Health Financial Systems	IU HEALTH GOSHE	N HOSPITAL		In Lieu	u of Form CMS-	2552-10
This report is required by law (42 USC 1395g; 42 C						
payments made since the beginning of the cost repo HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX COST REP			CCN: 150026	USC 1395g). Period:	OMB NO. 0938- Worksheet S	0050
AND SETTLEMENT SUMMARY	UKI CENTIFICATION	FIOVICEI	CCN. 130020	From 01/01/2015	Parts I-III	14
				то 12/31/2015	Date/Time Pre 5/27/2016 6:0	
PART I - COST REPORT STATUS					3/2//2010 0.0	
Provider 1.[X]Electronically filed cost re	port			Date: 5/27/20	16 Time: 6	5:03 pm
use only 2.[]Manually submitted cost repo		<i>.</i>				
3.[0]If this is an amended report 4.[F]Medicare Utilization. Enter	enter the number	r of times the '!" for low	e provider re	submitted this co	ost report	
	Received:	L TOT TOW.		PR Date:		
(1) As Submitted 7. Cont	ractor No.		11.0	ontractor's Vendo	or Code:	4
(2) Settled without Audit 8. [N]Initial Report f Final Report for	or this Provi	der CCN 12.	0]If line 5, co	olumn 1 is 4: E	inter
(3) Settled with Audit 9.LN (4) Reopened	I i mai kepore roj			number of this	es reopened =	0-9.
(5) Amended						
PART II - CERTIFICATION MISREPRESENTATION OR FALSIFICATION OF ANY INFORMAT.		TUTE COST BED				
ADMINISTRATIVE ACTION, FINE AND/OR IMPRISONMENT UN						
PROVIDED OR PROCURED THROUGH THE PAYMENT DIRECTLY						
ADMINISTRATIVE ACTION, FINES AND/OR IMPRISONMENT M	AY RESULT.					
		4->				
CERTIFICATION BY OFFICER OR ADMIN	ISTRATOR OF PROVI	DER(S)				
I HEREBY CERTIFY that I have read the abov	e certification s	tatement and	that T have	examined the acco	mnanving	
electronically filed or manually submitted						
Expenses prepared by IU HEALTH GOSHEN HOSP						
ending $12/31/2015$ and to the best of my kn						
complete and prepared from the books and r except as noted. I further certify that I						
health care services, and that the service						
laws and regulations.		//	0			
		In	MA I	(
Encryption Information	(Signed		0001 5	~		
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PI: Date: 5/27/2016 Time: 6:03 pm E:jGXYMhhSRIiaEbiToOyQ210o6sk0 Ybx9:0aFKnZX.roxb0j:H0BNN:uxVe .pj:00vKtY08d0cr PART III - SETTLEMENT SUMMARY 1.00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 4.00 SUBPROVIDER I 5.00 Swing bed - SNF 6.00 Swing bed - NF 7.00 SKILLED NURSING FACILITY 8.00 NURSING FACILITY 9.00 HOME HEALTH AGENCY I 10.00 RURAL HEALTH CLINIC I 11.00 FEDERALLY QUALIFIED HEALTH CENTER I 2.00 CMHC I 200.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r displays a valid OMB control number. The valid OMI required to complete and review the information co instructions, search existing resources, gather the have any comments concerning the accuracy of the t 7500 Security Boulevard, Attn: PRA Report Clearance Please do not send applications, claims, payments, Reports Clearance Office. Please note that any con	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Date Title Part A 2.00 89,079 0 0 0 0 0 0 0 0 0 0 0 0 0	110,35 110,35 110,35 110,35 110,35 e element of pond to a col rmation colle s per respons d review the for improvir Baltimore, M nts containir the informat , forwarded,	HIT 4.00 7 32,253 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 387,154 0 0 0 0 0 0 0 0 0 0 387,154 x indicated. mation unless 50. The time time to revie ection. If yo se write to: C 50. rmation to the urden approved	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 200.00 it
PI: Date: 5/27/2016 Time: 6:03 pm E:jGXYMhhSRiiaEbiro0yQ210o6sk0 Ybx9:0aFKnZX.roxb0j:H0BNN:uxVe .pj:00vKtY08d0cr PART III - SETTLEMENT SUMMARY 1.00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 4.00 SUBPROVIDER I 5.00 Swing bed - SNF 6.00 Swing bed - SNF 6.00 Swing bed - NF 7.00 SKILLED NURSING FACILITY 8.00 NURSING FACILITY 9.00 HOME HEALTH AGENCY I 10.00 RURAL HEALTH CLINIC I 11.00 FEDERALLY QUALIFIED HEALTH CENTER I 220.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r displays a valid OMB control number. The valid OMM required to complete and review the information co instructions, search existing resources, gather the have any comments concerning the accuracy of the t 7500 Security Boulevard, Attn: PRA Report Clearance Please do not send applications, claims, payments, Reports Clearance Office. Please note that any com	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Date Title Part A 2.00 89,079 0 0 0 0 0 0 0 0 0 0 0 0 0	110,35 110,35 110,35 110,35 110,35 e element of pond to a col rmation colle s per respons d review the for improvir Baltimore, M nts containir the informat , forwarded,	HIT 4.00 7 32,253 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 387,154 0 0 0 0 0 0 0 0 0 0 387,154 x indicated. mation unless 50. The time time to revie ection. If yo se write to: C 50. rmation to the urden approved	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 200.00 it
PI: Date: 5/27/2016 Time: 6:03 pm E:jGXYMhhSRiiaEbiro0yQ210o6sk0 Ybx9:0aFKnZX.roxb0j:H0BNN:uxVe .pj:00vKtY08d0cr PART III - SETTLEMENT SUMMARY 1.00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 4.00 SUBPROVIDER I 5.00 Swing bed - SNF 6.00 Swing bed - SNF 6.00 Swing bed - NF 7.00 SKILLED NURSING FACILITY 8.00 NURSING FACILITY 9.00 HOME HEALTH AGENCY I 10.00 RURAL HEALTH CLINIC I 11.00 FEDERALLY QUALIFIED HEALTH CENTER I 220.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r displays a valid OMB control number. The valid OMM required to complete and review the information co instructions, search existing resources, gather the have any comments concerning the accuracy of the t 7500 Security Boulevard, Attn: PRA Report Clearance Please do not send applications, claims, payments, Reports Clearance Office. Please note that any com	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Date Title Part A 2.00 89,079 0 0 0 0 0 0 0 0 0 0 0 0 0	110,35 110,35 110,35 110,35 110,35 e element of pond to a col rmation colle s per respons d review the for improvir Baltimore, M nts containir the informat , forwarded,	HIT 4.00 7 32,253 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 387,154 0 0 0 0 0 0 0 0 0 0 387,154 x indicated. mation unless 50. The time time to revie ection. If yo se write to: C 50. rmation to the urden approved	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 200.00 it
PI: Date: 5/27/2016 Time: 6:03 pm E:jGXYMhhSRiiaEbiro0yQ210o6sk0 Ybx9:0aFKnZX.roxb0j:H0BNN:uxVe .pj:00vKtY08d0cr PART III - SETTLEMENT SUMMARY 1.00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 4.00 SUBPROVIDER I 5.00 Swing bed - SNF 6.00 Swing bed - SNF 6.00 Swing bed - NF 7.00 SKILLED NURSING FACILITY 8.00 NURSING FACILITY 9.00 HOME HEALTH AGENCY I 10.00 RURAL HEALTH CLINIC I 11.00 FEDERALLY QUALIFIED HEALTH CENTER I 220.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r displays a valid OMB control number. The valid OMM required to complete and review the information co instructions, search existing resources, gather the have any comments concerning the accuracy of the t 7500 Security Boulevard, Attn: PRA Report Clearance Please do not send applications, claims, payments, Reports Clearance Office. Please note that any com	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Date Title Part A 2.00 89,079 0 0 0 0 0 0 0 0 0 0 0 0 0	110,35 110,35 110,35 110,35 110,35 e element of pond to a col rmation colle s per respons d review the for improvir Baltimore, M nts containir the informat , forwarded,	HIT 4.00 7 32,253 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 387,154 0 0 0 0 0 0 0 0 0 0 387,154 x indicated. mation unless 50. The time time to revie ection. If yo se write to: C 50. rmation to the urden approved	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 200.00 it
PI: Date: 5/27/2016 Time: 6:03 pm E:jGXYMhhSRiiaEbiro0yQ210o6sk0 Ybx9:0aFKnZX.roxb0j:H0BNN:uxVe .pj:00vKtY08d0cr PART III - SETTLEMENT SUMMARY 1.00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 4.00 SUBPROVIDER I 5.00 Swing bed - SNF 6.00 Swing bed - SNF 6.00 Swing bed - NF 7.00 SKILLED NURSING FACILITY 8.00 NURSING FACILITY 9.00 HOME HEALTH AGENCY I 10.00 RURAL HEALTH CLINIC I 11.00 FEDERALLY QUALIFIED HEALTH CENTER I 220.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r displays a valid OMB control number. The valid OMM required to complete and review the information co instructions, search existing resources, gather the have any comments concerning the accuracy of the t 7500 Security Boulevard, Attn: PRA Report Clearance Please do not send applications, claims, payments, Reports Clearance Office. Please note that any com	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Date Title Part A 2.00 89,079 0 0 0 0 0 0 0 0 0 0 0 0 0	110,35 110,35 110,35 110,35 110,35 e element of pond to a col rmation colle s per respons d review the for improvir Baltimore, M nts containir the informat , forwarded,	HIT 4.00 7 32,253 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 387,154 0 0 0 0 0 0 0 0 0 0 387,154 x indicated. mation unless 50. The time time to revie ection. If yo se write to: C 50. rmation to the urden approved	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 200.00 it
PI: Date: 5/27/2016 Time: 6:03 pm E:jGXYMhhSRiiaEbiro0yQ210o6sk0 Ybx9:0aFKnZX.roxb0j:H0BNN:uxVe .pj:00vKtY08d0cr PART III - SETTLEMENT SUMMARY 1.00 Hospital 2.00 Subprovider - IPF 3.00 Subprovider - IRF 4.00 SUBPROVIDER I 5.00 Swing bed - SNF 6.00 Swing bed - SNF 6.00 Swing bed - NF 7.00 SKILLED NURSING FACILITY 8.00 NURSING FACILITY 9.00 HOME HEALTH AGENCY I 10.00 RURAL HEALTH CLINIC I 11.00 FEDERALLY QUALIFIED HEALTH CENTER I 220.00 Total The above amounts represent "due to" or "due from" According to the Paperwork Reduction Act of 1995, r displays a valid OMB control number. The valid OMM required to complete and review the information co instructions, search existing resources, gather the have any comments concerning the accuracy of the t 7500 Security Boulevard, Attn: PRA Report Clearance Please do not send applications, claims, payments, Reports Clearance Office. Please note that any com	1.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Date Title Part A 2.00 89,079 0 0 0 0 0 0 0 0 0 0 0 0 0	110,35 110,35 110,35 110,35 110,35 e element of pond to a col rmation colle s per respons d review the for improvir Baltimore, M nts containir the informat , forwarded,	HIT 4.00 7 32,253 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	5.00 387,154 0 0 0 0 0 0 0 0 0 0 387,154 x indicated. mation unless 50. The time time to revie ection. If yo se write to: C 50. rmation to the urden approved	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 200.00 it

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX	IDENTIFICATION DA	TA	Provi	der CC	N: 150026	Period: From 01/01	/2015	Workshe Part I	eet S-2	
								/2015	Date/Ti	me Pre	pared:
	1.00	2.	00		3.00			4.00	5/27/20	JIO 5:4	
	Hospital and Hospital Health Care Co										
. 00 2. 00	Street: 200 HIGH PARK AVENUE City: GOSHEN	PO Box: State: I	N 7	ip Code	· 46526	5 Coun	ty: ELKHART				1.00
. 00	jorty. Goonen	Component Na		CCN	CBSA			Payme	ent Syst	em (P,	2.00
			N	lumber	Numbe	r Type	Certified	-	, 0, or		_
		1.00		2.00	3.00	4.00	5.00	V 6.00	XVIII 7.00	XI X 8.00	-
	Hospital and Hospital-Based Componen	t Identification:		2.00	01.00		0.00	1 0.00			
. 00	Hospi tal	I U HEALTH GOSHEN HOSPI TAL	1	50026	21140) 1	07/11/1966	5 N	P	0	3.00
1.00	Subprovider - IPF Subprovider - IRF Subprovider - (Other) Swing Beds - SNF Swing Beds - NF Hospital -Based SNF Hospital -Based NF Hospital -Based OLTC Hospital -Based HHA	CARE AT HOME SER	VI CES 1	57174	21140		04/17/1986	5 N	Ρ	N	4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00
	Separately Certified ASC										13.00
4.00	Hospi tal -Based Hospi ce	CARE AT HOME HOSI SERVICES	PICE 1	51527	21140)	04/17/1986	5			14.00
6.00 7.00 8.00	Hospital-Based Health Clinic – RHC Hospital-Based Health Clinic – FOHC Hospital-Based (CMHC) I Renal Dialysis Other	SERVICES									15.00 16.00 17.00 18.00 19.00
							From 1 OC		Tc		-
0.00	Cost Reporting Period (mm/dd/yyyy)						1.00		2.0		20.00
	Type of Control (see instructions)							2			21.00
2.00	Inpatient PPS Information Does this facility qualify and is it	currently receiv	(ing navmo)	nts for	dienro	portionato	e Y		N	1	22.00
	share hospital adjustment, in accord for yes or "N" for no. Is this facil amendment hospital?) In column 2, en	ance with 42 CFR ity subject to 42 ter "Y" for yes c	§412.106? 2 CFR Section "N" for	In co ion §41 no.	lumn 1, 2.06(c)	enter "Y" (2)(Pickle	2				
2. 01	Did this hospital receive interim un period? Enter in column 1, "Y" for y reporting period occurring prior to for no for the portion of the cost r (see instructions)	es or "N" for no October 1. Enter	for the point of t	ortion 2, "Y"	of the for ye	cost es or "N"	N		Y	, ,	22. 01
2. 02	Is this a newly merged hospital that determined at cost report settlement or "N" for no, for the portion of th in column 2, "Y" for yes or "N" for or after October 1.	? (see instruction e cost reporting	ons) Enter period pri	in col ior to	umn 1, October	"Y" for ye 1. Enter			N	I	22.02
2. 03	Did this hospital receive a geograph of the OMB standards for delineating in column 1, "Y" for yes or "N" for prior to October 1. Enter in column cost reporting period occurring on o hospital contain at least 100 but no 42 CFR 412.105)? Enter in column 3,	statistical area no for the portic 2, "Y" for yes or r after October 1 t more than 499 b	ns adopted on of the o "N" for i (see inspeds (as co	by CMS cost re no for structi	in FY2 porting the por ons) Do	2015? Enter g period tion of th bes this	ne		Ν	I	22. 03
23.00	Which method is used to determine Me 1, enter 1 if date of admission, 2 i method of identifying the days in th used in the prior cost reporting per	dicaid days on li f census days, or is cost reporting	nes 24 and 3 if date 9 period di	e of di ifferen	scharge t from	e. Is the the method	1	3	Ν	I	23.00
			In-State Medicaid paid days	Medi o el i gi unpa day	caid ble ! aid p /s	aid days	State Medi cai d el i gi bl e unpai d	Medica HMO da	ys Meo	ther di cai d days	
4 00	If this provider is an LDDC hard to	optor the	1.00	2.0		3.00	4.00	5.00		5.00	24.00
	If this provider is an IPPS hospital in-state Medicaid paid days in colum Medicaid eligible unpaid days in col out-of-state Medicaid paid days in c out-of-state Medicaid eligible unpai 4, Medicaid HMO paid and eligible bu column 5, and other Medicaid days in If this provider is an IRF, enter th Medicaid paid days in column 1, the	n 1, in-state umn 2, olumn 3, d days in column t unpaid days in column 6. e in-state	1, 43.	0	469 0	8 0	51	2,	0	162	24.00
	Medicaid paid days in column 1, the Medicaid eligible unpaid days in col out-of-state Medicaid days in column Medicaid eligible unpaid days in col HMO paid and eligible but unpaid day	umn 2, 3, out-of-state umn 4, Medicaid									

Heal th	Financial Systems IU HEAL	TH GOSH	HEN HOSPI TAL		1	n Lie	u of For	m CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provi der		Period: From 01/01, To 12/31,		Workshe Part I Date/Ti 5/27/20	me Pre	pared:
					Urban/Ru		Date of	Geogr	
26.00	Enter your standard geographic classification (not wa	ge) sta	atus at the beg	ginning of the	1.00) 1	2. (00	26.00
27.00	cost reporting period. Enter "1" for urban or "2" for Enter your standard geographic classification (not wa	ge) sta	atus at the end			1			27.00
35.00	reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi If this is a sole community hospital (SCH), enter the	cati on	in column 2.			0			35.00
	effect in the cost reporting period.		· ·· ·· ·· ·· ·· ··		Begi nni		Endi	na	
26.00	Enter and include has been and and and and datas of COU at	atua	Cubconint Line	2/ for number	1.00		2. (26.00
	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date If this is a Medicare dependent hospital (MDH), enter	S.				0			36.00 37.00
	is in effect in the cost reporting period.					0			
38.00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38.00
					Y/N 1.00		Y/ 2. (
39.00		s facility qualify for the inpatient hospital payment adjustment for low volume s in accordance with 42 CFR §412.101(b)(2)(ii)? Enter in column 1 "Y" for yes					N		39.00
	or "N" for no. Does the facility meet the mileage req	or no. Does the facility meet the mileage requirements in accordance with 42 or (10) (2) (11)? Enter in column 2 "Y" for yes or "N" for no. (see instructions)							
40.00	Is this hospital subject to the HAC program reduction	b)(2)(ii)? Enter in column 2 "Y" for yes or "N" for no. (see instructions) tal subject to the HAC program reduction adjustment? Enter "Y" for yes or n column 1, for discharges prior to October 1. Enter "Y" for yes or "N" fo							40.00
	no in column 2, for discharges on or after October 1.	(see	instructions)			V	XVIII	XIX	
	Prospective Payment System (PPS)-Capital					1.00) 2.00	3.00	
45.00	Does this facility qualify and receive Capital paymen with 42 CFR Section §412.320? (see instructions)	t for (di sproporti onat	te share in ac	cordance	N	Y	N	45.00
46.00	Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46.00
47. 00 48. 00	Is this a new hospital under 42 CFR §412.300 PPS capi Is the facility electing full federal capital payment					N N	N N	N N	47.00 48.00
56.00	Teaching Hospitals Is this a hospital involved in training residents in	approv	ed GME programs	s? Enter "Y"	for yes	N			56.00
57.00	or "N" for no. If line 56 is yes, is this the first cost reporting p								57.00
	GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont	h of tl	his cost report	ting period?	Enter "Y"				
	for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	, if a	pplicable.						
58.00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15–1, chapter 21, §2148? If yes,			ans' services	as				58.00
	Are costs claimed on line 100 of Worksheet A? If yes Are you claiming nursing school and/or allied health				2	N Y			59.00 60.00
	provider-operated criteria under §413.85? Enter "Y"						Di rect	L GME	
									-
61.00	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in	1.00 N	2.00	3.00	4.00	0.00	5. (61.00
61. 01	column 1. (see instructions) Enter the average number of unweighted primary care		0.00	0.0	DO.				61.01
01.01	FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see		0.00	0.0					01.01
61. 02	instructions) Enter the current year total unweighted primary care		0.00	0.0					61.02
01.02	FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of		0.00	0.0					01.02
61. 03	ACA). (see instructions) Enter the base line FTE count for primary care		0.00	0.0	bo				61.03
	and/or general surgery residents, which is used for determining compliance with the 75% test. (see								
61. 04	instructions) Enter the number of unweighted primary care/or		0.00	0.0	bo				61.04
	surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).								
61.05	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's		0.00	0.0	bo				61.05
	primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)								
61.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary		0.00	0.0	bo				61.06
	care or general surgery. (see instructions)								

OSPITAL AND HOSPITAL HEALTH CARE COMPL	EX IDENTIFICATION DA		F T	eriod: rom 01/01/2015 o 12/31/2015	Date/Time Pre 5/27/2016 5:4	pared:
		Program Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
		1.00	2.00	3.00	4.00	
 1.10 Of the FTEs in line 61.05, special special ty, if any, and the number for each new program. (see instrucol umn 1, the program name, enter program code, enter in col umn 3, unweighted count and enter in col FTE unweighted count. 1.20 Of the FTEs in line 61.05, special program special ty, if any, and th residents for each expanded progrinstructions) Enter in col umn 1, enter in col umn 2, the program column 4, direct GME FTE unweighted court 4, direct GME FTE unweighted court 	of FTE residents actions) Enter in in column 2, the the IME FTE umn 4, direct GME y each expanded he number of FTE ram. (see the program name, ode, enter in column ind enter in column			0. oc 0. oc		61. 1
ACA Provisions Affecting the Heal	th Posources and Ser	avicos Administrati			1.00	
2.00 Enter the number of FTE residents				od for which	0.00	62.00
your hospital received HRSA PCRE	funding (see instruc	ctions)			0.00	
2.01 Enter the number of FTE residents during in this cost reporting per Teaching Hospitals that Claim Res	iod of HRSA THC prog	gram. (see instruct	• •	your hospital	0.00	62. 0 ⁻
3.00 Has your facility trained resider "Y" for yes or "N" for no in colu	nts in nonprovider se	ettings during this	<u>ee instructions)</u>		N	63.00
			Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	
			Site			
Section 5504 of the ACA Base Year	ETE Posidonts in No	opprovidor Sotting	1.00	2.00	3.00	
period that begins on or after Ju			sinis base year	is your cost i	eportring	
4.00 Enter in column 1, if line 63 is in the base year period, the number resident FTEs attributable to rot settings. Enter in column 2 the resident FTEs that trained in you of (column 1 divided by (column 1	ver of unweighted nor ations occurring in number of unweighted ir hospital. Enter ir + column 2)). (see	n-primary care all nonprovider d non-primary care n column 3 the rati instructions)	0			64.00
	Program Name	Program Code	Unwei ghted FTEs Nonprovi der Si te	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
	1.00	2.00	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) O. OC	0. 000000	

	Financial Systems		TH GOSHEN HOSP	I TAL		1	n Lie	u of For	m CMS-2	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE COMP	LEX IDENTIFICATION DA	.TA Pro	ovi der	CCN: 150026	Period: From 01/01 To 12/31		Workshe Part I Date/Ti 5/27/20	me Pre	
					Unwei ghted FTEs Nonprovi der Si te	· · ·	in tal	Ratio (c (col. 1 2))	+ col.)	
	Section 5504 of the ACA Current	Year FTE Residents in	n Nonprovider S	Setting	1.00 sEffective	2.00		<u>3.0</u> ng perio		
66.00	beginning on or after July 1, 20 Enter in column 1 the number of FTEs attributable to rotations of Enter in column 2 the number of FTEs that trained in your hospit (column 1 divided by (column 1 +	unweighted non-primar ccurring in all nonpr unweighted non-primar al. Enter in column 3	rovider setting ry care residen 3 the ratio of	S.	0. (00	0. 00	0.	000000	66.00
		Program Name	Program Cc	ode	Unwei ghted FTEs Nonprovi der Si te	Unwei gł FTEs Hospi 1	in	Ratio (c (col. 3 4))	+ col.	
(7.00		1.00	2.00		3.00	4.00		5.0		(7.00
67.00	Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)				0. (00	0. 00	0.	000000	67.00
							1.00	0 2.00	3.00	
	Inpatient Psychiatric Facility F						1.00	5 2.00	3.00	
	Is this facility an Inpatient Ps Enter "Y" for yes or "N" for no If line 70 yes: Column 1: Did th recent cost report filed on or b 42 CFR 412.424(d)(1)(iii)(c)) Co program in accordance with 42 CF Column 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 tea D04? Enter "Y" lity train res D(D)? Enter "Y"	ching p for ye idents for ye	program in th es or "N" for in a new tea es or "N" for	no. (see ching no.	N		0	70. 00 71. 00
75 00	Inpatient Rehabilitation Facilit Is this facility an Inpatient Re		(IRF) or doe	sito	ontain an IRF		N			75.00
	subprovider? Enter "Y" for yes If line 75 yes: Column 1: Did th recent cost reporting period end no. Column 2: Did this facility CFR 412.424 (d)(1)(iii)(D)? Ente indicate 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"	oproved GME tea ember 15, 2004? new teaching p for no. Column	ching p Enter rogram 3: If	program in th "Y" for yes in accordance column 2 is '	or "N" for e with 42 Y,			0	76.00
								1.0	0	
	Long Term Care Hospital PPS Is this a long term care hospita Is this a LTCH co-located within "Y" for yes and "N" for no. TEFRA Providers					g period? E	inter	N N		80. 00 81. 00
	Is this a new hospital under 42 Did this facility establish a ne §413.40(f)(1)(ii)? Enter "Y" fo	w Other subprovider ((excluded unit)				no.	N		85. 00 86. 00
87.00	Is this hospital a "subclause (I for yes or "N" for no.			886(d)	(1)(B)(iv)(II)? Enter "Y	/"	N		87.00
						V		XLX		
	Title V and XIX Services					1.00)	2.0	0	
90.00	Does this facility have title V		hospital servi	ces? Er	nter "Y" for	N		Y		90.00
91.00	yes or "N" for no in the applica Is this hospital reimbursed for	title V and/or XIX th				N		N		91.00
92.00	full or in part? Enter "Y" for y Are title XIX NF patients occupy							N		92.00
	instructions) Enter "Y" for yes Does this facility operate an IC	or"N" for no in the	applicable col	umn.		N		N		93.00
	"Y" for yes or "N" for no in the	applicable column.								
94.00	Does title V or XIX reduce capit applicable column.	o in the	N		N		94.00			

Health Financial Systems IU HEALTH GOSH				n Lieu	u of Form		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der	CCN: 150026	Period: From 01/01/ To 12/31/		Workshee Part I Date/Tir	ne Pre	epared:
			V		5/27/20 ⁻ XI X		7 pm
95.00 If line 94 is "Y", enter the reduction percentage in the app	alicable colum	2	1.00	0.00	2.00		95.00
96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes applicable column.	s or "N" for no	o in the	N	0.00	Ν		96.00
97.00 If line 96 is "Y", enter the reduction percentage in the app Rural Providers	olicable columr	n.		0.00		0.00	97.00
105.00 Does this hospital qualify as a critical access hospital (C/ 106.00 If this facility qualifies as a CAH, has it elected the all		nod of paymen	t				105. 00 106. 00
for outpatient services? (see instructions) 107.00 If this facility qualifies as a CAH, is it eligible for cos training programs? Enter "Y" for yes or "N" for no in colum yes, the GME elimination is not made on Wkst. B, Pt. I, col. reimbursed. If yes complete Wkst. D-2, Pt. II.	n 1. (see instr	ructions) If	t				107.00
108.00 Is this a rural hospital qualifying for an exception to the CFR Section §412.113(c). Enter "Y" for yes or "N" for no.							108.00
	Physi cal 1.00	Occupationa 2.00	I Speech 3.00	n	Respira 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.	1.00	2.00			1.0		109.00
					1.00	C	
110.00Did this hospital participate in the Rural Community Hospita the current cost reporting period? Enter "Y" for yes or "N"		on project (4	10A Demo)for		N		110.00
				1.00	2.00	3.00	_
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes on	r "N" for no ir	n column 1 l	f column 1	N		0	115.00
is yes, enter the method used (A, B, or E only) in column 2. 3 either "93" percent for short term hospital or "98" percen psychiatric, rehabilitation and long term hospitals provider Pub.15-1, chapter 22, §2208.1.	lf column 2 i nt for long ter rs) based on th	is "E", enter rm care (incl ne definition	in column udes			0	
116.00 s this facility classified as a referral center? Enter "Y" 117.00 s this facility legally-required to carry malpractice insur- no.			"N" for	N Y			116. 00 117. 00
118.00 Is the malpractice insurance a claims-made or occurrence pol claim-made. Enter 2 if the policy is occurrence.	icy? Enter 1 i	f the policy	is	1			118.00
		Premiums	Losses	5	Insura	nce	
		1.00	2.00		3.00	<u></u>	-
118.01 List amounts of malpractice premiums and paid losses:		1, 129, 6		3, 500	5.00		118.01
			1.00		2.00)	-
118.02 Are mal practice premiums and paid losses reported in a cost Administrative and General? If yes, submit supporting schee and amounts contained therein.			N				118.02
119.00 DO NOT USE THIS LINE 120.00 Is this a SCH or EACH that qualifies for the Outpatient Hold §3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qu Hold Harmless provision in ACA §3121 and applicable amendment	n column 1, "Y ualifies for th	' for yes or ne Outpatient			N		119.00 120.00
Enter in column 2, "Y" for yes or "N" for no. 121.00 Did this facility incur and report costs for high cost impla patients? Enter "Y" for yes or "N" for no. Transport contact contacts and the contact of the contac	antable devices	s charged to	Y				121.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for	or 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, en in column 1 and termination date, if applicable, in column 2		fication date					126. 00
127.00 If this is a Medicare certified heart transplant center, en	ter 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, en	ter the certifi	cation date					128.00
in column 1 and termination date, if applicable, in column 2 129.00 If this is a Medicare certified lung transplant center, ento		cation date i	n				129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center,		tification					130. 00
date in column 1 and termination date, if applicable, in col 131.00 f this is a Medicare certified intestinal transplant center	r, enter the ce	ertification					131.00
date in column 1 and termination date, if applicable, in col 132.00 If this is a Medicare certified islet transplant center, en		cation date					132.00
in column 1 and termination date, if applicable, in column 2 133.00 f this is a Medicare certified other transplant center, en	2.						133.00
in column 1 and termination date, if applicable, in column 1 134.00 If this is an organ procurement organization (0P0), enter th	2.						
134. UUIT LINS IS AN UTUAN DIOCULENCIAL UTUAN ZALIUN (UEU). EULE D	ne OPO number i	n column 1					134.00

Health Financial Systems	IU HEALTH (GOSHEN HO	OSPI TAL				In Lie	u of Form CMS-:	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	X IDENTIFICATION DATA		Provider (CCN: 15002				Worksheet S-2	
								Part I Date/Time Pre	nared
						. 12	/ 51/ 2015	5/27/2016 5:4	
							1.00	2.00	
		an defin	ad the CMC				V	154050	140.00
							Ŷ	15H059	140.00
					515				
1.00		2.00					3.00	l	
					he nam	ne and	address	of the	
			ctor numbe					.1	141 00
		e: WPS		Contr	actor	's Nur	10er: 0810		141.00
		I N		Zin (ode.		4620	12	142.00
					Jouc.		1020		110.00
								1.00	1
144.00 Are provider based physicians' cos	sts included in Workshe	et A?						Y	144.00
									-
145 001 f agota far ranal carviana ara al	aimad an Wkat A Lina	74 050	the easte	for				2.00	145.00
					s		IN		145.00
period? Enter "Y" for yes or "N"	for no in column 2.				,				
							Ν		146.00
		ıb. 15-2,	chapter 4	0, §4020)) If				
yes, enter the approval date (mm/c	ia/yyyy) in column 2.								
								1.00	
147.00 Was there a change in the statisti	cal basis? Enter "Y" f	or yes o	r "N" for	no.				N	147.00
								N	148.00
149.00 Was there a change to the simplifi	ed cost finding method							N	149.00
								Title XIX	-
Does this facility contain a provi	der that qualifies for							4.00	
155.00Hospi tal			N	N			N	N	155.00
156.00 Subprovider – IPF			N	Ν			N	N	156.00
			N	N			N	N	157.00
			N	N			N	N	158.00 159.00
			1					N N	160.00
			i i					N	161.00
		I							
								1.00	
La construcción de la construcci								••	4/5 00
	impus hospital that has	s one or r	more campu	ses in di	ffere	nt CB	SAS?	N	165.00
Enter i for yes of in for no.	Name	Coi	untv	State	Zin	Code	CBSA	FTE/Campus	
	0			2.00			4.00	5.00	
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX TDENTIFICATION DATA Provider CON: 150022 Provid					166.00				
GSPITAL AND HOSPITAL HEATH CARE COMPLEX IDENTIFICATION DATA Provider CCR: 15002 Period: From BUIOL2, To 12/31/21 ALL Providers 1.00 ALL Providers 1.00 ALL Providers 1.00 ALL Providers 1.00 ALL Providers 0.00 Are there any related organization or home office costs as defined in CMS Pub. 15-1, chapter DP Enter Y: for yes or "N" for no in colum 1. If yes, and home office costs are claimed, enter the home office contractor name and contractor number. 3.00 If this facility is part of a chain organization corganization or home office contractor name and contractor number. 3.00 1.00 Colum 2 the home office contractor name and contractor number. 1.00 2.00 City: INNIAMAPOLIS State: IN Zip Code: 4 41.00 Are provider based physicians' costs included in Worksheet A? In patient services and claims' costs included in Worksheet A? 41.00 City: INNIAMAPOLIS State: IN Zip Code: 4 42.00 City: INNIAMAPOLIS Enter ''' for roy yes or ''N' for no in column 1. (See CMS Pub. 15-2, chapter 40, \$4020) IF 43.00 City: INNIAMAPOLIS State: IN and IN and Public A and Port 8. (See Port 1) 43.00 City: INNIAMAPOLIS To no in column 2. (See CMS Public A and Port 8. (See Port 1) 44.00 Are there a change in the statistical basis? Enter ''' for yes or ''' for no.									
	1								
	-							1.00	
						Act			1/7 00
						ontor	tho	Y	167.00 168.00
			user (Title	107 15	·),	entei	the		100.00
			s provider	qual i fy	for a	hard	shi p		168.01
exception under §413.70(a)(6)(ii)?	PEnter "Y" for yes or	"N" for i	no. (see i	nstructio	ons)		-		
		and is no	ot a CAH (line 105	is "N	"), e	nter the	0.25	169.00
transition factor. (see instructio	ons)					Dec		Ending	
								Endi ng 2.00	
170.00 Enter in columns 1 and 2 the EHR b	eginning date and endi	ng date t	for the re	porting					170.00
period respectively (mm/dd/yyyy)		5		. 0					

Health Financial Systems	In Lie	u of Form CMS	-2552-10		
HOSPITAL AND HOSPITAL HEALTH CARE COMPLE	EX IDENTIFICATION DATA	Provider CCN: 150026	Period: From 01/01/2015	Worksheet S-	2
				Date/Time Pr 5/27/2016 5:	
				572772010 5.	47 pm
				1.00	_
171.00 If line 167 is "Y", does this prov				N	171.00
Medicare cost plans reported on W (see instructions)	kst. S-3, Pt. I, line 2, col. (5? Enter "Y" for yes a	and "N" for no.		

	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STIONNALRE Provider		Period: From 01/01/2015		
				To 12/31/2015	Date/Time Pr 5/27/2016 5:	
				Y/N	Date	
	Company Instruction. Enter V for all VEC room	concess Enter N for all NO re	onences Ente		2.00	_
	General Instruction: Enter Y for all YES resp mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	ponses. Enter N for all NU re	esponses. Ente	r all dates in	the	
0	Provider Organization and Operation Has the provider changed ownership immediate	Ly prior to the boginging of	the cost	N		1.
0	reporting period? If yes, enter the date of	the change in column 2. (see	instructions)			
			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					2
<u> </u>	voluntary or "I" for involuntary.		N			
0	Is the provider involved in business transac contracts, with individuals or entities (e.g	chain home offices, drug	N			3.
	or medical supply companies) that are related	d to the provider or its				
	officers, medical staff, management personne of directors through ownership, control, or					
	relationships? (see instructions)					
			Y/N	Туре	Date	
	Financial Data and Reports		1.00	2.00	3.00	
0	Column 1: Were the financial statements pre		Y	Α		4.
	Accountant? Column 2: If yes, enter "A" for					
	or "R" for Reviewed. Submit complete copy or column 3. (see instructions) If no, see inst					
С	Are the cost report total expenses and total	revenues different from	N			5.
	those on the filed financial statements? If	yes, submit reconciliation.		Y/N	Legal Oper.	
				1.00	2.00	-
	Approved Educational Activities				1	_
0	Column 1: Are costs claimed for nursing schuthe legal operator of the program?	ool?Column 2: If yes, is th	he provider is	N		6.
D	Are costs claimed for Allied Health Programs'	? If "Y" see instructions.		Y		7.
0	Were nursing school and/or allied health pro		d during the	Ν		8.
5	cost reporting period? If yes, see instruction Are costs claimed for Interns and Residents		cal education	Ν		9.
	program in the current cost report? If yes,	see instructions.				
00	Was an approved Intern and Resident GME prog cost reporting period? If yes, see instruction		the current	N		10.
		onc				1 .0.
	Are GME cost directly assigned to cost center		proved	N		
		rs other than I & R in an App	proved	N	N/ (b)	
	Are GME cost directly assigned to cost center	rs other than I & R in an App	proved	N	Y/N 1.00	
00	Are GME cost directly assigned to cost center	rs other than I & R in an App	proved	N	<u>Y/N</u> 1. 00	
00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar	rs other than I & R in an App instructions. d debts? If yes, see instruct	ti ons.		1.00 Y	11.
00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad def	rs other than I & R in an App instructions. d debts? If yes, see instruct	ti ons.		1.00	11.
00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of	tions. during this co	st reporting	1.00 Y	11. 12. 13.
	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If	tions. during this co f yes, see ins	st reporting tructions.	1.00 Y N N	11. 12. 13. 14.
	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If	tions. during this co fyes, see ins yes, see inst	st reporting	1.00 Y N	11. 12. 13. 14.
	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description	tions. during this co f yes, see ins yes, see inst Pa Y/N	st reporting tructions. ructions. urt A Date	1.00 Y N N Part B Y/N	11. 12. 13. 14.
	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the price	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If	tions. during this co f yes, see ins yes, see inst Pa	st reporting tructions. ructions. urt A	1.00 Y N N Part B	11. 12. 13. 14.
00 00 00 00 00 00 00 00 00 00 00 00 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bac If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description	tions. during this co f yes, see ins yes, see inst Pa Y/N	st reporting tructions. ructions. urt A Date	1.00 Y N N Part B Y/N	11. 12. 13. 14. 15.
00 00 00 00 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes,	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description	tions. during this co f yes, see ins yes, see inst Pa Y/N 1.00	st reporting tructions. ructions. int A Date 2.00	1.00 Y N N Part B Y/N 3.00	11. 12. 13. 14. 15.
00 00 00 00 00 00 00 00 00 00 00 00 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior 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	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description	tions. during this co f yes, see ins yes, see inst Pa Y/N 1.00	st reporting tructions. ructions. int A Date 2.00	1.00 Y N N Part B Y/N 3.00	11. 12. 13. 14. 15.
00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior 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)	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description	tions. during this co f yes, see ins yes, see inst Pa Y/N 1.00 Y	st reporting tructions. ructions. int A Date 2.00	1.00 Y N Part B Y/N 3.00 Y	111. 12. 13. 14. 15. 16.
	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bad If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior 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	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	tions. during this co f yes, see ins yes, see inst Pa Y/N 1.00	st reporting tructions. ructions. int A Date 2.00	1.00 Y N N Part B Y/N 3.00	111. 12. 13. 14. 15. 16.
00 00 00 00 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior 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)	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	tions. during this co f yes, see ins yes, see inst Pa Y/N 1.00 Y	st reporting tructions. ructions. int A Date 2.00	1.00 Y N Part B Y/N 3.00 Y	111. 12. 13. 14. 15. 16.
	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior 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	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	tions. during this co f yes, see ins yes, see inst Pa Y/N 1.00 Y	st reporting tructions. ructions. int A Date 2.00	1.00 Y N Part B Y/N 3.00 Y	111. 12. 13. 14. 15. 16.
	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles and Bed Complement Did total beds available change from the prior 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 2 and 4. (see instructions)	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	tions. during this co f yes, see inst yes, see inst Y/N 1.00 Y	st reporting tructions. ructions. int A Date 2.00	1.00 Y N N Part B Y/N 3.00 Y	11. 12. 13. 14. 15. 16. 17.
	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior 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 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R Report data for additional	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	tions. during this co f yes, see ins yes, see inst Pa Y/N 1.00 Y	st reporting tructions. ructions. int A Date 2.00	1.00 Y N Part B Y/N 3.00 Y	11. 12. 13. 14. 15. 16.
	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior 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 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	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	tions. during this co f yes, see inst yes, see inst Y/N 1.00 Y	st reporting tructions. ructions. int A Date 2.00	1.00 Y N N Part B Y/N 3.00 Y	11. 12. 13. 14. 15. 16.
	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior 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 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	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	tions. during this co f yes, see inst yes, see inst Y/N 1.00 Y	st reporting tructions. ructions. int A Date 2.00	1.00 Y N N Part B Y/N 3.00 Y	11. 12. 13. 14. 15. 16.
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	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior 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 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. If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	tions. during this co f yes, see inst yes, see inst Y/N 1.00 Y N	st reporting tructions. ructions. int A Date 2.00	1.00 Y N N Part B Y/N 3.00 Y N N	11. 12. 13. 14. 15. 16. 17. 18.
00 00 00 00	Are GME cost directly assigned to cost center Teaching Program on Worksheet A? If yes, see Bad Debts Is the provider seeking reimbursement for bar If line 12 is yes, did the provider's bad del period? If yes, submit copy. If line 12 is yes, were patient deductibles a Bed Complement Did total beds available change from the prior 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 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. If line 16 or 17 is yes, were adjustments	rs other than I & R in an App instructions. d debts? If yes, see instruct bt collection policy change of and/or co-payments waived? If or cost reporting period? If Description 0	tions. during this co f yes, see inst yes, see inst Y/N 1.00 Y N	st reporting tructions. ructions. int A Date 2.00	1.00 Y N N Part B Y/N 3.00 Y N N	11. 12. 13. 14. 15. 16. 17. 18.
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Heal th	Financial Systems	LU HEALTH GOS	SHEN HOS	PI TAL		In Lie	eu of Form CMS-	2552-10
					CCN: 150026			
	PITAL AND HOSPITAL HEALTH CARE REINBURSEMENT QUESTIONNALRE Provider CCN: 150026 Period: From 01/01/2015 Worksheet S-2 From 01/01/2015 VM Description V/N Date 11 0 Date 11 0 Date 11 0 00 Was the cost report prepared only using the provider's records? If yes, see D N N 01 Was the cost report prepared only using the provider's records? If yes, see N N N 02 Uses the cost report prepared only using the provider's records? If yes, see instructions N N N 03 Have assets been relifed for Medicare purposes? If yes, see instructions N N N 04 Have assets been relifed for Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions. N N 04 Here new leases and/or amendments to existing leases entered into during the cost reporting period? If yes, see Instructions. N N 04 Here new loans, mortgage agreements or letters of credit entered into during the cost reporting period? If yes, see instructions. N 05 Hat the provider's capitalization policy changed during the cost reporting period? If yes, see instructions. N 04 Hat the provider's capitalization policy changed during the cost reporting period?				epared:			
	SPI TAL_AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNALRE Provider CCN: 150026 Period: Period: To 12/37/2015 Period: Period: Period: S2/2015 00 Was the cost report prepared only using the provider's records? If yes, see Instructions. Period: N Period: N Period: Period: N Period: Period: Period: N Period: Period: N Period: Period: Period: N Period: Period: Period: N Period: Period: Period: N Period: Period: N Period: Period: Period: N Period: Period: Period: N Period: Period: N Period: Period: N Period: Period: N Period: Period: Period: N Period: Period: N Period: Period: N Period: Period: N Period: Perio					1		
		Descr	-intion					
21.00	Was the cost report prepared only using the		0			2.00		21.00
21.00					IN		IN	21.00
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							1 00	
	COMPLETED BY COST RELMBURSED AND TEERA HOSPLT	ALS ONLY (FXC	EPT CHI	DRENS H			1.00	
		NEO ONET (EXO						-
22.00		es? If ves se	e instr	uctions			N	22.00
					als made duri	na the cost		23.00
20.00		atten expense	. uuo to	appiars		ig the cost		20.00
24.00		n Leases enter	ed into	duri na	this cost rep	ortina period?	N	24.00
21.00		<i>y</i> . edoco enter	04 1110	aarrig	1110 0001 i op	or ening porrour		2.1.00
25.00	5	ed into durina	the co	st repor	ting period?	f ves see	N	25.00
			,		51.1. 3 51.1.5.1.	<i>J</i> ==, ===		
26.00		uired during t	he cost	reporti	ng period? If	yes, see	N	26.00
		<u> </u>			5 1	J,		
27.00		nged during th	e cost	reportin	ng period? If	ves, submit	N	27.00
		5 5						
	Interest Expense							
28.00	Were new loans, mortgage agreements or letter	rs of credit e	entered	into dur	ing the cost	reporting	N	28.00
	period? If yes, see instructions.							
29.00					ebt Service Re	serve Fund)	N	29.00
30.00		scheduled mat	urity w	ith new	debt? If yes,	see	N	30.00
31.00		rity without i	ssuance	of new	debt? If yes,	see	N	31.00
				<u> </u>				
32.00					ed through con	tractual	N	32.00
22.00							N	22.00
33.00		sec. 2135.2 ap	pried p	ertainin	ig to competit	ve blading? IT	N	33.00
								-
24 00		ty under on a	rrangom	opt with	nrovidor bac	ad physicians?	V	34.00
34.00		ty under an a	ii i angeiii	ent with		eu physicians:	1	34.00
35.00		or amended ex	ristina	aareemen	ts with the n	rovi der-hased	N	35.00
55.00	5		0	0	its with the p	ovraci basca	14	33.00
	physicians during the cost reporting period:	<u>11 yes, see r</u>	noti uct	10113.		Y/N	Date	
	Home Office Costs						2.00	
		eport?				Y		36.00
			repared	by the	home office?			37.00
07100	J	acomorre boorr p	n opai oa	<i>bj</i> the				0,1,00
38.00		of the home of	fice di	fferent	from that of	N		38.00
39.00						Ν		39.00
				•	J .			
40.00	If line 36 is yes, did the provider render se	ervices to the	home o	ffi ce?	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	REX			SHERA		41.00
	held by the cost report preparer in columns f	1, 2, and 3,						
	respecti vel y.							
42.00	Enter the employer/company name of the cost r	report	ERNST	& YOUNG				42.00
	preparer.							
43.00	Enter the telephone number and email address		317681	/519		REX. SHERA@EY. C	OM	43.00
	report preparer in columns 1 and 2, respectiv	vei y.	1			1		11

	Financial Systems	IU HEALTH GOSHEN				u of Form CMS-	
HOSPI T <i>i</i>	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	STI ONNAI RE	Provi der	CCN: 150026	Peri od: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Pre 5/27/2016 5:4	epared:
		Part B					
		Date					
		4.00					
	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)	05/03/2016					16.00
17.00	Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions)						17.00
18.00	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.						18.00
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.						19.00
	If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:						20.00
21.00	Was the cost report prepared only using the provider's records? If yes, see instructions.						21.00
		_	3	00			
	Cost Report Preparer Contact Information			00			
41.00	Enter the first name, last name and the title held by the cost report preparer in columns ' respectively.		PED				41.00
	Enter the employer/company name of the cost r preparer.	report					42.00
43.00	Enter the telephone number and email address report preparer in columns 1 and 2, respectiv						43.00

	Financial Systems TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	IU HEALTH GOSH			CCN: 150026	Pe	eriod:	u of Form CMS- Worksheet S-3		
							rom 01/01/2015	Part I Date/Time Pre 5/27/2016 5:4	pare	
								I/P Days / O/P Visits / Trips		
	Component	Worksheet A Line Number	No.	of Beds	Bed Days Avai I abl e		CAH Hours	Title V		
		1.00		2.00	3.00		4.00	5.00	<u> </u>	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00		111	40, 5	15	0.00	0		00
2.00 3.00	HMO and other (see instructions) HMO IPF Subprovider								3.	00
4.00 5.00 6.00 7.00	HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation			111	40, 5	15	0.00	0 0 0	5. 6.	00 00 00 00
	beds) (see instructions)									
8.00 9.00	INTENSIVE CARE UNIT CORONARY CARE UNIT	31. 00 32. 00		12 0	4, 3	80 0	0.00 0.00	0		00 00
10.00 11.00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	33. 00 34. 00		0 0		0 0	0.00 0.00	0	10. 11.	00
12.00 13.00 14.00	OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions)	43.00		123	44, 8	05	0.00	0	12. 13. 14.	00
15.00	CAH visits	40.00					0.00	0	15.	00
16. 00 17. 00	SUBPROVIDER - IPF SUBPROVIDER - IRF	40. 00 41. 00		0 0		0 0		0	16. 17.	00
18.00 19.00	SUBPROVIDER SKILLED NURSING FACILITY	42.00 44.00		0 0		0 0		0	18. 19.	
20. 00 21. 00	NURSING FACILITY OTHER LONG TERM CARE	45.00 46.00		0 0		0 0		0	20. 21.	00
22.00 23.00 24.00 24.10	HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part)	101. 00 115. 00 116. 00 30. 00		0		0		0	22. 23. 24. 24.	00 00
25. 00 26. 00	CMHC - CMHC RURAL HEALTH CLINIC	99. 00 88. 00						0	25. 26.	00
26.25 27.00 28.00	FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days	89.00		123				0	26. 27. 28.	00
29.00 30.00	Ambulance Trips Employee discount days (see instruction)							0	20. 29. 30.	00
31.00 32.00	Employee discount days - IRF Labor & delivery days (see instructions)			0		0			31. 32.	00
32. 01 33. 00	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days								32. 33.	

Full Time Equivalents Component If I/P Days / 0/P Visits / Trips Full Time Equivalents Title X/II Title X/IX Total All Total Interns & Residents Employees On & Residents 1.00 Itopital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospited adays (see instructions) 7.049 659 17.631 10.00 2.00 HMO and other (see instructions) 3.114 2.090 0 0 3.00 HMS Subprovider 0 0 0 0 0 5.00 Ital Adults & Peds. Swing Bed NF 0 0 0 0 0 7.00 BURN INTENSIVE CARE UNIT 1,137 0 2.799 0 0 10.00 BURN INTENSIVE CARE UNIT 0 0 0 0 0 10.00 BURN INTENSIVE CARE UNIT 0 </th <th>HOSPI 1</th> <th>TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC</th> <th>AL DATA</th> <th>Provi der</th> <th>F</th> <th>eriod: rom 01/01/2015 o 12/31/2015</th> <th></th> <th>pared:</th>	HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	F	eriod: rom 01/01/2015 o 12/31/2015		pared:
Image: Patients Patients Residents Payrol I 1.00 lospital Adults & Peds. (columns 5, 6, 7 and B excillede Swing Bed. Observation Red and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 7,049 6.59 17,631 9.00 10.00 2.00 HMO and other (see instructions) 3,114 2,090 0<			I/P Days	/ O/P Visits	/ Trips	Full Time E	Equi val ents	
6.00 7.00 8.00 9.00 10.00 1.00 loopital Adults & Peds. (colums 5, 6, 7 and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 7,049 659 17,631 2.00 HM0 and other (see instructions) 3,114 2,090 0 0 3.00 HM0 IRF Subprovider 0 0 0 0 5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 0 0 0.01 HTRS Subprovider 0 0 0 0 0 0.00 Hospital Adults & Peds. Swing Bed NF 0 0 0 0 0 0.01 INTENSIVE CARE UNIT 1,137 0 2,799 0 0 0 10.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 11.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		Component	Title XVIII	Title XIX				
1.00 Hospital Adults & Peds. (columns 5, 6, 7 and B exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) 3,114 2,090 2.00 HB0 and other (see instructions) 3,114 2,090 0 3.00 HB0 and other (see instructions) 3,114 2,090 0 3.00 HB0 and other (see instructions) 0 0 0 3.00 HB0 and other (see instructions) 0 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 0 0 0 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 1,137 0 2,799 9.00 CORNARY CARE UNIT 1,137 0 2,799 10.00 BURG CAL INTENSIVE CARE UNIT 0 0 0 10.00 BURSERY 1,471 2,441 4.00 13.00 NURSERY 1,471 2,441 4.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0			6.00	7 00				
2.00 HNO and other (see instructions) 3, 114 2,090 3.00 HNO IPF Subprovider 0 0 4.00 HNO IPF Subprovider 0 0 5.00 HNO IPF Subprovider 0 0 5.00 HNO IPF Subprovider 0 0 6.00 Hospital Aduits & Peds. Swing Bed NF 0 0 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 1,137 0 2,799 8.00 INTENSIVE CARE UNIT 0 0 0 0 11.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 12.00 OTHER SPECIAL CARE (SPECIFY) 1 1,471 2,441 13.00 NURSERY 8,186 2,130 22,871 0.00 0.00 13.00 SUBPROVIDER - IPF 0 0 0 0.00 0.00 0.00 13.00 SUBPROVIDER - IRF 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00	1.00	8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2				7.00	10.00	1.00
3.00 HM0 1PF Subprovider 0 0 4.00 HM0 1PF Subprovider 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 0 0 6.00 Hospital Adults & Peds. Swing Bed NF 0 0 7.00 Total Adults & Peds. Swing Bed NF 0 0 0.01 Interval 1,137 0 2,799 9.00 CORONARY CARE UNI T 0 0 0 10.00 BURN INTENSIVE CARE UNI T 0 0 0 10.00 BURS ICAL INTENSIVE CARE UNI T 0 0 0 10.00 SUBSERV 1,471 2,441 4.41 14.00 Total (see instructions) 8,186 2,130 22.871 0.00 0 10.00 SUBPROVI DER - 1PF 0	2 00		2 114	2 000				2.00
4.00 HM0 1RF Subprovider 0 0 5.00 Hospital Adults & Peds. Swing Bed NF 0 0 6.00 Hospital Adults & Peds. Swing Bed NF 0 0 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 7,049 659 17,631 8.00 INTENSIVE CARE UNIT 1,137 0 2,799 0 0 0 9.00 CORONARY CARE UNIT 0			3, 114	2,090				3.00
5.00 Hospital Adults & Peds. Swing Bed SNF 0 0 0 6.00 Hospital Adults and Peds. (exclude observation beds) (see instructions) 7,049 659 17,631 0.00 Total Adults and Peds. (exclude observation beds) (see instructions) 1,137 0 2,799 9.00 CORONARY CARE UNIT 1,137 0 2,799 9.00 CORONARY CARE UNIT 0 0 0 11.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 12.00 OTHER SPECIAL CARE (SPECIFY) 1,471 2,441 .0.00 13.00 NURSERY 1,471 2,441 .0.00 14.00 Total (see instructions) 8,186 2,130 22,871 0.00 .0.00 15.00 CAH visits 0 0 0 0.00 0.00 .0.00 16.00 SUBPROVIDER - IPF 0 0 0 0.00 0.00 .0.00 17.00 0 0 0 0.00 0.00 .0.00 .0.00		· · ·	0	0				4.00
6.00 Hospital Adults & Peds. Swing Bed NF 0 0 7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 7,049 659 17,631 8.00 INTENSIVE CARE UNIT 1,137 0 2,799 9.00 CORONARY CARE UNIT 0 0 0 10.00 BURN INTENSIVE CARE UNIT 0 0 0 12.00 OTHER SPECIAL CARE (SPECIFY) 1,471 2,441 13.00 NURSERY 1,471 2,441 14.00 Total (see instructions) 8,186 2,130 22,871 0.00 998.62 15.00 CAH visits 0			0	0	0			5.00
7.00 Total Adults and Peds. (exclude observation beds) (see instructions) 7,049 659 17,631 8.00 INTENSIVE CARE UNIT 1,137 0 2,799 9.00 CORONARY CARE UNIT 0 0 10.00 BURN INTENSIVE CARE UNIT 0 0 11.00 SURGICAL INTENSIVE CARE UNIT 0 0 12.00 OTHER SPECIAL CARE (SPECIFY) 1,471 2,441 13.00 NURSERY 1,471 2,441 14.00 Total (see instructions) 8,186 2,130 22,871 0.00 998.62 15.00 CAH visits 0 0 0 0 0 0 16.00 SUBPROVIDER - IFF 0 0 0 0.00 0.00 0.00 17.00 SUBPROVIDER - IRF 0 0 0 0.00 0.00 0.00 10.00 SUBPROVIDER - IRF 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00			Ŭ,	0	0			6.00
9.00 CORONARY CARE UNIT 0 0 0 10.00 BURN INTENSIVE CARE UNIT 0 0 0 11.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 12.00 OTHER SPECIAL CARE (SPECIFY) 1,471 2,441 13.00 NURSERY 1,471 2,441 14.00 Total (see instructions) 8,186 2,130 22,871 0.00 998.62 15.00 CAH visits 0 <td>7.00</td> <td>Total Adults and Peds. (exclude observation beds) (see instructions)</td> <td></td> <td>659</td> <td></td> <td></td> <td></td> <td>7.00</td>	7.00	Total Adults and Peds. (exclude observation beds) (see instructions)		659				7.00
10.00 BURN INTENSIVE CARE UNIT 0 0 0 11.00 SURGICAL INTENSIVE CARE UNIT 0 0 0 12.00 OTHER SPECIAL CARE (SPECIFY) 1,471 2,441 13.00 NURSERY 1,471 2,441 14.00 Total (see instructions) 8,186 2,130 22,871 0.00 998.62 15.00 CAH visits 0 0 0 0 0 0 15.00 SUBPROVIDER - IPF 0 0 0 0.00 0.00 0.00 18.00 SUBPROVIDER 1RF 0 0 0 0.00 0.00 0.00 19.00 SKILLED NURSING FACILITY 0 0 0 0.00 0.00 0.00 10.00 NURSING FACILITY 0 0 0 0.00 0.00 0.00 0.00 20.00 NURSING FACILITY 0 0 0 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.00<			1, 137	0	2, 799			8.00
11.00 SURGI CAL INTENSIVE CARE UNIT 0 0 12.00 OTHER SPECIAL CARE (SPECIFY) 1,471 2,441 13.00 NURSERY 1,471 2,441 14.00 Total (see instructions) 8,186 2,130 22,871 0.00 998.62 15.00 CAH visits 0 0 0 0 0 0 15.00 SUBPROVI DER - IPF 0 0 0 0.00 0.00 0.00 17.00 SUBPROVI DER - IRF 0 0 0 0.00 0.00 0.00 18.00 SUBPROVI DER 0 0 0 0.00 0.00 0.00 19.00 SKI LED NURSING FACILITY 0 0 0 0.00 0.00 0.00 20.00 NURSING FACILITY 0 0 0 0.00 0.00 0.00 21.00 OHME HEALTH AGENCY 0 0 0 0.00 0.00 0.00 22.00 HOME HEALTH AGENCY 0 0 0 0 0.00 0.00 0.00 0.00			0	0	0			9.00
12.00 OTHER SPECIAL CARE (SPECIFY) 1,471 2,441 13.00 Total (see instructions) 8,186 2,130 22,871 0.00 998.62 15.00 CAH visits 0 0 0 0 0 0 16.00 SUBPROVIDER - IPF 0 0 0 0 0.00 0.00 0.00 17.00 SUBPROVIDER - IRF 0 0 0 0.00 0.00 0.00 0.00 18.00 SUBPROVIDER - IRF 0 0 0 0.00<			0	0	0			10.00
13.00 NURSERY 1, 471 2, 441 14.00 Total (see instructions) 8, 186 2, 130 22, 871 0.00 998. 62 15.00 CAH visits 0 0 0 0 0 0 15.00 SUBPROVIDER - IPF 0 0 0 0.00 0.00 0.00 17.00 SUBPROVIDER - IRF 0 0 0 0.00 0.00 0.00 18.00 SUBPROVIDER IFF 0 0 0 0.00 0.00 19.00 SKILED NURSING FACILITY 0 0 0 0.00 0.00 0.00 20.00 NURSING FACILITY 0 0 0.00 0.00 0.00 21.00 OTHER LONG TERM CARE 0 0 0.00 <t< td=""><td></td><td></td><td>0</td><td>0</td><td>0</td><td></td><td></td><td>11.00</td></t<>			0	0	0			11.00
14.00 Total (see instructions) 8,186 2,130 22,871 0.00 998.62 15.00 CAH visits 0 0 0 0 0 0 16.00 SUBPROVI DER - IPF 0 0 0 0.00 0.00 0.00 17.00 SUBPROVI DER - IRF 0 0 0 0.00 0.00 0.00 18.00 SUBPROVI DER 0 0 0 0.00 0.00 0.00 18.00 SUBPROVI DER 0 0 0 0.00 0.00 0.00 19.00 SKI LLED NURSI NG FACILITY 0 0 0 0.00 0.00 0.00 20.00 NURSI NG FACILITY 0 0 0 0.00 0.00 0.00 21.00 OTHER LONG TERM CARE 0 0 0 0.00 0.00 28.47 23.00 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				= .				12.00
15.00 CAH visits 0								13.00
16.00 SUBPROVIDER - IPF 0 0 0.00 0.00 17.00 SUBPROVIDER - IRF 0 0 0 0.00 0.00 18.00 SUBPROVIDER 0 0 0 0.00 0.00 0.00 18.00 SUBPROVIDER 0 0 0 0.00 0.00 0.00 19.00 SKILLED NURSING FACILITY 0 0 0.00 0.00 0.00 20.00 NURSING FACILITY 0 0 0.00 0.00 0.00 21.00 OTHER LONG TERM CARE 0 0 0.00 0.00 0.00 22.00 HOME HEALTH AGENCY 0 0 0 0.00 0.00 23.00 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0.00 0.00 24.00 HOSPICE 0 <td></td> <td></td> <td>8, 186</td> <td>2, 130</td> <td>22, 871</td> <td>0.00</td> <td>998.62</td> <td></td>			8, 186	2, 130	22, 871	0.00	998.62	
17.00 SUBPROVIDER - IRF 0 0 0.00 0.00 18.00 SUBPROVIDER 0 0 0 0.00 0.00 19.00 SKILLED NURSING FACILITY 0 0 0.00 0.00 0.00 20.00 NURSING FACILITY 0 0 0.00 0.00 0.00 21.00 OTHER LONG TERM CARE 0 0 0.00 0.00 0.00 22.00 HOME HEALTH AGENCY 0 0 0 0.00 0.00 23.00 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0.00 0.00 24.00 HOSPICE 0 0 0 0.00 0.00 24.10 HOSPICE (non-distinct part) 0 0 0 0 0 0 0 25.00 CMHC - CMHC 0			0	0	0	0.00	0.00	15.00
18.00 SUBPROVIDER 0 0 0.00 0.00 19.00 SKILLED NURSING FACILLITY 0 0 0.00 0.00 20.00 NURSING FACILLITY 0 0 0.00 0.00 21.00 OTHER LONG TERM CARE 0 0.00 0.00 0.00 22.00 HOME HEALTH AGENCY 0 0 0 0.00 0.00 23.00 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0.00 0.00 24.00 HOSPICE 0 0 0 0.00 0.00 25.00 CMHC - CMHC 0 0 0 0.00 0.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 27.00 Total (sum of lines 14-26) 0 0 0.00 1,040.86 28.00 Observation Bed Days 382 2,616 1,040.86 29.00 Ambulance Trips 0 0 0 1,040.86 20.00 Labor & delivery days (see instruction) 0 162 2999 2.01 1			0	0	0			•
19.00 SKILLED NURSING FACILITY 0 0 0.00 0.00 20.00 NURSING FACILITY 0 0 0.00 0.00 21.00 OTHER LONG TERM CARE 0 0.00 0.00 0.00 22.00 HOME HEALTH AGENCY 0 0 0.00 0.00 22.00 HOME HEALTH AGENCY 0 0 11,143 0.00 28.47 23.00 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0.00 0.00 24.00 HOSPICE 0 0 0 0.00 0.00 24.10 HOSPICE (non-distinct part) 0 0 0 0 0.00 25.00 CMRA - CMHC 0 0 0 0 0.00 0.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 27.00 Total (sum of lines 14-26) 0 0 0 0.00 1,040.86 28.00 Observation Bed Days 382 2,616 0 0 0 1,040.86 29.00			0	0				
20.00 NURSING FACILITY 0 0 0.00 0.00 21.00 OTHER LONG TERM CARE 0 0.00 0.00 22.00 HOME HEALTH AGENCY 0 0 11,143 0.00 28.47 23.00 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0.00 0.00 24.00 HOSPICE 0 0 0 0.00 0.00 24.10 HOSPICE (non-distinct part) 0 0 0 0 0.00 25.00 CMHC - CMHC 0 0 0 0.00 0.00 0.00 26.00 RURAL HEALTH CLINIC 0 0 0 0.00 0.00 0.00 26.25 FEDERALLY QUALI FIED HEALTH CENTER 0 0 0.00 0.00 0.00 27.00 Total (sum of lines 14-26) 382 2, 616 0 0 0 0 0.00 1, 040.86 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0				
21.00 OTHER LONG TERM CARE 0 0.00 0.00 22.00 HOME HEALTH AGENCY 0 0 11,143 0.00 28.47 23.00 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0.00 0.00 24.00 HOSPICE 0 0 0 0.00 0.00 24.10 HOSPICE (non-distinct part) 0 0 0 0 0 25.00 CMHC - CMHC 0 0 0 0.00 0.00 0.00 26.00 RURAL HEALTH CLINIC 0 0 0 0.00 0.00 0.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 27.00 Total (sum of lines 14-26) 0 0 0 0.00 1,040.86 29.00 Ambulance Trips 0 0 0 0 0 1,040.86 23.00 Employee discount days (see instruction) 0 0 0 0 0 1,040.86 23.00 Labor & delivery days (see instructions) 0 162 <td></td> <td></td> <td>U</td> <td>0</td> <td>0</td> <td></td> <td></td> <td></td>			U	0	0			
22.00 HOME HEALTH AGENCY 0 0 11,143 0.00 28.47 23.00 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0.00 0.00 24.00 HOSPICE 0 0 0 0.00 13.77 24.10 HOSPICE (non-distinct part) 0 0 0 0 0 25.00 CMHC - CMHC 0 0 0 0.00 0.00 0.00 26.00 RURAL HEALTH CLINIC 0 0 0 0.00 0.00 0.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 0.00 27.00 Total (sum of lines 14-26) 0 0 0 0.00 1,040.86 28.00 Observation Bed Days 382 2,616 0 0 0 0 0 1,040.86 1,040.86 1,040.86 1,040.86 1,040.86 1,040.86 1,040.86 1,040.86 1,040.86 1,040.86 1,040.86 1,040.86 1,040.86 1,040.86 1,040.86 1,040.86 1,040.86 1,040.86				0	0			•
23.00 AMBULATORY SURGICAL CENTER (D.P.) 0 0.00 0.00 24.00 HOSPICE 0 0 0.00 13.77 24.10 HOSPICE (non-distinct part) 0 0 0 0 0 25.00 CMHC - CMHC 0 0 0 0.00 0.00 0.00 25.00 RURAL HEALTH CLINIC 0 0 0 0.00 0.00 0.00 26.25 FEDERALLY OUALIFIED HEALTH CENTER 0 0 0.00 0.00 0.00 27.00 Total (sum of lines 14-26) 0 0 0.00 1,040.86 28.00 Observation Bed Days 382 2,616 1,040.86 29.00 Ambulance Trips 0 0 0 0 1,040.86 29.00 Employee discount days (see instruction) 0 162 299 1 1 1 1 1 32.01 Total ancillary labor & delivery room 0 162 299 0 1 1 1 1 1 1 1 1 1 1 1			0	0	11 1/3			
24.00 HOSPICE 0 0 0 0.00 13.77 24.10 HOSPICE (non-distinct part) 0 0 0 0 0 25.00 CMHC - CMHC 0 0 0 0.00 0.00 0.00 25.00 RURAL HEALTH CLINIC 0 0 0 0.00 0.00 0.00 26.00 RURAL HEALTH CLINIC 0 0 0 0.00 0.00 0.00 26.25 FEDERALLY OUALIFIED HEALTH CENTER 0 0 0.00 0.00 0.00 27.00 Total (sum of lines 14-26) 0 0 0 0.00 1,040.86 28.00 Observation Bed Days 382 2,616 0 1,040.86 29.00 Ambulance Trips 0 0 0 0 1,040.86 30.00 Employee discount days (see instruction) 0 0 0 1,040.86 31.00 Employee discount days - IRF 0 0 0 0 1,040.86 32.00 Labor & delivery days (see instructions) 0 162 29			Ű	0	11, 143			
24.10 HOSPICE (non-distinct part) 0 0 0 0 25.00 CMHC - CMHC 0 0 0 0.00 0.00 26.00 RURAL HEALTH CLINIC 0 0 0 0.00 0.00 0.00 26.05 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 0.00 27.00 Total (sum of lines 14-26) 382 2,616 0 0.00 1,040.86 28.00 Observation Bed Days 382 2,616 0 0 0.00 1,040.86 29.00 Ambulance Trips 0 0 0 0 0 1,040.86 30.00 Employee discount days (see instruction) 0 0 0 1,040.86 31.00 Employee discount days - IRF 0 0 0 1 1 32.00 Labor & delivery days (see instructions) 0 162 299 299 0 32.01 Total ancillary labor & delivery room 0 0 0 0 1			0	0	0			•
25.00 CMHC - CMHC 0 0 0.00 0.00 26.00 RURAL HEALTH CLINIC 0 0 0 0.00 0.00 26.02 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 27.00 Total (sum of lines 14-26) 382 2,616 0 0.00 1,040.86 28.00 Observation Bed Days 382 2,616 0 0 0 0.00 1,040.86 29.00 Ambulance Trips 0			0	0	0	0.00	10.77	24.10
26.00 RURAL HEALTH CLINIC 0 0 0.00 0.00 26.25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0.00 0.00 27.00 Total (sum of lines 14-26) 0 0 0 0.00 1,040.86 28.00 Observation Bed Days 382 2,616 0 0 1,040.86 29.00 Ambulance Trips 0 0 0 0 0 1,040.86 31.00 Employee discount days (see instruction) 0 0 0 0 1,040.86 32.00 Labor & delivery days (see instructions) 0 162 299 0 32.01 Total ancillary labor & delivery room 0 162 299 0			0	0	0	0.00	0.00	
26. 25 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0.00 0.00 27. 00 Total (sum of lines 14-26) 0 0.00 1,040.86 28. 00 Observation Bed Days 382 2,616 1,040.86 29. 00 Ambulance Trips 0 0 0 1,040.86 30. 00 Employee discount days (see instruction) 0 0 0 31. 00 Employee discount days - IRF 0 0 0 32. 00 Labor & delivery days (see instructions) 0 162 299 0 32. 01 Total ancillary labor & delivery room 0 0 0 0 0			0	0	0			
28.00Observation Bed Days3822,61629.00Ambulance Trips030.00Employee discount days (see instruction)031.00Employee discount days - IRF032.00Labor & delivery days (see instructions)032.01Total ancillary labor & delivery room0		FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00	0.00	26.25
29.00Ambulance Trips030.00Employee discount days (see instruction)031.00Employee discount days - IRF032.00Labor & delivery days (see instructions)032.01Total ancillary labor & delivery room0	27.00	Total (sum of lines 14-26)				0.00	1, 040. 86	27.00
30.00Employee discount days (see instruction)031.00Employee discount days - IRF032.00Labor & delivery days (see instructions)016232.01Total ancillary labor & delivery room0	28.00	Observation Bed Days		382	2, 616			28.00
31.00 Employee discount days - IRF 0 32.00 Labor & delivery days (see instructions) 0 162 299 32.01 Total ancillary labor & delivery room 0 0	29.00	Ambul ance Trips	О					29.00
32.00 Labor & delivery days (see instructions) 0 162 299 32.01 Total ancillary labor & delivery room 0	30.00	Employee discount days (see instruction)			0			30.00
32.01 Total ancillary labor & delivery room 0	31.00	Employee discount days - IRF			0			31.00
	32.00	Labor & delivery days (see instructions)	0	162	299			32.00
outpatient days (see instructions)	32.01				0			32.01
33.00 LTCH non-covered days 0								33.00

HOSPI 1	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provi der	CCN: 150026	Period: From 01/01/2015 To 12/31/2015	Worksheet S-3 Part I Date/Time Prep 5/27/2016 5:4	pared:
		Full Time Equivalents	·	Di s	scharges		
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers	10.00	10.00	11.00	Patients	
		11.00	12.00	13.00	14.00	15.00	1 00
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)		0	1, 8	64 1, 471	7, 053	1. 00
2.00	HMO and other (see instructions)			6	87 0		2.00
3.00	HMO I PF Subprovi der				0		3.00
4.00	HMO I RF Subprovider				0		4.00
5.00	Hospital Adults & Peds. Swing Bed SNF				0		5.00
6.00	Hospital Adults & Peds. Swing Bed NF						6.00
7.00	Total Adults and Peds. (exclude observation beds) (see instructions)						7.00
8.00	INTENSIVE CARE UNIT						8.00
9.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY		_				13.00
14.00	Total (see instructions)	0.00	0	1, 8	64 1, 471	7, 053	
15.00	CAH visits	0.00					15.00
16.00	SUBPROVIDER - IPF	0.00	0		0 0	0	16.00
17.00	SUBPROVIDER - IRF	0.00	0		0 0	0	17.00
18.00	SUBPROVIDER	0.00	0		0 0	0	18.00
19.00	SKILLED NURSING FACILITY	0.00					19.00
20.00 21.00	NURSING FACILITY	0. 00 0. 00				0	20.00 21.00
21.00	OTHER LONG TERM CARE HOME HEALTH AGENCY	0.00				0	21.00
22.00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					22.00
24.00	HOSPICE	0.00					24.00
24.10	HOSPICE (non-distinct part)	0.00					24.00
25.00	CMHC - CMHC	0.00					25.00
26.00	RURAL HEALTH CLINIC	0.00					26.00
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0.00					26.25
27.00	Total (sum of lines 14-26)	0.00					27.00
28.00	Observation Bed Days						28.00
29.00	Ambul ance Trips						29.00
30.00	Employee discount days (see instruction)						30.00
31.00	Employee discount days - IRF						31.00
32.00	Labor & delivery days (see instructions)						32.00
32. 01	Total ancillary labor & delivery room outpatient days (see instructions)						32. 01
33.00	LTCH non-covered days						33.00

PI T.	AL WAGE INDEX INFORMATION			Provi der	1	Period: From 01/01/2015 To 12/31/2015		parec
		Worksheet A Line Number	Amount Reported	Reclassificati on of Salaries (from Worksheet A-6)	Adj usted Sal ari es (col . 2 ± col . 3)	Related to	Average Hourly Wage (col. 4 ÷ col. 5)	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART II - WAGE DATA SALARIES							-
0	Total salaries (see	200. 00	64, 683, 425	i 0	64, 683, 42	5 2, 164, 977. 00	29.88	1. (
0	instructions) Non-physician anesthetist Part		C	0		0.00	0.00	2.0
0	A					0.00	0.00	2.
0	Non-physician anesthetist Part		C	0		0.00	0.00	3. (
0	Physician-Part A -		1, 468, 269	0	1, 468, 269	9 8, 062. 60	182. 11	4. (
1	Administrative Physicians - Part A - Teaching		<i>.</i>			0.00	0.00	4.0
0	Physician-Part B		6, 961, 119		6, 961, 11			
0	Non-physician-Part B		C	0	(0.00		
0	Interns & residents (in an	21.00	C	0	(0.00	0.00	7.
1	approved program) Contracted interns and		C			0.00	0.00	7.
	residents (in an approved					0.00		
0	programs) Home office personnel		C			0.00	0.00	8.
0	SNF	44.00	C			0.00		
00	Excluded area salaries (see		4, 996, 305	684, 922	5, 681, 22	7 208, 990. 00	27. 18	10.
	instructions) OTHER WAGES & RELATED COSTS							-
	Contract Labor: Direct Patient		169, 509	0	169, 509	9 3, 539. 43	47.89	111.
	Care			_				
00	Contract labor: Top level management and other		C	0		0.00	0.00	12.
	management and administrative							
~~	servi ces		507 000		507.00	1 0 (/ 00	057.00	10
00	Contract Labor: Physician-Part A - Administrative		507, 290	0	507, 290	0 1, 966. 33	257.99	13.
00	Home office salaries &		4, 878, 213	0	4, 878, 213	3 84, 102. 00	58.00	14.
00	wage-related costs					0.00	0.00	15
00	Home office: Physician Part A - Administrative		Ĺ			0.00	0.00	15.
00	Home office and Contract		C	0		0. OO	0.00	16.
	Physicians Part A - Teaching WAGE-RELATED COSTS							-
	Wage-related costs (core) (see		19, 745, 675	j 0	19, 745, 67	5		17.
00	instructions) Wage-related costs (other)		<i>.</i>					18.
00	(see instructions)		Ĺ			5		10.
	Excluded areas		1, 924, 694	0	1, 924, 694	4		19.
00	Non-physician anesthetist Part		C	0		D		20.
00	Non-physician anesthetist Part		C	0		b		21.
00	B Physician Part A -				E/E /1	2		22.
00	Admini strati ve		565, 612		565, 612	2		22.
01	Physician Part A - Teaching		C	0		С		22.
	Physician Part B		2, 681, 586	0	2, 681, 58	6		23. 24.
00 00	Wage-related costs (RHC/FQHC) Interns & residents (in an		C			0		24.
	approved program)	-						
	OVERHEAD COSTS - DIRECT SALARIE Employee Benefits Department	<u>S</u> 4.00	620, 245	i 0	620, 24	5 18, 944. 00	32.74	26.
	Administrative & General	5.00	11, 998, 643					
00	Administrative & General under		273, 566	0	273, 560	6 1, 737. 31	157. 47	28.
00	contract (see inst.) Maintenance & Repairs	6.00	C			0.00	0.00	29.
	Operation of Plant	7.00	736, 370		736, 370			
00	Laundry & Linen Service	8.00	36, 144	0	36, 14			
	Housekeepi ng	9.00	982, 311	0	982, 31			
00	Housekeeping under contract (see instructions)		Ĺ	, 0		0.00	0.00	33.
00	Dietary	10.00	697, 790	-472, 459	225, 33 ⁻			
00	Dietary under contract (see		C	0	(0.00	0.00	35.
00	i nstructi ons) Cafeteri a	11.00	ſ	472, 459	472, 459	38, 676. 00	12. 22	36.
	Maintenance of Personnel	12.00	C	0	(0.00		
	Nursing Administration	13.00	1, 488, 710		1, 488, 710			
	Central Services and Supply	14.00	206, 692	2 0	206, 692	2 12, 608. 00	16.39	1 39.

Health Financial Systems		IU HEALTH GOS	HEN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPITAL WAGE INDEX INFORMATION					Peri od:	Worksheet S-3	
					rom 01/01/2015		
				1	o 12/31/2015		
						5/27/2016 5:4	7 pm
	Worksheet A	Amount	Recl assi fi cati	Adj usted		Average Hourly	
	Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
			(from	(col.2 ± col.	Salaries in	col. 5)	
			Worksheet A-6)	3)	col. 4		
	1.00	2.00	3.00	4.00	5.00	6.00	
41.00 Medical Records & Medical Records Library	16.00	1, 395, 230	0	1, 395, 230	58, 396. 00	23. 89	41.00
42.00 Social Service	17.00	554, 804	0	554, 804	1 21, 550. 00	25. 74	42.00
43.00 Other General Service	18.00	C	0	(0.00	0.00	43.00

Heal th	Financial Systems		IU HEALTH GOS	HEN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
HOSPI 1	AL WAGE INDEX INFORMATION			Provi der		Period: From 01/01/2015 To 12/31/2015		
		Worksheet A	Amount	Recl assi fi cati	Adj usted	Paid Hours	Average Hourly	
		Line Number	Reported	on of Salaries	Sal ari es	Related to	Wage (col. 4 ÷	
				(from	(col.2 ± col.	Salaries in	col. 5)	
				Worksheet A-6)	3)	col. 4		
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART III - HOSPITAL WAGE INDEX	SUMMARY		1				
1.00	Net salaries (see		57, 995, 872	0	57, 995, 87	2 2, 138, 626. 41	27.12	1.00
	instructions)							
2.00	Excluded area salaries (see		4, 996, 305	684, 922	5, 681, 22	7 208, 990. 00	27. 18	2.00
2 00	instructions)			(04.000	FD 014 (4	F 1 000 (0(41	07.11	2 00
3.00	Subtotal salaries (line 1 minus line 2)		52, 999, 567	-684, 922	52, 314, 64	5 1, 929, 636. 41	27. 11	3.00
4.00	Subtotal other wages & related		5, 555, 012	0	5, 555, 01	2 89, 607. 76	61. 99	4.00
	costs (see inst.)							
5.00	Subtotal wage-related costs		20, 311, 287	0	20, 311, 28	7 0.00	38.83	5.00
	(see inst.)							
6.00	Total (sum of lines 3 thru 5)		78, 865, 866					
7.00	Total overhead cost (see		20, 488, 716	-684, 922	19, 803, 79	4 690, 239. 31	28.69	7.00
	instructions)							

Heal th	Financial Systems	IU HEALTH GOSHEN	HOSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPIT	AL WAGE RELATED COSTS		Provider CC	CN: 150026	Period: From 01/01/2015 To 12/31/2015	5/27/2016 5:4	pared:
						Amount	
						Reported 1.00	
	PART IV - WAGE RELATED COSTS					1.00	
	Part A - Core List						
	RETIREMENT COST						
1.00	401K Employer Contributions					1, 555, 919	1.00
2.00	Tax Sheltered Annuity (TSA) Employer Contril	bution				0	2.00
3.00	Nonqualified Defined Benefit Plan Cost (see					1, 713, 227	3.00
4.00	Qualified Defined Benefit Plan Cost (see ins					0	4.00
	PLAN ADMINISTRATIVE COSTS (Paid to External	Organi zati on)					
5.00	401K/TSA Plan Administration fees					0	5.00
6.00	Legal /Accounting/Management Fees-Pension Pla	an				0	6.00
7.00	Employee Managed Care Program Administration	n Fees				0	7.00
	HEALTH AND INSURANCE COST						
8.00	Health Insurance (Purchased or Self Funded)					16, 706, 118	8.00
9.00	Prescription Drug Plan					0	9.00
10.00	Dental, Hearing and Vision Plan					388, 510	
11.00	Life Insurance (If employee is owner or ben					187, 435	
12.00	Accident Insurance (If employee is owner or					0	
13.00	Disability Insurance (If employee is owner of					196, 008	
14.00	Long-Term Care Insurance (If employee is own	ner or beneficiary)				2, 800	
15.00	'Workers' Compensation Insurance					315, 120	
16.00	Retirement Health Care Cost (Only current ye	ear, not the extrao	rdi nary accru	al require	d by FASB 106.	0	16.00
	Non cumulative portion)						
47 00	TAXES						47 00
	FICA-Employers Portion Only					0	
18.00	Medicare Taxes - Employers Portion Only					3, 652, 523	
19.00	Unemployment Insurance					55, 970	
20.00						0	20.00
21 00	OTHER	Dati manat Cast Da		1 +		0	01 00
21.00	Executive Deferred Compensation (Other Than instructions))	Retirement Cost Re	ported on IIn	es i throu	ign 4 above. (see	-	21.00
22.00	Day Care Cost and Allowances					41, 594	
23.00	Tuition Reimbursement					102, 343	
24.00	Total Wage Related cost (Sum of lines 1 -23))				24, 917, 567	24.00
	Part B - Other than Core Related Cost						
25.00	OTHER WAGE RELATED COSTS (SPECIFY)					0	25.00

Heal th	Financial Systems	IU HEALTH GOSHEN H	IOSPI TAL	In Lie	u of Form CMS-2	2552-10
HOSPI T	AL CONTRACT LABOR AND BENEFIT COST		Provider CC	Peri od:	Worksheet S-3	
				From 01/01/2015		
				To 12/31/2015		
	Cost Center Description			Contract Labor	5/27/2016 5:4 Benefit Cost	/ pili
	Cost center bescription			1.00	2.00	
	PART V - Contract Labor and Benefit Cost			1.00	2.00	
	Hospital and Hospital-Based Component Identi	fication:				
1.00	Total facility's contract labor and benefit			0	0	1.00
2.00	Hospi tal			0	0	2.00
3.00	Subprovider - IPF			0	0	3.00
4.00	Subprovider - IRF			0	0	4.00
5.00	Subprovider - (Other)			0	0	5.00
6.00	Swing Beds - SNF			0	0	6.00
7.00	Swing Beds - NF			0	0	7.00
8.00	Hospital-Based SNF			0	0	8.00
9.00	Hospital-Based NF			0	0	9.00
10.00	Hospital-Based OLTC					10.00
11.00	Hospital-Based HHA			0	0	11.00
12.00	Separately Certified ASC			0	0	12.00
13.00	Hospital-Based Hospice			0	0	13.00
14.00	Hospital-Based Health Clinic RHC			0	0	14.00
15.00	Hospital-Based Health Clinic FQHC			0	0	15.00
16.00	Hospital-Based-CMHC			0	0	16.00
17.00	Renal Dialysis			0	0	17.00
18.00	Other			0	0	18.00

Heal th	Financial Systems	IU HEALTH GOS	HEN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	EALTH AGENCY STATI STI CAL DATA			CCN: 150026 t CCN: 157174	Period: From 01/01/2015 To 12/31/2015		
			Component	L CON. 137174	Home Health	5/27/2016 5:4	
					Agency I	PP3	
					1.	00	-
0.00	County	Title V	Title XVIII	Title XIX	ELKHART Other	Total	0.00
		1.00	2.00	3.00	4. 00	5.00	
1.00	HOME HEALTH AGENCY STATISTICAL DATA Home Health Aide Hours	0	967		0 17	984	1.00
2.00	Unduplicated Census Count (see instructions)	0.00		36. (116.00	670.00	
				NUMBER OF EM	ployees (Full Ti	me Equivalent)	
			er of hours in	Staff	Contract	Total	
		your normal	work week				
		()	1.00	2.00	3.00	
3.00	HOME HEALTH AGENCY - NUMBER OF EMPLOYEES Administrator and Assistant Administrator(s)		40.00	0.0	0.00	0.00	3.00
4.00	Director(s) and Assistant Director(s)		101 00	1. (0. 00	1.02	4.00
5.00 6.00	Other Administrative Personnel Direct Nursing Service			5.2			
7.00	Nursing Supervisor			6.4	40 0.00	6.40	7.00
8.00 9.00	Physical Therapy Service Physical Therapy Supervisor			2. 0. 0			
10.00	Occupational Therapy Service			1. 1			
11. 00 12. 00	Occupational Therapy Supervisor Speech Pathology Service			0.0			
13.00 14.00	Speech Pathology Supervisor Medical Social Service			0.0			
14.00	Medical Social Service Supervisor			0.0	0. 00	0.00	15.00
16.00 17.00	Home Health Aide Home Health Aide Supervisor			1.4			
18.00	Other (specify)			0.0			
19.00	HOME HEALTH AGENCY CBSA CODES Enter in column 1 the number of CBSAs where				2		19.00
	you provided services during the cost				-		
20.00	reporting period. List those CBSA code(s) in column 1 serviced			22140			20.00
	during this cost reporting period (line 20 contains the first code).						
20. 01				99915			20.01
			pisodes With Outliers	LUPA Episode	s PEP Only	Total (cols.	
		Outliers 1.00	2.00	3.00	Epi sodes 4. 00	<u>1-4)</u> 5.00	
	PPS ACTIVITY DATA	1		1		Ĩ	
21.00 22.00	Skilled Nursing Visits Skilled Nursing Visit Charges	3, 285 506, 850					
23.00	Physical Therapy Visits	1, 347	22		18 28	1, 415	23.00
24.00 25.00	Physical Therapy Visit Charges Occupational Therapy Visits	228, 310 582			50 4, 590 3 3	239, 530 612	
26.00	Occupational Therapy Visit Charges	98, 090	4, 080	51	10 510	103, 190	26.00
27.00 28.00	Speech Pathol ogy Visits Speech Pathol ogy Visit Charges	82 14, 580		7:	4 I 20 180	95 16, 920	
29.00	Medical Social Service Visits	114	5	F/	3 4 05 860	126	
30. 00 31. 00	Medical Social Service Visit Charges Home Health Aide Visits	24, 510 678			05 860 1 8	26, 950 712	31.00
32.00 33.00	Home Health Aide Visit Charges Total visits (sum of lines 21, 23, 25, 27,	57, 240 6, 088			30 640 50 95		
	29, and 31)						
34.00 35.00	Other Charges Total Charges (sum of lines 22, 24, 26, 28,	0 929, 580	-		0 0 25 14,685	-	
	30, 32, and 34)						
36.00	Total Number of Episodes (standard/non outlier)	417			96 8	521	
37.00 38.00	Total Number of Outlier Episodes Total Non-Routine Medical Supply Charges	4, 152, 385	3, 046		1 0 0	4 4, 155, 431	
50.00	The set wat he weared supply that ges	1 7, 132, 303	1 5, 040	1	- - -	1 7, 100, 401	1 00.00

Heal th	Financial Systems		IU HEALTH GOSH	HEN HOSPITAL		In Lie	u of Form CMS-2	2552-10
HOSPI 1	AL IDENTIFICATION DATA			Provi der	CCN: 150026	Peri od:	Worksheet S-9	
						From 01/01/2015		
				Component	CCN: 151527	To 12/31/2015		
						Hospi ce I	5/27/2016 5:4	/ pili
		Unduplicated				- nospice i		
		Days						
		Title XVIII	Title XIX	Title XVIII	Title XIX	All Other	Total (sum of	
				Skilled	Nursing		col s. 1, 2 &	
				Nursing	Facility		5)	
				Facility			- /	
		1.00	2.00	3.00	4.00	5.00	6.00	
	PART I - ENROLLMENT DAYS							
1.00	Continuous Home Care	0	0	0		0 0	0	1.00
2.00	Routine Home Care	16, 398	0	0		0 2,001	18, 399	2.00
3.00	Inpatient Respite Care	70	0	0		0 6	76	3.00
4.00	General Inpatient Care	275	0	0		0 121	396	4.00
5.00	Total Hospice Days	16, 743	0	0		0 2, 128	18, 871	5.00
	Part II - CENSUS DATA							
6.00	Number of Patients Receiving	317	12	0		0 46	375	6.00
	Hospi ce Care							
7.00	Total Number of Unduplicated	0. 00		0.00				7.00
	Continuous Care Hours Billable							
	to Medicare							
8.00	Average Length of Stay (line	52. 82	0.00	0.00	0.0	20 46.26	50. 32	8.00
	5/line 6)		10					
9.00	Unduplicated Census Count	304	12	0		0 45	361	9.00

Heal th	Financial Systems	IU HEALTH GOSHEN H	IOSPI TAL		In Li€	eu of Form CMS-	2552-10
	AL UNCOMPENSATED AND INDIGENT CARE DATA				Period:	Worksheet S-	
					From 01/01/2015		
					To 12/31/2015	Date/Time Pre 5/27/2016 5:4	
						572772010 5.4	
						1.00	
	Uncompensated and indigent care cost compute	ation					
1.00	Cost to charge ratio (Worksheet C, Part I I	ine 202 column 3 divi	ided by lir	ne 202 column	8)	0. 303383	1.00
	Medicaid (see instructions for each line)						
2.00	Net revenue from Medicaid					9, 165, 987	2.00
3.00	Did you receive DSH or supplemental payment	s from Medicaid?				Y	3.00
4.00	If line 3 is "yes", does line 2 include all			From Medicaid	?	Y	4.00
5.00	If line 4 is "no", then enter DSH or supple	mental payments from	Medi cai d			0	
6.00	Medicaid charges					57, 112, 284	
7.00	Medicaid cost (line 1 times line 6)					17, 326, 896	•
8.00	Difference between net revenue and costs fo	r Medicaid program (line 7 minu	us sum of lin	es 2 and 5; if	8, 160, 909	8.00
	< zero then enter zero)						
9,00	State Children's Health Insurance Program (SCHIP) (See Instructi	I ONS I OF ea	ach inne)			9.00
9.00 10.00	Net revenue from stand-alone SCHIP Stand-alone SCHIP charges						
10.00	5	0)					
12.00			(ling 11 mi	nus lino 0.	if < zero then		
12.00	enter zero)	stand-arone senin		nus i ne 7,			12.00
	Other state or local government indigent ca	re program (see instr	ructions fo	or each line)		1	
13.00	Net revenue from state or local indigent ca)		13.00
14.00	Charges for patients covered under state or					0	14.00
	10)	0					
15.00	State or local indigent care program cost (0	
16.00	Difference between net revenue and costs fo	r state or local ind	igent care	program (lin	e 15 minus line	(16.00
	13; if < zero then enter zero)						
47.00	Uncompensated care (see instructions for ea	ch line)					1 1 7 00
17.00	Private grants, donations, or endowment inc						17.00
18.00 19.00	Government grants, appropriations or transf				o (our of lines	0 1/0 000	
19.00	Total unreimbursed cost for Medicaid , SCHI 8, 12 and 16)	P and state and local	i indigent	care program	s (sum or lines	8, 160, 909	19.00
	0, 12 and 10)			Uni nsured	Insured	Total (col. 1	
				patients	patients	+ col . 2)	
				1.00	2.00	3.00	
20.00				11, 321, 41	4 0	11, 321, 414	20.00
	charges excluding non-reimbursable cost cen						
21.00	Cost of initial obligation of patients appr	oved for charity care	e (line 1	3, 434, 72	5 0	3, 434, 725	21.00
~~ ~~	times line 20)						
22.00	Partial payment by patients approved for ch				0 0 5 0		
23.00	Cost of charity care (line 21 minus line 22)		3, 434, 72	5 0	3, 434, 725	23.00
						1.00	
24 00	Does the amount in line 20 column 2 include	charges for natient	days beyon	nd a length o	f stav limit	1.00	24.00
24.00	imposed on patients covered by Medicaid or			ia a rength o	i Stay i i mit		24.00
25.00				oaram's lenat	h of stav limit	(25.00
26.00	5 5 1			5 5 5	,	22, 025, 481	
27.00						287, 189	
28.00				s line 27)		21, 738, 292	28.00
29.00	Cost of non-Medicare and non-reimbursable M	edicare bad debt exp	ense (line	1 times line	28)	6, 595, 028	29.00
30.00						10, 029, 753	
31.00	Total unreimbursed and uncompensated care c	ost (line 19 plus li	ne 30)			18, 190, 662	31.00

RECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	IU HEALTH GOSHE F EXPENSES			Period:	u of Form CMS-2 Worksheet A	2002-10
					rom 01/01/2015 o 12/31/2015	Date/Time Pre 5/27/2016 5:4	
	Cost Center Description	Sal ari es	Other	Total (col. 1 + col. 2)	Reclassificati ons (See A-6)	Reclassified Trial Balance (col. 3 +-	
		1.00	2.00	3.00	4.00	col. 4) 5.00	
	GENERAL SERVICE COST CENTERS			11 7/0 ///		5 007 700	1
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP		11, 768, 441	11, 768, 44		5, 307, 793 6, 542, 994	1.00 2.00
3.00	00300 OTHER CAP REL COSTS		0		0 0,012,771	0,012,771	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	620, 245	22, 393, 873	23, 014, 118		23, 333, 654	4.00
5. 01 5. 02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00591 OTHER ADMI NI STRATI VE AND GENERAL	870, 844	1, 158, 094	2, 028, 938 37, 494, 815		2, 028, 935	
6.00	00600 MAINTENANCE & REPAIRS	11, 127, 799	26, 367, 016 0	57,494,013) 410, 293	37, 913, 110 0	6.00
7.00	00700 OPERATION OF PLANT	736, 370	2, 126, 329	2, 862, 699	-46	2, 862, 653	7.00
8.00	00800 LAUNDRY & LINEN SERVICE	36, 144	565, 144	601, 288		601, 288	8.00
9.00 10.00	00900 HOUSEKEEPI NG 01000 DI ETARY	982, 311 697, 790	410, 464 1, 031, 670	1, 392, 775 1, 729, 460		1, 392, 775 558, 479	
11.00	01100 CAFETERI A	077,770	1,031,070	1, 727, 400		1, 170, 981	
12.00	01200 MAINTENANCE OF PERSONNEL	0	0		0 0	0	12.00
13.00	01300 NURSI NG ADMI NI STRATI ON	1, 488, 710	260, 975	1, 749, 685		1, 748, 184	
14.00 15.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	206, 692 1, 498, 211	291, 370 8, 230, 749	498, 062 9, 728, 960		496, 628 1, 660, 162	
16.00	01600 MEDICAL RECORDS & LIBRARY	1, 395, 230	2,034,387	3, 429, 617		3, 429, 617	16.00
17.00	01700 SOCIAL SERVICE	554, 804	17, 597	572, 40	0	572, 401	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	(0	0	19.00
20.00 21.00	02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0			0	20.00 21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0		0 0	0	22.00
23.00	02300 PARAMEDICAL EDUCATION PROGRAM	0	0		224, 977	224, 977	23.00
30.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	6, 249, 949	786, 286	7, 036, 235	961, 535	7, 997, 770	30.00
30.00	03100 I NTENSI VE CARE UNI T	6, 249, 949 1, 616, 620	786, 286 344, 210	1, 960, 830		1, 839, 604	30.00
32.00	03200 CORONARY CARE UNI T	0	0	(0 0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	(0 0	0	33.00
34.00 40.00	03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF	0	0			0	34.00 40.00
40.00	04100 SUBPROVIDER - IRF	0	0			0	40.00
42.00	04200 SUBPROVI DER	0	0		0 0	0	42.00
43.00	04300 NURSERY	2, 599, 875	489, 803	3, 089, 678	-2, 804, 424	285, 254	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0			0	44.00 45.00
45.00	04600 OTHER LONG TERM CARE	0	0			0	45.00
	ANCILLARY SERVICE COST CENTERS				1		
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	4, 076, 732 449, 888	8, 592, 617			7, 267, 256 472, 149	
52.00	05200 DELIVERY ROOM & LABOR ROOM	449,000	74, 823 0	524,71		1, 528, 444	
	05300 ANESTHESI OLOGY	0	0	(0 0	0	
53.01	05301 PALN MANAGEMENT	831, 020	1, 123, 462	1, 954, 482		1, 954, 482	
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	13, 780, 215 306, 111	24, 479, 313 32, 734	38, 259, 528 338, 845		23, 471, 033 338, 556	54.00 55.00
56.00	05600 RADI OLOGI - MERALEONIC	0	52,754	330, 043		0	56.00
56.01	05601 CARDI AC CATH LAB	925, 511	2, 895, 341	3, 820, 852	2 -2, 352, 169	1, 468, 683	
57.00	05700 CT SCAN	0	0	(0	0	57.00
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0			0	58.00 59.00
60.00	06000 LABORATORY	2, 546, 802	3, 572, 932	6, 119, 734	-1, 156, 082	4, 963, 652	60.00
60.01	06001 BLOOD LABORATORY	0	0		0 0	0	60.01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0			0	61.00 62.00
62.00 63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0	62.00
64.00	06400 I NTRAVENOUS THERAPY	0	0		0	0	64.00
65.00	06500 RESPI RATORY THERAPY	1,057,899	232, 932			1, 256, 730	
66.00 67.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 542, 655 529, 674	375, 966 11, 809	1, 918, 62 ⁻ 541, 483		1, 911, 039 538, 120	
67.00	06800 SPEECH PATHOLOGY	347, 706	11, 809	359, 549		357, 337	68.00
69.00	06900 ELECTROCARDI OLOGY	0	94, 791	94, 79		94, 752	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70.00
71.00 72.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		6, 181, 519 4, 440, 814	6, 181, 519 4, 440, 814	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0		21, 874, 660	21, 874, 660	
74.00	07400 RENAL DI ALYSI S	0	0		0 0	0	74.00
75.00	07500 ASC (NON-DI STI NCT PART)	0	0	(0 0	0	75.00
88.00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	0	(0	88.00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	89.00
90.00	09000 CLINIC	228, 617	138, 161	366, 778		364, 719	
90.02	09002 WOUND CLINIC	0	1, 566, 423	1, 566, 423	3 – 286, 248	1, 280, 175	90.02

Health Financial Systems	IU HEALTH GOSHE	N HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE C	F EXPENSES	Provi der		eriod:	Worksheet A	
				rom 01/01/2015 o 12/31/2015	Date/Time Prep	arod
			'	0 12/31/2015	5/27/2016 5:47	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
			+ col. 2)	ons (See A-6)	Trial Balance	
					(col. 3 +-	
					col. 4)	
	1.00	2.00	3.00	4.00	5.00	
90. 03 09003 MOBILE CLINIC	139	919	.,		1, 058	90.03
91.00 09100 EMERGENCY	2, 382, 557	875, 004	3, 257, 561	-96, 632	3, 160, 929	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART OTHER REI MBURSABLE COST CENTERS						92.00
99.00 09900 CMHC		0	C		0	99.00
101.00 10100 HOME HEALTH AGENCY	1, 764, 810	271,047	2, 035, 857	-22, 462	2, 013, 395	
SPECIAL PURPOSE COST CENTERS	1,704,010	271,047	2,035,057	-22, 402	2,013,345	101.00
113. 00 11300 I NTEREST EXPENSE		1, 215, 395	1, 215, 395	-1, 215, 395	0	113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	0	1, 213, 373	1, 210, 070	1, 213, 373		114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00
116. 00 11600 HOSPI CE	756, 062	1,027,845	1, 783, 907	-251, 422	1, 532, 485	
118.00 SUBTOTALS (SUM OF LINES 1-117)	62, 207, 992	124, 869, 765			186, 439, 246	
NONREI MBURSABLE COST CENTERS				· · · ·		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 249, 990	618, 368	1, 868, 358	-7	1, 868, 351	190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	165, 687	9, 789	175, 476	-32, 432	143, 044	190. 01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0	C	0 0	0	190. 02
190. 03 19003 LI FELI NE	0	0	C	0 0	0	190. 03
190. 04 19004 COMMUNI TY RELATI ONS	487, 343	4, 336, 381	4, 823, 724	670, 950	5, 494, 674	
190. 05 19005 PRI VATE DUTY	0	0	C	0 0		190. 05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	14, 486	1, 320, 107			1, 334, 593	
190. 07 19007 FOUNDTI ON	0	15	15	-		190. 07
190.08 19008 GOSHEN GACC CLINIC	0	62, 794			62, 794	
191. 00 19100 RESEARCH	557, 927	268, 664	826, 591	0	826, 591	
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	C	0		192.00
193.00 19300 NONPAI D WORKERS	0	0		0		193.00
200.00 TOTAL (SUM OF LINES 118-199)	64, 683, 425	131, 485, 883	196, 169, 308	8 0	196, 169, 308	200.00

ECLAS	SSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	UF EXPENSES		Provi der	CCN: 15002	From 01/01/2015	
						To 12/31/2015	
	Cost Center Description	Adjustments		Expenses Ilocation			
		(See A-8) 6.00		7.00			
	GENERAL SERVICE COST CENTERS		T				
. 00	00100 CAP REL COSTS-BLDG & FIXT	-661, 231		4,646,562	1		1.0
. 00	00200 CAP REL COSTS-MVBLE EQUIP	-1, 010, 390		5, 532, 604 0	1		2.
. 00 . 00	00300 OTHER CAP REL COSTS 00400 EMPLOYEE BENEFITS DEPARTMENT		2		1		3.
. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE			2, 028, 935			5.
. 02	00591 OTHER ADMINISTRATIVE AND GENERAL	-11, 362, 645		6, 550, 465			5.
. 00	00600 MAI NTENANCE & REPAI RS	C		0			6.
. 00	00700 OPERATION OF PLANT	C		2,862,653			7.
. 00	00800 LAUNDRY & LINEN SERVICE	C		601, 288			8.
. 00	00900 HOUSEKEEPING	C		1, 392, 775	1		9.
1.00	01000 DI ETARY 01100 CAFETERI A	-880, 171		558, 479 290, 810	1		10.
	01200 MAINTENANCE OF PERSONNEL	-000, 171		2,0,010	1		12.
	01300 NURSI NG ADMI NI STRATI ON	C		1, 748, 184	1		13.
4.00	01400 CENTRAL SERVICES & SUPPLY	C		496, 628	1		14.
5.00	01500 PHARMACY	C		1, 660, 162			15.
	01600 MEDI CAL RECORDS & LI BRARY	-58, 322		3, 371, 295	1		16.
	01700 SOCIAL SERVICE	C		572, 401	1		17.
	01900 NONPHYSI CLAN ANESTHETI STS			0	1		19.
	02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRV			0			20.
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV			0	1		22.
	02300 PARAMEDI CAL EDUCATI ON PROGRAM	-67, 704		157, 273	1		23.
	INPATIENT ROUTINE SERVICE COST CENTERS						
	03000 ADULTS & PEDIATRICS	C		7,997,770	1		30.
	03100 INTENSIVE CARE UNIT	C		1,839,604	1		31.
	03200 CORONARY CARE UNIT	C		0	1		32.
	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT			0			33.
	04000 SUBPROVIDER - IPF			0			40.
	04100 SUBPROVIDER - IRF			0			41.
	04200 SUBPROVI DER	C		0			42.
3.00	04300 NURSERY	C		285, 254			43.
	04400 SKILLED NURSING FACILITY	C		0			44.
5.00		C		0			45.
0.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	C		0	1		46.
0. 00	05000 OPERATI NG ROOM	C		7, 267, 256	,		50.
1. 00	05100 RECOVERY ROOM	C		472, 149	,		51.
	05200 DELIVERY ROOM & LABOR ROOM	C		1, 528, 444			52.
	05300 ANESTHESI OLOGY	C		0	1		53.
3.01	05301 PALN MANAGEMENT	-1, 431, 016		523, 466			53.
	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	-8, 619, 108		4,851,925 338,556	1		54. 55.
	05600 RADI OLOGI - MERAPEOTI C			338, 550	1		56.
	05601 CARDI AC CATH LAB			1, 468, 683			56.
	05700 CT SCAN	C		0			57.
B. 00	05800 MRI	C		0			58.
	05900 CARDI AC CATHETERI ZATI ON	C		0			59.
	06000 LABORATORY	-922, 502		4,041,150			60.
	06001 BLOOD LABORATORY	C		0			60.
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL			0			61.
	06300 BLOOD STORING, PROCESSING & TRANS.			0			63.
	06400 I NTRAVENOUS THERAPY			0			64.
	06500 RESPI RATORY THERAPY			1, 256, 730			65.
5.00	06600 PHYSI CAL THERAPY	-210		1, 910, 829			66.
	06700 OCCUPATIONAL THERAPY	C		538, 120			67.
	06800 SPEECH PATHOLOGY	C		357, 337			68.
		C		94, 752	1		69.
	07000 ELECTROENCEPHALOGRAPHY			0 4 101 E10	1		70.
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS			6, 181, 519 4, 440, 814	1		71.
	07200 TMPL: DEV. CHARGED TO PATIENTS			4, 440, 814 21, 874, 660			72.
	07400 RENAL DIALYSIS			1, 874, 000 0	1		74.
	07500 ASC (NON-DI STINCT PART)			0	1		75.
	OUTPATIENT SERVICE COST CENTERS	· · · · · · · · · · · · · · · · · · ·	·				
	08800 RURAL HEALTH CLINIC	C		0			 88.
	08900 FEDERALLY QUALIFIED HEALTH CENTER	C		0			89.
		C		364, 719	1		90.
	09002 WOUND CLINIC 09003 MOBILE CLINIC	-16, 657		1, 263, 518	1		90. 90.
<u>ה</u> ה ה				1, 058			1 90

Health Financial Systems	IU HEALTH GOSH	IEN HOSPI TAL		In Lieu	u of Form CMS-2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	F EXPENSES	Provider CC	CN: 150026	Peri od:	Worksheet A
				From 01/01/2015 To 12/31/2015	Date/Time Prepared:
				10 12/01/2010	5/27/2016 5: 47 pm
Cost Center Description	Adjustments	Net Expenses			
	(See A-8) 6.00	For Allocation			
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART	6.00	7.00			92.00
OTHER REIMBURSABLE COST CENTERS					92.00
99. 00 09900 CMHC	0	0			99.00
101.00 10100 HOME HEALTH AGENCY	0	2, 013, 395			101.00
SPECIAL PURPOSE COST CENTERS					
113.00 11300 INTEREST EXPENSE	0	0			113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF	0	0			114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0			115.00
116.00 11600 HOSPI CE	0	1, 532, 485			116.00
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREIMBURSABLE COST CENTERS	-25, 074, 162	161, 365, 084			118.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	1, 868, 351			190, 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	143,044			190.00
190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0			190. 02
190. 03 19003 LI FELI NE	0	0			190. 03
190.04 19004 COMMUNITY RELATIONS	0	5, 494, 674			190. 04
190. 05 19005 PRI VATE DUTY	0	0			190. 05
190.06 19006 PROFESSI ONAL DEVELOPMENT	0	1, 334, 593			190.06
190. 07 19007 FOUNDTI ON	0	15			190. 07
190. 08 19008 GOSHEN GACC CLINIC	0	62, 794			190. 08
191.00 19100 RESEARCH	0	826, 591			191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0			192.00
193.00 19300 NONPALD WORKERS		171 005 144			193.00
200.00 TOTAL (SUM OF LINES 118-199)	-25, 074, 162	171, 095, 146			200.00

	Financial Systems		IU HEALTH GOSH		CCN: 150026	Peri od:		of Form CM lorksheet A	
RECLAS	STELENTIONS			Provider	CCN. 150028	From 01/	01/2015	ate/Time P	
		Increases					5	5/27/2016 5	:47 pm
	Cost Center	Li ne #	Sal ary	Other					
	2.00 A - SUPPLIES	3.00	4.00	5.00					
1.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	6, 181, 526					1.00
2.00		72.00		4 440 014					2.00
2.00	I MPL. DEV. CHARGED TO PATI ENTS	72.00	0	4, 440, 814					2.00
3.00		0.00	0	0					3.00
4.00 5.00		0.00 0.00	0 0	0					4.00 5.00
6.00		0.00	0	0					6.00
7.00 8.00		0.00 0.00	0	0					7.00 8.00
9.00		0.00	0	0					9.00
10. 00 11. 00		0.00 0.00	0 0	0 0					10. 00 11. 00
12.00		0.00	0	0					12.00
13.00		0.00	0	0					13.00
14.00 15.00		0.00 0.00	0	0					14.00 15.00
16.00		0.00	0	0					16.00
17.00 18.00		0.00 0.00	0 0	0					17.00 18.00
19.00		0.00	0	0					19.00
20.00		0.00	0	0					20.00
21. 00 22. 00		0.00 0.00	0	0					21.00 22.00
23.00		0.00	0	0					23.00
24.00 25.00		0.00 0.00	0 0	0					24.00 25.00
26.00		0.00	0	0					26.00
27.00		0.00	0	00000000_					27.00
	B - PHARMACY		0	10, 022, 340					
1.00	DRUGS CHARGED TO PATIENTS	73.00	0	21, 877, 568					1.00
2.00 3.00		0.00 0.00	0 0	0 0					2.00 3.00
4.00		0.00	0	0					4.00
5.00 6.00		0.00 0.00	0 0	0					5. 00 6. 00
7.00		0.00	0	0					7.00
8.00 9.00		0.00 0.00	0 0	0					8.00 9.00
10.00		0.00	0	0					10.00
11.00		0.00	0	0					11.00
12. 00 13. 00		0.00 0.00	0	0					12.00 13.00
14.00		0.00	0	0					14.00
15. 00 16. 00		0.00 0.00	0	0					15.00 16.00
	TOTALS		ō	21, 877, 568					_
1.00	C – DI ETARY CAFETERI A	11.00	472, 459	698, 522					1.00
	TOTALS		472, 459	698, 522					
1.00	D - CAPITAL INSURANCE OTHER ADMINISTRATIVE AND	5.02	0	124, 989					1.00
	GENERAL								
2.00 3.00	EMPLOYEE BENEFITS DEPARTMENT OTHER ADMINISTRATIVE AND	4.00 5.02	0	358, 768 1, 005, 297					2.00 3.00
3.00	GENERAL	5.02	0	1,005,297					3.00
4.00	CAP REL COSTS-MVBLE EQUIP	2.00	0	4, 181					4.00
5.00	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	197, 817					5.00
	TOTALS		0	1, 691, 052					_
1.00	E - CAPITAL INTEREST CAP REL COSTS-BLDG & FIXT	1.00	0	1, 215, 395					1.00
	TOTALS		ō	1, 215, 395					
1.00	F - CAPITAL DEPRECIATION CAP REL COSTS-MVBLE EQUIP	2.00	0	6, 538, 813					1.00
2.00		<u>0.</u> 00	0	0					2.00
			0	6, 538, 813					_
1.00	G - CIRCLE OF CARE ADULTS & PEDIATRICS	30.00	1, 026, 171	156, 493					1.00
2.00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	<u>1, 326, 1</u> 96	202, 248					2.00
	TOTALS	I	2, 352, 367	358, 741					I

Heal th	Health Financial Systems			HEN HOSPITAL		In Lieu of Form CMS-2552		
RECLASSI FI CATI ONS				Provi der	CCN: 150026	Period: From 01/01/2015	Worksheet A-	6
						To 12/31/2015	Date/Time Pr 5/27/2016 5:	epared: 47 pm
		Increases						
	Cost Center	Line #	Salary	Other				
	2.00	3.00	4.00	5.00				
	H - COMMUNITY HEALTH							
1.00	COMMUNITY RELATIONS	190.04	684, 922	212, 509				1.00
2.00		0.00	0	0				2.00
3.00		0.00	0	0				3.00
	TOTALS		684, 922	212, 509				1
	I – EMT		·					1
1.00	PARAMEDI CAL EDUCATI ON	23.00	125, 818	99, 159				1.00
	PROGRAM							
	TOTALS		125, 818	99, 159				
500.00	Grand Total: Increases		3, 635, 566	43, 314, 099				500.00

Health Financial Systems RECLASSIFICATIONS

IU HEALTH GOSHEN HOSPITAL

In Lieu of Form CMS-2552-10

Provider CCN: 150026

 Period:
 Worksheet A-6

 From 01/01/2015
 Date/Time Prepared:

 To
 12/31/2015
 Date/Time Prepared:

Image: Construction of the second o							5/27/2016 5:	
A. Support A. 1.00 HIG OFF BREFITS OFFARTMENT (C.O. 0) 0.01 1,2 0 1,2 0 2,0 0 2,0 0 2,0 0 2,0 0 2,0 0 2,0 0 2,0 0 2,0 0 2,0 0 2,0 0 2,0 0 2,0 0 4,00 4,00 4,00 4,00 4,00 4,00 4,00 4,00 4,00 4,00 4,00 4,00 4,00 4,00 4,00 4,00 4,00 4,00 5,00 1,1,20 0 7,00 6,00 1,1,20 0 7,00 0,00 1,00 <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th> <th></th>								
1.00 PURPOYE REFETS PRAFEWART 4.00 0 1.2 0 0.00 PURE AND STRATUS NO 5.00 0 1.00 2.00 3.00 PURE AND STRATUS NO 1.00 0 1.00 3.00 3.00 PURE AND STRATUS NO 1.00 0 1.00 3.00 3.00 PURE AND STRATUS NO 1.00 0 1.434 0 4.00 4.00 PURE AND STRATUS NO 1.00 0 2.1226 0 4.00 5.00 ENTROL STRATUS NO 1.00 0 2.1226 0 4.00 7.00 UNTRISTY REAL 1.00 0 2.21266 0 1.00 10.00 DEFRATUR REAL 5.00 0 2.400 9.00 1.00 10.00 DEFRATUR REAL 5.00 0 2.41289 0 11.00 10.00 DERRATUR REAL 5.00 0 2.4289 0 14.00 10.00 DERRATUR REAL 5.00 0 2.428			7.00	8.00	9.00	10.00		
2.00 DUTRER ADM MISTRATIVE AMR 5.02 0 12.351 0 2.00 0.00 DERAMISA ADM MISTRATIVE AMR 7.00 0 4.00 0 4.00 0 4.00 0 4.00 0 4.00 0 4.00 0 4.00<	1 00		4 00	0	12	0		1 00
3 CEREBAL 00 00				-				
4.00 MURSING ADMIN STRUCTOR A SUPPLY 13.00 0 1.293 0 4.00 5.00 CTININA STRUCTOR A SUPPLY 15.00 0 7.568 0 6.00 6.00 PURMONCY 15.00 0 7.568 0 6.00 6.01 MERSINE CARE UNIT 31.00 0 7.568 0 6.00 9.00 MURSINE CARE UNIT 31.00 0 7.568 0 10.00 9.00 MURSINE CARE UNIT 31.00 0 7.57.868 0 11.00 10.01 MURSINE CARE UNIT 51.00 0 52.362 0 11.00 11.02 MURSINE CARE UNIT 55.00 0 7.35.960 0 11.00 11.03 MURSINE CARE UNIT 55.00 0 7.35.960 0 12.00 11.00 MURSINE CARE UNIT 65.00 0 7.35.960 0 12.00 10.00 MURSINE CARE UNIT 7.00 0 2.200 0 12.00 <	2.00	· · · · · · · · · · · · · · · · · · ·	0.02	Ŭ	12,001	0		2.00
5.00 CENTRAL SERVICES 4. SUPPLY 14.00 0 1.434 0 6.00 0.00 PRAMACY 15.00 0.756 0 7.00 0.00 PRAMACY 15.00 0.756 0 7.00 0.00 PRATINGS 30.00 0 221,129 0 7.00 0.00 PRATINGS 30.00 0 221,129 0 7.00 0.00 PRATING SCOM 55.00 0 5.400,589 0 110.00 0.00 PRATING SCOM 55.00 0 5.400,589 0 13.00 12.00 RADIT GRAY DERMONTIC 55.00 0 2.3582 0 15.00 10.00 PRASTANDRY THERMAY 66.00 0 7.582 0 15.00 10.00 PRASTANDRY THERMAY 66.00 0 7.93 0 15.00 10.00 ECCREARDADIOLOGY 9.00 0 2.059 0 22.00 22.00 DERCEARDADIOLOGY 9.00	3.00		7.00	0	46	0		3.00
6.00 PARAMACY 15.00 0 7.565 0 .00 8.00 INTINSIVE CAFE HUNT 31.00 D 21.129 0 .00 8.00 INTINSIVE CAFE HUNT 31.00 D 21.236 0 .00 8.00 INTINSIVE CAFE HUNT 31.00 D 52.560 0 10.00 11.00 ROTICOVED JAMOSTIC 54.00 0 7.476 0 11.00 12.00 RADI CACOV-THERMENTIC 55.00 0 2.939.00 11.00 13.00 RADI CACOV-THERMENTY 60.00 0 7.562 0 17.00 15.00 LARMANTAW 64.00 0 3.363 0 11.00 15.00 LARMANTAW 64.00 0 2.206 22.00 22.00 16.00 LECTROCARD LOROY 64.00 0 2.2462 0 22.00 17.00 DO 2.462 0 22.00 22.00 22.00 10.00 LECTROCARD LOROY<	4.00	NURSING ADMINISTRATION	13.00	0	1, 291	0		4.00
$\overline{1}$ 00 Applit Size PED ATR ICS $\overline{3}$ 00 $\overline{0}$ $\overline{2}$ 00 $\overline{1}$ 00	5.00	CENTRAL SERVICES & SUPPLY	14.00	0	1, 434	0		5.00
8.00 NINERSIVE CARE UNIT 31.00 0 121.226 0 40.00 10.00 0 40.00 NINERSIVE CARE UNIT 31.00 10.00 10.00 NINERSIVE A1.00 NINERSIVE A1.00 10.00 10.00 NINERSIVE A1.00 NINE				0		-		
0.00 NUSSEY 43.00 0 52.31 0 0 0 10.00 DESOVEY NOM 51.00 0 52.56.2 0 11.00 11.00 DESOVEY NOM 51.00 0 52.56.2 0 11.00 11.00 DESOVEY NOM 51.00 0 52.56.2 0 11.00 11.00 DESOVEY NOM 50.00 0 72.47.46 0 11.00 11.00 DESOVEY NOM 50.00 0 75.58.2 0 11.00 11.00 DESOVEY NOM 66.00 0 7.58.2 0 11.00 11.00 DESOVEY NOM 66.00 0 7.58.2 0 11.00 11.00 DESOVEY NOM 66.00 0 7.58.2 0 11.00 11.00 DESOVEY NOM 66.00 0 7.93 0 7.00 12.00 DANDIONC LINIC 90.00 2.05 7.00 7.00 7.00 7.00 7.00 7.00				-				
10.00 DEPERATING FOOM 50.00 0 5.400.509 0 10.00 12.00 RADIOLOCY-DE ADMOSTIC 54.00 0 724.746 0 12.00 12.00 RADIOLOCY-DE ADMOSTIC 54.00 0 724.746 0 12.00 14.00 MADIOLOCY-DE ADMOSTIC 54.00 0 724.746 0 12.00 14.00 MADIOLOCY-DE ADMOSTIC 54.00 0 724.746 0 13.00 14.00 MADIOLOCY-DE ADMOSTIC 56.00 0 72.3746 0 14.00 10.00 MADIOLOCY-DE ADMOSTIC 56.00 0 7.582 0 17.00 10.00 DELETINCAMD LOGY 46.00 0 2.204 0 18.00 10.00 DELEDINCAMD LOGY 66.00 0 2.204 0 22.00 22.00 MADIOLOGY 60.00 0 2.204 0 22.00 22.00 MADIOLOGY 10.00 0 2.24.22 0 22.00				-		-		
1:00 SECONERY NOM 51:00 0 52:55 0 11:00 1:20 RADIOLOGY-THEADOSTIC 54:00 0 72:746 0 13:00 1:30 RADIOLOGY-THEADOSTIC 55:00 0 229 0 13:00 1:30 RADIOLOGY-THEADOSTIC 55:00 0 229 0 13:00 1:00 CADRAC CATHI LAN 56:01 0 2,77:46 0 15:00 1:00 CADRAC CATHI LAN 56:01 0 2,00 15:00 15:00 1:00 CADRAC CATHI LAN 56:01 0 2,00 15:00 15:00 1:00 OCLINIC 0 0 2,204 0 15:00 1:00 0 52:50 0 22:00 22:00 22:00 1:00 0 2,204 0 22:00 22:00 22:00 1:00 0 2,025 0 22:00 22:00 22:00 22:00 22:00 22:00 22:				-				
12.00 RADIOLOCY-DEADRAPTIC 54.00 0 724.746 0 12.00 12.00 RADIOLOCY-DEADRAPTIC 55.00 0 2.89 0 13.00 14.00 CARDIAC CATH LAB 56.01 0 2.51.938 0 14.00 15.00 HABRATORY 66.00 0 15.60 0 15.00 16.00 CARDIAC CATH LAB 56.01 0 2.51.938 0 15.00 16.00 CARDIAC CATH LAB 56.01 0 2.75.938 0 15.00 17.00 0 7.35.05 0 15.00 10.00 10.00 10.00 SCUPANCHANCHANCHANCHANCHANCHANCHANCHANCHANCH				-		-		
12.00 RAD OLCOV-THERAPEUTIC 55.00 2589 0 13.00 13.00 CARDACOV CARDACOV 10.00 CARDACOV 14.00 13.00 RESPERATORY 60.00 0 1,150,009 15.00 13.00 RESPERATORY 14.00 15.00 15.00 15.00 13.00 RESPERATORY 14.00 17.00 <td< td=""><td></td><td></td><td></td><td>-</td><td></td><td></td><td></td><td></td></td<>				-				
14.00 CARDIAC CATH LAB 56.01 0 2.351, 356 0 14.00 15.00 LABRANORY 65.00 0 33, 949 0 15.00 16.00 RSPIRATORY. THERAPY 65.00 0 33, 949 0 15.00 10.00 DCLPARTIDANC, THERAPY 66.00 0 7, 582 0 17.00 10.00 DCLPARTIDANC, THERAPY 67.00 0 2, 53 0 22.00 00.01 DETECRATIDANC, THERAPY 67.00 0 2, 53 0 22.00 20.00 NUMAD CLINIC 90.00 0 2, 65 0 22.00 23.00 DERESPENCY 91.00 0 22.462 0 22.00 23.00 DERESPENCY 91.00 0 2.95 0 2.00 23.00 DERESPENCY 910.09 0 1.00 2.00 2.00 24.00 DERESPENCY 910.09 0 1.00 2.00 2.00 25.00				0		-		
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10.00 ESPIFATORY 05.00 0 33.949 0 16.00 10.00 PESPIFATORY 66.00 0 7.582 0 17.00 10.00 DCUPATIONAL THERAPY 66.00 0 7.582 0 17.00 10.00 DCUPATIONAL THERAPY 66.00 0 7.582 0 17.00 10.00 DCUPATIONAL THERAPY 66.00 0 2.204 0 18.00 20.00 LECTROCARDIOLOGY 69.00 0 2.069 0 2.00 22.				-				
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21.00 CLINIC State State <t< td=""><td>19.00</td><td>SPEECH PATHOLOGY</td><td>68.00</td><td>0</td><td>2, 204</td><td>0</td><td></td><td>19.00</td></t<>	19.00	SPEECH PATHOLOGY	68.00	0	2, 204	0		19.00
22.00 WOUND CLINIC 90.02 0 278.507 0 22.00 PERFENY 91.00 0 96.268 0 23.00 24.00 HARE HEALTH ACENCY 101.00 0 22.462 0 23.00 25.00 26.00 26.00 26.00 26.00 70.00 0 70.00 26.00 26.00 26.00 26.00 20.00 10.622.340 10.00 20.00	20.00	ELECTROCARDI OLOGY	69.00	0	39	0		20.00
23.00 EMERCENCY 91.00 0 96.268 0 23.00 23.00 24.00 23.00 24.00 23.00 24.00 25.00 105.01 24.00 25.00 20.00 20.01 2	21.00	CLINIC	90.00	0	2, 059	0		21.00
24.00 NOME HEALTH AGENCY 101.00 0 22.462 0 24.00 25.00 05.00				0	278, 507	-		
25:00 IOSPICE 116:00 0 29:920 0 26:00 27:00 10:00 26:00 27:00 10:00 27:00 10:00 27:00 10:00 27:00 27:00 10:00 20:00 27:00 27:00 27:00 20:				0		1		
26.00 GATT_FLOWER, COFFEE SHOP & 190.00 0 7 0 26.00 27.00 COMMUNITY, ELATIONS 190.04 0 1,504 0 27.00 TOTALS 190.04 0 1,504 0 27.00 27.00 TOTALS 0 0.622,340 0 1.00 27.00 27.00 CASH ERI NG/ACCOUNTS 5.01 0 39,220 0 1.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 2.00 4.00 3.00 0 2.00 2.00 4.00 3.00 0 2.00 2.00 4.00 4.00 4.00 4.00 4.00 4.00 4.00 5.00 6.00 5.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 6.00 7.00 7.00 6.00 1.00 7.00 6.00 7.23 0 9.00 7.00 7.00 7.10 1.00 1.00 1.00				0		0		
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TOTALS O 10, 0 222, 340 B - PARMACY - </td <td>27 00</td> <td></td> <td>100 04</td> <td>0</td> <td>1 504</td> <td>0</td> <td></td> <td>27 00</td>	27 00		100 04	0	1 504	0		27 00
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5.00 PHARMACY 15.00 0 8.061,233 0 5.00 6.00 NURSERY 43.00 0 85 0 6.00 7.00 OPERATING ROM 50.00 0 1,504 0 7.00 8.00 RADI OLGY-DI AGNOSTIC 54.00 0 13.00 9.00 0.00 CARDIA C CATH LAB 55.01 0 233 0 9.00 10.00 LABORATORY 66.00 0 152 0 11.00 12.00 SPEECH PATHOLOGY 68.00 0 8 0 12.00 13.00 OUND CLINIC 99.02 0 7.741 0 13.00 14.00 EMERGENCY 91.00 0 32.432 0 14.00 10.00 OTHER NR7CHP-GRANT 190.01 0 32.432 0 16.00 17COMMUNITY ED 0 0 21.877.568 1 2.00 3.00 2.00 CAP TAL INSURANCE 54.00								
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I/COMMUNITY ED	15.00			0		0		
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1.00 CAP REL COSTS-BLDG & FIXT 1.00 0 6, 109, 980 9 1.00 2.00 2.00 RADI OLOGY-DI AGNOSTI C 54.00 0 428, 833 0 2.00 2.00 TOTALS 0 6, 538, 813 0 1.00 2.00 1.00 2.00 1.00 NURSERY 43.00 2, 352, 367 358, 741 0 1.00 2.00				0				
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2.00 0 0 0 2.00								
		NURSERY		2, 352, 367	358, 741	1		
2, 332, 307 338, 741	∠.00			<u> </u>	0			2.00
			I I	2, 302, 307	550,741	I		I

Heal th	Financial Systems		IU HEALTH GOS	HEN HOSPITAL		In Lie	u of Form CMS	-2552-10
RECLAS	SIFICATIONS			Provi der	CCN: 150026	Period:	Worksheet A-	6
						From 01/01/2015 To 12/31/2015		epared: 47 pm
		Decreases						
	Cost Center	Line #	Sal ary	0ther	Wkst. A-7 Ref	· .		
	6.00	7.00	8.00	9.00	10.00			
	H - COMMUNITY HEALTH							
1.00	OTHER ADMI NI STRATI VE AND	5.02	684, 922	209, 594		0		1.00
	GENERAL							
2.00	DRUGS CHARGED TO PATIENTS	73.00	0	2, 908		0		2.00
3.00	MEDICAL SUPPLIES CHARGED TO	71.00	0	7		0		3.00
	PATI ENT							
	TOTALS		684, 922	212, 509				
	I – EMT							
1.00	COMMUNITY RELATIONS	190.04	125, 818	99, 159		0		1.00
	TOTALS		125, 818	99, 159				
500.00	Grand Total: Decreases		3, 635, 566	43, 314, 099				500.00

	Financial Systems	IU HEALTH GOSH					u of Form CMS-2	2552-10
RECONC	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150026		iod: m 01/01/2015 12/31/2015		pared:
			I	Acqui si ti on	S		0/2//2010 011	, pin
		Begi nni ng	Purchases	Donati on		Total	Disposals and	
		Bal ances					Retirements	
		1.00	2.00	3.00		4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES		_				
1.00	Land	3, 883, 887	150		0	150	0	1.00
2.00	Land Improvements	2, 988, 795	0		0	0	0	2.00
3.00	Buildings and Fixtures	98, 219, 167	1, 872, 591		0	1, 872, 591	87, 861	3.00
4.00	Building Improvements	113, 748	0		0	0	0	4.00
5.00	Fixed Equipment	13, 278, 447	436, 541		0	436, 541	10, 360	5.00
6.00	Movable Equipment	99, 735, 408	6, 339, 242		0	6, 339, 242	2, 264, 389	6.00
7.00	HIT designated Assets	0	0		0	0	0	7.00
8.00	Subtotal (sum of lines 1-7)	218, 219, 452	8, 648, 524		0	8, 648, 524	2, 362, 610	8.00
9.00	Reconciling Items	0	0		0	0	0	9.00
10.00	Total (line 8 minus line 9)	218, 219, 452	8, 648, 524		0	8, 648, 524	2, 362, 610	10.00
		Endi ng Bal ance	Fully					
		-	Depreci ated					
			Assets					
		6.00	7.00					
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSET	BALANCES						
1.00	Land	3, 884, 037	0					1.00
2.00	Land Improvements	2, 988, 795	762, 909					2.00
3.00	Buildings and Fixtures	100, 003, 897	7, 752, 751					3.00
4.00	Building Improvements	113, 748	76, 800					4.00
5.00	Fixed Equipment	13, 704, 628	3, 370, 713					5.00
6.00	Movable Equipment	103, 810, 261	61, 285, 682					6.00
7.00	HIT designated Assets	0	0					7.00
8.00	Subtotal (sum of lines 1-7)	224, 505, 366	73, 248, 855					8.00
9.00	Reconciling Items	0	0					9.00
10.00	Total (line 8 minus line 9)	224, 505, 366	73, 248, 855					10.00

Heal th	Financial Systems	IU HEALTH GOSH	IEN HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECONO	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 150026	Period:	Worksheet A-7	
					From 01/01/2015 To 12/31/2015		nared
					10 12/31/2013	5/27/2016 5:4	7 pm
			SL	IMMARY OF CAP	I TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	Taxes (see	
	Cost center bescription	Depreciation	Lease	Therest		instructions)	
		9.00	10.00	11.00	12.00	13.00	
-	PART II - RECONCILIATION OF AMOUNTS FROM WORK	SHEET A, COLUM	N 2, LINES 1 a	nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	11, 768, 441	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	11, 768, 441	0		0 0	0	3.00
		SUMMARY O	F CAPITAL				
	Cost Conton Decerintian	Other	Total (1) (sum				
	Cost Center Description	Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	thi ough 14)				
		14.00	15.00				
	PART II - RECONCILIATION OF AMOUNTS FROM WORK			nd 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	11, 768, 441				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	11, 768, 441				3.00

Health Financial Systems	IU HEALTH GOSI	HEN HOSPITAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 To 12/31/2015		
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets for Ratio	Ratio (see instructions)	Insurance	
		Leases	(col. 1 - col. 2)			
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FIXT	120, 695, 106					1.00
2.00 CAP REL COSTS-MVBLE EQUIP	103, 810, 261	0				2.00
3.00 Total (sum of lines 1-2)	224, 505, 367	0	224, 505, 367			3.00
	ALLOCA	TION OF OTHER (CAPI TAL	SUMMARY O	F CAPITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate	cols. 5			
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				1		
1.00 CAP REL COSTS-BLDG & FIXT	0	-	(4, 582, 902		1.00
2.00 CAP REL COSTS-MVBLE EQUIP	0	-	(6, 832, 015		2.00
3.00 Total (sum of lines 1-2)	0	°	() 11, 414, 917	0	3.00
		Sl	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
		instructions)	instructions)	Capi tal -Rel ate	of cols. 9	
				d Costs (see instructions)	through 14)	
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 CAP REL COSTS-BLDG & FIXT	1, 629, 723	-1, 566, 063	(0 0	4, 646, 562	1.00
2.00 CAP REL COSTS-MVBLE EQUIP	-1, 303, 592		(0 0	5, 532, 604	2.00
3.00 Total (sum of lines 1-2)	326, 131	-1, 561, 882		0 0	10, 179, 166	3.00

	Financial Systems MENTS TO EXPENSES		IU HEALTH GOS	Provi der CCN: 150026	Peri od:	u of Form CMS-2 Worksheet A-8	
					From 01/01/2015 To 12/31/2015		
				Expense Classification of	on Worksheet A	5/27/2016 5:4	7 pm
				To/From Which the Amount i	s to be Adjusted		
	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 - CAP REL	B		CAP REL COSTS-BLDG & FIXT	1.00	<u> </u>	1
00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL	В	-1 303 592	CAP REL COSTS-MVBLE EQUIP	2.00	11	2
00	COSTS-MVBLE EQUIP (chapter 2) Investment income - other	, D	1,000,072		0.00	0	
00	(chapter 2)		0		0.00	0	
00	Trade, quantity, and time discounts (chapter 8)	В	-37, 891	OTHER ADMINISTRATIVE AND GENERAL	5.02	0	4
00	Refunds and rebates of	В	-899, 451	OTHER ADMINISTRATIVE AND	5. 02	0	Ę
00	expenses (chapter 8) Rental of provider space by	В	-1,075,559	GENERAL CAP REL COSTS-BLDG & FIXT	1.00	9	6
00	suppliers (chapter 8) Telephone services (pay		0		0.00	0	
00	stations excluded) (chapter		0		0.00	0	
00	21) Television and radio service		0		0.00	0	8
00	(chapter 21) Parking Lot (chapter 21)		0		0.00	0	
00 . 00	Provider-based physician	A-8-2	-10, 001, 732		0.00	0	
. 00	adjustment Sale of scrap, waste, etc.		0		0.00	0	1.
	(chapter 23)				0.00		
00	Related organization transactions (chapter 10)	A-8-1	12, 669, 381			0	1
	Laundry and linen service Cafeteria-employees and guests	В	0-880-171	CAFETERI A	0.00 11.00	0	
00	Rental of quarters to employee		-880, 171 0	CALLIERIA	0.00	0	
. 00	and others Sale of medical and surgical		0		0.00	0	1
	supplies to other than					-	
. 00	patients Sale of drugs to other than		0		0.00	0	1
. 00	patients Sale of medical records and	В	-58, 322	MEDICAL RECORDS & LIBRARY	16.00	0	1
	abstracts	_	,				
. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	1
. 00	Vending machines Income from imposition of	В	0 -257 622	OTHER ADMINISTRATIVE AND	0. 00 5. 02	0	2
. 00	interest, finance or penalty	D D		GENERAL	0.02	0	
. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	2
	overpayments and borrowings to repay Medicare overpayments						
. 00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		2
	therapy costs in excess of limitation (chapter 14)						
. 00	Adjustment for physical therapy costs in excess of	A-8-3	0	PHYSI CAL THERAPY	66.00		2
	limitation (chapter 14)						
. 00	Utilization review - physicians' compensation		0	UTILIZATION REVIEW-SNF	114.00		2
00	(chapter 21)		0		1 00	0	
. 00	Depreciation - CAP REL COSTS-BLDG & FIXT		0	CAP REL COSTS-BLDG & FIXT	1.00	0	
. 00	Depreciation - CAP REL COSTS-MVBLE EQUIP		0	CAP REL COSTS-MVBLE EQUIP	2.00	0	2
	Non-physician Anesthetist		0	NONPHYSI CI AN ANESTHETI STS	19.00		28
	Physicians' assistant Adjustment for occupational	A-8-3	0	OCCUPATI ONAL THERAPY	0.00 67.00	0	20
	therapy costs in excess of limitation (chapter 14)						
. 99	Hospice (non-distinct) (see		0	ADULTS & PEDIATRICS	30.00		30
. 00	instructions) Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68.00		3.
	pathology costs in excess of		Ū				
. 00	limitation (chapter 14) CAH HIT Adjustment for		0		0.00	0	32
. 00	Depreciation and Interest OTHER ADJUSTMENTS (SPECIFY)		0		0.00	0	33
	(3)		0		0.00	0	

	IENTS TO EXPENSES			Provider CCN: 150026	Peri od:	Worksheet A-8	
	IENTS TO EXIENSES				From 01/01/2015	WOLKSHEEL A-0	
					To 12/31/2015		
						5/27/2016 5:4	7 pm
				Expense Classification (
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basi s/Code (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
		1.00	2.00	3.00	4.00	5.00	
3. 01	EMT CLASS TUITION	В		PARAMEDI CAL EDUCATI ON	23.00		33.01
				PROGRAM			
3. 02	MISC RADIOLOGY REV	В	-1, 943, 277	RADI OLOGY-DI AGNOSTI C	54.00	0	33.02
3. 03	MISC A&G REVENUE	В	-124, 798	OTHER ADMINISTRATIVE AND	5.02	0	33.03
				GENERAL			
3. 04	PERSONAL AUTO USAGE	A		OTHER ADMINISTRATIVE AND	5.02	0	33.04
				GENERAL		_	
3. 05	ALCOHOLI C BEVERAGE	A		OTHER ADMINISTRATIVE AND	5.02	0	33.05
3.06	LOBBYING EXPENSE	А		GENERAL OTHER ADMINISTRATIVE AND	5.02	0	33.06
3.00	LOBBITING EXFENSE	A		GENERAL	5.02	0	33.00
3.07	SHARED A&G EXPENSE	А		OTHER ADMINI STRATI VE AND	5.02	0	33.07
0.07				GENERAL	0102		
3. 08	PRIMECARE ASSESSMENT	A	-14, 161, 089	OTHER ADMINISTRATIVE AND	5.02	0	33.08
				GENERAL			
3. 10	PHYSI CI ANS RECRUI MENT	A		OTHER ADMINISTRATIVE AND	5.02	0	33.10
				GENERAL			
-	MISC LAB REV	В		LABORATORY	60.00		
	OP REHAB MI DDLEBURY MI SC	В	-210	PHYSICAL THERAPY	66.00	0	33.12
	I NCOME		2 015 221		F 02	0	22.11
3. 13	HAF OFFSET	A		OTHER ADMINISTRATIVE AND GENERAL	5.02	0	33.13
0 00	TOTAL (sum of lines 1 thru 49)		-25,074,162	-			50.00
	(Transfer to Worksheet A,		20,074,102				00.00
	column 6, line 200.)						

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

Heal th	Financial Systems	IU HEALTH GOS	SHEN HOSPITAL	In Lie	eu of Form CMS-	2552-10
	ENT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider CCN: 150026	Period: From 01/01/2015	Worksheet A-8	3-1
OFFICE				To 12/31/2015		
	Line No.	Cost Center	Expense Items	Amount of	Amount	
				Allowable Cost	Included in	
					Wks. A, column	
					5	
	1.00	2.00	3. 00	4.00	5.00	
	A. COSTS INCURRED AND ADJUSTN	ORGANIZATIONS OR	CLAI MED			
	HOME OFFICE COSTS:					
1.00	1.00	CAP REL COSTS-BLDG & FIXT	HOME OFFICE ALLOCATION	1, 929, 950	0	1.00
2.00	2.00	CAP REL COSTS-MVBLE EQUIP	HOME OFFICE ALLOCATION	293, 202	0	2.00
3.00	5. 02	OTHER ADMINISTRATIVE AND GEN	HOME OFFICE ALLOCATION	10, 446, 229	0	3.00
4.00	0.00			0	0	4.00
5.00	TOTALS (sum of lines 1-4).			12, 669, 381	0	5.00
	Transfer column 6, line 5 to					
	Worksheet A-8, column 2,					
	line 12.					

* 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.

has not been posted to worksheet A, cordinaris randzor 2, the amount arrowable should be indicated in cordinaria part.						
				Related Organization(s) and/	or Home Office	
	Symbol (1)	Name	Percentage of	Name	Percentage of	
			Ownershi p		Ownershi p	
	1.00	2.00	3.00	4.00	5.00	
B INTERDELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE						

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 B	0.00 I U HEALTH	0.00 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 GOSHEN H	HOSPI TAL	In Lie	u of Form CMS-2552-10
STATEMENT OF COSTS OF SERVICES FROM RELATED ORGANIZATIO	INS AND HOME	Provider CCN: 150026	Period: From 01/01/2015	Worksheet A-8-1
OFFICE COSTS				Date/Time Prepared:

			5/27/2016 5: 4	
	Net	Wkst. A-7 Ref.		
	Adjustments			
	(col. 4 minus			
	col. 5)*			
	6.00	7.00		
	A. COSTS INCUR	RED AND ADJUSTN	IENTS REQUIRED AS A RESULT OF TRANSACTIONS WITH RELATED ORGANIZATIONS OR CLAIMED	
	HOME OFFICE CO	STS:		
1.00	1, 929, 950	11		1.00
2.00	293, 202	9		2.00
3.00	10, 446, 229	0		3.00
4.00	0	0		4.00
5.00	12, 669, 381			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.

1103 1101	been posted to worksheet A,		
	Related Organization(s)		
	and/or Home Office		
	Type of Business		
	51		
	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	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 organization.

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

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

Heal th	Fi nanci al	Systems	

IU HEALTH GOSHEN HOSPITAL In Lieu of Form CMS-2552-10

near th	Thancial Syste	5113	TO TILALITI OU.	SHEN HUST THE				2332-10
PROVI DE	ER BASED PHYSIC	I AN ADJUSTMENT		Provi der		Period: From 01/01/2015 Fo 12/31/2015	Worksheet A-8	
							5/27/2016 5:4	
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
		Identi fi er	Remuneration	Component	Component		ider Component	
							Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	5. 02	OTHER ADMINISTRATIVE AND	1, 212, 191	9, 768	1, 202, 423	171, 400	3, 450	1.00
		GENERAL						
2.00	16.00	MEDICAL RECORDS & LIBRARY	175, 846	0	175, 846	171, 400	2, 484	2.00
3.00	53.01	PAIN MANAGEMENT	1, 452, 194	1, 416, 194	36,000	171, 400	257	3.00
4.00	54.00	RADI OLOGY-DI AGNOSTI C	6, 963, 150	6, 516, 400	446, 750	231, 100	2, 586	4.00
5.00		LABORATORY	931, 124	906, 124	25,000	219, 500	905	5.00
6.00	90.00	CLINIC	0	0	0	0	0	6.00
7.00	90.02	WOUND CLINIC	27,040	0	27,040	171, 400	126	7.00
8.00	91.00	EMERGENCY	62, 500	0	62, 500			8.00
9.00	0.00		0	0	0			9.00
10.00	0.00		0	0	0	0	0	10.00
200.00			10, 824, 045	8, 848, 486	1, 975, 559		10,030	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE		Cost of		Physician Cost	
		I denti fi er	Limit	Unadjusted RCE		Component	of Malpractice	
		i denti i i en		Limit	Conti nui ng	Share of col.	Insurance	
				2	Education	12	i nour anoo	
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00	5. 02	OTHER ADMINISTRATIVE AND	284, 293		0			1.00
		GENERAL						
2.00	16.00	MEDICAL RECORDS & LIBRARY	204, 691	10, 235	0	0	0	2.00
3.00		PAIN MANAGEMENT	21, 178		0	0	0	3.00
4.00		RADI OLOGY-DI AGNOSTI C	287, 319		0	0	0	4.00
5.00		LABORATORY	95, 504		4, 419	119	0	5.00
6.00		CLINIC	0	0	., ,	0	0	6.00
7.00		WOUND CLINIC	10, 383	-	0	0	0	7.00
8.00		EMERGENCY	18, 294		0	0	0	8.00
9.00	0.00		0,2,1	0	0	0	0	9.00
10.00	0.00			0	0		0	
200.00	0.00		921, 662	46, 084	4, 419	119	-	
200.00	Wkst. A Line #	Cost Center/Physician	Provi der	Adjusted RCE	RCE	Adjustment	0	200.00
	WRSt. A LINE π	I denti fi er	Component	Limit	Di sal I owance	Aujustilient		
		rdentifier	Share of col.		Disarrowance			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		OTHER ADMINISTRATIVE AND	0		918, 130			1.00
1.00	5.02	GENERAL		201,273	,10,100	,2,,0,0		1.00
2.00	16.00	MEDICAL RECORDS & LIBRARY	0	204, 691	0	0		2.00
3.00		PAIN MANAGEMENT	0	21, 178	14, 822	1, 431, 016		3.00
4.00		RADI OLOGY-DI AGNOSTI C	0		159, 431			4.00
5.00		LABORATORY	0	95, 623	0			5.00
6.00		CLINIC	0	0	0	0		6,00
7.00		WOUND CLINIC		10, 383	16, 657	-		7.00
8.00		EMERGENCY		18, 294	44, 206			8.00
9.00	0.00			10, 274	44,200			9.00
9.00 10.00	0.00							10.00
200.00	0.00		0	921, 781	1, 153, 246	10,001,732		200.00
200.00	I	l	1 0	1 721,701	1, 155, 240	10,001,732		200.00

	Financial Systems	IU HEALTH GOSH			eriod: com 01/01/2015	u of Form CMS-: Worksheet B Part I Date/Time Pre	pared:
			CAPI TAL REL	ATED COSTS		5/27/2016 5:4	
	Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFI TS DEPARTMENT	CASHI ERI NG/ACC OUNTS RECEI VABLE	
		0	1.00	2.00	4.00	5. 01	
1.00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	4, 646, 562	4, 646, 562				1.00
2.00 4.00 5.01 5.02 6.00	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00591 OTHER ADMI NI STRATI VE AND GENERAL 00600 MAI NTENANCE & REPAI RS	5, 532, 604 23, 333, 654 2, 028, 935 26, 550, 465 0	53, 781 77, 298 367, 225 0	5, 532, 604 1, 177 6, 216	23, 388, 612 317, 934 3, 812, 559 0	2, 430, 383 0 0	2.00 4.00 5.01 5.02 6.00
7.00 8.00 9.00 10.00 11.00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA	2, 862, 653 601, 288 1, 392, 775 558, 479 290, 810	61, 834	1, 346 10, 004 2, 831 5, 936	268, 839 13, 196 358, 629 82, 265 172, 489	0 0 0 0 0	7.00 8.00 9.00 10.00 11.00
12.00 13.00 14.00 15.00 16.00 17.00 19.00	01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS	0 1, 748, 184 496, 628 1, 660, 162 3, 371, 295 572, 401 0	0 18, 006 30, 584 25, 228 53, 033 7, 661 0	81, 293 6, 693	0 543, 509 75, 461 546, 977 509, 380 202, 552 0		12.00 13.00 14.00 15.00 16.00 17.00 19.00
20. 00 21. 00 22. 00 23. 00	02000 NURSI NG SCHOOL 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMEDI CAL EDUCATI ON PROGRAM I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0 0 0 157, 273	0 0 0	0 0 0	0 0 0 45, 935	000000000000000000000000000000000000000	20. 00 21. 00 22. 00 23. 00
30.00 31.00 32.00 33.00 34.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	7, 997, 770 1, 839, 604 0 0			2, 656, 417 590, 207 0 0	231, 639 58, 937 0 0 0	30.00 31.00 32.00 33.00 34.00
40.00 41.00 42.00 43.00 44.00 45.00 46.00	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY 04600 OTHER LONG TERM CARE	0 0 285, 254 0 0 0	0 0 15, 357 0 0 0	0	0 0 90, 362 0 0 0	0 0 12, 011 0 0 0	40.00 41.00 42.00 43.00 44.00 45.00 46.00
	ANCI LLARY SERVI CE COST CENTERS	1					
	05000 OPERATING ROOM 05100 RECOVERY ROOM	7, 267, 256 472, 149	37, 651	532	1, 488, 362 164, 248		51.00
52.00 53.00	05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	1, 528, 444	82, 298 0	47, 817 0	484, 177 0	34, 709 0	52.00 53.00
53.01 54.00 55.00	05301 PALN MANAGEMENT 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	523, 466 14, 851, 925 338, 556	34, 801 895, 089 10, 143 0	50, 523	303, 395 5, 030, 954 111, 757	7, 094 483, 839 6, 073	53.01 54.00 55.00
56.00 56.01 57.00 58.00	05600 RADI OI SOTOPE 05601 CARDI AC CATH LAB 05700 CT SCAN 05800 MRI	0 1, 468, 683 0 0	32, 639 0 0	0 194, 286 0 0	337, 892 0 0	0 83, 912 0 0	56.00 56.01 57.00 58.00
59.00 60.00 60.01 61.00 62.00	05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0 4,041,150 0 0 0	0 73, 913 0 0	0 72, 708 0 0	0 929, 804 0 0	0 170, 675 0 0	59.00 60.00 60.01 61.00 62.00
63.00 64.00 65.00 66.00 67.00	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	0 0 1, 256, 730 1, 910, 829 538, 120 257, 237	0 0 26, 261 214, 387 0	47, 869 283	0 0 386, 225 563, 203 193, 377 126 042	27, 034 11, 794	66. 00 67. 00
68.00 69.00 70.00 71.00 72.00 73.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS	357, 337 94, 752 0 6, 181, 519 4, 440, 814 21, 874, 660	0 87, 940 0 0 0 0	0 17, 941 0 0 0 0	126, 943 0 0 0 0 0 0	6, 711 20, 825 0 29, 640 63, 129 708, 785	69.00 70.00 71.00 72.00 73.00
74.00 75.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	0	0 0	0	74.00 75.00
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0		88. 00 89. 00

Health Financial Systems	IU HEALTH GOSH	HEN HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I	pared:
		CAPI TAL REL	LATED COSTS			
Cost Center Description	Net Expenses for Cost Allocation (from Wkst A col. 7)	BLDG & FIXT	MVBLE EQUIP	BENEFI TS DEPARTMENT	CASHI ERI NG/ACC OUNTS RECEI VABLE	
	0	1.00	2.00	4.00	5. 01	
90. 00 09000 CLINIC	364, 719		15, 13			
90. 02 09002 WOUND CLINIC	1, 263, 518				25, 277	90. 02
90. 03 09003 MOBILE CLINIC	1, 058		0/20		0	90.03
91.00 09100 EMERGENCY	3, 116, 723	242, 750	49, 02	869, 841	119, 989	
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
OTHER REIMBURSABLE COST CENTERS				a		
99.00 09900 CMHC	0	, s		0 0	0	
101.00 10100 HOME HEALTH AGENCY	2,013,395	30, 442	13, 25	644, 309	8,6/4	101.00
SPECIAL PURPOSE COST CENTERS						112 00
113.00 11300 INTEREST EXPENSE						113.00 114.00
114.00 11400 UTI LI ZATI ON REVIEW-SNF		0		0		
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	1 522 405	0		0 07(000		115.00
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1-117)	1, 532, 485			0 276, 028		
118.00 SUBTOTALS (SUM OF LINES 1-117) NONREI MBURSABLE COST CENTERS	161, 365, 084	4, 402, 172	5, 480, 28	22, 280, 742	2, 430, 383	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 868, 351	133, 229	35, 22	456, 355	0	190.00
190. 01 19000 OTHER NR/CHP-GRANT I/COMMUNITY ED	143,044			0 450, 355 0 60, 490		190.00
190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	143, 044	54,755		0 00,490		190.01
190. 03 19003 LI FELI NE	0	0		0 0		190.02
190. 04 19004 COMMUNI TY RELATIONS	5, 494, 674	56, 406	16, 38	382,044		190.03
190. 05 19005 PRI VATE DUTY	5, 494, 074	50, 400	10, 30	0 0		190.04
190. 06 19006 PROFESSIONAL DEVELOPMENT	1, 334, 593	0		0 5, 289		190.05
190. 07 19007 FOUNDTI ON	1, 334, 393	0		0 5,209		190.00
190. 08 19008 GOSHEN GACC CLINIC	62, 794			0 0		190.07
191. 00 19100 RESEARCH	826, 591	0	71			190.08
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	020, 391	0	/ 1	4 203, 092		191.00
193. 00 19300 NONPALD WORKERS	0	0		0 0		192.00
200.00 Cross Foot Adjustments	0	0		0	0	200.00
200.00 Regative Cost Centers				0		200.00
202.00 TOTAL (sum lines 118-201)	171, 095, 146	4, 646, 562	5, 532, 60	23, 388, 612		

1.00 2.00 4.00 5.01	Cost Center Description	Subtotal			To	12/31/2015	Date/Time Pre	narod
1.00 2.00 4.00 5.01	Cost Center Description	Subtotal	i i			12/01/2010	5/27/2016 5:4	pareu: 7 pm
1.00 2.00 4.00 5.01		Subtotal	OTHER ADMI NI STRATI VE AND GENERAL	MAI NTENANCE REPAI RS	&	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	
1.00 2.00 4.00 5.01		5A. 01	5. 02	6.00		7.00	8.00	
2.00 4.00 5.01	GENERAL SERVICE COST CENTERS	1	1	1	_			1 00
4.00 5.01	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP							1.00 2.00
	00400 EMPLOYEE BENEFITS DEPARTMENT							4.00
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE							5.01
1	00591 OTHER ADMINI STRATI VE AND GENERAL 00600 MAINTENANCE & REPAIRS	32, 496, 488			0			5.02 6.00
	00700 OPERATION OF PLANT	3, 537, 460			0	4, 366, 871		7.00
	00800 LAUNDRY & LINEN SERVICE	637, 768		1	0	25, 281	812, 583	8.00
	00900 HOUSEKEEPING	1, 767, 097		1	0	6, 556	0	9.00
	01000 DI ETARY 01100 CAFETERI A	673, 067 531, 069		1	0	33, 987 71, 258	0	10.00
	01200 MAINTENANCE OF PERSONNEL	C			0	0	0	12.00
	01300 NURSING ADMINISTRATION	2, 619, 131		1	0	20, 751	0	13.00
	01400 CENTRAL SERVICES & SUPPLY	683, 966		1	0	35, 246	0	14.00
	01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY	2, 239, 060 3, 960, 703		1	0	29, 073 61, 116	0	15.00 16.00
	01700 SOCIAL SERVICE	784, 164		1	0	8, 829	0	17.00
	01900 NONPHYSI CI AN ANESTHETI STS	C			0	0	0	19.00
	02000 NURSING SCHOOL 02100 I & SERVICES-SALARY & FRINGES APPRV				0	0	0	20.00
	02200 I &R SERVICES-OTHER PRGM COSTS APPRV				0	0	0	21.00
	02300 PARAMEDICAL EDUCATION PROGRAM	205, 880	48, 272	2	0	3, 080	0	23.00
	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	11, 479, 850	2, 691, 623		0	510, 907	175, 742	30.00
	03100 I NTENSI VE CARE UNI T	2, 741, 930			0	136, 330	51, 807	31.00
	03200 CORONARY CARE UNI T	C) C	þ	0	0	0	32.00
	03300 BURN INTENSIVE CARE UNIT	C			0	0	0	33.00
	03400 SURGI CAL INTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF				0	0	0	34.00 40.00
	04100 SUBPROVI DER – I RF				0	0	0	41.00
	04200 SUBPROVI DER	C) C		0	0	0	42.00
	04300 NURSERY	411, 908	96, 578		0	17, 698	5, 438	43.00
	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY				0	0	0	44.00
46.00	04600 OTHER LONG TERM CARE	C	0)	0	0	0	46.00
	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM	11,060,960	2, 593, 408	5	0	757, 190	190, 005	50.00
	05100 RECOVERY ROOM	695, 180		1	0	43, 390	190,003	51.00
	05200 DELIVERY ROOM & LABOR ROOM	2, 177, 445	510, 535	5	0	94, 842	29, 138	1
	05300 ANESTHESI OLOGY 05301 PALN MANAGEMENT	C 940 294	203, 817		0	0	0	1
	05400 RADI OLOGY-DI AGNOSTI C	869, 286 22, 231, 419			0	40, 105 1, 031, 517	165, 881	
55.00	05500 RADI OLOGY-THERAPEUTI C	517, 052			0	11, 689	0	55.00
	05600 RADI OI SOTOPE	0 117 110			0	0	0	
	05601 CARDIAC CATH LAB 05700 CT SCAN	2, 117, 412	496, 459		0	37, 614	4, 548 0	
	05800 MRI	C) C		0	Ő	0	
	05900 CARDI AC CATHETERI ZATI ON	C			0	0	0	59.00
	06000 LABORATORY 06001 BLOOD LABORATORY	5, 288, 250	1, 239, 910		0	85, 179 0	0	60.00 60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			Ŭ	Ŭ	0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	C) C		0	0	0	62.00
	06300 BLOOD STORING, PROCESSING & TRANS.	C			0	0	0	63.00
	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	1, 722, 916	403, 963		0	0 30, 264	0	64.00 65.00
	06600 PHYSI CAL THERAPY	2, 763, 322		1	0	247, 063	0	66.00
	06700 OCCUPATI ONAL THERAPY	743, 574		1	0	0	0	67.00
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	490, 991 221, 458			0	0 101, 344	0	68.00 69.00
	07000 ELECTROENCEPHALOGRAPHY	221,450) 51, 924		0	01, 344	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	6, 211, 159		1	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	4, 503, 943		1	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	22, 583, 445	5, 294, 980		0	0	0	73.00
	07500 ASC (NON-DI STI NCT PART)	C			0	0	0	
(OUTPATIENT SERVICE COST CENTERS	1	1		_			
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER				0	0	0	88.00 89.00
	09000 CLINIC	492, 832	115, 552		0	27, 102	0	90.00
	09002 WOUND CLINIC	1, 526, 964	358, 020		0	267, 923	0	90.02
90.03	09003 MOBILE CLINIC	6, 393 4, 398, 325			0	0	0	90.03

Health Financial Systems	IU HEALTH GOS	HEN HOSPITAL		In Li	eu of Form CMS-2	552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150026	Period: From 01/01/201 To 12/31/201		
Cost Center Description		OTHER ADMI NI STRATI VE AND GENERAL		PLANT	LAUNDRY & LINEN SERVICE	
	5A. 01	5.02	6.00	7.00	8.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0					92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900 CMHC	0	0		0	0 0	99.00
101.00 10100 HOME HEALTH AGENCY	2, 710, 071	635, 417		0 35, 08	2 0	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0		115.00
116.00 11600 HOSPI CE	1, 858, 568	435, 769		0 35,06	3 O [/]	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	159, 960, 506	29, 885, 804		0 4, 085, 23	3 812, 583 ⁻	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 493, 158	584, 558		0 153, 53	5 0	190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	258, 289	60, 560		0 63, 10	o o'	190. 01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0	o o'	190. 02
190. 03 19003 LI FELI NE	0	0		0	o o'	190. 03
190. 04 19004 COMMUNI TY RELATI ONS	5, 949, 505	1, 394, 951		0 65,00	3 0	190. 04
190. 05 19005 PRI VATE DUTY	0	0		0	o o'	190. 05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	1, 339, 882	314, 155		0	o o'	190. 06
190. 07 19007 FOUNDTI ON	15	4		0	o o'	190. 07
190. 08 19008 GOSHEN GACC CLINIC	62, 794	14, 723		0	o o'	190. 08
191. 00 19100 RESEARCH	1,030,997	241, 733		0	o o'	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0	o o'	192.00
193. 00 19300 NONPALD WORKERS	0	0		0		193.00
200.00 Cross Foot Adjustments	0					200.00
201.00 Negative Cost Centers	0	0		0	ol ol:	201.00
202.00 TOTAL (sum lines 118-201)	171, 095, 146	32, 496, 488		0 4, 366, 87	1 812, 583	202.00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	IU HEALTH GOSHE			Period:	u of Form CMS-2 Worksheet B	2552-10
					From 01/01/2015 To 12/31/2015	Part I Date/Time Pre	pared:
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	MAINTENANCE OF	5/27/2016 5: 4 NURSI NG	7 pm
	·	9.00	10.00	11.00	PERSONNEL 12.00	ADMI NI STRATI ON 13.00	
	GENERAL SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.01	00400 EMPLOYEE BENEFITS DEPARTMENT 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						4.00 5.01
5.02	00591 OTHER ADMINI STRATI VE AND GENERAL						5. 02
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00 9.00	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING	2, 187, 975					8.00 9.00
10.00	01000 DI ETARY	17, 154	882, 019				10.00
11.00	01100 CAFETERI A	35, 965	0	762, 809	9		11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	(0.005.000	12.00
13.00 14.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY	10, 473 17, 789	0	20, 553 5, 823		3, 285, 003 0	13.00 14.00
15.00	01500 PHARMACY	14, 674	0	17, 570		0	15.00
16.00	01600 MEDI CAL RECORDS & LI BRARY	30, 846	0	26, 971		0	16.00
17.00	01700 SOCIAL SERVICE	4, 456	0	9, 953	3 0	0	17.00
19.00 20.00	01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL	0	0	(0	19.00 20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	(0 0	0	21.00
22.00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0	(-	0	22.00
23.00	02300 PARAMEDICAL EDUCATION PROGRAM	1, 554	0	(0 0	0	23.00
30, 00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS	257, 865	761, 346	138, 141	0	1, 109, 554	30.00
31.00	03100 I NTENSI VE CARE UNI T	68, 808	120, 673	25, 490		272, 636	31.00
32.00	03200 CORONARY CARE UNI T	0	0	(0 0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0	(0	0	33.00
34.00 40.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF	0	0	ĺ		0	34.00 40.00
41.00	04100 SUBPROVI DER – I RF	0	0	(0 0	0	41.00
42.00	04200 SUBPROVI DER	0	0	(-	0	42.00
43.00		8, 933	0	4, 357		36, 888	
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	(0	44.00 45.00
46.00	04600 OTHER LONG TERM CARE	0	0	(°	0	46.00
	ANCILLARY SERVICE COST CENTERS				1		
50.00	05000 OPERATING ROOM	382, 168	0	66, 568		448, 822	50.00
51.00 52.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	21, 900 47, 869	0	5, 993 23, 344		73, 266 197, 649	
53.00	05300 ANESTHESI OLOGY	0	0	(0	53.00
53.01	05301 PALN MANAGEMENT	20, 242	0	5, 845		35, 468	
54.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	520, 628 5, 900	0	151, 684 6, 038		282, 087 13, 019	
		5, 400	0	0, 030		13, 019	56.00
56.01	05601 CARDI AC CATH LAB	18, 984	0	12, 445	5 0	78, 520	
57.00	05700 CT SCAN	0	0	(0	0	57.00
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0	(0	58.00 59.00
60.00	06000 LABORATORY	42, 991	0	38, 604	1 0	6, 618	60.00
60. 01	06001 BLOOD LABORATORY	0	0	(0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	(0	62.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	(0	64.00
65.00	06500 RESPI RATORY THERAPY	15, 275	0	16, 881		0	65.00
66.00	06600 PHYSI CAL THERAPY	124, 698	0	29, 222		0	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	7,806 4,585		0	67.00 68.00
	06900 ELECTROCARDI OLOGY	51, 150	0	4, 500		0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	(0	0	70.00
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	0	0	(0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	(0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	0	0	(0	73.00 74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	(0 0	0	75.00
	OUTPATIENT SERVICE COST CENTERS	1 1					
	08800 RURAL HEALTH CLINIC	0	0	(0	88.00
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	13, 679	0	3, 993		0	89.00 90.00
	09002 WOUND CLINIC	135, 226	0	(0	0	90.02
90.03	09003 MOBILE CLINIC	0	0	2	2 0	0	90.03
91.00 92.00	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	141, 195	0	44, 414	+ 0	363, 202	91.00 92.00
72.00	OF THE TRACE OF THE TART				1		72.00

Health Financial Systems	IU HEALTH GOSH	EN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Prep 5/27/2016 5:4	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	
	9.00	10.00	11.00	12.00	13.00	
OTHER REIMBURSABLE COST CENTERS						
99. 00 09900 CMHC	0	0		0 0	0	99.00
101.0010100 HOME HEALTH AGENCY	17, 706	0	27, 35	0 0	134, 023	101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	17 (00	0	10.00	0 0		115.00
116.00 11600 HOSPI CE 118.00 SUBTOTALS (SUM OF LINES 1-117)	17, 699 2, 045, 827	000.010	13, 22 706, 85		83, 228 3, 134, 980	
NONREIMBURSABLE COST CENTERS	2,045,827	882, 019	700, 85	0	3, 134, 980	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	77, 492	0	23, 15		91, 014	100 00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	31,848	0	23, 13			190.00
190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	51, 640	0	2,00			190.01
190. 03 19003 LI FELI NE	0	0				190.02
190. 04 19004 COMMUNITY RELATIONS	32, 808	0	19, 50	0		190.03
190. 05 19005 PRI VATE DUTY	02,000	0	17,00	0 0		190.05
190. 06 19006 PROFESSIONAL DEVELOPMENT	0	0		0 0		190.06
190. 07 19007 FOUNDTI ON	0	0		0 0	0	190.07
190. 08 19008 GOSHEN GACC CLINIC	0	0		0 0	0	190. 08
191. 00 19100 RESEARCH	0	0	10, 48	30 O	58, 743	191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0	0	192.00
193.00 19300 NONPALD WORKERS	0	0		0 0	0	193.00
200.00 Cross Foot Adjustments						200. 00
201.00 Negative Cost Centers	0	0		0 0		201.00
202.00 TOTAL (sum lines 118-201)	2, 187, 975	882, 019	762, 80	09 0	3, 285, 003	202.00

	Financial Systems	IU HEALTH GOSHE		CON. 150004		u of Form CMS-2	2552-10
CUST A	ALLOCATION - GENERAL SERVICE COSTS		Provi der	CCN: 150026	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part I Date/Time Pre 5/27/2016 5:4	pared: 7 pm
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCI AL SERVI CE	NONPHYSI CI AN ANESTHETI STS	
		14.00	15.00	16.00	17.00	19.00	
1 00	GENERAL SERVICE COST CENTERS						1 1 00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 15.\ 00\\ 14.\ 00\\ 17.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFITS DEPARTMENT 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00591 OTHER ADMINI STRATI VE AND GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-OTHER PRGM COSTS APPRV	903, 190 2, 190 1 20 0 0 0 0 0	2, 827, 548 0 0 0 0 0 0 0 0	5, 008, 28	33 0 991, 281 0 0 0 0 0 0 0 0 0 0 0 0 0	0	1.00 2.00 4.00 5.01 5.02 6.00 7.00 8.00 9.00 10.00 11.00 13.00 14.00 14.00 14.00 14.00 14.00 14.00 14.00 20.00 22.00
23.00	02300 PARAMEDICAL EDUCATION PROGRAM	0	0		0 0		23.00
20.25	INPATIENT ROUTINE SERVICE COST CENTERS	10, 10-			10 7// 7=-		20.05
30.00 31.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	40, 697 15, 251	0	477, 3 ⁻ 121, 44		0	30.00
32.00	03200 CORONARY CARE UNIT	0	0	121, 4	0 0	0	32.00
33.00	03300 BURN INTENSIVE CARE UNIT	0	0		0 0	0	33.00
34.00	03400 SURGI CAL INTENSI VE CARE UNI T	0	0		0 0	0	34.00
40.00 41.00	04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF	0	0			0	40.00
42.00	04200 SUBPROVI DER	0	0		0 0	0	42.00
43.00	04300 NURSERY	1, 673	0	24, 74		0	43.00
44.00 45.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0		0 0	0	44.00 45.00
46.00	04600 OTHER LONG TERM CARE	0	0		0 0	0	46.00
	ANCI LLARY SERVICE COST CENTERS	· · · · ·		1			
50.00 51.00	05000 OPERATING ROOM 05100 RECOVERY ROOM	397, 536 3, 516	0	488, 40		0	
52.00	05200 DELIVERY ROOM & LABOR ROOM	8, 964	0	71, 52		0	52.00
53.00	05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
53.01	05301 PALN MANAGEMENT 05400 RADI OLOGY-DI AGNOSTI C	80 100, 706	0	14, 6 ⁻ 996, 98		0	
54.00 55.00	05500 RADI OLOGY - THERAPEUTI C	568	0	12, 5		0	54.00
	05600 RADI OI SOTOPE	0	0		0 0	0	56.00
56.01	05601 CARDI AC CATH LAB	129, 686	0	172, 90	07 0	0	56.01
57.00 58.00	05700 CT SCAN 05800 MRI	0	0			0	57.00 58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00		108, 250	0	351, 68	38 0	0	60.00
60. 01 61. 00	06001 BLOOD LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		0 0	0	60.01 61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 7, 956	0	74, 98	0 0	0	64.00 65.00
66.00	06600 PHYSI CAL THERAPY	834	0	55, 70		0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	306	0	24, 30		0	67.00
68.00 69.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	164 239	0	13, 82 42, 91		0	68.00 69.00
	07000 ELECTROCARDIOLOGI	239	0	42,9	0 0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	61, 0		0	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0 2 927 E40	130, 08		0	72.00
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DI ALYSI S	0	2, 827, 548 0	1, 460, 80	0 0	0	73.00
	07500 ASC (NON-DI STI NCT PART)	0	0		0 0	0	
00.00	OUTPATIENT SERVICE COST CENTERS			1			
88.00 89.00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	88.00 89.00
	09000 CLINIC	436	0	12, 30	-	0	90.00
90.02	09002 WOUND CLINIC	19, 503	0	52, 08	36 0	0	90.02
	09003 MOBILE CLINIC	7	0	247 2	0 0	0	90.03
91.00	09100 EMERGENCY	24, 201	0	247, 24	46 120, 283	0	91.00

Health Financial Systems	IU HEALTH GOSH	EN HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der	F	eriod: rom 01/01/2015 o 12/31/2015	Date/Time Pre 5/27/2016 5:4	
Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	ANESTHETI STS	
	14.00	15.00	16.00	17.00	19.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900 CMHC	0	0	C	0	0	99.00
101.00 10100 HOME HEALTH AGENCY	2, 769	0	17, 874	. 0	0	101.00
SPECIAL PURPOSE COST CENTERS						1
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	C	0	0	115.00
116.00 11600 HOSPI CE	37, 106	0	40, 438	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	902, 659	2, 827, 548				118.00
NONREI MBURSABLE COST CENTERS		_,,	-,,	,		1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	332	0	C	0	0	190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	7	0	C	0	0	190.01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0	C	0	0	190.02
190. 03 19003 LI FELI NE	0	0	C	0	0	190.03
190. 04 19004 COMMUNITY RELATIONS	149	0	C	0	0	190.04
190. 05 19005 PRI VATE DUTY	0	0	C	0	0	190.05
190.06 19006 PROFESSIONAL DEVELOPMENT	0	0	C	0		190.06
190. 07 19007 FOUNDTI ON	0	0	C	0		190.07
190. 08 19008 GOSHEN GACC CLINIC	0	0	C	0		190.08
191. 00 19100 RESEARCH	43	0	C	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	C	0		192.00
193. 00 19300 NONPALD WORKERS	0	0	C	0		193.00
200.00 Cross Foot Adjustments	Ű	0		0		200.00
201.00 Negative Cost Centers	0	0	C C	0		201.00
202.00 TOTAL (sum Lines 118-201)	903, 190	2,827,548	5, 008, 283	991, 281		202.00
	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	2,027,040	0,000,200	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,	0	1-02.00

				Errom 01/01/201E		
				From 01/01/2015 To 12/31/2015	Part I Date/Time Pre	epared:
		INTERNS &	RESI DENTS		5/27/2016 5:4	7 pm
Cost Center Description NURSING SCH		& FRINGES	SERVICES-OTHE PRGM COSTS	EDUCATI ON	Subtotal	
20.00		APPRV 21.00	APPRV 22.00	PROGRAM 23.00	24.00	
GENERAL SERVICE COST CENTERS		21.00	22.00	23.00	24.00	
1.00 00100 CAP REL COSTS-BLDG & FIXT						1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00
5. 01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.01
5. 02 00591 OTHER ADMINI STRATI VE AND GENERAL						5.02
6. 00 00600 MAI NTENANCE & REPAI RS						6.00
7. 00 00700 OPERATION OF PLANT 8. 00 00800 LAUNDRY & LINEN SERVICE						7.00
9. 00 00900 HOUSEKEEPING						9.00
10. 00 01000 DI ETARY						10.00
11. 00 01100 CAFETERI A 12. 00 01200 MAI NTENANCE OF PERSONNEL						11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON						12.00
14. 00 01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 01500 PHARMACY						15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 17. 00 01700 SOCI AL SERVI CE						16.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS						19.00
20. 00 02000 NURSI NG SCHOOL	0					20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV		0				21.00
22. 00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV 23. 00 02300 PARAMEDI CAL EDUCATI ON PROGRAM				0 258, 786		22.00
INPATIENT ROUTINE SERVICE COST CENTERS			1	230,700		23.00
30. 00 03000 ADULTS & PEDI ATRI CS	0	0		0 0	18, 409, 807	
31. 00 03100 I NTENSI VE CARE UNI T	0	0		0 0	4, 280, 920	
32. 00 03200 CORONARY_CARE_UNI T 33. 00 03300 BURN_INTENSI VE_CARE_UNI T	0	0		0 0	0	
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	0		0 0	0	
40. 00 O4000 SUBPROVIDER - IPF	0	0		0 0	0	
41. 00 04100 SUBPROVI DER – I RF 42. 00 04200 SUBPROVI DER	0	0		0 0	0	
43. 00 04300 NURSERY	o	0		0 0	611, 602	
44.00 04400 SKILLED NURSING FACILITY	0	0		0 0	0	
45.00 04500 NURSI NG FACI LI TY	0	0		0 0	0	
46. 00 04600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	U	0	1	0 0	0	46.00
50. 00 05000 OPERATI NG ROOM	0	0)	0 0	16, 385, 057	50.00
51.00 O5100 RECOVERY ROOM	0	0		0 0	1, 048, 688	
52. 00 05200 DELI VERY ROOM & LABOR ROOM 53. 00 05300 ANESTHESI OLOGY	0	0		0 0	3, 178, 489	52.00
53. 01 05301 PALN MANAGEMENT	0	0		0 0	1, 189, 461	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	30, 693, 398	54.00
55. 00 O5500 RADI OLOGY-THERAPEUTI C	0	0		0 0	688, 010	1
56. 00 05600 RADI 0I SOTOPE 56. 01 05601 CARDI AC CATH LAB	0	0		0 0	0 3, 068, 575	
57. 00 05700 CT SCAN	0	0		0 0	0	
58.00 05800 MRI	0	0		0 0	0	
59. 00 05900 CARDIAC CATHETERIZATION 60. 00 06000 LABORATORY	0	0			0 7, 161, 490	
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0	
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY					0	
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	63.00 64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	2, 272, 239	
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	3, 868, 746	
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0			950, 331 624, 689	
69. 00 06900 ELECTROCARDI OLOGY	0	0		o o	469, 027	
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1	0 0	7, 728, 534	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS	0	0			5, 690, 042 32, 166, 773	
74. 00 07400 RENAL DI ALYSI S	0	0		0 0	0	
75. 00 07500 ASC (NON-DI STI NCT PART)	0	0		0 0	0	75.00
OUTPATIENT SERVICE COST CENTERS	0	0		0 0	0	88.00
				0 0	0	UO. UU
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0	0	89.00
	0	0		0 0	0 665, 958 2, 359, 722	90.00

Health Financial Systems	IU HEALTH GOS	HEN HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provi der		Peri od:	Worksheet B	
				From 01/01/2015	Part I	
				To 12/31/2015	Date/Time Pre 5/27/2016 5:4	pared: 7 nm
		INTERNS &	RESI DENTS		1 37 217 2010 3. 4	
			NEOT DENTO			
Cost Center Description	NURSING SCHOOL	SERVI CES-SALAR	SERVI CES-OTHE	R PARAMEDI CAL	Subtotal	
		Y & FRINGES	PRGM COSTS	EDUCATI ON		
		APPRV	APPRV	PROGRAM		
	20.00	21.00	22.00	23.00	24.00	
90.03 09003 MOBILE CLINIC	0	0 0		0 0	7, 901	90.03
91. 00 09100 EMERGENCY	0	0		0 258, 786	7, 098, 678	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REI MBURSABLE COST CENTERS	1	1				
99.00 09900 CMHC	0	-		0 0	0	
101.00 10100 HOME HEALTH AGENCY	0	0		0 0	3, 580, 292	101.00
SPECIAL PURPOSE COST CENTERS		1	1			
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF		_		_	_	114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116.00 11600 HOSPI CE	0	0		0 0 0	2, 521, 102	
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0	1	0 258, 786	156, 719, 531	118.00
NONREI MBURSABLE COST CENTERS					2 422 247	100.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	0		0 0	3, 423, 247	1
	0	0		0 0	416, 612	190.01
190. 02 19002 GI FT, FLOWER, COFFEE SHOP, & CANTEE 190. 03 19003 LI FELI NE		0		0 0		190.02
190. 04 19004 COMMUNITY RELATIONS		0		0 0	7, 462, 187	
190. 05 19005 PRI VATE DUTY	0			0 0		190.04
190. 06 19006 PROFESSIONAL DEVELOPMENT		0		0 0	1, 654, 037	
190. 07 19007 FOUNDTI ON	0					190.00
190. 08 19008 GOSHEN GACC CLINIC	0					190.07
191, 00 19100 RESEARCH					1, 341, 996	
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES						192.00
193. 00 19300 NONPAI D WORKERS	0			0 0		193.00
200.00 Cross Foot Adjustments		0		0 0		200.00
201.00 Negative Cost Centers		0		0 0		200.00
202.00 TOTAL (sum lines 118-201)		0		0 258, 786		
			1		,,	

IST AL	Financial Systems LOCATION - GENERAL SERVICE COSTS	IU HEALTH GOSHE		CCN: 150026	Period: From 01/01/2015 To 12/31/2015	u of Form CMS-2 Worksheet B Part I Date/Time Pre	
					12/01/2013	5/27/2016 5: 4	
	Cost Center Description	Intern & Residents Cost	Total				
		& Post					
		Stepdown					
		Adjustments					
		25.00	26.00				
H	GENERAL SERVICE COST CENTERS						1.
	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						2.
	00400 EMPLOYEE BENEFITS DEPARTMENT						4.
	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.
	00591 OTHER ADMINI STRATI VE AND GENERAL						5.
	00600 MAINTENANCE & REPAIRS						6.
00	00700 OPERATION OF PLANT						7.
00	00800 LAUNDRY & LINEN SERVICE						8.
	00900 HOUSEKEEPI NG						9.
	01000 DI ETARY						10.
	01100 CAFETERIA						11.
	01200 MAINTENANCE OF PERSONNEL						12.
	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13. 14.
	01400 CENTRAL SERVICES & SUPPLY						14.
	01600 MEDICAL RECORDS & LIBRARY						15.
	01700 SOCIAL SERVICE						17.
	01900 NONPHYSI CLAN ANESTHETI STS						19
	02000 NURSING SCHOOL						20.
. 00	02100 I&R SERVICES-SALARY & FRINGES APPRV						21.
. 00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV						22.
	02300 PARAMEDICAL EDUCATION PROGRAM						23.
	INPATIENT ROUTINE SERVICE COST CENTERS	- I I -					
	03000 ADULTS & PEDIATRICS	0	18, 409, 807				30.
	03100 I NTENSI VE CARE UNI T	0	4, 280, 920				31.
	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0	0				32. 33.
	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0				34.
	04000 SUBPROVIDER - IPF	0	0				40.
	04100 SUBPROVI DER – I RF	0	0				41.
	04200 SUBPROVI DER	0	0				42.
. 00	04300 NURSERY	0	611, 602				43.
	04400 SKILLED NURSING FACILITY	0	0				44.
	04500 NURSING FACILITY	0	0				45.
	04600 OTHER LONG TERM CARE	0	0				46.
	ANCI LLARY SERVI CE COST CENTERS	0	16, 385, 057				50
	05100 RECOVERY ROOM	0	1, 048, 688				50. 51.
	05200 DELIVERY ROOM & LABOR ROOM	0	3, 178, 489				52.
	05300 ANESTHESI OLOGY	0	0, 170, 107				53.
	05301 PALN MANAGEMENT	0	1, 189, 461				53.
	05400 RADI OLOGY-DI AGNOSTI C	0	30, 693, 398				54.
. 00	05500 RADI OLOGY-THERAPEUTI C	0	688, 010				55.
	05600 RADI OI SOTOPE	0	0				56
	05601 CARDIAC CATH LAB	0	3, 068, 575				56.
	05700 CT SCAN	0	0				57
		0	0				58
	05900 CARDI AC CATHETERI ZATI ON	0	7 161 400				59
	06000 LABORATORY 06001 BLOOD LABORATORY	0	7, 161, 490 0				60 60
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	J	0				61
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0				62
	06300 BLOOD STORING, PROCESSING & TRANS.	0	0				63
	06400 I NTRAVENOUS THERAPY	0	o				64
	06500 RESPI RATORY THERAPY	0	2, 272, 239				65
00	06600 PHYSI CAL THERAPY	0	3, 868, 746				66
	06700 OCCUPATI ONAL THERAPY	0	950, 331				67
	06800 SPEECH PATHOLOGY	0	624, 689				68
	06900 ELECTROCARDI OLOGY	0	469, 027				69
	07000 ELECTROENCEPHALOGRAPHY	0	7 700 504				70
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	7,728,534				71
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	5,690,042				72
	07300 DRUGS CHARGED TO PATIENTS	0	32, 166, 773 0				73
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0				74
	OTSOURSE (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0				1 'S
	08800 RURAL HEALTH CLINIC	0	0				88
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				89
~~	09000 CLINIC	0	665, 958				90.
. 00							

Health Financial Systems	IU HEALTH GOSHEN	N HOSPI TAL	In Lieu of Form CM	IS-2552-10
COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 150026	Period: Worksheet From 01/01/2015 Part I To 12/31/2015 Date/Time I 5/27/2016 5/27/2016 1000000000000000000000000000000000000	Prepared:
Cost Center Description	Intern & Residents Cost	Total		
	& Post			
	Stepdown			
	Adjustments			
	25.00	26.00		
90. 03 09003 MOBILE CLINIC	0	7, 901		90.03
91. 00 09100 EMERGENCY	0	7, 098, 678		91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			92.00
OTHER REIMBURSABLE COST CENTERS		-		
99.00 09900 CMHC	0	0		99.00
101.00 10100 HOME HEALTH AGENCY	0	3, 580, 292		101.00
SPECIAL PURPOSE COST CENTERS 113.00 I 11300 I NTEREST EXPENSE				113.00
114. 00 11400 UTI LI ZATI ON REVIEW-SNF				114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		115.00
116. 00 11600 HOSPI CE	0	2, 521, 102		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	156, 719, 531		118.00
NONREI MBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3, 423, 247		190. 00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	416, 612		190. 01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		190. 02
190. 03 19003 LI FELI NE	0	0		190. 03
190. 04 19004 COMMUNITY RELATIONS	0	7, 462, 187		190.04
190. 05 19005 PRI VATE DUTY	0	0		190.05
190. 06 19006 PROFESSIONAL DEVELOPMENT	0	1, 654, 037		190.06
190. 07 19007 FOUNDTI ON 190. 08 19008 GOSHEN GACC CLI NI C	0	19 77, 517		190. 07 190. 08
191. 00 19100 RESEARCH	0	1, 341, 996		190.08
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	1, 341, 990		192.00
193. 00 19300 NONPALD WORKERS	0	0		193.00
200.00 Cross Foot Adjustments	Ő	o		200.00
201.00 Negative Cost Centers	0	O		201.00
202.00 TOTAL (sum lines 118-201)	0	171, 095, 146		202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	IU HEALTH GOSH			eriod:	u of Form CMS-2 Worksheet B	2552-10
					rom 01/01/2015 o 12/31/2015	Part II Date/Time Pre	pared:
	· · · · · · · · · · · · · · · · · · ·		CAPITAL RE	LATED COSTS		5/27/2016 5:4	7 pm
	Cost Center Description	Directly Assigned New Capital	BLDG & FIXT	MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
		Related Costs 0	1.00	2.00	2A	4.00	
	GENERAL SERVICE COST CENTERS	0	1.00	2.00	28	4.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00 4.00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT	0	53, 781	1, 177	54, 958	54, 958	2.00 4.00
5.01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE	0	77, 298			747	
5.02	00591 OTHER ADMINISTRATIVE AND GENERAL	0	367, 225	1, 766, 239	2, 133, 464	8, 960	•
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT	0	0 358, 946	0 47, 022	0 405, 968	0 632	
7.00 8.00	00800 LAUNDRY & LINEN SERVICE	0	21, 938			31	
9.00	00900 HOUSEKEEPI NG	0	5, 689			843	•
10.00	01000 DI ETARY	0	29, 492			193	•
11. 00 12. 00	01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL	0	61, 834	5, 936	67, 770	405 0	
12.00	01300 NURSI NG ADMI NI STRATI ON	0	18, 006	309, 432	327, 438	1, 277	
	01400 CENTRAL SERVICES & SUPPLY	0	30, 584			177	1
	01500 PHARMACY	0	25, 228			1, 285	•
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE	0	53, 033 7, 661			1, 197 476	•
	01900 NONPHYSI CI AN ANESTHETI STS	0	0	1, 550	9,211	470	1
20.00	02000 NURSI NG SCHOOL	0	0	0	0	0	
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	
22. 00 23. 00	02200 I & R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMEDICAL EDUCATION PROGRAM	0	2,672		0 2,672	0 108	
23.00	INPATIENT ROUTINE SERVICE COST CENTERS	0	2,072	0	2,072	100	23.00
30.00	03000 ADULTS & PEDIATRICS	0	443, 335			6, 243	•
31.00	03100 I NTENSI VE CARE UNI T	0	118, 299	134, 883	253, 182	1, 387	
32.00 33.00	03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	0			0	0	
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	0	0	0	•
40.00	04000 SUBPROVI DER – I PF	0	0	0	0	0	
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER	0	0	0	0	0	
42.00	04300 NURSERY	0	15, 357	8, 924	24, 281	212	
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	
45.00	04500 NURSING FACILITY	0	0	0	0	0	
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0	0	0	0	0	46.00
50.00	05000 OPERATING ROOM	0	657, 045	1, 411, 276	2, 068, 321	3, 498	50.00
	05100 RECOVERY ROOM	0	37, 651				51.00
	05200 DELIVERY ROOM & LABOR ROOM	0	82, 298	47, 817	130, 115		52.00
53. 00 53. 01	05300 ANESTHESI OLOGY 05301 PALN MANAGEMENT	0	34, 801	530	35, 331	713	53.00 53.01
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	895, 089	1		11, 818	•
55.00	05500 RADI OLOGY-THERAPEUTI C	0	10, 143	50, 523	60, 666	263	•
56.00 56.01	05600 RADI OI SOTOPE 05601 CARDI AC CATH LAB	0	0 32, 639	0 194, 286	0 226, 925	0 794	
57.00	05700 CT SCAN	0	0	174,200	220, 925	0	
58.00	05800 MRI	0	0	0	0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0	0	
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY		73, 913	72, 708	146, 621 0	2, 185 0	
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY			Ĭ	0	0	61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0	0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0	0	0	
64.00 65.00	06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY		26, 261	17, 310	0 43, 571	0 908	
66. 00	06600 PHYSI CAL THERAPY	0	214, 387				•
67.00	06700 OCCUPATI ONAL THERAPY	0	0	283	283	454	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0	0	298	•
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY		87, 940	17, 941	105, 881 0	0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	0	0	1
	07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	
	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0			0	0	
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	
89.00 90.00	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC	0	0 23, 517	0 15, 131	0 38, 648	0	89.00 90.00
,0.00		0	1 20,017	1 15, 151	50, 040	190	1 / 0. 00

Health Financial Systems	IU HEALTH GOSH	EN HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150026	Period: From 01/01/2015	Worksheet B Part II	
				To 12/31/2015		pared: 7 pm
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	BLDG & FIXT	MVBLE EQUIP		EMPLOYEE BENEFITS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
90. 02 09002 WOUND CLINIC	0	232, 488	5, 68	238, 169	0	90.02
90.03 09003 MOBILE CLINIC	0	0	5, 28	5, 284	0	90.03
91.00 09100 EMERGENCY	0	242, 750	49, 02	22 291, 772	2,044	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART				0		92.00
OTHER REIMBURSABLE COST CENTERS	· · · · · · · · · · · · · · · · · · ·					1
99.00 09900 CMHC	0	0		0 0	0	99.00
101.00 10100 HOME HEALTH AGENCY	0	30, 442	13, 25	43, 693	1, 514	101.00
SPECIAL PURPOSE COST CENTERS						1
113.00 11300 I NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	30, 430		0 30, 430	649	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	4, 402, 172	5, 480, 28	9, 882, 458	52, 355	118.00
NONREI MBURSABLE COST CENTERS						1
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	133, 229	35, 22	168, 452	1, 072	190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	54, 755		0 54,755	142	190.01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0		190. 02
190. 03 19003 LI FELI NE	0	0		0 0	0	190. 03
190. 04 19004 COMMUNI TY RELATI ONS	0	56, 406	16, 38	72, 787	898	190.04
190. 05 19005 PRI VATE DUTY	0	0		0 0	0	190.05
190.06 19006 PROFESSIONAL DEVELOPMENT	0	0		0 0	12	190.06
190. 07 19007 FOUNDTI ON	0	0		0 0	0	190.07
190. 08 19008 GOSHEN GACC CLINIC	0	0		0 0	0	190.08
191. 00 19100 RESEARCH	0	0	71	4 714		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193. 00 19300 NONPALD WORKERS	0	0		0 0		193.00
200.00 Cross Foot Adjustments	Ĭ	0		0	Ű	200.00
201.00 Negative Cost Centers		0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	0	4, 646, 562	5, 532, 60	10, 179, 166		202.00

Health Financial Systems	IU HEALTH GOS	HEN HOSPITAL			In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			CCN: 150026		eriod: com 01/01/2015	Worksheet B Part II	
				To			pared:
Cost Center Description	CASHI ERI NG/ACC	OTHER	MAI NTENANCE	&	OPERATION OF	LAUNDRY &	7 pm
	OUNTS RECEI VABLE	ADMI NI STRATI VE AND GENERAL	REPAI RS		PLANT	LINEN SERVICE	
	5. 01	5. 02	6.00		7.00	8.00	
GENERAL SERVICE COST CENTERS		1	1				1.00
2.00 00200 CAP REL COSTS-BLDG & FIXT							2.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT							4.00
5. 01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 5. 02 00591 OTHER ADMI NI STRATI VE AND GENERAL	84, 261						5. 01 5. 02
6.00 00600 MAINTENANCE & REPAIRS)	0			5.02 6.00
7.00 00700 OPERATION OF PLANT	0	54, 682		0	461, 282		7.00
8. 00 00800 LAUNDRY & LI NEN SERVI CE 9. 00 00900 HOUSEKEEPI NG	0	9,859		0	2,671	35, 845 0	8.00 9.00
9. 00 00900 HOUSEKEEPI NG 10. 00 01000 DI ETARY		27, 316 10, 404		0	693 3, 590	0	9.00 10.00
11. 00 01100 CAFETERI A	0	8, 209		0	7, 527	0	11.00
12.00 01200 MAI NTENANCE OF PERSONNEL				0 0	0	0	12.00 13.00
13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY		40, 487 10, 573		0	2, 192 3, 723	0	13.00
15. 00 01500 PHARMACY	0	34, 611		0	3, 071	0	15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	0	0.7220		0	6, 456	0	16. 00 17. 00
19. 00 01900 NONPHYSI CLAN ANESTHETI STS) 12, 122) 0		0	933 0	0	17.00
20. 00 02000 NURSI NG SCHOOL	0			0	0	0	20.00
21.00 02100 I &R SERVICES-SALARY & FRINGES APPRV	0			0	0	0	21.00
22.00 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMEDICAL EDUCATION PROGRAM				0 0	0 325	0	22. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS			1				
30. 00 03000 ADULTS & PEDIATRICS	8,025			0	53, 968	7,752	30.00
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	2,042			0	14, 401 0	2, 285 0	31.00 32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0			0	0	0	33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	(0	0	0	34.00
40. 00 04000 SUBPROVI DER – I PF 41. 00 04100 SUBPROVI DER – I RF				0	0	0	40. 00 41. 00
42. 00 04200 SUBPROVI DER	0			0	0	0	42.00
43. 00 04300 NURSERY	416			0	1, 869	240	43.00
44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY				0	0	0	44.00 45.00
46.00 04600 OTHER LONG TERM CARE				0	0	0	46.00
	0.011	170, 980	J	0	79, 984	8, 383	F0 00
50.00 05000 0PERATING ROOM 51.00 05100 RECOVERY ROOM	8, 211		1	0	4, 583	o, sos 0	50.00 51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	1, 202			0	10, 018	1, 285	52.00
53. 00 05300 ANESTHESI OLOGY 53. 01 05301 PALN MANAGEMENT	246			0 0	0 4, 236	0	53. 00 53. 01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	16, 762			0	108, 962	7, 317	
55. 00 05500 RADI OLOGY-THERAPEUTI C	210	7, 993		0	1, 235	0	55.00
56. 00 05600 RADI OI SOTOPE 56. 01 05601 CARDI AC CATH LAB	2, 907	-		0	0 3, 973	0 201	56. 00 56. 01
57. 00 05700 CT SCAN	2, 907) 32,731		0	3, 773	0	57.00
58. 00 05800 MRI	0			0	0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	5, 913	0 0 3 81,746		0	0 8, 998	0	59. 00 60. 00
60. 01 06001 BLOOD LABORATORY	3, 913			0	0, 770	0	60. 00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		_					61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63.00 06300 BLOOD STORING, PROCESSING & TRANS.				0	0	0	62.00 63.00
64. 00 06400 I NTRAVENOUS THERAPY				0	0	0	64. 00
65. 00 06500 RESPI RATORY THERAPY	1, 261			0	3, 197	0	65.00
66. 00 06600 PHYSI CAL THERAPY 67. 00 06700 0CCUPATI ONAL THERAPY	937			0	26, 098	0	66.00 67.00
68. 00 06800 SPEECH PATHOLOGY	232			0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	721		5	0	10, 705	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1, 027	-		0	0	0	70. 00 71. 00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	2, 187			0	0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	24, 617	349, 061		0	0	0	73.00
74.00 07400 RENAL DIALYSIS				0 0	0	0	74.00
75. 00 07500 ASC (NON-DI STINCT PART) OUTPATI ENT SERVICE COST CENTERS		4 0	1	U	0	0	75.00
88.00 08800 RURAL HEALTH CLINIC	0			0	0	0	88.00
89. 00 08900 FEDERALLY QUALI FIED HEALTH CENTER 90. 00 09000 CLINIC	208	-		0	0 2, 863	0	89.00 90.00
90. 02 09000 CLINIC 90. 02 09002 WOUND CLINIC	876			0	2, 803 28, 301	0	90.00 90.02
90. 03 09003 MOBILE CLINIC	0	99		0	0	0	90. 03
91. 00 09100 EMERGENCY	4, 157	67,989	1	0	29, 551	8, 382	91.00

Health Financial Systems	IU HEALTH GOSI	HEN HOSPITAL		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150026	Period: From 01/01/2015 To 12/31/2015		
Cost Center Description	CASHI ERI NG/ACC		MAI NTENANCE		LAUNDRY &	
	OUNTS RECEI VABLE	ADMI NI STRATI VE AND GENERAL	REPAI RS	PLANT	LINEN SERVICE	
	5. 01	5. 02	6.00	7.00	8.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0.01	0.02	0.00	7.00	0.00	92.00
OTHER REIMBURSABLE COST CENTERS	1	1			1	
99.00 09900 CMHC	0	0		0 0	0 0	99.00
101.00 10100 HOME HEALTH AGENCY	301	41, 892		0 3, 706	0	101.00
SPECIAL PURPOSE COST CENTERS	1		1			
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	680			0 3, 704		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	84, 261	1, 970, 305		0 431, 533	35, 845	118.00
NONREI MBURSABLE COST CENTERS	-		1	-	-	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	38, 539		0 16, 218		190.00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	3, 993		0 6, 665		190.01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0		190.02
190. 03 19003 LI FELI NE	0	0		0 0		190.03
190. 04 19004 COMMUNI TY RELATIONS	0	91, 967		0 6, 866		190. 04
190. 05 19005 PRI VATE DUTY	0	0		0 0		190.05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	0	20, 712		0 0		190.06
190. 07 19007 FOUNDTI ON	0	0		0 0		190.07
190. 08 19008 GOSHEN GACC CLINIC	0	971		0 0		190.08
191.00 19100 RESEARCH	0	15, 937		0 0		191.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		0		192.00
193.00 19300 NONPAID WORKERS	0	0		0	1 0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	0					201.00
202.00 TOTAL (sum lines 118-201)	84, 261	2, 142, 424	1	0 461, 282	. 35,845	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	IU HEALTH GOSH			In Lie Period: From 01/01/2015	u of Form CMS-2 Worksheet B Part II	2552-10
				Т	o 12/31/2015	Date/Time Pre 5/27/2016 5:4	pared: 7 pm
	Cost Center Description	HOUSEKEEPING	DI ETARY	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON	
	GENERAL SERVICE COST CENTERS	9.00	10.00	11.00	12.00	13.00	
1.00	00100 CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.01 5.02	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00591 OTHER ADMINI STRATI VE AND GENERAL						5. 01 5. 02
6.00	00600 MAI NTENANCE & REPAI RS						6.00
7.00	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE	44 545					8.00
9.00 10.00	00900 HOUSEKEEPING 01000 DI ETARY	44, 545 349	46, 859				9.00 10.00
11.00	01100 CAFETERI A	732	40, 009	84, 643	3		11.00
12.00	01200 MAINTENANCE OF PERSONNEL	0	0	C			12.00
13.00	01300 NURSING ADMINISTRATION	213	0	2, 281		373, 888	
14.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY	362 299	0	646		0	14.00
15.00 16.00	01600 MEDICAL RECORDS & LIBRARY	628	0	1, 950 2, 993		0	15.00 16.00
17.00	01700 SOCI AL SERVICE	91	0	1, 104		0	17.00
19.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	C	0 0	0	19.00
20.00	02000 NURSI NG SCHOOL	0	0	C	0	0	20.00
21.00 22.00	02100 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-OTHER PRGM COSTS APPRV	0	0	C		0	21.00 22.00
22.00	02300 PARAMEDICAL EDUCATION PROGRAM	32	0	C		0	22.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	5, 250	40, 448	15, 328		126, 287	30.00
31.00	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T	1,401	6, 411 0	2, 828		31, 030	31.00
32.00 33.00	03300 BURN INTENSIVE CARE UNIT	0	0	L C		0	32.00 33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T	0	0	C) O	0	34.00
40.00	04000 SUBPROVI DER - I PF	0	0	C	0 0	0	40.00
41.00	04100 SUBPROVIDER - IRF	0	0	C	-	0	41.00
42.00 43.00	04200 SUBPROVI DER 04300 NURSERY	0 182	0	C 483	-	0 4, 198	42.00 43.00
43.00	04400 SKILLED NURSING FACILITY	0	0	483 C		4, 198	43.00
45.00	04500 NURSI NG FACI LI TY	0	0	C	0	0	45.00
46.00	04600 OTHER LONG TERM CARE	0	0	C	00	0	46.00
50.00	ANCI LLARY SERVI CE COST CENTERS	7, 781	0	7, 387	0	51, 083	50.00
51.00	05100 RECOVERY ROOM	446	0	665		8, 339	
52.00	05200 DELIVERY ROOM & LABOR ROOM	975	0	2, 590		22, 496	
53.00	05300 ANESTHESI OLOGY	0	0	C	-	0	53.00
53. 01 54. 00	05301 PALN MANAGEMENT 05400 RADI OLOGY-DI AGNOSTI C	412 10, 599	0	649 16, 830		4, 037 32, 106	
	05500 RADI OLOGY-THERAPEUTI C	120	0	670			55.00
56.00	05600 RADI OI SOTOPE	0	0	C		0	56.00
56.01	05601 CARDI AC CATH LAB	387	0	1, 381	0	8, 937	56.01
57.00	05700 CT SCAN	0	0	C	0	0	57.00
58.00 59.00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0	(0	58.00 59.00
60.00	06000 LABORATORY	875	0	4, 284	0	753	60.00
60. 01	06001 BLOOD LABORATORY	0	0	C	0 0	0	60. 01
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0			0	61.00
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0	0			0	62.00 63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	C		0	64.00
65.00	06500 RESPI RATORY THERAPY	311	0	1, 873	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	2, 539	0	3, 243		0	66.00
67.00 68.00	06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY	0	0	866 509		0	67.00 68.00
	06900 ELECTROCARDI OLOGY	1, 041	0	509		0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	C) Ö	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	C	0 0	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	C	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0	0			0	73.00 74.00
74.00	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART)	0	0	C		0	74.00 75.00
	OUTPATIENT SERVICE COST CENTERS						
	08800 RURAL HEALTH CLINIC	0	0	C	0	0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	, ,	0	89.00
90.00 90.02	09000 CLINIC 09002 WOUND CLINIC	278 2, 753	0	443		0	90. 00 90. 02
90. 02 90. 03	09003 MOBILE CLINIC	2,755	0	0		0	90.02 90.03
91.00	09100 EMERGENCY	2, 875	0	4, 928	3 0	41, 338	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00

Health Financial Systems	IU HEALTH GOSH	EN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period:	Worksheet B	
				From 01/01/2015 To 12/31/2015		narod
				10 12/31/2015	5/27/2016 5:4	
Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF		
				PERSONNEL	ADMI NI STRATI ON	
	9.00	10.00	11.00	12.00	13.00	
OTHER REI MBURSABLE COST CENTERS	1 1			-		
99.00 09900 CMHC	0	0		0 0	0	,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,,
101.00 10100 HOME HEALTH AGENCY	360	0	3, 03	5 0	15, 254	101.00
SPECIAL PURPOSE COST CENTERS	T T					110.00
113.00 11300 INTEREST EXPENSE 114.00 11400 UTI LI ZATI ON REVI EW-SNF						113.00 114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0	114.00
116. 00 11600 HOSPI CE	360	0	1, 46	8 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	41,651	46, 859	78, 43		356, 813	1
NONREI MBURSABLE COST CENTERS	11,001	107 00 7	, 0, 10			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	1, 578	0	2, 57	0 0	10, 359	190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	648	0	31	2 0	0	190. 01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0	0	190. 02
190. 03 19003 LI FELI NE	0	0		0 0	0	190. 03
190. 04 19004 COMMUNI TY RELATI ONS	668	0	2, 16	4 0	30	190. 04
190. 05 19005 PRI VATE DUTY	0	0		0 0		190. 05
190.06 19006 PROFESSIONAL DEVELOPMENT	0	0		0 0		190. 06
190. 07 19007 FOUNDTI ON	0	0		0 0		190. 07
190. 08 19008 GOSHEN GACC CLINIC	0	0		0 0		190.08
191. 00 19100 RESEARCH	0	0	1, 16	3 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 193. 00 19300 NONPALD WORKERS	0	0		0 0		192.00 193.00
200.00 Cross Foot Adjustments	0	0		0 0	0	200.00
201.00 Negative Cost Centers	0	0		0 0	0	200.00
202.00 TOTAL (sum lines 118-201)	44, 545	46, 859	84, 64	3 0		
			,	-1 -1		

Health Financial Systems	IU HEALTH GOSH	EN HOSPITAL		In Lie	u of Form CMS-:	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150026	Period: From 01/01/2015	Worksheet B Part II	
				To 12/31/2015		
Cost Center Description	CENTRAL	PHARMACY	MEDI CAL	SOCI AL SERVI CE	NONPHYSI CI AN	
	SERVICES & SUPPLY		RECORDS &		ANESTHETI STS	
	14.00	15.00	LI BRARY 16.00	17.00	19.00	
GENERAL SERVICE COST CENTERS						1 00
1. 00 00100 CAP REL COSTS-BLDG & FIXT 2. 00 00200 CAP REL COSTS-MVBLE EQUIP						1.00
4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 01 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.01
5. 02 00591 OTHER ADMINISTRATIVE AND GENERAL 6. 00 00600 MAINTENANCE & REPAIRS						5.02 6.00
7.00 00700 OPERATION OF PLANT						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPING 10. 00 01000 DI ETARY						9.00 10.00
11. 00 01100 CAFETERI A						11.00
12. 00 01200 MAI NTENANCE OF PERSONNEL 13. 00 01300 NURSI NG ADMI NI STRATI ON						12.00 13.00
13.00 01300 NURSING ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY	127, 358					13.00
15. 00 01500 PHARMACY	309	73, 446				15.00
16. 00 01600 MEDICAL RECORDS & LIBRARY 17. 00 01700 SOCIAL SERVICE	0	0	152, 52	7 0 23, 940		16.00 17.00
19. 00 01900 NONPHYSICIAN ANESTHETI STS	0	0		0 23, 940	0	
20. 00 02000 NURSI NG SCHOOL	0	0		0 0		20.00
21.00 02100 I &R SERVI CES-SALARY & FRI NGES APPRV 22.00 02200 I &R SERVI CES-OTHER PRGM COSTS APPRV	0	0		0 0		21.00
23. 00 02200 PARAMEDICAL EDUCATION PROGRAM	0	0		0 0		23.00
I NPATI ENT ROUTI NE SERVI CE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT	5, 739 2, 151	0	14, 52 3, 69			30.00 31.00
32. 00 03200 CORONARY CARE UNIT	2, 131	0	3,07	0 0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0	0		0 0		33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T 40. 00 04000 SUBPROVI DER - I PF	0	0		0 0		34.00 40.00
40. 00 04000 SUBPROVIDER - TPP 41. 00 04100 SUBPROVIDER - TRF	0	0		0 0		40.00
42. 00 04200 SUBPROVI DER	0	0		0 0		42.00
43.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY	236	0	75	3 82 0 0		43.00
45. 00 04400 SKIELED NORSTNG FACILITY	0	0		0 0		44.00
46.00 OTHER LONG TERM CARE	0	0	1	0 0		46.00
ANCI LLARY SERVI CE COST CENTERS	56,052	0	14, 86	1 0		50.00
51.00 05100 RECOVERY ROOM	496	0	1, 29			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	1, 264	0	2, 17			52.00
53. 00 05300 ANESTHESI OLOGY 53. 01 05301 PALN MANAGEMENT	0	0	44	0 0 5 0		53.00 53.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	14, 201	0	30, 33			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OLSOTOPE	80	0	38	1 0		55.00
56. 00 05600 RADI OI SOTOPE 56. 01 05601 CARDI AC CATH LAB	18, 288	0	5, 26	1 0		56.00 56.01
57. 00 05700 CT SCAN	0	0		0 0		57.00
58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON 60. 00 06000 LABORATORY	15, 265	0	10, 70	0 0		59.00 60.00
60. 01 06001 BLOOD LABORATORY	0	0		0 0		60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0		61.00 62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0		63.00
64.00 06400 I NTRAVENOUS THERAPY	0	0		0 0		64.00
65. 00 06500 RESPI RATORY THERAPY 66. 00 06600 PHYSI CAL THERAPY	1, 122 118	0	2,28			65.00
67. 00 06700 OCCUPATIONAL THERAPY	43	0	1, 69 73			66.00 67.00
68.00 06800 SPEECH PATHOLOGY	23	0	42	1 0		68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	34	0	1, 30	6 0		69.00 70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	1, 85	8 0		70.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	3, 95	8 0		72.00
73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DIALYSIS	0	73, 446	44, 58			73.00 74.00
74.00 07400 RENAL DIALYSIS 75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0 0 0		74.00
OUTPATIENT SERVICE COST CENTERS	·	-				
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0				88.00 89.00
90. 00 09000 CLINIC	61	0	37	6 0		90.00
90. 02 09002 WOUND CLINIC	2, 750	0	1, 58	5 0		90.02
90. 03 09003 MOBILE CLINIC 91. 00 09100 EMERGENCY	3, 413	0	7, 52	0 0 3 2, 905		90.03 91.00
	1 0, 10	•	.,02	2,700		

Health Financial Systems	IU HEALTH GOSH	IEN HOSPI TAL		In Lie	eu of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der		Period: From 01/01/2015 To 12/31/2015	Date/Time Pre 5/27/2016 5:4	
Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	ANESTHETI STS	
	14.00	15.00	16.00	17.00	19.00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS						
99.00 09900 CMHC	0	0		0 0		99.00
101.00 10100 HOME HEALTH AGENCY	390	0	54	4 0		101.00
SPECIAL PURPOSE COST CENTERS						
113.00 11300 INTEREST EXPENSE						113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.00
116. 00 11600 HOSPI CE	5, 233	0	1, 23	0 0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	127, 283	73, 446	152, 52	7 23, 940	0	118.00
NONREI MBURSABLE COST CENTERS			_		_	
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	47	0		0 0		190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	1	0)	0 0		190.01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0		190. 02
190. 03 19003 LI FELI NE	0	0		0 0		190.03
190. 04 19004 COMMUNI TY RELATIONS	21	0		0 0		190.04
190. 05 19005 PRI VATE DUTY	0	0		0 0		190.05
190.06 19006 PROFESSI ONAL DEVELOPMENT	0	0		0 0		190.06
190. 07 19007 FOUNDTI ON	0	0		0 0		190.07
190.08 19008 GOSHEN GACC CLINIC	0	0		0 0		190.08
191. 00 19100 RESEARCH	6	0		0 0		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0		0 0		192.00
193.00 19300 NONPALD WORKERS	0	0		0 0		193.00
200.00 Cross Foot Adjustments					0	200. 00
201.00 Negative Cost Centers	0	0		0 0	0	201.00
202.00 TOTAL (sum lines 118-201)	127, 358	73, 446	152, 52	7 23, 940	0	202.00

	Financial Systems TION OF CAPITAL RELATED COSTS	IU HEALTH GOS	HEN H		CCN: 150026	In Lie Period:	u of Form CMS-: Worksheet B	2552-10
ALLOCA	TION OF CAPITAL RELATED COSTS			FIOVICEI	CCN. 150020	From 01/01/2015 To 12/31/2015	Part II	pared:
				INTERNS &	RESI DENTS		372172010 3.4	
	Cost Center Description	NURSI NG SCHOOL	Y &	FRI NGES	PRGM COSTS	EDUCATI ON	Subtotal	
		20.00		APPRV 21.00	APPRV 22.00	PROGRAM 23.00	24.00	
1 00	GENERAL SERVICE COST CENTERS		1					1.00
1.00 2.00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP							1.00 2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT							4.00
5.01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE							5. 01
5.02	00591 OTHER ADMINI STRATI VE AND GENERAL							5.02
6.00 7.00	00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT							6.00 7.00
8.00	00800 LAUNDRY & LINEN SERVICE							8.00
9.00	00900 HOUSEKEEPI NG							9.00
10.00	01000 DI ETARY 01100 CAFETERI A							10.00
11. 00 12. 00	01200 MAINTENANCE OF PERSONNEL							11.00 12.00
	01300 NURSI NG ADMI NI STRATI ON							13.00
14.00	01400 CENTRAL SERVICES & SUPPLY							14.00
								15.00 16.00
	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE							17.00
	01900 NONPHYSICIAN ANESTHETISTS							19.00
	02000 NURSI NG SCHOOL	C	D	_				20.00
21.00 22.00	02100 I & R SERVICES-SALARY & FRINGES APPRV 02200 I & R SERVICES-OTHER PRGM COSTS APPRV			C		0		21.00 22.00
	02300 PARAMEDICAL EDUCATION PROGRAM					6, 319		22.00
	INPATIENT ROUTINE SERVICE COST CENTERS				1			
	03000 ADULTS & PEDIATRICS						1, 073, 561	30.00
	03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T						365, 219 0	31.00 32.00
	03300 BURN I NTENSI VE CARE UNI T						0	33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T						0	34.00
40.00	04000 SUBPROVIDER - IPF						0	40.00
41.00 42.00	04100 SUBPROVI DER – I RF 04200 SUBPROVI DER						0	41.00 42.00
43.00	04300 NURSERY						39, 319	•
	04400 SKILLED NURSING FACILITY						0	44.00
	04500 NURSING FACILITY						0	45.00
46.00	04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS		<u> </u>				0	46.00
50.00	05000 OPERATI NG ROOM						2, 476, 541	50.00
	05100 RECOVERY ROOM						65, 850	
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY						207, 333 0	
	05301 PALN MANAGEMENT						59, 517	1
	05400 RADI OLOGY-DI AGNOSTI C						2, 457, 285	1
	05500 RADI OLOGY-THERAPEUTI C						73, 100	
	05600 RADI OI SOTOPE 05601 CARDI AC CATH LAB						0 301, 785	
57.00	05700 CT SCAN						0	57.00
58.00	05800 MRI						0	58.00
59.00 60.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY				-		0	59.00
60. 00 60. 01	06000 LABORATORY 06001 BLOOD LABORATORY						277, 341	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	1						61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL						0	•
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY						0	63.00 64.00
65.00	06500 RESPIRATORY THERAPY						81, 158	
66.00	06600 PHYSI CAL THERAPY						340, 925	66.00
	06700 OCCUPATI ONAL THERAPY						14, 288	
	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY						9, 073 123, 111	1
	07000 ELECTROENCEPHALOGRAPHY						0	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT						98, 897	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS						75, 767	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS						491, 709 0	
	07500 ASC (NON-DI STINCT PART)						0	
	OUTPATIENT SERVICE COST CENTERS				1	1	-	
	08800 RURAL HEALTH CLINIC						0	
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC						0 50, 691	
	09002 WOUND CLINIC						298, 038	•
	· · · · ·							·

Health Financial Systems	IU HEALTH GOS	HEN HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 150026	Period: From 01/01/2015 To 12/31/2015	Worksheet B Part II Date/Time Pre 5/27/2016 5:4	pared: 7 pm
Cost Center Description		SERVI CES-SALAR Y & FRI NGES APPRV	PRGM COSTS APPRV	EDUCATION PROGRAM	Subtotal	
	20.00	21.00	22.00	23.00	24.00	
90. 03 09003 MOBILE CLINIC					5, 384	
91.00 09100 EMERGENCY					466, 877	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
OTHER REI MBURSABLE COST CENTERS 99.00 09900 CMHC	1	1	1		0	99.00
					0 110, 689	
101.00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS					110, 089	101.00
113. 00 11300 INTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)					0	115.00
116. 00 11600 H0SPI CE					81, 957	
118.00 SUBTOTALS (SUM OF LINES 1-117)	0			0 0	9, 645, 415	
NONREI MBURSABLE COST CENTERS		<u>, </u>	1	<u> </u>	7,010,110	110.00
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					238, 835	190.00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED					66, 516	
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE						190. 02
190. 03 19003 LI FELI NE						190.03
190. 04 19004 COMMUNI TY RELATI ONS					175, 401	190. 04
190. 05 19005 PRI VATE DUTY					0	190. 05
190. 06 19006 PROFESSI ONAL DEVELOPMENT					20, 724	190. 06
190. 07 19007 FOUNDTI ON					0	190. 07
190. 08 19008 GOSHEN GACC CLINIC					971	190. 08
191. 00 19100 RESEARCH					24, 985	191.00
192.00 19200 PHYSI CLANS' PRI VATE OFFI CES					0	192.00
193.00 19300 NONPAI D WORKERS					0	193.00
200.00 Cross Foot Adjustments	C) C		0 6, 319		200.00
201.00 Negative Cost Centers	C) C		0 0		201.00
202.00 TOTAL (sum lines 118-201)	C) C		0 6, 319	10, 179, 166	202.00

LOCA	n Financial Systems ATION OF CAPITAL RELATED COSTS	IU HEALTH GOSHE		CCN: 150026	Period: From 01/01/2015	u of Form CMS-25 Worksheet B Part II	
					To 12/31/2015	Date/Time Prepa 5/27/2016 5:47	
	Cost Center Description	Intern &	Total				
		Residents Cost					
		& Post					
		Stepdown Adjustments					
		25.00	26.00				
	GENERAL SERVICE COST CENTERS	23.00	20.00				-
00	00100 CAP REL COSTS-BLDG & FIXT						1.
00	00200 CAP REL COSTS-MVBLE EQUIP						2
0C	00400 EMPLOYEE BENEFITS DEPARTMENT						4
01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5
)2	00591 OTHER ADMINISTRATIVE AND GENERAL						5
00	00600 MAI NTENANCE & REPAI RS						6
00	00700 OPERATION OF PLANT						7
00	00800 LAUNDRY & LINEN SERVICE						8
00	00900 HOUSEKEEPI NG						9
00	01000 DI ETARY						10
00							11
00							12
00							13
00							14
00							15
00							16
00							17
00							19
							20 21
. 00 . 00							21
. 00							23
00	INPATIENT ROUTINE SERVICE COST CENTERS					· · · · · · · · · · · · · · · · · · ·	23
00		0	1, 073, 561				30
00		0	365, 219				31
00		0	0				32
00		0	o				33
00	03400 SURGICAL INTENSIVE CARE UNIT	0	o				34
00		0	o				40
00		0	o				41
. 00	04200 SUBPROVI DER	0	0				42
. 00	04300 NURSERY	0	39, 319				43
. 00		0	0				44
. 00		0	0				45
00		0	0			· · ·	46
00	ANCI LLARY SERVI CE COST CENTERS		2 474 541				EC
00		0	2, 476, 541 65, 850				50 51
	05200 DELIVERY ROOM & LABOR ROOM	0					
	05300 ANESTHESI OLOGY	0	207, 333 0				52 53
	05300 ANESTHESTOLOGY 05301 PALN MANAGEMENT	0	59, 517				53
	05400 RADI OLOGY-DI AGNOSTI C	0	2, 457, 285				54
00		0	73, 100				55
00		0	0				56
01		0	301, 785				56
00		Ő	0				57
00		Ó	0				58
00		0	0				59
00		0	277, 341				60
01	06001 BLOOD LABORATORY	0	o				60
00							61
00		0	0				62
00		0	0				63
00		0	0				64
00		0	81, 158				65
	06600 PHYSI CAL THERAPY	0	340, 925				66
00		0	14, 288				67
00		0	9,073				68
00		0	123, 111				69
00		0	0				70
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT	0	98, 897 75, 767				71
00	07200 I MPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0	75, 767				72
		0	491, 709 0				73
	07400 RENAL DIALYSIS	0	-				74
00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0				75
00	08800 RURAL HEALTH CLINIC	0	0				88
		0	0				89
00		0	50, 691				90

Health Financial Systems	IU HEALTH GOSHEN	HOSPI TAL	In Lieu of Fo	rm CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provider CCN: 150026		
Cost Center Description	Intern &	Total		
	Residents Cost			
	& Post			
	Stepdown			
	Adjustments 25.00	26.00		
90. 03 09003 MOBILE CLINIC	23.00	5, 384		90, 03
91. 00 09100 EMERGENCY	0	466, 877		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	100,077		92.00
OTHER REIMBURSABLE COST CENTERS				
99.00 09900 CMHC	0	0		99.00
101.00 10100 HOME HEALTH AGENCY	0	110, 689		101.00
SPECIAL PURPOSE COST CENTERS				
113.00 11300 INTEREST EXPENSE				113.00
114.00 11400 UTI LI ZATI ON REVI EW-SNF				114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		115.00
116. 00 11600 HOSPI CE	0	81, 957		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	9, 645, 415		118.00
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	238, 835		190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	66, 516		190. 01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		190.02
190. 03 19003 LI FELI NE	0	0		190.03
190. 04 19004 COMMUNITY RELATIONS	0	175, 401		190.04
190. 05 19005 PRI VATE DUTY	0	0		190.05
190. 06 19006 PROFESSI ONAL DEVELOPMENT	0	20, 724		190.06
190. 07 19007 FOUNDTI ON	0	0 971		190. 07 190. 08
190. 08 19008 GOSHEN GACC CLINIC 191. 00 19100 RESEARCH	0	24, 985		190.08
191.00 19100 RESEARCH 192.00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	24, 985		191.00
193. 00 19300 NONPALD WORKERS	0			192.00
200.00 Cross Foot Adjustments	0	6, 319		200.00
201.00 Negative Cost Centers	0	0, 317		200.00
202.00 TOTAL (sum Lines 118-201)	0	10, 179, 166		202.00
	-1			1

	Financial Systems ALLOCATION - STATISTICAL BASIS	IU HEALTH GOS			Period:	worksheet B-1	
					From 01/01/2015 To 12/31/2015	Date/Time Pre 5/27/2016 5:4	
		CAPI TAL RE	LATED COSTS				
	Cost Center Description	BLDG & FIXT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	CASHI ERI NG/ACC OUNTS RECEI VABLE (GROSS CHAR GES)	Reconciliation	
		1.00	2.00	4.00	5. 01	5A. 02	
. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT	391, 211					1.00
2.00 .00 .01 .02 .02	00200 CAP REL COSTS-MVBLE EQUI P 00400 EMPLOYEE BENEFI TS DEPARTMENT 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00591 OTHER ADMI NI STRATI VE AND GENERAL 00600 MAI NTENANCE & REPAI RS	4, 528 6, 508 30, 918	6, 480, 17 1, 37 7, 28	9 64, 063, 18 1 870, 84 8 10, 442, 87	4 516, 573, 103	-32, 496, 488 0	2.00 4.00 5.01
2.00 3.00 9.00 0.00	00700 OPERATI ON OF PLANT 00800 LAUNDRY & LI NEN SERVI CE 00900 HOUSEKEEPI NG 01000 DI ETARY	30, 221 1, 847 479 2, 483	1, 570 11, 71 3, 310	5 736, 37 6 36, 14 7 982, 31 6 225, 33	0 0 4 0 1 0 1 0	0 0 0 0	7.00 8.00 9.00 10.00
1.00 2.00 3.00 4.00 5.00	01100 CAFETERIA 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY	5, 206 0 1, 516 2, 575 2, 124	362, 42 95, 21 7, 83	0 8 1, 488, 71 6 206, 69 9 1, 498, 21	0 0 0 0 2 0 1 0	-	13.00 14.00 15.00
7.00 9.00 0.00	01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV	4, 465 645 0 0 0	1, 81) () (0 0 0 0 0	17.00 19.00 20.00 21.00
2.00	02200 I & SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMEDI CAL EDUCATI ON PROGRAM	0 225		0 0 125, 81	0 0 8 0	0	
	INPATIENT ROUTINE SERVICE COST CENTERS		1		-		
0.00 1.00 2.00 3.00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT	37, 326 9, 960 0	157, 98				31.00 32.00
4.00 0.00 1.00 2.00	03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER – I PF 04100 SUBPROVI DER – I RF 04200 SUBPROVI DER			0 0 0	0 0 0 0 0 0 0 0	0 0 0 0	34.00 40.00 41.00 42.00
3.00 4.00 5.00 6.00	04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	1, 293 0 0 0		0	8 2, 552, 715 0 0 0 0 0 0	0 0	44. 00 45. 00
0. 00	ANCI LLARY SERVICE COST CENTERS	55, 319	1, 652, 98	5 4, 076, 73	2 50, 376, 459	0	50.00
1. 00	05100 RECOVERY ROOM	3, 170	62	3 449, 88	8 4, 378, 369	0	51.00
2.00 3.00	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY	6, 929	56, 00	7 1, 326, 19 0	6 7, 377, 034 0 0	0	
3. 01 4. 00 5. 00	05301 PALN MANAGEMENT 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	2, 930 75, 361 854	1, 135, 67	8 13, 780, 21	5 102, 835, 073	0	55.00
6.00 6.01 7.00 8.00	05600 RADI OI SOTOPE 05601 CARDI AC CATH LAB 05700 CT SCAN 05800 MRI	2, 748 0	227, 56	0 1 925, 51 0	0 0 1 17, 834, 676 0 0 0 0		56.00 56.01 57.00 58.00
9.00 0.00 0.01 1.00	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY	0 6, 223 0) 85, 16)	0 1 2, 546, 80 0	0 0 2 36, 275, 233 0 0	0 0 0 0	59.00 60.00 60.01 61.00
62.00 63.00 64.00 65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY	0 0 0 2, 211	20, 27	0 0 0 5 1, 057, 89	0 0 0 0 0 0 9 7, 734, 257	0 0 0	62.00 63.00 64.00 65.00
6.00 6.00 7.00 8.00 9.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	18, 050 0 0 7, 404	56, 068 333	8 1, 542, 65 2 529, 67 0 347, 70	5 5, 745, 714 4 2, 506, 733	0 0 0	66. 00 67. 00 68. 00 69. 00
0.00 1.00 2.00 3.00	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS			D D D	0 6, 299, 755 0 13, 417, 412 0 150, 664, 738	0 0 0	70.00 71.00 72.00 73.00
4.00 5.00	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0		0	0 0 0 0	0 0	
8. 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0	1	0	0 0	0	88.00
	08800 FEDERALLY QUALIFIED HEALTH CENTER				0 0		88.00

lealth Financial Systems	IU HEALTH GOS				u of Form CMS-	
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2015	Worksheet B-1	
				To 12/31/2015	Date/Time Pre	parec
	_				5/27/2016 5:4	7 pm
	CAPI TAL REI	LATED COSTS				
					- · · · · ·	
Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE	CASHI ERI NG/ACC	Reconciliation	
	(SQUARE FEET)	(DOLLAR VALUE)	BENEFITS DEPARTMENT	OUNTS RECELVABLE		
			(GROSS	(GROSS CHAR		
			SALARI ES)	GES)		
	1.00	2.00	4.00	5. 01	5A. 02	
20. 00 09000 CLINIC	1, 980				0/11/02	90.
20. 02 09002 WOUND CLINIC	19, 574			0 5, 372, 422	0	
70. 03 09003 MOBILE CLINIC	0				0	
91.00 09100 EMERGENCY	20, 438				0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART			_,,			92.0
OTHER REIMBURSABLE COST CENTERS		1				
99.00 09900 CMHC	0	0		0 0	0	99.1
01.00 10100 HOME HEALTH AGENCY	2, 563	15, 521	1, 764, 81	0 1, 843, 637	0	101.
SPECIAL PURPOSE COST CENTERS						
13.00 11300 INTEREST EXPENSE						113.
14.00 11400 UTI LI ZATI ON REVI EW-SNF						114.
15.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0		0 0		115.
116. 00 11600 HOSPI CE	2, 562		756, 06			116.
18.00 SUBTOTALS (SUM OF LINES 1-117)	370, 635	6, 418, 893	61, 028, 64	3 516, 573, 103	-32, 496, 488	118.
NONREI MBURSABLE COST CENTERS		1	1			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	11, 217					190.
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNI TY ED	4, 610					190.
90. 02 19002 GI FT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0		190.
90. 03 19003 LI FELI NE	0	0		0 0		190.
90. 04 19004 COMMUNI TY RELATIONS	4, 749	19, 186	1, 046, 44	0		190.
90. 05 19005 PRI VATE DUTY	0	0	14.40	0 0		190.
190. 06 19006 PROFESSI ONAL DEVELOPMENT 190. 07 19007 FOUNDTI ON	0	0	14, 48			190. 190.
90. 08 19007 FOUNDITION 90. 08 19008 GOSHEN GACC CLINIC	0	0		0 0		190.
90. 08 19008 GOSHEN GACC CEINIC 91. 00 19100 RESEARCH	0	836	557, 92	0 0		190.
92. 00 19200 PHYSICIANS' PRIVATE OFFICES	0	830	557,92	0 0		191.
93. 00 19300 NONPALD WORKERS						192.
200.00 Cross Foot Adjustments	0			0	0	200.
201.00 Negative Cost Centers						200.
202.00 Cost to be allocated (per Wkst. B,	4, 646, 562	5 522 404	23, 388, 61	2 2, 430, 383		201.
Part I)	4,040,302	5, 532, 604	23, 300, 01	2 2, 430, 383		202.
203.00 Unit cost multiplier (Wkst. B, Part I)	11.877381	0. 853774	0. 36508	0. 004705		203.
204.00 Cost to be allocated (per Wkst. B,			54, 95			204.
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part			0. 00085	8 0. 000163		205.0
						1

Health Financial Systems COST ALLOCATION - STATISTICAL BASIS	IU HEALTH GOS		CCN: 150026 P	In Lie eriod:	u of Form CMS-2 Worksheet B-1	
				rom 01/01/2015 p 12/31/2015	Date/Time Pre	pared:
Cost Center Description	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST)	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT (SQUARE FEET)	LAUNDRY & LI NEN SERVI CE (POUNDS OF LAUNDRY)	5/27/2016 5:4 HOUSEKEEPING (SQUARE FEET)	/ pm
	5. 02	6.00	7.00	8.00	9.00	
1.00 GENERAL SERVICE COST CENTERS						1.00
1.00 00100 CAP REL COSTS-BUBG & FLAT 2.00 00200 CAP REL COSTS-MUBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 5.01 00580 CASHI ERING/ACCOUNTS RECEI VABLE 5.02 00591 OTHER ADMINISTRATIVE AND GENERAL 6.00 00600 MAINTENANCE & REPAIRS NO 00700 OPERATION OF PLANT 8.00 00800 LAUNDRY & LINEN SERVICE 9.00 00900 HOUSEKEEPING 10.00 01000 DI ETARY 11.00 01100 CAFETERIA 12.00 01200 MAINTENANCE OF PERSONNEL 13.00 01300 NURSI NG ADMINISTRATION 14.00 01400 CENTRAL SERVICES & SUPPLY 15.00 01500 PHARMACY 16.00 000 MEDICAL	138, 598, 658 0 3, 537, 460 637, 768 1, 767, 097 673, 067 531, 069 0 2, 619, 131 683, 966 2, 239, 060 3, 960, 703	349, 257 30, 221 1, 847 2, 483 5, 206 0 1, 516 2, 575 2, 124	319, 036 1, 847 479 2, 483 5, 206 0 1, 516 2, 575 2, 124	778, 516 0 0 0 0 0 0 0 0 0 0	316, 710 2, 483 5, 206 0 1, 516 2, 575 2, 124 4, 465	$\begin{array}{c} 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ \end{array}$
17. 0001700SOCI AL SERVICE19. 0001900NONPHYSICI AN ANESTHETI STS20. 0002000NURSI NG SCHOOL21. 0002100I &R SERVICES-SALARY & FRINGES APPRV22. 0002200I &R SERVICES-OTHER PRGM COSTS APPRV23. 0002300PARAMEDICAL EDUCATION PROGRAMINPATIENT ROUTINE SERVICE COST CENTERS	784, 164 0 0 0 205, 880	645 0 0 0 0		0 0 0 0	645 0 0 0 225	17. 00 19. 00
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT	11, 479, 850 2, 741, 930 0 0			168, 374 49, 635 0 0	37, 326 9, 960 0 0	31. 00 32. 00 33. 00
34.00 03400 SURGI CAL INTENSIVE CARE UNIT 40.00 04000 SUBPROVI DER - IPF 41.00 04100 SUBPROVI DER - IRF 42.00 04200 SUBPROVI DER 43.00 04300 NURSERY 44.00 04400 SKI LLED NURSI NG FACI LI TY 45.00 04500 NURSI NG FACI LI TY 46.00 04600 OTHER LONG TERM CARE ANCI LLARY SERVI CE COST CENTERS	0 0 0 411, 908 0 0 0 0	1, 293 0 0	0 0 0 1, 293 0 0 0	0 0 0 5, 210 0 0 0 0	0 0 0 1, 293 0 0 0 0	44.00
50. 00 05000 OPERATI NG ROOM	11, 060, 960	55, 319	55, 319	182, 039	55, 319	50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELI VERY ROOM & LABOR ROOM 53.00 05300 ANESTHESI OLOGY S3.01 PAI N MANAGEMENT	695, 180 2, 177, 445 0 869, 286	3, 170 6, 929 0	3, 170 6, 929 0	0 27, 916 0 0	3, 170 6, 929 0 2, 930	51. 00 52. 00 53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C 55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE 56. 01 05601 CARDI AC CATH LAB	22, 231, 419 517, 052 0 2, 117, 412	75, 361 854 0	75, 361 854 0	158, 927 0 0 4, 357	0	55.00
57. 00 05700 CT SCAN 58. 00 05800 MRI 59. 00 05900 CARDI AC CATHETERI ZATI ON	000000000000000000000000000000000000000	0 0 0	0 0 0	4, 337 0 0 0	0 0 0	57.00 58.00 59.00
60.00 06000 LABORATORY 60.01 06001 BLOOD LABORATORY 61.00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63.00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 64.00 06400 I NTRAVENOUS THERAPY	5, 288, 250 0 0 0 0	6, 223 0 0 0	6, 223 0 0 0	0 0 0	0 0	61.00 62.00 63.00
65.00 06500 RESPI RATORY THERAPY 66.00 06600 PHYSI CAL THERAPY 67.00 06700 0CCUPATI ONAL THERAPY 68.00 06800 SPEECH PATHOLOGY 69.00 06900 ELECTROCARDI OLOGY	1, 722, 916 2, 763, 322 743, 574 490, 991 221, 458	18, 050 0 0	18, 050 0 0	0 0 0 0 0	2, 211 18, 050 0 0	65. 00 66. 00 67. 00
70.00 07000 ELECTROENCEPHALOGRAPHY 71.00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 73.00 07300 DRUGS CHARGED TO PATIENTS 74.00 07400 RENAL DI ALYSIS 75.00 07500 ASC (NON-DI STINCT PART) 0UTPATIENT SERVICE COST CENTERS	0 6, 211, 159 4, 503, 943 22, 583, 445 0 0	0 0 0 0 0			0 0 0 0 0	70.00 71.00 72.00 73.00 74.00 75.00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC 90. 02 09002 WOUND CLINIC 90. 03 09003 MOBILE CLINIC	0 0 492, 832 1, 526, 964 6, 393	0 1, 980 19, 574	0 1, 980 19, 574	0 0 0 0 0	0 1, 980 19, 574	88.00 89.00 90.00 90.02 90.03

Health Financial Systems	IU HEALTH GOS	HEN HOSPITAL		In Lie	u of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				From 01/01/2015	Data (Tima Dua	
				Го 12/31/2015	Date/Time Pre 5/27/2016 5:4	
Cost Center Description	OTHER	MAINTENANCE &	OPERATION OF	LAUNDRY &	HOUSEKEEPI NG	
oust center bescription	ADMI NI STRATI VE		PLANT	LI NEN SERVI CE	(SQUARE FEET)	
	AND GENERAL	(SQUARE FEET)				
	(ACCUM. COST)			LAUNDRY)		
	5. 02	6.00	7.00	8.00	9.00	
91. 00 09100 EMERGENCY	4, 398, 325					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1,0,0,020	20, 100	20, 100	102,000	207 100	92.00
OTHER REIMBURSABLE COST CENTERS		1	1	1		
99. 00 09900 CMHC	0	0		0 0	0	99.00
101.00 10100 HOME HEALTH AGENCY	2, 710, 071	2, 563	2, 56	3 0	2, 563	101.00
SPECIAL PURPOSE COST CENTERS		_,	_,	-	_,	
113. 00 11300 I NTEREST EXPENSE			1			113.00
114. 00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0	0	115.00
116. 00 11600 HOSPI CE	1, 858, 568	2, 562		-		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	127, 464, 018					
NONREI MBURSABLE COST CENTERS	,		,			
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2, 493, 158	11, 217	11, 21	7 0	11, 217	190.00
190. 01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	258, 289					190.01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0	(0	0	190. 02
190. 03 19003 LI FELI NE	0	0		0 0		190.03
190. 04 19004 COMMUNI TY RELATI ONS	5, 949, 505	4, 749	4, 749	9 0	4, 749	190.04
190. 05 19005 PRI VATE DUTY	0	0		0 0	0	190.05
190.06 19006 PROFESSI ONAL DEVELOPMENT	1, 339, 882	0		0 0	0	190.06
190. 07 19007 FOUNDTI ON	15			0 0	0	190.07
190. 08 19008 GOSHEN GACC CLINIC	62, 794	0		0 0	0	190. 08
191. 00 19100 RESEARCH	1,030,997	0		0 0	0	191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
193. 00 19300 NONPALD WORKERS	0	0		0	0	193.00
200.00 Cross Foot Adjustments				-		200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	32, 496, 488	0	4, 366, 87	812, 583	2, 187, 975	202.00
Part I)						
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 234465	0. 000000	13. 68770	1. 043759	6. 908449	203.00
204.00 Cost to be allocated (per Wkst. B,	2, 142, 424	0	461, 282	2 35, 845	44, 545	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 015458	0. 000000	1. 445862	0. 046043	0. 140649	205.00

	Financial Systems LLOCATION - STATISTICAL BASIS	IU HEALTH GOSH		CCN: 150026	In Lie Period:	u of Form CMS- Worksheet B-1	
0001 /				0011. 100020	From 01/01/2015 To 12/31/2015		pared:
	Cost Center Description	DI ETARY (MEALS SERVED)	CAFETERI A (MANHOURS)	MAI NTENANCE PERSONNEL (NUMBER HOUSED)	OF NURSI NG ADMI NI STRATI ON (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY	
		10.00	11.00	12.00	13.00	14.00	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ \end{array}$	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-BLDG & FIXT 00400 EMPLOYEE BENEFITS DEPARTMENT 00580 CASHI ERING/ACCOUNTS RECEIVABLE 00591 OTHER ADMINISTRATIVE AND GENERAL 00600 MAINTENANCE & REPAIRS 00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01200 MAINTENANCE OF PERSONNEL 01300 NURSING ADMINISTRATION 01400 CENTRAL SERVICES & SUPPLY	78, 062 0 0 0	1, 651, 570 0 44, 500		0 0 469, 576 0 0	17 140 500	1.00 2.00 4.00 5.01 5.02 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00
15.00 16.00 17.00 19.00 20.00 21.00 22.00	01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMEDICAL EDUCATION PROGRAM INPATIENT ROUTINE SERVICE COST CENTERS		12, 608 38, 041 58, 396 21, 550 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	17, 162, 598 41, 617 27 382 0 0 0 0 0 0	15. 00 16. 00
$\begin{array}{c} 31.\ 00\\ 32.\ 00\\ 33.\ 00\\ 34.\ 00\\ 40.\ 00\\ 41.\ 00\\ 42.\ 00\\ 43.\ 00\\ 44.\ 00\\ 45.\ 00\\ 46.\ 00\\ \end{array}$	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SUBRIOLIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY 04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	67, 382 10, 680 0 0 0 0 0 0 0 0 0 0 0 0 0 0	299, 091 55, 189 0 0 0 0 0 0 0 0 9, 433 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 158, 606 0 38, 972 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	773, 342 289, 809 0 0 0 0 0 0 31, 789 0 0 0	31.00 32.00 33.00 34.00 40.00 41.00 42.00
$\begin{array}{c} 51.\ 00\\ 52.\ 00\\ 53.\ 01\\ 54.\ 00\\ 55.\ 00\\ 56.\ 01\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 00\\ 60.\ 00\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 65.\ 00\\ 66.\ 00\\ 67.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 73.\ 00\\ 74.\ 00\\ 75.\ 00\\ \end{array}$	05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05200 DELIVERY ROOM & LABOR ROOM 05301 PAIN MANAGEMENT 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 CARDI AC CATH LAB 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06001 BLOOD LABORATORY 06100 PBP CLINI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 07000 ELECTROCARDI OLOGY 07000 ELECTROCREDI OLOGY 07000 ELECTROCARDI OLOGY 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 07200 IMPL. DEV. CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STINCT PART) 0UTPATI ENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINI C		144, 128 12, 976 50, 543 0 12, 655 328, 413 13, 072 0 26, 945 0 0 83, 583 0 0 0 0 0 0 0 0 0 0 0 0 0		0 64, 157 0 10, 473 0 28, 253 0 0 0 5, 070 0 40, 323 0 1, 861 0 0 0 11, 224 0 0 0	170, 329 0 1, 523 1, 913, 662 10, 790 2, 464, 346 0 0 0 0	$\begin{array}{c} 52.\ 00\\ 53.\ 00\\ 53.\ 01\\ 54.\ 00\\ 55.\ 00\\ 56.\ 00\\ 56.\ 00\\ 56.\ 00\\ 56.\ 00\\ 57.\ 00\\ 58.\ 00\\ 59.\ 00\\ 60.\ 01\\ 61.\ 00\\ 62.\ 00\\ 63.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 65.\ 00\\ 64.\ 00\\ 67.\ 00\\ 70.\ 00\\ 71.\ 00\\ 72.\ 00\\ 71.\ 00\\ 72.\ 00\\ 74.\ 00\\ 75.\ 00\\ \end{array}$
89. 00 90. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09002 WOUND CLINIC	0 0 0 0	0 0 8, 645 0		0 0 0 0 0 0 0 0	0 0 8, 283 370, 602	89.00 90.00

Health Financial Systems	IU HEALTH GOSH	EN HOSPI TAL		In Lie	u of Form CMS-:	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der	CCN: 150026	Peri od:	Worksheet B-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre	narod
				10 12/31/2015	5/27/2016 5:4	
Cost Center Description	DI ETARY	CAFETERI A	MAINTENANCE C	OF NURSING	CENTRAL	
	(MEALS SERVED)	(MANHOURS)	PERSONNEL	ADMI NI STRATI ON	SERVICES &	
			(NUMBER		SUPPLY	
			HOUSED)	(DIRECT NRSING		
	10.00		10.00	HRS)	REQUIS.)	
	10.00	11.00	12.00	13.00	14.00	00.02
90. 03 09003 MOBILE CLINIC 91. 00 09100 EMERGENCY	0	5		0 0 0 51, 918	142 459, 878	
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	96, 161		0 51, 918	459,878	91.00
OTHER REIMBURSABLE COST CENTERS			<u> </u>			92.00
99. 00 09900 CMHC	0	0		0 0	0	99.00
101.00 10100 HOME HEALTH AGENCY	0	59, 216		0 19, 158	52, 610	
SPECIAL PURPOSE COST CENTERS	<u> </u>	57,210	1	17,100	52,010	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0 0	0	115.00
116. 00 11600 HOSPI CE	0	28, 635		0 11, 897	705, 099	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	78, 062	1, 530, 431		0 448, 131	17, 152, 517	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	50, 139		0 13, 010		190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	6, 079		0 0		190. 01
190.02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0		190. 02
190. 03 19003 LI FELI NE	0	0		0 0		190. 03
190. 04 19004 COMMUNI TY RELATIONS	0	42, 231		0 38		190. 04
190. 05 19005 PRI VATE DUTY	0	0		0 0		190.05
190. 06 19006 PROFESSIONAL DEVELOPMENT	0	0		0 0		190. 06 190. 07
190. 07 19007 FOUNDTI ON 190. 08 19008 GOSHEN GACC CLI NI C	0	0		0 0		190.07
190. 08 19008 GOSHEN GACC CLINIC 191. 00 19100 RESEARCH	0	22, 690		0 8, 397		190.08
191. 00 19100 RESEARCH 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	22, 090		0 0, 397		191.00
193. 00 19300 NONPALD WORKERS	0	0				192.00
200.00 Cross Foot Adjustments	0	0		0	0	200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B,	882,019	762, 809		0 3, 285, 003	903, 190	
Part I)		/		-,,		
203.00 Unit cost multiplier (Wkst. B, Part I)	11. 298955	0. 461869	0.00000	6. 995679	0. 052625	203.00
204.00 Cost to be allocated (per Wkst. B,	46, 859	84, 643		0 373, 888	127, 358	204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 600279	0. 051250	0.00000	0. 796225	0.007421	205.00
11)						

COST A	Financial Systems ALLOCATION - STATISTICAL BASIS	TO HEALTH GOST	IEN HOSPITAL Provider	CCN: 150026 F	Period:	u of Form CMS- Worksheet B-1	
				F	From 01/01/2015 To 12/31/2015	Date/Time Pre	epared:
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVICE	NONPHYSI CI AN	5/27/2016 5:4 NURSING SCHOOL	
		(COSTED REQUI S.)	RECORDS & LI BRARY (GROSS CHAR	(TIME SPENT)	ANESTHETISTS (ASSIGNED TIME)	(ASSI GNED TI ME)	
		15.00	GES) 16.00	17.00	19.00	20.00	
	GENERAL SERVICE COST CENTERS			T	T	Γ	
. 00 2. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP						1.0
1.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.0
5. 01	00580 CASHI ERI NG/ACCOUNTS RECEI VABLE						5.0
5. 02	00591 OTHER ADMINISTRATIVE AND GENERAL						5.0
. 00	00600 MAINTENANCE & REPAIRS						6.0
. 00	00700 OPERATION OF PLANT 00800 LAUNDRY & LINEN SERVICE						7.0
. 00	00900 HOUSEKEEPING						9.0
0.00	01000 DI ETARY						10.0
1.00	01100 CAFETERI A						11.0
2.00	01200 MAINTENANCE OF PERSONNEL						12.0
3.00 4.00	01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY						13.0
5.00	01500 PHARMACY	21, 877, 210					15.0
6.00	01600 MEDI CAL RECORDS & LI BRARY	0	516, 573, 103				16.0
7.00	01700 SOCIAL SERVICE	0	0		9		17.0
9.00	01900 NONPHYSI CI AN ANESTHETI STS	0	0	0	-		19.0
0.00	02000 NURSING SCHOOL	0	0	0	0	(
21.00 22.00	02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	0				21.0
2.00	02300 PARAMEDICAL EDUCATION PROGRAM	0	0				23.0
0.00	INPATIENT ROUTINE SERVICE COST CENTERS				-1	I	
0. 00	03000 ADULTS & PEDIATRICS	0	49, 232, 610	2, 722	2 0	(30.0
1.00	03100 I NTENSI VE CARE UNI T	0	12, 526, 545				
2.00	03200 CORONARY CARE UNIT	0	0	(
3.00	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0	0				
0.00	04000 SUBPROVIDER - IPF	0	0		, e		
1.00	04100 SUBPROVI DER – I RF	0	0	0	0 0	0	41.0
2.00	04200 SUBPROVI DER	0	0	0	0 0	0	
3.00		0	2, 552, 715				
4.00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	-	-		
6.00	04600 OTHER LONG TERM CARE	0	0				
	ANCI LLARY SERVI CE COST CENTERS				1		
0.00	05000 OPERATING ROOM	0	50, 376, 459				
1.00 2.00	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0	4, 378, 369 7, 377, 034		-) 51.C) 52.C
	05300 ANESTHESI OLOGY	0	1, 377, 034				53.0
3.01	05301 PALN MANAGEMENT	0	1, 507, 769	0	0 0	0	
	05400 RADI OLOGY-DI AGNOSTI C	0	102, 835, 073		0 0	C	
5.00	05500 RADI OLOGY-THERAPEUTI C	0	1, 290, 686		0 0	(
6.00 6.01	05600 RADI OI SOTOPE 05601 CARDI AC CATH LAB	0	0 17, 834, 676) 56.0) 56.0
7.00	05700 CT SCAN	0	17, 834, 878				
8.00	05800 MRI	0	0		0 0		
9.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0	0 0	0	59.0
0.00	06000 LABORATORY	0	36, 275, 233	0	0 0	0	
0.01	06001 BLOOD LABORATORY	0	0		0	0	
1.00 2.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	61.0 62.0
3.00	06300 BLOOD STORI NG, PROCESSI NG & TRANS.	0	0				
4.00	06400 I NTRAVENOUS THERAPY	0	0		0		
5.00	06500 RESPI RATORY THERAPY	0	7, 734, 257		0 0	0	
. 00	06600 PHYSI CAL THERAPY	0	5, 745, 714		0	(
. 00	06700 OCCUPATI ONAL THERAPY	0	2, 506, 733				
3.00 7.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	1, 426, 372 4, 426, 175				
	07000 ELECTROENCEPHALOGRAPHY	0	4, 420, 173) 0		
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	6, 299, 755		0	0	
2.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	13, 417, 412		0 0	0	
3.00		21, 877, 210	150, 664, 738		0	(
4.00	07400 RENAL DIALYSIS	0	0				
5.00	07500 ASC (NON-DISTINCT PART) OUTPATIENT SERVICE COST CENTERS	0	0	(0 0	() 75.0
8.00	08800 RURAL HEALTH CLINIC	0	0	0	0 0		88. 0
7.00		0	0		0		89.0
	09000 CLI NI C	0	1, 275, 321	(0 0	(
	09002 WOUND CLINIC	0	5, 372, 422		-		90.0

Health Financial Systems	IU HEALTH GOSH	IEN HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Period:	Worksheet B-1	
				From 01/01/2015 To 12/31/2015		pared:
					5/27/2016 5:4	
Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SOCIAL SERVIC		NURSING SCHOOL	
	(COSTED REQUIS.)	LIBRARY	(TIME SPENT)	ANESTHETI STS (ASSI GNED	(ASSI GNED	
	REQ013.)	(GROSS CHAR		TIME)	TIME)	
		GES)			,	
	15.00	16.00	17.00	19.00	20.00	
90. 03 09003 MOBILE CLINIC	0	C		0 0	-	90.03
91.00 09100 EMERGENCY	0	25, 502, 389	42	7 0	0	91.00
92. 00 09200 OBSERVATI ON BEDS (NON-DI STI NCT PART						92.00
OTHER REIMBURSABLE COST CENTERS 99. 00 09900 CMHC	0	0	N .	0 0	0	99.00
101.00 10100 HOME HEALTH AGENCY	0	1, 843, 637				101.00
SPECIAL PURPOSE COST CENTERS	<u> </u>	1, 043, 037		0 0	0	101.00
113. 00 11300 I NTEREST EXPENSE						113.00
114. 00 11400 UTI LI ZATI ON REVIEW-SNF						114.00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	C		0 0	0	115.00
116.00 11600 HOSPI CE	0	4, 171, 009		0 0	0	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	21, 877, 210	516, 573, 103	3, 51	9 0	0	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	C		0 0		190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED	0	C		0 0		190. 01
190. 02 19002 GIFT, FLOWER, COFFEE SHOP, & CANTEE	0	0		0 0		190.02
190. 03 19003 LI FELI NE	0	0		0 0		190.03
190. 04 19004 COMMUNI TY RELATI ONS 190. 05 19005 PRI VATE DUTY	0	U				190. 04 190. 05
190. 06 19005 PRI VATE DUTY 190. 06 19006 PROFESSI ONAL DEVELOPMENT	0	0				190.05
190. 07 19007 FOUNDTI ON	0	0				190.00
190. 08 19008 GOSHEN GACC CLINIC	0	0				190.07
191. 00 19100 RESEARCH	0	0		0 0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
193.00 19300 NONPALD WORKERS	0	C		0 0		193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers						201.00
202.00 Cost to be allocated (per Wkst. B, Part I)	2, 827, 548	5, 008, 283	991, 28	1 0	0	202.00
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 129246	0. 009695	281.69394	7 0. 000000	0.000000	203.00
204.00 Cost to be allocated (per Wkst. B,	73, 446	152, 527				204.00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 003357	0. 000295	6. 80306	9 0. 000000	0.000000	205.00
	· ·		1	I.	1	1

	Financial Systems ALLOCATION - STATISTICAL BASIS	IU HEALTH GOSI		CCN: 150026	Peri od:	u of Form CMS-2552-10 Worksheet B-1
					From 01/01/2015 To 12/31/2015	Date/Time Prepared:
		INTERNS &	RESI DENTS			5/27/2016 5:47 pm
	Cost Center Description	SERVI CES-SALAR Y & FRI NGES APPRV (ASSI GNED TI ME) 21.00	SERVI CES-OTHER PRGM COSTS APPRV (ASSI GNED TI ME) 22. 00	PARAMEDI CAL EDUCATI ON PROGRAM (ASSI GNED TI ME) 23.00		
	GENERAL SERVICE COST CENTERS	21.00	22.00	20.00		
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 4.\ 00\\ 5.\ 01\\ 5.\ 02\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 3.\ 00\\ \end{array}$	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00580 CASHI ERI NG/ACCOUNTS RECEI VABLE 00591 OTHER ADMI NI STRATI VE AND GENERAL 00600 MAI NTENANCE & REPAI RS 00700 OPERATI ON OF PLANT 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPI NG 01000 DI ETARY 01100 CAFETERI A 01200 MAI NTENANCE OF PERSONNEL 01300 NURSI NG ADMI NI STRATI ON 01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 I & SERVI CES-SALARY & FRI NGES APPRV 02200 I & SERVI CES-OTHER PRGM COSTS APPRV 02200 PARAMEDI CAL EDUCATI ON PROGRAM	0	o	1	00	1.00 2.00 4.00 5.01 5.02 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 19.00 20.00 21.00 22.00
$\begin{array}{c} 30.\ 00\\ 31.\ 00\\ 32.\ 00\\ 33.\ 00\\ 34.\ 00\\ 40.\ 00\\ 41.\ 00\\ 42.\ 00\\ 43.\ 00\\ 44.\ 00\\ 45.\ 00\\ 46.\ 00\\ \end{array}$	I NPATI ENT ROUTI NE SERVI CE COST CENTERS 03000 ADULTS & PEDI ATRI CS 03100 I NTENSI VE CARE UNI T 03200 CORONARY CARE UNI T 03300 BURN I NTENSI VE CARE UNI T 03400 SURGI CAL I NTENSI VE CARE UNI T 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER - I RF 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY 04500 NURSI NG FACI LI TY 04600 OTHER LONG TERM CARE					30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 46. 00
$\begin{array}{c} 50. \ 00\\ 51. \ 00\\ 52. \ 00\\ 53. \ 01\\ 53. \ 01\\ 54. \ 00\\ 55. \ 00\\ 56. \ 01\\ 57. \ 00\\ 60. \ 01\\ 61. \ 00\\ 60. \ 01\\ 61. \ 00\\ 62. \ 00\\ 63. \ 00\\ 63. \ 00\\ 64. \ 00\\ 65. \ 00\\ 64. \ 00\\ 65. \ 00\\ 66. \ 00\\ 67. \ 00\\ 68. \ 00\\ 70. \ 00\\ 71. \ 00\\ 71. \ 00\\ 71. \ 00\\ 73. \ 00\\ 74. \ 00\\ 75. \ 00\end{array}$	ANCI LLARY SERVI CE COST CENTERS 05000 OPERATI NG ROOM 05100 RECOVERY ROOM 05200 DELI VERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY 05301 PAI N MANAGEMENT 05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OLOGY-THERAPEUTI C 05600 CARDI AC CATH LAB 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY 07000 RENAL SUPPLI ES CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07300 DRUGS CHARGED TO PATI ENTS 07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART) OUTPATI ENT SERVICE COST CENTERS					50.00 51.00 52.00 53.01 54.00 55.00 56.01 57.00 58.00 58.00 59.00 60.01 61.00 62.00 63.00 64.00 63.00 64.00 65.00 66.00 67.00 68.00 67.00 68.00 70.00 71.00 72.00 73.00 74.00 75.00
88. 00 89. 00	08800 FEDERALLY QUALIFIED HEALTH CENTER	000			0	88. 00 89. 00

COST ALLOCATION - STATISTICAL BASIS Provider CCN: 150026 Period: From 01/01/2015 To 12/31/2015 Worksheet B- Date/Time Priod: To 12/31/2015 Cost Center Description INTERNS & RESIDENTS SERVICES-SALAR SERVICES-OTHER PRGM COSTS APPRV (ASSIGNED TIME) PARAMEDICAL EDUCATION PRGGRAM (ASSIGNED TIME) PRAMEDICAL EDUCATION PRGGRAM (ASSIGNED TIME) Version Provider CCN: 150026 Worksheet B- Date/Time Priod: EDUCATION PRGCRAM (ASSIGNED TIME) 90.00 09000 CLINIC 0 O PRGM COSTS APPRV PRGCRAM (ASSIGNED TIME) EDUCATION PROGRAM (ASSIGNED TIME) EDUCATION PROGRAM (ASSIGNED T	90. 00 90. 03
To 12/31/2015 Date/Time Pris/27/2016 5: Cost Center Description SERVICES-SALAR SERVICES-OTHER PRGM COSTS EDUCATION PROGRAM (ASSIGNED TIME) 90.00 09000 CLINIC 0<	90.00 90.02 90.03
INTERNS & RESIDENTS Cost Center Description SERVICES-SALAR SERVICES-OTHER Y & FRINGES APPRV PARAMEDICAL EDUCATION APPRV 90.00 09000 CLINIC (ASSIGNED TIME) (ASSIGNED TIME) (ASSIGNED TIME) 90.00 09000 CLINIC 0 0 90.02 09002 WOUND CLINIC 0 0 90.03 09003 MOBILE CLINIC 0 0 90.00 09100 EMERGENCY 0 0 91.00 09100 EMERGENCY 0 0 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 99.00 09900 CMHC 0 0 0 0100 IDME HEALTH AGENCY 0 0 0 99.00 11300 INTERST EXPENSE INTERST EXPENSE INTERST EXPENSE	90.00 90.02 90.03
Cost Center Description SERVICES-SALAR SERVICES-OTHER PARAMEDICAL EDUCATION PROGRAM (ASSIGNED TIME) Y & FRINGES PRPRV (ASSIGNED TIME) PROGRAM (ASSIGNED TIME) 90.00 09000 CLINIC 0 0 90.02 09002 WOUND CLINIC 0 0 0 90.02 09002 WOUND CLINIC 0 0 0 90.02 09003 MOBILE CLINIC 0 0 0 91.00 09100 EMERGENCY 0 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 99.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 99.00 09200 CMHC 0 0 0 0 101.00 IDIME HEALTH AGENCY 0 0 0 0 91.1300 INTEREST EXPENSE 0 0 0	90. 02 90. 03
Y & FRINGES APPRV (ASSIGNED TIME) PRGM COSTS APPRV (ASSIGNED TIME) EDUCATION PROGRAM (ASSIGNED TIME) 90.00 09000 CLINIC 0 21.00 22.00 23.00 90.02 09002 WOUND CLINIC 0 0 0 90.03 09003 MOBILE CLINIC 0 0 0 90.04 09003 MOBILE CLINIC 0 0 0 90.05 09003 MOBILE CLINIC 0 0 0 90.06 09000 CHERGENCY 0 0 0 91.00 09100 EMERGENCY 0 0 0 0 92.00 0BSERVATION BEDS (NON-DI STINCT PART 0 0 0 0 01.00 09000 CMHC 0 0 0 0 99.00 09900 CMHC 0 0 0 0 101.00 HOME HEALTH AGENCY 0 0 0 0 0 99.00 INMEREST EXPENSE III3.00	90. 02 90. 03
APPRV (ASSIGNED TIME) APPRV (ASSIGNED TIME) PROGRAM (ASSIGNED TIME) 90.00 09000 CLINIC 21.00 22.00 23.00 90.02 09002 WOUND CLINIC 0 0 0 90.03 09003 MOBILE CLINIC 0 0 0 90.04 09000 CLINIC 0 0 0 90.05 09003 MOBILE CLINIC 0 0 0 90.06 09100 EMERGENCY 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 092.00 0BSERVATION BEDS (NON-DISTINCT PART 0 0 0 01.00 10100 HOME HEALTH AGENCY 0 0 0 99.00 09900 CMHC 0 0 0 0 101.00 HOME HEALTH AGENCY 0 0 0 0 0 99.00 11300 INTEREST EXPENSE U U U U <td>90. 02 90. 03</td>	90. 02 90. 03
Image: Provide an analysis of the provided and the	90. 02 90. 03
TIME) TIME) TIME) 21.00 22.00 23.00 90.00 09002 WOUND CLINIC 0 0 90.02 09002 WOUND CLINIC 0 0 0 90.03 09003 MOBILE CLINIC 0 0 0 91.00 09100 EMERGENCY 0 0 0 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART 0 0 0 07HER REIMBURSABLE COST CENTERS 0 0 0 0 99.00 09900 CMHC 0 0 0 0 101.00 HOME HEALTH AGENCY 0 0 0 0 0 99.00 10100 HOME HEALTH AGENCY 0 0 0 0 101.00 IONE HEALTH AGENCY 0 0 0 0 0 0 0 113.00 INTEREST EXPENSE 11300 INTEREST EXPENSE 11300 11300 1000 1000	90. 02 90. 03
21.00 22.00 23.00 90.00 09000 CLINIC 0 0 0 90.02 09002 WOUND CLINIC 0 0 0 0 90.03 09003 MOBILE CLINIC 0 0 0 0 0 90.03 09003 MOBILE CLINIC 0 0 0 0 0 91.00 09100 EMERGENCY 0 <td>90. 02 90. 03</td>	90. 02 90. 03
90. 02 09002 WOUND CLINIC 0 0 0 90. 03 09003 MOBILE CLINIC 0 0 0 91. 00 09100 EMERGENCY 0 0 0 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 100 92. 00 09002 CMHC 0 0 0 99. 00 09900 CMHC 0 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 0 99. 00 10100 HOME HEALTH AGENCY 0 0 0 113.00 11300 INTEREST EXPENSE	90. 02 90. 03
90. 03 09003 MOBILE CLINIC 0 0 0 91. 00 09100 EMERGENCY 0 0 100 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 100 07. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0 07. 00 09200 CMHC 0 0 0 01.00 10100 HOME HEALTH AGENCY 0 0 0 99. 00 09900 CMHC 0 0 0 0 101.00 HOME HEALTH AGENCY 0 0 0 0 3PECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE Interest expense Interest expense	90.03
91.00 09100 EMERGENCY 0 100 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0 0 0THER REIMBURSABLE COST CENTERS 0 0 99.00 09900 CMHC 0 0 101.00 HOME HEALTH AGENCY 0 0 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 0 0	
92.00 OBSERVATION BEDS (NON-DISTINCT PART Image: Constraint of the state of th	
OTHER REI MBURSABLE COST CENTERS 99.00 09900 CMHC 0 0 101.00 10100 HOME HEALTH AGENCY 0 0 SPECI AL PURPOSE COST CENTERS 113.00 I NTEREST EXPENSE Image: Cost Image: Co	91.00
99. 00 09900 CMHC 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 SPECI AL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE <t< td=""><td>92.00</td></t<>	92.00
101.00 HOME HEALTH AGENCY 0 0 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE	99.00
113.00 11300 I NTEREST EXPENSE	101.00
	1
	113.00
	114.00
115.00 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0	115.00
116.00 11600 HOSPICE 0 0 0 118.00 SUBTOTALS (SUM OF LINES 1-117) 0 0 100	116.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 0 0 100 NONREI MBURSABLE COST CENTERS 0 0 100 0	118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0	190.00
190.01 19001 OTHER NR/CHP-GRANT I/COMMUNITY ED 0 0 0	190.01
190. 02 19002 GI FT, FLOWER, COFFEE SHOP, & CANTEE 0 0 0	190.02
190. 03 19003 LI FELI NE 0 0 0	190.03
190. 04 19004 COMMUNITY RELATIONS 0 0 0	190.04
190. 05 19005 PRI VATE DUTY 0 0 0	190.05
190. 06 19006 PROFESSI ONAL DEVELOPMENT 0 0 0	190.06
190. 07 19007 FOUNDTI ON 0 0 0 190. 08 19008 GOSHEN GACC CLINIC 0 0 0	190. 07 190. 08
191. 00 19100 RESEARCH 0 0 0	190.08
192.00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0	192.00
193.0019300 NONPAI D WORKERS 0 0 0	193.00
200.00 Cross Foot Adjustments	200.00
201.00 Negative Cost Centers	201.00
202.00 Cost to be allocated (per Wkst. B, 0 0 258, 786	202.00
Part I) 0.000000 0.000000 2,587.860000	203.00
204.00 Cost to be allocated (per Wkst. B, 0 0 6, 319	203.00
Part II)	
205.00 Unit cost multiplier (Wkst. B, Part 0.000000 0.000000 63.190000	1
	205.00

Health Fina	ncial Systems	IU HEALTH GOS	HEN HOSPITAL		In Lie	eu of Form CMS-	2552-10
COMPUTATI ON	N OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2015 To 12/31/2015	Date/Time Pre	epared:
			Titl	e XVIII	Hospi tal	5/27/2016 5:4 PPS	7 pm
	Cost Center Description	Total Cost (from Wkst. B, Part I, col.	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		26) 1.00	2.00	3.00	4.00	5.00	
	TI ENT ROUTI NE SERVI CE COST CENTERS		1				
	0 ADULTS & PEDIATRICS 0 INTENSIVE CARE UNIT	18, 409, 807 4, 280, 920		18, 409, 80 4, 280, 92			
	O CORONARY CARE UNIT	4, 200, 920		4, 200, 92	0 0	4, 200, 920	
	O BURN INTENSIVE CARE UNIT	0			0 0	0	
	O SURGICAL INTENSIVE CARE UNIT	0			0 0	0	
	0 SUBPROVI DER – I PF 0 SUBPROVI DER – I RF	0			0 0	0 0	
	0 SUBPROVIDER	0			0 0	0	
	0 NURSERY	611, 602		611, 60	2 0	611, 602	
	O SKILLED NURSING FACILITY	0			0 0	0	
	O NURSING FACILITY	0			0 0	0	
	O OTHER LONG TERM CARE LLARY SERVICE COST CENTERS	0	1		0 0	0	46.00
	O OPERATING ROOM	16, 385, 057		16, 385, 05	7 0	16, 385, 057	50.00
	O RECOVERY ROOM	1, 048, 688		1, 048, 68			
	O DELIVERY ROOM & LABOR ROOM	3, 178, 489		3, 178, 48	9 0	3, 178, 489	
	O ANESTHESI OLOGY	0		1 100 4/	0 0	0	
	1 PAI N MANAGEMENT 0 RADI OLOGY-DI AGNOSTI C	1, 189, 461 30, 693, 398		1, 189, 46 30, 693, 39			
	0 RADI OLOGY-THERAPEUTI C	688, 010		688, 01			
	0 RADI OI SOTOPE	0			0 0	0	
	1 CARDI AC CATH LAB	3, 068, 575		3, 068, 57	5 0	3, 068, 575	
	O CT SCAN	0			0 0	0	
58.00 0580 59.00 0590	O CARDI AC CATHETERI ZATI ON	0				0	
	0 LABORATORY	7, 161, 490		7, 161, 49	0 0	7, 161, 490	
	1 BLOOD LABORATORY	0			0 0	0	
	O PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	
	O WHOLE BLOOD & PACKED RED BLOOD CELL	0			0 0	0	
	0 BLOOD STORING, PROCESSING & TRANS. 0 I NTRAVENOUS THERAPY	0				0 0	
	O RESPIRATORY THERAPY	2, 272, 239	c	2, 272, 23	9 0	2, 272, 239	
	O PHYSI CAL THERAPY	3, 868, 746		3, 868, 74		3, 868, 746	
	0 OCCUPATI ONAL THERAPY	950, 331		950, 33		950, 331	
	0 SPEECH PATHOLOGY 0 ELECTROCARDI OLOGY	624, 689		624, 68 469, 02		624, 689	
	0 ELECTROENCEPHALOGRAPHY	469, 027				469, 027 0	
	O MEDICAL SUPPLIES CHARGED TO PATIENT	7, 728, 534		7, 728, 53	0		
	O I MPL. DEV. CHARGED TO PATIENTS	5, 690, 042		5, 690, 04		5, 690, 042	72.00
	O DRUGS CHARGED TO PATIENTS	32, 166, 773		32, 166, 77			
	0 RENAL DI ALYSI S 0 ASC (NON-DI STI NCT PART)	0			0 0		74.00 75.00
	ATIENT SERVICE COST CENTERS		1	1	0 0	0	/ 3. 00
	O RURAL HEALTH CLINIC	0			0 0	0	88.00
	O FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
90.00 0900		665, 958		665, 95		665, 958	
	2 WOUND CLINIC 3 MOBILE CLINIC	2, 359, 722 7, 901		2, 359, 72 7, 90		2, 376, 379 7, 901	1
	0 EMERGENCY	7, 098, 678		7, 098, 67			
	O OBSERVATION BEDS (NON-DISTINCT PART	2, 378, 624		2, 378, 62		2, 378, 624	
	R REIMBURSABLE COST CENTERS		1	1		I	
99.00 0990		0			0		99.00
	O HOME HEALTH AGENCY I AL PURPOSE COST CENTERS	3, 580, 292		3, 580, 29	∠	3, 580, 292	
	OINTEREST EXPENSE						113.00
114.00 1140	OUTILIZATION REVIEW-SNF						114.00
	O AMBULATORY SURGICAL CENTER (D. P.)	0			0		115.00
116.001160		2, 521, 102		2, 521, 10		2, 521, 102	
200.00 201.00	Subtotal (see instructions) Less Observation Beds	159, 098, 155 2, 378, 624		159, 098, 15 2, 378, 62		159, 333, 271 2, 378, 624	
202.00	Total (see instructions)	156, 719, 531					
I.				•			•

COMPUTATION OF RA	Systems TIO OF COSTS TO CHARGES	IU HEALTH GOSH		CCN: 150026	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/27/2016 5:4	epared:
				e XVIII	Hospi tal	PPS	
Cost	Center Description	I npati ent	<u>Charges</u> Outpati ent	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
		6.00	7.00	8.00	9.00	10.00	
	ROUTINE SERVICE COST CENTERS			27.0/5.1	2/	[
	TS & PEDIATRICS ISIVE CARE UNIT	37, 865, 126		37, 865, 12			30.00
	IARY CARE UNI T	12, 526, 545		12, 526, 54	+5		32.00
	INTENSIVE CARE UNIT	0			0		33.00
	CAL INTENSIVE CARE UNIT	0			0		34.00
40. 00 04000 SUBPI	ROVIDER - IPF	0			0		40.00
	ROVIDER – IRF	0			0		41.00
42.00 04200 SUBP		0		0.550.7	0		42.00
43.00 04300 NURSI		2, 552, 715		2, 552, 7			43.00
	ED NURSING FACILITY NG FACILITY	0			0		44.00
	LONG TERM CARE	0			0		46.00
	SERVICE COST CENTERS	<u> </u>		1	0	I	
50.00 05000 0PER/	ATING ROOM	17, 201, 477	33, 174, 982	50, 376, 4	59 0. 325252	0.00000	50.00
51.00 05100 RECO		1, 582, 322	2, 796, 047				
	/ERY ROOM & LABOR ROOM	7, 377, 034	0				
53.00 05300 ANES		0	0		0 0.00000		
1 1		1, 122 11, 026, 909	1, 506, 647 91, 808, 164			0.00000	
	DLOGY-DI AGNOSTI C DLOGY-THERAPEUTI C	79, 290	1, 211, 396				
56.00 05600 RADI (17,270	1, 211, 370	1, 270, 00	0 0.000000		
	AC CATH LAB	8, 306, 513	9, 528, 163	17, 834, 6		0.000000	
57.00 05700 CT SC		0	C		0 0.00000		
58.00 05800 MRI		0	C		0 0.000000	0.00000	58.00
	AC CATHETERI ZATI ON	0	C		0 0. 000000		
60.00 06000 LABO		13, 023, 383	23, 251, 850	36, 275, 23		0.00000	
) LABORATORY	0	0		0 0.000000		
	CLINICAL LAB SERVICES-PRGM ONLY E BLOOD & PACKED RED BLOOD CELL	0	0		0 0.000000 0 0.000000		
	STORING, PROCESSING & TRANS.	0	0		0 0.000000		
	AVENOUS THERAPY	0	C		0 0.000000		
	RATORY THERAPY	6, 398, 863	1, 335, 394	7, 734, 2			
66. 00 06600 PHYSI	CAL THERAPY	1, 263, 247	4, 482, 467	5, 745, 7	0. 673327	0. 000000	66.00
	PATIONAL THERAPY	1, 078, 538	1, 428, 195			0.00000	
	CH PATHOLOGY	170, 054	1, 256, 318				
		1, 149, 512	3, 276, 663				
	ROENCEPHALOGRAPHY	0 4, 666, 684	0 1, 633, 071		0 0.000000 55 1.226799		
	DEV. CHARGED TO PATIENTS	7, 051, 987	6, 365, 425				
	S CHARGED TO PATIENTS	33, 652, 128					
74.00 07400 RENAI		0	C		0 0. 000000		
75.00 07500 ASC	(NON-DISTINCT PART)	0	0		0 0.000000		
	SERVICE COST CENTERS						
		0	0		0		88.00
89.00 08900 FEDE 90.00 09000 CLIN	RALLY QUALIFIED HEALTH CENTER	0	1 275 221		0	0 00000	89.00
90.02 09000 CLINI 90.02 09002 WOUNI		0	1, 275, 321 5, 372, 422				
90. 02 09002 WOONI 90. 03 09003 MOBI I		0	5, 572, 422		0 0. 000000		
91.00 09100 EMER		4, 712, 767	20, 789, 622				
	RVATION BEDS (NON-DISTINCT PART	0	11, 367, 484				
	BURSABLE COST CENTERS						
99. 00 09900 CMHC 101. 00 10100 HOME		0	0 1, 843, 637		0 37		99.00 101.00
	RPOSE COST CENTERS			1			140.0
113. 00 11300 I NTE							113.00
	ZATION REVIEW-SNF ATORY SURGICAL CENTER (D.P.)	0	0		0		114. 00 115. 00
116.0011600 H0SPI		0	4, 171, 009	4, 171, 0			116.00
	otal (see instructions)	171, 686, 216	344, 886, 887				200.00
	Observation Beds						201.00
1 1	(see instructions)	171, 686, 216	344, 886, 887	516, 573, 10	13		202.00

	Financial Systems	IU HEALTH GOSHEN			u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150026	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/27/2016 5:4	
			Title XVIII	Hospi tal	PPS	
	Cost Center Description	PPS Inpatient Ratio				
		11.00				
	INPATIENT ROUTINE SERVICE COST CENTERS					1 20 00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT					30.00
	03200 CORONARY CARE UNI T					32.00
	03300 BURN INTENSIVE CARE UNIT					33.00
34.00	03400 SURGICAL INTENSIVE CARE UNIT					34.00
	04000 SUBPROVI DER – I PF					40.00
	04100 SUBPROVIDER - IRF					41.00
	04200 SUBPROVI DER 04300 NURSERY					42.00
	04400 SKILLED NURSING FACILITY					44.00
	04500 NURSING FACILITY					45.00
46.00	04600 OTHER LONG TERM CARE					46.00
	ANCI LLARY SERVI CE COST CENTERS					
	05000 OPERATING ROOM	0. 325252				50.00
	05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM	0. 239516 0. 430863				51.00 52.00
	05300 ANESTHESI OLOGY	0. 430803				53.00
	05301 PALN MANAGEMENT	0. 798719				53.01
	05400 RADI OLOGY-DI AGNOSTI C	0. 300022				54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 533058				55.00
	05600 RADI OI SOTOPE	0. 000000				56.00
	05601 CARDI AC CATH LAB	0. 172057				56.01
	05700 CT SCAN 05800 MRI	0. 000000 0. 000000				57.00
	05900 CARDI AC CATHETERI ZATI ON	0. 000000				59.00
	06000 LABORATORY	0. 197421				60.00
60. 01	06001 BLOOD LABORATORY	0. 000000				60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0.000000				62.00
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0. 000000 0. 000000				63.00 64.00
	06500 RESPI RATORY THERAPY	0. 293789				65.00
	06600 PHYSI CAL THERAPY	0. 673327				66.00
67.00	06700 OCCUPATI ONAL THERAPY	0. 379111				67.00
	06800 SPEECH PATHOLOGY	0. 437957				68.00
		0. 105967				69.00
	07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000 1. 226799				70.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	0. 424079				72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 213499				73.00
	07400 RENAL DIALYSIS	0. 000000				74.00
75.00	07500 ASC (NON-DISTINCT PART)	0. 000000				75.00
88 00	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC					88.00
	08800 FEDERALLY QUALIFIED HEALTH CENTER					88.00
	09000 CLINIC	0. 522189				90.00
	09002 WOUND CLINIC	0. 442329				90.02
	09003 MOBILE CLINIC	0. 000000				90.03
	09100 EMERGENCY	0. 280087				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0. 209248				92.00
	09900 CMHC					99.00
	10100 HOME HEALTH AGENCY					101.00
	SPECIAL PURPOSE COST CENTERS	· · ·				
	11300 INTEREST EXPENSE					113.00
	11400 UTI LI ZATI ON REVI EW-SNF					114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)					115.00 116.00
200.00	11600 HOSPICE Subtotal (see instructions)					200.00
	, , ,					200.00
201.00						1201.00

	Financial Systems	IU HEALTH GOS				u of Form CMS-	2552-10
COMPUT	ATION OF RATIO OF COSTS TO CHARGES		Provi der		Period: From 01/01/2015 To 12/31/2015		pared: 7 pm
			Tit	le XIX	Hospi tal	Cost	
	Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.	Total Costs	Costs RCE Di sal I owance	Total Costs	
		1.00	2.00	3.00	4.00	5.00	
30. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS	18, 409, 807		18, 409, 80	7 0	18, 409, 807	30.00
	03100 I NTENSI VE CARE UNI T	4, 280, 920		4, 280, 92			•
	03200 CORONARY CARE UNI T	0			0 0	0	•
	03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT	0			0 0	0	
	04000 SUBPROVIDER - IPF	0				0	
	04100 SUBPROVIDER - IRF	0			0 0	0	
	04200 SUBPROVI DER	0			0 0	0	•
	04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	611, 602		611, 60	2 0	611, 602 0	1
	04500 NURSING FACILITY	0				0	•
	04600 OTHER LONG TERM CARE	0			0 0		•
	ANCI LLARY SERVI CE COST CENTERS	4 (005 057	1	4 / 005 05	-	4 / 005 053	
	05000 OPERATING ROOM 05100 RECOVERY ROOM	16, 385, 057 1, 048, 688		16, 385, 05 1, 048, 68			
	05200 DELIVERY ROOM & LABOR ROOM	3, 178, 489		3, 178, 48		3, 178, 489	
53.00	05300 ANESTHESI OLOGY	0			0 0	0	•
53.01	05301 PALN MANAGEMENT	1, 189, 461		1, 189, 46			
54.00 55.00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C	30, 693, 398 688, 010		30, 693, 39 688, 01			•
	05600 RADI OLOGI - ITILKAP LOTI C	000,010			0 0	088,010	1
56.01	05601 CARDI AC CATH LAB	3, 068, 575		3, 068, 57	5 0	3, 068, 575	•
	05700 CT SCAN	0			0 0	0	
	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0				0	
	06000 LABORATORY	7, 161, 490		7, 161, 49	0 0	7, 161, 490	•
60. 01	06001 BLOOD LABORATORY	0			0 0	0	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0			0 0	0	
62.00 63.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS.	0				0	
64.00	06400 I NTRAVENOUS THERAPY	0			0 0	0	•
65.00	06500 RESPI RATORY THERAPY	2, 272, 239				2, 272, 239	
66.00	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	3, 868, 746		3, 868, 74		3, 868, 746	•
67.00 68.00	06800 SPEECH PATHOLOGY	950, 331 624, 689		950, 33 624, 68		950, 331 624, 689	
	06900 ELECTROCARDI OLOGY	469, 027		469, 02		469, 027	
	07000 ELECTROENCEPHALOGRAPHY	0			0 0	0	•
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	7, 728, 534		7, 728, 53		.,.==,==.	
	07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	5, 690, 042 32, 166, 773		5, 690, 04 32, 166, 77		5, 690, 042 32, 166, 773	73.00
74.00	07400 RENAL DI ALYSI S	0			0 0		74.00
75.00	07500 ASC (NON-DISTINCT PART)	0			0 0	0	75.00
<u> </u>	OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC	0				0	88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0			0 0	0	
	09000 CLINIC	665, 958		665, 95	8 0	665, 958	
	09002 WOUND CLINIC	2, 359, 722		2, 359, 72			•
	09003 MOBILE CLINIC 09100 EMERGENCY	7, 901 7, 098, 678		7, 90 7, 098, 67		7, 901 7, 142, 884	
	09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 378, 624		2, 378, 62		2, 378, 624	
	OTHER REIMBURSABLE COST CENTERS	· · ·	1	· · ·			
	09900 CMHC 10100 HOME HEALTH AGENCY	0 3, 580, 292		3, 580, 29	0 2	0 3, 580, 292	99.00 101.00
	SPECIAL PURPOSE COST CENTERS	1	I	1			1
	11300 INTEREST EXPENSE						113.00
	11400 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D.P.)	0			0	Λ	114.00 115.00
	11600 HOSPI CE	2, 521, 102		2, 521, 10	-	2, 521, 102	•
200.00	Subtotal (see instructions)	159, 098, 155	0	159, 098, 15	5 235, 116	159, 333, 271	200. 00
201.00		2, 378, 624		2, 378, 62		2, 378, 624	
202.00	Total (see instructions)	156, 719, 531	0	156, 719, 53	1 235, 116	156, 954, 647	1202. UU

COMPUTA	Financial Systems TION OF RATIO OF COSTS TO CHARGES	IU HEALTH GOSH		CCN: 150026	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/27/2016 5:4	epared:
			Ti t	le XIX	Hospi tal	Cost	
	Cost Center Description	Inpati ent	Charges Outpatient	Total (col. + col. 7)	6 Cost or Other Ratio	TEFRA I npati ent Rati o	
r		6.00	7.00	8.00	9.00	10.00	
	INPATIENT ROUTINE SERVICE COST CENTERS	27.0/5.10/		27.0/5.1		[
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	37, 865, 126		37, 865, 12			30.00
	03200 CORONARY CARE UNIT	12, 526, 545		12, 526, 54	+5		32.00
	03300 BURN INTENSIVE CARE UNIT	0			0		33.00
	03400 SURGICAL INTENSIVE CARE UNIT	0			0		34.00
	04000 SUBPROVI DER – I PF	0			0		40.00
	04100 SUBPROVI DER – I RF	0			0		41.00
	04200 SUBPROVI DER	0		0 550 7	0		42.00
	04300 NURSERY 04400 SKILLED NURSING FACILITY	2, 552, 715		2, 552, 7	0		43.00
	04500 NURSING FACILITY	0			0		45.00
	04600 OTHER LONG TERM CARE	0			0		46.00
	ANCILLARY SERVICE COST CENTERS						
	05000 OPERATING ROOM	17, 201, 477	33, 174, 982				
	05100 RECOVERY ROOM	1, 582, 322	2, 796, 047				
	05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESI OLOGY	7, 377, 034	0				
	05300 PALN MANAGEMENT	1, 122	1, 506, 647				
	05400 RADI OLOGY-DI AGNOSTI C	11,026,909	91, 808, 164			0.000000	
	05500 RADI OLOGY-THERAPEUTI C	79, 290	1, 211, 396				
	05600 RADI OI SOTOPE	0	0		0 0. 000000	0. 000000	56.00
	05601 CARDIAC CATH LAB	8, 306, 513	9, 528, 163	17, 834, 6		0.00000	
	05700 CT SCAN	0	C		0 0.000000		
		0	0		0 0.000000		
	05900 CARDI AC CATHETERI ZATI ON 06000 LABORATORY	13, 023, 383	23, 251, 850	36, 275, 23	0 0. 000000 33 0. 197421	0.000000	
	06001 BLOOD LABORATORY	13, 023, 303	23, 251, 850	30, 273, 2	0 0.000000		
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	C		0 0.000000		
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C)	0 0. 000000		
	06300 BLOOD STORING, PROCESSING & TRANS.	0	C		0 0. 000000	0.00000	63.00
	06400 I NTRAVENOUS THERAPY	0	0		0 0. 000000		
	06500 RESPI RATORY THERAPY	6, 398, 863	1, 335, 394				
	06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY	1, 263, 247 1, 078, 538	4, 482, 467 1, 428, 195			0.000000	
	06800 SPEECH PATHOLOGY	170,054	1, 256, 318				
	06900 ELECTROCARDI OLOGY	1, 149, 512	3, 276, 663				
	07000 ELECTROENCEPHALOGRAPHY	0	0		0 0. 000000	0. 000000	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	4, 666, 684	1, 633, 071	6, 299, 7	55 1. 226799	0.00000	71.00
	07200 I MPL. DEV. CHARGED TO PATIENTS	7, 051, 987	6, 365, 425				
	07300 DRUGS CHARGED TO PATIENTS	33, 652, 128					
	07400 RENAL DI ALYSI S 07500 ASC (NON-DI STI NCT PART)	0	0		0 0.000000 0 0.000000		
	DUTPATIENT SERVICE COST CENTERS	- V		1	0.00000	0.00000	, , , , , , , , , , , , , , , , , , , ,
	08800 RURAL HEALTH CLINIC	0	0		0 0.00000	0.00000	88. 00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	C		0 0.000000		
	09000 CLINIC	0	1, 275, 321				
		0	5, 372, 422				
	09003 MOBILE CLINIC 09100 EMERGENCY	0 4, 712, 767	0 20, 789, 622		0 0. 000000 39 0. 278353		
	09200 OBSERVATION BEDS (NON-DISTINCT PART	4, /12, /0/	20, 789, 822				
	OTHER REIMBURSABLE COST CENTERS		,, 101		0.207210		1
	09900 CMHC 10100 HOME HEALTH AGENCY	0	0 1, 843, 637		0		99.00
	SPECIAL PURPOSE COST CENTERS		., 0.10, 007	., ., ., ., .,		· · · · · · · · · · · · · · · · · · ·	1
	11300 INTEREST EXPENSE						7113.00
	11400 UTI LI ZATI ON REVI EW-SNF						114.00
	11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0		0		115.00
116.00 200.00	11600 HOSPICE Subtotal (see instructions)	171 696 216	4, 171, 009 344, 886, 887				116. 00 200. 00
200.00	Less Observation Beds	171, 686, 216	344,000,08/	516, 573, 10			200.00
-01.00	Total (see instructions)	171, 686, 216	344, 886, 887	516, 573, 10	22		201.00

	Financial Systems	IU HEALTH GOSHEN			u of Form CMS-	2552-10
COMPUTA	TION OF RATIO OF COSTS TO CHARGES		Provider CCN: 150026	Period: From 01/01/2015 To 12/31/2015	Worksheet C Part I Date/Time Pre 5/27/2016 5:4	
			Title XIX	Hospi tal	Cost	
	Cost Center Description	PPS Inpatient Ratio				
		11.00				
	NPATIENT ROUTINE SERVICE COST CENTERS					1 00 00
	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT					30.00
	03200 CORONARY CARE UNIT					32.00
	03300 BURN INTENSIVE CARE UNIT					33.00
34.00	03400 SURGI CAL I NTENSI VE CARE UNI T					34.00
	04000 SUBPROVI DER – I PF					40.00
	04100 SUBPROVIDER - IRF					41.00
	04200 SUBPROVI DER 04300 NURSERY					42.00
	04400 SKI LLED NURSI NG FACI LI TY					43.00
	04500 NURSI NG FACI LI TY					45.00
	04600 OTHER LONG TERM CARE					46.00
	ANCILLARY SERVICE COST CENTERS					
	D5000 OPERATING ROOM	0.000000				50.00
	D5100 RECOVERY ROOM D5200 DELIVERY ROOM & LABOR ROOM	0.000000				51.00
	D5300 ANESTHESI OLOGY	0.000000				52.00
	D5301 PALN MANAGEMENT	0. 000000				53.00
	05400 RADI OLOGY-DI AGNOSTI C	0. 000000				54.00
55.00 0	05500 RADI OLOGY-THERAPEUTI C	0. 000000				55.00
	D5600 RADI OI SOTOPE	0. 000000				56.00
	D5601 CARDI AC CATH LAB	0. 000000				56.01
	05700 CT_SCAN 05800 MRI	0.000000				57.00 58.00
	05900 CARDI AC CATHETERI ZATI ON	0.000000				59.00
	D6000 LABORATORY	0. 000000				60. OC
60.01	D6001 BLOOD LABORATORY	0. 000000				60.01
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000				61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000				62.00
	06300 BLOOD STORI NG, PROCESSI NG & TRANS. 06400 I NTRAVENOUS THERAPY	0.000000				63.00 64.00
	06500 RESPI RATORY THERAPY	0. 000000				65.00
	06600 PHYSI CAL THERAPY	0. 000000				66. OC
	06700 OCCUPATI ONAL THERAPY	0. 000000				67.00
	D6800 SPEECH PATHOLOGY	0. 000000				68.00
		0.000000				69.00
	D7000 ELECTROENCEPHALOGRAPHY D7100 MEDICAL SUPPLIES CHARGED TO PATIENT	0.000000				70.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	0.000000				72.00
	D7300 DRUGS CHARGED TO PATIENTS	0. 000000				73.00
	07400 RENAL DI ALYSI S	0. 000000				74.00
	D7500 ASC (NON-DISTINCT PART)	0. 000000				75.00
	DUTPATIENT SERVICE COST CENTERS	0.000000				88.00
	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000				89.00
	09000 CLINIC	0. 000000				90.00
90.02	D9002 WOUND CLINIC	0. 000000				90.02
	09003 MOBILE CLINIC	0.00000				90.03
	09100 EMERGENCY	0.000000				91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	0. 000000				92.00
	D9900 CMHC					99.00
	10100 HOME HEALTH AGENCY					101.00
S	SPECIAL PURPOSE COST CENTERS					
	11300 INTEREST EXPENSE					113.00
	11400 UTILIZATION REVIEW-SNF 11500 AMBULATORY SURGICAL CENTER (D.P.)					114.00 115.00
	11600 HOSPICE					116.00
200.00	Subtotal (see instructions)					200.00
201.00	Less Observation Beds					201.00
202.00	Total (see instructions)					202.00

Health Financial Systems	IU HEALTH GOSH			In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der	CCN: 150026	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part I Date/Time Pre 5/27/2016 5:4	
			e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient		
	Related Cost	Adjustment	Capi tal	Days	3 / col. 4)	
	(from Wkst. B,		Related Cos	t		
	Part II, col.		(col. 1 - co	I.		
	26)		2)			
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	1, 073, 561	0	1, 073, 5	61 20, 247	53.02	30.00
31.00 INTENSIVE CARE UNIT	365, 219		365, 2	19 2, 799	130.48	31.00
32.00 CORONARY CARE UNIT	0			0 0	0.00	32.00
33.00 BURN INTENSIVE CARE UNIT	0			0 0	0.00	•
34. 00 SURGICAL INTENSIVE CARE UNIT	0			0 0	0.00	
40. 00 SUBPROVIDER - IPF	0	0		0 0	0.00	
41. 00 SUBPROVIDER - IRF	0	0		0 0	0.00	
42. 00 SUBPROVI DER	0	0		0 0	0.00	
43. 00 NURSERY	39, 319	0	39, 3	19 2, 441	16. 11	
	39, 319		39, 3	2,441	0.00	
	0			0 0		
45. 00 NURSING FACILITY	0		4 470 0		0.00	45.00
200.00 Total (lines 30-199)	1, 478, 099	I man a th' a mate	1, 478, 0	99 25, 487		200.00
Cost Center Description	Inpatient	Inpati ent				
	Program days	Program				
		Capital Cost				
		(col. 5 x col.				
	(00	<u> </u>	-			
INPATIENT ROUTINE SERVICE COST CENTERS	6.00	7.00				
30. 00 ADULTS & PEDIATRICS	7,049	373, 738	1			30.00
31. 00 I NTENSI VE CARE UNI T	1, 137	148, 356				31.00
	1, 137	140, 300				32.00
	0	0	1			
33. 00 BURN INTENSIVE CARE UNIT	0	0				33.00
34. 00 SURGI CAL I NTENSI VE CARE UNI T	0	0				34.00
40. 00 SUBPROVIDER - IPF	0	0				40.00
41.00 SUBPROVIDER - IRF	0	0				41.00
42. 00 SUBPROVI DER	0	0				42.00
43.00 NURSERY	0	0				43.00
44.00 SKILLED NURSING FACILITY	0	0				44.00
			1			
45.00 NURSING FACILITY 200.00 Total (lines 30-199)	0 8, 186	0 522, 094				45.00

Health Financial Systems	IU HEALTH GOS	HEN HOSPITAL		In Lie	eu of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 150026	Period: From 01/01/2015 To 12/31/2015		
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
	Related Cost	(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ co	I. 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	T	I	1		I	
50. 00 05000 OPERATI NG ROOM	2, 476, 541					
51.00 05100 RECOVERY ROOM	65, 850					
52.00 05200 DELIVERY ROOM & LABOR ROOM	207, 333	7, 377, 034				52.00
53.00 05300 ANESTHESI OLOGY	0	-	0.0000			53.00
53.01 05301 PALN MANAGEMENT	59, 517				-	53.01
54.00 05400 RADI OLOGY-DI AGNOSTI C	2, 457, 285					
55. 00 05500 RADI OLOGY-THERAPEUTI C	73, 100	1, 290, 686				55.00
56. 00 05600 RADI OI SOTOPE	0	-	0.0000		0	56.00
56. 01 05601 CARDI AC CATH LAB	301, 785	17, 834, 676			46, 822	56.01
57.00 05700 CT SCAN	0	C	0.0000		0	57.00
58. 00 05800 MRI	0	C	0.0000	00 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C	0.0000	00 0	0	59.00
60. 00 06000 LABORATORY	277, 341	36, 275, 233	0.0076	45 6, 099, 250	46, 629	60.00
60. 01 06001 BLOOD LABORATORY	0	C	0.0000	00 0	0	60. 01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C	0.0000	00 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0.0000	00 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	C	0.0000	00 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	81, 158	7, 734, 257	0. 0104	93 3, 078, 593	32, 304	65.00
66. 00 06600 PHYSI CAL THERAPY	340, 925	5, 745, 714	0. 0593	36 651, 358	38, 649	66.00
67.00 06700 OCCUPATI ONAL THERAPY	14, 288	2, 506, 733	0. 0057	00 573, 063	3, 266	67.00
68.00 06800 SPEECH PATHOLOGY	9,073	1, 426, 372	0. 0063	61 108, 984	693	68.00
69. 00 06900 ELECTROCARDI OLOGY	123, 111	4, 426, 175	0. 0278	14 766, 699	21, 325	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	C	0.0000	00 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	98, 897	6, 299, 755	0. 0156	99 4, 354, 825	68, 366	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	75, 767	13, 417, 412	0. 0056	47 2, 501, 331	14, 125	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	491, 709	150, 664, 738	0.0032		45, 577	73.00
74.00 07400 RENAL DI ALYSI S	0	C	0.0000	00 00	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C	0.0000	00 00	0	75.00
OUTPATIENT SERVICE COST CENTERS		•			•	1
88.00 08800 RURAL HEALTH CLINIC	0	C	0.0000	00 00	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	c c	0.0000	00 00	0	89.00
90. 00 09000 CLINIC	50, 691	1, 275, 321	0.0397	48 0	0	90.00
90. 02 09002 WOUND CLINIC	298,038				0	90.02
90. 03 09003 MOBILE CLINIC	5, 384				0	90.03
91. 00 09100 EMERGENCY	466, 877					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	138, 709				0	92.00
200.00 Total (lines 50-199)	8, 113, 379			47, 420, 520	726, 098	
	1 · · · · · ·					

Health Financial Systems	IU HEALTH GOSH	IEN HOSPI TAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA	SS THROUGH COST			Period: From 01/01/2015 To 12/31/2015	Worksheet D Part III Date/Time Pre 5/27/2016 5:4	pared:
			e XVIII	Hospi tal	PPS	
Cost Center Description	Nursing School	Cost	Medical Education Cos	instructions)	Total Costs (sum of cols. 1 through 3, minus col. 4)	
	1.00	2.00	3.00	4.00	5.00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 03000 ADULTS & PEDIATRICS 31. 00 03100 INTENSIVE CARE UNIT 32. 00 03200 CORONARY CARE UNIT 33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT 34. 00 04000 SUBPROVIDER - IPF 41. 00 04100 SUBPROVIDER - IRF 42. 00 04200 SUBPROVIDER 43. 00 04300 NURSERY 44. 00 04400 SKILLED NURSING FACILITY 45. 00 04500 NURSING FACILITY 200. 00 Total (lines 30-199) Cost Center Description	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0	31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00
				Cost (col. 7 x col. 8)		
	6,00	7.00	8,00	9, 00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	7.00	0.00	7.00		
ATT LINE ADDULTS & PEDIATRICE COST CLINERS 30.00 03000 ADULTS & PEDIATRICE COST CLINERS 31.00 03100 INTENSIVE CARE UNIT 32.00 03200 CORONARY CARE UNIT 32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT 34.00 03400 SURGICAL INTENSIVE CARE UNIT 40.00 04000 SUBPROVIDER - IPF 41.00 04100 SUBPROVIDER - IRF 1 41.00 04300 NURSERY 44.00 04400 SKILLED NURSING FACILITY 45.00 04500 NURSING FACILITY 200.00 Total (lines 30-199) Total 1 1	20, 247 2, 799 0 0 0 0 0 2, 441 0 0 25, 487	0.00 0.00 0.00 0.00 0.00 0.00 0.00 0.0	1, 13	7 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		30.00 31.00 32.00 33.00 34.00 40.00 41.00 42.00 43.00 44.00 45.00 200.00

Health Financial Systems	IU HEALTH GOSH	IEN HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS	S Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet D Part IV Date/Time Pre 5/27/2016 5:4	pared: 7 pm
		Ti tl	e XVIII	Hospi tal	PPS	
Cost Center Description	Non Physician	Nursing School	Allied Healt	h All Other	Total Cost	
	Anesthetist			Medi cal	(sum of col 1	
	Cost			Education Cost	through col.	
					4)	
	1.00	2.00	3.00	4.00	5.00	
ANCILLARY SERVICE COST CENTERS				-		
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
51.00 05100 RECOVERY ROOM	0	0		0 0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
53.01 05301 PALN MANAGEMENT	0	0		0 0	0	53.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0 0	0	55.00
56. 00 05600 RADI OI SOTOPE	0	0		0 0	0	56.00
56. 01 05601 CARDI AC CATH LAB	0	0		0 0	0	56.01
57.00 05700 CT SCAN	0	0		0 0	0	57.00
58. 00 05800 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
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		0 0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	
74.00 07400 RENAL DIALYSIS	0	0		0 0	0	
75.00 07500 ASC (NON-DISTINCT PART)	0	0		0 0	0	75.00
OUTPATIENT SERVICE COST CENTERS	-1		1			
88.00 08800 RURAL HEALTH CLINIC	0	0		0 0	0	
89.00 08900 FEDERALLY QUALI FIED HEALTH CENTER	0	0		0 0	0	
90. 00 09000 CLINIC	0	0		0 0	0	90.00
90. 02 09002 WOUND CLINIC	0	0		0 0	0	90.02
90. 03 09003 MOBILE CLINIC	0	0		0 0	0	•
91.00 09100 EMERGENCY	0	0	258, 78		258, 786	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0		0 0	0	
200.00 Total (lines 50-199)	0	0	258, 78	0	258, 786	200.00

Health Financial Systems APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	IU HEALTH GOS	S Provi der	CCN: 150026	Period:	u of Form CMS-2 Worksheet D	
THROUGH COSTS				From 01/01/2015	Part IV	
				To 12/31/2015	Date/Time Pre	pared:
		T: +1	e XVIII	Hospi tal	5/27/2016 5:4 PPS	/ pm
Cost Center Description	Total	Total Charges			Inpati ent	
cost center bescription	Outpati ent	(from Wkst. C,		Ratio of Cost	Program	
	Cost (sum of	Part I, col.	$(col. 5 \div col$. to Charges	Charges	
	col . 2, 3 and		7)	$(col. 6 \div col.$	ondi geo	
	4)		.,	7)		
	6.00	7.00	8.00	9.00	10.00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATI NG ROOM	0	50, 376, 459	0. 00000	0 0. 000000	5, 085, 243	50.00
51.00 05100 RECOVERY ROOM	0	4, 378, 369	0. 00000	0 0. 000000	557, 349	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	7, 377, 034	0. 00000	0 0. 000000	420	52.00
53. 00 05300 ANESTHESI OLOGY	0	C	0. 00000	0 0. 000000	0	53.00
53. 01 05301 PALN MANAGEMENT	0	1, 507, 769	0. 00000	0 0. 000000	0	53.01
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	102, 835, 073	0. 00000	0 0. 000000	4, 186, 773	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	1, 290, 686	0. 00000	0 0. 000000	0	55.00
56. 00 05600 RADI OI SOTOPE	0	C	0. 00000	0 0. 000000	0	56.00
56.01 05601 CARDIAC CATH LAB	0	17, 834, 676	0. 00000	0 0. 000000	2, 767, 083	56.01
57.00 05700 CT SCAN	0	C	0. 00000	0 0. 000000	0	57.OC
58. 00 05800 MRI	0	C	0. 00000	0 0. 000000	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C	0. 00000	0 0. 000000	0	59.00
60. 00 06000 LABORATORY	0	36, 275, 233	0. 00000	0 0. 000000	6, 099, 250	60.00
60. 01 06001 BLOOD LABORATORY	0	C	0. 00000	0 0. 000000	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	C	0. 00000	0 0. 000000	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	C	0. 00000	0 0. 000000	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	C	0. 00000	0 0. 000000	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	7, 734, 257	0. 00000	0 0. 000000	3, 078, 593	65.00
66. 00 06600 PHYSI CAL THERAPY	0	5, 745, 714	0. 00000	0 0. 000000	651, 358	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	2, 506, 733	0. 00000	0 0. 000000	573, 063	67.00
68.00 06800 SPEECH PATHOLOGY	0	1, 426, 372	0. 00000	0 0. 000000	108, 984	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	4, 426, 175	0. 00000	0 0. 000000	766, 699	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0				0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0				4, 354, 825	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0				2, 501, 331	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0				13, 963, 401	73.00
74.00 07400 RENAL DIALYSIS	0				0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	C	0.00000	0 0.000000	0	75.00
OUTPATIENT SERVICE COST CENTERS			1			
88.00 08800 RURAL HEALTH CLINIC	0				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0				0	89.00
90. 00 09000 CLINIC	0	., =, . = .			0	90.00
90. 02 09002 WOUND CLINIC	0				0	90.02
90. 03 09003 MOBILE CLINIC	0	-			0	90.03
91. 00 09100 EMERGENCY	258, 786				2, 726, 148	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0			0 0. 000000	0	92.00
200.00 Total (lines 50-199)	258, 786	457, 614, 071			47, 420, 520	200.00

Health Financial Systems	IU HEALTH GOSH				u of Form CMS	-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS		CCN: 150026	Period: From 01/01/2015 To 12/31/2015	Date/Time Pr 5/27/2016 5:	epared: 47 pm
			e XVIII	Hospi tal	PPS	
Cost Center Description	Inpatient Program Pass-Through Costs (col. 8 <u>x col. 10)</u> 11.00	Outpatient Program Charges	Outpatient Program Pass-Throug Costs (col. <u>x col. 12</u>)			
	11.00	12.00	13.00			-
ANCI LLARY SERVI CE COST CENTERS		7 540 07/	1	0		
50. 00 05000 OPERATING ROOM	0	7, 548, 076		0		50.00
51.00 05100 RECOVERY ROOM	0	870, 164		0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0		0		52.00
53.00 05300 ANESTHESI OLOGY	0	0		0		53.00
53.01 05301 PALN MANAGEMENT	0	346, 301		0		53.01
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	20, 240, 546	1	0		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0		0		55.00
56. 00 05600 RADI 0I SOTOPE	0	0		0		56.00
56. 01 05601 CARDI AC CATH LAB	0	2, 701, 943		0		56.01
57.00 05700 CT SCAN	0	0		0		57.00
58. 00 05800 MRI	0	0)	0		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0		59.00
60. 00 06000 LABORATORY	0	4, 526, 535		0		60.00
60.01 06001 BLOOD LABORATORY	0	0		0		60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0		0		63.00
64.00 06400 INTRAVENOUS THERAPY	0	0		0		64.00
65. 00 06500 RESPI RATORY THERAPY	0	984, 395		0		65.00
66. 00 06600 PHYSI CAL THERAPY	0	1, 096	1	0		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	177		0		67.00
68. 00 06800 SPEECH PATHOLOGY	0	919		0		68.00
69. 00 06900 ELECTROCARDI OLOGY	0	3, 949, 804		0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	3, 747, 004		0		70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	2 424 544	1	0		71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENT	0	2, 436, 546		0		72.00
	-	1, 864, 334	1	0		
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	38, 165, 254	1	0		73.00
74.00 07400 RENAL DIALYSIS	0	0		0		74.00
75. 00 07500 ASC (NON-DI STI NCT PART) OUTPATI ENT SERVICE COST CENTERS	0	0	1	0		75.00
88.00 08800 RURAL HEALTH CLINIC	0	0		0		88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	1	0		89.00
90. 00 09000 CLINIC	0	815, 955		0		90.00
90. 02 09002 WOUND CLINIC	0	010, 700	1	0		90.02
90. 03 09003 MOBILE CLINIC	0	0		0		90.02
91. 00 09100 EMERGENCY	27,665	3, 306, 133	33, 5	-		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	27,005	3, 202, 928		0		92.00
200.00 Total (lines 50-199)	27,665	90, 961, 106				200.00
	27,005	70, 701, 100	J 55, 5	51		1200.00

Health Financial Systems	IU HEALTH GOS	HEN HOSPITAL		In Lie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi der		Period: From 01/01/2015		
				To 12/31/2015	Date/Time Pre 5/27/2016 5:4	pared: 7 pm
		Ti tl	e XVIII	Hospi tal	PPS	, b
			Charges		Costs	
Cost Center Description		PPS Reimbursed		Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C, Part I, col. 9	inst.)	Services Subject To	Services Not Subject To		
	raiti, coi. 🤊		Ded. & Coins.	Ded. & Coi ns.		
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 OPERATING ROOM	0. 325252			0 0		50.00
51.00 05100 RECOVERY ROOM	0. 239516			0 0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 430863			0 0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0.00000			0 0	0	53.00
53. 01 05301 PALN MANAGEMENT	0. 788888		1	0 0	273, 193	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 298472		1	0	6, 041, 236	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0. 533058 0. 000000				0	55.00 56.00
56. 01 05601 CARDI AC CATH LAB	0. 172057				464, 888	56.00
57. 00 05700 CT SCAN	0. 000000				404, 888	57.00
58. 00 05800 MRI	0. 000000			0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			0 0	0	59.00
60. 00 06000 LABORATORY	0. 197421			-	893, 633	60.00
60. 01 06001 BLOOD LABORATORY	0.000000			0 0	0	60.01
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0 0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000	0) (0 0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	0 0)	0 0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000			0 0	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0. 293789			0 0	289, 204	65.00
66. 00 06600 PHYSI CAL THERAPY	0. 673327			0 0	738	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 379111			0	67	67.00
68. 00 06800 SPEECH PATHOLOGY	0. 437957				402	68.00
69. 00 06900 ELECTROCARDI OLOGY 70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 105967 0. 000000				418, 549 0	69.00 70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 226799				2, 989, 152	
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 424079				790, 625	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 213499			145, 778		73.00
74. 00 07400 RENAL DI ALYSI S	0. 000000			0 0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0.000000			0 0	0	75.00
OUTPATIENT SERVICE COST CENTERS						
88.00 08800 RURAL HEALTH CLINIC	0. 000000				0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89.00
90. 00 09000 CLINIC	0. 522189		(0 0	426, 083	
90. 02 09002 WOUND CLINIC	0. 439229			0 0	0	90.02
90. 03 09003 MOBILE CLINIC	0.00000			0 0	0	90.03
91.00 09100 EMERGENCY	0. 278353			94	920, 272	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 200.00 Subtotal (see instructions)	0. 209248	3, 202, 928 90, 961, 106		0 0 7 145, 872	670, 206 24, 989, 937	92.00
200.00Subtotal (see instructions)201.00Less PBP Clinic Lab. Services-Program		90, 901, 106		145,872		200.00
Only Charges			· · · · · · · · · · · · · · · · · · ·	0		201.00
202.00 Net Charges (line 200 +/- line 201)		90, 961, 106	1, 46	7 145, 872	24, 989, 937	202.00

	nancial Systems	IU HEALTH GOSI					u of Form CMS	-2552-10
APPORTI ON	NMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi	der	CCN: 150026	Period: From 01/01/2015 To 12/31/2015	Worksheet D Part V Date/Time Pr 5/27/2016 5:	repared: 47 pm
			-	Ti tl	e XVIII	Hospi tal	PPS	17 pm
		Cos	sts					
	Cost Center Description	Cost	Cost					
		Reimbursed	Reimburse	ed				
		Servi ces	Servi ces I	Not				
		Subject To	Subject	Го				
		Ded. & Coins.	Ded. & Coi					
		(see inst.)	(see inst	.)				
		6.00	7.00					
	CI LLARY SERVICE COST CENTERS		1		1			
	OOO OPERATING ROOM	0		0				50.00
	100 RECOVERY ROOM	0		0				51.00
	200 DELIVERY ROOM & LABOR ROOM	0		0				52.00
	300 ANESTHESI OLOGY	0		0				53.00
	301 PALN MANAGEMENT	0		0				53.01
	400 RADI OLOGY-DI AGNOSTI C	0		0				54.00
	500 RADI OLOGY-THERAPEUTI C	0		0				55.00
	600 RADI OI SOTOPE	0		0				56.00
	601 CARDI AC CATH LAB	0		0				56.01
	700 CT SCAN	0		0				57.00
	800 MRI	0		0				58.00
	900 CARDI AC CATHETERI ZATI ON	0		0				59.00
	000 LABORATORY	290		0				60.00
	001 BLOOD LABORATORY	0		0				60.01
	100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0						61.00
	200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0				62.00
	300 BLOOD STORING, PROCESSING & TRANS.	0		0				63.00
	400 I NTRAVENOUS THERAPY	0		0				64.00
	500 RESPI RATORY THERAPY	0		0				65.00
	600 PHYSI CAL THERAPY	0		0				66.00
	700 OCCUPATI ONAL THERAPY	0		0				67.00
	800 SPEECH PATHOLOGY	0		0				68.00
	900 ELECTROCARDI OLOGY	0		0				69.00
	000 ELECTROENCEPHALOGRAPHY	0		0				70.00
	100 MEDICAL SUPPLIES CHARGED TO PATIENT	0		0				71.00
	200 IMPL. DEV. CHARGED TO PATIENTS	0		0				72.00
	300 DRUGS CHARGED TO PATIENTS	0		123				73.00
	400 RENAL DIALYSIS	0		0				74.00
	500 ASC (NON-DI STI NCT PART)	0		0				75.00
	TPATIENT SERVICE COST CENTERS		1		1			_
	800 RURAL HEALTH CLINIC	0		0				88.00
	900 FEDERALLY QUALIFIED HEALTH CENTER	0		0				89.00
	2000 CLINIC	0		0				90.00
	2002 WOUND CLINIC	0		0				90.02
	003 MOBILE CLINIC	0		0				90.03
	100 EMERGENCY	0		26	1			91.00
	200 OBSERVATION BEDS (NON-DISTINCT PART	0		0				92.00
200.00	Subtotal (see instructions)	290		149				200.00
201.00	Less PBP Clinic Lab. Services-Program	0						201.00
	Only Charges			4.40				
202.00	Net Charges (line 200 +/- line 201)	290	y 31,	149				202.00

MPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150026	Period: From 01/01/2015 To 12/31/2015	Worksheet D-1 Date/Time Pre	pare
		Title XVIII	Hospi tal	5/27/2016 5: 4 PPS	/ pn
	Cost Center Description			1.00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed days,	excluding newborn)		20, 247	1 1
00	Inpatient days (including private room days, excluding swing-be	d and newborn days)		20, 247	2
00	Private room days (excluding swing-bed and observation bed days do not complete this line.). If you have only pr	ivate room days,	8, 636	3
00	Semi-private room days (excluding swing-bed and observation bed			8, 995	4
00	Total swing-bed SNF type inpatient days (including private room reporting period	days) through Decembe	r 31 of the cost	0	5
00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6
00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	dave) through December	21 of the cost	0	7
00	reporting period	days) thi ough becember	ST OF THE COST	0	'
00	Total swing-bed NF type inpatient days (including private room	days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	7, 049	9
	newborn days)		0		
00	Swing-bed SNF type inpatient days applicable to title XVIII onl through December 31 of the cost reporting period (see instructi		oom days)	0	10
00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	oom days) after	0	11
00	December 31 of the cost reporting period (if calendar year, ent Swing-bed NF type inpatient days applicable to titles V or XIX		e room days)	0	12
. 00	through December 31 of the cost reporting period	only (the daring privat		0	'2
. 00	Swing-bed NF type inpatient days applicable to titles V or XIX after December 31 of the cost reporting period (if calendar yea			0	13
00	Medically necessary private room days applicable to the Program			0	14
00				0	
. 00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16
. 00	Medicare rate for swing-bed SNF services applicable to services	through December 31 o	f the cost	0.00	17
00	reporting period Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost	0.00	18
	reporting period				
. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19
. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0.00	20
00	reporting period			10 400 907	21
	Total general inpatient routine service cost (see instructions) Swing-bed cost applicable to SNF type services through December		ing period (line	18, 409, 807 0	
	5 x line 17)		0 1 1	0	
. 00	Swing-bed cost applicable to SNF type services after December 3 x line 18)	I OF THE COST REPORTIN	g period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after December 31	of the cost reporting	period (line 8	0	25
	x line 20)	or the cost roper trug	por ou (rino o		
	Total swing-bed cost (see instructions) General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		0 18, 409, 807	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	i		10, 407, 007	'
	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	52, 944, 386	
	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			22, 190, 518 30, 753, 868	
	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 347720	1
	Average private room per diem charge (line 29 ÷ line 3)			2, 569. 54	
	Average semi-private room per diem charge (line 30 ÷ line 4)	c line 22) (coo inctrue	tions)	3, 419. 00	
	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line	, ,	u uns <i>j</i>	0.00 0.00	
	Private room cost differential adjustment (line 3 x line 35)	- 1		0.00	
	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	18, 409, 807	
	27 minus line 36) PART II - HOSPITAL AND SUBPROVIDERS ONLY				-
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS	TMENTS			1
. 00	Adjusted general inpatient routine service cost per diem (see i	-		909.26	
	Program general inpatient routine service cost (line 9 x line 3	8)		6, 409, 374	39
. 00	Medically necessary private room cost applicable to the Program		1	0	

Health Financial Systems COMPUTATION OF INPATIENT OPERATING COST	IU HEALTH GOSHEN HOSPITAL Provider CCN: 150026		of Form CMS-2 Iorksheet D-1	2552-10
	1	From 01/01/2015 To 12/31/2015 D	ate/Time Prep 6/27/2016 5:47	
Cost Center Description	Title XVIII Total Total Inpatient Cost Inpati ent Days Diem (col. 2) Col. 2) 1.00 2.00		PPS rogram Cost ol. 3 x col. 4) 5.00	
42.00 NURSERY (title V & XIX only)	0 0 0.00	0 0	0	42.00
43.00 INTENSIVE CARE UNIT	4, 280, 920 2, 799 1, 529. 4	5 0	0	43.00
44. 00 CORONARY CARE UNIT	0 0 0.00		0	44.00
45.00 BURN INTENSIVE CARE UNIT	0 0 0.00	o c	0	45.00
46. 00 SURGI CAL I NTENSI VE CARE UNI T	0 0 0.00	0 (0	46.00
47.00 OTHER SPECIAL CARE (SPECIFY) Cost Center Description				47.00
48.00 Program inpatient ancillary service cost (Wk	st D-3 col 3 line 200)		1.00 16,561,251	48.00
49.00 Total Program inpatient costs (sum of lines			22, 970, 625	
PASS THROUGH COST ADJUSTMENTS	W <i>i i i</i>			
50.00 Pass through costs applicable to Program inp	atient routine services (from Wkst. D, sum	of Parts I and	522, 094	50.00
51.00 Pass through costs applicable to Program ing	atient ancillary services (from Wkst D su	m of Parts II	753, 763	51.00
and IV)			/55, /05	51.00
52.00 Total Program excludable cost (sum of lines	· · · · · · · · · · · · · · · · · · ·		1, 275, 857	
53.00 Total Program inpatient operating cost exclu		etist, and	21, 694, 768	53.00
medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)			
54.00 Program di scharges			0	54.00
55.00 Target amount per discharge				
56.00 Target amount (line 54 x line 55)			0	56.00
57.00 Difference between adjusted inpatient operat 58.00 Bonus payment (see instructions)	ng cost and target amount (line 56 minus i	ine 53)	0	57.00 58.00
59.00 Lesser of lines 53/54 or 55 from the cost re	porting period ending 1996, updated and cor	npounded by the	0.00	
market basket				
60.00 Lesser of lines 53/54 or 55 from prior year			0.00	
61.00 If line 53/54 is less than the lower of line which operating costs (line 53) are less that			0	61.00
amount (line 56), otherwise enter zero (see		the target		
62.00 Relief payment (see instructions)			0	62.00
63.00 Allowable Inpatient cost plus incentive pays PROGRAM INPATIENT ROUTINE SWING BED COST	ent (see instructions)		0	63.00
64.00 Medicare swing-bed SNF inpatient routine cos	ts through December 31 of the cost reportin	ng period (See	0	64.00
instructions)(title XVIII only)				
65.00 Medicare swing-bed SNF inpatient routine cos instructions)(title XVIII only)	ts after December 31 of the cost reporting	period (See	0	65.00
66.00 Total Medicare swing-bed SNF inpatient routi	ne costs (line 64 plus line 65)(title XVIII	only). For	0	66.00
CAH (see instructions)				(7.00
67.00 Title V or XIX swing-bed NF inpatient routir (line 12 x line 19)	e costs through December 31 of the cost rep	porting period	0	67.00
68.00 Title V or XIX swing-bed NF inpatient routin	e costs after December 31 of the cost repor	ting period	0	68.00
(line 13 x line 20) 69.00 Total title V or XIX swing-bed NF inpatient	coutine costs (line 67 + line 68)		0	69.00
PART III - SKILLED NURSING FACILITY, OTHER N	JRSING FACILITY, AND ICF/IID ONLY			
70.00 Skilled nursing facility/other nursing facil				70.00
71.00 Adjusted general inpatient routine service of 72.00 Program routine service cost (line 9 x line				71.00 72.00
73.00 Medically necessary private room cost applic	•			73.00
74.00 Total Program general inpatient routine serv	ce costs (line 72 + line 73)			74.00
75.00 Capital -related cost allocated to inpatient	routine service costs (from Worksheet B, Pa	art II, column		75.00
26, line 45) 76.00 Per diem capital-related costs (line 75 ÷ li	ne 2)			76.00
77.00 Program capital -related costs (line 9 x line				77.00
78.00 Inpatient routine service cost (line 74 minu	s line 77)			78.00
79.00 Aggregate charges to beneficiaries for exces		ic line 70)		79.00
80.00 Total Program routine service costs for comp 81.00 Inpatient routine service cost per diem limi		(4/ SIIII 61		80.00 81.00
82.00 Inpatient routine service cost limitation (I				82.00
83.00 Reasonable inpatient routine service costs (see instructions)			83.00
84.00 Program inpatient ancillary services (see in				84.00
85.00 Utilization review - physician compensation 86.00 Total Program inpatient operating costs (sum				85.00 86.00
PART IV - COMPUTATION OF OBSERVATION BED PAS				55.00
			2, 616	87.00
87.00 Total observation bed days (see instructions				
	diem (line 27 ÷ line 2)			

Health Financial Systems	IU HEALTH GOS	HEN HOSPITAL		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 5/27/2016 5:4	
		Titl	e XVIII	Hospi tal	PPS	
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	1, 073, 561	18, 409, 807	0. 05831	5 2, 378, 624	138, 709	90.00
91.00 Nursing School cost	0	18, 409, 807	0.00000	2, 378, 624	0	91.00
92.00 Allied health cost	0	18, 409, 807	0.00000	2, 378, 624	0	92.00
93.00 All other Medical Education	0	18, 409, 807	0.00000	2, 378, 624	0	93.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 150026	Period: From 01/01/2015	Worksheet D-1	
			To 12/31/2015	Date/Time Prep 5/27/2016 5:4	
	Cost Center Description	Title XIX	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS Inpatient days (including private room days and swing-bed	davs excluding newborn)	I	20, 247	
	Inpatient days (including private room days, excluding swill	ng-bed and newborn days)		20, 247	
00	Private room days (excluding swing-bed and observation bed		ivate room days,	7, 715	3
00	do not complete this line. Semi-private room days (excluding swing-bed and observation	n bed days)		9, 916	4
00	Total swing-bed SNF type inpatient days (including private		er 31 of the cost	0	5
00	reporting period Total swing-bed SNF type inpatient days (including private	room days) after December	31 of the cost	0	6
	reporting period (if calendar year, enter 0 on this line)	5.			
00	Total swing-bed NF type inpatient days (including private reporting period	room days) through December	31 of the cost	0	7
00	Total swing-bed NF type inpatient days (including private	room days) after December 3	1 of the cost	0	8
00	reporting period (if calendar year, enter 0 on this line) Total inpatient days including private room days applicable	a ta tha Dragram (avaludi na	, cwing bod and	659	9
00	newborn days)	e to the Program (excluding	swing-bed and	009	
. 00	Swing-bed SNF type inpatient days applicable to title XVII		room days)	0	10
. 00	through December 31 of the cost reporting period (see inst Swing-bed SNF type inpatient days applicable to title XVII		oom days) after	0	11
	December 31 of the cost reporting period (if calendar year	, enter 0 on this line)	5 /		
. 00	Swing-bed NF type inpatient days applicable to titles V or through December 31 of the cost reporting period	XIX only (including privat	e room days)	0	12
. 00	Swing-bed NF type inpatient days applicable to titles V or			0	13
00	after December 31 of the cost reporting period (if calenda Medically necessary private room days applicable to the Pro			0	14
	Total nursery days (title V or XIX only)		uujo)	2, 441	
	Nursery days (title V or XIX only)			1, 471	16
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to ser	vices through December 31 c	of the cost	0.00	17
~~	reporting period			0.00	
. 00	Medicare rate for swing-bed SNF services applicable to ser- reporting period	VICES ATTER December 31 of	the cost	0.00	11
. 00	Medicaid rate for swing-bed NF services applicable to serv	ices through December 31 of	the cost	0.00	19
. 00	reporting period Medicaid rate for swing-bed NF services applicable to serv	ices after December 31 of t	he cost	0.00	20
	reporting period				
	Total general inpatient routine service cost (see instruct Swing-bed cost applicable to SNF type services through Dec		ing period (line	18, 409, 807 0	21
	5 x line 17)	•	31 (0	
. 00	Swing-bed cost applicable to SNF type services after Decem x line 18)	ber 31 of the cost reportir	ng period (line 6	0	23
. 00	Swing-bed cost applicable to NF type services through Dece	mber 31 of the cost reporti	ng period (line	0	24
00	7 x line 19) Swing-bed cost applicable to NF type services after Decemb	or 21 of the cost reporting	poriod (line 9	0	25
. 00	x line 20)		period (inne o	0	20
	Total swing-bed cost (see instructions)			0	
	General inpatient routine service cost net of swing-bed com PRIVATE ROOM DIFFERENTIAL ADJUSTMENT	st (line 21 minus line 26)		18, 409, 807	27
. 00	General inpatient routine service charges (excluding swing	-bed and observation bed ch	arges)	38, 309, 528	
	Private room charges (excluding swing-bed charges)			15, 610, 982	
	Semi-private room charges (excluding swing-bed charges)	$27 \cdot 1$		22, 698, 546	
	General inpatient routine service cost/charge ratio (line :	21 - 11118 20)		0. 480554	
	Average private room per diem charge (line 29 ÷ line 3) Average semi-private room per diem charge (line 30 ÷ line -	4)		2, 023. 46 2, 289. 08	
	Average per diem private room charge differential (line 32		tions)	2, 289.08	
	Average per diem private room cost differential (line 34 x			0.00	
	Private room cost differential adjustment (line 3 x line 3			0.00	36
	General inpatient routine service cost net of swing-bed cost		fferential (line	18, 409, 807	37
	27 minus line 36)			, 107, 007	
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST /	AD ILISTMENTS			-
	Adjusted general inpatient routine service cost per diem (:			909.26	38
	Program general inpatient routine service cost (line 9 x l			599, 202	
	Medically necessary private room cost applicable to the Pro			0	40
	Total Program general inpatient routine service cost (line	20 , line 40		599, 202	1 4 4

OMPUT	Financial Systems FATLON OF INPATIENT OPERATING COST	IU HEALTH GOSH		CCN: 150026	Period: From 01/01/2015		1
					To 12/31/2015	Date/Time Pro	
		.		le XIX	Hospi tal	Cost	
	Cost Center Description	Total Inpatient Cost	Total Inpatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
2. 00	NURSERY (title V & XIX only)	1.00	2.00	3.00 250.5	<u>4.00</u> 55 1,471	5.00 368,559	9 42.
. 00	Intensive Care Type Inpatient Hospital Units		2, 441	250.3	1,471	308, 55	7 42.
. 00	I NTENSI VE CARE UNI T	4, 280, 920	2, 799				3 43.
. 00		0	0				0 44.
. 00 . 00	BURN INTENSIVE CARE UNIT SURGICAL INTENSIVE CARE UNIT	0	0	0. (0. (0 45. 0 46.
	OTHER SPECIAL CARE (SPECIFY)	0	0	0.0	0		47
	Cost Center Description					1.00	-
00	Program inpatient ancillary service cost (Wk	st. D-3, col. 3	, line 200)			2, 790, 41	1 48
. 00		41 through 48)(see instructio	ns)		3, 758, 172	2 49
. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inp	atient routine	services (from	Wkst D sum	of Parts L and	() () () () () () () () () ()	50
. 00							
. 00	Pass through costs applicable to Program inp	atient ancillar	ry services (fr	om Wkst. D, s	sum of Parts II	0	51
2. 00	and IV) Total Program excludable cost (sum of lines	50 and 51)					52
3.00	Total Program inpatient operating cost exclu		lated, non-phy	sician anesth	netist, and		53
	medical education costs (line 49 minus line TARGET AMOUNT AND LIMIT COMPUTATION	52)	-				-
. 00							54
. 00	5					0.00	
. 00	5						56
. 00 . 00	Difference between adjusted inpatient operat Bonus payment (see instructions)	ing cost and ta	irget amount (I	ine 56 minus	line 53)) 57) 58
. 00	Lesser of lines 53/54 or 55 from the cost re	portina period	endina 1996, u	pdated and co	mpounded by the		
market basket							
. 00	Lesser of lines 53/54 or 55 from prior year If line 53/54 is less than the lower of line				the amount by	0.00) 60) 61
. 00	which operating costs (line 53) are less that						
	amount (line 56), otherwise enter zero (see	instructions)			0		
2.00	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	uctions)) 62) 63
. 00	PROGRAM INPATIENT ROUTINE SWING BED COST						
. 00	5 1	ts through Dece	ember 31 of the	cost reporti	ng period (See	(64
5. 00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the c	ost reporting	n period (See		0 65
. 00	instructions) (title XVIII only)				g period (See		
6. 00	Total Medicare swing-bed SNF inpatient routi	ne costs (line	64 plus line 6	5)(title XVII	l only). For	(66 0
. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routin	e costs through	December 31 o	f the cost re	eporting period		67
	(line 12 x line 19)	Ũ					
3. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs after D	ecember 31 of	the cost repo	orting period	(68
9. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + line	68)			0 69
00	PART III - SKILLED NURSING FACILITY, OTHER N						
. 00	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service of	5					70
. 00	Program routine service cost (line 9 x line						72
. 00	Medically necessary private room cost applic	0	•	ne 35)			73
. 00	Total Program general inpatient routine serv Capital-related cost allocated to inpatient	•		orkshoot P	Part II column		74
5.00	26, line 45)	Tout the service	COSTS (TION W	ULKSHEEL D, F			1,2
. 00	Per diem capital-related costs (line 75 ÷ li						76
. 00 . 00	Program capital -related costs (line 9 x line						77
. 00	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces		rovi der record	s)			79
. 00	Total Program routine service costs for comp	· · ·		,	nus line 79)		80
. 00	Inpatient routine service cost per diem limi		`				81
. 00 . 00	Inpatient routine service cost limitation (I Reasonable inpatient routine service costs (82
. 00	Program inpatient ancillary services (see in						84
	Utilization review - physician compensation		ons)				85
. 00			rough 85)				86
7.00	PART IV - COMPUTATION OF OBSERVATION BED PAS Total observation bed days (see instructions					2,616	5 87
	Adjusted general inpatient routine cost per		line 2)			909.26	
3.00			. ,				

Health Financial Systems	IU HEALTH GOS	HEN HOSPITAL		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 5/27/2016 5:4	
		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	1, 073, 561	18, 409, 807	0. 05831	5 2, 378, 624	138, 709	90.00
91.00 Nursing School cost	0	18, 409, 807	0.00000	0 2, 378, 624	0	91.00
92.00 Allied health cost	0	18, 409, 807	0.00000	0 2, 378, 624	0	92.00
93.00 All other Medical Education	0	18, 409, 807	0. 00000	0 2, 378, 624	0	93.00

Health Fina	ncial Systems IU HEALTH	GOSHEN HOSPITAL		. In Lie	eu of Form CMS-	2552-10
INPATIENT A	ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150026	Period:	Worksheet D-3	5
				From 01/01/2015 To 12/31/2015	Date/Time Pre	epared:
					5/27/2016 5:4	7 pm
		Ti tl	e XVIII	Hospi tal	PPS	
	Cost Center Description		Ratio of Cos		Inpatient	
			To Charges	Program Charges	Program Costs (col. 1 x col.	
				charges	2)	
			1.00	2.00	3.00	
	TIENT ROUTINE SERVICE COST CENTERS					
	0 ADULTS & PEDIATRICS			15, 754, 259		30.00
	O INTENSIVE CARE UNIT			5, 768, 123		31.00
	O CORONARY CARE UNIT O BURN INTENSIVE CARE UNIT			0		32.00 33.00
	0 SURGICAL INTENSIVE CARE UNIT			0		34.00
	0 SUBPROVIDER - IPF			0		40.00
	0 SUBPROVI DER – I RF			0		41.00
42.00 0420	0 SUBPROVI DER			0		42.00
	0 NURSERY					43.00
	LLARY SERVICE COST CENTERS				1 (50.005	
	O OPERATING ROOM		0. 3252			
	ORECOVERY ROOM ODELIVERY ROOM & LABOR ROOM		0. 2395			
	0 ANESTHESI OLOGY		0. 4308			
	1 PALN MANAGEMENT		0. 7987		0	
	0 RADI OLOGY-DI AGNOSTI C		0.3000		-	
55.00 0550	0 RADI OLOGY-THERAPEUTI C		0. 5330	58 0	-	1
	0 RADI OI SOTOPE		0.0000		-	
	1 CARDI AC CATH LAB		0. 1720			
	O CT SCAN		0.0000		-	
58.00 0580 59.00 0590	O CARDI AC CATHETERI ZATI ON		0.0000		0	
	0 LABORATORY		0. 1974			
	1 BLOOD LABORATORY		0.0000		0	
	O PBP CLINICAL LAB SERVICES-PRGM ONLY		0.0000		0	
62.00 0620	O WHOLE BLOOD & PACKED RED BLOOD CELL		0.0000	00 0	0	62.00
	0 BLOOD STORING, PROCESSING & TRANS.		0.0000		0	
	O I NTRAVENOUS THERAPY		0.0000		0	
			0. 2937			
	0 PHYSI CAL THERAPY 0 OCCUPATI ONAL THERAPY		0. 6733			
	0 SPEECH PATHOLOGY		0. 3791			
	0 ELECTROCARDI OLOGY		0. 1059			
	0 ELECTROENCEPHALOGRAPHY		0.0000			1
	O MEDICAL SUPPLIES CHARGED TO PATIENT		1. 2267			71.00
	O I MPL. DEV. CHARGED TO PATI ENTS		0. 4240			
	O DRUGS CHARGED TO PATIENTS		0.2134		2, 981, 172	
	O RENAL DI ALYSI S		0.0000			
	O ASC (NON-DISTINCT PART) ATIENT SERVICE COST CENTERS		0.0000	00 0	0	/5.00
	O RURAL HEALTH CLINIC		0.0000	00	0	88.00
	O FEDERALLY QUALIFIED HEALTH CENTER		0.0000		0	
90.00 0900			0. 5221		0	90.00
	2 WOUND CLINIC		0. 4423		-	
	3 MOBILE CLINIC		0.0000		0	
	O EMERGENCY		0. 2800			1
92.00 0920 200.00	OOBSERVATION BEDS (NON-DISTINCT PART Total (sum of lines 50-94 and 96-98)		0. 2092		14 541 251	
200.00	Less PBP Clinic Laboratory Services-Program only	charges (line 61)		47, 420, 520	16, 561, 251	200.00
201.00	Net Charges (line 200 minus line 201)			47, 420, 520		202.00
001			1	, 120, 020	1	

42.00 04200 SUBEROVIDER 0 42.00 04300 43.00 A0.00 ADDURLARY SERVICE COST CENTERS			SHEN HOSPITAL			eu of Form CMS-	
Cast Center Description Title All X Respired in the Service cost centers Input entry in the Service cost centers 0.00 0.03300 [IRM INTERSIVE CARE UNIT 0.0 34.00 35.00 34.00 40.00 0.03500 [IRM INTERSIVE CARE UNIT 0.0 0.03500 [IRM INTERSIVE CARE UNIT 0.0 44.00 50.00 0.5000 [Service cost centers 0.0 0.0 0.0 35.00 50.00 0.5000 [Service cost centers 0.0 0.0 0.0 0.0 0.0 <t< td=""><td>INPATIENT A</td><td>ANCILLARY SERVICE COST APPORTIONMENT</td><td>Provi der</td><td>CCN: 150026</td><td></td><td></td><td>3</td></t<>	INPATIENT A	ANCILLARY SERVICE COST APPORTIONMENT	Provi der	CCN: 150026			3
Cost Center Description Intle XIX Hospital E27/2016 5: 47 pm Cost Center Description Ratio of Cost Inpatient Inpatient Inpatient 0 Cost Centeres Provide Provide Provide Provide 0 0 0 0 0 0 0 0 0							epared:
Cost Center Description Partin of Cost To Charges Input ient To Charges Input ient Charges Input ient Charges <thinput ient<br="">Charges Input ient Charges</thinput>						5/27/2016 5:4	
To Charges Program (2)			Ti t				
Impartment Charges Cool 1.00 2.00 3.00 30.00 000001 AUULTS & FERVICE COST CENTERS 2.827.398 30.00 30.00 30.00 000001 MURSLEY CARE UNIT 2.827.398 30.00 30.00 31.00 001001 MURSLEY CARE UNIT 0 31.0		Cost Center Description					
Impart ent Routh Routh Routh Routh Service Cost CENTERS Impart ent Routh Routh Routh Routh Routh Service Routh Routh Service Routh Routh Service Routh Routh Routh Service Routh Routh Routh Service Routh Routh Routh Service Routh R				To charges	5		
IMPATIENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 30.00 03000 AULITS & PEDIATRICS 2.827.398 30.00 30.00 03200 CORMARY CARE UNIT 209.841 31.00 32.00 03200 CORMARY CARE UNIT 0 33.00 33.00 03300 DUBRIN INTENSIVE CARE UNIT 0 34.00 34.00 DSUPCOVIDER - LIFF 0 0 43.00 41.00 DUBRISHI 133.759 43.00 51.00 DISOD CREATINE ROOM 0.325252 1.071.880 34.48.631 51.00 DISOD CREATINE ROOM & LABOR ROOM 0.329316 104.552 226.042 51.00 51.00 DISOD CREATINE ROOM & LABOR ROOM 0.33305 52.005 53.00 53.00 53.00 53.00 55.00					ondriges		
30. 00 03000 ADULTS & PEDLATRICS 9. 287, 398 90. 00 30. 00 03200 (DITRESIN VE CARE UNIT T 200, 841 31. 00 32. 00 03200 (DIRVISIN VE CARE UNIT T 0 33. 00 34. 00 03400 (SURGI CALL INTENSIVE CARE UNIT T 0 0 34. 00 03400 (SURGI CALL INTENSIVE CARE UNIT T 0 0 40. 00 0400 (DIALDISS URIRGI CALL INTENSIVE CARE UNIT T 0 0 40. 00 0410 (DIALDISS URIRGI DIRE - INF 0 0 41. 00 0 40. 00 0410 (DIALDISS URIRGI DIRE - INF 0 133. 759 42. 00 42. 00 0410 (DIALDISS URIRGI DIRE - INF 0 32.552 1. 071. 880 946. 631 0100 (DIALDISS URIRGI DIRE - INF 0. 32.552 1. 071. 880 946. 631 0100 (DIALDISS URIRGI DIRE - INF 0. 32.552 1. 071. 880 946. 631 0100 (DICENTERS URICAL ALLAR - INF 0. 32.552 1. 071. 880 946. 631 0100 (DICENTERS URICAL ALLAR - INF 0. 32.552 1. 071. 880 94. 631 0100 (DICENTERS URICAL ALLAR - INF 0. 32.552 1. 071. 880 95. 00 0100 (DICENTERS				1.00	2.00		
31.00 03100 INTERSIVE CARE UNIT 209, 841 31.00 32.00 03200 DRAWL INTERSIVE CARE UNIT 0 32.00 33.00 03300 BURN INTERSIVE CARE UNIT 0 33.00 40.00 MADD SUBPROVIDER - IPF 0 40.00 40.00 MADD SUBPROVIDER - IPF 0 40.00 40.00 MADD SUBPROVIDER - INF 0 41.00 41.00 MADD SUBPROVIDER - INF 0 42.00 00 04200 SUBPROVIDER - INF 0 43.00 43.00 MADD INSERTY 0.00 346.631 50.00 00 05100 PREATINE ROOM 0.325252 1,071,880 346.631 50.00 51.00 05100 RECOVERY ROM ALBOR ROM 0.325252 1,071,880 352.00 53.00 05300 AMESTIESI OLOSY 0.000000 0 0.53305 2,018,377 602.455 51.00 05300 RADOLOSY THERAPEUTIC 0.33058 2,018,377 602.455 55.06 13.3555 55.06 13.3555 56.00 13.3555 56.00 <td< td=""><td></td><td></td><td></td><td>1</td><td></td><td>1</td><td></td></td<>				1		1	
32.00 03200 CORONARY CARE UNIT 0 32.00 33.00 </td <td></td> <td></td> <td></td> <td></td> <td></td> <td></td> <td></td>							
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73.00 07300 DRUGS CHARGED TO PATIENTS 0.213499 1,164,360 248,590 73.00 74.00 07400 RENAL DIALYSIS 0.000000 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 0 75.00 0UTPATI ENT SERVICE COST CENTERS 0.000000 0 0 88.00 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 0 88.00 90.00 09000 CLINIC 0.000000 0 0 90.00 90.02 09002 WOUND CLINIC 0.000000 0 90.00 90.03 09003 MOBILE CLINIC 0.000000 0 90.02 90.00 09100 EMERGENCY 0.278353 1,335,909 371,854 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.209248 0 0 92.00 92.00 09200 BESERVATION SEDS -974 and 96-98) 0.209248 0 0 92.00 92.100 Less PBP Clinic Laboratory Services-Program only charges (Line 61) 0 0 01.0				1. 226	271, 635	5 333, 242	71.00
74.00 07400 RENAL DI ALYSI S 0.000000 0 74.00 75.00 07500 / ASC (NON-DI STINCT PART) 0.000000 0 0 75.00 0UTPATIENT SERVICE COST CENTERS 0.000000 0 0 88.00 880.0 880.0 880.0 0.000000 0 88.00 880.00 880.00 880.00 0.000000 0 88.00 88.00 880.00 880.00 88.00 89.00 90.00				0. 4240		-	
75.00 07500 ASC (NON-DISTINCT PART) 0.000000 0 75.00 OUTPATIENT SERVICE COST CENTERS 0.000000 0 0 88.00 88.00 88.00 88.00 0800 RURAL HEALTH CLINIC 0.000000 0 0 88.00 89.00 90.							
OUTPATI ENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 0 89.00 90.00 09000 CLINIC 0.522189 0 90.00 90.02 09002 WOUND CLINIC 0.000000 0 90.02 90.03 09003 MBILE CLINIC 0.000000 0 90.02 90.04 0.9002 WOUND CLINIC 0.00000 0 90.02 90.03 09003 MBILE CLINIC 0.00000 0 90.02 90.02 09002 WOUND CLINIC 0.00000 0 90.02 90.03 09100 EMERGENCY 0.278353 1,335,909 371,854 91.00 92.00 092020 OBSERVATION BEDS (NON-DISTINCT PART 0.209248 0 0 92.00 200.00 Eess PBP Clinic Laboratory Services-Program only charges (Line 61) 0 201.00 201.00 201.00 201.00							1
88.00 08800 RURAL HEALTH CLINIC 0.000000 0 88.00 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 90.00 09000 CLINIC 0.522189 0 90.00 90.02 09002 WOUND CLINIC 0.439229 0 90.02 90.03 09003 MOBILE CLINIC 0.000000 0 90.02 91.00 09100 EMERGENCY 0.278353 1,335,909 371,854 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART 0.209248 0 0 92.00 200.00 Total (sum of lines 50-94 and 96-98) 8,678,258 2,790,411 200.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00 201.00				0.0000	000 0	0 0	75.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0.000000 0 89.00 90.00 09000 CLINIC 0.522189 0 0 90.00 90.02 09002 WOUND CLINIC 0.439229 0 0 90.02 90.03 09003 MOBILE CLINIC 0.00000 0 90.02 90.04 09100 EMERGENCY 0.278353 1,335,909 371,854 91.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 0.209248 0 0 92.00 200.00 Total (sum of lines 50-94 and 96-98) 8,678,258 2,790,411 200.00 201.00 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 0 201.00 20				0.000	000		88 00
90.00 09000 CLINIC 0.522189 0 90.00 90.00 90.02 09002 WOUND CLINIC 0.439229 0 0.0 90.02 90.03 09003 MOBILE CLINIC 0.00000 0 90.03 90.03 91.00 09100 EMERGENCY 0.278353 1,335,909 371,854 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.209248 0 92.00 200.00 Total (sum of lines 50-94 and 96-98) 8,678,258 2,790,411 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 201.00							
90. 02 09002 WOUND CLINIC 0.439229 0 0 0 0.02 90. 03 09003 MOBILE CLINIC 0.00000 0 0 90.03 91. 00 09100 EMERGENCY 0.278353 1,335,909 371,854 91.00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.209248 0 0 92.00 200. 00 Total (sum of lines 50-94 and 96-98) 8,678,258 2,790,411 200.00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 201.00						-	
90. 03 09003 MOBILE CLINIC 0.00000 0 90. 03 90. 03 91. 00 09100 EMERGENCY 0.278353 1, 335, 909 371, 854 91. 00 92. 00 09200 OBSERVATI ON BEDS (NON-DISTINCT PART 0.209248 0 0 92. 00 200. 00 Total (sum of lines 50-94 and 96-98) 8, 678, 258 2, 790, 411 200. 00 201. 00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 201. 00							
91.00 09100 EMERGENCY 0.278353 1,335,909 371,854 91.00 92.00 09200 0BSERVATI ON BEDS (NON-DISTINCT PART 0.209248 0 0 92.00 200.00 Total (sum of lines 50-94 and 96-98) 8,678,258 2,790,411 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 0 201.00							
92.00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0.209248 0 92.00 200.00 Total (sum of lines 50-94 and 96-98) 8,678,258 2,790,411 200.00 201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00				1			
201.00 Less PBP Clinic Laboratory Services-Program only charges (line 61) 0 201.00							
					8, 678, 258	3 2, 790, 411	
202.00 Net Charges (line 200 minus line 201) 8,678,258 202.00			rges (line 61)		(ן ע	201.00
	202.00	Net Charges (line 200 minus line 201)		I	8, 678, 258	3	202.00

	Financial Systems IU HEALTH GOSHEN H ATION OF REIMBURSEMENT SETTLEMENT		CCN: 150026	In Lie Period:	u of Form CMS- Worksheet E	2552-1
				From 01/01/2015 To 12/31/2015	Part A Date/Time Pre 5/27/2016 5:4	
		Ti tl	e XVIII	Hospi tal	PPS	
			0	1.00	2.00	
	PART A - INPATIENT HOSPITAL SERVICES UNDER IPPS		0	1.00	2.00	
00	DRG Amounts Other than Outlier Payments	a prior		0		1.00
01	DRG amounts other than outlier payments for discharges occurrin to October 1 (see instructions)	g prior		10, 680, 114		1.0
02	DRG amounts other than outlier payments for discharges occurrin	g on or		3, 401, 683		1.02
03	after October 1 (see instructions) DRG for federal specific operating payment for Model 4 BPCI for			0		1.0
04	discharges occurring prior to October 1 (see instructions)			0		1.0
04	DRG for federal specific operating payment for Model 4 BPCI for discharges occurring on or after October 1 (see instructions)			0		1.0
00 01	Outlier payments for discharges. (see instructions) Outlier reconciliation amount			796, 700		2.0
02	Outlier payment for discharges for Model 4 BPCI (see instructio	ns)		0		2.0
00	Managed Care Simulated Payments			0		3.0
00	Bed days available divided by number of days in the cost report period (see instructions)	ing		115.83		4.0
	Indirect Medical Education Adjustment					1
00	FTE count for allopathic and osteopathic programs for the most cost reporting period ending on or before 12/31/1996. (see instr			0.00		5.00
00	FTE count for allopathic and osteopathic programs which meet th	e		0.00		6.00
	criteria for an add-on to the cap for new programs in accordanc CFR 413.79(e)	e with 42				
00	MMA Section 422 reduction amount to the IME cap as specified un	der 42		0.00		7.0
01	CFR §412.105(f)(1)(iv)(B)(1) ACA Section 5503 reduction amount to the IME cap as specified u	nder 42		0.00		7.0
0.	CFR §412.105(f)(1)(iv)(B)(2) If the cost report straddles July			0.00		
00	then see instructions. Adjustment (increase or decrease) to the FTE count for allopath	ic and		0.00		8.0
	osteopathic programs for affiliated programs in accordance with	42 CFR				
	413.75(b), 413.79(c)(2)(iv), 64 FR 26340 (May 12, 1998), and 67 (August 1, 2002).	FR 50069				
01	The amount of increase if the hospital was awarded FTE cap slot	s under		0.00		8.0
	section 5503 of the ACA. If the cost report straddles July 1, 2 instructions.	011, see				
02	The amount of increase if the hospital was awarded FTE cap slot	s from a		0.00		8.0
00	closed teaching hospital under section 5506 of ACA. (see instru Sum of lines 5 plus 6 minus lines (7 and 7.01) plus/minus lines			0.00		9.0
	and 8,02) (see instructions)	•		0.00		
0. 00	FTE count for allopathic and osteopathic programs in the curren from your records	t year		0.00		10.0
1.00	FTE count for residents in dental and podiatric programs.			0.00		11.0
2.00 3.00	Current year allowable FTE (see instructions) Total allowable FTE count for the prior year.			0.00 0.00		12.0
4. 00	Total allowable FTE count for the penultimate year if that year	ended on		0.00		14.0
5.00	or after September 30, 1997, otherwise enter zero. Sum of lines 12 through 14 divided by 3.			0.00		15.0
5.00	Adjustment for residents in initial years of the program			0.00		16.0
7.00	Adjustment for residents displaced by program or hospital closu	re		0.00		17.0
3.00 9.00	Adjusted rolling average FTE count Current year resident to bed ratio (line 18 divided by line 4).			0.00 0.000000		18.0
0. 00	Prior year resident to bed ratio (see instructions)			0. 000000		20.0
1.00 2.00	Enter the lesser of lines 19 or 20 (see instructions) IME payment adjustment (see instructions)			0. 000000 0		21.0
2. 01	IME payment adjustment - Managed Care (see instructions)			0		22.0
3. 00	Indirect Medical Education Adjustment for the Add-on for Sectio Number of additional allopathic and osteopathic IME FTE residen		he MMA	0.00		23.0
	slots under 42 Sec. 412.105 (f)(1)(iv)(C).	t cap				
4.00 5.00	IME FTE Resident Count Over Cap (see instructions) If the amount on line 24 is greater than -O-, then enter the lo	wor of		0.00 0.00		24.0 25.0
5. 00	line 23 or line 24 (see instructions)			0.00		25.0
5.00	Resident to bed ratio (divide line 25 by line 4)			0.000000		26.0
7.00 3.00	IME payments adjustment factor. (see instructions) IME add-on adjustment amount (see instructions)			0. 000000 0		27.0
3. 01	IME add-on adjustment amount - Managed Care (see instructions)			0		28.0
9.00 9.01	Total IME payment (sum of lines 22 and 28) Total IME payment - Managed Care (sum of lines 22.01 and 28.01)			0		29.0
	Disproportionate Share Adjustment					
0. 00	Percentage of SSI recipient patient days to Medicare Part A pat (see instructions)	ient days		1.63		30.0
1.00	Percentage of Medicaid patient days (see instructions)			18. 91		31.00
2.00	Sum of Lines 30 and 31			20.54		32.00
3.00	Allowable disproportionate share percentage (see instructions) Disproportionate share adjustment (see instructions)			6. 16 216, 860		33.00

	Financial Systems IU HEALTH GOSHE ATION OF REIMBURSEMENT SETTLEMENT		In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
CALCUL	ATTON OF RELMBORSEMENT SETTLEMENT		From 01/01/2015 To 12/31/2015	Part A	
		Title XVIII	Hospi tal	PPS	·
			Prior to	On/After	
		0	0ctober 1 1.00	0ctober 1 2.00	
	Uncompensated Care Adjustment			2100	
35.00	Total uncompensated care amount (see instructions)			6, 406, 145, 534	
35.01	Factor 3 (see instructions)		0.000124929	0.000119355	
35.02	Hospital uncompensated care payment (If line 34 is zero, enter zero on this line) (see instructions)		955, 413	764, 607	35.02
35.03	Pro rata share of the hospital uncompensated care payment		714, 596	192, 196	35.03
	amount (see instructions)				
36.00	Total uncompensated care (sum of columns 1 and 2 on line		906, 792		36.00
	35.03) Additional payment for high percentage of ESRD beneficiary d	ischarges (Lines 40 through	1 46)		
40.00	Total Medicare discharges on Worksheet S-3, Part I		0		40.00
	excluding discharges for MS-DRGs 652, 682, 683, 684 and				
	685 (see instructions)				
41.00	Total ESRD Medicare discharges excluding MS-DRGs 652, 682, 683, 684 an 685. (see instructions)		0		41.00
41.01	Total ESRD Medicare covered and paid discharges excluding		0		41.01
	MS-DRGs 652, 682, 683, 684 an 685. (see instructions)				
42.00	Divide line 41 by line 40 (if less than 10%, you do not		0.00		42.00
43.00	qualify for adjustment) Total Medicare ESRD inpatient days excluding MS-DRGs 652,		0		43.00
	682, 683, 684 an 685. (see instructions)		0		.0.00
44.00	Ratio of average length of stay to one week (line 43		0. 000000		44.00
45.00	divided by line 41 divided by 7 days) Average weekly cost for dialysis treatments (see		0.00		45.00
45.00	instructions)		0.00		45.00
46.00	Total additional payment (line 45 times line 44 times line		0		46.00
17 00	41.01)		44, 000, 440		
47.00 48.00	Subtotal (see instructions) Hospital specific payments (to be completed by SCH and		16, 002, 149		47.00 48.00
40.00	MDH, small rural hospitals only. (see instructions)		0		40.00
49.00	Total payment for inpatient operating costs (see		16, 002, 149		49.00
	instructions)				
50.00	Payment for inpatient program capital (from Wkst. L, Pt. I and Pt. II, as applicable)		1, 189, 664		50.00
51.00	Exception payment for inpatient program capital (Wkst. L,		0		51.00
	Pt. III, see instructions)				
52.00	Direct graduate medical education payment (from Wkst. E-4,		0		52.00
53.00	line 49 see instructions). Nursing and Allied Health Managed Care payment		0		53.00
54.00	Special add-on payments for new technologies		0		54.00
55.00	Net organ acquisition cost (Wkst. D-4 Pt. III, col. 1,		0		55.00
56.00	line 69) Cost of physicians' services in a teaching hospital (see		0		56.00
50.00	intructions)		0		50.00
57.00	Routine service other pass through costs (from Wkst. D,		0		57.00
F0.00	Pt. III, column 9, lines 30 through 35).		27.445		E0.00
58.00	Ancillary service other pass through costs from Wkst. D, Pt. IV, col. 11 line 200)		27, 665		58.00
59.00	Total (sum of amounts on lines 49 through 58)		17, 219, 478		59.00
60.00	Primary payer payments		13, 059		60.00
61.00	Total amount payable for program beneficiaries (line 59		17, 206, 419		61.00
62.00	minus line 60) Deductibles billed to program beneficiaries		1, 722, 712		62.00
63.00	Coinsurance billed to program beneficiaries		25, 200		63.00
64.00	Allowable bad debts (see instructions)		104, 907		64.00
	Adjusted reimbursable bad debts (see instructions)		68, 190		65.00
66.00	Allowable bad debts for dual eligible beneficiaries (see instructions)		22, 439		66.00
67.00	Subtotal (line 61 plus line 65 minus lines 62 and 63)		15, 526, 697		67.00
68.00	Credits received from manufacturers for replaced devices		0		68.00
40.00	for applicable to MS-DRGs (see instructions)		_		40.00
69.00	Outlier payments reconciliation (sum of lines 93, 95 and 96). (For SCH see instructions)		0		69.00
70.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		70.00
70. 50	RURAL DEMONSTRATION PROJECT		0		70.50
70. 89	Pioneer ACO demonstration payment adjustment amount (see		0		70.89
70. 90	instructions) HSP bonus payment HVBP adjustment amount (see		0		70.90
	instructions)		0		
	HSP bonus payment HRR adjustment amount (see instructions)		0		70. 91
	Bundled Model 1 discount amount (see instructions)		0		70. 92 70. 93
	HVBP payment adjustment amount (see instructions) HRR adjustment amount (see instructions)		23, 917 -88, 328		70.93
	Recovery of accel erated depreciation		00, 320		70.95

	Financial Systems IU HEALTH GOSHE ATLON OF RELIMBURSEMENT SETTLEMENT	EN HOSPITAL Provider CCN: 150026	De	eri od:	u of Form CMS- Worksheet E	2002
ALCUL			Fr	om 01/01/2015	Part A	
			To	12/31/2015		
		Title XVIII		Hospi tal	5/27/2016 5: 4 PPS	+7 pm
		in the Aviiii		Prior to	0n/After	
				October 1	October 1	
		0		1.00	2.00	
0. 96	Low volume adjustment for federal fiscal year (yyyy)		0	0		70. 9
	(Enter in column 0 the corresponding federal year for the					
	period prior to 10/1)					
0. 97	Low volume adjustment for federal fiscal year (yyyy)		0	0		70. 9
	(Enter in column 0 the corresponding federal year for the					
	period ending on or after 10/1)			-		
0. 98	Low Volume Payment-3			0		70.9
	HAC adjustment amount (see instructions)			0		70.9
1. 00	Amount due provider (line 67 minus lines 68 plus/minus			15, 462, 286		71.0
1. 01	lines 69 & 70) Sequestration adjustment (see instructions)			309, 246		71.0
2.00	Interim payments			15, 063, 961		72.0
	Tentative settlement (for contractor use only)			15,003,901		73.0
4.00	Balance due provider (Program) (line 71 minus lines 71.01,			89, 079		74.0
4.00	72, and 73)			07,017		/4.0
5 00	Protested amounts (nonallowable cost report items) in			1, 826, 371		75.0
0.00	accordance with CMS Pub. 15-2, chapter 1, §115.2			1, 020, 071		/ / / /
	TO BE COMPLETED BY CONTRACTOR (lines 90 through 96)					
	Operating outlier amount from Wkst. E, Pt. A, line 2 (see			0		7 90.0
	instructions)					
1.00	Capital outlier from Wkst. L, Pt. I, line 2			0		91.0
2.00	Operating outlier reconciliation adjustment amount (see			0		92.0
	instructions)					
3.00	Capital outlier reconciliation adjustment amount (see			0		93.0
4 00	instructions)			0.00		
4.00	The rate used to calculate the time value of money (see			0.00		94.0
E 00	instructions) Time value of money for operating expenses (see			0		95.0
5.00	instructions)			0		95.0
6.00	Time value of money for capital related expenses (see			0		96.0
0.00	instructions)			0		
				Prior to 10/1	On/After 10/1	
			ſ	1.00	2.00	
	HSP Bonus Payment Amount					
	HSP bonus amount (see instructions)			0	C) 100. C
	HVBP Adjustment for HSP Bonus Payment					
	HVBP adjustment factor (see instructions)			0.000000000		
	HVBP adjustment amount for HSP bonus payment (see instruction	ons)		0	C	102. (
	HRR Adjustment for HSP Bonus Payment				-	
	HRR adjustment factor (see instructions)			0.0000		
04 00	HRR adjustment amount for HSP bonus payment (see instruction	IS)		0	I C	104. 0

	Financial Systems DLUME CALCULATION EXHIBIT 4		IU HEALTH GOSI		CCN: 150026 F	Period:	u of Form CMS-2 Worksheet E	2002-
JW VC	Seome CALCOLATION EXHIBIT 4			FIOVIDEI	F	rom 01/01/2015	Part A Exhibi	t 4
						To 12/31/2015	5/27/2016 5:4	
		W/S E Dort A	Amounts (from	Titl Pre/Post	e XVIII Period Prior	Hospi tal Peri od	PPS Total (Col 2	
		line	E, Part A)	Entitlement	to 10/01	On/After 10/01		
		0	1.00	2.00	3.00	4.00	5.00	
00	DRG amounts other than outlier payments	1.00	0	0	C	0	0	1.
01	DRG amounts other than outlier payments for discharges	1.01	10, 680, 114	0	C	0 0	0	1.
02	occurring prior to October 1 DRG amounts other than outlier payments for discharges occurring on or after October	1. 02	3, 401, 683	0	C	14, 081, 797	14, 081, 797	1.
03	I DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1. 03	0	0	C	0	0	1.
04	DRG for Federal specific operating payment for Model 4 BPCL occurring on or after October 1	1. 04	0	0	C	0 0	0	1
00	Outlier payments for	2.00	796, 700	0	c	796, 700	796, 700	2
01	discharges (see instructions) Outlier payments for	2.02	0	о	c	o o	0	2
00	discharges for Model 4 BPCI Operating outlier	2, 01	0				0	3
	reconciliation		-	-		, 		
00	Managed care simulated payments	3. 00	0	0	(0	0	4
00	Indirect Medical Education Adju Amount from Worksheet E, Part	21.00	0. 000000	0. 000000	0. 000000	0. 000000		5
00	A, line 21 (see instructions) IME payment adjustment (see	22.00	0	0		0	0	6
	instructions)		0			, 		
)1	IME payment adjustment for managed care (see instructions)	22.01	0	-	C	0 0	0	6
00	Indirect Medical Education Adju IME payment adjustment factor	27.00	e Add-on for Se 0.000000			0.00000		7
0	(see instructions)	27.00	0.000000	0.000000	0.00000	0.000000		'
0	IME adjustment (see instructions)	28.00	0	0	C	0 0	0	8
)1	IME payment adjustment add on for managed care (see	28.01	0	0	C	0 0	0	8
00	instructions) Total IME payment (sum of	29.00	0	0	c	0 0	0	9
)1	lines 6 and 8) Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0	0	C	0	0	Ģ
	Disproportionate Share Adjustme	ent						
00	Allowable disproportionate share percentage (see	33.00	0. 0616	0. 0616	0. 0616	0. 0616		10
00	instructions) Disproportionate share adjustment (see instructions)	34.00	216, 860	0	c	216, 860	216, 860	11
01	Uncompensated care payments	36.00	906, 792		1, 670, 009	9 192, 196	1, 862, 205	11
00	Additional payment for high per Total ESRD additional payment (see instructions)	centage of ES 46.00	RD beneficiary 0	di scharges 0	(0 0	0	12
00 00	Subtotal (see instructions) Hospital specific payments (completed by SCH and MDH, small rural hospitals only.)	47.00 48.00	16, 002, 149 0	0 0	1, 670, 009 (9 14, 332, 140 0 0	16, 002, 149 0	
00	(see instructions) Total payment for inpatient operating costs (see instructions)	49.00	16, 002, 149	0	1, 670, 009	9 14, 332, 140	16, 002, 149	15
00	Payment for inpatient program capital	50.00	1, 189, 664	0	C	1, 189, 664	1, 189, 664	16
00	Special add-on payments for new technologies	54.00	0	0	C	0 0	0	17
01	Net organ aquisition cost	55.00	0	о	(c	o o	0	
02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0	0	C	0 0	0	17
. 00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0	0	C	0 0	0	18

Health Financial Systems		IU HEALTH GOSH	IEN HOSPI TAL		In Lie	u of Form CMS-	2552-10
LOW VOLUME CALCULATION EXHIBIT 4			Provi der	CCN: 150026	Period: From 01/01/2015 To 12/31/2015		pared:
			Ti tl	e XVIII	Hospi tal	PPS	
	W/S E, Part A	Amounts (from	Pre/Post	Period Prio	r Period	Total (Col 2	
	line	E, Part A)	Entitlement	to 10/01	0n/After 10/01	through 4)	
	0	1.00	2.00	3.00	4.00	5.00	
19.00 SUBTOTAL			0	1, 670, 0	09 15, 521, 804	17, 191, 813	19.00
	W/S L, line	(Amounts from L)					
	0	1.00	2.00	3.00	4.00	5.00	
20.00 Capital DRG other than outlier	1.00	1, 117, 259	0		0 1, 117, 259	1, 117, 259	20.00
20.01 Model 4 BPCI Capital DRG other than outlier	1.01	0	0		0 0	C	20. 01
21.00 Capital DRG outlier payments	2.00	24, 921	0		0 24, 921	24, 921	21.00
21.01 Model 4 BPCI Capital DRG outlier payments	2. 01	0	0		0 0	C	21.01
22.00 Indirect medical education percentage (see instructions)	5.00	0. 0000	0.0000	0.00	0.0000		22.00
23.00 Indirect medical education adjustment (see instructions)	6.00	0	0		0 0	C	23.00
24.00 Allowable disproportionate share percentage (see instructions)	10.00	0. 0425	0. 0425	0.04	0. 0425		24.00
25. 00 Di sproporti onate share adj ustment (see i nstructi ons)	11.00	47, 484	0		0 47, 484	47, 484	25.00
26.00 Total prospective capital payments (see instructions)	12.00	1, 189, 664	0		0 1, 189, 664	1, 189, 664	26.00
	W/S E, Part A	(Amounts to E,					
	line	Part A)					
	0	1.00	2.00	3.00	4.00	5.00	
27.00 Low volume adjustment factor				0.0000	0. 000000		27.00
28.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 96				0	O	28.00
29.00 Low volume adjustment (transfer amount to Wkst. E, Pt. A, line)	70. 97				0	O	29.00
100.00 Transfer low volume adjustments to Wkst. E, Pt. A.		Y					100. 00

HOSPI T	Financial Systems AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der	CCN: 150026	Period: From 01/01/2015	Worksheet E Part A Exhibi	t 5
					To 12/31/2015	Date/Time Pre 5/27/2016 5:4	pared:
				e XVIII	Hospi tal	PPS	
		Wkst. E, Pt. A, line	Amt. from Wkst. E, Pt. A)	Period to 10/01	Period on after 10/01	Total (cols. 2 and 3)	
		0	1.00	2.00	3.00	4.00	
1.00	DRG amounts other than outlier payments	1.00					1.00
1.01	DRG amounts other than outlier payments for discharges occurring prior to October 1	1.01	10, 680, 114		0	0	1. 01
1.02	DRG amounts other than outlier payments for discharges occurring on or after October 1	1.02	3, 401, 683		14, 081, 797	14, 081, 797	1.02
1.03	DRG for Federal specific operating payment for Model 4 BPCI occurring prior to October 1	1.03	0		0	0	1.03
1.04	DRG for Federal specific operating payment for Model 4 BPCI occurring on or after October 1	1.04	0		0	0	1. 04
2.00	Outlier payments for discharges (see instructions)	2.00	796, 700		0 796, 700	796, 700	2.00
2.01	Outlier payments for discharges for Model 4 BPCI	2.02	0		0 0	0	2.01
3.00	Operating outlier reconciliation	2.01	0		0 0	0	3.00
4.00	Managed care simulated payments	3.00	0		0 0	0	4.00
5.00	Indirect Medical Education Adjustment Amount from Worksheet E, Part A, line 21	21.00	0. 000000	0.0000	0. 000000		5.00
(00	(see instructions)	22.00			0	0	6 00
6. 00 6. 01	IME payment adjustment (see instructions) IME payment adjustment for managed care (see instructions)	22. 00 22. 01	0		0 0 0 0	-	6. 00 6. 01
	Indirect Medical Education Adjustment for the	Add-on for Se	ection 422 of t	he MMA			
7.00	IME payment adjustment factor (see instructions)	27.00	0. 000000	0.0000	0. 000000		7.00
8.00	IME adjustment (see instructions)	28.00	0		0 0		8.00
8. 01	IME payment adjustment add on for managed care (see instructions)	28.01	0		0 0	0	8. 01
9.00	Total IME payment (sum of lines 6 and 8)	29.00	0		0 0	0	9.00
9. 01	Total IME payment for managed care (sum of lines 6.01 and 8.01)	29.01	0		0 0	0	9. 01
10.00	Disproportionate Share Adjustment	00.00	0.0(1)	0.04			10.00
10.00	Allowable disproportionate share percentage	33.00	0. 0616	0.06	0. 0616		10.00
11. 00	(see instructions) Disproportionate share adjustment (see instructions)	34.00	216, 860		0 216, 860	216, 860	11.00
11. 01	Uncompensated care payments	36.00	906, 792	1, 670, 0	09 192, 196	1, 862, 205	11.01
	Additional payment for high percentage of ESR						
	Total ESRD additional payment (see instructions)	46.00	0		0 0		12.00
	Subtotal (see instructions)	47.00	16, 002, 149	1, 670, 00			
14.00	Hospital specific payments (completed by SCH and MDH, small rural hospitals only.) (see instructions)	48.00	0		0 0	0	14.00
15.00	Total payment for inpatient operating costs (see instructions)	49.00	16, 002, 149	1, 670, 00	09 14, 332, 140	16, 002, 149	15.00
16.00	Payment for inpatient program capital	50.00	1, 189, 664		0 1, 189, 664	1, 189, 664	16.00
17.00	Special add-on payments for new technologies	54.00	0		0 0	0	17.00
17.01	Net organ aquisition cost	55.00	0		0 0	0	17.01
17. 02	Credits received from manufacturers for replaced devices for applicable MS-DRGs	68.00	0		0 0	0	17.02
18.00	Capital outlier reconciliation adjustment amount (see instructions)	93.00	0		0 0		18.00
	SUBTOTAL			1, 670, 00	09 15, 521, 804		

	Financial Systems	IU HEALTH GOS				eu of Form CMS-	2552-10
HOSPI T	AL ACQUIRED CONDITION (HAC) REDUCTION CALCULA	TION EXHIBIT 5	Provi der	CCN: 150026	Period: From 01/01/2015 To 12/31/2015	Worksheet E Part A Exhibi Date/Time Pre 5/27/2016 5:4	pared:
			Ti tl	e XVIII	Hospi tal	PPS	
		Wkst. L, line	(Amt. from Wkst. L)				
		0	1,00	2.00	3.00	4.00	
20.00	Capital DRG other than outlier	1.00	1, 117, 259		0 1, 117, 259	1, 117, 259	20.00
20. 01	Model 4 BPCI Capital DRG other than outlier	1.01	0		0 0		
21.00	Capital DRG outlier payments	2.00	24, 921		0 24, 921	24, 921	21.00
21.01	Model 4 BPCI Capital DRG outlier payments	2.01	0		0 0	0	21.01
22.00	Indirect medical education percentage (see instructions)	5.00	0.0000	0.000	0.0000		22.00
23.00	Indirect medical education adjustment (see instructions)	6.00	0		0 0	0	23.00
24.00	Allowable disproportionate share percentage (see instructions)	10.00	0. 0425	0. 042	0. 0425		24.00
25.00	Disproportionate share adjustment (see instructions)	11.00	47, 484		0 47, 484	47, 484	25.00
26.00	Total prospective capital payments (see instructions)	12.00	1, 189, 664		0 1, 189, 664	1, 189, 664	26.00
		Wkst. E, Pt. A, line	(Amt. from Wkst. E, Pt. A)				
		0	1.00	2.00	3.00	4.00	
27.00							27.00
28.00	Low volume adjustment prior to October 1	70.96	0		0	0	28.00
29.00	Low volume adjustment on or after October 1	70. 97	0	1	C	0	29.00
30.00	HVBP payment adjustment (see instructions)	70. 93	23, 917		0 23, 917	23, 917	30.00
30. 01	HVBP payment adjustment for HSP bonus payment (see instructions)	70. 90	0		0 0	0	30. 01
31.00	HRR adjustment (see instructions)	70.94	-88, 328		0 -88, 328	-88, 328	31.00
31.01	HRR adjustment for HSP bonus payment (see instructions)	70. 91	0		0 0	0	31.01
						(Amt. to Wkst. E, Pt. A)	
	1	0	1.00	2.00	3.00	4.00	
	HAC Reduction Program adjustment (see instructions)	70. 99			0 0	0	02.00
100.00	Transfer HAC Reduction Program adjustment to Wkst. E, Pt. A.		N				100.00

LCUL	Financial Systems IU HEALTH GOSHEN ATI ON OF REI MBURSEMENT SETTLEMENT <	HOSPITAL Provider CCN: 150026	Peri od:	u of Form CMS-2 Worksheet E	
			From 01/01/2015	Part B	
			To 12/31/2015	Date/Time Pre 5/27/2016 5:4	
	· · · · · · · · · · · · · · · · · · ·	Title XVIII	Hospi tal	PPS	
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES			1.00	
00	Medical and other services (see instructions)			31, 439	1.
00	Medical and other services reimbursed under OPPS (see instructi	ons)		24, 956, 386	2.
00	PPS payments			17, 072, 391	
00	Outlier payment (see instructions)			135, 010	
00	Enter the hospital specific payment to cost ratio (see instruct	tions)		0.000	
00 00	Line 2 times line 5 Sum of line 3 plus line 4 divided by line 6			0 0.00	
00	Transitional corridor payment (see instructions)			0.00	
00	Ancillary service other pass through costs from Wkst. D, Pt. IV	V. col. 13. line 200		33, 551	
	Organ acqui si ti ons	.,		00,001	
	Total cost (sum of lines 1 and 10) (see instructions)			31, 439	
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
	Ancillary service charges			147, 339	
	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, lin	ne 69)		147 220	
. 00	Total reasonable charges (sum of lines 12 and 13) Customary charges			147, 339	14
00	Aggregate amount actually collected from patients liable for pa	avment for services on	a charge basis	0	115
	Amounts that would have been realized from patients liable for	5	U U	0	
	had such payment been made in accordance with 42 CFR §413.13(e)		J		
. 00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0.000000	17
	Total customary charges (see instructions)			147, 339	
. 00	Excess of customary charges over reasonable cost (complete only	y if line 18 exceeds li	ne 11) (see	115, 900	19
	instructions)		10) (0	0
. 00	Excess of reasonable cost over customary charges (complete only instructions)	y IT IT THE IT exceeds IT	ne 18) (see	0	20
. 00	Lesser of cost or charges (line 11 minus line 20) (for CAH see	instructions)		31, 439	21
	Interns and residents (see instructions)			01, 107	
	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	
. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)			17, 240, 952	24
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
	Deductibles and coinsurance (for CAH, see instructions)			0	
	Deductibles and Coinsurance relating to amount on line 24 (for		and 221 (and	3, 460, 552	
. 00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) pl instructions)	us the sum of lines 22	and 23] (see	13, 811, 839	27
. 00	Direct graduate medical education payments (from Wkst. E-4, lin	ne 50)		0	28
	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	
	Subtotal (sum of lines 27 through 29)			13, 811, 839	30
	Primary payer payments			973	31
. 00	Subtotal (line 30 minus line 31)			13, 810, 866	32
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	ES)			1
	Composite rate ESRD (from Wkst. 1-5, line 11)			0	
	Allowable bad debts (see instructions) Adjusted reimbursable bad debts (see instructions)			336, 921 218, 999	
	Allowable bad debts for dual eligible beneficiaries (see instru	(ctions)		166, 496	
	Subtotal (see instructions)			14, 029, 865	
	MSP-LCC reconciliation amount from PS&R			-9	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
. 50	Pioneer ACO demonstration payment adjustment (see instructions))		0	39
. 98	Partial or full credits received from manufacturers for replace	ed devices (see instruc	tions)	0	39
	RECOVERY OF ACCELERATED DEPRECIATION			0	
	Subtotal (see instructions)			14, 029, 874	
	Sequestration adjustment (see instructions)			280, 597	
	Interim payments Tentative settlement (for contractors use only)			13, 638, 920 0	
	Balance due provider/program (see instructions)			110, 357	
	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub 15-2	chapter 1	110, 357	
	§115. 2	10^{-2}	5aptor 1,	0	-
	TO BE COMPLETED BY CONTRACTOR				1
	Original outlier amount (see instructions)			0	
	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money			0.00	
	Time Value of Money (see instructions)			0	93

IALY:	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provi der	CCN: 150026	Period: From 01/01/2015 To 12/31/2015		pare
		Ti tl	e XVIII	Hospi tal	PPS	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
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 List separately each retroactive lump sum adjustment		15, 063, 9	61 0	13, 638, 920 0	
	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					
D1	ADJUSTMENTS TO PROVIDER			0	0	
02				0	0	
03 04				0		-
05				0	0	-
	Provider to Program					
50	ADJUSTMENTS TO PROGRAM			0	0	
51 52				0	0	-
5∠ 53				0		-
54				0	0	
99	Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98)			0	0	3
00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		15, 063, 9	61	13, 638, 920	4
00	TO BE COMPLETED BY CONTRACTOR List separately each tentative settlement payment after					5
00	desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
11	Program to Provider					Ι.
)1)2	TENTATI VE TO PROVI DER			0	0	
)2)3				0	0	
	Provider to Program					
50	TENTATI VE TO PROGRAM			0	0	
51 52				0	0	
52 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0	0	
00	Determined net settlement amount (balance due) based on the cost report. (1)					6
01	SETTLEMENT TO PROVIDER		89, 0		110, 357	6
02	SETTLEMENT TO PROGRAM		15 150 0	0	0	
00	Total Medicare program liability (see instructions)		15, 153, 0	40 Contractor	13, 749, 277 NPR Date	7
				Number	(Mo/Day/Yr)	
	Name of Contractor	()	1.00	2.00	8

Heal th	Financial Systems IU HEAL	TH GOSHEN HOSPITAL	In Lie	u of Form CMS-2	2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 150026	Peri od:	Worksheet E-1	
			From 01/01/2015 To 12/31/2015		narod
			10 12/31/2013	5/27/2016 5:4	
		Title XVIII	Hospi tal	PPS	
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST R	EPORTS			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CAN	_CULATI ON			
1.00	Total hospital discharges as defined in AARA §4102 f	rom Wkst. S-3, Pt. I col. 15 line	14	7, 053	1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of I	ines 1, 8-12		8, 186	2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line	e 2		3, 114	3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of I	ines 1, 8-12		20, 430	4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 lin	ne 200		516, 573, 103	5.00
6.00	Total hospital charity care charges from Wkst. S-10,	col. 3 line 20		11, 321, 414	6.00
7.00	CAH only - The reasonable cost incurred for the purch	hase of certified HIT technology	Wkst. S-2, Pt. I	0	7.00
	line 168				
8.00	Calculation of the HIT incentive payment (see instru-	ctions)		449, 686	
9.00	Sequestration adjustment amount (see instructions)			8, 994	9.00
10.00	Calculation of the HIT incentive payment after seque	stration (see instructions)		440, 692	10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instruct	ions)		408, 439	
31.00	Other Adjustment (specify)			0	31.00
32.00	Balance due provider (line 8 (or line 10) minus line	30 and line 31) (see instruction	s)	32, 253	32.00

CALCUL	ATION OF REIMBURSEMENT SETTLEMENT	rovider CCN: 150026	Period:	Worksheet E-3	
			From 01/01/2015 To 12/31/2015	Part VII Date/Time Pre 5/27/2016 5:4	
		Title XIX	Hospi tal	Cost	<i>,</i> bii
			I npati ent	Outpati ent	
			1.00	2.00	
	PART VII - CALCULATION OF REIMBURSEMENT - ALL OTHER HEALTH SERVIC	ES FOR TITLES V OR X	IX SERVICES		-
1.00	COMPUTATION OF NET COST OF COVERED SERVICES		3, 758, 172		1.00
2.00	Medical and other services		3, 730, 172	0	2.00
3.00	Organ acquisition (certified transplant centers only)		0	0	3.00
4.00	Subtotal (sum of lines 1, 2 and 3)		3, 758, 172	0	4.00
5.00	Inpatient primary payer payments		0		5.00
6.00	Outpatient primary payer payments			0	
7.00	Subtotal (line 4 less sum of lines 5 and 6)		3, 758, 172	0	7.00
	COMPUTATION OF LESSER OF COST OR CHARGES Reasonable Charges				-
8.00	Routine service charges		3, 170, 998		8.00
9.00	Ancillary service charges		8, 678, 258	0	9.00
10.00	Organ acquisition charges, net of revenue		0	-	10.00
11.00	Incentive from target amount computation		0		11.00
12.00	Total reasonable charges (sum of lines 8 through 11)		11, 849, 256	0	12.00
	CUSTOMARY CHARGES				1 4 9 9 9
13.00	Amount actually collected from patients liable for payment for se	rvices on a charge	0	0	13.00
14.00	basis Amounts that would have been realized from patients liable for pa	vment for services o	n O	0	14.00
14.00	a charge basis had such payment been made in accordance with 42 C			0	14.00
15.00	Ratio of line 13 to line 14 (not to exceed 1.000000)		0. 000000	0.000000	15.00
16.00	Total customary charges (see instructions)		11, 849, 256	0	16.00
17.00	Excess of customary charges over reasonable cost (complete only i	fline 16 exceeds	8, 091, 084	0	17.00
10.00	line 4) (see instructions)			0	10.00
18.00	Excess of reasonable cost over customary charges (complete only i 16) (see instructions)	r line 4 exceeds lin	e 0	0	18.00
19.00	Interns and Residents (see instructions)		0	0	19.00
20.00	Cost of physicians' services in a teaching hospital (see instruct	ions)	0	0	
21.00	Cost of covered services (enter the lesser of line 4 or line 16)		3, 758, 172	0	•
	PROSPECTIVE PAYMENT AMOUNT - Lines 22 through 26 must only be com	oleted for PPS provi	ders.		
22.00	Other than outlier payments		0	0	22.00
23.00	Outlier payments		0	0	
24.00	Program capital payments		0		24.00
25.00 26.00	Capital exception payments (see instructions) Routine and Ancillary service other pass through costs		0	0	25.00
27.00	Subtotal (sum of lines 22 through 26)		0	0	•
28.00	Customary charges (title V or XIX PPS covered services only)		0	0	28.00
29.00	Titles V or XIX (sum of lines 21 and 27)		3, 758, 172	0	•
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
30.00	Excess of reasonable cost (from line 18)		0	0	30.00
31.00	Subtotal (sum of lines 19 and 20, plus 29 minus lines 5 and 6)		3, 758, 172	0	
32.00	Deducti bl es		0	0	
	Coinsurance		0	0	
34.00 35.00	Allowable bad debts (see instructions) Utilization review		0	0	34.00 35.00
36.00	Subtotal (sum of lines 31, 34 and 35 minus sum of lines 32 and 33)	3, 758, 172	0	
37.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	,	0	0	37.00
38.00	Subtotal (line 36 ± line 37)		3, 758, 172	0	38.00
39.00	Direct graduate medical education payments (from Wkst. E-4)		0		39.00
40.00	Total amount payable to the provider (sum of lines 38 and 39)		3, 758, 172	0	
41.00	Interim payments		3, 371, 018	0	
42.00 43.00	Balance due provider/program (line 40 minus line 41) Protested amounts (nonallowable cost report items) in accordance		387, 154	0	
	PREATESTED AMOUNTS (NONALLOWANIA COST RENORT LITEMS) IN ACCORDANCE		0		43.00

	E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column onl		CCN: 150026	Period: From 01/01/2015	Worksheet G	
nu-t	ype accounting records, comprete the deneral rund cordinar on	y)		To 12/31/2015	Date/Time Pre 5/27/2016 5:4	
		General Fund	Speci fi c	Endowment Fund		
		1.00	Purpose Fund 2.00	3.00	4.00	
	CURRENT ASSETS					
00	Cash on hand in banks	14, 701, 060		0 0	0	
00 00	Temporary i nvestments Notes receivable	52,000		0 0	0 0	
00	Accounts receivable	72, 922, 284		0 0	0	
00	Other receivable	0		0 0	0	
00	Allowances for uncollectible notes and accounts receivable	-44, 224, 951		0 0	0	
00	Inventory	5, 144, 095		0 0	0	7.
00	Prepaid expenses	4, 080, 562		0 0	0	
00	Other current assets	0		0 0	0	
. 00 . 00	Due from other funds Total current assets (sum of lines 1-10)	52, 675, 050		0 0	0	
. 00	FIXED ASSETS	52, 675, 050	1	0 0	0	1
. 00	Land	3, 884, 037		0 0	0	12.
. 00	Land improvements	2, 988, 795		0 0	0	
. 00	Accumulated depreciation	-1, 679, 302		0 0	0	14.
. 00	Bui I di ngs	102, 629, 248		0 0	0	
. 00	Accumulated depreciation	-38, 340, 697	1	0 0	0	
. 00	Leasehold improvements	113, 748	1	0 0	0	
00	Accumulated depreciation	-109, 232		0 0	0	
00	Fixed equipment Accumulated depreciation	13, 704, 629 -7, 722, 262		0 0	0	
. 00	Automobiles and trucks	-7, 722, 202		0 0	0	
. 00	Accumulated depreciation	C C		0 0	0	
. 00	Major movable equipment	112, 863, 780)	0 0	0	
00	Accumulated depreciation	-81, 479, 091		0 0	0	24.
00	Minor equipment depreciable	C		0 0	0	25
00	Accumulated depreciation	C		0 0	0	
00	HIT designated Assets	0		0 0	0	
00	Accumulated depreciation	0		0 0	0	
00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12–29)	106, 853, 653		0 0 0 0	0	
00	OTHER ASSETS	100, 000, 000	1	0 0	0	30.
00	Investments	C)	0 0	0	31.
00	Deposits on Leases	C)	0 0	0	32.
00	Due from owners/officers	C		0 0	0	33.
00	Other assets	175, 088, 834	1	0 0	0	
00	Total other assets (sum of lines 31-34)	175, 088, 834		0 0	0	
00	Total assets (sum of lines 11, 30, and 35)	334, 617, 537		0 0	0	36
00	CURRENT LI ABI LI TI ES	8, 212, 123	1	0 0	0	37.
00	Accounts payable Salaries, wages, and fees payable	7, 752, 828	1	0 0	0	
00	Payroll taxes payable	442, 702		0 0	0	
00		0		0 0	0	
00	Deferred income	C)	0 0	0	
00	Accelerated payments	C				42
00	Due to other funds	C		0 0	0	
00	Other current liabilities	2, 146, 695		0 0	0	
00	Total current liabilities (sum of lines 37 thru 44)	18, 554, 348		0 0	0	45
00	LONG TERM LIABILITIES Mortgage payable	0		0 0	0	46.
00	Notes payable	0		0 0	0	
00	Unsecured Loans			0 0	0	
00	Other long term liabilities	31, 065, 128		0 0	0	
00	Total long term liabilities (sum of lines 46 thru 49	31, 065, 128		0 0	0	50
00	Total liabilites (sum of lines 45 and 50)	49, 619, 476		0 0	0	51
	CAPITAL ACCOUNTS		1			1
00	General fund balance	284, 998, 061				52
00	Specific purpose fund			0		53
00 00	Donor created - endowment fund balance - restricted Donor created - endowment fund balance - unrestricted			0		54 55
00	Governing body created - endowment fund balance - unrestricted			0		56
00	Plant fund balance - invested in plant			0	0	
00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	
00	Total fund balances (sum of lines 52 thru 58)	284, 998, 061		0 0	0	59.
00	Total liabilities and fund balances (sum of lines 51 and	334, 617, 537	4		0	60

Heal th	Financial Systems	IU HEALTH GOSH	EN HOSPITAL		In Lie	u of Form CMS-2	2552-10
	IENT OF CHANGES IN FUND BALANCES			CCN: 150026	Peri od: From 01/01/2015 To 12/31/2015	Worksheet G-1 Date/Time Pre 5/27/2016 5:4	pared:
		General	Fund	Speci al	Purpose Fund	Endowment Fund	
1.00	Fund halances at beginning of pariod	1.00	2.00	3.00	4.00	5.00	1.00
$\begin{array}{c} 1, 00\\ 2, 00\\ 3, 00\\ 4, 00\\ 5, 00\\ 6, 00\\ 7, 00\\ 8, 00\\ 9, 00\\ 10, 00\\ 11, 00\\ 12, 00\\ 13, 00\\ 14, 00\\ 15, 00\\ 16, 00\\ 17, 00\\ 18, 00\\ \end{array}$	Fund balances at beginning of period Net income (Loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions - EQUITY TRANSFER Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) CHANGE FROM PRIOR Total deductions (sum of lines 12-17)	-537, 698 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	263, 268, 193 22, 267, 566 285, 535, 759 -537, 698 284, 998, 061			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ \end{array}$
19.00	Fund balance at end of period per balance sheet (line 11 minus line 18)		284, 998, 061		0		19.00
		Endowment Fund	PI ant	Fund			
		6.00	7.00	8.00			
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions - EQUITY TRANSFER	0	0 0 0 0 0 0		0		1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00
10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) CHANGE FROM PRIOR Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0 0 0 0	0 0 0 0 0 0		0 0 0 0		10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00

STATEN	IENT OF PATIENT REVENUES AND OPERATING EXPENSES	Provi der	CCN: 150026		ri od:	Worksheet G-2	2
				Fro To	om 01/01/2015 12/31/2015	Parts I & II Date/Time Pre 5/27/2016 5:4	
	Cost Center Description	- 1	Inpati ent		Outpati ent	Total	
			1.00		2.00	3.00	
	PART I - PATIENT REVENUES						-
	General Inpatient Routine Services		05 303 4			05 303 400	1
1.00	Hospi tal		35, 797, 4			35, 797, 432	
2.00	SUBPROVIDER - IPF			0		0	
3.00 4.00	SUBPROVI DER – I RF SUBPROVI DER			0 0		0	
4.00 5.00	Subrout Der Swing bed - SNF			0		0	
6.00	Swing bed - NF			0		0	
7.00	SKILLED NURSING FACILITY			0		0	
8.00	NURSING FACILITY			0		0	
9.00	OTHER LONG TERM CARE			0		0	
10.00	Total general inpatient care services (sum of lines 1-9)		35, 797, 4	-		35, 797, 432	
	Intensive Care Type Inpatient Hospital Services						1
11.00	INTENSIVE CARE UNIT		12, 175, 4	22		12, 175, 422	11.00
12.00	CORONARY CARE UNIT			0		0	12.00
13.00	BURN INTENSIVE CARE UNIT			0		0	13.00
14.00	SURGICAL INTENSIVE CARE UNIT			0		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00
16.00	Total intensive care type inpatient hospital services (sum of	lines	12, 175, 4	22		12, 175, 422	16.00
	11-15)						
17.00	Total inpatient routine care services (sum of lines 10 and 16)		47, 972, 8	54		47, 972, 854	17.00
18.00	Ancillary services		105, 507, 9		302, 436, 094	407, 944, 045	
19.00	Outpatient services		6, 193, 0		30, 920, 935	37, 114, 028	
20.00	RURAL HEALTH CLINIC			0	0	0	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	
22.00	HOME HEALTH AGENCY				1, 843, 637	1, 843, 637	
23.00	AMBULANCE SERVICES					0	23.00
24.00				~	0	0	
25.00 26.00	AMBULATORY SURGICAL CENTER (D. P.) HOSPICE			0	Ű	0	
26.00	NURSERY		14, 580, 5	-	4, 171, 009 18, 639, 129	4, 171, 009 33, 219, 668	
27.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst	174, 254, 4		358, 010, 804	532, 265, 241	
20.00	G-3, line 1)	to wrst.	174, 254, 4	57	338, 010, 804	552, 205, 241	20.00
	PART II - OPERATING EXPENSES		1		I		
29.00	Operating expenses (per Wkst. A, column 3, line 200)				196, 169, 308		29.00
30.00	ADD (SPECIFY)			0	,,		30.00
31.00				0			31.00
32.00				0			32.00
33.00				0			33.00
34.00				0			34.00
35.00				0			35.00
36.00	Total additions (sum of lines 30-35)				0		36.00
37.00	DEDUCT (SPECI FY)			0			37.00
38.00				0			38.00
39.00				0			39.00
40.00				0			40.00
41.00				0			41.00
42.00	Total deductions (sum of lines 37-41)				0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42	\(transfor	1	1	196, 169, 308		43.00

Heal th	Financial Systems	IU HEALTH GOSHEN H	OSPI TAL		In Lie	u of Form CMS-2	2552-10
STATE	IENT OF REVENUES AND EXPENSES		Provider CCN	: 150026	Period:	Worksheet G-3	
					From 01/01/2015 To 12/31/2015	Date/Time Pre	harod
					10 12/31/2013	5/27/2016 5:4	
						1.00	
1.00	Total patient revenues (from Wkst. G-2, Part	I, column 3, line 2	28)			532, 265, 241	1.00
2.00	Less contractual allowances and discounts on	patients' accounts				316, 791, 907	2.00
3.00	Net patient revenues (line 1 minus line 2)					215, 473, 334	3.00
4.00	Less total operating expenses (from Wkst. G-2,	, Part II, line 43)				196, 169, 308	4.00
5.00	Net income from service to patients (line 3 m	inus line 4)				19, 304, 026	5.00
	OTHER INCOME						
6.00	Contributions, donations, bequests, etc					0	6.00
7.00	Income from investments					2, 819, 214	7.00
8.00	Revenues from telephone and other miscellaneo	us communication se	ervi ces			0	8.00
9.00	Revenue from television and radio service					0	9.00
10.00	Purchase di scounts					37, 891	10.00
11.00	Rebates and refunds of expenses					899, 451	11.00
12.00	Parking lot receipts					0	12.00
13.00	Revenue from Laundry and Linen service					0	13.00
14.00	Revenue from meals sold to employees and gues	ts				880, 171	14.00
15.00	Revenue from rental of living quarters					0	15.00
16.00	Revenue from sale of medical and surgical sup		n patients			58, 322	
	Revenue from sale of drugs to other than patie					0	
18.00	Revenue from sale of medical records and abst					0	18.00
	Tuition (fees, sale of textbooks, uniforms, e					0	
20.00	Revenue from gifts, flowers, coffee shops, and	d canteen				0	20.00
21.00	Rental of vending machines					0	21.00
22.00	Rental of hospital space					1, 075, 559	
23.00	Governmental appropriations					0	23.00
24.00	MISC OTHER OPER/NON OPER REVENUE					-2, 807, 068	
25.00	Total other income (sum of lines 6-24)					2, 963, 540	
26.00	Total (line 5 plus line 25)					22, 267, 566	
27.00	OTHER EXPENSES (SPECIFY)					0	27.00
	Total other expenses (sum of line 27 and subs					0	28.00
29.00	Net income (or loss) for the period (line 26	minus line 28)				22, 267, 566	29.00

	Financial Systems GIS OF PROVIDER-BASED HOME HEALT	H AGENCY COSTS	IU HEALTH GOS		CCN: 150026	Peri od:	u of Form CMS-: Worksheet H	2002
				HHA CCN:	157174	From 01/01/2015 To 12/31/2015	Date/Time Pre 5/27/2016 5:4	
						Home Health Agency I	PPS	
		Sal ari es	Employee Benefits	Transportation (see	chased		Total (sum of cols. 1 thru	
		1.00	2.00	instructions) 3.00	Services 4.00	5.00	5) 6.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	0.00	
0	Capital Related - Bldg. &			0		0	0	1
0	Fixtures Capital Related - Movable					3, 187	3, 187	2
0	Equipment					5, 107	3, 107	2
0	Plant Operation & Maintenance	0	C	0	70, 64	19 0	70, 649	3
0	Transportation	0	C	-		0 0	0	
0	Administrative and General HHA REIMBURSABLE SERVICES	641,063	C	69, 532	6, 98	89, 937	807, 516	5
0	Skilled Nursing Care	604, 284	C	C		0 0	604, 284	6
0	Physical Therapy	262, 040				0 0		
0	Occupational Therapy	107, 662	C	0		0 0	107, 662	
0	Speech Pathology	35, 889	C	0		0 0	35, 889	
00	Medical Social Services	67, 147	C			0 0	67,147	
00 00	Home Health Aide Supplies (see instructions)	46, 725				0 31, 115	46, 725 31, 115	
00	Drugs	0	C			0 -358		
00	DME	0	C	0		0 0		
	HHA NONREIMBURSABLE SERVICES							
00	Home Dialysis Aide Services	0	-			0 0		
00 00	Respiratory Therapy Private Duty Nursing	0	C			0 0	0	
00	Clinic					0 0	0	1
00	Health Promotion Activities	0	C			0 0	0	
00	Day Care Program	0	C	0		0 0	0	20
00	Home Delivered Meals Program	0	C	0		0 0	0	
00	Homemaker Service	0	C			0 0	0	
	All Others (specify) Total (sum of lines 1-23)	1, 764, 810		69, 532	77, 63	33 123, 881	2, 035, 856	
00		Recl assi fi cati	Recl assi fi ed	Adjustments	Net Expenses		2,000,000	
		on	Trial Balance		for Allocatic			
			(col. 6 +		(col. 8 + col			
		7.00	(col. 6 + col.7) 8.00	9.00	(col . 8 + col 9) 10.00			-
	GENERAL SERVI CE COST CENTERS	7.00	col . 7)	1	9) 10.00	•		
0	Capital Related - Bldg. &	7.00	col . 7) 8. 00	1	9) 10.00	0		1
	Capital Related - Bldg. & Fixtures	0	<u>col . 7)</u> 8.00 C	C	9) 10.00	0		
	Capital Related - Bldg. & Fixtures Capital Related - Movable		col . 7) 8. 00	C	9) 10.00	0		
0	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance	0	<u>col . 7)</u> 8.00 C	0 0 0	9) 10.00 3,18	0 37		2
0 0 0	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation	0 0 0 0 0	col . 7) 8. 00 3, 187 70, 649 C		9) 10.00 3,18 70,64	0 37 19 0		2 3 4
0 0	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General	0 0 0	col . 7) 8. 00 3, 187 70, 649 C		9) 10.00 3,18 70,64	0 37 19 0		2 3 4
0 0 0	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES	0 0 0 0 0	col . 7) 8. 00 3, 187 70, 649 0 807, 516		9) 10.00 3,18 70,64 807,51	0 37 49 0 6		2 3 4 5
0 0 0 0	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care	0 0 0 0 0	col . 7) 8. 00 3, 187 70, 649 C		9) 10.00 3,18 70,64 807,51 604,28	0 37 49 0 6 34		2 3 4 5 6
	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES	0 0 0 0 0	col . 7) 8. 00 3, 187 70, 649 0 807, 516 604, 284		9) 10.00 3,18 70,64 807,51 604,28	0 37 49 0 16 34		2 3 4 5 6 7
	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	0 0 0 0 0	col . 7) 8. 00 3, 187 70, 649 0 807, 516 604, 284 262, 040 107, 662 35, 889		9) 10.00 3,18 70,64 807,51 604,28 262,04 107,66 35,88	0 37 19 0 6 4 4 0 52 39		2 3 4 5 6 7 8 9
0 0 0 0 0 0 0 0 0 0	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	0 0 0 0 0	col . 7) 8. 00 3, 187 70, 649 0 807, 516 604, 284 262, 040 107, 662 35, 889 67, 147		9) 10.00 3,18 70,64 807,51 604,28 262,04 107,66 35,88 67,14	0 37 19 0 6 4 10 22 39 17		2 3 4 5 6 7 8 9 10
0 0 0 0 0 0 0 0 0 0 0 0 0	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide		Col . 7) 8. 00 3, 187 70, 649 Co 807, 516 604, 284 262, 040 107, 662 35, 889 67, 147 46, 725		9) 10.00 3, 18 70, 64 807, 51 604, 28 262, 04 107, 66 35, 88 67, 14 46, 72	0 37 49 0 6 6 34 40 52 39 7 25		2 3 4 5 6 7 8 9 10 11
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Capital Related - Bldg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions)	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	col . 7) 8. 00 3, 187 70, 649 0 807, 516 604, 284 262, 040 107, 662 35, 889 67, 147 46, 725 8, 296		9) 10.00 3, 18 70, 64 807, 51 604, 28 262, 04 107, 66 35, 88 67, 14 46, 72 8, 25	0 37 49 0 6 8 4 40 52 39 39 17 25 50 6		2 3 4 5 6 7 8 9 10 11 12
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Capital Related - Bidg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME		Col . 7) 8. 00 3, 187 70, 649 0 807, 516 604, 284 262, 040 107, 662 35, 889 67, 147 46, 725 8, 296 0		9) 10.00 3,18 70,64 807,51 604,28 262,04 107,66 35,88 67,14 46,72 8,29	0 37 49 0 6 6 34 40 52 39 7 25		2 3 4 5 6 7 8 8 9 10 11 12 13
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Capital Related - Bidg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Col . 7) 8. 00 3. 187 70, 649 C 807, 516 604, 284 262, 040 107, 662 35, 889 67, 147 46, 725 8, 296 C C		9) 10.00 3,18 70,64 807,51 604,28 262,04 107,66 35,88 67,14 46,72 8,29	0 37 19 0 16 34 40 52 39 77 25 26 0 0 0		2 3 4 5 6 7 8 9 10 11 12 13 14
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Capital Related - Bidg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	col . 7) 8. 00 3, 187 70, 649 0 807, 516 604, 284 262, 040 107, 662 35, 889 67, 147 46, 725 8, 296 0 0 0 0 0 0 0 0 0 0 0 0 0		9) 10.00 3, 18 70, 64 807, 51 604, 28 262, 04 107, 66 35, 88 67, 14 46, 72 8, 29	0 37 19 0 4 19 0 4 10 52 39 17 25 26 0 0 0 0		2 3 4 5 6 7 8 9 10 11 12 13 14 15
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Capital Related - Bidg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Col . 7) 8. 00 3. 187 70, 649 C 807, 516 604, 284 262, 040 107, 662 35, 889 67, 147 46, 725 8, 296 C C		9) 10.00 3, 18 70, 64 807, 51 604, 28 262, 04 107, 66 35, 88 67, 14 46, 72 8, 29	0 37 19 0 16 34 40 52 39 77 25 26 0 0 0		2 3 4 5 6 7 8 9 10 11 12 13 14 15 16
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Capital Related - Bidg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	col . 7) 8. 00 3, 187 70, 649 0 807, 516 604, 284 262, 040 107, 662 35, 889 67, 147 46, 725 8, 296 0 0 0 0 0 0 0 0 0 0 0 0 0		9) 10.00 3, 18 70, 64 807, 51 604, 28 262, 04 107, 66 35, 88 67, 14 46, 72 8, 29	0 37 19 0 4 19 0 4 10 52 39 17 25 26 0 0 0 0		2 3 4 5 7 8 9 10 11 11 12 13 14 15 16 17
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Capital Related - Bidg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	col . 7) 8. 00 3, 187 70, 649 0 807, 516 604, 284 262, 040 107, 662 35, 889 67, 147 46, 725 8, 296 0 0 0 0 0 0 0 0 0 0 0 0 0		9) 10.00 3, 18 70, 64 807, 51 604, 28 262, 04 107, 66 35, 88 67, 14 46, 72 8, 29	0 37 19 0 4 19 0 4 10 52 39 17 25 26 0 0 0 0		2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18
0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Capital Related - Bidg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	col . 7) 8. 00 3, 187 70, 649 0 807, 516 604, 284 262, 040 107, 662 35, 889 67, 147 46, 725 8, 296 0 0 0 0 0 0 0 0 0 0 0 0 0		9) 10.00 3, 18 70, 64 807, 51 604, 28 262, 04 107, 66 35, 88 67, 14 46, 72 8, 29	0 37 19 0 4 19 0 4 10 52 39 17 25 26 0 0 0 0		2 3 4 5 7 8 9 10 11 12 13 14 15 16 17 18 19
	Capital Related - Bidg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	col . 7) 8. 00 3, 187 70, 649 0 807, 516 604, 284 262, 040 107, 662 35, 889 67, 147 46, 725 8, 296 0 0 0 0 0 0 0 0 0 0 0 0 0		9) 10.00 3, 18 70, 64 807, 51 604, 28 262, 04 107, 66 35, 88 67, 14 46, 72 8, 29	0 37 19 0 4 19 0 4 10 52 39 17 25 26 0 0 0 0		2 3 4 5 6 7 8 9 10 11 12 13 14 15 16 17 18 19 20 20 21
00 00 00 00 00	Capital Related - Bidg. & Fixtures Capital Related - Movable Equipment Plant Operation & Maintenance Transportation Administrative and General HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	col . 7) 8. 00 3, 187 70, 649 0 807, 516 604, 284 262, 040 107, 662 35, 889 67, 147 46, 725 8, 296 0 0 0 0 0 0 0 0 0 0 0 0 0		9) 10.00 3, 18 70, 64 807, 51 604, 28 262, 04 107, 66 35, 88 67, 14 46, 72 8, 25	0 37 19 0 4 19 0 4 10 52 39 17 25 26 0 0 0 0		1 2 3 4 5 6 7 7 8 9 10 11 12 13 14 15 16 17 18 19 20 21 22 23

	Financial Systems		IU HEALTH GOSH		001 450004		u of Form CMS-	
OST A	LLOCATION - HHA GENERAL SERVICE	COST		HHA CCN:	1	Period: From 01/01/2015 Fo 12/31/2015	Worksheet H-1 Part I Date/Time Pre 5/27/2016 5:4	pared:
						Home Health Agency I	PPS	Pili
			Capital Rel	ated Costs		Agency		
		Net Expenses for Cost Allocation (from Wkst. H, col. 10)	BI dgs & Fixtures	Movable Equipment	Plant Operation & Maintenance	Transportati on	Subtotal (cols. 0-4)	-
		0	1.00	2.00	3.00	4.00	4A. 00	
00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	0	0				0	1.00
00	Fixtures Capital Related – Movable Equipment	3, 187		3, 187			C	2.00
. 00 . 00	Plant Operation & Maintenance Transportation	70, 649 0	0 0	0 0	70, 649	9 D 0	0	3.00
. 00	Administrative and General HHA REIMBURSABLE SERVICES	807, 516	0	3, 187	70, 649	9 0	881, 352	5.00
. 00	Skilled Nursing Care	604, 284	0	0	(0 0	604, 284	6.00
. 00 . 00	Physical Therapy Occupational Therapy	262, 040 107, 662	0	0			262, 040 107, 662	
00	Speech Pathol ogy	35, 889	0	0	(35, 889	
0.00	Medical Social Services	67, 147	0	0	(0	67, 147	
1.00 2.00	Home Health Aide Supplies (see instructions)	46, 725 8, 296	0	0			46, 725 8, 296	
3.00	Drugs	0	0	0	(0	13.00
4.00	DME HHA NONREI MBURSABLE SERVI CES	0	0	0	(0 0	0	14.00
5.00	Home Dialysis Aide Services	0	0	0	(0 0	0	
6.00	Respiratory Therapy	0	0	0	(0	
7.00 8.00	Private Duty Nursing Clinic	0	0	0			0	
9.00	Health Promotion Activities	0	0	0	(0 0	0	19.00
0.00	Day Care Program Home Delivered Meals Program	0	0	0	(0	
2.00	Homemaker Service	0	0	0	(0	
3.00	All Others (specify)	0	0	0	(0	0	
4.00	Total (sum of lines 1-23)	2,013,395 Admi ni strati ve	Total (cols.	3, 187	70, 649	9 0	2,013,395	24.00
		& General 5.00	4A + 5) 6.00			-		-
	GENERAL SERVICE COST CENTERS	5.00	8.00					
. 00	Capital Related - Bldg. &							1.00
. 00	Fixtures Capital Related - Movable							2.00
00	Equipment							
. 00	Plant Operation & Maintenance Transportation							3.00
. 00	Administrative and General	881, 352						5.00
. 00	HHA REIMBURSABLE SERVICES Skilled Nursing Care	470, 466	1,074,750					6.00
. 00	Physical Therapy	204, 011	466, 051					7.00
. 00	Occupational Therapy	83, 820	191, 482 63, 830					8.0
. 00 0. 00	Speech Pathology Medical Social Services	27, 941 52, 277	63, 830 119, 424					9.0
1. 00	Home Health Aide	36, 378	83, 103					11.0
2.00 3.00	Supplies (see instructions) Drugs	6, 459 0	14, 755 0					12.00
	DME	0	0					14.00
5.00	HHA NONREIMBURSABLE SERVICES Home Dialysis Aide Services	0	o					15.00
6.00	Respiratory Therapy	0	0					16.00
7.00	Private Duty Nursing	0	0					17.0
0 00	Clinic Health Promotion Activities	0	0					18.0
		l v	0					20.0
9.00	Day Care Program	0	0					
9.00 0.00 1.00	Home Delivered Meals Program	0	0					21.00
	3	0 0 0	0 0 0 0					21.00 22.00 23.00

Health Financial Systems IU HEALTH GOSHEN HOSPITAL In Lieu of Form CMS-2552-										
	NLLOCATION - HHA STATISTICAL BAS	SI S		Provi der HHA CCN:	CCN: 150026 157174	Period: From 01/01/2015 To 12/31/2015	Worksheet H-1 Part II Date/Time Pre 5/27/2016 5:4	pared:		
						Home Health Agency I	PPS			
		Capital Rel	ated Costs							
		· · · · ·	Movable Equipment (DOLLAR VALUE)	Operation & Maintenance (SQUARE FEET)	(MI LEAGE)	onReconciliation	& General (ACCUM. COST)	-		
		1.00	2.00	3.00	4.00	5A. 00	5.00			
1.00	GENERAL SERVICE COST CENTERS Capital Related - Bldg. &	2, 563				0		1.00		
2.00	Fixtures Capital Related - Movable Equipment		15, 521			0		2.00		
3.00 4.00	Plant Operation & Maintenance Transportation (see	0	0 0	2, 563 0		23		3.00 4.00		
5.00	instructions) Administrative and General	2, 563	15, 521	2, 563	3, 02	28 -881, 352	1, 132, 043	5.00		
6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00	HHA REIMBURSABLE SERVICES Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME HHA NONREIMBURSABLE SERVICES	0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0		13, 4 7, 4 1, 0 4, 7 18, 3	28 0 89 0 66 0 47 0	262, 040 107, 662 35, 889 67, 147 46, 725 8, 296 0	7.00 8.00 9.00 10.00 11.00 12.00 13.00		
$\begin{array}{c} 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 23.\ 00\\ 24.\ 00\\ 25.\ 00\\ \end{array}$	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-23) Cost To Be Allocated (per Worksheet H-1, Part I) Unit Cost Multiplier	0 0 0 0 0 0 0 2, 563 0 0 0. 000000	0 0 0 0 0 0 15, 521 3, 187	0 0 0 0 0 0 2, 563 70, 649	117, 4:	0	0 0 0 0 0 0 0 0 0 0 0 0 0	16.00 17.00 18.00 19.00 20.00 21.00 22.00 23.00 24.00 25.00		

ALLUCAT	ION OF GENERAL SERVICE COSTS 1	O HHA COST CEN	TERS	Provi der		Peri od:	Worksheet H-2	
				HHA CCN:		From 01/01/2015 To 12/31/2015	Part I Date/Time Pre 5/27/2016 5:4	
						Home Health	PPS	
			CAPI TAL REL	ATED COSTS		Agency I		
	Cost Center Description	HHA Trial Balance (1)	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE BENEFITS DEPARTMENT	CASHI ERI NG/ACC OUNTS RECEI VABLE	Subtotal	
		0	1.00	2.00	4.00	5. 01	5A. 01	
2.00 3.00 3.00 4.00 4.00 5.00 5.00 10.00 7.00 3.00 9.00 10.00 11.00 12.00 13.00 14.00 155.00 17.00 18.00 19.00 12.00 13.00 14.00 12.00 12.00 13.00 14.00 12.00 12.00 12.00 13.00 14.00 14.00 12.00 12.00 13.00 14.00 12.00 12.00 12.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 1, rounded to	0 1, 074, 750 466, 051 191, 482 63, 830 119, 424 83, 103 14, 755 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	30, 442 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	13, 251 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	220, 61 95, 66 39, 30 13, 10 24, 51 17, 05	6 0 7 0 6 0 3 0 4 0 9 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	286, 411 1, 295, 366 561, 718 230, 788 76, 933 143, 938 100, 162 14, 755 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19. 20.
	6 decimal places. Cost Center Description	OTHER ADMI NI STRATI VE	MAI NTENANCE & REPAI RS	OPERATION OF PLANT	LAUNDRY & LINEN SERVICE	HOUSEKEEPING	DI ETARY	
		AND GENERAL 5.02	6.00	7.00	8.00	9.00	10.00	
2.00 3.00 3.00 4.00 5.00 5.00 5.00 10.00 10.00 10.00 11.00 12.00 13.00 14.00 15.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00	Administrative and General Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Supplies (see instructions) Drugs DME Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19) (2) Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus	67, 153 303, 719 131, 703 54, 112 18, 038 33, 748 23, 484 3, 460 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	35, 082 35, 082 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		9.00 17,706 0 17,706	10.00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2. 3. 4. 5. 6. 7. 8. 9. 10. 11. 12. 13. 14. 15. 16. 17. 18. 19.

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

LOCATION OF GENERAL SERVICE COSTS 1	IO HHA COST CEI	NTERS	Provi der		Peri od:	Worksheet H-2	-
			HHA CCN:		From 01/01/2015 To 12/31/2015	Part I Date/Time Pre 5/27/2016 5:4	pared: 7 pm
					Home Health Agency I	PPS	
Cost Center Description	CAFETERI A	MAINTENANCE OF PERSONNEL	NURSI NG ADMI NI STRATI ON		PHARMACY	MEDI CAL RECORDS & LI BRARY	
	11.00	12.00	13.00	SUPPLY 14.00	15.00	16.00	
00Administrative and General00Skilled Nursing Care00Physical Therapy	12, 15 8, 198 2, 67	3 0 7 0	134, 023 0		0 0 0 0 0 0	17, 874 C C	2.0 3.0
00 Occupational Therapy 00 Speech Pathology 00 Medical Social Services 00 University of the distance	1, 629 380 930		0		0 0 0 0 0 0 0 0		5.0 6.0
00 Home Health Aide 00 Supplies (see instructions) 00 Drugs 0.00 DME		0 0	0	2, 76	0 0 9 0 0 0 0 0		8.0 9.0
.00Home Dialysis Aide Services2.00Respiratory Therapy3.00Private Duty Nursing			0000		0 0 0 0 0 0 0 0) 11.0 12.0
I.00 Clinic 5.00 Health Promotion Activities 5.00 Day Care Program 7.00 Hear Delivered Models Deserve			0		0 0 0 0 0 0 0 0 0 0		15.0 16.0
7.00Home Delivered Meals Program8.00Homemaker Service9.00All Others (specify)9.00Total (sum of lines 1-19) (2)	(0	2, 76	0 0 0	C C C 17, 874) 18.0 19.0 20.0
1.00 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 6 decimal places.							21.0
				I NTERNS	& RESIDENTS		
Cost Center Description		ANESTHETI STS		Y & FRI NGES APPRV	PRGM COSTS APPRV	EDUCATI ON PROGRAM	
	17.00	19.00	20.00	21.00	22.00	23.00	
Administrative and GeneralSkilled Nursing CarePhysical Therapy			0		0 0 0 0 0 0		2.0
00 Occupational Therapy00 Speech Pathology00 Medical Social Services	(0		0 0 0 0 0 0		5.0
00Home Health Aide00Supplies (see instructions)00Drugs					0 0 0 0 0 0		8. (9. (
 0.00 DME 00 Home Dialysis Aide Services 00 Respiratory Therapy 00 Directory Therapy 			0		0 0 0 0 0 0 0 0) 11.) 12.
 .00 Private Duty Nursing .00 Clinic .00 Health Promotion Activities .00 Day Care Program 	1		0		0 0 0 0 0 0 0 0 0 0) 14.) 15.
.00Home Delivered Meals Program.00Homemaker Service.00All Others (specify)			0) 17.) 18.) 19.
 100 Total (sum of lines 1-19) (2) 100 Unit Cost Multiplier: column 26, line 1 divided by the sum of column 26, line 20 minus column 26, line 1, rounded to 			,				20.

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

Heal th	Financial Systems		IU HEALTH GOSH	IEN HOSPI TAL		In Lie	u of Form CMS-:	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS T	O HHA COST CEN	TERS	Provider HHA CCN:	CCN: 150026 157174	Peri od: From 01/01/2015 To 12/31/2015		pared:
						Home Health	5/27/2016 5:4 PPS	/ pm
						Agency I	110	
	Cost Center Description	Subtotal	Intern &	Subtotal	Allocated HH	A Total HHA		
			Residents Cost		A&G (see Par	t Costs		
			& Post		11)			
			Stepdown					
		24.00	Adjustments 25.00	26.00	27.00	28.00		
1.00	Administrative and General	436, 377		436, 377		20.00		1.00
2.00	Skilled Nursing Care	1, 741, 306		1, 741, 306		92 1, 982, 998		2.00
3.00	Physical Therapy	696, 098		696, 098				3.00
4.00	Occupational Therapy	286, 529		286, 529				4.00
5.00	Speech Pathology	95, 357		95, 357				5.00
6.00	Medical Social Services	178, 616		178, 616				6.00
7.00	Home Health Aide	125, 025	0	125, 025	17, 3	54 142, 379		7.00
8.00	Supplies (see instructions)	20, 984	0	20, 984	2, 9	13 23, 897		8.00
9.00	Drugs	0	0	0		0 0		9.00
10.00	DME	0	0	0		0 0		10.00
11.00	Home Dialysis Aide Services	0	0	0		0 0		11.00
12.00	Respiratory Therapy	0	0	0		0 0		12.00
13.00	Private Duty Nursing	0	0	0		0 0		13.00
14.00	Clinic	0	0	0		0 0		14.00
15.00	Health Promotion Activities	0	0	0		0 0		15.00
16.00	Day Care Program	0	0	0		0 0		16.00
17.00	Home Delivered Meals Program Homemaker Service	0	0	0		0 0		17.00 18.00
18.00 19.00	All Others (specify)	0	0	0		0 0		18.00
20.00	Total (sum of lines 1-19) (2)	3, 580, 292	0	3, 580, 292	436, 3	77 3, 580, 292		20.00
20.00	Unit Cost Multiplier: column	3, 300, 272	0	3, 300, 272	0, 1388			20.00
21.00	26, line 1 divided by the sum				0. 1300			21.00
	of column 26, line 20 minus							
	column 26, line 1, rounded to							
	6 decimal places.							

(1) Column 0, line 20 must agree with Wkst. A, column 7, line 101.
(2) Columns 0 through 26, line 20 must agree with the corresponding columns of Wkst. B, Part I, line 101.

	n Financial Systems ATION OF GENERAL SERVICE COSTS T		IU HEALTH GOS		CCN: 150026	In Lie Period:	Worksheet H-2	
BASI S	ATTON OF GENERAL SERVICE COSTS	IU HHA COST CEN	TERS STATISTIC	HHA CCN:		From 01/01/2015 To 12/31/2015	Part II	pared:
						Home Health Agency I	PPS	
		CAPI TAL REL	ATED COSTS			Ageney		
	Cost Center Description	BLDG & FI XT (SQUARE FEET)	MVBLE EQUIP (DOLLAR VALUE)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	CASHI ERI NG/AC OUNTS RECEI VABLE (GROSS CHAR GES)	CReconciliation	OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST)	
		1.00	2.00	4.00	5.01	5A. 02	5.02	
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 20.\ 00\\ 21.\ 00\\ 21.\ 00\\ 22.\ 00\\ \end{array}$	Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19)	2, 563 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	262, 040 107, 662 35, 889 67, 147 46, 725 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	1, 843, 63 8, 67			3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 14.00 15.00 14.00 19.00 20.00 21.00
	Cost Center Description	MAI NTENANCE & REPAI RS (SQUARE FEET)	OPERATION OF PLANT	LAUNDRY &	HOUSEKEEPI NG		CAFETERI A	
1 00	Administrative and Cananal	6.00 2,563	7.00	8.00	9.00	<u> </u>	11.00	1.00
$\begin{array}{c} 1.\ 00\\ 2.\ 00\\ 3.\ 00\\ 4.\ 00\\ 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ 17.\ 00\\ 18.\ 00\\ 19.\ 00\\ 20.\ 00\\ 21.\ 00\\ 22.\ 00\\ 21.\ 00\\ 22.\ 00\\ 21.\ 00\\ 22.\ 00\\ 21.\ 00\\ 22.\ 00\\ 21.\ 00\\ 22.\ 00\\ 21.\ 00\\ 22.\ 00\\ 21.\ 00\\ 22.\ 00\\ 21.\ 00\\ 22.\ 00\\ 21.\ 00\\ 22.\ 00\\ 21.\ 00\\ 22.\ 00\\ 21.\ 00\\ 22.\ 00\\ 21.\ 00\\ 22.\ 00\\ 21.\ 00\\ 22.\ $	Home Dialysis Aide Services Respiratory Therapy Private Duty Nursing Clinic Health Promotion Activities Day Care Program Home Delivered Meals Program Homemaker Service All Others (specify) Total (sum of lines 1-19)	2, 563 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		2, 56		17, 749 5, 795 3, 526 835 2, 013 2, 985 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00 20.00 21.00

Heal th	Financial Systems		IU HEALTH GOSH	IEN HOSPITAL		In Lie	eu of Form CMS-2	2552-10
	ATION OF GENERAL SERVICE COSTS 1	TO HHA COST CEN			CCN: 150026	Peri od:	Worksheet H-2	
BASI S				HHA CCN:	157174	From 01/01/2015 To 12/31/2015	Part II Date/Time Prep 5/27/2016 5:47	
						Home Health Agency I	PPS	_ r
	Cost Center Description	MAINTENANCE OF	NURSI NG	CENTRAL	PHARMACY	MEDICAL	SOCIAL SERVICE	
			ADMI NI STRATI ON		(COSTED	RECORDS &		
		(NUMBER		SUPPLY	REQUIS.)	LI BRARY	(TIME SPENT)	
		HOUSED)	(DI RECT NRSI NG	(COSTED		(GROSS CHAR		
		12.00	HRS) 13.00	REQUIS.) 14.00	15.00	GES) 16.00	17.00	
1.00	Administrative and General	0		C		0 1, 843, 637	0	1.00
2.00	Skilled Nursing Care	0	19, 158	C		0 0	0	2.00
3.00	Physi cal Therapy	0	0	C		0 0	0	3.00
4.00	Occupational Therapy	0	-	C		0 0	0	4.00
5.00	Speech Pathol ogy	0	-	C		0 0	0	5.00
6.00	Medical Social Services Home Health Aide	0	0			0 0	0	6.00
7.00 8.00	Supplies (see instructions)	0	0	52, 610		0 0	0	7.00 8.00
9.00	Drugs		0	52,010		0 0	0	9.00
10.00	DME	0	0	C		0 0	0	10.00
11.00	Home Dialysis Aide Services	0	0	C		0 0	0	11.00
12.00	Respiratory Therapy	0	0	C		0 0	0	12.00
13.00	Private Duty Nursing	0	0	C		0 0	0	13.00
14.00	Clinic	0	0	C		0 0	0	14.00
15.00	Health Promotion Activities	0	0	C	0	0 0	0	15.00
16.00 17.00	Day Care Program Home Delivered Meals Program	0	0			0 0	0	16.00 17.00
17.00	Homemaker Service		0			0 0	0	18.00
19.00		0	0	C		0 0	0	19.00
20.00	Total (sum of lines 1-19)	0	19, 158	52, 610		0 1, 843, 637	0	20.00
21.00	Total cost to be allocated	0	134, 023	2, 769		0 17, 874	0	21.00
22.00	Unit cost multiplier	0. 000000	6. 995668	0.052633		0 0.009695	0. 000000	22.00
				INTERNS &	RESI DENTS			
	Cost Center Description	NONPHYSI CI AN	NURSING SCHOOL	SERVICES-SALAR	SERVICES-OTHE	R PARAMEDI CAL		
		ANESTHETI STS		Y & FRINGES	PRGM COSTS	EDUCATION		
		(ASSI GNED	(ASSI GNED	APPRV	APPRV	PROGRAM		
		TIME)	TIME)	(ASSI GNED	(ASSI GNED	(ASSI GNED		
		19.00	20.00	TI ME) 21.00	TIME) 22.00	TI ME) 23.00		
1.00	Administrative and General	19.00		21.00		0 0		1.00
2.00	Skilled Nursing Care	0	-	C		0 0		2.00
3.00	Physi cal Therapy	0	0	C		0 0		3.00
4.00	Occupational Therapy	0	0	C		0 0		4.00
5.00	Speech Pathol ogy	0	0	C		0 0		5.00
6.00	Medical Social Services	0	0	C		0 0		6.00
7.00	Home Health Aide	0	0			0 0		7.00
8.00 9.00	Supplies (see instructions) Drugs		0			0 0		8.00 9.00
10.00	DME	0	-	C		0 0		10.00
11.00	Home Dialysis Aide Services	0		C		0 0		11.00
12.00	Respiratory Therapy	0	0	C		0 0		12.00
13.00	Private Duty Nursing	0	0	C		0 0		13.00
14.00	Clinic	0	0	C		0 0		14.00
15.00		0	0	C		0 0		15.00
16.00	Day Care Program	0	0	C		0 0		16.00
17.00 18.00			0			0 0		17.00 18.00
18.00 19.00			-			0 0		18.00 19.00
20.00	(0	-			0 0		20.00
21.00	,	0	-	C		0 0		21.00
22.00		0. 000000	0. 000000	0.00000	0. 00000	0. 000000		22.00

Cost Center Description Cost Limits CBSA No. (1) Part A Program Visits Cost Subject to Deductibles & Deductibles & Deductibles & Deductibles & Colnsurance 8.00 Skilled Nursing Care 22140 0 3.00 4.00 5.00 9.00 Physical Therapy 22140 0 3.620 8.01 8.01 9.00 Physical Therapy 22140 0 1.415 9.00 9.01 9.01 9.01 9.01 9.01 9.01 9.01 9.01 1.415 9.00 9.01 9.01 1.415 9.00 10.01 0 1.01 10.01 11.00 12.01 <th>Heal th</th> <th>Financial Systems</th> <th></th> <th>IU HEALTH GOSH</th> <th>IEN HOSPI TAL</th> <th></th> <th>In Lie</th> <th>eu of Form CMS-2</th> <th>2552-10</th>	Heal th	Financial Systems		IU HEALTH GOSH	IEN HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HHA COV 127174 TO 127174	APPORT	IONMENT OF PATIENT SERVICE COST	S		Provi der	CCN: 150026			
Cost Center Description From. West. (c) Facility Costs (from West. (c) Shared Arcility (from West. (c) Total Wisk St. (c) Average Cost (c) Average Cost (HHA CCN:	157174		Date/Time Pre	pared: 7 pm
Hera Part I Crom West. (col. 3 + col. Part I) Ancillary Destrictor Costs (cols 1) Part II) Per Visit (Part III) Per Visit (Part IIII) Per Visit (Part IIII) Per Visit (Part IIII) Per Visit (Part IIII) Per Visit (Part IIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIIII					Ti tl	e XVIII			
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				HHA CCN:	157174	To 12/31/2015		epared 17 pm
				Ti tl	e XVIII	Home Health Agency I	PPS	
	Cost Center Description	6.00	7.00	8.00	9.00	10.00	11.00	
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		Prog	ram Covered Cha	rges	Cost of Servi ces			
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	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy	1, 095, 774 491, 755		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	1. 2.
. 00 . 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy	1, 095, 774 491, 755 199, 298		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	2. 3.
. 00 . 00 . 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology	1, 095, 774 491, 755 199, 298 73, 688		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 3. 4.
. 00 . 00 . 00 . 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	1, 095, 774 491, 755 199, 298 73, 688 138, 537		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OR	2	2. 3. 4. 5.
. 00 . 00 . 00 . 00 . 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide	1, 095, 774 491, 755 199, 298 73, 688 138, 537 103, 019		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	2. 3. 4. 5. 6.
. 00 . 00 . 00 . 00 . 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services	1, 095, 774 491, 755 199, 298 73, 688 138, 537 103, 019 2, 102, 071		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	2. 3. 4. 5.
. 00 . 00 . 00 . 00 . 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description	1, 095, 774 491, 755 199, 298 73, 688 138, 537 103, 019		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	2. 3. 4. 5. 6.
. 00 . 00 . 00 . 00 . 00 . 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation	1, 095, 774 491, 755 199, 298 73, 688 138, 537 103, 019 2, 102, 071		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	2. 3. 4. 5. 6. 7.
. 00 . 00 . 00 . 00 . 00 . 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care	1, 095, 774 491, 755 199, 298 73, 688 138, 537 103, 019 2, 102, 071		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF		2. 3. 4. 5. 6. 7. 8.
. 00 . 00 . 00 . 00 . 00 . 00 . 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation	1, 095, 774 491, 755 199, 298 73, 688 138, 537 103, 019 2, 102, 071		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF	2	2. 3. 4. 5. 6. 7.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 01 . 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care	1, 095, 774 491, 755 199, 298 73, 688 138, 537 103, 019 2, 102, 071		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF		2. 3. 4. 5. 6. 7. 8. 8. 8. 9.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 01 . 00 . 01 0. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy	1, 095, 774 491, 755 199, 298 73, 688 138, 537 103, 019 2, 102, 071		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF		2. 3. 4. 5. 6. 7. 8. 8. 8. 9. 9. 10.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 01 . 00 . 01 0. 00 0. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy	1, 095, 774 491, 755 199, 298 73, 688 138, 537 103, 019 2, 102, 071		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF		2. 3. 4. 5. 6. 7. 8. 8. 8. 9. 9. 10. 10.
. 00 . 00 . 00 . 00 . 00 . 00 . 00 . 01 . 00 . 01 0. 00 0. 01 1. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology	1, 095, 774 491, 755 199, 298 73, 688 138, 537 103, 019 2, 102, 071		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF		2. 3. 4. 5. 6. 7. 8. 8. 8. 9. 9. 10. 10. 10.
. 00 . 00 . 00 . 00 . 00 . 00 . 01 . 00 . 01 0. 00 0. 01 1. 00 1. 01	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology	1, 095, 774 491, 755 199, 298 73, 688 138, 537 103, 019 2, 102, 071		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF		2. 3. 4. 5. 6. 7. 8. 8. 8. 9. 9. 10. 10. 11. 11.
	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services	1, 095, 774 491, 755 199, 298 73, 688 138, 537 103, 019 2, 102, 071		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF		2. 3. 4. 5. 6. 7. 8. 8. 8. 9. 10. 10. 10. 11. 11. 11.
	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services	1, 095, 774 491, 755 199, 298 73, 688 138, 537 103, 019 2, 102, 071		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF		2. 3. 4. 5. 6. 7. 8. 8. 9. 9. 10. 10. 11. 11. 11. 12. 12.
2. 00 3. 00 4. 00 5. 00 7. 00 3. 00 5. 00 5. 00 6. 01 7. 00 9. 01 0. 00 0. 01 1. 00 1. 01 2. 00	BENEFICIARY COST LIMITATION Cost Per Visit Computation Skilled Nursing Care Physical Therapy Occupational Therapy Speech Pathology Medical Social Services Home Health Aide Total (sum of lines 1-6) Cost Center Description Limitation Cost Computation Skilled Nursing Care Skilled Nursing Care Skilled Nursing Care Physical Therapy Physical Therapy Occupational Therapy Occupational Therapy Speech Pathology Speech Pathology Medical Social Services	1, 095, 774 491, 755 199, 298 73, 688 138, 537 103, 019 2, 102, 071		GGREGATE OF TH	E PROGRAM LI	MITATION COST, OF		2. 3. 4. 5. 6. 7. 8. 8. 8. 9. 10. 10. 10. 11. 11. 11.

Health Financial Systems		IU HEALTH GOSH	HEN HO	OSPI TAL		_	In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF PATIENT SERVICE COS	ΓS			Provi der	ovider CCN: 150026 Period: From 01/01/2015			Worksheet H-3 Part II	
				HHA CCN:	157174	To	12/31/2015		
				Ti tl	e XVIII Home Health			PPS	
							Agency I		
Cost Center Description	From Wkst. C,	Cost to Charge	To	tal HHA	HHA Shared		Transfer to		
Part I, col. Ratio				ge (from	Ancillary		Part I as		
	9, line		provider Costs (col.		1	Indi cated			
			re	cords)	x col. 2)				
	0	1.00		2.00	3.00		4.00		
PART II - APPORTIONMENT OF COS	T OF HHA SERVIO	CES FURNI SHED B	Y SHA	RED HOSPI	TAL DEPARTME	NTS			
1.00 Physical Therapy	66.00	0. 673327		0		0 c c	ol. 2, line 2.	. 00	1.00
2.00 Occupational Therapy	67.00	0. 379111		0		0 c c	ol. 2, line 3.	. 00	2.00
3.00 Speech Pathology	68.00	0. 437957		0		0 c c	ol. 2, line 4	. 00	3.00
4.00 Cost of Medical Supplies	1. 226799		o		000	ol. 2, line 1	5. 00	4.00	
5.00 Cost of Drugs	0. 213499		0		0 c c	ol. 2, line 1	6. 00	5.00	

PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHA Reasonable Cost of Part A & Part B Services 00 Reasonable Cost of Services (see Instructions) 1 Total Charges 00 Amount tactually collected from patients liable for payment for services on a charge basis (from your records) 01 Amount tactually collected from patients liable for payment for services on a charge basis had such payment been made in accordanc with 42 CFR §413.13(b) 02 Ratio of line 3 to line 4 (not to exceed 1.00000) 03 Total customary charges (see Instructions) 04 Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1) 05 Excess of reasonable cost over customary charges (complete only if lin 1 exceeds line 6) 05 Primary payer amounts 05 Total PS Reimbursement - Full Episodes without Outliers 04 Total PS Reimbursement - Full Episodes 05 Total PPS Reimbursement - PEP Episodes 06 Total Other Payments 07 Total PPS Reimbursement - PEP Episodes 08 Total PPS Reimbursement - PEP Episodes 09 Total PPS Reimbursement S 00 Total PPS Reimbursement S 00 </th <th>V: 157174 tle XVIII Part A</th> <th>In Lie Period:</th> <th>Worksheet H-4</th> <th></th>	V: 157174 tle XVIII Part A	In Lie Period:	Worksheet H-4	
PART I - COMPUTATION OF THE LESSER OF REASONABLE COST OR CUSTOMARY CHA Reasonable Cost of Part A & Part B Services Reasonable cost of services (see instructions) Total charges Customary Charges QAnount actually collected from patients liable for payment for service on a charge basis (from your records) Amount that would have been realized from patients liable for payment for services on a charge basis had such payment been made in accordanc with 42 CFR \$413.13(b) QAttio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions) Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6) Primary payer amounts PART 11 - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT 1 exceeds line 6) Primary payer amounts PART 11 - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT 1 exceeds line 6) Primary payer amounts PART 11 - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT 1 exceeds line 6) Primary payer amounts PART 11 - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT 1 exceeds line 6) OTotal PPS Reimbursement - Full Episodes with Outliers 1 otal PPS Reimbursement - Full Episodes OTotal PPS Reimbursement - PEP Episodes 1 Total PPS Reimbursement - PEP Episodes 1 Total PPS Quitier Reimbursement - Full Episodes with Outlie		From 01/01/2015 To 12/31/2015	Part I-II Date/Time Pre 5/27/2016 5:4	
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 with 42 CFR §413.13(b) Ratio of line 3 to line 4 (not to exceed 1.000000) Total customary charges (see instructions) Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete only if line 6 exceeds line 1) Exceeds line 6) Primary payer amounts PART 11 - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Oxygen Payments OProsthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts (from your records) OHLER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0 0	0	4
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 Total customary charges (see instructions) Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6) Primary payer amounts PART 11 - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions) Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - FUI Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Oxygen Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Coinsurance billed to program patients (from your records) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instructions) OR Her ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	0.0000	0. 000000	0. 000000	
 Excess of total customary charges over total reasonable cost (complete only if line 6 exceeds line 1) Excess of reasonable cost over customary charges (complete only if line 1 exceeds line 6) Primary payer amounts PART 11 - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - Full Episodes Total PPS Reimbursement - PEP Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Oxygen Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction for a patient contaction of the page page page patients (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction patients (see instruction patients (see instruction patients) Reimbursable bad debts for dual eligible beneficiaries (see instruction patients) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0 5, 157, 600		
 Excess of reasonable cost over customary charges (complete only if lining exceeds line 6) Primary payer amounts PART 11 - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Quilier Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments Oxygen Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0 5, 157, 600		
1 exceeds line 6) Primary payer amounts PART 11 - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Qutlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments DME Payments DME deductibles billed to Medicare patients (exclude coinsurance) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				
Primary payer amounts PART 11 - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments DME Payments DATA B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)	9	0 0	0	
PART II - COMPUTATION OF HHA REIMBURSEMENT SETTLEMENT Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments Dotal Other Payments DME Payments DATE B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OT Total Costs - current cost reporting period (line 26 plus line 27)		0 0	0	
 Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - Full Episodes Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments OXygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		Part A	Part B	
 Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments OXygen Payments Prosthetic and Orthotic Payments Porsthetic and Orthotic Payments Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		Servi ces	Servi ces	
 Total reasonable cost (see instructions) Total PPS Reimbursement - Full Episodes without Outliers Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments OXygen Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		1.00	2.00	
<pre>00 Total PPS Reimbursement - Full Episodes without Outliers 00 Total PPS Reimbursement - Full Episodes with Outliers 00 Total PPS Reimbursement - LUPA Episodes 00 Total PPS Reimbursement - PEP Episodes 00 Total PPS Outlier Reimbursement - Full Episodes with Outliers 00 Total PPS Outlier Reimbursement - PEP Episodes 00 Total Other Payments 00 DME Payments 00 DME Payments 00 Prosthetic and Orthotic Payments 00 Prosthetic and Orthotic Payments 00 Part B deductibles billed to Medicare patients (exclude coinsurance) 00 Subtotal (sum of lines 10 thru 20 minus line 21) 00 Excess reasonable cost (from line 8) 00 Subtotal (line 22 minus line 23) 00 Coinsurance billed to program patients (from your records) 00 Net cost (line 24 minus line 25) 00 Reimbursable bad debts (from your records) 00 Reimbursable bad debts for dual eligible beneficiaries (see instruction 00 Total costs - current cost reporting period (line 26 plus line 27) 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)</pre>				
 Total PPS Reimbursement - Full Episodes with Outliers Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0		1
 Total PPS Reimbursement - LUPA Episodes Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0		
 Total PPS Reimbursement - PEP Episodes Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0	10, 478 37, 391	
 Total PPS Outlier Reimbursement - Full Episodes with Outliers Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments O Arygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction to the cost of the cost - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0	9, 121	
 Total PPS Outlier Reimbursement - PEP Episodes Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0	916	
 Total Other Payments DME Payments Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0	1, 157	
 Oxygen Payments Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0	0	
 Prosthetic and Orthotic Payments Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0	0	1
 Part B deductibles billed to Medicare patients (exclude coinsurance) Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0	0	
 Subtotal (sum of lines 10 thru 20 minus line 21) Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0	0	
 Excess reasonable cost (from line 8) Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 			0	
 Subtotal (line 22 minus line 23) Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0	1, 115, 629 0	
 Coinsurance billed to program patients (from your records) Net cost (line 24 minus line 25) Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0	1, 115, 629	
 00 Net cost (line 24 minus line 25) 00 Reimbursable bad debts (from your records) 00 Reimbursable bad debts for dual eligible beneficiaries (see instruction 00 Total costs - current cost reporting period (line 26 plus line 27) 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0	0	
 Reimbursable bad debts (from your records) Reimbursable bad debts for dual eligible beneficiaries (see instruction Total costs - current cost reporting period (line 26 plus line 27) OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) 		0	1, 115, 629	
00 Total costs - current cost reporting period (line 26 plus line 27) 00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				2
00 OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)				2
	ıs)	0		
50 Proneer ACU demonstration payment adjustment (see instructions)	ıs)	0	0	
	ıs)	0	1 115 620	
00 Subtotal (see instructions) 01 Sequestration adjustment (see instructions)	ns)	0	1, 115, 629 22, 291	
00 Interim payments (see instructions)	ns)	0	1, 093, 338	
00 Tentative settlement (for contractor use only)	ns)	0	1, 073, 330	
00 Balance due provider/program (line 31 minus lines 31.01, 32, and 33)	ns)	0	0	
00 Protested amounts (nonallowable cost report items) in accordance with	15)	0		3!

	GIS OF PAYMENTS TO PROVIDER-BASED HHAS FOR SERVICES RENDERED	T0 Pr	ovi der	CCN: 150026		eriod:	Worksheet H-5	
0GR/	M BENEFICIARIES	нн	IA CCN:	157174	Fr Tc	rom 01/01/2015 0 12/31/2015	Date/Time Prep 5/27/2016 5:47	parec 7 pm
						Home Health Agency I	PPS	
		I	npati en	t Part A		Par	t B	
	-	mm/dd		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				0		1, 093, 338 0	1. 2.
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.
01					0		0	3.
02					0		o	3.
03					0		0	3.
04					0		0	3.
05					0		0	3.
	Provider to Program							
0					0 0		0	3
51 52					0		0	3
53					0		0	3
54 54					0		0	3
99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)				0		0	3
0	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. H-4, Part II, column as appropriate, line 32)				0		1, 093, 338	4
	TO BE COMPLETED BY CONTRACTOR							_
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
	Program to Provider							
)1					0		0	5
)2)3					0 0		0	5 5
5	Provider to Program				U		0	5
0					0		0	5
51					0		0	5
2					0		0	5
9	Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98)				0		0	5
00	Determined net settlement amount (balance due) based on the cost report. (1)							6
)1	SETTLEMENT TO PROVIDER				0		0	6
)2	SETTLEMENT TO PROGRAM				0		1 002 220	6
00	Total Medicare program liability (see instructions)				0	Contractor	1,093,338 NPR Date	7
						Number	(Mo/Day/Yr)	
			C)	-	1.00	2.00	

Heal th	Financial Systems	IU HEALTH GOSHE	N HOSPITAL		In Lie	u of Form CMS-:	2552-10
ANALYS	SIS OF PROVIDER-BASED HOSPICE COSTS		Provi der	CCN: 150026	Peri od:	Worksheet K	
			Hospi ca (CN: 151527	From 01/01/2015 To 12/31/2015	Date/Time Pre	narod
			nospi ce c	, CNI. 131327	10 12/31/2013	5/27/2016 5:4	
					Hospi ce I		
		Salaries (from	Empl oyee	Transportatio		Other	
		Wkst. K-1) Be	enefits (from	(see inst.)			
		1.00	Wkst. K-2) 2.00	2.00	Wkst. K-3)	F 00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	Capital Related Costs-Bldg and Fixt.				0	0	1.00
2.00	Capital Related Costs-Movable Equip.				0	0	2.00
3.00	Plant Operation and Maintenance	0	0		0 0	0	3.00
4.00	Transportation - Staff	0	0		0 0	0	4.00
5.00	Volunteer Service Coordination	0	0		0 0	0	5.00
6.00	Administrative and General	0	0		0 21,089	166, 028	6.00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	756, 063	0		0 0	0	7.00
8.00	Inpatient - Respite Care	0	0		0 0	0	8.00
	VI SI TI NG SERVI CES						
9.00	Physi ci an Servi ces	0	0		0 0	0	9.00
10.00	Nursing Care	0	0		0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	0	0		0 0	0	11.00
12.00	Physical Therapy	0	0		0 0	0	12.00
13.00	Occupational Therapy	0	0		0 0	0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0	0	14.00
15.00	Medical Social Services	0	0		0 0	0	15.00
16.00	Spiritual Counseling	0	0		0 0	0	16.00
17.00 18.00	Dietary Counseling Counseling - Other	0	0		0 0	0	17.00 18.00
18.00	Home Health Aide and Homemaker	0	0		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20.00
21.00	Other	0	0		0 0	0	
21.00	OTHER HOSPICE SERVICE COSTS	0	0	<u> </u>		Ŭ	21.00
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	221, 502	22.00
23.00	Anal gesi cs	0	0		0 0	0	23.00
24.00	Sedatives / Hypnotics	0	0		0 0	0	24.00
25.00	Other - Specify	0	0		0 0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	26.00
27.00	Patient Transportation	0	0		0 0	0	27.00
28.00	Imaging Services	0	0		0 0	0	
29.00	Labs and Diagnostics	0	0		0 0	0	29.00
30.00	Medical Supplies	0	0		0 0	29, 920	
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32.00	Radiation Therapy	0	0		0 0	0	
33.00	Chemotherapy	0	0		0 0	0	33.00
34.00		0	0	<u> </u>	0 0	589, 305	34.00
35.00	HOSPICE NONREIMBURSABLE SERVICE Bereavement Program Costs	0	0		0 0	0	35.00
35.00 36.00	Volunteer Program Costs	0	0		0 0	0	35.00
37.00	Fundrai si ng	0	0		0 0	0	
38.00	Other Program Costs	0	0		0 0	0	
	Total (sum of lines 1 thru 38)	756, 063	0		0 21,089		
		,0	Ũ			,,	

Heal th	Financial Systems	IU HEALTH GOSI	HEN HOSF	PI TAL			In Lie	eu of Form CMS-	2552-10
ANALYS	IS OF PROVIDER-BASED HOSPICE COSTS		Pr	ovi der	CCN: 15002	6 P	Period:	Worksheet K	
			Но	spice (CCN: 1515		rom 01/01/2015 o 12/31/2015	Date/Time Pre 5/27/2016 5:4	
							Hospi ce I	0/2//2010 0.1	
		Total (cols.	Recl ass	i fi cati	Subtotal (COL.		Total (col. 8	
		1-5)	0		6 ± col.			± col. 9)	
		6.00	7.	00	8.00		9.00	10.00	
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related Costs-Bldg and Fixt.	0)	C)	C	0 0	0	1.00
2.00	Capital Related Costs-Movable Equip.	0		C		C	0 0	0	2.00
3.00	Plant Operation and Maintenance	0		0		C	0 0	0	3.00
4.00	Transportation - Staff	0		0		C	0 0	0	4.00
5.00	Volunteer Service Coordination	0		0		C	0 0	0	5.00
6.00	Administrative and General	187, 117		0	187	7, 117	0	187, 117	6.00
	I NPATI ENT CARE SERVI CE								
7.00	Inpatient - General Care	756, 063		0	756	5, 063	0	756, 063	7.00
8.00	Inpatient - Respite Care	0		0		C	0 0	0	8.00
	VI SI TI NG SERVI CES								1
9.00	Physician Services	0		C)	C	0 0	0	9.00
10.00	Nursing Care	0		0		C	0 0	0	10.00
11.00	Nursing Care-Continuous Home Care	0		C)	C	0 0	0	11.00
12.00	Physical Therapy	0		C)	C	0 0	0	12.00
13.00	Occupational Therapy	0		0		C	0	l o	13.00
14.00	Speech/ Language Pathol ogy	0		0		C	0	l o	14.00
15.00	Medical Social Services	0		0		C	0	0	15.00
16.00	Spiritual Counseling	0		0		C	0	0	16.00
17.00	Dietary Counseling	0		0		C	0	0	17.00
18.00	Counseling - Other	0		0		C	0	0	18.00
19.00	Home Health Aide and Homemaker	0		0		C	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0		0		C	0	l o	20.00
21.00	Other	0		0		C	0	0	21.00
	OTHER HOSPICE SERVICE COSTS	. · · · ·	1						
22.00	Drugs, Biological and Infusion Therapy	221, 502	-	221, 502		C) 0	0	22.00
23.00	Anal gesi cs	0		0		C	0	l o	23.00
24.00	Sedatives / Hypnotics	0		0		C	0	0	24.00
25.00	Other - Specify	0		0		C	0	0	25.00
26.00	Durable Medical Equipment/Oxygen	0		0		C	0	0	26.00
27.00	Patient Transportation	0		0		C	0	0	27.00
28.00	I maging Services	0		0		0	0	0	28.00
29.00	Labs and Diagnostics	0		0		C	0	0	29.00
30.00	Medical Supplies	29, 920		-29, 920		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0		0		0	0	0	31.00
32.00	Radi ati on Therapy	0		0		0	0	0	
33.00	Chemotherapy	0		0		C	-	0	33.00
34.00	Other	589, 305		Ő		ə. 305	, o		
01.00	HOSPICE NONREIMBURSABLE SERVICE	007,000	1			, 000	,	007,000	01.00
35.00	Bereavement Program Costs	0		0		C	0 0	0	35.00
36.00	Volunteer Program Costs	0		0		0	-	0	
37.00	Fundrai si ng	0		0		0	0 0	0	37.00
38.00	Other Program Costs	0		n n		n	0	0	38.00
	Total (sum of lines 1 thru 38)	1, 783, 907		251, 422	1, 532	2. 485	-		
07.00		.,	1		1 ., 002	_, .00		1, 002, 100	1 571 65

Heal th	Financial Systems	IU HEALTH GOSH	EN HOSPITAL			In Lie	u of Form CMS-2	2552-10
	E COMPENSATION ANALYSIS SALARIES AND WAGES		Provi der	CCN: 150026	Pe	eri od:	Worksheet K-1	
						om 01/01/2015		
			Hospi ce C	CCN: 151527	To	12/31/2015	Date/Time Pre	
							5/27/2016 5:4	/ pm
		Administrator	Director	Coolol	1	Hospi ce I	Nursee	
		Admi ni strator	Director	Soci al		Supervi sors	Nurses	
		1.00	2.00	Services 3.00	_	4.00	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00		4.00	5.00	
1.00	Capital Related Costs-Bldg and Fixt.							1.00
2.00	Capital Related Costs-Didg and TrXt.							2.00
3.00	Plant Operation and Maintenance	0	0		0	0	0	3.00
4.00	Transportation - Staff	0	0		0	0	0	4.00
4.00 5.00	Volunteer Service Coordination	0	0		0	0	0	4.00 5.00
6.00	Administrative and General	0	0		0	0	0	6.00
0.00	INPATIENT CARE SERVICE	0	0		0		0	0.00
7.00	Inpatient - General Care	0	0		0	0	474, 520	7.00
7.00 8.00		0	0		0	0	474, 520	8.00
0.00	I npatient - Respite Care VI SI TI NG SERVI CES	U	0		0		0	0.00
9.00	Physician Services	0	0		0	0	0	9.00
9.00 10.00	Nursi ng Care	0	0		0	0	0	9.00 10.00
	5	0	0		0	0	0	11.00
11.00	Nursing Care-Continuous Home Care		-			-	-	
12.00	Physical Therapy	0	0		0	0	0	12.00
13.00	Occupational Therapy	0	0		0	0	0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0	0	0	14.00
15.00	Medical Social Services	0	0		0	0	0	15.00
	Spiritual Counseling	0	0		0	0	0	16.00
17.00	Di etary Counsel i ng	0	0		0	0	0	17.00
18.00	Counseling - Other	0	0		0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	20.00
21.00	Other	0	0		0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS	T T						
22.00	Drugs, Biological and Infusion Therapy							22.00
23.00	Analgesics							23.00
24.00	Sedatives / Hypnotics							24.00
25.00	Other - Specify							25.00
26.00	Durable Medical Equipment/Oxygen				~		0	26.00
27.00	Patient Transportation	0	0		0	0	0	27.00
28.00	I magi ng Servi ces	0	0		0	0	0	28.00
29.00	Labs and Diagnostics	0	0		0	0	0	29.00
30.00	Medical Supplies	0	0		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	31.00
32.00	Radiation Therapy	0	0		0	0	0	32.00
33.00	Chemotherapy	0	0		0	0	0	33.00
34.00	Other	0	0		0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE	-				-		
35.00	Bereavement Program Costs	0	0		0	0	0	35.00
36.00	Volunteer Program Costs	0	0		0	0	0	36.00
37.00	Fundraising	0	0		0	0	0	37.00
38.00	Other Program Costs	0	0		0	0	0	38.00
39.00	Total (sum of lines 1 thru 38)	0	0	I	0	0	474, 520	39.00

Heal th	Financial Systems	IU HEALTH GOSHE	N HOSPI TAL		In Lie	u of Form CMS-2552-10
	CE COMPENSATION ANALYSIS SALARIES AND WAGES			CCN: 150026	Peri od:	Worksheet K-1
					From 01/01/2015	
			Hospi ce C	CN: 151527	To 12/31/2015	Date/Time Prepared:
						5/27/2016 5:47 pm
		Total	Aidaa	ALL Others	Hospi ce I	
		Total	Ai des	All-Other	Total (1)	
		Therapists 6.00	7.00	8,00	9,00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	0.00	9.00	
1.00	Capital Related Costs-Bldg and Fixt.					1.00
2.00	Capital Related Costs-Drug and Trxt.					2.00
3.00	Plant Operation and Maintenance		0		0 0	3.00
4.00	Transportation - Staff		0		0 0	4.00
4.00 5.00	Volunteer Service Coordination		0		0 0	4.00
6.00	Administrative and General		0		0 0	6.00
0.00	I NPATI ENT_CARE_SERVI CE		<u> </u>		0 0	0.00
7.00	Inpatient - General Care		05 510	186, 0	25 756, 063	7,00
8.00			95, 518 0	160, 0	0 0	8.00
0.00	Inpatient - Respite Care VI SI TI NG SERVI CES		0		0 0	8.00
9.00	Physician Services		0		0 0	9.00
9.00	Nursing Care		0		0 0	9.00
	5		0		0 0	10.00
11.00	Nursing Care-Continuous Home Care		0			
12.00	Physical Therapy	0	0		0 0	12.00
13.00	Occupational Therapy	0	0		0 0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0	14.00
15.00	Medical Social Services		0		0 0	15.00
16.00	Spiritual Counseling		0		0 0	16.00
17.00	Di etary Counsel i ng		0		0 0	17.00
18.00	Counseling - Other		0		0 0	18.00
19.00	Home Health Aide and Homemaker		0		0 0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0		0 0	20.00
21.00	Other		0		0 0	21.00
	OTHER HOSPICE SERVICE COSTS					
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Anal gesi cs					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0		0 0	27.00
28.00	Imaging Services		0		0 0	28.00
29.00	Labs and Diagnostics		0		0 0	29.00
30.00	Medical Supplies		0		0 0	30.00
31.00	Outpatient Services (including E/R Dept.)		0		0 0	31.00
32.00	Radiation Therapy		0		0 0	32.00
33.00	Chemotherapy		0		0 0	33.00
34.00	Other		0		0 0	34.00
	HOSPI CE NONREI MBURSABLE SERVI CE					
35.00	Bereavement Program Costs		0		0 0	35.00
36.00	Volunteer Program Costs		0		0 0	36.00
37.00	Fundrai si ng		0		0 0	37.00
38.00	Other Program Costs		0		0 0	38.00
39.00	Total (sum of lines 1 thru 38)	0	95, 518	186, 0	25 756, 063	39.00
						•

Heal th	Financial Systems	IU HEALTH GOSHE	N HOSPITAL			In Lie	u of Form CMS-:	2552-10
HOSPI C	E COMPENSATION ANALYSIS CONTRACTED SERVICES/	PURCHASED SERVICES	S Provider	CCN: 150026	Peri	od:	Worksheet K-3	
						01/01/2015		
			Hospi ce C	CN: 151527	To	12/31/2015	Date/Time Pre	
							5/27/2016 5:4	7 pm
						ospice I		
		Admi ni strator	Di rector	Soci al	Su	upervi sors	Nurses	
		1.00	2.00	Servi ces 3.00		4.00	5.00	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00		4.00	5.00	
1.00	Capital Related Costs-Bldg and Fixt.							1.00
2.00	Capital Related Costs-Brug and TrXt.							2.00
2.00	Plant Operation and Maintenance	0	0		0	0	0	2.00
		0	0		0	0	0	
4.00	Transportation - Staff	S S	Ű			Ű		
5.00	Volunteer Service Coordination	0	0		0	0	0	
6.00	Administrative and General	0	0		0	0	0	6.00
7.00	INPATIENT CARE SERVICE	0	0		0	0	0	7.00
7.00 8.00		0	0		0	0	0	
0.00	Inpatient - Respite Care VISITING SERVICES	U	0		0	0	0	0.00
9.00	Physician Services	0	0	[0	0	0	9.00
9.00 10.00	5	0	0		0	0	0	10.00
	Nursing Care	-				-		
11.00	Nursing Care-Continuous Home Care	0	0		0	0	0	
12.00	Physical Therapy	0	0		0	0	0	
13.00	Occupational Therapy	0	0		0	0	0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0	0	0	14.00
15.00	Medical Social Services	0	0		0	0	0	15.00
16.00	Spiritual Counseling	0	0		0	0	0	16.00
17.00	Di etary Counsel i ng	0	0		0	0	0	17.00
18.00	Counseling - Other	0	0		0	0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0	0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	
21.00	Other	0	0		0	0	0	21.00
	OTHER HOSPICE SERVICE COSTS	1						
22.00	Drugs, Biological and Infusion Therapy							22.00
23.00	Analgesics							23.00
24.00	Sedatives / Hypnotics							24.00
25.00	Other - Specify							25.00
26.00	Durable Medical Equipment/Oxygen				_		_	26.00
27.00	Patient Transportation	0	0		0	0	0	27.00
28.00	I magi ng Servi ces	0	0		0	0	0	
29.00	Labs and Diagnostics	0	0		0	0	0	
30.00	Medical Supplies	0	0		0	0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	31.00
32.00	Radiation Therapy	0	0		0	0	0	32.00
33.00	Chemotherapy	0	0		0	0	0	
34.00	Other	0	0		0	0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE	1						
35.00	Bereavement Program Costs	0	0		0	0	0	35.00
36.00	Volunteer Program Costs	0	0		0	0	0	
37.00	Fundrai si ng	0	0		0	0	0	37.00
38.00	Other Program Costs	0	0		0	0	0	
39.00	Total (sum of lines 1 thru 38)	0	0		0	0	0	39.00

Heal th	Financial Systems	IU HEALTH GOSHEN	HOSPI TAL		In Lie	u of Form CMS-2552-10
	E COMPENSATION ANALYSIS CONTRACTED SERVICES/F			CCN: 150026	Peri od:	Worksheet K-3
				100020	From 01/01/2015	
			Hospi ce C	CN: 151527	To 12/31/2015	Date/Time Prepared:
						5/27/2016 5:47 pm
		T 1 1			Hospi ce I	
		Total	Ai des	All-Other	Total (1)	
		Therapists 6.00	7.00	8.00	9.00	
	GENERAL SERVICE COST CENTERS	0.00	7.00	8.00	9.00	
1.00	Capital Related Costs-Bldg and Fixt.					1, 00
2.00	Capital Related Costs-Brug and TrXt.					2.00
2.00	Plant Operation and Maintenance		0		0 0	3.00
4.00	Transportation - Staff		0		0 0	4,00
4.00 5.00	Volunteer Service Coordination		0		0 0	5.00
6.00	Administrative and General		0	21, 0	0	6.00
0.00	I NPATI ENT_CARE_SERVI CE		0	21,0	21,007	0.00
7.00	Inpatient - General Care		0		0 0	7.00
8.00	Inpatient - Respite Care		0		0 0	8.00
0.00	VI SI TI NG SERVI CES		U		0 0	0.00
9.00	Physician Services		0		0 0	9,00
10.00	Nursi ng Care		0		0 0	10.00
11.00	Nursing Care-Continuous Home Care		0		0 0	11.00
12.00	Physical Therapy	0	0		0 0	12.00
13.00	Occupational Therapy	0	0		0 0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0	14.00
15.00	Medi cal Soci al Servi ces	0	0		0 0	15.00
	Spiritual Counseling		0		0 0	16.00
17.00	Di etary Counsel i ng		0		0 0	17.00
18.00	Counseling - Other		0		0 0	18.00
19.00	Home Health Aide and Homemaker		0		0 0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care		0		0 0	20.00
20.00	Other		0		0 0	20.00
21.00	OTHER HOSPICE SERVICE COSTS		0		0 0	21.00
22.00	Drugs, Biological and Infusion Therapy					22.00
23.00	Anal gesi cs					23.00
24.00	Sedatives / Hypnotics					24.00
25.00	Other - Specify					25.00
26.00	Durable Medical Equipment/Oxygen					26.00
27.00	Patient Transportation		0		0 0	27.00
28.00	Imaging Services		0		0 0	28.00
29.00	Labs and Diagnostics		0		0 0	29.00
30.00	Medical Supplies		0		0 0	30.00
31.00	Outpatient Services (including E/R Dept.)		0		0 0	31.00
32.00	Radi ati on Therapy		0		0 0	32.00
33.00	Chemotherapy		0		0 0	33.00
34.00	Other		0		0 0	34.00
54.00	HOSPICE NONREIMBURSABLE SERVICE	II	0		0	54.00
35.00	Bereavement Program Costs		0		0 0	35.00
36.00	Volunteer Program Costs		0		0 0	36.00
37.00	Fundrai si ng		0		0 0	37.00
38.00	Other Program Costs		Ő		0 0	38.00
	Total (sum of lines 1 thru 38)	0	0	21, 0	89 21, 089	39.00
			- 1	, -		

Heal th	Financial Systems	IU HEALTH GOSH	HEN HOSPITAL		In Lie	eu of Form CMS-:	2552-10
	ALLOCATION - HOSPICE GENERAL SERVICE COST			CCN: 150026 CCN: 151527	Period: From 01/01/2015 To 12/31/2015	Worksheet K-4 Part I	pared:
					Hospi ce I	372772010 3.4	7 piii
			CAPITAL RE	LATED COST	nospi ce i		
		NET EXPENSES	BUI LDI NGS &	MOVABLE		TRANSPORTATI ON	
		FOR COST	FI XTURES	EQUI PMENT	OPERATION &		
		ALLOCATI ON O	1.00	2.00	MAI NT. 3. 00	4.00	
_	GENERAL SERVICE COST CENTERS	0	1.00	2.00	5.00	4.00	
1.00	Capital Related Costs-Bldg and Fixt.	0	C				1.00
2.00	Capital Related Costs-Movable Equip.	0			0		2.00
3.00	Plant Operation and Maintenance	0	C		0 0		3.00
4.00	Transportation - Staff	0	C		0 0	0	4.00
5.00	Volunteer Service Coordination	0	C		0 0	0	5.00
6.00	Administrative and General	187, 117	0		0 0	0	6.00
	I NPATI ENT CARE SERVI CE						
7.00	Inpatient - General Care	756, 063			0 0		7.00
8.00	Inpatient - Respite Care	0	0		0 0	0	8.00
9.00	VI SI TI NG SERVI CES Physi ci an Servi ces	0	0	1	0 0	0	9.00
9.00 10.00	Nursi ng Care	0			0 0		10.00
11.00	Nursing Care-Continuous Home Care	0			0 0	0	
12.00	Physical Therapy	0				0	
12.00	Occupational Therapy	0				0	13.00
14.00	Speech/ Language Pathol ogy	0	0		0 0	0	
15.00	Medi cal Soci al Servi ces	0	0		0 0	0	15.00
16.00	Spiritual Counseling	0	0		0 0	0	
17.00	Dietary Counseling	0	0		0 0	0	17.00
18.00	Counseling - Other	0	C		0 0	0	18.00
19.00	Home Health Aide and Homemaker	0	C		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	C		0 0	0	20.00
21.00	Other	0	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS			1			
22.00	Drugs, Biological and Infusion Therapy	0	0		0 0	-	22.00
23.00	Anal gesi cs	0	0		0 0		
24.00	Sedatives / Hypnotics	0	0		0 0	0	
25.00	Other - Specify	0			0 0	0	25.00
26.00 27.00	Durable Medical Equipment/Oxygen Patient Transportation	0			0 0	0	26.00 27.00
27.00	Imaging Services	0			0 0	0	27.00
29.00	Labs and Diagnostics	0				0	29.00
30.00	Medical Supplies	0	0		0 0	0	30.00
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	31.00
32.00	Radi ati on Therapy	0	0		0 0	0	32.00
33.00	Chemotherapy	0	C		0 0	0	33.00
34.00	Other	589, 305	C		0 0	0	34.00
	HOSPICE NONREIMBURSABLE SERVICE						
35.00	Bereavement Program Costs	0	C		0 0		35.00
36.00	Volunteer Program Costs	0	0		0 0	-	
37.00	Fundraising	0	0		0 0	0	37.00
38.00	Other Program Costs	1 522 405			0 0	0	
39.00	Total (sum of lines 1 thru 38)	1, 532, 485	0	1	0 0	0	39.00

Heal th	Financial Systems	IU HEALTH GOS	HEN HOS	PI TAL			In Lie	u of Form CMS-	2552-10
	LLOCATION - HOSPICE GENERAL SERVICE COST				CCN: 150026	Peri	od:	Worksheet K-4	
							m 01/01/2015	Part I	
			H	ospi ce (CCN: 151527	To	12/31/2015	Date/Time Pre	
								5/27/2016 5:4	/ pm
		VOLUNTEER	CUD	TOTAL			Hospice I TAL (col. 5A		
		SERVI CES		0 - 5)	& GENERAL		\pm col. 6)		
		COORDI NATOR	(0013.	0 - 3)			± cor. 0)		
		5.00	ļ	5A	6.00	_	7.00		
	GENERAL SERVICE COST CENTERS								
1.00	Capital Related Costs-Bldg and Fixt.								1.00
2.00	Capital Related Costs-Movable Equip.								2.00
3.00	Plant Operation and Maintenance								3.00
4.00	Transportation - Staff								4.00
5.00	Volunteer Service Coordination	0							5.00
6.00	Administrative and General	0	D	187, 117	187, 1	17			6.00
	I NPATI ENT CARE SERVI CE								
7.00	Inpatient - General Care	0)	756, 063	105, 1	55	861, 218		7.00
8.00	Inpatient - Respite Care	0)	C)	0	0		8.00
	VISITING SERVICES	1	-i						
9.00	Physician Services	0		C		0	0		9.00
10.00	Nursing Care	0		C		0	0		10.00
11.00	Nursing Care-Continuous Home Care	0	D	C		0	0		11.00
12.00	Physical Therapy	0	D	C		0	0		12.00
13.00	Occupational Therapy	0		C		0	0		13.00
14.00	Speech/ Language Pathol ogy	0		C		0	0		14.00
15.00	Medical Social Services	0	1	C		0	0		15.00
16.00	Spiritual Counseling	0)	C)	0	0		16.00
17.00	Di etary Counsel i ng	0	2	C)	0	0		17.00
18.00	Counseling - Other	0		C		0	0		18.00
19.00	Home Health Aide and Homemaker	0		C		0	0		19.00
20.00	HH Aide & Homemaker - Cont. Home Care Other	0	1	C		0 0	0		20.00
21.00	OTHER HOSPICE SERVICE COSTS	0	<u>/</u>	L	/	U	0		21.00
22.00	Drugs, Biological and Infusion Therapy	0		C	1	0	0		22.00
22.00	Anal gesi cs	0		0		0	0		22.00
24.00	Sedatives / Hypnotics	0		C		0	0		24.00
25.00	Other - Specify	0		C		0	0		25.00
26.00	Durable Medical Equipment/Oxygen	0		C		0	0		26.00
27.00	Pati ent Transportati on	0		0		0	0		27.00
28.00	Imaging Services	0	Ď	C		0	0		28.00
29.00	Labs and Diagnostics	0		C		0	o		29.00
30.00	Medical Supplies	0		C		0	o		30.00
31.00	Outpatient Services (including E/R Dept.)	0		C		0	o		31.00
32.00	Radiation Therapy	0		C		0	0		32.00
33.00	Chemotherapy	0		C		0	0		33.00
34.00	Other	0	þ	589, 305	81, 9	62	671, 267		34.00
	HOSPICE NONREIMBURSABLE SERVICE		•						1
35.00	Bereavement Program Costs	0)	C)	0	0		35.00
36.00	Volunteer Program Costs	0	D	C		0	0		36.00
37.00	Fundrai si ng	0		C		0	0		37.00
38.00	Other Program Costs	0		C		0	0		38.00
39.00	Total (sum of lines 1 thru 38)	0) 1,	532, 485	j		1, 532, 485		39.00

Heal th	Financial Systems	IU HEALTH GOSH	HEN HOSPITAL		In Lie	u of Form CMS-	2552-10
	LLOCATION - STATISTICAL BASIS		Provi der	CCN: 150026	Period:	Worksheet K-4	
					From 01/01/2015	Part II	
			Hospi ce (CCN: 151527	To 12/31/2015	Date/Time Pre 5/27/2016 5:4	
					Hospi ce I	572772010 5.4	<u> pili</u>
		CAPITAL RE	LATED COST				
			2.1120 0001				
		BUILDINGS &	MOVABLE	PLANT	TRANSPORTATI ON	VOLUNTEER	
		FIXTURES (SQ.	EQUIPMENT (\$	OPERATION &	(MI LEAGE)	SERVI CES	
		FT.)	VALUE)	MAINT. (SQ.		COORDI NATOR	
				FT.)		(HOURS)	
		1.00	2.00	3.00	4.00	5.00	
	GENERAL SERVICE COST CENTERS	0.5/0		1			1
1.00	Capital Related Costs-Bldg and Fixt.	2, 562					1.00
2.00	Capital Related Costs-Movable Equip.	0	0		()		2.00
3.00	Plant Operation and Maintenance	0	0	_, _,			3.00
4.00	Transportation - Staff	0	0		0 0	0	4.00
5.00 6.00	Volunteer Service Coordination	° °			5	0	
6.00	Administrative and General	2, 562	0	2, 5	02 0	0	6.00
7.00	Inpatient - General Care	0	0		0 0	0	7.00
8.00	Inpatient - Respite Care	0			0 0	0	
0.00	VI SI TI NG SERVI CES	0	0		0 0	0	0.00
9.00	Physi ci an Servi ces	0	0		0 0	0	9.00
10.00	Nursi ng Care	0	0		0 0	0	
11.00	Nursing Care-Continuous Home Care	0			0 0	0	
12.00	Physical Therapy	0	0		0 0	0	
13.00	Occupational Therapy	0	0		0 0	0	
14.00	Speech/ Language Pathol ogy	0	0		0 0	0	
15.00	Medical Social Services	0	0		0 0	0	
16.00	Spiritual Counseling	0	0		0 0	0	
17.00	Dietary Counseling	0	0		0 0	0	1
18.00	Counseling - Other	0	0		0 0	0	18.00
19.00	Home Health Aide and Homemaker	0	0		0 0	0	19.00
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	20.00
21.00	Other	0	0		0 0	0	21.00
	OTHER HOSPICE SERVICE COSTS						
22.00	Drugs, Biological and Infusion Therapy	0			0 0	0	22.00
23.00	Anal gesi cs	0	-		0 0	0	
24.00	Sedatives / Hypnotics	0	0		0 0	0	
25.00	Other - Specify	0	0		0 0	0	
26.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	
27.00	Patient Transportation	0	0		0 0	0	
28.00	Imaging Services	0	0		0 0	0	
29.00	Labs and Diagnostics	0	0		0 0	0	
30.00	Medical Supplies	0	0		0 0	0	
31.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	1
32.00	Radiation Therapy	0	0		0 0	0	
33.00	Chemotherapy	0	0		0 0	0	
34.00	Other	0	0		0 0	0	34.00
35.00	HOSPICE NONREIMBURSABLE SERVICE	0	0		0 0	0	35.00
35.00 36.00	Bereavement Program Costs Volunteer Program Costs	0			0 0	0	
37.00	Fundrai si ng				0 0	0	
37.00	Other Program Costs				0 0	0	
39.00	Cost to be Allocated (per Wkst. K-4, Part I)	0 0			0 0	0	
	Unit Cost Multiplier	0. 000000	0. 000000	0.0000	0. 000000	0. 000000	
	1					3. 000000	1

	Financial Systems	IU HEALTH GOSHEN			u of Form CMS-2552-
COST A	LLOCATION - STATISTICAL BASIS		Provider CCN: 150026	Period: From 01/01/2015	Worksheet K-4 Part II
			Hospi ce CCN: 151527		Date/Time Prepared 5/27/2016 5:47 pm
				Hospi ce I	572772010 5.47 pill
		RECONCI LI ATI ON AD	MI NI STRATI VE		
			& GENERAL		
			(ACC. COST)		
		6A	6.00		
1 00	GENERAL SERVICE COST CENTERS				1
1.00	Capital Related Costs-Bldg and Fixt.	0			1.
2.00	Capital Related Costs-Movable Equip.	0			2.
3.00	Plant Operation and Maintenance	0			3.
4.00	Transportation - Staff	0			4.
5.00	Volunteer Service Coordination	107 117	1 045 040		5.
6.00	Administrative and General	-187, 117	1, 345, 368		6.
7 00	I NPATI ENT_CARE_SERVI CE		754 040		
7.00	Inpatient - General Care	0	756, 063		7.
8.00	Inpatient - Respite Care	0	0		8.
0 00	VI SI TI NG SERVI CES		0		
9.00	Physician Services	0	0		9.
10.00	Nursing Care		-		10.
11.00	Nursing Care-Continuous Home Care	0	0		11.
12.00	Physical Therapy	0	0		12.
13.00	Occupational Therapy	0	0		13.
14.00	Speech/ Language Pathology	0	0		14.
15.00	Medical Social Services	0	0		15.
16.00	Spiritual Counseling	0	0		16.
17.00	Dietary Counseling	0	0		17.
18.00	Counseling - Other	0	-		18.
19.00	Home Health Aide and Homemaker	0	0		19.
20.00	HH Aide & Homemaker - Cont. Home Care	0	0		20.
21.00	Other OTHER HOSPICE SERVICE COSTS	U	U		21.
22.00		0	0		22
22.00 23.00	Drugs, Biological and Infusion Therapy Analgesics	0	0		22.
23.00	Sedatives / Hypnotics	0	0		23.
	5.	0	0		
25.00	Other - Specify Durable Medical Equipment/Oxygen	0	0		25. 26.
26.00		0			
27.00	Pati ent Transportati on	0	0		27.
28.00	I maging Services	0	-		28.
29.00	Labs and Diagnostics	0	0		29.
30.00	Medical Supplies	0	-		30.
31.00	Outpatient Services (including E/R Dept.)	0	0		31.
32.00 33.00	Radiation Therapy	0	0		32.
	Chemotherapy	0	-		
34.00	Other HOSPICE NONREIMBURSABLE SERVICE	0	589, 305		
35.00	Bereavement Program Costs	0	0		35.
36.00	Volunteer Program Costs	0	0		36.
37.00	Fundrai si ng	0	0		30.
37.00	Other Program Costs	0	0		37.
38.00	Cost to be Allocated (per Wkst. K-4, Part I)	0	187, 117		38.
	Unit Cost Multiplier		0. 139082		39. 40.
-0.00		I I	0. 137002		I 40.

Heal th	Financial Systems	IU HEALTH GOSH	HEN HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST		Provi der	CCN: 150026 CCN: 151527	Period: From 01/01/2015 To 12/31/2015	Worksheet K-5 Part I	pared:
					Hospi ce I		
			CAPI TAL REI	LATED COSTS			
	Cost Center Description	Hospice Trial Balance (1)	BLDG & FIXT	MVBLE EQUIF	P EMPLOYEE BENEFITS DEPARTMENT	CASHI ERI NG/ACC OUNTS RECEI VABLE	
		0	1.00	2.00	4.00	5. 01	
1.00 2.00 3.00 4.00	Administrative and General Inpatient - General Care Inpatient - Respite Care Physician Services	861, 218 0 0	30, 430 0 0 0		0 276, 028 0 0 0 0 0 0 0 0	19, 625 0 0 0	1.00 2.00 3.00 4.00
5.00 6.00	Nursing Care Nursing Care-Continuous Home Care	0	0		0 0 0	0	5.00 6.00
7.00 8.00	Physical Therapy Occupational Therapy	0	0		0 0 0	0	7.00 8.00
9.00 10.00 11.00	Speech/ Language Pathology Medical Social Services Spiritual Counseling	0	0		0 0 0 0	0 0 0	9.00 10.00 11.00
12.00 13.00	Dietary Counseling Counseling - Other	0	0			0	12.00 13.00
14.00 15.00	Home Health Aide and Homemaker HH Aide & Homemaker - Cont. Home Care	0	0		0 0 0 0	0	14.00 15.00
16. 00 17. 00	Other Drugs, Biological and Infusion Therapy	0	0		0 0 0 0	0	16. 00 17. 00
18. 00 19. 00	Analgesics Sedatives / Hypnotics	0	0		0 0 0 0	0 0	18. 00 19. 00
20.00 21.00	Other - Specify Durable Medical Equipment/Oxygen	0	0		0 0 0	0	20.00 21.00
22.00 23.00	Patient Transportation Imaging Services	0	0		0 0 0 0	0 0 0	22.00 23.00
24.00 25.00 26.00	Labs and Diagnostics Medical Supplies Outpatient Services (including E/R Dept.)	0	0			0	24.00 25.00 26.00
20.00 27.00 28.00	Radi ati on Therapy Chemotherapy	0	0			0	20.00 27.00 28.00
29.00 30.00	Other Bereavement Program Costs	671, 267 0	0		0 0 0 0	0	29.00 30.00
31.00 32.00	Volunteer Program Costs Fundraising	0	0		0 0 0 0	0	31.00 32.00
33.00 34.00	Other Program Costs Total (sum of lines 1 thru 33) (2)	0 1, 532, 485	0 30, 430		0 0 0 276, 028	0 19, 625	33.00 34.00
35.00	Unit Cost Multiplier (see instructions)		l				35.00

Heal th	Financial Systems	IU HEALTH GOSI	HEN HOSPITAL			In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der Hospi ce (CCN: 150026 CCN: 151527	Fr	eriod: com 01/01/2015 p 12/31/2015	Worksheet K-5 Part I	pared:
						Hospi ce I		
	Cost Center Description	Subtotal	OTHER	MAI NTENANCE	&	OPERATION OF	LAUNDRY &	
			ADMI NI STRATI VE	REPAI RS		PLANT	LINEN SERVICE	
			AND GENERAL					
		5A. 01	5.02	6.00		7.00	8.00	
1.00	Administrative and General	326, 083	76, 455		0	35, 068	0	1.00
2.00	Inpatient - General Care	861, 218	201, 925		0	0	0	2.00
3.00	Inpatient - Respite Care	0	0		0	0	0	3.00
4.00	Physi ci an Servi ces	0	0		0	0	0	4.00
5.00	Nursi ng Care	0	0		0	0	0	5.00
6,00	Nursing Care-Continuous Home Care	0	0		0	0	0	6.00
7.00	Physical Therapy	0	0		0	0	0	7.00
8.00	Occupational Therapy	0			0	0	0	8.00
9,00	Speech/ Language Pathol ogy	0			0	0	0	9.00
10.00	Medical Social Services	0			0	0	0	10.00
11.00	Spiritual Counseling	0			0	0	0	11.00
12.00	Dietary Counseling	0	0		0	0	0	12.00
12.00	Counseling - Other	0			0	0	0	12.00
	5	0			0	0	0	
14.00	Home Health Aide and Homemaker	0			0	0		14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	15.00
16.00	Other	0	0		0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0	0	0	17.00
	Anal gesi cs	0	0		0	0	0	18.00
	Sedatives / Hypnotics	0	0		0	0	0	19.00
20.00	Other - Specify	0	0		0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0	0	0	21.00
22.00	Patient Transportation	0	0		0	0	0	22.00
23.00	Imaging Services	0	0		0	0	0	23.00
24.00	Labs and Diagnostics	0	0		0	0	0	24.00
25.00	Medical Supplies	0	0		0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	26.00
27.00	Radiation Therapy	0	0		0	0	0	27.00
28.00	Chemotherapy	0	0		0	0	0	28.00
29.00	Other	671, 267	157, 389		0	0	0	29.00
30.00	Bereavement Program Costs	0	0		0	0	0	30.00
31.00	Volunteer Program Costs	0	0		0	0	0	31.00
32.00	Fundrai si ng	0	0		0	0	0	32.00
33.00	Other Program Costs	0	0		0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	1, 858, 568	435, 769		0	35, 068	0	34.00
	Unit Cost Multiplier (see instructions)	0. 000000						35.00
					,		1	

Heal th	Financial Systems	IU HEALTH GOSHE	EN HOSPITAL		In Lie	u of Form CMS-2	2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der	CCN: 150026	Period: From 01/01/2015	Worksheet K-5 Part I	
			Hospi ce C	CCN: 151527			
					Hospi ce I		
	Cost Center Description	HOUSEKEEPI NG	DI ETARY	CAFETERI A	MAINTENANCE OF		
		9.00	10.00	11.00	PERSONNEL 12.00	ADMI NI STRATI ON 13. 00	
1.00	Administrative and General	17, 699	0	13, 2		83, 228	1.00
2.00	Inpatient - General Care	0	0	10,2	0 0	00,220	2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physi ci an Servi ces	0	0		0 0	0	4.00
5.00	Nursi ng Care	0	0		0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00	Physical Therapy	o	0		0 0	0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8,00
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9.00
10.00	Medi cal Soci al Servi ces	0	0		0 0	0	10.00
11.00	Spiritual Counseling	О	0		0 0	0	11.00
12.00	Dietary Counseling	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Patient Transportation	0	0		0 0	0	22.00
23.00	Imaging Services	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medical Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radiation Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	0		0 0	0	28.00
29.00	Other	0	0		0 0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0		0 0	0	31.00
32.00	Fundrai si ng	0	0		0 0	0	32.00
33.00	Other Program Costs	0	0		0 0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	17, 699	0	13, 2	26 0	83, 228	34.00
35.00	Unit Cost Multiplier (see instructions)						35.00

Heal th	Financial Systems	IU HEALTH GOSH	EN HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCA	TI ON OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		CCN: 150026 CCN: 151527	Period: From 01/01/2015 To 12/31/2015	Worksheet K-5 Part I	pared:
					Hospi ce I		
	Cost Center Description	CENTRAL SERVI CES & SUPPLY	PHARMACY	MEDI CAL RECORDS & LI BRARY	SOCIAL SERVICE	NONPHYSI CI AN ANESTHETI STS	
		14.00	15.00	16.00	17.00	19.00	
1.00	Administrative and General	37, 106	0	40, 4	38 0	0	1.00
2.00	Inpatient - General Care	0	0		0 0	0	2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physician Services	0	0		0 0	0	4.00
5.00	Nursing Care	0	0		0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00	Physical Therapy	0	0		0 0	0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9.00
10.00	Medical Social Services	0	0		0 0	0	10.00
11.00	Spiritual Counseling	0	0		0 0	0	11.00
12.00	Di etary Counsel i ng	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	0	15.00
16.00	Other	0	0		0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Patient Transportation	0	0		0 0	0	22.00
23.00	I magi ng Servi ces	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	23.00
24.00	Medi cal Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radiation Therapy	0	0		0 0	0	27.00
27.00	Chemotherapy	0	0		0 0	0	28.00
28.00	Other	0	0		0 0	0	28.00
29.00 30.00	Bereavement Program Costs	0	0		0 0	0	30.00
30.00	Volunteer Program Costs	0	0		0 0	0	30.00
31.00	0	0	0		0 0	0	31.00
	Fundrai si ng		0		0 0	0	
33.00 34.00	Other Program Costs Total (sum of lines 1 thru 33) (2)	37, 106	0	40, 4	-	0	33.00 34.00
	Unit Cost Multiplier (see instructions)	37,100	0	40, 4	30 0	0	34.00
35.00	Tour cost multiplier (see fistructions)	1		I	ļ	l l	1 33.00

Heal th	Financial Systems	IU HEALTH GOSH	HEN HOSPITAL			In Lie	u of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COS	CENTERS		CCN: 150026 CCN: 151527		eriod: rom 01/01/2015 p 12/31/2015	Worksheet K-5 Part I Date/Time Pre 5/27/2016 5:4	pared:
						Hospi ce I		
			I NTERNS &	RESI DENTS				
	Cost Center Description	NURSING SCHOOL	SEDVICES_SALAD		IFP	PARAMEDI CAL	Subtotal	
	cost center bescription	NORSTING SCHOOL	Y & FRI NGES	PRGM COSTS		EDUCATION	(col s. 4A-23)	
			APPRV	APPRV		PROGRAM		
		20.00	21.00	22.00		23.00	24.00	
1.00	Administrative and General	0	0		0	0	629, 303	1.00
2.00	Inpatient - General Care	0	0		0	0	1, 063, 143	2.00
3.00	Inpatient - Respite Care	0	0		0	0	0	3.00
4.00	Physi ci an Servi ces	0	0		0	0	0	4.00
5.00	Nursing Care	0	0		0	0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0	0	0	6.00
7.00	Physical Therapy	0	0		0	0	0	7.00
8.00	Occupational Therapy	0	0		0	0	0	8.00
9.00	Speech/ Language Pathology	0	0		0	0	0	9.00
10.00	Medical Social Services	0	0		0	0	0	10.00
11.00	Spiritual Counseling	0	0		0	0	0	11.00
12.00	Dietary Counseling	0	0		0	0	0	12.00
13.00	Counseling - Other	0	0		0	0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0	0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0	0	0	15.00
16.00	Other	0	0		0	0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0	0	0	17.00
18.00	Anal gesi cs	0	0		0	0	0	18.00
19.00	Sedatives / Hypnotics	0	0		0	0	0	19.00
20.00	Other - Specify	0	0		0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0	0	0	21.00
22.00	Patient Transportation	0	0		0	0	0	22.00
23.00	Imaging Services	0	0		0	0	0	23.00
24.00	Labs and Diagnostics	0	0		0	0	0	24.00
25.00	Medical Supplies	0	0		0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0	0	0	26.00
27.00	Radiation Therapy	0	0		0	0	0	27.00
28.00	Chemotherapy	0	0		0	0	0	28.00
29.00	Other	0	0		0	0	828, 656	29.00
30.00	Bereavement Program Costs	0	0		0	0	0	30.00
31.00	Volunteer Program Costs	0	0		0	0	0	31.00
32.00	Fundrai si ng	0	0		0	0	0	32.00
33.00	Other Program Costs	0	0		0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0		0	0	2, 521, 102	34.00
	Unit Cost Multiplier (see instructions)	1	1					35.00

Heal th	Financial Systems	IU HEALTH GOSH	IEN HOSPI TAL		In Lie	u of Form CMS-2552	-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS		CCN: 150026 CCN: 151527	Period: From 01/01/2015 To 12/31/2015	Worksheet K-5 Part I Date/Time Prepare 5/27/2016 5:47 pm	ed:
					Hospi ce I		
	Cost Center Description	Intern &	Subtotal	Allocated	Total Hospice		
	•	Residents Cost	(cols. 24 ±	Hospice A&G	Costs (cols.		
		& Post	25)	(See Part II) 26 ± 27)		
		Stepdown					
		Adjustments					
		25.00	26.00	27.00	28.00		
1.00	Administrative and General						. 00
2.00	Inpatient - General Care	0	1, 063, 143	353, 6	52 1, 416, 795		. 00
3.00	Inpatient - Respite Care	0	0		0 0		. 00
4.00	Physician Services	0	0		0 0		. 00
5.00	Nursing Care	0	0		0 0		. 00
6.00	Nursing Care-Continuous Home Care	0	0		0 0		. 00
7.00	Physical Therapy	0	0		0 0		. 00
8.00	Occupational Therapy	0	0		0 0		. 00
9.00	Speech/ Language Pathology	0	0		0 0		. 00
10.00	Medical Social Services	0	0		0 0	10.	
11.00	Spiritual Counseling	0	0		0 0	11.	
12.00	Dietary Counseling	0	0		0 0	12.	
13.00	Counseling - Other	0	0		0 0	13.	
14.00	Home Health Aide and Homemaker	0	0		0 0		. 00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0		0 0	15.	
16.00	Other	0	0		0 0	16.	
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	17.	
18.00	Anal gesi cs	0	0		0 0	18.	
19.00	Sedatives / Hypnotics	0	0		0 0	19.	
20.00	Other - Specify	0	0		0 0	20.	
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	21.	
22.00	Patient Transportation	0	0		0 0	22.	
23.00	Imaging Services	0	0		0 0	23.	
24.00	Labs and Diagnostics	0	0		0 0	24.	
25.00	Medical Supplies	0	0		0 0	25.	
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	26.	
27.00	Radiation Therapy	0	0		0 0	27.	
28.00	Chemotherapy	0	0		0 0	28.	
29.00	Other	0	828, 656	275, 6	51 1, 104, 307	29.	
30.00	Bereavement Program Costs	0	0		0 0	30.	
31.00	Volunteer Program Costs	0	0		0 0	31.	
32.00	Fundrai si ng	0	0		0 0	32.	
33.00	Other Program Costs	0	0		0 0		. 00
34.00	Total (sum of lines 1 thru 33) (2)	0	2, 521, 102		2, 521, 102	34.	
35.00	Unit Cost Multiplier (see instructions)			0. 3326	48	35.	. 00

Heal th	Financial Systems	IU HEALTH GOSH	IEN HOSPITAL			In Lie	eu of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi dei	- CCN: 150026		eriod:	Worksheet K-5	
STATI S	STICAL BASIS					rom 01/01/2015		
			Hospi ce	CCN: 151527	T	o 12/31/2015	Date/Time Pre 5/27/2016 5:4	
						Hospi ce I	372772010 3.4	/ piii
		CAPI TAL REL	ATED COSTS					
	Cost Center Description	BLDG & FIXT	MVBLE EQUIP	EMPLOYEE		CASHI ERI NG/ACC	Reconciliation	
		(SQUARE FEET)	(DOLLAR VALUE) BENEFITS		OUNTS		
				DEPARTMENT	Γ	RECEI VABLE		
				(GROSS		(GROSS CHAR		
		1.00		SALARI ES)		GES)	54.00	
1 00	Administrative and Conserve	1.00	2.00	4.00	00	5.01	5A. 02	1 00
1.00	Administrative and General	2, 562		-	00		0	1.00
2.00	Inpatient - General Care	0		0	0	0	-	2.00
3.00	Inpatient - Respite Care	0		0	0	0	0	3.00
4.00	Physician Services	0		0	0	0	0	4.00 5.00
5.00 6.00	Nursing Care Nursing Care-Continuous Home Care	0		0	0	0	0	5.00 6.00
8.00 7.00	Physical Therapy	0		0	0	0	0	8.00 7.00
8.00	Occupational Therapy	0		0	0	0	0	7.00 8.00
8.00 9.00	Speech/ Language Pathol ogy	0		0	0	0	0	8.00 9.00
10,00	Medical Social Services	0			0	0	0	10.00
11.00	Spiritual Counseling	0		0	0	0	0	10.00
12.00	Di etary Counsel i ng	0		0	0	0	0	12.00
13.00	Counsel i ng - Other	0		0	0	0	-	13.00
14.00	Home Health Aide and Homemaker	0		0	0	-	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0		0	0	-	-	15.00
16.00	Other	0		0	0	-	-	16.00
17.00	Drugs, Biological and Infusion Therapy	0		0	0	0	0	17.00
18.00	Anal gesi cs	0		0	0	0	0	18.00
19.00	Sedatives / Hypnotics	0		0	0	0	0	19.00
20.00	Other - Specify	0		0	0	0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0		0	0	0	0	21.00
22.00	Patient Transportation	0		0	0	0	0	22.00
23.00	Imaging Services	0		0	0	0	0	23.00
24.00	Labs and Diagnostics	0		0	0	0	0	24.00
25.00	Medical Supplies	0		0	0	0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0		0	0	0	0	26.00
27.00	Radiation Therapy	0		0	0	0	0	27.00
28.00	Chemotherapy	0		0	0	0	0	28.00
29.00	Other	0		0	0	0	0	29.00
30.00	Bereavement Program Costs	0		0	0	0	0	30.00
31.00	Volunteer Program Costs	0		0	0	0	0	31.00
32.00	Fundraising	0		U	0	0	0	32.00
33.00	Other Program Costs	0			0	0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	2, 562			00			34.00
35.00	Total cost to be allocated	30, 430	0 00000	0 276,0				35.00
30.00	Unit Cost Multiplier (see instructions)	11. 877440	0.00000	0 2, 760. 2800	000	0. 004705		36.00

STATI STI CAL BASI S Hospi ce CCN: 151527 From 01/01/2015 To 12/31/2015 Date/ 5/27/2	heet K-5 II Time Prepa 2016 5:47 KEEPING RE FEET)	ared:
Hospi ce CCN: 151527 To 12/31/2015 Date// 5/27/2 Hospi ce CCN: 151527 To 12/31/2015 Date// 5/27/2 Cost Center Description OTHER ADMI NI STRATI VE AND GENERAL (ACCUM. COST) MAI NTENANCE & REPAI RS (SOUARE FEET) OPERATION OF LAUNDRY & LI NEN SERVICE (POUNDS OF LAUNDRY) HOSPI ce I 1.00 Admin is strative and General 326,083 2,562 2,562 0 2.00 Inpati ent - General Care 326,083 2,562 2,562 0 3.00 Inpati ent - Respite Care 0 0 0 0 0 3.00 Physic can Services 0 0 0 0 0 5.00 Nursing Care 0 0 0 0 0	Time Prepa 2016 5:47 KEEPING E FEET)	
Cost Center Description OTHER ADMINISTRATIVE ADMINISTRATIVE (ACCUM. COST) MAINTENANCE & REPAIRS (SQUARE FEET) OPERATION OF PLANT (SQUARE FEET) LAUNDRY & LAUNDRY) HOUSEH (SQUARE (POUNDS OF LAUNDRY) 1.00 Administrative and General 326,083 2,562 2,562 0 2.00 Inpatient - General Care 861,218 0 0 0 3.00 Inpatient - Respite Care 0 0 0 4.00 Physician Services 0 0 0 5.00 Nursing Care 0 0 0	2016 5: 47 KEEPI NG E FEET)	
Hospice IHospice ICost Center DescriptionOTHER ADMINI STRATI VE AND GENERAL (ACCUM. COST)MAINTENANCE & REPAIRS (SQUARE FEET)Hospice ILAUNDRY & PLANT (SQUARE FEET)LAUNDRY & PLANT (SQUARE FEET)House PLANT (SQUARE FEET)1.00Administrative and General 3.00Inpatient - General CareB61,218 0OO1.00Administrative and General 3.00Inpatient - General CareB61,218 0OO3.00Inpatient - Respite Care000004.00Physician Services000005.00Nursing Care00000	KEEPING EFEET)	
Cost Center DescriptionOTHER ADMINI STRATIVE ADD GENERAL (ACCUM. COST)MAINTENANCE & REPAIRS (SQUARE FEET)OPERATION OF PLANT (SQUARE FEET)LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)HOUSEH (SQUAR1.00Administrative and General 0326,0832,5622,56202.00Inpatient - General Care 0861,2180003.00Inpatient - Respite Care 000004.00Physician Services 000005.00Nursing Care0000	E FEET)	
ADMI NI STRATI VE AND GENERAL (ACCUM. COST)REPAI RS (SQUARE FEET)PLANT (SQUARE FEET)LI NEN SERVI CE (POUNDS OF LAUNDRY)(SQUARE (POUNDS OF LAUNDRY)(SQUARE (POUNDS OF 	E FEET)	
AND GENERAL (ACCUM. COST) (SQUARE FEET) (SQUARE FEET) (POUNDS OF LAUNDRY) 1.00 Administrative and General 326,083 2,562 2,562 0 2.00 Inpatient - General Care 361,218 0 0 0 3.00 Inpatient - Respite Care 0 0 0 0 4.00 Physician Services 0 0 0 0 5.00 Nursing Care 0 0 0 0	. 00	
(ACCUM. COST) C LAUNDRY) 5.02 6.00 7.00 8.00 9. 1.00 Administrative and General 326,083 2,562 2,562 0 2.00 Inpatient - General Care 861,218 0 0 0 3.00 Inpatient - Respite Care 0 0 0 0 4.00 Physician Services 0 0 0 0 5.00 Nursing Care 0 0 0 0		
5.02 6.00 7.00 8.00 9. 1.00 Administrative and General 326,083 2,562 2,562 0 2.00 Inpatient - General Care 861,218 0 0 0 0 3.00 Inpatient - Respite Care 0 0 0 0 0 4.00 Physician Services 0 0 0 0 0 5.00 Nursing Care 0 0 0 0 0		
2.00 Inpatient - General Care 861,218 0 0 0 3.00 Inpatient - Respite Care 0 0 0 0 4.00 Physician Services 0 0 0 0 5.00 Nursing Care 0 0 0 0		
3.00 Inpatient - Respite Care 0 0 0 4.00 Physician Services 0 0 0 5.00 Nursing Care 0 0 0	2, 562	1.00
4.00 Physician Services 0	0	2.00
5.00 Nursing Care 0 0 0 0	0	3.00
	0	4.00
6.00 Nursing Caro Continuous Homo Caro	0	5.00
	0	6.00
7.00 Physical Therapy 0 0 0 0	0	7.00
8.00 Occupational Therapy 0 0 0 0	0	8.00
9.00 Speech/ Language Pathol ogy 0 0 0 0	0	9.00
10.00 Medical Social Services 0 0 0 0	0	10.00
11.00 Spiritual Counseling 0 0 0 0	0	11.00
12.00 Dietary Counseling 0 0 0 0		12.00
13.00 Counseling - Other 0 0 0 0		13.00
14.00 Home Health Aide and Homemaker 0 0 0 0		14.00
15.00 HH Aide & Homemaker - Cont. Home Care 0 0 0 0	-	15.00
16.00 0ther 0 0 0		16.00
17.00 Drugs, Biological and Infusion Therapy 0		17.00
18.00 Anal gesi cs 0 0 0 0	-	18.00
19.00 Sedatives / Hypnotics 0 0 0 0	-	19.00
20.00 Other - Speci fy 0 0 0 0		20.00
21.00 Durable Medical Equipment/Oxygen 0 0 0 0		21.00
22.00 Pati ent Transportation 0 0 0 0	-	22.00
23. 00 Imaging Services 0 0 0 0	-	23.00
24.00 Labs and Diagnostics 0 0 0		24.00
25.00 Medical Supplies 0 0 0 0		25.00
26.00 Outpatient Services (including E/R Dept.) 0 0 0		26.00
27.00 Radiation Therapy 0 0 0 0		27.00
28.00 Chemotherapy 0 0 0 0		28.00
29.00 Other 671,267 0 0 0		29.00
30.00 Bereavement Program Costs 0 0 0 31.00 Michael Strategy 0 0 0	-	30.00
31.00 Volunteer Program Costs 0 0 0		31.00
32.00 Fundraising 0 0 0 0		32.00
33.00 Other Program Costs 0 0 0 34.00 Tetal (sum of lines 1 thrus 22) (2) 1.050 F(2) 2.5(2) 2.5(2)	-	33.00
34.00 Total (sum of lines 1 thru 33) (2) 1,858,568 2,562 2,562 0 35.00 Total esset to be ellocated 435.760 35.060		34.00
35.00 Total cost to be allocated 435,769 0 35,068 0		35.00
36.00 Unit Cost Multiplier (see instructions) 0.234465 0.000000 13.687744 0.000000 6	6. 908275	JO. UU

Heal th	Financial Systems	IU HEALTH GOSH	IEN HOSPI TAL		In Lie	eu of Form CMS-:	2552-10
	ATION OF GENERAL SERVICE COSTS TO HOSPICE COST	CENTERS	Provi der	CCN: 150026	Peri od:	Worksheet K-5	
STATI S	STICAL BASIS		Hospi co. (CCN: 151527	From 01/01/2015 To 12/31/2015		narad
			Hospi ce (JUN: 151527	10 12/31/2015	5/27/2016 5:4	7 pm
					Hospi ce I		- -
	Cost Center Description	DI ETARY	CAFETERI A	MAI NTENANCE	OF NURSI NG	CENTRAL	
		(MEALS SERVED)	(MANHOURS)	PERSONNEL	ADMI NI STRATI ON		
				(NUMBER	(SUPPLY	
				HOUSED)	(DI RECT NRSI NG		
		10.00	11.00	12.00	HRS) 13.00	REQUIS.) 14.00	
1.00	Administrative and General	10.00	28, 365		0 11,897	705, 099	1.00
2.00	Inpatient - General Care	0	20, 303		0 0	03,077	2.00
3.00	Inpatient - Respite Care	0	0		0 0	0	3.00
4.00	Physi ci an Servi ces	0	0		0 0	0	4.00
5.00	Nursing Care	0	0		0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00	Physical Therapy	0	0)	0 0	0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9.00
10.00	Medical Social Services	0	0		0 0	-	10.00
11.00	Spiritual Counseling	0	0		0 0	0	11.00
12.00	Di etary Counsel i ng	0	0		0 0		12.00
13.00	Counseling - Other	0	0		0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0		0 0		14.00
15.00 16.00	HH Aide & Homemaker - Cont. Home Care Other	0	0		0 0	0	15.00 16.00
16.00	Drugs, Biological and Infusion Therapy	0	0			0	17.00
18.00	Anal gesi cs	0	0		0 0		18.00
19.00	Sedatives / Hypnotics	0	0		0 0	0	19.00
20.00	Other - Specify	0	0		0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0 0	0	21.00
22.00	Patient Transportation	0	0		0 0	0	22.00
23.00	Imaging Services	0	0)	0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medical Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radiation Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	0		0 0	0	28.00
29.00	Other	0	0		0 0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00 32.00	Volunteer Program Costs Fundraising	0	0			0	31.00 32.00
33.00	Other Program Costs	0	0		0 0	0	32.00
34.00	Total (sum of lines 1 thru 33) (2)		28, 365		0 11,897	-	
35.00	Total cost to be allocated	0	13, 226		0 83, 228		35.00
	Unit Cost Multiplier (see instructions)	0. 000000	0. 466279				
					1		•

Heal th	Financial Systems	IU HEALTH GOSH	IEN HOSPITAL		Inlie	eu of Form CMS-2	2552-10
ALLOCA	TION OF GENERAL SERVICE COSTS TO HOSPICE COST			CCN: 150026 CCN: 151527	Period: From 01/01/2015 To 12/31/2015	Worksheet K-5 Part II	pared:
					Hospi ce I		
	Cost Center Description	PHARMACY	MEDI CAL	SOCIAL SERVI		NURSING SCHOOL	
		(COSTED	RECORDS &		ANESTHET I STS		
		REQUIS.)	LI BRARY	(TIME SPENT	(ASSI GNED	(ASSI GNED	
		ŕ	(GROSS CHAR		TIME)	TIME)	
			GES)		· ·		
		15.00	16.00	17.00	19.00	20.00	
1.00	Administrative and General	0	4, 171, 009)	0 0	0	1.00
2.00	Inpatient - General Care	0	0)	0 0	0	2.00
3.00	Inpatient - Respite Care	0	0)	0 0	0	3.00
4.00	Physician Services	0	0)	0 0	0	4.00
5.00	Nursing Care	0	0)	0 0	0	5.00
6.00	Nursing Care-Continuous Home Care	0	0		0 0	0	6.00
7.00	Physical Therapy	0	0		0 0	0	7.00
8.00	Occupational Therapy	0	0		0 0	0	8.00
9.00	Speech/ Language Pathol ogy	0	0		0 0	0	9.00
10.00	Medical Social Services	0	0		0 0	0	10.00
11.00	Spiritual Counseling	0	0		0 0	0	11.00
12.00	Dietary Counseling	0	0		0 0	0	12.00
13.00	Counseling - Other	0	0)	0 0	0	13.00
14.00	Home Health Aide and Homemaker	0	0)	0 0	0	14.00
15.00	HH Aide & Homemaker - Cont. Home Care	0	0)	0 0	0	15.00
16.00	Other	0	0)	0 0	0	16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0 0	0	17.00
18.00	Anal gesi cs	0	0		0 0	0	18.00
19.00	Sedatives / Hypnotics	0	0)	0 0	0	19.00
20.00	Other - Specify	0	0)	0 0	0	20.00
21.00	Durable Medical Equipment/Oxygen	0	0)	0 0	0	21.00
22.00	Patient Transportation	0	0)	0 0	0	22.00
23.00	Imaging Services	0	0		0 0	0	23.00
24.00	Labs and Diagnostics	0	0		0 0	0	24.00
25.00	Medical Supplies	0	0		0 0	0	25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0 0	0	26.00
27.00	Radiation Therapy	0	0		0 0	0	27.00
28.00	Chemotherapy	0	0		0 0	0	28.00
29.00	Other	0	0		0 0	0	29.00
30.00	Bereavement Program Costs	0	0		0 0	0	30.00
31.00	Volunteer Program Costs	0	0		0 0	0	31.00
32.00	Fundrai si ng	0	0		0 0	0	32.00
33.00	Other Program Costs	0	0		0 0	0	33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	4, 171, 009		0 0	0	34.00
35.00	Total cost to be allocated	0	40, 438		0 0	0	35.00
36.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 009695	0.0000	0. 000000	0.000000	36.00

Heal th	Financial Systems	IU HEALTH GOSHE	N HOSPITAL			In Lieu	u of Form CMS	-2552-10
	TION OF GENERAL SERVICE COSTS TO HOSPICE COST TICAL BASIS	CENTERS	Provi der Hospi ce C	CCN: 150026 CCN: 151527		riod: om 01/01/2015 12/31/2015	Worksheet K- Part II Date/Time Pr 5/27/2016 5:	epared:
						Hospi ce I	372772010 3.	47 pili
		INTERNS & R	ESLDENTS			nospi ce i		
			LOT DENTO					
	Cost Center Description	SERVI CES-SALAR SE	RVI CES-OTHER	PARAMEDI CAL	_			
	•	Y & FRINGES	PRGM COSTS	EDUCATI ON				
		APPRV	APPRV	PROGRAM				
		(ASSI GNED	(ASSI GNED	(ASSI GNED				
		TIME)	TIME)	TIME)				
	1	21.00	22.00	23.00				
1.00	Administrative and General	0	0		0			1.00
2.00	Inpatient - General Care	0	0		0			2.00
3.00	Inpatient - Respite Care	0	0		0			3.00
4.00	Physician Services	0	0		0			4.00
5.00	Nursing Care	0	0		0			5.00
6.00	Nursing Care-Continuous Home Care	0	0		0			6.00
7.00	Physical Therapy	0	0		0			7.00
8.00	Occupational Therapy	0	0		0			8.00
9.00	Speech/ Language Pathol ogy	0	0		0			9.00
10.00	Medical Social Services	0	0		0			10.00
11.00	Spiritual Counseling	0	0		0			11.00
12.00	Dietary Counseling	0	0		0 0			12.00
13.00 14.00	Counseling - Other Home Health Aide and Homemaker	0	0		0			13.00
14.00	HH Aide & Homemaker - Cont. Home Care	0	0		0			14.00
16.00	Other	0	0		0			16.00
17.00	Drugs, Biological and Infusion Therapy	0	0		0			17.00
18.00	Anal gesi cs	0	0		õ			18.00
19.00	Sedatives / Hypnotics	0	0		õ			19.00
20.00	Other - Specify	0	0		0			20.00
21.00	Durable Medical Equipment/Oxygen	0	0		0			21.00
22.00	Patient Transportation	0	0		0			22.00
23.00	Imaging Services	0	0		0			23.00
24.00	Labs and Diagnostics	0	0		0			24.00
25.00	Medical Supplies	0	0		0			25.00
26.00	Outpatient Services (including E/R Dept.)	0	0		0			26.00
27.00	Radiation Therapy	0	0		0			27.00
28.00	Chemotherapy	0	0		0			28.00
29.00	Other	0	0		0			29.00
30.00	Bereavement Program Costs	0	0		0			30.00
31.00	Volunteer Program Costs	0	0		0			31.00
32.00	Fundrai si ng	0	0		0			32.00
33.00	Other Program Costs	0	0		0			33.00
34.00	Total (sum of lines 1 thru 33) (2)	0	0		0			34.00
35.00	Total cost to be allocated	0	0	0.0000	0			35.00
36.00	Unit Cost Multiplier (see instructions)	0. 000000	0. 000000	0.0000	00			36.00

Heal th	Financial Systems	IU HEALTH GOSHEN H	IOSPI TAL		In Lie	eu of Form CMS-2	2552-10
COMPUT	ATION OF TOTAL HOSPICE SHARED COSTS		Provi der	CCN: 150026	Peri od:	Worksheet K-5	
			Hospi ce (CCN: 151527	From 01/01/2015 To 12/31/2015		
					Hospi ce I		
	Cost Center Description	Wks	t. C, Part	Cost to Char	ge Total Hospice	Hospice Shared	
		L,	col. 11	Ratio	Charges	Ancillary	
			line			Costs (cols. 1	
					Records)	x 2)	
			0	1.00	2.00	3.00	
	ANCILLARY SERVICE COST CENTERS						
1.00	PHYSI CAL THERAPY		66.00			0	
2.00	OCCUPATIONAL THERAPY		67.00		11 0	0	2.00
3.00	SPEECH PATHOLOGY		68.00	0. 4379	57 0	0	3.00
4.00	DRUGS CHARGED TO PATIENTS		73.00	0. 2134	99 0	0	4.00
5.00	DURABLE MEDICAL EQUIP-RENTED		96.00				5.00
6.00	LABORATORY		60.00	0. 1974	21 0	0	6.00
6.01	BLOOD LABORATORY		60.01	0.0000	00 0	0	6. 01
7.00	MEDICAL SUPPLIES CHARGED TO PATIENT		71.00	1. 2267	99 0	0	7.00
8.00	OTHER OUTPATIENT SERVICE COST CENTER		93.00				8.00
9.00	RADI OLOGY-THERAPEUTI C		55.00	0. 5330	58 0	0	9.00
10.00	OTHER ANCILLARY SERVICE COST CENTERS		76.00				10.00
11.00	Totals (sum of lines 1–10)					0	11.00
							-

Health Financial Systems IU HEALTH GOS	HEN HOSPITAL		In Lie	u of Form CMS-2	2552-10
CALCULATION OF HOSPICE PER DIEM COST	Provi der	CCN: 150026	Period:	Worksheet K-6	
	Hospi ce (Hospi ce CCN: 151527		From 01/01/2015 7 To 12/31/2015 Date/Time Pro 5/27/2016 5:4	
	_		Hospi ce I	1	
	Title XVIII	Title XIX	0ther	Total	
	1.00	2.00	3.00	4.00	
1.00 Total cost (see instructions)				2, 521, 102	1.00
2.00 Total Unduplicated Days (Worksheet S-9, column 6, line 5)				18, 871	2.00
3.00 Average cost per diem (line 1 divided by line 2)				133.60	3.00
4.00 Upduplicated Medicare Days (Worksheet S-9, column 1, line 5)	16, 743				4.00
5.00 Aggregate Medicare cost (line 3 time line 4)	2, 236, 865				5.00
6.00 Unduplicated Medicaid Days (Worksheet S-9, column 2, line 5)			0		6.00
7.00 Aggregate Medicaid cost (line 3 time line 60)			0		7.00
8.00 Upduplicated SNF Days (Worksheet S-9, column 3, line 5)	0				8.00
9.00 Aggregate SNF cost (line 3 time line 8)	0				9.00
10.00 Unduplicated NF Days (Worksheet S-9, column 4, line 5)			0		10.00
11.00 Aggregate NF cost (line 3 times line 10)			0		11.00
12.00 Other Unduplicated days (Worksheet S-9, column 5, line 5)			2, 128		12.00
13.00 Aggregate cost for other days (line 3 times line 12)			284, 301		13.00

alth Financial Systems IU HEALTH GC ALCULATION OF CAPITAL PAYMENT	DSHEN HOSPITAL Provider CCN: 150026	In Lie Period: From 01/01/2015 To 12/31/2015	Worksheet L Parts I-III	pared:	
	Title XVIII	Hospi tal	PPS	<i>i</i> piii	
	· · · · ·				
			1.00		
PART I - FULLY PROSPECTIVE METHOD					
CAPITAL FEDERAL AMOUNT			1, 117, 259	1 1.0	
01 Model 4 BPCI Capital DRG other than outlier			0		
00 Capital DRG outlier payments			24, 921		
01 Model 4 BPCI Capital DRG outlier payments			0		
00 Total inpatient days divided by number of days in the cos	st reporting period (see inst	ructions)	56.79		
00 Number of interns & residents (see instructions)			0.00		
00 Indirect medical education percentage (see instructions)			0.00		
00 Indirect medical education adjustment (multiply line 5 by 1.01) (see instructions)			0	6.	
00 Percentage of SSI recipient patient days to Medicare Part 30) (see instructions)		, part A line	1.63		
00 Percentage of Medicaid patient days to total days (see in	nstructions)		18. 91		
00 Sum of lines 7 and 8			20.54		
.00 Allowable disproportionate share percentage (see instruct	i ons)		4.25		
. 00 Disproportionate share adjustment (see instructions)			47, 484		
.00 Total prospective capital payments (see instructions)			1, 189, 664	12.	
			1.00		
PART II - PAYMENT UNDER REASONABLE COST			0		
00 Program inpatient routine capital cost (see instructions)			0		
00 Program inpatient ancillary capital cost (see instruction 00 Total inpatient program capital cost (line 1 plus line 2)			0		
			0		
00 Capital cost payment factor (see instructions) 00 Total inpatient program capital cost (line 3 x line 4)			0		
to protar impatrent program capital cost (inne 3 x inne 4)			0	5.	
			1.00		
PART III - COMPUTATION OF EXCEPTION PAYMENTS			0	1	
00 Program inpatient capital costs (see instructions) 00 Program inpatient capital costs for extraordinary circums	tancos (soo instructions)		0		
00 Program inpatient capital costs for extraordinary circums 00 Net program inpatient capital costs (line 1 minus line 2)			0	· ~·	
00 Applicable exception percentage (see instructions)			0.00		
00 Capital cost for comparison to payments (line 3 x line 4)			0.00		
00 Percentage adjustment for extraordinary circumstances (se			0.00		
00 Adjustment to capital minimum payment level for extraordi		line 6)	0.00		
00 Capital minimum payment level (line 5 plus line 7)			0		
00 Current year capital payments (from Part I, line 12, as a	upplicable)		0		
.00 Current year comparison of capital minimum payment level		less line 9)	0		
.00 Carryover of accumulated capital minimum payment level ov Worksheet L, Part III, line 14)			0		
.00 Net comparison of capital minimum payment level to capita	l payments (line 10 plus lin	e 11)	0	12.	
.00 Current year exception payment (if line 12 is positive, e			0		
.00 Carryover of accumulated capital minimum payment level ov			-	14.	
(if line 12 is negative, enter the amount on this line)		, in g por ou	0		
.00 Current year allowable operating and capital payment (see	e instructions)		0	15.	
0.00 Current year operating and capital costs (see instruction	IS)		0	16.	