Health Fina	ncial Systems	IU HEALTH BLACKFO	RD HOSPI TAL	In Lieu	u of Form CMS-2552-10
	is required by law (42 USC 1395g				
payments ma	de since the beginning of the cos	t reporting period being	deemed overpayments (4	12 USC 1395g).	OMB NO. 0938-0050 EXPIRES 03-31-2022
	ID HOSPITAL HEALTH CARE COMPLEX COS IENT SUMMARY	ST REPORT CERTIFICATION	Provider CCN: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet S Parts I-III Date/Time Prepared: 6/29/2020 8:06 am
	OST REPORT STATUS				
Provi der	1. [X] Electronically prepare			Date: 6/29/20	20 Time: 8:06 am
use only	 2. [] Manually prepared cost 3. [0] If this is an amended 4. [F] Medicare Utilization. 	report enter the number	of times the provider _" for low.	resubmitted this co	ost report
Contractor use only	(1) Ås Submitted 7 (2) Settled without Audit 8	 Date Received: Contractor No. [N]Initial Report fo [N]Final Report for 	11. pr this Provider CCN 12.	NPR Date: Contractor's Vendo [0]If line 5, co number of tim	or Code: 4 Jumn 1 is 4: Enter Wes reopened = 0-9.
PART II - C	ERTI FI CATI ON		I		
ADMI NI STRAT PROVI DED OR	ITATION OR FALSIFICATION OF ANY IN IVE ACTION, FINE AND/OR IMPRISONM PROCURED THROUGH THE PAYMENT DIR IVE ACTION, FINES AND/OR IMPRISON	ENT UNDER FEDERAL LAW. ECTLY OR INDIRECTLY OF A	FURTHERMORE, IF SERVICE	ES IDENTIFIED IN TH	IIS REPORT WERE
CEF	RTIFICATION BY CHIEF FINANCIAL OFF	ICER OR ADMINISTRATOR OF	F PROVI DER(S)		
el e Exp and con exc hea	EREBY CERTIFY that I have read th ectronically filed or manually sub benses prepared by IU HEALTH BLACK d ending 12/31/2019 and to the bes mplete and prepared from the books cept as noted. I further certify alth care services, and that the s ws and regulations.	mitted cost report and t FORD HOSPITAL (15-1302 t of my knowledge and be and records of the prov that I am familiar with	the Balance Sheet and S) for the cost reportin elief, this report and s vider in accordance with the laws and regulation	tatement of Revenue ng period beginning statement are true, h applicable instru ns regarding the pr	e and g 01/01/2019 correct, ucti ons, rovi si on of
[>] have read and agree with the signature on this certification				
		(Si gned			
			Officer or Admin	istrator of Provid	er(s)
			CHIEF FINANCIAL O	FFICER	
			Title		

(Dated when report is electronically signed.)

Date

			Title	XVIII			
	Cost Center Description	Title V	Part A	Part B	HIT	Title XIX	
		1.00	2.00	3.00	4.00	5.00	
	PART III - SETTLEMENT SUMMARY						
1.00	Hospi tal	0	246, 637	-174, 216	0	0	1.00
2.00	Subprovider - IPF	0	0	0		0	2.00
3.00	Subprovider - IRF	0	0	0		0	3.00
5.00	Swing Bed - SNF	0	134, 077	0		0	5.00
6.00	Swing Bed - NF	0				0	6.00
200.00	Total	0	380, 714	-174, 216	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.

SPI T	Financial Systems AL AND HOSPITAL HEALTH CARE COMPLEX I		H BLACKFORE			15-1302	Peri od:		Workshe		<u>2552</u> 2
							From 01/0 To 12/3	1/2019 1/2019	Part I Date/Ti	me Pre	epare
	1.00	2	00		2 00				6/29/20		
	1.00 Hospital and Hospital Health Care Cor		00		3.00			4.00			
	Street: 410 PILGRIM STREET	P0 Box:									1.
)	City: HARTFORD CITY	State: I		ip Code			nty: BLACKF			(5	2.
		Component Na		CCN umber	CBSA Number	Provide	er Date Certifie		ent Syst , 0, or		
				unber	Number	Type					1
		1.00		2.00	3.00	4.00	5.00	6.00	7.00	8.00	
~	Hospital and Hospital-Based Componen			54000	00045		00 (10 (00)			0	
)	Hospi tal	IU HEALTH BLACKF(HOSPITAL		51302	99915	1	02/10/200	DO N	0	0	3
)	Subprovider - IPF	HUSTTIAL									4
	Subprovider - IRF										5
)	Subprovider - (Other)			- 7000	00045		00 (10 (00)				6
C	5	BLACKFORD COMMUN SWING BED		5Z302	99915		02/10/200	DO N	0	0	7.
С	Swing Beds - NF	SWING DED									8.
)	Hospital-Based SNF										9
	Hospital-Based NF										10.
	Hospi tal -Based OLTC Hospi tal -Based HHA										11.
	Separately Certified ASC										13.
00	Hospi tal -Based Hospi ce										14
	Hospital-Based Health Clinic - RHC										15
	Hospital-Based Health Clinic - FQHC Hospital-Based (CMHC) I										16
	Renal Dialysis										18
	Other										19
							Fro		To		-
0	Cost Reporting Period (mm/dd/yyyy)						1. (2. (12/31/		20
	Type of Control (see instructions)						2		12/ 51/	2017	21
	Inpatient PPS Information					1.00	2.0	00	3.0	00	
00	Does this facility qualify and is it	currently receiv	/ing paymer	nts for		N	N				22.
	disproportionate share hospital adjus	stment, in accord	lance with	42 CFR							
	§412.106? In column 1, enter "Y" for										
	facility subject to 42 CFR Section §4 hospital?) In column 2, enter "Y" for			lent							
D1	Did this hospital receive interim und	compensated care	payments f			Ν	N				22.
	cost reporting period? Enter in colur										
	the portion of the cost reporting per Enter in column 2, "Y" for yes or "N"										
	reporting period occurring on or afte				551						
	Is this a newly merged hospital that					Ν	N				22.
	payments to be determined at cost rep Enter in column 1, "Y" for yes or "N"				5)						
	cost reporting period prior to Octobe				/es						
	or "N" for no, for the portion of the										
าว	October 1. Did this bespital receive a geographi		on from	-bon +-		NI					0
03	Did this hospital receive a geographi rural as a result of the OMB standard				eas	Ν	N		N		22.
	adopted by CMS in FY2015? Enter in co	olumn 1, "Y" for	yes or "N"	for no	o						
	for the portion of the cost reporting				-						
	in column 2, "Y" for yes or "N" for r reporting period occurring on or afte										
	Does this hospital contain at least				s						
	counted in accordance with 42 CFR 412	2.105)? Enter in	column 3,	"Y" for	-						
າດ	yes or "N" for no. Which method is used to determine Med	licaid davs on Li	nes 24 and	1/or 25			3 N				23.
.0	below? In column 1, enter 1 if date of				- 3		5 11				23.
	if date of discharge. Is the method o	of identifying th	ne days in	this co							
	reporting period different from the r reporting period? In column 2, enter										
	reporting period? In column 2, enter	i i oi yes or	In-State	In-St	ate	Out-of	Out-of	Medi ca	id 0	ther	
			Medi cai d	Medi c	aid	State	State	HMO da		li cai d	
			paid days			ledicaid	Medicaid		C	lays	
				unpa day		aid days	el i gi bl e unpai d				
			1.00	2.0		3.00	4.00	5.00	6	b. 00	
00	If this provider is an IPPS hospital,	enter the	C		0	0	4.00	0.00	0		24.
	in-state Medicaid paid days in column	n 1, in-state									
	Medicaid eligible unpaid days in colu										
		lumn ?					1		1		
	out-of-state Medicaid paid days in co										
		d days in column									

SPI T	Financial Systems IU HEALTH AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA I	Provider CC	N: 15-1302	Peri od:			eet S-2	2
					From 01/0 To 12/3	01/2019 01/2019		ime Pre 020 8:0	
		In-State Medicaid paid days	In-State Medicaid eligible unpaid days	Out-of State Medicaid paid days	Out-of State Medicaid eligible unpaid	Medi ca HMO da	id C ys Mee	di cai d di sai d	
		1.00	2.00	3.00	4. 00	5.00		6.00	-
5.00	If this provider is an IRF, enter the in-state 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.	0			0		0		25.
	1				1.			00	
. 00	Enter your standard geographic classification (not wa cost reporting period. Enter "1" for urban or "2" for		at the beg	jinning of t	he	2			26.
. 00	Enter your standard geographic classification (not wa reporting period. Enter in column 1, "1" for urban or enter the effective date of the geographic reclassifi	age) status r "2" for r	ural. If ap		t	2			27.
. 00	If this is a sole community hospital (SCH), enter the effect in the cost reporting period.	e number of	periods SC	CH status in		0			35.
					Begi n 1.		Endi 2.	ng: 00	
. 00	Enter applicable beginning and ending dates of SCH st of periods in excess of one and enter subsequent date		cript line	36 for numb					36
. 00	If this is a Medicare dependent hospital (MDH), enter is in effect in the cost reporting period.		r of period	ls MDH statu	s	0			37
01	Is this hospital a former MDH that is eligible for th accordance with FY 2016 OPPS final rule? Enter "Y" fo instructions)								37
00	If line 37 is 1, enter the beginning and ending dates greater than 1, subscript this line for the number of enter subsequent dates.								38
					Y/ 1.		Y/ 2	′N 00	-
. 00	Does this facility qualify for the inpatient hospital hospitals in accordance with 42 CFR §412.101(b)(2)(i) 1 "Y" for yes or "N" for no. Does the facility meet t accordance with 42 CFR 412.101(b)(2)(i), (ii), or (ii) or "N" for no. (see instructions) Is this hospital subject to the HAC program reduction "N" for no in column 1, for discharges prior to Octob), (ii), or the mileage i)? Enter n adjustmen per 1. Ente	(iii)? Ent requiremen in column 2 t? Enter "Y r "Y" for y	er in colum nts in ? "Y" for ye /" for yes o	in is ir N		1		39 40
	no in column 2, for discharges on or after October 1.	(see Inst	ructions)			V	XVIII	XI X	
	Prospective Payment System (PPS)-Capital					1.00	2.00	3.00	
. 00	Does this facility qualify and receive Capital paymer	nt for disp	roporti onat	e share in	accordance	N	N	N	45
00	with 42 CFR Section §412.320? (see instructions) Is this facility eligible for additional payment exce pursuant to 42 CFR §412.348(f)? If yes, complete Wkst Pt. III.					N	N	N	46
00 00	Is this a new hospital under 42 CFR §412.300(b) PPS of Is the facility electing full federal capital payment Teaching Hospitals					N N	N N	N N	47 48
00	Is this a hospital involved in training residents in "N" for no in column 1. If column 1 is "Y", are you i GME payment reduction? Enter "Y" for yes or "N" for	mpacted by	CR 11642 (56
00	If line 56 is yes, is this the first cost reporting p GME programs trained at this facility? Enter "Y" for is "Y" did residents start training in the first mont for yes or "N" for no in column 2. If column 2 is "Y "N", complete Wkst. D, Parts III & IV and D-2, Pt. II	period durin ryes or "N th of this Y", complete , if applic	ng which re " for no in cost report e Worksheet cable.	n column 1. ing period? E-4. lf co	lf column 'Enter "Y lumn 2 is	1			57
00	If line 56 is yes, did this facility elect cost reimb defined in CMS Pub. 15-1, chapter 21, §2148? If yes,			ins' servi ce	s as				58
00	Are costs claimed on line 100 of Worksheet A? If yes	s, complete	Wkst. D-2,	Pt. I. NAHE 413.8	35 Workst		Pass-T	brough	59
				Y/N	Lin	e #	Qualifi Criteri	cation	
	L			1.00	2.	00	3.	00	
. 00	Are you claiming nursing and allied health education any programs that meet the criteria under 42 CFR 413. instructions) Enter "Y" for yes or "N" for no in col is "Y", are you impacted by CR 11642 (or subsequent C	85? (see umn 1. If	column 1	N					60

IOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DA	TA	Provider CC		eriod: rom 01/01/2019 p 12/31/2019	Worksheet S-2 Part I Date/Time Pre 6/29/2020 8:0	pared:
		Y/N	IME	Direct GME	IME	Direct GME	
		1.00	2.00	3.00	4.00	5.00	
	Did your hospital receive FTE slots under ACA section 5503? Enter "Y" for yes or "N" for no in column 1. (see instructions) Enter the average number of unweighted primary care FTEs from the hospital's 3 most recent cost reports ending and submitted before March 23, 2010. (see	N			0.00	0. OC	61.0
1. 02	instructions) Enter the current year total unweighted primary care FTE count (excluding OB/GYN, general surgery FTEs, and primary care FTEs added under section 5503 of ACA). (see instructions)						61.0
1. 03	Enter the base line FTE count for primary care and/or general surgery residents, which is used for determining compliance with the 75% test. (see instructions)						61.0
	Enter the number of unweighted primary care/or surgery allopathic and/or osteopathic FTEs in the current cost reporting period. (see instructions).						61.0
	Enter the difference between the baseline primary and/or general surgery FTEs and the current year's primary care and/or general surgery FTE counts (line 61.04 minus line 61.03). (see instructions)						61.0
1.06	Enter the amount of ACA §5503 award that is being used for cap relief and/or FTEs that are nonprimary care or general surgery. (see instructions)						61.0
		Pro	ogram Name	Program Code	Unweighted IME FTE Count	Unweighted Direct GME FTE Count	
			1.00	2.00	3.00	4.00	
	Of the FTEs in line 61.05, specify each new program specialty, if any, and the number of FTE residents for each new program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count. Of the FTEs in line 61.05, specify each expanded program specialty, if any, and the number of FTE residents for each expanded program. (see instructions) Enter in column 1, the program name. Enter in column 2, the program code. Enter in column 3, the IME FTE unweighted count. Enter in column 4, the direct GME FTE unweighted count.				0.00		61. 1
						1.00	1
	ACA Provisions Affecting the Health Resources and Ser						
	Enter the number of FTE residents that your hospital your hospital received HRSA PCRE funding (see instruc Enter the number of FTE residents that rotated from a during in this cost reporting period of HRSA THC prog Teaching Hospitals that Claim Residents in Nonprovide	ctions) a Teachi gram. (s	ng Health Cent see instruction	ter (THC) into			62.0 62.0
3. 00	Has your facility trained residents in nonprovider se "Y" for yes or "N" for no in column 1. If yes, comple	ettings	during this co	67. (see instru	ictions)	N	63. 0
				Unweighted FTEs Nonprovider Site	FTES in Hospital	Ratio (col. 1/ (col. 1 + col. 2))	-
	Section 5504 of the ACA Base Year FTE Residents in No	onprovi	der Settings	1.00 This base year	2.00	<u> </u>	
	period that begins on or after July 1, 2009 and befor Enter in column 1, if line 63 is yes, or your facilit in the base year period, the number of unweighted non resident FTEs attributable to rotations occurring in settings. Enter in column 2 the number of unweighted resident FTEs that trained in your hospital. Enter in of (column 1 divided by (column 1 + column 2)). (see	<u>re June</u> ty trair a-primar all nor d non-pr n columr	30, 2010. ned residents ry care nprovider rimary care n 3 the ratio	0.00	-		64.0

	EX IDENTIFICATION DA		Fr	eriod: com 01/01/2019		
			To	12/31/2019	Date/Time Pre 6/29/2020 8:0	pared 6 am
	Program Name	Program Code	Unwei ghted	Unwei ghted	Ratio (col. 3/	
			FTEs	FTEs in	$(col \cdot 3 + col \cdot$	
			Nonprovider Site	Hospi tal	4))	
	1.00	2.00	3.00	4.00	5.00	
00 Enter in column 1, if line 63			0.00	0.00	0. 000000	65.0
is yes, or your facility trained residents in the base year period, the program name associated with primary care FTEs for each primary care program in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3						
divided by (column 3 + column 4)). (see instructions)						
			Unweighted	Unwei ghted	Ratio (col. 1/	(
			FTEs Nonprovider	FTEs in Hospital	(col. 1 + col. 2))	
			Si te	nospi tai	2))	
			1.00	2.00	3.00	
Section 5504 of the ACA Current) beginning on or after July 1, 201		n Nonprovider Settir	ngsEffective fo	r cost reporti	ing periods	
Enter in column 2 the number of u FTEs that trained in your hospita (column 1 divided by (column 1 +	al. Enter in column					
	Program Name	structions) Program Code	Unweighted FTEs Nonprovider	Unweighted FTEs in Hospital	Ratio (col. 3/ (col. 3 + col. 4))	
			FTEs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00	_
00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	Program Name	Program Code	FTĔs Nonprovider Site	FTES in Hospital	(col. 3 + col. 4)) 5.00	
00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column	Program Name	Program Code	FTEs Nonprovi der Si te 3.00	FTES in Hospital	(col. 3 + col. 4)) 5.00 0.000000	_
00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	Program Name 1.00 2S	Program Code	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospital 4.00 0.00	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	
00 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 5, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions)	Program Name 1.00 25 25 25 25 25 25 25 25 25 25	Program Code	FTĚs Nonprovi der Si te 3.00 0.00	FTES in Hospital 4.00 0.00	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	
 O0 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF 00 Is this facility an Inpatient Psy Enter "Y" for yes or "N" for no. 00 If line 70 is yes: Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFF Column 3: If column 2 is Y, indic (see instructions) 	Program Name 1.00 1.00 2S /chiatric Facility (the facility have a 2fore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii :ate which program y	Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for	FTĚs Nonprovi der Si te 3.00 0.00 stain an IPF subp ning program in t yes or "N" for m 's in a new teach yes or "N" for m	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0.0000000	70.
 O0 Enter in column 1, the program name associated with each of your primary care programs in which you trained residents. Enter in column 2, the program code. Enter in column 3, the number of unweighted primary care FTE residents attributable to rotations occurring in all non-provider settings. Enter in column 4, the number of unweighted primary care resident FTEs that trained in your hospital. Enter in column 3, the ratio of (column 3 divided by (column 3 + column 4)). (see instructions) Inpatient Psychiatric Facility PF 00 Is this facility an Inpatient Psychiatric Synthesis Column 1: Did recent cost report filed on or be 42 CFR 412.424(d)(1)(iii)(c)) Col program in accordance with 42 CFC column 3: If column 2 is Y, indic 	Program Name 1.00 1.00 2S vchiatric Facility (the facility have a efore November 15, 2 umn 2: Did this fac 2 412.424 (d)(1)(iii ate which program y v PPS nabilitation Facilit	Program Code 2.00 IPF), or does it con n approved GME teach 004? Enter "Y" for ility train resident)(D)? Enter "Y" for ear began during thi	FTËs Nonprovi der Si te 3.00 0.00 intain an IPF subp sing program in t yes or "N" for m s cost reporting	FTES in Hospital 4.00 0.00 1.0 rovider? N he most o. (see ing o.	(col . 3 + col . 4)) 5.00 0.000000 0.0000000 0.0000000 0.000000	

Health Financial Systems IU HEALTH BLACKFORD HOSPITAL HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA Provider CCN: 15-1302 From To		u of Form CMS- Worksheet S-2 Part I Date/Time Pre 6/29/2020 8:0	2 epared:
		1.00	
Long Term Care Hospital PPS 80.00 Is this a long term care hospital (LTCH)? Enter "Y" for yes and "N" for no. 81.00 Is this a LTCH co-located within another hospital for part or all of the cost reporting per "Y" for yes and "N" for no.	riod? Enter	NNN	80. 00 81. 00
TEFRA Providers85.00Is this a new hospital under 42 CFR Section §413.40(f)(1)(i) TEFRA? Enter "Y" for yes or '86.00Did this facility establish a new Other subprovider (excluded unit) under 42 CFR Section §413.40(f)(1)(ii)? Enter "Y" for yes and "N" for no.	'N" for no.	N	85. 00 86. 00
87.00 s this hospital an extended neoplastic disease care hospital classified under section 1886(d)(1)(B)(vi)? Enter "Y" for yes or "N" for no.		Ν	87.00
	V 1.00	XI X 2.00	
Title V and XIX Services 90.00 Does this facility have title V and/or XIX inpatient hospital services? Enter "Y" for	N	Y	90.00
yes or "N" for no in the applicable column. 91.00 Is this hospital reimbursed for title V and/or XIX through the cost report either in	Ν	Ν	91.00
full or in part? Enter "Y" for yes or "N" for no in the applicable column. 92.00 Are title XIX NF patients occupying title XVIII SNF beds (dual certification)? (see		Ν	92.00
instructions) Enter "Y" for yes or "N" for no in the applicable column. 93.00 Does this facility operate an ICF/IID facility for purposes of title V and XIX? Enter	N	Ν	93.00
"Y" for yes or "N" for no in the applicable column. 94.00 Does title V or XIX reduce capital cost? Enter "Y" for yes, and "N" for no in the	N	Ν	94.00
applicable column. 95.00 fline 94 is "Y", enter the reduction percentage in the applicable column. 96.00 Does title V or XIX reduce operating cost? Enter "Y" for yes or "N" for no in the	0. 00 N	0. 00 N	95.00 96.00
 applicable column. 97.00 If line 96 is "Y", enter the reduction percentage in the applicable column. 98.00 Does title V or XIX follow Medicare (title XVIII) for the interns and residents post stepdown adjustments on Wkst. B, Pt. 1, col. 25? Enter "Y" for yes or "N" for no in 	0. 00 N	0. 00 Y	97.00 98.00
 column 1 for title V, and in column 2 for title XIX. 98.01 Does title V or XIX follow Medicare (title XVIII) for the reporting of charges on Wkst. C, Pt. 1? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for 	Ν	Y	98. 01
 title XIX. 98.02 Does title V or XIX follow Medicare (title XVIII) for the calculation of observation bed costs on Wkst. D-1, Pt. IV, line 89? Enter "Y" for yes or "N" for no in column 1 	Ν	Y	98. 02
for title V, and in column 2 for title XIX. 98.03 Does title V or XIX follow Medicare (title XVIII) for a critical access hospital (CAH) reimbursed 101% of inpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V or XIX	Ν	Ν	98. 03
for title V, and in column 2 for title XIX. 98.04 Does title V or XIX follow Medicare (title XVIII) for a CAH reimbursed 101% of outpatient services cost? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title VIX	Ν	Ν	98.04
 in column 2 for title XIX. 98.05 Does title V or XIX follow Medicare (title XVIII) and add back the RCE disallowance on Wkst. C, Pt. I, col. 4? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX. 	Ν	Y	98. 05
<pre>column 2 for title XIX. 98.06 Does title V or XIX follow Medicare (title XVIII) when cost reimbursed for Wkst. D, Pts. I through IV? Enter "Y" for yes or "N" for no in column 1 for title V, and in column 2 for title XIX.</pre>	Ν	Y	98.06
Rural Providers 105.00 Does this hospital qualify as a CAH?	Y		105.00
106.00 If this facility qualifies as a CAH, has it elected the all-inclusive method of payment for outpatient services? (see instructions)	N		106.00
107.00 Column 1: If line 105 is Y, is this facility eligible for cost reimbursement for L&R training programs? Enter "Y" for yes or "N" for no in column 1. (see instructions) Column 2: If column 1 is Y and line 70 or line 75 is Y, do you train L&Rs in an approved medical education program in the CAH's excluded IPF and/or LRF unit(s)? Enter "Y" for yes or "N" for no in column 2. (see instructions)	Ν		107.00
108.00 Is this a rural hospital qualifying for an exception to the CRNA fee schedule? See 42 (CFR Section §412.113(c). Enter "Y" for yes or "N" for no.	Ν		108.00
Physical Occupational 1.00 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" N N for yes or "N" for no for each therapy. Image: therapy services provided by outside supplier? Image: therapy services provided by outside supplier?	N	N	109.00
110 00 Did this boshital participate in the Dural Community Versital Demonstration and set (C1104		1.00 N	110.00
110.00 Did this hospital participate in the Rural Community Hospital Demonstration project (§410A Demonstration) for the current cost reporting period? Enter "Y" for yes or "N" for no. If yes complete Worksheet E, Part A, lines 200 through 218, and Worksheet E-2, lines 200 through 2 applicable.	es,	IN	

ealth Financial Systems IU HEALTH BLACKFO HOSPITAL AND HOSPITAL HEALTH CARE COMPLEX IDENTIFICATION DATA	Provi der CC	CN: 15-1302	Peri od:	<u>Lieu of Form CM</u> Worksheet S	
			From 01/01/2 To 12/31/2	2019 Date/Time F	
		I		6/29/2020 8	
11.00 If this facility qualifies as a CAH, did it participate in th Health Integration Project (FCHIP) demonstration for this cos "Y" for yes or "N" for no in column 1. If the response to col integration prong of the FCHIP demo in which this CAH is part Enter all that apply: "A" for Ambulance services; "B" for add for tele-health services.	t reporting p umn 1 is Y, e icipating in	period? Enter enter the column 2.	1.00 N	2.00	111. (
		1.00	2.00	3.00	_
12.00 Did this hospital participate in the Pennsylvania Rural Healt demonstration for any portion of the current cost reporting p Enter "Y" for yes or "N" for no in column 1. If column 1 is in column 2, the date the hospital began participating in the demonstration. In column 3, enter the date the hospital ceas participation in the demonstration, if applicable. Miscellaneous Cost Reporting Information	eriod? "Y", enter	N			112.0
15.00 Is this an all-inclusive rate provider? Enter "Y" for yes or in column 1. If column 1 is yes, enter the method used (A, B, in column 2. If column 2 is "E", enter in column 3 either "93 for short term hospital or "98" percent for long term care (i psychiatric, rehabilitation and long term hospitals providers the definition in CMS Pub. 15-1, chapter 22, §2208.1.	or E only) " percent ncludes) based on	N			0115.
16.00 Is this facility classified as a referral center? Enter "Y" f "N" for no.	or yes or	N			116. (
17.00 Is this facility legally-required to carry malpractice insura "Y" for yes or "N" for no.	nce? Enter	Ν			117.
18.00 Is the malpractice insurance a claims-made or occurrence poli if the policy is claim-made. Enter 2 if the policy is occurre			1		118.
		Premiums	Losses	s Insurance	
9.01 list amounts of malarastics promiums and paid lasses		1.00	2.00	3.00	0110
8.01 List amounts of malpractice premiums and paid losses:		27, 0	90	0	0 118.
8.02 Are malpractice premiums and paid losses reported in a cost c	optor other t	than the	1.00 N	2.00	118.
Administrative and General? If yes, submit supporting schedu and amounts contained therein. 9.00DD NOT USE THIS LINE 0.00 Is this a SCH or EACH that qualifies for the Outpatient Hold \$3121 and applicable amendments? (see instructions) Enter in "N" for no. Is this a rural hospital with < 100 beds that qua Hold Harmless provision in ACA \$3121 and applicable amendment	le listing co Harmless prov column 1, "Y" lifies for th	ost centers /ision in ACA ' for yes or ne Outpatient	N	Ν	119. 120.
Enter in column 2, "Y" for yes or "N" for no. 1.00Did this facility incur and report costs for high cost implan	table devices	s charged to	Y		121.
patients? Enter "Y" for yes or "N" for no. 2.00 Does the cost report contain healthcare related taxes as defi Act?Enter "Y" for yes or "N" for no in column 1. If column 1 the Worksheet A line number where these taxes are included.				5.00	122.
Transplant Center Information					_
5.00Does this facility operate a transplant center? Enter "Y" for yes, enter certification date(s) (mm/dd/yyyy) below.	yes and "N"	for no. If	N		125.
	er the certif	fication date			126.
					127.
6.00 If this is a Medicare certified kidney transplant center, entine in column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter	r the certifi	cation date			
 6.00 If this is a Medicare certified kidney transplant center, entin column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter enter in column 1 and termination date. 					128.
 6.00 If this is a Medicare certified kidney transplant center, entrin column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified lung transplant center, enter 	r the certifi	cation date	n		
 6.00 If this is a Medicare certified kidney transplant center, entrin column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, enter column 1. 	r the certifi the certific nter the cert	cation date cation date i	n		128. 129. 130.
 6.00 If this is a Medicare certified kidney transplant center, entrin column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified liver transplant center, enter column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in colum 1. 	r the certifi the certific nter the cert mn 2. enter the ce	cation date cation date i tification	n		129.
 6.00 if this is a Medicare certified kidney transplant center, entrin column 1 and termination date, if applicable, in column 2. 7.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 8.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 9.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 0.00 If this is a Medicare certified pancreas transplant center, enter date in column 1 and termination date, if applicable, in colum 1. 1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu 1.00 If this is a Medicare certified intestinal transplant center, date in column 1 and termination date, if applicable, in colu 	r the certifi the certific nter the cert mn 2. enter the ce mn 2.	cation date cation date i tification ertification	n		129. 130.
 26.00 If this is a Medicare certified kidney transplant center, entrin column 1 and termination date, if applicable, in column 2. 27.00 If this is a Medicare certified heart transplant center, enter in column 1 and termination date, if applicable, in column 2. 28.00 If this is a Medicare certified liver transplant center, enter in column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 29.00 If this is a Medicare certified lung transplant center, enter column 1 and termination date, if applicable, in column 2. 20.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in column 2. 20.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in colum 3. 20.00 If this is a Medicare certified pancreas transplant center, enter column 1 and termination date, if applicable, in colum 3. 	r the certifi the certific nter the cert mn 2. enter the ce mn 2. r the certifi	cation date cation date i tification ertification cation date	n		129. 130. 131.

	X IDENTIFICATION DATA	A	Provider CC	N: 15-130		riod: om 01/01/2019 12/31/2019		repared
1.00		2.00				3.00	0/2//2020 0	
If this facility is part of a cha	in organization, enter	r on lin	es 141 throu	igh 143 tl	ne name	e and address	of the	
home office and enter the home of			ractor numbe					
41.00 Name: IU HEALTH, INC	Contractor's Nam	ne: WPS		Contr	actor'	s Number: 081	01	141.0
42.00 Street: 340 W. 10TH STREET 43.00 City: INDIANAPOLIS	PO Box: State:	IN		7: 0 0	odo.	462	04	142. C
43. OUCT LY. TINDIANAPOLI S	state.	I IN		ZipC	oue.	402	04	143.0
							1.00	-
44.00 Are provider based physicians' cos	sts included in Worksh	heet A?					Y	144. 0
						1.00	2.00	
45.00 If costs for renal services are cl	aimed on Wkst. A, lir	ne 74, a	re the costs	for				145. 0
inpatient services only? Enter "Y								
no, does the dialysis facility ind		ation fo	r this cost	reporting	3			
period? Enter "Y" for yes or "N" 46.00Has the cost allocation methodolog		rovi oucl	v filod cost	roport?		Ν		146. (
Enter "Y" for yes or "N" for no in					If	IN		140.0
yes, enter the approval date (mm/c		20. 10	_, onaptor +	-, 51020)				
							1.00	
47.00Was there a change in the statisti							N	147. (
48.00 Was there a change in the order of					<u> </u>		N	148.0
49.00 Was there a change to the simplifi	ed cost finding metho	od? Ente					N N	149. (
			Part A	Part		Title V	Title XIX	_
Does this facility contain a provi	iden that mushifi as fo		1.00	2.00		3.00	4.00	_
or charges? Enter "Y" for yes or								
55. 00 Hospi tal			N	N	D. (30	N	<u> </u>	155. (
56.00 Subprovider - IPF			N	N		N	N	156. (
57.00 Subprovi der – IRF			N	Ν		Ν	N	157. (
58. 00 SUBPROVI DER								158.0
59. 00 SNF			N	Ν		Ν	N	159. 0
60.00 HOME HEALTH AGENCY			N	Ν		Ν	N	160. 0
61.00 CMHC				N		N	N	161.0
							1.00	_
Multicompuc							1.00	
Multicampus 65.00 s this hospital part of a Multica	ampus bospital that ha	as one o	r more campu	ses in di	fferer	t CBSAs2	N	165. 0
Enter "Y" for yes or "N" for no.			i nore campu	363 III UI	TTELEI	IL CDOAS:	IN	105.0
			County	State	Zip C			
	Name			Juliu		code CBSA	FTE/Campus	
	Name O		1.00	2.00	3.0		FTE/Campus 5.00	
66.00 f ine 165 is yes, for each							5.00	00 166. 0
66.00 If line 165 is yes, for each campus enter the name in column							5.00	00 166. (
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in							5.00	00 166. (
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,							5.00	00 166. (
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							5.00	00 166. (
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3,							5.00	00 166. (
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in							5.00	00 166. (
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in	0		1.00	2.00	3. 0	4.00	5.00	00 166. (
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user	0 T) incentive in the Ar r under §1886(n)? Ent	merican ter "Y"	1.00 Recovery and for yes or "	2.00	3. C	4.00 Act	5.00	167.0
66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Health Information Technology (HI 67.00 Is this provider a meaningful user 68.00 If this provider is a CAH (line 10	0 T) incentive in the Ar r under §1886(n)? Ent D5 is "Y") and is a me	merican ter "Y" eaningfu	1.00 Recovery and for yes or " I user (line	2.00	3. C	4.00 Act	5.00 0. 1.00	167.0
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 66.00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI) 67.00 Is this provider a meaningful usei 68.00 If this provider is a CAH (line 10 reasonable cost incurred for the Heater the seception under §413.70(a) (6) (ii)? 	0 T) incentive in the Ar r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or	merican ter "Y" eaningfu uctions) , does t r "N" fo	1.00 Recovery and for yes or " I user (line his provider r no. (see i	2.00 I Reinves N" for no 167 is ' qualify nstructic	3.0 3.0 5. 7"), e for a ons)	Act Act hardshi p	5.00 0. 1.00 Y	167. (168. (168. (
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 66. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67. 00 Is this provider a meaningful user 68. 00 If this provider is a CAH (line 10 reasonable cost incurred for the Fexception under §413. 70(a) (6) (ii) 7 (99. 00) If this provider is a meaningful (see instruction) 70. 00 Enter in columns 1 and 2 the EHR H period respectively (mm/dd/yyyy) 	0 T) incentive in the Ar r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons) peginning date and enc	merican ter "Y" eaningfu uctions) , does t r "N" fo) and is ding dat	1.00 Recovery and for yes or " I user (line his provider r no. (see i not a CAH (e for the re	2.00 I Reinvess N" for no 167 is ' qualify nstructic line 105 porting	3.0 3.0 5. 7"), e for a ons)	Act Act hardship), enter the Beginning 1.00	5.00 0. 1.00 Y 0. Endi ng	167. (168. (168. (00169. (170. (
 66. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67. 00 Is this provider a meaningful user 68. 00 If this provider is a CAH (line 10 reasonable cost incurred for the Fexception under §413. 70(a) (6) (ii) 7 (9. 00) If this provider is a meaningful (see instruction) 70. 00 Enter in columns 1 and 2 the EHR H period respectively (mm/dd/yyyy) 71. 00 If line 167 is "Y", does this provider is provider the formation for the formation formation for the formation formation for the formation formation formation formation for the formation format	0 T) incentive in the Ar r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") ons) peginning date and enco- vider have any days for	merican ter "Y" eaningfu uctions) , does t r "N" fo) and is ding dat	1.00 Recovery and for yes or " I user (line his provider r no. (see i not a CAH (e for the re iduals enrol	2.00 I Reinvess N" for no 167 is ' qualify nstructic line 105 porting	3. 0 tment /). Y"), e for a ons) i s "N"	Act Act hardship), enter the Beginning 1.00	5.00 0. 1.00 Y 0. Endi ng 2.00	167. (168. (168. (00169. (
 66. 00 If line 165 is yes, for each campus enter the name in column 0, county in column 1, state in column 2, zip code in column 3, CBSA in column 4, FTE/Campus in column 5 (see instructions) Heal th Information Technology (HI 67. 00 Is this provider a meaningful user 68. 00 If this provider is a CAH (line 10 reasonable cost incurred for the H 68. 01 If this provider is a CAH and is reception under §413. 70(a) (6) (ii) 7 (11 cm 16 cm	0 T) incentive in the Ar r under §1886(n)? Ent D5 is "Y") and is a me HIT assets (see instru- not a meaningful user, ? Enter "Y" for yes or user (line 167 is "Y") pons) beginning date and enc vider have any days for reported on Wkst. S-3,	merican ter "Y" eaningfu uctions) , does t r "N" fo) and is ding dat	1.00 Recovery and for yes or " I user (line his provider r no. (see i not a CAH (e for the re iduals enrol line 2, col	2.00 I Reinves N" for no 167 is ' qualify nstructic line 105 porting led in . 6? Ente	3.0 tment / b. Y"), e for a ons) is "N"	Act Act hardship), enter the Beginning 1.00	5.00 0. 1.00 Y 0. Endi ng 2.00	167. 168. 168. 00169. 170.

SPI T	AL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C	CN: 15-1302	Peri od: From 01/01/2019 To 12/31/2019	Worksheet S-: Part II Date/Time Pro	epared
				Y/N	<u>6/29/2020 8:0</u> Date	
				1,00	2.00	+
	General Instruction: Enter Y for all YES responses. Enter M mm/dd/yyyy format. COMPLETED BY ALL HOSPITALS	N for all NO re	sponses. Ente			_
	Provider Organization and Operation					
00	Has the provider changed ownership immediately prior to the			N		1.
	reporting period? If yes, enter the date of the change in a	column 2. (see				_
			Y/N	Date	V/I	
00	Has the provider terminated participation in the Medicare P	Drogrom2 lf	1.00 N	2.00	3.00	2.
0	yes, enter in column 2 the date of termination and in colum voluntary or "I" for involuntary.					2.
00	Is the provider involved in business transactions, includin contracts, with individuals or entities (e.g., chain home of or medical supply companies) that are related to the provid officers, medical staff, management personnel, or members of of directors through ownership, control, or family and other relationships? (see instructions)	offices, drug der or its of the board	Y			3.
			Y/N	Туре	Date	
			1.00	2.00	3.00	
	Financial Data and Reports					
00	Column 1: Were the financial statements prepared by a Cer- Accountant? Column 2: If yes, enter "A" for Audited, "C" or or "R" for Reviewed. Submit complete copy or enter date ava column 3. (see instructions) If no, see instructions.	for Compiled,	Y	A		4.
00	Are the cost report total expenses and total revenues diffe	erent from	N			5.
	those on the filed financial statements? If yes, submit red					
				Y/N	Legal Oper.	
				1.00	2.00	
~	Approved Educational Activities	1.6		N 1		- ,
00	Column 1: Are costs claimed for nursing school? Column 2: the legal operator of the program? Are costs claimed for Allied Health Programs? If "Y" see in	5	ie provider is	s N N		6.
00	Were nursing school and/or allied health programs approved cost reporting period? If yes, see instructions. Are costs claimed for Interns and Residents in an approved	and/or renewed	0	N		8. 9.
00	program in the current cost report? If yes, see instruction Was an approved Intern and Resident GME program initiated of	ns.		N		10.
00	cost reporting period? If yes, see instructions.					10.
00	Are GME cost directly assigned to cost centers other than I	l & R in an App	roved	N		11
	Teaching Program on Worksheet A? If yes, see instructions.					
					Y/N	_
					1.00	_
00	Bad Debts Is the provider seeking reimbursement for bad debts? If yes	s soo instruct	Long		Y	12
	If line 12 is yes, did the provider's bad debt collection p period? If yes, submit copy.			ost reporting	N	13
00	If line 12 is yes, were patient deductibles and/or co-payme	ents waived? If	yes, see ins	structions.	Ν	14
00	Bed Complement Did total beds available change from the prior cost reporti		yes, see inst t A	ructions. Par	N + R	15
		Y/N	Date	Y/N	Date	
		1.00	2.00	3.00	4.00	
00	PS&R Data Was the cost report prepared using the PS&R Report only? If either column 1 or 3 is yes, enter the paid-through	N		N		16
00	date of the PS&R Report used in columns 2 and 4 .(see instructions) Was the cost report prepared using the PS&R Report for totals and the provider's records for allocation? If	Y	04/01/2020	Y	04/01/2020	17
00	either column 1 or 3 is yes, enter the paid-through date in columns 2 and 4. (see instructions) If line 16 or 17 is yes, were adjustments made to PS&R	N		N		18
	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.					
00	If line 16 or 17 is yes, were adjustments made to PS&R Report data for corrections of other PS&R Report information? If yes, see instructions.	N		Ν		19

Health Financial Systems

In Lieu of Form CMS-2552-10

alth Financial Systems IU HEALTH BLAC	CKFORD HOSPITAL		In Lie	eu of Form CM	S-2552-1			
OSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE	Provider C		Period: From 01/01/2019					
			To 12/31/2019	Date/Time P 6/29/2020 8				
	Descr	iption	Y/N	Y/N				
		0	1.00	3.00				
D. 00 If line 16 or 17 is yes, were adjustments made to PS&R Report data for Other? Describe the other adjustments:			N	N	20. C			
	Y/N	Date	Y/N	Date				
	1.00	2.00	3.00	4.00				
1.00 Was the cost report prepared only using the provider's	N	2.00	N		21.0			
records? If yes, see instructions.								
				1.00				
COMPLETED BY COST REIMBURSED AND TEFRA HOSPITALS ONLY (EXC	CEPT CHILDRENS H	IOSPI TALS)						
Capital Related Cost				1				
2.00 Have assets been relifed for Medicare purposes? If yes, se				N	22. C 23. C			
	Have changes occurred in the Medicare depreciation expense due to appraisals made during the cost reporting period? If yes, see instructions.							
4.00 Were new leases and/or amendments to existing leases enter lf yes, see instructions	red into during	this cost rep	orting period?	N	24.0			
5.00 Have there been new capitalized leases entered into during instructions.	g the cost repor	ting period?	lfyes, see	N	25.0			
5.00 Were assets subject to Sec.2314 of DEFRA acquired during t	the cost reporti	ng period? If	yes, see	N	26.0			
instructions. 7.00 Has the provider's capitalization policy changed during th	he cost reportir	ng period? If	yes, submit	N	27.0			
copy. Interest Expense								
3.00 Were new Loans, mortgage agreements or letters of credit e period? If yes, see instructions.		-		N	28. (
2.00 Did the provider have a funded depreciation account and/or treated as a funded depreciation account? If yes, see inst		ebt Service Re	serve Fund)	N	29. (
0.00 Has existing debt been replaced prior to its scheduled mating instructions.	turity with new	debt? If yes,	see	N	30.			
 Has debt been recalled before scheduled maturity without i instructions. 	issuance of new	debt? If yes,	see	N	31. (
Purchased Servi ces				1				
2.00 Have changes or new agreements occurred in patient care se arrangements with suppliers of services? If yes, see instr		ed through con	tractual	N	32. (
3.00 If line 32 is yes, were the requirements of Sec. 2135.2 ap		ng to competit	ive bidding? If		33.			
Provi der-Based Physi ci ans					_			
1.00 Are services furnished at the provider facility under an a	arrangement with	nrovidor bas	od physicians?	Y	34.			
If yes, see instructions.	arrangement with		eu physicians:		54.1			
5.00 If line 34 is yes, were there new agreements or amended ex		nts with the p	rovi der-based	N	35.			
physicians during the cost reporting period? If yes, see i	instructions.	-) (/NI	D. I.	_			
			Y/N	Date				
Home Office Costs			1.00	2.00				
6.00 Were home office costs claimed on the cost report?			Y		36.			
.00 If line 36 is yes, has a home office cost statement been p	prepared by the	home office?	Ý		37.			
If yes, see instructions. 00 If line 36 is yes, was the fiscal year end of the home of			Ν		38.			
the provider? If yes, enter in column 2 the fiscal year er 0.00 If line 36 is yes, did the provider render services to oth			Y		39.			
see instructions. 0.00 If line 36 is yes, did the provider render services to the	e home office?	lfyes, see	Ν		40.			
i nstructi ons.								
	1.	00	2.	00				
		41.						
Cost Report Preparer Contact Information .00 Enter the first name, last name and the title/position	RHONDA		UTTER		11			
.00 Enter the first name, last name and the title/position held by the cost report preparer in columns 1, 2, and 3,	RHONDA							
1.00 Enter the first name, last name and the title/position	RHONDA I NDI ANA UNI VER	RSI TY HEALTH			42.			

Heal th	Financial Systems	FORD HOSP	I TAL	In Lie	In Lieu of Form CMS-2552-10			
HOSPITAL AND HOSPITAL HEALTH CARE REIMBURSEMENT QUESTIONNAIRE			Provid	der CCN: 15-1302	Period:	Worksheet S-2		
					From 01/01/2019 To 12/31/2019		pared: <u>6 am</u>	
				3.00				
	Cost Report Preparer Contact Information							
41.00	Enter the first name, last name and the ti-	tle/position	DI RECTOR,	GOVERNMENT			41.00	
	held by the cost report preparer in columns	s 1, 2, and 3,	PROGRAMS					
	respecti vel y.							
42.00	Enter the employer/company name of the cos	t report					42.00	
	preparer.							
43.00	Enter the telephone number and email addres	ss of the cost					43.00	
	report preparer in columns 1 and 2, respec	ti vel y.						

	Financial Systems I TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	U HEALTH BLACKF	Provider CC	N· 15-1302	Peri od:	u of Form CMS-2 Worksheet S-3	
1105111	AL AND HOST THE HEALTH CARE COMPLEX STATISTIC			N. 13-1302	From 01/01/2019 To 12/31/2019	Part I Date/Time Prej 6/29/2020 8:00	pared:
						I/P Days / O/P Visits / Trips	
	Component	Worksheet A Line Number	No. of Beds	Bed Days Available	CAH Hours	Title V	
		1.00	2.00	3.00	4.00	5.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	30.00	15	5,4	75 24, 360. 00	0	1.00
2.00 3.00 4.00 5.00	HMO and other (see instructions) HMO IPF Subprovider HMO IRF Subprovider Hospital Adults & Peds. Swing Bed SNF					0	2.00 3.00 4.00 5.00
6.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation beds) (see instructions)		15	5,4	75 24, 360. 00	0	6.00 7.00
8.00 9.00 10.00 11.00 12.00 13.00	I NTENSI VE CARE UNI T CORONARY CARE UNI T BURN I NTENSI VE CARE UNI T SURGI CAL I NTENSI VE CARE UNI T OTHER SPECI AL CARE (SPECI FY) NURSERY						8.00 9.00 10.00 11.00 12.00 13.00
14.00 15.00 16.00 17.00 18.00 19.00 20.00	Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER SKILLED NURSING FACILITY NURSING FACILITY		15	5, 4	75 24, 360. 00	0 0	14.00 15.00 16.00 17.00 18.00 19.00 20.00
 21.00 22.00 23.00 24.00 24.10 25.00 	OTHER LONG TERM CARE HOME HEALTH AGENCY AMBULATORY SURGICAL CENTER (D.P.) HOSPICE HOSPICE (non-distinct part) CMHC - CMHC	30. 00					21.00 22.00 23.00 24.00 24.10 25.00
26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00	RURAL HEALTH CLINIC FEDERALLY QUALIFIED HEALTH CENTER Total (sum of lines 14-26) Observation Bed Days Ambul ance Trips Employee discount days (see instruction) Employee discount days - IRF Labor & delivery days (see instructions)	89. 00	15 0		0	0	26.00 26.25 27.00 28.00 29.00 30.00 31.00 32.00
32. 01 33. 00 33. 01	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges						32. 01 33. 00 33. 01

HOSPI ⁻	TAL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider C	CN: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet S-3 Part I Date/Time Pre 6/29/2020 8:0	pared:
		I/P Days	/ O/P Visits	/ Trips	Full Time I	Equi val ents	
	Component	Title XVIII	Title XIX	Total All Patients	Total Interns & Residents	Employees On Payroll	
		6.00	7.00	8.00	9.00	10.00	
1.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days)(see instructions for col. 2 for the portion of LDP room available beds)	628	10		15		1.00
2.00	HMO and other (see instructions)	168	73				2.00
3.00	HMO IPF Subprovider	0	0				3.00
4.00	HMO I RF Subprovi der	0	0				4.00
5.00	Hospital Adults & Peds. Swing Bed SNF	855	0		55 82		5.00
5.00 7.00	Hospital Adults & Peds. Swing Bed NF Total Adults and Peds. (exclude observation	1, 483	0 10				6.00 7.00
3.00	beds) (see instructions) INTENSIVE CARE UNIT	1, 403	10	2,0	JZ		8.00
5.00 7.00	CORONARY CARE UNIT						9.00
10.00	BURN INTENSIVE CARE UNIT						10.00
11.00	SURGICAL INTENSIVE CARE UNIT						11.00
12.00	OTHER SPECIAL CARE (SPECIFY)						12.00
13.00	NURSERY						13.00
14.00	Total (see instructions)	1, 483	10	2,0	52 0.00	94.87	
15.00	CAH visits	0	0		0		15.00
16.00	SUBPROVIDER - IPF						16.0
17.00	SUBPROVIDER - IRF						17.0
18.00	SUBPROVI DER						18.0
9.00	SKILLED NURSING FACILITY						19.0
20.00	NURSING FACILITY						20.0
1. 00	OTHER LONG TERM CARE						21.0
22.00	HOME HEALTH AGENCY						22.0
3.00	AMBULATORY SURGICAL CENTER (D. P.)						23.0
24.00 24.10	HOSPICE				0		24.0
24. 10 25. 00	HOSPICE (non-distinct part) CMHC - CMHC				0		24.1
26.00	RURAL HEALTH CLINIC						26.0
26.25	FEDERALLY QUALIFIED HEALTH CENTER	0	0		0 0.00	0.00	
27.00	Total (sum of lines 14-26)	0	0		0.00		
8.00	Observation Bed Days		2	3	37	,	28.0
29.00	Ambul ance Trips	0		_			29.0
30.00	Employee discount days (see instruction)				0		30.0
1. 00	Employee discount days - IRF				0		31.0
2.00	Labor & delivery days (see instructions)	0	0		0		32.0
32.01	Total ancillary labor & delivery room				0		32.0
	outpatient days (see instructions)						
33.00	LTCH non-covered days	0					33.0
33.01	LTCH site neutral days and discharges	0					33.0

HOSPI T	AL AND HOSPITAL HEALTH CARE COMPLEX STATISTIC	AL DATA	Provider CC	Provider CCN: 15-1302		Worksheet S-3 Part I Date/Time Pre 6/29/2020 8:0	pared:
		Full Time Equivalents		Di s	charges		
	Component	Nonpai d Workers	Title V	Title XVIII	Title XIX	Total All Patients	
		11.00	12.00	13.00	14.00	15.00	
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00 10.00 11.00 12.00 13.00 14.00 15.00 14.00 15.00 16.00 17.00 18.00 20.00 21.00 23.00 24.00 23.00 24.00 25.00 26.00 26.00 26.00 27.00 28.00 29.00 30.00 31.00 32.00 32.00	Hospital Adults & Peds. (columns 5, 6, 7 and 8 exclude Swing Bed, Observation Bed and Hospice days) (see instructions for col. 2 for the portion of LDP room available beds) HMO and other (see instructions) HMO IPF Subprovider Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. Swing Bed SNF Hospital Adults & Peds. (exclude observation beds) (see instructions) INTENSI VE CARE UNIT CORONARY CARE UNIT SURGICAL INTENSIVE CARE UNIT OTHER SPECIAL CARE (SPECIFY) NURSERY Total (see instructions) CAH visits SUBPROVIDER - IPF SUBPROVIDER - IPF SUBPROVIDER - IRF SUBPROVIDER - IRF SU	0. 00 0. 00 0. 00	0		76 3 39 19 0 0 76 3	277	$\begin{array}{c} 1. \ 00\\ 2. \ 00\\ 3. \ 00\\ 4. \ 00\\ 5. \ 00\\ 6. \ 00\\ 7. \ 00\\ 10. \ 00\\ 11. \ 00\\ 11. \ 00\\ 12. \ 00\\ 13. \ 00\\ 13. \ 00\\ 13. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 15. \ 00\\ 14. \ 00\\ 12. \ 00\\ 20. \ 00\\ 21. \ 00\\ 22. \ 00\\ 23. \ 00\\ 24. \ $
32. 01 33. 00 33. 01	Total ancillary labor & delivery room outpatient days (see instructions) LTCH non-covered days LTCH site neutral days and discharges				0		32.0 33.0 33.0

Heal th Financial	Systems	IU HEALTH BLACKFOR	D HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
HOSPI TAL UNCOMPEN	NSATED AND INDIGENT CARE DATA		Provider CCM	N: 15-1302	Period: From 01/01/2019	Worksheet S-1	
					To 12/31/2019	Date/Time Pre 6/29/2020 8:0	
						1.00	
Uncompensa	ted and indigent care cost comput	tation				•	
	narge ratio (Worksheet C, Part I	line 202 column 3 di	vided by lin	e 202 columr	n 8)	0. 415938	1.00
	see instructions for each line)						
	e from Medicaid					859, 606	
	eceive DSH or supplemental paymen			с и II	. 10	N	3.00
	is yes, does line 2 include all l is no, then enter DSH and/or sup				110?	0	4.00 5.00
6.00 Medicaid c		prementar payments r	Tom Medicalu			7, 788, 172	6.00
	cost (line 1 times line 6)					3, 239, 397	
8.00 Difference	e between net revenue and costs for en enter zero)	or Medicaid program	(line 7 minu	s sum of lir	nes 2 and 5; if	2, 379, 791	
	Health Insurance Program (CHIP)	(see instructions f	or each line)			
9.00 Net revenu	e from stand-alone CHIP	•				0	9.00
10.00 Stand-al on	ne CHIP charges					0	10.00
	ne CHIP cost (line 1 times line 10					0	
enter zero						0	12.00
	e or local government indigent ca						
	e from state or local indigent ca					0	
14.00 Charges fo	or patients covered under state of	r local indigent car	e program (N	lot included	In Tines 6 or	0	14.00
	ocal indigent care program cost	(line 1 times line 1	4)			0	15.00
	e between net revenue and costs for			program (lir	ne 15 minus line	0	
	zero then enter zero)			// / /			
	nations and total unreimbursed co ns for each line)	ost for Medicaid, CH	IP and state	/local indig	jent care program	ns (see	
	ants, donations, or endowment in	come restricted to f	unding chari	tv care		0	17.00
	grants, appropriations or trans					0	
19.00 Total unre 8, 12 and	eimbursed cost for Medicaid , CHII 16)	P and state and loca	al indigent c	are programs	s (sum of lines	2, 379, 791	19.00
				Uni nsured	Insured	Total (col. 1	
			-	patients	patients	+ col . 2)	
Uncomponen	ted Care (see instructions for ea	ach lino)		1.00	2.00	3.00	
	are charges and uninsured discount		cility	1, 214, 30	59, 265	1, 273, 571	20.00
(see instr			lorrey	1, 211, 00	07,200	1, 2, 0, 0, 1	20.00
21.00 Cost of pa instructio	tients approved for charity care ons)	and uninsured disco	ounts (see	505, 0	76 59, 265	564, 341	21.00
22.00 Payments r charity ca	received from patients for amount: are	s previously written	n off as	6, 94	48 0	6, 948	22.00
	marity care (line 21 minus line 2)	2)		498, 12	28 59, 265	557, 393	23.00
						1.00	
	mount on line 20 column 2, inclu			nd a length	of stay limit	N	24.00
	n patients covered by Medicaid or is yes, enter the charges for pa			care program	n's length of	0	25.00
		ital complax (caa in	etructione)			1, 899, 821	26.00
stay limit		гтаг сошогех съее ГП	istiuctiulis)				
stay limit 26.00 Total bad	debt expense for the entire hospi		y (see inctr	uctions)		270 516	1 27 00
stay limit 26.00 Total bad 27.00 Medicare r	eimbursable bad debts for the en	tire hospital comple				278, 546 428 532	
stay limit 26.00 Total bad 27.00 Medicare r 27.01 Medicare a	eimbursable bad debts for the en Ilowable bad debts for the entire	tire hospital comple e hospital complex (428, 532	27.01
stay limit 26.00 Total bad 27.00 Medicare r 27.01 Medicare a 28.00 Non-Medica	eimbursable bad debts for the en	tire hospital comple e hospital complex (tions)	see instruct	i ons)			27. 01 28. 00
stay limit 26.00 Total bad 27.00 Medicare r 27.01 Medicare a 28.00 Non-Medica 29.00 Cost of no	eimbursable bad debts for the en allowable bad debts for the entire are bad debt expense (see instruc	tire hospital comple e hospital complex (tions) Medicare bad debt ex	see instruct	i ons)		428, 532 1, 471, 289	27.01 28.00 29.00

		U HEALTH BLACKFO				u of Form CMS-2	2552-10
RECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE OF	= EXPENSES	Provider CC		Period: From 01/01/2019	Worksheet A	
					To 12/31/2019	Date/Time Pre 6/29/2020 8:0	
	Cost Center Description	Sal ari es	Other	Total (col. 1	Recl assi fi cati	Recl assi fi ed	
				+ col. 2)	ons (See A-6)	Trial Balance	
						(col. 3 +-	
		1.00	0.00	0.00	1.00	col . 4)	
	GENERAL SERVICE COST CENTERS	1.00	2.00	3.00	4.00	5.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT		6, 206	6, 200	879, 867	886, 073	1.00
2.00	00200 NEW CAP REL COSTS-BEBU & TTXT		0, 200		0 0	000,073	2.00
3.00	00300 OTHER CAPITAL RELATED COSTS		0		0	0	3.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT	0	63, 635	63, 63	887,072	950, 707	4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	507, 822	4, 301, 351	4, 809, 17:		4, 726, 302	5.00
7.00	00700 OPERATION OF PLANT	192, 112	1, 412, 528	1, 604, 640	-526, 842	1, 077, 798	7.00
9.00	00900 HOUSEKEEPI NG	159, 977	187, 611	347, 588	3 -74, 303	273, 285	9.00
10.00	01000 DI ETARY	226, 708	217, 410	444, 118		209, 487	10.00
11.00	01100 CAFETERI A	0	0	(149, 141	
13.00	01300 NURSI NG ADMI NI STRATI ON	323, 806	112, 438			388, 900	
	01400 CENTRAL SERVICES & SUPPLY	0	8, 046			247, 310	
15.00	01500 PHARMACY	0	1, 487, 466	1, 487, 460	6 -614, 766	872, 700	15.00
~~ ~~	INPATIENT ROUTINE SERVICE COST CENTERS	1 (00 500	F (0, 000	0 100 01	440.044	4 700 (77	1 00 00
30.00	03000 ADULTS & PEDIATRICS ANCILLARY SERVICE COST CENTERS	1, 632, 580	560, 338	2, 192, 918	-412, 241	1, 780, 677	30.00
50.00	05000 OPERATING ROOM	167, 727	171, 942	339, 669	-85, 248	254, 421	50.00
53.00	05300 ANESTHESI OLOGY	107,727	190, 555			185, 631	53.00
	05400 RADI OLOGY-DI AGNOSTI C	573, 233	1, 070, 274				54.00
57.00	05700 CT SCAN	0,0,200	0		0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	o	0	(0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0	(0 0	0	59.00
60.00	06000 LABORATORY	0	1, 215, 932	1, 215, 93	-12, 584	1, 203, 348	60.00
60.01	06001 BLOOD LABORATORY	0	0	(0 0	0	60.01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	(0 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	479, 106	67, 181	546, 28	7 -36, 873	509, 414	•
65.01	06501 SLEEP LAB	0	0	(0 0	0	65.01
66.00	06600 PHYSI CAL THERAPY	324, 605	41, 975	366, 580		347, 635	
67.00	06700 OCCUPATI ONAL THERAPY	73, 036	0			88, 535	
68.00	06800 SPEECH PATHOLOGY	8, 115	0	8, 11		8, 115	
69.00	06900 ELECTROCARDI OLOGY	9, 943	432	10, 37		9, 943	•
	07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS	0	0		26, 951 3, 318	26, 951	
	07200 I MPL. DEV. CHARGED TO PATI ENT 07300 DRUGS CHARGED TO PATI ENTS	0	0			3, 318 632, 101	72.00
73.00	03140 CARDI OLOGY	0	0		032,101	032, 101	76.00
	07697 CARDI AC REHABI LI TATI ON	30, 563	8, 563	39, 120	6 -6, 251	32, 875	
10. 71	OUTPATIENT SERVICE COST CENTERS	30, 303	0, 303	57, 120	-0,231	52,075	/0. //
90.00	09000 CLINIC	43,099	20, 841	63, 940	-8, 028	55, 912	90.00
	09100 EMERGENCY	691, 192	2,087,442			2, 510, 549	•
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS]
	11300 INTEREST EXPENSE		0		0 0		113.00
118.00		5, 443, 624	13, 232, 166	18, 675, 790	2	18, 675, 792	118.00
40	NONREI MBURSABLE COST CENTERS				•		400
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	0	34 0	34			190.00 192.00
192.00 200.00		5, 443, 624	13, 232, 200				

ECLAS	SIFICATION AND ADJUSTMENTS OF TRIAL BALANCE O	F EXPENSES	Provider CCN: 1	5-1302	Period: From 01/01 To 12/31	/2019 /2019	Worksheet Date/Time 6/29/2020	Prepared:
	Cost Center Description	Adjustments (See A-8)	Net Expenses For Allocation		1		0/2//2020	
		6.00	7.00					
	GENERAL SERVICE COST CENTERS							
. 00	00100 NEW CAP REL COSTS-BLDG & FIXT	150, 282	1, 036, 355					1.0
. 00	00200 NEW CAP REL COSTS-MVBLE EQUIP	0	0					2.0
. 00	00300 OTHER CAPITAL RELATED COSTS	0	0					3.0
. 00	00400 EMPLOYEE BENEFITS DEPARTMENT	339, 101	1, 289, 808					4.0
. 00	00500 ADMINI STRATI VE & GENERAL	-90, 141	4, 636, 161					5.0
. 00	00700 OPERATION OF PLANT	24, 631	1, 102, 429					7.0
. 00	00900 HOUSEKEEPI NG	-14, 785	258, 500					9.0
0.00	01000 DI ETARY	0	209, 487					10.0
1.00	01100 CAFETERI A	-59, 300	89, 841					11.0
3.00	01300 NURSI NG ADMI NI STRATI ON	101, 110	490, 010					13.0
4.00	01400 CENTRAL SERVICES & SUPPLY	0	247, 310					14.0
4.00 5.00		-						
5.00	01500 PHARMACY	-174, 311	698, 389					15.0
~ ~~	I NPATI ENT ROUTI NE SERVI CE COST CENTERS		4 700 (77					
0.00	03000 ADULTS & PEDI ATRI CS	0	1, 780, 677					30. 0
	ANCI LLARY SERVICE COST CENTERS							
0.00	05000 OPERATING ROOM	-460						50.0
3.00	05300 ANESTHESI OLOGY	-185, 618	13					53.0
4.00	05400 RADI OLOGY-DI AGNOSTI C	88, 569	1, 333, 233					54.0
7.00	05700 CT SCAN	0	0					57.0
8.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0					58.0
9.00	05900 CARDI AC CATHETERI ZATI ON	0	0					59.0
0.00	06000 LABORATORY	0	1, 203, 348					60.0
0. 01	06001 BLOOD LABORATORY	0	О					60.0
2.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	o					62.0
5.00	06500 RESPI RATORY THERAPY	-1, 761	507, 653					65.0
5.01	06501 SLEEP LAB	0	0					65.0
6.00	06600 PHYSI CAL THERAPY	-5, 359	342, 276					66.0
7.00	06700 OCCUPATI ONAL THERAPY	0,007	88, 535					67.0
8.00	06800 SPEECH PATHOLOGY	0	8, 115					68.0
		E0 (40						
9.00	06900 ELECTROCARDI OLOGY	50, 640	60, 583					69.0
1.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	26, 951					71.0
2.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	3, 318					72.0
3.00	07300 DRUGS CHARGED TO PATIENTS	0	632, 101					73.0
6.00	O3140 CARDI OLOGY	0	0					76.0
6. 97	07697 CARDI AC REHABI LI TATI ON	6, 572	39, 447					76. 9
	OUTPATIENT SERVICE COST CENTERS							
0.00	09000 CLI NI C	0	55, 912					90.0
1.00	09100 EMERGENCY	-1, 390, 216	1, 120, 333					91.0
2.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)							92.0
	SPECIAL PURPOSE COST CENTERS							
13.00	11300 I NTEREST EXPENSE	0	0					113. 0
18.00		-1, 161, 046						118.0
. 5. 50	NONREI MBURSABLE COST CENTERS	1, 101, 040	17,011,710					
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32					190. 0
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	32					190.0

SSI FI CATI ONS			Provider CCN: 15-1		sheet A-6
					e/Time Prepar 9/2020 8:06 a
	Increases			0,2,	
2.00	Li ne # 3.00	Salary 4.00	0ther 5.00		
A - CAFETERIA	3.00	4.00	5.00		
CAFETERI A		94, 280	5 <u>4, 8</u> 61		1
		94, 280	54, 861		
B - MEDICAL SUPPLIES CENTRAL SERVICES & SUPPLY	14.00	0	239, 264		1
MEDI CAL SUPPLI ES CHARGED TO	71.00	0	26, 951		2
PATI ENTS					
IMPL. DEV. CHARGED TO PATIENT	72.00	0	3, 318		3
OPERATION OF PLANT	7.00	0	22		
NURSING ADMINISTRATION	13.00	0	13		5
	0.00	0	0		6
	0.00 0.00	0	0		3
	0.00	0	0		
	0.00	0	0		10
	0.00 0.00	0	0		11
	0.00	0	0		1:
	0.00	0	0		14
	0.00	<u>o</u>	0		1!
O C - DRUGS CHARGED TO PATIENTS		0	269, 568		
PHARMACY	15.00	0	18, 694		
DRUGS CHARGED TO PATIENTS	73.00	0	632, 101		
	0.00	0	0		
	0.00 0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00 0.00	0	0		
		0	650, 795		
E - EMPLOYEE BENEFITS					
EMPLOYEE BENEFITS DEPARTMENT	4.00 0.00	0	896, 152 0		
	0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00 0.00	0	0		
	0.00	0	0		
	0.00	0	0		
	0.00 0.00	0	0		1
		<u>0</u>	896, 152		
F - DEPRECIATION	4 00		0.47,000		
NEW CAP REL COSTS-BLDG & FLXT	1.00	0	867, 009		
	0.00	О	0		
	0.00	0	0		
	0.00 0.00	0	0		
	0.00	0	0		
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	0.00	õ	õ		1
	0.00	0	0		1:
	0.00 0.00	0	0		1:
′		0	867,009		
G - OUTPATIENT THERAPY					
OCCUPATI ONAL THERAPY	<u> </u>	15, 337	$ \frac{162}{162}$		
U H – AUTO & PROPERTY INSURANCE		15, 337	162		
NEW CAP REL COSTS-BLDG &	1.00	0	12, 858		
<u>FIXT</u>	+				
0 I - MALPRACTICE INSURANCE		0	12, 858		
ADMI NI STRATI VE & GENERAL	5.00	0	3, 078		
TOTALS		o	3, 078		
0 Grand Total: Increases		109, 617	2, 754, 483		500

Heal th	Fi nanci al	Systems
RECLAS	SIFICATION	IS

IU HEALTH BLACKFORD HOSPITAL Provider CCN: 15-1302

	Financial Systems	1	U HEALTH BLACKF			In Lieu of Form CN	
RECLAS	SI FI CATI ONS			Provi der	CCN: 15-1302	Period: Worksheet A From 01/01/2019 To 12/31/2019 Date/Time F	
		2					
	Cost Center	Decreases Line #	Salary	Other	 Wkst. A-7 Ref		
	6.00	7.00	8.00	9.00	10.00	<u> </u>	
	A - CAFETERIA				-1		
1.00	DI ETARY	<u>10.00</u>	<u>94, 280</u> 94, 280	5 <u>4,8</u> 6 54,86		Ō	1.0
	B - MEDI CAL SUPPLI ES		94, 200	54, 80	1		
1.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	100	D	0	1.0
2.00	ADMI NI STRATI VE & GENERAL	5.00	0	147		0	2.0
3.00	HOUSEKEEPING	9.00	0	5, 980	-	0	3.0
1.00 5.00	DI ETARY PHARMACY	10. 00 15. 00	0	738 4, 41		0	4.0 5.0
5. 00 5. 00	ADULTS & PEDIATRICS	30.00	0	58, 697	·	0	6.0
. 00	OPERATING ROOM	50.00	0	50, 018		0	7.0
8. 00	ANESTHESI OLOGY	53.00	0	4, 916	-	0	8.0
0.00	RADI OLOGY-DI AGNOSTI C	54.00	0	25, 336	-	0	9.0
0.00 1.00	RESPI RATORY THERAPY PHYSI CAL THERAPY	65.00 66.00	0	25, 24 2, 090		0	10.0
2.00	CARDI AC REHABI LI TATI ON	76.97	o	995		0	12.0
3.00	CLINIC	90.00	0	4, 236	5	0	13.0
4.00	EMERGENCY	91.00	0	86, 655		0	14.0
5.00	GIFT, FLOWER, COFFEE SHOP &	190.00	0	4	2	0	15.0
	<u>CANTEEN</u>	+		269, 568	3	-	
	C - DRUGS CHARGED TO PATIENTS	I		2077000			
. 00	PHARMACY	15.00	0	605, 093	-	0	1.0
2.00	EMPLOYEE BENEFITS DEPARTMENT	4.00	0	8, 980		0	2.0
3.00 4.00	ADULTS & PEDIATRICS OPERATING ROOM	30. 00 50. 00	0	9, 225 561	-	0	3.0 4.0
F. 00 5. 00	ANESTHESI OLOGY	53.00	o	30		0	5.0
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	19, 390	-	0	6.0
. 00	ELECTROCARDI OLOGY	69.00	О	432		0	7.0
. 00	CLINIC	90.00	0	949		0	8.0
. 00	EMERGENCY		<u>0</u>	<u>6, 15</u> 650, 795		0	9.0
	E - EMPLOYEE BENEFITS		V	050,773			
1.00	ADMI NI STRATI VE & GENERAL	5.00	0	56, 375	ō	0	1.0
2.00	OPERATION OF PLANT	7.00	0	46, 971		0	2.0
. 00	HOUSEKEEPING	9.00	0	67,059		0	3.0
. 00 . 00	DI ETARY NURSI NG ADMI NI STRATI ON	10. 00 13. 00	0	76, 107 47, 357		0	4.0 5.0
b. 00	ADULTS & PEDIATRICS	30.00	0	322, 380		0	6.0
. 00	OPERATING ROOM	50.00	0	25, 403	3	0	7.0
. 00	RADI OLOGY-DI AGNOSTI C	54.00	0	108, 932		0	8. C
. 00 0. 00	CARDI AC REHABI LI TATI ON CLI NI C	76. 97 90. 00	0	62 1, 77		0	9.0 10.0
1.00	EMERGENCY	90.00 91.00	o	143, 735		0	11.0
	0		ō	896, 152		-	
	F - DEPRECIATION	1	1		1		
. 00	ADMI NI STRATI VE & GENERAL	5.00	0	16, 569		9	1.0
. 00 . 00	OPERATION OF PLANT HOUSEKEEPING	7.00 9.00	0	479, 893 1, 264	-	0	2.0
. 00	DI ETARY	10.00	0	8, 645		0	4.0
. 00	PHARMACY	15.00	0	23, 956		0	5. C
. 00	ADULTS & PEDIATRICS	30.00	0	21, 939		0	6.0
. 00	OPERATING ROOM	50.00	0	9, 266		0	7.0
. 00 . 00	RADI OLOGY-DI AGNOSTI C LABORATORY	54.00 60.00	0	245, 185 12, 584		0	8. 0 9. 0
0.00	RESPI RATORY THERAPY	65.00	0	11, 626		0	10.0
1.00	PHYSI CAL THERAPY	66.00	0	1, 356	5	0	11.0
2.00	CARDI AC REHABI LI TATI ON	76.97	0	5, 194		0	12.0
3.00 4.00	CLINIC EMERGENCY	90.00 91.00	0	1, 072 28, 460		0	13.0 14.0
4.00		91.00	— — — 0				14.0
	G - OUTPATIENT THERAPY						
. 00	PHYSICAL THERAPY		1 <u>5, 3</u> 37	162		0	1.0
			15, 337	162	2		_
. 00	H - AUTO & PROPERTY I NSURANCE ADMI NI STRATI VE & GENERAL	5.00		12, 858	2 1	2	1.0
. 00			0	1 <u>2, 8</u> 58 12, 858			1.0
	I - MALPRACTICE INSURANCE			.2,000	<u> </u>		
. 00	EMERGENCY	91.00	0	3,078		0	1.0
00.00	TOTALS					_	500.0
		91.00	00 109, 617	<u>3,078</u> 3,078 2,754,483	3	<u> </u>	

	Financial Systems	IU HEALTH BLACK				eu of Form CMS-2	
RECONC	ILIATION OF CAPITAL COSTS CENTERS		Provi der CCN: 15-1302		Period: From 01/01/2019 To 12/31/2019		pared:
				Acquisition:			
		Begi nni ng Bal ances	Purchases	Donati on	Total	Disposals and Retirements	
		1.00	2.00	3.00	4.00	5.00	
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE	T BALANCES					
1.00	Land	190, 324	0		0 0	0	1.00
2.00	Land Improvements	259, 436	0		0 0	0	2.00
3.00	Buildings and Fixtures	15,007,745	0		0 0	0	3.00
4.00	Building Improvements	0	0		0 0	0	4.00
5.00	Fixed Equipment	0	0		0 0	0	5.00
6.00	Movable Equipment	4, 834, 229	584, 954		0 584, 954	888, 909	6.00
7.00	HIT designated Assets	0	0		0 0	0	7.00
8.00	Subtotal (sum of lines 1-7)	20, 291, 734	584, 954		0 584, 954	888, 909	8.00
9.00	Reconciling Items	0	0		0 0	0	9.00
10.00	Total (line 8 minus line 9)	20, 291, 734	584, 954		0 584, 954	888, 909	10.00
		Endi ng Bal ance					
			Depreciated				
			Assets				
		6.00	7.00				
	PART I - ANALYSIS OF CHANGES IN CAPITAL ASSE						
1.00	Land	190, 324					1.00
2.00	Land Improvements	259, 436					2.00
3.00	Buildings and Fixtures	15, 007, 745	2, 290, 839				3.00
4.00	Building Improvements	0	0				4.00
5.00	Fixed Equipment	0	0				5.00
6.00	Movable Equipment	4, 530, 274	2, 145, 326				6.00
7.00	HIT designated Assets	0	0				7.00
8.00	Subtotal (sum of lines 1-7)	19, 987, 779	4, 654, 551				8.00
9.00	Reconciling Items	0	0				9.00
10.00	Total (line 8 minus line 9)	19, 987, 779	4, 654, 551				10.00

Heal th	Financial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-2	2552-10
RECON	CILIATION OF CAPITAL COSTS CENTERS		Provider C	CN: 15-1302	Peri od:	Worksheet A-7	
					From 01/01/2019 To 12/31/2019		narod
					10 12/31/2019	6/29/2020 8:00	6 am
			SL	JMMARY OF CAP	TAL		
	Cost Center Description	Depreciation	Lease	Interest	Insurance (see	``	
		0.00	10.00	11.00		instructions)	
	DADT ILL DECONCLULATION OF ANOUNTS FROM WOR	9.00	10.00	11.00	12.00	13.00	
4 00	PART II - RECONCILIATION OF AMOUNTS FROM WOR		N 2, LINES I a	na 2			1 00
1.00	NEW CAP REL COSTS-BLDG & FIXT	6, 206	0		0 0	0	1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0		0 0	0	2.00
3.00	Total (sum of lines 1-2)	6, 206	0		0 0	0	3.00
		SUMMARY O	- CAPITAL				
	Cast Castan Description	0 + h = 15	Tatal (1) (a				
	Cost Center Description		Total (1) (sum				
		Capi tal -Rel ate					
		d Costs (see	through 14)				
		instructions)	15 00				
	DART IL DECONCLULATION OF ANOUNTS FROM WOR	14.00	15.00				
4 00	PART II - RECONCILIATION OF AMOUNTS FROM WOR	SHEET A, COLUM					1 00
1.00	NEW CAP REL COSTS-BLDG & FIXT	0	6, 206				1.00
2.00	NEW CAP REL COSTS-MVBLE EQUIP	0	0				2.00
3.00	Total (sum of lines 1-2)	0	6, 206				3.00

Health Financial Systems	U HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-2	552-10
RECONCILIATION OF CAPITAL COSTS CENTERS		Provider C	F T	Period: From 01/01/2019 Fo 12/31/2019	Worksheet A-7 Part III Date/Time Prep 6/29/2020 8:06	
	COM	PUTATION OF RAT	FI OS	ALLOCATION OF	OTHER CAPITAL	
Cost Center Description	Gross Assets	Capi tal i zed Leases	Gross Assets for Ratio (col. 1 - col. 2)		Insurance	
	1.00	2.00	3.00	4.00	5.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE			40.007.77	1 00000	0	4 00
1.00 NEW CAP REL COSTS-BLDG & FIXT	19, 987, 779	0	19, 987, 779		0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP 3.00 Total (sum of lines 1-2)	19, 987, 779		19, 987, 779	0.000000	0	2.00 3.00
		TION OF OTHER (F CAPITAL	3.00
	ALLUCA			JUNIMART	I CAFITAL	
Cost Center Description	Taxes	Other	Total (sum of	Depreciation	Lease	
		Capi tal -Rel ate	cols. 5			
		d Costs	through 7)			
	6.00	7.00	8.00	9.00	10.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE				1		
1.00 NEW CAP REL COSTS-BLDG & FIXT	0	0	0	1, 131, 307	0	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0 0	0	2.00
3.00 Total (sum of lines 1-2)	0	0	(1, 131, 307	0	3.00
		SL	JMMARY OF CAPI	TAL		
Cost Center Description	Interest	Insurance (see	Taxes (see	Other	Total (2) (sum	
'		instructions)	instructions)	Capi tal -Rel ate		
		· ·	· ·	d Costs (see	through 14)	
				instructions)		
	11.00	12.00	13.00	14.00	15.00	
PART III - RECONCILIATION OF CAPITAL COSTS CE						
1.00 NEW CAP REL COSTS-BLDG & FIXT	-107, 810	12, 858	0	0 0	1, 036, 355	1.00
2.00 NEW CAP REL COSTS-MVBLE EQUIP	0	0	0	0 0	0	2.00
3.00 Total (sum of lines 1-2)	-107, 810	12, 858	(0 0	1, 036, 355	3.00

	Financial Systems MENTS TO EXPENSES	11	J HLALIN DLAUN	FORD HOSPI TAL Provi der CCN: 15-1302	Period:	u of Form CMS-2 Worksheet A-8	-JJZ-1
100001	WILINIS IV LAFLINSES				From 01/01/2019		
					To 12/31/2019	Date/Time Prep 6/29/2020 8:00	
				Expense Classification		0,2,,,2020 0,0	<u>o um</u>
				To/From Which the Amount i	s to be Adjusted		
	Cost Center Description	Basis/Code (2) 1.00	Amount 2.00	Cost Center 3.00	Line # 4.00	Wkst. A-7 Ref. 5.00	
. 00	Investment income - NEW CAP	В		NEW CAP REL COSTS-BLDG &	1.00		1. C
	REL COSTS-BLDG & FIXT (chapter		,	FIXT			
	2)						
. 00	Investment income - NEW CAP		0	NEW CAP REL COSTS-MVBLE	2.00	0	2. C
	REL COSTS-MVBLE EQUIP (chapter 2)			EQUI P			
. 00	Investment income - other		0		0.00	0	3.0
	(chapter 2)						
. 00	Trade, quantity, and time		0		0.00	0	4.0
. 00	discounts (chapter 8) Refunds and rebates of		0		0.00	0	5.0
00	expenses (chapter 8)		0		0.00	0	5.0
00	Rental of provider space by		0		0.00	0	6. (
	suppliers (chapter 8)						
00	Tel ephone services (pay		0		0.00	0	7.0
	stations excluded) (chapter 21)						
00	Television and radio service		0		0.00	0	8. (
	(chapter 21)						
. 00	Parking lot (chapter 21)		0		0.00		9. (
0. 00	Provider-based physician adjustment	A-8-2	-1, 487, 530			0	10. (
1.00	Sale of scrap, waste, etc.		0		0.00	0	11. (
	(chapter 23)					_	
2.00	Related organization	A-8-1	2,048,302			0	12. (
	transactions (chapter 10)		0		0.00	0	12 (
3.00 4.00	Laundry and linen service Cafeteria-employees and guests	В	-59 300	CAFETERI A	11.00		13. (14. (
5.00	Rental of quarters to employee		0		0.00		15. (
	and others						
6.00	Sale of medical and surgical		0		0.00	0	16. (
	supplies to other than patients						
7.00	Sale of drugs to other than		0		0.00	0	17. (
	patients		Ū.		0.00	Ŭ	
3. 00	Sale of medical records and		0		0.00	0	18. (
0 00	abstracts		0		0.00	0	10 0
9.00	Nursing and allied health education (tuition, fees,		0		0.00	0	19. (
	books, etc.)						
0. 00	Vending machines	В	0	DI ETARY	10.00		20.0
1.00	Income from imposition of		0		0.00	0	21. (
	interest, finance or penalty charges (chapter 21)						
2.00	Interest expense on Medicare		Ω		0.00	0	22. (
	overpayments and borrowings to		0		0.00		22.0
	repay Medicare overpayments						
3.00	Adjustment for respiratory	A-8-3	0	RESPI RATORY THERAPY	65.00		23.0
	therapy costs in excess of						

23.00	Adjustment for respiratory	A-8-3	ORESPI RATORY THERAPY	65.00	
	therapy costs in excess of				
04.00	limitation (chapter 14)				
24.00	Adjustment for physical	A-8-3	OPHYSICAL THERAPY	66.00	
	therapy costs in excess of				
	limitation (chapter 14)				
25.00	Utilization review -		0 *** Cost Center Deleted ***	114.00	
	physicians' compensation				
	(chapter 21)				
26.00	Depreciation - NEW CAP REL		ONEW CAP REL COSTS-BLDG &	1.00	
	COSTS-BLDG & FIXT		FIXT		
27.00	Depreciation - NEW CAP REL		ONEW CAP REL COSTS-MVBLE	2.00	
	COSTS-MVBLE EQUIP		EQUI P		
28.00	Non-physician Anesthetist		0 *** Cost Center Deleted ***	19.00	
29.00	Physicians' assistant		0	0.00	
30.00	Adjustment for occupational	A-8-3	OOCCUPATI ONAL THERAPY	67.00	
	therapy costs in excess of				
	limitation (chapter 14)				
30, 99	Hospice (non-distinct) (see		OADULTS & PEDIATRICS	30, 00	
	instructions)				
31.00	Adjustment for speech	A-8-3	OSPEECH PATHOLOGY	68.00	
	pathology costs in excess of				
	limitation (chapter 14)				

24.00

25.00

28.00 29.00 30.00

> 30. 99 31. 00

0 26.000 27.00

Heal th	Financial Systems		U HEALTH BLACK			eu of Form CMS-2	2552-10
ADJUST	MENTS TO EXPENSES				Period:	Worksheet A-8	
					From 01/01/2019 Fo 12/31/2019		narod
					10 12/31/2019	6/29/2020 8:0	6 am
				Expense Classification on	Worksheet A		-
				To/From Which the Amount is			
	Cost Center Description	Pasis (Codo (2)	Amount	Cost Center	Line #	Wkst. A-7 Ref.	
	cost center beschiption	1.00	2,00	3.00	4,00	5. 00	
32.00	CAH HIT Adjustment for	A		NEW CAP REL COSTS-BLDG &	1.00		32.00
52.00	Depreciation and Interest		7,213	FLXT	1.00	,	52.00
33.00	CHARI TY CONTRI BUTI ONS	А	-95	ADMI NI STRATI VE & GENERAL	5.00	0	33.00
33.01	MI SCELLANEOUS I NCOME	В		ADMI NI STRATI VE & GENERAL	5.00	0	33.01
33. 02	MI SCELLANEOUS I NCOME	В	-542	OPERATION OF PLANT	7.00	0	33.02
33.03	MI SCELLANEOUS I NCOME	В	-14, 785	HOUSEKEEPI NG	9.00	0	33.03
33.04	MI SCELLANEOUS I NCOME	В	-77, 160	NURSING ADMINISTRATION	13.00	0	33.04
33.05	MI SCELLANEOUS I NCOME	В	-4, 910	RESPI RATORY THERAPY	65.00	0	33.05
33.06	MI SCELLANEOUS I NCOME	В	-1, 138	EMERGENCY	91.00	0	33.06
33.07	MI SCELLANEOUS I NCOME	В	-34	RADI OLOGY-DI AGNOSTI C	54.00	0	33.07
33.08	MARKETI NG/ADVERTI SI NG COSTS	A		ADMI NI STRATI VE & GENERAL	5.00		33.08
33.09	TELEPHONE EQUI PMENT	A		OPERATING ROOM	50.00		
33. 10	TELEPHONE EQUI PMENT	A		RESPI RATORY THERAPY	65.00		
33. 11	EMPLOYEE BENEFITS	A		EMPLOYEE BENEFITS DEPARTMENT			33.11
33. 12	HOSPITAL ASSESSMENT FEES	A		ADMINISTRATIVE & GENERAL	5.00		
33.13	NON-ALLOWABLE PATIENT REIMB	A		ADMI NI STRATI VE & GENERAL	5.00		
33.14	PTO EXPENSE ALLOCATION	A		ADMI NI STRATI VE & GENERAL	5.00	0	33.14
50.00	TOTAL (sum of lines 1 thru 49)		-1, 161, 046	9			50.00
	(Transfer to Worksheet A,						
	column 6, line 200.)					1	1

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

	Financial Systems	IU HEALTH BLAC		/ider CCN: 15-1302	Peri od:	eu of Form CMS-: Worksheet A-8	
	COSTS	UNI RELATED ORGANIZATIONS AND HON		710EI CCN. 15-1302	From 01/01/2019 To 12/31/2019		pared:
	Line No.	Cost Center	[Expense Items	Amount of	Amount	
					Allowable Cost		
						Wks. A, column	
	1.00	2.00		3.00	4.00	5 5. 00	
		STMENTS REQUIRED AS A RESULT OF	TDANSACT				
	HOME OFFICE COSTS:	STMENTS REQUIRED AS A RESULT OF	TRANSACT	ITONS WITH KELATED	UKGANIZATI UNJ UK		
00		OONEW CAP REL COSTS-BLDG & FIX	HOME OFF	I CE	262, 305	0	1.00
00		OO EMPLOYEE BENEFITS DEPARTMENT			1, 235, 253	0	2.00
00			HOME OFF		2, 965, 192	2, 638, 140	3.00
00			RELATED		891, 964	753, 681	4.00
01			RELATED		254, 439	229, 266	4.01
02			RELATED		189, 527	11, 257	4.02
03			RELATED		174, 171	348, 482	4.03
04			RELATED		13, 256	13, 668	4.04
05 06			RELATED RELATED		154, 718	154, 961 24, 651	4.05 4.06
07			RELATED		28, 050 29, 671	35, 030	4.00
07			RELATED		50, 640	35, 030 0	4.07
08			RELATED		8, 252	0	4.08
10			RELATED		24, 802	24, 802	4.10
11			RELATED	PARTY	305, 346	305, 346	4.11
12	7.	OO OPERATION OF PLANT	RELATED	PARTY	118, 617	118, 617	4.12
13			RELATED	PARTY	16, 926	16, 926	4.13
14	-		RELATED		187	187	4.14
15			RELATED		496, 195	496, 195	4.15
16			RELATED		6, 897	6, 897	4.16
17			RELATED		5, 679	5, 679	4.17
18			RELATED RELATED		298, 322	298, 322	4.18
19 20			RELATED		1, 147, 700 481, 262	1, 147, 700 481, 262	4.19 4.20
20 21			RELATED		325, 282	325, 282	4.20
22			RELATED		73, 036	73,036	4. 22
23			RELATED		8, 115	8, 115	4.23
24	69.	00 ELECTROCARDI OLOGY	RELATED	PARTY	9, 943	9, 943	4.24
25			RELATED	PARTY	29, 297	29, 297	4.25
26			RELATED		9, 587	9, 587	4.26
27			RELATED	PARTY	1, 689, 806	1, 689, 806	4.27
28		00			0	0	4.28
29		00			0	0	4.29
30 31		00 00			0	0	4.30 4.31
31 32		00				0	4.31
33		00			0	0	4.32
34		00			0	0	4.34
35	0.	00			0	0	4.35
36	0.	00			0	0	4.36
37		00			0	0	4.37
38		00			0	0	4.38
39		00			0	0	4.39
40		00			0	0	4.40
41 42		00			0	0	4.41
42 43		00 00			0	0	4.42 4.43
43 44		00				0	4.43
44 45		00				0	4.44
46		00			0	0	4.40
47		00			0	0	4.47
48		00			0	0	4.48
49		00			0	0	4.49
50	0.	00			0	0	4.50
00	lo		lo		11, 304, 437	9, 256, 135	5.00

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

				Related Organization(s) and/	or Home Office			
						· · · · · ·		
	Symbol (1)	Name	Percentage of	Name	Percentage of	1		
			Ownership		Ownershi p			
	1.00	2.00	3.00	4.00	5.00			
	B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:							

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that

Heal th	Financial Systems	IU HEALTH BLAC	KFORD HOSPITAL	In Li	eu of Form CMS-	2552-10
	NT OF COSTS OF SERVICES FROM	RELATED ORGANIZATIONS AND HOM	ME Provider (CCN: 15-1302 Peri od:	Worksheet A-8	3-1
OFFICE	COSTS			From 01/01/2010 To 12/31/2010		
				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	
the cos	ts applicable to services, fa	cilities, and supplies furnis	shed by organiz	ations related to you by comm	non ownership or	r
control	represent reasonable costs a	is determined under section 18	361 of the Soci	al Security Act. If you do r	not provide all	or any
part of	the request information, the	e cost report is considered ir	ncomplete and n	ot acceptable for purposes of	° claiming	
reimbur	sement under title XVIII.					
6.00	В		0.00	IU HEALTH	100.00	6.00
7.00	В		0.00	BALL HOSPI TAL	100.00	7.00
8.00			0.00		0.00	8.00
9.00			0.00		0.00	9,00
10.00			0.00		0.00	10.00
100.00	G. Other (financial or					100.00
	non-financial) specify:					

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

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

E. Individual is director, officer, administrator, or key person of provider and related organization. F. Director, officer, administrator, or key person of related organization or relative of such person has financial interest in provi der.

	Financial Syste		IU HEALTH BLACKFOR			of Form CMS-255
	ENT OF COSTS OF COSTS	SERVICES FROM RE	ELATED ORGANIZATIONS AND HOME	Provider CCN: 15-1302	From 01/01/2019	Worksheet A-8-1
	00010				To 12/31/2019	Date/Time Prepar 6/29/2020 8:06 a
		Wkst. A-7 Ref.	· · · · ·			
	Adjustments (col. 4 minus					
	col. 4 minus					
	6.00	7.00				
	A. COSTS INCUR	RED AND ADJUSTME	NTS REQUIRED AS A RESULT OF TRA	ANSACTIONS WITH RELATED	ORGANIZATIONS OR C	LAIMED
00	HOME OFFICE COS 262, 305	STS:9				
0	1, 235, 253	Ó				
0	327, 052	0				
0	138, 283	0				4
)1	25, 173	0				4
2	178, 270	0				4
3	-174, 311	0				4
4	-412	0				4
15 16	-243 3, 399	0				
7	-5, 359	0				2
8	50, 640	o				
9	8, 252	0				
0	0	0				4
1	0	0				
2	0	0				4
3	0	0				4
4	0	0				4
5	0	0				4
6 7	0	0				
8	0	0				
9	Ő	o				
0	0	0				
1	0	0				4
22	0	0				4
23	0	0				4
4	0	0				4
5 6	0	0				
27	0	0				2
28	0	0				2
9	0	0				
0	0	0				4
1	0	0				
2	0	0				4
3	0	0				
4 5	0	0				
5 6	0	0				
7		0				
, 8	0	0				
9	0	0				
0	0	0				
1	0	0				4
2	0	0				
3	0	0				4
4 5	0	0				
5 6	0	0				
o 7		0				
, 8	0	0				
9	0	Ő				
0	0	0				4
0	2, 048, 302					Ę

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.

			Home Offic			
		Туре	of Business	5		
			6.00			
	D		ATLONCIUD T		ODC ANU .	7 ^ 7

B. INTERRELATIONSHIP TO RELATED ORGANIZATION(S) AND/OR HOME OFFICE:

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

This information is used by the Centers for Medicare and Medicaid Services and its intermediaries/contractors in determining that

Heal th Financial	Systems		IU HEAL	TH BLACKFOR	RD HOSPI TAL	_		In Lieu of Form CMS-2552			52-10
STATEMENT OF COS	TS OF SERVICES FROM	RELATED OF	RGANI ZATI ONS	AND HOME	Provi der	CCN: 15-1302	Peri od:		Worksheet	A-8-1	1
OFFICE COSTS							From 01/C				
							To 12/3	31/2019	Date/Time	Prepa	ared:
									6/29/2020	8:06	am
Related	l Organization(s)										
and/	or Home Office										
Ti m	e of Business	-									
dé i	e of business										
		_									
	6.00										
the costs applica	able to services, f	acilities	and supplies	s furni shed	by organi:	zations relate	ed to you b	v commo	n ownershir	or	
	t reasonable costs										r anv
										111 01	any
	est information, th	e cost repo	ort is consid	aerea incom	prete and i	not acceptable	e for purpo	ises of	crarming		
reimbursement und	der title XVIII.										
6.00 HOSPITAL											6.00

7.00

8.00

9.00

10.00

100.00

HOSPI TAL 7.00 8.00 9.00 10.00 100.00

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

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

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

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

Heal th Financial	Systems	
PROVIDER BASED P	HYSI CI AN	ADJUSTMENT

IU HEALTH BLACKFORD HOSPITAL In Lieu of Form CMS-2552-10 Provider CCN: 15-1302 Period: Worksheet A-8-2

PROVI DE	R BASED PHYSIC	I AN ADJUSTMENT		Provider C		Period:	Worksheet A-8	8-2
						From 01/01/2019 To 12/31/2019		
	Wkst. A Line #	Cost Center/Physician	Total	Professi onal	Provi der	RCE Amount	Physi ci an/Prov	
	WRSt. A LINC #	I denti fi er	Remuneration	Component	Component		ider Component	
		Tuditer i for	Remainer art off	oomponent	oomponent		Hours	
	1.00	2.00	3.00	4.00	5.00	6.00	7.00	
1.00	53.00	ANESTHESI OLOGY	185, 618	185, 618		0	0	1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	61, 154	-88, 846	150, 000	0	0	2.00
3.00	76. 97	CARDIAC REHABILITATION	1, 680	1, 680	0	0	0	3.00
4.00	91.00	EMERGENCY	1, 739, 174	1, 389, 078	350, 096	0	o	4.00
5.00	0.00		0	0	0	0	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	o	7.00
8.00	0.00		0	0	0	0	o	8.00
9.00	0.00		0	0	0	0	o	9.00
10.00	0.00		0	0	0	0	o	10.00
200.00			1, 987, 626	1, 487, 530	500, 096		0	200.00
	Wkst. A Line #	Cost Center/Physician	Unadjusted RCE	5 Percent of	Cost of		Physician Cost	
		I denti fi er	Limit		Memberships &	Component	of Malpractice	
				Limit	Conti nui ng	Share of col.	Insurance	
					Educati on	12		
	1.00	2.00	8.00	9.00	12.00	13.00	14.00	
1.00		ANESTHESI OLOGY	0	0	0		0	1.00
2.00		RADI OLOGY-DI AGNOSTI C	0	0	-		0	2.00
3.00		CARDIAC REHABILITATION	0	0	0	Ű	0	3.00
4.00		EMERGENCY	0	0	-	-	0	4.00
5.00	0.00		0	0	0	Ű	0	5.00
6.00	0.00		0	0	0	0	0	6.00
7.00	0.00		0	0	0	0	0	7.00
8.00	0.00		0	0	0	0	0	8.00
9.00	0.00		0	0	0	0	0	9.00
10.00	0.00		0	0	0	0	0	10.00
200.00	What Aline #	Cost Contor (Dhusi si an	0 Provi der	Adjusted RCE	RCE			200.00
	Wkst. A Line #	Cost Center/Physician Identifier	Component	Limit	Di sal l owance	Adjustment		
		ruentinei	Share of col.		DISALIOWALICE			
			14					
	1.00	2.00	15.00	16.00	17.00	18.00		
1.00		ANESTHESI OLOGY	0	0				1.00
2.00	54.00	RADI OLOGY-DI AGNOSTI C	0	0	0	-88, 846		2.00
3.00	76.97	CARDIAC REHABILITATION	0	0	0	1, 680		3.00
4.00	91.00	EMERGENCY	0	0	0	1, 389, 078		4.00
5.00	0.00		0	0	0	0		5.00
6.00	0.00		0	0	0	0		6.00
7.00	0.00		0	0	0	0		7.00
8.00	0.00		0	0	0	0		8.00
9.00	0.00		0	0	0	0	, I	9.00
10.00	0.00		0	0	0	0		10.00
200.00			0	0	0	1, 487, 530		200.00

Cost Center Description Cost Center Description Expenses District and Cost Center Description CAP TAL RELATED COSTS Fix / Laboration Cost Center Description Subtrain District and Cost Center Description Subtrain District and Center District and Center Distr	Heal th Finance	TON - GENERAL SERVICE COSTS	U HEALTH BLACK	Provider CC	N· 15-1302	Peri od:	u of Form CMS-: Worksheet B	2552-10
Cost Center Description CAPITAL RELATED COSTS Afformation CAPITAL RELATED COSTS FIXT FUNDLOFE EBURING FIXT Subtotal EDURY EDU	CUST ALLUCAT	TOW - GENERAL SERVICE COSTS			SN. 10-1302	From 01/01/2019	Part I Date/Time Pre	
Incredit of the construction of the constru				CAPI TAL REL	ATED COSTS		0/29/2020 8.0	
CENERAL SERVICE COST CENTERS 0 1.00 2.00 4.00 4A 1.00 00100 NEW CAP REL COSTS -MULE A FIXT 1.036, 355 1, 036, 355 0 2.00 0.00 00200 NEW CAP REL COSTS -MULE A FULT 1.289, 808 0 0 1, 289, 808 0 2.00 0.00 00000 NEW CAP REL COSTS -MULE A ENTERL 4, 636, 6161 131, 335 0 120, 323 4, 887, 819 5.00 0.00 00000 OPERATION OF PLANT 1, 102, 429 200, 788 0 45, 519 1, 346, 746 7.00 0.00 00000 OPERATION OF PLANT 1, 102, 429 200, 788 0 45, 519 1, 346, 746 7.00 10.00 01000 CHETARY 299, 487 42, 123 0 31, 977 282, 660 17, 722 571, 088 11.00 1100 1100, 0 100, 0 100, 0 100, 0 100, 0 100, 0 100, 0 100, 0 100, 0 100, 0 100, 0 100, 0 100, 0 110, 0 100, 0 100, 0 100, 0 100, 0 100, 0 <td></td> <td>Cost Center Description</td> <td>for Cost Allocation (from Wkst A</td> <td></td> <td></td> <td>BENEFI TS</td> <td>Subtotal</td> <td></td>		Cost Center Description	for Cost Allocation (from Wkst A			BENEFI TS	Subtotal	
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COST ALLOCATION - GENERAL <service costs<="" th=""> Provider CCR: 15-1302 Provider CR: 1</service>	Heal th	Financial Systems	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-	2552-10
Cost Center Description DBM IN STRATIVE 6 GREERAL 5.00 PHANT PLANT HOUSEKEEPING 9.00 DIETARY 10.00 CAFETERIA 10.00 SCHETERIA 10.00 00100 NEW CAP CEL COST CENTERS 00100 10.00 11.00 10.00 11.00 10.00 11.00 00100 NEW CAP CEL COST S-MUBLE COST S-ENDER 000000 FUNCATION CENTERS 1.00 1.00 0.00 <t< td=""><td colspan="2">COST ALLOCATION - GENERAL SERVICE COSTS</td><td colspan="2">Provider CCN: 15-1302</td><td>CN: 15-1302</td><td>From 01/01/2019</td><td>Part I Date/Time Pre</td><td></td></t<>	COST ALLOCATION - GENERAL SERVICE COSTS		Provider CCN: 15-1302		CN: 15-1302	From 01/01/2019	Part I Date/Time Pre	
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69.00 06900 ELECTROCARDI OLOGY 24, 363 0 0 0 0 69.00 71.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 10, 433 0 0 0 0 71.00 72.00 MEDI CAL SUPPLIES CHARGED TO PATI ENTS 1, 284 0 0 0 72.00 73.00 O7300 DRUGS CHARGED TO PATI ENTS 244, 683 0 0 0 73.00 76.00 03140 CARDI OLOGY 0 0 0 0 76.00 76.97 07697 CARDI AC REHABI LI TATI ON 20, 084 13, 799 3, 790 0 0 76.97 00.00 09000 CLI NI C 33, 108 51, 555 14, 160 0 3, 465 90.00 90.00 OPO00 CLI NI C 33, 108 51, 555 14, 160 0 34, 455 90.00 92.00 DSERVATI ON BEDS (NON-DI STI NCT PART) 532, 121 240, 564 66, 075 0 34, 465 90.00 92.00 DSERVATI ON BEDS (NON-DI STI NCT PART) 113.00 11300 11300 11300 <	67.00	06700 OCCUPATI ONAL THERAPY	44, 222	12, 661	3, 4	78 0	3, 053	67.00
71.00 07100 MEDI CAL_SUPPLIES CHARGED TO PATIENTS 10,433 0 0 0 0 71.00 72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1,284 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 244,683 0 0 0 73.00 76.00 03140 CARDI AC REHABILITATION 20,084 13,799 3,790 0 0 76.97 70697 CARDI AC REHABILITATION 20,084 13,799 3,790 0 0 76.97 90.00 09000 CLINIC 33,108 51,555 14,160 0 3,465 90.00 91.00 09200 DESERVATION BEDS (NON-DISTINCT PART) 532,121 240,564 66,075 0 38,449 91.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 592.001 592.01 38,449 91.00 91.00 11300 INTEREST EXPENSE 113.00 1130.01 1130.00 1130.02 1130.01 1130.00 1130.00 1130.00 1130.00 1130.00 1130.00 190.0	68.00	06800 SPEECH PATHOLOGY	3, 930	303		83 0	330	68.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT 1,284 0 0 0 72.00 73.00 07300 DRUGS CHARGED TO PATIENTS 244,683 0 0 0 0 73.00 76.00 03140 CARDI OLOGY 0 0 0 0 0 0 76.00 76.97 OT697 CARDI AC REHABILITATION 20,084 13,799 3,790 0 0 76.97 00000 CLINIC 33,108 51,555 14,160 0 3,465 90.00 90.00 09000 CLINIC 33,108 51,555 14,160 0 3,465 90.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 532,121 240,564 66,075 0 38,449 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 118.00 113.00 113.00 113.00 1130.00 192.00 0 0 0 190.00 190.00 192.00 0 0 0 0 180.00	69.00	06900 ELECTROCARDI OLOGY	24, 363	0)	0 0	C	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 244,683 0 0 0 73.00 76.00 03140 CARDI OLOGY 0 0 0 0 0 0 76.00 76.00 07697 CARDI AC REHABILITATION 20,084 13,799 3,790 0 0 76.00 70.00 09000 CLINIC 33,108 51,555 14,160 0 3,465 90.00 91.00 09100 EMERGENCY 532,121 240,564 66,075 0 38,449 91.00 92.00 92.00 OBSERVATION BEDS (NON-DISTINCT PART) 592,121 240,564 66,075 0 38,449 92.00 91.00 11300 INTEREST EXPENSE 535,170 298,642 113.00 113.00 11300 INTEREST EXPENSE 113.00 11300 11300 11300 INTEREST EXPENSE 118.00 113.00 113.00 11300 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2,907 19,864 5,456 0 0 190.00 19000 192.00 200.00 200.00 0 0 0 <td>71.00</td> <td>07100 MEDICAL SUPPLIES CHARGED TO PATIENTS</td> <td>10, 433</td> <td>0</td> <td>)</td> <td>0 0</td> <td>C</td> <td>71.00</td>	71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	10, 433	0)	0 0	C	71.00
76.00 03140 CARDI OLOGY 0 0 0 0 0 0 0 0 76.00 76	72.00	07200 IMPL. DEV. CHARGED TO PATIENT	1, 284	0)	0 0	C	72.00
76. 97 07697 CARDI AC REHABILITATION 20,084 13,799 3,790 0 76.97 OUTPATIENT SERVICE COST CENTERS 0000 CLINIC 33,108 51,555 14,160 0 3,465 90.00 90.00 09100 EMERGENCY 532,121 240,564 66,075 0 38,449 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 532,121 240,564 666,075 0 38,449 91.00 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 532,121 240,564 666,075 0 38,449 91.00 92.00 OSERVATI ON BEDS (NON-DI STINCT PART) 590.00 535,170 298,642 113.00 11300 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 118.00 118.00 535,170 298,642 118.00 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2,907 19,864 5,456 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES	73.00	07300 DRUGS CHARGED TO PATIENTS	244, 683	0)	0 0	C	73.00
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 33,108 51,555 14,160 0 3,465 90.00 91.00 09100 EMERGENCY 532,121 240,564 66,075 0 38,449 91.00 92.00 OBSERVATI ON BEDS (NON-DI STINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 92.00 113.00 INTEREST EXPENSE 113.00 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 113.00 113.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2,907 19,864 5,456 0 0 190.00 192.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 0 0 0 192.00 200.00 200.00 200.00 0 192.00 0 0 0 0 0 192.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00 200.00	76.00	03140 CARDI OLOGY	0	0		0 0	0	76.00
90. 00 09000 CLINIC 33, 108 51, 555 14, 160 0 3, 465 90. 00 91. 00 09100 EMERGENCY 532, 121 240, 564 66, 075 0 38, 449 91. 00 92. 00 O9200 OBSERVATI ON BEDS (NON-DI STINCT PART) 532, 121 240, 564 66, 075 0 38, 449 92. 00 SPECIAL PURPOSE COST CENTERS SUBTOTALS (SUM OF LINES 1 through 117) 4, 884, 912 1, 850, 973 492, 698 535, 170 298, 642 113. 00 118. 00 NORREI MBURSABLE COST CENTERS NONREI MBURSABLE COST CENTERS 113. 00 1, 850, 973 492, 698 535, 170 298, 642 118. 00 190. 00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2, 907 19, 864 5, 456 0 0 190. 00 192. 00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192. 00 200. 00 Cross Foot Adjustments 0 0 0 0 200. 00 201. 00 0 0 201. 00	76.97	07697 CARDI AC REHABI LI TATI ON	20, 084	13, 799	3, 7	90 0	C	76.97
91.00 09100 EMERGENCY 532, 121 240, 564 66, 075 0 38, 449 91.00 92.00 92.00 OBSERVATI ON BEDS (NON-DI STI NCT PART) SPECI AL PURPOSE COST CENTERS 92.00		OUTPATIENT SERVICE COST CENTERS						
92.00 09200 0BSERVATI ON BEDS (NON-DI STINCT PART) 92.00 SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 113.00 INTEREST EXPENSE 1,850,973 492,698 535,170 298,642 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 4,884,912 1,850,973 492,698 535,170 298,642 118.00 NONRE IMBURSABLE COST CENTERS 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2,907 19,864 5,456 0 0 190.00 190.00 19200 PHYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00	90.00	09000 CLI NI C	33, 108	51, 555	14, 1	60 0	3, 465	90.00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 INTEREST EXPENSE 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 4,884,912 1,850,973 492,698 535,170 298,642 118.00 NONREI MBURSABLE COST CENTERS 118.00 190.00 19000 0 190.00 190.00 19200 192.00 19200 200.00 Cross Foot Adjustments 201.00 Negative Cost Centers	91.00	09100 EMERGENCY	532, 121	240, 564	66, 0	75 0	38, 449	91.00
113.00 1NTEREST EXPENSE 113.00 INTEREST EXPENSE 113.00 113.00 118.00 SUBTOTALS (SUM OF LINES 1 through 117) 4,884,912 1,850,973 492,698 535,170 298,642 118.00 NONREL MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2,907 19,864 5,456 0 0 190.00 192.00 PYSI CI ANS' PRI VATE OFFICES 0 0 0 0 192.00 0 0 0 192.00 0 200.00 200.00 201.00 Negative Cost Centers 0 0 0 0 200.00	92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
SUBTOTALS (SUM OF LINES 1 through 117) 4,884,912 1,850,973 492,698 535,170 298,642 118.00 NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2,907 19,864 5,456 0 0 190.00 192.00 192.00 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 192.00 200.00 Cross Foot Adjustments 200.00 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00		SPECIAL PURPOSE COST CENTERS						
NONREI MBURSABLE COST CENTERS 190.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2,907 19,864 5,456 0 0 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 192.00 200.00 Cross Foot Adj ustments 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 201.00	113.00	11300 INTEREST EXPENSE						113.00
190.00 190.00 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2,907 19,864 5,456 0 0 190.00 192.00 19200 PHYSI CLANS' PRI VATE OFFICES 0 0 0 0 192.00 200.00 Cross Foot Adjustments 0 0 0 0 200.00 201.00 Negative Cost Centers 0 0 0 0 0 0 201.00	118.00	SUBTOTALS (SUM OF LINES 1 through 117)	4, 884, 912	1, 850, 973	492, 6	98 535, 170	298, 642	118.00
192.00 PHYSI CLANS' PRI VATE OFFICES 0 0 0 192.00 200.00 Cross Foot Adjustments 200.00			-					
200.00 Cross Foot Adjustments 200.00			2,907	19, 864	5, 4	56 0	0	190.00
201.00 Negative Cost Centers 0 0 0 0 0 201.00	192.00	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	0	192.00
	200.00	Cross Foot Adjustments						200.00
202. 00 TOTAL (sum lines 118 through 201) 4,887,819 1,870,837 498,154 535,170 298,642 202.00	201.00	Negative Cost Centers	0	0		0 0	0	201.00
	202.00) TOTAL (sum lines 118 through 201)	4, 887, 819	1, 870, 837	498, 1	54 535, 170	298, 642	202.00

Heal th	Financial Systems	IU HEALTH BLACKF	ORD HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COST A	ALLOCATION - GENERAL SERVICE COSTS		Provider CC	N: 15-1302	Peri od:	Worksheet B	
					From 01/01/2019 To 12/31/2019		narod
					10 12/31/2019	6/29/2020 8:0	6 am
	Cost Center Description	NURSI NG	CENTRAL	PHARMACY	Subtotal	Intern &	
		ADMI NI STRATI ON	SERVICES &			Residents Cost	
			SUPPLY			& Post	
						Stepdown	
		10.00		15.00		Adjustments	
	GENERAL SERVICE COST CENTERS	13.00	14.00	15.00	24.00	25.00	
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT	[[1.00
2.00	00200 NEW CAP REL COSTS MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL						5.00
7.00	00700 OPERATION OF PLANT						7.00
9.00	00900 HOUSEKEEPI NG						9.00
10.00	01000 DI ETARY						10.00
11.00	01100 CAFETERI A						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	818, 133					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	0	452, 704				14.00
15.00	01500 PHARMACY	0	7, 169	1, 050, 41	6		15.00
	INPATIENT ROUTINE SERVICE COST CENTERS						
30.00	03000 ADULTS & PEDIATRICS	537, 244	70, 534	14, 89	5, 086, 271	0	30.00
	ANCI LLARY SERVI CE COST CENTERS						
50.00	05000 OPERATING ROOM	39, 496	62, 467	67		0	50.00
53.00	05300 ANESTHESI OLOGY	0	7, 811		3 7, 842	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	40, 181	3, 15		0	54.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60. 00 60. 01		0	30, 583 0		0 1, 886, 958 0 0	0	60.00 60.01
62,00	06001 BLOOD LABORATORY	0	0		0 0	0	62.00
65.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY	0	40, 246		0 982, 382		65.00
65.00	06501 SLEEP LAB	0	40, 240		0 962, 362		65.00
66, 00	06600 PHYSI CAL THERAPY	0	3, 129		0 859, 521	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	191		0 177, 845	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 14, 798	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 87, 302	0	69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	42, 120		0 79, 504	l o	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	5, 186		0 9,788	0	72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	0	0	1, 020, 24		0	73.00
76.00	03140 CARDI OLOGY	0	0	.,, -	0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0	1, 700		0 91, 256	0	76.97
	OUTPATIENT SERVICE COST CENTERS		i				
90.00	09000 CLINIC	20, 607	5, 929	1, 53	32 215, 886	0	90.00
91.00	09100 EMERGENCY	220, 786	135, 455	9, 90	2, 618, 015	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)					0	92.00
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113.00
118.00		818, 133	452, 701	1, 050, 41	6 17, 479, 039	0	118.00
100.00	NONREI MBURSABLE COST CENTERS				0 05 700	-	100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	3		0 35, 739		190.00
	19200 PHYSICIANS' PRIVATE OFFICES Cross Foot Adjustments	0	0		0 0		192.00
200.00 201.00			~		0 0		200. 00 201. 00
201.00		818, 133	452, 704	1, 050, 41	0		201.00
202.00	$\gamma_{\rm protect}$ (sum times the through 201)	1 010, 133	402,704	1, 030, 4	0 17, 514, 770	ı 0	202.00

Heal th	Fi nanci al	Systems	

	ILLOCATION - GENERAL SERVICE COSTS	U HEALTH BEACK	Provi der CCN: 15-1302	Peri od: Worksheet I From 01/01/2019 Part I To 12/31/2019 Date/Time I 6/29/2020 6/29/2020	B Prepared:
	Cost Center Description	Total			
	'	26.00			
	GENERAL SERVICE COST CENTERS				
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4.00
5.00	00500 ADMINI STRATI VE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
9,00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERI A				11.00
	01300 NURSI NG ADMI NI STRATI ON				13.00
	01400 CENTRAL SERVICES & SUPPLY				14.00
	01500 PHARMACY				15.00
101.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	1			
30 00	03000 ADULTS & PEDI ATRI CS	5, 086, 271			30.00
00.00	ANCI LLARY SERVICE COST CENTERS	0,000,271			
50.00	05000 OPERATI NG ROOM	953, 881			50.00
	05300 ANESTHESI OLOGY	7,842			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	2, 510, 764			54.00
57.00	05700 CT SCAN	2, 310, 704			57.00
	05800 MAGNETIC RESONANCE I MAGING (MRI)	0			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0			59.00
60.00	06000 LABORATORY	1, 886, 958			60.00
60.01	06001 BLOOD LABORATORY	1,000,700			60.01
62,00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			62.00
65.00	06500 RESPIRATORY THERAPY	982, 382			65.00
65.01	06501 SLEEP LAB	702, 302			65.01
66.00	06600 PHYSI CAL THERAPY	859, 521			66.00
	06700 OCCUPATIONAL THERAPY	177, 845			67.00
68.00	06800 SPEECH PATHOLOGY	14, 798			68.00
69.00	06900 ELECTROCARDI OLOGY	87, 302			69.00
	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	79, 504			71.00
	07200 I MPL. DEV. CHARGED TO PATIENT	9, 788			71.00
	07300 DRUGS CHARGED TO PATIENTS	1, 897, 026			72.00
	03140 CARDI OLOGY	1,077,020			76.00
	07697 CARDI AC REHABI LI TATI ON	91, 256			76.97
10. 91	OUTPATIENT SERVICE COST CENTERS	71,230			/0. //
90 00	09000 CLINIC	215, 886			90.00
	09100 EMERGENCY	2, 618, 015			90.00
	09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,010,013			92.00
7Z. UU	SPECIAL PURPOSE COST CENTERS				72.00
112 00	11300 I NTEREST EXPENSE				113.00
118.00		17, 479, 039			118.00
110.00	NONREIMBURSABLE COST CENTERS	17, 477, 037			
100 00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	35, 739			190.00
	19000 GFFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSI CLANS' PRI VATE OFFI CES	35,739			190.00
200.00		0			200.00
200.00		0			200.00
201.00		17, 514, 778			201.00
202.00		17, 514, 770			1202.00

LLOCATION OF CAPITAL RELATED COSTS	IU HEALTH BLACK	Provider CC	CN: 15-1302	Period: From 01/01/2019	u of Form CMS- Worksheet B Part II	
				To 12/31/2019		eparec 06 am
		CAPI TAL REL	ATED COSTS			
Cost Center Description	Directly Assigned New Capital Related Costs	NEW BLDG & FIXT	NEW MVBLE EQUI P	Subtotal	EMPLOYEE BENEFI TS DEPARTMENT	
	0	1.00	2.00	2A	4.00	
GENERAL SERVICE COST CENTERS						
.00 00100 NEW CAP REL COSTS-BLDG & FIXT						1.(
00 00200 NEW CAP REL COSTS-MVBLE EQUIP				0		2.
00 00400 EMPLOYEE BENEFI TS DEPARTMENT	0	121 225		0 0		
00 00500 ADMI NI STRATI VE & GENERAL	0	131, 335		0 131, 335		
00 00700 OPERATION OF PLANT	0	200, 798		0 200, 798		
00 00900 HOUSEKEEPING	0	21, 518		0 21, 518		
0.00 01000 DI ETARY	0	42, 123		0 42, 123		
	0	29, 966		0 29,966		
3. 00 01300 NURSI NG ADMI NI STRATI ON	0	4, 366		0 4, 366		
4. 00 01400 CENTRAL SERVICES & SUPPLY	0	22, 974		0 22, 974 0 15, 611		
5. 00 01500 PHARMACY I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	15, 611		0 15, 611) 15.
D. 00 03000 ADULTS & PEDIATRICS	0	168, 236		0 168, 236	C	30.
ANCI LLARY SERVICE COST CENTERS	0	100, 230		0 100, 230		J 30.
D. 00 05000 OPERATI NG ROOM	0	90, 782		0 90, 782	0	50.
3. 00 05300 ANESTHESI OLOGY	0	0,702		0 0		
4. 00 05400 RADI OLOGY-DI AGNOSTI C	0	82, 192		0 82, 192		
7. 00 05700 CT SCAN	0	02,172		0 0		
B. 00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0		
9. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0		
0. 00 06000 LABORATORY	0	31, 564		0 31, 564		
D. 01 06001 BLOOD LABORATORY	0	0		0 0		
2.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0		
5. 00 06500 RESPI RATORY THERAPY	0	11, 958		0 11, 958		
5. 01 06501 SLEEP LAB	0	0		0 0		
6. 00 06600 PHYSI CAL THERAPY	0	55, 422		0 55, 422		
7.00 06700 OCCUPATI ONAL THERAPY	0	4, 766		0 4,766		
8.00 06800 SPEECH PATHOLOGY	0	114		0 114		
9. 00 06900 ELECTROCARDI OLOGY	0	0		0 0		69.
1.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 0	0	
2.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0		72.
3. 00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	0	73.
6. 00 03140 CARDI OLOGY	0	0		0 0		76.
6. 97 07697 CARDI AC REHABI LI TATI ON	0	5, 194		0 5, 194	0	76.
OUTPATIENT SERVICE COST CENTERS					•	
D. 00 09000 CLINIC	0	19, 406		0 19, 406	(90.
1.00 09100 EMERGENCY	0	90, 553		0 90, 553	(C	91.
2.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)				0		92.
SPECIAL PURPOSE COST CENTERS						
13.00 11300 INTEREST EXPENSE						113.
18.00 SUBTOTALS (SUM OF LINES 1 through 11	7) 0	1, 028, 878		0 1, 028, 878	C) 118.
NONREI MBURSABLE COST CENTERS						
90.00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	7, 477		0 7, 477	0	190.
92. 00 19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0	(C) 192.
00.00 Cross Foot Adjustments				0		200.
01.00 Negative Cost Centers		0		0 0	0	201.
D2.00 TOTAL (sum lines 118 through 201)	0	1, 036, 355		0 1, 036, 355		202.

Heal th	Financial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-	2552-10
ALLOCATION OF CAPITAL RELATED COSTS			Provider C	CN: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre 6/29/2020 8:0	
	Cost Center Description	ADMI NI STRATI VE & GENERAL	OPERATION OF PLANT	HOUSEKEEPI N	G DI ETARY	CAFETERI A	
		5.00	7.00	9.00	10.00	11.00	
	GENERAL SERVICE COST CENTERS						_
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
5.00	00500 ADMI NI STRATI VE & GENERAL	131, 335					5.00
7.00	00700 OPERATION OF PLANT	14, 028	214, 826	,			7.00
9.00	00900 HOUSEKEEPI NG	3, 307	6, 564	31, 3	89		9.00
10.00	01000 DI ETARY	2,943	12, 850	1, 9	37 59, 853		10.00
11.00	01100 CAFETERI A	1, 478	9, 141	1, 3	78 0	41, 963	11.00
13.00	01300 NURSING ADMINISTRATION	5, 940	1, 332	20	01 0	1, 571	13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	2, 811	7, 008			C	
15.00	01500 PHARMACY	7, 426	4, 762		18 0	C	
101.00	INPATIENT ROUTINE SERVICE COST CENTERS	77120	1,702	· ·			10100
30, 00	03000 ADULTS & PEDIATRICS	24, 296	51, 321	7,7	35 59, 853	16, 700	30.00
00100	ANCI LLARY SERVICE COST CENTERS	217270	01,021		0,,000	10,700	
50.00	05000 OPERATI NG ROOM	3, 999	27, 693	4, 1	74 0	1, 478	50.00
53.00	05300 ANESTHESI OLOGY	0	2,,0,0	., .	0 0	., ., c	
54.00	05400 RADI OLOGY-DI AGNOSTI C	16, 135	25, 073	3, 7		5, 252	
57.00	05700 CT SCAN	10, 135	23, 073	5,7	0 0	3, 232 C	
58.00	05800 MAGNETIC RESONANCE I MAGING (MRI)	0	0		0 0	C	
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	C	
60.00	06000 LABORATORY	12,844	9, 629		-	5, 136	
60.00		12, 044	9,029			5, 130	
	06001 BLOOD LABORATORY	0			0 0	C	
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	U U	0				
65.00	06500 RESPI RATORY THERAPY	6, 585	3, 648	5		3, 293	
65.01	06501 SLEEP LAB	0	1(007		0 0	0	
66.00	06600 PHYSI CAL THERAPY	4, 899	16, 907			2, 168	
67.00	06700 OCCUPATI ONAL THERAPY	1, 188	1, 454		19 0	429	
68.00	06800 SPEECH PATHOLOGY	106	35		5 0	46	
69.00	06900 ELECTROCARDI OLOGY	655	C		0 0	C	
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	280	C		0 0	C	
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	35	C		0 0	C	
73.00	07300 DRUGS CHARGED TO PATIENTS	6, 574	C		0 0	C	
76.00	03140 CARDI OLOGY	0	C		0 0	C	
76.97	07697 CARDI AC REHABI LI TATI ON	540	1, 584	2	39 0	C	76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	890	5, 920		92 0	487	
91.00	09100 EMERGENCY	14, 298	27, 624	4, 10	63 0	5, 403	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92.00
	SPECIAL PURPOSE COST CENTERS						
113.00	11300 INTEREST EXPENSE						113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117)	131, 257	212, 545	31, 04	45 59, 853	41, 963	118.00
	NONREI MBURSABLE COST CENTERS			·			
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	78	2, 281	34	44 0	C	190.00
192.00	19200 PHYSICIANS' PRIVATE OFFICES	0	C		0 0	C	192.00
200.00							200.00
201.00	,	0	C		0 0	C	201.00
202.00	-5	131, 335	214, 826	31, 3	89 59, 853		202.00

Heal th	Financial Systems	IU HEALTH BLACKE	FORD HOSPITAL		In Lie	u of Form CMS-2	2552-10
	ATION OF CAPITAL RELATED COSTS		Provider CC		Period: From 01/01/2019 To 12/31/2019	Worksheet B Part II Date/Time Pre 6/29/2020 8:0	pared:
	Cost Center Description	NURSI NG ADMI NI STRATI ON	CENTRAL SERVI CES & SUPPLY	PHARMACY	Subtotal	Intern & Residents Cost & Post Stepdown Adjustments	
	1	13.00	14.00	15.00	24.00	25.00	
	GENERAL SERVICE COST CENTERS	T T		1	1		
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT						1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP						2.00
4.00 5.00	00400 EMPLOYEE BENEFITS DEPARTMENT						4.00
	00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT						5.00
7.00 9.00	00900 HOUSEKEEPI NG						7.00
9.00 10.00	01000 DI ETARY						9.00 10.00
11.00	01100 CAFETERIA						11.00
13.00	01300 NURSI NG ADMI NI STRATI ON	13, 410					13.00
14.00	01400 CENTRAL SERVICES & SUPPLY	13,410	33, 849				14.00
15.00	01500 PHARMACY	0	536	29, 05	2		15.00
15.00	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	0	550	27,03	J		15.00
30.00	03000 ADULTS & PEDIATRICS	8, 806	5, 274	41	2 342, 633	0	30.00
00100	ANCI LLARY SERVICE COST CENTERS	0,000	0,271		2 012,000		00100
50.00	05000 OPERATI NG ROOM	647	4, 671	1	9 133, 463	0	50.00
53.00	05300 ANESTHESI OLOGY	0	584		0 584	0	53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	0	3,004	8		0	54.00
57.00	05700 CT SCAN	0	0		0 0	0	57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0	58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0	59.00
60.00	06000 LABORATORY	0	2, 287		0 62, 911	0	60.00
60. 01	06001 BLOOD LABORATORY	0	0		0 0	0	60. 01
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0	62.00
65.00	06500 RESPI RATORY THERAPY	0	3, 009		0 29, 043	0	65.00
65.01	06501 SLEEP LAB	0	0		0 0	0	65.01
66.00	06600 PHYSI CAL THERAPY	0	234		0 82, 178	0	66.00
67.00	06700 OCCUPATI ONAL THERAPY	0	14		0 8, 070	0	67.00
68.00	06800 SPEECH PATHOLOGY	0	0		0 306	0	68.00
69.00	06900 ELECTROCARDI OLOGY	0	0		0 655	0	69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	3, 149		0 3, 429	0	71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	0	388		0 423	0	72.00
73.00 76.00	07300 DRUGS CHARGED TO PATIENTS 03140 CARDI OLOGY	0	0	28, 21		0	73.00 76.00
76.00	07697 CARDI OLOGY 07697 CARDI AC REHABI LI TATI ON	0	127		0 0 0 7,684	0	
70.97	OUTPATIENT SERVICE COST CENTERS	0	127		0 7,004	0	/0.9/
90.00	09000 CLINIC	338	443	4	2 28, 418	0	90.00
90.00	09100 EMERGENCY	3, 619	10, 129	27		0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	5,017	10, 129	27	4 150,005	0	
72.00	SPECIAL PURPOSE COST CENTERS					0	72.00
113 00	11300 I NTEREST EXPENSE						113.00
118.00		13, 410	33, 849	29, 05	3 1, 026, 175	0	118.00
110.00	NONREI MBURSABLE COST CENTERS	10, 110	00,017	27,00	1,020,170	0	110.00
190.00	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	0	0		0 10, 180	0	190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0	0		0 0		192.00
200.00			0		0		200.00
201.00	5	0	0		0 0		201.00
202.00	TOTAL (sum lines 118 through 201)	13, 410	33, 849	29, 05	3 1, 036, 355	0	202.00

Health Financial Systems

IU	HEALTH	BLACKFORD	HOSPI TAL

In Lieu of Form CMS-2552-10

	TI ON OF CAPITAL RELATED COSTS	U HEALTH BLACKF	Provi der CCN: 15-1302	Period: Worksheet From 01/01/2019 Part II To 12/31/2019 Date/Time 6/29/2020 6/29/2020	B Prepared:
	Cost Center Description	Total 26.00			
	GENERAL SERVICE COST CENTERS	20.00			
1.00	00100 NEW CAP REL COSTS-BLDG & FIXT				1.00
2.00	00200 NEW CAP REL COSTS-MVBLE EQUIP				2.00
4.00	00400 EMPLOYEE BENEFITS DEPARTMENT				4,00
5.00	00500 ADMINI STRATI VE & GENERAL				5.00
7.00	00700 OPERATION OF PLANT				7.00
9.00	00900 HOUSEKEEPI NG				9.00
10.00	01000 DI ETARY				10.00
11.00	01100 CAFETERI A				11.00
13.00	01300 NURSI NG ADMI NI STRATI ON				13.00
14.00	01400 CENTRAL SERVICES & SUPPLY				14.00
15.00	01500 PHARMACY				15.00
	I NPATI ENT ROUTI NE SERVI CE COST CENTERS	I			
30.00	03000 ADULTS & PEDI ATRI CS	342, 633			30.00
50.00	ANCI LLARY SERVICE COST CENTERS	342,033			
50.00	05000 OPERATING ROOM	133, 463			50.00
53.00	05300 ANESTHESI OLOGY	584			53.00
54.00	05400 RADI OLOGY-DI AGNOSTI C	135, 522			54.00
57.00	05700 CT SCAN	133, 322			57.00
58.00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0			58.00
59.00	05900 CARDI AC CATHETERI ZATI ON	0			59.00
60.00	06000 LABORATORY	62, 911			60.00
60. 00	06001 BLOOD LABORATORY	02, 911			60.00
62.00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			62.00
		-			65.00
65.00	06500 RESPI RATORY THERAPY 06501 SLEEP LAB	29, 043 0			
65.01		-			65.01
66.00	06600 PHYSI CAL THERAPY	82, 178			66.00
67.00	06700 OCCUPATIONAL THERAPY	8,070			67.00
68.00	06800 SPEECH PATHOLOGY	306			68.00
69.00	06900 ELECTROCARDI OLOGY	655			69.00
71.00	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	3, 429			71.00
72.00	07200 I MPL. DEV. CHARGED TO PATIENT	423			72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	34, 793			73.00
76.00	03140 CARDI OLOGY	0			76.00
76.97	07697 CARDI AC REHABI LI TATI ON	7, 684			76.97
00.00	OUTPATIENT SERVICE COST CENTERS	00.110			
90.00	09000 CLINIC	28, 418			90.00
91.00	09100 EMERGENCY	156, 063			91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART) SPECIAL PURPOSE COST CENTERS				92.00
112 00					112.00
	SUBTOTALS (SUM OF LINES 1 through 117)	1 004 175			113.00
118.00		1, 026, 175			118.00
100.00	NONREI MBURSABLE COST CENTERS	10, 100			100.00
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	10, 180			190.00
	19200 PHYSI CLANS' PRI VATE OFFI CES	0			192.00
200.00	5	0			200.00
201.00	ů, s	0			201.00
202.00	TOTAL (sum lines 118 through 201)	1, 036, 355			202.00

ST ALLOCATION - STATISTICAL BASIS		Provider CC	CN: 15-1302	Peri od:	Worksheet B-1	i
				From 01/01/2019 To 12/31/2019	Date/Time Pre	epare
	CAPI TAL REI	LATED COSTS			6/29/2020 8:0)6 ar
Cost Center Description	NEW BLDG &	NEW MVBLE	EMPLOYEE	Reconciliation	ADMI NI STRATI VE	
	FLXT	EQUI P	BENEFITS	nooonor r a tr on	& GENERAL	
	(SQUARE	(DOLLAR VALUE)	DEPARTMENT		(ACCUM. COST)	
	FEET)		(GROSS			
	1.00	0.00	SALARI ES)			-
GENERAL SERVICE COST CENTERS	1.00	2.00	4.00	5A	5.00	-
00 00100 NEW CAP REL COSTS-BLDG & FIXT	36, 314					1 1
00 00200 NEW CAP REL COSTS-MVBLE EQUIP	00,011	0				2
00 00400 EMPLOYEE BENEFITS DEPARTMENT	0		5, 443, 62	24		4
00500 ADMINISTRATIVE & GENERAL	4, 602		507, 82		12, 626, 959	
00700 OPERATION OF PLANT	7,036		192, 11		1, 348, 746	
00 00900 HOUSEKEEPI NG	754		159, 97		317, 923	
. 00 01000 DI ETARY	1, 476	0	132, 42		282, 987	
. 00 01100 CAFETERI A	1,050	0	94, 28	30 0	142, 146	11
. 00 01300 NURSING ADMINISTRATION	153	0	323, 80	06 0	571, 098	3 13
. 00 01400 CENTRAL SERVICES & SUPPLY	805	0		0 0	270, 284	1 14
. 00 01500 PHARMACY	547	0		0 0	714, 000) 15
INPATIENT ROUTINE SERVICE COST CENTERS	1					
00 03000 ADULTS & PEDIATRICS	5, 895	0	1, 632, 58	30 0	2, 335, 735	30
ANCI LLARY SERVI CE COST CENTERS	2 101		1/7 7		204 404	
00 05000 OPERATING ROOM	3, 181	0	167, 72		384, 484	
. 00 05300 ANESTHESI OLOGY . 00 05400 RADI OLOGY-DI AGNOSTI C	0		E70 01	0 0	13	
	2,880		573, 23		1, 551, 246	
00 05700 CT SCAN	0	0		0 0	0	
00 05800 MAGNETIC RESONANCE IMAGING (MRI) 00 05900 CARDIAC CATHETERIZATION		0		0 0	0	
. 00 06000 LABORATORY	1, 106	-		0 0	1, 234, 912	
01 06001 BLOOD LABORATORY	1, 100			0 0	1, 234, 712	
00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0			0 0	0	
00 06500 RESPIRATORY THERAPY	419	-	479, 10		633, 130	
01 06501 SLEEP LAB	417		477, 10	0 0	033, 130	
00 06600 PHYSI CAL THERAPY	1, 942	-	309, 26	-	470, 976	
00 06700 OCCUPATI ONAL THERAPY	167		88, 37		114, 240	
00 06800 SPEECH PATHOLOGY	4	0	8, 11		10, 152	
00 06900 ELECTROCARDI OLOGY	0	0	9, 94		62, 939	
00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0	.,.	0 0	26, 951	
.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 0	3, 318	
00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 0	632, 101	
00 03140 CARDI OLOGY	0	0		0 0	0	
97 07697 CARDI AC REHABI LI TATI ON	182	0	30, 56	0	51, 883	3 70
OUTPATIENT SERVICE COST CENTERS			· · · · ·		· · · · · ·	
. 00 09000 CLINIC	680	0	43, 09	99 0	85, 530	90
00 09100 EMERGENCY	3, 173	0	691, 19	92 0	1, 374, 656	
00 09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
SPECIAL PURPOSE COST CENTERS	1					4
3. 00 11300 I NTEREST EXPENSE						113
B. 00 SUBTOTALS (SUM OF LINES 1 through 117)	36, 052	0	5, 443, 62	-4, 887, 819	12, 619, 450	1118
NONREI MBURSABLE COST CENTERS	242	0			7 500	110
D. 00 19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 2. 00 19200 PHYSICIANS' PRIVATE OFFICES	262	0		0 0	7, 509) 192
2.00 19200 PHISICIANS PRIVATE OFFICES D. 00 Cross Foot Adjustments	0	0		0	0	200
1.00 Negative Cost Centers						200
2.00 Cost to be allocated (per Wkst. B,	1, 036, 355	0	1, 289, 80	18	4, 887, 819	
Part I)	1,030,355	0	1, 207, 00	00	4,007,017	202
3.00 Unit cost multiplier (Wkst. B, Part I)	28. 538718	0, 000000	0. 23693	20	0. 387094	203
4.00 Cost to be allocated (per Wkst. B,	20. 330710	0.000000	0.2307	0	131, 335	
Part II)					131, 333	1201
5.00 Unit cost multiplier (Wkst. B, Part			0.0000		0. 010401	205
			5. 00000		0.010101	
6.00 NAHE adjustment amount to be allocated	1					206
(per Wkst. B-2)						
7.00 NAHE unit cost multiplier (Wkst. D,]					207
Parts III and IV)	1	1				1

ST A	ALLOCATION - STATISTICAL BASIS		Provider C	CN: 15-1302	Peri od: From 01/01/2019 To 12/31/2019	Worksheet B-1 Date/Time Pre 6/29/2020 8:0	pare
	Cost Center Description	OPERATION OF PLANT (SQUARE FEET)	HOUSEKEEPI NG (SQUARE FEET)	DI ETARY (TOTAL PATI EN DAYS)	CAFETERI A IT (FTE' S)	NURSI NG ADMI NI STRATI ON (FTE' S)	
		7.00	9.00	10.00	11.00	13.00	
	GENERAL SERVICE COST CENTERS						
	00100 NEW CAP REL COSTS-BLDG & FIXT 00200 NEW CAP REL COSTS-MVBLE EQUIP 00400 EMPLOYEE BENEFITS DEPARTMENT 00500 ADMINISTRATIVE & GENERAL 00700 OPERATION OF PLANT 00900 HOUSEKEEPING 01000 DI ETARY 01100 CAFETERIA 01300 NURSING ADMINISTRATION 01400 CENTRAL GEDWIGEG & CURPLY	24, 676 754 1, 476 1, 050 153	23, 922 1, 476 1, 050 153	1, 01	0 7, 239 0 271	3, 335	
. 00	01400 CENTRAL SERVICES & SUPPLY	805			0 0	0	
. 00	01500 PHARMACY	547	547	1	0 0	0	15
. 00	03000 ADULTS & PEDIATRICS	5, 895	5, 895	1, 01	5 2, 881	2, 190	30
. 00	ANCI LLARY SERVICE COST CENTERS	5, 095	5, 875	, U	2,001	2, 190	
. 00	05000 OPERATI NG ROOM	3, 181	3, 181		0 255	161	50
. 00	05300 ANESTHESI OLOGY	0	C		0 0	0	
. 00	05400 RADI OLOGY-DI AGNOSTI C	2,880	2, 880		0 906	0	54
. 00	05700 CT SCAN	0	C		0 0	0	57
. 00	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C		0 0	0	
. 00	05900 CARDI AC CATHETERI ZATI ON	0	C)	0 0	0	
. 00	06000 LABORATORY	1, 106			0 886	0	
. 01	06001 BLOOD LABORATORY	0			0 0	0	
. 00 . 00	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS 06500 RESPI RATORY THERAPY	0 419			0 0 0 568	0	
. 00	06501 SLEEP LAB	419	413		0 0	0	
. 00	06600 PHYSI CAL THERAPY	1,942	1, 942		0 374	0	
. 00	06700 OCCUPATI ONAL THERAPY	167			0 74	0	67
. 00	06800 SPEECH PATHOLOGY	4	4		0 8	0	68
	06900 ELECTROCARDI OLOGY	0	C		0 0	0	
	07100 MEDI CAL SUPPLIES CHARGED TO PATIENTS	0	C)	0 0	0	
	07200 I MPL. DEV. CHARGED TO PATI ENT	0	C		0 0	0	1
	07300 DRUGS CHARGED TO PATIENTS	0	C)	0 0	0	
	03140 CARDI OLOGY 07697 CARDI AC REHABI LI TATI ON	0 182	182)	0 0	0	1
. 97	OUTPATIENT SERVICE COST CENTERS	182	182		0 0	0	1 /
. 00	09000 CLINIC	680	680		0 84	84	90
	09100 EMERGENCY	3, 173			0 932	900	
. 00	09200 OBSERVATION BEDS (NON-DISTINCT PART)						92
	SPECIAL PURPOSE COST CENTERS						
	11300 INTEREST EXPENSE						113
8.00		24, 414	23, 660	1, 01	5 7, 239	3, 335	118
~ ~~	NONREI MBURSABLE COST CENTERS		240			0	110/
	19000 GIFT, FLOWER, COFFEE SHOP & CANTEEN 19200 PHYSICIANS' PRIVATE OFFICES	262	262				190 192
0.00		0		^	0	0	200
1. 00	,,,,,,,						201
2.00	5	1, 870, 837	498, 154	535, 17	298, 642	818, 133	
	Part I)						
3.00		75. 816056	20. 824095			245. 317241	203
4.00		214, 826	31, 389	59, 85	53 41, 963	13, 410	204
5.00		8. 705868	1. 312139	58.96847	5. 796795	4. 020990	205
6. 00	II) NAHE adjustment amount to be allocated (per Wkst. B-2)						206
7.00							207
					1		

GE 1.00 00 2.00 00 5.00 00 7.00 00 9.00 00 11.00 01 13.00 01 14.00 01 30.00 02 53.00 05 54.00 05 57.00 05 58.00 05 59.00 05	Cost Center Description Cost Center Description ENERAL SERVICE COST CENTERS 0100 NEW CAP REL COSTS-BLDG & FIXT 0200 NEW CAP REL COSTS-BLDG & FIXT 0200 NEW CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0900 HOUSEKEEPING 1000 DI ETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS NCILLARY SERVICE COST CENTERS 5000 OPERATING ROOM 5300 ANESTHESIOLOGY 5400 RADIOLOGY-DIAGNOSTIC	CENTRAL SERVI CES & SUPPLY (COSTED REQUI S.) 14. 00 289, 667 4, 587 45, 132 39, 970 4, 998 25, 710	Provi der CCN: PHARMACY (COSTED REQUI S.) 15. 00 650, 795 9, 225 9, 225 416 8	Peri od: From 01/01/2019 To 12/31/2019	epared:
1.00 00 2.00 00 4.00 00 5.00 00 7.00 00 11.00 01 13.00 01 14.00 01 15.00 01 50.00 02 53.00 02 54.00 02 57.00 02 58.00 02 59.00 02	ENERAL SERVICE COST CENTERS 0100 NEW CAP REL COSTS-BLDG & FIXT 0200 NEW CAP REL COSTS-MVBLE EQUIP 0400 EMPLOYEE BENEFITS DEPARTMENT 0500 ADMINISTRATIVE & GENERAL 0700 OPERATION OF PLANT 0900 HOUSEKEEPING 1000 DI ETARY 1100 CAFETERIA 1300 NURSING ADMINISTRATION 1400 CENTRAL SERVICES & SUPPLY 1500 PHARMACY NPATIENT ROUTINE SERVICE COST CENTERS 3000 ADULTS & PEDIATRICS NCILLARY SERVICE COST CENTERS 5000 OPERATING ROOM 5300 ANESTHESIOLOGY 5400 RADIOLOGY-DIAGNOSTIC	SERVI CES & SUPPLY (COSTED REQUI S.) 14. 00 289, 667 4, 587 45, 132 39, 970 4, 998	(COSTED REQUI S.) 15. 00 650, 795 9, 225 416		1. 00 2. 00 4. 00 5. 00 7. 00 9. 00 10. 00 11. 00 13. 00 14. 00 15. 00
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30. 00 0. 30. 00 0. 50. 00 0. 53. 00 0. 54. 00 0. 57. 00 0. 58. 00 0. 59. 00 0.	NPATI ENT ROUTI NE SERVI CE COST CENTERS 3000 ADULTS & PEDI ATRI CS NCI LLARY SERVI CE COST CENTERS 5000 OPERATI NG ROOM 5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C	45, 132 39, 970 4, 998	9, 225		
30.00 03 50.00 05 53.00 05 54.00 05 57.00 05 58.00 05 59.00 05	3000 ADULTS & PEDI ATRI CS NCI LLARY SERVI CE COST CENTERS 5000 OPERATI NG ROOM 5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C	39, 970 4, 998	416		30.00
50.00 0! 53.00 0! 54.00 0! 57.00 0! 58.00 0! 59.00 0!	5000 OPERATI NG ROOM 5300 ANESTHESI OLOGY 5400 RADI OLOGY-DI AGNOSTI C	4, 998			
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58.00 05 59.00 05		0	0		57.00
	5800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		58.00
60.00 0	5900 CARDI AC CATHETERI ZATI ON	0	0		59.00
	6000 LABORATORY	19, 569	0		60.00
	6001 BLOOD LABORATORY	0	0		60.01
	6200 WHOLE BLOOD & PACKED RED BLOOD CELLS 6500 RESPI RATORY THERAPY	25, 752	0		62.00 65.00
	6501 SLEEP LAB	23,732	0		65.01
	6600 PHYSI CAL THERAPY	2,002	0		66.00
	6700 OCCUPATIONAL THERAPY	122	0		67.00
	6800 SPEECH PATHOLOGY 6900 ELECTROCARDI OLOGY	0	0		68.00
	7100 MEDICAL SUPPLIES CHARGED TO PATIENTS	26, 951	o		69.00
	7200 I MPL. DEV. CHARGED TO PATIENT	3, 318	0		72.00
	7300 DRUGS CHARGED TO PATIENTS	0	632, 101		73.00
	3140 CARDI OLOGY	0	0		76.00
	7697 CARDI AC REHABI LI TATI ON	1, 088	0		76.97
	UTPATI ENT SERVICE COST CENTERS 9000 CLINIC	3, 794	949		90.00
	9100 EMERGENCY	86, 672	6, 139		91.00
	9200 OBSERVATION BEDS (NON-DISTINCT PART)				92.00
	PECIAL PURPOSE COST CENTERS	I	I		
	1300 INTEREST EXPENSE	000 //5	(50.705		113.00
118.00	SUBTOTALS (SUM OF LINES 1 through 117) ONREIMBURSABLE COST CENTERS	289, 665	650, 795		118.00
	9000 GIFT, FLOWER, COFFEE SHOP & CANTEEN	2	0		190.00
	9200 PHYSI CI ANS' PRI VATE OFFI CES	0	0		192.00
200.00	Cross Foot Adjustments				200.00
201.00	Negative Cost Centers				201.00
202.00	Cost to be allocated (per Wkst. B, Part I)	452, 704	1, 050, 416		202.00
203.00	Unit cost multiplier (Wkst. B, Part I)	1. 562843	1.614051		203.00
204.00	Cost to be allocated (per Wkst. B,	33, 849	29, 053		204.00
	Part II)				
205.00	Unit cost multiplier (Wkst. B, Part	0. 116855	0. 044642		205.00
206.00	<pre>II) NAHE adjustment amount to be allocated</pre>				206.00
200.00	(per Wkst. B-2)				200.00
207.00	NAHE unit cost multiplier (Wkst. D, Parts III and IV)				207.00

COMPUTATION OF RATIO OF COSTS TO CHARGES Provider CCN: 15-1302 Period: From 0/107/2019 To 12/31/2019 Worksheet C Part 1 Cost Center Description Total Cost (From Wkst. B, Part 1, col.) Total Cost Part 1, col. Total Costs Cost Cost 03000 ADULTS & PEDIATRICS 1.00 2.00 3.00 4.00 5.00 30.00 BS000 OPERATINE SERVICE COST CENTERS 5.086, 271 5.086, 271 0 30.00 30.00 CS000 OPERATINE ROOM 93.881 953.881 0 0 53.00 50.00 DS000 OPERATINE ROOM 93.881 0 0 53.00 54.00 54.00	Health Fina	ncial Systems	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-	2552-10
Cost Center Description Total Cost (from West. B, 26) Therapy Limit Adj. Therapy Limit Adj. Total Costs Pisal I owance Total Costs RCE Disal I owance Total Costs 0.00 03000 Adult15 & PEDI ATRICS 5.086, 271 0	COMPUTATI ON	I OF RATIO OF COSTS TO CHARGES				From 01/01/2019	Part I Date/Time Pre	pared: 6 am
Cost Center Description Total Cost (from West. B, Part I, col. 26) Therapy Limit Adj. Total Costs Adj. Total Costs Disal I owance Total Costs 30.00 INPATI ENT ROUTINE SERVICE COST CENTERS 1.00 2.00 3.00 4.00 5.00 30.00 Jagood ADULTS & PEDIATRICS 5.086, 271 0				Title	XVIII	Hospi tal	Cost	
INPATI ENT ROUTINE SERVICE COST CENTERS Ádj. Di sal I owance 30: 00 INPATI ENT ROUTINE SERVICE COST CENTERS 5.086, 271 0 0 0 0.00 4.00 5.00 ANCILLARY SERVICE COST CENTERS 5.086, 271 0 0 0 0 50.00 50.00 0 50.00 51.00 <t< td=""><td></td><td></td><td></td><td></td><td></td><td></td><td></td><td></td></t<>								
INPATI ENT ROUTINE SERVICE COST CENTERS 0		Cost Center Description	(from Wkst. B, Part I, col. 26)	Âďj .		Di sal I owance		
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53.00 05300 AMESTHESI OLOGY 7,842 7,842 0 0 53.00 54.00 05400 RADI OLOGY-DI AGNOSTI C 2,510,764 0 0 0 54.00 57.00 05700 CT SCAN 0 0 0 0 57.00 58.00 05800 MAGNETI C RESONANCE I MAGI NG (MRI) 0 0 0 0 58.00 59.00 05900 CARDIAC CATHETERI ZATI ON 0 0 0 0 58.00 60.01 06000 LABORATORY 1,886,958 0 0 0 60.01 60.00 06000 LABORATORY 1,886,958 0 0 0 62.00 62.00 06000 LABORATORY 0 0 0 62.00 60.01 62.00 6500 RESPI RATORY THERAPY 982,382 0 982,382 0 0 65.01 65.01 06500 D6500 SEPSI RATORY THERAPY 859,521 0 859,521 0 66.00 0 0 0 14,798 0 14,798 0 67.00 68.00 06300 SPECH PATHOLOGY 14,798 0 14,798 0 70.00 <			050.004	1		4		
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ANCI LLARY SERVICE COST CENTERS Image: Content of the service of the se	Health Financial Systems	IU HEALTH BLACKF	ORD HOSPITAL		In Lie	eu of Form CMS-	2552-10
Cost Center Description Charges Total (col. 6) Cost of ther Ratio TEFRA Inpatient 0.00 03000 ADULTS & PEDIATRICS 2,862,795 30 0.00 05000 OPERATING ROOM 34,283 2,302,186 2,336,469 0.408258 0.0000000 53 53.00 05300 ARSTHESI OLOGY 1,022 45,923 46,945 0.167047 0.000000 53 54.00 05400 RADICT C RESONANCE I MAGING (MRI) 0 0 0 0.0000000 0.0000000 53 59.00 05900 CARDIA C CATHETER TATION 0 0 0 0.0000000 0.0000000 53 60.01 160001 BLODD LABDRATORY 487,328 3,156,432 3,643,760 0.51786.0 0.0000000 0.0000000 62 61.00 0.000000 RESPI RATORY THERAPY 371,370 803,857 1,175,227 0.835998 0.000000 62 62.00 0.00000000	COMPUTATION OF RATIO OF COSTS TO CHARGES				From 01/01/2019 To 12/31/2019	Part I Date/Time Pre	pared: 6 am
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72.00 07200 IMPL. DEV. CHARGED TO PATIENT 0 31,163 31,163 0.314090 0.000000 72. 73.00 07300 DRUGS CHARGED TO PATIENTS 1,680,199 4,364,109 6,044,308 0.313853 0.000000 73. 76.00 03140 CARDI OLOGY 0 0 0 0 0.000000 76. 76.00 03140 CARDI OLOGY 0 0 0 0 0.000000 76. 76.00 07697 CARDI AC REHABILITATION 3,294 470,080 473,374 0.192778 0.000000 76. 00 09000 CLI NI C 0 1,049,296 1,049,296 0.205744 0.000000 90. 90.00 09100 EMERGENCY 165,529 13,947,179 14,112,708 0.185508 0.000000 91. 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 2,850 1,740,029 1,742,879 0.443720 0.000000 91. 92.00 09200 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113. 20.00 35,757,476	69. 00 06900 ELECTROCARDI OLOGY	83, 509	120, 492			0.000000	69.00
73.00 07300 DRUGS CHARGED TO PATIENTS 1,680,199 4,364,109 6,044,308 0.313853 0.000000 73. 76.00 03140 CARDI OLOGY 0 0 0 0 0.000000 76. 76.07 07697 CARDI AC REHABILLITATI ON 3,294 470,080 473,374 0.192778 0.000000 76. 70.00 09000 CLI NI C 0 1,049,296 1,049,296 0.205744 0.000000 90. 90.00 09100 EMERGENCY 165,529 13,947,179 14,112,708 0.185508 0.000000 91. 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 2,850 1,740,029 1,742,879 0.443720 0.000000 91. 92.00 113.00 11300 INTEREST EXPENSE 5 113.00 11300 11300 INTEREST EXPENSE 113. 20.000 35,757,476 42,023,208 200.	71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 713	73, 969	76, 68	32 1. 036801	0.000000	71.00
76.00 03140 CARDI OLOGY 0 0 0 0.000000 0.000000 76.7 76.07 07697 CARDI AC_REHABI LI TATI ON 3, 294 470, 080 473, 374 0.192778 0.000000 76.7 0UTPATI ENT_SERVICE_COST_CENTERS 0 1, 049, 296 1, 049, 296 0.205744 0.000000 90.00 90.00 09100 EMERGENCY 165, 529 13, 947, 179 14, 112, 708 0.185508 0.000000 91.0 92.00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 2, 850 1, 740, 029 1, 742, 879 0.443720 0.000000 91.2 92.00 113.00 I 1300 I NTEREST EXPENSE 113.00 11300 I NTEREST EXPENSE 113.2 20.00 35, 757, 476 42, 023, 208 200.00	72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	31, 163	31, 10	0. 314090	0.000000	72.00
76. 97 07697 CARDI AC REHABI LI TATI ON 3, 294 470, 080 473, 374 0. 192778 0. 000000 76. 0UTPATI ENT SERVICE COST CENTERS 0 1, 049, 296 1, 049, 296 0. 205744 0. 000000 90. 90. 90. 0 09000 CLI NI C 0 1, 049, 296 1, 049, 296 0. 205744 0. 000000 90. 90. 90. 09100 EMERGENCY 165, 529 13, 947, 179 14, 112, 708 0. 185508 0. 000000 91. 91. 92. 0.9200 OBSERVATI ON BEDS (NON-DI STI NCT PART) 2, 850 1, 740, 029 1, 742, 879 0. 443720 0. 000000 91. SPECI AL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 113.00 11300 INTEREST EXPENSE 113.00 200.00 35, 757, 476 42, 023, 208 200. 200.		1, 680, 199	4, 364, 109	6, 044, 30			
OUTPATI ENT SERVICE COST CENTERS 90.00 09000 CLINIC 0 1,049,296 1,049,296 0.205744 0.000000 90.00 91.00 09100 EMERGENCY 165,529 13,947,179 14,112,708 0.185508 0.000000 91. 92.00 09200 DBSERVATI ON BEDS (NON-DI STINCT PART) 2,850 1,740,029 1,742,879 0.443720 0.000000 92. SPECIAL PURPOSE COST CENTERS 113.000 INTEREST EXPENSE 113.000 Subtotal (see instructions) 6,265,732 35,757,476 42,023,208 120.	76. 00 03140 CARDI OLOGY	0	0		0 0.000000	0.000000	76.00
90. 00 09000 CLI NI C 0 1, 049, 296 1, 049, 296 0. 205744 0. 000000 90. 91. 00 09100 EMERGENCY 165, 529 13, 947, 179 14, 112, 708 0. 185508 0. 000000 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 2, 850 1, 740, 029 1, 742, 879 0. 443720 0. 000000 92. SPECI AL PURPOSE COST CENTERS 113.00 113.00 INTEREST EXPENSE 6, 265, 732 35, 757, 476 42, 023, 208 113. 200.00 Subtotal (see instructions) 6, 265, 732 35, 757, 476 42, 023, 208 113.	76. 97 07697 CARDI AC REHABI LI TATI ON	3, 294	470, 080	473, 3	0. 192778	0.00000	76.97
91. 00 09100 EMERGENCY 165, 529 13, 947, 179 14, 112, 708 0. 185508 0. 000000 91. 92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 2, 850 1, 740, 029 1, 742, 879 0. 443720 0. 000000 92. SPECI AL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 6, 265, 732 35, 757, 476 42, 023, 208 113. 200.00	OUTPATIENT SERVICE COST CENTERS						
92. 00 09200 OBSERVATI ON BEDS (NON-DI STINCT PART) 2,850 1,740,029 1,742,879 0.443720 0.000000 92. SPECIAL PURPOSE COST CENTERS 113.00 11300 INTEREST EXPENSE 113.00 1000 1000 11300 11300 1000 1000 11300 11300 1000 1000 11300 1000 1000 1000 1000 11300 1000	90. 00 09000 CLINIC	0	1, 049, 296	1, 049, 29	0. 205744	0.00000	90.00
SPECIAL PURPOSE COST CENTERS 113.00 INTEREST EXPENSE 200.00 Subtotal (see instructions) 6, 265, 732 35, 757, 476 42, 023, 208 200.	91.00 09100 EMERGENCY	165, 529	13, 947, 179	14, 112, 70	0. 185508	0. 000000	91.00
113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 6, 265, 732 35, 757, 476 42, 023, 208 200.00	92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2, 850	1, 740, 029	1, 742, 8	0. 443720	0. 000000	92.00
113.00 11300 INTEREST EXPENSE 113.00 200.00 Subtotal (see instructions) 6, 265, 732 35, 757, 476 42, 023, 208 200.00	SPECIAL PURPOSE COST CENTERS						
	113.00 11300 INTEREST EXPENSE						113.00
	200.00 Subtotal (see instructions)	6, 265, 732	35, 757, 476	42, 023, 20	08		200.00
	201.00 Less Observation Beds						201.00
		6, 265, 732	35, 757, 476	42, 023, 20	08		202.00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL In Lieu of Form			」 of Form CMS-2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1302	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 6/29/2020 8:06 am
		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				30,00
ANCI LLARY SERVI CE COST CENTERS	- I			
50. 00 05000 OPERATI NG ROOM	0.000000			50.00
53. 00 05300 ANESTHESI OLOGY	0.000000			53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0.000000			54.00
57.00 05700 CT SCAN	0,000000			57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0.000000			58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0.000000			59.00
60. 00 06000 LABORATORY	0.000000			60,00
60. 01 06001 BLOOD LABORATORY	0,000000			60, 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0.000000			62.00
65. 00 06500 RESPI RATORY THERAPY	0.000000			65.00
65. 01 06501 SLEEP LAB	0.000000			65.01
66. 00 06600 PHYSI CAL THERAPY	0.000000			66.00
67.00 06700 OCCUPATI ONAL THERAPY	0.000000			67.00
68.00 06800 SPEECH PATHOLOGY	0.000000			68.00
69.00 06900 ELECTROCARDI OLOGY	0.000000			69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 000000			73.00
76. 00 03140 CARDI OLOGY	0.000000			76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0.000000			76.97
OUTPATIENT SERVICE COST CENTERS				
90. 00 09000 CLI NI C	0.000000			90.00
91.00 09100 EMERGENCY	0.000000			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00
SPECIAL PURPOSE COST CENTERS				
113. 00 11300 I NTEREST EXPENSE				113.00
200.00 Subtotal (see instructions)				200.00
201.00 Less Observation Beds				201.00
202.00 Total (see instructions)				202.00

Health Financial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Pre 6/29/2020 8:0	pared: 6 am
		Titl	e XIX	Hospi tal	Cost	
		· ·		Costs		
Cost Center Description	Total Cost (from Wkst. B, Part I, col. 26)	Therapy Limit Adj.		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 & PEDIATRICS	5, 086, 271		5, 086, 27	1 0	5, 086, 271	30.00
ANCILLARY SERVICE COST CENTERS			1	-		
50.00 05000 OPERATI NG ROOM	953, 881		953, 88		953, 881	•
53.00 05300 ANESTHESI OLOGY	7,842		7, 84		7, 842	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	2, 510, 764		2, 510, 76	4 0	2, 510, 764	
57.00 05700 CT SCAN	0			0 0	0	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0			0 0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0			0 0	0	
60. 00 06000 LABORATORY	1, 886, 958		1, 886, 95	8 0	1, 886, 958	60.00
60.01 06001 BLOOD LABORATORY	0			0 0	0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELI				0 0	0	
65. 00 06500 RESPI RATORY THERAPY	982, 382	0	982, 38	2 0	982, 382	
65.01 06501 SLEEP LAB	0	0		0 0	0	
66. 00 06600 PHYSI CAL THERAPY	859, 521	0	859, 52		859, 521	
67.00 06700 OCCUPATI ONAL THERAPY	177, 845	C	177, 84		177, 845	
68.00 06800 SPEECH PATHOLOGY	14, 798	C	14, 79		14, 798	68.00
69. 00 06900 ELECTROCARDI OLOGY	87, 302		87, 30	2 0	87, 302	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIEN			79, 50			71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	9, 788		9, 78	B 0	9, 788	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 897, 026		1, 897, 02	6 0	1, 897, 026	
76. 00 03140 CARDI OLOGY	0			0 0	0	
76. 97 07697 CARDI AC REHABI LI TATI ON	91, 256		91, 25	6 0	91, 256	76.97
OUTPATIENT SERVICE COST CENTERS				-		
90. 00 09000 CLI NI C	215, 886		215, 88		215, 886	
91.00 09100 EMERGENCY	2, 618, 015		2, 618, 01		2, 618, 015	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PAR	Г) 773, 351		773, 35	1	773, 351	92.00
SPECIAL PURPOSE COST CENTERS			1			
113.00 11300 INTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	18, 252, 390	0				
201.00 Less Observation Beds	773, 351		773, 35		773, 351	
202.00 Total (see instructions)	17, 479, 039	C	17, 479, 03	9 0	17, 479, 039	202.00

Health Financial Systems	IU HEALTH BLACKF	FORD HOSPI TAL		In Lie	eu of Form CMS-	2552-10
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider C		Period: From 01/01/2019 To 12/31/2019		epared: 06 am
			e XIX	Hospi tal	Cost	
		Charges				
Cost Center Description	Inpati ent	Outpati ent		6 Cost or Other		
			+ col. 7)	Rati o	Inpati ent	
					Ratio	
	6.00	7.00	8.00	9.00	10.00	
INPATIENT ROUTINE SERVICE COST CENTERS			0.040.74			1
30. 00 03000 ADULTS & PEDI ATRI CS	2, 862, 795		2, 862, 79	95		30.00
ANCI LLARY SERVICE COST CENTERS			1		1	-
50. 00 05000 OPERATI NG ROOM	34, 283	2, 302, 186				
53. 00 05300 ANESTHESI OLOGY	1, 022	45, 923				
54.00 05400 RADI OLOGY-DI AGNOSTI C	263, 651	6, 560, 411	6, 824, 06			
57.00 05700 CT SCAN	0	0		0 0.000000		
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0.000000		
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0.000000	0. 000000	59.00
60. 00 06000 LABORATORY	487, 328	3, 156, 432	3, 643, 70			
60. 01 06001 BLOOD LABORATORY	0	C		0 0.000000	0. 000000	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0.000000	0. 000000	62.00
65. 00 06500 RESPI RATORY THERAPY	371, 370	803, 857	1, 175, 22	0. 835908	0. 000000	65.00
65. 01 06501 SLEEP LAB	0	0		0 0.000000	0. 000000	65.01
66. 00 06600 PHYSI CAL THERAPY	218, 475	1, 029, 516	1, 247, 99	0. 688724	0. 000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	78, 292	62, 834	141, 12	1. 260186	0. 000000	67.00
68.00 06800 SPEECH PATHOLOGY	10, 422	0	10, 42	1. 419881	0. 000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	83, 509	120, 492	204, 00	0. 427949	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	2, 713	73, 969	76, 68	1. 036801	0.000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	31, 163	31, 10	0. 314090	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	1, 680, 199	4, 364, 109	6, 044, 30	0. 313853	0. 000000	73.00
76. 00 03140 CARDI OLOGY	0	0		0 0.000000	0. 000000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	3, 294	470, 080	473, 3	0. 192778	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS	· · · · ·	· · · ·	• · · · ·			1
90, 00 09000 CLINIC	0	1,049,296	1,049,29	0. 205744	0,00000	90.00
91.00 09100 EMERGENCY	165, 529	13, 947, 179			0.00000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	2,850	1, 740, 029				
SPECIAL PURPOSE COST CENTERS	_,	.,,,,	.,			1
113. 00 11300 I NTEREST EXPENSE						113.00
200.00 Subtotal (see instructions)	6, 265, 732	35, 757, 476	42, 023, 20	08		200.00
201.00 Less Observation Beds	0,200,702	00,707,470	12,020,20			201.00
202.00 Total (see instructions)	6, 265, 732	35, 757, 476	42, 023, 20	18		202.00
	0,200,702	00, 707, 470	1 12,020,20		I.	1202.00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL In Lieu of Form (」 of Form CMS-2552-10	0
COMPUTATION OF RATIO OF COSTS TO CHARGES		Provider CCN: 15-1302	Peri od: From 01/01/2019 To 12/31/2019	Worksheet C Part I Date/Time Prepared: 6/29/2020 8:06 am	_
		Title XIX	Hospi tal	Cost	
Cost Center Description	PPS Inpatient Ratio				
INDATIENT DOUTINE CEDVICE COST CENTERS	11.00				_
I NPATI ENT ROUTI NE SERVI CE COST CENTERS				20.00	~
30. 00 03000 ADULTS & PEDI ATRI CS				30.00	J
ANCI LLARY SERVI CE COST CENTERS	0.000000				~
50. 00 05000 OPERATI NG ROOM	0. 000000			50.00	
53. 00 05300 ANESTHESI OLOGY	0. 000000			53.00	
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000			54.00	
57. 00 05700 CT SCAN	0. 000000			57.00	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000			58.00	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000			59.00	
60. 00 06000 LABORATORY	0. 000000			60.00	
60.01 06001 BLOOD LABORATORY	0. 000000			60. 01	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000			62.00	
65. 00 06500 RESPI RATORY THERAPY	0. 000000			65.00	
65. 01 06501 SLEEP LAB	0. 000000			65.01	
66. 00 06600 PHYSI CAL THERAPY	0.000000			66.00	С
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000			67.00	
68.00 06800 SPEECH PATHOLOGY	0.000000			68.00	С
69. 00 06900 ELECTROCARDI OLOGY	0.000000			69.00	С
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0.000000			71.00	С
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0.000000			72.00	С
73.00 07300 DRUGS CHARGED TO PATIENTS	0.000000			73.00	С
76. 00 03140 CARDI OLOGY	0.000000			76.00	D
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000			76.97	7
OUTPATIENT SERVICE COST CENTERS					
90. 00 09000 CLINIC	0.000000			90.00	D
91.00 09100 EMERGENCY	0.000000			91.00	0
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0.000000			92.00	0
SPECIAL PURPOSE COST CENTERS					
113.00 11300 I NTEREST EXPENSE				113.00	0
200.00 Subtotal (see instructions)				200.00	
201.00 Less Observation Beds				201.00	
202.00 Total (see instructions)				202.00	
	1			1	

Health Financial Systems	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT ANCILLARY SERVICE CAPIT	AL COSTS	Provider C		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part II Date/Time Pre 6/29/2020 8:0	
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Capi tal	Total Charges	Ratio of Cos	t Inpatient	Capital Costs	
		(from Wkst. C,	to Charges	Program	(column 3 x	
	(from Wkst. B,	Part I, col.	(col. 1 ÷ col	. Charges	column 4)	
	Part II, col.	8)	2)			
	26)					
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	133, 463	2, 336, 469	0. 05712	2 19, 131	1, 093	50.00
53.00 05300 ANESTHESI OLOGY	584	46, 945	0. 01244	0 534		53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	135, 522	6, 824, 062	0. 01985	9 110, 036	2, 185	54.00
57.00 05700 CT SCAN	0	0	0.00000	0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0	0.00000	0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0	0.00000	0 0	0	59.00
60.00 06000 LABORATORY	62, 911	3, 643, 760	0. 01726	5 207, 463	3, 582	60.00
60.01 06001 BLOOD LABORATORY	0	0	0. 00000	0 0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0	0. 00000	0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	29, 043	1, 175, 227	0. 02471	3 177, 556	4, 388	65.00
65.01 06501 SLEEP LAB	0	0	0. 00000	0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	82, 178	1, 247, 991	0. 06584	8 37, 962	2, 500	66.00
67.00 06700 OCCUPATI ONAL THERAPY	8, 070	141, 126	0. 05718	3 9, 554	546	67.00
68.00 06800 SPEECH PATHOLOGY	306	10, 422	0. 02936	3, 192	94	68.00
69. 00 06900 ELECTROCARDI OLOGY	655	204, 001	0.00321	1 37, 932	122	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	3, 429	76, 682	0. 04471	7 2, 713	121	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	423	31, 163	0. 01357		0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	34, 793				4, 127	•
76.00 03140 CARDI OLOGY	0	C	0.00000		0	
76. 97 07697 CARDI AC REHABI LI TATI ON	7,684	473, 374			25	76.97
OUTPATIENT SERVICE COST CENTERS	,			, , , ,		1
90. 00 09000 CLINIC	28, 418	1,049,296	0. 02708	3 0	0	90.00
91. 00 09100 EMERGENCY	156, 063		1		106	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	52,096		1		0	
200.00 Total (lines 50 through 199)	735, 638			1, 334, 155	18, 896	200.00

Health Financial Systems	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE THROUGH COSTS	RVICE OTHER PASS		CN: 15-1302	Period: From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:0	pared: 6 am
			XVIII	Hospi tal	Cost	
Cost Center Description				Allied Health	Allied Health	
	Anestheti st	Post-Stepdown		Post-Stepdown		
	Cost	Adjustments		Adjustments		
	1.00	2A	2.00	3A	3.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0	0		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0	0		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	C)	0 0	0	54.00
57.00 05700 CT SCAN	0	C		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)	0	C		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C		0 0	0	59.00
60. 00 06000 LABORATORY	0	C		0 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0	C)	0 0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 0	0	65.00
65.01 06501 SLEEP LAB	0	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0	0		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0	C		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C		0 0	0	73.00
76. 00 03140 CARDI OLOGY	0	C		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS						1
90. 00 09000 CLINIC	0	C		0 0	0	90.00
91.00 09100 EMERGENCY	0	C		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0			0	0	92.00
200.00 Total (lines 50 through 199)	0	C		0 0	0	200.00

Health Financial Systems	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	eu of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SE	RVICE OTHER PASS	S Provider C	CN: 15-1302	Peri od:	Worksheet D	
THROUGH COSTS				From 01/01/2019		
				To 12/31/2019	Date/Time Pre 6/29/2020 8:0	
		Title	× XVIII	Hospi tal	Cost	
Cost Center Description	All Other	Total Cost	Total	Total Charges	Ratio of Cost	
	Medi cal	(sum of cols.	Outpatient	(from Wkst. C,		
	Education Cost	1, 2, 3, and	Cost (sum of		(col. 5 ÷ col.	
		4)	col s. 2, 3,	8)	7)	
			and 4)		(see	
					instructions)	
	4.00	5.00	6.00	7.00	8.00	
ANCI LLARY SERVI CE COST CENTERS	-					
50.00 05000 OPERATI NG ROOM	0	0		0 2, 336, 469		
53. 00 05300 ANESTHESI OLOGY	0	0		0 46, 945		
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0	0		0 6, 824, 062		
57.00 05700 CT SCAN	0	0		0 0	0. 000000	
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0		0 0	0.000000	
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	0		0 0	0. 000000	
60. 00 06000 LABORATORY	0	0		0 3, 643, 760		
60. 01 06001 BLOOD LABORATORY	0	0		0 0	0.000000	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0		0 0	0.000000	62.00
65. 00 06500 RESPI RATORY THERAPY	0	0		0 1, 175, 227	0.000000	65.00
65.01 06501 SLEEP LAB	0	0		0 0	0.000000	65.01
66. 00 06600 PHYSI CAL THERAPY	0	0		0 1, 247, 991	0.000000	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	0		0 141, 126	0.000000	67.00
68.00 06800 SPEECH PATHOLOGY	0	0		0 10, 422	0.000000	68.00
69. 00 06900 ELECTROCARDI OLOGY	0	0		0 204, 001	0. 000000	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	0		0 76, 682	0. 000000	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	0		0 31, 163	0. 000000	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	0		0 6, 044, 308	0. 000000	73.00
76. 00 03140 CARDI OLOGY	0	0		0 0	0. 000000	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	0		0 473, 374	0. 000000	76.97
OUTPATIENT SERVICE COST CENTERS			•		•	
90. 00 09000 CLI NI C	0	0		0 1, 049, 296	0.000000	90.00
91.00 09100 EMERGENCY	0	0		0 14, 112, 708	0. 000000	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	0		0 1, 742, 879	0. 000000	92.00
200.00 Total (lines 50 through 199)	0	0		0 39, 160, 413		200. 00

Health Financial Systems	IU HEALTH BLACKF	ORD HOSPITAL		In Lie	u of Form CMS-2	2552-10
APPORTIONMENT OF INPATIENT/OUTPATIENT ANCILLARY SEF THROUGH COSTS	RVICE OTHER PASS	Provider CO		Period: From 01/01/2019 To 12/31/2019	Worksheet D Part IV Date/Time Pre 6/29/2020 8:0	pared: 6 am
		Title	XVIII	Hospi tal	Cost	
Cost Center Description	Outpati ent	Inpati ent	Inpati ent	Outpati ent	Outpati ent	
	Ratio of Cost	Program	Program	Program	Program	
	to Charges	Charges	Pass-Through		Pass-Through	
	(col. 6 ÷ col.		Costs (col.	3	Costs (col. 9	
	7)		x col. 10)		x col. 12)	
	9.00	10.00	11.00	12.00	13.00	
ANCI LLARY SERVI CE COST CENTERS	1 1			- F		
50. 00 05000 OPERATI NG ROOM	0. 000000	19, 131		0 0	0	50.00
53. 00 05300 ANESTHESI OLOGY	0. 000000	534		0 0	0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 000000	110, 036		0 0	0	54.00
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 000000	207, 463		0 0	0	60.00
60.01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 000000	177, 556		0 0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 000000	37, 962		0 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	0. 000000	9, 554		0 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	0. 000000	3, 192		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0, 000000	37, 932		0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0, 000000	2, 713		0 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 000000	0		0 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0, 000000	717, 015		0 0	0	73.00
76. 00 03140 CARDI OLOGY	0. 000000	0		0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 000000	1, 520		0 0	0	76.97
OUTPATIENT SERVICE COST CENTERS		.,		-		
90. 00 09000 CLINIC	0.000000	0		0 0	0	90.00
91. 00 09100 EMERGENCY	0, 000000	9, 547		0 0	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 000000	0		0 0	0	92.00
200.00 Total (lines 50 through 199)		1, 334, 155		0 0	-	200.00
	· ·				-	

	IU HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
				From 01/01/2019 To 12/31/2019	Part V Date/Time Pre	narod
				10 12/31/2017	6/29/2020 8:0	
		Title	XVIII	Hospi tal	Cost	
			Charges		Costs	
Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
	Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
	Worksheet C,	inst.)	Servi ces	Services Not		
	Part I, col. 9		Subject To	Subject To		
			Ded. & Coins			
			(see inst.)	(see inst.)		
	1.00	2.00	3.00	4.00	5.00	
ANCI LLARY SERVI CE COST CENTERS						
50.00 05000 OPERATING ROOM	0. 408258	0	110/11		0	
53. 00 05300 ANESTHESI OLOGY	0. 167047	0	- /		0	53.00
54. 00 05400 RADI OLOGY-DI AGNOSTI C	0. 367928	0	1, 815, 60	05 0	0	
57.00 05700 CT SCAN	0. 000000	0		0 0	0	57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	59.00
60. 00 06000 LABORATORY	0. 517860	0	909, 54	3 0	0	60.00
60. 01 06001 BLOOD LABORATORY	0. 000000	0		0 0	0	60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
65. 00 06500 RESPI RATORY THERAPY	0. 835908	0	250, 45	2 0	0	65.00
65. 01 06501 SLEEP LAB	0. 000000	0		0 0	0	65.01
66. 00 06600 PHYSI CAL THERAPY	0. 688724	0	392, 58	3 0	0	66.00
67.00 06700 OCCUPATI ONAL THERAPY	1. 260186	0	19, 09	7 0	0	67.00
68.00 06800 SPEECH PATHOLOGY	1. 419881	0		0 0	0	68.00
69. 00 06900 ELECTROCARDI OLOGY	0. 427949	0	50, 40	0 0	0	69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1.036801	0	14, 97	8 0	0	71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0. 314090	0	9, 71	7 0	0	72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0. 313853	0	2, 609, 13	3 621	0	73.00
76. 00 03140 CARDI OLOGY	0. 000000	0	1	0 0	0	76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0. 192778	0	183, 73	5 0	0	76.97
OUTPATIENT SERVICE COST CENTERS					• •	1
90. 00 09000 CLI NI C	0. 205744	0	538, 68	3 0	0	90.00
91.00 09100 EMERGENCY	0. 185508	0	2, 952, 72	7 412	0	91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 443720	0	586, 27	3 0	0	92.00
200.00 Subtotal (see instructions)		0	11, 063, 89	5 1, 033	0	200.00
201.00 Less PBP Clinic Lab. Services-Program				0 0		201.00
Only Charges		_	11 0/0 0/	1 000	_	202.00
202.00 Net Charges (line 200 - line 201)		0	11, 063, 89	1, 033	0	202.00

Heal th	Financial Systems	U HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-	2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C	CN: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 6/29/2020 8:0	
			Title	XVIII	Hospi tal	Cost	
		Cos	sts				
	Cost Center Description	Cost	Cost				
		Reimbursed	Reimbursed				
		Servi ces	Services Not				
		Subject To	Subject To				
			Ded. & Coins.				
		(see inst.)	(see inst.)				
		6.00	7.00				
	ANCI LLARY SERVI CE COST CENTERS						_
	05000 OPERATING ROOM	291, 977					50.00
	05300 ANESTHESI OLOGY	2, 638	0				53.00
	05400 RADI OLOGY-DI AGNOSTI C	668, 012	0				54.00
	05700 CT SCAN	0	0				57.00
	05800 MAGNETIC RESONANCE IMAGING (MRI)	0	0				58.00
	05900 CARDI AC CATHETERI ZATI ON	0	0				59.00
	06000 LABORATORY	471, 016	0				60.00
60. 01	06001 BLOOD LABORATORY	0	0				60.01
	06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	0				62.00
	06500 RESPI RATORY THERAPY	209, 355	0				65.00
	06501 SLEEP LAB	0	0				65.01
66.00	06600 PHYSI CAL THERAPY	270, 381	0				66.00
67.00	06700 OCCUPATI ONAL THERAPY	24,066	0				67.00
68.00	06800 SPEECH PATHOLOGY	0	0				68.00
69.00	06900 ELECTROCARDI OLOGY	21, 569	0				69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	15, 529	0				71.00
72.00	07200 IMPL. DEV. CHARGED TO PATIENT	3, 052	0				72.00
73.00	07300 DRUGS CHARGED TO PATIENTS	818, 884	195				73.00
76.00	03140 CARDI OLOGY	0	0				76.00
76.97	07697 CARDI AC REHABI LI TATI ON	35, 420	0				76.97
	OUTPATIENT SERVICE COST CENTERS						
90.00	09000 CLI NI C	110, 831	0				90.00
91.00	09100 EMERGENCY	547, 754	76				91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	260, 141	0				92.00
200.00	Subtotal (see instructions)	3, 750, 625	271				200.00
201.00	Less PBP Clinic Lab. Services-Program	0					201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)	3, 750, 625	271				202.00

		IU HEALTH BLACK	FORD HOSPITAL		In Lie	u of Form CMS-:	2552-10
APPORTI	ONMENT OF MEDICAL, OTHER HEALTH SERVICES AND	VACCINE COST	Provider C		Peri od:	Worksheet D	
			Component (From 01/01/2019 To 12/31/2019		narod
			component	CCN. 13-2302	10 12/31/2019	6/29/2020 8:0	
			Title	e XVIII	Swing Beds - SNF		
				Charges		Costs	
	Cost Center Description	Cost to Charge	PPS Reimbursed	Cost	Cost	PPS Services	
		Ratio From	Services (see	Reimbursed	Reimbursed	(see inst.)	
		Worksheet C,	inst.)	Servi ces	Services Not		
		Part I, col. 9		Subject To	Subject To		
				Ded. & Coins			
				(see inst.)	(see inst.)		
		1.00	2.00	3.00	4.00	5.00	
	ANCI LLARY SERVI CE COST CENTERS						
	D5000 OPERATING ROOM	0. 408258	0		0 0	0	
	D5300 ANESTHESI OLOGY	0. 167047	0		0 0	0	
	D5400 RADI OLOGY-DI AGNOSTI C	0. 367928	0		0 0	0	
	D5700 CT SCAN	0. 000000	0		0 0	0	
	D5800 MAGNETIC RESONANCE IMAGING (MRI)	0. 000000	0		0 0	0	
	05900 CARDI AC CATHETERI ZATI ON	0. 000000	0		0 0	0	
	D6000 LABORATORY	0. 517860	0		0 0	0	
60.01 0	D6001 BLOOD LABORATORY	0. 000000	0		0 0	0	60.01
	D6200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0. 000000	0		0 0	0	62.00
	06500 RESPI RATORY THERAPY	0.835908	0		0 0	0	65.00
	D6501 SLEEP LAB	0. 000000	0		0 0	0	65.01
66.00 0	D6600 PHYSI CAL THERAPY	0. 688724	0		0 0	0	66.00
67.00 0	06700 OCCUPATI ONAL THERAPY	1. 260186	0		0 0	0	67.00
68.00 0	D6800 SPEECH PATHOLOGY	1. 419881	0		0 0	0	68.00
69.00	D6900 ELECTROCARDI OLOGY	0. 427949	0		0 0	0	69.00
71.00	07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	1. 036801	0		0 0	0	71.00
72.00	D7200 IMPL. DEV. CHARGED TO PATIENT	0. 314090	0		0 0	0	72.00
73.00	D7300 DRUGS CHARGED TO PATIENTS	0. 313853	0		0 0	0	73.00
76.00	D3140 CARDI OLOGY	0. 000000	0		0 0	0	76.00
76.97	07697 CARDI AC REHABI LI TATI ON	0. 192778	0		0 0	0	76.97
C	DUTPATIENT SERVICE COST CENTERS			_		_	
90.00	09000 CLI NI C	0. 205744	0		0 0	0	90.00
	D9100 EMERGENCY	0. 185508	0		0 0	0	91.00
92.00	09200 OBSERVATION BEDS (NON-DISTINCT PART)	0. 443720	0		0 0	0	92.00
200.00	Subtotal (see instructions)		0		0 0	0	200.00
201.00	Less PBP Clinic Lab. Services-Program				0 0		201.00
	Only Charges						
202.00	Net Charges (line 200 - line 201)		0	1	0 0	0	202.00

Health Financial Systems	U HEALTH BLACK	FORD HOSPI TAI		Inlie	u of Form CMS-	2552-10
APPORTIONMENT OF MEDICAL, OTHER HEALTH SERVICES AND		Provider C	CN: 15-1302 CCN: 15-Z302	Period: From 01/01/2019 To 12/31/2019	Worksheet D Part V Date/Time Pre 6/29/2020 8:0	pared:
		Title	XVIII	Swing Beds - SNF	Cost	
	Cos			<u> </u>		
Cost Center Description	Cost	Cost	1			
	Reimbursed	Reimbursed				
	Servi ces	Services Not				
	Subject To	Subject To				
	Ded. & Coins.	Ded. & Coins.				
	(see inst.)	(see inst.)				
	6.00	7.00				
ANCI LLARY SERVI CE COST CENTERS						
50.00 O5000 OPERATI NG ROOM	0	C				50.00
53.00 05300 ANESTHESI OLOGY	0	C				53.00
54.00 05400 RADI OLOGY-DI AGNOSTI C	0	C				54.00
57.00 05700 CT SCAN	0	C				57.00
58.00 05800 MAGNETIC RESONANCE IMAGING (MRI)	0	C				58.00
59. 00 05900 CARDI AC CATHETERI ZATI ON	0	C				59.00
60. 00 06000 LABORATORY	0	C				60.00
60. 01 06001 BLOOD LABORATORY	0	C				60. 01
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS	0	C				62.00
65. 00 06500 RESPI RATORY THERAPY	0	C				65.00
65.01 06501 SLEEP LAB	0	C				65.01
66. 00 06600 PHYSI CAL THERAPY	0	C				66.00
67.00 06700 OCCUPATI ONAL THERAPY	0	C				67.00
68.00 06800 SPEECH PATHOLOGY	0	C				68.00
69. 00 06900 ELECTROCARDI OLOGY	0	C				69.00
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS	0	C				71.00
72.00 07200 IMPL. DEV. CHARGED TO PATIENT	0	C				72.00
73.00 07300 DRUGS CHARGED TO PATIENTS	0	C				73.00
76. 00 03140 CARDI OLOGY	0	C				76.00
76. 97 07697 CARDI AC REHABI LI TATI ON	0	C				76.97
OUTPATIENT SERVICE COST CENTERS	1					
90. 00 09000 CLINIC	0	C				90.00
91.00 09100 EMERGENCY	0	C	•			91.00
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)	0	C				92.00
200.00 Subtotal (see instructions)	0	C				200.00
201.00 Less PBP Clinic Lab. Services-Program	0					201.00
Only Charges						
202.00 Net Charges (line 200 - line 201)	0	0	1			202.00

OMPUT	ATION OF INPATIENT OPERATING COST	Provider CCN: 15-1302	Period: From 01/01/2019	Worksheet D-1	
			To 12/31/2019	Date/Time Prep 6/29/2020 8:00	
	Cost Center Description	Title XVIII	Hospi tal	Cost	
	PART I - ALL PROVIDER COMPONENTS			1.00	
00	INPATIENT DAYS	(a avaluding nawharn)		2, 200	
00	Inpatient days (including private room days and swing-bed day Inpatient days (including private room days, excluding swing-			2, 389 1, 352	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
00	do not complete this line. Semi-private room days (excluding swing-bed and observation b	od dave)		1, 015	4.0
00	Total swing-bed SNF type inpatient days (including private ro		er 31 of the cost	855	
~~	reporting period				
00	Total swing-bed SNF type inpatient days (including private ro reporting period (if calendar year, enter 0 on this line)	oom days) after December	31 of the cost	0	6. (
00	Total swing-bed NF type inpatient days (including private roo	m days) through December	31 of the cost	182	7.
00	reporting period	m dava) often December (1 of the east	0	
00	Total swing-bed NF type inpatient days (including private roo reporting period (if calendar year, enter 0 on this line)	in days) after beceniber .	an of the cost	0	8.0
00	Total inpatient days including private room days applicable t	o the Program (excluding	g swing-bed and	628	9. (
D. 00	newborn days) (see instructions) Swing-bed SNF type inpatient days applicable to title XVIII o	nly (including private u	coom days)	855	10.
5.00	through December 31 of the cost reporting period (see instruc		com days)	000	10.
1.00	Swing-bed SNF type inpatient days applicable to title XVIII o		room days) after	0	11.
2.00	December 31 of the cost reporting period (if calendar year, e Swing-bed NF type inpatient days applicable to titles V or XI		te room days)	0	12.
	through December 31 of the cost reporting period	3 . 0 .	5 -		
3.00	Swing-bed NF type inpatient days applicable to titles V or XI after December 31 of the cost reporting period (if calendar y			0	13.
4.00	Medically necessary private room days applicable to the Progr			0	14.
5.00	Total nursery days (title V or XIX only)			0	
5.00	Nursery days (title V or XIX only) SWING BED ADJUSTMENT			0	16.
7.00	Medicare rate for swing-bed SNF services applicable to servic	es through December 31 o	of the cost		17.
3. 00	reporting period Medicare rate for swing-bed SNF services applicable to servic	es after December 31 of	the cost		18.
9. 00	reporting period Medicaid rate for swing-bed NF services applicable to service	s through December 31 of	f the cost	118.90	19.
	reporting period	-			
0. 00	Medicaid rate for swing-bed NF services applicable to service reporting period	es after December 31 of 1	the cost	0.00	20.
1.00	Total general inpatient routine service cost (see instruction	2		5, 086, 271	21.
2.00	Swing-bed cost applicable to SNF type services through Decemb 5×10^{-1} x line 17)	er 31 of the cost report	ting period (line	0	22.
3.00	Swing-bed cost applicable to SNF type services after December	31 of the cost reportin	ng period (line 6	0	23.
	x line 18)				
4.00	Swing-bed cost applicable to NF type services through Decembe 7×10^{-1} x line 19)	er 31 of the cost reporti	ng period (line	21, 640	24.
5.00	Swing-bed cost applicable to NF type services after December	31 of the cost reporting	g period (line 8	0	25.
5.00	x line 20) Total swing-bed cost (see instructions)			1, 983, 694	26.
7.00	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 102, 577	
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT				
3.00 9.00	General inpatient routine service charges (excluding swing-be Private room charges (excluding swing-bed charges)	d and observation bed cr	narges)	0	
D. 00	Semi-private room charges (excluding swing-bed charges)			0	
1.00	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	31.
2.00	Average private room per diem charge (line 29 ÷ line 3)			0.00	32.
3.00	Average semi-private room per diem charge (line 30 ÷ line 4)			0.00	33.
4.00	Average per diem private room charge differential (line 32 mi		ctions)	0.00	
5.00	Average per diem private room cost differential (line 34 x li	ne 31)		0.00	
5.00	Private room cost differential adjustment (line 3 x line 35)	and private ream east -	fforontial (li	0 2 102 577	
7.00	General inpatient routine service cost net of swing-bed cost 27 minus line 36)	anu private room cost di	Trefencial (TINe	3, 102, 577	37.
	PART II - HOSPITAL AND SUBPROVIDERS ONLY				1
	PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ			0.004.00	
	Additional and a second district and an out the second district of the second distribution of the s				
3.00	Adjusted general inpatient routine service cost per diem (see			2,294.80	
3. 00 9. 00 0. 00	Adjusted general inpatient routine service cost per diem (see Program general inpatient routine service cost (line 9 x line Medically necessary private room cost applicable to the Progr	38)		2, 294. 80 1, 441, 134 0	39.

PUTATION OF INPATIENT OPERATING COST		Provider C	CN: 15-1302	Period: From 01/01/2019	Worksheet D-1	1
				To 12/31/2019		
			XVIII	Hospi tal	Cost	
Cost Center Description	Total Inpatient Cost	Total npatient Days	Average Per Diem (col. 1 col. 2)		Program Cost (col. 3 x col. 4)	
	1.00	2.00	3.00	4.00	5.00	
00 NURSERY (title V & XIX only)						42.
Intensive Care Type Inpatient Hospital	Uni ts		1			1 42
00 INTENSIVE CARE UNIT 00 CORONARY CARE UNIT						43.
00 BURN INTENSIVE CARE UNIT						45.
00 SURGICAL INTENSIVE CARE UNIT						46.
00 OTHER SPECIAL CARE (SPECIFY)						47.
Cost Center Description					1.00	
00 Program inpatient ancillary service cos	t (Wkst D-3 col 3	Line 200)			593, 105	5 48.
00 Total Program inpatient costs (sum of I			ins)		2, 034, 239	
PASS THROUGH COST ADJUSTMENTS					I	
00 Pass through costs applicable to Progra	m inpatient routine s	services (from	ı Wkst. D, sur	n of Parts I and	C	50.
) 00 Pass through costs applicable to Progra	m innatient ancillary	, services (fr	om Wkst D 4	um of Parts II	C	51
and IV)			om wikst. D, s			
00 Total Program excludable cost (sum of I					c	
00 Total Program inpatient operating cost		ated, non-phy	sician anesth	netist, and	C	53
medical education costs (line 49 minus TARGET AMOUNT AND LIMIT COMPUTATION	line 52)					
00 Program di scharges					C	54
00 Target amount per discharge					0.00	
00 Target amount (line 54 x line 55)					C	
00 Difference between adjusted inpatient o	perating cost and tar	rget amount (I	ine 56 minus	line 53)	C	
00 Bonus payment (see instructions) 00 Lesser of lines 53/54 or 55 from the co	st reporting period e	nding 1996 i	indated and co	mounded by the	0.00	
market basket	st reporting period e	sharing 1770, c		inpounded by the	0.00	
00 Lesser of lines 53/54 or 55 from prior					0.00	
00 If line 53/54 is less than the lower of					C) 61
which operating costs (line 53) are les amount (line 56), otherwise enter zero		s (TThes 54 x	60), or 1% of	the target		
00 Relief payment (see instructions)					C	62
00 Allowable Inpatient cost plus incentive		ctions)			C	63
PROGRAM INPATIENT ROUTINE SWING BED COS 00 Medicare swing-bed SNF inpatient routin		where 21 of the	cost reporti	na pariod (Saa	1 042 054	1 44
00 Medicare swing-bed SNF inpatient routin instructions)(title XVIII only)	e costs thi ough becen		cost reporti	ng period (see	1, 962, 054	+ 04
00 Medicare swing-bed SNF inpatient routin	e costs after Decembe	er 31 of the c	ost reporting	g period (See	C	65
instructions)(title XVIII only)						
00 Total Medicare swing-bed SNF inpatient CAH (see instructions)	routine costs (line 6	64 plus line 6	5)(title XVII	I only). For	1, 962, 054	i 66
00 Title V or XIX swing-bed NF inpatient r	outine costs through	December 31 c	of the cost re	porting period	c c	67
(line 12 x line 19)					_	
00 Title V or XIX swing-bed NF inpatient r	outine costs after De	ecember 31 of	the cost repo	orting period	C	68
(line 13 x line 20) 00 Total title V or XIX swing-bed NF inpat	iont routino costs (1	ino 67 Llino	40)) 69
PART III - SKILLED NURSING FACILITY, OT	•		,			1 07
00 Skilled nursing facility/other nursing				1		70
00 Adjusted general inpatient routine serv		ne 70 ÷ line	2)			71
00 Program routine service cost (line 9 x		(lino 14 v !!	no 25)			72
00 Medically necessary private room cost a 00 Total Program general inpatient routine						73
00 Capital -related cost allocated to inpat	•			Part II, column		75
26, line 45)			,			
00 Per diem capital -related costs (line 75						76
00 Program capital-related costs (line 9 x 00 Inpatient routine service cost (line 74	-					77
00 Aggregate charges to beneficiaries for	,	rovi der record	ls)			79
00 Total Program routine service costs for			· · ·	nus line 79)		80
00 Inpatient routine service cost per diem						81
00 Inpatient routine service cost limitati	•					82
00 Reasonable inpatient routine service co 00 Program inpatient ancillary services (s	•	»)				83
00 Utilization review - physician compensa		ns)				85
00 Total Program inpatient operating costs					<u> </u>	86
DADT LV COMPLITATION OF ODCEDVATION DEL	D PASS THROUGH COST					
PART IV - COMPUTATION OF OBSERVATION BE						
Total observation bed days (see instruction of Adjusted general inpatient routine cost	tions)	line 2)			337 2, 294. 81	

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL			In Lieu of Form CMS-2552-1			
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period:	Worksheet D-1		
				From 01/01/2019 To 12/31/2019			
		Title	XVIII	Hospi tal	Cost		
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on		
		(from line 21)	column 2	Observati on	Bed Pass		
				Bed Cost (from	Through Cost		
				line 89)	(col. 3 x col.		
					4) (see		
					instructions)		
	1.00	2.00	3.00	4.00	5.00		
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST						
90.00 Capital-related cost	342, 633	5, 086, 271	0.06736	4 773, 351	52, 096	90.00	
91.00 Nursing School cost	0	5, 086, 271	0.00000	0 773, 351	0	91.00	
92.00 Allied health cost	0	5, 086, 271	0.00000	0 773, 351	0	92.00	
93.00 All other Medical Education	0	5, 086, 271	0. 00000	0 773, 351	0	93.00	

	TION OF INPATIENT OPERATING COST	Provider CCN: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre 6/29/2020 8:00	pared
		Title XIX	Hospi tal	Cost	
	Cost Center Description		-	1.00	
	PART I - ALL PROVIDER COMPONENTS				
	INPATIENT DAYS Inpatient days (including private room days and swing-bed day	(s excluding newborn)		2, 389	1.0
00	Inpatient days (including private room days, excluding swing-			1, 352	
00	Private room days (excluding swing-bed and observation bed da		rivate room days,	0	
	do not complete this line.		-		
00 00	Semi-private room days (excluding swing-bed and observation b Total swing-bed SNF type inpatient days (including private ro	5 /	or 21 of the cost	1, 015 855	
	reporting period	Join days) thi dugh becenbe	er st of the cost	600	5.
00	Total swing-bed SNF type inpatient days (including private ro	oom days) after December	31 of the cost	0	6.
	reporting period (if calendar year, enter 0 on this line)				
00	Total swing-bed NF type inpatient days (including private roc	om days) through December	⁻ 31 of the cost	182	7.
00	reporting period Total swing-bed NF type inpatient days (including private roc	m days) after December '	R1 of the cost	0	8.
	reporting period (if calendar year, enter 0 on this line)			0	0.
00	Total inpatient days including private room days applicable t	to the Program (excluding	g swing-bed and	10	9.
	newborn days) (see instructions)				10
00	Swing-bed SNF type inpatient days applicable to title XVIII o through December 31 of the cost reporting period (see instruc	only (including private i stions)	room days)	0	10.
00	Swing-bed SNF type inpatient days applicable to title XVIII o		room davs) after	0	11.
	December 31 of the cost reporting period (if calendar year, e				
00	Swing-bed NF type inpatient days applicable to titles V or XI	X only (including privat	te room days)	0	12.
00	through December 31 of the cost reporting period Swing-bed NF type inpatient days applicable to titles V or XI	V only (including privat	to room day(c)	0	13.
	after December 31 of the cost reporting period (if calendar y			0	13.
00	Medically necessary private room days applicable to the Progr	am (excluding swing-bed	days)	0	14.
	Total nursery days (title V or XIX only)			0	
	Nursery days (title V or XIX only)			0	16.
	SWING BED ADJUSTMENT Medicare rate for swing-bed SNF services applicable to servic	ces through December 31 (of the cost		17.
00	reporting period	the ough becember of t			''.
00	Medicare rate for swing-bed SNF services applicable to servic	ces after December 31 of	the cost		18.
	reporting period			110.00	10
00	Medicaid rate for swing-bed NF services applicable to service reporting period	es through December 31 of	the cost	118.90	19.
00	Medicaid rate for swing-bed NF services applicable to service	es after December 31 of t	the cost	0.00	20.
	reporting period				
	Total general inpatient routine service cost (see instruction			5, 086, 271	
00	Swing-bed cost applicable to SNF type services through Decemb 5 x line 17)	ber 31 of the cost report	ting period (line	0	22.
00	Swing-bed cost applicable to SNF type services after December	- 31 of the cost reportin	ng period (line 6	0	23.
	x line 18)	·	5 T X		
	Swing-bed cost applicable to NF type services through Decembe	er 31 of the cost reporti	ng period (line	21, 640	24.
	7 x line 19) Swing-bed cost applicable to NF type services after December	31 of the cost reporting	n period (line 8	0	25.
00	x line 20)			0	20.
	Total swing-bed cost (see instructions)			1, 983, 694	26.
	General inpatient routine service cost net of swing-bed cost	(line 21 minus line 26)		3, 102, 577	27.
	PRIVATE ROOM DIFFERENTIAL ADJUSTMENT General inpatient routine service charges (excluding swing-be	d and obsorvation had d	pargos)	0	28.
	Private room charges (excluding swing-bed charges)		lai yes)	0	
	Semi-private room charges (excluding swing-bed charges)			0	
	General inpatient routine service cost/charge ratio (line 27	÷line 28)		0.00000	
	Average private room per diem charge (line 29 ÷ line 3)			0.00	
	Average semi-private room per diem charge (line 30 ÷ line 4) Average per diem private room charge differential (line 32 mi	nus line 33) (see instru	tions)	0.00 0.00	
	Average per diem private room cost differential (line 34 x li		511 01137	0.00	
	Private room cost differential adjustment (line 3 x line 35)	,		0	
	General inpatient routine service cost net of swing-bed cost	and private room cost di	fferential (line	3, 102, 577	37.
	27 minus line 36)				1
	PART II - HOSPITAL AND SUBPROVIDERS ONLY PROGRAM INPATIENT OPERATING COST BEFORE PASS THROUGH COST ADJ	ILISTMENTS			-
	Adjusted general inpatient routine service cost per diem (see			2, 294. 80	38.
00	Program general inpatient routine service cost per drem (see	-		22, 948	39.

Heal th	Financial Systems	IU HEALTH BLACK	FORD HOSPI TAL		In Lie	u of Form CMS-2	2552-10
COMPUT	ATION OF INPATIENT OPERATING COST		Provider C	F	Period: From 01/01/2019 To 12/31/2019	Worksheet D-1 Date/Time Pre	pared:
			T: +1			6/29/2020 8:0	6 am
	Cost Center Description	Total	Total	e XIX Average Per	Hospital Program Days	Cost Program Cost	
			Inpatient Days			(col. 3 x col. 4)	
10.00		1.00	2.00	3.00	4.00	5.00	40.00
42.00	NURSERY (title V & XIX only) Intensive Care Type Inpatient Hospital Units						42.00
43.00	INTENSIVE CARE UNIT						43.00
44.00	CORONARY CARE UNIT						44.00
	BURN INTENSIVE CARE UNIT						45.00
	SURGICAL INTENSIVE CARE UNIT						46. 00 47. 00
47.00	OTHER SPECIAL CARE (SPECIFY) Cost Center Description						47.00
						1.00	
	Program inpatient ancillary service cost (Wk					12, 172	48.00
49.00	Total Program inpatient costs (sum of lines PASS THROUGH COST ADJUSTMENTS	41 through 48)(see instructio	ns)		35, 120	49.00
50.00	Pass through costs applicable to Program inp	atient routine	services (from	Wkst. D. sum	of Parts I and	0	50.00
	Pass through costs applicable to Program inp					0	51.00
	and IV)		,				
52.00	Total Program excludable cost (sum of lines				4 4	0	52.00
53.00	Total Program inpatient operating cost exclu medical education costs (line 49 minus line		erated, non-pny	sician anestne	etist, and	0	53.00
	TARGET AMOUNT AND LIMIT COMPUTATION	02)					
	Program discharges					0	
	Target amount per discharge						55. 00 56. 00
	Target amount (line 54 x line 55) Difference between adjusted inpatient operat	ing cost and ta	arget amount (L	ine 56 minus l	ine 53)	0	56.00 57.00
	Bonus payment (see instructions)	ing obot and ta	ingot amount (i		1110 00)	0	58.00
59.00	Lesser of lines 53/54 or 55 from the cost re	porting period	endi ng 1996, u	pdated and com	pounded by the	0.00	59.00
60. 00	market basket Lesser of lines 53/54 or 55 from prior year	cost roport un	dated by the m	arkat backat		0.00	60.00
	If line 53/54 is less than the lower of line				he amount by	0.00	61.00
	which operating costs (line 53) are less that	n expected cost					
(2.00	amount (line 56), otherwise enter zero (see	instructions)				0	(2.00
	Relief payment (see instructions) Allowable Inpatient cost plus incentive paym	ent (see instru	ictions)			0	62.00 63.00
00.00	PROGRAM INPATIENT ROUTINE SWING BED COST					0	00.00
64.00	Medicare swing-bed SNF inpatient routine cos	ts through Dece	ember 31 of the	cost reportir	ng period (See	0	64.00
65.00	instructions)(title XVIII only) Medicare swing-bed SNF inpatient routine cos	ts after Decemb	ver 31 of the c	ost reporting	neriod (See	0	65.00
00.00	instructions) (title XVIII only)			lost reporting	period (See	0	00.00
66.00	Total Medicare swing-bed SNF inpatient routi CAH (see instructions)	ne costs (line	64 plus line 6	5)(title XVIII	only). For	0	66.00
67.00	Title V or XIX swing-bed NF inpatient routin	e costs through	n December 31 o	f the cost rep	orting period	0	67.00
68.00	(line 12 x line 19) Title V or XIX swing-bed NF inpatient routin	e costs after D	ecember 31 of	the cost repor	ting period	0	68.00
69.00	(line 13 x line 20) Total title V or XIX swing-bed NF inpatient	routine costs ([line 67 + line	68)		0	69.00
70.00	PART III - SKILLED NURSING FACILITY, OTHER N						70.00
	Skilled nursing facility/other nursing facil Adjusted general inpatient routine service c						70. 00 71. 00
	Program routine service cost (line 9 x line		The 70 - True	2)			72.00
73.00	Medically necessary private room cost applic	able to Program	n (line 14 x li	ne 35)			73.00
74.00	Total Program general inpatient routine serv	•					74.00
75.00	Capital-related cost allocated to inpatient 26, line 45)	routine service	e costs (trom W	Orksneet B, Pa	irt II, column		75.00
76.00	Per diem capital-related costs (line 75 ÷ li	ne 2)					76.00
	Program capital-related costs (line 9 x line						77.00
	Inpatient routine service cost (line 74 minu Aggregate charges to beneficiaries for exces	,	rovi dor rocord	c)			78.00 79.00
80.00	Total Program routine service costs for comp				is line 79)		80.00
81.00	Inpatient routine service cost per diem limi						81.00
82.00	Inpatient routine service cost limitation (I		· .				82.00
	Reasonable inpatient routine service costs (is)				83.00 84.00
	Program inpatient ancillary services (see in Utilization review - physician compensation		ons)				84.00 85.00
	Total Program inpatient operating costs (sum	•					86.00
	PART IV - COMPUTATION OF OBSERVATION BED PAS						
	Total observation bed days (see instructions Adjusted general inpatient routine cost per		line 2)			337 2, 294. 81	87.00 88.00
	Observation bed cost (line 87 x line 88) (se	•	,			773, 351	

Health Financial Systems	IU HEALTH BLACK	FORD HOSPITAL		In Lie	eu of Form CMS-2	2552-10
COMPUTATION OF INPATIENT OPERATING COST		Provider CO		Period: From 01/01/2019	Worksheet D-1	
				To 12/31/2019		
		Titl	e XIX	Hospi tal	Cost	
Cost Center Description	Cost	Routine Cost	column 1 ÷	Total	Observati on	
		(from line 21)	column 2	Observati on	Bed Pass	
				Bed Cost (from	Through Cost	
				line 89)	(col. 3 x col.	
					4) (see	
					instructions)	
	1.00	2.00	3.00	4.00	5.00	
COMPUTATION OF OBSERVATION BED PASS THROUGH	COST					
90.00 Capital-related cost	342, 633	5, 086, 271	0.06736	4 773, 351	52, 096	90.00
91.00 Nursing School cost	0	5, 086, 271	0.00000	0 773, 351	0	91.00
92.00 Allied health cost	0	5, 086, 271	0. 00000	773, 351	0	92.00
93.00 All other Medical Education	0	5, 086, 271	0. 00000	0 773, 351	0	93.00

Health Financial Systems IU HEALTH BLACKFO			In Lie	u of Form CMS-2	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1302	Period:	Worksheet D-3	
			From 01/01/2019 To 12/31/2019		nared
			10 12/31/2017	6/29/2020 8:0	
	Title	XVIII	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
		1.00	2.00	2)	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00	2.00	3.00	
30. 00 03000 ADULTS & PEDIATRICS			1, 216, 484		30.00
ANCI LLARY SERVICE COST CENTERS			1, 210, 404		30.00
50. 00 05000 OPERATI NG ROOM		0. 4082	58 19, 131	7, 810	50.00
53. 00 05300 ANESTHESI OLOGY		0. 1670			
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.3679			
57. 00 05700 CT SCAN		0.0000		0	
58. 00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0.0000		0	
59. 00 05900 CARDIAC CATHETERIZATION		0.0000		0	
60. 00 06000 LABORATORY		0. 5178		107, 437	
60. 01 06001 BLOOD LABORATORY		0.0000		0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000	0 00	0	62.00
65. 00 06500 RESPI RATORY THERAPY		0. 8359	08 177, 556	148, 420	65.00
65. 01 06501 SLEEP LAB		0.0000	0 00	0	65.01
66. 00 06600 PHYSI CAL THERAPY		0. 6887	24 37, 962	26, 145	66.00
67. 00 06700 OCCUPATI ONAL THERAPY		1. 2601			
68.00 06800 SPEECH PATHOLOGY		1. 4198			
69. 00 06900 ELECTROCARDI OLOGY		0. 4279			
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 0368		2, 813	71.00
72.00 07200 I MPL. DEV. CHARGED TO PATIENT		0. 3140		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3138			
76. 00 03140 CARDI OLOGY		0.0000		0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 1927	78 1, 520	293	76.97
OUTPATIENT SERVICE COST CENTERS				-	
90. 00 09000 CLINIC		0.2057		0	
91.00 09100 EMERGENCY		0. 1855			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4437		0 502 105	
200.00Total (sum of lines 50 through 94 and 96 through 98)201.00Less PBP Clinic Laboratory Services-Program only charge	c (line 41)		1, 334, 155		200.00
	is (i i ne ol)		1 224 155		201.00
202.00 Net charges (line 200 minus line 201)		I	1, 334, 155	I	202.00

Health Financial Systems IU HEALTH BLACK			In Lie	eu of Form CMS-	2552-1
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider C	CN: 15-1302	Period:	Worksheet D-3	
	Component	CCN: 15-Z302	From 01/01/2019 To 12/31/2019		narod
				6/29/2020 8:0	
	Title	XVIII	Swing Beds - SNF		
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges		Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1		1	
30. 00 03000 ADULTS & PEDIATRICS			0		30.00
ANCI LLARY SERVI CE COST CENTERS					
50. 00 05000 OPERATING ROOM		0.4082		0	
53. 00 05300 ANESTHESI OLOGY		0. 1670		0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.3679			
57. 00 05700 CT SCAN		0.0000		0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
60. 00 06000 LABORATORY		0. 5178			
60. 01 06001 BLOOD LABORATORY		0.0000		0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	
65. 00 06500 RESPIRATORY THERAPY		0.8359			
65. 01 06501 SLEEP LAB		0.0000		0	
66. 00 06600 PHYSI CAL THERAPY		0. 6887			
67. 00 06700 OCCUPATI ONAL THERAPY		1.2601			
68.00 06800 SPEECH PATHOLOGY		1. 4198			
69. 00 06900 ELECTROCARDI OLOGY		0. 4279			
71.00 07100 MEDI CAL SUPPLI ES CHARGED TO PATI ENTS		1.0368		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 3140		0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3138			
76. 00 03140 CARDI OLOGY		0.0000		, o	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 1927	78 1, 769	341	76. 9
		0.0057	44		
90. 00 09000 CLINIC		0.2057		0	1
91.00 09100 EMERGENCY		0. 1855		0	
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4437		0 530 355	
200.00 Total (sum of lines 50 through 94 and 96 through 98)	(1: (1)		1, 063, 694	530, 255	
201.00 Less PBP Clinic Laboratory Services-Program only charge	ges (line 61)		1 0(2 (2)		201.00
202.00 Net charges (line 200 minus line 201)		I	1, 063, 694	1	202.00

Health Financial Systems	IU HEALTH BLACKFORD HOSPITAL			eu of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	Provider CC	CN: 15-1302	Peri od:	Worksheet D-3	3
			From 01/01/2019 To 12/31/2019		nared
			10 12/31/2019	6/29/2020 8:0	
		e XIX	Hospi tal	Cost	
Cost Center Description		Ratio of Cos		Inpati ent	
		To Charges	Program	Program Costs	
			Charges	(col. 1 x col.	
				2)	
		1.00	2.00	3.00	
I NPATI ENT ROUTI NE SERVI CE COST CENTERS			10.77/	1	
30. 00 03000 ADULTS & PEDI ATRI CS			18, 776		30.00
ANCI LLARY SERVI CE COST CENTERS					
50.00 05000 OPERATI NG ROOM		0. 40825		0	
53.00 05300 ANESTHESI OLOGY		0. 16704		0	
54.00 05400 RADI OLOGY-DI AGNOSTI C		0. 36792			
57.00 05700 CT SCAN		0.0000		0	
58.00 05800 MAGNETIC RESONANCE I MAGING (MRI)		0.0000		0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	
60. 00 06000 LABORATORY		0. 51786			
60. 01 06001 BLOOD LABORATORY		0.0000		0	
62.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000		0	
65. 00 06500 RESPI RATORY THERAPY		0.83590			
65. 01 06501 SLEEP LAB		0.0000		0	
66. 00 06600 PHYSI CAL THERAPY		0. 68872		0	00.00
67.00 06700 OCCUPATI ONAL THERAPY		1. 26018		0	
68.00 06800 SPEECH PATHOLOGY		1. 41988		0	
69. 00 06900 ELECTROCARDI OLOGY		0. 42794		0	
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1. 03680		0	
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 31409		0	1 2.00
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 31385		2, 317	
76. 00 03140 CARDI OLOGY		0.0000		0	
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 1927	78 0	0	76.97
OUTPATIENT SERVICE COST CENTERS				i	
90. 00 09000 CLINIC		0. 20574			
91.00 09100 EMERGENCY		0. 18550			
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 44372		0	
200.00 Total (sum of lines 50 through 94 an			34, 291	12, 172	200.00
201.00 Less PBP Clinic Laboratory Services-			0		201.00
202.00 Net charges (line 200 minus line 201)		34, 291		202.00

leal th Financial Systems IU HEALTH BLACKFORD		N 1E 1000	Der		u of Form CMS-	
INPATIENT ANCILLARY SERVICE COST APPORTIONMENT	rovider CC	CN: 15-1302		riod: om 01/01/2019	Worksheet D-3	
C	omponent (CCN: 15-Z302	To		Date/Time Pre	parec
	•				6/29/2020 8:0	
	Ti tl			ng Beds - SNF		
Cost Center Description		Ratio of Cos		Inpati ent	Inpati ent	
		To Charges			Program Costs	
				Charges	(col. 1 x col.	
		1.00		2.00	2) 3.00	
INPATIENT ROUTINE SERVICE COST CENTERS		1.00		2.00	3.00	
30. 00 03000 ADULTS & PEDI ATRI CS				0		30.0
ANCI LLARY SERVICE COST CENTERS				0		1 30. 1
50. 00 05000 OPERATI NG ROOM		0. 4082	58	0	0	50.0
53. 00 05300 ANESTHESI OLOGY		0, 1670		0	0	
54. 00 05400 RADI OLOGY-DI AGNOSTI C		0.3679		0	0	
57. 00 05700 CT SCAN		0.0000		0	0	
58.00 05800 MAGNETIC RESONANCE I MAGI NG (MRI)		0.0000		0	0	
59. 00 05900 CARDI AC CATHETERI ZATI ON		0.0000		0	0	59.
50. 00 06000 LABORATORY		0. 5178		0	0	
50. 01 06001 BLOOD LABORATORY		0.0000	00	0	0	60.
52.00 06200 WHOLE BLOOD & PACKED RED BLOOD CELLS		0.0000	00	0	0	62.
65. 00 06500 RESPI RATORY THERAPY		0.8359	08	0	0	65.
55. 01 06501 SLEEP LAB		0.0000	00	0	0	65.0
56. 00 06600 PHYSI CAL THERAPY		0. 6887	24	0	0	66.
57.00 06700 OCCUPATIONAL THERAPY		1. 2601	86	0	0	67.
58.00 06800 SPEECH PATHOLOGY		1. 4198	81	0	0	68.
59. 00 06900 ELECTROCARDI OLOGY		0. 4279	49	0	0	69.
71.00 07100 MEDICAL SUPPLIES CHARGED TO PATIENTS		1.0368	01	0	0	71.
72.00 07200 IMPL. DEV. CHARGED TO PATIENT		0. 3140		0	0	
73.00 07300 DRUGS CHARGED TO PATIENTS		0. 3138	53	0	0	73.
76. 00 03140 CARDI OLOGY		0.0000	00	0	0	76.
76. 97 07697 CARDI AC REHABI LI TATI ON		0. 1927	78	0	0	76.
OUTPATIENT SERVICE COST CENTERS						
90. 00 09000 CLINIC		0. 2057		0	0	
01.00 09100 EMERGENCY		0. 1855		0	0	1
92.00 09200 OBSERVATION BEDS (NON-DISTINCT PART)		0. 4437	20	0	0	1 12.
200.00 Total (sum of lines 50 through 94 and 96 through 98)				0	0	200.
201.00 Less PBP Clinic Laboratory Services-Program only charges (I	ine 61)			0		201.
202.00 Net charges (line 200 minus line 201)				0		202. (

	Financial Systems IU HEALTH BLACKFORD H ATION OF REIMBURSEMENT SETTLEMENT Pr	OSPITAL ovider CCN: 15-1302	In Lie Period:	u of Form CMS-2 Worksheet E	2552-10
ONECOL		ovrder oon. 13 1302	From 01/01/2019 To 12/31/2019	Part B Date/Time Pre	
		Title XVIII	Hospi tal	6/29/2020 8:00 Cost	6 am
				1.00	
	PART B - MEDICAL AND OTHER HEALTH SERVICES				
1.00 2.00	Medical and other services (see instructions) Medical and other services reimbursed under OPPS (see instruction	s)		3, 750, 896 0	1
3.00	OPPS payments			0	
4.00 4.01	Outlier payment (see instructions) Outlier reconciliation amount (see instructions)			0	
5.00	Enter the hospital specific payment to cost ratio (see instruction	ons)		0.000	
6.00 7.00	Line 2 times line 5			0 0.00	
7.00 8.00	Sum of lines 3, 4, and 4.01, divided by line 6 Transitional corridor payment (see instructions)			0.00	1
9.00	Ancillary service other pass through costs from Wkst. D, Pt. IV,	col. 13, line 200		0	
10.00 11.00	Organ acquisitions Total cost (sum of lines 1 and 10) (see instructions)			0 3, 750, 896	10.00
	COMPUTATION OF LESSER OF COST OR CHARGES				
12.00	Reasonable charges Ancillary service charges			0	12.00
13.00	Organ acquisition charges (from Wkst. D-4, Pt. III, col. 4, line	69)		0	13.00
14.00	Total reasonable charges (sum of lines 12 and 13) Customary charges			0	14.00
15.00	Aggregate amount actually collected from patients liable for paym	ent for services on	a charge basis	0	15.00
16.00	Amounts that would have been realized from patients liable for patients had such payment been made in accordance with 42 CEP \$412 12(c)	yment for services	on a chargebasis	0	16.00
17.00	had such payment been made in accordance with 42 CFR §413.13(e) Ratio of line 15 to line 16 (not to exceed 1.000000)			0. 000000	17.00
18.00	Total customary charges (see instructions)	flips 10 sysseds li	no 11) (coo	0	
19.00	Excess of customary charges over reasonable cost (complete only i instructions)	T TINE 18 exceeds T	ne II) (see	0	19.00
20.00	Excess of reasonable cost over customary charges (complete only i	fline 11 exceeds l	ne 18) (see	0	20.00
21.00	instructions) Lesser of cost or charges (see instructions)			3, 788, 405	21.00
22.00	Interns and residents (see instructions)			0	22.00
23.00 24.00	Cost of physicians' services in a teaching hospital (see instruct Total prospective payment (sum of lines 3, 4, 4.01, 8 and 9)	i ons)		0	
	COMPUTATION OF REIMBURSEMENT SETTLEMENT				
25.00 26.00	Deductibles and coinsurance amounts (for CAH, see instructions) Deductibles and Coinsurance amounts relating to amount on line 24	(for CAH see inst	ructions)	30, 620 1, 991, 647	
27.00	Subtotal [(lines 21 and 24 minus the sum of lines 25 and 26) plus			1, 766, 138	
28.00	instructions) Direct graduate medical education payments (from Wkst. E-4, line	50)		0	28.00
29.00	ESRD direct medical education costs (from Wkst. E-4, line 36)	50)		0	
30.00	Subtotal (sum of lines 27 through 29)			1, 766, 138	
31.00 32.00	Primary payer payments Subtotal (line 30 minus line 31)			137 1, 766, 001	
	ALLOWABLE BAD DEBTS (EXCLUDE BAD DEBTS FOR PROFESSIONAL SERVICES)				1
	Composite rate ESRD (from Wkst. I-5, line 11) Allowable bad debts (see instructions)			0 397, 605	
35.00	Adjusted reimbursable bad debts (see instructions)			258, 443	35.00
36.00 37.00	Allowable bad debts for dual eligible beneficiaries (see instruct Subtotal (see instructions)	i ons)		297, 069 2, 024, 444	
38.00	MSP-LCC reconciliation amount from PS&R			2, 024, 444	1
39.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
39. 50 39. 97	Pioneer ACO demonstration payment adjustment (see instructions) Demonstration payment adjustment amount before sequestration			0	39.50 39.97
39.98	Partial or full credits received from manufacturers for replaced	devices (see instru	ctions)	0	
39.99	RECOVERY OF ACCELERATED DEPRECIATION			0	
40. 00 40. 01	Subtotal (see instructions) Sequestration adjustment (see instructions)			2, 024, 444 40, 489	1
40. 02	Demonstration payment adjustment amount after sequestration			0	
40.03	Sequestration adjustment-PARHM pass-throughs				40.03
41.00	Interim payments			2, 158, 171	
41.01 42.00	Interim payments-PARHM Tentative settlement (for contractors use only)			0	41.01 42.00
42.01	Tentative settlement-PARHM (for contractor use only)				42.01
43.00 43.01	Balance due provider/program (see instructions) Balance due provider/program-PARHM (see instructions)			-174, 216	43.00 43.01
44.00	Protested amounts (nonallowable cost report items) in accordance §115.2	with CMS Pub. 15-2,	chapter 1,	172, 265	1
90.00	TO BE COMPLETED BY CONTRACTOR Original outlier amount (see instructions)			0	90.00
90.00 91.00	Outlier reconciliation adjustment amount (see instructions)			0	
	The rate used to calculate the Time Value of Money				92.00
92.00 93.00	Time Value of Money (see instructions)			0	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC	CN: 15-1302	Period: From 01/01/2019 To 12/31/2019		
		Title	XVIII	Hospi tal	Cost	
		I npati en	t Part A	Par	rt B	
		mm/dd/yyyy	Amount	mm/dd/yyyy	Amount	
		1.00	2.00	3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		1, 611, 33	32 0	2, 158, 171 0	1.00 2.00 3.00
3.00	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					3. 00
3.01	ADJUSTMENTS TO PROVIDER			0	0	3. 01
3.02				0	0	3. 02
3.03				0	0	3.03
3.04 3.05				0	0	3.04 3.05
3.05	Provider to Program			0	0	3.00
3.50	ADJUSTMENTS TO PROGRAM			0	0	3.50
3.51				0	0	3.51
3.52				0	0	3.52
3.53 3.54				0	0	3.53 3.54
3.99	Subtotal (sum of lines 3.01-3.49 minus sum of lines			0	0	3.99
	3. 50-3. 98)					
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		1, 611, 33	32	2, 158, 171	4.00
	TO BE COMPLETED BY CONTRACTOR			1		
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider					5.00
5.01	TENTATI VE TO PROVI DER			0	0	5. 01
5.02				0	0	5. 02
5.03				0	0	5.03
F F 6	Provider to Program					
5.50 5.51	TENTATI VE TO PROGRAM			0	0	5.50 5.51
5.52				0	0	5.52
5.99	Subtotal (sum of lines 5.01-5.49 minus sum of lines			0	0	5.99
6.00	5.50-5.98) Determined net settlement amount (balance due) based on the cost report. (1)					6.00
6. 01	SETTLEMENT TO PROVIDER		246, 63	37	0	6. 01
6.02	SETTLEMENT TO PROGRAM		2.0,00	0	174, 216	6. 02
7.00	Total Medicare program liability (see instructions)		1, 857, 96		1, 983, 955	7.00
			<u> </u>	Contractor Number	NPR Date (Mo/Day/Yr)	
		()	1.00	2.00	

ANALY	SIS OF PAYMENTS TO PROVIDERS FOR SERVICES RENDERED	Provider CC Component C	CN: 15-1302 CCN: 15-Z302		iod: m 01/01/2019 12/31/2019	Worksheet E-1 Part I Date/Time Pre 6/29/2020 8:0	pared:
		Title	XVIII	Swi r	ng Beds - SNF		0 alli
		I npati en				t B	
		mm/dd/yyyy	Amount		mm/dd/yyyy	Amount	
		1.00	2.00		3.00	4.00	
1.00 2.00 3.00	Total interim payments paid to provider Interim payments payable on individual bills, either submitted or to be submitted to the contractor for services rendered in the cost reporting period. If none, write "NONE" or enter a zero List separately each retroactive lump sum adjustment		2, 253, 8	93 0		0 0	
	amount based on subsequent revision of the interim rate for the cost reporting period. Also show date of each payment. If none, write "NONE" or enter a zero. (1) Program to Provider						
3.01	ADJUSTMENTS TO PROVIDER	07/23/2019	57, 5	00		0	3. 01
3. 02				0		0	
3.03				0		0	
3.04 3.05				0		0	
5.05	Provider to Program					0	0.00
3.50	ADJUSTMENTS TO PROGRAM			0		0	3.50
3. 51				0		0	
3.52				0		0	
3.53 3.54				0		0 0	
3. 99 3. 99	Subtotal (sum of lines 3.01–3.49 minus sum of lines 3.50–3.98)		57, 5	-		0	
4.00	Total interim payments (sum of lines 1, 2, and 3.99) (transfer to Wkst. E or Wkst. E-3, line and column as appropriate)		2, 311, 3	93		0	4.00
	TO BE COMPLETED BY CONTRACTOR						1
5.00	List separately each tentative settlement payment after desk review. Also show date of each payment. If none, write "NONE" or enter a zero. (1)						5.00
5.01	Program to Provider TENTATIVE TO PROVIDER			0		0	5.01
5.02				0		0	•
5.03				0		0	
	Provider to Program			_			
5.50 5.51	TENTATI VE TO PROGRAM			0		0	5.50 5.51
5.51 5.52				0		0	
5. 99	Subtotal (sum of lines 5.01–5.49 minus sum of lines 5.50–5.98)			0		0	
6.00	Determined net settlement amount (balance due) based on the cost report. (1)						6.00
6. 01	SETTLEMENT TO PROVIDER		134, 0)77		0	6. 01
6. 02	SETTLEMENT TO PROGRAM			0		0	
7.00	Total Medicare program liability (see instructions)		2, 445, 4		Controctor	0	7.00
					Contractor Number 1.00	NPR Date (Mo/Day/Yr)	
8.00	Name of Contractor	(J		1.00	2.00	8.00

Heal th	Financial Systems IU HEALTH BL	ACKFORD HOSPI TAL	In Lie	u of Form CMS	-2552-10
CALCUL	ATION OF REIMBURSEMENT SETTLEMENT FOR HIT	Provider CCN: 15-1302	Peri od: From 01/01/2019 To 12/31/2019	Date/Time Pr 6/29/2020 8:	epared: 06 am
		Title XVIII	Hospi tal	Cost	_
				1.00	
	TO BE COMPLETED BY CONTRACTOR FOR NONSTANDARD COST REPOR	RTS			
	HEALTH INFORMATION TECHNOLOGY DATA COLLECTION AND CALCUL	_ATI ON			
1.00	Total hospital discharges as defined in AARA §4102 from	Wkst. S-3, Pt. I col. 15 line	e 14		1.00
2.00	Medicare days from Wkst. S-3, Pt. I, col. 6 sum of lines	s 1, 8-12			2.00
3.00	Medicare HMO days from Wkst. S-3, Pt. I, col. 6. line 2				3.00
4.00	Total inpatient days from S-3, Pt. I col. 8 sum of lines	s 1, 8-12			4.00
5.00	Total hospital charges from Wkst C, Pt. I, col. 8 line 2	200			5.00
6.00	Total hospital charity care charges from Wkst. S-10, col	. 3 line 20			6.00
7.00	CAH only - The reasonable cost incurred for the purchase line 168	e of certified HIT technology	Wkst. S-2, Pt. I		7.00
8.00	Calculation of the HIT incentive payment (see instruction	ons)			8.00
9.00	Sequestration adjustment amount (see instructions)				9.00
10.00	Calculation of the HIT incentive payment after sequestra	ation (see instructions)			10.00
	INPATIENT HOSPITAL SERVICES UNDER THE IPPS & CAH				
30.00	Initial/interim HIT payment adjustment (see instructions	5)			30.00
31.00	Other Adjustment (specify)				31.00
32.00	Balance due provider (line 8 (or line 10) minus line 30	and line 31) (see instruction	ns)		32.00

ALCULA	Financial Systems IU HEALTH BLACKFORD TION OF REIMBURSEMENT SETTLEMENT - SWING BEDS P	rovider CCN: 15-1302	Peri od:	u of Form CMS-2 Worksheet E-2	
		omponent CCN: 15-Z3O2	From 01/01/2019 To 12/31/2019	Date/Time Pre 6/29/2020 8:0	
		Title XVIII	Swing Beds - SNF		
			Part A 1.00	<u>Part B</u> 2.00	
C	COMPUTATION OF NET COST OF COVERED SERVICES		1.00	2.00	
	Inpatient routine services - swing bed-SNF (see instructions)		1, 981, 675	0	1 1.
	npatient routine services - swing bed-NF (see instructions)				2.
	Ancillary services (from Wkst. D-3, col. 3, line 200, for Part A		535, 558	0	3.
	Part V, cols. 6 and 7, line 202, for Part B) (For CAH and swing-	bed pass-through, see			
1	nstructions)				
	Nursing and allied health payment-PARHM (see instructions) Per diem cost for interns and residents not in approved teaching	program (coo		0.00	3. 4.
	nstructions)	g pi ogi alli (see		0.00	4.
	Program days		855	0	5.
	Interns and residents not in approved teaching program (see inst	ructions)		0	6.
00 1	Jtilization review - physician compensation - SNF optional metho	od only	0		7.
	Subtotal (sum of lines 1 through 3 plus lines 6 and 7)		2, 517, 233	0	
	Primary payer payments (see instructions)		0	0	9.
	Subtotal (line 8 minus line 9)		2, 517, 233	0	10.
	Deductibles billed to program patients (exclude amounts applicab professional services)	ore to physician	0	0	11.
	Subtotal (line 10 minus line 11)		2, 517, 233	0	12.
	Coinsurance billed to program patients (from provider records) (exclude coinsurance	23, 332	0	
	for physician professional services)				
4.00 8	30% of Part B costs (line 12 x 80%)			0	14.
	Subtotal (see instructions)		2, 493, 901	0	
	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0	0	
	Pioneer ACO demonstration payment adjustment (see instructions)				16.
	Rural community hospital demonstration project (§410A Demonstrat adjustment (see instructions)	lon) payment	0		16.
	Demonstration payment adjustment amount before sequestration		0	0	16.
	Allowable bad debts (see instructions)		2, 272	0	
	Adjusted reimbursable bad debts (see instructions)		1, 477	0	
. 00 /	Allowable bad debts for dual eligible beneficiaries (see instruc	ctions)	0	0	18
	Total (see instructions)		2, 495, 378	0	
	Sequestration adjustment (see instructions)		49, 908	0	
	Demonstration payment adjustment amount after sequestration)		0	0	
1	Sequestration adjustment-PARHM pass-throughs		2, 311, 393	0	19 20
	nterim payments nterim payments-PARHM		2, 311, 373	0	20
	Tentative settlement (for contractor use only)		0	0	
	Tentative settlement-PARHM (for contractor use only)		0	Ũ	21
1	Balance due provider/program (line 19 minus lines 19.01, 20, and	1 21)	134, 077	0	22
. 01 E	Balance due provider/program-PARHM (see instructions)				22
	Protested amounts (nonallowable cost report items) in accordance	e with CMS Pub. 15-2,	57, 908	0	23
	chapter 1, §115.2	ion) Adjuctment			
	Rural Community Hospital Demonstration Project (§410A Demonstrat is this the first year of the current 5-year demonstration peric	d under the 21st			200
	Century Cures Act? Enter "Y" for yes or "N" for no.				200
	Cost Reimbursement				1
1.00	Medicare swing-bed SNF inpatient routine service costs (from Wks	st. D-1, Pt. II, line			201
	66 (title XVIII hospital))				
	Medicare swing-bed SNF inpatient ancillary service costs (from W	/kst. D-3, col. 3, lin	e		202
	200 (title XVIII swing-bed SNF)) Fotal (sum of lines 201 and 202)				203
	Medicare swing-bed SNF discharges (see instructions)				203
	computation of Demonstration Target Amount Limitation (N/A in fi	rst year of the curre	nt 5-vear demonst		
	period)	5			
	Medicare swing-bed SNF target amount				205
	Medicare swing-bed SNF inpatient routine cost cap (line 205 time				206
	djustment to Medicare Part A Swing-Bed SNF Inpatient Reimbursem		-		007
	Program reimbursement under the §410A Demonstration (see instruc		1		207
	Medicare swing-bed SNF inpatient service costs (from Wkst. E-2, and 3)	COL. I, SUM OF LINES			208
	Adjustment to Medicare swing-bed SNF PPS payments (see instructi	ons)			209
	Reserved for future use				210
	comparision of PPS versus Cost Reimbursement				1
5 00	Fotal adjustment to Medicare swing-bed SNF PPS payment (line 209	plus line 210) (see			215

ALCULATI	ON OF REIMBURSEMENT SETTLEMENT - SWING BEDS	Provider CCN: 15-1302	Peri od:	Worksheet E-2	
	C	Component CCN: 15-Z302	From 01/01/2019 To 12/31/2019	Date/Time Prepa 6/29/2020 8:06	
		Title XIX	Swing Beds - SNF		
			Part A	Part B	
			1.00	2.00	
	MPUTATION OF NET COST OF COVERED SERVICES				1
	patient routine services - swing bed-SNF (see instructions)		0		1 2
	patient routine services - swing bed-NF (see instructions)		-		
	cillary services (from Wkst. D-3, col. 3, line 200, for Part		0		3
	rt V, cols. 6 and 7, line 202, for Part B) (For CAH and swing	-bed pass-through, see			
1	istructions)				2
1	ursing and allied health payment-PARHM (see instructions) er diem cost for interns and residents not in approved teachin	-	0.00		3
	istructions)	g program (see	0.00		4
	ogram days		0		5
	iterns and residents not in approved teaching program (see ins	tructions)	0		6
	ilization review - physician compensation - SNF optional meth		0		7
	ibtotal (sum of lines 1 through 3 plus lines 6 and 7)	ou on y	0		8
	imary payer payments (see instructions)		0		9
	ubtotal (line 8 minus line 9)		0		10
	· · · · · · · · · · · · · · · · · · ·	hla ta physician	0		
	eductibles billed to program patients (exclude amounts applica rofessional services)	ore to physiciali	0		11
	btotal (line 10 minus line 11)		0		12
	insurance billed to program patients (from provider records)	(aveluda coi peuropeo	0		12
	prophysician professional services)	(exclude collisulance	0		13
	% of Part B costs (line 12 x 80%)		0		14
	btotal (see instructions)		0		14
	HER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)		0		16
	, , , ,		0		16
	oneer ACO demonstration payment adjustment (see instructions)	tion) noumant			
	ıral community hospital demonstration project (§410A Demonstra Ijustment (see instructions)	tron) payment			16
	monstration payment adjustment amount before sequestration		0		16
	lowable bad debts (see instructions)		0		17
	ljusted reimbursable bad debts (see instructions)		0		17
	lowable bad debts for dual eligible beneficiaries (see instru	ctions)	0		18
	tal (see instructions)		0		19
	equestration adjustment (see instructions)		0		19
	emonstration payment adjustment amount after sequestration)		0		19
	equestration adjustment-PARHM pass-throughs		0		19
	iterim payments		0		20
1	iterim payments-PARHM		0		20
	entative settlement (for contractor use only)		0		21
	entative settlement (for contractor use only)		0		21
	lance due provider/program (line 19 minus lines 19.01, 20, an	d 21)	0		22
	lance due provider/program-PARHM (see instructions)	u 21)	0		22
	rotested amounts (nonallowable cost report items) in accordanc	e with CMS Pub 15-2	0		23
	apter 1, §115.2	e wi th cm3 rub. 13-2,	0		20
	ral Community Hospital Demonstration Project (§410A Demonstra	tion) Adjustment			
	this the first year of the current 5-year demonstration peri			2	200
	entury Cures Act? Enter "Y" for yes or "N" for no.				
	st Reimbursement				
1.00 Me	dicare swing-bed SNF inpatient routine service costs (from Wk	st. D-1, Pt. II, line		2	201
66	o (title XVIII hospital))				
2.00 Me	dicare swing-bed SNF inpatient ancillary service costs (from	Wkst. D-3, col. 3, lin	e	2	202
20	0 (title XVIII swing-bed SNF))				
3. 00 To	tal (sum of lines 201 and 202)				203
	dicare swing-bed SNF discharges (see instructions)				204
	mputation of Demonstration Target Amount Limitation (N/A in f	irst year of the curre	nt 5-year demonst	ration	
	ri od)				
	dicare swing-bed SNF target amount				205
	dicare swing-bed SNF inpatient routine cost cap (line 205 tim			2	206
	justment to Medicare Part A Swing-Bed SNF Inpatient Reimburse				
	ogram reimbursement under the §410A Demonstration (see instru				207
	dicare swing-bed SNF inpatient service costs (from Wkst. E-2,	col. 1, sum of lines	1	2	208
	ijustment to Medicare swing-bed SNF PPS payments (see instruct	ions)			209
	eserved for future use			2	210
	mparision of PPS versus Cost Reimbursement				<u>-</u>
), UULLO	otal adjustment to Medicare swing-bed SNF PPS payment (line 20 Istructions)	y prus rine 210) (see		2	215

ALCUL	ATION OF REIMBURSEMENT SETTLEMENT	Provider CCN: 15-1302	Period: From 01/01/2019 To 12/31/2019	Worksheet E-3 Part V Date/Time Pre 6/29/2020 8:0	pare
		Title XVIII	Hospi tal	Cost	0 8
				1.00	
~ ~	PART V - CALCULATION OF REIMBURSEMENT SETTLEMENT FOR MED	DICARE PART A SERVICES - COS	T REIMBURSEMENT		
00	Inpatient services			2, 034, 239	
00	Nursing and Allied Health Managed Care payment (see inst	(ructions)		0	
00	Organ acquisition			0	
. 00 . 00	Subtotal (sum of lines 1 through 3)			2, 034, 239	4
. 00	Primary payer payments Total cost (line 4 less line 5). For CAH (see instruction	anc)		2, 054, 581	6
. 00	COMPUTATION OF LESSER OF COST OR CHARGES	JIIS)		2,034,301	
	Reasonable charges				1
. 00	Routi ne servi ce charges			0	1 7
00	Ancillary service charges			0	
00	Organ acquisition charges, net of revenue			0	9
0. 00	Total reasonable charges			0	10
	Customary charges				1
1.00	Aggregate amount actually collected from patients liable	e for payment for services on	a charge basis	0	11
2.00	Amounts that would have been realized from patients liab	ole for payment for services	on a charge basis	0	12
	had such payment been made in accordance with 42 CFR 413	3. 13(e)	-		
3.00	Ratio of line 11 to line 12 (not to exceed 1.000000)			0.00000	
1.00	Total customary charges (see instructions)			0	
5.00	Excess of customary charges over reasonable cost (comple	ete only if line 14 exceeds l	ine 6) (see	0	15
	instructions)			_	
6.00	Excess of reasonable cost over customary charges (comple	ete only if line 6 exceeds li	ne 14) (see	0	16
7 00	instructions)	i potruoti opo)		0	17
7.00	Cost of physicians' services in a teaching hospital (see COMPUTATION OF REIMBURSEMENT SETTLEMENT	e instructions)		0	1 1
3. 00	Direct graduate medical education payments (from Workshe	$et E_4$ line 49)		0	1 18
9.00 9.00	Cost of covered services (sum of lines 6, 17 and 18)	Set L-4, THE 47)		2, 054, 581	
). 00	Deductibles (exclude professional component)			177, 320	
1.00	Excess reasonable cost (from line 16)			0	
2.00	Subtotal (line 19 minus line 20 and 21)			1, 877, 261	
3.00	Coinsurance			0	
4.00	Subtotal (line 22 minus line 23)			1, 877, 261	24
5.00	Allowable bad debts (exclude bad debts for professional	services) (see instructions)		28, 655	
5.00	Adjusted reimbursable bad debts (see instructions)			18, 626	26
7.00	Allowable bad debts for dual eligible beneficiaries (see	e instructions)		17, 249	27
3. 00	Subtotal (sum of lines 24 and 25, or line 26)			1, 895, 887	28
9.00	OTHER ADJUSTMENTS (SEE INSTRUCTIONS) (SPECIFY)			0	
9.50	Pioneer ACO demonstration payment adjustment (see instru	uctions)		0	29
9.99	Demonstration payment adjustment amount before sequestra	ation		0	
). 00	Subtotal (see instructions)			1, 895, 887	
0. 01	Sequestration adjustment (see instructions)			37, 918	
0. 02	Demonstration payment adjustment amount after sequestrat	tion		0	
0.03	Sequestration adjustment-PARHM				30
1.00	Interim payments			1, 611, 332	
1.01	Interim payments-PARHM			-	31
2.00	Tentative settlement (for contractor use only)			0	
2.01	Tentative settlement-PARHM (for contractor use only)	20.02.21.55.02		044 407	32
3.00	Balance due provider/program (line 30 minus lines 30.01,		and 22 01)	246, 637	
3.01	Balance due provider/program-PARHM (lines 2, 3, 18, and			E0 145	33
4.00	Protested amounts (nonallowable cost report items) in ac §115.2	cordance with CMS Pub. 15-2,	chapter I,	50, 145	34

	Financial Systems IU HEALTH BLACK E SHEET (If you are nonproprietary and do not maintain ype accounting records, complete the General Fund column	Provider C	F	Period: From 01/01/2019 Fo 12/31/2019	Worksheet G Date/Time Pre 6/29/2020 8:0	pare
		General Fund	Specific Purpose Fund	Endowment Fund	Plant Fund	
	CURRENT ASSETS	1.00	2.00	3.00	4.00	-
00	Cash on hand in banks	3, 615, 206	(0 0	0	1.
00	Temporary investments	0	(0 0	0	2
00	Notes receivable	0	(0 0	0	
00	Accounts receivable	1, 928, 080	(-	0	
00	Other receivable	-1, 020, 607	(-	0	
00 00	Allowances for uncollectible notes and accounts receivable	0		-	0	
00 00	Inventory Prepaid expenses	245, 169 67, 664		-	0	
00	Other current assets	07,004		- -	0	
. 00	Due from other funds	0		-	0	
	Total current assets (sum of lines 1-10)	4, 835, 512	(0	0	
	FI XED ASSETS					
00	Land	190, 324	(0 0	0	12
. 00	Land improvements	259, 436	(0	
00	Accumulated depreciation	-256, 050	(-	0	
00	Buildings	15,007,745		-	0	
. 00 . 00	Accumulated depreciation Leasehold improvements	-9, 338, 613		- -	0	
. 00	Accumul ated depreciation	0		- -	0	
	Fi xed equipment			-	0	
	Accumulated depreciation	0		- -	0	
	Automobiles and trucks	0	(0 0	0	
	Accumulated depreciation	0		0 0	0	22
. 00	Major movable equipment	4, 530, 274		0 0	0	23
	Accumulated depreciation	-3, 126, 305	(0 0	0	
	Minor equipment depreciable	0	(- -	0	
	Accumulated depreciation	0	(- -	0	
	HIT designated Assets	0		-	0	
	Accumulated depreciation Minor equipment-nondepreciable	0			0	
	Total fixed assets (sum of lines 12-29)	7, 266, 811			0	
. 00	OTHER ASSETS	7,200,011				
. 00	Investments	0	(0 0	0	31
. 00	Deposits on Leases	0	(0 0	0	32
. 00	Due from owners/officers	0	(0 0	0	33
	Other assets	0	(-	0	
	Total other assets (sum of lines 31-34)	0	(0	
. 00	Total assets (sum of lines 11, 30, and 35)	12, 102, 323	(0 0	0	36
. 00	CURRENT LI ABILITIES Accounts payable	316, 615	(0 0	0	37
. 00	Salaries, wages, and fees payable	474, 933			0	
	Payroll taxes payable	0			0	
	Notes and Loans payable (short term)	0		o o	0	
	Deferred income	0	(0 0	0	
. 00	Accelerated payments	0				42
. 00	Due to other funds	0	(-	0	
. 00	Other current liabilities	1, 835, 700		0 0	0	
. 00	Total current liabilities (sum of lines 37 thru 44)	2, 627, 248	(0 0	0	45
00	LONG TERM LIABILITIES	0		0 0	0	
. 00 . 00	Mortgage payable Notes payable	0			0	
. 00	Unsecured Loans			- -	0	
. 00	Other long term liabilities	18, 774		-	0	
. 00	Total long term liabilities (sum of lines 46 thru 49)	18, 774			0	
. 00	Total liabilities (sum of lines 45 and 50)	2, 646, 022	(0 0	0	51
	CAPI TAL ACCOUNTS					
00	General fund balance	9, 456, 301			l	52
00	Specific purpose fund		(53
. 00	Donor created - endowment fund balance - restricted			0		54
. 00	Donor created - endowment fund balance - unrestricted			0		55
. 00 . 00	Governing body created - endowment fund balance Plant fund balance - invested in plant			0	0	56 57
. 00	Plant fund balance - reserve for plant improvement,				0	
	replacement, and expansion				0	"
00	Total fund balances (sum of lines 52 thru 58)	9, 456, 301		0 0	0	59
. 00						

		U HEALTH BLACKF	ORD HOSPITAL			In Lie	In Lieu of Form CMS-2552-10				
STATEMENT OF CHANGES IN FUND BALANCES			Provider CC	er CCN: 15-1302 Period: From 01/01/207 To 12/31/207		om 01/01/2019					
		General	Fund	Speci al	Pur	pose Fund	Endowment Func				
		1.00	2.00	3,00		4.00	5.00				
$\begin{array}{c} 1.00\\ 2.00\\ 3.00\\ 4.00\\ 5.00\\ 6.00\\ 7.00\\ 8.00\\ 9.00\\ 10.00\\ 11.00\\ 12.00\\ 13.00\\ 14.00\\ 15.00\\ 16.00\\ 17.00\\ 18.00\\ 19.00\\ \end{array}$	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) ROUNDING Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) Deductions (debit adjustments) (specify) Total deductions (sum of lines 12-17) Fund balance at end of period per balance	0 1 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0 0	10, 924, 217 -1, 467, 917 9, 456, 300 19, 456, 301 9, 456, 301 0 9, 456, 301	5.00	0 0 0 0 0 0 0 0 0 0 0 0			$\begin{array}{c} 5.\ 00\\ 6.\ 00\\ 7.\ 00\\ 8.\ 00\\ 9.\ 00\\ 10.\ 00\\ 11.\ 00\\ 12.\ 00\\ 13.\ 00\\ 14.\ 00\\ 15.\ 00\\ 16.\ 00\\ \end{array}$			
	sheet (line 11 minus line 18)	Endowment Fund	PI ant	Fund							
		6.00	7.00	8.00							
1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00	Fund balances at beginning of period Net income (loss) (from Wkst. G-3, line 29) Total (sum of line 1 and line 2) Additions (credit adjustments) (specify) ROUNDING	0	0 0 0 0 0		0			1.00 2.00 3.00 4.00 5.00 6.00 7.00 8.00 9.00			
10. 00 11. 00 12. 00 13. 00 14. 00 15. 00 16. 00 17. 00 18. 00 19. 00	Total additions (sum of line 4-9) Subtotal (line 3 plus line 10) 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 0 0 0 0 0		0 0 0			10.00 11.00 12.00 13.00 14.00 15.00 16.00 17.00 18.00 19.00			

Health Financial Systems IU HEALTH BLACK STATEMENT OF PATIENT REVENUES AND OPERATING EXPENSES		Provider CCN: 15-1302		In Lie Period: From 01/01/2019 To 12/31/2019		Worksheet G-2 Parts I & II Date/Time Pre 6/29/2020 8:0	epared:	
	Cost Center Description		Inpati ent		Outpati ent	Total		
	· · · · · · · · · · · · · · · · · · ·		1.00		2.00	3.00		
	PART I – PATIENT REVENUES							
	General Inpatient Routine Services		r					
1.00	Hospi tal		2, 019, 1	66		2, 019, 166		
2.00	SUBPROVIDER - IPF						2.00	
3.00	SUBPROVIDER - IRF						3.00	
4.00	SUBPROVI DER						4.00	
5.00	Swing bed - SNF		847, 0	29		847, 029	5.00	
6.00	Swing bed - NF			0		0	6.00	
7.00	SKILLED NURSING FACILITY						7.00	
8.00	NURSING FACILITY						8.00	
9.00	OTHER LONG TERM CARE						9.00	
10.00	Total general inpatient care services (sum of lines 1-9)		2, 866, 1	95		2, 866, 195	10.00	
	Intensive Care Type Inpatient Hospital Services							
11.00	INTENSIVE CARE UNIT						11.00	
12.00	CORONARY CARE UNIT						12.00	
13.00	BURN INTENSIVE CARE UNIT						13.00	
14.00	SURGI CAL I NTENSI VE CARE UNI T						14.00	
15.00	OTHER SPECIAL CARE (SPECIFY)						15.00	
16.00	Total intensive care type inpatient hospital services (sum of	lines		0		0	16.00	
	11-15)							
17.00	Total inpatient routine care services (sum of lines 10 and 16)	2, 866, 1			2, 866, 195		
18.00	Ancillary services		3, 234, 5		19, 020, 973	22, 255, 530		
19.00	Outpatient services		168, 3		16, 733, 104	16, 901, 483		
	RURAL HEALTH CLINIC			0	0	0	20.00	
21.00	FEDERALLY QUALIFIED HEALTH CENTER			0	0	0	21.00	
	HOME HEALTH AGENCY						22.00	
23.00	AMBULANCE SERVICES						23.00	
24.00							24.00	
25.00	AMBULATORY SURGICAL CENTER (D. P.)						25.00	
26.00	HOSPICE			_			26.00	
27.00	PHYSI CI AN REVENUE			0	72, 177	72, 177	27.00	
28.00	Total patient revenues (sum of lines 17-27)(transfer column 3	to Wkst.	6, 269, 1	31	35, 826, 254	42, 095, 385	28.00	
	G-3, line 1)						-	
20.00	PART II - OPERATING EXPENSES				10 475 024		200.00	
29.00 30.00	Operating expenses (per Wkst. A, column 3, line 200)			0	18, 675, 824		29.00 30.00	
	ADD (SPECI FY)							
31.00				0			31.00	
32.00				0			32.00 33.00	
33.00				0				
34.00				0			34.00	
35.00	Total additions (sum of lines 20.25)			U	~		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)) (+£			10 (75 004		42.00	
43.00	Total operating expenses (sum of lines 29 and 36 minus line 4 to Wkst. G-3, line 4)	2) (transfer			18, 675, 824		43.00	

Heal th	Alth Financial Systems IU HEALTH BLACKFORD HOSPITAL			u of Form CMS-2552-10		
STATEM	TATEMENT OF REVENUES AND EXPENSES Provider CCN: 15-1302 Period:					
			From 01/01/2019 To 12/31/2019	Date/Time Pre	nared	
			10 12/31/2017	6/29/2020 8:00		
				1.00		
1.00	Total patient revenues (from Wkst. G-2, Part I, column 3, li			42, 095, 385	1.00	
2.00	Less contractual allowances and discounts on patients' accou	ints		25, 290, 274	2.00	
3.00	Net patient revenues (line 1 minus line 2)			16, 805, 111	3.00	
4.00	Less total operating expenses (from Wkst. G-2, Part II, line	e 43)		18, 675, 824		
5.00	Net income from service to patients (line 3 minus line 4)			-1, 870, 713	5.00	
	OTHER INCOME					
6.00	Contributions, donations, bequests, etc			0	6.00	
7.00	Income from investments			0	7.00	
8.00	Revenues from telephone and other miscellaneous communication	on services		0	8.00	
9.00	Revenue from television and radio service			0	9.00	
	Purchase di scounts			0	10.00	
	Rebates and refunds of expenses			0	11.00	
	Parking lot receipts			0	12.00	
	Revenue from laundry and linen service			0	13.00	
	Revenue from meals sold to employees and guests			0	14.00	
	Revenue from rental of living quarters			0	15.00	
16.00	Revenue from sale of medical and surgical supplies to other	than patients		0	16.00	
	Revenue from sale of drugs to other than patients			0	17.00	
	Revenue from sale of medical records and abstracts			0	18.00	
19.00	Tuition (fees, sale of textbooks, uniforms, etc.)			0	19.00	
20.00	Revenue from gifts, flowers, coffee shops, and canteen			0	20.00	
21.00	Rental of vending machines			0	21.00	
22.00	Rental of hospital space			0	22.00	
23.00	Governmental appropriations			0	23.00	
24.00	MI SCELLANEOUS I NCOME			402, 796	24.00	
25.00	Total other income (sum of lines 6-24)			402, 796	25.00	
26.00	Total (line 5 plus line 25)			-1, 467, 917	26.00	
27.00	OTHER EXPENSES (SPECIFY)			0	27.00	
28.00	Total other expenses (sum of line 27 and subscripts)			0	28.00	
29.00	Net income (or loss) for the period (line 26 minus line 28)			-1, 467, 917	29.00	