PART II - CERTIFICATION

(3) Settled with Audit

(4) Reopened (5) Amended

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

CERTIFICATION BY OFFICER OR ADMINISTRATOR OF PROVIDER(S)

I HEREBY CERTIFY that I have read the above certification statement and that I have examined the accompanying electronically filed or manually submitted cost report and the Balance Sheet and Statement of Revenue and Expenses prepared by IU HEALTH PAOLI HOSPITAL (151306) for the cost reporting period beginning 01/01/2015 and ending 12/31/2015 and to the best of my knowledge and belief, this report and statement are true, correct, complete and prepared from the books and records of the provider in accordance with applicable instructions, except as noted. I further certify that I am familiar with the laws and regulations regarding the provision of health care services, and that the services identified in this cost report were provided in compliance with such laws and regulations.

> (Si gned) Officer or Administrator of Provider(s) Title Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HI T	Title XIX	
		1. 00	2. 00	3. 00	4. 00	5. 00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	115, 936	176, 075	0	0	1.00
2.00	Subprovi der - IPF	0	0	0		0	2.00
3.00	Subprovi der - I RF	0	0	0		0	3.00
4.00	SUBPROVI DER I	0	0	0		0	4.00
5.00	Swing bed - SNF	0	57, 069	0		0	5.00
6.00	Swing bed - NF	0				0	6.00
7.00	SKILLED NURSING FACILITY	0	0	0		0	7.00
8.00	NURSING FACILITY	0				0	8. 00
9.00	HOME HEALTH AGENCY I	0	0	0		0	9. 00
10.00	RURAL HEALTH CLINIC I	0		0		0	10.00
11.00	FEDERALLY QUALIFIED HEALTH CENTER I	0		0		0	11.00
12.00	CMHC I	0		0		0	12.00
200.00	Total	0	173, 005	176, 075	0	0	200.00

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

		used in the prior cost reporting period? In column:	2, enter "Y	" for yes	or "N" for	no.			
			In-State	In-State	Out-of	Out-of	Medi cai d	0ther	
			Medi cai d	Medi cai d	State	State	HMO days	Medi cai d	
			pai d days	el i gi bl e	Medi cai d	Medi cai d		days	
				unpai d	paid days	eligible			
				days		unpai d			
			1.00	2. 00	3. 00	4. 00	5. 00	6. 00	
2	24. 00	If this provider is an IPPS hospital, enter the	0	0	0	0	0	0	24.00
		in-state Medicaid paid days in column 1, in-state							
		Medicaid eligible unpaid days in column 2,							
		out-of-state Medicaid paid days in column 3,							
		out-of-state Medicaid eligible unpaid days in column							
		4, Medicaid HMO paid and eligible but unpaid days in							
		column 5, and other Medicaid days in column 6.							
2	25. 00	If this provider is an IRF, enter the in-state	0	0	0	0	0		25.00
		Medicaid paid days in column 1, the in-state							
		Medicaid eligible unpaid days in column 2,							
		out-of-state Medicaid days in column 3, out-of-state							
		Medicaid eligible unpaid days in column 4, Medicaid							
		HMO paid and eligible but unpaid days in column 5.							

Ν

23.00

hospital contain at least 100 but not more than 499 beds (as counted in accordance with

1, enter 1 if date of admission, 2 if census days, or 3 if date of discharge. Is the method of identifying the days in this cost reporting period different from the method

23.00 Which method is used to determine Medicaid days on lines 24 and/or 25 below? In column

42 CFR 412.105)? Enter in column 3, "Y" for yes or "N" for no.

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)

Health Financial Systems IU HEALTH PAOLI HO	SPI TAL		In Lie	eu of Form CMS	-2552-10
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der		eriod: rom 01/01/2015 o 12/31/2015	Date/Time Pr	epared:
			V	5/27/2016 5: XIX	10 pm
95.00 If line 94 is "Y", enter the reduction percentage in the applica			1.00	1	0 95.00
 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applica 			N O. 00	N O. O	96. 00 0 97. 00
Rural Providers 105.00 Does this hospital qualify as a critical access hospital (CAH)?			Υ		105.00
106.00 If this facility qualifies as a CAH, has it elected the all-incl for outpatient services? (see instructions)	usive met	hod of payment	Y		106. 00
107.00 If this facility qualifies as a CAH, is it eligible for cost rei training programs? Enter "Y" for yes or "N" for no in column 1. yes, the GME elimination is not made on Wkst. B, Pt. I, col. 25	(see inst	ructions) If	N		107. 00
reimbursed. If yes complete Wkst. D-2, Pt. II. 108.00 Is this a rural hospital qualifying for an exception to the CRNA CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	fee sche	dul e? See 42	Y		108. 00
Ph	nysi cal 1. 00	Occupati onal 2.00	Speech 3. 00	Respiratory 4.00	-
109.00 If this hospital qualifies as a CAH or a cost provider, are therapy services provided by outside supplier? Enter "Y" for yes or "N" for no for each therapy.	N	N	N	N	109.00
				1.00	
110.00 Did this hospital participate in the Rural Community Hospital De the current cost reporting period? Enter "Y" for yes or "N" for		on project (41	OA Demo)for	N	110.00
			1.0	0 2.00 3.00	
Miscellaneous Cost Reporting Information 115.00 s this an all-inclusive rate provider? Enter "Y" for yes or "N"	for no i	n column 1. If	column 1 N	0	115. 00
is yes, enter the method used (A, B, or E only) in column 2. If 3 either "93" percent for short term hospital or "98" percent for psychiatric, rehabilitation and long term hospitals providers) b	or long te	rm care (inclu	des		
Pub. 15-1, chapter 22, §2208.1. 116.00 s this facility classified as a referral center? Enter "Y" for 117.00 s this facility legally-required to carry malpractice insurance			"N" for Y		116. 00 117. 00
no. 118.00 s the malpractice insurance a claims-made or occurrence policy?	P Enter 1	if the policy	is 2		118. 00
claim-made. Enter 2 if the policy is occurrence.		Premi ums	Losses	Insurance	
		1. 00	2. 00	3. 00	
118.01 List amounts of malpractice premiums and paid losses:		50, 745	()	0118.01
118.02 Are malpractice premiums and paid losses reported in a cost cent			1. 00 N	2. 00	118. 02
Administrative and General? If yes, submit supporting schedule and amounts contained therein.	listing c	ost centers			
119.00 DO NOT USE THIS LINE 120.00 s this a SCH or EACH that qualifies for the Outpatient Hold Har	mless pro	vision in ACA	N	N	119. 00 120. 00
§3121 and applicable amendments? (see instructions) Enter in col "N" for no. Is this a rural hospital with < 100 beds that qualif Hold Harmless provision in ACA §3121 and applicable amendments?	umn 1, "Y ies for t	" for yes or he Outpatient			
Enter in column 2, "Y" for yes or "N" for no.	•	•	Y		121. 00
121.00 Did this facility incur and report costs for high cost implantable patients? Enter "Y" for yes or "N" for no.	ore device:	S charged to	T T		121.00
Transplant Center Information 125.00 Does this facility operate a transplant center? Enter "Y" for ye	es and "N"	for no. If	N		125. 00
yes, enter certification date(s) (mm/dd/yyyy) below. 126.00 f this is a Medicare certified kidney transplant center, enter	the certi	fication date			126. 00
in column 1 and termination date, if applicable, in column 2. 127.00 If this is a Medicare certified heart transplant center, enter t	he certifi	ication date			127. 00
in column 1 and termination date, if applicable, in column 2. 128.00 If this is a Medicare certified liver transplant center, enter t	he certif	ication date			128. 00
in column 1 and termination date, if applicable, in column 2. 129.00 f this is a Medicare certified lung transplant center, enter th	ne certifi	cation date in			129. 00
column 1 and termination date, if applicable, in column 2. 130.00 If this is a Medicare certified pancreas transplant center, ente	er the cer	ti fi cati on			130. 00
date in column 1 and termination date, if applicable, in column 131.00 of this is a Medicare certified intestinal transplant center, en		erti fi cati on			131. 00
date in column 1 and termination date, if applicable, in column 132.00 of this is a Medicare certified islet transplant center, enter t		ication date			132. 00
in column 1 and termination date, if applicable, in column 2. 133.00 of this is a Medicare certified other transplant center, enter t					133. 00
in column 1 and termination date, if applicable, in column 2. 134.00 f this is an organ procurement organization (OPO), enter the OP					134.00
and termination date, if applicable, in column 2.					

alth Financial Systems SPITAL AND HOSPITAL HEALTH CARE COMPLEX II		<u>TH PAOLI H</u> ATA	Provi der	CCN: 151	306 P	eri od:		u of Form CM Worksheet S	
STITAL AND HOSFITAL HEALTH CARE COWPLEX II	DENTITICATION DA	· · · · · · · · · · · · · · · · · · ·	FIOVICE	CCN. 151	F	rom 01	1/01/2015 2/31/2015	Part I Date/Time F 5/27/2016 5	Prepare
							1. 00	2.00	
All Providers							1.00	2.00	
0.00 Are there any related organization or chapter 10? Enter "Y" for yes or "N" are claimed, enter in column 2 the ho	for no in column	n 1. If yes	, and home	e office			Υ	15H059	140.
1. 00		2. 00					3. 00		
If this facility is part of a chain of office and enter the home office cont	9			ough 143	the na	ame an	d address	of the home	9
1.00 Name: I NDI ANA UNI VERSI TY HEALTH	Contractor's N		SIN PHYSIC	CI AN Con	tractor	r's Nu	mber: 0810	1	141.
2.00 Street: 340 WEST TENTH STREET	PO Box:	02							142.
3. 00 Ci ty: I NDI ANAPOLI S	State:	I N		Zi p	Code:		4620	6	143.
								1.00	
4.00 Are provider based physicians' costs	included in Work	ksheet A?						Y	144.
							1. 00	2. 00	_
5.00 If costs for renal services are claim	ed on Wkst. A, I	line 74, ar	e the cost	ts for			N N	2.00	145.
inpatient services only? Enter "Y" fo no, does the dialysis facility includ period? Enter "Y" for yes or "N" for	r yes or "N" for e Medicare utili	r no in col ization for	umn 1. If	col umn					
6.00Has the cost allocation methodology c Enter "Y" for yes or "N" for no in co yes, enter the approval date (mm/dd/y	hanged from the lumn 1. (See CMS	previ ousl y S Pub. 15-2	filed cos , chapter	st repor 40, §40	t? 20) If		N		146.
yes, enter the approval date (IIIII/dd/y	yyy) iii coruiiii 2	۷.							
								1. 00	
7.00 Was there a change in the statistical 3.00 Was there a change in the order of al								N N	147. 148.
0.00 Was there a change to the simplified					N" for	no.		N	149
			Part A		t B		tle V	Title XIX	
Does this facility contain a provider	that qualifies	for an eve	1.00	2.			3.00 f the Low	4.00	
or charges? Enter "Y" for yes or "N"									
5.00 Hospital 5.00 Subprovider - IPF			Y	1	<i>(</i>		N	N	155.
. 00 Subprovider - 1PF . 00 Subprovider - 1RF			N N	1	N N		N N	N N	156. 157.
3. 00 SUBPROVI DER									158
9.00 SNF D.00 HOME HEALTH AGENCY			Y N	1			N N	N N	159. 160.
1.00 CMHC			IV	'i			N	N N	161.
1. 10 CORF					N		N	N	161.
Mul ti campus								1.00	
5.00 Is this hospital part of a Multicampu Enter "Y" for yes or "N" for no.	s hospital that	has one or	more camp	ouses in	di ffer	ent Cl	BSAs?	N	165.
Eliter i foi yes di N foi fio.	Name		ounty	State		Code	CBSA	FTE/Campus	5
5.00 If line 165 is yes, for each	0		. 00	2. 00	3.	. 00	4. 00	5. 00	00 166.
campus enter the name in column								0.	00,100
O, county in column 1, state in									
column 2, zip code in column 3, CBSA in column 4, FTE/Campus in									
column 5 (see instructions)									
								1. 00	_
Health Information Technology (HIT) i	ncentive in the	American F	lecovery ar	nd Rei nv	estmen	t Act		1.00	
.00 Is this provider a meaningful user un	s "Y") and is a	meani ngful				entei	r the	Y	167. 0168.
reasonable cost incurred for the HIT B.01 If this provider is a CAH and is not			is provide	er quali	fy for	a hard	dshi p	N	168.
exception under §413.70(a)(6)(ii)? En	ter "Y" for yes	or "N" for	no. (see	instruc	tions)				. 00169.
transition factor. (see instructions)						Bed	gi nni ng	Endi ng	
9.00 f this provider is a meaningful user transition factor. (see instructions) 0.00 Enter in columns 1 and 2 the EHR begi						`	gi nni ng 1. 00 03/2015	Endi ng 2. 00 12/31/2015	5 170.

Health Financial Systems	u of Form CMS-	2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFI	From 01/01/2015 To 12/31/2015				epared:
				1. 00	
171.00 If line 167 is "Y", does this provider have	N	171.00			
Medicare cost plans reported on Wkst. S-3, F (see instructions)					

the other adjustments:

Health Financial Systems	IU HEALTH PAOLI HO	OSPI TAL		In Lie	u of Form CMS-2	2552-10
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUE	ESTI ONNAI RE	TI ONNAI RE Provi der CCN: 151306		From 01/01/2015	Worksheet S-2 Part II Date/Time Pre 5/27/2016 5:1	pared:
			Pa	rt A	Part B	
	Descriptio	n	Y/N	Date	Y/N	
	0		1.00	2. 00	3. 00	
21 00 Was the cost report prepared only using the			N		N	21 00

					5/27/2016 5:	. IO PIII		
			Par	-t A	Part B			
		Descri pti on	Y/N	Date	Y/N			
		0	1.00	2. 00	3. 00			
1. 00	Was the cost report prepared only using the provider's records? If yes, see instructions.		N		N	21.		
					1. 00			
	COMPLETED BY COST REIMBURSED AND TEFRA HOSPI	TALS ONLY (EXCEPT CHILDI	RENS HOSPITALS)		1.00			
	Capital Related Cost							
2. 00	Have assets been relifed for Medicare purpos	es? If yes, see instruc	ti ons		N	22.		
. 00	Have changes occurred in the Medicare depreception of the Medicare deprece			ng the cost	N	23.		
. 00		g leases entered into d	uring this cost rep	orting period?	Υ	24.		
. 00	Have there been new capitalized leases enter	ed into during the cost	reporting period?	If yes, see	N	25.		
. 00	instructions. Were assets subject to Sec. 2314 of DEFRA acq	uired during the cost r	eporting period? If	yes, see	N	26.		
. 00	instructions. Has the provider's capitalization policy cha	nged during the cost re	porting period? If	yes, submit	N	27.		
	copy. Interest Expense							
. 00	Were new Loans, mortgage agreements or Lette	rs of credit entered in	to during the cost	reporti ng	N	28.		
. 00	period? If yes, see instructions. Did the provider have a funded depreciation treated as a funded depreciation account? If		ds (Debt Service Re	serve Fund)	Υ	29		
. 00	Has existing debt been replaced prior to its instructions.		n new debt? If yes,	see	N	30		
00	Has debt been recalled before scheduled matu	see	N	31				
	instructions. Purchased Services							
. 00	Have changes or new agreements occurred in parrangements with suppliers of services? If		rni shed through con	tractual	N	32		
. 00	If line 32 is yes, were the requirements of no, see instructions.		taining to competit	ive bidding? If	,	33		
	Provi der-Based Physi ci ans							
00	Are services furnished at the provider facil If yes, see instructions.	ity under an arrangemen	t with provider-bas	ed physicians?	Y	34		
00	If line 34 is yes, were there new agreements physicians during the cost reporting period?	If yes, see instructions. If line 34 is yes, were there new agreements or amended existing agreements with the provider-based						
	iphysicians adming the cost reporting period.	If was see instruction	าร	r ovi der -based	Υ	35		
	·	If yes, see instruction	ns.			35		
		If yes, see instruction	ns.	Y/N	Date	35		
	Home Office Costs	If yes, see instruction	ns.			35		
00	Home Office Costs Were home office costs claimed on the cost r		ns.	Y/N 1.00	Date			
	Were home office costs claimed on the cost r If line 36 is yes, has a home office cost st	eport?		Y/N	Date	36		
00	Were home office costs claimed on the cost r If line 36 is yes, has a home office cost st If yes, see instructions. If line 36 is yes, was the fiscal year end	eport? atement been prepared b of the home office diffe	y the home office?	Y/N 1.00	Date	36		
00	Were home office costs claimed on the cost r If line 36 is yes, has a home office cost st If yes, see instructions. If line 36 is yes, was the fiscal year end the provider? If yes, enter in column 2 the If line 36 is yes, did the provider render s	eport? atement been prepared b of the home office diff fiscal year end of the	y the home office? erent from that of nome office.	Y/N 1.00	Date	36 37 38		
00	Were home office costs claimed on the cost of the line 36 is yes, has a home office cost start yes, see instructions. If line 36 is yes, was the fiscal year end the provider? If yes, enter in column 2 the lif line 36 is yes, did the provider render see instructions.	eport? atement been prepared b of the home office diff fiscal year end of the ervices to other chain	y the home office? erent from that of nome office. components? If yes,	Y/N 1.00 Y Y	Date	36 37 38 39		
00	Were home office costs claimed on the cost of the line 36 is yes, has a home office cost start yes, see instructions. If line 36 is yes, was the fiscal year end the provider? If yes, enter in column 2 the lif line 36 is yes, did the provider render see instructions.	eport? atement been prepared b of the home office diff fiscal year end of the ervices to other chain	y the home office? erent from that of nome office. components? If yes,	Y/N 1.00 Y Y N N	Date	36 37 38 39		
00 00 00	Were home office costs claimed on the cost of the line 36 is yes, has a home office cost start of the line 36 is yes, was the fiscal year end the provider? If yes, enter in column 2 the line 36 is yes, did the provider render see instructions. If line 36 is yes, did the provider render sinstructions.	eport? atement been prepared b of the home office diff fiscal year end of the ervices to other chain	y the home office? erent from that of nome office. components? If yes,	Y/N 1.00	Date	36 37 38 39		
00 00 00	Were home office costs claimed on the cost of If line 36 is yes, has a home office cost start yes, see instructions. If line 36 is yes, was the fiscal year end the provider? If yes, enter in column 2 the If line 36 is yes, did the provider render see instructions. If line 36 is yes, did the provider render sinstructions. Cost Report Preparer Contact Information	eport? atement been prepared by of the home office diffical year end of the ervices to other chain of	y the home office? erent from that of nome office. components? If yes, ce? If yes, see	Y/N 1.00 Y Y N N N	Date 2.00	36 37 38 39 40		
00 00 00	Were home office costs claimed on the cost of If line 36 is yes, has a home office cost start yes, see instructions. If line 36 is yes, was the fiscal year end the provider? If yes, enter in column 2 the If line 36 is yes, did the provider render see instructions. If line 36 is yes, did the provider render sinstructions. Cost Report Preparer Contact Information Enter the first name, last name and the titl held by the cost report preparer in columns	eport? atement been prepared by of the home office diffical year end of the ervices to other chain of ervices to the home off	y the home office? erent from that of nome office. components? If yes, ce? If yes, see	Y/N 1.00	Date 2.00	36 37 38 39		
. 00	Were home office costs claimed on the cost of the line 36 is yes, has a home office cost start yes, see instructions. If line 36 is yes, was the fiscal year end the provider? If yes, enter in column 2 the lif line 36 is yes, did the provider render see instructions. If line 36 is yes, did the provider render sinstructions. Cost Report Preparer Contact Information Enter the first name, last name and the titles.	eport? atement been prepared by of the home office diffical year end of the lervices to other chain of ervices to the home off e/position 1, 2, and 3,	y the home office? erent from that of nome office. components? If yes, ce? If yes, see	Y/N 1.00 Y Y N N N	Date 2.00	36 37 38 39 40		

Heal th	Financial Systems	IU HEALTH PA	OLI H	OSPI TAL		In Lie	of Form CMS-	2552-10
HOSPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT C	QUESTI ONNAI RE		Provi der	CCN: 151306	Peri od: From 01/01/2015 To 12/31/2015	Worksheet S-2 Part II Date/Time Pre 5/27/2016 5:1	pared:
		Part B						
		Date						
		4. 00						
	PS&R Data							
	Was the cost report prepared using the PS& Report only? If either column 1 or 3 is ye enter the paid-through date of the PS&R							16. 00

		Part B		
		Date		
		4. 00		
	PS&R Data			
16.00	Was the cost report prepared using the PS&R			16. 00
	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)			
17.00	Was the cost report prepared using the PS&R	04/24/2015		17.00
	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)			
18. 00	J			18. 00
	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.			
19. 00				19. 00
	made to PS&R Report data for corrections of			
	other PS&R Report information? If yes, see			
20.00	instructions.			20.00
20.00	If line 16 or 17 is yes, were adjustments			20.00
	made to PS&R Report data for Other? Describe the other adjustments:			
21 00	Was the cost report prepared only using the			21.00
21.00	provider's records? If yes, see			21.00
	instructions.			
	THISTI UCTIONS.			
			3.00	
	Cost Report Preparer Contact Information			
	Enter the first name, last name and the titl	e/position	MANAGER	41.00
	held by the cost report preparer in columns			
	respecti vel y.	•		
42.00	Enter the employer/company name of the cost	report		42.00
	preparer.	•		
43.00	Enter the telephone number and email address	of the cost		43.00
	report preparer in columns 1 and 2, respecti	vel y.		

Health Financial Systems IU HEALTH CARE COMPLEX STATISTICAL DATA

					T	12/31/2015	Date/Time Pre 5/27/2016 5:1	
				l			1/P Days /	O pili
							0/P Visits /	
							Trips	
	Component	Worksheet A	No.	of Beds	Bed Days	CAH Hours	Title V	
		Line Number			Avai I abl e			
		1. 00		2. 00	3.00	4. 00	5. 00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and	30.00		25	9, 125	15, 072. 00	0	1.00
	8 exclude Swing Bed, Observation Bed and							
	Hospice days)(see instructions for col. 2							
	for the portion of LDP room available beds)							
2. 00	HMO and other (see instructions)							2.00
3.00	HMO IPF Subprovider							3.00
4. 00	HMO IRF Subprovider							4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						0	5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						0	6. 00
7. 00	Total Adults and Peds. (exclude observation			25	9, 125	15, 072. 00	0	7. 00
	beds) (see instructions)			_	_		_	
8. 00	INTENSIVE CARE UNIT	31.00		0	_	0.00	0	8.00
9.00	CORONARY CARE UNIT	32.00		0	_	0. 00	0	9.00
10.00	BURN INTENSIVE CARE UNIT	33.00		0	_	0.00	0	10.00
11.00	SURGICAL INTENSIVE CARE UNIT	34. 00		0	0	0. 00	0	11.00
12.00	OTHER SPECIAL CARE (SPECIFY)	40.00						12.00
13.00	NURSERY	43. 00			0.405	45 070 00	0	13.00
14.00	Total (see instructions)			25	9, 125	15, 072. 00	0	14.00
15.00	CAH visits	40.00		0			0	15.00
16.00	SUBPROVI DER - I PF	40.00		0			0	16.00
17. 00	SUBPROVI DER - I RF	41.00		0	_		0	17.00
18.00	SUBPROVI DER	42.00		0	_		0	18.00
19.00	SKILLED NURSING FACILITY	44.00		0	-		0	19.00
20.00	NURSING FACILITY	45.00		0	0		0	20.00
21.00	OTHER LONG TERM CARE	46.00		U	U		0	21. 00 22. 00
22. 00	HOME HEALTH AGENCY	101.00					U	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	115.00		0				
24. 00 24. 10	HOSPICE	116. 00 30. 00		0	0			24. 00 24. 10
25. 00	HOSPICE (non-distinct part) CMHC - CMHC	99. 00					0	25.00
25. 00	CMHC - CORF	99. 00 99. 10					0	25. 00 25. 10
26. 00	1	99. 10 88. 00					0	26. 00
26. 00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER	88. 00 89. 00					0	26. 00
26. 25		89.00		25			U	26. 25
28. 00	Total (sum of lines 14-26) Observation Bed Days			23			0	28.00
29. 00	Ambul ance Trips						U	29.00
30.00	Employee discount days (see instruction)							30.00
31. 00	Employee discount days (see Fristraction)							31.00
32.00	Labor & delivery days (see instructions)			0	0			32.00
32. 00	Total ancillary labor & delivery room			U				32.00
JZ. U1	outpatient days (see instructions)							32.01
33 00	LTCH non-covered days							33. 00
55. 50	2.3 3370104 4433		l		I	ļ		50.00

Health Financial Systems IU HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2015 | Part I | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 151306

				''	0 12/31/2013	5/27/2016 5: 1	
		I/P Days	/ O/P Visits	/ Trins	Full Time I	Equi val ents	O piii
		171 bays	, , 0,1 113113	, 111 ps	Turr Trille	Equi vai onto	
	Component	Title XVIII	Title XIX	Total All	Total Interns	Employees On	
	Component	11 (10)	TI CIO XIX	Patients	& Residents	Payrol I	
		6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and	228	176	628	7. 00	10.00	1. 00
00	8 exclude Swing Bed, Observation Bed and	220	., 0	020			
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)						
2.00	HMO and other (see instructions)	31	0				2.00
3. 00	HMO IPF Subprovider	0	0				3. 00
4. 00	HMO IRF Subprovider	0	0				4. 00
5. 00	Hospital Adults & Peds. Swing Bed SNF	38	0	38			5. 00
6. 00	Hospital Adults & Peds. Swing Bed NF		0	19			6. 00
7. 00	Total Adults and Peds. (exclude observation	266	176	685			7. 00
7.00	beds) (see instructions)	200	170	000			7.00
8. 00	INTENSIVE CARE UNIT	0	0	0			8. 00
9. 00	CORONARY CARE UNIT	0	0	0			9.00
10.00	BURN INTENSIVE CARE UNIT	0	Ö	0			10.00
11. 00	SURGICAL INTENSIVE CARE UNIT	0	0	0			11.00
12. 00	OTHER SPECIAL CARE (SPECIFY)	J	O ₁	O			12.00
13. 00	NURSERY		191	246			13.00
14. 00	Total (see instructions)	266	367	931	0. 00	121. 68	
15. 00	CAH visits	0	0	0	0.00	121.00	15.00
16. 00	SUBPROVI DER - I PF	0	0	0	0. 00	0.00	
17. 00	SUBPROVIDER - I RF	0	0	0	0.00		
18. 00	SUBPROVI DER	0	0	0	0.00	0.00	
19. 00	SKILLED NURSING FACILITY	0	0	0	0. 00	0.00	
20. 00	NURSING FACILITY	J	0	0	0.00	0.00	
21. 00	OTHER LONG TERM CARE		Ŭ	0	0. 00	0.00	
22. 00	HOME HEALTH AGENCY	0	0	0	0. 00	0.00	
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	J	Ŭ	Ü	0. 00	0.00	
24. 00	HOSPI CE	0	0	0	0. 00	0.00	
24. 10	HOSPICE (non-distinct part)	0	0	0	0.00	0.00	24. 10
25. 00	CMHC - CMHC	0	0	0	0. 00	0.00	
25. 10	CMHC - CORF	0	0	0	0.00	l e	
26. 00	RURAL HEALTH CLINIC	0	0	0	0. 00	l	
26. 25	FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0.00		
27. 00	Total (sum of lines 14-26)	O ₁	U	O	0.00	l e	27. 00
28. 00	Observation Bed Days		99	834	0.00	121.00	28.00
29. 00	Ambulance Trips	0	99	034			29.00
30.00	Employee discount days (see instruction)	U		0			30.00
31.00	Employee discount days (see l'istruction)			0			31.00
32.00	Labor & delivery days (see instructions)	0	0	0			32.00
32. 00	Total ancillary labor & delivery room	U	۷	0			32.00
32.01	outpatient days (see instructions)			U			JZ. U1
33 ∪∪	LTCH non-covered days	o					33. 00
33.00	LIGHT HOH-COVELED Days	·				I	33.00

Health Financial SystemsIU HEALHOSPITAL AND HOSPITAL HEALTH CARE COMPLEX STATISTICAL DATA | Peri od: | Worksheet S-3 | From 01/01/2015 | Part I | Date/Time | Prepared: | Provi der CCN: 151306

				To	12/31/2015	Date/Time Pre 5/27/2016 5:1	
		Full Time	'	Di sch	arges	0,2,,,20.0 0	<u> </u>
		Equi val ents					
	Component	Nonpai d	Title V	Title XVIII	Title XIX	Total All	
		Workers				Pati ents	
		11. 00	12. 00	13. 00	14. 00	15. 00	
1. 00	Hospital Adults & Peds. (columns 5, 6, 7 and		0	89	180	424	1.00
	8 exclude Swing Bed, Observation Bed and						
	Hospice days) (see instructions for col. 2						
	for the portion of LDP room available beds)				_		
2.00	HMO and other (see instructions)			12	0		2.00
3. 00	HMO IPF Subprovi der				0		3.00
4. 00	HMO I RF Subprovi der				O		4.00
5. 00	Hospital Adults & Peds. Swing Bed SNF						5.00
6. 00	Hospital Adults & Peds. Swing Bed NF						6.00
7. 00	Total Adults and Peds. (exclude observation						7. 00
0.00	beds) (see instructions)						0.00
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	0.00	0	00	100	404	13.00
14. 00 15. 00	Total (see instructions)	0.00	0	89	180	424	14. 00 15. 00
16. 00	CAH visits SUBPROVIDER - IPF	0.00	0	o	0	0	16.00
17. 00		0. 00 0. 00	0		0	0	17. 00
17.00	SUBPROVI DER - I RF SUBPROVI DER	0.00	0		0	0	17.00
19. 00	SKILLED NURSING FACILITY	0.00	U	١	٩	U	19.00
20. 00	NURSING FACILITY	0.00					20.00
21. 00	OTHER LONG TERM CARE	0.00				0	21.00
22. 00	HOME HEALTH AGENCY	0.00				U	22.00
23. 00	AMBULATORY SURGICAL CENTER (D. P.)	0.00					23. 00
24. 00	HOSPICE	0.00					24.00
24. 10	HOSPICE (non-distinct part)	0.00					24. 10
25. 00	CMHC - CMHC	0.00					25. 00
25. 10	CMHC - CORF	0.00					25. 10
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	0.00					28. 00
29. 00	Ambulance 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						32. 01
	outpatient days (see instructions)						
33.00	LTCH non-covered days						33.00
		1		'	,	!	

ealth Financial Systems IU HEALTH PAOL HOSPITAL UNCOMPENSATED AND INDIGENT CARE DATA	I HOSPITAL Provider	CCN: 151306	Peri od:	u of Form CMS-2 Worksheet S-1	
OST THE GROOM ENOUGE THE THE CENT STILL BITTI	11 ovi dei		From 01/01/2015		
			To 12/31/2015	Date/Time Pre 5/27/2016 5:1	
-				3/2//2010 3. 1	U piii
				1. 00	
Uncompensated and indigent care cost computation					
.00 Cost to charge ratio (Worksheet C, Part I line 202 column 3 Medicaid (see instructions for each line)	divided by li	ne 202 columi	า 8)	0. 371665	1.0
.00 Net revenue from Medicaid				2, 800, 880	2.0
.00 Did you receive DSH or supplemental payments from Medicaid?				Υ Υ	3.
.00 If line 3 is "yes", does line 2 include all DSH or supplemen		from Medicai	/ ?	Υ	4.
.00 If line 4 is "no", then enter DSH or supplemental payments				0	5.
. 00 Medi cai d charges				8, 947, 099	6.
.00 Medicaid cost (line 1 times line 6)				3, 325, 324	7.
.00 Difference between net revenue and costs for Medicaid progra	am (line 7 min	us sum of li	nes 2 and 5; if	524, 444	8.
< zero then enter zero)					
State Children's Health Insurance Program (SCHIP) (see insti	ructions for e	ach line)		0	1
00 Net revenue from stand-alone SCHLP 0.00 Stand-alone SCHLP charges				0	
D.OO Stand-alone SCHIP charges 1.OO Stand-alone SCHIP cost (line 1 times line 10)				0	
2.00 Difference between net revenue and costs for stand-alone SCI	HIP (line 11 m	inus line 0.	if / zero then	0	1
enter zero)	(11110-11-11	irrius Trric 7,	TT \ ZCTO then	O	'2.
Other state or local government indigent care program (see i	instructions f	or each line			
3.00 Net revenue from state or local indigent care program (Not				1, 009, 031	13.
1.00 Charges for patients covered under state or local indigent of	care program (Not included	in lines 6 or	7, 163, 217	14.
10)					
5.00 State or local indigent care program cost (line 1 times line				2, 662, 317	
6.00 Difference between net revenue and costs for state or local	indigent care	program (li	ne 15 minus line	1, 653, 286	16.
13; if < zero then enter zero)					1
Uncompensated care (see instructions for each line) 7.00 Private grants, donations, or endowment income restricted to	o funding char	i ty caro		0	17.
3.00 Government grants, appropriations or transfers for support of				0	1
9.00 Total unreimbursed cost for Medicaid , SCHIP and state and			ns (sum of lines		
8, 12 and 16)	rocar margent	care program	iis (suii or rrrics	2,177,730	' '
		Uni nsured	Insured	Total (col. 1	
		patients	pati ents	+ col . 2) 3.00	
0.00 Total initial obligation of patients approved for charity ca	are (at full	1. 00 2, 661, 63	2. 00 0 577, 844	3, 239, 474	20.
charges excluding non-reimbursable cost centers) for the en		2,001,03	377, 044	3, 237, 474	20.
1.00 Cost of initial obligation of patients approved for charity		989, 23	5 214, 764	1, 203, 999	21.
times line 20)		,		.,,	- · ·
2.00 Partial payment by patients approved for charity care		10	0	100	22.
3.00 Cost of charity care (line 21 minus line 22)		989, 13	5 214, 764	1, 203, 899	23.
				4 00	
1.00 Does the amount in line 20 column 2 include charges for pati	ient dave heve	nd a Length	of stay limit	1. 00 N	24.
imposed on patients covered by Medicaid or other indigent ca		ila a rengtii t	or stay irmit	IV	24.
5.00 If line 24 is "yes," charges for patient days beyond an inc		ogram's Leng	th of stav limit	0	25.
6.00 Total bad debt expense for the entire hospital complex (see				3, 795, 038	
7.00 Medicare bad debts for the entire hospital complex (see ins	,			625, 428	1
• • • • • • • • • • • • • • • • • • • •		s line 27)		3, 169, 610	28.
5. 00 Non-Medicale and non-reimbursable Medicale bad debt expense	(11110 20 1111110				
			e 28)	1, 178, 033	29.
	expense (line		28)	1, 178, 033 2, 381, 932 4, 559, 662	30.

Health Financial Systems	IU HEALTH PAOLI		CCN: 1E1204 E		u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE	OF EXPENSES	Provi der	F	Period: From 01/01/2015	Worksheet A	
			1	To 12/31/2015	Date/Time Pre 5/27/2016 5:1	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat	Reclassi fi ed	O piii
· ·			+ col . 2)	i ons (See	Trial Balance	
				A-6)	(col. 3 +-	
	1. 00	2.00	3.00	4.00	col . 4) 5.00	
GENERAL SERVICE COST CENTERS						
1. 00 00100 CAP REL COSTS-BLDG & FLXT		0		843, 720		1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP 3. 00 00300 OTHER CAP REL COSTS		0		213, 009	213, 009 0	2. 00 3. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	125, 219	1, 154, 381	1, 279, 600	279, 515	1, 559, 115	4.00
5. 00 00500 ADMINISTRATIVE & GENERAL	721, 094	4, 525, 013			4, 300, 004	5. 00
7.00 O0700 OPERATION OF PLANT	342, 743	1, 025, 927	1, 368, 670		903, 818	7. 00
7. 01 00701 UTILITIES 8. 00 00800 LAUNDRY & LINEN SERVICE	0	(1 402	(1 40	450, 758	450, 758 63, 140	7. 01 8. 00
9. 00 00900 LAUNDRY & LINEN SERVICE 9. 00 00900 HOUSEKEEPI NG	192, 092	61, 403 101, 451			277, 749	
10. 00 01000 DI ETARY	181, 241	117, 722			229, 714	10.00
11. 00 01100 CAFETERI A	0	0	(,	65, 344	
13. 00 01300 NURSI NG ADMI NI STRATI ON 13. 01 01301 HOUSE SUPERVI SORS	480, 139 348, 972	92, 413 39, 948			401, 875 375, 423	
14. 00 01400 CENTRAL SERVICES & SUPPLY	5, 868	14, 828			438, 487	
15. 00 01500 PHARMACY	219, 896	1, 514, 121			281, 795	
16. 00 01600 MEDI CAL RECORDS & LI BRARY	0	2, 048	2, 048	0	2, 048	
17. 00 01700 SOCIAL SERVICE 18. 00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0		0	0 0	17. 00 18. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	334, 609	47, 534	382, 143	-15, 487	366, 656	
20. 00 02000 NURSI NG SCHOOL	0	0		0	0	20.00
21. 00 02100 1 &R SERVICES-SALARY & FRINGES APPRV	0	0)	0	0	21.00
22.00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV 23.00 02300 PARAMED ED PRGM-(SPECIFY)	0	0) (0	0	22. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	j U	0	/	<u> </u>	0	23.00
30. 00 03000 ADULTS & PEDIATRICS	1, 082, 008	310, 799	1, 392, 807	-111, 362	1, 281, 445	30.00
31. 00 03100 NTENSI VE CARE UNI T	0	0		0	0	31.00
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT	0	0		0	0	32. 00 33. 00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T		0			0	34.00
40. 00 04000 SUBPROVI DER - I PF	0	0) (0	0	40.00
41. 00 04100 SUBPROVI DER -	0	0		0	0	41.00
42. 00 04200 SUBPROVI DER 43. 00 04300 NURSERY	41, 510	36, 787	78, 297	-30, 750	0 47, 547	42. 00 43. 00
44. 00 04400 SKILLED NURSING FACILITY	0	0) 70, 27,	0	0	44.00
45.00 04500 NURSING FACILITY	0	0) (0	0	45.00
46. 00 04600 OTHER LONG TERM CARE	0	0) (0	0	46. 00
ANCILLARY SERVICE COST CENTERS 50. 00 05000 OPERATING ROOM	435, 277	293, 884	729, 161	-230, 055	499, 106	50.00
51.00 05100 RECOVERY ROOM	0	0	, (0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	52, 367	0	52, 367			
53. 00 05300 ANESTHESI OLOGY 54. 00 05400 RADI OLOGY-DI AGNOSTI C	715, 470	554, 239	1, 269, 709	٧	0 1, 184, 744	
55. 00 05500 RADI OLOGY-THERAPEUTI C	713, 470	034, 239	1, 204, 70	0	1, 184, 744	55.00
56. 00 05600 RADI 0I SOTOPE	0	0) (0	0	56.00
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
60. 00 06000 LABORATORY	16, 373	1, 182, 711	1, 199, 084	-4, 780		
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0) (0	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 64. 00 06400 INTRAVENOUS THERAPY	56, 445	19, 998	76, 443	0 3 -9, 523	66, 920	63.00
65. 00 06500 RESPI RATORY THERAPY	287, 965	60, 650				
66. 00 06600 PHYSI CAL THERAPY	571, 643	75, 544				1
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY	0	0		0	0	
70. 00 07000 ELECTROENCEPHALOGRAPHY		0		o o	Ö	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	11	11	63, 619	63, 630	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0		15, 465	15, 465	
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	0	0		1, 467, 588	1, 467, 588 0	73.00
75. 00 07500 ASC (NON-DISTINCT PART)		0			0	75.00
75. 01 07501 CARDI AC REHAB	61, 475	13, 214	74, 689	-915	73, 774	1
OUTPATIENT SERVICE COST CENTERS			,I		_	00.00
88. 00 08800 RURAL HEALTH CLINIC 89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0		0	0	88. 00 89. 00
90. 00 09000 CLI NI C		0		16, 789	-	1
91. 00 09100 EMERGENCY	1, 136, 556	555, 223	1, 691, 779		1, 522, 107	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	1		I		l	92.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECLASSIFICATION AND ADJUSTMENTS OF TRIAL BALANCE (OF EXPENSES	Provi der		Peri od: From 01/01/2015	Worksheet A	
				To 12/31/2015	Date/Time Pre 5/27/2016 5:1	
Cost Center Description	Sal ari es	Other	Total (col.	1 Reclassi fi cat	Recl assi fi ed	
			+ col . 2)	i ons (See	Tri al Bal ance	
				A-6)	(col. 3 +-	
					col. 4)	
	1. 00	2. 00	3.00	4. 00	5. 00	
OTHER RELMBURSABLE COST CENTERS						

			T	o 12/31/2015	Date/Time Pre 5/27/2016 5:1	
Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cat		
· ·			+ col . 2)	ions (See	Trial Balance	
			,	A-6)	(col. 3 +-	
				·	col. 4)	
	1. 00	2.00	3. 00	4. 00	5. 00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0	105.00
106. 00 10600 HEART ACQUISITION	0	0	0	0	0	106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0	107. 00
108.00 10800 LUNG ACQUI SI TI ON	0	0	0	0	0	108. 00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST EXPENSE		0	0	0	0	113. 00
114.00 11400 UTILIZATION REVIEW-SNF	0	0	0	0	0	114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)	0	0	0	0	0	115.00
116. 00 11600 HOSPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7, 408, 962	11, 799, 849	19, 208, 811	-671	19, 208, 140	118.00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
190.01 19001 VISITING SPECIALTY CLINIC	0	-383	-383	383	0	190. 01
190. 02 19002 OUTREACH	76, 085	31, 448	107, 533	-965	106, 568	190. 02
190. 03 19003 FOUNDATI ON	0	3, 385	3, 385	-773	2, 612	190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	5, 904	5, 904	0		190. 04
190.05 19005 PAOLI FAMILY PRACTICE	0	1, 670		0	1, 670	190. 05
190. 06 19006 OTHER PROPERTY	0	-2, 026	-2, 026	2, 026		190. 06
191. 00 19100 RESEARCH	0	0	0	0		191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	0	0		192. 00
193.00 19300 NONPALD WORKERS	0	0	0	0	0	193. 00
200.00 TOTAL (SUM OF LINES 118-199)	7, 485, 047	11, 839, 847	19, 324, 894	0	19, 324, 894	200. 00

Provi der CCN: 151306

Peri od: From 01/01/2015 To 12/31/2015 Date/Time Prepared:

			5/27/2016 5: 1	
Cost Center Description	Adjustments	Net Expenses		
	(See A-8)	For Allocation		
	6. 00	7.00		
GENERAL SERVICE COST CENTERS				
1. 00 00100 CAP REL COSTS-BLDG & FIXT	104, 231	947, 951		1.00
2. 00 00200 CAP REL COSTS-MVBLE EQUIP	0	l ' l		2.00
3. 00 00300 OTHER CAP REL COSTS 4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT	0 -224, 656	0 1, 334, 459		3. 00 4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL	3, 313, 774	7, 613, 778		5.00
7. 00 00700 OPERATION OF PLANT	-3, 985			7.00
7. 01 00701 UTI LI TI ES	0	450, 758		7. 01
8.00 00800 LAUNDRY & LINEN SERVICE	0	63, 140		8. 00
9. 00 00900 HOUSEKEEPI NG	0	277, 749		9. 00
10. 00 01000 DI ETARY	0	229, 714		10.00
11. 00 01100 CAFETERI A	-35, 136			11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 13. 01 01301 HOUSE SUPERVI SORS	0	401, 875 375, 423		13. 00 13. 01
14. 00 01400 CENTRAL SERVICES & SUPPLY	-1, 714	436, 773		14.00
15. 00 01500 PHARMACY	703	282, 498		15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	-2, 048	0		16.00
17. 00 01700 SOCIAL SERVICE	0	0		17. 00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0		18.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	366, 656		19.00
20. 00 02000 NURSI NG SCHOOL 21. 00 02100 I&R SERVI CES-SALARY & FRI NGES APPRV	0			20.00
22. 00 02200 1&R SERVICES-OTHER PRGM COSTS APPRV	0			22.00
23. 00 02300 PARAMED ED PRGM-(SPECIFY)	0			23. 00
INPATIENT ROUTINE SERVICE COST CENTERS		'		
30. 00 03000 ADULTS & PEDIATRICS	-59, 624	1, 221, 821		30.00
31. 00 03100 INTENSIVE CARE UNIT	0			31.00
32. 00 03200 CORONARY CARE UNIT	0	0		32.00
33. 00 03300 BURN INTENSIVE CARE UNIT 34. 00 03400 SURGICAL INTENSIVE CARE UNIT	0	0		33. 00 34. 00
40. 00 04000 SUBPROVI DER - PF	0			40.00
41. 00 04100 SUBPROVI DER - RF	0	o o		41.00
42. 00 04200 SUBPROVI DER	0	0		42.00
43. 00 04300 NURSERY	0	47, 547		43.00
44.00 04400 SKILLED NURSING FACILITY	0			44.00
45. 00 04500 NURSI NG FACILITY	0	1		45.00
46. 00 O4600 OTHER LONG TERM CARE ANCI LLARY SERVICE COST CENTERS	0	0		46. 00
50. 00 05000 OPERATI NG ROOM	0	499, 106		50.00
51.00 05100 RECOVERY ROOM	0	0		51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	59, 983		52.00
53. 00 05300 ANESTHESI OLOGY	0	0		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	601	1, 185, 345		54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0			55. 00 56. 00
57. 00 05700 CT SCAN	0	0		57.00
58. 00 05800 MRI	0	1		58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		59.00
60. 00 06000 LABORATORY	-3, 280	1, 191, 024		60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0		61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0		62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS. 64.00 06400 INTRAVENOUS THERAPY	0	66, 920		63. 00 64. 00
65. 00 06500 RESPI RATORY THERAPY	0	320, 036		65.00
66. 00 06600 PHYSI CAL THERAPY	-40	1		66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0		67.00
68. 00 06800 SPEECH PATHOLOGY	0	0		68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0		69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0		70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	0	63, 630 15, 465		71. 00 72. 00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0	1, 467, 588		73.00
74. 00 07400 RENAL DIALYSIS	0	0		74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	O		75. 00
75. 01 07501 CARDI AC REHAB	0	73, 774		75. 01
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0	0		88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0	16, 789		89. 00 90. 00
91. 00 09100 EMERGENCY	268, 820	1		91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART				92.00
OTHER REIMBURSABLE COST CENTERS				
94.00 09400 HOME PROGRAM DIALYSIS	0	0		94.00

Health FinancialSystemsIU HEALTHRECLASSIFICATIONAND ADJUSTMENTS OF TRIAL BALANCE OF EXPENSES IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10

| Peri od: | Worksheet A | From 01/01/2015 | To 12/31/2015 | Date/Ti me Prepared: Provi der CCN: 151306

Cost Center Description Adjustments (See A-8) For Allocation 6.00 7.00				To 12/31/2015 Date/Tim	ne Prepared: 6 5:10 pm
(See A-8) For Allocation 6.00 7.00	Cost Center Description	Adi ustments	Net Expenses	37277201	0 3. 10 piii
All ocation 6.00 7.00					
		, ,	Allocation		
OF OO OOFOO AMPHI ANCE SERVICES		6. 00	7. 00		
95. 00 09500 ANIDOLANICE SERVICES 0 0 95. 00	95. 00 09500 AMBULANCE SERVICES	0	0		95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 96. 00	96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	o		96.00
		0	0		97.00
		0	0		98.00
		0	0		99. 00
99. 10 09910 CORF 0 0 99. 10	99. 10 09910 CORF	0	0		99. 10
		0	0		100.00
101.00 10100 HOME HEALTH AGENCY 0 0 101.00		0	0		101. 00
SPECIAL PURPOSE COST CENTERS					
		0	0		105. 00
		0	0		106. 00
		0	0		107. 00
		0	0		108. 00
		0	0		109. 00
		0	0		110.00
		0	0		111.00
		0	0		113.00
		0	0		114.00
		0	0		115.00
		0	0		116. 00
		3, 357, 646	22, 565, 786		118. 00
NONREI MBURSABLE COST CENTERS					
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 190. 00		0	· ·		
190. 01 19001 VI SITING SPECIALTY CLINIC 0 0 190. 01		0	١		
190. 02 19002 OUTREACH 0 106, 568 190. 02		0	· .		
190. 03 19003 FOUNDATI ON 0 2, 612 190. 03		0			
		0			190. 04
190. 05 19005 PAOLI FAMILY PRACTICE 0 1, 670 190. 05		0	1, 670		
190. 06 19006 OTHER PROPERTY 0 0 190. 06		0	0		
		0	0		191.00
		0	0		192.00
		0	0 (00 540		193. 00
200. 00 TOTAL (SUM OF LINES 118-199) 3, 357, 646 22, 682, 540	200.00 TOTAL (SUM OF LINES 118-199)	3, 357, 646	22, 682, 540		200. 00

Heal th Financial Systems

IU HEALTH PAOLI HOSPITAL

Provider CCN: 151306
From 01/01/2015
To 12/31/2015
Prepared: 5/27/2016 5: 10 pm

Cont Gratter						5/27/2016 5: 10 pm
			Increases			
A DEPRICATION 1.00 A 705, 108 2.00		Cost Center	Li ne #	Sal ary	Other	
1.00			3. 00	4. 00	5. 00	
CAP FIEL COSIS-PURGLE COUP 2.00		A - DEPRECIATION				
1.00	1.00	CAP REL COSTS-BLDG & FIXT	1. 00	0	705, 108	1.00
1.00	2.00	CAP REL COSTS-MVBLE EQUIP	2. 00	o	213, 420	2.00
8 - PROPERTY TAX RECLASS 1.00 CAP FILE COSTS-BLOG A FIXT 1.00						
1.00		B - PROPERTY TAX RECLASS	<u> </u>		-, -	
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1.00		0		υĮ	0, 001	
0	1 00		1 00	ما	101 001	1 00
1.00	1.00	CAP REL COSTS-BLDG & FIXT				1.00
1.00 SUPPLYING EIRCH ITS DEPARTMENT 4.00 279,599 1.00 1		0		0	131, 931	
2.00 FOUNDATION 199.03 0 18 2.00 4.00 0.00 0.00 0 0 0 4.00 0.00 0.00 0 0 6.00 0.00 0.00 0 0 6.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 0 7.00 0.00 0.00 7.00						
3.00 4.00 5.00 5.00 6.00 6.00 6.00 6.00 6.00 6	1. 00	EMPLOYEE BENEFITS DEPARTMENT	4. 00	0	279, 529	1.00
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11.00				•	-	
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13.00	12.00		0. 00	ol	O	
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Color	19. 00		000			19.00
1.00		0		0	279, 547	
2.00		E - BILLABLE DRUGS				
2.00	1.00	ADMINISTRATIVE & GENERAL	5. 00		741	1.00
3. 00	2.00	CENTRAL SERVICES & SUPPLY	14.00		40	
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5.00		BROOS CHARGED TO TATTERTS		0		
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11.00	9.00		0. 00	0	0	9. 00
C	10.00		0.00	0	0	10.00
C	11. 00		0.00	0	0	11.00
1. 00 PHARMACY			+		1 468 369	
1.00		F - NON-BILLABLE DRUGS			.,,	
C	1 00		15 00	n	21 328	1 00
C - BILLABLE IMPLANTS	1.00					1.00
1. 00 MPL. DEV. CHARGED TO 72. 00 15, 465 2. 00 2. 00 0 0 0 0 0 0 0 0 0				U _I	۷۱, ۵۷0	
2. 00 PATI ENTS O	1 00		70.00		15 4/5	4 00
2.00	1.00		12.00		15, 465	1.00
D		PATTENTS				
H - BILLABLE SUPPLIES	2. 00		000			2.00
1.00		0		0	15, 465	
2.00						
2.00	1.00	LAUNDRY & LINEN SERVICE	8. 00	T	1, 737	1.00
3. 00 ADULTS & PEDI ATRI CS 30. 00 1, 868 3. 00 4. 00 NURSERY 43. 00 742 4. 00 5. 00 RESPI RATORY THERAPY 65. 00 113 5. 00 6. 00 PHYSI CAL THERAPY 66. 00 616 7. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 PATI ENT 7. 00	2.00	PHARMACY	15. 00		214	2.00
4. 00 NURSERY 43. 00 742 4. 00 5. 00 RESPIRATORY THERAPY 65. 00 113 5. 00 6. 00 PHYSI CAL THERAPY 66. 00 616 6. 00 7. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 63, 618 8. 00 EMERGENCY 91. 00 69, 357 1 - NON-BI LLABLE SUPPLI ES 1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 418, 061 2. 00 PATI ENT 3. 00 OUTREACH 190. 02 0 80 4. 00 OTHER PROPERTY 190. 06 0 2, 026 5. 00 6. 00 0 0 0 0 0 0 6. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		ADULTS & PEDIATRICS				
5. 00 RESPIRATORY THERAPY 65. 00 113 5. 00 6. 00 PHYSI CAL THERAPY 66. 00 616 6. 00 7. 00 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 71. 00 63, 618 7. 00 8. 00 EMERGENCY O O O 69, 357 0 69, 357 8. 00 1 - NON-BI LLABLE SUPPLI ES 1 - NON-BI LLABLE SUPPLI ES CHARGED TO PATI ENT 1 - NON-BI LLABLE SUPPLI ES C						
6. 00 PHYSI CAL THERAPY 66. 00 616 7. 00 MEDI CAL SUPPLIES CHARGED TO 71. 00 63, 618 7. 00 8. 00 EMERGENCY 91. 00 69, 357 I - NON-BI LLABLE SUPPLIES 1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 418, 061 2. 00 PATI ENT 2. 00 MEDI CAL SUPPLIES CHARGED TO 71. 00 0 1 2. 00 PATI ENT 3. 00 OUTREACH 190. 02 0 80 3. 00 4. 00 OTHER PROPERTY 190. 06 0 2, 026 4. 00 5. 00 0 0 0 0 0 0 0 6. 00 0 0 0 0 0 0 0 7. 00 0 0 0 0 0 0 7. 00 0 0 0 0 0 7. 00 0 0 0 0 0 7. 00 0 0 0 0 0 7. 00 0 0 0 0 0 7. 00 0 0 0 0 0 7. 00 0 0 0 0 0 7. 00 0 0 0 0 0 7. 00 0 0 0 0 0 7. 00 0 0 0 0 0 7. 00 0 0 0 0 0 7. 00 0 0 0 0 0 7. 00 0 0 0 0 0 9. 00 0 0 0 0 9. 00 0 0 0 9. 00 0 0 0 9. 00 0 0 0 9. 00 0 9. 00 0 0 9. 00 0						
7. 00 MEDI CAL SUPPLIES CHARGED TO 71. 00 63, 618 7. 00 8. 00 EMERGENCY 91. 00 0 69, 357 I - NON-BI LLABLE SUPPLIES 1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 418, 061 2. 00 MEDI CAL SUPPLIES CHARGED TO 71. 00 0 1 2. 00 PATI ENT 3. 00 OUTREACH 190. 02 0 80 3. 00 4. 00 OTHER PROPERTY 190. 06 0 2, 026 4. 00 5. 00 6. 00 0. 00 0 0 0 0 7. 00 0 0 0 0 0 7. 00 0 0 0 0 0 7. 00 0 0 0 0 7. 00 0 0 0 0 7. 00 0 0 0 0 7. 00 0 0 0 0 7. 00 0 0 0 0 7. 00 0 0 0 0 8. 00 0 0 0 0 0 8. 00 0 0 0 0 0 9. 00 0 0 0 0 9. 00 0 0 0 0 9. 00 0 0 0 9. 00 0 0 0 9. 00 0 0 9. 00 0 0 9. 00 0 0 9. 00 0 0 9. 00 0 0 9. 00 0 0 9. 00 0 0 9. 00 0 0 9. 00 0 0 9. 00 0 0 9. 00 0 0 9. 00 0 9.						
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8. 00 EMERGENCY 91. 00 449 0 69, 357 1 - NON-BI LLABLE SUPPLI ES 1. 00 CENTRAL SERVI CES & SUPPLY 14. 00 0 418, 061 2. 00 MEDI CAL SUPPLI ES CHARGED TO 71. 00 0 1 2. 00 PATI ENT 3. 00 OUTREACH 190. 02 0 80 3. 00 4. 00 OTHER PROPERTY 190. 06 0 2, 026 4. 00 5. 00 0. 00 0 0 0 0 0 0 0 0 0 0 0 0	7.00		/ 1. 00		03, 018	/.00
O O 69, 357 I - NON-BI LLABLE SUPPLI ES 1.00 CENTRAL SERVI CES & SUPPLY 14.00 O 418, 061 2.00 MEDI CAL SUPPLI ES CHARGED TO 71.00 O 1 2.00	0.00		21 25			
I - NON-BILLABLE SUPPLIES	8.00		91.00	+		8.00
1. 00 CENTRAL SERVICES & SUPPLY 14. 00 0 418, 061 2. 00 MEDICAL SUPPLIES CHARGED TO PATIENT 190. 02 0 80 3. 00 4. 00 OTHER PROPERTY 190. 06 0 2, 026 4. 00 5. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	69, 357	
2.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 1 2.00 PATIENT 3.00 OUTREACH 190.02 0 80 3.00 4.00 OTHER PROPERTY 190.06 0 2,026 4.00 5.00 6.00 0 0 0 6.00 6.00 7.00 0 0 0 7.00						
2.00 MEDICAL SUPPLIES CHARGED TO 71.00 0 1 2.00 PATIENT 3.00 OUTREACH 190.02 0 80 3.00 4.00 OTHER PROPERTY 190.06 0 2,026 4.00 5.00 6.00 0 0 0 6.00 6.00 7.00 0 0 0 7.00	1.00	CENTRAL SERVICES & SUPPLY	14. 00	O	418, 061	1.00
PATI ENT 3. 00 OUTREACH 190. 02 0 80 4. 00 OTHER PROPERTY 190. 06 0 2, 026 5. 00 6. 00 0. 00 0 0 5. 00 7. 00 0 0 0 0 0 0 7. 00						•
3. 00 OUTREACH 190. 02 0 80 3. 00 4. 00 OTHER PROPERTY 190. 06 0 2, 026 4. 00 5. 00 6. 00 0 0 0 0 5. 00 7. 00 0 0 0 0 0 7. 00				~	1	2.00
4. 00 OTHER PROPERTY 190. 06 0 2, 026 4. 00 5. 00 6. 00 0 0 5. 00 6. 00 7. 00 0 0 0 0 0 7. 00	3 00		190 02		20	3 00
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8.00 0.00 0 0 8.00				•		
	8.00		0. 00	0	O	8.00
			·		·	·

| Peri od: | Worksheet A-6 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 151306

					5/27/2016 5:	10 pm
		Increases		•		
	Cost Center	Li ne #	Sal ary	Other		
	2. 00	3. 00	4. 00	5. 00		
9.00		0. 00	0	0		9. 00
10.00		0.00	0	0		10.00
11.00		0. 00	0	0		11. 00
12.00		0.00	0	0		12.00
13.00		0. 00	0	0		13.00
14.00		0. 00	0	0		14. 00
15.00		0.00	0	0		15. 00
16.00		0. 00	0	0		16. 00
17. 00		0. 00	0	0		17. 00
18.00		0. 00	0	0		18. 00
19. 00		0.00	•	0		19. 00
	0		0	420, 168		_
	J - UTILITIES					
1. 00	UTILITIES	<u>7.</u> 01	0	<u>450, 758</u>		1.00
	U DI ETARY		0	450, 758		-
1 00	K - DI ETARY	10.00		20, 424		1 00
1. 00 2. 00	DI ETARY	10. 00 19. 00		20, 424		1.00
	NONPHYSICIAN ANESTHETISTS			130		2.00
3.00		0. 00 0. 00	0	0		3. 00 4. 00
4. 00 5. 00		0.00	0	0		5.00
6. 00		0.00	0	0		6.00
7. 00		0.00	0	0		7.00
8. 00		0.00	0	0		8.00
9. 00		0.00	0	0		9.00
10.00		0.00	0	0		10.00
11. 00		0.00	0	0		11.00
11.00			— — ŏ			11.00
	L - CAFE			20,00.		
1.00	CAFETERI A	11. 00	40, 138	25, 206		1.00
			40, 138	25, 206		
	M - COO	'	· · ·			
1.00	ADMINISTRATIVE & GENERAL	5. 00	151, 218	0		1. 00
	TOTALS		151, 218	0		1
	N - L&D					
1.00	NURSERY	43.00	0	5, 878		1.00
2.00	DELIVERY ROOM & LABOR ROOM	<u>52.</u> 00	0_	<u>7, 6</u> 16		2. 00
	0		0	13, 494		
	O - MARKETI NG					
1. 00	OUTREACH	190. 02		4, 510		1.00
2.00		0.00	•	0		2. 00
	TOTALS		0	4, 510		_
4 00	P - VSC	100.01	ام			4
1. 00	VISITING SPECIALTY CLINIC	<u> </u>	•	$ \frac{411}{1}$		1.00
	TOTALS		0	411		_
4 60	Q - CLINIC	221				4
1. 00	CLINIC	90.00		1 <u>6, 7</u> 89		1.00
E00 00	TOTALS		101 254	16, 789		F00 00
ouu. 00	Grand Total: Increases	I	191, 356	3, 863, 096		500.00

Health Financial Systems RECLASSIFICATIONS Provi der CCN: 151306

						5/27/2016 5:	
		Decreases		0.11			
	Cost Center 6.00	Li ne # 7.00	Sal ary 8. 00	0ther 9.00	Wkst. A-7 Ref. 10.00		
	A - DEPRECIATION	7.00	0.00	7.00	10.00		
1.00	ADMINISTRATIVE & GENERAL	5. 00	0	918, 528			1.00
2. 00		0.00	•	0	<u> </u>		2. 00
	0 B - PROPERTY TAX RECLASS		0	918, 528			-
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	6, 611	13		1.00
2. 00	PHARMACY	15. 00	o	70			2.00
	0		0	6, 681			
4 00	C - LEASE	5 00	اء	101 001	1 40		4
1. 00	ADMI NI STRATI VE & GENERAL		0	131, 931			1.00
	D - BENEFITS		υ	131, 931			-
1. 00	ADMINISTRATIVE & GENERAL	5. 00	0	28, 606	0		1.00
2.00	OPERATION OF PLANT	7. 00	О	13, 075			2.00
3.00	HOUSEKEEPI NG	9. 00	0	6, 444			3. 00
4. 00	DI ETARY	10.00	0	5, 338			4.00
5. 00 6. 00	NURSING ADMINISTRATION HOUSE SUPERVISORS	13. 00 13. 01	0	18, 743 13, 497			5. 00 6. 00
7. 00	CENTRAL SERVICES & SUPPLY	14. 00	ő	208			7. 00
8. 00	PHARMACY	15. 00	0	7, 293			8. 00
9. 00	NONPHYSICIAN ANESTHETISTS	19. 00	0	13, 362			9. 00
10.00	ADULTS & PEDIATRICS	30.00	0	46, 079			10.00
11. 00 12. 00	OPERATI NG ROOM RADI OLOGY-DI AGNOSTI C	50. 00 54. 00	0	17, 699 29, 408	1		11. 00 12. 00
13. 00	LABORATORY	60.00	0	238			13. 00
14. 00	INTRAVENOUS THERAPY	64.00	O	2, 302			14. 00
15.00	RESPI RATORY THERAPY	65. 00	0	9, 725	0		15. 00
16. 00	PHYSI CAL THERAPY	66. 00	0	17, 895			16. 00
17. 00 18. 00	CARDI AC REHAB EMERGENCY	75. 01 91. 00	0	52 45, 251			17. 00 18. 00
19. 00	OUTREACH	190. 02	0	45, 251	1		19.00
17.00	0	170.02	— — ŏ				17.00
	E - BILLABLE DRUGS		,				
1.00	PHARMACY	15. 00		1, 451, 221	0		1.00
2. 00	NONPHYSI CI AN ANESTHETI STS	19. 00 30. 00		82			2.00
3. 00 4. 00	ADULTS & PEDIATRICS NURSERY	43. 00		3, 618 109	1		3. 00 4. 00
5. 00	OPERATING ROOM	50.00		4, 717			5. 00
6.00	RADI OLOGY-DI AGNOSTI C	54.00		52			6. 00
7. 00	I NTRAVENOUS THERAPY	64. 00		579	0		7. 00
8. 00 9. 00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65. 00 66. 00		4 13	0		8. 00 9. 00
10.00	EMERGENCY	91.00		7, 636			10.00
11. 00	OUTREACH	190. 02		338			11.00
	0			1, 468, 369			
	F - NON-BILLABLE DRUGS						
1. 00	RADI OLOGY-DI AGNOSTI C	<u>54.</u> 00	0	2 <u>1, 3</u> 28 21, 328			1.00
	G - BILLABLE IMPLANTS		U _I	21, 328			-
1.00	OPERATING ROOM	50.00		14, 723	0		1.00
2.00	EMERGENCY	<u>91.</u> 00		742			2. 00
	0		0	15, 465			
1. 00	H - BILLABLE SUPPLIES CENTRAL SERVICES & SUPPLY	14. 00		102	0		1.00
2. 00	NONPHYSI CI AN ANESTHETI STS	19.00		163			2.00
3. 00	OPERATI NG ROOM	50. 00		66, 786			3. 00
4.00	RADI OLOGY-DI AGNOSTI C	54.00		2, 306	0		4. 00
5.00		0.00	0	0			5. 00
6. 00 7. 00		0. 00 0. 00	0	0	0		6. 00 7. 00
8. 00		0.00	0	0	0		8.00
				69, 357			
	I - NON-BILLABLE SUPPLIES						
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	14			1.00
2. 00 3. 00	ADMINISTRATIVE & GENERAL OPERATION OF PLANT	5. 00 7. 00	0	231 441	0		2. 00 3. 00
4. 00	HOUSEKEEPI NG	9. 00	0	9, 350	0		4.00
5. 00	DI ETARY	10. 00	o	2, 202			5. 00
6. 00	NURSING ADMINISTRATION	13. 00	o	24	0		6. 00
7. 00	PHARMACY	15.00	0	15, 180			7.00
8. 00 9. 00	NONPHYSICIAN ANESTHETISTS ADULTS & PEDIATRICS	19. 00 30. 00	0	2, 010 45, 220			8. 00 9. 00
9. 00 10. 00	NURSERY	43. 00	0	45, 220 37, 261			10.00
11. 00	OPERATI NG ROOM	50.00	Ö	124, 798	1		11. 00
-		·		-	. '		-

Provi der CCN: 151306

Peri od: Worksheet A-6
From 01/01/2015
To 12/31/2015 Date/Time Prepared: 5/27/2016 5: 10 pm

						5/27/2016 5:	10 pm
		Decreases					
	Cost Center	Li ne #	Sal ary	0ther	Wkst. A-7 Ref.		
	6. 00	7. 00	8. 00	9. 00	10.00		
12.00	RADI OLOGY-DI AGNOSTI C	54. 00	0	31, 754	0		12.00
13.00	LABORATORY	60.00	0	4, 542	0		13.00
14.00	INTRAVENOUS THERAPY	64. 00	0	4, 938	0		14.00
15.00	RESPI RATORY THERAPY	65. 00	O	18, 963	0		15.00
16.00	PHYSI CAL THERAPY	66. 00	o	7, 810	o		16.00
17.00	CARDI AC REHAB	75. 01	0	863			17. 00
18. 00	EMERGENCY	91. 00	0	114, 539			18.00
19. 00	VISITING SPECIALTY CLINIC	190. 01	0	28			19.00
17.00	0		— —	420, 168			17.00
	J - UTILITIES		O _I	420, 100			-
1. 00	OPERATION OF PLANT	7. 00	0	450, 758	0		1.00
1.00	0		— — ŏ	450, 758			1.00
	K - DI ETARY	L	<u> </u>	430, 730			-
1. 00	ADMINISTRATIVE & GENERAL	5. 00		7, 735	0		1.00
2. 00	OPERATION OF PLANT	7. 00		7, 739 578			2.00
	NURSING ADMINISTRATION	13. 00		602			1
3.00							3.00
4. 00	ADULTS & PEDIATRICS	30.00		4, 819			4.00
5. 00	OPERATING ROOM	50.00		1, 332			5. 00
6. 00	RADI OLOGY-DI AGNOSTI C	54.00		117			6. 00
7. 00	INTRAVENOUS THERAPY	64.00		1, 704			7. 00
8.00	PHYSI CAL THERAPY	66. 00		38			8. 00
9.00	EMERGENCY	91.00		1, 953	0		9. 00
10.00	OUTREACH	190. 02		885			10.00
11.00	FOUNDATI ON	190. 03			0		11.00
	0		0	20, 554			
	L - CAFE						
1.00	DI ETARY	10.00	40, 138	25, 206	0		1.00
		- $ +$	40, 138	2 <u>5,</u> 206			1
	M - COO						
1.00	NURSING ADMINISTRATION	13.00	151, 218	0	0		1.00
	TOTALS	$+$	151, 218				
	N - L&D	· · · · · · · · · · · · · · · · · · ·	, ,		·		
1.00	ADULTS & PEDIATRICS	30.00	0	13, 494	0		1.00
2. 00		0.00	0	0	0		2.00
2.00				13, 494	<u> </u>		1 2.00
	O - MARKETING		9	10, 171			
1. 00	ADMINISTRATIVE & GENERAL	5, 00		4, 420	0		1.00
2. 00	NURSING ADMINISTRATION	13. 00	•	90			2.00
2.00	TOTALS			$ \frac{70}{4,510}$			2.00
	P - VSC		<u> </u>	4, 310			-
1. 00	CAP REL COSTS-MVBLE EQUIP	2.00	0	411	9		1.00
1.00	TOTALS	— — - - 		411			1.00
	Q - CLINIC		Ŋ	411			-
1 00	DI ETARY	10.00	ما	14 700	O		1 00
1. 00	TOTALS	<u> </u>	— — 씢	1 <u>6, 7</u> 89	— — Ч		1.00
F00 00			0	16, 789			F00 00
500.00	Grand Total: Decreases	ı	191, 356	3, 863, 096			500.00

Health Financial Systems
RECONCILIATION OF CAPITAL COSTS CENTERS Provi der CCN: 151306

					o 12/31/2015	Date/Time Pre 5/27/2016 5:1	pared: O pm
				Acqui si ti ons			
		Begi nni ng	Purchases	Donati on	Total	Disposals and	
		Bal ances				Retirements	
		1. 00	2. 00	3. 00	4.00	5. 00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	57, 843		(90, 157	0	1.00
2.00	Land Improvements	508, 588	0	(0	70, 124	2.00
3.00	Buildings and Fixtures	5, 980, 020	0	(0	1, 238, 298	3.00
4.00	Building Improvements	253, 197	0	(0	0	4.00
5.00	Fixed Equipment	6, 183, 771	191, 232	(191, 232	0	5.00
6.00	Movable Equipment	4, 561, 424	0	(0	838, 968	6. 00
7.00	HIT designated Assets	0	0	(0	0	7. 00
8.00	Subtotal (sum of lines 1-7)	17, 544, 843	281, 389	(281, 389	2, 147, 390	8.00
9.00	Reconciling Items	0	0	(0	0	9. 00
10.00	Total (line 8 minus line 9)	17, 544, 843	281, 389	(281, 389	2, 147, 390	10.00
		Endi ng	Ful I y				
		Bal ance	Depreci ated				
			Assets				
		6. 00	7. 00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	148, 000	0				1.00
2.00	Land Improvements	438, 464	0				2.00
3.00	Buildings and Fixtures	4, 741, 722	0				3. 00
4.00	Building Improvements	253, 197	0				4.00
5.00	Fixed Equipment	6, 375, 003	0				5.00
6.00	Movable Equipment	3, 722, 456	0				6.00
7.00	HIT designated Assets	0	0				7. 00
8.00	Subtotal (sum of lines 1-7)	15, 678, 842	0				8. 00
9.00	Reconciling Items	0	0				9. 00
10.00	Total (line 8 minus line 9)	15, 678, 842	0				10.00

Heal th	n Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der	CCN: 151306	Peri od: From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
			SI	JMMARY OF CAP	<u> </u> ТА	5/27/2016 5: 1	O pm
	Cost Center Description	Depreciation	Lease	Interest	Insurance	Taxes (see	
					,	instructions)	
		9. 00	10. 00	11. 00	instructions)	13. 00	
	PART II - RECONCILIATION OF AMOUNTS FROM WOR			and 2	12.00	13.00	
1.00	CAP REL COSTS-BLDG & FIXT	0	0		0 0	0	1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	0	0		0 0	0	3.00
		SUMMARY 0	F CAPITAL				
	Cost Center Description	Other	Total (1)	1			
	cost center bescription	Capi tal -Rel at					
		ed Costs (see					
		instructions)					
		14. 00	15. 00				
	PART II - RECONCILIATION OF AMOUNTS FROM WOR	KSHEET A, COLUM	MN 2, LINES 1 a	and 2			
1.00	CAP REL COSTS-BLDG & FIXT	0	0				1.00
2.00	CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3. 00	Total (sum of lines 1-2)	0	0	1			3.00

Heal th	n Financial Systems	IU HEALTH PAC	DLI HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provi der		Period: From 01/01/2015 To 12/31/2015	Worksheet A-7 Part III Date/Time Prep 5/27/2016 5:10	pared:
		COMI	COMPUTATION OF RATIOS ALLOCATION OF OTHER CAPITA				
	Cost Center Description	Gross Assets	Capi tal i zed	Gross Assets		Insurance	
			Leases	for Ratio (col. 1 - col. 2)	instructions)		
		1. 00	2.00	3.00	4. 00	5. 00	
	PART III - RECONCILIATION OF CAPITAL COSTS C						
1.00	CAP REL COSTS-BLDG & FIXT	5, 581, 383		-,,			1.00
2.00	CAP REL COSTS-MVBLE EQUIP	10, 097, 460		10, 097, 46			2.00
3. 00	Total (sum of lines 1-2)	15, 678, 843		15, 678, 84			3. 00
		ALLOCATION OF OTHER CAPITAL SUMMARY OF CAPITAL					
	Cost Center Description	Taxes	Other	Total (sum of	F Depreciation	Lease	
			Capi tal -Rel at				
			ed Costs	through 7)			
	DART III DECONOLITATION OF CARLTAL COCTO	6. 00	7. 00	8. 00	9. 00	10.00	
1. 00	PART III - RECONCILIATION OF CAPITAL COSTS C	ENTERS 0	0		0 809, 339	131, 931	1. 00
2.00	CAP REL COSTS-BLDG & FIXT	0	l .		0 213, 009		2.00
3. 00	Total (sum of lines 1-2)	0			0 1, 022, 348		3.00
3.00	Trotal (Sam of Trites 1 2)	0	Sl	JMMARY OF CAPI		131, 731	3.00
	Cost Center Description	Interest	Insurance	Taxes (see	Other	Total (2)	
			(see	instructions)	Capi tal -Relat		
			instructions)		ed Costs (see	9 through 14)	
					instructions)		
		11. 00	12. 00	13. 00	14. 00	15. 00	
4 00	PART III - RECONCILIATION OF CAPITAL COSTS C				4	0.47 054	4 00
1. 00 2. 00	CAP REL COSTS-BLDG & FIXT CAP REL COSTS-MVBLE EQUIP	0	1	-,		947, 951 213, 009	1. 00 2. 00
2. 00 3. 00	Total (sum of lines 1-2)	0	1		٥		
3.00	Total (Suiii Of TITIES 1-2)	1	1	J 0, 08	1	1, 100, 960	3.00

Health Financial Systems
ADJUSTMENTS TO EXPENSES Provi der CCN: 151306

					rom 01/01/2015 o 12/31/2015		
				Expense Classification on		5/27/2016 5: 1	O pm
				To/From Which the Amount is	to be Adjusted		
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7	
	·	(2) 1. 00	2. 00	3.00	4. 00	Ref. 5.00	
1. 00	Investment income - CAP REL	1.00		CAP REL COSTS-BLDG & FLXT	1.00	5.00	1.00
2. 00	COSTS-BLDG & FIXT (chapter 2) Investment income - CAP REL		0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	2.00
2.00	COSTS-MVBLE EQUIP (chapter 2)		0	CAP REL COSTS-WVBEL EQUIP	2.00	J	2.00
3. 00	Investment income - other (chapter 2)		0		0.00	0	3. 00
4. 00	Trade, quantity, and time		0		0.00	0	4. 00
5. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5. 00
	expenses (chapter 8)		0		0.00		
6. 00	Rental of provider space by suppliers (chapter 8)		0		0.00	0	6. 00
7. 00	Telephone services (pay stations excluded) (chapter		0		0. 00	0	7. 00
	21)						
8. 00	Television and radio service (chapter 21)		0		0.00	0	8. 00
9. 00	Parking Lot (chapter 21)		0		0.00	0	9. 00
10. 00	Provider-based physician adjustment	A-8-2	-1, 357, 707			0	10.00
11. 00	Sale of scrap, waste, etc.		0		0.00	0	11.00
12. 00	(chapter 23) Related organization	A-8-1	6, 480, 183			0	12.00
12.00	transactions (chapter 10)				0.00		12.00
13. 00 14. 00	1 -	В	-35, 136	CAFETERI A	0. 00 11. 00	0	13. 00 14. 00
15. 00	Rental of quarters to employee and others		0		0.00	0	15. 00
16. 00	Sale of medical and surgical	В	-1, 447	CENTRAL SERVICES & SUPPLY	14. 00	0	16. 00
	supplies to other than patients						
17. 00	Sale of drugs to other than	В	703	PHARMACY	15. 00	0	17. 00
18. 00	patients Sale of medical records and	В	-2. 048	MEDICAL RECORDS & LIBRARY	16. 00	0	18. 00
	abstracts		,				
19. 00	Nursing school (tuition, fees, books, etc.)		0		0.00	0	19. 00
20.00	Vending machines		0		0. 00 0. 00	0	20. 00 21. 00
21. 00	interest, finance or penalty		U		0.00	U	21.00
22. 00	charges (chapter 21) Interest expense on Medicare		0		0.00	0	22. 00
22.00	overpayments and borrowings to		0		0.00	J	22.00
23. 00	repay Medicare overpayments Adjustment for respiratory	A-8-3	n	RESPI RATORY THERAPY	65. 00	-	23. 00
	therapy costs in excess of						
24. 00	limitation (chapter 14) Adjustment for physical	A-8-3	0	PHYSI CAL THERAPY	66. 00		24.00
	therapy costs in excess of limitation (chapter 14)						
25. 00	Utilization review -		0	UTILIZATION REVIEW-SNF	114. 00		25. 00
	physicians' compensation (chapter 21)						
26. 00	Depreciation - CAP REL		0	CAP REL COSTS-BLDG & FIXT	1. 00	0	26. 00
27. 00	COSTS-BLDG & FIXT Depreciation - CAP REL	-	0	CAP REL COSTS-MVBLE EQUIP	2. 00	0	27. 00
	COSTS-MVBLE EQUIP						
28. 00 29. 00	1 ' 3		0	NONPHYSICIAN ANESTHETISTS	19. 00 0. 00	0	28. 00 29. 00
30. 00	Adjustment for occupational	A-8-3	0	OCCUPATIONAL THERAPY	67. 00		30.00
	therapy costs in excess of limitation (chapter 14)						
30. 99	Hospice (non-distinct) (see instructions)		0	ADULTS & PEDIATRICS	30.00		30. 99
31. 00	Adjustment for speech	A-8-3	0	SPEECH PATHOLOGY	68. 00		31.00
	pathology costs in excess of limitation (chapter 14)						
		ı	l	1	1 I		

Heal t	h Financial Systems		IU HEALTH PAC	DLI HOSPITAL	In Lie	In Lieu of Form CMS-2552-10		
ADJUS	TMENTS TO EXPENSES		Provi der CCN: 151306 Peri od:			Worksheet A-8		
					From 01/01/2015			
					To 12/31/2015	Date/Time Pre 5/27/2016 5:1		
				Expense Classification o	n Workshoot A	3/2//2010 3. 1	O pili	
				To/From Which the Amount is				
				To thom will on the fundament	r to be haj astea			
	Cost Center Description	Basi s/Code	Amount	Cost Center	Li ne #	Wkst. A-7		
		(2)				Ref.		
		1. 00	2. 00	3. 00	4. 00	5. 00		
32.00		A	-33, 577	CAP REL COSTS-MVBLE EQUIP	2. 00	9	32.00	
	Depreciation and Interest	_						
	MI SCELLANEOUS REVENUE (5.00)	В		ADMINISTRATIVE & GENERAL	5. 00			
	MI SCELLANEOUS REVENUE (7.00)	В		OPERATION OF PLANT	7. 00		33. 02	
33. 03	` ,	В		ADULTS & PEDIATRICS	30. 00		33. 03	
33. 04	` ,	В	· ·	LABORATORY	60. 00		33. 04	
	MI SCELLANEOUS REVENUE (66.00)	В		PHYSI CAL THERAPY	66. 00		33. 05	
33. 06	1	Α		ADMINISTRATIVE & GENERAL	5. 00		33. 06	
33. 07	1	A		EMPLOYEE BENEFITS DEPARTMEN		0	33. 07	
33. 08	1	A		ADMINISTRATIVE & GENERAL	5. 00	0	33. 08	
22 00	CONTRI DUTI ONC	ι Λ	E 4 E	IADMINICTDATIVE O CENEDAL	E 00	l ^	22 00	

0

3, 357, 646

-545 ADMINISTRATIVE & GENERAL

-1, 320, 701 EMPLOYEE BENEFITS DEPARTMENT

-267 CENTRAL SERVICES & SUPPLY

5.00

14.00

4.00

0.00

0.00

33.09

33.10

33. 11

33.12 33. 13

50.00

column 6, line 200.) (1) Description - all chapter references in this column pertain to CMS Pub. 15-1.

Α

Α

TOTAL (sum of lines 1 thru 49)

(Transfer to Worksheet A,

CONTRI BUTI ONS

CONTRI BUTI ONS

33. 11 BENEFIT EXPENSE

33.09

33. 10

33. 12

33. 13

50.00

⁽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.

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

Provider CCN: 151306 From 01/01/2015

Worksheet A-8-1

UITTOL	0313			To 12/31/2015	Date/Time Pre 5/27/2016 5:1	pared: 0 pm
	Li ne No.	Cost Center	Expense Items	Amount of	Amount	
			·	Allowable Cost	Included in	
					Wks. A, column	
					5	
	1. 00	2. 00	3. 00	4. 00	5. 00	
	A. COSTS INCURRED AND ADJUSTI	MENTS REQUIRED AS A RESULT OF	TRANSACTIONS WITH RELATED O	RGANI ZATI ONS OF	CLAIMED HOME	
	OFFICE COSTS:					
1.00	5. 00	ADMINISTRATIVE & GENERAL	IUHBH MGMT SVC FEE	3, 896, 769	0	1.00
2.00	2. 00	CAP REL COSTS-MVBLE EQUIP	IUH MGMT SVC FEE	33, 577	0	2.00
3.00	1.00	CAP REL COSTS-BLDG & FIXT	IUH MGMT SVC FEE	104, 231	0	3.00
3. 01	4.00	EMPLOYEE BENEFITS DEPARTMENT	IUH MGMT SVC FEE	1, 218, 622	0	3.01
3.02	5. 00	ADMINISTRATIVE & GENERAL	IUH MGMT SVC FEE	2, 722, 466	3, 064, 986	3.02
3.03	7. 00	OPERATION OF PLANT	IUH MGMT SVC FEE	13, 423	13, 423	3.03
3.04	8.00	LAUNDRY & LINEN SERVICE	IUH MGMT SVC FEE	63, 140	63, 140	3.04
3.05	10.00	DI ETARY	IUH MGMT SVC FEE	21, 688	21, 688	3.05
3. 08	60.00	LABORATORY	IUH MGMT SVC FEE	1, 073, 802	1, 073, 802	3.08
3.09	66.00	PHYSI CAL THERAPY	IUH MGMT SVC FEE	67, 361	67, 361	3.09
3. 10	75. 01	CARDI AC REHAB	IUH MGMT SVC FEE	60, 263	60, 263	3. 10
3. 11	91.00	EMERGENCY	PBP ED COVERAGE	1, 851, 390	281, 886	3. 11
3. 12	0.00			0	o	3. 12
4.00	0.00			0	o	4.00
5.00	TOTALS (sum of lines 1-4).			11, 126, 732	4, 646, 549	5.00
	Transfer column 6, line 5 to				1	
	Worksheet A-8, column 2,				1	
	line 12.				ı	
* The	amounts on Lines 1-4 (and sub	nscripts as appropriate) are	transferred in detail to Wor	ksheet A colum	n 6 lines as	

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

			Related Organization(s) and/	or Home Office	
Symbol (1)	Name	Percentage of	Name	Percentage of	
		Ownershi p		Ownershi p	
1. 00	2. 00	3. 00	4. 00	5. 00	
B. INTERRELATIONSHIP TO RELAT	TED ORGANIZATION(S) AND/OR HO	ME OFFICE:			

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

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

6. 00	В	O. OO I U HEALTH BLOOM O. OO	6. 00
7. 00	В	O. OO I U HEALTH O. OC	7. 00
8. 00	С	0.00 IUH SIP 0.00	8. 00
9. 00		0.00	9. 00
10.00		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
- E. Individual is director, officer, administrator, or key person of provider and related organization.
- F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der

Health	Financial Syste	ems		IU HEALI	H PAOLI H	IOSPI TAL		In Lieu	a of Form CMS-	2552-10
STATEME	NT OF COSTS OF	SERVICES FROM	RELATED	ORGANI ZATI ONS AN	ID HOME	Provi der	CCN: 151306	Peri od:	Worksheet A-8	3-1
OFFICE	COSTS							From 01/01/2015		
								To 12/31/2015		
	N-±	WI+ A 7 D-6				Ь		L.	5/27/2016 5:	lo pili
		Wkst. A-7 Ref.								
	Adjustments									
	(col. 4 minus									
	col. 5)*									
	6. 00	7. 00								
		RED AND ADJUST	MENTS REG	QUIRED AS A RESUL	T OF TRAN	ISACTIONS \	WITH RELATED	ORGANI ZATI ONS OR	CLAIMED HOME	
	OFFICE COSTS:									
1.00	3, 896, 769	C								1.00
2.00	33, 577	9								2.00
3.00	104, 231	9								3.00
3. 01	1, 218, 622		ol .							3. 01
3. 02	-342, 520									3. 02
3. 03	0									3. 03
3. 04	0									3. 04
3. 05	0	1								3.05
3. 08	0									3. 08
3. 09	0									3.09
	0									
3. 10	1 5/0 50/		1							3. 10
3. 11	1, 569, 504	1 ()							3.11

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

3.12

4.00

5.00

nas no	t been posted to worksheet A,	cordinis i and/or 2, the amount arrowable should be mareated in cordinir 4 or this part	
	Rel ated Organi zation(s)		
	and/or Home Office		
	Type of Business		
	6.00		
	B. INTERRELATIONSHIP TO RELA	TED ORGANIZATION(S) AND/OR HOME OFFICE:	

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

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

6. 00	HOSPI TAL	6.00
7.00	HOME OFFICE	7.00
8.00	PHYSICIAN GROUP	8.00
9. 00 10. 00		9.00
10.00		10.00
100.00		100.00

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

0

0

6, 480, 183

3.12

4.00

5.00

0

- A. Individual has financial interest (stockholder, partner, etc.) in both related organization and in provider.
- Corporation, partnership, or other organization has financial interest in provider.
- Provider has financial interest in corporation, partnership, or other organization.
- D. Director, officer, administrator, or key person of provider or relative of such person has financial interest in related organi zati on.
- E. Individual is director, officer, administrator, or key person of provider and related organization.

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

PROVIDER BASED PHYSICIAN ADJUSTMENT

Provi der CCN: 151306 Peri od: From 01/01/2015

Worksheet A-8-2

200.00

1, 357, 707

12/31/2015 Date/Time Prepared: 5/27/2016 5: 10 pm Wkst. A Line # Cost Center/Physician Total Professi onal Provi der RCE Amount Physi ci an/Prov I denti fi er der Component Remuneration Component Component Hours 1.00 2.00 3. 00 4.00 5.00 6 00 7 00 30.00 ADULTS & PEDIATRICS 1.00 57, 624 57,624 0 1.00 0 2.00 54. 00 RADI OLOGY-DI AGNOSTI C -601 -601 0 0 2.00 60. 00 LABORATORY 3.00 54, 869 0 54, 869 0 0 0 3.00 75. 01 CARDI AC REHAB 6, 000 0 4.00 6,000 4.00 0 91. 00 EMERGENCY 5.00 1,851,390 1, 300, 684 550, 706 0 5.00 6.00 0.00 6.00 0 7.00 0.00 0 0 0 0 7.00 0.00 8.00 0 0 8.00 0 0 9.00 0.00 0 0 0 9.00 10.00 0.00 0 10.00 1, 969, 282 1, 357, 707 611, 575 200.00 200.00 Wkst. A Line # Cost Center/Physician Unadjusted RCE 5 Percent of Provi der Physician Cost Cost of I denti fi er Li mi t Unadjusted RCE Memberships & Component of Malpractice Limit Conti nui ng Share of col Insurance Education 12.00 1.00 2.00 8. 00 9.00 13.00 14. 00 1.00 30.00 ADULTS & PEDIATRICS 0 0 1.00 2.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 0 0 0 2.00 60. 00 LABORATORY 0 0 3.00 0 0 3.00 0 75. 01 CARDI AC REHAB 0 4.00 0 4 00 5.00 91. 00 EMERGENCY 0 0 0 5.00 0.00 0 0 6.00 0 0 0 0 6.00 0.00 0 0 7 00 7.00 0 0.00 0 0 0 8.00 0 8.00 9.00 0.00 0 0 9.00 0 10.00 0.00 0 0 0 0 10.00 0 200.00 200.00 Wkst. A Line # Cost Center/Physician Provi der Adjusted RCE RCE Adjustment I denti fi er Component Limit Di sal I owance Share of col. 14 16. 00 18.00 1.00 2.00 15.00 17.00 1.00 30. 00 ADULTS & PEDIATRICS 0 0 0 57,624 1.00 2.00 54. 00 RADI OLOGY-DI AGNOSTI C 0 -601 2.00 0 0 3.00 60. 00 LABORATORY 0 3.00 C 75. 01 CARDI AC REHAB 0 4.00 4.00 5.00 91. 00 EMERGENCY 0 0 0 1, 300, 684 5.00 6.00 0.00 0 0 0 6.00 0.00 0 7.00 7 00 0 0 0.00 0 8.00 0 0 8.00 9.00 0.00 0 0 9.00 0 0 10.00 0.00 0 0 10.00

200.00

Health Financial Systems IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provider CCN: 151306 Peri od: Worksheet B From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/27/2016 5:10 pm CAPITAL RELATED COSTS Net Expenses BLDG & FIXT MVBLE EQUIP **EMPLOYEE** Subtotal Cost Center Description **BENEFITS** for Cost DEPARTMENT Allocation (from Wkst A col. 7) 0 1.00 2.00 4. 00 4A GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 947, 951 947, 951 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 213,009 213,009 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 1, 334, 459 1, 335, 696 4.00 1,001 4.00 236 |00500| ADMINISTRATIVE & GENERAL 7, 896, 616 5.00 7, 613, 778 123, 027 28 943 130,868 5.00 7.00 00700 OPERATION OF PLANT 899, 833 74,607 17, 552 62, 203 1,054,195 00701 UTI LI TI ES 7.01 450, 758 450, 758 7.01 00800 LAUNDRY & LINEN SERVICE 63, 140 8 00 5 179 1 218 69 537 |00900|HOUSEKEEPI NG 9.00 277, 749 13, 309 3, 131 34,862 329, 051 9.00 10.00 01000 DI ETARY 229, 714 27, 878 6,559 32, 893 297, 044 11.00 01100 CAFETERI A 30, 208 17, 348 4,081 51, 637 01300 NURSING ADMINISTRATION 87 138 13 00 401 875 8, 994 500, 123 13 00 2, 116 13.01 01301 HOUSE SUPERVI SORS 375, 423 63, 333 438, 756 13.01 01400 CENTRAL SERVICES & SUPPLY 436, 773 35, 387 8, 325 481, 550 14.00 1,065 14.00 01500 PHARMACY 282, 498 20, 179 4,747 39, 908 347, 332 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 0 21, 578 5,076 0 26, 654 16.00 17.00 01700 SOCIAL SERVICE 0 0 17.00 0 0 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 0 0 01900 NONPHYSICIAN ANESTHETISTS O 427, 383 19 00 366, 656 C 60,727 19 00 02000 NURSING SCHOOL 20.00 0 C 0 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 0 02200 | &R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 0 ol 0 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 0 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 1, 221, 821 134, 542 31,652 196, 368 1,584,383 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 03200 CORONARY CARE UNIT 32 00 0 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 C 0 03400 SURGICAL INTENSIVE CARE UNIT 34 00 0 0 0 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 0 0 0 40.00 0 0 40.00 41 00 0 r 0 0 0 41 00 04200 SUBPROVI DER 42.00 0 42.00 04300 NURSERY 43.00 47, 547 4, 316 1,015 7,533 60, 411 04400 SKILLED NURSING FACILITY 44.00 44.00 0 0 45.00 04500 NURSING FACILITY 0 0 45.00 46.00 04600 OTHER LONG TERM CARE 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 499, 106 104, 039 24, 476 78.996 706, 617 50.00 51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM 59, 983 3,073 723 9,504 73, 283 52.00 05300 ANESTHESI OLOGY 53.00 53.00 0 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 1, 185, 345 100, 707 23, 692 129, 847 1, 439, 591 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 05600 RADI OI SOTOPE 0 56.00 0 0 56.00 0 05700 CT SCAN 57 00 0 C 0 0 Ω 57 00 58.00 05800 MRI 0 0 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 0 59.00 06000 LABORATORY 1, 191, 024 2.971 60.00 31, 814 7.484 1, 233, 293 60.00 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY Λ 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 64 00 06400 INTRAVENOUS THERAPY 66 920 6.905 10 244 85, 693 64 00 1 624 06500 RESPIRATORY THERAPY 65.00 320, 036 4, 902 1, 153 52, 261 378, 352 65.00 06600 PHYSI CAL THERAPY 622, 007 43, 035 10, 124 103, 745 778, 911 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 0 0 06800 SPEECH PATHOLOGY 0 68 00 68 00 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 63.630 0 ol 63.630 71.00

MCRI F32 - 8, 8, 159, 0

Health Financial Systems IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - GENERAL SERVICE COSTS Provi der CCN: 151306 Peri od: Worksheet B From 01/01/2015 Part I Date/Time Prepared: 12/31/2015 5/27/2016 5:10 pm CAPITAL RELATED COSTS BLDG & FIXT **EMPLOYEE** Cost Center Description Net Expenses MVBLE EQUIP Subtotal for Cost BENEFLTS DEPARTMENT Allocation (from Wkst A col. 7) 4. 00 0 1.00 2.00 4A 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 0 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 0 95.00 09500 AMBULANCE SERVICES 0 0 o 95.00 0 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 0 96.00 0 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 98.00 0 99.00 109900 CMHC 0 99.00 0 99. 10 09910 CORF 99. 10 0 0 0 100.00 10000 I &R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 107.00 108. 00 10800 LUNG ACQUISITION 0 0 108 00 0 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 0 0 110.00 0 0 111.00 11100 I SLET ACQUISITION 0 0 o 0 111.00 0 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 0 116,00 118.00 SUBTOTALS (SUM OF LINES 1-117) 22, 565, 786 867, 458 204, 074 1, 321, 888 22, 462, 550 118. 00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 190. 00 34, 956 190.01 19001 VISITING SPECIALTY CLINIC 43, 180 190. 01 8, 224 0 0 190. 02 19002 OUTREACH 106, 568 18, 798 0 13, 808 139, 174 190. 02 190. 03 19003 FOUNDATI ON 3, 021 6, 344 190. 03 2,612 711 5, 904 190. 04 19004 SPRING VALLEY FAMILY PRACTICE 0 5, 904 190. 04 0 190. 05 19005 PAOLI FAMILY PRACTICE 1, 670 190. 05 1,670 0 0 190.06 19006 OTHER PROPERTY 23, 718 0 23, 718 190. 06 191. 00 19100 RESEARCH 0 0 0 191.00 0 ol 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 192.00 0 0 C 193. 00 19300 NONPALD WORKERS O 0 193.00 0 C 0 200.00 Cross Foot Adjustments 0 200. 00

22, 682, 540

947.951

213, 009

1, 335, 696

0 201.00

22, 682, 540 202. 00

201.00

202.00

Negative Cost Centers

TOTAL (sum lines 118-201)

Provi der CCN: 151306

| Peri od: | Worksheet B | From 01/01/2015 | Part I | To 12/31/2015 | Date/Time Prepared:

				1	0 12/31/2015	Date/lime Pre 5/27/2016 5:1	
	Cost Center Description	ADMI NI STRATI V	OPERATION OF	UTILITIES	LAUNDRY &	HOUSEKEEPI NG	
		E & GENERAL	PLANT	7.04	LINEN SERVICE	2.22	
	GENERAL SERVICE COST CENTERS	5. 00	7. 00	7. 01	8. 00	9. 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
5.00	00500 ADMINISTRATIVE & GENERAL	7, 896, 616					5.00
7.00	00700 OPERATION OF PLANT	563, 007	1, 617, 202				7. 00
7. 01	00701 UTI LI TI ES	240, 733	0	691, 491			7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE	37, 137	13, 246	4, 902	124, 822	554 407	8.00
9.00	00900 HOUSEKEEPI NG 01000 DI ETARY	175, 734	34, 043	12, 598	0	551, 426	9.00
10. 00 11. 00	01100 CAFETERI A	158, 640 27, 577	71, 309 44, 375	26, 389 16, 422	0	24, 932 15, 515	10.00 11.00
13. 00	01300 NURSING ADMINISTRATION	267, 097	23, 004	8, 513	0	8, 043	1
13. 01	01301 HOUSE SUPERVI SORS	234, 323	0	0	0	0,0.0	13. 01
14.00	01400 CENTRAL SERVICES & SUPPLY	257, 178	90, 517	33, 497	0	0	14.00
15. 00	01500 PHARMACY	185, 497	51, 617	19, 101	0	0	15. 00
16. 00	01600 MEDICAL RECORDS & LIBRARY	14, 235	55, 193	20, 425	0	19, 297	16.00
17.00	01700 SOCIAL SERVICE	0	0	0	0	0	17.00
18. 00 19. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18. 00 19. 00
20. 00	01900 NONPHYSI CLAN ANESTHETI STS 02000 NURSI NG SCHOOL	228, 249	0	0	0	0	20.00
21. 00	02100 &R SERVICES-SALARY & FRINGES APPRV	0	0	0	0	0	21.00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	Ö	0	0	0	22.00
23. 00	02300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDI ATRI CS	846, 160	344, 140	127, 353	38, 161	120, 324	30.00
31. 00	03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32.00	03200 CORONARY CARE UNIT	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 SURGI CAL INTENSIVE CARE UNIT 04000 SUBPROVI DER - IPF	0	0	0	0	0	34. 00 40. 00
41. 00	04100 SUBPROVI DER – TFF	0	0	0	0	0	41.00
42. 00	04200 SUBPROVI DER	0	0	0	0	0	42.00
43. 00	04300 NURSERY	32, 263	11, 039	4, 085	285	3, 859	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0		44.00
45.00	04500 NURSING FACILITY	0	0	0	0	0	45.00
46. 00	04600 OTHER LONG TERM CARE	0	0	0	0	0	46. 00
FO 00	ANCILLARY SERVICE COST CENTERS	277 270	2// 110	00.401	0.000	02.044	
50. 00 51. 00	05000 OPERATING ROOM 05100 RECOVERY ROOM	377, 378	266, 119 0	98, 481 0	9, 999	93, 044 0	50. 00 51. 00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	39, 138	7, 859	2, 909	367	2, 748	ı
53.00	05300 ANESTHESI OLOGY	07,100	0	2, 707	0	2, 7.10	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	768, 832	257, 597	95, 327	20, 375	90, 065	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00	05600 RADI 0I SOTOPE	0	0	0	0	0	56. 00
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 06000 LABORATORY	658, 656	81, 377	20 11E	0	0 28, 452	
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	036, 030	01, 3//	30, 115	U	20, 432	60. 00 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
	06400 I NTRAVENOUS THERAPY	45, 765	17, 662	6, 536	0	6, 175	64.00
65.00	06500 RESPIRATORY THERAPY	202, 064	12, 540	4, 641	0	4, 384	65.00
66.00	06600 PHYSI CAL THERAPY	415, 988	8, 787	40, 736	8, 686	38, 487	66. 00
	06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
	06800 SPEECH PATHOLOGY	0	0	0	0	0	68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0	0	69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	33, 982	0	0	0	0	71.00
	07200 IMPL. DEV. CHARGED TO PATIENTS	8, 259	0	0	0	0	72.00
	07300 DRUGS CHARGED TO PATIENTS	783, 784	0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75. 00
75. 01	07501 CARDI AC REHAB	55, 733	40, 225	14, 886	0	14, 064	75. 01
00.00	OUTPATIENT SERVICE COST CENTERS				_	_	00.00
	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	88. 00 89. 00
	09000 CLINIC	8, 966	0	0	0	0	90.00
91.00	09100 EMERGENCY	1, 112, 752	178, 826	66, 177	46, 949	62, 523	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART	1,112,732	170,020	00, 177	70, 747	02, 323	92.00
	OTHER REIMBURSABLE COST CENTERS						1
	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
	09500 AMBULANCE SERVICES	0	0	0	_	0	
96. 00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96. 00

| Peri od: | Worksheet B | From 01/01/2015 | Part | To | 12/31/2015 | Date/Time Prepared:

			Т	o 12/31/2015	Date/Time Pre 5/27/2016 5:1	
Cost Center Description	ADMI NI STRATI V	OPERATION OF	UTILITIES	LAUNDRY &	HOUSEKEEPI NG	O pili
oost content boschipthon	E & GENERAL	PLANT	011211120	LINEN SERVICE	HOUSEREEFFING	
	5. 00	7. 00	7. 01	8. 00	9. 00	
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
99. 00 09900 CMHC	0	0	0	0	0	99. 00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0	0		105. 00
106. 00 10600 HEART ACQUISITION	0	0	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108. 00 10800 LUNG ACQUISITION	0	0	0	0		108. 00
109. 00 10900 PANCREAS ACQUI SI TI ON	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0		110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
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		115. 00
116. 00 11600 HOSPI CE	0	0	0	0		116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	7, 779, 127	1, 609, 475	633, 093	124, 822	531, 912	118. 00
NONREI MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190.00
190.01 19001 VISITING SPECIALTY CLINIC	23, 061	0	33, 088	0		190. 01
190. 02 19002 OUTREACH	74, 328	l .	0	0	•	190. 02
190. 03 19003 FOUNDATI ON	3, 388		2, 859	0	•	190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	3, 153	0	0	0		190. 04
190. 05 19005 PAOLI FAMILY PRACTICE	892	0	0	0		190. 05
190. 06 19006 OTHER PROPERTY	12, 667	0	22, 451	0		190. 06
191. 00 19100 RESEARCH	0	0	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
193. 00 19300 NONPALD WORKERS	0	0	0	0	0	193.00
200.00 Cross Foot Adjustments						200.00
201.00 Negative Cost Centers	7 00/ /1/	0	(04, 404	104 000		201.00
202.00 TOTAL (sum lines 118-201)	7, 896, 616	1, 617, 202	691, 491	124, 822	551, 426	1202.00

Provi der CCN: 151306

In Lieu of Form CMS-2552-10

Period:	Worksheet B
From 01/01/2015	Part
To 12/31/2015	Date/Time Prepared:
5/27/2016 5:10 pm	

Cost Contor Deparintion	DIETADY	CAFETERIA	MIDELNC	UOUSE	5/27/2016 5:1	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG ADMI NI STRATI O	HOUSE SUPERVI SORS	CENTRAL SERVICES &	
	10. 00	11. 00	N 13. 00	13. 01	SUPPLY 14.00	
GENERAL SERVICE COST CENTERS			I			
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP						1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT						2.00 4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5.00
7.00 00700 OPERATION OF PLANT						7.00
7. 01 00700 OPERATION OF PLANT 7. 01 00701 UTI LI TI ES						7.00
8.00 00800 LAUNDRY & LINEN SERVICE						8.00
9. 00 00900 HOUSEKEEPI NG						9.00
10. 00 01000 DI ETARY	578, 314					10.00
11. 00 01100 CAFETERI A	0	155, 526				11.00
13. 00 01300 NURSING ADMINISTRATION		8, 059				13.00
13. 01 01301 HOUSE SUPERVI SORS	O	8, 047		681, 126		13. 01
14.00 01400 CENTRAL SERVICES & SUPPLY	0	485		0	863, 227	14.00
15. 00 01500 PHARMACY	o	6, 298	0	0	0	15.00
16.00 01600 MEDICAL RECORDS & LIBRARY	0	0	О	0	0	16.00
17. 00 01700 SOCI AL SERVI CE	o	0	0	0	0	17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18. 00
19. 00 01900 NONPHYSICIAN ANESTHETISTS	0	3, 299	0	0	0	19. 00
20. 00 02000 NURSI NG SCHOOL	0	0	0	0	0	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	0	0	22.00
23. 00 O2300 PARAMED ED PRGM-(SPECIFY)	0	0	0	0	0	23.00
INPATIENT ROUTINE SERVICE COST CENTERS	F70 044	20.7/0	204 000	054.404		00.00
30. 00 03000 ADULTS & PEDI ATRI CS	578, 314	30, 768		254, 131	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T	0	0	0	0	0 0	31.00
32.00 03200 CORONARY CARE UNIT 33.00 03300 BURN INTENSIVE CARE UNIT		0		0	0	32. 00 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		0		0	0	40.00
41. 00 04100 SUBPROVI DER - 1 RF		0		0	0	41.00
42. 00 04200 SUBPROVI DER		0	0	0	Ö	42.00
43. 00 04300 NURSERY	0	2, 780	27, 465	22, 958	ő	43.00
44. 00 04400 SKILLED NURSING FACILITY	l o	2,700	0	0	Ö	44.00
45.00 04500 NURSING FACILITY	o	0	0	0	0	45.00
46.00 04600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	0	11, 163	110, 299	92, 199	6, 347	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	3, 507	34, 651	28, 965	0	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	20, 518	0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56. 00 05600 RADI 01 SOTOPE	0	0	0	0	0	56.00
57. 00 05700 CT SCAN	0	0	0	0	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	0	1 104	0	0	_	59.00
60.00 06000 LABORATORY 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	١	1, 104	1	U	318, 296	60. 00 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 I NTRAVENOUS THERAPY		1, 326	13, 102	10, 952	0	64.00
65. 00 06500 RESPIRATORY THERAPY		8, 845		0,732	ő	65.00
66. 00 06600 PHYSI CAL THERAPY		13, 393		0	Ö	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	o	0	Ō	0	0	67.00
68.00 06800 SPEECH PATHOLOGY	o	0	0	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	o	0	0	0	0	69.00
70.00 07000 ELECTROENCEPHALOGRAPHY	o	0	0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	o	0	0	0	433, 262	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	105, 322	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75. 01 07501 CARDI AC REHAB	0	52	0	0	0	75. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89.00
90. 00 09000 CLI NI C	0	0	0	0	0	90.00
91. 00 09100 EMERGENCY	0	32, 922	325, 302	271, 921	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00
OTHER REIMBURSABLE COST CENTERS 94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0				
. 1. 13 Jordan June Deliver Del	<u>, </u>			<u> </u>		, , , , , , ,

Provi der CCN: 151306

| Peri od: | Worksheet B | From 01/01/2015 | Part | | To | 12/31/2015 | Date/Time Prepared:

			10	12/31/2015	Date/lime Prep 5/27/2016 5:10	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	HOUSE	CENTRAL	У Ріп
			ADMI NI STRATI O	SUPERVI SORS	SERVICES &	
			N		SUPPLY	
	10.00	11. 00	13.00	13. 01	14. 00	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99. 00 09900 CMHC	0	0	0	0	0	99.00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0		105.00
106. 00 10600 HEART ACQUISITION	0	0	0	0		106. 00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107. 00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110. 00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST 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	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	578, 314	152, 566	814, 839	681, 126	863, 227	118. 00
NONRE MBURSABLE COST CENTERS				<u> </u>		
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
190.01 19001 VISITING SPECIALTY CLINIC	0	0	0	0		190. 01
190. 02 19002 OUTREACH	0	2, 960	0	0		190. 02
190. 03 19003 FOUNDATI ON	0	0	0	0		190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0		190. 04
190.05 19005 PAOLI FAMILY PRACTICE	0	0	0	0		190. 05
190. 06 19006 OTHER PROPERTY	0	0	0	0		190. 06
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES	0	0	0	0		192. 00
193. 00 19300 NONPALD WORKERS	0	0	0	0	•	193. 00
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)	578, 314	155, 526	814, 839	681, 126	863, 227	202. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS | Peri od: | Worksheet B | From 01/01/2015 | Part I | To 12/31/2015 | Date/Time Prepared: Provi der CCN: 151306

				'	0 12/31/2015	Date/lime Pre 5/27/2016 5:1	
			'		OTHER GENERAL		
	Cost Center Description	PHARMACY	MEDI CAL	SOCI AL	SERVI CE (SPECI FY)	NONPHYSI CI AN	
	cost center bescription	THANWACT	RECORDS &	SERVI CE	(SI LCITT)	ANESTHETI STS	
			LI BRARY				
	GENERAL SERVICE COST CENTERS	15. 00	16. 00	17. 00	18. 00	19.00	
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. 00 7. 00	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5. 00 7. 00
7. 00 7. 01	00700 OPERATION OF PLANT						7.00
8.00	00800 LAUNDRY & LINEN SERVICE						8.00
9. 00	00900 HOUSEKEEPI NG						9. 00
10. 00 11. 00	01000 DI ETARY 01100 CAFETERI A						10.00
13.00	01300 NURSING ADMINISTRATION						13.00
13. 01	01301 HOUSE SUPERVI SORS						13. 01
14. 00	01400 CENTRAL SERVICES & SUPPLY						14.00
15. 00 16. 00	01500 PHARMACY	609, 845	125 004				15.00
17. 00	01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE		135, 804 0				16. 00 17. 00
18. 00	01850 OTHER GENERAL SERVICE (SPECIFY)	l o	0	Č			18.00
19. 00	01900 NONPHYSICIAN ANESTHETISTS	O	0	C	0	658, 931	19. 00
20.00	02000 NURSI NG SCHOOL	0	0	C	1	•	20.00
21. 00 22. 00	02100 &R SERVICES-SALARY & FRINGES APPRV 02200 &R SERVICES-OTHER PRGM COSTS APPRV	0	0				21. 00 22. 00
	02300 PARAMED ED PRGM-(SPECIFY)		0				23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS				-		
30.00		0	1, 866	i e			1
31. 00 32. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT	0	0			1	1
33. 00	03300 BURN INTENSIVE CARE UNIT		0			_	1
34.00	03400 SURGICAL INTENSIVE CARE UNIT	o	0	C		1	
40.00	04000 SUBPROVI DER - I PF	0	0	1		1	40.00
41. 00 42. 00	04100 SUBPROVI DER - I RF 04200 SUBPROVI DER	0	0	1	0	0	41.00 42.00
43.00	04300 NURSERY		762			1	43.00
44.00	04400 SKILLED NURSING FACILITY	O	0	C	0	0	1
45.00	04500 NURSING FACILITY	0	0			l .	1
46. 00	04600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS] 0	0		0	0	46. 00
50.00		O	16, 947		0	658, 931	50.00
51.00	05100 RECOVERY ROOM	0	0	1			1
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	2, 358	C	0	_	52.00
53. 00 54. 00	05300 ANESTHESI OLOGY 05400 RADI OLOGY-DI AGNOSTI C	0	0 23, 582		0	0	53. 00 54. 00
55. 00	05500 RADI OLOGY-THERAPEUTI C		23, 362			0	55.00
56.00	05600 RADI 0I SOTOPE	O	0	C	Ö	o	1
	05700 CT SCAN	0	0	C	1	_	
58. 00 59. 00	05800 MRI 05900 CARDI AC CATHETERI ZATI ON	0	0			0	1
60.00			22, 761			0	1
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00		0	0	C	0	0	1
63. 00 64. 00		26, 595	0 10, 186			0	
65.00		20, 373	1, 789			0	1
66.00	06600 PHYSI CAL THERAPY	o	3, 812		0	0	66.00
	06700 OCCUPATI ONAL THERAPY	0	0	C	0	0	67.00
68.00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	0	0		0	0	68. 00 69. 00
70.00			0) 0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		914		o	o o	I
	07200 I MPL. DEV. CHARGED TO PATIENTS	0	280		0	0	
	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS	583, 250	14, 723 0	1	0	0	
75.00	07500 ASC (NON-DISTINCT PART)		0				1
	07501 CARDI AC REHAB		483	· -			1
	OUTPATIENT SERVICE COST CENTERS					1	1
	08800 RURAL HEALTH CLINIC	0	0	C	0		
	08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC		0 65			0	
	09100 EMERGENCY		35, 276		o o	ő	1
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART						92.00

				То	12/31/2015	Date/Time Pre 5/27/2016 5:1	
				(OTHER GENERAL	072772010 0. 1	J piii
					SERVI CE		
Cost Center Description	PHARMACY	MEDI CAL	SOCI AL		(SPECI FY)	NONPHYSI CI AN	
		RECORDS &	SERVI CE			ANESTHETI STS	
	15. 00	16. 00	17.00		18. 00	19. 00	
OTHER REIMBURSABLE COST CENTERS	15.00	16.00	17.00		16.00	19.00	
94. 00 09400 HOME PROGRAM DI ALYSI S	ol	0	1	0	ol	0	94.00
95. 00 09500 AMBULANCE SERVICES	o	0	,	0	o	0	95.00
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0		0	o	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0		0	o	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	o	0		0	o	0	98. 00
99. 00 09900 CMHC	0	0		0	0	0	99.00
99. 10 09910 CORF	0	0		0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0)	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0	0		0	0	0	101. 00
SPECIAL PURPOSE COST CENTERS							
105. 00 10500 KIDNEY ACQUISITION	0	0	1	0	0		105.00
106. 00 10600 HEART ACQUISITION	0	0	1	0	0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0	0		107.00
108. 00 10800 LUNG ACQUI SI TI ON	0	0		0	0		108.00
109. 00 10900 PANCREAS ACQUISITION	0	0		0	0		109.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON	0	0		0	0		110.00
111.00 11100 I SLET ACQUI SITION 113.00 11300 I NTEREST EXPENSE	U	U	1	U	۷		111. 00 113. 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	0		0	0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	609, 845	135, 804	Ί	0	0	658, 931	
NONREI MBURSABLE COST CENTERS	007, 043	133, 004	1	<u> </u>	<u> </u>	030, 731	1110.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	Ol	0		O	ol	0	190. 00
190. 01 19001 VISITING SPECIALTY CLINIC	ol	0		Ö	ol		190. 01
190. 02 19002 OUTREACH	o	0)	0	o		190. 02
190. 03 19003 FOUNDATI ON	o	0		0	o	0	190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	o	0	(0	o	0	190. 04
190.05 19005 PAOLI FAMILY PRACTICE	o	0		0	o	0	190. 05
190. 06 19006 OTHER PROPERTY	o	0		0	o	0	190. 06
191. 00 19100 RESEARCH	0	0)	0	0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	1	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	0	0	1	0	0		201.00
202.00 TOTAL (sum lines 118-201)	609, 845	135, 804	1	0	0	658, 931	J202. 00

	Financial Systems ALLOCATION - GENERAL SERVICE COSTS	IU HEALTH PAG	OLI H		CCN: 151306	ח	In Lie	u of Form CMS- Worksheet B	2552-10
	NELOCATION - GENERAL SERVICE CUSIS			ri ovi der	CUN. 1313U6		rom 01/01/2015	Part I Date/Time Pre	
	Cost Center Description	NURSI NG SCHOOL			RESI DENTS SERVI CES-0 R PRGM COS		PARAMED ED PRGM	Subtotal	
		20. 00		21. 00	APPRV 22. 00		23. 00	24. 00	
	GENERAL SERVICE COST CENTERS		1						
1. 00 2. 00 4. 00 5. 00 7. 00 7. 01 8. 00 9. 00 11. 00 13. 01 14. 00 15. 00 17. 00 18. 00	O0100 CAP REL COSTS-BLDG & FIXT O0200 CAP REL COSTS-MVBLE EQUIP O0400 EMPLOYEE BENEFITS DEPARTMENT O0500 ADMINISTRATIVE & GENERAL O0700 OPERATION OF PLANT O0701 UTILITIES O0800 LAUNDRY & LINEN SERVICE O0900 HOUSEKEEPING O1000 DIETARY O1100 CAFETERIA O1300 NURSING ADMINISTRATION O1301 HOUSE SUPERVISORS O1400 CENTRAL SERVICES & SUPPLY O1500 PHARMACY O1600 MEDICAL RECORDS & LIBRARY O1700 SOCIAL SERVICE (SPECIFY) O1900 NONPHYSICIAN ANESTHETISTS								1.00 2.00 4.00 5.00 7.01 8.00 9.00 11.00 13.00 13.01 14.00 15.00 16.00 17.00 18.00
20. 00 21. 00 22. 00 23. 00	02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)	C)	0)	0	0		20. 00 21. 00 22. 00 23. 00
30. 00 31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00 46. 00	INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY			0 0 0 0 0 0 0 0		0 0 0 0 0 0 0	0 0 0 0 0 0 0	4, 229, 620 C C C C C C C T65, 907	31.00 32.00 33.00 34.00 40.00 41.00 42.00 43.00 44.00 45.00
50. 00 51. 00 52. 00 53. 00 54. 00 55. 00 56. 00 57. 00 58. 00 69. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00	ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 05100 RECOVERY ROOM 05200 DELIVERY ROOM & LABOR ROOM 05300 ANESTHESIOLOGY 05400 RADIOLOGY-DIAGNOSTIC 05500 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05600 RADIOLOGY-THERAPEUTIC 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06600 OCCUPATIONAL THERAPY 06600 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROCARDIOLOGY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENT 07300 DRUGS CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 07501 CARDIAC REHAB			000000000000000000000000000000000000000			0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	2, 447, 524 C	50. 00 51. 00 52. 00 53. 00 55. 00 55. 00 56. 00 57. 00 58. 00 61. 00 62. 00 63. 00 64. 00 65. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 01
89. 00 90. 00 91. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART			0 0 0 0		0 0 0	0 0 0 0	0 0 25, 820 4, 216, 199	89. 00 90. 00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 Worksheet B Part I Date/Time Prepared: 5/27/2016 5:10 pm Provi der CCN: 151306 Peri od: From 01/01/2015 To 12/31/2015 INTERNS & RESIDENTS Cost Center Description NURSI NG SERVI CES-SALA | SERVI CES-OTHE PARAMED ED Subtotal R PRGM COSTS SCH00L RY & FRINGES PRGM APPRV APPRV 20. 00 21. 00 22.00 23.00 24.00 OTHER RELMBURSARIE COST CENTERS

OTHER REIM	MBURSABLE COST CENTERS						
94.00 09400 HOME	PROGRAM DIALYSIS	0	0	0	0	0 94.	00
95. 00 09500 AMBU	JLANCE SERVICES	0	0	0	0	0 95.	00
96. 00 09600 DURA	ABLE MEDICAL EQUIP-RENTED	O	0	0	o	0 96.	00
97. 00 09700 DURA	ABLE MEDICAL EQUIP-SOLD	O	0	0	o	0 97.	00
98. 00 09850 OTHE	R REIMBURSABLE COST CENTERS	О	0	0	o	0 98.	00
99.00 09900 CMHC		0	o	0	o	0 99.	00
99. 10 09910 CORF	=	0	o	0	o	0 99.	10
100. 00 10000 I &R	SERVICES-NOT APPRVD PRGM	0	O	0	o	0 100.	00
101. 00 10100 HOME	HEALTH AGENCY	0	O	0	o	0 101.	00
SPECIAL PL	JRPOSE COST CENTERS				<u> </u>		
105. 00 10500 KI DN	NEY ACQUISITION	0	0	0	0	0 105.	00
106. 00 10600 HEAR	RT ACQUISITION	0	0	0	0	0 106.	00
107. 00 10700 LI VE	R ACQUISITION	0	0	0	0	0 107.	00
108. 00 10800 LUNG	G ACQUISITION	0	0	0	0	0 108.	00
109. 00 10900 PANC	CREAS ACQUISITION	0	0	0	0	0 109.	00
110. 00 11000 I NTE	STINAL ACQUISITION	0	0	0	0	0 110.	00
111. 00 11100 I SLE	ET ACQUISITION	0	0	0	0	0 111.	00
113. 00 11300 I NTE	REST EXPENSE					113.	00
114. 00 11400 UTI L	IZATION REVIEW-SNF					114.	00
115. 00 11500 AMBU	JLATORY SURGICAL CENTER (D.P.)	0	0	0	0	0 115.	00
116. 00 11600 HOSP	PLCE	0	0	0	0	0 116.	00
118. 00 SUBT	OTALS (SUM OF LINES 1-117)	0	0	0	0	22, 256, 462 118.	00
NONREI MBUF	RSABLE COST CENTERS						
190. 00 19000 GI FT	, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0	0 190.	00
190. 01 19001 VI SI	TING SPECIALTY CLINIC	0	0	0	0	99, 329 190.	01
190. 02 19002 OUTR		0	0	0	0	233, 274 190.	02
190. 03 19003 FOUN		0	0	0	0	23, 020 190.	03
190. 04 19004 SPRI	NG VALLEY FAMILY PRACTICE	0	0	0	0	9, 057 190.	04
190. 05 19005 PAOL	I FAMILY PRACTICE	0	0	0	0	2, 562 190.	05
190. 06 19006 OTHE	R PROPERTY	0	0	0	0	58, 836 190.	06
191. 00 19100 RESE	EARCH	0	0	0	0	0 191.	00
192. 00 19200 PHYS	SICIANS' PRIVATE OFFICES	0	0	0	0	0 192.	00
193. 00 19300 NONP	PALD WORKERS	0	0	0	0	0 193.	00
200.00 Cros	ss Foot Adjustments	0	0	0	0	0 200.	00
	ntive Cost Centers	0	0	0	0	0 201.	
202. 00 TOTA	AL (sum lines 118-201)	0	0	0	0	22, 682, 540 202.	00

Health Financial Systems
COST ALLOCATION - GENERAL SERVICE COSTS IU HEALTH PAOLI HOSPITAL

Provi der CCN: 151306

				То	12/31/2015 Date/Time 5/27/2016	
	Cost Center Description	Intern &	Total			3. 10 piii
		Resi dents				
		Cost & Post				
		Stepdown Adjustments				
		25. 00	26. 00	-		
	GENERAL SERVICE COST CENTERS					
1.00	00100 CAP REL COSTS-BLDG & FIXT					1.00
2. 00 4. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT					2. 00 4. 00
5. 00	00500 ADMINISTRATIVE & GENERAL					5.00
7. 00	00700 OPERATION OF PLANT					7. 00
7. 01	00701 UTI LI TI ES					7. 01
8. 00	00800 LAUNDRY & LINEN SERVICE					8. 00
9. 00 10. 00	00900 HOUSEKEEPI NG 01000 DI ETARY					9. 00 10. 00
11. 00	01100 CAFETERI A					11.00
13. 00	01300 NURSI NG ADMI NI STRATI ON					13.00
13. 01	01301 HOUSE SUPERVI SORS					13. 01
14.00	I I					14.00
15.00						15.00
16. 00 17. 00						16. 00 17. 00
18. 00						18.00
19. 00						19. 00
20.00	1 1					20.00
21.00	02100 I &R SERVICES-SALARY & FRINGES APPRV					21.00
22.00	02200 I&R SERVICES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECIFY)					22. 00
23.00	INPATIENT ROUTINE SERVICE COST CENTERS					23.00
30.00		0	4, 229, 620			30.00
31. 00	1 1	0	0			31.00
32.00	1 1	0	0			32.00
33. 00 34. 00	+ I	0	0			33. 00 34. 00
40. 00	1 1	0				40.00
41.00	+ I	0	o			41.00
42.00	1 1	0	0	l .		42.00
43.00	+ I	0	165, 907			43.00
44. 00 45. 00	04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0	0	1		44. 00 45. 00
46. 00	1 1	0	Ö	1		46.00
	ANCILLARY SERVICE COST CENTERS					
	05000 OPERATING ROOM	0	, ,	1		50.00
51. 00 52. 00	1	0	0 195, 785			51. 00 52. 00
53. 00		0	175, 765			53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	2, 715, 887			54.00
55. 00	1 1	0	0			55.00
56.00		0	0			56.00
	05700 CT SCAN 05800 MRI	0	0			57. 00 58. 00
	05900 CARDI AC CATHETERI ZATI ON	0				59.00
60.00	+ I	0	2, 374, 054			60.00
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0			61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0			62.00
	06300 BLOOD STORING, PROCESSING & TRANS. 06400 INTRAVENOUS THERAPY	0	223, 992			63. 00 64. 00
	06500 RESPIRATORY THERAPY	0	612, 615	1		65. 00
66. 00	06600 PHYSI CAL THERAPY	0	1, 308, 800	1		66. 00
67. 00		0	0			67. 00
	06800 SPEECH PATHOLOGY	0	0			68.00
	06900 ELECTROCARDI OLOGY 07000 ELECTROENCEPHALOGRAPHY	0	0			69. 00 70. 00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		531, 788			71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	129, 326			72. 00
	07300 DRUGS CHARGED TO PATIENTS	0	2, 849, 345			73.00
	07400 RENAL DIALYSIS	0	0			74.00
	07500 ASC (NON-DISTINCT PART) 07501 CARDI AC REHAB	0	0 229, 800			75. 00 75. 01
73.01	OUTPATIENT SERVICE COST CENTERS	0	227, 000	'I		73.01
88. 00	08800 RURAL HEALTH CLINIC	0	0			88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			89. 00
	09000 CLINIC	0	25, 820	1		90.00
	09100 EMERGENCY 09200 OBSERVATION BEDS (NON-DISTINCT PART	0	4, 216, 199			91. 00 92. 00
,2.00	1872301 SECTION SEES (NON SISTING) TAKE	1	I	I		1 /2.00

Provider CCN: 151306 | Period: | Worksheet B | From 01/01/2015 | Part I

			From 01/01/2015	ared:
			5/27/2016 5: 10	pm
Cost Center Description	Intern &	Total		
	Resi dents			
	Cost & Post			
	Stepdown			
	Adjustments			
	25. 00	26. 00		
OTHER REIMBURSABLE COST CENTERS				
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		94.00
95. 00 09500 AMBULANCE SERVICES	0	0		95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED	0	0		96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		98. 00
99. 00 09900 CMHC	0	0		99.00
99. 10 09910 CORF	0	0		99. 10
100.00 10000 I &R SERVI CES-NOT APPRVD PRGM	0	0		00.00
101. 00 10100 HOME HEALTH AGENCY	0	0	10	01. 00
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUISITION	0		1/	05. 00
106. 00 10600 REART ACQUISITION	0	0		05. 00 06. 00
	0	0		06. 00 07. 00
107.00 10700 LIVER ACQUISITION 108.00 10800 LUNG ACQUISITION	0	0		07.00
109. 00 10900 PANCREAS ACQUISITION		0		08.00
110. 00 11000 NTESTI NAL ACQUI SI TI ON		0		10. 00
111. 00 11000 INTESTINAL ACQUISITION		0	l l	10.00
113.00 1130 NTEREST_EXPENSE	١	٩		13.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF				14.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)		0	l l	15. 00
116. 00 11600 HOSPICE	0	0		16.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)		22, 256, 462		18. 00
NONREI MBURSABLE COST CENTERS	<u> </u>	22, 230, 402		10.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	19	90. 00
190. 01 19001 VISITING SPECIALTY CLINIC	0	99, 329		90. 01
190. 02 19002 OUTREACH	ol	233, 274	19	90. 02
190. 03 19003 FOUNDATI ON	ol	23, 020	19	90. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	o	9, 057		90. 04
190. 05 19005 PAOLI FAMILY PRACTICE	o	2, 562	19	90. 05
190. 06 19006 OTHER PROPERTY	o	58, 836	19	90. 06
191. 00 19100 RESEARCH	o	o		91. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	o	19	92.00
193. 00 19300 NONPALD WORKERS	o	o	19	93. 00
200.00 Cross Foot Adjustments	o	o	20	00.00
201.00 Negative Cost Centers	0	o	20	01.00
202.00 TOTAL (sum lines 118-201)	0	22, 682, 540	20	02.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151306

Cost Center Description						Io	12/31/2015	Date/lime Pre 5/27/2016 5:1	
Chemical Strovice Cost Centres					CAPI TAL REI	LATED COSTS		072772010 0. 1	O piii
Chemical Strovice Cost Centres									
CEREAL SERVICE COST CENTERS			Cost Center Description		BLDG & FIXT	MVBLE EQUIP	Subtotal		
Selected STRING COST CENTRES 0									
DENERAL SERVICE COST CENTERS								DEI AKTMENT	
0.00 0.00					1. 00	2.00	2A	4. 00	
2.00				,					
4.00 00400 DIFFLOYER BENEFITS DEPARTMENT 0 1.001 230, 27 28, 943 151, 970 121 5.00 0.000 DIFFLOYER & CENERAL 0 123, 027 28, 943 151, 970 121 5.00 7.00		1	•						
5.00 00-600 (AMM INSTRATIVE & GENERAL 0 123,027 28,943 151,970 121 5.00 7.00 00-70 00-74,607 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 00-77 00-74 0				0	1 001	236	1 237	1 237	
7.00 0.0700 OPERATION OF PLANT 0 74,607 17,552 92,159 58 7.00 7.01 0.0701 UTILITIES 0 0 0 0 0 0 0 0 0		1	l .	0					
8.00 0800 LANDRY & LINEN SERVICE 0 5,179 1,218 6,307 0 8,00 0000 01000 DISTARY 0 27,878 6,559 34,437 30 10.00 11.00 1				0					
9.00 09900 HOUSEKEEN ING				0	-	_	۰		
10.00 01000 DETARY 0 27,878 6.559 34,437 30 10.00 10.00 0.00 CAFFTERIA 0 17,348 4.081 21,479 0 11.00 13.00 0300 NURSI NIS CADMINI STRATION 0 8,994 2,116 11,110 81 13.00		1	•	0		' '			
11. DO 1100 CAFETERIA		1	•	0					
13.00 01300 NURSING ADMINISTRATION 0 8, 994 2, 116 11, 110 81 13.00 13.01 101301 HOUSE SUPPRIVISORS 0 0 0 0 0 59 13.01 14.00		1	•	0					
13.01 01301 HOUSE SUPERVI SORS 0 0 0 0 59 13.01				0					
15.00 01500 PHARMACY 0 20,179 4,747 24,926 37 15,00 16.00 10.00 0100 0ED (CAL RECORDS & LIBRARY 0 21,578 5,076 26,654 0 16.00 17.00 01700 SOCIAL SERVICE 0 0 0 0 0 0 0 0 0				0		0	0	59	13. 01
16.00 01600 MEDICAL RECORDS & LIBRARY 0 21,578 5,076 26,654 0 16.00 17.00 17.00 01700 01700 01800 01850 014FG (ENERAL SERVICE (SPECIFY) 0 0 0 0 0 0 0 0 0				0					
17. 00 01700 SOCIAL SERVICE 0 0 0 0 0 0 0 17. 00 19. 00 10500 OTHER GENERAL SERVICE (SPECIFY) 0 0 0 0 0 0 0 0 19. 00 10500 OTHER GENERAL SERVICE (SPECIFY) 0 0 0 0 0 0 0 19. 00 01900 NURSH NS SCHOOL 0 0 0 0 0 0 0 21. 00 02100 NURSH NS SCHOOL 0 0 0 0 0 0 0 21. 00 02100 IAR SERVICES-SALARY & FRINGES APPRY 0 0 0 0 0 0 0 22. 00 02200 IAR SERVICES-SALARY & FRINGES APPRY 0 0 0 0 0 0 0 23. 00 03300 PARAMED ED PROM-(SPECIFY) 0 0 0 0 0 0 0 23. 00 03300 PARAMED ED PROM-(SPECIFY) 0 0 0 0 0 0 0 23. 00 03000 ADULTS & PEDIATRICS 0 134,542 31,652 166,194 182 30.00 30. 00 3000 INTERISTRATION SERVICE COST CENTERS 0 134,542 31,652 166,194 182 30.00 30. 00 30300 INTERISTRATION CONTRACTOR 0 0 0 0 0 0 33.00 30300 BURN INTERIST CARE UNIT 0 0 0 0 0 0 0 33.00 30300 SUBROVIDES & PEDIATRICS 0 0 0 0 0 0 0 0 0 4. 00 34000 SUBROVIDES & 1 FF 0 0 0 0 0 0 0 0		1	i e	0	•				
18. 00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 0 0 0 0 0 0 0 0				0		1			
19. 00 01900 NOMPYSI CIAN ANESTHETISTS 0 0 0 0 0 0 0 0 0		1	•	0	0	-	0		
20. 00 02000 NUESIN IN SCHOOL 0 0 0 0 0 0 20. 00				0	Ö	Ö	o		
22.00 02200 IAS SERVI CES-OTHER PROM COSTS APPRV 0 0 0 0 0 0 0 0 22.00	20.00			0	0	0	0	0	20. 00
23.0 02300 PARAMED ED PROM. (SPECIFY) 0 0 0 0 0 0 23.00				0	0	0	0		
INPATI ENT ROUTINE SERVICE COST CENTERS				0	0		-1		
30.00 03000 ADULTS & PEDI ATRICS 0 134,542 31,652 166,194 182 30.00 31.00 03100 03100 INTENSI VE CARE UNIT 0 0 0 0 0 0 0 0 31.00 33.00 33.00 03.00 03.00 0 0 0 0 0 0 0 0 0	23.00			0	0	0	U	0	23.00
31 00 03100 INTENSIVE CARE LINIT	30.00			0	134.542	31, 652	166, 194	182	30.00
33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 34.00		1	•	0					
34. 00 03400 SUBPROVI DER - I PF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	0	0	0	0	32.00
40.00 04000 SUBPROVI DER - I PF 0 0 0 0 0 0 0 0 0				0	0	0	0		
41.00 04100 SUBPROVI DER		1	l .	0	0	0	0		
A2, 00 04200 SUBPROVI DER		1	•	0	0	0	0	-	
43.00 04300 NURSERY 0 4, 316 1, 015 5, 331 7 43.00		1	•	0	0	0	0		
45. 00 04500 NURSING FACILITY 0 0 0 0 0 0 45. 00 46. 00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 46. 00 46. 00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 46. 00 46. 00 04600 OTHER LONG TERM CARE 0 0 0 0 0 0 46. 00 46. 00 05000 ODERATI NG ROOM 0 0 0 0 0 0 0 51. 00 05000 ODERATI NG ROOM 0 0 0 0 0 0 0 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 53. 00 05200 DELI VERY ROOM & LABOR ROOM 0 0 0 0 0 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 0 0 0 0 0 0 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 56. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 57. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 57. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 58. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 59. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 59. 00 05500 CARDI AC CATHETERI ZATI ON 0 0 0 0 59. 00 05500 CARDI AC CATHETERI ZATI ON 0 0 0 0 59. 00 05500 CARDI AC CATHETERI ZATI ON 0 0 0 0 61. 00 06600 LABORATORY 0 0 0 0 61. 00 06600 LABORATORY 0 0 0 0 62. 00 06200 MHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0 0 0 0 64. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 65. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 67. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 68. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 69. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 69. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 69. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 69. 00 06600 PHYSI CAL THERAPY 0 0 0 0 0 69. 00				0	4, 316	1, 015	5, 331		
46. 00 04600 0THER LONG TERM CARE 0 0 0 0 0 0 46. 00 ANCILLARY SERVICE COST CENTERS 50. 00 050000 OPERATI NG ROOM 0 104, 039 24, 476 128, 515 73 50. 00 51. 00 52. 00 05200 DELIVERY ROOM 0 0 0 0 0 0 0 51. 00 52. 00 05200 DELIVERY ROOM 0 0 0 0 0 0 0 51. 00 53. 00 53. 00 5300 ANESTHESI OLOGY 0 0 0 0 0 0 0 53. 00 53. 00 54. 00 05400 RADIO LOGY-THERAPEUTI 0 0 0 0 0 0 0 0 0				0	0	0	O	0	44.00
ANCILLARY SERVICE COST CENTERS		1	•	0			-1		
50. 00 05000 0PERATI NG ROOM 0 104,039 24,476 128,515 73 50. 00 51. 00 05100 0 0 0 0 0 0 0 0 0	46.00			0	0	0	O _I	0	46.00
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 51.00	50 00			0	104 039	24 476	128 515	73	50 00
53. 00 05300 ANESTHESI OLOGY 0 0 0 0 53. 00 54. 00 05400 RADI OLOGY-TJA GROSTI C 0 100,707 23,692 124,399 120 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 55. 00 0 0 0 0 0 0 0 0 55. 00 0 <td< td=""><td></td><td></td><td></td><td>0</td><td>0</td><td>0</td><td>0</td><td></td><td></td></td<>				0	0	0	0		
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0 100, 707 23, 692 124, 399 120 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0 55. 00 0	52.00			0	3, 073	723	3, 796	9	52.00
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 0 56. 00 57. 00 05700 CT SCAN 0 0 0 0 0 0 57. 00 58. 00 05800 MRI 0 0 0 0 0 0 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0 0 0 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0 0 0 0 0 0 59. 00 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0 31, 814 7, 484 39, 298 3 60. 00 6		1	•	0	0	0	0		
56. 00 05600 RADI OI SOTOPE 0 0 0 0 0 0 0 56. 00 57. 00 57. 00 57. 00 57. 00 57. 00 58. 00 58. 00 59				0					
57. 00 05700 CT SCAN 0				0			-1		
58. 00 05800 MRI 0 0 0 0 0 0 0 0 0 0 59. 00 0 0 0 0 0 0 0 59. 00 0 0 0 0 59. 00 0 0 0 0 0 59. 00 0				0	0	0	0		
60. 00		1	i e	0	0	Ö	Ö		
61. 00	59.00	05900	CARDI AC CATHETERI ZATI ON	0	0	0	0	0	59. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 0 62. 00 63. 00 643. 00 643. 00 644. 00 06400 I NTRAVENOUS THERAPY 0 6, 905 1, 624 8, 529 9 64. 00 64. 00 06500 RESPIRATORY THERAPY 0 4, 902 1, 153 6, 055 48 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 43, 035 10, 124 53, 159 96 66. 00 667. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 67. 00 680. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 68. 00 69. 00 07000 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	31, 814	7, 484	39, 298	3	
63. 00		1	l .	0			0	0	
64. 00 06400 INTRAVENOUS THERAPY 0 6, 905 1, 624 8, 529 9 64. 00 65. 00 06500 RESPIRATORY THERAPY 0 4, 902 1, 153 6, 055 48 65. 00 66. 00 06600 PHYSI CAL THERAPY 0 43, 035 10, 124 53, 159 96 66. 00 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0				0	0		0		
65. 00 06500 RESPIRATORY THERAPY 0 43, 035 10, 124 53, 159 96 66. 00 66. 00 06600 PHYSI CAL THERAPY 0 43, 035 10, 124 53, 159 96 66. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 68. 00 69. 00 0 0 0 0 0 0 0 0 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0				0	6, 905	1, 624	8, 529		
67. 00 06700 OCCUPATI ONAL THERAPY 0 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 69. 00 0 0 0 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		06500	RESPI RATORY THERAPY	0				48	
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 68. 00 69. 00 69. 00 0 0 0 0 0 69. 00 69. 00 0 0 0 0 0 0 0 69. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1	l .	0	43, 035	10, 124	53, 159	96	
69. 00 06900 ELECTROCARDI OLOGY 0 0 0 0 0 0 0 69.00 70. 00 07000 ELECTROENCEPHALOGRAPHY 0 0 0 0 0 0 70.00 71. 00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENT 0 0 0 0 0 0 71.00 72. 00 07200 IMPL. DEV. CHARGED TO PATI ENTS 0 0 0 0 0 0 72.00 73. 00 07300 DRUGS CHARGED TO PATI ENTS 0 0 0 0 0 0 73.00 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 74.00				0	0	0	0		
70. 00				0	0	0	0		
71. 00		1	l .	0	0	0	0		
73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 0 0 0 73.00 074.00 07400 RENAL DIALYSIS 0 0 0 0 0 74.00				0	Ö	Ö	Ö		
74.00 07400 RENAL DIALYSIS 0 0 0 0 74.00	72.00	07200	IMPL. DEV. CHARGED TO PATIENTS	0	0	0	0	0	72.00
				0	0	0	0		
75. UU U/30U A3C (NUN-DISTINCI PARI) U U U U U U 0 /5. 00				0	0	0	0		
				0	U 15 726	2 700	10 426		
75. 01 07501 CARDI AC REHAB 0 15, 726 3, 700 19, 426 10 75. 01 0UTPATI ENT SERVI CE COST CENTERS					15,726	3,700	17, 420	10	75.01
88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 88. 00				0	0	O	o	0	88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 89. 00				0	0	0	o		
90. 00 09000 CLI NI C 0 0 0 90. 00 0 90. 00 0 0 0 0 0 0 0 0				0	0	0	0 0		
91. 00 09100 EMERGENCY				0	69, 912	16, 447	· ·	192	
72. 00 07200 050ERWITTON DED3 (NON DE3TINOT FIRM	72.00	10 /200	TODOLINATION DEDO (NON-DIOTINOTIANI	1	<u> </u>	1	<u> </u>		1 /2.00

Provider CCN: 151306 Period: Worksheet B
From 01/01/2015 Part II
To 12/31/2015 Date/Time Prepared: Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

			To	12/31/2015	Date/Time Prepared: 5/27/2016 5:10 pm
		CAPI TAL REI	ATED COSTS		372772010 3. 10 piii
Cost Center Description	Di rectly	BLDG & FIXT	MVBLE EQUIP	Subtotal	EMPLOYEE
	Assi gned New				BENEFITS
	Capi tal				DEPARTMENT
	Related Costs 0	1. 00	2.00	2A	4. 00
OTHER REIMBURSABLE COST CENTERS	0 1	1.00	2.00	ZA	4.00
94. 00 09400 HOME PROGRAM DIALYSIS		0	O	O	0 94.00
95. 00 09500 AMBULANCE SERVICES		0	0	ol	0 95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0	0	o	0 96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0 97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0	0	ol	0 98.00
99. 00 09900 CMHC	o	0	o o	ol	0 99.00
99. 10 09910 CORF	o	0	0	o	0 99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	o	0	0	o	0 100. 00
101.00 10100 HOME HEALTH AGENCY	o	0	0	o	0 101.00
SPECIAL PURPOSE COST CENTERS					
105.00 10500 KIDNEY ACQUISITION	0	0	0	0	0 105.00
106. 00 10600 HEART ACQUISITION	0	0	0	0	0 106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0	0 107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0 108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0	0	0	0 109. 00
110. 00 11000 NTESTINAL ACQUISITION	0	0	0	0	0 110.00
111. 00 11100 I SLET ACQUI SI TI ON	0	0	0	O	0 111.00
113. 00 11300 NTEREST EXPENSE					113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		0	0		114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 116. 00 11600 HOSPICE	0	0	0	U O	0 115.00 0 116.00
118. 00 SUBTOTALS (SUM OF LINES 1-117)	0	867, 458	204, 074	1, 071, 532	1, 224 118. 00
NONREI MBURSABLE COST CENTERS	J U	807, 438	204, 074	1, 0/1, 532	1, 224 118.00
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN		0	0	O	0 190. 00
190. 01 19001 VISITING SPECIALTY CLINIC		34, 956	_	43, 180	0 190. 01
190. 02 19002 OUTREACH		18, 798		18, 798	13 190. 02
190. 03 19003 FOUNDATI ON	0	3, 021	711	3, 732	0 190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	o	0	0	0	0 190. 04
190. 05 19005 PAOLI FAMILY PRACTICE	o	0	0	o	0 190. 05
190. 06 19006 OTHER PROPERTY	o	23, 718	0	23, 718	0 190. 06
191. 00 19100 RESEARCH	o	0	0	o	0 191.00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	o	0	0	o	0 192. 00
193. 00 19300 NONPALD WORKERS	o	0	0	o	0 193. 00
200.00 Cross Foot Adjustments				o	200.00
201.00 Negative Cost Centers		0	0	o	0 201. 00
202.00 TOTAL (sum lines 118-201)	o	947, 951	213, 009	1, 160, 960	1, 237 202. 00

5. 00 7. 00 7. 01 GENERAL SERVICE COST CENTERS	NEN SERVICE 8. 00	9. 00	
1. 00 00100 CAP REL COSTS-BLDG & FLXT			
			1.00
2.00 00200 CAP REL COSTS-MVBLE EQUIP 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT			2. 00 4. 00
5. 00 00500 ADMI NI STRATI VE & GENERAL 152, 091			5. 00
7. 00 00700 OPERATION OF PLANT 10, 843 103, 060			7.00
7. 01 00701 UTI LI TI ES 4, 636 0 4, 636			7. 01
8. 00 00800 LAUNDRY & LI NEN SERVI CE 715 844 33	7, 989	00 440	8.00
9. 00 00900 HOUSEKEEPI NG 3, 385 2, 169 84 10. 00 01000 DI ETARY 3, 055 4, 544 177	0	22, 110 1, 000	9. 00 10. 00
11. 00 01100 CAFETERI A 531 2, 828 110	0	622	11.00
13. 00 01300 NURSI NG ADMI NI STRATI ON 5, 144 1, 466 57	Ö	322	13.00
13. 01 01301 HOUSE SUPERVI SORS 4, 513 0 0	0	0	13.01
14. 00 01400 CENTRAL SERVI CES & SUPPLY 4, 953 5, 768 225	0	0	14.00
15. 00 01500 PHARMACY 3, 573 3, 289 128 16. 00 01600 MEDI CAL RECORDS & LI BRARY 274 3, 517 137	0	0	15.00
16. 00 01600 MEDI CAL RECORDS & LI BRARY 274 3, 517 137 17. 00 01700 SOCI AL SERVI CE 0 0 0	0	774 0	16. 00 17. 00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	Ö	0	18. 00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS 4, 396 0 0	0	0	19.00
20. 00 02000 NURSI NG SCH00L 0 0 0	0	0	20.00
21. 00 02100 &R SERVI CES-SALARY & FRI NGES APPRV	0	0	21.00
22. 00 02200 1 &R SERVI CES-OTHER PRGM COSTS APPRV 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0	0	22. 00 23. 00
INPATIENT ROUTINE SERVICE COST CENTERS	U	U	23.00
30. 00 03000 ADULTS & PEDI ATRI CS 16, 297 21, 934 854	2, 442	4, 824	30.00
31.00 03100 I NTENSI VE CARE UNI T 0 0 0	0	0	31.00
32. 00 03200 CORONARY CARE UNIT	0	0	32.00
33. 00 03300 BURN I NTENSI VE CARE UNI T	0	0	33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T	0	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	0	0	42.00
43. 00 04300 NURSERY 621 703 27	18	155	43.00
44. 00 04400 SKI LLED NURSI NG FACI LI TY	0	0	44.00
45. 00 04500 NURSI NG FACI LI TY	0	0	45. 00 46. 00
ANCILLARY SERVICE COST CENTERS	<u> </u>	0	40.00
50. 00 05000 OPERATING ROOM 7, 268 16, 959 660	640	3, 731	50.00
51. 00 05100 RECOVERY ROOM 0 0 0	0	0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 754 501 19	24	110	52.00
53. 00 05300 ANESTHESI OLOGY 0 0 54. 00 05400 RADI OLOGY-DI AGNOSTI C 14, 808 16, 416 639	0 1, 304	0 3. 611	53. 00 54. 00
55. 00 05500 RADI 0L0GY-THERAPEUTI C	1, 304	3, 011	55. 00
56. 00 05600 RADI 0I SOTOPE 0 0	0	0	56.00
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 0 0 0 0 0 0 0 0 0 0 0 0 0	0	0 1, 141	59.00
60. 00 06000 LABORATORY 12, 686 5, 186 202 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY	U	1, 141	60. 00 61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0	0	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 881 1, 126 44	0	248	64.00
65. 00 06500 RESPI RATORY THERAPY 3, 892 799 31	0	176	65.00
66. 00 06600 PHYSI CAL THERAPY 8, 012 560 273 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0	556	1, 543 0	66. 00 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 654 0 0	0	0	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS 159 0 0	0	0	72.00
73. 00 07300 DRUGS CHARGED TO PATI ENTS 15, 096 0 0 74. 00 07400 RENAL DI ALYSI S 0 0 0 0	0	0	73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0	0	0	74. 00 75. 00
75. 01 07501 CARDI AC REHAB	0	564	75. 01
OUTPATIENT SERVICE COST CENTERS			
88. 00 08800 RURAL HEALTH CLINIC 0 0 0 0	0	0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0	0	0	89.00
90. 00 09000 CLI NI C 173 0 0 91. 00 09100 EMERGENCY 21, 436 11, 396 444	0 3, 005	0 2, 507	90. 00 91. 00
92. 00 09200 0BSERVATI ON BEDS (NON-DI STI NCT PART	3, 003	2, 307	92.00
OTHER REIMBURSABLE COST CENTERS			30
94. 00	0	0	94.00
95. 00 09500 AMBULANCE SERVI CES 0 0 0	0	0	95.00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0 0 0	0	0	96.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

E & GENERAL PLANT LI NEN SERVI CE	
3.00 7.00 7.00	
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 97	7. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 98	3. 00
99. 00 09900 CMHC 0 0 0 0 99	9. 00
99. 10 09910 CORF 0 0 0 0 99	9. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 0 0 100). 00
101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101	1.00
SPECIAL PURPOSE COST CENTERS	
105. 00 10500 KIDNEY ACQUISITION 0 0 0 0 0 0 105	5. 00
106. 00 10600 HEART ACQUISITION 0 0 0 0 0 0 106	ó. 00
107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 107	7. 00
108.00 10800 LUNG ACQUISITION 0 0 0 0 0 0 108	3. 00
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 109	₹. 00
110. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 0 1110). 00
111. 00 11100 ISLET ACQUISITION 0 0 0 0 0 1111	1.00
113. 00 11300 INTEREST EXPENSE	3. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF 114	4. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115	5. 00
116. 00 11600 H0SPI CE 0 0 0 0 0 0 116	ó. 00
118.00 SUBTOTALS (SUM OF LINES 1-117) 149,828 102,568 4,244 7,989 21,328 118	3. 00
NONREI MBURSABLE COST CENTERS	
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 0 190). 00
190. 01 19001 VISITING SPECIALTY CLINIC 444 0 222 0 0 0 190). 01
190. 02 19002 0UTREACH 1, 432 0 0 0 674 190). 02
190. 03 19003 FOUNDATI ON 65 492 19 0 108 190	
190.04 19004 SPRING VALLEY FAMILY PRACTICE 61 0 0 0 0 190). 04
190. 05 19005 PAOLI FAMILY PRACTICE 17 0 0 0 0 190). 05
190. 06 19006 OTHER PROPERTY 244 0 151 0 0 190). 06
191. 00 19100 RESEARCH 0 0 0 0 0 191	1.00
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192	2. 00
193. 00 19300 NONPALD WORKERS 0 0 0 0 0 193	3. 00
200.00 Cross Foot Adjustments 200	O. CO
201.00 Negative Cost Centers 0 0 0 0 0 0 0 201	
202.00 TOTAL (sum lines 118-201) 152,091 103,060 4,636 7,989 22,110 202	2. 00

Provi der CCN: 151306

Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	HOUSE	5/27/2016 5: 1 CENTRAL	
cost center bescription	DILIANI	CALLILATA	ADMI NI STRATI O	SUPERVI SORS	SERVICES &	
	10.00	11. 00	N 13. 00	13. 01	SUPPLY 14. 00	
GENERAL SERVICE COST CENTERS			I			1 00
1.00 00100 CAP REL COSTS-BLDG & FIXT 2.00 00200 CAP REL COSTS-MVBLE EQUIP			•			1. 00 2. 00
4. 00 00400 EMPLOYEE BENEFITS DEPARTMENT			•			4.00
5. 00 00500 ADMINISTRATIVE & GENERAL						5. 00
7. 00 00700 OPERATION OF PLANT						7. 00
7. 01 00701 UTI LI TI ES						7. 01
8.00 00800 LAUNDRY & LINEN SERVICE						8. 00
9. 00 00900 HOUSEKEEPI NG						9. 00
10. 00 01000 DI ETARY	43, 243	05 500				10.00
11. 00 01100 CAFETERIA 13. 00 01300 NURSING ADMINISTRATION	0	25, 520	1			11. 00 13. 00
13. 00 01300 NURSI NG ADMINI STRATI ON 13. 01 01301 HOUSE SUPERVI SORS	ا	1, 322 1, 320		5, 892		13.00
14. 00 01400 CENTRAL SERVICES & SUPPLY	O	80	1	0, 0,2	54, 739	14. 00
15. 00 01500 PHARMACY	o	1, 033	1	o	0 1,7 37	15. 00
16.00 01600 MEDICAL RECORDS & LIBRARY	O	0	1	0	0	16.00
17. 00 01700 SOCI AL SERVI CE	0	0	0	0	0	17.00
18.00 01850 OTHER GENERAL SERVICE (SPECIFY)	0	0	0	0	0	18.00
19. 00 01900 NONPHYSI CI AN ANESTHETI STS	0	541	0	0	0	19. 00
20. 00 02000 NURSI NG SCHOOL	0	0		0	0	20.00
21.00 02100 1 &R SERVI CES-SALARY & FRINGES API 22.00 02200 1 &R SERVI CES-OTHER PRGM COSTS API		0		0	0	21. 00 22. 00
23. 00 02200 TAK SERVICES-OTHER PROM COSTS API	0	0	0	0	0	23. 00
I NPATIENT ROUTINE SERVICE COST CENTERS				<u> </u>		23.00
30. 00 03000 ADULTS & PEDIATRICS	43, 243	5, 049	7, 276	2, 198	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	0	0	0	0	31.00
32. 00 03200 CORONARY CARE UNIT	0	0	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 40. 00 04000 SUBPROVI DER - I PF	0	0	0	0	0	34.00
41. 00 04100 SUBPROVI DER - 1 PF	١	0	0	0	0	40. 00 41. 00
42. 00 04200 SUBPROVI DER	o o	0	0	0	0	42. 00
43. 00 04300 NURSERY	Ö	456	657	199	0	43. 00
44.00 04400 SKILLED NURSING FACILITY	O	0	0	0	0	44.00
45.00 04500 NURSING FACILITY	o	0	0	0	0	45.00
46.00 O4600 OTHER LONG TERM CARE	0	0	0	0	0	46.00
ANCILLARY SERVICE COST CENTERS 50.00 OPERATING ROOM	0	1, 832	2 (40	798	402	50. 00
50.00 05000 OPERATING ROOM 51.00 05100 RECOVERY ROOM	ا	1, 032	2, 640	790	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	o o	575	829	251	0	52.00
53. 00 05300 ANESTHESI OLOGY	o	0	0	0	0	53. 00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	O	3, 367	0	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	O	0	0	0	0	55.00
56. 00 05600 RADI 0I SOTOPE	0	0	0	0	0	56.00
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 60. 00 06000 LABORATORY		181	0	0	20, 184	59. 00 60. 00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM 0	w v	101		o o	20, 104	61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD C	1	0	0	o	0	62. 00
63.00 06300 BLOOD STORING, PROCESSING & TRANS		0	0	0	0	63.00
64.00 06400 INTRAVENOUS THERAPY	0	218	314	95	0	64.00
65. 00 06500 RESPI RATORY THERAPY	0	1, 451	1	0	0	65.00
66. 00 06600 PHYSI CAL THERAPY	0	2, 198	0	0	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00 06800 SPEECH PATHOLOGY 69. 00 06900 ELECTROCARDI OLOGY		0	0	0	0	68. 00 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	o o	0	0	0	0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIL	ENT O	0	Ö	o	27, 474	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	O	0	0	0	6, 679	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	o	0	0	0	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75. 01 07501 CARDI AC REHAB	0	8	0	0	0	75. 01
0UTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC		^	^	ما	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTE	R n	0	0	0	0	89. 00
90. 00 09000 CLINI C	. 0	0	0	0	0	90.00
91. 00 09100 EMERGENCY	Ö	5, 403	7, 786	2, 351	0	91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PA	ART			, - , -		92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0		0	0	94.00
95. 00 09500 AMBULANCE SERVICES	0	0	0	0	0	95. 00

Provi der CCN: 151306

| Peri od: | Worksheet B | From 01/01/2015 | Part | I | To | 12/31/2015 | Date/Time Prepared:

			10	12/31/2015	Date/lime Pre 5/27/2016 5:1	
Cost Center Description	DI ETARY	CAFETERI A	NURSI NG	HOUSE	CENTRAL	o piii
			ADMI NI STRATI O	SUPERVI SORS	SERVICES &	
			N		SUPPLY	
	10.00	11. 00	13.00	13. 01	14. 00	
96.00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0	0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98.00
99. 00 09900 CMHC	0	0	0	0	0	99.00
99. 10 09910 CORF	0	0	0	0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0	0	0	0	100.00
101.00 10100 HOME HEALTH AGENCY	o	0	0	0	0	101.00
SPECIAL PURPOSE COST CENTERS						
105.00 10500 KIDNEY ACQUISITION	0	0	0	0		105.00
106. 00 10600 HEART ACQUISITION	0	0	0	0		106.00
107.00 10700 LIVER ACQUISITION	0	0	0	0		107.00
108.00 10800 LUNG ACQUISITION	0	0	0	0	0	108.00
109.00 10900 PANCREAS ACQUISITION	0	0	0	0		109. 00
110.00 11000 INTESTINAL ACQUISITION	0	0	0	0	0	110.00
111.00 11100 ISLET ACQUISITION	0	0	0	0	0	111. 00
113.00 11300 INTEREST 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 H0SPI CE	0	0	0	0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	43, 243	25, 034	19, 502	5, 892	54, 739	118. 00
NONRE MBURSABLE COST CENTERS						
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	0	0		190. 00
190.01 19001 VISITING SPECIALTY CLINIC	0	0	0	0		190. 01
190. 02 19002 OUTREACH	0	486	0	0		190. 02
190. 03 19003 FOUNDATI ON	0	0	0	0		190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	0	0	0		190. 04
190.05 19005 PAOLI FAMILY PRACTICE	0	0	0	0		190. 05
190. 06 19006 OTHER PROPERTY	0	0	0	0		190. 06
191. 00 19100 RESEARCH	0	0	0	0		191. 00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0	0	0		192.00
193. 00 19300 NONPALD WORKERS	0	0	0	0		193.00
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)	43, 243	25, 520	19, 502	5, 892	54, 739	202. 00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151306

					'	0 12/31/2015	Date/lime Pre 5/27/2016 5:1	
				<u>'</u>		OTHER GENERAL		
		Cost Contor Doscription	DHADMACV	MEDLCAL	SOCIAL	SERVI CE (SPECI FY)	NONDHASTCLVN	
		Cost Center Description	PHARMACY	MEDI CAL RECORDS &	SERVI CE	(SPECIFY)	NONPHYSI CI AN ANESTHETI STS	
				LI BRARY	SERVICE		7.1123111211313	
			15. 00	16. 00	17. 00	18.00	19. 00	
1. 00		AL SERVICE COST CENTERS CAP REL COSTS-BLDG & FIXT					Ι	1.00
2. 00		CAP REL COSTS-MVBLE EQUIP						2.00
4.00	1	EMPLOYEE BENEFITS DEPARTMENT						4.00
5. 00		ADMINISTRATIVE & GENERAL						5.00
7.00		OPERATION OF PLANT UTILITIES						7.00
7. 01 8. 00	1	LAUNDRY & LINEN SERVICE						7. 01 8. 00
9. 00		HOUSEKEEPI NG						9.00
10.00	01000	DI ETARY						10.00
11.00	1	CAFETERI A						11.00
13. 00 13. 01	1	NURSI NG ADMI NI STRATI ON HOUSE SUPERVI SORS						13. 00 13. 01
14. 00		CENTRAL SERVICES & SUPPLY						14.00
15. 00		PHARMACY	32, 986					15.00
16.00		MEDICAL RECORDS & LIBRARY	0	31, 356				16.00
17. 00 18. 00		SOCIAL SERVICE OTHER GENERAL SERVICE (SPECIFY)	0	0		0		17. 00 18. 00
19. 00	1	NONPHYSICIAN ANESTHETISTS		0		o o	4, 993	
20.00	02000	NURSI NG SCHOOL	o	0	C	0		20.00
21.00		I &R SERVICES-SALARY & FRINGES APPRV	0	0				21.00
22. 00 23. 00	1	I&R SERVICES-OTHER PRGM COSTS APPRV PARAMED ED PRGM-(SPECIFY)	0	0				22. 00 23. 00
23.00		TENT ROUTINE SERVICE COST CENTERS	<u> </u>	0		, 0		23.00
30.00		ADULTS & PEDIATRICS	0	431	C	0		30.00
31.00	1	INTENSIVE CARE UNIT	0	0				31.00
32. 00 33. 00	1	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0	0		_		32. 00 33. 00
34.00	1	SURGICAL INTENSIVE CARE UNIT		0				34.00
40.00	1	SUBPROVI DER - I PF	o	0	C	0		40.00
41.00		SUBPROVIDER - IRF	0	0	·	0		41.00
42. 00 43. 00	1	SUBPROVI DER NURSERY	0	0 176		0		42. 00 43. 00
44. 00	1	SKILLED NURSING FACILITY		0		_		44.00
45.00		NURSING FACILITY	o	0	C	0		45.00
46. 00		OTHER LONG TERM CARE	0	0	C	0		46. 00
50. 00		LARY SERVICE COST CENTERS OPERATING ROOM	O	3, 912		0		50.00
51.00		RECOVERY ROOM	o o	0				51.00
52.00		DELIVERY ROOM & LABOR ROOM	o	544	C	0		52.00
53.00		ANESTHESI OLOGY	0	0	C	0		53.00
54. 00 55. 00		RADI OLOGY-DI AGNOSTI C RADI OLOGY-THERAPEUTI C	0	5, 443		0		54. 00 55. 00
56.00		RADI OLOGI - MEKAL EUTT C		0		o o		56.00
57.00		CT SCAN	o	0	C	0		57.00
	1		0	0	C	0		58.00
59. 00 60. 00		CARDI AC CATHETERI ZATI ON LABORATORY	0	0 5, 253		0		59. 00 60. 00
61.00		PBP CLINICAL LAB SERVICES-PRGM ONLY		3, 233		,		61.00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELL	o	0	C	0		62.00
63.00	1	BLOOD STORING, PROCESSING & TRANS.	0	0	C	0		63.00
64. 00 65. 00		I NTRAVENOUS THERAPY RESPI RATORY THERAPY	1, 439	2, 351 413		0		64. 00 65. 00
66. 00	1	PHYSI CAL THERAPY	o o	880		o o		66.00
67.00		OCCUPATI ONAL THERAPY	o	0	C	0		67.00
68.00		SPEECH PATHOLOGY	0	0	C	0		68.00
69. 00 70. 00		ELECTROCARDI OLOGY ELECTROENCEPHALOGRAPHY	0	0		0		69. 00 70. 00
		MEDICAL SUPPLIES CHARGED TO PATIENT		211		o o		71.00
		IMPL. DEV. CHARGED TO PATIENTS	o	65	C	0		72.00
		DRUGS CHARGED TO PATIENTS	31, 547	3, 398		0		73.00
		RENAL DIALYSIS ASC (NON-DISTINCT PART)	0	0		_		74. 00 75. 00
		CARDIAC REHAB		112				75.00
2.0.		TIENT SERVICE COST CENTERS		. 12				1
	08800	RURAL HEALTH CLINIC	0	0	C	0		88. 00
89. 00 90. 00		FEDERALLY QUALIFIED HEALTH CENTER CLINIC	0	0		0		89. 00 90. 00
		EMERGENCY		15 8, 152		, 0		90.00
		OBSERVATION BEDS (NON-DISTINCT PART		2, .32]			92.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS

Cost Center Description					To 12/31/2015	Date/Time Pre 5/27/2016 5:1	
RECORDS & SERVICE ANESTHETISTS	Cost Center Description	PHARMACY	MEDI CAI	SOCI AI	SERVI CE		рш
OTHER REI MBURSABLE COST CENTERS 94,00 94,00 94,00 95,00 950	South Control Boson per on	11000000	RECORDS &		(3/20/17)		
94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 94.00 95.00 09500 ABBULANCE SERVICES 0 0 0 0 0 95.00 96.00 09600 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0 97.00 98.00 099500 OHRER EMBURSABLE COST CENTERS 0 0 0 0 0 0 99.00 99.00 09900 CMHC 0 0 0 0 0 0 0 99.00 99.10 09910 CORF 0 0 0 0 0 0 0 99.00 99.10 09910 CORF 0 0 0 0 0 0 0 99.10 100.00 10000 18 SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 100.00 SPECIAL PURPOSE COST CENTERS		15. 00	16. 00	17. 00	18. 00	19. 00	
95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 95. 00 96. 00 09500 DURABLE MEDI CAL EQUI P-RENTED 0 0 0 0 0 97. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 98. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 99. 00 09900 CMHC 0 0 0 0 0 0 99. 00 09900 CMHC 0 0 0 0 0 0 99. 00 09900 CMHC 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 0 101. 00 10000 187 SERVI (ES-NOT APPRVD PRGM 0 0 0 0 0 0 0 101. 00 10100 HEALTH AGENCY 0 0 0 0 0 0 101. 00 SPECI AL PURPOSE COST CENTERS							
99. 00 09500 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 97. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 97. 00 98. 00 09950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 98. 00 99. 00 09950 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 99. 00 99. 10 09910 CORF 0 0 0 0 0 0 99. 10 100. 00 10000 IAS SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101. 00 101. 00 10100 INDEY ACQUISITION 0 0 0 0 105. 00 105. 00 10500 KI DNEY ACQUISITION 0 0 0 0 106. 00 106. 00 10600 HARTH ACQUISITION 0 0 0 0 107. 00 107. 00 10700 LIVER ACQUISITION 0 0 0 0 107. 00 108. 00 10800 LIVING ACQUISITION 0 0 0 0 109. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109. 00 110. 00 11000 INTESTI NAL ACQUISITION 0 0 0 0 110. 00 111. 00 11100 ISLET ACQUISITION 0 0 0 0 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 114. 00 11400 UTLICATION REVIEW-SNF 113. 00 115. 00 11500 AMBULATORY SURGI CAL CENTER (D.P.) 0 0 0 0 0 115. 00 116. 00 10600 GFT, Ft. Ft. POWER, CEPTER SHOP & CANTEEN 0 0 0 0 0 190. 01 19000 VISTING SPECIALTY CLINIC 0 0 0 0 0 190. 01 190. 01 19000 FIN O'N ALLEY FAMILLY PRACTICE 0 0 0 0 0 190. 01 190. 01 19000 FIN O'N ALLEY FAMILLY PRACTICE 0 0 0 0 0 190. 01 190. 01 19000 PANCRERS 0 0 0 0 0 190. 01 190. 01 19000 PANCRERS 0 0 0 0 0 0 190. 01 190. 00 19000 FONDATION 0 0 0 0 0 0 0 190. 01 190. 00 19000 CFTS FOOT AGUISTERS 0 0 0 0 0 0 0 0 0		0	0		-		
97.00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 98.00 09900 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 99.00 099.00 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 99.00 099.00 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 0 0 0 0		0	0		0		
99. 00 09950 OTHER REIMBURSABLE COST CENTERS 0 0 0 0 0 99. 00 99. 10 09900 CMHC 0 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 0 99. 10 09910 CORF 0 0 0 0 0 99. 10 00910 CORF 0 0 0 0 0 99. 10 00910 CORF 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 0 106. 00 10600 HEART ACQUI SI TI ON 0 0 0 0 107. 00 10700 LI VER ACQUI SI TI ON 0 0 0 0 108. 00 10800 LINGA CQUI SI TI ON 0 0 0 0 109. 00 10900 PANCREAS ACQUI SI TI ON 0 0 0 0 110. 00 10000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 110. 00 10000 INTESTI NAL ACQUI SI TI ON 0 0 0 0 110. 00 11000 INTEREST EXPENSE 113. 00 113. 00 11300 INTEREST EXPENSE 114. 00 11400 ITILIZATI ON REVIEW-SNF 114. 00 11400 ITILIZATI ON REVIEW-SNF 114. 00 11400 ITILIZATI ON REVIEW-SNF 115. 00 115. 00 1500 AMBILIATORY SURGI CAL CENTER (D.P.) 0 0 0 0 0 116. 00 116. 00 1190. 00 190. 01 190. 00 190. 01		0	0		0		
99. 00 09900 CMHC 09910 CORF 0 0 0 0 0 0 0 99. 10 100. 00 10000 18R SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 SPECIAL PURPOSE COST CENTERS		0	0		0		
99. 10 09910 CORF 0 0 0 0 0 0 0 100.00 100.00 10000 1		0	0		0		
100. 00 10000 &R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 100. 00 101.		0	0		0		
101.00 10100 10100 108E HEALTH AGENCY 0 0 0 0 0 101.00		0	0		0		
SPECIAL PURPOSE COST CENTERS 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 105.00 106.00		0	0		0		
105.00 10500 KI DNEY ACQUI SI TI ON		l of			0 0		1101.00
106. 00 10600 HEART ACQUISITION		0	0		0 0		105 00
107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 107. 00 108.00 10800 LUNG ACQUISITION 0 0 0 0 0 0 108.00 109.00 10900 PANCREAS ACQUISITION 0 0 0 0 0 0 109.00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 110. 00 111. 0		0	0				
108. 00 10800 LUNG ACQUISITION		0	0		0 0		
110.00 11000 11000 INTESTINAL ACQUISITION 0 0 0 0 0 0 0 1110.00		0	0		0 0		1
111. 00	109. 00 10900 PANCREAS ACQUI SI TI ON	o	0		0 0		109.00
113. 00	110.00 11000 INTESTINAL ACQUISITION	0	0		0 0		110.00
114.00	111.00 11100 ISLET ACQUISITION	O	0		0 0		111.00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 116. 00 0 0 0 0 0 116. 00 116. 00 118. 00 0 0 0 0 0 0 116. 00 118. 00 0 0 0 0 0 0 0 118. 00 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	113.00 11300 INTEREST EXPENSE						113.00
116. 00	114.00 11400 UTILIZATION REVIEW-SNF						114.00
118.00 SUBTOTALS (SUM OF LINES 1-117) 32,986 31,356 0 0 0 118.00		0	0		0 0		115.00
NONREI MBURSABLE COST CENTERS 190.00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190.00 190.01 190.01 190.01 190.01 190.01 190.01 190.01 190.02 19002 19002 19002 19002 19003 19003 19003 19003 19003 19003 19003 19004 19004 19004 19004 19004 19005 19005 19005 19005 19005 19005 19006 190		0	0		0 0		
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 0 190. 00 190. 01 190.01 190.01 190.01 190.01 190.01 190.01 190.02 19002 19002 19002 19003 19003 19003 19003 19004 19004 19004 19004 19005 19005 19005 19005 19006 190		32, 986	31, 356		0 0	0	118. 00
190. 01 19001 19001 19001 19001 19001 19001 19001 19001 19001 19001 19001 190001 190002 19002 19002 19002 19003 19003 19003 19003 19003 19003 19004 19004 19004 19004 19005 19005 19005 19005 19006 1900				1			
190. 02 19002 19002 19002 19002 19003 19003 19003 19003 19003 19003 19004 19004 19004 19004 19004 19004 19005 19005 19005 19006		0	0				
190. 03 19003 FOUNDATION 0 0 0 0 190. 03 190. 04 190. 04 190. 04 190. 04 190. 05 190. 05 190. 05 190. 06 190. 06 190. 06 190. 06 190. 06 190. 06 190. 06 190. 06 190. 06 190. 06 190. 06 190. 07 190. 08 190.		0	0		0		
190. 04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 0 0 190. 04 190. 05 19005 PAOLI FAMILY PRACTICE 0 0 0 0 0 190. 05 19006 OTHER PROPERTY 0 0 0 0 0 190. 06 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 200. 00 Cross Foot Adjustments 4, 993 200. 00		0	0		0		
190. 05		0	0		0		
190. 06 19006 OTHER PROPERTY 0 0 0 0 190. 06 191. 00 19100 RESEARCH 0 0 0 0 0 191. 00 192. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 0 193. 00 200. 00 Cross Foot Adjustments 4, 993 200. 00		0	0		0		
191. 00 19100 RESEARCH		0	0		0		
192. 00 19200 PHYSI CI ANS' PRI VATE OFFI CES 0 0 0 0 192. 00 193. 00 19300 NONPAI D WORKERS 0 0 0 0 193. 00 200. 00 Cross Foot Adjustments 4, 993 200. 00		0	0		0		
193.00 19300 NONPALD WORKERS 0 0 0 0 193.00 200.00 Cross Foot Adjustments 0 4,993 200.00		0	0		0		
200.00 Cross Foot Adjustments 4,993 200.00			0				1
			0			4 993	
	, ,	0	0		0		
202.00 TOTAL (sum lines 118-201) 32,986 31,356 0 0 4,993 202.00	1 3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1	32, 986	31, 356		o o		

IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151306 Peri od: Worksheet B From 01/01/2015 Part II Date/Time Prepared: 12/31/2015 5/27/2016 5:10 pm INTERNS & RESIDENTS PARAMED ED NURSI NG SERVI CES-SALA SERVI CES-OTHE Subtotal Cost Center Description RY & FRINGES R PRGM COSTS SCHOOL PRGM **APPRV APPRV** 20. 00 21.00 23.00 24.00 22.00 GENERAL SERVICE COST CENTERS 1.00 1.00 00100 CAP REL COSTS-BLDG & FLXT 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2 00 4.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 00700 OPERATION OF PLANT 7.00 7.00 00701 UTI LI TI ES 7.01 7.01 8.00 00800 LAUNDRY & LINEN SERVICE 8.00 9.00 00900 HOUSEKEEPI NG 9.00 01000 DI ETARY 10.00 10.00 11.00 01100 CAFETERI A 11.00 13.00 01300 NURSING ADMINISTRATION 13.00 01301 HOUSE SUPERVI SORS 13.01 13.01 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 15. 00 | 01500 PHARMACY 15.00 16.00 01600 MEDICAL RECORDS & LIBRARY 16.00 01700 SOCIAL SERVICE 17 00 17 00 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 01900 NONPHYSICIAN ANESTHETISTS 19.00 19.00 02000 NURSING SCHOOL 20.00 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 22.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 270, 924 30.00 03100 INTENSIVE CARE UNIT 31.00 31.00 0 03200 CORONARY CARE UNIT 32.00 0 32.00 03300 BURN INTENSIVE CARE UNIT 33 00 0 33 00 34.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34.00 04000 SUBPROVI DER - I PF 40.00 40.00 0 41.00 04100 SUBPROVI DER - I RF 0 41.00 42.00 04200 SUBPROVI DER 0 42.00 43.00 04300 NURSERY 8, 350 43.00 04400 SKILLED NURSING FACILITY 44.00 44.00 45.00 04500 NURSING FACILITY 0 45.00 04600 OTHER LONG TERM CARE 46.00 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 167, 430 50.00 05100 RECOVERY ROOM 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 52.00 7, 412 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 05400 RADI OLOGY-DI AGNOSTI C 170, 107 54.00 54.00 55 00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 56.00 05600 RADI OI SOTOPE 0 56.00 57.00 05700 CT SCAN Ω 57.00 05800 MRI 58.00 58.00 0 05900 CARDI AC CATHETERI ZATI ON 59 00 Λ 59 00 06000 LABORATORY 84, 134 60.00 60.00 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 62.00 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 15, 254 64.00 06500 RESPIRATORY THERAPY 12,865 65.00 65.00 06600 PHYSI CAL THERAPY 66.00 67, 277 66,00 67.00 06700 OCCUPATI ONAL THERAPY 0 67.00 06800 SPEECH PATHOLOGY 68.00 0 68.00 06900 ELECTROCARDI OLOGY 69.00 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 28, 339 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 6,903 72.00 07300 DRUGS CHARGED TO PATIENTS 73 00 50.041 73 00 07400 RENAL DIALYSIS 74.00 0 74.00 07500 ASC (NON-DISTINCT PART) 75.00 75.00 0 07501 CARDI AC REHAB 75.01 23, 856 75.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 88.00 0 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90 00 09000 CLI NI C 188 90 00 91.00 09100 EMERGENCY 149, 031 91.00

92.00

92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lieu of Form CMS-2552-10
ALLOCATION OF CAPITAL RELATED COSTS	Provi der CCN: 151306 Peri	od: Worksheet B

Health Financial Systems	IU HEALTH PAG	OLI HOSPITAL		In Lie	u of Form CMS-2	2552-10
ALLOCATION OF CAPITAL RELATED COSTS		Provi der	CCN: 151306	Peri od:	Worksheet B	
				From 01/01/2015	Part II	
				To 12/31/2015		pared:
					5/27/2016 5:1	O pm
		INTERNS &	RESI DENTS			
Cost Center Description	NURSI NG	SERVI CES-SALA	SERVI CES-OTHE	PARAMED ED	Subtotal	
	SCH00L	RY & FRINGES	R PRGM COSTS	PRGM		
		APPRV	APPRV			
	20. 00	21. 00	22.00	23.00	24.00	
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSIS					0	94.00
95. 00 09500 AMBULANCE SERVICES					Ö	95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED					0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD					0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS					0	98. 00
99. 00 09900 CMHC					0	99. 00
99. 10 09910 CORF					0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM					0	100.00
101.00 10100 HOME HEALTH AGENCY					0	101.00
SPECIAL PURPOSE COST CENTERS						
105. 00 10500 KI DNEY ACQUI SI TI ON					0	105.00
106. 00 10600 HEART ACQUISITION						106.00
107. 00 10700 LI VER ACQUI SI TI ON						107. 00
108. 00 10800 LUNG ACQUISITION						107.00
						108.00
109. 00 10900 PANCREAS ACQUISITION						
110.00 11000 INTESTINAL ACQUISITION						110.00
111.00 11100 I SLET ACQUI SI TI ON					0	111. 00
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	115.00
116. 00 11600 HOSPI CE					0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)				0	1, 062, 111	118.00
NONREI MBURSABLE COST CENTERS		1		-	, , , ,	
190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN					0	190. 00
190. 01 19001 VISITING SPECIALTY CLINIC					43, 846	
190. 02 19002 OUTREACH					· ·	
					21, 403	
190. 03 19003 FOUNDATION						190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE						190. 04
190. 05 19005 PAOLI FAMILY PRACTICE						190. 05
190. 06 19006 OTHER PROPERTY					24, 113	
191. 00 19100 RESEARCH						191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES					0	192.00
193. 00 19300 NONPALD WORKERS					0	193. 00
200.00 Cross Foot Adjustments		ol o		0 0	4, 993	200.00
201.00 Negative Cost Centers				0		201. 00
202.00 TOTAL (sum lines 118-201)				o o	1, 160, 960	
202. 30 TOTAL (30m TTHOS TTO 201)		, i	1	٥,	1, 100, 700	_52.00

Health Financial Systems
ALLOCATION OF CAPITAL RELATED COSTS IU HEALTH PAOLI HOSPITAL

Provi der CCN: 151306

Intern & Red tests Red tes						To 12/31/20	15 Date/lime Prepar 5/27/2016 5:10 p	
Cost & Post Strepon Artjustments Artjustmen		Cost Center Description	Intern &	Total			072772010 0.10 p	5111
SEMPRIL SERVICE COST CEWTERS 26 00		·	Resi dents					
Adj usi sents Adj usi sent								
CENERAL SERVICE COST CENTERS 25.00 26.00			'					
BRIERIA SIRVICE COST CINTIES				26.00				
0.000 0.00		GENERAL SERVICE COST CENTERS	25.00	20.00				
4.00 00.000 DOLONG DOLONG BENEFIT IS DEPARTWENT 0.00 00.000 DOLONG DOLONG DOLONG DOLONG 0.00 00.000 DOLONG DOLONG DOLONG DOLONG DOLONG 0.00 00.000 DOLONG DOLONG DOLONG DOLONG 0.00 00.000 DOLONG DOLONG DOLONG 0.00 DOLONG DOL	1.00						1	1.00
0.000 0.0000 0.0000 0.000 0.0000 0.0000 0.0000 0.0000 0.0000 0.000	2.00	00200 CAP REL COSTS-MVBLE EQUIP					2	2.00
7.00 00700 DERATION OF PLANT	4.00	00400 EMPLOYEE BENEFITS DEPARTMENT					4	4.00
7. 0.1 0.0701 UTILITIES		1					i	5.00
8.00 00900 JANIBORY & I INFN SERVICE 009000 009000 00900 00900 00900 00900 00900 00900 00900 00900 0								7.00
9.00 00900		1						7. 01
10.00 01000 DETARY								8. 00 9. 00
11.0.0 01100 CAFETERIA		1						0.00
13.00 1300 MURSI NO, ADMINISTRATION		1					ı	1. 00
13.01 1300								3.00
15.00 01500 PHARMACY								3. 01
16.00 01600 MEDICAL RECORDS & LIBRARY	14.00	01400 CENTRAL SERVICES & SUPPLY					14	4.00
17.00 01700 SOCIAL SERVICE							15	5.00
18. DO 01850 OTHER CENERAL SERVICE (SPECIFY) 10. 00 1900 (NONPHYSI CLAN AMESTHETISTS) 20. 00 12000 (NONPHYSI CLAN CLAN CLAN CLAN CLAN CLAN CLAN CLAN								6.00
19. 00. 01900 NONPHYSICIAN AMESTHERISTS								7.00
20. 00 2000 NURS INS SCHOOL		· · · · · · · · · · · · · · · · · · ·						8.00
21. 00 02100 RR SERVICES-SALARY & FRINCES APPRV 23. 00 02300 PARSANDE DE PROM - (SPECI FY)							ı	9.00
22.00 02200 RAR SERVICES-OTHER PROM COSTS APPRV		l l						0.00
23.00 02300 PARAMED ED PROM (SPECIFY)		l						2. 00
INPART ENT ROUTI NO SERVICE COST CENTERS		l						3. 00
31. 00 03100 INTERSIVE CARE UNIT 0 0 0 0 0 0 0 0 0	20.00	. ,						0.00
31. 00 03100 INTERSIVE CARE UNIT 0 0 0 0 0 0 0 0 0	30.00		0	270, 924			30	0.00
33.0 0 03300 BURN INTERSIVE CARE UNIT 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0			31	1.00
34 00 03400 SUBRICAL INTENSIVE CARE UNIT 0 0 0 0 0 0 0 0 0	32.00	03200 CORONARY CARE UNIT	0	0			32	2.00
40. 00 0-0000 SUBPROVI DER - I PF		1	0	-				3.00
1.0 0.4100 SUBPROVI DER - IRF 0 0 0 0 0 0 0 0 0		1	0	-				4.00
A2. 00 04200 SUBPROVI DER		1	0				i	0.00
43. 00 04300 NURSERY			0					1.00
A4. 00 04400 SKILLED NURSING FACILITY		1	0					3. 00
45. 00 04500 04500 04500 04500 04500 07500 04500 075		1	0		i			4. 00
A6. 00 04600 OTHER LONG TERM CARE		1	0		•			5.00
50.00 05000 05000 05000 RECOVERY ROOM 0 0 0 0 0 0 0 0 0	46.00	04600 OTHER LONG TERM CARE	0	0			46	6.00
51.00 05100 RECOVERY ROOM 0 0 0 0 0 0 0 0 0								
52.00 05200 DELI VERY ROOM & LABOR ROOM 0 7, 412 53.00 05300 ANESTHESI OLOGY 0 0 0 0 0 0 0 0 0			0		1			0.00
53.00 05300 AMESTHESI OLOGY 0 0 0 0 0 0 0 0 0			0	-				1. 00 2. 00
54.00 05400 RADI OLOGY-DI ACNOSTI C 0 170, 107 55.00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0			0	7,412				3.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 0 0 0 0 0 0 0 0 0			0	170. 107				4. 00
57. 00 05700 CT SCAN 0 0 0 0 58. 00 05800 MRI 0 0 0 0 0 0 0 0 0			0	•				5.00
58. 00 05800 MRI	56.00	05600 RADI OI SOTOPE	0	0			56	6.00
59. 00 05900 CARDIAC CATHETERIZATION 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0			57	7.00
60. 00 06000 LABORATORY 0 84, 134 61. 00 6100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 0 0 0 0 0 0		l	0	0				8.00
61. 00			0	-				9.00
62. 00		l	0	84, 134				0.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 06400 INTRAVENOUS THERAPY 0 15, 254 06500 RESPIRATORY THERAPY 0 12, 865 0 06500 RESPIRATORY THERAPY 0 67, 277 0 06700 OCCUPATIONAL THERAPY 0 0 67, 277 0 06700 OCCUPATIONAL THERAPY 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			0	0				1.00
64. 00		1	0		•			3.00
65. 00			0					4. 00
66. 00 06600 PHYSI CAL THERAPY 0 67, 277 67. 00 06700 0CCUPATI ONAL THERAPY 0 0 0 0 0 0 0 0 0			o		•			5. 00
68. 00 06800 SPEECH PATHOLOGY 0 0 0 0 0 0 0 0 0			0					6.00
69. 00	67.00	06700 OCCUPATI ONAL THERAPY	0	0			67	7.00
70. 00			0	0				8. 00
71. 00			0	0				9.00
72. 00			0					0.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0 50, 041 74. 00 07400 RENAL DI ALYSIS 0 0 0 0 0 0 0 0 0			0		i e			1.00
74. 00								2.00
75. 00					1			4. 00
75. 01 07501 CARDÍAC REHAB 0 23, 856								5.00
OUTPATIENT SERVICE COST CENTERS			l ől	-				5. 01
88. 00 08800 RURAL HEALTH CLI NI C 0 0 0 0 0 0 0 0 0				., , , , , ,				
90. 00 09000 CLI NI C 0 188 1		08800 RURAL HEALTH CLINIC	0	0				8.00
			0					9.00
91, 00 09100 EMERGENCY 01 149, 031			0		1			0.00
			0	149, 031				1.00
92. 00 09200 0BSERVATION BEDS (NON-DISTINCT PART 0	92.00	INASONINRSEKANIION REDS (NON-DISIINCI LAKI	١		I		92	2. 00

IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 Health Financial Systems Worksheet B
Part II
Date/Time Prepared:
5/27/2016 5:10 pm ALLOCATION OF CAPITAL RELATED COSTS Provi der CCN: 151306 Peri od: From 01/01/2015 To 12/31/2015 Cost Center Description Intern & Total Resi dents Cost & Post Stepdown Adjustments 26. 00 25. 00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 0 0 0 0 0 0 0 95. 00 09500 AMBULANCE SERVICES 95.00 0 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 97.00 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 99. 00 09900 CMHC 99.00 99. 10 | 09910 | CORF 100. 00 | 10000 | I &R SERVICES-NOT APPRVD PRGM 0 99.10 0 100.00 101.00 10100 HOME HEALTH AGENCY

SPECIAL PURPOSE COST CENTERS 101. 00 0 105. 00 10500 KI DNEY ACQUI SI TI ON 0 105.00 106. 00 107. 00 106.00 10600 HEART ACQUISITION 0 107.00 10700 LIVER ACQUISITION

108.00 10800 LUNG ACQUISITION	0	0	108.00	
109.00 10900 PANCREAS ACQUISITION	0	0	109.00	
110.00 11000 INTESTINAL ACQUISITION	0	0	110.00	
111.00 11100 ISLET ACQUISITION	0	0	111.00	
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	115.00	
116. 00 11600 HOSPI CE	0	0	116.00	
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	1, 062, 111	118. 00	
NONREI MBURSABLE COST CENTERS				
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0	190.00	
190.01 19001 VISITING SPECIALTY CLINIC	0	43, 846	190. 01	
190. 02 19002 OUTREACH	0	21, 403	190. 02	
190. 03 19003 FOUNDATI ON	0	4, 416	190. 03	
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0	61	190. 04	
190. 05 19005 PAOLI FAMILY PRACTICE	0	17	190. 05	
190. 06 19006 OTHER PROPERTY	0	24, 113	190. 06	
191. 00 19100 RESEARCH	0	0	191.00	
192.00 19200 PHYSICIANS' PRIVATE OFFICES	0	0	192.00	
193. 00 19300 NONPALD WORKERS	0	0	193. 00	
200.00 Cross Foot Adjustments	0	4, 993	200.00	
201.00 Negative Cost Centers	0	0	201. 00	
202.00 TOTAL (sum lines 118-201)	0	1, 160, 960	202.00	

COST A	ALLOCATION - STATISTICAL BASIS		Provi der		Period: From 01/01/2015		
		CAPLTAL REL	_ATED_COSTS		To 12/31/2015	Date/Time Pre 5/27/2016 5:1	
	Cost Center Description	BLDG & FLXT (SQUARE FEET)	MVBLE EQUIP (SQUARE FEET)	EMPLOYEE BENEFITS DEPARTMENT (GROSS SALARIES)	Reconciliatio n	ADMINISTRATIV E & GENERAL (ACCUM. COST)	
		1. 00	2.00	4.00	5A	5. 00	
1. 00	GENERAL SERVICE COST CENTERS 00100 CAP REL COSTS-BLDG & FLXT	54, 915					1.00
2. 00 4. 00 5. 00 7. 00 7. 01	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 UTILITIES	58 7, 127 4, 322 0	52, 452 58 7, 127 4, 322	7, 359, 82 721, 09 2 342, 74	4 -7, 896, 616	1, 054, 195 450, 758	2. 00 4. 00 5. 00 7. 00 7. 01
8. 00 9. 00 10. 00 11. 00 13. 00 13. 01	00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01301 HOUSE SUPERVISORS	300 771 1, 615 1, 005 521	771 1, 615	192, 09 181, 24 480, 13	1 0 0 0 9 0	500, 123	8. 00 9. 00 10. 00 11. 00 13. 00 13. 01
13. 01 14. 00 15. 00 16. 00 17. 00 18. 00	01400 CENTRAL SERVI CES & SUPPLY 01500 PHARMACY 01600 MEDI CAL RECORDS & LI BRARY 01700 SOCI AL SERVI CE 01850 OTHER GENERAL SERVI CE (SPECI FY)	2, 050 1, 169 1, 250 0	2, 050 1, 169	5, 86 219, 89	8 0	438, 756 481, 550 347, 332 26, 654 0	14.00 15.00 16.00 17.00
19. 00 20. 00 21. 00 22. 00 23. 00	01900 NONPHYSI CI AN ANESTHETI STS 02000 NURSI NG SCHOOL 02100 &R SERVI CES-SALARY & FRI NGES APPRV 02200 &R SERVI CES-OTHER PRGM COSTS APPRV 02300 PARAMED ED PRGM-(SPECI FY)	0 0 0 0 0		334, 60	9 0 0 0 0 0 0 0 0 0	427, 383 0 0 0	18. 00 19. 00 20. 00 21. 00 22. 00 23. 00
	INPATIENT ROUTINE SERVICE COST CENTERS	_			-		
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, 794 0 0 0	7, 794 C C	1, 082, 00)))	8 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	04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 04200 SUBPROVI DER 04300 NURSERY 04400 SKI LLED NURSI NG FACI LI TY	0 0 0 250	250 0		0 0	0 0 0 60, 411	40.00 41.00 42.00 43.00 44.00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0		1	0 0	0	45. 00 46. 00
10. 00	ANCILLARY SERVICE COST CENTERS			4	<u> </u>		10.00
50.00	05000 OPERATING ROOM	6, 027	6, 027	435, 27	7 0	706, 617	50.00
51. 00 52. 00 53. 00	O5100 RECOVERY ROOM O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	178 0	l e	1	0 7 0	73, 283 0	51.00 52.00 53.00
54. 00 55. 00 56. 00	05400 RADI OLOGY-DI AGNOSTI C 05500 RADI OLOGY-THERAPEUTI C 05600 RADI OI SOTOPE	5, 834 0 0	5, 834 0	1	٥	1, 439, 591 0 0	
57. 00 58. 00 59. 00 60. 00 61. 00	05700 CT SCAN 05800 MRI 05900 CARDIAC CATHETERIZATION 06000 LABORATORY 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0 0 0 1,843	0 0 0 1,843)) 3 16, 37	0 0 0 0 0 0 3 0	0 0 0 1, 233, 293	57. 00 58. 00 59. 00 60. 00 61. 00
62. 00 63. 00 64. 00 65. 00 66. 00 67. 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL 06300 BLOOD STORING, PROCESSING & TRANS. 06400 I NTRAVENOUS THERAPY 06500 RESPIRATORY THERAPY 06600 PHYSICAL THERAPY 06700 OCCUPATIONAL THERAPY	0 400 284 2, 493	284	287, 96	5 0	0 0 85, 693 378, 352 778, 911	62. 00 63. 00 64. 00 65. 00 66. 00 67. 00
68. 00 69. 00 70. 00 71. 00 72. 00 73. 00	06800 SPEECH PATHOLOGY 06900 ELECTROCARDIOLOGY 07000 ELECTROENCEPHALOGRAPHY 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS	0 0 0 0				63, 630 15, 465 1, 467, 588	68. 00 69. 00 70. 00 71. 00 72. 00 73. 00
74. 00 75. 00 75. 01	07400 RENAL DIALYSIS 07500 ASC (NON-DISTINCT PART) 07501 CARDIAC REHAB 0UTPATIENT SERVICE COST CENTERS	0 0 0 911	911	61, 47	0 0 0	1, 467, 588 0 0 0 104, 357	74. 00 75. 00 75. 01
88. 00 89. 00 90. 00 91. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY	0 0 0 4,050	0 0 0 4, 050		0 0 0 0 0 0 6 0	0 0 16, 789 2, 083, 551	88. 00 89. 00 90. 00 91. 00

Health Financial Systems	IU HEALTH PAC	LI HOSPITA	۸L		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi	ider		Peri od:	Worksheet B-1	
					From 01/01/2015	5	
					Γο 12/31/2015	Date/Time Pre 5/27/2016 5:1	pared:
	CAPI TAL REI	ATED COSTS	c			3/2//2010 3. 1	O pili
	CALLIAL KEE	LATED COST.	ا ا				
Cost Center Description	BLDG & FIXT	MVBLE EQI	III P	EMPLOYEE	Reconciliatio	ADMINISTRATIV	
oost conten beschiptron	(SQUARE FEET)	(SQUARE FI		BENEFI TS	n	E & GENERAL	
	(SQUARE TEET)	(34371112 11		DEPARTMENT		(ACCUM. COST)	
				(GROSS		(7.000	
				SALARI ES)			
	1. 00	2.00		4.00	5A	5. 00	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART							92.00
OTHER REIMBURSABLE COST CENTERS							
94.00 09400 HOME PROGRAM DIALYSIS	0		0		0	0	
95. 00 09500 AMBULANCE SERVICES	0		0		0		
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0		0	0	96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0	(0	0	
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0		0	(0	0	98.00
99. 00 09900 CMHC	0		0	(0	0	
99. 10 09910 CORF	0		0	(0	0	
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0		0	(0	0	100.00
101.00 10100 HOME HEALTH AGENCY	0		0	(0	0	101.00
SPECIAL PURPOSE COST CENTERS							
105. 00 10500 KI DNEY ACQUI SI TI ON	0		0		0		105.00
106. 00 10600 HEART ACQUI SI TI ON	0		0		0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0		0		0		107. 00
108.00 10800 LUNG ACQUISITION	0		0		0		108. 00
109.00 10900 PANCREAS ACQUISITION	0		0	(0	0	109. 00
110.00 11000 INTESTINAL ACQUISITION	0		0	(0		110.00
111.00 11100 I SLET ACQUI SI TI ON	0		0	(0	0	111. 00
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	0		0	(0	0	116. 00
118.00 SUBTOTALS (SUM OF LINES 1-117)	50, 252	50	, 252	7, 283, 743	-7, 896, 616	14, 565, 934	118. 00
NONREI MBURSABLE COST CENTERS							
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0		0		0		190. 00
190.01 19001 VISITING SPECIALTY CLINIC	2, 025		, 025		0		
190. 02 19002 OUTREACH	1, 089	l .	0	76, 08		139, 174	
190. 03 19003 FOUNDATI ON	175		175		0		190. 03
190.04 19004 SPRING VALLEY FAMILY PRACTICE	0		0		0		190. 04
190.05 19005 PAOLI FAMILY PRACTICE	0		0	`	0		190. 05
190.06 19006 OTHER PROPERTY	1, 374		0	(0		190. 06
191. 00 19100 RESEARCH	0		0	(0		191. 00
192.00 19200 PHYSICIANS' PRIVATE OFFICES	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,	947, 951	213	, 009	1, 335, 696	5	7, 896, 616	202.00
Part I)							
203.00 Unit cost multiplier (Wkst. B, Part I)	17. 262151	4. 06	1027	0. 18148		0. 534063	
204.00 Cost to be allocated (per Wkst. B,				1, 23	7	152, 091	204.00
Part II)							
205.00 Unit cost multiplier (Wkst. B, Part				0. 000168	3	0. 010286	205.00
1)		l					I

	Financial Systems ALLOCATION - STATISTICAL BASIS	IU HEALTH PAC		CCN: 151306 Po	In Lie	u of Form CMS-2 Worksheet B-1	2552-10
				Fi To	rom 01/01/2015 o 12/31/2015		
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	UTILITIES (SQUARE FEET)	LAUNDRY & LINEN SERVICE (POUNDS OF LAUNDRY)	HOUSEKEEPI NG (SQUARE FEET)	5/27/2016 5: 1 DI ETARY (MEALS SERVED)	Орш
		7. 00	7. 01	8.00	9. 00	10.00	
1 00	GENERAL SERVICE COST CENTERS		1				1 00
1. 00 2. 00 4. 00 5. 00 7. 00 7. 01 8. 00 9. 00 10. 00 13. 01 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00	00100 CAP REL COSTS-BLDG & FIXT 00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 UTILITIES 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DIETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01301 HOUSE SUPERVISORS 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I&R SERVICES-SALARY & FRINGES APPRV	36, 626 0 300 771 1, 615 1, 005 521 0 2, 050 1, 169 1, 250 0 0	42, 319 300 771 1, 615 1, 005 521 0 2, 050 1, 169 1, 250 0	13, 594 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	35, 719 1, 615 1, 005 521 0 0 0 1, 250 0 0 0	4, 563 0 0 0 0 0 0 0 0	11. 00 13. 00 13. 01 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00
22. 00	02200 I &R SERVICES-OTHER PRGM COSTS APPRV	0	_	_	0	0	22.00
30. 00	02300 PARAMED ED PRGM-(SPECIFY) INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS CADE UNIT CADE	7, 794	7, 794	4, 156	7, 794	4, 563	30.00
31. 00 32. 00 33. 00 34. 00 40. 00 41. 00 42. 00 43. 00 44. 00 45. 00	03100 INTENSIVE CARE UNIT 03200 CORONARY CARE UNIT 03300 BURN INTENSIVE CARE UNIT 03400 SURGICAL INTENSIVE CARE UNIT 04000 SUBPROVIDER - IPF 04100 SUBPROVIDER - IRF 04200 SUBPROVIDER 04300 NURSERY 04400 SKILLED NURSING FACILITY 04500 NURSING FACILITY	0 0 0 0 0 0 0 250	250 C	0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	0 0 0 0 0 0 250 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 45. 00
46. 00	04600 OTHER LONG TERM CARE	0	<u>C</u>	0	0	0	46. 00
54. 00 55. 00 56. 00 57. 00 58. 00 59. 00 60. 00 61. 00 62. 00 63. 00 64. 00 66. 00 67. 00 68. 00 69. 00 70. 00 71. 00 72. 00 73. 00 74. 00 75. 00	05600 RADI OI SOTOPE 05700 CT SCAN 05800 MRI 05900 CARDI AC CATHETERI ZATI ON 06000 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 INTRAVENOUS THERAPY 06500 RESPI RATORY THERAPY 06600 PHYSI CAL THERAPY 06700 OCCUPATI ONAL THERAPY 06800 SPEECH PATHOLOGY 06900 ELECTROCARDI OLOGY	6, 027 0 1788 0 5, 834 0 0 0 1, 843 0 400 284 199 0 0 0 0 0 0 0 0 0 0 0 0 0	178 5, 834 0 0 0 0 1, 843 0 400 284 2, 493 0 0 0 0 0 0 0 0 0 0 0 0 0	0 40 0 2, 219 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	6, 027 0 178 0 5, 834 0 0 0 0 1, 843 0 400 284 2, 493 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	
88. 00 89. 00 90. 00 91. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER 09000 CLINIC 09100 EMERGENCY	0 0 0 4, 050	C	0	0 0 0 4, 050	0 0 0 0	88. 00 89. 00 90. 00 91. 00
92. 00	O9200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS						92.00
94. 00	09400 HOME PROGRAM DIALYSIS	0	С	0	0	0	94.00

Health Financial Systems IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151306 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 5:10 pm Cost Center Description OPERATION OF UTI LI TI ES LAUNDRY & HOUSEKEEPI NG DI ETARY PLANT (SQUARE FEET) LINEN SERVICE (SQUARE FEET) (MEALS (SQUARE FEET) (POUNDS OF SERVED) LAUNDRY) 7. 00 7. 01 9. 00 10.00 8.00 95.00 09500 AMBULANCE SERVICES 0 0 0 0 95.00 96. 00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 0 96.00 0 0 0 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 0 0 0 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 98.00 99. 00 09900 CMHC 0 0 99.00 0 0 0 99. 10 09910 CORF 0 0 0 99. 10 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 100.00 0 0 C 101.00 10100 HOME HEALTH AGENCY 0 101.00 SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SI TI ON 0 0 0 105. 00 0 0 106.00 10600 HEART ACQUISITION 0 106.00 Ω 107.00 10700 LIVER ACQUISITION 0 0 0 0 0 0 107.00 108. 00 10800 LUNG ACQUISITION 0 0 0 108.00 0 0 109.00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 110.00 11000 INTESTINAL ACQUISITION C 0 0 110.00 111.00 11100 | SLET ACQUISITION 0 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.) 0 0 0 0 115.00 116. 00 11600 HOSPI CE 0 116.00 0 4, 563 118.00 SUBTOTALS (SUM OF LINES 1-117) 38, 745 13, 594 34, 455 118.00 36, 451 NONREI MBURSABLE COST CENTERS 0 190. 00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190.01 19001 VISITING SPECIALTY CLINIC 0 190.01 0 2,025 0 0 0 0 0 190, 02 190. 02 19002 OUTREACH 1.089 190. 03 19003 FOUNDATI ON 0 0 190.03 175 175 175 190. 04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 190.04 0 190.05 190. 05 19005 PAOLI FAMILY PRACTICE 0 0 0 C 0 190.06 19006 OTHER PROPERTY 0 0 0 190.06 1, 374 0 0 191. 00 19100 RESEARCH 0 0 191.00 192. 00 19200 PHYSICIANS' PRIVATE OFFICES 0 0 0 192.00 C 0 193. 00 19300 NONPALD WORKERS 0 O 0 0 193.00 C 200.00 Cross Foot Adjustments 200.00 201.00 Negative Cost Centers 201.00

1, 617, 202

44. 154480

103, 060

2.813848

691, 491

4,636

16. 339966

0.109549

124, 822

9.182139

0.587686

7, 989

551, 426

22, 110

0.618998

15. 437890

578, 314 202. 00

43, 243 204. 00

9. 476879 205. 00

126, 739864 203, 00

202.00

203.00

204.00

205.00

Part I)

Part II)

11)

Cost to be allocated (per Wkst. B,

Cost to be allocated (per Wkst. B,

Unit cost multiplier (Wkst. B, Part

Unit cost multiplier (Wkst. B, Part I)

	FINANCIAI SYSTEMS	TU HEALTH PAC		00N 4E4004 D		u or form CMS-2	
COST	ALLOCATION - STATISTICAL BASIS		Provi der	F	eriod: rom 01/01/2015 o 12/31/2015		pared:
	Cost Center Description	CAFETERIA (MAN HOURS)	NURSI NG ADMI NI STRATI O N (DI RECT	HOUSE SUPERVI SORS (DI RECT NRSI NG HRS)	CENTRAL SERVI CES & SUPPLY (COSTED	PHARMACY (COSTED REQUIS.)	
			NRŜI NG HRS)	,	REQUIS.)		
	GENERAL SERVICE COST CENTERS	11. 00	13. 00	13. 01	14. 00	15. 00	
1.00	00100 CAP REL COSTS-BLDG & FLXT						1.00
2. 00 4. 00 5. 00 7. 00 7. 01 8. 00 9. 00 11. 00 13. 01 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00 20. 00 21. 00 22. 00 23. 00	00200 CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00701 UTILITIES 00800 LAUNDRY & LINEN SERVICE 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01301 HOUSE SUPERVISORS 01400 CENTRAL SERVICES & SUPPLY 01500 PHARMACY 01600 MEDICAL RECORDS & LIBRARY 01700 SOCIAL SERVICE 01850 OTHER GENERAL SERVICE (SPECIFY) 01900 NONPHYSICIAN ANESTHETISTS 02000 NURSING SCHOOL 02100 I &R SERVICES-SALARY & FRINGES APPRV 02200 I &R SERVICES-OTHER PRGM COSTS APPRV	196, 113 10, 162 10, 147 612 7, 942 0 0 4, 160	103, 987 0 0 0 0 0 0 0 0 0			1, 534, 508 0 0 0 0 0 0	2. 00 4. 00 5. 00 7. 00 7. 01 8. 00 9. 00 10. 00 11. 00 13. 00 13. 01 14. 00 15. 00 16. 00 17. 00 18. 00 20. 00 21. 00 22. 00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 31. 00	03000 ADULTS & PEDIATRICS 03100 INTENSIVE CARE UNIT	38, 798	1	38, 798 0		1	30.00
32.00	03200 CORONARY CARE UNIT		Ö	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	0	0	34. 00 40. 00
41.00	04100 SUBPROVI DER - TPF				0		41.00
42. 00	04200 SUBPROVI DER	0	Ö	Ö	Ō	Ö	42.00
43.00	04300 NURSERY	3, 505	3, 505	3, 505	0	0	43.00
44.00	04400 SKILLED NURSING FACILITY	0	0	0	0	0	44.00
45. 00 46. 00	04500 NURSING FACILITY 04600 OTHER LONG TERM CARE	0	0	0	0	0	45. 00 46. 00
40.00	ANCI LLARY SERVI CE COST CENTERS		,, 0		0		40.00
50.00	05000 OPERATING ROOM	14, 076	14, 076	14, 076	932	0	
51.00	05100 RECOVERY ROOM	0	1	0	0	0	
52. 00 53. 00	O5200 DELI VERY ROOM & LABOR ROOM O5300 ANESTHESI OLOGY	4, 422		4, 422 0		0	52. 00 53. 00
54.00	05400 RADI OLOGY-DI AGNOSTI C	25, 873	-	1	_		
	05500 RADI OLOGY-THERAPEUTI C	0	Ō	Ö	_	0	1
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	
57. 00 58. 00	05700 CT SCAN 05800 MRI	0	0	0	0	0	57. 00 58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON			0	0	0	59.00
60.00	06000 LABORATORY	1, 392	0	0	46, 737	0	60.00
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	0	0	62.00
64. 00	06400 I NTRAVENOUS THERAPY	1, 672	1, 672	1, 672	0	66, 920	
65.00	06500 RESPIRATORY THERAPY	11, 153	1	0	0	0	65.00
66.00	06600 PHYSI CAL THERAPY	16, 888	0	0	0	0	66.00
67. 00 68. 00	O6700 OCCUPATI ONAL THERAPY O6800 SPEECH PATHOLOGY	0	0	0	0	0	67.00
69. 00	06900 ELECTROCARDI OLOGY			0	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	Ō	Ö	0	Ō	70.00
71. 00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0	0	63, 618	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0	15, 465	1 447 500	72.00
73. 00 74. 00	07300 DRUGS CHARGED TO PATIENTS 07400 RENAL DIALYSIS		0	0	0	1, 467, 588 0	73. 00 74. 00
75. 00	07500 ASC (NON-DISTINCT PART)		ő	Ö	0	Ö	75.00
75. 01	07501 CARDI AC REHAB	65	0	0	0	0	75. 01
00.00	OUTPATIENT SERVICE COST CENTERS		_	_	_	_	00 00
88. 00 89. 00	08800 RURAL HEALTH CLINIC 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	1	0		0	88. 00 89. 00
90.00	09000 CLINIC		Ö	0	0	0	90.00
91.00	09100 EMERGENCY	41, 514	41, 514	41, 514	0	0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART		1	l			92.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COST ALLOCATION - STATISTICAL BASIS		Provi der		Peri od:	Worksheet B-1	
				From 01/01/2015	D-+- /T: D	
				To 12/31/2015	Date/Time Pre 5/27/2016 5:1	pared: O nm
Cost Center Description	CAFETERI A	NURSI NG	HOUSE	CENTRAL	PHARMACY	O piii
	(MAN HOURS)	ADMI NI STRATI O	SUPERVI SORS	SERVICES &	(COSTED	
	(, , ,	N	(DI RECT	SUPPLY	REQUIS.)	
		(DI RECT	NRSI NG HRS)	(COSTED	,	
		NRSING HRS)	,	REQUIS.)		
	11. 00	13. 00	13. 01	14. 00	15. 00	
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0		0	0	94. 00
95. 00 09500 AMBULANCE SERVICES	0	0		0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0		0	0	96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0		0 0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0		0 0	0	98. 00
99. 00 09900 CMHC	0	0		0 0	0	99.00
99. 10 09910 CORF	0	0		0 0	0	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0		0 0	0	100.00
101. 00 10100 HOME HEALTH AGENCY	0	0		0 0	0	101.00
SPECIAL PURPOSE COST CENTERS			ı	ما		
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		0 0		105.00
106. 00 10600 HEART ACQUISITION	0	0		0 0		106.00
107. 00 10700 LI VER ACQUI SI TI ON	0	0		0 0		107. 00 108. 00
108. 00 10800 LUNG ACQUISITION	0	0		0		
109. 00 10900 PANCREAS ACQUISITION	0	0		0		109.00
110. 00 11000 INTESTINAL ACQUISITION	0	0		0		110.00
111. 00 11100 SLET ACQUI SI TI ON 113. 00 11300 INTEREST EXPENSE	U	Ü		U U	U	111.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF						113. 00 114. 00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0			^	115.00
116. 00 11600 HOSPI CE	0	0		0		116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	192, 381	103, 987	103, 98	7 126, 752		1
NONREI MBURSABLE COST CENTERS	172, 301	103, 707	103, 70	120, 732	1, 554, 500	1110.00
190. 00 19000 GI FT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 0	0	190. 00
190. 01 19001 VISITING SPECIALTY CLINIC	0	0				190. 01
190. 02 19002 OUTREACH	3, 732	0				190.02
190. 03 19003 FOUNDATI ON	0, 732	0				190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE	0	0		0		190. 04
190. 05 19005 PAOLI FAMILY PRACTICE	0	0		o o		190.05
190. 06 19006 OTHER PROPERTY	0	0		0		190. 06
191. 00 19100 RESEARCH	0	0		o o		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	o	0		ol ol		192.00
193. 00 19300 NONPALD WORKERS	0	0		ol ol	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,	155, 526	814, 839	681, 12	6 863, 227	609, 845	202.00
Part I)	·	•				
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 793043	7. 835970	6. 55010	7 6. 810362	0. 397421	203.00
204.00 Cost to be allocated (per Wkst. B,	25, 520	19, 502	5, 89	2 54, 739	32, 986	204. 00
Part II)						
205.00 Unit cost multiplier (Wkst. B, Part	0. 130129	0. 187543	0. 05666	0. 431859	0. 021496	205. 00
11)						

COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151306 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 5:10 pm OTHER GENERAL SERVI CE MEDI CAL SOCI AL NONPHYSI CI AN NURSI NG Cost Center Description (SPECIFY) RECORDS & **SERVICE** (TIME SPENT) **ANESTHETLSTS** SCHOOL (ASSI GNED (TIME SPENT) LI BRARY (ASSI GNED (GROSS REVE TIME) TIME) NUE) 16. 00 17. 00 18.00 19.00 20.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1 00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 5.00 00500 ADMINISTRATIVE & GENERAL 5.00 7.00 00700 OPERATION OF PLANT 7.00 7.01 00701 UTI LI TI ES 7.01 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 13.01 01301 HOUSE SUPERVI SORS 13.01 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 57, 926, 130 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 18.00 01850 OTHER GENERAL SERVICE (SPECIFY) 0 18.00 01900 NONPHYSICIAN ANESTHETISTS 0 O 100 19 00 19 00 02000 NURSING SCHOOL 0 20.00 0 C 0 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 0 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 0 22.00 0 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 0 0 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 30.00 03000 ADULTS & PEDIATRICS 795, 948 0 0 0 30.00 0 03100 INTENSIVE CARE UNIT 0 31.00 0 0 31.00 32.00 0 03200 CORONARY CARE UNIT 0 0 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 0 0 0 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 0 34 00 0 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 0 0 0 0 40.00 0 0 41 00 0 C 0 41.00 04200 SUBPROVI DER 42.00 42.00 0 0 04300 NURSERY 0 43.00 324, 971 0 0 43.00 0 04400 SKILLED NURSING FACILITY 44.00 0 44.00 0 0 0 45.00 04500 NURSING FACILITY 0 C 0 45.00 46.00 04600 OTHER LONG TERM CARE 0 0 0 0 46.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 50.00 7, 230, 162 \cap 100 0 0 51.00 05100 RECOVERY ROOM 0 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 1,005,852 0 0 0 52.00 0 0 05300 ANESTHESI OLOGY 0 53.00 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 10,060,771 C 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 0 0 0 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 05700 CT SCAN 0 57 00 0 C 0 57 00 58.00 05800 MRI 0 C 0 58.00 05900 CARDI AC CATHETERI ZATI ON 0 0 59.00 0 0 59.00 06000 LABORATORY 9.710.337 0 60.00 0 60.00 0 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 C 0 0 O 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0 0 0 0 0 63.00 0 64 00 06400 INTRAVENOUS THERAPY 4. 345. 429 0 0 64 00 0 06500 RESPIRATORY THERAPY 0 65.00 763, 139 C 0 65.00 06600 PHYSI CAL THERAPY 1, 626, 396 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 0 0 0 67.00 0 0 06800 SPEECH PATHOLOGY Ω 0 68 00 68 00 0 0 0 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 70.00 0 0 0 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 389, 917 0 0 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 119 537 72 00 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 6, 281, 050 0 0 0 73.00 07400 RENAL DIALYSIS 0 0 74.00 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 75.00 07501 CARDI AC REHAB 75.01 206, 255 0 0 0 0 75.01 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 n 0 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 0 0 89.00 0 90.00 09000 CLI NI C 27, 754 0 0 0 90.00 91. 00 09100 EMERGENCY 15, 038, 612 0 0 ol 91.00 COST ALLOCATION - STATISTICAL BASIS Provi der CCN: 151306 Peri od: Worksheet B-1 From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 5:10 pm OTHER GENERAL SERVI CE NONPHYSI CI AN NURSI NG Cost Center Description MEDI CAL SOCI AL (SPECI FY) RECORDS & **SERVICE** (TIME SPENT) **ANESTHETISTS** SCHOOL (TIME SPENT) (ASSI GNED (ASSI GNED LI BRARY (GROSS REVE TIME) TIME) NUE) 19.00 20.00 16. 00 17. 00 18.00 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 92.00 OTHER REIMBURSABLE COST CENTERS 94.00 09400 HOME PROGRAM DIALYSIS 94.00 000000 0 95.00 09500 AMBULANCE SERVICES 0 0 95.00 0 09600 DURABLE MEDICAL EQUIP-RENTED 96.00 0 96.00 0 0 0 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 98.00 09850 OTHER REIMBURSABLE COST CENTERS 0 o 0 98.00 0 0 99.00 109900 CMHC 0 99.00 0 99. 10 09910 CORF 0 0 99.10 0 100.00 10000 I&R SERVICES-NOT APPRVD PRGM 0 0 0 0 0 100.00 101.00 10100 HOME HEALTH AGENCY 0 0 0 0 0 101.00 SPECIAL PURPOSE COST CENTERS 105.00 10500 KIDNEY ACQUISITION 0 0 0 0 0 105. 00 106.00 10600 HEART ACQUISITION 0 0 0 0 0 106.00 0 107. 00 10700 LIVER ACQUISITION 0 0 0 0 0 107.00 108.00 10800 LUNG ACQUISITION 0 0 108 00 Ω 109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 109.00 110.00 11000 INTESTINAL ACQUISITION 0 o 0 110.00 0 0 111.00 11100 I SLET ACQUISITION 0 0 o C 0 111.00 113.00 11300 INTEREST EXPENSE 113.00 114.00 11400 UTILIZATION REVIEW-SNF 114.00 115.00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 ol 0 115.00 116. 00 11600 HOSPI CE 0 0 0 0 116,00 118.00 SUBTOTALS (SUM OF LINES 1-117) 57, 926, 130 0 100 0 118.00 NONREIMBURSABLE COST CENTERS 190. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 0 0 0 190. 00 0 190.01 19001 VISITING SPECIALTY CLINIC 0 190.01 0 0 0 190. 02 19002 OUTREACH 0 0 0 0 190.02 190. 03 19003 FOUNDATI ON 0 0 0 190.03 0 0 190. 04 19004 SPRING VALLEY FAMILY PRACTICE 0 0 0 190.04 190. 05 19005 PAOLI FAMILY PRACTICE 0 0 190 05 C 0 0 190.06 19006 OTHER PROPERTY 0 190.06 191. 00 19100 RESEARCH 0 0 0 191.00 0 192. 00 19200 PHYSI CLANS' PRI VATE OFFI CES 0 0 0 192.00 0 C 193. 00 19300 NONPALD 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, 135, 804 658, 931 0 202.00 0 Part I) 203.00 Unit cost multiplier (Wkst. B, Part I) 0.002344 0.000000 0.000000 6, 589. 310000 0.000000 203.00 204.00 Cost to be allocated (per Wkst. B, 31, 356 4, 993 0 204.00 Part II) 0.000000 205.00 205.00 Unit cost multiplier (Wkst. B, Part 0.000541 0.000000 0.000000 49.930000 II)

Health Financial Systems IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 COST ALLOCATION - STATISTICAL BASIS Provider CCN: 151306 Period: Worksheet B-1

From 01/01/2015 12/31/2015 Date/Time Prepared: 5/27/2016 5:10 pm INTERNS & RESIDENTS SERVI CES-SALA | SERVI CES-OTHE PARAMED ED Cost Center Description RY & FRINGES R PRGM COSTS PRGM (ASSI GNED **APPRV APPRV** (ASSI GNED (ASSI GNED TIME) TIME) TIME) 21. 00 22.00 23.00 GENERAL SERVICE COST CENTERS 1.00 00100 CAP REL COSTS-BLDG & FLXT 1.00 00200 CAP REL COSTS-MVBLE EQUIP 2.00 2.00 00400 EMPLOYEE BENEFITS DEPARTMENT 4.00 4.00 00500 ADMINISTRATIVE & GENERAL 5.00 5.00 7.00 00700 OPERATION OF PLANT 7.00 7.01 00701 UTI LI TI ES 7.01 00800 LAUNDRY & LINEN SERVICE 8.00 8 00 00900 HOUSEKEEPI NG 9.00 9.00 10.00 01000 DI ETARY 10.00 11.00 01100 CAFETERI A 11.00 01300 NURSING ADMINISTRATION 13 00 13 00 13.01 01301 HOUSE SUPERVI SORS 13.01 01400 CENTRAL SERVICES & SUPPLY 14.00 14.00 01500 PHARMACY 15.00 15.00 01600 MEDICAL RECORDS & LIBRARY 16.00 16.00 17.00 01700 SOCIAL SERVICE 17.00 01850 OTHER GENERAL SERVICE (SPECIFY) 18.00 18.00 01900 NONPHYSICIAN ANESTHETISTS 19 00 19 00 02000 NURSING SCHOOL 20.00 20.00 02100 I&R SERVICES-SALARY & FRINGES APPRV 21.00 21.00 02200 I&R SERVICES-OTHER PRGM COSTS APPRV 22.00 0 22.00 02300 PARAMED ED PRGM-(SPECIFY) 0 23.00 23.00 INPATIENT ROUTINE SERVICE COST CENTERS 03000 ADULTS & PEDIATRICS 30.00 0 30.00 0 03100 INTENSIVE CARE UNIT 0 31.00 0 31.00 32.00 0 03200 CORONARY CARE UNIT 0 32.00 33.00 03300 BURN INTENSIVE CARE UNIT 00000000 0 0 33.00 03400 SURGICAL INTENSIVE CARE UNIT 0 34 00 34.00 04000 SUBPROVI DER - I PF 04100 SUBPROVI DER - I RF 40.00 0 0 40.00 0 41.00 C 41 00 04200 SUBPROVI DER 0 42.00 42.00 04300 NURSERY 0 43.00 0 43.00 04400 SKILLED NURSING FACILITY 0 44.00 0 44.00 45.00 04500 NURSING FACILITY C 45.00 46.00 04600 OTHER LONG TERM CARE 0 0 46,00 ANCILLARY SERVICE COST CENTERS 05000 OPERATI NG ROOM 50.00 0 \cap 50.00 0 0 51.00 05100 RECOVERY ROOM 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0000000 0 52.00 0 05300 ANESTHESI OLOGY 0 53.00 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 54.00 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 56.00 05600 RADI OI SOTOPE 0 56.00 05700 CT SCAN 0 57 00 C 57 00 58.00 05800 MRI C 58.00 0 05900 CARDIAC CATHETERIZATION 0 59.00 0 59.00 06000 LABORATORY 0 60.00 0 60.00 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 06300 BLOOD STORING, PROCESSING & TRANS. 63.00 0000000000000 0 63.00 64 00 06400 I NTRAVENOUS THERAPY 0 0 64 00 06500 RESPIRATORY THERAPY 0 65.00 C 65.00 66.00 06600 PHYSI CAL THERAPY 66.00 06700 OCCUPATI ONAL THERAPY 67.00 0 0 67.00 0 06800 SPEECH PATHOLOGY Ω 68 00 68 00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 0 70.00 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 72 00 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 0 0 73.00 07400 RENAL DIALYSIS 0 74.00 0 74.00 0 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 07501 CARDI AC REHAB 75.01 0 0 0 75.01 OUTPATIENT SERVICE COST CENTERS 88 00 08800 RURAL HEALTH CLINIC 0 0 0 88 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 0 89.00 90.00 09000 CLI NI C 0 0 90.00 91. 00 09100 EMERGENCY 0 91.00

Health Financial Systems
COST ALLOCATION - STATISTICAL BASIS Provider CCN: 151306 | Period: | Worksheet B-1 | From 01/01/2015 | To 12/31/2015 | Date/Time Prepared:

			To	0 12/31/2015 Date/Ti	me Prepared: 16 5:10 pm
	INTERNS &	RESI DENTS		3/21/20	10 3. 10 pili
		I			
Cost Center Description		SERVICES-OTHE R PRGM COSTS	PARAMED ED PRGM		
	RY & FRINGES APPRV	APPRV	(ASSI GNED		
	(ASSI GNED	(ASSI GNED	TIME)		
	TIME)	TIME)	111112)		
	21. 00	22. 00	23. 00		
92.00 O9200 OBSERVATION BEDS (NON-DISTINCT PART					92.00
OTHER REIMBURSABLE COST CENTERS					
94. 00 09400 HOME PROGRAM DIALYSIS	0	0			94.00
95. 00 09500 AMBULANCE SERVI CES	0	0			95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0			96. 00 97. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0		98.00
99. 00 09900 CMHC	0		0		99.00
99. 10 09910 CORF	0	0	l ĭ		99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0	0			100.00
101.00 10100 HOME HEALTH AGENCY	0	Ö			101.00
SPECIAL PURPOSE COST CENTERS	1	•			
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0		105. 00
106. 00 10600 HEART ACQUI SI TI ON	0	1			106. 00
107.00 10700 LIVER ACQUISITION	0	0	I -		107. 00
108. 00 10800 LUNG ACQUISITION	0	0	· · · · · · · · · · · · · · · · · · ·		108. 00
109. 00 10900 PANCREAS ACQUISITION	0	0			109.00
110.00 11000 INTESTINAL ACQUISITION	0	0	0		110.00
111. 00 11100 ISLET ACQUISITION 113. 00 11300 INTEREST EXPENSE	0	0	U		111. 00 113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF					114.00
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	0		115.00
116. 00 11600 HOSPI CE	0	0			116.00
118.00 SUBTOTALS (SUM OF LINES 1-117)	0	0			118.00
NONREI MBURSABLE COST CENTERS					
190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	-			190. 00
190.01 19001 VISITING SPECIALTY CLINIC	0	1			190. 01
190. 02 19002 OUTREACH	0	0	·		190. 02
190. 03 19003 FOUNDATION	0	0	0		190. 03
190. 04 19004 SPRING VALLEY FAMILY PRACTICE 190. 05 19005 PAOLI FAMILY PRACTICE	0	0	0		190. 04 190. 05
190.06 19006 0THER_PROPERTY	0		·		190.05
191. 00 19100 RESEARCH	0	0	0		191.00
192. 00 19200 PHYSI CLANS' PRI VATE OFFICES	0	0	Ö		192.00
193. 00 19300 NONPALD WORKERS	0	Ö	Ö		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	0		202. 00
Part I)					
203.00 Unit cost multiplier (Wkst. B, Part I)	0. 000000	0. 000000			203.00
204.00 Cost to be allocated (per Wkst. B,	0	0	0		204. 00
Part II) 205.00 Unit cost multiplier (Wkst. B, Part	0. 000000	0. 000000	0. 000000		205. 00
II)	0.00000	0.00000	0.000000		203.00
1 1117	1	ı	1		ı

nearth Financial Systems	TU HEALTH PAULI HUSPITAL	in Lie	u 01 F01111 CW3-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151306	From 01/01/2015	Date/Time Prepared:
			5/27/2016 5: 10 pm

					5/27/2016 5:1	O pm
		Ti tl	e XVIII	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	
INPATIENT ROUTINE SERVICE COST CENTERS		,	,			
30. 00 03000 ADULTS & PEDI ATRI CS	4, 229, 620		4, 229, 620	0	0	30.00
31. 00 03100 I NTENSI VE CARE UNI T 32. 00 03200 CORONARY CARE UNI T			0	0	0	31. 00 32. 00
33. 00 03300 BURN INTENSIVE CARE UNIT				0	0	33.00
34. 00 03400 SURGI CAL I NTENSI VE CARE UNI T			0	0	Ö	34.00
40. 00 04000 SUBPROVI DER - PF	0		Ö	0	0	40.00
41. 00 04100 SUBPROVI DER - I RF	0		0	0	0	41.00
42. 00 04200 SUBPROVI DER	0		0	0	0	42.00
43. 00 04300 NURSERY	165, 907		165, 907	0	0	43.00
44. 00 04400 SKILLED NURSING FACILITY	0		0	0	0	44.00
45.00 04500 NURSING FACILITY 46.00 04600 OTHER LONG TERM CARE			0	0	0 0	45. 00 46. 00
ANCILLARY SERVICE COST CENTERS	1 0			0	0	40.00
50. 00 05000 OPERATING ROOM	2, 447, 524		2, 447, 524	0	0	50.00
51. 00 05100 RECOVERY ROOM	0	l .	0	0	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	195, 785		195, 785	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	0		0	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 715, 887		2, 715, 887	0	0	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C 56. 00 05600 RADI OI SOTOPE	0		0	0	0	55. 00 56. 00
57. 00 05700 CT SCAN				0	0	57.00
58. 00 05800 MRI			0	0	ő	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0		Ö	0	0	59.00
60. 00 06000 LABORATORY	2, 374, 054		2, 374, 054	0	0	60.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	222 002		0	0	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY 65. 00 06500 RESPI RATORY THERAPY	223, 992 612, 615	l .	223, 992 612, 615		0	64. 00 65. 00
66. 00 06600 PHYSI CAL THERAPY	1, 308, 800	l .	1, 308, 800		0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	Ö	0	0	Ö	67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00 06900 ELECTROCARDI OLOGY	0		0	0	0	69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0		0	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 72.00 07200 MPL. DEV. CHARGED TO PATIENTS	531, 788 129, 326		531, 788 129, 326		0 0	71. 00 72. 00
73.00 07300 DRUGS CHARGED TO PATTENTS	2, 849, 345	l .	2, 849, 345		0	73.00
74. 00 07400 RENAL DI ALYSI S	2,047,343		2,047,343	0	Ö	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0		Ö	0	0	75. 00
75. 01 07501 CARDI AC REHAB	229, 800		229, 800	0	0	75. 01
OUTPATIENT SERVICE COST CENTERS	_		,			
88. 00 08800 RURAL HEALTH CLINIC	0		0		0	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	25 920		0			89. 00 90. 00
91. 00 09100 EMERGENCY	25, 820 4, 216, 199		25, 820 4, 216, 199			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	2, 350, 254		2, 350, 254		Ö	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0		0		0	94.00
95. 00 09500 AMBULANCE SERVICES	0		0	_	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 98. 00 09850 OTHER REIMBURSABLE COST CENTERS			0	0	0	97. 00 98. 00
99. 00 09900 CMHC				U	0	99.00
99. 10 09910 CORF	0		0		ő	99. 10
100.00 10000 I&R SERVICES-NOT APPRVD PRGM	0		0		0	100.00
101.00 10100 HOME HEALTH AGENCY	0		0		0	101. 00
SPECIAL PURPOSE COST CENTERS		1	1			
105. 00 10500 KI DNEY ACQUI SI TI ON 106. 00 10600 HEART ACQUI SI TI ON	0	+	0 0			105. 00 106. 00
107. 00 10700 LIVER ACQUISITION						107.00
108. 00 10800 LUNG ACQUI SI TI ON	0		0			108.00
109.00 10900 PANCREAS ACQUISITION	0		0		0	109.00
110.00 11000 INTESTINAL ACQUISITION	0		0			110.00
111. 00 11100 SLET ACQUISITION	0		0		0	111.00
113. 00 11300 NTEREST EXPENSE						113.00
114.00 11400 UTILIZATION REVIEW-SNF 115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)			_		_	114. 00 115. 00
116. 00 11600 H0SPI CE						116.00
200.00 Subtotal (see instructions)	24, 606, 716	О	24, 606, 716	0		200.00
						<u> </u>

Health Fina	ncial Systems	IU HEALTH PAC	LI H	OSPI TAL		In Lie	u of Form CMS-	2552-10
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES			Provi der		Peri od:	Worksheet C	
						From 01/01/2015		
						To 12/31/2015	Date/Time Pre	pared:
							5/27/2016 5: 1	0 pm
				Ti tl	e XVIII	Hospi tal	Cost	
						Costs		
	Cost Center Description	Total Cost	Ther	apy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.		Adj .		Di sal I owance		
		B, Part I,						
		col. 26)						
		1. 00		2.00	3. 00	4. 00	5. 00	
201.00	Less Observation Beds	2, 350, 254			2, 350, 25	4	0	201.00
202. 00	Total (see instructions)	22, 256, 462		0	22, 256, 46	2 0	0	202.00

Hearth Financial Systems 10	HEALTH PAULT HUSPITAL	in Lieu	1 OF FORM CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES	Provi der CCN: 151306	From 01/01/2015	Worksheet C Part I Date/Time Prepared: 5/27/2016 5:10 pm

Cost Center Description			Ti +I		Hospi tal	5/27/2016 5: 1 Cost	
Cost Center Description				e viii	поѕргтаг	COST	
INVALLED TROUTINE SERVICE COST CENTERS 795, 948 795, 948 33 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	Cost Center Description	·	Outpati ent	+ col. 7)	Ratio	Inpati ent Rati o	
30.00 GROUND FAURESINE CARE UNIT 0 0 0 0 0 0 0 0 0	INDATIENT DOUTINE CEDVICE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
31-00 SISTOD INTERSIVE CARE UNIT 0		795 948		795 948			30 00
32.00 03000		1 1		0			
34.00 034000 SURGICAL INTERSIVE CARE UNIT		0		0			32.00
0.000 0.0000 SUBPROVIDER - 1 PF		0		0			
1-1.00 G1-100 SUBPROVIDER 1 IFF		0		0			
42.00 0.4200 SURPROVIDER 0 0 0 42.00		0					
44.00 04-000 04-0000 04-0000 04-0000 04-0000 04-0000 04-0000 04-0000 04-0000 04-0000 04-0000		0					•
45.00 0.4500 DIRES IND. FACILITY 0 0 0 45.00	43. 00 04300 NURSERY	324, 971		324, 971			43.00
46.00		0		0			
ANCILLARY SERVICE COST CENTRES 50.00 (05000) OPERATING ROOM 51.00 (05000) OPERATING ROOM 51.00 (05000) OPERATING ROOM 53.00 (05000) OPERATING ROOM 54.00 (05000) OPERATING ROOM 55.00 (05000) OPERATING ROOM 56.00 (05000) OPERATING ROOM 56.0		0		0			•
50.00 50.000 FERNATING ROOM \$32, 406 \$4, 881, 504 \$7, 714, 000 \$0, 17283 \$0, 000000 \$5, 00 \$50.000 \$50.0000000 \$50.0000000 \$50.0000000 \$50.0000000 \$50.0000000 \$50.0000000 \$50.0000000 \$50.0000000 \$50.0000000 \$50.0000000 \$50.0000000 \$50.0000000 \$50.0000000 \$50.0000000 \$50.0000000 \$50.00000000 \$50.00000000 \$50.00000000 \$50.00000000 \$50.00000000 \$50.00000000 \$50.000000000 \$50.000000000 \$50.000000000 \$50.000000000 \$50.00000000000000000000000000000000000		0					46.00
51.00 0100 ELCOVERY ROOM 0 0 0 0 0 0 0 0 0		832, 496	6, 881, 504	7, 714, 000	0. 317283	0. 000000	50.00
53.00 0.5300 AMESTHESIOLOGY 0 0 0.000000 0.000000 0.500000 0.550 0.050 0		1 1	0				•
54.00 05400 RADI CLOY-IN LERAPLY 10 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		754, 643	251, 209	1, 005, 852			•
55.00		0 07 025	0	ή			
56. DO 05600 RADIO ISOTOPE DO DO DO DO DO DO DO D		97, 935	9, 962, 836	10,060,771			
57.00 05700 CT SCAN 0 0 0 0 0 0 0 0 0			0		l		
99 00 059000 CARDATOR CATHETERIZATION 0 0 0 0 0 0 0 0 0		0	0	0	l		
60.00		0	0	0			1
0.000 0.0000 0.000000 0.0000		0	0	0			1
Color Color Color BLOOD & PACKED RED BLOOD CELL 0		1	9, 2/1, 9/6		l		1
0.0000 0.0000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.00000		1	0	i i			1
65.00 06.500 RESPIRATORY THERAPY 45.094 718, 045 763, 139 0.807757 0.00000 65.00		O	0	Ö			
66.00 06-600 PINSI (CAL THERAPY 56,790 1,569,606 1,626,396 0.804724 0.000000 67.00 67.00 67.00 0.000000 0.000000 67.00 68.00 0.8000 0.800000 0.000000 0.000000 67.00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00		1					1
67.00 06/700 05/7		1 1			l		•
88. 00 08800 SPEECH PATHOLOGY 0 0 0 0 0 0 0.000000 0.000000 68. 00		56, 790	1, 569, 606		l		•
69. 00 0.00000 0.0000000 0.000000 0.000000 0.0000000 0.0000000 0.0000000 0.0000000 0.00000000		0	0				
17.0		o	0	Ö			•
12.00 07200 IMPL DEV. CHARGED TO PATIENTS 1, 067 97, 344 98, 411 1, 314142 0, 000000 73, 00 73.0		0	0	0	0. 000000		
173.00 07300 DRIVES CHARGED TO PATIENTS 512,856 5,768,194 6,281,050 0.453642 0.000000 74.00 074.00 074.00 074.00 074.00 074.00 075.00 0.0000000 0.000000 0.000000 0.000000 0.000000 0.0000000 0.000000 0.00		1					
74. 00 07400 RENAL DI IALYSIS 0 0 0 0 0 0 0 0 0		1 1					•
75. 00 07500 ASC (NON-DISTINCT PART) 0 0 0 0 0 0 0 0 0		1	3, 700, 194 N				•
Name			0	Ö			•
88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 88.00 90.00 08900 FEBERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 99.00		0	206, 255	206, 255	1. 114155	0. 000000	75. 01
89.00 09900 EDERALLY QUALIFIED HEALTH CENTER 0 0 0 0 0 0 0 0 0							
90. 00 09000 CLINIC 1,449 26,305 27,754 0.930316 0.000000 90.00 91. 00 09100 EMERGENCY 86,862 14,951,750 15,038,612 0.280358 0.000000 91.00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 20,278 1,452,837 1,473,115 1.595431 0.000000 91.00 94. 00 09400 HOME PROGRAM DIALYSIS 0 0 0 0 0 0.000000 0.000000 0.000000 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0.000000 0.000000 95.00 96. 00 09500 OURABLE MEDICAL EQUIP-RENTED 0 0 0 0 0.000000 0.000000 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 0 0 0.000000 0.000000 97.00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0.000000 0.000000 97.00 99. 10 09900 CMHC 0 0 0 0 0 0.000000 0.000000 97.00 99. 10 09910 CORF 0 0 0 0 0 0 0.000000 0.000000 99.00 99. 10 09910 CORF 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		- 1	0				•
91. 00 09100 EMERGENCY 86, 862 14, 951, 750 15, 038, 612 0. 280358 0. 000000 91. 00 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART 20, 278 1, 452, 837 1, 473, 115 1.595431 0. 000000 92. 00 94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0 0. 000000 0. 000000 94. 00 95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0. 000000 0. 000000 95. 00 97. 00 09700 OURABLE MEDI CAL EQUI P-RINTED 0 0 0 0 0. 000000 0. 000000 96. 00 97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0. 000000 0. 000000 97. 00 98. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0 0. 000000 0. 000000 97. 00 99. 00 09900 CMHC 0 0 0 0 0 0. 000000 0. 000000 98. 00 99. 10 09910 CORF 0 0 0 0 0 0 0 0. 000000 0. 000000 99. 00 99. 10 09910 LARS SERVI CES-NOT APPRVD PRGM 0 0 0 0 0 0 0 0 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 106. 00 10600 LARS TA CQUI SI TI ON 0 0 0 0 0 0 106. 00 10600 LIVER ACQUI SI TI ON 0 0 0 0 0 0 107. 00 10700 LIVER ACQUI SI TI ON 0 0 0 0 0 0 109. 00 10900 PANCEAS ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 11100 HOME ACQUI SI TI ON 0 0 0 0 0 0 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 11100 INTESTI NAL ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 11100 HOME ACQUI SI TI ON 0 0 0 0 0 0 0 111. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 116. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0		1 1	26 305	27 754	0 930316	0 000000	
OTHER REIMBURSABLE COST CENTERS 0							
94. 00 09400 HOME PROGRAM DI ALYSIS 0 0 0 0 0.000000 0.000000 94. 00 95. 00 9500 AMBULANCE SERVI CES 0 0 0 0 0.000000 0.000000 95. 00 96. 00 09500 DIRABLE MEDI CAL EQUI P-RENTED 0 0 0 0.000000 0.000000 95. 00 97. 00 09700 DIRABLE MEDI CAL EQUI P-SOLD 0 0 0 0.000000 0.000000 97. 00 98. 00 99. 00 09850 OTHER REI MBURSABLE COST CENTERS 0 0 0 0 0.000000 0.000000 98. 00 99. 00 99. 00 0.000000 0.000000 0.000000 99. 00 99. 10 0.000000 0.000000 0.000000 99. 00 0.0000000 0.00000000	,	20, 278	1, 452, 837	1, 473, 115	1. 595431	0.000000	92.00
95. 00 09500 AMBULANCE SERVI CES 0 0 0 0 0 0 0 0 0			0	J 0	0.000000	0.000000	04.00
96. 00		1					1
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD 0 0 0 0 0 0 0 0 0				1			1
99. 00		0	0	0			97.00
99. 10		0	0	0	0. 000000	0. 000000	
100. 00 10000 1&R SERVI CES-NOT APPRVD PRGM 0 0 0 100. 00 101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 101. 00 101. 00 SPECI AL PURPOSE COST CENTERS		0	0				
101. 00 10100 HOME HEALTH AGENCY 0 0 0 0 0 0 101. 00		0	0				•
SPECIAL PURPOSE COST CENTERS 105. 00 10500 KI DNEY ACQUI SITION 0 0 0 0 105. 00 106. 00 106. 00 106. 00 106. 00 106. 00 107. 00 107. 00 107. 00 107. 00 107. 00 107. 00 108. 00 108. 00 108. 00 109. 0		1					
106. 00 10600 HEART ACQUISITION		,		,			
107. 00 10700 LI VER ACQUI SITION 0 0 107. 00 108. 00 10800 LUNG ACQUI SITION 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUI SITION 0 0 0 109. 00 110. 00 110. 00 INTESTINAL ACQUI SITION 0 0 0 110. 00 111. 00 11100 ISLET ACQUI SITION 0 0 0 111. 00 113. 00 11300 INTEREST EXPENSE 113. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 115. 00 116. 00 116. 00 116. 00 116. 00 116. 00 200. 00 59, 883, 083 200. 00		1					
108. 00 10800 LUNG ACQUISITION 0 0 0 108. 00 109. 00 10900 PANCREAS ACQUISITION 0 0 0 109. 00 110. 00 11000 INTESTINAL ACQUISITION 0 0 0 0 111. 00 11100 ISLET ACQUISITION 0 0 0 0 113. 00 11300 INTERST EXPENSE 111. 00 0 0 113. 00 114. 00 11400 UTILIZATION REVIEW-SNF 0 0 0 0 115. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115. 00 116. 00 11600 HOSPI CE 0 0 0 0 0 116. 00 200. 00 Subtotal (see instructions) 4, 220, 083 55, 663, 000 59, 883, 083 50. 00 59, 883, 083 50. 00 200. 00		0	0				
109. 00 10900 PANCREAS ACQUISITION 0 0 0 0 0 110. 00 110. 00 110. 00 110. 00 111. 00 111. 00 111. 00 111. 00 111. 00 113. 00 113. 00 113. 00 114. 00 114. 00 115. 00 115. 00 115. 00 115. 00 115. 00 116.		0	0				
110. 00 11000 1 NTESTI NAL ACQUI SI TI ON		0	0				•
111. 00 11100 1 SLET ACQUI SITION 0 0 0 0 0 0 111. 00 113. 00 11300 I NTEREST EXPENSE 114. 00 11400 UTI LI ZATI ON REVI EW-SNF 115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 0 0 0 0 0 115. 00 116. 00 11600 HOSPI CE 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0			Ö	ol o			
114. 00 11400 UTILIZATION REVIEW-SNF 114. 00 115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 0 115. 00 116. 00 11600 HOSPICE 0 0 0 0 116. 00 200. 00 Subtotal (see instructions) 4, 220, 083 55, 663, 000 59, 883, 083 200. 00	111.00 11100 ISLET ACQUISITION	0	0	0			
115. 00 11500 AMBULATORY SURGICAL CENTER (D. P.) 0 0 0 115. 00 116. 00 11600 HOSPICE 0 0 0 116. 00 200. 00 Subtotal (see instructions) 4, 220, 083 55, 663, 000 59, 883, 083 200. 00							
116. 00 11600 HOSPI CE			0				
200.00 Subtotal (see instructions) 4,220,083 55,663,000 59,883,083 200.00			0				
201.00 Less Observation Beds 201.00	200.00 Subtotal (see instructions)	4, 220, 083	55, 663, 000	59, 883, 083			200. 00
	201.00 Less Observation Beds			1			201. 00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Peri od:	Worksheet C	
				From 01/01/2015 To 12/31/2015	Date/Time Pre	epared:
					5/27/2016 5: 1	
		Ti tl	e XVIII	Hospi tal	Cost	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	Cost or Other	TEFRA	
			+ col. 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
202.00 Total (see instructions)	4, 220, 083	55, 663, 000	59, 883, 08	3		202.00

Title XVIII

		Title XVIII	Hospi tal	Cost	
Cost Center Description	PPS Inpatient				
	Ratio				
	11. 00				
INPATIENT ROUTINE SERVICE COST CENTERS					
30. 00 03000 ADULTS & PEDI ATRI CS					0. 00
31.00 03100 INTENSIVE CARE UNIT				3.	1.00
32. 00 03200 CORONARY CARE UNIT				32	2.00
33.00 03300 BURN INTENSIVE CARE UNIT				33	3.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT				34	4.00
40. 00 04000 SUBPROVI DER - 1 PF	İ			40	0.00
41. 00 04100 SUBPROVI DER - I RF				l l	1.00
42. 00 04200 SUBPROVI DER					2.00
43. 00 04300 NURSERY					3. 00
44. 00 04400 SKILLED NURSING FACILITY				I	4. 00
45. 00 04500 NURSI NG FACILITY					5. 00
46. 00 04600 OTHER LONG TERM CARE				l l	6. 00
ANCILLARY SERVICE COST CENTERS					0.00
50. 00 05000 OPERATING ROOM	0. 000000				0. 00
51. 00 05100 RECOVERY ROOM	0. 000000				1. 00
	1				
52. 00 05200 DELIVERY ROOM & LABOR ROOM	0.000000				2.00
53. 00 05300 ANESTHESI OLOGY	0. 000000				3.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			l l	4.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			l l	5.00
56. 00 05600 RADI OI SOTOPE	0. 000000			l l	6. 00
57. 00 05700 CT SCAN	0. 000000			l l	7. 00
58. 00 05800 MRI	0. 000000			l l	8. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			l l	9. 00
60. 00 06000 LABORATORY	0. 000000			60	0.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			6	1.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000			62	2.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000			63	3.00
64.00 06400 INTRAVENOUS THERAPY	0. 000000				4.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000			l l	5. 00
66. 00 06600 PHYSI CAL THERAPY	0. 000000			l l	6. 00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000				7. 00
68. 00 06800 SPEECH PATHOLOGY	0. 000000				8. 00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			l	9. 00
	1 1				0.00
	0.000000				
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0. 000000				1.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	0. 000000			l l	2.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	0. 000000				3.00
74. 00 07400 RENAL DI ALYSI S	0. 000000				4.00
75.00 07500 ASC (NON-DISTINCT PART)	0. 000000				5. 00
75. 01 07501 CARDI AC REHAB	0. 000000			75	5. 01
OUTPATIENT SERVICE COST CENTERS					
88. 00 08800 RURAL HEALTH CLINIC				l l	8. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER				89	9. 00
90. 00 09000 CLI NI C	0. 000000			90	0.00
91. 00 09100 EMERGENCY	0. 000000			9	1.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 000000			92	2.00
OTHER REIMBURSABLE COST CENTERS					
94.00 09400 HOME PROGRAM DIALYSIS	0. 000000			94	4.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95	5.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			l l	6. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			l l	7. 00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			l l	8. 00
99. 00 09900 CMHC	0.00000			l l	9. 00
99. 10 09910 CORF					9. 10
100. 00 10000 I &R SERVI CES-NOT APPRVD PRGM					0.00
101. 00 10100 HOME HEALTH AGENCY				l l	1. 00
				10	1.00
SPECIAL PURPOSE COST CENTERS				100	F 00
105. 00 10500 KI DNEY ACQUI SI TI ON					5.00
106. 00 10600 HEART ACQUISITION				l l	6.00
107. 00 10700 LI VER ACQUI SI TI ON				l l	7.00
108. 00 10800 LUNG ACQUI SI TI ON					8. 00
109. 00 10900 PANCREAS ACQUISITION				l l	9.00
110.00 11000 INTESTINAL ACQUISITION				l l	0. 00
111.00 11100 ISLET ACQUISITION				l l	1.00
113. 00 11300 I NTEREST EXPENSE				113	3.00
114.00 11400 UTILIZATION REVIEW-SNF				1114	4.00
115.00 11500 AMBULATORY SURGICAL CENTER (D.P.)				115	5.00
116. 00 11600 HOSPI CE				l l	6.00
200.00 Subtotal (see instructions)				l l	0.00
201.00 Less Observation Beds				l l	1.00
202.00 Total (see instructions)					2. 00
1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2	1			1201	

Hearth Financial Systems	TU HEALTH PAULT H	USPLIAL	In Liet	J OT FORM CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 151306	Peri od:	Worksheet C
			From 01/01/2015	Part
			To 12/31/2015	Date/Time Prepared:
				5/27/2016 5: 10 pm
		Title XIX	Hosni tal	DDS

						0 12/31/2013	5/27/2016 5:1	0 pm
				Tit	le XIX	Hospi tal	PPS	
		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	
		IENT ROUTINE SERVICE COST CENTERS						
30.00		ADULTS & PEDIATRICS	4, 229, 620		4, 229, 620	0	4, 229, 620	
31.00		INTENSIVE CARE UNIT	0		0	0	0	
32. 00 33. 00		CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0		0	0	0	32. 00 33. 00
34.00		SURGICAL INTENSIVE CARE UNIT	0		J 0	0	0	34.00
40. 00	1	SUBPROVI DER - I PF	0		0	0	ő	40.00
41. 00		SUBPROVI DER - I RF	Ō		Ō	0	0	41.00
42.00		SUBPROVI DER	0		0	0	0	42.00
43.00		NURSERY	165, 907		165, 907	0	165, 907	43.00
44.00		SKILLED NURSING FACILITY	0		0	0	0	
45. 00 46. 00		NURSING FACILITY OTHER LONG TERM CARE	0		0	0	0 0	
46.00		LARY SERVICE COST CENTERS	0			0	U	46. 00
50.00	05000	OPERATING ROOM	2, 447, 524		2, 447, 524	0	2, 447, 524	50.00
51. 00		RECOVERY ROOM	0		0	0	0	51.00
52.00		DELIVERY ROOM & LABOR ROOM	195, 785		195, 785	0	195, 785	52.00
53.00		ANESTHESI OLOGY	0		0	0	0	53.00
54.00		RADI OLOGY TUEBAREUT C	2, 715, 887		2, 715, 887	0	2, 715, 887	54.00
55. 00 56. 00		RADI OLOGY-THERAPEUTI C RADI OI SOTOPE	0		0	0	0	55. 00 56. 00
57.00		CT SCAN	0		0	0	0	57.00
58. 00	05800		Ö		Ö	0	0	58.00
59.00	05900	CARDI AC CATHETERI ZATI ON	0		0	0	0	59.00
60.00		LABORATORY	2, 374, 054		2, 374, 054	0	2, 374, 054	•
61.00		PBP CLINICAL LAB SERVICES-PRGM ONLY	0		0	0	0	61.00
62.00		WHOLE BLOOD & PACKED RED BLOOD CELL	0		0	0	0	62.00
63. 00 64. 00		BLOOD STORING, PROCESSING & TRANS. INTRAVENOUS THERAPY	223, 992		223, 992	0	0 223, 992	63. 00 64. 00
65. 00	1	RESPIRATORY THERAPY	612, 615	0		0	612, 615	1
66. 00		PHYSI CAL THERAPY	1, 308, 800	l e	1, 308, 800	0	1, 308, 800	1
67.00		OCCUPATI ONAL THERAPY	0	0	0	0	0	67.00
68. 00		SPEECH PATHOLOGY	0	0	0	0	0	68. 00
69. 00		ELECTROCARDI OLOGY	0		0	0	0	69.00
70. 00 71. 00		ELECTROENCEPHALOGRAPHY MEDICAL SUPPLIES CHARGED TO PATIENT	531, 788		531, 788	0	0 531, 788	70. 00 71. 00
71.00		IMPL. DEV. CHARGED TO PATIENTS	129, 326	ł	129, 326	0	129, 326	1
73. 00		DRUGS CHARGED TO PATIENTS	2, 849, 345	l e	2, 849, 345	0	2, 849, 345	1
74.00		RENAL DIALYSIS	0		0	0	0	74.00
75. 00		ASC (NON-DISTINCT PART)	0		0	0	0	75. 00
75. 01		CARDI AC REHAB	229, 800		229, 800	0	229, 800	75. 01
88. 00		TIENT SERVICE COST CENTERS RURAL HEALTH CLINIC	0		0	0	0	88. 00
	1	FEDERALLY QUALIFIED HEALTH CENTER	0	l	0		0	
90.00		CLINIC	25, 820		25, 820	0	25, 820	90.00
91.00	1	EMERGENCY	4, 216, 199		4, 216, 199	0	4, 216, 199	
92. 00		OBSERVATION BEDS (NON-DISTINCT PART REIMBURSABLE COST CENTERS	2, 350, 254		2, 350, 254		2, 350, 254	92.00
94.00		HOME PROGRAM DI ALYSIS	0		0	0	0	94.00
95.00		AMBULANCE SERVICES	0		0	0	0	1
96.00		DURABLE MEDICAL EQUIP-RENTED	0		0	0	0	96.00
97. 00		DURABLE MEDI CAL EQUI P-SOLD	0		0	0	0	97.00
98. 00 99. 00	09850	OTHER REIMBURSABLE COST CENTERS	0		0	0	0	98. 00 99. 00
99. 10			0		0		0	•
		I&R SERVICES-NOT APPRVD PRGM	Ö		Ö			100.00
101.00		HOME HEALTH AGENCY	0		0		0	101.00
405.00		AL PURPOSE COST CENTERS	_	1				105.00
		KIDNEY ACQUISITION HEART ACQUISITION	0		0			105. 00 106. 00
		LIVER ACQUISITION	0		0			107.00
		LUNG ACQUISITION	Ō		Ō			108.00
109.00	10900	PANCREAS ACQUISITION	0		0		0	109. 00
		INTESTINAL ACQUISITION	0		0			110. 00
		ISLET ACQUISITION	0		0		0	111.00
	1	INTEREST EXPENSE UTILIZATION REVIEW-SNF						113. 00 114. 00
		AMBULATORY SURGICAL CENTER (D.P.)	_		n		n	115.00
		HOSPI CE	0		0		0	116. 00
200.00)	Subtotal (see instructions)	24, 606, 716	0	24, 606, 716	0	24, 606, 716	200. 00

Heal th Fina	IU HEALTH PAOLI HOSPITAL				In Lieu of Form CMS-2552-10			
COMPUTATI ON	OF RATIO OF COSTS TO CHARGES			Provi der		Peri od:	Worksheet C	
						From 01/01/2015		
						To 12/31/2015		pared:
							5/27/2016 5: 1	0 pm
				Ti t	le XIX	Hospi tal	PPS	
						Costs		
	Cost Center Description	Total Cost	Ther	apy Limit	Total Costs	RCE	Total Costs	
		(from Wkst.		Adj .		Di sal I owance		
		B, Part I,						
		col. 26)						
		1. 00		2. 00	3. 00	4. 00	5. 00	
201.00	Less Observation Beds	2, 350, 254			2, 350, 25	4	2, 350, 254	201.00
202.00	Total (see instructions)	22, 256, 462		0	22, 256, 46	2 0	22, 256, 462	202. 00

Health Financial Systems	TU HEALTH PAOLI F	HOSPITAL	In Lieu	u of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der CCN: 151306	From 01/01/2015	Worksheet C Part I Date/Time Prepared: 5/27/2016 5:10 pm

		T: +	le XIX	U 12/31/2015	5/27/2016 5:1	
		Charges	ie xix	Hospi tal	PPS	
Cost Center Description	I npati ent	Outpati ent	+ col. 7)	Cost or Other Ratio	TEFRA I npati ent Rati o	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS	6. 00	7. 00	8. 00	9. 00	10. 00	
30. 00 O3000 ADULTS & PEDIATRICS	795, 948		795, 948			30.00
31. 00 03100 I NTENSI VE CARE UNI T	0		0			31.00
32. 00 03200 CORONARY CARE UNIT	0		0			32.00
33. 00 03300 BURN INTENSIVE CARE UNIT	0		0			33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNIT	0		0			34.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF	0		0			40. 00 41. 00
42. 00 04200 SUBPROVI DER	0					42.00
43. 00 04300 NURSERY	324, 971		324, 971			43.00
44.00 04400 SKILLED NURSING FACILITY	0		0			44.00
45. 00 04500 NURSING FACILITY	0		0			45.00
46. 00 O4600 OTHER LONG TERM CARE ANCILLARY SERVICE COST CENTERS	0		0			46. 00
50. 00 05000 OPERATING ROOM	832, 496	6, 881, 504	7, 714, 000	0. 317283	0. 000000	50.00
51.00 05100 RECOVERY ROOM	0	0	0	0. 000000	0.000000	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	754, 643	251, 209	1, 005, 852		0.000000	52.00
53. 00 05300 ANESTHESI OLOGY	0 07 025	0	0	0.000000	0. 000000	53.00
54. 00 05400 RADI 0L0GY-DI AGNOSTI C 55. 00 05500 RADI 0L0GY-THERAPEUTI C	97, 935	9, 962, 836	10, 060, 771	0. 269948 0. 000000	0. 000000 0. 000000	54. 00 55. 00
56. 00 05600 RADI 0I SOTOPE		0		0. 000000	0. 000000	56.00
57. 00 05700 CT SCAN	0	0	0	0. 000000	0. 000000	57.00
58. 00 05800 MRI	0	0	0	0. 000000	0. 000000	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0	0.000000	0. 000000	59.00
60.00 06000 LABORATORY 61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	438, 361	9, 271, 976	9, 710, 337	0. 244487 0. 000000	0. 000000 0. 000000	60. 00 61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0		0.000000	0.000000	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	o	0	Ö	0. 000000	0. 000000	63.00
64.00 06400 INTRAVENOUS THERAPY	197, 018	4, 148, 411	4, 345, 429		0.000000	64.00
65. 00 06500 RESPI RATORY THERAPY	45, 094	718, 045			0. 000000	65.00
66. 00 06600 PHYSI CAL THERAPY	56, 790	1, 569, 606		l	0.000000	66.00
67. 00 06700 OCCUPATI ONAL THERAPY 68. 00 06800 SPEECH PATHOLOGY	0	0	0	0. 000000 0. 000000	0. 000000 0. 000000	67. 00 68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0	Ö	0. 000000	0. 000000	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	0	0. 000000	0.000000	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	54, 315	356, 728			0. 000000	71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1, 067	97, 344		1. 314142	0.000000	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSIS	512, 856 0	5, 768, 194	6, 281, 050	0. 453642 0. 000000	0. 000000 0. 000000	73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	Ö	0. 000000	0. 000000	75.00
75. 01 07501 CARDI AC REHAB	0	206, 255	206, 255	l	0.000000	75. 01
OUTPATIENT SERVICE COST CENTERS	1					
88.00 08800 RURAL HEALTH CLINIC 89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0		0.000000	88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0 1, 449	26, 305	0 27, 754		0. 000000 0. 000000	
91. 00 09100 EMERGENCY	86, 862	14, 951, 750			0. 000000	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	20, 278	1, 452, 837		l .	0.000000	92.00
OTHER REIMBURSABLE COST CENTERS						
94. 00 09400 HOME PROGRAM DI ALYSIS 95. 00 09500 AMBULANCE SERVICES	0 0	0		0. 000000 0. 000000	0. 000000 0. 000000	94. 00 95. 00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED		0	1		0.000000	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	o	0	Ö	0. 000000	0. 000000	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0. 000000	0.000000	98. 00
99. 00 09900 CMHC	0	0	0			99.00
99. 10 09910 CORF 100. 00 10000 L&R SERVI CES-NOT APPRVD PRGM	0	0				99. 10
100.00 10000 T&R SERVICES-NOT APPROD PROM 101.00 10100 HOME HEALTH AGENCY	0 0	0				100. 00 101. 00
SPECIAL PURPOSE COST CENTERS	<u> </u>		,			1101.00
105. 00 10500 KIDNEY ACQUISITION	0	0	0			105.00
106. 00 10600 HEART ACQUISITION	0	0				106. 00
107. 00 10700 LI VER ACQUI SITI ON 108. 00 10800 LUNG ACQUI SITI ON	0	0	0			107. 00 108. 00
109. 00 10900 PANCREAS ACQUISITION		0				108.00
110. 00 11000 NTESTINAL ACQUISITION		0				110.00
111. 00 11100 SLET ACQUISITION		0	0			111.00
113.00 11300 I NTEREST EXPENSE			1			113. 00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF		_				114.00
115. 00 11500 AMBULATORY SURGI CAL CENTER (D. P.) 116. 00 11600 HOSPI CE	0	0				115. 00 116. 00
200.00 Subtotal (see instructions)	4, 220, 083	55, 663, 000	59, 883, 083			200.00
201.00 Less Observation Beds			<u> </u>	<u> </u>		201.00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provi der		Peri od:	Worksheet C	
				From 01/01/2015 To 12/31/2015	Date/Time Pro	
					5/27/2016 5: 1	10 pm
		Ti t	le XIX	Hospi tal	PPS	
		Charges				
Cost Center Description	I npati ent	Outpati ent	Total (col.	6 Cost or Other	TEFRA	
			+ col . 7)	Ratio	I npati ent	
					Ratio	
	6. 00	7. 00	8. 00	9. 00	10.00	
202.00 Total (see instructions)	4, 220, 083	55, 663, 000	59, 883, 08	3		202. 00

				5/27/2016 5: 10 pm
Cook Cooker Doorsinking	DDC I+:+	Title XIX	Hospi tal	PPS
Cost Center Description	PPS Inpatient Ratio			
	11. 00			
INPATIENT ROUTINE SERVICE COST CENTERS	11100			
30. 00 03000 ADULTS & PEDIATRICS				30.00
31.00 03100 INTENSIVE CARE UNIT				31.00
32. 00 03200 CORONARY CARE UNIT				32.00
33. 00 03300 BURN I NTENSI VE CARE UNIT				33.00
34. 00 03400 SURGI CAL INTENSI VE CARE UNI T				34.00
40. 00 04000 SUBPROVI DER - PF 41. 00 04100 SUBPROVI DER - RF				40.00
42. 00 04200 SUBPROVI DER				42.00
43. 00 04300 NURSERY				43.00
44.00 04400 SKILLED NURSING FACILITY				44.00
45.00 04500 NURSING FACILITY				45.00
46.00 O4600 OTHER LONG TERM CARE				46. 00
ANCILLARY SERVICE COST CENTERS	0.017000			
50. 00 05000 OPERATI NG ROOM	0. 317283			50.00
51.00 05100 RECOVERY ROOM 52.00 05200 DELIVERY ROOM & LABOR ROOM	0. 000000 0. 194646			51. 00 52. 00
53. 00 05300 ANESTHESI OLOGY	0. 194040			53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 269948			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0. 000000			55. 00
56. 00 05600 RADI OI SOTOPE	0. 000000			56.00
57.00 05700 CT SCAN	0. 000000			57.00
58. 00 05800 MRI	0. 000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00
60. 00 06000 LABORATORY	0. 244487			60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0.000000			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0.000000			62.00
64. 00 06400 INTRAVENOUS THERAPY	0. 000000 0. 051547			63. 00 64. 00
65. 00 06500 RESPIRATORY THERAPY	0. 802757			65.00
66. 00 06600 PHYSI CAL THERAPY	0. 804724			66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0. 000000			70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 293753			71.00
72. 00 07200 IMPL. DEV. CHARGED TO PATIENTS	1. 314142			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 74. 00 07400 RENAL DI ALYSI S	0. 453642 0. 000000			73. 00 74. 00
75. 00 07500 ASC (NON-DISTINCT PART)	0. 000000			75.00
75. 01 07501 CARDI AC REHAB	1. 114155			75. 01
OUTPATIENT SERVICE COST CENTERS				
88. 00 08800 RURAL HEALTH CLINIC	0. 000000			88. 00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000			89.00
90. 00 09000 CLI NI C	0. 930316			90.00
91. 00 09100 EMERGENCY 92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	0. 280358			91.00
OTHER REIMBURSABLE COST CENTERS	1. 595431			92.00
94. 00 09400 HOME PROGRAM DIALYSIS	0. 000000			94.00
95. 00 09500 AMBULANCE SERVICES	0. 000000			95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000			96.00
97.00 09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000			97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0. 000000			98.00
99. 00 09900 CMHC				99. 00
99. 10 09910 CORF				99. 10
100. 00 10000 I &R SERVICES-NOT APPRVD PRGM				100.00
101. 00 10100 HOME HEALTH AGENCY SPECIAL PURPOSE COST CENTERS				101.00
105. 00 10500 KI DNEY ACQUISITION				105.00
106. 00 10600 HEART ACQUISITION				106.00
107. 00 10700 LIVER ACQUISITION				107. 00
108.00 10800 LUNG ACQUISITION				108.00
109.00 10900 PANCREAS ACQUISITION				109. 00
110.00 11000 INTESTINAL ACQUISITION				110.00
111. 00 11100 SLET ACQUISITION				111.00
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.)				115. 00 116. 00
116.00 11600 HOSPICE 200.00 Subtotal (see instructions)				200. 00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00
	. '			'

Health Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provi der CCN: 151306

				12,01,2010	5/27/2016 5: 1	0 pm
		Tit	le XIX	Hospi tal	PPS	
Cost Center Description	Total Cost	Capital Cost	Operati ng	Capi tal	Operati ng	
	(Wkst. B,	(Wkst. B,	Cost Net of	Reducti on	Cost	
	Part I, col.	Part II col.	Capital Cost		Reducti on	
	26)	26)	(col. 1 -		Amount	
	4.00	0.00	col . 2)	4 00	F 00	
ANCILLARY SERVICE COST CENTERS	1. 00	2. 00	3.00	4. 00	5. 00	
50. 00 05000 OPERATING ROOM	2, 447, 524	167, 430	2, 280, 094	٥	0	50. 00
51. 00 05100 RECOVERY ROOM	2,447,324	107, 430	2, 280, 094	0	0	51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	195, 785	7, 412	_	0	0	52.00
53. 00 05300 ANESTHESI OLOGY	173, 703	7,412	100, 373	0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 715, 887	170, 107	2, 545, 780	0	Ö	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	2,713,007	170, 107	2, 343, 700	0	Ö	55. 00
56. 00 05600 RADI OI SOTOPE			0	0	0	56.00
57. 00 05700 CT SCAN			0	0	0	57. 00
58. 00 05800 MRI		0	o o	0	0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0	0	0	0	59. 00
60. 00 06000 LABORATORY	2, 374, 054	84, 134	2, 289, 920	0	0	60.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0	Ö	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	ol	0	0	63.00
64.00 06400 I NTRAVENOUS THERAPY	223, 992	15, 254	208, 738	O	0	64.00
65. 00 06500 RESPIRATORY THERAPY	612, 615			O	0	65.00
66. 00 06600 PHYSI CAL THERAPY	1, 308, 800	1		O	0	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0	0	O	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	0	o	0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	o	0	0	69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0	o	0	0	70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	531, 788	28, 339	503, 449	О	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	129, 326	6, 903	122, 423	О	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	2, 849, 345	50, 041	2, 799, 304	o	0	73.00
74.00 07400 RENAL DIALYSIS	0	0	0	0	0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0	0	0	0	75.00
75. 01 07501 CARDI AC REHAB	229, 800	23, 856	205, 944	0	0	75. 01
OUTPATIENT SERVICE COST CENTERS						
88. 00 08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90. 00 09000 CLI NI C	25, 820	1		0	0	90.00
91. 00 09100 EMERGENCY	4, 216, 199			0	0	91.00
92. 00 O9200 OBSERVATION BEDS (NON-DISTINCT PART	2, 350, 254	154, 548	2, 195, 706	0	0	92.00
OTHER REIMBURSABLE COST CENTERS			1	ما		
94. 00 09400 HOME PROGRAM DI ALYSI S	0	0	0	0	0	94.00
95. 00 09500 AMBULANCE SERVI CES	0		0	0	0	95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0			0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0		0	U	0	97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS				0	0	98.00
99. 00 09900 CMHC 99. 10 09910 CORF				0	0	99. 00 99. 10
100.00 10000 1&R SERVICES-NOT APPRVD PRGM				0		100. 00
101.00 10100 HOME HEALTH AGENCY				0		100.00
SPECIAL PURPOSE COST CENTERS		<u> </u>	<u> </u>	U	U	101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0		٥	0	105. 00
106. 00 10600 HEART ACQUISITION				0		106.00
107. 00 10700 LI VER ACQUI SI TI ON				0		100.00
108. 00 10800 LUNG ACQUISITION				0		107.00
109. 00 10900 PANCREAS ACQUISITION				0		109.00
110. 00 11000 I NTESTI NAL ACQUI SI TI ON			o o	0		110.00
111. 00 11100 SLET ACQUISITION				n		111.00
113. 00 11300 NTEREST EXPENSE				Ĭ		113.00
114. 00 11400 UTI LI ZATI ON REVI EW-SNF	1	1				114. 00
115.00 11500 AMBULATORY SURGICAL CENTER (D. P.)	0	0	o	o	0	115. 00
116. 00 11600 HOSPI CE	1 0	o o	o o	ol		116. 00
200.00 Subtotal (sum of lines 50 thru 199)	20, 211, 189	937, 385	19, 273, 804	o		200.00
201.00 Less Observation Beds	2, 350, 254	1		o		201.00
202.00 Total (line 200 minus line 201)	17, 860, 935			0	0	202. 00
	•	•	. '	'		

Health Financial Systems

CALCULATION OF OUTPATIENT SERVICE COST TO CHARGE RATIOS NET OF REDUCTIONS FOR MEDICALD ONLY Provi der CCN: 151306

					5/27/2016 5: 1) pm
			le XIX	Hospi tal	PPS	
Cost Center Description	Cost Net of	Total Charges	Outpati ent			
	Capital and	(Worksheet C,	Cost to			
	Operating	Part I,	Charge Ratio			
	Cost	column 8)	(col. 6 /			
	Reduction		col . 7)			
ANOLULA DV. OFRIU OF COOT OFFITERS	6. 00	7. 00	8. 00			
ANCILLARY SERVICE COST CENTERS	0 447 504	7 744 000	0.047000			F0 00
50. 00 05000 OPERATING ROOM	2, 447, 524		0. 317283			50.00
51. 00 05100 RECOVERY ROOM	105 705	-	0.000000			51.00
52. 00 05200 DELIVERY ROOM & LABOR ROOM	195, 785	1, 005, 852	0. 194646			52.00
53. 00 05300 ANESTHESI OLOGY	0 745 007	10 0/0 774	0.000000			53.00
54. 00 05400 RADI OLOGY - DI AGNOSTI C	2, 715, 887	10, 060, 771	0. 269948			54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.000000			55.00
56. 00 05600 RADI OI SOTOPE	0	0	0.000000			56.00
57. 00 05700 CT SCAN	0	0	0.000000			57.00
58. 00 05800 MRI	0	0	0.000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0 074 054	0 740 007	0.000000			59.00
60. 00 06000 LABORATORY	2, 374, 054	9, 710, 337	0. 244487			60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0	0	0.000000			61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0. 000000			62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 000000			63.00
64. 00 06400 I NTRAVENOUS THERAPY	223, 992					64.00
65. 00 06500 RESPI RATORY THERAPY	612, 615					65.00
66. 00 06600 PHYSI CAL THERAPY	1, 308, 800	1				66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	1	0. 000000			67.00
68. 00 06800 SPEECH PATHOLOGY	0	0	0. 000000			68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0	0. 000000			69.00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	-	0. 000000			70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	531, 788	•	1. 293753			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	129, 326		1. 314142			72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	2, 849, 345					73.00
74. 00 07400 RENAL DI ALYSI S	0	0	0. 000000			74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0.000000			75.00
75. 01 O7501 CARDI AC REHAB	229, 800	206, 255	1. 114155			75. 01
OUTPATIENT SERVICE COST CENTERS	1 0		0.000000			00 00
88. 00 08800 RURAL HEALTH CLINIC	0	l e	0.000000			88.00
89. 00 08900 FEDERALLY QUALIFIED HEALTH CENTER 90. 00 09000 CLINIC	0					89.00
	25, 820		0. 930316			90. 00 91. 00
	4, 216, 199					
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS	2, 350, 254	1, 473, 115	1. 595431			92.00
94. 00 09400 HOME PROGRAM DIALYSIS	0	0	0. 000000			94.00
95. 00 09500 AMBULANCE SERVICES			0. 000000			95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED			0. 000000			96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD		0	0. 000000			97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS			0. 000000			98.00
99. 00 09900 CMHC		0	0. 000000			99.00
99. 10 09910 CORF		0	0. 000000			99. 10
100.00 10000 & SERVICES-NOT APPRVD PRGM		0	0. 000000			100.00
101. 00 10100 HOME HEALTH AGENCY			0. 000000			100.00
SPECIAL PURPOSE COST CENTERS	0	0	0.000000			101.00
105. 00 10500 KI DNEY ACQUI SI TI ON	0	0	0. 000000			105.00
106. 00 10600 HEART ACQUISITION	0					106.00
107. 00 10700 LI VER ACQUI SI TI ON	0		0. 000000			100.00
108. 00 10800 LUNG ACQUISITION		0	0. 000000			107.00
109. 00 10900 PANCREAS ACQUISITION		0	0. 000000			109.00
110. 00 11000 NTESTINAL ACQUISITION	0		0.000000			110.00
111. 00 11100 SLET ACQUISITION	0	0	0. 000000			111.00
113. 00 11300 NTEREST EXPENSE			0.000000			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. 000000			115.00
116. 00 11600 HOSPI CE	0	0	0. 000000			116.00
200.00 Subtotal (sum of lines 50 thru 199)	20, 211, 189	58, 762, 164	3.000000			200.00
201.00 Less Observation Beds	2, 350, 254					201.00
202.00 Total (line 200 minus line 201)	17, 860, 935					202.00
			. '			

Health Financial Systems	IU HEALTH PAC	LI HOSPITAL		In Lie	u of Form CMS-:	<u> 2552-10</u>
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 151306	Peri od:	Worksheet D	
				From 01/01/2015		
				To 12/31/2015	Date/Time Pre	pared:
					5/27/2016 5:1	0 pm
			e XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal		Ratio of Cos		Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col. 26)					
	1. 00	2.00	3.00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS						
50. 00 05000 OPERATING ROOM	167, 430	7, 714, 000	0. 02170	05 31, 501	684	50.00
51.00 05100 RECOVERY ROOM	0		0. 00000	00	0	51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	7, 412	1, 005, 852	1		170	1
53. 00 05300 ANESTHESI OLOGY	0	.,,	0.00000		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	170, 107	10, 060, 77			433	1
55. 00 05500 RADI OLOGY-THERAPEUTI C	170, 107	10,000,77	0.00000		0	55.00
56. 00 05600 RADI OI SOTOPE	0		0.00000		0	56.00
	0		•		· -	
57. 00 05700 CT SCAN	0		0.00000		0	57.00
58. 00 05800 MRI	0	(0	58. 00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	(0.00000		0	59. 00
60. 00 06000 LABORATORY	84, 134	9, 710, 337	0. 00866	82, 726	717	60.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	(0. 00000	00	0	62.00
63.00 06300 BLOOD STORING, PROCESSING & TRANS.	0	(0. 00000	00	0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	15, 254	4, 345, 429	0.0035	10 0	0	64.00
65. 00 06500 RESPIRATORY THERAPY	12, 865	763, 139			365	65.00
66. 00 06600 PHYSI CAL THERAPY	67, 277	1, 626, 396			832	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0,,2,,	1,020,070	0.00000		0.002	67.00
68. 00 06800 SPEECH PATHOLOGY	0		0.00000		0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0		0.00000		0	69.00
	0		•			1
70. 00 07000 ELECTROENCEPHALOGRAPHY	00.000	444 046	0.00000		0	70.00
71. 00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	28, 339	411, 043	•			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	6, 903	98, 411	1		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	50, 041	6, 281, 050				
74. 00 07400 RENAL DI ALYSI S	0	(0	74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	(0. 00000	00	0	75.00
75. 01 07501 CARDI AC REHAB	23, 856	206, 255	0. 11566	53 0	0	75. 01
OUTPATIENT SERVICE COST CENTERS						1
88. 00 08800 RURAL HEALTH CLINIC	0	(0.00000	00 0	0	88.00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	(1		0	89.00
90. 00 09000 CLINIC	188	27, 754	•		1	90.00
91. 00 09100 EMERGENCY	149, 031	15, 038, 612				91.00
92. 00 09200 OBSERVATION BEDS (NON-DISTINCT PART	154, 548	1, 473, 115				
OTHER REIMBURSABLE COST CENTERS	134, 346	1,4/3,113	0. 1049	12 0	U	92.00
			0.0000	20 0	1 0	04.00
94. 00 09400 HOME PROGRAM DI ALYSI S	0	(0.00000	00	0	
95. 00 09500 AMBULANCE SERVI CES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	(96. 00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	(0. 00000	0	0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	(0.00000	00	0	98. 00
200.00 Total (lines 50-199)	937, 385	58, 762, 164	1	351, 495	4, 451	200.00
·						

THROUGH COSTS

						5/27/2016 5:1	0 pm
				e XVIII	Hospi tal	Cost	
	Cost Center Description	Non Physician	Nursi ng	Allied Health	All Other	Total Cost	
		Anesthetist	School		Medi cal	(sum of col 1	
		Cost			Educati on	through col.	
					Cost	4)	
	T	1. 00	2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS			_	_		
50.00	05000 OPERATING ROOM	658, 931	0		0	658, 931	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
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	0	0	0	0	54.00
55.00	O5500 RADI OLOGY-THERAPEUTI C	0	0	0	0	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0	0	0	56.00
57.00	05700 CT SCAN	0	0	0	0	0	57.00
58.00	05800 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	U	U	0	0	0	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		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. 06400 INTRAVENOUS THERAPY	0	0	0	0	0	63.00
64. 00 65. 00	06500 RESPIRATORY THERAPY	0	0	0	0	0	64. 00 65. 00
66.00	06600 PHYSI CAL THERAPY		0	0	0	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY		0	0	0	0	67.00
68. 00	06800 SPEECH PATHOLOGY		0		0	0	68.00
69.00	06900 ELECTROCARDI OLOGY		0		0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY		0	0	0	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT		0	0	0	0	71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS		0	0	0	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS		0	0	0	0	73.00
74.00	07400 RENAL DIALYSIS		0	0	0	Ö	74.00
75. 00	07500 ASC (NON-DISTINCT PART)		0	0	0	0	75.00
75. 00	07501 CARDI AC REHAB		0		0	0	75.00
73.01	OUTPATIENT SERVICE COST CENTERS	<u> </u>		·			73.01
88. 00	08800 RURAL HEALTH CLINIC	0	0	0	0	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0	0	0	89. 00
90.00	09000 CLINIC	0	0	0	0	0	90.00
91. 00	09100 EMERGENCY	0	0	0	0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0	Ö	0	Ō	92.00
	OTHER REIMBURSABLE COST CENTERS	· -1					
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0	0	0	94.00
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	O	0	0	0	0	•
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0	0	0	•
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0	0	0	98. 00
200.00	Total (lines 50-199)	658, 931	0	0	0	658, 931	200. 00
		•					

| Peri od: | Worksheet D | From 01/01/2015 | Part IV | To | 12/31/2015 | Date/Time | Prepared: THROUGH COSTS

				'	0 12/31/2013	5/27/2016 5: 1	
			Ti tl	e XVIII	Hospi tal	Cost	
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati ent	
	·	Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
		Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
		col . 2, 3 and	col. 8)	col. 7)	(col. 6 ÷		
		4)			col. 7)		
		6. 00	7. 00	8.00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS						
50.00	05000 OPERATING ROOM	0	7, 714, 000	0. 085420	0.000000	31, 501	50.00
51.00	05100 RECOVERY ROOM	0	0	0.000000	0. 000000	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 005, 852	0.000000	0. 000000	23, 125	52.00
53.00	05300 ANESTHESI OLOGY	0	0	0.000000	0. 000000	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	10, 060, 771	0.000000	0. 000000	25, 594	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0	0	0.000000	0.000000	0	55.00
56.00	05600 RADI OI SOTOPE	0	0	0.000000	0. 000000	0	56.00
57.00	05700 CT SCAN	0	0			0	57.00
58.00	05800 MRI	0	0	0.00000		0	58. 00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	0.000000	0.000000	0	59.00
60.00	06000 LABORATORY	0	9, 710, 337	0.000000	0.000000	82, 726	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0.000000	0.000000	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0. 000000	0.000000	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0	4, 345, 429	0.000000	0.000000	0	64.00
65.00	06500 RESPIRATORY THERAPY	0	763, 139	0.000000	0.000000	21, 660	65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 626, 396	0.000000	0.000000	20, 121	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0. 000000	0.000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0. 000000	0.000000	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0. 000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	411, 043	0.000000	0.000000	1, 324	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	98, 411	0.000000	0.000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 281, 050	0.000000	0.000000	145, 369	73.00
74.00	07400 RENAL DIALYSIS	0	0	0.000000	0.000000	0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	0.000000	0.000000	0	75.00
75. 01	07501 CARDI AC REHAB	0	206, 255	0.000000	0.000000	0	75. 01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0.000000	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0. 000000	0.000000	0	89. 00
90.00	09000 CLI NI C	0	27, 754	0.000000	0.000000	75	90.00
91.00	09100 EMERGENCY	0	15, 038, 612	0.000000	0.000000	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	1, 473, 115	0.000000	0.000000	0	92.00
	OTHER REIMBURSABLE COST CENTERS						
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0.000000	0	94.00
95.00	09500 AMBULANCE SERVICES						95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0. 000000	0.000000	0	96.00
97.00	09700 DURABLE MEDICAL EQUIP-SOLD	0	0	0. 000000	0. 000000	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 000000	0.000000	0	98. 00
200.00	Total (lines 50-199)	0	58, 762, 164			351, 495	200. 00
					•		

 Heal th Financial
 Systems
 IU HEALTH PAOLI

 APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY
 SERVICE OTHER PASS
 IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2552-10 Provi der CCN: 151306

THROUGH COSTS

						5/2//2016 5: 1	U pili
				e XVIII	Hospi tal	Cost	
	Cost Center Description	I npati ent	Outpati ent	Outpati ent			
		Program	Program	Program			
		Pass-Through	Charges	Pass-Through			
		Costs (col. 8	3	Costs (col. 9			
		x col . 10)		x col. 12)			
		11.00	12. 00	13.00			
	ANCILLARY SERVICE COST CENTERS		12.00	10.00			
50.00	05000 OPERATING ROOM	2, 691	0	0			50.00
51.00	05100 RECOVERY ROOM	2,071	0				51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	0	1			52.00
53.00	05300 ANESTHESI OLOGY		0				53.00
54.00	I I		0				54.00
	05400 RADI OLOGY - DI AGNOSTI C	0	0				
55.00	05500 RADI OLOGY-THERAPEUTI C	0	U				55.00
56. 00	05600 RADI OI SOTOPE	0	0	0			56.00
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	0	0			60.00
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.	ol	0	0			63.00
64.00	06400 I NTRAVENOUS THERAPY	0	0	0			64.00
65. 00	06500 RESPI RATORY THERAPY	0	0	0			65.00
66.00	06600 PHYSI CAL THERAPY	o o	0	1			66.00
67. 00	06700 OCCUPATI ONAL THERAPY		0				67.00
68. 00	06800 SPEECH PATHOLOGY		0	1			68.00
69.00	06900 ELECTROCARDI OLOGY		0				69.00
	i i		0				1
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0				70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	Ü				71.00
72. 00	07200 I MPL. DEV. CHARGED TO PATIENTS	0	0	0			72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0	0	0			73. 00
74. 00	07400 RENAL DI ALYSI S	0	0	0			74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	0	1			75. 00
75. 01	07501 CARDI AC REHAB	0	0	0			75. 01
	OUTPATIENT SERVICE COST CENTERS						
88.00	08800 RURAL HEALTH CLINIC	0	0	0			88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0	0			89. 00
90.00	09000 CLI NI C	0	0	0			90.00
91.00	09100 EMERGENCY	0	0	0			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0	0	0			92.00
	OTHER REIMBURSABLE COST CENTERS			,	<u>'</u>		
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0			94.00
95. 00	09500 AMBULANCE SERVICES		· ·				95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED		0	0			96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0				97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS		0	0			98.00
	l l	2 401	-	1			1
200.00	Total (lines 50-199)	2, 691	0	ıı U	I		200.00

APPORTI O	NMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provi de	er CCN: 151306	Peri od:	Worksheet D	
					From 01/01/2015 To 12/31/2015		nared.
					10 12/31/2013	5/27/2016 5: 1	0 pm
			Ti	tle XVIII	Hospi tal	Cost	
				Charges		Costs	
	Cost Center Description	Cost to	PPS	Cost	Cost	PPS Services	
		Charge Ratio	Reimbursed			(see inst.)	
		From	Services (s		Services Not		
		Worksheet C,	inst.)	Subject To			
		Part I, col.		Ded. & Coin			
		9		(see inst.			
0.0	IOLLI ADV. CEDVI OF COCT. OFNITEDO	1. 00	2. 00	3.00	4. 00	5. 00	
	ICILLARY SERVICE COST CENTERS	0.217202		0 1 704	100		F0 00
	5000 OPERATING ROOM	0. 317283		0 1, 734,			
	5100 RECOVERY ROOM	0. 000000		0	0 0		51.00
	5200 DELIVERY ROOM & LABOR ROOM	0. 194646		0 6,8			52.00
	5300 ANESTHESI OLOGY	0. 000000		0	0 0		53.00
	5400 RADI OLOGY-DI AGNOSTI C	0. 269948		0 2, 792,			54.00
	5500 RADI OLOGY-THERAPEUTI C	0. 000000		0	0 0		55.00
	6600 RADI OI SOTOPE	0. 000000		0	0 0		56.00
	5700 CT SCAN	0. 000000		0	0 0		57.00
	5800 MRI	0. 000000		0	0 0	_	58. 00
	5900 CARDI AC CATHETERI ZATI ON	0. 000000		0	0 0		59.00
	5000 LABORATORY	0. 244487		0 2, 938, 8			60.00
	5100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000			0		61.00
	3200 WHOLE BLOOD & PACKED RED BLOOD CELL	0. 000000		0	0	l .	62.00
	3300 BLOOD STORING, PROCESSING & TRANS.	0. 000000		0	0	l .	63.00
	5400 INTRAVENOUS THERAPY	0. 051547		0 1, 719, 5		0	64.00
	5500 RESPI RATORY THERAPY	0. 802757		0 275,	182 0	0	65.00
	6600 PHYSI CAL THERAPY	0. 804724		0 445, 4	135 0	0	66.00
	5700 OCCUPATI ONAL THERAPY	0. 000000		0	0	0	67.00
	5800 SPEECH PATHOLOGY	0. 000000		0	0	0	68.00
	5900 ELECTROCARDI OLOGY	0. 000000		0	0	0	69.00
	7000 ELECTROENCEPHALOGRAPHY	0. 000000		0	0	0	70.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 293753		0 47, 5		0	71.00
	7200 IMPL. DEV. CHARGED TO PATIENTS	1. 314142		0 34, 3	331 0	0	72.00
	7300 DRUGS CHARGED TO PATIENTS	0. 453642		0 2,005,	735 5, 942	0	73.00
	7400 RENAL DIALYSIS	0. 000000		0	0	0	74.00
75. 00 07	7500 ASC (NON-DISTINCT PART)	0. 000000		0	0	0	75.00
	7501 CARDI AC REHAB	1. 114155		0 111, 8	807 0	0	75. 01
	ITPATIENT SERVICE COST CENTERS						
	3800 RURAL HEALTH CLINIC	0. 000000				0	
	3900 FEDERALLY QUALIFIED HEALTH CENTER	0. 000000				0	89. 00
	9000 CLI NI C	0. 930316		0 2	278 0	0	90.00
	9100 EMERGENCY	0. 280358		0 4, 241, 5	583 961	0	91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART	1. 595431		0 711, ()31 157	0	92.00
	THER REIMBURSABLE COST CENTERS						
	9400 HOME PROGRAM DIALYSIS	0. 000000			0		94.00
	9500 AMBULANCE SERVICES	0. 000000			0		95.00
	9600 DURABLE MEDICAL EQUIP-RENTED	0. 000000		0	0	0	
	9700 DURABLE MEDICAL EQUIP-SOLD	0. 000000		0	0 0	0	
	9850 OTHER REIMBURSABLE COST CENTERS	0. 000000		0	0	0	98. 00
200.00	Subtotal (see instructions)			0 17, 065, 4	7, 060	0	200. 00
201.00	Less PBP Clinic Lab. Services-Program				0		201.00
	Only Charges						
202. 00	Net Charges (line 200 +/- line 201)			0 17, 065, 4	7, 060	0	202. 00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151306 Peri od: Worksheet D From 01/01/2015 Part V Date/Time Prepared: 12/31/2015 5/27/2016 5:10 pm Title XVIII Hospi tal Cost Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 550, 327 50.00 05100 RECOVERY ROOM 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 1, 325 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 753, 815 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 0 56.00 05600 RADI OI SOTOPE 0 0 56.00 57.00 05700 CT SCAN 0 57.00 58.00 05800 MRI 0 0 58.00 05900 CARDI AC CATHETERI ZATI ON 59.00 0 0 59.00 60.00 06000 LABORATORY 718, 518 0 60.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62 00 0 62 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 88, 638 64.00 06500 RESPIRATORY THERAPY 65.00 221, 145 65.00 06600 PHYSI CAL THERAPY 66.00 358, 452 0 66 00 06700 OCCUPATIONAL THERAPY 67.00 0 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY Ω 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 61, 539 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 45, 116 72.00 07300 DRUGS CHARGED TO PATIENTS 909, 886 73.00 2.696 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 75.00 07501 CARDI AC REHAB 124, 570 75.01 0 75.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89.00 90.00 09000 CLI NI C 259 0 90.00 1, 189, 162 91.00 09100 EMERGENCY 91.00 269 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1, 134, 401 250 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 94.00 09500 AMBULANCE SERVICES 0 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 200.00 Subtotal (see instructions) 6, 157, 153 3, 215 200.00

6, 157, 153

3, 215

201.00

202.00

201.00

202.00

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

Only Charges

 Heal th Financial
 Systems
 IU HEALTH PAOLI
 HOSPITAL

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 Provide

Cost Center Description
Charge Ratio From Worksheet C, Part I, col. 9
From Services Services Services Subject To Ded. & Coins. (see inst.) Ded. & Coins. Ded. & Coin
Note
Part I, col. 9
NOTILITARY SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5
1.00 2.00 3.00 4.00 5.00
1.00 2.00 3.00 4.00 5.00
50. 00 05000 OPERATI NG ROOM 0. 317283 0 0 0 0 50. 00 51. 00 05100 RECOVERY ROOM 0. 000000 0 0 0 0 51. 00 52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 194646 0 0 0 0 0 52. 00 53. 00 05300 ANESTHESI OLOGY 0. 000000 0 0 0 0 52. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 269948 0 0 0 0 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 0 0 55. 00 57. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 0 0 55. 00 58. 00 05600 RADI OLOGY-T
51.00 05100 RECOVERY ROOM 0.000000 0 0 0 51.00 52.00 05200 DELI VERY ROOM & LABOR ROOM 0.194646 0 0 0 0 52.00 53.00 05300 ANESTHESI OLOGY 0.000000 0 0 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 0.269948 0 0 0 0 0 54.00 55.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 0 55.00 56.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 0 55.00 56.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 0 0 55.00 56.00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 0 0 55.00 0 0 0 0 55.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 194646 0 0 0 52. 00 53. 00 05300 ANESTHESI OLOGY 0. 000000 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 269948 0 0 0 0 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 0 55. 00 57. 00 05700 CT SCAN 0. 000000 0 0 0 0 57. 00 58. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 0 0 0
52. 00 05200 DELI VERY ROOM & LABOR ROOM 0. 194646 0 0 0 52. 00 53. 00 05300 ANESTHESI OLOGY 0. 000000 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 269948 0 0 0 0 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 0 55. 00 56. 00 05600 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 0 0 0 0 56. 00 0 0 0 0 0 56. 00 0 0 0 0 55. 00 0 0 0 0 0 57. 00 0 0 0 0 57. 00 0 0 0 58. 00 0 0 0 0
53. 00 05300 ANESTHESI OLOGY 0.000000 0 0 0 53. 00 54. 00 05400 RADI OLOGY-DI AGNOSTI C 0.269948 0 0 0 0 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 0 55. 00 56. 00 05600 RADI OLISOTOPE 0.000000 0 0 0 0 56. 00 57. 00 05700 CT SCAN 0.000000 0 0 0 0 57. 00 58. 00 05800 MRI 0.000000 0 0 0 0 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 0 58. 00 60. 00 06000 LABORATORY 0.244487 0 0 0 0 0 0 60. 00 61. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 0 0 0
54. 00 05400 RADI OLOGY-DI AGNOSTI C 0. 269948 0 0 0 54. 00 55. 00 05500 RADI OLOGY-THERAPEUTI C 0. 000000 0 0 0 0 55. 00 56. 00 05600 RADI OI SOTOPE 0. 000000 0 0 0 0 56. 00 57. 00 05700 CT SCAN 0. 000000 0 0 0 0 57. 00 58. 00 05800 MRI 0. 000000 0 0 0 0 0 57. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0. 000000 0 0 0 0 0 0 58. 00 60. 00 06000 LABORATORY 0. 000000 0
55. 00 05500 RADI OLOGY-THERAPEUTI C 0.000000 0 0 0 55. 00 56. 00 05600 RADI OI SOTOPE 0.000000 0 0 0 56. 00 57. 00 05700 CT SCAN 0.000000 0 0 0 0 57. 00 58. 00 05800 MRI 0.000000 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 0 0 0 0 58. 00 60. 00 06000 LABORATORY 0.000000 0
56. 00 05600 RADI OI SOTOPE 0.000000 0 0 0 56. 00 57. 00 05700 CT SCAN 0.000000 0 0 0 0 57. 00 58. 00 05800 MRI 0.000000 0 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 0 0 58. 00 60. 00 06000 LABORATORY 0.000000 0
57. 00 05700 CT SCAN 0.000000 0 0 0 57. 00 58. 00 05800 MRI 0.000000 0 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0.000000 0<
58. 00 05800 MRI 0.000000 0 0 0 58. 00 59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 0 59. 00 60. 00 06000 LABORATORY 0.244487 0 0 0 0 0 0 0 00. 00 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0.000000 0 0 0 0 0 0 0 0 0 0 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 0 0 0 0 0 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 0 0 0 0 0 0 0 63. 00 64. 00 06400 I NTRAVENOUS THERAPY 0.051547 0 </td
59. 00 05900 CARDI AC CATHETERI ZATI ON 0.000000 0 0 0 59. 00 60. 00 06000 LABORATORY 0.244487 0 0 0 0 0 60. 00 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0.000000 0 0 0 0 61. 00 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 0 0 0 62. 00 63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 0 0 0 0 0 63. 00 64. 00 06400 I NTRAVENOUS THERAPY 0.051547 0 0 0 0 0 0 64. 00 65. 00 06500 RESPI RATORY THERAPY 0.802757 0 0 0 0 0 0 65. 00 67. 00 06700 OCCUPATI ONAL THERAPY 0.804724 0 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 0 0 0 0 0 0 </td
60. 00 06000 LABORATORY 0 0 0 0 0 0 0 0 60. 00 61. 00 06100 PBP CLI NI CAL LAB SERVI CES-PRGM ONLY 0. 000000 0 0 0 0 0 62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0. 000000 0 0 0 0 0 63. 00 06300 BLOOD STORI NG PROCESSI NG & TRANS. 0. 000000 0 0 0 0 64. 00 06400 INTRAVENOUS THERAPY 0. 051547 0 0 0 0 65. 00 06500 RESPI RATORY THERAPY 0. 802757 0 0 0 0 66. 00 06600 PHYSI CAL THERAPY 0. 804724 0 0 0 0 67. 00 06700 0CCUPATI ONAL THERAPY 0. 000000 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0. 000000 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0. 000000 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0. 0000000 0 0 0 0 68. 00 06900 SPEECH PATHOLOGY 0. 0000000 0 0 0 0 69. 00 06900 SPEECH PATHOLOGY 0. 0000000 0 0 0 0 69. 00 06900 00 00 00 0 0 61. 00 00 00 00 0 61. 00 00 00 00 00 61. 00 00 00 00 61. 00 00 00 00 61. 00 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 00 61. 00 00 61. 00 00 00 61. 00 00 00 62. 00 00 00 63. 00 00 00 64. 00 00 00 64. 00 00 00 65. 00 00 00 66. 00 00 00 67. 00 00 00 68. 00 00 00 69. 00 00 00 69. 00 00 00 69. 00 00 00 69. 00 00 00 69. 00 00 00 69. 00 00 00 69. 00 00 00 69. 00 00 00 69. 00 00 00 69. 00 00 00 69.
61. 00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0.000000 0 0 0 62.00 63.00 64.00 64.00 64.00 64.00 65.00 65.00 65.00 65.00 66.00
63. 00 06300 BLOOD STORI NG, PROCESSI NG & TRANS. 0.000000 0 0 0 0 63. 00 64. 00 64. 00 65. 00 65. 00 665. 00 666. 00 06600 PHYSI CAL THERAPY 0.802757 0 0 0 0 65. 00 66. 00 06700 0CCUPATI ONAL THERAPY 0.000000 0 0 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 0 0 0 0
64. 00 06400 INTRAVENOUS THERAPY 0. 051547 0 0 0 0 0 64. 00 065. 00 065. 00 065. 00 065. 00 066. 00 066. 00 066. 00 067. 00 067. 00 067. 00 068. 00 06800 SPEECH PATHOLOGY 0. 000000 0 0 0 0 0 0 0 0 0 0 0 0 0
65. 00 06500 RESPIRATORY THERAPY 0.802757 0 0 0 0 0 65. 00 066. 00 066. 00 066. 00 067. 00 067. 00 067. 00 068. 00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 0 0 0 0 0 0 0 0 68. 00 068. 00
66. 00 06600 PHYSI CAL THERAPY 0 0 0 0 66. 00 67. 00 067. 00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 0 68. 00 06800 SPEECH PATHOLOGY 0.000000 0 0 0 0 0 0 68. 00 0 0 0 0 0 0 0 0 0
67. 00 06700 OCCUPATI ONAL THERAPY 0. 000000 0 0 0 67. 00 68. 00 06800 SPEECH PATHOLOGY 0. 000000 0 0 68. 00
68. 00 06800 SPEECH PATHOLOGY 0.000000 0 0 68. 00
69. 00 06900 ELECTROCARDI OLOGY 0. 000000 0 0 0 0 69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY 0. 000000 0 0 0 0 70. 00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 1.293753 0 0 0 71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS 1.314142 0 0 0 0 72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS 0. 453642 0 0 0 0 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 0 75.00
75. 01 07501 CARDI AC REHAB 1. 114155 0 0 0 75. 01
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 CLI NI C 0. 930316 0 0 90. 00
91.00 09100 EMERGENCY 0.280358 0 0 0 91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 1.595431 0 0 0 0 92.00
OTHER REIMBURSABLE COST CENTERS
94. 00 09400 HOME PROGRAM DI ALYSIS 0.000000 0 94. 00
95. 00 09500 AMBULANCE SERVI CES 0. 000000 0 95. 00
96. 00 09600 DURABLE MEDI CAL EQUI P-RENTED 0. 000000 0 0 0 96. 00
97. 00 09700 DURABLE MEDI CAL EQUI P-SOLD
25 1 5 1 5 1 1 1 1 5 2 2 5 1 5 1 1 1 1 1
0nly Charges 202.00 Net Charges (line 200 +/- line 201) 0 0 0 0 0 202.00
202.00 Net Charges (line 200 +/- line 201) 0 0 0 0 0 202.00

 Heal th Financial
 Systems
 I U HEALTH PAO

 APPORTIONMENT OF
 MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST
 IU HEALTH PAOLI HOSPITAL

| In Lieu of Form CMS-2552-10 | Provider CCN: 151306 | Period: | Worksheet D | From 01/01/2015 | Part V | To 12/31/2015 | Date/Time Prepared: | 5/27/2016 5: 10 pm

						5/27/2016 5:	10 pm
		Ti tl	e XVIII	Swi ng E	Beds - S		
	Cost	S					
Cost Center Description	Cost	Cost					
	Rei mbursed	Rei mbursed					
	Servi ces	Servi ces Not					
	Subject To	Subject To					
	Ded. & Coins. D	Ded. & Coins.					
	(see inst.)	(see inst.)					
	6. 00	7. 00					
ANCILLARY SERVICE COST CENTERS							
50. 00 05000 OPERATING ROOM	0	0					50.00
51.00 05100 RECOVERY ROOM	0	0					51.00
52.00 05200 DELIVERY ROOM & LABOR ROOM	0	0					52.00
53. 00 05300 ANESTHESI OLOGY	o	0					53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	o	0					54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0					55.00
56. 00 05600 RADI 0I SOTOPE	0	0					56.00
57. 00 05700 CT SCAN	o	0					57.00
58. 00 05800 MRI		0					58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON		0					59.00
60. 00 06000 LABORATORY		0					60.00
61. 00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY		O					61.00
62. 00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0					62.00
	0	0					
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	1 -1	ŭ					63.00
64. 00 06400 I NTRAVENOUS THERAPY	0	0					64.00
65. 00 06500 RESPI RATORY THERAPY	0	0					65.00
66. 00 06600 PHYSI CAL THERAPY	0	0					66.00
67. 00 06700 OCCUPATI ONAL THERAPY	0	0					67.00
68. 00 06800 SPEECH PATHOLOGY	0	0					68. 00
69. 00 06900 ELECTROCARDI OLOGY	0	0					69. 00
70. 00 07000 ELECTROENCEPHALOGRAPHY	0	0					70.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	0					71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENTS	0	0					72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0					73.00
74.00 07400 RENAL DIALYSIS	0	0					74.00
75.00 07500 ASC (NON-DISTINCT PART)	0	0					75.00
75. 01 07501 CARDI AC REHAB	0	0					75. 01
OUTPATIENT SERVICE COST CENTERS							
88. 00 08800 RURAL HEALTH CLINIC	0	0					88. 00
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0					89.00
90. 00 09000 CLI NI C	O	0					90.00
91. 00 09100 EMERGENCY	o	0					91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	o	0					92.00
OTHER REIMBURSABLE COST CENTERS							
94.00 09400 HOME PROGRAM DIALYSIS	0	0					94.00
95. 00 09500 AMBULANCE SERVICES	o						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	o	0					96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	0					97.00
98. 00 09850 OTHER REIMBURSABLE COST CENTERS		0					98.00
200.00 Subtotal (see instructions)		0					200.00
201.00 Less PBP Clinic Lab. Services-Program		O					201.00
Only Charges							201.00
202.00 Net Charges (line 200 +/- line 201)	0	0					202.00
202.00 Met onarges (Trile 200 17 Trile 201)	١	O	I				1202.00

Health Financial Systems	IU HEALTH PAO				u of Form CMS-	2552-10
APPORTIONMENT OF INPATIENT ROUTINE SERVICE CAPITAL	COSTS	Provi der		Peri od: From 01/01/2015	Worksheet D Part I	
				To 12/31/2015	Date/Time Pre	epared:
					5/27/2016 5: 1	IÖ pm
			le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Swing Bed	Reduced	Total Patient	Per Diem	
	Related Cost (from Wkst.	Adjustment	Capital Related Cost	Days	(col. 3 / col. 4)	
	B, Part II,		(col. 1 -		COI. 4)	
	col. 26)		col . 2)			
	1. 00	2.00	3.00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS						
30. 00 ADULTS & PEDIATRICS	270, 924	6, 863	264, 06	1, 462	180. 62	30.00
31.00 INTENSIVE CARE UNIT	0			0	0.00	31.00
32. 00 CORONARY CARE UNIT	0			0	0. 00	
33.00 BURN INTENSIVE CARE UNIT	0			0	0. 00	
34.00 SURGICAL INTENSIVE CARE UNIT	0			0	0. 00	
40. 00 SUBPROVI DER - I PF	0	0		0	0. 00	
41. 00 SUBPROVI DER – I RF	0	0		0	0. 00	
42. 00 SUBPROVI DER	0 250	0	I .	0 0	0.00	
43.00 NURSERY 44.00 SKILLED NURSING FACILITY	8, 350		8, 35	0 246	33. 94 0. 00	
45.00 NURSING FACILITY	0			0 0	0.00	
200.00 Total (lines 30-199)	279, 274		272, 41	0		200.00
Cost Center Description	Inpati ent	Inpati ent	272,41	1, 700		200.00
out contain page. I per on	Program days	Program				
		Capital Cost				
		(col. 5 x				
		col. 6)				
	6. 00	7. 00				
INPATIENT ROUTINE SERVICE COST CENTERS	1 471	04 700	1			
30.00 ADULTS & PEDIATRICS 31.00 INTENSIVE CARE UNIT	176	31, 789	1			30. 00 31. 00
31.00 INTENSIVE CARE UNIT 32.00 CORONARY CARE UNIT	0	0				32.00
33.00 BURN INTENSIVE CARE UNIT	0	0				33.00
34. 00 SURGI CAL INTENSI VE CARE UNI T	0	0				34.00
40. 00 SUBPROVI DER - I PF		0				40.00
41. 00 SUBPROVI DER - I RF	0	0				41.00
42. 00 SUBPROVI DER	0	0				42.00
43. 00 NURSERY	191	6, 483				43.00
44.00 SKILLED NURSING FACILITY	0	0	1			44.00
45.00 NURSING FACILITY	0	0				45 00

38, 272

45. 00 200. 00

43.00 NURSERY
44.00 SKILLED NURSING FACILITY
45.00 NURSING FACILITY
200.00 Total (lines 30-199)

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPITA	AL COSTS	Provi der	CCN: 151306	Peri od:	Worksheet D	
				From 01/01/2015 To 12/31/2015	Part II	
				To 12/31/2015	Date/Time Pre 5/27/2016 5:1	pared:
		T. 1	1		5/2//2016 5: 1	U pm
01. 01 D	0		le XIX	Hospi tal	PPS	
Cost Center Description	Capi tal	Total Charges			Capital Costs	
	Related Cost	(from Wkst.	to Charges	Program	(column 3 x	
	(from Wkst.	C, Part I,	(col. 1 ÷	Charges	column 4)	
	B, Part II,	col. 8)	col . 2)			
	col . 26)					
	1. 00	2. 00	3. 00	4. 00	5. 00	
ANCILLARY SERVICE COST CENTERS	4/7 400	7 744 000	0.00470	- 40, 400	4 074	F0 00
50. 00 05000 OPERATI NG ROOM	167, 430	7, 714, 000			1, 074	
51. 00 05100 RECOVERY ROOM	0	0	0.00000		0	51.00
52. 00 05200 DELI VERY ROOM & LABOR ROOM	7, 412	1, 005, 852			206	52.00
53. 00 05300 ANESTHESI OLOGY	0	0	0.00000		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	170, 107	10, 060, 771	0. 01690		197	54.00
55. 00 05500 RADI OLOGY-THERAPEUTI C	0	0	0.00000		0	55.00
56. 00 05600 RADI 0I SOTOPE	0	0	0. 00000	0	0	56.00
57.00 05700 CT SCAN	0	0	0.00000	0 0	0	57.00
58. 00 05800 MRI	0	0	0.00000	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0	0	59.00
60. 00 06000 LABORATORY	84, 134	9, 710, 337	0. 00866	4 29, 145	253	60.00
61.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY						61.00
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL	0	0	0. 00000	0	0	62.00
63. 00 06300 BLOOD STORING, PROCESSING & TRANS.	0	0	0.00000		0	63.00
64. 00 06400 I NTRAVENOUS THERAPY	15, 254	4, 345, 429			109	64.00
65. 00 06500 RESPIRATORY THERAPY	12, 865				9	65.00
66. 00 06600 PHYSI CAL THERAPY	67, 277	1, 626, 396	1		45	66.00
67. 00 06700 OCCUPATI ONAL THERAPY	07,277	1,020,370	0.00000		0	67.00
68. 00 06800 SPEECH PATHOLOGY		0	0.00000		0	68.00
69. 00 06900 SPEECH PATHOLOGY	0	0	0.00000		0	69.00
	0	0				
70. 00 07000 ELECTROENCEPHALOGRAPHY	00 000	444 040	0.00000		0	70.00
71. 00 07100 MEDI CAL SUPPLIES CHARGED TO PATIENT	28, 339				219	71.00
72. 00 07200 I MPL. DEV. CHARGED TO PATIENTS	6, 903	98, 411	0. 07014		0	72.00
73. 00 07300 DRUGS CHARGED TO PATIENTS	50, 041	6, 281, 050			206	
74. 00 07400 RENAL DI ALYSI S	0	0			0	74.00
75. 00 07500 ASC (NON-DISTINCT PART)	0	0	0.00000		0	75.00
75. 01 07501 CARDI AC REHAB	23, 856	206, 255	0. 11566	3 0	0	75. 01
OUTPATIENT SERVICE COST CENTERS		Г .	T	.1		
88. 00 08800 RURAL HEALTH CLINIC	0				-	
89.00 08900 FEDERALLY QUALIFIED HEALTH CENTER	0		0.0000		0	89. 00
90. 00 09000 CLI NI C	188	27, 754	0. 00677	4 25	0	90.00
91. 00 09100 EMERGENCY	149, 031	15, 038, 612	0. 00991	0 10, 039	99	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART	154, 550	1, 473, 115	0. 10491	4 2, 340	245	92.00
OTHER REIMBURSABLE COST CENTERS						
94.00 09400 HOME PROGRAM DIALYSIS	0	0	0.00000	0 0	0	94.00
95. 00 09500 AMBULANCE SERVICES						95.00
96. 00 09600 DURABLE MEDICAL EQUIP-RENTED	0	0	0.00000	0 0	0	96.00
97. 00 09700 DURABLE MEDICAL EQUIP-SOLD	0	l o	0.00000		0	97.00
98.00 09850 OTHER REIMBURSABLE COST CENTERS	0	0	0. 00000		0	98.00
200.00 Total (lines 50-199)	937, 387	58, 762, 164		192, 270		200.00
1 1 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2 2		,	•		_,,	,

Health Financial Systems IU HEALTH PAOLI HOSPITAL In Lieu of Form CMS-2							
APPORTIONMENT OF INPATIENT ROUTINE SERVICE OTHER PA					Period: From 01/01/2015 To 12/31/2015	Worksheet D Part III	pared:
			Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Nursi ng	Alli	ed Heal th	All Other	Swi ng-Bed	Total Costs	
	School		Cost	Medi cal	Adjustment	(sum of cols.	
				Educati on	Amount (see	1 through 3,	
				Cost	instructions)	minus col. 4)	
	1. 00		2. 00	3. 00	4. 00	5. 00	
INPATIENT ROUTINE SERVICE COST CENTERS							1
30. 00 03000 ADULTS & PEDI ATRI CS	0	- 1	0		0 0	0	30.00
31.00 03100 INTENSIVE CARE UNIT	0	9	0		0	0	31.00
32. 00 03200 CORONARY CARE UNIT	0		0		0	0	32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0		0		0	0	33.00
34.00 03400 SURGI CAL INTENSI VE CARE UNIT	0	9	0		0	0	34.00
40. 00 04000 SUBPROVI DER - I PF	0	2	0		0	·	40.00
41. 00 04100 SUBPROVI DER - RF	0	2	0		0	0	41.00
42. 00 04200 SUBPROVI DER	0	2	0		0	ľ	42.00
43. 00 04300 NURSERY	0	9	0		0	0	10.00
44. 00 04400 SKILLED NURSING FACILITY	0	2	0		0	0	44.00
45. 00 04500 NURSI NG FACI LITY	0	2	0		0	0	
200.00 Total (lines 30-199)	0)	0		0	0	200.00
Cost Center Description	Total Patient		er Diem	Inpatient	I npati ent		
	Days		ol . 5 ÷	Program Days			
		C	ol . 6)		Pass-Through		
					Cost (col. 7 x col. 8)		
	6. 00		7. 00	8. 00	9.00		
INPATIENT ROUTINE SERVICE COST CENTERS	0.00	1	7.00	8.00	9.00		
30. 00 03000 ADULTS & PEDI ATRI CS	1, 462	2	0. 00	17	6 0		30.00
31.00 03100 INTENSIVE CARE UNIT	0		0. 00		0 0		31.00
32.00 03200 CORONARY CARE UNIT	0		0. 00		0		32.00
33.00 03300 BURN INTENSIVE CARE UNIT	0		0. 00		0 0		33.00
34.00 03400 SURGICAL INTENSIVE CARE UNIT	0		0. 00		0 0		34.00
40. 00 04000 SUBPROVI DER - I PF	0		0. 00		0 0		40.00
41. 00 04100 SUBPROVI DER - I RF	0		0. 00		0		41.00
42. 00 04200 SUBPROVI DER	0	1	0. 00		0	l	42.00
43. 00 04300 NURSERY	246	5	0. 00	19		l .	43.00
44.00 04400 SKILLED NURSING FACILITY	0		0. 00		0	l .	44.00
45.00 04500 NURSING FACILITY	0	1	0. 00		0	l	45. 00
200.00 Total (lines 30-199)	1, 708	3		36	07 0		200. 00

Health Financial Systems	IU HEALTH PAOLI I	HOSPI TAL	In Lieu	u of Form CMS-2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT	ANCILLARY SERVICE OTHER PASS	Provi der CCN: 151306	Peri od:	Worksheet D
THROUGH COSTS			From 01/01/2015	Part IV

To 12/31/2015 Date/Time Prepared: 5/27/2016 5:10 pm Title XIX Hospi tal Cost Center Description Non Physician Allied Health Total Cost Nursi ng All Other Anestheti st Medi cal (sum of col 1 School Cost Educati on through col. Cost 1. 00 2.00 3.00 4. 00 5.00 ANCILLARY SERVICE COST CENTERS 05000 OPERATING ROOM 658, 931 50 00 50 00 658, 931 0 0 51.00 05100 RECOVERY ROOM 0 0 51.00 52.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 0 0 0 0 0 0 0 0 0 53.00 05300 ANESTHESI OLOGY 00000000 0 53.00 0 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 0 55.00 56.00 05600 RADI OI SOTOPE 0 0 0 56.00 05700 CT SCAN 0 57.00 57.00 0 0 0 05800 MRI 0 58.00 58.00 0 59.00 05900 CARDI AC CATHETERI ZATI ON 0 0 59.00 60.00 06000 LABORATORY 60.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 62.00 0000000000000 0 62.00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 0 0 0 0 0 0 0 0 0 0 0 63.00 06400 I NTRAVENOUS THERAPY 0 64.00 0 0 64.00 06500 RESPIRATORY THERAPY 0 65.00 0 65.00 0 66.00 06600 PHYSI CAL THERAPY 0 0 66.00 06700 OCCUPATI ONAL THERAPY 0 67.00 67.00 0 06800 SPEECH PATHOLOGY 68.00 68.00 0 06900 ELECTROCARDI OLOGY 69.00 0 0 69.00 0 70.00 07000 ELECTROENCEPHALOGRAPHY 0 0 70.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 71.00 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 07300 DRUGS CHARGED TO PATIENTS 72.00 0 0 Ω 72.00 0 73.00 0 0 73.00 74.00 07400 RENAL DIALYSIS 0 74.00 07500 ASC (NON-DISTINCT PART) 0 0 o 75.00 0 0 75.00 07501 CARDI AC REHAB 0 0 0 75.01 75.01 C 0 OUTPATIENT SERVICE COST CENTERS 08800 RURAL HEALTH CLINIC 0 88.00 88.00 000 0 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 0 89 00 0 0 89.00 09000 CLI NI C 0 90.00 0 90.00 0 91.00 09100 EMERGENCY 0 0 0 0 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS

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658, 931

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0 94.00

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658, 931 200. 00

92.00

95.00

96.00

97.00

92.00

94.00

95.00 96.00

97 00

200.00

09400 HOME PROGRAM DIALYSIS

09600 DURABLE MEDICAL EQUIP-RENTED

09700 DURABLE MEDICAL EQUIP-SOLD

98. 00 09850 OTHER REIMBURSABLE COST CENTERS

Total (lines 50-199)

09500 AMBULANCE SERVICES

THROUGH COSTS

						5/27/2016 5: 1	0 pm
			Ti t	le XIX	Hospi tal	PPS	
	Cost Center Description	Total	Total Charges	Ratio of Cost	Outpati ent	I npati ent	
		Outpati ent	(from Wkst.	to Charges	Ratio of Cost	Program	
		Cost (sum of	C, Part I,	(col. 5 ÷	to Charges	Charges	
		col . 2, 3 and	col. 8)	col. 7)	(col. 6 ÷	ŭ	
		4)	Í		col. 7)		
		6. 00	7. 00	8.00	9. 00	10.00	
	ANCILLARY SERVICE COST CENTERS	1					
50.00	05000 OPERATI NG ROOM	0	7, 714, 000	0. 085420	0.000000	49, 482	50.00
51.00	05100 RECOVERY ROOM	0	l	0. 000000	0. 000000	0	51.00
52. 00	05200 DELIVERY ROOM & LABOR ROOM	0	1, 005, 852			27, 967	52.00
53. 00	05300 ANESTHESI OLOGY	0	1,000,002	0. 000000		0	53.00
54. 00	05400 RADI OLOGY-DI AGNOSTI C	0	10, 060, 771	0. 000000		11, 647	54.00
55. 00	05500 RADI OLOGY-THERAPEUTI C	0	10,000,771	0. 000000		0	55. 00
56.00	05600 RADI OI SOTOPE	0	0	0. 000000		0	56.00
57. 00	05700 CT SCAN			0.000000		0	57.00
58. 00	05800 MRI		0	0. 000000		0	58.00
59.00		0	0			0	59.00
	05900 CARDI AC CATHETERI ZATI ON	0	0 710 227	0.000000		-	
60.00	06000 LABORATORY	0	9, 710, 337	0. 000000	0. 000000	29, 145	60.00
61.00	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY				0.000000		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 I NTRAVENOUS THERAPY	0	4, 345, 429			31, 045	64.00
65.00	06500 RESPI RATORY THERAPY	0	763, 139			511	65.00
66.00	06600 PHYSI CAL THERAPY	0	1, 626, 396	0.000000	0. 000000	1, 095	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	0	0.000000	0. 000000	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0	0.000000	0.000000	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0	0.000000	0.000000	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0	0	0.000000	0.000000	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	0	411, 043	0.000000	0. 000000	3, 179	71. 00
72.00	07200 IMPL. DEV. CHARGED TO PATIENTS	0	98, 411	0.000000	0. 000000	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	6, 281, 050	0. 000000	0. 000000	25, 795	73.00
74.00	07400 RENAL DIALYSIS	0	l	1		0	74.00
75.00	07500 ASC (NON-DISTINCT PART)	0	l o	0. 000000	0. 000000	0	75. 00
75. 01	07501 CARDI AC REHAB	0	206, 255			0	75. 01
	OUTPATIENT SERVICE COST CENTERS	_				-	
88. 00	08800 RURAL HEALTH CLINIC	0	0	0.000000	0. 000000	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0	0			0	89. 00
90.00	09000 CLINIC	0	27, 754			25	90.00
91.00	09100 EMERGENCY	0	l			10, 039	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	0				2, 340	92.00
72.00	OTHER REIMBURSABLE COST CENTERS		1,475,115	0.00000	0.000000	2, 340	72.00
94.00	09400 HOME PROGRAM DIALYSIS	0	0	0.000000	0. 000000	0	94.00
95.00	09500 AMBULANCE SERVICES		0	0.00000	0.000000	U	95.00
96.00	09600 DURABLE MEDI CAL EQUI P-RENTED		,	0. 000000	0 000000	0	95. 00 96. 00
			0			0	
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD		0			-	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0	0		0. 000000	102.270	98.00
200.00	Total (lines 50-199)	0	58, 762, 164	l		192, 270	200.00

In Lieu of Form CMS-2552-10 Health Financial Systems IU HEALTH PAOLI HOSPITAL APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SERVICE OTHER PASS Provi der CCN: 151306 Peri od: Worksheet D From 01/01/2015 Part IV Date/Time Prepared: THROUGH COSTS

12/31/2015

200.00

5/27/2016 5:10 pm Title XIX Hospi tal PPS Outpati ent Outpati ent Cost Center Description Inpatient Program Program Program Pass-Through Pass-Through Charges Costs (col. Costs (col. x col. 10) x col. 12) 11. 00 12. 00 13.00 ANCILLARY SERVICE COST CENTERS 50 00 4, 227 50 00 05000 OPERATING ROOM 51. 00 | 05100 | RECOVERY ROOM 51.00 05200 DELIVERY ROOM & LABOR ROOM 0 0 0 52.00 52.00 0 05300 ANESTHESI OLOGY 0 0 53.00 53.00 05400 RADI OLOGY-DI AGNOSTI C 0 54.00 54.00 0 55.00 05500 RADI OLOGY-THERAPEUTI C 00000 0 55.00 56.00 05600 RADI OI SOTOPE 0 0 56.00 05700 CT SCAN 0 57 00 0 57.00 58.00 05800 MRI 0 58.00 59.00 05900 CARDI AC CATHETERI ZATI ON 0 59.00 06000 LABORATORY 0 60.00 0 60.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 61.00 62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 0 0 62.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 000000000000000 0 63.00 0 06400 I NTRAVENOUS THERAPY 64.00 0 64.00 65.00 06500 RESPIRATORY THERAPY 0 65.00 06600 PHYSI CAL THERAPY 0 66.00 66.00 06700 OCCUPATI ONAL THERAPY 0 0 67.00 67.00 OI 06800 SPEECH PATHOLOGY 0 68.00 68.00 69.00 06900 ELECTROCARDI OLOGY 0 69.00 07000 ELECTROENCEPHALOGRAPHY 70.00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 0 71.00 07200 I MPL. DEV. CHARGED TO PATIENTS 0 0 72.00 72.00 73. 00 07300 DRUGS CHARGED TO PATIENTS 0 73.00 07400 RENAL DIALYSIS 0 0 74.00 74.00 0 07500 ASC (NON-DISTINCT PART) 75 00 0 75 00 07501 CARDI AC REHAB 75.01 0 75.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 0 0 0 88.00 0 08900 FEDERALLY QUALIFIED HEALTH CENTER 89.00 0 89.00 90.00 09000 CLI NI C 0 90.00 09100 EMERGENCY 0 0 91.00 91.00 09200 OBSERVATION BEDS (NON-DISTINCT PART OTHER REIMBURSABLE COST CENTERS 92.00 0 0 0 92.00 94.00 09400 HOME PROGRAM DIALYSIS 0 0 0 94.00 95.00 09500 AMBULANCE SERVICES 95.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 0 96.00 0 0 96.00 97. 00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 0 0 0 98.00 0

4.227

Total (lines 50-199)

200.00

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST			From		Period: From 01/01/2015			
						To 12/31/2015	Date/Time Pre 5/27/2016 5:1	pared: O nm
				Ti t	le XIX	Hospi tal	PPS	<u> </u>
					Charges		Costs	
	Cost Center Description	Cost to		PPS	Cost	Cost	PPS Services	
	·	Charge Ratio	Rei	mbursed	Rei mbursed	Rei mbursed	(see inst.)	
		From	Servi	ces (see	Servi ces	Services Not	,	
		Worksheet C,		nst.)	Subject To	Subject To		
		Part I, col.			Ded. & Coins	Ded. & Coins.		
		9			(see inst.)	(see inst.)		
		1. 00		2. 00	3. 00	4. 00	5. 00	
	ANCILLARY SERVICE COST CENTERS							
50.00	05000 OPERATING ROOM	0. 317283		0	272, 18		0	50.00
51.00	05100 RECOVERY ROOM	0. 000000		0		0	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 194646		0	29, 23		0	52.00
53.00	05300 ANESTHESI OLOGY	0. 000000		0		0 0	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 269948		0	437, 70	0	0	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000		0		0 0	0	55.00
56.00	05600 RADI OI SOTOPE	0. 000000		0		0 0	0	56.00
57.00	05700 CT SCAN	0. 000000		0		0 0	0	57.00
58.00	05800 MRI	0. 000000		0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0. 000000		0		0 0	0	59.00
60.00	06000 LABORATORY	0. 244487		0	506, 12	6 0	0	60.00
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		O		0 0	0	62.00
63.00	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000	1	0		0 0	0	63.00
64.00	06400 I NTRAVENOUS THERAPY	0. 051547		0	136, 71		0	64.00
65. 00	06500 RESPI RATORY THERAPY	0. 802757		0	33, 46		0	65.00
66. 00	06600 PHYSI CAL THERAPY	0. 804724		0	57, 81		0	66.00
67. 00	06700 OCCUPATI ONAL THERAPY	0. 000000		0	0,,0.	o o	0	67.00
68. 00	06800 SPEECH PATHOLOGY	0. 000000		0		o o	0	68.00
69. 00	06900 ELECTROCARDI OLOGY	0. 000000		0		o o	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0. 000000		0		o o	0	70.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 293753		0	21. 96		0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENTS	1. 314142	•	0	4, 65	- 1	0	72.00
73. 00	07300 DRUGS CHARGED TO PATIENTS	0. 453642	ŀ	0	140, 44		0	73.00
74.00	07400 RENAL DIALYSIS	0. 000000	ł	0	140, 44	o o	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000		0		0 0	0	75. 00
75. 00	07501 CARDI AC REHAB	1. 114155		0		0 0	0	75. 00
73.01	OUTPATIENT SERVICE COST CENTERS	1. 114133		0		0	0	73.01
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. 930316		0	85	6 0	0	90.00
91.00	09100 EMERGENCY	0. 280358		0			0	91.00
92. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 595431	ŀ	0			0	92.00
72.00	OTHER REIMBURSABLE COST CENTERS	1. 575431		U	02, 01	1] 0	0	72.00
94.00	09400 HOME PROGRAM DIALYSIS	0. 000000	1			0		94.00
95. 00	09500 AMBULANCE SERVICES	0. 000000		0		o		95.00
96.00	09600 DURABLE MEDICAL EQUIP-RENTED	0. 000000		0		o o	0	96.00
97. 00	09700 DURABLE MEDICAL EQUIP-SOLD	0. 000000		0		0 0	0	97.00
98.00	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000	1	0		0 0	0	98.00
200.00	1 1	0.00000		0	2, 603, 87		-	200.00
200.00			1	U	2,003,07	0	U	201.00
201.00	Only Charges					ا ا		201.00
202.00				0	2, 603, 87	7 0	Λ	202. 00
202.00	1 2 200	I	1	٥١	2,000,07	٠, ٩	O	

APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND VACCINE COST Provider CCN: 151306 Peri od: Worksheet D From 01/01/2015 Part V 12/31/2015 Date/Time Prepared: 5/27/2016 5:10 pm Title XIX Hospi tal PPS Costs Cost Center Description Cost Cost Rei mbursed Rei mbursed Servi ces Services Not Subject To Subject To Ded. & Coins. Ded. & Coins. (see inst.) (see inst.) 6.00 7.00 ANCILLARY SERVICE COST CENTERS 50.00 05000 OPERATING ROOM 86, 360 50.00 05100 RECOVERY ROOM 51.00 51.00 0 05200 DELIVERY ROOM & LABOR ROOM 0 52.00 5,690 52.00 53.00 05300 ANESTHESI OLOGY 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 118, 157 0 54.00 05500 RADI OLOGY-THERAPEUTI C 55.00 0 55.00 0 56.00 05600 RADI OI SOTOPE 0 0 56.00 57.00 05700 CT SCAN 0 57.00 58.00 05800 MRI 0 0 58.00 05900 CARDIAC CATHETERIZATION 59.00 0 0 59.00 60.00 06000 LABORATORY 123, 741 0 60.00 06100 PBP CLINICAL LAB SERVICES-PRGM ONLY 61.00 0 61.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELL 0 62 00 0 62 00 63.00 06300 BLOOD STORING, PROCESSING & TRANS. 0 63.00 64.00 06400 I NTRAVENOUS THERAPY 7,047 0 64.00 06500 RESPIRATORY THERAPY 65.00 26, 863 65.00 66.00 06600 PHYSI CAL THERAPY 46, 526 0 66 00 06700 OCCUPATIONAL THERAPY 67.00 0 0 67.00 06800 SPEECH PATHOLOGY 0 68.00 69.00 06900 ELECTROCARDI OLOGY 0 0 69.00 70 00 07000 ELECTROENCEPHALOGRAPHY 0 70 00 0 71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENT 28, 420 0 71.00 07200 IMPL. DEV. CHARGED TO PATIENTS 0 6, 111 72.00 07300 DRUGS CHARGED TO PATIENTS 63, 713 0 73.00 73.00 74.00 07400 RENAL DIALYSIS 0 0 74.00 75.00 07500 ASC (NON-DISTINCT PART) 0 0 75.00 07501 CARDI AC REHAB 75.01 0 0 75.01 OUTPATIENT SERVICE COST CENTERS 88.00 08800 RURAL HEALTH CLINIC 0 0 88.00 08900 FEDERALLY QUALIFIED HEALTH CENTER 0 89.00 90.00 09000 CLI NI C 796 0 90.00 91.00 09100 EMERGENCY 252, 295 91.00 0 92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART 100, 211 0 92.00 OTHER REIMBURSABLE COST CENTERS 09400 HOME PROGRAM DIALYSIS 94.00 0 94.00 09500 AMBULANCE SERVICES 0 95.00 95.00 96.00 09600 DURABLE MEDICAL EQUIP-RENTED 0 96.00 97.00 09700 DURABLE MEDICAL EQUIP-SOLD 0 0 97.00 98. 00 09850 OTHER REIMBURSABLE COST CENTERS 98.00 0 0

865, 930

865 930

0

0

200.00

201.00

202.00

200.00

201.00

202.00

Subtotal (see instructions)

Only Charges

Less PBP Clinic Lab. Services-Program

Net Charges (line 200 +/- line 201)

Health Financial Systems	IU HEALTH PAOLI H	OSPI TAL	In Lieu of Form CMS-2552-1			
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 151306	Peri od: From 01/01/2015	Worksheet D-1		
			To 12/31/2015	Date/Time Pre 5/27/2016 5:1		
		Title XVIII	Hospi tal	Cost		

		Title XVIII	Hospi tal	5/27/2016 5: 1 Cost	0 pm	
	Cost Center Description	THE AVITT	поэрт саг	0031		
				1. 00		
	PART I - ALL PROVIDER COMPONENTS INPATIENT DAYS					
1.00	Inpatient days (including private room days and swing-bed days,	excluding newborn)		1, 519	1.00	
2.00	Inpatient days (including private room days, excluding swing-be	d and newborn days)		1, 462	2. 00	
3.00	Private room days (excluding swing-bed and observation bed days	i). If you have only pr	ivate room days,	0	3.00	
4. 00	do not complete this line.	dava		628	4. 00	
5.00	Semi-private room days (excluding swing-bed and observation bed Total swing-bed SNF type inpatient days (including private room		or 31 of the cost		5.00	
0.00	reporting period	radys) thi odgir becembe	. 01 01 110 0031	00	0.00	
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00	
7.00	reporting period (if calendar year, enter 0 on this line)			40	7.00	
7. 00	Total swing-bed NF type inpatient days (including private room reporting period	days) through December	31 of the cost	19	7. 00	
8. 00	Total swing-bed NF type inpatient days (including private room	days) after December 3	31 of the cost	0	8. 00	
	reporting period (if calendar year, enter 0 on this line)					
9.00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	228	9. 00	
10. 00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII onl	y (including private r	soom days)	38	10.00	
10.00	through December 31 of the cost reporting period (see instructi		oolii days)	30	10.00	
11.00	Swing-bed SNF type inpatient days applicable to title XVIII onl		oom days) after	0	11.00	
	December 31 of the cost reporting period (if calendar year, ent					
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	12.00	
13 00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13.00	
13.00	after December 31 of the cost reporting period (if calendar year			O	13.00	
14.00	Medically necessary private room days applicable to the Program			0	14.00	
15.00				0	15.00	
16. 00	Nursery days (title V or XIX only)			0	16. 00	
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 c	of the cost		17. 00	
17.00	reporting period	till odgir becember 31 c	i the cost		17.00	
18.00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18. 00	
40.00	reporting period			101.00	40.00	
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	134. 09	19. 00	
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0. 00	20. 00	
	reporting period					
21.00	,			4, 229, 620		
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	31 of the cost report	ing period (line	. 0	22. 00	
23. 00	1	1 of the cost reportir	na period (line 6	0	23. 00	
	x line 18)		.g p (
24. 00	Swing-bed cost applicable to NF type services through December	31 of the cost reporti	ng period (line	2, 548	24.00	
25 00	7 x line 19)	of the cost reporting	noried (line O	0	25 00	
25.00	Swing-bed cost applicable to NF type services after December 31 x line 20)	or the cost reporting	period (iine 8	0	25. 00	
26.00	Total swing-bed cost (see instructions)			109, 634	26. 00	
27. 00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		4, 119, 986	27. 00	
00.00	PRI VATE ROOM DI FFERENTI AL ADJUSTMENT	I . b P b . l . d		-	00.00	
28. 00 29. 00	General inpatient routine service charges (excluding swing-bed Private room charges (excluding swing-bed charges)	and observation bed cr	narges)	0		
30.00	Semi-private room charges (excluding swing-bed charges)			0		
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000		
32.00	Average private room per diem charge (line 29 ÷ line 3)			0. 00	32.00	
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)	>		0. 00		
34. 00 35. 00	Average per diem private room charge differential (line 32 minu Average per diem private room cost differential (line 34 x line		ctions)	0. 00 0. 00	34. 00 35. 00	
36. 00	Private room cost differential adjustment (line 3 x line 35)	31)		0.00	36.00	
37. 00	General inpatient routine service cost net of swing-bed cost ar	d private room cost di	fferential (line	-	37.00	
	27 minus line 36)	·	·			
	PART II - HOSPITAL AND SUBPROVIDERS ONLY	TMENTO				
38 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS Adjusted general inpatient routine service cost per diem (see i			2, 818. 05	38.00	
39. 00	Program general inpatient routine service cost per drem (see i			642, 515	39.00	
	Medically necessary private room cost applicable to the Program	*		0	40.00	
41. 00	Total Program general inpatient routine service cost (line 39 +	line 40)		642, 515	41.00	

MCRI F32	-	8. 8. 159. 0

	Financial Systems	TO TILALITI FAUL	_I HOSPITAL		IN LIE	u of Form CMS-2	<u> 2552</u> -10
	ATION OF INPATIENT OPERATING COST			CCN: 151306	Period: From 01/01/2015	Worksheet D-1	
					To 12/31/2015	Date/Time Pre	pared:
			T; +1	e XVIII	Hospi tal	5/27/2016 5: 10	0 pm
	Cost Center Description	Total	Total	Average Per	Hospital Program Days	Cost Program Cost	
	oost conton boost (pt. c.)	Inpatient	I npati ent	Diem (col. 1		(col. 3 x	
		Cost	Days	÷ col . 2)		col. 4)	
42.00	NUDCEDY (+; +Lo V 0 VLV only)	1.00	2.00	3.00	4.00	5. 00	42.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units	0	(0. 0	<u> </u>	0	42.00
43.00	INTENSIVE CARE UNIT	0	(0. 0	00	0	43.00
44.00	CORONARY CARE UNIT	0	(0	
	BURN INTENSIVE CARE UNIT	0	(I I	0	45.00
	SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY)	0	(0.0	0 0	0	46. 00 47. 00
47.00	Cost Center Description						47.00
						1. 00	
	Program inpatient ancillary service cost (Wk			222)		142, 938	
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see mstructi	ONS)		785, 453	49.00
50. 00	Pass through costs applicable to Program inp	atient routine	services (fro	m Wkst. D, su	m of Parts I and	0	50.00
					6.5		
51. 00	Pass through costs applicable to Program inp and IV)	atient ancillar	y servíces (f	rom Wkst. D,	sum of Parts II	0	51.00
52. 00	Total Program excludable cost (sum of lines	50 and 51)				0	52.00
53. 00	Total Program inpatient operating cost exclu		lated, non-ph	ysician anest	hetist, and	0	53.00
	medical education costs (line 49 minus line	52)					
54. 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges					0	54. 00
55. 00	Target amount per discharge						55.00
56. 00	Target amount (line 54 x line 55)					0	56.00
	Difference between adjusted inpatient operat	ing cost and ta	rget amount (line 56 minus	line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost re	0 00	58. 00 59. 00				
37.00	market basket	portring perrou	ending 1770,	upuateu anu c	ompounded by the	0.00	37.00
60. 00	Lesser of lines 53/54 or 55 from prior year						60.00
61. 00	If line 53/54 is less than the lower of line					0	61.00
	which operating costs (line 53) are less tha amount (line 56), otherwise enter zero (see		s (lines 54 x	60), or 1% o	T the target		
62. 00	Relief payment (see instructions)					0	62.00
63. 00	Allowable Inpatient cost plus incentive paym	ent (see instru	ctions)			0	63.00
64. 00	PROGRAM INPATIENT ROUTINE SWING BED COST Medicare swing-bed SNF inpatient routine cos	ts through Daca	mber 31 of th	e cost report	ing period (See	107, 086	64 00
04.00	instructions)(title XVIII only)	ts through bece	inder 31 dr tr	c cost report	The period (see	107,000	04.00
65. 00	Medicare swing-bed SNF inpatient routine cos	ts after Decemb	er 31 of the	cost reportin	g period (See	0	65.00
<i>((</i> 00	instructions)(title XVIII only)	no oceto (lino	(4 plus lips	(E) (+: +1 o V)/I	II only) For	107.004	44 00
66. 00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (Title	04 prus rine	os)(title xvi	ii oniy). Foi	107, 086	00.00
67. 00	Title V or XIX swing-bed NF inpatient routin	e costs through	December 31	of the cost r	eporting period	ol	67.00
	(line 12 x line 19)			5 11			
68. 00	Title V or XIX swing-bed NF inpatient routin (line 13 x line 20)	e costs arter D	ecember 31 or	the cost rep	orting period	0	68.00
69. 00	Total title V or XIX swing-bed NF inpatient	routine costs (line 67 + lin	e 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 72. 00	Adjusted general inpatient routine service c Program routine service cost (line 9 x line	,	ine /o ÷ iine	۷)			71.00
73. 00	Medically necessary private room cost applic		(line 14 x l	ine 35)			73.00
74. 00	Total Program general inpatient routine serv	ice costs (line	72 + line 73)			74.00
75. 00	Capital-related cost allocated to inpatient	routine service	costs (from	Worksheet B,	Part II, column		75.0
76. 00	26, line 45) Per diem capital-related costs (line 75 ÷ li	ne 2)					76.0
77. 00	Program capital-related costs (line 9 x line						77.0
78.00	Inpatient routine service cost (line 74 minu			!->			78.0
79. 00 80. 00	Aggregate charges to beneficiaries for exces Total Program routine service costs for comp				nus line 70)		79. 00 80. 00
81. 00	Inpatient routine service costs for comp		ost mill tatil	(11116 /6 1111	nus IIIIc /7)		81.0
	Inpatient routine service cost limitation ()				82.0
83.00	Reasonable inpatient routine service costs (s)				83.0
84. 00 85. 00	Program inpatient ancillary services (see in		ne)				84.0
	Utilization review - physician compensation Total Program inpatient operating costs (sum						85. 0 86. 0
			,				1 -5. 5.
	PART IV - COMPUTATION OF OBSERVATION BED PASS	3 INKUUGH CUSI					1
86. 00 87. 00	Total observation bed days (see instructions)	11 2			834	
86. 00 87. 00 88. 00) diem (line 27 ÷				834 2, 818. 05 2, 350, 254	88. 0

Health Financial Systems	IU HEALTH PAOLI HOSPITAL			In Lieu of Form CMS-2552-10			
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1		
				From 01/01/2015 To 12/31/2015			
		Ti tl	e XVIII	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation		
		(from line	column 2	Observation	Bed Pass		
		27)		Bed Cost	Through Cost		
				(from line	(col. 3 x		
				89)	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	270, 924	4, 119, 986	0. 06575	8 2, 350, 254	154, 548	90.00	
91.00 Nursing School cost	0	4, 119, 986	0.00000	0 2, 350, 254	0	91.00	
92.00 Allied health cost	0	4, 119, 986	0.00000	0 2, 350, 254	0	92.00	
93.00 All other Medical Education	0	4, 119, 986	0. 00000	0 2, 350, 254	0	93. 00	

Health Financial Systems	IU HEALTH PAOLI H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der CCN: 151306	Peri od: From 01/01/2015	Worksheet D-1	
			To 12/31/2015	Date/Time Pre 5/27/2016 5:1	pared: O pm
		Title XIX	Hospi tal	PPS	
Cost Center Description					
				1. 00	
PART I - ALL PROVIDER COMPONENTS					

		Title XIX	Hospi tal	PPS	
	Cost Center Description			1. 00	
	PART I - ALL PROVIDER COMPONENTS			1.00	
	I NPATI ENT DAYS				
1.00	Inpatient days (including private room days and swing-bed days,			1, 519	1.00
2.00	Inpatient days (including private room days, excluding swing-be			1, 462	2.00
3. 00	Private room days (excluding swing-bed and observation bed days). If you have only pr	ivate room days,	0	3. 00
4. 00	do not complete this line. Semi-private room days (excluding swing-bed and observation bed	days)		628	4.00
5. 00	Total swing-bed SNF type inpatient days (including private room		r 31 of the cost	38	•
	reporting period	3 .			
6.00	Total swing-bed SNF type inpatient days (including private room	days) after December	31 of the cost	0	6. 00
7. 00	reporting period (if calendar year, enter 0 on this line) Total swing-bed NF type inpatient days (including private room	days) through Docombor	21 of the cost	19	7. 00
7.00	reporting period	days) thi odgir beceilber	31 Of the cost	17	7.00
8.00	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)				
9. 00	Total inpatient days including private room days applicable to	the Program (excluding	swing-bed and	176	9. 00
10.00	newborn days) Swing-bed SNF type inpatient days applicable to title XVIII onl	v (including private r	nom days)	0	10.00
10.00	through December 31 of the cost reporting period (see instructi		com days)	· ·	10.00
11.00	Swing-bed SNF type inpatient days applicable to title XVIII onl	y (İncluding private r	oom days) after	0	11.00
	December 31 of the cost reporting period (if calendar year, ent				
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX through December 31 of the cost reporting period	only (including privat	e room days)	0	12. 00
13. 00	Swing-bed NF type inpatient days applicable to titles V or XIX	only (including privat	e room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year	r, enter 0 on this lin	e)	Ü	
14.00	Medically necessary private room days applicable to the Program	(excl udi ng swi ng-bed	days)	0	14.00
15.00	Total nursery days (title V or XIX only)			246	ı
16. 00	Nursery days (title V or XIX only)			191	16. 00
17 00	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to services	through December 31 o	if the cost		17.00
17.00	reporting period	tin dagn becomber of e	T the cost		17.00
18.00	Medicare rate for swing-bed SNF services applicable to services	after December 31 of	the cost		18.00
40.00	reporting period	II I. D		0.00	10.00
19. 00	Medicaid rate for swing-bed NF services applicable to services reporting period	through December 31 of	the cost	0.00	19. 00
20. 00	Medicaid rate for swing-bed NF services applicable to services	after December 31 of t	he cost	0. 00	20.00
	reporting period				
21.00				4, 229, 620	1
22. 00	Swing-bed cost applicable to SNF type services through December 5×1 line 17)	31 of the cost report	ing period (line	0	22. 00
23. 00	Swing-bed cost applicable to SNF type services after December 3	1 of the cost reportin	a period (line 6	0	23. 00
	x line 18)]		
24.00] 3 11	31 of the cost reporti	ng period (line	0	24.00
25 00	7 x line 19)	-6 thtt'		0	25 00
25. 00	Swing-bed cost applicable to NF type services after December 31 x line 20)	of the cost reporting	period (iine 8	0	25. 00
26. 00				107, 150	26. 00
27.00	General inpatient routine service cost net of swing-bed cost (I	ine 21 minus line 26)		4, 122, 470	27.00
	PRI VATE ROOM DIFFERENTIAL ADJUSTMENT				
28.00	General inpatient routine service charges (excluding swing-bed	and observation bed ch	arges)	0	
30.00	Private room charges (excluding swing-bed charges) Semi-private room charges (excluding swing-bed charges)			0	29. 00 30. 00
31. 00	General inpatient routine service cost/charge ratio (line 27 ÷	line 28)		0. 000000	
32.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	ı
33. 00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	1
34.00	Average per diem private room charge differential (line 32 minu		tions)	0.00	
35. 00 36. 00	Average per diem private room cost differential (line 34 x line Private room cost differential adjustment (line 3 x line 35)	31)		0.00	35. 00 36. 00
36.00	General inpatient routine service cost net of swing-bed cost an	d private room cost di	fferential (line	4, 122, 470	ł
57.00	27 minus line 36)	a p. i vato i dom cost ui		1, 122, 470	57.00
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUS				
38.00	Adjusted general inpatient routine service cost per diem (see i	,		2, 819. 75	
39. 00 40. 00	Program general inpatient routine service cost (line 9 x line 3 Medically necessary private room cost applicable to the Program			496, 276 0	39. 00 40. 00
	Total Program general inpatient routine service cost (line 39 +			496, 276	
55	1.112 25. dai. go.lo. dipat. o 1 outillo ooi vi oo ooot (11110 07 1		ı	170, 210	

10.00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days)	0	10.00
11 00	through December 31 of the cost reporting period (see instructions)	0	11 00
11. 00	Swing-bed SNF type inpatient days applicable to title XVIII only (including private room days) after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	U	11. 00
12. 00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	12. 00
12.00	through December 31 of the cost reporting period	O	12.00
13.00	Swing-bed NF type inpatient days applicable to titles V or XIX only (including private room days)	0	13.00
	after December 31 of the cost reporting period (if calendar year, enter 0 on this line)	_	
14.00	Medically necessary private room days applicable to the Program (excluding swing-bed days)	0	14.00
15.00	Total nursery days (title V or XIX only)	246	15.00
16.00	Nursery days (title V or XIX only)	191	16.00
	SWING BED ADJUSTMENT		
17.00	Medicare rate for swing-bed SNF services applicable to services through December 31 of the cost		17.00
	reporting period		
18. 00	Medicare rate for swing-bed SNF services applicable to services after December 31 of the cost		18. 00
40.00	reporting period	0.00	40.00
19. 00	Medicaid rate for swing-bed NF services applicable to services through December 31 of the cost	0.00	19. 00
20.00	reporting period	0.00	20.00
20. 00	Medicaid rate for swing-bed NF services applicable to services after December 31 of the cost reporting period	0.00	20. 00
21. 00	Total general inpatient routine service cost (see instructions)	4, 229, 620	21 00
	Swing-bed cost applicable to SNF type services through December 31 of the cost reporting period (line		22. 00
22.00	5 x line 17)	0	22.00
23. 00	Swing-bed cost applicable to SNF type services after December 31 of the cost reporting period (line 6	0	23. 00
	x line 18)	_	
24.00	Swing-bed cost applicable to NF type services through December 31 of the cost reporting period (line	0	24.00
	7 x line 19)		
25. 00	Swing-bed cost applicable to NF type services after December 31 of the cost reporting period (line 8 x line 20)	0	25. 00
26. 00	Total swing-bed cost (see instructions)	107, 150	26. 00
	General inpatient routine service cost net of swing-bed cost (line 21 minus line 26)	4, 122, 470	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT		
28.00	General inpatient routine service charges (excluding swing-bed and observation bed charges)	0	28. 00
29.00	Private room charges (excluding swing-bed charges)	0	29.00
30.00	Semi-private room charges (excluding swing-bed charges)	0	30.00
31.00	General inpatient routine service cost/charge ratio (line 27 ÷ line 28)	0.000000	31.00
	Average private room per diem charge (line 29 ÷ line 3)		32.00
	Average semi-private room per diem charge (line 30 ÷ line 4)		33.00
	Average per diem private room charge differential (line 32 minus line 33)(see instructions)		34.00
	Average per diem private room cost differential (line 34 x line 31)		35.00
	Private room cost differential adjustment (line 3 x line 35)	0	
37. 00	General inpatient routine service cost net of swing-bed cost and private room cost differential (line	4, 122, 470	37. 00
	27 minus line 36)		
	PART II - HOSPITAL AND SUBPROVIDERS ONLY		
38. 00	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJUSTMENTS Adjusted general inpatient routine service cost per diem (see instructions)	2, 819. 75	20 00
	Program general inpatient routine service cost (line 9 x line 38)	496, 276	
	Medically necessary private room cost applicable to the Program (line 14 x line 35)	490, 270	
	Total Program general inpatient routine service cost (line 39 + line 40)	496, 276	
Ŧ 1 . UU	Total Trogram general ripatricit routine Service Cost (Tille 37 + Tille 40)	470, 270	71.00

Heal th	Financial Systems IU	HEALTH PAOLI HOSP	I TAI	In lie	u of Form CMS-2	2552-10
	FATION OF INPATIENT OPERATING COST		ovi der CCN: 151306	Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015	Date/Time Pre	pared:
			T: +1 - VIV		5/27/2016 5: 1	
	Cost Center Description	Total Tot	Title XIX al Average Per	Hospital Program Days	PPS Program Cost	
		pati ent I npat	ient Diem (col. 1		(col. 3 x	
		Cost Da 2.		4.00	col . 4) 5.00	
42. 00	NURSERY (title V & XIX only)	165, 907	246 674. 4		128, 814	42.00
	Intensive Care Type Inpatient Hospital Units					
43.00	I NTENSI VE CARE UNI T	0	0 0.0		0	43.00
44. 00 45. 00	CORONARY CARE UNIT BURN INTENSIVE CARE UNIT	0 0	0 0.0		0	44. 00 45. 00
46. 00		Ö	0 0.0		Ö	46. 00
47. 00	OTHER SPECIAL CARE (SPECIFY)					47. 00
	Cost Center Description			•	1. 00	
48. 00					56, 691	48. 00
49. 00	Total Program inpatient costs (sum of lines 41 th	nrough 48)(see ins	structions)		681, 781	49. 00
50. 00	PASS THROUGH COST ADJUSTMENTS Pass through costs applicable to Program inpatier	nt routine service	as (from Wkst D sur	of Parts I and	38, 272	50. 00
30.00		it routine service	23 (110m mx3t. b, 3di	r or raits r and	30, 272	30.00
51. 00	Pass through costs applicable to Program inpatier	nt ancillary servi	ces (from Wkst. D, s	sum of Parts II	6, 889	51.00
52. 00	and IV) Total Program excludable cost (sum of lines 50 ar	nd 51)			45, 161	52 00
53. 00	Total Program inpatient operating cost excluding		non-physician anesth	netist, and	636, 620	
	medical education costs (line 49 minus line 52)					
54 00	TARGET AMOUNT AND LIMIT COMPUTATION Program discharges			T	0	54. 00
55. 00						55. 00
56.00	,				0	56.00
57. 00		cost and target ar	nount (line 56 minus	line 53)	0	57.00
58. 00 59. 00	Bonus payment (see instructions) Lesser of lines 53/54 or 55 from the cost reporti	na period endina	1996 undated and co	mpounded by the	0.00	58. 00 59. 00
07.00	market basket	ng perred charng	1770, apacted and ex	inpounded by the	0.00	07.00
60.00	' '				0. 00	60.00
61. 00	If line 53/54 is less than the lower of lines 55, which operating costs (line 53) are less than exp				0	61. 00
	amount (line 56), otherwise enter zero (see instr		23 34 X 00), OI 1/1/01	the target		
62. 00					0	62.00
63.00 Allowable Inpatient cost plus incentive payment (see instructions) PROGRAM INPATIENT ROUTINE SWING BED COST					0	63. 00
64.00		nrough December 3°	l of the cost reporti	ng period (See	0	64.00
65. 00	<pre>instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine costs af</pre>	Fton Docombon 21 (of the cost reporting	noried (See	0	65. 00
65.00	instructions)(title XVIII only)	rter beceiliber 31 (n the cost reporting	j perrou (see	U	65.00
66.00		osts (line 64 plus	s line 65)(title XVII	I only). For	0	66. 00
67. 00	CAH (see instructions) Title V or XIX swing-bed NF inpatient routine cos	sts through Decemb	ner 31 of the cost ro	enorting period	0	67. 00
07.00	(line 12 x line 19)	ors through become	or or or the cost in	por tring perrod		07.00
68. 00	Title V or XIX swing-bed NF inpatient routine cos	sts after December	31 of the cost repo	orting period	0	68. 00
69. 00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient routi	ne costs (line 6	7 + line 68)		0	69. 00
	PART III - SKILLED NURSING FACILITY, OTHER NURSIN	NG FACILITY, AND I	CF/IID ONLY			
70.00			` '			70.00
71. 00 72. 00	Adjusted general inpatient routine service cost program routine service cost (line 9 x line 71)	ber diem (line 70	÷ IIne 2)			71. 00 72. 00
73. 00	, ,	to Program (line	14 x line 35)			73.00
74.00	Total Program general inpatient routine service of					74.00
75. 00	Capital-related cost allocated to inpatient routi 26, line 45)	ne service costs	(from Worksheet B, F	Part II, column		75. 00
76.00)				76. 00
77. 00						77. 00
78. 00 79. 00	Inpatient routine service cost (line 74 minus line Aggregate charges to beneficiaries for excess cost		rocords)			78. 00 79. 00
80.00	Total Program routine service costs for comparison			nus line 79)		80.00
81.00	Inpatient routine service cost per diem limitation	on	•	,		81.00
82. 00 83. 00	Inpatient routine service cost limitation (line S	* .				82. 00 83. 00
83.00	Reasonable inpatient routine service costs (see i Program inpatient ancillary services (see instruc					83.00
85.00	Utilization review - physician compensation (see					85.00
86.00			35)			86. 00
87. 00	PART IV - COMPUTATION OF OBSERVATION BED PASS THE Total observation bed days (see instructions)	KOUGH COST		T	834	87. 00
88. 00	Adjusted general inpatient routine cost per diem	(line 27 ÷ line 2	2)		2, 819. 75	
89. 00	Observation bed cost (line 87 x line 88) (see ins	structions)			2, 351, 672	89. 00

Health Financial Systems	IU HEALTH PAO	LI HOSPITAL		In Lie	u of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provi der		Peri od:	Worksheet D-1	
				From 01/01/2015 To 12/31/2015		
		Ti t	le XIX	Hospi tal	PPS	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observation	
		(from line	column 2	Observation	Bed Pass	
		27)		Bed Cost	Through Cost	
				(from line	(col. 3 x	
				89)	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	270, 924	4, 122, 470	0. 06571	9 2, 351, 672	154, 550	90.00
91.00 Nursing School cost	0	4, 122, 470	0.00000	0 2, 351, 672	0	91.00
92.00 Allied health cost	0	4, 122, 470	0.00000	0 2, 351, 672	0	92.00
93.00 All other Medical Education	0	4, 122, 470	0. 00000	0 2, 351, 672	0	93. 00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lieu	ı of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 151306	Peri od:	Worksheet D-3

	Trilancial Systems To HEALTH FACEL Hos		III LI C	u or rorm cws-2	
INPATI	ENT ANCILLARY SERVICE COST APPORTIONMENT		Peri od:	Worksheet D-3	
			rom 01/01/2015		
		7	To 12/31/2015	Date/Time Pre	pared:
				5/27/2016 5: 1	0 pm
		Title XVIII	Hospi tal	Cost	
	Cost Center Description	Ratio of Cost		I npati ent	
	oust defiter bescription				
		To Charges	Program	Program Costs	
			Charges	(col. 1 x	
				col. 2)	
		1. 00	2. 00	3. 00	
	INPATIENT ROUTINE SERVICE COST CENTERS	•			
30. 00	03000 ADULTS & PEDIATRICS		292, 026		30.00
			292, 020		1
	03100 INTENSIVE CARE UNIT		0		31.00
32.00	03200 CORONARY CARE UNIT		0		32.00
33.00	03300 BURN INTENSIVE CARE UNIT		0		33.00
			0		
	03400 SURGICAL INTENSIVE CARE UNIT		0		34.00
	04000 SUBPROVI DER - I PF		0		40. 00
41.00	04100 SUBPROVI DER - I RF		0		41.00
42.00	04200 SUBPROVI DER		0		42.00
	04300 NURSERY				43.00
43.00					43.00
	ANCILLARY SERVICE COST CENTERS				
50. 00	05000 OPERATING ROOM	0. 317283	31, 501	9, 995	50.00
51.00	05100 RECOVERY ROOM	0. 000000	ol o	0	51.00
52.00	05200 DELIVERY ROOM & LABOR ROOM	0. 194646	23, 125	4, 501	52.00
	05300 ANESTHESI OLOGY	0.000000		0	
54.00	05400 RADI OLOGY-DI AGNOSTI C	0. 269948	25, 594	6, 909	54.00
55.00	05500 RADI OLOGY-THERAPEUTI C	0. 000000	ol o	0	55.00
56.00	05600 RADI 0I S0T0PE	0. 000000	0	0	56.00
	05700 CT SCAN	0.000000		0	57.00
58. 00	05800 MRI	0.000000	0	0	58. 00
59. 00	05900 CARDI AC CATHETERI ZATI ON	0.000000	0	0	59.00
60.00	06000 LABORATORY	0. 244487	82, 726	20, 225	60.00
	06100 PBP CLINICAL LAB SERVICES-PRGM ONLY	0. 000000	·	0	61.00
	06200 WHOLE BLOOD & PACKED RED BLOOD CELL				62.00
		0.000000		0	1
	06300 BLOOD STORING, PROCESSING & TRANS.	0. 000000		0	63.00
64. 00	06400 INTRAVENOUS THERAPY	0. 051547	7 0	0	64.00
65. 00	06500 RESPIRATORY THERAPY	0. 802757	21, 660	17, 388	65.00
	06600 PHYSI CAL THERAPY	0. 804724		16, 192	1
					1
	06700 OCCUPATI ONAL THERAPY	0.000000		0	1
	06800 SPEECH PATHOLOGY	0.000000	0	0	68. 00
69. 00	06900 ELECTROCARDI OLOGY	0.000000	0	0	69.00
70.00	07000 ELECTROENCEPHALOGRAPHY	0.000000	0	0	70.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENT	1. 293753		1, 713	
		l l			
	07200 I MPL. DEV. CHARGED TO PATIENTS	1. 314142		0	72.00
	07300 DRUGS CHARGED TO PATIENTS	0. 453642	145, 369	65, 945	73.00
74.00	07400 RENAL DI ALYSI S	0.000000	0	0	74.00
75. 00	07500 ASC (NON-DISTINCT PART)	0. 000000	0	0	75.00
	07501 CARDI AC REHAB	1. 114155		0	1
75.01		1. 114130	, 0	0	75.01
	OUTPATIENT SERVICE COST CENTERS	T	.1	_	
	08800 RURAL HEALTH CLINIC	0.000000)	0	88. 00
89. 00	08900 FEDERALLY QUALIFIED HEALTH CENTER	0.000000		0	89. 00
90. 00	09000 CLI NI C	0. 930316	75	70	90.00
	09100 EMERGENCY	0. 280358			
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART	1. 595431	0	0	92.00
	OTHER REIMBURSABLE COST CENTERS				1
94.00	09400 HOME PROGRAM DIALYSIS	0.000000	0	0	94.00
95.00	09500 AMBULANCE SERVICES				95.00
	09600 DURABLE MEDI CAL EQUI P-RENTED	0. 000000	0	0	1
				_	
	09700 DURABLE MEDI CAL EQUI P-SOLD	0. 000000		0	
	09850 OTHER REIMBURSABLE COST CENTERS	0. 000000		0	98. 00
200.00	Total (sum of lines 50-94 and 96-98)		351, 495	142, 938	200.00
201.00	Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)	0		201.00
202.00		´	351, 495		202.00
202.00	1.10 Shar goo (1110 200 militas 1110 201)	I .	331, 473	l	1-02.00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lieu of Form CMS-2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provi der CCN: 151306 Pe	eriod: Worksheet D-3

NPATIENT ANCILLARY SERVICE COST APPORTIONMENT

Provider CCN: 151306 | Period: From 01/01/2015 | To 12/31/2015 | Date/Time Prepared: 5/27/2016 5: 10 pm

		Componen	t CCN: 15Z306	10 12/31/2015	Date/lime Pre 5/27/2016 5:1	
		Ti tl	e XVIII	Swing Beds - SNF		Орш
	Cost Center Description		Ratio of Cos		Inpatient	
	·		To Charges	Program	Program Costs	
				Charges	(col. 1 x	
					col . 2)	
			1.00	2. 00	3. 00	
	ATIENT ROUTINE SERVICE COST CENTERS		1	_	T	
	00 ADULTS & PEDIATRICS			0		30.00
	00 INTENSIVE CARE UNIT			0		31.00
	00 CORONARY CARE UNIT			0		32.00
1	00 BURN INTENSIVE CARE UNIT			0		33. 00 34. 00
	00 SURGICAL INTENSIVE CARE UNIT 00 SUBPROVIDER - IPF					40.00
	00 SUBPROVI DER – I RF					41.00
	00 SUBPROVI DER				1	42.00
1	00 NURSERY					43.00
	I LLARY SERVI CE COST CENTERS					10.00
	00 OPERATING ROOM		0. 31728	3 0	0	50.00
51.00 0510	00 RECOVERY ROOM		0.00000		0	51.00
52.00 0520	OO DELIVERY ROOM & LABOR ROOM		0. 19464	6 0	0	52.00
53. 00 0530	00 ANESTHESI OLOGY		0.00000	0	0	53.00
54. 00 0540	00 RADI OLOGY-DI AGNOSTI C		0. 26994	8 2, 199	594	54.00
55. 00 0550	00 RADI OLOGY-THERAPEUTI C		0.00000	0	0	55.00
56.00 0560	00 RADI OI SOTOPE		0.00000	0	0	56.00
	00 CT SCAN		0.00000	0	0	57.00
	00 MRI		0. 00000		_	58.00
	00 CARDI AC CATHETERI ZATI ON		0.00000		_	59.00
	00 LABORATORY		0. 24448		819	60.00
	00 PBP CLINICAL LAB SERVICES-PRGM ONLY		0.00000		_	61.00
	00 WHOLE BLOOD & PACKED RED BLOOD CELL		0.00000		_	62.00
	00 BLOOD STORING, PROCESSING & TRANS.		0.00000			63.00
	00 INTRAVENOUS THERAPY		0. 05154			64.00
1	00 RESPI RATORY THERAPY		0.80275			65.00
	00 PHYSI CAL THERAPY 00 OCCUPATI ONAL THERAPY		0.80472			66. 00 67. 00
	00 SPEECH PATHOLOGY		0. 00000 0. 00000			68.00
	00 ELECTROCARDI OLOGY		0.00000			69.00
	00 ELECTROENCEPHALOGRAPHY		0.00000			70.00
	00 MEDICAL SUPPLIES CHARGED TO PATIENT		1. 29375			71.00
	00 IMPL. DEV. CHARGED TO PATIENTS		1. 31414			72.00
	00 DRUGS CHARGED TO PATIENTS		0. 45364			73.00
1	00 RENAL DIALYSIS		0. 00000		1	74.00
1	00 ASC (NON-DISTINCT PART)		0.00000			75.00
	01 CARDI AC REHAB		1. 11415		0	75. 01
OUTI	PATIENT SERVICE COST CENTERS					
	00 RURAL HEALTH CLINIC		0.00000	0	0	88. 00
	00 FEDERALLY QUALIFIED HEALTH CENTER		0.00000	0	0	89. 00
1	00 CLINIC		0. 93031		0	90.00
	00 EMERGENCY		0. 28035		l .	91.00
	00 OBSERVATION BEDS (NON-DISTINCT PART		1. 59543	1 0	0	92.00
	ER REIMBURSABLE COST CENTERS		0.00000		1 -	04.00
	00 HOME PROGRAM DI ALYSIS		0.00000	0	0	94.00
	00 AMBULANCE SERVICES		0.00000			95.00
	00 DURABLE MEDICAL EQUIP-RENTED 00 DURABLE MEDICAL EQUIP-SOLD		0. 00000 0. 00000		_	96. 00 97. 00
	50 OTHER REIMBURSABLE COST CENTERS		0.00000			98.00
200. 00	Total (sum of lines 50-94 and 96-98)		0.00000	32, 715		
201.00	Less PBP Clinic Laboratory Services-Program only charges	(line 61)		32,713		201.00
202.00	Net Charges (line 200 minus line 201)	(32, 715		202.00
	1		1	52,710	T. Control of the Con	

Health Financial Systems	IU HEALTH PAOLI H	OSPI TAL	In Lie	u of Form CMS-2	2552-10
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT		Provi der CCN: 151306	Peri od: From 01/01/2015	Worksheet D-3	
			To 12/31/2015	Date/Time Prep 5/27/2016 5:10	
		Title XIX	Hospi tal	PPS	
Cost Center Description		Ratio of Cos		Inpatient	

				То	12/31/2015	Date/Time Pre	
		Ti t	le XIX		Hospi tal	5/27/2016 5: 1 PPS	o piii
	Cost Center Description	11 (Ratio of Cos		Inpati ent	Inpati ent	
	oust defiter beschiptron		To Charges		Program	Program Costs	
			l onar goo		Charges	(col. 1 x	
					5	col . 2)	
			1.00		2. 00	3. 00	
I	NPATIENT ROUTINE SERVICE COST CENTERS						
30.00	D3000 ADULTS & PEDIATRICS				26, 895		30.00
31.00	D3100 INTENSIVE CARE UNIT				0		31.00
	D3200 CORONARY CARE UNIT				0		32.00
1	D3300 BURN INTENSIVE CARE UNIT				0		33.00
1	D3400 SURGI CAL INTENSI VE CARE UNI T				0		34.00
	04000 SUBPROVI DER - I PF				0		40.00
	04100 SUBPROVI DER – I RF				0		41.00
	04200 SUBPROVI DER				0 7 7 7		42.00
	04300 NURSERY				27, 767		43. 00
	ANCILLARY SERVICE COST CENTERS D5000 OPERATING ROOM		0. 31728	22	49, 482	15, 700	50. 00
	D5100 RECOVERY ROOM		0. 00000		49, 402	15, 700	51.00
1	D5200 DELIVERY ROOM & LABOR ROOM		0. 19464		27, 967	5, 444	52.00
1	D5300 ANESTHESI OLOGY		0. 00000		27, 907	0, 444	53.00
1	D5400 RADI OLOGY-DI AGNOSTI C		0. 26994		11, 647	3, 144	54. 00
	D5500 RADI OLOGY-THERAPEUTI C		0. 00000		0	0, 111	55. 00
4	D5600 RADI OI SOTOPE		0. 00000		ő	0	56.00
4	D5700 CT SCAN		0. 00000		ol	0	57. 00
4	D5800 MRI		0. 00000		o	0	58.00
59.00	D5900 CARDI AC CATHETERI ZATI ON		0. 00000	00	o	0	59.00
	D6000 LABORATORY		0. 24448	37	29, 145	7, 126	60.00
61.00	D6100 PBP CLINICAL LAB SERVICES-PRGM ONLY		0. 00000	00	0	0	61.00
1	06200 WHOLE BLOOD & PACKED RED BLOOD CELL		0. 00000	00	0	0	62.00
	D6300 BLOOD STORING, PROCESSING & TRANS.		0. 00000		0	0	63.00
1	D6400 I NTRAVENOUS THERAPY		0. 05154		31, 045	1, 600	64.00
	D6500 RESPI RATORY THERAPY		0. 80275		511	410	65.00
	D6600 PHYSI CAL THERAPY		0. 80472		1, 095	881	66.00
	D6700 OCCUPATI ONAL THERAPY		0. 00000		0	0	67.00
	06800 SPEECH PATHOLOGY		0.00000		0	0	68.00
1	06900 ELECTROCARDI OLOGY		0.00000		0	0	69.00
1	07000 ELECTROENCEPHALOGRAPHY		0.00000		2 170	4 112	70.00
4	07100 MEDICAL SUPPLIES CHARGED TO PATIENT 07200 IMPL. DEV. CHARGED TO PATIENTS		1. 29375 1. 31414		3, 179	4, 113 0	71. 00 72. 00
	07300 DRUGS CHARGED TO PATTENTS		0. 45364		25, 795	11, 702	73.00
4	07400 RENAL DIALYSIS		0. 00000		23, 7,75	0	74.00
1	D7500 ASC (NON-DISTINCT PART)		0. 00000		ol	0	75.00
	D7501 CARDI AC REHAB		1. 11415		o	0	75. 01
	DUTPATIENT SERVICE COST CENTERS				- 1	-	
	D8800 RURAL HEALTH CLINIC		0.00000	00	0	0	88. 00
89.00	08900 FEDERALLY QUALIFIED HEALTH CENTER		0. 00000	00	o	0	89.00
90.00	09000 CLI NI C		0. 93031	16	25	23	90.00
91.00	D9100 EMERGENCY		0. 28035	8	10, 039	2, 815	91.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART		1. 59543	31	2, 340	3, 733	92.00
-	OTHER REIMBURSABLE COST CENTERS						
	D9400 HOME PROGRAM DI ALYSI S		0. 00000	00	0	0	94.00
1	09500 AMBULANCE SERVI CES						95.00
	09600 DURABLE MEDICAL EQUIP-RENTED		0.00000		0	0	96.00
	09700 DURABLE MEDICAL EQUIP-SOLD		0.00000		0	0	97.00
	D9850 OTHER REIMBURSABLE COST CENTERS		0. 00000	JU	100 070	0 E/ /01	98. 00
200.00	Total (sum of lines 50-94 and 96-98)	ino (1)			192, 270	56, 691	
201. 00 202. 00	Less PBP Clinic Laboratory Services-Program only charges (I Net Charges (line 200 minus line 201)	ine 61)			192, 270		201. 00 202. 00
202.00	The Condiges (Title 200 IIII has Title 201)		I	I	192, 270		202.00

Health Financial Systems	IU HEALTH PAOLI HOSPITAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT	Provi der CCN: 151306	From 01/01/2015	Worksheet E Part B Date/Time Prepared: 5/27/2016 5:10 pm
	T1 11 20011		

			To 12/31/2015	Date/Time Pre 5/27/2016 5:1	
-	Title XVIII Hospital				о рііі
				1. 00	
1 00	PART B - MEDICAL AND OTHER HEALTH SERVICES			4 140 240	1 00
1. 00 2. 00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruct	ions)		6, 160, 368 0	1.00 2.00
3. 00	PPS payments	10113)		0	•
4. 00	Outlier payment (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instruc	tions)		0. 000	5.00
6.00	Line 2 times line 5			0	6.00
7. 00	Sum of line 3 plus line 4 divided by line 6			0.00	•
8. 00	Transitional corridor payment (see instructions)	/ aal 12 lina 200		0	
9. 00 10. 00	Ancillary service other pass through costs from Wkst. D, Pt. I'Organ acquisitions	v, coi. 13, line 200		0	9. 00 10. 00
11. 00	Total cost (sum of lines 1 and 10) (see instructions)			6, 160, 368	
	COMPUTATION OF LESSER OF COST OR CHARGES			37 . 327 333	
	Reasonable charges				
12.00	Ancillary service charges				12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, Iii	ne 69)		0	
14. 00	Total reasonable charges (sum of lines 12 and 13)			0	14. 00
15. 00	Customary charges Aggregate amount actually collected from patients liable for particular contents are particular to the particular contents and particular contents are particular to the	avment for services on	a charge hasis	0	15. 00
16. 00	Amounts that would have been realized from patients liable for			0	•
	had such payment been made in accordance with 42 CFR §413.13(e		on a onal gozaolo	Ĭ	10.00
17.00	Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17. 00
18. 00	Total customary charges (see instructions)			0	18. 00
19. 00	Excess of customary charges over reasonable cost (complete only	y if line 18 exceeds li	ne 11) (see	0	19. 00
20. 00	instructions)	wifling 11 avende li	no 10) (coo	0	20.00
20.00	Excess of reasonable cost over customary charges (complete onlinstructions)	0	20.00		
21. 00					21.00
22.00	Interns and residents (see instructions)	,		0	1
23. 00	Cost of physicians' services in a teaching hospital (see instr	0	23. 00		
24. 00	Total prospective payment (sum of lines 3, 4, 8 and 9)	0	24. 00		
25 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT				25.00
25. 00 26. 00					25. 00 26. 00
27. 00	· · · · · · · · · · · · · · · · · · ·				•
	instructions)		(3, 269, 681	
28. 00	Direct graduate medical education payments (from Wkst. E-4, li	ne 50)		0	28. 00
29. 00	ESRD direct medical education costs (from Wkst. E-4, line 36)			0	29. 00
30.00	Subtotal (sum of lines 27 through 29)			3, 269, 681	1
31. 00 32. 00	Primary payer payments Subtotal (line 30 minus line 31)			419 3, 269, 262	
32.00	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICE	-S)		3, 207, 202	32.00
33. 00	Composite rate ESRD (from Wkst. I-5, line 11)	-07		0	33.00
34.00	Allowable bad debts (see instructions)			947, 662	1
35.00	Adjusted reimbursable bad debts (see instructions)			615, 980	1
	Allowable bad debts for dual eligible beneficiaries (see instr	uctions)		878, 846	
	Subtotal (see instructions) MSP-LCC reconciliation amount from PS&R			3, 885, 242	1
39.00				0	38. 00 39. 00
39. 50	· · · · · · · · · · · · · · · · · · ·				39.50
39. 98					39. 98
39. 99	·				39. 99
40.00	· · · · · · · · · · · · · · · · · · ·				40. 00
40. 01					40. 01
41.00					41.00
42. 00 43. 00	Balance due provider/program (see instructions)			0 176, 075	
44. 00	Protested amounts (nonallowable cost report items) in accordance	ce with CMS Pub. 15-2.	chapter 1.	41, 792	1
	§115. 2		- ====: '/	,.,2	
	TO BE COMPLETED BY CONTRACTOR				
	Original outlier amount (see instructions)			0	
91.00	Outlier reconciliation adjustment amount (see instructions)			0	
92. 00 93. 00	The rate used to calculate the Time Value of Money Time Value of Money (see instructions)			0.00	92.00 93.00
	Total (sum of lines 91 and 93)				94.00
00	1 ('	Ŭ	

Health Financial Systems 10 H
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 151306

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 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 ADJUSTMENTS TO PROVIDER 07/27/2015 91,800 0 3. 3. 03 0 0 0 3. 3. 04 0 0 0 3. 3. 05 0 0 0 3. 3. 05 0 0 0 3. 3. 05 0 0 0 3. 3. 06 0 0 0 3. 3. 07 0 0 0 0 3. 3. 08 0 0 0 0 0 3. 3. 09 NONE of the program NONE of the payment of the program NONE of the payment of the program NONE of the payment of the program NONE of the payment of the payment of the program NONE of the payment of the paymen						5/27/2016 5: 10	0 pm
1.00							
1.00 Total Interim payments paid to provider 1.00 2.00 3.00 4.00 3.631,462 1.00 1.00 1.00 1.00 3.00 3.00 4.00 3.631,462 1.00 3.631,462 1.00 3.631,462 1.00 3			Inpati er	nt Part A	Par	rt B	
1.00			mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
Substituted or to be submitted or to contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero				2.00		4.00	
Substituted or to be submitted or to contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero	1. 00	Total interim payments paid to provider		486, 398	3	3, 631, 462	1. 00
Services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	2. 00)		2. 00
Write "NONE" or enter a zero St. 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)							
List separately each retroactive lump sum adjustment and unumb ased 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							
amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 3. 01 3. 02 3. 03 3. 04 3. 05 8	3.00						3.00
Dayment, If none, write "NONE" or enter a zero. (1) Program to Provider							
Program to Provider		for the cost reporting period. Also show date of each					
ADJUSTMENTS TO PROVIDER		payment. If none, write "NONE" or enter a zero. (1)					
3.02 3.03 3.04 0 0 0 3.3 3.04 0 0 0 0 3.3 3.05 0 0 0 0 3.3 5.06 0 0 0 0 3.3 7.07 0 0 0 0 3.3 8.15 0 0 0 0 0 3.3 8.15 0 0 0 0 0 3.3 8.15 0 0 0 0 0 3.3 8.15 0 0 0 0 0 3.3 8.15 0 0 0 0 0 3.3 8.15 0 0 0 0 0 3.3 8.15 0 0 0 0 0 3.3 8.15 0 0 0 0 0 3.3 8.15 0 0 0 0 0 0 8.15 0 0 0 0 0 9.15 0 0 0 0 9.16 0 0 0 0 9.17 0 0 0 0 9.17 0 0 0 0 9.17 0 0 0 0 9.17 0 0 0 9.18 0 0 0 9.19 0 0 0 9.10 0 9.10 0 0 9.10 0		Program to Provider					
3.03 0	3. 01	ADJUSTMENTS TO PROVIDER	07/27/2015	91, 800)		3. 01
3.05 Provider to Program	3. 02						3. 02
3.05 Provider to Program	3. 03)	0	3. 03
Provider to Program	3.04			()	0	3.04
3.50 ADJUSTMENTS TO PROGRAM 0	3.05			()	0	3. 05
3.51							
3. 52 0 0 0 0 3. 3. 53 3. 54		ADJUSTMENTS TO PROGRAM		()		3.50
3. 53 3. 54 3. 99 Subtotal (sum of lines 3. 01-3. 49 minus sum of lines 3. 50-3. 98) 91,800 0 3. 3. 50-3. 98) 4. 00 Total interim payments (sum of lines 1, 2, and 3. 99) 578, 198 3,631,462 4. (transfer to Wkst. E or Wkst. E-3, line and column as appropriate) TO BE COMPLETED BY CONTRACTOR							3. 51
3.54 3.99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 91,800 0 3.						1	3. 52
3. 99 Subtotal (sum of lines 3.01-3.49 minus sum of lines 3.50-3.98) 3. 50-3.98) 3. 50-3.98) 578, 198 3. 631, 462 4.				1		1 -1	3. 53
3.50-3.98							3.54
Total interim payments (sum of lines 1, 2, and 3.99)	3. 99			91, 800)	0	3. 99
(transfer to Wkst. E or Wkst. E-3, line and column as appropriate) 10 BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) 5. 1.01 Program to Provider 0 0 5. 5.02 5.03 0 0 5. 5.00 Frovider to Program 0 0 5. 5.50 TeNTATIVE TO PROGRAM 0 0 5. 5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 0 0 5. 6.00 Determined net settlement amount (balance due) based on 6. 6.							
appropriate TO BE COMPLETED BY CONTRACTOR	4. 00			578, 198	3	3, 631, 462	4.00
TO BE COMPLETED BY CONTRACTOR 5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider 5.01 TENTATIVE TO PROVIDER 5.02 0 0 0 5. 5.03 Provider to Program 5.50 TENTATIVE TO PROGRAM 7.50 TENTATIVE TO PROGRAM 8.50 0 0 0 5. 8.51 0 0 0 0 5. 9.51 0 0 0 5. 9.52 0 0 0 5. 9.53 0 0 0 0 5. 9.54 0 0 0 5. 9.55 0 0 0 0 5. 9.55 0 0 0 0 5. 9.55 0 0 0 0 5. 9.56 0 0 0 0 5. 9.57 0 0 0 0 0 5. 9.58 0 0 0 0 0 5. 9.59 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 9.50 0 0 0 0 0 5. 9.50 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0							
5.00 List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider							
desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider	F 00		I	T			E 00
write "NONE" or enter a zero. (1) Program to Provider	5.00						5. 00
Program to Provider							
5. 01 TENTATI VE TO PROVI DER 0 0 0 5. 5. 02 5. 03 0 0 0 5. 5. 03 0 0 0 5. 5. 03 0 0 0 0 5. 5. 03 0 0 0 0 0 5. 5. 03 0 0 0 0 0 0 5. 5. 50 0 0 0 0 0 0 5. 5. 50 0 0 0							
5. 02 5. 03 Provider to Program 5. 50 TENTATIVE TO PROGRAM 5. 51 5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on	5 01			1	1	0	5. 01
5. 03 Provider to Program		TENTATIVE TO TROVIDER		1		1	5. 02
Provider to Program						1	5. 03
5.50 TENTATIVE TO PROGRAM 5.51 5.52 5.99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.60	0.00	Provider to Program			1		0.00
5.51	5 50)	0	5. 50
5. 52 5. 99 Subtotal (sum of lines 5. 01-5. 49 minus sum of lines 5. 5. 50-5. 98) 6. 00 Determined net settlement amount (balance due) based on 6.						0	5. 51
5. 99 Subtotal (sum of lines 5.01-5.49 minus sum of lines 5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.						0	5. 52
5.50-5.98) 6.00 Determined net settlement amount (balance due) based on 6.		Subtotal (sum of lines 5.01-5.49 minus sum of lines				o	5. 99
Ithe cost report (1)	6. 00	Determined net settlement amount (balance due) based on the cost report. (1)					6. 00
	6 01			115 034		176 075	6. 01
				113, 930		170,075	6. 02
				604 12/		3 807 537	7. 00
7. 00 Total Medicale program Habitity (see Histractions) 094, 134 3, 807, 337 7.	7.00	10 tal modificate program readitity (See Thistractions)		074, 132			7.00
Number (Mo/Day/Yr)							
0 1.00 2.00				0			
	8. 00	Name of Contractor					8. 00

Health Financial Systems 10 H
ANALYSIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED Provi der CCN: 151306 | Peri od: | From 01/01/2015 | Worksheet E-1 | Part | Part | Date/Time Prepared: | 5/27/2016 5: 10 pm

		Component	1 0014. 102000	12/01/2010	5/27/2016 5: 1	0 pm
				Swing Beds - SNF	Cost	
		Inpatien	t Part A	Par	t B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3. 00	4. 00	
1.00	Total interim payments paid to provider		68, 41	0	0	1.00
2.00	Interim payments payable on individual bills, either			0	0	2.00
	submitted or to be submitted to the contractor for					
	services rendered in the cost reporting period. If none,					
	write "NONE" or enter a zero					
3. 00	List separately each retroactive lump sum adjustment					3.00
	amount based on subsequent revision of the interim rate					
	for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1)					
	Program to Provider					1
3. 01	ADJUSTMENTS TO PROVIDER			ol	0	3. 01
3. 02	ADSOSTMENTS TO TROVIDER			0	0	3. 02
3. 03				Ö	Ö	3. 03
3. 04				O	0	3. 04
3. 05				0	0	
	Provider to Program					1
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3. 51
3. 52				0	0	3. 52
3. 53				0	0	3. 53
3.54				0	0	3. 54
3. 99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3. 99
	3. 50-3. 98)				_	
4. 00	Total interim payments (sum of lines 1, 2, and 3.99)		68, 41	0	0	4.00
	(transfer to Wkst. E or Wkst. E-3, line and column as					
	appropriate) TO BE COMPLETED BY CONTRACTOR					1
5. 00	List separately each tentative settlement payment after					5.00
3.00	desk review. Also show date of each payment. If none,					3.00
	write "NONE" or enter a zero. (1)					
	Program to Provider					İ
5. 01	TENTATI VE TO PROVI DER			0	0	5.01
5.02				0	0	5. 02
5.03				0	0	5.03
	Provider to Program					
5. 50	TENTATI VE TO PROGRAM			0	0	5. 50
5. 51				0	0	
5. 52				0	0	
5. 99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5. 99
,	5. 50-5. 98)					
6. 00	Determined net settlement amount (balance due) based on					6.00
6 01	the cost report. (1) SETTLEMENT TO PROVIDER		57, 06	0	0	6. 01
6. 01 6. 02	SETTLEMENT TO PROVIDER			0	0	
7. 00	Total Medicare program liability (see instructions)		125, 47	-	0	
7.00	Total modical opingram frability (see filstractions)		125, 47	Contractor	NPR Date	7.00
				Number	(Mo/Day/Yr)	
		()	1. 00	2.00	

Provider CCN: 151306 Period: From 01/01/2015 To 12/31/2015 To 12/31/2015 Part II Par	Heal th	Financial Systems I	IU HEALTH PAOLI HO	OSPI TAL	In Lie	u of Form CMS-2	2552-10
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from Wkst. S-3, Pt. I, col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst. C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 8.00 Cal cul ation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Cal cul ation of the HIT incentive payment after sequestration (see instructions) 10.00 Initial / interim HIT payment adjustment (see instructions) 10.00 Other Adjustment (specify) 1.00 Ostal hospital charity care charges from Wkst. S-10, col. 3 line 20 3.00 Other Adjustment (specify) 3.00 Other Adjustment (specify)	From 01/01/2015 Part II						
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 8.00 Cal culation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Cal culation of the HIT incentive payment after sequestration (see instructions) 10.00 Initial/interim HIT payment adjustment (see instructions) 10.00 Other Adjustment (specify)					To 12/31/2015		
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 2.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 2.00 Total inpatient days from Wkst. S-3, Pt. I, col. 8 line 2 2.00 Total hospital charges from Wkst. S-7, Pt. I, col. 8 line 20 3.00 Total hospital charges from Wkst. S-10, col. 3 line 20 3.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 3.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 3.00 Calculation of the HIT incentive payment (see instructions) 3.00 Sequestration adjustment amount (see instructions) 3.00 Calculation of the HIT incentive payment after sequestration (see instructions) 3.00 Initial/interim HIT payment adjustment (see instructions) 3.00 Other Adjustment (specify)				Title XVIII	Hospi tal	Cost	
TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPORTS HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 2.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 2.00 Total inpatient days from Wkst. S-3, Pt. I, col. 8 line 2 2.00 Total hospital charges from Wkst. S-7, Pt. I, col. 8 line 20 3.00 Total hospital charges from Wkst. S-10, col. 3 line 20 3.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 3.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 3.00 Calculation of the HIT incentive payment (see instructions) 3.00 Sequestration adjustment amount (see instructions) 3.00 Calculation of the HIT incentive payment after sequestration (see instructions) 3.00 Initial/interim HIT payment adjustment (see instructions) 3.00 Other Adjustment (specify)							
HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCULATION 1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 424 1.00 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 228 2.00 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 31 3.00 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 628 4.00 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 59, 883,083 5.00 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 3, 239,474 6.00 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 I ine 168 8.00 Calculation of the HIT incentive payment (see instructions) 0 8.00 9.00 Sequestration adjustment amount (see instructions) 0 9.00 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify)						1. 00	
Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst. C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Other Adjustment (specify)		TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD	COST REPORTS				
2.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I or 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Other Adjustment (specify)		HEALTH INFORMATION TECHNOLOGY DATA COLLECTION	AND CALCULATION				
3.00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 0 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Other Adjustment (specify) 31 3.00 4.00 Sequestration and patch and part of the post of the post of the post of the payment after sequestration (see instructions) 10 30.00 31.00	1.00	1.00 Total hospital discharges as defined in AARA §4102 from Wkst. S-3, Pt. I col. 15 line 14 424					1.00
4.00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12 5.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 6.00 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Other Adjustment (specify)	2.00	.00 Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines 1, 8-12 228					2.00
Total hospital charges from Wkst C, Pt. I, col. 8 line 200 Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 8.00 Calculation of the HIT incentive payment (see instructions) 0 8.00 9.00 Sequestration adjustment amount (see instructions) 0 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 0 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify) 5 9,883,083 5.00 59,883,083 5.00 7.00 7.00	3.00	00 Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2 31					3.00
Total hospital charity care charges from Wkst. S-10, col. 3 line 20 7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 8.00 Calculation of the HIT incentive payment (see instructions) 0 8.00 9.00 Sequestration adjustment amount (see instructions) 0 9.00 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 0 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify) 31.00	4.00	00 Total inpatient days from S-3, Pt. I col. 8 sum of lines 1, 8-12					4.00
7.00 CAH only - The reasonable cost incurred for the purchase of certified HIT technology Wkst. S-2, Pt. I 0 7.00 line 168 8.00 Calculation of the HIT incentive payment (see instructions) 0 8.00 Sequestration adjustment amount (see instructions) 0 9.00 Calculation of the HIT incentive payment after sequestration (see instructions) 0 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify)	5.00	.00 Total hospital charges from Wkst C, Pt. I, col. 8 line 200 59,883,083					5.00
line 168	6.00	Total hospital charity care charges from Wkst.	S-10, col. 3 lir	ne 20		3, 239, 474	6.00
8.00 Calculation of the HIT incentive payment (see instructions) 9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify)	7.00	CAH only - The reasonable cost incurred for th	ne purchase of cer	tified HIT technology	Wkst. S-2, Pt. I	0	7.00
9.00 Sequestration adjustment amount (see instructions) 10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 31.00 Other Adjustment (specify)		line 168					
10.00 Calculation of the HIT incentive payment after sequestration (see instructions) 10.00 INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 30.00 Other Adjustment (specify) 10.00 31.00	8.00	Calculation of the HIT incentive payment (see	instructions)			0	8.00
INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH 30.00 Initial/interim HIT payment adjustment (see instructions) 0 30.00 Other Adjustment (specify) 0 31.00	9.00	Sequestration adjustment amount (see instructi	ons)			0	9.00
30.00 Initial/interim HIT payment adjustment (see instructions) 0 Other Adjustment (specify) 0 30.00 31.00	10.00	Calculation of the HIT incentive payment after	sequestration (s	see instructions)		0	10.00
31.00 Other Adjustment (specify)		INPATIENT HOSPITAL SERVICES UNDER THE LPPS & CAH					
	30.00	Initial/interim HIT payment adjustment (see in	nstructions)			0	30.00
32.00 Balance due provider (line 8 (or line 10) minus line 30 and line 31) (see instructions) 0 32.00	31.00	Other Adjustment (specify)				0	31.00
	32.00	Balance due provider (line 8 (or line 10) minu	us line 30 and lir	ne 31) (see instruction	ns)	ol	32.00

Health Financial Systems	IU HEALTH PAOLI H	OSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT -	SWI NG BEDS	Provi der CCN: 151306		Worksheet E-2
			From 01/01/2015	
		Component CCN: 15Z306	To 12/31/2015	Date/Time Prepared:
				5/27/2016 5: 10 pm
•				

		Component Con. 152506	10 12/31/2015	5/27/2016 5: 1	
		Title XVIII	Swing Beds - SNF	Cost	
			Part A	Part B	
			1. 00	2. 00	
	COMPUTATION OF NET COST OF COVERED SERVICES				
1. 00	Inpatient routine services - swing bed-SNF (see instructions)		108, 157	0	1.00
2. 00	Inpatient routine services - swing bed-NF (see instructions)				2.00
3. 00	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part		19, 883	0	3.00
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH, see inst				
4. 00	Per diem cost for interns and residents not in approved teaching	g program (see		0. 00	4. 00
	instructions)				
5. 00	Program days		38	0	5.00
6. 00	Interns and residents not in approved teaching program (see ins			0	6.00
7. 00	Utilization review - physician compensation - SNF optional method	od only	0		7.00
8. 00	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		128, 040	0	8.00
9. 00	Primary payer payments (see instructions)		0	0	9. 00
	Subtotal (line 8 minus line 9)		128, 040	0	10.00
11. 00	Deductibles billed to program patients (exclude amounts applical	ble to physician	0	0	11.00
	professional services)				
	Subtotal (line 10 minus line 11)		128, 040	0	
13. 00	Coinsurance billed to program patients (from provider records)	(excl ude coi nsurance	0	0	13.00
	for physician professional services)				
	80% of Part B costs (line 12 x 80%)			0	
	Subtotal (enter the lesser of line 12 minus line 13, or line 14))	128, 040	0	15.00
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	16.00
	Pioneer ACO demonstration payment adjustment (see instructions)		0	0	16. 50
	410A RURAL DEMONSTRATION PROJECT		0		16. 55
	Allowable bad debts (see instructions)		0	0	17.00
	Adjusted reimbursable bad debts (see instructions)		0	0	17. 01
18. 00	Allowable bad debts for dual eligible beneficiaries (see instru	ctions)	0	0	18. 00
	Total (see instructions)		128, 040	0	19.00
19. 01	Sequestration adjustment (see instructions)		2, 561	0	19. 01
20.00	Interim payments		68, 410	0	20.00
	Tentative settlement (for contractor use only)		0	0	21.00
	Balance due provider/program (line 19 minus lines 19.01, 20, and		57, 069	0	22. 00
23.00	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	860	0	23. 00
	chapter 1, §115.2				

Health Financial Systems	IU HEALTH PAOLI HO	OSPI TAL	In Lieu	u of Form CMS-2552-10
CALCULATION OF REIMBURSEMENT SETTLEMENT		Provi der CCN: 151306	From 01/01/2015	Worksheet E-3 Part V Date/Time Prepared: 5/27/2016 5:10 pm
		T: +1 - \/\/	Henri Ant	0+

			10 12/31/2013	5/27/2016 5: 1	
		Title XVIII	Hospi tal	Cost	
				1. 00	
	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MEDICARE F	PART A SERVICES - COS	T REIMBURSEMENT		
1.00	Inpati ent services			785, 453	1.00
2.00	Nursing and Allied Health Managed Care payment (see instruction	ns)		0	2.00
3.00	Organ acquisition			0	3.00
4.00	Subtotal (sum of lines 1 through 3)			785, 453	4.00
5.00	Primary payer payments			0	5.00
6.00	Total cost (line 4 less line 5). For CAH (see instructions)			793, 308	6.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
	Reasonabl e charges				
7.00	Routine service charges			0	7.00
8.00	Ancillary service charges			0	8.00
9.00	Organ acquisition charges, net of revenue			0	9. 00
10.00	Total reasonable charges			0	10.00
	Customary charges				
	Aggregate amount actually collected from patients liable for pa			0	
12.00	Amounts that would have been realized from patients liable for	payment for services	on a charge basis	0	12.00
	had such payment been made in accordance with 42 CFR 413.13(e)			0. 000000	13. 00
13. 00					
	00 Total customary charges (see instructions)				14. 00
15. 00	Excess of customary charges over reasonable cost (complete only if line 14 exceeds line 6) (see				15.00
	instructions)			_	
16. 00	Excess of reasonable cost over customary charges (complete only	y if line 6 exceeds li	ne 14) (see	0	16. 00
17 00	instructions)			0	17 00
17. 00	Cost of physicians' services in a teaching hospital (see instru	uctions)		0	17. 00
18. 00	COMPUTATION OF REIMBURSEMENT SETTLEMENT Direct graduate medical education payments (from Worksheet E-4,	Line 40)		0	18. 00
	Cost of covered services (sum of lines 6, 17 and 18)	111le 49)		793, 308	
	Deductibles (exclude professional component)			94, 456	
	Excess reasonable cost (from line 16)			94, 430	21. 00
	Subtotal (line 19 minus line 20 and 21)			698, 852	
23. 00				070, 652	23. 00
	Subtotal (line 22 minus line 23)			698, 852	
	Allowable bad debts (exclude bad debts for professional service	e) (see instructions)		14, 536	
	Adjusted reimbursable bad debts (see instructions)	es) (see mistructions)		9, 448	
	Allowable bad debts for dual eligible beneficiaries (see instru	ictions)		8, 482	
		de ti ons)		708, 300	
	Subtotal (sum of lines 24 and 25, or line 26)			700, 300	29. 00
	O OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY) O Pioneer ACO demonstration payment adjustment (see instructions)			0	29. 50
29. 99				0	29. 99
	Subtotal (see instructions)			708, 300	
				14, 166	
	Interim payments			578, 198	
	Tentative settlement (for contractor use only)			0	32. 00
	Balance due provider/program (line 30 minus lines 30.01, 31, and	nd 32)		115, 936	
34. 00	Protested amounts (nonallowable cost report items) in accordance	,	chapter 1,	5, 329	
	§115. 2			•	

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

Peri od: Worksheet G From 01/01/2015 To 12/31/2015 Date/Time Prepared: 5/27/2016 5:10 pm Provi der CCN: 151306

				12/31/2013	5/27/2016 5: 1	
	<u> </u>	General Fund	Speci fi c	Endowment	Plant Fund	
		1.00	Purpose Fund	Fund	4.00	
	CURRENT ASSETS	1.00	2. 00	3. 00	4. 00	
1. 00	Cash on hand in banks	16, 130, 806	0	0	0	1. 00
2.00	Temporary investments	0		o	0	2.00
3.00	Notes receivable	47, 508	0	o	0	3.00
4.00	Accounts receivable	1, 972, 625		0	0	4.00
5.00	Other receivable	-119, 978		0	0	5.00
6. 00 7. 00	Allowances for uncollectible notes and accounts receivable Inventory	527, 459	0	0	0	6. 00 7. 00
8. 00	Prepai d expenses	104, 383		0	0	8. 00
9. 00	Other current assets	0		ol	0	9. 00
10.00	Due from other funds	O	0	o	0	10.00
11.00	Total current assets (sum of lines 1-10)	18, 662, 803	0	0	0	11.00
40.00	FI XED ASSETS			ما		40.00
12.00	Land	148, 000		0	0	12.00
13. 00 14. 00	Land improvements Accumulated depreciation	438, 464 -279, 860		0	0	13. 00 14. 00
15. 00	Buildings	5, 889, 858		ő	0	15. 00
16. 00	Accumulated depreciation	-2, 788, 672		ō	0	16. 00
17.00	Leasehold improvements	253, 197		o	0	17.00
18. 00	Accumulated depreciation	-253, 197		0	0	18.00
19.00	Fixed equipment	6, 375, 003		0	0	19.00
20. 00 21. 00	Accumulated depreciation Automobiles and trucks	-3, 298, 501 678		0	0	20. 00 21. 00
21.00	Accumulated depreciation	0/0		0	0	22.00
23. 00	Major movable equipment	3, 717, 806	_	ő	0	23. 00
24. 00	Accumulated depreciation	-2, 769, 462		o	0	24.00
25.00	Mi nor equi pment depreci abl e	0	0	o	0	25.00
26. 00	Accumulated depreciation	0	0	0	0	26.00
27. 00	HIT designated Assets	0	0	0	0	27. 00
28. 00	Accumulated depreciation	0	0	0	0	28. 00 29. 00
29. 00 30. 00	Minor equipment-nondepreciable Total fixed assets (sum of lines 12-29)	7, 433, 314	0	0	0	30.00
30.00	OTHER ASSETS	7, 433, 314	<u> </u>	<u> </u>		30.00
31.00	Investments	19, 251, 207	0	0	0	31.00
32.00	Deposits on Leases	0	0	o	0	32.00
33.00	Due from owners/officers	0	0	0	0	33.00
34.00	Other assets	4, 484		0	0	34.00
35. 00 36. 00	Total other assets (sum of lines 31-34) Total assets (sum of lines 11, 30, and 35)	19, 255, 691 45, 351, 808		0	0	35. 00 36. 00
30.00	CURRENT LIABILITIES	45, 351, 606	<u> </u>	<u> </u>	0	30.00
37.00	Accounts payable	855, 252	0	0	0	37. 00
38.00	Salaries, wages, and fees payable	688, 206	0	o	0	38.00
39. 00	Payroll taxes payable	0	0	0	0	39. 00
40.00	Notes and Loans payable (short term)	0	0	0	0	40.00
41.00	Deferred income	0	0	O	0	41.00
42. 00 43. 00	Accelerated payments Due to other funds	0	0	0	0	42. 00 43. 00
	Other current liabilities	2, 872, 703		0	0	
45. 00	Total current liabilities (sum of lines 37 thru 44)	4, 416, 161	Ö	ō	0	
	LONG TERM LIABILITIES					
46.00	Mortgage payable	0	0	0	0	46. 00
47. 00	Notes payable	0		0	0	47.00
48. 00	Unsecured Loans	0	_	0	0	48. 00
49. 00 50. 00	Other long term liabilities Total long term liabilities (sum of lines 46 thru 49	34, 426 34, 426		0	0	49. 00 50. 00
51.00	Total liabilites (sum of lines 45 and 50)	4, 450, 587		o	0	51.00
01.00	CAPI TAL ACCOUNTS	17 1007 007	<u> </u>	<u> </u>		011.00
52.00	General fund balance	40, 901, 221				52.00
53.00	Specific purpose fund		0			53.00
54.00	Donor created - endowment fund balance - restricted			0		54.00
55.00	Donor created - endowment fund balance - unrestricted			0		55.00
56. 00 57. 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56. 00 57. 00
58. 00	Plant fund balance - reserve for plant improvement,				0	58.00
00	replacement, and expansion				· ·	
59. 00	Total fund balances (sum of lines 52 thru 58)	40, 901, 221		o	0	59. 00
60.00	Total liabilities and fund balances (sum of lines 51 and	45, 351, 808	0	0	0	60.00
	[59]	I	I I	I		1

Health Financial Systems
STATEMENT OF CHANGES IN FUND BALANCES | OSPITAL | In Lieu of Form CMS-2552-10 |
| Provider CCN: 151306 | Period: | Worksheet G-1 |
| From 01/01/2015 | Worksheet G-1 |

					Fro	om 01/01/2015 12/31/2015	Date/Time Pr 5/27/2016 5:		
		Genera	Fund	Speci al	Pur	pose Fund	Endowment Fund		
		1. 00	2. 00	3.00		4. 00	5. 00	+	
1. 00 2. 00 3. 00 4. 00 5. 00 6. 00 7. 00 8. 00 9. 00 10. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING Total additions (sum of line 4-9)	2 0 0 0 0	37, 356, 500 3, 544, 719 40, 901, 219		0 0 0 0 0	0		- 1	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	Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) 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	40, 901, 221 0 40, 901, 221		0 0 0 0 0	0		0 0 0 0 0	11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00
	Janeer (Trite 17 mirius Trite 10)	Endowment	PI ant	Fund					
		Fund							
		6. 00	7. 00	8. 00					
1. 00 2. 00 3. 00 4. 00 5. 00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) ROUNDING	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 13. 00 14. 00 15. 00 16. 00 17. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify)	0	0 0 0 0 0 0 0		0 0				6. 00 7. 00 8. 00 9. 00 10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00
18. 00 19. 00	Total deductions (sum of lines 12-17) Fund balance at end of period per balance sheet (line 11 minus line 18)	0			0			- 1	18. 00 19. 00

Health Financial Systems I STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES Provi der CCN: 151306

				12/01/2010	5/27/2016 5: 1	0 pm
	Cost Center Description		Inpati ent	Outpati ent	Total	
	<u> </u>		1. 00	2. 00	3. 00	
	PART I - PATIENT REVENUES					
	General Inpatient Routine Services					
1.00	Hospi tal		1, 120, 919		1, 120, 919	1.00
2.00	SUBPROVI DER - I PF		0		0	2.00
3.00	SUBPROVI DER - I RF		0		0	3.00
4. 00	SUBPROVI DER		0		0	4. 00
5.00	Swing bed - SNF		0		0	5. 00
6. 00	Swing bed - NF		0		0	6. 00
7. 00	SKILLED NURSING FACILITY		0		0	7. 00
8. 00	NURSI NG FACILITY		0		0	8. 00
9.00	OTHER LONG TERM CARE		0		0	9.00
10. 00	Total general inpatient care services (sum of lines 1-9)		1, 120, 919		1, 120, 919	10. 00
	Intensive Care Type Inpatient Hospital Services				-	44.00
11.00	INTENSIVE CARE UNIT		0		0	
12.00	CORONARY CARE UNIT		0		0	12.00
13.00	BURN INTENSIVE CARE UNIT		0		0	13.00
14.00	SURGI CAL INTENSIVE CARE UNIT		U		0	14.00
15.00	OTHER SPECIAL CARE (SPECIFY)		0		0	15. 00 16. 00
16. 00	Total intensive care type inpatient hospital services (sum of line 11-15)	es	0		U	16.00
17. 00	Total inpatient routine care services (sum of lines 10 and 16)		1, 120, 919		1, 120, 919	17. 00
18. 00	Ancillary services		2, 990, 575	38, 748, 270	41, 738, 845	
19. 00	Outpati ent servi ces		108, 589	16, 430, 892	16, 539, 481	19. 00
20. 00	RURAL HEALTH CLINIC		0	10, 430, 072	0, 337, 401	20.00
21. 00	FEDERALLY QUALIFIED HEALTH CENTER		0	0	0	21.00
22. 00	HOME HEALTH AGENCY		o o	0	0	22. 00
23. 00	AMBULANCE SERVICES		0	0	0	23. 00
24. 00	CMHC		Ŭ	0	0	24. 00
24. 10	CORF		0	0	0	24. 10
25. 00	AMBULATORY SURGICAL CENTER (D. P.)		0	0	0	25. 00
26. 00	HOSPI CE		0	Ö	0	26. 00
27. 00	OTHER (SPECIFY)		0	Ö	0	27. 00
28. 00	Total patient revenues (sum of lines 17-27)(transfer column 3 to N	Wkst.	4, 220, 083	55, 179, 162	59, 399, 245	
	G-3, line 1)		., ., .,			
	PART II - OPERATING EXPENSES					
29.00	Operating expenses (per Wkst. A, column 3, line 200)			19, 324, 894		29. 00
30.00	ADD (SPECIFY)		0			30.00
31.00			0			31.00
32.00			0			32.00
33.00			0			33.00
34.00			0			34.00
35.00			0			35.00
36.00	Total additions (sum of lines 30-35)			0		36.00
37. 00	DEDUCT (SPECIFY)		0			37.00
38. 00			0			38. 00
39. 00			0			39. 00
40.00			0			40.00
41.00			0			41.00
42.00	Total deductions (sum of lines 37-41)			0		42.00
43.00	Total operating expenses (sum of lines 29 and 36 minus line 42)(ti	ransfer		19, 324, 894		43.00
	to Wkst. G-3, line 4)					

	Ith Financial Systems IU HEALTH PAOLI HOSPITAL		u of Form CMS-2	
STA	ATEMENT OF REVENUES AND EXPENSES Provider CCN: 151306	Period: From 01/01/2015	Worksheet G-3	
		To 12/31/2015	Date/Time Pre	pared:
			5/27/2016 5:1	
			1. 00	
1. 0			59, 399, 245	1.00
2. 0	· ·		36, 814, 220	2.00
3. 0			22, 585, 025	3. 00
4. 0			19, 324, 894	4. 00
5. 0			3, 260, 131	5. 00
	OTHER I NCOME			
6. 0			0	
7. 0			0	
8. 0			0	0.00
9. 0			0	,,
10.			0	10.00
11.			0	
12.			0	
13.			0	
14.	1 3		0	
15.	3 11 11 11 11 11 11 11 11 11 11 11 11 11			15. 00
16.	3			16.00
17.	3 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1 1		-	17.00
18.			0	
19.			0	
20.	3		0	
21.	3		0	21.00
22.	and the second s		0	22.00
23.			0	23.00
	00 MI SCELLANEOUS I NCOME		284, 588	
	00 Total other income (sum of lines 6-24)		284, 588	
	00 Total (line 5 plus line 25)		3, 544, 719	
	00 OTHER EXPENSES (SPECIFY)		0	
20	ON Total other eynenses (sum of line 27 and subscripts)		Λ	28 00

28.00

3, 544, 719 29. 00

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