Heal th Financia	al Systems	IU HEALTH BLACKFORD	HOSPI TAL	In Lieu	of Form CMS-2552-10
	required by law (42 USC 1395g				
payments made	since the beginning of the cos	st reporting period being d	eemed overpayments (	(42 USC 1395g).	OMB NO. 0938-0050
HOSPITAL AND H AND SETTLEMENT	OSPITAL HEALTH CARE COMPLEX CC SUMMARY	OST REPORT CERTIFICATION	Provider CCN: 151302	From 01/01/2015	Worksheet S Parts I-III Date/Time Prepared: 5/26/2016 11:07 am
PART I - COST	REPORT STATUS				
Provi der	1. [ X ] Electronically filed of	cost report		Date: 5/26/20	16 Time: 11:07 am
use only	2. [ ] Manually submitted cos	st report			
	3. [ 0 ] If this is an amended 4. [ F ] Medicare Utilization.			resubmitted this co	ost report
Contractor use only	<pre>5. [ 1 ]Cost Report Status   (1) As Submitted   (2) Settled without Audit   (3) Settled with Audit   (4) Reopened   (5) Amended</pre>	7. Contractor No.	this Provider CCN 12		r Code: 4 lumn 1 is 4: Enter es reopened = 0-9.
PART II - CERT	I FI CATI ON				

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

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

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH BLACKFORD HOSPITAL (151302) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

(Si	gned)	

Officer or Administrator of Provider(s)

CHIEF FINANCIAL OFFICER Title

05/26/2016

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	186, 465	-602, 977	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing bed - SNF	0	305, 453	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
200.00	Total	0	491, 918	-602, 977	0	0	200.00

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

HOSPLI	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX		I BLACKFORD	HOSPI TAL Provi der		51302	Peri od:	n Lieu		rm CMS-: eet S-2	2552-10 !
							From 01/01 To 12/31		Part I	ime Pre	
	1.00	2	00	3.0	0			4.00		016 8:1	
	Hospital and Hospital Health Care Co		00	3.0	0			4.00			
1.00	Street: 410 PILGRIM STREET	PO Box:									1.00
2.00	City: HARTFORD CITY	State: I Component Na		p Code: 47 CCN C		rovi der	ty: BLACKFOI Date		nt Syst	em (P	2.00
					mber	Туре	Certi fi ed	T,	0, or	N)	
		1.00			00	4 00	E 00	V	XVIII	XIX	-
	Hospital and Hospital-Based Componen			2.00 3	. 00	4.00	5.00	6.00	7.00	8.00	
3.00	Hospi tal	IU HEALTH BLACKF	ORD 15	51302 99	9915	1	02/10/2000	D N	0	0	3.00
1.00	Subprovider - IPF	HOSPI TAL									4.00
5.00	Subprovider - IRF										5.00
5.00 7.00	Subprovider - (Other) Swing Beds - SNF	BLACKFORD COMMUN		5Z302 99	9915		02/10/2000	) N	0	0	6.00
. 00	Swing Beas - SNF	SWING BED		2302 99	7915		02/10/2000				/.00
3. 00	Swing Beds - NF										8.00
9.00 10.00	Hospi tal -Based SNF Hospi tal -Based NF										9.00
11.00	Hospi tal -Based OLTC										11.00
2.00	Hospital-Based HHA										12.00
3.00 4.00	Separately Certified ASC Hospital-Based Hospice										13.00
5.00	Hospital-Based Health Clinic - RHC										15.00
6.00	Hospital-Based Health Clinic - FQHC										16.00
7.00 8.00	Hospital-Based (CMHC) I Renal Dialysis										17.00
19.00	Other										19.00
							From		To		
0.00	Cost Reporting Period (mm/dd/yyyy)						1.00		2.		20.00
1.00	Type of Control (see instructions) Inpatient PPS Information							2			21.00
2.00	Does this facility qualify and is it	currently receiv	ing paymen	ts for dis	sproport	tionate	N		١	1	22.00
	share hospital adjustment, in accord										
	for yes or "N" for no. Is this facil amendment hospital?) In column 2, en				5(0)(2)(	PICKIE					
2. 01	Did this hospital receive interim un	compensated care	payments f	or this co			N		Ν	I	22.01
	period? Enter in column 1, "Y" for y reporting period occurring prior to										
	for no for the portion of the cost r										
	(see instructions)										
2. 02	Is this a newly merged hospital that determined at cost report settlement						N N		Ν	1	22. 02
	or "N" for no, for the portion of th	e cost reporting	period pri	or to Octo	ober 1.	Enter					
	in column 2, "Y" for yes or "N" for	no, for the porti	on of the	cost repor	rting pe	eriod o	n				
22. 03	or after October 1. Did this hospital receive a geograph	i c reclassi fi cati	on from ur	ban to rur	ral as a	a resul	t N		Ν	I	22. 03
	of the OMB standards for delineating										
	in column 1, "Y" for yes or "N" for prior to October 1. Enter in column						e				
	cost reporting period occurring on o										
	hospital contain at least 100 but no	t more than 499 b	eds (as co	unted in a	accordar	nce wit	h				
23.00	42 CFR 412.105)? Enter in column 3, Which method is used to determine Me			/or 25 bel	ow? In	col umn		2	N	ı	23.00
	1, enter 1 if date of admission, 2 i	f census days, or	3 if date	of discha	arge. Is	s the					
	method of identifying the days in th used in the prior cost reporting per	1 0									
	lased in the prior cost reporting per		In-State	In-State				Medi ca	id C	ther	
			Medicaid paid days	Medicaid eligible			State Medicaid	HMO dag	·	di cai d	
			paru uays	unpai d	paid		eligible			days	
				days		-	unpai d				
4.00	If this provider is an IPPS hospital	enter the	1.00	2.00	3.0	00	4.00	5.00	0	<u>5.00</u> 0	24.00
- <del>1</del> . UU	in-state Medicaid paid days in colum		0				U			0	/ 24.00
	Medicaid eligible unpaid days in col	umn 2,									
	out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai										
	isat or otato modiculu crigibic dilpar										
	4, Medicaid HMO paid and eligible bu										1
	4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in		-			_					
?5. 00	4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th	e in-state	0		0	0	0		0		25.00
25.00	4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	e in-state in-state umn 2,	0		0	0	O		0		25.00
25. 00	4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col out-of-state Medicaid days in column	e in-state in-state umn 2, 3, out-of-state	0		0	0	0		0		25. 00
25. 00	4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the Medicaid eligible unpaid days in col	e in-state in-state umn 2, 3, out-of-state umn 4, Medicaid	0		0	O	0		0		25.00

			FORD HOSPI TAL		l i	n Lieu	of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION D	ATA	Provi der		eriod: rom 01/01/ p 12/31/		Workshe Part I Date/Ti 5/24/20	me Pre	pared:
					Urban/Rur 1.00			Geogr	2 pm
26.00	Enter your standard geographic classification (not w			jinning of the	1.00	2	2.0	)0	26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not w reporting period. Enter in column 1, "1" for urban of	age) st or "2" f	atus at the end or rural. If ap			2			27.00
35. 00	enter the effective date of the geographic reclassif If this is a sole community hospital (SCH), enter the effect in the cost reporting period.			CH status in		О			35.00
					Begi nni 1. 00		Endi 2. (		
36.00	Enter applicable beginning and ending dates of SCH s		Subscript line	36 for number	1.00		2.0		36.00
37.00	of periods in excess of one and enter subsequent dat If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		umber of period	ls MDH status		О			37.00
38.00	If line 37 is 1, enter the beginning and ending date greater than 1, subscript this line for the number of enter subsequent dates.								38.00
					Y/N 1.00		Y/ 2.0		
39.00	Does this facility qualify for the inpatient hospita hospitals in accordance with 42 CFR §412.101(b)(2)(i or "N" for no. Does the facility meet the mileage re CFR 412.101(b)(2)(ii)? Enter in column 2 "Y" for yes	i)? Énte equireme	er in column 1 nts in accordan	"Y" for yes nce with 42	N		N		39.00
40.00	Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octo no in column 2, for discharges on or after October 2	ber 1.	Enter "Y" for y		N		N		40.00
						V 1.00	XVIII 2.00	XI X 3.00	
45.00	Prospective Payment System (PPS)-Capital Does this facility qualify and receive Capital payme	ent for	di sproporti onat	e share in acc	ordance	N	N	N	45.00
46.00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exo pursuant to 42 CFR §412.348(f)? If yes, complete Wks					N	N	N	46.00
47.00 48.00	Pt. III. Is this a new hospital under 42 CFR §412.300 PPS cap <u>Is the facility electing full federal capital paymer</u> Teaching Hospitals				0.	N N	N N	N N	47. 00 48. 00
56.00	Is this a hospital involved in training residents in	approv	ed GME programs	? Enter "Y" f	or yes	N			56.00
57.00	or "N" for no. If line 56 is yes, is this the first cost reporting GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mor for yes or "N" for no in column 2. If column 2 is ' "N", complete Wkst. D, Parts III & IV and D-2, Pt. I	or yes o oth of t Y", com	r "N" for no in his cost report plete Worksheet	n column 1. If ing period? E	column 1 nter "Y"				57.00
58.00	If line 56 is yes, did this facility elect cost rein defined in CMS Pub. 15-1, chapter 21, §2148? If yes,	nburseme	nt for physicia	ins' services a	S				58.00
	Are costs claimed on line 100 of Worksheet A? If ye Are you claiming nursing school and/or allied health					N N			59.00 60.00
	provider-operated criteria under §413.85? Enter "Y				tions) IME		Di rect	GME	
61.00	Did your hospital receive FTE slots under ACA	1.00	2.00	3.00	4.00	0.00	5.0		61.00
61.00	section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions)					0.00		0.00	01.00
61.01	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		0.00	0.00					61.01
61. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of	è	0. 00	0.00					61. 02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see		0.00	0.00					61. 03
61. 04	instructions) Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the		0.00	0.00					61. 04
61. 05	current cost reporting period (see instructions). Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line		0. 00	0.00					61. 05
61.06	61.04 minus line 61.03). (see instructions) Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)		0. 00	0.00					61.06

OSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DA	TA	Provi der		eriod: rom 01/01/2015 o 12/31/2015	Worksheet S-2 Part I Date/Time Pre	
		Program	Name	Program Code	Unweighted IME FTE Count	5/24/2016 8:10 Unweighted Direct GME FTE Count	
		1. C	0	2.00	3.00	4.00	
<ol> <li>1.10 Of the FTEs in line 61.05, special ty, if any, and the number for each new program. (see instruccolumn 1, the program name, enter program code, enter in column 3, unweighted count and enter in colum FTE unweighted count.</li> <li>1.20 Of the FTEs in line 61.05, special ty, if any, and the residents for each expanded program special ty, if any, and the residents for each expanded program column 2, the program column 4, direct GME FTE unweighted count</li> </ol>	of FTE residents ctions) Enter in in column 2, the the IME FTE umn 4, direct GME y each expanded e number of FTE am. (see the program name, de, enter in column ad enter in column				0.00		61. 1
		I		1			
				(1150.1)		1.00	
ACA Provisions Affecting the Heal 2.00 Enter the number of FTE residents					od for which	0.00	62. C
your hospital received HRSA PCRE			uns cost	reporting peri		0.00	02.0
2.01 Énter the number of FTE residents during in this cost reporting per Teaching Hospitals that Claim Res	od of HRSA THC prog	<u>jram. (seë i</u>			your hospital	0.00	62.0
3. 00 Has your facility trained residen "Y" for yes or "N" for no in colu	ts in nonprovider se	ettings duri		instructions)		N	63. 0
				Unweighted FTEs Nonprovider Site	FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
				1.00	2.00	3.00	
Section 5504 of the ACA Base Year period that begins on or after Ju				inis base year	is your cost r	eporting	
4.00 Enter in column 1, if line 63 is in the base year period, the numb resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	yes, or your facilit er of unweighted nor ations occurring in number of unweighteor hospital. Enter ir + column 2)). (see	y trained r p-primary ca all nonprov non-primar column 3 t instruction	esidents re ider y care he ratio s)	0. 00			
	Program Name	Program	Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.0	0	3.00	4.00	5.00	
5.00 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				0. 00	0.00	0. 000000	65.0

	inancial Systems		BLACKFORD	HOSPI TAL		L.	n Lie	u of Form CMS-	2552-10
HOSPI TAL	AND HOSPITAL HEALTH CARE COMPI	EX IDENTIFICATION DA	ТА	Provi der	1	Period: From 01/01/ To 12/31/		Worksheet S-2 Part I Date/Time Pre 5/24/2016 8:	epared:
					Unweighted FTEs Nonprovider Site	Unwei gh FTEs i Hospi t	n al	Ratio (col. 1. (col. 1 + col 2))	
S	ection 5504 of the ACA Current	Year FTE Residents ir	n Nonprovide	r Setting	1.00 sEffective f	2.00 For cost re		3.00 ng periods	
b	eginning on or after July 1, 20	10	•						
F Ei F	nter in column 1 the number of TEs attributable to rotations o nter in column 2 the number of TEs that trained in your hospit column 1 divided by (column 1 +	ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider setti ry care resid 3 the ratio (	ngs. dent	0.0		0.00	0. 00000	0 00.00
		Program Name	Program	Code	Unweighted FTEs Nonprovider	Unweigh FTEs i Hospit	n	Ratio (col. 3. (col. 3 + col 4))	
		1.00	2.0	0	Si te 3. 00	4.00		5.00	-
na yy El ca ca ca ca ca ca ca ta ca ta sa yy y S 5 d	nter in column 1, the program ame associated with each of our primary care programs in hich you trained residents. nter in column 2, the program ode. Enter in column 3, the umber of unweighted primary are FTE residents attributable o rotations occurring in all on-provider settings. Enter in olumn 4, the number of nweighted primary care esident FTEs that trained in our hospital. Enter in column , the ratio of (column 3 ivided by (column 3 + column )). (see instructions)	1.00	2.0		0.0		0.00		0 67.00
							1.00	0 2.00 3.00	-
	npatient Psychiatric Facility P						1.00	5 2.00 3.00	
EI 71.00   - 4. pi Co (:	s this facility an Inpatient Ps nter "Y" for yes or "N" for no f line 70 yes: Column 1: Did th ecent cost report filed on or b 2 CFR 412.424(d)(1)(iii)(c)) Co rogram in accordance with 42 CF olumn 3: If column 2 is Y, indi see instructions)	e facility have an ap efore November 15, 20 lumn 2: Did this faci R 412.424 (d)(1)(iii) cate which program ye	pproved GME 004? Enter ' lity train i (D)? Enter '	teaching 'Y" for y residents 'Y" for y	program in the es or "N" for in a new teac es or "N" for	e most no. (see ching no.	N	0	70.00
	npatient Rehabilitation Facilit s this facility an Inpatient Re		(IRF), or (	does it c	ontain an IRF		N		75.00
76.00 I ro no Cl	ubprovider? Enter "Y" for yes f line 75 yes: Column 1: Did th ecent cost reporting period end o. Column 2: Did this facility FR 412.424 (d)(1)(iii)(D)? Ente ndicate which program year bega	and "N" for no. e facility have an ap ing on or before Nove train residents in a r "Y" for yes or "N"	pproved GME mber 15, 200 new teaching for no. Colu	teaching )4? Enter g program umn 3: If	program in the "Y" for yes o in accordance column 2 is Y	or "N" for e with 42 7,		0	76.00
								1.00	-
80.00 I : 81.00 I :	ong Term Care Hospital PPS s this a long term care hospita s this a LTCH co-located within Y" for yes and "N" for no.					) period? Ei	nter	N N	80.00 81.00
85.00 I : 86.00 Di	EFRA Providers s this a new hospital under 42 id this facility establish a ne 413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider (	excl uded uni				no.	N	85. 00 86. 00
87.00 Is	s this hospital a "subclause (I or yes or "N" for no.			n 1886(d)	(1)(B)(iv)(II)	? Enter "Y		N	87.00
						V		XI X	
T	itle V and XIX Services					1.00		2.00	
90.00 D	oes this facility have title V		hospital ser	rvi ces? E	nter "Y" for	N		Y	90.00
91.00 Ĭ :	es or "N" for no in the applica s this hospital reimbursed for	title V and/or XIX th				N		N	91.00
	ull or in part? Enter "Y" for y re title XIX NF patients occupy							N	92.00
i	nstructions) Enter "Y" for yes oes this facility operate an IC	or"N" for no in the	applicable of	column.		N		N	93.00
94.00 De	Y" for yes or "N" for no in the oes title V or XIX reduce capit pplicable column.	applicable column.				N		N	93.00
a						T		I	1

Health Financial Systems         IU HEALTH BLACKFOR           HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA			eri od:		Workshe		2552-10 2
		T	rom 01/01/ p 12/31/		Part I Date/Ti 5/24/20		
			V 1.00		XI 2 2. C	x	
95.00 If line 94 is "Y", enter the reduction percentage in the appli 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes of applicable column.			N	0.00	N	0.00	0 95.00 96.00
97.00 If line 96 is "Y", enter the reduction percentage in the appli Rural Providers	cable columr	۱.		0. 00		0.00	97.00
105.00 Does this hospital qualify as a critical access hospital (CAH) 106.00 If this facility qualifies as a CAH, has it elected the all-ir		nod of payment	Y N				105.00 106.00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cost r training programs? Enter "Y" for yes or "N" for no in column 1 yes, the GME elimination is not made on Wkst. B, Pt. I, col. 2 reimbursed. If yes complete Wkst. D-2, Pt. II.	1. (see instr	ructions) lf	N				107.00
108.00 Is this a rural hospital qualifying for an exception to the CF CFR Section §412.113(c). Enter "Y" for yes or "N" for no.			N				108.00
-	Physi cal 1.00	Occupational 2.00	Speech 3.00	ו	Respir 4.0		-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N		N		109.00
110,000 d this best the section of the Durch Committee Upperite	Demonstration			-	1.0		110.00
110.00 Did this hospital participate in the Rural Community Hospital the current cost reporting period? Enter "Y" for yes or "N" for		on project (410	A Demo)tor		N		110.00
				1.00	2.00	3.00	
Miscellaneous Cost Reporting Information 115.00 Is this an all-inclusive rate provider? Enter "Y" for yes or " is yes, enter the method used (A, B, or E only) in column 2. I 3 either "93" percent for short term hospital or "98" percent psychiatric, rehabilitation and long term hospitals providers)	lf column 2 i for long ter	s "E", enter i rm care (includ	n column les	N		0	115. 00
Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" fo 117.00 s this facility legally-required to carry malpractice insurar	or yes or "N'	' for no.		N N			116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence polic				1			118.00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	5	Insura	ance	
		1.00	2.00		3.0	0	-
118.01 List amounts of malpractice premiums and paid losses:		36, 494		0			0 118. 01
			1.00		2.0	0	118.02
118.02 Are mal practice premiums and paid losses reported in a cost ce Administrative and General? If yes, submit supporting schedul and amounts contained therein.			N				
119.00D0 NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold H §3121 and applicable amendments? (see instructions) Enter in o "N" for no. Is this a rural hospital with < 100 beds that qual Hold Harmless provision in ACA §3121 and applicable amendments Enter in column 2. "Y" for you or "N" for po	column 1, "Y lifies for th	' for yes or ne Outpatient	N		N		119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00Did this facility incur and report costs for high cost implant patients? Enter "Y" for yes or "N" for no. Transplant Center Information	table devices	s charged to	Y				121.00
125.00 Does this facility operate a transplant center? Enter "Y" for	yes and "N"	for no. If	N				125.00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 If this is a Medicare certified kidney transplant center, enter	er the certif	fication date					126.00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter	r the certifi	cation date					127.00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter	r the certifi	cation date					128.00
in column 1 and termination date, if applicable, in column 2. 129.00 f this is a Medicare certified lung transplant center, enter	the certific	cation date in					129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, er		ti fi cati on					130. 00
date in column 1 and termination date, if applicable, in colum 131.00 f this is a Medicare certified intestinal transplant center,	enter the ce	erti fi cati on					131.00
date in column 1 and termination date, if applicable, in colum 132.00 If this is a Medicare certified islet transplant center, enter		cation date					132.00
in column 1 and termination date, if applicable, in column 2. 133.00 If this is a Medicare certified other transplant center, enter							133.00
in column 1 and termination date, if applicable, in column 2. 134.00 If this is an organ procurement organization (OPO), enter the and termination date, if applicable, in column 2.	0P0 number i	n column 1					134.00

Health Financial Systems	IU HEALTH BI	LACKFORD	HOSPI TAL				In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Provider (	CCN: 15130		eri od:		Worksheet S-2	
					Fr  To		/01/2015	Part I Date/Time Pre	nared
						, 12	/ 51/ 2013	5/24/2016 8: 1	
									-
							1.00	2.00	
All Providers 140.00 Are there any related organization	or home office costs	as defin	ed in CMS	Pub 15_1			Y	15H059	140.00
chapter 10? Enter "Y" for yes or '							•		
are claimed, enter in column 2 the									
1.00		2.00					3.00		
If this facility is part of a chai					ne nam	ie and	address	of the	
home office and enter the home off 141.00Name: IU HEALTH, INC	Contractor name an				actor'	's Num	ber: 0810	1	141.00
142.00 Street: 340 W. 10TH STREET	PO Box:	c. m 5			actor	3 1101			142.00
143.00 City: INDIANAPOLIS	State:	IN		Zip C	ode:		4620	4	143.00
								1.00	
144.00 Are provider based physicians' cos	sts included in Workshe	eet A?						Y	144.00
					ŀ		1.00	2.00	-
145.00 If costs for renal services are cl	aimed on Wkst A line	e 74 are	the costs	for			N	2.00	145.00
inpatient services only? Enter "Y					s				
no, does the dialysis facility ind	clude Medicare utilizat								
period? Enter "Y" for yes or "N"									
146.00 Has the cost allocation methodolog					1.6		Ν		146.00
Enter "Y" for yes or "N" for no ir yes, enter the approval date (mm/o		uD. 15-2,	chapter 4	0, 94020)					
					I				
								1.00	1
147.00 Was there a change in the statisti								N	147.00
148.00 Was there a change in the order of								N	148.00
149.00 Was there a change to the simplifi	ed cost finding method						+1 - \/	N Title VIV	149.00
			Part A 1.00				tle V 3.00	Title XIX 4.00	-
Does this facility contain a provi	der that qualifies for	r an exem							
or charges? Enter "Y" for yes or '									
155.00Hospi tal			N	N			N	N	155.00
156.00 Subprovi der – IPF			N	N			N	N	156.00
157.00 Subprovider - IRF			N	N			N	N	157.00
158. 00 SUBPROVI DER 159. 00 SNF			N	Ν			N	N	158.00 159.00
160.00HOME HEALTH AGENCY			N	N			N	N	160.00
161. 00 CMHC				N			N	N	161.00
								1.00	
Multicampus	mpus beenited that has			ooo in di	fforo	n+ CD0	`A-2	N	1/5 00
165.00 Is this hospital part of a Multica Enter "Y" for yes or "N" for no.	ampus nospitai that has	s one or	nore campu	ses in ai	rierei	nt CB:	SAS?	IN	165.00
	Name	Со	unty	State	Zip	Code	CBSA	FTE/Campus	
	0		. 00	2.00	3. (		4.00	5.00	
166.00 If line 165 is yes, for each								0.00	166. 00
campus enter the name in column									
0, county in column 1, state in column 2, zip code in column 3,									
CBSA in column 4, FTE/Campus in									
column 5 (see instructions)									
	F) / / / / /							1.00	
Heal th Information Technology (HI						Act		Y	167.00
167.00 Is this provider a meaningful user 168.00 If this provider is a CAH (line 10						enter	the		167.00
reasonable cost incurred for the H				107 13	. ), .	enter	the		100.00
168.01 If this provider is a CAH and is r	not a meaningful user,	does thi				hards	shi p		168. 01
exception under §413.70(a)(6)(ii)?	? Enter "Y" for yes or	"N" for	no. (see i	nstructio	ons)				
169.00 If this provider is a meaningful u		and is n	ot a CAH (	II ne 105	is "N	"), ei	nter the	0.00	169. 00
transition factor. (see instructio	ліо <i>)</i>					Rec	i nni ng	Endi ng	
							1. 00	2.00	
170.00 Enter in columns 1 and 2 the EHR k	peginning date and endi	ing date	for the re	porting			03/2015		170.00
period respectively (mm/dd/yyyy)									

Health Financial Systems	IU HEALTH BLACKFORD	HOSPI TAL	In Lie	u of Form CMS-	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX	K IDENTIFICATION DATA	Provider CCN: 151302	Period: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part I Date/Time Pro 5/24/2016 8:	epared:
				1.00	
171.00 If line 167 is "Y", does this prov Medicare cost plans reported on Wk (see instructions)	Y	171.00			

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STIUNNALRE Provider		Period: From 01/01/2015	Worksheet S-2 Part II	2
				To 12/31/2015		epared
				Y/N	Date	
				1.00	2.00	
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format.	onses. Enter N for all NO re	sponses. Enter	all dates in t	the	
	COMPLETED BY ALL HOSPITALS					_
0	Provider Organization and Operation Has the provider changed ownership immediate	v prior to the beginning of	the cost	N	1	1.
<u> </u>	reporting period? If yes, enter the date of					
			Y/N	Date	V/I	-
0	Has the provider terminated participation in	the Medicare Program? If	1.00 N	2.00	3.00	2.
0	yes, enter in column 2 the date of termination voluntary or "I" for involuntary.					
C	Is the provider involved in business transact		Y			3.
	contracts, with individuals or entities (e.g. or medical supply companies) that are related	, chain home offices, drug				
	officers, medical staff, management personnel					
	of directors through ownership, control, or t	family and other similar				
	relationships? (see instructions)		Y/N	Туре	Date	-
			1.00	2.00	3.00	+
	Financial Data and Reports				00.05.001	<u> </u>
0	Column 1: Were the financial statements prep Accountant? Column 2: If yes, enter "A" for		Y	С	03/25/2016	4.
	or "R" for Reviewed. Submit complete copy or	enter date available in				
0	column 3. (see instructions) If no, see instructions		N			
C	Are the cost report total expenses and total those on the filed financial statements? If		N			5.
				Y/N	Legal Oper.	
	Approved Educational Activities			1.00	2.00	-
C	Column 1: Are costs claimed for nursing scho	col?Column 2: If yes, is th	ne provider is	N	1	6.
	the legal operator of the program?					
) )	Are costs claimed for Allied Health Programs' Were nursing school and/or allied health proc		during the	N		7.
5	cost reporting period? If yes, see instruction		r during the	IN IN		0.
0	Are costs claimed for Interns and Residents i		al education	N		9.
00	program in the current cost report? If yes, s Was an approved Intern and Resident GME progr		the current	N		10.
	cost reporting period? If yes, see instruction	ons.				
00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see		proved	N		11.
	Treaching rrogram on worksheet A: Tr yes, see				Y/N	
					1.00	
	Bad Debts Is the provider seeking reimbursement for bad	debts? If ves see instruct			Y	12.
າດ				st reporting	N	1
	If line 12 is yes, did the provider's bad del	bt collection policy change c				13.
00	period? If yes, submit copy.	. , , , ,	0		N	
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a	. , , , ,	0	ructions.	N	
00 00	period? If yes, submit copy.	and/or co-payments waived? If	f yes, see inst yes, see instr	ructions.	N	14.
00 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments waived? If	f yes, see inst yes, see instr	ructions. rt A	N Part B	14.
00 00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	and/or co-payments waived? If	f yes, see inst yes, see instr	ructions.	N	14.
	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio	and/or co-payments waived? If or cost reporting period? If Description	yes, see instr yes, see instr Par Y/N 1.00	ructions. rt A Date	N Part B Y/N 3.00	14.
	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio PS&R Data Was the cost report prepared using the PS&R	and/or co-payments waived? If or cost reporting period? If Description	f yes, see instr yes, see instr Par Y/N	ructions. rt A Date	N Part B Y/N	14.
00	period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio	and/or co-payments waived? If or cost reporting period? If Description	yes, see instr yes, see instr Par Y/N 1.00	ructions. rt A Date	N Part B Y/N 3.00	14.
	period? If yes, submit copy.         If line 12 is yes, were patient deductibles a         Bed Complement         Did total beds available change from the priod         PS&R Data         Was the cost report prepared using the PS&R         Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R         Report used in columns 2 and 4 . (see	and/or co-payments waived? If or cost reporting period? If Description	yes, see instr yes, see instr Par Y/N 1.00	ructions. rt A Date	N Part B Y/N 3.00	14.
00 00 00 00	period? If yes, submit copy.         If line 12 is yes, were patient deductibles a         Bed Complement         Did total beds available change from the priod         PS&R Data         Was the cost report prepared using the PS&R         Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R         Report used in columns 2 and 4 . (see instructions)	and/or co-payments waived? If or cost reporting period? If Description	yes, see instr yes, see instr Par Y/N 1.00	ructions. rt A Date 2.00	N Part B Y/N 3.00	_ 14. 
00 00 00 00	period? If yes, submit copy.         If line 12 is yes, were patient deductibles a         Bed Complement         Did total beds available change from the priod         PS&R Data         Was the cost report prepared using the PS&R         Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R         Report used in columns 2 and 4 . (see instructions)         Was the cost report prepared using the PS&R	and/or co-payments waived? If or cost reporting period? If Description 0	yes, see instr yes, see instr Par Y/N 1.00	ructions. rt A Date	N Part B Y/N 3.00	_ 14. 
00 00 00 00	period? If yes, submit copy.         If line 12 is yes, were patient deductibles a         Bed Complement         Did total beds available change from the priod         PS&R Data         Was the cost report prepared using the PS&R         Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R         Report used in columns 2 and 4 . (see instructions)         Was the cost report prepared using the PS&R         Report for totals and the provider's records for allocation? If either column 1 or 3 is	and/or co-payments waived? If or cost reporting period? If Description 0	yes, see instr yes, see instr Par Y/N 1.00	ructions. rt A Date 2.00	N Part B Y/N 3.00	_ 14. 15. 16.
00 00 00 00	period? If yes, submit copy.         If line 12 is yes, were patient deductibles a         Bed Complement         Did total beds available change from the priod         PS&R Data         Was the cost report prepared using the PS&R         Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&R         Report used in columns 2 and 4 . (see instructions)         Was the cost report prepared using the PS&R         Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns	and/or co-payments waived? If or cost reporting period? If Description 0	yes, see instr yes, see instr Par Y/N 1.00	ructions. rt A Date 2.00	N Part B Y/N 3.00	_ 14. 
00 00 00 00	period? If yes, submit copy.If line 12 is yes, were patient deductibles aBed ComplementDid total beds available change from the priodPS&R DataWas the cost report prepared using the PS&RReport only? If either column 1 or 3 is yes, enter the paid-through date of the PS&RReport used in columns 2 and 4 . (see instructions)Was the cost report prepared using the PS&RReport for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)If line 16 or 17 is yes, were adjustments	and/or co-payments waived? If or cost reporting period? If Description 0	yes, see instr yes, see instr Par Y/N 1.00	ructions. rt A Date 2.00	N Part B Y/N 3.00	_ 14. 15. 16. 17.
00 00 00 00	period? If yes, submit copy.If line 12 is yes, were patient deductibles aBed ComplementDid total beds available change from the priodWas the cost report prepared using the PS&RReport only? If either column 1 or 3 is yes, enter the paid-through date of the PS&RReport used in columns 2 and 4 . (see instructions)Was the cost report prepared using the PS&RReport for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional	and/or co-payments waived? If or cost reporting period? If Description 0	yes, see instr yes, see instr Y/N 1.00 N	ructions. rt A Date 2.00	N Part B Y/N 3.00 N	_ 14.     16.  17.
00 00 00 00	period? If yes, submit copy.If line 12 is yes, were patient deductibles aBed ComplementDid total beds available change from the priodPS&R DataWas the cost report prepared using the PS&RReport only? If either column 1 or 3 is yes, enter the paid-through date of the PS&RReport used in columns 2 and 4 . (see instructions)Was the cost report prepared using the PS&RReport for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)If line 16 or 17 is yes, were adjustments	and/or co-payments waived? If or cost reporting period? If Description 0	yes, see instr yes, see instr Y/N 1.00 N	ructions. rt A Date 2.00	N Part B Y/N 3.00 N	_ 14.    16.  17.
	period? If yes, submit copy.If line 12 is yes, were patient deductibles aBed ComplementDid total beds available change from the priodWas the cost report prepared using the PS&RReport only? If either column 1 or 3 is yes, enter the paid-through date of the PS&RReport used in columns 2 and 4 . (see instructions)Was the cost report prepared using the PS&RReport for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	and/or co-payments waived? If or cost reporting period? If Description 0	yes, see instr yes, see instr Y/N 1.00 N Y N	ructions. rt A Date 2.00	N Part B Y/N 3.00 N Y	14. 15. 16. 17.
	<pre>period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prio Was the cost report prepared using the PS&amp;R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&amp;R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&amp;R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for additional claims that have been billed but are not included on the PS&amp;R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments</pre>	and/or co-payments waived? If or cost reporting period? If Description 0	yes, see instr yes, see instr Y/N 1.00 N	ructions. rt A Date 2.00	N Part B Y/N 3.00 N	14. 15. 16. 17.
00 00	period? If yes, submit copy.If line 12 is yes, were patient deductibles aBed ComplementDid total beds available change from the priodWas the cost report prepared using the PS&RReport only? If either column 1 or 3 is yes, enter the paid-through date of the PS&RReport used in columns 2 and 4 . (see instructions)Was the cost report prepared using the PS&RReport for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional claims that have been billed but are not included on the PS&R Report used to file this cost report? If yes, see instructions.	and/or co-payments waived? If or cost reporting period? If Description 0	yes, see instr yes, see instr Y/N 1.00 N Y N	ructions. rt A Date 2.00	N Part B Y/N 3.00 N Y	13. 14. 15. 16. 17. 18. 19.
	<pre>period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the priod Was the cost report prepared using the PS&amp;R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&amp;R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&amp;R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for additional claims that have been billed but are not included on the PS&amp;R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for corrections of other PS&amp;R Report information? If yes, see instructions.</pre>	and/or co-payments waived? If or cost reporting period? If Description 0	Yes, see instr Yes, see instr Par Y/N 1.00 N Y N N	ructions. rt A Date 2.00	N Part B Y/N 3.00 N Y Y N	14. 15. 16. 17. 18.
	<pre>period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the priod Was the cost report prepared using the PS&amp;R Report only? If either column 1 or 3 is yes, enter the paid-through date of the PS&amp;R Report used in columns 2 and 4 . (see instructions) Was the cost report prepared using the PS&amp;R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for additional claims that have been billed but are not included on the PS&amp;R Report used to file this cost report? If yes, see instructions. If line 16 or 17 is yes, were adjustments made to PS&amp;R Report data for corrections of other PS&amp;R Report information? If yes, see</pre>	and/or co-payments waived? If or cost reporting period? If Description 0	yes, see instr yes, see instr Y/N 1.00 N Y N	ructions. rt A Date 2.00	N Part B Y/N 3.00 N Y	14. 15. 16. 17. 18.

Heal th	Financial Systems	U HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-	2552-10
	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE			CCN: 151302 F	Peri od:	Worksheet S-2	
				F	rom 01/01/2015	Part II	
					o 12/31/2015	Date/Time Pre 5/24/2016 8:	epared:
				Par	rt A	Part B	
		Descr	iption	Y/N	Date	Y/N	
			0	1.00	2.00	3.00	
21.00	Was the cost report prepared only using the		0	N 1.00	2.00	3.00	21.00
21.00	provider's records? If yes, see			IN		IN	21.00
	instructions.						
						1.00	
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPIT	ALS ONLY (EXCE	EPT CHILDRENS H	IOSPI TALS)		1.00	
	Capital Related Cost	NEO ONET (EXOL					-
22.00	Have assets been relifed for Medicare purpose	s? If ves see	• instructions			N	22.00
	Have changes occurred in the Medicare depreci			sals made durir	a the cost	N	23.00
20.00	reporting period? If yes, see instructions.	att on expense			ig the cost		20.00
24.00	Were new leases and/or amendments to existing	leases entere	ed into durina	this cost repo	orting period?	Ν	24.00
21.00	If yes, see instructions	<i>y</i> 100000 0110010	ou into uuring	the boot rope	a ting portour		200
25.00	Have there been new capitalized leases entere	ed into durina	the cost repor	rting period?	f ves see	Ν	25.00
	instructions.				. <b>J</b> ,		
26.00	Were assets subject to Sec. 2314 of DEFRA acqu	uired during th	ne cost reporti	ng period? If	ves, see	Ν	26.00
	instructions.	5	1	51	<b>J</b>		
27.00	Has the provider's capitalization policy char	nged during the	e cost reportir	ng period?lfy	ves, submit	Ν	27.00
	сору.	5 5		51 5			
	Interest Expense						
28.00	Were new loans, mortgage agreements or letter	rs of credit er	ntered into dur	ring the cost r	reporting	Ν	28.00
	period? If yes, see instructions.						
29.00	Did the provider have a funded depreciation a			ebt Service Res	erve Fund)	Ν	29.00
	treated as a funded depreciation account? If	yes, see instr	ructions				
30.00	Has existing debt been replaced prior to its	schedul ed matu	urity with new	debt? If yes,	see	N	30.00
	instructions.						
31.00	Has debt been recalled before scheduled matur	rity without is	ssuance of new	debt? If yes,	see	N	31.00
	instructions.						_
	Purchased Services						
32.00	Have changes or new agreements occurred in pa			ed through cont	ractual	N	32.00
	arrangements with suppliers of services? If y						
33.00	If line 32 is yes, were the requirements of S	sec. 2135.2 app	piled pertainir	ng to competiti	ve bidding? IT		33.00
	no, see instructions.						
24 00	Provider-Based Physicians	tu undar an a	arangamant with	n novidar baca	d physicians?	V	1 24 00
34.00	Are services furnished at the provider facili If yes, see instructions.	ty under an ar	rangement with	i provider-base	eu physicians?	Y	34.00
35.00	If line 34 is yes, were there new agreements	or amondod ovi	isting agroomor	ate with the pr	ovidor bacod	Ν	35.00
35.00	physicians during the cost reporting period?		0 0	its with the pi	ovi del -based	IN	35.00
-	physicians during the cost reporting period:	TT yes, see TT			Y/N	Date	
					1.00	2.00	
	Home Office Costs				1.00	2.00	
36.00	Were home office costs claimed on the cost re	eport?			Y		36.00
	If line 36 is yes, has a home office cost sta		repared by the	home office?	Ý		37.00
07.00	If yes, see instructions.	rement been p	i opul ou by the				07.00
38.00	If line 36 is yes, was the fiscal year end of	of the home off	fice different	from that of	Ν		38.00
00.00	the provider? If yes, enter in column 2 the f						
39.00	If line 36 is yes, did the provider render se				Y		39.00
	see instructions.			, j.,			
40.00	If line 36 is yes, did the provider render se	ervices to the	home office?	lf yes, see	N		40.00
	instructions.			5			
			1.	00	2.	00	
	Cost Report Preparer Contact Information						
41.00	Enter the first name, last name and the title	e/position	RHONDA		UTTER		41.00
	held by the cost report preparer in columns f	I, 2, and 3,					
	respectively.						
42.00	Enter the employer/company name of the cost r	report	INDIANA UNIVER	RSETY HEALTH			42.00
	preparer.						
43.00	Enter the telephone number and email address		317-962-1093		RUTTER@I UHEALT	H. URG	43.00
	report preparer in columns 1 and 2, respectiv	/el y.	1				

ealth Financial Syst	L HEALTH CARE REIMBURSEMENT QUE	U HEALTH BLACKF		CCN: 15130		u of Form CMS Worksheet S-	
USPITAL AND HUSPITA	L HEALIH CARE REIMBURSEMENT QUE:	STI UNNALKE	Provi der	CCN: 15130.	From 01/01/2015		repare
		Part B					17 piii
		Date					
		4.00					
PS&R Data		1100					
	report prepared using the PS&R						16.
	f either column 1 or 3 is yes,						
	d-through date of the PS&R						
	columns 2 and 4 . (see						
i nstructi ons)							
	report prepared using the PS&R	04/02/2016					17.
	tals and the provider's records	04/02/2010					'''
	n? If either column 1 or 3 is						
	e paid-through date in columns						
2 and 4. (see							
	17 is yes, were adjustments						18
	Report data for additional						10
	ave been billed but are not						
	he PS&R Report used to file						
	ort? If yes, see instructions.						
	17 is yes, were adjustments						19.
	Report data for corrections of						17.
	port information? If yes, see						
i nstructi ons.	Joint Third matron: The yes, see						
	17 is yes, were adjustments						20.
	Report data for Other? Describe						20.
the other adju							
	report prepared only using the						21.
	cords? If yes, see						21.
i nstructi ons.	Jor us. 11 903, 300						
			3.	. 00			
Cost Report Pr	eparer Contact Information						
1.00 Enter the firs	st name, last name and the title	e/position M	ANAGER, GOVER	RNMENT PROG	RAMS		41.
	ost report preparer in columns 1						
respectively.							
2.00 Enter the empl	oyer/company name of the cost r	report					42.
preparer.							
3.00 Enter the tele	ephone number and email address	of the cost					43.
	er in columns 1 and 2, respectiv						

IOSPI 1	Financial Systems I AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.			HOSPI TAL Provi der	CCN: 151302		eriod:	u of Form C Worksheet		
						Fi   To	rom 01/01/2015 p 12/31/2015	Part I Date/Time 5/24/2016		
								I/P Days /		
								<u>Visits / Tr</u>	i ps	
	Component	Worksheet A	No.	of Beds	Bed Days		CAH Hours	Title V		
		Line Number 1.00		2.00	Available 3.00		4.00	5.00		
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		2.00		75	25, 104.00	5.00	0	1.(
. 00	8 exclude Swing Bed, Observation Bed and	30.00		15	5,4	15	25, 104.00		0	'.'
	Hospice days) (see instructions for col. 2									
	for the portion of LDP room available beds)									
. 00	HMO and other (see instructions)									2.
. 00	HMO I PF Subprovider									3.
. 00	HMO IRF Subprovider									4.
. 00	Hospital Adults & Peds. Swing Bed SNF								0	5.
. 00	Hospital Adults & Peds. Swing Bed NF								0	6.
. 00	Total Adults and Peds. (exclude observation			15	5, 4	75	25, 104. 00		0	7.
	beds) (see instructions)									
. 00	INTENSIVE CARE UNIT									8.
. 00	CORONARY CARE UNIT									9.
0. 00	BURN INTENSIVE CARE UNIT									10.
1. 00	SURGICAL INTENSIVE CARE UNIT									11.
2.00	OTHER SPECIAL CARE (SPECIFY)									12.
3.00	NURSERY								_	13.
4.00	Total (see instructions)			15	5, 4	75	25, 104. 00		0	14.
5.00	CAH visits								0	15.
6.00	SUBPROVIDER - IPF									16.
7.00	SUBPROVIDER - IRF									17. 18.
9.00	SUBPROVIDER SKILLED NURSING FACILITY									18.
9.00	NURSING FACILITY									20.
1.00	OTHER LONG TERM CARE									20.
2.00	HOME HEALTH AGENCY									22.
3.00	AMBULATORY SURGICAL CENTER (D. P. )									23.
4.00	HOSPI CE									24.
4.10	HOSPICE (non-distinct part)	30. 00								24.
5.00	CMHC - CMHC	00100								25.
6.00	RURAL HEALTH CLINIC									26.
6. 25	FEDERALLY QUALIFIED HEALTH CENTER									26.
7.00	Total (sum of lines 14-26)			15						27.
3. 00	Observation Bed Days								0	28.
9.00	Ambulance Trips									29.
0. 00	Employee discount days (see instruction)									30.
1.00	Employee discount days - IRF									31.
2.00	Labor & delivery days (see instructions)			0		0				32.
2. 01	Total ancillary labor & delivery room									32.
	outpatient days (see instructions)									
3.00	LTCH non-covered days									33.

IOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 151302	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part I Date/Time Pre 5/24/2016 8:1	pared
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
. 00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	691	11			10.00	1.0
. 00	HMO and other (see instructions)	107	55				2.0
. 00	HMO I PF Subprovi der	0	0				3.0
. 00	HMO I RF Subprovider	0	0				4.0
. 00	Hospital Adults & Peds. Swing Bed SNF	1,055	0	1, 0	55		5.0
. 00	Hospital Adults & Peds. Swing Bed NF	1,000	0		<del>7</del> 9		6.0
. 00	Total Adults and Peds. (exclude observation beds) (see instructions)	1, 746	11	2, 3			7.0
. 00	INTENSIVE CARE UNIT						8.
00	CORONARY CARE UNIT						9.
0.00	BURN INTENSIVE CARE UNIT						10.
1.00	SURGICAL INTENSIVE CARE UNIT						11.
2.00	OTHER SPECIAL CARE (SPECIFY)						12.
3.00	NURSERY	4 744				o/ 00	13.
4.00	Total (see instructions)	1, 746	11 0	2, 3	0.00	96.83	
5.00	CAH visits	0	0		0		15.
5.00 7.00	SUBPROVI DER – I PF SUBPROVI DER – I RF						16.
3.00	SUBPROVIDER - TRF						17.
<i>7.</i> 00	SUBPROVIDER SKILLED NURSING FACILITY						10.
). 00	NURSING FACILITY						20.
. 00	OTHER LONG TERM CARE						20.
2.00	HOME HEALTH AGENCY						22.
3.00	AMBULATORY SURGICAL CENTER (D. P. )						23.
I. 00	HOSPICE						24.
I. 10	HOSPICE (non-distinct part)	0	0		0		24.
5.00	CMHC - CMHC	-	-		-		25.
5.00	RURAL HEALTH CLINIC						26.
5. 25	FEDERALLY QUALIFIED HEALTH CENTER						26.
. 00	Total (sum of lines 14-26)				0.00	96.83	27.
3. 00	Observation Bed Days		0	1:	20		28.
9.00	Ambul ance Trips	2					29.
0. 00	Employee discount days (see instruction)				0		30.
1.00	Employee discount days - IRF				0		31.
2.00	Labor & delivery days (see instructions)	О	0		0		32.
2. 01	Total ancillary labor & delivery room outpatient days (see instructions)				0		32.
3.00	LTCH non-covered days	0					33.

HOSPI 1	FAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC.	AL DATA	Provi der	CCN: 151302	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part I Date/Time Pre 5/24/2016 8:1	pared:
		Full Time Equivalents	·	Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider		0		15 3 32 16 0	477	1.0 2.0 3.0
4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions) INTENSIVE CARE UNIT CORONARY CARE UNIT BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)				0		4. 00 5. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00
<ol> <li>13. 00</li> <li>14. 00</li> <li>15. 00</li> <li>16. 00</li> <li>17. 00</li> <li>18. 00</li> <li>19. 00</li> <li>20. 00</li> <li>21. 00</li> <li>22. 00</li> <li>23. 00</li> </ol>	NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.)	0.00	0	2	15 3	477	13. 0 14. 0 15. 0 16. 0 17. 0 18. 0 19. 0 20. 0 21. 0 22. 0 23. 0
24. 00 24. 10 25. 00 26. 00 26. 25 27. 00 28. 00 29. 00 30. 00 31. 00 32. 00 32. 01	HOSPICE HOSPICE (non-distinct part) CMHC - CMHC RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambulance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions) Total ancillary labor & delivery room outpatient days (see instructions)	0. 00					24. 0 24. 1 25. 0 26. 2 27. 0 28. 0 29. 0 30. 0 31. 0 32. 0

Heal th	Financial Systems	IU HEALTH BLACKFORD	HOSPI TAL		In Li€	u of Form CMS-	2552-10
HOSPI T	AL UNCOMPENSATED AND INDIGENT CARE DATA		Provi der	CCN: 151302	Period:	Worksheet S-1	0
					From 01/01/2015		
					To 12/31/2015		
						<u>  5/24/2016_8:1</u>	9 pm
						1.00	
	Uncompensated and indigent care cost comput	ation				1.00	
1.00	Cost to charge ratio (Worksheet C, Part I I		ded by lir	ne 202 column	8)	0. 435454	1.00
	Medicaid (see instructions for each line)		<u>uou 25 111</u>	10 202 001 4111	0)	01100101	1
2.00	Net revenue from Medicaid					439, 931	2.00
3.00	Did you receive DSH or supplemental payment	ts from Medicaid?				N N	3.00
4.00	If line 3 is "yes", does line 2 include all		payments 1	From Medicaid	?		4.00
5.00	If line 4 is "no", then enter DSH or supple					0	5.00
6.00	Medi cai d charges	1.3				3, 561, 083	
7.00	Medicaid cost (line 1 times line 6)					1, 550, 688	
8.00	Difference between net revenue and costs for	or Medicaid program (I	ine 7 minu	us sum of lin	es 2 and 5: if	1, 110, 757	
	< zero then enter zero)				,		
	State Children's Health Insurance Program (	SCHIP) (see instructi	ons for ea	ach line)			
9.00	Net revenue from stand-alone SCHIP					0	9.00
10.00	Stand-alone SCHIP charges					0	10.00
	Stand-alone SCHIP cost (line 1 times line	10)				0	11.00
	Difference between net revenue and costs for		line 11 mi	nus line 9;	f < zero then	0	12.00
	enter zero)						
	Other state or local government indigent ca	are program (see instr	uctions fo	or each line)			
13.00	Net revenue from state or local indigent ca	are program (Not inclu	uded on lir	nes 2, 5 or 9	)	501, 009	13.00
14.00	Charges for patients covered under state or	-local indigent care	program (1	Not included	n lines 6 or	3, 441, 418	14.00
	10)						
	State or local indigent care program cost					1, 498, 579	
16.00	Difference between net revenue and costs for	or state or local indi	gent care	program (lin	e 15 minus line	997, 570	16.00
	13; if < zero then enter zero)						
17 00	Uncompensated care (see instructions for ea						1 4 7 4 4
	Private grants, donations, or endowment ind					0	
	Government grants, appropriations or transf					0	1 .0.00
19.00	Total unreimbursed cost for Medicaid , SCHI 8, 12 and 16)	P and state and local	i nai gent	care program	s (sum of lines	2, 108, 327	19.00
				Uni nsured	Insured	Total (col. 1	
				patients	pati ents	+ col. 2)	
				1.00	2.00	3.00	
20.00	Total initial obligation of patients approv			2, 891, 92	9 554, 462	3, 446, 391	20.00
	charges excluding non-reimbursable cost cer						
21.00	Cost of initial obligation of patients appr	roved for charity care	e (line 1	1, 259, 30	2 241, 443	1, 500, 745	21.00
~~ ~~	times line 20)						
	Partial payment by patients approved for ch			8		98	
23.00	Cost of charity care (line 21 minus line 22	2)		1, 259, 21	8 241, 429	1, 500, 647	23.00
						1.00	
24.00	Deep the ensure in Line 20 column 2 include	fra anti-ant			C	1.00 N	24.00
24.00	Does the amount in line 20 column 2 include			nd a rength o	r stay limit	N	24.00
25.00	imposed on patients covered by Medicaid or If line 24 is "yes," charges for patient of			oaram's longt	of ctay limit	0	25.00
	Total bad debt expense for the entire hospi				i or stay rimit	1, 234, 996	
	Medicare bad debts for the entire hospital					298, 164	1
	Non-Medicare and non-reimbursable Medicare			sline 27)		936, 832	
	Cost of non-Medicare and non-reimbursable Medicare				28)	407, 947	
	Cost of uncompensated care (line 23 column	•		i times tille	20)	1, 908, 594	
	Total unreimbursed and uncompensated care of		ne 30)			4, 016, 921	
51.00	The second and another barrow care and					1 ., 010, 721	, 000

Cost Center Description         Sal aries         Other         Total (col. + col. 2)         Reclassificati ons (see A-6)         Reclassificati ons (see A-6)           1.00         00100 (NEW CAP REL COST CENTERS         1.00         2.00         3.00         4.00         5.00           1.00         00100 (NEW CAP REL COSTS-BLDG & FIXT 0.00 (OD00 OTHER CAPITAL RELATED COSTS 0.00 (O200 OTHER CAPITAL RELATED COST 0.0	552-10	u of Form CMS-2	In Lie			IU HEALTH BLACKF		
Cost Center Description         Salaries         Other         Total (col. 1 + col. 2)         Reclassification on (See A-6)           1.00         2.00         3.00         4.00         5.00           6ENERAL SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           0.00 0000 NEW CAP REL COSTS-BLDG & FIXT         143.557         143.557         804.491         948.040           0.00 00300 OTHER CAPITAL RELATED COSTS         0 <t< td=""><td></td><td>Worksheet A</td><td></td><td></td><td>Provi der</td><td>OF EXPENSES</td><td>CLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (</td><td>RECLASS</td></t<>		Worksheet A			Provi der	OF EXPENSES	CLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	RECLASS
Cost Center Description         Sal aries         Other         Total (col. 1 + col. 2)         Recl assified trial Balance (col. 3)           0         GENERAL SERVICE COST CENTERS         1.00         2.00         3.00         4.00         5.00           10.00         00000 NEW CAP REL COSTS-BLDG & FIXT         143,557         143,557         804,491         948,048           2.00         00200 NEW CAP REL COSTS-MUBLE EQUIP         0 <td>arod</td> <td>Dato/Timo Prov</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	arod	Dato/Timo Prov						
Cost Center Description         Sal aries         Other         Total (col. + col. 2)         Reclassificati ons (see A-6)         Reclassificati ons (see A-6)           1.00         2.00         3.00         4.00         5.00           1.00         00100 NEW CAP REL COSTS - BLDG & FIXT         143,557         143,557         804,491         948,048           2.00         00200 NEW CAP REL COSTS - MUBLE EQUIP         0		5/24/2016 8: 19	0 12/31/2013					
Construct         Construct <thconstruct< th=""> <thconstruct< th=""> <thc< td=""><td></td><td></td><td>Recl assi fi cati</td><td>Total (col. 1</td><td>Other</td><td>Sal ari es</td><td>Cost Center Description</td><td></td></thc<></thconstruct<></thconstruct<>			Recl assi fi cati	Total (col. 1	Other	Sal ari es	Cost Center Description	
CONTROL         Control <t< td=""><td></td><td>Trial Balance</td><td>ons (See A-6)</td><td>+ col. 2)</td><td></td><td></td><td></td><td></td></t<>		Trial Balance	ons (See A-6)	+ col. 2)				
ENERGY CONTRIBUTION         1.00         2.00         3.00         4.00         5.00           1.00         00100         NEW CAP REL COST CENTERS         143,557         143,557         804,491         948,048           2.00         00200         NEW CAP REL COSTS-BLDG & FLXT         0								
GENERAL SERVICE COST CENTERS           1.00         00100 NEW CAP REL COSTS - MUBLE EQUIP         0								
1         00         00100         INEW CAP REL COSTS-BLDC & FIXT         143,557         143,557         804,491         948,048           2.00         00200         NEW CAP REL COSTS-WDEL EOUIP         0		5.00	4.00	3.00	2.00	1.00		
2         00         00200         INEW CAP REL COSTS - WUBLE EQUIP         0			004.404	1 10 553	110 553			
3.00         00300         OTHER CAPITAL RELATED COSTS         0         0         0         0         0           4.00         00400         EMPLOYEE BENEFITS DEPARTMENT         12,568         946,018         958,586         19,576         978,162           5.01         00570         ADMITTING         102,767         8,264         111,031         -265         110,766           5.02         00590         OTHER ADMIN AND GENERAL         498,646         1,840,633         2,339,279         -46,890         2,292,389           7.00         00900         HOUSKEEPING         135,284         118,326         253,610         -20,347         233,263           10.00         OTOO CAPERATION OF PLANT         190,050         10,074,864         -107,801         163,604           11.00         OTOO CAPERATING         0         0         0         101,823         101,823           12.00         DISOO PHARMARY         0         848,669         -452,725         395,944           13.00         DISOO PHARMARY         0         848,669         -452,725         395,944           14.00         DIAUC SERVICE COST CENTERS         -452,725         395,944         -106,608         1,678,122           30.00	1.00							
4. 00         00400         EMPLOYEE BENEFITS DEPARTMENT         12,568         946,018         958,586         19,576         978,162           5. 01         00570         ADMITTING         102,767         8,264         111,031         -265         110,766           5. 02         00590         OTHER ADMIN AND GENERAL         498,646         1,840,633         2,339,279         -46,890         2,292,389           7. 00         00700         OPERATI ON OF PLANT         119,050         1,071,684         1,190,734         -514,072         676,662           9.00         00900         HUSEKEPI NG         135,284         118,326         253,610         -20,347         233,263           10.00         01000         DI ETARY         100,425         120,980         271,405         -107,801         163,604           11.00         01100         CAFETERI A         0         0         0         101,823         101,823           13.00         10300         NURSING ADMINISTRATION         203,547         28,159         231,706         -641         231,065           14.00         O1400         CENTRAL SERVICE COST CENTERS         104,750         10,479         174,963         245,725         395,944           1NPATIENT RO	2.00							
5. 01         00570         ADMI TT ING         102,767         8,264         111,031        265         110,766           5. 02         00590         OTHER ADMI N AND GENERAL         498,646         1,840,633         2,339,279         -46,890         2,292,389           7. 00         00700         OPERATI ON OF PLANT         119,050         1,071,684         1,190,734         -514,072         676,662           9. 00         00900         HUSEKEEPI NG         135,284         118,326         253,610         -20,347         233,263           10. 00         DI ETARY         150,425         120,980         271,405         -107,801         163,604           11. 00         01100         CAFTERI A         0         0         0         101,823         101,823           13. 00         01300         NURSI NG ADMI NI STRATI ON         203,547         28,159         231,706         -641         231,065           14. 00         01500         PHARMACY         0         148,669         848,669         -452,725         395,944           INPATI ENT ROUTI NE SERVI CE COST CENTERS         -         -         -         -         -         -         -         -         -         -         -         -	3.00		-	-	0	12 540		
5.02         00590         OTHER ADMIN AND GENERAL         4498, 646         1, 840, 633         2, 339, 279         -46, 890         2, 292, 389           7.00         00700         OPERATI ON OF PLANT         119, 050         1, 071, 684         1, 190, 734         -514, 072         676, 662           9.00         00900         HOUSEKEEPI NG         135, 284         1188, 326         253, 610         -20, 347         233, 263           10.00         OTOCO         DETARY         150, 425         120, 980         271, 405         -107, 801         163, 604           11.00         OTIOC CAFETERI A         0         0         0         101, 823         101, 823           13.00         01300         NURSI NG ADMI NI STRATI ON         203, 547         28, 159         231, 706         -641         231, 065           14.00         O1400         CENTAL SERVICES & SUPPLY         0         10, 479         10, 479         274, 963         285, 442           15.00         OHARMACY         0         848, 669         2452, 725         395, 944           1NPATI ENT ROUTINE SERVICE COST CENTERS         1, 514, 560         264, 170         1, 778, 730         -100, 608         1, 678, 122           50.00         OS000         OPERATI NG ROOM <td>4. 00 5. 01</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	4. 00 5. 01							
7.00       00700       OPERATION OF PLANT       119,050       1,071,684       1,190,734       -514,072       676,662         9.00       00900       HOUSEKEEPING       135,284       118,326       253,610       -20,347       233,263         10.00       01000       DIETARY       150,425       120,980       271,405       -107,801       163,604         11.00       01100       CAFETERIA       0       0       0       101,823       101,823         13.00       01300       NURSING ADMINI STRATI ON       203,547       28,159       231,706      641       231,065         14.00       01400       CENTRAL SERVICES & SUPPLY       0       10,479       10,479       274,963       285,442         1000       DISOD PHARMACY       0       848,669       848,669       -452,725       395,944         1000       DOSOD OPERATI NE SERVICE COST CENTERS       0       1,514,560       264,170       1,778,730       -100,608       1,678,122         50.00       05000       OPERATI NG ROOM       259,006       234,137       493,143       -136,942       356,201         51.00       05000       OPERATI NG ROOM       259,006       234,137       493,143       -136,942       356,201 </td <td>5.01</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	5.01							
9.00       00900       HOUSEKEEPING       135,284       118,326       253,610       -20,347       233,263         10.00       01000       DETARY       150,425       120,980       271,405       -107,801       163,604         11.00       01100       CAFETERIA       0       0       0       101,823       101,823         13.00       01300       NURSING ADMINISTRATION       203,547       28,159       231,706       -641       231,065         14.00       01400       CENTRAL SERVICES & SUPPLY       0       10,479       10,479       274,963       285,442         15.00       10500       PHARMACY       0       848,669       848,669       -452,725       395,944         16.00       03000       ADULTS & PEDIATRICS       1,514,560       264,170       1,778,730       -100,608       1,678,122         40.01LLARY SERVICE COST CENTERS	7.02							
10.00         01000         DI ETARY         150, 425         120, 980         271, 405         -107, 801         163, 604           11.00         01100         CAFETERIA         0         0         0         101, 823         128, 844         231, 706        641         231, 706        641         231, 706        641         231, 706         -452, 725         395, 944           15.00         01500         PHARMACY         0         848, 669         848, 669         -452, 725         395, 944           15.00         05000         PEATI IN E SERVI CE COST CENTERS         1, 514, 560         264, 170         1, 778, 730         -100, 608         1, 678, 122           50.00         05000         PARTI IN R ROOM         259, 006         234, 137         493, 143         -136, 942         356, 201           53.00         05300         ARSTHESI OLOGY         0         0         0         0         0         0	9.00							
11.00       01100       CAFETERIA       0       0       0       101,823       101,823         13.00       01300       NURSI NG ADMI NI STRATI ON       203,547       28,159       231,706      641       231,065         14.00       01400       CENTRAL SERVI CES & SUPPLY       0       10,479       10,479       274,963       285,442         01500       PHARMACY       0       848,669       848,669       848,669       -452,725       395,944         TOTO INTE SERVICE COST CENTERS         30.00       O3000       ADULTS & PEDIATRICS       1,514,560       264,170       1,778,730       -100,608       1,678,122         50.00       O5000       PERATI NG ROOM       259,006       234,137       493,143       -136,942       356,201         53.00       05300       ANCELLARY SERVICE COST CENTERS       0	10.00							
13.00       01300       NURSI NG ADMI NI STRATI ON       203, 547       28, 159       231, 706       -641       231, 065         14.00       CENTRAL SERVI CES & SUPPLY       0       10, 479       10, 479       274, 963       285, 442         15.00       D1500 PHARMACY       0       848, 669       848, 669       -452, 725       395, 944         10.00       D3000 ADULTS & PEDI ATRI CS       1, 514, 560       264, 170       1, 778, 730       -100, 608       1, 678, 122         30.00       O3000 ADULTS & PEDI ATRI CS       1, 514, 560       264, 170       1, 778, 730       -100, 608       1, 678, 122         ANCI LLARY SERVICE COST CENTERS       0       0       108, 411       108, 411       -15, 711       92, 700         53.00       05000       PERATING ROOM       259, 006       234, 137       493, 143       -136, 942       356, 201         54.00       05000 RADI OLOGY - DI AGNOSTI C       457, 038       676, 116       1, 133, 154       -86, 516       1, 046, 638         57.00       05700 CT SCAN       0<	11.00				-			
14.00       01400       CENTRAL SERVICES & SUPPLY       0       10,479       10,479       274,963       285,442         15.00       01500       PHARMACY       0       848,669       848,669       -452,725       395,944         INPATI ENT ROUTI NE SERVICE COST CENTERS       0       03000       ADULTS & PEDIATRICS       1,514,560       264,170       1,778,730       -100,608       1,678,122         ANCILLARY SERVICE COST CENTERS       0       05000       OPERATI NG ROOM       259,006       234,137       493,143       -136,942       356,201         53.00       05300       ANESTHESI OLOGY       0       108,411       108,411       -15,711       92,700         54.00       05400       RADI OLOGY-DI AGNOSTIC       457,038       676,116       1,133,154       -86,516       1,046,638         57.00       05700       CT SCAN       0	13.00			-	-	-		
15.00         01500         PHARMACY         0         848,669         848,669         -452,725         395,944           1NPATI ENT ROUTI NE SERVICE COST CENTERS         1,514,560         264,170         1,78,730         -100,608         1,678,122           ANCI LLARY SERVICE COST CENTERS         1,514,560         264,170         1,78,730         -100,608         1,678,122           50.00         05000         OPERATI NG ROOM         259,006         234,137         493,143         -136,942         356,201           53.00         05300         ANESTHESI OLOGY         0         108,411         108,411         -15,711         92,700           54.00         05400         RADI OLOGY-DI AGNOSTI C         457,038         676,116         1,133,154         -86,516         1,046,638           57.00         05700         CT SCAN         0	14.00							
INPATI ENT ROUTI NE SERVI CE COST CENTERS           30. 00         03000 ADULTS & PEDI ATRI CS         1,514,560         264,170         1,778,730         -100,608         1,678,122           ANCI LLARY SERVICE COST CENTERS         05000         OPERATI NG ROOM         259,006         234,137         493,143         -136,942         356,201           53.00         05000         OPERATI NG ROOM         259,006         234,137         493,143         -136,942         356,201           54.00         05400         RADI OLOGY-DI AGNOSTI C         457,038         676,116         1,133,154         -86,516         1,046,638           57.00         05700         CT SCAN         0	15.00							
ANCI LLARY SERVICE COST CENTERS           50.00         05000         OPERATI NG ROOM         259,006         234,137         493,143         -136,942         356,201           53.00         05300         ANESTHESI OLOGY         0         108,411         108,411         -15,711         92,700           54.00         05400         RADI OLOGY-DI AGNOSTI C         457,038         676,116         1,133,154         -86,516         1,046,638           57.00         05700         CT SCAN         0								
50.00         05000         OPERATING ROOM         259,006         234,137         493,143         -136,942         356,201           53.00         05300         ANESTHESI OLOGY         0         108,411         108,411         -15,711         92,700           54.00         05400         RADI OLOGY-DI AGNOSTI C         457,038         676,116         1,133,154         -86,516         1,046,638           57.00         05700         CT SCAN         0 <td>30.00</td> <td>1, 678, 122</td> <td>- 100, 608</td> <td>1, 778, 730</td> <td>264, 170</td> <td>1, 514, 560</td> <td>. 00 03000 ADULTS &amp; PEDIATRICS</td> <td>30.00</td>	30.00	1, 678, 122	- 100, 608	1, 778, 730	264, 170	1, 514, 560	. 00 03000 ADULTS & PEDIATRICS	30.00
53.00       05300       ANESTHESI OLOGY       0       108, 411       108, 411       -15, 711       92, 700         54.00       05400       RADI OLOGY - DI AGNOSTI C       457, 038       676, 116       1, 133, 154       -86, 516       1, 046, 638         57.00       05700       CT SCAN       0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>ANCI LLARY SERVICE COST CENTERS</td> <td>ĺ</td>							ANCI LLARY SERVICE COST CENTERS	ĺ
54.00         05400         RADI OLOGY-DI AGNOSTI C         457,038         676,116         1,133,154         -86,516         1,046,638           57.00         05700         CT SCAN         0	50.00	356, 201				259, 006		
57.00         05700         CT SCAN         0	53.00	92, 700				0		
58.00         05800         MAGNETI C RESONANCE I MAGI NG (MRI)         0 <td>54.00</td> <td>1, 046, 638</td> <td></td> <td>1, 133, 154</td> <td>676, 116</td> <td>457, 038</td> <td></td> <td></td>	54.00	1, 046, 638		1, 133, 154	676, 116	457, 038		
59.00         05900         CARDI AC CATHETERI ZATI ON         0	57.00	0	-	°	0	0		
60.00         06000         LABORATORY         0         1, 184, 940         1, 184, 940         -15, 147         1, 169, 793           60.01         06001         BLOOD LABORATORY         0	58.00	0	-	0 0	0	0		
60. 01         06001         BLOOD LABORATORY         0 <td>59.00</td> <td>0</td> <td>Ű</td> <td>0</td> <td>0</td> <td>0</td> <td></td> <td></td>	59.00	0	Ű	0	0	0		
62.00         06200         WHOLE BLOOD & PACKED RED BLOOD CELLS         0         0         0         0         0           65.00         06500         RESPI RATORY THERAPY         435,366         62,407         497,773         -41,890         455,883           65.01         06501         SLEEP LAB         0         0         0         0         0           66.00         06600         PHYSI CAL THERAPY         232,258         48,464         280,722         -58,130         222,592           67.00         06700         OCCUPATI ONAL THERAPY         45,244         0         45,244         10,435         55,679           68.00         06800         SPEECH PATHOLOGY         3,835         0         3,835         0         3,835           69.00         06900         ELECTROCARDI OLOGY         0         0         0         0           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0         37,364         37,364	60.00			1, 184, 940	1, 184, 940	0		
65. 00         06500         RESPI RATORY THERAPY         435, 366         62, 407         497, 773         -41, 890         455, 883           65. 01         06501         SLEEP LAB         0	60.01	-	0	0	0	0		
65. 01         06501         SLEEP LAB         0	62.00		11 000		0	425 277		
66.00         06600         PHYSI CAL THERAPY         232, 258         48, 464         280, 722         -58, 130         222, 592           67.00         06700         OCCUPATI ONAL THERAPY         45, 244         0         45, 244         10, 435         55, 679           68.00         06800         SPEECH PATHOLOGY         3, 835         0         3, 835         0         3, 835           69.00         06900         ELECTROCARDI OLOGY         0         0         0         0           71.00         07100         MEDI CAL SUPPLI ES CHARGED TO PATI ENTS         0         0         0         37, 364         37, 364	65.00 65.01		-41,890	497,773	62,407	435, 366		
67. 00         06700         OCCUPATI ONAL THERAPY         45, 244         0         45, 244         10, 435         55, 679           68. 00         06800         SPEECH PATHOLOGY         3, 835         0         3, 835         0         3, 835         0         3, 835         0         3, 835         0         3, 835         0         <	66. 00	-	EQ 120		19 141	222.250		
68. 00         06800         SPEECH         PATHOLOGY         3, 835         0         3, 835         0         3, 835           69. 00         06900         ELECTROCARDI OLOGY         0 </td <td>67.00</td> <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td></td>	67.00				-			
69. 00         06900         ELECTROCARDI OLOGY         0<	68.00				0			
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS 0 0 0 37, 364 37, 364	69.00		-		0			
	71.00		-	-	0	0		
72 OD 1072001 MPL DEV CHARGED TO PATTENT I OL OL OL OL 5 957 5 957	72.00	5, 957	5, 957		0	0		
	73.00	481, 262		0	0	0		
	76.00	0	0	0	0	0		
	76.97	40, 289	-3, 257	43, 546	6, 908	36, 638		
OUTPATI ENT SERVI CE COST CENTERS				•	· · · ·	· · · ·		
90. 00 09000 CLINIC 66, 317 17, 356 83, 673 -7, 815 75, 858	90.00	75, 858	-7, 815	83, 673	17, 356	66, 317	. 00 09000 CLINIC	90.00
91. 00 09100 EMERGENCY 1, 665, 133 773, 715 2, 438, 848 -127, 114 2, 311, 734	91.00	2, 311, 734	-127, 114	2, 438, 848	773, 715	1, 665, 133	. 00 09100 EMERGENCY	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART)	92.00						. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	92.00
SPECIAL PURPOSE COST CENTERS								
	113.00			-	-			
	118.00	14, 451, 075	0	14, 451, 075	8, 513, 393	5, 937, 682		
NONREI MBURSABLE COST CENTERS						1 1		
	190.00							
	192.00				0	Ŭ,		
200. 00         TOTAL (SUM OF LINES 118-199)         5, 937, 682         8, 513, 393         14, 451, 075         0         14, 451, 075	200.00	14, 451, 075	0	14, 451, 075	8, 513, 393	5, 937, 682	U. UU    IUIAL (SUM UF LINES 118-199)	200.00

	n Financial Systems SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (	IU HEALTH BLACKF	Provi der CC	N: 151302	Peri od:	u of Form CM Worksheet A	
112027				101002	From 01/01/2015		
					To 12/31/2015	Date/Time F 5/24/2016 8	
	Cost Center Description		Net Expenses				
			or Allocation				
	GENERAL SERVICE COST CENTERS	6.00	7.00				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	69, 564	1,017,612				1.0
2.00	00200 NEW CAP REL COSTS DEDG & TTXT	07, 304	0				2.0
3.00	00300 OTHER CAPITAL RELATED COSTS	0	0				3.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	92, 985	1, 071, 147				4.0
5.01	00570 ADMI TTI NG	72,705	110, 766				5.0
5.01	00590 OTHER ADMIN AND GENERAL	2, 977, 509	5, 269, 898				5.0
7.02	00700 OPERATION OF PLANT	2, 977, 509	676, 662				7.0
9.00	00900 HOUSEKEEPI NG	0	233, 263				9.0
9.00 10.00	01000 DI ETARY	-					
		-27, 268	136, 336				10.0
11.00		-33, 845	67, 978				11.0
13.00	01300 NURSI NG ADMI NI STRATI ON	-1, 515	229, 550				13.0
14.00	01400 CENTRAL SERVICES & SUPPLY	0	285, 442				14.0
15.00	01500 PHARMACY	0	395, 944				15.0
20.00	INPATIENT ROUTINE SERVICE COST CENTERS		1 (70 100				- 20.0
30.00	03000 ADULTS & PEDIATRICS	0	1, 678, 122				30.0
F0 00	ANCI LLARY SERVICE COST CENTERS		257 201				
50.00	05000 OPERATI NG ROOM	0	356, 201				50.0
53.00	05300 ANESTHESI OLOGY	0	92, 700				53.0
54.00		0	1,046,638				54.0
57.00	05700 CT SCAN	0	0				57.0
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.0
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59.0
60.00	06000 LABORATORY	0	1, 169, 793				60.0
60.01	06001 BLOOD LABORATORY	0	0				60.0
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.0
65.00	06500 RESPI RATORY THERAPY	0	455, 883				65.0
65.01	06501 SLEEP LAB	0	0				65.0
66.00	06600 PHYSI CAL THERAPY	-1, 184	221, 408				66. 0
67.00	06700 OCCUPATI ONAL THERAPY	0	55, 679				67.0
68.00	06800 SPEECH PATHOLOGY	0	3, 835				68.0
69.00	06900 ELECTROCARDI OLOGY	0	0				69.0
71.00		0	37, 364				71.0
72.00		0	5, 957				72.0
73.00	07300 DRUGS CHARGED TO PATIENTS	0	481, 262				73.0
76.00	03140 CARDI OLOGY	0	0				76.0
76.97	07697 CARDI AC REHABI LI TATI ON	-640	39, 649				76.9
	OUTPATIENT SERVICE COST CENTERS						
90.00		0	75, 858				90.0
91.00	09100 EMERGENCY	-978, 277	1, 333, 457				91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
	SPECIAL PURPOSE COST CENTERS						
113.00	D 11300 I NTEREST EXPENSE	0	0				113. 0
118.00	SUBTOTALS (SUM OF LINES 1-117)	2,097,329	16, 548, 404				118. 0
	NONREI MBURSABLE COST CENTERS						
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0				190. 0
192.00	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0	o				192.0
200.00	TOTAL (SUM OF LINES 118-199)	2,097,329	16, 548, 404				200. 0

SSI FI CATI ONS			Provider CO	From 01/01/2015	rksheet A-6
					te/Time Prepar 24/2016 8:19 p
Cost Center	Li ne #	Salary	Other		
2.00	3.00	4.00	5.00		
A - CAFETERIA	11.00	E7 70/	44 117		
CAFETERI A	<u>11.00</u>	5 <u>7,706</u> 57,706	4 <u>4, 117</u> 44, 117		
B - MEDICAL SUPPLIES					
OTHER ADMIN AND GENERAL	5.02	0	29		
CENTRAL SERVICES & SUPPLY MEDICAL SUPPLIES CHARGED	ТО 14.00 71.00	0	274, 952 37, 364		
PATI ENTS					
I MPL. DEV. CHARGED TO PATI ENT	72.00	0	5, 957		
FAILENT	0.00	о	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	о	0		1
	0.00	0	0		1
	0.00	0	0		1
	0.00	0	0		1
	0.00 0.00	0	0		1
		— — — <u>o</u>	318, 302		
C - DRUGS CHARGED TO PATI			2.244		
OTHER ADMIN AND GENERAL CENTRAL SERVICES & SUPPLY	5.02 14.00	0	3, 366 11		
PHARMACY	15.00	0	15, 693		
DRUGS CHARGED TO PATIENTS	73.00	0	481, 262		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00 0.00	0	0		1
		0	500, 332		
D - LEASE EXPENSE NEW CAP REL COSTS-BLDG &	1.00	0	43, 196		
<u>FIX</u> T					
O E - EMPLOYEE BENEFITS		0	43, 196		
EMPLOYEE BENEFITS DEPARTM	ENT 4.00	0	24, 845		
OTHER ADMIN AND GENERAL	5.02	0	467		
	0.00 0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00 0.00	0	0		
	0.00	0	0		
	0.00	0	0		1
0		— — — <u>o</u>	25, 312		· · · · · · · · · · · · · · · · · · ·
F - DEPRECIATION NEW CAP REL COSTS-BLDG &	1 00	0			
FIXT	1.00	0	745, 345		
	0.00	О	0		
	0.00 0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		1
	0.00	0	0		1
	0.00	0	0		1
	0.00	0	0		1
0	0.00	0	745, 345		1
G - OUTPATIENT THERAPY					
OCCUPATI ONAL THERAPY	67.00	10, 416	19		

Heal th	Financial Systems		IU HEALTH BLAC	KFORD HOSPI TAL		In Lie	u of Form CMS-	2552-10
RECLAS	SEFECATIONS			Provi der	CCN: 151302	Period: From 01/01/2015	Worksheet A-0	6
						To 12/31/2015	Date/Time Pre 5/24/2016 8:	
		Increases						
	Cost Center	Line #	Sal ary	0ther				
	2.00	3.00	4.00	5.00				
	H - PROPERTY INSURANCE							
1.00	NEW CAP REL COSTS-BLDG &	1.00	0	15, 950				1.00
	FIXT							
	TOTALS		0	15, 950				[
500.00	Grand Total: Increases		68, 122	1, 692, 573				500.00

Decrements         Uncertain state         Display and state           A - Over Head A         10 and a / and / and a / and a / and a / and / and a / and a / and	LASSI	FICATIONS			Provi der	- CCN: 151302	Period:	Worksheet A-6	5
Operation         Operating         Operating         Operating         Kext. A-7 Ref.           0         5.00         7.00         8.00         7.00         44.117         0         0           0         FM FORM         10.00         5.7.00         44.117         0         0           0         FM FORM         SUPPLIFS         0         137         0         0           0         FM FORM         SUPPLIFS         0         0         64.00         0           0         PREATOR         0         0         0         0         0           0         PREATOR         SUPPLIFS         0         0         0         0           0         PREATOR         0         0         0         0         0         0           0         PREATOR         0         <							To 12/31/2015	Date/Time Pre	
6.00         7.60         8.00         9.00         10.00           0         DIT MAY								572472010 8.1	
A         CATTERIA         Control           0         UETAX         10.00         07.760         44.117         0           0         Marce Call SUPPITIS         0         57.760         44.117         0           0         MATCRE SUPPITIS         0         0         60         0         0           0         MATCRE SUPPITIS         0         0         64         0         0           0         MATCRE SUPPITIS         0         0         64         0         0           0         MATCRE SUPPITIS         5.01         0         64         0         0           0         MATCRE SUPPITIS         5.00         0         1.403         0         0           0         MATCRE SUPPITIS         53.00         0         1.403         0         0           0         MATCRE SUPPITIS         53.00         0         1.403         0         0         1.403         0           0         MATCRE SUPPITIS         9         0         1.00         0         7.475         0           0         MATCRE SUPPITIS         9         0         7.475         0         1.100         0         1.100 <td< th=""><th></th><th></th><th></th><th></th><th></th><th></th><th><u>.</u></th><th></th><th></th></td<>							<u>.</u>		
D         DETARY			7.00	8.00	9.00	10.00			
D			10,00	57, 706	44, 117	,	0		1
00         ENERGY DEPARTIENT         4.00         0         137         0           00         MINITIN GF PLART         7.00         0         2.0         0           00         PRANCY         7.00         0         2.0         0           00         MINITING         9.00         2.0         0.0         1.0           00         MINITING         9.0         2.0         0         1.0           00         MINITING         1.0.0         0         1.1         0           01         MINITING         1.0.0         0         1.4         0.0           01         MINITING         1.0.00         0         1.4         1.50           01         MINITING         1.0         0         2.1         1.5           00         MINITING         1.0         0         2.1         1.5           00         MINITING         1.0         0         2.1         1.5           00         MINITING         1.0         0         2.1         1.6           00         MINITING         1.0         0         1.0         1.0           00         MINITING         1.0         0         1.0 </td <td>0</td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>	0								
Dot         Description         Construction         Construction         Construction           Description         0.00 FEART         0.00         0.00         0.00         0.00         0.00           DEFERSE         0.00         0.0	В	- MEDICAL SUPPLIES			·				
00         0FARTION OF PLANT         2.00         0         5.4         0           01005EVEF1NC         9.00         0.00         273         0           01005EVEF1NC         10.00         0         273         0           01005EVEF1NC         10.00         0         273         0           01005EVEF1NC         10.00         0         130         0           01005EVEF1NC         51.00         0         9.9373         0           00         PARSILGLARK ROM         53.00         0         14.159         0           00         RADILGOVD LACKSTIC         54.00         0         2.7.425         0           0100         PARSILGLARK ROM         50.60         0         2.1.01         0         2.1.01           0100         PARSILGLARKED TO PARTENT         4.00         0         3.1.03         0           0100         PARSILGLARKED TO PARTENT         4.00         0         3.4.38         0           0100         PARSILGLARKED TO PARTENT         4.00         0         3.4.38         0           0100         PARSILGLARKED TO PARTENT         4.00         0         3.4.38         0           010000         9.10					137				1
00         D057EKEPINS         9,00         0         20,044         0           00         NUTSING         ADMINISTRATION         13,00         0         33         0           00         NUTSING         ADMINISTRATION         13,00         0         33         0           00         NUTSING         FEDITATION         13,00         0         33         0           00         NUTSING         50,00         0         50,958         0           00         NESTRETCLOOV         53,00         0         14,159         0           00         RESPIRATOLOCY         65,00         0         24,361         0           00         RESPIRATOLOCY         65,00         0         27,425         0           00         CADUAT REABLITATION         76,97         0         519         0           01         CADUAT SCHABELT TO PATIENTS         0         37,637         0           01         MARANCY         15,00         0         437,647         0           01         MARANCY         15,00         0         2,348         0           01         MARINERSON         50,00         0         2,348         0 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>2</td>									2
00         DETARY         10.00         0         67.3         0           00         PHARMACY         15.00         0         1,403         0           00         PHARMACY         15.00         0         1,403         0           00         PHARMACY         15.00         0         50.00         99.378         0           00         PHARINE AROM         50.00         0         99.378         0           00         PHARIAL CONTRATIC         53.00         0         14.151         0           00         PHARIAL CHERNPY         65.00         0         27.425         0           00         PHARIAL THERNPY         66.00         0         3.108         0           00         CLINIC         110.00         0         34.33         0           00         CLINIC         110.00         0         34.33         0           00         CLINIC         50.00         0         45.7.617         0           00         OPARTINES         50.00         0         5.438         0           00         OPARTINES         50.00         0         2.338         0           00         OPARTINES <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>3</td>									3
D0         MESING, ADMIN IN STATUON         13.00         0         31         0           D0         HARANCY         15.00         0         1,403         0           D0         AULTS & FEDIATICS         30.00         0         50.958         0           D0         AUSTRESIDUCION         50.00         0         770         0           D0         AUSTRESIDUCION         50.00         0         777.425         0           D0         PESPIENDENTIC         50.00         0         7.426         0           D0         PASTRESIDUCION         70.00         0         7.1300         0           D0         CADUCAS CHABLITATION         76.97         0         519         0           D0         CADUCAS CHABLITATION         76.97         0         7.1400         0           D0         CADUCAS CHABLITATION         76.97         0         7.1410         0           D0         CADUCAS CHABLITATION         76.97         0         7.1410         0           D0         CHADICAS CHABLITATION         50.00         0         7.431         0           D0         FEDIATICS         30.00         0         7.441         0 <td></td> <td></td> <td></td> <td>-</td> <td></td> <td></td> <td>°  </td> <td></td> <td>4</td>				-			°		4
D0         HARMACY         15.00         0         1,403         0           DAULTS & FEDIATRICS         30.00         0         50.00         0         50.00         0         50.00         0         50.00         0         50.00         0         50.00         0         50.00         0         50.00         0         50.00         0         50.00         0         50.00         0         24.361         0           D0         MARSTRESIO.0CV         0         24.361         0         0         24.361         0           D0         PARSIGLAT.HERBY         66.00         0         2.4301         0         0           D1         PARSIGLAT.HERBY         40.00         0         3.438         0         0           D1         DAULTS & FRANELT TATION         7.00         0         71.500         0         0         0         0           D1         DAULTS & FRANELT TATION         7.00         0         74.301         0 <t< td=""><td></td><td></td><td></td><td>-</td><td></td><td></td><td>°  </td><td></td><td>5</td></t<>				-			°		5
D0         AULTS & FEDIATRICS         30.00         0         50.998         0           00         MRESTHESIOLOGY         53.00         0         14.159         0           00         RADICLOSY DARANGSTIC         54.00         0         27.425         0           00         MRESTHESIOLOGY         THERAPY         65.00         0         27.425         0           00         PHYSICAL THERAPY         65.00         0         27.425         0           00         PHYSICAL THERAPY         65.00         0         4.800         0           01         PHYSICAL THERAPY         91.00         0         71.500         0           02         PHYSICAL THERAPY         4.00         0         3.438         0           03         PHARMACY         SUBARCED TO PATIENTS				-					6
00         CPERATING ROUM         50.00         0         99.370         0           01         ANLSTHES/LOLGY         53.00         0         14.159         0           01         RESPERATING THERAPY         66.00         0         24.361         0           02         RESPERATING THERAPY         66.00         0         3.108         0           03         RESPERATING THERAPY         66.00         0         7.1000         0           04         CARDIA REHABIL LTATION         76.67         0         4.519         0           05         CLINIC         90.00         0         7.1000         0         7.1000           05         CEREMY         15.00         0         4.57.617         0         0           06         PREVEYS         53.00         0         1.641         0         0         4.58           07         PREVEY         56.00         0         3.438         0         0         4.511         0           08         ALSTERATORY THERAPY         66.00         0         4.38         0         0         1.641         0           08         CLINIC         5.01         0         2.05         0				Ű			0		8
00         MASTHESIOLOCY         53.00         0         14.19         0           0         RADIOLOCY DIACNOSTIC         54.00         0         27.425         0           0         PHYSICAL HERAPY         65.00         0         3.108         0           0         OPHYSICAL HERAPY         66.00         0         3.108         0           0         CLINIC         90.00         0         4.300         0           0         CLINIC         91.00         0         4.57.617         0           0         PHARMAC         BANILTS & PEDIATRICS         50.00         0         1.641         0           0         RADIOLOCYDIACNOSTIC         53.00         0         2.384         0         0           0         RADIOLOCYDIACNOSTIC         53.00         0         2.384         0         0           0         PHARMAC         90.00         0         3.198         0				-			-		9
00         RESPIRATORY THERAPY         66.00         0         24.3c1         0           01         RESPIRATORY THERAPY         66.00         0         3.108         0           01         CABLICAT REMAIL LITATION         76.97         0         3.108         0           02         CABLICAT REMAIL LITATION         76.97         0         3.108         0           03         EMPRENEY         0         0         3.108         0           04         CLINIC         90.00         0         4.300         0           05         EMPRINCY         0         0         3.438         0           05         MARCHESTICATOR FORMANT         4.00         0         4.57.617         0           06         AMESTIRESTOLOGY         53.00         0         1.641         0           06         RESPIRATOR FOLOGY         53.00         0         2.2384         0           07         FLASE EXPENSE         0         0.00         2.33         0           07         CLASE EXPENSE         0         0.00         2.33         0           08         CLINIC VE THERAPY         46.00         0         3.30         0				-			0		10
00         RESPIRATORY THERAPY         65.00         0         22.425         0           00         PHYSICAL THERAPY         66.00         0         3.106         0           00         CLINIC         90.00         0         71.500         0           01         CLINIC         90.00         0         71.500         0           02         CLINICS         CHARGED TO PATIENTS         0         318.302         0           03         CLINICS         FEDRATICS         50.00         0         447.617         0           03         RADICINCY FEDRETITS DEPARTMENT         15.00         0         447.617         0           04         RADICINCY FEDRETITS         50.00         0         447.617         0           05         RADICINCY FIERDERY         65.00         0         35.0         0           05         RADICINCY FIERDERY         65.00         0         33.2         0           06         FIERTANY FIERDERY         65.00         0         43.196         10           06         CLINIC         90.00         0         43.196         10           01         CLINICY         91.00         0         43.196         <				1			0		11
00         CRU AC REVABLICATION         76. 77         0         519         0           01         CLU NC         90.00         0         71.500         0           02         -         71.500         0         71.500         0           03         -         71.500         0         71.500         0           04         -         71.500         0         43.33         0           05         -         71.500         0         455.617         0           06         -         71.500         0         455.617         0           07         -         71.500         0         455.60         0           08         -         -         71.600         145.66         0           00         -         -         0         23.34         0           00         -         -         0         43.18         0           01         -         -         0         35.00         0           02         -         -         0         30.00         0         30.01         0         0         10.01         0         10.01         0         10.01         0 <td>00 RI</td> <td>ESPI RATORY THERAPY</td> <td>65.00</td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td> <td>12</td>	00 RI	ESPI RATORY THERAPY	65.00	0			0		12
00         CLINIC         90.00         0         4.300         0           ELERCENCY         91.00         0         71.500         0           C - DRUS CHARGED TO PATIENTS         0         318.302         0           00         HURNERCY         0         318.302         0           01         HURNERCY         0         0         348.302         0           01         HURNERCY         50.00         0         457.617         0           01         HARANCY THE SOLDARY         53.00         0         556.0         0           02         HARANCY THERAPY         66.00         0         4.31         0           03         CLINIC         54.00         0         4.31         0           04         CLINIC         54.00         0         4.31         0           05         CLINIC         54.00         0         4.31         0           05         CLINIC         50.01         0         2.33         0           06         CLINIC         0         0         4.3196         10           07         CLINIC         0         0         3.196         10           08<	00 PI	HYSICAL THERAPY	66.00	О	3, 108	6	0		13
00         ENERGENCY         91.00         0         71, 500         0           0         -         70, 500         318, 302         -           0         EMPLOYEE BENEFITS DEPARTMENT         4.00         0         3.4, 338         0           0         PAURIACY         15.00         0         457, 617         0           00         ADULTS & PEDIATRICS         30.00         0         9, 614         0           00         AMESTHESIOLOGY         53.00         0         22.384         0           01         RESPIRATOR THERAPY         66.00         0         23.00         0           0         CLINIC         90.00         0         2.4,471         0         0           0         CLINIC         90.00         0         2.4,3196         10         0           0         CLINIC         90.00         0         301         0	00 C/	ARDI AC REHABI LI TATI ON	76.97	0	519		0		14
0         -         0         318, 302         1           0         C - DRUGS CHARGED TO PATIENTS         4,00         0         3,438         0           00         PHANACY         15,00         0         457,617         0           00         PHANACY         15,00         0         457,617         0           00         ADULTS & PEDIATRICS         30,00         0         9,014         0           00         PARAMACY         53,00         0         556         0           01         AABULTS & PEDIATRICS         50,00         0         438         0           01         RADIOLOCO-DIACMOSTIC         56,00         0         355         0           02         DESPIRATORY THERAPY         66,00         0         43,196         -           02         D LEASE EXPENSE         -         0         -         0         -         0         -         0         -         0         -         0         -         0         -         0         -         0         -         0         -         0         -         0         -         0         -         0         -         0         -         0 </td <td></td> <td></td> <td></td> <td>0</td> <td></td> <td></td> <td>0</td> <td></td> <td>15</td>				0			0		15
C         Device Construction         Device Construction           00         FUNCTION         4.00         0         3.33         0           00         PAULTS & DEPARTINENT         15.00         0         4.77.41         0           00         PAULTS & PEDIATRICS         30.00         0         4.77.41         0           00         PRESTREATION CS         30.00         0         9.74.41         0           010         RESTREATION CS         53.00         0         55.6         0           010         RESTREATORY THERAPY         66.00         0         33.8         0           010         CLINIC         90.00         0         4.471         0           010         CLINIC         90.00         0         4.3.196         0           010         DEREGENCY         91.00         0         4.3.196         0           0110         DEREGENCY         91.00         0         33.3         0           01111         NG         5.01         0         20.5         0           010         DEREGENCY         91.00         0         333.0         0           010         DEREGENCY         9.00 <td< td=""><td>00 EI</td><td>MERGENCY</td><td>91.00</td><td></td><td></td><td></td><td>익</td><td></td><td>16</td></td<>	00 EI	MERGENCY	91.00				익		16
00         ENPLOYEE BENEFITS DEPARTMENT         4.00         0         3.438         0           01         PHARMACY         15.00         0         477.617         0           01         ADULTS & PEDLATRICS         30.00         0         9,014         0           02         PARAMACY         53.00         0         556         0           03         ADULTS & PEDLATRICS         50.00         0         438         0           04         RADICLOCPLA GADOSTIC         54.00         0         22.384         0           04         PHASTACK         THERAPY         66.00         0         35.0         0           05         D         -         43.196         -         0         -         -           05         D         -         43.196         -         0         -         -           06         -         -         0         301         0         0         -	0			0	318, 302				
00         PARAMACY         15.00         0         457,617         0           00         ADULTS PEDIATRICS         30.00         0         9,641         0           00         PERATING ROM         50.00         0         1,641         0           00         RESPIRATORY THERAPY         65.00         0         22,384         0           01         RESPIRATORY THERAPY         66.00         0         35         0           02         CLINIC         90.00         0         4,471         0           01         CLINIC         90.00         0         43,196         10           01         -         0         0         500,332         0           01         -         0         0         303         0           02         -         0         0         303         0           03         MANTING         5.01         0         205         0           04         ADUTS & PEDIATRICS         30.00         0         303         0           04         OPERATING ROMM         55.01         0         205         0           05         DELEATRY         10.00         0			4 00		0 400		0		
D0         ADULTS & PEDIATRICS         30.00         0         9.014         0           00         OPERATING ROM         50.00         0         1.641         0           00         RADIOLOSCY-DIAGNOSTIC         53.00         0         2.384         0           010         RADIOLOSCY-DIAGNOSTIC         54.00         0         2.384         0           010         RADIOLOSCY-DIAGNOSTIC         54.00         0         35         0           010         CLINIC         90.00         0         -4.31         0           01         LEASE EXPENSE         0         -4.31         10           01         LEASE EXPENSE         0         -4.31         10           01         ELASE EXPENSE         -         0         -4.31         10           01         ELASE EXPENSE         -         0         -         4.31         10           02         ELASE EXPENSE         -         0         -         4.31         10           03         DO         0         0.301         0         0         0         0           04         DETATIN         13.00         0         0.333         0         0 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td>1</td></t<>									1
00         DEPEAT ING. ROOM         50.00         0         1.641         0           01         AMESTHESI LOGY         53.00         0         556         0           02         MADIOLOGY-DI ANDSTIC         54.00         0         22.384         0           03         PRSPIRATORY THERAPY         66.00         0         358         0           03         CLINIC         90.00         0         738         0           04         District Anterapy         66.00         0         332         0           04         District Anterapy         0         43.196         10         0           05         District Anterapy         0         43.196         10         0           05         District Anterapy         0         0         301         0           06         District Anterapy         10         0         205         0           07         District Anterapy         10         0         303         0           08         District Anterapy         10         0         303         0           09         District Anterapy         10         0         303         0           00				-			-		
00         APESTHESI OLOGY         53.00         0         556         0           01         RADIOLOGY-DI AGNOSTI C         54.00         0         22.384         0           02         READIOLOGY-DI AGNOSTI C         55.00         0         22.384         0           03         READIOLOGY-DI AGNOSTI C         56.00         0         35         0           04         PHYSI CAL THERAPY         66.00         0         738         0           0         LEASE EXPENSE				-			-		4
00         RAD OLOGY-DI AGNOSTI C         54.00         0         22.384         0           00         RESPIRATORY THERAPY         65.00         0         335         0           00         PHYSI CAL THERAPY         66.00         0         738         0           00         CLINIC         90.00         0         738         0           01         LEASE EXPENSE         0         43.196         0           02         -         -         0         303         0           04         AMM TIN KG         5.01         0         205         0           01         HURSICAL THERAPY         10.00         303         0         0           01         HURSICAL THERAPY         10.00         3033         0         0           02         PERATION OF PLANT         7.00         0         303         0           03         HURSICAL THERAPY         10.00         3833         0         0           03         HURSICAL THERAPY         10.00         3833         0         0           04         HULTS & FEDIATRICS         30.00         0         4.35         0           04         HURSICAL THERAPY				-			0		5
00         RESPIRATORY THERAPY         65.00         0         438         0           00         PHYSICAL THERAPY         66.00         0         35         0           01         CLINIC         90.00         0         4.71         0           0         D         0         4.71         0         0           0         D         0         4.3.196         10           0         0         0         43.196         10           0         0         0         301         0           0         0         0         301         0           0         0         0         303         0           0         0         0         333         0           0         0         0         343         0           0         0         0         343         0           0         0         0         343         0           0         0         0         333         0           0         0         0         3435         0           0         0         0         1.640         0           0         0				o			0		6
D0     CLNIC     90.00     0     738     0       D0     EMERGENCY				0			0		7
OP         EMERGENCY         91.00         0         4.471         0           D         - LEASE EXPENSE	00 PI	HYSICAL THERAPY	66.00	О	35		0		8
0	00 CI	LINIC	90.00	0	738	6	0		9
D         - LEASE         EXPENSE         -         <	00 <u>El</u>	MERGENCY	<u> </u>	0			0		10
00       PHYSICAL THERAPY       66.00       0       43,196       10         0       43,196       10       0       43,196       10         0       ADMITTING       5.01       0       205       0         0       OPERATION OF PLANT       7.00       0       301       0         0       DIETARY       10.00       0       333       0         00       AURSING ADMINISTRATION       13.00       0       610       0         00       ADULTS & PEDIATRICS       30.00       0       2.896       0         00       ADULTS & PEDIATRICS       50.00       0       4.35       0         00       CARDIAC REHABILITATION       76.97       0       97       0         00       EMEGENCY       91.00       0       18.916       0         00       EMEGENERY       91.00       0       18.916       0         00       EMEGENCY       91.00       0       34.802       0         00       DEREGENCY       91.00       0       31.971       0         01       DEREGENCY       91.00       0       34.802       0         00       DEREGENCY       <	0			0	500, 332				
0         -         -         0         43, 196         -           E         -         Imageeeeeeeeeeeeeeeeee			(( 00	ol	42 104	1	0		1
E         EMPLOYEE         BENEFITS         205           00         ADMITTING         5.01         0         205         0           00         OPERATION OF PLANT         7.00         0         301         0           00         OPERATION OF PLANT         7.00         0         303         0           00         PUETARY         10.00         0         333         0           00         NURSING ADMINISTRATION         13.00         0         610         0           00         ADULTS & PEDIATRICS         30.00         0         2.896         0           00         OPERATING ROM         50.00         0         4.35         0           00         CARDIA CREHABILITATION         76.97         0         97         0           00         CARDIA CREHABILITATION         76.97         0         97         0           00         CARDIA CREHABILITATION         76.97         0         97         0           00         CHENCY         91.00         0         1.694         9           00         OPERATION OF PLANT         7.00         0         3.3,717         0           00         OPERATING ROM			<u>00.00</u>				<u>u</u>		1
D0     DVMI TTI NG     5.01     0     205     0       D0     DPERATI DN OF PLANT     7.00     0     301     0       D0     DISEXEEPING     9.00     0     303     0       D0     DISEXEEPING     9.00     0     303     0       D0     DISEXEEPING     9.00     0     303     0       D0     DISEXEEPING     9.00     0     610     0       D0     DISEXEEPING     30.00     0     2.896     0       D0     OPERATING ROOM     50.00     0     435     0       D0     CARDIAC REHABILITATION     76.97     0     97     0       D0     CARDIAC REHABILITATION     76.97     0     166     0       D0     CARDIAC REHABILITATION     76.97     0     25.312     0       F     - DEPRECIATION     4.00     0     1.694     9       D0     OTHER ADMIN AND GENERAL     5.02     0     34.802     0       D0     DIETARY     10.00     0     4.722     0       D0     PHARMACY     15.00     0     9.740     0       D0     PHARMACY     50.00     0     38.770     0       D0     ARDIO	F	- EMPLOYEE BENEFLTS	I	0	43, 190				-
00     OPERATION OF PLANT     7.00     0     301     0       00     HOUSEKEPING     9.00     0     303     0       00     DIETARY     10.00     0     383     0       00     MURSING ADMINISTRATION     13.00     0     610     0       00     ADULTS & PEDIATRICS     30.00     0     2.896     0       01     DETARY     0     0     135     0       02     OPERATING ROOM     50.00     0     435     0       03     CARDIAC REHABILITATION     76.97     0     97     0       04     CARDIAC REHABILITATION     76.97     0     18.916     0       05     EMPLORE BENEFITS DEPARTMENT     4.00     0     1.694     9       06     THER ADMIN AND GENERAL     5.02     0     34.802     0       07     OPERATINON OF PLANT     7.00     0     513.717     0       08     ADULTS & PEDIATRICS     30.00     0     37.740     0       09     OPERATING ROOM     50.00     0     38.770     0       00     DERARY     60.00     0     1.356     0       00     LARORATORY     66.00     0     1.5.147     0			5.01	0	205	;	0		1
D0     D1 ETARY     10.00     0     383     0       D0     NURSI NG ADMI N STRATI ON     13.00     0     610     0       D0     ADULTS & PEDI ATRI CS     30.00     0     2.896     0       D0     OPERATI NG ROOM     50.00     0     435     0       D0     OPERATI NG ROOM     50.00     0     435     0       D0     OCARDI AC REHABI LI TATI ON     76.97     0     97     0       D0     CARDI AC REHABI LI TATI ON     76.97     0     97     0       D0     CARDI AC REHABI LI TATI ON     76.97     0     97     0       D0     CARDI AC REHABI LI TATI ON     70.00     0     165     0       D0     EMERGENCY     91.00     0     1694     9       D0     OTHER ADMI N AND GENERAL     5.02     0     34.802     0       D0     DI ETARY     10.00     0     4.722     0       D0     DI ETARY     10.00     0     37.740     0       D1     PEDI ATRI CS     30.00     0     38.770     0       D0     ADULTS & PEDI ATRI CS     30.00     0     38.770     0       D0     ADULTS & FORM     FEADORY THERAPY     66.00 <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td>0</td> <td></td> <td>2</td>							0		2
D0     NURSI NG ADMI NI STRATI ON     13.00     0     610     0       D0     ADULTS & PEDI ATRI CS     30.00     0     2,896     0       D0     PERATI NG ROM     50.00     0     435     0       D0     CADI LOGY-DI AGNOSTI C     54.00     0     1.001     0       D0     CARDI AC REHABI LI TATI ON     76.97     0     97     0       D0     CLI NI C     90.00     0     165     0       D0     CLI NI C     90.00     0     165     0       D0     EMERGENCY     91.00     0     1694     9       D0     OTHER ADMI N AND GENERAL     5.02     0     34,802     0       D0     DEFART AMM N AND GENERAL     5.02     0     34,802     0       D0     DEFART NG ROM     7.00     0     513,717     0       D0     DEFART NG ROM     50.00     0     9,398     0       D0     DEFART NG ROM     50.00     0     35,496     0       D1     APPE NING ROM     50.00     0     38,770     0       D0     ANDIST NG ROM     50.00     0     14,027     0       D1     ADADITS & PEDI ATRI CS     30.00     0     38,770 <td>о н</td> <td>OUSEKEEPI NG</td> <td>9.00</td> <td>o</td> <td>303</td> <td></td> <td>0</td> <td></td> <td>3</td>	о н	OUSEKEEPI NG	9.00	o	303		0		3
D0       ADULTS & PEDIATRICS       30.00       0       2,896       0         D0       OPERATING ROM       50.00       0       435       0         D0       RADILOGY-DIAGNOSTIC       54.00       0       1,001       0         D0       CARDIAC REHABILITATION       76.97       0       97       0         D0       CARDIAC REHABILITATION       76.97       0       97       0         D0       CARDIAC REHABILITATION       76.97       0       97       0         D0       CLINIC       90.00       0       165       0         D0       EMPLOYEE BENEFITS DEPARTMENT       4.00       0       1,694       9         D0       OTHER ADMIN AND GENERAL       5.02       0       34.802       0         D0       DEFARY       10.00       0       4.722       0         D0       PHARMACY       15.00       9.388       0         D0       PHARMACY       15.00       9.388       0         D0       PHARMACY       53.00       9.996       0         D0       RADI LOGY-DI AGNOSTIC       54.00       0       38.770       0         D0       RADI LOGY-DI AGNOSTIC	00 D	I ETARY	10.00	0	383	6	0		4
D0         OPERATING ROM         50.00         0         435         0           D0         RADIOLOGY-DIAGNOSTIC         54.00         0         1,001         0           D0         CARDIAC REHABILITATION         76.97         0         97         0           0.00         CLINIC         90.00         0         165         0           0.00         EMERGENCY         91.00         0         155,312         0           0         Topo         0         25,312         0         0           0         OTHER ADMIN AND GENERAL         5.02         0         34,802         0           00         OPERATION OF PLANT         7.00         0         513,717         0           00         DIETARY         10.00         4,722         0           00         ADULTS & PEDIATRICS         30.00         0         37,740         0           00         DIETARY         10.00         0         38,770         0         0           00         ADULTS & PEDIATRICS         53.00         0         14,027         0           00         ABORATORY         60.00         0         14,027         0           00				-			0		5
D0       RADI OLOGY-DI AGNOSTI C       54.00       0       1,001       0         D0       CARDI AC REHABI LI TATI ON       76.97       0       97       0         D0       CLI NI C       90.00       0       165       0         0       D0       0       25.312       0       0         F       D0       0       16.94       9       0         00       OTHER ADMIN AND GENERAL       5.02       0       34.802       0         00       OPERATION OF PLANT       7.00       0       51.3717       0         00       DI ETARY       10.00       0       4.722       0         01       PHARMACY       15.00       0       93.8       0         020       ADULTS & PEDI ATRI CS       30.00       0       37.740       0         020       ADULTS & SOLOGY       53.00       0       996       0         030       ADULTS & SOLOGY       53.00       0       94.60       0         04       RADI OLOGY-DI AGNOSTI C       54.00       0       38.770       0         00       RADI OLOGY-DI AGNOSTI C       55.00       0       14.027       0         00 </td <td></td> <td></td> <td>30.00</td> <td>0</td> <td>2, 896</td> <td></td> <td>0</td> <td></td> <td>6</td>			30.00	0	2, 896		0		6
D0       CARDIAC REHABILITATION       76.97       0       97       0         D0       CLINIC       90.00       0       165       0         D0       EMERGENCY       91.00       0       18.916       0         D0       EMPLOYEE BENEFITS DEPARTMENT       4.00       0       1.694       9         D0       OTHER ADMIN AND GENERAL       5.02       0       34.802       0         D0       OPERATION OF PLANT       7.00       0       4.722       0         D0       DI ETARY       10.00       4.722       0         D1 ETARY       10.00       9.398       0         D0       OPERATION GROM       50.00       0       35.496       0         D0       ANDUTS & PEDIATRICS       30.00       0       38.770       0         D0       ANDUTS & PEDIATRICS       50.00       0       15.147       0         D0       ANDUTS & PEDIATRICS       60.00       0       15.147       0         D0       ANDUTS & PEDIATRICS       0       0       38.770       0         D0       ANDUTS WARCHARDY       66.00       0       1,356       0         D0       CARDIAC EHABILITATIO									7
00       CLINIC       90.00       0       165       0         00       EMERCENCY       0       18.916       0         0       25.312       0         F       DEPRECIATION       0       1.694       9         00       OTHER ADMIN AND GENERAL       5.02       0       34.802       0         00       OFERATION OF PLANT       7.00       0       513.717       0         00       DI ETARY       10.00       0       4.722       0         00       ADUTS & PEDIATRICS       30.00       0       37.740       0         00       ADUTS & PEDIATRICS       30.00       38.770       0         00       ARDI GROSTI C       54.00       0       38.770       0         00       RADI GROSTI C       54.00       0       14.027       0         00       RESPI RATORY THERAPY       66.00       0       1.356       0         00       CARDIA C REHABI LI TATI ON       76.97       0       2.641       0         00       CARDI AC REHABI LI TATI ON       76.97       0       2.641       0         00       CLINIC       90.00       0       2.641       0							-		8
00         EMERGENCY									9
O         O         25, 312           F         - DEPRECIATION           00         EMPLOYEE BENEFITS DEPARTMENT         4.00         0         1, 694         9           00         OTHER ADMIN AND GENERAL         5.02         0         34, 802         0           00         OPERATION OF PLANT         7.00         0         513, 717         0           00         DIETARY         10.00         0         4, 722         0           01         PARMACY         15.00         0         9, 398         0           00         PDERATIOR OF PLANT         7.00         0         37, 740         0           01         PARMACY         15.00         0         9, 398         0           00         ADULTS & PEDIATRICS         30.00         0         37, 740         0           00         OPERATING ROM         50.00         0         38, 770         0           00         LABORATORY         66.00         0         14, 027         0           00         RESPI RATORY THERAPY         65.00         0         1, 356         0           00         CARDIAC REHABILITATION         76.97         0         2, 641         0				0					10
F         - DEPRECIATION           EMPLOYEE BENEFITS DEPARTMENT         4.00         0         1,694         9           00         OTHER ADMIN AND GENERAL         5.02         0         34,802         0           00         OPERATION OF PLANT         7.00         0         513,717         0           00         DI ETARY         10.00         0         4,722         0           01         PHARMACY         15.00         0         9,398         0           020         PHARMACY         15.00         0         9,398         0           030         ADULTS & PEDI ATRICS         30.00         0         35,496         0           030         ANESTHESI OLOGY         53.00         0         996         0           04         RADI OLOGY-DI AGNOSTI C         54.00         0         38,770         0           05         RADORY THERAPY         66.00         0         14,027         0           06         RESPI RATORY THERAPY         66.00         0         1,356         0           07         CARDI AC REHABI LI TATI ON         76.97         0         2,641         0           08         EMERGENCY         91.00			91.00				4		11
D0         EMPLOYEE BENEFITS DEPARTMENT         4.00         0         1,694         9           D0         OTHER ADMIN AND GENERAL         5.02         0         34,802         0           D0         OPERATION OF PLANT         7.00         0         513,717         0           D0         DI ETARY         10.00         0         4,722         0           D0         PHARMACY         15.00         0         9,398         0           D0         ADULTS & PEDI ATRI CS         30.00         0         35,496         0           D0         ANESTHESI OLOGY         53.00         0         996         0           D0         RADI OLOGY-DI AGNOSTI C         54.00         0         38,770         0           D0         RESPI RATORY THERAPY         60.00         0         1,356         0           D0         RESPI RATORY THERAPY         66.00         0         2,641         0           D0         CLI NI C         90.00         0         32,227         0           D0         CLI NI C         90.00         0         32,227         0           D0         CLI NI C         90.00         0         32,227         0	F	- DEPRECIATION		0	23, 312	1			1
00       OTHER ADMIN AND GENERAL       5.02       0       34,802       0         00       OPERATION OF PLANT       7.00       0       513,717       0         00       DI ETARY       10.00       0       4,722       0         00       PHARMACY       15.00       0       9,398       0         00       ADULTS & PEDI ATRI CS       30.00       0       37,740       0         00       OPERATI NG ROOM       50.00       0       38,770       0         00       ABORTORY       60.00       0       15,147       0         00       RABORTORY       60.00       0       1,356       0         00       RESPI RATORY THERAPY       65.00       0       14,027       0         00       CABORTORY       60.00       0       2,641       0         00       CARDI AC REHABI LI TATI ON       76.97       0       2,641       0         00       EMERGENCY       91.00       0       32,227       0       0         00       EMERGENCY       91.00       0       32,227       0       0         00       EMERGENCY       10,416       19       0       1       <			4.00	o	1. 694		9		1
00     OPERATION OF PLANT     7.00     0     513,717     0       00     DIETARY     10.00     0     4,722     0       00     PHARMACY     15.00     0     9,398     0       00     ADULTS & PEDIATRICS     30.00     0     37,740     0       00     OPERATING ROOM     50.00     0     35,496     0       00     ANESTHESI OLOGY     53.00     0     996     0       00     LABORATORY     60.00     0     15,147     0       00     LABORATORY     66.00     0     14,027     0       00     CARDI AC REHABILITATION     76.97     0     2,641     0       00     EMERGENCY     91.00     0     32,227     0       00     EMERGENCY     91.00     0     32,227     0       00     EMERGENCY     91.00     0     32,227     0       01     O     10,416     19     0       02     PHYSI CAL THERAPY     66.00     10,416     19       01     TOTALS     10,416     19     0       02     OTHACL THERAPY     66.00     10,416     19       03     OTALS     10,416     19     12									2
D0       DI ETARY       10.00       0       4,722       0         D0       PHARMACY       15.00       0       9,398       0         D0       ADULTS & PEDI ATRI CS       30.00       0       37,740       0         D0       ADULTS & PEDI ATRI CS       30.00       0       37,740       0         D0       OPERATI NG ROOM       50.00       0       35,496       0         D0       ANESTHESI OLOGY       53.00       0       996       0         D0       RADI OLOGY - DI AGNOSTI C       54.00       0       38,770       0         D0       RABORATORY       66.00       0       14,027       0         D0       RESPI RATORY THERAPY       66.00       0       1,356       0         D0       CLINI C       90.00       0       2,641       0         D0       EMERGENCY       91.00       0       32,227       0         D0       EMERGENCY       91.00       0       32,227       0         D0       EMERGENCY       91.00       0       32,227       0         D0       EMERGENCY       10,416       19       1         H       PROPERTY INSURANCE<				-			-		3
D0       ADULTS & PEDIATRICS       30.00       0       37,740       0         D0       OPERATING ROOM       50.00       0       35,496       0         D0       ANESTHESIOLOGY       53.00       0       996       0         D0       RADIOLOGY-DIAGNOSTIC       54.00       0       38,770       0         D0       RADIOLOGY-DIAGNOSTIC       54.00       0       15,147       0         D0       LABORATORY       60.00       0       14,027       0         D0       RESPIRATORY THERAPY       66.00       0       1,356       0         D0       CARDIAC REHABILITATION       76.97       0       2,641       0         D0       CLINIC       90.00       0       32,227       0         D0       EMERGENCY       91.00       0       32,227       0         D0       EMERGENCY       91.00       0       32,227       0         D0       PHYSI CAL THERAPY       66.00       10,416       19       0         TOTALS       10,416       19       1       1       1       1         D0       OTHER ADMIN AND GENERAL       5.02       0       15,950       12       <	00 D	I ETARY					0		4
D0       OPERATING ROOM       50.00       0       35,496       0         D0       ANESTHESI OLOGY       53.00       0       996       0         D0       RADI OLOGY-DI AGNOSTI C       54.00       0       38,770       0         D0       LABORATORY       60.00       0       15,147       0         D0       RESPI RATORY THERAPY       65.00       0       14,027       0         D0       PHYSI CAL THERAPY       66.00       0       1,356       0         D0       CLRDI AC REHABI LI TATI ON       76.97       0       2,641       0         D0       CLINI C       90.00       0       32,227       0       0         D0       EMERGENCY       91.00       0       32,227       0       0         D0       PHYSI CAL THERAPY       66.00       10,416       19       0         D0       PHYSI CAL THERAPY       66.00       10,416       19       0         H       PROPERTY INSURANCE       10,416       19       1       1         D0       OTHER ADMIN AND GENERAL       5.02       0       15,950       12			15.00	0	9, 398	8	0		5
D0       ANESTHESI OLOGY       53.00       0       996       0         D0       RADI OLOGY-DI AGNOSTI C       54.00       0       38,770       0         D0       LABORATORY       60.00       0       15,147       0         D0       RESPI RATORY THERAPY       65.00       0       14,027       0         D0       PHYSI CAL THERAPY       66.00       0       1,356       0         D0       CARDI AC REHABI LI TATI ON       76.97       0       2,641       0         D0       CLINIC       90.00       0       32,227       0         D0       EMERGENCY       91.00       0       32,227       0         D0       PHYSI CAL THERAPY       66.00       10,416       19       0         TOTALS       10,416       19       0       10,416       19       0         H - PROPERTY INSURANCE       5.02       0       15,950       12       12				0			0		6
D0       RADI OLOGY-DI AGNOSTI C       54.00       0       38,770       0         D0       LABORATORY       60.00       0       15,147       0         D0       RESPI RATORY THERAPY       65.00       0       14,027       0         D0       PHYSI CAL THERAPY       66.00       0       1,356       0         D0       CARDI AC REHABI LI TATI ON       76.97       0       2,641       0         D0       CLI NI C       90.00       0       2,612       0         D0       EMERGENCY       91.00       0       32,227       0         D0       PHYSI CAL THERAPY       66.00       10,416       19       0         D0       FMYSI CAL THERAPY       66.00       10,416       19       0         D0       PHYSI CAL THERAPY       66.00       10,416       19       0         TOTALS       10,416       19       10,416       19       10,416       19         D0       OTHER ADMI N AND GENERAL       5.02       0       15,950       12       12				0			0		7
00       LABORATORY       60.00       0       15,147       0         00       RESPIRATORY THERAPY       65.00       0       14,027       0         00       PHYSI CAL THERAPY       66.00       0       1,356       0         00       CARDI AC REHABI LI TATI ON       76.97       0       2,641       0         00       CLI NI C       90.00       0       2,612       0         00       EMERGENCY       91.00       0       32,227       0         0       O       0       10,416       19       0         00       PHYSI CAL THERAPY       66.00       10,416       19       0         00       PHYSI CAL THERAPY       66.00       10,416       19       0         01       TOTALS       10,416       19       10,416       19         00       OTHER ADMIN AND GENERAL       5.02       0       15,950       12				0			0		8
00       RESPIRATORY THERAPY       65.00       0       14,027       0         00       PHYSI CAL THERAPY       66.00       0       1,356       0         00       CARDI AC REHABI LI TATI ON       76.97       0       2,641       0         00       CLI NI C       90.00       0       2,612       0         00       EMERGENCY       91.00       0       32,227       0         0       G - OUTPATI ENT THERAPY       66.00       10,416       19       0         00       PHYSI CAL THERAPY       66.00       10,416       19       0         0       H - PROPERTY INSURANCE       10,416       19       12				0			0		9
00       PHYSI CAL THERAPY       66.00       0       1,356       0         00       CARDI AC REHABI LI TATI ON       76.97       0       2,641       0         00       CLI NI C       90.00       0       2,612       0         00       EMERGENCY       91.00       0       32,227       0         0       O       745,345       0       745,345         0       PHYSI CAL THERAPY       66.00       10,416       19         0       TOTALS       10,416       19       0         H       PROPERTY I NSURANCE       0       15,950       12				0					10
00       CARDI AC REHABI LI TATI ON       76.97       0       2,641       0         00       CLI NI C       90.00       0       2,612       0         00       EMERGENCY       91.00       0       32,227       0         0       6       0       10,416       19       0         00       PHYSI CAL THERAPY       66.00       10,416       19       0         10       10,416       19       0       10,416       19       10         H       PROPERTY I NSURANCE       5.02       0       15,950       12				0					11
00       CLINIC       90.00       0       2,612       0         00       EMERGENCY       91.00       0       32,227       0         0       0       745,345       0         0       0       745,345       0         0       0       10,416       19       0         0       10,416       19       0       0         0       0       10,416       19       0         0       0       10,416       19       0         0       0       15,950       12							0		12 13
00       EMERGENCY        91.00        0       32,227        0         0       0       745,345        0       745,345        0         00       PHYSI CAL THERAPY         66.00       10,416        19          01       TOTALS        10,416       19        0							0		13
O         O         745, 345           G         O         745, 345           G         O         745, 345           O         PHYSI CAL         THERAPY           O         10, 416         19           TOTALS         10, 416         19           H         PROPERTY         I NSURANCE           O         OTHER         ADMIN           AND         GENERAL         5. 02         0         15, 950         12							ő		14
G         OUTPATI ENT THERAPY           00         PHYSI CAL THERAPY        66.00         10, 416         19        0           TOTALS        10, 416         19        0        0        0           H         - PROPERTY I NSURANCE        0        15, 950        12							Ĭ		
D0       PHYSI CAL THERAPY      66.00       10, 416       19      0         TOTALS      10, 416       19      0         H - PROPERTY INSURANCE      0      15, 950      12         D0       OTHER ADMIN AND GENERAL      5.02      0      15, 950      12	G	- OUTPATIENT THERAPY		0	, 10, 040		1		1
TOTALS     10, 416     19       H - PROPERTY INSURANCE     0     15, 950     12			66.00	10, 416	19	)	0		1
H         - PROPERTY INSURANCE           00         OTHER_ADMIN_AND_GENERAL							1		1.
00 OTHER ADMIN AND GENERAL5.02015,95012									1
			5.02	0	15, 950	11	2		1
TUTALS U 10, 950	Т	OTALS		0	15, 950				

RECONC		o nenem benond	FORD HOSPI TAL		In Lie	u of Form CMS-2	2552-10
	ILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151302	Period: From 01/01/2015 To 12/31/2015		pared:
				Acqui si ti ons	3		
		Begi nni ng	Purchases	Donation	Total	Disposals and	
		Bal ances				Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES					
1.00	Land	190, 324	0		0 0	0	1.00
2.00	Land Improvements	274, 136	0		0 0	0	2.00
3.00	Buildings and Fixtures	15, 007, 745	0		0 0	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	5, 118, 601	76, 974		0 76, 974	0	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20, 590, 806	76, 974		0 76, 974	0	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	20, 590, 806	76, 974		0 76, 974	0	10.00
		Ending Balance	Fully				
		Ũ	Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET						
1.00	Land	190, 324	0				1.00
2.00	Land Improvements	274, 136	0				2.00
3.00	Buildings and Fixtures	15, 007, 745	0				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	5, 195, 575	0				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	20, 667, 780	0				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	20, 667, 780	0				10.00

Heal th	Financial Systems	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151302	Peri od:	Worksheet A-7	
					From 01/01/2015 To 12/31/2015		norod.
					To 12/31/2015	Date/Time Pre 5/24/2016 8:19	pareu: 9 nm
			SL	JMMARY OF CAF	PI TAL	0/21/2010 011	
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
						instructions)	
		9.00	10.00	11.00	12.00	13.00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			nd 2			
1.00	NEW CAP REL COSTS-BLDG & FIXT	143, 557	0		0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	143, 557			0 0	0	3.00
		SUMMARY 0	F CAPITAL				
			L	-			
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	15.00	-			
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM		1			
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	143, 557				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	143, 557				3.00

Health Financial Systems	U HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 Fo 12/31/2015		pared:
	COMI	PUTATION OF RAT	TI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets	Ratio (see	Insurance	
		Leases	for Ratio (col. 1 - col. 2)	instructions)		
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI		1		-		
1.00 NEW CAP REL COSTS-BLDG & FIXT	20, 667, 780		20, 667, 780			1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	U U	(	0. 000000		2.00
3.00 Total (sum of lines 1-2)	20, 667, 780		20, 667, 780			3.00
	ALLOCA	TION OF OTHER (	CAPITAL	SUMMARY C	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate				
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI		-				
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	(	958, 466		1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	(	0	0	2.00
3.00 Total (sum of lines 1-2)	0	0	(	958, 466	43, 196	3.00
		SL	JMMARY OF CAPI	IAL		
Cost Center Description	Interest	Insurance (see			Total (2) (sum	
		instructions)	instructions)			
				d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CI		15, 950			1 017 (12	1.00
2.00 NEW CAP REL COSTS-BLDG & FIXT	0				1, 017, 612 0	2.00
3.00 Total (sum of lines 1-2)		-			1, 017, 612	2.00
5.00 110tai (Sulli 01 111165 1-2)	0	10,900	I C	ן U	1, 017, 012	3.00

DJUST	MENTS TO EXPENSES			F	Period: From 01/01/2015	Worksheet A-8	
					To 12/31/2015	Date/Time Pre 5/24/2016 8:19	
				Expense Classification on To/From Which the Amount is			
	Cost Center Description	Basi s/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Li ne # 4.00	Wkst. A-7 Ref. 5.00	
. 00	Investment income - NEW CAP REL COSTS-BLDG & FIXT (chapter			NEW CAP REL COSTS-BLDG & FIXT	1.00	0	1.0
. 00	2) Investment income - NEW CAP REL COSTS-MVBLE EQUIP (chapter		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	2.0
. 00	2) Investment income - other		C		0.00	0	3. 0
. 00	(chapter 2) Trade, quantity, and time		C		0.00	0	4.0
. 00	discounts (chapter 8) Refunds and rebates of		C		0.00	0	5.0
. 00	expenses (chapter 8) Rental of provider space by		C		0.00	0	6.0
. 00	suppliers (chapter 8) Telephone services (pay stations excluded) (chapter		C	0	0.00	0	
. 00	21) Television and radio service (chapter 21)		C		0.00	0	8. (
. 00 0. 00	Parking lot (chapter 21) Provider-based physician	A-8-2	ر 957, 856-	-	0.00	0 0	
1. 00	adjustment Sale of scrap, waste, etc.		C		0.00	0	11. (
2.00	(chapter 23) Related organization transactions (chapter 10)	A-8-1	4, 453, 658	3		0	12. (
3.00 4.00	Laundry and linen service Cafeteria-employees and guests	В	-33 84F	) CAFETERI A	0. 00 11. 00	0	
5.00	Rental of quarters to employee and others		C		0.00	0	15.0
6.00	Sale of medical and surgical supplies to other than patients		C		0.00	0	16.0
7.00	Sale of drugs to other than patients		C		0.00	0	17.0
8.00	Sale of medical records and abstracts		C		0.00	0	18.0
9. 00	Nursing school (tuition, fees, books, etc.)		C		0.00	0	19. (
	Vending machines Income from imposition of interest, finance or penalty	В	-27, 268 (	DIETARY	10. 00 0. 00	0 0	20. ( 21. (
2. 00	charges (chapter 21) Interest expense on Medicare overpayments and borrowings to		C		0.00	0	22. (
3. 00	repay Medicare overpayments Adjustment for respiratory therapy costs in excess of	A-8-3	C	RESPI RATORY THERAPY	65.00		23. (
4. 00	limitation (chapter 14) Adjustment for physical therapy costs in excess of	A-8-3	C	PHYSI CAL THERAPY	66.00		24. (
5.00	limitation (chapter 14) Utilization review - physicians' compensation		C	*** Cost Center Deleted ***	114.00		25. (
6. 00	(chapter 21) Depreciation - NEW CAP REL COSTS-BLDG & FIXT		C	NEW CAP REL COSTS-BLDG & FLXT	1.00	0	26. (
7.00	Depreciation - NEW CAP REL COSTS-MVBLE EQUIP		C	NEW CAP REL COSTS-MVBLE EQUIP	2.00	0	27.(
8.00 9.00	Non-physician Anesthetist Physicians' assistant		C	*** Cost Center Deleted ***	19.00 0.00	0	28. 0 29. 0
9.00 0.00	Adjustment for occupational therapy costs in excess of	A-8-3	C	OCCUPATI ONAL THERAPY	67.00	0	30. (
0. 99	limitation (chapter 14) Hospice (non-distinct) (see instructions)		С	ADULTS & PEDIATRICS	30.00		30. 9
1. 00	Adjustment for speech pathology costs in excess of	A-8-3	C	SPEECH PATHOLOGY	68.00		31. C
2.00	limitation (chapter 14) CAH HIT Adjustment for Depreciation and Interest	А	-23, 783	NEW CAP REL COSTS-BLDG & FLXT	1.00	9	32.0

Heal th Fi	nancial Systems	1	U HEALTH BLACK	FORD HOSPI TAL	In Lie	u of Form CMS-2	2552-10
ADJUSTMEN	ITS TO EXPENSES				Peri od:	Worksheet A-8	
					From 01/01/2015 To 12/31/2015	Date/Time Pre 5/24/2016 8:1	
				Expense Classification o	n Worksheet A		
				To/From Which the Amount is	to be Adjusted		
			<b>.</b> .				
	Cost Center Description	• /	Amount	Cost Center	-	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
	RKETING/ADVERTISING COSTS	A		OTHER ADMIN AND GENERAL	5.02		33.00
	SCELLANEOUS INCOME	В		OTHER ADMIN AND GENERAL	5.02		34.00
	SCELLANEOUS INCOME	В	-1, 515	NURSING ADMINISTRATION	13.00		35.00
	SCELLANEOUS INCOME	В	-1, 184	PHYSICAL THERAPY	66.00		36.00
37.00 MI	SCELLANEOUS INCOME	В	-75	EMERGENCY	91.00	0	37.00
38.00 EM	PLOYEE BENEFITS	A	-897,673	EMPLOYEE BENEFITS DEPARTMEN	T 4.00	0	38.00
39.00 NO	N-ALLOWABLE PATIENT	А	-4, 237	OTHER ADMIN AND GENERAL	5.02	0	39.00
RE	IMBURSEMENT						
40.00 PT	O EXPENSE ALLOCATION	А	-32,044	OTHER ADMIN AND GENERAL	5.02	0	40.00
41.00 CH	ARI TY CONTRI BUTI ONS	А	-36, 425	OTHER ADMIN AND GENERAL	5.02	0	41.00
42.00 PH	YSICIAN MALPRACTICE	А		OTHER ADMIN AND GENERAL	5.02		42.00
I N	SURANCE						
43.00 PH	YSICIAN MALPRACTICE	А	-20, 986	EMERGENCY	91.00	0	43.00
	SURANCE						
	F FEES	А	-209, 191	OTHER ADMIN AND GENERAL	5.02	0	44.00
50.00 TO	TAL (sum of lines 1 thru 49)		2,097,329				50.00
	ransfer to Worksheet A,						
	lumn 6, line 200.)						

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

(2) basis for adjustment (see first detroits).
A. Costs - if cost, including applicable overhead, can be determined.
B. Amount Received - if cost cannot be determined.
(3) Additional adjustments may be made on lines 33 thru 49 and subscripts thereof.
Note: See instructions for column 5 referencing to Worksheet A-7.

Heal th	Financial Systems	IU HEALTH BLAC	KFORD HOSPI TAL	In Lie	eu of Form CMS-2	2552-10
STATEME OFFICE	ENT OF COSTS OF SERVICES FROM COSTS	RELATED ORGANIZATIONS AND HO		Period: From 01/01/2015 To 12/31/2015		pared:
	Li ne No.	Cost Center	Expense Items	Amount of Allowable Cost	Amount	2 011
	1.00	2.00	3.00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTM HOME OFFICE COSTS:	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED OF	RGANIZATIONS OR	CLAI MED	
1.00	1.00	NEW CAP REL COSTS-BLDG & FIX	BUILDING CAPITAL-HOME OFFICE	93, 347	0	1.00
2.00	4.00	EMPLOYEE BENEFITS DEPARTMENT	EMPLOYEE BENEFITS-HOME OFFIC	993, 816	3, 158	2.00
3.00	5.02	OTHER ADMIN AND GENERAL	A&G-HOME OFFICE & BALL	4, 856, 285	1, 486, 632	3.00
4.00	7.00	OPERATION OF PLANT	PLANT-HOME OFFICE	83, 342	83, 342	4.00
4.01	10.00	DI ETARY	DI ETARY-BALL	16, 116	16, 116	4.01
4.02			PHARMACY-BALL	368, 024	368, 024	4.02
4.03			SHARED EMPLOYEE EXP-BALL	14, 941	14, 941	4.03
4.04	50.00	OPERATING ROOM	SHARED EMPLOYEE EXP-BALL	12, 554	12, 554	4.04
4.05		RADI OLOGY-DI AGNOSTI C	SHARED EMPLOYEE EXP-BALL	348, 692	348, 692	4.05
4.06		LABORATORY	SHARED EMPLOYEE EXP-BALL	1, 109, 054	1, 109, 054	4.06
4.07		RESPI RATORY THERAPY	SHARED EMPLOYEE EXP-BALL	439, 474	439, 474	4.07
4.08		PHYSI CAL THERAPY	SHARED EMPLOYEE EXP-BALL	275, 454	275, 454	4.08
4.09		OCCUPATI ONAL THERAPY	SHARED EMPLOYEE EXP-BALL	45, 244	45, 244	4.09
4.10		SPEECH PATHOLOGY	SHARED EMPLOYEE EXP-BALL	3, 835	3, 835	4.10
4.11		CARDIAC REHABILITATION	SHARED EMPLOYEE EXP-BALL	523	523	4.11
4.12		CLINIC	SHARED EMPLOYEE EXP-BALL	1, 183	1, 183	4.12
4.13		EMERGENCY	SHARED EMPLOYEE EXP-BALL	4, 967	4, 967	4.13
4.14	0.00			0	0	4.14
4.15	0.00			0	0	4.15
4.16	0.00			0	0	4.16
4.17	0.00			0	0	4.17
4.18	0.00			0	0	4.18
4.19	0.00			0	0	4.19
4.20	0.00			0	0	4.20
4.21	0.00			0	0	4.21
4.22	0.00			0	0	4.22
4.23	0.00			0	0	4.23
5.00	0		0	8, 666, 851	4, 213, 193	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.

na	13 1101	been posted to worksheet A,	corumns r anu/or z, the amour	it allowable si		or this part.	
					Related Organization(s) and/	or Home Office	
		Symbol (1)	Name	Percentage of	Name	Percentage of	
		Symbol (1)	Name	Ownership	Name	Ownership	
		1.00	2.00	3.00	4.00	5,00	

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE: The Secretary, by virtue of the authority granted under section 1814(b)(1) of the Social Security Act, requires that you furnish the information requested under Part B of this worksheet.

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

6.00	В	0.00 I U HEALTH 100.00	6.00
7.00		0.00 0.00	7.00
8.00		0.00 0.00	8.00
9.00		0.00 0.00	9.00
10.00		0.00 0.00	10.00
100.00	G. Other (financial or		100.00
	non-financial) specify:		

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

A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.

B. Corporation, partnership, or other organization has financial interest in provider.

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

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

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

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

Health Financial Systems	IU HEALTH BLACKFORD	HOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM OFFICE COSTS	RELATED ORGANIZATIONS AND HOME	Provider CCN: 151302	From 01/01/2015	
			To 12/31/2015	Date/Time Prepared:

							5/24/2016 8:1	<u>19 pm</u>
	Net	Wkst. A-7 Ref.						
	Adjustments							
	(col. 4 minus							
	col. 5)*							
	6.00	7.00						
			MENTS REQUIRED AS A RES	ULT OF TRANSACTIO	ONS WITH RELA	TED ORGANI ZATI	ONS OR CLAIMED	
	HOME OFFICE CO							
1.00	93, 347							1.00
2.00	990, 658	0						2.00
3.00	3, 369, 653	0						3.00
4.00	0	0						4.00
4.01	0	0						4.01
4.02	0	0						4.02
4.03	0	0						4.03
4.04	0	0						4.04
4.05	0	0						4.05
4.06	0	0						4.06
4.07	0	0						4.07
4.08	0	0						4.08
4.09	0	0						4.09
4.10	0	0						4.10
4.11	0	0						4.11
4.12	0	0						4.12
4.13	0	0						4.13
4.14	0	0						4.14
4.15	0	0						4.15
4.16	0	0						4.16
4.17	0	0						4.17
4.18	0	0						4. 18
4.19	0	0						4, 19
4.20	0	0						4.20
4.21	0	0						4.21
4.22	0	0						4.22
4.23	0	0						4.23
5.00	4, 453, 658	-						5.00
* The			scripts as appropriate	) are transferred	in detail t	o Worksheet A	column 6 lines as	

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

Rel ated Organi zati on(s)		
and/or Home Office		
Type of Business		
6. 00		
B INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE	

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

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

6.00 7.00	HOSPI TAL	6.00
7.00		7.00
8.00		8.00
9.00		9.00
10.00		10.00
8.00 9.00 10.00 <u>100.00</u>		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 organi zati on.

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

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

Heal th	Financial Syste	ems	IU HEALTH BLAC	KFORD HOSPITA	L	In Lie	eu of Form CMS-	2552-10
	R BASED PHYSIC				r CCN: 151302	Peri od:	Worksheet A-8	
						From 01/01/2015		
						To 12/31/2015	5 Date/Time Pre 5/24/2016 8:1	epared: 19 nm
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		I denti fi er	<b>Remuneration</b>	Component	Component		ider Component	
				•			Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00		ANESTHESI OLOGY	92, 623		0 92, 62		-	
2.00		RADI OLOGY-DI AGNOSTI C	150, 000		0 150, 00		-	
3.00		LABORATORY	36, 000		0 36,00		0	
4.00		CARDIAC REHABILITATION	640	64		0 0	0	
5.00		EMERGENCY	1, 334, 285	957, 21			0	
6.00	0.00		0		-	0 0	0	
7.00	0.00		0		-	0 0	0	
8.00	0.00		0		-	0 0	0	
9.00	0.00		0		0	0 0	0	
10.00	0.00		1 (12 540	057 05		0 0 al	0	
200.00	Wkst. A Line #	Cost Center/Physician	1, 613, 548 Unadj usted RCE	957,85 5 Percent of		Provi der	0 Physician Cost	200.00
	WKSL A LINE #	I denti fi er			E Memberships &		of Malpractice	
		rdentifier		Limit	Continuing	Share of col.	Insurance	
				Limit	Educati on	12	i insui unee	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	53.00	ANESTHESI OLOGY	0		0	0 0	0	1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	0			0 0	0	2.00
3.00		LABORATORY	0			0 0	0	3.00
4.00	76. 97	CARDIAC REHABILITATION	0		0	0 0	0	4.00
5.00		EMERGENCY	0		-	0 0	0	
6.00	0.00		0		0	0 0	0	0.00
7.00	0.00		0		0	0 0	0	
8.00	0.00		0		-	0 0	0	
9.00	0.00		0		0	0 0	0	
10.00	0.00		0		-	0 0	0	
200.00	W/L-+ A Li //	Cart Carter (Dhuri ai ar	0 Drazvi da ra		-	0 0	0	200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Provider Component	Adjusted RCE Limit	Di sal Lowance	Adj ustment		
		Identifier	Share of col.		DISALLOWALICE			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00	1	
1.00		ANESTHESI OLOGY	0			0 0		1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	0		0	o o		2.00
3.00	60.00	LABORATORY	0		0	0 0		3.00
4.00	76. 97	CARDIAC REHABILITATION	0		0	0 640		4.00
5.00	91.00	EMERGENCY	0		0	0 957, 216		5.00
6.00	0.00		0		0	0 0		6.00
7.00	0.00		0		0	0 0		7.00
8.00	0.00		0		0	0 0		8.00
9.00	0.00		0			0 0		9.00
10.00	0.00		0		-	0 0		10.00
200.00			0		0	0 957, 856		200.00

COST A	LLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151302	Period: From 01/01/201 To 12/31/201		nared.
					10 12/31/201	5/24/2016 8:1	
			CAPI TAL REL	ATED COSTS			
	Cost Center Description	Net Expenses for Cost Allocation	NEW BLDG & FIXT	NEW MVBLE EQUI P	EMPLOYEE BENEFITS DEPARTMENT	ADMI TTI NG	
		(from Wkst A			DEFARTMENT		
		col. 7)	1.00		4.00	<b>F</b> 01	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	4.00	5.01	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	1,017,612	1,017,612				1.00
2.00	00200 NEW CAP REL COSTS-BEDG & TTXT	1,017,012	1, 017, 012		0		2.00
2.00 4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	1,071,147	0		0 1, 071, 14	7	4.00
4.00 5.01	00570 ADMI TTI NG	110, 766	14, 928		0 18, 57		
5. 02	00590 OTHER ADMIN AND GENERAL	5, 269, 898	74, 522		0 90, 14		
7.02	00700 OPERATION OF PLANT	676, 662	306, 271		0 21, 52		
7.00 7.00					2.7.02		
	00900 HOUSEKEEPI NG	233, 263	13, 625				
10.00	01000 DI ETARY	136, 336	30, 264		0 16, 76		
1.00	01100 CAFETERIA	67, 978	18, 835		0 10, 43		
3.00	01300 NURSI NG ADMI NI STRATI ON	229, 550	2, 974		0 36, 79		
4.00	01400 CENTRAL SERVICES & SUPPLY	285, 442	15, 647			0 0	
5.00	01500 PHARMACY	395, 944	10, 632		0	0 0	15.0
	INPATIENT ROUTINE SERVICE COST CENTERS						
0.00	03000 ADULTS & PEDIATRICS	1, 678, 122	147, 683		0 273, 80	4 11, 087	30.0
50.00	ANCI LLARY SERVI CE COST CENTERS	356, 201	101, 326		0 46, 82	3 11, 379	50.00
53.00	05300 ANESTHESI OLOGY	92, 700	101, 320				1
53.00 54.00			-			000	
	05400 RADI OLOGY-DI AGNOSTI C	1, 046, 638	78, 798				
57.00	05700 CT SCAN	0	0		0	0 0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0	0 0	
9.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	0 0	
0.00	06000 LABORATORY	1, 169, 793	21, 497		0	0 27, 797	
50. 01	06001 BLOOD LABORATORY	0	0		0	0 0	
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0	0 0	
5.00	06500 RESPI RATORY THERAPY	455, 883	8, 144		0 78, 70	6 6, 405	
55. 01	06501 SLEEP LAB	0	0		0	이 이	
6. 00	06600 PHYSI CAL THERAPY	221, 408	52, 519		0 40, 10	5 3, 361	66.0
57.00	06700 OCCUPATI ONAL THERAPY	55, 679	3, 304		0 10, 06	2 401	67.0
58.00	06800 SPEECH PATHOLOGY	3, 835	0		0 69	3 30	68.0
69.00	06900 ELECTROCARDI OLOGY	0	0		0	0 0	69.0
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 364	0		0	0 343	71.0
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	5, 957	0		0	0 136	72.0
3.00	07300 DRUGS CHARGED TO PATIENTS	481, 262	0		0	0 16, 371	73.0
76.00	03140 CARDI OLOGY	0	0		0	o o	76.0
76.97	07697 CARDI AC REHABI LI TATI ON	39, 649	641		0 6, 62	3 1, 191	76.9
	OUTPATIENT SERVICE COST CENTERS					•	1
90.00	09000 CLI NI C	75, 858	36, 892		0 11, 98	9 2, 781	90.00
91.00	09100 EMERGENCY	1, 333, 457	74, 017		0 301, 02	4 32, 137	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS	. 1					1
13.00	11300 INTEREST EXPENSE						113.0
18.00		16, 548, 404	1, 012, 519		0 1, 071, 14	7 144, 272	
	NONREI MBURSABLE COST CENTERS				, , , , , , , , , , , , , , , , , , , ,	, , , , , , , , , , , , , , , , , , , ,	
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5, 093		0	0 0	190. 0
	19200 PHYSI CLANS' PRI VATE OFFICES	0	0		0		192.00
200.00			Ű		-		200. 0
			0			d 0	201.00
201.00			( ))		0	()  ()	

COST	n Financial Systems ALLOCATION - GENERAL SERVICE COSTS	IU HEALTH BLACK		CCN: 151302	Peri od:	u of Form CMS- Worksheet B	2002 10
0001 /			11001 del	0011. 101002	From 01/01/2015	Part I	
					To 12/31/2015	Date/Time Pre 5/24/2016 8:1	
	Cost Center Description	Subtotal	OTHER ADMIN	OPERATION O	F HOUSEKEEPI NG	DI ETARY	9 pili
		5A. 01	AND GENERAL 5.02	PLANT 7.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	JA. 01	5.02	7.00	7.00	10.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02	00590 OTHER ADMIN AND GENERAL	5, 434, 566	5, 434, 566				5. 02
7.00	00700 OPERATION OF PLANT	1, 004, 455	491, 169		24		7.00
9.00	00900 HOUSEKEEPI NG	271, 345	132, 685				9.00
10.00	01000 DI ETARY	183, 362	89, 662			367, 539	
11.00	01100 CAFETERI A	97, 245	47, 552			0	
13.00	01300 NURSI NG ADMI NI STRATI ON	269, 321	131, 696			0	
14.00	01400 CENTRAL SERVICES & SUPPLY		147, 230			0	
		301,089				-	
15.00	01500 PHARMACY	406, 576	198, 812	25, 5	70 7,635	0	15.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	0.110.(0)	1 000 110	055.4	70 404 050	0/7 500	1 00 00
30.00		2, 110, 696	1, 032, 112	355, 1	73 106, 053	367, 539	30.00
	ANCI LLARY SERVICE COST CENTERS	545 700	050 407				
50.00		515, 729	252, 187				
53.00	05300 ANESTHESI OLOGY	93, 086	45, 518		0 0	0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	1, 238, 527	605, 629			0	
57.00	05700 CT SCAN	0	C		0 0	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	)	0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	
60.00	06000 LABORATORY	1, 219, 087	596, 123	51, 7	01 15, 437	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C	)	0 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	549, 138	268, 524	19, 5	86 5, 848	0	65.00
65.01	06501 SLEEP LAB	0	C		0 0	0	65.01
66.00	06600 PHYSI CAL THERAPY	317, 393	155, 202	126, 3	06 37, 714	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	69, 446	33, 958	7,9	47 2, 373	0	67.00
68.00	06800 SPEECH PATHOLOGY	4, 558	2, 229		0 0	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 707	18, 438		0 0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	6,093	2, 979		0 0	0	
73.00		497, 633	243, 338		0 0	0	
76.00		0	210,000		0 0	0	
76.97		48, 104	23, 522	1, 5	-	0	
/0. //	OUTPATIENT SERVICE COST CENTERS	10,101	20, 022	1,0	10		/0. //
90.00		127, 520	62, 356	88, 7	23 26, 492	0	90.00
91.00		1, 740, 635	851, 155			0	
91.00		1, 740, 835	601, 100	1/0,0	07 55, 152	0	91.00
92.00		0					92.00
112 0	SPECIAL PURPOSE COST CENTERS			1			112 00
	D 11300 I NTEREST EXPENSE	1/ 540 011	F 400 07/	1 402 2	400 140		113.00
118.00		16, 543, 311	5, 432, 076	1, 483, 3	77 433, 142	367, 539	118.00
100 5	NONREI MBURSABLE COST CENTERS			10-5	47 0 :	-	100 0-
	D 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	5, 093	2, 490				190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	C		0 0	0	192.00
200.00		0					200.00
201.00		0	C	)	0 0		201.00
202.00	D TOTAL (sum lines 118-201)	16, 548, 404	5, 434, 566	1, 495, 6	24 436, 799	367, 539	1202 00

COST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 151302	Period: From 01/01/2015	Worksheet B Part I	
					To 12/31/2015	Date/Time Pre 5/24/2016 8:1	pared: 9 nm
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVICES & SUPPLY	PHARMACY	Subtotal	
		11.00	13.00	14.00	15.00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02	00590 OTHER ADMIN AND GENERAL						5.02
7.00	00700 OPERATION OF PLANT						7.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A	203, 618					11.00
13.00	01300 NURSING ADMINISTRATION	7,631	417, 936				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	C	0	497, 1	85		14.00
15.00	01500 PHARMACY	C	0 0	2, 1	68 640, 761		15.00
	INPATIENT ROUTINE SERVICE COST CENTERS	r	-	1			
30.00	03000 ADULTS & PEDIATRICS	87, 912	257, 791	73, 3	98 10, 849	4, 401, 523	30.00
	ANCI LLARY SERVI CE COST CENTERS		1	1		-	
50.00	05000 OPERATING ROOM	10, 053	29, 045			1, 219, 476	
53.00	05300 ANESTHESI OLOGY	C				161, 004	
54.00	05400 RADI OLOGY-DI AGNOSTI C	25, 878		, .	47 1, 472	2, 153, 344	
57.00	05700 CT SCAN	C	-		0 0	0	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	C	-		0 0	0	
59.00	05900 CARDI AC CATHETERI ZATI ON	C	-		0 0	0	
60.00	06000 LABORATORY	C	0			1, 920, 578	
60. 01	06001 BLOOD LABORATORY	C	-		0 0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	C	-		0 0	0	
65.00	06500 RESPI RATORY THERAPY	18, 726				904, 195	
65.01	06501 SLEEP LAB	C	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	8, 617				649, 717	
67.00	06700 OCCUPATIONAL THERAPY	1, 464			64 0	115, 452	
68.00	06800 SPEECH PATHOLOGY	141			0 0	6, 928	
69.00	06900 ELECTROCARDI OLOGY	C	-		0 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	C	0			113, 885	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	C				18, 278	
73.00	07300 DRUGS CHARGED TO PATIENTS	C			0 620, 514	1, 361, 485	
76.00	03140 CARDI OLOGY	C	-		0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	1, 887	7, 346	7	43 0	83, 606	76.97
	OUTPATIENT SERVICE COST CENTERS	T	1	1			-
90.00	09000 CLI NI C	4, 618				328, 721	
91.00	09100 EMERGENCY	36, 691	112, 339	108, 9	84 5, 762	3, 086, 725	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS		1	1			
	11300 INTEREST EXPENSE						113.00
118.00		203, 618	417, 936	497, 1	85 640, 761	16, 524, 917	1118.00
	NONREI MBURSABLE COST CENTERS		1	1			
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	C			0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	C	0		0 0		192.00
200.00							200.00
201.00		C	0		0 0		201.00
202.00		203, 618	417, 936	497, 1	85 640, 761		

	Systems - GENERAL SERVICE COSTS	IU HEALTH BLACKFO	Provi der C	CN: 151302	Peri od:	u of Form CMS-25 Worksheet B	<u>152-1</u>
COST ALLOCATION	- GENERAL SERVICE COSTS			. IJIJUZ	From 01/01/2015	Part I	
					To 12/31/2015	Date/Time Prepa 5/24/2016 8:19	ared: pm
Cos	t Center Description	Intern &	Total		- L		
		Residents Cost					
		& Post Stepdown					
		Adjustments					
		25.00	26.00				
GENERAL S	SERVICE COST CENTERS	20100	20100				
	/ CAP REL COSTS-BLDG & FIXT						1.0
1 1	/ CAP REL COSTS-MVBLE EQUIP						2.0
	PLOYEE BENEFITS DEPARTMENT						4.0
5.01 00570 ADM							5.0
	IER ADMIN AND GENERAL						5.0
	RATION OF PLANT						7.0
	ISEKEEPI NG						9.0
10.00 01000 DI E							10.0
11.00 01100 CAF 13.00 01300 NUF	RSING ADMINISTRATION						11. 0 13. 0
	ITRAL SERVICES & SUPPLY						14.0
15.00 01500 PHA							15.0
	ROUTINE SERVICE COST CENTERS						15.0
	ILTS & PEDIATRICS	0	4, 401, 523				30. 0
	/ SERVICE COST CENTERS	V	4,401,323				50.0
	ERATING ROOM	0	1, 219, 476				50.0
	STHESI OLOGY	0	161, 004				53.0
	DI OLOGY-DI AGNOSTI C	0	2, 153, 344				54.0
57.00 05700 CT		0	0				57.0
58.00 05800 MAG	SNETIC RESONANCE IMAGING (MRI)	0	o				58.0
	RDI AC CATHETERI ZATI ON	0	o				59.0
60.00 06000 LAE	BORATORY	0	1, 920, 578				60.0
60.01 06001 BLC	OD LABORATORY	0	o				60.0
62.00 06200 WHC	LE BLOOD & PACKED RED BLOOD CELLS	0	0				62.0
	SPI RATORY THERAPY	0	904, 195				65.0
65.01 06501 SLE		0	0				65.0
	SI CAL THERAPY	0	649, 717				66. 0
1 1	CUPATIONAL THERAPY	0	115, 452				67.0
	ECH PATHOLOGY	0	6, 928				68.0
1 1	CTROCARDI OLOGY	0	0				69.0
	DI CAL SUPPLI ES CHARGED TO PATI ENTS	0	113, 885				71.0
	PL. DEV. CHARGED TO PATIENT	0	18, 278				72.0
	JGS CHARGED TO PATIENTS	0	1, 361, 485 0				73.0
		0	-				76. 0 76. 9
	NDIAC REHABILITATION	0	83, 606				70.9
90.00 09000 CLI		0	328, 721				90.0
91.00 09100 EME		0	3, 086, 725				91.0
	SERVATION BEDS (NON-DISTINCT PART)	0	5, 555, 20				92.0
	PURPOSE COST CENTERS						
113.00 11300 I NT						1	13.0
	STOTALS (SUM OF LINES 1-117)	0	16, 524, 917				18.0
	JRSABLE COST CENTERS						-
	T, FLOWER, COFFEE SHOP & CANTEEN	0	23, 487			1	90. 0
192.00 19200 PHY	SICIANS' PRIVATE OFFICES	0	0				92.0
200.00 Cro	oss Foot Adjustments	0	o			2	200. 0
	pative Cost Centers	0	o				201. 0
202.00 TOT	AL (sum lines 118-201)	o	16, 548, 404			2	202.0

ALL OCA	TION OF CAPITAL RELATED COSTS		Provi der	CCN: 151302	Peri od:	Worksheet B	2552-10
ALLOOA	THOR OF WATTINE RELATED GUID			CON. 131302	From 01/01/2015 To 12/31/2015	Part II Date/Time Pre 5/24/2016 8:1	pared: 9 pm
			CAPI TAL REL	ATED COSTS		0/21/2010 0.1	
	Cost Center Description	Di rectl y Assi gned New Capi tal Rel ated Costs	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	0		0 0	0	4.00
5.01	00570 ADMI TTI NG	0	14, 928		0 14, 928	0	5.01
5.02	00590 OTHER ADMIN AND GENERAL	0	74, 522		0 74, 522	0	5.02
7.00	00700 OPERATION OF PLANT	0	306, 271		0 306, 271	0	7.00
9.00	00900 HOUSEKEEPI NG	0	13, 625		0 13, 625	0	9.00
10.00	01000 DI ETARY	0	30, 264		0 30, 264	0	10.00
11.00	01100 CAFETERI A	0	18, 835		0 18, 835	0	11.00
13.00	01300 NURSING ADMINISTRATION	0	2, 974		0 2,974	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	0	15, 647		0 15, 647	0	14.00
	01500 PHARMACY	0	10, 632		0 10, 632	0	15.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	-				-	1
30.00	03000 ADULTS & PEDIATRICS	0	147, 683		0 147,683	0	30.00
	ANCI LLARY SERVICE COST CENTERS	-	,	L		-	1
50.00	05000 OPERATING ROOM	0	101, 326		0 101, 326	0	50.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	78, 798		0 78, 798	0	54.00
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	21, 497		0 21, 497	0	60.00
60.00	06001 BLOOD LABORATORY	0	21,477		0 0	0	60.01
52. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
52.00 65.00	06500 RESPI RATORY THERAPY	0	8, 144		0 8, 144	0	65.00
65.00	06501 SLEEP LAB	0	0, 144		0 0,144	0	65.00
66.00	06600 PHYSI CAL THERAPY	0	52, 519		0 52, 519	0	66.00
	06700 OCCUPATIONAL THERAPY	0					•
67.00		0	3, 304			0	67.00 68.00
68.00		0	0		0 0	0	
	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATI ENT	0	0		0 0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.00
76.00	03140 CARDI OLOGY	0	0		0 0	0	76.00
76. 97	07697 CARDI AC REHABI LI TATI ON	0	641		0 641	0	76.97
~ ~ ~	OUTPATIENT SERVICE COST CENTERS				0 0 000		1 00 00
		0	36, 892		0 36, 892	0	90.00
	09100 EMERGENCY	0	74, 017		0 74, 017	0	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.00
	SPECIAL PURPOSE COST CENTERS	1					
	11300 INTEREST EXPENSE					_	113.00
118.00		0	1, 012, 519		0 1, 012, 519	0	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	5, 093		0 5, 093		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
200.00					0		200.00
201.00	Negative Cost Centers		0		0 0	0	201.00
202.00	TOTAL (sum lines 118-201)		1, 017, 612		0 1, 017, 612		202.00

ALLOC	ATION OF CAPITAL RELATED COSTS		Provi der	CCN: 151302	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Pre 5/24/2016 8:1	epared: 9 pm
	Cost Center Description	ADMI TTI NG	OTHER ADMIN AND GENERAL	OPERATION OF PLANT		DI ETARY	
		5.01	5.02	7.00	9.00	10.00	
	GENERAL SERVICE COST CENTERS	1		1			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.0
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.0
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5.01	00570 ADMI TTI NG	14, 928					5.0
5.02	00590 OTHER ADMIN AND GENERAL	0	74, 522				5.0
7.00	00700 OPERATION OF PLANT	0	6, 735	313, 00	06		7.0
9.00	00900 HOUSEKEEPI NG	0	1, 819	6, 85	58 22, 302		9.0
10.00		0	1, 229			47, 835	
11.00		0	652			0	11.0
13.00		0	1, 806			0	
		-					
14.00		0	2,019			0	
15.00		0	2, 726	5, 3	51 390	0	15.0
	INPATIENT ROUTINE SERVICE COST CENTERS			1			-
30.00		1, 146	14, 155	74, 33	30 5, 412	47, 835	30.0
	ANCI LLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	1, 176	3, 458	50, 99	99 3, 715	0	50.0
53.00	05300 ANESTHESI OLOGY	40	624		0 0	0	53.0
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 149	8, 304	39,60	60 2, 889	0	54.0
57.00		0	0		0 0	0	57.0
58.00		0	0		0 0	0	
59.00		0	0		0 0	0	
60.00		2,873	0	10, 82	-	0	
	06001 BLOOD LABORATORY	2,0/3	8, 174	10, 6,			
60.01		0	0		0 0	0	60.0
62.00		0	0		0 0	0	
65.00		662	3, 682	4,04		0	
65.01	06501 SLEEP LAB	0	0		0 0	0	65.0
66.00	06600 PHYSI CAL THERAPY	347	2, 128	26, 43	34 1, 926	0	66.0
67.00	06700 OCCUPATI ONAL THERAPY	41	466	1, 60	63 121	0	67.0
68.00	06800 SPEECH PATHOLOGY	3	31		0 0	0	68.0
69.00	06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.0
71.00		35	253		0 0	0	
72.00		14	41		0 0	0	
73.00		1, 692	3, 337		0 0	0	
76.00		1,092	3, 337		0 0	0	
76.97		123	323	3.	23 24	0	76.9
	OUTPATIENT SERVICE COST CENTERS			1			
90.00		287	855	18, 56	68 1, 353	0	
91.00	09100 EMERGENCY	3, 340	11, 671	37, 25	54 2, 714	0	91.0
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.0
	SPECIAL PURPOSE COST CENTERS						1
113.0	0 11300 I NTEREST EXPENSE						1113. 0
118.0		14, 928	74, 488	310, 44	43 22, 115	47, 835	
. 10. 0	NONREI MBURSABLE COST CENTERS	17, 720	, +, 400	1 510, 4	22,113	+7,033	1 10.0
100 0	0 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	34	2.5	63 187	<u> </u>	190. 0
		-		2, 50			
	0 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.0
200.0							200. 0
201.0		0	0		0 0		201. 0
202.0	0 TOTAL (sum lines 118-201)	14, 928	74, 522	313, 00	22, 302	47, 835	1202 0

ALLOCA	Financial Systems ATION OF CAPITAL RELATED COSTS	IU HEALTH BLACK		CCN: 151302	Period: From 01/01/2015	u of Form CMS- Worksheet B Part II	
					To 12/31/2015	Date/Time Pre 5/24/2016 8:1	
	Cost Center Description	CAFETERI A	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	Subtotal	
		11.00	13.00	14.00	15.00	24.00	
	GENERAL SERVICE COST CENTERS						
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01	00570 ADMI TTI NG						5.01
5.02	00590 OTHER ADMIN AND GENERAL						5.02
7.00	00700 OPERATION OF PLANT						7.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY						9.00
11.00	01100 CAFETERI A	29, 658					10.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 112	7, 498				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	1, 112	7,498	26, 11	15		13.00
15.00	01500 PHARMACY	0	0	20, 1			14.00
15.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	0	L 1.	17,215		10.00
30.00	03000 ADULTS & PEDIATRICS	12, 804	4, 625	3, 85	55 325	312, 170	30.00
00.00	ANCI LLARY SERVICE COST CENTERS	12/001	17 020	0,00	020	012/170	
50.00	05000 OPERATI NG ROOM	1, 464	521	5, 01	17 15	167, 691	50.00
53.00	05300 ANESTHESI OLOGY	0	0	1, 13	39 21	1, 824	
54.00	05400 RADI OLOGY-DI AGNOSTI C	3, 769	0	1, 87	78 44	138, 491	
57.00	05700 CT SCAN	0	0		0 0	0	
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	0	0	2,00	0 80	46, 160	
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	
65.00	06500 RESPI RATORY THERAPY	2, 728	0	2, 22		21, 840	
65.01	06501 SLEEP LAB	0	0		0 0	0	
66.00	06600 PHYSI CAL THERAPY	1, 255	0	23		84, 845	
67.00	06700 OCCUPATI ONAL THERAPY	213	0		0	5, 822	
68.00	06800 SPEECH PATHOLOGY	21	0		0 0	55	
69.00	06900 ELECTROCARDI OLOGY	0	0	2.07	0 0	0	
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	0	3, 03		3, 321	
72.00 73.00	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	0	0	48		539	
76.00	03140 CARDI OLOGY	0	0		0 18,606 0 0	23, 635 0	
76.97	07697 CARDI AC REHABI LI TATI ON	275	132		39 O	1, 880	
/0. //	OUTPATIENT SERVICE COST CENTERS	275	152		0	1,000	10. 77
90.00	09000 CLINIC	673	205	34	19 29	59, 211	90.00
91.00	09100 EMERGENCY	5, 344	2,015	5, 72		142, 251	
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)		_,	-,		,	92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1-117)	29, 658	7, 498	26, 11	19, 213	1, 009, 735	118.00
	NONREI MBURSABLE COST CENTERS						
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0		190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
200.00							200.00
201.00		0	0		0 0		201.00
202.00	) TOTAL (sum lines 118-201)	29,658	7, 498	26, 11	19, 213	1, 017, 612	1202 00

ALLOCATION OF CAPITAL RELAT	FD COSTS	IU HEALTH BLACKFO		CCN: 151302	Peri od:	Worksheet B	2552-
				0011. 101002	From 01/01/2015 To 12/31/2015	Part II Date/Time Prep	bared
Cost Center Des	anintian	Intern &	Total			5/24/2016 8: 19	) pm
Cost Center Des	scription	Residents Cost	TOLAI				
		& Post					
		Stepdown					
		Adjustments					
		25.00	26.00				
GENERAL SERVICE COST	CENTERS						
1.00 00100 NEW CAP REL COS							1. (
2.00 00200 NEW CAP REL COS							2. (
1.00 00400 EMPLOYEE BENEF	TS DEPARTMENT						4.(
5. 01 00570 ADMI TTI NG							5.(
5. 02 00590 OTHER ADMIN ANI	) GENERAL						5.0
2.00 00700 OPERATION OF PI	_ANT						7.(
0.00 00900 HOUSEKEEPING							9. (
0. 00 01000 DI ETARY							10.
1.00 01100 CAFETERIA							11.
3.00 01300 NURSING ADMINIS	STRATI ON						13.0
4.00 01400 CENTRAL SERVICI	ES & SUPPLY						14.
5.00 01500 PHARMACY							15.
INPATIENT ROUTINE SE	RVICE COST CENTERS		I				
0. 00 03000 ADULTS & PEDIA		0	312, 170				30.
ANCI LLARY SERVICE CO							
0. 00 05000 OPERATI NG ROOM		0	167, 691				50.
3. 00 05300 ANESTHESI OLOGY		0	1, 824				53.
4. 00 05400 RADI OLOGY-DI AGI	INSTI C	0	138, 491				54.
7. 00 05700 CT SCAN		0	0				57.
8. 00 05800 MAGNETIC RESON	NCE IMAGING (MRL)	0	0				58.
9. 00 05900 CARDI AC CATHETI	. ,	0	0				59.
0. 00 06000 LABORATORY		0	46, 160				60.
0. 01 06001 BLOOD LABORATO	ov.	0	40, 100				60.
	PACKED RED BLOOD CELLS	0	0				62.
5. 00 06500 RESPI RATORY TH		0	21, 840				65.
5. 01 06501 SLEEP LAB		0	21, 840				65.
6. 00 06600 PHYSI CAL THERA	ov.	0	84, 845				66.
7.00 06700 OCCUPATIONAL TI		0	5, 822				67.
		0					68.
		0	55 0				
		0					69. 71
	ES CHARGED TO PATIENTS	-	3, 321				71.
2.00 07200 I MPL. DEV. CHAI		0	539				72.
3. 00 07300 DRUGS CHARGED	IU PATTENIS	0	23, 635				73.
6.00 03140 CARDI OLOGY		0	0				76.
6. 97 07697 CARDI AC REHABI I		0	1, 880				76.
0.00 09000 CLINIC	JST CENTERS	0	E0 211				00
			59, 211				90. 01
	S (NON DISTINCT DADT)	0	142, 251				91. 02
	OS (NON-DI STINCT PART)	0					92.
SPECIAL PURPOSE COST		1					110
13. 00 11300 I NTEREST EXPENS			1 000 705				113.
	OF LINES 1-117)	0	1,009,735			1	118.
NONREI MBURSABLE COST			7 07-1				100
90.00 19000 GIFT, FLOWER, (		0	7, 877				190.
92.00 19200 PHYSI CLANS' PR		0	0				192.
00.00 Cross Foot Adju		0	0				200.
Negative Cost (		0	0				201.
02.00 TOTAL (sum line	118_201)	0	1,017,612				202.

Heal th	Financial Systems	U HEALTH BLACK	FORD HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST A	LLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2015 To 12/31/2015		
		CAPI TAL REI	LATED COSTS			5/24/2016 8:1	9 pm
	Cost Center Description	NEW BLDG & FIXT (SQUARE FEET)	NEW MVBLE EQUI P (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	ADMI TTI NG (GROSS CHARGES)	Reconciliation	
		1.00	2.00	4.00	5. 01	5A. 02	
	GENERAL SERVICE COST CENTERS	50.051	I	L		1	
1.00 2.00 4.00 5.01	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING	52, 354 0 768	0 0 0	5, 925, 11 102, 76			1.00 2.00 4.00 5.01
5.02 7.00	00590 OTHER ADMIN AND GENERAL 00700 OPERATION OF PLANT	3, 834 15, 757	0	498, 64 119, 05		-5, 434, 566 0	1
	00900 HOUSEKEEPI NG 01000 DI ETARY	701 1, 557	0	135, 28 92, 71		0	
	01100 CAFETERIA 01300 NURSING ADMINISTRATION	969 153	0	57, 70 203, 54		0	11.00 13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	805	0		0 0	0	14.00
15.00	01500 PHARMACY INPATIENT ROUTINE SERVICE COST CENTERS	547	0		0 0	0	15.00
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	7, 598	0	1, 514, 56	0 2, 916, 096	0	30.00
	05000 OPERATING ROOM	5, 213		259, 00		0	
	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0 4,054	0	457, 03	0 101, 425 8 8, 013, 449	0	53.00 54.00
	05700 CT SCAN 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
	06000 LABORATORY 06001 BLOOD LABORATORY	1, 106 0	0		0 7, 311, 199 0 0	0	60.00 60.01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPIRATORY THERAPY	0 419	0	435, 36	0 0 6 1, 684, 650	0	62.00 65.00
65.01	06501 SLEEP LAB	0	0		0 0	0	65.01
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	2, 702 170	0	221, 84 55, 66		0	66.00 67.00
68.00	06800 SPEECH PATHOLOGY	0	0	3, 83		0	68.00
	06900 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		0 0 0 90, 176	0	69.00 71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 35, 644	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 03140 CARDIOLOGY	0	0		0 4, 305, 790 0 0	0	
76.97	07697 CARDIAC REHABILITATION OUTPATIENT SERVICE COST CENTERS	33	0	36, 63	8 313, 369	0	76.97
	09000 CLI NI C	1, 898					
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	3, 808	0	1, 665, 13	3 8, 455, 477	0	91.00 92.00
112 00	SPECIAL PURPOSE COST CENTERS						112 00
113.00 118.00	11300 I NTEREST EXPENSE SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	52, 092	0	5, 925, 11	4 37, 948, 727	-5, 434, 566	113.00 118.00
192.00 200.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES Cross Foot Adjustments Negative Cost Centers	262 0	0		0 0 0 0		190.00 192.00 200.00 201.00
201.00 202.00	Cost to be allocated (per Wkst. B, Part I)	1, 017, 612	0	1, 071, 14	7 144, 272		201.00
203.00 204.00	Unit cost multiplier (Wkst. B, Part I) Cost to be allocated (per Wkst. B,	19. 437139	0. 000000	0. 18078	1 0. 003802 0 14, 928		203. 00 204. 00
205.00	Part II) Unit cost multiplier (Wkst. B, Part II)			0.00000	0 0. 000393		205. 00

alth Financial Systems ST ALLOCATION - STATISTICAL BASIS		FORD HOSPI TAL	CCN: 151302	Peri od:	u of Form CMS- Worksheet B-1	
ST ALLOCATION - STATISTICAL DASIS		FIOVIDEI		From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/24/2016 8:1	
Cost Center Description	OTHER ADMIN	OPERATION OF	HOUSEKEEPING	DI ETARY	CAFETERI A	T
	AND GENERAL	PLANT	(SQUARE	(MEALS	(FTE'S)	
	(ACCUM. COST)	(SQUARE	FEET)	SERVED)		
		FEET)				-
	5.02	7.00	9.00	10.00	11.00	-
GENERAL SERVICE COST CENTERS 00 00100 NEW CAP REL COSTS-BLDG & FIXT		1	1			1 1
00 00200 NEW CAP REL COSTS-BLDG & FIXT						
00 00400 EMPLOYEE BENEFITS DEPARTMENT						
01 00570 ADMI TTI NG						
02 00590 OTHER ADMIN AND GENERAL	11, 113, 838					5
00 00700 OPERATION OF PLANT	1, 004, 455					1
00 00900 HOUSEKEEPI NG	271, 345		1	4		ģ
. 00 01000 DI ETARY	183, 362					10
. 00 01100 CAFETERIA	97, 245				7, 231	
. 00 01300 NURSI NG ADMI NI STRATI ON	269, 321		1		271	
00 01400 CENTRAL SERVICES & SUPPLY	301, 089		1		0	
00 01500 PHARMACY	406, 576				0	
INPATIENT ROUTINE SERVICE COST CENTERS	100,070	017		0		
00 03000 ADULTS & PEDIATRICS	2, 110, 696	7, 598	7, 59	8 100	3, 122	30
ANCI LLARY SERVI CE COST CENTERS				-		
. 00 05000 OPERATI NG ROOM	515, 729	5, 213	5, 21	3 0	357	50
. 00 05300 ANESTHESI OLOGY	93, 086			0 0	0	53
. 00 05400 RADI OLOGY-DI AGNOSTI C	1, 238, 527	4, 054	4, 05	64 0	919	54
00 05700 CT SCAN	0	0		0 0	0	5
00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	)	0 0	0	58
. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	)	0 0	0	5
. 00 06000 LABORATORY	1, 219, 087	1, 106	1, 10	06 0	0	6
. 01 06001 BLOOD LABORATORY	0	-		0 0	0	60
. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62
. 00 06500 RESPI RATORY THERAPY	549, 138	419	41	9 0	665	65
. 01 06501 SLEEP LAB	0	0		0 0	0	65
. 00 06600 PHYSI CAL THERAPY	317, 393	2, 702	2,70	02 0	306	66
. 00 06700 OCCUPATI ONAL THERAPY	69, 446	170	17	0 0	52	67
. 00 06800 SPEECH PATHOLOGY	4, 558	0	)	0 0	5	68
. 00 06900 ELECTROCARDI OLOGY	0	0	)	0 0	0	69
. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	37, 707	0	)	0 0	0	7
. 00 07200 IMPL. DEV. CHARGED TO PATIENT	6,093	0	)	0 0	0	72
. 00 07300 DRUGS CHARGED TO PATIENTS	497, 633	0	)	0 0	0	73
. 00 03140 CARDI OLOGY	0	0	)	0 0	0	70
. 97 07697 CARDI AC REHABI LI TATI ON	48, 104	33	3	3 0	67	70
OUTPATIENT SERVICE COST CENTERS		·				
. 00 09000 CLINIC	127, 520	1, 898	1, 89	0 8	164	90
. 00 09100 EMERGENCY	1, 740, 635	3, 808	3, 80	0 8	1, 303	9
. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
SPECIAL PURPOSE COST CENTERS						
3.00 11300 INTEREST EXPENSE						113
8.00 SUBTOTALS (SUM OF LINES 1-117)	11, 108, 745	31, 733	31, 03	100	7, 231	118
NONREI MBURSABLE COST CENTERS						
0.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	5, 093		1			190
2. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192
D. 00 Cross Foot Adjustments						200
1.00 Negative Cost Centers						20'
2.00 Cost to be allocated (per Wkst. B,	5, 434, 566	1, 495, 624	436, 79	9 367, 539	203, 618	202
Part I)						
3.00 Unit cost multiplier (Wkst. B, Part I)						
4.00 Cost to be allocated (per Wkst. B,	74, 522	313, 006	22, 30	47, 835	29, 658	204
Part II)						-
5.00 Unit cost multiplier (Wkst. B, Part	0. 006705	9. 782966	0. 71266	478.350000	4. 101507	205
						1

	Financial Systems LLOCATION - STATISTICAL BASIS	IU HEALTH BLACK		CCN: 151302	In Lieu of Form C Period: Worksheet	
CUSTA	LEUCATION - STATISTICAL BASIS		PLOVE	CCN. 151502	From 01/01/2015	D-1
					To 12/31/2015 Date/Time 5/24/2016	Prepared:
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	072172010	
		ADMI NI STRATI ON	SERVICES &	(COSTED		
		(ETE'S)	SUPPLY	REQUIS.)		
		(FTE'S)	(COSTED REQUI S. )			
		13.00	14.00	15.00		
	GENERAL SERVICE COST CENTERS					
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT					1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP					2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00570 ADMITTING					4.00
5.01	00590 OTHER ADMIN AND GENERAL					5.02
7.00	00700 OPERATION OF PLANT					7.00
9.00	00900 HOUSEKEEPI NG					9.00
10.00	01000 DI ETARY					10.00
	01100 CAFETERI A					11.00
	01300 NURSING ADMINISTRATION	3, 698				13.00
	01400 CENTRAL SERVICES & SUPPLY	0	321, 731			14.00
15.00		0	1, 403	496, 9	65	15.00
30.00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	2, 281	47, 496	8,4	14	30.00
30.00	ANCI LLARY SERVICE COST CENTERS	2,201	47,490	0,4	14	
50.00	05000 OPERATING ROOM	257	61, 811	3	84	50.00
	05300 ANESTHESI OLOGY	0	14, 031		56	53.00
	05400 RADI OLOGY-DI AGNOSTI C	0	23, 132			54.00
	05700 CT SCAN	0	0		0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0	59.00
	06000 LABORATORY	0	24, 739		0	60.00
	06001 BLOOD LABORATORY	0	0	)	0	60.01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	)	0	62.00
	06500 RESPIRATORY THERAPY	0	27, 420		0	65.00
	06501 SLEEP LAB 06600 PHYSI CAL THERAPY	0	2, 902		0	65. 01 66. 00
67.00	06700 OCCUPATIONAL THERAPY	0	2,902			67.00
	06800 SPEECH PATHOLOGY	0	0		0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	1	0	69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	37, 364	Ļ	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	0	5, 957		0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	481, 20	62	73.00
76.00	03140 CARDI OLOGY	0	0		0	76.00
76.97	07697 CARDIAC REHABILITATION	65	481		0	76. 97
00.00	OUTPATIENT SERVICE COST CENTERS	101	4.000	7.	20	
90.00		101 994	4, 300		38	90.00
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART)	994	70, 524	4,40	09	91.00
92.00	SPECIAL PURPOSE COST CENTERS					92.00
113 00	11300 I NTEREST EXPENSE					113.00
118.00		3, 698	321, 731	496, 90	65	118.00
	NONREI MBURSABLE COST CENTERS					
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	)	0	190. 00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	192.00
200.00	5					200.00
201.00						201.00
202.00		417, 936	497, 185	640, 70	61	202.00
202.00	Part I)	112 01/7//	1 545044	1 0000	40	202.02
203.00		113.016766	1. 545344			203.00
204.00	Cost to be allocated (per Wkst. B, Part II)	7, 498	26, 115	19, 2 <sup>-</sup>	13	204.00
		2 027502	0 001170	0. 0386	(1	205.00
205.00	Unit cost multiplier (Wkst. B, Part	2. 027582	0. 081170			

	nancial Systems	IU HEALTH BLACK				u of Form CMS-	2552-10
COMPUTATI	ION OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151302	Peri od:	Worksheet C	
					From 01/01/2015 To 12/31/2015	Part I Date/Time Pre	nared
					10 12/31/2013	5/24/2016 8:1	9 pm
			Ti tl	e XVIII	Hospi tal	Cost	
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)	0.00	0.00	4.00	F 00	
LN	PATIENT ROUTINE SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
	000 ADULTS & PEDIATRICS	4, 401, 523	1	4, 401, 5	23 0	0	30.00
	CILLARY SERVICE COST CENTERS	4,401,323		4,401,5.	23 0	0	30.00
	000 OPERATING ROOM	1, 219, 476	1	1, 219, 4	76 0	0	50.00
	300 ANESTHESI OLOGY	161,004		1, 219, 4		0	
	400 RADI OLOGY-DI AGNOSTI C	2, 153, 344		2, 153, 3		0	
	700 CT SCAN	2, 155, 544		2, 100, 0	0 0	0	
	800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	
	1900 CARDI AC CATHETERI ZATI ON	0			0 0	0	
	000 LABORATORY	1, 920, 578		1, 920, 5	78 0	0	
	001 BLOOD LABORATORY	0		1,720,0	0 0	0	
	200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 0	0	
	500 RESPI RATORY THERAPY	904, 195	(	904, 1	95 0	0	65.00
	501 SLEEP LAB	0	0		0 0	0	65.01
66.00 06	600 PHYSI CAL THERAPY	649, 717	0	649, 7	17 0	0	66.00
67.00 06	700 OCCUPATIONAL THERAPY	115, 452		115, 4	52 0	0	67.00
68.00 06	800 SPEECH PATHOLOGY	6, 928	0	6, 9	28 0	0	68.00
	900 ELECTROCARDI OLOGY	0			0 0	0	69.00
71.00 07	100 MEDICAL SUPPLIES CHARGED TO PATIENTS	113, 885		113, 8	35 0	0	71.00
	200 IMPL. DEV. CHARGED TO PATIENT	18, 278		18, 2	78 0	0	
	300 DRUGS CHARGED TO PATIENTS	1, 361, 485		1, 361, 4	35 0	0	73.00
76.00 03	140 CARDI OLOGY	0			0 0	0	
	697 CARDI AC REHABI LI TATI ON	83, 606		83, 60	0 0	0	76.97
	TPATIENT SERVICE COST CENTERS	-					
	2000 CLINIC	328, 721		328, 72		0	
	100 EMERGENCY	3, 086, 725		3, 086, 72		0	
	200 OBSERVATION BEDS (NON-DISTINCT PART)	236, 371		236, 3	71	0	92.00
	ECIAL PURPOSE COST CENTERS	-1	1	Т			
	300 INTEREST EXPENSE						113.00
200.00	Subtotal (see instructions)	16, 761, 288					200.00
201.00	Less Observation Beds	236, 371		236, 3			201.00
202.00	Total (see instructions)	16, 524, 917	(	16, 524, 9	17 0	0	202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	IU HEALTH BLACK		CCN: 151302	Peri od:	u of Form CMS- Worksheet C	
				From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/24/2016 8:1	epared:
		Titl	e XVIII	Hospi tal	Cost	7 pm
		Charges				
Cost Center Description	I npati ent	Outpati ent		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						
30. 00 03000 ADULTS & PEDI ATRI CS	2, 597, 909		2, 597, 90	09		30.00
ANCI LLARY SERVI CE COST CENTERS	1 1		1			
50. 00 05000 OPERATI NG ROOM	514, 220	2, 478, 551			0.00000	
53. 00 05300 ANESTHESI OLOGY	40, 993	60, 432			0.00000	
54.00 05400 RADI OLOGY-DI AGNOSTI C	435, 573	7, 577, 876	8, 013, 4		0. 000000	
57.00 05700 CT SCAN	0	0		0 0. 000000	0. 000000	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0. 000000	0. 000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0. 000000	0. 000000	
60. 00 06000 LABORATORY	1, 261, 539	6, 049, 660	7, 311, 1		0. 000000	
60. 01 06001 BLOOD LABORATORY	0	0		0 0. 000000	0. 000000	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0. 000000	0. 000000	
65. 00 06500 RESPI RATORY THERAPY	513, 426	1, 171, 224	1, 684, 6		0. 000000	
65. 01 06501 SLEEP LAB	0	0		0 0. 000000	0. 000000	
66. 00 06600 PHYSI CAL THERAPY	171, 149	712, 937			0. 000000	
67.00 06700 OCCUPATI ONAL THERAPY	63, 231	42, 160			0. 000000	
68.00 06800 SPEECH PATHOLOGY	7, 812	0	7,8		0.00000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0. 000000	0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	42, 471	47, 705			0.00000	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	7,632	28, 012	35, 64		0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	2,053,094	2, 252, 696	4, 305, 7			
76. 00 03140 CARDI OLOGY	0	0		0 0.000000	0.00000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	461	312, 908	313, 30	69 0. 266797	0.00000	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	731, 392	731, 39	92 0. 449446	0.00000	90.00
91. 00 09100 EMERGENCY	63, 567	8, 391, 910	8, 455, 4	77 0. 365056	0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 415	309, 772	318, 18	87 0. 742868	0.00000	92.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	7, 781, 492	30, 167, 235	37, 948, 7	27		200.00
201.00 Less Observation Beds						201.00
202.00 Total (see instructions)	7, 781, 492	30, 167, 235	37, 948, 72	27		202.00

Health Financial Systems	IU HEALTH BLACKFOR	D HOSPI TAL	In Lieu	」of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 151302	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepared: 5/24/2016 8:19 pm
		Title XVIII	Hospi tal	Cost
Cost Center Description	PPS Inpatient			
	Ratio			
	11.00			
INPATIENT ROUTINE SERVICE COST CENTERS				
30. 00 03000 ADULTS & PEDIATRICS				30. 00
ANCI LLARY SERVI CE COST CENTERS				
50.00 05000 OPERATING ROOM	0.000000			50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00
57.00 05700 CT SCAN	0.000000			57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000			59.00
60. 00 06000 LABORATORY	0.000000			60.00
60.01 06001 BLOOD LABORATORY	0, 000000			60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65. 00 06500 RESPI RATORY THERAPY	0.000000			65.00
65. 01 06501 SLEEP LAB	0.000000			65.01
66.00 06600 PHYSI CAL THERAPY	0.000000			66,00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000			67.00
68.00 06800 SPEECH PATHOLOGY	0.000000			68.00
69.00 06900 ELECTROCARDI OLOGY	0.000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00
76. 00 03140 CARDI OLOGY	0,000000			76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000			76, 97
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0.000000			90.00
91.00 09100 EMERGENCY	0.000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS				12100
113. 00 11300 I NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
	1			1-021 00

Health Fina	ancial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATI O	N OF RATIO OF COSTS TO CHARGES		Provi der	CCN: 151302	Period: From 01/01/2015	Worksheet C Part I	
					To 12/31/2015	Date/Time Pre 5/24/2016 8:1	epared: 9 pm
			Ti t	le XIX	Hospi tal	Cost	•
					Costs		
	Cost Center Description	Total Cost	Therapy Limit	Total Costs		Total Costs	
		(from Wkst. B,	Adj.		Di sal I owance		
		Part I, col.					
		26)					
		1.00	2.00	3.00	4.00	5.00	_
	ATIENT ROUTINE SERVICE COST CENTERS	4 404 500	1	1 1 101 5			
	DO ADULTS & PEDIATRICS	4, 401, 523		4, 401, 5	23 0	4, 401, 523	30.00
	LLARY SERVICE COST CENTERS	1 040 474	1	1 010 4	7/	1 010 17/	50.00
	DO OPERATING ROOM	1, 219, 476		1, 219, 4		.,	
		161,004		161, 0		161, 004	
	DO RADI OLOGY-DI AGNOSTI C DO CT SCAN	2, 153, 344		2, 153, 3	44 0	2, 153, 344	
	DO MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	
	DO CARDIAC CATHETERIZATION	0			0 0		
	DO LABORATORY	1, 920, 578		1, 920, 5	79 0	1, 920, 578	
	DI BLOOD LABORATORY	1, 720, 378		1, 720, 5		1, 720, 578	
	DO WHOLE BLOOD & PACKED RED BLOOD CELLS	0				0	
	DO RESPIRATORY THERAPY	904, 195		904, 1	95 O	904, 195	
	DI SLEEP LAB	0,175		) , , , ,	,9 0 0	0	
	DO PHYSI CAL THERAPY	649, 717		649,7	17 0	649, 717	
	DO OCCUPATI ONAL THERAPY	115, 452		115, 4		115, 452	
	DO SPEECH PATHOLOGY	6, 928		6,9		6, 928	
69.00 0690	DO ELECTROCARDI OLOGY	0			0 0	0	
	DO MEDICAL SUPPLIES CHARGED TO PATIENTS	113, 885		113, 8	85 0	113, 885	71.00
72.00 0720	DO IMPL. DEV. CHARGED TO PATIENT	18, 278		18, 2	78 0	18, 278	72.00
73.00 0730	DO DRUGS CHARGED TO PATIENTS	1, 361, 485		1, 361, 4	85 0	1, 361, 485	73.00
76.00 0314	40 CARDI OLOGY	0			0 0	0	76.00
76.97 0769	97 CARDI AC REHABI LI TATI ON	83, 606		83, 6	06 0	83, 606	76.97
	PATIENT SERVICE COST CENTERS	-			-		
	DO CLINIC	328, 721		328, 7			
	DO EMERGENCY	3, 086, 725		3, 086, 7		0/000//20	
	DO OBSERVATION BEDS (NON-DISTINCT PART)	236, 371		236, 3	71	236, 371	92.00
	CIAL PURPOSE COST CENTERS			1			
	DO INTEREST EXPENSE		-		-		113.00
200.00	Subtotal (see instructions)	16, 761, 288	C				
201.00	Less Observation Beds	236, 371		236, 3		236, 371	
202.00	Total (see instructions)	16, 524, 917	0	16, 524, 9	17  0	16, 524, 917	J202.00

Health Financial Systems COMPUTATION OF RATIO OF COSTS TO CHARGES	IU HEALTH BLACK		CCN: 151302	Peri od:	u of Form CMS- Worksheet C	
				From 01/01/2015 To 12/31/2015	Date/Time Pre	epared:
					5/24/2016 8:1	9 pm
		Charges	le XIX	Hospi tal	Cost	
Cost Center Description	Inpatient	Outpati ent	Total (col	6 Cost or Other	TEFRA	
cost center beschiption	inpatrent	outpatrent	+ col. 7	Ratio	Inpatient	
				Natio	Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS	1					
30. 00 03000 ADULTS & PEDI ATRI CS	2, 597, 909		2, 597, 9	09		30. 00
ANCI LLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	514, 220	2, 478, 551	2, 992, 7	0. 407474	0. 000000	50.00
53. 00 05300 ANESTHESI OLOGY	40, 993	60, 432	101, 4	25 1. 587419	0.00000	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	435, 573	7, 577, 876	8, 013, 4	49 0. 268716	0. 000000	54.00
57.00 05700 CT SCAN	0	0		0 0.000000	0. 000000	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0.000000	0. 000000	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0.000000	0. 000000	59.00
60. 00 06000 LABORATORY	1, 261, 539	6, 049, 660	7, 311, 1	0. 262690	0. 000000	60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0.000000	0. 000000	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0.000000	0. 000000	62.00
65. 00 06500 RESPI RATORY THERAPY	513, 426	1, 171, 224	1, 684, 6		0.00000	
65. 01 06501 SLEEP LAB	0	0		0 0.000000	0.00000	65.01
66. 00 06600 PHYSI CAL THERAPY	171, 149	712, 937	884, 0	86 0. 734902	0.00000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	63, 231	42, 160	105, 3	91 1. 095464	0.00000	67.00
68.00 06800 SPEECH PATHOLOGY	7, 812	0	7,8		0.00000	
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0. 000000	0.00000	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	42, 471	47, 705			0.00000	
72.00 07200 I MPL. DEV. CHARGED TO PATIENT	7,632	28, 012	35, 6		0.00000	
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 053, 094	2, 252, 696	4, 305, 7			
76. 00 03140 CARDI OLOGY	0	0		0 0. 000000		
76. 97 07697 CARDI AC REHABI LI TATI ON	461	312, 908	313, 3	69 0. 266797	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	731, 392				
91.00 09100 EMERGENCY	63, 567	8, 391, 910			0.00000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	8, 415	309, 772	318, 1	0. 742868	0.00000	92.00
SPECIAL PURPOSE COST CENTERS	1 1		1			
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	7, 781, 492	30, 167, 235	37, 948, 7	27		200.00
201.00 Less Observation Beds						201.00
202.00  Total (see instructions)	7, 781, 492	30, 167, 235	37, 948, 7	27		202.00

Health Financial Systems	IU HEALTH BLACKFORI	D HOSPI TAL	In Lieu	」of Form CMS-25	52-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 151302	Peri od: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Prepa 5/24/2016 8:19	ared: pm
	- I	Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11.00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					30.00
ANCI LLARY SERVICE COST CENTERS					
50.00 05000 OPERATING ROOM	0. 000000			!	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.000000				54.00
57.00 05700 CT SCAN	0.000000				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0.000000				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000				59.00
60. 00 06000 LABORATORY	0.000000				60.00
60.01 06001 BLOOD LABORATORY	0. 000000				60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000				62.00
65. 00 06500 RESPIRATORY THERAPY	0. 000000				65.00
65. 01 06501 SLEEP LAB	0. 000000				65.01
66. 00 06600 PHYSI CAL THERAPY	0. 000000				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0. 000000				71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENT	0. 000000				72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
76. 00 03140 CARDI OLOGY	0.000000				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000				76.97
OUTPATIENT SERVICE COST CENTERS	0.000000				10. 71
90. 00 09000 CLINIC	0.000000				90.00
91. 00 09100 EMERGENCY	0.000000				90.00 91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000				91.00 92.00
SPECIAL PURPOSE COST CENTERS	0.000000				72. UU
113. 00 11300 I NTEREST EXPENSE				1	13.00
200.00 Subtotal (see instructions)					00.00
200.00 Subtotal (see Instructions) 201.00 Less Observation Beds					00.00 01.00
201.00 Total (see instructions)					01.00
				2	02.00

Health Financial Systems	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS			Period: From 01/01/2015 To 12/31/2015	Worksheet D Part II Date/Time Pre 5/24/2016 8:1	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,			. 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	1	-	- F		
50. 00 05000 OPERATI NG ROOM	167, 691					
53. 00 05300 ANESTHESI OLOGY	1, 824					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	138, 491	8, 013, 449			3, 799	
57.00 05700 CT SCAN	0	0	0.00000		0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0 0	0	59.00
60. 00 06000 LABORATORY	46, 160	7, 311, 199	0. 00631	4 585, 470	3, 697	60.00
60. 01 06001 BLOOD LABORATORY	0	0	0.00000	0 0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0.00000	0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	21, 840	1, 684, 650	0. 01296	4 221, 960	2, 877	65.00
65. 01 06501 SLEEP LAB	0	0	0.00000	0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	84, 845	884, 086	0. 09596	9 16, 460	1, 580	66.00
67.00 06700 OCCUPATI ONAL THERAPY	5, 822	105, 391	0. 05524	2 4, 319	239	67.00
68.00 06800 SPEECH PATHOLOGY	55	7, 812	0. 00704	0 3, 411	24	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 321	90, 176	0. 03682	.8 9, 314	343	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	539	35, 644	0. 01512	2 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	23, 635	4, 305, 790	0. 00548	646, 267	3, 547	73.00
76. 00 03140 CARDI OLOGY	0	0	0.00000	0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	1,880	313, 369	0.00599	9 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLI NI C	59, 211	731, 392	0. 08095	7 0	0	90.00
91.00 09100 EMERGENCY	142, 251			4 2, 863	48	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	32, 127				0	92.00
200.00   Total (lines 50-199)	729, 692	35, 350, 818		1, 832, 497	22, 742	200. 00

Health Financial Systems	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEE THROUGH COSTS	RVICE OTHER PASS	S Provi der	CCN: 151302	Period: From 01/01/2015 To 12/31/2015		
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anestheti st	-		Medi cal	(sum of col 1	
	Cost			Education Cost		
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVICE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
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
57.00 05700 CT SCAN	0	0	)	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	)	0 0	0	58.00
59.00 05900 CARDI AC CATHETERI ZATI ON	0	0	)	0 0	0	59.00
60. 00 06000 LABORATORY	0	0	)	0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0	0	)	0 0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	)	0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0	)	0 0	0	65.00
65.01 06501 SLEEP LAB	0	0	)	0 0	0	65. 01
66.00 06600 PHYSI CAL THERAPY	0	0	)	0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	l o	)	0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	l o		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	l o		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	)	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0	)	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	)	0 0	0	73.00
76. 00 03140 CARDI OLOGY	0	0	)	0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0	)	0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	C		0 0	0	90.00
91.00 09100 EMERGENCY	0	c c		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DI STINCT PART)	0	c c		0 0	0	
200.00 Total (lines 50-199)	0	c c		0 0	0	200.00
						•

Health Financial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SER	RVICE OTHER PAS	S Provi der		Period:	Worksheet D	
THROUGH COSTS				From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/24/2016 8:1	
		Ti tl	e XVIII	Hospi tal	Cost	<u>, bui</u>
Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	Inpati ent	
	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	(col. 5 ÷ col.	to Charges	Charges	
	col. 2, 3 and	8)	7)	(col. 6 ÷ col.	-	
	4)			7)		
	6.00	7.00	8.00	9.00	10.00	
ANCI LLARY SERVI CE COST CENTERS	1	1		-		
50. 00 05000 OPERATI NG ROOM	0	2, 992, 771				•
53. 00 05300 ANESTHESI OLOGY	0	101, 425				•
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	8, 013, 449				54.00
57.00 05700 CT SCAN	0	C	0. 00000			
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C	0. 00000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C	0. 00000			59.00
60. 00 06000 LABORATORY	0	7, 311, 199				60.00
60. 01 06001 BLOOD LABORATORY	0	C	0. 00000			60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C	0. 00000	0. 000000	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 684, 650	0. 00000	0. 000000	221, 960	65.00
65. 01 06501 SLEEP LAB	0	C	0.00000	0. 000000	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0	884, 086	0.00000	0. 000000	16, 460	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	105, 391	0.00000	0. 000000	4, 319	67.00
68.00 06800 SPEECH PATHOLOGY	0	7, 812	0. 00000	0. 000000	3, 411	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 00000	0. 000000	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	90, 176	0.00000	0. 000000	9, 314	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	35, 644	0.00000	0. 000000	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	4, 305, 790	0. 00000	0. 000000	646, 267	73.00
76. 00 03140 CARDI OLOGY	0	0	0. 00000	0. 000000	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	313, 369	0.00000	0. 000000	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0	731, 392	0. 00000	0. 000000	0	90.00
91. 00 09100 EMERGENCY	0	8, 455, 477				
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	318, 187		0. 000000		
200.00   Total (lines 50-199)	0	35, 350, 818	8		1, 832, 497	200.00

Health Financial Systems	IU HEALTH BLACK	ORD HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF	RVICE OTHER PASS	Provi der	CCN: 151302	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2015	Part IV	nored.
				To 12/31/2015	Date/Time Pre 5/24/2016 8: 2	
		Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description	I npati ent	Outpati ent	Outpati ent			
	Program	Program	Program			
	Pass-Through	Charges	Pass-Throug			
	Costs (col. 8		Costs (col.	9		
	x col. 10)		x col. 12)			
	11.00	12.00	13.00			
ANCI LLARY SERVICE COST CENTERS			-			
50. 00 05000 OPERATI NG ROOM	0	0		0		50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0		54.00
57.00 05700 CT SCAN	0	0		0		57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.00
60. 00 06000 LABORATORY	0	C	)	0		60.00
60. 01 06001 BLOOD LABORATORY	0	0		0		60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0		62.00
65. 00 06500 RESPI RATORY THERAPY	0	C	)	0		65.00
65.01 06501 SLEEP LAB	0	C	)	0		65.01
66. 00 06600 PHYSI CAL THERAPY	0	C	)	0		66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C	)	0		67.00
68.00 06800 SPEECH PATHOLOGY	0	C	)	0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C	)	0		69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C	)	0		71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C	)	0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C	)	0		73.00
76. 00 03140 CARDI OLOGY	0	C	)	0		76.00
76. 97 07697 CARDIAC REHABILITATION	0	C	)	0		76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLI NI C	0	C		0		90.00
91. 00 09100 EMERGENCY	0	C	)	0		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C		0		92.00
200.00   Total (lines 50-199)	0	C	p	0		200. 00

	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AN	D VACCINE COST	Provi der	CCN: 151302	Peri od:	Worksheet D	
				From 01/01/2015 To 12/31/2015	Part V Date/Time Pre	pared.
				10 12/01/2010	5/24/2016 8:1	
		Titl	e XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To Ded. & Coins	Subject To		
			(see inst.)	. Ded. & Coins. (see inst.)		
	1.00	2.00	<u>(see mst.)</u> 3.00	4,00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0. 407474	0	828, 21	13 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	1. 587419				0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 268716	0	2, 329, 1		0	54.00
57. 00 05700 CT SCAN	0. 000000	0	_,, .	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 262690	0	1, 767, 52	24 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 536726	0	504, 17	0 0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 734902	0	288, 95	50 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1. 095464	0	6, 03	30 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 886841	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 262919	0	13, 03	34 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 512793		8, 41		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 316199		871, 92	947 947	0	73.00
76. 00 03140 CARDI OLOGY	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 266797	0	136, 29	90 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	0. 449446				0	
91. 00 09100 EMERGENCY	0. 365056		_//		0	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART)	0. 742868	0	138, 86		0	92.00
200.00 Subtotal (see instructions)		0	9, 807, 53		0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		~		0.47	~	202.00
202.00   Net Charges (line 200 +/- line 201)	1	0	9, 807, 53	30 947	0	202.00

Heal th	Financial Systems	U HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST		CCN: 151302	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pre 5/24/2016 8:	epared: 19 pm
			Ti tl	e XVIII	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost Reimbursed Services Subject To Ded. & Coins. (see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
		6.00	7.00				
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	337, 475	0				50.00
53.00	05300 ANESTHESI OLOGY	20, 344	0				53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	625, 870	0				54.00
57.00	05700 CT SCAN	0	0				57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60.00	06000 LABORATORY	464, 311	0				60.00
60.01	06001 BLOOD LABORATORY	0	0				60.01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
65.00	06500 RESPI RATORY THERAPY	270, 602	0				65.00
65.01	06501 SLEEP LAB	0	0				65.01
66.00	06600 PHYSI CAL THERAPY	212, 350	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	6, 606	0				67.00
68.00	06800 SPEECH PATHOLOGY	0	0				68.00
69.00	06900 ELECTROCARDI OLOGY	0	0				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	16, 461	0				71.00
	07200 IMPL. DEV. CHARGED TO PATIENT	4, 313	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	275, 702	299				73.00
76.00	03140 CARDI OLOGY	0	0				76.00
76.97	07697 CARDIAC REHABILITATION	36, 362	0				76.97
C	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	215, 265	0				90.00
91.00	09100 EMERGENCY	884, 614	0				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	103, 161	0				92.00
200.00	Subtotal (see instructions)	3, 473, 436	299				200.00
201.00	Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00	Net Charges (line 200 +/- line 201)	3, 473, 436	299				202.00

		IU HEALTH BLACK	FORD HOSPI TAL		In Lie	eu of Form CMS-	2552-10
APPORTI ONME	NT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151302	Peri od:	Worksheet D	
			Component	CCN: 15Z302	From 01/01/2015 To 12/31/2015		narod
			component	CCN. 152502	10 12/31/2013	5/24/2016 8:1	
			Ti tl	e XVIII	Swing Beds - SNF		
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	LARY SERVICE COST CENTERS		-	1		-	
	OPERATING ROOM	0. 407474			0 0	0	
	ANESTHESI OLOGY	1. 587419			0 0	0	
	RADI OLOGY-DI AGNOSTI C	0. 268716			0 0	0	
	CT SCAN	0. 000000			0 0	0	
	MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			0 0	0	
	CARDIAC CATHETERIZATION	0. 000000			0 0	0	
	LABORATORY	0. 262690			0 0	0	
	BLOOD LABORATORY	0. 000000			0 0	0	
	WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			0 0	0	
	RESPI RATORY THERAPY	0. 536726			0 0	0	
	SLEEP LAB	0. 000000			0 0	0	65. 01
	PHYSI CAL THERAPY	0. 734902	0		0 0	0	
	OCCUPATIONAL THERAPY	1. 095464	0		0 0	0	
	SPEECH PATHOLOGY	0. 886841	0		0 0	0	
	ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
	MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 262919	0		0 0	0	
	IMPL. DEV. CHARGED TO PATIENT	0. 512793	0		0 0	0	
	DRUGS CHARGED TO PATIENTS	0. 316199			0 0	0	
76.00 03140		0. 000000	0		0 0	0	76.00
	CARDI AC REHABI LI TATI ON	0. 266797	0		0 0	0	76.97
	TIENT SERVICE COST CENTERS						
		0. 449446			0 0	0	90.00
	EMERGENCY	0. 365056	0		0 0	0	
	OBSERVATION BEDS (NON-DISTINCT PART)	0. 742868	0		0 0	0	
200.00	Subtotal (see instructions)		0		0 0	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 +/- line 201)		0		0 0	0	202.00

Health Financial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151302	Period: From 01/01/2015	Worksheet D Part V	
		Componen	t CCN: 15Z3O2			
		Ti tl	e XVIII	Swing Beds - SNF		<u>, bui</u>
	Cos	sts		<u> </u>		
Cost Center Description	Cost	Cost	1			
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
		Ded. & Coins.				
	(see inst.)	(see inst.)	-			
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						F0 00
50. 00 05000 OPERATING ROOM	0	C				50.00
53. 00 05300 ANESTHESI OLOGY	0					53.00
54.00 O5400 RADI OLOGY-DI AGNOSTI C	0					54.00
57.00 05700 CT SCAN	0					57.00
58.00 O5800 MAGNETIC RESONANCE I MAGING (MRI)	0					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	0					59.00
	0					60.00
60. 01 06001 BLOOD LABORATORY	0					60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0					62.00
65. 00 06500 RESPI RATORY THERAPY 65. 01 06501 SLEEP LAB	0					65.00 65.01
	0					65.01 66.00
	0					67.00
67. 00 06700 0CCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0					67.00 68.00
69. 00 06900 ELECTROCARDI OLOGY	0					68.00 69.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0					69.00 71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0					72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0					72.00
76. 00 03140 CARDI OLOGY	0					76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0					76.97
OUTPATIENT SERVICE COST CENTERS	0					10.91
90. 00 09000 CLINIC	0	C				90, 00
91. 00 09100 EMERGENCY						90.00 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						91.00 92.00
200.00 Subtotal (see instructions)						200.00
201.00 Less PBP Clinic Lab. Services-Program			<u></u>			200.00
Only Charges						201.00
202.00 Net Charges (line 200 +/- line 201)	0	c c				202.00

	IU HEALTH BLACK			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151302	Peri od:	Worksheet D	
				From 01/01/2015 To 12/31/2015	Part V Date/Time Pre	nared
				10 12/31/2013	5/24/2016 8: 1	
		Tit	le XIX	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge			Cost	PPS Services	
		Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
	1.00	2.00	(see inst.) 3.00	(see inst.) 4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
50. 00 05000 OPERATI NG ROOM	0. 407474	0	29, 74	13 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	1. 587419	0			0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 268716	0	278, 62		0	54.00
57. 00 05700 CT SCAN	0. 000000	0	270,02		0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0			0	59.00
60. 00 06000 LABORATORY	0. 262690	0	224, 87	71 0	0	60,00
60. 01 06001 BLOOD LABORATORY	0. 000000	0	221,07	0 0	0	60.01
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 536726	0	40, 89	0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 734902	0	12, 54	12 0	0	66,00
67.00 06700 OCCUPATI ONAL THERAPY	1.095464	0	93		0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 886841	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000	0		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 262919	0	1	0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 512793	0	50	0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 316199	0	65, 08	31 0	0	73.00
76. 00 03140 CARDI OLOGY	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 266797	0	4, 86	0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS	r					
90. 00 09000 CLINIC	0. 449446	0			0	
91.00 09100 EMERGENCY	0. 365056	0			0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 742868	0	5, 84		0	92.00
200.00 Subtotal (see instructions)		0	1, 092, 50		0	200. 00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges			1 000 5			
202.00   Net Charges (line 200 +/- line 201)		0	1, 092, 50	04 0	0	202.00

Health Financial Systems	U HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der	CCN: 151302	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pre 5/24/2016 8:	epared: 19 pm
		Tit	le XIX	Hospi tal	Cost	
	Cos	sts				
Cost Center Description	(see inst.)	Cost Reimbursed Services Not Subject To Ded. & Coins. (see inst.)				
	6.00	7.00				
ANCI LLARY SERVICE COST CENTERS						
50. 00         05000         OPERATI NG         R00M           53. 00         05300         ANESTHESI OLOGY           54. 00         05400         RADI OLOGY-DI AGNOSTI C	12, 119 2, 651 74, 870	0				50.00 53.00 54.00
57.00 05700 CT SCAN	0	0				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
60. 00 06000 LABORATORY	59, 071	0				60.00
60. 01 06001 BLOOD LABORATORY	0	0				60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
65. 00 06500 RESPI RATORY THERAPY	21, 947	0				65.00
65.01 06501 SLEEP LAB	0	0				65.01
66. 00 06600 PHYSI CAL THERAPY	9, 217					66.00
67.00 06700 OCCUPATI ONAL THERAPY	1, 019	0				67.00
68.00 06800 SPEECH PATHOLOGY	0	0				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	256					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	20, 579	0				73.00
76. 00 03140 CARDI OLOGY	0	0				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	1, 297	0				76.97
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC	1, 680	0				90.00
91.00 09100 EMERGENCY	154, 497	0				91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	4, 340	0				92.00
200.00 Subtotal (see instructions)	363, 543	0				200.00
201.00 Less PBP Clinic Lab. Services-Program Only Charges	0					201.00
202.00   Net Charges (line 200 +/- line 201)	363, 543	0				202.00

	Financial Systems IU HEALTH BLACKFORD ATION OF INPATIENT OPERATING COST	Provi der CCN: 151302	Period: From 01/01/2015 To 12/31/2015	J of Form CMS-2 Worksheet D-1 Date/Time Prep 5/24/2016 8:19	pared:
	Cast Contor Description	Title XVIII	Hospi tal	Cost	
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS				-
1.00	Inpatient days (including private room days and swing-bed days	, excluding newborn)		2, 420	1.00
2.00	Inpatient days (including private room days, excluding swing-b			1, 166	
3.00	Private room days (excluding swing-bed and observation bed days do not complete this line.	s). If you have only pr	rivate room days,	0	3.00
4.00	Semi-private room days (excluding swing-bed and observation be			1, 046	4.00
5.00	Total swing-bed SNF type inpatient days (including private room	m days) through Decembe	er 31 of the cost	1, 055	5.00
6.00	reporting period Total swing-bed SNF type inpatient days (including private roo	m days) after December	31 of the cost	0	6.00
	reporting period (if calendar year, enter 0 on this line)			100	
7.00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	- 31 OF THE COST	199	7.00
8.00	Total swing-bed NF type inpatient days (including private room	days) after December 3	31 of the cost	0	8.00
9.00	reporting period (if calendar year, enter 0 on this line)	the Dreanon (avaluding	, owing had and	691	9.00
9.00	Total inpatient days including private room days applicable to newborn days)	the Program (excruding	g swing-bed and	091	9.00
10. 00	Swing-bed SNF type inpatient days applicable to title XVIII on		room days)	1, 055	10.00
11 00	through December 31 of the cost reporting period (see instruct Swing-bed SNF type inpatient days applicable to title XVIII on	<i>,</i>	coom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, en	ter 0 on this line)	5 /		
12.00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including privat	te room days)	0	12.0
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	te room days)	0	13.0
4 4 . 00	after December 31 of the cost reporting period (if calendar year				
	Medically necessary private room days applicable to the Program Total nursery days (title V or XIX only)	m (excluding swing-bed	days)	0	
	Nursery days (title V or XIX only)				16.00
17 00	SWING BED ADJUSTMENT	c through December 21	of the cost		1 17 0
17.00	Medicare rate for swing-bed SNF services applicable to services reporting period	s through becember 31 c	DI THE COST		17.0
18.00	Medicare rate for swing-bed SNF services applicable to service	s after December 31 of	the cost		18.00
19.00	reporting period Medicaid rate for swing-bed NF services applicable to services	through December 31 of	f the cost	134.09	19 0
	reporting period	0			
20.00	Medicaid rate for swing-bed NF services applicable to services reporting period	after December 31 of 1	the cost	0.00	20.0
21.00	Total general inpatient routine service cost (see instructions)	)		4, 401, 523	21.0
22.00	Swing-bed cost applicable to SNF type services through December	r 31 of the cost report	ting period (line	0	22.0
23.00	5 x line 17) Swing-bed cost applicable to SNF type services after December 3	31 of the cost reportir	na period (line 6	0	23.0
	x line 18)		51 (		
24.00	Swing-bed cost applicable to NF type services through December $7 \times 1$ (ine 19)	31 of the cost reporti	ng period (line	26, 684	24.00
25.00	Swing-bed cost applicable to NF type services after December 3	1 of the cost reporting	g period (line 8	0	25.0
24 00	x line 20)			2 104 701	24.0
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (	line 21 minus line 26)		2, 104, 781 2, 296, 742	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed ch	narges)	0	28.0
	Semi-private room charges (excluding swing-bed charges)			0	30.0
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
	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	
	Average per diem private room charge differential (line 32 min	us line 33)(see instruc	ctions)	0.00	
	Average per diem private room cost differential (line 34 x line	e 31)		0.00	
	Private room cost differential adjustment (line 3 x line 35) General inpatient routine service cost net of swing-bed cost a	nd private room cost di	fferential (line	0 2, 296, 742	36.00
	27 minus line 36)			2,2,0,172	] 37.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	DROCRAM INDATIENT OPERATING COST REFORE DASS TUROUSU COST AD UK	CTMENITC			
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see			1, 969. 76	38.00
38. 00 39. 00		i nstructi ons) 38)		1, 969. 76 1, 361, 104 0	39.0

Heal th	Financial Systems	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
					From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
						5/24/2016 8:1	
		<b>T</b> 1 1		e XVIII	Hospi tal	Cost	
	Cost Center Description	Total	Total Inpatient Days	Average Per	Program Days	Program Cost (col. 3 x col.	
				col. 2)	•	4)	
		1.00	2.00	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)						42.00
43.00	Intensive Care Type Inpatient Hospital Units INTENSIVE CARE UNIT						43.00
	CORONARY CARE UNIT						43.00
	BURN I NTENSI VE CARE UNI T						45.00
	SURGI CAL INTENSI VE CARE UNI T						46.00
47.00	OTHER SPECIAL CARE (SPECIFY)						47.00
	Cost Center Description					1.00	
48.00	Program inpatient ancillary service cost (Wks	st D=3 col 3	Line 200)			1.00	48.00
	Total Program inpatient costs (sum of lines			ons)		1, 988, 839	
	PASS THROUGH COST ADJUSTMENTS						
50.00	Pass through costs applicable to Program inpa	atient routine	services (from	n Wkst. D, sum	of Parts I and	0	50.00
51.00	) Pass through costs applicable to Program inpa	atient ancillar	y services (fr	rom Wkst. D, s	um of Parts II	0	51.00
F2 00	and IV)						F2 00
52.00 53.00	Total Program excludable cost (sum of lines ! Total Program inpatient operating cost exclud		lated non-nhy	vsician anesth	atist and	0	52.00 53.00
55.00	medical education costs (line 49 minus line !	5 1	nated, non-phy		etist, anu	0	55.00
	TARGET AMOUNT AND LIMIT COMPUTATION						
	Program discharges					0	
	Target amount per discharge						55.00
	Target amount (line 54 x line 55)	ing post and to	ract employet (1	ing E( minug	Line E2)	0	56.00 57.00
	Difference between adjusted inpatient operati Bonus payment (see instructions)	ing cost and ta	irget amount (i	The so minus	Tine 53)		57.00
	Lesser of lines 53/54 or 55 from the cost rep	porting period	endina 1996, u	updated and co	mpounded by the	0.00	
	market basket	511	5		,		
	Lesser of lines 53/54 or 55 from prior year of					0.00	60.00
61.00	If line 53/54 is less than the lower of lines					0	61.00
	which operating costs (line 53) are less than amount (line 56), otherwise enter zero (see i		s (Times 54 x	60), OF 1% OF	the target		
62.00	Relief payment (see instructions)					0	62.00
	Allowable Inpatient cost plus incentive payme	ent (see instru	icti ons)			0	63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST						
64.00	Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts through Dece	ember 31 of the	e cost reporti	ng period (See	2, 078, 097	64.00
65.00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reportina	period (See	0	65.00
	instructions) (title XVIII only)						
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus line 6	5)(title XVII	l only). For	2, 078, 097	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routing	e costs through	December 31 d	of the cost re	porting period	0	67.00
	(line 12 x line 19)	0					
68.00	Title V or XIX swing-bed NF inpatient routine (line 13 x line 20)	e costs arter D	ecember 31 or	the 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 NU Skilled nursing facility/other nursing facili		•			[	70.00
	Adjusted general inpatient routine service of	5		,			70.00 71.00
	Program routine service cost (line 9 x line			2)			72.00
73.00	Medically necessary private room cost applica	able to Program	n (line 14 x li	ne 35)			73.00
74.00	Total Program general inpatient routine servi	•					74.00
75.00	Capital-related cost allocated to inpatient	routine service	e costs (from W	lorksheet B, P	art II, column		75.00
76.00	26, line 45) Per diem capital-related costs (line 75 ÷ lin	ne 2)					76.00
	Program capital -related costs (line 9 x line						77.00
78.00	Inpatient routine service cost (line 74 minus	s line 77)					78.00
79.00	Aggregate charges to beneficiaries for excess	• •					79.00
80.00	Total Program routine service costs for comparing		cost limitation	i (line /8 min	us line /9)		80.00
81.00 82.00	Inpatient routine service cost per diem limi Inpatient routine service cost limitation (li		)				81.00 82.00
	Reasonable inpatient routine service cost frim tatron (in		· .				83.00
	Program inpatient ancillary services (see in						84.00
	Utilization review - physician compensation						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)					120	87.00
88.00	Adjusted general inpatient routine cost per o		line 2)			1, 969. 76	
	Observation bed cost (line 87 x line 88) (see					236, 371	

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL			In Lieu of Form CMS-2552-1			
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1		
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/24/2016 8:1		
		Titl	e XVIII	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 27)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	312, 170	2, 296, 742	0. 13591	9 236, 371	32, 127	90.00	
91.00 Nursing School cost	0	2, 296, 742	0.00000	0 236, 371	0	91.00	
92.00 Allied health cost	0	2, 296, 742	0. 00000	0 236, 371	0	92.00	
93.00 All other Medical Education	0	2, 296, 742	0. 00000	0 236, 371	0	93.00	

MPUT.	ATION OF INPATIENT OPERATING COST	Provider CCN: 151302	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Pre 5/24/2016 8:1	pare
	Cost Center Description	Title XIX	Hospi tal	Cost	1
				1.00	
	PART I – ALL PROVIDER COMPONENTS INPATIENT DAYS				-
00	Inpatient days (including private room days and swing-bed days, e	excluding newborn)		2, 420	1.
00	Inpatient days (including private room days, excluding swing-bed			1, 166	
00	Private room days (excluding swing-bed and observation bed days). do not complete this line.	If you have only pr	rivate room days,	0	3.
00	Semi-private room days (excluding swing-bed and observation bed d	ays)		1, 046	4
00	Total swing-bed SNF type inpatient days (including private room d	ays) through Decembe	er 31 of the cost	1, 055	5
00	reporting period Total swing-bed SNF type inpatient days (including private room d	avs) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line)	ays) arter becember		0	
00	Total swing-bed NF type inpatient days (including private room da	ys) through December	31 of the cost	199	7
00	reporting period Total swing-bed NF type inpatient days (including private room da	vs) after December 2	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line)	ys) arter becember 3	in on the cost	0	
00	Total inpatient days including private room days applicable to th	e Program (excluding	swing-bed and	11	9
. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII only	(including private r	nom davs)	0	10
. 00	through December 31 of the cost reporting period (see instruction			0	
. 00	Swing-bed SNF type inpatient days applicable to title XVIII only		oom days) after	0	11
2. 00	December 31 of the cost reporting period (if calendar year, enter Swing-bed NF type inpatient days applicable to titles V or XIX on		e room days)	0	12
. 00	through December 31 of the cost reporting period	ing (Therading privat		0	1 12
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX on			0	13
. 00	after December 31 of the cost reporting period (if calendar year, Medically necessary private room days applicable to the Program (			0	14
. 00	Total nursery days (title V or XIX only)	exer during swring bed	uuys)	0	
. 00	Nursery days (title V or XIX only)			0	16
7.00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services t	brough December 31 c	of the cost		1 17
. 00	reporting period	Through December 51 C	in the cost		
8. 00	Medicare rate for swing-bed SNF services applicable to services a	fter December 31 of	the cost		18
. 00	reporting period Medicaid rate for swing-bed NF services applicable to services th	rouah December 31 of	the cost	0.00	19
	reporting period	0			
0. 00	Medicaid rate for swing-bed NF services applicable to services af reporting period	ter December 31 of t	he cost	0.00	20
. 00	Total general inpatient routine service cost (see instructions)			4, 401, 523	21
2.00	Swing-bed cost applicable to SNF type services through December 3	1 of the cost report	ing period (line	0	22
3.00	5 x line 17) Swing-bed cost applicable to SNF type services after December 31	of the cost reportin	a ported (line 6	0	23
. 00	x line 18)	of the cost reportin		0	
. 00	Swing-bed cost applicable to NF type services through December 31	of the cost reporti	ng period (line	0	24
5. 00	7 x line 19) Swing-bed cost applicable to NF type services after December 31 o	f the cost reporting	pariod (line 9	0	25
. 00	x line 20)	in the cost reporting		0	23
b. 00	Total swing-bed cost (see instructions)			2, 090, 778	
. 00	General inpatient routine service cost net of swing-bed cost (lin PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	e 21 minus line 26)		2, 310, 745	27
. 00	General inpatient routine service charges (excluding swing-bed an	d observation bed ch	arges)	0	28
. 00	Private room charges (excluding swing-bed charges)		0	0	1
. 00	Semi-private room charges (excluding swing-bed charges)	no 20)		0 0. 000000	
. 00 . 00	General inpatient routine service cost/charge ratio (line 27 ÷ li Average private room per diem charge (line 29 ÷ line 3)	THE 20)		0.000000	
. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	
. 00	Average per diem private room charge differential (line 32 minus	, <b>、</b>	tions)	0.00	
5.00 5.00	Average per diem private room cost differential (line 34 x line 3 Private room cost differential adjustment (line 3 x line 35)	1)		0.00	
. 00 . 00	General inpatient routine service cost net of swing-bed cost and	private room cost di	fferential (line	2, 310, 745	
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTM	ENTS			-
	TROURAW TWEATTENT OF LIKATING COST DEFUKE PASS THROUGH COST ADJUSTM	LINIJ			1
	Adjusted general inpatient routine service cost per diem (see ins	tructions)		1, 981. 78	38
8. 00 9. 00 9. 00				1, 981. 78 21, 800 0	39

Heal th	Financial Systems	U HEALTH BLACK	FORD HOSP	I TAL		In Lie	u of Form CMS-2	2552-10
	ATION OF INPATIENT OPERATING COST		Prov	/i der		Peri od:	Worksheet D-1	
						From 01/01/2015 To 12/31/2015	Date/Time Pre	nared
						12/01/2010	5/24/2016 8:1	
					le XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Tota Lopati opt		Average Per	Program Days	Program Cost (col. 3 x col.	
		inpatrent cost	пратент	Days		-	(COL 3 X COL 4)	
		1.00	2.00	)	3.00	4.00	5.00	
42.00	NURSERY (title V & XIX only)							42.00
42.00	Intensive Care Type Inpatient Hospital Units		1			1		40.00
	INTENSIVE CARE UNIT CORONARY CARE UNIT							43.00 44.00
	BURN INTENSIVE CARE UNIT							45.00
46.00	SURGI CAL I NTENSI VE CARE UNI T							46.00
47.00	OTHER SPECIAL CARE (SPECIFY)							47.00
	Cost Center Description						1.00	
48.00	Program inpatient ancillary service cost (Wks		3. line 20	)0)			32, 680	48.00
	Total Program inpatient costs (sum of lines 4				ns)		54, 480	
	PASS THROUGH COST ADJUSTMENTS							
50.00	Pass through costs applicable to Program inpa	atient routine	servi ces	(from	Wkst. D, sum	of Parts I and	0	50.00
51.00	Pass through costs applicable to Program inpa	atient ancillar	ry service	es (fr	om Wkst. D, su	um of Parts II	0	51.00
52.00	and IV) Total Program excludable cost (sum of lines {	50 and 51)					0	52.00
	Total Program inpatient operating cost exclude		elated, no	on-phy	sician anesthe	etist, and	0	53.00
	medical education costs (line 49 minus line 8							
F 4 00	TARGET AMOUNT AND LIMIT COMPUTATION						0	F 4 00
	Program discharges Target amount per discharge						0	54.00 55.00
	Target amount (line 54 x line 55)						0.00	56.00
	Difference between adjusted inpatient operati	ing cost and ta	arget amou	ınt (I	ine 56 minus l	ine 53)	0	57.00
	Bonus payment (see instructions)						0 0.00	58.00
59.00								59.00
60.00	market basket Lesser of lines 53/54 or 55 from prior year o	cost report, up	dated by	the m	arket basket		0.00	60.00
	If line 53/54 is less than the lower of lines					he amount by	0	61.00
	which operating costs (line 53) are less than		s (lines	54 x	60), or 1% of	the target		
62.00	amount (line 56), otherwise enter zero (see i Pelief payment (see instructions)	nstructions)					0	62.00
								63.00
	PROGRAM INPATIENT ROUTINE SWING BED COST							
64.00	Medicare swing-bed SNF inpatient routine cost	ts through Dece	ember 31 d	of the	cost reportir	ng period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cost	ts after Decemh	per 31 of	the c	ost reporting	neriod (See	0	65.00
00.00	instructions) (title XVIII only)			110 0	lost reporting		0	00.00
66.00	Total Medicare swing-bed SNF inpatient routin	ne costs (line	64 plus l	ine 6	5)(title XVIII	only). For	0	66.00
67.00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine	e costs through	December	- 31 o	f the cost rep	orting period	0	67.00
68 00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routine	a costs after [	)ocombor 3	1 of	the cost repor	ting period	0	68.00
	(line 13 x line 20)					tring period		
69.00	Total title V or XIX swing-bed NF inpatient PART III - SKILLED NURSING FACILITY, OTHER NU						0	69.00
70.00	Skilled nursing facility/other nursing facili		•					70.00
	Adjusted general inpatient routine service co	2						71.00
	Program routine service cost (line 9 x line 7							72.00
73.00	Medically necessary private room cost applica				ne 35)			73.00
74.00 75.00	Total Program general inpatient routine servi Capital-related cost allocated to inpatient r				orksheet B Pa	art II column		74.00 75.00
/0/00	26, line 45)				0111011001 0, 10			/0/00
	Per diem capital-related costs (line 75 ÷ lin							76.00
	Program capital-related costs (line 9 x line Inpatient routine service cost (line 74 minus	,						77.00
78.00 79.00	Aggregate charges to beneficiaries for excess	,	orovider r	record	s)			78.00 79.00
80.00	Total Program routine service costs for compa	• •			· · ·	ıs line 79)		80.00
81.00	Inpatient routine service cost per diem limit	tati on				-		81.00
82.00	Inpatient routine service cost limitation (li							82.00
83.00 84.00	Reasonable inpatient routine service costs (s Program inpatient ancillary services (see ins		15)					83.00 84.00
	Utilization review - physician compensation		ons)					84.00 85.00
	Total Program inpatient operating costs (sum							86.00
	PART IV - COMPUTATION OF OBSERVATION BED PASS	S THROUGH COST						
87.00 88.00	Total observation bed days (see instructions) Adjusted general inpatient routine cost per o		lino 2				120 1, 981. 77	87.00 88.00
	Observation bed cost (line 87 x line 88) (see						237, 812	
		, , , ,						

Health Financial Systems	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Period:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre 5/24/2016 8:1	
		Tit	le XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 27)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	312, 170	2, 310, 745	0. 13509	5 237, 812	32, 127	90.00
91.00 Nursing School cost	0	2, 310, 745	0. 00000	0 237, 812	0	91.00
92.00 Allied health cost	0	2, 310, 745	0. 00000	0 237, 812	0	92.00
93.00 All other Medical Education	0	2, 310, 745	0. 00000	0 237, 812	0	93.00

Health Financial Systems IU HEALTH BLACKFORD HC	-	001 454000		u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	rovider	CCN: 151302	Period: From 01/01/2015	Worksheet D-3	5
			To 12/31/2015	Date/Time Pre	epared:
				5/24/2016 8:1	
	Ti tl	e XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	1, 118, 121		30.00
ANCI LLARY SERVI CE COST CENTERS			1, 110, 121		1 30.00
50. 00 05000 OPERATI NG ROOM		0.4074	74 115, 186	46, 935	50.00
53. 00 05300 ANESTHESI OLOGY		1. 5874			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2687			
57. 00 05700 CT SCAN		0.0000		0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	59.00
60. 00 06000 LABORATORY		0. 2626	90 585, 470	153, 797	60.00
60. 01 06001 BLOOD LABORATORY		0.0000	0 00	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000	0 00	0	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 5367		119, 132	
65. 01 06501 SLEEP LAB		0.0000		0	
66. 00 06600 PHYSI CAL THERAPY		0. 7349		12, 096	
67. 00 06700 OCCUPATI ONAL THERAPY		1.0954			
68.00 O6800 SPEECH PATHOLOGY		0. 8868		3, 025	
69. 00 06900 ELECTROCARDI OLOGY		0.0000		0	
71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		1.2629		11, 763	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0.5127		0	
73. 00 07300 DRUGS CHARGED TO PATIENTS		0. 3161		204, 349	
76. 00 03140 CARDI OLOGY		0.0000		0	
76. 97 O7697 CARDI AC REHABI LI TATI ON		0. 2667	97 0	0	76.97
		0.4404	4/	0	
90. 00 09000 CLINIC 91. 00 09100 EMERGENCY		0. 4494 0. 3650		0	
91.00 09100 EMERGENCY 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				1, 045 0	
200.00 Total (sum of lines 50-94 and 96-98)		0.7428	1, 832, 497	627, 735	
201.00 Less PBP Clinic Laboratory Services-Program only charges (li	no 61)		1, 832, 497	027,735	200.00
201.00 Less PBP CITILIC Laboratory services-Program only charges (T 202.00 Net Charges (Line 200 minus Line 201)			1, 832, 497		201.00
202.00 Inter onalyes (The 200 Intrus The 201)		I	1,032,497	l	1202.00

Health Financial Systems	IEALTH BLACKFORD HOSPI TAL		In Lie	eu of Form CMS-	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 151302	Peri od:	Worksheet D-3	
		001 457000	From 01/01/2015		
	Component	CCN: 15Z302	To 12/31/2015	Date/Time Pre 5/24/2016 8:1	pared: 9 nm
	Titl	e XVIII	Swing Beds - SNF		<u>, bui</u>
Cost Center Description		Ratio of Cos	t Inpatient	Inpatient	
·		To Charges	Program	Program Costs	
		-	Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS			-		
30. 00 03000 ADULTS & PEDI ATRI CS			0		30.00
ANCI LLARY SERVI CE COST CENTERS					-
50. 00 05000 OPERATI NG ROOM		0. 4074			
53. 00 05300 ANESTHESI OLOGY		1. 5874		, °	
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 2687			•
57.00 05700 CT SCAN		0.0000		, °	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)		0.0000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
60. 00 06000 LABORATORY		0. 2626			•
60. 01 06001 BLOOD LABORATORY		0.0000		-	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0. 53672		102, 909	
65. 01 06501 SLEEP LAB		0.0000		, v	
66. 00 06600 PHYSI CAL THERAPY		0. 73490			
67.00 06700 OCCUPATI ONAL THERAPY		1.0954			
68.00 06800 SPEECH PATHOLOGY		0. 8868		3, 903	•
69. 00 06900 ELECTROCARDI OLOGY		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 2629		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 5127		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3161		258, 944	73.00
76. 00 03140 CARDI OLOGY		0.0000		, °	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 2667	97 242	65	76.97
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC		0. 4494			
91. 00 09100 EMERGENCY		0.3650		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7428		0	
200.00 Total (sum of lines 50-94 and 96-98)			1, 563, 460	606, 698	
201.00 Less PBP Clinic Laboratory Services-Progra	m only charges (line 61)		0		201.00
202.00 Net Charges (line 200 minus line 201)			1, 563, 460		202.00

Health Financial Systems IU HEALTH BLACKFORD HO	-	CCN: 151302	Peri od:	u of Form CMS- Worksheet D-3	
	ovidei	CCN. 131302	From 01/01/2015	WOLKSHEEL D-3	,
			To 12/31/2015	Date/Time Pre	epared:
				5/24/2016 8:1	19 pm
	Ti t	le XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS		1	23, 829		30.0
ANCI LLARY SERVICE COST CENTERS			23, 027		- 50. 0
50. 00 05000 OPERATI NG ROOM		0.4074	74 35, 735	14, 561	50.0
53. 00 05300 ANESTHESI OLOGY		1. 5874		3, 589	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0. 2687			
57.00 05700 CT SCAN		0.0000		0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	58.0
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
50. 00 06000 LABORATORY		0. 2626	90 10, 236	2, 689	60.0
50. 01 06001 BLOOD LABORATORY		0.0000	0 00	0	60. 0
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000	0 00	0	62.0
55. 00 06500 RESPI RATORY THERAPY		0. 5367	26 3, 993	2, 143	65. C
55. 01 06501 SLEEP LAB		0.0000	0 00	0	65. C
56. 00 06600 PHYSI CAL THERAPY		0.7349		0	
57. 00 06700 OCCUPATI ONAL THERAPY		1.0954		0	
58.00 06800 SPEECH PATHOLOGY		0. 8868		0	
59. 00 06900 ELECTROCARDI OLOGY		0.0000		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 2629		2, 451	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 5127		0	
3.00 07300 DRUGS CHARGED TO PATIENTS		0. 3161		4, 794	
76. 00 03140 CARDI OLOGY		0.0000		0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 2667	97 0	0	76.9
OUTPATI ENT SERVICE COST CENTERS					
20. 00 09000 CLINIC		0. 4494			
P1. 00 09100 EMERGENCY		0.3650			91.0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 7428			92.0
200.00 Total (sum of lines 50-94 and 96-98)			75, 504	32, 680	
201.00 Less PBP Clinic Laboratory Services-Program only charges (lin	ne 61)		0		201.0
202.00 Net Charges (line 200 minus line 201)			75, 504		202.0

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL				In Lie	eu of Form CMS-	2552-1
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der	- CCN: 1	51302	Peri		Worksheet D-3	
	Componer	At CON	157202		n 01/01/2015 12/31/2015		narod
	Componer	IL CON:	152302	10	12/31/2015	5/24/2016 8:1	
	Ti	tle XIX			ig Beds - SNF	Cost	
Cost Center Description			of Cos		Inpati ent	Inpati ent	
		To C	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		1			0		20.00
30. 00 03000 ADULTS & PEDIATRICS					0		30.00
ANCI LLARY SERVI CE COST CENTERS 50. 00 05000 OPERATI NG ROOM		1	0.4074	74	0	0	50.00
53. 00 05300 ANESTHESI OLOGY			1.5874		0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C			0. 2687		0		
57. 00 05700 CT SCAN			0.2007		0	0	
58. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)			0.0000		0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON			0.0000		0	0	
60. 00 06000 LABORATORY			0. 2626		0	0	
60. 01 06001 BLOOD LABORATORY			0.0000		0	-	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS			0.0000		0	0	
65. 00 06500 RESPI RATORY THERAPY			0.5367		0	o o	
65. 01 06501 SLEEP LAB			0.0000		0	0	65.01
66. 00 06600 PHYSI CAL THERAPY			0.7349	02	0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY			1.0954	64	0	0	67.00
68.00 06800 SPEECH PATHOLOGY			0.8868	41	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY			0.0000	00	0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS			1.2629	19	0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT			0.5127	93	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS			0.3161	99	0	0	73.00
76. 00 03140 CARDI OLOGY			0.0000	00	0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON			0.2667	97	0	0	76.97
OUTPATIENT SERVICE COST CENTERS							
90. 00 09000 CLINIC			0.4494		0		
91.00 09100 EMERGENCY			0.3650		0	-	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)			0.7428	68	0	0	
200.00 Total (sum of lines 50-94 and 96-98)					0	0	200.00
201.00 Less PBP Clinic Laboratory Services-Pr	ogram only charges (line 61)				0		201.00
202.00 Net Charges (line 200 minus line 201)					0		202.00

	LATION OF REIMBURSEMENT SETTLEMENT Provider CCN: 151302 Period: From 01/07		u of Form CMS-2 Worksheet E Part B Date/Time Prep	
	Ti tle XVIII Hospi t		5/24/2016 8: 1 Cost	
			1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES		1.00	
1.00	Medical and other services (see instructions)		3, 473, 735	1.00
2.00 3.00	Medical and other services reimbursed under OPPS (see instructions) PPS payments		0	2.00 3.00
4.00	Outlier payment (see instructions)		0	4.00
5.00	Enter the hospital specific payment to cost ratio (see instructions)		0.000	5.00
6.00 7.00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6		0 0. 00	6.00 7.00
8.00	Transitional corridor payment (see instructions)		0	8.00
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 13, line 200		0	9.00
10.00 11.00	5		0 3, 473, 735	10.00
11.00	COMPUTATION OF LESSER OF COST OR CHARGES		0, 170, 700	11.00
10.00	Reasonable charges			10.00
	5 5		0	12.00 13.00
	Total reasonable charges (sum of lines 12 and 13)		0	14.00
45 00	Customary charges	· · ·		45 00
	Aggregate amount actually collected from patients liable for payment for services on a charge ba Amounts that would have been realized from patients liable for payment for services on a chargeb		0	15.00 16.00
10.00	had such payment been made in accordance with 42 CFR §413.13(e)			
17.00			0.00000	
19.00	Total customary charges (see instructions) Excess of customary charges over reasonable cost (complete only if line 18 exceeds line 11) (see	÷ .	0	18.00 19.00
	instructions)		-	
20.00	Excess of reasonable cost over customary charges (complete only if line 11 exceeds line 18) (see instructions)	;	0	20.00
21.00			3, 508, 472	21.00
	Interns and residents (see instructions)		0	22.00
	Cost of physicians' services in a teaching hospital (see instructions) Total prospective payment (sum of lines 3, 4, 8 and 9)		0	23.00 24.00
24.00	COMPUTATION OF REIMBURSEMENT SETTLEMENT		0	24.00
			20, 152	
	5		1, 613, 425 1, 874, 895	26.00 27.00
27.00	instructions)		1, 074, 073	27.00
	5		0	28.00
	ESRD direct medical education costs (from Wkst. E-4, line 36) Subtotal (sum of lines 27 through 29)		0 1, 874, 895	29.00 30.00
			525	
32.00	Subtotal (line 30 minus line 31)		1, 874, 370	32.00
33 00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES) Composite rate ESRD (from Wkst. I-5, line 11)		0	33.00
	Allowable bad debts (see instructions)		415, 944	
			270, 364	
	Allowable bad debts for dual eligible beneficiaries (see instructions) Subtotal (see instructions)		307, 281 2, 144, 734	36.00 37.00
	MSP-LCC reconciliation amount from PS&R		0	38.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	39.00
39.50 39.98			0	39.50 39.98
39.99			0	39.99
	Subtotal (see instructions)		2, 144, 734	
40.01	Sequestration adjustment (see instructions) Interim payments		42, 895 2, 704, 816	
	Tentative settlement (for contractors use only)		0	42.00
			-602, 977	
43.00	Protested amounts (nonallowable cost report items) in accordance with CMS Pub. 15-2, chapter 1, §115.2		0	44.00
43.00				
43.00 44.00	TO BE COMPLETED BY CONTRACTOR			-
43.00 44.00 90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)		0	90.00
43.00 44.00 90.00 91.00	TO BE COMPLETED BY CONTRACTOR		0	90. 00 91. 00 92. 00

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 151302	Period: From 01/01/2015 To 12/31/2015	Worksheet E-1 Part I Date/Time Prep 5/24/2016 8:19	
			e XVIII	Hospi tal	Cost	
		Inpatien	t Part A	Par	tВ	
		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		1, 541, 68	37 0	2, 548, 416 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	ADJUSTMENTS TO PROVIDER	07/23/2015	66, 60	00 07/23/2015	156, 400	3.0
3.02				0	0	3.02
3.03				0	0	3.03
3.04				0	0	3.04
3.05	Provider to Program			0	0	3. 05
3.50	ADJUSTMENTS TO PROGRAM			0	0	3. 5
3.51				0	0	3.5
3.52				0	0	3.5
3.53				0	0	3.5
3.54 3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		66, 60	0	0 156, 400	3.54 3.99
3.99	3. 50-3. 98)		00, 00	00	156, 400	3.9
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 608, 28	37	2, 704, 816	4.0
	TO BE COMPLETED BY CONTRACTOR	1				
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)					5.0
5. 01	Program to Provider TENTATIVE TO PROVIDER			0	0	5.0
5.02				0	0	5.0
5.03				0	0	5.0
	Provider to Program					
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.5
5.51 5.52				0	0	5.5 5.5
5.99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	5.9
	5. 50-5. 98)			-		
0. 00	Determined net settlement amount (balance due) based on the cost report. (1)				_	6.0
b. 01	SETTLEMENT TO PROVIDER		186, 40	65	0	6.C
0. 02 . 00	SETTLEMENT TO PROGRAM Total Medicare program liability (see instructions)		1, 794, 7	U	602, 977 2, 101, 839	6. C 7. C
. 00			1,774,73	Contractor	NPR Date	7.0
				Number	(Mo/Day/Yr)	
			)	1.00	2.00	

NALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED			Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	pared
		T: +1	o VV/111	Cuing Dada CNI	5/24/2016 8:1	9 pm
			e XVIII 🤤 t Part A	Swing Beds - SNF	Cost T B	
		inpatron		141		
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
. 00 . 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		2, 253, 46	5 0	0	2.0
. 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					3.0
. 01	ADJUSTMENTS TO PROVIDER	07/23/2015	81, 10	0	0	3.0
. 02				0	0	
. 03				0	0	
. 04 . 05				0	0	
. 05	Provider to Program			0	0	3.0
50	ADJUSTMENTS TO PROGRAM			0	0	3.
51				0	0	
52				0	0	
53				0	0	
. 54 . 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines		81, 10	0	0	
,,	3. 50-3. 98)		01,10	0		0.
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 334, 56	5	0	4.0
~~	TO BE COMPLETED BY CONTRACTOR	1			1	1
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) Program to Provider					5.
01	TENTATI VE TO PROVIDER			0	0	5.
02				0	0	5.
03				0	0	5.
-	Provider to Program	1				
50 51	TENTATI VE TO PROGRAM			0	0	5. 5.
52				0	0	5.
99	Subtotal (sum of lines 5.01–5.49 minus sum of lines			0	0	
00	5.50-5.98) Determined net settlement amount (balance due) based on					6.
01	the cost report. (1)		20E 4E	2		
01 02	SETTLEMENT TO PROVIDER SETTLEMENT TO PROGRAM		305, 45	3	0	
02	Total Medicare program liability (see instructions)		2, 640, 01	0	0	
	,			Contractor Number	NPR Date (Mo/Day/Yr)	
			)	1,00	2.00	

Heal th	Financial Systems IU HEALTH BL.	ACKFORD HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT		CCN: 151302	Period: From 01/01/2015 To 12/31/2015		
		Titl	e XVIII	Hospi tal	Cost	
				-	1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPOR					
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL					
1.00	Total hospital discharges as defined in AARA §4102 from		col. 15 line	14	477	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines	1, 8-12			691	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				107	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines	1, 8-12			1, 046	
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 2	00			37, 948, 727	5.00
6.00	Total hospital charity care charges from Wkst. S-10, col	. 3 line 20			3, 446, 391	6.00
7.00	CAH only - The reasonable cost incurred for the purchase line 168	of certified HIT	technol ogy	Wkst. S-2, Pt. I	0	7.00
8.00	Calculation of the HIT incentive payment (see instructio	ns)			0	8.00
9.00	Sequestration adjustment amount (see instructions)				0	9.00
10.00	Calculation of the HIT incentive payment after sequestra	tion (see instruc	tions)		0	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH					
30.00	Initial/interim HIT payment adjustment (see instructions	)			0	30.00
31.00	Other Adjustment (specify)				0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30	and line 31) (see	e instruction	s)	0	32.00

Heal th	Financial Systems IU HEALTH BLACKFORD	HOSPI TAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 151302	Peri od:	Worksheet E-2	
		Company CON 157202	From 01/01/2015		
		Component CCN: 15Z302	To 12/31/2015	Date/Time Pre 5/24/2016 8:19	pared: 9 nm
		Title XVIII	Swing Beds - SNF		<i>/</i> piii
			Part A	Part B	
			1.00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1.00	Inpatient routine services - swing bed-SNF (see instructions)		2, 098, 878	0	1.00
2.00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3.00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		612, 765	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst				
4.00	Per diem cost for interns and residents not in approved teaching	ıg program (see		0.00	4.00
	instructions)				
5.00	Program days		1, 055	0	5.00
6.00	Interns and residents not in approved teaching program (see ins			0	6.00
7.00	Utilization review - physician compensation - SNF optional meth	iod only	0		7.00
8.00 9.00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2, 711, 643	0	8.00 9.00
9.00 10.00	Primary payer payments (see instructions)		2 711 (42	0	9.00 10.00
11.00	Subtotal (line 8 minus line 9) Deductibles billed to program patients (exclude amounts applica	blo to physician	2, 711, 643	0	10.00
11.00	professional services)	bre to physician	0	0	11.00
12.00	Subtotal (line 10 minus line 11)		2, 711, 643	0	12.00
13.00	Coinsurance billed to program patients (from provider records) for physician professional services)	(exclude coinsurance	21, 338	0	13.00
14.00	80% of Part B costs (line 12 x 80%)			0	14.00
	Subtotal (enter the lesser of line 12 minus line 13, or line 14	.)	2, 690, 305	0	15.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
16.50	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16.50
16.55	410A RURAL DEMONSTRATION PROJECT		0		16.55
17.00	Allowable bad debts (see instructions)		5, 525	0	17.00
17.01	Adjusted reimbursable bad debts (see instructions)		3, 591	0	17.01
	Allowable bad debts for dual eligible beneficiaries (see instru	ictions)	5, 511	0	18.00
19.00	Total (see instructions)		2, 693, 896	0	19.00
19.01	Sequestration adjustment (see instructions)		53, 878		19.01
	Interim payments		2, 334, 565	0	20.00
	Tentative settlement (for contractor use only)		0	0	21.00
22.00	Balance due provider/program (line 19 minus lines 19.01, 20, an		305, 453	0	22.00
23.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	0	0	23.00
	chapter 1, §115.2		1		

Heal th	Financial Systems	IU HEALTH BLACKFORD	HOSPI TAL	In Lie	u of Form CMS-	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT - SWING E	BEDS	Provider CCN: 151302	Period: From 01/01/2015	Worksheet E-2	2
			Component CCN: 15Z302			
			Title XIX	Swing Beds - SNF	5/24/2016 8:1 Cost	19 pili
				Part A	Part B	
				1,00	2.00	
	COMPUTATION OF NET COST OF COVERED SERVICES					
1.00	Inpatient routine services - swing bed-SNF	(see instructions)		0		1.00
2.00	Inpatient routine services - swing bed-NF (	see instructions)		0		2.00
3.00	Ancillary services (from Wkst. D-3, col. 3,	line 200, for Part	A, and sum of Wkst. D,	0		3.00
	Part V, cols. 6 and 7, line 202, for Part B				l	
4.00	Per diem cost for interns and residents not	in approved teachin	ıg program (see	0.00		4.00
	instructions)				l	
5.00	Program days			0		5.00
6.00	Interns and residents not in approved teach			0		6.00
7.00	Utilization review - physician compensation		iod only	0	l	7.00
8.00	Subtotal (sum of lines 1 through 3 plus lin	ies 6 and 7)		0	l .	8.00
9.00	Primary payer payments (see instructions)			0	1	9.00
10.00	Subtotal (line 8 minus line 9)			0	1	10.00
11.00	Deductibles billed to program patients (exc professional services)	lude amounts applica	ble to physician	0		11.00
12.00	Subtotal (line 10 minus line 11)			0		12.00
13.00	Coinsurance billed to program patients (fro for physician professional services)	m provider records)	(excl ude coi nsurance	0		13.00
14.00	80% of Part B costs (line 12 x 80%)			0		14.00
15.00	Subtotal (enter the lesser of line 12 minus	line 13, or line 14	.)	0		15.00
16.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECI			0		16.00
16.50	Pioneer ACO demonstration payment adjustmen	t (see instructions)		0		16.50
16.55	410A RURAL DEMONSTRATION PROJECT			0		16.55
17.00	Allowable bad debts (see instructions)			0		17.00
17.01	Adjusted reimbursable bad debts (see instru	icti ons)		0		17.01
18.00	Allowable bad debts for dual eligible benef	iciaries (see instru	ictions)	0	l	18.00
19.00	Total (see instructions)			0		19.00
19.01	Sequestration adjustment (see instructions)			0		19.01
20.00	Interim payments			0		20.00
21.00	Tentative settlement (for contractor use on			0		21.00
22.00	Balance due provider/program (line 19 minus			0		22.00
23.00	Protested amounts (nonallowable cost report	items) in accordanc	e with CMS Pub. 15-2,	0		23.00
	chapter 1, §115.2				i.	

	Financial Systems IU HEALTH BLACK			u of Form CMS-2	
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 151302	Period: From 01/01/2015	Worksheet E-3 Part V	
			To 12/31/2015	Date/Time Pre	pared.
				5/24/2016 8:1	
		Title XVIII	Hospi tal	Cost	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICAL			1.00	
1.00	Inpatient services	RE PART A SERVICES - CUST	REIMBURSEMENT	1, 988, 839	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruc	tions)		1, 900, 039	2.00
3.00	Organ acqui si ti on	(1013)		0	
4.00	Subtotal (sum of lines 1 through 3)			1, 988, 839	
5.00	Primary payer payments			0	
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			2,008,727	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	
9.00	Organ acquisition charges, net of revenue			0	
10.00	Total reasonable charges			0	10.00
11 00	Customary charges				1 4 4 4 4
11.00	Aggregate amount actually collected from patients liable fo				11.00
12.00	Amounts that would have been realized from patients liable had such payment been made in accordance with 42 CFR 413.13		n a charge basis	0	12.0
13.00	Ratio of line 11 to line 12 (not to exceed 1.000000)	(e)		0, 000000	13 00
14.00	Total customary charges (see instructions)			0.000000	
15.00	Excess of customary charges over reasonable cost (complete	only if line 14 exceeds li	ne 6) (see	0	
101 00	instructions)			Ũ	
16.00	Excess of reasonable cost over customary charges (complete	only if line 6 exceeds lin	e 14) (see	0	16.00
	instructions)				
17.00	Cost of physicians' services in a teaching hospital (see in:	structions)		0	17.00
	COMPUTATION OF REIMBURSEMENT SETTLEMENT			-	
18.00	Direct graduate medical education payments (from Worksheet	E-4, line 49)		0	
19.00	Cost of covered services (sum of lines 6, 17 and 18)			2,008,727	
20.00	Deductibles (exclude professional component)			201, 556	
21.00	Excess reasonable cost (from line 16) Subtotal (line 19 minus line 20 and 21)			0 1, 807, 171	
22.00	Coi nsurance			1, 807, 171	
24.00	Subtotal (line 22 minus line 23)			1, 807, 171	
25.00	Allowable bad debts (exclude bad debts for professional ser	vices) (see instructions)		37, 245	
26.00	Adjusted reimbursable bad debts (see instructions)			24, 209	
27.00	Allowable bad debts for dual eligible beneficiaries (see in:	structions)		12, 910	
28.00	Subtotal (sum of lines 24 and 25, or line 26)			1, 831, 380	
29.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	29.00
29.50	Pioneer ACO demonstration payment adjustment (see instruction	ons)		0	29.50
29.99	Recovery of Accel erated Depreciation			0	29.9
30.00	Subtotal (see instructions)			1, 831, 380	30.00
30. 01	Sequestration adjustment (see instructions)			36, 628	30. 0 <sup>.</sup>
31.00	Interim payments			1, 608, 287	
32.00	Tentative settlement (for contractor use only)			0	
33.00	Balance due provider/program (line 30 minus lines 30.01, 31			186, 465	
34.00	Protested amounts (nonallowable cost report items) in accord	dance with CMS Pub 15-2	chanter 1	102, 209	34.00

MCRI F32 - 8.8.159.0

	SHEET (If you are nonproprietary and do not maintain pe accounting records, complete the General Fund column onl			Period: From 01/01/2015	Worksheet G	
ina-ty	pe accounting records, comprete the general rund cordination	y)		To 12/31/2015	Date/Time Pre 5/24/2016 8:1	epare
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3.00	4.00	-
	CURRENT ASSETS		1			
	Cash on hand in banks	7, 434, 684		0 0	0	
	Temporary investments Notes receivable	0		0 0	0 0	
	Accounts receivable	2, 018, 636		0 0	0	
	Other receivable	-229, 547		0 0	0	
	Allowances for uncollectible notes and accounts receivable	0		0 0	0	
00	Inventory	202, 216		0 0	0	7.
	Prepaid expenses	53, 183		0 0	0	
	Other current assets	0		0 0	0	
	Due from other funds Tatal surrant assats (sum of lines 1 10)	9, 479, 172		0 0 0 0	0	
	Total current assets (sum of lines 1-10)	9,479,172		0 0	0	<u> </u>
	Land	190, 324		0 0	0	12.
	Land improvements	274, 136		0 0	0	
00	Accumulated depreciation	-253, 789		0 0	0	14.
	Bui I di ngs	15, 007, 745		0 0	0	
	Accumulated depreciation	-7, 411, 013		0 0	0	
	Leasehold improvements	0		0 0	0	
	Accumulated depreciation			0 0	0	
	Fixed equipment Accumulated depreciation	50, 626 -23, 999		0 0	0	
	Accumulated deprecration Automobiles and trucks	-23, 999		0 0	0	
	Accumulated depreciation			0 0	0	
	Major movable equipment	5, 144, 948		0 0	0	
	Accumul ated depreciation	-4, 011, 316		0 0	0	
	Minor equipment depreciable	0		0 0	0	25
00	Accumul ated depreciation	0		0 0	0	26
	HIT designated Assets	0		0 0	0	
	Accumulated depreciation	0		0 0	0	
	Minor equipment-nondepreciable	0		0 0	0	
	Total fixed assets (sum of lines 12-29) DTHER ASSETS	8,967,662		0 0	0	30
	Investments	0		0 0	0	31
	Deposits on Leases	o o		0 0	0	
	Due from owners/officers	0		0 0	0	
00	Other assets	0		0 0	0	34
00	Total other assets (sum of lines 31-34)	0		0 0	0	35
	Total assets (sum of lines 11, 30, and 35)	18, 446, 834		0 0	0	36
	CURRENT LI ABI LI TI ES					
	Accounts payable	374, 489		0 0	0	
	Salaries, wages, and fees payable	441, 830		0 0	0	
	Payroll taxes payable Notes and loans payable (short term)			0 0	0	
	Deferred income			0 0	0	
	Accelerated payments	0		0	0	42
	Due to other funds	0		0 0	0	
00	Other current liabilities	2, 095, 360		0 0	0	44
	Total current liabilities (sum of lines 37 thru 44)	2, 911, 679		0 0	0	45
	LONG TERM LIABILITIES	-	1			
	Mortgage payable	0		0 0	0	
	Notes payable Unsecured Loans			0 0	0	
	Other long term liabilities	25, 885		0 0	0	
	Total long term liabilities (sum of lines 46 thru 49	25, 885		0 0	0	
	Total liabilites (sum of lines 45 and 50)	2, 937, 564		0 0	0	
	CAPI TAL ACCOUNTS					
00	General fund balance	15, 509, 270				52
	Specific purpose fund			0		53
	Donor created - endowment fund balance - restricted			0		54
	Donor created - endowment fund balance - unrestricted			0		55
	Governing body created - endowment fund balance			0	~	56
	Plant fund balance - invested in plant				0	
	Plant fund balance - reserve for plant improvement, replacement, and expansion				0	58
	Total fund balances (sum of lines 52 thru 58)	15, 509, 270		0 0	0	59
	Total liabilities and fund balances (sum of lines 51 and	18, 446, 834		0 0	0	
). 00				-, 0		

Health Financial Systems IU HEALTH BLACKFORD HOSPITAL In Lieu of Form CMS-2552-10								
	ENT OF CHANGES IN FUND BALANCES			- CCN: 151302		eriod: com 01/01/2015	Worksheet G-	1 epared:
		General	Fund	Speci al	Pur	rpose Fund	Endowment Fun	b
1.00	Fund balances at beginning of period	1.00	2.00	3.00		4.00	5.00	1.00
2.00 3.00 4.00 5.00	Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0	2, 746, 46 15, 509, 27	2	0	0		2.00 3.00 4.00 5.00
6.00 7.00 8.00 9.00 10.00	Total additions (sum of line 4-9)	0 0 0 0		0	0 0 0 0	0		0       6.00         0       7.00         0       8.00         0       9.00         10.00
11.00 12.00 13.00 14.00 15.00 16.00 17.00	Subtotal (line 3 plus line 10) ROUNDING	3 0 0 0 0	15, 509, 27	3	000000	0		11.00 12.00 13.00 14.00 15.00 16.00 17.00
	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	Ĵ	15, 509, 27		0	0 0		18.00 19.00
		Endowment Fund	PI an	t Fund				
		6.00	7.00	8.00				
1.00 2.00 3.00 4.00 5.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2)	0		0	0			1.00 2.00 3.00 4.00 5.00
5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) ROUNDING	0 0			0 0			5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00
17.00 18.00 19.00	Total deductions (sum of lines 12–17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0		ō	0 0			17.00 18.00 19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 151302		iod: m 01/01/2015 12/31/2015	Worksheet G-2 Parts I & II Date/Time Prep 5/24/2016 8:19	pared
	Cost Center Description		I npati ent		Outpati ent	Total	· ·
			1.00		2.00	3.00	
	PART I – PATIENT REVENUES						
	General Inpatient Routine Services						
1.00	Hospi tal		2, 597, 9	909		2, 597, 909	1.0
2.00	SUBPROVIDER - IPF						2.0
3.00	SUBPROVIDER - IRF						3.0
4.00	SUBPROVI DER						4.0
5.00	Swing bed - SNF			0		0	5.0
6.00	Swing bed - NF			0		0	6.0
7.00	SKILLED NURSING FACILITY						7.0
8.00	NURSING FACILITY						8.0
9.00	OTHER LONG TERM CARE						9.0
10.00	Total general inpatient care services (sum of lines 1-9)		2, 597, 9	909		2, 597, 909	10.0
	Intensive Care Type Inpatient Hospital Services						
11.00	INTENSIVE CARE UNIT						11.0
12.00	CORONARY CARE UNI T						12.0
13.00	BURN INTENSIVE CARE UNIT						13.0
14.00	SURGICAL INTENSIVE CARE UNIT						14.0
15.00	OTHER SPECIAL CARE (SPECIFY)						15.0
16.00	Total intensive care type inpatient hospital services (sum of I	nes		0		0	16.0
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)		2, 597, 9			2, 597, 909	
18.00	Ancillary services		5, 175, 1		29, 857, 462	35, 032, 628	
19.00	Outpatient services		8, 4	15	309, 772	318, 187	
20.00	RURAL HEALTH CLINIC			0	0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
22.00	HOME HEALTH AGENCY						22.0
23.00	AMBULANCE SERVICES						23.0
24.00	СМНС						24.0
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.0
26.00	HOSPICE						26.0
27.00	PHYSI CI AN REVENUE			0	1, 821, 697	1, 821, 697	27.0
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3 to	o Wkst.	7, 781, 4	90	31, 988, 931	39, 770, 421	28.0
	G-3, line 1)						
	PART II - OPERATING EXPENSES		1		T		
29.00	Operating expenses (per Wkst. A, column 3, line 200)			_	14, 451, 075		29.0
30.00	ADD (SPECIFY)			0			30.0
31.00				0			31.0
32.00				0			32.0
33.00				0			33.0
34.00				0			34.0
35.00				0			35.0
36.00	Total additions (sum of lines 30-35)				0		36.0
37.00	DEDUCT (SPECIFY)			0			37.0
38.00				0			38.0
39.00				0			39.0
40.00				0			40.0
41.00				0			41.0
42.00	Total deductions (sum of lines 37-41)				0		42.0
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)	(transfer			14, 451, 075		43.0
	to Wkst. G-3, line 4)						

Heal th	Health Financial Systems IU HEALTH BLACKFORD HOSPITAL In Lie					
	STATEMENT OF REVENUES AND EXPENSES Provider CCN: 151302 Period: From 01/01/2015			Worksheet G-3		
	Date/Time Prepared:					
	5/24/2016 8:19 pm					
				1.00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, line	39, 770, 421	1.00			
2.00	Less contractual allowances and discounts on patients' accounts		21, 956, 951	2.00		
3.00	Net patient revenues (line 1 minus line 2)			17, 813, 470	3.00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line 43	)		14, 451, 075		
5.00	Net income from service to patients (line 3 minus line 4)			3, 362, 395	5.00	
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc			0	6.00	
7.00	Income from investments			0	7.00	
8.00	Revenues from telephone and other miscellaneous communication s	0				
9.00	Revenue from television and radio service	0				
10.00	Purchase di scounts			0		
11.00	Rebates and refunds of expenses			0	11.00	
12.00	Parking lot receipts			0		
13.00	Revenue from Laundry and Linen service	0				
14.00		0				
	Revenue from rental of living quarters	0				
16.00		0	16.00			
	Revenue from sale of drugs to other than patients	0	17.00			
18.00		0	18.00			
19.00		0	19.00			
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00	
21.00				0	21.00 22.00	
22.00	Rental of hospital space			-		
23.00	Governmental appropriations			0	23.00	
24.00	MI SCELLANEOUS I NCOME			-615, 933		
25.00	Total other income (sum of lines 6-24)			-615, 933		
26.00	Total (line 5 plus line 25) OTHER EXPENSES (SPECIFY)			2, 746, 462 0	26.00 27.00	
27.00	Total other expenses (sum of line 27 and subscripts)			0	27.00	
	Net income (or loss) for the period (line 26 minus line 28)			2, 746, 462		
27.00	Iner meanine (or ross) for the period (true zo initias fille zo)		I	2, 740, 402	27.00	