		:			27.00
1. 00					777007010		
2. 00   DRUGS CHARGED TO PATIENTS   73. 00   0   22, 466, 617   3. 00   3. 00   3. 00   4. 00   5. 00   6. 00   0   0   0   0   0   0   0   0   0	1.00		14.00	(	7. 508		1. 00
3.00       0.00       0       0       3.00         4.00       5.00       0       0       5.00         6.00       0.00       0       0       6.00         7.00       0.00       0       0       0         8.00       0.00       0       0       0         9.00       0.00       0       0       0         10.00       0.00       0       0       10.00         11.00       0.00       0       0       11.00         12.00       0.00       0       0       11.00         13.00       0.00       0       0       12.00         13.00       0.00       0       0       13.00         14.00       0.00       0       0       13.00         14.00       0.00       0       0       15.00         16.00       0.00       0       0       15.00         18.00       0.00       0       0       17.00         18.00       0.00       0       0       19.00         20.00       0.00       0       0       21.00         23.00       0.00       0       0       22.00<							
4,00       0.00       0       0       4.00         5,00       0.00       0       0       6.00         7,00       0.00       0       0       0         8,00       0.00       0       0       0         9,00       0.00       0       0       0         10,00       0.00       0       0       10.00         11,00       0.00       0       0       11.00         12,00       0.00       0       0       11.00         13,00       0.00       0       0       12.00         13,00       0.00       0       0       13.00         14,00       0.00       0       0       13.00         14,00       0.00       0       0       15.00         16,00       0.00       0       0       15.00         16,00       0.00       0       0       17.00         18,00       0.00       0       0       17.00         19,00       0.00       0       0       0       19.00         20,00       0.00       0       0       0       22.00         23,00       0.00       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
5.00         0.00         0         0         5.00           6.00         0.00         0         0         6.00           7.00         0         0         0         7.00           8.00         0.00         0         0         7.00           9.00         0.00         0         0         9.00           10.00         10.00         0         0         10.00           11.00         0.00         0         0         11.00           12.00         0.00         0         0         11.00           12.00         0.00         0         0         12.00           13.00         0.00         0         0         13.00           14.00         0.00         0         0         14.00           15.00         0.00         0         0         14.00           15.00         0.00         0         0         14.00           17.00         0         0         0         17.00           18.00         0.00         0         0         17.00           18.00         0.00         0         0         19.00           21.00         0							
6.00       0.00       0       0       6.00         7.00       0.00       0       0       7.00         8.00       9.00       0       0       0       8.00         9.00       0.00       0       0       0       9.00         10.00       11.00       0       0       0       11.00       11.00         12.00       0.00       0       0       0       11.00       12.00       11							
7.00       8.00       0.00       0       0       7.00         8.00       9.00       0.00       0       0       8.00         9.00       0.00       0       0       0       9.00         10.00       0.00       0       0       0       10.00         11.00       0.00       0       0       0       11.00         12.00       13.00       0       0       0       12.00         13.00       0.00       0       0       0       13.00         14.00       0.00       0       0       0       14.00         15.00       0.00       0       0       0       15.00         16.00       0.00       0       0       0       15.00         17.00       0.00       0       0       0       17.00         18.00       0.00       0       0       0       17.00         19.00       0.00       0       0       0       19.00         20.00       0.00       0       0       0       21.00         22.00       0.00       0       0       0       22.00         24.00       0.00							
8. 00       0. 00       0. 00       0. 00       0. 00       9. 00         10. 00       0. 00       0. 00       0. 00       10. 00       11. 00         11. 00       0. 00       0. 00       0. 00       11. 00       12. 00       11. 00         12. 00       0. 00       0. 00       0. 00       0. 00       12. 00       13. 00       12. 00       13. 00       14. 00       14. 00       14. 00       14. 00       15. 00       16. 00       15. 00       16. 00       17. 00       16. 00       17. 00       16. 00       17. 00       18. 00       17. 00       18. 00       19. 00       19. 00       19. 00       20. 00       19. 00       20. 00       21. 00       22. 00       22. 00       22. 00       22. 00       22. 00       22. 00       22. 00       22. 00       23. 00       24. 00       25. 00       25. 00       25. 00       25. 00       25. 00       25. 00       25. 00       25. 00       25. 00       25. 00       25. 00       25. 00       25. 00       25. 00       26. 00       26. 00       26. 00       26. 00       26. 00       26. 00       26. 00       26. 00       26. 00       26. 00       26. 00       26. 00       26. 00       26. 00       27. 00							
9.00       0.00       0.00       0.00       0.00       10.00         11.00       0.00       0.00       0.00       11.00       11.00         12.00       0.00       0.00       0.00       11.00       12.00         13.00       0.00       0.00       0.00       13.00       14.00         14.00       0.00       0.00       0.00       14.00       15.00       16.00       15.00       16.00       17.00       16.00       17.00       18.00       17.							
10.00     0.00     0     0     10.00       11.00     0.00     0     0     11.00       12.00     0.00     0     0     11.00       13.00     0.00     0     0     12.00       13.00     0.00     0     0     13.00       14.00     0.00     0     0     14.00       15.00     0.00     0     0     15.00       16.00     0.00     0     0     16.00       17.00     0.00     0     0     17.00       18.00     0.00     0     0     18.00       19.00     0.00     0     0     19.00       20.00     0.00     0     0     20.00       21.00     0.00     0     0     22.00       23.00     0.00     0     0     0     23.00       24.00     0.00     0     0     0     0       25.00     0.00     0     0     0     0							
11. 00       0.00       0       0       0       11. 00         12. 00       0.00       0       0       0       12. 00         13. 00       0.00       0       0       0       13. 00         14. 00       0.00       0       0       0       14. 00         15. 00       0.00       0       0       0       15. 00         16. 00       0.00       0       0       0       16. 00         17. 00       0.00       0       0       0       17. 00         18. 00       0.00       0       0       0       18. 00         19. 00       0.00       0       0       0       19. 00         20. 00       0.00       0       0       0       20. 00         21. 00       0.00       0       0       0       21. 00         22. 00       0.00       0       0       0       0       22. 00         23. 00       0.00       0       0       0       0       24. 00         25. 00       0.00       0       0       0       0       0       0							
12.00       0.00       0       0       12.00         13.00       0.00       0       0       13.00         14.00       0.00       0       0       14.00         15.00       0.00       0       0       15.00         16.00       0.00       0       0       15.00         17.00       0.00       0       0       17.00         18.00       0.00       0       0       17.00         19.00       0.00       0       0       19.00         20.00       0.00       0       0       20.00         21.00       0.00       0       0       0       21.00         22.00       0.00       0       0       0       22.00         23.00       0.00       0       0       0       0       24.00         25.00       0.00       0       0       0       0       0       0							
13. 00       0.00       0       0       0       13. 00         14. 00       0.00       0       0       0       14. 00         15. 00       0.00       0       0       0       15. 00         16. 00       0.00       0       0       0       16. 00         17. 00       0.00       0       0       0       17. 00         18. 00       0.00       0       0       0       18. 00         19. 00       0.00       0       0       0       19. 00         20. 00       0.00       0       0       0       20. 00         21. 00       0.00       0       0       0       21. 00         22. 00       0.00       0       0       0       22. 00         23. 00       0.00       0       0       0       0       24. 00         25. 00       0.00       0       0       0       0       0       0       0							
14. 00     0.00     0     0     14. 00       15. 00     0.00     0     0     15. 00       16. 00     0.00     0     0     16. 00       17. 00     0.00     0     0     17. 00       18. 00     0.00     0     0     18. 00       19. 00     0.00     0     0     18. 00       19. 00     0.00     0     0     19. 00       20. 00     0.00     0     0     20. 00       21. 00     0.00     0     0     22. 00       23. 00     0.00     0     0     0       24. 00     0.00     0     0     0       25. 00     0.00     0     0     0							
15. 00     0.00     0     0     15. 00       16. 00     0.00     0     0     16. 00       17. 00     0.00     0     0     17. 00       18. 00     0.00     0     0     18. 00       19. 00     0.00     0     0     19. 00       20. 00     0.00     0     0     20. 00       21. 00     0.00     0     0     21. 00       22. 00     0.00     0     0     0       23. 00     0.00     0     0     0       24. 00     0.00     0     0     0       25. 00     0.00     0     0     0							
16. 00     0.00     0     0     16. 00       17. 00     0.00     0     0     17. 00       18. 00     0.00     0     0     18. 00       19. 00     0.00     0     0     19. 00       20. 00     0.00     0     0     20. 00       21. 00     0.00     0     0     21. 00       22. 00     0.00     0     0     22. 00       23. 00     0.00     0     0     23. 00       24. 00     0.00     0     0     0     24. 00       25. 00     0.00     0     0     0     25. 00							
17. 00     0.00     0     0     17. 00       18. 00     0.00     0     0     18. 00       19. 00     0.00     0     0     19. 00       20. 00     0.00     0     0     20. 00       21. 00     0.00     0     0     21. 00       22. 00     0.00     0     0     22. 00       23. 00     0.00     0     0     23. 00       24. 00     0.00     0     0     0     24. 00       25. 00     0.00     0     0     0     25. 00							
18.00     0.00     0     0     18.00       19.00     0.00     0     0     19.00       20.00     0.00     0     0     20.00       21.00     0.00     0     0     21.00       22.00     0.00     0     0     22.00       23.00     0.00     0     0     23.00       24.00     0.00     0     0     24.00       25.00     0.00     0     0     0							
19.00     0.00     0     0     19.00       20.00     0.00     0     0     20.00       21.00     0.00     0     0     21.00       22.00     0.00     0     0     22.00       23.00     0.00     0     0     23.00       24.00     0.00     0     0     24.00       25.00     0.00     0     0     0							
20. 00     0. 00     0     0     20. 00       21. 00     0. 00     0     0     21. 00       22. 00     0. 00     0     0     22. 00       23. 00     0. 00     0     0     23. 00       24. 00     0. 00     0     0     24. 00       25. 00     0. 00     0     0     25. 00					•		
21.00     0.00     0     0     21.00       22.00     0.00     0     0     22.00       23.00     0.00     0     0     23.00       24.00     0.00     0     0     24.00       25.00     0.00     0     0     0							
22. 00       23. 00       24. 00       25. 00       0. 00							
23. 00     0. 00     0     0     23. 00       24. 00     0. 00     0     0     24. 00       25. 00     0. 00     0     0     0							
24. 00 25. 00 0.00 0 0 22. 00 25. 00							
25.00 0.00 0 0 25.00							
26. 00   0. 00   0   25. 00   26. 00							
20.00   1 0.00 0 0 0   20.00			0.00				
	20.00	1	0.00		. <sub>1</sub>		

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared: Provider CCN: 15-0051

					5/23/2017 1	
		Increases				
	Cost Center 2.00	Li ne # 3.00	Sal ary 4. 00	0ther 5.00		
	TOTALS	3.00	4.00			
	E - IMPLANTS SUPPLIES					
1.00	IMPL. DEV. CHARGED TO	72.00	C	13, 899, 799		1. 00
0.00	PATI ENTS	0.00				0.00
2. 00 3. 00		0. 00 0. 00	0			2. 00 3. 00
4. 00		0.00	0			4. 00
5. 00		0.00	O	1		5. 00
6.00		0.00	0	-		6. 00
7.00		0.00	0	_		7. 00
8. 00		0.00	0	1		8. 00
9. 00 10. 00		0. 00 0. 00	0			9. 00 10. 00
11. 00		0.00	0			11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0			13. 00
14. 00		0.00	<u></u>			14. 00
	TOTALS  F - LEASE EXPENSE		0	13, 899, 799		
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	1, 459, 127		1.00
2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	O			2. 00
3.00		0.00	0	•		3. 00
4.00		0.00	0	1		4. 00
5.00		0. 00 0. 00	0			5. 00 6. 00
6. 00 7. 00		0.00	0	1		7. 00
8. 00		0.00	0			8. 00
9. 00		0.00	0			9. 00
10.00		0.00	0			10.00
11. 00 12. 00		0. 00 0. 00	0	-		11. 00 12. 00
13. 00		0.00	0			13. 00
14. 00		0.00	Ö	1		14. 00
15.00		0.00	0	0		15. 00
16. 00		0.00	0	-		16. 00
17. 00	TOTAL C	0.00	0			17. 00
	TOTALS G - NON-BI LLABLE DRUGS			1, 635, 190		
1. 00	PHARMACY	15. 00	C	8, 312		1.00
2.00		0.00	0			2. 00
3.00		0.00	0			3. 00
4. 00	TOTAL C	0.00	0			4. 00
	TOTALS H - NON-BILLABLE MEDICAL SUPP	L L PLLES		0,312		
1. 00	ADMI NI STRATI VE & GENERAL	5.00	C	5, 641		1.00
2.00	CENTRAL SERVICES & SUPPLY	14.00	0	9, 933, 669		2. 00
3. 00		0.00	0	•		3. 00
4. 00 5. 00		0. 00 0. 00	0	1		4. 00 5. 00
6. 00		0.00	0			6. 00
7. 00		0.00	0			7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0			9. 00
10. 00 11. 00		0. 00 0. 00	0			10. 00 11. 00
12. 00		0.00	0			12. 00
13. 00		0.00	0			13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	0			15. 00
16.00		0.00	0			16. 00
17. 00 18. 00		0. 00 0. 00	0			17. 00 18. 00
19. 00		0.00	0			19. 00
20. 00		0.00	0			20. 00
21. 00		0.00	0			21. 00
22. 00		0.00	0			22. 00
23. 00 24. 00		0. 00 0. 00	0	•		23. 00 24. 00
24. 00 25. 00		0.00	0			25. 00
26. 00		0.00	Ö			26. 00
27.00		0.00	0	0		27. 00
28. 00		0.00	0			28. 00
29. 00 30. 00		0. 00 0. 00	0			29. 00 30. 00
50.00	I .	0.00		, U		1 30.00

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0051 Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

					To 12/31/2016 Date/Time Pre 5/23/2017 10:	
		Increases		0.11		
	Cost Center 2.00	Li ne # 3.00	Sal ary 4.00	0ther 5.00		
31. 00	2. 00	0.00	0	0		31. 00
32.00		0.00	О	0		32.00
33.00		0.00	0	0		33. 00
34. 00		0.00	0	0		34.00
35. 00 36. 00		0. 00 0. 00	0	0		35. 00 36. 00
37. 00		0.00	o	Ö		37. 00
38.00		0.00	О	0		38.00
39. 00		0.00	0	0		39. 00
40. 00		0.00	•	0		40. 00
	TOTALS  J - INTEREST EXPENSE		0	9, 939, 310		
1. 00	CAP REL COSTS-BLDG & FLXT	1.00	0	1, 314, 118		1. 00
	TOTALS			1, 314, 118		
	K - PHARMACY RESIDENCY					
1. 00	PARAMED ED PRGM-PHARMACY	23. 00	254, 680	0		1. 00
	RESI DENCY	+	254, 680	— — <sub>o</sub>		
	L - PSYCH ADMIN		254, 000	<u> </u>		
1.00	OP_PSYCH_CLINIC	90. 05	262, 482	22, 219		1.00
	TOTALS		262, 482	22, 219		
1 00	M - SOFTWARE LICENSE CAP REL COSTS-MVBLE EQUIP	2.00	0	250 105		1 00
1. 00 2. 00	CT SCAN	57.00	0	258, 185 30, 621		1. 00 2. 00
3. 00	PAIN CLINIC	90. 03	o	3, 000		3. 00
4.00		0.00	О	0		4.00
5. 00		0.00	0	0		5. 00
6.00		0. 00 0. 00	0	0		6. 00
7. 00 8. 00		0.00	0	0		7. 00 8. 00
9. 00		0.00	ő	Ö		9. 00
10.00		0.00	О	0		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12.00
13. 00	TOTALS — — — — —	0.00	0	291, 806	-	13. 00
	N - CAFETERIA		<u> </u>	271,000		
1.00	CAFETERI A	11.00	905, 827	71 <u>6, 3</u> 58		1. 00
	TOTALS	140	905, 827	716, 358		
1. 00	O - SHORT TERM DISABILITY/FLM EMPLOYEE BENEFITS DEPARTMENT	4.00	0	434		1. 00
2. 00	ADMI NI STRATI VE & GENERAL	5. 00	o	7, 881		2. 00
3.00	OPERATION OF PLANT	7.00	О	12, 490		3.00
4.00	HOUSEKEEPI NG	9.00	0	14, 312		4. 00
5. 00 6. 00	DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	0	10, 266 18, 202		5. 00 6. 00
7. 00	PHARMACY	15. 00	0	14, 935		7. 00
8. 00	ADULTS & PEDIATRICS	30.00	o	156, 627		8. 00
9.00	INTENSIVE CARE UNIT	31.00	О	23, 885		9. 00
10.00	SUBPROVI DER - I RF	41.00	0	11, 186		10.00
11.00	NURSERY	43. 00 50. 00	0	6, 262 33, 952		11.00
12. 00 13. 00	OPERATING ROOM RECOVERY ROOM	51. 00	0	18, 283		12. 00 13. 00
14. 00	DELIVERY ROOM & LABOR ROOM	52.00	ő	32, 355		14. 00
15.00	RADI OLOGY-DI AGNOSTI C	54.00	О	8, 877		15.00
16. 00	RADI OLOGY-THERAPEUTI C	55.00	0	4, 737		16. 00
17. 00 18. 00	CT SCAN MAGNETIC RESONANCE IMAGING	57. 00 58. 00	0	14, 092 2, 340		17. 00 18. 00
10.00	(MRI)	38.00	٥	2, 340		10.00
19. 00	CARDIAC CATHETERIZATION	59.00	O	4, 181		19. 00
20.00	RESPI RATORY THERAPY	65. 00	0	14, 244		20.00
21.00	PHYSICAL THERAPY	66.00	0	34, 870		21. 00
22. 00 23. 00	CARDIAC REHABILITATION CLINIC	76. 97 90. 00	0	3, 533 2, 154		22. 00 23. 00
24. 00	OP ONCOLOGY INFUSION CENTER	90.00	0	2, 134 8, 694		24. 00
25. 00	WOUND CARE CENTER	90. 02	Ö	7, 847		25. 00
26. 00	PAIN CLINIC	90. 03	0	544		26. 00
27. 00	OP PSYCH CLINIC	90.05	0	2, 744		27. 00
28. 00 29. 00	EMERGENCY AMBULANCE SERVICES	91. 00 95. 00	0	44, 724 17, 374		28. 00 29. 00
31.00	PROMPTCARE	190. 01	0	5, 277		31. 00
32. 00	OLCOTT	190. 03	Ö	1, 969		32. 00
33. 00	FOUNDATI ON	190. 05	0	1, 798		33. 00
34. 00	HME STORE	190. 07	0	1, 370		34. 00

Provider CCN: 15-0051 Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

					5/23/2017 10 5/23/2017 10	epared: ): 42 am
		Increases				
	Cost Center	Li ne #	Sal ary	0ther		
	2. 00	3.00	4. 00	5. 00		
35.00	COMMUNITY HEALTH SERVICES	1 <u>90.</u> 11	0	1 <u>9, 0</u> 73		35. 00
	TOTALS		0	561, 512		
	P - UTILITIES EXPENSE					
1.00	OPERATION OF PLANT	7. 00	0	269, 022		1. 00
2.00	LAUNDRY & LINEN SERVICE	8. 00	0	2, 332		2. 00
3.00	RESPI RATORY THERAPY	65. 00	0	323		3. 00
4.00		0.00	0	0		4. 00
5.00		0.00	0	0		5. 00
6.00		0.00	0	0		6. 00
7.00		0.00	0	0		7. 00
8.00		0.00	0	0		8. 00
9.00		0.00	0	0		9. 00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11. 00
12.00		0.00	0	0		12. 00
13.00		0.00	0	0		13. 00
14.00		0.00	0	0		14. 00
15. 00		0.00	•	0		15. 00
	TOTALS		0	271, 677		_
4 00	Q - MARKETING EXPENSE	7.00		4.0		4 00
1. 00 2. 00	OPERATION OF PLANT PHYSICAL THERAPY	7. 00 66. 00	0	12 753		1. 00 2. 00
			0			
3.00	MARKETI NG	190.06	0	149, 600		3. 00
4. 00 5. 00		0. 00 0. 00	U O	0		4. 00
5.00	TOTALS — — — — —			0 150, 365		5. 00
	R - OCCUPATIONAL HEALTH ADMIN		U	150, 365		
1. 00	ADMINISTRATIVE & GENERAL	5.00	159, 476	0		1, 00
1.00	TOTALS		15 <u>9, 476</u> 159, 476	0		1.00
	S - HHA AND HOSPICE SALARIES		137, 470	U		
1. 00	HOME HEALTH AGENCY	101.00	2, 345, 358	0		1.00
2. 00	HOSPI CE	116.00	2, 336, 851	Ö		2. 00
2.00	TOTALS	110.00	4, 682, 209	ŏ		2.00
	T - ER PHYSICIAN FEES		1, 002, 207	<u> </u>		
1. 00	EMERGENCY	91.00	O	2, 176, 440		1.00
	TOTALS			2, 176, 440		1
	U - MED NUTRITION THERAPY		<u> </u>	_, ., .,		
1. 00	CLINIC	90.00	118, 668	32, 054		1.00
	TOTALS	— — <del></del>	118, 668	32, 054		1
500, 00	Grand Total: Increases		6, 383, 342	97, 529, 009		500.00
	1	1	-,,			1

Provider CCN: 15-0051

| Peri od: | From 01/01/2016 | To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/23/2017 10: 42 am

						5/23/2017 10	): 42 am
	2 1 2 1	Decreases	6.1	0.11			
	Cost Center 6.00	Li ne # 7.00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - BENEFITS	7.00	6.00	9.00	10.00		
1.00	ADMINISTRATIVE & GENERAL	5.00	0	1, 270, 613	9		1.00
2.00	OPERATION OF PLANT	7. 00	0	488, 829	9		2. 00
3.00	HOUSEKEEPI NG	9. 00	0	593, 186	0		3. 00
4.00	DI ETARY	10.00	0	496, 561	0		4. 00
5. 00	NURSING ADMINISTRATION	13. 00	0	570, 675			5. 00
6. 00	PHARMACY	15. 00	0		l .		6. 00
7.00	CENTRAL STERILIZATION	18. 01	0	108, 460			7. 00
8. 00	PARAMED ED PRGM-PHARMACY RESIDENCY	23. 00	0	1, 717	0		8. 00
9. 00	ADULTS & PEDIATRICS	30.00	0	3, 670, 595	o		9, 00
10.00	INTENSIVE CARE UNIT	31.00	0	484, 408			10.00
11. 00	SUBPROVI DER - I RF	41. 00	0		- 1		11. 00
12. 00	NURSERY	43. 00	0		1		12. 00
13.00	OPERATING ROOM	50.00	0				13. 00
14.00	RECOVERY ROOM	51.00	0		1		14. 00
15.00	DELIVERY ROOM & LABOR ROOM	52.00	0	394, 807	0		15. 00
16. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	678, 814			16. 00
17. 00	RADI OLOGY-THERAPEUTI C	55.00	0	338, 759	l .		17. 00
18. 00	CT SCAN	57.00	0	108, 044			18. 00
19. 00	MAGNETIC RESONANCE I MAGING	58. 00	0	68, 456	0		19. 00
20.00	(MRI)	E0 00	^	102 074			20.00
20. 00 21. 00	CARDI AC CATHETERI ZATI ON LABORATORY	59. 00 60. 00	0	182, 974 153			20. 00 21. 00
22. 00	RESPIRATORY THERAPY	65.00	0				22. 00
23. 00	PHYSICAL THERAPY	66.00	0	985, 160			23. 00
24. 00	ELECTROCARDI OLOGY	69.00	0	140, 918			24. 00
25. 00	ELECTROENCEPHALOGRAPHY	70.00	0	35, 832			25. 00
26. 00	OP PHARMACY	73. 01	0	42, 760			26. 00
27. 00	CARDIAC REHABILITATION	76. 97	0		o		27. 00
28. 00	CLINIC	90.00	0				28. 00
29.00	OP ONCOLOGY INFUSION CENTER	90. 01	0	162, 337	O		29. 00
30.00	WOUND CARE CENTER	90. 02	0	165, 043	0		30.00
31.00	PAIN CLINIC	90. 03	0	51, 439	0		31.00
32.00	OP PSYCH CLINIC	90. 05	0	229, 411	l .		32. 00
33. 00	EMERGENCY	91.00	0		l .		33. 00
34. 00	AMBULANCE SERVICES	95. 00	0	,			34. 00
35. 00	GIFT, FLOWER, COFFEE SHOP &	190. 00	0	12, 483	0		35. 00
36. 00	CANTEEN PROMPTCARE	190. 01	0	192, 793	o		36. 00
37. 00	OLCOTT	190.01	0	50, 144	1		37. 00
38. 00	FOUNDATI ON	190.05	0	103, 498			38. 00
39. 00	HME STORE	190.07	0	20, 869			39. 00
40. 00	CLINICAL TRIALS	190. 09	0	52, 483	l .		40.00
41. 00	MORGAN OP BEHAVIORAL HEALTH	190. 10	0		l .		41. 00
	CLINIC						
42.00	COMMUNITY HEALTH SERVICES	190.11	0				42. 00
	TOTALS		0	16, 896, 573			
1 00	B - CAPITAL RELATED	4 00		20.007	9		1 00
1. 00 2. 00	EMPLOYEE BENEFITS DEPARTMENT ADMINISTRATIVE & GENERAL	4. 00 5. 00	0				1. 00 2. 00
3.00	OPERATION OF PLANT	7.00	0				3. 00
4.00	LAUNDRY & LINEN SERVICE	8.00	0				4. 00
5. 00	HOUSEKEEPI NG	9. 00	0	479			5. 00
6. 00	DI ETARY	10.00	0				6. 00
7.00	NURSING ADMINISTRATION	13.00	0	190, 063	1		7. 00
8.00	PHARMACY	15.00	0	95, 515	0		8. 00
9.00	MEDICAL RECORDS & LIBRARY	16.00	0	3, 200	O		9. 00
10.00	CENTRAL STERILIZATION	18. 01	0	39, 627	0		10.00
11. 00	ADULTS & PEDIATRICS	30.00	0				11. 00
12. 00	INTENSIVE CARE UNIT	31.00	0	45, 899	l .		12. 00
13.00	SUBPROVI DER - I RF	41.00	0				13. 00
14.00	NURSERY	43.00	0				14. 00
15.00	OPERATING ROOM	50.00	0				15. 00
16. 00	RECOVERY ROOM	51.00	0	198			16.00
17. 00 18. 00	DELIVERY ROOM & LABOR ROOM	52.00 54.00	0	83, 415 505, 626	l .		17. 00
18. 00 19. 00	RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	54. 00 55. 00	0		l .		18. 00 19. 00
20. 00	CT SCAN	57.00	0				20. 00
21. 00	MAGNETIC RESONANCE I MAGING	58.00	0				21. 00
00	(MRI)	33.30	O				55
22. 00	CARDIAC CATHETERIZATION	59. 00	0	600, 304	o		22. 00
23. 00	LABORATORY	60.00	0	1	l .		23. 00
24. 00	RESPIRATORY THERAPY	65.00	0	99, 459	o		24. 00

Health Financial Systems RECLASSIFICATIONS Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared: Provider CCN: 15-0051

Description							5/23/2017 10	
CO			Decreases					
25.00		Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
2.00   Company				8. 00				
27.00   PROPERTY   PRO		1		0	1			1
29.00   DP PARAMACY					1			1
29.00 PRIMAL DILAYSIS 74.00 0 337.0 0 29.00 30.00 LOSDING SEMBALITATION 79.07 0 5.995 0 30.00 30.00 LOSDING SEMBALITATION 79.07 0 5.905 0 30.00 30.00 LOSDING SEMBALITATION 79.07 0 30.00 30.00 LOSDING SEMBALITATION 79.07 0 30.00 30.00 LOSDING SEMBALITATION 79.07 0 30.00 30.00 LOSDING SEMBALITATION 79.00 30.00 LOSDING SEMBALITATION		1		-	,			1
30.00   CARDIAC REMARKE LATION   76.97   0   5.925   0   30.00		1		0	.,		l l	1
31.00		1		0	1		l	1
3.0   DEFONDED FOR PRINTED SERVICES   90,01   0   19,296   0   33,00   34,00		l I			1			1
AND CLIMIC   90.05   0   8.318   0   33.00		1		O	1	0		1
35.00   OP PSYCH CLINIC	33.00	l I		O	1			1
See	34.00	PAIN CLINIC	90. 03	0	8, 318			34. 00
APPLICATION	35.00	OP PSYCH CLINIC	90. 05	0	766			35. 00
38.00   PROMETICABE   100.01   0   12,375   0   38.00		1		0	l .		l l	1
Senter   Properties   190, 02   0   40,077   0   95,000   10,000				0	1			1
40.00		1		Ü	l .			1
1.00   FOUNDATION   190.05   0   393   0   41.00				0	1			1
1.00   MILE STORE   190.07   0   2,094   0   42,00		1		0		_		1
		1		0	i e			1
IOTALS   0   19,202,838				-				1
1.00   ADMINISTRATIVE & GENERAL   5.00   0   168   0   2.00   0   3.00   CENTRAL SERVICES & SUPPLY   14.00   0   8.255   0   3.00   0   4.00   0   4.00   0   6.00   0   5.00   0   4.00   0   6.00   0   5.00   0   6.00   0   5.00   0   6.00   0   5.00   0   6.00								
2.00 MURSING ADMINISTRATION 13.00 0 74,641 0 2.00 3.00 CENTRAL SERVICES SUPPLY 14.00 0 8.225 0 3.00 4.00 ADULTS & PEBILATICS 30.00 0 82,360 0 4.00 5.00 INTENSIVE CARE UNIT 31.00 0 17,249 0 5.00 6.00 SUBPROVIDER - I.RF 41.00 0 9.52 0 6.00 7.00 OPERATING ROOM 51.00 0 4.210,495 0 7.00 8.00 RECOVERY ROOM A LABOR ROOM 51.00 0 214 0 9.00 8.00 RECOVERY ROOM A LABOR ROOM 52.00 0 1977.771 0 9.00 8.00 RECOVERY ROOM A LABOR ROOM 52.00 0 1977.771 0 9.00 8.01 OLO CHARDOSTIC 54.00 0 844,822 0 0 11.00 8.01 OLO CHARDOSTIC 54.00 0 7.268 0 11.00 8.02 OLO CHARDOSTIC 55.00 0 7.288 0 0 11.00 8.03 OLO CHARDOSTIC 55.00 0 7.288 0 0 11.00 8.04 OLO CHARDOSTIC 55.00 0 7.726 0 12.00 8.05 OLO CHARDOSTIC 55.00 0 7.726 0 12.00 8.06 OLO CHARDOSTIC 55.00 0 7.726 0 13.00 8.07 OLO CHARDOSTIC 55.00 0 7.726 0 13.00 8.08 CHARDOSTIC 55.00 0 7.726 0 13.00 8.09 OLO CHARDOSTIC 55.00 0 7.726 0 15.00 8.00 OLO CHARDOSTIC 55.00 0 15.00 8.00 OLO CHARDOSTIC 55.00 0 15.00 8.00 OLO CHARDOS		C - BILLABLE MEDICAL SUPPLIES	5					
3.00 CENTRAL SERVICES & SUPPLY 4.00 ADULTS & PEDIATRIN S 3.00 0 0 82,360 0 0 44,00 5.00 INTENSIVE CARE UNIT 31.00 0 17,249 0 5.00 6.00 SUBPROWIDER - IRF 41.00 0 9 592 0 6.00 6.00 SUBPROWIDER - IRF 41.00 0 9 592 0 6.00 6.00 SUBPROWIDER - IRF 41.00 0 9 592 0 6.00 6.00 SUBPROWIDER - IRF 41.00 0 9 592 0 6.00 6.00 SUBPROWIDER - IRF 41.00 0 9 4,216,495 0 7.00 6.00 FERROWING S 6.00 RECOVERY ROOM 5.0 0 0 4,216,495 0 7.00 6.00 RECOVERY ROOM 8 LABOR ROOM 5.0 0 0 9 2,144 0 0 8.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 9 197,977 0 0 9.00 7.01 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 197,977 0 0 9.00 7.02 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 197,977 0 0 9.00 7.03 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 17,426 0 11.00 7.04 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 17,426 0 11.00 7.05 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 17,426 0 11.00 7.07 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 0 17,426 0 11.00 7.08 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 0 17,426 0 11.00 7.09 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 0 17,426 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 0 17,426 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 0 17,426 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 0 17,426 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 0 17,426 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 0 17,426 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VERY ROOM 8 LABOR ROOM 5.0 0 0 11.00 7.00 DELI VE	1.00	ADMINISTRATIVE & GENERAL	5. 00	C	188		l e	1. 00
ADULTS & PEDIATRICS		1		0				1
NTERSIVE CARE UNIT   31,00					1			1
6.00 SUBPROVIDER - IRF								1
7. 00         DPERATI NO. ROOM         50. 00         0         4, 216, 495         0         8. 00           9. 00         DELI YERY ROOM & LABOR ROOM         51. 00         0         197, 971         0         9. 00           9. 00         DELI YERY ROOM & LABOR ROOM         52. 00         0         197, 971         0         9. 00           11. 00         RADIOLOGY-THERAPEUTI C         54. 00         0         84.4, 822         0         11. 00           12. 00         C TSON         57. 00         0         7.426         0         12. 00           13. 00         MACNETT C RESONANCE I MAGI NO         57. 00         0         7.426         0         12. 00           14. 00         CARDIA C CATHETERI ZATI ON         59. 00         0         7.766         0         13. 00           14. 00         CARDIA C CATHETERI ZATI ON         59. 00         0         5. 964         0         15. 00           16. 00         PHYSI CAL THERRAPY         66. 00         0         31. 295         0         16. 00           18. 00         ELECTRICK NEEPHALLOGRAPHY         70. 00         0         3. 474         0         18. 00           21. 00         DEPRIMANCY         73. 01         0					1			1
B. 00   RECOVERY ROOM   51,00   0   214   0   9,00					1		l I	1
9.00   DELI VERY ROOM & LABOR ROOM   52.00   0   197, 971   0   10.00   RADI LOGY-PIAROSTIC   54.00   0   844, 822   0   0   11.00   11.00   RADI LOGY-PIAROSTIC   55.00   0   2.380   0   11.00   11.00   12.00   12.00   12.00   13.00   MAGMETIC RESONANCE I MAGI NG (MR)   13.00   176   0   13.00   13.00   14.00   14.00   15.00				0	1		l l	1
10. 00   RADI OLOGY—DIAGNOSTIC   54. 00   0   844, 822   0   0   11. 00   12. 00   12. 00   0   12. 00   0   12. 00   0   12. 00   13. 00   14. 00   15. 00   15. 00   15. 00   15. 00   16. 00   17. 00   16. 00   17. 00   16. 00   17. 0		1		0	1			1
11. 00   RADI OLGOY-THERAPEUTIC   55. 00   0   2,380   0   11. 00   12. 00   13. 00   MAGNETIC RESONANCE I MAGI NG (NRI )   13. 00   176   0   13. 00   14. 00   14. 00   15				0	1		l	1
12 00   CT SCAN   57.00   0   7.426   0   12.00		1		0	1		l l	1
(MRI)	12.00	l I	57. 00	0	1			12.00
14. 00   CARDÍAC CATHETERI ZATI ON   59. 00   0   2. 140, 368   0   14. 00   15. 00   16. 00   PHYSI CAL THERAPY   65. 00   0   31, 295   0   16. 00   17. 00   16. 00   PHYSI CAL THERAPY   66. 00   0   31, 295   0   16. 00   17. 00   18. 00   19. 00   0   0   0   0   0   0   0   0   0	13.00	MAGNETIC RESONANCE IMAGING	58. 00	0	176	0		13. 00
15. 00   RESPIRATORY THERAPY		` ′						
16. 00   PHYSI CAL THERAPY		1		0	1		l .	1
17. 00   ELECTROCARDIOLOGY		1		0			l e	1
18. 00   CLECTROENCEPHALOGRAPHY   70. 00   0   3,474   0   19. 00   19. 00   0   0   0   144   0   19. 00   19. 00   0   0   0   144   0   19. 00		1			1		l e e e e e e e e e e e e e e e e e e e	1
19, 00   PPHARMACY   73, 01   0   1444   0   19, 00   20, 00   20, 00   20, 00   20, 00   20, 00   20, 00   20, 00   20, 00   21, 00   22, 00   22, 00   22, 00   23, 00   23, 00   24, 00   20, 00   24, 00   24, 00   24, 00   24, 00   24, 00   24, 00   24, 00   24, 00   24, 00   24, 00   24, 00   24, 00   24, 00   25, 00   26, 00   2				-			l I	1
20. 00   RENAL DI ALYSIS   74. 00   0   600   0   20. 00				0	] ", ", "			1
21.00   CARDIAC REHABILITATION   76, 97   0   254   0   21.00		<b>I</b>		0	1			1
22. 00   CLINIC   90. 00   1, 160   0   22. 00				0	1			1
24.00   MOUND CARE CENTER   90.02   0				0	1			
25. 00   PAIN CLINIC   90. 03   0   6,171   0   25. 00	23.00	OP ONCOLOGY INFUSION CENTER	90. 01	0	207, 703	0		23. 00
26. 00   OP PSYCH CLINIC   90. 05   0   119   0   26. 00   27. 00   EMERGENCY   91. 00   0   41, 120   0   27. 00   28. 00   AMBULANCE SERVICES   95. 00   0   31, 620   0   29. 00   PROMPTCARE   190. 01   0   1, 600   0   TOTALS   0   7, 936, 313    D - BILLABLE DRUGS  1. 00   EMPLOYEE BENEFITS DEPARTMENT   4. 00   0   99, 326   0   2. 00   ADMINISTRATIVE & GENERAL   5. 00   0   17   0   3. 00   OPERATION OF PLANT   7. 00   0   17   0   4. 00   NURSI NG ADMINISTRATION   13. 00   0   19, 655, 748   0   5. 00   PHARMACY   5. 00   0   260   0   6. 00   ADULTS & PEDIATRICS   30. 00   0   260   0   7. 00   INTENSIVE CARE UNIT   31. 00   0   149, 586   0   8. 00   OPERATION & LABOR ROOM   52. 00   0   21, 952   9. 00   DELIVERY ROOM & LABOR ROOM   52. 00   0   21, 952   10. 00   RADIOLOGY-DIAGNOSTIC   54. 00   0   21, 952   11. 00   CT SCAN   30. 00   0   110, 019   0   11. 00   CARDIAC CATHETERIZATION   59. 00   0   149, 858   0   11. 00   CARDIAC CATHETERIZATION   59. 00   0   149, 858   0   11. 00   OP PHARMACY   15. 00   0   110, 019   0   11. 00   CARDIAC CATHETERIZATION   59. 00   0   149, 858   0   11. 00   OP PHARMACY   15. 00   0   110, 019   0   11. 00   CARDIAC CATHETERIZATION   59. 00   0   149, 858   0   11. 00   OP PHARMACY   73. 01   0   129, 830   0   16. 00   17. 00   OP PHARMACY   73. 01   0   1, 877, 191   0   17. 00   18. 00   RENAL DIALYSIS   74. 00   0   1, 979   0   19. 00   CARDIAC CARHABILITATION   76. 97   0   285   0	24.00	WOUND CARE CENTER	90. 02	0	11, 538			24. 00
27. 00 EMERGENCY 91. 00 0 41, 120 0 27. 00 28. 00 AMBULANCE SERVICES 95. 00 0 31, 620 0 29. 00 PROMPTCARE 190. 01 0 1, 600 0 TOTALS 0 7, 936, 313  D - BILLABLE DRUGS  1. 00 EMPLOYEE BENEFITS DEPARTMENT 5. 00 0 99, 326 0 1. 00 2. 00 ADMINISTRATI VE & GENERAL 5. 00 0 200 0 200 3. 00 OPERATI ON OF PLANT 7. 00 0 1, 307 0 4. 00 4. 00 NURSI NG ADMINISTRATI ON 13. 00 0 19, 658, 748 0 5. 00 6. 00 ADULTS & PEDI ATRICS 30. 00 0 260 0 5. 00 8. 00 OPERATING ROOM 50. 00 149, 586 0 7. 00 8. 00 OPERATING ROOM 50. 00 149, 586 0 8. 00 9. 00 DELI VERY ROOM & LABOR ROOM 52. 00 0 149, 586 0 9. 00 11. 00 RADI OLOGY-DI AGNOSTIC 54. 00 0 11, 922 0 10. 00 12. 00 CT SCAN 57. 00 0 11, 989 0 11. 00 13. 00 MAGNETIC RESONANCE I MAGING 58. 00 0 12, 922 0 11. 00 13. 00 CARDI AC CATHETERAPEUTI C 55. 00 0 110, 019 0 12. 00 15. 00 PHARMACY 73. 01 0 129, 830 0 15. 00 16. 00 CARDI AC CATHETER ZATI ON 59. 00 0 129, 830 0 15. 00 17. 00 OPERATING COMBAIL OF THE RAPPEUTI C 55. 00 0 110, 019 0 12. 00 15. 00 PHARMACY 73. 01 0 129, 830 0 16. 00 17. 00 OPERATING COMBAIL OF THE RAPPEUTI C 55. 00 0 110, 019 0 12. 00 18. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 129, 830 0 16. 00 17. 00 OPERATING COMBAIL OF THE RAPPEUTI C 55. 00 0 129, 830 0 16. 00 17. 00 OPERATING COMBAIL OF THE RAPPEUTI C 55. 00 0 129, 830 0 16. 00 17. 00 OPERATING COMBAIL OF THE RAPPEUTI C 55. 00 0 129, 830 0 16. 00 17. 00 OPERATING COMBAIL OF THE RAPPEUTI C 73. 01 0 1, 877, 191 0 17. 00 18. 00 RABAL DI ALYSIS 74. 00 0 1, 979 0 285 0 19. 00				-	-,			1
28. 00   AMBULANCE SERVICES   95. 00   0   31, 620   0   29. 00   29. 00   1,600   0   0   1,600   0   29. 00   1,600   0   1,600   0   0   1,600   0   0   0   1,600   0   0   0   0   0   0   0   0   0				•	1	_		
PROMPTICARE		l I			1		l l	1
TOTALS		l I			1		l l	
D - BILLABLE DRUGS	29.00		190.01	=				29.00
1. 00     EMPLOYEE BENEFITS DEPARTMENT     4. 00     0     99, 326     0       2. 00     ADMI NI STRATI VE & GENERAL     5. 00     0     200     0       3. 00     OPERATI ON OF PLANT     7. 00     0     17     0       4. 00     NURSI NG ADMI NI STRATI ON     13. 00     0     1, 307     0     4. 00       5. 00     PHARMACY     15. 00     0     19, 658, 748     0     5. 00       6. 00     ADULTS & PEDI ATRI CS     30. 00     0     260     0     6. 00       7. 00     I NTENSI VE CARE UNIT     31. 00     0     36     0     7. 00       8. 00     OPERATI NG ROOM     50. 00     0     149, 586     0     8. 00       9. 00     DELI VERY ROOM & LABOR ROOM     52. 00     0     623     0     9. 00       10. 00     RADI OLOGY-DI AGNOSTI C     54. 00     0     21, 922     0     10. 00       11. 00     RADI OLOGY-BI AGNOSTI C     55. 00     0     11, 989     0     11. 00       12. 00     CT SCAN     57. 00     0     110, 019     0     12. 00       13. 00     MAGNETIC RESONANCE I MAGI NG     58. 00     0     64, 404     0     13. 00       14. 00     CARDI AC C					7, 730, 313			+
2. 00   ADMINISTRATIVE & GENERAL   5. 00   0   200   0   3. 00     3. 00   OPERATION OF PLANT   7. 00   0   17   0   3. 00     4. 00   NURSING ADMINISTRATION   13. 00   0   1, 307   0   4. 00     5. 00   PHARMACY   15. 00   0   19, 658, 748   0   5. 00     6. 00   ADULTS & PEDIATRICS   30. 00   0   260   0   0     7. 00   INTENSIVE CARE UNIT   31. 00   0   36   0   7. 00     8. 00   OPERATING ROOM   50. 00   0   149, 586   0   8. 00     9. 00   DELIVERY ROOM & LABOR ROOM   52. 00   0   623   0   9. 00     10. 00   RADI OLOGY-DI AGNOSTI C   54. 00   0   21, 922   0   10. 00     11. 00   RADI OLOGY-THERAPEUTI C   55. 00   0   110, 019   0     12. 00   CT SCAN   57. 00   0   110, 019   0   12. 00     13. 00   MAGNETI C RESONANCE I MAGING   58. 00   0   64, 404   0     14. 00   CARDI AC CATHETERI ZATI ON   59. 00   0   137, 149   0   14. 00     15. 00   PHYSI CAL THERAPY   66. 00   0   129, 830   0   16. 00     17. 00   OP PHARMACY   73. 01   0   1, 877, 191   0   17. 00     18. 00   RENAL DI ALYSIS   74. 00   0   1, 979   0   18. 00     19. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0   19. 00      2. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0   19. 00      2. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0   19. 00      3. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0   19. 00      3. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0   19. 00      3. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0   19. 00      3. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0   19. 00      3. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0   19. 00      3. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0   19. 00      3. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0   19. 00      3. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0   19. 00      3. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0   19. 00      3. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0   19. 00      3. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0	1.00		4.00	0	99, 326	0		1.00
3. 00   OPERATI ON OF PLANT   7. 00   0   17   0   0   4. 00   4. 00   4. 00   5. 00   PhARMACY   15. 00   0   19, 658, 748   0   0   6. 00   6. 00   6. 00   1. 00   1. 00   0   1. 00   0   1. 00   0   0   0   0   0   0   0   0   0					1			1
4. 00       NURSI NG ADMI NI STRATI ON       13. 00       0       1, 307       0       4. 00         5. 00       PHARMACY       15. 00       0       19, 658, 748       0       5. 00         6. 00       ADULTS & PEDI ATRI CS       30. 00       0       260       0       6. 00         7. 00       INTENSI VE CARE UNIT       31. 00       0       36       0       7. 00         8. 00       OPERATI NG ROOM       50. 00       0       149, 586       0       8. 00         9. 00       DELI VERY ROOM & LABOR ROOM       52. 00       0       623       0       9. 00         10. 00       RADI OLOGY-DI AGNOSTI C       54. 00       0       21, 922       0       10. 00         11. 00       RADI OLOGY-THERAPEUTI C       55. 00       0       11, 989       0       11. 00         12. 00       CT SCAN       57. 00       0       110, 019       0       12. 00         13. 00       MAGNETI C RESONANCE I MAGI NG (MRI)       58. 00       0       64, 404       0       13. 00         14. 00       CARDI AC CATHETERI ZATI ON       59. 00       0       137, 149       0       14. 00         15. 00       PHYSI CAL THERAPY       66. 00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>1</td>								1
6. 00 ADULTS & PEDIATRICS 30. 00 0 260 0 7. 00 INTENSIVE CARE UNIT 31. 00 0 36 0 7. 00 8. 00 OPERATING ROOM 50. 00 0 149, 586 0 8. 00 9. 00 DELIVERY ROOM & LABOR ROOM 52. 00 0 623 0 9. 00 10. 00 RADI OLOGY-DIAGNOSTIC 54. 00 0 21, 922 0 10. 00 11. 00 11. 989 0 11. 00 12. 00 CT SCAN 57. 00 0 110, 019 0 12. 00 13. 00 MAGNETIC RESONANCE IMAGING (MRI) 59. 00 0 137, 149 0 13. 00 (MRI) 15. 00 PHYSI CAL THERAPY 66. 00 0 129, 830 0 15. 00 16. 00 ELECTROCARDI OLOGY 69. 00 0 129, 830 0 16. 00 PHARMACY 73. 01 0 1, 877, 191 0 18. 00 RENAL DIALYSIS 74. 00 0 1, 979 0 18. 00 0 19. 00 CARDIAC REHABILITATION 76. 97 0 285 0 0 19. 00	4.00	NURSING ADMINISTRATION	13. 00	0	1, 307	0		4. 00
7. 00         INTENSI VE CARE UNI T         31. 00         0         36         0         7. 00           8. 00         OPERATI NG ROOM         50. 00         0         149, 586         0         8. 00           9. 00         DELI VERY ROOM & LABOR ROOM         52. 00         0         623         0         9. 00           10. 00         RADI OLOGY-DI AGNOSTI C         54. 00         0         21, 922         0         10. 00           11. 00         RADI OLOGY-THERAPEUTI C         55. 00         0         11, 989         0         11. 00           12. 00         CT SCAN         57. 00         0         110, 019         0         12. 00           13. 00         MAGNETI C RESONANCE I MAGI NG (MRI)         58. 00         0         64, 404         0         0           14. 00         CARDI AC CATHETERI ZATI ON         59. 00         0         137, 149         0         14. 00           15. 00         PHYSI CAL THERAPY         66. 00         0         115. 00         15. 00           16. 00         ELECTROCARDI OLOGY         69. 00         0         129, 830         0         16. 00           18. 00         RENAL DI ALYSI S         74. 00         0         1, 877, 191	5.00	PHARMACY	15. 00	0	19, 658, 748			5. 00
8. 00       OPERATING ROOM       50. 00       0       149, 586       0       0       9. 00       9. 00         9. 00       DELIVERY ROOM & LABOR ROOM       52. 00       0       623       0       9. 00         10. 00       RADI OLOGY-DI AGNOSTI C       54. 00       0       21, 922       0       10. 00         11. 00       RADI OLOGY-THERAPEUTI C       55. 00       0       11, 989       0       11. 00         12. 00       CT SCAN       57. 00       0       110, 019       0       12. 00         13. 00       MAGNETI C RESONANCE I MAGI NG (MRI)       58. 00       0       64, 404       0         14. 00       CARDI AC CATHETERI ZATI ON       59. 00       0       137, 149       0       14. 00         15. 00       PHYSI CAL THERAPY       66. 00       0       115       0       15. 00         16. 00       ELECTROCARDI OLOGY       69. 00       0       129, 830       0       16. 00         17. 00       OP PHARMACY       73. 01       0       1,877, 191       0       17. 00         18. 00       RENAL DI ALYSI S       74. 00       0       1,979       0       18. 00         19. 00       CARDI AC REHABI LI TATI ON <td></td> <td></td> <td></td> <td>0</td> <td>1</td> <td></td> <td></td> <td>1</td>				0	1			1
9.00 DELI VERY ROOM & LABOR ROOM				0	1			1
10. 00 RADI OLOGY-DI AGNOSTI C 54. 00 0 21, 922 0 10. 00 11. 00 RADI OLOGY-THERAPEUTI C 55. 00 0 11, 989 0 11. 00 12. 00 CT SCAN 57. 00 0 110, 019 0 12. 00 13. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 0 13. 00  14. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 137, 149 0 14. 00 15. 00 PHYSI CAL THERAPY 66. 00 0 15. 00 16. 00 ELECTROCARDI OLOGY 69. 00 0 129, 830 0 16. 00 17. 00 OP PHARMACY 73. 01 0 1, 877, 191 0 17. 00 18. 00 RENAL DI ALYSI S 74. 00 0 1, 979 0 18. 00 19. 00 CARDI AC REHABI LI TATI ON 76. 97 0 285 0 19. 00		1		0	1		l l	1
11. 00       RADI OLOGY-THERAPEUTI C       55. 00       0       11, 989       0       11. 00         12. 00       CT SCAN       57. 00       0       110, 019       0       12. 00         13. 00       MAGNETI C RESONANCE I MAGI NG (MRI)       58. 00       0       64, 404       0       0       13. 00         14. 00       CARDI AC CATHETERI ZATI ON       59. 00       0       137, 149       0       14. 00         15. 00       PHYSI CAL THERAPY       66. 00       0       115       0       15. 00         16. 00       ELECTROCARDI OLOGY       69. 00       0       129, 830       0       16. 00         17. 00       OP PHARMACY       73. 01       0       1, 877, 191       0       17. 00         18. 00       RENAL DI ALYSI S       74. 00       0       1, 979       0       18. 00         19. 00       CARDI AC REHABI LI TATI ON       76. 97       0       285       0       19. 00		1		Ü			l e	1
12. 00 CT SCAN 57. 00 0 110, 019 0 12. 00 13. 00 MAGNETI C RESONANCE I MAGI NG (MRI) 14. 00 CARDI AC CATHETERI ZATI ON 59. 00 0 137, 149 0 14. 00 15. 00 PHYSI CAL THERAPY 66. 00 0 115 0 15. 00 16. 00 ELECTROCARDI OLOGY 69. 00 0 129, 830 0 16. 00 17. 00 OP PHARMACY 73. 01 0 1, 877, 191 0 17. 00 18. 00 RENAL DI ALYSI S 74. 00 0 1, 979 0 18. 00 19. 00 CARDI AC REHABI LI TATI ON 76. 97 0 285 0 19. 00				0	1		l e e e e e e e e e e e e e e e e e e e	1
13. 00 MAGNETIC RESONANCE I MAGING (MRI)  14. 00 CARDIAC CATHETERIZATION 59. 00 0 137, 149 0 14. 00  15. 00 PHYSI CAL THERAPY 66. 00 0 115 0 15. 00  16. 00 ELECTROCARDI OLOGY 69. 00 129, 830 0 16. 00  17. 00 OP PHARMACY 73. 01 0 1, 877, 191 0 17. 00  18. 00 RENAL DI ALYSI S 74. 00 0 1, 979 0 18. 00  19. 00 CARDIAC REHABI LI TATI ON 76. 97 0 285 0 19. 00				0	1		l I	1
14. 00   CARDI AC CATHETERI ZATI ON   59. 00   0   137, 149   0   14. 00     15. 00   PHYSI CAL THERAPY   66. 00   0   115   0   15. 00     16. 00   ELECTROCARDI OLOGY   69. 00   0   129, 830   0   16. 00     17. 00   OP PHARMACY   73. 01   0   1, 877, 191   0   17. 00     18. 00   RENAL DI ALYSI S   74. 00   0   1, 979   0   18. 00     19. 00   CARDI AC REHABI LI TATI ON   76. 97   0   285   0   19. 00				0	1		l I	
14. 00     CARDÍ AC CATHETERIZATION     59. 00     0     137, 149     0     14. 00       15. 00     PHYSI CAL THERAPY     66. 00     0     115     0     15. 00       16. 00     ELECTROCARDI OLOGY     69. 00     0     129, 830     0     16. 00       17. 00     OP PHARMACY     73. 01     0     1, 877, 191     0     17. 00       18. 00     RENAL DI ALYSI S     74. 00     0     1, 979     0     18. 00       19. 00     CARDI AC REHABI LI TATI ON     76. 97     0     285     0     19. 00	13.00		30.00	O	04, 404			13.00
15. 00     PHYSI CAL THERAPY     66. 00     0     115     0     15. 00       16. 00     ELECTROCARDI OLOGY     69. 00     0     129, 830     0     16. 00       17. 00     OP PHARMACY     73. 01     0     1, 877, 191     0     17. 00       18. 00     RENAL DI ALYSI S     74. 00     0     1, 979     0     18. 00       19. 00     CARDI AC REHABI LI TATI ON     76. 97     0     285     0     19. 00	14.00		59. 00	0	137, 149	0		14. 00
17. 00     OP PHARMACY     73. 01     0     1,877,191     0     17. 00       18. 00     RENAL DI ALYSI S     74. 00     0     1,979     0     18. 00       19. 00     CARDI AC REHABI LI TATI ON     76. 97     0     285     0     19. 00	15.00			0	1			15. 00
18. 00     RENAL DI ALYSI S     74. 00     0     1, 979     0     18. 00       19. 00     CARDI AC REHABI LI TATI ON     76. 97     0     285     0     19. 00	16.00	ELECTROCARDI OLOGY		0	129, 830			
19. 00 CARDI AC REHABI LI TATI ON 76. 97 0 285 0 19. 00				0				
		1					l e	1
20. 00					l .		l e	1
	∠∪. ∪∪	OLI NI C	90.00	0	y 8/9	1 0	l .	∠∪. ∪∪

Health Financial Systems RECLASSIFICATIONS Provider CCN: 15-0051 Peri od: Worksheet A-6 From 01/01/2016 To 12/31/2016 Date/Time Prepared:

						5/23/2017 10 bate/11 lie Pi	
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10. 00		
21.00	WOUND CARE CENTER	90. 02	0	11, 882	0		21. 00
22. 00	PAIN CLINIC	90. 03	0	32, 979	1		22. 00
23. 00	EMERGENCY	91.00	0	4, 499	0		23. 00
24. 00	AMBULANCE SERVICES	95.00	0	62, 187			24. 00
25. 00	PROMPTCARE	190. 01	0	79, 387	0		25. 00
26. 00	COMMUNITY HEALTH SERVICES	1 <u>90.</u> 11	0	1 <u>7, 3</u> 26			26. 00
	TOTALS		0	22, 474, 125			
	E - IMPLANTS SUPPLIES						
1. 00	HOUSEKEEPI NG	9. 00	0	816	1		1. 00
2.00	NURSING ADMINISTRATION	13. 00	0	20, 204	1		2. 00
3.00	ADULTS & PEDIATRICS	30.00	0	3, 800			3. 00
4.00	INTENSIVE CARE UNIT	31.00	0	9, 397	0		4. 00
5.00	SUBPROVI DER - I RF	41. 00	0	106	0		5. 00
6.00	OPERATING ROOM	50.00	0	10, 086, 223	0		6. 00
7.00	RECOVERY ROOM	51.00	0	62	0		7. 00
8.00	RADI OLOGY-DI AGNOSTI C	54.00	0	385, 915	0		8. 00
9.00	CT SCAN	57.00	0	833	0		9. 00
10.00	CARDIAC CATHETERIZATION	59.00	0	3, 381, 239	0		10.00
11. 00	OP ONCOLOGY INFUSION CENTER	90. 01	0	5, 432	0		11. 00
12.00	WOUND CARE CENTER	90. 02	0	4, 639	0		12. 00
13.00	EMERGENCY	91.00	0	1, 083	0		13. 00
14.00	PROMPTCARE	190. 01	0	50	0		14. 00
	TOTALS			13, 899, 799			
	F - LEASE EXPENSE	<u> </u>	<u>'</u>		· · · · · · · · · · · · · · · · · · ·		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	53, 482	9		1. 00
2.00	ADMINISTRATIVE & GENERAL	5.00	0	81, 129	9		2. 00
3.00	OPERATION OF PLANT	7.00	0	278, 909	0		3.00
4.00	CENTRAL SERVICES & SUPPLY	14.00	0	128, 377	0		4. 00
5.00	RADI OLOGY-DI AGNOSTI C	54.00	o	7, 596	1		5. 00
6.00	LABORATORY	60.00	0	33, 212	1		6. 00
7. 00	RESPIRATORY THERAPY	65. 00	0	9, 675			7. 00
8. 00	PHYSI CAL THERAPY	66.00	o	418, 692			8. 00
9. 00	OP ONCOLOGY INFUSION CENTER	90. 01	o	59, 483			9. 00
10.00	WOUND CARE CENTER	90. 02	o	65, 886			10.00
11. 00	PAIN CLINIC	90. 03	o	18, 291			11. 00
12. 00	OP PSYCH CLINIC	90. 05	o	122, 491			12. 00
13. 00	AMBULANCE SERVICES	95.00	0	152, 590			13. 00
14. 00	PROMPTCARE	190. 01	o	48, 817			14. 00
15. 00	FOUNDATION	190.01	0	60, 217			15. 00
16. 00	MORGAN OP BEHAVIORAL HEALTH	190. 03	0	38, 673			16. 00
10.00	CLINIC	170.10	٥	30, 073	,		10.00
17. 00	COMMUNITY HEALTH SERVICES	190. 11	o	57, 670	o		17. 00
	TOTALS			1, 635, 190			
	G - NON-BILLABLE DRUGS	<u> </u>	<u>'</u>		· · · · · · · · · · · · · · · · · · ·		
1.00	OPERATING ROOM	50.00	0	1, 636	0		1. 00
2.00	RADI OLOGY-DI AGNOSTI C	54.00	0	3, 389	0		2. 00
3.00	CT SCAN	57.00	0	2, 959	0		3. 00
4.00	MAGNETIC RESONANCE IMAGING	58.00	0	328	0		4. 00
	(MRI)						
	TOTALS		0	8, 312			
	H - NON-BILLABLE MEDICAL SUPF	PLIES					
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	59, 937	14		1. 00
2.00	OPERATION OF PLANT	7.00	0	6, 282	0		2. 00
3.00	LAUNDRY & LINEN SERVICE	8. 00	0	2, 761	0		3. 00
4.00	HOUSEKEEPI NG	9.00	0	80, 004	0		4. 00
5.00	DI ETARY	10.00	0	33, 424	0		5. 00
6.00	NURSING ADMINISTRATION	13. 00	0	78, 980	0		6. 00
7.00	PHARMACY	15. 00	0	81, 274	0		7. 00
8.00	CENTRAL STERILIZATION	18. 01	0	223, 392	0		8. 00
9.00	ADULTS & PEDIATRICS	30.00	0	1, 683, 977	0		9. 00
10.00	INTENSIVE CARE UNIT	31.00	0	399, 125	0		10.00
11.00	SUBPROVI DER - I RF	41.00	0	57, 376			11. 00
12.00	NURSERY	43.00	0	172, 516	0		12. 00
13.00	OPERATING ROOM	50.00	0	3, 281, 627			13. 00
14.00	RECOVERY ROOM	51.00	0	73, 075			14. 00
15. 00	DELIVERY ROOM & LABOR ROOM	52.00	0	325, 346			15. 00
16.00	RADI OLOGY-DI AGNOSTI C	54.00	0	179, 256			16. 00
17.00	RADI OLOGY-THERAPEUTI C	55.00	0	527, 520			17. 00
18.00	CT SCAN	57. 00	0	109, 958			18. 00
19. 00	MAGNETIC RESONANCE I MAGING	58. 00	Ō	13, 003			19. 00
	(MRI)		]	-,	1		
20.00	CARDÍAC CATHETERIZATION	59.00	0	439, 473	0		20. 00
21.00	RESPIRATORY THERAPY	65.00	0	396, 277	0		21. 00
22.00	PHYSI CAL THERAPY	66. 00	0	35, 086	0		22. 00
	•		'				•

In Lieu of Form CMS-2552-10
Worksheet A-6

Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/23/2017 10: 42 am

		Dooroooo				5/23/2017 10:	42 alli
	Cost Contor	Decreases	Colory	Othor	Wkst A 7 Dof		
	Cost Center	Li ne #	Sal ary	0ther 9.00	Wkst. A-7 Ref.		
22.00	6.00	7.00	8. 00		10.00		22.00
23. 00	ELECTROCARDI OLOGY	69.00	0	22, 439			23. 00
24. 00	ELECTROENCEPHALOGRAPHY	70.00	0	52, 104			24. 00
25. 00	OP PHARMACY	73. 01	0	477	1		25. 00
26. 00	RENAL DI ALYSI S	74.00	0	20, 713			26. 00
27. 00	CARDIAC REHABILITATION	76. 97	0	7, 503			27. 00
28. 00	CLINIC	90.00	0	8, 996	1		28. 00
29. 00	OP ONCOLOGY INFUSION CENTER	90. 01	0	124, 016			29. 00
30. 00	WOUND CARE CENTER	90. 02	0	99, 982			30. 00
31.00	PAIN CLINIC	90. 03	0	26, 202	2 0		31.00
32.00	OP PSYCH CLINIC	90. 05	0	1, 305	0		32.00
33.00	EMERGENCY	91.00	0	956, 728	0		33. 00
34.00	AMBULANCE SERVICES	95.00	o	220, 464	o		34.00
35.00	PROMPTCARE	190. 01	o	80, 418	o o		35. 00
36.00	OLCOTT	190. 03	o	122	el ol		36.00
37.00	HME STORE	190. 07	ol	48, 837	ol		37. 00
38. 00	CLINICAL TRIALS	190. 09	ol	62	1		38. 00
39. 00	COMMUNITY HEALTH SERVICES	190. 11	Ö	9, 233			39. 00
40. 00	IU HEALTH SIP	194. 03	ő	40			40.00
10.00	TOTALS	— · <del>//:</del> • • •	— — — ŏ	9, 939, 310			10.00
	J - INTEREST EXPENSE	l l	<u> </u>	7, 737, 310	/		l
1.00	INTEREST EXPENSE	113.00	0	1, 314, 118	9		1.00
1.00	TOTALS	— — 1 <u>13.</u> 00	— — — ö	1, 314, 118			1.00
	K - PHARMACY RESIDENCY		U U	1,314,110	'		
1 00		15 00	254 400				1 00
1. 00	PHARMACY		25 <u>4, 6</u> 80				1. 00
	TOTALS		254, 680		1		1
1 00	L - PSYCH ADMIN	20.00	0/0 400	00.010	,		1 00
1. 00	ADULTS & PEDI ATRI CS	30.00	<u>262, 4</u> 82	2 <u>2, 2</u> 19			1. 00
	TOTALS		262, 482	22, 219	<u>'</u>		1
	M - SOFTWARE LICENSE		_1				
1. 00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	15, 309	1		1. 00
2.00	ADMINISTRATIVE & GENERAL	5. 00	0	190, 628	1		2. 00
3. 00	OPERATION OF PLANT	7. 00	0	12, 416			3. 00
4.00	PHARMACY	15. 00	0	598	1		4. 00
5.00	ADULTS & PEDIATRICS	30.00	0	8, 772	2 0		5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00	0	1, 286	0		6. 00
7.00	RADI OLOGY-THERAPEUTI C	55.00	0	2, 366	0		7. 00
8.00	PHYSI CAL THERAPY	66.00	o	600	o		8. 00
9.00	ELECTROENCEPHALOGRAPHY	70.00	o	6, 983	ol ol		9. 00
10.00	AMBULANCE SERVICES	95.00	o	31, 859			10.00
11. 00	OLCOTT	190. 03	o	20, 366			11. 00
12. 00	CLINICAL TRIALS	190. 09	0	335			12. 00
13. 00	COMMUNITY HEALTH SERVICES	190. 11	0	288			13. 00
	TOTALS			291, 806			
	N - CAFETERIA		<u> </u>	271,000	'II		
1.00	DI ETARY	10.00	905, 827	716, 358	0		1.00
1.00	TOTALS — — — —	— <del>10.</del> 00	905, 827	716, 358			1.00
	O - SHORT TERM DISABILITY/FLM	ΙΙ ΛΑ	700, 027	710,000	1		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	434	C	0		1.00
2. 00	ADMINISTRATIVE & GENERAL	5.00	7, 881				2. 00
3.00	OPERATION OF PLANT	7.00	12, 490	C	1		3. 00
4.00	HOUSEKEEPI NG	9.00	14, 312	C			4. 00
5.00	DI ETARY	10.00	10, 266	C	1		5. 00
6. 00	NURSING ADMINISTRATION	13. 00	18, 202	(	1	1	6. 00
		l .		C	1	-	1
7. 00 8. 00	PHARMACY	15.00	14, 935				7. 00 8. 00
	ADULTS & PEDIATRICS	30.00	156, 627		1		1
9.00	INTENSIVE CARE UNIT	31.00	23, 885	C	1		9.00
10.00	SUBPROVI DER - I RF	41.00	11, 186	C	1		10.00
11. 00	NURSERY	43.00	6, 262	C	1		11.00
12.00	OPERATING ROOM	50.00	33, 952	C -	0		12.00
13.00	RECOVERY ROOM	51.00	18, 283	C -	0		13.00
14.00	DELIVERY ROOM & LABOR ROOM	52.00	32, 355	C	1 1		14. 00
15. 00	RADI OLOGY-DI AGNOSTI C	54.00	8, 877	C	0		15. 00
16. 00	RADI OLOGY-THERAPEUTI C	55.00	4, 737	C	1		16.00
17. 00	CT SCAN	57.00	14, 092	C	0		17. 00
18. 00	MAGNETIC RESONANCE I MAGING	58. 00	2, 340	C	0		18. 00
	(MRI)						
19. 00	CARDIAC CATHETERIZATION	59. 00	4, 181	C			19. 00
20.00	RESPI RATORY THERAPY	65. 00	14, 244	C	1		20. 00
21. 00	PHYSI CAL THERAPY	66. 00	34, 870	C	0		21. 00
22.00	CARDIAC REHABILITATION	76. 97	3, 533	C	1 1		22. 00
23. 00	CLINIC	90.00	2, 154	C	0		23. 00
24.00	OP ONCOLOGY INFUSION CENTER	90. 01	8, 694	C	1		24. 00
25. 00	WOUND CARE CENTER	90. 02	7, 847	C			25. 00
26.00	PAIN CLINIC	90. 03	544	C	o		26. 00
		· · · · · · · · · · · · · · · · · · ·	'				

Health Financial Systems RECLASSIFICATIONS | Peri od: | From 01/01/2016 | To 12/31/2016 | Worksheet A-6 | Date/Time Prepared: 5/23/2017 10: 42 am Provider CCN: 15-0051

						5/23/2017 10: 4	12 am_
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
27.00	OP PSYCH CLINIC	90. 05	2, 744	0			27.00
28.00	EMERGENCY	91. 00	44, 724	0			28.00
29.00	AMBULANCE SERVICES	95.00	17, 374	0	0		29.00
31.00	PROMPTCARE	190. 01	5, 277	0	O		31.00
32.00	OLCOTT	190. 03	1, 969	0	0		32.00
33.00	FOUNDATI ON	190. 05	1, 798	0	o		33.00
34.00	HME STORE	190. 07	1, 370	0	o		34.00
35. 00	COMMUNITY HEALTH SERVICES	190. 11	19, 073	0			35. 00
	TOTALS	— — <del>```</del> `` <del>`</del> †	561, 512	0			
	P - UTILITIES EXPENSE		001,012				
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	3, 524	0		1. 00
2. 00	ADMINISTRATIVE & GENERAL	5. 00	Ö	7, 454			2. 00
3.00	RADI OLOGY-DI AGNOSTI C	54.00	0	12, 744			3. 00
4. 00	RADI OLOGY-THERAPEUTI C	55.00	0	146, 936			4. 00
5. 00	PHYSICAL THERAPY	66.00	0	· ·			5. 00
		•	0	28, 136			
6.00	CLINIC	90.00	0	667		•	6. 00
7.00	OP ONCOLOGY INFUSION CENTER	90. 01	0	2, 274			7. 00
8.00	PAIN CLINIC	90. 03	0	5, 351	0		8. 00
9.00	OP PSYCH CLINIC	90. 05	0	949			9. 00
10. 00	AMBULANCE SERVICES	95. 00	0	24, 187			10. 00
11. 00	PROMPTCARE	190. 01	0	1, 588		1	11. 00
12.00	RENTAL PROPERTIES	190. 02	0	17, 962			12.00
13.00	FOUNDATI ON	190. 05	0	7, 449	0		13.00
14.00	CLINICAL TRIALS	190. 09	0	430	0		14.00
15.00	COMMUNITY HEALTH SERVICES	190. 11		12, 026	0		15.00
	TOTALS		0	271, 677			
	Q - MARKETING EXPENSE						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	119	0		1.00
2.00	ADMINISTRATIVE & GENERAL	5.00	o	135, 705	0		2.00
3.00	AMBULANCE SERVICES	95.00	o	100	o		3.00
4.00	FOUNDATI ON	190. 05	o	8, 631	o		4.00
5. 00	COMMUNITY HEALTH SERVICES	190. 11	0	5, 810			5. 00
	TOTALS	— ·-···		150, 365			
	R - OCCUPATI ONAL HEALTH ADMIN						
1.00	PROMPTCARE	190. 01	159, 476	0	0		1. 00
1.00	TOTALS		159, 476	$ \frac{0}{0}$	<u> </u>		1.00
	S - HHA AND HOSPICE SALARIES		107, 170	<u> </u>			
1.00	HOME HEALTH AGENCY	101.00	O	2, 345, 358	0		1. 00
2. 00	HOSPI CE	116.00	0	2, 336, 851			2. 00
2.00	TOTALS			4, 682, 209			2.00
			υ	4, 002, 209			
4 00	T - ER PHYSICIAN FEES	F 00		0.477.440			4 00
1.00	ADMI NI STRATI VE & GENERAL	5.00	•	<u>2, 176, 440</u>			1. 00
	TOTALS		0	2, 176, 440			
	U - MED NUTRITION THERAPY						
1.00	COMMUNITY HEALTH SERVICES	1 <u>90.</u> 11	11 <u>8, 6</u> 68	3 <u>2, 0</u> 54			1. 00
	TOTALS Grand Total: Decreases		118, 668 2, 262, 645	32, 054 101, 649, 706			500. 00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provider CCN: 15-0051

					To 12/31/2016		pared:
				Acqui si ti ons	,	3/23/2017 10.	42 alli
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2. 00	3. 00	4. 00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	Γ BALANCES					
1.00	Land	19, 760, 652	0		0	19, 204	1. 00
2.00	Land Improvements	2, 072, 522	0		0	14, 315	2. 00
3.00	Buildings and Fixtures	154, 510, 826	0		0	3, 713, 293	3. 00
4.00	Building Improvements	8, 430, 041	2, 957, 487		0 2, 957, 487		4. 00
5.00	Fi xed Equipment	20, 471, 772	4, 316, 330		0 4, 316, 330		5. 00
6.00	Movable Equipment	172, 808, 155	80, 827, 971		0 80, 827, 971	64, 959, 231	6. 00
7.00	HIT designated Assets	0	0		0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	378, 053, 968	88, 101, 788		0 88, 101, 788	93, 678, 786	8. 00
9.00	Reconciling Items	0	0		0	0	9. 00
10. 00	Total (line 8 minus line 9)	378, 053, 968	88, 101, 788		0 88, 101, 788	93, 678, 786	10. 00
		Endi ng Bal ance	Fully				
			Depreci ated				
		4 00	Assets				
	DART I ANALYCIC OF CHANCEC IN CARLTAL ACCE	6.00	7. 00				
1 00	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET		0				1 00
1.00	Land	19, 741, 448	0				1.00
2.00	Land Improvements	2, 058, 207	0				2.00
3. 00 4. 00	Buildings and Fixtures	150, 797, 533	0				3.00
5. 00	Building Improvements	11, 202, 888	0				4. 00 5. 00
6.00	Fixed Equipment	100 (7/ 005	0				
6. 00 7. 00	Movable Equipment HIT designated Assets	188, 676, 895	0				6. 00 7. 00
8.00	Subtotal (sum of lines 1-7)	372, 476, 970	0				8.00
9. 00	Reconciling Items	312,410,910	0				9.00
10, 00	Total (line 8 minus line 9)	372, 476, 970	0				10.00
10.00	Tiotal (Title 6 millus Title 9)	312,410,910	υ <sub> </sub>			ļ	10.00

Heal th	Financial Systems II	U HEALTH BLOOMINGTON HOSPITAL			In Lieu of Form CMS-2552-10			
RECONCILIATION OF CAPITAL COSTS CENTERS			Provi der CC	CN: 15-0051	Peri od: From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:	
			SI	JMMARY OF CAP	I TAI	5/23/2017 10:	42 am	
			30	DIVINIANT OF CAL	IIAL			
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see instructions)			
		9. 00	10.00	11. 00	12.00	13. 00		
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	ol	2. 00	
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3. 00	
		SUMMARY O	F CAPITAL					
	Cost Center Description	Other	Total (1) (sum					
	·	Capi tal -Rel ate	of cols. 9					
		d Costs (see	through 14)					
		instructions)						
		14.00	15. 00					
	PART II - RECONCILIATION OF AMOUNTS FROM WORK	KSHEET A, COLUM	N 2, LINES 1 a	nd 2				
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1. 00	
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2. 00	
	1 - 1 - 4 - 6 - 1 - 1 - 6 - 6 - 1	1		1				

0 0 0

0 0 0

1. 00 2. 00 3. 00

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

Heal th	n Financial Systems	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der Co		Period: From 01/01/2016 To 12/31/2016		pared: 42 am
		COMPUTATION OF RATIOS			ALLOCATION OF	OTHER CAPITAL	
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio	instructions)		
				(col . 1 - col 2)	•		
		1.00	2.00	3.00	4. 00	5. 00	
PART III - RECONCILIATION OF CAPITAL COSTS CENTERS							
1.00	CAP REL COSTS-BLDG & FLXT	183, 800, 076		183, 800, 07		0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	188, 676, 895					2. 00
3.00	Total (sum of lines 1-2)	372, 476, 971		372, 476, 97			3. 00
		ALLOCA	TION OF OTHER (	CAPI TAL	SUMMARY O	F CAPITAL	
	Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
			Capi tal -Relate				
		/ 00	d Costs	through 7)	0.00	10.00	
	PART III - RECONCILIATION OF CAPITAL COSTS C	6. 00	7. 00	8.00	9. 00	10. 00	
1. 00	CAP REL COSTS-BLDG & FIXT	INIERS			17, 564, 530	0	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP				8, 145, 678		2. 00
3.00	Total (sum of lines 1-2)	0	0		25, 710, 208		3. 00
<u> </u>			Sl	JMMARY OF CAPI		-	0.00
	Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
	cost conton boson per on	111101 001	instructions)			` ' '	
			,	, , , , , , , , , , , , , , , , , , , ,	d Costs (see	through 14)	
					instructions)	Ů,	
		11.00	12.00	13.00	14. 00	15. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C			1			
1.00	CAP REL COSTS-BLDG & FLXT	0			0	17, 564, 530	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	1		0	-,	
3. 00	Total (sum of lines 1-2)	0	0	1	0	25, 710, 208	3. 00

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 IU HEALTH BLOOMINGTON HOSPITAL Provider CCN: 15-0051

	,				12/31/2010	5/23/2017 10:	
				Expense Classification on			
				To/From Which the Amount is	to be Aujusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	oost center bescriptron	1.00	2. 00	3.00	4. 00	5. 00	
1.00	Investment income - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	1. 00
2.00	COSTS-BLDG & FIXT (chapter 2)		0	CAP REL COSTS-MVBLE EQUIP	2.00		2 00
2. 00	Investment income - CAP REL COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL CUSTS-MVBLE EQUIP	2. 00	0	2. 00
3.00	Investment income - other		0		0. 00	0	3. 00
4 00	(chapter 2)		0		0.00		4 00
4. 00	Trade, quantity, and time discounts (chapter 8)		0		0. 00	0	4. 00
5.00	Refunds and rebates of		0		0.00	0	5. 00
, 00	expenses (chapter 8)				0.00		
6. 00	Rental of provider space by suppliers (chapter 8)		0		0. 00	0	6. 00
7. 00	Tel ephone servi ces (pay		0		0.00	O	7. 00
	stations excluded) (chapter						
8. 00	21) Television and radio service		0		0. 00	0	8. 00
0.00	(chapter 21)		O		0.00	Ĭ	0.00
9. 00	Parking Lot (chapter 21)		0		0.00	O	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-14, 996, 692			0	10. 00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11. 00
	(chapter 23)						
12. 00	Related organization	A-8-1	16, 101, 753			0	12. 00
13. 00	transactions (chapter 10) Laundry and linen service		0		0.00	0	13. 00
14. 00	Cafeteria-employees and guests	В	-1, 129, 877	CAFETERI A	11. 00	1	14. 00
15. 00	Rental of quarters to employee		0		0.00	o	15.00
16. 00	and others Sale of medical and surgical		0		0. 00	0	16. 00
16.00	supplies to other than		Ü		0.00	0	10.00
	patients						
17. 00	Sale of drugs to other than		0		0.00	0	17. 00
18. 00	patients Sale of medical records and		0		0.00	0	18. 00
10.00	abstracts		O		0.00	Ĭ	10.00
19. 00	Nursing school (tuition, fees,		0		0.00	0	19. 00
20. 00	books, etc.) Vending machines		0		0.00	0	20. 00
21. 00	Income from imposition of		0		0.00	1	21. 00
	interest, finance or penalty						
22.00	charges (chapter 21)		0		0.00	0	22.00
22. 00	Interest expense on Medicare overpayments and borrowings to		0		0. 00	U	22. 00
	repay Medicare overpayments						
23. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65. 00		23. 00
	therapy costs in excess of limitation (chapter 14)						
24. 00	Adjustment for physical	A-8-3	0	PHYSICAL THERAPY	66.00		24. 00
	therapy costs in excess of						
25. 00	limitation (chapter 14) Utilization review -		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
23.00	physicians' compensation		O	OTTETZATION REVIEW-SIN	114.00		23.00
	(chapter 21)						
26. 00	Depreciation - CAP REL COSTS-BLDG & FLXT		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	Depreciation - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	o	27. 00
	COSTS-MVBLE EQUIP						
28. 00	Non-physician Anesthetist		0	*** Cost Center Deleted ***	19.00		28. 00
29. 00 30. 00	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	0. 00 67. 00	1	29. 00 30. 00
30. 00	therapy costs in excess of	A 0 3	O	OCCUPATIONAL THERAIT	07.00		30. 00
	limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30. 00		30. 99
31. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31. 00
	pathology costs in excess of		· ·				
22.00	limitation (chapter 14)		_		2 22	_	22.00
32. 00	CAH HIT Adjustment for Depreciation and Interest		0		0. 00	0	32. 00
33. 00	INTEREST EXPENSE - UNNECESSARY	A	-850, 366	CAP REL COSTS-BLDG & FIXT	1.00	9	33. 00
33. 01	ACCRUED PTO - STAFF SUPPORT	A	-1, 090, 970	EMPLOYEE BENEFITS DEPARTMENT	4. 00	o	33. 01

Health Financial Systems
ADJUSTMENTS TO EXPENSES In Lieu of Form CMS-2552-10
Worksheet A-8 Peri od: Worksheet A-8 From 01/01/2016 To 12/31/2016 Date/Time Prepared: Provider CCN: 15-0051

				To	12/31/2016	Date/Time Prep 5/23/2017 10:4	
				Expense Classification on	Worksheet A	5/23/2017 10.2	+2 dIII
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Rasis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
	Sost content besent per on	1.00	2.00	3.00	4. 00	5. 00	
33. 02	BENEFIT RELATED COSTS	A		EMPLOYEE BENEFITS DEPARTMENT	4.00	0	33. 02
33. 03 33. 04	IUH MORGAN TOTAL OPER EXPENSES IUH PAOLI TOTAL OPER EXPENSES	A A		IU HEALTH MORGAN HOSPITAL IU HEALTH PAOLI HOSPITAL	194. 02 194. 00	0	33. 03 33. 04
33. 05	TUH BEDFORD TOTAL OPER	A		IU HEALTH BEDFORD HOSPITAL	194. 01	0	33. 05
33. 06	EXPENSES ACCELERATED DEPR	A	1 661 922	CAP REL COSTS-MVBLE EQUIP	2. 00	9	33. 06
33. 07	MI SCELLANEOUS I NCOME	B		EMPLOYEE BENEFITS DEPARTMENT	4. 00	Ő	33. 07
33. 08	MI SCELLANEOUS I NCOME	В		ADMINISTRATIVE & GENERAL	5.00	0	33. 08
33. 09 33. 10	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		OPERATION OF PLANT LAUNDRY & LINEN SERVICE	7. 00 8. 00	0	33. 09 33. 10
33. 11	MI SCELLANEOUS I NCOME	В	-236, 381	1	10. 00	Ö	33. 11
33. 12	MI SCELLANEOUS I NCOME	В		NURSI NG ADMI NI STRATI ON	13.00	0	33. 12
33. 13 33. 14	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		PHARMACY ADULTS & PEDIATRICS	15. 00 30. 00	0	33. 13 33. 14
33. 15	MI SCELLANEOUS I NCOME	В		RADI OLOGY-DI AGNOSTI C	54. 00	О	33. 15
33. 16 33. 17	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		RADI OLOGY-THERAPEUTI C LABORATORY	55. 00 60. 00	0	33. 16 33. 17
33. 17	MI SCELLANEOUS I NCOME	В		PHYSI CAL THERAPY	66.00	0	33. 17
33. 19	MI SCELLANEOUS I NCOME	В		ELECTROENCEPHALOGRAPHY	70. 00	0	33. 19
33. 20 33. 21	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B	-9, 104 -42, 783	CARDIAC REHABILITATION	76. 97 90. 00	0	33. 20 33. 21
33. 22	MI SCELLANEOUS I NCOME	В		WOUND CARE CENTER	90. 02	0	33. 22
33. 23	MI SCELLANEOUS I NCOME	В	· ·	OP ONCOLOGY INFUSION CENTER	90. 01	0	33. 23
33. 24 33. 25	MI SCELLANEOUS I NCOME MI SCELLANEOUS I NCOME	B B		OP PSYCH CLINIC AMBULANCE SERVICES	90. 05 95. 00	0	33. 24 33. 25
33. 26	MI SCELLANEOUS I NCOME	В		PROMPTCARE	190. 01	o	33. 26
33. 27	MI SCELLANEOUS I NCOME	В		COMMUNITY HEALTH SERVICES	190. 11	0	33. 27
33. 28 33. 29	CONTRIBUTION EXP	A A		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	5. 00 5. 00	0	33. 28 33. 29
33. 30	HOME HEALTH EXPENSES	A		HOME HEALTH AGENCY	101. 00	o	33. 30
33. 31 33. 32	HOSPICE EXPENSES RECRUITING EXP	A A	4, 102, 444 -60, 551	HOSPICE ADMINISTRATIVE & GENERAL	116. 00 5. 00	0 0	33. 31 33. 32
33. 33	RECRUITING EXP	A		PHARMACY	15. 00	0	33. 33
33. 34	RECRUITING EXP	A		ADULTS & PEDIATRICS	30.00	0	33. 34
33. 35 33. 36	RECRUITING EXP	A A		OPERATING ROOM LABORATORY	50. 00 60. 00	0 0	33. 35 33. 36
33. 37	NON ALLOW PHYSICIAN SERVICES	A	-547	ELECTROCARDI OLOGY	69. 00	0	33. 37
33. 38 33. 39	1983 INTEREST WEGMILLER	A A		CAP REL COSTS-BLDG & FIXT CAP REL COSTS-BLDG & FIXT	1. 00 1. 00	9	33. 38 33. 39
33. 40	CARRYFORWARD ADJ	A		CAP REL COSTS-BLDG & TIXT	1.00	9	33. 40
33. 41			0		0.00	0	33. 41
33. 42 33. 43	START UP COSTS	A	-3, 140, 312 0	ADMINISTRATIVE & GENERAL	5. 00 0. 00	0	33. 42 33. 43
33. 44			Ö		0. 00	Ö	33. 44
33. 45			0		0.00	0	33. 45
33. 46 33. 47			0		0. 00 0. 00	0	33. 46 33. 47
33. 48			0		0. 00	О	33. 48
33. 49 33. 50			0		0. 00 0. 00	0	33. 49 33. 50
33. 51			0		0.00	o	33. 51
33. 52			0		0.00	0	33. 52
33. 53 33. 54			0		0. 00 0. 00		33. 53 33. 54
33. 55			Ö		0.00	Ö	33. 55
33. 56			0		0.00	0	33. 56
33. 57 33. 58			0		0. 00 0. 00	0	33. 57 33. 58
33. 59			0		0. 00	0	33. 59
33. 60 33. 61			0		0. 00 0. 00	0	33. 60 33. 61
33. 62			0		0.00	o	33. 62
33. 63			0		0. 00	0	33. 63
33. 64 33. 65			0		0. 00 0. 00	0 	33. 64 33. 65
33. 66			Ö		0. 00	ō	33. 66
33. 67			0		0.00	0	33. 67
33. 68 33. 69			0		0. 00 0. 00	0	33. 68 33. 69
	•				- 77	1	

From 01/01/2016 | To 12/31/2016 | Date/Time Prepared:

					0 12/31/2010	5/23/2017 10:	pareu. 42 am
				Expense Classification on	Worksheet A		
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basis/Code (2)	Amount	Cost Center	Li ne #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4. 00	5. 00	
33. 70			0		0.00	0	33. 70
33. 71			0		0.00	0	33. 71
33. 72			0		0.00	0	33. 72
33. 73			0		0.00	0	33. 73
33. 74			0		0.00	0	33. 74
33. 75			0		0.00		33. 75
33. 76			0		0.00	0	33. 76
33. 77			0		0.00	0	33. 77
33. 78			0		0.00		33. 78
33. 79			0		0.00		33. 79
33. 80			0		0.00		33. 80
33. 81			0		0.00		33. 81
33. 82			0		0.00		33. 82
33. 83			0		0.00	0	33. 83
33. 84			0		0.00	0	33. 84
33. 85			0		0.00	0	33. 85
33. 86	TOTAL (		0		0.00	0	33. 86
50. 00	TOTAL (sum of lines 1 thru 49)		5, 584, 079				50. 00
	(Transfer to Worksheet A,						
	column 6, line 200.)						<u> </u>

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

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

B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.

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

Worksheet A-8-1

809, 618

22.048

264, 192

122, 590

611, 539

38.673

2, 176, 440

70, 639, 659

4.10

4.12

4 13

4.14

4.15

4. 16

5.00

809,618

264, 192

122, 590

611, 539

38, 673

5, 936, 500

86, 741, 412

22, 048

From 01/01/2016 12/31/2016 Date/Time Prepared: 5/23/2017 10:42 am Li ne No. Cost Center Expense I tems Amount of Amount Allowable Cost Included in Wks. A, column 1.00 3.00 4.00 5.00 2.00 COSTS INCURRED AND ADJUSTMENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED HOME OFFICE COSTS 1.00 1.00 1. 00 CAP REL COSTS-BLDG & FIXT 3.019.203 2.00 1, 314, 118 2.00 3.00 2.00 CAP REL COSTS-MVBLE EQUIP 633, 651 0 3.00 4.00 4. 00 EMPLOYEE BENEFITS DEPARTMENT 14, 500, 516 0 4.00 4.01 5. 00 ADMINISTRATIVE & GENERAL 44, 829, 858 51, 546, 876 4.01 5. 00 ADMINISTRATIVE & GENERAL 2, 209, 746 2, 209, 746 4 02 4 02 13.00 NURSING ADMINISTRATION 4.03 243, 785 0 4.03 4.04 16.00 MEDICAL RECORDS & LIBRARY 1, 975, 674 4.04 4.05 30. 00 ADULTS & PEDIATRICS 674.068 674.068 4 05 43. 00 NURSERY 4.06 869, 790 869, 790 4.06 4.07 50. 00 OPERATING ROOM 314, 800 314, 800 4.07 60. 00 LABORATORY 4.08 9, 506, 382 9, 506, 382 4.08 66. 00 PHYSI CAL THERAPY 158, 779 158 779 4 09 4 09

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3.00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	ED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6.00	C		0. 00	IU HEALTH SIP	0. 00	6. 00
7.00	С		0.00	IU HEALTH PAOLI	0.00	7. 00
8.00	В	IU HEALTH	0.00		0. 00	8. 00
9.00			0.00		0. 00	9. 00
10.00			0.00		0. 00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

(1) Use the following symbols to indicate interrelationship to related organizations:

70. 00 ELECTROENCEPHALOGRAPHY

190. 10 MORGAN OP BEHAVIORAL HEALTH

90. 02 WOUND CARE CENTER

95. 00 AMBULANCE SERVICES

90. 00 CLI NI C

91. 00 EMERGENCY

190. 01 PROMPTCARE

- 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.
- Provider has financial interest in corporation, partnership, or other organization.
- Director, officer, administrator, or key person of provider or relative of such person has financial interest in related
- Individual is director, officer, administrator, or key person of provider and related organization.
- Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

4.10

4.11

4.12

4.13

4.14

4.15

4.16

5.00

9 4.01 -6, 717, 018 0 4.01 4 02 4 02 4.03 243, 785 4.03 4.04 1, 975, 674 0 4.04 0 4.05 0 4.05 0 4.06 0 4.06 4.07 0 0 4.07 0 4.08 0 4.08 0 0 4 09 4 09 4.10 0 4. 10 4.11 0 0 4.11 4.12 0 0 4.12 4.13 3, 760, 060 4. 13 4.14 0 4.14 0 4.15 0 4. 15 0 4. 16 4.16 0 5.00 16, 101, 753 5.00

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

Related Organization(s) and/or Home Office		
Type of Business		
6. 00		
 B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

r er ilibu	rsement under title XVIII.		
6.00	PHYSICIAN GROUP		6. 00
7.00	HOSPI TAL		7.00
8.00			8.00
9.00			9. 00
10.00			10.00
100.00			100.00

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

Health Financial Systems
PROVIDER BASED PHYSICIAN ADJUSTMENT

Provider CCN: 15-0051

In Lieu of Form CMS-2552-10
Worksheet A-8-2

Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 5/23/2017 10:42 am

							5/23/2017 10:	42 am
	Wkst. A Line #		Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	Remuneration	Component	Component		ider Component	
	4 00	0.00	2.00	4.00	F 00		Hours	
1 00	1.00	2. 00 ADMI NI STRATI VE & GENERAL	3.00	4.00	5. 00	6. 00 246, 400	7. 00	1. 00
1. 00 2. 00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	1, 278, 025 710, 486	1, 278, 025 710, 486	0		0	
3. 00		ADMINISTRATIVE & GENERAL	387, 703		0	246, 400		
4. 00		ADMINISTRATIVE & GENERAL	2, 815, 529		0	197, 500		
5. 00		ADMINISTRATIVE & GENERAL	806, 118		0	239, 400		5. 00
6. 00		ADMINISTRATIVE & GENERAL	149, 263		28, 154	211, 500	244	6. 00
7. 00		ADMINISTRATIVE & GENERAL	77, 190		20, 134	211, 500	0	ı
8. 00		ADMINISTRATIVE & GENERAL	606, 790		0	211, 500		ı
9. 00		ADMINISTRATIVE & GENERAL	119, 349		0	211, 500	Ö	
10. 00		ADMINISTRATIVE & GENERAL	97, 948			211, 500	Ö	10.00
11. 00		ADMINISTRATIVE & GENERAL	72, 290		0	211, 500	o o	i e
12. 00		ADMINISTRATIVE & GENERAL	75, 000		0	211, 500	o o	
13. 00		ADMINISTRATIVE & GENERAL	322, 100		14, 175		109	
14. 00		ADMINISTRATIVE & GENERAL	655, 980		0	211, 500	0	i e
15. 00		ADMINISTRATIVE & GENERAL	75, 813		41, 458	181, 300	937	15. 00
16. 00		NURSERY	869, 790		636, 330	237, 100	7, 473	16. 00
17. 00	5. 00	ADMINISTRATIVE & GENERAL	100, 000	100, 000	0	211, 500	o	17. 00
18. 00	5. 00	ADMINISTRATIVE & GENERAL	36, 300	36, 300	0	271, 900	o	18. 00
19. 00	5. 00	ADMINISTRATIVE & GENERAL	308, 568	0	308, 568	260, 300	1, 749	19. 00
20.00	66. 00	PHYSI CAL THERAPY	108, 779	108, 779	0	211, 500	0	20. 00
21.00		WOUND CARE CENTER	164, 192	164, 192	0	211, 500	0	21. 00
22. 00	69. 00	ELECTROCARDI OLOGY	114, 329	54, 886	59, 443	211, 500	1, 070	22. 00
23.00	30. 00	ADULTS & PEDIATRICS	485, 738	464, 610	21, 128	181, 300	443	23. 00
24.00	90. 05	OP PSYCH CLINIC	185, 657	33, 458	152, 199	181, 300	3, 128	24.00
25. 00	91. 00	EMERGENCY	5, 537, 502		0	197, 500	0	25. 00
200.00			16, 160, 439	14, 898, 984	1, 261, 455		15, 153	
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit				of Malpractice	i
				Limit	Conti nui ng	Share of col.	Insurance	
	1.00			2.22	Education	12	44.00	
1 00	1. 00	2.00	8. 00	9. 00	12. 00	13. 00	14. 00	4.00
1.00		ADMINISTRATIVE & GENERAL	0	-	0		0	
2.00		ADMINISTRATIVE & GENERAL	0	0		0	0	
3.00		ADMINISTRATIVE & GENERAL	0	0	0	0	0	
4. 00 5. 00		ADMINISTRATIVE & GENERAL	0	0	0	ا	0	
6. 00		ADMINISTRATIVE & GENERAL	24, 811		0	ا	0	
7. 00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL	24,011	1, 241	0	ا		
8. 00		ADMINISTRATIVE & GENERAL		0	0	٥		
9. 00		ADMINISTRATIVE & GENERAL		0	0	ام	0	
10. 00		ADMINISTRATIVE & GENERAL		0	0	0		
11. 00		ADMINISTRATIVE & GENERAL		0	o o	0	Ö	
12. 00		ADMINISTRATIVE & GENERAL	0	Ö	ő	0	Ö	12. 00
13. 00		ADMINISTRATIVE & GENERAL	9, 501	475	ő	0	l o	
14. 00		ADMINISTRATIVE & GENERAL	,, 551	0	0	ا م	o	14. 00
15. 00		ADMINISTRATIVE & GENERAL	81, 672	4, 084	0	ا م	ol	i
16. 00		NURSERY	851, 850		-	0	ol	
17. 00		ADMINISTRATIVE & GENERAL	0	0	0	ol	o	l
18. 00		ADMINISTRATIVE & GENERAL	0	0	0	0	o	
19. 00		ADMINISTRATIVE & GENERAL	218, 877	10, 944	0	ol	o	
20.00	66. 00	PHYSI CAL THERAPY	0	0	0	ol	o	
21. 00		WOUND CARE CENTER	0	0	0	o <sup>l</sup>	0	
22. 00		ELECTROCARDI OLOGY	108, 800	5, 440	0	o <sup>l</sup>	0	
23. 00	30. 00	ADULTS & PEDIATRICS	38, 613	1, 931	0	ol	0	23. 00
24.00	90. 05	OP PSYCH CLINIC	272, 647	13, 632	0	ol	0	24.00
25. 00	91. 00	EMERGENCY	0	0	0	ol	0	25. 00
200.00			1, 606, 771	80, 340	0	0	0	200. 00
	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment		
		I denti fi er	Component	Limit	Di sal I owance			
			Share of col.					
	4.00	2.22	14	1/ 00	17.00	10.00		
1 00	1.00	2. 00	15. 00	16. 00	17. 00	18.00		4.60
1.00		ADMINISTRATIVE & GENERAL	]	0	0	1, 278, 025		1.00
2.00		ADMINISTRATIVE & GENERAL	0	0	0	710, 486		2.00
3.00		ADMINISTRATIVE & GENERAL		0	0	387, 703		3.00
4.00		ADMINISTRATIVE & GENERAL		0	0	2, 815, 529		4.00
5.00		ADMINISTRATIVE & GENERAL		24 011	2 242	806, 118		5. 00
6. 00		ADMINISTRATIVE & GENERAL		24, 811	3, 343	124, 452 77, 190		6. 00
7. 00 8. 00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL				77, 190 606, 790		7. 00 8. 00
9. 00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL				606, 790 119, 349		9. 00
9. 00 10. 00		ADMINISTRATIVE & GENERAL ADMINISTRATIVE & GENERAL		0	0	97, 948		10.00
								, 10.00
11 00			1	_				1 11 00
11. 00		ADMINISTRATIVE & GENERAL	0	_				11. 00

Date/Time Prepared: 5/23/2017 10:42 am 12/31/2016 Cost Center/Physician Provi der Wkst. A Line # Adjusted RCE RCE Adjustment I denti fi er Component Li mi t Di sal I owance Share of col. 14 1.00 2.00 15. 00 16.00 17. 00 18. 00 12. 00 5. 00 ADMINISTRATIVE & GENERAL 75,000 12.00 13.00 5. 00 ADMINISTRATIVE & GENERAL 0 9, 501 4,674 312, 599 13.00 0 14.00 5. 00 ADMINISTRATIVE & GENERAL 0 655, 980 14.00 0 5. 00 ADMINISTRATIVE & GENERAL 15.00 81, 672 34, 355 15.00 0 43. 00 NURSERY 0 16.00 851, 850 233, 460 16.00 17.00 5. 00 ADMINISTRATIVE & GENERAL 0 100,000 17.00 0 5. 00 ADMINISTRATIVE & GENERAL 36, 300 18.00 18.00 5. 00 ADMINISTRATIVE & GENERAL 218, 877 89, 691 89, 691 19.00 19.00 66. 00 PHYSI CAL THERAPY 20.00 0 0 0 108, 779 20.00 21.00 90. 02 WOUND CARE CENTER 164, 192 21.00 69. 00 ELECTROCARDI OLOGY 22.00 54, 886 108, 800 0 22.00 30.00 ADULTS & PEDIATRICS 23.00 38, 613 0 464, 610 23.00 24.00 90. 05 OP PSYCH CLINIC 0 272, 647 33, 458 24.00

1, 606, 771

5, 537, 502

14, 996, 692

97, 708

25.00

200.00

25.00

200.00

91. 00 EMERGENCY

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051 Peri od: Worksheet B From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/23/2017 10:42 am CAPITAL RELATED COSTS Cost Center Description Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal for Cost **BENEFITS** DEPARTMENT Allocation (from Wkst A col. 7) 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 17, 564, 530 17, 564, 530 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 8, 145, 678 8, 145, 678 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 22, 350, 014 169, 948 80,828 22, 600, 790 4.00 00500 ADMINISTRATIVE & GENERAL 3, 610, 973 63, 729, 582 5 00 56, 654, 462 1, 717, 403 1, 746, 744 5 00 7.00 00700 OPERATION OF PLANT 8, 812, 576 2,076,097 987, 406 568, 290 12, 444, 369 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 125, 971 29, 661 14, 107 169, 739 8.00 00900 HOUSEKEEPI NG 2, 475, 151 64, 281 30, 573 386, 908 2, 956, 913 9.00 9.00 01000 DI ETARY 1, 950, 273 97 890 2, 528, 645 205, 822 274,660 10 00 10.00 11.00 01100 CAFETERI A 492, 308 110, 921 52, 755 205, 486 861, 470 11.00 01300 NURSING ADMINISTRATION 5, 117, 276 147, 497 940, 306 6, 515, 203 13.00 310, 124 13.00 01400 CENTRAL SERVICES & SUPPLY 9, 975, 762 100, 173 47, 643 10, 123, 578 14.00 14.00 47, 336 1, 011, 742 15.00 01500 PHARMACY 5, 126, 692 99, 528 6, 285, 298 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 2, 299, 052 112, 635 53, 570 2, 465, 257 16.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 18.00 01851 CENTRAL STERILIZATION 483, 900 57, 331 87, 953 656, 451 18.01 18.01 27, 267 23.00 02300 PARAMED ED PRGM-PHARMACY RESIDENCY 254, 680 C 57.774 312, 454 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 25, 456, 198 2, 464, 457 1, 172, 113 4, 658, 972 33, 751, 740 30.00 03100 INTENSIVE CARE UNIT 31.00 3, 464, 601 189, 433 90.096 600, 766 4, 344, 896 31.00 04100 SUBPROVI DER - I RF 41.00 1, 112, 630 224, 182 106, 623 204, 761 1, 648, 196 41.00 04200 SUBPROVI DER 42.00 42.00 0 52, 176 3, 0<u>96, 681</u> 04300 NURSERY 2, 585, 933 109, 704 348, 868 43.00 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 7, 044, 773 905, 412 430, 620 984, 294 9, 365, 099 50.00 05001 CV SURGERY 50.01 50.01 51.00 05100 RECOVERY ROOM 3, 089, 618 63, 876 30, 380 618, 968 3, 802, 842 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 3, 221, 839 637, 798 303, 341 580, 447 4, 743, 425 52.00 05300 ANESTHESI OLOGY 53.00 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 4, 043, 634 390, 406 185, 680 740, 905 5, 360, 625 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 3, 405, 962 404, 896 192, 571 493, 111 4, 496, 540 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 57.00 1,007,884 23, 873 11, 354 132, 632 1, 175, 743 57.00 05800 MAGNETIC RESONANCE I MAGING (MRI) 35, 781 17, 018 767, 790 58.00 626, 682 88.309 58.00 05900 CARDIAC CATHETERIZATION 56, 796 1, 682, 533 119, 419 244, 309 2, 103, 057 59.00 59 00 60.00 06000 LABORATORY 10, 485, 234 322, 125 153, 205 83 10, 960, 647 60.00 64.00 06400 INTRAVENOUS THERAPY 64.00 0 2, 524, 898 65 00 06500 RESPIRATORY THERAPY 2.067.070 421, 921 24 334 11 573 65 00 06600 PHYSI CAL THERAPY 66.00 7, 036, 464 292, 058 138, 905 1, 423, 789 8, 891, 216 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68.00 68.00 C 0 06900 ELECTROCARDI OLOGY 21, 507 177, 499 892, 917 45 220 1, 137, 143 69 00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 1,005,566 79,803 37, 955 43, 250 1, 166, 574 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 7, 885, 795 7, 885, 795 71.00 C 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 13, 899, 799 0 13, 899, 799 72.00 0 07300 DRUGS CHARGED TO PATIENTS 22, 466, 617 73.00 22, 466, 617 0 73 00 73.01 07302 OP PHARMACY 345, 457 15, 872 7,549 72, 181 441, 059 73.01 07400 RENAL DIALYSIS 6, 909 74.00 913, 894 14, 526 935, 329 74.00 07500 ASC (NON-DISTINCT PART) 75.00 0 75.00 0 C 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 75.01 0 75 01 949, 221 07697 CARDIAC REHABILITATION 700, 129 69, 295 32, 957 146, 840 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 1, 909, 998 09000 CLINIC 1, 379, 314 165, 948 78.926 285, 810 90.00 90.01 09001 OP ONCOLOGY INFUSION CENTER 1, 201, 328 62, 235 29, 599 233, 509 1, 526, 671 90.01 09002 WOUND CARE CENTER 793, 023 40, 945 176, 372 1, 096, 429 90.02 86, 089 90.02 09003 PAIN CLINIC 26, 303 54, 016 421, 466 90.03 285.843 55. 304 90.03 78, 908 373, 001 90.05 09005 OP PSYCH CLINIC 2, 398, 086 90.05 1, 780, 266 165, 911 91.00 09100 EMERGENCY 6, 659, 262 488, 109 232, 148 1, 010, 862 8, 390, 381 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 0 92.00 OTHER REIMBURSABLE COST CENTERS 94 00 09400 HOME PROGRAM DIALYSIS Λ 94 00 95. 00 09500 AMBULANCE SERVICES 5, 477, 964 260, 904 1, 044, 955 6, 907, 911 95.00 124, 088 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 3, 503, 590 112, 322 53, 421 532, 042 4, 201, 375 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00

4, 102, 444

88, 412

42,049

530, 112

114.00

0 115.00

4, 763, 017 116. 00

116. 00 11600 HOSPI CE

114.00 11400 UTILIZATION REVIEW-SNF

115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2016 Part I Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051

			T <sub>1</sub>	rom 01/01/2016 o 12/31/2016	Part I Date/Time Pre 5/23/2017 10:	
		CAPI TAL REL	CAPITAL RELATED COSTS			
Cost Center Description	Net Expenses	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Subtotal	
	for Cost Allocation			BENEFITS DEPARTMENT		
	(from Wkst A			DEPARTMENT		
	col. 7)					
	0	1.00	2. 00	4. 00	4A	
118.00 SUBTOTALS (SUM OF LINES 1-117)	291, 452, 588	14, 865, 198	7, 069, 990	21, 502, 447	286, 579, 225	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	113, 529	17, 384	·		150, 777	
190. 01 19001 PROMPTCARE	1, 630, 212	118, 645	·		1, 985, 618	
190. 02 19002 RENTAL PROPERTIES	21, 047	860, 469	·		1, 290, 761	
190. 03 19003 OLCOTT	296, 721	50, 695	24, 111	56, 675	428, 202	
190. 04 19004 PHYSICIAN RECRUITMENT	0	0	0	0		190. 04
190. 05 19005 FOUNDATI ON	766, 686	118, 847	56, 525	138, 617	1, 080, 675	
190. 06 19006 MARKETI NG	149, 600	0	0	0	149, 600	
190. 07 19007 HME STORE	374, 187	0	0	74, 277	448, 464	
190. 08 19008 UNUSED SPACE	0	573, 885	·	0	846, 829	
190. 09 19009 CLINI CAL TRI ALS	487, 692	16, 536	7, 865	62, 782	574, 875	
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	196, 666	0	0	41, 135	237, 801	
190. 11 19011 COMMUNITY HEALTH SERVICES	3, 086, 616	505, 254	240, 302	532, 928	4, 365, 100	
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	10, 400, 972	0	0	0	10, 400, 972	1
194.01 07951 IU HEALTH BEDFORD HOSPITAL	14, 805, 317	0	0	0	14, 805, 317	
194.02 07952 IU HEALTH MORGAN HOSPITAL	7, 712, 812	0	0	0	7, 712, 812	
194.03 07953 IU HEALTH SIP	3	437, 617	0	0	437, 620	
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00   TOTAL (sum lines 118-201)	331, 494, 648	17, 564, 530	8, 145, 678	22, 600, 790	331, 494, 648	202. 00

Provider CCN: 15-0051

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/23/2017 10: 42 am

				''	0 12/31/2010	5/23/2017 10:	
	Cost Center Description	ADMI NI STRATI VE		LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE	0.00	10.00	
	GENERAL SERVICE COST CENTERS	5. 00	7. 00	8. 00	9. 00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	63, 729, 582					5. 00
7.00	00700 OPERATION OF PLANT	2, 961, 834	15, 406, 203				7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE	40, 399	39, 032				8. 00
9.00	00900 HOUSEKEEPI NG	703, 763	84, 589			0 447 504	9. 00
10.00	01000 DI ETARY	601, 833	270, 846		15, 200	3, 416, 524	10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON	205, 035 1, 550, 657	145, 963 408, 100		7, 451	0	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	2, 409, 472	131, 820		17, 883	0	14.00
15. 00	01500 PHARMACY	1, 495, 939	130, 971			0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	586, 746	148, 219		10, 432	0	16. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	o o	0	0	18. 00
18. 01	01851 CENTRAL STERILIZATION	156, 239	75, 444	3, 825	o	0	18. 01
23. 00	02300 PARAMED ED PRGM-PHARMACY RESIDENCY	74, 366	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	8, 033, 003	3, 243, 036		1, 583, 825	2, 926, 436	1
31.00	03100 I NTENSI VE CARE UNI T	1, 034, 111	249, 280	•		276, 614	31.00
41. 00 42. 00	04100   SUBPROVI DER	392, 281	295, 007	0	102, 230	213, 474 0	41. 00 42. 00
43. 00	04300 NURSERY	737, 029	144, 362	ή	154, 687	0	43.00
43.00	ANCILLARY SERVICE COST CENTERS	737,027	144, 302	. 1,010	154, 007		75.00
50.00	05000 OPERATI NG ROOM	2, 228, 950	1, 191, 454	25, 798	266, 753	0	50.00
50. 01	05001 CV SURGERY	0	0	0	o	0	50. 01
51. 00	05100 RECOVERY ROOM	905, 099	84, 056	0	18, 777	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	1, 128, 964	839, 294	20, 167	442, 004	0	52.00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00	05400 RADI OLOGY - DI AGNOSTI C	1, 275, 861	513, 745			0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	1, 070, 203	532, 813	0	15, 498	0	55. 00
56. 00 57. 00	05600	279, 834	31, 415	0	6, 855	0	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	182, 739	47, 086	1	9, 836	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	500, 540	157, 146			0	59.00
60. 00	06000 LABORATORY	2, 608, 700	423, 892		2, 086	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	.20, 0,2	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	600, 941	32, 021	0	Ö	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	2, 116, 163	384, 327	1	71, 829	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	O	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	270, 647	59, 506		29, 507	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	277, 652	105, 015	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1, 876, 867	0	0	0	0	71.00
72. 00 73. 00	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	3, 308, 236 5, 347, 190	0		102, 528	0	72. 00 73. 00
73. 00	07300 DROGS CHARGED TO PATTENTS	104, 975	20, 887	0	·	0	73.00
	07400 RENAL DIALYSIS	222, 614	19, 116	1		Ö	74. 00
75. 00	1 1	0	. , ,	o o	0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	O	O	o o	o	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	225, 920	91, 188	0	o	0	76. 97
	OUTPATIENT SERVICE COST CENTERS			,			
90.00	09000 CLI NI C	454, 591	218, 375			0	90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	363, 357	81, 897		0	0	90. 01
90. 02	09002 WOUND CARE CENTER	260, 957	113, 287		0	0	90. 02
90. 03	09003 PALN CLINIC	100, 311	72, 775 218, 326		0	0	90.03
90. 05 91. 00	09005 OP PSYCH CLINIC 09100 EMERGENCY	570, 759 1, 996, 961	218, 326 642, 315	1	417, 863	0	90. 05 91. 00
91.00		1, 990, 901	042, 313	17,009	417, 003	0	91.00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	C	0	ol	0	94.00
	09500 AMBULANCE SERVICES	1, 644, 124	343, 330	0	o	0	95. 00
100.0	10000 I&R SERVICES-NOT APPRVD PRGM	O	0	0	o	0	100. 00
101.0	10100 HOME HEALTH AGENCY	999, 952	147, 807	0	0	0	101. 00
	SPECIAL PURPOSE COST CENTERS						
	11300 I NTEREST EXPENSE						113. 00
	0 11400 UTILIZATION REVIEW-SNF						114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	1 122 (27	114 244	0	42.010		115.00
116.0	11600 HOSPICE SUBTOTALS (SUM OF LINES 1-117)	1, 133, 627 53, 039, 441	116, 344 11, 854, 086	1	42, 919 3, 741, 390	3, 416, 524	116.00
110.0	NONREI MBURSABLE COST CENTERS	J JJ, UJ9, 44 I	11, 004, 080	را <u>۲</u> 40, 349	3, 141, 390	3, 410, 324	1110.00
190 0	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	35, 886	22, 876	0	3, 875	Ω	190. 00
	1 19001 PROMPTCARE	472, 589	156, 127				190. 01
	2 19002 RENTAL PROPERTI ES	307, 209	1, 132, 312		l .		190. 02

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS

Provider CCN: 15-0051

					5/23/2017 10:	42 am
Cost Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	& GENERAL	PLANT	LINEN SERVICE			
	5. 00	7.00	8. 00	9. 00	10.00	
190. 03 19003 OLCOTT	101, 915	66, 711	0	0	0	190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	0	0	0	0	190. 04
190. 05 19005 FOUNDATI ON	257, 207	156, 394	0	0	0	190. 05
190. 06 19006 MARKETI NG	35, 606	0	0	0	0	190. 06
190.07 19007 HME STORE	106, 737	0	0	0	0	190. 07
190. 08 19008 UNUSED SPACE	201, 550	755, 190	0	0	0	190. 08
190. 09 19009 CLINICAL TRIALS	136, 824	21, 760	0	0	0	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	56, 598	0	0	0	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	1, 038, 920	664, 876	0	0	0	190. 11
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	2, 475, 494	0	0	0	0	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	3, 523, 754	0	0	0	0	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	1, 835, 696	0	0	0	0	194. 02
194.03 07953 IU HEALTH SIP	104, 156	575, 871	0	0	0	194. 03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	0	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	63, 729, 582	15, 406, 203	249, 170	3, 745, 265	3, 416, 524	202. 00

Provider CCN: 15-0051

			10	12/31/2010	Date/lime Pre 5/23/2017 10:	
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
	11. 00	13. 00	SUPPLY 14.00	15. 00	LI BRARY 16. 00	
GENERAL SERVICE COST CENTERS						
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 O0200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00   00400   EMPLOYEE BENEFITS DEPARTMENT 5. 00   00500   ADMINISTRATIVE & GENERAL						4. 00 5. 00
7.00 00700 OPERATION OF PLANT						7.00
8. 00   00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00   00900   HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	4 040 040					10.00
11. 00   01100   CAFETERI A 13. 00   01300   NURSI NG   ADMI NI STRATI ON	1, 219, 919 51, 050	8, 525, 010				11. 00 13. 00
14. 00   01400 CENTRAL SERVICES & SUPPLY	51,050	8, 525, 010	12, 682, 753			14.00
15. 00   01500 PHARMACY	49, 780	ő	28, 570	7, 990, 631		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	0	0	3, 210, 654	16. 00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18. 00
18. 01   01851   CENTRAL STERI LI ZATI ON	9, 171	0	90, 335	0	0	18. 01
23. 00   02300   PARAMED ED PRGM-PHARMACY RESIDENCY   I NPATIENT ROUTINE SERVICE COST CENTERS	0	U	0	O <sub>]</sub>	0	23. 00
30. 00 03000 ADULTS & PEDIATRICS	323, 303	4, 252, 946	715, 804	0	281, 667	30.00
31. 00 03100 INTENSIVE CARE UNIT	39, 703	224, 129	172, 172	0	40, 741	
41. 00   04100   SUBPROVI DER - 1 RF	13, 708	248, 151	23, 629	0	12, 707	41.00
42. 00   04200   SUBPROVI DER	0	0	0	0	0	42.00
43. 00 04300 NURSERY ANCI LLARY SERVI CE COST CENTERS	20, 239	470, 075	68, 342	0	29, 384	43.00
50. 00 05000 OPERATING ROOM	61, 088	398, 691	7, 110, 737	0	478, 858	50.00
50. 01   05001 CV SURGERY	01,000	0	0	Ö	0	50. 01
51.00 05100 RECOVERY ROOM	36, 108	58, 922	29, 662	0	71, 219	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	35, 311	720, 368	211, 618	0	80, 400	
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C	46, 704 26, 332	171, 685 94, 009	570, 170 214, 280	0	146, 515 162, 683	1
56. 00   05600   RADI 01 SOTOPE	20, 332	94, 009	214, 200	0	102, 003	56.00
57. 00 05700 CT SCAN	7, 656	Ö	47, 804	Ö	68, 802	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	5, 065	0	5, 329	0	22, 464	
59. 00 05900 CARDI AC CATHETERI ZATI ON	15, 022	254, 930	2, 410, 530	0	172, 453	
60. 00   06000   LABORATORY	10	0	0	0	288, 941	
64. 00   06400   I NTRAVENOUS   THERAPY 65. 00   06500   RESPI RATORY   THERAPY	24, 554	0	162, 657	0	0 27, 782	64. 00 65. 00
66. 00   06600 PHYSI CAL THERAPY	79, 407	414	26, 843	Ö	68, 611	
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	10, 589	75, 845	9, 108	0	59, 381	
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 461	0	22, 475	0	30, 094 104, 866	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	263, 502	
73. 00 07300 DRUGS CHARGED TO PATIENTS	o	o	0	7, 990, 631	359, 605	1
73. 01 07302 OP PHARMACY	3, 170	0	251	0		73. 01
74. 00   07400   RENAL DI ALYSI S	0	0	8, 619	0	9, 257	1
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01   03550  PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 97   07697  CARDI AC REHABI LI TATI ON	8, 244	54, 948	3, 138	0	0 7, 511	75. 01 76. 97
OUTPATIENT SERVICE COST CENTERS	0, 244	34, 740	3, 130	<u> </u>	7, 311	70.77
90. 00 09000 CLI NI C	12, 547	128, 712	4, 107	0	3, 877	90. 00
90.01 09001 OP ONCOLOGY INFUSION CENTER	14, 604	274, 409	136, 337	o	29, 473	
90. 02   09002   WOUND CARE CENTER	10, 239	97, 000	46, 972	0	11, 596	
90. 03   09003   PAIN CLINIC 90. 05   09005   OP PSYCH CLINIC	3, 527	37, 881	13, 091	0	4, 787	1
90. 05   09005   0P PSYCH CLINIC 91. 00   09100   EMERGENCY	16, 122 71, 737	116, 344 143, 264	576 403, 946	0	6, 256 242, 331	1
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	71,737	143, 204	403, 740	Ŭ	242, 331	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	
95. 00 09500 AMBULANCE SERVICES	92, 181	0	101, 937	0	98, 387	
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	25 004	217 140	0	0		100. 00 101. 00
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS	25, 004	216, 149	U	U	1, 194	1101.00
113. 00 11300   NTEREST EXPENSE						113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	О	0	0	o		115. 00
116. 00 11600 HOSPI CE	32, 535	320, 549		0		116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	1, 148, 171	8, 359, 421	12, 639, 039	7, 990, 631	3, 210, 654	1178.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 567	ol	O	0	n	190. 00
190. 01 19001 PROMPTCARE	13, 324	40, 944	33, 186	0	0	190. 00
				- 1		

Provider CCN: 15-0051

| Peri od: | Worksheet B | From 01/01/2016 | Part | | Date/Time Prepared: | 5/23/2017 | 10: 42 am

					5/23/2017 10:	42 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
190. 02 19002 RENTAL PROPERTIES	0	0	0	0	0	190. 02
190. 03 19003 OLCOTT	3, 415	21	49	0	0	190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	0	0	0	0	190. 04
190. 05 19005 FOUNDATI ON	6, 258	0	0	0	0	190. 05
190. 06 19006 MARKETI NG	0	0	0	0	0	190. 06
190.07 19007 HME STORE	2, 115	0	7, 766	0	0	190. 07
190. 08 19008 UNUSED SPACE	0	0	0	0	0	190. 08
190. 09 19009 CLINI CAL TRI ALS	3, 333	21, 528	25	0	0	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	1, 393	0	0	0	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	40, 343	103, 096	2, 672	0	0	190. 11
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	0	0	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	0	0	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0	194. 02
194.03 07953 IU HEALTH SIP	0	0	16	0	0	194. 03
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0	o	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	1, 219, 919	8, 525, 010	12, 682, 753	7, 990, 631	3, 210, 654	202. 00

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

					To 12/31/2016	Date/lime Pre 5/23/2017 10:	
		OTHER GENE	RAL SERVICE			0,20,201, 10.	TE GIII
	Cost Center Description	(SPECIFY)	CENTRAL STERI LI ZATI ON	PARAMED ED PRGM-PHARMAC' RESI DENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		18. 00	18. 01	23. 00	24.00	25.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT						2. 00 4. 00
5. 00	00500 ADMI NI STRATI VE & GENERAL						5. 00
7. 00	00700 OPERATION OF PLANT						7. 00
8.00	00800 LAUNDRY & LINEN SERVICE						8. 00
9.00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10.00
11. 00 13. 00	O1100   CAFETERI A   O1300   NURSI NG   ADMI NI STRATI ON						11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY						14. 00
15. 00	01500 PHARMACY						15. 00
16.00	01600 MEDICAL RECORDS & LIBRARY						16. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	C	001 1/5				18. 00
18. 01 23. 00	O1851   CENTRAL STERI LIZATION   O2300   PARAMED ED PRGM-PHARMACY RESIDENCY		991, 465 0	1	0		18. 01 23. 00
23.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		, 0	360, 62	<u> </u>		23.00
30.00	03000 ADULTS & PEDI ATRI CS	C	41, 861		0 55, 297, 122	2 0	30. 00
31.00	03100 INTENSIVE CARE UNIT	C	1, 288		0 6, 659, 148	0	31. 00
41.00	04100 SUBPROVI DER – I RF	C	0		0 2, 949, 383		41. 00
42. 00 43. 00	04200   SUBPROVI DER   04300   NURSERY		0 11, 270		0 0 4, 733, 887	1	42. 00 43. 00
43.00	ANCI LLARY SERVI CE COST CENTERS		11,270		0 4, 733, 887	1 0	43.00
50.00	05000 OPERATI NG ROOM	C	895, 508		0 22, 022, 936	0	50. 00
50. 01	05001 CV SURGERY	C	0		0 0	0	50. 01
51. 00	05100 RECOVERY ROOM	C	0		0 5, 006, 685		51. 00
52. 00 53. 00	05200   DELI VERY ROOM & LABOR ROOM   05300   ANESTHESI OLOGY		0		0 8, 221, 551 0 0		52. 00 53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		5, 152		0 8, 180, 584		54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C		0, 102	1	0 6, 612, 358		55. 00
56.00	05600 RADI OI SOTOPE	C	0		o c		56. 00
57. 00	05700 CT SCAN	C	0	l	0 1, 618, 109	1	57. 00
58. 00	O5800   MAGNETIC RESONANCE I MAGING (MRI)		0		0 1, 040, 309	1	58. 00
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY		7, 406		0 5, 698, 918 0 14, 284, 383		59. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY		o o		0 11, 201, 000		64. 00
65. 00	06500 RESPI RATORY THERAPY	C	4, 508		0 3, 377, 361	0	65. 00
66.00	06600 PHYSI CAL THERAPY	C	0	•	0 11, 652, 857	1	66. 00
67. 00 68. 00	O6700   OCCUPATI ONAL THERAPY   O6800   SPEECH PATHOLOGY		0		0 0	0	67. 00 68. 00
69. 00	06900 ELECTROCARDI OLOGY		8, 372		0 1, 660, 098	1	69. 00
	07000 ELECTROENCEPHALOGRAPHY	i c	4, 830		0 1, 610, 101	1	70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0		0 9, 867, 528	0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	C	0		0 17, 471, 537	1	72. 00
73. 00 73. 01	O7300   DRUGS CHARGED TO PATIENTS   O7302   OP PHARMACY		0	386, 82		1	73. 00 73. 01
74. 00	07400 RENAL DIALYSIS		0	l	0 575, 592 0 1, 195, 531		74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	C	0		0 0		75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	C	0		0 0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	C	0		0 1, 340, 170	0	76. 97
00 00	OUTPATIENT SERVICE COST CENTERS  O9000 CLINIC		0		0 2, 732, 207	0	90. 00
90. 00	09001 OP ONCOLOGY INFUSION CENTER		0		0 2, 732, 207 0 2, 426, 748		90.00
	09002 WOUND CARE CENTER	C	Ō		0 1, 636, 480	1	90. 02
90. 03	09003 PAIN CLINIC	C	322		0 654, 160		90. 03
90.05	09005 OP PSYCH CLINIC	C	0		0 3, 326, 469	1	90. 05
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)		4, 830		0 12, 331, 297	0 0	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
	09400 HOME PROGRAM DIALYSIS	C	0		0 0	0	94. 00
	09500 AMBULANCE SERVICES	C	0		9, 187, 870		95. 00
	10000 I &R SERVI CES-NOT APPRVD PRGM	C	0		0 5 500 001		100.00
101.00	10100 HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	C	<u>ı</u> 0		0 5, 598, 081	0	101. 00
113. 00	11300 INTEREST EXPENSE						113. 00
114.00	11400 UTILIZATION REVIEW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	C	0		0 0	1	115. 00
116.00	11600 H0SPI CE	[ C	0		0 6, 422, 451	1 0	116. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2016 Part I Provider CCN: 15-0051

			T	o 12/31/2016		
	OTHER GENER	RAL SERVICE				
Cost Center Description	(SPECI FY)	CENTRAL	PARAMED ED	Subtotal	Intern &	
		STERI LI ZATI ON	PRGM-PHARMACY		Residents Cost	
			RESI DENCY		& Post	
					Stepdown	
	18. 00	18. 01	23. 00	24.00	Adjustments 25.00	
118.00 SUBTOTALS (SUM OF LINES 1-117)	10.00					118. 00
NONREI MBURSABLE COST CENTERS		700,017	000,020	272,010,002		1110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	214, 981	0	190. 00
190. 01 19001 PROMPTCARE	0	322	0	2, 702, 731	0	190. 01
190. 02 19002 RENTAL PROPERTIES	0	0	0	2, 730, 282	0	190. 02
190. 03 19003 OLCOTT	0	0	0	600, 313	0	190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	0	0		190. 04
190. 05 19005 FOUNDATI ON	0	0	0	1, 500, 534		190. 05
190. 06 19006 MARKETI NG	0	0	0	185, 206		190. 06
190. 07 19007 HME STORE	0	0	0	565, 082		190. 07
190. 08 19008 UNUSED SPACE	0	0	0	1, 803, 569		190. 08
190. 09 19009 CLINICAL TRIALS	0	0	0	758, 345		190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	295, 792		190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	0	0	6, 215, 007		190. 11
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194. 00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	12, 876, 466		194. 00
194. 01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	18, 329, 071		194. 01
194. 02 07952 I U HEALTH MORGAN HOSPI TAL	0	0	0	9, 548, 508		194. 02
194. 03 07953 I U HEALTH SI P	0	5, 796	0	1, 123, 459		194. 03
200.00 Cross Foot Adjustments			0	0		200.00
201.00 Negative Cost Centers	0	001 445	20/ 222	0		201. 00
202.00   TOTAL (sum lines 118-201)	0	991, 465	386, 820	331, 494, 648	1 0	202. 00

| In Lieu of Form CMS-2552-10 | Period: Worksheet B | From 01/01/2016 Part I | To 12/31/2016 Date/Time Prepared: 5/23/2017 10: 42 am Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 15-0051

		5/23/2017 10: 42 am
Cost Center Description	Total	0, 20, 2017 10. 12 dill
	26. 00	
GENERAL SERVICE COST CENTERS		4.00
1.00 O0100 CAP REL COSTS-BLDG & FLXT		1.00
2. 00   00200 CAP REL COSTS-MVBLE EQUI P		2.00
4.00   00400   EMPLOYEE BENEFITS DEPARTMENT 5.00   00500   ADMINISTRATIVE & GENERAL		4.00
7.00   OO700   OPERATION OF PLANT		5. 00 7. 00
8.00   00800   LAUNDRY & LINEN SERVICE		8.00
9. 00   00900   HOUSEKEEPI NG		9.00
10. 00   01000 DI ETARY		10.00
11. 00   01100   CAFETERI A		11.00
13. 00   01300   NURSI NG ADMI NI STRATI ON		13.00
14. 00 01400 CENTRAL SERVI CES & SUPPLY		13. 30
15. 00   01500   PHARMACY		15.00
16. 00 01600 MEDICAL RECORDS & LI BRARY		16. 00
18. 00 01850 OTHER GENERAL SERVICE (SPECIFY)		18. 00
18. 01 01851 CENTRAL STERILIZATION		18. 01
23. 00 02300 PARAMED ED PRGM-PHARMACY RESIDENCY		23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		20.00
30. 00 03000 ADULTS & PEDIATRICS	55, 297, 122	30.00
31. 00 03100 I NTENSI VE CARE UNI T	6, 659, 148	31. 00
41. 00   04100   SUBPROVI DER -   RF	2, 949, 383	41. 00
42. 00   04200   SUBPROVI DER	0	42.00
43. 00 04300 NURSERY	4, 733, 887	43.00
ANCILLARY SERVICE COST CENTERS		
50. 00 05000 OPERATI NG ROOM	22, 022, 936	50.00
50. 01   05001   CV   SURGERY	0	50. 01
51.00 05100 RECOVERY ROOM	5, 006, 685	51. 00
52.00 05200 DELIVERY ROOM & LABOR ROOM	8, 221, 551	52.00
53. 00   05300   ANESTHESI OLOGY	o	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	8, 180, 584	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	6, 612, 358	55.00
56. 00   05600   RADI 0I SOTOPE	0	56.00
57. 00 05700 CT SCAN	1, 618, 109	57. 00
58.00   05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 040, 309	58.00
59. 00   05900 CARDI AC CATHETERI ZATI ON	5, 698, 918	59.00
60. 00   06000   LABORATORY	14, 284, 383	60.00
64.00 06400 I NTRAVENOUS THERAPY	0	64.00
65. 00 06500 RESPI RATORY THERAPY	3, 377, 361	65. 00
66. 00 06600 PHYSI CAL THERAPY	11, 652, 857	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	67. 00
68.00 06800 SPEECH PATHOLOGY	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	1, 660, 098	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	1, 610, 101	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 867, 528	71.00
72.00 07200 MPL. DEV. CHARGED TO PATIENTS	17, 471, 537	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	36, 653, 391	73. 00
73. 01   07302   OP PHARMACY	575, 592	73. 01
74. 00   07400   RENAL DI ALYSI S	1, 195, 531	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON	1, 340, 170	76. 97
OUTPATIENT SERVICE COST CENTERS	0.700.05=	
90. 00   09000   CLI NI C	2, 732, 207	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	2, 426, 748	90. 01
90. 02 09002 WOUND CARE CENTER	1, 636, 480	90. 02
90. 03   09003   PAIN CLINIC	654, 160	90. 03
90. 05   09005   OP PSYCH CLINIC	3, 326, 469	90. 05
91. 00 09100 EMERGENCY	12, 331, 297	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		92. 00
OTHER REIMBURSABLE COST CENTERS		04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0 107 070	94.00
95. 00 09500 AMBULANCE SERVICES	9, 187, 870	95.00
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	F F00 001	100.00
101.00 10100 HOME HEALTH AGENCY	5, 598, 081	101. 00
SPECIAL PURPOSE COST CENTERS		112.00
113.00 11300 INTEREST EXPENSE		113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF		114.00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P. )	6 422 451	115.00
116.00 11600 HOSPI CE	6, 422, 451	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	272, 045, 302	118. 00
NONREI MBURSABLE COST CENTERS	214 001	190. 00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190. 01 19001 PROMPTCARE	214, 981	190. 00 190. 01
1	2, 702, 731	190.01
190. 02 19002  RENTAL PROPERTI ES 190. 03 19003  0LCOTT	2, 730, 282 600, 313	190.02
170. 03 17003 0L001 I	000, 313	[190. 03

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS	Provi der CCN: 15-0051	Peri od: Worksheet B From 01/01/2016 Part I To 12/31/2016 Date/Time Prepared:

		10	12/31/2016	5/23/2017 10:42 am
Cost Center Description	Total		.1.	07 207 20 17 TO: 12 dill
·	26.00			
190. 04 19004 PHYSI CI AN RECRUI TMENT	0			190. 04
190. 05 19005 FOUNDATI ON	1, 500, 534			190. 05
190. 06 19006 MARKETI NG	185, 206			190. 06
190. 07 19007 HME STORE	565, 082			190. 07
190. 08 19008 UNUSED SPACE	1, 803, 569			190. 08
190. 09 19009 CLI NI CAL TRI ALS	758, 345			190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	295, 792			190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	6, 215, 007			190. 11
191. 00 19100 RESEARCH	0			191. 00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0			192. 00
193. 00 19300 NONPALD WORKERS	0			193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	12, 876, 466			194. 00
194. 01 07951 I U HEALTH BEDFORD HOSPITAL	18, 329, 071			194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	9, 548, 508			194. 02
194. 03 07953 IU HEALTH SIP	1, 123, 459			194. 03
200.00 Cross Foot Adjustments	0			200. 00
201.00 Negative Cost Centers	0			201. 00
202.00   TOTAL (sum lines 118-201)	331, 494, 648			202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

				lo	12/31/2016	Date/lime Pre 5/23/2017 10:	
			CAPI TAL REI	LATED COSTS		072072017 10.	12 (1111
		D	DI DO A FLIVE	10/01 5 50/// 5		5454 0455	
	Cost Center Description	Directly Assigned New	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS	
		Capi tal				DEPARTMENT	
		Related Costs					
	T	0	1. 00	2.00	2A	4. 00	
1. 00	GENERAL SERVICE COST CENTERS  OO100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	169, 948	80, 828	250, 776	250, 776	4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	0	3, 610, 973		5, 328, 376	19, 381	5. 00
7.00	00700 OPERATION OF PLANT	0	2, 076, 097		3, 063, 503	6, 305	1
8. 00 9. 00	00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG	0	29, 661 64, 281		43, 768 94, 854	0 4, 293	8. 00 9. 00
10. 00	01000 DI ETARY	0	205, 822		303, 712	3, 047	10.00
11. 00	01100 CAFETERI A	0	110, 921		163, 676	2, 280	1
13. 00	01300 NURSI NG ADMI NI STRATI ON	0	310, 124		457, 621	10, 433	1
14.00	01400 CENTRAL SERVICES & SUPPLY	0	100, 173		147, 816	0	14.00
15. 00 16. 00	O1500   PHARMACY   O1600   MEDICAL RECORDS & LIBRARY	0	99, 528 112, 635		146, 864 166, 205	11, 226 0	15. 00 16. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	112, 033		100, 203	0	18. 00
18. 01	01851 CENTRAL STERI LI ZATI ON	0	57, 331		84, 598	976	18. 01
23. 00	02300 PARAMED ED PRGM-PHARMACY RESIDENCY	0	0	0	0	641	23. 00
20.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		2 4/4 457	1 170 110	2 (2( 570	F1 700	20.00
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	0	2, 464, 457 189, 433		3, 636, 570 279, 529	51, 703 6, 666	30. 00 31. 00
41. 00	04100 SUBPROVI DER – I RF	0	224, 182		330, 805	2, 272	41. 00
42.00	04200 SUBPROVI DER	0	0	· .	0	. 0	42.00
43. 00	04300 NURSERY	0	109, 704	52, 176	161, 880	3, 871	43. 00
EO 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	0	00F 412	420, 420	1 224 022	10, 021	FO 00
50. 00 50. 01	05000 OPERATING ROOM	0	905, 412 0		1, 336, 032 0	10, 921 0	50. 00 50. 01
51. 00	05100 RECOVERY ROOM	Ö	63, 876	-	94, 256	6, 868	1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	637, 798		941, 139	6, 440	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54.00	05400 RADI OLOGY - DI AGNOSTI C	0	390, 406		576, 086	8, 221	54.00
55. 00 56. 00	05500   RADI OLOGY-THERAPEUTI C   05600   RADI OI SOTOPE	0	404, 896	192, 571	597, 467 0	5, 471 0	55. 00 56. 00
57. 00	05700 CT SCAN	l o	23, 873	-	35, 227	1, 472	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	35, 781	17, 018	52, 799	980	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	119, 419		176, 215	2, 711	59. 00
60. 00 64. 00	06000 LABORATORY 06400 I NTRAVENOUS THERAPY	0	322, 125 0		475, 330 0	1 0	60. 00 64. 00
65. 00	06500 RESPIRATORY THERAPY	0	24, 334	-	35, 907	4, 681	65. 00
66. 00	06600 PHYSI CAL THERAPY	O	292, 058		430, 963	15, 798	1
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	45, 220 79, 803		66, 727 117, 758	1, 969 480	1
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	79,803		117, 738	0	1
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73. 00
73. 01	07302 OP PHARMACY	0	15, 872		23, 421	801	73. 01
74. 00 75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	14, 526 0		21, 435 0	0	74. 00 75. 00
75. 00	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	Ö	o	ő	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	69, 295	32, 957	102, 252	1, 629	1
00	OUTPATIENT SERVICE COST CENTERS				24 1		00.5-
90. 00 90. 01	O9000   CLINIC   O9001   OP ONCOLOGY INFUSION CENTER	0	165, 948 62, 235		244, 874 91, 834	3, 171 2, 501	90. 00 90. 01
90. 01	09001 WOUND CARE CENTER		62, 235 86, 089		127, 034	2, 591 1, 957	1
90. 03	09003 PAIN CLINIC	0	55, 304		81, 607	599	1
90. 05	09005 OP PSYCH CLINIC	0	165, 911		244, 819	4, 139	
91.00	09100 EMERGENCY	0	488, 109	232, 148	720, 257	11, 216	1
92. 00	09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS				0		92. 00
94. 00	09400 HOME PROGRAM DIALYSIS	ol	0	0	0	0	94. 00
	09500 AMBULANCE SERVICES	O	260, 904		384, <b>9</b> 92		95. 00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100. 00
101.00	10100 HOME HEALTH AGENCY	0	112, 322	53, 421	165, 743	5, 903	101. 00
112 00	SPECIAL PURPOSE COST CENTERS   11300   INTEREST EXPENSE						113. 00
	111400 UTI LI ZATI ON REVI EW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0	О	0	115. 00
	11600 HOSPI CE	0	88, 412		130, 461		116. 00
118.00	SUBTOTALS (SUM OF LINES 1-117)	0	14, 865, 198	7, 069, 990	21, 935, 188	238, 589	J118. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2016 Part II Provider CCN: 15-0051

			To	12/31/2016	Date/Time Pre 5/23/2017 10:	
		CAPI TAL REL	_ATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE BENEFITS DEPARTMENT	
	0	1. 00	2.00	2A	4. 00	
NONREI MBURSABLE COST CENTERS	,					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	17, 384	8, 268	25, 652	129	190. 00
190. 01 19001 PROMPTCARE	0	118, 645	56, 428	175, 073	2, 001	190. 01
190. 02 19002 RENTAL PROPERTI ES	0	860, 469	409, 245	1, 269, 714		190. 02
190. 03 19003 OLCOTT	0	50, 695	24, 111	74, 806	629	190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0	0	0		190. 04
190. 05 19005 FOUNDATI ON	0	118, 847	56, 525	175, 372	·	190. 05
190. 06 19006 MARKETI NG	0	0	0	0	-	190. 06
190. 07 19007 HME STORE	0	0	0	0		190. 07
190. 08 19008 UNUSED SPACE	0	573, 885	, , , , ,	846, 829		190. 08
190. 09 19009 CLINI CAL TRIALS	0	16, 536	7, 865	24, 401		190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0		190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	505, 254	240, 302	745, 556	·	190. 11
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	0		194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	0		194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0		194. 02
194.03 07953 IU HEALTH SIP	0	437, 617	0	437, 617		194. 03
200.00 Cross Foot Adjustments	[			0		200. 00
201.00 Negative Cost Centers		0	0	0		201. 00
202.00   TOTAL (sum lines 118-201)	0	17, 564, 530	8, 145, 678	25, 710, 208	250, 776	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Provider CCN: 15-0051

Peri od: Worksheet B From 01/01/2016 Part II To 12/31/2016 Date/Time Prepared:

5/23/2017 10:42 am Cost Center Description ADMINISTRATIVE OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY & GENERAL PLANT LINEN SERVICE 9.00 10.00 5.00 7.00 8.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5, 347, 757 5 00 5 00 7.00 00700 OPERATION OF PLANT 248, 539 3, 318, 347 7.00 00800 LAUNDRY & LINEN SERVICE 3, 390 8.00 8, 407 55, 565 8.00 9.00 00900 HOUSEKEEPI NG 59, 055 18, 220 176, 422 9.00 C 01000 DI ETARY 416, 315 10.00 10.00 50, 502 58.338 0 716 11.00 01100 CAFETERI A 17, 205 31, 439 351 11.00 0 13.00 01300 NURSING ADMINISTRATION 130, 122 87, 901 0 0 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 202.188 28.393 0 14 00 842 0 15.00 01500 PHARMACY 125, 530 28, 210 16 0 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 49, 236 31, 925 0 491 0 16.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 0 18.00 0 0 01851 CENTRAL STERILIZATION 18.01 13, 111 16, 250 853 0 0 18.01 23.00 02300 PARAMED ED PRGM-PHARMACY RESIDENCY 6, 240 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 356, 596 30.00 03000 ADULTS & PEDIATRICS 674.044 698, 517 30.00 31.999 74.606 03100 INTENSIVE CARE UNIT 33, 706 31.00 86.776 53, 692 2,775 12, 425 31.00 04100 SUBPROVIDER - IRF 32, 918 4,816 26, 013 41.00 41.00 63, 542 C 04200 SUBPROVI DER 42.00 0 0 42.00 04300 NURSERY 31, 094 43.00 61,847 406 7, 287 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 187. 040 256, 628 5, 753 12, 565 0 50.00 50.01 05001 CV SURGERY 50.01 0 C 05100 RECOVERY ROOM 75. 950 51.00 18, 105  $\cap$ 884 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 94, 736 180, 776 4, 497 20, 821 0 52.00 05300 ANESTHESI OLOGY 53.00 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 107.062 110, 656 54.00 425 4.156 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 89,805 114, 763 C 730 0 55.00 56.00 05600 RADI OI SOTOPE 0 0 56.00 05700 CT SCAN 57.00 23, 482 0 323 0 57.00 6, 766 58 00 05800 MAGNETIC RESONANCE I MAGING (MRI) 15 334 10, 142 0 58 00 0 463 05900 CARDIAC CATHETERIZATION 59.00 42,002 33,848 1,605 3, 327 0 59.00 06000 LABORATORY 218, 906 24 98 0 60.00 60.00 91, 302 64.00 06400 INTRAVENOUS THERAPY 0 64.00 C 0 06500 RESPIRATORY THERAPY 65.00 50.427 6, 897 Ω 0 65.00 66.00 06600 PHYSI CAL THERAPY 177, 575 82, 780 3, 133 3, 384 0 66.00 06700 OCCUPATIONAL THERAPY 67.00 C 0 67.00 68 00 06800 SPEECH PATHOLOGY O Ω 68 00 06900 ELECTROCARDI OLOGY 1, 390 69.00 22, 711 12,817 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 23, 299 0 70.00 70.00 22, 619 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 157, 495 0 ol 0 71.00 C 07200 IMPL. DEV. CHARGED TO PATIENTS 277, 607 0 72 00 72 00 C 0 0 73.00 07300 DRUGS CHARGED TO PATIENTS 448, 703 4, 830 0 73.00 73.01 07302 OP PHARMACY 8,809 4, 499 0 0 0 73.01 07400 RENAL DIALYSIS 0 74.00 18.680 28 0 74.00 4, 117 0 07500 ASC (NON-DISTINCT PART) 75.00 75.00 0 C 0 0 75.01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 0 0 75.01 07697 CARDIAC REHABILITATION 76.97 18, 958 19,641 0 0 76.97 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 38, 146 47.036 0 0 0 90 00 90.01 09001 OP ONCOLOGY INFUSION CENTER 30, 491 0 0 0 90.01 17, 640 90 02 09002 WOUND CARE CENTER 21, 898 24, 401 0 0 O 90.02 09003 PAIN CLINIC 8.418 15, 675 90.03 90.03 0 0 0 90.05 09005 OP PSYCH CLINIC 47.895 47, 025 Λ 0 0 90.05 09100 EMERGENCY 167, 573 3, 940 19, 684 91.00 91.00 138, 349 0 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 94.00 95.00 95. 00 09500 AMBULANCE SERVICES 137, 965 73, 950 0 0 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 83, 910 31, 836 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 I NTEREST EXPENSE 113.00 114.00 11400 UTI LI ZATI ON REVI EW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 115.00 116. 00 11600 HOSPI CE 95, 127 25, 059 C 2,022 0 116.00 55, 426 118.00 SUBTOTALS (SUM OF LINES 1-117) 4, 450, 707 2, 553, 255 176, 239 416, 315 118. 00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 3,011 4, 927 183 0 190.00 0 190. 01 19001 PROMPTCARE 0 190. 01 39, 657 33, 628 139 0 190. 02 19002 RENTAL PROPERTIES 25.779 0 0 190.02 243 889 0

| In Lieu of Form CMS-2552-10 | Period: | Worksheet B | From 01/01/2016 | Part II | To 12/31/2016 | Date/Time Prepared: 5/23/2017 10: 42 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

						3/23/2017 10.	42 am
Cost	Center Description	ADMI NI STRATI VE	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
		& GENERAL	PLANT	LINEN SERVICE			
		5.00	7. 00	8. 00	9. 00	10.00	
190. 03 19003 OLCOT	Т	8, 552	14, 369	0	0	0	190. 03
190. 04 19004 PHYSI	CIAN RECRUITMENT	0	0	0	0	0	190. 04
190. 05 19005 FOUND	ATI ON	21, 583	33, 686	0	0	0	190. 05
190. 06 19006 MARKE	TING	2, 988	0	0	0	0	190. 06
190.07 19007 HME S	TORE	8, 957	0	0	0	0	190. 07
190. 08 19008 UNUSE	D SPACE	16, 913	162, 661	0	0	0	190. 08
190. 09 19009 CLI NI	CAL TRIALS	11, 481	4, 687	0	0	0	190. 09
190. 10 19010 MORGA	N OP BEHAVIORAL HEALTH CLINIC	4, 749	0	0	0	0	190. 10
190. 11 19011 COMMU	NITY HEALTH SERVICES	87, 180	143, 208	0	0	0	190. 11
191. 00 19100 RESEA	RCH	0	0	0	0	0	191. 00
192. 00 19200 PHYSI	CLANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
193. 00 19300 NONPA	ID WORKERS	0	0	0	0	0	193. 00
194.00 07950 IU HE	ALTH PAOLI HOSPITAL	207, 728	0	0	0	0	194. 00
194. 01 07951 IU HE	ALTH BEDFORD HOSPITAL	295, 692	0	0	0	0	194. 01
194. 02 07952 IU HE	ALTH MORGAN HOSPITAL	154, 040	0	0	0	0	194. 02
194. 03 07953 IU HE	ALTH SIP	8, 740	124, 037	0	0	0	194. 03
200.00 Cross	Foot Adjustments						200. 00
201.00 Negat	ive Cost Centers	0	0	0	0	0	201. 00
202. 00 TOTAL	. (sum lines 118-201)	5, 347, 757	3, 318, 347	55, 565	176, 422	416, 315	202. 00

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Period: Worksheet B
From 01/01/2016 Part II
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	Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	5/23/2017 10: MEDI CAL	
			ADMI NI STRATI ON	SERVICES & SUPPLY		RECORDS & LI BRARY	
	CENEDAL CEDVICE COST CENTEDS	11. 00	13.00	14. 00	15. 00	16. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5.00	00500 ADMINISTRATIVE & GENERAL						5.00
7. 00 8. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7. 00 8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11.00	01100 CAFETERIA	214, 951					11.00
13. 00 14. 00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	8, 995	695, 072	379, 239			13. 00 14. 00
15. 00	01500 PHARMACY	8, 771	íl ő	854	321, 471		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	C	ol ol	0	0	247, 857	
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	1 (1)	1	0	0	0	18.00
18. 01 23. 00	01851   CENTRAL STERI LI ZATI ON   02300   PARAMED ED PRGM-PHARMACY RESIDENCY	1, 616	1	2, 701	0	0	18. 01 23. 00
23.00	I NPATIENT ROUTINE SERVICE COST CENTERS		<u> </u>	<u> </u>	<u> </u>	<u> </u>	25.00
30.00	03000 ADULTS & PEDIATRICS	56, 965		21, 404	0	21, 761	1
31.00	03100 I NTENSI VE CARE UNI T	6, 996		5, 148	0	3, 148	
41. 00 42. 00	04100  SUBPROVI DER - I RF 04200  SUBPROVI DER	2, 415		707	0	982 0	41. 00 42. 00
43. 00	04300 NURSERY	3, 566	1	2, 044	0	2, 270	1
	ANCILLARY SERVICE COST CENTERS				-	,	
50.00	05000 OPERATING ROOM	10, 764		212, 623	0	36, 801	50.00
50. 01 51. 00	05001   CV SURGERY   05100   RECOVERY ROOM	6, 362	1	0 887	0	0 5, 502	50. 01 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	6, 222		6, 328	0	6, 212	1
53. 00	05300 ANESTHESI OLOGY	(		0	0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	8, 229		17, 050	0	11, 320	1
55. 00	05500 RADI OLOGY-THERAPEUTI C	4, 640		6, 408	0	12, 569	1
56. 00 57. 00	05600	1, 349	1	0 1, 429	0	0 5, 316	56. 00 57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	892		159	Ö	1, 736	1
59. 00	05900 CARDI AC CATHETERI ZATI ON	2, 647	20, 785	72, 081	0	13, 323	59. 00
60.00	06000 LABORATORY	2	0	0	0	22, 323	
64. 00 65. 00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	4, 326		4, 864	0	0 2, 146	64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	13, 992		803	0	5, 301	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	. (	1	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	(	1	0	0	0	68. 00
69. 00 70. 00	06900  ELECTROCARDI OLOGY   07000  ELECTROENCEPHALOGRAPHY	1, 866 610		272 672	0	4, 588 2, 325	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	010		0/2	0	8, 102	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	d	o o	0	0	20, 358	72. 00
73. 00		C		0	321, 471	27, 782	
73. 01	1	559	1	7	0		73. 01
74. 00 75. 00	07500 ASC (NON-DISTINCT PART)			258 0	0	0	74. 00 75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	ď	1	0	Ö	0	75. 01
76. 97	07697 CARDIAC REHABILITATION	1, 453	4, 480	94	0	580	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS O9000 CLINIC	2 211	10 404	122	O	200	90.00
90. 00 90. 01	09001 OP ONCOLOGY INFUSION CENTER	2, 211 2, 573		123 4, 077	0	300 2, 277	
90. 02	09002 WOUND CARE CENTER	1, 804		1, 405	o	896	1
90. 03	09003 PAIN CLINIC	621		391	0	370	
90.05	09005 OP PSYCH CLINIC	2, 841		17	0	483	
91. 00 92. 00	O9100   EMERGENCY   O9200   OBSERVATION   BEDS (NON-DISTINCT PART)	12, 640	11, 681	12, 079	0	18, 722	91. 00 92. 00
72.00	OTHER REIMBURSABLE COST CENTERS						72.00
94. 00	09400 HOME PROGRAM DIALYSIS	(	0	0	0	0	94. 00
	09500 AMBULANCE SERVICES	16, 242	2 0	3, 048	0	7, 601	
	D10000 1&R SERVICES-NOT APPRVD PRGM D10100 HOME HEALTH AGENCY	4, 406	0 5 17, 623	0	0		100. 00 101. 00
101.00	SPECIAL PURPOSE COST CENTERS	4, 400	) 17,023	U	U	002	101.00
	11300 I NTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114.00
	D11500 AMBULATORY SURGICAL CENTER (D. P.) D11600 HOSPICE	5, 733	) 0 3 24 135	0	0		115. 00 116. 00
116.00		202, 308		377, 933	321, 471	1, 040 247, 857	
	NONREI MBURSABLE COST CENTERS			3,,,,,,,,,	32., ., .,	2.,,307	]
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	276		0	0		190. 00
190. 01	1 19001 PROMPTCARE	2, 348	3, 338	992	0	0	190. 01

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared: 5/23/2017 10: 42 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

					5/23/201/ 10:	42 am
Cost Center Description	CAFETERI A	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	
		ADMI NI STRATI ON	SERVICES &		RECORDS &	
			SUPPLY		LI BRARY	
	11. 00	13. 00	14.00	15. 00	16. 00	
190. 02 19002 RENTAL PROPERTI ES	0	0	0	0	0	190. 02
190. 03 19003 OLCOTT	602	2	1	0	0	190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	o	0	0	0	190. 04
190. 05 19005 FOUNDATI ON	1, 103	o	0	0	0	190. 05
190. 06 19006 MARKETI NG	0	o	0	0	0	190. 06
190. 07 19007 HME STORE	373	o	232	0	0	190. 07
190. 08 19008 UNUSED SPACE	0	o	0	0	0	190. 08
190. 09 19009 CLINICAL TRIALS	587	1, 755	1	0	0	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	245	o	0	0	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	7, 109	8, 406	80	0	0	190. 11
191. 00 19100 RESEARCH	0	0	0	0	0	191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0	0	192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	0	0	194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	0	0	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0	0	194. 02
194.03 07953 IU HEALTH SIP	0	0	0	0	0	194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	o	0	0	0	201. 00
202.00 TOTAL (sum lines 118-201)	214, 951	695, 072	379, 239	321, 471	247, 857	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

						5/23/2017 10:	42 am
		OTHER GENER	AL SERVICE			072072017 10.	12 Gill
Cost Center Descriptio	n	(SPECI FY)	CENTRAL STERI LI ZATI ON	PARAMED ED PRGM-PHARMACY RESI DENCY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
		18. 00	18. 01	23. 00	24. 00	25. 00	
GENERAL SERVICE COST CENTERS   1.00	IXT UIP RTMENT AL						1. 00 2. 00 4. 00 5. 00 7. 00 8. 00
9. 00   00900   HOUSEKEEPING 10. 00   01000   DI ETARY 11. 00   01100   CAFETERIA 13. 00   01300   NURSING ADMINISTRATION 14. 00   01400   CENTRAL SERVICES & SUP 15. 00   01500   PHARMACY 16. 00   01600   MEDICAL RECORDS & LIBR 18. 00   01850   OTHER GENERAL SERVICE	PLY	0					9. 00 10. 00 11. 00 13. 00 14. 00 15. 00 16. 00 18. 00
18. 01   01851   CENTRAL STERI LI ZATI ON   02300   PARAMED   ED   PRGM-PHARMA		0 0	120, 105 0	6, 881			18. 01 23. 00
30. 00   03000   ADULTS & PEDIATRICS   31. 00   03100   INTENSIVE CARE UNIT   41. 00   04100   SUBPROVI DER   1 RF   42. 00   04200   SUBPROVI DER   43. 00   04300   NURSERY	SI CENIERS	0 0 0 0	5, 071 156 0 0 1, 365		5, 975, 992 509, 291 484, 703 0 313, 957	0 0 0 0	30. 00 31. 00 41. 00 42. 00 43. 00
ANCI LLARY SERVI CE COST CENTE 50. 00 05000 OPERATI NG ROOM	ERS	ol	108, 482		2, 210, 116	0	
50. 01   05001   CV   SURGERY   51. 00   05100   RECOVERY   ROOM		0	0		213, 618	0	50. 01 51. 00
52. 00   05200   DELI VERY ROOM & LABOR   53. 00   05300   ANESTHESI OLOGY	ROOM	0	0		1, 325, 905	0	52. 00 53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C 55. 00   05500   RADI OLOGY-THERAPEUTI C		0	624 0		857, 827 839, 518	0	54. 00 55. 00
56. 00   05600   RADI OI SOTOPE 57. 00   05700   CT   SCAN		0	0		75, 364	0	56. 00 57. 00
58. 00 05800 MAGNETIC RESONANCE I MA 59. 00 05900 CARDIAC CATHETERIZATIO		0	0 897		82, 505 369, 441	0	58. 00 59. 00
60. 00   06000   LABORATORY 64. 00   06400   NTRAVENOUS THERAPY		0	0		807, 986	0	60.00
65. 00   06500   RESPI RATORY   THERAPY   66. 00   06600   PHYSI CAL   THERAPY		0	546 0		109, 794 733, 763	0	65. 00 66. 00
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY		0	0		733, 703	0	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY		0	1, 014		119, 538	0	69. 00
71.00 07100 MEDICAL SUPPLIES CHARG	ED TO PATIENTS	0	585 0		168, 348 165, 597	0	71. 00
73.00 07300 DRUGS CHARGED TO PATIE		0	0		297, 965 802, 786	0	72. 00 73. 00
73. 01   07302   0P PHARMACY 74. 00   07400   RENAL DI ALYSI S	,	0	0		38, 502 45, 233	0	
75. 00   07500   ASC   (NON-DI STI NCT PART 75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI 76. 97   07697   CARDI AC REHABI LI TATI ON	CAL SERVICES	0	0		0	0	75. 01
OUTPATIENT SERVICE COST CENT		0	0		149, 087	0	76. 97
90. 00   09000   CLINIC 90. 01   09001   OP ONCOLOGY INFUSION C	ENTER	0	0		346, 355 173, 856	0	90. 01
90. 02   09002   WOUND CARE CENTER 90. 03   09003   PALN CLINIC		0 0	0 39		187, 304 110, 809	0	90. 02 90. 03
90. 05   09005   OP PSYCH CLINIC 91. 00   09100   EMERGENCY		0	0 585		356, 705 1, 116, 726	0	
92.00 09200 OBSERVATION BEDS (NON- OTHER REIMBURSABLE COST CENT						0	92. 00
94. 00 O9400 HOME PROGRAM DI ALYSI S 95. 00 O9500 AMBULANCE SERVI CES		0 0	0		0 635, 392	0	
100.00 10000   &R SERVICES-NOT APPRV 101.00 10100 HOME HEALTH AGENCY		0 0	0 0		0 310, 023		100. 00 101. 00
SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE							113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CE 116. 00 11600 HOSPI CE		0	0		0 291, 459		114. 00 115. 00 116. 00

In Lieu of Form CMS-2552-10
Period: Worksheet B
From 01/01/2016 Part II Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

				To 12/31/2016	Date/Time Pre	pared:
					5/23/2017 10:	42 am
	OTHER GENER	RAL SERVICE				
	(005015)()	OFNERAL				
Cost Center Description	(SPECI FY)	CENTRAL	PARAMED ED	Subtotal	Intern &	
		STERI LI ZATI ON			Residents Cost	
			RESI DENCY		& Post	
					Stepdown	
	18. 00	18. 01	23. 00	24.00	Adjustments 25.00	
118.00 SUBTOTALS (SUM OF LINES 1-117)	16.00					118. 00
NONREI MBURSABLE COST CENTERS		119, 304		20, 223, 403	U	110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0		34, 178	0	190. 00
190. 01 19001 PROMPTCARE	0	39		257, 215		190. 00
190. 02 19002  RENTAL   PROPERTI ES	0	37		1, 539, 382		190. 01
190. 03 19003 0LCOTT	0	0		98, 961		190. 02
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	0		70, 701		190. 03
190. 05 19005 FOUNDATION	0	0		233, 282		190. 04
190. 06 19006 MARKETI NG	0	0		2, 988		190. 06
190. 07 19007 HME STORE	0	0		10, 386		190. 00
190. 08 19008 UNUSED SPACE	0	0		1, 026, 403	-	190. 07
190. 09 19009 CLI NI CAL TRI ALS	0	0		43, 609		190. 00
190. 10 19010 MORGAN OP BEHAVI ORAL HEALTH CLINIC	0	0		5, 450		190. 09
190. 11 19011 COMMUNITY HEALTH SERVICES	0	0		997, 452		190. 10
191. 00 19100 RESEARCH	0	0		777, 432		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0		192. 00
193. 00 19300 NONPALD WORKERS	0	0		0		193. 00
194. 00 07950 I U HEALTH PAOLI HOSPITAL	0	0		207, 728		194. 00
194. 01 07951 LU HEALTH BEDFORD HOSPITAL	0	0		295, 692		194. 01
194. 02 07952 I U HEALTH MORGAN HOSPITAL	0	0		154, 040	-	194. 02
194. 03 07953 I U HEALTH SI P	0	702		571, 096	-	194. 03
200.00 Cross Foot Adjustments			6, 881		-	200. 00
201.00 Negative Cost Centers	0	0	0,00			201. 00
202.00   TOTAL (sum lines 118-201)	0	120, 105	6, 881	25, 710, 208		202. 00

In Lieu of Form CMS-2552-10

Period: Worksheet B
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared: 5/23/2017 10: 42 am Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provider CCN: 15-0051

				5/23/2017 10:	
		Cost Center Description	Total		
	CENED	AL SERVICE COST CENTERS	26. 00	<u> </u>	
1.00		CAP REL COSTS-BLDG & FIXT			1.00
2.00	1	CAP REL COSTS-MVBLE EQUIP			2. 00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT			4. 00
5.00	1	ADMINISTRATIVE & GENERAL			5. 00
7. 00 8. 00	1	OPERATION OF PLANT LAUNDRY & LINEN SERVICE	+		7. 00 8. 00
9. 00	1	HOUSEKEEPI NG			9. 00
10.00	1	DI ETARY			10. 00
11.00	1	CAFETERI A			11.00
13. 00 14. 00	1	NURSING ADMINISTRATION CENTRAL SERVICES & SUPPLY			13. 00 14. 00
15. 00		PHARMACY			15. 00
16. 00	1	MEDICAL RECORDS & LIBRARY			16. 00
18. 00	1	OTHER GENERAL SERVICE (SPECIFY)			18. 00
18. 01	1	CENTRAL STERI LI ZATI ON			18. 01
23. 00		PARAMED ED PRGM-PHARMACY RESIDENCY IENT ROUTINE SERVICE COST CENTERS			23. 00
30. 00		ADULTS & PEDIATRICS	5, 975, 992		30.00
31.00	1	INTENSIVE CARE UNIT	509, 291		31. 00
41.00	1	SUBPROVI DER - I RF	484, 703		41.00
42. 00 43. 00	1	SUBPROVI DER NURSERY	0 313, 957		42. 00 43. 00
43.00		LARY SERVICE COST CENTERS	313, 737		43.00
50.00		OPERATING ROOM	2, 210, 116		50.00
50. 01		CV SURGERY	0		50. 01
51.00	1	RECOVERY ROOM	213, 618		51.00
52. 00 53. 00	1	DELIVERY ROOM & LABOR ROOM ANESTHESIOLOGY	1, 325, 905 0		52. 00 53. 00
54. 00	1	RADI OLOGY-DI AGNOSTI C	857, 827		54. 00
55. 00	1	RADI OLOGY-THERAPEUTI C	839, 518		55. 00
56. 00	1	RADI OI SOTOPE	0		56. 00
57. 00 58. 00	1	CT SCAN MAGNETIC RESONANCE IMAGING (MRI)	75, 364 82, 505		57. 00 58. 00
59.00	1	CARDIAC CATHETERIZATION	369, 441		59.00
60.00	1	LABORATORY	807, 986		60.00
64. 00	1	INTRAVENOUS THERAPY	0		64. 00
65. 00		RESPI RATORY THERAPY	109, 794		65. 00
66. 00 67. 00	1	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	733, 763		66. 00 67. 00
68. 00	1	SPEECH PATHOLOGY	0		68. 00
69. 00	1	ELECTROCARDI OLOGY	119, 538		69. 00
70. 00	1	ELECTROENCEPHALOGRAPHY	168, 348		70. 00
71. 00 72. 00	1	MEDICAL SUPPLIES CHARGED TO PATIENTS IMPL. DEV. CHARGED TO PATIENTS	165, 597 297, 965		71. 00 72. 00
73. 00	1	DRUGS CHARGED TO PATTENTS	802, 786		73. 00
73. 01		OP PHARMACY	38, 502		73. 01
		RENAL DIALYSIS	45, 233		74. 00
		ASC (NON-DISTINCT PART)	0		75. 00
		PSYCHIATRIC/PSYCHOLOGICAL SERVICES CARDIAC REHABILITATION	0 149, 087		75. 01 76. 97
70. 77		TIENT SERVICE COST CENTERS	147,007		70. 77
90.00	09000	CLI NI C	346, 355		90. 00
90. 01		OP ONCOLOGY INFUSION CENTER	173, 856		90. 01
90. 02 90. 03		WOUND CARE CENTER PAIN CLINIC	187, 304 110, 809		90. 02 90. 03
90. 05	1	OP PSYCH CLINIC	356, 705		90. 05
91.00	09100	EMERGENCY	1, 116, 726		91.00
92. 00		OBSERVATION BEDS (NON-DISTINCT PART)			92. 00
04.00		REIMBURSABLE COST CENTERS HOME PROGRAM DIALYSIS			94. 00
	1	AMBULANCE SERVICES	635, 392		95. 00
		I&R SERVICES-NOT APPRVD PRGM	0		100.00
101.00		HOME HEALTH AGENCY	310, 023		101. 00
110 00		AL PURPOSE COST CENTERS			112 00
		INTEREST EXPENSE UTILIZATION REVIEW-SNF			113. 00 114. 00
		AMBULATORY SURGICAL CENTER (D. P.)	0		115. 00
116.00	11600	HOSPI CE	291, 459		116. 00
118.00		SUBTOTALS (SUM OF LINES 1-117)	20, 225, 465		118. 00
100.00		IMBURSABLE COST CENTERS GIFT, FLOWER, COFFEE SHOP & CANTEEN	24 170		190. 00
		PROMPTCARE	34, 178 257, 215		190. 00
190. 02	19002	RENTAL PROPERTIES	1, 539, 382		190. 02
		OLCOTT	98, 961		190. 03

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 15-0051	Peri od: Worksheet B From 01/01/2016 Part II To 12/31/2016 Date/Time Prepared:

Cost Center Description	Total	
	26. 00	
190. 04 19004 PHYSI CI AN RECRUI TMENT	0	190. 04
190. 05 19005 FOUNDATI ON	233, 282	190. 05
190. 06 19006 MARKETI NG	2, 988	190. 06
190. 07 19007 HME STORE	10, 386	190. 07
190. 08 19008 UNUSED SPACE	1, 026, 403	190. 08
190. 09 19009 CLINICAL TRIALS	43, 609	190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	5, 450	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	997, 452	190. 11
191. 00 19100 RESEARCH	0	191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	192. 00
193. 00 19300 NONPALD WORKERS	0	193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	207, 728	194. 00
194. 01 07951 I U HEALTH BEDFORD HOSPITAL	295, 692	194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	154, 040	194. 02
194. 03 07953 IU HEALTH SIP	571, 096	194. 03
200.00 Cross Foot Adjustments	6, 881	200. 00
201.00 Negative Cost Centers	0	201. 00
202.00 TOTAL (sum lines 118-201)	25, 710, 208	202. 00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS In Lieu of Form CMS-2552-10
Worksheet B-1 IU HEALTH BLOOMINGTON HOSPITAL Provider CCN: 15-0051 Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/23/2017 10:42 am CAPITAL RELATED COSTS

		CAPITAL REL	_ATED COSTS				
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQ FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliation	ADMINISTRATIVE & GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5A	5. 00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 CAP REL COSTS-BLDG & FIXT	952, 806	l .				1. 00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	9, 219	929, 067 9, 219				2. 00 4. 00
5.00	00500 ADMINISTRATIVE & GENERAL	195, 881	195, 881			267, 765, 066	5. 00
7. 00	00700 OPERATION OF PLANT	112, 620					7. 00
8.00	00800 LAUNDRY & LINEN SERVICE	1, 609	1, 609			169, 739	8. 00
9.00	00900 HOUSEKEEPI NG	3, 487	l			2, 956, 913	9. 00
10.00	01000 DI ETARY 01100 CAFETERI A	11, 165				_,,	
11. 00 13. 00	01300 NURSING ADMINISTRATION	6, 017 16, 823	6, 017 16, 823			861, 470 6, 515, 203	11. 00 13. 00
14. 00	01400 CENTRAL SERVICES & SUPPLY	5, 434	l				
15. 00	01500 PHARMACY	5, 399	l		0	6, 285, 298	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	6, 110	l	1	0	2, 465, 257	16. 00
18.00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	1	0	0	18. 00
18. 01 23. 00	01851 CENTRAL STERILIZATION 02300 PARAMED ED PRGM-PHARMACY RESIDENCY	3, 110	l	1			18. 01 23. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	254, 000	0	312, 434	23.00
30. 00	03000 ADULTS & PEDI ATRI CS	133, 687	133, 687	20, 537, 823	0	33, 751, 740	30. 00
31.00	03100 INTENSIVE CARE UNIT	10, 276	10, 276				31. 00
41. 00	04100 SUBPROVI DER - I RF	12, 161	12, 161			., ,	41. 00
42.00	04200 SUBPROVI DER	0	0	-			42.00
43. 00	04300   NURSERY   ANCI LLARY SERVI CE COST CENTERS	5, 951	5, 951	1, 537, 888	0	3, 096, 681	43. 00
50. 00	05000 OPERATING ROOM	49, 115	49, 115	4, 338, 984	0	9, 365, 099	50. 00
50. 01	05001 CV SURGERY	0	0			0	50. 01
51. 00	05100 RECOVERY ROOM	3, 465	1		0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	34, 598	1		0	4, 743, 425	52. 00
53. 00 54. 00	05300   ANESTHESI OLOGY   05400   RADI OLOGY - DI AGNOSTI C	21, 178	0 21, 178	1	_	0 5, 360, 625	53. 00 54. 00
55. 00	05500 RADI OLOGY - THERAPEUTI C	21, 178				4, 496, 540	55. 00
56. 00	05600 RADI OI SOTOPE	0	0			0	56. 00
57.00	05700 CT SCAN	1, 295	1, 295	584, 670	0	1, 175, 743	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 941	1, 941				
59. 00 60. 00	05900   CARDI AC   CATHETERI ZATI ON   06000   LABORATORY	6, 478 17, 474				_,,	59. 00 60. 00
64. 00	06400 I NTRAVENOUS THERAPY	17,474	17,474	1		10, 960, 647	64. 00
65. 00	06500 RESPI RATORY THERAPY	1, 320	1	1	_	2, 524, 898	65. 00
66.00	06600 PHYSI CAL THERAPY	15, 843	15, 843	6, 276, 372	0	8, 891, 216	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0			0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	702 455		0	68. 00
69. 00 70. 00	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	2, 453 4, 329				1, 137, 143 1, 166, 574	69. 00 70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	13, 899, 799	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	1			,	
73. 01 74. 00	07302 OP PHARMACY	861	861			441, 059	
75. 00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	788 0	l			935, 329	74. 00 75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	Ö		0		75. 01
76. 97	07697 CARDIAC REHABILITATION	3, 759	3, 759	647, 305	0	949, 221	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC 09001 OP ONCOLOGY INFUSION CENTER	9, 002					90.00
90. 01 90. 02	09001 OP UNCOLOGY THRUSTON CENTER	3, 376 4, 670				1, 526, 671 1, 096, 429	90. 01 90. 02
90. 03	09003 PAIN CLINIC	3,000				421, 466	90. 03
90. 05	09005 OP PSYCH CLINIC	9, 000	l		0	2, 398, 086	90. 05
91. 00	09100 EMERGENCY	26, 478	26, 478	4, 456, 101	0	8, 390, 381	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92. 00
94.00	09400 HOME PROGRAM DI ALYSI S	0					94. 00
	09500  AMBULANCE SERVICES   10000  I&R SERVICES-NOT APPRVD PRGM	14, 153	14, 153	4, 606, 389	0		95. 00 100. 00
	10000  1&R SERVICES-NOT APPRVD PRGM   10100  HOME HEALTH AGENCY	6, 093	6, 093	2, 345, 358	_	4, 201, 375	
101.00	SPECIAL PURPOSE COST CENTERS	0,073	0,073	2, 545, 556		7, 201, 375	
	11300 INTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0 224 051	0		115. 00
110.00	11600 H0SPI CE	4, 796	4, 796	2, 336, 851	0	4, 763, 017	1110.00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2016 12/31/2016 Date/Time Prepared: 5/23/2017 10:42 am CAPITAL RELATED COSTS Reconciliation ADMINISTRATIVE Cost Center Description BLDG & FIXT MVBLE EQUIP **EMPLOYEE BENEFITS** (SQUARE FEET) (SQ FEET) & GENERAL DEPARTMENT (ACCUM. COST) (GROSS SALARI ES) 1.00 2.00 5A 5.00 4.00 118.00 SUBTOTALS (SUM OF LINES 1-117) 806, 378 806, 378 94, 787, 542 -63, 729, 582 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 943 943 51, 116 190. 01 19001 PROMPTCARE 6, 436 6, 436 794, 949 190. 02 19002 RENTAL PROPERTIES 46, 677 C

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2016 12/31/2016 Date/Time Prepared: 5/23/2017 10:42 am Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A (HOURS OF (MEALS SERVED) PLANT LINEN SERVICE (MANHOURS) (SQUARE FEET) (POUNDS OF SERVICE) LAUNDRY) 7.00 9.00 10.00 11.00 8.00 GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 1.00 1.00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4 00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 635, 086 7 00 00800 LAUNDRY & LINEN SERVICE 1,609 8.00 468, 347 8.00 00900 HOUSEKEEPI NG 9.00 3, 487 12, 566 9.00 10.00 01000 DI ETARY 11, 165 51 207, 081 10.00 11.00 01100 CAFETERI A 6,017 25 3, 049, 628 11.00 01300 NURSING ADMINISTRATION 16, 823 0 13.00 C C 127, 617 13.00 14.00 01400 CENTRAL SERVICES & SUPPLY 5, 434 r 60 0 0 14.00 15.00 01500 PHARMACY 5, 399 138 C 0 124, 443 15.00 0 01600 MEDICAL RECORDS & LIBRARY 16.00 6.110 C 35 16.00 0 01850 OTHER GENERAL SERVICE (SPECIFY) 0 18.00 0 C 0 Λ 18.00 18.01 01851 CENTRAL STERILIZATION 3, 110 7, 190 0 22, 925 18.01 02300 PARAMED ED PRGM-PHARMACY RESIDENCY 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 133, 687 269, 726 5, 314 177, 376 808, 210 30.00 03100 INTENSIVE CARE UNIT 10, 276 885 16, 766 99, 251 31.00 31.00 23, 386 41.00 04100 SUBPROVI DER - I RF 343 12, 939 34, 269 41.00 12, 161 04200 SUBPROVI DER 42 00 42 00 O 0 0 04300 NURSERY 43.00 5, 951 3, 418 519 0 50, 595 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 48, 490 895 0 152, 712 50 00 49, 115 05001 CV SURGERY 0 50.01 C 0 50.01 05100 RECOVERY ROOM 3, 465 0 90, 264 51.00 63 51.00 05200 DELIVERY ROOM & LABOR ROOM 52.00 34, 598 37, 906 1, 483 0 88, 272 52.00 05300 ANESTHESI OLOGY 53 00 53 00 0 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 21.178 3, 581 296 116, 754 54.00 05500 RADI OLOGY-THERAPEUTI C 0 65, 827 55.00 21, 964 52 55.00 0 56.00 05600 RADI 0I SOTOPE Ω C 56, 00 05700 CT SCAN 1, 295 19, 140 57.00 23 Ω 57 00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 1,941 33 12, 661 58.00 0 05900 CARDIAC CATHETERIZATION 6, 478 59.00 13, 528 237 37, 554 59.00 0 60.00 06000 LABORATORY 17, 474 201 60.00 25 06400 I NTRAVENOUS THERAPY 64.00 0 C 0 0 64.00 0 65.00 06500 RESPIRATORY THERAPY 1, 320 61, 381 0 65.00 66.00 06600 PHYSI CAL THERAPY 15,843 26, 404 241 0 198, 507 66.00 06700 OCCUPATIONAL THERAPY 67.00 67.00 0 C 0 06800 SPEECH PATHOLOGY 68.00 0 C 0 Λ 68 00 69.00 06900 ELECTROCARDI OLOGY 2, 453 0 99 0 0 0 26, 471 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 4, 329 0 8,653 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71.00 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 72.00 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 344 0 0 73.00 0 07302 OP PHARMACY 0 7, 925 73.01 73.01 861 C 07400 RENAL DIALYSIS 74.00 788 C 2 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 0 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES o 75. 01 0 Ω 0 75.01 07697 CARDIAC REHABILITATION 76.97 3,759 0 0 20, 610 76.97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 9.002 C 31, 366 90.00 0 09001 OP ONCOLOGY INFUSION CENTER 0 36, 507 90.01 90.01 3.376 0 09002 WOUND CARE CENTER 0 25, 597 90 02 4,670 Ω 0 90 02 90.03 09003 PAIN CLINIC 3,000 C 0 0 8,816 90.03 09005 OP PSYCH CLINIC 0 90.05 9,000 C 40, 304 90.05 09100 EMERGENCY 26, 478 0 91.00 91.00 33, 211 1.402 179, 332 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 94.00 95. 00 09500 AMBULANCE SERVICES 14.153 Ω 0 0 230, 441 95 00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM C 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 6,093 0 62, 506 101. 00 0 SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113 00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 116. 00 11600 HOSPI CE 4, 796 144 0 81, 333 116. 00 SUBTOTALS (SUM OF LINES 1-117) 488, 658 12, 553 207, 081 467, 179 2, 870, 268 118. 00 118.00 NONREI MBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 943 0 13 0 3, 917 190. 00

| Period: | Worksheet B-1 | From 01/01/2016 | To 12/31/2016 | Date/Time Prepared: Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051

			Т	o 12/31/2016	Date/Time Pre 5/23/2017 10:	
Cost Center Description	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	12 (1111
	PLANT	LINEN SERVICE		(MEALS SERVED)	(MANHOURS)	
	(SQUARE FEET)	(POUNDS OF	SERVICE)	`	,	
	,	LAUNDRY)	, i			
	7. 00	8. 00	9. 00	10.00	11. 00	
190. 01 19001 PROMPTCARE	6, 436	1, 168	0	0	33, 307	190. 01
190. 02 19002 RENTAL PROPERTI ES	46, 677	0	0	0	0	190. 02
190. 03 19003 OLCOTT	2, 750	0	0	0	8, 538	190. 03
190.04 19004 PHYSICIAN RECRUITMENT	0	0	0	0	0	190. 04
190. 05 19005 FOUNDATI ON	6, 447	0	0	0	15, 645	190. 05
190. 06 19006 MARKETI NG	0	0	0	0		190. 06
190. 07 19007 HME STORE	0	0	0	0		190. 07
190. 08 19008 UNUSED SPACE	31, 131	0	0	0		190. 08
190. 09 19009 CLINI CAL TRI ALS	897	0	0	0		190. 09
190.10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	0	0		190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	27, 408	0	0	0	100, 853	1
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193. 00
194.00 07950 IU HEALTH PAOLI HOSPITAL	0	0	0	0		194. 00
194.01 07951 IU HEALTH BEDFORD HOSPITAL	0	0	0	0		194. 01
194.02 07952 IU HEALTH MORGAN HOSPITAL	0	0	0	0		194. 02
194. 03 07953 IU HEALTH SIP	23, 739	0	0	0		194. 03
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers						201. 00
202.00   Cost to be allocated (per Wkst. B, Part I)	15, 406, 203	249, 170	3, 745, 265	3, 416, 524	1, 219, 919	202. 00
203.00 Unit cost multiplier (Wkst. B, Part I)	24. 258452	0. 532020	298. 047509	16. 498491	0. 400022	203. 00
204.00 Cost to be allocated (per Wkst. B,	3, 318, 347	55, 565	176, 422	416, 315	214, 951	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	5. 225036	0. 118641	14. 039631	2. 010397	0. 070484	205. 00
1 )						

COST A	ALLOCATION - STATISTICAL BASIS		Provi der CO		Peri od:	Worksheet B-1	
					rom 01/01/2016 o 12/31/2016		pared:
						5/23/2017 10:	42 am
						OTHER GENERAL SERVI CE	
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	(SPECLEY)	
		ADMI NI STRATI ON	SERVICES &	(COSTED	RECORDS &	(TIME SPENT)	
			SUPPLY	REQUI S. )	LI BRARY		
		(DI RECT NURS.	(COSTED		(GROSS		
		HRS. ) 13. 00	REQUISITIONS) 14.00	15. 00	CHARGES) 16.00	18. 00	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	10.00	10.00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2. 00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4. 00
5. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5. 00 7. 00
8. 00	00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00	00900 HOUSEKEEPI NG						9. 00
10.00	01000 DI ETARY						10. 00
11.00	01100 CAFETERI A	000 (75					11.00
13. 00 14. 00	O1300   NURSI NG   ADMI NI STRATI ON   O1400   CENTRAL   SERVI CES & SUPPLY	823, 675	31, 363, 574				13. 00 14. 00
15. 00	01500 PHARMACY	0	70, 651	100	)		15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	0	0	(			16. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	(	0	0	18. 00
18. 01	01851 CENTRAL STERILIZATION	0	223, 392	(	0	0	18. 01
23. 00	02300   PARAMED ED PRGM-PHARMACY RESIDENCY   INPATIENT ROUTINE SERVICE COST CENTERS	0	0	(	0	0	23. 00
30. 00	03000 ADULTS & PEDIATRICS	410, 914	1, 770, 137	(	111, 595, 308	0	30.00
31.00	03100 INTENSIVE CARE UNIT	21, 655	425, 771	C	16, 141, 419	0	1
41. 00	04100 SUBPROVI DER - I RF	23, 976	58, 433	(		0	
42. 00 43. 00	04200 SUBPROVI DER 04300 NURSERY	0	140.004	(		0	
43.00	ANCI LLARY SERVICE COST CENTERS	45, 418	169, 006		11, 641, 919	0	43.00
50.00	05000 OPERATI NG ROOM	38, 521	17, 584, 345	(	189, 948, 881	0	50.00
50. 01	05001 CV SURGERY	0	0	(		0	
51. 00 52. 00	O5100 RECOVERY ROOM   O5200 DELIVERY ROOM & LABOR ROOM	5, 693 69, 601	73, 351 523, 317	(	28, 216, 607 31, 854, 144	0	51. 00 52. 00
53. 00	05300 ANESTHESI OLOGY	09, 601	523, 317 0			0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	16, 588	1, 409, 993	Ċ	58, 048, 743	0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	9, 083	529, 900	(	64, 454, 598	0	55. 00
56.00	05600 RADI OI SOTOPE	0	110 217	(	0	0	56. 00 57. 00
57. 00 58. 00	05700 CT SCAN   05800 MAGNETIC RESONANCE I MAGING (MRI)		118, 217 13, 178		27, 259, 027 8, 900, 331	0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	24, 631	5, 961, 082		68, 325, 223	0	1
60.00	06000 LABORATORY	0	0	(	114, 477, 507	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	402 241	(	0	0	64. 00
65. 00 66. 00	06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY	40	402, 241 66, 381		11, 007, 252 27, 183, 368	l o	65. 00 66. 00
	06700 OCCUPATI ONAL THERAPY	0	00, 301			0	
	06800 SPEECH PATHOLOGY	0	0	(	·	0	
	06900 ELECTROCARDI OLOGY	7, 328	22, 523	(	23, 526, 628	0	
70.00	07000   ELECTROENCEPHALOGRAPHY   07100   MEDICAL SUPPLIES CHARGED TO PATIENTS	0	55, 578	(	11, 923, 015 41, 547, 575	0	
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0			0	1
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	100		0	73. 00
73. 01	07302 OP PHARMACY	0	620	(		0	73. 01
74. 00 75. 00	07400   RENAL DI ALYSI S   07500   ASC (NON-DI STI NCT PART)	0	21, 313	(	3, 667, 512	0	74. 00 75. 00
75. 00 75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0		0	0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON	5, 309	7, 759	(	2, 975, 696	0	
	OUTPATIENT SERVICE COST CENTERS						
	O9000   CLINIC   O9001   OP ONCOLOGY INFUSION CENTER	12, 436	10, 157	(		0	
90. 01 90. 02	09002 WOUND CARE CENTER	26, 513 9, 372	337, 152 116, 159		11, 676, 916 4, 594, 373	0	
90. 03	09003 PAIN CLINIC	3, 660	32, 373			ő	
90. 05	09005 OP PSYCH CLINIC	11, 241	1, 424	(	_,,	0	
91.00	09100 EMERGENCY	13, 842	998, 931	(	96, 010, 813	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS						92.00
94. 00	09400 HOME PROGRAM DI ALYSI S	0	0	(	0	0	94. 00
95. 00	09500 AMBULANCE SERVICES	0	252, 084	(	38, 980, 782	0	
	10000 I &R SERVI CES-NOT APPRVD PRGM	0	0	(			100.00
101.00	10100 HOME HEALTH AGENCY   SPECIAL PURPOSE COST CENTERS	20, 884	0		3, 088, 152	0	101. 00
113.00	11300 I NTEREST EXPENSE						113. 00
114.00	11400 UTI LI ZATI ON REVI EW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D.P.)  11600 HOSPICE	30, 971	0	(	0 5 222 022		115. 00 116. 00
110.00	/	30, 9/1	U		5, 332, 933	<u> </u>	1110.00

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL	-	In Lie	eu of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der C	CN: 15-0051	Peri od: From 01/01/2016	Worksheet B-1	
				To 12/31/2016		
					OTHER GENERAL	
Cook Cooker Docement on	NURSI NG	CENTRAL	PHARMACY	MEDI CAL	SERVI CE (SPECI FY)	
Cost Center Description	ADMI NI STRATI ON		(COSTED	RECORDS &	(SPECIFY) (TIME SPENT)	
	ADMINISTRATION	SUPPLY	REQUIS.)	LI BRARY	(ITWE SPENT)	
	(DI RECT NURS.	(COSTED	KLQUI 3. )	(GROSS		
	HRS. )	REQUISITIONS)		CHARGES)		
	13.00	14. 00	15. 00	16.00	18. 00	
118.00 SUBTOTALS (SUM OF LINES 1-117)	807, 676	31, 255, 468	10	0 1, 272, 277, 676	0	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C	ļ		0 0		190. 00
190. 01 19001 PROMPTCARE	3, 956	82, 068	3	0		190. 01
190. 02 19002 RENTAL PROPERTIES	C	0		0		190. 02
190. 03 19003 OLCOTT	2	122	2	0		190. 03
190. 04 19004 PHYSI CI AN RECRUI TMENT	C	0		0		190. 04
190. 05 19005 FOUNDATI ON	C	0	)	0		190. 05
190. 06 19006 MARKETI NG	C	0	)	0		190. 06
190. 07 19007 HME STORE	C	19, 205		0		190. 07
190. 08 19008 UNUSED SPACE	0.000	0	2	0		190. 08
190. 09 19009 CLI NI CAL TRI ALS	2, 080	l e	1	0		190. 09
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0.0/1	0	1	0		190. 10 190. 11
190. 11 19011 COMMUNITY HEALTH SERVICES 191. 00 19100 RESEARCH	9, 961	6, 608		0		190. 11
192.00 19200  PHYSICIANS' PRIVATE OFFICES		0		0		191.00
193. 00 19300 NONPALD WORKERS		0		0		192.00
194.00 07950 IU HEALTH PAOLI HOSPITAL				0		194.00
194. 01 07951 I U HEALTH BEDFORD HOSPITAL				0		194. 00
194. 02 07952 I U HEALTH MORGAN HOSPITAL				0		194. 02
194. 03 07953 I U HEALTH SIP		40		0		194. 03
200.00 Cross Foot Adjustments			1		Ĭ	200.00
201.00 Negative Cost Centers						201. 00
202.00 Cost to be allocated (per Wkst. B,	8, 525, 010	12, 682, 753	7, 990, 63	1 3, 210, 654	0	202. 00
Part I)	7,522,515	,,		7, 2, 2, 7, 2, 2,	_	
203.00 Unit cost multiplier (Wkst. B, Part I	) 10. 349968	0. 404378	79, 906. 31000	0. 002524	0. 000000	203. 00
204.00 Cost to be allocated (per Wkst. B,	695, 072	379, 239	321, 47	1 247, 857	0	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 843867	0. 012092	3, 214. 71000	0. 000195	0.000000	205. 00
1 )						

In Lieu of Form CMS-2552-10 IU HEALTH BLOOMINGTON HOSPITAL COST ALLOCATION - STATISTICAL BASIS Provider CCN: 15-0051 Peri od: Worksheet B-1 From 01/01/2016 12/31/2016 Date/Time Prepared: 5/23/2017 10:42 am OTHER GENERAL SERVI CE Cost Center Description CENTRAL PARAMED ED STERI LI ZATI ON PRGM-PHARMACY (TIME SPENT) RESI DENCY (COSTED REQUIS.) 18. 01 23.00 GENERAL SERVICE COST CENTERS 1 00 00100 CAP REL COSTS-BLDG & FLXT 1 00 2.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 00500 ADMINISTRATIVE & GENERAL 5 00 5 00 7.00 00700 OPERATION OF PLANT 7.00 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10 00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13.00 13.00 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 18.00 01851 CENTRAL STERILIZATION 18.01 3,079 18.01 23.00 02300 PARAMED ED PRGM-PHARMACY RESIDENCY 100 23 00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 130 0 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 0 04100 SUBPROVI DER - I RF 0 41.00 0 41.00 04200 SUBPROVI DER 0 0 42.00 42.00 43.00 04300 NURSERY 35 0 43.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 2, 781 0 50.00 05001 CV SURGERY 50.01 0 50.01 51.00 05100 RECOVERY ROOM 0 0 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 0 52.00 05300 ANESTHESI OLOGY 0 53.00 0 53.00 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 16 0 0 0 0 23 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 0 57.00 57.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 0 58.00 58.00 05900 CARDIAC CATHETERIZATION 0 59.00 59.00 0 60.00 06000 LABORATORY 0 60.00 64.00 06400 I NTRAVENOUS THERAPY 0 64.00 14 0 0 0 26 06500 RESPIRATORY THERAPY 0 65 00 65 00 06600 PHYSI CAL THERAPY 0 66.00 66.00 67.00 06700 OCCUPATIONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 06900 ELECTROCARDI OLOGY 0 69 00 69 00 70.00 07000 ELECTROENCEPHALOGRAPHY 15 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 0 71.00 000000 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 72.00 07300 DRUGS CHARGED TO PATIENTS 73.00 73.00 100 73.01 07302 OP PHARMACY 0 73.01 07400 RENAL DIALYSIS 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 0 75.00 75.00 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 75.01 0 75 01 07697 CARDIAC REHABILITATION 0 76.97 76.97 OUTPATIENT SERVICE COST CENTERS 90 00 09000 CLINIC 0 90.00 0 90.01 09001 OP ONCOLOGY INFUSION CENTER 0 0 90.01 09002 WOUND CARE CENTER 0 90.02 0 90.02 09003 PAIN CLINIC 1 90.03 0 90.03 09005 OP PSYCH CLINIC 0 90.05 0 90.05 91.00 09100 EMERGENCY 15 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) 92.00 92.00 OTHER REIMBURSABLE COST CENTERS 94 00 09400 HOME PROGRAM DIALYSIS 0 0 94 00 95. 00 09500 AMBULANCE SERVICES 0 0 95.00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 101.00 0 0 SPECIAL PURPOSE COST CENTERS 113. 00 11300 | INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 0

0

0

116.00

116. 00 11600 HOSPI CE

Health Financial Systems	IU HEALTH BLOOMING	TON HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - STATISTICAL BASIS		Provider CCN: 15-0051	Peri od: From 01/01/2016 To 12/31/2016	Worksheet B-1 Date/Time Prepared: 5/23/2017 10:42 am
Cost Center Description	OTHER GENERAL SERVI CE CENTRAL	PARAMED ED		0,20,20,7,10,12,0,11

			5/23/2017 10:42 am
	OTHER GENERAL		
	SERVI CE		
Cost Center Description	CENTRAL	PARAMED ED	
	STERI LI ZATI ON	PRGM-PHARMACY	
	(TIME SPENT)	RESI DENCY	
		(COSTED	
		REQUIS.)	
	18. 01	23.00	
118.00 SUBTOTALS (SUM OF LINES 1-117)	3, 060	100	118. 00
NONREI MBURSABLE COST CENTERS			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190. 00
190. 01 19001 PROMPTCARE	1	0	190. 01
190. 02 19002 RENTAL PROPERTI ES	0	0	190. 02
190. 03 19003 OLCOTT	0	0	190. 03
190. 04 19004 PHYSI CLAN RECRUITMENT	0	0	190. 04
190. 05 19005 FOUNDATION	0	0	190. 05
190. 06 19006 MARKETI NG	0	0	190. 06
190. 07 19007 HME STORE	0	0	190. 07
190. 08 19008 UNUSED SPACE	0	0	190. 08
190. 09 19009 CLINICAL TRIALS	0	0	190.09
190. 10 19010 MORGAN OP BEHAVIORAL HEALTH CLINIC	0	0	190. 10
190. 11 19011 COMMUNITY HEALTH SERVICES	0	l o	190. 11
191. 00 19100 RESEARCH	0	l o	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	192.00
193. 00 19300 NONPALD WORKERS	0	0	193.00
194. 00 07950 I U HEALTH PAOLI HOSPITAL		l o	194.00
194. 01 07951 I U HEALTH BEDFORD HOSPITAL			194.01
194. 02 07952 I U HEALTH MORGAN HOSPITAL			194. 02
194. 03 07953  I U HEALTH SI P	18		194. 02
200.00 Cross Foot Adjustments	10		200.00
201.00 Negative Cost Centers			201.00
202.00 Cost to be allocated (per Wkst. B,	991, 465	386, 820	
Part I)	771, 400	300, 620	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	322. 008769	3, 868. 200000	203.00
204.00 Cost to be allocated (per Wkst. B,	120, 105		l l
Part II)	120, 103	0,001	204.00
205.00 Unit cost multiplier (Wkst. B, Part	39. 007795	68. 810000	205. 00
	37.007793	00.010000	203. 00
	1	I	ı

					From 01/01/2016 To 12/31/2016	Date/Time Pre	pared:
			Title	XVIII	Hospi tal	5/23/2017 10: PPS	42 alli
					Costs		
	Cost Center Description		Therapy Limit	Total Costs	RCE	Total Costs	
		(from Wkst. B,	Adj .		Di sal I owance		
		Part I, col.					
		26)	0.00	0.00	4.00	F 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3. 00	4. 00	5. 00	
30. 00	03000 ADULTS & PEDIATRICS	55, 297, 122		55, 297, 12	2 0	55, 297, 122	30. 00
31. 00	03100   NTENSI VE CARE UNI T	6, 659, 148		6, 659, 14		6, 659, 148	
41. 00	04100 SUBPROVI DER – I RF	2, 949, 383		2, 949, 38		2, 949, 383	41. 00
42. 00	04200 SUBPROVI DER	0			ol ol	0	42. 00
43.00	04300 NURSERY	4, 733, 887		4, 733, 88	7 0	4, 733, 887	43.00
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	22, 022, 936		22, 022, 93		22, 022, 936	50. 00
50. 01	05001 CV SURGERY	0			0 0	0	50. 01
51. 00	05100 RECOVERY ROOM	5, 006, 685		5, 006, 68		5, 006, 685	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	8, 221, 551		8, 221, 55		8, 221, 551	•
53.00	05300 ANESTHESI OLOGY	0 100 504			0 0	0 100 504	53.00
54. 00 55. 00	05400  RADI OLOGY-DI AGNOSTI C   05500  RADI OLOGY-THERAPEUTI C	8, 180, 584 6, 612, 358		8, 180, 58 6, 612, 35		8, 180, 584 6, 612, 358	54. 00 55. 00
56. 00	05600 RADI OLOGI - ITIERAF LUTT C	0, 012, 330		0, 012, 33		0, 012, 330	56.00
57. 00	05700 CT SCAN	1, 618, 109		1, 618, 10		1, 618, 109	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	1, 040, 309		1, 040, 30		1, 040, 309	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 698, 918		5, 698, 91		5, 698, 918	59. 00
60.00	06000 LABORATORY	14, 284, 383		14, 284, 38	3 0	14, 284, 383	60.00
64.00	06400 I NTRAVENOUS THERAPY	O			0 0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	3, 377, 361	0	3, 377, 36	1 0	3, 377, 361	65. 00
66. 00	06600 PHYSI CAL THERAPY	11, 652, 857	0	11, 652, 85	7 0	11, 652, 857	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	4 ( ( 0 0 0 0	0 0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	1, 660, 098		1, 660, 09		1, 660, 098	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 610, 101		1, 610, 10		1, 610, 101	70.00
71. 00 72. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 07200 IMPL. DEV. CHARGED TO PATIENTS	9, 867, 528 17, 471, 537		9, 867, 52 17, 471, 53		9, 867, 528 17, 471, 537	71. 00 72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	36, 653, 391		36, 653, 39		36, 653, 391	•
73. 01	07302 OP PHARMACY	575, 592		575, 59		575, 592	73. 01
74. 00	07400 RENAL DIALYSIS	1, 195, 531		1, 195, 53		1, 195, 531	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	O			o o	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		(	o o	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 340, 170		1, 340, 17	0	1, 340, 170	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLINIC	2, 732, 207		2, 732, 20		2, 732, 207	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	2, 426, 748		2, 426, 74		2, 426, 748	90. 01
90. 02 90. 03	O9002   WOUND CARE CENTER   O9003   PAIN CLINIC	1, 636, 480 654, 160		1, 636, 48 654, 16		1, 636, 480 654, 160	90. 02 90. 03
90. 05	09005 OP PSYCH CLINIC	3, 326, 469		3, 326, 46		3, 326, 469	90.05
91. 00	09100 EMERGENCY	12, 331, 297		12, 331, 29		12, 331, 297	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 316, 334		6, 316, 33		6, 316, 334	
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0			0 0	0	94. 00
	09500 AMBULANCE SERVI CES	9, 187, 870		9, 187, 87	0	9, 187, 870	95. 00
	10000 I&R SERVICES-NOT APPRVD PRGM	0			0		100. 00
101.00	10100 HOME HEALTH AGENCY	5, 598, 081		5, 598, 08	1	5, 598, 081	101. 00
112 00	SPECIAL PURPOSE COST CENTERS	Т Т			1		112 00
	11300 INTEREST EXPENSE  11400 UTILIZATION REVIEW-SNF						113. 00 114. 00
	11400   OTTLIZATION REVIEW-SNF   11500   AMBULATORY SURGICAL CENTER (D.P.)	0			o		115. 00
	11600 HOSPICE	6, 422, 451		6, 422, 45		6, 422, 451	
200.00		278, 361, 636	0	278, 361, 63		278, 361, 636	200.00
201.00		6, 316, 334	· ·	6, 316, 33		6, 316, 334	
202.00		272, 045, 302	0			272, 045, 302	202. 00
		·			·		

Health Financial Systems

IU HEALTH BLOOMINGTON HOSPITAL

In Lieu of Form CMS-2552-10

COMPUTATION OF RATIO OF COSTS TO CHARGES

Provider CCN: 15-0051

From 01/01/2016
To 12/31/2016

Period:
From 01/01/2016
To 12/31/2016

Part I
Date/Time Prepared:
5/23/2017 10: 42 am

Charges

Cost Center Description

Inpatient Outpatient Total (col. 6 Cost or Other TEFRA

						5/23/201/ 10:	42 am
				XVIII	Hospi tal	PPS	
			Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
				+ col . 7)	Rati o	I npati ent	
						Ratio	
		6.00	7.00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	91, 731, 290		91, 731, 290			30. 00
31.00	03100 INTENSIVE CARE UNIT	16, 141, 419		16, 141, 419			31.00
41.00	04100 SUBPROVI DER - I RF	5, 034, 383		5, 034, 383			41.00
42.00	04200 SUBPROVI DER	o		0			42.00
43.00	04300 NURSERY	11, 641, 919		11, 641, 919			43.00
	ANCILLARY SERVICE COST CENTERS	,,		,,			1
50.00	05000 OPERATING ROOM	76, 303, 433	113, 645, 448	189, 948, 881	0. 115941	0. 000000	50.00
50. 01	05001 CV SURGERY	0	0.10,010,110	1		0. 000000	
51. 00	05100 RECOVERY ROOM	8, 059, 810	20, 156, 797	28, 216, 607		0. 000000	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	29, 545, 973	2, 308, 171	1		0. 000000	
53. 00	05300 ANESTHESI OLOGY	27,010,770	2,000,171	01,001,111		0. 000000	
54. 00	05400 RADI OLOGY-DI AGNOSTI C	16, 642, 112	41, 406, 631	· -		0. 000000	
55. 00	05500 RADI OLOGY-THERAPEUTI C	3, 123, 319	61, 331, 279	1		0. 000000	
56. 00	05600 RADI OI SOTOPE	3, 123, 317	01, 331, 277	1		0. 000000	
57. 00	05700 CT SCAN	8, 625, 175	18, 633, 852	· -		0. 000000	
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	2, 498, 448	6, 401, 883			0. 000000	
59. 00	05900 CARDIAC CATHETERIZATION	26, 699, 227	41, 625, 996			0. 000000	1
60.00	06000 LABORATORY	48, 997, 567	65, 479, 940			0. 000000	
64. 00	06400 I NTRAVENOUS THERAPY	40, 997, 307	00, 479, 940	114, 477, 507			
65. 00		0.010.007	2 000 245	· ·		0.000000	
	06500 RESPI RATORY THERAPY	8, 918, 887	2, 088, 365			0.000000	
66.00	06600 PHYSI CAL THERAPY	13, 175, 103	14, 008, 265	l		0.000000	
67.00	06700 OCCUPATI ONAL THERAPY	0	0	_		0.000000	
68.00	06800 SPEECH PATHOLOGY	10 004 (75	0	· ·		0.000000	
69. 00	06900 ELECTROCARDI OLOGY	10, 084, 675	13, 441, 953			0.000000	
70. 00	07000 ELECTROENCEPHALOGRAPHY	1, 438, 428	10, 484, 587			0. 000000	
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 617, 446	23, 930, 129			0. 000000	1
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	66, 064, 182	38, 334, 555			0. 000000	
73. 00	07300 DRUGS CHARGED TO PATIENTS	70, 591, 756	71, 882, 597			0. 000000	1
73. 01	07302 OP PHARMACY	0	2, 080, 144	1		0. 000000	
74. 00	07400 RENAL DI ALYSI S	2, 493, 465	1, 174, 047	1		0. 000000	
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0		0. 000000	
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0		0. 000000	
76. 97	07697 CARDI AC REHABI LI TATI ON	342, 915	2, 632, 781	2, 975, 696	0. 450372	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	15, 957	1, 520, 230			0. 000000	
90. 01	09001 OP ONCOLOGY INFUSION CENTER	114, 730	11, 562, 186			0.000000	90. 01
90. 02	09002 WOUND CARE CENTER	13, 535	4, 580, 838	4, 594, 373		0. 000000	90. 02
90. 03	09003 PAIN CLINIC	1, 498	1, 895, 067	1, 896, 565	0. 344918	0.000000	90. 03
90. 05	09005 OP PSYCH CLINIC	17, 756	2, 460, 829	2, 478, 585	1. 342084	0. 000000	90. 05
91.00	09100 EMERGENCY	18, 124, 672	77, 886, 141			0.000000	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 125, 144	17, 738, 874	19, 864, 018	0. 317979	0.000000	92.00
	OTHER REIMBURSABLE COST CENTERS						1
94.00	09400 HOME PROGRAM DIALYSIS	0	0			0. 000000	94. 00
95.00	09500 AMBULANCE SERVICES	91, 617	38, 889, 165	38, 980, 782	0. 235703	0. 000000	95. 00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0			100.00
	10100 HOME HEALTH AGENCY	o	3, 088, 152	3, 088, 152			101.00
	SPECIAL PURPOSE COST CENTERS			•			1
113.00	11300 I NTEREST EXPENSE						113. 00
	11400 UTILIZATION REVIEW-SNF			1			114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0			115. 00
	11600 HOSPI CE	1, 039, 973	4, 292, 960				116. 00
200.00		557, 315, 814		1, 272, 277, 676			200.00
201.00		33., 515, 514	, , , , , , , , , , , , , , , , ,	1,2.2,2,7,370			201.00
202.00		557, 315, 814	714 961 862	1, 272, 277, 676			202. 00
202.00	1.212. (333 1.131. 431. 31.3)		, , 5 . , 662	1 ., 2.2, 2, 0.0	1	I	,_ ,_ ,

				5/23/2017 10:42 am
		Title XVIII	Hospi tal	PPS
Cost Center Description	PPS Inpatient			
	Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00   03000   ADULTS & PEDI ATRI CS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
41. 00   04100   SUBPROVI DER - I RF				41.00
42. 00   04200   SUBPROVI DER				42. 00
43. 00 04300 NURSERY				43.00
ANCILLARY SERVICE COST CENTERS	<u>'</u>			
50. 00 05000 OPERATING ROOM	0. 115941			50.00
50. 01   05001 CV SURGERY	0. 000000			50. 01
51. 00   05100   RECOVERY ROOM	0. 177438			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 258100			52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000			53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 140926			54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0. 102589			55.00
56. 00   05600   RADI 01 SOTOPE	0. 000000			56.00
57. 00   05700 CT SCAN	0. 059360			57. 00
58. 00   05800   MAGNETI C RESONANCE   MAGING (MRI)	0. 034300			58.00
				l l
	0. 083409			59.00
60. 00   06000   LABORATORY	0. 124779			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0.000000			64.00
65. 00 06500 RESPIRATORY THERAPY	0. 306831			65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 428676			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. 070563			69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 135041			70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 237499			71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 167354			72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 257263			73. 00
73. 01 07302 OP PHARMACY	0. 276708			73. 01
74. 00   07400   RENAL DI ALYSI S	0. 325979			74.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000			75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			75. 01
76. 97   07697 CARDIAC REHABILITATION	0. 450372			76. 97
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	1. 778564			90.00
90.01 09001 OP ONCOLOGY INFUSION CENTER	0. 207824			90. 01
90. 02 09002 WOUND CARE CENTER	0. 356192			90. 02
90. 03   09003   PAIN CLINIC	0. 344918			90. 03
90. 05 09005 OP PSYCH CLINIC	1. 342084			90. 05
91. 00 09100 EMERGENCY	0. 128437			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 317979			92. 00
OTHER REIMBURSABLE COST CENTERS	0.01777			72.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0. 000000			94. 00
95. 00 09500 AMBULANCE SERVICES	0. 235703			95. 00
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM	0. 200700			100.00
101. 00 10100 HOME HEALTH AGENCY				101. 00
SPECIAL PURPOSE COST CENTERS				101.00
113. 00 11300   NTEREST EXPENSE				113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)				115. 00
116. 00 11600 HOSPI CE				116.00
200.00 Subtotal (see instructions)				200.00
201. 00 Less Observation Beds				201. 00
202.00   Total (see instructions)				202. 00

From 01/01/2016 Part I Date/Time Prepared: 12/31/2016 5/23/2017 10:42 am Hospi tal Title XIX PPS Costs Cost Center Description Total Cost Therapy Limit Total Costs RCF Total Costs from Wkst. B, Adj Di sal I owance Part I, col. 26) 1.00 2.00 3.00 4.00 5.00 INPATIENT ROUTINE SERVICE COST CENTERS 30 00 03000 ADULTS & PEDIATRICS 55, 297, 122 55, 297, 122 55, 297, 122 30.00 03100 INTENSIVE CARE UNIT 6, 659, 148 6, 659, 148 0 6, 659, 148 31.00 31.00 04100 SUBPROVIDER - IRF o 41.00 2, 949, 383 2, 949, 383 2, 949, 383 41.00 04200 SUBPROVI DER 42.00 0 42.00 0 04300 NURSERY 43.00 4, 733, 887 4, 733, 887 4, 733, 887 43.00 ANCILLARY SERVICE COST CENTERS 50 00 05000 OPERATING ROOM 22, 022, 936 0 22, 022, 936 50.00 22, 022, 936 05001 CV SURGERY 0 50.01 Λ 50 01 51.00 05100 RECOVERY ROOM 5,006,685 5,006,685 0 5,006,685 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 8, 221, 551 8, 221, 551 0 0 0 8, 221, 551 52.00 05300 ANESTHESI OLOGY 53.00 53.00 C 0 05400 RADI OLOGY-DI AGNOSTI C 8, 180, 584 8, 180, 584 8, 180, 584 54.00 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 6, 612, 358 6, 612, 358 6, 612, 358 55.00 05600 RADI OI SOTOPE 56.00 0 0 56.00 05700 CT SCAN 57 00 1 618 109 1 618 109 1, 618, 109 57 00 58.00 05800 MAGNETIC RESONANCE IMAGING (MRI) 1,040,309 1, 040, 309 1, 040, 309 58.00 05900 CARDIAC CATHETERIZATION 5, 698, 918 5, 698, 918 0 5, 698, 918 59.00 59.00 0 60.00 06000 LABORATORY 14, 284, 383 14, 284, 383 14, 284, 383 60.00 06400 I NTRAVENOUS THERAPY 64 00 C 0 64 00 0 65.00 06500 RESPIRATORY THERAPY 3, 377, 361 3, 377, 361 3, 377, 361 65.00 66.00 06600 PHYSI CAL THERAPY 11, 652, 857 11, 652, 857 0 11, 652, 857 66.00 67 00 06700 OCCUPATIONAL THERAPY 67 00 0 O 0 68.00 06800 SPEECH PATHOLOGY 0 Ω 68.00 0 06900 ELECTROCARDI OLOGY 1, 660, 098 1, 660, 098 1, 660, 098 69.00 69.00 70.00 07000 ELECTROENCEPHALOGRAPHY 1,610,101 1, 610, 101 0 1,610,101 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS 71 00 9 867 528 9, 867, 528 9, 867, 528 71 00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 17, 471, 537 17, 471, 537 17, 471, 537 72.00 36, 653, 391 07300 DRUGS CHARGED TO PATIENTS 36, 653, 391 36, 653, 391 73.00 0 73.00 73.01 07302 OP PHARMACY 575, 592 575, 592 575, 592 73.01 07400 RENAL DIALYSIS 1, 195, 531 1, 195, 531 74 00 1, 195, 531 74 00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 0 C 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 0 75.01 75.01 1, 340, 170 76. 97 07697 CARDI AC REHABI LI TATI ON 1, 340, 170 0 1, 340, 170 76. 97 OUTPATIENT SERVICE COST CENTERS 90.00 09000 CLI NI C 2, 732, 207 2, 732, 207 0 2, 732, 207 90.00 90 01 09001 OP ONCOLOGY INFUSION CENTER 2, 426, 748 2, 426, 748 0 2, 426, 748 90 01 0 09002 WOUND CARE CENTER 1, 636, 480 1, 636, 480 1, 636, 480 90.02 90.02 90.03 09003 PAIN CLINIC 654, 160 654, 160 654, 160 90.03 90.05 09005 OP PSYCH CLINIC 3, 326, 469 3, 326, 469 0 3, 326, 469 90.05 91.00 09100 EMERGENCY 12, 331, 297 12, 331, 297 12, 331, 297 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)
OTHER REIMBURSABLE COST CENTERS 92.00 6, 316, 334 6, 316, 334 6, 316, 334 92.00 09400 HOME PROGRAM DIALYSIS 94.00 95. 00 09500 AMBULANCE SERVICES 9, 187, 870 9, 187, 870 9, 187, 870 95.00 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 100.00 101.00 10100 HOME HEALTH AGENCY 5, 598, 081 5, 598, 081 5, 598, 081 101. 00 SPECIAL PURPOSE COST CENTERS 113. 00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114. 00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 115.00 116. 00 11600 HOSPI CE 6, 422, 451 6, 422, 451 6, 422, 451 116. 00 278, 361, 636 278, 361, 636 200.00 Subtotal (see instructions) C 0 278, 361, 636 200. 00

6, 316, 334

272, 045, 302

6, 316, 334

272, 045, 302

6, 316, 334 201. 00 272, 045, 302 202. 00

201.00

202.00

Less Observation Beds

Total (see instructions)

Health Financial Systems

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-0051

						5/23/2017 10:	42 am
			Titl	e XIX	Hospi tal	PPS	
	·		Charges				
	Cost Center Description	I npati ent	Outpati ent	Total (col. 6	Cost or Other	TEFRA	
	•		•	+ col. 7)	Ratio	Inpati ent	
				,		Ratio	
		6.00	7. 00	8.00	9. 00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	91, 731, 290		91, 731, 290			30. 00
	03100   NTENSI VE CARE UNIT	16, 141, 419		16, 141, 419			31.00
	04100 SUBPROVI DER – I RF	5, 034, 383		5, 034, 383			41. 00
	04200 SUBPROVI DER	3,034,303		3, 034, 303			42.00
		11 (41 010		11 / 41 010			1
	04300 NURSERY	11, 641, 919		11, 641, 919			43. 00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	7/ 202 422	112 / 45 440	100 040 001	0 115041	0.000000	FO 00
		76, 303, 433	113, 645, 448		0. 115941	0.000000	
	05001 CV SURGERY	0	0			0.000000	
	05100 RECOVERY ROOM	8, 059, 810	20, 156, 797			0. 000000	
	05200 DELIVERY ROOM & LABOR ROOM	29, 545, 973	2, 308, 171			0. 000000	
	05300 ANESTHESI OLOGY	0	0		0. 000000	0. 000000	
	05400 RADI OLOGY-DI AGNOSTI C	16, 642, 112	41, 406, 631	58, 048, 743		0. 000000	
	05500 RADI OLOGY-THERAPEUTI C	3, 123, 319	61, 331, 279	64, 454, 598	0. 102589	0. 000000	55. 00
56.00	05600 RADI OI SOTOPE	0	0	0	0.000000	0.000000	56. 00
57.00	05700 CT SCAN	8, 625, 175	18, 633, 852	27, 259, 027	0. 059360	0.000000	57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	2, 498, 448	6, 401, 883	8, 900, 331	0. 116884	0.000000	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	26, 699, 227	41, 625, 996	68, 325, 223	0. 083409	0.000000	59. 00
	06000 LABORATORY	48, 997, 567	65, 479, 940			0. 000000	
	06400 I NTRAVENOUS THERAPY	0	0		0. 000000	0. 000000	
	06500 RESPI RATORY THERAPY	8, 918, 887	2, 088, 365	11, 007, 252		0.000000	
	06600 PHYSI CAL THERAPY	13, 175, 103	14, 008, 265			0. 000000	
	06700 OCCUPATI ONAL THERAPY	0	0 11,000,200			0. 000000	
	06800 SPEECH PATHOLOGY		0		0. 000000	0. 000000	
	06900 ELECTROCARDI OLOGY	10, 084, 675	13, 441, 953	_		0. 000000	
		1					
	07000 ELECTROENCEPHALOGRAPHY	1, 438, 428	10, 484, 587			0.000000	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	17, 617, 446	23, 930, 129			0.000000	
	07200 I MPL. DEV. CHARGED TO PATIENTS	66, 064, 182	38, 334, 555			0. 000000	
	07300 DRUGS CHARGED TO PATIENTS	70, 591, 756	71, 882, 597			0. 000000	
	07302 OP PHARMACY	0	2, 080, 144			0. 000000	
	07400 RENAL DI ALYSI S	2, 493, 465	1, 174, 047			0. 000000	
	07500 ASC (NON-DISTINCT PART)	0	0			0. 000000	
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0. 000000	0. 000000	75. 01
	07697 CARDI AC REHABI LI TATI ON	342, 915	2, 632, 781	2, 975, 696	0. 450372	0. 000000	76. 97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	15, 957	1, 520, 230	1, 536, 187	1. 778564	0.000000	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	114, 730	11, 562, 186	11, 676, 916	0. 207824	0.000000	90. 01
90. 02	09002 WOUND CARE CENTER	13, 535	4, 580, 838	4, 594, 373	0. 356192	0. 000000	90. 02
90. 03	09003 PAIN CLINIC	1, 498	1, 895, 067	1, 896, 565	0. 344918	0. 000000	90. 03
	09005 OP PSYCH CLINIC	17, 756	2, 460, 829			0.000000	90. 05
	09100 EMERGENCY	18, 124, 672	77, 886, 141			0. 000000	
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 125, 144	17, 738, 874			0. 000000	
	OTHER REIMBURSABLE COST CENTERS	2, 120, 111	17,700,071	17,001,010	0.017777	0.000000	72.00
	09400 HOME PROGRAM DI ALYSIS	0	0	0	0. 000000	0. 000000	94. 00
	09500 AMBULANCE SERVICES	91, 617	38, 889, 165			0. 000000	
1		1			0. 233703	0.000000	
	10000 I &R SERVI CES-NOT APPRVD PRGM	0	0 000 150				100.00
	10100 HOME HEALTH AGENCY	0	3, 088, 152	3, 088, 152			101. 00
	SPECIAL PURPOSE COST CENTERS			I			
	11300 I NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF						114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0			115. 00
1	11600 HOSPI CE	1, 039, 973	4, 292, 960				116. 00
200.00	Subtotal (see instructions)	557, 315, 814	714, 961, 862	1, 272, 277, 676			200. 00
201.00	Less Observation Beds						201. 00
202.00	Total (see instructions)	557, 315, 814	714, 961, 862	1, 272, 277, 676			202. 00
		•			·		

| In Lieu of Form CMS-2552-10 | Period: | Worksheet C | From 01/01/2016 | Part | To 12/31/2016 | Date/Time Prepared: | 5/23/2017 10: 42 am

		Title XIX	Hospi tal	PPS	. 42 aiii
Cost Center Description	PPS Inpatient	THE WAY	noop: tui		
3001 30001 ptron	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS	111111				
30. 00 03000 ADULTS & PEDIATRICS					30.00
31. 00   03100   NTENSI VE CARE UNI T					31. 00
41. 00   04100   SUBPROVI DER -   RF					41. 00
42. 00   04200   SUBPROVI DER					42. 00
43. 00   04300 NURSERY					43. 00
ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00   05000   OPERATING ROOM	0. 115941				50.00
50. 01   05001 CV SURGERY	0. 000000				50. 00
51. 00   05100   RECOVERY ROOM					•
	0. 177438				51.00
52. 00   05200   DELIVERY ROOM & LABOR ROOM	0. 258100				52.00
53. 00   05300   ANESTHESI OLOGY	0.000000				53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	0. 140926				54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 102589				55. 00
56. 00   05600   RADI OI SOTOPE	0. 000000				56. 00
57. 00   05700   CT   SCAN	0. 059360				57. 00
58.00   05800   MAGNETIC RESONANCE I MAGING (MRI)	0. 116884				58. 00
59. 00   05900   CARDI AC CATHETERI ZATI ON	0. 083409				59. 00
60. 00  06000 LABORATORY	0. 124779				60.00
64. 00   06400   I NTRAVENOUS THERAPY	0. 000000				64. 00
65. 00   06500   RESPI RATORY THERAPY	0. 306831				65. 00
66. 00  06600 PHYSI CAL THERAPY	0. 428676				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. 070563				69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 135041				70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 237499				71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 167354				72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 257263				73. 00
73. 01 07302 OP PHARMACY	0. 276708				73. 01
74.00 07400 RENAL DIALYSIS	0. 325979				74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000				75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000				75. 01
76. 97 O7697 CARDI AC REHABI LI TATI ON	0. 450372				76. 97
OUTPATIENT SERVICE COST CENTERS	0. 100072				1 / 51 / /
90. 00 09000 CLINIC	1. 778564				90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	0. 207824				90. 01
90. 02 09002 WOUND CARE CENTER	0. 356192				90. 02
90. 03   09003   PAIN CLINIC	0. 344918				90. 03
90. 05   09005   OP PSYCH CLINIC	1. 342084				90.05
91. 00   09100   EMERGENCY	0. 128437				91.00
	1				92.00
	0. 317979				92.00
OTHER REIMBURSABLE COST CENTERS	0.000000				- 04 00
94. 00   09400   HOME   PROGRAM DI ALYSI S	0.000000				94.00
95. 00 09500 AMBULANCE SERVI CES	0. 235703				95.00
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM					100.00
101. 00 10100 HOME HEALTH AGENCY					101. 00
SPECIAL PURPOSE COST CENTERS					4
113. 00 11300   I NTEREST EXPENSE					113. 00
114.00 11400 UTI LI ZATI ON REVI EW-SNF					114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)					115. 00
116. 00 11600 HOSPI CE					116. 00
200.00 Subtotal (see instructions)					200. 00
201.00 Less Observation Beds					201. 00
202.00 Total (see instructions)					202. 00

Health Financial Systems

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

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

Period: Worksheet C
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared: 5/23/2017 10: 42 am Provider CCN: 15-0051

				'	0 12/01/2010	5/23/2017 10:	42 am
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Total Cost		Operating Cost		Operating Cost	
	<b>'</b>	(Wkst. B, Part				Reduction	
		1, col. 26)		Cost (col. 1 -		Amount	
		, , ,		col . 2)			
		1.00	2. 00	3.00	4. 00	5. 00	
Α	NCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	22, 022, 936	2, 210, 116	19, 812, 820	0	0	50.00
	05001 CV SURGERY	0	_,,	1			50. 01
	05100 RECOVERY ROOM	5, 006, 685	213, 618				51.00
	05200 DELIVERY ROOM & LABOR ROOM	8, 221, 551	1, 325, 905				52.00
	05300 ANESTHESI OLOGY	0,221,001	1,020,700	1			53. 00
	05400 RADI OLOGY-DI AGNOSTI C	8, 180, 584	857, 827	1	1		54.00
	05500 RADI OLOGY-THERAPEUTI C	6, 612, 358					55. 00
	05600 RADI OI SOTOPE	0,012,000	037, 310			1	56. 00
	05700 CT SCAN	1, 618, 109	1	1	1	1	57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 040, 309				1	58. 00
	05900 CARDI AC CATHETERI ZATI ON	5, 698, 918					59.00
	06000 LABORATORY	14, 284, 383					60.00
	06400 I NTRAVENOUS THERAPY	14, 204, 303	007, 900	1		1	64.00
	•	2 277 2/1	۱ -	1	_	1	•
	06500 RESPI RATORY THERAPY	3, 377, 361	109, 794		_	1	65. 00
	06600 PHYSI CAL THERAPY	11, 652, 857	733, 763	1			66.00
	06700 OCCUPATI ONAL THERAPY	0	C	_	0	1	67. 00
	06800 SPEECH PATHOLOGY	0	0	1			68. 00
	06900 ELECTROCARDI OLOGY	1, 660, 098					69. 00
	07000 ELECTROENCEPHALOGRAPHY	1, 610, 101	168, 348				70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 867, 528				· ·	71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	17, 471, 537	297, 965				72. 00
	07300 DRUGS CHARGED TO PATIENTS	36, 653, 391	802, 786				73. 00
	07302 OP PHARMACY	575, 592		1		0	73. 01
	07400 RENAL DIALYSIS	1, 195, 531	45, 233	1, 150, 298		0	74. 00
	07500 ASC (NON-DISTINCT PART)	0	[ C	(			75. 00
75. 01 0	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	C	(	0	0	75. 01
76. 97 0	07697 CARDI AC REHABI LI TATI ON	1, 340, 170	149, 087	1, 191, 083	0	0	76. 97
0	OUTPATIENT SERVICE COST CENTERS						
90.00 0	09000 CLI NI C	2, 732, 207	346, 355	2, 385, 852	0	0	90. 00
90. 01 0	09001 OP ONCOLOGY INFUSION CENTER	2, 426, 748	173, 856	2, 252, 892	0	0	90. 01
90. 02 0	09002 WOUND CARE CENTER	1, 636, 480	187, 304	1, 449, 176	0	0	90. 02
90. 03 0	09003 PAIN CLINIC	654, 160	110, 809	543, 351	0	0	90. 03
90.05 0	09005 OP PSYCH CLINIC	3, 326, 469	356, 705	2, 969, 764	0	0	90. 05
91.00 0	09100 EMERGENCY	12, 331, 297	1, 116, 726	11, 214, 571	0	0	91.00
92.00 0	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 316, 334	682, 613	5, 633, 721	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DIALYSIS	0	C		0	0	94.00
95. 00 0	09500 AMBULANCE SERVICES	9, 187, 870	635, 392	8, 552, 478	0	0	95. 00
	10000 I&R SERVICES-NOT APPRVD PRGM	0			0	0	100.00
101, 00 1	10100 HOME HEALTH AGENCY	5, 598, 081	310, 023	5, 288, 058	0	0	101.00
	SPECIAL PURPOSE COST CENTERS				•	•	İ
	11300   NTEREST EXPENSE						113. 00
	11400 UTI LI ZATI ON REVI EW-SNF			1		l	114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P. )	0	l c	(	0	l .	115. 00
	11600 HOSPI CE	6, 422, 451	291, 459	1			116. 00
200.00	Subtotal (sum of lines 50 thru 199)	208, 722, 096					200.00
201.00	Less Observation Beds	6, 316, 334				l	201. 00
202.00	Total (line 200 minus line 201)	202, 405, 762				l e	202.00
202.00	1.513. (1116 200 111110 201)	202, 100, 702	12, , 11, 522	107, 101, 240	., 0	1	1-02.00

Provider CCN: 15-0051 REDUCTIONS FOR MEDICALD ONLY

						5/23/2017 10: 42 am
			Ti tl	e XIX	Hospi tal	PPS
	Cost Center Description	Cost Net of	Total Charges	Outpati ent		
		Capital and	(Worksheet C,	Cost to Charge		
		Operating Cost	Part I, column	Ratio (col. 6		
		Reducti on	8)	/ col. 7)		
		6.00	7. 00	8. 00		
	ANCILLARY SERVICE COST CENTERS					
50.00	05000 OPERATI NG ROOM	22, 022, 936	189, 948, 881	0. 115941		50.00
50. 01	05001 CV SURGERY	0	1	0.000000		50. 01
51.00	05100 RECOVERY ROOM	5, 006, 685	28, 216, 607			51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 221, 551	31, 854, 144			52.00
53. 00	05300 ANESTHESI OLOGY	0,,				53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	8, 180, 584	58, 048, 743			54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	6, 612, 358				55. 00
56. 00	05600 RADI OI SOTOPE	0,012,000	0.7.10.7070			56. 00
57. 00	05700 CT SCAN	1, 618, 109	1			57. 00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	1, 040, 309				58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	5, 698, 918				59.00
60.00	06000 LABORATORY	14, 284, 383				60.00
64. 00	06400 I NTRAVENOUS THERAPY	14, 204, 303	1			64.00
65. 00	06500 RESPIRATORY THERAPY	_	1			65. 00
66. 00	06600 PHYSI CAL THERAPY	3, 377, 361	11, 007, 252			66. 00
		11, 652, 857	27, 183, 368			ı
67. 00	06700 OCCUPATIONAL THERAPY	0	0			67. 00
68. 00	06800 SPEECH PATHOLOGY	1 ((0 000	0 50, (00			68. 00
69.00	06900 ELECTROCARDI OLOGY	1, 660, 098				69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	1, 610, 101	11, 923, 015			70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	9, 867, 528				71.00
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	17, 471, 537				72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	36, 653, 391	142, 474, 353			73. 00
73. 01	07302 OP PHARMACY	575, 592				73. 01
74. 00	07400 RENAL DIALYSIS	1, 195, 531	3, 667, 512			74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	1			75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0			75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	1, 340, 170	2, 975, 696	0. 450372		76. 97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	2, 732, 207				90. 00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	2, 426, 748				90. 01
90. 02	09002 WOUND CARE CENTER	1, 636, 480	4, 594, 373	0. 356192		90. 02
90. 03	09003 PAIN CLINIC	654, 160	1, 896, 565	0. 344918		90. 03
90. 05	09005 OP PSYCH CLINIC	3, 326, 469	2, 478, 585	1. 342084		90. 05
91.00	09100 EMERGENCY	12, 331, 297	96, 010, 813	0. 128437		91. 00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	6, 316, 334	19, 864, 018	0. 317979		92.00
	OTHER REIMBURSABLE COST CENTERS					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000		94. 00
95.00	09500 AMBULANCE SERVI CES	9, 187, 870	38, 980, 782	0. 235703		95. 00
100.00	10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0.000000		100.00
	10100 HOME HEALTH AGENCY	5, 598, 081	3, 088, 152	1. 812761		101. 00
	SPECIAL PURPOSE COST CENTERS					
113.00	11300   NTEREST EXPENSE					113. 00
	11400 UTI LI ZATI ON REVI EW-SNF					114. 00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0.000000		115. 00
	11600 HOSPI CE	6, 422, 451				116. 00
200.00			1, 147, 728, 665			200. 00
201.00		6, 316, 334				201. 00
202.00			1, 147, 728, 665			202. 00
202.00	1.0001 (1110 200 1111103 11110 201)	202, 400, 702	1 ., 117, 720, 000	ı	I	1202.00

Health Financial Systems	IU HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPIT	TAL COSTS	Provi der Co		Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 10:	pared: 42 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced		Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col . 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col . 1 - col			
	26)		2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30.00 ADULTS & PEDIATRICS	5, 975, 992	0	5, 975, 99	2 48, 658	122. 82	30.00
31.00 INTENSIVE CARE UNIT	509, 291		509, 29	1 4, 074	125. 01	31.00
41. 00 SUBPROVI DER - I RF	484, 703	0	484, 70	3, 144	154. 17	41.00
42. 00 SUBPROVI DER	0	0		0	0.00	42.00
43. 00 NURSERY	313, 957		313, 95	7 3, 478	90. 27	43.00
200.00 Total (lines 30-199)	7, 283, 943		7, 283, 94	3 59, 354		200.00
Cost Center Description	I npati ent	Inpati ent				
·	Program days	Program				
		Capital Cost				
		(coi. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	17, 051	2, 094, 204				30.00
31.00 INTENSIVE CARE UNIT	2, 692	336, 527				31. 00
41. 00 SUBPROVI DER - I RF	2, 018	311, 115				41.00
42. 00 SUBPROVI DER	0	0				42.00
43. 00 NURSERY	0	0				43.00
200.00 Total (lines 30-199)	21, 761	2, 741, 846				200. 00

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

	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	L COSTS	Provider Co		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Pre 5/23/2017 10:	pared: 42 am
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges		t Inpatient	Capi tal Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			1			
50. 00   05000   OPERATI NG ROOM	2, 210, 116		0. 01163		400, 124	50.00
50. 01   05001   CV   SURGERY	0		0. 00000		0	50. 01
51. 00   05100   RECOVERY ROOM	213, 618				27, 546	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	1, 325, 905	31, 854, 144			2, 822	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0.00000		0	53.00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	857, 827	58, 048, 743			126, 713	54.00
55. 00   05500   RADI OLOGY-THERAPEUTI C	839, 518				22, 123	55.00
56. 00   05600   RADI OI SOTOPE	0	1	0.00000		0	56.00
57. 00   05700   CT   SCAN	75, 364	27, 259, 027			11, 739	57. 00
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	82, 505		0.00927		10, 361	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	369, 441	68, 325, 223			64, 208	59.00
60. 00   06000   LABORATORY	807, 986	114, 477, 507			141, 601	
64. 00   06400   I NTRAVENOUS THERAPY	0	44 007 050	0.00000		0	64.00
65. 00 06500 RESPIRATORY THERAPY	109, 794				46, 379	65.00
66. 00   06600   PHYSI CAL THERAPY 67. 00   06700   OCCUPATI ONAL THERAPY	733, 763		0. 02699 0. 00000		105, 771 0	66. 00 67. 00
67. 00   06700   0CCUPATI ONAL THERAPY 68. 00   06800   SPEECH PATHOLOGY	0	1	0.00000		0	68.00
69. 00   06900   SPEECH PATHOLOGY	119, 538	1			27, 064	69.00
70. 00 07000 ELECTROEARDI OLOGI 70. 00 07000 ELECTROENCEPHALOGRAPHY	168, 348				9, 349	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	165, 597	41, 547, 575			30, 830	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	297, 965				93, 175	72.00
73. 00 07300 DRUGS CHARGED TO PATTENTS	802, 786		•		178, 363	73.00
73. 01   07302   0P   PHARMACY	38, 502		•		170, 303	73. 00
74. 00   07400   RENAL DI ALYSI S	45, 233				17, 810	74. 00
75. 00   07500   ASC (NON-DISTINCT PART)	43, 233				17, 010	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0		0. 00000		0	75. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	149, 087	2, 975, 696				76. 97
OUTPATIENT SERVICE COST CENTERS	1177007	2, , , 0, 0, 0	0.00010	., ., ., ., .,	0, 0.1.	70.77
90. 00 09000 CLI NI C	346, 355	1, 536, 187	0. 22546	9, 651	2, 176	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	173, 856				1, 273	90. 01
90. 02 09002 WOUND CARE CENTER	187, 304	4, 594, 373			539	90. 02
90. 03   09003   PALN CLINIC	110, 809				88	90. 03
90. 05 09005 OP PSYCH CLINIC	356, 705				2, 532	90. 05
91. 00 09100 EMERGENCY	1, 116, 726			1 8, 938, 516	103, 964	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	682, 613				39, 003	92.00
OTHER REIMBURSABLE COST CENTERS	•					1
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.00000	0 0	0	94. 00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	12, 387, 261	1, 100, 326, 798		184, 078, 185	1, 474, 194	200. 00

Uselith Firemaial Contant	II IIFALTII DI OOMI	NOTON HOCDLEAL		1 - 1 : -	£ E CMC	2552 10
Health Financial Systems II APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	U HEALTH BLOOMI			Peri od:	eu of Form CMS-: Worksheet D	2552-10
ALTORITONIMENT OF THE ATTENT ROOTING SERVICE OTHER TA	133 THROUGH COS	13   110VI del C		From 01/01/2016		
			-	Γo 12/31/2016		
					5/23/2017 10:	42 am
			XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
		Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
	1.00	2.00	2.00		minus col. 4)	
INPATIENT ROUTINE SERVICE COST CENTERS	1. 00	2. 00	3.00	4. 00	5. 00	
30. 00 03000 ADULTS & PEDIATRICS		1 0	J			30.00
31. 00  03000 ADULTS & PEDIATRICS					0	31.00
41. 00   04100   SUBPROVI DER -   1 RF						41.00
42. 00   04200   SUBPROVI DER						42.00
43. 00   04200  SUBPROVI DER 43. 00   04300  NURSERY					0	43. 00
200. 00 Total (lines 30-199)			)			200. 00
Cost Center Description	Total Dationt	Per Diem (col.	Inpatient	Inpati ent	0	200.00
cost center bescription	Days	5 ÷ col . 6)	Program Days			
	Days	3 . 601 . 0)	1 1 Ogi alli bays	Pass-Through		
				Cost (col. 7 x		
				col . 8)		
	6. 00	7. 00	8. 00	9. 00		
INPATIENT ROUTINE SERVICE COST CENTERS	<u>'</u>					
30. 00 03000 ADULTS & PEDI ATRI CS	48, 658	0.00	17, 05°	1 0	)	30.00
31.00 03100 INTENSIVE CARE UNIT	4,074	0.00	2, 692	2 0	,	31. 00
41. 00   04100   SUBPROVI DER - I RF	3, 144	0.00	2, 018	3 0	,	41. 00
42. 00   04200   SUBPROVI DER	0	0.00		0	,	42.00
43. 00 04300 NURSERY	3, 478	0.00		0	,	43. 00
200.00 Total (lines 30-199)	59, 354		21, 76°	1 0	,	200. 00
	•	•	•	•		•

| Peri od: | Worksheet D | From 01/01/2016 | Part IV | To 12/31/2016 | Date/Time Prepared: | To 12/31/2017 | 
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

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

					10 12/31/2016	5/23/2017 10:	
			Title	XVIII	Hospi tal	PPS	12 (1111
	Cost Center Description	Non Physician N				Total Cost	
	· · · · · · · · · · · · · · · · · · ·	Anesthetist	3		Medi cal	(sum of col 1	
		Cost			Education Cost		
						4)	
		1.00	2.00	3.00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATI NG ROOM	0	0		0	0	50. 00
50. 01	05001 CV SURGERY	0	0		0	0	50. 01
51. 00	05100 RECOVERY ROOM	0	0		0	0	51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	0	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	0	55. 00
56.00	05600   RADI 01 SOTOPE	0	0		0	0	56. 00
57. 00	05700 CT SCAN	0	0		0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0	59. 00
60. 00	06000 LABORATORY	0	0		0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	386, 82		386, 820	1
73. 01	07302 OP PHARMACY	0	0		0	0	73. 01
74. 00	07400 RENAL DI ALYSI S	0	0		0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0		0	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0		75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
90.00	09000 CLINIC	0	0		0 0		90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	0		0	0	90. 01
90. 02	09002 WOUND CARE CENTER	0	0		0	0	90. 02
90. 03	09003 PAIN CLINIC	0	0		0	0	90. 03
90.05	09005 OP PSYCH CLINIC	0	0		0	0	90.05
91.00	09100 EMERGENCY	0	0		0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 0	0	92.00
94. 00	OTHER REIMBURSABLE COST CENTERS  09400 HOME PROGRAM DI ALYSI S	0	0		0 0	0	94. 00
	09500 AMBULANCE SERVICES	١	0		0	1	95.00
200.00	I I	0	^	204 07	0	386, 820	
200.00	/	١	0	386, 82	.0	J 300, 620	1200.00

| Peri od: | Worksheet D | Part IV | To | 12/31/2016 | Date/Time Prepared: Provider CCN: 15-0051 THROUGH COSTS

			Т	o 12/31/2016	Date/Time Prep 5/23/2017 10:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	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.	ŭ	
	4)		,	7)		
	6.00	7. 00	8. 00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50.00   05000   OPERATING ROOM	0	189, 948, 881	0.000000		34, 389, 655	50. 00
50. 01   05001   CV   SURGERY	0	0			0	50. 01
51.00   05100   RECOVERY ROOM	0	28, 216, 607	0.000000	0.000000	3, 638, 351	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	0	31, 854, 144	0.000000	0.000000	67, 790	52.00
53. 00   05300   ANESTHESI OLOGY	0	0	0.000000	0.000000	0	53.00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0	58, 048, 743	0.000000	0.000000	8, 574, 457	54.00
55. 00   05500 RADI OLOGY-THERAPEUTI C	0	64, 454, 598	0.000000	0.000000	1, 698, 492	55. 00
56. 00   05600 RADI 0I SOTOPE	0	0	0.000000	0.000000	0	56. 00
57. 00   05700 CT SCAN	0	27, 259, 027	0.000000	0.000000	4, 245, 722	57. 00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	8, 900, 331	0.000000	0.000000	1, 117, 670	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	68, 325, 223	0.000000	0.000000	11, 874, 944	59. 00
60. 00   06000   LABORATORY	0	114, 477, 507	0. 000000	0.000000	20, 062, 538	60.00
64.00 06400 INTRAVENOUS THERAPY	0	0	0. 000000	0.000000	0	64.00
65. 00 06500 RESPIRATORY THERAPY	0	11, 007, 252	0. 000000	0. 000000	4, 649, 479	65. 00
66. 00 06600 PHYSI CAL THERAPY	0	27, 183, 368	0. 000000	0. 000000	3, 918, 450	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0. 000000	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0. 000000	0. 000000	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	23, 526, 628	0. 000000	0. 000000	5, 326, 506	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	11, 923, 015	0. 000000	0. 000000	662, 104	70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41, 547, 575	0. 000000	0. 000000	7, 734, 649	71. 00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	104, 398, 737			32, 647, 078	
73.00 07300 DRUGS CHARGED TO PATIENTS	386, 820				31, 652, 793	
73. 01 07302 OP PHARMACY	0	2, 080, 144			0	73. 01
74.00 07400 RENAL DIALYSIS	0	3, 667, 512			1, 444, 069	74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0			0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0			0	75. 01
76. 97 07697 CARDI AC REHABI LI TATI ON	0	2, 975, 696			172, 478	
OUTPATIENT SERVICE COST CENTERS		_,,			,	
90. 00 09000 CLINIC	0	1, 536, 187	0.000000	0. 000000	9, 651	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	0	11, 676, 916			85, 482	90. 01
90. 02 09002 WOUND CARE CENTER	0	4, 594, 373			13, 212	90. 02
90. 03   09003   PAIN CLINIC	0	1, 896, 565			1, 498	
90. 05   09005   OP PSYCH CLINIC	0	2, 478, 585			17, 597	90. 05
91. 00   09100   EMERGENCY	0	96, 010, 813			8, 938, 516	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				1, 135, 004	92.00
OTHER REIMBURSABLE COST CENTERS		, 22., 010		2: 223000	.,, 001	
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0.000000	0.000000	0	94. 00
95. 00 09500 AMBULANCE SERVICES		_			-	95. 00
200.00 Total (lines 50-199)	386, 820	1, 100, 326, 798			184, 078, 185	200. 00
			•	'		

Provider CCN: 15-0051 THROUGH COSTS

						5/23/2017 10:42 am
			Ti tl e	: XVIII	Hospi tal	PPS
	Cost Center Description	I npati ent	Outpati ent	Outpati ent		
	·	Program	Program	Program		
		Pass-Through	Charges	Pass-Through	1	
		Costs (col. 8	3	Costs (col.		
		x col. 10)		x col. 12)		
		11.00	12.00	13.00		
	ANCILLARY SERVICE COST CENTERS	11.00	12.00	10.00		
50.00	05000 OPERATI NG ROOM	0	26, 752, 458		0	50, 00
50. 00	05001 CV SURGERY		20, 732, 430		0	50.00
	i i	1 -1	4 572 200		0	
51. 00	05100 RECOVERY ROOM	0	4, 572, 209		0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	52.00
53. 00	05300 ANESTHESI OLOGY	0			0	53. 00
54. 00	05400  RADI OLOGY-DI AGNOSTI C	0	15, 554, 367		0	54. 00
55. 00	05500   RADI OLOGY-THERAPEUTI C	0	30, 386, 211		0	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0	56.00
57.00	05700 CT SCAN	0	5, 237, 721		0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	1, 609, 105		0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	O	14, 603, 530		0	59. 00
60.00	06000 LABORATORY	ol	9, 093, 081		0	60.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	64.00
65. 00	06500 RESPI RATORY THERAPY		645, 356		0	65. 00
66. 00	06600 PHYSI CAL THERAPY		148, 573		0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY		140, 373		0	67.00
68. 00	06800 SPEECH PATHOLOGY		0		0	68. 00
		0	0 500 240		0	•
69. 00	06900 ELECTROCARDI OLOGY	0	9, 598, 340		0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	2, 410, 515		0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	8, 992, 331		0	71. 00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	16, 313, 411		0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	85, 937	16, 953, 346	46, 02	28	73. 00
73. 01	07302 OP PHARMACY	0	0		0	73. 01
74.00	07400 RENAL DIALYSIS	0	156, 321		0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	o	0		0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	o	1, 292, 487		0	76. 97
	OUTPATIENT SERVICE COST CENTERS	•				
90.00	09000 CLI NI C	0	452, 262		0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	o	4, 701, 378	•	0	90. 01
90. 02	09002 WOUND CARE CENTER		1, 894, 977		0	90. 02
90. 03	09003 PAIN CLINIC		542, 298	1	0	90. 03
90. 05	09005 OP PSYCH CLINIC	0	444, 632	1	o	90. 05
91.00	09100 EMERGENCY				0	90.03
		1	16, 860, 768		0	•
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	7, 942, 663		U	92. 00
04.00	OTHER REIMBURSABLE COST CENTERS					04.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0		0	94.00
95. 00	09500 AMBULANCE SERVICES					95. 00
200.00	Total (lines 50-199)	85, 937	197, 158, 340	46, 02	28	200. 00

Heal th	Financial Systems I	O HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORT	IONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der Co	CN: 15-0051	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre	pared.
					10 12/01/2010	5/23/2017 10:	
			Title	e XVIII	Hospi tal	PPS	
	·		·	Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	·	Ratio From	Services (see	Rei mbursed	Rei mbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins	. Ded. & Coins.		
				(see inst.)	(see inst.)		
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0. 115941	26, 752, 458	3	0 0	3, 101, 707	50.00
50. 01	05001 CV SURGERY	0. 000000	0		0	0	50. 01
51.00	05100 RECOVERY ROOM	0. 177438	4, 572, 209	)	0	811, 284	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 258100	0		0	0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 140926	15, 554, 367	·	0 0	2, 192, 015	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 102589	30, 386, 211		0 0	3, 117, 291	55. 00
56.00	05600 RADI OI SOTOPE	0. 000000		1	0 0	0	1
57. 00	05700 CT SCAN	0. 059360			0 0	310, 911	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 116884	1, 609, 105	•	0 0	188, 079	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0. 083409			0 0	1, 218, 066	1
60.00	06000 LABORATORY	0. 124779				1, 134, 626	
64. 00	06400 I NTRAVENOUS THERAPY	0. 000000		]	o o	0 1, 10 1, 020	1
65. 00	06500 RESPI RATORY THERAPY	0. 306831	645, 356			198, 015	
66. 00	06600 PHYSI CAL THERAPY	0. 428676		1		63, 690	1
67. 00	06700 OCCUPATI ONAL THERAPY	0. 428070			0 0	03, 040	1
68. 00	06800 SPEECH PATHOLOGY	0. 000000			0 0	0	1
69. 00	06900 ELECTROCARDI OLOGY	0. 070563		1	0 0		1
70. 00		1		•	0 0	677, 288	
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 135041 0. 237499	2, 410, 515		-	325, 518	
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1		1	-	2, 135, 670	
72. 00 73. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 167354			0 0	2, 730, 115	
	07300 DRUGS CHARGED TO PATIENTS	0. 257263			152, 801	4, 361, 469	
73. 01	07302 OP PHARMACY	0. 276708		'	0	0	
74.00	07400 RENAL DIALYSIS	0. 325979			0	50, 957	1
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000		<u>'</u>	0	0	
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0. 000000			0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0. 450372	1, 292, 487	1	0 0	582, 100	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	4 7705/4	450.040			004 077	
90.00	09000 CLINIC	1. 778564			0 0		
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0. 207824		l	0	977, 059	1
90. 02	09002 WOUND CARE CENTER	0. 356192			0	674, 976	1
90. 03	09003 PAIN CLINIC	0. 344918			0	187, 048	
90. 05	09005 OP PSYCH CLINIC	1. 342084	1	•	0	596, 733	1
91. 00	09100 EMERGENCY	0. 128437			0		
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 317979	7, 942, 663	8	0 0	2, 525, 600	92.00
	OTHER REIMBURSABLE COST CENTERS						1
94. 00	09400 HOME PROGRAM DI ALYSI S	0. 000000			0		94. 00
95. 00	09500 AMBULANCE SERVICES	0. 235703			0		95. 00
200.00	,		197, 158, 340	3, 48		31, 130, 140	
201.00					0		201. 00
	Only Charges		107.450.515				
202.00	Net Charges (line 200 +/- line 201)		197, 158, 340	) 3, 48	152, 801	31, 130, 140	J202. 00

In Lieu of Form CMS-2552-10

Period:	Worksheet D
From 01/01/2016	Part V
To 12/31/2016	Date/Time Prepared:
5/23/2017	10: 42 am Provider CCN: 15-0051

	23/2017 10:42 am
Title XVIII Hospital	PPS
Costs	
Cost Center Description Cost Cost	
Rei mbursed Rei mbursed	
Services   Services Not	
Subj ect To Subj ect To	
Ded. & Coi ns. Ded. & Coi ns.	
(see inst.) (see inst.)	
6.00 7.00	
ANCI LLARY SERVI CE COST CENTERS	
50. 00   05000   OPERATI NG ROOM   0   0	50.00
50. 01   05001   CV   SURGERY   0   0   0   0   0   0   0   0   0	50. 01
51. 00   05100   RECOVERY ROOM	51.00
52. 00   05200   DELI VERY ROOM & LABOR ROOM	52.00
53. 00   05300   ANESTHESI OLOGY	53. 00
54. 00   05400   RADI OLOGY - DI AGNOSTI C	54.00
55. 00   05500   RADI 0LOGY-THERAPEUTI C	55. 00
56. 00   05600   RADI 0I SOTOPE   0 0   0   0   0   0   0   0   0   0	56.00
57. 00   05700   CT SCAN	57. 00
58. 00   05800   MAGNETI C RESONANCE I MAGI NG (MRI) 0 0	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	59.00
	60.00
64. 00   06400   I NTRAVENOUS THERAPY	64.00
	65. 00 66. 00
66. 00   06600   PHYSI CAL THERAPY	67.00
68. 00   06800   SPEECH PATHOLOGY 0 0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	69.00
70. 00   07000   ELECTROENCEPHALOGRAPHY	70.00
71. 00   07100   MEDI CAL SUPPLI ES CHARGED TO PATI ENTS   0 0	71.00
72. 00   07200   MPL. DEV. CHARGED TO PATIENTS 0 0	71.00
73. 00   07300   DRUGS CHARGED TO PATIENTS   8   39, 310	73. 00
73. 01   07302   OP PHARMACY   0   0	73.00
74. 00   07400   RENAL DI ALYSI S 0 0	74. 00
75. 00   07500   ASC (NON-DI STI NCT PART) 0 0	75.00
75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES   0   0	75. 00
76. 97   07697   CARDI AC REHABI LI TATI ON 0 0	76. 97
OUTPATIENT SERVICE COST CENTERS	76.77
90. 00   09000  CLI NI C   0   0	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER 0 0	90. 01
90. 02   09002   WOUND CARE CENTER   0   0	90. 02
90. 03   09003   PAI N   CLI NI C   0   0	90. 03
90. 05 09005 OP PSYCH CLINIC 0 0	90. 05
91. 00   09100   EMERGENCY   0   0	91. 00
92.00   09200   OBSERVATION BEDS (NON-DISTINCT PART)   0   0	92. 00
OTHER REIMBURSABLE COST CENTERS	
94. 00   09400   HOME   PROGRAM DI ALYSI S   0   0	94. 00
95. 00 O9500 AMBULANCE SERVICES O	95. 00
200.00 Subtotal (see instructions) 439 39, 310	200. 00
201.00 Less PBP Clinic Lab. Services-Program 0	201. 00
Only Charges	
202.00   Net Charges (line 200 +/- line 201)   439   39,310	202. 00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		Inlie	u of Form CMS-2	2552_10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA		Provi der C	CN: 15-0051 CCN: 15-T051	Peri od: From 01/01/2016 To 12/31/2016	Worksheet D	pared:
		Ti tl e	xVIII	Subprovi der  - I RF	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost (from Wkst. B,	(from Wkst. C, Part I, col.		Program . Charges	(column 3 x column 4)	
	Part II, col.	8)	2)	. Charges	COT UIIIIT 4)	
	26)					
	1.00	2.00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS				_		
50. 00 05000 OPERATING ROOM	2, 210, 116	189, 948, 881	0. 01163	35 16, 676	194	50.00
50. 01   05001   CV   SURGERY	0	0	0.00000	00	0	50. 01
51.00   05100   RECOVERY ROOM	213, 618		l .		0	51.00
52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 325, 905	31, 854, 144	l .		0	52. 00
53. 00   05300   ANESTHESI OLOGY	0	0	0. 00000		0	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	857, 827	58, 048, 743	l .		1, 684	
55. 00   05500   RADI OLOGY-THERAPEUTI C	839, 518				92	
56. 00   05600   RADI 01 SOTOPE	0	0	0.00000		0	56. 00
57. 00 05700 CT SCAN	75, 364	27, 259, 027	0.00276		106	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	82, 505		0.00927		66	
59. 00 05900 CARDI AC CATHETERI ZATI ON	369, 441	68, 325, 223			0	59.00
60. 00   06000   LABORATORY	807, 986		0.00705		3, 593	60. 00 64. 00
64. 00   06400   I NTRAVENOUS THERAPY 65. 00   06500   RESPI RATORY THERAPY	109, 794	0 11, 007, 252	0.0000		0 706	
66. 00   06600   PHYSI CAL THERAPY	733, 763		0.0049		104, 236	
67. 00 06700 OCCUPATI ONAL THERAPY	733,703	27, 183, 300	0.00000		104, 230	67.00
68. 00 06800 SPEECH PATHOLOGY	0		0.00000		0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	119, 538	1	l .		580	
70. 00 07000 ELECTROENCEPHALOGRAPHY	168, 348				148	
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	165, 597	41, 547, 575			216	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	297, 965		0.00285		0	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	802, 786				5, 962	
73. 01 07302 OP PHARMACY	38, 502			09	0	73. 01
74.00 07400 RENAL DIALYSIS	45, 233	3, 667, 512	0. 01233	78, 082	963	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000		0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0. 00000	00	0	75. 01
76. 97 07697 CARDIAC REHABILITATION	149, 087	2, 975, 696	0. 05010	)2 264	13	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	346, 355				200	
90. 01 09001 OP ONCOLOGY INFUSION CENTER	173, 856				0	,
90. 02 09002 WOUND CARE CENTER	187, 304				0	90. 02
90. 03   09003 PAIN CLINIC	110, 809	1, 896, 565	0. 05842		0	90. 03
90. 05   09005   OP PSYCH CLINIC	356, 705				0	90.05
91. 00 09100 EMERGENCY	1, 116, 726				234	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS	0	19, 864, 018	0.00000	00 41, 778	0	92.00
94. 00 O9400 HOME PROGRAM DIALYSIS	1 0	0	0.00000	00	0	94.00
95. 00   09500   AMBULANCE   SERVI CES			0.00000		U	95.00
200.00 Total (lines 50-199)	11, 704, 648	1, 100, 326, 798		6, 002, 574	118, 993	
1,222. (	,,,,,,,,	, , , ,	1	2,002,071	, , , ,	,

Health Financial Systems	U HEALTH BLOOMING	GTON HOSPITAL		In lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER		Provi der CO		Peri od:	Worksheet D	2002 .0
THROUGH COSTS		Component (	CCN: 15-T051	From 01/01/2016 To 12/31/2016		pared: 42 am
		Title	XVIII	Subprovi der - I RF	PPS	
Cost Center Description	Non Physician Nu Anesthetist Cost	ursing School	Allied Healt	h All Other Medical Education Cost	Total Cost (sum of col 1 through col.	
					4)	
	1.00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS			ı			50.00
50.00   05000   OPERATING ROOM 50.01   05001 CV SURGERY	0	0		0 0	0	
51. 00   05100   RECOVERY ROOM	0	0		0	0	
52. OO   05200   DELIVERY ROOM & LABOR ROOM		0		0 0	0	1
53. 00   05300   ANESTHESI OLOGY		0			0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0			Ö	
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	
56. 00   05600   RADI OI SOTOPE	0	0		0 0	0	1
57. 00   05700   CT   SCAN	0	0		0 0	Ö	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	Ö	
59. 00   05900   CARDI AC   CATHETERI ZATI ON	o	0		0 0	Ö	
60. 00   06000   LABORATORY	O	0		0 0	0	
64.00 06400 INTRAVENOUS THERAPY	O	0		0 0	0	64. 00
65. 00 06500 RESPIRATORY THERAPY	O	0		0 0	0	65. 00
66. 00   06600 PHYSI CAL THERAPY	0	0		0 0	0	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00   06900   ELECTROCARDI OLOGY	0	0		0	0	
70. 00  07000 ELECTROENCEPHALOGRAPHY	0	0		0	0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	386, 82	.0	386, 820	1
73. 01   07302   0P PHARMACY	0	0		0	0	
74. 00   07400   RENAL DI ALYSI S	0	0		0	0	
75. 00   07500   ASC (NON-DISTINCT PART)	0	0		0	0	
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	,
76. 97 O7697 CARDI AC REHABI LI TATI ON	0	0		0 0	0	76. 97

0

0

0 0

0 0

386, 820

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0 0 0

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0

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0 90.00

0 90. 01

0

0 90. 05

0

0 92.00

386, 820 200. 00

90.02 0

90. 03

91.00

94.00

95.00

09002 WOUND CARE CENTER

09005 OP PSYCH CLINIC

94. 00 09400 HOME PROGRAM DIALYSIS

95. 00 09500 AMBULANCE SERVICES

09003 PAIN CLINIC

09100 EMERGENCY

07697 CARDIAC REHABILITATION
OUTPATIENT SERVICE COST CENTERS

09001 OP ONCOLOGY INFUSION CENTER

OTHER REIMBURSABLE COST CENTERS

Total (lines 50-199)

09200 OBSERVATION BEDS (NON-DISTINCT PART)

09000 CLI NI C

90.00

90. 01

90.02

90.03

90. 05

91.00

92.00

200.00

	TIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER SH COSTS	VICE OTHER PASS			Period: From 01/01/2016 To 12/31/2016		pared: 42 am
			Ti tl e	: XVIII	Subprovider - IRF	PPS	
	Cost Center Description	Total	Total Charges		0utpati ent	Inpati ent	
		Outpati ent	(from Wkst. C,	to Charges	Ratio of Cost	Program	
		Cost (sum of	Part I, col.	(col . 5 ÷ col	9	Charges	
		col. 2, 3 and	8)	7)	(col . 6 ÷ col .		
		4)	7.00	0.00	7)	10.00	
	ANCILLARY SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10.00	
50. 00	05000 OPERATING ROOM		189, 948, 881	0.00000	0. 000000	16, 676	50.00
	05000 OPERATING ROOM	0				16, 676	
50. 01	05100 RECOVERY ROOM	0				0	
51.00	l l					0	
52. 00 53. 00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY					0	02.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C		-	0. 00000 0. 00000		113, 934	
55. 00	05500 RADI OLOGY-DI AGNOSTI C					7, 072	
56. 00	05600 RADI OLOGY - THERAPEUTI C					7,072	
57. 00	05700 CT SCAN		1			38, 226	1
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)			•		7, 136	1
59. 00	05900 CARDIAC CATHETERIZATION	0				7, 130	1
60. 00	06000 LABORATORY	0				509, 014	
64. 00	06400 I NTRAVENOUS THERAPY		, ,	0. 00000		0	
65. 00	06500 RESPI RATORY THERAPY	0				70, 745	
66. 00	06600 PHYSI CAL THERAPY	0		•		3, 861, 604	
67.00	06700 OCCUPATIONAL THERAPY	0		1		0	67. 00
68.00	06800 SPEECH PATHOLOGY	0	l c	0. 00000	0. 000000	0	68. 00
69.00	06900 ELECTROCARDI OLOGY	0	23, 526, 628	0.00000	0. 000000	114, 202	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	11, 923, 015	0. 00000	0. 000000	10, 474	70. 00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41, 547, 575	0.00000	0. 000000	54, 281	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	104, 398, 737	0.00000	0. 000000	97	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	386, 820	142, 474, 353	0. 00271	5 0. 002715	1, 057, 986	73. 00
73. 01	07302 OP PHARMACY	0	2, 080, 144	0.00000	0. 000000	0	
74.00	07400 RENAL DIALYSIS	0	3, 667, 512			78, 082	
75. 00	07500 ASC (NON-DISTINCT PART)	0	_			0	
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	_			0	
76. 97	07697 CARDI AC REHABI LI TATI ON	0	2, 975, 696	0.00000	0. 000000	264	76. 97
	OUTPATIENT SERVICE COST CENTERS			1			
90. 00	09000 CLI NI C	0				887	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0				0	
90. 02	09002 WOUND CARE CENTER	0	., ,			0	
90. 03	09003 PAIN CLINIC	0	.,			0	
90.05	09005 OP PSYCH CLINIC	0	_,,			0	90. 05
91. 00 92. 00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0				20, 116 41, 778	
<b>ッ</b> と、いし	1072001003EKVATION DED3 UNUN-DISTINGI PAKTI	. ()			.,, ,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	ι 41.//δ	1 サム. いし

0.000000

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19, 864, 018

0

386, 820 1, 100, 326, 798

0.000000

0.000000

6, 002, 574 200. 00

41, 778

92.00

94.00 0

95.00

92.00

200.00

94. 00 09400 HOME PROGRAM DIALYSIS

95. 00 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART)

OTHER REIMBURSABLE COST CENTERS

Total (lines 50-199)

Health Financial Systems	IU HEALTH BLOOMING	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0051 Component CCN: 15-T051		Worksheet D Part IV Date/Time Prepared: 5/23/2017 10:42 am
		T: +L o V/// / /	Cubago, d dos	DDC

			Title	· XVIII	Subprovi der -	PPS	
	Cook Cooks Doors at a		0	0	IRF		
	Cost Center Description	Inpatient Program	Outpatient Program	Outpatient Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	charges	Costs (col.			
		x col. 10)		x col. 12)			
		11.00	12.00	13.00			
	ANCILLARY SERVICE COST CENTERS			•			
50.00	05000 OPERATI NG ROOM	0	0		0		50.00
50. 01	05001 CV SURGERY	0	0		0		50. 01
51.00	05100  RECOVERY ROOM	0	0		0		51. 00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52. 00
53.00	05300  ANESTHESI OLOGY	0	0		0		53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54. 00
	05500 RADI OLOGY-THERAPEUTI C	0	0		0		55. 00
56. 00	05600 RADI OI SOTOPE	0	0		0		56. 00
57. 00	05700 CT SCAN	0	0	1	0		57. 00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0		58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	l .	0		59. 00
60.00	06000 LABORATORY	0	0		0		60.00
64. 00 65. 00	06400   I NTRAVENOUS THERAPY   06500   RESPI RATORY THERAPY	0	0		0		64. 00 65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0		66.00
	06700 OCCUPATI ONAL THERAPY		0		0		67. 00
68. 00	06800 SPEECH PATHOLOGY		0		0		68. 00
	06900 ELECTROCARDI OLOGY		0		0		69. 00
	07000 ELECTROENCEPHALOGRAPHY		0		0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0		71. 00
	07200 IMPL. DEV. CHARGED TO PATIENTS	o	0		O		72. 00
	07300 DRUGS CHARGED TO PATIENTS	2, 872	0		0		73.00
73. 01	07302 OP PHARMACY	0	0		O		73. 01
74.00	07400 RENAL DIALYSIS	0	0		0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0		75. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0		75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0		76. 97
	OUTPATIENT SERVICE COST CENTERS						
	09000 CLI NI C	0	0		0		90. 00
	09001 OP ONCOLOGY INFUSION CENTER	0	0		0		90. 01
	09002 WOUND CARE CENTER	0	0		0		90. 02
	09003 PAIN CLINIC	0	0		0		90. 03
	09005 OP PSYCH CLINIC	0	0		U O		90. 05
	09100 EMERGENCY	0	0	1	0		91.00
92. 00	O9200   OBSERVATION BEDS (NON-DISTINCT PART)   OTHER REIMBURSABLE COST CENTERS	0	0		U		92. 00
94. 00	09400 HOME PROGRAM DIALYSIS	0	0		0		94. 00
	09500 AMBULANCE SERVICES	١	0		٥		95. 00
200.00	1	2, 872	0		o		200.00
_00.00	1 11111 (111100 00 177)	2,072	· ·	1	-1		1-00.00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der Co		Period: From 01/01/2016 To 12/31/2016		pared: 42 am
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem (col.	
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cost			
	Part II, col.		(col. 1 - col			
	26)		2)			
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	5, 975, 992	0	5, 975, 99	2 48, 658	122. 82	30.00
31.00 INTENSIVE CARE UNIT	509, 291		509, 29	1 4, 074	125. 01	31.00
41. 00 SUBPROVI DER - I RF	484, 703	0	484, 70	3, 144	154. 17	41.00
42. 00 SUBPROVI DER	0	0		0 0	0.00	42. 00
43. 00 NURSERY	313, 957		313, 95	7 3, 478	90. 27	43.00
200.00 Total (lines 30-199)	7, 283, 943		7, 283, 94	3 59, 354		200. 00
Cost Center Description	Inpati ent	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
		6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDI ATRI CS	629	77, 254				30. 00
31.00 INTENSIVE CARE UNIT	696	87, 007				31.00
41. 00 SUBPROVI DER - I RF	14	2, 158				41.00
42. 00 SUBPROVI DER	0	0	1			42. 00
43. 00 NURSERY	1,742	157, 250				43. 00
200.00 Total (lines 30-199)	3, 081	323, 669				200. 00
	•	•	•			•

	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provider C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part II Date/Time Pre 5/23/2017 10:	pared: 42 am
		Ti tI	e XIX	Hospi tal	PPS	12 (111)
Cost Center Description	Capi tal	Total Charges	Ratio of Cos		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						1
50. 00   05000   OPERATING ROOM	2, 210, 116	189, 948, 881			8, 868	
50. 01   05001   CV   SURGERY	0		0.00000		0	
51. 00   05100   RECOVERY ROOM	213, 618				629	
52.00   05200   DELIVERY ROOM & LABOR ROOM	1, 325, 905	31, 854, 144			31, 379	
53. 00   05300   ANESTHESI OLOGY	0	0	0.00000	0 0	0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C	857, 827	58, 048, 743	0. 01477	8 319, 251	4, 718	
55. 00   05500   RADI OLOGY-THERAPEUTI C	839, 518	64, 454, 598			834	
56. 00   05600   RADI 0I SOTOPE	0		0.00000		0	
57. 00  05700   CT   SCAN	75, 364	27, 259, 027	0. 00276	5 148, 546	411	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	82, 505	8, 900, 331	0. 00927	0 66, 058	612	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	369, 441	68, 325, 223	0.00540	7 107, 364	581	59.00
60. 00   06000   LABORATORY	807, 986	114, 477, 507	0.00705	8 1, 426, 940	10, 071	60.00
64. 00   06400   I NTRAVENOUS THERAPY	0	0	0.00000	0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	109, 794	11, 007, 252	0. 00997	5 424, 256	4, 232	65.00
66. 00   06600   PHYSI CAL THERAPY	733, 763	27, 183, 368	0. 02699	3 208, 090	5, 617	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0 0	0	67.00
68. 00   06800   SPEECH PATHOLOGY	0	0	0.00000	0 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	119, 538	23, 526, 628	0.00508	1 164, 985	838	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	168, 348	11, 923, 015	0. 01412	0 57, 512	812	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	165, 597	41, 547, 575	0.00398	6 235, 569	939	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	297, 965	104, 398, 737	0. 00285	4 372, 963	1, 064	72. 00
73.00 07300 DRUGS CHARGED TO PATIENTS	802, 786	142, 474, 353	0. 00563	5 2, 267, 361	12, 777	73.00
73. 01   07302   OP PHARMACY	38, 502	2, 080, 144	0. 01850	9 0	0	73. 01
74.00 07400 RENAL DIALYSIS	45, 233	3, 667, 512	0. 01233	3 122, 793	1, 514	74. 00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000	0 0	0	75. 00
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.00000	0 0	0	75. 01
76. 97 07697 CARDI AC REHABILI TATI ON	149, 087	2, 975, 696	0. 05010	2 4, 342	218	76. 97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	346, 355	1, 536, 187	0. 22546	4 2, 617	590	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	173, 856	11, 676, 916	0. 01488	9 2, 514	37	90. 01
90. 02   09002   WOUND CARE CENTER	187, 304	4, 594, 373	0. 04076	8 0	0	90. 02
90. 03   09003   PAIN CLINIC	110, 809		1		0	
90. 05 09005 OP PSYCH CLINIC	356, 705				0	
91. 00   09100   EMERGENCY	1, 116, 726				4, 300	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	682, 613	19, 864, 018	0. 03436	4 31, 492	1, 082	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.00000	0 0	0	
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00   Total (lines 50-199)	12, 387, 261	1, 100, 326, 798	1	7, 995, 427	92, 123	200. 00

Health Financial Systems II	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA			CN: 15-0051	Period: From 01/01/2016	Worksheet D	
				To 12/31/2016	Date/Time Pre	
		Ti +I	e XIX	Hospi tal	5/23/2017 10: PPS	42 am_
Cost Center Description	Nursing School	Allied Health		Swi ng-Bed	Total Costs	
oust center beserver on	indi si rig scrioor	Cost	Medi cal	Adjustment	(sum of cols.	
			Education Cos		1 through 3,	
				instructions)	minus col. 4)	
	1.00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS	0	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0		O	0	31. 00
41. 00   04100   SUBPROVI DER - I RF	0	0		0	0	41. 00
42. 00   04200   SUBPROVI DER	0	0		0	0	42. 00
43. 00   04300   NURSERY	0	0		O	0	43.00
200.00 Total (lines 30-199)	0	0		0	0	200. 00
Cost Center Description		Per Diem (col.	Inpati ent	Inpati ent		
	Days	5 ÷ col. 6)	Program Days			
				Pass-Through		
				Cost (col. 7 x		
		7.00	0.00	col . 8)	-	
INPATIENT ROUTINE SERVICE COST CENTERS	6. 00	7.00	8. 00	9. 00		
30. 00 03000 ADULTS & PEDIATRICS	48, 658	0.00	62	9 0		30.00
31. 00   03000 ADDLTS & PEDIATRICS	48, 658					31. 00
41. 00   04100   SUBPROVI DER -   I RF	3, 144					41. 00
42. 00   04200   SUBPROVI DER	3, 144	0.00		0		42.00
43. 00   04300   NURSERY	3, 478					43. 00
200.00 Total (lines 30-199)	59, 354		3, 08		,	200. 00
200.00   10tal (11165 30-177)	1 57, 354	I	J 3, 00	'	I	1200.00

| In Lieu of Form CMS-2552-10 | Peri od: | Worksheet D | From 01/01/2016 | Part IV | To 12/31/2016 | Date/Time Prepared: | To 12/31/2016 | Date/Time Prepared: | To 12/31/2016 | Date/Time Prepared: | To 12/31/2017 | To 12/3 
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

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

				''	0 12/31/2010	5/23/2017 10:	
			Ti tl	e XIX	Hospi tal	PPS	
	Cost Center Description	Non Physician			All Other	Total Cost	
		Anesthetist			Medi cal	(sum of col 1	
		Cost			Education Cost	through col.	
						4)	
		1.00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	0	ľ	0	0	50. 00
50. 01	05001 CV SURGERY	0	0	0	0	0	50. 01
51. 00	05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	0	0	0	0	52. 00
53. 00	05300 ANESTHESI OLOGY	0	0	0	0	0	53. 00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55. 00
56. 00	05600 RADI OI SOTOPE	0	0	0	0	0	56. 00
57. 00	05700 CT SCAN	0	0	0	0	0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0	0	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
60.00	06000 LABORATORY	0	0	0	0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0	0	0	64. 00
65. 00	06500 RESPI RATORY THERAPY	0	0	0	0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0	0	0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	0	0	0	69. 00
70. 00	07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	70. 00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	0	0	0	
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72. 00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	386, 820	0	386, 820	•
73. 01	07302 OP PHARMACY	0	0	0	0	0	73. 01
74. 00	07400 RENAL DI ALYSI S	0	0	0	0	0	74. 00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0	0	0	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS						00.00
90.00	09000 CLINIC	0	0	0	0	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	0	0	0	0	90. 01
90. 02	09002 WOUND CARE CENTER	0	0	0	0	0	90. 02
90. 03	09003 PAIN CLINIC	0	0	0	0	0	90. 03
90. 05	09005 OP PSYCH CLINIC	0	0	0	0	0	90.05
91.00	09100 EMERGENCY	0	0		0	0	
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	l ol	0	0	U U	0	92. 00
94. 00	OTHER REIMBURSABLE COST CENTERS  O9400 HOME PROGRAM DIALYSIS	0	^	0	O	0	94. 00
94. 00 95. 00	09500 AMBULANCE SERVICES	١	0		١		95.00
200.00	1		0	386, 820	0	386, 820	1
200.00	Tiotal (Titles 50-177)	١	0	J 300, 620	ı Y	300, 620	<sub>1</sub> 200.00

 
 Heal th Financial
 Systems
 IU HEALTH BLOOMINGTON HOSPITAL

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

			e XIX	Hospi tal	PPS	
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
	Outpati ent	(from Wkst. C,	to Charges	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.	Ü	
	4)	,		7)		
	6. 00	7.00	8.00	9. 00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	189, 948, 881	0.000000	0.000000	762, 160	50.00
50. 01   05001 CV SURGERY	0	0	1		0	50. 01
51. 00   05100   RECOVERY   ROOM	0	28, 216, 607				51. 00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0	31, 854, 144				52. 00
53. 00   05300   ANESTHESI OLOGY		31,034,144	•		733, 003	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C		58, 048, 743				54. 00
55. 00   05500 RADI OLOGY-THERAPEUTI C		64, 454, 598				55. 00
		04, 434, 390				56. 00
	0	07.050.007	0.000000			
57. 00 05700 CT SCAN	0	27, 259, 027				57. 00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	8, 900, 331				58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0	68, 325, 223				59. 00
60. 00   06000   LABORATORY	0	114, 477, 507				60.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0	1 0.00000			64. 00
65. 00 06500 RESPIRATORY THERAPY	0	11, 007, 252	0.000000	0.000000	424, 256	65.00
66. 00   06600   PHYSI CAL THERAPY	0	27, 183, 368	0.000000	0.000000	208, 090	66. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0.000000	0.000000	0	67. 00
68. 00 06800 SPEECH PATHOLOGY	0	0	0. 000000	0.000000	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	23, 526, 628	0.000000	0. 000000	164, 985	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	11, 923, 015				70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	41, 547, 575				
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	0	104, 398, 737				72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	386, 820					73. 00
73. 01 07302 OP PHARMACY	300, 020	2, 080, 144				73. 00
74. 00   07400 RENAL DIALYSIS		3, 667, 512	•			
75. 00   07500   ASC (NON-DISTINCT PART)		3,007,512	1			75. 00
75. 01   03550   PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES 76. 97   07697   CARDI AC REHABI LI TATI ON	0	0 075 (0)	0.000000			75. 01
		2, 975, 696	0. 000000	0. 000000	4, 342	76. 97
OUTPATIENT SERVICE COST CENTERS		1 50/ 407				
90. 00 09000 CLI NI C	0	.,				90. 00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	0	11, 676, 916				90. 01
90. 02   09002   WOUND CARE CENTER	0	4, 594, 373				90. 02
90. 03   09003   PAIN CLINIC	0	1, 896, 565				90. 03
90. 05   09005   OP PSYCH CLINIC	0	2, 478, 585	0.000000	0. 000000	0	90. 05
91. 00   09100   EMERGENCY	0	96, 010, 813	0.000000	0.000000	369, 664	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	19, 864, 018	0. 000000	0. 000000	31, 492	92. 00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DIALYSIS	0	C	0.000000	0.000000	0	94.00
95. 00 09500 AMBULANCE SERVICES						95. 00
200.00 Total (lines 50-199)	386, 820	1, 100, 326, 798			7, 995, 427	
	1 227,020	,	1	1		

Provider CCN: 15-0051 THROUGH COSTS

						5/23/2017 10:42 am
			Titl	e XIX	Hospi tal	PPS
	Cost Center Description	I npati ent	Outpati ent	Outpati ent		
	·	Program	Program	Program		
		Pass-Through	Charges	Pass-Through	1	
		Costs (col. 8	Ü	Costs (col.	9	
		x col. 10)		x col. 12)		
		11.00	12.00	13.00		
-	ANCILLARY SERVICE COST CENTERS	·				
50.00	05000 OPERATI NG ROOM	0	0		0	50.00
50. 01	05001 CV SURGERY	o	0		0	50. 01
51. 00	05100 RECOVERY ROOM	0	0		0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	52.00
53. 00	05300 ANESTHESI OLOGY	0	0		0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0	55.00
56. 00	05600 RADI OI SOTOPE		0		0	56. 00
57. 00	05700 CT SCAN		0		0	57. 00
58. 00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0		0	58.00
59. 00	05900 CARDIAC CATHETERIZATION		0		0	59.00
60.00	06000 LABORATORY		0		0	
	l l	0	U			60.00
64.00	06400 I NTRAVENOUS THERAPY	0	U		0	64.00
65.00	06500 RESPI RATORY THERAPY	0	0		0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0		0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	l .	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0	71. 00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 156	0		0	73. 00
73. 01	07302 OP PHARMACY	0	0		0	73. 01
74.00	07400 RENAL DIALYSIS	0	0		0	74. 00
75.00	07500 ASC (NON-DISTINCT PART)	0	0		0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0		0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON	0	0		0	76. 97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C	0	0		0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	0	0		0	90. 01
90. 02	09002 WOUND CARE CENTER	0	0		0	90. 02
90. 03	09003 PAIN CLINIC	0	0		0	90. 03
90. 05	09005 OP PSYCH CLINIC	0	0		0	90.05
91. 00	09100 EMERGENCY	O	Ö		o	91. 00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0	l .	0	92.00
,2.00	OTHER REIMBURSABLE COST CENTERS	<u> </u>			<u> </u>	72.00
94. 00	09400 HOME PROGRAM DI ALYSI S	O	C		0	94. 00
95. 00	09500 AMBULANCE SERVICES	٩	C		٦	95. 00
200.00	1	6, 156	O		0	200. 00
200.00	/	0, 130	U	1	9	1200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provi der C		Period: From 01/01/2016 To 12/31/2016	Worksheet D Part V Date/Time Pre 5/23/2017 10:	
		Ti tl	e XIX	Hospi tal	PPS	12 0
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Rei mbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins.	Ded. & Coins.		
			(see inst.)	(see inst.)		
ANOUNT ARK OFFINIOS COOT OFFITTERS	1.00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	0 115041	1 0	1 //7 /0	4 0	0	50.00
50. 00   05000   OPERATI NG ROOM	0. 115941	1	.,,		_	
50. 01   05001   CV   SURGERY	0.000000	1	1	0	-	50. 01
51. 00   05100   RECOVERY ROOM	0. 177438	<b>I</b>				51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0. 258100	1	139, 16			52.00
53. 00   05300   ANESTHESI OLOGY	0. 000000			0	_	53. 00
54. 00   05400   RADI OLOGY-DI AGNOSTI C	0. 140926		720, 00		0	54. 00
55. 00   05500   RADI OLOGY-THERAPEUTI C	0. 102589	1	643, 01		_	55. 00
56. 00   05600   RADI 01 SOTOPE	0. 000000			0		56. 00
57. 00   05700   CT   SCAN	0. 059360		253, 63		0	57. 00
58. 00   05800   MAGNETIC RESONANCE   MAGING (MRI)	0. 116884		68, 13		_	58. 00
59. 00   05900   CARDI AC   CATHETERI ZATI ON	0. 083409		275, 89			59. 00
60. 00   06000   LABORATORY	0. 124779	1	802, 27			60.00
64. 00 06400 I NTRAVENOUS THERAPY	0. 000000			0	_	64. 00
65. 00 06500 RESPI RATORY THERAPY	0. 306831	1	29, 11			65. 00
66. 00   06600   PHYSI CAL THERAPY	0. 428676	I .	813, 23			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			0		67.00
68. 00 06800 SPEECH PATHOLOGY	0.000000		100.07	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 070563	l e	129, 06			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 135041		178, 42			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 237499		260, 96		0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 167354				0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 257263		1, 061, 05		0	73.00
73. 01   07302   0P PHARMACY	0. 276708		20.22	0	0	73. 01
74. 00   07400   RENAL DI ALYSI S 75. 00   07500   ASC (NON-DI STI NCT PART)	0. 325979 0. 000000		39, 23	0 0	0	74. 00 75. 00
75. 00   07500   ASC (NON-DISTINCT PART) 75. 01   03550   PSYCHIATRIC/PSYCHOLOGICAL SERVICES	0. 000000	1		0 0	0	75. 00
76. 97 07697 CARDI AC REHABILITATION	0. 450372		87	-	-	76. 97
OUTPATIENT SERVICE COST CENTERS	0. 430372		1 07	0	0	70.77
90. 00 09000 CLINIC	1. 778564		16, 24	8 0	0	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER	0. 207824	l .				90. 01
90. 02   09002   WOUND CARE CENTER	0. 356192		59, 82		0	90. 02
90. 03   09003   PAI N   CLI NI C	0. 344918		1, 93		Ő	90. 03
90. 05 09005 OP PSYCH CLINIC	1. 342084				Ö	90. 05
91. 00   09100   EMERGENCY	0. 128437	1				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 317979	1				92.00
OTHER REIMBURSABLE COST CENTERS	0.01,777		00.70.	,, ,		72.00
94. 00 09400 HOME PROGRAM DIALYSIS	0. 000000			0		94. 00
95. 00 09500 AMBULANCE SERVICES	0. 235703	1	1, 008, 76	7		95.00
200.00 Subtotal (see instructions)		C			0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0		201.00
Only Charges						
202.00   Net Charges (line 200 +/- line 201)	1	( c	12, 131, 11	3 0	0	202. 00

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL In Lieu of Form CMS-2552-10 APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 15-0051 Peri od: Worksheet D From 01/01/2016 Part V Date/Time Prepared: 12/31/2016 5/23/2017 10:42 am Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 193, 354 0 50.01 05001 CV SURGERY 0 51. 00 05100 RECOVERY ROOM 0 53 968 05200 DELIVERY ROOM & LABOR ROOM 52.00 35, 917 0 53. 00 | 05300 | ANESTHESI OLOGY 0 54.00 05400 RADI OLOGY-DI AGNOSTI C 101, 467 0 05500 RADI OLOGY-THERAPEUTI C 0 55.00 65, 966 56.00 05600 RADI OI SOTOPE 0 05700 CT SCAN 0 57.00 15,056 05800 MAGNETIC RESONANCE IMAGING (MRI) 7, 964 0 58 00 59.00 05900 CARDI AC CATHETERI ZATI ON 23, 012 0

2, 226, 428

0

202.00

202.00

Net Charges (line 200 +/- line 201)

	Financial Systems   I TONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	U HEALTH BLOOMI	Provi der C		Peri od:	u of Form CMS-2 Worksheet D	2552-10
APPURI	TOINMENT OF THEATTENT ANCILLARY SERVICE CAPITE	IL (US13	Provider C	UN. 13-0031	From 01/01/2016	Part II	
			Component	CCN: 15-T051	To 12/31/2016	Date/Time Pre 5/23/2017 10:	
			Ti tl	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description	Capi tal	Total Charges	Ratio of Cos		Capital Costs	
		Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
		(from Wkst. B,	Part I, col.		. Charges	column 4)	
		Part II, col.	8)	2)			
		26)					
		1. 00	2.00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	2, 210, 116				0	
50. 01	05001 CV SURGERY	0	_			0	50. 01
51. 00	05100 RECOVERY ROOM	213, 618				0	
52. 00	05200 DELIVERY ROOM & LABOR ROOM	1, 325, 905	31, 854, 144			0	52.00
53. 00	05300 ANESTHESI OLOGY	0	_			0	
54. 00	05400  RADI OLOGY-DI AGNOSTI C	857, 827		l .		0	
55. 00	05500  RADI OLOGY-THERAPEUTI C	839, 518	64, 454, 598			0	55.00
56. 00	05600  RADI 0I SOTOPE	0	ļ	0.0000		0	
57. 00	05700  CT SCAN	75, 364				0	57.00
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	82, 505	8, 900, 331	0.00927		0	58.00
59. 00	05900 CARDI AC CATHETERI ZATI ON	369, 441	68, 325, 223	0.00540	0	0	59.00
60.00	06000 LABORATORY	807, 986	114, 477, 507	0.00705	58 0	0	60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0	0.00000	00	0	64.00
65. 00	06500 RESPI RATORY THERAPY	109, 794	11, 007, 252	0.00997	75 0	0	65.00
66. 00	06600 PHYSI CAL THERAPY	733, 763	27, 183, 368	0. 02699	0	0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	0.00000	0 0	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0	0	0.00000	0 0	0	68.0
69. 00	06900 ELECTROCARDI OLOGY	119, 538	23, 526, 628	0. 00508	31 0	0	69.0
70. 00	07000 ELECTROENCEPHALOGRAPHY	168, 348	11, 923, 015	0. 01412	20 0	0	70.0
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	165, 597	41, 547, 575	0.00398	86 0	0	71.0
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS	297, 965	104, 398, 737	0. 00285	64 0	0	72.0
73. 00	07300 DRUGS CHARGED TO PATIENTS	802, 786	142, 474, 353	0.00563	35 0	0	73.00
73. 01	07302 OP PHARMACY	38, 502	2, 080, 144	0. 01850	0	0	73. 0°
74. 00	07400 RENAL DIALYSIS	45, 233	3, 667, 512	0. 01233	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0.00000	0 0	0	75.00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	0	0.00000	0 0	0	75. 0°
76. 97	07697 CARDI AC REHABI LI TATI ON	149, 087	2, 975, 696	0. 05010	0	0	76. 97
	OUTPATIENT SERVICE COST CENTERS	<u> </u>		•			1
90.00	09000 CLI NI C	346, 355	1, 536, 187	0. 22546	0	0	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	173, 856			89 0	0	90. 01
90. 02	09002 WOUND CARE CENTER	187, 304			0 8	0	90. 02
90. 03	09003 PAIN CLINIC	110, 809				0	90.03
90. 05	09005 OP PSYCH CLINIC	356, 705				0	90. 0!
91. 00	09100 EMERGENCY	1, 116, 726	96, 010, 813	0. 01163	0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0		0.00000	00	0	
	OTHER REIMBURSABLE COST CENTERS	•			· '		1
14 00	09400 HOME PROGRAM DLALYSLS	0	0	0 00000	0 0	0	94 0

11, 704, 648 1, 100, 326, 798

0.000000

0

0 94.00 95.00 0 200.00

94.00 09400 HOME PROGRAM DIALYSIS 95.00 09500 AMBULANCE SERVICES 200.00 Total (lines 50-199)

Heal th	Financial Systems II	J HEALTH BLOOMIN	IGTON HOSPITAL		Inlie	u of Form CMS-2	2552_10
	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER		Provi der Co	CN: 15-0051 F	Peri od:	Worksheet D	2332 10
THROUG	GH COSTS		Component (		From 01/01/2016 To 12/31/2016		pared: 42 am
			Ti tl	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description	Non Physician N	lursing School	Allied Health		Total Cost	
		Anestheti st			Medi cal	(sum of col 1	
		Cost			Education Cost		
		1.00	2.00	3.00	4. 00	4) 5. 00	
	ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00	05000 OPERATING ROOM		0		0	0	50.00
50. 01	05001 CV SURGERY	o	0		-	0	
51. 00	05100 RECOVERY ROOM	o	0			0	51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0		0	0	52. 00
53.00	05300 ANESTHESI OLOGY	o	0		0	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	O	0		0	0	54. 00
55.00	05500 RADI OLOGY-THERAPEUTI C	O	0	(	0	0	55. 00
56.00	05600 RADI OI SOTOPE	0	0		0	0	56. 00
57.00	05700 CT SCAN	0	0	(	0	0	57. 00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	(	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0	0	(	0	0	59. 00
60.00	06000 LABORATORY	0	0		0	0	60. 00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64. 00
65.00	06500 RESPI RATORY THERAPY	0	0		0	0	65. 00
66. 00	06600 PHYSI CAL THERAPY	0	0		0	0	66. 00
67. 00	06700 OCCUPATI ONAL THERAPY	0	0	(	٥	0	67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0	0	(	٥	0	69. 00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(	-	0	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	9	-	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0		0	0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	386, 820		386, 820	
73. 01 74. 00	07302 OP PHARMACY		0		-	0	1 , 0. 0 .
74. 00 75. 00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)		0			0	74. 00 75. 00
75. 00 75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0			J 0	75. 00
76. 97	07697 CARDI AC REHABI LI TATI ON		0		-	J 0	76. 97
10. 11	OUTDATION CERVICE COST CENTERS	<u> </u>	0		J 0		10.71

0 0 0

0 0 0

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90. 01

90.02 0

90. 03

90. 05

91.00

0 90.00

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0

09000 CLI NI C

09002 WOUND CARE CENTER

09005 OP PSYCH CLINIC

09003 PAIN CLINIC

09100 EMERGENCY

07697 CARDIAC REHABILITATION
OUTPATIENT SERVICE COST CENTERS

09001 OP ONCOLOGY INFUSION CENTER

90.00

90.01

90.02

90.03

90. 05

91.00

Heal th	Financial Systems I	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPOR	FIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF SH COSTS	RVICE OTHER PAS			Period: From 01/01/2016 To 12/31/2016	Worksheet D Part IV Date/Time Pre 5/23/2017 10:	epared: 42 am
			Ti tl	e XIX	Subprovi der - I RF	PPS	
	Cost Center Description	Total Outpatient Cost (sum of col. 2, 3 and 4)	8)	to Charges (col. 5 ÷ col 7)	Outpatient Ratio of Cost to Charges (col. 6 ÷ col. 7)	Inpatient Program Charges	
	ANCILLARY SERVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
50. 00	05000 OPERATING ROOM	0	189, 948, 881	0.00000	0. 000000	0	50.00
50. 01	05001 CV SURGERY	0		0. 00000	0. 000000	0	50. 01
51. 00	05100 RECOVERY ROOM	0	28, 216, 607			0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	31, 854, 144			0	
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	F0 040 743	0.0000		0	
55. 00	05500 RADI OLOGY - DI AGNOSTI C	0				0	
56. 00	05600 RADI OI SOTOPE			0.00000		0	
57. 00	05700 CT SCAN		_			0	
58. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0				0	
59. 00	05900 CARDI AC CATHETERI ZATI ON	0				0	59.00
60.00	06000 LABORATORY	0	114, 477, 507			0	
64.00	06400 I NTRAVENOUS THERAPY	0		0. 00000		0	
65. 00	06500 RESPI RATORY THERAPY	0				0	
66.00	06600 PHYSI CAL THERAPY	0				0	
67.00	06700 OCCUPATIONAL THERAPY 06800 SPEECH PATHOLOGY	0	_	0. 00000 0. 00000		0	
68. 00 69. 00	06900 ELECTROCARDI OLOGY	0	_	•		0	
70.00	07000 ELECTROENCEPHALOGRAPHY		11, 923, 015			0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		41, 547, 575			0	
72. 00	07200 IMPL. DEV. CHARGED TO PATIENTS					0	
73. 00	07300 DRUGS CHARGED TO PATIENTS	386, 820		•		0	
73. 01	07302 OP PHARMACY	0	2, 080, 144	0.00000	0. 000000	0	73. 01
74.00	07400 RENAL DIALYSIS	0	3, 667, 512	0.00000	0. 000000	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0.00000	0. 000000	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES	0	_	0. 00000		0	
76. 97	07697 CARDI AC REHABILI TATI ON	0	2, 975, 696	0.00000	0. 000000	0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS		1 524 107	0.00000	0 000000		00.00
90. 00 90. 01	09000 CLINIC 09001 OP ONCOLOGY INFUSION CENTER	0	,			0	
90.01	09001 OP ONCOLOGY THRUSTON CENTER		, , , , , , ,			0	
	00003 DVI VI CI IVI C					0	

0.000000

0.000000

0.000000

0.000000

0.000000

1, 896, 565 2, 478, 585 96, 010, 813

19, 864, 018

0

386, 820 1, 100, 326, 798

0.000000

0.000000

0.000000

0.000000

0.000000

90.03

90.05

0 94.00 95.00 0 200.00

0 91. 00

0 92.00

90. 03 09003 PAIN CLINIC

91.00

92.00

200.00

90. 05 09005 OP PSYCH CLINIC

09100 EMERGENCY

94. 00 09400 HOME PROGRAM DIALYSIS

95. 00 09500 AMBULANCE SERVICES

09200 OBSERVATION BEDS (NON-DISTINCT PART)

OTHER REIMBURSABLE COST CENTERS

Total (lines 50-199)

Health Financial Systems	IU HEALTH BLOOMING	In Lie	u of Form CMS-2552-10	
APPORTIONMENT OF INPATIENT/OUTPATIENT THROUGH COSTS	ANCILLARY SERVICE OTHER PASS	Provider CCN: 15-0051 Component CCN: 15-T051		Worksheet D Part IV Date/Time Prepared: 5/23/2017 10:42 am
		T: +1 o VIV	Cubago, d dos	DDC

			Ti tl	e XIX	Subprovi der -	PPS	
	Cost Center Description	Inpatient	Outpati ent	Outpati ent	I RF		
	, , , , , , , , , , , , , , , , , , ,	Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	_	Costs (col. 9	9		
		x col. 10)		x col. 12)			
		11. 00	12.00	13. 00			
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	0	0		0		50. 00
50. 01	05001 CV SURGERY	0	0	l .	0		50. 01
51. 00	05100 RECOVERY ROOM	0	0	1	0		51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1	0		52. 00
53. 00	05300 ANESTHESI OLOGY	0	0		0		53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	0		0		55. 00
56. 00	05600 RADI OI SOTOPE	0	0		0		56. 00
57. 00	05700 CT SCAN	0	0	1	0		57. 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	ŭ		0		60.00
64. 00	06400 I NTRAVENOUS THERAPY	0	0				64.00
65. 00	06500 RESPIRATORY THERAPY	0	0				65. 00
66. 00 67. 00	06600  PHYSI CAL THERAPY   06700  OCCUPATI ONAL THERAPY	0	0				66. 00 67. 00
68. 00	06800 SPEECH PATHOLOGY	0	0		0		68.00
69. 00	06900 ELECTROCARDI OLOGY	0	0		0		69.00
	07000 ELECTROENCEPHALOGRAPHY	0	0		0		70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0		0		71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS		0		0		72.00
	07300 DRUGS CHARGED TO PATIENTS		0		0		73. 00
	07302 OP PHARMACY		0		0		73. 01
	07400 RENAL DI ALYSI S	0	0		0		74. 00
	07500 ASC (NON-DISTINCT PART)		0		0		75. 00
	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0		0		75. 01
	07697 CARDI AC REHABI LI TATI ON	0	0	j	O		76. 97
	OUTPATIENT SERVICE COST CENTERS	-1	-				1
90.00	09000 CLI NI C	0	0		0		90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER	O	0		0		90. 01
90. 02	09002 WOUND CARE CENTER	O	0	1	0		90. 02
90. 03	09003 PAIN CLINIC	o	0		0		90. 03
90. 05	09005 OP PSYCH CLINIC	O	0		0		90. 05
91.00	09100 EMERGENCY	O	0	)	0		91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0		92. 00
	OTHER REIMBURSABLE COST CENTERS						
	09400 HOME PROGRAM DIALYSIS	0	0		0		94. 00
	09500 AMBULANCE SERVICES						95. 00
200.00	Total (lines 50-199)	0	0	1	0		200. 00

Health Financial Systems	IU HEALTH BLOOMINGT	In Lieu of Form CMS-255			
COMPUTATION OF INPATIENT OPERATING COST		Provider CCN: 15-0051	Peri od: From 01/01/2016	Worksheet D-1	
			To 12/31/2016	Date/Time Pre 5/23/2017 10:	pared: 42 am_
		Title XVIII	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					
I NPATI ENT DAYS					
				10 (50	

		Title XVIII	Hospi tal	PPS		
	Cost Center Description			1 00		
	PART I - ALL PROVIDER COMPONENTS			1. 00		
	INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)			48, 658	1.00	
2.00	Inpatient days (including private room days, excluding swing-			48, 658	1	
3.00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,					
	do not complete this line.		-			
4.00	Semi-private room days (excluding swing-bed and observation b			43, 100	4. 00	
5. 00	Total swing-bed SNF type inpatient days (including private ro	31 of the cost	0	5. 00		
	reporting period			0	, ,,,	
6. 00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	om days) after December .	31 of the cost	0	6. 00	
7. 00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	0	7. 00	
7.00	reporting period	iii days) tiii dagii beeciiibei	31 01 1110 0031	O	7.00	
8.00	Total swing-bed NF type inpatient days (including private roo	0	8.00			
	reporting period (if calendar year, enter 0 on this line)	orting period (if calendar year, enter 0 on this line)				
9.00	Total inpatient days including private room days applicable t	o the Program (excluding	swi ng-bed and	17, 051	9. 00	
	newborn days)					
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII o		oom days)	0	10. 00	
11 00	through December 31 of the cost reporting period (see instruc		om dovo) often	0	11 00	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII o December 31 of the cost reporting period (if calendar year, e		John days) arter	U	11. 00	
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		room days)	0	12. 00	
	through December 31 of the cost reporting period			_		
13.00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including private	e room days)	0	13. 00	
	after December 31 of the cost reporting period (if calendar y					
14. 00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed o	lays)	0		
15. 00	Total nursery days (title V or XIX only)			0	15.00	
16. 00	Nursery days (title V or XIX only)			0	16. 00	
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 of	tho cost	0.00	17. 00	
17.00	reporting period	es till odgir becember 31 of	the cost	0.00	17.00	
18. 00	Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of i	he cost	0.00	18. 00	
	reporting period					
19.00	Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	the cost	0.00	19. 00	
	reporting period					
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of th	ne cost	0. 00	20. 00	
21. 00	reporting period Total general inpatient routine service cost (see instruction	e)		55, 297, 122	21. 00	
22. 00	Swing-bed cost applicable to SNF type services through Decemb		na period (line	33, 277, 122	22.00	
22.00	5 x line 17)	o. o. o coo ope	g po ou (	Ü	22.00	
23.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reporting	period (line 6	0	23. 00	
	x line 18)					
24. 00	Swing-bed cost applicable to NF type services through Decembe	r 31 of the cost reportin	ng period (line	0	24. 00	
25 00	7 x line 19)	21 -6		0	25 00	
25. 00	Swing-bed cost applicable to NF type services after December x line 20)	31 of the cost reporting	period (line 8	0	25. 00	
26. 00	Total swing-bed cost (see instructions)			0	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		55, 297, 122		
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT			,,, .22		
28. 00	General inpatient routine service charges (excluding swing-be	d and observation bed cha	arges)	0	28. 00	
	Private room charges (excluding swing-bed charges)			0	1	
30. 00	Semi-private room charges (excluding swing-bed charges)			0		
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000		
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00		
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	nuo lino 22) ( !	-i ana)	0.00		
34. 00 35. 00	Average per diem private room charge differential (line 32 mi Average per diem private room cost differential (line 34 x li		.i uns)	0. 00 0. 00		
36. 00	Private room cost differential adjustment (line 3 x line 35)	ile 31)		0.00	36.00	
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost dit	ferential (line	55, 297, 122		
57.00	27 minus line 36)	55, 271, 122	57.00			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY					
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	USTMENTS			]	
38. 00	Adjusted general inpatient routine service cost per diem (see			1, 136. 44	38. 00	
39. 00	Program general inpatient routine service cost (line 9 x line	-		19, 377, 438	ı	
40.00	Medically necessary private room cost applicable to the Progr	,		0	40.00	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 4())		19, 377, 438	I 41. 00	

COMPUT	Financial Systems TATION OF INPATIENT OPERATING COST	U HEALTH BLOOMIN	Provider CCN		Peri od:	wof Form CMS-2 Worksheet D-1	
					From 01/01/2016 To 12/31/2016		
			Title	XVIII	Hospi tal	5/23/2017 10: <sup>2</sup> PPS	42 am
	Cost Center Description	Total Inpatient Costl	Total	Average Per	Program Days	Program Cost (col. 3 x col. 4)	
10.00	Thursday, (11.11. 14.5 May 11.1)	1.00	2.00	3. 00	4. 00	5. 00	
42. 00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	0	0.0	0 0	0	42.00
43. 00	INTENSIVE CARE UNIT	6, 659, 148	4, 074	1, 634. 5	5 2, 692	4, 400, 209	
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT						44. 00 45. 00
	SURGICAL INTENSIVE CARE UNIT						46.00
	OTHER SPECIAL CARE (SPECIFY)						47. 00
	Cost Center Description					1. 00	
48. 00	Program inpatient ancillary service cost (W	kst. D-3, col. 3,	line 200)			31, 045, 809	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 through 48)(see instructions)						49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS  Pass through costs applicable to Program in	2, 430, 731	50. 00				
			·				
51. 00	Pass through costs applicable to Program in and IV)	patient ancillary	services (fro	m Wkst. D, sı	um of Parts II	1, 560, 131	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				3, 990, 862	52.00
53. 00	Total Program inpatient operating cost excl	9 1	ated, non-phys	ician anesth	etist, and	50, 832, 594	53.00
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)					
54. 00						0	54.00
55. 00							55. 00
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient opera	0	56. 00 57. 00				
58. 00	1	Ö	58.00				
59. 00	Lesser of lines 53/54 or 55 from the cost re	eporting period e	nding 1996, up	dated and co	mpounded by the	0.00	59.00
60.00	market basket Lesser of lines 53/54 or 55 from prior year	cost report, upd	lated by the ma	rket basket		0.00	60.00
61. 00	If line 53/54 is less than the lower of line	es 55, 59 or 60 e	nter the Lesse	r of 50% of		0	61.00
	which operating costs (line 53) are less that amount (line 56), otherwise enter zero (see		(lines 54 x 6	0), or 1% of	the target		
62. 00		0	62.00				
63. 00	Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	0	63.00				
64. 00	Medicare swing-bed SNF inpatient routine co	sts through Decem	ber 31 of the	cost reporti	ng period (See	0	64.00
/F 00	instructions)(title XVIII only)	-+ <del>-</del>	- 21 -6			o	/ F 0/
65. 00	Medicare swing-bed SNF inpatient routine costs after December 31 of the cost reporting period (See instructions)(title XVIII only)						65.00
66. 00	Total Medicare swing-bed SNF inpatient routine costs (line 64 plus line 65)(title XVIII only). For						66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine costs through December 31 of the cost reporting period						67. 00
	(line 12 x line 19)						07.00
68. 00	Title V or XIX swing-bed NF inpatient routine costs after December 31 of the cost reporting period (line 13 x line 20)						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						70.00
70. 00 71. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service	•		,			70.00 71.00
72. 00	Program routine service cost (line 9 x line 71)						72.00
73. 00 74. 00	Medically necessary private room cost application of the service o		•	e 35)			73. 00 74. 00
75. 00	Capital -related cost allocated to inpatient			rksheet B, Pa	art II, column		75.00
	26, line 45)		`				
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ li Program capital-related costs (line 9 x line						76. 00 77. 00
78. 00	Inpatient routine service cost (line 74 minus line 77)						78.00
79. 00							79.00
80. 00 81. 00	Inpatient routine service costs for com Inpatient routine service cost per diem lim		ısı ilmitation	(iiile /8 mini	us iine 79)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (		82. 0				
83.00	Reasonable inpatient routine service costs		83.0				
84. 00 85. 00	Program inpatient ancillary services (see in Utilization review - physician compensation		84. 00 85. 00				
	Total Program inpatient operating costs (su	m of lines 83 thr					86. 00
	PART IV - COMPUTATION OF OBSERVATION BED PAS						07.0
07 00	ITotal obcorruation had dove (con inctruction	- 1				, E EEUI	
87. 00 88. 00	Total observation bed days (see instructions Adjusted general inpatient routine cost per	•	line 2)			5, 558 1, 136. 44	

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
				From 01/01/2016 Fo 12/31/2016	Date/Time Prep 5/23/2017 10:4	
		Title	XVIII	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2. 00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	5, 975, 992	55, 297, 122	0. 10807	6, 316, 334	682, 613	90.00
91.00 Nursing School cost	0	55, 297, 122	0.00000	6, 316, 334	0	91.00
92.00 Allied health cost	0	55, 297, 122	0.00000	6, 316, 334	0	92.00
93.00 All other Medical Education	0	55, 297, 122	0. 000000	6, 316, 334	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0051	Peri od: From 01/01/2016	Worksheet D-1
	Component CCN: 15-T051	To 12/31/2016	Date/Time Prepared: 5/23/2017 10:42 am
	Title XVIII	Subprovi der -	PPS

		litie XVIII	Subprovider -	PPS	
	Cost Center Description		TIM	1.00	
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 144	1. 00
2.00	Inpatient days (including private room days, excluding swing-			3, 144	2. 00
3. 00	Private room days (excluding swing-bed and observation bed day do not complete this line.	ys). If you have only pr	rivate room days,	0	3. 00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 144	4. 00
5. 00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	0	5. 00
	reporting period				
6.00	Total swing-bed SNF type inpatient days (including private reporting period (if calendar year, enter 0 on this line)	om days) after December	31 of the cost	0	6. 00
7. 00	Total swing-bed NF type inpatient days (including private room	m days) through December	r 31 of the cost	0	7. 00
	reporting period				
8.00	Total swing-bed NF type inpatient days (including private room	m days) after December 3	31 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	o the Program (excluding	a swing-bod and	2, 018	9. 00
7.00	newborn days)	o the rrogram (excruding	g swillig-bed and	2,010	7. 00
10.00	Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private r	room days)	0	10. 00
44.00	through December 31 of the cost reporting period (see instruc				44 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII on December 31 of the cost reporting period (if calendar year, en		room days) after	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12. 00
	through December 31 of the cost reporting period				
13. 00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar year)			0	13. 00
14. 00	Medically necessary private room days applicable to the Progra			0	14. 00
15. 00	Total nursery days (title V or XIX only)	, 3 3	,	0	15. 00
16. 00	Nursery days (title V or XIX only)			0	16. 00
17. 00	SWING BED ADJUSTMENT  Medicare rate for swing-bed SNF services applicable to service	os through Docombor 21 o	of the cost	0.00	17. 00
17.00	reporting period	es through becember 51 c	of the cost	0.00	17.00
18. 00	Medicare rate for swing-bed SNF services applicable to service	es after December 31 of	the cost	0. 00	18. 00
19. 00	reporting period Medicaid rate for swing-bed NF services applicable to services	s through Docombor 21 of	f the cost	0.00	19. 00
19.00	reporting period	3 thi dugii becember 31 di	the cost	0.00	19.00
20. 00	Medicaid rate for swing-bed NF services applicable to service	s after December 31 of t	the cost	0. 00	20. 00
21. 00	reporting period Total general inpatient routine service cost (see instructions	e)		2, 949, 383	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December		ting period (line	2, 747, 303	22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportir	ng period (line 6	0	23. 00
24. 00	x line 18) Swing-bed cost applicable to NF type services through December	r 31 of the cost reporti	ing period (line	0	24. 00
	7 x line 19)				
25. 00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25. 00
26. 00	x line 20)  Total swing-bed cost (see instructions)			o	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		2, 949, 383	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	narges)		28. 00
29. 00 30. 00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27	÷ line 28)		0. 000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	
33.00	Average semi-private room per diem charge (line 30 ÷ line 4)	li 22) ( it	-+:>	0.00	
34. 00 35. 00	Average per diem private room charge differential (line 32 mil Average per diem private room cost differential (line 34 x li		LI UIIS)	0. 00 0. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	/		0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	ifferential (line	2, 949, 383	37. 00
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	USTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			938. 10	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line			1, 893, 086	
40. 00 41. 00	Medically necessary private room cost applicable to the Progra Total Program general inpatient routine service cost (line 39)			0 1, 893, 086	
41.00	Tiotai Trogram general Impatrent routine service cost (ITNe 39	+ 1111C 40)		1, 073, 080	41.00

		J HEALTH BLOOMIN				eu of Form CMS-2	
COMPUT	ATION OF INPATIENT OPERATING COST		Provider Component	CCN: 15-0051 CCN: 15-T051	Peri od: From 01/01/2016 To 12/31/2016		
			·	XVIII	Subprovi der -	5/23/2017 10: PPS	
	Cost Center Description	Total	Total	Average Per	IRF Program Days	Program Cost	
	cost center bescription	Inpatient Cost				(col. 3 x col. 4)	
42 00	NURSERY (title V & XIX only)	1. 00	2.00	3.00	4.00	5. 00	42. 00
12.00	Intensive Care Type Inpatient Hospital Units	-1					
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	0	0	O. C	0	0	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00
47.00	Cost Center Description						47.00
48. 00	Program inpatient ancillary service cost (Wk:	st D-3 col 3	line 200)			1. 00 2, 099, 996	48. 00
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS			ons)		3, 993, 082	
50. 00	Pass through costs applicable to Program inp	atient routine :	services (from	n Wkst. D, sum	of Parts I and	311, 115	50. 00
51. 00	<pre>III) Pass through costs applicable to Program inpa and IV)</pre>	atient ancillar	y services (fr	rom Wkst. D, s	um of Parts II	121, 865	51. 00
52. 00	Total Program excludable cost (sum of lines					432, 980	•
53. 00	Total Program inpatient operating cost exclumedical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		lated, non-phy	sician anesth	etist, and	3, 560, 102	53. 00
54. 00	Program discharges					0	54. 00
55. 00	Target amount per discharge					0.00	ł
56. 00 57. 00	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0 0	
58. 00	Bonus payment (see instructions)	· ·			•	0	58. 00
59. 00	Lesser of lines 53/54 or 55 from the cost remarket basket	porting period (	ending 1996, u	ipdated and co	mpounded by the	0.00	59. 00
60. 00	Lesser of lines 53/54 or 55 from prior year					0.00	•
61. 00	If line 53/54 is less than the lower of line which operating costs (line 53) are less that					0	61. 00
42.00	amount (line 56), otherwise enter zero (see	nstructions)			Ü	0	62. 00
62. 00 63. 00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	1
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Dece	mber 31 of the	cost reporti	na period (See	0	64. 00
65. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	period (See	0	65. 00
66. 00	instructions)(title XVIII only) Total Medicare swing-bed SNF inpatient routi	ne costs (line d	64 nlus line 6		l only) For	0	66. 00
	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing				•	0	
68. 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routing	-				0	
	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient			·	. tring portion	0	
	PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY,	AND ICF/IID	ONLÝ			
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service o						70. 00 71. 00
72. 00	Program routine service cost (line 9 x line	71)					72. 00
73. 00 74. 00	Medically necessary private room cost applications and program general inpatient routine services.	•	•				73. 00 74. 00
75. 00	Capital-related cost allocated to inpatient (26, line 45)	•			art II, column		75. 00
76. 00	Per diem capital related costs (line 75 ÷ line						76. 00
77. 00 78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						77. 00 78. 00
79. 00	Aggregate charges to beneficiaries for excess						79. 00
80. 00 81. 00	Total Program routine service costs for companient routine service cost per diem limi		ost limitation	ı (ııne /8 min	us line /9)		80. 00 81. 00
82. 00	Inpatient routine service cost limitation (I	ne 9 x line 81					82. 00
83. 00 84. 00	Reasonable inpatient routine service costs ( Program inpatient ancillary services (see in:		s)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ns)				85. 00
86. 00	Total Program inpatient operating costs (sum		rough 85)				86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS Total observation bed days (see instructions					0	87. 00
88. 00 89. 00	Adjusted general inpatient routine cost per observation bed cost (line 87 x line 88) (see		line 2)				88. 00 89. 00
07.00	Tobaci vation bod cost (Time of A Time oo) (Set					1	1 07.00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2016 To 12/31/2016		pared: 42 am_
		Title	XVIII	Subprovi der – I RF	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	484, 703	2, 949, 383	0. 16434	0 0	0	90.00
91.00 Nursing School cost	0	2, 949, 383	0. 00000	0	0	91.00
92.00 Allied health cost	0	2, 949, 383	0. 00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 949, 383	0. 00000	0	0	93. 00

Heal th	Financial Systems	IU HEALTH BLOOMINGT	TON HOSPITAL	In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der CCN: 15-0051	Peri od: From 01/01/2016	Worksheet D-1	
				To 12/31/2016	Date/Time Prep 5/23/2017 10:4	
			Title XIX	Hospi tal	PPS	
	Cost Center Description					
					1. 00	
	PART I - ALL PROVIDER COMPONENTS					
	I NPATI ENT DAYS					
1.00	Inpatient days (including private room da	ays and swing-bed days	s, excluding newborn)		48, 658	1.00
					40 450	

	Cook Cooking Description   ITTLE XIX   Hospital	PPS	
	Cost Center Description	1. 00	
	PART I - ALL PROVIDER COMPONENTS	1.00	
	I NPATI ENT DAYS		1
1.00	Inpatient days (including private room days and swing-bed days, excluding newborn)	48, 658	1. 00
2.00	Inpatient days (including private room days, excluding swing-bed and newborn days)	48, 658	
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only private room days,	0	3. 00
4. 00	do not complete this line.	42 100	4. 00
5. 00	Semi-private room days (excluding swing-bed and observation bed days)  Total swing-bed SNF type inpatient days (including private room days) through December 31 of the cost	43, 100	5. 00
3.00	reporting period	O	3.00
6.00	Total swing-bed SNF type inpatient days (including private room days) after December 31 of the cost	0	6. 00
	reporting period (if calendar year, enter 0 on this line)		
7. 00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
0.00	reporting period Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	0.00
8. 00	reporting period (if calendar year, enter 0 on this line)	U	8. 00
9. 00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	629	9. 00
	newborn days)		
10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
	through December 31 of the cost reporting period (see instructions)	_	
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	0	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	· ·	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)		
14. 00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	
15. 00 16. 00	Total nursery days (title V or XIX only) Nursery days (title V or XIX only)	3, 478 1, 742	15. 00 16. 00
10.00	SWING BED ADJUSTMENT	1, 742	10.00
17. 00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0.00	18. 00
10.00	reporting period	0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost reporting period	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
	reporting period		
21. 00	Total general inpatient routine service cost (see instructions)	55, 297, 122	
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	22. 00
23. 00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6)	0	23. 00
23.00	x line 18)	O	25.00
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
26. 00	x line 20)   Total swing-bed cost (see instructions)	0	26. 00
27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	55, 297, 122	
27.00	PRIVATE ROOM DI FFERENTI AL ADJUSTMENT	00/2/// 122	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Private room charges (excluding swing-bed charges)	0	
30. 00	Semi-private room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0. 000000	1
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)	0. 00 0. 00	1
34. 00	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	1
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	1
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	55, 297, 122	37. 00
	27 minus line 36)		1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		-
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS  Adjusted general inpatient routine service cost per diem (see instructions)	1, 136. 44	38. 00
39. 00	Program general inpatient routine service cost (line 9 x line 38)	714, 821	
40. 00	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	1
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	714, 821	41.00

7.00	Total swing-bed NF type inpatient days (including private room days) through December 31 of the cost	0	7. 00
	reporting period		
8.00	Total swing-bed NF type inpatient days (including private room days) after December 31 of the cost	0	8. 00
	reporting period (if calendar year, enter 0 on this line)		
9.00	Total inpatient days including private room days applicable to the Program (excluding swing-bed and	629	9. 00
10.00	newborn days)	0	10 00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10. 00
11 00	through December 31 of the cost reporting period (see instructions)  Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after	0	11. 00
11. 00	December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	11.00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XLX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	O	12.00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13. 00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14. 00
15.00	Total nursery days (title V or XIX only)	3, 478	15. 00
16.00	Nursery days (title V or XIX only)	1, 742	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost	0.00	17. 00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost	0. 00	18. 00
10.00	reporting period	0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
20. 00	reporting period Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost	0.00	20. 00
20.00	reporting period	0.00	20.00
21. 00	Total general inpatient routine service cost (see instructions)	55, 297, 122	21. 00
22. 00	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line	0	
	5 x line 17)		
23.00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)		
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24. 00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8	0	25. 00
24 00	x line 20) Total swing-bed cost (see instructions)	0	24 00
26. 00 27. 00	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	55, 297, 122	26. 00 27. 00
27.00	PRIVATE ROOM DI FFERENTIAL ADJUSTMENT	33, 241, 122	27.00
28. 00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29. 00	Pri vate room charges (excluding swing-bed charges)	0	29. 00
30. 00	Semi -pri vate room charges (excluding swing-bed charges)	0	
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	
32. 00	Average private room per diem charge (line 29 ÷ line 3)	0.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	0.00	
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x line 31)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	0	36. 00
37.00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	55, 297, 122	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS		
	Adjusted general inpatient routine service cost per diem (see instructions)	1, 136. 44	
39. 00	Program general inpatient routine service cost (line 9 x line 38)	714, 821	39. 00
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	0	
41. 00	Total Program general inpatient routine service cost (line 39 + line 40)	714, 821	41. 00

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	Financial Systems TATION OF INPATIENT OPERATING COST	IU HEALTH BLOOMI	NGTON HOSPITAL Provider Co		In Lie Period:	u of Form CMS-2 Worksheet D-1	
COMPU	ATTON OF THEATTENT OFERATING COST		Frovider C		From 01/01/2016 To 12/31/2016		
						5/23/2017 10:	
	Cost Center Description	Total	Ti tl	e XIX Average Per	Hospital Program Days	PPS Program Cost	
	oost conten boschiptron	Inpatient Cost				(col. 3 x col.	
		1.00	2.00	col . 2)	4. 00	4)	
42. 00	NURSERY (title V & XIX only)	1. 00 4, 733, 887	2. 00 3, 478	3. 00 1, 361. 0		5. 00 2, 371, 019	42. 00
	Intensive Care Type Inpatient Hospital Unit	S					
43. 00 44. 00	INTENSIVE CARE UNIT CORONARY CARE UNIT	6, 659, 148	4, 074	1, 634. 5	5 696	1, 137, 647	43. 00 44. 00
45. 00	BURN INTENSIVE CARE UNIT						45. 00
46. 00	SURGICAL INTENSIVE CARE UNIT						46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)  Cost Center Description						47. 00
	cost center bescription					1. 00	
48. 00	Program inpatient ancillary service cost (W					1, 597, 896	
49. 00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(	see instructio	ns)		5, 821, 383	49.00
50.00	Pass through costs applicable to Program in	patient routine	services (from	Wkst. D, sum	of Parts I and	321, 511	50.00
F1 00			(6-	WI+ D -	£ Dt- II	00 070	F1 00
51. 00	Pass through costs applicable to Program in and IV)	patient anciliar	y services (Tr	OM WKST. D, S	um or Parts II	98, 279	51.00
52. 00	Total Program excludable cost (sum of lines					419, 790	
53. 00	Total Program inpatient operating cost excl medical education costs (line 49 minus line		lated, non-phy	sician anesth	etist, and	5, 401, 593	53. 00
	TARGET AMOUNT AND LIMIT COMPUTATION	: 32)					
	Program discharges						54.00
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)						55. 00 56. 00
57. 00	,	ting cost and ta	rget amount (I	ine 56 minus	line 53)	0	
58. 00	Bonus payment (see instructions)					0	
59. 00	Lesser of lines 53/54 or 55 from the cost r market basket	reporting period	ending 1996, u	pdated and co	mpounded by the	0.00	59. 00
60.00	Lesser of lines 53/54 or 55 from prior year						60.00
61. 00	If line 53/54 is less than the lower of lin which operating costs (line 53) are less th					0	61.00
	amount (line 56), otherwise enter zero (see		3 (TITIES 54 X	00), 01 1% 01	the target		
	Relief payment (see instructions)					0	
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST						0	63.00
64.00	Medicare swing-bed SNF inpatient routine co	sts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine co</pre>	sts after Decemb	er 31 of the c	ost renorting	neriod (See	0	65. 00
	instructions)(title XVIII only)						
66. 00	Total Medicare swing-bed SNF inpatient rout CAH (see instructions)	ine costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00
67. 00	Title V or XIX swing-bed NF inpatient routi	ne costs through	December 31 o	f the cost re	porting period	0	67. 00
(0.00	(line 12 x line 19)	t6t D		*b*			(0.00
68.00	Title V or XIX swing-bed NF inpatient routi (line 13 x line 20)	ne costs after D	ecember 31 or	tne cost repo	rting 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 Skilled nursing facility/other nursing faci						70.00
71. 00	Adjusted general inpatient routine service	,		` ,			71.00
72. 00				25)			72. 00
73. 00 74. 00	Medically necessary private room cost appli Total Program general inpatient routine ser						73.00
75. 00	Capital -related cost allocated to inpatient	,			art II, column		75. 00
7/ 00	26, line 45)	ino 2)					74 00
76. 00 77. 00	Per diem capital-related costs (line 75 ÷ l Program capital-related costs (line 9 x lin	. *					76. 00 77. 00
78. 00	, '						78. 00
79.00	Aggregate charges to beneficiaries for exce Total Program routine service costs for com				us line 70)		79. 00 80. 00
81. 00	Inpatient routine service costs for com	•	ost irmitation	(11116 70 111111	GO 11110 /7)		81. 00
82.00	Inpatient routine service cost limitation (		* .				82.00
83. 00 84. 00	Reasonable inpatient routine service costs Program inpatient ancillary services (see i	•	is)				83. 00 84. 00
85. 00	Utilization review - physician compensation		ins)				85. 00
86. 00	Total Program inpatient operating costs (su	m of lines 83 th					86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PA Total observation bed days (see instruction					5, 558	87. 00
88. 00	Adjusted general inpatient routine cost per	diem (line 27 ÷				1, 136. 44	88. 00
	Observation bed cost (line 87 x line 88) (s					6, 316, 334	

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CC		Peri od:	Worksheet D-1	
				From 01/01/2016 To 12/31/2016	Date/Time Prep 5/23/2017 10:4	
		Ti tl	e XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital -related cost	5, 975, 992	55, 297, 122	0. 10807	6, 316, 334	682, 613	90.00
91.00 Nursing School cost	0	55, 297, 122	0.00000	6, 316, 334	0	91.00
92.00 Allied health cost	0	55, 297, 122	0.00000	6, 316, 334	0	92.00
93.00 All other Medical Education	0	55, 297, 122	0. 00000	6, 316, 334	0	93. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
COMPUTATION OF INPATIENT OPERATING COST	Provi der CCN: 15-0051	Peri od: From 01/01/2016	Worksheet D-1
	Component CCN: 15-T051	To 12/31/2016	Date/Time Prepared: 5/23/2017 10:42 am
	Title XIX	Subprovi der -	PPS

		litle XIX	I RF	PPS	
	Cost Center Description		TIXI		
	PART I - ALL PROVIDER COMPONENTS			1. 00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days			3, 144	1. 00
2. 00 3. 00	Inpatient days (including private room days, excluding swing-l Private room days (excluding swing-bed and observation bed day		ivata room days	3, 144 0	2. 00 3. 00
3.00	do not complete this line.	ys). IT you have only pr	I vate 100m days,	U	3.00
4.00	Semi-private room days (excluding swing-bed and observation be	ed days)		3, 144	4. 00
5.00	Total swing-bed SNF type inpatient days (including private room	om days) through Decembe	r 31 of the cost	0	5. 00
6. 00	reporting period Total swing-bed SNF type inpatient days (including private roo	om days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	n days) through December	31 of the cost	0	7. 00
8. 00	reporting period Total swing-bed NF type inpatient days (including private room	n days) after December 3	1 of the cost	0	8. 00
9. 00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	14	9. 00
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII or		oom days)	0	10. 00
11. 00	through December 31 of the cost reporting period (see instructions). Swing-bed SNF type inpatient days applicable to title XVIII or	nly (including private r	oom days) after	0	11. 00
12. 00	December 31 of the cost reporting period (if calendar year, en Swing-bed NF type inpatient days applicable to titles V or XI)		e room days)	0	12. 00
13. 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX			0	13. 00
14. 00	after December 31 of the cost reporting period (if calendar you Medically necessary private room days applicable to the Program			0	14. 00
15.00	Total nursery days (title V or XIX only)				15.00
16. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			1, 742	16. 00
17. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es through December 31 o	f the cost	0. 00	17. 00
18. 00	Medicare rate for swing-bed SNF services applicable to service reporting period	es after December 31 of	the cost	0.00	18. 00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s through December 31 of	the cost	0. 00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	s after December 31 of t	he cost	0.00	20. 00
21. 00 22. 00	Total general inpatient routine service cost (see instructions Swing-bed cost applicable to SNF type services through December		ing period (line	2, 949, 383 0	21. 00 22. 00
	5 x line 17)	·			
23. 00	Swing-bed cost applicable to SNF type services after December x line 18)	·		0	23. 00
24. 00	Swing-bed cost applicable to NF type services through December 7 x line 19)	•		0	
25. 00	Swing-bed cost applicable to NF type services after December (x line 20)	31 of the cost reporting	period (line 8	0	25. 00
26. 00 27. 00	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		0 2, 949, 383	26. 00 27. 00
27.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	(Tric 21 millus Tric 20)		2, 747, 303	27.00
	General inpatient routine service charges (excluding swing-bed	d and observation bed ch	arges)		28. 00
29. 00	Private room charges (excluding swing-bed charges)			0	
30.00	Semi -private room charges (excluding swing-bed charges)	1: 20)		0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27	Filne 28)		0.000000	
32. 00 33. 00	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line 4)			0. 00 0. 00	
34. 00	Average per diem private room charge differential (line 32 mi)	nus line 33)(see instruc	tions)	0.00	
35. 00	Average per diem private room cost differential (line 34 x lin		111 0113)	0.00	
36. 00	Private room cost differential adjustment (line 3 x line 35)			0.00	36. 00
37. 00	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	2, 949, 383	37. 00
	27 minus line 36)				
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJU	ISTMENTS			
38. 00	Adjusted general inpatient routine service cost per diem (see			938. 10	38, 00
39. 00	Program general inpatient routine service cost (line 9 x line			13, 133	
40.00	Medically necessary private room cost applicable to the Progra			0	
41. 00	Total Program general inpatient routine service cost (line 39	+ line 40)		13, 133	41. 00

		J HEALTH BLOOMI				eu of Form CMS-2		
COMPUT	ATION OF INPATIENT OPERATING COST			CN: 15-0051 CCN: 15-T051	Peri od: From 01/01/2016 To 12/31/2016			
			·	e XIX	Subprovi der -	5/23/2017 10: PPS		
	Cost Center Description	Total	Total	Average Per	. I RF	Program Cost		
	cost center bescription	Inpatient Cost				(col. 3 x col.		
42.00	NURSERY (title V & XIX only)	1.00	2. 00	3.00	4.00	5.00	42. 00	
	Intensive Care Type Inpatient Hospital Units	-		1				
43. 00 44. 00	INTENSIVE CARE UNIT	0	C	0.0	00 0	0	43. 00 44. 00	
45.00	BURN INTENSIVE CARE UNIT						45. 00	
46. 00 47. 00	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)						46. 00 47. 00	
17.00	Cost Center Description						17.00	
48. 00	Program inpatient ancillary service cost (Wk	st. D-3. col. 3	. line 200)		_	1.00	48. 00	
49. 00				ons)		13, 133	1	
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	n of Parts I and	2, 158	50.00	
51. 00	Pass through costs applicable to Program inpa and IV)	atient ancillar	y services (fr	om Wkst. D, s	sum of Parts II	0	51. 00	
52.00	Total Program excludable cost (sum of lines!					2, 158		
53. 00	Total Program inpatient operating cost exclude medical education costs (line 49 minus line ! TARGET AMOUNT AND LIMIT COMPUTATION		lated, non-phy	sıcıan anestr	netist, and	10, 975	53. 00	
54. 00	Program di scharges					0		
55. 00 56. 00	Target amount per discharge Target amount (line 54 x line 55)					0.00	1	
57. 00	Difference between adjusted inpatient operati	ng cost and ta	rget amount (I	ine 56 minus	line 53)	0	57. 00	
58. 00 59. 00	8.00 Bonus payment (see instructions) 9.00 Lesser of lines 53/54 or 55 from the cost reporting period ending 1996, updated and compounded by the							
60. 00	market basket Lesser of lines 53/54 or 55 from prior year (	cost report, up	dated by the m	narket basket		0.00	60.00	
61.00 If line 53/54 is less than the lower of lines 55, 59 or 60 enter the lesser of 50% of the amount by which operating costs (line 53) are less than expected costs (lines 54 x 60), or 1% of the target							61. 00	
62. 00	amount (line 56), otherwise enter zero (see i Relief payment (see instructions)	nstructions)				0	62. 00	
	Allowable Inpatient cost plus incentive payme	ent (see instru	ctions)			0		
64. 00	,	ts through Dece	mber 31 of the	cost reporti	ng period (See	0	64. 00	
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cosinstructions)(title XVIII only)</pre>	ts after Decemb	er 31 of the o	cost reportino	g period (See	0	65. 00	
66. 00	Total Medicare swing-bed SNF inpatient routin   CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVII	I only). For	0	66. 00	
67. 00	Title V or XIX swing-bed NF inpatient routing (line 12 x line 19)	e costs through	December 31 c	of the cost re	eporting period	0	67. 00	
68. 00	Title V or XIX swing-bed NF inpatient routing (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	orting period	0	68. 00	
69. 00	Total title V or XIX swing-bed NF inpatient I PART III - SKILLED NURSING FACILITY, OTHER NU	JRSING FACILITY	, AND ICF/IID	ONLÝ		0		
70. 00 71. 00	Skilled nursing facility/other nursing facili Adjusted general inpatient routine service of						70. 00 71. 00	
72. 00	Program routine service cost (line 9 x line		70 . 11116	-)			72. 00	
73. 00 74. 00	Medically necessary private room cost application of the cost application of t		•				73. 00 74. 00	
75. 00	Capital-related cost allocated to inpatient (26, line 45)	•			Part II, column		75. 00	
76. 00 77. 00	Per diem capital related costs (line 75 ÷ lin	. *					76. 00 77. 00	
78. 00	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus						78. 00	
79. 00 80. 00	Aggregate charges to beneficiaries for excess				ous line 70)		79. 00 80. 00	
81. 00	Total Program routine service costs for comparing the routine service cost per diem limit		ost iiiiii tati Oi	. (11116 10 IIIII	ius IIIIe /9)		81.00	
82. 00 83. 00	Inpatient routine service cost limitation (li Reasonable inpatient routine service costs (		* .				82. 00 83. 00	
84. 00	Program inpatient ancillary services (see ins		3)				84. 00	
85. 00 86. 00	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 00 86. 00	
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST	rough oo)					
87. 00 88. 00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per of		line 2)			0 00	87. 00 88. 00	
	Observation bed cost (line 87 x line 88) (see	•	2)				89. 00	

Health Financial Systems II	NGTON HOSPITAL		In Lieu of Form CMS-2552			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Peri od:	Worksheet D-1	
		Component (		From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 10:	
		Ti tl	e XIX	Subprovi der -	PPS	
				IRF		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
				,	4) (see	
					instructions)	
	1. 00	2.00	3. 00	4. 00	5. 00	
COMPUTATION OF OBSERVATION BED PASS THROUGH O	OST					
90.00 Capital -related cost	484, 703	2, 949, 383	0. 16434	0 0	0	90. 00
91.00 Nursing School cost	0	2, 949, 383	0.00000	0 0	0	91. 00
92.00 Allied health cost	0	2, 949, 383	0.00000	0 0	0	92.00
93.00 All other Medical Education	0	2, 949, 383	0. 00000	0 0	0	93. 00
90.00 Capital-related cost 91.00 Nursing School cost 92.00 Allied health cost	OST	2, 949, 383 2, 949, 383 2, 949, 383	0. 16434 0. 00000 0. 00000	0 0 0 0 0 0	instructions) 5.00	91. 00 92. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC	F	From 01/01/2016	Worksheet D-3 Date/Time Prep 5/23/2017 10:4	pared:
	Title	XVIII	Hospi tal	PPS	
Cost Center Description		Ratio of Cost	Inpati ent	Inpati ent	

				From 01/01/2016 To 12/31/2016		
		Ti tl e	e XVIII	Hospi tal	5/23/2017 10: PPS	42 alli
	Cost Center Description	11 61 6	Ratio of Cos		Inpati ent	
	oost contor bescription		To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
				3	2)	
			1. 00	2. 00	3. 00	
00.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS			00 407 (50		00.00
30. 00 31. 00	03000 ADULTS & PEDI ATRI CS			39, 487, 653		30.00
41. 00	03100   I NTENSI VE CARE UNI T   04100   SUBPROVI DER -   I RF			8, 721, 420 0		31. 00 41. 00
41.00	04200 SUBPROVI DER			0		42.00
43. 00	04300 NURSERY			0		43.00
43.00	ANCI LLARY SERVI CE COST CENTERS					43.00
50. 00	05000 OPERATING ROOM		0. 11594	34, 389, 655	3, 987, 171	50.00
50. 01	05001 CV SURGERY		0.00000		0	50. 01
51. 00	05100 RECOVERY ROOM		0. 17743		645, 582	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 25810	00 67, 790		52. 00
53.00	05300 ANESTHESI OLOGY		0. 00000	00	0	53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C		0. 14092	8, 574, 457	1, 208, 364	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C		0. 10258	1, 698, 492	174, 247	55. 00
56.00	05600  RADI 0I SOTOPE		0.00000	00	0	56. 00
57.00	05700 CT SCAN		0. 05936		252, 026	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)		0. 11688			
59. 00	05900 CARDI AC CATHETERI ZATI ON		0. 08340			
60.00	06000 LABORATORY		0. 12477			
64. 00	06400 I NTRAVENOUS THERAPY		0.00000		0	64. 00
65. 00	06500 RESPI RATORY THERAPY		0. 30683			1
66.00	06600 PHYSI CAL THERAPY		0. 42867			66.00
67. 00	06700 OCCUPATI ONAL THERAPY		0.00000		0	67.00
68. 00 69. 00	06800 SPEECH PATHOLOGY		0.00000		0	68. 00 69. 00
70. 00	06900   ELECTROCARDI OLOGY   07000   ELECTROENCEPHALOGRAPHY		0. 0705 <i>6</i> 0. 1350 <sup>4</sup>		375, 854 89, 411	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 13302			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0. 16735			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0. 25726			
73. 01	07302 OP PHARMACY		0. 27670		0,,	73. 01
74. 00	07400 RENAL DI ALYSI S		0. 32597		470, 736	
75.00	07500 ASC (NON-DISTINCT PART)		0. 00000	00	0	75. 00
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.00000	00	0	75. 01
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 45037	172, 478	77, 679	76. 97
	OUTPATIENT SERVICE COST CENTERS					
90.00	09000 CLI NI C		1. 77856		17, 165	90.00
90. 01	09001 OP ONCOLOGY INFUSION CENTER		0. 20782			1
90. 02	09002 WOUND CARE CENTER		0. 35619			1
90. 03	09003 PAIN CLINIC		0. 34491			90. 03
90.05	09005 OP PSYCH CLINIC		1. 34208	•	23, 617	90.05
91.00	09100 EMERGENCY		0. 12843			91.00
92. 00	09200 OBSERVATI ON BEDS (NON-DISTINCT PART) OTHER REIMBURSABLE COST CENTERS		0. 31797	79 1, 135, 004	360, 907	92. 00
94. 00	09400 HOME PROGRAM DI ALYSIS		0.00000	00 0	0	94. 00
95. 00	09500 AMBULANCE SERVI CES		0.00000	,0		95.00
200.00				184, 078, 185	31, 045, 809	1
201.00		(Line 61)		104, 070, 109	3.,010,007	201.00
202.00		(		184, 078, 185		202. 00
			•	, , , , , , , , , , , , , , , , , , , ,	•	

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITA	L	In lie	eu of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONM		CCN: 15-0051	Peri od:	Worksheet D-3	
	Component	CCN: 15-T051	From 01/01/2016 To 12/31/2016		
	Ti tl	e XVIII	Subprovi der - I RF	PPS	
Cost Center Description		Ratio of Cos To Charges	Inpatient Program Charges	Inpatient Program Costs (col. 1 x col. 2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTER	25	1.00	2.00	3.00	
30. 00   03000   ADULTS & PEDI ATRI CS 31. 00   03100   I NTENSI VE CARE UNI T 41. 00   04100   SUBPROVI DER -   I RF 42. 00   04200   SUBPROVI DER 43. 00   04300   NURSERY			3, 227, 240 0		30. 00 31. 00 41. 00 42. 00 43. 00
ANCILLARY SERVICE COST CENTERS		0.4450	44 47 474	4 000	
50. 00   05000   OPERATI NG ROOM		0. 1159			1
50. 01   05001   CV   SURGERY 51. 00   05100   RECOVERY   ROOM		0. 0000 0. 1774		0	
52. 00 05200 DELIVERY ROOM & LABOR ROOM		0. 1774		0	
53. 00   05200   DELI VERT ROOM & LABOR ROOM   53. 00   05300   ANESTHESI OLOGY		0. 2381		0	
54. 00   05400   RADI OLOGY-DI AGNOSTI C		0. 1409		_	
55. 00   05500 RADI OLOGY-THERAPEUTI C		0. 1407			1
56. 00   05600   RADI OI SOTOPE		0.0000		720	1
57. 00 05700 CT SCAN		0. 0593		_	
58. 00 05800 MAGNETIC RESONANCE I MAGING (MRI	)	0. 1168			1
59. 00 05900 CARDI AC CATHETERI ZATI ON	,	0. 0834		0	
60. 00   06000   LABORATORY		0. 1247			1
64. 00 06400 I NTRAVENOUS THERAPY		0.0000	·	0	
65. 00 06500 RESPIRATORY THERAPY		0. 3068	31 70, 745	21, 707	65. 00
66. 00 06600 PHYSI CAL THERAPY		0. 4286	76 3, 861, 604	1, 655, 377	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		0.0000	00	0	67.00
68. 00 06800 SPEECH PATHOLOGY		0.0000	00 0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY		0. 0705		8, 058	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0. 1350			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PAT	TI ENTS	0. 2374		12, 892	
72.00 07200 I MPL. DEV. CHARGED TO PATIENTS		0. 1673		16	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 2572			
73. 01 07302 OP PHARMACY		0. 2767		0	
74. 00   07400   RENAL DI ALYSI S		0. 3259			
75. 00   07500   ASC (NON-DISTINCT PART)	050	0.0000			
75. 01 03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI	CES	0.0000		0	
76. 97 O7697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS		0. 4503	72 264	119	76. 97
90. 00 09000 CLINIC		1. 7785	64 887	1, 578	90.00
90. 01 09001 OP ONCOLOGY INFUSION CENTER		0. 2078		1,370	1
90. 02 09002 WOUND CARE CENTER		0. 3561		ő	
90. 03   09003   PAIN CLINIC		0. 3449			
90 05 09005 OP PSYCH CLINIC		1 3420		0	

90.05

91.00

92.00

95.00

201. 00

202. 00

0

0 94.00

2, 099, 996 200. 00

2, 584

13, 285

0

0

20, 116

41, 778

6, 002, 574

6, 002, 574

1.342084

0.128437

0. 317979

0.000000

09005 OP PSYCH CLINIC

94.00 09400 HOME PROGRAM DIALYSIS

95. 00 09500 AMBULANCE SERVICES

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

Net Charges (line 200 minus line 201)

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

09100 EMERGENCY

90.05

91.00

92.00

200.00

201.00

202.00

Health Financial Systems	IU HEALTH BLOOMINGT	ON HOSPITAL		In Lieu of Form CMS-2552-10
INDATIENT ANGLILARY SERVICE COST APPORTIONMENT		Provider CCN: 15-0051	Dari od:	Workshoot D_3

	Financial Systems To HEALTH BLOOMING				eu of Form CWS	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der C	CN: 15-0051	Peri od:	Worksheet D-3	
				From 01/01/2016		
				To 12/31/2016		pared:
			2/12/		5/23/2017 10:	42 am_
		liti	e XIX	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		I npati ent	
			To Charges	Program	Program Costs	
				Charges	(col. 1 x col.	
					2)	
			1.00	2. 00	3.00	
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS					
30. 00	03000 ADULTS & PEDI ATRI CS			2, 703, 719		30.00
31. 00	03100   NTENSI VE CARE UNI T			879, 828		31.00
41. 00	04100 SUBPROVI DER - I RF					41. 00
				49, 876	<u>'</u>	1
42. 00	04200 SUBPROVI DER				)	42. 00
43.00	04300 NURSERY			768, 327		43. 00
	ANCILLARY SERVICE COST CENTERS					
50.00	05000  OPERATI NG ROOM		0. 11594	11 762, 160	88, 366	50.00
50. 01	05001 CV SURGERY		0.00000	00	0	50. 01
51.00	05100 RECOVERY ROOM		0. 17743	83, 083	14, 742	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM		0. 25810			
53. 00	05300 ANESTHESI OLOGY		0. 00000	·	0	1
54. 00	05400 RADI OLOGY-DI AGNOSTI C		0. 14092			
					•	1
55. 00	05500 RADI OLOGY-THERAPEUTI C		0. 10258			
56. 00	05600 RADI OI SOTOPE		0.00000		0	
57. 00	05700 CT SCAN		0.05936			1
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)		0. 11688	66, 058	7, 721	58. 00
59.00	05900   CARDI AC   CATHETERI ZATI ON		0. 08340	09 107, 364	8, 955	59. 00
60.00	06000 LABORATORY		0. 12477	1, 426, 940	178, 052	60.00
64.00	06400 I NTRAVENOUS THERAPY		0.00000	00	0	64. 00
65. 00	06500 RESPI RATORY THERAPY		0. 30683			1
66. 00	06600 PHYSI CAL THERAPY		0. 42867	·	1	1
67. 00	06700 OCCUPATI ONAL THERAPY		0. 00000	•		1
						1
68. 00	06800 SPEECH PATHOLOGY		0.00000		1	
69. 00	06900 ELECTROCARDI OLOGY		0. 07056		•	1
70.00	07000 ELECTROENCEPHALOGRAPHY		0. 13504		•	1
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		0. 23749			1
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS		0. 16735	372, 963	62, 417	72. 00
73.00	07300 DRUGS CHARGED TO PATIENTS		0. 25726	2, 267, 361	583, 308	73. 00
73. 01	07302 OP PHARMACY		0. 27670	0 8	0	73. 01
74.00	07400 RENAL DI ALYSI S		0. 32597		40, 028	74.00
75. 00	07500 ASC (NON-DISTINCT PART)		0.00000		1	1
75. 01	03550 PSYCHI ATRI C/PSYCHOLOGI CAL SERVI CES		0.00000		1	
76. 97	07697 CARDI AC REHABI LI TATI ON		0. 45037		1	
10. 71			0.4503	4, 342	. 1, 750	70.97
00.00	OUTPATIENT SERVICE COST CENTERS		4 7705	0 (47	4 /55	00.00
90. 00	09000 CLI NI C		1. 77856	•	1	1
90. 01	09001 OP ONCOLOGY INFUSION CENTER		0. 20782		1	1
90. 02	09002 WOUND CARE CENTER		0. 35619		1	
90. 03	09003  PAIN CLINIC		0. 34491	18 0	0	90. 03
90.05	09005 OP PSYCH CLINIC		1. 34208	34 0	0	90. 05
91.00	09100 EMERGENCY		0. 12843	369, 664	47, 479	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 31797			
	OTHER REI MBURSABLE COST CENTERS					1
94.00	09400 HOME PROGRAM DIALYSIS		0.00000	00 0	0	94. 00
95. 00	09500 AMBULANCE SERVICES		0.00000	, ,	1	95. 00
				7 OOF 407	1 507 007	1
200.00		(1)		7, 995, 427	1, 597, 896	1
201.00		s (IIne 61)		0	!	201. 00
202.00	Net Charges (line 200 minus line 201)		1	7, 995, 427	Ί	202. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	From 01/01/2016	Worksheet E Part A Date/Time Prepared: 5/23/2017 10:42 am

-		Title XVIII	Hospi tal	5/23/2017 10: PPS	42 am
				1.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS			1. 00	
1.00	DRG Amounts Other than Outlier Payments			0	1. 00
1. 01	DRG amounts other than outlier payments for discharges occurring	see	30, 315, 328	1. 01	
1. 02	instructions) DRG amounts other than outlier payments for discharges occurring	on or after October 1	(see	9, 432, 962	1. 02
1.03	instructions) DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring p	orior to October	0	1. 03
1.04	1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for	discharges occurring o	on or after	0	1. 04
2.00	October 1 (see instructions) Outlier payments for discharges. (see instructions)			3, 149, 954	2. 00
2. 01 2. 02	Outlier reconciliation amount Outlier payment for discharges for Model 4 BPCI (see instruction	ne)		0	2. 01 2. 02
3. 00	Managed Care Simulated Payments	3)		0	3. 00
4. 00	Bed days available divided by number of days in the cost reporti Indirect Medical Education Adjustment	ng period (see instruc	ctions)	241. 81	4. 00
5.00	FTE count for allopathic and osteopathic programs for the most r or before 12/31/1996. (see instructions)	ecent cost reporting p	period ending on	0.00	5. 00
6. 00	FTE count for allopathic and osteopathic programs which meet the for new programs in accordance with 42 CFR 413.79(e)	criteria for an add-c	on to the cap	0. 00	6. 00
7.00	MMA Section 422 reduction amount to the IME cap as specified und	er 42 CFR §412.105(f)(	(1) (i v) (B) (1)	0.00	7. 00
7. 01	ACA Section 5503 reduction amount to the IME cap as specified ur If the cost report straddles July 1, 2011 then see instructions.	der 42 CFR §412.105(f)	(1) (i v) (B) (2)	0. 00	7. 01
8. 00	Adjustment (increase or decrease) to the FTE count for allopathi affiliated programs in accordance with 42 CFR 413.75(b), 413.79(1998), and 67 FR 50069 (August 1, 2002).			0.00	8. 00
8. 01	The amount of increase if the hospital was awarded FTE cap slots the cost report straddles July 1, 2011, see instructions.	under section 5503 of	the ACA. If	0. 00	8. 01
8. 02	The amount of increase if the hospital was awarded FTE cap slots under section 5506 of ACA. (see instructions)	from a closed teachin	ng hospital	0. 00	8. 02
9. 00	Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines (instructions)	(8, 8,01 and 8,02) (s	see	0.00	9. 00
10.00	FTE count for allopathic and osteopathic programs in the current	year from your record	ls	0.00	
11. 00 12. 00	FTE count for residents in dental and podiatric programs. Current year allowable FTE (see instructions)				11. 00 12. 00
13. 00	Total allowable FTE count for the prior year.			0. 00	
14. 00	Total allowable FTE count for the penultimate year if that year otherwise enter zero.	ended on or after Sept	cember 30, 1997,	0. 00	14. 00
15. 00	Sum of lines 12 through 14 divided by 3.			0.00	15. 00
16. 00	Adjustment for residents in initial years of the program				16. 00
17. 00	Adjustment for residents displaced by program or hospital closur	e			17. 00
18.00	Adjusted rolling average FTE count				18.00
19. 00 20. 00	Current year resident to bed ratio (line 18 divided by line 4).  Prior year resident to bed ratio (see instructions)			0. 000000 0. 000000	
21. 00	Enter the lesser of lines 19 or 20 (see instructions)			0.000000	
22. 00	IME payment adjustment (see instructions)			0.000000	22. 00
22. 01	IME payment adjustment - Managed Care (see instructions)			0	22. 01
	Indirect Medical Education Adjustment for the Add-on for Section	422 of the MMA			
23. 00	Number of additional allopathic and osteopathic IME FTE resident $(f)(1)(iv)(C)$ .	cap slots under 42 Se	ec. 412.105	0. 00	23. 00
24.00	IME FTE Resident Count Over Cap (see instructions)			0.00	
25. 00	If the amount on line 24 is greater than -0-, then enter the low instructions)	er of line 23 or line	24 (see	0. 00	25. 00
26. 00	Resident to bed ratio (divide line 25 by line 4)			0. 000000	26. 00
27. 00	IME payments adjustment factor. (see instructions)			0.000000	
28.00	IME add-on adjustment amount (see instructions)			0	28. 00
28. 01	IME add-on adjustment amount - Managed Care (see instructions)			0	28. 01
29.00	Total IME payment ( sum of lines 22 and 28)			0	29. 00
29. 01	Total IME payment - Managed Care (sum of lines 22.01 and 28.01) Disproportionate Share Adjustment			0	29. 01
30.00	Percentage of SSI recipient patient days to Medicare Part A pati	ent days (see instruct	i ons)	5. 89	30. 00
31. 00	Percentage of Medicaid patient days (see instructions)			26. 96	
32. 00	Sum of lines 30 and 31			32. 85	
33. 00	Allowable disproportionate share percentage (see instructions)			15. 98	
34.00	Disproportionate share adjustment (see instructions)		I	1, 587, 944	34.00

	Financial Systems IU HEALTH BLOC ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-0051	Peri od:	u of Form CMS-2 Worksheet E	∠55Z-1	
CALCUI	ATTON OF RETWINDORSEMENT SETTEEMENT	Trovider con. 13-0031	From 01/01/2016 To 12/31/2016	Part A	narod:	
			10 12/31/2010	5/23/2017 10:		
		Title XVIII	Hospi tal	PPS		
			Prior to 10/1 1.00	2. 00		
	Uncompensated Care Adjustment					
35. 00	Total uncompensated care amount (see instructions)			5, 977, 483, 147		
35. 01 35. 02	Factor 3 (see instructions) Hospital uncompensated care payment (If line 34 is zero,	enter zero on this line)	0. 000345252 2, 211, 732			
JJ. UZ	(see instructions)	enter zero on this rine)	2,211,732	2, 030, 443	33.0	
35. 03	Pro rata share of the hospital uncompensated care payment		1, 655, 778			
36. 00	Total uncompensated care (sum of columns 1 and 2 on line Additional payment for high percentage of ESRD beneficiar		2, 169, 578		36.0	
40. 00	Total Medicare discharges on Worksheet S-3, Part I exclud		0		40.0	
	652, 682, 683, 684 and 685 (see instructions)					
41. 00	Total ESRD Medicare discharges excluding MS-DRGs 652, 68 instructions)	32, 683, 684 an 685. (see	0		41. C	
41. 01		n MS-DRGs 652, 682, 683, 68	4 0		41.0	
	an 685. (see instructions)					
42.00	Divide line 41 by line 40 (if less than 10%, you do not o		0.00		42.0	
43. 00	Total Medicare ESRD inpatient days excluding MS-DRGs 652 instructions)	2, 682, 683, 684 an 685. (Se	e U		43.0	
44. 00	Ratio of average length of stay to one week (line 43 divi	ded by line 41 divided by 7	0. 000000		44. C	
45. 00	days)	i and)	0.00		45. C	
46. 00	Average weekly cost for dialysis treatments (see instruct Total additional payment (line 45 times line 44 times line)		0.00		46.0	
47. 00	Subtotal (see instructions)	,	46, 655, 766		47. 0	
48. 00		OH, small rural hospitals	0		48. 0	
	only. (see instructions)			Amount		
				1. 00		
49. 00	Total payment for inpatient operating costs (see instruct			46, 655, 766		
50. 00 51. 00	Payment for inpatient program capital (from Wkst. L, Pt. Exception payment for inpatient program capital (Wkst. L,	• •	)	3, 631, 677 0	1	
52. 00	Direct graduate medical education payment (from Wkst. E-4			Ö	1	
53. 00	Nursing and Allied Health Managed Care payment			0	53. 0	
54. 00 54. 01	Special add-on payments for new technologies Islet isolation add-on payment			7, 929 0	1	
55. 00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1, li	ne 69)		0	1	
56. 00	Cost of physicians' services in a teaching hospital (see	•		0		
57. 00	Routine service other pass through costs (from Wkst. D. F		through 35).	0 05 027	57. (	
58. 00 59. 00	Ancillary service other pass through costs from Wkst. D, Total (sum of amounts on lines 49 through 58)	Pt. TV, Cot. 11 Time 200)		85, 937 50, 381, 309	•	
50. 00	Primary payer payments			40, 590		
51. 00	Total amount payable for program beneficiaries (line 59 m	ninus line 60)		50, 340, 719		
52. 00 53. 00	Deductibles billed to program beneficiaries Coinsurance billed to program beneficiaries			4, 104, 912 75, 593		
54. 00				249, 823		
	Adjusted reimbursable bad debts (see instructions)			162, 385	1	
6.00	Allowable bad debts for dual eligible beneficiaries (see	instructions)		243, 523	•	
57. 00 58. 00	Subtotal (line 61 plus line 65 minus lines 62 and 63) Credits received from manufacturers for replaced devices	for applicable to MS_DPGs (	see instructions)	46, 322, 599 0	1	
9. 00	Outlier payments reconciliation (sum of lines 93, 95 and			0	1	
0. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	, ,	•	0	70. (	
0. 50	RURAL DEMONSTRATION PROJECT			0		
70. 88 70. 89	SCH or MDH volume decrease adjustment Pioneer ACO demonstration payment adjustment amount (see	instructions)		0 0	1	
70. 69	HSP bonus payment HVBP adjustment amount (see instruction	•		0		
70. 91	HSP bonus payment HRR adjustment amount (see instructions	•		0	70. 9	
70. 92	Bundled Model 1 discount amount (see instructions)			0 133, 197		
	HVBP payment adjustment amount (see instructions)					
70. 93 70. 94					70. 9	

Heal th	Financial Systems IU HEALTH BLOOMING	TON HOSPITAL		In lie	u of Form CMS-2	2552-10
	ATION OF REIMBURSEMENT SETTLEMENT	Provi der CC		Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part A	pared:
		Title	XVIII	Hospi tal	PPS	
			FFY	(yyyy)	Amount	
				0	1. 00	
70. 96	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period prior to 10/1)	n column 0		0	0	70. 96
70. 97	Low volume adjustment for federal fiscal year (yyyy) (Enter in the corresponding federal year for the period ending on or af			0	0	70. 97
70. 98	Low Volume Payment-3				0	70. 98
70. 99	HAC adjustment amount (see instructions)				0	70. 99
71.00	Amount due provider (line 67 minus lines 68 plus/minus lines	69 & 70)			46, 455, 796	71. 00
71. 01	Sequestration adjustment (see instructions)				929, 116	71. 01
72.00	Interim payments				44, 838, 105	72.00
73.00	Tentative settlement (for contractor use only)				0	73.00
74.00	Balance due provider (Program) (line 71 minus lines 71.01, 72	, and 73)			688, 575	74.00
75.00	Protested amounts (nonallowable cost report items) in accordan	nce with			311, 386	75. 00
	CMS Pub. 15-2, chapter 1, §115.2					
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
90.00	Operating outlier amount from Wkst. E, Pt. A, line 2 (see ins	tructions)			0	90. 00
91.00	Capital outlier from Wkst. L, Pt. I, line 2				0	91. 00
92.00	Operating outlier reconciliation adjustment amount (see instr	uctions)			0	92. 00
93.00	Capital outlier reconciliation adjustment amount (see instruc	tions)			0	93. 00
94.00	The rate used to calculate the time value of money (see instru	uctions)			0.00	94.00
95.00	Time value of money for operating expenses (see instructions)				0	95. 00
96.00	Time value of money for capital related expenses (see instruc	tions)			0	96.00
				Prior to 10/1	On/After 10/1	
				1. 00	2.00	
	HSP Bonus Payment Amount					
100.00	HSP bonus amount (see instructions)			0	0	100. 00
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0. 0000000000	0.0000000000	101. 00
102.00	HVBP adjustment amount for HSP bonus payment (see instructions	s)		0	0	102. 00
	HRR Adjustment for HSP Bonus Payment					
103.00	HRR adjustment factor (see instructions)			0.0000	0.0000	103. 00
104.00	HRR adjustment amount for HSP bonus payment (see instructions)	)		0	0	104. 00

Provider CCN: 15-0051

Peri od:

Part A Exhibit 5

From 01/01/2016 Date/Time Prepared: 12/31/2016 5/23/2017 10:42 am Hospi tal Title XVIII PPS Period to Total (cols. 2 Wkst. E, Pt. Amt. from Peri od on Wkst. E, Pt. 10/01 after 10/01 A. line and 3) A) 2.00 3. 00 0 4.00 1.00 1.00 DRG amounts other than outlier payments 1. 00 1. 00 30, 315, 328 DRG amounts other than outlier payments for 1.01 1.01 30, 315, 328 30, 315, 328 1.01 discharges occurring prior to October 1 1.02 DRG amounts other than outlier payments for 1.02 9, 432, 962 9, 432, 962 9, 432, 962 1.02 discharges occurring on or after October 1 1.03 DRG for Federal specific operating payment 1.03 С 0 1.03 for Model 4 BPCI occurring prior to October DRG for Federal specific operating payment 1.04 1.04 1.04 0 0 for Model 4 BPCI occurring on or after October 1 2.00 Outlier payments for discharges (see 2.00 3, 149, 954 2, 916, 536 233, 418 3, 149, 954 2.00 instructions) 2.01 Outlier payments for discharges for Model 4 2.02 0 0 O 2. 01 **BPCI** Operating outlier reconciliation 3 00 2 01 O 0 0 3 00 4.00 Managed care simulated payments 3.00 0 0 4.00 Indirect Medical Education Adjustment 5.00 Amount from Worksheet E, Part A, line 21 21.00 0.000000 0.000000 0.000000 5.00 (see instructions) 6 00 IME payment adjustment (see instructions) 22 00 0 0 0 6 00 IME payment adjustment for managed care (see 0 0 6.01 22.01 0 6.01 instructions) Indirect Medical Education Adjustment for the Add-on for Section 422 of the MMA 7.00 0.000000 0.000000 7.00 IME payment adjustment factor (see 27.00 0.000000 instructions) 8.00 IME adjustment (see instructions) 28.00 0 8.00 IME payment adjustment add on for managed 0 8.01 28.01 0 8.01 care (see instructions) Total IME payment (sum of lines 6 and 8) 9.00 29.00 0 0 0 9.00 9.01 Total IME payment for managed care (sum of 29.01 C 9.01 lines 6.01 and 8.01) Disproportionate Share Adjustment 10.00 Allowable disproportionate share percentage 33.00 0. 1598 0. 1598 0.1598 10.00 (see instructions) 11.00 Disproportionate share adjustment (see 34.00 1.587.944 1, 211, 097 376, 847 1, 587, 944 11.00 instructions) 2, 169, 578 11.01 Uncompensated care payments 36.00 2, 169, 578 1, 655, 778 513,800 11.01 Additional payment for high percentage of ESRD beneficiary discharges 12 00 Total ESRD additional payment (see O 12 00 46 00 0 instructions) 13.00 Subtotal (see instructions) 47.00 46, 655, 766 36, 098, 739 10, 557, 027 46, 655, 766 13.00 14.00 Hospital specific payments (completed by SCH 48.00 14.00 and MDH, small rural hospitals only.) (see instructions) Total payment for inpatient operating costs 15.00 49.00 46, 655, 766 36, 098, 739 10, 557, 027 46, 655, 766 15.00 (see instructions) 16.00 Payment for inpatient program capital 50.00 3, 631, 677 2, 793, 278 838, 399 3, 631, 677 16.00 Special add-on payments for new technologies 17.00 54.00 7,929 7,929 7,929 17.00 Net organ acquisition cost 17.01 17.01 17.02 Credits received from manufacturers for 68.00 0 0 17.02 replaced devices for applicable MS-DRGs Capital outlier reconciliation adjustment 18.00 93.00 0 18.00 amount (see instructions) SUBTOTAL 38, 899, 946 11, 395, 426 50, 295, 372 19.00 19 00

Health Financial Systems	U HEALTH BLOOMI	NGTON HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	ATION EXHIBIT 5			Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 10:	pared:
			XVIII	Hospi tal	PPS	
	Wkst. L, line	(Amt. from Wkst. L)				
	0	1.00	2.00	3. 00	4. 00	
20.00 Capital DRG other than outlier	1.00	3, 192, 481	2, 428, 69	3 763, 788	3, 192, 481	20. 00
20.01 Model 4 BPCI Capital DRG other than outlier	1. 01	0		0 0		20. 01
21.00 Capital DRG outlier payments	2, 00	219, 553	197, 49	1 22, 062	219, 553	21. 00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0	·	0 0	0	1
22.00 Indirect medical education percentage (see	5. 00	0.0000	0.000	0.0000		22. 00
instructions)						
23.00 Indirect medical education adjustment (see instructions)	6. 00	0		0 0	0	23. 00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0688	0. 068	0. 0688		24. 00
25.00 Disproportionate share adjustment (see instructions)	11.00	219, 643	167, 09	4 52, 549	219, 643	25. 00
26.00 Total prospective capital payments (see instructions)	12.00	3, 631, 677	2, 793, 27	8 838, 399	3, 631, 677	26. 00
	Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt.				
	·	A)				
	0	1. 00	2.00	3. 00	4. 00	
27. 00						27. 00
28.00 Low volume adjustment prior to October 1	70. 96	0		0	0	28. 00
29.00 Low volume adjustment on or after October 1	70. 97	0		0	0	29. 00
30.00 HVBP payment adjustment (see instructions)	70. 93	133, 197	132, 08	1 1, 116	133, 197	30.00
30.01 HVBP payment adjustment for HSP bonus	70. 90	0	·	0 0	0	30. 01
payment (see instructions)						
31.00 HRR adjustment (see instructions)	70. 94	0		0 0	0	31.00
31.01 HRR adjustment for HSP bonus payment (see	70. 91	0		0 0	0	31. 01
instructions)						
					(Amt. to Wkst.	
					E, Pt. A)	
	0	1. 00	2.00	3. 00	4. 00	
32.00 HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	32. 00
100.00 Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100. 00

Health Financial Systems	IU HEALTH BLOOMINGTON HOS	PITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi	der CCN: 15-0051	Peri od: From 01/01/2016 To 12/31/2016	Worksheet E Part B Date/Time Prepared: 5/23/2017 10:42 am

			To 12/31/2016	Date/Time Pre 5/23/2017 10:	
		Title XVIII	Hospi tal	PPS	12 (111)
				1 00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1. 00	
1.00	Medical and other services (see instructions)			39, 749	1. 00
2.00	Medical and other services reimbursed under OPPS (see instruct	ti ons)		31, 084, 112	2. 00
3.00	PPS payments			28, 614, 619	
4.00	Outlier payment (see instructions)			937, 964	
5.00	Enter the hospital specific payment to cost ratio (see instruc	ctions)		0. 000	
6. 00 7. 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0. 00	6. 00 7. 00
8.00	Transitional corridor payment (see instructions)			0.00	8.00
9. 00	Ancillary service other pass through costs from Wkst. D, Pt. I	IV. col. 13. Line 200		46, 028	
10.00	Organ acqui si ti ons			0	10.00
11.00	Total cost (sum of lines 1 and 10) (see instructions)			39, 749	11. 00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12 00	Reasonable charges			15/ 20/	12.00
12. 00 13. 00	Ancillary service charges Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Ii	ne 60)		156, 286 0	
14. 00	Total reasonable charges (sum of lines 12 and 13)	THE 07)		156, 286	
00	Customary charges			100, 200	
15.00	Aggregate amount actually collected from patients liable for p	payment for services on	a charge basis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for		on a chargebasis	0	16. 00
47.00	had such payment been made in accordance with 42 CFR §413.13(6	e)			47.00
17. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	
18. 00 19. 00	Total customary charges (see instructions)  Excess of customary charges over reasonable cost (complete only	lv if line 18 exceeds li	no 11) (soo	156, 286 116, 537	
17.00	instructions)	Ty IT TITLE TO EXCEEDS IT	116 11) (366	110, 557	17.00
20.00	Excess of reasonable cost over customary charges (complete onl	y if line 11 exceeds li	ne 18) (see	0	20. 00
	instructions)				
21. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	e instructions)		39, 749	
22. 00	Interns and residents (see instructions)	susti ana)		0	22. 00 23. 00
23. 00 24. 00	Cost of physicians' services in a teaching hospital (see instractional prospective payment (sum of lines 3, 4, 8 and 9)	uctions)		29, 598, 611	
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT			27, 370, 011	24.00
25. 00	Deductibles and coinsurance (for CAH, see instructions)			0	25. 00
26.00	Deductibles and Coinsurance relating to amount on line 24 (for	r CAH, see instructions)		5, 370, 644	26. 00
27. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) p	olus the sum of lines 22	2 and 23] (see	24, 267, 716	27. 00
28. 00	<pre>instructions) Direct graduate medical education payments (from Wkst. E-4, li</pre>	no FO)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)	THE 50)		0	29. 00
30. 00	Subtotal (sum of lines 27 through 29)			24, 267, 716	
31.00	Primary payer payments			2, 529	
32. 00	Subtotal (line 30 minus line 31)			24, 265, 187	32. 00
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE)	CES)	T		
33.00	Composite rate ESRD (from Wkst. I-5, line 11)			740.002	
34. 00 35. 00	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			769, 982 500, 488	
36. 00	Allowable bad debts for dual eligible beneficiaries (see instr	ructions)		759, 161	
37. 00	Subtotal (see instructions)	401.0		24, 765, 675	
38. 00	MSP-LCC reconciliation amount from PS&R				38. 00
39. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50	Pioneer ACO demonstration payment adjustment (see instructions	•		0	
39. 98	Partial or full credits received from manufacturers for replace	ced devices (see instruc	ctions)	33, 349	
39. 99 40. 00	RECOVERY OF ACCELERATED DEPRECIATION Subtotal (see instructions)			0 24, 765, 381	39. 99 40. 00
40. 00	Sequestration adjustment (see instructions)			495, 308	1
41. 00	Interim payments			24, 010, 195	
42.00	Tentative settlement (for contractors use only)			0	42.00
43.00	Balance due provider/program (see instructions)			259, 878	43.00
44. 00	Protested amounts (nonallowable cost report items) in accordance	nce with CMS Pub. 15-2,	chapter 1,	0	44. 00
	§115. 2 TO BE COMPLETED BY CONTRACTOR				
90. 00	Original outlier amount (see instructions)			0	90.00
91. 00	Outlier reconciliation adjustment amount (see instructions)			0	91. 00
92.00	The rate used to calculate the Time Value of Money			0.00	92. 00
	Time Value of Money (see instructions)			0	
94. 00	Total (sum of lines 91 and 93)			0	94. 00

Health Financial Systems IU HEAL ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Peri od: Worksheet E-1
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/23/2017 10: 42 am Provider CCN: 15-0051

					5/23/2017 10: 4	12 am_
		Title	XVIII	Hospi tal	PPS	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4.00	
1.00	Total interim payments paid to provider		44, 808, 405	5	24, 010, 195	1. 00
2.00	Interim payments payable on individual bills, either		(		0	2. 00
2.00	submitted or to be submitted to the contractor for					2.00
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
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)					
0.04	Program to Provider	07/00/004/	00.70	<u> </u>		0.01
3. 01	ADJUSTMENTS TO PROVIDER	07/29/2016	29, 700		0	3. 01
3. 02			(		0	3. 02
3.03			(		0	3. 03
3.04			(		0	3. 04
3.05			(		0	3. 05
	Provider to Program					
3.50	ADJUSTMENTS TO PROGRAM		(		0	3. 50
3.51			(		0	3. 51
3.52			(		0	3. 52
3.53			(		0	3. 53
3.54			(		0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		29, 700		l ol	3. 99
	3. 50-3. 98)		,			
4.00	Total interim payments (sum of lines 1, 2, and 3.99)		44, 838, 105	5	24, 010, 195	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropri ate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5.00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
	Program to Provider			<u>.                                      </u>	•	
5. 01	TENTATI VE TO PROVI DER		(		0	5. 01
5. 02			Ċ			5. 02
5. 03			Ċ			5. 03
	Provi der to Program					
5.50	TENTATI VE TO PROGRAM		(		0	5. 50
5. 51					l ol	5. 51
5. 52						5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines					5. 99
0. , ,	5. 50-5. 98)		Ì			0. , ,
6.00	Determined net settlement amount (balance due) based on					6. 00
0.00	the cost report. (1)					0.00
6. 01	SETTLEMENT TO PROVIDER		688, 575	5	259, 878	6. 01
6. 02	SETTLEMENT TO PROGRAM		000, 37		257, 676	6. 02
7. 00	Total Medicare program liability (see instructions)		45, 526, 680		24, 270, 073	7. 00
7.00	Trotal medicale program traditity (see this tructions)		45, 520, 000	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
			)	1. 00	2. 00	
8. 00	Name of Contractor			1.00	2.00	8. 00
3.00	Intallic of contractor	I		1	1 1	0.00

Component CCN: 15-T051

Title XVIII

		Title	XVIII	Subprovi der - I RF	PPS	
		Inpatien	t Part A		t B	
		(111				
		mm/dd/yyyy 1.00	Amount 2.00	mm/dd/yyyy 3.00	Amount 4.00	
1.00	Total interim payments paid to provider	1.00	3, 467, 445		4.00	1. 00
2.00	Interim payments payable on individual bills, either		3, 407, 443		0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3.00	List separately each retroactive lump sum adjustment					3. 00
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each					
	payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					
3.01	ADJUSTMENTS TO PROVIDER		0		0	3. 01
3.02			0		0	3. 02
3.03			0		0	3. 03
3.04			0		0	3. 04
3. 05	Dravi dan ta Draggam		0		0	3. 05
3. 50	Provider to Program ADJUSTMENTS TO PROGRAM		0		0	3. 50
3. 51	ADSOSTMENTS TO FROGRAM				l ől	3. 51
3. 52			Ö		Ö	3. 52
3.53			0		0	3. 53
3.54			0		0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		0		0	3. 99
4 00	3. 50-3. 98)		0 4/7 445			4 00
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		3, 467, 445		0	4. 00
	appropriate)					
	TO BE COMPLETED BY CONTRACTOR					
5.00	List separately each tentative settlement payment after					5. 00
	desk review. Also show date of each payment. If none,					
	write "NONE" or enter a zero. (1)					
E 01	Program to Provider TENTATIVE TO PROVIDER		0		0	5. 01
5. 01 5. 02	TENTATIVE TO PROVIDER					5. 01
5. 03					0	5. 02
	Provider to Program		_	L		
5.50	TENTATI VE TO PROGRAM		0		0	5. 50
5. 51			0		0	5. 51
5. 52			0		0	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)		0		0	5. 99
6.00	Determined net settlement amount (balance due) based on					6. 00
	the cost report. (1)					
6. 01	SETTLEMENT TO PROVIDER		32, 204		0	6. 01
6. 02	SETTLEMENT TO PROGRAM		2 400 (40		0	6. 02
7. 00	Total Medicare program liability (see instructions)		3, 499, 649	Contractor	NPR Date	7. 00
				Number	(Mo/Day/Yr)	
		(	)	1. 00	2. 00	
8. 00	Name of Contractor					8. 00

	Financial Systems IU HEALTH BLOOMING	STON HOSPITAL		u of Form CMS-2	<u> 2552-10</u>
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-0051	Peri od:	Worksheet E-1	
			From 01/01/2016		
			To 12/31/2016	Date/Time Prep 5/23/2017 10:4	
		Title XVIII	Hospi tal	PPS	42 alli
		I II tile XVIII	поѕрі таі	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR MONOTANDARD COOT REPORTS			1. 00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS				
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION				
1. 00	Total hospital discharges as defined in AARA §4102 from Wkst.		: 14	13, 796	1. 00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8	3-12		19, 743	2. 00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2			4, 793	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8	3-12		47, 174	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 200			1, 272, 277, 676	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col. 3 I	ine 20		24, 339, 560	6.00
7.00	CAH only - The reasonable cost incurred for the purchase of c	certified HIT technology	Wkst. S-2, Pt. I	0	7. 00
	line 168	33			
8.00	Calculation of the HIT incentive payment (see instructions)			600, 485	8. 00
9.00	Sequestration adjustment amount (see instructions)			12, 010	9. 00
10.00	Calculation of the HIT incentive payment after sequestration	(see instructions)		588, 475	10.00
	I NPATI ENT HOSPI TAL SERVI CES UNDER THE I PPS & CAH	(======================================		33373	
30. 00	Initial/interim HIT payment adjustment (see instructions)			583, 560	30.00
	Other Adjustment (specify)			0	31. 00
22.00	1 3/	ine 21) (ose instruction	)	4 015	

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

583, 560 30. 00 0 31. 00 4, 915 32. 00

Не	alth Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2552-10
CA	LCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 15-0051	Peri od: From 01/01/2016	Worksheet E-3
		Component CCN: 15-T051		Date/Time Prepared: 5/23/2017 10:42 am
		Title XVIII	Subprovi der -	PPS
			LDE	

		II the Aviii	I RF	PP3	
				1. 00	
	PART III - MEDICARE PART A SERVICES - IRF PPS				
1.00	Net Federal PPS Payment (see instructions)			3, 218, 816	
2.00	Medicare SSI ratio (IRF PPS only) (see instructions)			0. 0282	2. 00
3.00	Inpatient Rehabilitation LIP Payments (see instructions)			149, 675	3. 00
4.00	Outlier Payments			233, 103	
5.00	Unweighted intern and resident FTE count in the most recent co	ost reporting period e	nding on or prior	0. 00	5. 00
5. 01	to November 15, 2004 (see instructions) Cap increases for the unweighted intern and resident FTE coun	t for residents that we	ro displaced by	0. 00	5. 01
5.01	program or hospital closure, that would not be counted withou			0.00	5.01
	CFR §412. 424(d)(1)(iii)(F)(1) or (2) (see instructions)	t a temporary cap adjus	tilicitt dilder 42		
6.00	New Teaching program adjustment. (see instructions)			0. 00	6. 00
7. 00	Current year's unweighted FTE count of I&R excluding FTEs in	the new program growth	period of a "new	0.00	
	teaching program" (see instructions)	pg g			
8.00	Current year's unweighted I&R FTE count for residents within	the new program growth	period of a "new	0.00	8.00
	teaching program" (see instructions)				
9.00	Intern and resident count for IRF PPS medical education adjus	tment (see instructions	)	0. 00	9. 00
10.00	Average Daily Census (see instructions)			8. 590164	
11. 00	Teaching Adjustment Factor (see instructions)			0. 000000	
12. 00	Teaching Adjustment (see instructions)			0	12.00
13. 00	Total PPS Payment (see instructions)			3, 601, 594	
14. 00	Nursing and Allied Health Managed Care payments (see instruct	i on)		0	14. 00
15. 00	Organ acquisition (DO NOT USE THIS LINE)				15. 00
16. 00	Cost of physicians' services in a teaching hospital (see inst	ructions)		0	
17. 00	Subtotal (see instructions)			3, 601, 594	
18.00	Primary payer payments			0	
19.00	Subtotal (line 17 less line 18).			3, 601, 594	
20.00	Deductibles			23, 156	
21. 00	Subtotal (line 19 minus line 20)			3, 578, 438	
22. 00	Coinsurance			11, 914	
23. 00 24. 00	Subtotal (line 21 minus line 22)	cos) (soo instructions)		3, 566, 524	
25. 00	Allowable bad debts (exclude bad debts for professional serviorable bad debts (see instructions)	ces) (see Histructions)		2, 576 1, 674	
26. 00	Allowable bad debts for dual eligible beneficiaries (see inst	rusti ons)		2, 576	
27. 00	Subtotal (sum of lines 23 and 25)	ructions)		3, 568, 198	
28. 00	Direct graduate medical education payments (from Wkst. E-4, 1)	ine 40)		3, 300, 170	28. 00
29. 00	Other pass through costs (see instructions)	1116 49)		2, 872	
30.00	Outlier payments reconciliation			0	
31. 00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			ő	31. 00
31. 50	Pioneer ACO demonstration payment adjustment (see instructions	s)		ő	31. 50
31. 99	Recovery of Accelerated Depreciation	-,		ol	
32. 00	Total amount payable to the provider (see instructions)			3, 571, 070	32. 00
32. 01	Sequestration adjustment (see instructions)			71, 421	
33.00	Interim payments			3, 467, 445	33.00
34.00	Tentative settlement (for contractor use only)			o	34.00
35.00	Balance due provider/program (line 32 minus lines 32.01, 33,	and 34)		32, 204	35.00
36.00	Protested amounts (nonallowable cost report items) in accordan	nce with CMS Pub. 15-2,	chapter 1,	1, 051	36.00
	§115. 2				
E0 05	TO BE COMPLETED BY CONTRACTOR			000 45-	F0 00
50.00	Original outlier amount from Wkst. E-3, Pt. III, line 4			233, 103	
51.00	Outlier reconciliation adjustment amount (see instructions)			0 00	51.00
	The rate used to calculate the Time Value of Money			0.00	52. 00 53. 00
33.00	Time Value of Money (see instructions)		ļ	υĮ	55.00

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

Provi der CCN: 15-0051

Peri od: Worksheet G From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/23/2017 10: 42 am

oni y)				12/01/2010	5/23/2017 10:	42 am
		General Fund	Specific Purpose Fund	Endowment Fund		
	AUDDENT ACCETS	1.00	2.00	3. 00	4. 00	
1. 00	CURRENT ASSETS Cash on hand in banks	242, 719, 336		0	0	1.00
2.00	Temporary investments	242, /19, 330				
3.00	Notes receivable	0			0	
4. 00	Accounts recei vable	49, 521, 836		o o		
5. 00	Other recei vable	-9, 141, 462			Ō	1
6.00	Allowances for uncollectible notes and accounts receivable	0		0	0	
7.00	Inventory	5, 157, 680	(	0	0	7. 00
8.00	Prepai d expenses	1, 836, 149	(	0	0	8. 00
9.00	Other current assets	0	(	0	0	9. 00
10. 00	Due from other funds	0		0		
11. 00	Total current assets (sum of lines 1-10)	290, 093, 539	(	0	0	11. 00
10.00	FI XED ASSETS	40 744 447				40.00
12.00	Land	19, 741, 447			<b>l</b>	
13. 00 14. 00	Land improvements	2, 058, 207				
15. 00	Accumulated depreciation Buildings	-1, 738, 535 162, 180, 907	•		0	1
16. 00		-119, 082, 608		-	0	1
17. 00	•	7, 012, 847		-	0	1
	Accumulated depreciation	-5, 182, 356			0	1
19. 00		0, 102, 000		o o	0	1
	Accumulated depreciation	Ö			o o	1
21. 00	•	442, 458		0	l o	
22. 00		0		0	0	1
23.00	•	181, 817, 048		0	0	23. 00
24.00	Accumulated depreciation	-164, 189, 409		0	0	24. 00
25.00	Mi nor equi pment depreci abl e	0	(	0	0	25. 00
26.00	Accumulated depreciation	0	(	0	0	26. 00
27. 00	HIT designated Assets	0	(	0	0	
28. 00	•	0	(			
	Mi nor equi pment-nondepreci abl e	0	(			
30. 00	Total fixed assets (sum of lines 12-29)	83, 060, 006	(	0 0	0	30. 00
21 00	OTHER ASSETS	7 555 711				21 00
31. 00 32. 00		-7, 555, 711	(	0 0	l	
32.00	Deposits on leases Due from owners/officers	0				
34. 00	Other assets	172, 058, 903				1
35. 00		164, 503, 192			· ·	1
36. 00	,	537, 656, 737				
00.00	CURRENT LI ABI LI TI ES	00770007707		<u>,                                     </u>		00.00
37.00		15, 056, 582	(	0	0	37. 00
38.00		9, 919, 945		0	0	38. 00
39.00	Payrol I taxes payable	0	(	0	0	39. 00
40.00	Notes and Loans payable (short term)	1, 605, 000	(	0	0	40. 00
41. 00	Deferred income	0	(	0	0	41. 00
42.00	Accel erated payments	0				42. 00
43.00		0	(	0	0	
	Other current liabilities	5, 519, 449	•	-		
45. 00	Total current liabilities (sum of lines 37 thru 44)	32, 100, 976	(	0	0	45. 00
44 00	LONG TERM LIABILITIES		1 /	0	0	4/ 00
46. 00 47. 00	Mortgage payable Notes payable	0		0 0	1	
48. 00	Unsecured Loans	0			l .	
49. 00	Other long term liabilities	45, 310, 841	•			
50. 00	Total long term liabilities (sum of lines 46 thru 49)	45, 310, 841				
51. 00	Total liabilities (sum of lines 45 and 50)	77, 411, 817		o o	•	
	CAPITAL ACCOUNTS			-		
52.00	General fund balance	460, 244, 920				52. 00
53.00	Specific purpose fund					53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55. 00
56.00	Governing body created - endowment fund balance			0		56. 00
57. 00	Plant fund balance - invested in plant				0	
58. 00	Plant fund balance - reserve for plant improvement,				0	58. 00
FO 00	replacement, and expansion	1/0 044 000		_	_	FO 00
59. 00 60. 00	Total fund balances (sum of lines 52 thru 58) Total liabilities and fund balances (sum of lines 51 and	460, 244, 920 537, 656, 737		0	0	
00.00	[59]	337,030,737		1	l "	00.00
	1 - 7	ı	1	ı	ı	1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES Period: Worksheet G-1 From 01/01/2016 Provi der CCN: 15-0051

					To	12/31/2016 12/31/2016	Date/Time Pre 5/23/2017 10:	
		General	Fund	Speci al	Purpo	ose Fund	Endowment Fund	
		1.00	2.00	3.00		4. 00	5. 00	
1. 00	Fund balances at beginning of period	.,,,,,	388, 754, 901			0		1. 00
2.00	Net income (loss) (from Wkst. G-3, line 29)		79, 911, 101					2. 00
3.00	Total (sum of line 1 and line 2)		468, 666, 002			0		3. 00
4.00	ROUNDI NG	2			0		0	4. 00
5. 00		0			0		0	5. 00
6. 00		0			0		0	6. 00
7.00		0			0		0	7. 00
8. 00 9. 00		0			0		0	8. 00 9. 00
10.00	Total additions (sum of line 4-9)	٩	2		U	0	Ŭ	10.00
11. 00	Subtotal (line 3 plus line 10)		468, 666, 004			0		11.00
12. 00	Deductions (debit adjustments) (specify)		400, 000, 004		0	O	0	12.00
13. 00	HHA CHARGES	3, 088, 152			0		Ö	13. 00
14. 00	HOSPI CE CHARGES	5, 332, 932			0		ő	14. 00
15. 00		0			0		0	15. 00
16.00		0			0		0	16. 00
17. 00		0			0		0	17. 00
18. 00	Total deductions (sum of lines 12-17)		8, 421, 084			0		18. 00
19. 00	Fund balance at end of period per balance		460, 244, 920			0		19. 00
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund				
		Endownert Fund	Prant	Fullu				
		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
3.00	Total (sum of line 1 and line 2)	0			0			3. 00
4.00	ROUNDI NG		0					4. 00
5.00			0					5. 00
6. 00 7. 00			0					6. 00 7. 00
8. 00			0					8.00
9. 00			0					9. 00
10. 00	Total additions (sum of line 4-9)	o	· ·		0			10. 00
11. 00	Subtotal (line 3 plus line 10)	0			0			11. 00
12.00	Deductions (debit adjustments) (specify)		0					12. 00
13.00	HHA CHARGES		0					13. 00
14. 00	HOSPI CE CHARGES		0					14. 00
15. 00			0					15. 00
16.00			0					16.00
17. 00	Total deductions (our of lines 12 17)		0					17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0			0			18. 00 19. 00
17.00	choot (Line 11 minus Line 19)	١		1	U			1 7.00

sheet (line 11 minus line 18)

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

		T	o 12/31/2016	Date/Time Pre 5/23/2017 10:	
	Cost Center Description	Inpatient	Outpati ent	Total	12 dill
	<u> </u>	1.00	2. 00	3. 00	
	PART I - PATIENT REVENUES				
	General Inpatient Routine Services				
1.00	Hospi tal	103, 373, 209		103, 373, 209	1. 00
2.00	SUBPROVI DER - I PF				2. 00
3.00	SUBPROVI DER - I RF	5, 034, 383		5, 034, 383	3. 00
4.00	SUBPROVI DER	0		0	4. 00
5.00	Swing bed - SNF	C		0	5.00
6.00	Swing bed - NF			0	6. 00
7.00	SKILLED NURSING FACILITY				7. 00 8. 00
8. 00 9. 00	NURSING FACILITY OTHER LONG TERM CARE				9.00
10.00	Total general inpatient care services (sum of lines 1-9)	108, 407, 592		108, 407, 592	10.00
10.00	Intensive Care Type Inpatient Hospital Services	100, 407, 372		100, 407, 572	10.00
11. 00	INTENSIVE CARE UNIT	16, 141, 419		16, 141, 419	11. 00
12. 00	CORONARY CARE UNIT	10, 111, 117		10, 111, 117	12. 00
13. 00	BURN INTENSIVE CARE UNIT				13. 00
14.00	SURGICAL INTENSIVE CARE UNIT				14.00
15.00	OTHER SPECIAL CARE (SPECIFY)				15. 00
16.00	Total intensive care type inpatient hospital services (sum of lines	16, 141, 419		16, 141, 419	16. 00
	11-15)				
17. 00	Total inpatient routine care services (sum of lines 10 and 16)	124, 549, 011		124, 549, 011	17. 00
18. 00	Ancillary services	411, 221, 920		960, 189, 456	18. 00
19. 00	Outpati ent servi ces	20, 413, 292		137, 940, 328	
20.00	RURAL HEALTH CLINIC	0	-	0	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER	C		0	21. 00
22. 00	HOME HEALTH AGENCY	01 (17	3, 088, 152	3, 088, 152	22. 00
23. 00 24. 00	AMBULANCE SERVICES CMHC	91, 617	38, 889, 165	38, 980, 782	23. 00 24. 00
25. 00	AMBULATORY SURGICAL CENTER (D. P. )		0	0	25. 00
26. 00	HOSPICE	1, 039, 973	4, 292, 960		26. 00
27. 00	NRCC	1,037,773	8, 054, 130	8, 054, 130	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to Wkst.	557, 315, 813		1, 278, 134, 792	28. 00
20.00	G-3, line 1)	00770107010	72070107777	., 2, 0, 10 1, 7, 72	20.00
	PART II - OPERATING EXPENSES		'		
29.00	Operating expenses (per Wkst. A, column 3, line 200)		325, 910, 569		29. 00
30.00	ADD (SPECIFY)	C			30.00
31.00		C			31. 00
32.00		C			32. 00
33. 00		0			33. 00
34.00		C			34.00
35. 00	T	C			35. 00
36.00	Total additions (sum of lines 30-35)		0		36. 00
37. 00	DEDUCT (SPECIFY)	0			37. 00
38. 00 39. 00		0			38. 00 39. 00
40. 00					40.00
41. 00					41. 00
42. 00	Total deductions (sum of lines 37-41)				42.00
43. 00	Total operating expenses (sum of lines 29 and 36 minus line 42)(transfer		325, 910, 569		43. 00
	to Wkst. G-3, line 4)				

Heal th	Financial Systems IU HEALTH BLOOMING	TON HOSPITAL	In lie	u of Form CMS-2	2552-10
	ENT OF REVENUES AND EXPENSES	Provi der CCN: 15-0051	Peri od:	Worksheet G-3	
			From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 10:	
				1. 00	
1. 00	Total patient revenues (from Wkst. G-2, Part I, column 3, lin			1, 278, 134, 792	1. 00
2.00	Less contractual allowances and discounts on patients' accoun	ts		892, 675, 070	
3.00	Net patient revenues (line 1 minus line 2)			385, 459, 722	3. 00
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	43)		325, 910, 569	
5.00	Net income from service to patients (line 3 minus line 4)			59, 549, 153	5. 00
	OTHER I NCOME				
6.00	Contributions, donations, bequests, etc			0	6. 00
7. 00	Income from investments			0	7. 00
8.00	Revenues from telephone and other miscellaneous communication	servi ces		0	8. 00
9.00	Revenue from television and radio service			0	9. 00
10. 00	Purchase di scounts			0	10. 00
11. 00	Rebates and refunds of expenses			0	11. 00
12. 00	Parking lot receipts			0	12.00
13. 00	Revenue from Laundry and Linen service			0	13. 00
14. 00	Revenue from meals sold to employees and guests			0	14. 00
15. 00	Revenue from rental of living quarters			0	15. 00
16. 00	Revenue from sale of medical and surgical supplies to other t	han patients		0	16. 00
	Revenue from sale of drugs to other than patients			0	17. 00
18. 00	Revenue from sale of medical records and abstracts			0	18. 00
19. 00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19. 00
20. 00	Revenue from gifts, flowers, coffee shops, and canteen			0	20. 00
21. 00	Rental of vending machines			0	21. 00
22.00	Rental of hospital space			0	22. 00
23.00	Governmental appropriations			0	23. 00
24.00	OTHER INCOME			20, 361, 948	24. 00
25.00	Total other income (sum of lines 6-24)			20, 361, 948	25. 00
26.00	Total (line 5 plus line 25)			79, 911, 101	26. 00
27 00	OTHED EVDENSES (SDECLEV)			0	27 00

79, 911, 101 | 29. 00

28. 00

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

27. 00 OTHER EXPENSES (SPECIFY)

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17.00

18.00

19 00

20.00

21.00

22.00

23 00

23.50

24.00

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

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18.00

19 00 20.00

21.00

22.00

23.00

23. 50

Drugs

Clinic

HHA NONREIMBURSABLE SERVICES

Home Dialysis Aide Services

Health Promotion Activities

Home Delivered Meals Program

Respiratory Therapy

Day Care Program

Homemaker Service

Tel emedi ci ne

All Others (specify)

24.00 Total (sum of lines 1-23)

Private Duty Nursing

DME

COST A	LLOCATION - HHA STATISTICAL BAS	IS		Provider CO	CN: 15-0051 15-7011	Peri od: From 01/01/2016 To 12/31/2016		pared:
						Home Health	PPS	
		Conital Dol	ated Costs			Agency I		
		Capitai kei	ated Costs					
		BI dgs & Fixtures (SQUARE FEET)	Movable Equipment (DOLLAR VALUE)	Plant Operation & Maintenance (SQUARE FEET)	Transportation (MI LEAGE)	onReconciliation	Admi ni strati ve & General (ACCUM. COST)	
	T	1. 00	2. 00	3. 00	4. 00	5A. 00	5. 00	
	GENERAL SERVICE COST CENTERS		1		1	1		
1. 00	Capital Related - Bldg. & Fixtures	0				0		1. 00
2. 00	Capital Related - Movable		0			0		2.00
	Equi pment		_					
3.00	Plant Operation & Maintenance	0	0	0		0		3.00
4.00	Transportation (see	0	0	0		0		4. 00
F 00	instructions)					4 500 400	4 004 000	
5. 00	Administrative and General HHA REIMBURSABLE SERVICES	0	0	0		0 -1, 509, 492	1, 994, 098	5. 00
6. 00	Skilled Nursing Care	0	0	0		0 0	1, 271, 897	6. 00
7. 00	Physical Therapy	ĺ	0	0		0 0	523, 867	
8. 00	Occupational Therapy	Ö	0	Ö		0 0	134, 007	
9. 00	Speech Pathology	0	0	0		0 0	0	9. 00
10.00	Medical Social Services	0	0	0		0 0	33, 091	10.00
11. 00	Home Health Aide	0	0	0		0 0	31, 236	11.00
12.00	Supplies (see instructions)	0	0	0		0 0	0	12.00
13. 00	Drugs	0	0	0	1	0	0	13.00
14. 00	DME	0	0	0		0 0	0	14.00
	HHA NONREIMBURSABLE SERVICES		T		1			
	Home Dialysis Aide Services	0				0 0	0	
16. 00	Respiratory Therapy	0	0	0		0 0	0	
17. 00	Private Duty Nursing	0	0	0	•	0 0	0	
18. 00	Clinic	0	0	0		0 0	0	
19.00	Health Promotion Activities	0	0	0		0	0	
20.00	Day Care Program	0	0	0		0	0	
21. 00	Home Delivered Meals Program	0	0	0		0	0	
22. 00	Homemaker Service	0	0	0		0	0	
23. 00	All Others (specify)			0		0 0	0	
23. 50 24. 00	Telemedicine Total (sum of lines 1-23)		0	0		0 -1, 509, 492	1 004 000	23. 50 24. 00
24. 00 25. 00	Cost To Be Allocated (per					- 1, 509, 492	1, 994, 098 1, 509, 492	
23.00	Worksheet H-1, Part I)			١	1	U .	1, 309, 492	25.00
26. 00	Unit Cost Multiplier	0. 000000	0. 000000		0. 0000			26. 00

Part I

То 12/31/2016 Date/Time Prepared: 5/23/2017 10:42 am Home Health PPS Agency I CAPITAL RELATED COSTS MVBLE EQUIP **EMPLOYEE** ADMI NI STRATI VE HHA Trial BLDG & FIXT Cost Center Description Subtotal Bal ance (1) **BENEFITS** & GENERAL DEPARTMENT 0 1.00 2.00 5. 00 4.00 4A 1.00 Administrative and General 112, 322 53, 421 79, 683 245, 426 58, 413 1.00 2, 234, 697 Skilled Nursing Care 2 00 2 00 288. 528 2, 523, 225 600, 542 3.00 Physical Therapy 920, 424 0 0 118, 839 1, 039, 263 247, 351 3.00 4.00 Occupational Therapy 235, 448 0 0 0 0 30, 399 265, 847 63, 273 4.00 Speech Pathology 5 00 Ω 5 00 6.00 Medical Social Services 58, 140 C 7,507 65, 647 15,624 6.00 7.00 Home Health Aide 54, 881 7,086 61, 967 14, 749 7.00 8.00 Supplies (see instructions) 00000000 0 8.00 0 0 0 0 9.00 Ω 0 0 9 00 Drugs 0 10.00 DMF 0 0 10.00 Home Dialysis Aide Services 0 11.00 11.00 0 Respiratory Therapy 0 12.00 12.00 13.00 Private Duty Nursing 0 13.00 0 14.00 Clinic 0 14.00 Health Promotion Activities 15.00 15.00 0 0 Day Care Program 0 0 0 16, 00 16.00 17.00 Home Delivered Meals Program C 0 17 00 18.00 Homemaker Service 0 0 18.00 19.00 All Others (specify) 0 0 0 19.00 19.50 Tel emedi ci ne 19.50 0 3, 503, 590 999, 952 20.00 Total (sum of lines 1-19) (2) 112, 322 53, 421 532.042 4, 201, 375 20.00 Unit Cost Multiplier: column 0.000000 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places. Cost Center Description OPERATION OF LAUNDRY & HOUSEKEEPI NG DI ETARY CAFETERI A NURSI NG **PLANT** LINEN SERVICE ADMI NI STRATI ON 7.00 8.00 9.00 10.00 11.00 13. 00 1.00 Administrative and General 147, 807 25 004 216, 149 1 00 000000000000000000000 0 2.00 Skilled Nursing Care C 2.00 3.00 Physical Therapy 0 0 0 0 3.00 0 0 4.00 Occupational Therapy 0 0 0 0 4.00 0 Speech Pathology 0 0 5 00 O 5 00 6.00 Medical Social Services 0 0 6.00 7.00 Home Health Aide 7.00 0 8 00 0 0 0 0 0 0 0 0 0 8.00 Supplies (see instructions) 9.00 Drugs 0 0 9.00 10.00 DME 10.00 0 0 11.00 Home Dialysis Aide Services 0 11.00 0 12 00 Respiratory Therapy 0 12 00 13.00 Private Duty Nursing 0 13.00 0 14.00 14.00 Clinic Health Promotion Activities 15.00 0 15.00 0 0 Day Care Program 0 16.00 16.00 0 17.00 Home Delivered Meals Program 0 0 0 17.00 Homemaker Service 18.00 18.00 All Others (specify) 0 0 0 19.00 0 19.00 19.50 Tel emedi ci ne 0 C 0 19.50 20.00 Total (sum of lines 1-19) (2) 147, 807 25, 004 216, 149 20.00 21.00 Unit Cost Multiplier: column 21.00 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to

Provider CCN: 15-0051

HHA CCN:

15-7011

Peri od:

From 01/01/2016

6 decimal places.

<sup>(1)</sup> Column O, line 20 must agree with Wkst. A, column 7, line 101.

<sup>(2)</sup> Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Health Financial Systems IU HEA ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS Peri od: Worksheet H-2
From 01/01/2016 Part I
To 12/31/2016 Date/Time Prepared: 5/23/2017 10: 42 am

Home Heal th PPS Provider CCN: 15-0051 HHA CCN: 15-7011

						Home Health	PPS	
					OTHER GENE	Agency I RAL SERVICE		
					OTTIER GENE	INE SERVICE		
	Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	(SPECI FY)	CENTRAL	PARAMED ED	
		SERVICES &		RECORDS &		STERI LI ZATI ON	PRGM-PHARMACY	
		SUPPLY 14. 00	15. 00	16. 00	18. 00	18. 01	RESI DENCY 23. 00	
1. 00	Administrative and General	14.00	15.00	7, 794	16.00		23.00	1. 00
2. 00	Skilled Nursing Care	0	o o	,,,,,	Ö			2. 00
3. 00	Physical Therapy	0	o	0	l c	0	o	3. 00
4.00	Occupational Therapy	0	o	0	C	0	0	4.00
5.00	Speech Pathology	0	0	0	C	0	0	5.00
6.00	Medical Social Services	0	0	0	C	0	0	6. 00
7.00	Home Health Aide	0	0	0		0	0	7. 00
8. 00 9. 00	Supplies (see instructions) Drugs	0	0	0	l d	0	0	8. 00 9. 00
10. 00	DME	0		0		0	0	10. 00
11. 00	Home Dialysis Aide Services	Ö	o	0	i c	Ö	Ö	11. 00
12.00	Respiratory Therapy	0	0	0	C	0	0	12.00
13.00	Private Duty Nursing	0	0	0	1		1	13.00
14.00	Clinic	0	0	0	C	_	0	14.00
15. 00 16. 00	Health Promotion Activities Day Care Program	0	0	0		_	0	15. 00 16. 00
17. 00	Home Delivered Meals Program	0		0		_	0	17. 00
18. 00	Homemaker Service	Ō	o	0	C	0	o	18. 00
19. 00	All Others (specify)	0	O	0	C	0	0	19.00
19. 50	Tel emedi ci ne	0	0	0	C	0	0	19. 50
20.00	Total (sum of lines 1-19) (2)	0	0	7, 794	C	0	0	20.00
21. 00	Unit Cost Multiplier: column 26, line 1 divided by the sum							21. 00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							
	Cost Center Description	Subtotal	Intern &	Subtotal	Allocated HHA	Total HHA		
			Pasidants Cost		ARG (see Dart			
			Residents Cost & Post		A&G (see Part	Costs		
			Residents Cost & Post Stepdown		A&G (see Part II)			
			& Post Stepdown Adjustments		11)	Costs		
1.00	Administrative and Consul	24. 00	& Post Stepdown Adjustments 25.00	26.00				1.00
1.00	Administrative and General	24. 00 700, 593	& Post Stepdown Adjustments 25.00	700, 593	27. 00	28. 00		1.00
2.00	Skilled Nursing Care	24. 00 700, 593 3, 123, 767	& Post Stepdown Adjustments 25.00 0	700, 593 3, 123, 767	27. 00 446, 861	28. 00 3, 570, 628		2. 00
	1	24. 00 700, 593	& Post Stepdown Adjustments 25.00	700, 593	27. 00 446, 861 184, 051	28. 00 3, 570, 628 1, 470, 665		
2.00 3.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	24. 00 700, 593 3, 123, 767 1, 286, 614	& Post Stepdown Adj ustments 25.00 0 0	700, 593 3, 123, 767 1, 286, 614	27. 00 446, 861 184, 051	28. 00 3, 570, 628 1, 470, 665 376, 201		2. 00 3. 00
2. 00 3. 00 4. 00 5. 00 6. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	& Post Stepdown Adjustments 25.00 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	27. 00 446, 861 184, 051 47, 081 0 11, 626	28. 00 3, 570, 628 1, 470, 665 376, 201 0 92, 897		2. 00 3. 00 4. 00 5. 00 6. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0	& Post Stepdown Adjustments 25.00 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 0	27. 00 446, 861 184, 051 47, 081 0 11, 626	28. 00 3, 570, 628 1, 470, 665 376, 201 0 92, 897		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	& Post Stepdown Adjustments 25.00 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	27. 00 446, 861 184, 051 47, 081 0 11, 626	28. 00 3, 570, 628 1, 470, 665 376, 201 0 92, 897		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	& Post Stepdown Adjustments 25.00 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	27. 00 446, 861 184, 051 47, 081 0 11, 626	28. 00 3, 570, 628 1, 470, 665 376, 201 0 92, 897		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	& Post Stepdown Adjustments 25.00 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	27. 00 446, 861 184, 051 47, 081 0 11, 626	28. 00 3, 570, 628 1, 470, 665 376, 201 0 92, 897		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	& Post Stepdown Adjustments 25.00 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	27. 00 446, 861 184, 051 47, 081 0 11, 626	28. 00 3, 570, 628 1, 470, 665 376, 201 0 92, 897		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	& Post Stepdown Adjustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	27. 00 446, 861 184, 051 47, 081 0 11, 626	28. 00 3, 570, 628 1, 470, 665 376, 201 0 92, 897		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	& Post Stepdown Adjustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	27. 00 446, 861 184, 051 47, 081 0 11, 626	28. 00 3, 570, 628 1, 470, 665 376, 201 0 92, 897		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	& Post Stepdown Adjustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	27. 00 446, 861 184, 051 47, 081 0 11, 626	28. 00 3, 570, 628 1, 470, 665 376, 201 0 92, 897		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	& Post Stepdown Adjustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	27. 00 446, 861 184, 051 47, 081 0 11, 626	28. 00 3, 570, 628 1, 470, 665 376, 201 0 92, 897		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	& Post Stepdown Adjustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	27. 00 446, 861 184, 051 47, 081 0 11, 626	28. 00 3, 570, 628 1, 470, 665 376, 201 0 92, 897		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 17. 00 18. 00 19. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	& Post Stepdown Adjustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	27. 00 446, 861 184, 051 47, 081 0 11, 626	28. 00 3, 570, 628 1, 470, 665 376, 201 0 92, 897		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271 76, 716 0 0 0 0 0 0 0 0 0 0 0 0 0	& Post Stepdown Adjustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 81, 271 76, 716 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27. 00 446, 861 184, 051 47, 081 0 11, 626 10, 974 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00  3, 570, 628 1, 470, 665 376, 201 0 92, 897 87, 690 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2)	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	& Post Stepdown Adjustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271	27. 00  446, 861 184, 051 47, 081 0 11, 626 10, 974 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00  3, 570, 628 1, 470, 665 376, 201 0 92, 897 87, 690 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 00
2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271 76, 716 0 0 0 0 0 0 0 0 0 0 0 0 0	& Post Stepdown Adjustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 81, 271 76, 716 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27. 00 446, 861 184, 051 47, 081 0 11, 626 10, 974 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00  3, 570, 628 1, 470, 665 376, 201 0 92, 897 87, 690 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271 76, 716 0 0 0 0 0 0 0 0 0 0 0 0 0	& Post Stepdown Adjustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 81, 271 76, 716 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27. 00  446, 861 184, 051 47, 081 0 11, 626 10, 974 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00  3, 570, 628 1, 470, 665 376, 201 0 92, 897 87, 690 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271 76, 716 0 0 0 0 0 0 0 0 0 0 0 0 0	& Post Stepdown Adjustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 81, 271 76, 716 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27. 00  446, 861 184, 051 47, 081 0 11, 626 10, 974 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00  3, 570, 628 1, 470, 665 376, 201 0 92, 897 87, 690 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 00
2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 19. 50 20. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Telemedicine Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	24. 00 700, 593 3, 123, 767 1, 286, 614 329, 120 0 81, 271 76, 716 0 0 0 0 0 0 0 0 0 0 0 0 0	& Post Stepdown Adjustments 25.00 0 0 0 0 0 0 0 0 0 0 0 0	700, 593 3, 123, 767 1, 286, 614 329, 120 81, 271 76, 716 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	27. 00  446, 861 184, 051 47, 081 0 11, 626 10, 974 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28. 00  3, 570, 628 1, 470, 665 376, 201 0 92, 897 87, 690 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 14. 00 15. 00 17. 00 18. 00 19. 00 19. 00

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

Peri od: Worksheet H-2
From 01/01/2016 Part II
To 12/31/2016 Date/Time Prepared: 5/23/2017 10: 42 am
Home Heal th PPS BASIS HHA CCN: 15-7011

						Home Health	PPS	
						Agency I		
		CAPITAL REL	LATED COSTS					
	C+ C+ D!!	DIDC & FLVT	MVDLE FOULD	EMDL OVEE	D!!!-+!	ADMINI CEDATI VE	ODEDATION OF	
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	OPERATION OF	
		(SQUARE FEET)	(SQ FEET)	BENEFITS DEPARTMENT		& GENERAL	PLANT (SQUARE FEET)	
				(GROSS		(ACCUM. COST)	(SQUARE FEET)	
				SALARI ES)				
		1.00	2. 00	4. 00	5A	5. 00	7. 00	
1. 00	Administrative and General	6, 093	6, 093				6, 093	1. 00
2. 00	Skilled Nursing Care	0,075	0,073		1		0, 073	2. 00
3. 00	Physical Therapy		0	1			o	3. 00
4. 00	Occupational Therapy	0	0	1	_		o	4. 00
5. 00	Speech Pathology		0	0	1		ő	5. 00
6. 00	Medical Social Services		0	33, 091	1		ő	6. 00
7. 00	Home Health Aide		0	31, 236	l .		Ö	7. 00
8. 00	Supplies (see instructions)		0	01, 230			ő	8. 00
9. 00	Drugs	Ö	0		Ö		Ö	9. 00
10. 00	DME	Ö	0		Ö		0	10. 00
11. 00	Home Dialysis Aide Services	Ö	0		Ö	-	Ö	11. 00
12. 00	Respiratory Therapy	0	0		Ö		Ö	12. 00
13. 00	Private Duty Nursing	Ö	0		Ö		Ö	13. 00
14. 00	Clinic	0	0	o o			0	14. 00
15. 00	Health Promotion Activities	0	0		Ö		Ö	15. 00
16. 00	Day Care Program	0	0		Ö	-	Ö	16. 00
17. 00	Home Delivered Meals Program	0	0		i c		o	17. 00
18. 00	Homemaker Service	0	0	o o	i c		o	18. 00
	All Others (specify)	0	0	o o			o	19. 00
19. 50	Tel emedi ci ne	0	0	0	i d	0	o	19. 50
20. 00	Total (sum of lines 1-19)	6, 093	6, 093	2, 345, 358		4, 201, 375	6, 093	20. 00
21. 00	Total cost to be allocated	112, 322	53, 421		1	999, 952	147, 807	21. 00
22. 00	Unit cost multiplier	18. 434597	8. 767602	1	1	0. 238006	24. 258493	
	Cost Center Description	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	CAFETERI A	NURSI NG	CENTRAL	
	, , , , , , , , , , , , , , , , , , ,	LINEN SERVICE	(HOURS OF	(MEALS SERVED)	(MANHOURS)	ADMI NI STRATI ON	SERVICES &	
		(POUNDS OF	SERVI CE)	,	,		SUPPLY	
		LAUNDRY)				(DIRECT NURS.	(COSTED	
						HRS. )	REQUISITIONS)	
		8. 00	9. 00	10.00	11. 00	13. 00	14. 00	
1.00	Administrative and General	0	0				0	1. 00
2.00	Skilled Nursing Care	0	0	0	1	_	0	2. 00
3.00	Physical Therapy	0	0	0	C		0	3. 00
4.00	Occupational Therapy	0	0	0	C		0	4. 00
5.00	Speech Pathology	0	0	0	O C		0	5. 00
6.00	Medical Social Services	0	0	0	1		0	6. 00
7.00	Home Heal th Aide	0	0		C	-	0	7. 00
8.00	Supplies (see instructions)	0	0		C		0	8. 00
9.00	Drugs	0	0		C		0	9. 00
10.00	DME	0	U		C		0	10.00
11. 00	Home Dialysis Aide Services	0	U		C		U	11. 00
12. 00 13. 00	Respiratory Therapy	0	0		C		0	12.00
	Private Duty Nursing	0	0				0	13.00
14. 00	Clinic	0	0				0	14.00
15. 00 16. 00	Health Promotion Activities Day Care Program		0		O C		0	15. 00 16. 00
17. 00	Home Delivered Meals Program		0					17. 00
17.00	Homemaker Service		0				0	17.00
19. 00	All Others (specify)		0				0	19. 00
19. 50			0				٥	19. 50
20. 00	Total (sum of lines 1-19)		0		62, 506	20, 884	0	20. 00
21. 00	Total cost to be allocated		0		25, 004			21. 00
	Unit cost multiplier	0. 000000	0. 000000	0. 000000			0. 000000	
00	12 2 3332 mai ti pi 131	3. 000000	3. 000000	3. 000000	3. 100020		3. 000000	00

| In Lieu of Form CMS-2552-10 | Period: | Worksheet H-2 | From 01/01/2016 | Part II | Date/Time Prepared: | 5/23/2017 10: 42 am | PPS | Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL ALLOCATION OF GENERAL SERVICE COSTS TO HHA COST CENTERS STATISTICAL Provider CCN: 15-0051 BASIS HHA CCN: 15-7011

						Home Health	PPS
						Agency I	
				OTHER GENE	RAL SERVICE		
	Cost Center Description	PHARMACY	MEDI CAL	(SPECI FY)	CENTRAL	PARAMED ED	
		(COSTED	RECORDS &	(TIME SPENT)		PRGM-PHARMACY	
		REQUIS.)	LI BRARY		(TIME SPENT)	RESI DENCY	
			(GROSS			(COSTED	
		45.00	CHARGES)	10.00	40.04	REQUIS.)	
1.00		15. 00	16.00	18. 00	18. 01	23. 00	1.00
1.00	Administrative and General	0	3, 088, 152	C	)	0	1. 00
2.00	Skilled Nursing Care	0	0	C	)	0	2. 00
3.00	Physical Therapy	0	0	C		0	3.00
4.00	Occupational Therapy	0	0	C	) C	이	4. 00
5.00	Speech Pathology	0	0	C	0	이	5. 00
6. 00	Medical Social Services	0	0	C	)  C	0	6. 00
7. 00	Home Health Aide	0	0	C	0	0	7. 00
8.00	Supplies (see instructions)	0	0	C	0	0	8. 00
9. 00	Drugs	0	0	C	0	0	9. 00
10.00		0	0	C	) C	0	10.00
11. 00	1	0	0	C	) C	0	11. 00
12.00	1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	0	0	C	)  C	0	12. 00
13.00	3	0	0	C	)  C	0	13. 00
14.00		0	0	C	) c	0	14.00
15.00	Health Promotion Activities	0	0	C	) c	0	15. 00
16.00		0	0	C	) c	0	16. 00
17.00	Home Delivered Meals Program	0	0	C	) c	0	17. 00
18.00	Homemaker Service	0	0	C	) c	0	18. 00
19. 00	All Others (specify)	0	0	C	) c	0	19. 00
19. 50	Telemedicine	0	0	C	) c	0	19. 50
20.00	Total (sum of lines 1-19)	0	3, 088, 152	C	) C	0	20. 00
21.00	Total cost to be allocated	0	7, 794	C	) C	0	21. 00
22. 00	Unit cost multiplier	0. 000000	0. 002524	0.000000	0.000000	0. 000000	22. 00

Hoal th	Financial Systems	11	J HEALTH BLOOMI	NCTON HOSDITAL		In lie	eu of Form CMS-2	2552_10
	TONMENT OF PATIENT SERVICE COST		J HEALTH BLOOM		CN: 15-0051 F	Peri od:	Worksheet H-3	
				HHA CCN:		From 01/01/2016 To 12/31/2016	Part I Date/Time Prep 5/23/2017 10:4	
				Title	e XVIII	Home Health Agency I	PPS	42 diii
	Cost Center Description		Facility Costs		Total HHA	Total Visits	Average Cost	
		H-2, Part I, col. 28, line	(from Wkst.	Ancillary Costs (from	Costs (cols. 1 + 2)		Per Visit (col. 3 ÷ col.	
		20, 11116	11-2, Tart 1)	Part II)	+ 2)		4)	
	T	0	1.00	2.00	3.00	4. 00	5. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	OF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	HE PROGRAM LIMI	TATION COST, OF	₹	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	2. 00	3, 570, 628		3, 570, 628	8, 722	409. 38	1.00
2.00	Physi cal Therapy	3. 00						2. 00
3.00	Occupational Therapy Speech Pathology	4. 00 5. 00		0	376, 201			•
4. 00 5. 00	Medical Social Services	6. 00			92, 897	1		
6. 00	Home Health Aide	7. 00		•	87, 690			1
7.00	Total (sum of lines 1-6)		5, 598, 081	C	-11			7. 00
			l		Program Visits			
	Cost Center Description	Cost Limits	CBSA No. (1)	Part A	Not Subject to	Subject to		
	cost center beserver on	COST ETIM TS	CDSA NO. (1)	Tare A	Deductibles &			
					Coi nsurance			
	1	0	1.00	2. 00	3. 00	4. 00	5. 00	
8. 00	Limitation Cost Computation Skilled Nursing Care		14020	C	3, 360			8.00
8. 01	Skilled Nursing Care		26900	Č				8. 01
8. 02	Skilled Nursing Care		99915	C				8. 02
9.00	Physical Therapy		14020	C				9. 00
9. 01 9. 02	Physical Therapy Physical Therapy		26900 99915		1			9. 01 9. 02
10. 00	Occupati onal Therapy		14020					10.00
10. 01	Occupational Therapy		26900	Ċ				10. 01
10. 02	Occupational Therapy		99915	C	1			10. 02
11.00	Speech Pathology		14020	C				11.00
11. 01 11. 02	Speech Pathology Speech Pathology		26900 99915					11. 01 11. 02
12. 00	Medical Social Services		14020		1			12.00
12. 01	Medical Social Services		26900	Ċ				12. 01
12. 02	Medical Social Services		99915	C				12. 02
13.00	Home Heal th Aide		14020	C				13.00
13. 01 13. 02	Home Health Aide Home Health Aide		26900 99915		1			13. 01 13. 02
14. 00			77713		1			14. 00
		From Wkst. H-2	Facility Costs		Total HHA	Total Charges	Ratio (col. 3	
		Part I, col.	(from Wkst.	Ancillary	Costs (cols. 1	•	÷ col . 4)	
		28, line	H-2, Part I)	Costs (from Part II)	+ 2)	Records)		
		0	1.00	2.00	3.00	4. 00	5. 00	
	Supplies and Drugs Cost Computa							
15. 00 16. 00		8. 00 9. 00						1
10.00	Cost of brugs	9.00	Program Visits		Cost of	0	0.000000	10.00
					Servi ces			
	0 1 0 1 5 11		Par			Part B	0 1 1 1 1	
	Cost Center Description	Part A	Not Subject to Deductibles &		Part A	Not Subject to Deductibles &		
			Coi nsurance	Coi nsurance		Coi nsurance	Coi nsurance	
	T	6. 00	7. 00	8. 00	9. 00	10.00	11. 00	
	PART I - COMPUTATION OF LESSER BENEFICIARY COST LIMITATION	UF AGGREGATE F	PROGRAM COST, A	GGREGATE OF TH	IE PROGRAM LIMI	TATION COST, OF	₹	
	Cost Per Visit Computation							
1.00	Skilled Nursing Care	0	.,		(			1.00
2.00	Physical Therapy	0						2.00
3. 00 4. 00	Occupational Therapy Speech Pathology		900 32					3. 00 4. 00
5. 00	Medical Social Services	0	148					5. 00
6.00	Home Health Aide	0	327			45, 371		6. 00
7.00	Total (sum of lines 1-6)	0	8, 725			3, 099, 389		7. 00

APPORT	TIONMENT OF PATIENT SERVICE COST	S		Provider CC	15-7011	Period: From 01/01/2016 To 12/31/2016	Date/Time Pre 5/23/2017 10:	pared:
				Title	XVIII	Home Health Agency I	PPS	
	Cost Center Description	6. 00	7. 00	8. 00	9. 00	10.00	11.00	
	Limitation Cost Computation	0.00	7.00	6.00	9.00	10.00	11.00	
8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide Total (sum of lines 8-13)							8. 00 8. 01 8. 02 9. 00 9. 01 10. 00 10. 01 11. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02 14. 00
14.00	Total (suil of Titles 0-13)	Prog	ram Covered Cha	rges	Cost of			14.00
					Servi ces			
	Cost Center Description	Part A	Part Not Subject to Deductibles & Coinsurance	Subject to Deductibles & Coinsurance	Part A	Part B Not Subject to Deductibles & Coinsurance	Deductibles & Coinsurance	
	Supplies and Drugs Cost Computa	6.00 ations	7. 00	8. 00	9. 00	10. 00	11.00	
	Cost of Medical Supplies	C	1	0		0 0		
16.00	Cost Center Description	Total Program Cost (sum of cols. 9-10) 12.00	0	0		0		16.00
	PART I - COMPUTATION OF LESSER	OF AGGREGATE I	PROGRAM COST, A	GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	?	
	BENEFICIARY COST LIMITATION Cost Per Visit Computation							1
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00	Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	1, 872, 095 902, 117 228, 312 0 51, 494 45, 371 3, 099, 389						1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00
	Limitation Cost Computation	12. 00						
8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 10. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02	Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Speech Pathology Medical Social Services Medical Social Services Medical Social Services Home Health Aide Home Health Aide							8. 00 8. 01 8. 02 9. 00 9. 01 9. 02 10. 00 11. 01 11. 02 12. 00 12. 01 12. 02 13. 00 13. 01 13. 02

Health Financial Systems	II	J HEALTH BLOOMI	NGTON HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF PATIENT SERVICE COST	ΓS		Provi der C		Peri od:	Worksheet H-3	
			HHA CCN:		From 01/01/2016 To 12/31/2016		narod:
			TITIA CCN.	15-7011	10 12/31/2010	5/23/2017 10:	42 am
					Home Health	PPS	
Agency I							
Cost Center Description	From Wkst. C,	Cost to Charge		HHA Shared	Transfer to		
	Part I, col.	Ratio	Charge (from	Ancillary	Part I as		
	9, line		provi der	Costs (col.	1 Indicated		
			records)	x col. 2)			
	0	1.00	2. 00	3.00	4. 00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVIC	ES FURNI SHED B	Y SHARED HOSPI	TAL DEPARTMEN	ITS		
1.00 Physical Therapy	66. 00	0. 428676	0		0 col. 2, line 2	. 00	1. 00
2.00 Occupational Therapy	67. 00	0. 000000	0		0 col. 2, line 3	. 00	2. 00
3.00 Speech Pathology	68. 00	0. 000000	0		0 col. 2, line 4	. 00	3. 00
4.00 Cost of Medical Supplies	71. 00	0. 237499	43, 329	10, 29	01 col. 2, line 1	5. 00	4. 00
5.00 Cost of Drugs	73. 00	0. 257263	0		0 col. 2, line 1	6. 00	5. 00
5.01 Cost of Drugs 1	73. 01	0. 276708	0		0 col. 2, line 1	6. 01	5. 01
·				•	•		

th Financial Systems IU HEALTH BLOOMINGTO	Provider CC	N: 15-0051	Peri od:	Worksheet H-4	
	HHA CCN:	15-7011	From 01/01/2016 To 12/31/2016		
	Title	XVIII	Home Health Agency I	PPS	
		Part A	Not Subject to Deductibles &	Deductibles &	
	-	1 00	Coi nsurance	Coi nsurance	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTO	MADV CHADGE	1.00	2. 00	3. 00	
Reasonable Cost of Part A & Part B Services	WART CHARGE	<u>,                                      </u>			1
Reasonable cost of services (see instructions)			0 0	0	1
Total charges			0 0		
Customary Charges					
Amount actually collected from patients liable for payment for	servi ces		0 0	0	i] :
on a charge basis (from your records)					
Amount that would have been realized from patients liable for for services on a charge basis had such payment been made in a with 42 CFR §413.13(b)			0 0	0	
Ratio of line 3 to line 4 (not to exceed 1.000000)		0.0000	0. 000000	0. 000000	
Total customary charges (see instructions)		2. 2300	0 0	0	
Excess of total customary charges over total reasonable cost (only if line 6 exceeds line 1)			0 0	0	
Excess of reasonable cost over customary charges (complete onl	y if line		0 0	0	1
1 exceeds line 6) Primary payer amounts			0 0	0	,
Firmary payer amounts			Part A	Part B	
			Servi ces 1. 00	Servi ces 2. 00	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT			1.00	2.00	
Total reasonable cost (see instructions)			0	0	1
Total PPS Reimbursement - Full Episodes without Outliers			0	1, 429, 093	1
Total PPS Reimbursement - Full Episodes with Outliers			0	23, 004	
Total PPS Reimbursement - LUPA Episodes			0	27, 020	
Total PPS Reimbursement - PEP Episodes			0	6, 749	
Total PPS Outlier Reimbursement - Full Episodes with Outliers			0	9, 987	
O Total PPS Outlier Reimbursement - PEP Episodes			0	0	
00  Total Other Payments 00  DME Payments			0	0	
00 DME Payments 00 Oxygen Payments			0	0	
00   Prosthetic and Orthotic Payments			0	0	
00 Part B deductibles billed to Medicare patients (exclude coinsu	rance)			Ö	
00 Subtotal (sum of lines 10 thru 20 minus line 21)	i dilee)		0	1, 495, 853	
00 Excess reasonable cost (from line 8)			0	0	1
00 Subtotal (line 22 minus line 23)			0	1, 495, 853	
OO Coinsurance billed to program patients (from your records)				0	1
Net cost (line 24 minus line 25)			0	1, 495, 853	2
Reimbursable bad debts (from your records)					2
Reimbursable bad debts for dual eligible beneficiaries (see in					2
Total costs - current cost reporting period (line 26 plus line	27)		0	1, 495, 853	
OO OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	`		0	0	
60 Pioneer ACO demonstration payment adjustment (see instructions	)		0	1 405 053	
00   Subtotal (see instructions)			0	1, 495, 853	
01   Sequestration adjustment (see instructions) 00   Interim payments (see instructions)			0	29, 917	
ar reneering Davineres (See EDSTEDCTLODS)			0	1, 465, 937 0	
,					
Tentative settlement (for contractor use only)	nd 33)		0		
,		Pub 15-2	0	-1 0	3

Health Financial Systems

I U HEALTH BLOOMINGTON HOSPITAL

ANALYSIS OF PAYMENTS TO HOSPITAL-BASED HHAS FOR SERVICES RENDERED

TO PROGRAM BENEFICIARIES

I U HEALTH BLOOMINGTON HOSPITAL

Provider CO Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 5/23/2017 10: 42 am PPS Provider CCN: 15-0051 HHA CCN: 15-7011

				Home Health Agency I	PPS	+2 aiii
		Inpatien	t Part A		t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1. 00	2.00	3. 00	4. 00	
1.00 2.00	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			0	1, 465, 937 0	1. 00 2. 00
3. 00	List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)  Program to Provider					3. 00
3. 01				0	0	3. 01
3.02				0	0	3. 02
3. 03				0	0	3. 03
3. 04 3. 05				0	0	3. 04 3. 05
3.05	Provider to Program			U	U	3. 05
3. 50	11 OVI del 10 11 Ogi alli			ol	0	3. 50
3. 51				O	0	3. 51
3.52				o	0	3. 52
3. 53				0	0	3. 53
3.54				0	0	3.54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
4. 00	3.50-3.98) Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate,			0	1, 465, 937	4. 00
	line 32)					
	TO BE COMPLETED BY CONTRACTOR					
5. 00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					5. 00
	Program to Provider			-		
5. 01				0	0	5. 01
5. 02				0	0	5. 02
5. 03				0	0	5. 03
5. 50	Provider to Program			ol	0	5. 50
5. 51				0		5. 51
5. 52				o	l ő	5. 52
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)			0	0	5. 99
6.00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
6. 01	SETTLEMENT TO PROVIDER			0	0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0	1 445 024	6. 02
7. 00	Total Medicare program liability (see instructions)			Contractor	1, 465, 936 NPR Date	7. 00
		(	)	Number	(Mo/Day/Yr)	
8. 00	Name of Contractor		J	1. 00	2. 00	8. 00
0.00	Name of contractor			I	ı l	0.00

Heal th	Financial Systems IU HEALTH BLOOMINGTON HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL		eri od:	Worksheet I-5	
		rom 01/01/2016		
		o 12/31/2016		
			5/23/2017 10:	42 am
		1. 00	2. 00	
	PART I - CALCULATION OF REIMBURSABLE BAD DEBTS - TITLE XVIII - PART B			
1.00	Total expenses related to care of program beneficiaries (see instructions)	0		1.00
2.00	Total payment due (from Wkst. I-4, col. 6, line 11) (see instructions)	o	0	2.00
2.01	Total payment due (from Wkst. I-4, col. 6.01, line 11) (see instructions)			2. 01
2.02	Total payment due(from Wkst. I-4, col. 6.02, line 11) (see instructions)			2. 02
2.03	Total payment due (see instructions)	o	0	2. 03
2.04	Outlier payments	O		2. 04
3.00	Deductibles billed to Medicare (Part B) patients (see instructions)	O	0	3.00
3. 01	Deductibles billed to Medicare (Part B) patients (see instructions)			3. 01
3.02	Deductibles billed to Medicare (Part B) patients (see instructions)			3. 02
3. 03	Total deductibles billed to Medicare (Part B) patients (see instructions)	o	0	3. 03
4.00	Coinsurance billed to Medicare (Part B) patients	o	0	4.00
4. 01	Coinsurance billed to Medicare (Part B) patients (see instructions)			4. 01
4. 02	Coinsurance billed to Medicare (Part B) patients (see instructions)			4. 02
4.03	Total coinsurance billed to Medicare (Part B) patients (see instructions)	o	0	4. 03
5.00	Bad debts for deductibles and coinsurance, net of bad debt recoveries	o	0	5. 00
5. 01	Transition period 1 (75-25%) bad debts for deductibles and coinsurance net of bad debt	o	0	5. 01
	recoveries for services rendered on or after 1/1/2011 but before 1/1/2012			
5.02	Transition period 2 (50-50%) bad debts for deductibles and coinsurance net of bad debt	O	0	5. 02
	recoveries for services rendered on or after 1/1/2012 but before 1/1/2013			
5.03	Transition period 3 (25-75%) bad debts for deductibles and coinsurance net of bad debt	0	0	5. 03
	recoveries for services rendered on or after 1/1/2013 but before 1/1/2014			
5.04	100% PPS bad debts for deductibles and coinsurance net of bad debt recoveries for	0	0	5. 04
	services rendered on or after 1/1/2014			
5.05	Total bad debts (sum of line 5 through line 5.04)	0	0	5. 05
6.00	Allowable bad debts (see instructions)	0		6. 00
7.00	Reimbursable bad debts for dual eligible beneficiaries (see instructions)	0		7. 00
8.00	Net deductibles and coinsurance billed to Medicare (Part B) patients (see	0	0	8. 00
	instructions)			
9.00	Program payment (see instructions)	0	0	9. 00
10.00	Unrecovered from Medicare (Part B) patients (see instructions)			10. 00
11. 00	Reimbursable bad debts (see instructions) (transfer to Worksheet E, Part B, line 33)	0		11. 00
	PART II - CALCULATION OF FACILITY SPECIFIC COMPOSITE COST PERCENTAGE			
12. 00	Total allowable expenses (see instructions)	0		12. 00
13. 00	Total composite costs (from Wkst. I-4, col. 2, line 11)	0		13. 00
14. 00	Facility specific composite cost percentage (line 13 divided by line 12)	0. 000000		14. 00

Provider CCN: 15-0051 Peri od: Worksheet 0 From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/23/2017 10:42 am Hospi ce CCN: 15-1509

					Heeni ee I	3/23/2017 10.	12 (1111
		CALABLEC	OTHER	CUPTOTAL ( )	Hospi ce I	CURTOTAL	
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
		1.00	0.00	1 plus col. 2)	CATI ONS	F 00	
	OFNEDAL CERVI OF COCT CENTERS	1.00	2. 00	3.00	4. 00	5. 00	
4 00	GENERAL SERVICE COST CENTERS		007.050	007.050		007.050	4 00
1. 00	CAP REL COSTS-BLDG & FIXT*		287, 050		0	287, 050	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP*		17, 560		0	17, 560	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT*	0	692, 542		0	692, 542	3. 00
4.00	ADMINISTRATIVE & GENERAL*	210, 122	34, 745		0	244, 867	4. 00
5.00	PLANT OPERATION & MAINTENANCE*	0	24, 544	24, 544	0	24, 544	5. 00
6.00	LAUNDRY & LINEN SERVICE*	0	0	0	0	0	6. 00
7.00	HOUSEKEEPI NG*	0	2, 200	2, 200	0	2, 200	7. 00
8.00	DI ETARY*	0	18, 130	18, 130	0	18, 130	8. 00
9.00	NURSI NG ADMI NI STRATI ON*	o	0	o	0	0	9. 00
10.00	ROUTINE MEDICAL SUPPLIES*	0	110, 419	110, 419	0	110, 419	10.00
11. 00	MEDI CAL RECORDS*	o	0	0	0	0	11. 00
12. 00	STAFF TRANSPORTATION*	0	17, 271	17, 271	0	17, 271	12.00
13. 00	VOLUNTEER SERVICE COORDINATION*	0	17, 271	17,271	0	0	13. 00
14. 00	PHARMACY*	0	220, 596	220, 596	0	220, 596	14.00
15. 00	PHYSI CI AN ADMINI STRATI VE SERVI CES*				0	14, 226	15. 00
		- I	14, 226	14, 226	0		
16.00	OTHER GENERAL SERVICE*	0	U	١	U	0	16.00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	DIRECT PATIENT CARE SERVICE COST CENTERS				_1		
25. 00	INPATIENT CARE-CONTRACTED**	0	0	0	0	0	25. 00
26. 00	PHYSI CI AN SERVI CES**	0	0	0	0	0	26. 00
27. 00	NURSE PRACTITIONER**	0	0	0	0	0	27. 00
28. 00	REGI STERED NURSE**	1, 094, 515	0	1, 094, 515	0	1, 094, 515	28. 00
29. 00	LPN/LVN**	248, 109	0	248, 109	0	248, 109	29. 00
30.00	PHYSI CAL THERAPY**	0	0	0	0	0	30.00
31.00	OCCUPATIONAL THERAPY**	0	0	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY**	o	0	o	O	0	32. 00
33.00	MEDICAL SOCIAL SERVICES**	124, 214	0	124, 214	0	124, 214	33. 00
34.00	SPIRITUAL COUNSELING**	o	0	ol	o	0	34.00
35. 00	DI ETARY COUNSELI NG**	0	0		0	0	35. 00
36. 00	COUNSELING - OTHER**	147, 313	0	147, 313	0	147, 313	36. 00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES**	281, 320	0	281, 320	0	281, 320	37. 00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	201, 320	1, 354		0	1, 354	38. 00
39. 00	PATIENT TRANSPORTATION**		1, 334	1, 334	0	1, 334	39. 00
40. 00		0	0	,	0		40.00
	I MAGING SERVI CES**	0	4 504	4 504	U	0	
41. 00	LABS & DI AGNOSTI CS**	0	4, 594	4, 594	0	4, 594	41.00
42. 00	MEDI CAL SUPPLI ES-NON-ROUTI NE**	0	0	0	0	0	42.00
43.00	OUTPATIENT SERVICES**	0	0	0	0	0	43. 00
44. 00	PALLIATIVE RADIATION THERAPY**	0	0	0	0	0	44. 00
45. 00	PALLI ATI VE CHEMOTHERAPY**	0	0	0	0	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)**	113, 725	437, 895	551, 620	0	551, 620	46. 00
	NONREI MBURSABLE COST CENTERS						
60.00	BEREAVEMENT PROGRAM *	0	0	0	0	0	60.00
61.00	VOLUNTEER PROGRAM *	o	0	ol ol	o	0	61.00
62.00	FUNDRAI SI NG*	o	0	ol ol	o	0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS*	0	0		0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM*	0	0	أ	0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES*		0		0	0	65. 00
66. 00	RESIDENTIAL CARE*		0		0	0	66.00
67. 00	ADVERTI SI NG*	0	0		0	0	67. 00
			0	, J	0	-	
68. 00	TELEHEALTH/TELEMONI TORI NG*		0		O <sub>1</sub>	0	68.00
69.00	THRIFT STORE*	O	0	<u>[</u>	0	0	69.00
70.00	NURSING FACILITY ROOM & BOARD*	O	0		O	0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)*	0	0	0 ا	0	0	71. 00
100.00	TOTAL	2, 219, 318	1, 883, 126	4, 102, 444	0	4, 102, 444	100. 00
* Tran	sfer the amounts in column 7 to Wkst 0-5 co.	lumn 1 lino ac	appropri ata				

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Peri od: From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/23/2017 10:42 am Hospi ce CCN: 15-1509 Hospi ce I

STRIERM   SERVICE COST CENTERS			10 111071151170	TOTAL ( 1 5	HOSPICE I	1
CAP REL COSTS -BLOS & FLXT			ADJUSTMENTS	TOTAL (col. 5		
GENERAL SERVICE COST CENTERS   1.00			4.00			
1.00   CAP REL COSTS-BIDG & FIXT"   0   287,050   2.20   CAP REL COSTS-WIDGE EQUIP"   0   17,560   2.20   CAP REL COSTS-WIDGE EQUIP"   0   17,560   2.20   3.00   4.00   ADMINISTRATIVE & GENERAL"   0   622,542   3.00   4.00   ADMINISTRATIVE & GENERAL"   0   244,667   4.00   6.00		DENIEDAL CEDIU DE COCT DENIEDO	6.00	7.00		
2.00   CAP REL COSTS-WINEL EQUIP"   0   17,560   2,00   4.00   ADMINISTRATIVE & GENERAL"   0   244,867   4,00   5.00   PLANT OPERATION & MAINTENANCE"   0   244,867   5,00   6.00   LAUNDRY & LINEN SERVICE"   0   0   0   6,00   7.00   HOUSEREPHING"   0   2,200   7,00   8.00   DI FTARY   0   18,130   8,00   9.00   OI FTARY   0   18,130   8,00   9.00   OI FTARY   0   18,130   9,00   9.00   OI FTARY   0   10,410   9,00   9.00   OI FTARY   0   10,410   9,00   9.00   OI FTARY   0   11,041   9,00   9.00   OI FTARY   0   11,041   9,00   9.00   OI FTARY   0   12,200   9.00   OI FTARY   0   14,226   9.00   OI FTARY   0   14,226   9.00   OI FTARY   0   0   9.00   OI FT	4 00			007.050	J	4 00
A.00   ADMINISTRATIVE & GENERAL*   0   622,542   3.00			1			
ADMINISTRATIVE & GENERAL*   0   244,867   6.00		l control of the cont	-1			
Death Operation & Maintenance*   0		l control of the cont	1			
6.00 LANNORY & LINEN SERVICE* 0 0 2,200 7,700  8.00 DI ETARY* 0 18,130 8,00  9.00 NUSSIN AGMINI STRATION* 0 18,130 8,00  10.00 ROUTH & MEDICAL SUPPLIES* 0 110,419 10,00  10.00 ROUTH & MEDICAL SUPPLIES* 0 110,419 11,00  12.00 STAFF TRANSPORTATION* 0 0 0 113,201  14.00 PHARMACY* 0 220,596 11,00  15.00 PHAST TRANSPORTATION* 0 17,271 12,00  16.00 O 133,00 VOLUMERER SERVICE CORORINATION* 0 0 0 13,300  16.00 O O THE RESIDENCE CORORINATION* 0 14,220 15,00  16.00 O THE RESIDENCE CORORINATION* 0 14,220 15,00  16.00 O THE RESIDENCE CORORINATION* 0 14,220 15,00  16.00 O THE RESIDENCE CORORINATION* 0 0 0 0 14,220 15,00  16.00 O THE RESIDENCE CORORINATION* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0			
7. 0.0   HOUSEKEEPING*   0   2, 200   7, 0.0   9. 0.0   NURSI NG ADMINISTRATION*   0   0   0   9, 0.0   11. 0.0   NURSI NG ADMINISTRATION*   0   10   0   11. 0.0   11. 0.0   ROUTINE MEDICAL SUPPLIES*   0   10, 419   11. 0.0   11. 0.0   MEDICAL RECORDS*   0   0   0   11. 0.0   12. 0.0   STAFF TRANSPORTATION*   0   12, 201   13. 0.0   13. 0.0   VOLUNTEER SERVICE COORDINATION*   0   20, 596   11. 0.0   15. 0.0   PHYSI CLAN ALMINISTRATIVE SERVICES*   0   220, 596   11. 0.0   16. 0.0   THERE GENERAL SERVICES*   0   14, 226   15. 0.0   17. 0.0   PHYSI CLAN ALMINISTRATIVE SERVICES*   0   14, 226   15. 0.0   17. 0.0   DIRECT PATLENT CARE SERVICE COST CENTERS   17. 0.0   18. 0.0   PATLENT/RESIDENTIAL CARE SERVICES*   0   0   0   22. 0.0   19. 0.0   PATLENT/RESIDENTIAL CARE SERVICES*   0   0   25. 0.0   19. 0.0   PATLENT/RESIDENTIAL CARE SERVICES*   0   0   22. 0.0   10. 0.0   PHYSI CLAN SERVICES*   0   0   0   25. 0.0   10. 0.0   PHYSI CLAN SERVICES*   0   0   0   25. 0.0   10. 0.0   PHYSI CLAN SERVICES**   0   0   0   26. 0.0   10. 0.0   PHYSI CLAN SERVICES**   0   0   0   26. 0.0   10. 0.0   PHYSI CLAN SERVICES**   0   0   0   26. 0.0   11. 0.0   DIRECT PATLENT CARE SERVICES**   0   0   0   26. 0.0   12. 0.0   PHYSI CLAN SERVICES**   0   0   0   26. 0.0   13. 0.0   PHYSI CLAN SERVICES**   0   1,094,515   28. 0.0   14. 0.0   PHYSI CLAN SERVICES**   0   1,094,515   28. 0.0   15. 0.0   PHYSI CLAN SERVICES**   0   1,094,515   28. 0.0   16. 0.0   PHYSI CLAN SERVICES**   0   0   0   248,109   29. 0.0   17. 0.0   PHYSI CLAN SERVICES**   0   1,094,515   28. 0.0   18. 0.0   PHYSI CLAN SERVICES**   0   0   0   0   0   19. 0.0   PHYSI CLAN SERVICES**   0   0   0   0   0   19. 0.0   PHYSI CLAN SERVICES**   0   1,094,515   28. 0.0   19. 0.0   PHYSI CLAN SERVICES**   0   0   0   0   0   19. 0.0   PHYSI CLAN SERVICES**   0   1,094,515   28. 0.0   19. 0.0   PHYSI CLAN SERVICES**   0   0   0   0   0   19. 0.0   PHYSI CLAN SERVICES**   0   0   0   0   0   19. 0.0   PHYSI CLAN SERVICES**   0   0   0   0   0   19. 0.0   PHYSI CLAN SERVIC		l control of the cont	0	24, 544		
B. 00   DIETARY*   0   18, 130   8, 00   9, 00   10, 00   0   0, 00   0, 00   10, 00   0, 00   10, 00   0, 00   10, 00   10, 00   10, 00   11, 00		LAUNDRY & LINEN SERVICE*	0	0		
9.00 NURSI NG ADMINISTRATION* 0.00 NUTION MEDICAL SUPPLIES* 0.110.01 NUTIO	7.00	HOUSEKEEPI NG*	0	2, 200		7. 00
10. 00   ROUTI NE MEDICAL SUPPLIES*   0   110, 419   110, 00   1	8.00	DI ETARY*	0	18, 130		8. 00
11.00   MEDI CAL RECORDS*   0 0 0   11.00   12.00   13.00   10.00   13.00   10.00   13.00   10.00   13.00   10.00   13.00   10.00   13.00   13.00   10.00   13.00   13.00   13.00   13.00   14.00   15.00	9.00	NURSING ADMINISTRATION*	0	0		9. 00
11.00   MEDI CAL RECORDS*   0   0   11.00   12.00   13.00   10.00   13.00   10.00   13.00   10.00   13.00   10.00   13.00   10.00   13.00	10.00	ROUTINE MEDICAL SUPPLIES*	o	110, 419		10.00
12.00   STAFF TRANSPORTATION*   0   17, 271   12.00   13.00   14.00   PHARMACY*   0   220, 566   14.00   15.00   PHARMACY*   0   220, 566   14.00   15.00   PHARMACY*   0   220, 566   15.00   PHARMACY*   0   14.226   15.00   16.00   OTHER GENERAL SERVICE*   0   14.226   15.00   PHARMACY*   0   0   0   0   14.00   16.00   17.00   PHARMACY*   0   0   0   0   0   0   0   0   0	11. 00	MEDI CAL RECORDS*	o	0		11.00
13. 00   VOLUNTEER SERVICE COORDINATION*   0   0   13. 00     14. 00   PHYSICIAN ADMINISTRATIVE SERVICES*   0   14. 226   15. 00     16. 00   OHER GENERAL SERVICE*   0   0   0     17. 00   DITER GENERAL SERVICES*   0   14. 226   17. 00     18. 00   DITER SERVICES   0   0   0     19. 00   PATIENT/RESIDENTIAL CARE SERVICES   0   0   0     25. 00   DITER SERVICES*   0   0   0   0     26. 00   PHYSICIAN ADMINISTRATIVE SERVICES*   0   0   0     27. 00   DITER SERVICES**   0   0   0   0     28. 00   PHYSICIAN SERVICES**   0   0   0   0     29. 00   NURSE PRACTITIONER**   0   0   0   0     29. 00   NURSE PRACTITIONER**   0   0   0   0     29. 00   LPA/LVIV**   0   248, 109   0   0     30. 00   PHYSICIAN SERVICES**   0   1, 094, 515   28, 80     30. 00   PHYSICIAN SERVICES**   0   0   0   0     31. 00   OCCUPATIONAL THERAPY**   0   0   0   0     32. 00   SERVICES*   0   124, 214   0   0   0     33. 00   MEDICAL SOCIAL SERVICES**   0   124, 214   0   0   0     33. 00   MEDICAL SOCIAL SERVICES**   0   124, 214   0   0   0     30. 00   PHYSICIAN SERVICES**   0   147, 313   0   35, 00     30. 00   DITARY COUNSELING*   0   0   0   0     30. 00   DITARY COUNSELING*   0   0   0   0   0     30. 00   DITARY COUNSELING*   0   0   0   0   0     30. 00   DITARY COUNSELING*   0   0   0   0   0     30. 00   DITARY COUNSELING*   0   0   0   0   0     30. 00   DITARY COUNSELING*   0   0   0   0   0     30. 00   DITARY COUNSELING*   0   0   0   0   0     30. 00   DITARY COUNSELING*   0   0   0   0   0     30. 00   DITARY COUNSELING*   0   0   0   0   0     30. 00   DITARY COUNSELING*   0   0   0   0   0     30. 00   DITARY COUNSELING*   0   0   0   0   0     30. 00   DITARY COUNSELING*   0   0   0   0   0   0     30. 00   DITARY COUNSELING*   0   0			0	17, 271		
14. 00   PHARMACY*			0	0		
15. 00   PHYSI CIAN ADMINISTRATIVE SERVI CES* 0   14, 226   16. 00   16. 00   17.			0	220 596		
16. 00   OTHER GENRAL SERVICE*   0   0   16. 00   17. 00			0			
17. 00   PATI ENT/RESIDENTI AL CARE SERVI CES			1	14, 220		
DIRECT PATIENT CARE SERVICE COST CENTERS				O		
25.00   NPATIENT CARE-CONTRACTED**   0 0 0   26.00	17.00					17.00
26. 00	25 00			0		25 00
27.00   NURSE PRACTITIONER*   0   0   27.00			1		i e	1
28. 00   REGISTERED NURSE**   0   1,094,515   28. 00			1			
29. 00   DPN/LWN**			1			
30.00   PHYSICAL THERAPY**   0		I control of the cont	0		l .	
31.00   OCCUPATIONAL THERAPY**   0   0   0   32.00     32.00   SPECH/LANGUAGE PATHOLOGY**   0   0   0   0     32.00   SPECH/LANGUAGE PATHOLOGY**   0   0   0     33.00   MEDI CAL SCCI AL SERVI CES**   0   124, 214   33. 00     34.00   SPIRI TUAL COUNSELI NG**   0   0   0   35. 00     35.00   DI TARRY COUNSELI NG**   0   0   0   35. 00     36.00   COUNSELI NG - OTHER**   0   147, 313   36. 00     37.00   HOSPI CE AI DE & HOMEMAKER SERVI CES**   0   281, 320   37. 00     38.00   DATA LENDER LE MEDI CAL EQUI PMENT / OXYGEN**   0   0   1, 354   38. 00     39.00   PATI ENT TRANSPORTATI ON**   0   0   0   0     40.00   IMAGI NG SERVI CES**   0   0   0   0     41.00   LABS & DI AGNOSTI CS**   0   0   0   0     42.00   MEDI CAL SUPPLIES-NON-ROUTI NE**   0   0   0   0     43.00   OUTPATI ENT SERVI CES**   0   0   0   0     44.00   PALLI ATI VE CHEMOTHERAPY**   0   0   0   0     45.00   PALLI ATI VE CHEMOTHERAPY**   0   0   0   0     46.00   THER PATIENT CARE SERVI CES (SPECI FY) **   0   0   0     60.00   EGREAVEMENT PROGRAM *   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   CESTALLI ATI VE CARE PROGRAM*   0   0   0     60.00   THER PATISING*   0			0		l .	
32. 00   SPECH/LANGUAGE PATHOLOGY**   0 0 0   32. 00   33. 00   MEDI CAL SOCI AL SERVI CES**   0   124, 214   33. 00   33. 00   SPIRI TUAL COUNSELING**   0 0 0   34. 00   35. 00   DI ETARY COUNSELING**   0 0 0   35. 00   36. 00   COUNSELING - OTHER**   0 0 147, 313   36. 00   37. 00   HOSPICE AIDE & HOMEMAKER SERVI CES**   0 147, 313   36. 00   38. 00   DURABLE MEDI CAL EQUI PMENT/OXYGEN**   0 1,354   38. 00   39. 00   PATIENT TRANSPORTATI ON**   0 0   0   39. 00   40. 00   IMAGI NG SERVI CES**   0 0 0   40. 00   41. 00   LABS & DI AGNOSTI CS**   0 14,594   41. 00   42. 00   MEDI CAL SUPULIES-NON-ROUTI NE**   0 0 0   42. 00   43. 00   OUTPATIENT SERVI CES**   0 0 0   42. 00   44. 00   PALLI ATIVE RADIATI ON THERAPY**   0 0 0   42. 00   45. 00   PALLI ATIVE CHEMOTHERAPY**   0 0 0   45. 00   46. 00   OTHER PATIENT CARE SERVI CES (SPECI FY) **   0 551,620   60. 00   BEREAVEMENT PROGRAM   61. 00   61. 00   VOLUNTEER PROGRAM *   0 0 0   62. 00   FUNDRAI SI ING*   0 0   63. 00   64. 00   PALLI ATIVE CARE PROGRAM *   0 0 0   65. 00   OTHER PHYSI CIAN SERVI CES*   0 0 0   66. 00   OTHER PHYSI CIAN SERVI CES*   0 0 0   66. 00   OTHER PHYSI CIAN SERVI CES*   0 0 0   66. 00   OTHER PHYSI CIAN SERVI CES*   0 0 0   66. 00   OTHER PHYSI CIAN SERVI CES*   0 0 0   66. 00   OTHER PHYSI CIAN SERVI CES*   0 0 0   66. 00   OTHER PHYSI CIAN SERVI CES*   0 0 0   67. 00   OTHER PHYSI CIAN SERVI CES*   0 0 0   68. 00   TELEHEALTH/TELEMONI TORING*   0 0   69. 00   THRIFT STORE*   0 0 0 0   69. 00   THRIFT		A Company of the Comp	0		•	
33. 00 MEDI CAL SOCI AL SERVI CES** 0 124,214 3.00 SPIRI TUAL COUNSELING** 0 0 0 34. 00 35. 00 DI ETARY COUNSELING** 0 0 0 35. 00 0 DI ETARY COUNSELING** 0 0 0 35. 00 0 DI ETARY COUNSELING** 0 140, 0 0 35. 00 0 35. 00 DI ETARY COUNSELING** 0 147, 313 35. 00 DI ETARY COUNSELING* 0 147, 313 36. 00 37. 00 HOSPIC EA IDE & HOMEMAKER SERVI CES** 0 281, 320 37. 00 HOSPIC EA IDE & HOMEMAKER SERVI CES** 0 1, 354 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 1, 354 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 39. 00 PATI ENT TRANSPORTATI ON** 0 0 0 39. 00 40. 00 1 MAGI NG SERVI CES** 0 0 0 0 4, 594 41. 00 LABS & DI AGNOSTI CS** 0 0 0 4, 594 41. 00 LABS & DI AGNOSTI CS** 0 0 0 4, 594 41. 00 LABS & DI AGNOSTI CS** 0 0 0 4, 594 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 44. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 44. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 44. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 0 45. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0		1
34. 00 35. 00 DI ETARY COUNSELING** 0 0 10 147, 313 35. 00 37. 00 HOSPICE AI DE & HOMEMAKER SERVICES** 0 147, 313 35. 00 37. 00 HOSPICE AI DE & HOMEMAKER SERVICES** 0 1, 354 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 1, 354 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 1, 354 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 1, 354 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		All control of the co	0	0		
35. 00 DI ETARY COUNSELING** 0 0 0 0 35. 00 36. 00 COUNSELING** 0 147, 313 313 35. 00 36. 00 COUNSELING - OTHER** 0 147, 313 313 36. 00 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 281, 320 37. 00 39. 00 PATI ENT TRANSPORTATI ON** 0 0 0 4.354 38. 00 39. 00 PATI ENT TRANSPORTATI ON** 0 0 0 4.00 1 MAGI NG SERVI CES** 0 0 0 0 4.00 1 MAGI NG SERVI CES** 0 0 0 0 4.00 1 MAGI NG SERVI CES** 0 0 0 0 4.00 1 MAGI NG SERVI CES** 0 0 0 0 4.20 00 10 1 MAGI NG SERVI CES** 0 0 0 0 4.30 00 10 17 PATI ENT SERVI CES** 0 0 0 0 4.30 00 10 17 PATI ENT SERVI CES** 0 0 0 0 4.30 00 10 17 PATI ENT SERVI CES** 0 0 0 0 4.30 00 10 14 10 10 10 10 10 10 10 10 10 10 10 10 10	33. 00	MEDICAL SOCIAL SERVICES**	0	124, 214		33. 00
36. 00 COUNSELING - OTHER**  37. 00 HOSPICE AI DE & HOMEMAKER SERVI CES**  0	34.00	SPI RI TUAL COUNSELI NG**	0	0		
37. 00 HOSPICE AIDE & HOMEMAKER SERVICES** 0 281, 320 33. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN** 0 1, 354 38. 00 49. 00 HAGNIE MEDI CAL EQUI PMENT/OXYGEN** 0 0 0 0 39. 00 40. 00 IMAGI NG SERVI CES** 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS** 0 0 4, 594 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE** 0 0 0 0 4, 594 42. 00 43. 00 OUTPATI ENT SERVI CES** 0 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 44. 00 45. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	35.00	DI ETARY COUNSELI NG**	0	0		35. 00
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN** 0 1,354 38. 00 39. 00 PATIENT TRANSPORTATION** 0 0 0 40. 00 IMAGING SERVICES** 0 0 0 41. 00 LABS & DIAGNOSTICS** 0 0 4,594 41. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE** 0 0 0 43. 00 OUTHATIENT SERVICES** 0 0 0 44. 00 PALLIATIVE RADIATION THERAPY** 0 0 0 45. 00 PALLIATIVE CHEMOTHERAPY** 0 0 0 46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 551,620 46. 00 61. 00 ONNEIMBURSABLE COST CENTERS 60. 00 BEREAVEMENT PROGRAM * 0 0 0 61. 00 VOLUNTEER PROGRAM * 0 0 0 62. 00 FUNDRAI SING* 0 0 0 63. 00 HOSPICE/PALLIATIVE MEDICINE FELLOWS* 0 0 0 64. 00 PALLIATIVE CARE PROGRAM* 0 0 0 0 65. 00 OTHER PHYSICIAN SERVICES* 0 0 0 0 66. 00 OTHER PHYSICIAN SERVICES* 0 0 0 0 67. 00 ADVERTISING* 0 0 0 0 68. 00 TELEHEALTH/TELEMONITORING* 0 0 0 69. 00 THRIFT STORE* 0 0 0 71. 00 OTHER NONREIMBURSABLE (SPECIFY)*	36.00	COUNSELING - OTHER**	0	147, 313		36. 00
39. 00 PATLENT TRANSPORTATION** 0 0 0 0 40. 00 1 MAGI NG SERVI CES** 0 0 0 0 45.594 41. 00 42. 00 MEDI CAL SUPPLIES-NON-ROUTI NE** 0 0 0 0 45.594 41. 00 42. 00 MEDI CAL SUPPLIES-NON-ROUTI NE** 0 0 0 0 44. 00 44. 00 PALLI ATI VE RADI ATI NO THERAPY** 0 0 0 0 44. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 0 0 46. 00 OTHER PATLENT CARE SERVI CES (SPECI FY) ** 0 551, 620 NONNEI MBURSABLE COST CENTERS	37.00	HOSPICE AIDE & HOMEMAKER SERVICES**	0	281, 320		37. 00
40. 00   IMAGI NG SERVI CES**	38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN**	o	1, 354		38. 00
40. 00   IMAGI NG SERVI CES**   0   0   0   41. 00   41. 00   LABS & DI AGNOSTI CS**   0   4,594   41. 00   42. 00   MEDI CAL SUPPLI ES-NON-ROUTI NE**   0   0   0   43. 00   OUTPATI ENT SERVI CES**   0   0   0   44. 00   PALLI ATI VE RADI ATI ON THERAPY**   0   0   0   45. 00   PALLI ATI VE CHEMOTHERAPY**   0   0   0   46. 00   OTHER PATIENT CARE SERVI CES (SPECI FY) **   0   551, 620   MONREI MBURSABLE COST CENTERS   60. 00   BEREAVEMENT PROGRAM *   0   0   0   61. 00   VOLUNTEER PROGRAM *   0   0   0   62. 00   FUNDRAI SI NG*   0   0   63. 00   HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS*   0   0   64. 00   PALLI ATI VE CARE PROGRAM*   0   0   0   65. 00   OTHER PHYSI CI AN SERVI CES*   0   0   66. 00   RESI DENTI AL CARE*   0   0   67. 00   ADVERTI SI NG*   0   0   68. 00   TELEHEALTH/TELEMONI TORI NG*   0   0   69. 00   THRI FT STORE*   0   0   71. 00   OTHER NONREI MBURSABLE (SPECI FY)*   0   71. 00   OTHER NONREI MBURSABLE (SPECI	39.00	PATI ENT TRANSPORTATION**	o	0		39. 00
41. 00	40.00	I MAGING SERVI CES**	o	0		
42. 00	41.00		0	4, 594		
43. 00			0	., 0 , .		
44. 00 PALLI ATI VE RADI ATI ON THERAPY** 0 0 0 0 45. 00 45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 551, 620  46. 00 OTHER PATI ENT CARE SERVI CES (SPECI FY) ** 0 551, 620  60. 00 BEREAVEMENT PROGRAM * 0 0 0 61. 00 61. 00 VOLUNTEER PROGRAM * 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 63. 00 64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 65. 00 65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 66. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 66. 00 67. 00 ADVERTI SI NG* 0 0 0 66. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 68. 00 69. 00 THER TSTORE* 0 0 0 0 68. 00 71. 00 OTHER NONREI MBURSABLE (SPECI FY)*			0	0		1
45. 00 PALLI ATI VE CHEMOTHERAPY** 0 0 551, 620 46. 00  THER PATI ENT CARE SERVI CES (SPECI FY)** 0 551, 620 46. 00  NONREI MBURSABLE COST CENTERS  60. 00 BERAVEMENT PROGRAM * 0 0 0 61. 00 61. 00 61. 00 62. 00 63. 00 FUNDRAI SI NG* 0 0 0 62. 00 63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 64. 00 65. 00 0 65. 00 0 66. 00 0 66. 00 66. 00 0 0 0						
46. 00 OTHER PATIENT CARE SERVICES (SPECIFY)** 0 551, 620  NONREI MBURSABLE COST CENTERS  60. 00 BEREAVEMENT PROGRAM * 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0						
NONREIMBURSABLE COST CENTERS				· ·	1	
60. 00   BEREAVEMENT PROGRAM *   0   0   0   0   0   0   0   0   0	40.00		١	331, 020	/	40.00
61. 00	40.00			0		40.00
62. 00			1			
63. 00 HOSPI CE/PALLI ATI VE MEDI CI NE FELLOWS* 0 0 0 0 64. 00 65. 00 66. 00 0 0 0 0 65. 00 66. 00 66. 00 66. 00 66. 00 66. 00 66. 00 67. 00 68. 00 67. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			1		i e	
64. 00 PALLI ATI VE CARE PROGRAM* 0 0 0 0 65. 00 65. 00 66. 00 RESI DENTI AL CARE* 0 0 0 0 66. 00 67. 00 68. 00 67. 00 0 68. 00 67. 00 0 68. 00 67. 00 0 68. 00 67. 00 0 68. 00 67. 00 0 68. 00 0 69. 00 0 68. 00 67. 00 0 0 68. 00 67. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0		i	1
65. 00 OTHER PHYSI CI AN SERVI CES* 0 0 0 66. 00 67. 00 68. 00 67. 00 ADVERTI SI NG* 0 0 0 68. 00 67. 00 69. 00 67. 00 0 68. 00 67. 00 0 68. 00 67. 00 0 68. 00 67. 00 0 68. 00 67. 00 0 68. 00 0 68. 00 69. 00 70. 00 NURSI NG FACI LI TY ROOM & BOARD* 0 0 0 THER NONREI MBURSABLE (SPECI FY)* 0 0 0 0 71. 00			0			
66. 00 RESI DENTI AL CARE* 0 0 0 0 67. 00 68. 00 67. 00 68. 00 TELEHEALTH/TELEMONI TORI NG* 0 0 0 68. 00 69. 00 THRI FT STORE* 0 0 0 0 69. 00 70. 00 NURSI NG FACILI TY ROOM & BOARD* 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0			
67. 00			0		•	1
68. 00   TELEHEALTH/TELEMONI TORI NG*		I control of the cont	0			
69. 00		All control of the co	0			
70.00   NURSING FACILITY ROOM & BOARD*			0	0	)	
71.00 OTHER NONREIMBURSABLE (SPECIFY)* 0 0 71.00	69. 00	THRI FT STORE*	0	0		69. 00
	70.00	NURSING FACILITY ROOM & BOARD*	0	0		70.00
100. 00 TOTAL 0 4, 102, 444 100. 00			0	0		71. 00
	100.00	TOTAL	0	4, 102, 444		100.00

<sup>\*</sup> Transfer the amounts in column 7 to Wkst. 0-5, column 1, line as appropriate.
\*\* See instructions. Do not transfer the amounts in column 7 to Wkst. 0-5.

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE CONTINUOUS Provider CO Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 5/23/2017 10: 42 am Provider CCN: 15-0051 HOME CARE Hospi ce CCN: 15-1509

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1. 00	2.00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	INPATIENT CARE-CONTRACTED						25. 00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27.00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28.00	REGI STERED NURSE	0	0	0	0	0	28. 00
29. 00	LPN/LVN	0	0	0	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30.00
31.00	OCCUPATI ONAL THERAPY	O	0	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	o	0	0	0	0	32.00
33.00	MEDICAL SOCIAL SERVICES	o	0	0	0	0	33. 00
34.00	SPIRITUAL COUNSELING	o	0	0	0	0	34.00
35.00	DI ETARY COUNSELI NG	o	0	0	0	0	35. 00
36.00	COUNSELING - OTHER	o	0	0	0	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	o	0	0	0	0	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	o	0	0	0	0	38. 00
39.00	PATIENT TRANSPORTATION	o	0	0	O	0	39. 00
40.00	I MAGING SERVICES	o	0	0	o	0	40. 00
41.00	LABS & DIAGNOSTICS	o	0	0	o	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	o	0	0	0	0	42. 00
43.00	OUTPATIENT SERVICES	o	0	0	0	0	43. 00
44.00	PALLIATIVE RADIATION THERAPY	o	0	0	0	0	44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	o	0	0	o	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	o	0	0	0	0	46. 00
	TOTAL *	0	0	0	0	0	100. 00
* Tran	sfor the amount in column 7 to Wkst 0-5 col	umn 1 line 50					

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

		ADJUSTMENTS	TOTAL (col. 5	
			± col. 6)	
		6.00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS			
25. 00	INPATIENT CARE-CONTRACTED			25. 00
26. 00	PHYSI CI AN SERVI CES	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	0	27. 00
28. 00	REGI STERED NURSE	0	0	28. 00
29. 00	LPN/LVN	0	0	29. 00
30.00	PHYSI CAL THERAPY	0	0	30.00
31. 00	OCCUPATIONAL THERAPY	0	0	31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	0	32.00
33. 00	MEDICAL SOCIAL SERVICES	0	0	33. 00
34.00	SPI RI TUAL COUNSELI NG	0	0	34.00
35. 00	DI ETARY COUNSELI NG	0	0	35.00
36. 00	COUNSELING - OTHER	0	0	36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES	0	0	37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	0	38. 00
39. 00	PATIENT TRANSPORTATION	0	0	39. 00
40.00	I MAGI NG SERVI CES	0	0	40.00
41. 00	LABS & DIAGNOSTICS	0	0	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	42.00
43.00	OUTPATI ENT SERVI CES	0	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	0	0	44. 00
45.00	PALLIATIVE CHEMOTHERAPY	0	0	45.00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	46.00
100.00	TOTAL *	0	0	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 50.

Health Financial Systems IU HEALTH BLOOMINGTON HOSPITAL ANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE ROUTINE HOME Provider CO Peri od: From 01/01/2016 To 12/31/2016 Date/Ti me Prepared: 5/23/2017 10: 42 am Provider CCN: 15-0051 CARE Hospi ce CCN: 15-1509

SALARIES   OTHER   SUBTOTAL (col.   RECLASIFI - CATIONS						Hospi ce I		
DIRECT PATIENT CARE SERVICE COST CENTERS			SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
DIRECT PATIENT CARE SERVICE COST CENTERS					1 + col . 2)	CATI ONS		
25. 00   INPATI ENT CARE-CONTRACTED   25. 00   26. 00   26. 00   26. 00   27. 00   27. 00   28. 00   29. 00			1.00	2. 00	3. 00	4. 00	5. 00	
26. 00       PHYSI CI AN SERVI CES       0       0       0       0       0       26. 00         27. 00       NURSE PRACTI TI ONER       0       0       0       0       0       27. 00         28. 00       REGI STERED NURSE       634, 891       0       634, 891       0       634, 891       0       634, 891       0       634, 891       0       634, 891       0       634, 891       0       634, 891       0       634, 891       0       634, 891       0       634, 891       0       634, 891       0       634, 891       0       634, 891       0       634, 891       0       634, 891       0       634, 891       0       224, 229       0       224, 229       0       224, 229       0       224, 229       0       224, 229       0       32.00       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0       0 <td></td> <td>DIRECT PATIENT CARE SERVICE COST CENTERS</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>		DIRECT PATIENT CARE SERVICE COST CENTERS						
27. 00       NURSE PRACTITIONER       0       0       0       0       27. 00         28. 00       REGI STERED NURSE       634, 891       0       634, 891       0       634, 891       28. 00         29. 00       LPN/LVN       224, 229       0       224, 229       0       224, 229       0       224, 229       0       224, 229       0       20. 0       0	25.00	INPATIENT CARE-CONTRACTED						25. 00
28. 00 REGI STERED NURSE 634, 891 0 634, 891 0 634, 891 28. 00 29. 00 LPN/LVN 224, 229 0 224, 229 0 224, 229 0 224, 229 29. 00 30. 00 PHYSI CAL THERAPY 0 0 0 0 0 0 0 30. 00 31. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
29. 00 LPN/LVN	27.00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
30. 00 PHYSI CAL THERAPY 0 0 0 0 0 0 0 30. 00 31. 00 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 124, 214 0 124, 214 0 124, 214 0 124, 214 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 0 0 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 0 0 0 35. 00 36. 00 COUNSELI NG 0 0 0 0 0 147, 313 0 147, 313 0 147, 313 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 271, 609 0 271, 609 0 271, 609 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 1, 354 1, 354 0 1, 354 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	28.00	REGI STERED NURSE	634, 891	0	634, 891	0	634, 891	28. 00
31. 00 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 31. 00 32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 124, 214 0 124, 214 0 124, 214 0 124, 214 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 0 0 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 0 0 0 34. 00 36. 00 COUNSELI NG 0 0 0 0 0 147, 313 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 271, 609 0 271, 609 0 271, 609 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 1, 354 1, 354 0 1, 354 0 1, 354 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 0 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	29.00	LPN/LVN	224, 229	0	224, 229	0	224, 229	29. 00
32. 00 SPEECH/LANGUAGE PATHOLOGY 0 0 0 0 0 32. 00 33. 00 MEDI CAL SOCI AL SERVI CES 124, 214 0 124, 214 0 124, 214 0 124, 214 0 124, 214 33. 00 34. 00 SPI RI TUAL COUNSELI NG 0 0 0 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 0 0 0 0 35. 00 36. 00 COUNSELI NG 0 0 147, 313 0 147, 313 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 271, 609 0 271, 609 0 271, 609 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 1, 354 1, 354 0 1, 354 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 0 0 39. 00 40. 00 IMAGI NG SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30.00	PHYSI CAL THERAPY	0	0	0	0	0	30.00
33. 00 MEDI CAL SOCI AL SERVI CES 124, 214 0 124, 214 0 0 34. 00 34. 00 SPIRI TUAL COUNSELI NG 0 0 0 0 0 0 34. 00 35. 00 DI ETARY COUNSELI NG 0 0 0 0 0 0 35. 00 36. 00 COUNSELI NG - OTHER 147, 313 0 147, 313 0 147, 313 0 147, 313 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 271, 609 0 271, 609 0 271, 609 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 1, 354 1, 354 0 1, 354 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 0 39. 00 40. 00 IMAGI NG SERVI CES 0 0 0 0 0 0 0 0 0 0 0. 41. 00 LABS & DI AGNOSTI CS 0 1, 910 1, 910 1, 910 0 0 0 0 0 0 0 0. 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 0 0 0 0 0 0. 43. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0. 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0.	31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00
34. 00 SPIRITUAL COUNSELING 0 0 0 0 0 0 34. 00 35. 00 DI ETARY COUNSELING 0 0 0 0 0 0 35. 00 36. 00 COUNSELING - OTHER 147, 313 0 147, 313 0 147, 313 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 271, 609 0 271, 609 0 271, 609 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 1, 354 1, 354 0 1, 354 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 0 0 39. 00 40. 00 IMAGI NG SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
35. 00 DI ETARY COUNSELING 0 0 0 0 0 35. 00 36. 00 COUNSELING - OTHER 147, 313 0 147, 313 0 147, 313 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 271, 609 0 271, 609 0 271, 609 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 1, 354 1, 354 0 1, 354 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 0 39. 00 40. 00 IMAGI NG SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	33.00	MEDICAL SOCIAL SERVICES	124, 214	0	124, 214	0	124, 214	33. 00
36. 00 COUNSELING - OTHER 147, 313 0 147, 313 0 147, 313 36. 00 37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 271, 609 0 271, 609 0 271, 609 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 1, 354 1, 354 0 1, 354 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 0 39. 00 40. 00 IMAGI NG SERVI CES 0 0 0 0 0 0 0 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 1, 910 1, 910 0 1, 910 0 1, 910 42. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 0 0 42. 00 43. 00 OUTPATI ENT SERVI CES 0 0 0 0 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 0 0 0 0 44. 00	34.00	SPIRITUAL COUNSELING	o	0	0	o	0	34.00
37. 00 HOSPI CE AI DE & HOMEMAKER SERVI CES 271, 609 0 271, 609 0 271, 609 37. 00 38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 1, 354 1, 354 0 1, 354 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	35.00	DI ETARY COUNSELI NG	o	0	0	o	0	35. 00
38. 00 DURABLE MEDI CAL EQUI PMENT/OXYGEN 0 1, 354 1, 354 0 1, 354 38. 00 39. 00 PATI ENT TRANSPORTATI ON 0 0 0 0 0 39. 00 40. 00 I MAGI NG SERVI CES 0 0 0 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTI CS 0 1, 910 1, 910 0 1, 910 41. 00 42. 00 MEDI CAL SUPPLI ES-NON-ROUTI NE 0 0 0 0 0 0 43. 00 44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 0 0 0 44. 00	36.00	COUNSELING - OTHER	147, 313	0	147, 313	o	147, 313	36. 00
39. 00 PATIENT TRANSPORTATION 0 0 0 0 0 39. 00 40. 00 IMAGING SERVICES 0 0 0 0 0 0 40. 00 41. 00 LABS & DI AGNOSTICS 0 1, 910 1, 910 0 1, 910 41. 00 42. 00 MEDICAL SUPPLIES-NON-ROUTINE 0 0 0 0 0 0 42. 00 43. 00 OUTPATIENT SERVICES 0 0 0 0 0 0 43. 00 44. 00 PALLIATIVE RADIATION THERAPY 0 0 0 0 0 0 44. 00	37.00	HOSPICE AIDE & HOMEMAKER SERVICES	271, 609	0	271, 609	0	271, 609	37.00
40. 00       I MAGI NG SERVI CES       0       0       0       0       40. 00         41. 00       LABS & DI AGNOSTI CS       0       1, 910       1, 910       0       1, 910       41. 00         42. 00       MEDI CAL SUPPLI ES-NON-ROUTI NE       0       0       0       0       0       0       42. 00         43. 00       OUTPATI ENT SERVI CES       0       0       0       0       0       43. 00         44. 00       PALLI ATI VE RADI ATI ON THERAPY       0       0       0       0       0       44. 00	38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	0	1, 354	1, 354	0	1, 354	38. 00
41. 00       LABS & DI AGNOSTI CS       0       1, 910       1, 910       0       1, 910       41. 00         42. 00       MEDI CAL SUPPLI ES-NON-ROUTI NE       0       0       0       0       0       42. 00         43. 00       OUTPATI ENT SERVI CES       0       0       0       0       0       43. 00         44. 00       PALLI ATI VE RADI ATI ON THERAPY       0       0       0       0       0       44. 00	39.00	PATIENT TRANSPORTATION	o	0	0	o	0	39. 00
42. 00       MEDI CAL SUPPLI ES-NON-ROUTI NE       0       0       0       0       42. 00         43. 00       OUTPATI ENT SERVI CES       0       0       0       0       0       43. 00         44. 00       PALLI ATI VE RADI ATI ON THERAPY       0       0       0       0       0       44. 00	40.00	I MAGING SERVICES	0	0	0	0	0	40.00
43. 00   OUTPATIENT SERVICES   0 0 0 0 0 43. 00 44. 00   PALLIATIVE RADIATION THERAPY   0 0 0 0 0 44. 00	41.00	LABS & DIAGNOSTICS	0	1, 910	1, 910	0	1, 910	41.00
44. 00 PALLI ATI VE RADI ATI ON THERAPY 0 0 0 0 44. 00	42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0	0	0	0	42.00
	43.00	OUTPATIENT SERVICES	o	0	0	o	0	43.00
45. 00 PALLI ATI VE CHEMOTHERAPY 0 0 0 0 45. 00	44.00	PALLIATIVE RADIATION THERAPY	0	0	0	0	0	44.00
	45.00	PALLI ATI VE CHEMOTHERAPY	0	0	0	0	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY) 113, 725 437, 895 551, 620 0 551, 620 46.00	46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	113, 725	437, 895	551, 620	o	551, 620	46. 00
100. 00 TOTAL * 1, 515, 981 441, 159 1, 957, 140 0 1, 957, 140 100. 00	100.00	TOTAL *	1, 515, 981	441, 159	1, 957, 140	0	1, 957, 140	100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

		ADJUSTMENTS	TOTAL (col. 5	
		ADSOSTWENTS	± col. 6)	
		6. 00	7.00	
	DIRECT PATIENT CARE SERVICE COST CENTERS	0.00	7.00	
25.00	I NPATI ENT CARE-CONTRACTED			25.00
26.00	PHYSI CI AN SERVI CES	C	ol	26.00
27.00	NURSE PRACTITIONER	C	ol	27.00
28.00	REGI STERED NURSE	C	634, 891	28.00
29.00	LPN/LVN	C	224, 229	29.00
30.00	PHYSI CAL THERAPY	C	o	30.00
31.00	OCCUPATIONAL THERAPY	C	o	31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	C	0	32.00
33.00	MEDICAL SOCIAL SERVICES	C	124, 214	33.00
34.00	SPIRITUAL COUNSELING	C	0	34.00
35.00	DI ETARY COUNSELI NG	C	o	35.00
36.00	COUNSELING - OTHER	C	147, 313	36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	C	271, 609	37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN	C	1, 354	38.00
39.00	PATI ENT TRANSPORTATION	C	0	39.00
40.00	I MAGING SERVICES	C	0	40.00
41.00	LABS & DIAGNOSTICS	C	1, 910	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	C	0	42.00
43.00	OUTPATIENT SERVICES	C	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	C	0	44.00
45.00	PALLIATIVE CHEMOTHERAPY	C	o	45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	C	551, 620	46.00
100.00	TOTAL *	C	1, 957, 140	100.00

 $<sup>^{\</sup>star}$  Transfer the amount in column 7 to Wkst. 0-5, column 1, line 51.

RESPITE CARE

Provider CCN: 15-0051 Hospi ce CCN: 15-1509 Peri od: Worksheet 0-3 From 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/23/2017 10:42 am

				Hospi ce I		
	SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
	JALAKI LS	UTILK	1 + col . 2)	CATIONS	SUBTUTAL	
	1.00	2.00	3.00	4. 00	5. 00	
DIRECT PATIENT CARE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	3.00	
25. 00 INPATIENT CARE-CONTRACTED	n	0	0	0	0	25. 00
26. 00 PHYSI CI AN SERVI CES		0	0	0	0	26. 00
27. 00 NURSE PRACTITIONER		0	0	0	0	27. 00
28. 00 REGI STERED NURSE	98, 649	0	98, 649	0	98, 649	28. 00
29. 00 LPN/LVN	5, 126	0	5, 126	0	5, 126	
30. 00 PHYSI CAL THERAPY	0, 120	0	0, 120	0	0, 120	30.00
31. 00 OCCUPATIONAL THERAPY	o o	0	0	0	0	31.00
32. 00 SPEECH/LANGUAGE PATHOLOGY		0	0	0	0	32. 00
33. 00 MEDI CAL SOCI AL SERVI CES	0	0	0	0	0	33. 00
34. 00   SPIRITUAL COUNSELING		0	0	0	0	34.00
35. 00 DI ETARY COUNSELING	0	0	0	0	0	35. 00
36. 00 COUNSELING - OTHER	0	0	0	0	0	36. 00
37. 00 HOSPICE AIDE & HOMEMAKER SERVICES	2, 084	0	2, 084	0	2, 084	
38. 00 DURABLE MEDICAL EQUIPMENT/OXYGEN	_,,	_	_,		=,	38. 00
39. 00 PATIENT TRANSPORTATION	o	0	0	0	0	39. 00
40. 00 I MAGI NG SERVI CES	o	0	0	0	0	40.00
41.00 LABS & DIAGNOSTICS	o	0	0	0	0	41.00
42. 00 MEDICAL SUPPLIES-NON-ROUTINE	o	0	0	0	0	42.00
43. 00 OUTPATIENT SERVICES	0	0	0	0	0	43.00
44.00 PALLIATIVE RADIATION THERAPY	0	0	0	o	0	44.00
45.00 PALLIATIVE CHEMOTHERAPY	0	0	0	O	0	45. 00
46.00 OTHER PATIENT CARE SERVICES (SPECIFY)	0	0	0	o	0	46. 00
100. 00 TOTAL *	105, 859	0	105, 859	0	105, 859	100.00
			•			

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6.00	7. 00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25.00	I NPATI ENT CARE-CONTRACTED	0	0		25.00
26.00	PHYSI CI AN SERVI CES	0	0		26.00
27.00	NURSE PRACTITIONER	0	0		27.00
28.00	REGI STERED NURSE	0	98, 649		28. 00
29.00	LPN/LVN	0	5, 126		29. 00
30.00	PHYSI CAL THERAPY	0	0		30.00
31.00	OCCUPATI ONAL THERAPY	0	0		31.00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33.00	MEDICAL SOCIAL SERVICES	0	0		33.00
34.00	SPIRITUAL COUNSELING	0	0		34.00
35.00	DI ETARY COUNSELING	0	0		35.00
36.00	COUNSELING - OTHER	0	0		36.00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	0	2, 084		37.00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38.00
39.00	PATIENT TRANSPORTATION	0	0		39.00
40.00	I MAGING SERVICES	0	0		40.00
41.00	LABS & DIAGNOSTICS	0	0		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATIENT SERVICES	0	0		43.00
44.00	PALLIATIVE RADIATION THERAPY	0	o		44.00
45.00	PALLI ATI VE CHEMOTHERAPY	0	o		45.00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	o		46.00
100.00	TOTAL *	0	105, 859		100.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 52.

Health Financial Systems IU HEALTH BANALYSIS OF HOSPITAL-BASED HOSPICE COSTS FOR HOSPICE GENERAL Provider CCN: 15-0051 Peri od: Worksheet 0-4 From 01/01/2016 To 12/31/2016 INPATIENT CARE Date/Time Prepared: 5/23/2017 10:42 am Hospi ce CCN: 15-1509

					Hospi ce I		
		SALARI ES	OTHER	SUBTOTAL (col.	RECLASSIFI -	SUBTOTAL	
				1 + col . 2)	CATI ONS		
		1.00	2.00	3. 00	4. 00	5. 00	
	DIRECT PATIENT CARE SERVICE COST CENTERS						
25.00	I NPATIENT CARE-CONTRACTED	0	0	0	0	0	20.00
26.00	PHYSI CI AN SERVI CES	0	0	0	0	0	26. 00
27. 00	NURSE PRACTITIONER	0	0	0	0	0	27. 00
28. 00	REGI STERED NURSE	360, 975	0	360, 975	0	360, 975	28. 00
29.00	LPN/LVN	18, 754	0	18, 754	0	18, 754	29. 00
30.00	PHYSI CAL THERAPY	0	0	0	0	0	30. 00
31.00	OCCUPATI ONAL THERAPY	0	0	0	0	0	31. 00
32.00	SPEECH/LANGUAGE PATHOLOGY	0	0	0	0	0	32. 00
33.00	MEDICAL SOCIAL SERVICES	o	0	0	0	0	33. 00
34.00	SPIRITUAL COUNSELING	o	0	0	o	0	34.00
35.00	DI ETARY COUNSELI NG	o	0	0	o	0	35. 00
36.00	COUNSELING - OTHER	o	0	0	o	0	36. 00
37.00	HOSPICE AIDE & HOMEMAKER SERVICES	7, 627	0	7, 627	o	7, 627	37. 00
38.00	DURABLE MEDICAL EQUIPMENT/OXYGEN						38. 00
39.00	PATIENT TRANSPORTATION	o	0	0	o	0	39. 00
40.00	I MAGI NG SERVI CES	o	0	0	o	0	40.00
41.00	LABS & DIAGNOSTICS	o	2, 684	2, 684	o	2, 684	41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	o	0	0	o	0	42.00
43.00	OUTPATIENT SERVICES	l ol	0	0	o	0	43.00
44.00	PALLIATIVE RADIATION THERAPY	o	0	0	o	0	44. 00
45.00	PALLI ATI VE CHEMOTHERAPY	o	0	0	o	0	45. 00
46.00	OTHER PATIENT CARE SERVICES (SPECIFY)	o	0	0	o	0	46. 00
	TOTAL *	387, 356	2, 684	390, 040	o	390, 040	100. 00
+ T	-6 th	1 1: 52			•		

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

		ADJUSTMENTS	TOTAL (col. 5		
			± col. 6)		
		6.00	7. 00		
	DIRECT PATIENT CARE SERVICE COST CENTERS				
25. 00	INPATIENT CARE-CONTRACTED	0	0		25.00
26. 00	PHYSI CI AN SERVI CES	0	0		26.00
27. 00	NURSE PRACTITIONER	0	0		27.00
28. 00	REGI STERED NURSE	0	360, 975		28. 00
29. 00	LPN/LVN	0	18, 754		29. 00
30. 00	PHYSI CAL THERAPY	0	0		30.00
31. 00	OCCUPATI ONAL THERAPY	0	0		31.00
32. 00	SPEECH/LANGUAGE PATHOLOGY	0	0		32.00
33. 00	MEDICAL SOCIAL SERVICES	0	0		33.00
34. 00	SPI RI TUAL COUNSELI NG	0	0		34.00
35. 00	DI ETARY COUNSELI NG	0	0		35.00
36. 00	COUNSELING - OTHER	0	0		36.00
37. 00	HOSPICE AIDE & HOMEMAKER SERVICES	0	7, 627		37.00
38. 00	DURABLE MEDICAL EQUIPMENT/OXYGEN				38. 00
39. 00	PATI ENT TRANSPORTATION	0	0		39. 00
40. 00	I MAGING SERVICES	0	0		40.00
41. 00	LABS & DIAGNOSTICS	0	2, 684		41.00
42.00	MEDICAL SUPPLIES-NON-ROUTINE	0	0		42.00
43.00	OUTPATI ENT SERVI CES	0	0		43.00
44. 00	PALLIATIVE RADIATION THERAPY	0	0		44.00
45. 00	PALLIATIVE CHEMOTHERAPY	0	0		45.00
46. 00	OTHER PATIENT CARE SERVICES (SPECIFY)	0	0		46.00
100.00	TOTAL *	0	390, 040	11	00.00

<sup>\*</sup> Transfer the amount in column 7 to Wkst. 0-5, column 1, line 53.

Heal th	Financial Systems IU HEALTH BLOOMIN	GTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	LLOCATION - DETERMINATION OF HOSPITAL-BASED HOSPICE NET	Provider C	CN: 15-0051	Peri od:	Worksheet 0-5	
EXPENS	ES FOR ALLOCATION	Hospi ce CCI		From 01/01/2016 To 12/31/2016	Date/Time Prep 5/23/2017 10:4	
				Hospi ce I		
	Descriptions		HOSPICE DIREC	T GENERAL	TOTAL EXPENSES	
			EXPENSES (see		(sum of cols.	
			instructions)	EXPENSES FROM	1 + 2)	
				WKST B PART I		
				(see		
				instructions)		
			1.00	2. 00	3. 00	
	GENERAL SERVICE COST CENTERS					
1.00	CAP REL COSTS-BLDG & FIXT		287, 05		375, 462	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP		17, 56	· ·	59, 609	2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT		692, 54	· ·	1, 222, 654	3. 00
4.00	ADMINISTRATIVE & GENERAL		244, 86	7 1, 166, 162	1, 411, 029	4. 00
5.00	PLANT OPERATION & MAINTENANCE		24, 54	4 116, 344	140, 888	5. 00
6.00	LAUNDRY & LINEN SERVICE			0	0	6.00
7.00	HOUSEKEEPI NG		2, 20	42, 919	45, 119	7.00
8.00	DI ETARY		18, 13	0	18, 130	8. 00
9.00	NURSI NG ADMI NI STRATI ON			320, 549	320, 549	9. 00
10.00	ROUTINE MEDICAL SUPPLIES		110, 41	9 0	110, 419	10.00
11. 00	MEDI CAL RECORDS			13, 460	13, 460	11.00
12.00	STAFF TRANSPORTATION		17, 27	1	17, 271	12.00
13.00	VOLUNTEER SERVICE COORDINATION			O	0	13.00
14.00	PHARMACY		220, 59	6 0	220, 596	14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES		14, 22	6	14, 226	15. 00
16.00	OTHER GENERAL SERVICE			0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES			0	0	17. 00
	LEVEL OF CARE			•		
50.00	HOSPI CE CONTI NUOUS HOME CARE			O	0	50.00
E4 00	HOODI OF DOUTING HOME OADE		4 057 44	ام	4 057 440	F4 00

1, 957, 140

105, 859

390, 040

0

2, 320, 007

4, 102, 444

51.00

52.00

53.00

61.00

62.00 0

63.00

64.00

65.00

67.00

68.00

69. 00

70.00

99.00

1, 957, 140

105, 859

390, 040

0 60.00

0

0 66.00

0

0

0

0 71.00

6, 422, 451 100. 00

51.00

52.00

53.00

60.00

61.00

62.00

63.00

64.00

65.00

66.00

67.00

68.00

69.00

71.00

100.00 TOTAL

HOSPICE ROUTINE HOME CARE

BEREAVEMENT PROGRAM

PALLIATIVE CARE PROGRAM

OTHER PHYSICIAN SERVICES

TELEHEALTH/TELEMONI TORI NG

OTHER NONREIMBURSABLE (SPECIFY)

70.00 NURSING FACILITY ROOM & BOARD

VOLUNTEER PROGRAM

RESIDENTIAL CARE

FUNDRAI SI NG

ADVERTI SI NG

THRIFT STORE

99.00 NEGATIVE COST CENTER

HOSPICE INPATIENT RESPITE CARE

HOSPICE GENERAL INPATIENT CARE NONREIMBURSABLE COST CENTERS

HOSPICE/PALLIATIVE MEDICINE FELLOWS

Hear th	Financiai Systems i	O HEALTH BLOOMIN	IGTUN HUSPITAL		in Lie	U OF FORM CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SE	RVICE COSTS	Provi der Co		Peri od:	Worksheet 0-6	
					From 01/01/2016	Part I	
			Hospi ce CCI	N: 15-1509	To 12/31/2016	Date/Time Pre	pared:
					Hospi ce I	5/23/2017 10:	42 am
	Descriptions	TOTAL EXPENSES	AD DEL DIDC 0	CAD DEL MADLE		SUBTOTAL	
	Descriptions	TOTAL EXPENSES				SUBTUTAL	
			FIX	EQUI P	BENEFITS DEDARTMENT		
			4 00	0.00	DEPARTMENT	0.4	
	CENEDAL CEDALOF COCT CENTEDO	0	1. 00	2.00	3. 00	3A	
4 00	GENERAL SERVI CE COST CENTERS	0.75 4/0	0.75 4/0				4 00
1. 00	CAP REL COSTS-BLDG & FLXT	375, 462	375, 462				1. 00
2.00	CAP REL COSTS-MVBLE EQUIP	59, 609		59, 60			2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	1, 222, 654	0		0 1, 222, 654		3. 00
4.00	ADMINISTRATIVE & GENERAL	1, 411, 029	0		0 0	1, 411, 029	4.00
5.00	PLANT OPERATION & MAINTENANCE	140, 888	0		ol ol	140, 888	5. 00
6.00	LAUNDRY & LINEN SERVICE	0	0		ol ol	. 0	6. 00
7. 00	HOUSEKEEPI NG	45, 119	0		o o	45, 119	7. 00
8.00	DI ETARY	18, 130	0			18, 130	1
9. 00	NURSING ADMINISTRATION	320, 549	0			320, 549	1
		1	0				1
10.00	ROUTINE MEDICAL SUPPLIES	110, 419	ū		-1	110, 419	1
11. 00	MEDI CAL RECORDS	13, 460	0		0	13, 460	
12. 00	STAFF TRANSPORTATION	17, 271	0		0 0	17, 271	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	0	0		0	0	13. 00
14.00	PHARMACY	220, 596	0		0 0	220, 596	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	14, 226	0		0 0	14, 226	15. 00
16.00	OTHER GENERAL SERVICE	O	0		ol ol	0	16. 00
17.00	PATIENT/RESIDENTIAL CARE SERVICES		0		ol l	0	17. 00
	LEVEL OF CARE			•	'		1
50.00	HOSPI CE CONTI NUOUS HOME CARE	0			0	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	1, 957, 140			922, 519	2, 879, 659	1
52. 00	HOSPICE INPATIENT RESPITE CARE	105, 859	80, 557	12, 78			1
53. 00	HOSPICE GENERAL INPATIENT CARE	390, 040	294, 905			967, 482	1
33.00	NONREI MBURSABLE COST CENTERS	370, 040	274, 703	40, 02	0 233,717	707, 402	33.00
60. 00	BEREAVEMENT PROGRAM	0	0		0 0	0	60.00
61. 00			0			0	00.00
	VOLUNTEER PROGRAM	0	0			0	61.00
62.00	FUNDRAI SI NG	0	0		۳ <sub>ا</sub> ۳۱	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0	0		0 0	0	63. 00
64.00	PALLIATIVE CARE PROGRAM	0	0		0 0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0	0		0	0	65. 00
66.00	RESI DENTI AL CARE	0	0		0 0	0	66.00
67.00	ADVERTI SI NG	0	0		0 0	0	67.00
68.00	TELEHEALTH/TELEMONI TORI NG	O	0		ol ol	0	68. 00
69. 00	THRI FT STORE	O	0		ol ol	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD					0	70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)		Ω		0	0	71.00
99. 00	NEGATIVE COST CENTER		0			O	99.00
	TOTAL	6, 422, 451	375, 462	59, 60	9 1, 222, 654	6, 422, 451	
100.00	710171	0, 422, 431	373,402	37,00	1, 222, 034	0, 722, 431	1.50.00

near th	Financiai Systems i	U HEALTH BLOOMI	NGTUN HUSPITAL		In Lie	U OT FORM CMS	2552-10
COST A	LLOCATION - HOSPITAL-BASED HOSPICE GENERAL SI	ERVICE COSTS	Provi der C		Peri od:	Worksheet 0-6	1
			Hospi ce CC		From 01/01/2016 To 12/31/2016	Part     Date/Time Pre	narodi
			Hospi ce cc	N: 15-1509	10 12/31/2016	5/23/2017 10:	pareu: 42 am
					Hospi ce I	072072017 10.	12 (111
	Descriptions Descriptions	ADMI NI STRATI VE	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	
	56661 1 p 11 6116	& GENERAL	OPERATION &	LINEN SERVICE		51217111	
			MAI NTENANCE				
		4.00	5. 00	6.00	7. 00	8. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL	1, 411, 029	•				4.00
5. 00	PLANT OPERATION & MAINTENANCE	39, 669	180, 557	,			5. 00
6. 00	LAUNDRY & LINEN SERVICE	0	0	•	0		6. 00
7. 00	HOUSEKEEPI NG	12, 704	Ö		57, 823		7. 00
8.00	DI ETARY	5, 105	Ö		0.7,020	23, 235	1
9. 00	NURSING ADMINISTRATION	90, 255	Ö		0	20, 200	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	31, 090	Ö		0		10.00
11. 00	MEDI CAL RECORDS	3, 790	0		0		11.00
12. 00	STAFF TRANSPORTATION	4, 863	0		0		12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	4,005			0		13. 00
14. 00	PHARMACY	62, 112	0		0		14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	4, 006			0		15. 00
16. 00	OTHER GENERAL SERVICE	4,000			0		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0			0		17. 00
17.00	LEVEL OF CARE	0		1	J		17.00
50. 00	HOSPICE CONTINUOUS HOME CARE	0					50.00
51. 00	HOSPICE ROUTINE HOME CARE	810, 802					51.00
52. 00	HOSPICE INPATIENT RESPITE CARE	74, 226	38, 739		12, 406	4, 987	
53. 00	HOSPICE GENERAL INPATIENT CARE	272, 407	141, 818		0 45, 417		1
55.00	NONREI MBURSABLE COST CENTERS	272,407	141,010	9	3 43,417	10, 240	33.00
60. 00	BEREAVEMENT PROGRAM	0	0		0		60.00
61. 00	VOLUNTEER PROGRAM	0		1	0		61.00
62. 00	FUNDRAI SI NG	0			0		62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0		63. 00
64. 00	PALLIATIVE CARE PROGRAM				0		64. 00
65. 00	OTHER PHYSICIAN SERVICES	0			0		65. 00
66. 00	RESI DENTI AL CARE	0		΄,	0	0	1
67. 00	ADVERTI SI NG	0		()	0	U	67.00
68. 00	1	0			0		
69. 00	TELEHEALTH/TELEMONI TORI NG   THRI FT STORE	0			0		68.00
		U		'	U		
70.00	NURSING FACILITY ROOM & BOARD OTHER NONREIMBURSABLE (SPECIFY)		_	,		_	70.00
71. 00				•	0	0	
99. 00	NEGATIVE COST CENTER	1 411 000	100 553	1	0 57, 823	0	
100.00	TOTAL	1, 411, 029	180, 557	1	J <sub>1</sub> 57, 823	23, 235	100. 00

Health Financial Systems	IU HEALTH BLOOMIN	GTON HOSPITAL	In L	ieu of Form CMS-2552-10
COCT ALLOCATION LICEDITAL	DACED HOODI OF OFNEDAL CEDIM OF COCTO	D 1 1 00N 4E 00E4	D : 1	W 1 1 0 6

Heal th	Financial Systems	IU HEALTH BLOOMING	GTON HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST A	ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL	SERVICE COSTS	Provi der Co		Peri od:	Worksheet 0-6	
			l		rom 01/01/2016	Part I	
			Hospi ce CCI	N: 15-1509	Γο 12/31/2016	Date/Time Pre 5/23/2017 10:	
					Hospi ce I	3/23/2017 10.	42 dili
	Descriptions	NURSI NG	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	
	20301 1 p t 1 0 113	ADMI NI STRATI ON	MEDI CAL	RECORDS	TRANSPORTATION	SERVI CE	
			SUPPLI ES			COORDI NATI ON	
		9.00	10.00	11. 00	12.00	13. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FIXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5. 00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6. 00
7. 00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8.00
9. 00	NURSI NG ADMI NI STRATI ON	410, 804					9. 00
10.00	ROUTINE MEDICAL SUPPLIES	110,004	141, 509				10.00
11. 00	MEDICAL RECORDS		141, 307	17, 25			11. 00
12. 00	STAFF TRANSPORTATION			17,25	22, 134		12.00
13. 00	VOLUNTEER SERVICE COORDINATION				22, 134	0	13. 00
14. 00	PHARMACY				0	0	14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES				0	0	15. 00
16. 00	OTHER GENERAL SERVICE				0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	٩			٩	Ü	17. 00
17.00	LEVEL OF CARE						17.00
50.00	HOSPICE CONTINUOUS HOME CARE	O	0		ol o	0	50. 00
51.00	HOSPICE ROUTINE HOME CARE	o o	131, 860			0	51. 00
52. 00	HOSPICE INPATIENT RESPITE CARE	88, 140	2, 071	25		0	52. 00
53. 00	HOSPICE GENERAL INPATIENT CARE	322, 664	7, 578	•		0	53. 00
33.00	NONREI MBURSABLE COST CENTERS	322,004	7, 370	72	1, 105	0	33.00
60. 00	BEREAVEMENT PROGRAM	O			O	0	60.00
61. 00	VOLUNTEER PROGRAM	o o			0	0	61.00
62. 00	FUNDRAI SI NG				0	0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS				0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM				0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES					0	65. 00
66. 00	RESI DENTI AL CARE					0	66. 00
67. 00	ADVERTI SI NG					0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG					0	68. 00
69. 00	THRI FT STORE					0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD					O	70.00
71.00	OTHER NONREIMBURSABLE (SPECIFY)				0	0	71.00
99. 00	NEGATIVE COST CENTER		0			0	99. 00
	TOTAL	410, 804	141, 509	17, 25	22, 134		100.00
100.00	7.0	110,004	111, 307	1 17, 23	22, 104	0	1.50.00

Hear th	Financiai Systems It	HEALTH BLOOMI	NGTON HUSPITAL		In Lie	eu of Form CMS	2552-10
COST A	COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL SERVICE COSTS				Peri od: From 01/01/2016	Worksheet 0-6 Part I	
			Hospi ce CC	N: 15-1509	To 12/31/2016	Date/Time Pre 5/23/2017 10:	epared: 42 am
					Hospi ce I		
	Descriptions	PHARMACY	PHYSI CI AN	OTHER GENERAL	L PATI ENT/	TOTAL	
			ADMI NI STRATI VE	SERVI CE	RESI DENTI AL		
			SERVI CES		CARE SERVICES		
		14. 00	15. 00	16. 00	17. 00	18. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSI NG ADMI NI STRATI ON						9. 00
10.00	ROUTINE MEDICAL SUPPLIES						10.00
11. 00	MEDI CAL RECORDS						11.00
12.00	STAFF TRANSPORTATION						12. 00
13.00	VOLUNTEER SERVICE COORDINATION						13.00
14.00	PHARMACY	282, 708					14.00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	0	18, 232				15. 00
16. 00	OTHER GENERAL SERVICE	0		1	0		16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE	<u>'</u>	•	•			
50.00	HOSPICE CONTINUOUS HOME CARE	0	C	)	0	0	50.00
51.00	HOSPICE ROUTINE HOME CARE	263, 432	16, 989		0	4, 139, 441	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	4, 137	267	·	0 0	489, 172	52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	15, 139	976	,	0 0	1, 793, 838	53.00
	NONREI MBURSABLE COST CENTERS		•	•			
60.00	BEREAVEMENT PROGRAM	0			0	0	60.00
61.00	VOLUNTEER PROGRAM	0			0	0	61.00
62.00	FUNDRAI SI NG	0			0	0	62.00
63.00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0			0	0	63.00
64.00	PALLIATIVE CARE PROGRAM	0			0	0	64.00
65. 00	OTHER PHYSICIAN SERVICES	0			0	0	65.00
66. 00	RESI DENTI AL CARE	0	1		0	0	66.00
67. 00	ADVERTI SI NG	0	_		0	0	67.00
68. 00	TELEHEALTH/TELEMONI TORI NG	0			0	0	1
69. 00	THRI FT STORE	0			0	0	69.00
70. 00	NURSING FACILITY ROOM & BOARD					0	1
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0			0	0	1
99. 00	NEGATI VE COST CENTER	1 0	1	•	0 0	l o	99.00
	TOTAL	282, 708	18, 232		0 0	6, 422, 451	
100.00	1.0=	202,700	10, 232	1	- <sub>1</sub> Ο <sub>1</sub>	5, 422, 431	1100.00

Health Financial Systems	IU HEALTH BLOOMINGTON HOSPITAL	_	In Lieu of Form CMS-2552-10		
COST ALLOCATION - HOSPITAL-BASED HOSPIC STATISTICAL BASIS	CE GENERAL SERVICE COSTS Provider C Hospice CC	CCN: 15-0051 CN: 15-1509	From 01/01/2016	Worksheet 0-6 Part II Date/Time Prepared:	

			Hospi ce CCN	: 15-1509 T	12/31/2016	Date/Time Pre 5/23/2017 10:	
					Hospi ce I	072072017 10.	12 (1111
	Cost Center Descriptions	CAP REL BLDG & C/ FIX (SQUARE FEET) (D	EQUI P	EMPLOYEE BENEFITS DEPARTMENT (GROSS	RECONCI LI ATI ON	ADMINISTRATIVE & GENERAL (ACCUMULATED COSTS)	
				SALARI ES)		000.0)	
		1.00	2.00	3. 00	4A	4. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT	4, 796					1. 00
2.00	CAP REL COSTS-MVBLE EQUIP		4, 796				2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT	0	0	2, 009, 195			3. 00
4.00	ADMI NI STRATI VE & GENERAL	0	0	0	-1, 411, 029	5, 011, 422	4.00
5.00	PLANT OPERATION & MAINTENANCE	0	0	0	0	140, 888	1
6.00	LAUNDRY & LI NEN SERVI CE HOUSEKEEPI NG	0	0	0	0	0 4F 110	6.00
7. 00 8. 00	DI ETARY		0	0	0	45, 119 18, 130	7. 00 8. 00
9. 00	NURSING ADMINISTRATION		0	0	0	320, 549	1
10. 00	ROUTINE MEDICAL SUPPLIES		0	0	0	110, 419	1
11. 00	MEDI CAL RECORDS		Ö	0	0	13, 460	
12. 00	STAFF TRANSPORTATION		Ö	0	Ö	17, 271	12. 00
13. 00	VOLUNTEER SERVICE COORDINATION	l ol	o	0	0	0	13. 00
14. 00	PHARMACY	O	o	0	0	220, 596	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0	0	0	0	14, 226	15. 00
16.00	OTHER GENERAL SERVICE	0	o	0	0	0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0	0		0	0	17. 00
	LEVEL OF CARE						
50.00	HOSPICE CONTINUOUS HOME CARE			0	0	0	00.00
51. 00	HOSPICE ROUTINE HOME CARE			1, 515, 981	0	2, 879, 659	
52. 00	HOSPICE INPATIENT RESPITE CARE	1, 029	1, 029	105, 858	0	263, 623	
53. 00	HOSPICE GENERAL INPATIENT CARE	3, 767	3, 767	387, 356	0	967, 482	53. 00
(0.00	NONREI MBURSABLE COST CENTERS		O	0	ما	0	/0.00
60. 00 61. 00	BEREAVEMENT PROGRAM VOLUNTEER PROGRAM	0	0	0	0	0	60. 00 61. 00
62.00	FUNDRAI SI NG		0	0	0	0	62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS		0	0	0	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM		0	0	0	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES	0	o	0	0	0	65. 00
66. 00	RESI DENTI AL CARE	o	o	0	O	0	66. 00
67. 00	ADVERTI SI NG	0	0	0	0	0	67. 00
68.00	TELEHEALTH/TELEMONI TORI NG	0	О	0	0	0	68. 00
69.00	THRI FT STORE	0	0	0	0	0	69. 00
70.00	NURSING FACILITY ROOM & BOARD				0		70. 00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	
99. 00	NEGATIVE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	375, 462	59, 609	1, 222, 654		1, 411, 029	
101. 00	UNIT COST MULTIPLIER	78. 286489	12. 428899	0. 608529		0. 281563	101.00

Health Financial Systems I	NGTON HOSPITAL		In Lie	u of Form CMS-2	2552-10	
COST ALLOCATION - HOSPITAL-BASED HOSPICE GENERAL S	ERVICE COSTS	Provi der CO	CN: 15-0051	Peri od:	Worksheet 0-6	
STATISTICAL BASIS				From 01/01/2016		
		Hospi ce CCI	N: 15-1509	To 12/31/2016		
					5/23/2017 10:	42 am_
				Hospi ce I		
Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
	OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMI NI STRATI ON	
	MAI NTENANCE	(IN-FACILITY		DAYS)		
	(SQUARE FEET)	DAYS)			(DIRECT NURS.	

					Hospi ce I		
	Cost Center Descriptions	PLANT	LAUNDRY &	HOUSEKEEPI NG	DI ETARY	NURSI NG	
		OPERATION &	LINEN SERVICE	(SQUARE FEET)	(IN-FACILITY	ADMI NI STRATI ON	
		MAI NTENANCE	(IN-FACILITY		DAYS)		
		(SQUARE FEET)	DAYS)			(DI RECT NURS.	
						HRS. )	
		5. 00	6. 00	7. 00	8. 00	9. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT						1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5.00	PLANT OPERATION & MAINTENANCE	4, 796					5. 00
6.00	LAUNDRY & LINEN SERVICE	0	4, 796				6. 00
7.00	HOUSEKEEPI NG	0		4, 796			7. 00
8.00	DI ETARY	0		0	1, 668		8. 00
9. 00	NURSING ADMINISTRATION	0		0		4, 796	9. 00
10.00	ROUTINE MEDICAL SUPPLIES	0		0		0	10.00
11. 00	MEDICAL RECORDS	0		0		0	11. 00
12.00	STAFF TRANSPORTATION	0		0		0	12. 00
13.00	VOLUNTEER SERVICE COORDINATION	0		0		0	13. 00
14.00	PHARMACY	0		0		0	14. 00
15.00	PHYSICIAN ADMINISTRATIVE SERVICES	0		0		0	15. 00
16.00	OTHER GENERAL SERVICE	0		0		0	16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES	0		0			17. 00
	LEVEL OF CARE						
	HOSPICE CONTINUOUS HOME CARE					0	50. 00
51.00	HOSPICE ROUTINE HOME CARE					0	51.00
52.00	HOSPICE INPATIENT RESPITE CARE	1, 029		1, 029			52. 00
53.00	HOSPICE GENERAL INPATIENT CARE	3, 767	3, 767	3, 767	1, 310	3, 767	53. 00
	NONREI MBURSABLE COST CENTERS						
60. 00	BEREAVEMENT PROGRAM	0		0		0	60. 00
61. 00	VOLUNTEER PROGRAM	0		0		0	61. 00
62.00	FUNDRAI SI NG	0		0		0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS	0		0		0	63. 00
64. 00	PALLIATIVE CARE PROGRAM	0		0		0	64. 00
	OTHER PHYSICIAN SERVICES	0		0		0	65. 00
66. 00	RESI DENTI AL CARE	0	0	0	0	"	66. 00
67. 00	ADVERTI SI NG	0		0		0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG	0		0		0	68. 00
69. 00	THRI FT STORE	0		0		0	69. 00
	NURSING FACILITY ROOM & BOARD						70. 00
	OTHER NONREIMBURSABLE (SPECIFY)	0	0	0	0	0	71. 00
	NEGATI VE COST CENTER						99. 00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	180, 557		57, 823	· ·		
101. 00	UNIT COST MULTIPLIER	37. 647415	0. 000000	12. 056505	13. 929856	85. 655546	101. 00

Health Financial Systems	IU HEALTH BLOOMING	TON HOSPITAL	In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GEN	ERAL SERVICE COSTS	Provider CCN: 15-0051	Peri od:	Worksheet 0-6
STATISTICAL BASIS			From 01/01/2016	Part II

STATIS	STICAL BASIS		Hospi ce CCI		rom 01/01/2016 o 12/31/2016	Date/Time Prep 5/23/2017 10:4	
					Hospi ce I		
	Cost Center Descriptions	ROUTI NE	MEDI CAL	STAFF	VOLUNTEER	PHARMACY	
		MEDI CAL	RECORDS	TRANSPORTATION	I SERVI CE	(CHARGES)	
		SUPPLI ES	(PATIENT DAYS)		COORDI NATI ON		
		(PATIENT DAYS)		(MI LEAGE)	(HOURS OF		
					SERVICE)		
		10.00	11. 00	12.00	13.00	14. 00	
	GENERAL SERVICE COST CENTERS						
1.00	CAP REL COSTS-BLDG & FLXT					  -	1. 00
2.00	CAP REL COSTS-MVBLE EQUIP						2. 00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3. 00
4.00	ADMINISTRATIVE & GENERAL						4. 00
5. 00	PLANT OPERATION & MAINTENANCE						5. 00
6.00	LAUNDRY & LINEN SERVICE						6. 00
7.00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9.00	NURSING ADMINISTRATION					·	9. 00
10. 00	ROUTINE MEDICAL SUPPLIES	24, 463					10.00
11. 00	MEDI CAL RECORDS		24, 463	•		·	11. 00
12. 00	STAFF TRANSPORTATION			24, 463	3		12. 00
13. 00	VOLUNTEER SERVICE COORDINATION			C	0		13. 00
14. 00	PHARMACY			C	-	24, 463	
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES			C	1 1	0	
16. 00	OTHER GENERAL SERVICE			( C	0	0	
17. 00	PATIENT/RESIDENTIAL CARE SERVICES						17. 00
	LEVEL OF CARE						
50. 00	HOSPICE CONTINUOUS HOME CARE	0	0	) C	-	0	50.00
51. 00	HOSPICE ROUTINE HOME CARE	22, 795				22, 795	
52. 00	HOSPICE INPATIENT RESPITE CARE	358				358	
53. 00	HOSPICE GENERAL INPATIENT CARE	1, 310	1, 310	1, 310	0	1, 310	53. 00
	NONREI MBURSABLE COST CENTERS		ı				
60.00	BEREAVEMENT PROGRAM			C		0	
61.00	VOLUNTEER PROGRAM			C		0	61.00
62. 00	FUNDRAL SI NG			C	-	0	62. 00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			C	-	0	63. 00
64. 00	PALLIATIVE CARE PROGRAM			C	1	0	64. 00
65. 00	OTHER PHYSICIAN SERVICES			C	0	0	65. 00
66. 00	RESI DENTI AL CARE				0	0	66. 00
67. 00	ADVERTI SI NG			C	0	0	67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG				0	0	68. 00
69. 00	THRI FT STORE			C	0	0	69. 00
70. 00	NURSING FACILITY ROOM & BOARD			_			70.00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)			C	기 이	0	
99. 00		444 500	47.050			000 700	99.00
	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)					282, 708	
101.00	UNIT COST MULTIPLIER	5. 784613	0. 705147	0. 904795	0. 000000	11. 556555	1101.00

Health Financial Systems	IU HEALTH BLOOMING	TON HOSPITAL		In Lie	u of Form CMS-2552-10
COST ALLOCATION - HOSPITAL-BASED HOSPICE GE STATISTICAL BASIS	ENERAL SERVICE COSTS	Provider CCN:	15-0051	Peri od: From 01/01/2016	Worksheet 0-6 Part II
STATISTI ONE BROTO		Hospi ce CCN:	15-1509	To 12/31/2016	Date/Time Prepared:

			nospi ce cc	N. 13-1307	10 12/31/2010	5/23/2017 10	
					Hospi ce I		
	Cost Center Descriptions	PHYSI CI AN	OTHER GENERAL	PATI ENT/			
	μ	ADMI NI STRATI VE		RESI DENTI AL			
		SERVI CES	(SPECI FY	CARE SERVICE			
		(PATIENT DAYS)	BASIS)	(IN-FACILITY			
		(		DAYS)			
		15. 00	16. 00	17. 00			
	GENERAL SERVICE COST CENTERS	101.00	10.00	17.00			
1.00	CAP REL COSTS-BLDG & FLXT						1.00
2.00	CAP REL COSTS-MVBLE EQUIP						2.00
3.00	EMPLOYEE BENEFITS DEPARTMENT						3.00
4. 00	ADMINISTRATIVE & GENERAL						4.00
5.00	PLANT OPERATION & MAINTENANCE						5. 00
6. 00	LAUNDRY & LINEN SERVICE						6. 00
7. 00	HOUSEKEEPI NG						7. 00
8.00	DI ETARY						8. 00
9. 00	NURSI NG ADMINI STRATI ON						9. 00
10. 00	ROUTINE MEDICAL SUPPLIES						10. 00
11. 00	MEDI CAL RECORDS						11. 00
12.00	STAFF TRANSPORTATION						12. 00
13.00	VOLUNTEER SERVICE COORDINATION						13. 00
14.00	PHARMACY						14. 00
15. 00	PHYSICIAN ADMINISTRATIVE SERVICES	24, 463					15. 00
16.00	OTHER GENERAL SERVICE		l c				16. 00
17. 00	PATIENT/RESIDENTIAL CARE SERVICES				0		17. 00
	LEVEL OF CARE			•	<u>'</u>		
50.00	HOSPICE CONTINUOUS HOME CARE	0	C				50.00
51. 00	HOSPICE ROUTINE HOME CARE	22, 795	l c				51.00
	HOSPICE INPATIENT RESPITE CARE	358	<b>l</b>	1	o		52. 00
	HOSPICE GENERAL INPATIENT CARE	1, 310	l e	1	0		53. 00
33. 00	NONREI MBURSABLE COST CENTERS	1,310		′1	0		33.00
60.00	BEREAVEMENT PROGRAM		C	1			60.00
61. 00	VOLUNTEER PROGRAM						61.00
	FUNDRAI SI NG			1			62.00
63. 00	HOSPICE/PALLIATIVE MEDICINE FELLOWS			1			63.00
	PALLIATIVE CARE PROGRAM			1			64. 00
				1			
	OTHER PHYSICIAN SERVICES						65. 00
	RESI DENTI AL CARE	0		2	0		66. 00
67. 00	ADVERTI SI NG			)			67. 00
68. 00	TELEHEALTH/TELEMONI TORI NG		C	)			68. 00
	THRI FT STORE		C	)			69. 00
	NURSING FACILITY ROOM & BOARD						70. 00
71. 00	OTHER NONREIMBURSABLE (SPECIFY)	0	C	)	0		71. 00
99. 00	NEGATIVE COST CENTER						99. 00
100.00	COST TO BE ALLOCATED (per Wkst. 0-6, Part I)	18, 232	C	)	0		100. 00
101.00	UNIT COST MULTIPLIER	0. 745289	0. 000000	0.00000	00		101. 00

		U HEALTH BLOOMI				u of Form CMS-	
	FIONMENT OF HOSPITAL-BASED HOSPICE SHARED SER	VICE COSTS BY	Provi der Co	CN: 15-0051	Peri od: From 01/01/2016	Worksheet 0-7	
LEVEL	OF CARE		Hospi ce CCI	N: 15-1509	To 12/31/2016	Date/Time Pre 5/23/2017 10:	pared: 42 am
					Hospi ce I		
			·	Charges by	/ LOC (from Provi	der Records)	
	Cost Center Descriptions	From Wkst. C,	Cost to Charge	HCHC	HRHC	HI RC	
		Part I, Col. 9	Ratio				
		line					
	T	0	1. 00	2.00	3. 00	4. 00	
4 00	ANCILLARY SERVICE COST CENTERS	1/ 00	0.400474	ı			1 00
1.00	PHYSI CAL THERAPY OCCUPATI ONAL THERAPY	66. 00 67. 00			0 0	0	
2. 00 3. 00	SPEECH PATHOLOGY	67.00			0 0	0	
4. 00	DRUGS CHARGED TO PATIENTS	73. 00			0	0	1
4. 00	OP PHARMACY	73.00			0 0	0	
5. 00	DURABLE MEDICAL EQUIP-RENTED	96.00				ı	5.00
6. 00	LABORATORY	60.00			0 0	0	
7. 00	MEDICAL SUPPLIES CHARGED TO PATIENTS	71. 00		l .	0 0	Ō	
8.00	OTHER OUTPATIENT SERVICE COST CENTER	93. 00					8.00
9.00	RADI OLOGY-THERAPEUTI C	55. 00	0. 102589		0 0	0	9. 00
10. 97	CARDI AC REHABI LI TATI ON	76. 97	0. 450372		0 0	0	10. 97
11. 00	Totals (sum of lines 1-11)						11. 00
		Charges by LOC		Shared Serv	ice Costs by LOC		
		(from Provider					
	Cost Contor Descriptions	Records) HGIP	UCUC (col. 1 v	UDUC (ast 1	xHIRC (col. 1 x	UCLD (ast 1 v	
	Cost Center Descriptions	HGI P	col. 2)	col. 3)	col. 4)	col. 5)	
		5. 00	6.00	7.00	8.00	9.00	
	ANCILLARY SERVICE COST CENTERS	0.00	0.00	7.00	0.00	7.00	
1.00	PHYSI CAL THERAPY	0	0		0 0	0	1.00
2.00	OCCUPATI ONAL THERAPY	0	0		0 0	0	2. 00
3.00	SPEECH PATHOLOGY	0	0		0 0	0	
4.00	DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
4. 01	OP PHARMACY	0	0		0	0	4. 01

0

0

0 0

4. 01 5. 00

6. 00

7.00

8. 00

9. 00

10. 97 0

0 11.00

0

5.00

6.00

7.00

8.00

9.00

OP PHARMACY
DURABLE MEDICAL EQUIP-RENTED

RADI OLOGY-THERAPEUTI C

11.00 Totals (sum of lines 1-11)

10. 97 CARDIAC REHABILITATION

MEDICAL SUPPLIES CHARGED TO PATIENTS

OTHER OUTPATIENT SERVICE COST CENTER

LABORATORY

Health Financial Systems	IU HEALTH BLOOMING	TON HOSPITAL	In Lie	u of Form CMS-2552-10
CALCULATION OF HOSPITAL-BASED HOSPICE F	ER DIEM COST	Provider CCN: 15-0051	Peri od: From 01/01/2016	Worksheet 0-8

Hospi ce CCN: 15-1509 Ferror 01/01/2016 To 12/31/2016 Date/Time Prepared: 5/23/2017 10: 42 am

				10 12/01/2010	5/23/2017 10: 4	
				Hospi ce I		
			TITLE XVIII	TITLE XIX	TOTAL	
			MEDI CARE	MEDI CAI D		
			1.00	2. 00	3. 00	
	HOSPICE CONTINUOUS HOME CARE					
1.00	Total cost (Wkst. 0-6, Part I, col. 18, line 50 plus Wkst. 0-7	7, col. 6,			0	1. 00
	line 11)					
2.00	Total unduplicated days (Wkst. S-9, col. 4, line 10)				0	2. 00
3.00	Total average cost per diem (line 1 divided by line 2)				0.00	3. 00
4.00	Unduplicated program days (Wkst. S-9 col. as appropriate, line	10)		0		4. 00
5.00	Program cost (line 3 times line 4)			0 0		5. 00
	HOSPICE ROUTINE HOME CARE					
6.00	Total cost (Wkst. 0-6, Part I, col. 18, line 51 plus Wkst. 0-7	7, col. 7,			4, 139, 441	6. 00
	line 11)					
7.00	Total unduplicated days (Wkst. S-9, col. 4, line 11)				22, 795	7. 00
8.00	Total average cost per diem (line 6 divided by line 7)				181. 59	8. 00
9.00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 11)	21, 10	69 43		9. 00
10.00	Program cost (line 8 times line 9)		3, 844, 0	7, 808		10.00
	HOSPICE INPATIENT RESPITE CARE					
11. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 52 plus Wkst. 0-7	7, col. 8,			489, 172	11. 00
	line 11)					
12. 00	Total unduplicated days (Wkst. S-9, col. 4, line 12)					12.00
13. 00	Total average cost per diem (line 11 divided by line 12)				1, 366. 40	
14. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 12)	_	48 0		14. 00
15. 00	Program cost (line 13 times line 14)		475, 50	07 0		15. 00
	HOSPICE GENERAL INPATIENT CARE					
16. 00	Total cost (Wkst. 0-6, Part I, col. 18, line 53 plus Wkst. 0-7	7, col. 9,			1, 793, 838	16. 00
	line 11)					
17. 00	Total unduplicated days (Wkst. S-9, col. 4, line 13)					17. 00
18. 00	Total average cost per diem (line 16 divided by line 17)				1, 369. 34	
19. 00	Unduplicated program days (Wkst. S-9, col. as appropriate, lir	ne 13)	1, 0			19. 00
20. 00	Program cost (line 18 times line 19)		1, 447, 39	92 50, 666		20. 00
	TOTAL HOSPICE CARE					
21. 00	Total cost (sum of line 1 + line 6 + line 11 + line 16)				6, 422, 451	
22. 00	Total unduplicated days (Wkst. S-9, col. 4, line 14)				24, 463	
23. 00	Average cost per diem (line 21 divided by line 22)				262. 54	23. 00

Heal th	Financial Systems IU HEALTH BL	OOMINGTON HOSPITAL	Inlie	u of Form CMS-2	2552_10
	ATION OF CAPITAL PAYMENT	Provi der CCN: 15-0051	Peri od: From 01/01/2016 To 12/31/2016	Worksheet L Parts I-III	pared:
		Title XVIII	Hospi tal	PPS	
	PART I - FULLY PROSPECTIVE METHOD			1. 00	
	CAPITAL FEDERAL AMOUNT				
1.00	Capital DRG other than outlier			3, 192, 481	1. 00
1. 01	Model 4 BPCI Capital DRG other than outlier			0	
2.00	Capital DRG outlier payments			219, 553	
2.01	Model 4 BPCI Capital DRG outlier payments	east reporting period (ass inst	rusti ons)	121 02	
3. 00 4. 00	Total inpatient days divided by number of days in the c Number of interns & residents (see instructions)	ost reporting perrod (see riist	.i ucti ons)	131. 02 0. 00	
5.00	Indirect medical education percentage (see instructions	3)		0.00	
6.00	Indirect medical education adjustment (multiply line 5		. columns 1 and	0.00	
	1.01) (see instructions)		,	_	
7. 00	Percentage of SSI recipient patient days to Medicare Pa 30) (see instructions)	rt A patient days (Worksheet E	E, part A line	5. 89	7. 00
8.00	Percentage of Medicaid patient days to total days (see	instructions)		26. 96	8. 00
9.00	Sum of lines 7 and 8	•		32. 85	9. 00
10.00	Allowable disproportionate share percentage (see instru	ictions)		6. 88	10. 00
11. 00	Disproportionate share adjustment (see instructions)			219, 643	
12. 00	Total prospective capital payments (see instructions)			3, 631, 677	12. 00
				1. 00	
	PART II - PAYMENT UNDER REASONABLE COST				
1.00	Program inpatient routine capital cost (see instruction			0	
2.00	Program inpatient ancillary capital cost (see instructi			0	
3.00	Total inpatient program capital cost (line 1 plus line	2)		0	
4.00	Capital cost payment factor (see instructions)			0	
5. 00	Total inpatient program capital cost (line 3 x line 4)			0	5. 00
				1. 00	
	PART III - COMPUTATION OF EXCEPTION PAYMENTS				
1.00	Program inpatient capital costs (see instructions)			0	
2. 00 3. 00	Program inpatient capital costs for extraordinary circu Net program inpatient capital costs (line 1 minus line			0	
4. 00	Applicable exception percentage (see instructions)	2)		0.00	
5.00	Capital cost for comparison to payments (line 3 x line	4)		0.00	5.00
6.00	Percentage adjustment for extraordinary circumstances (			0.00	
7.00	Adjustment to capital minimum payment level for extraor		(line 6)	0	7. 00
8.00	Capital minimum payment level (line 5 plus line 7)	·	·	0	8. 00
9.00	Current year capital payments (from Part I, line 12, as			0	9. 00
10.00	Current year comparison of capital minimum payment leve			0	
11. 00	Carryover of accumulated capital minimum payment level Worksheet L, Part III, line 14)	over capital payment (from pri	or year	0	11. 00
12.00	Net comparison of capital minimum payment level to capi			0	12. 00
13. 00	Current year exception payment (if line 12 is positive,			0	
14. 00	Carryover of accumulated capital minimum payment level		following period	0	14. 00
15. 00	(if line 12 is negative, enter the amount on this line) Current year allowable operating and capital payment (s			0	15. 00
16. 00	Current year operating and capital costs (see instructi	•		0	
	Current year exception offset amount (see instructions)			Ö	
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